PART 2
ROUTINE STI SCREENING AND HPV VACCINATION

Routine STI screening promotes positive sexual health in your patients and the community.

Asymptomatic infections often go undiagnosed and untreated, leading to chronic pain; infertility, and the continued spread of disease.

Contents:
› Why Screen for STIs?
› Healthcare Effectiveness Data and Information Set (HEDIS) Measures
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› How to Offer a Routine STI Screening
› HIV: How to Offer Routine HIV Screening
› HIV Informed Consent
› Types of Diagnostic Tests for HIV
› Sequence of Laboratory Markers for HIV infection
› HPV Vaccination: Rationale and Recommendations
› HPV Vaccination Guidelines
› How to Offer Routine HPV Vaccination
› A Note about Herpes Simplex Virus (HSV)
WHY SCREEN FOR STIS?

- Screening for STIs is an essential and underutilized component of primary care.

- An average of 80% of chlamydia infections and 75% of gonorrhea infections are asymptomatic in both men and women. Asymptomatic infections often go undiagnosed and untreated, leading to chronic pain, infertility, and the continued spread of disease.

- Chlamydia and gonorrhea are important preventable causes of pelvic inflammatory disease (PID) and infertility.

- Untreated syphilis may progress to late stage syphilis, resulting in severe morbidity, including paralysis and organ damage.

- As many as 50% of HIV transmissions occur during the acute and early stages of infection. Patients with acute HIV infection are at particularly high risk of transmitting HIV because of high viral loads.

- A recent national study found that only 20% of adolescent patients visiting a healthcare provider had a documented sexual history. Of those patients reporting sexual activity, only 17% were offered gonorrhea, chlamydia, and HIV testing.

- A 2009 study of men who have sex with men (MSM) found that only 61% had been offered STI screening by a healthcare provider in the previous two years, despite 98% of the men having visited a provider in year prior to the study.
HEDIS MEASURES

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of performance measures developed by National Committee for Quality Assurance (NCQA) that have been incorporated into the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting System (PQRS). Individual eligible professionals and practices* that do not satisfactorily report on the measures will not receive full reimbursement.\(^{14}\) Some private-payers are using the HEDIS measures as a basis for Value Based Payment initiatives. The following 2016 HEDIS measures support preventive care through STI screening and vaccination.\(^{23}\)

<table>
<thead>
<tr>
<th>HEDIS Measures 2016</th>
<th>Gender</th>
<th>Age</th>
<th>Care, Screening, or Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHLAMYDIA</td>
<td>Females</td>
<td>16-24</td>
<td>Screening test for chlamydia yearly in women identified as presumed sexually active by pharmacy Rx data or claims data indicating potential sexual activity. Exclusions: Women who had a pregnancy test followed within 7 days by either a prescription for Accutane (isotretinoin) or an X-ray.</td>
</tr>
<tr>
<td>HUMAN PAPILLOMAVIRUS (HPV) VACCINE FOR FEMALE ADOLESCENTS</td>
<td>Females</td>
<td>&lt; 13 years</td>
<td>Three doses of HPV vaccine with different dates of service, on or between the 9th and 13th birthday. Exclusions: Anaphylactic reaction to the vaccine or its components on or before 13th birthday</td>
</tr>
<tr>
<td>CERVICAL CANCER SCREENING</td>
<td>Females</td>
<td>21 - 64</td>
<td>PAP test within the measurement year or prior 2 years. OR PAP/HPV co-testing within the measurement year or prior 4 years. Exclusions: Women who have had a complete hysterectomy with no residual cervix.</td>
</tr>
</tbody>
</table>

*Providers at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) cannot participate in PQRS. More information can be found at: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016.aspx
The Centers for Disease Control and Prevention regularly releases STI screening recommendations.

For routine screening recommendations, see next page.

More frequent screening is recommended if a patient is at “increased risk.” Some markers of increased risk include:

- Multiple sex partners
- Anonymous sex partners
- Sex partner has other sex partners
- Exchanging sex for drugs and/or money
- Injection drug users
- Inconsistent or no condom use
- Reinfection from untreated partner(s)
- Sexual network with high infection prevalence

Maryland-Specific Prenatal Screening

Maryland state law requires that pregnant women be screened for syphilis at their first prenatal visit, again at the 28-week visit, and in the third trimester if they are at continued risk. (COMAR 10.06.01.17).

Syphilis screening is required at Labor and Delivery for all Baltimore City deliveries (Baltimore City Health Commissioner’s Order).
## CDC 2015 SCREENING RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Women</th>
<th>Pregnant Women</th>
<th>Men</th>
<th>Persons with HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHLAMYDIA</strong>&lt;br&gt;Sexually active women under 25 years of age</td>
<td>All pregnant women under 25 years of age</td>
<td>Consider screening young men in high prevalence clinical settings or in populations with high burden of infection (e.g. MSM)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter</td>
</tr>
<tr>
<td>Sexually active women aged 25 years and older if at increased risk&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Pregnant women, aged 25 years and older if at increased risk&lt;sup&gt;a&lt;/sup&gt;</td>
<td>At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use</td>
<td>More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology</td>
</tr>
<tr>
<td>Retest approximately 3 months after treatment&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Retest during the 3rd trimester for women under 25 years of age or at risk&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Every 3 to 6 months if at increased risk&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pregnant women with chlamydial infection should have a test-of-cure 3-4 weeks after treatment and be retested within 3 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CDC&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td><strong>GONORRHEA</strong>&lt;br&gt;Sexually active women under 25 years of age</td>
<td>All pregnant women under 25 years of age and older women if at increased risk&lt;sup&gt;d&lt;/sup&gt;</td>
<td>At least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx) regardless of condom use</td>
<td>For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter</td>
</tr>
<tr>
<td>Sexually active women age 25 years and older if at increased risk&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
<td>Every 3 to 6 months if at increased risk&lt;sup&gt;c&lt;/sup&gt;</td>
<td>More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology</td>
</tr>
<tr>
<td>Retest 3 months after treatment&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Retest 3 months after treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CDC&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CDC&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
</tr>
</tbody>
</table>
## CDC 2015 Screening Recommendations

### Women

<table>
<thead>
<tr>
<th>SYPHILIS</th>
<th>Women at higher risk of syphilis infection&lt;sup&gt;a&lt;/sup&gt;</th>
<th>All pregnant women at the first prenatal visit&lt;sup&gt;USPSTF&lt;sup&gt;3&lt;/sup&gt; women at higher risk of syphilis infection&lt;sup&gt;e&lt;/sup&gt;</th>
<th>Men at higher risk of syphilis infection and under the age of 29&lt;sup&gt;e&lt;/sup&gt;</th>
<th>At least annually for sexually active MSM&lt;sup&gt;CDC&lt;sup&gt;2&lt;/sup&gt; men at higher risk of syphilis infection and under the age of 29&lt;sup&gt;e&lt;/sup&gt;</th>
<th>For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter&lt;sup&gt;CDC, HRSA, IDSA, NIH&lt;sup&gt;6-8&lt;/sup&gt;&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRICHOMONAS</td>
<td>Consider for women receiving care in high-prevalence settings (e.g., STI clinics and correctional facilities) and for women at high risk for infection (e.g., women with multiple sex partners, exchanging sex for payment, illicit drug use, and a history of STIs)</td>
<td>Retest early in the third trimester and at delivery if at high risk&lt;sup&gt;AAP/ACOG&lt;sup&gt;4&lt;/sup&gt; women at higher risk of syphilis infection&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Every 3 to 6 months if at increased risk&lt;sup&gt;c&lt;/sup&gt;</td>
<td>More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology&lt;sup&gt;CDC&lt;sup&gt;3&lt;/sup&gt; women at higher risk of syphilis infection&lt;sup&gt;e&lt;/sup&gt;&lt;/sup&gt;</td>
<td>Recommended for sexually active women at entry to care and at least annually thereafter&lt;sup&gt;CDC&lt;sup&gt;6&lt;/sup&gt;&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

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<sup>a</sup> CDC 2015 Screening Recommendations

<sup>b</sup> USPSTF 2019: Screening for Syphilis

<sup>c</sup> USPSTF 2019: Screening for Trichomonas

<sup>d</sup> AAP/ACOG 2016: Pregnancy Care

<sup>e</sup> CDC 2015: HIV-Related Screening

<sup>f</sup> CDC 2015: Laboratory Testing

<sup>g</sup> CDC 2015: Sexually Transmitted Infections

<sup>h</sup> CDC 2015: Antiretroviral Therapy
## CDC 2015 Screening Recommendations

<table>
<thead>
<tr>
<th>Women</th>
<th>Pregnant Women</th>
<th>Men</th>
<th>Men Who Have Sex With Men (MSM)</th>
<th>Persons with HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HERPES</strong></td>
<td>Type-specific HSV serologic testing should be considered for women presenting for an STI evaluation (especially for women with multiple sex partners)</td>
<td>Evidence does not support routine HSV-2 serologic screening among asymptomatic pregnant women. However, type-specific serologic tests might be useful for identifying pregnant women at risk for HSV infection and guiding counseling regarding the risk for acquiring genital herpes during pregnancy</td>
<td>Type-specific HSV serologic testing should be considered for men presenting for an STI evaluation (especially for men with multiple sex partners)</td>
<td>Type-specific HSV serologic testing should be considered for persons presenting for an STI evaluation (especially for those persons with multiple sex partners), persons with HIV infection, and MSM at increased risk for HIV acquisition</td>
</tr>
<tr>
<td>All women aged 13-64 years (opt-out)</td>
<td>All pregnant women should be screened at first prenatal visit (opt-out)</td>
<td>All men aged 13-64 years (opt-out)</td>
<td>At least annually for sexually active MSM if HIV status is unknown or negative and the patient himself or his sex partner(s) have had more than one sex partner since most recent HIV test</td>
<td></td>
</tr>
<tr>
<td>All women who seek evaluation and treatment for STIs</td>
<td>Retest in the third trimester if at high risk</td>
<td>All men who seek evaluation and treatment for STIs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*For more information on screening for Herpes, please see page 45*
## CDC 2015 Screening Recommendations

<table>
<thead>
<tr>
<th>Category</th>
<th>Women</th>
<th>Pregnant Women</th>
<th>Men</th>
<th>Men Who Have Sex With Men (MSM)</th>
<th>Persons with HIV</th>
</tr>
</thead>
</table>
| **Cervical Cancer**           | Women 21-29 years of age every 3 years    | Pregnant women should be screened at same intervals as nonpregnant women  
USPSTF¹¹, ACOG¹², ACS¹³  | Men born between 1945-1965  
USPSTF¹⁸  | All MSM should be tested for HBsAg  
CDC¹⁵  | Women should be screened within 1 year of sexual activity or initial HIV diagnosis using conventional or liquid-based cytology; testing should be repeated 6 months later  
CDC, NIH, IDSA¹⁴  |
| **Hepatitis B Screening**     | Women at increased risk  
CDC¹⁵  | Test for HBsAg at first prenatal visit of each pregnancy regardless of prior testing; retest at delivery if at high risk  
CDC¹⁵, USPSTF¹⁶  | Men at increased risk  
CDC¹⁵  | Test for HBsAg and anti-HBc and/or anti-HBs.  
CDC¹⁵  |
| **Hepatitis C Screening**     | Women born between 1945-1965  
CDC¹⁷, USPSTF¹⁸  | Other pregnant women if risk factors are present  
USPSTF¹⁸  | Men born between 1945-1965  
CDC¹⁷, USPSTF¹⁸  | MSM born between 1945-1965  
USPSTF¹⁸  | Serologic testing at initial evaluation  
CDC, NIH, IDSA²¹⁴  |
|                               | Other women if risk factors are present  
USPSTF¹⁸  |                              | Other men if risk factors are present  
USPSTF¹⁸  | Other MSM if risk factors are present  
USPSTF¹⁸  | Annual HCV testing in MSM with HIV infection  
CDC²  |

Notes:
- USPSTF: United States Preventive Services Task Force
- ACOG: American College of Obstetricians and Gynecologists
- ACS: American Cancer Society
- CDC: Centers for Disease Control and Prevention
- NIH: National Institutes of Health
- IDSA: Infectious Diseases Society of America
- **: Recommendations are based on U.S. data only.

References:
- CDC¹⁵
- USPSTF¹⁶
- ACOG¹²
- ACS¹³
- CDC¹⁷
- USPSTF¹⁸
- CDC²
- NIH, IDSA¹⁴
Notes

a Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection

b Adolescent clinics, correctional facilities, and STI clinics

c More frequent STI screening (i.e., for syphilis, gonorrhea, and chlamydia) at 3–6-month intervals is indicated for MSM, including those with HIV infection if risk behaviors persist or if they or their sexual partners have multiple partners

d Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has an STI. Additional risk factors for gonorrhea include inconsistent condom use among persons who are not in mutually monogamous relationships; previous or coexisting sexually transmitted infections; and exchanging sex for money or drugs. Clinicians should consider the communities they serve and may opt to consult local public health authorities for guidance on identifying groups that are at increased risk.

e Those at higher risk for syphilis infection including history of incarceration, commercial sex work, geography, and race/ethnicity

f USPSTF recommends screening in adults and adolescents ages 15-65

g Women who use illicit drugs, have STIs during pregnancy, have multiple sex partners during pregnancy, live in areas with high HIV prevalence, or have partners with HIV infection

h Those at increased risk include persons born in regions of high endemicity (≥2% prevalence), Injection drug users (IDU), MSM, persons on immunosuppressive therapy, hemodialysis patients, HIV positive individuals, and others

i Past or current injection drug use, receipt of blood transfusion before 1992, long term hemodialysis, born to mother with Hepatitis C, intranasal drug use, receipt of an unregulated tattoo, and other percutaneous exposures.
References


CDC 2015 SCREENING RECOMMENDATIONS CONT.

References Cont.


HOW TO OFFER
A ROUTINE STI SCREENING

Example Script for Routine STI Screening

"As part of routine care, we screen all patients like you for sexually transmitted infections, or STIs, at least once per year, whether or not they think they are risk.

We do this to keep our patients healthy. Often, people with STIs don’t have symptoms, and most STIs are treatable.

These information sheets on pages 96-107 tell you about STIs and why you should be screened. We are giving them to all of our patients.

I would be glad to answer any questions you have. Like all medical screens, the results will be confidential.

You can decline the test and it will not affect the care you receive today."

If patient declines:
"Would you read the information sheets about STIs, and we’ll talk about it next time?"

"Are there concerns you have about the test?"

What NOT to Say:
If a patient asks for an STI test, make sure NOT to...
» act surprised
» ask what they’ve been up to
» dissuade them

Instead, consider the following response:
"Yes, we can provide STI testing. Do you have specific concerns about your sexual health? Are you having any symptoms you are concerned about?"

*For minors, remember to discuss Explanation of Benefits (EOB) documents as a potential breach of confidentiality.*
HOW TO OFFER ROUTINE HIV SCREENING

Example Scripts for Routine HIV Screening

- "We provide HIV testing. If you do not want to be tested today let me know."
- "Based on our visit today, I am ordering the following tests and procedures for you, including a test for HIV."
- "We screen all patients between the ages of 13-65 for HIV regardless of risk unless they decline. This pamphlet gives you information about HIV and the importance of testing. Do you have any questions about HIV or testing?"
HIV INFORMED CONSENT

A change in Maryland law that went into effect on July 1, 2015 normalizes HIV screening in health care facilities so that it is offered routinely to all patients age 13 to 65 at least once in their lifetime as a part of routine care regardless of risk.

What has changed?

Previously, providers had to ask patients if they would like to be screened for HIV and to document an acceptance in their record. HIV screening is now a routine test that is covered under the general consent for medical treatment form that a patient signs to consent for the procedures and tests the medical facility will conduct as part of that patient’s care (HIV does not need to be specifically stated). When a patient signs a general consent for medical treatment and is made aware that the test will be performed, they will be tested for HIV unless they decline.

Informed Consent

Do we need to use a separate consent form for HIV screening? A separate consent form for HIV screening is not required. A medical facility may not require written consent from a patient for an HIV test. All patients must be informed that they are being screened for HIV, given pre-test information, and informed that they may decline a test.

What if someone has signed a general consent before this law took effect? If a general consent has been obtained previously, then a new or separate consent form does not need to be signed (see above for more details).
Pretest Requirements

May a provider test someone for HIV without the patient knowing? No, all individuals must be informed they are being tested and that they may decline. Examples of how to provide this information include:

- Discussing with the patient the tests and procedures recommended
- Through written and visual material such as pamphlets, posters, and/or videos
- Detailing this information in the facility’s general consent form for treatment (although the law does not intend to single out HIV, this may be done for ease of clinic flow or patient management)
- A combination of the above

Decline Requirements

How do patients decline a test and what documentation is required? Providers will document in the medical record when an individual declines an HIV test. Patients may decline testing verbally. An individual’s refusal to undergo an HIV test may not be used as the sole basis by an institution or laboratory to deny services or treatment.
# Types of Diagnostic Tests for HIV

<table>
<thead>
<tr>
<th>Test Types</th>
<th>Use</th>
<th>Detects</th>
<th>Source of Sample</th>
<th>Processed by a Lab</th>
<th>Time for Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid Test</td>
<td>Initial HIV screening</td>
<td>HIV antibodies</td>
<td>Finger prick or oral fluids</td>
<td>No</td>
<td>20 minutes or less</td>
</tr>
<tr>
<td>ELISA (Enzyme linked immune absorbent assay)</td>
<td>Initial HIV screening</td>
<td>HIV antibodies</td>
<td>Blood, urine or oral fluids</td>
<td>Yes</td>
<td>2–14 days</td>
</tr>
<tr>
<td>Western Blot</td>
<td>Confirmatory test</td>
<td>HIV antibodies</td>
<td>Blood</td>
<td>Yes</td>
<td>2–14 days</td>
</tr>
<tr>
<td>Plasma HIV RNA (viral load test)</td>
<td>Identify acute/recent HIV infection</td>
<td>Amount of HIV (viral load) in the blood</td>
<td>Blood</td>
<td>Yes, may require specialized lab</td>
<td>1–3 weeks</td>
</tr>
<tr>
<td>&quot;4th Generation&quot; Testing (4th Generation)</td>
<td>Identify HIV infections (Acute infections are determined if HIV RNA is reactive)</td>
<td>HIV-1 and HIV-2 Antibodies, HIV-1 p24 Antigen</td>
<td>Blood</td>
<td>Yes</td>
<td>Up to 1 hour (Additional testing needed, if reactive)</td>
</tr>
</tbody>
</table>
SEQUENCE OF LABORATORY MARKERS FOR HIV INFECTION

- **HIV RNA (plasma)**
- **HIV-1 p24 Antigen**
- **HIV Antibody**

**Days**
0 10 20 30 40 50 60 70 80 180 360 540 720

**Eclipse Period**
Viral Detection
Nucleic Acid Test

**Acute HIV Infection**
Antibody Detection
3rd generation Immunoassay

**Established HIV Infection**
Antibody Detection
1st generation Immunoassay

**Seroconversion window**

*Source: CDC (2014, June 27)*

Sequence of appearance of laboratory markers for HIV-1 infection

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41 STI Action Kit
HPV VACCINATION: RATIONALE AND RECOMMENDATIONS

- Estimates suggest that 70–90% of new oropharyngeal cancers are caused by HPV infection.16

- The bivalent and quadrivalent vaccines offer protection against HPV types 16 and 18, which account for 66% of all cervical cancers, and the 9-valent vaccine protects against five additional types accounting for 15% of cervical cancers. The quadrivalent HPV vaccine also protects against types 6 and 11, which cause 90% of genital warts.17

- Four out of ten adolescent girls and six out of ten adolescent boys have not started the HPV vaccine series, and are vulnerable to oropharyngeal and anal cancers caused by some HPV infections.18

- Cervical cancer-causing strains of HPV may not manifest any symptoms until the disease is at an advanced state and much harder to treat.12

- Although provider recommendation is a stronger predictor of HPV vaccination, only 73% of physicians nationally report strongly recommending the HPV vaccine to their adolescent patients and their parents.19
**HPV VACCINATION GUIDELINES**

All HPV vaccines are administered as a 3-dose series of IM injections over a 6-month period, with the second and third doses given 1-2 and 6 months after the first dose, respectively. The same vaccine product should be used for the entire 3-dose series.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE 9-10</td>
<td>Vaccine may be administered</td>
<td>Vaccine may be administered</td>
</tr>
<tr>
<td>AGE 11-12</td>
<td>Cervarix, Gardasil, Gardasil 9 recommended</td>
<td>Gardasil or Gardasil 9 recommended</td>
</tr>
<tr>
<td>AGE 13-21</td>
<td>Cervarix, Gardasil, Gardasil 9 recommended to all females who did not start or finish the series at age 11 or 12</td>
<td>Gardasil or Gardasil 9 recommended for all males who did not start or finish the series at age 11 or 12.</td>
</tr>
<tr>
<td>AGE 22-26</td>
<td>Gardasil or Gardasil 9 recommended for all men who have sex with men who did not start or finish the series at an earlier age</td>
<td></td>
</tr>
</tbody>
</table>

16
**HOW TO OFFER ROUTINE HPV VACCINATION**

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**Example Script for Routine HPV Vaccination**

"As part of routine care, we recommend that all patients in your (or your child’s) age group receive a vaccine for protection against cancers caused by HPV, or human papillomavirus.

We do this to keep our patients healthy. Most men and women will be infected with HPV at some point in their lives, and most of the time, the body’s immune system can get rid of the infection on its own. Once in a while, the virus will remain in the body, and can cause cervical, oral, or other cancers including cancer of the vulva, vagina, penis or anus.

HPV is transmitted through sexual contact, and it is important to get the vaccine before the start of sexual activity. This gives the immune system time to develop a response to the virus. If you are (or your child is) already sexually active, the vaccine is still recommended, although it will not protect against a virus that is already in the body.

This information sheet on page 102 tells you about HPV and why you (or your child) should be vaccinated. We are giving it to all of our patients. I would be glad to answer any questions that you have.

You can decline the vaccine, and it will not affect the care you receive today."

**If patient declines:**

"Would you read the information sheet about HPV, and we’ll talk about it next time?"

"Are there any concerns you have about the vaccine?"
A NOTE ABOUT HERPES SIMPLEX VIRUS (HSV)

Neither the CDC nor the U.S. Preventive Services Task Force recommend routine screening for Herpes Simplex Virus (HSV) in asymptomatic individuals.\textsuperscript{21,22}

**What to Say When an Asymptomatic Person Seeking STI Screening Asks for "Everything"

"At this time, it is not our policy to screen for herpes, unless you have a specific concern. For example, if you have genital symptoms that look like herpes or have a partner with an active herpes infection, a blood test to screen for herpes might be right for you.

The reason that we do not screen everyone is that there is no cure for herpes, and a herpes infection does not usually cause serious complications in healthy adults. Sometimes the infection can cause painful genital ulcers or sores, and we do have medicine that can help reduce those symptoms. The other sexually transmitted infections that we will screen for today—chlamydia, gonorrhea, and syphilis—can be cured with antibiotics, and they can result in serious health problems if left untreated.

If you would like to be screened for herpes today, a blood test is available. I do want to make you aware that this test can be expensive and many health insurance companies will not cover the cost unless you are experiencing symptoms."