**RT-1**

**Delivering Quality HIV Care in Resource Poor Settings:  A Discussion by Nurses**

**Delivering HIV Care in the Rural/Frontier Areas of the United States**

Judy Wessell2

Richard Gettings1

Anne Benson3

Jessica Lum4

Paula Peters3

1Chase Brexton Health Care, Easton, Maryland, USA

2Eastern Virginia Medical School, Norfolk, Virginia, USA

3Itinerent HIV care provider, Northern Arizona, USA

4State of Arizona, Case Management, Northern Arizona, USA

5Health Delivery Inc., Saginaw, Michigan, USA

**Background:**   HIV care is available to everyone in the United States.  Rural and frontier areas however are often similar in situation to what we would consider resource poor settings in the developing world.  Nurses working in rural areas are at the forefront of identifying barriers and developing /adapting programs to overcome those barriers.

**Purpose:**  To educate the nurses of ANAC regarding the particular barriers found in rural/frontier areas of the United States.  To discuss the solutions employed by providers and nurses to assure that quality HIV care is available to all.

**Methods:**  A panel discussion by providers and nurses who work in rural/frontier settings within the United States.  Topics/presenters to be represented on the panel:

                Tele-health provider working with primary care providers to get quality HIV care to patients.

                Travelling provider who takes HIV care to remote areas-where the patients live.

                Program director for a large city based clinic that serves a large rural area.

                A Nurse Provider that is working to maintain quality patient education in rural clinics

                A Case manager who works at obtaining support services for patients in rural/frontier USA.

**Conclusions:**  Barriers found in rural United States are similar to those found in the developing world.  Nurses are working in the rural/frontier areas of the United States to make sure that everyone has access to quality HIV care.

**Implications for Practice:**  Nurses working in rural/frontier areas address barriers that have heretofore been limited to non-metropolitan areas.  We intend to share our assessments of the barriers and the solutions we have developed with our colleagues working in rural areas as well as those colleagues in metropolitan practices.

**Objectives:**  The learner will be able to:

* Identify and discuss barriers particular to HIV nursing in rural/frontier areas of the United States.  Furthermore they will be able to discuss the solutions being used by the government as well as the nurses on the front lines;
* Compare and contrast education strategies in rural areas compared to those in metropolitan settings;
* Identify and discuss case management issues related to HIV care in rural/frontier areas.

**RT-2**

**Associations between Depressive Symptoms and Drug/Alcohol use on**

**Different Domains of HIV-Associated Neurocognitive Impairment:**

**An Age-Stratified Analysis**

Jennifer Attonito

Jessy G. Dévieux

Michele Jean Gilles

Florida International University, Robert Stempel College of Public

Health and Social Work, Miami, FL, USA

**Background:** Alcohol and other drug (AOD) use, age and depression have been independently linked with poorer neurocognitive (NC) functioning on several different domains.

**Purpose:** This study seeks to explore cognitive domains affected by these factors in a cohort of people living with HIV (PLWH).

**Methods:** Data was collected at baseline from 300 PLWH with a history of alcohol abuse in Miami, FL.  NC measures included: Color Trails Test 1 and 2; Auditory Verbal Learning Test; Short Category Test; and Complex Figure Test (copy and delayed recall). Independent variable measures included: number of days (in past 30) experiencing serious depression; years living with HIV; number of times (in past 90 days) using alcohol, marijuana, cocaine, and other drugs; and degree of alcohol dependence using the AUDIT. Associations were calculated for participants ≤44 and >44 years old using univariate and multivariable logistic regression.

**Results:** The mean age of participants was 44.7 years, 76% displayed some degree of NC impairment (>1SD below mean on at least 2 NC measures), and 210 (72%) scored >8 on AUDIT.  In the univariate analysis, marijuana use was associated with impairment on the greatest number of NC measures. In the multivariable model for younger participants, cocaine predicted poorer CTT2, marijuana predicted poorer AVLT, other drugs predicted poorer CFT copy, and depression predicted poorer CFT delay. For older participants, marijuana predicted poorer CTT2, other drugs predicted poorer CFT copy, and AUDIT predicted poorer CFT delay. In both univariate and final models marijuana was protective against NC impairment on the SCT for younger participants.

**Conclusion:** Marijuana use can affect an array of cognitive domains for PLWH—psychomotor speed, attention and auditory memory—for both younger and older people living with HIV; however it may also serve as a protective factor in some circumstances.

**Implications for Practice:** Clinicians should consider the mixed cognitive effects of marijuana use and should also screen for impacts upon visual construction and memory associated with depressive symptoms and alcohol abuse, particularly when caring for older patients. All of these NC domains have been implicated in various risk behaviors as well as patients’ ability to follow medical recommendations.

**Objectives: The learner will be able to:**

* Identify associations between alcohol and drug use and each major domain of neurocognitive functioning for younger and older adults;
* Identify associations between depressive symptoms and each major domain of neurocognitive functioning for younger and older adults.

**RT-3**

**FACES of Diversity: Fostering Awareness of Cultural Equity and Solidarity**

Darcel Reyes1

Eric Fenkl2

1HELP/PSI Health Services, Bronx, New York, USA

2Florida International University, Miami, Florida, USA

**Background:** Cultural competence does not adequately address conflicting scientific views of race as a biological, cultural, or social construct, inadvertently reinforcing racial stereotypes about health disparities.  Consequently, many nurses do not realize that their perception of the patient's culture, race, or ethnicity may not match the patient's self-identity.  This mismatch results in mistrust on the part of patients, leading to disengagement from care, poorer health outcomes, and ultimately manifesting as racial or ethnic health disparities. Diversity training stimulates awareness, knowledge, and changes in healthcare providers' attitudes and behaviors about race and ethnicity. This roundtable seeks to promote self-awareness about the unconscious cultural, racial, and ethnic biases that influence the nurse-patient relationship.

**Methods:** Participants will examine their ideas about culture, race and ethnicity through interactive exercises and discussion:

* Six Degrees of Culture: Participants self-identify using 6 cultural characteristics without mentioning profession, title, job, or degrees.  Post-exercise discussion will address:

1. how it feels to reveal your "cultural self,"
2. compare individual descriptions with other participants' notions about the person, and
3. explore how knowing the person's self-identity changes communication.

* The Race Card:  Participants write 6-word essays on any aspect of race (examples provided), then share their essays and it's meaning for them.
* Strut Your Status: Participants will take a step forward, back, or stay in place depending on answers to 30 questions that determine their "place" in society based on race, ethnicity, gender, and sexual orientation.  Post-exercise discussion explores relationships between privilege, prejudice, and institutional racism.
* Reflecting on their experiences with the exercises, participants will discuss how unexamined ideas about race, perceptions of other people's culture, and institutionalized racism affect patient care.
* Participants will leave the roundtable with a "Diversity Scavenger Hunt" to complete by the end of the conference (this is just for fun).

**Conclusion:**  The roundtable experience will promote greater understanding of the role that biases and stereotypes play in health disparities.

**Implications for Practice:** Nurses are in a better position to address health disparities and provide culturally competent care by examining their attitudes and behaviors for signs of unconscious racism.

**Objectives: The learner will be able to:**

* Identify the effect of cultural, racial, and ethnic stereotypes on nursing practice and patient-clinician communication;
* Acknowledge their own cultural, racial and ethnic misperceptions;
* Recognize the effect of institutional racism on health disparities

**RT-4**

**The Quest for an Effective Adherence Intervention:**

**A DOT-HAART Case Study**

Erin Athey

George Washington University, Washington, DC, USA

**Background:** The difficulties of adhering to antiretroviral medications for people living with HIV/AIDS (PLWHA) are well documented; Most HIV clinicians know this first hand.  It is often evident that the clinic-based appointment, even with the support of a interdisciplinary team, may not be enough to support patients who need more.  While there is evidence that some form of psychological and social support is often necessary for PLWHA to effectively adhere to their medications, exactly which interventions to employ, with which patients, is not always known.

Directly observed therapy for highly active antiretroviral therapy (DOT-HAART) has been one proposed method for increasing adherence in PLWHA who struggle with their daily HIV regimens.  However, determining which patients are appropriate for DOT-HAART and how long they will need it remains to be unknown, as well as the theoretical foundation for such an intervention.

**Purpose:** This case study describes a clinic’s attempt at using directly observed therapy for highly active antiretroviral therapy (DOT-HAART) for a woman who was failing to adhere to her medications due to various psychological and social barriers.

**Methods/Practice:** This casedescribes a complex, yet not altogether atypical patient, where DOT-HAART was employed to attempt to address non-adherence to HIV treatment.  The intervention lasted six-weeks and was conducted by an interdisciplinary clinic team of six, which included the following:  a physician, a nurse practitioner, a case manager, a psychotherapist, a patient navigator and a receptionist.

**Conclusions:** The DOT-HAART intervention for this patient was ultimately unsustainable due to numerous issues including: staff safety, an enormous amount of staff time and effort and a lack of evidence of long-term benefit.

**Implications for Practice**:  Using the experience of this case study, along with the published literature on DOT-HAART, the utility of DOT-HAART will be presented, as well as, direction for future research.

**Objectives: The learner will be able to:**

* Describe the various factors associated with HAART non-adherence and the issues related to treating complex patients;
* Compare and contrast the benefits of DOT-HAART and determine which patients may benefit from such an intervention.

**RT-5**

**Antiretroviral Adherence in the Setting of HCV Therapy**

Pamela Gorman

Elizabeth Fletcher

Pola de la Torre

Cooper Health System, Camden, New Jersey, USA

**Background:** According to the CDC, approximately 1.2 million persons in the United States are infected with HIV and one fourth of these are co-infected with hepatitis C virus (HCV).  Data shows that HCV progresses more rapidly in HIV co-infected persons leading to increased morbidity and mortality.  A study done by the data collection on adverse events of anti-HIV drugs (DAD) shows liver disease as the second leading cause of death among HIV infected persons.

**Purpose:** The Cooper EIP HCV care team hypothesized that our patient population would endure greater challenges with adherence to HIV antiretroviral therapy when additional medications are added for the treatment of HCV.  Many HIV-infected persons receiving medical care services at Cooper EIP are socioeconomically disadvantaged due to unemployment, limited education, mental illness and addiction to substances.  Barriers associated with these issues have a direct effect on our patients' ability to adapt to lifestyle changes necessary for adherence to a medical care treatment plan.  Therefore, our goal was to assess if adding HCV therapy will affect the patient's adherence to HIV therapy.

**Methods/Practice:** This project evaluated patient responses using three different assessment tools, the treatment adherence questionnaire, the newest vital sign score which determines health literacy level, and calculation of number of side effects reported with HCV and HIV therapy as tabulated on our side effect spreadsheet.  HIV viral load and CD4 cell count laboratory tests results served as our clinical outcome measurements.  HIV viral load suppression determined if patients were successful with adhering to antiretroviral therapy.

**Conclusions:** After 16 months of monitoring patients receiving HCV and HIV therapy, 33.3% successfully completed HCV therapy; 26.6% remain on therapy; 33.3% discontinued therapy and one patient died which was not related to the project intervention.  Patients that successfully completed HCV treatment were adherent to antiretroviral therapy as demonstrated by HIV viral load suppression.

**Implications for Practice:** HCV and HIV therapies may be given concurrently without affecting patients' treatment adherence to antiretroviral therapy.

**Objectives: The learner will be able to:**

* Understand the utility of using multiple assessment tools to evaluate patient’s adherence to therapy;
* Validate the effectiveness of using clinical performance measurements to determine adherence to antiretroviral therapy in the setting of HCV therapy;
* Compare the patient’s adherence to HIV therapy and the relationship of adding HCV therapy in terms of the occurrence of serious adverse events.

**RT-6**

**Patients on Suppressive HAART Report**

**Symptoms of HIV-associated Enteropathy**

Audrey Shaw

Eric Weaver

Entera Health, Cary, NC, USA

**Background:** HIV-associated enteropathy continues to affect patients with HIV in post-HAART era yet relatively few therapeutic strategies are available. Additionally, the potential involvements of gastrointestinal inflammation, alterations in microbiome, and intestinal permeability and malabsorption have not been well documented in HAART-treated patients with enteropathy. The potential contribution of inflammation within the GI tract may also interfere with immune reconstitution in the gut. The structural, functional and immunologic damage of the mucosal barrier can lead to microbial translocation, immune activation and disease progression. New therapeutic approaches are needed to restore the immunological and epithelial integrity of the mucosal barrier. A pilot study demonstrated that serum-derived bovine immunoglobulin protein isolate (SBI), a medical food, significantly increased intestinal CD4+ lymphocyte count, improved duodenal function and showed evidence of promoting intestinal repair in patients with HIV-enteropathy.

**Methods:** Subjects on suppressive HAART diagnosed with HIV-associated enteropathy have been randomized to a placebo-controlled trial evaluating the effects of SBI (2.5g or 5.0g BID) on stool frequency and consistency, nutrient absorption, and the microbiome for 4 weeks with a 20 week extension. Gastrointestinal symptom and QOL questionnaires, nutrient absorption, and anthropomometry measurements are being assessed. Blood is collected for markers microbial translocation, inflammation, immune activation and intestinal barrier function. Stool samples will be assessed for changes in the microbiome.

**Results:** Ninety patients diagnosed with HIV-associated enteropathy for a mean of 6.5 (0.1, 29) years have been randomized to the study. The majority (70%) are male. Mean baseline HIV plasma viral load is 27 (19, 168) copies/ml and peripheral blood CD4+ T cell count is 675 (189, 1,611) cells/µL. Baseline gastrointestinal symptoms include: mean bowel movements/day of 4.61 (2.57, 10.57) with 38% nocturnal bowel movements; mean stool consistency [1-formed to 6-watery] 4.85 (2.95, 6.00); mean daily abdominal pain or discomfort [scale 0-none to 3-severe] 1.58 (0.0, 3.00); 69% of patients reported daily presence of urgency and 35% with daily presence of fecal incontinence.

**Conclusions:** Despite effective treatment with HAART, HIV-associated enteropathy continues to be a common clinical syndrome. Further studies and therapeutic strategies are warranted to further understand the long-term consequences and management of enteropathy in HIV patients

**Objectives: The learner will be able to:**

* Identify the current features of the clinical presentation of HIV-associated enteropathy including the initiation of the etiology and what biomarkers should be added to determine impact of HIV disease progression besides viral load and CD4 counts;
* Learn properties of serum-derived bovine immunoglobulin (SBI) and it’s potential role in the dietary management of HIV-associated enteropathy.

**RT-7**

**The Big Blue Pill: PrEP, PEP and Sexual Health Services in an Urban Youth Clinic**

Jonathan Van Nuys1,2

Ifeoma Udoh2

Kristin Kennedy2

Michael D'Arata2

1UCSF, San Francisco, CA, USA

2East Bay AIDS Center, Oakland, CA, USA

**Background:** LGBTQ youth of color remain disproportionately affected by the U.S. HIV epidemic.  The FDA approved Truvada as PrEP (Pre-exposure prophylaxis) as a safe and effective HIV prevention tool in July 2012, but more research is needed to see how PrEP will be best utilized amongst urban youth.  The Connecting Resources for Urban Sexual Health (CRUSH) project, located at the East Bay AIDS Center in Oakland, has introduced PrEP, PEP (post-exposure prophylaxis) and drop in sexual health services as part of a comprehensive effort to improve sexual health and reduce HIV transmission in youth of color (18-29) in the East Bay of California.

**Purpose:** CRUSH aims to: 1. Test and link MSM youth (18-29) of color to sexual health services with youth specific outreach, social network testing and partnership with local youth serving agencies.  2. Enhance & evaluate engagement & retention strategies for young MSM of color who are HIV+ through peer mentoring and psychosocial support.  3.  Engage & retain young MSM of color in Sexual Health Services (SHS); including PREP, PEP and STI testing.

**Methods and Practice:** Participants are recruited through youth specific outreach, social network testing an in-reach strategy at the existing EBAC HIV clinic.  Study benefits include: Access to PrEP and PEP, STI testing and treatment, nucleic acid testing (NAT) and retention services including case management, peer mentoring and Integrated Next Step Counseling. A computer based, survey is self-administered at designated study visits to evaluate behavioral, psychological and health access information.

**Conclusions:** Twenty participants have enrolled since January 2014.  Participants come from a variety of socio-economic and ethnic backgrounds.  Five participants came to the clinic seeking PEP and decided to transition to PrEP after their initial 28 day PEP course. Two participants came to clinic seeking PrEP, but upon clinical interview, it was discovered that PEP was needed.

**Implications for Practice:** Experiences have highlighted the educational needs for urban youth around sexual health services, PEP and PrEP.  Innovative outreach strategies are needed to engage youth not currently accessing sexual health services as part of a comprehensive strategy to reduce the burden of HIV amongst urban youth.

**Objectives: The learner will be able to:**

* Learn how to best utilize PrEP as a prevention tool working with youth of color;
* Identify barriers to PrEP rollout for urban youth of color;
* Examine potential benefits and  unintended consequences of PrEP utilization in urban youth of color.