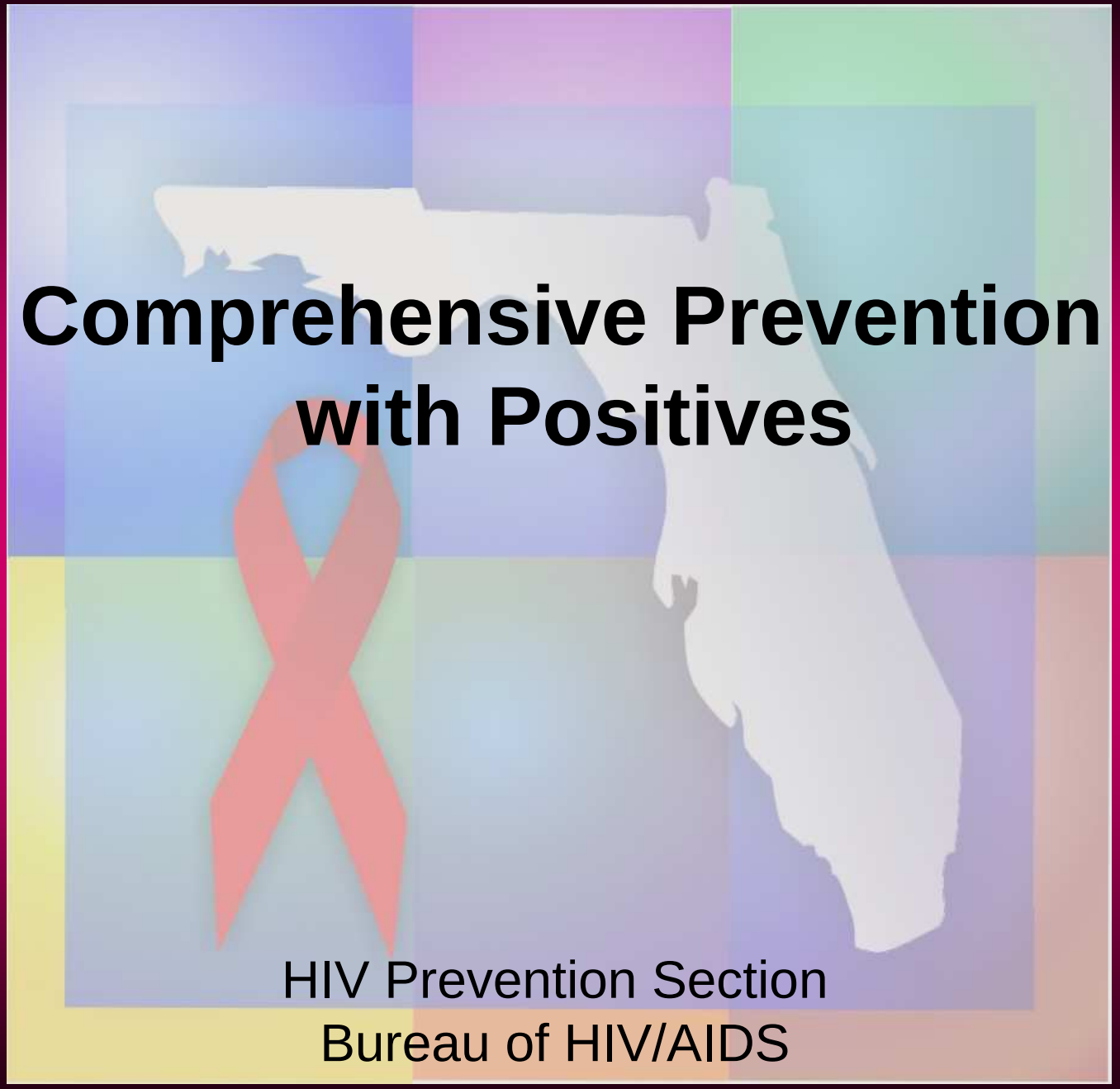
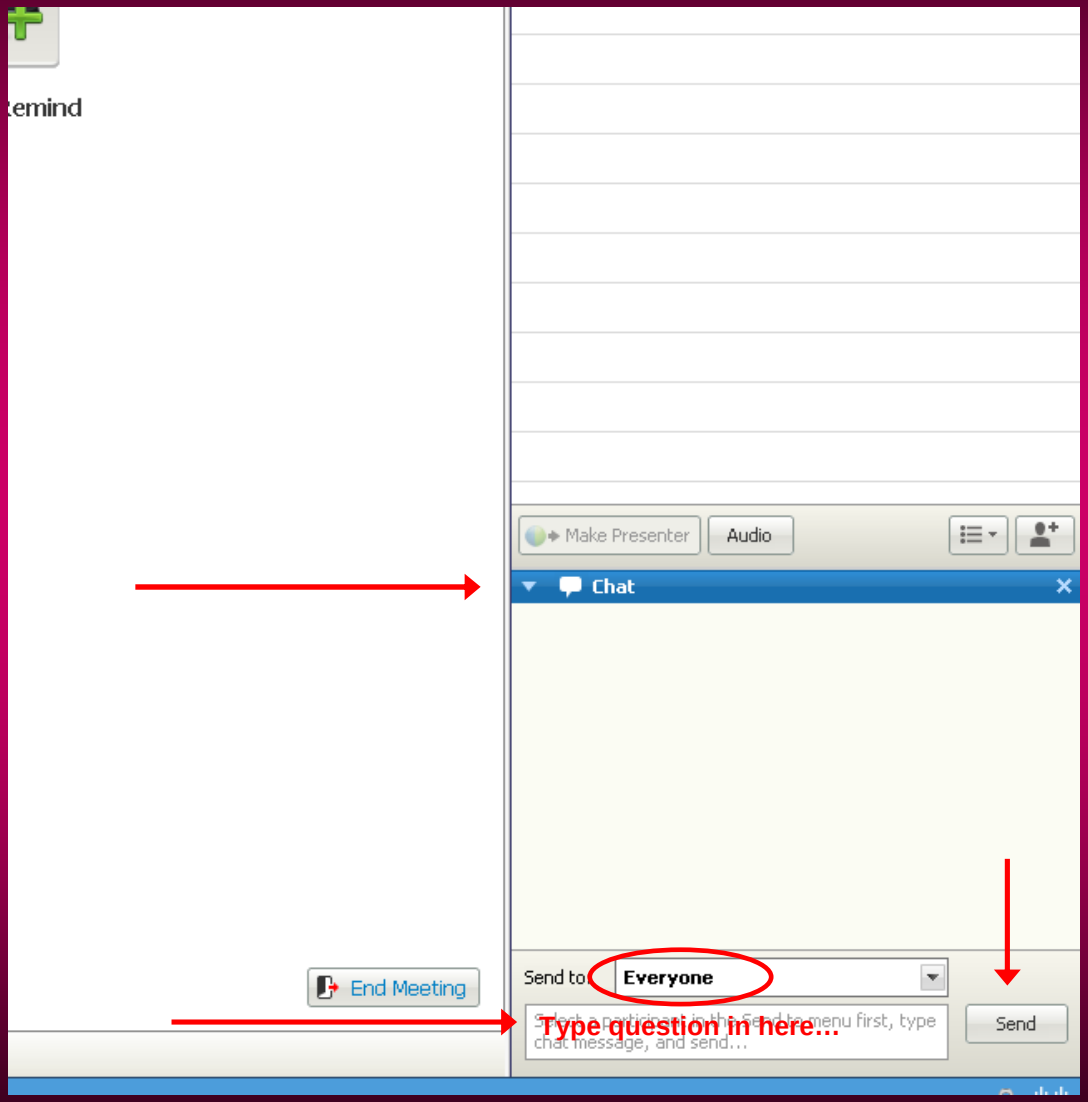
Comprehensive Prevention with Positives



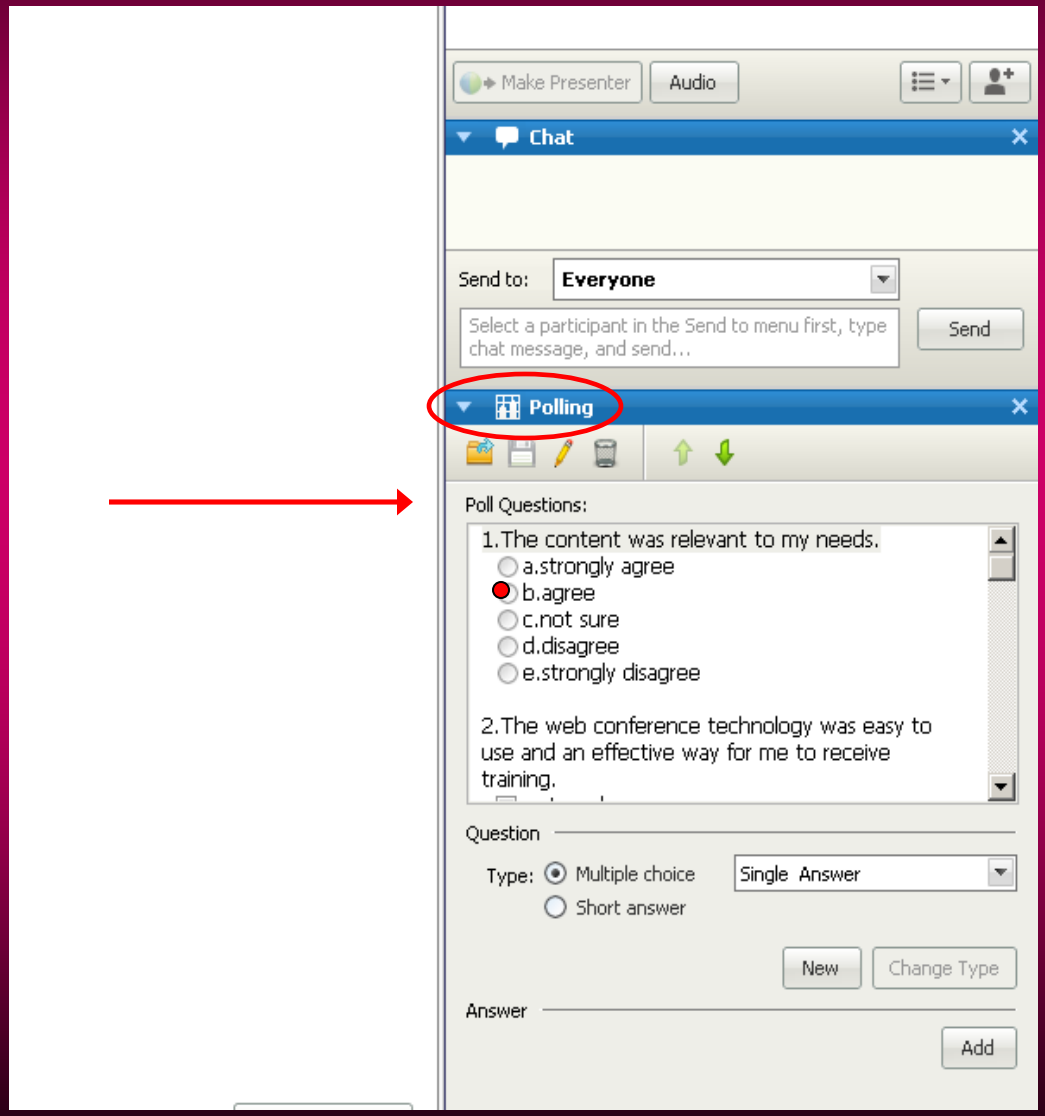
HIV Prevention Section
Bureau of HIV/AIDS

FLORIDA DEPARTMENT OF HEALTH

Typing a Question in the Chat Box



Completing the Webinar Evaluation
(opened at end of webinar)



Nat'l HIV/AIDS Strategy (NHAS)

Prevention with Positives

All people who are diagnosed with HIV should receive:

1. Services to assist with notifying recent sex and drug-use partners of the need to get tested
2. Access to evidence-based behavioral and biomedical interventions
3. Screening for and linkage to other medical and social services as needed (e.g., drug treatment, family planning, housing, mental health)

Nat'l HIV/AIDS Strategy Goals

Expand prevention with HIV-infected individuals

- 85% of newly HIV-diagnosed persons linked to clinical care within 3 months of diagnosis
- 80% of Ryan White (RW) program patients in continuous care (at least 2 primary care visits over 12 months; visits spaced at least 3 months apart)
- Increase proportion of HIV-diagnosed persons who have undetectable viral load by 20%

What is prevention for positives?

Includes supporting positive persons to:

- prevent transmission of HIV virus to others
- prevent the possibility of HIV re-infection
- prevent other sexually transmitted infections
- make informed decisions about health choices, including contraception and pregnancy

Why is prevention for positives crucial?

- It prevents new HIV infections.
- It improves wellness and reduces illness and hospitalizations related to HIV disease among PLWHA.
- For ART clients (current or past users), it decreases the potential of transmitting ARV-resistant HIV strains.

High Impact Prevention (HIP)

Scientifically proven HIV prevention interventions

This DOES NOT mean *only* DEBIs. What it *does* mean is the following:

- **HIV testing and linkage to care**
- **Antiretroviral therapy**
- **Access to condoms and sterile syringes***
- **Prevention programs for people living with HIV and their partners**
- **Prevention programs for people at high risk of HIV infection**
- **Substance abuse treatment**
- **Screening and treatment for other STIs**

*Syringe exchange is currently prohibited in FL due to certain paraphernalia laws.

Source: Centers for Disease Control and Prevention (CDC). *High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States*. August 2011. Atlanta, GA.

Advancing HIV Prevention (AHP) vs. HIP

NHAS and HIP *build upon* AHP by stressing:

- Linkage to and retention in medical care
- Treatment adherence counseling, education, and support
- Working with uninfected partners in sero-discordant relationships
- Expanding referrals to mental health, substance abuse, and other supportive services
- Expanding STD prevention and treatment for HIV-infected individuals

Updated CDC Guidelines for Prevention with Positives

ETA ~ 2013

- Special considerations for groups with unique prevention needs (e.g., minors, MSM, migrants, pregnant women, homeless)
- Linkage to and retention in medical care
- Risk assessment and risk reduction
- Partner Services (PS)
- ARV treatment and its role in prevention
- Medication adherence
- STD services (treatment/prevention)
- Referral to other medical and social services
- Sexual and reproductive health
- Preventing HIV transmission during pregnancy
- Policy, legal, and ethical considerations
- Monitoring and evaluation

Scope of Florida Epidemic

- It is estimated that 130,000 persons are living with HIV in Florida,
- Of those, approximately 20% are not aware of their positive HIV status (26,000 people undiagnosed)
- Approximately 40,000 individuals ARE AWARE of their HIV infection and are NOT in care

Source: Bureau of HIV/AIDS Surveillance, *The American Academy of HIV Medicine,* Connecting HIV-Infected Patients to Care: A Review of Best Practices, 1/20/2009

Linkage, Retention, Re-engagement

Basic Concepts

- **Linkage to care** is the process of assisting HIV-diagnosed persons to enter medical care (“linked” = successful entry)
- **Retention in care** is the process of helping HIV patients keep their scheduled appointments and attend clinic regularly
- **Re-engagement** refers to re-connecting HIV patients to care after they have missed appointments or fallen out of care

Linkage is More Than a Referral

Linkage

Ask the client for their preference in care providers, make the appointment with them, and if possible, assist the client in attending the appointment. Follow-up to ensure the client attended their first appointment.

Referral

Involves giving the client the contact information for the care provider and leaving it up to them to call, get the date and time, and attend the initial appointment. No follow-up is expected.

Systems, Structural, and Organizational Factors Associated with Care Entry

- Rapid HIV testing (vs. traditional)
- HIV testing site is co-located with primary care site
- HIV counselor cross-trained as linkage facilitator
- Training for linkage staff (models, programs, resources)
- Partnerships/processes established between testing sites and HIV care facilities
- Active assistance (e.g., identifying provider, making appt)
- Getting newly diagnosed “in the door” ASAP
- Follow-up contacts

Retention in Care Over Time

- Peers can play an important role in helping people understand the importance of maintaining medical care.
- HIV clinics and medical providers also have a responsibility to assist clients in keeping their appointments.
  - Reminder phone calls/texts
  - A welcoming atmosphere in the clinical setting
  - Respecting client as member of the health care team
  - Follow-up and reschedule no-shows
  - After an extended absence, refer client to linkage program

Medication Adherence

It is important that people understand that taking HIV meds only some of the time is more harmful than not taking any meds at all.

Viral Resistance

Medication Adherence

- Suppressed viral load* reduces infectiousness
- Lowers risk of transmitting HIV to others
- New medication adherence interventions coming in 2013
- Locally-developed activities/strategies can also work
- **Treatment = Prevention**

* *Consistently* suppressed viral load

The Health Literacy of American Adults

2003 National Assessment of Adult Literacy

Definition: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. People in America have health literacy that is:

- Below basic 14%
- Basic 22%
- Intermediate 53%
- Proficient 12%

High Risk Behavior Among PLWHAs- Lessons Learned

- Complacency regarding safe sex practices- patient and medical provider- “Prevention Fatigue” ***Prevention efforts should be ongoing- not just at the initial/annual visit***
- Misconception of risk, especially if viral load is low. ***Acknowledge that although risk of transmission is less with low VL, it is not eliminated***
- Untreated STD can lead to increased local shedding of HIV in genital tract. ***Vigilant STD screening should be part of our prevention efforts***
- Substance use, socioeconomic factors, and mental illness underlie HIV transmission behavior. ***Providers should know their patients and address the issues that may contribute to ongoing risky behavior (e.g., substance abuse and mental health, other supportive services).***

Prevention Interventions for PLWHA

- Individual-level (e.g., CLEAR, CRCS, ARTAS)
- Group-level (e.g., Healthy Relationships, WILLOW)
- Community-level- *potentially*
- Structural (e.g., condom distribution)
- Clinic-based (e.g., Partnership for Health, Interdiction Project)
- Peer-based (e.g., system of care navigation)
- Risk Screening, Risk Reduction Counseling (for PLWHA and couples in serodiscordant relationships)
- Medication adherence interventions/counseling
- Integrated STD screening/treatment

Peer Programs Work

- Someone who has “been there” has a more powerful message than others
- Someone who shares the same gender, sexual orientation, or stage of life can make a stronger impact

Peers use their own experiences with HIV to mentor, advocate for, and support PLWHA.

Peer programs play four important roles:

1. Provide information and support through shared experiences with the system of care.
2. Model adherence skills.
3. Offer emotional support, including encouragement, reinforcement, and decreased isolation.
4. Bring mutual reciprocity through shared problem solving and by giving and receiving help on a shared medical issue.

Source: PEER Center • Health & Disability Working Group • BU School of Public Health • 715 Albany Street • Boston, MA 02118-2526 • (617) 638-1930

Behavioral Interventions and Case Management Models

Intervention	Description	Level of Intervention
ARTAS (Antiretroviral Treatment and Access to Services)	A multi-session, time-limited intervention to link individuals who have been recently diagnosed with HIV to medical care. ARTAS is based on the Strengths-based Case Management (SBCM) model, which is rooted in Social Cognitive Theory (particularly self-efficacy) and Humanistic Psychology. SBCM is a case management model that encourages the client to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the Linkage Coordinator (LC).	Individual
CLEAR (Choosing Life: Empowerment! Action! Results!)	Health promotion intervention for males and females (16 yrs.+), living with HIV/AIDS. Uses cognitive behavioral techniques to change behavior and provides clients with the skills necessary to be able to make healthy choices for their lives. It involves 5 core skill sessions, plus 21 additional/optional modules specific to different risk behaviors/factors.	Individual
CRCS (Comprehensive Risk Counseling and Services)	Formerly termed Prevention Case Management, CRCS provides multiple sessions of client-centered HIV risk reduction counseling with the goal of helping clients initiate and maintain behavior change to prevent the transmission of HIV; it also addresses competing needs that may make HIV prevention a lower priority. Involves the coordination of intensive prevention activities and often involves close collaboration with Ryan White case management providers.	Individual
Healthy Relationships	A five-session intervention for males and females living with HIV/AIDS. Based on social cognitive theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills. Focuses on disclosure, coping skills, decision-making skills, and adoption/maintenance of safer sex behaviors.	Group
The Interdiction Project (TIP)	A clinic-based prevention strategy for HIV-infected individuals that brings targeted prevention services to persons who present with a new STD infection and/or a pattern of unprotected sex, and their sex partners. TIP is a collaboration between HIV, STD, and other health services programs; participation from all partners is critical.	Individual, Clinic-based
LIFE (Learning Immune Function Enhancement)	A fifteen-session self-management and health-enhancement program based on biological, psychological, and social cofactors for people living with HIV/AIDS. L.I.F.E. is designed to address the power that social relationships and psychological issues have on physical health.	Group and Individual
Partnership for Health	A provider-delivered intervention that uses message framing, repetition, and reinforcement during patient visits to increase HIV positive patients' knowledge, skills, and motivations to practice safer sex. The program is designed to improve patient-provider communication about safer sex, disclosure of HIV serostatus, and HIV prevention.	Individual, Clinic-based
WILLOW (Women Involved in Life Learning from Other Women)	A four-session skills-training intervention for women living with HIV. Through interactive discussions within groups of 8-10 women, the intervention emphasizes gender pride and informs women how to identify and maintain supportive people in their social networks. The intervention enhances awareness of HIV transmission risk behaviors, discredits myths regarding HIV prevention for people living with HIV, teaches communication skills for negotiating safer sex, and reinforces the benefits of consistent condom use.	Group

Coming in 2013 from CDC…Medication Adherence Strategies

Table 1. Brief description of the 5 evidence-based HIV medication adherence strategies selected for translation into e-learning trainings for HIV providers.

Strategy Name	Target population	Description	Duration
Project HEART[a] Helping Enhance Adherence to Antiretroviral Therapy	ART- naïve	Social support/problem-solving, individual/dyadic intervention delivered before and in the first 2 months after initiation of ART. A patient-identified support partner is required to attend at least 2 of the first 4 sessions.	Five 1 ½ to 2 hr. sessions and 5 phone calls over 6 months
Partnership for Health[b]	ART-experienced	Brief, clinic-based individual-level, provider-administered intervention emphasizing the importance of the patient-provider relationship to promote patient's healthful behavior. Adherence messages are delivered to the patient during routine medical visits and the use of posters and brochures convey the partnership theme and adherence messages.	3 to 5 minute session at each clinic visit
Peer Support[a]	ART-experienced-or ART naïve	Individual-and group-level intervention, where HIV-positive individuals, currently adherent to ART serve as peers, who provide medication-related social support through group and weekly telephone calls to patients initiating or changing their ART regimen.	Six twice-monthly 1-hour group meetings and weekly phone calls over 3 months
Text Messaging[c]	ART-experienced-or ART naïve	Individual-level intervention, where patients receive text message reminders customized to their daily medication regimen.	Daily customized text messages over 3 months
SMART Couples[a] Sharing Medical Adherence Responsibilities Together	HIV-serodiscordant couples, with poor medication adherence in the HIV-positive partner	A couple-level intervention administered to sero-discordant couples that addresses adherence to ART and safe sex behaviors within the couple dyad, fostering active support of both individuals.	Four 45-60 minute sessions over 5 weeks

[a] Effective in improving medication adherence
[b] Effective in improving medication adherence and viral load
[c] Effective in improving viral load

Partner Services (PS)
Working With Your DIS

- When a person tests HIV positive in Florida, the Disease Intervention Specialists (DIS) are notified immediately.
- In Florida, only a DIS can provide partner services to a newly diagnosed person.
- Make sure you let your local DIS know that your agency is available to assist newly diagnosed persons in accessing medical care and treatment.

The ARTAS Model

- Antiretroviral Treatment Access to Services (ARTAS)
- CDC driven evidence-based intervention
- Most successful in areas with high prevalence
- Short-term case management
- Limited to 5 face-to-face visits

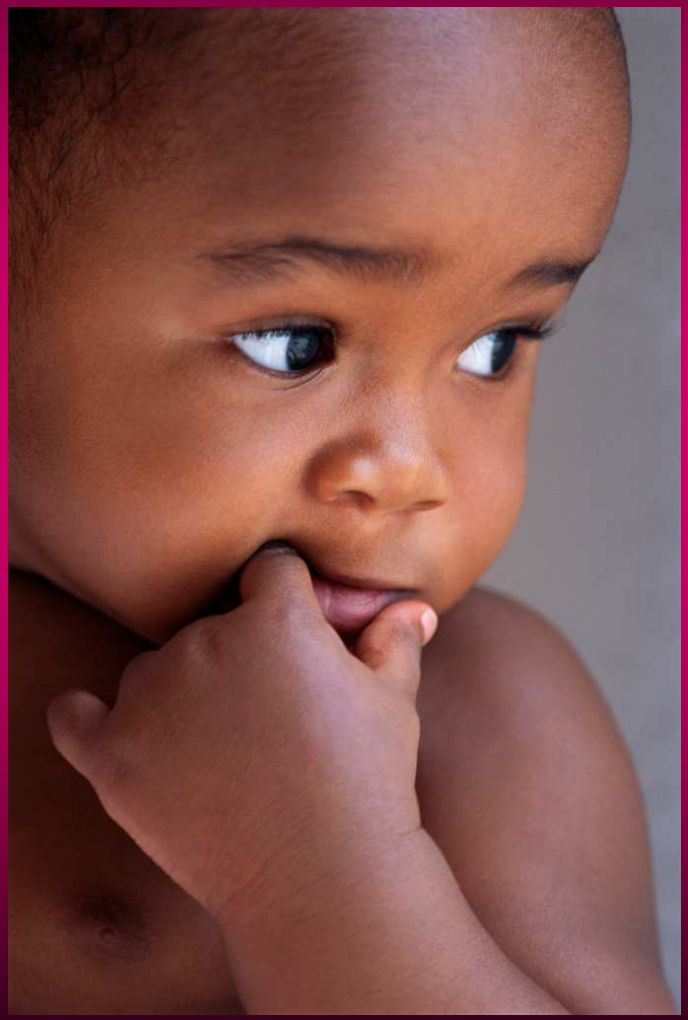
ARTAS is Rooted in Strengths-Based Case Management Principles

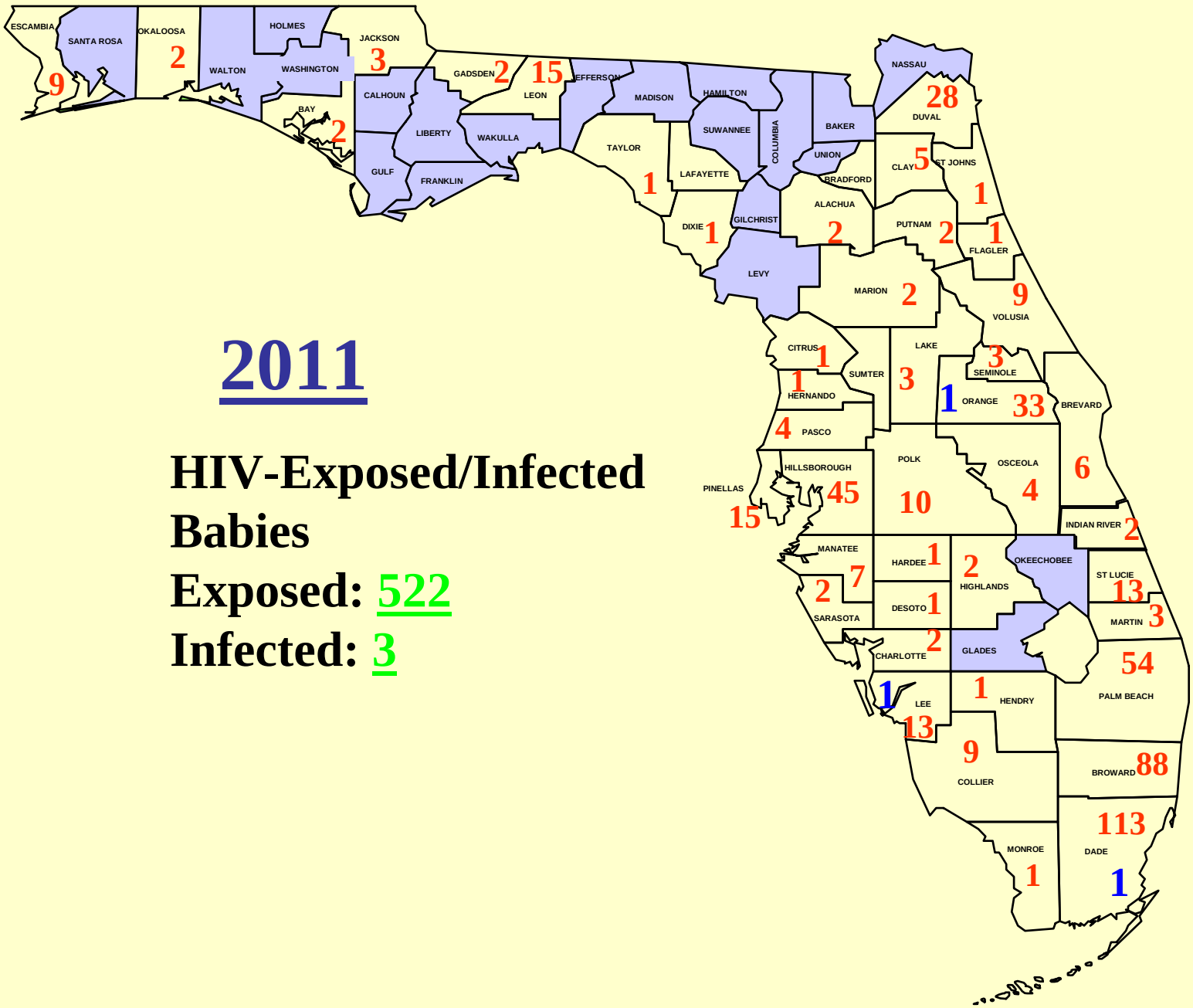
1. Encourage clients to identify and use their own strengths and abilities
2. Support client control over goal-setting
3. Work as a team with the client
4. Identify informal sources of support (family members, friends, and neighbors)
5. Case management as a community-based activity

Source: Craw, Gardner, et al; BMC Health Services Research 2010, Structural factors and best practices in implementing a linkage to HIV care program using the ARTAS model, 10:246

Perinatal HIV Prevention is an Important Aspect of Prevention for Positives

- ~600 HIV-infected women give birth each year in Florida
- By following the CDC guidelines, their babies can be protected from contracting HIV >98% of the time
- Florida has a multifaceted approach to preventing mother-to-child HIV transmission
  - Testing
  - Outreach
  - Education for Clinicians
  - Providing Medications for Exposed Newborns





2011

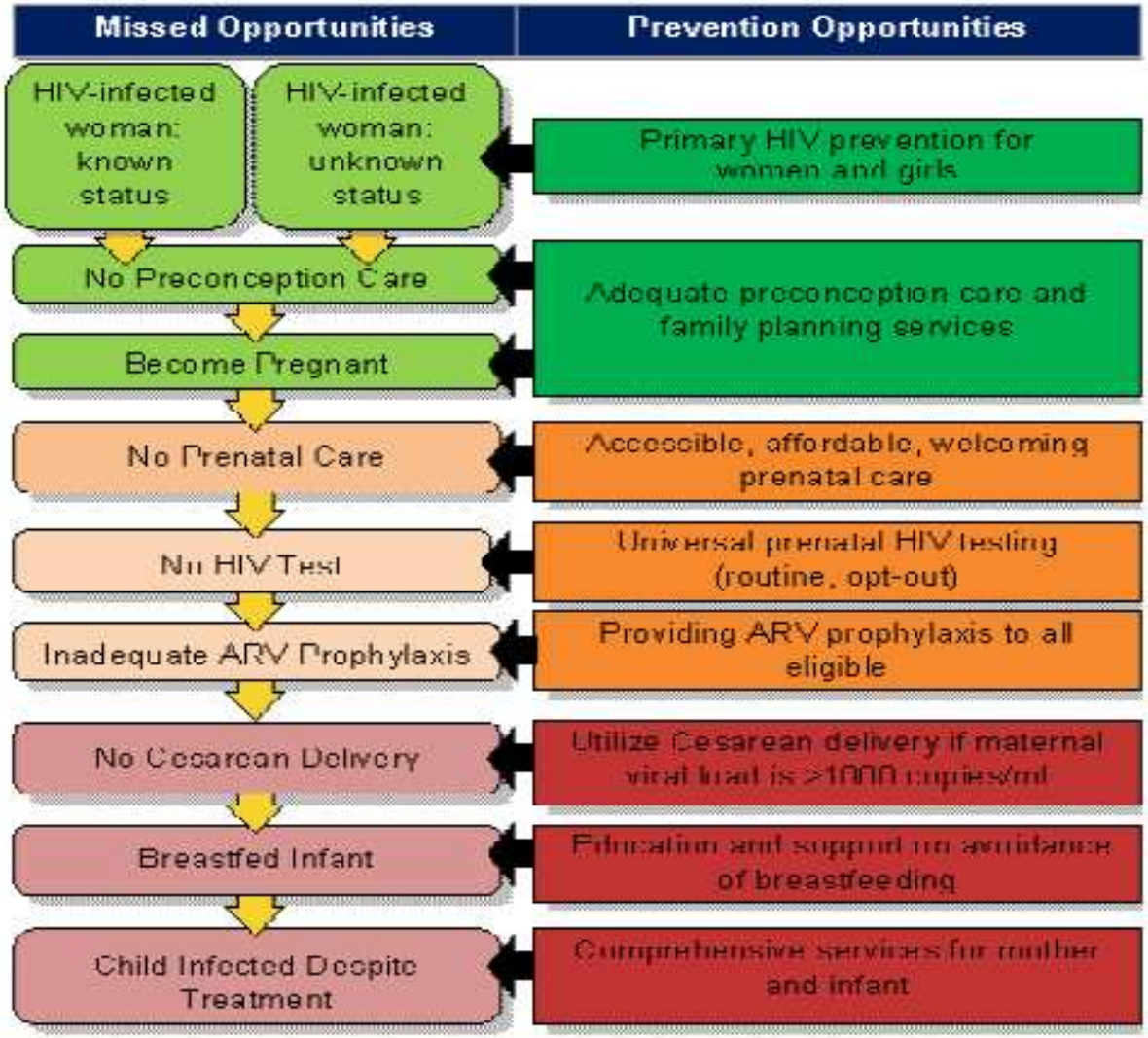
HIV-Exposed/Infected Babies

Exposed: 522

Infected: 3

Updated 4/4/12

Perinatal HIV Prevention Cascade



Pregnant Women Should Be Tested for HIV:

- At initial prenatal care visit
- Again at 28 – 32 weeks *
- With a rapid HIV test during labor if no prenatal care or 2nd test after 27 weeks

* 20% of HIV-infected babies (2000 – 2007) were born to moms who became infected **during the pregnancy.**

Perinatal Prevention Programs

- Targeted Outreach for Pregnant Women Act (TOPWA)
- The Perinatal Project at the University of South Florida provides ongoing education to obstetricians, midwives, labor and delivery staff, and others
- Baby RxPress Program provides free AZT for the first six weeks of life to families of exposed newborns who have no other way to pay for this medication
- Local “Mama Bear Coalitions” meet regularly to ensure individual HIV-infected pregnant women get needed services

Focus on Incarcerated Populations

- Florida has a Pre-Release Planning Program for HIV-infected inmates leaving the Department of Corrections (prison) and Jail Linkage Programs
- Each individual is provided with an appointment for medical care a few days after release
- If your program wants to assist these clients in linking to and maintaining care, please contact the bureau corrections coordinator, Kathy McLaughlin: kathy_mclaughlin@doh.state.fl

Collaboration & Coordination

- Critical for prevention with positives activities to be successful
- Needed to identify previously diagnosed positives that may not be engaged in care or not medically adherent
- Essential for information sharing between entities that may work with positive clients
- Key to facilitating linkage to medical and other social service for both newly and previously diagnosed individuals
- Emphasis on PCSI (Program Collaboration & Service Integration)

Success Checklist:

Implementing a Linkage to Care Program

- Existing, strong working relationships with
  - County/State Health Departments
  - Disease Intervention Specialists and C & T Services
  - HIV Case Management Systems
  - Medical Care Facilities
  - Ryan White Funded Agencies
- Reciprocal Referral Relationships with the Above
- Experienced staff, strong in understanding the system of care
- Major networking skills!
- Customer Service (view professionals as **secondary client**)

"That Information is CONFIDENTIAL"

How do you share client-level data between entities??

- ✓ The “Gold Standard” is a signed consent from the client
- ✓ The linkage program can be co-located as an additional service of the medical provider
- ✓ The linkage program can become a Business Associate of the medical provider

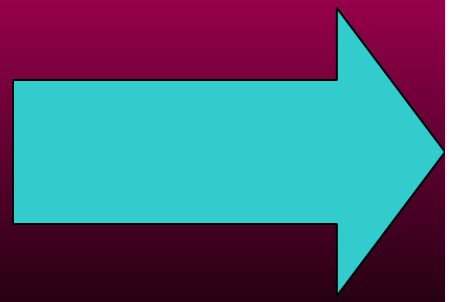
HIPAA BUSINESS ASSOCIATE AGREEMENT

The _____, hereinafter Covered Entity, and _____, hereinafter Business Associate, agree to the following terms and conditions in addition to an existing agreement to perform services that involve the temporary possession of protected health information to develop a product for the use and possession of Business Associate. After completion of the contracted work all protected health information is returned to the Covered Entity or destroyed as directed by the Covered Entity.

- **This form allows for the establishment of a relationship between the Covered Entity and the Business Associate.**
- **The Covered Entity (medical provider) can disclose the contact information for clients who have fallen out of care to the Business Associate (linkage program.)**
- **The agreement allows the linkage program to bring the client back to that medical provider only.**

Webinar Evaluation

- **Before you leave the webinar**, please take a moment to complete the evaluation in the polling section (to the right of your screen)
- Your feedback is extremely important to us and will help improve on current and future trainings
- The more feedback the better!



Resources

High Impact Prevention: CDC's Approach to Reducing HIV Infections in the United States
http://www.cdc.gov/hiv/strategy/

Prevention with Positives Resources, AIDS Research Institute, UCSF
http://ari.ucsf.edu/programs/policy_pwpresources_general.aspx

HIV Prevention with Positives. Research Initiative: Treatment Action! The Center for AIDS Information & Advocacy, Winter 2011. http://www.centerforaids.org/pdfs/ritawinter2011.pdf

Incorporating HIV Prevention into the Medical Care of Persons Living with HIV. MMWR, July 2003. CDC.
http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance/medical_care.htm

Preventing HIV Transmission/Prevention with Positives. AETC National Resource Center.
http://www.aidsetc.org/aidsetc?page=cg-303_prevention_with_positives

Linkage Team, FL HIV Prevention Section Website http://www.preventhivflorida.org/Linkage.html

CDC's DEBI Website https://www.effectiveinterventions.org/en/Home.aspx

FL HIV Prevention Section Website (slides from today's webinar will be available here, under ***Resources & Materials***) http://www.preventhivflorida.org/

FL Bureau of HIV/AIDS & Hepatitis Website
http://www.floridaaids.org/

Questions/Comments

Contact Information

Nita Harrelle
Linkage Team Lead
Nita_Harelle@doh.state.fl.us

Mara Michniewicz, MPH, CHES
Interventions Team Lead
Mara_Michniewicz@doh.state.fl.us

Bureau of HIV/AIDS, Prevention Section
Florida Department of Health
4052 Bald Cypress Way, Bin A-09
Tallahassee, FL 32399
(850) 245-4336

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