

**New York/  
New Jersey  
AIDS  
Education  
and  
Training  
Center**

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I S S U E**

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# Regional Review

WINTER 2007

## In this issue of the *Regional Review*...

In September 2006, the Centers for Disease Control and Prevention (CDC) issued a report “Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings” (published in *Morbidity and Mortality Weekly Report* 55(RR14);1-17). The key revisions from previously published guidelines are the recommendations that HIV screening be done routinely for all patients 13-64 years old using an opt-out strategy, without written consent, and without the need for prevention counseling. The fact that approximately one-quarter of Americans living with HIV infection are not aware of their diagnosis and the lack of decline in incidence of new HIV infections in this country in recent years were major driving forces behind the effort to make HIV testing part of routine medical care.

The new CDC recommendations have generated considerable controversy and debate both regionally and nationally. Since the New York/New Jersey AETC has been at the forefront of training clinicians in HIV testing and the early recognition of both acute and chronic HIV infection, we are devoting this issue of our newsletter to debate the issues raised by the CDC recommendations and their impact on our region. We are fortunate to have distinguished NY/NJ AETC faculty who have given much thought to these issues and are sharing their perspectives here. We are also grateful to our other contributors for sharing their expertise.

**Marshall Glesby, MD, PhD**  
*NY/NJ AETC Regional Clinical Director*

## The Report on “The Report”: Confronting HIV/AIDS in the African American Community

**By: Robert Fullilove, EdD**  
*Columbia University, Mailman School of Public Health*

As a former PI and faculty member of the NY/NJ AETC it is my pleasure to comment on the CDC recommendations with respect to the African American community. On November 16th of last year, I published a report for the National Minority AIDS Council (NMAC), “African Americans, Health Disparities and HIV/AIDS: Recommendations for Confronting the Epidemic in Black America.” The epidemic has become a disease that hits African Americans with particular force, with recent data suggesting that blacks comprise 51 percent of those living with HIV in the United States.

The NMAC report asserts “while identifying undiagnosed infections is an important goal, we must look beyond medical interventions as the sole solution to our nation’s problem with HIV/AIDS. By itself, a national testing strategy will not prevent or eliminate HIV/AIDS, particularly if it results in large numbers of individuals who have no access to care. Simply put, the epidemic is rapidly outpacing our efforts to control it using standard public health, infection-control procedures.”

The report also notes the significant role that stigma – particularly homophobia – plays in preventing African Americans from getting tested or becoming more actively engaged in community-wide HIV prevention initiatives. In addition, the lack of affordable housing (a resource that is rapidly disappearing in urban America) is a factor that destabilizes communities and renders the task of providing appropriate HIV care all the more difficult. Unstably-housed persons living with HIV have a far worse prognosis when being treated for their infections than those who have stable housing. Finally, the report cites the role that injection drug use plays in driving the epidemic in the African American community, and recommends the expansion of drug treatment programs and, in particular, an increase in needle exchange programs as a way of minimizing the risk that drug abuse plays in disseminating HIV/AIDS.

While the CDC’s new testing recommendations are one step forward, what is needed is a set of initiatives that seek to attack the structural forces in poor

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# What's New?

## Revised CDC Recommendations for HIV Testing

Nearly one quarter of HIV positive individuals in the United States do not know that they are infected with the virus. In September 2006, the CDC issued "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Healthcare Settings." The objectives of the revised recommendations are to "increase HIV screening of patients, including pregnant women, in health-care settings; foster earlier detection of HIV infection; identify and counsel persons with unrecognized HIV infection and link them to clinical and prevention services; and further reduce perinatal transmission of HIV in the United States." Routine screening is also intended to de-stigmatize the disease, by treating HIV more like other serious health conditions. The revisions are targeted at HIV testing in healthcare settings and do not affect guidelines for HIV testing, counseling, and referrals in non-clinical and community-based settings. Major revisions from previously published guidelines are as follows:

### For patients in all health-care settings

- HIV screening is recommended for patients in all health-care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening).
- Persons at high risk for HIV infection should be screened for HIV at least annually.
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in health-care settings.

### For pregnant women

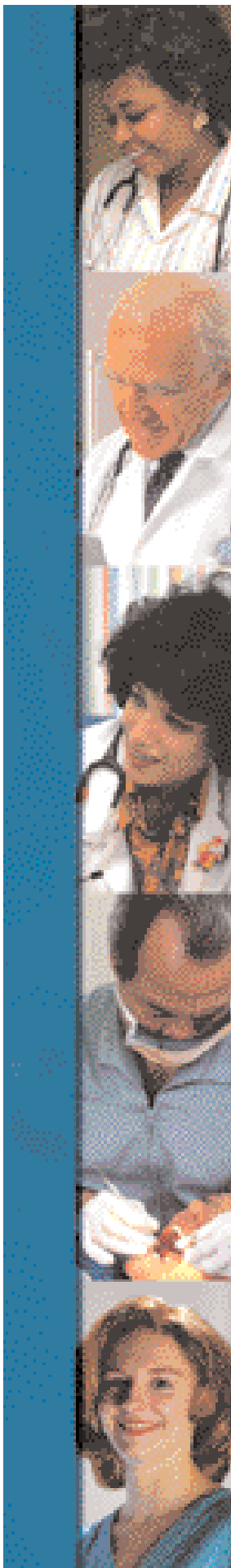
- HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women.
- HIV screening is recommended after the patient is notified that testing will be performed unless the patient declines (opt-out screening).
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Repeat screening in the third trimester is recommended in certain jurisdictions with elevated rates of HIV infection among pregnant women.

"Opt-out" testing refers to testing that will be performed as a part of routine medical care unless the patient specifically declines the test. Currently, New York and New Jersey both require separate, written informed consent, or "opt-in" testing. With "opt-out" testing, general consent for medical care is sufficient to consent to an HIV test, as long as the patient is aware that the test will be performed and is given an opportunity to ask questions or decline testing. Removing written informed consent for opt-out testing would require a change in public health laws.

### Opt-Out vs. Opt-In Testing

**Opt-out Testing:** HIV testing performed as part of routine medical care unless the patient specifically declines to have the test. Patients are informed that the test will be conducted and given a chance to refuse testing.

**Opt-in Testing:** Requires written, informed consent for patients to receive HIV testing.



## Comparison of CDC HIV Testing Recommendations with Current Guidelines in New York and New Jersey

Recommendation	NYSDOH Guidance	NJ DOHSS Requirements	CDC Revised Recommendations
HIV Testing should be offered at least once as a routine part of health care for all adults	Yes	HIV testing is offered to all pregnant women*	Yes
HIV pre-test counseling should be streamlined and may be done by offering patients written materials to review and an opportunity to ask questions	Yes	Under consideration*	Yes
Written informed consent is required for testing (Opt-in testing)	Yes	Yes*	No
People who test HIV- positive should be promptly referred for evaluation of their clinical status and consideration for antiretroviral therapy	Yes	Yes	Yes

\*The extent to which New Jersey will adopt CDC recommendations or change public health law is currently under discussion: NJ law requires written consent for pregnant women.

### The Report on “The Report”: Confronting HIV/AIDS in the African American Community cont'd from cover

communities of color that are driving the epidemic. Chief among those cited are increasing rates of incarceration, which have dramatically increased the number of African American men behind bars. With drug users comprising a significant proportion of the increase in the numbers of Americans behind bars, the group at greatest risk for an HIV infection will find themselves in settings that rarely, if ever, provide the resources to conduct effective, aggressive HIV prevention programs, much less the treatment facilities necessary to assist those struggling with HIV disease. There are notable exceptions to this rule, but prisons with enlightened policies and programs for combating the epidemic are far too rare.

Perhaps the most significant aspect of the report is the number of civil rights leaders and members of the Black Congressional Caucus of the US Congress who signed onto the report as part of its Blue Ribbon Review Panel. For years, advocates in the Black community have struggled to have HIV/AIDS as part of the political and programmatic agenda of the nation's African American political leaders. Twenty-five years into

the epidemic, having the support of men and women such as Julian Bond (NAACP), Mark Morial (Urban League), Marian Wright Edelman (Children's Defense Fund) and public health leaders such as David Satcher (former US Surgeon General), The Honorable Louis Sullivan (Former Secretary of Health and Human Services) marks an important “first” in our efforts to raise national awareness – particularly in the African American political community –of the urgency of our fight against the epidemic.

My hope is that the NMAC report, together with the CDC's new recommendations, will generate new political discussion that will help members of the Black Congressional Caucus succeed in passing legislation that will have an impact on the structural issues that drive the epidemic nationwide. Only time will tell, of course, but the widespread press coverage that the report and recommendations have received has left me, at the very least, cautiously optimistic.

The report is available at [www.nmac.org](http://www.nmac.org)

## Informed Consent for HIV Counseling & Testing

**By: Douglas M. Fish, MD**

*Head, Division of HIV Medicine, Albany Medical College*

With more than 40,000 new HIV infections annually for the past eight years, it is clear we need to act if we expect different results. In the spirit that each of us has an HIV serostatus, be it positive or negative, expanded efforts to make HIV testing more available and more routine are critical. So the question is not the “what,” but rather the “how.”

I believe people are best served by preserving informed, written consent with streamlined HIV counseling. While we have made progress in 25 years as a society, enormous stigma still exists for those diagnosed with HIV infection. Simply testing more people will not change stigma for those diagnosed as HIV-infected.

There are three principles of bioethics we need to keep in mind: justice, beneficence, and autonomy. Justice demands that we treat people fairly and equally. Beneficence requires that we do “good,” and above all, do no harm. Autonomy preserves patients’ rights for self-determination.

It is critical that patients understand what an HIV test is, why testing is recommended, and what a positive or negative test result means. With the exception of the rapid test, HIV screening is reflexively linked to the diagnostic Western Blot. There is not an additional opportunity to share information and answer questions before the final test result. Patients deserve to understand the test that is being done and that HIV is eminently treatable, should they test positive. An assent-only process bypasses information exchange, making the test itself the goal, rather than informing the person before us.

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**“It is critical that patients understand what an HIV test is, why testing is recommended, and what a positive or negative test result means.”**

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We have all heard that the consent form is a significant barrier to testing, and yet I believe this is a smokescreen issue. How many of you received information and signed a consent form for your flu shot? How much of an obstacle was it? Sure it would be easier to test if we don’t have to talk to the patient, but is that what this is really about? I have lived in New York State for 13 years, and saw verbal consenting in another state prior to this. The slippery slope is going from “we recommend this test for the betterment of your health,” to “we need this test in order to treat you.” There is subtle and sometimes not-so-subtle coercion implied in the latter, and the most vulnerable populations will be those least able to advocate for themselves, especially if they fear they won’t get the treatment they need.

Advocates of opt-out testing point to the success in curbing perinatal transmission, an enormous accomplishment of which we should all be proud. However, in New York State we did this maintaining our structure of written, informed consent. The 2005 guidelines for streamlined HIV counseling and testing have been very helpful. Counseling can be done in minutes, without extensive or specialized training.

I believe what clinicians need are the tools to counsel and test patients efficiently. I would recommend a massive campaign, much like the smoking cessation campaigns, targeting both providers and patients. We should arm every clinician in the state with the consent and reporting forms, and a pocket guide to assist them. The ACTS guide\* developed by Dr. Donna Futterman and her team at the Montefiore Adolescent AIDS Program is an excellent example. By also targeting patients in this campaign, we can give them enough information that they will ask their clinicians about getting tested.

We all have the same goal in mind. Let’s inform our patients as well as recommend HIV testing, so those who do test positive will have some foundation on which to build and we can get them safely into care.

*\* For more information about the ACTS Guide, see page 6 of this newsletter.*



# Opt-Out

## Routine Testing to Reduce HIV/AIDS Disparities in Minority Populations

**By: Karen Brudney, MD**

*Director, Columbia University Medical Center Infectious Diseases Clinic*

LB, a 33-year-old African American woman with a history of asthma was admitted to a New York City hospital with two weeks of shortness of breath and cough. She had been treated for asthma one week earlier and sent home, but felt short of breath again and returned. She had no significant medical history—except asthma—did not smoke, drank socially, and had never used drugs. She worked in a department store and lived with her healthy 12-year-old son. After rapid respiratory deterioration, she required intubation, admission to the Medical Intensive Care Unit, and upon bronchoscopy, was diagnosed with PCP. She tested positive for HIV and had a CD4 count of 11. LB was deeply shocked by her diagnosis. Although followed regularly in a hospital-based clinic for her asthma, she had never been tested for HIV because she did not consider herself to be at risk.

LB is one among thousands of New Yorkers who have HIV/AIDS and do not know it. She nearly died of respiratory failure—entirely unnecessarily.

It is 2007 and the AIDS epidemic is more than 25 years old in New York City. Those with the highest death rates are African Americans. African American men are six times more likely to die of AIDS than white men with AIDS. African American women like LB are nine times more likely to die of AIDS than white women who have the same diagnosis. LB was a late tester. In survey after survey, late testers are significantly more likely to be younger (18-29), to be black or Hispanic, to have been exposed to HIV through heterosexual contact and to have a high school or less education.

Why was LB never tested?

The process of obtaining written informed consent under New York State Law requires a lengthy explanation of technical details including the meaning of an antibody test and the percentages that may be falsely positive or negative. When performed properly, this process requires at least 20 minutes. No other medical illness requires any such consent process—including syphilis, hepatitis B, and diabetes. The law dates from a time when there was no treatment for HIV and there was little to gain from knowing one's HIV status except horrible stigmatization. This is no longer the case. HIV has become a chronic but

entirely treatable disease, like diabetes or hypertension. Fatal complications are completely preventable and avoidable in New York and New Jersey with easily accessible medications that are far less difficult to take than insulin.

Physicians who care for the population dying at the highest rates of HIV work in busy hospital clinics and do not want to break the law and rush patients through the consent process. They make their own assessments about their patients' risk for HIV. Often times, they focus on diabetes and hypertension, which can be easily tested for without a prolonged written consent process. Despite the fact that HIV medications are free to all African Americans in New York City who need them, more African Americans continue to die of untreated AIDS than any other group of New Yorkers.

Opponents to opt-out routine testing point to the stigmatization of receiving an HIV diagnosis as justification for the long, written consent process. The insistence on a testing process so different than that used for any other fatal disease simply maintains and exacerbates the stigma associated with HIV/AIDS. It is time to enable those most in need to obtain early knowledge of and treatment for their disease. The numbers speak for themselves. It is time to stop African Americans from dying of AIDS.

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**“The insistence on a testing process so different than that used for any other fatal disease simply maintains and exacerbates the stigma associated with HIV/AIDS.”**

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# HIV Testing in Action

## HIV Seroconverters at Callen-Lorde Community Health Center

By: Rona Vail, MD

The CDC revised recommendations for HIV testing urge health care facilities to routinely offer HIV testing in an attempt to diagnose HIV-infected individuals who are unaware of their status. Recognizing the signs of the early stages of HIV infection is another important strategy in diagnosing HIV cases. Callen Lorde has been successful at diagnosing individuals in the first weeks of their HIV infection, or Acute HIV infection (AHI). Individuals with AHI typically have soaring levels of virus in their blood and genital secretions, and consequently are highly infectious to their sexual partners; therefore identifying these patients is important for public health. About 80% of people with AHI will experience flu-like symptoms and many will seek care. Unfortunately, medical care settings typically misdiagnose AHI because they often do not distinguish AHI symptoms from other viral syndromes or consider patients' risk behaviors.

Callen-Lorde Community Health Center (CLCHC) in New York City provides primary medical care and prevention services primarily to the Lesbian, Gay, Bisexual and Transgender community. Our medical staff are trained to recognize the signs and symptoms of AHI. To assess the effectiveness of this awareness, CLCHC conducted a retrospective chart review of AHIs diagnosed at Callen-Lorde over the past 18 months.

The chart review identified fifteen HIV seroconverters. Ten infections had been diagnosed at seroconversion; five were "missed" upon initial presentation. Eight of the 10 patients diagnosed with AHI presented with symptoms. Notably, two of the 10 diagnosed patients with AHI reported no symptoms but were diagnosed due to repeat testing because of high HIV risk.

Two of the five missed patients presented with recognizable seroconversion symptoms that were attributed to other viral syndromes, and three presented with subtle symptoms that proved difficult to detect even with providers trained to recognize HIV seroconversion. While high fever and rash are discussed in the literature as common symptoms of AHI, we found that only seven of the fifteen patients presented with a fever  $>101$ , and only three patients presented with rash. More common than rash were pharyngitis (nine patients) and oral and anal ulcers (five patients).

Identifying and counseling individuals with AHI and reaching out to their sexual contacts could quickly break chains of HIV transmission in vulnerable communities. CLCHC is now talking with the New York City Department of Health to improve rapid partner notification strategies.

### Sexual Transmission Risk and Rapid Public Health Intervention in Acute HIV Infection

Christopher D Pilcher<sup>1\*</sup>, E Foust<sup>2</sup>, R Ashby<sup>2</sup>, J Kuruc<sup>1</sup>, T Nguyen<sup>1</sup>, L Hightow<sup>1</sup>, N Harrison<sup>1</sup>, S McCoy<sup>1</sup>, D Williams<sup>2</sup>, and P Leone<sup>1,2</sup> Univ of North Carolina at Chapel Hill, US and<sup>2</sup> North Carolina Div of Publ Hth, Raleigh, US, CROI 2006

## ACTS of Routine HIV Testing

By: Stephen Stafford

The CDC's new guidelines for routine HIV testing highlight the critical need to improve HIV case finding. Many of the 250,000 HIV+ people in the US who are unaware that they are infected interact with health care systems, but because HIV testing is not offered routinely, they remain undiagnosed and thus unconnected to life-saving treatment and prevention services. More than a decade of stagnant case finding is proof that the current model of burdening psychosocial staff with the lion's share of HIV testing is not working. If case finding efforts are ever to catch up with treatment advances, medical providers must integrate HIV testing into routine care—a shift that will identify more positives and allow for better use of scarce psychosocial resources to support those who are HIV+.

AETCs can and should lead efforts to solve this problem. AETCs were instrumental in the successful scale-up of prenatal HIV testing, and now our leadership is needed to mobilize and educate our colleagues about the benefits of integrating HIV testing into routine care for all patients.

The Adolescent AIDS Program in the Bronx, one of the AETC training sites led by Donna Futterman, MD, developed ACTS (Assess, Consent, Test, Support), an adaptable system that helps providers make this shift. ACTS simplifies and demystifies HIV counseling and testing, so that providers can offer the test themselves in less than five minutes—either with the current written consent process or the future "opt-out" process. ACTS also offers administrators easy-to-use tools to address the logistical requirements for routine provider-delivered screening.

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## Adventures in Opt-In: Routine HIV Testing at St. Vincent's Catholic Medical Center

**By: Antonio Urbina, MD**

Medical Director, HIV/AIDS Education and Training,  
St. Vincent's Comprehensive HIV Center

In 1993, the CDC issued recommendations calling for all health care institutions located in areas with HIV prevalence of 1% or greater to offer routine HIV testing. Despite these recommendations, we found only two institutions in the literature that actually implemented them. The area surrounding St. Vincent Catholic Medical Center-Manhattan (SVH) has a prevalence of 4%.

Starting July 1, 2006, the St. Vincent's HIV Education and Training Program trained all housestaff in the Department of Medicine to offer HIV testing to all medical and psychiatric inpatient admissions. Specifically, we trained housestaff to conduct a streamlined pre-test counseling protocol, developed and distributed 4 x 6 laminated cards (which provided the HIV testing protocol) for housestaff to carry in their labcoats, copied hundreds of NYS

### ACTS of Routine HIV Testing

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In a trial of 10 community health centers in the Bronx, the five sites using ACTS doubled their HIV testing rates, while the five control sites saw only a minimal improvement in testing. While ACTS has doubled testing rates, it is important to note that testing in these clinics went from 10% of eligible patients to 24%.

ACTS alone is not enough. Based on extensive qualitative feedback from providers, the extra time and forms (for consent and reporting) for HIV testing constitute the greatest barrier to testing. We believe that eliminating written consent would greatly improve the uptake of HIV testing in any clinical setting.

However, until New York and New Jersey make the legislative changes needed to implement the CDC's "opt-out" recommendation, providers can make the consent process faster and easier by utilizing ACTS and pre-packaging "consent kits" for exam rooms that contain necessary forms.

For additional tips on how you can make HIV testing more routine in your clinical setting, visit [www.AdolescentAIDS.org](http://www.AdolescentAIDS.org) or call Stephen Stafford at (718) 882-0232.

counseling and testing forms (Part A and B) and state mandated HIV-I antibody laboratory forms, collated and placed these forms into the standard history and physical (H&P) forms used by housestaff to admit all hospitalized patients, and finally, conducted follow up trainings at housestaff meetings to ensure that they were offering HIV testing pursuant to the protocol.

Despite this intensive training and ongoing monitoring, we encountered some substantial organizational and institutional barriers: clerks often neglected or forgot to copy state forms and/or place these forms into the H&P forms, nurse supervisors objected to the additional work involved in maintaining the HIV testing protocol, and housestaff forgot or were too busy to offer HIV testing.

After three months, we surveyed housestaff to better understand their reasons for not offering HIV testing. We found that 60% reported forgetting to offer HIV testing, 46% reported doing their own risk assessment as the reason for declining HIV testing and 48% reported that they were too busy with other patient care to offer HIV testing.

Since implementing this protocol, the number of inpatient HIV tests performed at SVH increased from about 20 tests per month to 40 tests per month. On average, SVH admits 30 patients per day. Of these, 24 are considered unique admissions. This increased number of HIV tests represents <1% of all our unique medical admissions. We have identified four cases since implementing this protocol.

These are preliminary results and our evaluation is ongoing. We feel that the current, opt-in, NYS HIV testing law, requiring a separate, written informed consent creates substantial operational barriers which result in many patients not being offered HIV testing despite the best intentions of our staff.

### Resources

**HRSA/AETC National HIV/AIDS Clinicians' Consultation Center which includes the:**

**Warmline:**

**1-800-933-3413**

Offering treating clinicians current HIV clinical and drug information and individualized, expert case consultation.

**Post-Exposure Prophylaxis 24 hour hotline (PEPLINE):**

**1-888-HIV-4911**

Providing consultation for occupational exposure.

**Perinatal Hotline**

**1-888-448-8765**

Providing consultation for perinatal exposure and treatment.

**The AETC HIV/AIDS National Resource Center:**

**<http://www.aidsetc.org/>**

Provides resources (including curricula and lecture slide sets) on HIV disease treatment, education and data.

# Provider Perspectives

## Integration of HIV Testing into Routine Dental Care

**By: Stephen N. Abel, DDS, MSD**

*Dental Co-Director, NY/NJ AETC*

For dental practitioners, HIV Counseling & Testing is not an issue of whether patients should “opt-in” or “opt-out”, but whether they should “opt-at-all”. Are oral health professionals willing to play a role in HIV testing and how will dental patients view and receive HIV testing in the dental office?

Stakeholders from HRSA, the CDC Division of Oral Health, dental schools, community health centers and the private sector have convened over the last year to explore the issue of integrating HIV testing into routine dental care. J. Cleveland from the CDC has recently reported on the additional number of HIV cases that could be detected if one-time HIV screening were offered in dental offices. Medical and dental data was reviewed among (1) those at risk, (2) who had never been tested for HIV, (3) and who had a dental visit in the previous year but had no medical visit. Her data suggested that dental offices might be useful alternative screening sites for identifying additional cases of HIV, particularly among dental settings in high HIV prevalence areas.

A significant expansion of HIV testing into dental settings may require a paradigm shift among practitioners. A recent survey of US dental school administrators found that only 50% of respondents felt that HIV C&T should be performed in the dental schools and fewer than 40% of dental schools were even somewhat likely to consider rapid testing in their clinics. With little or no training on HIV C&T in dental school curricula, most US dentists currently lack the skills and/or interest in performing HIV C&T.

If HIV testing is to be incorporated into dental practices, the integration should begin slowly and start in the public health arena, most notably with community health centers that currently provide dental services. Linkages for confirmatory testing, prevention and medical treatment are far more likely to be in place within those dental settings than in the offices of private dental practitioners.

Several community dental health clinics in the US that have recently begun to offer rapid HIV testing. Over the next several years these new programs will begin to provide data on dental professionals’ willingness to participate in HIV testing, patients’ willingness to accept an HIV test

within a dental setting, and a host of other practical and logistical considerations. More importantly, we will begin to have real data on the numbers of new cases that have and can be diagnosed within the dental setting. Only at that time will we be able to measure the true costs, value and benefits of opting-to-perform HIV screenings in dental settings. For more information, or to request an HIV Oral Health training in New York or New Jersey, please call Howard Lavigne at (315) 477-8479.

## Support for CDC Recommendations Among Family Nurse Practitioners

**By: Maryanne Crowther, RN, APNC, CCRN**

*Forum of Nurses in Advanced Practice President, NJSNA  
American Academy of Nurse Practitioners New Jersey State Representative*

Advanced Practice Nurses in New Jersey are already in the forefront of opinion about these new recommendations. Claire Lindberg, Family Nurse Practitioner, believes the new CDC recommendations “represent a step forward toward reducing the incidence of HIV and AIDS. The recommendations should increase sensitivity of providers to the need for testing.” Claire also thinks the new guidelines may “normalize” and “demystify” HIV testing.

Connie R. Kartoz, Family Nurse Practitioner, thinks it is “wonderful to be encouraged to test all, without regard to the patients “stated” risk factors. Teenagers (and adults) often do not give full disclosure of their health habits to providers. Testing all should remove the stigma of testing, and allow us to identify those at risk to spread the disease.”

Both of these advanced practice nurses like the idea of counseling changes. Connie thinks the timing of it should be left to the provider’s discretion. It concerns her, however, that “providers may feel free to blanket test all individuals and (yet) people with significant risks or lack of knowledge may not receive (as thorough) care and counseling they need” on risk reduction behaviors. Claire thinks that by streamlining and facilitating counseling procedures, more providers will be willing to provide testing and therefore testing will be available to more individuals. She thinks it important to have the “capacity for identification of the infection in the early stages when much can be done to monitor and treat patients and to educate them” and

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# Provider Perspectives

## HIV Testing and Family Physicians

**By: Richard Bonanno, MD**

*President, New York State Academy of Family Physicians Foundation; Past President, New York State Academy of Physicians*

As a family physician who serves as a medical director for a publicly funded family health center, I applaud the CDC's recent recommendation for expanding HIV testing to all adults, as part of routine medical care. As some have stated, it means moving from a "personal rights" model to a "public health" model. In recent years we have made great strides in HIV treatment and had some success in prevention, but the family physician and others in primary care must take a more aggressive role in diagnosis and prevention if we are to identify the estimated quarter million Americans who do not know they are HIV positive. We can do a great deal to help these individuals stay healthy, and evidence is fairly solid that people who know their status are less likely to transmit HIV through sexual contact. We cannot accomplish this, however, unless we follow the recommendations of CDC by eliminating the cumbersome process for HIV testing which is part of our legal requirement in New York.

New York and other states require extensive counseling and written consent for an HIV test. I am fortunate at my center to have additional staff funded to assist with counseling and testing, but this is a luxury which most practices don't enjoy, and it makes it impossible to test to the extent New York State



recommends. Although there certainly is still some stigma attached to HIV, it is far less than it was even a decade ago. By testing everyone as part of a routine, we can reduce the stigma further and place prevention and treatment at a higher priority in general medical care.

Family physicians are accustomed to giving brief explanation to patients when ordering any diagnostic test. We realize that it is our obligation to provide follow-up counseling and education, whether we are identifying a diabetic or an HIV positive individual. Our time and that of our staff can be better spent on direct service to the patients who need it most, rather than on a cumbersome written process. For those who would like a more detailed assessment of this issue, I would refer you to the October 25, issue of JAMA, and the Commentary written by a lawyer, Lawrence O. Gostin.

I certainly realize that there are many learned and dedicated individuals who have worked on the HIV/AIDS cause since its beginning, who disagree with this approach. Most family physicians I work with in HIV care, however, believe it is time to move to the public health approach for increasing the scope of HIV testing as the CDC advises. New York should make the changes in its laws that are necessary to allow this to occur.

## Revised HIV Testing Recommendations – The Effect on Pharmacists

**By: John J. Faragon, PharmD, NY/NJ AETC Regional Pharmacy Director**

The new CDC testing recommendations are an important step in helping to identify undiagnosed HIV infection. However, the effect of these recommendations on the role of pharmacists is difficult to predict.

Pharmacists working in various settings may specialize in disease state management (DSM) for diabetes, hyperlipidemia, hypertension and other disease states, including HIV. Successful DSM involves not only ensuring that treatment goals of current diseases are being met, but also referring patients to health care providers for general health maintenance and early identification and treatment of new conditions. For example, pharmacists in some states are allowed to administer immunizations, so they may arrange influenza clinics to be held in their pharmacy. Successful interventions have also included recommending low dose aspirin to patients with



diabetes mellitus. Since patients often visit their pharmacy more frequently than their health care provider, pharmacists can play an important role in HIV awareness by recommending HIV testing in patients from the ages of 13-64. Pharmacists located in areas of high HIV prevalence can also play a role in ensuring and/or recommending annual HIV testing to their patients.

Pharmacists play a crucial role in providing education and patient counseling on medications for multiple chronic conditions, and in general health maintenance and prevention. Short of actually providing HIV testing, pharmacists can encourage testing in a variety of ways, such as including reminder leaflets with prescriptions,

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# Provider Perspectives

## HIV Testing and Care in Rural New Jersey

By: David V. Condoluci D.O., F.A.C.O.I. and Kelly Rand, M.A.

Though a small state, New Jersey is defined by a diverse geography and varied needs for its population. New Jersey is a very densely populated state, often thought of as suburbs for New York or Philadelphia. However, northern and southern New Jersey differ greatly. Rural communities characterize much of southern New Jersey. Many of these areas are also classified as New Jersey's medically underserved areas.

New Jersey has a high incidence of people infected with HIV/AIDS. There are over 33,000 people reported living with HIV/AIDS in New Jersey. Minorities predominate and nearly 70% of persons living with HIV/AIDS in NJ are over 40 years of age. Most HIV positive individuals live in high prevalence areas around the cities such as Newark, Jersey City, Camden and Atlantic City. However, rural areas in New Jersey have significant numbers of people living with HIV/AIDS, who face specific and uniquely rural barriers to getting testing and care.

The major barriers to care in rural regions include lack of transportation, a migrant population, stigma for those seeking testing or care, and limited access to care. Because the areas affected are rural there is very little established public transportation and people may have to travel great distances for care or testing. The primary industry for many of these regions is farming and in order to work the farms New Jersey rely on a population of migrant and seasonal farm workers. People in these small, marginalized communities are at increased risk for HIV, but face significant barriers that prevent them from seeking HIV prevention or treatment services.

One successful HIV/AIDS program in Southern New Jersey is the Early Intervention Program at Kennedy in association with Garden State Infectious Disease Associates. This program is based in Voorhees and has satellite facilities in Salem and Cumberland counties, providing care and treatment to these rural areas. This program relies on a scaled-down version of a multidisciplinary team to provide care and treatment for HIV positive patients. Peer education for providers in this rural area helps to improve the day-to-day care and treatment of those infected with HIV.

The State of New Jersey has implemented rapid testing in the emergency rooms of many of the hospitals and in some clinical settings. This provides rapid identification of those tested within

a half an hour and those found to be positive can be linked to one of the several early intervention programs throughout the state. This initiative is especially crucial in rural settings, where the ER or clinician's office may be the only place where a person can readily receive an HIV test.

Rural areas often require creative ways to provide testing and treatment to underserved and under funded areas. New Jersey has sought to fill the gap through the use of Early Intervention Programs, peer-to-peer education, and rapid testing. The ultimate goal is to reduce transmission and keep people in care and treatment. If implemented in New Jersey, the CDC's new testing recommendations would help identify new cases and connect patients to care faster, especially the most marginalized of populations. This will ultimately help to reduce health disparities and save lives.

## Support for CDC Recommendations, cont'd from page 8

their families about lifestyle changes to decrease transmission and promote health.”

Overall, these new CDC HIV testing recommendations were well received by NJ APNs, who regularly provide education, prevention strategies, and early treatment of disease to all of our patients in need. The recommendations aim to improve the health of not only our patients, but their loved-ones and our global society.

## Revised HIV Testing Recommendations – The Effect on Pharmacists, cont'd from page 9

posting signs to announce testing sites, or doing a mailing to pharmacy customers. Their active engagement in recommending HIV testing in appropriate populations is feasible and should be encouraged.

For more information or to request HIV education for pharmacists in New York or New Jersey, please contact John Faragon, PharmD at (518) 641-2130 or via email at faragoj@mail.amc.edu.

## Spotlight on...

### Other Federally Funded Regional Training Centers in the Region

Training centers will play a crucial role in enhancing the capacity of health care providers to further integrate HIV screening into routine medical care. **In addition to the NY/NJAETC** (see back page for AETC training center locations), the following training centers provide free education and technical assistance regarding a broad range of HIV-related topics throughout NY & NJ.

Training Center	Region II STD/HIV Prevention Training Center (PTC)	Northeast Addiction Technology Transfer Center (ATTC)	Planned Parenthood of NYC HIV Integration Project (RTC)	Title X Region II Family Planning Training Center at Cicatelli Associates Inc. (RTC)
Funded By	Centers for Disease Control and Prevention (CDC)	Substance Abuse Mental Health Services Administration (SAMHSA)	Centers for Disease Control and Prevention (CDC)	Office of Population Affairs (OPA) of the US Department of Health and Human Services
Location	NYC Department of Health and Mental Hygiene (DOHMH) 125 Worth Street CN 73 New York, NY 10013	Institute for Research, Education, and Training in Addictions Regional Enterprise Tower 425 Sixth Ave Suite 1710 Pittsburgh, PA 15219	26 Bleecker Street New York, NY 10012	505 Eighth Avenue 16th Floor New York, NY 10018
Website	<a href="http://www.nyc.gov/health/std">www.nyc.gov/health/std</a>	<a href="http://www.neatcc.org">www.neatcc.org</a>	<a href="http://www.ppnyc.org">www.ppnyc.org</a>	<a href="http://www.cicatelli.org/TitleX/home.htm">www.cicatelli.org/TitleX/home.htm</a>
Mission	To reduce sexually transmitted diseases (STDs) and HIV morbidity and improve reproductive health by addressing the educational needs of medical providers throughout New York City, New York State, New Jersey, Puerto Rico, and the U.S. Virgin Islands.	To help facilitate collaboration between main stakeholders involved in applying addiction science in New Jersey, New York, and Pennsylvania.	To integrate HIV services into reproductive health centers/services in New York, New Jersey, Puerto Rico, and the U.S. Virgin Islands.	To assist Title X providers in providing a broad range of acceptable and effective family planning methods and services. Cicatelli Associates Inc. is the Title X Family Planning center for New York, New Jersey, Puerto Rico, U.S. Virgin Islands.
Target Audience for Trainings	MD, NP, RN, PA who provide clinical care	Providers in the treatment of substance abuse disorders	Family planning providers	Staff and providers in Title X family planning programs
Training Programs offered	Classroom and online training, print resources, evening conferences, online courses	Training, technical assistance, information resources on current research, state-specific resources, information on current conferences and initiatives	Technical assistance, free training in HIV counseling and testing, HIV/AIDS overview, rapid HIV testing, and other topics	Classroom and online training, technical assistance, and regional conferences
Contact Person	Gowri Nagendra (212) 788-6618 <a href="mailto:gnagendr@health.nyc.gov">gnagendr@health.nyc.gov</a>	Amy Shanahan (412) 258-8565 <a href="mailto:amy@ireta.org">amy@ireta.org</a>	Akilah M Whittaker (212) 274-7206 <a href="mailto:akilah.whittaker@ppnyc.org">akilah.whittaker@ppnyc.org</a>	Michelle Gerka (212) 594-7741 ext. 214 <a href="mailto:michelle@cicatelli.org">michelle@cicatelli.org</a>

PTC (Prevention Training Center) - ATTC (Addiction Technology Transfer Center) - RTC (Regional Training Center)



## Program Partners

The following organizations and institutions provide training for the NY/NJ AETC network, serving the needs of the local health care communities. Please call the training site in your area if you are interested in receiving training.

### NY/NJ AETC Central Office

HIV Center, Dept. of Psychiatry  
Columbia University College of Physicians and Surgeons  
722 West 168th Street, 11th Floor, Room 1110A  
New York, NY 10032  
(212) 305-8291

### Adolescent AIDS Program

Children's Hospital at Montefiore  
Bronx, NY  
(718) 882-0232

### Albany Medical College

AIDS Program  
Albany, NY  
(518) 262-6864

### Bronx-Lebanon Hospital Center

HIV/AIDS Clinical Education Program  
Bronx, NY  
(718) 960-1476

### Cicatelli Associates Inc.

New York, NY  
(212) 594-7741

### Columbia University

HIV Mental Health Training Project  
New York, NY  
(212) 543-5412/13

### Cornell Clinical Trials Unit

New York, NY  
(212) 746-4160

### Garden State Infectious Disease Assoc.

Voorhees, NJ  
(856) 805-0002

### Infectious Disease Associates, Inc.

Hillsborough, NJ  
(908) 725-2522

### New York State Department of Health

AIDS Institute  
New York, NY  
(315) 477-8479

### Rutgers The State University of New Jersey, College of Nursing

Center for Professional Development  
Newark, NJ  
(973) 353-5895

### Raritan Bay Medical Center

Children's Center Hospital at Montefiore  
Perth Amboy, NJ  
(732) 324-5369

### Saint Vincent Catholic Medical Center- Manhattan HIV/AIDS Education and Training

New York, NY  
(212) 604-2980

### SUNY Downstate Medical Center

Brooklyn, NY  
(718) 270-4752

### SUNY Stony Brook

Center for Public Health Education  
Stony Brook, NY  
(631) 444-8292

### University of Medicine and Dentistry of New Jersey

Center for Continuing & Outreach  
Education, Division of AIDS Education  
Newark, NJ  
(973) 972-3604

NY/NJ AIDS Education and Training Center  
Columbia University  
College of Physicians and Surgeons  
722 West 168th Street, 11th Floor, Room 1110A  
New York, NY 10032  
212-305-8291  
www.nyjaetc.org  
nyjaetc@columbia.edu

