HIV Screening in Behavioral Health Settings: The Need is Clear

Alyssa A. Bittenbender, MPH

Program Director, Arizona AIDS Education and Training Center
University of Arizona College of Medicine
MISSION

Provide healthcare professionals with the knowledge and skills necessary to provide outstanding care to people living with HIV and AIDS

www.AETC-Arizona.org
Objectives

1. Describe HIV infection trends on global, national and local levels

2. Articulate the importance of early HIV detection and intervention

3. Describe how stigma affects HIV screening and access to care

4. Explain the importance of mental health professionals addressing HIV with their clients
Introductions

• Name

• Job

• Experience with HIV

• What you hope to learn from this training
George

50 year old white male presents in an out-patient setting
- Seeing him for alcohol abuse and depression
- States he’s “not gay”
- Always lived in Phoenix
- Indicates that he has never used injection drugs

What can you tell him about his HIV risk?
Epidemiology - World

Number of people living with HIV by region and proportion of total

- Oceania: 57,000
- Caribbean: 240,000
- Sub-Saharan Africa: 22.5m
- Western & Central Europe: 820,000
- North America: 1.5m
- East Asia: 770,000
- Middle East & North Africa: 460,000
- East, South & South-East Asia: 4.1m
- Central & South America: 1.4m

Overall proportion: 68%
Women as Share of People Living with HIV by Region, 2009

- Global: 52%
- Sub-Saharan Africa: 60%
- Caribbean: 55%
- Middle East/North Africa: 48%
- Eastern Europe/Central Asia: 49%
- Oceania: 46%
- South/South-East Asia: 35%
- Central/South America: 35%
- East Asia: 29%
- Western/Central Europe: 29%
- North America: 26%

NOTE: Among adults, aged 15 and older.
Epidemiology - USA

- About 1.1 million people living with HIV/AIDS
- Prevalence 0.6%
- Men > Women
- Every 9.5 minutes someone in the US gets infected
- Leading cause of death in minorities 25-44 yrs

Diagnoses of HIV Infection among Adults and Adolescents, by Race/Ethnicity, 2006–2009—40 States and 5 U.S. Dependent Areas

Note. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting.
Diagnoses of HIV Infection and Population, by Race/Ethnicity, 2009—40 States

Diagnoses of HIV infection
N=42,011

- American Indian/Alaska Native: 18%
- Asian: 1%
- Black/African American: 52%
- Hispanic/Latino\(^a\): 1%
- Native Hawaiian/Other Pacific Islander: 1%
- Multiple races: <1%

Population, 40 States
N=241,832,054

- White: 68%
- Hispanic/Latino\(^a\): 13%
- Black/African American: 13%
- Native Hawaiian/Other Pacific Islander: 1%
- Asian: 3%
- Multiple races: <1%

Note: Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting.

*Hispanics/Latinos can be of any race.
AIDS Diagnosis Rate per 100,000 by Race/Ethnicity, United States, 2009

- Black: 44.4
- Multiple Races: 15.1
- Latino: 13.9
- Native Hawaiian/Pacific Islander: 11.2
- American Indian/Alaska Native: 6.6
- White: 4.7
- Asian: 3.1

NOTE: Data are estimates for adults/adolescents aged 13 and older and do not include cases from the U.S. dependencies, possessions, and associated nations, and cases of unknown residence.

HIV in American Subpopulations

• In Washington DC:
  • 1 in 30 adults are infected
  • 1 in 16 black men are infected

• In New York City:
  • 1 in 40 black Americans are infected
  • 1 in 10 men who have sex with men (MSM) are infected
  • 1 in 8 injection drug users (IDU) are infected

El-Sadr WM et al. AIDS in America – Forgotten but Not Gone. New England Journal of Medicine, March 2010
HIV Prevalence in Adults from Selected Countries in Sub-Saharan Africa and Subpopulations

El-Sadr WM et al. AIDS in America – Forgotten but Not Gone. New England Journal of Medicine, March 2010
Arizona HIV Prevalence
Cases of HIV & AIDS, 2009

White Non-Hispanic: 8,175
Black Non-Hispanic: 1,614
Hispanic: 3,624
Asian / Pacific Islander: 178
American Indian: 464
Multiple Race /Other: 210

Total = 14,265

ADHS 2011 HIV/AIDS Annual Report
Arizona HIV Epidemiology

Arizona Demography
- Total residents
  - 6,595,778 – 2009
- Race distribution
  - White – 57.3%
  - Black – 4.4%
  - AI/AN – 4.9%
  - Asian/PI – 2.6%
  - Hispanic – 30.8%

Arizona HIV Epidemiology
- HIV prevalence
  - 14,435 at time of analysis
  - 0.2% - of total AZ residents
  - 0.6% - of adults in US
- Race distribution of the 14,435
  - White – 56.8%
  - Black – 11.1%
  - AI/AN – 3.2%
  - Asian/PI – 1.2%
  - Hispanic – 25.3%
  - Other/Unk – 3.2%

US Census Bureau – 2009
ADHS HIV/AIDS surveillance - 2010
Arizona HIV prevalence by race and gender

![Graph showing HIV prevalence rates by race and gender in Arizona. The graph compares prevalence rates per 100K for different racial and ethnic groups, including Black Non-Hispanic, White Non-Hispanic, AI/AN Non-Hispanic, Hispanic, A/PI/H Non-Hispanic, and MR/Non-Hispanic Other. The data is from ADHS HIV/AIDS Surveillance - 2008.]
Arizona Emergent HIV/AIDS Diagnoses, 1999-2009

![Graph showing the number of HIV/AIDS diagnoses by year from 1999 to 2009. The graph indicates a decrease in the number of AIDS diagnoses and an increase in HIV diagnoses over the years.](image-url)
Arizona 5-Year Emergent HIV/AIDS Case Rate Trend, 1990-2009
Arizona Prevalent HIV, AIDS, and HIV/AIDS cases, December 2004 – March 2011

ADHS 2011
Arizona County-Specific Prevalent HIV/AIDS, 2011

*28% of prevalent cases in Pinal County are among persons currently incarcerated
**15% of prevalent cases in Graham County are among persons currently incarcerated
Arizona County-Specific Emergent HIV/AIDS, 2005-2009

State Emergence Rate = 11.5

*26% of emergent cases in Pinal County are among persons incarcerated at the time of diagnosis
Arizona Emergent HIV/AIDS by Gender, 2000-2009
Arizona Relative Percentage of Emergent Cases by Reported Risk Behavior, 1990-2009

ADHS 2011
Male United States and Arizona Estimates of New HIV Infections, By Transmission Category

US Males
- MSM: 63%
- IDU: 17%
- MSM/IDU: 7%
- HET: 13%

AZ Males
- MSM: 71%
- IDU: 7%
- MSM/IDU: 6%
- HET: 3%
- NRR/OTHER: 13%

ADHS 2011
Female United States and Arizona Estimates of New HIV Infections, By Transmission Category

US Females

- Heterosexual: 73%
- IDU: 26%
- Other: 1%

AZ Females

- Heterosexual: 40%
- NRR/OTHER: 39%
- IDU: 21%

ADHS 2011
Arizona Percent/Rate Currently Infected with HIV Among Estimated Risk Group Population
Elvin

24 year old Latino gay male is thinking about getting tested but isn’t really sure he wants to because...

– He doesn’t know where he can go to get tested
– He’s gay and believes its inevitable that he will get the disease
– Heard that the medications have bad side effects
– He doesn’t have health insurance
– Rather not know because there is nothing he can do about it anyway

Do you think Elvin should get tested? Why?
Why test?

Better for the patient

- Extend life of patient, reduce HIV related illnesses

Better for the community

- Change in risky behavior
- Lower community viral load

Better for the economy

- Even though HIV treatment is expensive, it appears to still be less costly to treat early than to wait and deal with the opportunistic infections, cancers, and other co-morbidities seen in late stage HIV/AIDS
The Public's Experience With HIV Testing

- **Tested in last 12 months**
  - 16% (47%)

- **Tested, but not in last 12 months**
  - 30% (51%)

**Yes, been tested**  **No, never tested**

Notes: Don’t know responses not shown; Numbers may not add up exactly due to rounding. Source: Kaiser Family Foundation Survey of Americans on HIV/AIDS (conducted January 26 – March 8, 2009).
Awareness of Serostatus Among People with HIV and Estimates of Transmission

~25% Unaware of Infection

~75% Aware of Infection

Accounting for:

~54% of New Infections

~46% of New Infections

Marks, et al. AIDS 2006;20:1447-50
Natural History of HIV-1 Infection

- Acute Retroviral Syndrome: 1-12 weeks
- Clinical Latency: 6-10 years
- AIDS: 1-2 years

Viral Load
CD4 count
Knowledge is Power

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

• Reduction in unprotected anal or vaginal intercourse with negative partner: -- 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.
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
Reasons for testing: late versus early testers
Supplement to HIV/AIDS Surveillance, 2000-2003

- Late (Tested < 1 yr before AIDS dx)
- Early (Tested >5 yrs before AIDS dx)

- Illness
- Self/partner at risk
- Wanted to know
- Routine check up
- Required
- Other

[Graph depicting reasons for testing late versus early testers]
Rationale for Revising CDC HIV Testing 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.
CDC Revised HIV Testing Guidelines for Adults and Adolescents

• 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
Arizona HIV Testing Law

- Revised in September 2008
- No written consent form required for HIV testing
- No formal pre or post test counseling is required with a HIV test
- Verbal consent is sufficient for a HIV test
- HIV testing can be incorporated into general medical consent that is signed by each patient prior to initiating medical care
- It is recommended but NOT required that the provider document that written or oral consent information was given to the patient
Melinda

- 27 year old African American woman
- Member of AA, clean and sober, 5 years
- 2 children ages 2 and 4
- Works part time as a cashier at the local supermarket, has no benefits
- In a long term heterosexual relationship with an abusive partner
- Recently found out she was infected with HIV when she went to the Maricopa Medical Center ED after a violent incident with her partner
- She was referred to a local non-profit for HIV case management but did not show-up for her appointment

Why did Melinda miss her appointment?
# HRSA Continuum of Engagement

## Not in Care
- **Unaware of HIV status**
- **Aware of HIV status**
- **May be receiving other medical care but not HIV care**
- **Entered HIV medical care but dropped out**
- **In and out of HIV care or infrequent user**

## Fully engaged
- **Fully engaged in HIV medical care**

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Later: Retention in Care

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Why is Engagement Important for People Living with HIV?

Better for the patient
- Extend life of patient, reduce HIV related illnesses

Better for the community
- Change in risky behavior
- Lower community viral load

Better for the economy
- Even though HIV treatment is expensive, it appears to still be less costly to treat early than to wait and deal with the opportunistic infections, cancers, and other co-morbidities seen in late stage HIV/AIDS
Who misses appointments? (I)
HIV-related clinical markers

Higher CD4 count  (Catz, 1999; McClure, 1999; Arici, 2002)

Not having an AIDS diagnosis  (Israeleski, 2001; Arici, 2002)

Detectable VL & AIDS-defining CD4 count  (Berg, 2005)
Who misses appointments? (II)

Health Issues

Substance Abuse

- HIV treatment not a priority
- Lack of access to health care due to economic instability
- Feel guilty for using and don’t want to see doctor

(Kissinger, 1995; Lucas, 1999; McClure, 1999; Arici, 2002; Mugavero, 2009)

Mental health issues

- Better adherence if mental health issues are treated
- Need to stabilize other social and medical needs to make HIV a priority

(Expert Panel of HIV Care Providers, LAC, 2010)
Who misses appointments? (III)
Health Care System Issues

Testing site did not link to care  (Mayer 2011; Aziz ,2011)

Language and cultural barriers  (Moore 2011)

Less engagement with health care provider  (Bakken ,2000)

Provider Discrimination  (Aziz ,2011; Mayer ,2011; Christopoulos ,2011)

Patient Mistrust  (Aziz ,2011; Mayer ,2011; Christopoulos ,2011)
Who misses appointments? (IV)
Structural Issues

Lack of child care, transportation  (Norris, 1990; Aziz, 2011; Catz, 2011)

Lack of health insurance  (Mugavero, 2007)

Economics  (Expert Panel of HIV Care Providers, LAC, 2010)

Undocumented Status  (Galvin, 2000)

Incarceration  (Zaller, 2011)
Who misses appointments? (V)

Issues on the Individual Level

Forgetting appointment, meant to cancel (Palacio, 1999; Quinones, 2004)

Not feeling well (Palacio, 1999)

Competing time issues (e.g., work, appointment, family illness) (Norris, 1990; Palacio, 1999; Aziz, 2011)

Fear of stigma and violence (Aziz, 2011)

Depression and low self image (Aziz 2011)

Difficulty with self acceptance (Christopoulos 2011)

Language and Cultural barriers (Moore 2011)
Questions?

Alyssa Bittenbender, MPH
alyssa1@email.arizona.edu
520-626-0723
www.aetc-arizona.org