



# New Jersey HIVLinks



FALL 2017

Newsletter

HIV, STD and TB news and information for primary care providers

## People Living with HIV (PLWH) Need Health Care Coverage

Loretta Dutton, MPA, Director of HIV Care and Treatment

### WHY SHOULD PRIMARY CARE PROVIDERS ADVOCATE FOR HEALTH COVERAGE?

The Marketplace has afforded individuals with HIV the opportunity to obtain health care coverage without the threat of being dropped or denied coverage based on pre-existing health conditions like HIV or hepatitis C. Insurers are prohibited from cancelling or rescinding coverage because of application errors and lifetime caps cannot be imposed on benefits. Additionally, patients without health care coverage run the risk of tax penalties up to 2.5% of their household income or up to \$695 per person, with a maximum penalty of \$2,085 per family.

may still be eligible for expanded Medicaid. Single adults without children are still eligible if their income is at or below 138% of the Federal Poverty Level. Since New Jersey opted for Medicaid expansion, PLWH who meet the income threshold will no longer be required to wait for an AIDS diagnosis to become eligible for Medicaid (eg, disability coverage).

Patients can now receive life-extending care and treatment to reduce or eliminate the progression to AIDS. Additionally, once your patient is virally suppressed, the likelihood that he/she can transmit HIV is negligible.

There are other benefits PLWH can gain from having insurance coverage. Preventive care becomes available to patients. Co-occurring health conditions such as diabetes, heart disease, hepatitis C, malignancies and other illnesses are also covered. The AIDS Drug Assistance Program (ADDP) that the Department of Health funds can help patients with free HIV medication; however, it does not cover medications for other co-morbidities. Health insurance does. Premium payments for patients and plans that are eligible for the Health Insurance Premium Payment (HIPP) program will be covered 100%.

The Ryan White Part B (RWB) Program provides funds to cover the cost of private health insurance premiums to assist eligible PLWH, low-income clients to maintain health insurance. In New Jersey that

## Routine HIV Screening in Primary Care

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### Did you know?

- Since 2006, the Centers for Disease Control and Prevention (CDC) has recommended routine HIV screening, regardless of known risk factors, in primary care settings for patients aged 13 to 64.
- HIV screening is covered as a preventive care service under most insurance plans.
- Most patients will agree to a routine HIV screening test if recommended by a primary care provider.

### UNDIAGNOSED HIV

According to the most recent estimates from the Centers for Disease Control and Prevention (CDC) as of 2014, 1.1 million people aged ≥13 were living with HIV in the United States (US), including approximately 166,000 (15%) who were unaware that they were infected.<sup>1</sup> Lack of awareness of HIV infection can lead to late presentation to care, and poorer long-term prognosis for patients. Additionally, transmission to others continues since research suggests that those who are infected but undiagnosed are responsible for 30% to 49% of new HIV transmissions.<sup>2,3</sup>

### WHAT IS AVAILABLE FOR MY HIV POSITIVE PATIENT?

With no concrete changes made to the Affordable Care Act (ACA), your patient

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# How Do Providers Discuss, Screen and Treat STDs?

Francesca Esposito-Weir, MPH  
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## WHAT ARE THE STATS?

The World Health Organization, estimates that more than 1 million STDs are acquired every day. Each year, there are an estimated 357 million new infections with 1 of 4 STDs: chlamydia (131 million), gonorrhea (78 million), syphilis (5.6 million) and trichomoniasis (143 million). More than 500 million people are living with genital HSV (herpes) infection. At any point in time, more than 290 million women have an HPV infection.<sup>1</sup>

According to the Centers for Disease Control and Prevention (CDC), nearly 20 million new STDs occur annually in the US, 25% of these infections are in people ages 15-24 years old, and result in about \$16 billion of healthcare costs. A single STD has both immediate and long term health implications including infertility and increasing one's risk of acquiring HIV or other STDs.<sup>2,3</sup>

## WHAT ARE THE SYMPTOMS?

Not all infected individuals present with signs or symptoms of STDs. However, some symptoms may include unusual discharge, pain in the pelvic area, vaginal bleeding, sores, bumps, blisters, lesions, dysuria, increased urinary frequency or urgency, genital swelling or itching, swelling or redness of the throat, flu-like symptoms, and a rash.

STDs can be transmitted from one person to another through the exchange of bodily fluid during sexual intercourse (oral, anal, or vaginal), skin to skin contact, sharing of sex toys, and sharing of contaminated drug injection needles/equipment. Practicing abstinence is the only method that ensures no risk of transmission can occur. Condoms, when used correctly and consistently from beginning to end greatly reduces, but does not completely eliminate, the risk of acquiring or spreading

STDs (ie, those STDs transmitted by skin to skin contact not covered by the condom).

## WHAT ARE THE 3 T'S?

Providers should utilize the 3 T's: Talk, Test, and Treat.<sup>4-6</sup> Talk to patients about how to protect themselves from STDs. This means that there needs to be more discussions about condom use, and safer sex practices. This can only be determined by asking the right questions, engaging your patients, establishing a rapport, and obtaining their trust by being sexually and culturally competent. Providers need to understand what it means to be gender fluid, bisexual, gay, lesbian, heterosexual, or just curious/questioning. To best screen and provide prevention education on STDs/ STIs, providers need to know: what kind of sex (including use of sex toys), the number of partners, how partners are met (eg, anonymous, online or mobile app hook-ups), and whether condoms and/or dental dams are used. The discussion should include a variety of options that are judgment-free and fact-based. Discussions may include abstinence, condoms/ dental dams, the need for routine STD/STI screening, and overall health and emotional wellbeing. Patients may also need to be referred to more intensive programs that provide condom negotiation, partner communication, and basic harm-reduction skills.

- **ABSTAIN:** Not having sex is an option, but other available options should be presented.
- **CONDOMS:** Use condoms consistently and correctly when having oral, anal, and vaginal sex. Also discuss other options like dental dams, the female condom, and finger cots for digital masturbation.
- **TESTING:** Get STD/STI screening done regularly.<sup>7</sup>

- **OVERALL HEALTH AND EMOTIONAL WELL BEING:** Keeping up with yearly routine medical physicals and vaccinations like the HPV vaccine (for those between 9-26 years old), managing co-morbidities, eating right and exercising, and addressing mental health issues.

The next component is "Test", and this includes regular comprehensive STD/STI screening with anal swabs, oral swabs, genital screening (urine or vaginal swabs), and blood draws when applicable. Lastly, "Treat" any STD/STI as recommended by the CDC.<sup>8</sup>

## EXPEDITED PARTNER THERAPY

Expedited Partner Therapy (EPT) is when a healthcare provider gives a patient with a STD an antibiotic or a written prescription for the patient's sexual partner(s) to take without first examining the partner to treat chlamydia and trichomoniasis. This is allowable by New Jersey State Administrative Code (N.J.A.C. 13:35-7.1),<sup>9</sup> and allows providers to prescribe and treat without medical examination when denying such timely treatment has a reasonable possibility of "placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part."<sup>9,10</sup>

The CDC recommends EPT for heterosexual partners of patients diagnosed with chlamydia or trichomoniasis when other strategies are unfeasible or have failed to engage the partner to enter care.<sup>10</sup> Since 2012, the CDC no longer recommends EPT for gonorrhea for anyone unless it is a last resort because of increasing gonorrhea antibiotic resistance.<sup>10</sup> EPT is a valuable tool but should be limited to chlamydia and trichomoniasis because they can only be treated with oral antibiotics and should

# How Do Providers Discuss, Screen and Treat STDs?

be an option of last resort to prevent reinfection.

## NJ STD REPORTING REQUIREMENTS

All healthcare providers should be familiar with the reporting requirements for the New Jersey Department of Health (NJDOH).<sup>11</sup> The NJDOH requires that both healthcare providers and laboratories report confirmed cases of STDs, including chancroid, chlamydia, gonorrhea, granuloma inguinale, lymphogranuloma venereum, and all stages of syphilis. As required by Chapter 2 of the State Sanitary Code (N.J.A.C. 8:57-1.2); providers must submit completed STD-11 reports to DOH within 24 hours. Directions for reporting are available at the NJDOH STD Website at <http://www.nj.gov/health/hivstdtb/stds/>. The STD-11 form is available at <http://www.nj.gov/health/forms/std-11.pdf>.

## DIAGNOSIS AND TREATMENT OF STDs

Treatment of STDs vary from stages of disease and co-morbidities and infections. The 2015 CDC treatment guidelines provides an overview for screening and treating patients. Diagnostic considerations are based on clinical suspicion, epidemiologic information, and the exclusion of other etiologies for proctocolitis, inguinal lymphadenopathy, or genital, rectal, or oropharyngeal ulcers. Genital lesions, rectal specimens, and lymph node specimens can be tested by culture, direct immunofluorescence, or nucleic acid detection.<sup>8</sup> Additional molecular procedures (eg, PCR-based genotyping) may also be used to further differentiate and diagnose an STD.

**Most common types of reportable STDs in New Jersey** – see chart on next page. All information is based on CDC 2015 Treatment Guidelines.<sup>8</sup>

## PARTNER SERVICES IN NEW JERSEY

A critical function of partner services (PS) is partner notification, a process through which infected persons are interviewed to elicit information about their partners, who can then be confidentially notified of their possible exposure or potential risk. The overall goal of PS in New Jersey is to reduce the burden of HIV and STDs on communities and individuals by providing support and linkage to service for infected persons and their partners. PS are offered to individuals who are infected with STDs, to their partners, and to other persons who are at increased risk for infection to prevent transmission of these diseases and to related morbidities and mortalities. Patients can be referred to PS by providers, positive lab reports, and by patient referral upon disclosure of their sexual partners. Partner Services is a collaboration between clients, providers, and the community to ensure timely access to care and treatment.

Discussing STDs and partner solicitation can be very difficult and confusing for some. Providers are encouraged to discuss potential partner violence with their patients. PS can assist in making appropriate referrals for mental health support and domestic violence services to address abusive situations. Intimate partner violence occurs between two people in a close relationship, including current and former partners. Intimate partner violence can range from a single occurrence to ongoing battering and includes four types of behavior: physical violence, sexual violence, threats of physical or sexual violence, and emotional abuse.<sup>12</sup>

Providers are encouraged to speak with patients about their sex partners. Partner notification is not only a key component in preventing re-infection, but also in reaching out to those at risk to provide

early diagnosis and treatment, and prevent complications of untreated STDs. Partner notification can take any number of forms, depending on the client's relationship with that partner:

- Ask your clients with STDs to bring their partners with them when returning for treatment or follow-up. You, the healthcare provider, can offer care and treatment as well as couples counseling, if both partners give permission.
- Encourage persons with STDs to notify their sex partners and urge those partners to seek medical evaluation and treatment. Also advise patients that NJDOH PS may be in contact with them to follow up.
- Clients can use "inSPOT", by going to <http://www.inspot.org/>, or "DONTSPREADIT", <https://dontspreadit.com>, where clients can have their sexual partners notified anonymously that they have been exposed to an STD. The target population for this site are clients with gonorrhea or chlamydia; those with syphilis are interviewed by public health representatives.<sup>13</sup>
- Ensure that the NJDOH is notified of all reportable STDs within 24 hours of diagnosis (see "STD Reporting Requirements" in this article).

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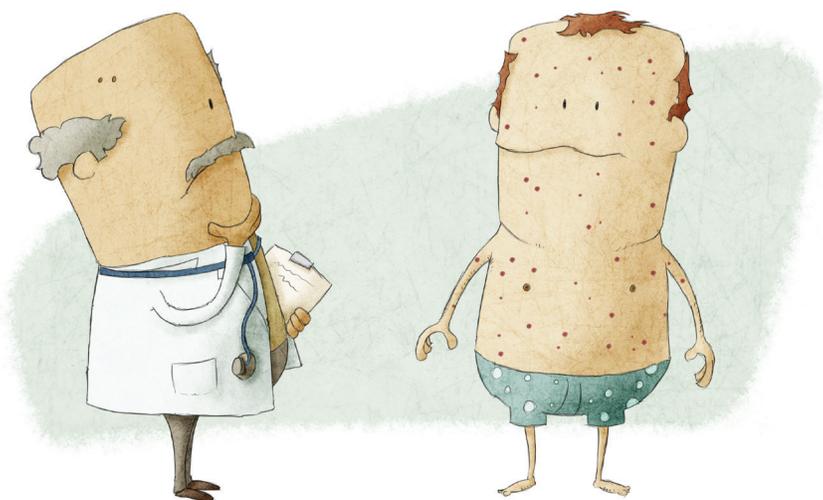


**...more than 1 million STDs are acquired every day.** Each year, there are an estimated 357 million new infections with 1 of 4 STDs: chlamydia (131 million), gonorrhea (78 million), syphilis (5.6 million) and trichomoniasis (143 million). More than 500 million people are living with genital HSV (herpes) infection. At any point in time, more than 290 million women have an HPV infection.<sup>1</sup>

# How Do Providers Discuss, Screen and Treat STDs? continued

## Some Reportable STDs in New Jersey

If You Have These Signs	You Might Have This Disease	Who Should Be Screened?	Diagnostic Testing
Painful urination and/or discharge from genitalia	<ul style="list-style-type: none"> <li>Gonorrhea</li> <li>Chlamydia</li> </ul>	<ol style="list-style-type: none"> <li>All sexually active women and men under age 25 years of age. Sexually active women and men age 25 or older, if at increased risk.</li> <li>All pregnant women under 25 years of age and older women if at increased risk.</li> <li>High Risk include women and men with multiple partners, exchanging sex for payment, illicit drug use and history of STDs like HIV.</li> <li>Retest 3 months after treatment (test for cure).</li> </ol>	<ul style="list-style-type: none"> <li>Culture and NAAT testing are available for the detection of genitourinary infection with <i>N. gonorrhoeae</i>; culture requires endocervical (women) or urethral (men) swab specimens. Sexually active gay and bisexual men should have sites of contact (urethra, rectum, pharynx) tested, regardless of condom use.</li> </ul>
Painful blisters or sores on genitalia	<ul style="list-style-type: none"> <li>Chancroid</li> <li>Trichomoniasis</li> </ul>	<ol style="list-style-type: none"> <li>All sexually active women and men under age 25 years of age. Sexually active women and men age 25 or older, if at increased risk.</li> <li>All pregnant women under 25 years of age and older women if at increased risk.</li> <li>High Risk include women and men with multiple partners, exchanging sex for payment, illicit drug use and history of STDs like HIV.</li> <li>Retest 3 months after treatment (test for cure).</li> </ol>	<ul style="list-style-type: none"> <li>A definitive diagnosis of chancroid requires the identification of <i>H. ducreyi</i> on special culture media that is not widely available from commercial sources; even when these media are used, sensitivity is &lt;80%. Testing can be performed by clinical laboratories that have developed their own PCR test and have conducted CLIA verification studies in genital specimens</li> <li>A Nucleic Amplification Assay Test (NAAT) or a wet-mount microscopy can be used to detect <i>T. vaginalis</i> infections.</li> </ul>
Painless sores on genitalia. Generalized body rash, especially on hands and feet.	<ul style="list-style-type: none"> <li>Primary, Secondary, or Early Latent Syphilis &lt;1 year</li> </ul>	<ol style="list-style-type: none"> <li>All pregnant women at the first prenatal visit. Retest early in the third trimester and at delivery if at high risk.</li> <li>All women and men engaging in high risk behavior such as multiple sex partners, exchanging sex for drugs and money, illicit drug use and a history of STD's including HIV.</li> </ol>	<ul style="list-style-type: none"> <li>A presumptive diagnosis of syphilis requires use of two tests: a nontreponemal test (ie, Venereal Disease Research Laboratory [VDRL] or Rapid Plasma Reagin [RPR]) and a treponemal test (ie, fluorescent treponemal antibody absorbed [FTA-ABS] tests, the T. pallidum passive particle agglutination [TP-PA] assay, various enzyme immunoassays [EIAs], chemiluminescence immunoassays, immunoblots, or rapid treponemal assays).</li> </ul>



### Some Reportable STDs in New Jersey (continued)

First Symptom Appearance Range	If Not treated, This Could Happen	CDC 2015 Treatment Guidelines <sup>8</sup> - Recommended RX
<ul style="list-style-type: none"> <li>▪ 2 to 6 days</li> <li>▪ 1 to 3 weeks</li> </ul>	<ul style="list-style-type: none"> <li>▪ Arthritis, blindness, sterility, prostate problems in men, pelvic inflammatory disease (PID) in women, pneumonia or blindness in newborns.</li> <li>▪ Sterility, testicular problems in men, PID in women, eye damage in newborns.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ceftriaxone 250 mg IM in a single dose and Azithromycin 1 gram orally in a single dose</li> <li>▪ Azithromycin 1 gram orally in a single dose or Doxycycline 100 mg orally 2x/day for 7 days</li> </ul>
<ul style="list-style-type: none"> <li>▪ 2 to 6 days</li> <li>▪ 4 to 28 days</li> </ul>	<ul style="list-style-type: none"> <li>▪ Scarring. Other germs may infect open sore.</li> <li>▪ Painful intercourse. Damage to female sex organs.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Azithromycin 1 gram orally in a single dose</li> <li>▪ Metronidazole 2 grams orally in a single dose</li> </ul>
<ul style="list-style-type: none"> <li>▪ 10 to 90 days</li> </ul>	<ul style="list-style-type: none"> <li>▪ Stillbirth or serious damage to newborns. Blindness, insanity, nerve damage, heart damage, death.</li> </ul>	<ul style="list-style-type: none"> <li>▪ 2.4 million units Benzathine Penicillin G (Bicillin) IM in a single dose. Latent Syphilis (&gt;1 year or unknown duration) 2.4 million units Benzathine Penicillin G (Bicillin) x 3 doses at 1 week interval</li> </ul>

**Resources** - Table based on the CDC 2015 Treatment Guidelines — <https://www.cdc.gov/std/tg2015/default.htm>, <https://www.cdc.gov/std/tg2015/tg-2015-print.pdf>, <https://www.cdc.gov/std/tg2015/screening-recommendations.htm>

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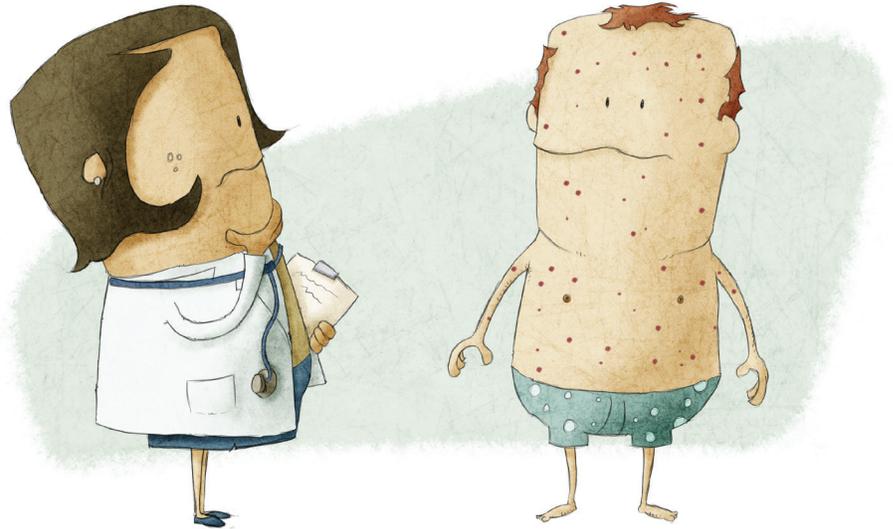
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# HIV/STD Partner Services in New Jersey

Francesca Esposito-Weir, MPH – NJDOH HIV/STD Partner Services.

The Centers for Disease Control and Prevention (CDC), defines Partner Services (PS) as a comprehensive approach to offering services to persons with HIV infection, syphilis, gonorrhea, or chlamydial infection and their partners. A critical function of partner services is partner notification, a process through which infected persons are interviewed to elicit information about their partners, who can then be confidentially notified of their possible exposure or potential risk. Other functions of partner services include prevention counseling, testing for HIV, and other types of STDs (not necessarily limited to syphilis, gonorrhea, and chlamydial infection), hepatitis screening and vaccination, treatment or linkage to medical care, linkage or referral to other prevention services, and linkage or referral to other services (eg, reproductive health services, prenatal care, substance abuse treatment, social support, housing assistance, legal services, and mental health services).<sup>1</sup>

Over the past several years, the Department of Health, Division of HIV, STD, and TB services began developing plans to integrate the STD and HIV Programs. To better serve communities, Partner Services seeks to reduce duplication, using valuable resources and incorporating new technologies like social media and rapid testing. Partner Services provides education, support and provides clients information on a variety of both medical and community services throughout the state. The newly merged STD-HIV Partner Services was officially launched in January 2017.



## GOALS FOR PARTNER SERVICES

The overall goal of partner services in New Jersey is to reduce the burden of HIV and STDs in communities as rates of disease increase nationwide. Partner Services reaches out to infected or exposed individuals seeking to provide linkages to care and treatment, disease education, partner solicitation and notification, and referrals to support services in their community.

Partner services are offered to individuals who are infected with STDs, to their partners, and to others who are at increased risk for infection to prevent transmission of these diseases and to reduce suffering from complications. We tailor our services to meet the needs of the patient and their partner. DIS are skilled in motivational interviewing and provide clients risk reduction strategies to reduce the risk of transmission or improve disease management.

We strive to collaborate with local STD programs, federally qualified health centers, and community based organizations to:

- Provide all HIV and priority STD infected persons with support

to ensure that their partners are confidentially informed of their exposure

- Maximize early linkage of infected persons and their partners to medical care, treatment, and/or interventions to reduce the risk of continued transmission like PrEP
- Maximize linkage to other support services that promote the overall health of individuals including prenatal care, mental health services, and medical care
- Maximize the proportion of partners who are notified of their exposure
- Reduce rates of transmission by facilitating early diagnosis, treatment and provision of health prevention services to infected persons and their partners

## PUBLIC HEALTH REPRESENTATIVE FIELD ACTIVITIES

New Jersey Department of Health public health representatives go through extensive CDC training to be a disease intervention specialist (DIS). Disease intervention specialists are public health workers who are responsible for



that are infected for appropriate treatment and follow up with local STD clinics. High priority field investigations focus on reaching those that are most vulnerable and at risk due to high risk behaviors.

## SOME TARGETED GROUPS

- Pregnant women
- Male index patients known to have pregnant female partners
- Index patients suspected of (or known to be) engaging in behaviors that significantly increase the risk for transmission to multiple other persons
- Men who have sex with other men (MSM)
- Persons co-infected with HIV and one or more other STDs
- Persons with recurrent STDs

programs to reduce the rates of sexually transmitted diseases in communities. ❖

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2. Program Operations Guide – Guidelines to STD Prevention, <https://www.cdc.gov/std/program/partners.pdf> Page Accessed: 08/17/17. Page last updated: 04/12/16.

locating infected or at risk individuals, interviewing and initiating partner solicitation, confirming adequate treatment is completed and educating the patient about preventing future exposure to sexually transmitted diseases. DIS can also offer rapid HIV testing to clients in the field and provide appropriate referrals. Partner Services receives patient referrals from private providers, public health and commercial laboratories, and counseling and testing programs. PS works with providers to re-engage patients that have been lost to care, patients who do not return for confirmatory testing, and to direct individuals that either may have been exposed to an STD or individuals

STD and HIV Partner Services works closely with both department and division counterparts, HIV Prevention and HIV Care & Treatment, to promote collaboration and service integration to ensure that effective linkages are made to programs to address care for pregnant women, co-infected HIV clients, primary, secondary and congenital syphilis. NJDOH strives to improve access to care and work with our local health departments and community based



## Viral Suppression Goal

Viral suppression is the goal of HIV medical care. There are four key steps:

- Step 1: HIV testing and diagnosis.**
  - About 14% of people living with HIV have never been diagnosed.
  - Everyone needs to be tested to find out if they have HIV so they can start getting the medical care needed for viral suppression and reduce their risk of transmitting the virus to others.
- Step 2: Getting and keeping people living with HIV in medical care.**
  - Only 40% of people living with HIV have received regular HIV medical care.
  - Once in medical care, people can get HIV medicines and prevention services to help them stay healthy and protect their partners.
  - Doctors, nurses, and other health care providers can use strategies, such as appointment reminders, to help patients stay in care.
- Step 3: Prescribing HIV medicines.**
  - Only 37% of people living with HIV are prescribed HIV medicines. Too many have not been diagnosed or are not in HIV medical care.
  - However, of patients in HIV medical care, 92% are prescribed HIV medicines.
  - Doctors, nurses, and other health care providers should prescribe HIV medicines to everyone with HIV to lower the amount of virus in the body.
- Step 4: Helping patients achieve viral suppression.**
  - Only 30% of all people living with HIV have achieved viral suppression. Too many have not been diagnosed, are not in medical care, or are not taking HIV medicines.
  - However, of patients in HIV medical care, 76% achieve viral suppression.
  - Doctors, nurses, and other health care providers play an important role in helping their patients start and stay on HIV medicines.

## NEED TO TALK RIGHT NOW? NJ AIDS/HIV/STD HOTLINE 1-800-624-2377

The NJ AIDS/HIV/STD hotline is staffed 24 hours a day, 365 days a year. Help is available via phone, text message, or live chat.

Visit us at <http://www.nj.gov/health/hivstdtb/contact.shtml>





# CONGENITAL SYPHILIS: What Providers Need to Know

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## CONGENITAL SYPHILIS IS ON THE RISE

Although national rates of congenital syphilis declined steadily by 25% between 2008 and 2012, this trend has reversed with an increase of 35% between 2012 and 2015, a rate now that is higher than it was 15 years ago.<sup>1,2</sup> Perhaps not surprisingly, these trends parallel those of primary and secondary syphilis among women. Increases in congenital syphilis have been observed across all racial/ethnic groups, with the highest increases seen in black populations.<sup>1</sup> Among women, primary and secondary syphilis cases decreased by 35% between 2008 and 2012 and increased by 58% from 2012 to 2015.<sup>2</sup>

Though the timing lags that of the nation overall, these trends are reflected in New Jersey (NJ). Between 2008 and 2012, cases of congenital syphilis decreased by 75%, and in the period of 2013-2015, there were zero cases of congenital syphilis reported in NJ. This was followed by an increase to 12 cases in 2016. Primary and secondary syphilis cases among females

in NJ decreased by 9.5% between 2008 and 2012 and increased by 37% between 2012 and 2015.<sup>2</sup>

To reduce Sexually Transmitted Diseases (STDs) and prevent pregnant women from passing syphilis on to their newborns, the New Jersey Department of Health and key partners launched the “Protect Your Baby from Syphilis” awareness campaign this fall to educate pregnant women, their partners and doctors about the importance of getting tested and treated for syphilis. The campaign includes a new prevention webpage, ([http://www.nj.gov/health/hivstdtb/stds/congenital\\_syphilis.shtml](http://www.nj.gov/health/hivstdtb/stds/congenital_syphilis.shtml)<sup>3</sup>) downloadable congenital syphilis prevention posters in English, Spanish, Haitian Creole, Portuguese, Bengali and Arabic, social media using #teSTD4baby, bus and corner store advertising, and journal publications. Campaign materials have been shared with county and local health departments, hospitals, community health centers, WIC offices, college campuses, Family Success Centers, county welfare offices and

boards of social services, public housing authorities, child care centers, the New Jersey Poison Information and Education System (NJPIES), faith-based groups and community health workers, who are attending a training in September focused on STDs and congenital syphilis.

Because physicians play a key role in preventing congenital syphilis, eight medical and family health groups joined Health Commissioner Cathleen Bennett in co-signing a letter to health care providers promoting the campaign. Providers were asked to post a link to [http://www.nj.gov/health/hivstdtb/stds/congenital\\_syphilis.shtml](http://www.nj.gov/health/hivstdtb/stds/congenital_syphilis.shtml)<sup>3</sup>, share the prevention message and display copies of the congenital syphilis poster in clinics, medical offices, health care facility lobbies, client waiting rooms, and other high traffic areas. Providers were also asked to promote the campaign on social media using the hashtag #teSTD4baby and to follow the Department on Twitter @njdeptofhealth, Facebook /njdeptofhealth, Instagram @njdeptofhealth and Snapchat @njdoh.

The campaign was developed based on input from a focus group of community health workers and an internal Department task force that met over the summer. The letter was signed by Commissioner Bennett and includes the endorsement of the New Jersey Hospital Association; the state chapters of the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists (ACOG), and the Academy of Family Physicians; the New Jersey Primary Care Association; and the Maternal and Child Health Consortia: the Central Jersey Family Health Consortium, the Partnership for Maternal and Child Health of Northern NJ, and the Southern Jersey Perinatal Cooperative.

The "Protect Your Baby From Syphilis" public awareness campaign is the third STD public awareness campaign the Department has launched this year. "Get #TeSTD" drew attention to the fact that one in two sexually active young people will get an STD by age 25. Posters were shared with colleges and universities, local health departments, and on social media (Twitter, Facebook, Instagram) where young people spend a lot of time. The posters are available to download on the Department's website. In addition, an STD awareness campaign called #Never2old

([http://nj.gov/health/hivstdtb/stds/senior\\_std\\_posters.shtml](http://nj.gov/health/hivstdtb/stds/senior_std_posters.shtml)<sup>3</sup>) targeted seniors and was shared with senior centers.

Most pregnancies in NJ are unplanned<sup>4</sup> and therefore the prevention, detection and treatment of syphilis in women of reproductive age is a key component in the prevention of congenital syphilis. Some recent cases of congenital syphilis in NJ occurred in women who were infected later in pregnancy and were not tested until delivery or shortly before.

Syphilis in pregnancy can lead to significant health problems. Up to 40% of pregnancies in women with untreated syphilis will result in miscarriage, stillbirth, or infant death.<sup>5</sup> Infants born with syphilis can develop severe medical conditions including skeletal abnormalities, anemia, blindness, deafness, meningitis and developmental delays.<sup>5</sup> NJ providers are in an advantageous position to prevent congenital syphilis by applying proven practices of sexual health and sexually transmitted disease (STD) prevention and treatment to pregnant women and all women of childbearing age.



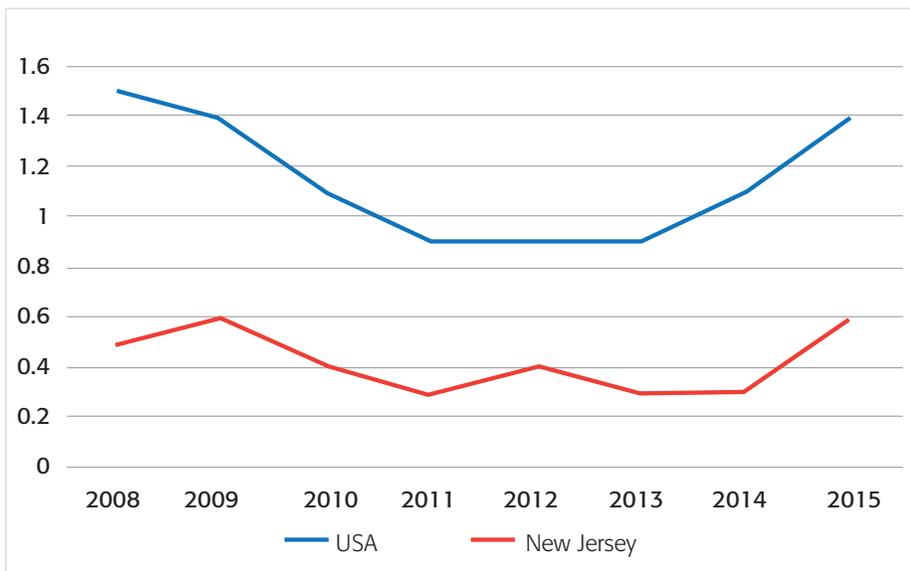
## WHAT HEALTH CARE PROVIDERS CAN DO

**Screen all pregnant women for syphilis in the first and third trimesters.** All pregnant women should be tested for syphilis at their first prenatal visit. Some women may be in the asymptomatic stage of syphilis, but they can still spread the infection to their unborn babies.

The Centers for Disease Control and Prevention (CDC) and ACOG recommend that women at increased risk also be rescreened early in their third trimester and again at delivery. This includes women with a history of syphilis infection, incarceration, drug use, multiple or concurrent partners, and those who live in areas with higher rates of syphilis.<sup>6</sup> Given the overall sharp increase in syphilis cases in NJ, the Department of Health recommends that providers consider re-screening all pregnant women early in the third trimester and at the time of delivery.

**Treat patients infected with syphilis immediately.** If a woman is diagnosed with syphilis, immediate treatment is essential. Proper diagnosis and staging of syphilis is crucial as pregnant women should be treated with the regimen appropriate to their stage of infection. Penicillin G is the only known effective medication for syphilis in pregnant women. No proven alternatives are available. Thus, pregnant women with an allergy to penicillin should be desensitized and treated. Pregnant women receiving three doses of penicillin must complete the course. If any dose is missed, the patient must restart the entire course of

## Primary and Secondary Syphilis Rates: 2008-2015



*continued on page 10*

# CONGENITAL SYPHILIS: What Providers Need to Know *continued*

treatment. Treatment at least 30 days prior to delivery is likely to prevent congenital syphilis. See CDC's 2015 STD Treatment Guidelines for more information.<sup>7</sup>

## Screen all sex partners for syphilis.

To prevent reinfection, the woman's sex partner(s) should also be tested and treated. Be sure that patients understand the risks of reinfection and encourage them to tell all partners about the infection and provide resources for testing. Patients should also be informed of the possibility that they will be contacted by a representative of the Department for follow-up and partner management, and encourage cooperation with this assistance. Screening for interpersonal violence/domestic violence risk is important as part of this process as well since some women may be at further risk of violence with partner notification.

## Talk to patients about their sexual health and history.

Do not make assumptions about patient risk factors. Remember that practices of STD prevention apply to pregnant women as well. Take a sexual history throughout the course of a woman's pregnancy. While many women and providers may be uncomfortable at first, these conversations create important opportunities for assessment of risk and identification of appropriate screenings, and opens the door for risk-reduction counseling and education. See CDC's Guide to Taking a Sexual History for more information and guidance.<sup>6</sup>

**Immediately report all cases of syphilis and congenital syphilis to the NJDOH, STD Program.** In NJ, all healthcare providers are required to report all cases of reportable STDs, including syphilis, within 24 hours.<sup>9</sup> Once reported, a NJDOH Disease Intervention Specialist (DIS) can investigate cases and provide partner services to help patients and partners get tested and treated to stop the spread of infection

and prevent congenital syphilis. Providing any information requested by DIS who contact your office will be beneficial to aid in the investigation. Information about the requirements and processes for reporting STDs in NJ can be found at <http://www.nj.gov/health/hivstdtb/stds/>.<sup>10</sup>

## Follow-up throughout prenatal care and at delivery.

If a woman is diagnosed with syphilis, serologic titers should be repeated throughout pregnancy and at delivery. Successful prevention of congenital syphilis is unlikely if delivery occurs less than 30 days after treatment.<sup>7</sup> Before discharging the mother or newborn from the hospital, verify that the mother has been tested for syphilis at least once during pregnancy or at the time of delivery, and that any appropriate treatment has occurred.<sup>6</sup> Pregnant women who present to the hospital for delivery who have no documented history of prenatal care should be tested for syphilis immediately. If treatment is given at the time of delivery or less than 30 days prior, evaluate and manage the infant according to the CDC 2015 STD Treatment Guidelines for congenital syphilis.<sup>7</sup> Evaluation and management of both the mother and infant should be a collaborative effort between the prenatal provider, delivering physician, infectious disease and pediatric specialists.

## Collaborate with health departments and community agencies.

Report all cases of syphilis immediately to the NJDOH. Work with your local health departments, maternal-child community health agencies, local health clinics and other support agencies to reduce barriers to accessing prenatal care for pregnant women, and sexual health care for all populations.

## Congenital syphilis is preventable.

Healthcare providers are uniquely positioned with direct access to patients. No opportunity should be missed to help patients receive the education, support and medical screening and treatments

they need to prevent congenital syphilis and other syphilis morbidities. ❖

## HELPFUL RESOURCES

- CDC 2015 STD Treatment Guidelines: <https://www.cdc.gov/std/tg2015/default.htm>
- CDC Guide to Taking a Sexual History: <https://www.cdc.gov/std/treatment/sexualhistory.pdf>
- CDC Call to Action: Congenital Syphilis: <https://www.cdc.gov/std/syphilis/syphiliscalltoactionapril2017.pdf>

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# People Living with HIV (PLWH) Need Health Care Coverage

*continued from page 1*

program is called the Health Insurance Premium Payment (HIPP) program. The Department of Health administers this program. The program, however, is optional for the patient. There are other benefits that your patients may be eligible for, such as coverage through Medicaid, Medicare, CHIP, and other state-funded programs.

These are third party payers. Because RWB funds are finite, RWB is considered payer of last resort and can only be used after all these options are exhausted. The federal government mandates that we vigorously pursue these benefits first and enroll patients in them. Enrollment in health care coverage can be completed through Medical Case Managers in any one of the many clinics that the Department of Health funds to provide HIV care services.

## WHO ARE THE INSURERS IN NJ?

There are three health insurance companies in the NJ Marketplace. Horizon Blue Cross and Blue Shield, AmeriHealth, and returning in 2018 is Oscar Health. Oscar is planning a 2018 return to New Jersey and will serve 14 counties: Essex, Hudson, Union, Bergen, Passaic, Monmouth, Morris, Sussex, Warren, Middlesex, Somerset, Hunterdon, Mercer and Ocean.

Is insurance affordability a concern for patients who opt out of HIPP or are non-Ryan White patients? Marketplaces are here to make health insurance more affordable. There are Certified Applications Counselors throughout New Jersey to help people access quality, affordable coverage. The Marketplace also provides financial assistance for people with low and middle incomes in the form of advanced tax credits that can lower monthly premiums and lower out-of-pocket costs.

Advanced Premium Tax Credits (APTC) are available to Marketplace applicants based on reported income when the person completes an application through

[HealthCare.gov](http://HealthCare.gov). Eligible income levels are 138% to 400% of the federal poverty level. The APTC will be automatically generated through the application process. Additionally, patients whose income is 135% to 250% of FPL may be eligible for cost sharing benefits. Cost sharing is a discount that lowers the amount your patient must pay for deductibles, copayments, and coinsurance. In the Health Insurance Marketplace, cost-sharing reductions are often called “extra savings”. Cost sharing benefits will also be automatically assessed during the application process.

We believe essential health benefits are vital to ensure that HIV positive patients receive coordinated care. Therefore, New Jersey funds HIV clinics that receive referrals on demand. Your patients will be linked to medical care within the same or next business day.

The 2017 Open Enrollment period is shortened this year and will run from November 1, 2017 to December 15, 2017. We ask that every effort be made to enroll as many eligible patients as possible. The Health Insurance Premium Payment program (HIPP) will support silver marketplace plans with prescription coverage that meet the HIV consumer’s needs. DOH prefers plans that provide 70% to 80% of the cost of coverage. The selected plan must include at least one drug in each class of core antiretroviral therapeutics from the Health and Human Service Clinical Guidelines for the Treatment of HIV/AIDS, as well as appropriate primary care services. As stated above, patients can access the HIPP program through their Medical Case Manager.

HIPP eligibility requires the applicant to be active in the AIDS Drug Distribution Program (ADDP). This will ensure that all Ryan White eligibility standards are met regarding diagnosis, residence and income.

Individuals with household incomes of 139% to 500% of the Federal Poverty Level (FPL) are eligible for HIPP. Applicants falling between 139% and 400% of the FPL must apply for an Advance Tax Credit and have 100% of that credit applied to their monthly premium. The Advance Tax Credit is determined by the applicant’s projection of annual income that must be adjusted on their tax return. Overstating or understating income may result in a tax refund or tax liability; either way the HIPP tax reconciliation policy must be followed by the Medical Case Manager. In addition, applicants with FPL of 401 – 500% are eligible for out-of-market Silver Plans through private vendors. The premium cost may not exceed \$900 per month. Clients with a household income of 0 – 138% of FPL are eligible for Medicaid Expansion.

Medical Case Managers also help refer those patients to NJFamilyCare, which administers the Medicaid program for the state. A downloadable online application can be found at [http://www.njfamilycare.org/need\\_help.aspx](http://www.njfamilycare.org/need_help.aspx) along with a list of Medicaid Assistants. ❖

## ADDITIONAL HELPFUL RESOURCES INCLUDE:

- <https://careacttarget.org/ace>
- <https://careacttarget.org/library/planning-ahead-open-enrollment-whats-new-2018>
- <https://marketplace.cms.gov/>
- [http://www.investopedia.com/terms/h/health-insurance-marketplace.asp?optly\\_redirect=integrated&gl=my-%20finance-dynamic-tags](http://www.investopedia.com/terms/h/health-insurance-marketplace.asp?optly_redirect=integrated&gl=my-%20finance-dynamic-tags)
- <https://www.hemophilia.org/sites/default/files/document/files/Toolkit-Health-Insurance-Marketplace-Exchange-An-Overview.pdf>
- <https://www.nastad.org/webinars/preparing-2018-insurance-plan-year>

# Antiretroviral Therapy for Primary Care Providers

Jihad Slim, MD

## INTRODUCTION:

People living with HIV (PLWH) are living longer, mainly as a result of starting on antiretroviral therapy (ART) as soon as possible after diagnosis with improved antiretroviral regimens. These improved regimens support greater adherence as a result of decreased pill burden, frequency of administration, and less side effects.

With increased longevity and improved immune system, PLWH are facing multiple comorbidities that are expected with aging, even though they are more prevalent in this cohort, namely diabetes mellitus, hyperlipidemia, cardiovascular disorders, and various cancers.

This paper will summarize the recommendations of the US Department of Health and Human Services on antiretroviral guidelines for adults and adolescents with HIV infection.<sup>1</sup> The emphasis would be on what primary care providers (PCP) will need to know regarding ART when caring for PLWH.

## TREATMENT GOALS:

Long-term suppression of HIV viremia, prevents the selection of drug-resistance mutants, improves the immune system,<sup>2</sup> prevents many comorbid conditions, and decrease the risk of transmission.<sup>3</sup>

The SMART trial has established that treatment interruption is associated with increased morbidity and mortality.<sup>4</sup> Thus, treatment interruption should be discouraged and prevented as best of possible. Once ART is initiated, it should be continued until a cure is available.

After initiation of ART, one should expect an undetectable viral load (VL) usually after 12 weeks of therapy.

## WHEN TO START THERAPY?

ART is recommended for all HIV-infected individuals, to reduce morbidity and mortality associated with this infection, and to prevent HIV transmission.

While ART is recommended for all PLWH, the following conditions increase the urgency to initiate therapy: pregnancy; AIDS-defining conditions, like HIV-associated dementia and AIDS-associated malignancies; certain acute opportunistic infections (especially those with no adequate therapeutic options); a CD4 count <200 cells/mm<sup>3</sup>, HIV-associated nephropathy, acute HIV infection, and co-infection with hepatitis B or C virus (HBV or HCV).

## WHAT TO START WITH?

There are currently more than 25 antiretroviral drugs, in 6 different mechanistic classes that are FDA-approved for treatment of HIV infection.

These 6 classes include the nucleoside/nucleotide reverse transcriptase inhibitors (NRTIs), non-nucleoside reverse transcriptase inhibitors (NNRTIs), protease inhibitors (PIs), a fusion inhibitor (FI), a CCR5 antagonist, and integrase strand transfer inhibitors (INSTIs). In addition, two drugs, ritonavir (r) and cobicistat (c) are used only as pharmacokinetic (PK) enhancers to improve the activity of some ARV drugs (eg, PIs and the INSTI elvitegravir [EVG]).

The initial ARV regimen for a treatment naïve patient generally consists of two NRTIs, usually abacavir/lamivudine (ABC/3TC), tenofovir alafenamide/emtricitabine (TAF/FTC), or tenofovir disoproxil fumarate/emtricitabine (TDF/FTC), plus a drug from one of three drug classes: an INSTI, an NNRTI, or a PK-enhanced PI.

Considerations regarding the 2 NRTIs chosen for the recommended regimen are TAF/FTC versus TDF/FTC, it is noted that TAF is included in several recommended regimens based on data from comparative trials demonstrating that TAF-containing regimens are as effective in achieving or maintaining virologic suppression as TDF-containing regimens, but with more favorable effects on markers of renal and bone health. In these studies, participants randomized to receive TDF had more favorable lipid profiles than those who received TAF.<sup>5,6</sup> The main advantages of TAF and TDF over ABC are their activity against hepatitis B virus and the fact that HLA-B\*5701 testing is not required prior to their use. ABC has been linked to cardiovascular events in some,<sup>7</sup> but not all, observational studies. There have been no head-to-head studies comparing ABC and TAF to date.



The third agent on the recommended regimens include an INSTI or PI (DRV/r) (see Table 1); the choices containing RAL or DTG will have no significant CYP 3A4-associated drug-drug interactions (DDI). In addition, in several head-to-head comparisons between boosted PI- and INSTI-containing regimens, the INSTI was better tolerated with fewer treatment

discontinuations.<sup>8,9</sup> That is the rationale for including all 3 available INSTIs among the recommended regimens and, in general, an INSTI-containing regimen should be selected for most patients. An exception is in those individuals with uncertain adherence or in whom treatment needs to begin before resistance testing results are available (eg, during acute HIV infection, pregnancy, in the setting of certain opportunistic infections). In this context, DRV/r may have an important role given the low rate of transmitted PI resistance, its high genetic barrier to resistance, and possibly less potential for immune reconstitution inflammatory syndrome (IRIS) in patients starting out with a very low CD4 count (eg, <50 cells/mm<sup>3</sup>).

**Table 1: Recommended Regimen Options**

Single-Tablet Regimen (INSTI)	Multiple-Tablet Regimen (INSTI)
DTG/ABC/3TC (if HLA-B*5701 negative)	DTG plus TDF/FTC
EVG/c/TAF/FTC	DTG plus TAF/FTC
EVG/c/TDF/FTC if eGFR>70ml/min	RAL plus TDF/FTC
	RAL plus TAF/FTC
Boosted PI	
DRV/r plus either TDF/FTC or TAF/FTC	

## MANAGEMENT OF DRUG EXPERIENCED PATIENTS:

Patients on ART for more than 24 weeks should have an undetectable VL, and that is the best way to avoid emergence of drug-resistant mutations.<sup>10</sup> A “blip”, defined by viral suppression followed by an isolated detectable VL, and a subsequent return to undetectable VLs, is usually not associated with selection of resistant mutants. There is controversy regarding the clinical implications of persistently detectable VLs of <200 copies/mL in patients on ART.<sup>11,12</sup> In contrast, persistent VLs ≥200 copies/mL are often associated with evidence of drug-resistance mutations,<sup>13</sup> and is considered a virologic failure (VF).

Reasons for VF are usually divided into categories, patient-related, or regimen-related (see Table 2). The management will vary depending on the etiology. Often

a resistance testing will be done, and if a change in regimen is required, the use of at least 2 (preferably 3) fully active drugs, while keeping a low pill burden, is ideal.

**Table 2: Reasons for Virologic Failure**

Patient-Related	ART-Related
High pretreatment VL	Drug adverse effects
Low pretreatment CD4 count	Suboptimal pharmacokinetics (variable absorption, or metabolism)
Presence of HIV resistance	Suboptimal virologic potency
Presence of neurocognitive deficit	Decreased drug levels through DDI, or food requirement.
Interruption of or intermittent access to ART	High pill burden and/or dosing frequency
Psychiatric disease	Prescription errors
Active substance use	Cost and affordability of ARVs

## DRUG CHARACTERISTICS:

All ART regimens may cause IRIS, and have the potential for abnormal fat distribution. However, below are the main characteristics of the drugs, and their class, that a primary care provider needs to be familiar with when taking care of PLWH.

1. **NRTI Characteristics:** They all carry a black box warning for lactic acidosis, probably related to their inhibition of mitochondrial DNA replication; it is more likely to occur with the use of old generation NRTIs, namely didanosine (ddI), stavudine (D4T), and zidovudine (AZT). Although these 3 NRTIs are rarely used in the US now, here are their most common dose-dependent toxicities: for ddI it is pancreatitis, for D4T peripheral neuropathy, and for AZT bone marrow suppression. The 5 most commonly used NRTIs are usually combined in pairs as ABC/3TC, TDF/FTC, or TAF/FTC. ABC is the only one that is mainly liver metabolized, and its major side effect is a hypersensitivity reaction (HSR) seen mainly in patients who test positive for HLA-B5701. Symptoms of HSR may include fever, rash, nausea, vomiting, diarrhea, abdominal pain, malaise, fatigue, or respiratory symptoms such as sore throat, cough, or shortness of breath. Usually patients develop a combination of those symptoms

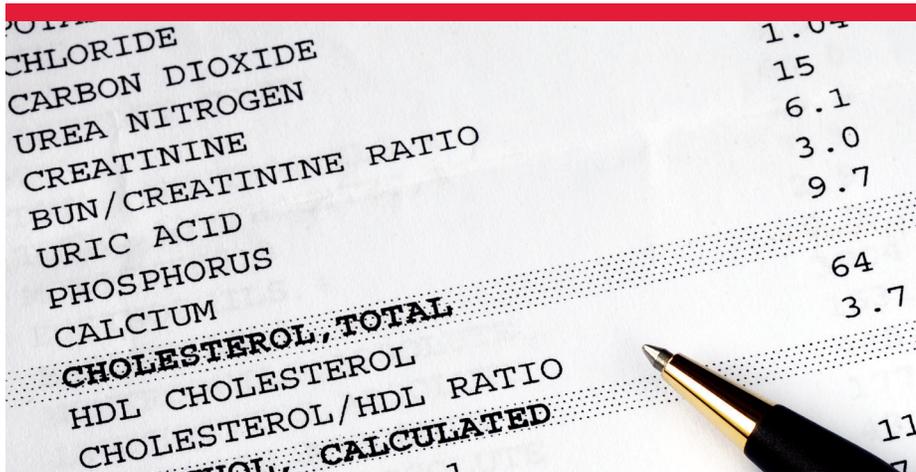
starting a week or so from exposure to ABC and worsening as patients continue taking their regimen. Patients will start feeling progressively better after they stop ABC containing regimen, and they should never be rechallenged because they could develop severe hypotension and shock. Tenofovir on the other hand can cause renal insufficiency, Fanconi syndrome, or proximal renal tubulopathy, as well as osteomalacia, and decrease in bone mineral density which may be dose dependent and are seen less often when TAF is used. Another important point related to TDF/FTC and TAF/FTC in patients co-infected with HBV; if ART is to be discontinued for some reason one needs to watch for an acute flare up of HBV.

2. **NNRTI Characteristics:** As a class they may cause a rash. This rash is usually benign and resolves with continuation of therapy, but in certain cases may lead to a severe rash that can be life-threatening. May also cause hepatitis in the first few weeks of exposure.

**Efavirenz (EFV)** has been linked to neuropsychiatric symptoms, dizziness, and vivid dreams. Although there were initial concerns about potential teratogenicity with EFV, further study has shown that the risks of teratogenicity (specifically, neural tube defects) after first trimester EFV exposure are not greater than those in the general population. HHS guidelines place no restriction on EFV use before 8 weeks gestation.<sup>14</sup>

**Nevirapine (NVP)** is rarely used in the US due to the severe rash, including Stevens-Johnson syndrome, and symptomatic hepatitis, including fatal hepatic necrosis, that occurs at significantly higher frequency in ART-naïve female patients with pre-NVP CD4 counts >250 cells/mm<sup>3</sup> and in ARV-naïve male patients with pre-NVP CD4 counts >400 cells/mm<sup>3</sup>.

*continued on page 14*



**Etravirine (ETR)** is mainly used in drug experienced patients, and one should pay attention to its DDI potential, it is a CYP3A4 inducer, and 2C19 inhibitor.

**Rilpivirine (RPV)** requires food for adequate absorption and it is also pH-dependent, so it should not be used with proton pump inhibitors.

- PI Characteristics:** They all could cause abnormal bleeds in hemophiliacs, and potentially cause hyperlipidemia, and insulin resistance. Some have been linked with increased risk of cardiovascular disorder (CVD). Since DRV is now the most commonly used in this class, the following highlight only the most important adverse events linked to each of the other PIs. Nelfinavir mainly diarrhea, and the lowest genetic barrier in the class; indinavir nephrolithiasis, lopinavir diarrhea, and cumulative use linked to increased CVD; fosamprenavir skin rash, diarrhea, nausea, and vomiting; tipranavir hepatitis (including hepatic decompensation); and, atazanavir indirect hyperbilirubinemia, and sometimes nephrolithiasis. DRV needs a “booster” to achieve therapeutic levels, it is always used with ritonavir or cobicistat, as 800 mg once a day in patients with no DRV mutations, or 600 mg twice a day in those who are treatment experienced with one or more DRV mutations. It is usually well tolerated, although skin rash can

happen up to 10% (Stevens-Johnson syndrome, toxic epidermal necrolysis, acute generalized exanthematous pustulosis, and erythema multiforme have been reported), hepatotoxicity can occur as well as diarrhea, and nausea. An increase in creatinine due to its decrease in tubular secretion can be observed when boosted with cobicistat. This happens in the first 2 weeks of exposure and can be as high as 0.4mg/dl.

- INSTI Characteristics:** They are generally well tolerated, but they may cause an increase in CPK, and their absorption is compromised by short acting antacids. There are 3 available agents: raltegravir (RAL) the first approved, and possibly the one with the least DDI; elvitegravir (EVG) the only one that requires boosting; and, dolutegravir (DTG) with a higher genetic barrier than the first two, it also decreases tubular secretion of creatinine and may increase creatinine in the first 2 weeks of therapy.

- Fusion Inhibitor Characteristics:** **Enfuvirtide (T20)** is the only agent in this class. It is used as a subcutaneous injection twice a day, and may cause local injection site reactions with pain, erythema, and nodule formation in almost all patients. These nodules can be confused with abscess formation, except they have no fluctuance, and neither antibiotics nor incision and drainage should be used.

- CCR5 Antagonist Characteristics:** **Maraviroc (MVC)** is the only agent in this class for now. It is well tolerated, but watch for orthostatic hypotension especially in patients with severe renal insufficiency.

## CONCLUSION:

This paper summarizes some of the important features of current ART, mainly to remember that all PLWH should be on therapy generally, and once on treatment for more than 24 weeks, their VL should be undetectable. The other important take-away message is that DDIs are very important and common with ART, so looking up a reliable source for DDI anytime a new medication is being prescribed is of utmost importance. Finally, it is important to recognize some unusual side effects from certain ART, like an increased creatinine in the first 2 weeks of starting a DTG or cobicistat containing regimen, an increased bilirubin after starting ATV, or orthostatic hypotension while on MVC ❖

## UNDETECTABLE = UNTRANSMITTABLE (U=U)

On September 27, 2017, CDC released a *Dear Colleague letter* stating that “scientific advances have shown that antiretroviral therapy (ART) preserves the health of people living with HIV. We also have strong evidence of the prevention effectiveness of ART. When ART results in viral suppression, defined as less than 200 copies/ml or undetectable levels, it prevents sexual HIV transmission. 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.”<sup>1</sup>

1. Dear Colleague, Information from CDC’s Division of HIV/AIDS Prevention, available online at <https://www.cdc.gov/hiv/library/dcl/dcl/092717.html>

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# ADDRESSING HIV-related Stigma in Primary Care

Ann D. Bagchi, PhD, DNP, APN – Rutgers School of Nursing



## Did you know?

- HIV-related stigma is a significant barrier to testing and treatment for HIV.
- Stigma is significantly associated with depression and anxiety among people living with HIV (PLWH).
- Among PLWH in New Jersey, two of the most significant fears are of being gossiped about and of having one's HIV status disclosed by another person without consent.

## STIGMA AND HIV

HIV-related stigma is a significant barrier to ending the HIV epidemic since it discourages people from accessing prevention and testing services, and prevents people living with HIV (PLWH) from engaging and remaining in care and adhering to treatment plans.<sup>1-4</sup> Stigma is also associated with a lower overall quality of life among PLWH and is a significant factor driving disparities in the incidence

and prevalence of HIV in the United States (US).<sup>5-7</sup> Even though the original National HIV/AIDS Strategy (NHAS) called for HIV-related care and services “free from stigma and discrimination” (p. vii),<sup>8</sup> stigma remains a persistent and intractable problem in achieving goals of eliminating HIV.

## NEW JERSEY'S PLWH STIGMA INDEX STUDY

The People Living with HIV Stigma Index (hereafter the “Stigma Index”) was developed by a consortium of international organizations following the Greater Involvement of People Living with HIV (GIPA) principle, which supports the active participation of PLWH in research and other activities that influence their health and well-being.<sup>9,10</sup> The Stigma Index serves two primary goals. First, it is a comprehensive data collection tool, designed to elicit information on participants' experiences with HIV-related stigma across a range of life experiences and domains. Second, it is an intervention which provides empathetic support to PLWH by training PLWH as interviewers and encourages HIV-related advocacy among study participants.<sup>10</sup>

With funding from the New Jersey Department of Health's Division of HIV, STD, and TB Services (DHSTS), Rutgers University's School of Nursing undertook a study to implement the Stigma Index through a 1% sample of PLWH from throughout New Jersey's 21 counties. Recent research and anecdotal reports suggest that health care subject PLWH to significant stigma, especially those working outside the Ryan White HIV/AIDS Program and its system of care.<sup>11,12</sup> However, based on the responses from the 326 participants in the New Jersey Stigma Index study,

the most common sources of HIV-related stigma are family and friends.<sup>13</sup> The most common examples of stigmatizing and discriminatory behaviors reported by study participants were being treated differently due to misperceptions about how HIV is transmitted (eg, being forced to eat off paper plates) and being the subject of gossip and involuntary disclosures of one's HIV status.<sup>13</sup>

## PRIMARY CARE PROVIDERS MAY UNWITTINGLY CONTRIBUTE TO HIV-RELATED STIGMA

Although New Jersey's Stigma Index study did not suggest extensive HIV-related stigma from health care providers, personnel may unwittingly contribute to stigma in many ways. Although relatively few participants in the Stigma Index study reported these behaviors, the following were the most commonly cited:

- Treating HIV as an illness unlike other chronic health conditions.
- Failing to protect patient confidentiality and disclosing one's HIV status unnecessarily.
- Making assumptions about how a patient contracted HIV (eg, being asked how many people they had slept with or what types of injection drugs they were using).
- Being referred to specialty providers for management of antiretroviral therapy (ART).
- Providers taking unnecessary precautions to prevent infection (eg, double gloving for non-invasive procedures).

## WHAT CAN PRIMARY CARE PROVIDERS DO?

There are a number of measures that primary care providers can undertake to help eliminate HIV-related stigma in their practices generally and, specifically, when interacting with PLWH.

- Implement routine HIV screening. This demonstrates to all patients that HIV is a chronic health condition that can be prevented and managed successfully with appropriate pharmacotherapy.
- Follow common HIPAA procedures and request a patient's permission to share their HIV status and do so only on a need-to-know basis.
- Do not make assumptions about how a patient may have contracted HIV. While it is appropriate to address on-going risk behaviors, discussions of modes of infection and transmission should be undertaken in the context of general health and wellness concerns.
- Look for opportunities to learn about the management of HIV. Many patients can now be treated with a single-pill regimen and most PLWH face the same ongoing health concerns as the majority of patients (eg, metabolic disorders, hypertension, and cardiac disease). It may be necessary to consult with an HIV specialist when initiating ART or to address complications related to HIV infection, but most patients can manage their HIV successfully with regular blood work and support from their primary care provider.

- Be mindful of the mental health needs of PLWH. As with anyone facing a chronic health condition, many PLWH experience depression and anxiety and need psychosocial support to remain adherent to treatment and to address disclosure concerns.
- Use universal precautions in all patient encounters. The majority of interactions in primary care settings do not involve exchange of bodily fluids that put health care providers at risk for infection, so extraordinary precautions are unnecessary.

## CONCLUSIONS

More than 30 years into the HIV epidemic, misconceptions and stigma remain significant barriers to prevention, testing, and engagement/retention in care. Stigma contributes significantly to the failure to eradicate HIV. Primary care providers serve as trusted role models; by demonstrating empathy and compassion they can ensure a more expansive and supportive system of care for all of those affected by HIV. By helping to address HIV-related stigma, primary care providers have a significant role to play in eliminating HIV in the US. ❖

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# Routine HIV Screening in Primary Care

*continued from page 1*



Attaining universal viral load suppression among people living with HIV (PLWH) would help to end the HIV epidemic since the rate of transmission for those who are virally suppressed is less than 1%.<sup>4-6</sup> However, attaining this goal requires a concerted effort to ensure that all PLWH are aware of their status and actively engaged and retained in care, including long-term adherence to antiretroviral therapy (ART).

## CDC RECOMMENDATIONS FOR ROUTINE HIV SCREENING

In 2006, the CDC released updated recommendations on HIV screening, which included the following:

- Opt-out HIV screening (ie, HIV testing is performed unless the patient declines) for patients aged 13 to 64 in all health care settings,
- Annual HIV screening for persons at high risk for infection,
- Elimination of separate written consent for HIV testing, and
- Elimination of prevention counseling when HIV screening is performed for purposes of diagnosis or as part of routine testing in health care settings.<sup>7</sup>

In 2013, the US Preventive Task Force (USPSTF) reaffirmed these recommendations with an “A” grade for all patients aged 15-64.<sup>8-10</sup> Ensuring that every PLWH is aware of his or her serostatus is the first step in the HIV care continuum, from testing and diagnosis to viral load suppression.<sup>11</sup> Based on the CDC’s recommendations, primary care sites are essential to achieving this goal.<sup>12</sup>

## BARRIERS TO ROUTINE HIV SCREENING IN PRIMARY CARE

A number of patient-level factors serve as barriers to routine HIV screening. Patients may lack awareness of HIV prevalence and may falsely perceive that they are not at risk for infection. HIV-related stigma also plays a role, with fear of discrimination and rejection by loved ones serving as an impediment to testing.<sup>13</sup> A recent review of the literature<sup>14</sup> identified 41 categories of provider-level barriers to routine HIV screening; the most commonly cited are summarized in Table 1.

**Table 1. Ten Common Provider Level Barriers to Routine HIV Screening<sup>14</sup>**

▪ Patients do not want to be tested for HIV.
▪ Consent from a parent/guardian should be obtained prior to screening for HIV in an adolescent.
▪ Risk of breaking patient confidentiality when billing for HIV screening.
▪ HIV screening is not relevant to the reason for the patient visit.
▪ Financial costs to patients if testing is not covered by insurance.
▪ Lack of standardized practice protocol for HIV screening.
▪ Lack of awareness of the CDC recommendation.
▪ Lack of access to point-of-care testing (ie, a rapid test) for HIV.
▪ Inadequate training in how to discuss HIV with patients.
▪ Forgetting to screen for HIV.

## BENEFITS TO ROUTINE HIV SCREENING

Incorporating routine HIV screening into primary care has a number of benefits. First, it helps to identify patients who are unaware that they are infected, which has subsequent benefits in line with the Triple Aim.<sup>15</sup> Ensuring that PLWH are identified early in the course of infection and engaged and retained in care improves individual health outcomes. Assisting those who are infected to initiate and adhere to ART reduces individual and community viral load, which limits transmission and serves to improve community health. Finally, increasing engagement in care can limit health care costs in the long-term.<sup>16-18</sup>

Routinizing HIV screening also has the potential to significantly reduce HIV-related stigma. Including HIV screening along with other routine laboratory tests (eg, lipid panels, fasting glucose, thyroid panel, etc.) allows HIV to be seen in the same context as other chronic health conditions. In some cases, patients may prefer to receive care within their primary care setting since having to travel to practices or clinics known to specialize in HIV prevention and care may lead to involuntary disclosure of one's HIV status. Furthermore, patients may perceive referrals to these sites of care as a discrimination on the part of one's health care provider.

## INCREASING ROUTINE HIV SCREENING IN PRIMARY CARE

Evidence suggests that the best way to increase routine HIV screening is to treat it as common practice. Research suggests that 86% of patients will agree to HIV testing if suggested by a primary care provider.<sup>19</sup> Phrases such as, "I recommend HIV screening to all of my patients" and "I can include an HIV test with your other blood work" help to normalize the practice. Providers can also cite the CDC recommendations and should understand that HIV testing does not require extra time through separate consent and counseling when conducted in health care settings. To ensure that testing is done, prompts can be included in electronic medical records. Primary care providers can also partner with HIV specialists to initiate and monitor ART. Routine HIV screening among pregnant women has become a standard of care and has helped to reduce the number of perinatal transmissions by 90% since the early 1990s.<sup>20</sup>

## CONCLUSIONS

Increasing rates of routine HIV screening in primary care settings can help to reduce the number of people unknowingly living with HIV and promises to improve health care outcomes in line with the Triple Aim. Achieving these goals can also move the US closer to the United Nation's ambitious 90-90-90 objective – that by 2020, 90% of PLWH know their status, 90% of those who know their status receive ART, and 90% of those on ART achieve viral suppression.<sup>21</sup> Through these efforts, primary care providers have a critical role to play in ending the HIV epidemic in the US. ❖

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