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Erratum

The March 2008 *NASTAD Prevention Bulletin* incorrectly asserted that non-occupational post-exposure prophylaxis (nPEP) has been found to be efficacious. Currently, there are no data to support this. However, as Michelle Roland, MD, NASTAD member and nPEP expert notes, “While there are no efficacy data on this intervention, this does not mean nPEP should not be considered for scale up.” For a revised version of the nPEP story, please visit NASTAD’s [website](#).

Encourage All People Living with HIV/AIDS to Know Their Status

Research shows that the majority of new HIV infections in the U.S. can be attributed to those unaware of their status. Because many Americans living with HIV/AIDS are still unaware of their status, knowledge of one’s serostatus is an essential principle in a forward agenda for domestic HIV prevention. Individuals who are aware of their HIV status have the necessary information to make choices about their risk-taking behavior. Additionally, those who are living with HIV/AIDS can be linked to, and ensured that they receive, care and antiretroviral treatment, perhaps the nation’s most impressive success since the beginning of the epidemic. In addition to improved health status, individuals living with HIV infection lower the probability they will transmit the virus to others if they adhere to a treatment regimen, particularly given the ever-improving regimens that are available. Hence, knowing one’s HIV status is one of the key principles in NASTAD’s [HIV Prevention Blueprint](#).

To meet the goal of getting all those living with HIV to know their status, we must continue to scale up targeted HIV testing and routine HIV screening efforts. Coupled with this scale up, the nation must ensure that care and treatment services are available to every American living with HIV/AIDS regardless of the status of their health care coverage. Systems like Medicare and Medicaid, the AIDS Drug Assistance Program, as well as all other parts of the Ryan White Program, must be funded accordingly and have appropriate policies in place to ensure access to care and treatment.

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Armed with recommendations and guidance issued by CDC, health departments, community-based organizations (CBOs) and other public health and health care professionals have made significant headway in efforts to identify individuals living with HIV/AIDS who are unaware of their status. Since the beginning of the epidemic, CDC recommendations have included both targeted testing for those with identified HIV risk and routine testing for those seeking treatment for STDs. In 1993, CDC recommended that voluntary counseling and testing include health care settings and, a decade later, CDC's *Advancing HIV Prevention* initiative included, as a key strategy, making HIV testing a routine part of medical care. In September 2006, CDC codified this approach in the *MMWR Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings*. A key facet of the revised recommendations for health care settings is decoupling counseling from HIV testing, to reduce the possible barrier counseling may pose to medical providers offering testing as a routine part of medical care.

Many have expressed concern that CDC and other supporters of the revised recommendations have overemphasized routine testing in health care settings as a mechanism to increase the number of new HIV diagnoses. The potential yield of routine testing in health care settings, in terms of numbers of individuals tested and numbers of new positives identified, must be considered against the yield and relative cost and cost effectiveness of other approaches, particularly highly-targeted, community-based counseling and testing programs.

While the increased emphasis on testing and the expansion of available testing sites and venues over the past several years have been a critical component of a comprehensive response to the HIV/AIDS epidemic, testing in isolation of other behavioral and biomedical interventions can never end the epidemic. It remains essential for health departments to balance their prevention and education programs with evidence-based interventions that compliment expanded testing. In particular, health departments' and community based organizations' prevention programs must continue to implement innovative, population-specific, evidence-based behavioral interventions and scale up implementation of other promising interventions, like non-occupational post-exposure prophylaxis, for individuals who seek services in their programs.

The effectiveness of linkages to prevention and care services is also a critical consideration. It is essential that all individuals living with HIV infection have the opportunity to receive high-quality medical care, as well as other prevention and support services, to keep them healthy and to reduce the likelihood that they will transmit HIV to their partners. An increase in the number of new diagnoses is not sufficient justification for expanded HIV testing in health care settings unless the expansion is accompanied by a commitment and adequate resources to support and ensure that individuals living with HIV/AIDS are effectively linked to care, treatment and appropriate prevention services.

Furthermore, while many health departments, community planning groups and others see the value in implementing routine HIV screening in health care settings, there are many critical challenges to expanding this approach. Financing is a key concern to all stakeholders. There are currently very few

jurisdictions in which routine HIV screening is reimbursed by Medicaid or other third-party payers. Lack of reimbursement for routine HIV screening is a disincentive to health care providers. With respect to public funds, such as those that flow to health departments and community based organizations, health departments and CPGs express ongoing concerns about how to prioritize routine HIV screening in health care settings relative to targeted and/or community-based counseling and testing programs as well as other prevention services such as behavioral interventions. With declining public funding for HIV prevention, supporting implementation and expansion of routine HIV screening in health care settings means redirecting resources from other important prevention services and activities. Thus, it is important that we achieve a balance in our prevention efforts, one which optimizes prevention by making use of all of the prevention tools that we have available to us.

National HIV Testing Day

Another important strategy in a national approach to promoting the importance of the knowledge of one's serostatus and of making HIV testing a more routine and less exceptional component of medical diagnostics is the annual campaigns centered around [National HIV Testing Day \(NHTD\)](#). Founded and coordinated by the National Association of People with AIDS (NAPWA) and sponsored by NASTAD, NHTD has been held every June 27 for over ten years and focuses attention on the importance of HIV testing through state and local testing campaigns. Each year, state and local health departments, working with their communities, develop increasingly creative and innovative NHTD campaign events, all of which contribute to keeping the importance of HIV testing and knowledge of serostatus in the collective consciousness of the American public, as well as those most impacted by the epidemic.

Estimating the National Costs and Consequences of Opt-Out Testing: An Interview with David Holtgrave

In September 2006, the CDC issued its *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings*. CDC has recommended that routine HIV testing be performed on a routine (i.e., "opt-out") basis in all health care settings for individuals 13-64 years old. In its recommendations, CDC has indicated that written consent specific to HIV testing and risk assessment / risk reduction counseling should not be required for HIV testing in such settings. In CDC's view, implementation of routine HIV testing in health care settings is a critical strategy to ensuring that HIV-infected individuals are diagnosed as early as possible so that they can benefit from medical treatment. Early diagnosis, or diagnosis soon after actual infection, is also cited as an important prevention strategy. While CDC has provided funding to health departments and others to support implementation of these recommendations, the true costs associated with implementation of the recommendations, along with the true public health impact, are not known.

David Holtgrave, PhD, Chair of the Department of Health, Behavior and Society at the Bloomberg School of Public Health, John's Hopkins University, has conducted research on this issue. NASTAD spoke with Dr. Holtgrave recently to better understand the "costs and consequences" of implementing CDC's recommendations for routine HIV testing in health care settings.

NASTAD: Why did you decide to research the “costs and consequences” of CDC’s recommendations?

David Holtgrave: It really started with a forum sponsored by the Kaiser Family Foundation. I was on a panel with the CDC and the question came from the audience, “What is the cost of the recommendations? What are the benefits?” CDC’s response was that it was too early to really tell what the cost was going to be. At the same time, professional organizations such as the American Medical Association and others were working in a number of states to change state laws to accommodate “opt out” testing. It struck me that without knowing the cost and the public health consequences of the recommendations, we might be moving too aggressively to implement them without really understanding what it was going to cost, relative to the public health benefit. Further, I was interested in whether it would be better to spend HIV testing resources in the “opt-out” way recommended by CDC or whether there are other HIV testing policies that might have a greater public health impact.

NASTAD: What did you learn from your research?

Holtgrave: I did a “scenario analysis” in which I examined the costs associated with implementing testing in each of four distinct scenarios; I compared the scenarios on the basis of the yield of new HIV diagnoses, the number of potential infections averted and the cost-per-infection prevented.

The first scenario involved opt-out HIV testing as recommended by CDC - no pre-test counseling, no post-test counseling for negatives, but post-test counseling for HIV-positive patients. In this scenario, I found that CDC’s recommended program of opt-out testing could test approximately 65.5 million people, yielding about 57,000 new diagnoses and could prevent transmission to about 3,700 partners at a total price tag of about \$864 million. The cost of medical care for people newly diagnosed would be about \$961 million (just examining the medical costs that would likely be covered by the public sector).

In a second scenario, I explored the idea that if no counseling is provided to high-risk negative patients that risk behavior might actually be reinforced. I did this because there is evidence that client-centered counseling accompanying testing can reduce incident STD, and there is a concern that negative test results given without counseling for some people might encourage risk behavior. It’s hard to know how much of a “behavioral offset” might be associated with not providing counseling to high-risk negatives, but I at least wanted to allow for the possibility that there is some impact. Under this scenario, the same number of people are tested and newly diagnosed as under the first scenario and for the same cost. However, this approach might increase infections among at-risk HIV negative clients by about 569 over one year.

In a third scenario, I looked at what would happen if “opt-out” testing was provided (i.e., everybody still gets tested regardless of risk) but everybody also got counseling. In this scenario, I found that this increases the cost of the program to about \$1.4 billion. However, it would prevent transmission/infection to about 5,333 persons in a year, representing an additional 1,689 annual HIV infections averted when compared with “opt-out” testing without counseling

(first scenario).

Finally, I ran a fourth scenario. I really wanted to think more broadly about different kinds of testing polices. For this scenario, I wanted to explore what could be achieved if we had the same amount of money (\$864 million) it would take to implement CDC's recommendations and apply it to a targeted counseling and testing approach. I found that for that same cost of \$864 million, about 30 million people would be tested, fewer than would be tested under CDC's recommended program, but the number of newly diagnosed persons would be increased more than three-fold to 188,170. This approach would also result in 14,553 averted infections. Of course, identifying so many more infections drives up the cost of care to \$3.2 billion.

NASTAD: So targeted counseling and testing is best?

Holtgrave: In my research, the targeted counseling and testing approach (the fourth scenario) outperformed the other three scenarios, including CDC's recommended program for routine ("opt-out") testing. If you look at the four scenarios from the perspective of cost-per-infection averted, targeted counseling and testing ends up being less expensive, \$59,383 per transmission/infection averted, when compared to "opt out" testing which costs about \$237,149 per transmission/infection averted. It identified more people living with HIV (providing a life-saving pathway to care) and prevented more HIV infections.

NASTAD: If we're doing targeted counseling and testing already, what can be gained from the "opt out" approach that CDC recommends?

Holtgrave: I don't want to mischaracterize the targeted counseling and testing scenario. I am talking here about targeting by geography, facility type (e.g., emergency department, health center) and seroprevalence, not by individuals. The targeted approach isn't necessarily at odds with an opt-out approach; it just means that you want to look for venues and communities that will get you higher seroprevalence and more persons newly diagnosed with HIV. In these venues, you'll test fewer people, but will also find more undiagnosed seropositives and reach more persons at higher risk and therefore avert more infections. This lowers the cost-per-infection averted but it also results in a much higher cost for public support for HIV care.

"The targeted approach isn't necessarily at odds with an opt-out approach; it just means that you want to look for venues and communities that will get you higher seroprevalence and more persons newly diagnosed with HIV."

— David Holtgrave

I did a sensitivity analysis to find out how "robust" these findings are. I wanted

to understand how far you could push this and still get a finding that targeted counseling and testing is better. Ultimately I took it down to a prevalence of about 0.3 percent. At this level of prevalence, targeted counseling and testing is still better than the opt-out scenario, as recommended by CDC. This suggests that even in relatively low-prevalence communities and facilities, implementing a targeted approach makes sense.

NASTAD: What should health departments, community planning groups (CPGs) and others think about in making their decisions about HIV counseling and testing and, in particular, how to use CDC's recommendations about implementing HIV testing in health care settings?

Holtgrave: I don't have a precise answer for that, because so much depends on the epidemic in a state or city and on other factors such as resources and provider capacity. I think that it's probably beneficial to think about two components of a plan - one component could address testing in a locale (both in health care settings and community-based counseling and testing settings) and the other plan component could address non-testing HIV prevention interventions. The reason I say this is for the 40,000 or so new infections estimated to occur each year, opt-out testing in health care settings might get you part of the way to moving the number of new infections toward zero, but it won't get you all the way; and although targeted counseling and testing would perform better, neither would it get to, say, a 50 percent reduction in new infections. Not everybody interfaces with the health care system, and those individuals who do not regularly interface with health care may be at the greatest risk for HIV.

Health departments and CPGs also need to think about ways of keeping counseling in their testing efforts, even in health care settings, because of the value and benefit that counseling has for behavior change and, thus, for reducing incident STD. Put quite simply, counseling is important, we know that it works and we can't discard counseling without consequence.

We also know that there are a variety of other behavioral, social and structural interventions that are effective in supporting behavioral risk reduction. Each state and community needs to decide what the best mix is for them, but it's a concern to me and should be a concern to CPGs and health departments that we don't over rely on one approach. If we overemphasize testing in our prevention efforts, we will lose our comprehensive approach to HIV prevention and that will harm us in the long run. I am definitely not against testing by any means; I just believe we need a comprehensive HIV prevention plan that *includes* testing.

Health departments and CPGs also need to think about getting people into care and treatment and ensuring that resources are adequate to provide sustained quality care. Across all the scenarios that I examined, the cost of public support for HIV care, associated with expanded testing, is quite substantial - nearly \$1 billion in the CDC "opt out" testing program and exceeding \$3 billion in the targeted counseling and testing scenario. Our health care system at current resources, particularly at current resource levels for HIV care, is not infinitely elastic and cannot take a number of new patients without the funding and plans in place to do so. So when we plan our counseling and testing efforts, with an

overarching goal of identifying as many new infections as possible, we need to simultaneously think about how we guarantee access to care. The Institute of Medicine report on the topic of public financing of HIV care in the U.S.

(<http://www.iom.edu/CMS/3793/4814.aspx>)

asserted that access to HIV care should be considered a right and not a discretionary program element. I do not believe that we should avoid testing because treatment resources have to be expanded; rather, I believe we must expand treatment resources to meet the demand generated by increased testing.

A full discussion of Dr. Holtgrave's study findings is available in the article "Costs and Consequences of the U.S. Centers for Disease Control and Prevention's recommendations for opt-out HIV testing." PLoS Med 4 (6):e194.doi:10.1371/journal.pmed.0040194. It can be accessed online at www.plosmedicine.org.

Targeting Counseling, Testing and Referral Programs to Address HIV/AIDS Disparities Among African Americans: An 07-768 Program in the Los Angeles County Jail System

Through efforts of publicly funded counseling, testing, and referral (CTR) programs, over two million HIV tests are carried out each year.¹ The revised CTR guidelines CDC released in 2001 outlined goals and principles for CTR and addressed strategies to improve HIV testing efforts, including incorporating routine testing for adolescents and adults in medical settings (outlined the *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*).² Nevertheless, traditional CTR programs are continuing to use new and innovative strategies for early identification of new HIV cases and effective HIV prevention counseling, including embracing social networking strategies and incorporating testing into outreach taking place in settings such as bars and bathhouses.

In 2007, to further expand testing, CDC released a new program announcement, PS07-768, targeted toward African American communities (*PS-07-768: Expanded and Integrated HIV Testing for Populations Disproportionately Affected by HIV, Primarily African American*). This funding supports a three-year testing program as part of CDC's *Heightened National Response* – CDC's response to the persistent HIV epidemic among African American communities in the U.S. As outlined in the program announcement, the funding supports increased testing strategies among primarily African American and other populations with significant HIV disparities who are unaware of their HIV status.³ Due to comparable incidence and prevalence, integrated testing strategies are also encouraged for hepatitis B and C, other STDs, and tuberculosis. Twenty-three city and state jurisdictions having 140 or more AIDS cases among Blacks diagnosed in 2005 accounting for 95 percent of the AIDS cases among Blacks in 2005, were funded for the program.

To explain more about targeted efforts using 07768 funding, Joanne Oliver, Program Manager of HIV Services in the Los Angeles County Sheriff's Department, shared information about a new strategy being implemented through the Los Angeles County Jails. Oliver says that Los Angeles chose to focus on testing in a correctional setting for this project because each day, anywhere from 450-1000

inmates are booked into the Los Angeles County Jail, and currently, African American males make up 34.9 percent of the male prison population and African American females make up 41.45 percent of the female prison population in the county. The Los Angeles County Department of Public Health's HIV Epidemiology Program has worked with corrections to help them understand that race, age, and zip code are indicators of risk as well as the crimes that inmates are booked for.

From the Inmate Reception Center, which processes the booking and medical screening for each new inmate, the program has a list of individuals that meet the criteria for this program. They then take the list of "new" inmates that is generated through an assessment tool and compare it to the population previously served so there is no duplication (even if they give different names, the classification by fingerprints provides the original name). Once a list of possible candidates for testing is developed and housing locations gathered (there are currently eight open county jail sites), Oliver's program schedules "Mini" Health Fairs at each location that include all inmates at that housing facility to be reached. The program offers rapid HIV testing, STD testing combined with counseling components and health education components. Health education messages include HIV education, STD education, tuberculosis, hepatitis, and MRSA (Methicillin-resistant Staphylococcus aureus, or Staph). If vaccine is available, the program also offers hepatitis A and B vaccinations and flu shots. Once the rapid HIV test results are available, any preliminary positive results then have phlebotomy to draw blood confirmatory tests with enough vials obtained to process t-cell and viral load.

In terms of the challenges for this program, Oliver says that because the initiative is in a jail system that has "short term" stays, they need to streamline the processes as much as possible. This model minimizes inmate movement, which also helps allay concerns regarding security. The program itself performs the phlebotomy and collects all of the tubes of blood for processing because of the need for rapid collection of information. Therefore, the use of rapid HIV testing shortens the results and disclosure time and increases the numbers that know their status and receive education and risk reduction. Inmates that receive a confirmatory positive result have a transitional case manager assigned to them along with counseling, support, and treatment adherence education. Community-based organizations (CBOs) funded by the Los Angeles County Department of Public Health Office of AIDS Program and Policy, in collaboration with the Los Angeles County Sheriff's Department Medical Services Bureau and the Los Angeles County Department of Public Health Sexually Transmitted Disease Program, deliver these case management and education services.

The transitional case managers address the transition needs of the inmates post-release. The program acknowledges that each inmate is unique in their needs, but some need information about clinic locations and assistance in setting up their first appointment, obtaining transportation, housing, food, and employment assistance. Should an inmate be released prior to receiving a confirmatory result, the Public Health Investigators find them in the community and provide the disclosure and counseling.

As this is a very new program, Oliver says they are still learning and will be eager

to share lessons and results as the program evolves. For more information on this project, please contact [Magdalena Esquivel](#) in the Los Angeles County Department of Public Health or [Joanne Oliver](#) at the Los Angeles County Jails.

References:

1. CDC. HIV CT Client Record Report, 2000 U.S. Total; unpublished data from http://www.cdc.gov/hiv/topics/testing/resources/factsheets/rt_counseling.htm.
 2. CDC. Revised Guidelines for HIV Counseling, Testing, and Referral. MMWR 50 (RR19);1-58 from <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm..>
 3. CDC. Expanded and Integrated Human Immunodeficiency Virus (HIV) Testing for Populations Disproportionately Affected by HIV, Primarily African Americans Program Announcement.
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Conclusion

There is no doubt that making HIV testing more accessible to more people - both through specific targeting of those at highest risk, as well as through routine HIV screening in health care settings to help those who otherwise do not identify a risk to know their status—is critically important to stemming the tide of the epidemic. More resources are needed to adequately support not only testing efforts, but also the infrastructure to support their successful deployment. Yet, while we wholly support the scale up of early diagnosis efforts, we must firmly remind the nation that these services can never supplant a full scale-up of interventions that have the potential to *prevent* new infections. Finally, as HIV testing and screening efforts are primarily a diagnostic procedure, financing must be appropriately portioned out to all possible payers, most importantly the public and private insurance systems in America.

Meeting and Planning Calendar

Capacity Building Opportunities: For a searchable database of CDC-supported capacity building trainings and events, please visit the [Capacity Building Branch's Group Events Management System site](#).

May 6-7, 2008

2008 Colorado Viral Hepatitis Conference, Denver, CO. For more information, view the [conference brochure](#).

May 19, 2008

World Hepatitis Day. For more information, link to the [newsletter](#).

May 19, 2008

National Asian and Pacific Islander AIDS Awareness Day. For more information, visit the event [website](#).

May 22-25, 2008

20th Annual National Conference on Social Work and HIV/AIDS, Washington, D.C.
For more information, visit the [conference website](#).

June 11-14, 2008
HIV Prevention Leadership Summit (HPLS), Detroit, MI. For more information,
visit the [conference website](#).

June 27, 2008
National HIV Testing Day. Sponsored by NAPWA. For more information, visit:
www.NAPWA.org

July 28-29, 2008
2008 National Conference on Latinos and HIV/AIDS, Miami, FL. For more
information, visit the [conference website](#).

August 3-8, 2008
XVIII International AIDS Conference, Mexico City, Mexico. For more information,
visit the [conference website](#).

August 25-28, 2008
Ryan White HIV/AIDS Program Training and Technical Assistance Grantees
Meeting and 11th Annual Clinical Update, Washington, D.C. Convened by HRSA.

September 15-16, 2008
1st Global Conference on Methamphetamine: Science, Strategy, and Response,
Prague, intended to bring together scientists, world leaders and professionals to
discuss the intersection between methamphetamine use, public health, law
enforcement and civil society. For more information, visit the [conference
website](#).

September 18-21, 2008
United States Conference On AIDS (USCA), Miami Beach, FL. For more
information, visit the [conference website](#).

November 13-16, 2008
Toward A National Policy: The 7th National Harm Reduction Conference, Miami,
FL. For more information, visit the [conference website](#).

Credits, Feedback and Input

The *NASTAD Prevention Bulletin* is edited by NASTAD staff and is written by staff and prevention experts from around the country. NASTAD's production of the *Bulletin* is made possible through funding provided by CDC's Division of HIV/AIDS Prevention (DHAP) in the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention.

If you have an idea or program that you would like to include in the *Bulletin*, please contact [Dave Kern](#) or [Lynne Greabell](#) (202/434-8090). NASTAD welcomes feedback to issues presented in *Bulletin*. To submit commentary, please e-mail

us at NASTAD@NASTAD.org.

Electronic versions of the *Bulletin* are available on our [webpage](#).

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