To the Editor—Universal screening for human immunodeficiency virus (HIV) is the standard of care in the United States [1] but remains largely an unfunded mandate. A number of studies explored universal screening in the setting of an emergency department [2–4], but this has not been studied as extensively in the setting of an outpatient clinic. Our goal was to assess the feasibility of a universal opt-in rapid HIV testing protocol in the Internal Medicine outpatient care clinic of the University of Illinois at Chicago. We measured the participation rate and relationship to demographic markers.

All patients were approached in the waiting area of the clinic and offered enrollment in the study, which included rapid HIV testing and a demographic survey. Patients who declined testing could participate by just filling out the survey. Only English-speaking patients aged >18 years were included. We used the INSTI-Test enzyme-linked immunosorbent assay (ELISA), based on a blood sample obtained by finger-stick. Testing and counseling were performed in private while patients were waiting for their appointments.

Of the 910 patients who were approached, 471 (52%) agreed to participate in the study. The mean age was 49.3 years (range: 18–89); 27% were male, 64% African American, 19% white, and 11% Hispanic. Three hundred forty-three (73%) of the enrolled patients opted to undergo HIV testing, yielding 337 negative tests, 4 indeterminate results due to inadequate samples and 2 positive results. Additionally, 134 enrolled patients declined testing and provided the reasons as illustrated in Figure 1.

Using χ² analysis, we determined that there was no statistically significant relationship between sex (P = .90), race (P = .21), or previous testing status (P = .56) and acceptance of testing. There was a statistically significant (P = .001) relationship between age and testing acceptance: those aged <30 years were more likely to accept testing compared with those aged 30–60 years (odds ratio [OR], 4.34; 95% confidence interval [CI], 1.02–183.44) or >60 years (OR, 19.95; 95% CI, 4.65–85.50) groups.

The main limitation of our study is the lack of data regarding the 439 patients who were approached but declined participation in the study. We were unable to formally ask these patients’ motives for refusal, but some of the reasons that were volunteered included hassle of filling out paperwork, and lack of financial incentive. Because patients were approached in the clinic waiting room, some refusals were likely due to embarrassment/stigma, which has been shown to be a significant barrier to HIV testing due to fear of repercussions of a positive result [5,6]. Better integration of testing into the clinic visit might facilitate acceptance of testing.

As shown above, younger age was significantly associated with willingness to undergo testing. Although more research is clearly needed, reducing barriers to universal testing may require more education to address stigma or embarrassment, involvement of the primary care provider in promoting testing as routine, and movement toward opt-out testing in primary care settings. Use of a rapid, finger-stick point-of-care ELISA HIV test did not present a significant barrier and was easily integrated into the milieu of an outpatient clinic, providing test results that could be addressed during the same visit.

Notes

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