



PUBLIC HEALTH

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State Board of Health Briefing
HIV Counseling and Testing, Chapter 246-100 WAC
John F. Peppert, Director, IDRH

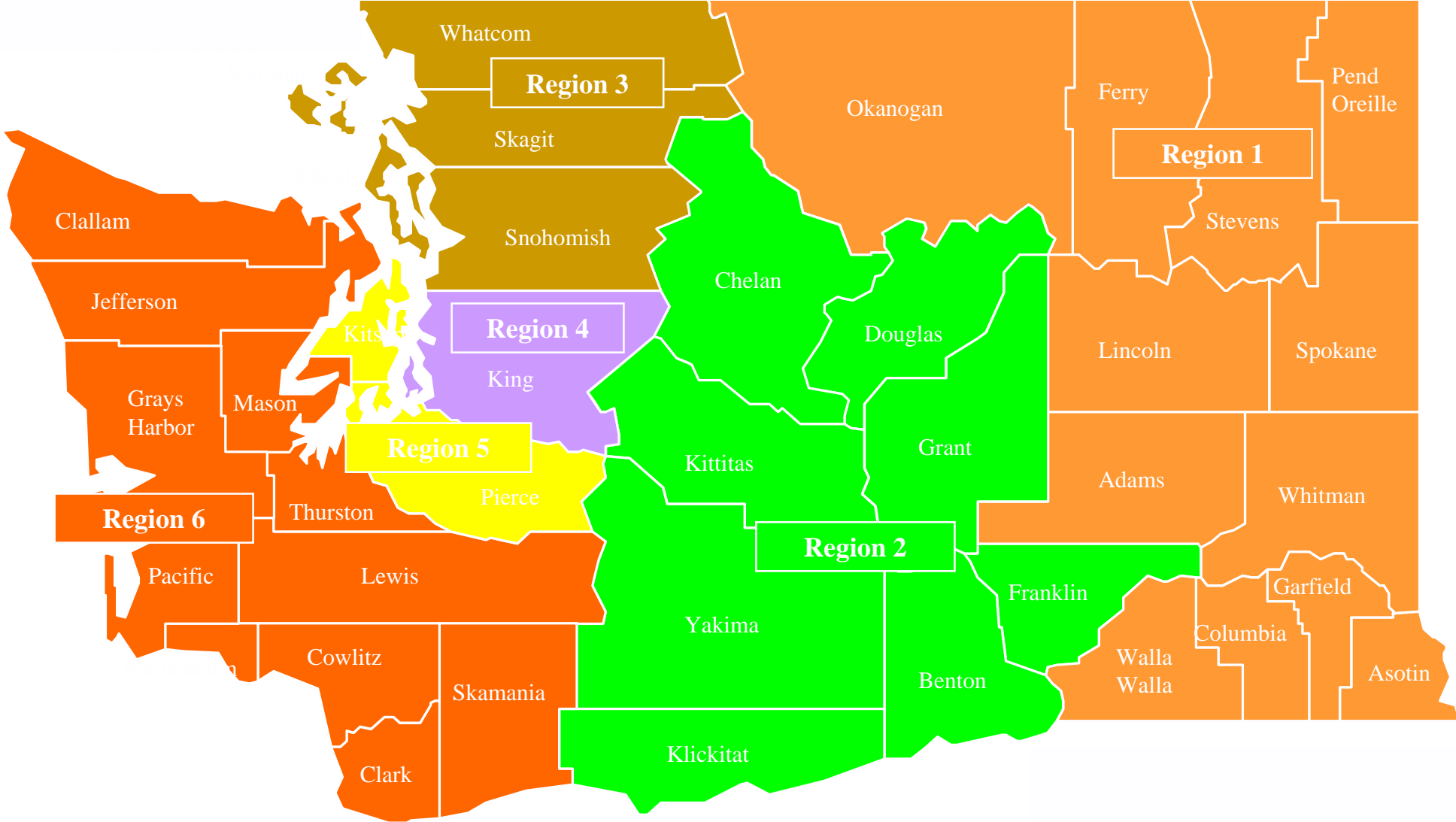
June 11, 2008

Topics To Be Discussed In This Presentation

- How are HIV public health services organized in our state?
- Why did CDC revise recommendations regarding HIV testing?
- Why are the AIDSNETs and others recommending changes in WAC?
- Proposed Next Steps

Washington State AIDS Services Networks

“AIDSNET Regions”



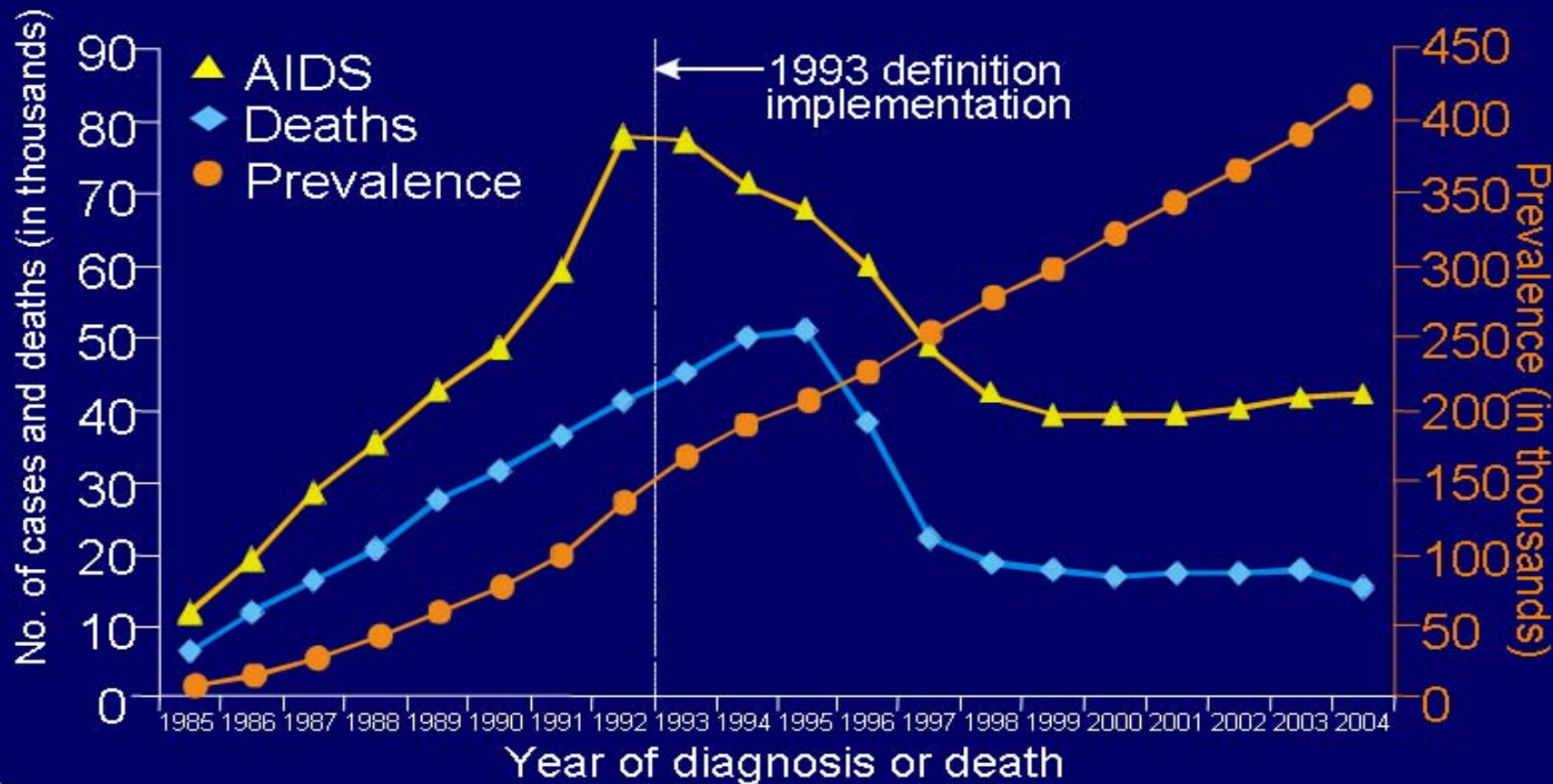
Revised Recommendations for HIV Testing in Healthcare Settings in the U.S.

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Estimated Number of AIDS Cases, Deaths, and Persons Living with AIDS, 1985-2004, United States



Note. Data adjusted for reporting delays.



Awareness of HIV Status among Persons with HIV, United States

Number HIV infected	1,039,000 – 1,185,000
Number unaware of their HIV infection	252,000 - 312,000 (24%-27%)
Estimated new infections annually	40,000



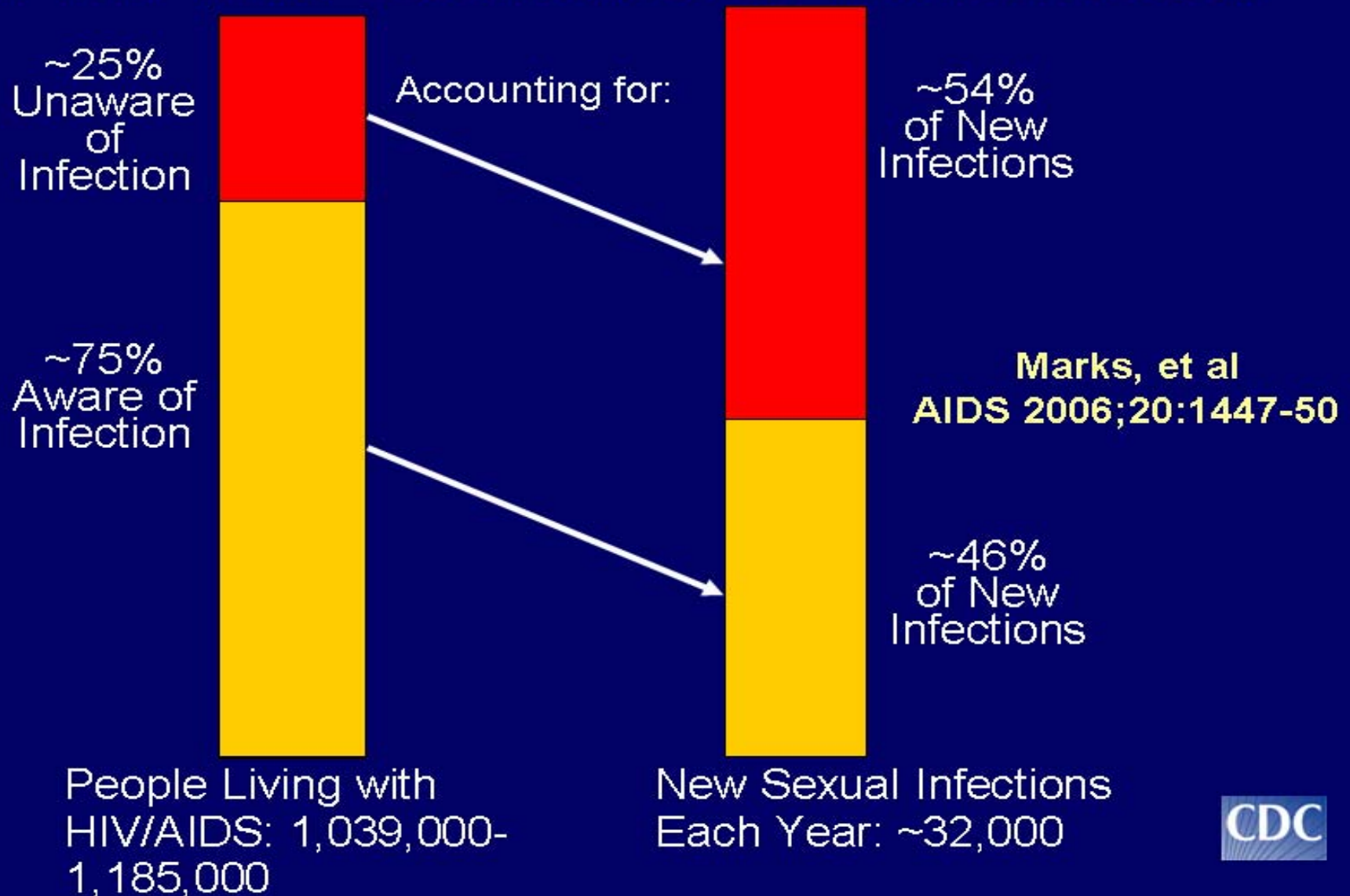
Glynn M, Rhodes P. 2005 HIV Prevention Conference



Awareness of HIV Status among Persons with HIV, Washington State

- Number HIV infected 11,000 – 12,000
- Number unaware of their HIV infection 1,100 – 2,400 (10%-20%)
- Number new infections annually 400?

Awareness of Serostatus Among People with HIV and Estimates of Transmission



Source of HIV Tests and Positive Tests

- 38% - 44% of adults age 18-64 have been tested
- 16-22 million persons age 18-64 tested annually in U.S.

	HIV tests*	HIV+ tests**
Private doctor/HMO	44%	17%
Hospital, ED, Outpatient	22%	27%
Community clinic (public)	9%	21%
HIV counseling/testing	5%	9%
Correctional facility	0.6%	5%
STD clinic	0.1%	6%
Drug treatment clinic	0.7%	2%

**National Health Interview Survey, 2002*

***Suppl. to HIV/AIDS surveillance, 2000-2003*



HIV testing in Washington State

- 18-64 Year Olds Ever Tested 37% (95% CI, 36%-39%)
About 1,455,475 WA residents
- 18-64 Year Olds Recently Tested 10% (95% CI, 9%-11%)
About 391,713 WA residents

Source: 2006 BRFSS

Where WA Residents Were HIV Tested

- Private doctor/HMO 42%
- Hospital 16%
- Clinic 28%
- Drug Treatment Facility 5%
- HIV Counseling/Testing 4%
- At Home 3%
- Correctional Facility 1%
- Other 1%

Source: BRFSS (based on location of last test)

Late HIV Testing is Common

Supplement to HIV/AIDS Surveillance, 2000-2003

- Among 4,127 persons with AIDS*, 45% were first diagnosed HIV-positive within 12 months of AIDS diagnosis (“late testers”)
- Late testers, compared to those tested early (>5 yrs before AIDS diagnosis) were more likely to be:
 - Younger (18-29 yrs)
 - Heterosexual
 - Less educated
 - African American or Hispanic

MMWR June 27, 2003

*16 states



HIV testing in Washington State

- 31% of individuals diagnosed with HIV between 2002 and 2006 were first diagnosed HIV positive within 12 months of AIDS diagnosis (“late testers”)

Source: Washington State HIV/AIDS Reporting System

Previous CDC Recommendations Adults and Adolescents

- Routinely recommend HIV screening in settings with high HIV prevalence ($\geq 1\%$)
- Targeted testing based on risk assessment
- Routinely recommend HIV Testing seeking treatment for STDs
- Annual testing for sexually active MSM



Recommendations Are Not Having Their Intended Effect in Acute Care Settings

- EDs account for 10% of all ambulatory care visits

	2000	2001	2002
ED visits	108 million	107 million	110 million
Age 15-64	68.3 million	69.4 million	69.6 million
HIV serology	215,000	201,000	163,000



HIV Testing Practices in EDs

- Survey of 95 Academic EDs
- For patients with suspected STDs:
 - ◆ 93% screen for gonorrhea
 - ◆ 88% screen for chlamydia
 - ◆ 58% screen for syphilis
 - ◆ 3% screen for HIV



- Wilson et al, 1999: Am J Emerg Med



HIV Testing Practices in EDs

- Survey of 154 ED providers
 - Average: 13 STD patients per week
 - Only 10% always recommend HIV test
- Reasons for not testing for HIV:
 - 51% concerned about follow up
 - 45% not a “certified” counselor
 - 19% too time-consuming
 - 27% HIV testing not available

-Fincher-Mergi et al, 2002: AIDS Pat Care STDs



The Case for HIV Screening



Criteria that Justify Routine Screening

1. Serious health disorder that can be detected before symptoms develop
2. Treatment is more beneficial when begun before symptoms develop
3. Reliable, inexpensive, acceptable screening test
4. Costs of screening are reasonable in relation to anticipated benefits

Principles and Practice of Screening for Disease
-WHO Public Health Paper, 1968



Rationale for Revising Recommendations

- Many HIV-infected persons access health care but are not tested for HIV until symptomatic
- Effective treatment available
- Awareness of HIV infection leads to substantial reductions in high-risk sexual behavior
- Inconclusive evidence about prevention benefits from typical counseling for persons who test negative
- Great deal of experience with HIV testing, including rapid tests



Knowledge of HIV Infection and Behavior

After people become aware they are HIV-positive, the prevalence of high-risk sexual behavior is reduced substantially.

Reduction in Unprotected Anal or
Vaginal Intercourse with HIV-neg partners: **68%**
HIV-pos Aware vs. HIV-pos Unaware

Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the U.S.

Marks G, et al. JAIDS. 2005;39:446



Summary of Review of Evidence

- HIV meets the criteria for screening, and effective treatment is available
- Many patients with HIV visit healthcare providers but their infection goes undetected
- People decrease their risk behaviors when they find out they are infected with HIV
- HIV screening in healthcare settings is cost-effective
- Opt-out screening increases testing rates



Revised Recommendations Adults and Adolescents - I

- Routine, voluntary HIV screening for all persons 13-64 in health care settings, not based on risk
- Repeat HIV screening of persons with known risk at least annually
- Opt-out HIV screening with the opportunity to ask questions and the option to decline
- Include HIV consent with general consent for care; separate signed informed consent not recommended
- Prevention counseling in conjunctions with HIV screening in health care settings is not required



Revised Recommendations

Adults and Adolescents - II

- Intended for all health care settings, including inpatient services, EDs, urgent care clinics, STD clinics, TB clinics, public health clinics, community clinics, substance abuse treatment centers, correctional health facilities, primary care settings
- Communicate test results in same manner as other diagnostic/screening tests
- Provide clinical HIV care or establish reliable referral to qualified providers



Why are the AIDSNETs and others recommending changes in WAC?

- Current WAC is in conflict with CDC routine HIV screening recommendations
- The conflict between the CDC recommendations and WAC requirements is confusing to Washington medical care providers
- Some Washington providers are reluctant or unwilling to implement the CDC initiative until these conflicts are resolved

Why are the AIDSNETs and others recommending changes in WAC?

- Under existing WAC, public health is restricted from routinely pursuing partner notification
- Public health is required to get authorization to contact the patient from principal health care provider
- This is a different standard than for other sexually transmitted diseases

Proposed Next Steps

- Continue discussions with the Governor's Advisory Council on HIV/AIDS
- Begin informing other stakeholders, organizations, and interested persons of the recommendations and gain input
- Identify all subsections of Administrative Code that may need revision
- In the next 30 – 60 days, request that a CR 101 be filed

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