



NASTAD™

NATIONAL ALLIANCE OF STATE
& TERRITORIAL AIDS DIRECTORS

Expanded HIV Testing Report

March 2009

Report on the Centers for Disease Control and Prevention (CDC) Expanded Testing Initiative: Successes and Challenges for Health Department HIV/AIDS Programs

INTRODUCTION AND BACKGROUND

Since the first appearance of HIV/AIDS in the United States, public health has played a vital and pivotal role in both prevention and treatment of the disease. Great strides have been made in stopping the spread of HIV among those most at-risk and in providing life-saving care and treatment to those living with the virus.

Despite these successes, many significant challenges remain. Millions of Americans have never been tested for HIV, many of whom are at risk. African American communities have been particularly hard hit by HIV/AIDS and require an increased focus and commitment from the public health system to reduce the spread of HIV and provide effective strategies for long-term prevention.

With more than one million Americans living with HIV and prevalence among African Americans nearly eight times that of whites¹. It has become ever more urgent to make HIV testing available, accessible and routine for all Americans. As part of this effort, in September

2007, CDC funded 23 state and city health departments for a three-year program,² through program announcement PS07-768 Expanded and Integrated Human Immunodeficiency Virus (HIV) Testing for Populations Disproportionately Affected by HIV, Primarily African Americans, or the “Expanded Testing Initiative (ETI).” Each of these 23 jurisdictions was charged with developing innovative and creative ways of increasing HIV testing, particularly among African-Americans and other groups at significant risk and who are unaware of their HIV status. Two additional jurisdictions were added in FY 2008, bringing the total funded to 25. The ETI funding encourages novel and strategic approaches to meeting public health challenges, including the use of rapid HIV testing technologies to ensure that HIV-positive persons receive their test results and establishing routine HIV testing as a standard across health care services.

In addition to rapid testing efforts, the ETI supports counseling and referral programs, including integration of HIV testing programs with partner services

programs that outreach to partners of HIV-positive persons in order to notify, counsel and test them. The ETI also encourages integration of HIV program efforts with public health programs targeting viral hepatitis, sexually transmitted diseases (STD) and tuberculosis. The establishment of routine HIV testing in these contexts increases the opportunities public health systems have to reach at-risk individuals.

CDC’s stated goals are to achieve 1.5 million tests and identify 20,000 newly reported cases of HIV infection annually, with 80 percent of those tests taking place in clinical settings such as hospital emergency departments(EDS), community health clinics and correctional health care systems. Jurisdictions receiving ETI funding have made significant and effective strides toward meeting these goals, implementing testing programs in clinical settings, identifying HIV infections and building the infrastructure and capacity needed to meet CDC’s ambitious goals for HIV testing.

SURVEY OF EXPANDED TESTING INITIATIVE ACTIVITIES

In December 2008, the National Alliance of State and Territorial AIDS Directors (NASTAD) conducted a survey³ of the 25 jurisdictions receiving ETI funding⁴. The goal of the survey was to identify specific program goals and outcomes for the initiative, as well as any challenges jurisdictions face in reaching those goals. The survey requested data available from the first year of ETI implementation. Due to the start-up times involved in launching some programs, as well as the funding of some jurisdictions after the start of the funding cycle, year one program data is not yet fully reflective of the work accomplished in meeting ETI goals. However, the data are indicative of the rapid progress jurisdictions have made in moving forward with the stated goals, reaching targeted populations and building the program infrastructure to meet HIV testing goals for years two and three.

The following information from the survey clearly shows the progress jurisdictions have made in achieving ETI goals,

from reaching African American populations to routinization of HIV testing to the use of innovative program models.

Given that a primary mandate of the ETI is that 80 percent of funded HIV testing should take place within clinical settings, it is encouraging that jurisdictions have established HIV testing in a wide variety of clinical venues. Ninety-two percent of ETI-funded jurisdictions conduct testing in hospital EDs, 76 percent support testing in community health clinics, and 64 percent conduct testing in correctional facilities. As shown in *Figure 1*, clinical venues are readily encompassed under ETI activities, both in traditional public health venues such as STD clinics, as well as non-traditional public health venues such as EDs community health clinics and correctional facilities.

Also important to CDC's stated goals is the range of activities funded by jurisdictions in addition to HIV testing in clinical settings. Sixty-four percent of jurisdictions also conduct testing in non-clinical venues such as community-based organizations, (CBOs) while 88 percent have used ETI funds for the

purchase of rapid tests. Other activities include social marketing campaigns, viral hepatitis testing and partner services (*Figure 2*).

Another important goal of the ETI is the "routinization" of HIV testing: making the offer of an HIV test a standard of care in clinical settings regardless of a patient's or client's indicated risk behaviors. This is referred to as a "screening" or "routine HIV testing" program, in which a client must actively decline an offered HIV test. Eighty-four percent of jurisdictions report providing routine HIV testing within clinical settings. Those jurisdictions included both "routine" and "targeted" programs. The primary locations in which HIV testing is routinized are EDs, community health clinics, correctional facilities and STD clinics. (*Figure 3*)

A number of jurisdictions conduct their HIV testing programs under legislative or regulatory rules that mandate "opt-in" testing, in which a client must provide consent (usually signed) before having an HIV test. Seven jurisdictions report legislative or regulatory efforts to change consent requirements for

Figure 1: ETI-Funded Venues

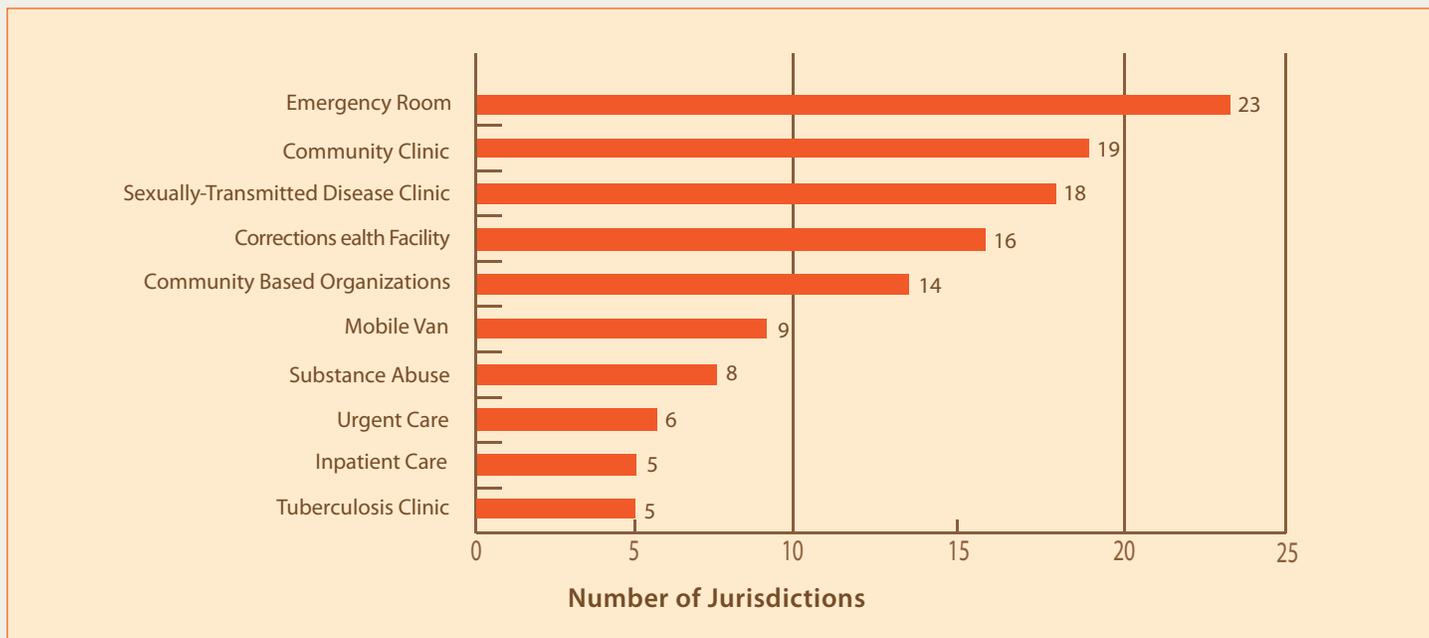


Figure 2: Other ETI-Funded Activities

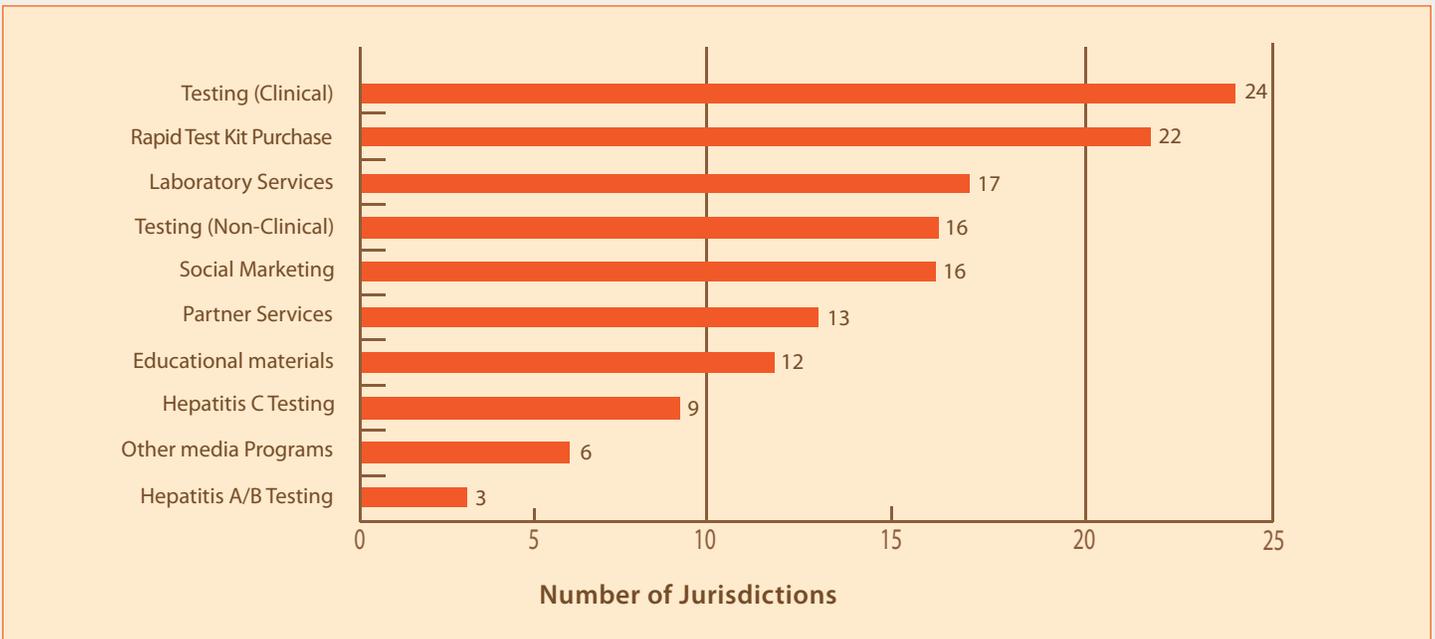


Figure 3: Routine HIV Testing



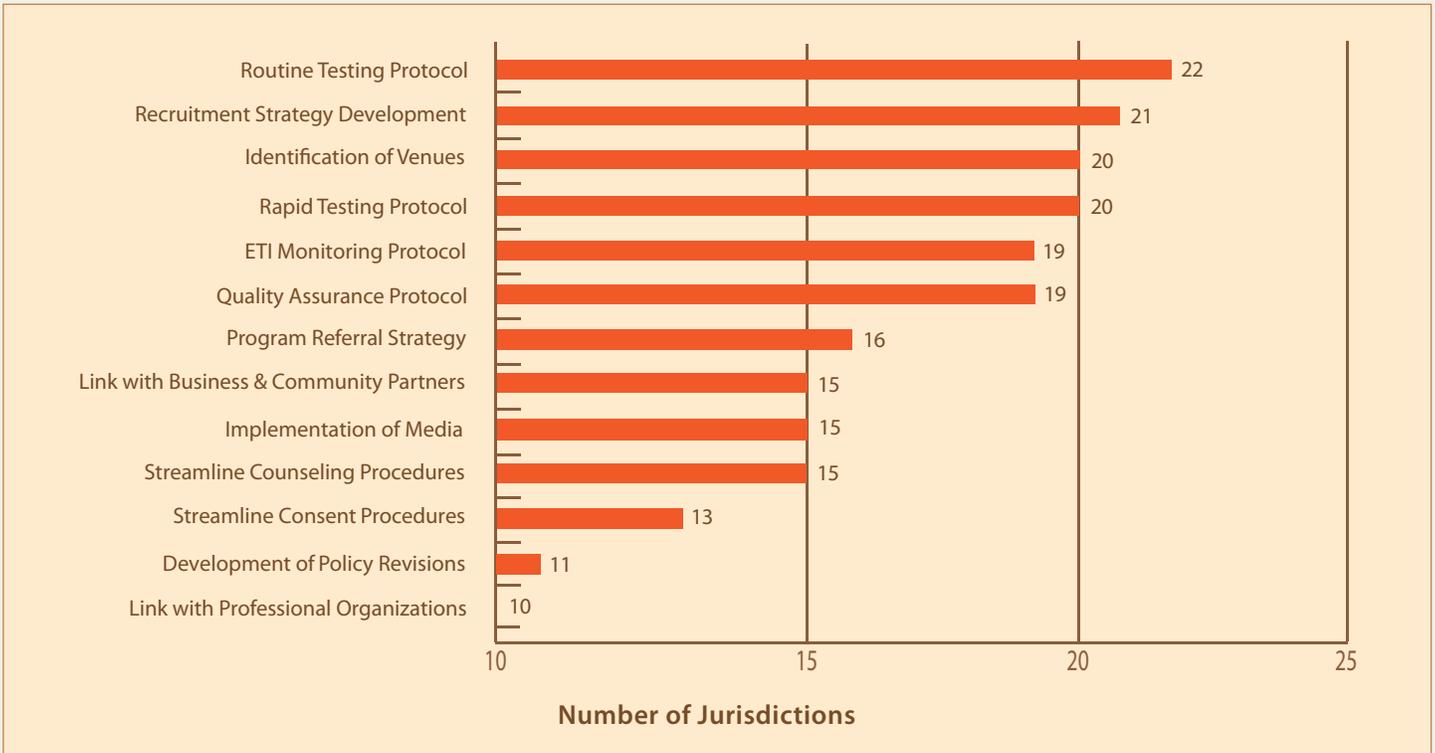
routine HIV testing. Since September 2007, jurisdictions have conducted numerous activities in support of implementation of ETI programs, including streamlining of consent requirements (whether opt-in or opt-out) (52 percent) and counseling requirements³ (60 percent). A large majority of jurisdictions have devoted health department staff time to providing technical assistance to health department sub-grantees on issues including implementation of rapid testing (80 percent)

and routine testing (76 percent), as well as linkages to HIV/AIDS care (76 percent) and partner services (72 percent). A significant number of jurisdictions also report efforts to develop linkages with professional organizations (e.g., medical associations), businesses and community organizations. (Figure 4)

For many jurisdictions, ETI funding has significantly enhanced the reach of public health programs targeting HIV/AIDS prevention and care. Accord-

ingly, most jurisdictions are “blending” the CDC funds with state, local and/or other federal funding to support ETI activities. As part of the mandate for innovation and creativity, 92 percent of jurisdictions reported ETI funding has facilitated expansion of programs into settings or venues not previously supported by the health department. Twenty jurisdictions increased the number of facilities using routine testing and 21 increased the number of facilities providing rapid testing

Figure 4: ETI-Funded Infrastructure



(84 percent).

Although ETI funding for year one activities began at the end of FY2007, a number of jurisdictions faced significant challenges implementing new programs and expanding existing ones, particularly regarding such issues as hiring and model program development (see *Challenges and Recommendations, page 6*). As a result, start dates for actual HIV testing under ETI programs in year one varies by jurisdiction, making an initial evaluation of overall ETI progress by aggregate data difficult. Data and experiences from individual jurisdictions, however, show that, despite some challenges in initial implementation, significant progress was made in year one, particularly in reaching African American populations and providing routine HIV testing in clinical venues. Projected numbers for year two indicate that jurisdictions are on track to meet ETI goals.

SUCCESS STORIES FROM THE EXPANDED TESTING INITIATIVE

While all funded jurisdictions have reported progress with their programs, a number of jurisdictions have established or expanded programs in ways that highlight particularly successful approaches to meeting ETI goals. Some of those efforts are described in this section.

California – Emergency Department Models

With a lower overall proportion of African Americans as a part of the state’s population than the nation as a whole, each of these high-volume ED settings are using a model of providing dedicated staff for HIV testing or providing technical assistance to support medical care provider HIV testing in the ED.

These programs have earned buy-in from ED staff by providing diagnostic

data that helps in the treatment and care of ED patients. Knowledge of patients’ HIV status assists physicians in making determinations about the health of, and treatment for, patients. The staff funded by the ETI also provide feedback to the ED staff about the linkage to care and follow up for patients receiving HIV positive results. Additionally, one program has integrated the routine offer of HIV testing into the ED registration process, showing success in reducing additional testing and data collection burdens on clinical staff. While much of year one was taken up with contracting and other procedures necessary for hiring and funding the state’s ETI efforts, initial results for year two show the programs already reaching 75 percent of their stated goals of testing 30,000 clients annually.

Chicago – HIV Testing in Corrections Clinic

In year one, the Chicago Department of Public Health’s ETI provided total

program 41,514 tests and identified 388 HIV infections. African Americans accounted for 29,854 (72 percent) of those HIV tests and 233 (60 percent) of HIV infections. For year two, CDPH projects 70,000 HIV tests and a range of 700 to 1,400 identified new infections.

The CDPH has used ETI funding to expand the ongoing HIV testing program at the Cook County Jail, a large county jail system with 11 physical tiers (including maximum security and psychiatric wards). Working with a sub-grantee agency, the *Chicago Women's AIDS Project*, CDPH designed an HIV testing program that includes outreach and education about HIV testing conducted during intake each night. Opt-in testing is conducted on weekdays in the tiers and on Saturdays in a weekend clinic.

Approximately seventy percent of the jail population is male and a majority is African-American. One of the challenges that the program has overcome is securing buy-in for the program from the sheriffs⁴ at the jail. The sheriffs are responsible for escorting detainees on weekends to and from the clinic for HIV testing, making their acceptance a key element of the program's success.

Recent cuts in funding for HIV and STD health services at Cook County Jail created a significant gap in program services. This gap has been filled, in part, by PS07-768, allowing for the reintegration of HIV testing for inmates. According to CDPH, this program would not be able to continue at this level without this funding.

Michigan – Expanding Programs to Conduct Targeted Testing

As part of its efforts under the ETI, the Michigan Department of Community Health expanded its social networking model. The program works specifically

with clients who test positive for HIV, or who report significant risk behaviors for HIV infection, to determine members of their social networks to whom HIV testing should be offered. “Social networks” include family and friends of at-risk individuals in addition to sexual or needle-sharing partners. Prior to ETI funding, social networking programs were primarily conducted by community-based organizations. ETI funding has allowed the health department to add the effort to its public health focus, as well as increase the health department's efforts in reaching African American men who have sex with men (MSM).

In addition to its new public health efforts on social networking, Michigan is reaching ETI goals for testing African Americans in part through offering HIV tests in high-volume EDs such as the Henry Ford Hospital in Detroit, which receives more than 100,000 ED visits per year. In year one, ETI funded programs tested 16,130 persons, including 10,961 African Americans, identifying 75 new cases of HIV infection. For year two, Michigan expects to test more than 36,600 people and identify 350 new cases of HIV infection.

The EDs receiving ETI funding have also shown great success in referring patients who test positive for HIV into care and treatment. The department is currently expanding its testing program to include ED medical staff, including physicians assistants, and providing training to them on rapid HIV testing technologies and procedures in order to increase the comfort level for those offering HIV testing.

New York City – Routine Testing in Emergency Department Settings

With its multiple programs and populations, the New York City Department

of Health and Mental Hygiene has used ETI funding to support and expand efforts to greatly increase the number of persons tested annually for HIV. In particular, the funding has helped to expand the department's *The Bronx Knows: Get Smart. Get Safe. Get Tested* program, which aims to perform 250,000 HIV tests over three years. Planning for the program began in 2007 and was launched in June 2008. Currently, the department is on-track for reaching its goal of 80,000 annual tests.

With 90 percent of testing being conducted with rapid testing technology, ETI funding has helped purchase rapid testing kits for use in *The Bronx Knows*. These testing kits are used specifically for uninsured Bronx residents and for CBOs that are testing and don't have dedicated funds with which to purchase testing kits.

An area seeing particular success as part of the initiative is the routinization of testing in ED settings, six of which are supported through ETI in the Bronx and other New York City boroughs. While New York City is currently pursuing regulatory and legislative changes to HIV-testing consent laws to facilitate easier implementation of routine testing in some settings, current programs have routinized testing under existing regulations requiring signed consent (“opt in”). In ED settings, this routinization has been approached in a number of ways. The department realizes that “one size doesn't fit all” and therefore, computer-based counseling and data collection, as well as a focus on availability of on-site HIV counselors, has been employed. Without the ETI funding, the department reports it unlikely would have pursued a social network strategy, which works with clients to identify their own social connections to identify others at risk for HIV infection. With

continued ETI funding, the department sees the promise of building a sustained effort that meets the needs of the jurisdiction's communities.

New York State – Routine Testing in Dental Clinics

Innovation in increasing HIV testing in clinical settings can also come from clinical providers themselves. In New York State, two community dental clinics provide HIV testing to patients as part of the state's ETI program. The impetus for the project came directly from the dental clinics, where management and staff saw an opportunity to link oral health care with other related health care issues. By routinizing the offer of rapid HIV testing for patients at these dental clinics, two relatively small programs in year one have already identified three HIV positive patients who would not otherwise have known their HIV status.

As with other clinically based programs, challenges include staff buy-in and sustainability. In the case of the dental clinic, staff buy-in was achieved through committed efforts by management and technical assistance provided in conjunction with the health department. As a result, the dental program has kicked off interest from other providers, both private and community-based, in applying the routine testing approach.

The initial success of the dental program is representative of the overall success New York State has seen in the application of ETI funding. New York State began work on routinization of testing in 2005. ETI funding has given the state the ability to concentrate on a number of clinical settings and focus on building stream-lined models for HIV test provision. In year one, New York ETI funded programs tested more than 12,000 individuals, identifying 40 new

infections. The health department plans to test more than 15,000 people in year two, with a goal to identify more than 160 new HIV infections.

Massachusetts – Expanding Focus into Routine Testing in Clinical Settings

Massachusetts is one of the many jurisdictions with laws and regulations that require specific informed written consent for HIV testing, which can be a challenge for the implementation of routine testing. However, with the focus of ETI on increasing the number of tests performed and routinizing testing as part of standard health care practices, the Massachusetts Department of Public Health has taken that focus to a number of programs situated in clinical settings. For example, the Codman Square Health Center, a comprehensive primary care clinic with specialized HIV services, has replaced its targeted HIV counseling and testing program with a center-wide integration of routine HIV screening throughout their primary system. The Boston Medical Center offers routine HIV screening with approaches differing by venue, such as inpatient services versus urgent care services. Tailoring the routine offer of HIV testing to the clinical needs and available resources within a specific venue provides the flexibility needed for provision of overall healthcare services while still increasing the number of people who are aware of their HIV status.

The provision of ETI funding has enabled the state to expand its existing programs, from client recruitment to social marketing campaigns, to meet the HIV testing goals. Both clinic-based and outreach programs link HIV screening funded under this grant to existing screening programs for STDs and viral hepatitis.

Maryland – Innovative Approaches to Clinical Testing and Program Linkages

The Maryland AIDS Administration has answered the ETI call for innovation and creativity by finding new ways to expand the focus of existing programs to meet new goals. One of Maryland's ETI projects is the JACQUES initiative at the University of Maryland, which was first created to address the issue of HIV-therapy adherence for people living with HIV/AIDS. With the addition of ETI funding, JACQUES has been able to grow into providing linkages that ensure the people who are tested for HIV receive their results.

With routine testing offered through ETI funding in Baltimore, the JACQUES initiative works with EDs to provide counseling and testing staff, as needed. The initiative also focuses on following up with patients who receive preliminary positive HIV test results, with a staff counselor immediately setting up an appointment for the patient to receive a confirmatory HIV test. During the time before that confirmatory test, the counselor maintains contact with the client, providing reminders of the appointment and answering questions or concerns of the client.

While some of the initial challenges involved obtaining the buy-in of ED staff, outreach on the part of JACQUES and the health department helped to gain staff buy-in for the routine offering of HIV testing. With the success of the program, the new challenge is finding the ability to expand the hours and availability, as well as ensuring sustainability for the program over time.

CHALLENGES AND RECOMMENDATIONS

While the ETI has shown progress toward its stated goals – routinization of

HIV testing, increased use of rapid testing and identifying new HIV infections in African American communities – a number of significant challenges remains to meeting those goals.

Data and reporting issues. Many jurisdictions emphasized the challenges with getting data from clinical facilities, particularly those conducting a high volume of tests. Additionally, with the increased focus from CDC on the implementation and evaluation of ETI activities, data reporting requirements have increased at the same time that health departments have been working to implement prior CDC requirements for electronic data reporting. ETI oversight has also called for a number of new and duplicative reporting forms to CDC, increasing the overall staff burden. NASTAD recommends that CDC continue to work closely with grantees to address data and reporting issues.

Staffing and contracting. A significant number of jurisdictions are operating under hiring freezes or other hiring restrictions that disallow or delay hiring the appropriate staff for implementing and/or managing ETI programs. Additionally, health department contracting procedures are often lengthy due to state and local laws and regulations. The short time between the announcement of the ETI funds by CDC and the start of the program did not allow sufficient time for health departments to fulfill their contracting obligations and meet ETI timetables. Health departments are ideal institutions to deliver structural level change. It is, however, essential that appropriate start-up time be factored into future funding opportunity announcements to allow for adequate time to bring programs to scale.

Capacity. The focus on testing in clinical settings for the ETI requires a number of significant structural

changes for clinical venues in which routine HIV testing is provided by clinical staff. In addition to obtaining buy-in and the engagement of clinic staff, training, education and technical assistance are all necessary to assist venues in identifying and/or adding the needed staff to implement routine rapid testing in a manner that is compatible with clinic operations and flow.

Sustainability. Particularly in clinical venues such as EDS and primary care facilities, programs need assurances that their programs will be able to maintain funding from either grants or billing streams (e.g. Medicare, Medicaid or other insurance) as they move forward. The continued participation and buy-in of health care staff, including nurses and physicians, is vital if routine HIV testing is to become a standard of care. The ETI is complex and of great magnitude. The critical groundwork that health departments have laid to establish relationships in clinical settings has set the essential foundation, particularly those conducting a high volume of tests. NASTAD recommends that funding for targeted expanded testing be made available for additional years and to additional jurisdictions.

CLOSING

Despite the significant advances made in prevention, care and treatment, HIV/AIDS remains one of the primary challenges for the American public health systems. Health departments continue to play an essential role in meeting the challenges of HIV/AIDS, from prevention with at-risk populations to treatment for those infected.

The goals for CDC's ETI are ambitious and necessary. With the availability of ETI funding, health departments have risen to the challenge by implementing new programs and expanding existing ones, from the wider implementation of

rapid testing to the effective introduction of routine HIV testing in EDs and other clinical settings.

With such high and necessary goals in the battle against HIV/AIDS, the sustainability of these programs is a vital issue for state and local health departments responsible for meeting those goals. The ETI has created opportunities for success in public health. Continuation of that funding will be vital for the ongoing work of curtailing, and ending, the epidemic.

ENDNOTES

- 1 "HIV Prevalence Estimates – United States, 2006," Morbidity and Mortality Weekly Report, October 3, 2008.
- 2 In year one of the Expanded Testing Initiative, 23 jurisdictions received funding. For FY2008, those 23 jurisdictions received year two funding, and two additional jurisdictions, Texas and Mississippi, received first-time funding, making a current total of 25 ETI funded jurisdictions. The jurisdictions funded for ETI are California, Chicago, Connecticut, District of Columbia, Florida, Georgia, Houston, Los Angeles county, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, New Jersey, New York City, New York, North Carolina, Ohio, Pennsylvania, Philadelphia, South Carolina, Tennessee, Texas, Virginia. These jurisdictions accounted for 95 percent of the AIDS cases among African Americans in 2005.
- 3 A copy of the survey can be found at http://www.nastad.org/Docs/Public/Resource/2009227_NASTAD%20ETI%20Survey%20Final%2011-14-08.pdf.
- 4 The survey response rate was 100 percent.
- 5 Counseling requirements vary by jurisdiction and may include legislative or regulatory mandates on information that must be provided to every client presenting for HIV testing. "Streamlining" counseling requirements generally refers to efforts to tailor counseling to specific client and venue needs to meet both the goals of providing accurate health information to clients and reducing burden on counseling and/or clinical staff.
- 6 All security in the Cook County Jail is provided by sheriffs.

ACKNOWLEDGEMENTS

Sean Bugg, NASTAD consultant and Natalie Cramer, Associate Director, Prevention are responsible for the overall development, production and quality control of this document. NASTAD gratefully acknowledges the 25 expanded testing grantees for their completion of the survey and willingness to be interviewed for the report. NASTAD recognizes its staff for their editorial and technical support, particularly Julie Scofield, NASTAD Executive Director, Liisa Randall, NASTAD consultant and other NASTAD staff, Murray Penner, Dave Kern, Laura Hanen and Ann Lefert for their guidance and expertise.

This publication was supported by cooperative agreement # U62PS323958 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

NASTAD strengthens state and territory-based leadership, expertise and advocacy, and brings them to bear in reducing the incidence of HIV infection and on providing care and support to all who live with HIV/AIDS. Our vision is a world free of HIV/AIDS.

March 2009
Julie M. Scofield, Executive Director
Tom Liberti, Chair



444 North Capitol Street, NW • Suite 339
Washington, DC 20001-1512
www.NASTAD.org
Phone: 202-434-8090 • Fax: 202-434-8092