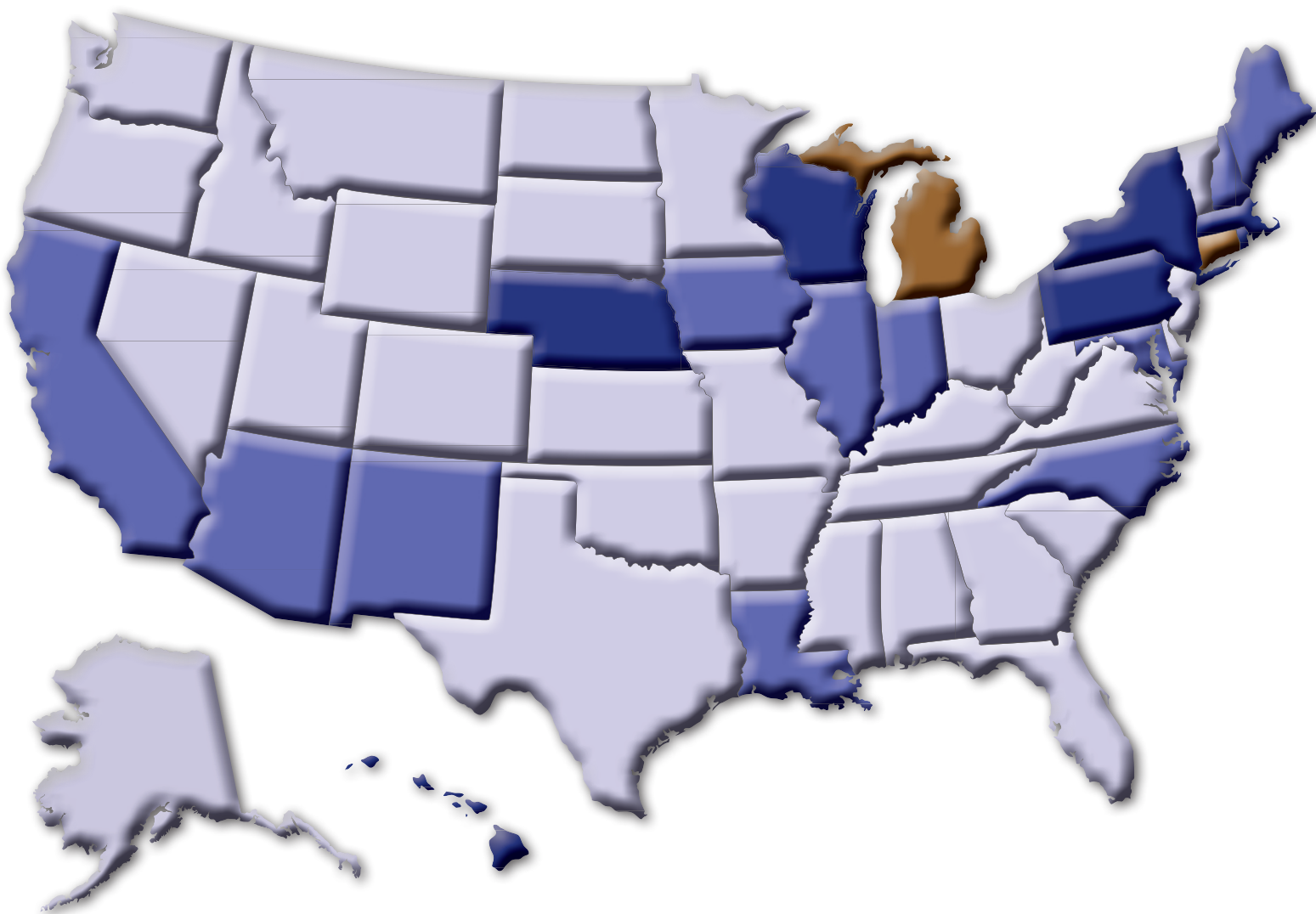


2008 National Summit

ON HIV DIAGNOSIS, PREVENTION AND ACCESS TO CARE

FINAL PROGRAM AND ABSTRACT BOOK



NOVEMBER 19-21, 2008 • ARLINGTON, VA

ABOUT THE COVER...

Title:

CURRENT STATUS OF LEGISLATION TO CHANGE HUMAN
IMMUNODEFICIENCY VIRUS TESTING LAWS IN THE UNITED STATES

Legend:

(lightest blue) No legislative restrictions at time of CDC recommendations (September 22, 2006)

(medium blue) Legislation enacted to reduce or eliminate prior restrictions

(darkest blue) Legislation introduced to remove requirement for a separate consent but not enacted or decision pending

(brown) Restrictive legislation at time of CDC recommendations and no subsequent proposal to change legislation

2008 National Summit

ON HIV DIAGNOSIS, PREVENTION AND ACCESS TO CARE

JOINT SPONSORSHIP:



PLATINUM LEVEL:



BRONZE LEVEL:



SUPPORTING LEVEL:



FRIEND:



ASSOCIATE:



SCIENTIFIC PLANNING COMMITTEE MEMBERS

CO-CHAIRS

John Bartlett, MD*
Professor of Medicine
Chief, Johns Hopkins AIDS Service
Johns Hopkins University School of Medicine
Baltimore, MD

Kenneth H. Mayer, MD*
Professor Medicine and Community Health
Brown University/Miriam Hospital
Medical Research Director
Fenway Community Health
Providence, RI

FACULTY

Judith Aberg, MD
Principal Investigator, AIDS Clinical Trials Unit
Director of HIV, Bellevue Hospital Center
New York University School of Medicine
New York, NY

Cornelius Baker
National Policy Advisor
National Black Gay Men's Advocacy Coalition
Washington, D.C.

Bernard M. Branson, MD*
Associate Director for Laboratory Diagnostics
National Center for HIV, Viral Hepatitis, STD, and TB Prevention
Center for Disease Control and Prevention
Atlanta, GA

Carol Brosgart, MD
Vice President, Public Health and Policy
Gilead Sciences, Inc.
Foster City, CA

Vicki Cargill MD MSCE
Director, Minority Health and Clinical Studies
Office of AIDS Research
National Institutes of Health
Washington, DC

Laura Cheever, MD, ScM
Chief Medical Officer
Deputy Associate Administrator
HIV/AIDS Bureau
Health Resources and Services Administration
Rockville, MD

Westley Clark, MD, JD, MPH, CAS, FASAM
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Myron Cohen, MD
J. Herbert Bate Distinguished Professor of Medicine
Microbiology and Immunology
Chief, Division of Infectious Diseases
Director, UNC Center for HIV/STDS and Infectious Diseases
University of North Carolina at Chapel Hill
Chapel Hill, NC

Carl Dieffenbach, PhD
Director, Division of AIDS
National Institute of Allergy and Infectious Diseases
National Institutes of Health
Bethesda, MD

Patricia J. Emmanuel, MD
Associate Professor of Pediatrics
Chief, Division of Infectious Disease
University of South Florida College of Medicine
Tampa, FL

Emily Erbeling, MD, MPH
Associate Professor of Medicine, Pediatrics and Epidemiology
Johns Hopkins University School of Medicine
Baltimore, MD

Judith Feinberg, MD
Professor of Medicine, Division of Infectious Diseases
Department of Internal Medicine
Director AIDS Clinical Trials Unit
Board of Directors, American Academy of HIV Medicine
University of Cincinnati College of Medicine
Cincinnati, OH

* Denotes Steering Committee

SCIENTIFIC PLANNING COMMITTEE MEMBERS

FACULTY CONT...

Kevin Fenton, MD, PhD, FFPH

Director
National Center for HIV/AIDS, Viral Hepatitis,
STD, and TB Prevention
Center for Disease Control and Prevention
Atlanta, GA

Donna Futterman, MD

Professor of Clinical Pediatrics
Albert Einstein College of Medicine
Director, Adolescent AIDS Program
Children's Hospital at Montefiore
Bronx, NY

Michael Horberg, MD, MAS

Director of HIV/AIDS Policy
Quality Improvement & Research Committee for HIV/AIDS
Kaiser Permanente
Oakland, CA

Shannon Hader, MD, MPH

Sr. Deputy Director of the HIV/AIDS Administration
District of Columbia Department of Health
Washington, D.C.

David Kern

Director
Strategic Initiatives
National Alliance of State and Territorial AIDS Directors
Washington, D.C.

Christine Lubinski

Vice President for Global Health
International Diseases Society for America
Arlington, VA

Kathy McNamara, RN

Assistant Director
Clinical Affairs
National Association of Community Health Centers, Inc.
Bethesda, MD

Veronica Miller, PhD

Director, Forum for Collaborative HIV Research
Research Professor
Department of Prevention & Community Health
George Washington University
Washington, D.C.

David Ernesto Munar

Associate Director for Policy and Communications
AIDS Foundation of Chicago
Chicago, IL

Israel Nieves-Rivera

Director, Policy Unit
HIV Prevention Section
San Francisco Department of Public Health
San Francisco, CA

Roger Pomerantz, MD, FACP

President
Tibotec, Inc.
Yardley, PA

Richard Rothman, MD, PhD, FACEP

Associate Professor, Director EM Residency
and Research Fellowship Program
Departments of Emergency Medicine and Infectious Disease
Johns Hopkins University
Baltimore, MD

Monica S. Ruiz, PhD, MPH

Director, HIV Prevention Research
Forum for Collaborative HIV Research
George Washington University
Washington, D.C.

Michael S. Saag, MD

Professor of Medicine
Jim Straley Chair in AIDS Research
Director, Division of Infectious Diseases and The William C.
Gorgas Center for Geographic Medicine
Director, Center for AIDS Research
University of Alabama at Birmingham
Birmingham, AL

* Denotes Steering Committee

SCIENTIFIC PLANNING COMMITTEE MEMBERS

FACULTY CONT...

Daniel Seekins, MD

Group Director, HIV Medical Strategy, USMA
Bristol Myers Squibb
Plainsboro, NJ

Valerie E. Stone, MD, MPH

Director, Primary Care Residency Program
Massachusetts General Hospital
Professor of Medicine
Harvard University
Boston, MA

Monica Sweeney, MD, MPH, FACP

Vice President, Medical Affairs
Bedford Stuyvesant Family Health Center, Inc.
New York City Department of Health
Brooklyn, NY

Donna Sweet, MD

Professor of Internal Medicine
University of Kansas School of Medicine
Wichita, KS

Ronald Valdiserri, MD, MPH

Chief Consultant
Public Health Group
U.S. Department of Veterans Affairs
Washington, D.C.

Rochelle Walensky, MD, MPH

Associate Professor of Medicine
Harvard Medical School
Massachusetts General Hospital
Brigham and Women's Hospital
Boston, MA

* Denotes Steering Committee

2008 National Summit

ON HIV DIAGNOSIS, PREVENTION AND ACCESS TO CARE

SUMMIT PROGRAM

WEDNESDAY, NOVEMBER 19, 2008

4:00 PM	REGISTRATION	Ballroom Level
6:00 PM	WELCOME RECEPTION	Regency Ballroom C
7:00 PM	WELCOME DINNER	Regency Ballroom C

THURSDAY, NOVEMBER 20, 2008

7:00 AM	REGISTRATION BREAKFAST	Ballroom Level Independence Center A
8:00 AM	WELCOME ADDRESSES FORUM WELCOME: Veronica Miller, PhD, <i>Forum for Collaborative HIV Research</i> CO-CHAIRS WELCOME: John Bartlett, MD, <i>Johns Hopkins University</i> Kenneth Mayer, MD, <i>Brown University</i> OFFICIAL WELCOME: Pierre Vigilance, MD, MPH, <i>District of Columbia Department of Health</i>	Regency Ballroom E
8:30 AM	UPDATES UPDATE ON HIV/AIDS EPIDEMIOLOGY IN THE UNITED STATES Kevin Fenton, MD, PhD, FFPH, <i>Centers for Disease Control and Prevention</i> OVERVIEW OF ROUTINE/EXPANDED HIV TESTING IN THE US Bernard Branson, MD, <i>Centers for Disease Control and Prevention</i> RESPONSE TO UPDATE: UNMET NEEDS & BARRIERS Donna Futterman, MD, <i>Adolescent AIDS Program, Montefiore Medical Center</i> Jesse Milan, Jr., JD, <i>Altarum Institute</i> SPECIAL GUEST SPEAKER TBA	Regency Ballroom E
10:00 AM	ADDRESSING THE EPIDEMIC: FROM PLANNING TO PRACTICE LOCAL APPROACHES TO FIGHTING HIV/AIDS Moderator: Monica S. Ruiz, PhD, MPH, <i>Forum for Collaborative HIV Research</i> Shannon Hader, MD, MPH, <i>District of Columbia Department of Health</i> Jane Cheeks, JD, MPH, <i>Alabama Division of HIV/AIDS Prevention & Control</i> Daniela Torres, <i>Alameda County Public Health Department, Office of AIDS Administration</i>	Regency Ballroom E
10:40 AM	COFFEE BREAK	
11:00 AM	TRACKS A. ROUTINE/EXPANDED HIV TESTING MODELS AND SYSTEMS DEVELOPMENTPotomac 6 B. PREVENTION MODELS IN THE SETTING OF ROUTINE OR EXPANDED HIV TESTINGPotomac 4 C. OUTCOMES AND IMPACT EVALUATION OF HIV TESTING ACTIVITIESWashington A D. ACCESS TO AND RETENTION IN CARE AS A PART OF ROUTINE/EXPANDED TESTINGWashington B	
12:00 PM	LUNCH	Independence Center A
1:00 PM	TRACKS A. ROUTINE/EXPANDED HIV TESTING MODELS AND SYSTEMS DEVELOPMENTPotomac 6 B. PREVENTION MODELS IN THE SETTING OF ROUTINE OR EXPANDED HIV TESTINGPotomac 4 C. OUTCOMES AND IMPACT EVALUATION OF HIV TESTING ACTIVITIESWashington A D. ACCESS TO AND RETENTION IN CARE AS A PART OF ROUTINE/EXPANDED TESTINGWashington B	
5:30 PM	POSTER RECEPTION	Independence Center B
7:30 PM	DINNER	Regency Ballroom E

FRIDAY, NOVEMBER 21, 2008

7:00 AM	REGISTRATION BREAKFAST	Ballroom Level Independence Center A
8:00 AM	TRACK FEEDBACK & DISCUSSION Moderator: Kenneth Mayer, MD, <i>Brown University</i>	Regency Ballroom E
9:00 AM	TESTING, SEROSTATUS KNOWLEDGE, AND IMPLICATIONS FOR PREVENTION Gary Marks, PhD, <i>Centers of Disease Control and Prevention</i>	Regency Ballroom E
9:30 AM	WHO PAYS FOR HIV TESTING? Moderator: Monica Sweeney, MD, MPH, FACP, <i>New York City Department of Health and Mental Hygiene</i> Speakers: Marsha Martin, DSW, <i>Get Screened Oakland</i> Carl Schmid, MBA, <i>The AIDS Institute</i>	Regency Ballroom E
10:00 AM	COFFEE BREAK	
10:15 AM	PANEL DISCUSSION: WHEN TO START HIV TREATMENT? Moderator: John Bartlett, MD, <i>Johns Hopkins University</i> Presenter: Fred Gordin, MD, <i>Veterans Affairs Medical Center</i> Veronica Miller, PhD, <i>Forum for Collaborative HIV Research</i> Frank Oldham Jr., <i>The National Association of People Living with AIDS</i> Discussants: Rochelle Walensky, MD, MPH, <i>Harvard University</i> Myron Cohen, MD, <i>University of North Carolina School of Medicine</i>	Regency Ballroom E
11:00 AM	PANEL DISCUSSION LINKING TESTING TO CARE: WHERE DO WE GO FROM HERE? Moderator: John Bartlett, MD, <i>Johns Hopkins University</i> Panelists: Kevin Fenton, MD, PhD, FFPH, <i>Centers for Disease Control and Prevention</i> Deborah Parham Hopson, PhD, RN, <i>Health Resources and Services Administration, HIV/AIDS Bureau</i> Carl Dieffenbach, PhD, <i>National Institutes of Health</i>	Regency Ballroom E
11:30 AM	PANEL DISCUSSION THE HIV CARE WORKFORCE: WHERE DO WE GO FROM HERE? Moderator: Michael Saag, MD, <i>University of Alabama</i> Panelists: Arlene Bardequez, MD, MPH, FACOG, <i>HIV Medicine Association</i> Laura Cheever, MD, ScM, <i>Health Resources and Services Administration, HIV/AIDS Bureau</i> Judith Feinberg, MD, <i>American Academy of HIV Medicine</i>	Regency Ballroom E
12:00 PM	INCREASING IMPLEMENTATION OF ROUTINE HIV TESTING: PROPOSAL FOR A NATIONAL PLAN OF ACTION Moderator: Veronica Miller, PhD, <i>Forum for Collaborative HIV Research</i> Speakers: Christine Lubinski, <i>HIV Medicine Association/IDSA</i> David Ernesto Munar, <i>AIDS Foundation of Chicago</i>	Regency Ballroom E
12:20 PM	CLOSING COMMENTS FORUM: Veronica Miller, PhD, <i>Forum for Collaborative HIV Research</i> CO-CHAIRS: John Bartlett, MD, <i>Johns Hopkins University</i> Kenneth Mayer, MD, <i>Brown University</i>	Regency Ballroom E
12:30 PM	LUNCH	Independence Center A

TRACK A - ROUTINE/EXPANDED HIV TESTING MODELS AND SYSTEMS DEVELOPMENT

The objectives of this track are to highlight the state of the art in implementation of routine HIV testing in a variety of health care settings, as well as examine the continued barriers and challenges to implementation.

Chairs: Judith Aberg, MD, *New York University School of Medicine / Bellevue Hospital Center*
Richard Rothman, MD, PhD, FACEP, *Johns Hopkins University*

11:00 AM - 12:00 PM

SESSION 1: UPDATE ON NEW HIV DIAGNOSTIC TECHNOLOGIES

The goal of this session is to provide information on the latest developments in HIV diagnostic testing technologies.

Moderator: Peter Leone, MD, *North Carolina Health Department*

Presenter: Bernard Branson, MD, *Centers for Disease Control and Prevention*

1:00 PM - 2:00 PM

SESSION 2: ADDRESSING POLICY CHANGES: LESSONS LEARNED

The goal of this session is to examine how current federal, state, and local policies may facilitate or impede the implementation of routine HIV testing. Each panelist will be asked to present their experience or perspectives from their programmatic area. This will be followed by a moderated discussion.

Moderator: Rob Janssen, MD, *Gilead*

Panelists: Bebe Anderson, JD, *Lambda Legal*

Christopher Bates, MPA, *US Department of Health and Human Services, Office of HIV/AIDS Policy*

Ann Hilton Fisher, JD, *AIDS Legal Council of Chicago*

Heather Hauck, MSW, LICSW, *Maryland Department of Health and Mental Hygiene, AIDS Administration*

2:00 PM - 3:00 PM

SESSION 3: IMPLEMENTATION OF ROUTINE TESTING: STATE, CITY AND DOH INITIATIVES

The goal of this session is to discuss what happens when a city and/or DOH implements routine HIV testing. This includes discussions of the new interactions that are created and the new partnerships that are formed with different community stakeholders.

Moderator: Henry Masur, MD, *Critical Care Medicine Department*

Panelists: Judith Aberg, MD, *New York University School of Medicine / Bellevue Hospital Center*

Judy Auerbach, PhD, *San Francisco AIDS Foundation*

Thomas Bendle, *Florida Department of Health*

Marsha Martin, DSW, *Get Screened Oakland*

3:00 PM - 4:00 PM

SESSION 4: IMPLEMENTATION OF ROUTINE TESTING: TRADITIONAL AND NON-TRADITIONAL CLINICAL SETTING

The goal of this session is to highlight the case studies of and lessons learned from care settings that have implemented routine HIV testing.

Each panelist will give a short presentational highlighting key characteristics, issues, barriers, facilitators for their program, followed by general discussion.

Moderator: Richard Rothman, MD, PhD, FACEP, *Johns Hopkins University*

Panelists: Erika Aaron, MSN, CRNP, *Drexel University College of Medicine*

Curt Beckwith, MD, *Warren Alpert Medical School, Brown University*

Jeremy Brown, MD, *The George Washington University Medical Center*

Jason Leider, MD, PhD, *Jacobi Medical Center*

Celia Maxwell, MD, FACP, *Howard University - Women's Health Institute*

Kathy McNamara, RN, *National Association of Community Health Centers, Inc.*

Amy Nunn, ScD, *Brown University Medical School Division of Infectious Diseases*

4:00 PM - 5:00 PM

SESSION 5: IMPLEMENTATION OF ROUTINE TESTING: NON-CLINICAL SETTINGS

The goal of this session is to examine the complexities of identifying and then providing HIV testing in non-clinical settings.

Moderator: Judith Aberg, MD, *New York University School of Medicine / Bellevue Hospital Center*

Panelists: Demetre Daskalakis, MD, *New York University School of Medicine*

Jean Redmann, *NO/AIDS Task Force*

Nestor Rocha, MPH, *District of Columbia Department of Health*

Benjamin Tsoi, MD, MPH, *New York City Department of Health and Mental Hygiene*

TRACK B - PREVENTION MODELS IN THE SETTING OF ROUTINE OR EXPANDED HIV TESTING

The objective of this track is to examine the ways in which routine HIV testing can be more effectively linked to HIV prevention, both for uninfected and infected persons.

Chairs: Kenneth Mayer, MD, *Brown University*
Ronald Valdiserri, MD, MPH, *US Department of Veterans Affairs*

11:00 AM - 12:00 PM

SESSION 1: PREVENTION FOR POSITIVES: LINKING INFECTED PERSONS TO HIV PREVENTION SERVICES

The goal of this session is to discuss the ways in which persons who test HIV positive during routine screening (and through other non-routine screening processes) can be linked to HIV prevention counseling and services as a component of care.

Moderator: Frank Oldham Jr., *The National Association of People Living with AIDS*

SUBSTANCE ABUSE AND RISK BEHAVIOR AMONG HIV-INFECTED PERSONS: IMPLICATIONS FOR INTERVENTIONS

David Purcell, JD, PhD, *Centers for Disease Control and Prevention*

INTERVENTIONS FOR DEPRESSION, STRESS MANAGEMENT, AND ENGAGEMENT IN CARE FOR HIV-INFECTED PERSONS

Steve Safren, PhD, *MGH/Harvard and Fenway Community Health*

EVALUATING THE HRSA SPNS PROJECTS ON PEER- AND CLINICIAN-DELIVERED INTERVENTIONS FOR HIV-POSITIVE PATIENTS IN CLINICAL CARE

Janet Myers, PhD, MPH, *University of California*

DISCUSSION/Q&A

1:00 PM - 2:00 PM

SESSION 2: "YOU HAVE 3 MINUTES": RECONFIGURING HIV PREVENTION MESSAGES AND INTERVENTIONS FOR THE ROUTINE TESTING CONTEXT

The goal of this session is to examine ways in which HIV prevention messaging and abbreviated counseling can be incorporated into testing contexts that do not allow for extended client-provider discussion.

Moderator: Ronald Valdiserri, MD, MPH, *US Department of Veterans Affairs*

COMPUTER TOOL FOR ROUTINE RAPID HIV COUNSELING AND TESTING IN EMERGENCY CARE SETTINGS

Freya Spielberg, MD, MPH, *Research Triangle Institute International/University of California San Francisco*

VIDEO-DELIVERED RAPID HIV PRE-TEST INFORMATION TO STREAMLINE HIV TESTING

Roland Merchant, MD, MPH, ScD, *Warren Alpert Medical School at Brown University*

PROGRAM BRIEF: A 32-MONTH ANALYSIS OF A HIGH VOLUME RAPID HIV TESTING MULTIMEDIA MODEL

Yvette Calderon, MD, *Jacobi Medical Center*

DISCUSSION/Q&A

2:00 PM - 3:00 PM

SESSION 3: ADDRESSING THE NEED FOR HIV PREVENTION PROGRAMS FOR PRIORITIZED COMMUNITIES

The goal of this session is to discuss ways in which current and future HIV prevention efforts can better address the needs of communities that are at greatest risk of infection (e.g., MSM of color, women of color, etc.).

Moderator: Monica S. Ruiz, PhD, MPH, *Forum for Collaborative HIV Research*

HIV PREVENTION NEEDS OF MSM OF COLOR

Gregorio Millett, MPH, *Centers for Disease Control and Prevention*

HIV PREVENTION NEEDS OF WOMEN OF COLOR

Sally Hodder, MD, *University of Medicine and Dentistry of New Jersey*

HIV PREVENTION NEEDS OF SUBSTANCE USING MSM

Ron Stall, PhD, MPH, *University of Pittsburgh*

HIV PREVENTION NEEDS OF CORRECTIONAL POPULATIONS

Barry Zack, MPH, *The Bridging Group, LLC*

DISCUSSION/Q&A

TRACK B - PREVENTION MODELS IN THE SETTING OF ROUTINE OR EXPANDED HIV TESTING CONT...

3:00 PM - 4:00 PM

SESSION 4: EXAMINING NON-TRADITIONAL METHODS FOR REDUCING THE RATE OF NEW INFECTIONS: PANEL DISCUSSIONS ABOUT THE IMPACT OF SEROSORTING AND THE USE OF ART TO LOWER COMMUNITY VIRAL LOAD

The goal of this session is to discuss how two non-traditional prevention strategies -- serosorting and ART use -- are being viewed by some as strategies that should be employed to reduce the rates of new infections in the US.

Moderator: Kenneth Mayer, MD, *Brown University*

THE ROLE OF ANTIRETROVIRAL THERAPY IN PREVENTING HIV TRANSMISSION

Myron Cohen, MD, *University of North Carolina School of Medicine*

HIV DIAGNOSIS AND STI CONTROL: WHAT IS THE IMPACT OF INCREASING AWARENESS OF HIV SEROSTATUS IN THE CONTEXT OF UNDIAGNOSED AND UNTREATED STIs?

William McFarland, MD, PhD, *San Francisco Department of Health*

COMMUNITY PERCEPTIONS ABOUT ART AS PREVENTION, SEROSORTING, STRATEGIC POSITIONING, AND DISCLOSURE AND HOW THESE AFFECT RISK BEHAVIOR

Richard Wolitski, PhD, *Centers for Disease Control and Prevention*

DISCUSSION/Q&A

4:00 PM - 5:00 PM

SESSION 5: SOCIAL MARKETING FOR HIV TESTING AND PREVENTION

The goal of this session is to examine how social marketing strategies can be used to encourage uptake of HIV testing as well as promote HIV prevention/risk-reduction behaviors.

Moderator: W. Douglas Evans, PhD, *George Washington University School of Public Health and Health Services*

SO YOU THINK YOU'RE SAFE? INCREASING AWARENESS FOR HIV RISK AMONG WOMEN AT A FAMILY PLANNING CLINIC

Carmen Zorilla, MD, *CHAC/University of Puerto Rico School of Medicine*

OPERATION SWEET TOOTH: EFFECTIVE USE OF SOCIAL MARKETING CAMPAIGNS IN NON-TRADITIONAL SOCIAL SETTINGS

Terence McPhaul, MA, NCSC, *National AIDS Education & Services for Minorities*

FROM PALMCARDS TO PSAs AND BEYOND: THE ROLE OF MEDIA IN MAKING HIV SCREENING A NEW COMMUNITY NORM

Abby Ginzberg, *Ginzberg Productions*

DISCUSSION/Q&A

TRACK C - OUTCOMES AND IMPACT EVALUATION OF HIV TESTING

ACTIVITIES

The objectives of this track are to examine the evidence pertaining to how effectively routine HIV testing is being implemented, as well as the impact testing is having on linking infected individuals to HIV care.

Chairs: Michael Horberg, MD, MAS, Kaiser Permanente
Roger Pomerantz, MD, FACP, Tibotec

11:00 AM - 12:00 PM

SESSION 1: WHAT WE KNOW AND WHAT WE DON'T KNOW ABOUT THE EFFECTIVENESS OF IMPLEMENTING ROUTINE HIV TESTING

The goal of this session is to examine the metrics of routine/expanded HIV testing, both in terms of the data we currently have (e.g., number of tests offered, number of tests accepted, acceptability of routine testing, number of persons diagnosed, number of persons referred, etc.) as well as the gaps in current knowledge.

Moderator: Michael Horberg, MD, MAS, Kaiser Permanente

RATES OF HIV TESTING IN THE US SINCE THE 2006 RECOMMENDATIONS: METRICS FOR DIFFERENT SITES AND VENUES

Denise Duran, MPH, Centers for Disease Control and Prevention

HRSA PERSPECTIVE

Faye Malitz, MS, Health Resources and Services Administration

PRIVATE SECTOR PERSPECTIVE

Michael Horberg, MD, MAS, Kaiser Permanente

DISCUSSION/Q&A

1:00 PM - 2:00 PM

SESSION 2: ROUTINE TESTING AND ACCESS TO CARE: INDIVIDUAL AND SYSTEMS-LEVEL METRICS

The session of this question is to examine whether or not routine testing is having an impact on infected persons accessing care sooner.

Moderator: Daniel Seekins, MD, Bristol-Myers Squibb

MEASURING IMPACT OF ROUTINE TESTING ON DISEASE STAGE AT TIME OF ENTRY INTO CARE

Elena Losina, PhD, Brigham and Women's Hospital

THE POTENTIAL FOR ROUTINE TESTING TO REDUCE THE RACIAL/ETHNIC DISPARITIES ASSOCIATED WITH LATE ENTRY INTO CARE

Victoria Cargill, MD, MSCE, Office of AIDS Research/National Institutes of Health

DISCUSSION/Q&A

2:00 PM - 3:00 PM

SESSION 3: PANEL DISCUSSION OF IMPLEMENTATION METRICS AND COSTS

The goal of this session is to examine and compare implementation and evaluation metrics and costs from different federal agencies and professional organizations.

Moderator: Deborah Cotton, MD, MPH, The Clinton Foundation

COST OF FINDING ONE NEWLY DIAGNOSED HIV CASE IN NEW YORK CITY

Benjamin Tsoi, MD, MPH, New York City Department of Health and Mental Hygiene

USING CAPACITY BUILDING MODELS TO ESTIMATE ORGANIZATIONAL COSTS OF HIV CARE WITHIN THE UNITED STATES

DEPARTMENT OF VETERANS' AFFAIRS

Henry Anaya, PhD, MS, US Department of Veteran's Affairs

COST EFFECTIVENESS OF ROUTINE OPT-OUT RAPID HIV SCREENING IN THE EMERGENCY DEPARTMENT: RESULTS FROM AN ONGOING PROSPECTIVE CLINICAL TRIAL

Jason Haukoos, MD, MSc, Denver Health Medical Center

DISCUSSION/Q&A

TRACK C - OUTCOMES AND IMPACT EVALUATION OF HIV TESTING ACTIVITIES CONT...

3:00 PM - 4:00 PM

SESSION 4: WHO ARE THE REMAINING 25%: IDENTIFYING THOSE WITH UNDIAGNOSED HIV INFECTION

The goal of this session is to examine and discuss the ways in which undiagnosed, HIV-infected persons in the community could be reached, encouraged to receive testing, and brought into care.

Moderator: Carl Dieffenbach, PhD, *National Institutes of Health*

LOOKING BEHIND THE BARRIER: WHAT WE KNOW ABOUT UNDIAGNOSED, HIV-INFECTED POPULATIONS

Elizabeth DiNenno, PhD, *Centers for Disease Control and Prevention*

REACHING THE UNDIAGNOSED IN THE SOUTH

Cheryl Modica, PhD, *National Association of Community Health Centers, Inc.*

IDENTIFYING THE UNDIAGNOSED IN SOUTH CAROLINA

Wayne Duffus, MD, PhD, *South Carolina Department of Health and Environmental Control*

DISCUSSION/Q&A

4:00 PM - 5:00 PM

SESSION 5: UNINTENDED AND UNANTICIPATED SOCIAL OUTCOMES ASSOCIATED WITH HIV TESTING

The goal of this session is to examine the various unintended negative personal, interpersonal, and social sequelae of HIV testing, as well as what providers and others in the health care community can do to prevent and minimize such outcomes.

Moderator: Kevin Fenton, MD, PhD, FFPH, *Centers for Disease Control and Prevention*

HOW DO WE KNOW WHAT WE KNOW? MEASURING THE UNINTENDED CONSEQUENCES OF HIV TESTING - PROGRAM PERSPECTIVE

Israel Nieves-Rivera, *Urban Coalition of HIV Prevention Services*

HOW DO WE KNOW WHAT WE KNOW? MEASURING THE UNINTENDED CONSEQUENCES OF HIV TESTING - COMMUNITY PERSPECTIVE

Kali Lindsey, *National Association of People with AIDS*

HIV DIAGNOSIS IN PEDIATRIC AND ADOLESCENT POPULATIONS

Natella Rakhmanina, MD, FAAP, AAHIVS, *Children's National Medical Center*

DISCUSSION/Q&A

TRACK D - ACCESS TO AND RETENTION IN CARE AS A PART OF ROUTINE/EXPANDED TREATMENT

The objectives of this track are to examine the ways in which routine HIV testing can be more effectively linked to HIV care, as well as to examine the challenges inherent in providing HIV care in the US.

Chairs: John Bartlett, MD, *Johns Hopkins University*
Michael Saag, MD, *University of Alabama*

11:00 AM - 12:00 PM

SESSION 1: FINANCING TESTING, CARE, AND RETENTION IN CARE

The goal of this session is to address current challenges in providing care in the context of low reimbursements and flat Ryan White funding.

Moderator: Christine Lubinski, *HIV Medicine Association/Infectious Diseases Society of America*

OVERVIEW OF PUBLIC SECTOR FINANCING

John Bartlett, MD, *Johns Hopkins University*

OVERVIEW OF PRIVATE SECTOR FINANCING

David Mosen, MD, MPH, *Kaiser Permanente Center*

HIDDEN COSTS OF CARE

Michael Saag, MD, *University of Alabama*

DISCUSSION/Q&A

1:00 PM - 2:00 PM

SESSION 2: LATE ENTRY INTO CARE; RETENTION IN CARE: CURRENT FINDINGS AND IMPLICATIONS

The goal of this session is to review and discuss changing trends of the stage of immunodeficiency at entry into care, the implications for survival, the challenges this provides for treatment programs and workforce.

Moderator: John Bartlett, MD, *Johns Hopkins University*

WHO IS SHOWING UP LATE INTO CARE?

John Bartlett, MD, *Johns Hopkins University*

INNOVATIVE PROGRAMS FOR RETENTION IN CARE?

Sally Hodder, MD, *University of Medicine and Dentistry of New Jersey*

BARRIERS TO RETENTION IN CARE

Michael Mugavero, MD, *University of Alabama at Birmingham*

DISCUSSION/Q&A

2:00 PM - 3:30 PM

SESSION 3: WORKFORCE NEEDS AND CHALLENGES IN DELIVERY OF HIV CARE

The goal of this session is to examine the various issues having an impact on the growth and sustainability of the HIV care workforce.

Moderator: Michael Saag, MD, *University of Alabama at Birmingham*

HIVMA-FCHR SURVEY ON WORKFORCE NEEDS

Andrea Weddle, MSW, *HIV Medicine Association*

TREATMENT EFFECTIVENESS: HOW MANY PEOPLE ARE FAILING TREATMENT? WHAT ARE THE PROJECTIONS?

Veronica Miller, PhD, *Forum for Collaborative HIV Research*

OPTIMAL PROVIDER TO PATIENT RATIOS

Michael Saag, MD, *University of Alabama at Birmingham*

DISCUSSION/Q&A

3:30 PM - 5:00 PM

SESSION 4: LINKING TESTING TO CARE; RETENTION IN CARE IN VARIOUS SETTINGS

The goal of this session is to examine how linkages to care can be facilitated and improved for persons who are diagnosed with HIV infection through routine testing in non-traditional, non-clinical settings.

Moderator: Joseph Bick, MD, *California Department of Corrections and Rehabilitation*

LINKAGES TO CARE FOR THE DISTRICT OF COLUMBIA'S MOST VULNERABLE POPULATIONS

Michael Kharfen, *District of Columbia Department of Health, HIV/AIDS Administration*

CHALLENGES ASSOCIATED WITH LINKING HIV-INFECTED INMATES WITH POST-RELEASE CARE AND SERVICES

Josiah Rich, MD, MPH, *Brown University*

OUTREACH ACTIVITIES BY THE NATIONAL MEDICAL ASSOCIATION

Wilbert Jordan, MD, *Oasis Clinic*

DISCUSSION/Q&A

Abstracts

page	session	title and author	abstract	poster
21		ROUTINE/EXPANDED HIV TESTING MODELS AND SYSTEMS DEVELOPMENT		
22		Implementing Routine HIV Testing in the Emergency Department of an Urban University Hospital <i>E Aaron</i>	101	
22		Providing Rapid HIV Testing in a Non-medical Setting: In-home Testing of Pregnant Women and Their Families <i>E Aaron</i>	102	
23		Successful Integration of Rapid HIV Screening into an Urban Women's Care Specialty Clinic <i>E Aaron</i>	103	
24		Integration of HIV Testing within Routine Care in a Large Public Hospital System <i>J Aberg</i>	104	
24		Building Organizational Capacity and Innovation to Address Acute HIV Infection in San Francisco Through Expanded Outreach and Testing <i>JD Auerbach</i>	105	
25		Magnet/SFAF: Rapid HIV Antibody and Viral RNA Testing for Gay Men in San Francisco <i>S Gibson</i>	106	
26		State-level Policy Change to Address Systemic Barriers to Expanding HIV Testing <i>C Mulhern-Pearson</i>	107	
27		Implementation of a Jail-based Rapid HIV Testing Pilot Program <i>CG Beckwith</i>	108	
27		Expanded HIV Testing in Medical Settings in Florida: Challenges and Successes <i>T Bendle</i>	109	
28		Synergizing HIV/AIDS and Hepatitis B Programs to Increase Access in Hard-to-Reach Populations <i>C Bermudez</i>	110	
29		Efforts to Increase HIV Testing in a Large HMO in Washington, DC <i>SJ Bersoff-Matcha</i>	111	
30		HIV Rapid Testing in the ER: Willingness to Participate <i>J Burrage, Jr.</i>	112	
30		HIV Screening Among Privately Insured Members at High Risk of Acquiring HIV Infection <i>J Chen</i>	113	

page	session	title and author	abstract	poster
31		Prenatal HIV Screening Among Privately Insured Women: Association with Regional AIDS Prevalence and Incidence <i>J Chen</i>	114	
32		Bellevue/New York University (NYU) Langone Medical Center Men's Sexual Health Project (MSHP): A Collaborative HIV and Sexually Transmitted Infection (STI) Testing Strategy Targeting Highly Sexually Active Men Who Have Sex with Men (MSM) in New York City (NYC) <i>D Daskalakis</i>	115	
32		Interviewing Late Testers to Identify Barriers to Early HIV Diagnosis <i>JW Dilley</i>	116	
33		Qualitative Assessment of Implementing Routine Rapid HIV Testing <i>JE Feld</i>	117	
34		ACTS (Advise, Consent, Test, Support): A Successful Model for Routinizing HIV Testing in Clinical and Community Settings Using Existing Resources <i>D Futterman</i>	118	
35		Feasibility, Acceptability and Accuracy of Patient Self-testing for HIV using Point-of-care (POC) HIV Tests in an Emergency Department Setting <i>CA Gaydos</i>	119	
36		<i>Blocks</i> : An Innovative Community-Based, Block-by-Block Approach to Rapid HIV Testing in New York City <i>S Gillen</i>	120	
37		Evaluation of Readiness to Implement HIV Rapid Testing in SUD Clinics <i>JF Golden</i>	121	
37		Impact of the 2006 CDC HIV Testing Recommendations on State HIV Testing Laws <i>RH Goldschmidt</i>	122	
38		Increasing HIV Testing Rates by Obstetrician-gynecologists among Non-pregnant Women and Adolescents and the Number of HIV-infected Women Who Know that they are Infected <i>D Hawks</i>	123	
39		Emergency Medicine Resident Attitudes and Perceptions of HIV Testing Before and After an Educational Program and Testing Implementation <i>Y-H Hsieh</i>	124	
40		HIV Testing Practices and Diffusion of 2006 CDC HIV Testing Recommendations among New York City Internal Medicine Residents <i>CL Jain</i>	125	

<i>page</i>	<i>session</i>	<i>title and author</i>	<i>abstract</i>	<i>poster</i>
40		Initiation of Point-of-service HIV Testing in Sexually Transmitted Disease Clinics <i>J Jones</i>	126	
41		Routine Point-of-care Rapid HIV Testing of Medicine Service Admissions in the Emergency Department <i>R Lubelchek</i>	127	
42		Citywide HIV Screening Initiative as a Municipal Response to HIV <i>M Martin</i>	128	
42		A Model for Routinized Hospital-wide HIV Screening: Lessons Learned and Public Health Implications <i>CJ Maxwell</i>	129	
43		Bridging: Linking Sub-Saharan Africans to Comprehensive Care <i>C McMahon</i>	130	
44		Are the 2006 CDC HIV Testing Recommendations Ethically Justified? It Depends! <i>RC Merchant</i>	131	
44		Strategies for Routinizing Rapid HIV Testing and Linkage to Care Throughout St. Luke's-Roosevelt Hospital Center <i>P Mills</i>	132	
45		Routine HIV Testing in Community Health Centers Should Include Models for Post Test Counseling and Linkage to HIV Care while also Gathering Important Outcome Data <i>CA Modica</i>	133	
46		HIV Testing Outcomes and Risk Behaviors in an Urban STI Clinic in Philadelphia <i>A Nunn</i>	134	
46		Reducing Health Disparities Through HIV Testing: Assessing and Managing Co-morbidities in an Urban Population Undergoing HIV Testing <i>A Nunn</i>	135	
47		HIV Rapid Testing in the Emergency Department - Cultural Fit and Community Support <i>I Pizarro</i>	136	
48		Acceptance of Oral Rapid HIV Testing in the Emergency Department of an Urban Pediatric Hospital: Rates of Agreement between Adolescents and their Guardians <i>N Rakhmanina</i>	137	
48		Impact of Routine Testing in Health Care Settings <i>L Randall</i>	138	

page	session	title and author	abstract	poster
49		HIV Testing and Access to Care for Latino Immigrants in Post-Katrina New Orleans <i>J Redmann</i>	139	
50		Reaching High Risk Populations: Patient Social Networks to Promote Rapid HIV Testing and Linkage to Care <i>SR Saha</i>	140	
50		Results from a Targeted, Integrated, Standard EIA HIV Testing Program at an Urban, Academic Emergency Department <i>JA Schneider</i>	141	
51		Integrating HIV Testing Targeting African Americans into the Prevention Programs of a Community-based Organization <i>R Simmons</i>	142	
52		Social Marketing and New Technologies to Engage Youth in HIV Testing <i>M Singer</i>	143	
53		Physician Barriers to Implementing Routine HIV Testing in Primary Care Settings: A Qualitative Analysis <i>JM Sosman</i>	144	
54		HIV Screening in Jails - What is the Yield? <i>AC Spaulding</i>	145	
54		Patient Attitudes <i>versus</i> Staff Attitudes about Human Immunodeficiency Virus Testing in the Emergency Department <i>VY Totten</i>	146	
55		Staff Attitudes Towards Human Immunodeficiency Virus Testing in the Emergency Department <i>VY Totten</i>	147	
56		Routine Offer of a Rapid HIV Test in New York City Single Adult Homeless Assessment Shelters <i>B Tsoi</i>	148	
57		HIV Testing Targeting MSM in Non-traditional Settings in New Orleans <i>A Vertovec</i>	149	
57		"Get Real Get Tested": North Carolina's Statewide HIV Testing and Education Campaign <i>H Watkins</i>	150	
58		Do Clinicians Prefer the 2006 or 2001 CDC HIV Testing Recommendations? <i>MJ Waxman</i>	151	
59		HIV Testing in a Kenyan Emergency Department <i>MJ Waxman</i>	152	

page	session	title and author	abstract	poster
59		AIDS Education and Training Centers Efforts to Assist Healthcare Organizations Implement Routine HIV Testing <i>L Wegman</i>	153	
60		Early <i>versus</i> Late Testing for HIV Infection: A Study of Incarcerated Individuals in South Carolina <i>E Youmans</i>	154	
61		Expanding HIV Testing in the San Francisco Jails – 2008 <i>J Yuan</i>	155	
62		PREVENTION MODELS IN THE SETTING OF ROUTINE OR EXPANDED HIV TESTING		
63		The Prevalence of Rectal, Urethral, and Pharyngeal <i>Neisseria gonorrhoeae</i> and <i>Chlamydia trachomatis</i> among Asymptomatic Men who have Sex with Men in a Prospective Cohort in Washington, DC <i>J Baker</i>	201	
63		HIV Risk Behavior Pre- and Post-HIV Testing and Counseling in Jail <i>CG Beckwith</i>	202	
64		Program B.R.I.E.F: A 32 Month Analysis of High Volume Rapid HIV Testing Multimedia Model <i>Y Calderon</i>	203	
64		Testing Our Readiness: Benefits of Increased Access to Testing in the Integrating Planning for ARVs <i>J Davids</i>	204	
65		Unique and Innovative Approaches in Traditional Settings can Promote HIV/AIDS Awareness and Provide Public Health Solutions <i>GW Edwards</i>	205	
66		Southern AIDS Coalition Web-based “Living Quilt” to Increase Awareness of HIV Prevalence Amongst Women of Color in the Southern United States <i>E Foust</i>	206	
66		Communities Learning Together (CLT): Recommendations for Enhancing Prevention Practices <i>P Gamache</i>	207	
67		Use of a Blinded Serosurvey to Assess Undiagnosed HIV Infection among New York City Jail Entrants in the Setting of a Large Scale Routine Testing Program <i>C Jain</i>	208	
68		Utilizing Mental Health Counseling in African American Men who have Sex with Men Minority Populations as a Primary and Secondary HIV Prevention Tool <i>T McPhaul</i>	209	
69		Video-delivered Rapid HIV Pre-test Information to Streamline HIV Testing <i>RC Merchant</i>	210	

<i>page</i>	<i>session</i>	<i>title and author</i>	<i>abstract</i>	<i>poster</i>
69		Collaboration of Two County Programs in Expanding Partner Services to Increase HIV Prevention and Testing <i>KMK Shanley</i>	211	
70		Effectiveness of Enhanced and Cluster Interviewing to Identify Sexual Venues across Health Jurisdictions for Sexually Transmitted Diseases (STD) and HIV Transmission <i>CL Silva</i>	212	
71		Using GIS to Evaluate Utilization of Sexually Transmitted Diseases (STD) and HIV Services in a Northern California County with Substantial HIV Late Presentation <i>CL Silva</i>	213	
72		Computer Tool for Routine Rapid HIV Counseling and Testing in Emergency Care Settings <i>F Spielberg</i>	214	
72		So You Think You're Safe?: Increasing Awareness for HIV Risk Among Women at a Family Planning Clinic <i>CD Zorrilla</i>	215	
74		OUTCOMES AND IMPACT EVALUATION OF HIV TESTING ACTIVITIES		
75		CD4 Counts of HIV Positive Patients Detected Through a Routine Emergency Department HIV Screening Program in a High Prevalence Area <i>J Brown</i>	301	
75		Routine ED HIV Testing Has No Effect on Length of Stay <i>J Brown</i>	302	
76		Experience with Opt-out HIV Testing in an Urban Hospital <i>M Czarnogorski</i>	303	
77		Rates of HIV Testing in the United States, 2006 <i>D Duran</i>	304	
77		Using Capacity Planning Models to Estimate Organizational Costs of HIV Care within the United States Department of Veterans Affairs <i>J Feld</i>	305	
78		Clinical Effectiveness of Routine Opt-out Rapid HIV Screening in the Emergency Department: Results from an Ongoing Prospective Clinical Trial <i>JS Haukoos</i>	306	
79		National Estimation of Rates of HIV Serology Testing in US Emergency Departments 1993-2005: Baseline prior to the 2006 CDC Recommendations <i>Y-H Hsieh</i>	307	
79		Outcomes and Cost Analysis of Three Operational Models for Rapid HIV Testing Services in an Academic Inner-city Emergency Department <i>Y-H Hsieh</i>	308	

<i>page</i>	<i>session</i>	<i>title and author</i>	<i>abstract</i>	<i>poster</i>
80		Comparisons of HIV Testing History Among Men who Have Sex with Men (MSM) in New York City <i>SM Jenness</i>	309	
81		HIV Testing among High-risk Heterosexuals in New York City <i>SM Jenness</i>	310	
81		Facilitators and Barriers to Routine HIV Testing among Massachusetts Community Health Centers <i>CV Johnson</i>	311	
82		Twenty Years Experience with HIV Testing Among Emergency Department Patients at the Johns Hopkins Hospital <i>CK Kraus</i>	312	
83		A Simple Method for Estimating the Epidemiology of Undiagnosed HIV Infection: Practical Guidance for Designing a New HIV Screening Program <i>C Lindsell</i>	313	
84		Comparison of ED HIV Testing Data with Visit or Patient as the Unit of Analysis <i>MS Lyons</i>	314	
84		Impact of an Emergency Department HIV Testing and Screening Program on the Proportion of Patients Who Have Received Prior Testing <i>MS Lyons</i>	315	
85		Operation Sweet Tooth: Effective Use of Social Marketing Campaigns in Non-Traditional Social Settings <i>T McPhaul</i>	316	
86		Do Emergency Department Patients Want to be Screened for HIV? <i>RC Merchant</i>	317	
86		Health Care Access and HIV Testing Frequency Among at Risk MSM in Massachusetts <i>MJ Mimiaga</i>	318	
87		MSM Access Critical to Achieving High Seropositivity in Latino-targeted Testing Programs <i>C Portillo</i>	319	
88		Perceived Public Health and Clinical Impact of Emergency Department Based HIV Testing: Expert Perspectives from the 2007 Conference of the National Emergency Department HIV Testing Consortium <i>R Rothman</i>	320	
89		Outpatient HIV Point-of-care Testing at the VA Medical Center in Washington, DC (VAMC-DC) <i>M Siegel</i>	321	
90		A Pilot Evaluation to Assess Physicians' Adoption of Routine HIV Testing and Counseling in Primary Care <i>JM Sosman</i>	322	

<i>page</i>	<i>session</i>	<i>title and author</i>	<i>abstract</i>	<i>poster</i>
91		Cost of Finding One Newly Diagnosed HIV Case in New York City <i>B Tsoi</i>	323	
91		Comparison of HIV Risk Profiles for Patients that Consent to or Decline Targeted Opt-in ED HIV Screening <i>ND Ubhayakar</i>	324	
92		HIV Partner Notification: Which Interviews Yield the Most New Positive Partners in NYC? <i>C Udeagu</i>	325	
93		Preventive HIV Vaccine Research and Routine HIV Testing: The Challenge of Vaccine-induced Sero-positivity (VISP) <i>S Wakefield</i>	326	
94		ACCESS TO CARE AS A PART OF ROUTINE/EXPANDED TESTING		
95		HIV Testing and Linkage of Care Collaboration: Doctor, Insurer, Community Organization, and Pharmaceutical Company Working Together to Find, and Link to Care HIV Positive Patients <i>L Eisenstein</i>	401	
95		Tenderloin Health's (TLH) Linkage to Care (LTC) Program for Newly Diagnosed HIV Positives Partnership with Gilead Sciences <i>C Fann</i>	402	
96		Obtaining HIV Patient Input: Accessibility and Quality of HIV Care & Treatment in Pennsylvania AIDS Drug Assistance Program <i>LR Frank</i>	403	
97		Cost Effectiveness of Routine Opt-out Rapid HIV Screening in the Emergency Department: Results from an Ongoing Prospective Clinical Trial <i>JS Haukoos</i>	404	
98		Implementation of a Collaborative HIV Testing Model Between an Emergency Department and Infectious Disease Clinic in North Carolina <i>BE Hoots</i>	405	
98		Linking Newly Diagnosed HIV Positive Individuals to Specialized Care from the Emergency Department Setting <i>J Leider</i>	406	
99		HIV Risk Behaviors and Seroprevalence in an Urban Population Over the Age of 50 Undergoing HIV Rapid Testing <i>A Nunn</i>	407	
100		Rapid HIV Testing in Labor and Delivery Units: An Essential Part of the Safety Net for Perinatal HIV Prevention <i>A Statton</i>	408	

Routine/Expanded HIV Testing Models and Systems Development

ABSTRACT 101

Implementing Routine HIV Testing in the Emergency Department of an Urban University Hospital

A Hilley, J Bell-Merriam, S Criniti, and E Aaron

Division of Infectious Diseases and HIV Medicine, Drexel University College of Medicine, Philadelphia, PA, USA

OBJECTIVE: In 2006, the CDC called for an increase in HIV screening in all health care settings, including emergency departments (EDs). In response to these recommendations, a universal HIV testing program was launched in the ED of Hahnemann University Hospital, a busy, urban hospital in Philadelphia, PA. Using a counselor-driven testing model, the program's objectives were to identify new HIV cases and link the newly diagnosed individuals into care.

METHODS: The program began with certified HIV counselors offering point-of-care rapid HIV testing in exam rooms to all eligible patients regardless of risk factors for 10 hours daily Monday-Friday. In response to client demand, the program was expanded to offer testing to partners, friends, and family members of ED patients. HIV counselors collected demographic information, obtained consent, performed counseling and testing, and provided results. Screening was done via oral swab using the OraQuick ADVANCE[®] Rapid HIV-1/2 Antibody Test. Patients with preliminary positive results were immediately offered confirmatory testing in the ED and actively referred for care at an affiliated HIV outpatient clinic.

RESULTS: From May 2007 through July 2008, 1,816 individuals were offered rapid HIV screening, and 82.5% accepted testing, including 73 non-ED patients. The average time for entire counselor/patient interaction was 5 minutes and 30 seconds. Only two screened patients left the ED before receiving their results. Among those who accepted, the mean age was 35.6, 50.6% were female, and 79.8% were black. At least 25% of these patients reported this as their first HIV test. Eighteen patients tested preliminarily positive for HIV. Of these, 11 were confirmed positive, 4 were confirmed as false positive, and

3 did not receive confirmatory testing. The seropositivity rate was 0.73%. Among the 11 confirmed positives, five were successfully linked to follow-up care with at least one or more clinic visits. The other six have not yet engaged in care despite repeated and ongoing attempts to contact and engage them.

CONCLUSIONS: Strengths of our program include the number of patients offered, and accepting, testing; the use of a streamlined consent and point of care testing process; and the successful delivery of results to patients. Given the rates of false-positives, the use of oral fluid with Ora-Quick Advanced Rapid HIV test needs further evaluation. Areas for improvement include involving the ED personnel in performing HIV screening and increasing the proportion of linked positives.

ABSTRACT 102

Providing Rapid HIV Testing in a Non-medical Setting: In-home Testing of Pregnant Women and Their Families

E Aaron, S Criniti, and A Hilley

Drexel University College of Medicine, Philadelphia, PA, USA

OBJECTIVES: The CDC's recently revised estimate of annual U.S. HIV transmissions – an increase from 40,000 to 56,000 – has reinforced the need for accessible models of HIV testing. In addition, testing pregnant women for HIV is critical to preventing transmission to infants and partners. An innovative in-home rapid HIV testing program of pregnant women and their family members was started in an urban high risk population. Goals were to identify HIV-infected individuals, link them into care, and provide HIV/STD prevention counseling to clients and their families.

METHODS: In 2005, a program was initiated through a partnership between a community-based maternal health organization, an HIV medical clinic, and a faith-based community organization to incorporate HIV testing into an in-home prenatal and postpartum care program

in an urban high-risk neighborhood. HIV counselors accompanied prenatal advocates on home visits, offering HIV education, prevention counseling, and rapid testing to women, their partners, and families.

RESULTS: Eighty individuals received HIV education, 73 were tested: 40 clients (16 pregnant) and 33 partners or family members of clients. The acceptance rate was 69% among those clients who were offered testing. Prevention messages were given on an individual basis as well as through “kitchen table” family and friends participation. Prenatal care advocates were trained to perform rapid testing and HIV prevention counseling and have incorporated this into their routine home visits.

CONCLUSIONS: In-home HIV testing may reach individuals who lack access to testing and encourages communication among household members. Acceptance rates were high and innovative methods of providing prevention counseling were employed. Challenges included the integration of a new HIV testing service to an existing in-home prenatal care program ensuring safety, security, and client confidentiality in a home setting. New models for improving HIV diagnosis and linkage into care are necessary as the incidence of HIV transmission continues to rise.

ABSTRACT 103

Successful Integration of Rapid HIV Screening into an Urban Women’s Care Specialty Clinic

E Aaron¹, S Criniti¹, A Hilley¹, and S Wolf²

¹ Division of Infectious Diseases and HIV Medicine, Drexel University College of Medicine, Philadelphia, PA, USA;

² Department of OB/GYN, Drexel University College of Medicine, Philadelphia, PA, USA

OBJECTIVES: In response to the 2006 CDC recommendations calling for increased HIV testing in all medical settings, a routine rapid HIV testing program was initiated in an urban family planning (FP) and OB/GYN clinic. Since heterosexual HIV transmission now accounts for

78% of new infections in women in U.S., testing was offered to all patients regardless of risk. In addition to identifying new cases of HIV, program sustainability and smooth integration into the clinic flow were key objectives.

METHODS: In 2003, the FP/OB/GYN clinic began offering on-site rapid HIV screening to patients with one full-time dedicated HIV counselor stationed in the clinic. In 2007, in order to increase and routinize screening, all testing responsibilities were transitioned to clinic staff. Within one year, routine rapid HIV screening of all patients had been fully integrated into the clinic’s standard of care. Additionally, semi-annual HIV educational programs to staff, a physician referral system, and procedures for immediate referrals for linkage into HIV care for positives were established.

RESULTS: Between 2003 and 2008, 4,109 patients were screened for HIV using rapid testing technology in the clinic; 37 were identified as HIV infected (0.9% seropositivity). Fifteen of the positives were pregnant women who were identified during routine prenatal screenings; all infant transmissions were prevented. Overall, the HIV screening rate increased from 34% of patients having an HIV test in the previous year in 2003 to 65% in 2007 with 97% of prenatal patients screened. All newly identified patients were immediately referred into HIV specialty care.

CONCLUSIONS: Full integration of rapid HIV testing into a busy urban FP/OB/GYN clinic is feasible. Identifying key stakeholders and establishing support from administration and clinic managers is essential. A streamlined consent and counseling model, ongoing trainings to increase knowledge of HIV, buy-in of staffs’ role in educating patients, patient-appropriate education materials and consents, and linkage into HIV care are all necessary to accomplish the integration of opt-out HIV testing into clinic flow. Program challenges included addressing training needs, lack of staff time to perform testing, and need to develop a streamlined counseling model to fit into flow of busy clinic.

ABSTRACT 104

Integration of HIV Testing within Routine Care in a Large Public Hospital System

J Omi¹, J Aberg², T Hamilton¹, and A De Los Reyes¹

1 New York City Health and Hospitals Corporation, NY, USA; 2 Bellevue Hospital Center, New York City Health and Hospitals Corporation, NY, USA

ISSUES: In 2005 the largest municipal hospital system in the nation, initiated an HIV testing expansion initiative to: 1) increase the number of patients who know their HIV status; 2) identify individuals early in their disease, and 3) retain identified patients in care.

DESCRIPTION: Seventeen hospitals and clinics participated. After training clinicians and staff, facilities: adopted the use of rapid HIV tests; offered HIV testing in outpatient clinics, inpatient care and emergency rooms; integrated testing into routine care, and urged physicians to offer the test.

LESSONS LEARNED: From FY05 through FY08, testing increased by 159% (62,023/160,900) with more than 86% conducted using rapid HIV testing technology. 15.5% of all unique patients 13 and older were tested, an increase of 146%. The number of positive patients more than doubled, from 720 in FY05 to 1,863 in FY08. The prevalence of HIV varied across facilities and was 1.16% among all patients tested. Of those patients newly diagnosed with HIV and scheduled for a first primary care appointment, 73% were seen in same month of their diagnosis (509/698). With nearly 297,000 rapid HIV tests performed since the launch of the initiative, HHC has not encountered a significant number of false HIV positive results and has found these tests to accurately diagnose HIV infection.

RECOMMENDATIONS: The use of rapid tests and the integration of testing within routine care can significantly increase the number of positive individuals identified and identify individuals who would otherwise be unaware of their status. The rate of testing acceptance and follow-up appointment compliance may be affected by site of test and the offering process used. Methods used and lessons

learned provide significant insight for other health care institutions considering the initiation or expansion of HIV testing.

LEARNING OBJECTIVES:

- To identify two ways in which HIV testing can be integrated into routine care within inpatient, outpatient and emergency departments.
- To identify issues that can impact the prevalence of HIV in patients tested by location.

To identify three factors that contributes to testing acceptance and patient completion of the first follow-up medical appointment.

ABSTRACT 105

Building Organizational Capacity and Innovation to Address Acute HIV Infection in San Francisco Through Expanded Outreach and Testing

JD Auerbach

San Francisco AIDS Foundation (SFAF), San Francisco, CA, USA

OBJECTIVE: To strengthen the capacity of a community-based organization (CBO) to reduce the number of new HIV infections in San Francisco by designing, implementing, and evaluating innovative, evidence-based strategies to enhance HIV testing and improve detection of acute HIV infection.

It is estimated that approximately 21% of HIV-positive people in SF do not know they are infected. Individuals are at exceptionally high risk of transmission during the acute infection stage. Finding people at this stage and providing appropriate treatment and prevention services to them is essential for reducing new HIV infections in the city.

METHODS: SFAF launched an internal Innovative Projects Initiative (IPI) allocating \$200,000 per year for two years to: (1) increase staff knowledge regarding acute HIV infection; (2) fund innovative projects that address barriers to HIV testing during the acute infection stage;

(3) build agency-wide program and proposal development skills; (4) strengthen organizational partnerships with researchers and the link between evidence and programs; (5) enhance interdepartmental collaboration; and (6) expand staff expertise in monitoring and evaluation.

The IPI was announced to all SFAF staff in May 2008. Two trainings open to all staff were provided by outside experts on (1) basic information about acute HIV infection and existing research and program efforts to address it; and (2) program and proposal development skills. Next, all staff were invited to participate in a facilitated “Open Space” exercise to generate program ideas. From this, six interdepartmental working groups formed to develop brief concept proposals outlining key aims, approaches and outcomes, staffing and technical assistance needs, and budgets. Over one-third of all SFAF staff—from front-line service providers to policy analysts—attended these sessions.

RESULTS: Eight innovative concept proposals have been submitted, including messaging through art, film, and social marketing; monolingual Spanish information campaign; expanded, clinic-based HIV antibody and RNA testing and counseling; and targeted outreach to underserved populations through a mobile van. SFAF’s Leadership Team will review and prioritize these proposals on merit and feasibility, select concept proposals for development into full project plans, provide additional technical assistance to project teams, and make funding decisions in November. Final results of this process will be presented at the Summit.

CONCLUSIONS: A novel approach to building CBO internal capacity to address acute HIV infection through enhanced HIV testing that includes appropriate staff training, technical support, and funding is feasible and acceptable. Concept proposals submitted to SFAF’s IPI exhibited acquisition of content knowledge, project development skills, and an outcomes orientation among CBO staff at all levels of the organization.

ABSTRACT 106

Magnet/SFAF: Rapid HIV Antibody and Viral RNA Testing for Gay Men in San Francisco

S Gibson¹, D Gluth¹, T Ryan¹, J Austin², S Facente³, and C Hall¹

1 Magnet/SFAF, San Francisco, CA, USA; 2 San Francisco AIDS Foundation, San Francisco, CA, USA; 3 San Francisco Department of Public Health, CA, USA

OBJECTIVE: To identify gay men at high-risk of HIV infection including acute infection to prevent new HIV infections.

Overall prevalence of HIV among MSM in SF is 27% (SFDPH, 2007). MSM and MSM-IDU represent 90% of HIV/AIDS cases in San Francisco (SFDPH, 2007) with the Castro District having the highest density of HIV/AIDS cases citywide (SFDPH, 2007).

METHODS: Magnet—a program of the San Francisco AIDS Foundation—is the city’s only health center and community space for gay men. Magnet provides drop-in, rapid oral HIV antibody testing and sexual health services through an innovative storefront facility in the Castro. Magnet is the only facility in the Castro to provide routine HIV antibody testing.

HIV RNA testing is offered to high-risk clients accessing HIV antibody testing. An algorithm is used to identify high-risk clients to prompt them to request RNA testing. RNA testing is offered to gay men who have had unprotected receptive anal intercourse (URAI) with a partner of unknown status in the past two weeks to three months; clients who have had unprotected insertive anal intercourse (UIAI) with a known positive partner within the same time period; and clients with a rectal STD diagnosis within the previous six months.

RESULTS: Magnet has provided HIV antibody testing services to 7,291 men since July 2003 and will provide more than 3,000 tests in FY2008–2009. Magnet’s overall HIV positivity rate is 2%.

Approximately 300 men have participated in Magnet's HIV RNA testing program. HIV RNA testing among high-risk clients at Magnet has identified 2% of men testing antibody negative as being acutely infected (N=6).

Between 2004–2007, 5,902 HIV antibody tests were administered at Magnet. Self-reported URAI decreased from 45% in 2006 to 25% in 2007. Of those testing HIV+, 36% were men of color and 80% lived in San Francisco. This group reported an average of six previous HIV tests and reported an average of 37 sexual partners in the past two years.

Nearly 100% of those testing HIV-positive were able to access primary care services.

CONCLUSIONS: Testing gay men in a high-prevalence neighborhood and targeted HIV RNA testing among high-risk clients may be an effective way to identify men with acute or recent infections. Gay men presenting at Magnet are assessing their level of risk of acquiring HIV and are seeking testing services as appropriate. Increased access to HIV testing among gay men in San Francisco would further identify acute or recent infections and therefore reduce new infections.

ABSTRACT 107

State-level Policy Change to Address Systemic Barriers to Expanding HIV Testing

C Mulhern-Pearson and JD Auerbach

San Francisco AIDS Foundation, San Francisco, CA, USA

OBJECTIVE: The California State Office of AIDS estimates that 30,000-40,000 Californians are unaware they are HIV-positive and, therefore, are not receiving appropriate HIV treatment and possibly jeopardizing their own health and that of their sex and drug-using partners. To address this, San Francisco AIDS Foundation (SFAF) has developed an evidence-based, multi-pronged policy and legislative strategy to modify existing systemic barriers with the aim of increasing HIV testing.

METHODS: SFAF, in collaboration with an alliance of state organizations embarked on strategy to change existing law and policy through direct lobbying and advocacy and coalition work. Challenges from professional associations, other advocates, and legislators have been met with negotiation, compromise (e.g., bill amendments), and persistence, as appropriate.

In addition to our legislative campaign, SFAF is participating in many state-wide efforts to inform medical providers about the CDC recommendations with the aim of expanding HIV testing into a variety of settings, including emergency and urgent care departments.

RESULTS: In 2007, we worked to introduce two bills. AB 682 eliminated the requirement for doctors to get a separate written informed consent for conducting an HIV test while protecting the confidentiality and opt-out rights of patients. It passed and went into effect on January 1, 2008. AB 1442 addressed the state requirement that providers obtain a separate clinical laboratory license in order to perform rapid HIV testing. It has been held in the Legislature while making these changes through regulation instead is being explored.

In the current legislative session, SFAF is supporting AB 1894, which would require health insurers to cover an HIV test even if it is unrelated to the primary diagnosis. The bill has successfully passed out of the Legislature and has been sent to the Governor, hopefully for signature. An update on these pending bills and strategies will be provided at the Summit.

To address a further barrier to expanded HIV testing, SFAF will introduce a bill in the 2009 Legislative session to eliminate the current requirement in California law that a person have a limited phlebotomy license in order to perform a rapid HIV test.

CONCLUSIONS: SFAF, working in coalition with other organizations, legislators, and health care professionals, has been successful in using legislation, advocacy, and education to address systemic barriers to increasing HIV testing in California.

ABSTRACT 108

Implementation of a Jail-based Rapid HIV Testing Pilot Program

CG Beckwith^{1,2}, MD Schleinitz^{1,3}, E Patry², LB Bazerman², and MT Poshkus^{1,4}

1 Alpert Medical School of Brown University, Providence, RI, USA; 2 The Miriam Hospital, Providence, RI, USA; 3 Rhode Island Hospital, Providence, RI, USA; 4 Rhode Island Department of Corrections, Cranston, RI, USA

OBJECTIVE: With FDA approval of rapid HIV tests, new opportunities for correctional screening programs have emerged. Since jail incarceration is often brief, the utilization of rapid HIV testing in jail may have significant advantages over standard testing through increased test result delivery and more efficient linkage to care. The goal of this project is to perform a rapid HIV testing pilot program within the Rhode Island Department of Corrections (RIDOC) jail.

METHODS: Currently, the RIDOC offers routine opt-out standard HIV testing upon jail processing with confirmed results available in approximately 7-10 days. During the six month pilot program, one-day per week will be devoted to routine opt-out rapid HIV testing. An oral mucosal transudate specimen will be self-collected by the detainee and the specimen will be used to run the OraQuick® Advance HIV 1/2 rapid HIV test. Detainees who have a reactive oral fluid rapid test will undergo repeat rapid testing using a wholeblood specimen obtained by fingerstick in order to distinguish those persons with two reactive rapid tests utilizing different biological specimens (concordant rapid tests) from those with a reactive oral fluid OraQuick test and a negative wholeblood OraQuick test (discordant rapid tests). Detainees with any reactive rapid HIV test will have confirmatory testing by western blot completed. Protocols have also been established for delivery of test results and linkage to care in the community.

RESULTS: The rapid testing program will commence in September 2008. It is anticipated that approximately 1,000 detainees will complete rapid testing over the project period. Data will be collected in order to evaluate and compare outcomes of interest by each testing method, including

the proportions of detainees completing testing, receiving test results, and with positive, negative, and indeterminate HIV test results. In addition, micro- and macro-level cost data will be collected on both the standard and rapid HIV testing programs in order to conduct a comparative cost analysis.

CONCLUSIONS: The ultimate goal of this project is the facilitation of a routine, opt-out rapid HIV testing program at the RIDOC Intake Service Center which functions as the central jail for Rhode Island. Therefore, a demonstration of improved medical care and overall cost savings would help to justify a change from the current HIV testing policy. In addition, the development and implementation of this program will serve as a model for other correctional institutions that are faced with similar decisions in the face of limited resources.

ABSTRACT 109

Expanded HIV Testing in Medical Settings in Florida: Challenges and Successes

T Bendle¹, M LaLota², M Barnes³, and T Liberti⁴

1 HIV Counseling and Testing Coordinator, Florida Department of Health, Tallahassee, FL, USA; 2 HIV Prevention Director, Florida Department of Health, Tallahassee, FL, USA; 3 African American Testing Initiative Coordinator, Florida Department of Health, Tallahassee, FL, USA; 4 Chief, Bureau of HIV/AIDS, Florida Department of Health, Tallahassee, FL, USA

OBJECTIVE: In support of CDC's *Revised Recommendations for HIV Testing of Adults Adolescents, and Pregnant Women in Health-Care Settings*, Florida implemented an African American Testing Initiative (AATI) focusing on reaching HIV-infected persons, primarily blacks who are unaware of their infection, through the expansion of HIV testing in medical settings. These are primarily hospital emergency rooms, community health centers, correctional settings, and specialty clinics, but also include non-medical community testing centers.

Florida's goal in year one was to test 150,000 individuals and identify 2,000 new positives.

METHODS: Our initiative incorporates innovative recruitment strategies in a variety of clinical and non-clinical settings to meet our goal of testing 150,000 persons. We have partnered with providers that are most likely to serve populations disproportionately affected by HIV – primarily African Americans unaware of their HIV status. We will describe how various barriers such as statutory limitations, contract issues, training, and stakeholder engagement.

We provide infrastructure support and supplies, such as rapid HIV test kits, along with laboratory support for hepatitis, STD, viral load, and CD4 testing for participating sites. Sites link persons testing positive for HIV to medical care, support and prevention services and HIV/STD Partner Services (PS).

Our initiative also includes a social marketing component that includes radio, posters, public relations, and outdoor advertising targeting populations likely to access services at our AATI provider locations. Our message provides information on the disproportionate impact of HIV on blacks and encourages testing, particularly in healthcare settings.

We developed strong data collection, evaluation, and quality assurance systems that allow us to capture information on tests conducted, new infections diagnosed, receipt of test results, linkage to care, and demographics of those tested. These systems ensure that our partners are performing in accordance with our stated goals and objectives.

RESULTS: In the first year, our clinical sites included nine major hospitals; 3 community health centers; 10 STD clinics; 10 correctional facilities, and a variety of specialty clinics. Eight community-based organizations with a historical positivity rate of 2% or greater serve as non-clinical sites.

From October 1, 2007 to July 30, 2008 AATI sites have conducted 43,481 HIV tests and identified 1,042 positives (2.4%).

CONCLUSIONS: In the first project year, Florida successfully expanded or implemented HIV testing in

a variety of clinical and non-clinical settings. Through organization, commitment, dedication, and engagement, Florida has proven that expanded HIV testing opportunities, especially in medical settings, is achievable, productive, and beneficial.

ABSTRACT 110

Synergizing HIV/AIDS and Hepatitis B Programs to Increase Access in Hard-to-Reach Populations

C Bermudez and MM Kwan

Asian & Pacific Islander Wellness Center, California, USA

OBJECTIVE: Asian & Pacific Islander Wellness Center's Testing Clinic aims to increase HIV/AIDS awareness, education, and access to counseling and testing services in hard-to-reach communities, in which HIV/AIDS is little-known and heavily stigmatized. An effective way of achieving these goals is to use familiar community-based health services, such as hepatitis B screening and education, as a gateway to initiate dialogue and awareness around HIV/AIDS.

METHODS: Asian & Pacific Islander Wellness Center's Testing Clinic effectively introduces HIV/AIDS prevention services to hard-to-reach Asian communities that would otherwise avoid this heavily stigmatized topic by incorporating key prevention messages into essential hepatitis B screening and education sessions. It is our belief that individuals accessing hepatitis B screening and education are in turn able to influence the behavior and attitudes of their family, peers, and community.

During screening events at community-based fairs, cultural venues (temples, etc.) and at our community-based office locations, culturally/language-competent educators convey basic information about HIV/AIDS risk factors, transmission methods, and the importance of testing. Depending on the event, HIV testing may be immediately available onsite or through direct referral to our agency. Changes in HIV/AIDS knowledge are measured through the use of verbally-administered pre/post tests. The

progress of this evidence-based model is tracked through a comprehensive monitoring and evaluation system.

RESULTS: Of 232 individuals screened for hepatitis B from June 2007 to May 2008:

- 95% are monolingual or speak English as a second language
- 47% are uninsured
- 12.5% tested positive for chronic hepatitis B
- 37% received follow-up vaccinations
- 84% had never accessed community health services
- 70% were not aware that hepatitis B and HIV have similar risk factors before speaking with an educator
- 57% were interested in HIV testing after speaking with an educator
- 15% have accessed onsite HIV testing (testing done at other sites has not been tracked)

CONCLUSION: Preliminary data has highlighted both the efficacy and challenges of such an integration program. It is clear that we provide essential hepatitis B screening, education, and follow-up vaccinations, increased knowledge of HIV risk factors, transmission methods and access to HIV testing to hard-to-reach populations that would otherwise have no access to these services. While we have faced some challenges in tracking longer-term changes in behavior and attitude, we have strong collaborative relationships with community partners and are in the process of developing a tracking tool to better assess our impact.

ABSTRACT 111

Efforts to Increase HIV Testing in a Large HMO in Washington, DC

SJ Bersoff-Matcha, MH Snyder, J Blank, and M Simon

Kaiser Permanente of the Mid-Atlantic States, Rockville, MD, USA

OBJECTIVE: To increase HIV testing within Kaiser Permanente of the Mid-Atlantic States (KPMAS).

METHODS: KPMAS currently provides care for 480,000 members in the DC Metro area including Northern

Virginia, Maryland and the District of Columbia. More than 1800 (0.39%) of our members are infected with HIV. Between April 2005 and March 2008 only 11.7% of our members over the age of 18 years were tested for HIV. A major barrier to HIV testing was the requirement for written consent in Maryland and Virginia, and the requirement within KPMAS that all patients sign a written consent regardless of the jurisdiction in which the test was performed. On July 1, 2008 the law in MD and VA requiring written consent for HIV testing was changed such that informed consent for HIV testing was still required, however, written authorization was no longer needed. Because of the high burden of HIV disease in Washington, DC, where 1 in 20 residents is infected with HIV and 1 in 40 has AIDS, with the change in the laws surrounding consent for HIV testing, KPMAS launched a major effort to increase testing. After legal review, on July 28, 2008 a broadcast memo alerting all KPMAS employees about the change in the law was sent. Laboratory personnel were educated to no longer expect consent forms with orders for an HIV test. Consent forms were removed from our electronic medical record and were no longer available for use. A KPMAS sponsored lunchtime continuing medical education (CME) lecture series was/will be offered at each medical center to highlight the importance of HIV testing and early intervention.

RESULTS: A total of 2359 HIV antibody screening tests were performed in July, 2008 (prior to the removal of written consent forms) for 144,690 patient visits; 1.63% patients tested at their July office visit. By August 27, 2008, nearly one month after the requirement for written consent had been removed and the educational series had begun, 2116 HIV antibody screening tests had been performed for 117,074 patient visits; 1.81% patients tested at their visit in August. To date, only 3 of 32 medical centers have received their CME lecture. More data will be available by the time of presentation in November.

CONCLUSIONS: We are hopeful that the change in the laws requiring written informed consent and our concurrent education program will lead to further increases in the rate of HIV testing at KPMAS.

ABSTRACT 112

HIV Rapid Testing in the ER: Willingness to Participate

J Burrage, Jr.¹, A Nyamathi², and M Weaver¹

1 Indiana University School of Nursing, IN, USA;

2 UCLA School of Nursing, CA, USA

OBJECTIVE: To determine the factors which predict or influence willingness to participate in rapid testing methods if offered in ER waiting rooms. Nyamathi's Comprehensive Health Seeking and Coping Paradigm guided the study. **Aims:** To describe relationships between the outcomes of willingness to participate in ER rapid HIV testing and enter care if HIV infected and: 1) personal factors (self-esteem) coping resources (social support) and cognitive appraisal (perceived stigma, perceived risk for AIDS, AIDS Knowledge); 2) health seeking and coping (problem and emotion-focused coping, risky drug and sexual behavior), and 3) sociodemographic factors.

METHODS: 267 non acute individuals completed face to face pencil and paper standardized questionnaires at a county ER waiting area in this open enrollment cross-sectional descriptive study. The sample consisted of 69% (n=163) women and 31% (n=104) men. Seventy-six per cent (n= 203) were African American, 20% (n=53) Caucasian, 1 % (n=3) Latino and 3% (n=6) Native American. Statistical Analyses consisted of Multiple Regression, ANOVA, and Spearman Correlation.

RESULTS: Personal factors (self-esteem) coping resources (social support) and cognitive appraisal (perceived stigma, perceived risk for AIDS, AIDS Knowledge) predicted likelihood of testing ($R^2=0.07$; $p=0.002$) with, CDC Knowledge as an independent predictor ($p=0.002$). Likewise the same factors predicted likelihood of care entry ($R^2=0.07$; $p=.004$) with social support as an independent predictor ($p=0.04$). No statistically significant relationships were found for health seeking and coping (problem and emotion-focused coping, risky drug and sexual behavior with likelihood of testing or care entry. However, emotion-focused coping inversely predicted care entry ($p=0.04$) independently. Other significant bivariate relationships

involved Income (Spearman $r=.15$; $p=0.03$ – with likelihood to test) and Race (both likelihood to test $p=0.01$ and care entry $p=0.02$). Higher income participants tended to have lower likelihoods to test. Caucasians had higher means for likelihood to test and care entry than non-Caucasians.

CONCLUSIONS: These findings provide a basis for identification of at-risk individuals and the development of psychosocial interventions to increase HIV testing/care entry in groups such as African American men. Consideration must also be given to demographic variables such as race and income in intervention development.

ABSTRACT 113

HIV Screening Among Privately Insured Members at High Risk of Acquiring HIV Infection

J Chen¹, H Tian¹, E Dahlin-Lee¹, F Everhard², and K Mayer³

1 Health Benchmarks Inc, CA, USA; 2 Gilead Sciences, CA, USA; 3 Brown University, RI, USA

OBJECTIVE: To assess predictors of HIV screening among commercially insured members at high risk for HIV (i.e., sexually active adolescents and members seeking treatment for sexually transmitted diseases).

METHOD: We used 2006 administrative claims data for 8 US health plans, with a total of 7.8 million insured lives. Our study sample consists of continuously enrolled members 14-64 years who have been screened, diagnosed, or treated for an STD (i.e., chancroid, chlamydia, gonorrhea, epididymitis, granuloma inguinale, herpes, human papillomavirus, non-gonococcal urethritis, syphilis, and trichomonas), or hepatitis B or C, and women ages 14-24 with abortion/miscarriage (n=259,961). We excluded members with a history of HIV. We assessed HIV screening rates in the 60 days prior to and after the presenting event (120 days total) and examined factors associated with receipt of HIV screening using multivariate analyses.

RESULTS: Overall, 36% of members in this study were screened for HIV. Cohort size and HIV screening rates

were as follows: STD only (138,425, 18%), hepatitis only (59,707, 23%), abortion/ miscarriage only (753, 10%); STD and hepatitis (59,997, 86%), STD and abortion/ miscarriage (797,33%), hepatitis and abortion/miscarriage (13, 54%), and STD, hepatitis, and abortion/miscarriage (269, 93%). Multivariate analyses revealed that women were less likely to be screened than men (OR 0.9, 95% CI 0.8-0.9, $p < 0.001$). Members 18 to 50 years were more likely to be screened than members 14 to 17 (OR 1.2, 95% CI 1.1-1.3, $p < 0.001$), but members 51-64 were less likely to be screened than members 14 to 17 (OR 0.5, 95% CI 0.4-0.5, $p < 0.001$). Members treated in emergency rooms (ER) were less likely to be screened than members seen in other settings (OR 0.86, 95% CI 0.85-0.87, $p < 0.001$).

CONCLUSION: HIV screening rates among groups at high risk for HIV appears to be low, even when multiple high risk factors are present. Women, the very young (age 14-17), older members (age 51-64), and members receiving treatment in the ER were less likely to be screened for HIV. Interventions to increase HIV screening rates, specifically targeting these at-risk groups are needed.

ABSTRACT 114

Prenatal HIV Screening Among Privately Insured Women: Association with Regional AIDS Prevalence and Incidence

E Dahlin-Lee¹, J Chen¹, H Tian¹, F Everhard², and K Mayer³

1 Health Benchmarks Inc, CA, USA; 2 Gilead Sciences, CA, USA; 3 Brown University, RI, USA

OBJECTIVE: To assess prenatal HIV screening rates among commercially insured women and investigate the correlation to regional HIV/AIDS prevalence or incidence.

METHODS: We used 2006 administrative claims data for commercial health plans serving members in 7 States within the US, representing a total of 7.5 million insured lives. Of these plans, 2 are located in the West, 2 in the Midwest and 3 in the South. Our study sample consisted

of women who delivered vaginally or via cesarean section during 2006, were continuously insured during the entire prenatal period, and who had no history of HIV prior to the date of delivery ($n=56,561$). Using correlation, we compared HIV statistics in the corresponding state, as reported by the CDC in 2006 (2004 year data) to the plan-level rate of HIV screening (including rapid HIV tests) during the 10 months prior to delivery.

RESULTS: Prenatal HIV testing rates for the plans ranged from 58.92% to 91.72%. Mean regional screening rates were as follows: West 72.4%, ($n=4,733$), Midwest 78.9% ($n=24,395$), South 88.2% ($n=27,433$). The estimated number of persons living with AIDS during 2004 in states represented by the plans ranged from 0.3% to 7.2% (mean 2.2%) of the national total. The strongest correlation was with prenatal screening rates and the estimated number of persons living with HIV/AIDS as of 2004, by region and the regional screening rate ($r=0.75$). When we compared screening rates with statistics for women only, we found strong correlations between plan level testing rates and statewide incident cases ($r=0.81$) as well as prevalence ($r=0.80$).

CONCLUSIONS: Results indicate that the CDC guidelines on prenatal HIV screening did not seem to be systematically implemented for commercially insured women in all health plans. Large variations in screening were seen across geographic regions and screening rates correlated strongly with HIV/AIDS prevalence. Interventions by commercial plans to improve HIV prenatal screening among their members will contribute to achieving universal routine prenatal HIV screening nationwide.

ABSTRACT 115

**Bellevue/New York University
(NYU) Langone Medical Center
Men's Sexual Health Project (MSHP):
A Collaborative HIV and Sexually
Transmitted Infection (STI) Testing
Strategy Targeting Highly Sexually
Active Men Who Have Sex with Men
(MSM) in New York City (NYC)**

*D Daskalakis^{1,2}, K Torres², S Blumenthal², D Rakower²,
L Grugett², R Silvera¹, D Stein¹, R Hagerty¹, F Valentine¹,
M Marmor¹, and J Aberg^{1,2}*

1 NYU Langone Medical Center, New York, NY, USA;

2 Bellevue Hospital Center, New York, NY, USA

OBJECTIVE: MSHP is a collaborative program combining diagnostic and referral services from Bellevue Hospital Center (BHC) and NYU Center for AIDS Research (CFAR) that has extended HIV and STI testing services to commercial sex venues (CSV) catering to MSM in NYC.

METHODS: MSHP has combined the diagnostic services of BHC and the NYC Public Health Lab (PHL) with research supported by the NYU CFAR. Rapid HIV testing services and staff are provided by BH-HHC. In kind testing for STI including Gonorrhea, Chlamydia, and Syphilis are provided through the NYC PHL. Pooled plasma viral load testing and Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS) to detect acute and recent HIV infections are provided by NYU CFAR. Between 30-35 hours of testing are offered weekly at two NYC bathhouses. Although outreach had initially been limited to patrons of these venues, aggressive internet marketing introduced in late 2007 has diversified sources of referrals to MSHP services. This strategy included a very successful "blast" email to all NYC area subscribers of Manhunt.net, a popular MSM social and sexual networking web site.

RESULTS: To date, 1275 MSHP visits have occurred among 903 unique clients, 10% of whom had never been

tested for HIV. HIV seroprevalence is 2.8% with 40% of these newly diagnosed infections demonstrating evidence of recent infection. Three acute infections (PCR positive, antibody negative) have been identified including one through partner referral. 75% of these men have been successfully connected to care with appointments made by secure, remote computer access to BH-HHC. 51% of the men tested in MSHP were racial or ethnic minorities. Overall, 21% of MSHP participants were 18-28 years of age, with an increasing number of younger men testing as a direct result of internet outreach (44% of internet recruited participants are 18-29 years old). 25% were not gay identified (NGI), and 23% reported female sex partners. Unprotected anal sex was reported by 46% of participants. Inclusion of testing and referral for STI has demonstrated that 7% of participants had Gonorrhea, Chlamydia, or Syphilis diagnosed at their visit.

CONCLUSION: Housing an HIV and STI testing program in the context of a CSV may neutralize stigma and appeal to a particularly high risk and diverse group of MSM recruited from diverse sources. The MSHP model of collaboration has created an integrated service adding a CSV-based HIV/STI diagnostic and preventive presence in NYC for sexually active MSM.

ABSTRACT 116

**Interviewing Late Testers to Identify
Barriers to Early HIV Diagnosis**

JW Dilley¹, S Schwarcz², H Frank³, and C Wenzel⁴

1 Interim Chief of Psychiatry, San Francisco General Hospital and Executive Director, University of California, San Francisco AIDS Health Project, San Francisco, CA, USA; 2 Director of Research and Special Studies, San Francisco Department of Public Health, San Francisco, CA, USA; 3 Project Director, San Francisco Department of Public Health, San Francisco, CA, USA; 4 Research Assistant, UCSF, San Francisco, CA, USA

OBJECTIVE: Late diagnosis of HIV results in increased morbidity and mortality, increased medical costs, and likely increased HIV transmission as such persons may unknowingly transmit HIV. Despite the widespread availability of free, confidential and anonymous testing

and other HIV prevention services, nearly 40% of persons diagnosed with AIDS in San Francisco (SF) were diagnosed with HIV within the 12 months prior to their AIDS diagnosis between 2000 and 2005. Factors contributing to late testing are poorly understood. The goal of this study is to identify and interview late testers, identify barriers to early testing and develop strategies to address identified barriers.

METHODS: Late testers were identified using the AIDS case registry at the SF Dept. of Public Health (defined as persons whose HIV diagnosis occurred within 12 months of their AIDS diagnosis based upon the date of the first known HIV-positive test, the first CD4 or viral load test, or first date noted to have been prescribed antiretroviral therapy, whichever was earliest,). Eligible participants were those diagnosed with AIDS after June 1, 2007. The diagnosing health care provider was contacted and asked to refer the patient and, if the patient consented, a qualitative and quantitative interview was conducted.

RESULTS: Between January 1, 2007 and March 2008, 143 late testers were identified. Recruitment has been initiated at public health care facilities; expansion to private providers will begin September 1, 2008. All patients approached agreed to participate and sixteen interviews have been completed. Participants included: 12 men, 2 women, and 2 male to female transgender; 8 gay/bisexual males, 4 heterosexual males, 2 heterosexual females, and 1 gay identified and 1 heterosexual transgender. Racial characteristics: 6 Caucasian, 6 Latin American/Hispanic, 2 American Indian, and 2 Black/African American. 13 had no health insurance prior to their HIV diagnosis and 11 had an annual income level of \$12,000 or less. 7 were from outside the United States and 6 did not finish high school. Preliminary results suggest a few common factors that led to late diagnosis. These include: an attitude of “why bother?” as participants were unaware of the life saving effect of current HIV treatment; a feeling that “care wouldn’t be available anyway”; a fear of facing a possible diagnosis; frankly denying one’s own level of risk, and failing to appreciate that certain behaviors were risky.

CONCLUSIONS: Although only part way through data collection (a total of 50 interviews are planned) results to date suggest important themes to promote early

HIV diagnosis, including developing public awareness campaigns focusing on the availability of free/low cost HIV medical care, marketing the successes of current therapies in maintaining health, and improving dissemination of specific HIV prevention information to those at high risk.

ABSTRACT 117

Qualitative Assessment of Implementing Routine Rapid HIV Testing

JE Feld¹, JF Golden¹, B Bokhour^{2,3}, and HD Anaya¹

1 Center for the Study of Healthcare Provider Behavior, U.S. Department of Veterans Affairs Greater Los Angeles Health Services Research and Development (HRS&D) Center of Excellence, VA Greater Los Angeles Healthcare System, Los Angeles CA, USA; 2 Center for Health Quality, Outcomes and Economic Research, Veterans Affairs Medical Center, Bedford, MA, USA; 3 Boston University, School of Public Health, USA

OBJECTIVE: To explore and document barriers, facilitators, and unintended consequences of implementing nurse-based rapid testing (NRT) model of HIV testing.

METHODS: Using modified snow-ball techniques, we recruited 18 VA Los Angeles Outpatient Center (LAOPC) staff for semi-structured interviews 3 months post NRT launch at LAOPC; 4 key stakeholders/administrators and 14 front-line practitioners certified in HIV RT in the following areas: mental health, community care, substance use disorder, walk-in, and dental clinics. Interviews explored the following: rapid *versus* conventional HIV testing, the use of nurses and other staff to administer and interpret HIV tests, organizational and personal willingness to adopt/support NRT. Moreover, issues related to job performance, task comprehension, and unintended consequences of NRT were examined.

RESULTS: Interview responses suggest high levels of interest in continued NRT efforts: 11 of 14 practitioners rated routine NRT as ‘very important’ compared to testing for other chronic diseases. Interestingly, despite high levels of patient and provider interest in NRT following the NRT training launch, only 6 of 13 certified practitioners had administered a RT; 7 of 13 performed standard referrals to

either walk-in clinic or to informally-designated primary care RN who emerged as the main HIV RT representative. The suggestibility of such HIV RT implementation varied according to provider motivation and service area. Interviews yielded distinct information regarding potential barriers and facilitators associated with HIV RT implementation.

CONCLUSIONS: Distinct themes emerged as barriers/facilitators to practitioner adoption of routine HIV RT. Tentative themes include the importance of:

- congruence of HIV RT with perceived roles and responsibilities (i.e. preventative and medical *versus* non-medical, urgent care);
- practitioner confidence/efficacy for entire HIV RT processes;
- clinical workload/staffing as sufficient for uptake of routine testing *versus* risk-based testing;
- attainment of designated HIV RT clinical support across multiple departments (i.e.; dentistry, primary care, mental health, social work.);
- consistency of staff implementation trainings that is tailored; site-specific to departmental service logistics and mechanics;
- desired expansion of HIV RT training to include LVNs/LVPs.

The assessment and qualitative analysis of implementing routine HIV RT has important implications for estimating organization impacts associated with operations and changes in care delivery. Local policies (including allowing LVNs/LVPs to participate in rapid testing) have been initiated. These qualitative findings will be used as the basis of future efforts at implementing routine HIV rapid testing at other local and national VA facilities.

ABSTRACT 118

ACTS (Advise, Consent, Test, Support): A Successful Model for Routinizing HIV Testing in Clinical and Community Settings Using Existing Resources

D Futterman¹, S Stafford¹, M Lyle¹, and P Meissner²

1 Adolescent AIDS Program, Montefiore Medical Center, Bronx, NY, USA; 2 Montefiore Medical Center, Department of Family Medicine, Bronx, NY, USA

OBJECTIVE: Approximately one-third of HIV+ people in the US have not been tested and thus do not benefit from life-saving treatment and prevention services. In clinical settings, barriers to more routine HIV testing include: lengthy counseling, insufficient counseling staff, HIV testing's separation from routine health care and risk-based screening. This report summarizes experiences in scaling up testing in urban community health centers from 2004 through 2007.

METHODS: A streamlined, 5-10 minute approach to HIV testing called ACTS (Advise everyone be tested, obtain Consent, Test and provide Support to HIV+ and HIV-clients) was developed to improve the routine offer of HIV testing to eligible patients (non-pregnant and ages 13-64) in clinical settings. Key innovations of ACTS included task-shifting that charged providers to routinely offer testing and counselors to become more involved in the support of HIV+ patients. Additionally, ACTS addressed key administrative barriers to testing. Ten clinics were randomized with five receiving the ACTS intervention (logistical planning, staff training and follow-up) and 5 serving as lagged controls. Routinely collected lab data was used to monitor results. **RESULTS:** At baseline (2003) all sites tested less than 10% of eligible patients. By the end of the trial (2005), ACTS clinics were testing 22% of eligible patients while control clinics had only increased to 8%. After the '03 - '05 trial of ACTS, intervention clinics were provided ongoing technical assistance for an additional year (2006). Testing continued to increase to 28% in ACTS clinics *vs.* 14% in control clinics.

In 2006, control sites were trained to implement ACTS

and in one year's time (2007) increased their testing by 50%, from 14% to 21%. Without the ongoing support of technical assistance in 2007, HIV testing declined at the intervention sites from 28% to 26%. No significant change noted in the number of HIV+ patients identified. Providers found ACTS easy to use, but reported that required HIV testing paperwork restricted routine testing achievements.

CONCLUSIONS: The ACTS approach to streamlined testing, staff training and ongoing data collection and feedback facilitated significant increases in HIV testing, while utilizing existing personnel resources. Doctors, nurses and other health care providers reported that ACTS allowed them to offer a more comprehensive package of routine care, which was worth the extra time added to their clinical encounters. Sustained practice change required intensive support via monthly data reports, site-specific technical assistance and training of new staff. Given the potential clinics have in improving case finding and linking undiagnosed HIV-positive patients to care, ACTS should be utilized to scale-up routine HIV testing in these settings. The success of ACTS in this trial led to its use by clinical and community partners in the largest municipal scale up of routine HIV testing in the US, *The Bronx Knows HIV Testing Initiative* sponsored by the New York City Department of Health and Mental Hygiene and a consortium of Bronx community partners. Additionally, the DOHs in Washington, DC, Oakland and Pennsylvania use ACTS as well as prominent care organizations. Internationally, ACTS is funded by the President's Emergency Plan for AIDS Relief (PEPFAR) to scale up HIV diagnosis and linkage to care among South African youth in clinic and community settings. Additionally, ACTS formed the basis of the Botswana Ministry of Health's national policy on routine provider-delivered HIV testing.

ABSTRACT 119

Feasibility, Acceptability and Accuracy of Patient Self-testing for HIV using Point-of-care (POC) HIV Tests in an Emergency Department Setting

CA Gaydos^{1,2}, J Gagnon², Y-H Hsieh², A Burah², M Barnes¹, P Agreda¹, H Won¹, and R Rothman^{1,2}

1 Johns Hopkins University Division of Infectious Diseases, Baltimore, MD, USA; 2 Johns Hopkins University Department of Emergency Medicine, Baltimore, MD, USA

OBJECTIVE: To evaluate the feasibility, acceptability and accuracy of existing point-of-care (POC) HIV tests performed by an untrained patient compared to results of a standard-of-care POC HIV test performed by a trained health care professional in an urban emergency department (ED).

METHODS: From April-August 2008, patients who had already completed a standard-of-care HIV test performed by a trained healthcare worker and who were unaware of their result were recruited to volunteer to perform a rapid POC HIV. Consented patients were given a choice of performing the OraQuick Advance (oral fluid) or Trinity Unigold (fingerstick blood) Patients aged 18 to 64 years without a previous HIV diagnosis were eligible. Acceptability was assessed by a questionnaire.

RESULTS: Of 129 patients approached for testing, 115 (89%) accepted and performed a POC test; 85% chose OraQuick whereas 15% chose Unigold ($p < 0.05$). For patients preferring the oral test, the median age was 43 yr., 57% patients were female, 79% were African American and 19% were white. Within the fingerstick group, the median age was 37 yr., 35% patients were female, 82% were African American and 12% were white. Test results from both groups had a 100% concordance rate with the test results obtained by the trained healthcare worker. One indeterminate Unigold test had to be repeated due to insufficient blood. Eighty percent of patients in the oral group and 94% of patients in the blood group trusted the

self-administered test result “very much”. Results obtained by the healthcare worker were trusted “very much” by 87% and 77% of patients in the oral and fingerstick test group, respectively. Ninety-eight percent of participants in the oral test group reported oral fluid “not at all hard to collect” while 76% stated blood was “not at all hard to collect” from the fingerstick. Ninety percent of participants in the oral and 100% in the fingerstick test group reported they would “definitely” or “probably recommend” self-testing to a friend, whereas 94% and 97% would “probably” or “definitely” perform a test at home if it were available over the counter.

CONCLUSION: A significant proportion of patients offered POC testing in the ED preferred using oral testing over fingerstick testing. Patients’ results were concordant with those obtained by trained healthcare workers. The majority of participants trusted their results and would perform a POC HIV test at home, if given the opportunity.

ABSTRACT 120

Blocks: An Innovative Community-Based, Block-by-Block Approach to Rapid HIV Testing in New York City

S Gillen, Z Naqvi, and P McGovern

Harlem United Community AIDS Center, New York City, NY, USA

OBJECTIVE: Historically, HIV prevention efforts have focused on risk-based approaches. While this model has been effective, it may be less so in high-prevalence communities that are experiencing a generalized epidemic. In Central and East Harlem, for example, prevalence rates are as high as 1 in 37 residents (NYCDOH 2006 Epidemiology Report). In this context, geographic-based approaches that promote routine testing of all residents, regardless of risk, may be required. With seed funding from the MAC AIDS Fund in 2007, Harlem United, a community-based service provider, established a block-by-block rapid HIV testing campaign. Its primary aims were two-fold: 1) eliminate barriers to testing (e.g., HIV stigma,

homophobia, etc) through guerilla marketing and provide routine HIV testing to all residents and 2) gather data to assess the impact of this innovative, geographic-based testing approach.

INTERVENTION METHOD: Using epidemiological and program data, we identified two 10-block, high-impact zones within the Harlem community. We trained eight part-time peer educators and two community organizers to conduct systematic outreach to the area. These staff became a routine presence in the zone, working diligently to blanket the area with HIV prevention messages using both non-direct (e.g., posters and flyers), as well as direct means (e.g., street outreach, rallies, and health fairs). The program also set up mobile HIV testing in the area for 30 hours each week. Every fourth months, the Blocks team moved to zones to further expand our geographic reach. We return periodically to existing zones to reinforce messages and make testing accessible.

STUDY METHOD: A community-level survey was conducted at baseline, prior to campaign initiation and then, again, six months later. This paper and pencil survey consisted of numerous scales, including measures of HIV-related knowledge, attitudes, and behaviors, as well as measures of intervention saturation. Assessments were conducted interview style or independently, in Spanish or in English, according to respondent preferences.

RESULTS: Analysis of preliminary findings suggest that, while knowledge and attitudes were not affected, the Blocks Project was successful in promoting HIV testing among residents in the area; according to our analysis, testing rates in the last six months increased from 39% to 69% from baseline to six month follow-up ($p < .001$).

CONCLUSIONS: Although the project is still in its infancy, preliminary data suggest that the Blocks Project’s geographic, community-organizing approach to HIV testing may be a viable supplement to risk-based approaches in high prevalence communities that are experiencing a generalized epidemic.

ABSTRACT 121

Evaluation of Readiness to Implement HIV Rapid Testing in SUD Clinics

JF Golden¹, JE Feld¹, SR Henry¹, H Hagedorn^{2,3}, H Knapp¹, and HD Anaya¹

1 Center for the Study of Healthcare Provider Behavior, U.S. Department of Veterans Affairs Greater Los Angeles Health Services Research and Development (HRS&D) Center of Excellence, VA Greater Los Angeles Healthcare System, Los Angeles CA, USA; 2 U.S. Department of Veterans Affairs Quality Enhancement Research Initiative, Substance Use Disorders Center; 3 Department of Psychiatry, University of Minnesota, MN, USA

OBJECTIVE: To conduct a formative evaluation to determine whether HIV nurse-based rapid (HIV NRT) testing can be integrated into Substance Use Disorder (SUD) clinics within the U.S. Department of Veterans Affairs.

METHODS: Using modified snow-ball survey techniques, we conducted semi-structured interviews with key SUD stakeholders (i.e. SUD program administrators, providers and staff) at three sites within the Greater Los Angeles Healthcare System (GLA). Furthermore, we surveyed front-line SUD staff to examine organizational capacity and readiness for HIV NRT using selected questions from existing Organizational Readiness scales to assess evidence and context. The survey assessed the following domains: Leadership support, employee attitudes toward NRT in SUD clinics, feasibility of possible future intervention, and organizational readiness for routine implementation.

RESULTS: SUD staff identified the following as barriers and facilitators to organizational readiness for routine HIV NRT implementation: Availability of space for pre/post-test counseling, availability of on-site/on-call mental health specialist(s) and adequate clinic staffing. In addition, SUD staff identified comprehensive post-test sensitivity training for positive results as a key component to individual readiness for routine HIV NRT implementation.

CONCLUSIONS: Overall, preliminary results garnered by surveys and interviews suggest support for SUD clinic

implementation of routine HIV NRT amongst GLA's SUD clinic staff. Willingness to adopt routine HIV NRT could vary by SUD clinic. Based upon the high prevalence of HIV infected individuals in SUD clinics, and overall staff willingness, VA stakeholders should consider SUD clinics as a viable option in regard to implementation of routine HIV RT.

ABSTRACT 122

Impact of the 2006 CDC HIV Testing Recommendations on State HIV Testing Laws

SE Neff and RH Goldschmidt

National HIV/AIDS Clinicians' Consultation Center, San Francisco General Hospital, University of California, San Francisco, CA, USA

OBJECTIVE: Human immunodeficiency virus (HIV) testing laws are under the jurisdiction of each state. They are also influenced by the 2006 national CDC recommendations on HIV testing in healthcare settings. State laws and national recommendations can be disparate, presenting conflicting information to clinicians. The *Compendium of State HIV Testing Laws* is a living, online document that serves as a national resource to help clinicians understand their state HIV testing laws and the CDC revised recommendations. This abstract presents the current status of state HIV testing laws in relation to the 2006 CDC recommendations.

METHODS: The *Compendium* consists of frequently updated profiles for each state that summarize current HIV testing laws pertinent for clinicians. Information sources include www.lexisnexis.com, www.guttmacher.com, www.kaisernetwork.org, and state legislative websites. To assess the current status of state HIV testing laws and compare these laws before and after the issuance of the 2006 CDC recommendations, the *Compendium* was screened for updates that concern consent and counseling between September 2006 and September 2008. These laws were assessed for compatibility with the CDC recommendations based on the

following subparameters: specific consent *vs.* general consent; written consent *vs.* either oral or written consent; opt-in consent process *vs.* opt-out consent process; and pre- and post-test counseling. Compatibility was defined as not conflicting with CDC recommendations.

RESULTS: Currently, 41 states (including Washington, D.C.) have laws compatible with CDC recommendations on the consent and counseling subparameters evaluated. Of these 41, eight states' laws specify testing through the opt-out process, 33 do not specify either opt-in or opt-out, and none require opt-in testing. State laws in 10 states are not compatible with CDC recommendations on at least one subparameter (see table). For some states, new legislation designed to be more compatible with CDC recommendations on some parameters has created an internal conflict within that state's HIV testing laws. At least 16 states have passed legislation making their laws more compatible with the CDC recommendations on one or more parameters of consent and counseling; an additional eight states have introduced similar legislation.

CONCLUSIONS: The majority of states have HIV testing laws that are compatible with CDC recommendations. Some states have laws that directly conflict with the CDC recommendations; other states have multiple HIV testing laws that are internally inconsistent. The *Compendium* at www.nccc.ucsf.hivcntr can be a valuable tool for clinicians in understanding HIV testing laws, especially as changes in state laws and national recommendations occur.

Compatibility	Number of States
Compatible on all parameters	41*
<i>Specify opt-out language</i>	8
<i>Language does not address opt-in or opt-out</i>	33*
Incompatible (at least 1 parameter)	10
<i>Specific Consent Required</i>	6
<i>Written Consent Required</i>	8
<i>Opt-in Required</i>	0
<i>Pre-test Prevention Counseling Required</i>	0
<i>Post-test Prevention Counseling Required</i>	1
Changed Legislation since September 2006	16
Legislation Pending	8

*Including Washington, DC

ABSTRACT 123

Increasing HIV Testing Rates by Obstetrician-gynecologists among Non-pregnant Women and Adolescents and the Number of HIV-infected Women Who Know that they are Infected

D Hawks¹, R Carlson¹, and D Jamieson²

1 American College of Obstetricians and Gynecologists, Washington DC, USA; 2 Centers for Disease Control and Prevention, Atlanta, GA, USA

OBJECTIVE: Increase the percentage of ob-gyns who are recommending routine HIV screening for nonpregnant women and adolescents. Increase the number of HIV-infected women who know that they are infected.

METHODS: The American College of Obstetricians and Gynecologists (ACOG), a medical specialty society comprised of over 95% of board-certified obstetrician-gynecologists (ob-gyns) totaling over 52,000 members, endorsed CDC's new guidelines for routine HIV screening. ACOG published new clinical guidelines in a peer-reviewed medical journal recommending routine HIV screening for non-pregnant women and sexually active female adolescents that also targeted women of color and other high-risk groups. ACOG widely promoted this endorsement and these new professional guidelines and patient resources in a national distribution to practicing ob-gyns, hospital emergency departments, and the leadership of other health care, public health, policymakers and advocacy groups. ACOG also widely disseminated these professional guidelines and patient resources on websites, the media, and postgraduate courses. ACOG developed a branding for these routine HIV materials to heighten awareness among ob-gyns and their patients. ACOG produced specialized professional and patient materials on routine HIV screening, including a physician script on how to recommend HIV testing for non-pregnant women and adolescents. ACOG convened an advisory group of ob-gyns nationally known for their expertise in HIV in reproductive health care settings to provide consultation

on activities and survey reports. ACOG is developing a postgraduate course (for CMEs) on incorporating routine HIV screening into gynecologic and primary care for ob-gyns. ACOG also is producing a CD-Rom (for CMEs) on family planning and pre- and inter-conception care of HIV-positive women, including clinical case vignettes and a video of a clinical interview with an HIV-positive woman of reproductive age for ob-gyns and other women's health care professionals. ACOG will conduct a post-distribution survey to measure changes in ob-gyns' HIV testing practices with non-pregnant women and to evaluate the efficacy of ACOG's activities on ob-gyns' knowledge, attitudes and screening practices.

RESULTS: ACOG previously conducted a patient survey and found that 2/3 of respondents reported having been tested for HIV, many by their ob-gyn. ACOG previously conducted a physician survey on HIV screening and found that the majority of ob-gyns would strongly recommend HIV testing for nonpregnant patients for several reasons.

CONCLUSIONS: ACOG has demonstrated that development and wide promulgation of professional organization's clinical guidelines and resources for health care providers and consumers can expanded the number of ob-gyns recommending HIV screening for women and adolescents.

ABSTRACT 124

Emergency Medicine Resident Attitudes and Perceptions of HIV Testing Before and After an Educational Program and Testing Implementation

Y-H Hsieh, J Shahan, J Jung, D Moring-Paris, G Kelen and R Rothman

Department of Emergency Medicine, The Johns Hopkins University School of Medicine, Baltimore, MD, USA

OBJECTIVE: To determine attitudes & perceptions (A&P) of emergency medicine (EM) residents towards emergency department (ED) routine provider-driven

rapid HIV testing services and the impact of both an educational program (EP) and implementation of HIV testing.

METHODS: We conducted a three phase consecutive anonymous identity-unlinked survey at pre-, post-EP, and 6-month post-implementation. The survey was designed to assess residents' A&P, using a five-point Likert scale. A pre-implementation EP provided the rationale for the HIV testing program, and operational details. The HIV testing program used ED providers only (physicians and nurses) to deliver HIV testing as part of standard-of-care in an academic ED. The impact of the EP and implementation on A&P were analyzed. A favorable A&P was defined as an average score > 3.5.

RESULTS: Thirty of thirty-six residents (83.3%) participated in all three phases. Areas of positive A&P present in phase 1 and sustained through phases 2 and 3, included "ED serving as a testing venue" (score range: 3.7-4.1) and "ED physicians offering the test" (score range: 3.9-4.1). Areas of negative A&P identified in phase 1 were all operational barriers, including required paperwork (score=2.9), inadequate staff support (score=2.3), counseling and referral requirements (score range: 2.2-3.1), and time requirements (score=2.7). Following the EP, significant increases in favorable views were observed with regard to modification of patient risk behaviors, decrease in HIV transmission as a result of the testing program, availability of support staff, self-confidence in counseling, and referral ($p<0.05$). At 6-month post-implementation, all A&P except time requirements, lack of support staff, and required paperwork, scored favorably. During the study period, 388 patients were offered and tested for HIV and 6 (1.5%) were confirmed positive.

CONCLUSIONS: ED residents conceptually supported HIV testing services. Most A&P were favorably influenced by both the EP and implementation. All areas of negative A&P involved operational requirements, which likely influenced the relatively low overall uptake of HIV testing conducted by the study participants.

ABSTRACT 125

HIV Testing Practices and Diffusion of 2006 CDC HIV Testing Recommendations among New York City Internal Medicine Residents

CL Jain^{1,2}, CM Wyatt², R Burke¹, K Sepkowitz¹, and EM Begier¹

1 New York City Department of Health and Mental Hygiene, Bureau of HIV/AIDS Prevention and Control, New York, NY, USA; 2 Mount Sinai School of Medicine, New York, NY, USA

OBJECTIVE: In September 2006, the CDC endorsed routine voluntary HIV testing in health care settings to identify the many HIV-infected but undiagnosed persons. Realizing this goal will require primary-care providers including internal medicine (IM) physicians to order HIV tests routinely. In particular, urban IM trainees who work in high HIV prevalence settings need to adopt this approach. We therefore examined diffusion of the 2006 guidelines to this group.

METHODS: We conducted a self-administered electronic cross-sectional survey of New York City's (NYC) IM residents on HIV testing-related knowledge, attitudes, and behaviors with 29 multiple-choice questions. Fifteen of 42 NYC IM residency programs participated in early 2007.

RESULTS: 450/1175 (38.3%) residents responded. Most (63.9%) ordered ≤ 10 HIV tests in the past six months. Only 32.6% were aware of current guidelines, and few (35.8%) utilized a routine testing approach. Respondents aware of current guidelines were more likely to practice routine testing (OR 3.7, 95% CI: 2.4–5.6) and ordered more HIV tests (OR 1.7, 95% CI: 1.1–2.5). Two common barriers to testing were procedural: time-consuming consent process (27.1%); difficulty locating consent forms (19.3%). Most (68.4%) respondents indicated that oral consent would facilitate more testing.

CONCLUSION: Most NYC IM residents are unaware of new CDC HIV testing guidelines and continue to test patients according to perceived patient HIV risk. This is

likely contributing to their low testing rates. Policy barriers to routine testing were identified. Efforts should be made to improve dissemination of guidelines as well as address policy barriers to allow more people to learn their HIV status.

ABSTRACT 126

Initiation of Point-of-service HIV Testing in Sexually Transmitted Disease Clinics

J Jones^{1,2}, L Johnsen^{1,2}, B Wilgus^{1,2}, and E Erbedding^{1,2}

1 The Baltimore City Health Department, Baltimore, MD, USA; 2 Johns Hopkins University School of Medicine, Baltimore, MD, USA

BACKGROUND: Knowledge of one's HIV serostatus is a critical component of the national HIV prevention strategy. Point-of-Service (POS) HIV tests in HIV clinics may increase rates of HIV case finding, post-test counseling and improve linkage to care.

OBJECTIVE: To describe characteristics of patients choosing a POS HIV testing program initiated in the Baltimore City Health Department STD clinics.

METHODS: The Baltimore City Health Department STD clinics offered POS HIV testing (OraQuick ADVANCE[®] Rapid HIV-1/2 Antibody Test, OraSure Technologies, Inc.) as an option for walk-in patients beginning in May, 2008. Those consenting to HIV testing were offered the option of POS testing or traditional testing (results in one week). Those electing a POS test saw a health educator who performed the test (either on oral mucosal fluid or whole blood); sera from POS + HIV tests had confirmatory Western Blots. POS + patients received post-test counseling, had additional HIV staging labs (CD4 and HIV RNA), and were referred for same-day partner notification services. We used the standard medical record to describe characteristics of patients undergoing POS testing and their early follow-up.

RESULTS: From May 1, 2008 through September 24, 2008, 2360 POS HIV tests were performed among 2310

patients. Of these, 35 patients tested POS + and 26 (1.1 % overall) were HIV+ by confirmatory Western Blot (PPV=74%). Of those with HIV infection, 11.5% also had gonorrhea and 19.2% had reactive serology testing for syphilis. 50 % of these HIV+ infected patients enrolled in on-site HIV care.

CONCLUSIONS: POS HIV testing in STD clinics is feasible and can reach a population at high risk for HIV/STD co-morbidity. It provides the opportunity to deliver same-day HIV/STD testing, post-test counseling, partner services, and initiate HIV care. Testing algorithms that reduce rates of false-positive POS tests and systems that strengthen engagement in care after POS testing are priorities for STD clinic settings.

ABSTRACT 127

Routine Point-of-care Rapid HIV Testing of Medicine Service Admissions in the Emergency Department

R Lubelchek^{1,2}, KA Kroc², D Levine^{1,2}, M Gonzalez², D Parks², and RR Roberts^{1,2}

1 John H. Stroger, Jr. Hospital of Cook County, Chicago, IL, USA; 2 Ruth M. Rothstein CORE Center, Chicago, IL, USA

OBJECTIVE: Identify previously undiagnosed HIV-infected patients among emergency department (ED) patients pending admission to medicine services, with the goals of redirecting them to the inpatient HIV service and improving linkage with ambulatory HIV care.

METHODS: Two health educators (HEs) staffed this urban public hospital ED weekdays from 8:30am-8pm, offering point-of-care rapid testing (RT) to patients aged 18 – 64 who were being admitted to medicine services. HEs offered testing, obtained consent and finger-stick blood, performed the test (Trinity Biotech, Uni-Gold Recombigen HIV-1), provided results to patients, and recorded results in the electronic medical record. Patients testing positive received counseling and the HE obtained a

serum specimen for confirmatory testing. Prior to hospital discharge, patients received appointments at the nearby, affiliated CORE Center HIV clinic.

RESULTS: Between March 1 and August 22 of 2008, a total of 1945 patients awaiting admission routinely received RT in the ED. Of these, 15 (0.8%) were confirmed HIV-positive. Patients with positive RT results were redirected to the inpatient HIV service. During the two preceding years, confirmed HIV-positive patients had a mean of 2.8 prior ED visits without receiving HIV testing. The mean age was 39 years (range: 25-50); 9/15 (60%) were African American, 5/15 Latino (33%) and 1/15 (7%) White – similar to our general demographics. The mean viral load was 5.3 log (range: 2.9 – 5.9); 13/14 (93%) had CD4 counts < 200 cells/mm³ (mean 73). Pneumocystis pneumonia was the most common discharge diagnosis (6/15; 40%). One patient died during hospitalization; the remaining 14 were scheduled for follow up at the CORE Center. Of those, 11/14 (79%) have reported for care (mean time: 13 days from RT), 2/14 (14%) are being followed by a retention specialist, and one appointment is pending. Of 11 patients in care, 2/9 (22%) with baseline HIV genotyping done demonstrated resistance. Of six started on anti-retroviral therapy, five have had > 1 log drop in viral load.

CONCLUSION: Patients diagnosed with HIV infection in our ED prior to admission are extremely ill, with all but one having an AIDS diagnosis. Routine RT in this population provided a reliable link to both inpatient and outpatient HIV care. Acceptance of HIV testing by our ED staff in this large, public safety-net hospital was bolstered by the use of HEs, who handled every aspect of the HIV testing and notification process.

ABSTRACT 128

Citywide HIV Screening Initiative as a Municipal Response to HIV

M Martin

Get Screened Oakland, Oakland, CA, USA

OBJECTIVE: To describe the strategic framework for the development of a community-wide approach to make HIV screening/testing a routine part of health care.

METHODS: Working closely with the local elected officials, community-based AIDS Service Organizations, county health officials, faith leaders, social service agencies, clinics, hospitals, philanthropic organizations and community foundations, Get Screened Oakland has developed a methodology for coordinating capacity building, technical assistance, social marketing, community engagement and coalition building necessary for implementation of a successful municipal response to HIV.

RESULTS: More than 8000 individuals have been reached and offered HIV educational materials through Get Screened Oakland supported HIV screening outreach events. Of the 8000, more than 1000 have been tested for HIV. All community clinics and area hospitals that serve the greater Oakland/Alameda County have received technical assistance and agreed to participate in the HIV screening initiative.

CONCLUSIONS: Get Screened Oakland is a municipal program designed to support a community collaborative HIV agenda that includes: prevention education and awareness, medical protocols and a social marketing campaign that will increase HIV awareness, expand HIV screening in clinical and non-clinical settings and connect or reconnect those living with the virus to care. GSO has successfully worked with partners to expand HIV testing capacity, to develop educational messages about HIV for their constituents/clients/consumers, while simultaneously working with local government agencies to adopt and adapt strategies which increase their ability to partner with other providers in both the public and private

sectors. GSO's collaborative partners comprise key sectors of the Oakland community which form the framework and backdrop of its municipal model.

ABSTRACT 129

A Model for Routinized Hospital-wide HIV Screening: Lessons Learned and Public Health Implications

CJ Maxwell¹, AM Sitapati², SS Abdus-Salaam¹, P Summers¹, GE Bonney³, V Apprey³, VF Scott⁴, M Martin⁵, M Daftary⁶, M Washington⁷, F Daniels, III⁷, V Webster¹, A Smith¹, C Mouton⁸, and G Mountvarner⁷

1 Women's Health Institute, Howard University, Washington, DC, USA; 2 Owen Clinic, University of California San Diego, San Diego, CA, USA; 3 Statistical Genetics and Bioinformatics Unit at the National Human Genome Center, Howard University, Washington, DC, USA; 4 Department of Medicine, Howard University, Washington, DC, USA; 5 Office of the Mayor, Oakland, CA, USA; 6 College of Pharmacy, Howard University, Washington, DC, USA; 7 Emergency Department, Howard University Hospital, Washington, DC, USA; 8 Department of Community and Family Medicine, Howard University, Washington, DC, USA

CONTEXT: The Centers for Disease Control and Prevention estimates that approximately 250,000 Americans who are HIV-positive do not know they are infected. This group represents an important reservoir for virus transmission. The revised CDC recommendations for HIV screening promote routine screening in the healthcare setting.

OBJECTIVE: To develop and implement a routinized hospital-wide routine rapid HIV screening program.

METHODS: Rapid oral fluid-based HIV testing was conducted at Howard University Hospital (HUH) on consenting patients ages 13 years and older using the OraSure OraQuick *Advance*[®] Rapid HIV-1/2 Antibody Test. Screened patients received immediate test results with subsequent confirmatory testing in the event of a preliminary reactive result. Patients were offered a direct

link to continued care. We report here on the results of screening during the 12-month period October 23, 2006 through October 22, 2007.

Data on the number of patients offered HIV screening, the number tested, the number of screened patients with a preliminary reactive result, and the results of confirmatory testing are provided. Information on the numbers of patients tested were characterized by location of testing, gender, racial make-up, and age.

RESULTS: Of the 12,836 patients offered HIV testing, 7,528 consented. A preliminary reactive test result was identified in 176 patients (2.3%). Overall, 45.5% of the preliminary reactive results were confirmed, with 82.5% confirmed positive. A change in the screening protocol led to an improved 100% confirmatory testing rate.

CONCLUSIONS: Hospital-wide routine HIV screening is feasible and can be implemented effectively and efficiently. The HIV screening campaign instituted at HUH identified a substantial number of HIV-positive individuals and provided a critical connection to follow-up testing, counseling, and disease management services.

ABSTRACT 130

Bridging: Linking Sub-Saharan Africans to Comprehensive Care

C McMahon¹, B Schiano¹, and S Davis³

1 Sibusiso, Stoneham, MA, USA; 2 Massachusetts General Hospital, Boston, MA, USA

OBJECTIVE: The Bridging Program was a one-year pilot program in the Boston metropolitan area to outreach to the sub-Saharan immigrant community. The goals of the program were to: 1) **Identify** and **Engage** leaders of sub-Saharan African communities within Massachusetts by sharing information on HIV/AIDS health and support services that are available and critical for referring their populations into care. 2) **Assess** the needs of the local Sub Saharan African community in order to develop community-specific and culturally relevant projects aimed

at raising awareness on HIV/AIDS/Hepatitis B prevention, transmission, treatment, and support. 3) **Educate** Sub Saharan Africans who reside in Massachusetts on HIV/AIDS/Hepatitis, and services that are available for those infected and affected by these illnesses. 4) **Refer** Sub Saharan African community members for HIV and Hepatitis B testing and counseling, and if necessary refer to comprehensive quality care services.

METHODS: Innovative outreach strategies utilized to gain access to the Sub-Saharan African immigrant communities included collaborations with first contact organizations such as the Red Cross, Immigrant Centers, community cultural organizations, and African festivals. Outreach to African faith based communities was accomplished by engaging faith based leaders and providing general health education imbedded with HIV and Hepatitis B education at larger African faith based events. These outreach activities would often lead to larger and more formal educational presentations in the community, as well as referrals to community health centers and infectious disease clinics.

RESULTS: In order to gain access to the often hidden sub-Saharan community, a multi-pronged approach to outreach was initiated; contacts were made with 85 community organizations in the Boston and Worcester areas including refugee and immigrant centers, faith based organizations, cultural centers, and sub Saharan proprietors, and media venues, 20 area community health centers, and 5 academic medical centers, 210 individual contacts via health fairs and African festivals, and 500 individuals attended formal and informal discussions, group presentations and community events. Outreach meetings included education on HIV and Hepatitis B, local community resources, referral to local HIV and Hepatitis B testing sites, and referral for medical care.

CONCLUSIONS: The Bridging program addressed obstacles to care for the sub-Saharan community. After identifying financial, physical, and cultural barriers to care a comprehensive care program was developed that includes three major programs; Bridging to Care, Community Gateway, and Pastoral Care Outreach. A health care provider advisory board is being formed including physicians, nurses, nurse practitioners, social workers, and case managers. Sibusiso will utilize expertise

from this board to develop strategies to provide culturally appropriate access to HIV and Hepatitis B testing and care.

ABSTRACT 131

Are the 2006 CDC HIV Testing Recommendations Ethically Justified? It Depends!

RC Merchant¹, MJ Jaxman¹, MA Clark¹, MT Celada², and AM Sherwin¹

¹ Brown University, Providence, RI, USA; ² Wheaton College, Norton, MA, USA

OBJECTIVE: Leaders in HIV have voiced conflicting views regarding the ethics of the 2006 Centers for Disease Control and Prevention (CDC) HIV testing recommendations. We sought to identify the major elements of conflict raised in the medical and lay literature, conduct in-depth interviews with HIV leaders regarding the ethical concerns and justifications of the recommendations, and then use qualitative analytic techniques to elucidate the prevailing ethical themes.

METHODS: We performed a MEDLINE and internet search for all published works in the medical and lay literature on the 2006 CDC HIV testing recommendations. We compiled a list of US HIV leaders who authored or were quoted in these publications and assigned them to one of five groups, based upon their comments and occupation: supportive advocates, concerned advocates, supportive clinicians/researchers, concerned clinicians/researchers, and public officials. We conducted semi-structured telephone interviews of 5 individuals in each of these groups. We attempted to balance the demographic characteristics of the respondents in each group. Each respondent gave his/her perspective on how the recommendations either respect or violate ethical obligations to patients and how the recommendations either respect or violate patients' rights. Interviews were audio-recorded and transcribed. Major themes were summarized.

RESULTS: We identified seven major areas of conflicting ethical views: (1) opt-out *vs.* opt-in HIV testing, (2)

general medical *vs.* specific written consent for HIV testing, (3) optional *vs.* mandatory prevention counseling, (4) universal screening as a routine practice, (5) making HIV testing similar to other kinds of routine medical tests, (6) performing HIV screening without assured linkage to care, and (7) paying for HIV screening. Respondents were not uniform in their interpretation of the CDC recommendations, which was reflected in their differing views on the ethical concerns and justifications about the recommendations. One prevailing theme was the tension between competing priorities of public health *vs.* personal health needs. There was disagreement on whether HIV testing still requires unique processes and procedures. Respondents' beliefs about how well informed patients are about HIV and HIV testing appear to influence their consideration of the new recommendations as ethically concerning or justified. Ethical arguments were dependent upon whether the respondents viewed the procedures accompanying HIV testing as necessary or optional, as representing rights or privileges, or as serving as safeguards or barriers.

CONCLUSIONS: Concerns regarding responsibilities to patients and violations of patients' rights were highly dependent upon the manner in which respondents believed the recommendations will be implemented.

ABSTRACT 132

Strategies for Routinizing Rapid HIV Testing and Linkage to Care Throughout St. Luke's-Roosevelt Hospital Center

P Mills, SD Ellwein, and A Rice

Center for Comprehensive Care, St. Luke's-Roosevelt Hospital, New York, NY, USA

OBJECTIVE: In 2004, St. Luke's Hospital was one of the first medical centers in the U.S. to begin offering emergency department (ED) patients a free, rapid HIV test. With the goal of routinizing HIV testing, the rapid testing program was expanded to include all areas of both St. Luke's and Roosevelt Hospitals. This program aims to identify new

cases of HIV in the earliest stages of infection and to link all who test positive into care.

METHODS: In the ED, patients are offered an HIV test during initial triage. Signs advertising the test are posted above every bed, and physicians offer the test to patients as well. Physicians can order the test using either blood or an oral swab. Patients are given blood test results in under two hours. The oral test, which takes 20 minutes, is administered by an HIV Counselor. Patients who test preliminary positive receive a confirmatory test and are linked to follow-up care.

Doctors and nurses on inpatient units and outpatient medical clinics order rapid blood tests or administer oral swabs. In the case of a positive result, they contact either the HIV Counselor or inpatient HIV Social Workers who help inform patients and link them into care.

RESULTS: Since the program's inception, the number and percentage of patients tested have increased each year. 1860 eligible ED patients (5%) were tested from January to June in 2008, an increase from the 1163 patients (3%) tested during the first two quarters of 2007. Hospital-wide, a total of 3864 patients were tested in the first two quarters of 2008; 2729 were tested during the first two quarters of 2007.

The program has been successful in identifying people who did not know that they were HIV positive and linking them into care. Of the 134 patients who tested positive in 2007, 75% were linked to care at our Center for Comprehensive Care or with another healthcare provider. (64% were new diagnoses.) Of the 97 people who tested positive from January to July 2008, 84% were linked into care. (53% were new diagnoses.)

CONCLUSION: When HIV testing is routinely offered as a standard of care, many people who may not otherwise seek testing take the opportunity to learn their status. The rapid testing program at St. Luke's-Roosevelt Hospital Center also plays an important role in diagnosing HIV positive patients early and promptly linking them to specialized care.

ABSTRACT 133

Routine HIV Testing in Community Health Centers Should Include Models for Post Test Counseling and Linkage to HIV Care while also Gathering Important Outcome Data

CA Modica¹, JJ Myers², and K McNamara¹

1 National Association of Community Health Centers, Inc., Bethesda, MD, USA; 2 AIDS Research Institute, University of California, San Francisco, CA, USA

OBJECTIVES: The Centers for Disease Control and Prevention's (CDC) revised recommendations of September 2006 advocate routine voluntary HIV screening as a normal part of medical practice. Despite these recommendations, few medical practices have moved to routine HIV screening. The National Association of Community Health Centers, Inc. (NACHC), together with key national partners and health centers in four states, developed a model for the integration of HIV testing into routine primary care along with a model for post test counseling and referral to HIV specialty care, where needed.

METHODS: A primary care based model has been developed that integrates rapid HIV testing into the nurse intake process of a routine primary care visit. Testing occurs within the context of the primary care visit and, through partnerships with state or local Disease Intervention Specialists (DIS), all confirmed positives receive full post test counseling along with a complement of other services such as partnership notification and testing. The model also builds in the process of referring to HIV specialty care if such services are not provided by a health center. As part of the model, data is collected on such factors as demographics, acceptance and decline (including reason for decline) as well as information on previous HIV test history.

RESULTS: Ten health centers, representing 24 clinical sites, have successfully applied this model to integrate HIV rapid testing into primary care. As a result of this model,

over 15,000 patients have received an HIV test. Of these, 17 (.15%) new cases of HIV were identified, all but one of whom were successfully linked to care or are in contact with DIS or health center staff regarding their decision to refuse care. Fifty-six percent (56%) of patients tested through this pilot were tested for HIV for the first time. This project articulates a model of integrated rapid HIV testing that is acceptable to both patients and staff. The model, along with testing data, including results and linkage to care, will be presented.

CONCLUSIONS: A model for the integration of HIV screening into routine primary care has been developed that has been successfully integrated into over two dozen health center sites. This model has wide implications for the adoption of routine HIV screening at primary care sites nationwide.

ABSTRACT 134

HIV Testing Outcomes and Risk Behaviors in an Urban STI Clinic in Philadelphia

A Nunn¹, H Kwakwa², and R Ebuoroh²

1 Brown University Medical School Division of Infectious Diseases, Providence, RI, USA; 2 Philadelphia Department of Public Health, Philadelphia, PA, USA

BACKGROUND: The CDC has recommended opt-out HIV testing since 2006. In response to new CDC guidelines, the city of Philadelphia launched a rapid HIV testing and counseling campaign in public hospital emergency rooms, family planning and sexually transmitted infection (STI) clinics, and public health clinics in 2007.

OBJECTIVE AND METHODS: A survey was conducted among 1,697 individuals counseled and tested for HIV at an STI clinic in urban Philadelphia between July 1, 2007 and August 1, 2008. Data were collected on demographics, HIV risk behaviors, and HIV test results. Participants were also asked to rate their own HIV risk behaviors.

RESULTS: Fifty-six percent of testers were male; 44% were

female. Participants were overwhelmingly (96%) African American. Approximately 1.1% of the population tested HIV-positive. The patient population generally reported high-risk HIV behaviors: ten percent of testers reported ever having a same sex partner and 56% reported ever having an STI. Approximately 25% reported having ever used cocaine; 13% reported ever exchanging sex for drugs or money, and 12% reported more than 5 sexual partners in the last year. Twenty-seven percent of respondents reported never using condoms. In spite of these reported risk behaviors, when asked to report their risks for HIV, 91% reported their risks as zero or low.

CONCLUSION: Of 1,697 individuals counseled and tested for HIV in a public STI clinic in Philadelphia, over 1% tested HIV-positive. Even after counseling and testing, many individuals underestimate their risk for HIV. Testing based on self-reported HIV risks may fail to diagnose large numbers of people living with HIV/AIDS.

ABSTRACT 135

Reducing Health Disparities Through HIV Testing: Assessing and Managing Co-morbidities in an Urban Population Undergoing HIV Testing

H Kwakwa¹, B Marshall¹, J Shepard¹, and A Nunn²

1 Philadelphia Department of Public Health, PA, USA; 2 Brown University Medical School Division of Infectious Diseases, Providence, RI, USA

OBJECTIVE: To describe chronic, asymptomatic co-morbidities, previously undiagnosed or untreated, that are diagnosed and treated upon linkage to HIV care in a largely minority urban population undergoing routine rapid HIV testing.

METHODS: HIV rapid testing was offered to individuals seeking care at the walk-in clinics or urgent care centers of Philadelphia's District Health Centers between July 1, 2007 and July 30, 2008, with all individuals testing positive linked to care. Data on chronic asymptomatic co-morbidities that were previously diagnosed but untreated until linkage to

care, and co-morbidities that were newly diagnosed within the first 6 months of linkage to care were collected.

RESULTS: Of 4,978 individuals tested for HIV during this time period, 56 tested seropositive for HIV. Of the entire population tested, 57% were women and 43% men. African Americans comprised 72% of the population tested, foreign-born individuals 13%, Hispanics 10% and Caucasians 4%. Of the 56 individuals testing positive, 43% were women and 57% men. Eighty-six percent were African American, 6% Caucasian, 4% Hispanic and 4% foreign-born.

Previously undiagnosed chronic co-morbidities among those testing HIV-positive included hypertension, diabetes mellitus, coronary artery disease, chronic hepatitis C, chronic renal insufficiency, depression and early stage colon cancer. Previously diagnosed but untreated co-morbidities included chronic hepatitis C, depression, hypertension and diabetes mellitus.

CONCLUSIONS: HIV-testing provides important opportunities to link HIV-positive individuals to critical treatment and care services. Routine HIV testing among African Americans and uninsured urban populations can also foster timely diagnosis and management of other undiagnosed or untreated health conditions.

ABSTRACT 136

HIV Rapid Testing in the Emergency Department - Cultural Fit and Community Support

D Sendzik, I Pizarro, and M Nieves

The Brooklyn Hospital Center, Brooklyn, NY, USA

OBJECTIVES:

- Reach out to every patient who enters the Emergency Department, Monday-Friday, 1 PM – 9 PM (busiest hours).
- Encourage every Emergency Department patient to accept HIV rapid testing, because Brooklyn is a high-incidence area for HIV.

- Ensure that every HIV-positive patient is linked to care (PATH is the HIV ambulatory care service of Brooklyn Hospital Center).
- Follow-up carefully with every newly-diagnosed patient to ensure she or he enters and is retained in care.

METHODS:

- Engage PATH’s Advisory Board (patients and community members), PATH staff and Emergency Department (E.D.) staff in planning the E.D. HIV Rapid Testing initiative, with special emphasis on reaching a multilingual, multicultural English/Spanish patient population.
- Build close referral linkages between E.D. and PATH.
- Integrate HIV rapid testing seamlessly into the E.D. patient flow.
- Implement outreach to every E.D. patient, hiring a bilingual (English-Spanish) HIV Counselor.
- Welcome, engage and retain new patients in PATH.

RESULTS:

In calendar year 2007, the Brooklyn Hospital E.D. Rapid Testing Initiative:

- Provided HIV education and testing information to 1,496 patients.
- Provided HIV testing to 1,153 patients (77% of those reached).
- Identified 24 newly-diagnosed HIV-positive patients.
- Engaged 24 new patients in care (100% of those receiving a positive result).

CONCLUSIONS:

- HIV rapid testing in the Emergency Department setting is highly effective and well placed.
- Culturally appropriate staffing (multilingual, multicultural) can result in a high level of patient acceptance of HIV testing.
- Engaging existing patients, community members and staff in the planning process will help to ensure the project’s success.
- Careful integration of HIV testing into the E.D. work flow will encourage staff to use the HIV testing service and encourage patients to accept it.
- Future expansion should consider providing HIV outreach and testing services in the E.D. 24 hours a day, 7 days a week.

ABSTRACT 137

Acceptance of Oral Rapid HIV Testing in the Emergency Department of an Urban Pediatric Hospital: Rates of Agreement between Adolescents and their Guardians

N Rakhmanina^{1,3,4,5}, *A Baghdassarian*^{4,5}, *L Walkoff*^t,
D Liberman^{2,4,5}, *M Khan*⁵, *J Chamberlain*^{2,3,4,5}, and *A Sill*⁵

1 Division of Infectious Diseases; 2 Division of Emergency Medicine, Departments of 3 Pediatrics; 4 The George Washington University School of Medicine and Health Sciences; 5 Children's National Medical Center, Washington, DC, USA

BACKGROUND: The CDC recommendation to implement routine HIV testing in Emergency Departments (ED) requires special considerations for adolescent patients. Children's National Medical Center is in the initial stages of implementing a routine oral fluid rapid HIV testing in the ED. In preparation for the HIV screening roll-out, we studied the acceptance rates toward HIV screening among adolescents and their guardians.

METHODS: From May 2008 to September 2008 we conducted an anonymous, voluntary, self-administered survey of adolescents (13-21 yrs) and their guardians about their acceptance of oral fluid HIV screening and their preferences in result disclosure. Patients in acute trauma and/or pain, developmental delay and psychiatric complaints were not approached. Frequency distributions of the responses were reported in percentages, and % agreement was calculated by 2x2 contingency analyses.

RESULTS: Of the 487 adolescent/guardian pairs approached 409 (84%) agreed to participate in the survey. The majority of adolescents were female (57%) and 70% were African American (median age - 15 yrs), and the majority (81%) of the guardians were also female and 84% were African American (median age - 41 yrs). Among adolescents, 79% reported that they would accept HIV test in the ED, while 83% of guardians would agree to have their teenagers tested in ED. Of the adolescents who wished to receive results directly from ED personnel, 90%

of their guardians also agreed to direct disclosure of the test results to their teenagers. Of the adolescents who wished to have their guardians informed about the test results, 84% of the guardians also preferred direct disclosure of the results by the ED personnel. While 71% of the adolescents preferred to be disclosed about the test results prior to their guardians, 87% of the guardians preferred to be disclosed prior to the adolescents.

CONCLUSIONS: HIV screening of adolescents poses a challenge for ED providers who must address the testing of the adolescent and acknowledge the involvement of the guardian. While the majority of the adolescents and their guardians accept the HIV screening in ED, there is a high rate of disagreement between the adolescents and their guardians on who should be notified about the HIV test results first. Expanding HIV testing to youth in ED will require balancing of the adolescents' right to confidentiality with the presence of their guardians.

ABSTRACT 138

Impact of Routine Testing in Health Care Settings

L Randall and *J Hernandez*

Michigan Department of Community Health, Division of Health, Wellness and Disease Control, Lansing, MI, USA

OBJECTIVES: Participants will be able to identify barriers and facilitators to implementing routine testing in clinical settings. Participants will learn about operational issues and data impact relative to different test locations and implementation models used for routine testing. Yield analysis and cost analysis data for each site will also be discussed.

METHODS: To increase the effectiveness of prevention programs relative to identifying new infections, the Michigan Department of Community Health in 2004 began implementing routine HIV testing in selected high prevalence clinical settings. Since that initial implementation, additional sites have been added to provide screening and/or routine testing to at risk populations.

In CY07, 31,200 clients were tested using rapid tests and a .8% positivity rate was identified. Of the new positives identified, 78% were high risk, and over half were African American MSM. Implementation of screening into clinical settings has not happened without challenges. Determining who, what, where, when and how to implement HIV screening into the everyday routine of clinical services has proven to be a learning experience. An evaluation of routine testing using different models and various implementation strategies in multiple health care settings was completed.

RESULTS: MDCH determined routine testing was feasible in the context of testing being a routine recommendation, clinicians must play an active role in the process, consent was obtained and linkage to care was facilitated for newly identified positive clients. Issues associated with implementation of routine HIV testing identified a range of operational factors that served as both challenges and facilitators to implementation of routine HIV testing.

CONCLUSIONS: HIV testing must be fully incorporated into both standards of care and standard clinic operating procedures. Engagement and participation of all staff, particularly clinicians is essential. Patient messaging is critical. Reinforcement of messages about HIV testing is important both for providers and patients. HIV testing processes must be streamlined. HIV testing services must be flexible to accommodate different settings and patient populations. HIV testing activities should be monitored and evaluated, especially during initial implementation phases. Routine HIV testing in clinical settings must be supported by the public health community.

ABSTRACT 139

HIV Testing and Access to Care for Latino Immigrants in Post-Katrina New Orleans

J Redmann and A Vertovec

NO/AIDS Task Force, New Orleans, LA, USA

OBJECTIVE: In the wake of Hurricane Katrina, New Orleans saw an enormous influx of undocumented, Latino

workers who have helped with recovery efforts. In reaction to this new population, the NO/AIDS Task Force has collaborated with other agencies to provide HIV services, including HIV Testing, in non-traditional settings.

METHODS: The NO/AIDS Task Force tests the majority of its Latino clients in non-traditional settings using the OraQuick Advance—this allows for results in a timely manner and easy operation. A Mobile Medical Unit, *The CareVan*, was given to the agency by the Elizabeth Taylor AIDS Foundation after Katrina to ensure services were still getting to clients in New Orleans. The CareVan allows for the agency to travel to areas where this population congregates, and as those locations change, so do the testing sites. This ensures that the agency reaches the greatest number of clients in the most efficient, and client-centered manner. The NO/AIDS Task Force has comprehensive Primary Medical Care and Case Management Departments, both with Spanish speaking staff, which allows those who test HIV positive to be linked to care with ease and efficiency. Often when out in the community, the agency will collaborate with others to provide more primary medical services and social services (legal advice, I.D acquisition etc) to this population. This helps clients to incorporate HIV testing into their other medical services.

RESULTS: Since receiving the CareVan and funding for a full time driver/maintenance-person, the NO/AIDS Task Force has provided HIV testing to nearly 500 Latinos throughout the greater New Orleans Area. Of the clients whose results are positive, the NO/AIDS Task Force works with those clients to get them into HIV services (even if they lack a social security number). While the number of confirmed positives to date is low (2) this program has created valuable links to an at risk community that can be challenging to access.

CONCLUSION: By creating a chain of cultural competency—working with Latino outreach workers, providing testing in the community, having bilingual HIV testing staff and links to bilingual medical care and supportive services—it is possible to implement an effective program to bring immigrants, both legal and undocumented into care.

ABSTRACT 140

Reaching High Risk Populations: Patient Social Networks to Promote Rapid HIV Testing and Linkage to Care

SR Saha^{1,2}, LJ Sanders¹, JK Cohen¹, and JH Burack^{1,2}

1East Bay AIDS Research Institute, East Bay AIDS Center, Oakland, CA, USA; 2University of California, Berkeley, School of Public Health, Berkeley, CA, USA

OBJECTIVE: Identification of new cases of HIV infection through the social networks of persons with HIV provides an innovative approach to uncovering previously undiagnosed HIV infections. We applied this strategy within an HIV specialty clinic in Oakland, California, drawing on the social networks of our existing patients to bring individuals from the community in for rapid HIV testing. Our key objectives were to evaluate the effectiveness of this strategy for reaching individuals at high risk for HIV, the feasibility of linkage to care for newly identified cases, and in clinic acceptability.

METHODS: Current HIV patients were trained as peer recruiters, and asked to encourage their social, sexual and drug contacts to come for HIV testing and counseling. Patients were given cards with clinic information to give to their contacts. Patients were given \$10 for each referral, and network associates were given \$10 for taking an OraQuick rapid HIV-1/2 antibody test, and \$10 for completing a survey. All network associates received pre-test risk assessment and post-test counseling. Those with positive OraQuick results were immediately introduced to a social worker on site that facilitated additional counseling, confirmatory HIV testing, and follow-up care appointments.

RESULTS: Between September 2007 and June 2008, 310 cards were distributed to 30 peer recruiters who brought in 251 network associates for HIV testing. Peer recruiters were primarily African American or Latino with a mean age of 36.1 years (range: 16-58 years). Network associates were similarly diverse with a mean age of 43.1 years (range: 16-72 years). HIV incidence among network associates

was 5.9% (95% CI: 3.4%, 9.6%), and varied by gender and race. Risk for HIV was highest among transgenders (RR=20.7, 95% CI: 11.9, 35.9). All new HIV-positive cases were linked to a social worker for follow-up; approximately 25% entered care at our clinic. Among survey respondents (n=151), 30.1% said they would not have gotten tested if not asked by their friend. Nearly 74% of respondents had thought about getting an HIV test in the past. Over 17% of respondents reported never using a condom during sex.

CONCLUSIONS: Utilizing patient social networks offers a promising way to target high risk populations for HIV testing, while valuing our patients as a resource. Incidence rates in our study population were higher than those seen previously in emergency room screening programs in our region, suggesting that we did reach high risk populations.

*** Note: Preliminary data from this study was presented at the XVII International AIDS Conference in Mexico City, August 4-8, 2008. Updated material is presented above and any future presentations will be similarly updated as analysis progresses.*

ABSTRACT 141

Results from a Targeted, Integrated, Standard EIA HIV Testing Program at an Urban, Academic Emergency Department

SJ Schrantz Jr.¹, CA Babcock², S Brown², S Mercer², MT Pillow², K Watts², M Taylor², DL Pitrak², and JA Schneider²

1Evanston Hospital, Evanston IL, USA; 2 University of Chicago, Chicago IL, USA

OBJECTIVES: The current CDC recommendations for HIV testing emphasize testing in Emergency Department (ED) settings. Various HIV testing models have been employed and validated at other institutions, but universal application has been lacking due to limited time and financial resources. The current University of Chicago model uses a separate, opt-in, written consent and HIV testing that is targeted, integrated, using a standard (non-rapid) EIA with follow-up and linkage of care provided through

cooperation with the section of Infectious Diseases. A web based patient tracking system is used to systematically alert physicians to patients meeting criteria for HIV testing. We investigated the outcomes of this testing model.

METHODS: An observational, retrospective study of outcomes and characteristics of patients approached for HIV testing at the University of Chicago ED. Chi-squared analysis was performed using STATA v.10.

RESULTS: From January 2007 to April 15, 2008, 561 were tested. Implementation of computer flagging system began in February 13, 2008 and in 2 months increased individuals tested from 30.75 patients per month to 80.5 (262%) with no change in overall ED patient volume. Targeted risk factors included (% of approached): symptoms of STI (39%), pregnancy (34.6%), suspicion of bacterial pneumonia in patients aged <65 (10.9%), history of IVDU (2.2%), history of MSM (1.5%), and other (11.9%). 81.4% of those approached for testing were African-American, 80% were female and 34.3% of these females were tested as compared to 49.4% of males ($p=0.009$). 33 (5.9%) patients were true positives. 11 of the 33 were considered new diagnoses after comparison to department of public health records (2% of total tested). Of the 33 patients testing positive, 31 were notified of diagnosis (94%), 29 were linked to care (88.6%) and 23 (70%) kept their appointments. Only 2 false positive HIV EIA tests occurred. Average baseline CD4 count for new diagnoses was 138 cells/ μ l (95% CI=34-242).

CONCLUSION: This HIV testing model has been successful in identifying HIV infected individuals and successfully notifying them of diagnosis. Our program uses current ED staff including residents for consenting/testing and relies on collaboration with Infectious Diseases for notification to decrease additional personnel and time. We found men were more likely to accept testing in this setting. This is a viable and sustainable program that can be implemented in many ED settings without external funding for a parallel, rapid test based HIV testing program.

ABSTRACT 142

Integrating HIV Testing Targeting African Americans into the Prevention Programs of a Community-based Organization

R Simmons

Us Helping Us, Inc., Washington, DC, USA

OBJECTIVE: Us Helping Us (UHU) is a community-based AIDS services organization that provides HIV education and risk reduction interventions targeted to African American. UHU was funded by the CDC and the local health department to provide HIV counseling, testing, and referrals (CTR) to African-American men and women.

METHODS: UHU decided to integrate HIV testing into its prevention programs for maximum effectiveness by:

- Training over half the staff in rapid testing and orasure testing (8 of 13 full-time staff even though only four full-time were funded by the testing program)
- Utilizing a mobile van for HIV testing
- Integrating CTRS in all of its prevention programs (e.g., the Many Men, Many Voices intervention; Popular Opinion Leader intervention; support groups, etc. by having HIV testers available during all programs)
- Hosting quarterly testing days with community outreach and the providing of food
- Providing incentives for testing (e.g., gift cards, trips to the amusement park, beauty salon and nail salon certificates, phone cards, etc.)
- Recruiting through social networks in the House/Ball community
- Partnering with churches to conduct on-site testing
- Partnering with Howard University to conduct on-site testing in the dormitories
- Providing orasure testing immediately for confirmation of rapid testing for positive results.

RESULTS: In 2007, UHU provided CTR for a total of 1,492 people (764 men and 728 women; 1,302 of whom were African-American). Of those tested, 49 were HIV-

positive for a prevalence rate of 3.3%. UHU had one of the highest prevalence rate of any AIDS service organization in the District.

CONCLUSIONS: CTR should not be treated as a separate program within a community-based organization. CTR should be integrated in all of an agency's prevention programs. Every program should reinforce CTR and CTR should be an integral part of every program.

ABSTRACT 143

Social Marketing and New Technologies to Engage Youth in HIV Testing

M Kharfen¹, A Tenner², and M Singer²

1 Capacity Building and Community Outreach, HIV AIDS Administration, Washington DC Department of Health, Washington DC, USA; 2 Metro TeenAIDS, Washington DC, USA

OBJECTIVE: The DC HIV and AIDS Administration sponsored a marketing campaign, implemented by Metro TeenAIDS who worked with target youth to design materials and format. Objectives were to change youth attitudes about HIV testing, increase access and utilization of HIV testing by youth and enhance the capacity and expertise of HIV service. This campaign, designed to increase testing and reduce HIV transmission among adolescents and young adults, engaged the target group in the planning process, created mechanisms for influence in the framing of positive messages and provided leadership opportunities during the implementation. The campaign included bus and metro signs, text messaging information and a website for additional resources.

METHODS: The methodology used focused on using youth-friendly messages and communication techniques to share information about HIV/AIDS and stimulate youth to get tested and know their HIV status. The campaign traveled to youth venues and conduct contests including Rap battles, trivia contests and raffles for giveaways to engage youth. The program was conducted with a Youth

Advisory Board to ensure cultural competency and target population involvement throughout the project. Program elements were disseminated and pilot tested among the target population. Of particular note was the text messaging and Internet component of the campaign which provided instant answers and information about HIV testing, safer sex and resources for testing.

RESULTS: Partners saw an increase in testing numbers, many of whom indicated that the campaign was a factor in their getting a test. The campaign, run over the summer, had waves of information so that youth received information in a variety of settings and contexts, increasing the likelihood that they would text, get tested or pick up resources and materials to protect themselves. Results are being compiled and analyzed at the present time. However, early indicators are that youth friendly and culturally appropriate messaging increases understanding of HIV / AIDS and abilities to discuss it. Additionally, community-based testing was successful in increasing testing numbers and rates in targeted communities.

CONCLUSIONS: The materials combined with coordination across summer youth venues (summer employment, parks and recreation sites, buses, metro) ensured a pervasiveness of image and information so that targeted youth repeatedly saw, heard and received information and materials. In its next phase the campaign will work with other community based organizations to "normalize" conversations and document the effects of HIV/AIDS on communities.

ABSTRACT 144

Physician Barriers to Implementing Routine HIV Testing in Primary Care Settings: A Qualitative Analysis

PG Bashook¹, MI Edison¹, LE Sullivan², M Bass¹, G Berkenblit³, J Cofrancesco³, V Stone⁴, BJ Turner⁵, and JM Sosman⁶

1 University of Illinois College of Medicine, Chicago, IL, USA; 2 Yale University School of Medicine, New Haven, CT, USA; 3 Johns Hopkins University School of Medicine, Baltimore, MD, USA; 4 Harvard Medical School, Boston, MA, USA; 5 University of Pennsylvania School of Medicine, Philadelphia, PA, USA; 6 University of Wisconsin School of Medicine and Public Health, Madison, WI, USA

BACKGROUND: The Centers for Disease Control and Prevention (CDC) expects primary care clinicians to implement HIV routine testing recommendations in clinics and other practice settings. Most studies about adopting the CDC HIV testing guidelines concern implementation in clinics but none consider front-line clinicians' attitudes or expectations. This study reports general internists' perceptions about implementation barriers and what would help them implement routine HIV screening in diverse clinical settings.

METHODS: We recruited four focus groups, each comprised of five to eight experienced general internists, from pre-registered attendees at the 2007 national conference of the Society of General Internal Medicine. Purposeful sampling was used to ensure both demographic and practice setting diversity. Trained educational psychologists using a structured interview protocol facilitated the focus groups. The focus group discussions were taped, transcribed and systematically analyzed for major themes using grounded theory.

RESULTS: Focus group findings are based upon statements from 28 physicians from diverse clinical settings actively engaged in clinical care. Participant responses centered on five key themes: (1) guideline justification, (2) clinical settings, (3) state and local regulations, (4) financial barriers, and (5) education needs. Participants generally accepted the justification for universal HIV

screening. Participants recognized that routine testing could potentially reduce the stigma of HIV/AIDS, and increase the identification and treatment of HIV-infected individuals. But they reported that the challenge to implement the CDC recommendations is clinical setting-specific and not amenable to a general approach. Frequently mentioned barriers were: state/local informed consent restrictions, rapid-testing availability, how to incorporate HIV testing into low-risk patient visits, clinic visit time constraints, competing patient care needs, paying for testing, seronegative patient notification, and seropositive follow-up counseling/referral. Participants recommended creating setting-specific tool kits that contain: 1) scripts for dialogue between physicians and patients, 2) institutional protocols with current information for their setting, 3) education and promotion materials to inform clinicians, patients, and the general public regarding the value of routine testing, and 4) practical strategies with examples and best practice approaches for facilitating routine HIV testing.

CONCLUSIONS: Despite a general acceptance of the justification for universal HIV screening in internal medicine primary care settings, this study identified multiple barriers to the implementation of the CDC guidelines. Critical guidance is required, on a setting-specific basis, with regard to obtaining consent, providing adequate financial reimbursement, and helping clinicians to understand how to talk to patients about HIV testing. These priority areas are targets for the development of effective education interventions and technical assistance to facilitate HIV screening in primary care settings.

Supported by a grant from the CDC.

ABSTRACT 145

HIV Screening in Jails—What is the Yield?

AC Spaulding, K Ramos, A Sumbry, J Ratto, KRJ Arriola, and Members of the Enhancing Jail Linkages Study Group

Rollins School of Public Health of Emory University, Atlanta, GA, USA

OBJECTIVE: To demonstrate the feasibility and yield of HIV screening in jails.

BACKGROUND: HIV screening and testing in jails is often not systematic, even for inmates with longer lengths of stay. The National Survey of Jail Inmates conducted in 2002 found that 1.3% of detainees self-reported being tested for HIV and were positive; 37.1% had never been tested. From 2003-2006, CDC supported demonstration projects for jail-based, rapid HIV testing in Florida, Louisiana, upstate New York and Wisconsin and found 1.3% of voluntary screening tests were preliminarily positive. Among those tested, 0.8% (range by site: 0.2% - 1.3%) of the persons tested were previously undiagnosed with HIV infection. The five-year Enhancing Linkages project, an initiative funded since 2006 by the HIV/AIDS Bureau of HRSA as a Special Project of National Significance, has 10 demonstration sites that will assess the effectiveness of selected models of providing linkages to HIV primary care services for jail releasees. Emory University and Abt Associates have teamed together to form the Evaluation and Support Center that will perform the multi-site evaluation of how services for releasees have been integrated within the community's HIV continuum of care. Several sites are enhancing HIV screening services while conducting their linkage demonstration projects. We aimed to determine if HIV prevalence in detainees screened matched that found in the earlier CDC Jail Demonstration Project.

METHODS: Supplemental funding from HRSA was available at the beginning of FY2008; several sites used the funding for enhancing voluntary screening and testing services. Each site could determine whether screening would be offered routinely or targeted to subgroups of the detainee population, when to offer testing, and the

setting in which screening was offered. The Evaluation and Support Center requested data from the sites on current screening and testing activities, some of which was funded by the supplemental funding.

RESULTS: Demonstration sites have taken a wide diversity of approaches to HIV screening. Acceptance rate for voluntary screening ranged from 12.4% to 93%. Positive results on rapid tests ranged from 0.2% to 0.5% of tests conducted. New HIV diagnoses are being made at lower rates than in the CDC jail demonstration projects. Some patients coming forward for testing are revealing, when the test returns positive, that they have tested positive in the past but did not have stable linkage to HIV care.

CONCLUSION: HIV testing in jail settings is feasible. Rates of accepting offers for HIV testing vary with sites. Programs are reaching some individuals who seek confirmation of previously made diagnoses; for these persons, the jail testing these jail screening programs demonstrate that new HIV diagnoses are being made at slightly lower rates than in the CDC demonstration projects. Possible reasons for low detection rate of new infections could be the local epidemiology or that predominately worried well or previously known positives are coming forward in voluntary testing programs. Screening the 9 million persons who pass through US jails each year may find a portion of the 25% of Americans with HIV who are unaware of their

ABSTRACT 146

Patient Attitudes *versus* Staff Attitudes about Human Immunodeficiency Virus Testing in the Emergency Department

VY Totten¹, MN Aggarwal^{2,3}, H Kador³, and W Wang²

1 University Hospitals of Case Medical Center, Cleveland, OH, USA; 2 Case Western Reserve University, Cleveland, OH, USA; 3 UH Research Assistant Team, Cleveland OH, USA

STUDY OBJECTIVES: 1. To compare staff and patient attitudes about Human Immunodeficiency Virus

(HIV) testing in the emergency department (ED).
2. To identify the most appropriate person to deliver the results of a rapid test.

METHODS: Self-administered surveys; staff and patients of a large urban emergency department. Staff includes registered nurses (RNs), attending physicians, paramedics, clinical staff and other clinical staff. Patient respondents were 18 to 65 year-olds who were in the ED waiting room between 2 pm and 6 pm.

RESULTS: Respondents included 34 clinical staff and 256 patients. The majority 55.9% (19) were RNs. The remainder was evenly distributed among physicians, medics, and “other”. The patients were largely (76%) African American; 60% were female. Half of the patients surveyed claimed that their doctor had offered an HIV test in the past while half admitted to asking their doctors themselves to test them for HIV.

DESIRE FOR TESTING: Although a large majority of the staff (64.7%) were against testing for HIV in the ED, 88% of patients were in favor of testing. 67.6% of the staff were against high risk testing only while 64.7% were against universal testing. Among patients, 69% of patients would be willing to be tested right away and 87% of them would want results within 30 minutes. Over half of these patients would be willing to pay for such tests.

DELIVERY OF RESULTS: Both the patients and staff agreed that a physician should reveal results to the patient, especially a positive result. Most agreed that an RN could deliver results as well, but few of either staff or patients felt that results could be disclosed by a counselor, resident/intern, or social worker. Yet, approximately 50% of all staff felt comfortable revealing either positive or negative results.

CONCLUSION: 1. ED staff do not want rapid HIV testing in the ED, while patients largely do want it. 2. Both staff and patients agreed that results, both positive and negative, are best delivered by an attending physician.

ABSTRACT 147

Staff Attitudes Towards Human Immunodeficiency Virus Testing in the Emergency Department

VY Totten¹, MN Aggarwal, K Radonich², O Kozlovskaya², P Shkraba², and H Kador³

1 University Hospitals of Case Medical Center, Cleveland, OH, USA; 2 UH Research Assistant Team, Undergraduate Students at Cleveland State University, Cleveland, OH, USA; 3 UH Research Assistant Team

STUDY OBJECTIVES: 1. To assess staff attitudes about HIV testing in the emergency department. 2. To identify barriers to rapid HIV testing in the emergency department.

METHODS: Self-administered survey; staff of a large urban University ED. Registered nurses (RNs), attending physicians, paramedics, clinical staff and Patient Care Assistants were eligible.

RESULTS: 34 staff members responded. 14.7% (5) were attending physicians, 55.9% (19) RNs, 14.7% (5) medics and 5 (14.7%), “other” or declined to answer. 76.6% had been at this location for < 5 years, but over half had > 5 years professional experience.

Desire for Testing: 58.8% felt that the ED should **not** offer HIV testing; 26.5% favored testing. 29.5% of respondents thought HIV testing would take too much time; 39.5% did not. Few (11.8%) were concerned that patients would be offended if offered testing. 29.4% thought the ED should offer HIV testing to high risk patients; 23.6% approved of universal testing. Conversely, 67.6% were against high risk testing only and 64.7% were against universal testing.

Delivery of Results: 49.1% felt **comfortable disclosing POSITIVE** results; 41.2% were not. 54.9% would be comfortable disclosing **NEGATIVE** results; 29.5% were not. The majority thought all results should be disclosed by an attending (73.5%); the remainder were divided among nurse, resident/intern; counselor or other. Not one felt that a social worker would be an appropriate person to disclose the results.

Barriers to Rapid HIV Testing in the ED: (Multiple answers permitted.) Half felt that the biggest barrier would be the insufficient time for counseling. 47% expected an avalanche of people would come to the ED just to get tested. 35.3% of staff had privacy and confidentiality concerns, while 23.5% thought that the subject matter was too sensitive. 20.7% percent of the staff would **feel uncomfortable** talking to **HIV positive patients**. 17.7% said that there would not be enough time to perform an HIV test, and 5.9% thought that it would be too difficult. 20.6% gave “other” reasons while 5.9% did not respond.

CONCLUSION: 1. ED staff do not want rapid HIV testing done in the ED. 2. The ED staff identified several barriers that would prevent them from offering rapid HIV testing.

ABSTRACT 148

Routine Offer of a Rapid HIV Test in New York City Single Adult Homeless Assessment Shelters

M Malave¹, V Woog¹, B Tsoi¹, A Gutkovich², D Marder², M Sweeney¹, and B Cutler¹

1 New York City Department of Health and Mental Hygiene, New York, NY, USA; 2 New York City Department of Homeless Services, New York, NY, USA

OBJECTIVE: A 2005 health report on homeless New York City (NYC) adults showed increased rates of HIV-related morbidity and mortality when comparing homeless adults using city shelters to the general NYC adult population. The NYC Department of Health and Mental Hygiene and the NYC Department of Homeless Services (DHS) collaborated to offer a rapid HIV test to everyone who presented to medical clinics in homeless assessment shelters for single adults. We analyzed these HIV test results from September 2006–August 2007.

METHODS: Adults entering the DHS single adult shelter system are referred to assessment shelters for medical screenings. All adults receiving medical screenings were to be offered an HIV test. Shelters reported on number

and demographics of people offered testing, tested, testing positive, linked to care, refusing testing, and reasons for refusal. A subset of preliminary positives was compared to the HIV/AIDS Registry System (HARS) to determine if they were previously known to be positive or were newly diagnosed.

RESULTS: Data for five of seven assessment shelters showed that 4,017 people (76%) who received a physical exam were offered an HIV test. Of those offered, 2,067 persons (51%) accepted and were tested, with 37 (1.79%) identified as preliminary positive. Slightly over half were confirmed positive. 22% declined a confirmatory test because they were known positive. The remaining 21% refused confirmatory testing for another reason, had missing data, or were lost to care. One person received a false positive result. 85% of clients with a positive confirmatory test were linked to care. Males accounted for 1,268 (61%) of people tested. The majority of people tested were non-Hispanic Black (67%) or Hispanic (24%). 1,591 (77%) of clients tested were aged 18–49. Those refusing testing had similar demographics to those accepting testing with the exception of gender. Of clients offered an HIV test, 56% of men and 29% of women refused the offer, and the majority who refused, 1,516 (78%), reported they had been tested previously. Out of 14 preliminary positive clients matched to HARS, three were newly diagnosed, and all newly diagnosed were men aged 18–29.

CONCLUSIONS: Half of adults in NYC single adult assessment shelters accepted an HIV test when routinely offered. Obtaining confirmatory test results and linking the positive clients to care remain a challenge in this population. More research is needed to lower refusal rates among homeless adults offered an HIV test, especially homeless men.

ABSTRACT 149

HIV Testing Targeting MSM in Non-traditional Settings in New Orleans*J Redmann and A Vertovec*

NO/AIDS Task Force, New Orleans, LA, USA

OBJECTIVE: Men who have sex with men (MSM) are the highest prioritized population for secondary HIV prevention interventions (Primary Prevention with HIV+ clients is the highest)—as indicated by the Louisiana State HIV/AIDS Program, and remain the group with the highest rates of HIV infection in New Orleans. To tackle the issue, the NO/AIDS Task Force provides free, rapid HIV Testing (using the OraQuick Advance) in bars and bath houses where these populations are found. Providing testing in a non-traditional setting helps to increase access and eliminate the stigma associated with going to an HIV clinic.

METHODS: Nine times a month, staff from the NO/AIDS Task Force goes to sites in the French Quarter area of New Orleans where they set up an HIV Testing area (usually upstairs, away from business patrons). All supplies are carried in a travel bag and HIV testing protocol is closely followed. Testing clients at the various establishments receive pre and post test counseling, referrals, and learn their HIV status without having to actively go to a clinic or testing site. Confidentiality is a top priority and clients who are not comfortable testing in a bar setting are given referrals to other locations. Clients who test positive are referred to appointments set aside with the agency for confirmatory testing, and a majority of them access HIV medical care through the NO/AIDS Task Force.

RESULTS: Testing in these settings has proven to be an effective way to identify new positives and link clients to appropriate care. In 2007, 8 clients of the 176 tested were new positives, for a rate of 4.5%. Of these, only 1, from out of state was not linked directly to care. Testing in these locations is also a way to inform MSM of the risks of HIV and give them the tools (negotiation skills, condoms etc) to keep themselves safe.

CONCLUSION: Providing testing in locations familiar

and easily accessible to MSM such as bars and bathhouses helps a high risk population get tested and linked to care. Careful logistical planning is needed to ensure confidentiality and proper test procedures, but these challenges can be surmounted. Clients in these locations may not have taken the initiative to go get tested had testing not been readily available to them.

ABSTRACT 150

"Get Real Get Tested": North Carolina's Statewide HIV Testing and Education Campaign*H Watkins, E Foust, and D Williams*

North Carolina Communicable Disease Branch, Raleigh, NC, USA

OBJECTIVE: Currently, North Carolina has 31,000 persons living with HIV disease. In recent years, North Carolina has averaged about 1,800 new HIV reports annually. On average, 25% to 30% of the new cases being reported, alarmingly, are new AIDS cases. The CDC HIV incidence estimate for North Carolina was 2,200 new cases reported in 2006. Approximately 67% of all HIV/AIDS cases reported in North Carolina are among African Americans and the Latino community is also being disproportionately affected. In an effort to reduce late AIDS diagnoses, North Carolina, using a new CDC HIV testing grant launched the "Get Real Get Tested" statewide HIV testing and education campaign. This campaign also provides STD testing and rapid referral to care and treatment.

METHODS: Surveillance and Field Services staff of the N.C. Communicable Disease Branch worked to identify high morbidity areas and venues in order to target HIV testing and education efforts. Specific locations for these testing events were also chosen based on local health department and community input. Local and statewide media played an important role in helping the community become aware of HIV/STD risks including where to get free and confidential HIV testing. Complementing the door to door community campaign, other partners, including

WRAZ/FOX 50 and Gilead, worked to develop several public service announcements for the campaign which are aired in prime time and on TV stations across North Carolina.

RESULTS: From 2006 to 2007, HIV testing increased by 18% in North Carolina; which translates to an additional 25,000 HIV tests administered.

Non traditional test sites (this excludes doctor's offices and hospitals) in North Carolina conducted 7,422 HIV tests and identified 71 individuals who tested positive for HIV.

During the 2006-07 "Get Real Get Tested" door to door community campaign, 2,248 individuals were tested. Of the 2,248 people tested, we identified 27 people who tested positive for the HIV.

CONCLUSIONS: This campaign taught us valuable lessons. Offering HIV/STD testing door to door is a successful tool to increase HIV/STD testing in North Carolina's high risk communities. Lack of transportation and stigma still make it difficult for some people to be tested in traditional venues such as primary health clinics or health departments. Statewide public service announcements coupled with door to door campaigns increase community awareness of HIV/AIDS and decrease missed opportunities to reduce late stage AIDS diagnoses.

ABSTRACT 151

Do Clinicians Prefer the 2006 or 2001 CDC HIV Testing Recommendations?

MJ Waxman¹, RC Merchant¹, JG Maher¹, MA Clark¹, EA Simmons¹, MT Celada², CG Beckwith¹, T Liu¹, and KH Mayer¹

¹Brown University, Providence, RI, USA; ²Wheaton College, Norton, MA, USA

OBJECTIVE: 2006 Centers for Disease Control and Prevention (CDC) HIV testing recommendations contain major HIV testing methods changes compared to the 2001 recommendations. We surveyed clinicians about their

preference for the 2006 or the 2001 CDC-recommended methods to conduct HIV testing in the health care setting.

METHODS: We developed an internet-based, anonymous, self-administered survey that presented a series of pictorial scenes of a fictional clinician testing a patient for HIV using the 2006 vs. the 2001 CDC-recommended methods: (1) "opt-out" vs. "opt-in", (2) general medical vs. specific written consent, and (3) optional vs. mandatory prevention counseling at the time of HIV testing. Participants indicated the testing methods they prefer and the main reason for their preference. Resident and attending physicians, nurse practitioners, and physician assistants from the internal medicine clinics, family medicine clinics, and emergency departments at three Brown University-affiliated hospitals were surveyed. Multinomial multivariable logistic regression models were created to identify clinician characteristics (gender, age, Latino ethnicity, race, specialty, clinician type, and HIV testing history) associated with favoring the 2006 vs. the 2001 recommendations. Odds ratios (ORs) with corresponding 95% confidence intervals were estimated.

RESULTS: Of the 241 respondents, 50.6% were female; the median age was 32 years; 4.2% were Latino; 80.5% were white, 1.2% were black, 13.7% were Asian, and 4.6% were of other race; 44.4% were emergency medicine, 15.3% were family medicine, and 40.3% were internal medicine clinicians; 63.2% were residents/fellows, 31.4% were attending physicians, and 5.4% were nurse practitioners/physician assistants; and 66.4% had ever been tested for HIV. 38.6% preferred "opt-out," 44.4% "opt-in," and 17% had no preference; 29.1% preferred general medical consent, 57.7% specific written consent, 13.2% had no preference; and 10.4% preferred optional prevention counseling, 78.8% mandatory prevention counseling, and 10.8% had no preference. Main reasons cited for the preferences were: "opt-in" "treats patients with respect"; specific written consent "makes sure doctors talk to their patients about HIV"; and mandatory prevention counseling "is a chance to help patients reduce their risk of getting HIV." With the exception of females who preferred the "opt-out" over "opt-in" [OR 2.03 (1.14-3.64)], no other characteristics were associated with preference for the 2006 HIV testing methods.

CONCLUSIONS: Except for females who favored “opt-out”, providers uniformly did not prefer the 2006 CDC recommendations across these medical school-affiliated primary care and emergency medicine clinicians. CDC needs to build support among clinicians to aid in the implementation of the new recommendations.

ABSTRACT 152

HIV Testing in a Kenyan Emergency Department

MJ Waxman^{1,2}, *S Kimaiyo*^{3,4}, *A Mwangi*⁴, *N Ongaro*^{2,3}, *K Wools-Kaloustian*^{4,5}, and *EJ Carter*¹

1 Brown University, Providence, RI, USA; 2 Moi Teaching and Referral Hospital, Eldoret, Kenya; 3 Moi University School of Medicine, Eldoret, Kenya; 4 USAID-AMPATH Partnership, Eldoret, Kenya; 5 Indiana University School of Medicine, Indianapolis, IN, USA

OBJECTIVE: Resource poor communities, whether in sub-Saharan Africa or in inner cities in the United States, are often dually afflicted with both high HIV prevalence rates and limited resources to care for their sick populations. In these settings, screening for HIV becomes both difficult to accomplish yet is ever more critically important. In 2006, Moi Teaching and Referral Hospital, in Western Kenya, initiated an HIV testing program in the emergency department (ED). This abstract reports on initial data collected from this HIV testing program.

METHODS: We performed a retrospective log and chart review of the initial five months experience (January 2006-April 2006) of the HIV testing program at one large referral center in Western Kenya. In addition, we performed a small case control study to determine the differences in age, gender, WHO stage, and CD4 count by patient referral source: ED *vs.* all other venues of referral combined.

RESULTS: Patients were selected for HIV testing by a combination of routine screening and provider initiated referrals. 1,371 patients were approached for HIV testing. 1,339 (97.7%) of these patients were tested for HIV. 312 (22.7%) of patients tested were HIV positive. Within a sample group of approximately 60 patients newly diagnosed

with HIV in the ED, 82% were compliant with their initial HIV clinic visit and 65% were compliant with a 1-month follow-up visit. The median CD4 count (75 cells/mm³) of patients referred from the ED from this sample group was lower than the CD4 count (229 cells/mm³) of the patients referred from all other venues.

CONCLUSION: The implementation of an ED-based HIV testing program in a high HIV prevalence and resource poor country is feasible – with a high percentage of patients accepting HIV testing and a high percentage of positive patients presenting to follow-up care. Establishment of rapid HIV testing in EDs can identify significant numbers of HIV positive patients who would otherwise remain undiagnosed as well as providing an educational opportunity for patients who are HIV negative. The newly diagnosed HIV patients referred from the ED had a lower CD4 count (mean of 75 cells/mm³) than patients referred from all other sites. Because many of the patients diagnosed with HIV in the ED are very far progressed (as demonstrated by their low CD4 count) diagnosis of these patients in the emergency department is imperative to preclude further delay of diagnosis, progression of HIV, and possible death.

ABSTRACT 153

AIDS Education and Training Centers Efforts to Assist Healthcare Organizations Implement Routine HIV Testing

L Wegman

US Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, MD, USA

OBJECTIVE: To assist hospital emergency and labor and delivery departments, community health centers, and other healthcare settings to implement CDC’s HIV Testing Recommendations. The 11 Regional AIDS Education and Training Centers (AETCs), including 130 local sites, are federally funded grants through the Health Resources and Services Administration. Their mission is to provide

clinical training and education on all aspects of HIV/AIDS care and treatment.

METHODS: The CDC provided funds to HRSA for the AETCs to begin this work. Each AETC used different approaches, but all worked with partners and stakeholders within their local communities to explore ways to best implement the Recommendations. A variety of techniques were used, including:

- Development of TA tools such as brochures, posters, resource binders, and a state law compendium regarding testing and consent;
- Delivery of on-site and distance learning training and TA regarding the Recommendations and associated legal and consent issues;
- Design of infrastructure development tools including written policies, protocols, and procedures;
- Training for staff on delivering testing results; and
- Education for staff on available local counseling and referral resources to ensure HIV positive patients are linked to, and assisted with, access to care and treatment.

RESULTS: The AETCs provided training to well over 20,000 clinicians and staff at over 1,000 training/TA events during the past 2 years. One-time training is not sufficient to gain buy-in to routine testing; multiple contacts and TA events are necessary for implementation. Some settings moved quickly to implement routine testing, others were slower, and some have yet to implement it. Reasons for lack of implementation include: lack understanding of the Recommendations; lack of financial resources to purchase kits and pay for lab work; lack of staff time to implement/administer testing; lack of a clinical champion at the institution; and clinical/administrative staff resistance to the necessity for and cost effectiveness of testing.

CONCLUSIONS: A variety of methods have been utilized to assist with implementing the Recommendations, yet one size does not fit all – even across the same clinical setting – such as Emergency Departments. Resources must be tailored to each individual site. Stakeholders should be brought into the process early to get buy-in and participation if implementation is to be successful. Two things seem certain; a variety of time-consuming TA efforts are necessary to implement the Recommendations, and the

AETCs serve as valuable expert resources to assist clinical settings with their training needs and with implementing the Recommendations.

ABSTRACT 154

Early *versus* Late Testing for HIV Infection: A Study of Incarcerated Individuals in South Carolina

WA Duffus^{1,2}, E Youmans³, RH Potter⁴

1 Department of Health and Environmental Control, SC, USA; 2 University of South Carolina School of Medicine, SC, USA; 3 Arnold School of Public Health, University of South Carolina, SC, USA; 4 Department of Criminal Justice & Legal Studies, University of Central Florida, FL, USA

OBJECTIVE: Approximately 25% of all HIV-infected individuals in the United States pass through a correctional facility each year. This study investigated the extent to which incarcerated South Carolina (SC) HIV/AIDS cases could have been diagnosed earlier at a prior arrest.

METHODS: Retrospective cohort design linking case reports from the SC HIV/AIDS Reporting System and the SC Law Enforcement Division Computerized Criminal History database. HIV data from individuals first diagnosed with HIV infection between January 2001 and December 2005 were linked using variables such as race/ethnicity, gender, residence, and age with the statewide arrest records occurring from January 1996 through December 2005. Odds ratios and 95% confidence intervals were used to determine demographic variables and arrest reasons as determinants of testing. Individuals were categorized as ‘late testers’ if they developed AIDS within one year of testing or as ‘early testers’ if diagnosed with HIV-only (non-AIDS) within three years of testing.

RESULTS: Of the overall 4,117 newly diagnosed HIV positive individuals, 1,675 (41%) were arrested within 10 years prior to testing HIV positive. Of the 1,177 individuals included in this analysis, 696 (59%) were late testers and 481 (41%) were early testers. After controlling for sex, age, race, HIV transmission category and source of HIV report, the odds of being a late tester increased with

age ($p < 0.001$). Persons ≥ 25 years of age had an increased odds of late testing when compared to 20–24 year olds (OR 3.65; 95% CI 2.35, 5.67). Overall, 3,449 separate arrests were recorded for these 1,177 individuals and 448 (13%) arrests were for drug and alcohol or sex crimes. Individuals with ≥ 4 arrests were more likely to be late testers when compared to those with < 4 arrest (OR 3.36; 95% CI 2.28, 4.95). Individuals whose eventual source of HIV report was from a hospital were more likely to be late testers (OR 1.77; 95% CI 1.16, 2.70). When comparing the likelihood of being a late tester and number of arrests by race, blacks were more likely to have > 4 arrests (OR 2.63; 95% CI 1.82, 3.80). Additionally, men were more likely to be late testers and have > 4 arrests (OR 2.47; 95% CI 1.69, 3.59).

CONCLUSIONS: Early identification of HIV infection is of public health importance. Correctional facilities present missed opportunities to identify individuals with undiagnosed HIV infection. Implementation of routine HIV testing in these facilities, specifically jails, should be of consideration.

ABSTRACT 155

Expanding HIV Testing in the San Francisco Jails – 2008

J Yuan, I Gonzalez, K Monico Klein, T Dowling, M Estes, J Goldensen, and JD Klausner

San Francisco Department of Public Health, San Francisco, CA, USA

OBJECTIVE: Jails and prisons are uniquely positioned to identify people at risk for HIV infection, test them and connect them to care. We sought to expand HIV testing in the San Francisco county jail through a clinic-based voluntary screening program and improve uptake through continuous quality improvement.

METHODS: We established a voluntary clinic-based screening program at two San Francisco county jails whereby all patients presenting to clinical services were offered routine HIV testing (OraSure® HIV-1 Oral Specimen Collection Device). We used Palm-IT technology to gather

information including ethnicity, sexual risk behaviors, and injection drug use. We defined an eligible patient as a patient not known to be HIV positive who had not tested within six months. We evaluated the program by assessing the number of patients tested, refusal rate, percentage of eligible patients, seropositivity rate, and percent of newly diagnosed persons linked to care. As continuous quality improvement, staff met monthly to review testing data to determine program penetration and identify measures to increase testing acceptance. We conducted focus groups with inmates to help guide strategies to access a greater proportion of the facility population.

RESULTS: From March through August 2008, we completed twice as many HIV tests in the targeted San Francisco county jails compared with the same period last year. We approached 773 eligible persons for testing; 82% agreed to test. Of the 495 patients tested between April and July, 84% identified as heterosexual, 5% identified as homosexual, and 1% as transgender. 26% had injected drugs. Patients were 51% African-American, 20% white, 18% Latino, 3% Asian, 2% Native American, and 1% Pacific Islander. We identified two (0.4%) patients with previously unrecognized HIV infection and both were linked to comprehensive care. Prior to the expanded program only 22% of patients approached at the clinic had been recently tested; within two months, 47% had been recently tested. Through record review, we determined that, on a given day, the HIV status was known for approximately 30% of the jail population in the targeted facilities. Focus group findings supported consistent outreach at the targeted jail facilities and social marketing to further increase awareness in the jail of HIV and HIV testing methods.

CONCLUSIONS: An enhanced voluntary clinic-based screening program successfully increased HIV testing in the San Francisco County Jail. However, screening those who seek clinical services may not provide access to the majority of the jail population. Palm-IT technology and rapid and routine data evaluation allowed for timely adjustment of the program to reach a broader segment of the population. Future programs should consider using continuous quality improvement methods to guide program development.

Prevention Models in the Setting of Routine or Expanded HIV Testing

ABSTRACT 201

The Prevalence of Rectal, Urethral, and Pharyngeal *Neisseria gonorrhoeae* and *Chlamydia trachomatis* among Asymptomatic Men who have Sex with Men in a Prospective Cohort in Washington, DC

*J Baker*¹, *M Plankey*², *Y Josayma*¹, *R Elion*¹, *P Chiliade*³, *A Shahkolahi*⁴, *M Menna*¹, *K Minitier*¹, *R Slack*², *Y Yang*², and *JB Margolick*⁵

1 Whitman Walker Clinic, Washington, DC, USA;
2 Georgetown University Medical Center, Washington, DC, USA; 3 Family Health International, Arlington, VA, USA;
4 AIDS Clinical Trials Group, Silver Spring, MD, USA;
5 Johns Hopkins University Bloomberg School of Public Health, Baltimore, MD, USA

OBJECTIVES: In STD/HIV clinics, the estimated prevalences of *Neisseria gonorrhoeae* (GC) and *Chlamydia trachomatis* (CT) among men who have sex with men (MSM) are 6-25% and 2-12%, respectively, and 4-11% for both in HIV-infected MSM. To evaluate screening strategies for GC/CT among MSM, data are needed from venues where GC/CT detection is not a high probability diagnosis as it is at STD/HIV clinics. Therefore, we determined the 'natural history' prevalence of GC/CT infection and correlates of infection among MSM participating in the Washington, DC site of the Multicenter AIDS Cohort Study (MACS).

METHODS: During semiannual study visits from December 2006-December 2007, urine, rectal, and pharyngeal samples were collected at 257 patient-visits provided by 147 MSM. Samples were tested for presence of GC/CT using a validated nucleic acid amplification technique (NAAT).

RESULTS: There were 16 positive tests yielding a GC/CT prevalence from all anatomic sites of 6.2%. In the pharynx, nine samples were positive for GC (3.5%) and one for CT (0.4%). In the rectum, two samples were positive for GC (0.8%) and four for CT (1.6%). No urine tests were positive for either organism. Meeting sexual partners on the internet was reported by 64% of men with positive tests.

CONCLUSIONS: Within a longstanding, prospective cohort study of MSM, the prevalence of asymptomatic GC/CT infection and the most commonly infected sites (rectum/pharynx) were similar to results found among predominantly HIV infected, asymptomatic MSM tested at STD/HIV clinics. Meeting sexual partners on the internet was the only statistically significant correlate of infection.

ABSTRACT 202

HIV Risk Behavior Pre- and Post-HIV Testing and Counseling in Jail

CG Beckwith^{1,3}, *T Liu*², *LB Bazerman*³, *AK Delong*², *S DesJardins*³, and *TP Flanigan*^{1,3}

1 Alpert Medical School of Brown University, Providence, RI, USA; 2 Center for Statistical Sciences, Brown University, Providence, RI, USA; 3 The Miriam Hospital, Providence, RI, USA

OBJECTIVE: Jail detainees are at increased risk of HIV. Rapid HIV testing is ideal for jails given rapid turn-over of detainees and if coupled with risk reduction counseling, may reduce HIV risk behavior. We compared the effect of standard HIV testing with minimal counseling to rapid HIV testing with risk reduction counseling on HIV risk behavior following release from jail.

METHODS: Randomly selected detainees at the RI Dept. of Corrections jail were voluntarily enrolled. All subjects had venipuncture for standard HIV testing upon intake. In a before and after study design, 132 subjects enrolled in the Standard Arm (SA) completing standard HIV testing per jail protocol followed by 132 subjects in the Rapid Arm (RA) completing rapid HIV testing with receipt of results and counseling. Risk behavior was assessed at enrollment and at a follow-up visit (FUV) 6 weeks after release. The effects of SA *versus* RA on risk behavior were analyzed using a transition model accounting for length of incarceration and propensity to complete the FUV.

RESULTS: The FUV was completed by 58 subjects in the SA and 50 in the RA. There was no significant difference in baseline HIV risk between the SA and RA. Cocaine use and sexual risk were common yet active injection drug use was

not. Cocaine use and sexual risk behaviors decreased from enrollment to the FUV [cocaine use, -56%; unprotected sex with any partner, -11%; no condom at last sex, -5%]. There were no significant differences between the SA and RA.

CONCLUSIONS: We hypothesized that the RA would decrease risk behavior more than the SA given rapid test result receipt in conjunction with individualized counseling. Overall, there was a decrease in cocaine use and sexual risk behaviors but there was not a difference between the SA and RA. Interventional studies with jailed populations are logistically challenging yet these preliminary findings will inform the development of larger HIV prevention studies designed for jail populations.

ABSTRACT 203

Program B.R.I.E.F: A 32 Month Analysis of High Volume Rapid HIV Testing Multimedia Model

Y Calderon^{1,2}, J Leider^{1,2}, R Chin^{1,2}, T Goring^{1,2}, W Wang^{1,2}, SM Hailpern, CM Edmundson², R Ghosh², J Fetting¹, P Gennis^{1,2}, P Bijur², and L Bauman²

1 Jacobi Medical Center, Bronx, NY, USA; 2 Albert Einstein College of Medicine, Bronx, NY, USA

OBJECTIVE: As of 2006 the CDC recommends that routine voluntary HIV screening be available in healthcare settings such as Emergency Departments (EDs). This study evaluates a novel approach to C&T in a high-volume inner-city ED in terms of its receptiveness, acceptance and effectiveness.

METHODS: This prospective cross-sectional evaluation was conducted for 32 months. A convenience sample of stable patients presenting to an inner-city Emergency Medicine (ED) Department were recruited. A previously evaluated multimedia tool, which included validated videos for HIV pre- and post-test counseling, was used. Demographic characteristics, risk factors, and sexual history were collected from those patients who both agreed to and refused testing. Data were collected on the

number of patients tested, number of HIV positive patients identified, patient satisfaction and knowledge conveyed, to assess acceptability and effectiveness of the tool.

RESULTS: Demographics characteristics of the participants were as follows: 45.1% males, mean age 34.5 ± 13.3, 45.5% Hispanic, and 34.5% African American. Of the 15,425 patients who were approached, 14,881 (96.5%) met criteria for eligibility. Of the eligible patients, 14,690 (98.7%) agreed to be HIV tested. There were 92 newly diagnosed or confirmed HIV positive patients.

Ninety three percent of patients felt rapid HIV testing in the ED was helpful and 96.5% felt the PHA made the process easier for them. 84.7% felt they learned a moderate to large amount of new information and 80.2% felt that the information influenced them to change their sexual practices. On average, patients scored 78.8% on the post-test knowledge measure.

CONCLUSION: An integrated HIV testing program, using a multimedia tool for self-administered data collection and video counseling, rapid HIV testing combined with a live, actively recruiting counselor, was met with high acceptability by our patients. High quality counseling, measured by standards of satisfaction and education were preserved while maintaining a significant volume of HIV testing.

ABSTRACT 204

Testing Our Readiness: Benefits of Increased Access to Testing in the Integrating Planning for ARVs

R Clary¹, C Collins², J Davids³, C Feuer², R Reinard⁴, J Thomas³, and M Warren²

1 Project Inform, San Francisco, CA, USA; 2 AIDS Vaccine Advocacy Coalition, New York, NY, USA; 3 Community HIV/AIDS Mobilization Project, Providence, RI, USA; 4 Public Health Consultant, San Francisco, CA, USA

OBJECTIVE: Assess knowledge and use of access to testing to promote study and implementation of antiretroviral therapy (ARVs) in novel prevention interventions.

METHODS: Our project methods include an environmental scan, focus groups and guided interviews with medical service providers, funders, stakeholders, policymakers and community representatives to:

- probe for pre-existing knowledge of the benefits increased testing access may bring to studies and implementation of Post-Exposure Prophylaxis (PEP) guidelines and service provision; Pre-Exposure Prophylaxis (PrEP) research; the role of ARVs in serodiscordant couples; and early initiation of ARV therapy for acute infection;
- assess the level of knowledge and utility about the role of testing in these recommended and experimental interventions; and
- evaluate the potential of training and structured, strategic planning to reduce barriers to testing access on the potential integration of ARVs as prevention tools.

RESULTS: The outcomes of the program will include:

- Summary of project methods
- Analysis of data from environmental scan, focus groups and interviews
- Recommendations on the use of training and strategic planning on the integration of testing and ARVs as prevention as a method for increasing focused collaboration on reducing barriers to testing.

Preliminary data will be available at the time of the conference.

CONCLUSIONS: In a time of increased interest in the role of ARVs in primary HIV prevention, the role of testing as a key component for prevention may rapidly be amplified beyond counseling or behavioral interventions. Initial results of PrEP trials are expected in the next 18 months.

Initial planning for the project has revealed a need for basic information and opportunities for dialogue on issues of ARVs as prevention among stakeholders, those at risk of HIV infection, funders and decision-makers, as well as a high level of interest in exploring structures to utilize the momentum of explorations of ARVs as prevention as a motivating factor for spurring more comprehensive or rapid efforts to increase testing access.

ABSTRACT 205

Unique and Innovative Approaches in Traditional Settings can Promote HIV/AIDS Awareness and Provide Public Health Solutions

GW Edwards and MG Winter

Flowers Heritage Foundation, Oakland, CA, USA

People under 25 are estimated to make up HALF of all new HIV infections in the U.S. and in a 2006 study, the California Department of Health Services Office of AIDS declared nearly 37% of all persons living with AIDS statewide are between the ages of 13 and 29. Early intervention, screening and testing among sexually active young adults can cut infections rate and impact public health outcomes.

High school students' awareness of the AIDS health crisis increases and their risk behaviors reduce respectively after an interactive presentation where they get the facts regarding HIV risk and prevention. Students are challenged to creatively interpret their own thinking through artistic expression. Art education teachers promote the program in their fall curriculum and encourage students to participate. An art contest serves as a vehicle for inspiring creativity, learning art technique, and raising awareness on this sensitive subject.

Focusing on low-income, under-funded high schools and promoting an HIV prevention-the annual high school student art competition exhibits student talent. Local artist, museum curators, and art critics judge the artworks that are exhibited in a major gallery over World AIDS Day commemorations. Students learn that they are able to apply their talents to raise awareness and change public health outcomes in their community. Guests bid on the artwork by silent auction, raising funds for future programs, and contest winners and their schools receive awards and public recognition.

Students, their family and friends, and guests become more sensitive to and better informed about issues related to HIV/AIDS care, screening and testing through

this program; and participants become potential peer educators, public health ambassadors, and public service advocates.

ABSTRACT 206

Southern AIDS Coalition Web-based “Living Quilt” to Increase Awareness of HIV Prevalence Amongst Women of Color in the Southern United States

K Heirs¹, E Foust^{2,3}, G Puckrein⁴, and H Watkins⁵

1 AIDS Alabama and Co-chair, Southern AIDS Coalition (SAC), Birmingham, AL, USA; 2 HIV/AIDS Prevention, North Carolina Department of Health, NC, USA; 3 Southern AIDS Coalition (SAC), Raleigh, NC, USA; 4 National Minority Quality Forum, Washington, DC, USA; 5 North Carolina Communicable Disease Branch, Raleigh, NC, USA

OBJECTIVE: The Centers for Disease Control and Prevention (CDC) in 2006 recommended routine HIV testing in all healthcare facilities. This recommendation came amidst estimates that as many as one quarter of the 1.2 million Americans with HIV are unaware of their status and present a higher risk of spreading the disease. In an effort to reduce the number of undiagnosed Americans, the on-line Living Quilt Project utilizes first-person testimonials focusing on women living with or impacted by HIV and AIDS in the south. The website will evolve as additional stories are shared. This project utilizes audio, video and social networking to promote these testimonials and other educational resources on HIV and AIDS, encouraging routine screening and early diagnosis.

METHODS: Stories for the project were collected during interview sessions at local HIV and AIDS and STD clinics and AIDS conferences. Stories were collected in the southeastern United States. Each participant was asked to share their story of infection, diagnosis, treatment and share the overall impact HIV is having in their lives.

RESULTS: The Living Quilt project is the first web-based platform dedicated to sharing stories about HIV-positive women and their communities in the southern United

States. Each of these stories encourages others to know their status through routine screening, draws attention to the south as an epicenter of HIV and AIDS, provides HIV and AIDS resources and will eventually reduce stigmas associated with the disease.

CONCLUSIONS: The Living Quilt Project empowers women to share their stories of life on the frontlines with HIV and AIDS. These first-hand accounts highlight the importance of routine testing and educational efforts to reduce new transmissions and provide access to care for those in need.

ABSTRACT 207

Communities Learning Together (CLT): Recommendations for Enhancing Prevention Practices

P Gamache, J Salazar, M Ogleton-Williams, and B Hujdich

The CAEAR Foundation, Washington, DC, USA

OBJECTIVE: Data gathered from CAEAR Foundation Communities Learning Together (CLT) program participants holding administrative and direct client-services roles will inform HIV/AIDS service providers how to identify fiscal/organizational barriers, conduct effective outreach and engagement, and evaluate new knowledge transfer and utilization. This presentation will also illustrate how participants' recommended methods to enhance training and technical assistance can be used to support prevention practices.

METHODS: Consent to provide confidential interview data was obtained from six participants who each spent one hour responding to questions and sharing ideas. A semi-structured interview format that included response themes were validated in-vivo through summative checks throughout to ensure clarity and specificity. Detailed call notes were then sent to respondents to confer transparency, provide an additional layer of validation, allow for additional contributions, and increase relational ties for follow-up data gathering.

RESULTS: Participants hold 46 years of combined experience providing HIV/AIDS services and maintain organizational roles consistent with the intended audience for the CLT organizational/fiscal training. Prevention, treatment, and care program areas include substance abuse treatment, dental services, medication co-payment assistance, treatment adherence counseling, and home care. Aggregate response themes pertaining to prevention activities include unique considerations for targeted populations (e.g., outreach team composition, stigma reduction), staff incentives (e.g., recognition and merit awards), and client follow-up (e.g., adherence, monitoring, re-engagement).

CONCLUSIONS: Prevention project teams are a natural evolution of the CLT program model. Through these efforts, organizations can be matched with peers that have similar prevention profiles and mentors at advanced organizational stages. The opportunity to inform an evaluation of this process will be presented to 2008 National HIV Summit attendees.

ABSTRACT 208

Use of a Blinded Serosurvey to Assess Undiagnosed HIV Infection among New York City Jail Entrants in the Setting of a Large Scale Routine Testing Program

Y Bennani, F Parvez, L Forgiione, J Herrera, L Torian, M Gbur, E Begier, and C Jain

New York City Department of Health & Mental Hygiene, New York, NY, USA

OBJECTIVE: Jail inmates are at higher risk for HIV infection, thus jails provide opportunity for HIV testing and prevention. NYC Dept. of Health and Mental Hygiene (DOHMH) began to offer voluntary rapid HIV testing to all jail entrants during medical intake in 2004. Testing volume increased from 6,500 in 2003 using serology to 25,000 in 2006 using rapid testing. To guide further service improvement, DOHMH conducted a blinded serosurvey

of NYC jail entrants to determine current HIV prevalence and estimate the proportion of HIV+ jail entrants who were undiagnosed despite the current large scale routine testing program.

METHODS: Remnant serum from routine intake syphilis screening was salvaged when available from consecutive new NYC jail admissions until sample size goals were met. Data from NYC Dept. of Correction and jail electronic medical intake record were matched to NYC's HIV surveillance registry (HARS) to identify previously reported HIV infections. Data and specimens were stripped of personal identifiers, and specimens were HIV tested. We defined "undiagnosed" infections as HIV+ inmates who at intake did not self-report being HIV+ and were not in HARS. "Jail testing" refers to voluntary clinical testing conducted in jail.

RESULTS: Specimens were obtained from 4,699 unique males (63.4% of new admissions) and 1,758 unique females (60.9%). HIV prevalence was 4.7% (4.1%–5.3%) in males and 9.7% (8.3%–11.1%) in females. Sixty-five of 219 HIV+ males (29.7%) and 40 of 171 females (23.4%) were previously undiagnosed. Thirty-two (30.5%) of the 105 undiagnosed agreed to testing at intake; 12 (11.4%) were diagnosed during jail testing. Only 10 (10.7%) of the 105 undiagnosed reported MSM or IDU activity. An additional 36 (22.8%) reported a history of a STD, unprotected sex, and/or multiple sex partners, but these were not significant predictors of HIV infection among inmates without an established HIV diagnosis at intake.

CONCLUSIONS: HIV prevalence among NYC jail entrants has decreased since the last serosurvey (1998): 7.6% to 4.7% in males and 18.1% to 9.7% in females. However, ~25% of HIV+ jail entrants appear to be undiagnosed. Despite a fourfold increase in jail HIV testing, most undiagnosed infections are not identified, largely due to low acceptance of HIV rapid testing. Most undiagnosed did not report recognized HIV risk factors. This underscores the importance of increasing the proportion of inmates tested through the current routine testing program at intake and at other medical visits during their jail stay.

ABSTRACT 209

Utilizing Mental Health Counseling in African American Men who have Sex with Men Minority Populations as a Primary and Secondary HIV Prevention Tool

T McPhaul

National AIDS Education & Services for Minorities (NAESM),
2140 Martin Luther King, Jr. Dr., S.W., Atlanta, GA 30310, USA

OBJECTIVE: Persons receive an HIV positive diagnosis, and often do not have adequate tools for processing this information in a healthy manner. Counseling can be extremely helpful as an HIV Prevention tool from the framework that often people engage in either risky or self-destructive behaviors due to a variety of other factors such as depression, low self-esteem, as well as a lifetime of neglect, deprivation and abuse. As a secondary prevention tool mental health counseling will address underlying causes for self-destructive behavior in HIV+ individuals and lead to less risk taking, and healthy disclosure. The U.S. Surgeon General has reported that overall only one-third of Americans with a mental illness or a mental health problem get care. Yet, the percentage of African Americans receiving needed care is only half that of non-Hispanic whites.

METHODS: In this model counseling services will be provided by a Licensed Professional Counselor, or Licensed Clinical Social Worker. In addition to collaborations with various agencies providing services to at-risk populations, social marketing campaigns aimed at venues frequented by at risk populations will be employed; resulting in HIV+, and high risk HIV- individuals accessing mental health services. Individuals accepted into care will have a plan developed with a counselor, which will include a course of counseling ranging from 3 months to one year.

RESULTS: Limited data is available at this time because this program has been recently funded. Individuals clearly falling within critical values will then go on for an intake and assessment where depth and complexity of issues are examined. At the conclusion of the counseling term,

an additional assessment will be provided to evaluate counseling effectiveness. Data will be analyzed and scored to chart success of the counseling term.

CONCLUSIONS: African American Men who have Sex with Men, those hardest hit by the HIV/AIDS epidemic, have complex psychological underpinnings that are often augmented by racism, homophobia, familial and societal rejection, physical and emotional abuse, self-loathing and a struggle for identity. Culturally competent mental health counseling can help to prevent HIV transmission, and contribute to improved quality of life for HIV positive individuals. There exists research identifying that African Americans from various walks of life do not seek mental health treatment as often as is warranted, or as regular as their Caucasian counterparts. There may be no one cause defined for this phenomenon, however, historically African Americans and other people of color have had similar resistance and/or obstacles to receiving care for physical health as well. Studies show that counseling for African Americans can be effective when accessed in a timely pattern.

Knowing at the outset certain factors that have influenced an individual's mental health foundation, such as level of stability of the family structure that a person experienced as a child, can yield valuable insight into behavior patterns that if known by those providing HIV prevention services could yield quite different results. Thus, it is critical that the necessity for good mental health be realized and utilized as a tool to aid in both primary and secondary HIV prevention. Fully embracing this idea may be the most formidable approach to the eradication of HIV/AIDS.

ABSTRACT 210

Video-delivered Rapid HIV Pre-test Information to Streamline HIV Testing

RC Merchant¹, MA Clark¹, KH Mayer¹, GR Seage III², VG DeGruttola², and BM Becker¹

1Brown University, Providence, RI, USA; 2 Harvard University, Boston, MA, USA

OBJECTIVES: We sought to determine if the video, “Do you know about rapid HIV testing?” can streamline rapid HIV testing efforts. We compared the video to an in-person discussion with an HIV counselor in regards to equivalence of patient comprehension of HIV and HIV testing fundamentals, time needed to deliver the information, and patient acceptance of the video.

METHODS: Patients at a US emergency department were randomized into two groups in a non-inferiority trial to receive pre-test information from a video or an in-person discussion prior to being HIV tested. Participant comprehension of the pre-test information was evaluated using a questionnaire. The non-inferiority criterion was that the video would be accepted as non-inferior if the 95% CI of the difference (Δ) in mean scores on the questionnaire between the two information groups was less than a 10% decrease in the in-person discussion group’s mean score. Time to deliver the pre-test information was measured. Participants were surveyed on which delivery method of rapid HIV pre-test information they preferred to receive. Two-sample tests of binomial proportions were used to compare groups.

RESULTS: Of the 574 participants, 54% were female and most were white (64%), never married/single (48%), had twelve or fewer years of formal education (60%), and had previously been tested for HIV (62%). The mean scores on the questionnaire were (20.1; 95% CI: 19.7-20.5) for the video and (20.8; 95% CI: 20.4-21.2) for the in-person discussion group ($\Delta = 0.68$; 95% CI: 0.18-1.26), which satisfied and non-inferiority criterion. The median time elapsed to deliver pre-test information was 10 minutes for each group. Of those who received pre-

test information from the HIV counselor, 74.9% preferred receiving pre-test information from a person, 1.7% from a video, and 23.4% from either. Of those who received pre-test information from the video, 31.2% preferred receiving pre-test information from a person, 14.3% from a video, and 54.5% from either. Fewer patients in the video than the in-person discussion group had a preference for an in-person discussion (31.2% vs. 74.9%; $p < 0.001$) and more had no preference for type of pre-test information delivery method (54.5% vs. 23.4%; $p < 0.001$).

CONCLUSIONS: The video appears to be a good substitute for an in-person discussion in terms of patient comprehension of HIV pre-test fundamentals and time needed to provide the information. Participants were more open to the video as an information delivery method if the video was the source of their pre-test information.

ABSTRACT 211

Collaboration of Two County Programs in Expanding Partner Services to Increase HIV Prevention and Testing

KMK Shanley, CL Silva, and V Levy

San Mateo County Health Department, San Mateo, CA, USA

OBJECTIVES: To analyze systems of HIV and STD case identification for eligibility and acceptability of HIV Partner Services (PS). HIV and STD services in San Mateo County (SMC) are implemented by two distinct health department programs: STD Control Program and AIDS Program. These programs collaborated beginning January 2008 to offer PS to all STD/HIV co-infected patients and newly identified HIV cases reported to the SMC Health Department through California’s name-based reporting system. CDC guidelines for PS in co-infected populations currently describe routine PS offers for early syphilis/HIV co-infected patients, but few studies have examined the acceptability and relevance of PS for patients co-infected with gonorrhea and/or Chlamydia.

METHODS: In California all positive HIV, gonorrhea, Chlamydia and syphilis results are reportable by health provider and laboratory to the local health department or jurisdiction. Eligible PS clients were identified through HIV name-based surveillance, weekly case-matching of HIV and new STD results, STD case investigation, provider referrals, or self-referral. PS were offered through cross-program coordination between STD and AIDS Program staff and resources. Systems of identification and PS acceptability were analyzed in MS Access.

RESULTS: To date, 52 eligible patients have been identified for PS. Notably, 39% (20) were identified through case-matching of HIV and new STD reports, while 23% (12) were identified through STD case investigation, 21% (11) through HIV surveillance, and 8% (4) through provider referrals. 33% (17) of the 52 clients contacted for PS named at least one partner. Eight of those who named partners were previously positive for HIV, and 5 of those were co-infected with gonorrhea or Chlamydia and would not otherwise have been offered PS. Staff members from both AIDS Program and STD Control conducted the PS offers in various sites around the county, including HIV Counseling & Testing sites, private venues, County clinics, and on the telephone.

CONCLUSIONS: Case-matching incident STD reports, especially gonorrhea and Chlamydia, with name-based HIV data greatly expands the number of PS eligible clients compared to HIV surveillance alone. Clients offered PS in this context found it acceptable at similar rates to those offered PS through other means of case identification. Consideration should be given to expanding HIV PS beyond persons with incident HIV infection and those with longstanding HIV/early syphilis, to include HIV infected persons co-infected with other bacterial STDs.

ABSTRACT 212

Effectiveness of Enhanced and Cluster Interviewing to Identify Sexual Venues across Health Jurisdictions for Sexually Transmitted Diseases (STD) and HIV Transmission

CL Silva, BA Jacobson, S Deshpande, and V Levy

San Mateo County Health Department, San Mateo, CA, USA

OBJECTIVE: San Mateo County (SMC) Health Department's STD Control Program implemented enhanced interviewing in August of 2006 and cluster interviewing in October of 2007 of all reported gonorrhea (GC), early syphilis and clients co-infected with HIV. We sought to evaluate the effectiveness of these interviewing techniques in identifying social acquaintances, social networks, sexual venues, and new STD and HIV infections.

METHOD: SMC Health Department staff performed enhanced and cluster interviews of newly reported cases of GC, early syphilis and clients co-infected with HIV. The *enhanced interview* elicited sexual partners, venues, internet sites, and risk behaviors of the index case. The *cluster interview* elicited high-risk, non-sexual acquaintances, venues, and internet sites that others use to meet sex partners. Health department staff attempted to contact elicited sexual and non-sexual high-risk acquaintances to offer free STD and HIV testing. Rates of all reported cases and elicited sexual venues were mapped and an analysis of identified internet sites will be visually displayed.

RESULT: From October 2007 through March 2008, 203 enhanced and/or cluster interviews were completed by Health Department staff. Of these, 40% (81) identified internet sites as a venue where they or their community meet sexual partners. Of the non-internet sexual venue sites named (bars, club, bookstore, etc. [18]), 50% (9) were physically located outside of SMC, in the neighboring San Francisco County.

Sexual and non-sexual partners were elicited from both interview techniques. The enhanced interviews elicited 30

sexual partners and the cluster interviews elicited one high-risk, non-sexual acquaintance. Twenty-nine percent of these individuals reside outside of SMC.

CONCLUSION: San Mateo County residents with STDs often go to venues in San Francisco County to meet sex partners. Most venues identified in SMC are close to zip codes with high STD morbidity. With web sites mentioned 163 times by 81 index cases, the internet is a significant medium to arrange sexual encounters. Future research of this nature requires inter-county cooperation and modified interviewing techniques to better elicit social networks.

ABSTRACT 213

Using GIS to Evaluate Utilization of Sexually Transmitted Diseases (STD) and HIV Services in a Northern California County with Substantial HIV Late Presentation

CL Silva, JJ Tang, and V Levy

San Mateo County Health Department, San Mateo, CA, USA

OBJECTIVE: San Mateo County (SM) has a higher prevalence of HIV late presentation (62%) than neighboring Bay Area counties (San Francisco [SF] 39%) and the national average (43%). SM's syphilis rate tripled in 2006 (4.5 cases per 100,000) compared to 2005 and half of these cases were HIV infected. We sought to evaluate utilization and access to STD and HIV services at County and neighboring county (SF and Santa Clara [SC]) STD clinics.

METHOD: Residential information on all SM residents who visited one of the three County Bay Area STD Clinics (SM, SF and SC Clinics) in 2006 were mapped using ArcGIS 9.1 by zip code. These data were compared with all confirmed STD cases reported to the SM Health Department in 2006.

RESULT: SM STD clinic had 2,109 visits in 2006 and performed 721 HIV tests. Approximately 85% of those

visits were from SM residents and the rest were from non-SM residents. Of those visits from non-SM residents, over 35% were from SF. The majority of SM STD visits were from mid (38%) and south-county areas (26%), which are geographically closest to the SM clinic.

SF Clinic had a reported 1,219 visits (out of a total 21,688 visits) from SM residents. Though this represents only 5.5% of SF Clinic's total volume, this is almost 60% of SM Clinic's total volume, demonstrating that a large proportion of SM residents are accessing another county's STD/HIV services. 75% of SF visits from SM residents were from north-county, where 40% of all confirmed STD cases in SM reside.

SC Clinic visits by SM residents were insignificant, with only 1.7% SM residents accessing this clinic.

CONCLUSION: Inter-jurisdictional use of STD clinical services between these counties is common. Northern SM has both high STD morbidity and significant use of SF STD clinic services. Individuals utilizing STD Clinic services may not access care in their resident county due to the nature of work/life schedules, confidentiality, clinic locations/schedules and/or Bay Area geography. Given the shared clinical populations, approaches that are inter-jurisdictional may be most effective in prevention outreach and reducing morbidity. STD and HIV morbidity and service seeking appear not to be confined by local health jurisdiction (LHJs) boundaries. Regional prevention approaches between LHJs may be cost effective and acceptable for some behavioral risk populations.

ABSTRACT 214

Computer Tool for Routine Rapid HIV Counseling and Testing in Emergency Care Settings

F Spielberg^{1,2}, AE Kurth^{3,4}, A Severynen¹, Y-H Hsieh⁵, and R Rothman⁵

1 Research Triangle Institute International, San Francisco, CA, USA; 2 University of California San Francisco Department of Family and Community Medicine, San Francisco, CA, USA; 3 University of Washington (UW) School of Nursing, Biobehavioral Nursing and Health Systems, Seattle, WA, USA; 4 UW Department of Global Health, Schools of Medicine, and of Public Health; 5 Johns Hopkins University Department of Emergency Medicine, School of Medicine, Baltimore, MA, USA

OBJECTIVES: Despite national recommendations, many emergency care settings (ECs) are unable to provide routine HIV testing. Those that do, cannot provide associated risk reduction counseling. We hypothesized that an interactive computer tool could facilitate both rapid HIV testing and risk reduction counseling in ECs.

METHODS: We conducted acceptability and usability studies of the "CARE" tool in Seattle and Baltimore ECs. In Seattle we conducted a subsequent Randomized Controlled trial among adults presenting to an urban ECS where patients received either CARE computer counseling and rapid HIV testing prior to their visit (n=258), or a standard ECs visit with chart review (n=259). We compared HIV testing between arms and assessed intervention acceptability and cost.

RESULTS: The acceptability and usability study in Seattle and Baltimore showed that staff had some concerns about implementing computer assisted HIV testing in ECs, but appreciated the benefits to patients, and that even the low literacy patients found the tool easy to use, private, and liked the lack of judgment that computer counseling offered. In the Seattle RCT 97% of CARE users (prevalence 0.4%) completed the computer counseling session and received HIV test results. In the control arm no participants received HIV counseling or test results. For those participants who completed the CARE session, 55% said they would choose computer over face-to-face counseling for future HIV

testing. Non-study cost of the CARE system was \$40 per test result received with a one staff/one computer model.

CONCLUSIONS: An interactive computer tool was an acceptable, feasible and effective method for increasing delivery of routine rapid HIV testing, risk reduction counseling and referrals to patients in ECs.

ABSTRACT 215

So You Think You're Safe?: Increasing Awareness for HIV Risk Among Women at a Family Planning Clinic

G Silva, A Lozada, R Torres, C Hilerio, LE Santiago, and CD Zorrilla

University of Puerto Rico, Medical Sciences Campus San Juan, Puerto Rico

BACKGROUND AND OBJECTIVE: During the past 10 years Puerto Rico has ranked among the top five jurisdictions in the United States in AIDS cases rates, among men, women and children (CDC, 2007). Of the new reported infections in both males and females, 38% were related to IDU and 33% with heterosexual contact. Heterosexual transmission is the main risk factor for HIV infection in women (63%) (PR Department of Health, 2008). This is a significant challenge from a public health perspective and emphasizes the importance of studies focusing on risk reduction interventions and effective prevention strategies for women. The aim of this study is to develop and test an intervention that assesses STD and HIV risk in women with low and high risk for HIV and to demonstrate its effectiveness. This presentation describes the experience with the women in the low risk category.

METHODS: A risk reduction counseling intervention for HIV, the Hispanic/Latino Respect was administered to 63 women from a family planning clinic considered at low risk for acquiring HIV and STDs. This longitudinal study consisted of four visits per participant over a one year period. During the first and fourth visits, HIV pre counseling was performed. This assessed the participant's knowledge and current risks of HIV/STDs, risk reduction techniques, future plans, support networks, myths, and

worries about HIV. A rapid HIV test was performed with a post counseling session. The participants were contacted within a three month interval for all follow up visits, were their risk reduction plan was evaluated.

RESULTS: This intervention has proven to be effective reducing STD risk behaviors among the interviewed women. During the post intervention participants expressed greater awareness towards STDs and ways to protect themselves (*i.e.* getting regular HIV testing, using condoms or avoiding unprotected sex before both parts get tested). This applied to females who were either in a steady relationship or single.

CONCLUSIONS: The Hispanic/Latino Respect can be used as a routine preventive tool to diminish the impact of the HIV transmission among women. This intervention has proven effective assessing HIV and STDs risk among women with varying levels of risks in a non threatening manner. Women's positive responsiveness towards this intervention was perceived as well as increased awareness of risk perception and risk reducing behaviors. After a one year follow-up all the participants recognized their risk behaviors for HIV and adopted safer sexual practices.

Sponsored by: NCRR 1-U54RR019507

Outcomes and Impact Evaluation of HIV Testing Activities

ABSTRACT 301

CD4 Counts of HIV Positive Patients Detected Through a Routine Emergency Department HIV Screening Program in a High Prevalence Area

J Brown¹, M Czarnagorski², and V Lee¹

1 Department of Emergency Medicine, The George Washington University Medical Center, Washington DC, USA; 2 National Institutes for Allergy and Infectious Diseases, National Institutes of Health, Bethesda MD, USA

OBJECTIVE: Routine emergency department (ED) HIV screening has been recommended by The Centers for Disease Control since September 2006. A knowledge of the initial viral load and CD4 counts of patients detected through ED screening programs would help describe chronicity of the infection, as well as the severity of disease at presentation. We analyzed the CD4 counts and viral loads of patients whose HIV diagnosis began with a positive routine ED HIV screen.

METHODS: Routine opt-out ED HIV testing was performed using a rapid oral swab (OraQuick) at a university hospital in Washington DC. We reviewed the CD4 counts and viral loads from results of patients whose initial positive ED screen was confirmed with by Western Blot. Demographic information was also obtained.

RESULTS: In the two year study period, 11,190 ED patients were screened HIV. Of these, 72 (6%) had a reactive screen. A confirmed positive Western Blot was obtained in 35 cases, and the CD4 counts and/or viral loads was completed in follow-up data was available for 34 of these patients. One patient had a reported viral load but not a CD4 count, and 6 patients had an initial CD4 count but no viral load. The results are shown in the Table below. 19 patients (56%) had a CD4 count of less than 200, and of these, 12 patients (63%) were admitted. The mean viral load (k) was 211 (range 10-1558).

CONCLUSIONS: More than half of the patients in whom a confirmatory test was positive had an initial CD4 count

of 200 or less. This suggests that further efforts at the early detection of HIV infection should be encouraged.

Patient	Sex	Ethnicity	Age	Presenting	Admitted?	CD4	VL (k)
1	Male	Black	62	Abdominal pain	Yes	26	NA
2	Female	Black	57	hernia	No	56	50
3	Female	Black	34	Boils	No	2	> 100
4	Female	other	35	short of breath	Yes	183	518
5	Female	Black	56	weakness,	Yes	4	58
6	Male	Black	20	eye complaint	No	65	> 100
7	Male	Black		std screen	No	48	100
8	Male	Black	21	arm pain	No	339	NA
9	Male	Black	25	hemorrhoids	No	326	268
10	Male	Black	41	swollen glands	No	386	21
11	Female	Black	24	Suicidal ideation	Yes	710	11
12	Male	Hispanic	36	stomach pain	No	400	< 50
13	Female	Black	28	Abdominal pain	Yes	5	> 100
14	Male	Black	25	UGI bleed	Yes	162	NA
15	Male	white	26	eye	Yes	176	71
16	Male	Black	43	abdo pain	Yes	438	NA
17	Female	Black	52	Headache	Yes	157	NA
18	Female	Other	50	Abdominal pain	No	76	NA
19	Male	Black	32	GI Complaint	Yes	23	> 100
20	Male	Black	47	hematuria	No	< 50	1043
21	Female	Black	42	weight loss	Yes	18	1558
22	Male	White	21	perianal abscess	No	480	86
23	Male	Black	55	rash	No	3	> 100
24	Female	Black	35	PV bleeding	Yes	418	10
25	Male	white	25	short of breath	Yes	48	592
26	Male	Black	31	short of breath	Yes	69	> 100
27	Male	Black	39	leg swelling	Yes	290	50
28	Male	White	34	std screen	No	507	< 50
29	Male	Black	31	Weakness	No	543	23
30	Male	Black	42	Asthma	No	649	31
31	Male	Black	47	rash	No	26	500
32	Male	Black	43	burn	No	NA	28
33	Female	Black	50	rash	Yes	68	150
34	Male	Black	26	chest pain	Yes	1136	43

ABSTRACT 302

Routine ED HIV Testing Has No Effect on Length of Stay

J Brown¹, N Collier¹, I Kuo², and V Lee¹

1Department of Emergency Medicine, The George Washington University Medical Center, Washington DC, USA; 2 Dept of Epidemiology and Biostatistics, School of Public Health, The George Washington University, Washington DC, USA

OBJECTIVES: In September 2006 the Centers for Disease Control (CDC) recommended routine HIV testing for all patients in the Emergency department. One of the concerns is that adoption of these recommendations would lead to an increase in the length of stay (LOS) for

ED patients. We therefore analyzed the effect of routine HIV screening on LOS in a cohort of ED patients.

METHODS: The analysis was performed in an ED which offers routine opt-out HIV screening using dedicated HIV screeners. We analyzed the LOS of those patients who accepted HIV screening between January and July 2007, and compared them with a cohort of patients from the same time period in the previous year. Admitted patients were excluded from the analysis.

RESULTS: We analyzed all patients who accepted screening and were routinely discharged during this time (1,025) and compared them to a convenience sample of patients seen in the department between January 2006 and July 2006 prior to the initiation of testing. The mean LOS in the tested patients (n=1,025) was 262 minutes while the mean LOS in the non-tested patients (n=(21, 604), was 257 minutes. A two sample t-test with equal variances (CI=95%) showed no statistical difference (p=0.15).

CONCLUSIONS: This is the first report of the effect of routine ED HIV testing on ED LOS, and we conclude that HIV screening using an additional staff model has no effect on the overall length of stay. However, these conclusions apply only to our staffing model, and may not apply to other staffing models.

ABSTRACT 303

Experience with Opt-out HIV Testing in an Urban Hospital

M Czarnogorski^{1,2}, J Brown¹, A Roberts¹, AE Greenberg¹, and GL Simon¹

1 The George Washington University Medical Center, Washington, DC, USA; 2 SAIC-Frederick, in support of NIAID/National Institute of Health, Bethesda, MD, USA

BACKGROUND: The seroprevalence rate of HIV infection in Washington, D.C., has been estimated to be as high as 5%. In 2006 CDC issued recommendations promoting routine opt-out HIV testing in all health care settings in order to foster earlier detection and treatment.

METHODS: Our Emergency Department (ED) offered OraQuik rapid HIV testing to all patients on an opt-out basis. Demographic data including age, gender, ethnicity, insurance status, and zip code were collected. Patients with positive OraQuik tests had a confirmatory western blot and were referred for HIV care.

RESULTS: 6554 patients registered in the ED and were offered HIV testing. 45% were male; 50% African-American, 39% white, 4.5% Hispanic. 3653 patients accepted testing. The OraQuik test was positive in 35 of 3653 patients tested (1.0%); 28 of 35 had positive confirmatory western blot tests. 21 were male; 24 African-American, 3 white and 1 Hispanic. Of the 1231 individuals who lived in the lowest median annual household income (\$27,964) wards and who were offered the test, 34% chose not to be tested. In contrast, among those (1081) in the highest income area (\$130,891), 49% opted out (P < 0.0001). Among seropositive individuals 12 of 809 who were tested were from the lowest income ward and 7 of 555 tested lived in the wealthiest ward of the city (NS). Individuals with private insurance opted out more frequently than did those with federal or no insurance (51% v 46%, P = 0.0002).

CONCLUSION: Among 3653 patients tested, a 0.76% HIV seroprevalence was found, much lower than the predicted seroprevalence rate. However, it is quite possible that this apparently low rate is due to a higher rate among the population that chose not to be tested. Although it appears that higher income and private insurance is more common among those individuals who chose not to be tested, those factors that inhibit testing need to be explored in order to maximize the effectiveness of the opt-out approach.

ABSTRACT 304

Rates of HIV Testing in the United States, 2006

D Duran¹, L Belcher², J Beltrami¹, and B Branson¹

1 Centers for Disease Control and Prevention, Atlanta, GA, USA; 2 Macro International Inc., Atlanta, GA, USA

OBJECTIVE: At the end of 2003, approximately one fourth of the estimated 1.0–1.2 million persons living with HIV remained unaware of their infection. In 2006, CDC issued recommendations for routine HIV screening in health-care settings for all persons aged 13–64 years. To establish a baseline for evaluating the effect of these recommendations and other strategies to increase HIV testing, CDC analyzed data from the National Health Interview Survey (NHIS), an annual, cross-sectional, multistage probability sample survey representing the civilian, non-institutionalized U.S. population.

METHODS: We analyzed NHIS HIV testing data for adults aged 18–64 years. Estimates of the number of persons ever tested for HIV (excluding test done for blood donation) and tested during the preceding 12 months were calculated for the period 1987–2006. Stratification by demographics, pregnancy status, HIV risk factor status, and testing setting was performed for data from the 2006 survey.

RESULTS: The percentage of persons ever tested for HIV increased from 6.0% in 1987 to 38.0% in 1997, and then ranged from 36.4% to 38.4% during 1998–2000. Since 2001, the percentages have remained stable: approximately 40% (an estimated 71.5 million persons) reported ever being tested, and each year, 10.4% (an estimated 17.8 million persons) reported being tested in the preceding 12 months. In 2006, greater percentages of persons aged 18–34 years (15.6%), women (11.6%), residents of the South region of the United States (12.1%), non-Hispanic blacks (21.7%), pregnant women (60.7%), and respondents who acknowledge having an HIV risk factor (23.0%) reported an HIV test during the preceding 12 months. Among the persons that had a test in the preceding 12 months, 82.6% (an estimated 14.6 million persons), reported they

were tested in a clinical setting: 53.2% (an estimated 9.4 million persons) by a private doctor or health maintenance organization, and 17.6% (an estimated 3.1 million persons) in a hospital, emergency room, or outpatient clinic.

CONCLUSIONS: Despite consistent rates of annual testing, many persons in the United States have never been tested for HIV infection. New strategies to increase testing are necessary to reduce the number of persons who are unaware of their HIV infection to improve access to effective therapy and to reduce HIV transmission.

ABSTRACT 305

Using Capacity Planning Models to Estimate Organizational Costs of HIV Care within the United States Department of Veterans Affairs

HD Anaya¹, MB Goetz^{1,2,3}, U Karmarkar⁴, and SM Asch^{1,2,5}, and J Feld¹

1 Center for the Study of Healthcare Provider Behavior, US Department of Veterans Affairs, Greater Los Angeles Health Services Research and Development (HRS&D) Center of Excellence, VA Greater Los Angeles Healthcare System, Los Angeles CA, USA; 2 Division of General Internal Medicine, David Geffen School of Medicine at UCLA; 3 Infectious Diseases, U.S. Department of Veterans Affairs; 4 UCLA Anderson's Business and Information Technologies Project (BIT); 5 RAND Corporation

OBJECTIVES: The objectives were to obtain the sufficient capacity to perform a rigorous evaluation of organizational costs associated with increases in HIV screening rates, based on expertly-chosen criterion. As policy-driven researchers, it is not enough that we substantiate that a given HIV quality improvement research project is effective; it should also be elucidated clearly to non-research facility managers for whom costs associated with proposed changes are paramount. Business case modeling provides us with that link.

METHODS: Longitudinal design linked to estimates of HIV-related facility expenditures in one large, university-affiliated VA facility in Southern California.

Models were constructed using MS Excel. Inputs were derived from providers familiar with patient care factors. We estimated first-year costs in specific categories under two scenarios: 1) increasing screening rates from 0-5%, 2) increasing from 0-10%. Endpoints included antiretroviral and drug costs, patient flow estimates, testing/treating HIV patients, changes in staff, pharmacy and lab costs.

RESULTS: For HIV caseload increases, facilities incur a variety of quarter-to-quarter expenses. Expenses fluctuate over time, depending on the category. Explanations for these differences are provided.

CONCLUSIONS: The effectiveness of cost modeling has important implications for organizational impacts associated with changes in care delivery. Stakeholders and facility/organizational managers should consider the use of capacity planning models of this sort to extrapolate future costs based on current actions.

ABSTRACT 306

Clinical Effectiveness of Routine Opt-out Rapid HIV Screening in the Emergency Department: Results from an Ongoing Prospective Clinical Trial

JS Haukoos^{1,3}, E Hopkins¹, RL Byyny^{1,2}, J Forsyth⁴, A Marlow-Geter⁵, S Johnson⁷, and M Thrun^{1,2,8} for the Denver Emergency Department HIV Testing Study Group

1 Denver Health Medical Center, Denver, CO, USA; 2 University of Colorado Denver School of Medicine, Aurora, CO, USA; 3 Colorado School of Public Health, Aurora, CO, USA; 4 Children's Hospital of Denver, Denver, CO, USA; 5 Colorado Department of Public Health and Environment, Denver, CO, USA; 6 University of Colorado HIV/AIDS Program, Denver, CO, USA; 7 Denver Public Health, Denver, CO, USA

OBJECTIVES: Approximately 250,000 unrecognized HIV infections exist in the US and 56,300 new infections occur annually. In 2006, the CDC published revised recommendations for performing HIV screening in

healthcare settings, calling for routine opt-out HIV screening of persons 13-64 years of age in all healthcare settings, including emergency departments (EDs). The impact of these recommendations has not been assessed. The objective of this study is to evaluate the clinical effectiveness of performing routine opt-out rapid HIV screening when compared to physician-based diagnostic rapid HIV testing in an urban ED.

METHODS: *Study Design:* Prospective quasi-experimental equivalent time-samples clinical trial. *Setting:* The ED at Denver Health Medical Center in Denver, Colorado. Denver Health is an urban, inner-city hospital with an annual census of approximately 55,000 adult patients. *Interventions:* Routine opt-out rapid HIV screening (intervention) and physician-based diagnostic rapid HIV testing (control) alternated in four-month time periods. *Population:* During intervention periods, all ED patients (>15 years) were offered rapid HIV testing on an opt-out basis during registration. During control periods, emergency physicians used a diagnostic approach (i.e., testing on the basis of clinical findings or behavioral risks) to offer rapid HIV testing to patients. Each method was fully integrated into ED operations. *Outcomes:* Number of patients identified with HIV infection and linked to medical and preventative care. Incidence densities and incidence rate ratios (IRRs) with 95% confidence intervals (CIs) were calculated.

RESULTS: As of August 15, 2008, two intervention and two control periods were completed. During the cumulative control period, 29,309 eligible patients presented to the ED and 166 (0.6%) completed testing. Of these, 3 (1.8%, 95% CI: 0.4% - 5.2%) were diagnosed with HIV infection. During the cumulative intervention period, 30,281 eligible patients presented to the ED and 5,377 (18%) completed HIV testing. Of these, 14 (0.3%, 95% CI: 0.1-0.4%) were diagnosed with HIV infection. The incidence densities of HIV identification during the intervention and control periods were 0.7 cases and 0.2 cases per 10,000 patient-hours, respectively. The IRR for intervention to control periods was 4.7 (95% CI: 1.3 - 25.6). All but one HIV-infected patient was linked into care.

CONCLUSIONS: Preliminary findings suggest that routine opt-out rapid HIV screening is more effective than

physician diagnostic rapid HIV at identifying patients with HIV infection in the ED. It remains unclear, however, how the two rapid HIV testing programs compare relative to ED processes of care or cost effectiveness.

ABSTRACT 307

National Estimation of Rates of HIV Serology Testing in US Emergency Departments 1993-2005: Baseline prior to the 2006 CDC Recommendations

Y-H Hsieh¹, R Rothman¹, D Newman-Toker^{2,3}, and G Kelen¹

1 Department of Emergency Medicine; 2 Department of Neurology, The Johns Hopkins University School of Medicine; 3 The Department of Epidemiology, The Johns Hopkins University Bloomberg School of Public Health; Baltimore, MD, USA

OBJECTIVE: The 2006 CDC recommendations place increased emphasis on emergency departments (EDs) as one of the most important medical care settings for implementing routine HIV testing. No longitudinal estimates exist regarding national rates of HIV testing in EDs. We analyzed a nationally representative ED database to assess HIV testing rates and characterize patients who received HIV testing, prior to the release of the 2006 guidelines.

METHODS: We conducted a cross-sectional analysis of US ED visits (1993–2005) using the National Hospital Ambulatory Medical Care Survey (NHAMCS). Patients aged 13-64 years included for analysis. Diagnoses grouped with Healthcare Cost and Utilization Project Clinical Classifications Software. Analyses performed using procedures for multiple-stage survey data.

RESULTS: HIV testing was performed in an estimated 2.8 million ED visits (95% CI: 2.4-3.2) or rate of 3.2 per 1,000 ED visits (95% CI: 2.8-3.7). Patients aged 20-39 years, African American, and Hispanic had the highest testing rates. Among those tested, leading reasons for visit were abdominal pain (9%), puncture wound/needlestick (8%),

rape victim (6%), and fever (5%). The leading medication class prescribed was antimicrobials (32%). The leading ED diagnosis was injury/poisoning (30%), followed by infectious diseases (18%). Of note, 6%, of those tested, were diagnosed with HIV infection during their ED visits.

CONCLUSIONS: Prior to the release of the 2006 CDC guidelines for routine HIV testing in all health care settings, baseline national HIV testing rates in EDs were extremely low and appeared to be driven by clinical presentation.

ABSTRACT 308

Outcomes and Cost Analysis of Three Operational Models for Rapid HIV Testing Services in an Academic Inner-city Emergency Department

Y-H Hsieh¹, J Jung¹, J Shahan¹, H Pollack², H Hairston¹, D Moring-Paris¹, G Kelen¹ and R Rothman¹

1 Department of Emergency Medicine, The Johns Hopkins University School of Medicine, Baltimore, MD, USA; 2 School of Social Service Administration, University of Chicago, Chicago, IL, USA

OBJECTIVE: To compare the outcomes and operational cost-effectiveness associated with alternative staffing models for emergency department (ED)-based rapid HIV testing program in an inner-city ED.

METHODS: An ED-based rapid HIV testing (OraQuick Advance, oral fluid) program was instituted in an academic inner-city ED in November 2005. Eligibility for testing: 18-64 years; no previous diagnosis of HIV; no test in the past 3 months; able to provide informed consent. Three operational models compared over 24.5 months: medical staff only (MS; 8 months); 100% facilitator (100F; 2 months), or facilitator plus medical staff coverage (Hybrid; 14.5 months). In each model, medical staff and/or facilitators performed written consent for HIV testing and brief pre-test counseling, obtained specimen collection kits, collected oral swab specimens, returned specimens to ED satellite laboratory, and performed post-test counseling. Total numbers of patients tested, reactive, confirmed

positive, and linked to care, for each operational model were tallied. Cost-effectiveness analysis was performed to estimate cost per patient tested and cost per patient linked to care. Cost variables included personnel (ED medical staff, laboratory technicians, and facilitators) and test kits.

RESULTS: Overall, 2,958 eligible patients were tested for HIV. Sixty-six (2.2%) tested reactive, and 44 (1.5%) were confirmed positive. Among them, 30 (68.2%) patients were linked to care. Model 100F had the highest number of patients tested per month while Model MS had the lowest number (587 versus 57). Confirmed positivity rate was higher in both Model MS and Model Hybrid (2.2% and 2.0%) versus Model 100F (0.6%). 100% of confirmed positive patients were linked to care in Model MS, while less than 60% were linked to care in the 2 other models (100F: 57.1%; Hybrid: 59.3%). Model MS had the highest cost per patient tested, followed by Model Hybrid and Model 100F (\$109, \$71, and \$39, respectively). Model 100F had the highest cost per patient linked to care, followed by Model Hybrid and Model MS (\$11,454, \$7,213, \$4,937, respectively).

CONCLUSIONS: A graded trend based on the magnitude of facilitation employed for ED-based HIV testing was observed with regard to cost per patient tested, and cost per patient linked to care. Although the more-intensive (i.e. facilitated) staffing models exhibit lower costs per patient tested, medical staff-only model was most cost-effective in identification of previously undiagnosed HIV infection and linkage of these newly-diagnosed patients into care.

ABSTRACT 309

Comparisons of HIV Testing History Among Men who Have Sex with Men (MSM) in New York City

SM Jenness, S Raj-Singh, K-L Liu, M Navejas, and C Murrill

HIV Epidemiology and Field Services, New York City
Department of Health and Mental Hygiene, New York, NY, USA

BACKGROUND: HIV testing is an important prevention strategy for populations at risk for HIV. Our objective was

to compare the HIV testing history among men who have sex with men (MSM) from behavioral surveys conducted in 2004 – 2007 in New York City.

METHODS: The data source of this analysis came from four cross-sectional anonymous surveys that used venue-based sampling [National HIV Behavioral Surveillance (NHBS) and House Ball Survey (HBS)] or web-based recruitment [two cycles of Web-based HIV Behavioral Surveillance (WHBS)]. Only sexually active MSM who self-reported negative/unknown HIV status were included.

RESULTS: The following table shows HIV testing history across surveys.

	NHBS (n=452)	HBS (n=303)	WHBS-1 (n=674)	WHBS-2 (n=1582)
Study Year	2004	2004	2006	2007
Median Age (Yr)	28	21	32	26
Race/Ethnicity (%)				
White	40	3	78	64
Black	23	51	5	12
Latino	28	44	12	18
Other	10	2	7	6
Ever HIV Tested (%)	90	86	85	83
HIV Tested in Past 12 Months (%)	63	60	57	56
Location of Last HIV Test in Past 12 Months (%)				
Medical	77	73	82	82
Community-based	10	15	11	11
Other	10	11	7	6
Type of Last HIV Test in Past 12 Months (%)				
Rapid Test (Blood)	18	10	n/a	n/a
Rapid Test (Oral)	10	17	n/a	n/a
Traditional Blood Test	70	72	n/a	n/a

Across the surveys, the most frequently reported reasons for not testing in the past 12 months were perception of not being at risk for HIV, fear of positive HIV diagnosis, and lack of time.

CONCLUSIONS: While most MSM reported having ever tested for HIV, many were not tested in the last year. The majority of MSM reported testing in medical settings. These findings underscore the importance of CDC recommendations that medical providers routinely offer HIV testing to all patients regardless of reported risk status, and offer testing to MSM at least annually.

ABSTRACT 310

HIV Testing among High-risk Heterosexuals in New York City

SM Jenness¹, CS Murrill¹, K-L Liu¹, T Wendel², E Begier¹, and H Hagan²

1 New York City Department of Health and Mental Hygiene, New York, NY, USA; 2 National Development and Research Institutes, Inc., New York, NY, USA

BACKGROUND: HIV testing is an important HIV prevention strategy, yet heterosexuals at high risk for HIV do not test as frequently as other risk groups. We examined the association of past year HIV testing and encounters with institutional settings where the CDC recommends annual testing for high-risk heterosexuals.

METHODS: We recruited high-risk heterosexuals in New York City through respondent-driven sampling in 2006-7. Respondents were asked the date of their most recent HIV test and any potential encounters with four testing settings (homeless shelters, jails/prisons, drug/alcohol treatment programs, and healthcare providers). For this analysis, we excluded respondents who self-reported as HIV-positive and stratified statistical tests by gender. In multiple logistic regression, adjusted odds ratios (AOR) were controlled by current health insurance, age, history of injection, past year male to male sex, risky heterosexual sex, and STD diagnosis.

RESULTS: Of the 846 respondents, only 31% of men (n=410) and 35% of women (n=436) had a past year HIV test, but over 90% of men and women encountered at least one potential testing setting. HIV seroprevalence was 8% (previously undiagnosed according to self-report).

Few men (23.5%) or women (18.9%) thought that, in general, HIV testing was currently a routine procedure in medical care, but most men (67.1%) and women (75.6%) thought that it should be. In multiple logistic regression, recent HIV testing was significantly associated with recent encounters with homeless shelters [AOR=2.3] and jails/prisons [AOR=2.0] for men, and with recent encounters with healthcare providers for both men [AOR=2.6] and women [AOR=4.3].

CONCLUSIONS: Self-reported HIV testing was low overall but higher for those with potential exposures to routine testing settings. Nearly all of this high risk/high prevalence group encountered at least one potential routine testing setting. Given the strong support for routine testing among participants, further expansion of testing in these settings would likely increase testing rates and may decrease new HIV infections among high-risk heterosexuals.

ABSTRACT 311

Facilitators and Barriers to Routine HIV Testing among Massachusetts Community Health Centers

CV Johnson¹, MJ Mimiaga^{1,2}, R VanDerwarker¹, and KH Mayer^{1,3}

1 The Fenway Institute, Fenway Community Health, Boston, MA, USA; 2 Harvard Medical School/Massachusetts General Hospital, Boston, MA, USA; 3 Brown Medical School/Miriam Hospital, Providence, RI, USA

OBJECTIVES: The current study evaluated HIV testing efforts in primary care settings among Massachusetts community health centers (CHCs), to determine the extent to which the CDC's 2006 revised recommendations have or will influence routine HIV testing in these care environments and to identify the barriers to routine HIV testing.

METHODS: Thirty-two CHCs were enrolled: 16 were recipients of funding from at least one part of the Ryan White Treatment Modernization Act; 16 matched centers received no Ryan White funding. An anonymous survey was administered to five personnel from each CHC,

including 1) a senior-level administrator, 2) the medical director, and 3) three medical providers (e.g. MDs, NPs, PAs), with a minimum of two medical doctors participating. Additionally, a semi-structured, qualitative interview was administered to one senior personnel from each CHC (N=32). For this study, routine HIV testing was defined as “Voluntary HIV testing performed for all patients in a setting unless the patient specifically declines HIV testing, i.e., ‘opt out’ testing.”

RESULTS: To date, 77 participants from 25 unique CHCs have completed the survey (18 senior administrators, 15 medical directors, and 44 medical providers). Eleven individuals have participated in the qualitative interview. One-hundred percent of the CHCs provide HIV testing at their centers, with an average 733 tests performed in the past 12 months. Fifty-nine percent of administrators reported having implemented routine HIV testing at their health centers; however, among medical directors/providers, only 28% reported having implemented routine testing in their practices. Fifty-six percent of senior administrators indicated that both they and their health centers are aware of the CDC’s 2006 revised recommendations. Among administrators, the five most frequently reported barriers to implementing routine HIV testing were: 1) constraints on provider’s time (88%), 2) lack of provider buy-in (75%), 3) time required to administer informed consent (62%) and 4) counseling (62%), and 5) availability of staff (44%). Among medical directors/providers, the 5 most common barriers were 1) constraints on provider’s time (74%), 2) time required to administer counseling (74%) and 3) informed consent (61%), 4) availability of staff (37%), and 5) lack of funding to support implementation (37%).

CONCLUSIONS: Routine HIV testing is not currently being implemented uniformly among Massachusetts CHCs. Future efforts to increase implementation should consider addressing concerns regarding time, by streamlining ways to facilitate obtaining informed consent and providing counseling, increasing availability of staff, and funding.

ABSTRACT 312

Twenty Years Experience with HIV Testing Among Emergency Department Patients at the Johns Hopkins Hospital

CK Kraus¹, JB Shahan¹, RE Rothman¹, Y-H Hsieh¹, O Laeyendecker^{2,3}, A Oliver², J Gamiel², TC Quinn^{2,3}, and GD Kelen¹

1 The Johns Hopkins University Department of Emergency Medicine, Baltimore, MD, USA; 2 The Johns Hopkins University Department of Medicine, Division of Infectious Diseases, Baltimore, MD, USA; 3 The National Institute of Allergy and Infectious Diseases, The National Institutes of Health, Bethesda, MD, USA

OBJECTIVES: To evaluate and describe trends in HIV infection among patients presenting to the Johns Hopkins Hospital (JHH) Emergency Department (ED) between 1987 and 2007.

METHODS: The JHH ED is an urban, academic center with an annual census of approximately 60,000 visits that is a regional tertiary referral center that also serves the local population of socio-economically disadvantaged, minority patients. Using an IRB-approved identity-unlinked methodology, we conducted an 8 week (Jun-Aug 2007) cross-sectional study of all adult ED patients (ages ≥ 18 years) with excess sera available from clinical care. Similar methodology surveys were conducted over distinct periods of 6 weeks to 8 months beginning in 1987. Research assistants ascertained HIV and other bloodborne infectious risk factors. Demographic and clinical data were collected from charts, electronic medical records, and administrative databases. Excess blood/sera were obtained from the ED satellite or central hospital lab.

RESULTS: In 2007, of 8,943 adult visits to the ED during the study period, 5,685 (64%) unique subjects were interviewed by study staff and 3,762 (66% of enrolled) had excess blood specimens available for serologic testing. Enrolled subjects were older (mean 44.5 ± 16.5 years v. 40.7 ± 15.6 years, $p < 0.05$), but no other significant demographic differences existed. Overall HIV prevalence

was 7.4% with males (60%, $p < 0.05$) and those ages 35-64 years (73%, $p < 0.05$) accounting for the majority of infections. HIV prevalence in previous years was: 5.2% (1987), 6.0% (1988), 7.8% (1989), 11.4% (1992), 9.3% (2000), 11.8% (2001), and 11.1% (2003), respectively. Unrecognized HIV prevalence in 2007 was 3.1%; 74% of unrecognized infections were among subjects ages 35-54 years. The range in previous years was 2-4%. Historically, unrecognized infections as a percentage of overall HIV prevalence have trended downward, from 77% in 1987 to 20% in 2003, but now trend upward to 42% in 2007. In 2007, self-reported injection drug users comprised 43% of HIV infections compared to 47% in 2003 and 19% in 1987, while males who have sex with males comprised 33% of HIV infections in 2007 compared to 36% in 1987. In 2007, 61% of patients who reported sex with an HIV positive partner also had positive serostatus.

CONCLUSIONS: Our data suggest that the rates of unknown HIV infection among ED patients at the JHH had decreased steadily over the first 15 years, but may be increasing again. Our data also suggest a reduction in overall HIV prevalence in our population over the past 5 years. Since most of the decrease is due to patients with diagnosed HIV, these data may represent an improved health profile related to treatment advances.

ABSTRACT 313

A Simple Method for Estimating the Epidemiology of Undiagnosed HIV Infection: Practical Guidance for Designing a New HIV Screening Program

C Lindsell¹, C Fichtenbaum², A Trott¹, and M Lyons¹

¹ Department of Emergency Medicine, University of Cincinnati College of Medicine, OH, USA; ² Infectious Disease Center, University of Cincinnati College of Medicine, OH, USA

OBJECTIVES: The effectiveness of HIV screening depends in large part on the prevalence of undiagnosed disease. While difficult to ascertain, this knowledge would help select screening strategies and venues and

could motivate screening when prevalence is erroneously assumed to be below the threshold recommended for screening. HIV case rate (incidence per 100,000) may be equated with the lower limit of undiagnosed prevalence, and we hypothesized that case rates specific to various emergency department (ED) settings can be computed. We further hypothesized that the case rate differs for diverse yet geographically proximate settings.

METHODS: Zip codes were obtained for patients seen at an urban academic ED, urban community ED, and suburban community ED during 2002. Zip codes of newly diagnosed HIV patients ($N = 291$, 1999-2003) were obtained from a clinic serving 85% of regional HIV patients that are in a care relationship. Population counts for 5-digit zip code tabulation areas (ZCTA) were obtained from census data. ZCTA case rates were calculated as the ratio of incident diagnoses to population. The ED case rate was estimated as the mean ZCTA case rate, weighted by the proportion of ED patients living in each ZCTA.

RESULTS: The academic ED had 65,606 patients (mean age 37, 58% African American, 49% male), the urban community ED had 27,620 patients (mean age 44, 48% African American, 37% male), and the suburban community ED had 25,606 patients (mean age 48, 27% African American, 39% male). The reported local Metropolitan Statistical Area (MSA) AIDS case rate for 1999-2003 ranged from 2.4-3.8, excluding 2002 for spurious data. Postal zip codes matched one of 273 5-digit ZTCAs in the MSA for 98% of cases. Our estimate of the 2002 HIV case rate was 1.7 in the metropolitan statistical area, 7.8 at the academic center ED, 6.0 at the urban community ED, and 3.5 in the suburban community ED). If time to diagnosis was 5 years (mean CD4 at diagnosis was 353 (CI_{95} 317 to 388)), the 5-year case rate would reflect the lower limit of undiagnosed ED HIV prevalence, calculated as 43.3, 37.1, and 16.8, respectively.

CONCLUSIONS: Setting-specific case rates can be readily estimated from existing data, and this method might avoid screening initiation with subsequent cessation if the positivity rate is below a stated threshold. Publicly reported regional AIDS or HIV statistics do not reflect setting-specific epidemiology and are of limited utility in motivating screening or selecting screening strategies.

ABSTRACT 314

Comparison of ED HIV Testing Data with Visit or Patient as the Unit of Analysis

MS Lyons¹, CJ Lindsell¹, DL Raab¹, AH Ruffner¹, AT Trott¹, and CJ Fichtenbaum²

1 Department of Emergency Medicine, University of Cincinnati College of Medicine, OH, USA; 2 Infectious Disease Center, University of Cincinnati College of Medicine, OH, USA

OBJECTIVES: Understanding programmatic outcome measures is necessary for operational planning and quality assurance as well as research development and surveillance of public health outcomes. We examined the differences in programmatic outcomes observed between patient-level and traditional visit-level analysis for our ED HIV testing program. We hypothesized that while the program does test some patients repeatedly, the primary programmatic outcome of percent positive is not substantially altered by the unit of analysis.

METHODS: We reviewed the clinical database of an ED HIV testing program at a large, urban, teaching hospital from 2003-2007. Data were analyzed descriptively. The main outcome measure was the rate of positive test results computed with either the visit or the patient as the unit of analysis.

RESULTS: HIV testing was provided at 9,629 visits, representing 8,450 unique patients. For patient-level analysis, the proportion of patients found to be positive was 0.91%. For visit-level analysis, the proportion of tests with positive results was 0.83%. Of the 910 patients with repeat testing, 7 (0.77%) were identified as positive at a repeat test. The median time between tests was 383 days (range 1-1742).

CONCLUSIONS: Results changed relatively little regardless of whether unique patients or unique visits were used as the unit of analysis. Potential differences in positive rates were mitigated by the contribution of repeat testing to the identification of newly infected patients. Given these findings, and the frequent difficulty of tracking repeat

testing over time, visit-level analysis may be appropriate for comparing reports of basic program methods when detailed modeling of epidemiology, cost, and/or outcomes is not required.

ABSTRACT 315

Impact of an Emergency Department HIV Testing and Screening Program on the Proportion of Patients Who Have Received Prior Testing

MS Lyons¹, CJ Lindsell¹, AH Ruffner¹, AT Trott¹, and CJ Fichtenbaum²

1 Department of Emergency Medicine, University of Cincinnati College of Medicine, OH, USA; 2 Infectious Disease Center, University of Cincinnati College of Medicine, Ohio, USA

OBJECTIVES: As the number of patients tested by ED-based HIV testing programs increases, it is hoped that eligible patient populations will become fully screened over time. We hypothesized that the proportion of patients tested by our targeted emergency department (ED) HIV testing and screening program who have had a prior HIV test increases over time.

METHODS: The ED HIV testing program offers targeted testing and screening 24 hours per day to eligible patients. Conventional HIV testing with delayed result notification is used. Testing is done by providers or by trained patient counselors. Data were extracted from electronic program records for the period January 2005 to December 2007. For each month, we ascertained the proportion of patients who self reported a prior HIV test and the proportion of tests that were for patients previously tested by our program. Linear regression was used to assess whether the proportion of tests that were for patients self reporting a prior test, or who were previously tested by our program, increased over time.

RESULTS: Over the five year period, there were 9,629 tests performed in the ED. Patient age ranged from 12 to 77, with a median of 27 years; 53% of tests were for female

patients, and 70% of tests were for black patients. Multiple sexual partners were reported by 55%, MSM behavior by 4%, IDU by 8%, and MSM with IDU by 0.5%. There were 77 positive tests (0.8%). The proportion of tests that were for patients self-reporting a prior test was relatively stable; 66% in year 1, 71% in year 2, 67% in year 3, 70% in year 4 and 71% in year 5. Linear regression suggested a small but significant increase of about 0.07% per month (95%CI 0.00 to 0.14, $p=0.044$). The proportion of tests that were for patients previously tested by the program also increased significantly over time: 3% in year 1, 11% in year 2, 8% in year 3, 13% in year 4 and 18% in year 5. Linear regression suggested an increase of 0.26% per month (95%CI 0.22 to 0.30, $p<0.001$).

CONCLUSION: The proportion of patients both self-reporting prior testing and known to be previously tested by our program increased over time. After five years, one in five tests were for an individual known to the program. This is critical to understanding the cost-effectiveness of ED HIV testing programs, and for reporting on HIV epidemiology using ED screening data.

ABSTRACT 316

Operation Sweet Tooth: Effective Use of Social Marketing Campaigns in Non-Traditional Social Settings

T McPhaul

National AIDS Education & Services for Minorities, Inc.,
Atlanta, GA, USA

OBJECTIVE: Operation “Sweet Tooth” is a social marketing campaign designed to capture the attention of African American MSMs. The campaign was designed to draw attention to some of the potential HIV/STD exposure risks associated with oral sex. The organization’s goal was to distribute 10,000 condoms during the Black Gay Pride Labor Day Weekend, and to have quality education sessions regarding oral sex risks with at least 1000 event-goers.

METHODS: The subtheme was “Team Survival” Your Mission: To Stay Safe Staff and volunteers wore T-Shirts

bearing the “Team Survival” slogan; also they wore hats, with khaki shorts, boots, a canteen and dog tags. Candy is associated with candy flavored condoms (i.e. cherry candy with cherry flavored condoms). Individuals are encouraged not to brush teeth just prior to performing oral sex use mints, gum and candy as an alternative. Safer sex kits were packaged in 2.5” X 4.5” manila envelopes. There was a label on the exterior of the package displaying “Your Mission: To Stay Safe”. Condom kits contained a condom, lubrication, and a piece of candy. Social marketing campaigns can appear less threatening while adding clarity; often they provide brevity and sometimes levity. The advertisements are catchy even to non-gay men; this can lead to a diffusion of “guilt.”

RESULTS: NAESM provided education in 1500 encounters in 2007. Even with the outreach efforts being lead by a different core group in 2008, more than 1000 education encounters was achieved. The message was visible at all of the larger and more popular gatherings from educational to merely social. Individuals were seeking out condoms and information on their own rather than being aggressively pursued; likely leading to the education being more effective.

CONCLUSIONS: A significant amount of “health education” was provided during this opportunity. It was a chance to do more than just hand out condoms, which alone would have still proven beneficial. In total NAESM distributed over 10,000 condoms in 2007 and 9,000 condoms in 2008. Moreover, We could not afford to do any more. The “Operation Sweet Tooth” images help reflect that healthier behavior is the “in” thing. This particular campaign is one whereby immediate and consistent positive feedback was provided from event-goers. A large number of those who came in direct contact with the images in “Operation Sweet Tooth” advertisements expressed that they enjoyed the images and the accompanying information which often prompted more STD/HIV related questions by our guests. The questions even extended to medical care requests and social services inquiries beyond those provided by the organization. However, the staff was knowledgeable about the full range of resources available.

ABSTRACT 317

Do Emergency Department Patients Want to be Screened for HIV?

RC Merchant¹, MA Clark¹, GR Seage III², KH Mayer¹, VG DeGruttola², and BM Becker¹

1 Brown University, Providence, RI, USA; 2 Harvard University, Boston, MA, USA

OBJECTIVES: The Centers for Disease Control and Prevention and other groups recommend that US emergency departments (EDs) conduct HIV screening programs. Patient acceptance of ED-based HIV screening methods will impact the success of these programs. We surveyed patients on their history of HIV testing, assessed their uptake of “opt-in” rapid HIV screening, and evaluated their satisfaction with being screened for HIV in the ED.

METHODS: At an academic medical center ED in New England, a random sample of 18-55-year-old patients with a sub-critical illness or injury were surveyed about their history of HIV testing and were offered non-targeted, “opt-in,” rapid HIV screening. Variations in patient history of HIV testing and uptake of screening were analyzed with multivariable logistic regression models. Odds ratios (ORs) with corresponding 95% CIs were estimated. Patients tested for HIV were surveyed about their satisfaction with the HIV testing process.

RESULTS: Of the 2,099 participants, 54.5% had previously been tested for HIV; 42.5% within the prior year. Participants who were male (OR: 1.32 [1.37-2.73]), white (OR: 1.93 [1.37-2.73]), married (OR: 1.53 [1.12-2.08]), and had private healthcare insurance (OR: 2.10 [1.69-2.61]) were less likely to have been tested for HIV previously. There was a U-shaped relationship between age and previously having been tested for HIV; younger and older patients were less likely to have been tested. History of HIV testing and years of formal education were not related. 39.3% of participants agreed to undergo HIV screening in the ED. Uptake of screening was higher among those < 40 years-old (OR 1.61 [1.32-2.00]), non-white (OR 1.28 [1.04-1.58]), not-married (OR 1.82 [1.44-2.28]), without private health care insurance (OR 1.40 [1.13-1.74]) and

≤ 12 years of education (OR 1.43 [1.16-1.75]). Of 561 tested for HIV, 92.5% believed that their medical care was “not at all” delayed because of being tested, 94.1% believed that testing did “not at all” divert attention from the reason for their ED visit, 80.9% thought that testing in the ED was “not at all” stressful, 90.7% thought that their privacy was “very much” respected while being tested, and 61.3% would be likely or very likely to undergo testing even if it prolonged their ED visit.

CONCLUSIONS: In this “opt-in,” non-targeted, ED-based HIV screening program, patient uptake of HIV screening varied by patient demography. This finding indicates that this approach will not result in universal screening. Patients appear to be highly accepting of ED-based HIV screening efforts.

ABSTRACT 318

Health Care Access and HIV Testing Frequency Among at Risk MSM in Massachusetts

MJ Mimiaga^{1,2}, CV Johnson¹, SL Reisner¹, R VanDerwarker¹, and KH Mayer^{1,3}

1 The Fenway Institute, Fenway Community Health, Boston, MA, USA; 2 Harvard Medical School/Massachusetts General Hospital, Boston, MA, USA; 3 Brown Medical School/Miriam Hospital, Providence, RI, USA

OBJECTIVES: Despite CDC recommendations that all sexually active men who have sex with men (MSM) receive routine screening for HIV, many MSM remain unaware of their HIV status. The current study assessed behavioral risk factors for HIV acquisition, health care access, and rates of screening for HIV among at risk MSM in Massachusetts.

METHODS: Using a modified respondent-driven sampling method, this study recruited a diverse sample of MSM (n=126). All participants completed a quantitative survey between March 2006 and May 2007. This abstract describes findings from the HIV-uninfected MSM in the sample (46%).

RESULTS: The men’s mean age was 42 (SD=9); 64%

were racial/ethnic minorities. In the past 12 months, they reported an average 8 male sexual partners (including an average 4 anonymous partners) and high rates of unprotected receptive (33%) and insertive (57%) anal sex, demonstrating their increased risk for HIV acquisition. Ninety-five percent had health insurance, 76% had a regular primary care provider (PCP), and 47% had visited a health care provider (HCP) in the past year. However, only 14% indicated that their HCP recommended HIV testing during their last visit, and 23% reported that their PCP ever recommended getting tested for HIV. Ninety-seven percent had been tested for HIV at least once; 81% had been tested for HIV during the 2 years prior to baseline. Thirty-eight percent reported that they were not “out” about being MSM with their HCPs. Participants who had disclosed being MSM to their HCPs were almost 6 times more likely to have been tested for HIV (OR = 5.81; $p < 0.005$) and 3 times more likely to have been tested for other sexually transmitted infections (STIs, OR = 2.79; $p < 0.02$) in the past 2 years than those who did not disclose, yet non-disclosers were more likely to engage in risky sexual behavior ($p < 0.05$). In the past 12 months, participants were tested for HIV in community clinics (68%), private physicians’ offices (42%), STI clinics (19%), emergency rooms or urgent care clinics (19%), and other settings (21%; e.g., jail, mobile testing van, shelter).

CONCLUSIONS: In light of current discussions regarding routine HIV testing, these differences illustrate the need for clinicians and other health care providers to create environments where MSM patients are comfortable disclosing their sexual orientation, regardless how men identify or present themselves.

ABSTRACT 319

MSM Access Critical to Achieving High Seropositivity in Latino-targeted Testing Programs

C Portillo, D Aguirre, R Contreras, and A Munoz

BIENESTAR, CA, USA

OBJECTIVE: Compare success in identifying HIV positive Latinos by two separate rapid testing alternative test site (ATS) efforts in Southern California, so as to identify what factors increase likelihood of identifying HIV positive individuals and better target resources.

METHODS: Analyze and compare data generated from two Southern California (ATS) efforts targeting Latinos, one focused on “National Testing Week” campaign results, the other from seven months of continuous services in one location.

RESULTS: Continuous testing availability in one location nets double positivity of one-week campaign (4.1% *versus* 1.95%). Seropositivity increases with percentage of participants who identify as MSM.

CONCLUSIONS: Community organizations that provide HIV ATS participate in health fairs and national testing week activities as a mechanism for increasing awareness and participation in the community, but higher seropositivity (4.1% *versus* 1.95%) was netted from dedicated testing in a single well-placed, MSM-friendly location available to community access over time.

BIENESTAR’s National HIV Testing Week results document 205 individuals received testing in a one-week period at eleven different venues, including fixed-location sites with regular access, a health fair, and mobile unit visits to a night club and two participating service centers not affiliated with BIENESTAR or HIV services.

BIENESTAR focuses its testing week efforts as part of national efforts on the same week, but targets its promotion in Spanish language media. While every effort is made to focus media efforts on communities at risk such as MSM,

many non-MSM participants do access HIV testing as a result of the mass-media nature of the campaign. The testing week results netted a seropositivity of 1.95% (n=4), with one positive result in each of the following risk categories: MSM; YMSM; MSMW; and WSR. During testing week, self-identified women and heterosexual participants comprised 68% of those testing.

In contrast, BIENESTAR's San Diego HIV test site is available in one location during hours convenient to walk-ins by community members. Additionally, center hours, staffing and location are designed to maximize a sense of welcoming to MSM and transgender community. Self-identified women and heterosexual men comprised only 36% of those testing. Overall seropositivity was 4.10% (n=11) at the San Diego site, over twice as high as that achieved by National Testing Week efforts. Positive results were documented as follows: MSM=7; MWMW=4; TSR=1.

As HIV continues to primarily be spread among MSM communities in Southern California, programs that increase access by MSM should yield higher seropositivity than those which do not.

ABSTRACT 320

Perceived Public Health and Clinical Impact of Emergency Department Based HIV Testing: Expert Perspectives from the 2007 Conference of the National Emergency Department HIV Testing Consortium

G Torres¹, D Holtgrave², C Lindsell³, J Brown⁴, J Heffelfinger⁵, E Couture⁶, J Jung⁷, S Connell⁷, A Kecojevic⁷, and R Rothman⁷

1 Health Education and Research Trust, AHA, Chicago, IL, USA; 2 Department of Health, Behavior, and Society, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA; 3 Department of Emergency Medicine, University of Cincinnati, Cincinnati, OH, USA; 4 Department of Emergency Medicine, The George Washington University Medical School, Washington, DC, USA; 5 Centers for Disease Control and Prevention, Atlanta, GA, USA; 6 Department of Emergency Medicine, Stroger Hospital, Rush Medical School, Chicago, IL, USA; 7 Department of Emergency Medicine, The Johns Hopkins University School of Medicine, Baltimore, MD, USA

OBJECTIVE: To assess the opinions of a broad national group of experts regarding the impact of ED based HIV testing from both the public health and clinical perspective.

METHODS: The National ED HIV Testing Consortium held its inaugural meeting in November 2007. Invitations were widely extended across the US to those with first-hand experience in ED based HIV testing. Forty academic and non-academic institutions represented; total of ninety-five participants. Public health impact assessed using SWOT (strength, weakness, opportunity, and threat) analysis; Clinical impact assessed using a structured questionnaire and a modified Delphi technique to assess perceptions from both provider and patient perspective, with regard to diagnostic testing, screening, and counseling. Scenarios considered either positive or negative HIV test results. Data was collected from participants and compiled from each focus group session by reviewing transcribed notes and video recordings.

RESULTS: Public Health Impact: Top five strengths/opportunities of ED HIV testing, hierarchically ordered were ED testing captures a population that normally has limited access to the health care system (48 votes), reduces stigma (35), leads to earlier HIV diagnosis (33), improves linkage to care (31), and reaches a high volume high prevalence population (25). Top five weaknesses/threats were that ED HIV testing increases burden on ED staff (55), is not adequately funded (40), provides inadequate linkage to care (36), does not adequately assure patient confidentiality (32), and is not fully supported by ED providers (19). Clinical Impact: Participants reported a perceived favorable impact for both diagnostic testing and screening (from both patient and provider perspective for all test scenarios), with the exception of an HIV negative screening test, which was perceived to have a negative impact from the providers perspective. HIV counseling was perceived to have a positive impact from the patient perspective, but a negative impact from the providers perspective.

CONCLUSIONS: A group of experts in ED based HIV testing recognized many of the CDC noted the public health benefits of broadened HIV testing in EDs, but identified burden on ED staff and lack of adequate funding as major areas of concern. Diagnostic testing, screening and counseling were viewed positively with regard to clinical impact from the patient perspective for all possible test outcome scenarios. However, from the ED provider perspective, HIV counseling, and identification of HIV-negative patients by means of screening was seen in a negative light. The balance between these issues demands further study, education, and policy change if the full potential of HIV testing in EDs is to be realized.

ABSTRACT 321

Outpatient HIV Point-of-care Testing at the VA Medical Center in Washington, DC (VAMC-DC)

S Mishra¹, M Siegel¹, L Kennedy¹, M Lankford², S Cummins², M Turner², D Benator², and V Kan²

1 George Washington University, Washington DC, USA; 2 DC Veterans Administration Medical Center, Washington DC, USA

OBJECTIVE: VAMC-DC is an urban facility that provides care to over 40,000 veterans in the metropolitan area of the District of Columbia (DC). From 2000 to 2006, the average rate of HIV testing targeted for risk factors was 4.2% with an HIV incidence of 3.6% among those tested. Since DC has the highest prevalence of HIV/AIDS in the US, exceeding the CDC recommended 0.1% prevalence rate for universal HIV testing, we evaluated a rapid HIV point-of-care (HIV-POC) testing program using saliva samples to assess expansion of HIV testing at the VAMC-DC.

METHODS: A program of HIV-POC testing using the OraQuick[®] Advance Rapid HIV Test was offered in several outpatient clinics including the Women's Clinic, Hepatitis C Clinic, Substance and Alcohol Rehab Program and Partial Hospitalization Program. Pre-test counseling was provided with written informed consent as required by federal law. The results of the HIV test and post-test counseling was provided within two hours of testing. Condoms were offered at the time of post-test counseling. All reactive HIV-POC results required western blot confirmation.

RESULTS: From 11/13/07-8/27/08, HIV-POC testing was offered to 1029 outpatients of whom 560 were consented and tested. There were 7 reactive screening tests of which 3 were confirmed by western blots, one had an indeterminate western blot with the subsequent viral load found to be undetectable, and two had negative western blots. One result was later found to be from a known HIV clinic patient and was not confirmed with a western blot. The CD4 range was 80 to 271 cells/mm³, and the HIV RNA range was 4,445 to 193,000 copies/mL. The overall acceptance rate of HIV-POC testing was 54.4% of those

offered testing, and the incidence of new HIV diagnosis was 0.54% among those tested. The false positive rate was also 0.54%.

CONCLUSIONS: Our program of expanded HIV-POC testing was accepted by 54.4% of patients when routinely offered to patients participating in several outpatient clinics at our institution. This program identified three new HIV patients, yielding an incidence of 0.54% among those tested. HIV-POC testing offers a cost-effective method to increase the diagnosis of HIV among veterans who are unaware of their HIV status and should be implemented as part of routine medical care in all primary care clinics at the VA.

ABSTRACT 322

A Pilot Evaluation to Assess Physicians' Adoption of Routine HIV Testing and Counseling in Primary Care

LE Sullivan¹, P Bashook², M Bass², M Edison²,
GV Berkenblit³, J Cofrancesco³, R Cook⁴, PT Korthuis⁵, and
JM Sosman⁶

1 Yale University, New Haven, CT, USA; 2 University of Illinois, Chicago, IL, USA; 3 Johns Hopkins University, Baltimore, MD, USA; 4 University of Florida, Gainesville, FL, USA; 5 Oregon Health & Science University, Portland OR, USA; 6 University of Wisconsin SMPH, Madison, WI, USA

OBJECTIVE: Many questions remain about the feasibility and optimal strategies for implementing the CDC's HIV screening guidelines in office based primary care settings where HIV prevalence is often low. We used a mixed-methods approach to describe perceived successes and failures of general internists' experiences implementing routine HIV testing in their clinic.

METHODS: The SGIM HIV Prevention Program initiated a 6-month multi-site pilot demonstration project to assess knowledge, attitudes and behaviors of a national cohort of practicing general internist *Clinician Advisors* (CA) as they attempt to implement the CDC's routine HIV

testing guidelines. Longitudinal data is collected through a baseline, 3- and 6-month surveys, weekly reports and monthly conference calls. We compared thematic analysis of conference calls with survey data to explore HIV testing barriers and facilitators.

RESULTS: Eight general physicians agreed to participate as CAs: most were women (6) and white (6), with an average age of 42 years. At baseline 6 of 8 CAs reported offering HIV testing to high-risk patients only, while 2 reported performing HIV testing on all patients. Seven of the 8 CAs indicated that injection drug users (IDUs), men having sex with men (MSM), sexually active individuals, pregnant women, and those below 65 years should be offered HIV testing. After 3 months, only 3 of 8 CAs reported offering routine HIV testing to all persons under age 65 according to CDC guidelines. The most frequent barriers identified at baseline included *competing priorities at time of visit* (8), *lack of time* (6), *patient reluctance/refusal* (6), and *cultural* (5) or *language* (4) issues. After participating in the routine testing effort for 3 months, fewer clinicians reported these barriers, but they did report *forgetting to ask* (4), and *viewing their patients as low risk* (3). The CAs identified a number of potential facilitators including risk reduction counseling training for office staff (5), test promotion literature for patients (6), and reimbursement for patient test counseling (5).

CONCLUSIONS: At baseline the majority of Clinician Advisors in a national pilot demonstration reported HIV testing only *at-risk* patients. Barriers to routine testing included time issues and patient refusal, while perceived facilitators included education for staff and patients and increased reimbursement. Subsequent data collected at 6 months will reveal actual successes and failures as experienced by these practicing physicians implementing routine HIV testing.

ABSTRACT 323

Cost of Finding One Newly Diagnosed HIV Case in New York City

B Tsoi, V Woog, C Ramaswamy, DB Hanna, E Begier, MM Sweeney, and B Cutler

New York City Department of Health and Mental Hygiene, New York, NY, USA

OBJECTIVE: In 2006, CDC recommended routine HIV screening in healthcare settings. The New York City Department of Health and Mental Hygiene (NYCDOHMH) funds hospitals, clinics, and community-based organizations (CBOs) to conduct HIV testing. The goals of these testing programs are to increase the number of persons tested for HIV and to identify previously undiagnosed HIV cases. We sought to characterize the cost associated with finding new HIV cases in our funded programs.

METHODS: NYCDOHMH reviewed 2006 testing data from its testing programs. We matched identified HIV cases against NYCDOHMH's population-based HIV/AIDS Surveillance Registry to determine whether the cases were newly diagnosed or repeat testers who were previously diagnosed. We calculated the cost to identify one newly diagnosed case, comparing cases identified through screening in healthcare settings with cases identified through targeted testing in CBOs.

RESULTS: In 2006, 30,211 HIV tests were conducted by NYCDOHMH-funded programs, yielding 443 confirmed HIV cases. Routine screening yielded 23,963 tests and identified 360 cases. Targeted testing yielded 6,258 tests and identified 83 cases. 59% cases identified through screening were newly diagnosed, compared with 64% cases identified through targeted testing. The median cost to identify one newly diagnosed HIV case through routine screening and through targeted testing was \$9,021 (range: \$4,968-\$23,283) and \$47,189 (\$5,863-\$77,184), respectively.

CONCLUSIONS: The cost to identify one newly diagnosed case is lower through routine screening in healthcare settings than through targeted testing in CBOs. However, some CBOs using targeted testing may be as effective in identifying newly diagnosed cases as some hospitals using routine screening.

ABSTRACT 324

Comparison of HIV Risk Profiles for Patients that Consent to or Decline Targeted Opt-in ED HIV Screening

ND Ubhayakar¹, CJ Lindsell¹, DL Raab¹, AH Ruffner¹, AT Trott¹, CJ Fichtenbaum², and MS Lyons¹

¹ Department of Emergency Medicine, University of Cincinnati College of Medicine, OH, USA; ² Infectious Disease Center, University of Cincinnati College of Medicine, OH, USA

OBJECTIVES: Methods to increase HIV testing consent rates are a topic of current debate, yet the HIV risk among those who decline is not well understood. We hypothesized patients who decline targeted emergency department (ED) screening offered by conventional opt-in consent have increased HIV risk compared with those who consent. We secondarily hypothesized that formal risk-assessment and prevention counseling could increase consent among those initially declining.

METHODS: Patients who declined conventional targeted, opt-in ED HIV screening offered by counselors were invited to participate in risk-reduction counseling. During counseling, 15 epidemiological risk indicators were captured using a questionnaire-driven interview. We then compared the self-reported HIV risk of those declining testing to the risk profile data for patients who had consented. Patients who initially declined but requested testing after counseling were analyzed according to their initial decision.

RESULTS: Between April and June, 2008, 199 eligible patients were approached for HIV testing during study periods. Of these, 106 consented and 93 declined. The primary reason for declining was a prior negative HIV

test (73.3%). Of those declining testing, 60/93 (64.5%) consented to the recording of risk-assessment information for study purposes. Among patients consenting to testing, 3% reported MSM behavior, 7% reported intravenous drug use, and 32% self-reported having sex with an at-risk partner. For decliners, these proportions were 2%, 5% and 30%, respectively. There were no significant differences in HIV risk profiles between patients who declined or consented to testing. After prevention counseling, 4/60 (6.7%) who initially declined asked to be tested.

CONCLUSIONS: The finding that patients declining testing report similarly high risk for HIV as those consenting generally supports the need for progressive consent methods, such as are recommended by the CDC, even when patient selection is targeted. This should be tempered by the fact that nearly three-quarters declined because of a recent negative test. Risk reduction counseling was rarely associated with reversal of the initial consent decision, and may not be an effective method to increase consent rates.

ABSTRACT 325

HIV Partner Notification: Which Interviews Yield the Most New Positive Partners in NYC?

A Bocour, C Udeagu, R Gutierrez, Y Ramos, T Renaud, and E Begier

New York City Department of Health and Mental Hygiene
(NYC DOHMH), New York, NY, USA

OBJECTIVE: NYC DOHMH HIV/AIDS Field Services Unit conducts partner notification interviews with persons diagnosed with HIV at 8 large hospitals in NYC. To improve existing partner notification protocols and focus potential expansion, we sought to identify which index case interviews lead to the identification of more newly diagnosed positives.

METHODS: We calculated the number of index cases that needed to be interviewed (NNTI, interviewed index cases/newly diagnosed partners) to identify one previously

undiagnosed HIV-infected person, overall and by case characteristics. The NYC HIV/AIDS Registry (HARS) was used to confirm that partners were not previously diagnosed. Chi-squared analysis identified significant differences in yield by case characteristics.

RESULTS: Between July 2006–November 2007, 1,435 index cases were interviewed and 34 of their partners were newly diagnosed with HIV infection (overall NNTI=43 [1435/34]). Significant variation ($p<0.05$) in NNTI was seen by sex (male 30 [805/27]; female 91 [631/7]); CDC transmission risk (heterosexual male: 18 [126/7], MSM: 24 [254/11], IDU male: 38 [112/3], no identified risk (NIR) male: 51 [302/6], heterosexual female: 60 [237/4], IDU female: undefined [41/0], and NIR female: 118 [353/3]); time from diagnosis to interview (<2 years: 32 [801/25], 2–10 years: 56 [389/7], >10 years 123 [246/2]), and age (13–29 years: 33 [327/10], 30–39 years: 25 [320/13], 40–49 years: 57 [455/8], 50+ years: 112 [334/3]).

CONCLUSIONS: Partner notification interviews with men (especially those with heterosexual and MSM risk), younger persons, and those more recently diagnosed with HIV were significantly more likely to result in the diagnosis of a new positive case. Program protocols have been modified so that cases diagnosed >2 years prior to report are not interviewed unless the provider requests assistance. Future expansion plans will focus on facilities reporting large numbers of MSM. Analysis of case yield (*i.e.*, NNTI) by index case characteristics can guide partner notification program improvement.

ABSTRACT 326

Preventive HIV Vaccine Research and Routine HIV Testing: The Challenge of Vaccine-induced Sero-positivity (VISP)

S Wakefield¹, G Broder¹, C Cooper², B Metch², and G Djomand¹

1 HIV Vaccine Trials Network, Fred Hutchinson Cancer Research Center, Seattle, WA, USA; 2 Statistical Center for HIV/AIDS Research and Prevention, Fred Hutchinson Cancer Research Center, Seattle, WA, USA

OBJECTIVE: Participants in preventive HIV vaccine clinical trials may develop antibodies to HIV because of the vaccine, rather than HIV infection. Health care providers can misinterpret HIV test results as infection if they are unaware of the individual's trial participation. This can cause problems for the participant, potential surveillance errors when reporting new HIV cases, and unanticipated trial unblinding.

METHODS: Participants are counseled to be tested only at the research site, where testing can distinguish between vaccine-induced seropositivity (VISP) and true HIV infection.

However, in light of the CDC's new HIV Testing Guidelines, people may now be tested in situations they have not previously encountered, or they may not realize the need to opt out of testing. HIV test results could be easily misinterpreted if the provider is unaware of the individual's participation in a vaccine trial. This can cause social harm for the individual, and creates a potential for errors in reporting new HIV cases to government agencies. Participants are routinely questioned about any social harms they may have experienced due to study participation, including those related to off-study HIV testing. Data regarding rates of VISP among trial participants and case studies from recent trials will be presented.

RESULTS: End of study HIV test results among 1870 participants in 25 HVTN phase I and 2 Phase II trials who received a vaccine product showed that 813 had a vaccine-

induced positive result, for a rate of 43.5% (95% CI 41.2%, 45.8%). Solutions and issues for additional follow-up are identified.

CONCLUSIONS: As HIV testing becomes more routine, trials expand globally, and more complex immunogens are used in HIV vaccine clinical trials, there is an increased potential risk of problems with participants being incorrectly identified as HIV-infected when tested off-study. The HVTN has recently begun pilot projects at two trial sites to determine the most effective ways to make health care providers aware of VISP and clinical trial HIV testing procedures, and to encourage communication between research staff and HIV testing providers in various local clinical settings. An increased awareness of VISP and the challenges it can create for trial participants is needed to prevent further social harm in the current HIV testing climate.

Access to Care and Retention in Care as a Part of Routine/Expanded Testing

ABSTRACT 401

HIV Testing and Linkage of Care Collaboration: Doctor, Insurer, Community Organization, and Pharmaceutical Company Working Together to Find, and Link to Care HIV Positive Patients

L Eisenstein

Winthrop-University Hospital, Mineola, NY, USA

OBJECTIVE: The goal of our collaborative effort is to reach out to, and provide easily accessible, free rapid HIV screening to an underserved population, and ensure follow-up linkage to care.

METHODS: This is a collaboration between an HIV health care provider, HIV insurance provider, and community service organization. The project is also funded by a grant from a pharmaceutical company to the health care provider. During set, advertised times, free rapid HIV screening takes place at the headquarters of the community service organization which is located in an area of high HIV prevalence, with an underserved medical community. The community organization provides the testing site, advertising, and patient population. The health care provider provides counseling, testing, and follow-up HIV related care (testing supplies paid for through a corporate grant.) The Medicaid insurance provider is onsite with support staff, and immediately enrolls uninsured patients who qualify so that patients are able to be linked immediately with the physician for follow-up care.

RESULTS: Project in progress.

CONCLUSION: Collaborative efforts of physician, insurer, community organization, and funding organization results in a higher level of successful HIV testing and linkage to care. By combining forces, more patients are reached, and fewer lost to follow-up care.

ABSTRACT 402

Tenderloin Health's (TLH) Linkage to Care (LTC) Program for Newly Diagnosed HIV Positives Partnership with Gilead Sciences

Z Amirkhanian and C Fann

Tenderloin Health, San Francisco, CA, USA

OBJECTIVE: Implement LTC based on the efficacy of the CDC's ARTAS. Over 12 months, TLH proposed: 50 recently diagnosed positives completing tracking documentation and approval of follow-up; enrollment in HIV care; reengagement for those 'lost-to-follow-up;' monthly HIV forums; conducting routine satisfaction surveys with 80% satisfaction; provision of 1,680 HIV tests, 1,344 of which were OraQuick; provision of resources linking recent positive into medical; linking recent positive to psychosocial services; providing routine follow-up to ensure medical appointment attendance; collection, evaluation and dissemination of data.

METHODS: Counseling and referral to onsite medical, case management, mental health and substance use counseling services for recent positives. Documentation of extensive locator information on the new positive and approval from the client of intent to follow-up and monitor connection to care. Using locator information, staff continued to follow up to encourage and support access into care. Using internal computerized records to track, follow-up, and monitor client progress, staff conducted multiple visits to ensure clients' connection to a Case Manager (CM), who was tasked with assessing and addressing any barriers to care and working collaboratively to develop a care plan with positive health outcomes. Working to marshal needed wrap-around services, CM documented interactions, barriers, services provided to overcome the barriers, linkages, and access to healthcare.

RESULTS: To date, of 28 who tested positive, 18 were linked to care; 9 were 'lost-to-follow-up;' 30 clients were re-engaged in social and medical through outreach efforts; 12 forums were held; 85% expressed that they were either

“very satisfied” or “satisfied;” 1,292 HIV tests administered, of which 1,088 were OraQuick; 100% of clients who began medical care were assessed by a CM and 100% referred to onsite mental health services; among 448 case-managed clients, 210 were followed up with through outreach for medical appointments at some point in the year; results were disseminated.

CONCLUSION: The main challenge is immediate engagement into care, with barriers: lack of education and benefits, active substance use and homelessness. The majority of our populations are homeless, compounded by mental health, substance use and other co-morbidities, making it difficult to maintain regular appointments. The majority who test positive do not want to engage in care immediately; some already thought they might be positive but are still not willing or ready to deal with HIV when aware of positive status; others cannot deal with it at all. Using the ARTAS model, we have been able to engage over 50% of people who test positive into care. However, because of the populations we serve, it requires more intensive outreach interventions of up to 15 to 20 interactions.

ABSTRACT 403

Obtaining HIV Patient Input: Accessibility and Quality of HIV Care & Treatment in Pennsylvania AIDS Drug Assistance Program

LR Frank, J Folby, and A Lochab

Graduate School of Public Health, University of Pittsburgh,
Pittsburgh, PA, USA

OBJECTIVE: The AIDS Drug Assistance Program under the Ryan White CARE Act has been pivotal in reducing the burden of HIV-care delivery and providing drugs for most vulnerable and uninsured HIV-infected populations since 1990. Studies in past, have shown challenges in access, delivery and quality of HIV health care due to lack of insurance coverage and high cost of HIV care and services. This study was conducted to determine the access, utilization and quality of care provided to HIV-

infected individuals enrolled in the Pennsylvania AIDS Drug Assistance Program (ADAP) in 2005.

METHODS: A postal questionnaire survey was designed for a cross sectional descriptive study to assess consumer satisfaction and quality of HIV health care delivery. A statewide convenience sample of 1,103 adults who received HIV-related medications through Pennsylvania AIDS Drug Assistance Program (ADAP) and had responded to study questionnaire was included in the study. Main variables and outcome measures for the study were demographic variables, self-reported HIV status, satisfaction with care provider, access to health care providers and quality of care i.e. viral load & CD4 counts testing, viral resistance and genetic testing.

RESULTS: The data shows 59% of respondents reported undetectable viral load and 71% reported their CD4 counts more than 200 cells/cu.mm. Eighty percent (80%) of respondents reported ease in access to their medical care providers. However, access to mental health and substance abuse providers was more difficult (71% and 57.7% respectively). A perceived positive relationship with treating clinicians was reported by 93% of respondents and 77% were compliant with medication and treatment plans. At least, 87% of respondents were recommended to standard of care in a timely manner. The impact of timely and current antiretroviral treatment and monitoring is further supported by low rates of hospital admissions and emergency room visits in the study population.

CONCLUSION: Persons living with HIV who have consistent access to antiretroviral treatment with the HRSA-funded Pennsylvania AIDS Drug Assistance Program report access to high quality health care independent of provider type, improved health status, and reduction in inpatient and emergency department visits.

ABSTRACT 404

Cost Effectiveness of Routine Opt-out Rapid HIV Screening in the Emergency Department: Results from an Ongoing Prospective Clinical Trial

AA Conroy¹, E Hopkins², RL Byyny^{1,2}, S Eisert^{2,3}, and JS Haukoos¹⁻³ for the Denver Emergency Department HIV Testing Study Group

1 University of Colorado Denver School of Medicine, Aurora, CO, USA; 2 Denver Health Medical Center, Denver, CO, USA; 3 Colorado School of Public Health, Aurora, CO, USA

OBJECTIVES: In 2006, the CDC published revised recommendations for performing HIV screening in healthcare settings, calling for routine opt-out rapid HIV screening in all healthcare settings. Cost effectiveness is critical when considering potential clinical venues for performing routine HIV testing. The objective of this study was to compare the cost effectiveness of performing routine opt-out rapid HIV screening with physician diagnostic testing in an urban emergency department (ED).

METHODS: *Design:* Cohort study nested in a prospective controlled clinical trial. *Setting:* The Denver Health Medical Center ED has an annual census of approximately 55,000 patients. *Interventions:* Routine opt-out rapid HIV screening (intervention) and physician diagnostic rapid HIV testing (control) alternated in four-month time periods. *Population:* During intervention periods, all ED patients (>15 years) were offered rapid HIV testing on an opt-out basis during registration. During control periods, emergency physicians used a diagnostic approach (testing on the basis of clinical findings or behavioral risks) to offer rapid HIV testing to patients. Each method was fully integrated into ED operations. *Cost Analysis:* Direct program costs were determined using the perspective of the payer. Program costs included startup, personnel, test kit, and supplies and equipment costs. Time-motion methodology was used to estimate costs related to the performance of all personnel activities related to each testing method. *Outcomes:* Number of patients newly

diagnosed with HIV infection. All data were expressed in 2008 US dollars, and average and incremental cost effectiveness ratios were calculated. Sensitivity analyses were performed where appropriate.

RESULTS: By August 15, 2008, two intervention and two control periods were completed. During the cumulative eight-month control period, 29,309 eligible patients presented to the ED and 166 (0.6%) completed testing. Of these, 2 (1.2%) were newly diagnosed with HIV infection. During the cumulative eight-month intervention period, 30,281 eligible patient presented to the ED and 5,377 (18%) completed testing. Of these, 8 (0.2%) were newly diagnosed with HIV infection. Total costs for opt-out HIV screening were \$101,102, whereas total costs for diagnostic HIV testing were \$20,279. The average annual costs per new HIV diagnosis for both testing methods were \$18,957 and \$15,210, respectively. Compared to diagnostic HIV testing, opt-out HIV screening would identify 6 more HIV infections annually at a cost of \$20,229 per new infection identified. The results were not sensitive to most input parameters.

CONCLUSIONS: Compared to diagnostic testing, routine screening was more costly but identified more HIV infections. Differences in the lifetime medical costs and transmissions averted between the two arms may have a large impact on cost-effectiveness.

ABSTRACT 405

Implementation of a Collaborative HIV Testing Model Between an Emergency Department and Infectious Disease Clinic in North Carolina

BE Hoots¹, PA Leone², and CL Gay²

1 University of North Carolina School of Public Health, Chapel Hill, NC, USA; 2 University of North Carolina School of Medicine, Chapel Hill, NC, USA

OBJECTIVES: To create an acceptable and sustainable HIV testing program in the University of North Carolina (UNC) Emergency Department (ED) with post-test counseling and linkage to care provided by the UNC Infectious Disease (ID) Clinic. To prospectively characterize the patients targeted by ED providers for HIV testing and determine the proportion testing positive and successfully linked into HIV care.

METHODS: ED providers obtain verbal consent to test for HIV from the patient and order a serum HIV antibody test. Testing is performed by the hospital's laboratory, where all HIV antibody-negative specimens are pooled for RNA testing to detect acute HIV infection. Patients are given a referral card with information on obtaining their results on a walk-in basis in the hospital-based ID clinic at least one week after their ED visit to allow for Western Blot confirmation and HIV RNA testing. All HIV test results from the ED are sent to the ID clinic twice a week and reviewed for positives. Patients with positive HIV results are contacted and encouraged to come to the ID clinic to receive counseling and immediate standard-of-care evaluation. If an HIV-positive patient does not present to the ID clinic, North Carolina Disease Intervention Specialists are notified of the need for tracing and notification. Seronegative individuals who come to the ID clinic for results receive post-test prevention counseling.

RESULTS: From May 11 to August 21, 2008, 220 patients received HIV tests in the UNC ED. Nine patients tested positive for HIV (4.1%). Of these, four were new HIV

diagnoses, and five were previously known positives not in care at the time of their ED visit. All nine patients were linked to care in the UNC ID clinic. One of the newly diagnosed patients presented to the ED with acute HIV infection and was seen in the ID clinic within 48 hours of the ED visit.

CONCLUSIONS: A collaborative HIV testing program between the UNC ED and ID clinic was developed and has been successfully implemented. The program is expected to be sustainable due to its reliance on existing hospital personnel and resources. While the use of this model has successfully identified undiagnosed HIV infection in the ED, the overall level of testing has been low in the early phases of the program. Next steps are to encourage ED personnel to expand testing to all patients meeting risk-based criteria and routine screening of all patients during particular shifts.

ABSTRACT 406

Linking Newly Diagnosed HIV Positive Individuals to Specialized Care from the Emergency Department Setting

J Leider^{1,2}, Y Calderon^{1,2}, R Chin^{1,2}, T Goring^{1,2}, W Wang^{1,2}, CM Edmundson², R Ghosh², J Fettig¹, P Gennis^{1,2}, P Bijur², and L Bauman²

1 Jacobi Medical Center, Bronx, NY, USA; 2 Albert Einstein College of Medicine, Bronx, NY, USA

OBJECTIVE: Program BRIEF combines rapid HIV testing in an emergency department setting, video-based counseling, in-person counseling, and expedited linkage to specialized care for HIV positive individuals. This model has been shown to achieve high volume HIV testing and increase knowledge regarding HIV risk-reduction. This study aims to establish whether Program BRIEF effectively links HIV positive individuals to care.

METHODS: We retrospectively reviewed the medical records of patients who tested HIV positive via Program

BRIEF. We analyzed patient records for follow-up visits, treatment, and patient response to treatment.

RESULTS: Over 27 months, 6299 patients tested for HIV using a rapid oral antibody test. 57 HIV positive individuals were identified. 47 individuals were naïve to HIV treatment and 10 were treatment experienced. 23 (49%) naïve patients and 4 (40%) experienced patients were diagnosed with AIDS within 12 months of the HIV test. For naïve patients, mean initial CD4 levels and Viral Loads (VL) were 260 (n=42) and 202,313copies/mL (n=37) respectively. For experienced patients (n=9) CD4=296 and VL=104,128c/mL. Of naïve patients, 39 (83%) were linked to care, with 35 attending our hospital HIV clinic (ACS). Median linkage time was 14 days (range 0-162days). Among patients attending ACS, 22 are on HAART and 6 do not require HAART by DHHS guidelines (CD4>350 and VL<100,000c/mL). Among patients on HAART, 12 have VL<400. Of experienced patients, 10 (100%) were linked to care, with 9 attending ACS. Median linkage time was 17 days (range 1-730). Of patients attending ACS, 5 are on HAART and 4 do not require HAART. Among patients on HAART, 3 have VL<400.

CONCLUSIONS: The Program BRIEF model successfully links a large proportion of HIV positive individuals to specialized care. This model leads to positive outcomes regarding patient health, and benefits communities by reducing the potential for further HIV transmission.

ABSTRACT 407

HIV Risk Behaviors and Seroprevalence in an Urban Population Over the Age of 50 Undergoing HIV Rapid Testing

H Kwakwa¹, C Holdsworth¹, P Doggett¹, and A Nunn²

1 Philadelphia Department of Public Health, PA, USA; 2 Brown University Medical School Division of Infectious Diseases, Providence, RI, USA

OBJECTIVE: To describe sexual and drug use HIV risk behaviors, HIV testing history, HIV risk perception and

HIV seroprevalence in the over-50 age group in an urban population undergoing routine HIV rapid testing at the Philadelphia District Health Centers.

METHODS: HIV rapid testing was offered to individuals over the age of 13 seeking care at the walk-in clinics or urgent care centers of Philadelphia's District Health Centers between July 1, 2007 and July 30, 2008. Demographic information, testing history, risk estimation and risk behavior data were collected for all individuals tested. Data for the over-50 age group were compared to data for the 13-49 age group.

RESULTS: Philadelphia District Health Centers tested 897 individuals over 50 years of age and 4,072 individuals under age 50. Of the over-50 age group, 51% were women, 83% were African American, 6% Hispanic and 8% foreign-born. This contrasts with 58% women, 70% African American, 11% Hispanic and 12% foreign-born in the under-50 group. While 71% of the under-50 group had been tested for HIV in the past, and 82% of those received results, only 51% of the over-50 group had been tested, of which 67% received results. Five percent of the over-50 group, and 7% of the under-50 group reported same-sex encounters, and 7% of each group reported ever exchanging sex for drugs or money. In the over-50 group, 20% reported cocaine use while 2% reported heroin and 12% reported alcohol use. In the under-50 group, 11% reported cocaine use, while 1% reported heroin and 11% reported alcohol use. Approximately 57% of the over-50 group estimated their own HIV risk as zero and 37% estimated low HIV risk. In the under-50 group, 40% estimated their risk as zero, and 50% estimated their HIV risks as low. HIV seroprevalence was 1.1% in both age groups.

CONCLUSIONS: When compared to the under-50 cohort, the over-50 age group seeking care at District Health Centers of the Philadelphia Department of Public Health more frequently estimated their HIV risk as zero, and were less likely to have ever been tested for HIV. This is in spite of similar HIV risk behaviors and HIV seroprevalence to the under-50 cohort. Routine HIV screening should be an important public health priority for the over-50 population in urban areas.

ABSTRACT 408

Rapid HIV Testing in Labor and Delivery Units: An Essential Part of the Safety Net for Perinatal HIV Prevention

A Statton¹, Y Olszewski², S Deardorff-Carter³, P Garcia^{1,3}, M Cohen², and L Ayala³

1 Pediatric AIDS Chicago Prevention Initiative, Chicago, IL, USA; 2 Cook County Bureau of Health Services, Chicago, IL, USA; 3 Northwestern Memorial Hospital, Chicago, IL, USA

OBJECTIVE: Although there has been great success in reducing perinatal HIV transmission in the U.S., efforts are limited by evolving treatment guidelines, inexperienced medical providers, and disenfranchised women unable to link to care. Illinois has developed a safety net for perinatal HIV prevention that targets identification and linkage to care of HIV-undocumented women who present to labor and delivery (L&D) units and known HIV-infected pregnant women unlinked to care.

METHODS: Through progressive public funding, rapid testing on L&D was established in August 2004 in 133 birthing hospitals in Illinois. Monthly reports are collected from every hospital on women presenting with undocumented HIV status, women who decline or are rapid tested, newborns without documented HIV status and mandatory rapid HIV tests on newborns. Hospitals with a preliminary positive rapid HIV test on a pregnant woman are required to call the 24/7 Perinatal HIV Hotline to report the case and link with case management.

RESULTS: By the end of the second quarter of 2008, 94.7% of women presenting to birthing hospitals had a documented prenatal HIV test as compared to 72% in 2002. Most women eligible for HIV testing accepted the voluntary test (99.2%) at L&D, and 99.98% of mother/baby pairs left the hospital with known HIV status. Data from rapid tests conducted from August 2004 - August 2008 show that 121 women/babies had a preliminary positive test of which 88 were confirmed as true positives and 32 confirmed as false positives. All of the confirmed positive women delivered of which five babies are positive,

48 are negative, 31 have negative PCR testing to date, three have unknown/lost status, one undelivered and three had perinatal losses. Data from the 359 hotline calls made from January 2004 through June 2008, shows the reasons for calls were social work consults/linkage to case management (42.6%), linkage to medical care (37.6%), and medical consultation (36.5%). Pregnant HIV-infected women unlinked to care were linked to medical care 124/159 (78%) and to case management 123/159 (77.42%). One hundred nineteen women were diagnosed with a rapid test. The Hotline provided medical consultation for 50/119 (42.0%), linkage to medical care for 70/119 (58.8%) and case management for 73/119 (61.3%). The demographics of the case managed women shows the average age is 26, predominately non-Hispanic Black (75%) or Hispanic (15%). Over half (52%) were diagnosed with HIV during the current pregnancy and 58% had not engaged prenatal care at referral.

CONCLUSIONS: Rapid HIV testing of delivering women with an undocumented HIV status on L&D combined with mandatory calls to the Illinois 24/7 Perinatal HIV Hotline and linkage to case management of the women identified are keys to the safety net for perinatal HIV prevention in Illinois. This system enables the identification of women previously not known to be positive so that treatment can be initiated to help prevent transmission of HIV to their infants. Real-time reporting of rapidly tested women to the Perinatal HIV Hotline allows for immediate medical consultation and linkage to enhanced case management for follow-up care. Of these case managed high-risk women, only five delivered an HIV-infected baby. However, during the same time period, 28 other HIV-infected babies were born in Chicago to women who were not in the Perinatal Enhanced Case Management program.

Author Index

<i>Author</i>	<i>Abstract</i>	<i>Page</i>	<i>Author</i>	<i>Abstract</i>	<i>Page</i>
Aaron, E	101, 102, 103	22, 23	Lyons, MS	314, 315	84
Aberg, J	104	24	Martin, M	128	42
Auerbach, JD	105	24	Maxwell, CJ	129	42
Baker, J	201	63	McMahon, C	130	43
Beckwith, CG	108, 202	27, 63	McPhaul, T	209, 316	68, 85
Bendle, T	109	27	Merchant, RC	131, 210, 317	44, 69, 86
Bermudez, C	110	28	Mills, P	132	44
Bersoff-Matcha, SJ	111	29	Mimiaga, MJ	318	86
Brown, J	301, 302	75	Modica, CA	133	45
Burrage, Jr., J	112	30	Mulhern-Pearson, C	107	26
Calderon, Y	203	64	Nunn, A	134, 135, 407	46, 99
Chen, J	113, 114	30, 31	Pizarro, I	136	47
Czarnogorski, M	303	76	Portillo, C	319	87
Dauids, J	204	64	Rakhmanina, N	137	48
Dilley, JW	115	32	Randall, L	138	48
Duran, D	304	77	Redmann, J	139	49
Edwards, GW	205	65	Rothman, R	320	88
Eisenstein, L	401	95	Saha, SR	140	50
Fann, C	402	95	Schneider, JA	141	50
Feld, JE	117, 305	33, 77	Shanley, KMK	211	69
Foust, E	206	66	Siegel, M	321	89
Frank, LR	403	96	Silva, CL	212, 213	70, 71
Futterman, D	118	34	Simmons, R	142	51
Gamache, P	207	66	Singer, M	143	52
Gaydos, CA	119	35	Sosman, JM	144, 322	53, 90
Gibson, S	106	25	Spaulding, AC	145	54
Gillen, S	120	36	Spielberg, F	214	72
Golden, JF	121	37	Statton, A	408	100
Goldschmidt, RH	122	37	Totten, VY	146, 147	54, 55
Haukoos, JS	306, 404	78, 97	Tsoi, B	148, 323	56, 91
Hawks, D	123	38	Ubhayakar, ND	324	91
Hoots, BE	405	98	Udeagu, C	325	92
Hsieh, Y-H	124, 307, 308	39, 79	Vertovec, A	149	57
Jain, CL	125, 208	40, 67	Wakefield, S	326	93
Jenness, SM	309, 310	80, 81	Watkins, H	150	57
Johnson, CV	311	81	Waxman, MJ	151, 152	58, 59
Jones, J	126	40	Wegman, L	153	59
Kraus, CK	312	82	Youmans, E	154	60
Leider, J	406	98	Yuan, J	155	61
Lindsell, C	313	83	Zorrilla, CD	215	72
Lubelchek, R	127	41			