Arkansas Minority Health Commission
Arkansas HIV/AIDS Minority Task Force

House Bill 2100 of 2011 Interim Study

REPORT TO THE
ARKANSAS GENERAL ASSEMBLY

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House Bill 2100 Interim Study Planning Committee

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Executive Summary

Statement of the Problem

More than 5,300 Arkansans have been diagnosed and are living with HIV or AIDS. When people who are living with HIV or AIDS but who are unaware of their status are included, the number rises to more than 6,400. Research has shown that people who know that they have HIV are much less likely to engage in behaviors that can transmit the virus, and HIV positive people who take medication early in the course of their disease reduce the likelihood of infecting others by 96%. The Centers for Disease Control and Prevention has recommended since 2006 that all people ages 13-64 be voluntarily screened for HIV. The United States Preventive Services Task Force (USPSTF) has put forth a draft recommendation giving routine screening for HIV in adolescents and adults an "A" grade, meaning that the organization has determined that there is a "high certainty that the net benefit is substantial," and that practitioners should "offer or provide this service."

Despite these facts, evidence suggests that Arkansas health care providers are not often testing for HIV, even in the presence of symptoms, and that barriers to HIV testing persist. These barriers contribute to the inability to significantly reduce the number of new HIV cases in Arkansas. Barriers to HIV testing mean that people who do get diagnosed are often farther along in their disease progression, and thus more likely to need expensive medical interventions, and to have previously inadvertently transmitted HIV. The burden of HIV is borne disproportionately by African Americans in Arkansas, who make up about 15% of the state's population, but represented 51% of AIDS cases reported in 2011. Minority communities are even more likely to face barriers to HIV screening, due to factors like lack of health insurance, lack of access to health care, and social stigma.

In order for Arkansas to make progress in efforts to reduce the numbers of new HIV infections, and reduce the disproportionate HIV burden in minority communities, more information about attitudes towards HIV testing and barriers to screening was needed. House Bill 2100 authorized an interim study to investigate these attitudes and barriers, and the Arkansas HIV/AIDS Minority Task Force and Minority Health Commission undertook research in 2012 among both patients and health care providers to gain more information, as well as reviewing Arkansas law related to HIV testing. This report summarizes the research conducted and sets out recommendations for reducing barriers to voluntary HIV screening in the state.

Key Recommendations

- Embrace the USPSTF "Grade A" recommendation for routine, voluntary HIV screening, and increase awareness among Arkansans about the recommendation and the fact that under the Affordable Care Act, USPSTF Grade A or B recommendations must be covered without cost sharing by health insurers.

- Encourage efforts to combat social stigma related to HIV to help alleviate Arkansans' fears of being treated badly if they were to test HIV positive.

- Support efforts to address misconceptions among Arkansans that they are not at risk of acquiring HIV.

- Consider higher reimbursement rates for HIV screening to encourage more health care providers to offer this service.

- Encourage efforts to educate health care providers about the importance of their role in offering regular HIV screening to their patients.

- Consider modifying existing law to clarify and strengthen protections for minors who choose to be tested for HIV.

- Consider amending Arkansas law to reduce barriers to routine HIV screening and facilitate linkage to care for individuals testing HIV positive.

Introduction

Early HIV diagnosis can save lives, prevent new infections, and reduce health care expenditures. Individuals who are aware that they are living with HIV, for example, are less than a third as likely to transmit the infection as those who are unaware.[1] A breakthrough recent study found that people who took HIV medications early in the course of their disease, thus reducing the amount of virus in their bodies, were 96% less likely to transmit HIV.[2] Early access to medical care and treatment—the standard of care for HIV—preserves health and is cost-effective compared to later, more intensive medical interventions like inpatient hospitalization. Yet nationally, 32% of people diagnosed with HIV receive an AIDS diagnosis within 12 months.[3] Given that it takes an average of ten years to progress from initial HIV infection to AIDS, this means that nearly one-third of people with HIV are being diagnosed late in their disease progression. The Centers for Disease Control and Prevention (CDC) notes that "late diagnoses represent missed opportunities for treatment and prevention."[4]

Despite the benefits associated with early HIV screening, many Arkansans—particularly minorities—face barriers to HIV testing. These barriers could stem from lack of health insurance or lack of access to an HIV testing site, or from social stigma and misinformation. The State Healthcare Access Research Project (SHARP) report, produced in 2010 by the Center for Health Law and Policy Innovation of Harvard Law School in collaboration with Arkansas community partners, identified stigma as a significant challenge to HIV testing and access to care. The SHARP report identified routine, opt-out HIV testing as one possible way to reduce HIV-related stigma. By treating screening for HIV like that for other conditions (such as high blood pressure or high cholesterol), the report reasoned, HIV could be "normalized" for people, decreasing the stigma associated with HIV. The SHARP report suggested that Arkansas consider requiring health plans to cover an annual HIV test for people ages 13-64, in line with the federal Centers for Disease Control and Prevention recommendations.

Early HIV diagnosis is vital: individuals who are aware that they are living with HIV are less likely to transmit the disease than those who are unaware.

Recognizing these testing barriers, and in light of the SHARP report recommendations, Representative Fred Allen (Dist. 33) introduced House Bill 2100 (H.B. 2100) in the Arkansas General Assembly in 2011.[5] The bill asks Arkansas's House and Senate Committees on Public Health, Welfare, and Labor to study, with the assistance of the state's Minority Health Commission, the barriers contributing to Arkansas's "inability to reduce the incidence of HIV infection."[6]

In response to H.B. 2100, the Arkansas Minority Health Commission (AMHC) and the Arkansas HIV/AIDS Minority Task Force ("Task Force") surveyed more than 800 individuals from around the state over the summer and fall of 2012. Respondents were asked if they had been tested for HIV—if they had, they were asked about their experience getting tested. If they had not, they were questioned about their views on a number of potential barriers to HIV testing. AMHC and the Taskforce also surveyed more than 100 health care providers in the state about their views on asking patients about HIV testing. This was the most comprehensive survey on HIV testing barriers ever conducted in Arkansas.

In addition to the survey, AMHC and the Taskforce conducted two focus groups: one in Forrest City, and the other in Pine Bluff. The focus groups included men and women, African-American and white, and HIV positive and HIV negative individuals.

This report presents the findings of the surveys and the focus groups, and makes a number of recommendations that, if implemented, are likely to reduce the barriers to HIV testing that Arkansans continue to face.

Background

HIV/AIDS in Arkansas

According to the Arkansas Department of Health, 5,351 Arkansans were living with HIV or AIDS at the end of 2011.[7] This number represents only Arkansans who have been diagnosed and reported as living with HIV or AIDS. The Centers for Disease Control and Prevention (CDC) estimates that approximately 20% of people living with HIV in the United States have not been diagnosed and are unaware of their HIV status.[8] Applying this statistic to Arkansas means that there were likely more than 6,400 people living with HIV/AIDS in the state at the end of 2011.

Minorities in Arkansas are disproportionately affected by HIV. African Americans, for example, comprised 51% of HIV cases reported in Arkansas in 2011,[9] even though they make up about 15% of the state's population.[10]

Arkansans living with HIV face barriers to accessing health care. In a 2010 report, the Arkansas Department of Health determined that over 65% of Arkansans confirmed to be living with HIV as of December 2006 were "not in care," meaning that they did not receive vital treatment and/or laboratory testing in the past year.[11] The Department of Health noted that barriers to care for Arkansans with HIV include cost, lack of HIV treatment expertise, stigma, lack of awareness, and misinformed fatalism.[12]

House Bill 2100

House Bill 2100 recognizes that certain barriers to HIV testing continue to thwart efforts to limit the incidence of the disease in Arkansas. It also recognizes that these barriers may particularly affect minority groups in the state. It therefore authorizes an interim study to investigate barriers to testing and consider the possibility of an opt-out routine HIV screening program.

To this end, the bill specifically asks the Arkansas House and Senate Committees on Public Health, Welfare, and Labor to study the following matters, among others:

(1) Provider-related and patient-related factors that act as barriers to HIV testing;
(2) Acceptance of HIV screening, and reasons for opting out;
(3) How state law can be clarified regarding informed consent for adolescents seeking HIV testing and pre-testing and post-testing requirements;
(4) The health care settings that could effectively implement routine HIV screening; and
(5) The billing-related obstacles that might prevent routine, voluntary HIV screenings.

The bill calls for a report by December 2012.[13]

A new development: USPSTF recommends HIV screening for all adults and adolescents

The United States Preventive Services Task Force (USPSTF) is an independent panel of non-federal experts that conducts reviews of scientific evidence on preventive health services, and accordingly makes recommendations to primary care clinicians and health systems. In November 2012, while this report was being prepared, the USPSTF issued a draft recommendation strongly recommending HIV screening for all adults and adolescents ages 15 to 65. USPSTF gave HIV screening a "Grade A" recommendation.[14] A "Grade A" recommendation means that the USPSTF has determined that there is a "high certainty that the net benefit is substantial," and that practitioners should "offer or provide this service."[15] The USPSTF draft recommendation now aligns more closely with the Centers for Disease Control and Prevention, which has recommended routine voluntary HIV screening for adults and adolescents in health care settings since 2006.[16] The public comment period for the draft USPSTF HIV screening recommendation closed on December 17, 2012; the USPSTF will be finalizing its recommendation after that time.

Under the Affordable Care Act (ACA), eligible health plans and Medicare are required to cover preventive services given an "A" or "B" grade by the USPSTF without beneficiary cost sharing when delivered by in-network health care providers. For new USPSTF recommendations, plans and issuers have one year from the effective date of the recommendation to comply.[17,18]

Survey methodology

Prior to the adoption of H.B. 2100 as an Interim Study, there was virtually no information available about attitudes and practices related to HIV testing among Arkansas patients and health care providers. The H.B. 2100 Interim Study Planning Committee ("Planning Committee") determined that surveys of both patients and providers would need to be conducted to have adequate information to inform the study report. A list of individuals participating on the Planning Committee and attending meetings on the interim study is listed on Page 4 of this report. A Research Subcommittee of the Planning Committee was formed, and included representatives from the University of Arkansas for Medical Sciences (UAMS), the Arkansas Department of

Health (ADH), the Arkansas Minority Health Commission (AMHC), and the Center for Health Law and Policy Innovation of Harvard Law School (CHLPI).

The survey instruments were initially designed by the CHLPI team, including staff with education and experience in HIV legal services, HIV medical care (nursing), and public health. The Research Subcommittee and the Planning Committee provided feedback and edits for the draft surveys. The patient survey was evaluated for plain language readability by Dr. Kristie Hadden, Director of Health Literacy at UAMS Center for Rural Health, and was determined to need no changes, as the document read at a level of grade six or lower.

Patient surveys used a convenience sampling method. Surveys were administered both in-person and online. The in-person surveys were administered with the consent and assistance of Community Health Centers of Arkansas, Inc. (CHC) to CHC patients who volunteered. Patients were not compensated for filling out the surveys. Ten CHCs were selected as sites for administering patient surveys; the sampling justification was designed by epidemiologists at ADH and is included as Appendix G of this report. Volunteers administered the patient surveys at CHC; the instructions and guidelines followed by those volunteers are included as Appendix E of this report. In addition, in-person surveys were administered by AMHC at six public forums held in Little Rock, Stuttgart, El Dorado, Pine Bluff, Forrest City and West Memphis. There was also an online survey available to the general public through surveymonkey.com, which was publicized through the contact lists of members of the Arkansas HIV/AIDS Minority Task Force, Future Builders, Inc., Jefferson Comprehensive Care Systems, Inc., ARCare, the Arkansas HIV Consumer Advisory Board, and HIV Arkansas. The original in-person patient surveys were retained by AMHC, with copies being sent to CHLPI for data entry and analysis.

The provider survey was also a convenience sample, and was coordinated by ADH and administered online through surveymonkey.com. The Arkansas Medical Society and Arkansas Medical, Dental and Pharmaceutical Association assisted with distribution of the provider survey.

Survey and focus group results

There were 851 patient surveys (both in-person and online) and 118 provider surveys (online only) received. Fifty-one of the patient surveys were not included because they contained directly contradictory answers (e.g., “I have never been tested for HIV” and “I have had an HIV test in the past year”) and it was impossible to determine which answer was accurate, or they were missing pages, or they were too incomplete.

Demographics

In the general survey, the average age of respondents was 47.8 years. Over 70% of respondents were female (only two respondents identified themselves as transgendered); and about 61% of respondents were African American (31% non-Latino white; 6% Latino). 32% of respondents said that they had never been screened for HIV, but 36% had been screened in the past five years.

Patient survey respondent characteristics

Average Age	47.8 years
Gender	
Female	72.2%
Male	27.5%
Transgender	0.3%
Race/Ethnicity	
African American	61%
White (non-Latino)	31%
Latino	6%
Other	2%
Previous HIV testing	
Never	32.3%
Less than 1 year ago	18.5%
Less than 5 years ago	18.1%
More than 5 years ago	31.1%

In the first focus group in Forrest City, there were a total of 9 participants: 2 men and 7 women. 3 of the participants were HIV positive. In the second focus group in Pine Bluff, there were 10 participants: 4 men and 6 women. All of the participants in this focus group were HIV positive.

In the providers' survey, providers were asked to estimate the percentage of their patients who belonged to different races or ethnicities. On average, providers estimated that 51% of their patients were white and non-Latino, 36% were African-American, and 10% were Hispanic. Asian-Americans and Native Americans made up most of the rest of the patients.

Providers were also asked about their medical specialty. Among those who responded, over 31% had a family practice, 11% were HIV providers, and 9% were pediatricians. Primary care providers and internal medicine practitioners each made up 8% of respondents. Fewer than 2% of respondents were not practicing physicians.

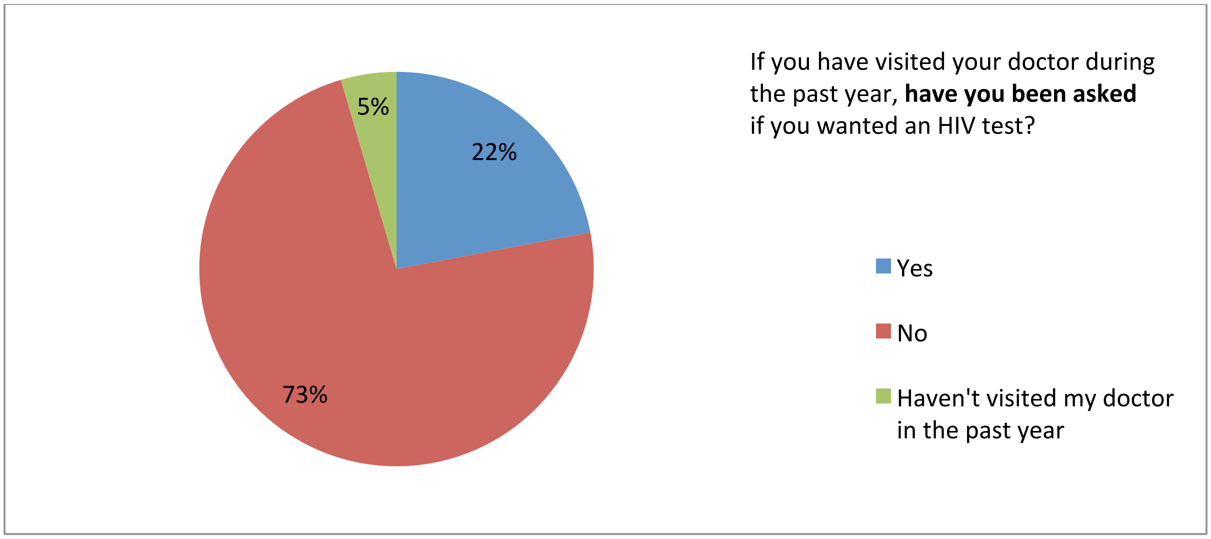
Survey respondents' views on HIV screening

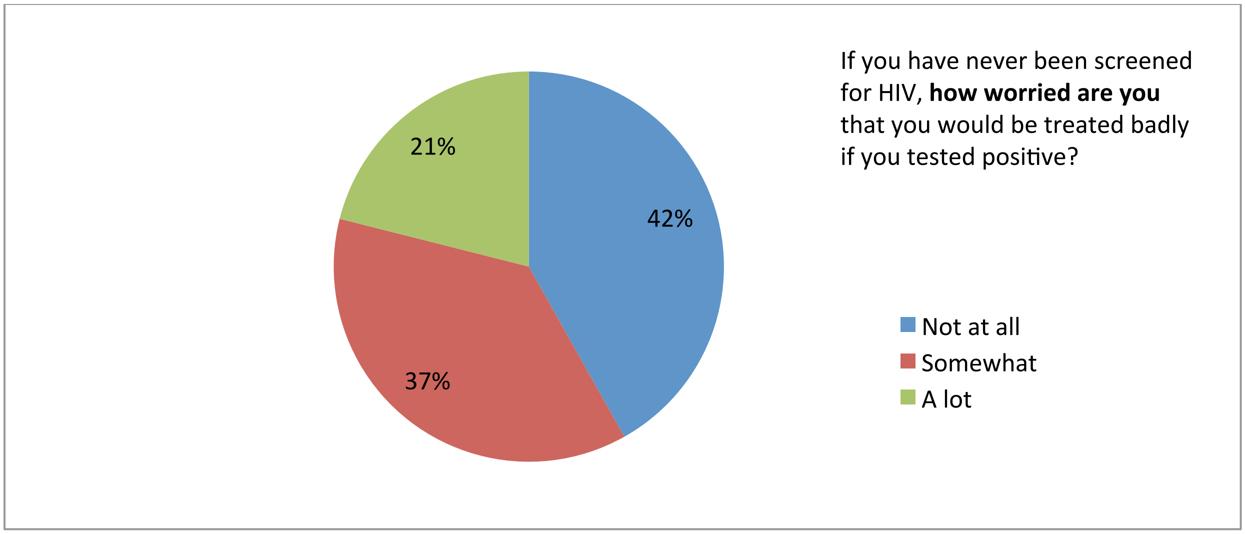
An overwhelming 85% of general public respondents agreed that HIV screening should be part of a regular check-up, and 83% of respondents said that they would not be upset if their doctor asked them about HIV screening. Almost all respondents said that they would go back to their doctor even if she asked them about HIV screening. Despite this, 73% of respondents said that their doctor did not ask them if they wanted to be screened for HIV in the past year.

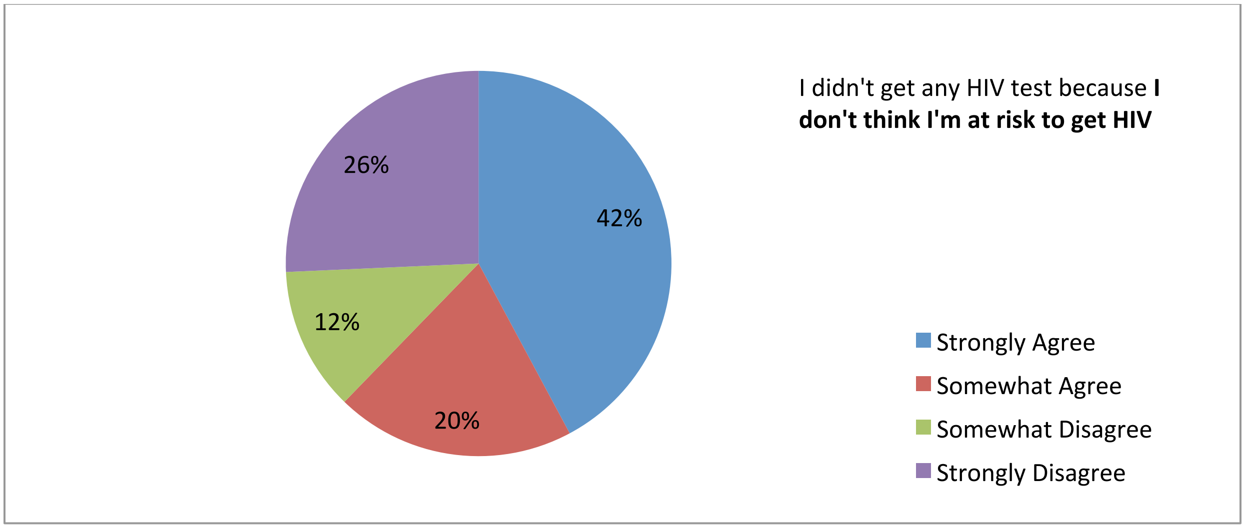
While most respondents were not worried that others would find out if they got tested for HIV, 58% of respondents admitted that they were worried that they would be treated badly if they tested *positive* for HIV (with a fifth of respondents admitting that they were "very worried"). Of respondents answering the question, 5% (41 people) were worried that an HIV test could infect them with the virus.

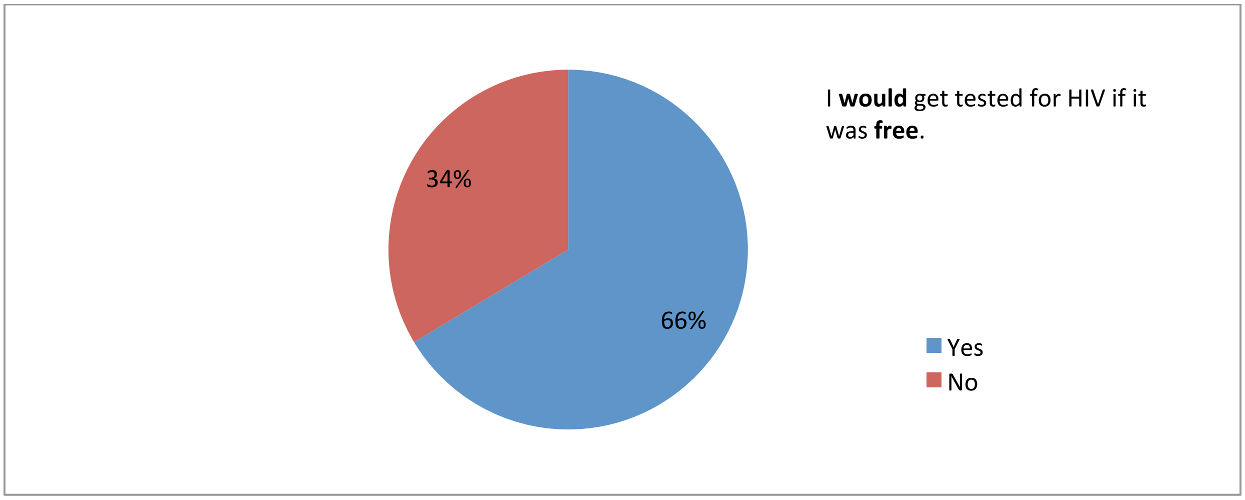
More than 32% of all respondents (259 people) said that they had never been screened for HIV. The most prevalent reasons why these individuals had not been tested was because their doctor never asked them if they wanted to get tested (64%), and because they believed that they were not at risk of acquiring HIV (62%). Two-thirds (66%) of these respondents said that they would get screened for HIV if it was free.

Of the respondents who had been tested for HIV, most had been tested at a clinic or at their doctor's office (a smaller number got tested at health fairs, at the health department, at a hospital, or while in prison or in the military). These respondents largely disagreed with the notion that it was hard for them to find a place to get tested (74% of respondents answering the question), and with the notion that their doctor was reluctant to test them for HIV (77% of respondents answering the question).




If you have never been screened for HIV, **how worried are you** that you would be treated badly if you tested positive?


I didn't get any HIV test because **I don't think I'm at risk to get HIV**


I **would** get tested for HIV if it was **free**.

Focus group participants' views on HIV screening

The focus groups revealed two important barriers to HIV screening: social stigma, and a lack of awareness.

At the first focus group, in Forrest City, participants appeared to have a poor understanding of risk behavior, with many HIV negative participants believing that they could not be infected by HIV. This aligns with the results of the general survey, where over 60% of respondents who had never been screened for HIV felt that they were not at risk of being infected. Participants also cited "fear of the unknown" and "a lack of understanding from their peers" as reasons for their avoiding being screened for HIV.

At the second focus group, held in Pine Bluff, all participants were HIV positive. The participants conceded that prior to contracting HIV they knew nothing about it, and did not suspect that they were at risk of getting it. The participants agreed that HIV was taboo in the faith-based community, and they urged school systems, universities, and community leaders to play a bigger role in advocating regular HIV screening, through print and media campaigns.

Health care providers' views on HIV screening

There were a total of 118 respondents for the provider survey. Most providers surveyed had experience dealing with patients with HIV: 26% of survey respondents had treated between 1 and 10 patients with HIV; over 17% of respondents had treated between 11 and 50 such patients; and about 14% of respondents had treated over 100 HIV+ patients throughout their careers. About 8% of respondents had not treated any patients with HIV; just over 27% of respondents (n=33) did not answer this question.

An overwhelming 86% of providers answering the question agreed that "HIV testing should be treated just like routine screening for any other disease," and 91% of providers agreed that HIV screening should be included as part of a patient's regular check-up, without any need for specific written consent. All providers agreed that if a patient requests an HIV test, she should receive one, regardless of whether she is a high-risk individual.

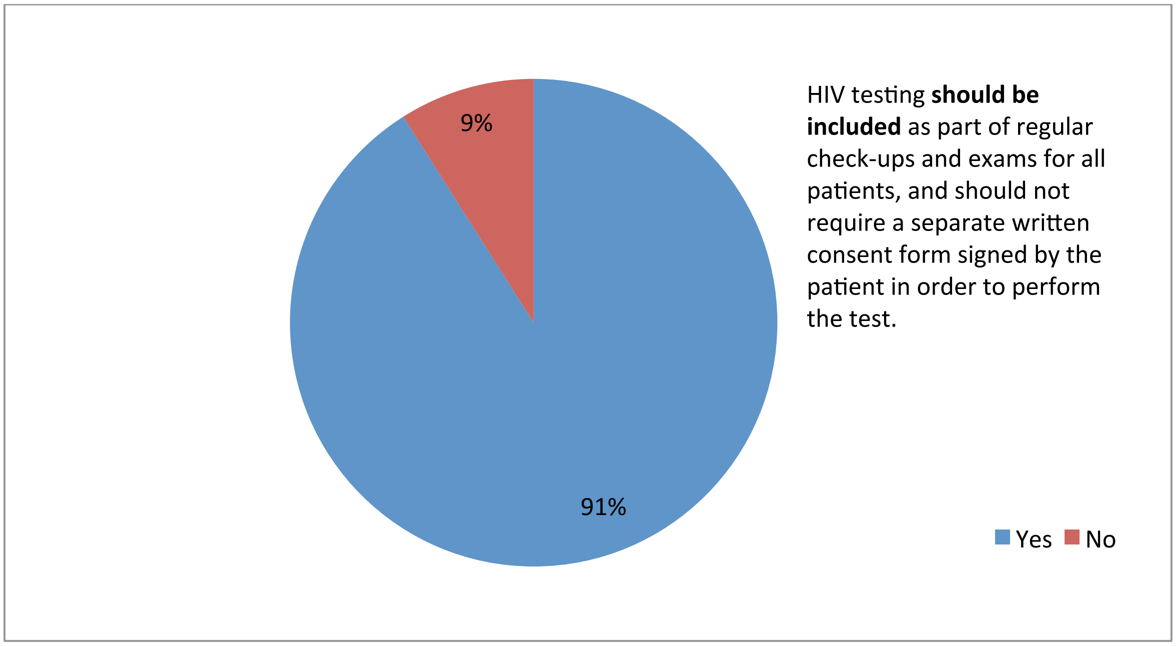
Providers were asked to share their thoughts on how their patients responded to the idea of HIV screening. Nearly nine in ten providers said that their patients had not been offended when asked about HIV screening, and that their patients did not refuse HIV screening when asked. Nine in ten providers also felt confident that bringing up HIV screening would not hurt their provider-patient relationship.

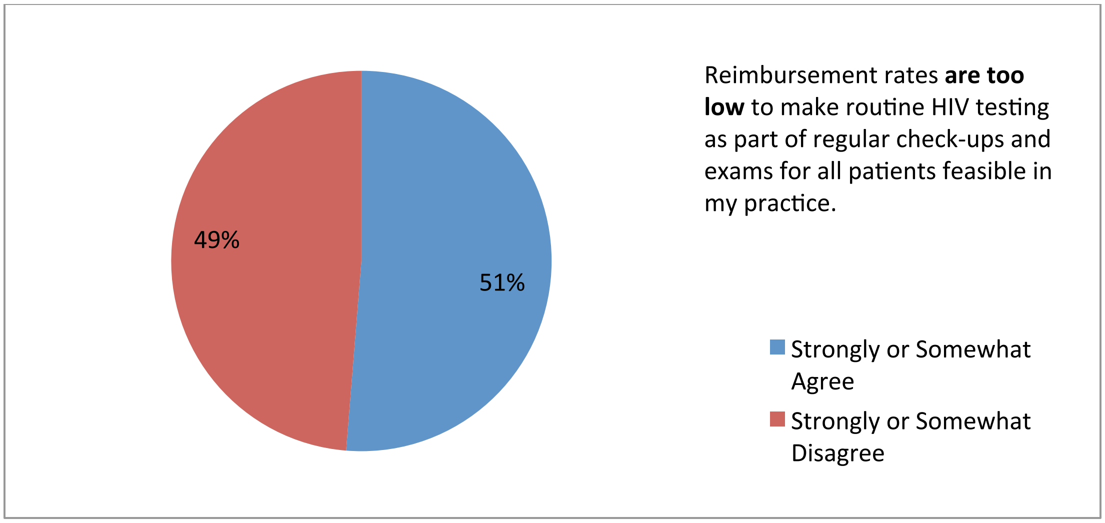
This encouraging picture changed when providers were asked about other factors that might discourage HIV screening. 65% of providers felt that routine HIV screening was appropriate for their practice, but 51% of providers felt that reimbursement rates *were too low* to allow for routine HIV screening. About 25% of providers felt that the billing procedures for HIV screening were too onerous.

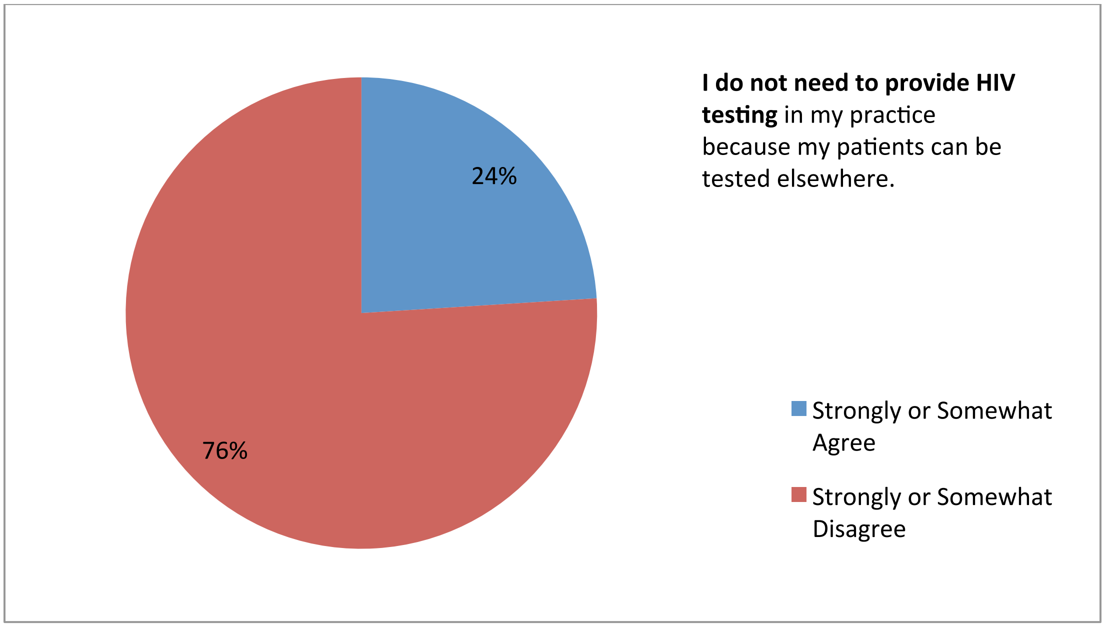
Some providers (about 25%) felt that they did not have enough time to carry on routine HIV screening for all their patients. About 24% of providers felt that they did not need to provide HIV screening, since their patients could avail of that service elsewhere, even though the general survey reveals that most Arkansans rely on their doctors for HIV screening.

Finally, providers were asked to identify the threat of certain HIV risk factors. Over 80% of providers agreed that intravenous drug use and unprotected sex were "high risk" factors. Over 70% of providers felt that having multiple sex partners, having bisexual sex partners, and testing positive for an STI were "high risk" factors.

About half of all surveyed providers felt that race/ethnicity, low income, low level of education, location, alcohol use, and non-intravenous recreational drug use were HIV risk factors, albeit not "high risk" factors. About a quarter of providers did not consider race/ethnicity to be a risk factor, and over a third did not consider location to be one. There was disagreement as to whether gender was a risk factor: over a third of providers felt that it was not, but a similar percentage felt that it was somewhat of a risk factor.




Reimbursement rates **are too low** to make routine HIV testing as part of regular check-ups and exams for all patients feasible in my practice.


I do not need to provide HIV testing in my practice because my patients can be tested elsewhere.

Discussion of survey results

This survey is the most comprehensive investigation into barriers to HIV screening in Arkansas. It presents a wealth of insight regarding patient and provider attitudes towards HIV screening.

The survey reveals that Arkansans largely support regular HIV screening, and would like their doctors to discuss the matter. That said, the fear of social stigma continues to color views on HIV testing: over 50% of survey respondents confided that they were worried that they would be treated badly if they tested positive for HIV. Focus group participants noted that a lack of

Key Findings of Surveys and Focus Groups

Patient views

- Most Arkansans (85%) think HIV screening should be part of regular check-ups
- Most Arkansans (83%) would NOT be upset if their doctor asked them if they wanted an

The vast majority of providers surveyed support including HIV screening in their patients' regular check-ups. Making HIV screening routine may help combat the social stigma associated with the procedure and the disease. Providers can also regularly discuss HIV screening with all their patients, in a further effort to address social stigma.

Misinformation also serves as a barrier to HIV testing: more than six in ten respondents who had never been tested for HIV believed that they were not at risk of acquiring the infection; and focus group participants appeared to have little understanding of HIV risk factors. This is troublesome, particularly since it is known that between 20-26% of individuals with HIV report none of the risk factors associated with the infection.[19] HIV advocates can work with schools and receptive faith-based organizations to run print and media campaigns that address the misinformation surrounding HIV.

Cost was cited as a barrier to HIV testing in the survey: 61% of respondents who had never been tested for HIV said that they would get tested if HIV screening was free. The USPSTF's recommendation may somewhat mitigate cost as a barrier to HIV testing: health care payers will soon be required to cover HIV screening for their beneficiaries without cost sharing.

Cost is a concern for health care providers as well. 51% of providers felt that reimbursement rates for HIV screening were too low to warrant regular screening. It is unclear if the USPSTF's recommendation will improve this situation for providers, or if it will improve the billing procedures for HIV screening that about 25% of providers found onerous.

It remains unclear if provider attitudes towards HIV serve as a barrier to HIV screening. 64% of respondents who had never been tested for HIV stated that their doctor had never asked them if they wanted to get tested. However, many respondents who *had* been screened for HIV dismissed the notion that their doctors were reluctant to test them (77% of respondents who answered a question regarding whether their doctors were reluctant to screen them for HIV). Most providers surveyed also appeared to be confident in their ability to discuss HIV screening with their patients without harming their provider-patient relationship. However, about a quarter of providers felt that they did not need to provide regular HIV screening since there were alternative testing sites, even though the general survey revealed that many respondents relied on their doctors for HIV screening. The providers who participated in this survey may be more likely than most to screen their patients for HIV, since the majority of them have had patients with HIV.

These mixed results reveal that some physicians and health care providers in Arkansas remain reluctant to talk to their patients about HIV screening, despite evidence that Arkansans want to talk to their doctors about this matter.

Caveats

It is possible that the survey might paint a more positive picture than the reality in Arkansas. Individuals who chose to participate in the general survey may be more open to discussing HIV, and to regular HIV screening, than the average Arkansan. Similarly, providers who chose to participate in the survey may have more experience working with HIV positive individuals, and might therefore be more open to the idea of regular HIV screening. The focus groups, by their very nature, reflect a small segment of Arkansan society that was very receptive to having a discussion on HIV.

Arkansas law regarding informed consent for adolescents seeking HIV testing and pretesting and posttesting requirements

Minors and HIV testing

Like all other states,[20] Arkansas has a law allowing minors who believe that they may have a sexually transmitted disease (STD) to consent to medical care.[21] Parental or guardian consent is not necessary to authorize care or services.[22] Unlike laws in 31 states,[23] the Arkansas law does not specifically include HIV as a condition that providers may test and treat for without parental consent. In practice, however, the Arkansas Department of Health indicates that minors may consent to HIV testing.

The current CDC recommendations for HIV testing note special considerations for adolescents. The CDC recommends that providers incorporate HIV screening into the "anticipatory guidance" provided to adolescents at primary care visits.[24] Anticipatory guidance is the health promotion and prevention counseling that adolescents and families receive at primary care appointments. According to the CDC guidelines, adolescents should be informed about infection, testing, transmission, and implications of infection; providers should encourage screening of sexually active adolescents.[25]

Arkansas law currently allows, but does not require, medical providers to inform parents about STD treatment "given or needed" to a minor, even "over the express objection of the minor."[26] Arkansas is one of 18 states with a law permitting providers to inform parents.[27] Disclosure to parents is on "the advice and direction of a treating physician."[28] The CDC HIV testing recommendations and the American Academy of Pediatrics (AAP) both suggest that providers should try to protect adolescents' privacy; the AAP further recommends that disclosure of an adolescent's HIV status should be treated legally and ethically in the same manner as disclosure of an adult's status.[29]

Pretest and posttest requirements

Existing Arkansas law is largely consistent with the pretest and posttest guidelines in the current CDC recommendations for HIV testing.[30] The Arkansas HIV Shield Law provides that:

> Informed consent, information, and counseling are not required for the performance of an HIV test when, in the judgment of the physician, the testing is medically indicated to provide an appropriate diagnosis and treatment to the subject of the test, provided that the subject of the test has otherwise provided his or her consent to the physician for medical treatment.[31]

The law also states that "[h]ealth care providers or facilities may not deny appropriate care based upon the results of an HIV test."[32]

The CDC recommendations call for routine, opt-out HIV screening for people ages 13-64 in all health care settings. "Opt-out" screening means that the patient is notified that HIV testing will be performed unless the patient declines.[33] The CDC further notes that general consent for medical care should be considered enough to encompass consent for HIV testing (without needing separate written consent), and recommends that prevention counseling not be required with HIV diagnostic testing or screening programs in health care settings.

Arkansas's HIV Shield Law addresses situations where HIV testing is "medically indicated" (in the treating physician's judgment) for "appropriate diagnosis and treatment" for an individual. It seems intended to protect both health care providers and patients. Patients may not be denied care based on the results of an HIV test. Providers who conduct HIV testing in circumstances where it is not practical or possible to obtain informed consent are shielded from liability.

The Arkansas HIV Shield Law does not specifically address the situation of routine, voluntary HIV screening. The CDC defines screening as "a basic public health tool used to identify unrecognized health conditions so treatment can be offered before symptoms develop and, for communicable diseases, so interventions can be implemented to reduce the likelihood of continued transmission."[34] It is unclear whether routine, voluntary HIV screening would fall into the category of "medically indicated" testing under the Arkansas HIV Shield Law, although it seems that this is not the situation the statute was intended to address. Should the HIV Shield Law be interpreted as applying to routine testing, it would contravene CDC recommendations that providers conduct routine testing only with a patient's "knowledge and understanding that HIV testing is planned," and after the patient has had an opportunity to ask questions and decline the test.[35]

Health care settings for routine HIV screening

H.B. 2100 directed that the interim study consider which health care settings could effectively implement routine HIV screening. With proper training and support, any health care setting should be able to implement routine HIV screening. According to the CDC recommendations for HIV testing, the guidelines "are intended for all health-care providers in the public and private sectors, including those working in hospital emergency departments, urgent care clinics, inpatient services, substance abuse treatment clinics, public health clinics, community clinics, correctional health-care facilities, and primary care settings."[36] Many of these settings are already familiar with HIV testing protocols. For those that are not, one resource is the Delta Region AIDS Education and Training Center, which is federally-funded to provide trainings to clinicians on a range of HIV-related topics, including routine HIV testing.[37]

Billing-related obstacles to routine, voluntary HIV screening

As previously noted, under the Affordable Care Act, most insurers will be required to cover, without cost sharing, preventive services given an "A" or "B" grade by the United States

Preventive Services Task Force. Assuming that the USPSTF draft recommendation of a "Grade A" for routine, voluntary HIV testing for individuals ages 15-65 becomes the final recommendation, insurers will need to comply with this provision of the ACA. It should be noted that the USPSTF recommendation does not, in any way, create a requirement that people be tested annually for HIV. It simply recommends to practitioners that it is good clinical practice to offer or provide the service. In their survey responses, Arkansas providers noted that low reimbursement rates for HIV testing were a barrier to routine HIV testing; this could potentially be considered a "billing-related obstacle."

Recommendations

In light of the national draft recommendation on routine HIV screening from the United States Preventive Services Task Force, this report does not recommend passage of state legislation at the present time to create a routine, opt-out HIV screening program or an Arkansas-specific insurance mandate for HIV screening. Based on the information gained from the interim study, we respectfully present the following recommendations:

There is widespread support for regular HIV testing. Embrace the United States Preventive Services Task Force "Grade A" recommendation.

Given the widespread support for routine HIV testing among survey respondents, including providers, the General Assembly should embrace the USPSTF "Grade A" recommendation for routine, voluntary HIV screening. Assuming that the USPSTF draft recommendation becomes final, the General Assembly can encourage efforts to increase awareness among Arkansans about the recommendation and the fact that insurers would cover HIV testing without cost sharing. 66% of general survey respondents who had never been tested for HIV said that they would get screened if the procedure was free—learning about the USPSTF recommendation may encourage many of these Arkansans to seek out HIV screening.

There is a fear of being treated badly if a test reveals an individual to be HIV positive. Encourage efforts to combat this social stigma.

In the general survey, 56% of respondents admitted that they were worried that they would be treated badly if they tested *positive* for HIV (with a fifth of respondents saying that they were "very worried"). This fear can discourage Arkansans from undergoing HIV screening. The General Assembly can help improve the situation by supporting initiatives to increase knowledge and understanding and reduce HIV-related stigma, and by encouraging health care providers to discuss HIV screening with their patients during regular check-ups.

A large number of survey respondents did not get screened for HIV because they believed that they were not at risk. Support efforts to address this misconception.

In the general survey, 59% of respondents who had never been tested for HIV explained this by contending that they were not at risk of acquiring the infection. It is unclear if these respondents fall in a "high-risk" category for acquiring HIV, but this is beside the point, since 20-26% of individuals with HIV report no risk factors.[38] The General Assembly can support public education and awareness efforts that dispel the misconception that only certain people should be screened for HIV and that promote regular HIV screening for all.

A number of physicians stated that reimbursement rates were too low to encourage regular HIV screening. Consider higher reimbursement rates for this vital service.

HIV screening can save Arkansas millions of dollars. Individuals who are aware that they are living with HIV, for example, are much less likely to transmit the infection than those who are unaware—fewer individuals living with HIV translates into lower health care costs for the state.

Given the significant financial and public health incentives for investing in HIV screening, the General Assembly may want to encourage higher reimbursement rates for the service. This would give health care providers the impetus to encourage their patients to get regularly screened for HIV. More than half of health care providers responding to the survey believe that reimbursement rates for HIV screening are currently too low to encourage them to regularly screen their patients. Higher reimbursement rates would address this concern.

A number of physicians believe that they do not need to provide regular HIV screening because their patients can be screened elsewhere, even though Arkansans often rely on their physicians for HIV screening. Encourage efforts to educate providers about this issue.

Nearly a quarter of providers surveyed stated that they did not need to provide regular HIV screening because their patients could be screened elsewhere. This stands in contrast to this survey's finding that many Arkansans rely on their physicians for HIV screening. The General Assembly should support efforts by state agencies and organizations to improve providers' awareness regarding the important role that they play in screening Arkansans for HIV.

Arkansas law could do better in encouraging adolescents to be tested for HIV. Consider modifying existing law to clarify and strengthen protections for minors.

Both the CDC testing guidelines and the USPSTF draft recommendation on routine HIV screening call for testing of adolescents. By amending the statute allowing providers to test minors for sexually transmitted diseases without parental consent to expressly include HIV, Arkansas law would be more compatible with current HIV testing recommendations. To encourage more adolescents to be screened for HIV, Arkansas law could be modified to better protect adolescents' privacy. Arkansas could consider adopting provisions like one in Oklahoma that prohibits disclosing test information without the minor's consent if the minor tested negative,[39] or one in Delaware that directs providers to have "primary regard for the interests of the minor" when deciding whether to disclose information to parents or guardians.[40]

Current Arkansas law regarding HIV testing does not address routine, voluntary HIV screening. Consider amending the law to reduce barriers to routine screening and facilitate linkage to care for individuals testing HIV positive.

The Arkansas HIV Shield Law does not specifically address routine, voluntary HIV screening, and seems intended to apply to situations where it may not be practicable to obtain specific informed consent for HIV testing. To better align with CDC testing recommendations, Arkansas law could be modified to provide for routine HIV screening only when the patient understands that HIV testing is planned and has the opportunity to decline the test. Arkansas could also adopt laws and policies that support posttest counseling and linkage to care for people testing HIV positive. Other states (e.g., Washington and Rhode Island) have laws promoting linkage to care.[41]

Appendix A: Text of House Bill 2100

State of Arkansas
88th General Assembly
Regular Session, 2011

HOUSE BILL 2100

By: Representative Allen

As Engrossed: H3/30/11

A Bill

For An Act To Be Entitled

AN ACT TO CREATE AN OPT-OUT HIV SCREENING PROGRAM; AND FOR OTHER PURPOSES.

Subtitle

AN ACT TO CREATE AN OPT-OUT HIV SCREENING PROGRAM.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. DO NOT CODIFY. Routine HIV Screening Interim Study.

(a) The House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor shall study barriers to HIV testing that contribute to the inability to reduce the incidence of HIV infection in Arkansas.

(b) The House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor shall study without limitation the following:

(1) Provider-related and patient-related factors may act as barriers and prevent health care providers from testing for HIV;

(2) How the acceptance rates among patients can be assessed to understand reasons for opting out of HIV screening;

(3) How state law may be clarified regarding informed consent for adolescents seeking HIV testing and pretesting and posttesting requirements;

(4) The health care settings that could effectively implement 34 routine HIV screening; and

(5) The billing-related obstacles that might prevent routine, voluntary HIV screenings.

(c) The committees may consider the following:

(1) Although African Americans compose thirteen percent (13%) of the state's population, yet they compose forty-three percent (43%) of the 2010 HIV cases in the state and fifty percent (50%) of the 2010 AIDS cases;

(2) There is evidence that indicates that health care providers often do not test for HIV, even in the presence of symptoms;

(3) For individuals who lack health insurance and lack access to health care, the opportunity to engage in HIV screening is even further reduced;

(4) These barriers to HIV testing contribute to the inability to reduce the incidence of HIV infection and make it even more difficult for individuals from ethnic minority groups who are diagnosed significantly late in the disease;

(5) Late diagnosis increases the risk for the development of the life-threatening infections and most importantly also increases the risk for transmission of HIV to others;

(6) There is evidence that once an individual knows his or her HIV status, that individual is significantly less likely to engage in behaviors that might transmit HIV to another person;

(7) There is a need for HIV testing to become a readily available routine screening procedure that can be easily accessed by the general public;

(8) Easily accessible disease prevention and health screening services currently exist for other infectious and chronic diseases;

(9) For example, one can obtain an influenza vaccine, have one's blood pressure checked, or have one's blood glucose or cholesterol measured while at the grocery store, a school activity, or a sporting event, but no such ready access to HIV screening exists in Arkansas;

(10) The Centers for Disease Control and Prevention has recommended routine, HIV screening for every person between the ages of thirteen (13) and sixty-four (64) in any health care setting, with no requirement for separate written consent or pretest counseling; and

(11) By making HIV screening a part of routine medical care, consent to HIV testing is inferred, unless the individual declines testing.

(d) The House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor may invite the Arkansas Minority Health Commission to assist the committees with completing this study.

(e) The House Committee on Public Health, Welfare, and Labor and the Senate Committee on Public Health, Welfare, and Labor shall present final findings concerning this interim study and recommendations for legislation to the Governor and the Legislature Council on or before December 1, 2012.

/s/Allen

Appendix B: Patient Survey

Arkansas HIV Testing Study: 2012 Consumer Survey

We are trying to find out more about what people in Arkansas think about HIV testing. We would like to know what you think. All your answers are anonymous—we will not know who you are. Thank you for your help!

Part 1: Background Information

1. How old are you? ______

2. What is your sex/gender? (Circle all that apply)
   Male

   Female

   Male to Female Transsexual or Transgender

   Female to Male Transsexual or Transgender

   Prefer not to answer

3. What is your race? (Circle all that apply)
   White

   Black or African American

   Asian

   Native Hawaiian or Other Pacific Islander

   American Indian or Alaska Native

   Marshallese

   Hispanic or Latino

   Don't know / Not sure

   Prefer not to answer

   Other: ______________________________

Part 2: General HIV Testing Questions

1. When was the last time you were tested for HIV? (Circle your response)
   Never

   Less than 1 year ago

   Less than 5 years ago

   More than 5 years ago

2. If you have visited your usual doctor during the past 12 months, have you been asked if you wanted an HIV test? (Circle your response)

   No
   Yes
   I haven't visited my doctor in the last 12 months

3. How worried are you that people would find out if you were tested for HIV? (Circle your response)

   Not worried A little worried Worried Very worried

4. Do you think that you can catch HIV by getting tested for it? (Circle your response)

   Yes
   No

5. HIV testing should be a part of my regular check-up, like getting tested for cholesterol and other diseases. (Circle your response)

   Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

6. I would be upset if my doctor asked me if I wanted to be tested for HIV. (Circle your response)

   Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

7. Please circle your selection below that would complete this sentence for you.

   If my doctor asked if I wanted to be tested for HIV, I would…
   Definitely **not** go back to that doctor again
   Maybe not go back to that doctor again
   Not change anything about my visits to my doctor
   Definitely go back to that doctor again

8. How worried are you that you would be treated badly if you tested positive for HIV? (Circle your response)

A lot Somewhat Not at all

*****Instructions*****

If you have NOT had an HIV test before, go to Part 3 of this survey. If you HAVE had an HIV test, go to Part 4 of the survey.

Part 3: Questions for people who have NOT had an HIV test

1. I didn’t get an HIV test because I was afraid of what the results would be. (Circle your response)

   Strongly agree Somewhat agree Somewhat disagree Strongly disagree

2. I didn’t get an HIV test because I was afraid of being pricked by a needle. (Circle your response)

   Strongly agree Somewhat agree Somewhat disagree Strongly disagree

3. I didn’t get an HIV test because I was worried about the cost. (Circle your response)

   Strongly agree Somewhat agree Somewhat disagree Strongly disagree

4. I didn’t get an HIV test because I don’t think I’m at risk to get HIV. (Circle your response)

   Strongly agree Somewhat agree Somewhat disagree Strongly disagree

5. I didn’t get an HIV test because my doctor has not asked me if I wanted a test. (Circle your response)

   Strongly agree Somewhat agree Somewhat disagree Strongly Disagree

6. I would get tested for HIV at least once a year if I could get the test at my doctor’s office. (Circle your response)
   Yes
   No

7. I would get tested for HIV if it was free. (Circle your response)
   Yes
   No

Part 4: Questions for people who HAVE had an HIV test

1. I asked my doctor for an HIV test. (Circle your response)
   Yes
   No

2. When I asked my doctor for an HIV test, my doctor at first didn't want to do it. (Circle your response)

   Strongly agree Somewhat agree Somewhat disagree Strongly Disagree

3. My doctor asked me if I wanted to be tested for HIV. (Circle your response)

   Yes
   No

4. It was hard for me to find a place to get an HIV test. (Circle your response)

   Strongly agree Somewhat agree Somewhat disagree Strongly Disagree

5. Where were you tested for HIV? (Circle your response)

   at a clinic or health center
   at my doctor's office
   at the health department
   at a special testing event (like a health fair)
   other: ________________________________

THANK YOU FOR YOUR HELP ON THIS SURVEY!

Appendix C: Provider Survey

Arkansas HIV Testing Study: 2012 Provider Survey

Arkansas House Bill 2100 (passed in 2011) directs the Arkansas General Assembly House and Senate Committees on Public Health, Welfare, and Labor to study "barriers to HIV testing that contribute to the inability to reduce the incidence of HIV infection in Arkansas." To help inform the study, we are conducting this survey among health care providers in Arkansas, including providers who do not have any HIV-positive patients as well as those who specialize in providing services to persons living with HIV. All answers are anonymous. We value your perspective and opinions, and thank you for your participation!

Part 1: Demographic Information (we will *not* use this information in any way that could identify you)

What is the zip code where you practice? _______________

Please indicate which best describes your specialty:

a. Internal Medicine
b. Family Practice
c. Primary Care
d. Obstetrics / Gynecology
e. Pediatrics
f. HIV Provider
g. Other specialty: ________________________________

Approximately how many HIV/AIDS patients have you treated throughout your career?

None
Fewer than 10
11-50
51-100
More than 100

Please indicate what percentage of your patient population is the following race/ethnicity:

________White (non-Hispanic)

________Black or African American

________Asian

________Native Hawaiian or Other Pacific Islander

________American Indian or Alaska Native

________Marshallese

________Hispanic / Latino

________Other:___________________________

Part 2: General HIV Testing Questions

Which statement is closest to your opinion (circle one)

- HIV testing should be treated just like routine screening for any other disease and should be offered as part of regular check-ups and exams for all patients.

- Providers should only ask patients who are high-risk if they would like to be tested for HIV.

- Providers should never ask patients if they would like to be tested for HIV.

Which statement is closer to your opinion (circle one)

- HIV testing should be included as part of regular check-ups and exams for all patients, and should not require a separate written consent form signed by the patient in order to perform the test.

- HIV testing is special and should require special procedures, such as a separate written consent form signed by the patient, in order to perform the test.

Which statement is closer to your opinion (circle one)

- If a patient requests an HIV test, it should always be performed, even if the patient is not high-risk.

- HIV testing should only be performed if the patient is high-risk, even if the patient requests a test.

PLEASE CIRCLE ONE RESPONSE IN THE QUESTIONS BELOW:

- In the past, my patients have been offended or have been less likely to return to my practice when I asked them whether they would like an HIV test.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree Not Applicable

- I worry that asking my patients if they would like an HIV test would harm our provider-patient relationship or rapport.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

- Routine HIV testing as part of regular check-ups and exams for all patients is not appropriate for my practice, because, generally, my patients are not at risk for HIV infections.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

- Most of my patients refuse HIV testing when I offer it to them during their visit.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree Not Applicable

- Reimbursement rates are too low to make routine HIV testing as part of regular check-ups and exams for all patients feasible in my practice.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

- I do not have enough time during visits to perform routine HIV testing as part of regular check-ups and exams for all patients.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

- I feel confident in my ability to tell a patient that he or she has tested HIV positive.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

- I feel confident in my ability to counsel patients testing HIV positive about next steps for their treatment and my ability to connect them to appropriate resources.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

- My staff does not like to perform HIV testing or refuses to perform it.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

- I do not want to offer routine HIV testing as part of regular check-ups and exams for all patients because the billing procedure for HIV testing is too burdensome.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

- I do not need to provide HIV testing in my practice because my patients can be tested elsewhere.

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

The following factors put a patient at risk for HIV infection: (please circle your response to each factor)

Being of certain gender	☐ High Risk	☐ Some Risk	☐ No Risk Associated
Being of certain ethnicity / race	☐ High Risk	☐ Some Risk	☐ No Risk Associated
Where the patient lives	☐ High Risk	☐ Some Risk	☐ No Risk Associated
Low level of education	☐ High Risk	☐ Some Risk	☐ No Risk Associated
Low income	☐ High Risk	☐ Some Risk	☐ No Risk Associated
Alcohol use	☐ High Risk	☐ Some Risk	☐ No Risk Associated
Recreational drug use (non-IV)	☐ High Risk	☐ Some Risk	☐ No Risk Associated
Intravenous/injection drug use	☐ High Risk	☐ Some Risk	☐ No Risk Associated
Unprotected sex	☐ High Risk	☐ Some Risk	☐ No Risk Associated
Having had a blood transfusion	☐ High Risk	☐ Some Risk	☐ No Risk Associated
Having been in prison	☐ High Risk	☐ Some Risk	☐ No Risk Associated
Having multiple sex partners	☐ High Risk	☐ Some Risk	☐ No Risk Associated
Having bisexual sex partners	☐ High Risk	☐ Some Risk	☐ No Risk Associated
Positive STI/STD test	☐ High Risk	☐ Some Risk	☐ No Risk Associated
HIV positive family members	☐ High Risk	☐ Some Risk	☐ No Risk Associated

THANK YOU FOR YOUR HELP ON THIS SURVEY!

Appendix D: Guidelines for Volunteers Administering Patient Surveys

GUIDELINES FOR HB2100 VOLUNTEERS ADMINISTERING PATIENT SURVEYS

SCHEDULED SITE VISITS

- Site visits have been scheduled based on the information you provided regarding your availability for pre-selected sites within the Community Health Centers of Arkansas.
- Volunteers must be available to administer surveys for a full day to ensure an adequate sample of patients are surveyed (unless arrangements have been made with another volunteer to work shifts).
- In the event you will not be able to visit your assigned site, please contact Britni Mitchell **IMMEDIATELY** by email (Britni.mitchell@arkansas.gov) **AND** phone (direct: 501-683-4966, front desk: 501-686-2720) to allow adequate time to find another volunteer or reschedule with the clinic director.

If you would like to administer surveys at a clinic site or other location please contact Britni Mitchell.

BEFORE THE SITE VISIT

- I will contact you prior to your site visit.
- A packet will be prepared for you prior to your site visit. Your packet will include surveys, clinic address, and pertinent contact information.
- Packets can be picked up from the AMHC office or shipped to volunteers who are located out of town.

AT THE SITE VISIT

- When you arrive at the clinic, please sign in at the front desk
- Please be mindful to be respectful of the time and space of the staff and the facilities
- Please allow clients to sign in before requesting their participation in the survey

WHILE FACILITATING SURVEYS

- This study is utilizing a convenience sample; feel free to ask any patient if they would be willing to participate in the study
- Be sure to advise that the survey is completely anonymous
- It is not necessary to read the survey to participants unless requested or needed
- Pay attention to behaviors, and gently offer to help anyone who seems to be having trouble but not asking for assistance

- Make certain to read the survey precisely as written each time (i.e. [be consistent] and don't try to interpret or 'help' the patient answer the questions)
- If asked to define anything on the survey, only offer up a brief definition or example of that one word/thing

AFTER THE SITE VISIT

- Once you have completed your site visit, please place the completed and blank surveys in the pre-addressed shipping envelop provided or return to the office of the Arkansas Minority Health Commission
- For eligible volunteers, you will need to complete and submit a W-9 and TR-1 form to be reimbursed for travel. Mileage will be determined using Google Maps. These documents can be completed electronically or hard copy after the site visit.

If you have any questions or concerns, please contact:

Britni Mitchell, AMHC HIV Project Manager
britni.mitchell@arkansas.gov
501-683-4966

Appendix E: Focus Group Consent Form and Questions

Express Consent Statement

Arkansas HIV/AIDS Minority Taskforce
Arkansas HIV Testing Study Focus Group

The Arkansas House Committee on Public Health, Welfare and Labor and the Senate Committee on Public Health, Welfare and Labor has requested a study to examine ways to reduce the number of new cases of HIV in Arkansas. The purpose of this study is to understand the barriers to routine HIV testing at medical facilities. There are minimal risks expected from participation in this study. It is hoped that the information gained by this study will help describe the issues that may prevent people from receiving an HIV test at their health care facility.

If you participate in this focus group, questions will be asked about preferences regarding your HIV testing. It should take about one hour to complete the questions. You are free to skip any of the questions, and to end your participation at any time. Your name or the name of your program will not be written in the transcribed record. No identifying information will be used in the study report. The audio recording and transcribed record will be kept in a locked office accessible only to the researcher. The data will be kept for three years and then be destroyed.

Your participation in this study is completely voluntary. You have the right not to participate if you so desire, to refuse to discuss issues if you prefer, and to stop at any time from continuing once the questionnaire has begun. There will be no cost to you for participating in this focus group. You will receive a $20 Wal-Mart gift card for participating in this study.

The contact for this study is Britni Mitchell, HIV Outreach Initiatives Project Manager for the Arkansas Minority Health Commission. If you have any questions or concerns, please feel free to contact her at (501) 683-4966.

1) Are you willing to participate in this focus group?
   Yes _______ No ______

2) Are you willing to keep all information discussed during this focus group confidential?
   Yes _______ No ______

3) I have read the terms of this statement and give my express consent as a voluntary participant.
   Yes _______ No ______

____

Print Name

____

Signature Date

Arkansas HIV/AIDS Minority Taskforce

Arkansas HIV Testing Study
Focus Group
August 4, 2012

We are trying to find out more about what people in Arkansas think about HIV testing. We would like to know what you think. All your answers are anonymous – we will not know who you are. The results of the study will be published; however, your name and/or any other identification will not be revealed. To maintain your privacy, a number will be assigned in place of your identification and will be used to identify all of data collected in reference to your participation (notes, transcripts, etc.). Thank you for your help.

1. What do you know about HIV?
2. Do you understand the difference between HIV and AIDS? If so, what is it?
3. What are some of the ways that people can get HIV?
4. If you wanted to get an HIV test, where would you go?
5. How often do you think someone would need to be tested for HIV?
6. What would cause you to decide to get an HIV test?
7. How often do you go to the doctor?
8. How many of you know someone who has been affected by HIV?
9. Did you learn anything from this person(s) experience or stories that may be shared?
10. From where or from whom do you get information about health?
11. Who do you feel needs to communicate information about HIV to the community?
12. Should HIV testing be a part of your regular check-up, like getting tested for cholesterol and other diseases? Please explain why.

13. Have you ever taken an HIV test? If not, why?

14. What do you believe are some reasons why people do not get tested for HIV in Arkansas?

15. Has your physician ever asked you if you would like an HIV test without you first mentioning it to him or her?

16. How can medical professionals be encouraged to recognize the importance of routine testing for HIV?

17. How can faith-based and community-based organizations be encouraged to recognize the importance of and assist with increased HIV routine testing?

18. Is there anything else that you would like for us to know about HIV in the community?

Appendix F: Sampling Justification

Arkansas HIV Testing Study: 2012 Patient Survey Sampling

Selecting Community Health Center (CHC) clinic locations for the administration of Arkansas HIV Testing Study: 2012 Survey:

Step 1: All Arkansas Department of Health Public Health Regions (ADH Regions) were considered for the survey

Step 2: A distribution list of CHC clinics by ADH Region was created

Step 3: Due to limited time/resource and lack of centralized electronic clinic data, the survey was decided to be administered in two clinic locations within each ADH Region instead of all 75 clinic locations.

Step 3A: Using U.S. Census data, the race/ethnicity distribution of the population of each city was reviewed, where the clinic was located

Step 3B: Using U.S. Census data, the race/ethnicity distribution of the population of each County was reviewed, where the clinic was located*

Step 3C: The final selection was based on the city/county of the clinic where the proportion of African American was comparatively higher than other city/county.

**The process helped deselect clinics, if there were more than two in the same city/county.*

Step 3C was justified by the fact that HIV/AIDS morbidity/mortality rates are much higher in AA compared to any other race or ethnic group in Arkansas.

Step 4: In the Northwest Region, selection of clinic location was designed to capture a better sample of Marshallese and / or Hispanic patient population.

Step 5: In the Northeast Region, selection of clinic location was designed to capture a better sample of Hispanic patient population.

List of CHC clinics to be sampled

Northwest Region:

- Community Clinic Rogers Medical – Benton
- Green Forest - Carroll

Northeast Region:

- East Arkansas Family Health Center – Crittenden
- Parkin Medical Clinic - Cross

Central Region:

- England Health Center – Lonoke
- College Station Health Clinic - Pulaski

Southwest Region:

- CABUN Rural Health Services - Calhoun
- Hope Migrant/Community Health Center - Hempstead

Southeast Region:

- Eudora Medical Clinic - Chicot
- Lake View Area Clinic - Phillips

REFERENCES

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[1] Gary Marks, et al., *Estimating sexual transmission of HIV from persons who are unaware and aware that they are infected with the virus in the USA* (2006), 20 AIDS 1447.

[2] National Institutes of Health press release, *HIV study named Breakthrough of the Year by Science*, December 22, 2011, http://www.nih.gov/news/health/dec2011/niaid-22.htm (accessed December 7, 2012).

[3] Centers for Disease Control and Prevention, HIV in the United States: An Overview, March 2012, http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/pdf/HIV_overview_2012.pdf (accessed December 7, 2012).

[4] Centers for Disease Control and Prevention, HIV in the United States: An Overview, March 2012, http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/pdf/HIV_overview_2012.pdf (accessed December 7, 2012).

[5] Ark. State Legislature, House Bill 2100 (2011), http://www.arkleg.state.ar.us/assembly/2011/2011R/Bills/HB2100.pdf (*last visited* Sept. 19, 2012) [hereinafter H.B. 2100].
[6] H.B. 2100 at § 1(a).

[7] Dr. Michelle Smith, Arkansas Department of Health, Electronic mail correspondence, December 11, 2012. Data source: eHARS (accessed November 27, 2012).

[8] Centers for Disease Control and Prevention, HIV in the United States: An Overview, March 2012, http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/pdf/HIV_overview_2012.pdf (accessed December 7, 2012).

[9] Ark. Dep't of Health, Arkansas HIV Annual Report—2011, 8, *available at* http://www.healthy.arkansas.gov/programsServices/healthStatistics/Documents/STDSurveillance/HIVAIDSAnnualReport.pdf (*last visited* Sept. 19, 2012).

[10] United States Census Bureau, Arkansas, http://quickfacts.census.gov/qfd/states/05000.html (accessed Sept. 19, 2012).

[11] Ark. Dep't of Health, 2009-2010 Arkansas Statewide Coordinated Statement of Need & Comprehensive Plan, http://www.healthy.arkansas.gov/programsServices/infectiousDisease/hivStdHepatitisC/Documents/HIVAIDSServicesPlanning.pdf.

[12] Ark. Dep't of Health, HIV/AIDS Quarterly Report (June 30, 2009), www.healthyarkansas.com/stats/hiv_aids/2nd_QTR_2009_HIV-MORB-REPORT_.pdf.

[13] H.B. 2100 at § 1(e).

[14] U.S. Preventive Services Task Force, Screening for HIV: U.S. Preventive Services Task Force Recommendation Statement DRAFT (Nov. 20, 2012), http://www.uspreventiveservicestaskforce.org/draftrec.htm.

[15] U.S. Preventive Services Task Force, Screening for HIV: U.S. Preventive Services Task Force Recommendation Statement DRAFT (Nov. 20, 2012), http://www.uspreventiveservicestaskforce.org/draftrec.htm.

[16] Bernard M. Branson et al, *Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings* (2006), 55 MMWR Recomm. Rep.,

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[17] DEP'T OF HEALTH AND HUMAN SERVS., U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATIONS, http://www.healthcare.gov/law/resources/regulations/prevention/taskforce.html (*last visited* Dec. 7, 2012).

[18] Michelle Andrews, *Health Law Expands Medicare Coverage of Preventive Care*, KAISER HEALTH NEWS, August 10, 2010, http://www.kaiserhealthnews.org/features/insuring-your-health/health-law-expands-medicare-preventive-care-coverage.aspx (accessed December 9, 2012).

[19] Thomas A. Peterman, et al., *Opportunities for targeting publicly funded human immunodeficiency virus counseling and testing* (1996), 12 J. OF ACQUIRED IMMUNE DEFICIENCY SYNDROME HUMAN RETROVIROL. 694.

[20] GUTTMACHER INSTITUTE, *State Policies In Brief: Minors' Access to STI Services*, December 1, 2012, available at http://www.guttmacher.org/statecenter/spibs/spib_MASS.pdf (accessed December 10, 2012).

[21] Ark. Code Ann. §20-16-508.

[22] Ark. Code Ann. §20-16-508(a)(2).

[23] GUTTMACHER INSTITUTE, *State Policies In Brief: Minors' Access to STI Services*, December 1, 2012, available at http://www.guttmacher.org/statecenter/spibs/spib_MASS.pdf (accessed December 10, 2012).

[24] Bernard M. Branson et al, *Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings* (2006), 55 MMWR RECOMM. REP..

[25] Bernard M. Branson et al, *Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings* (2006), 55 MMWR RECOMM. REP..

[26] Ark. Code Ann. §20-16-508(b).

[27] GUTTMACHER INSTITUTE, *State Policies In Brief: Minors' Access to STI Services*, December 1, 2012, available at http://www.guttmacher.org/statecenter/spibs/spib_MASS.pdf (accessed December 10, 2012).

[28] Ark. Code Ann. §20-16-508(b)

[29] Bernard M. Branson et al, *Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings* (2006), 55 MMWR RECOMM. REP, AMERICAN ACADEMY OF PEDIATRICS COMMITTEE ON PEDIATRIC AIDS AND COMMITTEE ON ADOLESCENCE, *Adolescents and Human Immunodeficiency Virus Infection: The Role of the Pediatrician in Prevention and Intervention*, PEDIATRICS Vol. 107 No. 1 at 188-89 (January 2001), available at http://pediatrics.aappublications.org/content/107/1/188.short.

[30] National HIV/AIDS Clinicians' Consultation Center at San Francisco General Hospital, Compendium of State HIV Testing Laws: Arkansas, April 8, 2011.

[31] Ark. Code Ann. §20-15-905(c)(1).

[32] Ark. Code Ann. §20-15-905(d).

[33] Bernard M. Branson et al, *Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings* (2006), 55 MMWR RECOMM. REP..

[34] Bernard M. Branson et al, *Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings* (2006), 55 MMWR RECOMM. REP.

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[35] Bernard M. Branson et al, *Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings* (2006), 55 MMWR RECOMM. REP.

[36] Bernard M. Branson et al, *Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings* (2006), 55 MMWR RECOMM. REP.

[37] Delta Region AIDS Education and Training Center website, http://www.deltaaetc.org/default.htm.

[38] Thomas A. Peterman, et al., *Opportunities for targeting publicly funded human immunodeficiency virus counseling and testing* (1996), 12 J. OF ACQUIRED IMMUNE DEFICIENCY SYNDROME HUMAN RETROVIROL. 694.

[39] Okla. Stat. Ann. tit. 63 §2602(A)(3).

[40] Del. Code Ann. tit. 13 §710(c).

[41] Wash. Rev. Code Ann §70.24.325; R.I. Gen. Laws Ann §23-6.3-3.