Getting to Zero: Implementing High Impact Prevention in Your Health Center

Mississippi Primary Health Care Association
Mississippi AIDS Education Training Center
Primary Care Development Corporation
Welcome!

• Introductions/Icebreaker
• Housekeeping
About the Primary Care Development Corporation (PCDC)

Founded in 1993, PCDC’s mission is to catalyze excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity.

• Certified as a Community Development Financial Institution (CDFI) by the U.S. Treasury
• Offices in New York City and Los Angeles County
• Three Programs:
  – Capital Investment
  – Performance Improvement
  – Policy & Advocacy
PCDC’s **HIP in Health Care program** is funded by the U.S. Centers for Disease Control and Prevention (CDC) to build the capacity of health care organizations to deliver HIV prevention services and strategies within clinical settings.

Training and technical assistance at **no cost** to healthcare organizations (i.e., direct service providers).

**HIGH-IMPACT PREVENTION (HIP)**

*Applying the science of implementation to maximize impact*

- Primary goal is to prevent the largest possible number of new HIV infections and reduce disparities.
- Framework for using data to maximize impact of available resources and technologies.
- Directs effort and resources to the right places, populations, and strategies.

[www.cdc.gov/hiv/policies/hip.html](http://www.cdc.gov/hiv/policies/hip.html)
About HIP in Health Care

Meet the Team

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JOIN PCDC’s **Getting to Zero**
Learning Collaborative in Mississippi

*Save the Date: December 2017*
Core Elements of MS Getting to Zero Learning Collaborative

HIV Screening

Creating a Welcoming Environment

TASP

CDC PrEP Institute

The Continuum of Care

nPEP and PrEP
Learning Objectives

1. Discuss local epidemiology of HIV to guide focused prevention efforts.
2. Describe main components of High Impact HIV Prevention, including HIV screening, linkage to care, treatment as prevention and Pre-exposure Prophylaxis (PrEP).
3. Describe best practices for sexual orientation and gender identity (SO/GI) data collection, including implementation strategies.
Today’s Agenda

• HIV in Mississippi: What We Know, Challenges Ahead
• The Core Elements of High Impact HIV Prevention
  – HIV Testing
  – Treatment as Prevention (TASP)
  – PrEP
• PrEP/PEP Clinical Update
• Lunch
• Practice Transformation to Create an Affirming Environment for those with HIV or at High Risk for HIV
• “Getting to Zero” MS Learning Collaborative
HIV in Mississippi: What We Know, Challenges Ahead

Dr. Leandro Mena
Principal Investigator, Mississippi AETC
Associate Professor of Medicine with the Division of Infectious Diseases
Medical Director, Crossroads Clinic, MSDH
Medical Director, Open Arms Healthcare Center
Overview of the National HIV AIDS Strategy (NHAS), High Impact Prevention and the HIV Care Continuum

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Continuing Medical Education Disclosure

CME Talk, October 4, 2017.
Program Faculty: Sarah Blust, LMSW, MPH
Disclosure: No relevant financial relationships. Presentation does not include discussion of off-label products.
A New Era of HIV Prevention

• Recent scientific advances have shown that antiretroviral therapy (ART) not only preserves the health of people living with HIV, but also dramatically lowers their risk of transmitting HIV to others by reducing the amount of virus in the body.

• These developments have transformed the nation’s approach to HIV prevention.
NATIONAL HIV/AIDS STRATEGY: UPDATED TO 2020
WHAT YOU NEED TO KNOW

THE VISION
The United States will become a place where new HIV infections are rare, and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

THE GOALS
- Reducing new HIV infections
- Improving access to care and health outcomes
- Reducing HIV-related health disparities
- Achieving a more coordinated national response

OUR STRATEGY
This is a national Strategy, not just a Federal one. Everyone is needed to put this Strategy into action and end the HIV epidemic. The updated Strategy calls for coordinated efforts from all sectors of society. The many Federal agencies and offices engaged in HIV activities will develop a Federal Action Plan to guide implementation of the Strategy across the U.S. government.
National HIV/AIDS Strategy

• Increase the % of people living with HIV who know their status to at least: 90%

• Increase the % of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least: 85%

• Increase the % of persons with diagnosed HIV who are virally suppressed to at least: 80%
High Impact HIV Prevention

• **High Impact HIV Prevention** is CDC’s strategic response to NHAS

• Aims to achieve the greatest possible reductions in HIV infections by making sure that resources go to the regions, populations and prevention strategies where they will have the greatest impact.
High Impact Prevention in health care settings

• Assessing for HIV risk on a routine basis (sexual health history taking)
• Universal HIV screening
• Information on how to prevent HIV
• Access to nPEP and PrEP
• STI screening and treatment

• Providing the best possible care to HIV-infected individuals, including:
  – Linkage to Care
  – Access to anti-retroviral therapy (ART)
  – Adherence counseling
  – Disclosure and partner services
HIV CARE CONTINUUM:

The series of steps a person with HIV takes from initial diagnosis through their successful treatment with HIV medication.
HIV in the United States

Not all people with HIV are getting the care they need.

1.1 million people living with HIV in the US in 2014

- 85% diagnosed
- 62% received care
- 48% retained in care*
- 49% virally suppressed**

* Had 2 tests at least 3 months apart to measure level of virus in the body. ** Virus at low enough level to stay healthy and reduce transmission risk. Based on most recent test.

HIV Care Continuum

• The ultimate goal of HIV treatment is to achieve viral suppression, meaning the amount of HIV in the body is very low or undetectable.

• This is important for people with HIV to stay healthy, live longer and reduce their chances of passing HIV to others.
In fact...

U=U

UNDETECTABLE = UNTRANSMITTABLE

A person living with HIV who has an undetectable viral load does not transmit the virus to their partners.

The International AIDS Society is proud to endorse the U=U consensus statement of the Prevention Access Campaign.
“This means that people who take ART daily as prescribed and achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner”

Centers for Disease Control and Prevention (CDC), Dear Colleague, September 27th, 2017
“The science really does verify and validate that U=U”

Dr. Anthony Fauci, Director, NIAID, NIH
Populations Most Affected by HIV, US 2015

- HIV continues to disproportionately affect certain populations (CDC, 2016)
  - In 2015, African Americans represented 14% of the US population, but accounted for 45% of HIV diagnoses
  - Hispanics/Latinos represented about 18% of the US population, but accounted for 24% of HIV diagnoses

- Male to male sex accounted for about 67% of new diagnoses in 2015 (CDC, 2016)
  - A study in 20 major U.S. cities found that about 1 in 5 (22%) men who have sex with men is living with HIV
  - 1 in 4 of MSM living with HIV is unaware of being infected (CDC, 2016)
HIV Diagnoses Among Gay & Bisexual Men 2015

39,513 total HIV diagnoses in US (all ages)

67% of all diagnoses were among gay or bisexual men*

Of all gay or bisexual men diagnosed

- 39% were black
- 29% were white
- 27% were Hispanic/Latino

* Does not include infections attributed to male-to-male sexual contact and injection drug use

CDC.gov/actagainstaids
HIV Diagnoses Among Young Gay & Bisexual Men 2015

8,807 total HIV diagnoses among young people (13-24) of all diagnoses in youth were among young gay or bisexual men*

Of all young gay or bisexual men diagnosed

- 55% were black
- 24% were Hispanic/Latino
- 16% were white

* Does not include infections attributed to male-to-male sexual contact and injection drug use

cdc.gov/actagainstaids
Basic Steps to Improve HIV Prevention in Clinical Settings

Universal HIV Screening

HIV Positive
- HIV care / antiretroviral therapy/
  Counseling / Adherence

Reduce HIV Incidence

HIV Negative
- Safer sex
- Address STIs
- PEP or PrEP
- Counseling / Adherence

(USPSTF, 2013 and CDC, 2010)
HIV SCREENING (METHODOLOGY, TECHNOLOGY, WORK FLOW)
CDC’s 2006 Recommendations: Whom to Test

- “CDC recommendations advocate routine voluntary HIV screening as a normal part of medical practice” (p. 4)
- “HIV screening should not be contingent on an assessment of patients’ behavioral risks.” (p. 12)
- Whom to test
  - All patients aged 13 to 64 years in health care settings
  - All pregnant women
  - All patients being treated for STIs
  - All patients starting treatment for TB

CDC’s 2006 Recommendations: Whom to Test

• Repeat HIV screening for high-risk patients
  – Sex partners of persons living with HIV
  – **Men who have Sex with Men** (MSM)
  – **People Who Inject Drugs** (PWID)
  – **Sex Workers** (SW)

• Providers should have “high level of suspicion for acute HIV infection” in all patients who (p. 8)
  – At risk for HIV
  – Have a compatible clinical syndrome
  – Report recent high-risk behavior

• Prompt clinical care for HIV-infected persons

HIV Screening Intervals

Evidence is insufficient to determine optimum time intervals for HIV screening. One “reasonable approach” would be:

1. One-time screening of adolescent and adult patients to identify persons who are already HIV-positive;
2. Repeated screening of those who:
   – are known to be at risk for HIV infection
   – those who are actively engaged in risky behaviors
   – and those who live or receive medical care in a high-prevalence setting.

According to the CDC, a high-prevalence setting is a geographic location or community with an HIV seroprevalence of at least 1%.

United States Preventive Task Force, Final Recommendation Statement
*Human Immunodeficiency Virus (HIV) Infection: Screening*
CDC’s 2006 Recommendations: “User Friendly”

- **Opt-out screening**: patients should be told screening will be performed but may decline testing
- Always voluntary
- Specific written consent should not be required
- Prevention counseling should not be required as part of HIV screening
- “Prevention counseling” defined as (p. 2.)
  - “An interactive process…”
  - Risk assessment
  - Education about risk and protective behaviors
  - Creation of plan to reduce risks

2006 Rationales for Routine Screening

• Universal HIV screening strategies have been highly effective
  – Screening blood donors for HIV has nearly eliminated transfusion-associated HIV (Dodd, et al. 2002)
  – Routine HIV testing of pregnant women

• Routine HIV testing reduces the stigma associated with testing that requires assessment of risk behaviors (Hutchinson A.B., et al. 2004; Spielberg, et al. 2003)

• Many people living with HIV access health care but are not tested for HIV until symptomatic (Klein D, 2003; Alpert, et al. 1996; Liddicoat, et al. 2004)
2006 Rationales for Routine Screening

- HIV screening in healthcare settings is cost effective (Sanders, G.D., et al. 2005)
- Effective treatment available (Branson, 2006. p. 4)
- Awareness of HIV infection leads to substantial reductions in high-risk sexual behavior (Marks, G., et al. 2005)
  - Reduce frequency of condomless sex by 50%
  - Show a 68% reduction in condomless anal or vaginal intercourse with HIV-neg partners for HIV-pos aware vs. HIV-pos unaware
2006 Rationales for Routine Screening

• Why age 13? Youth 13 to 19 years of age:
  – 47% of youth surveyed had sex at least once (CDC, 2006)
  – 37% of sexually active youth did not use condom during most recent sex (CDC, 2006)
  – 11.9% had been tested for HIV (CDC, 2006)

• Why age 13? 2015 (CDC, 2016)
  – 41% of 9th to 12th graders had sex at least once (p. 26)
  – 42.1% of those who had sex did not use condom (p. 27)
  – Only 10.2% have been tested for HIV (p. 30)

• Risk-based screening alone won’t identify all infected persons
  – Branson et al. (2006, p. 4.) cite 4 studies from 1996 to 2006 demonstrating diminishing usefulness of risk-based screening
Post-2006 Rationales for Routine HIV Screening

Risk-based screening alone won’t identify all infected persons

• Pascale Wortley presented findings that patients do not always disclose or may not be aware of their risk (Wortley, Pascale. 2012)
  – 39% of men who had sex with a man within the past year did not disclose this to their health care provider (Bernstein KT, et al. 2008)
  – 51% of rapid test newly diagnosed patients identified in Emergency Department (ED) screening had no identified risk (Lyss SB, et al. 2007)

• 2015, Hankin, et al. found that 70% of persons newly diagnosed with HIV had neither behavioral risk nor symptomatic indicators for HIV screening (Hankin, et al. 2015)
Post-2006 Rationales: Awareness of HIV Infection Reduces Risk Behavior

• 2013: HIV diagnosis can influence HIV risk behavior
  o MSM reduced condomless sex by with HIV-negative or person with unknown HIV status by 40% after 2 years and by 75% after 5 years (Vallabhaneni, S., et al. 2013)
  o MSM and heterosexual men and women living with HIV have reduced condomless sex that lasted a year past diagnosis and beyond (Dombrowski, J. C., et al. 2013)

• 2016: HIV diagnosis in MSM can lead to reduced condomless sex with HIV-negative or unknown status by 84% (Khosropour, C. M., 2016)
Post-2006 Rationales: Connecting to Care → Reduced Risk Behavior

• People living with HIV who are engaged in care
  o 66% of patients reduced risky sexual behavior after 6 months in care
  o After 12 months in care 49% of patients reduced risky sexual behavior
  o Patients with 3 or more clinical contacts were more likely to reduce risk than those with fewer visits

Sources of New Transmissions

- 63.3% of persons living with HIV are not engaged in care
  - 18.1% don’t know they have HIV
  - 45.2% know they have HIV, but are not engaged in care
- 91.5% of new HIV infections come from people with HIV who are not engaged in care

If Things Don’t Change

Lifetime Risk of HIV Diagnosis among MSM by Race/Ethnicity

African American MSM  1 in 2
Hispanic MSM  1 in 4
White MSM  1 in 11

LOWEST RISK  HIGHEST RISK

Source: Centers for Disease Control and Prevention


If Things Do Change….

Four Scenarios of the Potential Impact of Expanded HIV Testing, Treatment and PrEP in the United States, 2015-2020

- New infections
- HIV infections prevented due to expanded testing and treatment
- HIV infections prevented due to PrEP (assumes PrEP use among high-risk populations = 40% MSM; 10% PWID; 10% HET)

**Scenario 1:**
Projected new infections by 2020 at current testing and treatment rates
- Total number of new HIV infections: 265,330

**Scenario 2:**
If PrEP use increases among high-risk populations at current testing and treatment rates
- Total number of new HIV infections: 217,109
- Infections prevented through PrEP: 48,221

**Scenario 3:**
If 85% of people diagnosed are linked to care, 60% achieve viral suppression, plus PrEP use
- Total number of new HIV infections: 144,434
- Infections prevented through testing and treatment: 88,908

**Scenario 4:**
Achieving NHAS goals – if 85% of people diagnosed are linked to care, 80% achieve viral suppression, plus PrEP use
- Total number of new HIV infections: 80,270
- Infections prevented through testing and treatment: 168,132

Source: Centers for Disease Control and Prevention
Updating our Rationale: The “Neutral Continuum of Care”

HIV CARE AND PREVENTION ARE THE SAME=GETTING TO HIV NEUTRAL

New York City Department of Health and Mental Hygiene
Updating our Rationale: The “Neutral Continuum of Care”

- Provider responds no matter which result
- Services for both HIV+ and HIV- results
  - Prevention and primary care for HIV-
  - Care for HIV+

End-points
- HIV+
  - Suppressed viral load
- HIV-
  - Clinical Prevention
  - PrEP
How Has the Testing Landscape Changed Since 2006?

• Coverage and reimbursement
• Improved testing technology
• CDC recommendations
• Advances in treatment and prevention
Coverage and Reimbursement

• 2013: US Prevention Services Task Force (USPSTF) gives HIV testing an A grade
  – Affordable Care Act (ACA) requires HIV screening without copay for qualifying health plans
• Center for Medicare & Medicaid Services (CMS) approved coverage for recipients aged 15-65 years
Improved Testing Technology and CDC Recommendations

• In 2014, CDC recommended the use of 4th Generation HIV tests as the first step in their new HIV Laboratory Testing Algorithm
  o Detects Antibodies for HIV-1 and HIV-2
  o HIV-1 p-24 Antigens which are present before HIV antibodies develop

• Algorithm allows
  o Differentiation for HIV-1 from HIV-2 antibodies
  o Detection of acute HIV infection

• 4th Generation tests can better detect HIV infection earlier than 3rd gen
  o Detects HIV antigens which are present in weeks 1-7 post infection, before HIV antibodies develop

• One 4th generation point-of-care rapid test currently FDA approved

Acute HIV Infection

• “Acute HIV infection is the interval between the appearance of detectable HIV RNA and the first detection of antibodies.” (CDC, 2014. p. 10.)

• Highly infectious stage of acute HIV infection
  – 20 to 200 times more likely to transmit HIV during acute phase
  – Patient usually doesn’t know he or she has HIV

• Patient with HIV risk and flu-like symptoms should be tested for acute HIV infection

Alternatives to Recommended Lab Algorithm

• Not all health care settings or labs are using 4\textsuperscript{th} generation yet

• The CDC describes alternatives to the new algorithm:\textsuperscript{1}
  – 3rd generation HIV-1/2 antibody immunoassay
  – HIV-1 Western blot or HIV-1 IFA as the supplemental test
  – Use of HIV-1 Nucleic Acid Test (NAT) as second test

• Many organizations using Point-of-Care or Rapid Tests as initial HIV test
  – Dr.’s offices not connected with lab
  – Mobile health vans
  – Health fairs

Evolution of HIV Tests: Four Generations

Evolution of HIV Tests

- **1st generation**: whole viral lysate, detects IgG antibody
- **2nd generation**: synthetic peptides, detects IgG antibody
- **3rd generation**: detect IgM and IgG antibodies
- **4th generation**: detects IgM, IgG antibodies, p24 antigen
  - “Combi” tests: detect both HIV-1 and HIV-2 antibodies
  - “Combo” tests: detect both antigen and antibody

- Nucleic acid tests (NAT): detect HIV RNA

Point of Care Testing: “HIV Rapid Tests”

- The CDC lists 7 Point of Care or “Rapid HIV” Tests
  - All detect antibodies to both HIV-1 and HIV-2
  - 6 are 3rd generation HIV tests that detect antibodies only
  - 1 is a 4th Generation HIV Rapid test that detects HIV antibodies and antigens to HIV-1
- All use finger stick or blood draw
- Results in 2 minutes to 40 minutes depending on the test used
Point of Care Testing: “HIV Rapid Tests”

• Unlike laboratory testing, CDC has no published guidelines for point-of-care testing algorithms.

• CDC suggests 3 Point-of-Care algorithms for providers using rapid tests
  1. Single rapid test with immediate linkage to clinical provider if initial test is reactive
  2. Single rapid test followed by laboratory-based follow-up testing if initial test is reactive
  3. Single rapid test immediately followed by a second rapid test on-site if initial test is reactive

• Follow local Health Department mandate

4th Generation HIV-1/2 HIV Ab/Ag Combo Rapid Test

- Results in about 20 minutes
- Finger stick
- Requires follow up with the 2014 CDC's recommended Laboratory testing algorithm
- 4th Generation lab tests detect HIV sooner than 4th generation rapid test
Four Pillars of Routine HIV Screening Programs

1. Testing integrated into normal clinic flow
   – Promotes the normalization and sustainability of testing

2. Electronic Medical Record Notification
   – To prompt testing, automate process, populate laboratory orders and track performance

3. Systemic policy change
   – Multilevel, organization-wide commitment to implement routine testing and linkage to care

4. Training, feedback and quality improvement
   – To identify best practices and motivate staff

Sanchez TH, et.al. (2014).
Before Testing: Consent and Pretest Information

Opt-out: HIV testing will be performed unless patient declines

• Patient notified about HIV testing
  o Information regarding HIV,
  o Risks and benefits of testing
  o Implications of HIV test results
  o How test results will be communicated
  o Opportunity to ask questions

• Separate written consent should not be required for HIV testing

• Prevention counseling in conjunction with HIV screening in health care settings should not be required
ACTS: 4 features of opt-out HIV screening for a clinical practice

• **Advising**
  – Inform patients of screening recommendation
  – Invite and answer questions
  – Reassure patients that they have not been singled out for testing

• **Consent**
  – Specifics depend on local, state laws

• **Test**
  – Collect appropriate specimen, submit for analysis

• **Support**
  – Posttest counseling, support

ACTS Model Takeaways

• Estimate 1-2 minutes for delivering “opt-out” testing script (broaching HIV testing, informing most of negative status)
• All members of clinical team can be trained on the “ask” and the follow up
• Understand basic elements of HIV counseling
  – At minimum, patients must know they are being tested;
  – Practitioner will advise next steps according to results
• Identify plan for HIV-positive individuals
• Select an HIV screening technology and testing plan

Futterman D, et.al. (2016)
Registration Staff Script

• “During today’s health visit you will receive some routine tests including an HIV test. If you decide not to take this test, let the medical assistant (or your nurse or doctor) know.”

• “Durante la visita de salud de hoy usted recibirá unas pruebas de rutina, incluida una prueba del VIH. Si usted decide no tomar esta prueba, déjéle saber ala enfermera.”

Jacobson, Kathleen, M.D., et al. (2012)
Script for Testing – Sample (From LA County - University of Southern California)

**Tester Script**

- “Hello, today’s visit includes an HIV test. The result will be ready in 20 minutes and the doctor will give you the results.”
- “Hola, la visita de hoy incluye una prueba el del VIH. Los resultados estarán listos en 20 minutos y el doctor le dará los resultados.”
Importance of the Physician’s Recommendation

• The doctor’s *suggestion* of HIV testing is important (Kaiser Family Foundation. 2009, p. 5.)
  – 82% of who have discussed HIV with their provider were ever tested.
  – Only 25% of those who had not discussed HIV with the doctor got tested
  – 25% of patients *assumed* they were tested as a routine part of their examination

• 45% of patients report *discussing* HIV with providers; but few providers *suggest* HIV testing (Kaiser Family Foundation, 2011)
  – 2009: 17% of adults say a physician or health-care worker has ever *suggested* an HIV test
  – 2011: 29% of adults say a physician or health-care worker has ever *suggested* an HIV test
• **Why am I having an HIV test?**
  – [Name of hospital or clinic] has made rapid HIV testing a standard, routine test for our patients in order to give you the best care we can.

• **What does the rapid HIV test tell me?**
  – The Rapid HIV test tells whether you have HIV. The test can detect antibodies, which the body makes to fight the virus, as early as two weeks after a person has been exposed, but it could take longer for some.

• **What if my rapid HIV test is positive?**
  – A positive result means it is very likely that you have HIV. We will then do a second test to confirm the diagnosis. That second test result will take a few days. If it is confirmed that you have HIV we will [your clinic’s linkage to care].

• **What if my rapid HIV test is negative?**
  – A negative rapid test result usually indicates that you do not have HIV. If you still have sex without condoms or share drug needles with others, you should be retested in six months. We have [health educators, HIV counselors, HIV physician] here to answer any questions or give you information on being safe and staying healthy.

• **What if I do not want to have a rapid HIV test?**
  – If for some reason you do not want to have a rapid HIV test, please complete the section below and give this paper to a staff member.

After Testing: Delivery of Results & Follow-Up

• **HIV-negative results**
  – Can be given in other ways than face-to-face (follow State law)
  – “Persons known to be at high risk for HIV infection also should be advised of the need for periodic retesting and should be offered prevention counseling or referred for prevention counseling.” (Branson, 2006. p. 10.)

• **HIV-positive results:**
  – “HIV-positive test results should be communicated confidentially through personal contact by a clinician, nurse, mid-level practitioner, counselor, or other skilled staff.” (Branson, 2006. p. 10.)
  – Family and friends not used as interpreters
  – “Active efforts” to link patient to care, counseling and support
  – If rapid test, explain to patient the need for confirmatory test
If HIV is diagnosed, next step is Linkage to Care

• Giving the positive HIV test result is only the first step
  o Timely linkage to care for newly diagnosed HIV infected persons is key for good clinical outcomes.
  o Barriers to linkage exist, including patient denial, operational issues, insurance, etc.
  o Important for clinical facility to play a role in linking patient to care
  o Ample resources exist. CDC has a compendium of effective interventions for linkage: https://www.cdc.gov/hiv/research/interventionresearch/compendium/lrc/index.html

• Referral to HIV care to other health care organization?
  o Resources to assist with linkage to care:
    o Ryan White grantees
    o Local Health Department?
    o Local AIDS Service Organizations can help
  o Who in the your organization can best help guide the patient to get HIV medical care?
UDS Measure: HIV Linkage to Care

HIV Linkage to Care

- **Goal**: Initiate HIV treatment for patients newly diagnosed with HIV within 90 days of diagnosis
- **Universe**: Patients first diagnosed with HIV by the health center between October 1, 2015, and September 30, 2016, and who had at least one medical visit during 2015 or 2016

<table>
<thead>
<tr>
<th>Line</th>
<th>HIV Linkage to Care</th>
<th>Total Patients First Diagnosed with HIV (a)</th>
<th>Charts Sampled or EHR Total (b)</th>
<th>Number of Patients Seen within 90 Days of Diagnosis of HIV (c)</th>
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<tr>
<td>20</td>
<td>MEASURE: Percentage of patients whose first ever HIV diagnosis was made by</td>
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UDS Measure: HIV Linkage to Care

MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1 of the prior year and September 30 of the measurement year and who were seen for follow-up treatment within 90 days of that first ever diagnosis.

HIV Linkage to Care

- **Goal**: Initiate HIV treatment for patients newly diagnosed with HIV within 90 days of diagnosis.
- **Universe**: Patients first diagnosed with HIV by the health center between October 1, 2015, and September 30, 2016, and who had at least one medical visit during 2015 or 2016.

UDS Measure: HIV Linkage to Care

Measurement Standard:

• Newly diagnosed HIV patients that received treatment within 90 days of diagnosis. Include patients who were newly diagnosed by your health center providers, and
  – Had a medical visit with your health center provider who initiates treatment for HIV, or
  – Had a visit with a referral resource who initiates treatment for HIV
  – Visit must be conducted and referral loop closed

UDS Measure: HIV Linkage to Care

Universe:
• Includes patients referred to the health center after a reactive, initial test done elsewhere where you run the supplemental test
• Does not include persons who have only a reactive, initial test without confirmation by a positive, supplemental test
• Should be less than the number of patients with HIV reported on Table 6A since Table 6B is limited to newly diagnosed

Measurement Standard:
• Actual treatment must be initiated
• For referrals to care to meet the measurement standard, the referral loop must be closed

National Comparison:
2015 Health Center Program average: 74.7%

HIV Linkage to Care

The Most Critical Elements!

1. Assessment and education of the client
2. Referral to HIV medical provider if appropriate (outside provider)- make the appointment for the patient! (within one week)
3. If capable, assess for eligibility for HIV support services and assist with referral (or start paperwork)
4. Follow-up with client to ensure successful linkage and attendance at first appointment
5. Communicate with patient in the interim to check-in and provide support
6. Draw initial labs on the patient and get records to the outside provider
7. Discuss the need for partner services (testing/notification/referral)

HIV Negative Results: Prevention Services

• As before (2006)
  – Reminder of window period
  – Need for periodic re-testing
  – Prevention counseling and support
  – Navigation to prevention services

• New: PrEP and PEP
  – PEP in case of exposure (within 72 hours)
  – PrEP for partners of persons living with HIV, those who continue condomless sex or other HIV risk.
Electronic Medical Records’ (EMRs) role in HIV Screening

• EMR reminders can increase awareness and yield
  – Can prompt testing, automate laboratory orders, and track performance

• Concern
  – Pop-up fatigue
  – All new changes require IT coordination and/or vendor support
  – Who manages?
EMR-Based HIV Testing Eligibility Assessment

- HIV test eligibility assessment tool embedded in the electronic medical record (EMR)
- At visit, patient’s EMR tracks and excludes patients who
  - Are documented as HIV-positive
  - Had an HIV-negative test result in the 6 months before the current visit
- Patients without these criteria are offered the “opt-out” HIV Test
- Considered “linked to care” if
  - Follow-up visit documented in EMR
  - Patient reported linked

EMR’s role in HIV Screening

Good evidence that EMR consideration leads to results

• Significantly increased HIV screening rates in NYC and New Orleans clinics (Lin, X., et.al. 2014)
• Simply adding an EMR “alert” for HIV testing nearly doubled testing rates in MN primary care clinic (Marcelin J. et.al. 2016)
• Increased new HIV diagnoses 4.5-fold over rate before EMR alerts in Bronx in-patient admissions (Felsen, U., et al. 2017)
Common Concerns to Implementing Routine HIV Screening Programs in Clinical Settings

- Logistical issues
- Inadequate reimbursement/cost of providing HIV testing
- Lack of understanding of rationale; Why HIV testing?
- State laws may hamper efforts
- Clinic staff concerns
- Patient concerns
Common Concerns to Implementing Routine HIV Screening – A Local Perspective

- 2013 Qualitative study in MS:
  - 4 Ryan White Care providers
  - 5 providers from federally qualified health centers
  - 16 primary care providers in private practice
- With the exception of local Ryan White clinicians, none of the providers in the sample routinely tested their patients for HIV.
- Most providers offered HIV tests based on patients' self-perceived risk or their own perception of patients' HIV risk.
- Many providers believed that Mississippi law still requires separate informed consent for HIV testing, and cited this as a barrier to implementing routine testing.
- Most providers stated they would be willing to offer routine HIV testing if they were able to bill for it.
- Providers believed that more treatment and care services should be integrated into primary care practices to reduce patient travel burden.

Overcoming Logistical Issues of HIV Screening in Clinical Settings

• Traditional concerns regarding provision of HIV testing in clinical settings have been addressed, including:
  
• Separate written consent for an HIV test should no longer be required in nearly all jurisdictions.
  • Consent for HIV testing can be combined with general medical consent
  • Some states require only oral consent that is documented in the patient’s record

• Prevention Counseling should not be required in conjunction with HIV screening programs.
  • In some jurisdictions, regulations used to required extensive prevention counseling for anyone getting tested for HIV
  • For HIV screening in clinical settings, information now can generally be given as a fact sheet or referrals for prevention counseling.
Incorporating HIV Screening into Clinic Operations

- Test must fit into primary care visit without disrupting patient
  - Point-of-care (rapid) HIV tests give quick results – during visit, usually 20 minutes or less
  - Easier now that separate consent or counseling not a requirement
  - Incorporate into Electronic Medical Record

- Linkage to services (MOUs with referral agencies)
  - HIV Care for newly diagnosed
  - Link to prevention and PrEP services for HIV-negative at-risk patients

- Ongoing staff education and monitoring of testing rates;

- New staff buy in

Reimbursement for HIV Testing

- **Private Insurance:**
  - ACA requires coverage of routine HIV testing without cost-sharing
  - Exceptions for “grandfathered” plans

- **Medicaid:**
  - “Medically necessary” HIV testing
  - State coverage of “routine” HIV screening varies
    - Optional benefit under Medicaid
    - More than 2/3 of state Medicaid programs cover routine HIV screening

- **Medicare:** 2015, CMS expanded Medicare coverage to include annual HIV testing for
  - Beneficiaries ages 15-65 regardless of risk
  - Those outside this age range at increased risk

Reimbursement for HIV Testing

- National Alliance of State and Territorial AIDS Directors
- HIV Medicine Association
- Billing for HIV Screening and Prevention Services
  - Health Departments
  - Health Care Providers
Reimbursement for HIV Testing

- CPT & ICD-10 codes
- Lab tests for HIV and other STIs
- PrEP initiation and follow up in medical offices and clinics
- Adherence, Linkage, Counseling, Other Services

### Procedure Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>86689</td>
<td>HTLV or HIV antibody, confirmatory test (e.g., Western Blot)</td>
</tr>
<tr>
<td>86701</td>
<td>HIV-1</td>
</tr>
<tr>
<td>86702</td>
<td>HIV-2</td>
</tr>
<tr>
<td>86703</td>
<td>HIV-1 and HIV-2, single result</td>
</tr>
<tr>
<td>87534</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA)</td>
</tr>
<tr>
<td>87535</td>
<td>HIV-1, direct probe technique</td>
</tr>
<tr>
<td>87536</td>
<td>HIV-1, amplified probe technique, includes reverse transcription when performed</td>
</tr>
</tbody>
</table>

### Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
<th>Use For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z11.4</td>
<td>Encounter for screening for human immunodeficiency virus [HIV]</td>
<td>HIV screening</td>
</tr>
<tr>
<td>Z20.2</td>
<td>Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission</td>
<td>HIV, STI screening</td>
</tr>
<tr>
<td>Z20.6</td>
<td>Contact with and (suspected) exposure to human immunodeficiency virus [HIV]</td>
<td>HIV screening</td>
</tr>
<tr>
<td>Z51.81</td>
<td>Encounter for therapeutic drug level monitoring</td>
<td>PrEP monitoring</td>
</tr>
<tr>
<td>Z72.51</td>
<td>High risk heterosexual behavior</td>
<td>HIV, STI screening</td>
</tr>
<tr>
<td>Z72.52</td>
<td>High risk homosexual behavior</td>
<td>HIV, STI screening</td>
</tr>
<tr>
<td>Z72.53</td>
<td>High risk bisexual behavior</td>
<td>HIV, STI screening</td>
</tr>
</tbody>
</table>
Limited Understanding of Rationale for Routine HIV Screening

- Lack of understanding on what is required
  - Confusion between “prevention counseling” and “information about the HIV test”
  - Legacy of separate consent for HIV testing and resource intensive counseling requirements
  - In nearly all jurisdictions, these requirements have been removed for HIV screening programs
  - “Active measures” to link to services
    - Care for HIV-positive
    - Preventive and PrEP services for HIV-negative
  - CDC recommendations vs state law requirements
Limited Understanding of Rationale for Routine HIV Screening

- Low Awareness of recommendations for HIV screening in clinical settings
  - Multiple resources exist for training staff
  - Resources provided at end of presentation

- Concerns about patient acceptance of “Opt-Out” HIV testing
  - Majority of patients don’t object to HIV testing offer
  - 2011: More patients accepted “opt-out” than “opt-in” HIV testing (White, D. A., et al., 2011)
  - 2016: “Opt-out” accepted by nearly twice as many patients as accepted “opt-in” testing (Montoy, Juan Carlos C., et al., 2016)
## State Specific HIV Testing Laws

- 2015 all U.S. states except Nebraska were consistent with CDC recommendations not to require separate written consent or prevention counseling with HIV screening. (Sullivan, P. S., et al. (2016). pp. 1-4)
- Mississippi law no longer requires separate written informed consent for HIV testing [http://www.hivlawandpolicy.org/state-hiv-laws](http://www.hivlawandpolicy.org/state-hiv-laws)
Possible Clinic Staff Concerns

- Concerns about patient flow and documentation
- Little awareness of the need for HIV testing
- Difficulty in demonstrating direct clinical benefit
- Competing priorities in treating patients' chief complaint, or
- Other public health issues may be more pressing for individual patients

Staff Concerns: What Is Needed?

- Clearly defined staff roles
- Oversight by a project manager / program coordinator
- Consistent funding or reimbursement: a clear funding stream
- Testing coordinated with other duties with a specific Standard Operating Practices (SOP)
  - Designated HIV clinical care provider
  - Linkage procedures
Staff Concerns: Buy-In from Key Personnel

• Develop an inclusive working group
  – Provides input to HIV Testing Protocols
  – Input enhances sense of ownership
  – Assures support for patients

• Working Group Membership
  – Medical Directors and/or Dept. Chairs
  – Nursing Directors
  – Laboratory Director
  – HIV Clinic
    • Medical Directors
    • Nursing Directors
      – Assure responsibility for patients (no dumping)
  – Consumer Advisory Board Members
Commonly Asked Questions from Patients

- Why should I have an HIV test?
- How do you test for HIV?
- How is HIV infection diagnosed?
- What does it mean if I have HIV?
- Who will pay for my HIV test?


If a Patient Has Concerns about an HIV Test...

• Listen and respond to the patient’s questions and concerns as they express them

• Educate & provide informational materials

• Emphasize that
  o The test is suggested not because we think you might have HIV, but because
  o HIV screening test is routine for all patients

• “Explain to the patient that he or she may never have been screened for HIV infection, even if other physicians have performed other types of blood tests”*

*Centers for Disease Control and Prevention. (2013). Slide 49:
Public Health Reports
Volume 131(Suppl 1); Jan-Feb 2016

• Dedicated to Implementing Routine HIV Testing
  o Community Health Centers
  o Emergency Departments
  o Other Settings

• Download
  o Free of Charge!
  o https://www.ncbi.nlm.nih.gov/pmc/issues/263832/
TREATMENT AS PREVENTION (TASP)

TREATMENT IS PREVENTION

A scientific breakthrough in 2011 showed that HIV treatment not only saves lives, but reduces the risk by 96% of transmitting the disease.
Treatment and Prevention (since 2006)

• Treatment as Prevention: The HIV Prevention Trials Network (HPTN) research study HPTN 052 found 93% reduction in risk of HIV transmission with viral suppression

• Change in HIV treatment recommendations (Panel on antiretroviral guidelines for adults and adolescents. 2016).
  - Diagnosis of HIV infection is criterion for treatment initiation
  - Removal of CD4 threshold for treatment initiation

• Test and Treat Strategy

• 2012: Approval of Pre-Exposure Prophylaxis for prevention of HIV infection
TasP

• Treatment as Prevention or TasP

• Utilizing HIV treatment, or antiretroviral therapy (ART), in individuals living with HIV to decrease risk of transmitting HIV to HIV-negative partners

• Reducing viral load to “undetectable” level significantly reduces transmission risk

• A 2011 study showed a 96% reduction in transmission of HIV to HIV-negative partners

• Studies have continued to support TasP as an effective HIV prevention strategy

• Rapid linkage to care remains key in TasP effectiveness

HIV-Positive Results: Test and Treat Strategy

• Goal is to shorten dramatically the time from diagnosis to starting ART, and thereby reducing time to suppressed viral load

• How it is done: Person is offered treatment during visit
  – First Confirmed HIV-positive Result
  – Results of first CD4 test
## DHHS: Guidelines on ART Initiation

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<tbody>
<tr>
<td>&gt; 500</td>
<td>Offer if VL &gt; 20,000</td>
<td>Offer if VL &gt; 55,000</td>
<td>Consider if VL ≥ 100,000</td>
<td>Consider in certain groups</td>
<td>Consider</td>
<td>Treat</td>
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<tr>
<td>350-500</td>
<td>Offer if VL &gt; 20,000</td>
<td>Consider if VL &gt; 55,000</td>
<td>Consider if VL ≥ 100,000</td>
<td>Consider in certain groups</td>
<td>Treat</td>
<td>Treat</td>
</tr>
<tr>
<td>200-350</td>
<td>Offer if VL &gt; 20,000</td>
<td>Offer, but controversy exists</td>
<td>Offer after discussion with patient</td>
<td>Treat</td>
<td>Treat</td>
<td>Treat</td>
</tr>
<tr>
<td>&lt; 200 or symptomatic disease</td>
<td>Treat</td>
<td>Treat</td>
<td>Treat</td>
<td>Treat</td>
<td>Treat</td>
<td>Treat</td>
</tr>
</tbody>
</table>

https://aidsinfo.nih.gov/guidelines
Currently Approved ARVs

https://www.poz.com/legacy/poz_magazine/articles/2014/p197_drug_chart.jpg
Anti-retroviral Therapy

• Six different drug classes: Nucleoside Reverse Transcriptase Inhibitors (RTIs), Non-Nucleoside RTIs, Protease Inhibitors, Fusion Inhibitors, Entry Inhibitors and Intergrase Inhibitors

• Three HIV medications must be combined to successfully treat HIV

• Reduce HIV-related morbidity and prolong survival

• Improve quality of life

• Restore Immune System

• Increase Viral Suppression (undetectable)

In summary

Advances in HIV treatment have positioned community health centers at the epicenter of HIV prevention.
Community Health Centers

Community health centers are important sites for:

- Providing access to HIV testing and prevention messages
- Finding new infections
- Linking individuals who test positive into HIV care
- Treating individuals living with HIV
- Preventing new infections