2014 Recommendations for HIV Prevention with Adults and Adolescents with HIV in the US: The Pivotal Role of RNs and Advance Practice RNs

Webinar on March 26, 2015

Kim Carbaugh, Executive Director and Carole Treston, Chief Nursing Officer
Association of Nurses in AIDS Care
Kathleen Irwin, MD, MPH, US Centers for Disease Control and Prevention
Agenda

- Webinar Basics
- Process for CNE Credits
- Background & rationale

Recommendations relevant to
- Linkage to and retention in HIV care
- Early ART initiation and sustained adherence
- Services to promote safer sexual activity and drug use
- STD preventive services

- Case studies highlighting the role of RNs and APRNs
- Q and A
For successful completion of this CNE activity, participants must attend the entire webinar AND complete an evaluation (online link is at end of webinar).

No members of planning committee or the presenters have any conflicts of interest to disclose.

This event does not have any sponsorship or commercial support, will not endorse any commercial products, and will not discuss off-label use of any commercial product.
Webinar Objectives

Participants will be able to:

1. Describe the rationale for updating the Recommendations for HIV Prevention with Adults and Adolescents with HIV in the US.

2. Explain the scope of the Recommendations.

3. Discuss the role of nurses in utilizing and implementing the Recommendations.
Guideline Development Process: Cross-sector collaboration was central

- CDC: DHAP, DSTD, DASH, DRH
- HRSA: Bureaus of HIV, Primary Care, MCH, Health workforce
- NIH: NIAID, NIDA, NIMH, NICHD
- Co-Sponsors
  - Association of Nurses in AIDS Care
  - American Academy of HIV Medicine
  - International Association of Providers of AIDS Care
  - National Minority AIDS Council
  - Urban Coalition for HIV/AIDS Prevention Services

Federal agencies

Co-sponsor organizations

CBOs
Health dept
Clinicians
Persons with HIV
HIV advocates

Non-governmental HIV prevention and care organizations

Other stakeholders
ANAC Role as Co-Sponsoring Organization

- 2011-2013 ANAC participated in a series of external consultations with CDC

- 2014 ANAC Review Group
  - Michelle M. Agnoli, RN, MSN, ACRN
  - Lucy Bradley-Springer, PhD, RN, ACRN, FAAN
  - Norma Rolfsen RN, FNP, AACRN
  - Carole Treston RN, MPH, ACRN
Rationale for Guideline:
HIV Prevalence and Incidence
United States, 1980-2010

Number of people living with HIV has grown because incidence is relatively stable and survival has increased

Rationale for PWP Recommendations

- 2010 National HIV/AIDS Strategy stresses
  - improving HIV care
  - preventing onward transmission or “Prevention with Positives” (PWP)
  - reducing racial/ethnic disparities
Rationale: Gaps on the Care Continuum

Percentage of persons with HIV engaged in selected stages of continuity of care

Rationale: Update 2003 Guidelines on Incorporating HIV Prevention into HIV Medical Care

- 2003 recommendations were outdated
  - Aimed only at HIV medical providers
  - Only covered 4 topics
    - Behavioral risk screening and risk reduction
    - STD screening and treatment
    - Referral to support services (e.g., drug treatment)
    - Services for sex and drug-injection partners

- Did not include many new, evidence-based prevention strategies, especially ART for preventing transmission

- CDC and HRSA recognized value of
  - consolidating all federal guidance on PWP in 1 document
  - expanding audience to HD and CBOs
Why Now

Historical emphasis on Prevention with Negatives - Add to this paradigm by focusing on PWP. Clinicians can:

- Perform a brief screening for HIV transmission-risk behaviors
- Communicate prevention messages from a positive perspective, including sex positive
- Discuss UDVL = Lower Transmission Risk
- Provide positive reinforcements for modifying sexual and drug use behavior
- Refer patients for services such as substance abuse treatment; facilitate partner notification, and identify and treat other STDs
- Assess impact of structural factors (e.g. housing)
Guideline Goals and Development Methods

- Describes numerous strategies to
  - ↓ infectiousness of persons with HIV
  - ↓ risk of exposing others

- Consolidates recommendations based on scientific evidence, program evaluations, and/or expert opinion from
  - Other existing federal guidance published through June 2014
  - New recommendations developed by PWP Guideline Workgroup and vetted by >200 internal and external experts, formal consultation, and public
  - Aligned with latest standards for clinical practice guidelines
Guideline Audiences

Staff of health care facilities who serve patients (MD, RN, APRN, health educators, pharmacists, case managers, etc)

Staff of CBOs and HD who offer individual-level services, such as health education, testing, risk reduction interventions, and partner services

Staff of HD and HIV planning groups who provide population-level services, such as surveillance, public policy, and media campaigns
Definition of Clinical Providers and Nonclinical Providers Recognizes Diverse Roles of RNs and APRNs in HIV Prevention and Care
Guideline Scope

- Emphasis on
  - New effective, evidence-based interventions

- Topics include:
  - Context: social, ethical & legal issues
  - Linkage to and retention in HIV medical care
  - ART initiation and adherence
  - Risk screening and risk reduction interventions
  - HIV partner services
  - STD screening and treatment
  - Reproductive health and pregnancy services
  - Referrals for ancillary medical and social services
  - Quality improvement and program evaluation
Intervention Topics for Webinar

- Linkage to and retention in HIV medical care
- Early ART initiation and adherence support
- Services to promote safer sexual activity and drug use
- STD preventive services
Linkage and Retention

- Early initiation of ART improves health and ↓ transmission
- Linkage and retention strategies require more proactive efforts than traditional “passive” referrals
- ↑ access to other medical and social services can
  - speed initiation of ART
  - ↑ retention in HIV medical care
  - ↑ adherence to ART
- Clinical and nonclinical providers can actively support continuous care
Establish infrastructure to link, retain, and re-engage persons into HIV medical care

Inform patients/clients about benefits of starting ART (for own health and preventing transmission) and staying in care

Assess facilitators and barriers to linkage and retention

Provide/make referrals for other medical and social services to overcome barriers
Provide immediate, active, repeated linkage services to enable care as soon as possible, but within 3 months of diagnosis.

Help persons enroll in health insurance or medical assistance programs.

Collaborate with other providers including health departments to provide services to promote linkage and retention.

Track outcomes of linkage and retention services and provide follow-up assistance.
Compendium of Evidence-based Interventions: Linkage to, Retention in, and Re-engagement in HIV care

NEW Linkage to, Retention in, and Re-engagement in HIV Care (LRC) Chapter

Background

LRC Best Practices Review Methods

LRC Best Practices Criteria

Complete List of LRC Best Practices

Stratified List of All LRC Best Practices, by Characteristic

This new chapter of the Compendium categorizes the best practices in promoting Linkage to, Retention in, and Re-engagement in HIV Care among people living with HIV, one of the priorities outlined in the U.S. National HIV/AIDS Strategy. Additional details about the LRC Chapter or the Prevention Research Synthesis (PRS) Project can be obtained by contacting PRS.

The complete LRC Chapter includes 10 LRC Best Practices

Updated on December 16, 2014

5 Evidence-Based Interventions (EBIs)

<table>
<thead>
<tr>
<th>EBIs</th>
<th>Target Population</th>
<th>Intervention Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retention Through Enhanced Personal Contacts NEW 2014</td>
<td>HIV clinic patients inconsistent in care or new clinic patients</td>
<td>Retention in HIV Care</td>
</tr>
<tr>
<td>ARTAS</td>
<td>Recently diagnosed HIV-positive persons</td>
<td>Linkage to HIV care Retention in HIV care</td>
</tr>
<tr>
<td>Clinic-based Buprenorphine Treatment</td>
<td>Opioid dependent HIV clinic patients</td>
<td>Retention in HIV care</td>
</tr>
<tr>
<td>Extended Counseling</td>
<td>Recently diagnosed HIV-positive patients in Uganda</td>
<td>Linkage to HIV care</td>
</tr>
<tr>
<td>Virology FastTrack</td>
<td>HIV care providers and their HIV clinic patients</td>
<td>Retention in HIV care</td>
</tr>
</tbody>
</table>

5 Evidence-Informed Interventions (EIs)

<table>
<thead>
<tr>
<th>EIs</th>
<th>Target Population</th>
<th>Intervention Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilingual/Bicultural Care Team</td>
<td>Hispanic/Latino HIV clinic patients</td>
<td>Retention in HIV care</td>
</tr>
<tr>
<td>Centralized HIV Services</td>
<td>Young black or African American and Hispanic/Latino HIV clinic patients</td>
<td>Retention in HIV care</td>
</tr>
<tr>
<td>Project CONNECT</td>
<td>Recently diagnosed HIV clinic patients</td>
<td>Linkage to HIV care</td>
</tr>
<tr>
<td>Stay Connected</td>
<td>HIV clinic patients</td>
<td>Retention in HIV care</td>
</tr>
</tbody>
</table>

ART Treatment and Adherence

- Early ART initiation improves health and ↓ transmission
- Starting ART involves commitment to lifelong, sustained high adherence
- Newer regimens ↓ pill burden, dosing frequency and side effects
- CD4 count and viral load (VL) can estimate ART effectiveness that adherence may influence
- Challenges to using ART include
  - sustained access to affordable medications
  - interactions with other drugs and substances
ART for Prevention: Recommendations for Clinical and Nonclinical Providers

Inform all HIV+ persons, regardless of CD4 count, about:
- Benefits of ART to improve health, ↑ longevity and ↓ transmission to others
- Limitations of ART
  • need for lifelong Rx with sustained high adherence
  • potential side effects
  • may not eliminate all risk of transmission

Inform HIV+ persons about availability for HIV- partners of:
- preexposure prophylaxis (PrEP) and non-occupational postexposure prophylaxis (nPEP) if
  • clinically indicated to ↓ acquisition risk
  • note PrEP and nPEP may not eliminate all risk of acquisition
  • note where HIV- partners can seek clinical evaluation
ART for Prevention: Additional Recommendations for Clinical Providers

Offer ART according to HHS recommendations, regardless of CD4 count, for both treatment and prevention.

Before prescribing, assess readiness, facilitators, and barriers to starting ART.

When prescribing, provide information to ↑ understanding of:
- ART benefits and risks
- Need to commit to sustained high adherence
- Need for frequent follow up visits
- ART use is voluntary; declining won’t preclude other services
ART Adherence:
Recommendations for Clinical and Nonclinical Providers

- Participate in multi-disciplinary teams to assess and to support adherence
- Inform HIV+ persons about benefits of high adherence, even if feel well, and risks of low adherence (drug resistance, transmission)
- Provide adherence support, e.g., evidence-based interventions
- Provide/refer for services that address factors that impair adherence (e.g., unstable housing, mental illness, drug abuse)
- Offer advice on obtaining coverage or subsidies for ART costs
ART Adherence: 
Additional Recommendations for Clinical Providers

1. Offer effective regimens, preferably that ↓ pill burden, dosing frequency, and dietary restrictions.

2. Engage patient in Rx decisions; address Qs and concerns to address potential problems before virologic failure occurs.

3. Advise to take ART as prescribed after check understanding of:
   - regimen details
   - how to manage missed doses and side effects
   - interactions with other drugs and substances
   - hazards of sharing ART with others

4. If patient defers or stops ART, periodically reoffer ART.
ART Adherence: Additional Recommendations for Clinical Providers

- At each visit, assess self-reported adherence using a nonjudgmental manner.
- Monitor viral load, a measure of ART effectiveness that adherence may affect.
- Assess and manage side effects at each visit.
- Discuss possibility of HIV transmission even if virus not detectable in blood.
Resources to Promote these Recommendations

Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention
- NEW Linkage to, Retention in, and Re-engagement in HIV Care (LRC) Chapter
- Risk Reduction (RR) Chapter
- Medication Adherence (MA) Chapter

Complete Listing of Medication Adherence Evidence-based Behavioral Interventions
- Adherence Through Home Education and Nursing Assessment (ATHENA) (Good)
  - Risk category: Treatment Experienced
  - Sex: 52% Male, 48% Female
  - Race: 42% White, 35% African American, 19% Hispanic, 4% Other
  - Intervention level: Individual-level
- Directly Administered Antiretroviral Therapy (DAART) for Drug Users (Good)
  - Risk category: Treatment Experienced, Treatment Naive, Drug Users
  - Sex: 69% Male, 31% Female
  - Race: 56% African American, 22% White, 19% Hispanic, 1% Other
  - Intervention level: Individual-level
- Directly Administered Antiretroviral Therapy (DAART) in Methadone Clinic (Good)
  - Risk category: Treatment Experienced, Treatment Naive, Drug Users
  - Sex: 85% Male, 15% Female
  - Race: 79% African American
  - Intervention level: Individual-level
- Healthy Living Project (HLP) (NEW 2014) (Good)
  - Risk category: HIV-
  - Sex: 79% Male, 21% Female
  - Race: 45% African American, 32% White, 15% Hispanic, 8% Other
  - Intervention level: Individual-level
- Helping Enhance Adherence to antiretroviral Therapy (Project HEART) (Good)
  - Risk category: Treatment Naive
  - Sex: 64% Male, 36% Female
  - Race: 83% African American, 12% White, 3% Other, 2% Hispanic

Risk Screening and Risk-reduction Interventions to Promote Safer Sex and Drug Use Behaviors

- Risk screening is a brief evaluation to assess behavioral and biologic factors that affect risk of HIV transmission
  - Biologic factors include ART use, viral load, current STD symptoms, partner with STD

- Risk-reduction interventions promote safer sexual and drug use behaviors

- Many new group- and individual-level interventions shown to be effective
Risk Reduction: Selected Recommendations for Clinical and Nonclinical Providers

1. Establish infrastructure to support routine risk screening and brief risk-reduction interventions

2. Train staff to create trusting, nonjudgmental atmosphere that encourages
   - honest, voluntary disclosure of sex and drug behaviors and health information
   - client/patient questions and shared decision-making

3. Screen persons with HIV at initial visit and at least yearly (or more often as needed) thereafter for:
   - behavioral risks such as sex without condoms
   - biologic risks related to ART use, viral load, recent STDs
   - characteristics of partners (e.g., recent STDs, PrEP use)
Offer positive reinforcement to persons who report safer behaviors to motivate continued use.

Use risk screening to identify most suitable risk-reduction messages and interventions.

Offer risk-reduction information and interventions that are tailored to person’s risks, such as:
• correcting misperceptions about transmission
• stressing benefits of high adherence to ↓ transmission
• offering condoms and referrals for legal syringe services
CDC Compendium of Evidence-Based Risk-reduction Interventions

**AMIGAS** NEW 2014
*Best*
- Risk category: Heterosexual Adult
  - Sex: 100% Female
  - Race: 100% Latina
  - Intervention level: Group-level

**Assisting in Rehabilitating Kids (ARK)**
*Good*
- Risk category: High Risk Youth
  - Sex: 59% Male, 32% Female
  - Race: 75% White, 22% African American, 2% American Indian, 1% Hispanic
  - Intervention level: Group-level

**Becoming a Responsible Teen (BART)**
*Best*
- Risk category: High Risk Youth
  - Sex: 28% Male, 72% Female
  - Race: 100% African American
  - Intervention level: Group-level

**Be Proud! Be Responsible!**
*Best*
- Risk category: High Risk Youth
  - Sex: 100% Male
  - Race: 100% African American
  - Intervention level: Group-level

**Brief Alcohol Intervention for Needle Exchangers (BRAINE)**
*Good*
- Risk category: Drug Users
  - Sex: 52% Male, 38% Female
  - Race: 90% White, 10% Other
  - Intervention level: Individual-level

**Brief Group Counseling**
*Best*
- Risk category: MSM
  - Sex: 100% Male
  - Race: 100% Asian/Pacific Islander
  - Intervention level: Group-level

**Centering Pregnancy Plus (CPP)**
*Best*
- Risk category: Heterosexual Adult
  - Sex: 100% Female
  - Race: 80% African American, 13% Hispanic, 6% White, 1% Other
  - Intervention level: Group-level

**CHAT** NEW 2014
STD Preventive Services

STD services for HIV+ persons include

- Assessment of biologic and behavioral risks

- STD screening and treatment that ↓ HIV viral load in blood and anogenital fluids

- Engaging services for sex partners
STD Preventive Services: Recommendations for Clinical and Nonclinical Providers

Inform persons with HIV about
- STDs that can ↑ HIV viral load
- benefits of screening for STDs that often lack symptoms

Screen for STD as appropriate to setting
- Nonclinical settings: self-collected specimens or venous blood (by trained phlebotomist)
- Clinical settings: self- or provider-collected specimens
### Recommended STD Screening Tests for Persons with HIV

<table>
<thead>
<tr>
<th>MEN</th>
<th>WOMEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis serology*</td>
<td>Syphilis serology*</td>
</tr>
<tr>
<td>Gonorrhea§</td>
<td>Gonorrhea§</td>
</tr>
<tr>
<td>Chlamydia§</td>
<td>Chlamydia§</td>
</tr>
<tr>
<td>Herpes Simplex Type-2*</td>
<td>Herpes Simplex Type-2*</td>
</tr>
<tr>
<td></td>
<td>Trichomonas†</td>
</tr>
</tbody>
</table>

* Requires phlebotomy

§ CDC recommends nucleic acid amplification test with self- or provider-collected specimen

† CDC recommends nucleic acid amplification test with provider-collected specimen
Provide/link persons with STD symptoms or partners who have been treated for STD to:

- onsite presumptive STD treatment (including intramuscular (IM) Rx for syphilis and gonorrhea)
- risk-reduction interventions and condoms
- partner notification and HIV and STD screening

Provide/link persons with positive screening tests to:

- clinical evaluation within 24 hours in facility that offers on-site, IM treatment
- risk-reduction interventions and condoms
- partner notification and HIV and STD screening
STD Preventive Services:
Additional Recommendations for Clinical Providers

At first HIV care visits, provide:
- Detailed history of sexual activity, STD, and drug use
- Physical exam, including oropharynx and rectum
- STD screening and diagnostic tests
- For persons with sex or drug-use risk behaviors:
  - Refer to risk-reduction services and partner services
- For persons with exam or tests indicative of STD:
  - Provide onsite STD Rx as per CDC recommendations
  - Advise to return 3 months after STD Rx for retesting

At follow-up HIV visits, provide:
- Review of history since last visit
- STD screening (at least annually or more often if needed)
- Other services relevant to history, exam, or test results
Strategies to Implement these Recommendations

Clinical providers

- Standing orders or EMR prompts for STD tests
- Fast track, walk-in visits for frequent STD screening with self-collected tests

Nonclinical providers

- Offer gonorrhea and chlamydia testing using self-collected specimens in storefront sites, colleges, health fairs, etc.
# Guideline Reach

**December 2014 - March 2015**

## Website visits from mid-Dec to mid-March

<table>
<thead>
<tr>
<th>Report</th>
<th>Website visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Guideline</td>
<td>20,074</td>
</tr>
<tr>
<td>Summary for Clinical Providers</td>
<td>5,176</td>
</tr>
<tr>
<td>Summary for Nonclinical Providers</td>
<td>2,095</td>
</tr>
<tr>
<td>Summary for Health Departments and HIV Planning Groups</td>
<td>2,528</td>
</tr>
</tbody>
</table>
Raymond James, CRNP, AACRN has been hired by a CHC to improve retention in care rates for HIV patients, part of a new initiative to integrate HIV services into a large primary care facility. He must use critical analysis and creative problem solving to foster a staff culture that will allow the changes needed to produce different results. Data on lost to care in this facility is incomplete, but he is able to tap into Planning Council data to educate staff as to regional population level impact of lost to care. He identified and supported nurse & other champions on staff. He established MOU with 2 ASO testing sites, identified CHC RN as Nurse Contact for linkage program w/ rapid scheduling/re-schedule system. Established “customer-service” in-service training for all staff, including non-judgmental approaches to re-engagement, positive reinforcement strategies, and patient friendly scheduling. Instituted new patient orientation visit for initial and re-engaged patients, including staff directory/ business cards. Provided staff training on social/structural issues (unstable housing, MH, SA, IPV, transport) that impact retention. With inter-professional team, developed referrals and referral tracking for social/structural issues. Benchmarks for success were agreed upon, data on retention to be reviewed at 6 & 12 mos.
Connie Parks, BSN, RN, ACRN is the nurse coordinator for an HIV Clinic housed within a University Hospital Center. She recently became familiar with data showing that only 44% of HIV patients from a MMP/CDC representative sample reported HIV/STD prevention counseling from a healthcare provider. In her clinic 23% of patients had GC and 26% tested positive for Syphilis. 35% of patients have documentation of past/present SA. There is no data on rate/frequency of HIV/STD prevention counseling. She wants to institute a screening/brief intervention (SBI) standard, focusing on alcohol use and safer sexual behaviors, delivered by clinical staff. She organized a interprofessional staff in-service session featuring the CDC PWP GL, MMP data, etc. Staff explored how 10 mins could be protected during a visit for SBI. Simplified, shortened screening tools were modified for alcohol and sexual behaviors assessments. Common BI messages were developed, including clinic posters. Motivational interviewing strategies were reviewed. Fields for alcohol and sexual behavior SBI were incorporated into EMR to coincide with annual STD screenings. PrEP and nPEP access for partners was established & advertised. Benchmarks for success were agreed upon, data on SBI rates to be reviewed at 6 &12 months.
Resources

CDC Website:
- Main Guideline and Summaries
- Training resources
- Decision support tools
- Fact sheets for patients and providers

http://www.cdc.gov/hiv/prevention/programs/pwp/

HRSA HAB Target Center
- Training resources
- Decision support tools and fact sheets

https://careacttarget.org/
Next Steps for RNs and APRNs who Provide HIV Prevention or Care

- Become a champion for “Prevention with Positives” in your practice
- Read Summaries for Clinical Providers and Nonclinical Providers
- Explore Implementation Resources for practical tools
- Alert your colleagues about the guideline, summaries, and implementation resources
Additional Questions?
erin@anacnet.org
Continuing Nursing Education

To earn CNE contact hours for today’s webinar, click on the following link to complete an evaluation:

www.nursesinaidscare.org/CNEPWP3262015