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New hurricane season sparks discussions about lessons learned

STD/HIV officials say communications were a major problem

Hurricane threats have become so common in recent years for Louisiana coastal residents that when state STD and HIV government officials closed their office doors in New Orleans on the Friday before Hurricane Katrina struck, they were convinced they would be returning on Monday morning to do business as usual.

Instead, it was weeks before some offices opened, and some state employees relocated permanently and never returned to their jobs.

There also have remained problems with collecting, storing, retrieving, and mailing laboratory specimens, locating clients of the STD program or HIV AIDS Drug Assistance Program (ADAP), and preparing for the next natural disaster.

As another hurricane season begins in June, some survivors of the New Orleans hurricane and flooding disaster of August 2005, discuss lessons learned from the last time around.

"When we left work on Friday afternoon, we didn't even know the storm was coming this way," says **Lisa Longfellow**, MPH, STD director for the Louisiana Office of Public Health in New Orleans. "Then on Saturday morning, we received mandatory evacuation orders, and we all took three days worth of clothes and thought we'd be back to work in the middle of the week." Longfellow was a scheduled speaker at the 2006 National STD Prevention Conference, held May 8-11 in Jacksonville, FL.

For the STD program and AIDS Drug Assistance Program, one of the biggest initial problems was employees being unable to return to the offices and retrieve files and computer data which was necessary to find clients and continue operations. **(See story on finding STD and HIV/AIDS clients post-hurricane, p. 64.)**

"There was a mandatory evacuation in place in New Orleans, which was not lifted until Sept. 23 or 24th, and we couldn't come into the city without police escort," says **Beth Scalco**, LCSW, MPA, administrative director for the Louisiana Office of Public Health HIV/AIDS program in New Orleans.

"We were able to return to our office twice to access files and servers that we had to have to restore basic functioning, but basically we couldn't get into the city," Scalco says. "Then, once the mandatory evacuation was lifted, our building still was closed."

Scalco and Longfellow share their experiences and offer this advice about recovery and preparation for a natural disaster:

• **Finding a surrogate office:** The Louisiana Office of Public Health's HIV/AIDS Program could not return to its office building, which is located four blocks from the Superdome, until early November 2005, more than two months after Hurricane Katrina and flooding devastated the city.

"We were very happy to be back, but the building had a great deal of damage to it, and as time went on it seemed to deteriorate," Scalco says.

With the help of the CDC, the HIV/AIDS program first found space on Oct. 3, 2005, in Kindred Hospital, where 28 employees and computers jammed into the space of four hospital rooms, Scalco says. "Up until then, we worked in Baton Rouge, Lafayette, and the North Shore of the lake to try to do as much as we could that way."

Even after employees returned to their pre-hurricane building, the stay was short. The HIV/AIDS Program was evicted from the deteriorating building in mid-February 2006, and in April, it was moved temporarily into another building, located two blocks away, Scalco says.

Although the new building is part of an emergency move, the staff hopes the office will be able to make it a permanent home, she notes.

"We're hoping this building is the one because the moving has taken a toll," Scalco says. "I have staff that are living with relatives or living in a FEMA trailer, and they don't have their homes back together, and then to have to make an office move too is a fair amount of stress."

The STD office also has been relocated from an eight-story building to a two-story building, she says.

"Before, we were on the sixth floor of an eight-story building, and we didn't have to worry about the roof leaking," Longfellow says. "No we're on the second floor of a two-story building, and we have to worry about that."

Each night, the computers have to be backed up and protected when they leave the office, she adds.

• **Locating staff:** The HIV/AIDS program's staffing also suffered after the hurricane. More than one-quarter of the 57 employees who worked in the week before Hurricane Katrina struck decided not to return to New Orleans or their jobs, Scalco says.

"Some people lost their homes and everything

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they owned, and they made an immediate decision not to come back," Scalco says. "So we had resignations immediately."

There also was some turnover among the eight employees of the STD office at the Louisiana Office of Public Health, Longfellow says. "We have people who still are not in their homes," Longfellow says. "We lost some staff because once they evacuated, they never came back and didn't have a house to return to in some cases."

Of the remaining employees, one person has to camp out in someone else's apartment; another commutes 1.5 hours to work while waiting for her home to be repaired, and yet another person has to live in a FEMA trailer, Longfellow says.

It took days or even weeks to track down staff because no one's cell phones worked in the immediate days after the storm, they say.

"The main method we had to contact people was their cell phones, and because all cell phone towers were damaged, there was no way to contact people," Longfellow says.

"Every day, I would try to call people on their cell phones, and finally I'd get through to one person, and that person would talk to another person."

The office's staff had evacuated as far away as California and Utah, she notes.

The HIV/AIDS office was similarly handicapped by the storm.

"Although we did all those wonderful things to prepare for a disaster by having a contact list, we had left the office with very little on Friday afternoon," Scalco says. "Even if we had the contact list, they were of very little value because none of the cell phones worked, and emergency contact numbers within the New Orleans area were also not working."

• **Information technologies and communications problems:** The unexpectedness of the storm's direct hit and the subsequent flooding undermined all disaster preparedness plans regarding communications, Scalco and Longfellow say.

The ADAP system protects all client data with security measures and computer file back-ups, but the back-up files were also located in New Orleans, so they couldn't be accessed immediately after the disaster, Scalco explains.

"In retrospect, what we've decided to do is back up even more things like fiscal information necessary to process invoices for contractors and locate these in a geographic area that's more distant," Scalco adds.

By the end of the second week post-Katrina, the HIV/AIDS program staff used conference call bridges, supplied by the National Alliance of State and Territorial AIDS Directors (NASTAD) and the Kaiser Foundation, to hold staff meetings about getting the program back together and getting clients linked to services, including their ADAP medications, Scalco says.

"It was a permanent conference call line available for our use," she explains. "So we'd tell everybody to call into this toll-free number at 11 a.m., and we'd have 60 people on the line at the same time."

The staff also used the conference line to communicate with contractors, she notes.

"Our main charge was to put the program back together and get HIV services up and running," Scalco says. "But a lot of our initial time was trying to help people who were dislocated get to new services."

Immediately after the storm subsided, Longfellow reported to the office of public health emergency operations center and was assigned to answer the volunteer phone line. She assisted in the call for volunteer nurses and physicians to work in the special needs shelters in Louisiana, and there were thousands of responses, she says.

At the same time, she was trying to locate her own staff and try to return to surveillance work.

"Our first step was to work with the management information system department to bring back computer access," Longfellow says. "As soon as they were able to they went to New Orleans and moved the computer out."

Fortunately, the computer servers were on the second floor, and the water only rose five feet high, she notes.

"So they went in with flashlights and boots and transferred and restored data from a back-up, before moving the server," Longfellow says. "Our biggest problem as far as restoring our STD surveillance system is that it's not a web-based system."

This meant that data could only be found on computers involved in the system. Whenever there is a change, software needs to be changed on all of the computers within the system, which are located throughout the state, she says.

"Another program in the Office of Public Health that had an Internet-based computer system had no problems with accessing their information," Longfellow says. "So that's one of our goals — to move toward an Internet-based system." ■

No easy task: Finding clients post-hurricane

Many still have not returned to Louisiana

Nine months after one of the deadliest and costliest hurricane disasters hit the United States, the Louisiana HIV/AIDS program still is looking for hundreds of clients who had been on medication lists prior to the New Orleans' flooding destruction.

In August 2005, the AIDS Drug Assistance Program (ADAP) served 1,720 people, and in September 2005, that number dropped to 1,139 people, says **Beth Scalco**, LCSW, MPA, administrative director for the Louisiana Office of Public Health HIV/AIDS program in New Orleans.

As of March, 2006, the program had 1,350 clients. "So we're heading in the right direction, but obviously we're missing 300 to 400 people," Scalco says. "Texas had hundreds of our clients on ADAP, so we're hoping a lot of the missing people are still on other state's ADAPs, with the primary one being in Texas."

Another problem for HIV clients was that the main HIV clinic in New Orleans was closed for months. Prior to the disaster, it served 3,000 HIV clients, and now it serves about 1,400, Scalco says.

The state's HIV/AIDS program staff worries about the long-term impact from the disaster.

"This disaster, no doubt, impacted adherence to medication," Scalco says. "If you don't have a house and you don't have a job, and you might be far from your family, then your medication is not the top priority on your list."

There likely are HIV clients who have fallen out of care, and the HIV care providers and state program might not see them again until their lives have become stable, or, in a worst case scenario, they become ill, Scalco adds.

"One of the things we're going to do better now is to prepare our AIDS Drug Assistance Program (ADAP) clients for a hurricane," Scalco says.

"What we're planning to do when clients pick up their medication from the pharmacy in June is to give them an information sheet that says, 'In the event of a hurricane, these are the other distribution sites where you can get your medicine if your site is closed,'" Scalco says.

If someone is evacuated to another state, they will be instructed to call that state's health department and ask or the AIDS Drug Assistance Program, supplying that state with a list of their medications that will be kept on a little wallet card, she adds.

The STD program at the Louisiana Office of Public Health in New Orleans has a syphilis registry in its computer database, and this was impacted by the hurricane disaster, says **Lisa Longfellow**, MPH, STD director.

In 2004, New Orleans was first in the country in its rate for syphilis, so when hundreds of thousands of people from the area were relocated after the hurricane, the STD office needed quick access to its database, Longfellow says.

Since people who have had syphilis will test positive even if they're not infectious and do not need to be treated, the database was the only way to verify who needed treatment and who did not, she says.

STD officials from states that welcomed Louisiana evacuees began to call two weeks after the hurricane to find out if patients were on the database or if they needed treatment, Longfellow says. "So it was crucial we get that database up and running."

Another problem for the STD program was the closing of STD clinics and services in the hurricane-impacted areas. Of seven clinics that were closed as a result of the disaster, only two had reopened by May 2006, Longfellow says.

"The good and bad news is the STD reports are down significantly in the New Orleans area, and so we haven't seen a tremendous increase in traffic in the two parish clinics that are open," Longfellow notes. "One thing our staff is doing now as far as a surveillance program is working closely with other providers to ensure STD cases are reported, and we're collaborating with the people who are providing the services."

Each HIV clinic in Louisiana receives contract funding based on how many clients they are expected to serve in a year's time. Since the hurricane shifted some of New Orleans' HIV clients to areas that typically might serve only a small number of HIV clients, then adjustments in contract amounts needed to be made, but it wasn't possible for the HIV/AIDS program to make these changes immediately.

"We worked with the clinics to help them receive evacuees and then worked out the reimbursement," Scalco says.

The clinics and other contractors also were forced to be patient with receiving their checks.

Louisiana's contract payment system involved sending invoices through an internal approval

process and then through the state system for payment, Scalco says. "One of the problems was we had this huge amount of invoices located in New Orleans, and we couldn't get into the building to get those invoices, so we had to work with contractors and say, 'Do you have a copy of the invoice, or can you recreate this so we can move it along through Baton Rouge to get your payment,'" Scalco explains.

State officials now are discussing a way to handle this process electronically, so it wouldn't matter where the physical invoices are stored, she notes.

Another big issue tackled after the storm was finding ADAP clients. The Centers for Disease Control and Prevention (CDC), the American Red Cross, and FEMA provided some assistance by giving some names of evacuees and their locations, which the HIV/AIDS program staff could then match to its own list of clients, Scalco says.

Many New Orleans people infected with HIV had moved to other states, so the HIV/AIDS program staff also worked with other states' ADAPs to make certain they were willing to provide help to Louisiana ADAP clients, Scalco says.

They had a national conference call in the first week after the storm, hosted by the National Alliance for State and Territorial AIDS Directors and the Health Resources and Services Administration.

"That was to get all of the medication assistance coordinators on the telephone and talk through what was going on and how they were going to respond to it," Scalco says.

Texas ADAP officials did an excellent job of getting hurricane evacuees medication and assistance, she notes.

This wasn't easy because many of the HIV clients would arrive in another city or state and not know what medications they were taking or even whether they received drugs through ADAP or some other program, Scalco says.

Several other unexpected challenges occurred, including the loss of rapid HIV testing kits and hepatitis B vaccine kits, which needed to be refrigerated.

Although the facility had generators, these were useless if they were flooded or the gasoline fuel ran out, Scalco notes.

"The other big impact that we didn't expect was that we process our HIV tests at the Office of Public Health laboratory in New Orleans, and the lab was in a building that lost electricity," Scalco says. "We had a lot of specimens that were in a controlled temperature environment that we lost because the generators ran out of gasoline."

So all of the HIV clients who had samples pending in the laboratory would need to be retested, she says.

"It took us about four weeks to figure out an alternate mechanism to process laboratory tests," Scalco says. "We went to the CDC and asked them if they could process our test with new specimens coming in, but, unfortunately, that's a very slow process." Ultimately, while the issue was being resolved, the state lost four weeks of HIV testing and had to suspend all testing activities statewide, Scalco says. ■

Program links newly HIV-diagnosed patients to care

Intervention uses well-trained case finders

The Baltimore (MD) City Health Department has found success with an HIV program that is modeled after an intervention already employed in sexually transmitted disease (STD) care.

The city health department has used a disease intervention specialist (DIS) to bring people infected with STDs into treatment, and now a similar model is being used to bring people infected with HIV into care, says **Steven L. Dashiell**, Ryan White Minority AIDS Initiative (MAI) outreach program coordinator in the health promotion and disease prevention office. Dashiell presented an abstract about the disease intervention techniques at the 2006 National STD Prevention Conference, titled, "Beyond The Hidden Epidemic: Evolution or Revolution?" held May 8-11, 2006, in Jacksonville, FL.

"The disease intervention specialist is assigned to individuals, who are told they have been exposed to an STD, and the specialist gets these people into care and breaks down the barriers to getting them into care," Dashiell explains.

With funding of $210,000, provided last year from the Health Resources and Services Administration and the MAI, the method employed for HIV clients involves working with HIV-positive individuals, who are found through city outreach. They're assigned as active cases to three case finders.

"Our problem was how do we get a person from HIV testing sites to HIV care sites if those

sites are not in the same places," Dashiell says. "We have plenty of individuals who find out they are positive at one site that is not a care place, and they are not linked to care."

Traditionally, when people tested positive for HIV they were given a lot of information, but were not assisted further in entering treatment, he says.

"This critical gap simply existed because none of us in the field nationally realized the level of stress the individual might go through when given an HIV diagnosis," Dashiell says. "When we gave clients information at the post-test counseling, there was the expectation that people would follow-up for the benefit of their own health."

What health officials failed to understand was that all of the information in the world might not be enough to get some people to the door of an HIV clinic, he adds.

"We didn't recognize the financial factors of 'I simply cannot afford a place of care,' or 'I work from nine to five, when the clinic is open,'" Dashiell says.

"You get this huge news of an HIV infection, and someone gives you all of these papers and expects you to read them and go somewhere for help," says **Kima Joy Taylor**, MD, MPH, assistant commissioner of the health promotion and disease prevention branch of the Baltimore City Health Department.

"People are completely shocked and can't take in the information," Taylor adds.

Their solution was to use techniques employed by DIS workers by giving specially trained case finders the names of people who the health department had tested and found to be positive, Dashiell says.

Case finders also serve a case manager role by assisting HIV clients with finding transportation, obtaining treatment for substance use, and other issues, Dashiell notes.

"They make sure the clients get to their clinic appointments and provide them with bus passes or whatever they need," he says.

"It is not considered a successful intervention unless the individual the case finder is assigned gets to at least two appointments," Dashiell adds.

Training case finder is very intensive and includes the best elements of the CDC STD intervention training and traditional HIV outreach training. Case finders include both DIS workers and community partners who have better access to at-risk populations, including men who have sex with men, substance users, and others.

Caseloads number 15 to 20 people, he says. Building caseloads was the easy part. The Baltimore health department tested more than 8,000 people for HIV last year, Dashiell says. "We take the list of those with positive HIV tests and cross-reference it to look at the clinic database to see if the people have been informed that they're HIV positive."

Case finders also are encouraged to find, through their own community work, people who are HIV positive and then link them to care. And some clients are found through the corrections system.

Those who have been newly-diagnosed are then referred to a case finder who recruits them, asking clients to sign releases permitting the health department to collect information about their health clinic appointments, CD4 cell counts, and viral load, Dashiell says.

Clients can refuse, but those who agree to be part of the program will be contacted by the case finder until they have attended two primary care and case management appointments.

The care centers have been able to handle the extra clients and are participating in referring patients to the program, Dashiell says. "It's obvious that the good work of the health department is bearing fruit, so they want us to refer people to their care sites," he adds. "Other methods of going out to a group of people, testing them, and then attempting to link them to care is far more involved, and the end result is the same." ■

25 Years of HIV/AIDS

CDC to remove pre-test counseling requirements

Latest stats: Nearly half of infected are black

After two and a half decades of fighting one of the most insidious and stigmatized public health epidemics in recent history, U.S. public health officials say they are ready to simplify HIV testing guidelines, including eliminating requirements for HIV pre-test counseling.

This move is expected to make HIV testing more routine and easier for clinicians to use as a screening tool for all patients, rather than as a recommended part of care only for high-risk patients.

"We're proposing to simplify and remove pre-test counseling in clinical settings, says **Kevin Fenton**, MD, PhD, director of the CDC's National

Proportion of AIDS Cases among Adults and Adolescents, by Race/Ethnicity and Year of Diagnosis, 1985 – 2004, United States

Year of Diagnosis	White, not Hispanic	Black, not Hispanic	Hispanic	Asian/Pacific Islander	American Indian/Alaska Native
1985	59	25	15	1	0
1986	59	25	15	1	0
1987	58	27	15	1	0
1988	54	28	17	1	0
1989	52	30	17	1	0
1990	50	32	17	1	0
1991	48	33	18	1	0
1992	46	35	18	1	0
1993	42	38	19	1	0
1994	39	40	19	1	0
1995	39	41	19	1	0
1996	35	44	20	1	0
1997	32	47	20	1	0
1998	31	48	20	1	0
1999	30	48	20	1	0
2000	29	49	20	1	0
2001	28	50	20	1	0
2002	29	49	20	1	0
2003	28	49	21	1	0
2004	28	49	20	1	0

Center for HIV, STD, and TB Prevention. Fenton recently spoke at a national teleconference that highlighted the progress made and challenges remaining as the epidemic reaches the 25-year mile post.

"What we're essentially trying to do is address the barriers for HIV testing, and we know that one significant barrier is the amount of time it takes for pre-test counseling," Fenton says.

"One of our current strategies is to increase the number of people who know their HIV infection status," says **Timothy Mastro**, MD, acting director of the CDC's division of HIV/AIDS prevention.

"These guidelines address clinical settings, and they recommend routinizing the nature of HIV testing so it's not based on an assessment of the risk of an individual or the prevalence of the community in which the person resides so that there would be a routine screening for HIV of all persons between the ages of 13 and 64," Mastro says.

People with ongoing risk behaviors should be tested more frequently, but everyone else in the 13 to 64 age group should be tested at least once, Mastro adds.

Infectious disease and other clinicians have been reluctant to push for routine HIV testing among patients because of the amount of time it takes to meet counseling guidelines, health care officials have said.

The new guidelines about pre-test counseling, which are expected to be released this summer, will remove that concern, Fenton says.

A recent study, presented at the 2006 National STD Prevention Conference, held May 8-11, 2006, in Jacksonville, FL, demonstrated success with a policy switch from a selective HIV testing system to an opt-out system, in which HIV testing became routine. **(See story about Denver HIV testing opt-out system, p. 69.)**

The most recent update on the state of the HIV/AIDS epidemic in the United States confirms the major accomplishments in reducing AIDS deaths, but also confirms one of the epidemic's most disturbing trends: African Americans are

disproportionately impacted by the epidemic, representing nearly half of all AIDS cases.

In the early years of the epidemic, about 60% of the people with AIDS were white, and blacks accounted for about 25% of AIDS cases. Now, blacks account for 49% of AIDS cases, while white AIDS cases have remained under 30% for five years. **(See chart on proportion of AIDS cases among adults and adolescents, page 67.)**

AIDS cases among Hispanics has risen from 15% of the total AIDS cases in 1985 to 20% in 2004.

The CDC estimates that 47% of people living with HIV infection are black, while 34% are white, and 17% are Hispanic.

"African Americans are the hardest hit by AIDS, accounting for more than one-third of deaths to date," Fenton says. "African American men who are men who have sex with men (MSM) are especially hard hit." One study found that half of black MSM in one area were infected with HIV, he says.

AIDS cases by gender also have changed considerably since the 1980s, the CDC reports. While female AIDS cases were one-tenth the number of male AIDS cases in 1985, by 2004, women had one-third as many AIDS cases as men. **(See estimated AIDS cases by sex and year of diagnosis, right.)**

The city of Baltimore, which has a high prevalence of HIV/AIDS cases, has seen a similar trend to the national statistics, says **Kima Joy Taylor**, MD, MPH, an assistant commissioner of health promotion and disease prevention at the Baltimore City Health Department.

"Our actual numbers [of HIV cases] seem to be leveling off, but the numbers of African Americans and women are increasing," Taylor says. "So even though the overall prevalence seems to be flattening out, we still have to address these groups."

Much of the credit for the U.S. epidemic's decline in transmission belongs to the gay community, which has been a strong force in promoting HIV prevention and funding for the past 25 years, says **James W. Curran**, MD, MPH, dean of Emory University's Rollins School of Public Health in Atlanta, GA. Curran was among the first health care authorities to discover links between the first men presenting with AIDS symptoms.

"We in public health played a role, but much of it was due to the overwhelming presence of the epidemic and the willingness [of the gay community] to discuss HIV and get tested and know about it," Curran says. "AIDS was palpable in the gay community; everyone knew people who were sick or infected, and they knew people who had died, and that presence led to a constant discussion which impacted young people."

Now, attention to the epidemic has subsided, and the pressure is off politicians, making it more difficult to sustain attention and focus on prevention, Curran notes.

"New things are news, and old stories are not news," Curran says. "And it's been more difficult in the highly active antiretroviral therapy era to find newsworthy items that relate to the domestic situation."

The continuing spread of the epidemic among young gay men is not as compelling a story as it would be if it was more broadly spread among middle class people, and the continued invisibility and stigmatization of homosexuality is probably a factor, Curran adds.

The AIDS epidemic began as an insidious infection that first came to public health authorities'

Estimated AIDS Cases by Sex and Year of Diagnosis, 1985 – 2004, United States

Year of Diagnosis	Sex	
	(1) Male	(2) Female
1985	10,985	984
1986	17,561	1,664
1987	25,885	2,911
1988	31,601	4,027
1989	37,596	5,159
1990	42,130	6,571
1991	50,808	8,564
1992	65,643	12,273
1993	63,687	13,858
1994	57,312	13,595
1995	53,939	13,796
1996	46,356	13,259
1997	37,083	11,498
1998	31,405	10,197
1999	29,737	9,813
2000	29,027	10,486
2001	28,797	10,409
2002	29,787	10,480
2003	30,605	11,226
2004	31,053	11,461

attention in June, 1981, with the unusual cluster of Pneumocystis carinii pneumonia infections among five young men, who all were gay, Curran says.

"Shortly thereafter, in the next few months, cases were reported in the injecting drug users [community]," Curran says.

"Even in the early 1980s, we were always greatly concerned that we would underestimate the burden and impact of AIDS around the world," Curran says. "Perhaps silence still does equal death in the worldwide scene."

The past 25 years have gone by in a heartbeat, and the scientific progress has been amazing, Curran says.

"But I'm more amazed at the progress of the virus around the world," Curran adds.

Although AIDS cases peaked in the United States in 1992, and there is some evidence that they may be reaching a peak worldwide now, this trend is no reason to become complacent in HIV prevention efforts, Mastro says.

"We're in this for the long haul, and we're 25 years into it," he says. "Despite our efforts on HIV prevention to date, while we may create success in some areas, the epidemic continues to change, and there are, we think, an ongoing 40,000 infections in the United States."

The CDC would like to bring down the number of new HIV diagnoses considerably, Mastro says.

An increase in HIV testing is one of the key initiatives promoted by the CDC and the U.S. government, Fenton says.

Also, more attention must be paid to HIV prevention, particularly among the populations most impacted by the epidemic, Fenton says.

"In the face of 40,000 new infections each year, clearly the work is cut out for us, and not only with MSM, but with other populations that are marginalized in our society," Fenton says. "The nature of the evolution of the epidemic means we need to look at the driving factors in a whole new way."

Drug use and sexually transmitted diseases place African Americans at increased risk for HIV, and there is no simple solution for reducing HIV transmission, Fenton says.

"One element of a comprehensive approach is to involve communities at risk with implementation and evaluation and development of interventions," Fenton says. "We also need to ensure we work more closely with community leaders to make sure interventions are appropriate." ■

Opt-out system for HIV testing proves successful

More are tested and referred to care

The Denver (CO) Public Health Department has changed its HIV testing program over the past few years to an opt-out, rapid HIV test program, which has resulted in a 50% increase in HIV positive cases identified in the sexually transmitted infection (STI) clinic.

"The number of HIV positives has increased from 39 in 2003 to 48 in 2004 to 55 in 2005," says **Kees Rietmeijer**, MD, PhD, director for the STD Prevention Program.

"The people we find with HIV infection who initially tell us they are at low risk has increased over the years," Rietmeijer says. "In the old times, we excluded those people from testing because we thought they were low risk."

The STI clinic began to offer the rapid HIV test in November, 2003, after years of providing standard HIV testing with pre-test and post-test counseling.

"One of the problems with this, and it's something that's been acknowledged for a long time, is a lot of people — 66% — did not call back for the results," Rietmeijer says. "So there were quite a few people we missed."

With the rapid HIV test, 100% of people receive their results, so that was the first improvement to the clinic's HIV testing program, he says.

"I was concerned at the beginning about whether this type of testing would be acceptable because most people who come to the clinic do not necessarily come to get an HIV test," Rietmeijer says. "But the rapid test was quickly embraced by the clientele, and on July 1, 2004, we discontinued the standard test and only did rapid testing."

With a complete switch to rapid HIV testing, a major logistical change had to take place, he notes.

"In the old days, people came to the clinic, registered, and signed a consent form that said they will allow all of the tests that need to be done as part of a routine check-up, but the HIV test was excepted from that form," Rietmeijer says.

Instead, the previous method was to have the patient meet with the clinician, who would conduct a brief risk assessment and then offer the HIV test if the person was deemed at high risk, Rietmeijer says.

When the rapid test was introduced, this created a logistical problem: the rapid test takes 20 minutes, so if it the clinician offers it after a risk assessment, it generally will add unproductive time to the visit, he explains.

"So we said we needed to do something different here because that was not working," Rietmeijer says.

The solution was to move all of the blood tests to the beginning of the patient's visit, before the clinician even sees the patient, he says. This way the person has blood drawn only once for STIs and HIV, and the HIV test results are ready while the patient is still seeing the clinician.

Once this change was made, it seemed logical to change HIV testing from an opt-in process to an opt-out process. So the consent form was changed to include a statement that requests patients check the box if they choose not to receive an HIV test, Rietmeijer says.

"We saw an increase in HIV testing acceptance [among people who said they did not know their status] from 80% prior to the rapid testing to 97% currently," Rietmeijer says. "For gay men the acceptance rate was 90%, and my suspicion is there are men who know they are HIV positive, but they may not tell the clinician this."

The clinic's demographics include about two-thirds men and 10% to 15% are men who have sex with men (MSM). Most are in the 20-30-year age group. About 60% of the clinic's patients are not white, including 22% African American and 33% Latino, Rietmeijer says.

The Denver clinic's change from selected HIV testing accompanied by pre-test counseling to the current system of routine testing and no pre-test counseling could soon be the standard way HIV testing is done in many clinical settings, he notes.

"You will see increasingly a changing attitude toward HIV testing and counseling," Rietmeijer predicts.

"For most of the patients who come to an STD clinic, it's a no-brainer: HIV testing is part of the experience," Rietmeijer says. "They know HIV is by and large a sexually transmitted disease — we have a very low prevalence among injection drug users."

As a result of this understanding, there has been pattern of HIV testing becoming a more normal part of the STD clinic experience for patients, and clinicians have had to catch up with this shift in philosophy, Rietmeijer notes.

"I was the director of HIV prevention for a number of years, and when they had rapid HIV testing, I was critical and unsure about it," he says. "But our experience has been very positive."

Patients who are tested for HIV and receive a positive finding are automatically tested for viral load and CD4 cell count at the same visit, Rietmeijer says.

"Then we link them to our care manager for a visit in a week to discuss the results, and we link them to HIV services within the public health system or elsewhere," he says. "We follow-up with additional services if they need them, including prevention services, counseling, and mental health."

The Centers for Disease Control and Prevention (CDC) will publish new recommendations shortly, and Rietmeijer's study is part of a national effort of demonstrating the success of switching to routine HIV testing. The recommendations will suggest that in some settings, including emergency rooms, private physician practices, and STD clinics, HIV testing does not have to be accompanied by pre-test counseling.

"We've always known that the amount of counseling we could offer specifically related to HIV was more limited," Rietmeijer says.

"I'm a total proponent for counseling because I think it's very important, and we know good counseling can prevent STDs," Rietmeijer says. "But I think we should provide counseling to all patients in a clinic, regardless of whether they receive an HIV test."

The traditional way of handling HIV counseling was to provide it as a separate entity, developed around HIV pre-test and post-test, he notes.

Research has shown that patients who are at risk for STDs, but not at risk for HIV, had 20% lower rate of STDs if they received good prevention counseling, Rietmeijer says.

"We have an audience who come to the STD clinic for a certain crisis," Rietmeijer says. "For a majority of people, the diagnosis is a shocking thing, and it's a moment when they're susceptible to counseling messages, if they're done well."

Rather than provide HIV pre-test counseling, the clinic has a good risk assessment process with open-ended questions, Rietmeijer says.

"We get patients to open up with the risks they are engaging in and get them to identify a risk they think they can work on and change," he explains. "And we negotiate a risk reduction plan around that behavior."

Since STD clinics frequently provide risk assessments and counseling services, the Denver clinic is working with clinicians to incorporate

the essence of good prevention counseling into their daily interactions with patients, Rietmeijer says.

"The whole interaction takes 20 to 45 minutes, depending on the complexity of the case," he says. "If we get into substance abuse or mental health problems or alcohol issues, it could take a while longer." ■

FDA Notifications

FDA issues guidance about HIV vaccine study

The FDA is issuing guidance to sponsors on initiation of HIV vaccine studies involving pediatric patients. The guidance also provides recommendations to investigators and institutional review boards (IRBs) involved with such studies.

This guidance specifically addresses issues regarding development of a preventive HIV vaccine for use in healthy U.S. pediatric populations.

The guidance is available on the FDA web site at www.fda.gov/cber/gdlns/pedhiv.htm. Copies are also available from the Office of Communication, Training and Manufacturers Assistance (HFM-40), 1401 Rockville Pike, Suite 200N, Rockville, MD 20852-1448 or by calling 1-800-835-4709 or 301-827-1800.

Written comments on this guidance may be submitted at any time to the Division of Dockets Management (HFA-305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852. Submit electronic comments to http://www.fda.gov/dockets/ecomments. You should identify all comments with the title of this guidance: "Development of Preventive HIV Vaccines for Use in Pediatric Populations." ▼

HIV-1 adult treatment guidelines are updated

"The Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents" has been revised to include new recommendations for resistance testing, treatment interruption, and HBV/HIV co-infection. Tables have been revised to include up-to-date information about drug interactions and about the lopinavir/ritonavir 200/50 mg tablet formulation.

Changes to the document are summarized in the "What's New in the Document?" section, and all changes to the document are highlighted in yellow throughout the text.

The updated guidelines document is available in the adult guidelines section of the guidelines page on the www.AIDSinfo.nih.gov web site. The site also contains an option to order hard copies of the guidelines or request an electronic copy by e-mail. ▼

Two tenofovir containing products approved

On March 8, 2006, the FDA granted traditional approval to two tenofovir DF containing products manufactured by Gilead Sciences, tenofovir disoproxil fumarate (Viread) and fixed dose combination of tenofovir DF and emtricitabine (Truvada). Both products are indicated for the treatment of HIV in combination with other antiretroviral drugs.

Both products had received accelerated approval on Oct. 26, 2001 and August 2, 2004, respectively. Traditional approval is supported by previously submitted studies and the recently submitted Study 934, which compared the antiviral activity of tenofovir DF, emtricitabine, and efavirenz to zidovudine, lamivudine and efavirenz in treatment of naïve HIV-infected individuals receiving these regimens through 48 weeks. ■

COMING IN FUTURE MONTHS

- One pill, once-a-day may keep AIDS away
- Recommendations from international meeting on AIDS
- Computerized intervention improves condom use
- Rwanda makes progress in reducing mother-to-child HIV transmission

CE/CME objectives

The CE/CME objectives for *AIDS Alert*, are to help physicians and nurses be able to:
• Identify the particular clinical, legal, or scientific issues related to AIDS patient care;
• Describe how those issues affect nurses, physicians, hospitals, and clinics;
• Cite practical solutions to the problems associated with those issues, based on overall expert guidelines from the Centers for Disease Control and Prevention or other authorities and/or based on independent recommendations from specific clinicians at individual institutions?

Physicians and nurses participate in this medical education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any question answered incorrectly, please consult the source material.

After competing this activity at the end of each semester, you must complete the evaluation form provided and return it in the reply envelope provided to receive a certificate of completion. When your evaluation is received, a letter of credit will be mailed to you.

CE/CME *questions*

21. In the event of a major natural disaster, what would be a state AIDS office's best strategy for protecting and retrieving HIV client data, according to those who survived Hurricane Katrina?
A. Make sure generators are on the second floor
B. Back up all data in paper format and store on a top floor
C. Have computer back-up files located outside of the city/state that would be impacted so they could be retrieved immediately after the disaster
D. All of the above

22. According to the Centers for Disease Control and Prevention, the AIDS epidemic has shifted its demographics from 60% white and 25% black in the mid-1980s to what racial percentages now?
A. 49% black; 30% white; 20% Hispanic
B. 60% black; 30% white; 10% Hispanic
C. 65% black; 22% white; 12% Hispanic
D. None of the above

23. What percentage agreed to accept an HIV test after a Denver STD clinic's initiated a rapid HIV test and opt-out of HIV testing policy?
A. 89%
B. 92%
C. 95%
D. 97%

24. A new Baltimore, MD, public health intervention program for linking HIV clients to care uses case finders to perform what services?
A. Recruit HIV clients and ask them to sign releases permitting the health department to collect information about their health clinic appointments, CD4 cell counts, and viral load
B. Make certain newly-diagnosed HIV clients attend two primary care and case management appointments
C. Provide assistance with transportation, substance use services, and other services to new HIV clients, as needed
D. All of the above

Answers: 21. C; 22. A; 23. D; 24. D