May 19, 2009

TESTIMONY OF DR. RAYMOND CATARINO MARTINS BEFORE THE SENATE SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT, THE FEDERAL WORKFORCE, AND THE DISTRICT OF COLUMBIA "PUBLIC HEALTH CHALLENGES IN THE NATION'S CAPITAL"

Chairman Akaka, Senator Voinovich and Members of the Subcommittee, thank you for inviting me to testify at this hearing concerning Public Health Challenges in the Nation's Capital about the demographics of HIV/AIDS in the District, some of the current responses to HIV/AIDS in the District, and collaborative partnerships that relate.

Let me begin with some information about my professional experience. I am a primary care and HIV physician who lives in Ward 2 of the District, and have been the Chief Medical Officer for Whitman-Walker Clinic for the past 15 months. Through its two District health centers, Whitman-Walker Clinic provides much needed health care to the lesbian, gay, bisexual and transgender community, persons living with HIV, and others who face barriers to care. Our Elizabeth Taylor Medical Center is located in the northwest quadrant of the city and our Max Robinson Center is located east of the Anacostia River. Whitman Walker provides a primary medical home to more than 3000 HIV-positive patients. In 2008, 541 individuals were diagnosed with HIV by Whitman-Walker. Prior to this, I worked in private practice in the DC metropolitan area and at The George Washington University serving a predominantly gay, lesbian, transgender and HIV-positive clientele. These experiences, along with recent data and research results, form the basis of my comments.

My comments fall into three main categories: 1) The District should continue an aggressive HIV testing campaign; 2) The recommendations surrounding treatment for HIV should be analyzed and updated; and 3) Collaborations among health care providers and local and federal government should increase.

I. General Comments regarding the District of Columbia

The District of Columbia is in a truly unique situation with respect to HIV/AIDS as compared with other jurisdictions in the United States. The 2008 District of Columbia HIV/AIDS Epidemiology Update, released during February of 2009, found that 3% of District residents have been confirmed to be living with HIV. Unfortunately, random sampling research has shown that many more are likely to be HIV-positive and that the number infected with HIV is likely closer to 5% (National HIV Behavioral Surveillance Project 2001-2006). These numbers far exceed most cities within the United States.

ELIZABETH TAYLOR MEDICAL CENTER ADMINISTRATION
1701 14th Street, NW
Washington, DC 20009
202.797.3500

MAX ROBINSON CENTER
2301 M L King, Jr. Avenue, SE
Washington, DC 20020
202.678.8877

CALL CENTER
202.745.7000

www.wwc.org

A major factor contributing to the unique situation of our city in comparison to other cities is the increased prevalence of HIV in multiple communities. Throughout the rest of the United States, Men Who Have Sex with Men (MSM) is the predominant mode of transmission for new HIV infections. Here in the District, heterosexual intercourse is the main mode of transmission at 36%, followed by MSM at 26%, and IV Drug Users at 13%. Washington, DC is the only major city in the United States where HIV is so pervasive in the heterosexual community.

Why is this the case? The 2001-2006 National HIV Behavioral Surveillance Project, Heterosexual Survey, a joint effort between the Centers for Disease Control, DC Department of Health (DOH), and The George Washington University, attempted to answer that question. That study demonstrated that heterosexual DC residents who are in "committed" relationships were often not monogamous, with 50% of the participants and 50% of their partners having sex outside of the relationship within the last year. This sex outside of the relationship along with lack of condom use (<30%) in a population with a high prevalence of HIV likely explain the increased incidence of HIV infections in the heterosexual community.

II. Specific Recommendations for the District of Columbia

- The District should continue an aggressive HIV testing campaign

First, individual behaviors are inherently difficult to change, as we are all human and fallible. My clinical experience reveals that, for so many individuals, sexual behaviors are even more challenging to alter than other behaviors since they are so instinctual and impulsive. A recent review of randomized clinical trials using behavioral interventions for HIV at-risk populations showed that although the study participants reported less sexual risk-taking behaviors, none have been shown to decrease the incidence of HIV or other sexually transmitted infections (Conference of Retroviruses and Opportunistic Infection, 2009, Symposium: Behavioral Intervention Trials).

I do not believe we should give up on education, prevention and behavioral change models, but I think it would be unwise to focus all resources solely on education and behavioral change. I rather postulate that we should rely on aggressive HIV testing strategies to identify everyone who is HIV-positive, and change clinical treatment strategies to lessen new infections. Everyone in the District should have routine HIV testing. HIV Opt-Out testing was started in 2007 by the DC DOH and has shown a great increase in the number of tests performed. The CDC has defined HIV opt-out testing as "performing HIV screening after notifying the patient that the test will be performed and the patient may elect to decline or defer testing. Assent is inferred unless the patient declines testing." Testing is recommended in all healthcare settings, and individuals should be screened at least annually. Perhaps the greatest success story to date has been the fact that with the push for HIV testing, we are catching people earlier in their disease. The average CD4 count (specific type of white blood cell that is destroyed during the course of HIV infection) at diagnosis in 2002 was 180 cells/ml, and in 2007 it was 332 cells/ml. This vast

improvement shows that the District is now diagnosing people with HIV, on average, before they develop AIDS and any associated complications.

- Re-evaluate HIV clinical guidelines regarding treatment – Using treatment as prevention

Clinically we need to reconsider current treatment guidelines for HIV medications. The CD4 count is important to understand for my recommendation for changing such guidelines. The average CD4 count of a patient without HIV is about 1000 cells/ml. Current treatment guidelines recommend following a patient with regular blood tests until their CD4 count falls below 350 cells/ml, and then to recommend initiating anti-retroviral therapy. During those years off medications, the patients often have a large amount of HIV in the blood, i.e., a high HIV viral load, and can easily infect others. Alternatively, if we treated patients with HIV medications soon after infection (at higher CD4 counts), their viral loads would be suppressed to very low levels much sooner and it would be more difficult for them to transmit HIV to someone else. Recent clinical trials, such as "Initiating rather than deferring HAART at a CD4 count greater than 500 is associated with improved survival" (New England Journal of Medicine, April 2009), have demonstrated clinical benefit for patients when starting HIV medications earlier. Therefore changing clinical guidelines to beginning anti-retroviral medications earlier in disease will benefit both the infected individual (with less HIV-related mortality) as well as the public health of the District (with likely less HIV transmission and new infections). This change in public health protocol will only work with a change in guidelines from the International AIDS Society, the Infectious Disease Society of America, the Department of Health and Human Services, and/or other government agencies. If that is not possible, there should be at least a recommendation specific to the District to offer HIV medications earlier to potentially curb new transmissions.

- Increase collaboration among health care providers and government within the District

Increased coordination among local institutions, the District government and the federal government provides additional opportunities to better leverage clinical knowledge and resources against the District's HIV epidemic. Whitman-Walker has been involved with the District's Department of Health and HIV/AIDS Administration, the National Institute of Health's National Institute of Allergy and Infectious Disease and National Institute on Drug Abuse, The George Washington University and other community health centers and universities. Many programs, such as the DC Center for AIDS Research, have focused on increasing grants for HIV clinical and basic research. One program that should have an immediate impact on the HIV epidemic is the DC Cohort. This collaboration between the DC HIV/AIDS Administration, The George Washington University, Cerner Corporation, and the major HIV providers in DC will allow the District to follow nearly 10,000 clients to better understand the HIV epidemic and the ongoing issues surrounding care, treatment, and survival. This project will incorporate best practices in data management and allow real-time evaluation of the HIV epidemic in the District. DOH

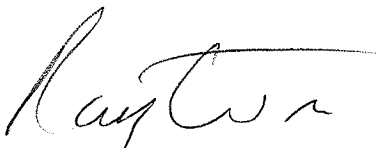
programs that have promising initial data include STD testing in high schools, needle exchange for IV drug users, and the HIV Opt-Out testing as I had mentioned earlier.

III. Conclusion/Closing

I strongly believe that one of the only ways we can change the course of the District's HIV epidemic is through a coordinated and aggressive response. Collaborations between local health authorities, universities and other research institutions, and community health centers and private practices will be critical. After the 2008 DC HIV/AIDS Epidemiology Update was released, there was some media attention to the increased HIV numbers, but this was quickly forgotten by a large majority of the public. There needs to be an aggressive media campaign so the public is frequently reminded of the severity of the issue along with a recommendation for everyone to be tested for HIV on a regular basis. Truly the solution to the epidemic is by identifying people who have HIV, and then by reducing HIV transmissions with early institution of therapy. By using the "Treatment as Prevention" strategy, patients will be started on HIV medications earlier in their disease and will be less likely to transmit to others. Through these programs, more individuals will be diagnosed with HIV and will need to be entered into clinical care. To handle caring for these patients, the District's HIV primary care infrastructure will need to be strong with expanded capacity for HIV testing and treatment.

Despite the complexity and costs associated with addressing the District's HIV epidemic, Whitman-Walker Clinic appreciates the leadership of the Subcommittee and remains committed to working closely with you and other agencies in solving this critical issue.

Sincerely,



Raymond Catarino Martins, M.D.
Chief Medical Officer
Whitman-Walker Clinic
Assistant Clinical Professor of Medicine
The George Washington University