The Centers for Disease Control and Prevention has made HIV antibody testing the centerpiece of its new HIV prevention initiative. A key component of this approach is the introduction of rapid HIV testing, in particular, the OraQuick test. While rapid testing offers many potential advantages to clients at testing venues, it requires a wide range of changes to existing HIV counseling and testing protocols. This issue of PERSPECTIVES describes the new testing process, now being piloted in California and several other states, and the challenges and opportunities it raises for both HIV prevention and care and for HIV antibody test counseling.

Research

The OraQuick Rapid HIV-1 Antibody Test is the first “rapid” test that is being disseminated by the Centers for Disease Control and Prevention for widespread use in publicly funded HIV counseling and testing venues. The test, which has been shown to be extremely accurate, was approved in 2003 by the U.S. Food and Drug Administration for use by non-clinical personnel outside of a traditional laboratory setting. This means that the entire antibody testing process, from obtaining a blood sample to disclosing the test result, can occur within 30 to 60 minutes in settings ranging from mobile test sites to corrections facilities to labor and delivery rooms. It also means that HIV antibody test counselors who are trained in single session counseling (which includes test kit operation training and testing) and have obtained “limited phlebotomy technician certification” may conduct rapid testing.

The rapid test has become the cornerstone of a new initiative launched by the CDC in April 2003. The goal of the initiative—a response to increasing numbers of new HIV infections—is to halve the number of new infections by the year 2005. To achieve this goal, the initiative seeks to increase detection of new infections, identify these cases more quickly, and link HIV-positive clients to services. California has taken the lead in implementing the OraQuick test. Other states, including Minnesota, New York, Oklahoma, and Florida, are undertaking pilot projects in various venues in an effort to develop the most effective protocols for use with the rapid test. The California Office of AIDS hopes to offer the rapid test in most settings in the state by the end of 2004.

The New CDC Prevention Initiative

Since 1998, the number of AIDS cases and deaths has remained stable after a substantial decline between 1995 and 1998, the years that triple combination antiviral treatment first became available. Between 1999 and 2001, the 25 states that currently report HIV infection statistics to the CDC uncovered increases in the number of new HIV infections of between 10 percent and 14 percent. The CDC also estimates that 25 percent of the people living with HIV in the United States are unaware of their HIV status. In some populations, this figure is much higher: for example, in an urban sample of young men who have sex with men who had tested HIV-positive as part of the study, 77 percent had not been aware of their status and a majority had believed that they were at low or no risk.

The CDC believes that rapid HIV testing can provide the cornerstone for new prevention efforts for several reasons. First, the CDC states that approximately 25 percent of those receiving HIV-positive test results at CDC-funded test sites did not return for their results. In addition, between 1994 and 1999, 41 percent of those receiving HIV-positive test results at CDC-funded test sites did not return for their results. In addition, between 1994 and 1999, 41 percent of those receiving HIV-positive test results at CDC-funded test sites did not return for their results. In addition, between 1994 and 1999, 41 percent of those diagnosed HIV-positive progressed to AIDS within one year, indicating they became aware of their serostatus late...
in the course of infection. In a sample of 7,236 individuals with a recent HIV diagnosis, 42 percent reported the reason for testing was illness. Only 10 percent to 17 percent reported testing because of the availability of testing or a recommendation to test by a health care provider. Earlier detection of infection, which the CDC asserts would be facilitated by rapid testing, would facilitate earlier and more effective treatment, greater treatment options, a delay in the onset of AIDS, and the adoption of preventive behaviors.

There are four major components to the CDC initiative. First, increase the availability of HIV testing as a routine part of medical care. Second, implement rapid testing in venues outside of medical settings, such as correctional facilities and community-based organizations; pilot projects in these settings are currently in process. Third, integrate prevention efforts into the primary care of people with HIV and increase rapid testing for partners identified through partner counseling and referral services (PCRS). PCRS entails the voluntary disclosure of the names and contact information of sexual and needle-sharing partners of people who test HIV-positive, followed by the notification of these individuals that they may have been exposed to HIV. Studies have shown that 8 percent to 39 percent of notified partners test HIV-positive.

Fourth, encourage the availability of rapid testing to women in labor and at delivery. Of the more than 6,000 HIV-positive mothers who gave birth in 2000, 40 percent had not known they were HIV-positive. The CDC estimates that identification of these women while in labor could reduce the number of perinatal transmissions by 50 percent through voluntary cesarean sections, introduction of HIV antiviral treatment, and reduced breast-feeding.

**Antibody Testing Technology**

The first HIV antibody test, the enzyme-linked immunosorbent assay (ELISA), became available in 1984 and was initially used for the screening of donated blood. In 1985, the CDC expanded this approach, making counseling and testing broadly available to individuals. But, the ELISA has an unacceptably high rate of “false positives,” results that inaccurately identified a client as HIV-positive. In response, the CDC required a second test—the Western blot or immunofluorescent assay—to confirm any HIV-positive ELISA result. This two-step process has necessitated a waiting period of between one to two weeks after a phlebotomist draws a blood sample before a client can receive results.

The two-session counseling protocol, still in use today, was developed in response to this waiting period. The initial session focuses on risk assessment, emphasizing a client’s understanding of HIV transmission, his or her level of risk, and the identification of interventions that might move them from one stage of behavior change to the next. The second session discloses the test result, assesses the effectiveness of the initial session’s interventions, identifies next steps, and provides resources and referrals.

Many people, however, do not return for their results after the waiting period, undermining both the risk reduction counseling benefit and the HIV screening benefit. For example, in California in 2001, about one-third of those testing in publicly funded settings and whose blood sample tested HIV-positive did not return for their results. In addition, both the ELISA and the Western blot test require refrigeration, expensive equipment, and a great deal of technical expertise to perform. This means that these tests have largely been limited to countries with significant health care resources. For all of these reasons, researchers have sought to develop tests that would be easier and cheaper to administer and would allow for quicker results. More than 60 rapid tests were developed throughout the 1980s and 1990s; however, the FDA has approved only three, only two of which are currently on the market.

In 1992, the FDA approved the Single Use Diagnostic System for HIV-1 (SUDS). While the SUDS test allows for rapid identification of HIV antibodies, it is complicated to administer. Blood specimens need to be centrifuged in order to separate the serum required for testing. The relative complexity of this procedure has meant that the SUDS test requires sophisticated equipment and more highly trained personnel. It is also less accurate than the ELISA.

In November 2002, the FDA approved the OraQuick test, which is more reliable and simpler to administer than the ELISA. In CDC clinical trials of the test, there was an accuracy rate of 99.9 percent for 780 tests. Further, OraQuick, which requires only a finger stick blood sample rather than a blood draw, is simple enough to administer that the U.S. Department of Health and Human Services granted the test a waiver under the Clinical Laboratory Improvement Amendments (CLIA) in January 2003. This enables the test to be legally administered in CLIA-certified but non-traditional laboratory settings by non-laboratory personnel. These two advantages—accuracy and ease of use—led the CDC to broadly implement the test. However, rapid testing does pose challenges: it requires a second test to confirm preliminary HIV-positive results; and it has required changes to the well-regarded counseling protocol to accommodate a single session.

**The OraQuick Test**

The OraQuick test requires a finger stick blood sample. The tester quickly pierces the skin on the side of the client’s “non-dominant” index finger, that is, if the client is right-handed, the
non-dominant hand is his or her left hand. The tester places the blood sample from the finger stick on a specimen collection loop, a toothpick-sized plastic stick with a tiny loop at one end to collect the blood. The tester then mixes the sample into a vial containing developer reagent solution. The developer solution turns pink. Next, the tester places the testing device into the vial. The testing device is a four-inch plastic stick consisting of a flat pad at one end and a result window at the other; during the test, the flat pad end touches the bottom of the vial and draws the fluid and blood mixture up into the testing device’s result window, which turns pink.

It takes a minimum of 20 minutes for the chemical reaction to occur and for the test results to appear in the result window once the testing device is placed in the developing solution. The results must be read within 60 minutes of administering the test. The test is sensitive to both temperature and motion. To develop accurately, the temperature must be between 59º and 80º Fahrenheit, and the sample must remain completely undisturbed during processing.

The result window has the letter C (Control) and the letter T (Test) printed on the side. After 20 minutes, if the test is valid and no matter what the result is, the results window should change from pink to a clear color. In addition, a solid red line will appear next to the letter C. Invalid tests may be the result of numerous factors including user error, temperature control problems, and manufacturer errors.

Antibody test results appear next to the letter T. The absence of a line next to the letter T indicates an HIV-negative antibody result, otherwise known as a “non-reactive” test. A line next to the letter T, even a very faint one, indicates a “preliminary positive” result, otherwise known as a “reactive” test. Reactive Tests: “Preliminary Positives” Studies have shown the OraQuick test to have an overall accuracy rate of 99.9 percent, higher than either the ELISA or the SUDS. However, the rapid test currently requires a standard laboratory test to confirm any reactive OraQuick results. For this reason, reactive results are referred to as “preliminary positive” tests. This indicates that it is extremely likely that the client is HIV-positive, but that it is necessary to confirm the result. To confirm, a tester must collect either a standard blood draw sample or an OraSure oral mucosa sample. This sample is then sent to a laboratory for standard processing with both the ELISA and Western blot confirmatory test, whose results are available one to two weeks later. In the future, a rapid confirmation test will enable clients to receive both preliminary and confirmatory results during a single session.

Since HIV-negative results detected by the OraQuick test are considered highly accurate, it is not necessary to confirm non-reactive OraQuick test results. Clients with non-reactive results can be assured that, if they are outside the window period of infection, they are in fact uninfected.

Quality Assurance Although the test has been approved for use by non-laboratory technicians, there are several conditions that are crucial to ensure its proper administration. For this reason, OraQuick restricts sale of the test solely to settings that ensure adequate quality assurance and “operator” training.

For example, as mentioned above, the test vial must remain undisturbed for the duration of the test period, and room temperature must remain between 59º and 80º Fahrenheit. In addition, because the line next to the letter T—indicating a preliminary positive result—can be extremely faint, bright light is required to read the result; testers in some outreach or non-clinical settings have used flashlights to facilitate reading. OraQuick provides control kits, which must be run when each new lot, or batch of test kits, is opened. These control kits ensure that each lot is functioning appropriately.

In addition to these technical conditions required to ensure the accuracy of the test, the CDC and the state of California have imposed other quality control standards. The CDC requires
that the test be administered in a private area to ensure confidentiality. The California Office of AIDS requires that the counseling and testing components occur separately in two spaces to minimize client anxiety and distraction. The CDC requires testers to exercise a range of “universal precautions,” such as wearing gloves and lab coats and properly disposing of potentially infectious materials.

Finally, the OraQuick test has received a waiver under the Clinical Laboratory Improvement Amendments (CLIA) guidelines, a federal law created in 1988 to regulate clinical laboratory testing. Depending on the type of test and specimen, CLIA dictates the level of personnel training and site requirements necessary to ensure accurate procedures.

Tests that are categorized by CLIA as “moderate” or “high complexity” require certified laboratory personnel and specific laboratory conditions for the administration of the test. The OraQuick test was granted a waiver under the CLIA regulations in January 2003. As a result, the OraQuick test may be used outside of a traditional laboratory setting as long as a test site meets CLIA waiver requirements.

It also means that HIV test counselors who have been properly trained may conduct the test. This is important, since it maximizes the advantages of rapid testing by enabling a single person to perform both the test and the counseling supporting it. At the same time, it may complicate the process, since some HIV test counselors may be uncomfortable with this more “medical” role.

While the CLIA waiver eliminates federal barriers to the widespread use of rapid testing, there are currently limitations at the state level. In California, for example, the finger stick necessary for OraQuick may be administered only by individuals who have a “limited phlebotomy technician certification.” This certificate requires approximately 20 hours of didactic training in addition to supervised practice in administering finger sticks.

What about Counseling?

Counseling has been an integral part of HIV testing and prevention efforts since the introduction of antibody testing in 1985. Over the course of the 1980s and 1990s, counseling protocols evolved to include not only the communication of information from counselor to client, but also a focus on the client’s psychosocial concerns. The RESPECT study—a five-city, U.S. investigation that ran from 1993 to 1996—confirmed the efficacy of this client-centered counseling approach. A 1999-2000 follow-up study—RESPECT-2—suggested that a one-session, client-centered counseling protocol, designed with rapid testing in mind, could also be effective.

Using the data from the RESPECT studies, the UCSF AIDS Health Project has developed new counseling protocols for rapid testing. The single-session protocols in development in California employ client-centered counseling and behavior change theory, but in response to the time constraints and emotional charge of rapid testing, focus more narrowly. The protocol emphasizes the specific HIV-related risk incident that brought the client in to test. It seeks to address the client’s thinking and feeling before, during, and after the incident. Further, it encourages the client to identify an incremental, achievable step that will help him or her reduce the risk that brought the client in to test.

Pilot studies in California have demonstrated that single-session counseling provides a high degree of client and counselor satisfaction. For example, counselors participating in the pilot at the counseling and testing program of San Francisco’s Glide Memorial Church, originally expressed anxiety about rapid testing. Once the pilot began, however, they reported excitement and satisfaction, stating that the short time frame of the testing process and the expectation of the client to receive an immediate test result have created an increased sense of intimacy in counseling sessions. In addition, because of the structure of single-session counseling, pilot sites reported the greatest success—that is, the greatest opportunity for self-reflection—with clients who were able to identify the specific incident that brought them in to test.

Counselor Training

In September 2003, California began training counselors working at state-funded test sites in the new single-session protocols. These protocols demand that counselors be able to remain focused and concise in their efforts to help clients define manageable steps. In addition, they must be even more skilled than they have been in tolerating the range of feelings—from both clients and themselves—because of the compression of time between taking the test and receiving results.

The state is, therefore, requiring counselors who perform rapid tests to be certified as proficient in single-session counseling. In addition, the state is developing rigorous quality assurance protocols that will include regular observation of counselors and training for counselor supervisors.
Implications for Counseling

The single-session counseling protocol—with or without the additional responsibility of test administration—is significantly different from currently used counseling protocols. If, or when, counselors, themselves, implement rapid testing—and this will likely vary from one testing program and test site to another—their experience of counseling will change even more dramatically. The chief counseling challenges relate not so much to the new technology, however, but to the implementation of single-session counseling.

Experience with single-session counseling, thus far, has uncovered four major differences that are potentially challenging for counselors. First, both client and counselor may experience an uncomfortable awareness of the impending test result from the moment of consent to the moment of disclosure. Further, this awareness may intensify feelings during the explorations of the counseling session. Second, the counseling protocol focuses attention on the specific incident that brought the client in to test, and counselors may have to sort through many issues with clients in order to identify this incident.

Third, counselors will be called upon to help each client develop an achievable, incremental risk reduction step as a result of the session, and it may be difficult to identify a single step in the context of a client’s larger needs. Finally, counselors may struggle with anxiety about changes in the counseling protocol, about the feeling that they are closer to contagions than they were before, or about managing the intense feelings that may arise for clients in the short time frame between testing and disclosure.

Managing the Impending Test Result

The most obvious difference between a standard HIV antibody test and the rapid test is that clients receive results within 30 minutes to 60 minutes of signing their consent form. It is important for counselors to acknowledge this fact to clients from the beginning of the session and, in doing so, minimize the possibility that unspoken anxiety about timing might become a distraction for both client and counselor. Acknowledging the timing of the test results can also facilitate the work of counseling by keeping both client and counselor focused on the most recent HIV-related risk behavior.

The informed consent process provides the opportunity for counselors to frame the session, describing what will happen during the testing portion, the risk assessment, and the results disclosure, and including information on the time frame for the test results and the possibility of the need to collect an additional sample to confirm a preliminary positive result. In addition to ensuring informed consent, this description of the process can encourage clients’ active participation by clearly outlining expectations for both client and counselor during their short time together.

This is a good time for a counselor to begin to explore and validate a client’s feelings about the impending result. In addition, some clients may benefit from “emotional checks” throughout the session; simply asking a client “How are you doing?” may give him or her an opportunity to express anxiety about the proximity of results, thereby reducing this anxiety and helping him or her focus on the other issues of the session. Some clients may not feel the need to discuss the impending nature of the result, preferring to focus on a risk assessment.

While it is important for counselors to actively acknowledge client anxiety, it is also essential for counselors not to confuse their own anxieties with the client’s concerns. It can be as uncomfortable for a client to feel that a counselor is overemphasizing their concerns as it is to feel their concerns are being ignored. As in all counseling sessions, counselors must be adept in identifying their own anxieties and bringing them up in appropriate venues such as supervision.

Identifying a Specific Risk Incident

Some elements of risk assessment remain the same for rapid testing as for two-session approaches; others have become more focused. For example, counselors continue to ask clients to describe what has motivated them to test that day. The emphasis of risk assessment, however, is on a specific risk incident that a client has experienced rather than, for example, the exploration of feelings related to grief about the loss of a friend or the fact that a friend has recently seroconverted. The goal of this exploration is to move clients toward the creation of and commitment to an achievable, incremental needs.

Still Have Questions?

Next spring or summer, we will publish a special PERSPECTIVES supplement on the rapid test counseling experience. After you have had a chance to implement rapid testing, please send questions you would like to see covered to Rob Marks: rmarks@itsa.ucsf.edu or UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.

A Counselor’s Perspective

“Rapid testing does not mean rapid counseling. Ironically, it gives me more time to slow down and work with a client and breathes new life into the risk assessment.”
step, a change in behavior that the client believes he or she can achieve to reduce future risk.

Counselors should be as focused as possible in their quest to help clients unveil thoughts, feelings, and behaviors that the client associates with the specific risk incident. Potential questions to facilitate this unveiling might include: “Can you tell me about the last time you put yourself at risk for HIV?” “When was the last time you took someone else’s body fluids into your body?” “Did you do this with someone you knew?” “Is it unusual for you to do this or have you done it often?” “How comfortable are you with this behavior?” “What do you think kept you from protecting yourself?” “What was it about where you were or who you were with that allowed you to take this risk?” “Was there anything else going on in your life at the time, or now, that was or could be increasing your potential risk for HIV?”

There are many potential contextual issues to explore when looking at the circumstances surrounding a specific risk incident. It is important to clarify the level of risk that is acceptable to the client and to identify any patterns of behavior. Counselors can explore triggers, that is, situations that may increase the likelihood a client will engage in behaviors that have greater risks than they feel comfortable accepting. Assessing the client’s ability and comfort in communicating with partners can help to clarify whether interpersonal issues may be leading the client to participate in behaviors with which he or she is uncomfortable. This assessment may also help to forecast potential problems with sexual negotiation and disclosure should the client have a confirmed HIV-positive result. It is always essential for counselors to remember to identify and explore any of the client’s successful attempts at risk reduction as well as any obstacles he or she has encountered while trying to reduce risk.

Planning an Achievable Step

The process of identifying an achievable, incremental step can be facilitated by summarizing the session, particularly information about the specific risk incident and any patterns of behavior that seem to be most related to risk. As always, this summary should reinforce the client’s positive risk reduction efforts before raising “problematic” areas. Counselors may choose to focus on the issue or issues that have surfaced as most relevant to the specific risk incident; for example, a counselor might say, “We’ve talked a lot about difficulties in communication with your partners,” or “You seem more likely to put yourself at risk when . . .” or “There are several things going on in your life that seem to be affecting your risk behavior.”

As in all client-centered counseling, rely on the client as the best source of information. Ask him or her what might most help reduce risk in the future. Most clients will create steps that can, with some discussion, be refined into manageable steps that adhere to the guideline of small, incremental, and achievable risk reduction. For example, a client who has been unable to negotiate safety with any partner and now embraces the strategy to talk to all partners might benefit from discussions designed to narrow goals. This discussion might include identifying the specific situations most worrisome to him or her and finding one small thing he or she can do differently in these situations.

Counselor Anxiety

Rapid testing and single-session approaches may raise considerable anxiety among counselors. Concerns range from proximity to potential contagions such as blood for those counselors who might, themselves, administer a finger stick, to emotional closeness to clients whom they usher from informed consent to finger stick through risk assessment and test result all in the course of less than an hour.

Anxiety about contagions can best be managed through training and support. Counselors who are called upon to administer tests will receive extensive training in finger stick protocols.

References

Case Study

Sam is a 34-year-old gay man who is involved in a long-term relationship. He and his partner, Alan, have agreed that they can have occasional sex outside of the relationship as long as they do not do anything sexually that puts themselves at risk for HIV. But Sam is worried that an encounter several months ago might have infected him. He has been waiting for the window period to be over before testing. Sam comes to the clinic for testing, goes through the informed consent process, chooses to have a rapid test because he is eager to know the results as soon as possible, and then undergoes the finger stick.

After the finger stick procedure, Sam looks anxious. He says, “It’s a little strange knowing my test is developing in the next room.” Validate Sam’s feelings and remind him about the timing of the test: “I can imagine it feels a little weird knowing that your result will be available soon. I suggest that we don’t focus on the time and talk instead about what brings you in to test today.”

Sam explains how he and Alan have agreed that oral sex is an acceptable sexual behavior for each of them when having sex outside of the relationship and that this agreement had worked fine until he met a man six months ago. “I ended up going further than I felt comfortable,” he says, admitting that he had had unprotected anal sex.

As you start to ask Sam more about this incident, he interrupts, tapping his watch and saying, “Uh . . . shouldn’t my results be ready about now?” You acknowledge Sam’s desire to want his results, replying, “I know how difficult the waiting can be, but let’s take a couple moments to talk about your experience. What was different about this time when you departed from your agreement? Were you feeling differently about Alan, about this new partner, about other things in your life?”

As he reflects on these questions, Sam tells you that he and Alan had had a particularly difficult argument the day before. When Sam went out the following night, he was still upset with Alan. He remembers thinking, “Nothing a couple more drinks can’t fix,” acknowledging that this was a couple more than usual. After that, he met someone who was particularly hot, and one thing led to another—without the negotiations he usually has before he has sex with people other than Alan.

When you ask Sam what he thinks he might do differently the next time, he says that he will do his best never to fight with his partner like that again. You acknowledge this feeling and ask him how, if he did have a fight with his partner, he might handle the sexual situation differently, for example, by going to a different place—a friend’s house or a movie—when he’s angry or upset. You suggest that Sam not drink in these situations, because alcohol can disinhibit people enough to allow them to do things they may not otherwise do. Sam does not think he can go out without having a couple drinks, but he says he can go to a movie with a friend after a fight with Alan.

To increase the likelihood that Sam will remain accountable to his plan, suggest that he talk to a couple of friends now, explaining to them his plan and enlisting their help in advance. Affirm Sam’s choice and his willingness to discuss these issues.

Ask Sam if he is ready for you to go get his test result, reminding him that you will leave the room and be back in two minutes. Upon returning, check in with Sam again. Remain neutral and let Sam know his result.
Test Yourself

Review Questions
1. True or False: The entire rapid antibody testing process, from obtaining a blood sample to disclosing the test result, can occur within 30 to 60 minutes.

2. Even though the OraQuick rapid test is more accurate than other HIV antibody tests, HIV-positive results are considered “preliminary” until confirmed because: a) the rapid test is new technology; b) the positive result is so fleeting; c) all medical screening tests require confirmation; d) all of the above.

3. To ensure the accuracy of OraQuick rapid test results, a) the test vial must remain undisturbed; b) room temperature must remain between 59º and 80º Fahrenheit; c) bright lighting is required to read results; d) all of the above.

4. True or False: Rapid testing may be conducted by any certified HIV counselor.

5. True or False: Rapid testing requires rapid counseling.

6. Rapid testing counseling protocols sustain a focus on client-centered counseling, but they differ from standard counseling by: a) acknowledging the impending test result; b) abbreviating the informed consent process; c) limiting discussion of a specific risk event; d) all of the above.

7. A key rapid test counseling challenge is: a) implementing the Western blot test; b) helping clients negotiate a range of feelings in a single session; c) watching test results develop while talking to the client; d) all of the above.

Discussion Questions
1. What criteria might supervisors and counselors use to decide whether a counselor is best suited for rapid testing training?

2. What might be lost through single-session counseling and how can counselors compensate to make rapid test counseling most effective?

3. How might a counselor respond to a client who becomes so focused on the fact that the test result is developing in the testing room that he or she cannot focus on HIV prevention counseling?

4. What approaches might help a client who cannot identify an incremental and achievable step to reduce risk?

5. How might a counselor interrupt a productive and emotionally rich counseling interaction in order to check test results as the 60-minute limit approaches?

6. What are some effective ways to describe a “preliminary HIV-positive” result to clients and help them understand what this means for them while they wait for confirmation?

7. What might help counselors adjust to the fact that rapid testing does not allow them to “prepare” to deliver HIV-positive results in the same way that two-session counseling did?

Answers to Test Yourself
1. True.
2. c.
3. d.
4. False. To conduct rapid testing, counselors must meet certain requirements. In California, for example, they must be certified in single-session counseling and receive a “limited phlebotomy technician certification,” which requires approximately 20 hours of didactic training and supervised practice in administering finger sticks.
5. False. Although testers must check test results before the 60-minute limit elapses, there is no time limit to the counseling that accompanies rapid testing.
6. a.
7. b.
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