of nonteaching hospitals. Thus, many hospitalist programs are not part of academic hospitals. Because hospitals are not financially accountable for their patients after discharge, only those hospitals with strong commitments to quality are likely to institute programs designed to ensure continuity of care between hospitalists and patients’ primary care physicians. Evidence suggests that hospitalist programs can be effective, but internal changes for efficiency do not assure better outcomes after discharge. We need empirical evidence regarding performance of a representative sample of hospitalist programs, regardless of the sponsorship under which they operate. Assuming that all programs are as effective as the literature may miss important opportunities for improving patients’ experiences and outcomes.

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Table. Compatibility of Consent and Counseling Laws With 2006 CDC Recommendations (as of January 2011)

<table>
<thead>
<tr>
<th>Parameter and Subparameter</th>
<th>Compatible States</th>
<th>Incompatible States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent</td>
<td>AL, AK, AZ, AR, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MI, MN, MS, MO, MT, NV, NH, NJ, NM, NC, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WV, WY</td>
<td>MA, NE, NY, PA</td>
</tr>
<tr>
<td>Opt-in vs opt-out</td>
<td>AL, AK, AZ, AR, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, WA, WA, WI, WV, WY</td>
<td>MA</td>
</tr>
<tr>
<td>Specific vs general</td>
<td>AL, AK, AZ, AR, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MI, MN, MS, MO, MT, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, WA, WA, WI, WV, WY</td>
<td>MA, NE</td>
</tr>
<tr>
<td>Written vs oral or written</td>
<td>AL, AK, AZ, AR, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MI, MN, MS, MO, MT, NV, NH, NJ, NM, NC, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, WA, WA, WI, WV, WY</td>
<td>MA, NE, NY, PA</td>
</tr>
<tr>
<td>Counseling</td>
<td>AL, AK, AZ, AR, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, WA, WA, WI, WV, WY</td>
<td>PA, RI</td>
</tr>
<tr>
<td>Prevention vs testing counseling</td>
<td>AL, AK, AZ, AR, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, WA, WA, WI, WV, WY</td>
<td>RI</td>
</tr>
<tr>
<td>In-person vs discretionary notification/counseling</td>
<td>AL, AK, AZ, AR, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, WA, WA, WI, WV, WY</td>
<td>PA</td>
</tr>
</tbody>
</table>

Abbreviations: CDC, Centers for Disease Control and Prevention; HIV, human immunodeficiency virus.

*In New York, written consent is required except in cases of rapid testing (oral consent is sufficient) and may be incorporated into the general medical consent; the consent form must have a clearly marked place adjacent to the signature where the test participant has the opportunity to decline HIV-related testing in writing.

*In Arizona, compatibility for written vs oral or written consent differs by health care setting (consent in nonhospitals may be oral or written; consent in hospitals must be written), as well as type of health care professional (consent to testing by physicians, registered nurse practitioners, and physician assistants may be oral or written).

*In Missouri, compatibility for counseling differs by health care professional (laws for physicians are compatible; those for others are not).
The compendium contains detailed profiles of HIV testing laws drawn from state statutes and administrative codes, excluding case law and policies issued by other regulatory agencies. The database is updated regularly; accuracy and validity are maintained by review and feedback. We also tracked consent and counseling legislation introduced since the recommendations’ issuance. Consent and counseling laws were further evaluated by subparameters (TABLE).

Key terms such as opt-out and HIV-prevention counseling were interpreted as defined in the CDC recommendations. We defined specific consent as a separate HIV testing consent form distinct from the general consent for medical care; test counseling as HIV test counseling, information, or education provided verbally or with written materials or videos; and discretionary notification as delivery of results through a mode deemed appropriate by the clinician (eg, telephone, mail, electronic means, or in person). Laws and policies were considered compatible if they were not in conflict with CDC recommendations and incompatible if they would preclude implementation of CDC recommended routine testing. When laws were ambiguous or open to interpretation (14% of states), we consulted state and national experts to help resolve differences.

**Results.** As of January 2011, 46 states and jurisdictions (including Washington, DC) (90.2%) were coded as compatible with the 2006 CDC recommendations for consent and counseling; 5 states were incompatible on at least 1 measured subparameter. For some states, compatibility varied by health care provider, setting, scenario, or type of law (Table). Although 21 states were already compatible in 2006 and had no legislative action since, 24 states (including Washington, DC) subsequently changed their statutes, administrative code, or both, making them more compatible (FIGURE). State laws remained in flux. In 2009-2010, 9 states (Connecticut, Hawaii, Michigan, Montana, New York, Ohio, Rhode Island, Washington, and Wisconsin) made their laws more compatible with CDC recommendations.

**Comment.** Nearly all states’ HIV testing laws and administrative codes were compatible with the current CDC HIV testing recommendations on consent and counseling as of January 2011. Although 5 states still had incompatible laws, 24 states actively changed their laws toward compatibility with CDC recommendations. This study is limited to state HIV testing statutes and administrative code available online and does not include case law or policies issued by other regulatory agencies (eg, health departments). State HIV testing laws are often complicated; can be contradictory or subject to interpretation; and can vary across populations, settings, scenarios, or providers. When assessed for overall compatibility, however, HIV testing laws in nearly all states no longer present obstacles to routine HIV testing.

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