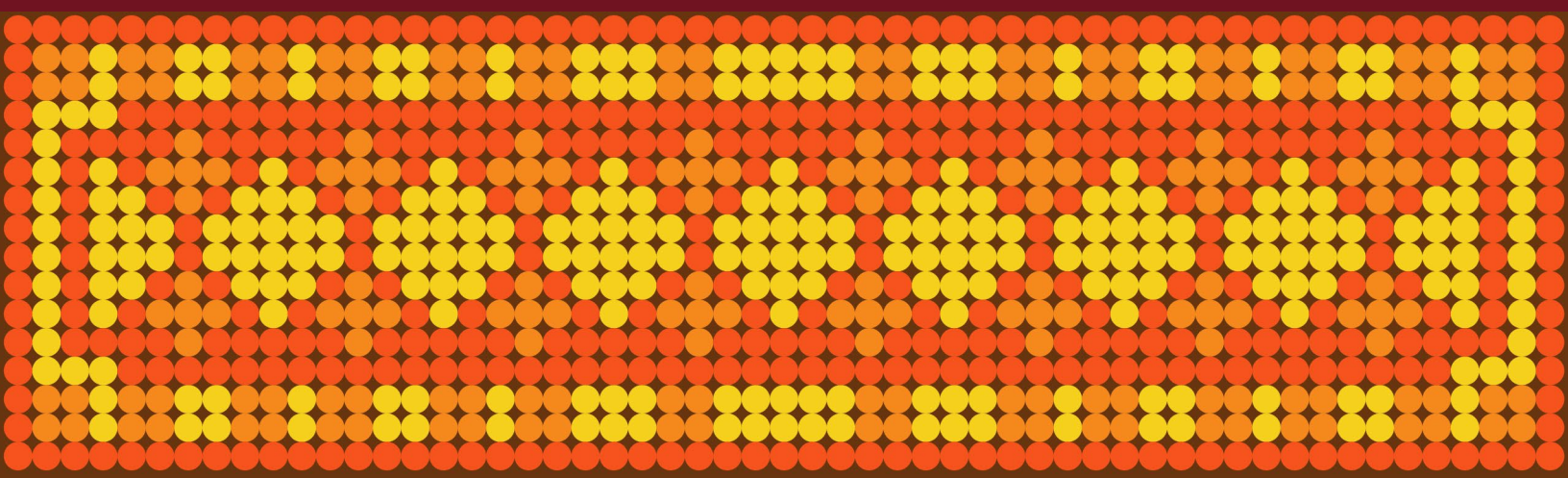


HIV Care and Sexual Assessment for American Indian and Alaska Native Patients Provider Toolkit



**Urban Indian
Health Institute**
A Division of the Seattle Indian Health Board



CARDEA
Training, Organizational Development and Research

This toolkit is a companion to the e-learning modules in the course HIV Care and Sexual Health Assessment for American Indians and Alaska Native Patients. Module briefs and relevant resources are included in the toolkit.

Acknowledgments

Urban Indian Health Institute, the research division of Seattle Indian Health Board, created an e-learning course in collaboration with Cardea Services that focuses on educating healthcare professionals on providing culturally attuned HIV and sexual health care to American Indian and Alaska Native patients.

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Introduction

The e-learning modules and toolkit in the course *titled HIV Care and Sexual Health Assessment for American Indians and Alaska Native Patients* are designed for staff who provide medical care for American Indian and Alaska Native people.

This includes physicians, physician assistants, nurse practitioners, nurses, medical assistants, and other staff involved in patient care working with the Indian Health Service, tribal clinics, and Urban Indian Organizations.

The e-learning modules and toolkit will help prepare staff to provide optimal HIV prevention, screening, and treatment in any primary care setting. Providers will learn practical tips for performing a brief sexual health assessment and how to provide HIV and sexual health services in a culturally sensitive manner to people of all genders and sexual orientations. These e-learning modules were created by Urban Indian Health Institute and Cardea Services.

Urban Indian Health Institute (UIHI) is one of 12 Tribal Epidemiology Centers and the only one that services Urban Indian Organizations nationwide. UIHI recognizes research, data, and evaluation as Indigenous values while utilizing the strengths of Western science and staying grounded in traditional ways of knowing. UIHI's mission is to decolonize data, for Indigenous people, by Indigenous people.

Module 1 Brief: Culturally Proficient Sexual Health Care for People of all Genders and Sexual Orientations

Urban Indian Health Institute, the research division of Seattle Indian Health Board, created an e-learning course in collaboration with Cardea Services that focuses on educating healthcare professionals on providing culturally attuned HIV and sexual health care to American Indian and Alaska Native patients.

“Well, there’s one universal commonality in the Two Spirit, LGBTQ population... and the one commonality is that we’re everywhere. And there isn’t a population on the planet that doesn’t have one of us in some capacity.”

—Emily Ashbaugh, MD

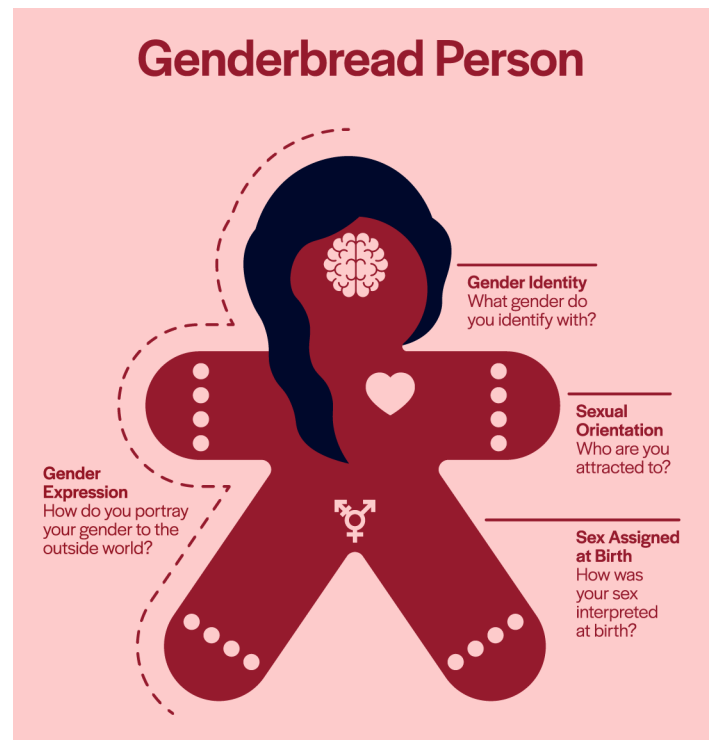
Two-Spirit History

Two-Spirit is an umbrella term used to reflect and honor ancient traditions that are understood in diverse ways across tribes and urban areas. The term was adopted by consensus at a conference for lesbian and gay native people in 1990.

Although Two-Spirit is connected to gender outside the western binary, the term does not simply mean someone who is Native and LGBTQ. Two-Spirit roles and identities exist as a broader understanding of gender.

After colonization, Natives who did not conform to gender binary were singled out and targeted with physical violence, including murder, causing Two-Spirit traditions/practices to go underground or disappear.

Aspects of Gender and Sexual Orientation



A graphic to show the variations within gender and sexual identity.

Showing Respect

The most important thing is that all people deserve to be treated with respect. Take your patient’s lead and let them define their own identity. Your kindness and willingness to learn matter more than how many of these terms you can define.

Sexual Healthcare Needs and Concerns

Disparities

In 2018, 75% of HIV transmissions in American Indian and Alaska Natives were linked to males who had sexual contact with other males.

Elderly LGBTQ2S individuals may face additional barriers to healthcare because of isolation and a lack of social services and culturally proficient providers.

Sexual Healthcare Needs and Concerns

Discrimination

33% of respondents in the 2015 US Transgender Survey reported “at least one negative experience related to being transgender in the past year.” These negative experiences included being refused care, harassed, or physically assaulted.

28% of Native adults of all genders and sexual orientations who were surveyed reported experiencing discrimination when receiving health care treatment.

Strategies to Provide Quality Health Care

1 Physical Environment

- Post a non-discrimination policy
- Provide gender neutral restrooms
- Have posters, literature, brochures, and website images that are inclusive of LGBTQ2S people
- Hire and/or involve LGBTQ2S people in your organization

2 Communication with Patients

- Only ask questions necessary for patient care
- Use inclusive language with ALL patients
- Use affirming name and pronouns
- Don't rely solely on patients to educate you—do research on your own
- Expect defensiveness or uncertainty from your Native LGBTQ2S patients—remember that many have had negative healthcare experiences throughout their lives and in the history of their communities, so do your best to build rapport and gain trust
- Consider updating paperwork and intake forms so that they are inclusive of all genders and sexual orientations (option for preferred name)

Correcting Mistakes

What can you do if you make a mistake and upset or offend your patient?

It is important to apologize right away. Make it brief and refocus on the patient's needs. Moving on right away avoids putting your patient in the position of taking care of your feelings about your mistake. If further action is truly needed, check in with your patient about how they want to move forward. Use your own mistakes to help educate your colleagues and coworkers.

Module 2 Brief: Sexual Health Assessment

Urban Indian Health Institute, the research division of Seattle Indian Health Board, created an e-learning course in collaboration with Cardea Services that focuses on educating healthcare professionals on providing culturally attuned HIV and sexual health care to American Indian and Alaska Native patients.

“I think it really speaks to whole-person care, and that sexual health is a rich source of information, that sexual health is a source of joy and fulfillment and vitalization for people... I don't see that there's a better avenue to gain trust and to gain critical information for whole-person care than through sexual history”

—Emily Ashbaugh, MD

Why do a Sexual Health Assessment (SHA)?

Asymptomatic STDs can negatively impact a patient's health and fertility without the person-or their provider-ever even knowing it. Patients don't usually bring up the topic of sex, even if they have questions or concerns, and primary care providers rarely bring up the topic to their patients. Bringing it up increases STD/HIV testing and treatment, and helps tailor sexual health care to the needs of each unique patient.

From 2012–2016, American Indian and Alaska Native had the 2nd highest rates of chlamydia and gonorrhea among all racial/ethnic groups. For all ethnic groups, having another STD increases a person's risk for getting or transmitting HIV.

Native peoples are often diagnosed with HIV later than the general population. An estimated 1 in 5 AI/AN don't know they have it.

How to Ask Questions

Sex positive, health equity and rights-based definition of sexual health

World Health Organization definition addresses more than absence of disease, it includes a, “...positive and respectful approach to sexuality and relationships, the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence... (and) the sexual rights of all persons...respected, protected and fulfilled.”

Privacy and permission

Reassure your patients: “What we talk about is private between you and me, and only shared with other health care staff as needed.” Pause, then: “To better understand any health risks you might have or any tests you might need, I need to ask you some really personal questions about sex, is that OK?”

Even if they do not choose to engage, asking this shows that you are respecting the patient's autonomy and personal power regarding their health care, and can foster trust and appreciation in the moment and during future visits to the clinic.

Confidentiality

Know that this information is private and not shared with others, except other health care staff if needed to provide the best care for the patient

Exceptions: may be shared with other staff if needed, for mandatory reporting for keeping youth safe, or due to tribal, federal and/or state-specific reporting requirements for STD results.

Understanding these exceptions is especially important for patients who may have suffered personal and historical trauma that can lead to mistrust, including when receiving medical care.

Asking about gender and anatomy: Asking about gender, preferred pronouns, and anatomy early on provides a foundation for subsequent questions about sexual behaviors and health risks.

OARS Model

A simple model for patient-centered communication that continues to build rapport is the OARS Model. These communication skills help you focus on the patient's goals, needs, and preferences in a respectful way, treating each patient as a unique individual.

Open-ended questions: help patients express their needs, encourage sharing.

Affirmations: validation helps to foster a positive, supportive, and trusting relationship.

Reflective listening: let the patient know you are listening through saying out loud the words, feelings, and behaviors that you see and hear from the patient, and check current understanding.

Summarizing: review and transition to another topic. This can happen at any point of conversation

Other Ways to Build and Maintain Rapport

Use transitional statements: helps move the conversation from one topic to another topic, rather than abruptly beginning to talk about sexual health.

Normalize: normalizing statements help patients feel that others have similar issues or concerns.

Tell why you are asking: helps patients understand the reason for being asked very personal questions about sex.

Use concrete and clear language: helps patients better understand a clear description of terms and processes.

Use a range of options or scaling questions: helps patients feel that their answer will be heard and not judged, regardless of where it falls along the range of possible options. "e.g. "Do you often, sometimes, or never use a condom.""

Affirm the patient's right not to answer helps patients feel their autonomy and personal power is respected.

Use a non-judging, non-shaming tone and approach: helps patients feel respected and open to engagement.

What to ask about

Focus your questions on the Five Ps: Partners, Practices, Protection from STDs, Past History of STDs, and Pregnancy Plans and Prevention. In addition to this module, we have created a Sexual Health Assessment form to guide your conversations through the Five Ps and document your patient's responses.

Find this form on our website at: uihi.org/projects/urban-indian-hiv-and-aids/.

Sexual Health Assessment

Partners, Practices, Protection from STDs, Past History of STDs, and Pregnancy Plans and Prevention (the five P's) are essential topics to cover in a routine Sexual Health Assessment. The following can be utilized as your clinic's sexual health assessment form. This form may also be used as a reference to modify your current sexual health assessment practices.

PARTNERS

Determining the number and gender of your patient's sex partners helps assess the vulnerability of contracting an STD and/or HIV. As you listen, seek signs of consent, a healthy relationship, and pleasure. For instance, ask about possible intimate partner violence on intake forms or in person, or share a pamphlet or safety card. Affirm that you and clinic staff are a welcoming place should the patient reach out about abuse at any time.

In the past few months, how many sex partners have you had?

In the past year, how many sex partners have you had?

What kind of anatomy do you your partner(s) have?

How long is/was your most recent relationship?

Is it possible that any of your sex partners in the past 12 months had sex with someone else while they were still in a sexual relationship with you?

PRACTICES

Discussing practices helps determine the need for STD and/or HIV testing, including the anatomical sites to collect specimens for testing. Some patients prefer open-ended questions, while others want yes or no questions.

What kind of sexual contact do you have currently or have had in the past?

Have you had vaginal sex (penis in vagina)?

Have you had anal sex (penis in rectum/anus)?

For men who have sex with other men: Are you the receptive (bottom) or insertive (top) partner?

Have you had oral sex (mouth on penis/vagina)?

Have you had unprotected vaginal, oral, or anal sex?

Have you exchanged sex for drugs, money and/or other things?

PROTECTION FROM STDS

Discussing protection from STDs helps determine how you will talk to your patient about vulnerability-reduction. Topics may include condoms, perception of vulnerability, and STD testing. Start with a simple question, and build on your patient's response

What do you and your partner(s) do to prevent yourselves from getting STD or HIV from sex?

Do you and your partner(s) use any protection against STDs?

If so, what kind of protection?

How often do you use this protection?

In what situations do you use this protection, or with whom?

If you don't use protection, why not?

Tell me about your use of condoms with your most recent partner.

PAST HISTORY OF STDS

If your patient has had an STD in the past, their likelihood of having another is higher, and the patient would be more likely to get HIV since the behaviors and networks that put them at risk for other STDs also put them at risk for HIV

Have you ever been tested for HIV or other STDs?

We recommend that everyone gets an HIV test at some point in their lives, would you like to be tested for HIV or any other STDs today?

Have you ever been diagnosed with an STD and/or HIV?

Which STD?

When were you diagnosed?

What was the outcome—treatment, recurrence?

Has your current partner or have any of your previous partners ever been diagnosed or treated for an STD and/or HIV?

PREGNANCY PLANS AND PREVENTION

Discussing pregnancy plans and prevention allows the patient to share about their contraceptive knowledge, use, and needs. Assess reproductive goals for ALL people of reproductive age

Do you think you might like to have (more) children at some point?

When do you think that might be?

How important is it to you to prevent pregnancy (until then)?

Module 3 Part 1 Brief: Talking with Patients About HIV Transmission and Testing

Urban Indian Health Institute, the research division of Seattle Indian Health Board, created an e-learning course in collaboration with Cardea Services that focuses on educating healthcare professionals on providing culturally attuned HIV and sexual health care to American Indian and Alaska Native patients.

Talking About Transmission

Start by asking patients “How do people get HIV?” or “Tell me what you’ve heard about HIV.”

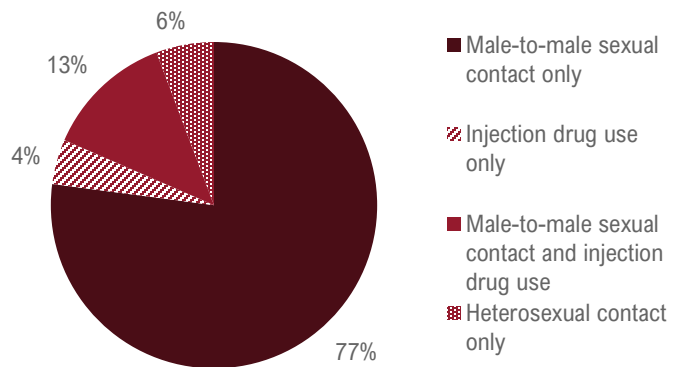
If patients state incorrect information, you can say, “Other people I talk with have also heard that...there is some updated information I can share with you...”

This helps patients feel validated with whatever understanding they have and allows you to correct misinformation.

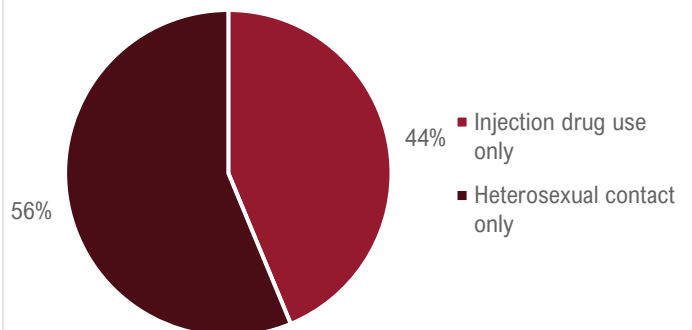
Technical language is often unfamiliar to patients. Patients might be uncomfortable telling you that they don’t understand words like receptive and insertive. Referring to specific body parts can be helpful (e.g. penis, rectum, and vagina).

HIV Diagnosis Among AI/AN in the US by Transmission

HIV Diagnosis Among AI/AN Males in the US
by Transmission Category in 2018



HIV Diagnosis Among AI/AN Females in the US
by Transmission Category in 2018



HIV CAN BE TRANSMITTED BY



HIV CANNOT BE TRANSMITTED BY



Talking About Testing

Tell patients: “One thing we share with all of our patients is that many people don’t know they have HIV. Since testing is the only way to diagnose HIV, we offer HIV testing to adults in our clinic who have been sexually active unless you tell us you don’t want testing.”

Everyone between the ages of 13 and 64 should be tested for HIV at least once.

If patients fit any of the following criteria, they should be tested at least once a year. If you don’t know, ask the patients in a nonjudgmental and respectful way:

- Is a man who has had sex with another man. Some sexually active gay and bisexual men may benefit from more frequent testing (every 3–6 months)
 - Has had sex with an HIV positive partner
 - Has had more than one partner since last HIV test
 - Has shared needles, syringes, or other equipment to inject drugs
 - Has exchanged sex or drugs for money
 - Has another sexually transmitted disease, hepatitis, or TB
 - Has had sex with anyone who has done anything listed above or with someone whose sexual history you don’t know
-

Let patients know that written consent and prevention counseling is not required. This helps reduce barriers to testing.

Giving HIV Test Results

Positive Result

Although HIV is treatable, patient knowledge of current approaches to HIV treatment and care can vary, so responses to this news can vary greatly. Even for those who know about current treatment, diagnosis with a significant illness is unsettling. You should:

- Ask if the person is ready to hear the result
- Share the results and pause
- Ask how the patient is feeling
- Reassure that you will answer questions and provide support
- If your clinic doesn’t provide HIV care, facilitate a referral
- Provide referrals for cultural/traditional healing and emotional support
- Begin discussion about sharing the positive results with sexual and/or needle sharing partners
- Emphasize the importance of starting on treatment as soon as possible
- Follow up in a few days to see how the patient is doing

Negative Result

If applicable, describe the window period and clarify the timing for the next HIV test to confirm the patient’s HIV status.

Talk to your patient about how they can continue to prevent HIV (condom use, safe injection practices, etc.).

Module 3 Part 2 Brief: Talking with Patients about HIV Prevention

Urban Indian Health Institute, the research division of Seattle Indian Health Board, created an e-learning course in collaboration with Cardea Services that focuses on educating healthcare professionals on providing culturally attuned HIV and sexual health care to American Indian and Alaska Native patients.

The HIV Care Continuum and American Indian and Alaska Native (AI/AN) Populations

National HIV Prevention Objectives

1. Increase awareness of HIV status among people with HIV to 90%
2. Increase newly diagnosed with HIV who are linked to care, within one month to 85%
3. Increase HIV diagnosed individuals whose virus is effectively suppressed to 80%

National 2016/2017 Statistics on AI/AN in HIV Care

- 82% of AI/AN living with HIV have been diagnosed
- 85% of AI/AN patients were linked to HIV medical care within 1 month of diagnosis¹
- 49% of AI/AN patients received HIV medical care and achieved viral suppression

Helpful Phrases When Talking with Patients about HIV Prevention

Using phrases like these show respect for a patient's autonomy and personal power regarding their health care. Even when they choose not to engage, this can foster trust and appreciation in the moment and during future visits to the clinic.

“We want to help anyone who finds that they have HIV get treatment that can help them stay healthy.”

“It's great you came in to get tested. Knowing your HIV status helps you and others.”

“There is a lot to think about, but we'll take it one step at a time and make sure all of your questions are answered.”

What other services/support might you offer to patients at your site or by referral?

- HIV primary care
- HIV treatment and additional lab work
- Treatment for substance
- Needle exchange programs
- Emotional/mental health care
- Insurance coverage
- Case management
- Support groups
- Spiritual and cultural traditional healing

HIV Prevention Strategies

Discuss prevention strategies with open-ended questions, reflective listening, and affirmative, resilience-building statements. This will help to understand patient's needs and preferences in a meaningful way.

A harm reduction approach centered around respect for patient self-direction is key when discussing strategies for reducing HIV contraction associated with drug and alcohol use. Be prepared to provide referrals, and assist in creating realistic, helpful prevention strategies.

¹ Linked to care means patients had \geq 1 CD4 or VL test within 1 month of their initial HIV test

Strategies for Reducing HIV Vulnerability

REDUCING VULNERABILITY ASSOCIATED WITH SEXUAL BEHAVIORS

Ongoing testing for HIV

Use condoms correctly for anal and vaginal sex and a barrier for oral sex

Consider HIV medications to prevent transmission, such as:

Treatment as Prevention

Prevention of Mother-to-Child Transmission

Pre-Exposure Prophylaxis (PrEP)

Post-Exposure Prophylaxis (PEP)

Get testing and treatment for other STDs

Disclose HIV status with sexual partner(s)

REDUCING VULNERABILITY ASSOCIATED WITH DRUG AND ALCOHOL USE

If injecting drugs:

Use clean needles and other injection equipment

Avoid sharing needles or works

Use syringe service programs

Start taking PrEP medication

Use condoms

If using alcohol and other drugs:

Avoid sexual activity while drinking or high

Use condoms

Ongoing testing for HIV

Discuss treatment options for a substance use disorder

Additional HIV Prevention Steps

HIV testing for patients who are pregnant or plan to become pregnant, and treatment if they test positive for HIV

Recommend testing for sexual partners of patients who test positive for HIV or STDs

Interventions that improve access to prevention tools:

- Syringe service programs
- Laws allowing sterile syringe purchase
- Condom distribution programs
- Drug treatment (including Medication Assisted Therapy)

Utilize universal precautions in all health care settings

Create HIV treatment protocols for both occupational and non-occupational exposure

The aim is to have a non-judgmental conversation, facilitating access to resources and services and remaining respectful of each individual and the communities in which they live. Be a judgement-free champion for your patient's health!

Module 4 Brief: Biomedical Prevention of HIV

Urban Indian Health Institute, the research division of Seattle Indian Health Board, created an e-learning course in collaboration with Cardea Services that focuses on educating healthcare professionals on providing culturally attuned HIV and sexual health care to American Indian and Alaska Native patients.

“When you offer PrEP...it gives them the choice and a little bit of freedom that everybody else is entitled to as well, and it offers them the protection of something that can be prevented”

—Jamie Tom, DNP, FNP

From 2010–2017, HIV diagnoses increased 39% for all AI/AN

Only 46% of AI/AN living with HIV remain in medical care and on treatment once diagnosed with HIV

It is important to give patients the option of multiple methods of HIV prevention, including biomedical prevention of HIV. People who are HIV negative can take HIV medications after they have been exposed, called Post-Exposure Prophylaxis, or PEP. If they are continually vulnerable to acquiring HIV, they can take HIV medication known as Pre-Exposure Prophylaxis, or PrEP. These methods have shown great promise in reducing new HIV infections and can be prescribed and monitored by an infectious disease specialist or in primary care and family planning clinics.

Talking with Patients About PEP and PrEP

Tips for Talking with Patients:

- Establish and build rapport and trust
- Focus on the patient's needs and preferences
- Avoid making assumptions about the patient, including their gender
- Pause for emotional responses and address questions or concerns
- Build on the patient's experiences and discuss their beliefs and concerns
- Use open-ended questions, affirmations, reflective listening, and summarizing techniques

Care Before and After PEP and PrEP

BEFORE PRESCRIBING PEP OR PREP

Initial HIV and STD tests (including gonorrhea, chlamydia, syphilis, and hep C)

Risk assessment

Consider patient tolerability for medication and quarterly appointments

AFTER PRESCRIBING PEP OR PREP

Follow up HIV tests for PEP and PrEP

STD tests (including gonorrhea, chlamydia, syphilis, and hep C)

Tests of serum creatine for kidney function

Check on medication adherence, tolerability, and any other barriers

HIV Prevention Options

	WHAT IT IS	WHY IT IS IMPORTANT	WHO IS A CANDIDATE
PEP (Post-Exposure Prophylaxis)	A 28 day course of HIV medication prevents infection within 72 hours after an exposure to HIV. In this time, a window of opportunity exists as HIV is infecting cells at the site of exposure. Patients are given a tailored HIV regimen containing 3 or more ART drugs.	<ul style="list-style-type: none"> • Can stop infection after exposure • One month of pills versus a lifetime of HIV-related medical care 	Anyone with recent exposure to HIV, including occupational or non-occupational exposures. Medications are chosen based on adherence, toxicity, cost and other considerations.
PrEP (Pre-Exposure Prophylaxis)	<p>A daily medication for people who are HIV negative to prevent them from becoming infected with HIV. Because it is a daily medication, some barriers include:</p> <ul style="list-style-type: none"> • Forgetting or being away from home • Changes in daily routine • Depression • Alcohol/substance abuse • Secrecy/stigma • Feeling sick • Distance to clinic • Out of stock 	<ul style="list-style-type: none"> • Can reduce the risk of HIV acquisition from sex by 99% when taken consistently • Reduces risk of HIV acquisition from injecting drugs by more than 74% when taken consistently (Centers for Disease Control, 2019) 	<p>Men who have sex with other men, or trans women and men, heterosexual women and men, especially:</p> <ul style="list-style-type: none"> • Patients with HIV-positive sexual partner • Patients with recent bacterial STI, high number of sexual partners, history of inconsistent or no condom use, or commercial sex work <p>People who inject drugs, especially:</p> <ul style="list-style-type: none"> • Patients with HIV-positive injecting partner • Who share injection equipment • Recent drug treatment (but currently injecting)

Module 5 Brief: Initial Management of HIV in the Primary Care Setting

Urban Indian Health Institute, the research division of Seattle Indian Health Board, created an e-learning course in collaboration with Cardea Services that focuses on educating healthcare professionals on providing culturally attuned HIV and sexual health care to American Indian and Alaska Native patients.

HIV Care Continuum

The HIV continuum of care is a public health model designed to outline the stages that patients go through in their journey with HIV care and treatment. Patients can use this outline to better understand the process, and providers can use it as a framework to assess the outcomes and progress of care.

There are five stages included within this model:

Stage 1 Diagnosed with HIV

Stage 2 Linked to care

Stage 3 Received HIV medical care

Stage 4 Stayed in care

Stage 5 Achieved viral suppression

Achieving viral suppression for patients with HIV is the ultimate goal. When a patient's viral load is below a detectable level, the patient is no longer able to transmit the virus to others. This is commonly referred to as *U=U*, or *Undetectable = Untransmittable*. It's important to note that viral loads can increase again if treatment isn't continuous.

The Role of Primary Care Providers

Primary care providers are in a unique position to support patients throughout the HIV care continuum. Having an established relationship with a patient who has been diagnosed with HIV can increase the chances of the patient staying in care and achieving viral suppression.

Stage 1: Receiving a positive diagnosis for HIV

Routinely screen patients ages 13–64. Yearly screen those who

- inject drugs or a partner of a person who injects drugs (PWID).
- exchange sex for money or drugs.
- have a sexual partner with HIV.
- have had, or their partner has had, multiple sexual partners since most recent HIV test.

Stage 2: Being linked to a care provider

The first link to care is the disclosure visit where a patient learns they have tested positive for HIV. Here, providers will conduct a physical assessment, refer to wrap around services like case management and traditional medicine, collect health history, and discuss psychosocial aspects that might impact their mental health and engagement in care.

Stage 3: Receiving medical care for HIV

At this stage, primary care providers can start offering HIV medical care as needed. This can be a range of things such as laboratory testing, immunizations, preventing infections, and selecting an antiretroviral therapy (ART) regimen.

Stage 4: Remaining engaged in HIV care over time

A patient with HIV is engaged in care when they are consistent in attending their appointments and taking their ART. Providers should support the patient as needed by addressing new symptoms, referring to specialists, supporting the patient's family, and supporting adherence to medications and treatment.

Stage 5: Achieving viral suppression

Achieving viral suppression isn't a singular point in time. Patients need continued support in order to maintain a low viral load. Providers can support that goal by scheduling regular check-ins and monitoring and adjusting the ART regimen as needed. Most people living with HIV should have their CD4 counts measured every 3–6 months. Barriers such as housing, domestic violence, transitions between clinics, etc. can be addressed in order to minimize the gaps in care.

Initial Management of HIV

The following information that will be gathered during appointments in the initial management stage.

Initial history and physical examination

- HIV condition and previous HIV treatment
- Risk factors such as substance use and/or sexual practices
- General medical history
- History of other sexually transmitted infections
- Signs of opportunistic infections

Psychosocial aspects

- Preferred gender pronouns
- Who is aware of their status?
- How safe do they feel in disclosing their diagnosis to others?
- Financial and housing situations
- History of depression, anxiety, suicidality, trauma (including historical), or abuse
- Social, family, and community support networks

Initial laboratory testing

For all newly diagnosed patients with HIV, the goal of testing is three-fold:

1. Assess the patient's HIV severity and immune system impairment.

There are three main HIV-specific tests:

- HIV viral load, which reflects the severity of infection
 - CD4 count, which is the most accurate measure of immune system impairment and prognosis
 - HIV resistance, which helps assess whether ART-resistant mutations are genetically present
2. Screen for comorbidities such as tuberculosis and STIs such as viral hepatitis.
 3. Establishing a general health baseline to identify any existing condition such as pre-diabetes or renal issues. Documenting the baseline prior to starting ART is crucial in order to mitigate any adverse reactions that might occur.

Primary care providers look at the whole person in a holistic approach, such as their gender and sexual identity, their cultural and spiritual practices, as well as other health or mental health challenges they face. Helping the patient feel supported and heard can turn the conversation to health rather than illness. All along the way, you as a primary care provider can make a positive difference in patients' lives.

—Subject Matter Expert

Treatment and immunizations

The main goal of the initial management of HIV is to get the patient on the road to achieving viral suppression. Current recommendations are to start antiretroviral therapy (ART) as soon as possible, particularly for patients with a low CD4 count. ART has a high barrier to resistance with low chances of adverse side effects and can even be prescribed in the first visit prior to obtaining a CD4 count. Regimens can vary and are generally composed of 2–3 unique antiretroviral medications. U.S. guidelines for specific initial ART recommendations are updated regularly; please refer to **Appendix A** for the most current recommendations.

Since HIV compromises a patient's immune system, staying up to date on vaccinations is an essential part of initial management. Please refer to the summary table in **Appendix B** for a complete list of recommended immunizations for adult patients with HIV.

Consultation and Co-management

It is always encouraged that as providers learn and practice more, they reach out to HIV experts and consultation hotlines to receive co-management or advice for special cases. These might include cases where

- comorbidities or previous conditions are present, especially hepatitis or tuberculosis.
- lab results show a complex drug resistance profile.
- the patient is receiving ART but has not reached viral suppression after 24 weeks.
- there are adverse reactions to medications.

There are several existing resources available for consultation with HIV experts. If providers do wish to refer to an expert, here are some options of where to reach out:

- University of California–San Francisco, Clinician Consultation Center: HIV/AIDS Management
- Project ECHO
- AIDS Education and Training Centers

Appendix A

CURRENTLY RECOMMENDED INITIAL ANTIRETROVIRAL REGIMENS FOR MOST TREATMENT-NAÏVE ADULTS WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV), AS OF JANUARY 2021 †

*Coformulated bictegravir 50 mg/emtricitabine 200 mg/tenofovir alafenamide 25 mg (Biktarvy), once daily

Coformulated dolutegravir 50 mg/abacavir 600 mg/lamivudine 300 mg (Triumeq), once daily
Do not use if HLA-B*5701 positive or HBV co-infection

*Dolutegravir 50 mg (Tivicay), once daily

Plus, any one of the following:

Coformulated emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg (Truvada), once daily

or

Coformulated emtricitabine 200 mg/tenofovir alafenamide 25 mg (Descovy), once daily

or

Coformulated lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg (Cimduo), once daily

Coformulated dolutegravir 50 mg/lamivudine 300 mg (Dovato), once daily

Do not use if initial HIV RNA (viral load) > 500,000 copies/mL or HBV co-infection;

May be preferable for patients who wish to take fewer medications (i.e., 2 antiretroviral agents rather than 3)

Raltegravir 400 mg (Isentress), twice daily

Plus, any one of the following:

Coformulated emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg (Truvada), once daily

or

Coformulated emtricitabine 200 mg/tenofovir alafenamide 25 mg (Descovy), once daily

or

Coformulated lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg (Cimduo), once daily

†Antiretroviral use in pregnancy should be guided by consultation and/or established treatment guidelines. Regimen selection for individual patients should be guided by factors such as virologic efficacy, toxicity/side effect profile, pill burden and dosing frequency, drug-drug interaction potential, HIV drug resistance testing results, co-morbid conditions (especially renal and/or liver disease), medication access, and formulary availability/cost. The DHHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV are updated regularly.

Additionally, the International Antiviral Society-USA Panel releases updated treatment recommendations every few years (www.iasusa.org/resources/guidelines/). These resources provide additional details and considerations for select clinical case scenarios. Free, point-of-care consultation is also available through the National Clinician Consultation Center (www.nccc.ucsf.edu): (800) 933-3413.

*Option for “rapid”/immediate ART initiation, i.e., before baseline HIV drug resistance (genotype) testing results are available

Additional clinical resources: National HIV Curriculum (hiv.uw.edu), University of Liverpool HIV Drug Interactions (www.hivdruginteractions.org), Toronto General Hospital drug interaction tables (hivclinic.ca/drug-information/drug-interactiontables/).

Appendix B

TABLE 2. IMMUNIZATIONS FOR ADULTS WITH HUMAN IMMUNODEFICIENCY VIRUS INFECTION

Vaccine	Dosing
Hepatitis	Indicated when identified risk patient*
Hepatitis B	Standard schedule†
Herpes zoster	Contraindicated if CD4 lymphocyte count < 200 cells per mm ³ (0.20 x 10 ⁸ per L), otherwise standard schedule
Human papillomavirus	Standard schedule‡
Influenza (inactivated only)	Standard schedule
Measles, mumps, rubella	Contraindicated if CD4 count < 200 cells per mm ³ , otherwise standard schedule
Meningococcal	Indicated when identified risk present§
Pneumococcal	Standard schedule unless previously immunized
Tetanus, diphtheria, pertussis	Standard schedule
Varicella	Contraindicated if CD4 count < 200 cells per mm ³ , otherwise standard schedule

*—Men who have sex with men, injection drug users, and patients with hepatitis B, hepatitis C, or chronic liver disease, if not already immune

†—Some experts recommend double-dose hepatitis B vaccinations, especially if the patient does not respond to the initial vaccination series

‡—For high-risk women and men 26 years and younger.

§—Recommended when outbreaks occur in the community.

||—13-valent pneumococcal conjugate vaccine (Prevnar 13) initially, followed by 23-valent pneumococcal polysaccharide vaccine (PPSV23; Pneumovax) at least eight weeks later; PPSV23 booster recommended five years after initial PPSV23 vaccine. See reference 13 for recommendations for patients who were previously immunized or who are 19 years or younger.

Information from reference 13.

Excerpt from: Goldschmidt RH, Chu C, Dong BJ. Initial Management of Patients with HIV Infection. *AM Fam Physician*. 2016 Nov 1;04(9):708–716. PMID:27929247.

Please note, patients with HIV who have CD4 counts less than 200 cells per mm should not receive live vaccines such as oral polio, live attenuated influenza, or varicella vaccine. These vaccines can be provided once the immune system has been restored.”

Module 6 Brief: Harm Reduction Principles for Reducing the Risk of HIV

Urban Indian Health Institute, the research division of Seattle Indian Health Board, created an e-learning course in collaboration with Cardea Services that focuses on educating healthcare professionals on providing culturally attuned HIV and sexual health care to American Indian and Alaska Native patients.

Principles of Harm Reduction

Harm reduction is a term used to define a set of practical strategies and ideas aimed at reducing negative consequences associated with behavioral choices. For example, behaviors that might increase the risk of contracting HIV include injecting drugs and condomless sex. In this scenario, harm reduction can include using condoms and taking PrEP (pre-exposure prophylaxis). Please refer to Appendix C to see the primary principles of harm reduction.

- Behavior that carries risk is part of our world, choose to minimize harmful effects
- Understand behavior as a complex multi-faceted phenomenon
- Non-judgmental, non-coercive provision of services
- Quality of individual and community life and well-being as the criteria
- The people affected have a voice in designing programs and policies
- Peoples as the primary agents of reducing the harms of their behavioral choices
- Poverty, racism, past trauma, and other social inequalities
- Doesn't minimize or ignore the real and tragic harm and danger

Trauma and Behavior

For many people, engaging in behaviors that carry risk can be a coping mechanism for dealing with trauma. Particularly in Indigenous communities, historical trauma is an important factor to consider when talking about behaviors that carry risk.

Historical trauma stems from an event, like forced removal or genocide, that happened in previous generations but its effects extend beyond an individual lifespan. Post-trauma coping mechanisms might include alcohol and drug use, gambling, sex, and/or self-harm.

Dispelling Myths About Harm Reduction

HARM REDUCTION DOES..	HARM REDUCTION DOES NOT..
Promote a spectrum of safer techniques and managed use to minimize potential harm	Enable substance misuse or behaviors that carry significant health risk
Understand that there are complex reasons behind behaviors and quitting and/or abstinence isn't always an option	Exclude abstinence-based treatment models as viable options
Provide a framework for understanding how structural inequalities like poverty, racism, homophobia, etc. impact individual behavior	Minimize or ignore the historical trauma and social inequities that often lead patients to seek out coping mechanisms

Many of these myths result in dangerous misconceptions around harm reduction.

Interventions such as syringe service programs can be extremely beneficial in preventing HIV, hepatitis C, and abscesses in people who inject drugs (PWID), but stigma has made implementation controversial. As a result, many PWID might be avoidant of or distrusting toward seeking help. Harm reduction can go a long way in bridging this gap.

Harm Reduction in a Clinical Setting

Harm reduction means meeting people where they are, but not leaving them there.

Here's how it might look in practice:

- Understand where a person is at in their journey.
- Incorporate the Indigenous understanding of wellness, considering the person's life and balance holistically.
- Combining mental, physical, and spiritual health to benefit the whole person
- Provide linkage to services such as support groups, medication-assisted treatment (MAT), syringe service programs (SSP), free condoms, STI testing and sexual health assessments, PrEP, expedited partner therapy (EPT), etc.

Harm reduction focuses on minimizing the potential harm to the person, with an understanding that there are complex reasons behind the behavior and quitting is not always an option.

—Subject Matter Expert

How You Can Include Harm Reduction in Your Practice

Providers can take a number of steps to include harm reduction in everyday practice. These steps can go a long way in ensuring the patients are able to access the resources necessary to minimize potential harm:

Understand the connection between trauma and behavior—always continue learning

Build a collection of local resources or referral guides for patients.

Identify ways to improve communication and build rapport with patients, encouraging them to establish relationships when not in crisis, so a provider is available when the need arises.

Utilize motivational interviewing.

Module 7 Brief: Creating an Adolescent-friendly Environment for Sexual Health Assessment and Treatment

Urban Indian Health Institute, the research division of Seattle Indian Health Board, created an e-learning course in collaboration with Cardea Services that focuses on educating healthcare professionals on providing culturally attuned HIV and sexual health care to American Indian and Alaska Native patients.

Introduction to Sexually Transmitted Infections in Adolescents

Younger age groups, specifically in the 15–24 age range, are disproportionately affected by rising STI infections, accounting for half of all new infections. American Indian and Alaska Native youth are at an even greater risk than other demographic groups.

A LOOK AT THE NUMBERS...

In 2018, the rate of reported chlamydia cases among AI/AN in the U.S. was 3.7 times the rate among non-Hispanic Whites.

The rate of reported gonorrhea cases among AI/AN in the U.S. was 4.6 times the rate among non-Hispanic Whites.

The rate of reported primary and secondary syphilis cases among AI/AN in the U.S. was 2.6 times the rate among non-Hispanic Whites.

Early detection and treatment of STI's is a cornerstone in sexual health.

- Early detection and treatment prevent STIs from being spread to additional sexual partners.
- Many STIs are symptomless and can cause long-term damage if not treated in a timely manner.
- STI complications disproportionately affect women. Undiagnosed and untreated STIs can lead to pelvic inflammatory disease, ectopic pregnancy, and adverse fetal and neonatal outcomes.
- People who have STIs are more likely to get HIV compared to people who do not have STIs.

While the CDC and other professional medical organizations have issued recommendations around providing sexual and reproductive care to adolescents, studies show that there is still room for improvement.

- Not enough adolescents are receiving sexual health information, assessments, or screenings for STIs from their health providers. In a sample of sexually experienced adolescents, only one-third reported receipt of information on contraception and STI and/or HIV prevention from their health care provider.
- Care can be more culturally sensitive for AI/AN youth and it can be more inclusive of different gender expressions, sexual orientations, disabilities, and other factors.

Healthcare providers can play a significant role in addressing youth sexual and reproductive health needs, creating a strong foundation for transition to adult care services.

—Subject Matter Expert

Best Practices for an Adolescent-friendly Environment

To create an environment that is safe and accepting for everyone, it's important to provide respectful and inclusive care to all genders, gender expressions, and sexual orientations. As adolescents explore these facets of their identity, building that trust will empower youth to share their sexual experiences and behaviors more openly.

Toward this aim, a number of studies have been conducted to understand what provider elements youth value the most.

From these studies, eight domains have emerged as central for adolescents to have positive experiences with care.

01 Accessibility of health care

location, affordability

02 Staff attitude

respectful, supportive, trustworthy, friendly

03 Guideline-driven care

confidentiality, autonomy, transition to adult health care services, comprehensive care

04 Medical competency

technical skills and procedures

05 Communication

clarity, active listening, tone, culturally sensitive, sex-positive rather than fear-based

06 Age-appropriate environment: flexibility, separate/private physical space, teen-oriented information, continuity of care

07 Involvement in health care

empowering, ensuring understanding, support decision making

08 Health outcomes

pain management, quality of life, mental health, achieving personal health goals

Youth-tailored assessments

It is also recommended that providers use youth-tailored assessments that accurately evaluate the determinants of health for young adults and adolescents. An example of this is the HEADSS Assessment.

HEADSS ASSESSMENT

Home: living situation, family members, and the adolescent's relationship with them

Education and employment: including current and future plans and challenges

Ethnicity and race: For AI/AN youth, providers can use this time to discuss ethnicity and race, as well as their identity and relationship to the community.

Activities: hobbies, sports, church, and participation in the community

Drugs: alcohol, cigarettes, vaping, marijuana, and other drugs, as well as factors associated with substance use

Suicidality and depression: current symptoms or history of mental health struggles

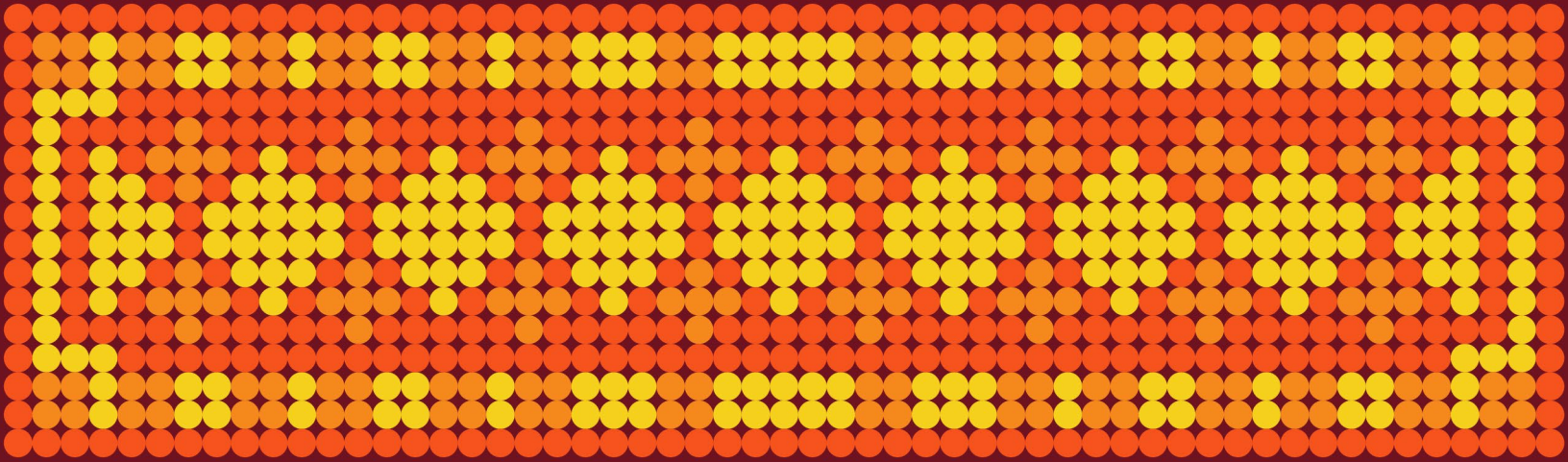
Sexuality and abuse: orientation, sexual experiences, history of pregnancy or STIs, and safe sex practices

References

This toolkit is a companion to the e-learning modules in the course HIV Care and Sexual Health Assessment for American Indians and Alaska Native Patients.

Module briefs and relevant resources are included in the toolkit.

- Module 1: Culturally Proficient Sexual Health Care for People of all Genders and Sexual Orientations
- Module 2: Sexual Health Assessment
- Module 3: Talking with Patients about HIV
- Module 4: Biomedical Prevention of HIV (ART, PEP, and PrEP)
- Module 5: Initial Management of HIV in the Primary Care Setting
- Module 6: Harm Reduction Principles for Reducing the Risk of HIV
- Module 7: Creating an Adolescent-Friendly Environment for Sexual Health Assessment and Treatment



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**Our mission is to decolonize data,
for indigenous people, by indigenous people.**
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