Rapid HIV Testing in the Dental Setting

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WELCOME

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REMINDERS

Complete and turn in at end of presentation:
– Sign in sheet
– Participant Information Form (PIF)
– Evaluation form
Oral Health Preceptorships

- **Audience:** Dentist and Hygienists
- **Venue:** New York City and Buffalo
- **Duration:** 1 day up to 5 days
- **CDE/CEU:** Provided
- **Cost:** None
- **Enroll:** Howard Lavigne
  315-477-8479
HIV Infection

Synopsis

- Definition
- Targets
- Demographics
- Globalization
Early in the AIDS pandemic, laboratory tests were developed with a primary purpose of protecting the nation’s blood supply.

At that time the risk of HIV infection through transfusion was approximately 1 in 100. Estimates in 2004 placed the risk at approximately 1 in 1.9 million.
HIV Epidemic vs. Pandemic

- **Epidemic**: disease in a specific location, a city, town, school, cruise ship.

- **Pandemic**: world-wide spread of disease.
AIDS Definition

- An individual is diagnosed with AIDS if signs or symptoms from CDC defined Clinical Category C are present.
- CD4 cell count is below 200 cells.
Lifetime Cost of HIV Care in the US in the Current Treatment Era

$500,000

B R Schackman, et al Abstract, 3rd IAS Conference
HIV Incidence

Since 1999, HIV infections have remained steady at 40-45,000/year

CDC HIV/AIDS Surveillance Report
Adults And Children Estimated To Be Living With HIV, 2007

North America
1.3 million
[480 000 – 1.9 million]

Caribbean
230 000
[210 000 – 270 000]

Latin America
1.6 million
[1.4 – 1.9 million]

Western & Central Europe
760 000
[600 000 – 1.1 million]

Eastern Europe & Central Asia
1.6 million
[1.2 – 2.1 million]

Middle East & North Africa
380 000
[270 000 – 500 000]

Sub-Saharan Africa
22.5 million
[20.9 – 24.3 million]

East Asia
800 000
[620 000 – 960 000]

South & South-East Asia
4.0 million
[3.3 – 5.1 million]

Caribbean
230 000
[210 000 – 270 000]

Oceania
75 000
[53 000 – 120 000]

Total: 33.2 (30.6 – 36.1) million
Proportion of Population Living with HIV/AIDS
NYC, per 100,000 Pop., by UHF Neighborhood, 2002

- 0.11% - 0.30%
- 0.31% - 0.68%
- 0.69% - 1.48%
- 1.49% - 3.61%
Death Rate Among New Yorkers Living with HIV/AIDS by UHF Neighborhood, per 1,000 PLWHA, 2002

- 14.8 - 20.6
- 20.7 - 31.7
- 31.8 - 40.4
- 40.5 - 55.6
Prevention vs. Treatment

- Structure of US health system favors treatment over prevention
- Access to healthcare is tied to labor market and not citizenship
- Our for-profit health system favors treatment over prevention
  - More profits are generated when people are *ill* as opposed to when they are *well*
Improve HIV Detection

- Normalize HIV Testing
  - outpatient and inpatient settings
- Increase detection of persons in acute HIV infection (AHI)
- Use pooled plasma viral load testing (PPLVT) in high risk settings, i.e. STD clinics
Immune Suppression and Increasing Risk of Opportunistic Infections
Source of HIV Tests and Positive Tests

- 38% - 44% of adults age 18-64 have been tested
- 16-22 million persons age 18-64 tested annually in U.S.

<table>
<thead>
<tr>
<th>Source</th>
<th>HIV tests*</th>
<th>HIV+ tests**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private doctor/HMO</td>
<td>44%</td>
<td>17%</td>
</tr>
<tr>
<td>Hospital, ED, Outpatient</td>
<td>22%</td>
<td>27%</td>
</tr>
<tr>
<td>Community clinic (public)</td>
<td>9%</td>
<td>21%</td>
</tr>
<tr>
<td>HIV counseling/testing</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>Correctional facility</td>
<td>0.6%</td>
<td>5%</td>
</tr>
<tr>
<td>STD clinic</td>
<td>0.1%</td>
<td>6%</td>
</tr>
<tr>
<td>Drug treatment clinic</td>
<td>0.7%</td>
<td>2%</td>
</tr>
</tbody>
</table>

*National Health Interview Survey, 2002
**Suppl. to HIV/AIDS surveillance, 2000-2003
### HIV Prevalence and Proportion of Unrecognized HIV Infection Among 1,767 MSM, by Age Group and Race/Ethnicity

**NHBS, Baltimore, LA, Miami, NYC, San Francisco**

<table>
<thead>
<tr>
<th>Age Group (yrs)</th>
<th>Total Tested</th>
<th>HIV Prevalence</th>
<th>Unrecognized HIV Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>18-24</td>
<td>410</td>
<td>57 (14)</td>
<td>45</td>
</tr>
<tr>
<td>25-29</td>
<td>303</td>
<td>53 (17)</td>
<td>37</td>
</tr>
<tr>
<td>30-39</td>
<td>585</td>
<td>171 (29)</td>
<td>83</td>
</tr>
<tr>
<td>40-49</td>
<td>367</td>
<td>137 (37)</td>
<td>41</td>
</tr>
<tr>
<td>≥ 50</td>
<td>102</td>
<td>32 (31)</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Total Tested</th>
<th>HIV Prevalence</th>
<th>Unrecognized HIV Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>White</td>
<td>616</td>
<td>127 (21)</td>
<td>23</td>
</tr>
<tr>
<td>Black</td>
<td>444</td>
<td>206 (46)</td>
<td>139</td>
</tr>
<tr>
<td>Hispanic</td>
<td>466</td>
<td>80 (17)</td>
<td>38</td>
</tr>
<tr>
<td>Multiracial</td>
<td>86</td>
<td>16 (19)</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>139</td>
<td>18 (13)</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>1,767</td>
<td>450 (25)</td>
<td>217</td>
</tr>
</tbody>
</table>

**MMWR June 24, 2005**
Estimated New HIV Infections, 2006, Overall and by Gender

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>56,300</td>
</tr>
<tr>
<td>Male</td>
<td>41,400</td>
</tr>
<tr>
<td>Female</td>
<td>15,000</td>
</tr>
</tbody>
</table>

Note: Estimates from subgroups do not add to total due to rounding.

Source: Centers for Disease Control and Prevention
Estimated Rates of New HIV Infections, 2006, by Race/Ethnicity

- Black:
- Hispanic:
- White:
- American Indian/Alaska Native:
- Asian/Pacific Islander:

Cases per 100,000 population

Source: Centers for Disease Control and Prevention
Estimated New HIV Infections, 2006, by Transmission Category

- 53% MSM
- 31% Heterosexual
- 12% IDU
- 4% MSM-IDU

Source: Centers for Disease Control and Prevention
The number of people living with AIDS has more than tripled since the early 1990s.

People living with AIDS at year end

People Living with HIV (non-AIDS) at year end

Annual number of deaths among reported cases

Number diagnosed each year with AIDS

*Data as of February 2007
^ HIV named reporting began in NYS in 2000

Adapted from NYSDOH/BHAE
Awareness of Serostatus Among People with HIV and Estimates of Transmission

~25% Unaware of Infection

~75% Aware of Infection

accounting for:

~54% of New Infections

~46% of New Infections

People Living with HIV/AIDS: 1,039,000-1,185,000

New Sexual Infections Each Year: ~32,000

Marks, et al
AIDS 2006;20:1447-50

CDC
Rapid Testing
Although the success of treatment depends, in part, on timely diagnosis of an HIV infection; HIV treatment with the combination of highly active antiretroviral therapy (HAART), and the improved management of opportunistic infections has markedly improved HIV survival rates. According to CDC data in 2005, 38% of people with AIDS had their initial positive HIV test less than one year before their AIDS diagnosis. In the HAART era, it is more important than ever to diagnose HIV disease earlier, so effective treatment can be provided.
What are we looking for?

- HIV-1
  - Groups M, N, O
  - 11+ subtypes (clades) in group M
  - Subtype B in US and western Europe

- HIV-2
Diagnostic Testing

- ELISA
- Western blot
## Four FDA-approved Rapid HIV Tests

<table>
<thead>
<tr>
<th>Test Description</th>
<th>Sensitivity (95% C.I.)</th>
<th>Specificity (95% C.I.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OraQuick Advance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- whole blood</td>
<td>99.6 (98.5 - 99.9)</td>
<td>100 (99.7 - 100)</td>
</tr>
<tr>
<td>- oral fluid</td>
<td>99.3 (98.4 - 99.7)</td>
<td>99.8 (99.6 - 99.9)</td>
</tr>
<tr>
<td>- plasma</td>
<td>99.6 (98.5 - 99.9)</td>
<td>99.9 (99.6 - 99.9)</td>
</tr>
<tr>
<td><strong>Uni-Gold</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recombigen</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- whole blood</td>
<td>100 (99.5 - 100)</td>
<td>99.7 (99.0 - 100)</td>
</tr>
<tr>
<td>- serum/plasma</td>
<td>100 (99.5 - 100)</td>
<td>99.8 (99.3 - 100)</td>
</tr>
</tbody>
</table>
Four FDA-approved Rapid HIV Tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Sensitivity (95% C.I.)</th>
<th>Specificity (95% C.I.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reveal G2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>serum</td>
<td>99.8 (99.2 – 100)</td>
<td>99.1 (98.8 – 99.4)</td>
</tr>
<tr>
<td>plasma</td>
<td>99.8 (99.0 – 100)</td>
<td>98.6 (98.4 – 98.8)</td>
</tr>
<tr>
<td><strong>Multispot</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>serum/plasma</td>
<td>100 (99.9 – 100)</td>
<td>99.9 (99.8 – 100)</td>
</tr>
<tr>
<td>HIV-2</td>
<td>100 (99.7 – 100)</td>
<td></td>
</tr>
</tbody>
</table>
Confirmatory Testing

- Confirmatory test is essential (not just EIA)
- For Western blot:
  - Venipuncture for whole blood
  - Oral fluid specimen
- Follow-up testing of persons with negative or indeterminate Western blot results after 4 weeks
Rapid Testing

- OraQuick
  - 99% sensitive/specific
  - Fingerstick, oral swab
  - Results available as soon as 20 minutes
  - Needs confirmation with Western blot if positive
  - Informed consenting process the same

- CLIA-waived test

- Not for known HIV-infected pts on HAART

- Unavailability of rapid test result should not delay initiation of PEP
OraQuick Advance
Interpretation of Rapid HIV Tests

Interpretation of rapid HIV tests is the same as other, conventional HIV screening tests.

- A negative result from a single test is interpreted as being negative. However, if a person is at risk of having been exposed to HIV within three months of the test, a repeat test at a later time is recommended.

- A positive (or reactive) result is considered to be a preliminary positive test result. This must be confirmed using a Western blot, an immunofluorescence assay (IFA). This confirmatory testing should be done as soon as possible.

- If the rapid HIV test is a preliminary positive and the confirmatory test is negative (discrepant results) both the rapid HIV test and the confirmatory test should be repeated. A consultation with an infectious disease specialist is recommended. If the rapid HIV test does not provide a valid test result, most likely the test kit did not work properly and the rapid HIV test should be repeated.
Counseling Patients with a Negative Rapid HIV Test

Patients whose rapid HIV test result is negative can be told that they are not infected, unless they have had a recent (within 3 months) known or possible exposure to HIV. Retesting should be recommended for these patients because sufficient time needs to elapse in order for development of the antibodies that are detected by the test.
Counseling

Counseling Patients with a Preliminary Positive Rapid HIV Test

- Confirmatory testing is always required to confirm a reactive rapid HIV test result. The challenge is providing reactive (preliminary positive) results to patients without the benefit of a same-day confirmatory test.

- For all patients with a reactive rapid HIV test result, however, it is essential to:
  - Explain that this is a preliminary test result that needs to be confirmed.
  - Emphasize the importance of confirmatory testing and schedule a return visit for the confirmatory test results.

- Underscore the importance of taking precautions to avoid the possibility of transmitting infection to others while awaiting results of confirmatory testing.
NYC DOHMH reports higher false positive rate with OraQuick Advance Oral Rapid HIV-1/2 Ab tests
  – Clusters from late 2005, and late 2007 through May, 2008
  – False + rate exceeded that expected from manufacturer
  – March 2005 – May 2008, rate was 0.27%, within the manufacturer’s limits overall

FDA requires 98% specificity (testing negative if you don’t have the disease)

MMWR 57(early release) 1-5; June 18, 2008.
There is no reason to change testing policies or stop using oral fluid rapid tests.

Routine monitoring of rapid testing and a review of false positive rates should be in place.

Patients/clients should be informed of the strengths and limitations of oral fluid rapid tests.

All reactive rapid tests results require confirmatory testing.

Humberto Cruz; NY State DOH AIDS Institute, 6/08.
Before you begin:  
Hurdles

- Ensure tight QA protocol is in place
- Validate every new box of kits
- Run controls every day as specified by your protocol.
- Calibrate thermometers/timers
- Train only a small group of diligent testers
- Competency assessment for testers twice a year
- Implement proficiency testing
- Zero tolerance for poor documentation
Best Practices

- Cost
  - Regulatory requirements
- Management
  - Physical requirements
- Personnel
  - Personnel training
  - Competency Assessment
- Policy & Procedure

Before Implementation
Best practices—During testing

- Check for supplies
- Testing Area
- Quality Control
- Documentation
- Confirmatory test
- Corrective action
- Adhere to the manufacturer’s instructions
- Follow up
HIV Counseling and Testing should be streamlined by offering written materials and an opportunity for questions.

Written informed consent is required for testing. CDC recommends the "opt-out" model where the patient is informed that testing will be performed unless he/she declines. However, in NYS written informed consent is still required by public health law.

Post-test counseling for people who test HIV positive including partner notification services and prompt referral for evaluation of their clinical status and consideration for antiretroviral therapy.

Post-test counseling for patients who test HIV negative. Both CDC and NYC recommend that people who test HIV negative be informed of the meaning of their test result and that high risk individuals should be referred for prevention services. In NYS, post-test counseling for a negative HIV test can be streamlined. A simple one page patient handout is available.
Important Phone Numbers

New York State HIV/AIDS Hotlines (toll-free)
Call the Hotlines for information about HIV and AIDS and to find HIV testing sites
- 1-800-541-AIDS (2437) • English
- 1-800-233-SIDA (7432) • Spanish

New York State TTY/TTD HIV/AIDS Information Line
- 1-212-925-9560
Voice callers use the TTY relay:
711 or 1-800-421-1220 and ask the operator for: 1-212-925-9560

New York State HIV/AIDS Counseling Hotline
- 1-800-872-2777

NYSDOH Anonymous HIV Counseling and Testing Program
For HIV information, referrals, or information on how to get a free, anonymous HIV test, call the Anonymous HIV Counseling and Testing Programs.
- Albany Region 1-800-962-5065
- Buffalo Region 1-800-962-5064
- Nassau Region 1-800-462-5095
- New Rochelle Region 1-800-926-0004
- Queens Region 1-800-962-4785
- Rochester Region 1-800-962-5063
- Suffolk Region 1-800-462-6176
- Syracuse Region 1-800-562-5423

NYCDOHMH HIV/AIDS Hotline: 1-800-TALK-HIV (1-800-825-5446)

New York State Partner Assistance Program: 1-800-541-AIDS

New York City Contact Notification Assistance Program: 1-212-693-1419

Confidentiality
- New York State Confidentiality Hotline 1-800-962-5065
- Legal Action Center 1-212-243-1313 or 1-800-223-4044

Human Rights/Discrimination
- New York State Division of Human Rights 1-800-522-2437
- New York City Commission on Human Rights 1-212-306-7500

NEW YORK STATE DEPARTMENT OF HEALTH
AIDS Institute

Informed Consent to Perform HIV Testing

HIV testing is voluntary. Consent can be withdrawn at any time by informing your provider. Please read Parts A and B of this form, and sign at the bottom of Part B, if you understand the following information and want HIV testing.

HIV infection is a serious health concern. The New York State Department of Health recommends HIV testing. For pregnant women, the Department recommends HIV testing early in pregnancy and again late in pregnancy.

Except for expedited HIV testing on labor units, this form replaces other HIV testing consent forms as of June 1, 2005.

NOTE: this form is intended to be used in conjunction with DOH-2356, Part B.

Part A
HIV is the virus that causes AIDS.

- HIV is passed from one person to another during unprotected sex (vaginal, anal, or oral sex without a condom) with someone who has HIV.
- HIV is passed through contact with blood as in sharing needles (piercing, tattooing, or injecting drugs of any kind) or sharing works with a person who has HIV.

The only way to know if you have HIV is to be tested.

- HIV tests are safe. They involve collecting one or more specimens (blood, oral fluid, urine).
- Your counselor or doctor will explain your test result as well as any other tests you may need.

Your HIV test today includes:

- A test to see if you have HIV infection (an antibody test or a test for the virus);
- If you are HIV positive, additional tests may include tests to:
  - help your doctor decide the best treatment for you;
  - help guide the health department with HIV prevention programs.

Several testing options are available:

- You can choose to have a confidential test where the result becomes part of your medical record and can be given to your health care provider for HIV and other health care services, or
- You can choose to have an anonymous test, which means that you don’t give your name and no record is kept of the test result. If your anonymous test is HIV-positive, you can choose to give your name later so you can get medical care more quickly.
- To get more information about options for testing and for confidential testing sites, ask your counselor/doctor or call 1-800-541-AIDS.

HIV testing is important for your health.

- If your test result is negative, you can learn how to protect yourself from being infected in the future.
- If your test result is positive:
  - You can take steps to prevent passing the virus to others.
  - You can receive treatment for HIV and learn about other ways to stay healthy. As part of treatment, additional tests will be done to determine the best treatment for you. These tests may include viral load and viral resistance tests.

HIV testing is especially important for pregnant women.

- An infected mother can pass HIV to her child during pregnancy or birth or through breastfeeding.
- It is much better to know your HIV status before or early in pregnancy so you can make important decisions about your own health and the health of your baby.
- If you are pregnant and have HIV, treatment is available for your own health and to prevent passing HIV to your baby. If you have HIV and do not get treatment, the chance of passing HIV to your baby is one in four. If you get treatment, your chance of passing HIV to your baby is much lower.
- If you are not tested during pregnancy, your provider will recommend testing when you are in labor. In all cases, your baby will be tested after birth. A positive test on your baby means that you have HIV and your baby has been exposed to the virus.

If your test positive:

State law protects the confidentiality of your test results and also protects you from discrimination based on your HIV status.

- In almost all cases, you will be asked to give written approval before your HIV test result can be shared.
- Your HIV information can be released to health providers caring for you or your exposed child; to health officials when required by law; to insurers to permit payment; to persons involved in foster care or adoption; to official correctional, probation and parole staff; to emergency or health care staff who are accidentally exposed to your blood; or by special court order.
- The names of persons with HIV are reported to the State Health Department for tracking the epidemic and for planning services.
- The HIV Confidentiality Hotline at 1-888-963-5065 can answer your questions and help with confidentiality problems.
- The New York State Division of Human Rights at 1-800-529-2437 can help you if you think you’ve been discriminated against based on your HIV status.

Your counselor/doctor will talk with you about notifying your sex or needle-sharing partners of possible exposure to HIV.

- Your partners need to know that they may have been exposed to HIV so they can be tested and get treated if they have HIV.
- If your health care provider knows the name of your spouse or partner, he or she must report the name to the health department.
- Health department counselors can help notify your partner(s) without ever telling them your name.
- To ensure your safety, your counselor or doctor will ask you questions about the risk of domestic violence for each partner to be notified.
- If there is any risk, the Health department will not notify partners right away and will assist you in getting help.
Informed Consent to Perform HIV Testing

My health care provider has answered any questions I have regarding HIV testing and has given me written information with the following details about HIV testing:

- HIV is the virus that causes AIDS.
- The only way to know if you have HIV is to be tested.
- HIV testing is important for your health, especially for pregnant women.
- HIV testing is voluntary. Consent can be withdrawn at any time.
- Several testing options are available, including anonymous and confidential.
- State law protects the confidentiality of test results and also protects test subjects from discrimination based on HIV status.
- My health care provider will talk with me about notifying my sex or needle-sharing partners of possible exposure, if I test positive.

I agree to testing for the diagnosis of HIV infection. If I am found to have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

For pregnant women only:
In addition to the testing described above, I authorize my health care provider to repeat HIV diagnostic testing later in this pregnancy. I understand that my health care provider will discuss this testing with me before the test is repeated and will provide me with the test results. The consent to repeat diagnostic testing is limited to the course of my current pregnancy and can be withdrawn at any time.

Signature: ____________________________ Date: __________

(Tests subject or legally authorized representative)

If legal representative, indicate relationship to subject: ____________________________

Printed Name: ____________________________

Medical Record #: ____________________________

Except for expedited HIV testing on labor units, this form replaces other HIV testing consent forms as of June 1, 2005.

NOTE: this form is intended to be used in conjunction with DOM-2556, Part A.
DOM-2556 (505)
Forgotten HIV Test

- 40,000 new cases of HIV infection per year in the United States
- 250,000 of those infected not aware of status
- CDC recommends that every patient aged 13-64 should be offered an HIV test.
- Very few healthcare settings are offering routine HIV testing
Forgotten HIV Test

Barriers
- Time
- Knowledge of Counseling and Testing Procedures
- Protocol (paperwork needed, processing of paperwork, logistics of testing)
- Experience providing a positive test result
- Follow-up concerns
- Provider’s knowledge of HIV disease
- Financial
Exceptionalism

- 40 percent of those with newly diagnosed AIDS discover their infection less than 1 year before diagnosis.
- CDC has extended routine testing to the entire population.
- Patients would be told that HIV testing was a part of routine care and given the opportunity to opt out.
- NOT OPTION IN NEW YORK STATE, yet.
2006 CDC Recommendations

In September of 2006, the Centers for Disease Control revised their recommendations for HIV testing in Health-Care Settings.

The objectives of these recommendations are intended for “all health-care providers”.

– increase HIV screening of patients
– foster earlier detection of HIV infection
– identify and counsel persons with unrecognized HIV infection
– link patients to clinical care services; and therefore reduce transmission of HIV in the United States.
2006 CDC Recommendations

- HIV infection is consistent with all generally accepted criteria that justify screening.
  - HIV infection is a serious health disorder that can be diagnosed before symptoms develop.
  - HIV can be detected by reliable, inexpensive, and non-invasive screening tests.
  - Infected patients have years of life to gain if treatment is initiated early, before symptoms develop; and
  - The costs of screening are reasonable in relation to the anticipated benefits.
It is known that routine HIV testing reduces the stigma associated with testing that requires assessment of “risk behaviors”.

A substantial number of people do not perceive that they themselves are at risk for HIV.

According to the CDC, more patients accept recommended HIV testing when it is offered routinely to everyone; not just those perceived to be at high risk.
Consent and provision of pre-test information are also addressed in the September 2006 CDC recommendations. Screening should be voluntary and done only with the patient's knowledge and understanding that HIV testing is planned. Patients should be informed orally or in writing that HIV testing will be performed unless they decline (opt-out screening). However, you need to check with the state and local laws and regulations to make sure that opt-out testing can be done in your jurisdiction.
New York University College of Dentistry HIV Screening Pilot

- There was no precedence for screening, counseling and testing of HIV disease in the dental school setting.
- New York University’s College of Dentistry was the first dental school in the United States to offer such a screening to its general patient population.
- At NYUCD, testing is done without a risk assessment and is offered to patients as a routine part of their health assessment. We are testing the “general population” and, in theory, we will identify more HIV infections earlier than they might otherwise have been.
New York University College of Dentistry HIV Screening Pilot

- Provides patients with a much-needed service.
- Provides students with clinical experience and introduces them to the emerging role “siaology” plays in the dental practice.
- NYUCD’s affiliations with the Schools of Nursing and Medicine will assure patients with newly identified HIV infection immediate access to clinical care.
Our revised protocol involves the NYUCD New Patient Admissions Clinic (Clinic 1A) for recruitment purposes.

Patients were informed of the research study and asked about their interest in participation by administrative staff during the registration process. The administrative staff described the study and routinely ask if the patient is interested in participating in this study.

If a patient expressed interest in participating in the study, the patient was assigned to a student in the routine manner for the NYUCD admissions process and the administrative staff informed the doctor of the potential subject. If the patient did not wish to consider participation in this study the routine dental exam proceeded as usual.
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- At the conclusion of the admissions procedures, the patient was escorted to a different clinic (1B).

- Clinic 1B has private rooms so that the study can be described and the potential subject’s questions answered in complete privacy. There was no discussion of the study, HIV testing or results other than in that room. The informed consent process, HIV pretest counseling and the oral HIV test will be done in the private room.

- In the event of a positive oral HIV test result, the subject will immediately be referred to the nurse practitioner for further counseling, serologic confirmation of the positive result and referral for medical care.
The patient will be informed that the results will be available in 20 minutes.

If the test result is negative, the patient will receive the New York State mandated post-test counseling in the same private room.

If the test result reads “preliminary positive”, the nurse practitioner on call will be summoned and made aware of the patient’s preliminary HIV status.

In the private room RN and doctor will conduct post test counseling. At this point confirmatory western blot testing will be done.

MD of Bellevue/New York University School of Medicine, Demetre Daskalakis, is available STAT via pager for immediate consult. MD will either walk over to the dental clinic or patient will be escorted to MD office for immediate visit.

At this time the patient will be offered the opportunity to schedule a future appointment for dental care so that he or she will not have a negative perception of the clinic (i.e., abandonment) and to maintain continuity of care.
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Research Questions

- The prevalence of HIV disease within the general dental school patient population. We are interested in the number of people asked to be in the study, the number who agree, and the number who refuse to be in the study.
- What percentage of patients coming to New York University College of Dentistry for a routine dental visit in our Admissions Clinic would be willing to undergo HIV testing?
- While patients are part of our pilot study, there will be no charge to them. In the future, we may have to charge our patients for testing. Therefore, by questionnaire, we will assess how much patients would be willing to pay for HIV testing?
- We will also assess the acceptability of HIV testing by patients and clinicians. This will be done by questionnaire.
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Phase I

– We asked about 270 people
– 80 people agreed to be tested
– Tested about 35 people
– Barriers
  - Logistics
  - Time
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Phase II

- Approximately 100 patients approached
- 99 patients agreed to be tested
- 99 patients tested
- Barriers
  - Time
Conclusion

- Changes in HIV testing recommendations, along with the increasing use of rapid, sensitive, and specific HIV screening technology is allowing better integration of HIV testing into routine clinical care.

- An advantage of rapid HIV testing is that more patients are receiving their results and are therefore able to act upon the information. Some of the newer EIA assays and NAAT testing shorten the window period between HIV infection and detection.

- As Oral Health Care Providers, we could increase the number of HIV infected people who know their status. Patients can then be referred earlier for treatment, prevention, and social services.
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