Clinical Education Initiative
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ECHO: HIV COUNSELING, TESTING, AND LINKAGE TO CARE

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[video transcript]

00:08
Today we will have our didactic presentation from Dr. Judy Parra on HIV counseling, testing and linkage to care. And our case presentation will be from Dr. Tony Urbina. I just want to start by reviewing the format for HIV ECHO. ECHO is a telementoring program for providers of HIV AIDS clinical care, which includes a case presentation and didactic, usually from two different people. Through these monthly teleconferences, HIV echo links expert specialists teams at an academic hub with clinicians and local practice settings known as spokes in the model. Together, they develop a learning community where the spokes receive mentoring and feedback from the hub, spokes are encouraged to send in real de identify cases for discussion. And if you have a case that you would like to get feedback on, please reach out to me at Mark.stratton@mountsinai.org. And we can discuss it at future eco sessions. So just for some other housekeeping announcements, if you have any questions, you can use the q&a function at the bottom of your screen or the chat box. And we will read aloud your questions at the end of the didactic presentation, and then again after the case presentation. If you're logged on for today's session, your attendance is accounted for. And you will receive an email later today with instructions on how you can evaluate this course for CME credits. And Copies of today's slides will also be sent out to everyone in attendance and HIV echo abides by confidentiality and HIPAA laws within each session by providing cases with de identified information. So next slide please. This course is approved for one credit F continuing medical education from the University of Rochester School of Medicine and Dentistry. Next slide. Here are the planning committee disclosures. Please know that all relevant financial relationships listed have been mitigated and no commercial funding was received to support this activity. Next slide. And this the CIS health equity acknowledgement. We recognize that social structures and institutions impact health outcomes not just an individual's behaviors, structural racism and other unfair criminal justice practices and other systems resulting in inequitable health outcomes at both individual and community levels. And so we will do our best at CDI to try and incorporate a health equity lens, but we might not get some, we might not get it right all of the time. So please be sure to let us know how we can make this training more inclusive when you complete the evaluation form. Next slide please. Okay, so before we jump into our didactic, I would love to have our hub members introduce themselves. And the first person I see on my screen is Dr. Jeff Kwong. So if you can introduce yourself, please. Hi,

02:56
everybody, Jeff Kwong. I'm a nurse practitioner and a professor at Rutgers University. And they practice at Gotham Medical Group in Chelsea.

03:06
Dr. Judy Para.

03:09
Good afternoon and Judy Para. My family medicine physician and I currently practice at Heartland united.

03:16
And Dr. Max Lichtenstein.

03:19
I'm Max I'm a psychiatrist. I'm a trained adult psychiatry and consultation liaison psychiatry, and I'm the director of psychiatry at the Institute for Advanced medicine with Dr. Amina

03:31
and Dr. Veena.

03:32
Right. Hi, and good afternoon, everyone. I'm Tony Urbina, and I am the principal investigator of the clinical education initiatives, primary care and HIV Center of Excellence. And I'm a practicing internist, also at the Institute for Advanced Medicine at Mount Sinai. Welcome, everyone.

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Thank you all for being with us today. And so now, we are going to turn it over to Dr. Judy pot up for her didactic on HIV counseling, testing and linkage to care.

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Great, thank you. So I'm hoping that this session is as interactive as possible. So certainly feel free to put comments and there's a few topics, sir, before that I have no financial relationships. And so what are the learning objectives for today, we I want to make sure that we identify the strategies to incorporate HIV screening as part of routine care. Also how to disclose positive HIV results to a patient. And last but not least, we're going to be reviewing the next steps how to report and do partner notification, how to screen for social determinants of health and also then talk about rapid a or T initiation. So let's start here. There's some questions that I want to pose to the audience and these are, who should be screened for HIV. When and how often should you screen patients for HIV and And just how do you offer HIV screening? Can you put a little bit of some of the answers if you feel comfortable, also unmute yourself to provide some of the answers.

05:15
You can take the responses into the chat box too.

05:28
Okay, here are some comments. So everyone should be screened for HIV. It says that we should test every year. Okay. And so, okay, I'm seeing some answers there. So let's start every three months. Okay. Okay. So let's see. So we are going to start with what does everyone Okay, so let's talk about what are the guidelines and what are the practices and when we are talking about guidelines, we can discuss what CDC says. We can also mention, whether USPS DFS, and then what New York status. So CDC recommends that everyone between the ages of 13 and 64. So they say, you know, at 64, somehow you have to stop checking for HIV. But then we really should kind of question and think about this clinically, however, it says for people with

certain risk factors, CDC recommends getting tested at least once a year. So that's CDC, then we go to your USP SDF, which says that the age range is a slightly different assays from 15 to 65. So once it's 1364, the other 115 65. And this also is a level of the recommendation. So this is the highest level that a recommendation for preventive interventions can get. So A is the highest level, then we go to the next one. And so also, what are some of the risks that CDC recommend, for some patients would be test more often. So this is what a patient when they go to the portal, they would say, a patient should get tested at least once a year if a man having sex with another man, if a patient is having anal or vaginal sex with someone who has HIV. And you can see that I put an asterisk there because we should never forget about undetectable on transmittable, so we can talk about that in a second. CDC also says as someone who has one sex partners since the last HIV test more than one sex partners I'm sorry, someone who shares needles, syringes, or any drug ingestion equipment. As someone who has changed sex for drugs, someone who has been diagnosed or treated for another sexually transmitted disease within the last year, someone diagnosed or treated for Hepatitis and tuberculosis, and someone who had sex with someone who has done anything listed above or with someone whose sexual history is unknown. So this is what a patient who goes to the CDC website would see as a recommendation for getting tested at least once a year. And now, let's go to one New York stay safe. And I actually like the vocabulary that he uses. That it starts by saying HIV should never be an isolate activity. So we shouldn't treat HIV any differently than asking someone I should be screening you for diabetes, I should be checking you for cholesterol. And this is with the goal are trying to take the stigma away of offering HIV as a testing, intervention that is separate from any prevention. So if we offer it to everyone, they're coming for an annual visit. They're coming for a you know, physical or new patient. And we say I'm going to be doing routine testing. And that includes cholesterol, diabetes, HIV testing STI is if we're offering it in a neutral way, it takes the stigma away from HIV because some patient could feel like you know, if we offer HIV alone, there is a level of judgment associated with that. So New York state mandates that physicians, clinicians in general, offer an HIV test to all patients who are 30 years of all however, they should be younger if there is a level of risk. And as you can see here, there is no age limit as to when we should start offering this depends on specific risk factors and practices. I know their point, several years ago, we had to do in grid and consent, then the grid and consent went away. And then there were some verbal consent, consent that was added. So the important thing right now is that we really do not need either writing or oral consent to be able to do HIV testing. However, we should make the patient aware that this has been included in the general testing And it's voluntary. So if I offer it, you know, I'm doing part of your routine testing this are the labs that I'm ordering, then we're advising the patient that we're doing that so they have the right to decline. But the goal of this is really decreasing the barriers to testing. And so by testing and having more people being offered this this, we're more likely to, to find patients who are not in care and who are not linked to care. And these are other some other indications that the New York state puts in terms of how often we should be doing it. And so the frequency so we can see here from three to six months for patients who are having for patients who has changed sets for drugs who have a live in partner with HIV who are not detectable for men who have sex with men. And then here we also see every year and then we see three to five years as well for all patients who are sexually active so that the take home message is that we should be offering as often as possible, depending on specific practices, risks, fast risk factors as well, and always always prevented, presented in a non stigmatizing is part of routine care. And this is more is

help us increase our chances that the patients are going to affect the test. So this is not worth switching. So we went to who we offer tests. So I hope that the message is to everyone in a non stigmatizing neutral way. And then it's like, okay, now I have a test, what do I do, and this is where sir getting all like scary and overwhelming. But the reality is that the tests that we have right now, are very sensitive, they're fourth generation. In most, there might be some clinics that have third generation, but I would say nationally, probably the fourth generation test is the most widely available, and that includes an antigen and antibody. So things to remember, there's a screening test, and there is a confirmatory test. As you can see here, the first test could be positive or negative. But if if it happens to be positive, we need to add the lab the reflex to additional testing. And that's what we call either a differentiation or confirmatory test. I don't want to spend too much time here. But I want just to make sure that we're all aware that when we receive a test, the screening test is not an it's not enough, we need to make sure there is a confirmatory test to make sure there's a true positive or a true negative, is there a true positive, and if at some point, there is suspicion, at some point, you still think there is indeterminate. This is when we would have to do an RNA test, which is the most sensitive. So a couple of things to keep in mind. If a patient tells you that they could have been exposed within the last week, or within the last two weeks, the tests that we have currently are gray and are sensitive, but there's still a period from the time they were supposed to the time the test will become positive. So some suggestions if you are suspecting that they could have been exposed within the last two weeks, and they have any symptoms of an acute HIV infection, send a more sensitive test, which is the RNA test. But also recommend repeating this test in a couple of weeks in a month after the exposure to make sure that we're not missing any possible exposures. So next one, I think there's a question in the meantime.

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Thank you. Yeah, we'll come back to that one. So now, we have a patient who tested positive for HIV. How do we disclose the notes, certainly, this are very difficult news to share with someone there are difficulties for someone to to hear. And so the goal of presenting this information is in a non stigmatizing way, in a patient centered and trauma informed approach. So what does that truly mean, right? And so the vocabulary the that we use, the setting where we disclose the news are important, the support services that we give the patients is going to be important. So I will start by using vocabulary moving away from vocabulary that says you're infected with HIV. And we can see that in the literature. Sometime we're still stuck here. Or we can repeat patients infected with HIV. And that's vocabulary that has been used in academia for a long time and we're moving more towards people living with HIV, or test the PA center for HIV. And this is to remind, you know, HIV doesn't define a human doesn't define a patient is a diagnosis that they carry. So really, that is one important step. That when we're disclosing the news now saying you are infected with HIV, but instead say, you know, your test came back positive for HIV, allowing the space and the time to process the news, silence is okay. There could be many emotions that could happen in that setting. And so the more comfortable we are as clinicians, and to provide providing the information, disclose and bad news, the more supportive that we can be to patients. Also, another element that is important is that the HIV disease can be managed with the right care, and the medications that patients take, they can stay healthy, depending on how the encounter goes, because there might be just not enough time to provide more information to provide ask more questions. But it's also important to clarify

the difference between HIV as the virus that causes AIDS. And then from acquiring the virus to progress and to AIDS, there is a very, very long gap. And this is also if patients are not able to take their medications. And if they have any other barriers, sometimes student the initial encounter, if the time and the circumstances allows, it will be important to ask about chronic medical conditions and other medication, especially if we're going to start medications right away. What was the mode of transmission? When was the last negative HIV test? We want to assess their mental health. And we also want to assess their safety regarding especially if the circumstances of how they acquire HIV was through a traumatic event. What is the safety of this patient going home? With this new diagnosis? Do they have a support system? You know, are we concerned for their emotional well being after they leave the visit? Are we concerned that they're going to any risk of suicidal homicidal ideation based on their underlying medical history and mental state? So those are things to to assess? And then if we're going to be starting medications, and the question is, are they ready for that, but medication is only an element of this initial encounter, there's a lot of other things that we have to think about. So the social determinants of health, I think we can say that HIV medications, prescribing it, perhaps is the easiest element in 2023. The social determinants are what plays sometimes a harder factor in helping patients stay on undetectable. So depending on how much time and the circumstances during that initial encounter, it is important to find out whether housing status, are they are they stable the house? Or are they concerned that if someone finds a diagnosis, they will be kicked from their house? Are they experiencing street homelessness? Are they one of the newly arrived immigrants or refugees who were diagnosed with HIV in their country of origin and face persecution? Are they you know, all these questions are important because we can refer them for housing services. So in New York State, you know, we can connect them with specific agencies, where based on their HIV status, they have different levels of housing for an emergency housing, where they can be placed, you know, same day to older programs where they can receive a voucher that dependent on their income, they can apply for housing, there's also supportive housing where they have case management. So really asking those questions are important, an important step so that we can make sure they feel safe. And another thing to ask, you know, what's their insurance insurance status. So I work at a federally qualified health center, we see everyone regardless of their ability to pay, and that covers their the care that they receive here, it will cover their labs, it will cover their medications, but also will help them apply for this program that is called a gap. So with a dab regardless of their immigration status, regardless of their insurance status, it can help them either apply for the full medication or sometimes it can help them apply for co pays if their co pays are very high through the insurance plans that they have. So that's another second element that sometimes patients don't know that they qualify for. Sometimes clinicians didn't know about this is an important reminder, and then harm reduction resources. is, if there are patients who are actively using drugs, do we, you know, do we have access to a needle exchange clinic do we have access to other support services, if there's a patient who is doing is work is working as a sex worker, we also want to make sure that we are preventing the transmission to older to other patients. So also thinking of, of treatment as prevention. And so we can prevent, prevent other diagnosis. And then additional benefits, just I'm throwing a lot of resources there and putting the link assets at the bottom. Some of these resources might not be something that you can address during the initial visit, but they're reminded is that as, as clinicians, you don't have to do this alone, you do this with that team, with social workers with case management. So some patients depending on the

number of chronic diseases that they have, they can be referred to help them or health home plots and help Health Home Plus are for patients who have the diagnosis of HIV, and have other chronic conditions. And they have, they need a higher level of support from case management. And they make sure they go to their appointments, they make sure that they qualify for transportation benefits. And these are team members that are able to do home visits. So they're able to follow up patients, if they get admitted to the hospital, they will be able to support. There are also older programs like adult day health care programs, and some of them are specific for people living with HIV, where they can find a support system. They have art therapy, they have counselors, they have nutritionists. And so this is also a very important program to let patients know I refer them. And Let's also not forget about legal counsel. And so we want to make sure if they are concerned for persecution, if they were concerned that they weren't discriminated based on their HIV status, they are resources and support that patients can receive. So now we are transitioning to started medications. So let's assume that the patient is ready to start medication they received a diagnosis that they you assess for safety you assess for,

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for housing, and they are telling you that they are ready to start taking medication. This itself can be at full presentation. That could take a whole hour, but I just wanted to put it there and let you know about some resources that you can reference so that we can start patients or medications right away. If they're ready. The benefits of this are well established. It prevents you know, by having patients starting on medication we are helping, they're more likely to stay in treatment. If they're connected with resources and they are started on medication the same that is within 72 hours of diagnosis. So just to be mindful, there are three possible regimens that you can use. And I'm using the brand names have big Tarbet is a single tablet regimen that has three medications, or you can use this COVID Tbk or sim twosome. One thing clinically is that most patients will be okay starting it. But if there's any chance or any concern that a patient has an opportunistic infections, there are specific things that you have to look into. And that will be the case if you're concerned that they had tuberculosis, or they have meningitis. But most patients should be able to be started on one of those regimens listed above their initial labs order and just summarize some of them here. But this link will be able you'll be able to pull that table and see oh, what are the labs that I should order. So don't feel like you need to memorize and remember all of them. But you can go to this table and order them in general are you certainly want to have a confirmatory test if you don't have it a viral though a CD for count for system testing. And this is in case that a patient at wire a virus that has transmitted resistance, Hepatitis B serology, Hepatitis C screening, you want to look at lipids, random glucose, you know, pregnancy test, if this is a person of childbearing potential, because we have to then be mindful of the regimens I will choose as well. And the main thing that I really want to point here is close follow up. This is not a patient that she's scheduled to come back three months from now, this is a patient that I would encourage either a form visit in a week, or if you can, if you have availability in your schedule, within a week to make sure that you're monitoring for side effects that you're monitoring for any other questions. that could come up. Because all that information that you provided on the first visit is a lot and probably half of it, you know, it's not something that the patient could really process given this, you know, the just the dimension of this new diagnosis. So you might be repeating a lot of information you might be taking this time to explain what is a CD for cow, what is a viral load? Why are those labs important, and you will be able to

assess, again, for safety for housing for any other resources that a patient could benefit for. And last but not least, I It's also important to think about what are your requirements as a clinician when it comes to report. So if you have a new diagnosis, were required to report it to the state, there is a paper form which you can download, which is this format, Doh 4189. But I also encourage everyone to make sure that you are familiar with the health comer systems, and there is an HIV ace portal provide a portal where you can post you can report the new diagnosis. One thing to also mentioned to patients is that we want to support the notification of any partners. So if they don't feel comfortable or safe, notifying the partners themselves, they can give us the information and that can be done and on anonymously, to make sure that other patients who could be possibly a SPOs, are notified to make sure that they are getting tested. And depending on where you're located on the state their specific offices. So you can use this link to make sure that you can locate your local office that will be helping with partner notification. So I know we've covered a lot of topics, but the idea of this is to give you an overview and empower you with the resources that you have. And they say the most important thing really just treat patients with humanity without the stigma and make sure that you don't don't forget beyond the medicine, there are all these other social resources that are important to connect patients with

27:18
the set. I'm open to any questions and let me see the some.

27:30
Do you have this one comment here about the syphilis screening?

27:32
Okay,

27:34
thank you says no, the syphilis screening is also a USB SD F grade recommendation done either to blog or PCL tests and the risk factor are quite similar, right. So if we're screening a patient for HIV, and their specific risk factors, we should also be screening for syphilis.

27:53
Got a

28:00
quick comment? Great job. Excellent. Presentation. Just one thing that all just mentioned for people's FYI, I've been doing some work. Also with sage, which is an organization for those are LGBT adults. But they've been doing a lot of work on the policy front to work with CDC to help change or modify and remove the upper age barrier on the CDC recommendations. Those recommendations have not been updated since 2006. And the CDC is in the process of revising, I don't know what the final recommendations are. But

28:43

thank you. Now that's helpful to know, right? Because he just makes an assumption that all of the sudden exits defy screening has to stop. So that's why I would say certainly New York has done a great job. And he's very inclusive, and is also us clinicians. We should feel comfortable asking those questions, regardless of the age and that make assumptions regarding the patient's social practices, and regarding patients, you know, this way of life and we should just be normalizing and asking everyone

29:19
so your question again? Yeah, I agree. Great presentation, really nice overview, lots of really great resources and information. How do you approach just the partner notification? So with patients newly diagnosed I, I often think that we kind of neglect that, you know what I mean? We're just really focused on the patient, which I think is super important. But how do you introduce that topic? And just are there ever situations where you kind of feel that either like the Public Health Department can help you more and when Did you decide to call them?

30:03
Yeah, that? That is certainly a hard one, I would say. The first part is, do I have concerns for the safety of the patient who is immediately there? Because if that patient who is in front of me, you know, are they concerned that if somehow they can be known that even if we say that we're going to do it in an anonymous way, that they're not going to reveal their name, but if there's some way that they're concerned from safety, so they if they're in a history of partner inter partner violence? If there is any concern, you know, that I think that is the part that I would need to make sure, you know, that we ask about that. Are you concerned that you could be identify when the partners are contacted that it could be linked to you? And are you concerned for the safety? So I would say that is one element to try to gather. And that might be hard to get from the first visit, if you don't know this patient? You know, if they just come to you as a new patient, so there is no level of trust that has been developed yet that they might not know about things. So I would say that is one part. The second element if like safety is less of a second of our concern there, I would say we want to make sure that the chain of transmission

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is sort of,

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hey, that's a tough one. Yeah, I had to even think what was the last time in it, you know, we want to make sure that any other patient who could possibly have been exposed that they're linked to care, the benefits are treating HIV, as soon as possible are there long term, it can be a chronic disease. And so we are empowering, no patients who get tested so they get they can get in treatment. And so I guess it really, truly depends. Most of the times they say I will notify the patient. So very few times, I truly have done partner notification through the Department of Health, because they really do not provide any information. Especially I think the older part culturally if they had been in health care heterosexual couple, and one of the partners, you know, is concerned for infidelity or anything like that, I think he also gets very, very difficult. So I don't know there have been I would say this is where sometimes calling partners services and

say, you know, how do I deal with this bar, I just wonder what everyone else experiences with this has been if anyone else wants to share?

33:00
With you, Max, or Jeffrey just maxed with anybody kind of newly diagnosed in terms of just Yeah, partner disclosures, or,

33:09
I mean, that's always really difficult. I think knowing your patients, sort of relationship with their partner, certainly in the queer community, it's not always a monogamous relationship. It can be an open relationship, a polyamorous relationship. You know, for some folks, this is going to be a major conversation because their partner doesn't know about the the other partners they're sleeping with who may have gotten them HIV. You know, making sure you're having conversation about you know, substance use, that if this is related to something like IV drug use, that's being addressed with the partner as well. But I think that's such an individual issue, it kind of have to know the contours of the relationship a little bit more. One thing I think it's really important around early diagnosis or right after diagnosis and sort of the we'll call the adjustment reaction to folks being diagnosed with HIV, is if they have a more severe adjustment reaction with depression, you know, approaching something like a major depressive episode, there's been a number of pretty good studies dating back to the 2000s and 1990s, that if they have a very strong adjustment reaction to the diagnosis, they're more likely to develop a depressive episode later on, that may well be treated by things like medication management, and folks tend to do better in mental health treatment. So if you do notice, someone has a very strong adjustment reaction upon their first diagnosis, keep that in mind, you know, for referral to mental health services later on. They even if the as the adjustment reaction, you know, resolves they're much more likely to develop a major depressive episode in the subsequent years.

35:00
You know, I'll just add, again, just sort of layer on what Max mentioned, just in terms of knowing that individual situation a little bit more, there could also be that risk of violence or other things that could come up. So, you know, I say, if you're not sure how to handle it, or if he's not sure what switching, also contacting the partner notification services and city health department and ask him the recommendations is also a good option to just say, it's the best way to your situation.

35:38
One thing that I do remind me, Jeff, when sometimes partner notifications goes into the community, and sometimes when there is communities that has a higher incidence of cases, sometimes that can be tricky to when they like go and try to notify the foreigner. I think they're trying to do it enough, certainly private way. But sometimes you have worked for the organization for so long, that if you're in the community, oh, you know that from DOH? I think that that was I remember in the past, someone mentioned that, that they kind of knew and it's similar sometimes with Hassall has a certain locations are in a specific buildings. And so they know that people living with HIV are in those buildings. So sometimes that can be tricky to that if they are recognized by the community in but yeah, calling them for advice, and maybe they will

send someone different, I don't know. But there's all these other intricacies that come into partner notification for them to help us navigate that.

36:51
Well, thank you so much for that presentation. Dr. Para .

[End Transcript]