The Changing Landscape of State Legislation and Expanded HIV Testing

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The Centers for Disease Control and Prevention (CDC) recommendations for routine human immunodeficiency virus (HIV) screening in clinical settings were released in September 2006.[1] Although they were the end of one lengthy process of review and development for physicians in practice, they represented the beginning of another, perhaps even more challenging process: implementation. It was clear to me that our emergency department (ED) needed to build an HIV screening program, for we serve Washington, D.C., which has the highest rate of HIV in the nation. As we prepared to implement our program consistent with the new CDC recommendations, I searched for any legislation that could affect the program. I came up empty-handed. There seemed to be no statutes in the District of Columbia (DC) that would affect the way that routine opt-out HIV screening could be conducted. I remained troubled that there were indeed legal requirements, but that I was simply unable to find them.

I need not have been concerned, however, for it turned out that apart from some old legislation affecting those getting an HIV test for insurance purposes, DC had nothing in its statutes that addressed informed consent, counseling, notification, or any of the other issues that can impact HIV screening. In DC, you just needed to ask a patient if he or she wanted an HIV test, and if they agreed, the test could be done. It was that simple.

Two years later, I met with some colleagues from Maryland who were keen to start their own ED testing program based on the successful program we had been running. The first issue we needed to address was the legislation in our neighboring state that might affect the way the program could be structured, and things could not have been more different from DC. Maryland state law at that time required the health-care provider to discuss no fewer than 35 separate issues.[2] This contrast between the historical legislation in two neighboring areas—both with frighteningly high rates of HIV—exemplifies the very disparate ways in which states have addressed HIV testing. For many years, these differences could be viewed as reflecting local concerns and biases, but this way of looking at laws that affect HIV screening has changed since CDC published

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its revised recommendations for HIV testing in health-care settings, including EDs, in 2006.[1]

CDC addressed standards that should be followed in obtaining consent, and recommended that consent for HIV screening should be incorporated into the patient's general informed consent for medical care on the same basis as other screening or diagnostic tests. A separate consent form for HIV testing was not recommended. With this small step, CDC had encountered the difficult and contentious issue of how jurisdictions should legislate around HIV testing.

In January 2007, the National Alliance of State and Territorial AIDS Directors (NASTAD) held a meeting in Miami where representatives of local and state health departments, EDs, CDC, and experts in infectious diseases met to discuss the implications of CDC's recommendations. It became apparent that the matter of how states should legislate around routine opt-out HIV screening is one of the most contentious issues facing those involved in the interface of HIV screening and public health. Some argued for detailed legislation regulating precisely how an HIV test can be requested, and what a patient must learn about and sign before such a test is administered. They claimed that despite great strides forward in the medical treatment of HIV infection, prejudice and discrimination still abound, and patients should not have an HIV test unless these issues are discussed fully. Others in the field argued—based on the same data—that the age of exceptionalism in HIV testing was over, and that HIV infection can and should be treated as just another infectious disease. Indeed, they argued that less legislation is the way forward and would result in more patients being aware of their HIV status. Both camps have the patients' best interests in mind, and yet have conclusions that may be diametrically opposed. In all of this, what is the emergency physician to do when considering undertaking any aspect of ED HIV screening?

There is a great deal of interest in, and increasing federal support of, the implementation of CDC's recommendations. For example, CDC is sponsoring a number of workshops across the U.S. that bring together those with expertise in ED HIV screening with those who wish to implement the process in their own ED.[3] Federal money is also being targeted to support expanded ED HIV testing. In September 2007, CDC awarded $35 million to support increased HIV testing, and much of this money will be used to finance EDs that offer testing to high-risk populations.[4] To implement these recommendations, a large number of logistical and financial barriers need to be addressed and overcome.[5] Among the most important steps to consider are the specific state laws that impact the feasibility of any ED HIV screening program. Following is a look at these areas of legislation, as well as important recent changes made in several states.

IMPACT OF STATE LAWS ON CDC'S EXPANDED, INTEGRATED HIV TESTING PROGRAM

There exists a wide variation in state laws that pertain to HIV testing, including consent, confidentiality, and notification decisions. For those who wish to review specific state laws, the most useful tool is a compendium on state HIV testing laws from the National HIV/AIDS Clinicians' Consultation Center.[6] In 2003, CDC commissioned the National Conference on State Legislatures (NCSL) to compile a statute database of laws that may have affected CDC's Advancing HIV Prevention Initiative launched in 2003. The database was reviewed and updated by the National HIV/AIDS Clinicians' Consultation Center at the University of California San Francisco/San Francisco General Hospital. This database was updated using the Lexis-Nexis database of statutes to ensure that any statutes passed after 2003 were included, and the most recent update to the database was in February 2008.

In some states, the new CDC guidelines cannot be fully implemented without significant changes to the states' current legislation. It is of course still possible for states to provide opt-out screening under their existing legislation, but such a program would be far from meeting CDC's full recommendations. Because CDC's HIV screening guidelines represent a federal recommendation, they can be interpreted as a standard of care, and many states will not be in compliance with these federal recommendations. Three aspects of legal requirements around HIV screening are particularly important considerations for EDs: counseling, informed consent, and disclosure.

Counseling requirements

Many states required pretest counseling, which made sense for patients who have approached a health-care worker requesting an HIV test. Precisely how that counseling was conducted and the nature of the information it contained was in some areas laid out in legal detail and in others left to the provider's discretion. Within the realities of an urban ED, any requirement to provide counseling before being allowed to offer an HIV test would make the test—however technically easy to perform—practically useless, for there simply is not the time available to add this step to an already lengthy ED stay. Moreover, because the vast majority of patients will have a negative HIV screening test,

any requirement to prepare all patients for the possibility of a positive screening test would be a misuse of available resources. Counseling may provide some benefits to those who receive it in terms of the messages of prevention that are taught, but this somewhat intangible benefit comes at an enormous price. Many states now realize that the historic requirements for counseling need to be revisited if widespread ED HIV testing is to become a reality. For example, California has simplified its pretest counseling requirement,[7] and Maine removed its requirement for pretest counseling, now only requiring the counseling of patients who test positive.[8]

Informed consent

In some states there is a requirement to obtain written consent before performing an HIV screening test. Other states require written or verbal consent, and still others have a consent requirement but do not specify if it needs to be written or verbal. In Texas, general consent is considered sufficient to perform an HIV screening test.[9]

Although CDC regulations call for consent to HIV screening to be rolled into the patient's general consent to medical treatment, there are important legal distinctions between the two types of consent. General consent covers procedures whose risks and benefits are generally well-known, whereas informed consent is "…a process of communication between a patient and physician that results in the patient's authorization or agreement to undergo a specific medical intervention."[10] The issue of the necessary content of a consent that is to be considered informed has been addressed by the courts. Based on a 1972 federal appeals court decision,[11] the reasonable person standard emerged as a standard that has been adopted by about half of U.S. states. This standard requires that information about risks be determined by what a reasonable person in that patient's position would want to know. Furthermore, the information that is required to ensure that consent is informed is contextual, and requires that the health-care provider convey any information that a layperson might not otherwise be expected to know. Meeting this requirement regarding an HIV screening test is challenging if the information about this test is bundled into a general consent process.

The CDC recommendations have encouraged several states to reconsider their requirements for written consent. For example, since publication of the recommendations, Maine and Maryland have changed their requirements from written to verbal informed consent.[12,13] The legislation in Maryland represents an example of how counseling techniques have been updated to thoughtfully address new methods of providing patient education. Maryland now specifies that counseling may be provided ". . . in writing, verbally or by video, or a combination of these strategies . . ."[13] allowing the ED to play an information video on a loop and invite those who wish to be tested to watch the contents. This would enable expensive personnel to be redirected from providing counseling to performing testing.

Disclosure

Disclosure is another area that affects the way ED HIV screening is performed. Because a positive screening test requires a confirmatory test, it seems reasonable that any disclosure of the test results to the sexual contacts of a patient should only be done once the results have been confirmed. EDs are not set up to provide for any longitudinal patient contact, and to require partner notification would make an ED HIV screening program unworkable. However, in some states, contact tracing or partner notification are performed only by officials with the health department. For example, in New York, the tracing and informing of contacts is not initiated by the physician but rather by the district health officer.[14] In Texas, the law requires the health department to set up a partner notification and referral service.[15] Under this program, a person with HIV may voluntarily disclose the name or names of sexual partners, who are then contacted by a state employee. In general, it seems reasonable to continue to place the requirements of partner notification on state public health officials who are usually contacted directly by the laboratory once a positive test has been confirmed.

RECENT CHANGES TO STATE LAWS AFFECTING ED HIV TESTING

Among the CDC recommendations was the realization that states will have differing statutory regulations that may affect—or impede—the ability to perform effective opt-out tests. CDC recommended that, "Where such policies exist, jurisdictions should consider strategies to best implement these recommendations within current parameters and consider steps to resolve conflicts with these recommendations."[1] It is important to note that in the two years since the recommendations were made public, several states have revisited the language of their legislation affecting HIV testing and have legislated changes making routine opt-out HIV testing more practicable. Some of these changes have been noted previously, and other examples follow:

- Effective June 2008, Illinois instituted a change in its requirements counseling, and specified that pretest information must be made available to the person tested. Illinois also changed its requirement of prior "written informed consent" to "documented informed consent."[16]
- Maryland passed a law (House Bill 991) removing a requirement for specific written consent and reducing the legal requirements governing the content of the pretest counseling offered.[13]
- California added language that enables opt-out testing to be performed in a manner consistent with the CDC recommendations. "Prior to ordering a test that identifies infection with HIV, a medical care provider shall inform the patient that the test is planned, provide information about the test, inform the patient that there are numerous treatment options available for a patient who tests positive for HIV and that a person who tests negative for HIV should continue to be routinely tested, and advise the patient that he or she has the right to decline the test. If a patient declines the test, the medical care provider shall note that fact in the patient's medical file."[7]
- New Hampshire has enacted legislation that consent for an HIV test should be "in accordance with the most current testing and consent recommendations of the Centers for Disease Control and Prevention."[17]
- Rhode Island also references the CDC recommendations specifically as the standard to follow, although it requires written consent.[18]
- New Mexico does not require full pretest counseling when the HIV test is "part of routine medical care."[19]
- A bill before the DC Council would require that health insurers provide health insurance benefits to cover the cost of a voluntary HIV test, performed during an insured patient's visit to a hospital ED, irrespective of the reason for the hospital ED visit.[20]

However, requirements for consent or counseling in some states continue to make routine ED HIV testing difficult to implement. Some creative strategies to comply with the legal requirements while still operating an efficient program have been suggested. For example, in states in which there is a requirement for pretest counseling, it may be possible to play a video loop that contains all the required information.

CONCLUSIONS

Although routine ED HIV testing is in its infancy, complex state laws regulating almost every aspect of HIV testing have existed for many years. Historically, these laws have made implementation of the CDC recommendations very challenging. EDs that are considering following these recommendations should carefully review current laws to ensure that any HIV screening program is compliant with them.

However, there is evidence of a growing trend to streamline these legal requirements. Several states have recently made changes to some of their legislation, allowing for a routine opt-out test to be offered without contravening the letter or spirit of the law. Further efforts will be needed to encourage states to readdress their existing statutes so that new strategies in the delivery of HIV testing services—such as routine ED HIV testing—may be more easily implemented. Early data suggest that patients are in favor of some kind of ED HIV screening program.[21] Bearing this in mind, as the base of scientific literature and public health practice literature grows, and given emerging scientific evidence supporting increased testing as a cost-effective public health measure, legislators and medical communities must work together to ensure that legislation in all states supports the ability to offer large-scale ED HIV testing.

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