



MUNICIPAL SCALE-UP OF HIV TESTING IN THE UNITED STATES: CURRENT STATUS, CHALLENGES AND OPPORTUNITIES FROM A MULTI-STAKEHOLDER PERSPECTIVE

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ABSTRACT: The recommendation to perform HIV screening as part of routine medical care was made by the Centers for Disease Control and Prevention in 2006 in order to increase detection of HIV infection. As a result, local and state health departments, clinics, advocacy groups and federal agencies have changed their policies and/or procedures to support new programs to improve HIV diagnosis and linkage to care. A number of municipalities in the U.S. have launched municipal “scale-up programs” to increase testing and to encourage providers to perform -- and clients to request -- HIV testing. A meeting was convened to share lessons learned among cities that have initiated scale-up programs. The information can be used by other cities that are poised to expand testing. Three key lessons emerged from the Roundtable on “Municipal Scale-up of HIV Testing in the United States”:

- Building partnerships at the municipal level is critical to the success of scale-up programs. At the very beginning, programs should engage all the relevant stakeholders, including local and state health departments and clinical and community providers, to create a network of services.
- Obtaining buy-in from clinical providers is essential. Efforts to promote routine testing among primary care providers and networks of providers (such as hospitals, emergency departments, and community health centers) can be achieved with provider education campaigns.
- Social marketing to both providers and consumers promotes uptake of HIV testing. Campaigns designed for specific populations can be very effective in increasing testing rates, particularly among vulnerable populations.

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BACKGROUND

In 2006, the Centers for Disease Control and Prevention (CDC) recommended HIV screening for patients in all health care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening), unless the prevalence of undiagnosed HIV infection among patients in the setting has been documented to be <0.1%. [1]. The CDC further recommended that “separate written informed consent for HIV testing should not be required” and that “prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in health-care settings.” While the epidemic in the U.S. is widespread, surveillance data show that the burden of cases is clustered in a limited number of cities. At the end of 2007 more than 60% of AIDS cases in the U.S. were concentrated in fewer than 20 metropolitan statistical areas (MSAs)[2].

Improved control of the HIV epidemic in the U.S. could be facilitated by HIV screening scale-up in these MSAs. Several municipal areas across the United States have begun comprehensive HIV screening scale-up programs. These programs are designed to increase the numbers of persons who are tested, who are aware of their HIV status, and to link HIV infected persons to care. Initial efforts were undertaken in Washington, DC and Oakland, CA, followed by scale-up in the Bronx, NY, Miami, FL, and Houston, TX. Representatives from these five municipal areas and from Louisiana, Georgia and Massachusetts were invited to the roundtable to discuss scale-up efforts.

Scale-up efforts in municipal areas face challenges if state law is interpreted to require separate written consent for HIV testing. New York State revised its law in 2011 (after the Forum Roundtable) to permit verbal consent for rapid HIV testing when conducted in a hospital or medical clinic, but the requirement for separate written consent remains for conventional confirmatory testing or for rapid testing in a community setting [3]. Current laws in California, Texas, Florida and Washington, DC allow HIV testing to be conducted on an opt-out basis in accord with the CDC recommendations [4].

The Forum Municipal Roundtable provided an opportunity to gather public health officials from these municipal areas to discuss their scale-up programs in order to facilitate further progress and potential collaboration. On May 18th, 2010, the Forum convened the roundtable with these officials and representatives from federal agencies, academic researchers, and leaders from municipal areas that are poised to begin scale-up. The goals of the roundtable were to discuss lessons learned from ongoing scale-up efforts, to discuss different models for scale-up under varying state and local regulations, and to discuss models for sustaining municipal-wide testing programs with limited resources and competing program needs.

MODELS OF MUNICIPAL SCALE-UP OF HIV TESTING

Come Together DC, Get Screened for HIV

At the end of 2008, the prevalence of HIV-infected persons among Washington DC’s eight wards ranged from 0.4-3.4% [5]. At that time, the District counted 15,120 persons infected with HIV, translating into an overall prevalence of 3.2% of adults. Estimates from the National HIV Behavioral Surveillance Study indicate that in DC as many as one third to one half of infected persons are unaware of their infection [6].

Washington began promoting routine opt-out testing in 2006 for persons ages 14-84 through the city’s hospitals, hospital emergency departments, community health centers, and the DC jail as part of the campaign “Come Together DC, Get Screened for HIV.” The District health department provides rapid testing kits to clinics, as well as toolkits with supportive materials that can aid providers with messages and information for delivering an HIV test result.

As a result of these endeavors, HIV testing has increased substantially since 2006. In Fiscal Year 2008, the district conducted 72,864 tests, a 68.4% increase from the previous period. An additional 27% increase (to 92,748 tests annually) took place in Fiscal Year 2009. Washington’s efforts to expand testing resulted in improved linkage to care and improvements in median CD4 count at diagnosis. From 2004 to 2008, the median CD4 count of persons newly diagnosed with HIV steadily increased from 216 to 343 cells/mm³. During that time period, the proportion of HIV-diagnosed individuals linked to care within three months increased from approximately 50% to 77%, while the proportion of individuals linked to care more than one year after HIV diagnosis dropped from over 40% to approximately 20%. By comparison, the recently released National HIV/AIDS Strategy has set a goal of increasing the proportion of persons who are linked to care within 3 months of diagnosis from 65% to 85% by 2015 [7].

Get Screened Oakland

Oakland and Alameda county, with a population of approximately one half million persons, reported more than 7,000 cumulative AIDS cases diagnosed between 1980 and 2006, yielding an AIDS prevalence 25% higher than the overall rate in the state of California (10.9 per 100,000 persons in Alameda County vs. 7.5 per 100,000 in California) [8][9]. Of these cases, 44% were African American, 86% were male, 61% were men who have sex with men (MSM). Thirty nine percent received an AIDS diagnosis within 12 months of their initial HIV diagnosis. Twenty-two percent received a concurrent AIDS diagnosis with their first HIV test, indicating the high proportion of persons testing very late.



“Get Screened Oakland” - the city’s testing and social marketing campaign - was the second city-wide scale-up in the U.S and was officially launched in June 2007. The program, initiated by Mayor Ron V. Dellums’ office, emphasized that all residents should know their HIV status. The program works with community-based organizations (CBOs), hospitals, clinics, physician groups, and managed care organizations to develop strategies for implementing routine HIV screening in their respective settings [9]. The effort to improve HIV testing is a public-private partnership between the city and industry supporters, and local agencies are invited to partner with the campaign. Since the initiation of the *Get Screened Oakland* campaign, testing rates have increased 20%.

The Bronx Knows

The Bronx, a borough of New York City with a population of 1.3 million people, has a rate of HIV associated death that is higher than the overall New York City rate (24.8 vs. 13.0 per 100,000 persons in 2007)[11]. The Bronx has an estimated HIV prevalence of 1.3%, with 21% of those-or 0.3% of the total population-being undiagnosed. Many newly diagnosed persons with HIV are diagnosed late. Thus local leaders decided that the Bronx was an excellent site to scale-up HIV screening [12].

The New York City health department, together with the community of Bronx clinical providers and advocates, spent a year developing an HIV screening scale-up and awareness campaign called “The Bronx Knows.” The campaign involved building local capacity, developing action plans tailored for specific site scale-up, provider training, and data collection. To monitor the progress of *the Bronx Knows* campaign, the health department initiated a web-based reporting system to collect information on the number of tests conducted, numbers of persons linked to care, and provider feedback on program implementation [13]. While the key to success of the program was interest and investment from the local health department, collaboration between the city and community providers (known as the Bronx HIV Testing Network) was essential to the initiation of the program.

The scale-up program, initiated in June 2008, included providers in the network of hospitals, health centers and community-based organizations. The program was based on the ACTS model (Advise, Consent, Test, Support) developed by the Adolescent AIDS Program at Montefiore Hospital [14]. In the first year, 159,934 individuals were tested, representing an overall 28% increase in tests conducted. Increases were comparable in community health centers and in hospitals. Increases in testing were also observed in CBOs that provide HIV prevention and care services (12,884 tests, 15% increase). The observed increase in CBOs is noteworthy, as these settings are not traditionally sites for primary medical care, but sites that provide HIV testing targeted to

vulnerable populations. As such, CBOs should be operating at maximal capacity already.

Of the 159,934 individuals tested in the first year of the program, 1,506 persons were confirmed to be HIV-infected (a 0.9% positivity rate). Forty-five percent of persons testing positive were newly diagnosed, and 63% of confirmed HIV-infected persons were linked to care. The rate of positive tests is lower than the overall estimated HIV prevalence of 1.3% for the Bronx. This may suggest that a significant proportion of HIV-infected individuals are either opting-out of testing or not accessing (or do not have access to) health care settings or CBOs.

The preparation by local public health and community health leaders and a well-planned communication/education plan were key to the successful increase in testing and consequent identification of 1,506 new cases. On World AIDS Day 2010, the health department announced the launch of a new program, “Brooklyn Knows,” a scale-up program in another New York borough.

Test Miami

Miami began the process of scaling up HIV testing in 2009 [9]. As of 2009, the city, with a population of approximately 2.5 million, had an estimated 47,288 persons living with a diagnosis of HIV infection including 25,819 living with a diagnosis of AIDS. The state of Florida has the third largest number of persons living with an HIV diagnosis in the United States: 92,149 persons at the end of 2008 [10]. Among residents of Miami-Dade, 1 in 108 persons is living with HIV/AIDS and that number increases to 1 in 44 for the black population. The city performs 60,000 publicly funded HIV tests annually in jails, community health centers, STD clinics, CBO’s and other clinical settings at over 100 registered test sites. The substantial number of publicly funded tests is only a fraction of the overall tests performed since the majority of testing takes place in private doctor’s offices.

In developing the “Test Miami” scale-up program and testing strategies for the Miami-Dade area, the health department created a three-step approach: 1) mobilize the health sector, 2) work with the community, and 3) enhance HIV prevention. The Miami health department invited providers to a meeting in 2009 to explore scaling up testing in the city and to develop a plan for the *Test Miami* campaign [15]. With the assistance of the Flowers Heritage Foundation and the *Get Screened Oakland* program, the Miami health department brought together leaders from clinics including hospital CEOs, medical directors, and clinic network partners to talk about expanding routine HIV testing in clinical settings. To assist providers with expanding testing, the city developed pocket cards outlining CDC recommendations and Florida legal codes and regulations. The health department identified six prominent physicians to serve as physician ambassadors within the



community. Physician ambassador videos were developed to be shown in clinical waiting rooms. Additional components of the city's scale-up efforts include bus campaigns aimed at reducing homophobia and stigma around HIV [16].

Houston

Houston is in Harris County, the largest county in Texas and the third most populous in the United States. The city is home to approximately four million residents. As of March 2009, 18,404 residents of Houston were living with HIV and 36% of persons with newly diagnosed HIV infections received an AIDS diagnosis within one year, indicating the extent of late diagnosis [17].

Houston's HIV testing efforts have focused on four primary means of counseling, referral and testing: 1) protocol-based counseling, 2) mass HIV screening programs, 3) targeted HIV testing and 4) routine HIV screening. Protocol based counseling and targeted testing have long been the standard approaches to HIV testing conducted in community-based settings. Mass screening for HIV, like Houston's "Hip Hop for HIV" (see textbox) is a newer approach to expand testing in focused areas and within specific populations. Efforts to make testing routine in Houston are taking place in the city's hospitals, community health centers and STD clinics.

Houston's programs for routine testing in hospitals have

focused on the rapid delivery of results rather than the use of rapid HIV test technologies. In the city's large public hospitals, HIV testing is conducted using one of two testing platforms (the Siemens ADVIA Centaur or the Ortho VITROS) capable of conducting multiple kinds of tests, including HIV, and delivering results within an hour. In the Harris County Hospital District emergency departments and other clinics, any patient having blood drawn is informed that they will be tested for HIV unless they decline. The test order can be placed by a nurse with a simple check on the patient's chart; test results are delivered electronically to the patient's record. At Memorial-Hermann Hospital, HIV testing is offered to all patients. Through testing scale-up in hospitals and clinics, Houston has more than quadrupled the number of tests that they are able to support (approaching 90,000 tests in 2009 from an average of approximately 20,000 tests per year in 2003.)

The Houston health department reports that the percent of patients who decline an HIV test is low (only 3.92%) in the context of this streamlined approach to offering and conducting the test. Furthermore, the cost per test decreases substantially with the increase in tests conducted (approximately \$80 per test in June 2008 for less than 1,000 tests to \$11 per test in September 2009 for greater than 6,000 tests). One of the largest challenges that Houston faces in implementing routine HIV screening is reimbursement, particularly for private institutions. A reduction in test cost

HOUSTON'S HIP HOP FOR HIV

"Hip Hop for HIV" was begun at the recommendation of a Texas State representative in 2007 to create a mass screening program tailored to African Americans aged 15-40 [27]. In the first year, AIDS Foundation Houston partnered with the local health department to conduct 6,200 HIV tests in exchange for free concert tickets for a one of a kind Hip Hop concert. What was unique about the concert was that tickets were only available in exchange for HIV testing. In 2008, the program focused additional efforts on educational components and program evaluation. Additionally, a decision was made to lower the numbers of persons tested to 2,500 to focus on the educational component of the program.

In the summer of 2009, the organizers began their plans to increase "Hip Hop for HIV" to 15,000 tests. In 19 days, the program tested 14,472 people. The testing program allowed for blood to be drawn and provided syphilis testing and treatment with 3,446 syphilis tests conducted. Through the event, 86 individuals with HIV infection (0.6%) and 45 individuals with syphilis infection were identified.

The testing campaign, which was a collaboration between Houston community-based organizations, the health department, event sponsors and local radio, emphasized letting each of the stakeholders focus on their expertise and relied on others to do the same. As experts in HIV testing and education, the health department and community based organizations took responsibility for those areas. Over the three years of the program, at the request of the CBOs and health department, the artists shifted from performing with little or no mention of HIV to providing messages about HIV from the stage.

To measure the impact of the program, the organizers conducted pre- and post-test surveys and program evaluation and have shown that the program is reaching the intended audience. Additionally, while the post-educational activity surveys show an increase in knowledge on questions about HIV infection and transmission, what is most remarkable is that the program is reaching high numbers of participants that have never had an HIV test (36% in 2009) or had been tested more than 12 months ago (19%). Ten percent of participants indicated that their last HIV test was at the previous year's Hip Hop for HIV event.



would be a significant factor to facilitate sustainability.

TYPES OF SOCIAL MARKETING CAMPAIGNS

Roundtable participants emphasized the importance of tailoring messages to different communities and applauded the implementation and success of social marketing campaigns like Hip Hop for HIV in Houston. An example of tailoring messages includes addressing the increasing epidemic among young gay men. Social marketing campaigns focusing on young gay men will require very specific messages about testing and re-testing strategies which need to be targeted to both consumers and providers.

As part of Washington DC's efforts to increase HIV testing, the city implemented a major social marketing campaign to encourage testing. The District's *Come Together DC, Get Screened for HIV* campaign encourages increasing HIV testing uptake by providers. Additional campaign materials include messages directed at consumers urging them to "ask for the test."

CHALLENGES AND OPPORTUNITIES

Challenges

The challenges faced by HIV testing scale-up programs include provider engagement/resistance, availability of public health resources, reimbursement, identifying appropriate testing methodology, and inconsistent policies on obtaining informed consent. In DC, the health department has recognized that resistance from both primary care providers and HIV care specialists exists. Primary care providers may lack time or believe that testing should be limited to patients that they perceive to be at high risk for HIV. Further, scaling up programs challenges the limited resources of providers working in HIV care and community based organizations. Emergency Departments (EDs), one of the key areas of testing expansion, must not only test but be able to provide appropriate linkage to care which will take place outside of the ED. This concern led the DC Department of Health HIV/AIDS to create a "red carpet entry" program which links individuals to providers who have committed to caring for clients within 48 hours of diagnosis.

A significant challenge identified by all programs is the issue of reimbursement. Reimbursement for HIV testing is mandated by regulation in California, but in other places it is dependent on policies of the insurer, managed care organization, or state Medicaid program [18]. Some state Medicaid programs provide for reimbursement or even incentivize testing. New York Medicaid's reimbursement for rapid HIV testing performed in the ED is approximately \$100 per test – more than the cost. However, few in New York are covered through fee-for-service Medicaid. The majority are covered by managed care Medicaid programs for which there is no financial incentive.

Common Procedural Terminology (CPT) codes developed and maintained by the American Medical Association and used to code services for payment or reimbursement purposes are available for preventative services and HIV testing, providing an opportunity for billing specifically for testing. Early challenges in seeking reimbursement for conventional versus rapid tests were addressed by The American Academy of HIV Medicine, which compiled a list of CPT codes specifically for HIV testing, including rapid tests. In December 2009, the Centers for Medicare & Medicaid Services (CMS) announced a national coverage determination that authorizes Medicare coverage for HIV screening of those at increased risk for infection or those who request testing. Moreover, AETNA released a clinical policy bulletin on HIV testing that provided the appropriate codes for reimbursement.

Insurers' reimbursement policies are only part of the challenge. Another issue is the amount of reimbursement as compared to the cost of HIV testing. The charge to the patient or insurer for a test may be significantly higher than the cost of the test itself. In cases where hospital emergency departments have negotiated bundled services with insurance companies, the only mechanism to include HIV test reimbursement is through inclusion of these charges in future negotiations. In cases where the hospital or ED charges for services are not covered, the charge would be passed on to the individual. Provider concern about such pass-through charges may cause providers to hesitate before ordering costly tests.

Choosing the appropriate technology for HIV testing is another critical issue many clinics face. As many roundtable participants noted, most HIV testing is ordered by providers in private offices, in the form of traditional blood enzyme immunoassays (EIA). Public health departments and clinics have adopted the blood or oral rapid point-of-care testing technology because the advantage of obtaining results in

TEST MIAMI

The Test Miami campaign began in 2009: 60 buses, selected based on bus ridership and routes that covered high risk communities, were covered in messages about the city's "Test Miami" campaign. The messages also addressed social drivers of the epidemic such as homophobia. The bus campaign reaches approximately 200,000 persons per month with information about Test Miami.

In addition, the Test Miami campaign hosts a website and links consumers to the Florida State HIV Hotline. A series of public service announcement videos directed at consumers to get tested feature physicians urging other physicians to offer HIV testing. Copies of the videos were distributed to hospitals, community health centers, and other clinics to be played in clinic waiting rooms.



under 20 minutes means a higher percentage of individuals tested receive their test results. However, for facilities capable of supporting platforms that provide rapid results, such as the Centaur or Vitros, results from testing performed in the lab can be provided to patients during the same visit without the additional personnel, training, and time need to perform individual rapid tests.

Rapid tests require subsequent confirmatory tests that usually consist of a Western blot. Questions have been raised about whether or not it would be possible to confirm a positive rapid test result with a second, different rapid test. With the development of 4th generation antigen/antibody tests, CDC is developing a new algorithm. Clients would receive the combination antigen/antibody test. Positive test results would be followed by an antibody test capable of differentiating HIV-1 and HIV-2. The currently available differentiation test, Bio-Rad's Multispot, requires serum or plasma but takes approximately 15 minutes to perform. For those with a positive antigen/antibody test and negative HIV-1/2 differentiation test, RNA testing would be performed to test for acute HIV infection [19].

The last remaining challenge is the persistence of provider belief in the need for a separate, written consent, notwithstanding revision of prior regulatory or legal mandates. During the initial scale-up of HIV testing in the Bronx, New York State required separate written consent for testing, a policy that has since been changed for rapid tests conducted in clinical settings [2]. In DC, there are no regulations that require pre-test counseling or separate, written consent for HIV testing. However, hospital risk managers may determine that hospital policy requires such consent and counseling [20]. The goal of risk managers is to protect patients from harm and to protect the clinic from possible liability. Providers and health departments may be able to meet the concerns of risk managers with education on the importance of HIV testing and the changes in laws that permit opt-out HIV testing. Other states retain requirements for separate written consent and, in those states, education about the most effective means to provide such consent and also provide testing is needed.

Opportunities

The Texas state health department has formed the Test Texas Coalition to bring together stakeholders, to identify leaders in routine testing, and to encourage expansion of testing through diffusion of innovation. The Test Texas exercise has yielded important lessons for expanding testing. Through this process, the state is identifying venues where routine screening should be scaled-up, but also identifying sites where, due to low HIV prevalence (less than 0.1%), CDC's recommendations would not support the need to conduct routine, opt-out screening instead of risk-based testing.

In Louisiana, the state health department was able to double the number of publicly funded tests provided by expanding testing programs in the state's public hospital system and expanding testing to the department of corrections.

In Georgia, the state has begun the process of expanding testing in hospital emergency departments, community health centers and the student health services in historically black colleges and universities (HBCUs). The state is uniquely positioned for expansion in HBCUs because of the number of HBCUs in the state.

WHAT RESOURCES ARE NEEDED TO IMPLEMENT AND SUSTAIN PROGRAMS?

Resources availability

State health departments' responsibilities include developing and enforcing policies regarding testing, providing services directly or through funded and contracted organizations, and partnering with organizations that are not directly funded by the health department. Health departments may provide support for test kit procurement, laboratory costs, workforce, and assistance with capacity and infrastructure building. In Fiscal Year 2007, the total of HIV prevention budgets for health departments in the U.S was \$581 million, \$337 million (65%) from CDC and \$205 million (35%) directly from the states [21]. Health departments spent about 26% of their total prevention budgets on HIV testing programs for screening and risk-based HIV testing. Since that time, the percentage of state funds available for HIV prevention has decreased as a result of state budget cuts. While the need to provide increased HIV testing grows, budget cuts threaten the prioritization of funds for testing and other necessary HIV prevention activities.

In 2007, CDC released PS 07-768 to provide \$150.5 million over three years to 25 jurisdictions for the *Expanded Integrated Human Immunodeficiency Virus (HIV) Testing for Populations Disproportionately Affected Primarily African Americans*, referred to as the Expanded Testing Initiative (ETI). Subsequently in 2010, *PS10-10138 Expanded Integrated Human Immunodeficiency Virus (HIV) Testing for Disproportionately Affected Populations* expanded the ETI to provide an additional \$168.9 million over three years to 30 eligible jurisdictions for scaling up HIV testing among African American and Hispanic men and women, MSM, and IDU. Beginning in 2012, these programs will become part of the core health department HIV prevention cooperative agreement under Category B of *PS12-1201 Comprehensive HIV Prevention Programs for Health Departments*. Thirty six health departments will be eligible for approximately \$54.8 million annually for a five year funding period. The funds allocated by CDC, particularly through program announcements supporting testing, are critical to the work that health departments do. However, it is not the only



federal investment in testing. Opportunities for testing through funding from SAMHSA, HRSA, testing conducted by the VA, paid for by CMS, or supported by other federal initiatives create a complex patchwork of systems that state and local health departments must learn to navigate. Responding to multiple systems within the federal government, multiple funding applications and reporting requirements can lead to duplication of activities as well as onerous monitoring and evaluation requirements. Efforts to coordinate the HIV/AIDS activities of the federal agencies are being addressed by the National HIV/AIDS strategy and may help to streamline reporting requirements in the future and preserve resources.

In 2010, as part of the implementation of the U.S. National HIV/AIDS Strategy, the U.S. Department of Health and Human Services initiated the 12 Cities Project, a project focusing on the 12 cities with highest AIDS burden in the country [22]. Efforts like these to address the epidemic in the hardest hit areas should include efforts to scale-up testing and link newly diagnosed individuals to care.

Impact of Scale-up on Treatment and Services

Concerns remain about the demand of increased testing on already over-burdened care systems.

Shortages in resources for care are evident through AIDS Drug Assistance Programs (ADAP) waiting lists that are fueled by increasing enrollment in state ADAP programs. Clinics, however, do not keep or report waiting lists, so the true unmet need in communities may be difficult to assess. Funding for Ryan White Part C increased by 2.4% overall from 2002 to 2008; in contrast, the number of patients that Part C served during that period increased by approximately 39% [23-25]. A survey on workforce capacity issues and workforce challenges for Ryan White Part C providers (conducted jointly by the HIVMA and the HIV Forum) revealed serious challenges with recruiting and retaining clinical providers. Issues facing providers included reimbursement, availability of resources, and a lack of qualified clinicians [26]. Efforts to improve health care reimbursement as part of the recent health care reform legislation may mitigate some of the issues faced by providers by lowering eligibility requirements for Medicaid and increasing the proportion of persons with health insurance, by making coverage more affordable, and by addressing medical workforce shortages.

SUMMARY

The importance and benefit of expanding HIV testing and improving early diagnosis of HIV infection is clear. Scaling up testing in cities in the U.S. will help to accomplish these goals. Initiating scale-up programs requires the formation of partnerships at the city level between local health departments, community based organizations and providers. An essential component of the scale-up partnerships involves

leadership. Buy-in from local government is critical, but does not mean that program leadership is the responsibility of only the health department. Successful scale-up programs in the Bronx, NY and Oakland, CA have been initiated by community and clinic programs. A key responsibility of a successful scale-up program is training of local providers, and that can be coordinated by either government or non-governmental organizations

Barriers such as legal requirements for provision of separate, written consent for HIV testing and pre-test HIV counseling have been addressed by many states. While the legal barriers to obtaining consent and providing counseling may have been removed at the state level, support from clinic administrators and risk managers should be obtained to allow for streamlined provision of opt-out HIV testing. Other considerations that should be made at the clinical level involve choosing the appropriate testing technology for the setting. While rapid testing has led to quicker provision of test results, the work and cost of rapid testing may mean that it is not the appropriate technology in settings where platform-based laboratory testing can be done more efficiently.

At the city level, one of the most important aspects of a successful scale-up program is social marketing. Testing campaigns that encourage providers to offer HIV testing and encourage consumers to request HIV testing are critical to improvement of HIV diagnosis. Direct-to-consumer HIV testing campaigns in places like DC, Houston and Miami can increase the number of tests conducted and can also increase testing among populations at higher risk for HIV infection.

Developing metrics to evaluate the increases in testing and success of testing programs in identifying HIV infection earlier is important, but can be challenging. The National HIV/AIDS Strategy includes several proposals to address the most pressing issues including efforts to identify municipal areas most in need of scale-up and ways to maximize federal investments in HIV diagnosis, prevention and access to care.



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