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Changes over time in offering on-site testing for HIV, sexually transmitted infections, and hepatitis C virus in opioid treatment programs

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To the Editor

Opioid dependence is a risk factor for human immunodeficiency virus (HIV), sexually transmitted infections (STIs), and hepatitis C virus (HCV) infection.¹ Opioid treatment programs, which provide medication-assisted treatment to over 300 000 opioid-dependent Americans,² are well-positioned to offer testing for these infectious diseases to a high-risk population. They were among the first venues to offer HIV testing and are more likely to offer HIV, STI, and HCV testing than other drug treatment programs.¹ Private for-profit opioid treatment programs are increasingly widespread and such programs offer on-site HIV testing less often than nonprofit and public programs.³ However, with the 2006 national recommendations for routine opt-out HIV testing,⁴ we hypothesized that the percent of programs offering on-site testing for HIV, STIs, and HCV would increase.

Methods

To determine the percent of opioid treatment programs offering on-site HIV, STI, and HCV testing over time, we analyzed the National Survey of Substance Abuse Treatment Services.⁵ The survey is sent to directors of all known drug treatment facilities (response rate 91.4–96.5%); survey questions had minor wording changes over time. We tabulated the percent of opioid treatment programs offering on-site HIV, STI, and HCV testing from 2000 to 2011, there was no survey in 2001. Next, we compared the percent of for-profit, nonprofit, and public (those owned and operated by local, state, tribal, or federal government) programs offering on-site testing over time. Programs with missing data (0.2–3.9% per year) were excluded. We calculated the relative difference and 95% confidence interval in programs offering on-site testing in 2000 and 2011 using SAS 9.3 (SAS Institute). *P* values were calculated using chi-square tests for trend. A two-sided *P* value 0.05 was considered significant. Because the survey is publicly available and contains no patient-level data, our affiliated IRB determined this study was not considered human research.

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No other disclosures were reported.

Results

The number of U.S. opioid treatment programs increased from 849 in 2000 to 1175 in 2011. The percent of programs operating as for-profit businesses increased from 43% to 54%; nonprofits decreased from 43% to 36% and public programs decreased from 14% to 10%. From 2000 to 2011, the absolute number of programs offering testing for HIV, STIs, and HCV increased but the percent offering on-site HIV testing declined 18% (95% CI: 13–23%; $P < 0.001$), STI testing declined 13% (95% CI: 7–18%; $P < 0.001$), with no significant change in HCV testing ($P = 0.63$; Figure 1). Greater than 75% of public programs offered on-site testing for each infection, with no significant change over time. Offering on-site HIV testing declined 20% among for-profit programs (95% CI: 10–29%; $P < 0.001$) and 11% among nonprofit programs (95% CI: 6–17%; $P < 0.001$; Figure 2). Offering on-site STI testing declined 23% in for-profit programs (95% CI: 16–30%; $P < 0.001$). Offering HCV testing declined 13% in for-profit programs (95% CI: 3–22%; $P = 0.002$) and increased 14% in nonprofit programs (95% CI: 4–25%; $P < 0.001$).

Conclusion

The proportion of U.S. opioid treatment programs offering on-site testing for HIV and STIs declined substantially between 2000 and 2011, despite guidelines recommending routine opt-out HIV testing in all health-care settings, including substance abuse treatment facilities. Declines were most pronounced in for-profit programs, suggesting that persons enrolled in these programs may be at increased risk for delayed diagnosis and continued transmission of HIV, STIs, and HCV.

This study had limitations. Referral-based testing was not recorded; however, referral-based services often do not translate into patient utilization.⁶ Testing for STIs may be limited to syphilis, which is often required by health departments. The survey is cross-sectional with no identifiers linking responses over time. Because patient-level data are not available, patient requests, utilization, and opting out of testing cannot be determined.

Opioid treatment programs are important venues for offering testing to high-risk individuals. As the number of for-profit opioid treatment programs increases, and the opioid, HIV, and HCV epidemics continue to intersect, further work is needed to understand and reverse declines in offering on-site testing.

Acknowledgments

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Dr. Bachhuber had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis

Dr. Cunningham's husband was recently employed by Pfizer Pharmaceuticals and is currently employed by Quest Diagnostics.

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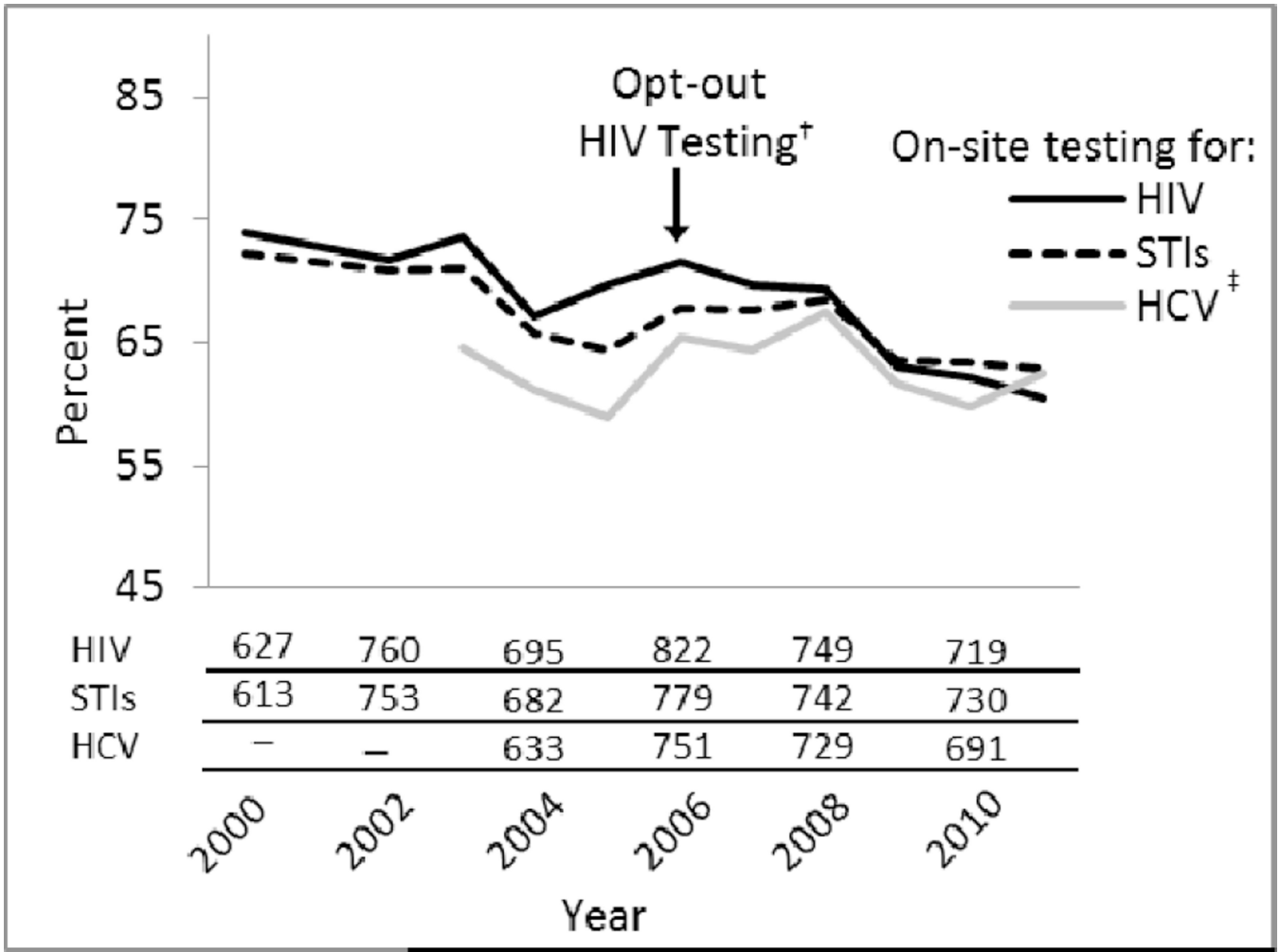


Figure 1. Percent of U.S. opioid treatment programs offering testing for HIV, sexually transmitted infections, and hepatitis C virus, 2000–2011*
 STI = sexually transmitted infection; HCV = hepatitis C virus
 *Lines show the percent of programs offering on-site testing for each infection; absolute numbers of programs offering on-site testing in 2000 and 2011 are below graph.
 †Refers to revised recommendations from the Centers for Disease Control and Prevention in 2006 to screen all adults, adolescents, and pregnant women for HIV infection in all health-care settings, unless the patient declines⁵
 ‡On-site testing specifically for hepatitis C virus was recorded starting in 2003.

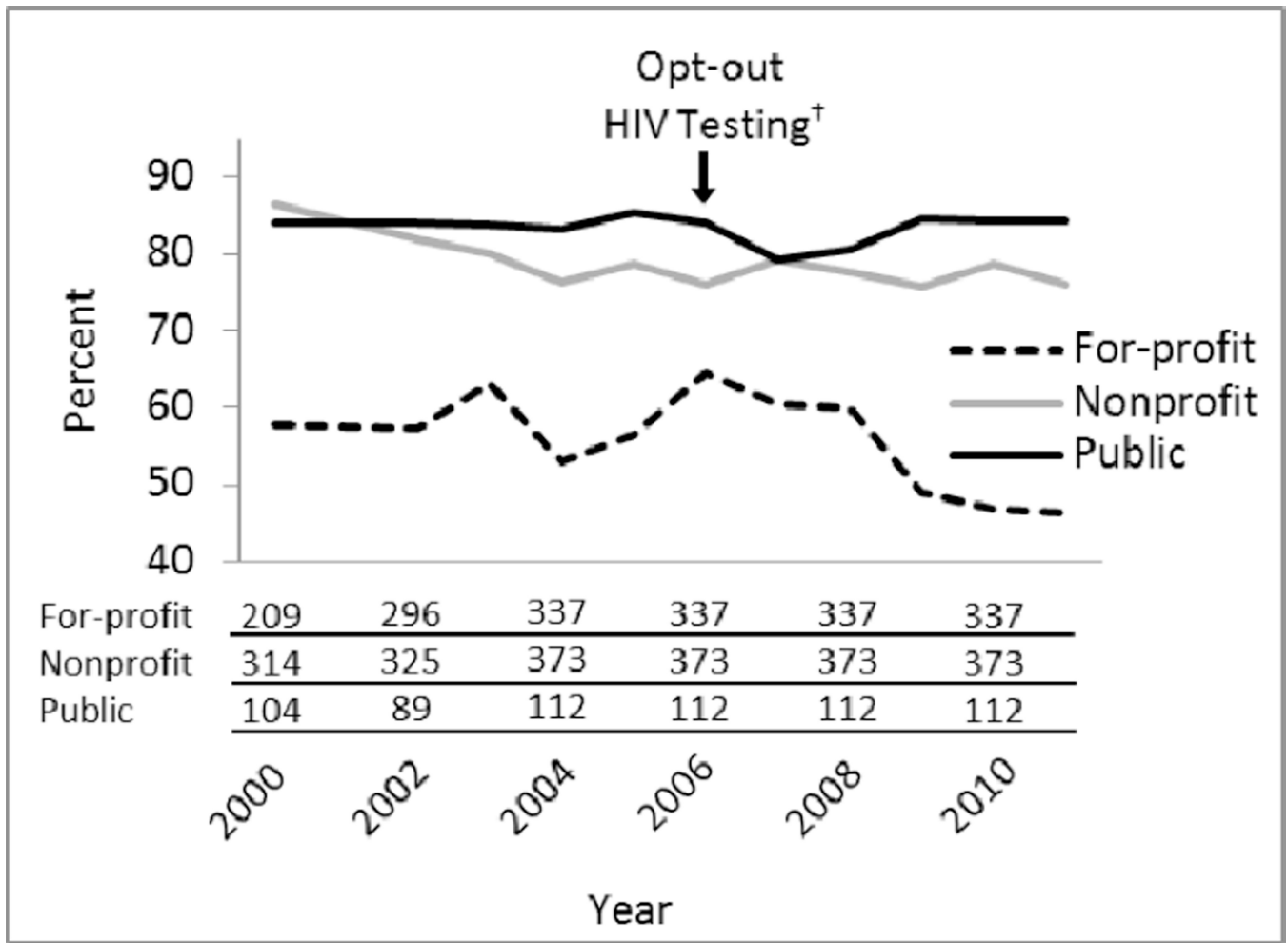


Figure 2. Percent of for-profit, nonprofit, and publicly owned U.S. opioid treatment programs offering on-site HIV testing, 2000–2011*

*Lines show the percent of programs offering on-site testing for each infection; absolute numbers of programs offering on-site testing in 2000 and 2011 are below graph.

†Refers to revised recommendations from the Centers for Disease Control and Prevention in 2006 to screen all adults, adolescents, and pregnant women for HIV infection in all health-care settings, unless the patient declines⁵