

**HIV/AIDS**  
**TESTING** *and*  
**TREATMENT**  
**CONSENSUS**  
**PANEL**



National  
Medical  
Association



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# EXECUTIVE SUMMARY

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## INTRODUCTION

In the National Medical Association's (NMA) consensus report, "Addressing the HIV/AIDS Crisis in the African American Community: Fact, Fiction and Policy," several recommendations were compiled to address the prevention, care, and treatment of HIV/AIDS in ethnic minorities. In the report, the NMA acknowledges that urgent action is needed to overcome the myriad barriers to adequate HIV/AIDS testing and treatment to accomplish a reduction in the prevalence of the HIV/AIDS within communities of color, especially African Americans. For this reason, the NMA HIV/AIDS Testing and Treatment Consensus Panel convened to examine clinical, research, and policy issues specifically related to HIV/AIDS testing and treatment.

This paper, developed by the NMA HIV/AIDS Testing and Treatment Consensus Panel, summarizes the research and data as it relates to these two critical areas—testing and treatment— and puts forth a set of recommendations for improving health outcomes and reducing HIV/AIDS-related deaths in the African American community.

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## ABOUT THE NATIONAL MEDICAL ASSOCIATION

The National Medical Association is the oldest and largest organization representing physicians of African descent in the United States. Established in 1895, the NMA is comprised of more than 30,000 physicians who serve millions of diverse patients, many of whom are underserved, underinsured, and predominately people of color. The NMA, is composed of six geographic

regions, has 33 state and 98 local affiliated medical societies. There is a ratio of approximately one (1) NMA society for every 259,000 African Americans across the United States. The organizational structure of the NMA provides a network of affiliated community-based organizations with a powerful reach to African American communities. All of the states with large minority populations, especially African Americans, are represented within this NMA network of societies.

The NMA is charged with representing the collective interests of African American physicians and patients (which includes native born Black Americans and immigrated persons of African descent). This trust is displayed in the Association's vision to act as a leading force for parity in medicine, which is accomplished by the mission to promote health and wellness, and eliminate health disparities among persons of color.

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## STATEMENT OF THE PROBLEM

According to the Centers for Disease Control and Prevention (CDC), HIV/AIDS continues to have a greater impact on African Americans than any other racial or ethnic group. In 2004, CDC reported HIV/AIDS as the second leading cause of death of African Americans ages 25 to 44.<sup>1</sup> Although African Americans make up only 13% of the population, a staggering 50% of those affected by HIV and AIDS are African American.<sup>2</sup> It is of great concern that HIV/AIDS is the number one leading cause of death for African American women ages 25 to 34.<sup>3</sup> Research shows that African American women are nearly 20 times more likely to be infected with HIV/AIDS than their Caucasian

counterparts.<sup>4</sup> Black men who have sex with men (MSM) are more severely affected by HIV than white and Hispanic MSM. Based on data from the CDC's 2004–2005 National HIV Behavioral Surveillance (NHBS) project, of the 450 MSM who tested positive, 46% were Black, 21% were white, and 17% were Hispanic.<sup>5</sup>

African Americans accounted for about 48% of all new HIV/AIDS diagnoses for persons ages 25 to 44 during 2001–2005.<sup>6</sup> Although African American ages 13–19 represent only 16% of U.S. teenagers, they account for 69% of new AIDS cases reported among adolescents in 2005.<sup>14,7</sup>

This crisis in the African American community reflects the failure of current strategies to effectively address community needs with respect to HIV/AIDS education, testing, and treatment. There is a critical need for a multi-tiered approach that adequately addresses improved testing strategies to increase awareness of HIV status, more effective targeted preventive education, and better access to effective treatment for populations at highest risk.

It is estimated that 16 to 22 million persons are tested annually for HIV in the United States.<sup>8</sup> However, an estimated 252,000 to 320,000 persons were unaware of their HIV-positive status at the end of 2003.<sup>9</sup> Lack of awareness is a major contributor to continued infection and to the delayed initiation of treatment until later stages of the disease.<sup>10</sup> Today, the CDC estimates that among the general population, 54% of new cases of HIV annually are accounted for by the estimated 320,000 HIV-positive persons who are unaware of their status. Tragically, African Americans are diagnosed at an advanced disease stage, and, as a result, do not benefit from the reduced morbidity and mortality early treatment can provide.

Results of the National Center for Health Statistics' 2006 U.S. National Health Interview Survey shows that nearly 52 % of non-Hispanic Black men and 54% of non-Hispanic Black women were more likely to report being tested for HIV compared to the nearly 31% and 34% rates of testing among their white counterparts, respectively.<sup>11</sup> However, while African Americans

as a group are more likely to report having ever been tested, the continued high sero conversion rates underscore the need and testing efforts to prevent secondary disease transmission for those unaware of their HIV status. Further targeted studies of the African American population are necessary to better understand the barriers to earlier testing and to guide implementation of successful prevention efforts.

Tailored treatment models for target populations such as pregnant women and infants; education of non-traditional providers (dentists, OB-GYNs, pediatricians, psychiatrists, and addiction specialists); and the integration of treatment modalities for co-morbid conditions as standard practice will significantly impact morbidity and mortality rates among HIV-positive African Americans.

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## METHODOLOGY

After identifying key HIV/AIDS experts in academia, private clinical practice (including medicine and dental), service, research, and public health, the HIV/AIDS Testing and Treatment Consensus Panel was convened. The panel was charged with reviewing the literature regarding HIV testing and HIV/AIDS treatment among people of African descent living in the United States, examining barriers to testing and treatment for this population, and identifying gaps in the current CDC recommendations on HIV testing. As a result of a two-day deliberative process by the NMA HIV/AIDS Testing and Treatment Consensus Panel and their comprehensive review of the literature, this consensus paper provides specific recommendations related to HIV testing and treatment for African Americans.

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## RECOMMENDATIONS

The consensus panel identified a series of recommendations addressing: (1) routine testing, (2) patient care and treatment, (3) comprehensive care, (4) physician workforce, and (5) funding.

# INTRODUCTION

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## CURRENT TESTING GUIDELINES

The CDC released revised recommendations for HIV testing in health-care settings in 2006, recommending routine HIV screening for all persons ages 13 to 64, and repeat screening at least annually for those at high risk.<sup>12</sup> Screening should be voluntary, with an “opt-out,” where the patient is notified that the test will be performed and consent is inferred unless the patient declines (as is the case for most laboratory tests in health-care settings) versus “opt-in,” where the HIV test is offered to the patient, who must then explicitly consent, often in writing. Repeat screenings, at least annually, are recommended for all persons identified as high risk for HIV infection. The CDC is expected to release new testing guidelines for non-clinical settings in the fall of 2008.

Among the CDC’s recommendations, is the use of Rapid HIV tests, which are especially effective in settings such as urgent care and STD clinics, where an ongoing relationship with the patient is not typical and a great amount of time is spent trying to locate persons who failed to return or call back for their test results. Rapid HIV tests are among the recommendations that may be especially effective in settings such as urgent care and STD clinics. In these settings patients are often lost due to follow up or are difficult to locate if they fail to return for test results. Rapid HIV tests may also reduce the overall costs associated with conventional testing by facilitating direct referral for ongoing care the day of testing.

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## TREATMENT

The introduction of Highly Active Antiretroviral Therapy (HAART), in 1995, significantly advanced the treatment of HIV infection and AIDS. The early use of combination regimens of antiretroviral medications relieves HIV-related symptoms and dramatically improved survival rates.<sup>13</sup>

In recent HIV treatment guidelines issued by the International AIDS Society-USA, U.S. Department of Health and Human Services (DHHS), there is no specific recommendations for African Americans.<sup>14, 15</sup> Newer HIV treatment research indicates African Americans experience certain vulnerabilities, but these findings are still new and rare among the treatment literature. However, these research findings can still be used as a consideration for physicians treating African Americans when prescribing certain medications. For example, ethnic genetic markers like polymorphism appear to be more common among specific ethnic groups such as African Americans and Hispanics.<sup>16</sup> This may influence how physicians address treatment interruption of certain non-nucleoside reverse transcriptase inhibitors (NNRTIs) used as part of HAART.

Current research is exploring how to address the discontinuation of NNRTIs in patients who have genetic factors that may contribute to vulnerability of developing resistance. Population groups that are perceived to be less likely to adhere to treatment, such as African Americans, Latinos, women, and persons with low-income, are less likely to be prescribed antiretroviral medications. Protease inhibitors, if prescribed at all, are often introduced later to African Americans than to whites.<sup>17</sup>



Identifying the optimal treatment for improved African American efficacy requires evaluation and analysis through clinical trials. Historically, there had been poor representation of African Americans in clinical trials both as participants or investigators. Several initiatives to encourage African Americans to participate in clinical research have been proposed recently. The National Institute of Allergy and Infectious Diseases (NIAID) issued a statement on National Black HIV/AIDS Awareness Day, February 7, 2007, that included requests for greater representation of Blacks in clinical

trials. However, there are few campaigns to demonstrate how African American interests will be protected. Recommendations to participate in clinical trials should also inform African American patients how they and their loved ones can regulate and minimize their risk, and become better informed of accountability regulations to which the medical researchers must adhere as part of these clinical trials.

The NMA's Project I.M.P.A.C.T.—Increasing Minority Participation in Clinical Trials—is working to address these issues.

## METHODOLOGY

The NMA identified key experts in the HIV/AIDS field—from academic centers, private practices, associations, research centers, public health and dental and legal groups—to join the HIV/AIDS Testing and Treatment Consensus Panel. This group was tasked to examine the barriers to HIV/AIDS testing and treatment among people of African descent living in the United States and to develop and publish policy guidelines on HIV/AIDS testing and treatment for African Americans.

A briefing paper prepared by the NMA staff was disseminated to members of the Consensus Panel. The briefing paper summarized (1) recent research and findings on the incidence and prevalence of HIV/AIDS in the United States, and its effects on minorities and the African American population; (2) current testing guidelines; (3) HIV/AIDS treatment; (4) co-morbid conditions; and (5) activities undertaken by the NMA to reduce the

incidence and prevalence of HIV/AIDS in the African American community.

Members of the NMA's HIV/AIDS Testing and Treatment Consensus Panel reviewed the paper and convened in Washington, D.C., December 14–16, 2007. Additional research and information included presentations on the science of HIV and data from the CDC.

This document is based on recommendations that emerged from the Consensus Panel's deliberations. The issues addressed by the panel include HIV/AIDS screening and testing, disparities in care and treatment, counseling, physician education, cultural competence, funding, and research. These recommendations were developed within the context of the African American and other populations to seek to reduce the disproportionate burden of HIV/AIDS within these underserved community. It should also be noted that evidence-based medicine served as the foundation for the formation of these recommendations.

## FINDINGS

There are a number of barriers to HIV testing and several HIV/AIDS treatment concerns, which are further complicated by various

concomitant health conditions. Like HIV/AIDS, some of these coexisting conditions disproportionately affect African Americans.

The NMA HIV/AIDS Testing and Treatment Consensus Panel addresses the prevalence of concomitant conditions and the need for adequate screening and comprehensive care and treatment of HIV patients through recommendations set forth in this document.

**Substance Abuse.** Persons with HIV/AIDS and substance abuse disorders require a full range of treatment services. However, many patients with HIV/AIDS only seek treatment for their substance abuse problem due to a fear of disclosing their HIV/AIDS status. Health care providers who screen for and assess possible substance abuse treatment needs should be trained to offer routine HIV testing. Inclusion of nurses, certified health educators, and nutritionists who specialize in substance abuse, can be used to augment the range of HIV/AIDS screening, care, and symptom treatment management provided in medical settings.<sup>18</sup>

**Mental Health.** Per the 1999 Surgeon General's report on Mental Health, African Americans are over-represented in populations that are most at risk for psychiatric illnesses. These populations include those who are homeless; incarcerated; children in foster care and the child welfare system; and people exposed to violence. Unfortunately, these are the populations that are also at high risk for contracting HIV. While we know that mental illness can be a risk factor for HIV/AIDS infection, the co morbidity of the two also has long-term care implications for HIV infected persons.

Mental health impairment limits a person's ability to obtain and/or manage proper treatment for infectious diseases such as HIV/AIDS. Having a chronic illness such as HIV/AIDS, along with the associated stigma, greatly impacts a person's mental health. The behaviors required for one to manage the HIV infection successfully can be impacted by his or her mental health status. For example, the presence of depression can compromise adherence to HAART or lead to discontinuation, as shown by studies in HIV-infected men in the Multicenter AIDS Cohort study and HIV-infected women in the Women's Interagency HIV-Study (WIHS).<sup>19,20</sup>

However, evidence indicates that recognizing and treating depression in HIV patients can

improve outcomes. In an analysis of 1,371 HIV-infected women screening positive for depression, use of antidepressant medication and psychotherapy or psychotherapy alone was significantly associated with increased use of HAART when controlling for CD4 count and viral load ( $P = 0.021$  and  $P = 0.009$ , respectively). In this study, however, African American women were less likely to receive any mental treatment (antidepressants, psychotherapy, or antidepressants plus psychotherapy) than the non-African American women study participants.<sup>21</sup> Other studies have also indicated that depression is frequently undertreated among African Americans.<sup>22</sup> There is a need for culturally appropriate and effective diagnosis and treatment of depressions tailored to the needs of this patient population.<sup>23</sup>

**Hepatitis B and C Viruses.** The occurrence of HIV/hepatitis B (HBV) and/or HIV/hepatitis C (HCV) co-infection in persons with HIV/AIDS has been shown to be a significant cause of morbidity and death in HIV-infected populations.<sup>24</sup> The course of liver disease is more rapid in HIV/HBV and HIV/HCV co-infected persons. In addition, the risk for liver cirrhosis is nearly double that of persons with HBV or HCV infection alone.<sup>25,26</sup>

It has been estimated that HCV infection is present in 15% to 30% of HIV-infected individuals.<sup>27</sup> This co-infection presents a particular challenge in the treatment of patients with HIV due to the inflammatory effects of antiretroviral drugs on a liver that is also compromised by the hepatitis viral infection.<sup>28</sup> Though not clearly understood, it appears the co-morbid impact is greater when the patient is African-American and is genotype 1.<sup>29</sup> HAART has provided a means to manage the impact of opportunistic infections in patients with HIV/AIDS. Treatment of HCV in co-infected persons is believed to improve tolerance to HAART. Specifically, treating to eradicate the HCV infection will reduce the rate of HCV progression and thus limit its interference with HAART.<sup>30</sup> However, HCV treatment in co-infected persons is believed by some to be investigational. Ongoing clinical trials will offer more data from which

to better understand the best approach for addressing HIV/HCV co-infection.<sup>31,32</sup>

Persons with HIV/HBV co-infection, experience similar hepatic outcomes as those with HIV/HCV co-infection. Some studies have shown HIV/HBV co-infected persons experience increased mortality compared to those with HIV infection alone.<sup>33</sup>

Screening of persons seeking care in STD clinics or other primary care settings should be conducted to identify those who require hepatitis B or C counseling and testing. Due to the high prevalence of HIV/HBV and HIV/HCV co-infections and the critical clinical management issues for co-infected persons, all HIV-infected persons should be tested for hepatitis infection.

**HIV Associated Nephropathy.** People of African descent are more at risk for kidney disease and renal failure, which may contribute to their increased risk of developing

HIV Associated Nephropathy (HIVAN)—kidney damage caused by HIV infection. Though HIVAN is relatively rare, those diagnosed with it are overwhelmingly Black. The only reliable way to diagnose or rule out the presence of HIVAN is a renal biopsy.

Based on guidelines set forth by the HIV Medicine Association of the Infectious Disease Society of America (ISDA), a screening urinalysis should be provided at the time a patient is diagnosed with HIV to check for proteinuria and a calculated estimate of renal function. Carefully monitored renal function (every 6 months, at the minimum) allows the physician to properly prescribe antiretroviral and other commonly used medications that require renal adjustment. For example, the drug tenofovir, when needed, warrants regular monitoring of renal function.<sup>34</sup> Annual screening is recommended for patients

## DISCUSSION

CDC recommends routine HIV screening for all persons, ages 13 to 64, and repeat screening at least annually for those at high risk. It is anticipated that increased HIV testing will further

who are HIV-positive and who show no evidence of proteinuria at the initial evaluation.

**Oral Health.** Oral manifestations of HIV disease, such as thrush, warts, and gum disease, occur in a large percentage of people living with HIV/AIDS.<sup>35</sup> Approximately 37% of people living with HIV/AIDS commonly reported symptoms of xerostomia (dry mouth) and 25% have white patches in their mouths.<sup>36</sup>

These manifestations of HIV are categorized as fungal, viral, and bacterial infections; neoplasms; and nonspecific presentations, such as salivary gland disease and aphthous ulcers. Manifestations of these diseases in those affected with HIV tend to be in the most severe form. However, people living with HIV disease often have limited access to oral health care.

Problems in the mouth may not only be the first symptom of HIV infection, but also can signify clinical progression. Therefore, access to oral health care, for both the person at risk for HIV infection and for the individual already living with HIV disease, is critical. However, care is often not available, nor accessed. Reasons range from lack of funding, limited or no insurance or lack of willingness to treat. Also geographic isolation and problems that are so devastating for the patient that those related to oral health seem relatively unimportant.

For the person who is HIV-positive and who is unaware of his or her serostatus aside from developing oral symptoms are developing, no access to dental care represents a lost opportunity for HIV screening, counseling and testing. Because of its relationship to good nutrition, oral health care is no less essential for the person who is HIV-positive and already in care. HAART, despite reducing the incidence of some oral health conditions, with increased incidence does not compensate for poor access to oral health care.

show the disproportion in HIV and AIDS cases among African Americans, and have a direct impact on the lack of culturally competent and linguistically appropriate treatment providers.

Studies show that when given the opportunity to select health care providers, minority patients are more likely to choose someone of their own racial and ethnic background.<sup>37</sup> However, the current pool of minority physicians trained in HIV treatment is neither large enough to meet the current needs of the population. Initiatives designed to address this shortage are needed to ensure that a new generation of minority medical providers are trained in infectious diseases and these physicians provide quality HIV-related patient care.

Another threat to improved treatment outcomes is the allocation of public resources are not consistent with the distribution of HIV/AIDS cases by race/ethnicity and geographical location. CDC surveillance shows that one-third of HIV-infected persons are not receiving medical care. Targeting the communities that could benefit most from HIV/AIDS prevention, testing, and treatment services is a critical strategy to decreasing HIV infections and AIDS-related illnesses and deaths among the African American population.

There are multiple factors influencing the epidemic of HIV/AIDS cases, including policies that serve as disincentives for physicians to treat HIV-positive patients in their community. Changes in policy that address funding, modifications in guidelines that govern screening, testing, counseling, and treatment are necessary to relieve the excessive burden on physicians and their predominantly minority patients.

Ultimately, improved clinical outcomes in patients with HIV may rely heavily on effective antiretroviral therapy (ART). Deciding when to start ART continues to be re-evaluated as the availability of less strenuous regimens and the ability to better preserve the immune system, support earlier initiation than previous guidelines suggested. Successful treatment of HIV-positive persons has as much to do with “how” patients will be treated as it does with “when” patients begin treatment. The right decision on which combination of drugs to administer when initiating antiretroviral therapy can improve outcomes for people living with HIV.

## RELATED NMA ACTIVITIES

In keeping with its mission to eliminate health disparities in HIV/AIDS, the NMA is currently undertaking a project for 2,000 Black primary care physicians to incorporate HIV testing as part of routine care to all patients. Additionally, physicians are also encouraged to include prevention messages to their patients. The project will take place in six proposed cities—Baton Rouge, LA; East St. Louis, IL; Jackson, MS; Memphis, TN; Oakland, CA; and Raleigh/Durham, NC. These cities were chosen because they are among the top U.S. cities where the prevalence of HIV cases is the highest. Program objectives include:

- Developing and distributing a capacity assessment among NMA primary care physicians in order to evaluate their knowledge, attitudes, perceptions, and practices (including best practices)

regarding HIV prevention, including HIV testing, as part of routine medical care for all patients.

- Developing HIV/AIDS practice standards for physicians treating Black and at-risk patients.
- Developing HIV/AIDS quality of care training materials such as curricula, administrative tools, and policy manuals.
- Training 2,000 NMA physicians to a) offer rapid HIV testing to all patients in all settings, b) deliver ongoing, effective HIV prevention messages, and c) counsel patients about safe sex and drug use behaviors (especially those who are infected) as a routine part of medical care.
- Creating or adapting culturally- and linguistically-appropriate consumer literature or other educational tools,

- including distribution among NMA members and other collaborators for dissemination to patients and their partners.
- Promoting project protocols to NMA physicians, such as HIV testing of pregnant women, incorporation of HIV prevention into the medical care of persons living with HIV, and providing HIV/STD services to high-risk individuals.
  - Networking with other medical organizations such as the American Academy of HIV Medicine and the National Black Nurses Association, in order to increase awareness of the HIV epidemic and to promote effective prevention strategies for clinical settings.
  - Piloting the acceptability of the CDC's provider tool kits entitled: "Take Charge. Take the Test," an HIV testing social marketing campaign for African American women, and "Prevention is Care," designed to help clinicians incorporate prevention services into the care of persons living with HIV.
  - During the spring of 2007, the NMA implemented HIV/AIDS educational and outreach activities including:
    - The Plenary Session Program, "Addressing the HIV/AIDS Crises in the African American Community: Fact, Fiction and Practice," was presented at the NMA's Annual Convention in 2007. Over 450 participants attended the meeting.
    - An HIV/AIDS physician needs assessment was administered during the 2007 annual convention and was published in the NMA e-newsletter. To date, there are over 300 physician member respondents. The assessment will also be made available in the March 2008 issue of the *Journal of the National Medical Association*.
    - Convened HIV/AIDS programming during six NMA regional meetings
    - Developed cultural competent and health literate HIV/AIDS consumer material including a website <http://hiv.NMAnet.org>.

## CONSENSUS PANEL RECOMMENDATIONS

Because African Americans are particularly vulnerable to this pandemic, the NMA HIV/AIDS Testing and Treatment Consensus Panel recommends the National Medical Association assume national leadership on this issue, and, as such, the Association demands change on how HIV/AIDS is addressed in people of African descent as a major public health concern. Specifically, the consensus panel identified a series of recommendations addressing: (1) routine testing, (2) patient care and treatment, (3) comprehensive care, (4) physician workforce, and (5) funding.

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### ROUTINE TESTING

Studies have shown that targeting HIV testing based on reported risk factors will miss many

HIV-infected clients; therefore, the NMA strongly supports universal testing to reduce the stigma associated with AIDS. In response to the large number of persons—an estimated 252,000 to 320,000—who are unaware of their HIV-positive status, the NMA HIV/AIDS Testing and Treatment Consensus Panel strongly supports the use of routine testing consistent with the CDC recommendations. The consensus panel recommends CDC add to its recommendations as specified below.

Research shows most older persons—those above 50 years of age—are first diagnosed with HIV at a late stage of infection, and older persons with AIDS often die sooner than their younger counterparts. In 2005, of the estimated 40,540 cases of adults

and adolescents with AIDS, 801 cases were in adults over age 65.<sup>37</sup> For women, the percentage of AIDS cases rises to 13.2%<sup>38</sup> for ages 60 to 69 years and 28.7% for those ages 65 years and older.<sup>39</sup> To this end, the NMA HIV/AIDS Testing and Treatment Consensus Panel recommends:

- CDC also recommend screening for HIV infection be performed routinely for patients over age 64.

The current CDC HIV testing recommendations include repeat screening for those identified as high risk, such as injection-drug users and their sex partners. However, sharing a needle is not the only risk for HIV associated with substance abuse. The National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism found the use of drugs and alcohol interferes with judgment about sex and other behavior. Thereby, substance users may be more likely to have unplanned and unprotected sex. For this reason, the panel recommends:

- CDC specifies in its recommendations that all patients with a history of chemical dependence or substance abuse be tested annually for HIV.

Because there is a chance that an individual may be infected even though the results of the HIV test were negative, the NMA recommends:

- CDC recommendations for HIV testing include post counseling for persons who test negative for HIV to explain the window period for HIV infection and the possible need for retesting, while addressing the risks for acquiring the infection in the future.

Finally, the NMA reviewed the CDC definition of “high risk”, (heterosexual contact with a person known to have, or to be at high risk for HIV infection) and the implications this definition has, for example, on African American heterosexual women, as well as heterosexual men who are not MSM, but have participated in a single sexual act with another man. The NMA recommends:

- CDC redefine the definition of high risk as it relates to surveillance hierarchy and categorization.

In addition to the above proposed expansion to the CDC recommendations, the NMA suggests:

- Routine pediatric testing be increased among vulnerable populations, such as infants, children, and adolescents who are in foster care; infants, children, and adolescents who have been sexually abused; and youths who are currently in juvenile detention facilities or re-entering the community.
- Mandatory testing for those who are incarcerated or in federal institutions, as this population may be at an increased risk for being infected with and transmitting the HIV virus.
- States include HIV testing as a marriage license requirement for both partners prior to any marriage or remarriage.
- Electronic Personal Health Records be used by patients to record all HIV/AIDS tests and test results.

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## PATIENT CARE AND TREATMENT

Despite recommendations for universally applied, quality care, the racial disparity in quality of care and treatment exists across all health issues. In acknowledging that these gaps exist, the consensus panel has responded with several strategies to address the care and treatment needs of African American HIV/AIDS patients. Hence, the panel makes the following recommendations:

- The research arm of the NMA, the W. Montague Cobb/NMA Health Institute (Cobb Institute), should conduct research that will establish a standard of care for HIV/AIDS treatment in African Americans.

- All patients presenting with symptoms of acute retroviral syndrome (ARS) (indications and symptoms people experience when first infected with HIV) be tested for HIV infection.
  - Establish a standard of care for the initiation of antiretroviral therapy based on the following criteria: the initiation of ART in all patients with CD4 <350 and strong consideration be made to initiate with CD4 <500—with the exception of pregnant women—HIV positive persons who do not use condoms or sexual barriers, and co-infected persons with hepatitis C, active hepatitis B, or active tuberculosis.
  - The NMA advocate for linkage to care among patients who have tested positive for HIV, and encourage linkages to experienced and knowledgeable providers who treat HIV/AIDS patients.
  - The NMA advocate for representation on the U.S. Department of Health and Human Services Panel on Antiretroviral Guidelines for Adults and Adolescents.
  - The NMA advocate for assurance that all FDA-approved antiretroviral medications are available in every payors' formulary.
  - Expand the representation of culturally and linguistically competent health care providers.
- In response to the large number of HIV/AIDS concomitant conditions, the panel recommends:
- The NMA develop a multidisciplinary continuing medical education program for managing HIV infection and concomitant conditions and replicate that model nationwide.
- Because it is not uncommon for the first symptom of HIV to first present in the mouth, it is critical that medical doctors partner with oral health practitioners. The panel recommends:
- The NMA develop continued educational and training opportunities for oral health and primary health care providers to enhance knowledge, attitudes, and capacity to provide quality care to people living with the disease.
  - The NMA collaborate with the National Dental Association to encourage minority dentists to provide more information about HIV/AIDS as part of routine care for their patients.

Mental health services are not currently acknowledged as part of the standard complement of services for HIV/AIDS care. Also, psychotropic medications are limited on most drug formularies, therefore the range of medications required to treat HIV/AIDS patients with psychiatric disorders is not available. The consensus panel made the following recommendations to address these issues:

- Screen newly-diagnosed HIV-positive patients for psychiatric illness or mental health problems and refer those in need of treatment, as indicated.
- Assure that an adequate range of psychotropic medications commonly used in treatment of psychiatric illnesses in HIV/AIDS is available in every payors' formulary.

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## COMPREHENSIVE CARE

Non-U.S. born persons represent a significant proportion of Black and Hispanic populations living with and recently diagnosed with HIV. Immigrants living with HIV largely originate from three major regions of the world: Africa, the Caribbean, and Central/South America. In addition to cultural challenges, providers are increasingly experiencing language barriers. For this reason, the NMA HIV/AIDS Testing and Treatment Consensus Panel the following:

- Expand culturally specific information about the efficacy of HIV testing and treatment.
- Develop materials in the language and visual images for communities of color.

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## PHYSICIAN WORKFORCE

The panel acknowledges the need for recruitment, training, and retention of a diverse physician workforce to serve the needs of African Americans and other minorities who are HIV positive or living with AIDS. It is estimated that by 2050, nearly half of the U.S. population will consist of racial and ethnic minorities; however, the pool of minority physicians is not increasing to meet the needs of this future population. In 2004, less than 10% of physicians and surgeons in the United States were members of racial and ethnic minority groups.<sup>40</sup> The panel is concerned that even less are choosing infectious disease or primary care medicine as a subspecialty. To address these concerns, the consensus panel has made the following recommendations:

- Increase NMA programmatic initiatives to address the lack of trained and experienced clinicians treating HIV patients.
- Develop a Geographic Information Systems (GIS) map to overlay the epidemiology of HIV and locations of clinicians as a tool to illustrate the maldistribution, and target those areas. The GIS map will allow data to be viewed in ways that reveal relationships, patterns, and trends.
- Collaborate with medical schools and medical education associations to develop strategies for creating a pipeline for minority students.
- Collaborate with the Veterans Administration Medical Centers, which could serve as an effective training ground for treating patients with HIV/AIDS.
- Engage the American Academy of HIV Medicine to discuss review of its HIV Specialist™ credentialing process, assess the appropriateness of the process for minority practitioners, and advocate for NMA to have an organizational role in the credentialing process.
- Collaborate with the Accreditation Council for Graduate Medical Education (ACGME) in developing core competencies for HIV/AIDS training curricula.
- Advocate for the incorporation of more HIV/AIDS-related curricula in dental schools.

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## FUNDING

The HIV/AIDS Testing and Treatment Consensus Panel supports access to quality care for African Americans and other minorities who are HIV-positive, living with AIDS, or at risk for infection, through adequate federal and state funding sources. The consensus panel recommends that the NMA should:

- Call for a domestic comprehensive approach to combating AIDS in the United States with the same level of funding that has been committed to the President George W. Bush's Emergency Plan for AIDS Relief (PEPFAR) initiative.
- Advocate the establishment of a crosswalk document of the International Classification of Diseases-9 (ICD-9) and comparable oral healthcare Current Dental Terminology (CDT) code to support effective reimbursement for the costs associated with testing and general cost of testing.
- Assure all healthcare payors' delivery systems cover annual HIV testing.
- Address inadequate reimbursement as a deterrent to providers treating HIV/AIDS patients.
- Ensure federal and state resource allocations match epidemiology as identified by the surveillance data.
- Support the inclusion of circumcision of male newborns as part of the State Children's Health Insurance Program (SCHIP).



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