Expanding Perinatal HIV Prevention Efforts

A Key Strategy to End the HIV Epidemic in Los Angeles County

Michael Haymer, MD, MSW

NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT 2024

Project Support

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Disclosures

Michael Haymer has no relevant financial relationships with ineligible companies to disclose.

Learning Objectives

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At the conclusion of this activity, participants will be able to:

1. Increase knowledge of data-to-care approaches that can improve timely identification of perinatal cases in your jurisdiction.
2. Understand how to develop a perinatal HIV prevention provider outreach campaign.
3. Identify key components of a perinatal case management program serving highly vulnerable pregnant people with HIV.

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Recent LAC Trends in Perinatal HIV

Current and Projected Annual HIV/AIDS Landscape in Los Angeles County: Persons Living with HIV (PLWH), New Infections, HIV Diagnoses, Stage 3 HIV Infection (AIDS), and Deaths, 1982-2021[1,2,3,4]

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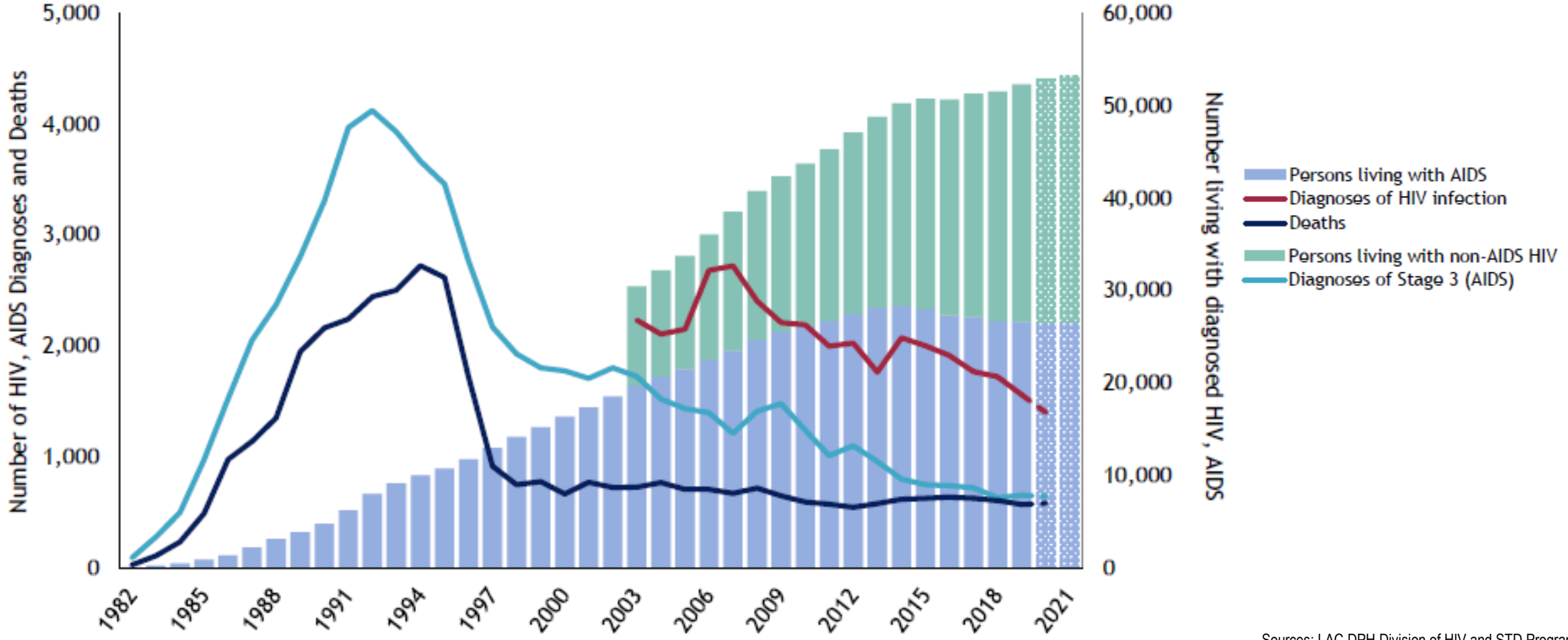
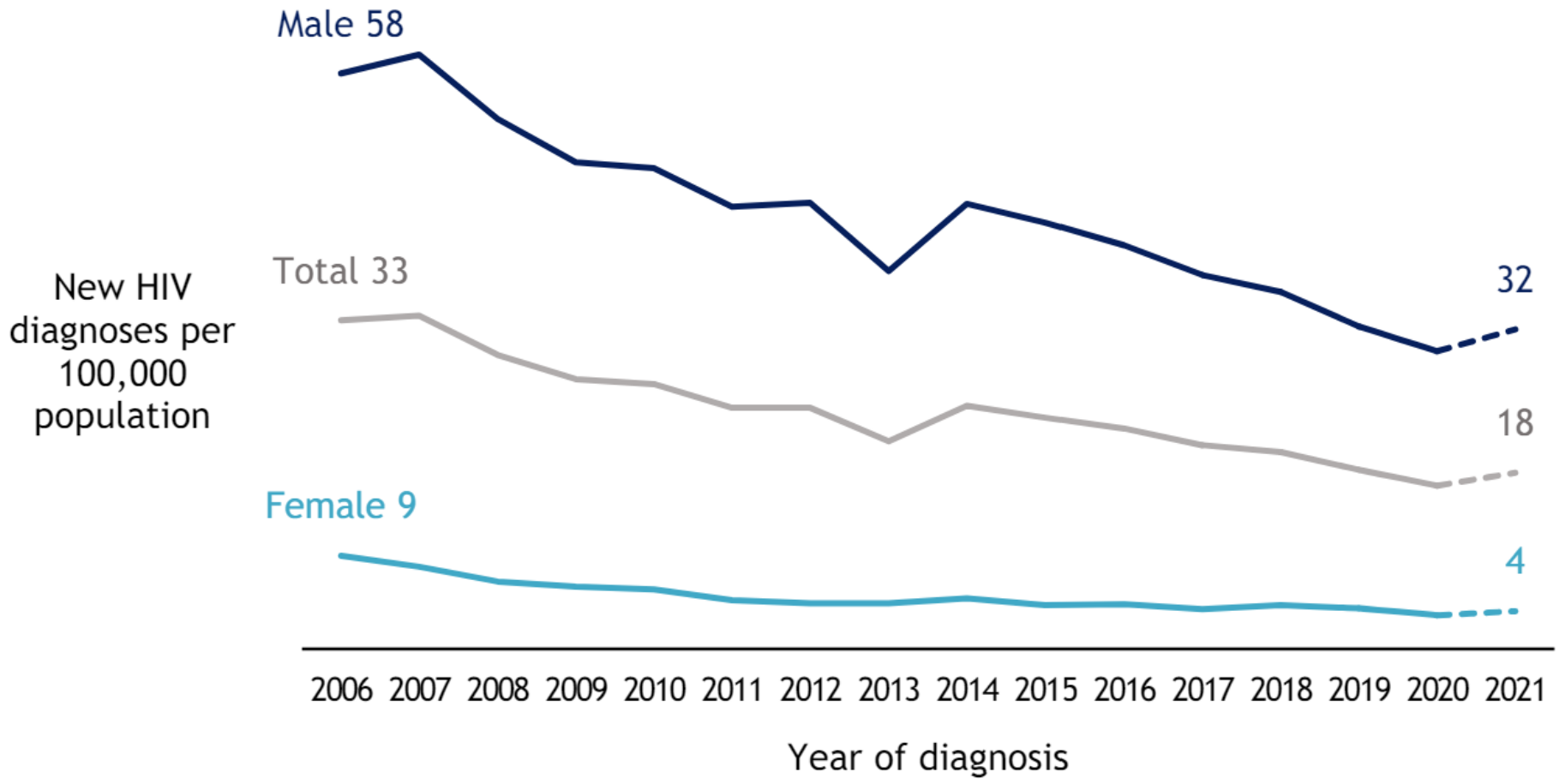


Sources: LAC DPH Division of HIV and STD Programs

[1] Includes new diagnoses of HIV infection regardless of the disease stage at time of diagnosis.
[2] Persons living with non-AIDS HIV and AIDS in Los Angeles County (LAC) are based on last reported address at the end of each calendar year.
[3] Includes persons whose residence at death was in LAC or whose most recent known address before death was in LAC, when residence at death is missing.
[4] 2020 data for diagnoses of HIV/AIDS and deaths and 2020/2021 data for persons living with non-AIDS HIV and AIDS are provisional as indicated by the dashed line and patterned bar. 2021 diagnoses of HIV/AIDS and deaths are underreported/unreliable due to significant reporting delay, and therefore are not shown.

HIV diagnoses rates by sex among persons aged ≥13 years, LAC 2006-2021



Sources: LAC DPH Division of HIV and STD Programs

1. Rates are presented by sex at birth due to the unavailability of population size estimates in LAC by gender categories.
2. Due to reporting delay, 2021 HIV diagnosis data are provisional as indicated by the dashed line.

HIV and Homelessness

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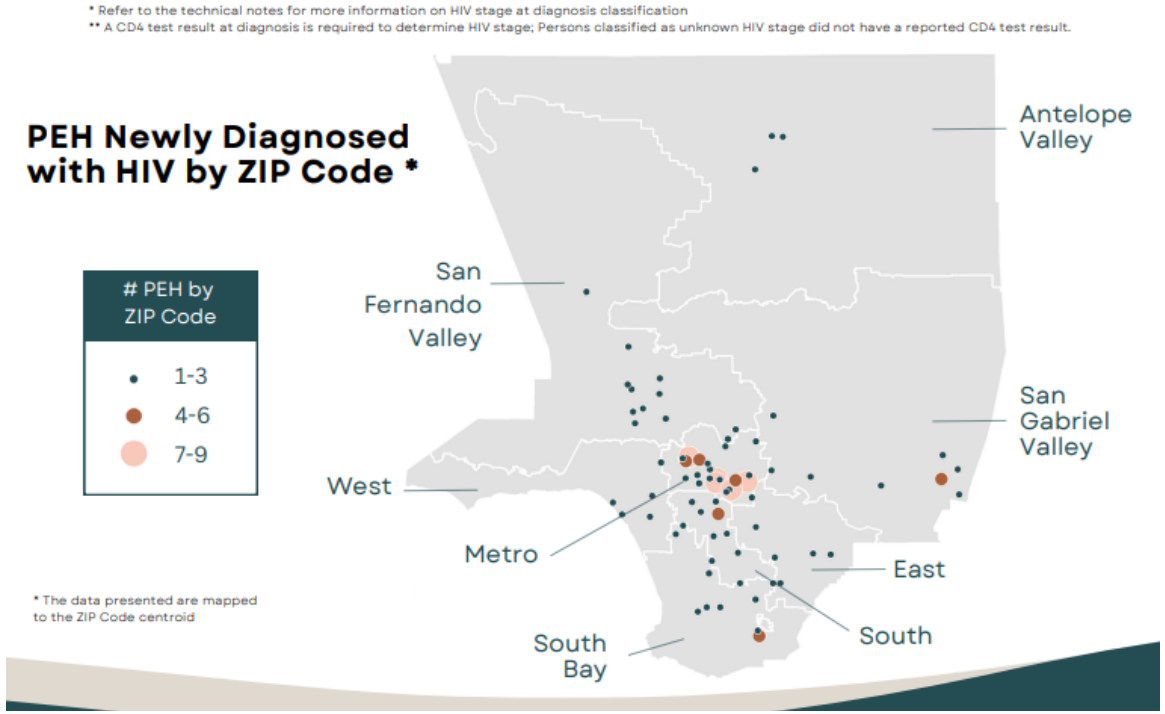
- In 2022, 13% of all new HIV diagnoses (184 people) were among people experiencing homelessness
  - 3x the rate compared to 2012
  - 20% were cisgender women (compared to 10% of HIV diagnoses in LAC)
  - 11% were trans women (compared to 4% of HIV diagnoses in LAC)
  - Methamphetamine use common >34%
  - 54% diagnosed in a hospital setting



Sources: LAC DPH Division of HIV and STD Programs

Number of Female and Congenital Syphilis Cases[1,2] Los Angeles County, 2010-2021[3] (excludes Long Beach and Pasadena)

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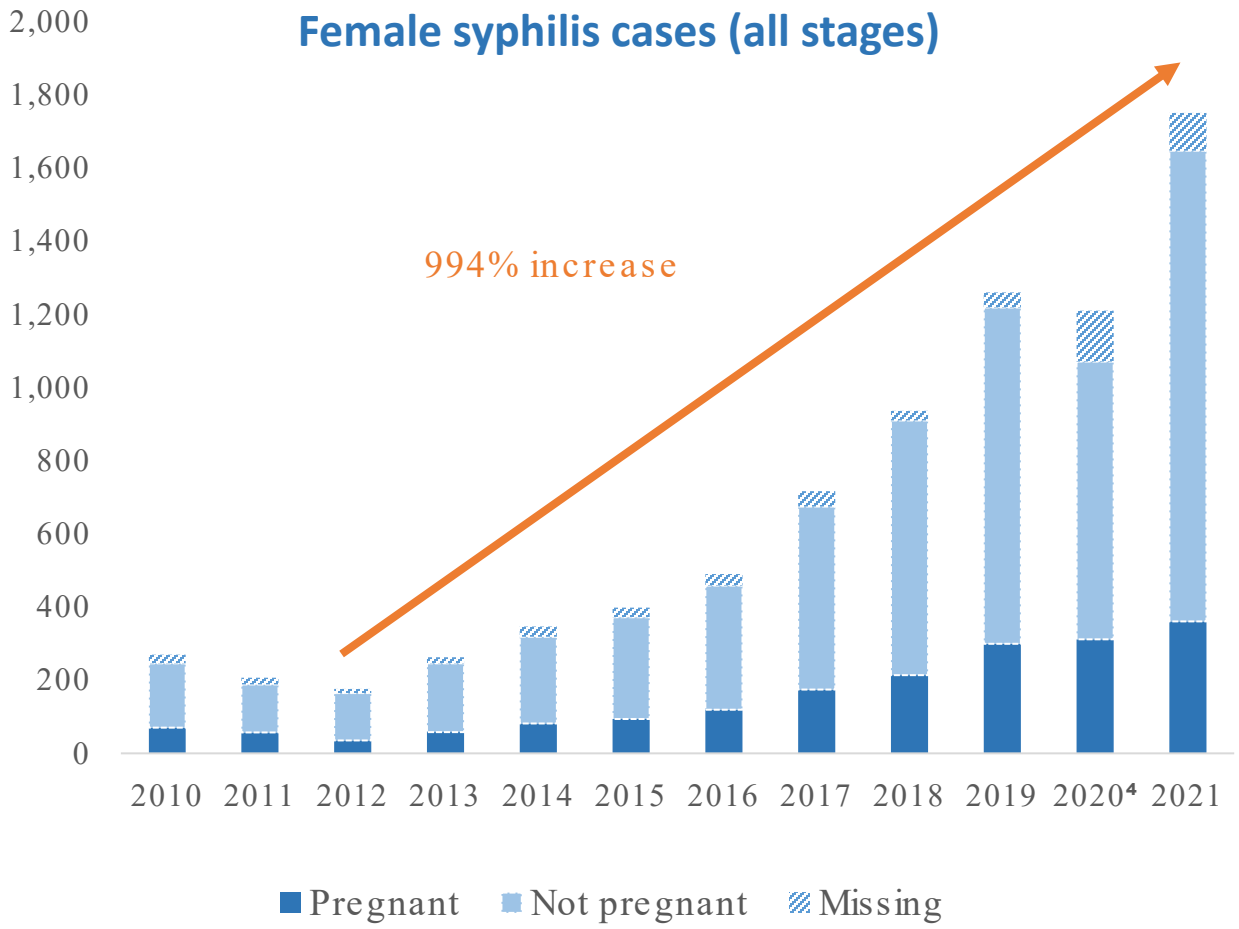

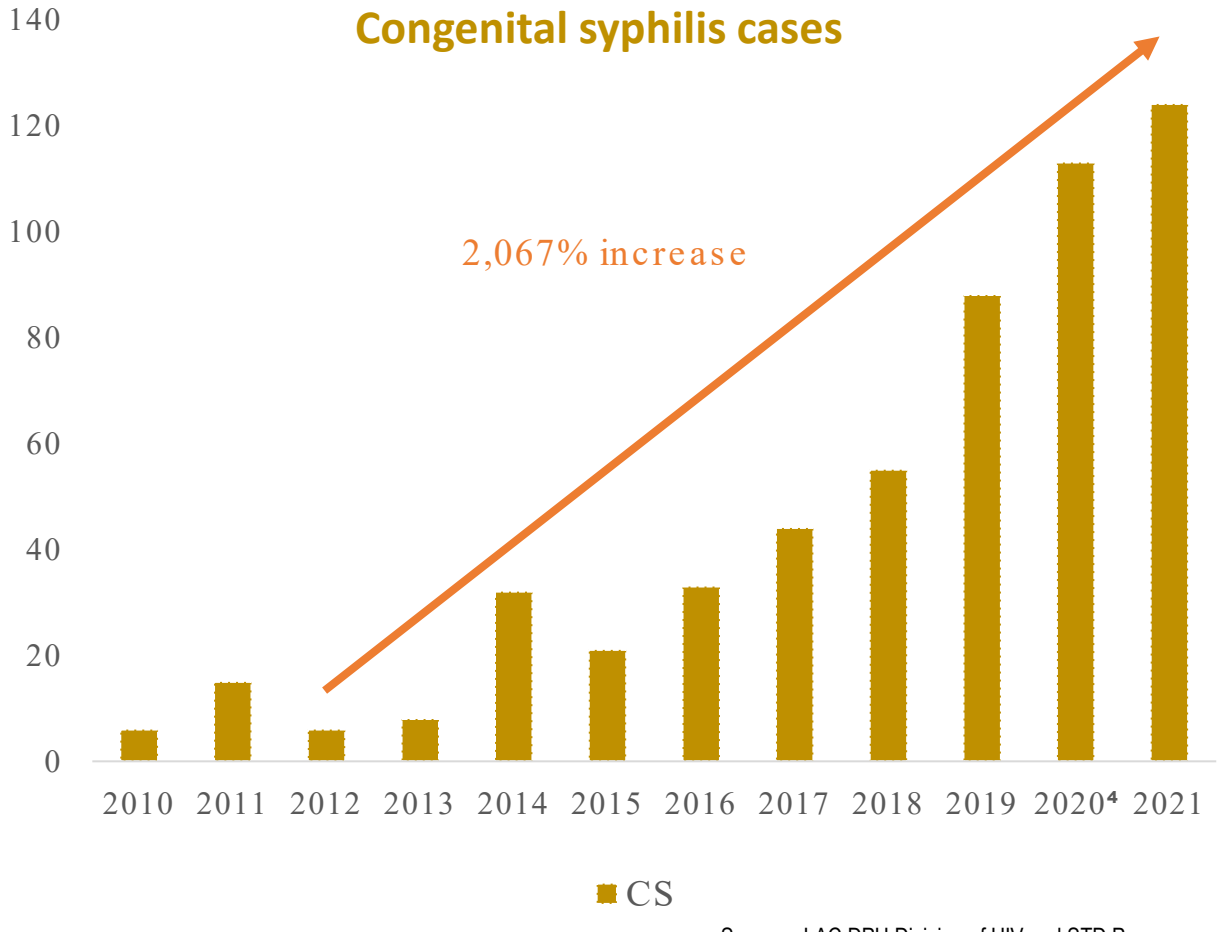

Sources: LAC DPH Division of HIV and STD Programs

1. Syphilis among females of childbearing age (ages 15-44) including all cases staged as primary, secondary, early non-primary non-secondary (previously early latent) and unknown duration/late (previously late latent).
2. Congenital syphilis includes syphilitic stillbirths.
3. LAC data as of March 23, 2023.
4. Note that the number of reported STDs in 2020 decreased as a result of decreased STD screening and increased use of telemedicine during the COVID-19 Stay at Home Health Officer Order.

Number of infants with perinatal HIV exposure and perinatally acquired HIV, LAC 2013-2023

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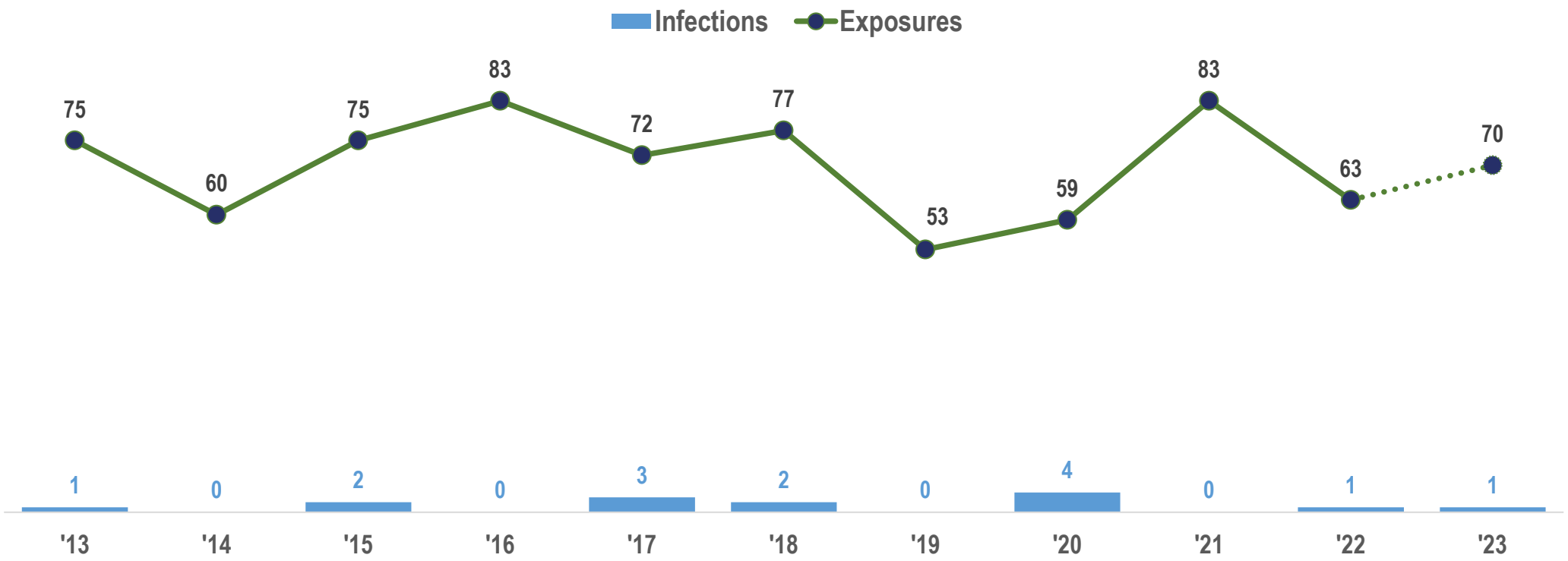

1 Due to reporting delay, HIV data for 2023 are provisional as indicated by the dotted line.
2 The number of infants with perinatally acquired HIV includes perinatal transmissions among babies born and/or diagnosed in LAC for a given birth year. The number of perinatal HIV exposures in infants was derived from 7 pediatric HIV-specialty sites which serve over 90% of the perinatal exposures and infections in children seeking HIV evaluation and care in Los Angeles County as well as from a birth registry match provided by the California Department of Public Health. This is an underestimate of the total number of infants with perinatal HIV exposure in the County since HIV exposure reporting is not mandated.

Source: HIV Surveillance data as of March 2024

Number of Perinatally Exposed Infants Born per Facility, 2023 -2024 Year-to-Date (N=91)

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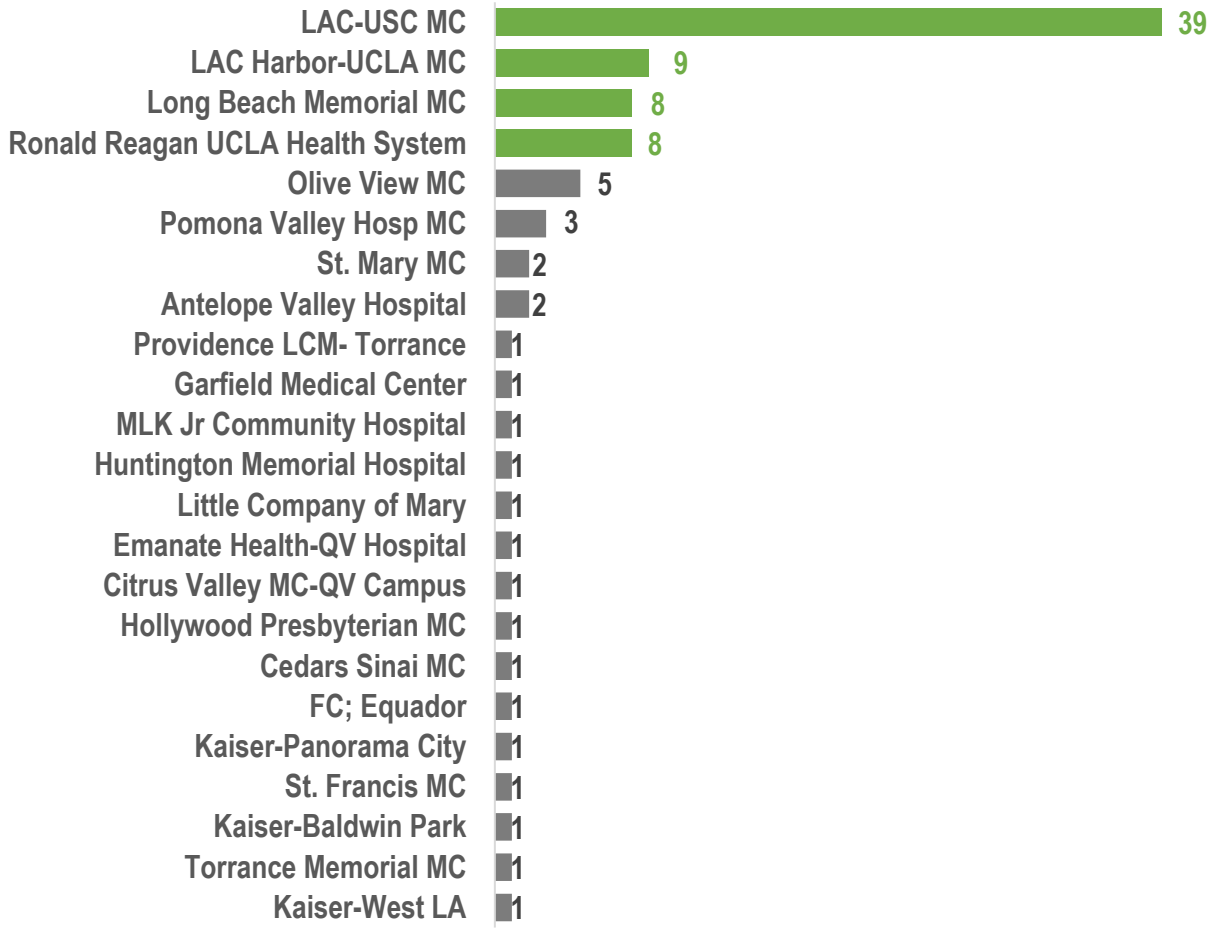

Source: HIV Surveillance data as of March 2024

Characteristics of PLWH who delivered in LAC, 2020-2023 (N=277)

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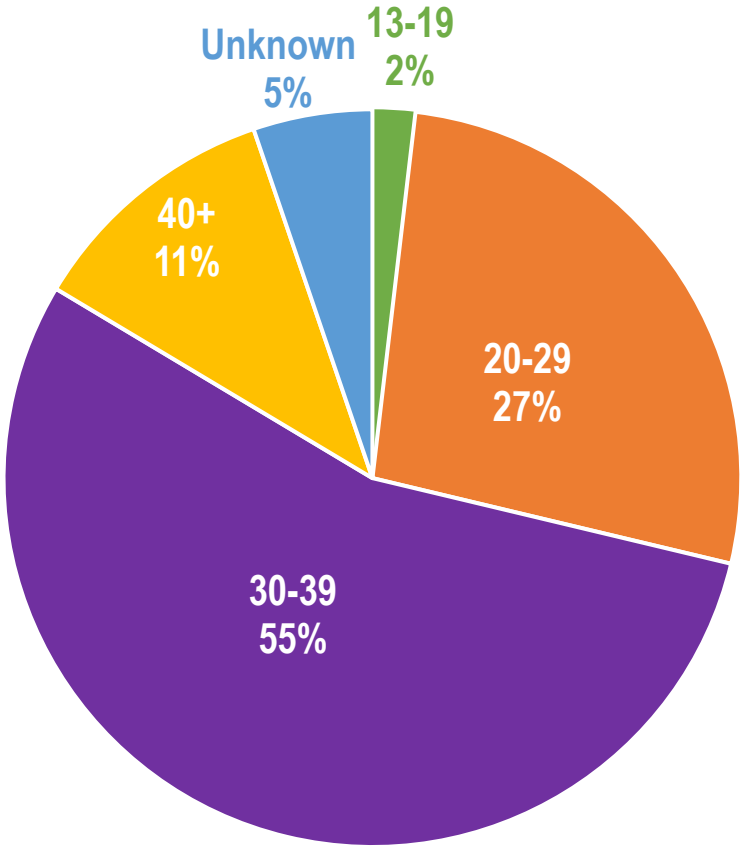
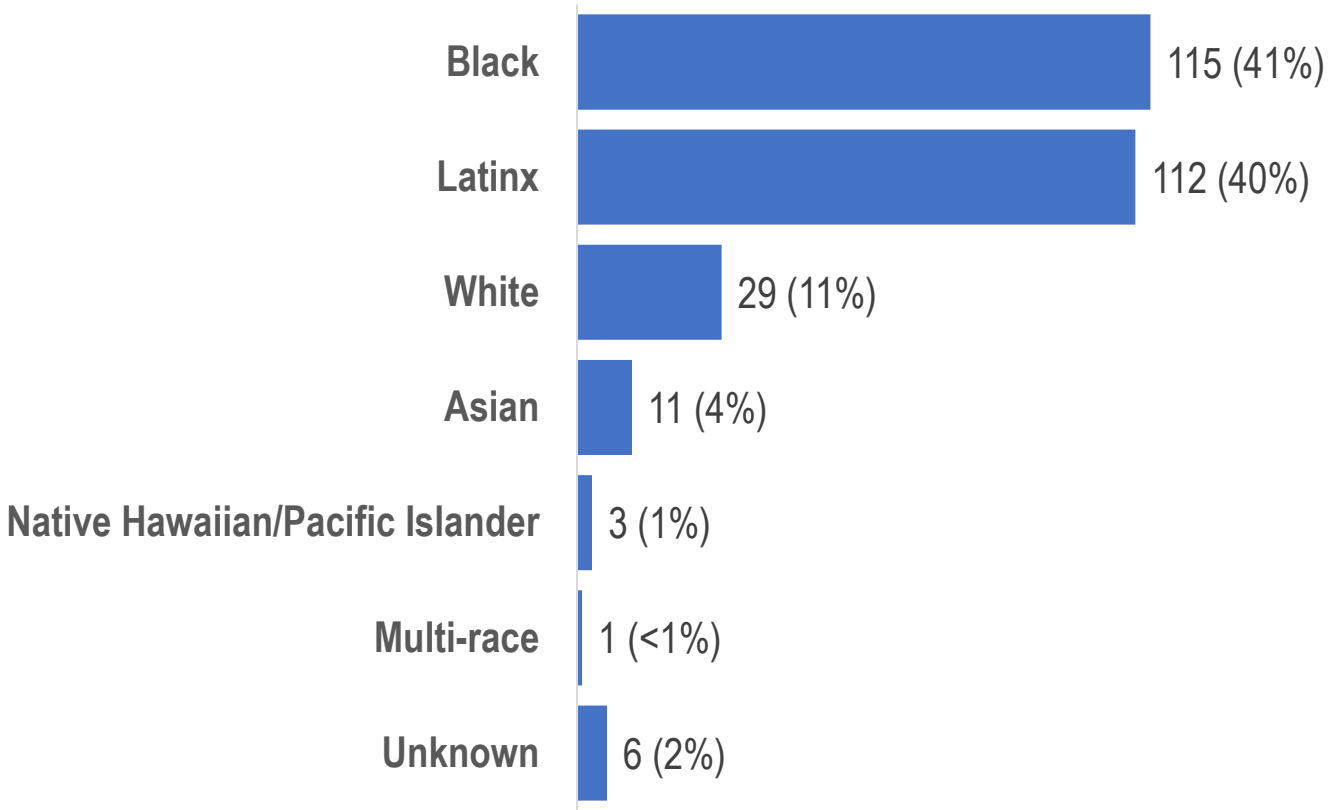
Age at Delivery (Years)



Race/Ethnicity



*At time of presentation, there were no HIV exposed births reported to American Indian/Alaska Natives in 2020 -2023.

Source: HIV Surveillance data as of March 2024

Characteristics of PLWH who delivered in LAC, 2020-2023 (N=277)

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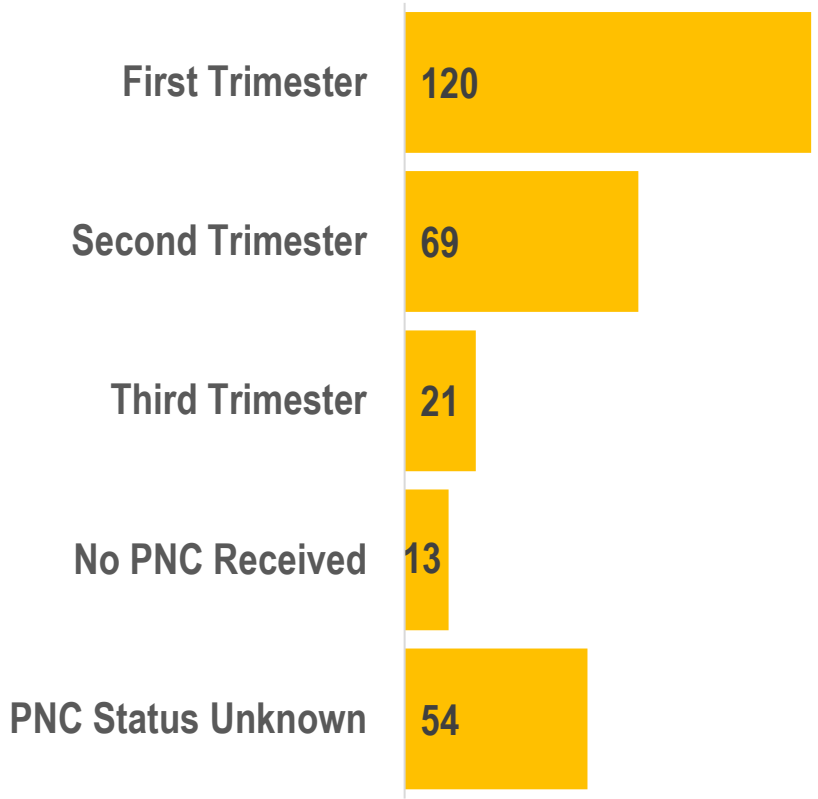
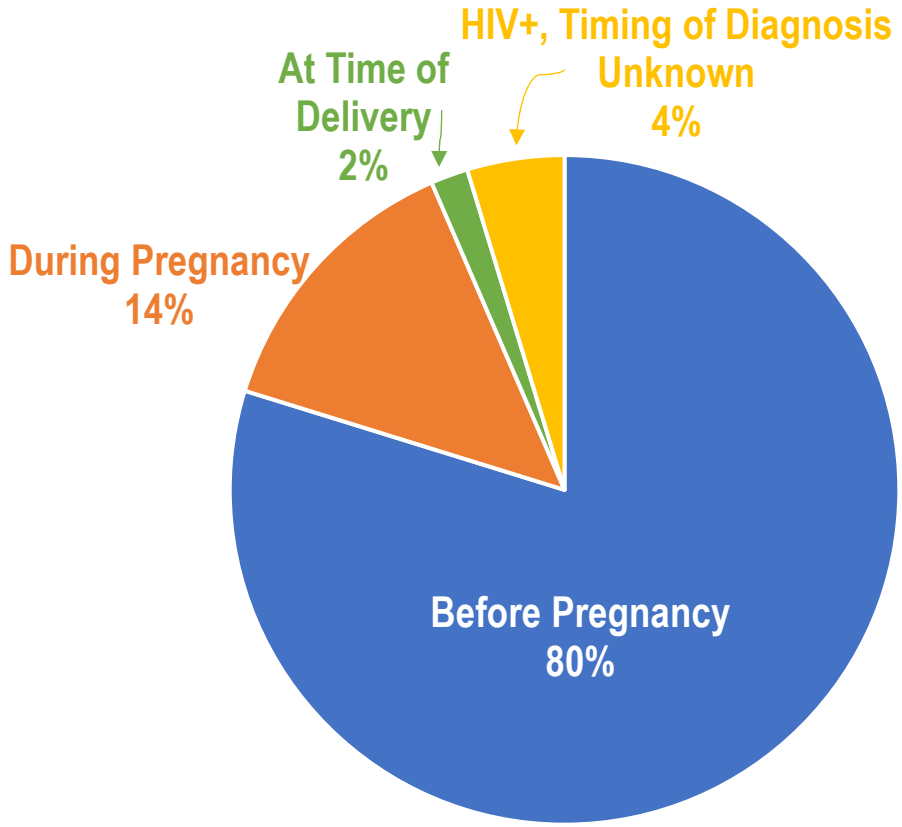
Entry into Prenatal Care



Timing of HIV Diagnosis



Source: HIV Surveillance data as of March 2024

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Health Department Activities

PCBP Surveillance Alert Processes

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Daily

- Automated surveillance check for new positive Ab/Ag or VL among people of childbearing potential (PCBP, birth sex of female and current age 15-44)
- Alert sent to DIS Supervisor for prioritized partner services

Source: HIV Surveillance data as of December 2023

PCBP Surveillance Alert Processes

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Monthly

- Surveillance generates 3 PCBP lists for perinatal HIV prevention team
  - **Unsuppressed:** OOC > 12 months w/ last VL > 200 copies/mL
  - **No Viral Load:** OOC > 12 months w/ no prior VL
  - **Viremic List:** PCBP in care w/ last VL > 1,000 copies/mL
    - Exclusions
      - First VL result after HIV dx
      - ART started within 1 month of most recent VL
    - Flagged if seen by RW provider in last 12 months
- Use of additional data sources (LexisNexis, County EMR, local databases) to provide additional client-level notes

Source: HIV Surveillance data as of December 2023

Linkage and Re-engagement Program (LRP)

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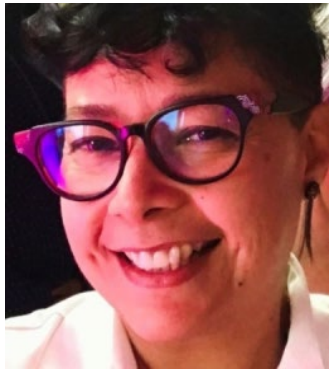
Megan Foley, LCSW, MPH
she/her

Rosario Carrera, MSW, MA
She/her/ella

Kathy Bouch
she/her/ella

Guillermo Campos
he/him/el

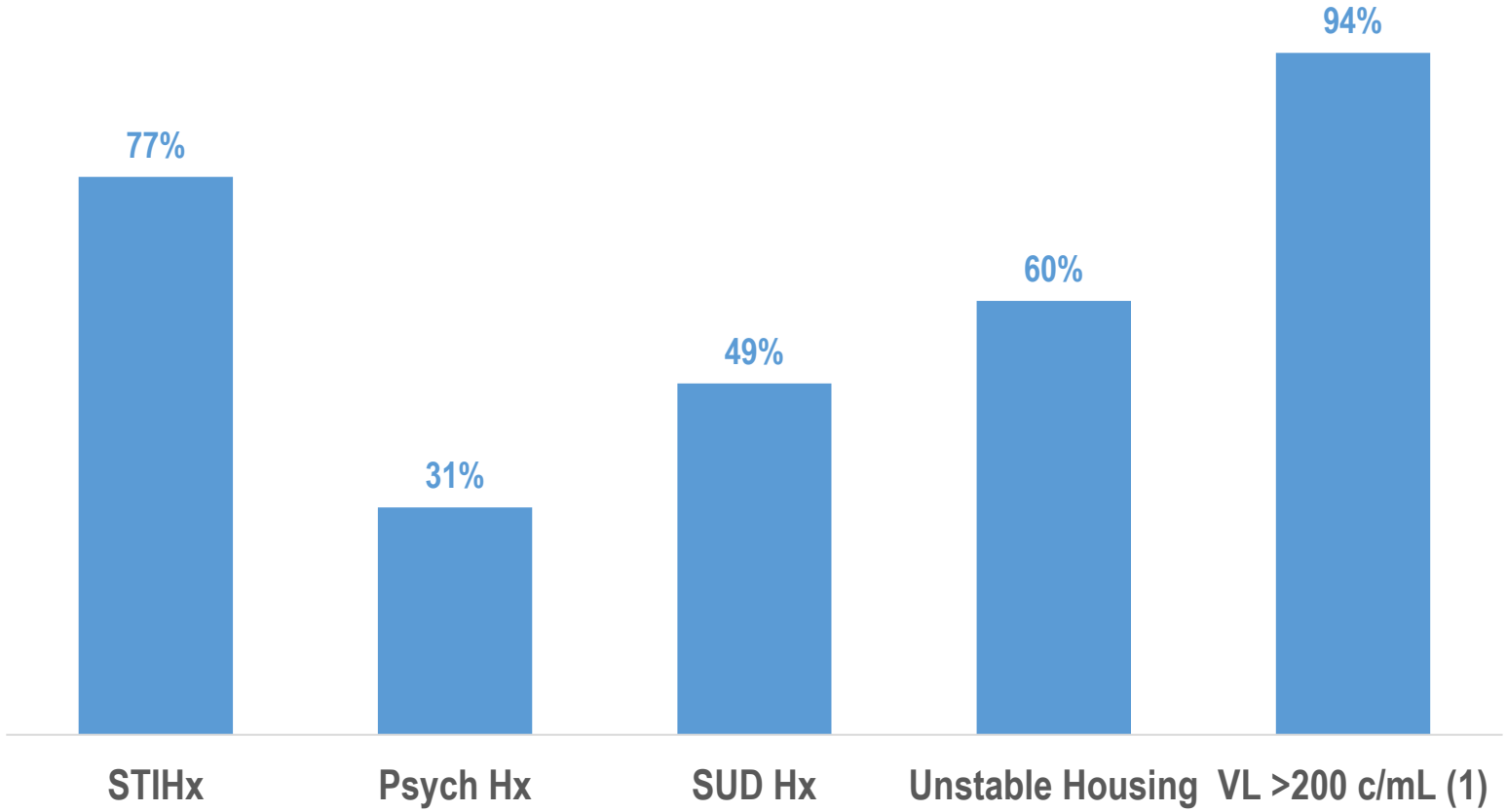
Pamela Mendoza
she/her



Susana Moreno
she/her/ella

Tracy Vasquez
she/her

Barriers to care for LRP clients who delivered in 2023 and 2024 YTD, (n= 35)



[1] Indicates Viral load at time of enrollment into LRP intensive case management program. Clients with no viral load within the past year are considered to be out of care and considered to be virally unsuppressed (Viral Load > 200 c/mL)

Source: HIV Surveillance data as of March 2024

LRP Case Example

Demographics: 32 y/o African-American cisgender woman, G3P2
HIV Diagnosis Date: 1/31/2017
Estimate delivery date: 1/15/23
Actual delivery date: 12/29/22 (C/S)
Substance use history: Active methamphetamine use
Housing status: Hx homelessness and unstable housing
Trauma history: PTSD (stillbirth in 2020)
Psych history: Historical dx of mood disorder with psychotic features; has been prescribed antipsychotics in the past
Incarceration history: 1 past incarceration (1 day)

LRP Case Example

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November 2022

- Local hospital notifies DPH that a pregnant PLWH (33 weeks) is making frequent trips to the ER and not in PNC
- LRP finds client; she is experiencing unstable housing, SUD, and symptoms of mental illness
- LRP assists client with housing – DPSS for motel vouchers

December 2022

- Client declines linkage to HIV OB specialty site. LRP coordinates and accompanies to hospital OB and ID visits. Started on ART. Hospital team recommends specialty HIV OB care.
- LRP attempts linkage to SUD program; client ultimately chooses not to enroll
- Continued housing assistance; client accepted to shelter program
- LRP links to HIV OB care; provides transportation and accompanies client; has elevated BP
- Client has scheduled C/S. Newborn PCR test is negative.
- DCSF case is opened during hospitalization; newborn placed in foster care

2023

- Client starts attending outpatient SUD program with CM and parenting classes
- Client remains on ART and psychiatric services
- Client has another pregnancy; delivers 12/2023 and retains custody
- Client and her partner move into Alegria family shelter program*
- Family has weekly visits with first child, on path to regaining custody

Date	VL	CD4
6/2022	147,000	89
12/2022	296	118
2/2023	1,499	270
4/2023	29	253
9/2023	<20	304
11/2023	<20	268
1/2024	<20	133

Critical success factors

- Support
- Longitudinal relationships
- Family housing programs
- Specialty perinatal HIV programs
- Harm reduction approach

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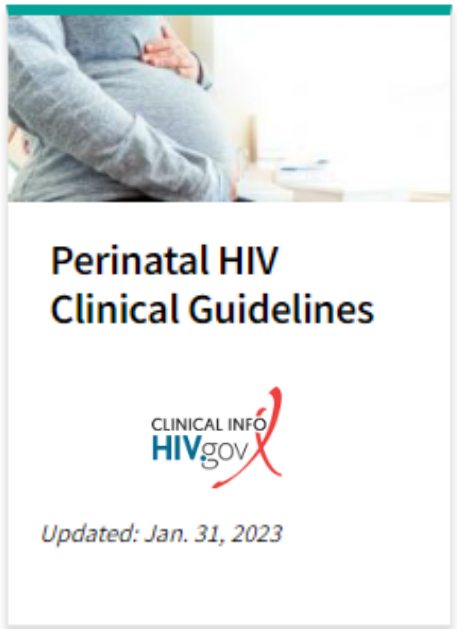
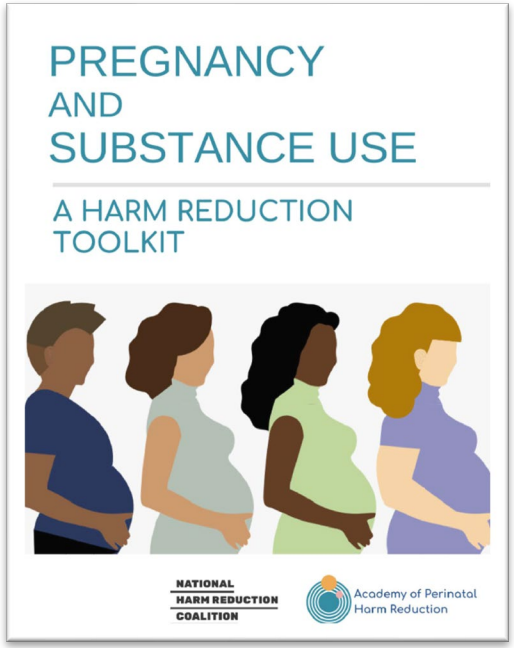
Resources





NATIONAL
CLINICIAN
CONSULTATION
CENTER

Rapid perinatal HIV consultation from practicing providers

(888) 448-8765
Available 24/7

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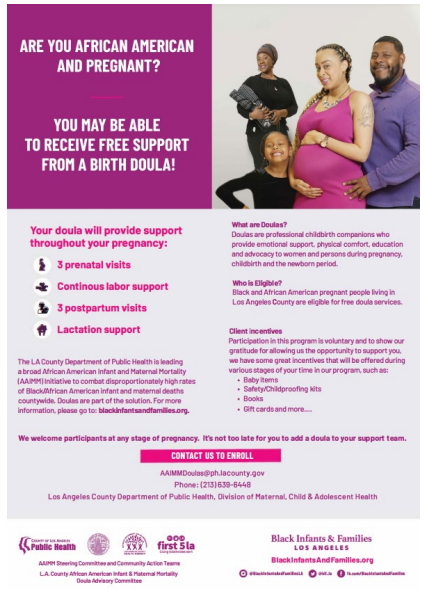
thewellproject

BEEEBAH

Building Equity, Ethics, and Education on Breastfeeding and HIV



Black Infants & Families
LOS ANGELES

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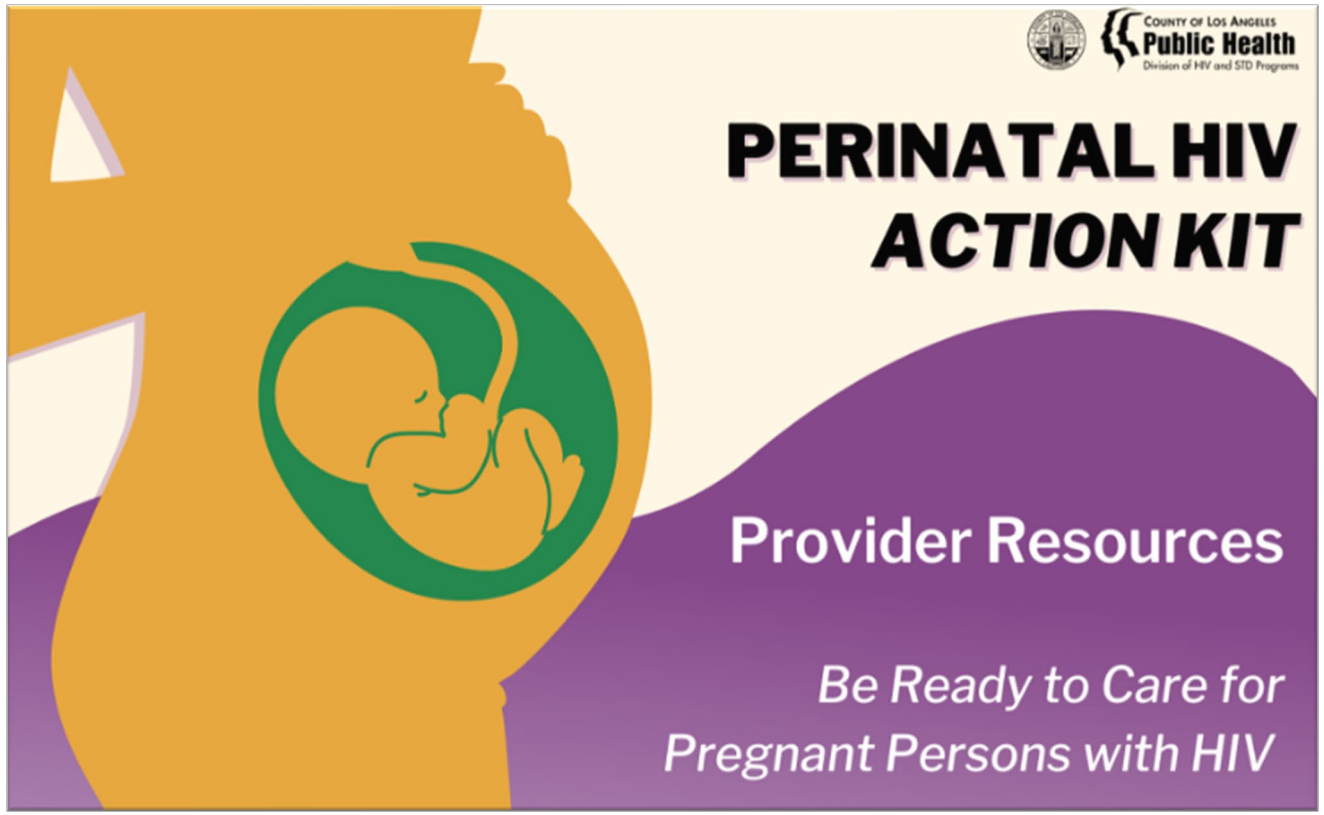
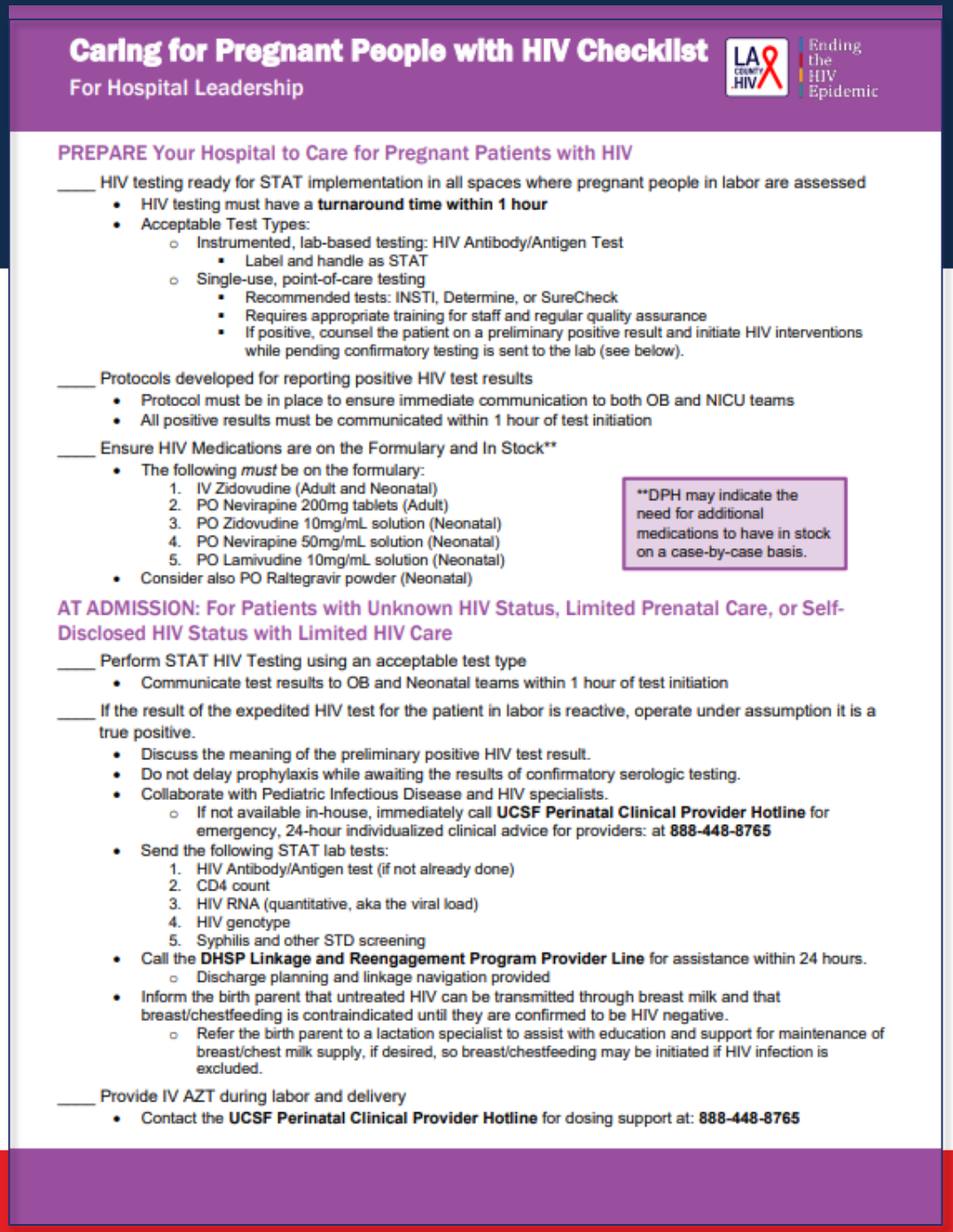
Perinatal HIV Action Kit



- Resource designed for providers serving pregnant people with HIV
- Available on DHSP's website: http://publichealth.lacounty.gov/dhsp/Perinatal_HIV_Action_Kit.htm



Caring for Pregnant People with HIV Checklist

For Hospital Leadership

Ending the HIV Epidemic

PREPARE Your Hospital to Care for Pregnant Patients with HIV

____ HIV testing ready for STAT implementation in all spaces where pregnant people in labor are assessed

- HIV testing must have a **turnaround time within 1 hour**
- Acceptable Test Types:
  - Instrumented, lab-based testing: HIV Antibody/Antigen Test
    - Label and handle as STAT
  - Single-use, point-of-care testing
    - Recommended tests: INSTI, Determine, or SureCheck
    - Requires appropriate training for staff and regular quality assurance
    - If positive, counsel the patient on a preliminary positive result and initiate HIV interventions while pending confirmatory testing is sent to the lab (see below).

____ Protocols developed for reporting positive HIV test results

- Protocol must be in place to ensure immediate communication to both OB and NICU teams
- All positive results must be communicated within 1 hour of test initiation

____ Ensure HIV Medications are on the Formulary and In Stock**

- The following *must* be on the formulary:
  1. IV Zidovudine (Adult and Neonatal)
  2. PO Nevirapine 200mg tablets (Adult)
  3. PO Zidovudine 10mg/mL solution (Neonatal)
  4. PO Nevirapine 50mg/mL solution (Neonatal)
  5. PO Lamivudine 10mg/mL solution (Neonatal)
- Consider also PO Raltegravir powder (Neonatal)

**DPH may indicate the need for additional medications to have in stock on a case-by-case basis.

AT ADMISSION: For Patients with Unknown HIV Status, Limited Prenatal Care, or Self-Disclosed HIV Status with Limited HIV Care

____ Perform STAT HIV Testing using an acceptable test type

- Communicate test results to OB and Neonatal teams within 1 hour of test initiation

____ If the result of the expedited HIV test for the patient in labor is reactive, operate under assumption it is a true positive.

- Discuss the meaning of the preliminary positive HIV test result.
- Do not delay prophylaxis while awaiting the results of confirmatory serologic testing.
- Collaborate with Pediatric Infectious Disease and HIV specialists.
  - If not available in-house, immediately call **UCSF Perinatal Clinical Provider Hotline** for emergency, 24-hour individualized clinical advice for providers: at **888-448-8765**
- Send the following STAT lab tests:
  1. HIV Antibody/Antigen test (if not already done)
  2. CD4 count
  3. HIV RNA (quantitative, aka the viral load)
  4. HIV genotype
  5. Syphilis and other STD screening
- Call the **DHSP Linkage and Reengagement Program Provider Line** for assistance within 24 hours.
  - Discharge planning and linkage navigation provided
- Inform the birth parent that untreated HIV can be transmitted through breast milk and that breast/chestfeeding is contraindicated until they are confirmed to be HIV negative.
  - Refer the birth parent to a lactation specialist to assist with education and support for maintenance of breast/chest milk supply, if desired, so breast/chestfeeding may be initiated if HIV infection is excluded.

____ Provide IV AZT during labor and delivery

- Contact the **UCSF Perinatal Clinical Provider Hotline** for dosing support at: **888-448-8765**

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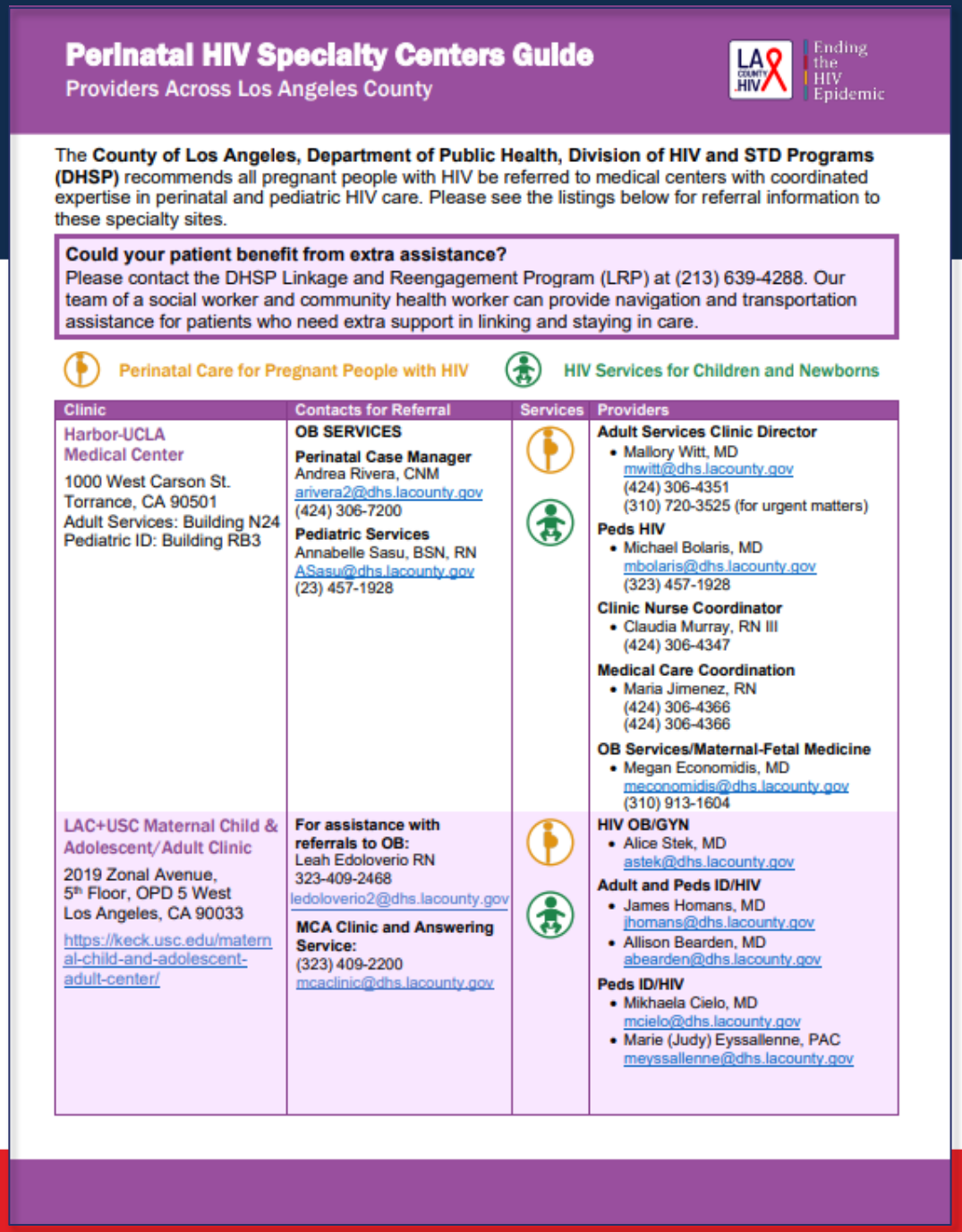
(1) Caring for Pregnant People with HIV Checklist: Checklist for delivery hospitals to ensure they are prepared for and implementing standard-of-care services for pregnant people with HIV and their newborns.



Perinatal HIV Specialty Centers Guide

Providers Across Los Angeles County

LA County HIV — Ending the HIV Epidemic

The **County of Los Angeles, Department of Public Health, Division of HIV and STD Programs (DHSP)** recommends all pregnant people with HIV be referred to medical centers with coordinated expertise in perinatal and pediatric HIV care. Please see the listings below for referral information to these specialty sites.

Could your patient benefit from extra assistance?
Please contact the DHSP Linkage and Reengagement Program (LRP) at (213) 639-4288. Our team of a social worker and community health worker can provide navigation and transportation assistance for patients who need extra support in linking and staying in care.

Perinatal Care for Pregnant People with HIV

HIV Services for Children and Newborns

Clinic	Contacts for Referral	Services	Providers
Harbor-UCLA Medical Center 1000 West Carson St. Torrance, CA 90501 Adult Services: Building N24 Pediatric ID: Building RB3	**OB SERVICES** **Perinatal Case Manager** Andrea Rivera, CNM arivera2@dhs.lacounty.gov (424) 306-7200 **Pediatric Services** Annabelle Sasu, BSN, RN ASasu@dhs.lacounty.gov (23) 457-1928		**Adult Services Clinic Director** • Mallory Witt, MD mwitt@dhs.lacounty.gov (424) 306-4351 (310) 720-3525 (for urgent matters) **Peds HIV** • Michael Bolaris, MD mbolaris@dhs.lacounty.gov (323) 457-1928 **Clinic Nurse Coordinator** • Claudia Murray, RN III (424) 306-4347 **Medical Care Coordination** • Maria Jimenez, RN (424) 306-4366 (424) 306-4366 **OB Services/Maternal-Fetal Medicine** • Megan Economidis, MD meconomidis@dhs.lacounty.gov (310) 913-1604
LAC+USC Maternal Child & Adolescent/Adult Clinic 2019 Zonal Avenue, 5th Floor, OPD 5 West Los Angeles, CA 90033 https://keck.usc.edu/maternal-child-and-adolescent-adult-center/	**For assistance with referrals to OB:** Leah Edoloverio RN 323-409-2468 ledoloverio2@dhs.lacounty.gov **MCA Clinic and Answering Service:** (323) 409-2200 mcaclinic@dhs.lacounty.gov		**HIV OB/GYN** • Alice Stek, MD astek@dhs.lacounty.gov **Adult and Peds ID/HIV** • James Homans, MD jhomans@dhs.lacounty.gov • Allison Bearden, MD abearden@dhs.lacounty.gov **Peds ID/HIV** • Mikhaela Cielo, MD mcielo@dhs.lacounty.gov • Marie (Judy) Eyssallenne, PAC meyssallenne@dhs.lacounty.gov

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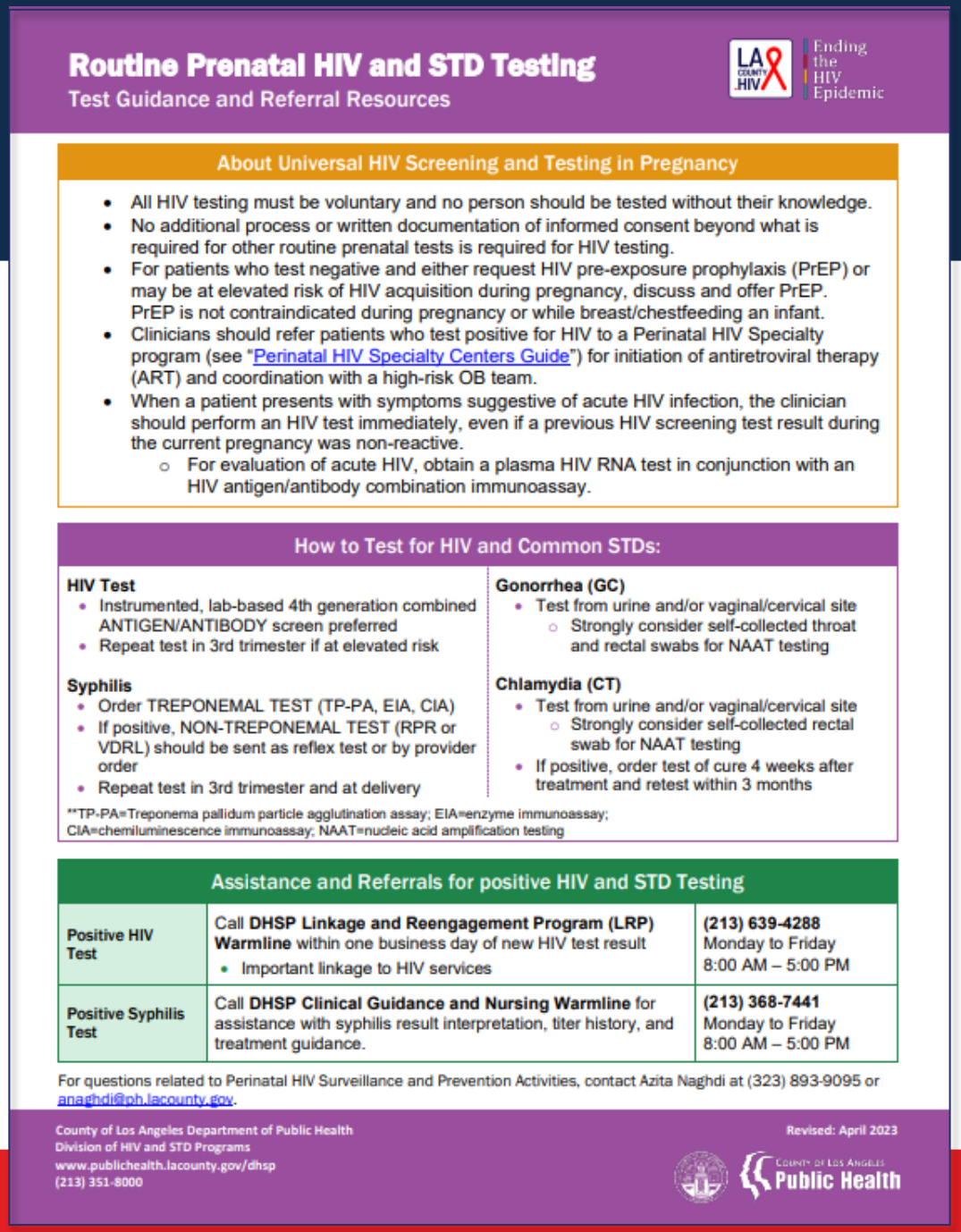
(2) Perinatal HIV Specialty Centers Guide: Listing of local programs with HIV expertise and coordination of care across OB, ID, and pediatric departments.



Routine Prenatal HIV and STD Testing

Test Guidance and Referral Resources

Ending the HIV Epidemic

About Universal HIV Screening and Testing in Pregnancy

- All HIV testing must be voluntary and no person should be tested without their knowledge.
- No additional process or written documentation of informed consent beyond what is required for other routine prenatal tests is required for HIV testing.
- For patients who test negative and either request HIV pre-exposure prophylaxis (PrEP) or may be at elevated risk of HIV acquisition during pregnancy, discuss and offer PrEP. PrEP is not contraindicated during pregnancy or while breast/chestfeeding an infant.
- Clinicians should refer patients who test positive for HIV to a Perinatal HIV Specialty program (see "Perinatal HIV Specialty Centers Guide") for initiation of antiretroviral therapy (ART) and coordination with a high-risk OB team.
- When a patient presents with symptoms suggestive of acute HIV infection, the clinician should perform an HIV test immediately, even if a previous HIV screening test result during the current pregnancy was non-reactive.
  - For evaluation of acute HIV, obtain a plasma HIV RNA test in conjunction with an HIV antigen/antibody combination immunoassay.

How to Test for HIV and Common STDs:

HIV Test
- Instrumented, lab-based 4th generation combined ANTIGEN/ANTIBODY screen preferred
- Repeat test in 3rd trimester if at elevated risk

Syphilis
- Order TREPONEMAL TEST (TP-PA, EIA, CIA)
- If positive, NON-TREPONEMAL TEST (RPR or VDRL) should be sent as reflex test or by provider order
- Repeat test in 3rd trimester and at delivery

Gonorrhea (GC)
- Test from urine and/or vaginal/cervical site
  - Strongly consider self-collected throat and rectal swabs for NAAT testing

Chlamydia (CT)
- Test from urine and/or vaginal/cervical site
  - Strongly consider self-collected rectal swab for NAAT testing
- If positive, order test of cure 4 weeks after treatment and retest within 3 months

**TP-PA=Treponema pallidum particle agglutination assay; EIA=enzyme immunoassay; CIA=chemiluminescence immunoassay; NAAT=nucleic acid amplification testing

Assistance and Referrals for positive HIV and STD Testing

Positive HIV Test	Call **DHSP Linkage and Reengagement Program (LRP) Warmline** within one business day of new HIV test result • Important linkage to HIV services	**(213) 639-4288** Monday to Friday 8:00 AM – 5:00 PM
Positive Syphilis Test	Call **DHSP Clinical Guidance and Nursing Warmline** for assistance with syphilis result interpretation, titer history, and treatment guidance.	**(213) 368-7441** Monday to Friday 8:00 AM – 5:00 PM

For questions related to Perinatal HIV Surveillance and Prevention Activities, contact Azita Naghdi at (323) 893-9095 or anaghdi@ph.lacounty.gov.

County of Los Angeles Department of Public Health
Division of HIV and STD Programs
www.publichealth.lacounty.gov/dhsp
(213) 351-8000

Revised: April 2023

County of Los Angeles Public Health

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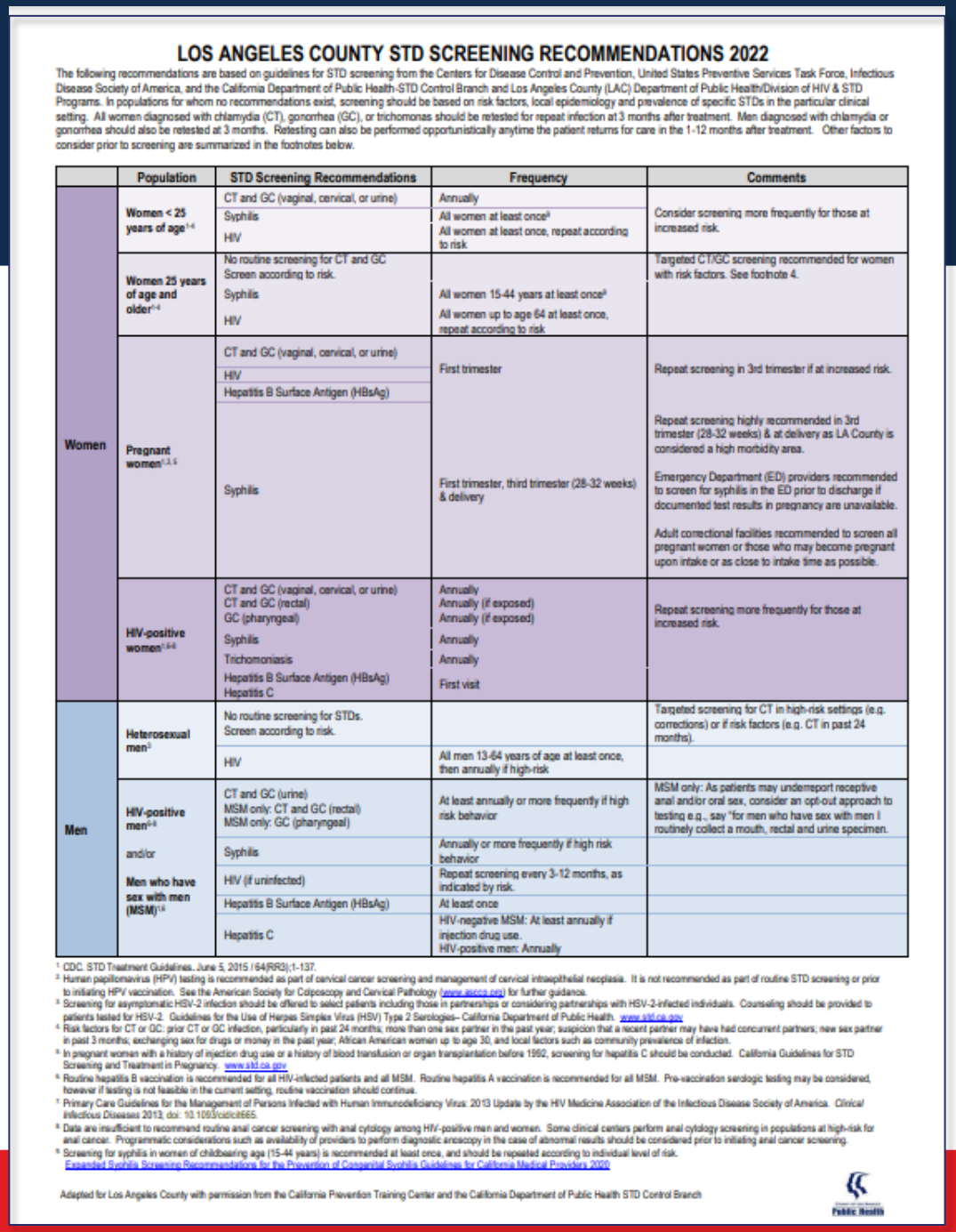
(3) Routine Prenatal HIV and STD Testing: Detailed guidance on universal screening, test types and referral resources.



LOS ANGELES COUNTY STD SCREENING RECOMMENDATIONS 2022

The following recommendations are based on guidelines for STD screening from the Centers for Disease Control and Prevention, United States Preventive Services Task Force, Infectious Disease Society of America, and the California Department of Public Health-STD Control Branch and Los Angeles County (LAC) Department of Public Health/Division of HIV & STD Programs. In populations for whom no recommendations exist, screening should be based on risk factors, local epidemiology and prevalence of specific STDs in the particular clinical setting. All women diagnosed with chlamydia (CT), gonorrhea (GC), or trichomonas should be retested for repeat infection at 3 months after treatment. Men diagnosed with chlamydia or gonorrhea should also be retested at 3 months. Retesting can also be performed opportunistically anytime the patient returns for care in the 1-12 months after treatment. Other factors to consider prior to screening are summarized in the footnotes below.

	Population	STD Screening Recommendations	Frequency	Comments
Women	Women < 25 years of age[1-4]	CT and GC (vaginal, cervical, or urine)	Annually	Consider screening more frequently for those at increased risk.
		Syphilis	All women at least once[5]	
		HIV	All women at least once, repeat according to risk	
	Women 25 years of age and older[1-4]	No routine screening for CT and GC Screen according to risk.		Targeted CT/GC screening recommended for women with risk factors. See footnote 4.
		Syphilis	All women 15-44 years at least once[5]	
		HIV	All women up to age 64 at least once, repeat according to risk	
	Pregnant women[1,3,5]	CT and GC (vaginal, cervical, or urine)	First trimester	Repeat screening in 3rd trimester if at increased risk.
		HIV		
		Hepatitis B Surface Antigen (HBsAg)		Repeat screening highly recommended in 3rd trimester (28-32 weeks) & at delivery as LA County is considered a high morbidity area.
		Syphilis	First trimester, third trimester (28-32 weeks) & delivery	Emergency Department (ED) providers recommended to screen for syphilis in the ED prior to discharge if documented test results in pregnancy are unavailable.
				Adult correctional facilities recommended to screen all pregnant women or those who may become pregnant upon intake or as close to intake time as possible.
	HIV-positive women[1,4-6]	CT and GC (vaginal, cervical, or urine)	Annually	Repeat screening more frequently for those at increased risk.
		CT and GC (rectal)	Annually (if exposed)	
		GC (pharyngeal)	Annually (if exposed)	
		Syphilis	Annually	
		Trichomoniasis	Annually	
		Hepatitis B Surface Antigen (HBsAg)	First visit	
		Hepatitis C		
Men	Heterosexual men[3]	No routine screening for STDs. Screen according to risk.		Targeted screening for CT in high-risk settings (e.g. corrections) or if risk factors (e.g. CT in past 24 months).
		HIV	All men 13-64 years of age at least once, then annually if high-risk	
	HIV-positive men[4-6] and/or Men who have sex with men (MSM)[1,6]	CT and GC (urine)	At least annually or more frequently if high risk behavior	MSM only: As patients may underreport receptive anal and/or oral sex, consider an opt-out approach to testing e.g., say "for men who have sex with men I routinely collect a mouth, rectal and urine specimen.
		MSM only: CT and GC (rectal)		
		MSM only: GC (pharyngeal)		
		Syphilis	Annually or more frequently if high risk behavior	
		HIV (if uninfected)	Repeat screening every 3-12 months, as indicated by risk.	
		Hepatitis B Surface Antigen (HBsAg)	At least once	
		Hepatitis C	HIV-negative MSM: At least annually if injection drug use. HIV-positive men: Annually	

[1] CDC. STD Treatment Guidelines. June 5, 2015 / 64(RR3);1-137.
[2] Human papillomavirus (HPV) testing is recommended as part of cervical cancer screening and management of cervical intraepithelial neoplasia. It is not recommended as part of routine STD screening or prior to initiating HPV vaccination. See the American Society for Colposcopy and Cervical Pathology (www.ascccp.org) for further guidance.
[3] Screening for asymptomatic HSV-2 infection should be offered to select patients including those in partnerships or considering partnerships with HSV-2-infected individuals. Counseling should be provided to patients tested for HSV-2. Guidelines for the Use of Herpes Simplex Virus (HSV) Type 2 Serologies– California Department of Public Health. www.std.ca.gov
[4] Risk factors for CT or GC: prior CT or GC infection, particularly in past 24 months; more than one sex partner in the past year; suspicion that a recent partner may have had concurrent partners; new sex partner in past 3 months; exchanging sex for drugs or money in the past year; African American women up to age 30, and local factors such as community prevalence of infection.
[5] In pregnant women with a history of injection drug use or a history of blood transfusion or organ transplantation before 1992, screening for hepatitis C should be conducted. California Guidelines for STD Screening and Treatment in Pregnancy. www.std.ca.gov
[6] Routine hepatitis B vaccination is recommended for all HIV-infected patients and all MSM. Routine hepatitis A vaccination is recommended for all MSM. Pre-vaccination serologic testing may be considered, however if testing is not feasible in the current setting, routine vaccination should continue.
[7] Primary Care Guidelines for the Management of Persons Infected with Human Immunodeficiency Virus: 2013 Update by the HIV Medicine Association of the Infectious Disease Society of America. *Clinical Infectious Diseases* 2013; doi: 10.1093/cid/cit665.
[8] Data are insufficient to recommend routine anal cancer screening with anal cytology among HIV-positive men and women. Some clinical centers perform anal cytology screening in populations at high-risk for anal cancer. Programmatic considerations such as availability of providers to perform diagnostic anoscopy in the case of abnormal results should be considered prior to initiating anal cancer screening.
[9] Screening for syphilis in women of childbearing age (15-44 years) is recommended at least once, and should be repeated according to individual level of risk.
Expanded Syphilis Screening Recommendations for the Prevention of Congenital Syphilis Guidelines for California Medical Providers 2020

Adapted for Los Angeles County with permission from the California Prevention Training Center and the California Department of Public Health STD Control Branch

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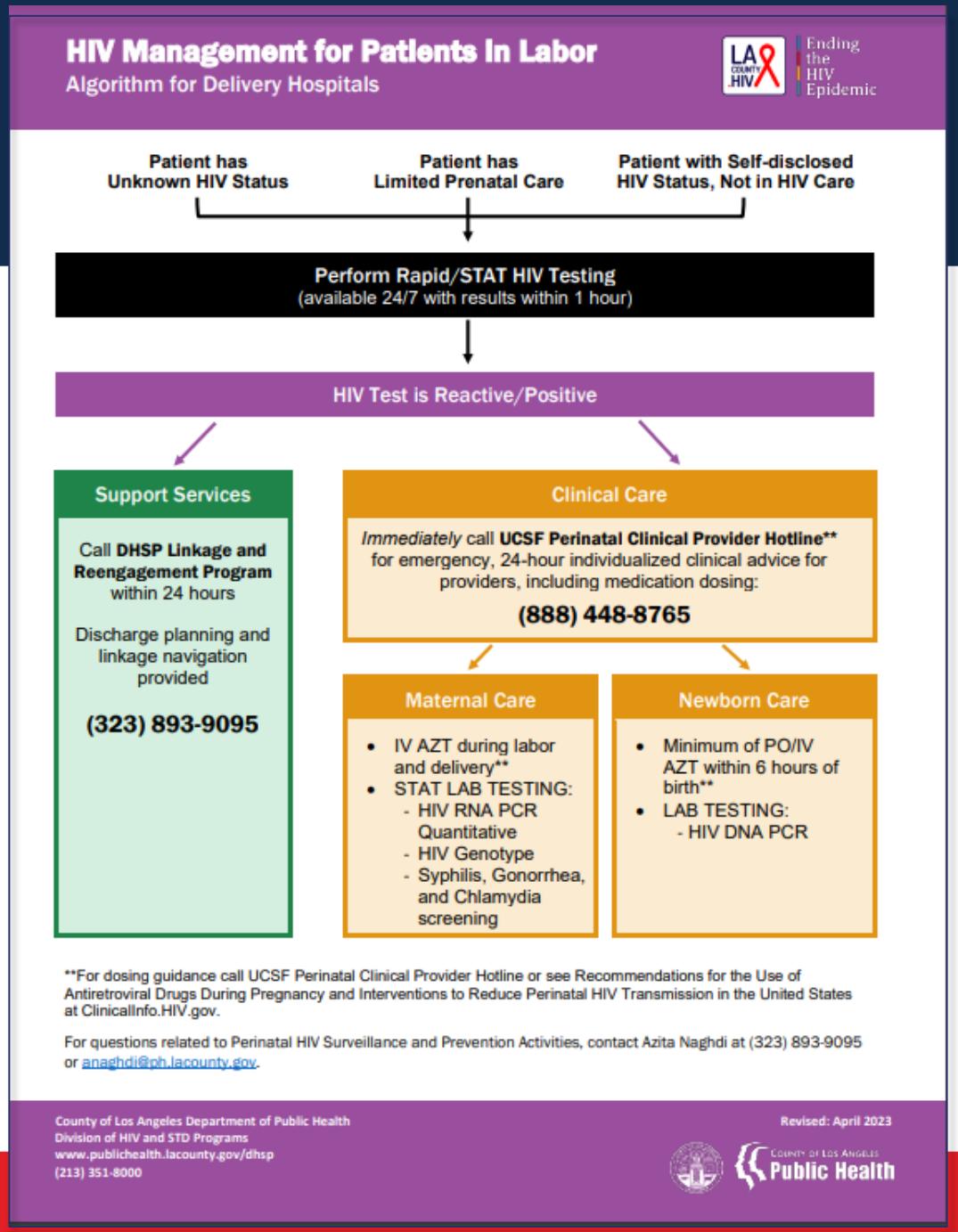
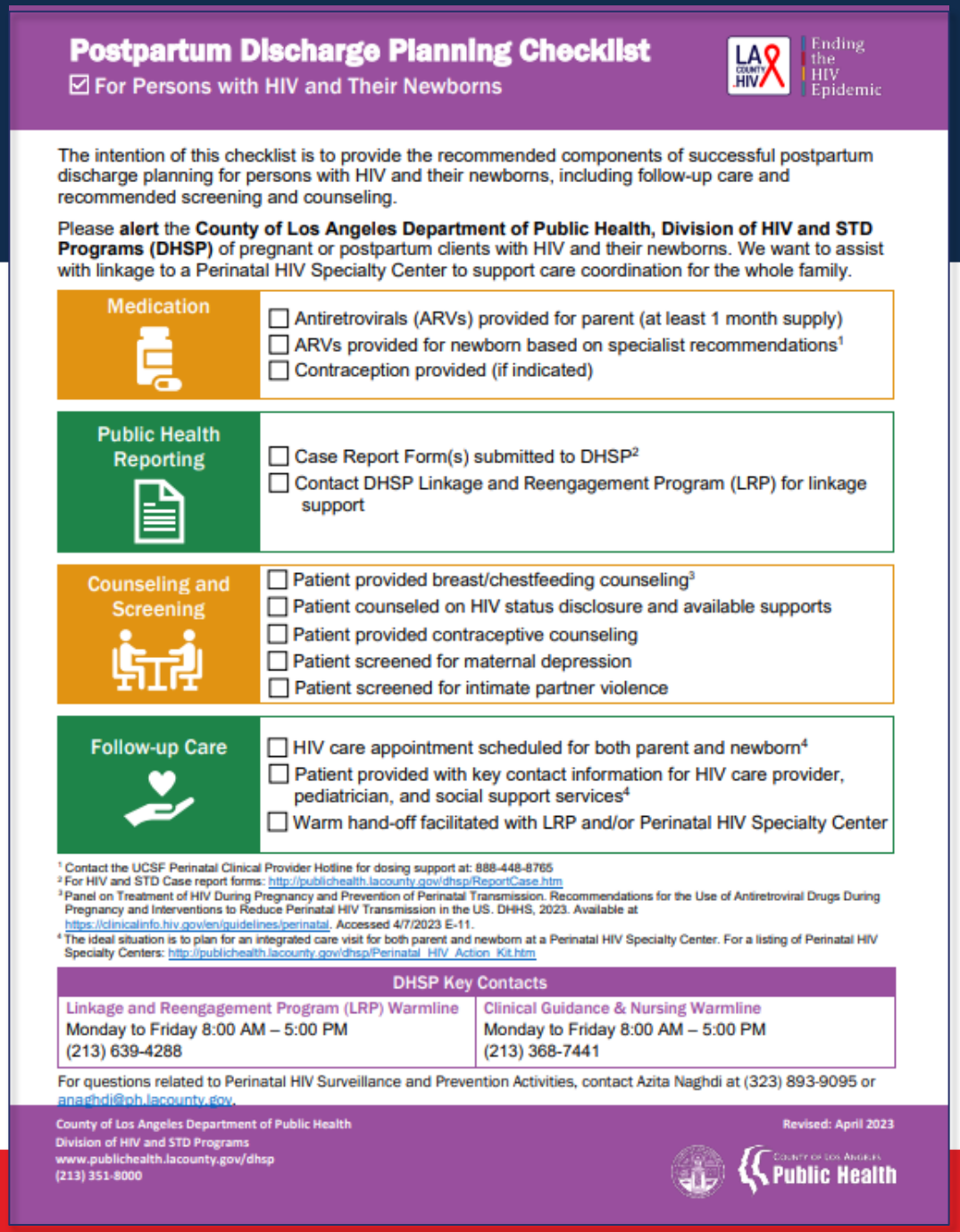
(4) LAC STD Screening and Treatment Recommendations: Updated tables representing the latest federal, state and local guidance.



NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT 2024

(5) HIV Management for Patients in Labor: Expected practice guidance for delivery hospitals with patients with unknown HIV status, limited prenatal care, or reporting a history of HIV infection but not in care.



Postpartum Discharge Planning Checklist

☑ For Persons with HIV and Their Newborns

Ending the HIV Epidemic

The intention of this checklist is to provide the recommended components of successful postpartum discharge planning for persons with HIV and their newborns, including follow-up care and recommended screening and counseling.

Please **alert** the **County of Los Angeles Department of Public Health, Division of HIV and STD Programs (DHSP)** of pregnant or postpartum clients with HIV and their newborns. We want to assist with linkage to a Perinatal HIV Specialty Center to support care coordination for the whole family.

Medication

- ☐ Antiretrovirals (ARVs) provided for parent (at least 1 month supply)
- ☐ ARVs provided for newborn based on specialist recommendations[1]
- ☐ Contraception provided (if indicated)

Public Health Reporting

- ☐ Case Report Form(s) submitted to DHSP[2]
- ☐ Contact DHSP Linkage and Reengagement Program (LRP) for linkage support

Counseling and Screening

- ☐ Patient provided breast/chestfeeding counseling[3]
- ☐ Patient counseled on HIV status disclosure and available supports
- ☐ Patient provided contraceptive counseling
- ☐ Patient screened for maternal depression
- ☐ Patient screened for intimate partner violence

Follow-up Care

- ☐ HIV care appointment scheduled for both parent and newborn[4]
- ☐ Patient provided with key contact information for HIV care provider, pediatrician, and social support services[4]
- ☐ Warm hand-off facilitated with LRP and/or Perinatal HIV Specialty Center

[1] Contact the UCSF Perinatal Clinical Provider Hotline for dosing support at: 888-448-8765
[2] For HIV and STD Case report forms: http://publichealth.lacounty.gov/dhsp/ReportCase.htm
[3] Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission. Recommendations for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the US. DHHS, 2023. Available at https://clinicalinfo.hiv.gov/en/guidelines/perinatal. Accessed 4/7/2023 E-11.
[4] The ideal situation is to plan for an integrated care visit for both parent and newborn at a Perinatal HIV Specialty Center. For a listing of Perinatal HIV Specialty Centers: http://publichealth.lacounty.gov/dhsp/Perinatal_HIV_Action_Kit.htm

DHSP Key Contacts

Linkage and Reengagement Program (LRP) Warmline	Clinical Guidance & Nursing Warmline
Monday to Friday 8:00 AM – 5:00 PM	Monday to Friday 8:00 AM – 5:00 PM
(213) 639-4288	(213) 368-7441

For questions related to Perinatal HIV Surveillance and Prevention Activities, contact Azita Naghdi at (323) 893-9095 or anaghdi@ph.lacounty.gov.

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Division of HIV and STD Programs
www.publichealth.lacounty.gov/dhsp
(213) 351-8000

Revised: April 2023

County of Los Angeles Public Health

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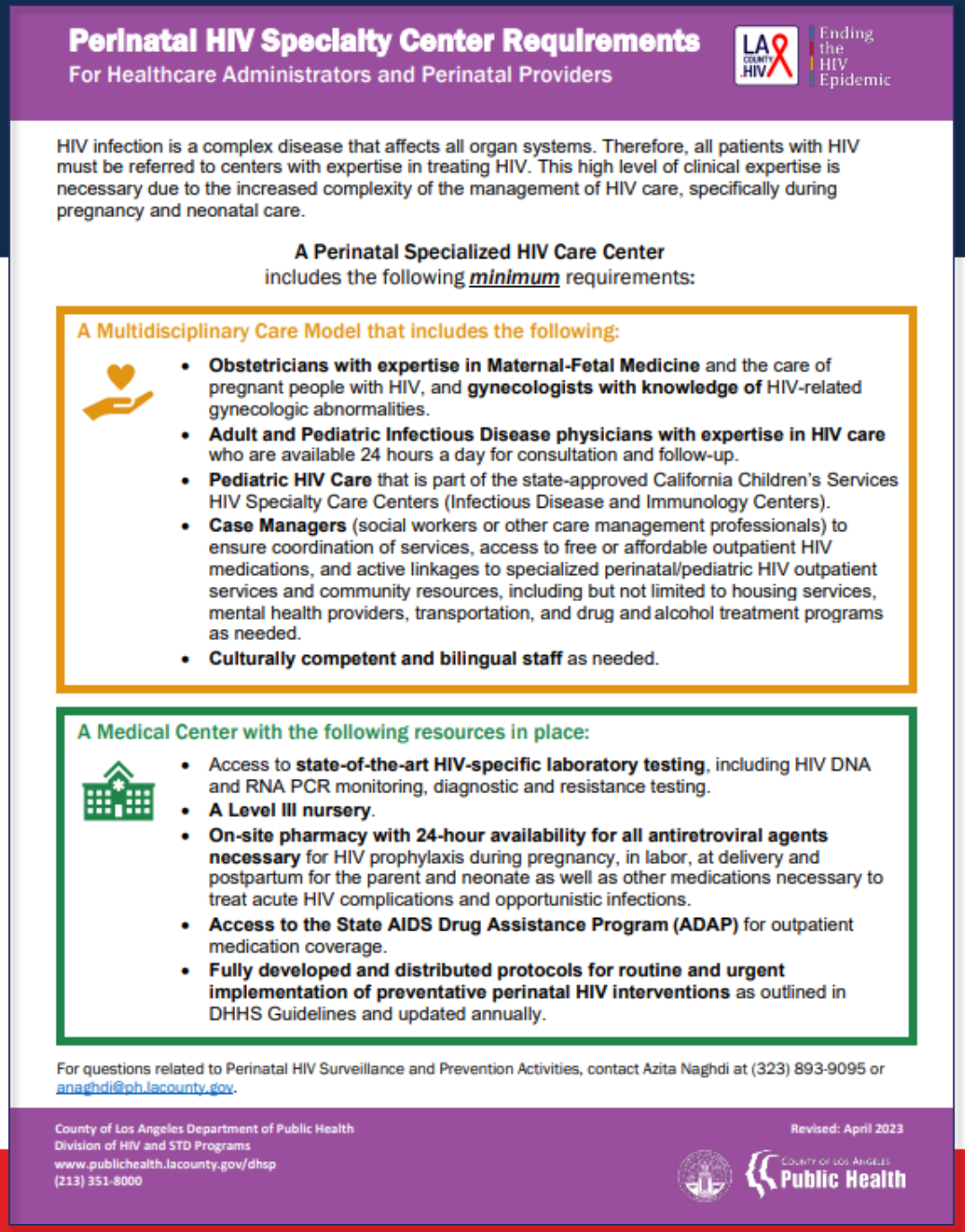
(6) Postpartum Discharge Planning Checklist: Guidance for discharge planning, including key DHSP resources.



Perinatal HIV Specialty Center Requirements

For Healthcare Administrators and Perinatal Providers

LA County HIV — Ending the HIV Epidemic

HIV infection is a complex disease that affects all organ systems. Therefore, all patients with HIV must be referred to centers with expertise in treating HIV. This high level of clinical expertise is necessary due to the increased complexity of the management of HIV care, specifically during pregnancy and neonatal care.

A Perinatal Specialized HIV Care Center
includes the following ***minimum*** requirements:

A Multidisciplinary Care Model that includes the following:

- **Obstetricians with expertise in Maternal-Fetal Medicine** and the care of pregnant people with HIV, and **gynecologists with knowledge of** HIV-related gynecologic abnormalities.
- **Adult and Pediatric Infectious Disease physicians with expertise in HIV care** who are available 24 hours a day for consultation and follow-up.
- **Pediatric HIV Care** that is part of the state-approved California Children's Services HIV Specialty Care Centers (Infectious Disease and Immunology Centers).
- **Case Managers** (social workers or other care management professionals) to ensure coordination of services, access to free or affordable outpatient HIV medications, and active linkages to specialized perinatal/pediatric HIV outpatient services and community resources, including but not limited to housing services, mental health providers, transportation, and drug and alcohol treatment programs as needed.
- **Culturally competent and bilingual staff** as needed.

A Medical Center with the following resources in place:

- Access to **state-of-the-art HIV-specific laboratory testing**, including HIV DNA and RNA PCR monitoring, diagnostic and resistance testing.
- **A Level III nursery**.
- **On-site pharmacy with 24-hour availability for all antiretroviral agents necessary** for HIV prophylaxis during pregnancy, in labor, at delivery and postpartum for the parent and neonate as well as other medications necessary to treat acute HIV complications and opportunistic infections.
- **Access to the State AIDS Drug Assistance Program (ADAP)** for outpatient medication coverage.
- **Fully developed and distributed protocols for routine and urgent implementation of preventative perinatal HIV interventions** as outlined in DHHS Guidelines and updated annually.

For questions related to Perinatal HIV Surveillance and Prevention Activities, contact Azita Naghdi at (323) 893-9095 or anaghdi@ph.lacounty.gov.

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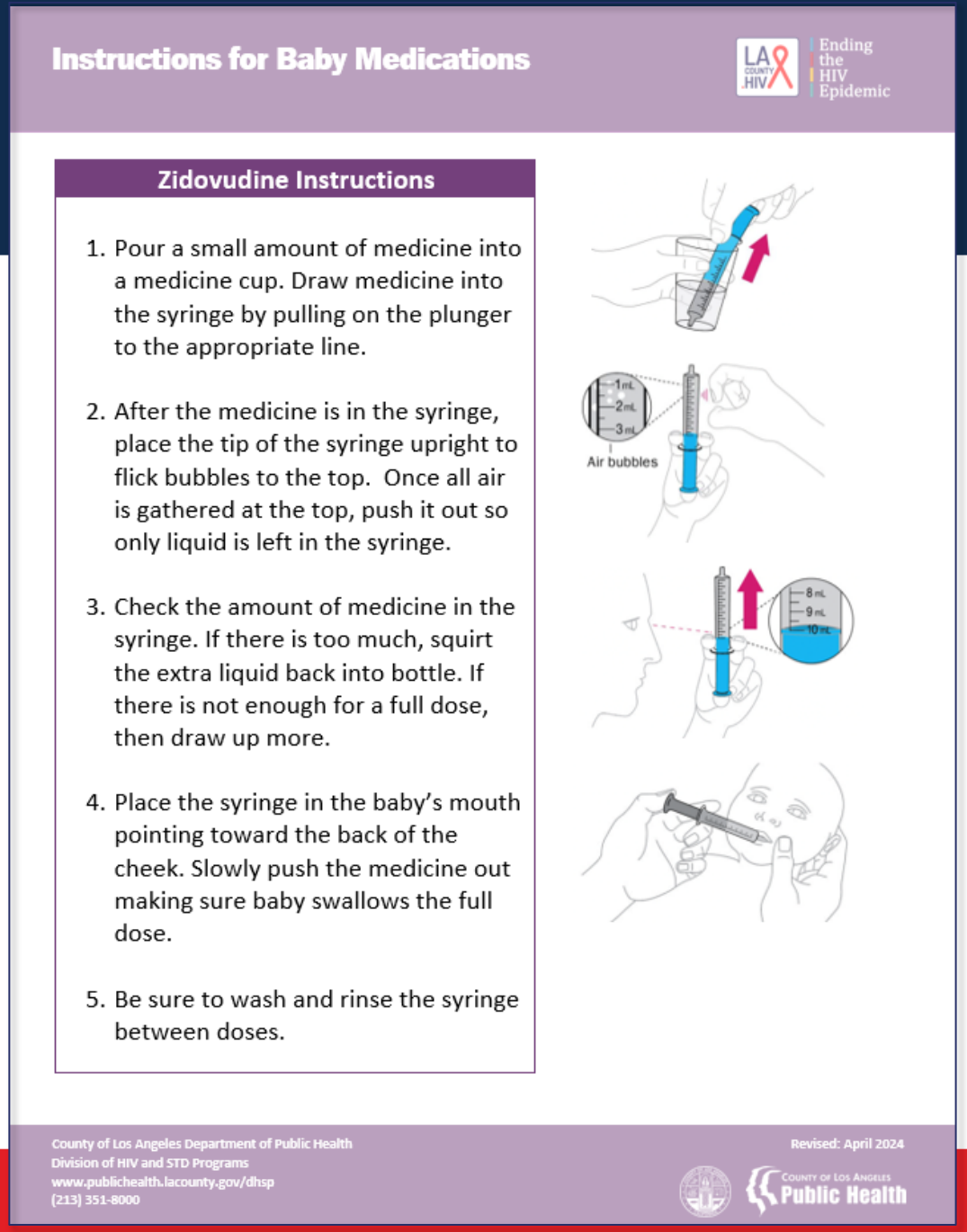
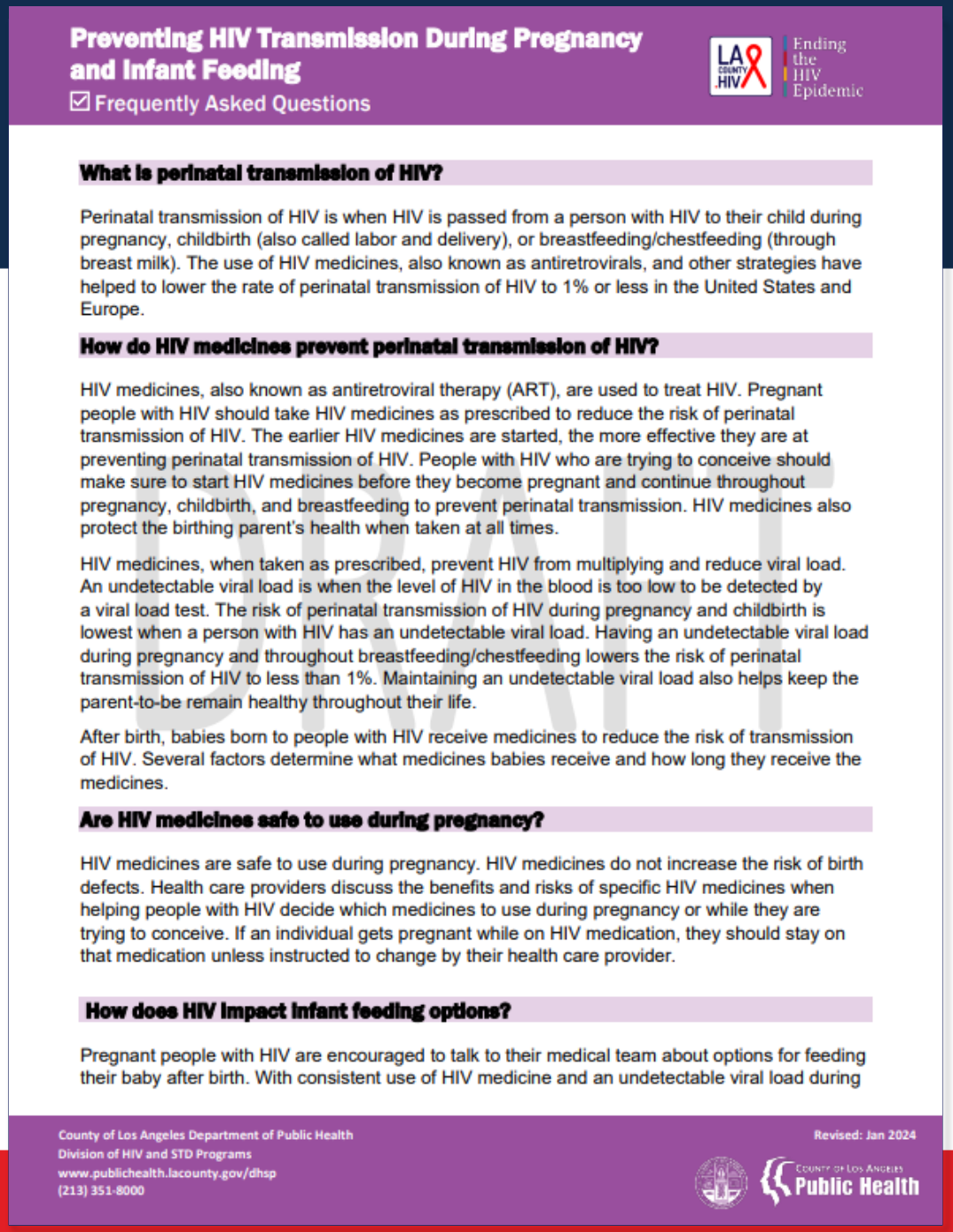
(7) HIV Management for Patients in Labor: Expected practice guidance for delivery hospitals with patients with unknown HIV status, limited prenatal care, or reporting a history of HIV infection but not in care.



NATIONAL 2024 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

(NEW) Infant medication administration guidance for parents



Preventing HIV Transmission During Pregnancy and Infant Feeding

☑ Frequently Asked Questions

LA County HIV — Ending the HIV Epidemic

What is perinatal transmission of HIV?

Perinatal transmission of HIV is when HIV is passed from a person with HIV to their child during pregnancy, childbirth (also called labor and delivery), or breastfeeding/chestfeeding (through breast milk). The use of HIV medicines, also known as antiretrovirals, and other strategies have helped to lower the rate of perinatal transmission of HIV to 1% or less in the United States and Europe.

How do HIV medicines prevent perinatal transmission of HIV?

HIV medicines, also known as antiretroviral therapy (ART), are used to treat HIV. Pregnant people with HIV should take HIV medicines as prescribed to reduce the risk of perinatal transmission of HIV. The earlier HIV medicines are started, the more effective they are at preventing perinatal transmission of HIV. People with HIV who are trying to conceive should make sure to start HIV medicines before they become pregnant and continue throughout pregnancy, childbirth, and breastfeeding to prevent perinatal transmission. HIV medicines also protect the birthing parent's health when taken at all times.

HIV medicines, when taken as prescribed, prevent HIV from multiplying and reduce viral load. An undetectable viral load is when the level of HIV in the blood is too low to be detected by a viral load test. The risk of perinatal transmission of HIV during pregnancy and childbirth is lowest when a person with HIV has an undetectable viral load. Having an undetectable viral load during pregnancy and throughout breastfeeding/chestfeeding lowers the risk of perinatal transmission of HIV to less than 1%. Maintaining an undetectable viral load also helps keep the parent-to-be remain healthy throughout their life.

After birth, babies born to people with HIV receive medicines to reduce the risk of transmission of HIV. Several factors determine what medicines babies receive and how long they receive the medicines.

Are HIV medicines safe to use during pregnancy?

HIV medicines are safe to use during pregnancy. HIV medicines do not increase the risk of birth defects. Health care providers discuss the benefits and risks of specific HIV medicines when helping people with HIV decide which medicines to use during pregnancy or while they are trying to conceive. If an individual gets pregnant while on HIV medication, they should stay on that medication unless instructed to change by their health care provider.

How does HIV impact infant feeding options?

Pregnant people with HIV are encouraged to talk to their medical team about options for feeding their baby after birth. With consistent use of HIV medicine and an undetectable viral load during

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Revised: Jan 2024

County of Los Angeles Public Health

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(NEW) Preventing HIV Transmission During Pregnancy and Infant Feeding: Client-facing FAQ

- For questions or comments, please email Michael Haymer at mhaymer@ph.lacounty.gov

Crucial Conversations:
Interrupting Perinatal HIV Transmissions

David Griffith MD, Matthew Grant MD, Anna Powell MD, Natella Rakhmanina MD PhD FAAP FCP AAHIVS, & Allison Agwu MD ScM FAAP FIDSA

Johns Hopkins Medicine Collaboration with WICY for Excellence in HIV Care across Central Maryland

Johns Hopkins School of Medicine Baltimore Maryland, USA

August 22, 2024

Disclosures*

Allison Agwu: Gilead scientific advisory board, site investigator under clinical research contract managed through JHU; ViiV scientific advisory board

Natella Rakhmanina: no disclosures

Matthew Grant: no disclosures

David Griffith: no disclosures

Anna Powell: no disclosures

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Objectives

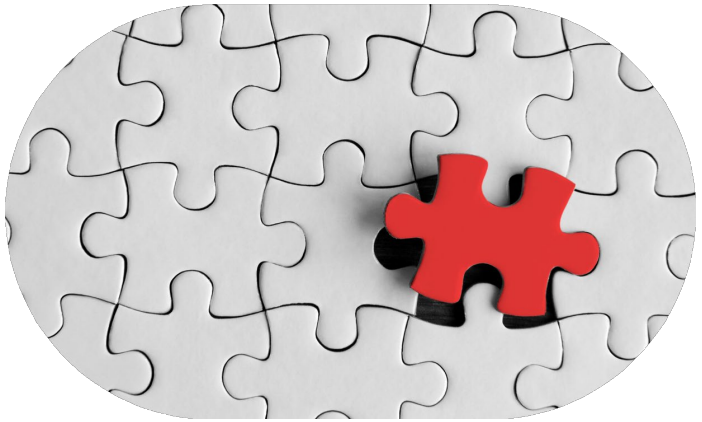
- Discuss trends in perinatal HIV transmissions in Maryland and the U.S.
- Review guidelines and recommendations for preventing perinatal HIV transmissions.
- Examine cases of recent transmission to identify key issues, barriers, stakeholders, and opportunities to interrupt future transmissions.

JHM WICY Collaboration for Excellence in HIV Care Across Central Maryland: Mission

NATIONAL 2024 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

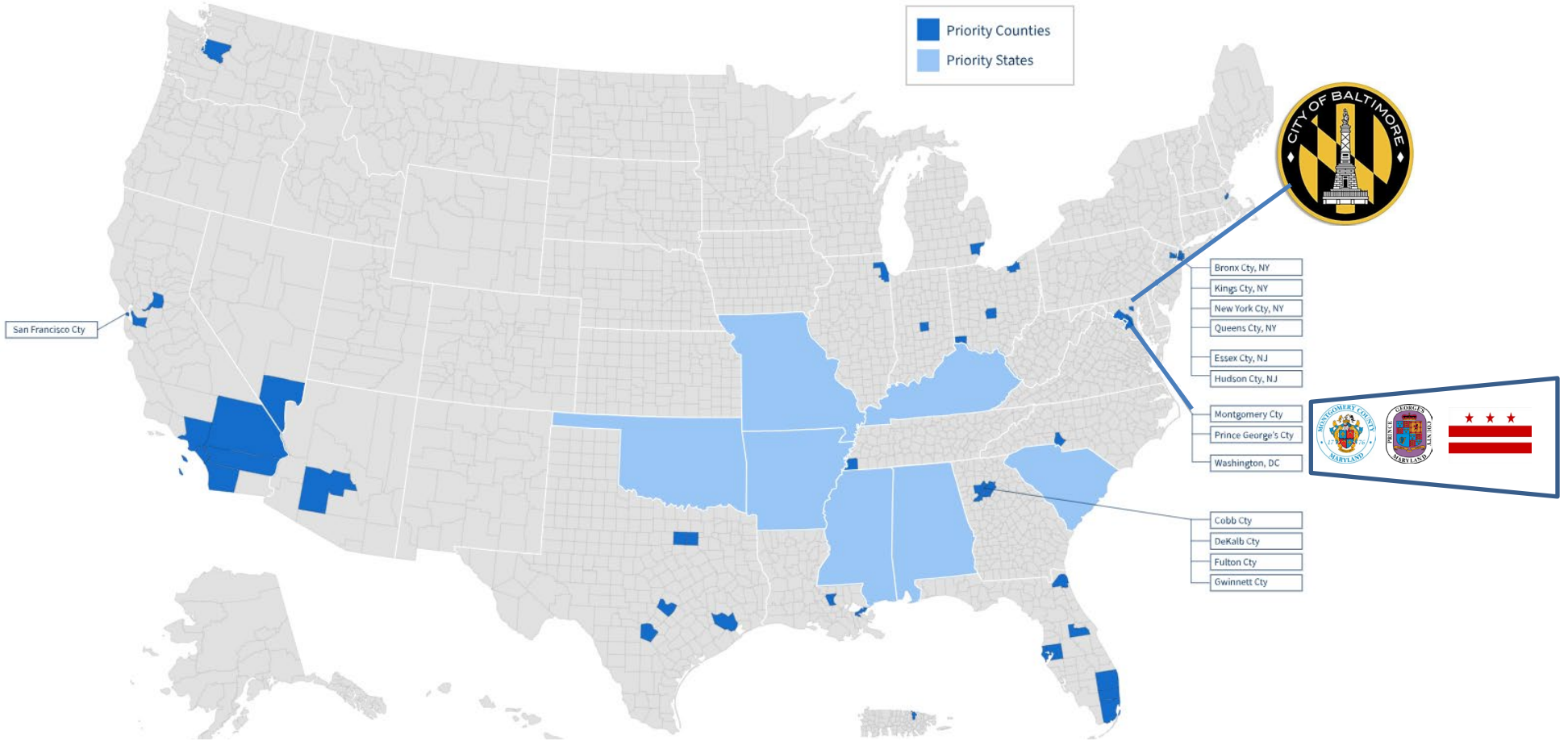
To provide accessible, evidenced-based, culturally- sensitive, comprehensive- coordinated patient and family- centered care

To improve access to early identification of HIV status and facilitate linkage and retention in care



To engage and energize care providers by offering technical assistance aimed to improve health care quality leading to better health outcomes for WICY.

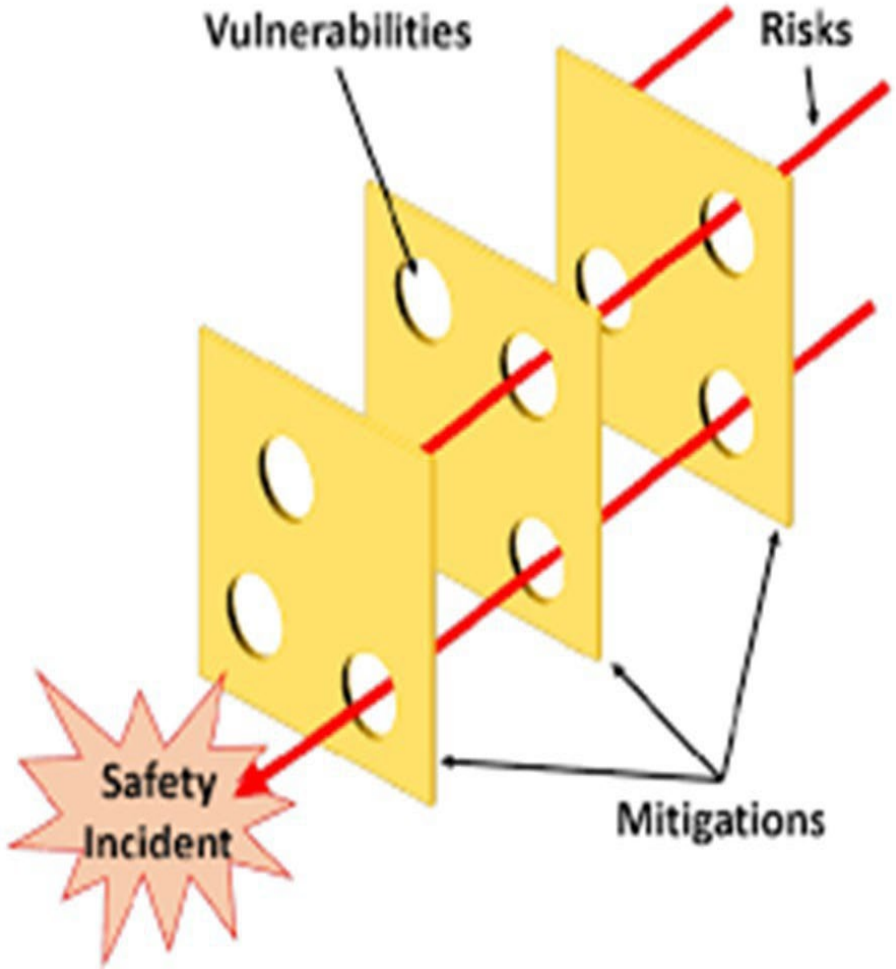
Our Locale



https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/jurisdictions/phase-one

Areas of Focus

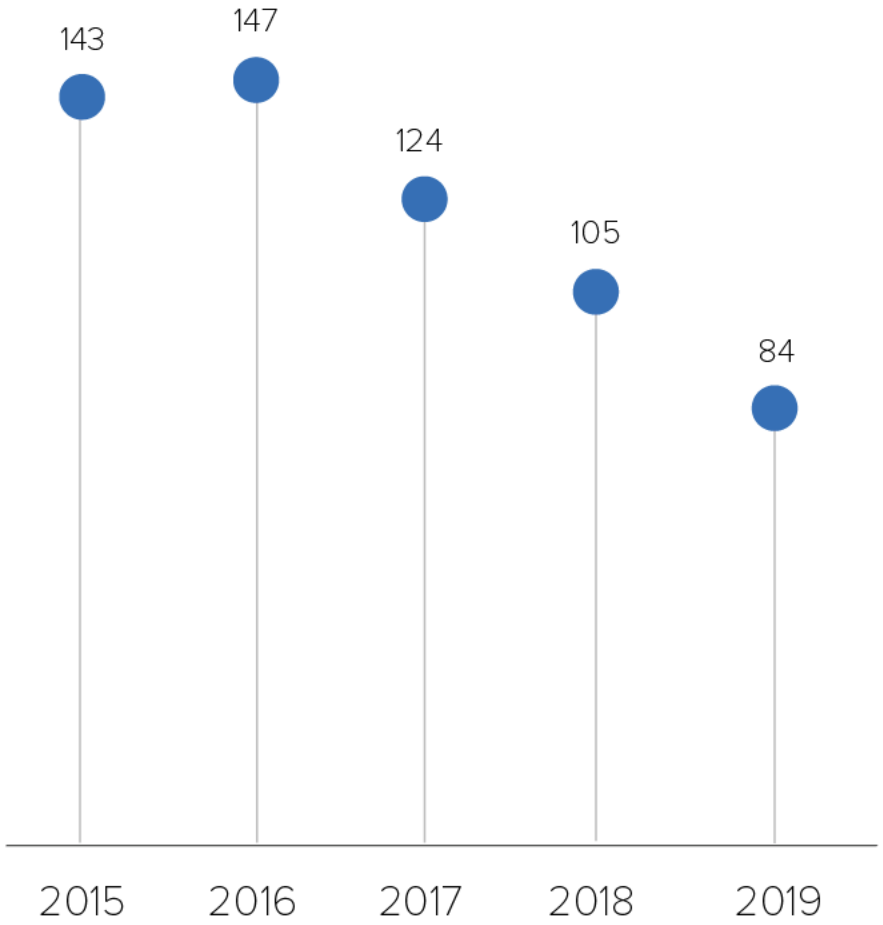
- Maternal child health
  - **Prevention of vertical transmission (PMTCT)**
  - Breast/chestfeeding*
  - Gyn specialty care*
- Improving testing and linkage to care to WICY
- **Sentinel Event Response Team Initiative (SERT)***
- Access to care (transportation, child care)*
- Gender-affirming care for youth
- Transition to adult care
- Enhancing/optimizing referrals to specialty care
  - Mental health services, including telehealth*
- Education and Technical Assistance*
- Clinical Quality Management
- Access to research and clinical trials
- Other areas identified



*Highlighted Initiatives

Trends in New Perinatal HIV Diagnoses in the US and Dependent Areas, 2015-2019*

Perinatal HIV diagnoses decreased 41% from 2015 to 2019.



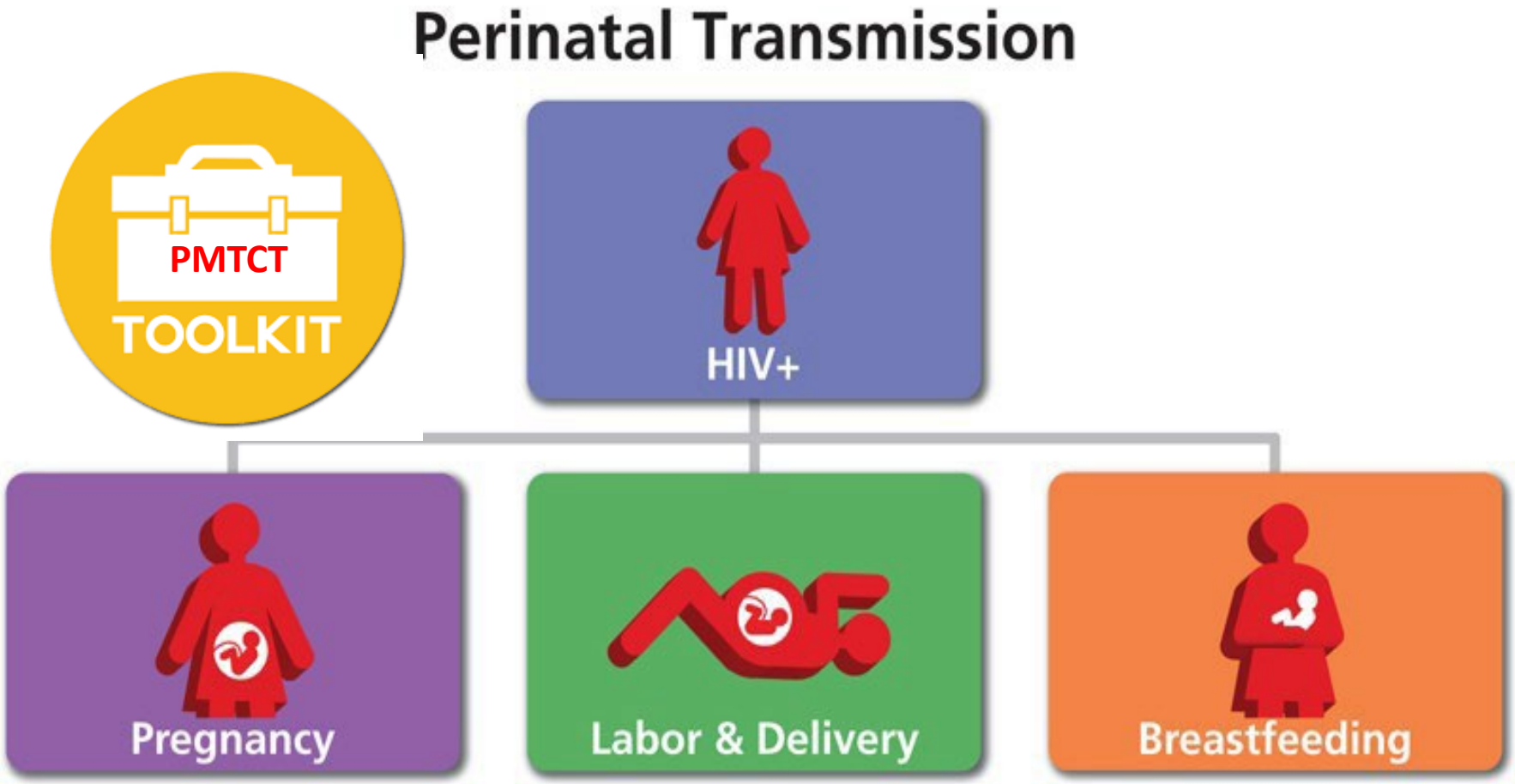
*Includes HIV diagnoses attributed to perinatal transmission among adults, adolescents, and children.

Source: CDC. Diagnoses of HIV infection in the United States and dependent areas, 2019. *HIV Surveillance Report* 2021;32.

JOHNS HOPKINS MEDICINE

CDC

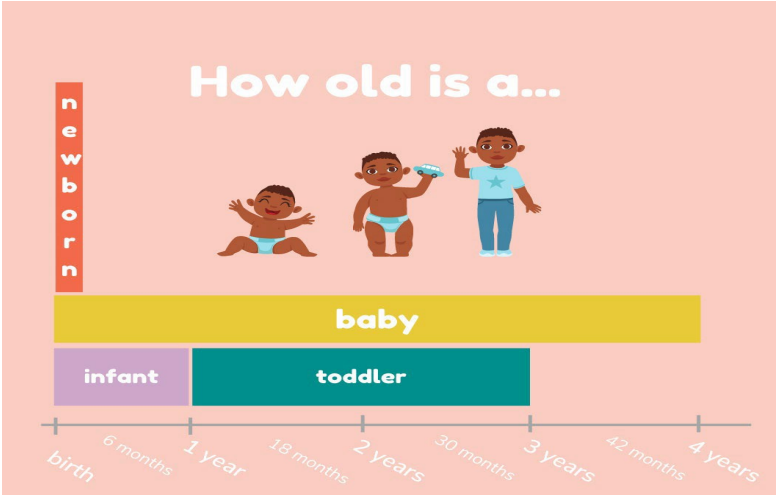
Perinatal Transmission Toolkit



https://clinicalinfo.hiv.gov/en/glossary/perinatal-transmission

Current protocols for PMTCT (U.S.)

- Universal testing
- Maternal testing 1st **and** 3rd trimester, delivery if unknown
- Maternal ART ± IP AZT prophylaxis
- Infant AZT (± NVP & 3TC) (risk dependent)
- 2-6 weeks of infant prophylaxis
- Infant testing at 0, 2, 4, 6 wks, 4 months, 18 months



All infant testing 0-4 months is nucleic acid testing and NOT antibody; 18 months ab sufficient

Prevention of mother to child transmission; https://toddlertalk.com/blog/how-old-are-toddlers

DHHS Guidelines

Perinatal Testing Laws

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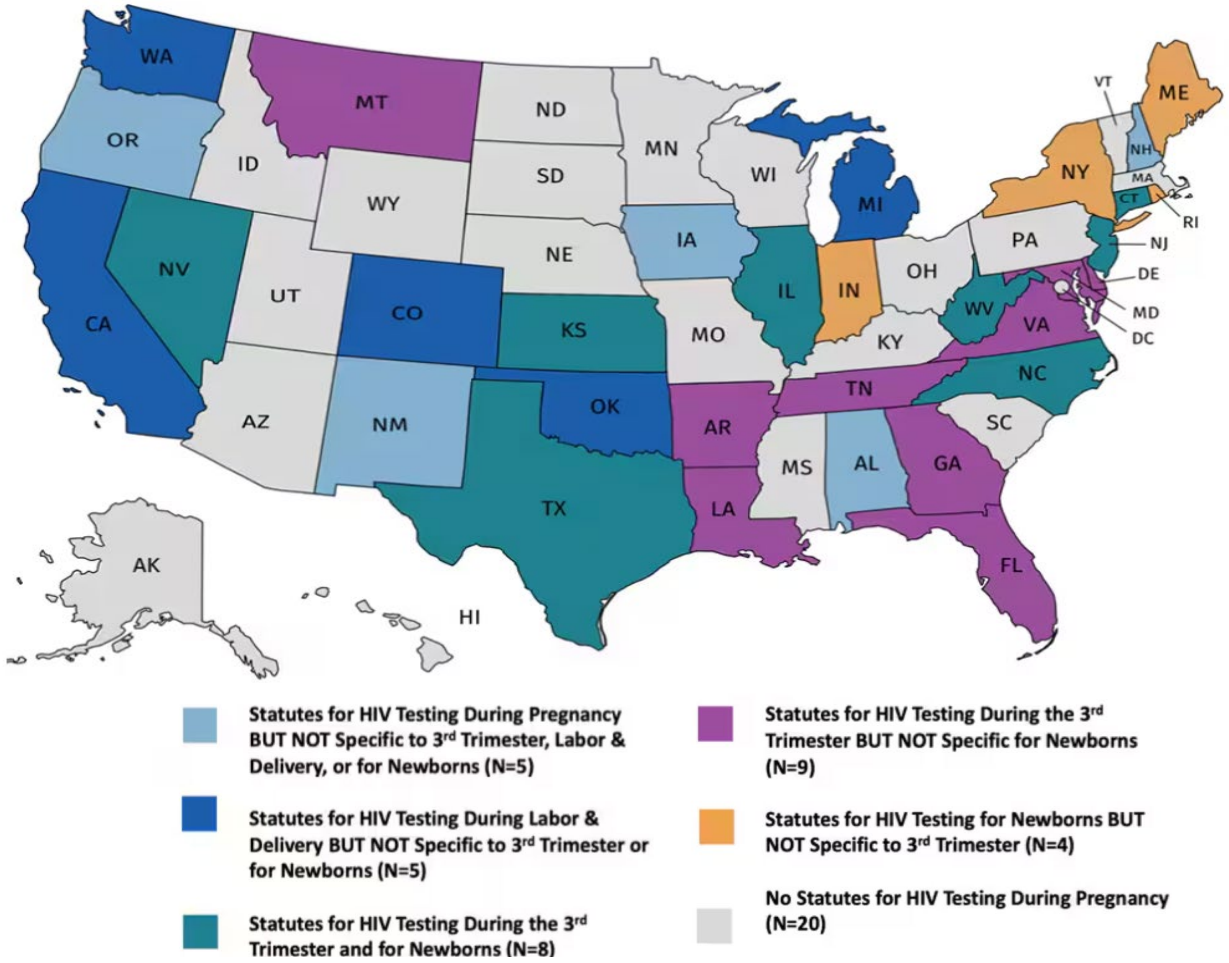
Based on CDC HIV testing recommendations (2006), CDC analyzed 3 components of perinatal HIV testing laws. Specifically, whether the law requires HIV testing:

1. Of pregnant women in their 3rd trimester

2. During labor and delivery when HIV status was undocumented

3. Of the newborn if the mother's HIV status remains unknown.



Salvant Valentine, S; Poulin , A. Consistency of State Statutes and Regulations With Centers for Disease Control and Prevention's 2006 Perinatal HIV Testing Recommendations. *Public Health Reports* 2018, Vol. 133(5) 601-605.

Time of Maternal HIV Testing among Children with Diagnosed Perinatally Acquired HIV Infection and Children Exposed to HIV, Birth Years 2010–2016—United States and Puerto Rico

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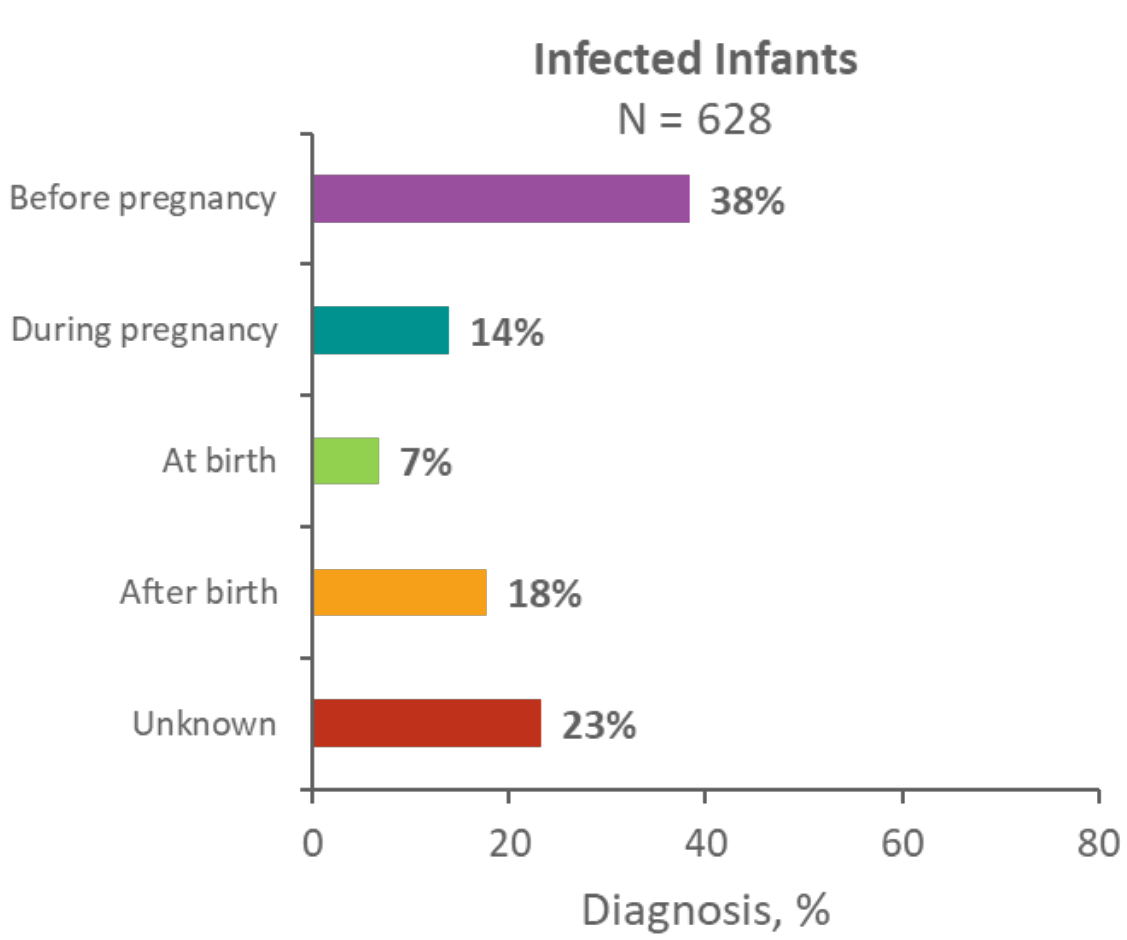
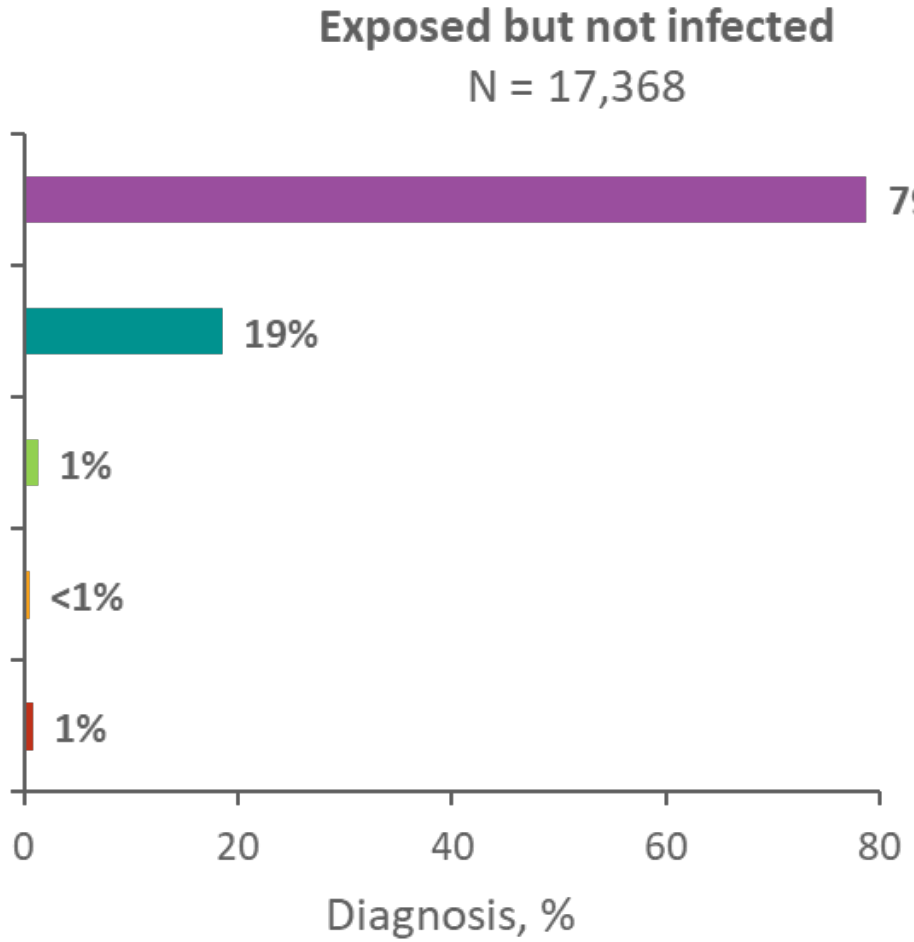
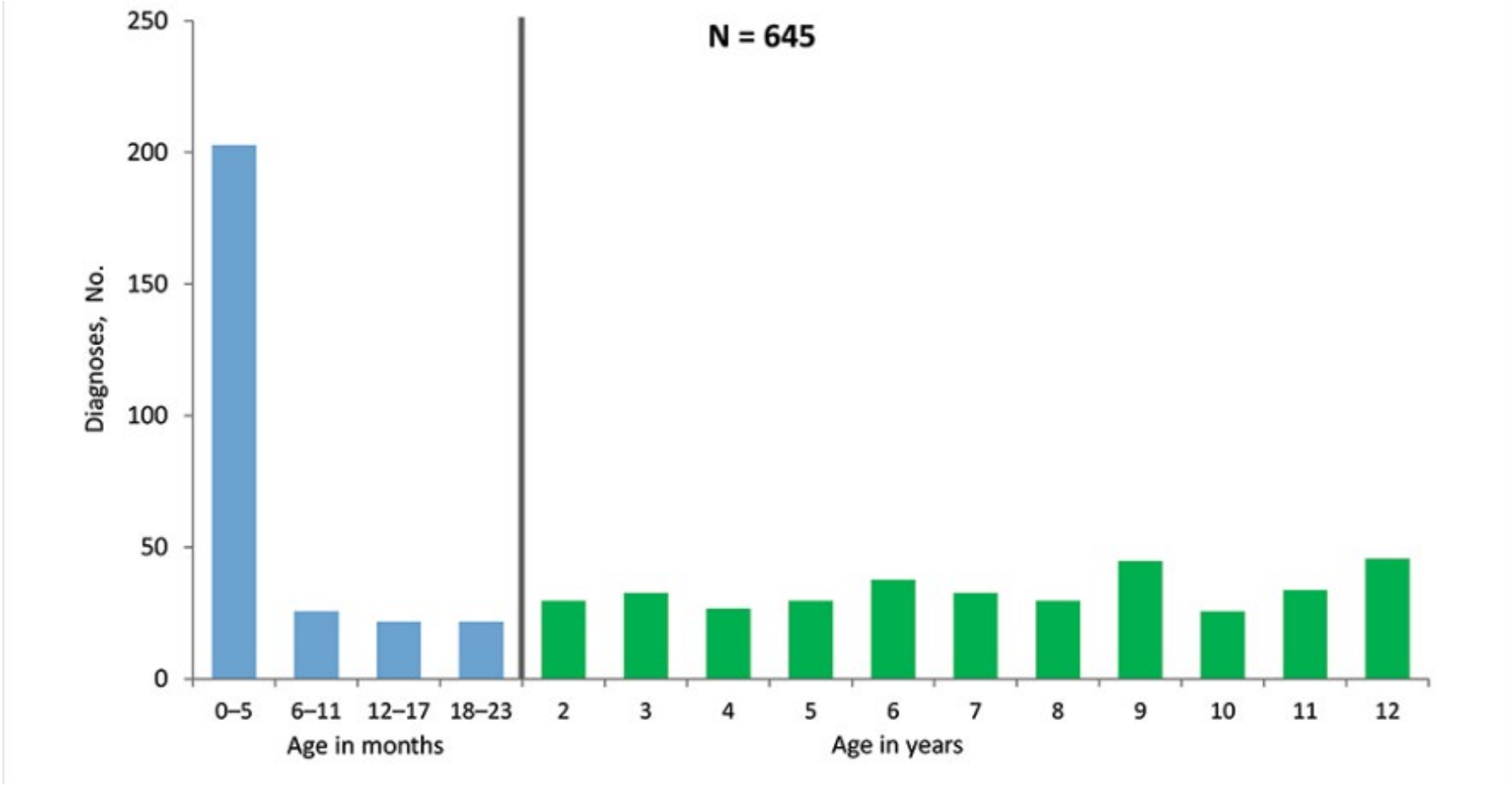




Diagnoses of HIV Infection among Children Aged <13 Years, by Age at Diagnosis, 2014–2018—U.S.



Perinatal Transmission by Year, 2012-2021

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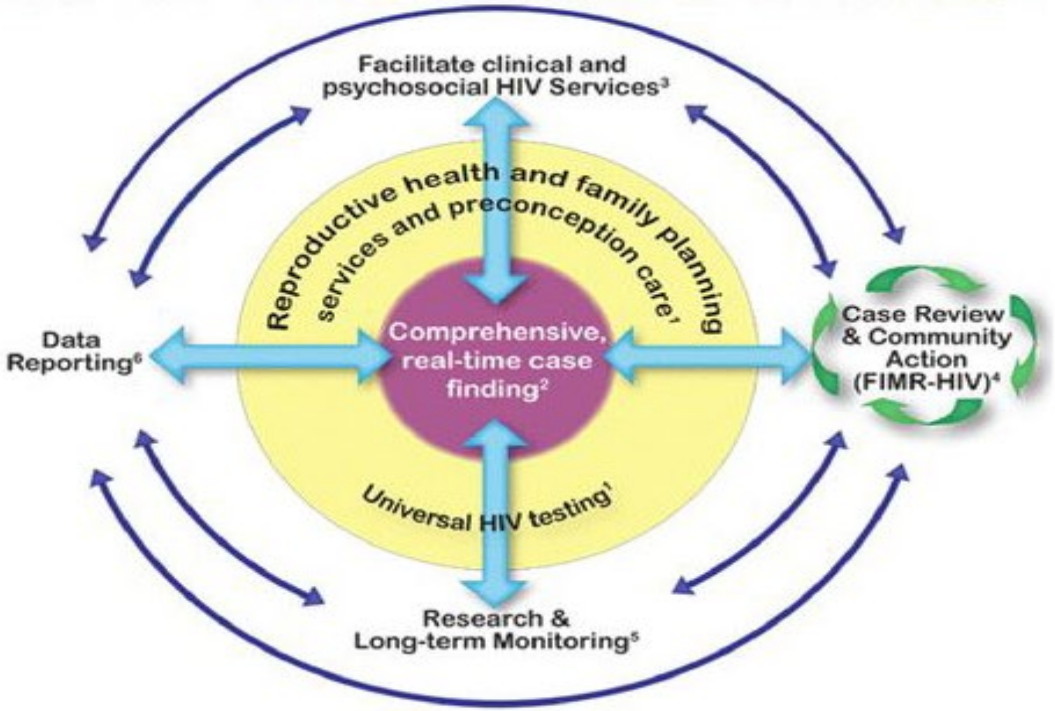
Perinatal HIV Transmissions by Year of Birth

Year of Birth	Live Births	People of Childbearing Age Living with Diagnosed HIV	Reported Perinatal HIV Exposures
	No.	No.	No.
2012	72,751	6,696	183
2013	71,806	6,770	163
2014	73,588	6,345	202
2015	73,544	6,468	152
2016	73,073	6,078	185
2017	71,589	5,724	169
2018	71,037	5,234	162
2019	70,130	5,062	168
2020	68,546	4,630	151
2021	--	4,592	156
Total	**646,064**	**57,599**	**1,691**

Live births from Maryland Vital Statistics Annual Report 2021

Framework to Eliminate Perinatal HIV Transmission in the United States. v. 1.0

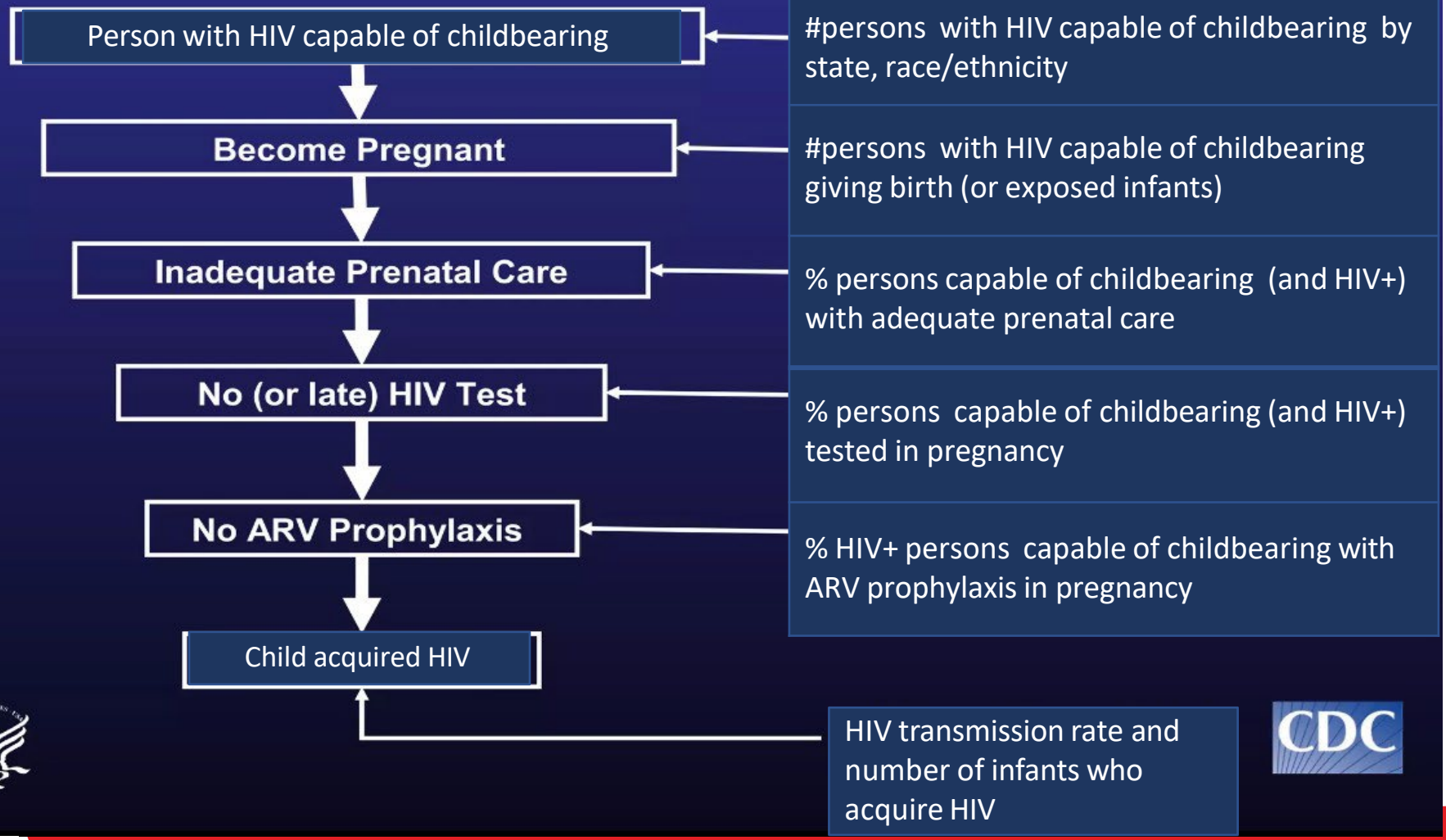
PMTCT TOOLKIT



Nesheim S, Taylor A, Lampe M, et al. Pediatrics. Vol 130, Num 4, October 2012.

https://clinicalinfo.hiv.gov/en/glossary/perinatal-transmission

Perinatal Prevention Cascade



Cases

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

February 17, 2023

Dear Colleague:

Background and Current Situation

The purpose of this notice is to alert the provider community of a recent, substantial increase in perinatal HIV transmission in Maryland during 2022. The Maryland Department of Health is investigating six recent reports of confirmed perinatal HIV infection. Perinatal HIV transmissions are rare in Maryland. Over the five-year period from 2016-2020, there were only six confirmed transmissions. During 2021, there were 156 confirmed perinatal HIV exposures and zero cases of perinatal HIV infections in babies born in Maryland. Since July 2022, five babies from four different jurisdictions in the state have acquired HIV through perinatal transmission and a sixth perinatal HIV infection was reported in a young child born several years earlier. All six children are currently in care. Review of case data showed that in most cases there was late initiation of prenatal care followed by late or no initiation of HIV antiretroviral therapy (ART). Other maternal risk factors included mental health issues, history of sexually transmitted infections (STIs), and substance use.

Guidelines to Prevent Perinatal HIV Infection

It is important that providers remain vigilant in their efforts to prevent perinatal HIV infection by adhering to the following guidelines:

- Prenatal care is essential for good health outcomes and its importance should be communicated to all sexually active patients who may become pregnant.
- **HIV testing is the standard of care for all pregnant persons** and is a routine component of preconception care; many pregnant persons are not diagnosed with HIV until they are tested during the pregnancy.
- In Maryland, HIV testing must be offered during both the first and third trimesters, and again at labor and delivery if there is no indication of a test prior to delivery.

Child Demographics, HIV and Delivery Characteristics

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Case	GA	Age at dx	Testing at diagnosis	Breastfed (Y/N)	Initial ART prophylaxis	Perinatal HIV factors
1	29 wks	Birth	PCR DNA+;HIV RNA 51,499 copies/mL	No	AZT	Lack of perinatal care and maternal ART in setting of opioid use disorder
2	38 wks	2 wks	PCR DNA+ at 2 wks; HIV RNA 38 copies/mL at 4wks	No	AZT/3TC/NVP	Late maternal HIV diagnosis; delayed perinatal care
3	28 wks	3 wks	PCR RNA+ at 2 wks; HIV RNA 159,000 copies/mL at 3 wks	No	AZT	Late maternal HIV diagnosis; incomplete maternal linkage to care/no maternal ART; prematurity
4	38 wks	10 wks	DNA+ at birth; HIV RNA 160,000 copies/mL at 10 wks after ART stopped	No	AZT/3TC/NVP	Late prenatal care and lack of maternal ART adherence
5	25 wks	9 wks	DNA+ at birth; HIV RNA 4,990,000 copies/mL at 9 wks after ART stopped	No	AZT/3TC/NVP	Late prenatal care; incomplete maternal linkage to care/no maternal ART; prematurity
6	Full term	7 years	HIV Ag/Ab+ HIV RNA 1,786,000 copies/mL	Yes	None	Negative maternal HIV in 2nd trimester, likely seroconversion during 3rd trimester; no third trimester/delivery testing

Perinatal Task Force; Griffith (submitted)

Challenges identified and opportunities for improvement

Identified Risk factor for perinatal transmission
Delayed HIV diagnosis until pregnancy
HIV acquisition during pregnancy
Delayed linkage to HIV care and ART initiation for individuals diagnosed during pregnancy
Substance use and lack of perinatal/HIV care

Challenges identified and opportunities for improvement

Identified Risk factor for perinatal transmission
Poor ART adherence during pregnancy
HIV acquired in sexual assault with delayed diagnosis and entry to care
Missed HIV diagnosis in pregnancy /lack of testing of children following maternal/parental diagnosis
Lack of dosing of preventative antiretrovirals for premature infants

Griffith (submitted)

Additional Thoughts

- Knowledge gaps (childbearing individuals and providers)
  - E.g- increased training in rural Maryland counties
  - Educational initiatives for providers (sexual health in pregnancy)
- Linkages and transfers
  - better linkage with academic medical centers for treatment advice, ensuring warm hand offs of patients newly diagnosed with HIV, etc
- Stigma
- Other?

Perinatal Action – Maryland Department of Health

1. **Task force developed including relevant stakeholders**
2. **Perinatal Campaign (statewide, multi-platform)**

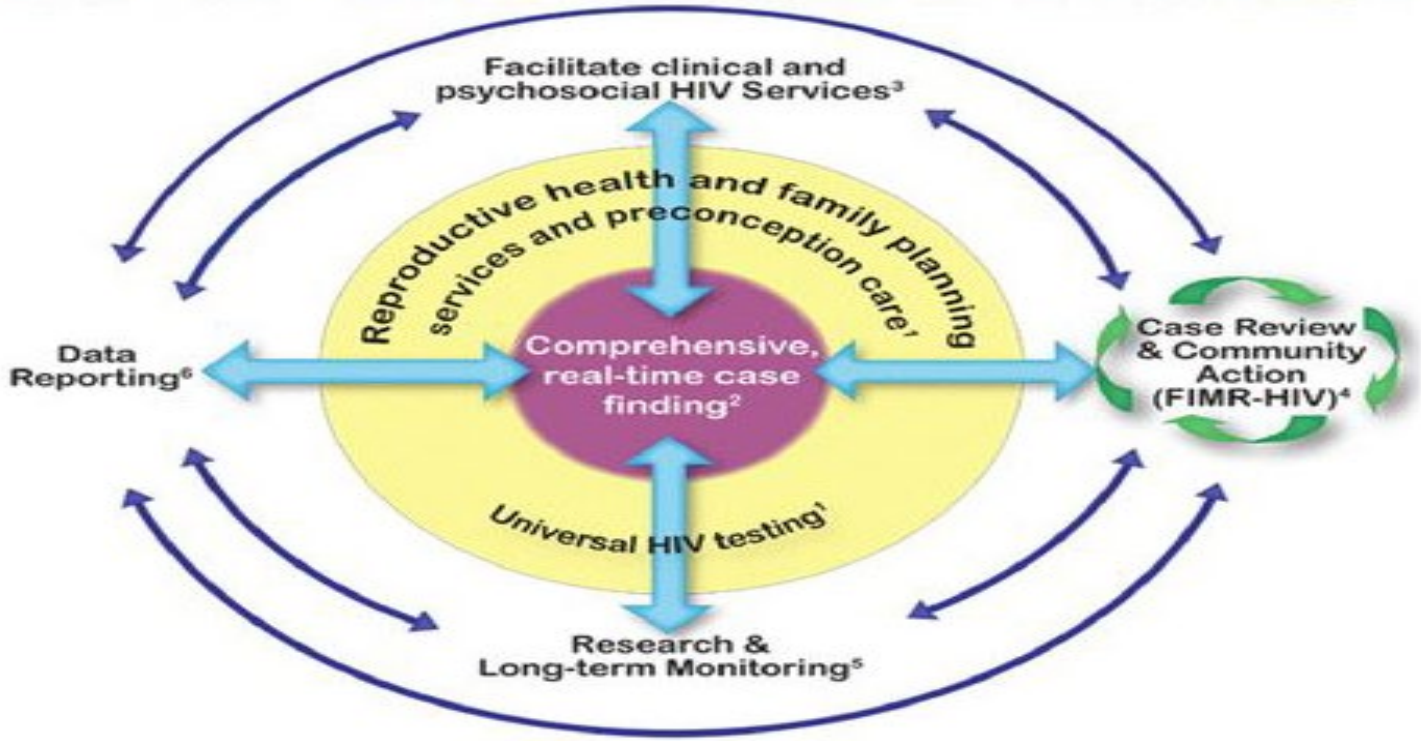
Messages: Encourage pregnant persons to seek prenatal care; get tested for HIV, syphilis, and viral hepatitis; encourages partner testing

3. ***Provider letter and additional department communication regarding testing of children born outside of the U.S.***
4. ***Perinatal Prevention Policy*: House Bill (HB) 119/Senate Bill (SB) 211** – Public Health - Giving Infants a Future Without Transmission (GIFT) Act aims to amend HIV and syphilis reporting and testing requirements for hospitals and health care providers attending to pregnant persons and newborns. Mandates: (1) HIV & syphilis testing at Labor & Delivery; (2) newborn HIV testing in cases where the pregnant person's HIV status is unknown; (3) inclusion of pregnancy status when reporting an HIV diagnosis. This bill has passed and will become effective on 10/1/2024.

http://health.maryland.gov/pregnancycare; personal communication MDH

Practice Improvement

Framework to Eliminate Perinatal HIV Transmission in the United States. v. 1.0



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- ACE Program
- Bartlett Team
- IPC/PAHAP
- The JHU HIV Clinical Research Team
- Center for Adolescent and Young Adult Health
- CFAR
- JHU Pediatric & Adult Infectious Disease Program

RESOURCES

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Perinatal HIV Consultation and Referral Services (Perinatal HIV Hotline): 888-HIV-8765 (888-448-8765)

For questions about the care of pregnant persons with HIV as well as indications and interpretations of rapid and standard HIV tests. Available 24 hours/day, 7 days/week.

Johns Hopkins:

Access Line (HAL): 410-955-9444 (Peds ID on-call) (24/7)
HIV specialists: *Agwu, Griffith, Persaud, Griffith*
Intensive Primary Care clinic nurse case managers: 443-255-2049 or 443-488-1842
OB preconception counseling: 410-614-4496
HALO clinic: 410-502-3200 (NCM: 443-571-1776); L&D on-call 410-955-5850

Children's National Hospital/Medstar Washington Hospital Center

Special Immunology Services (SIS) Pager: 202-476-5000 (Peds ID/HIV Attending on-call) (24/7)
HIV Prevention and Treatment Specialists (HPTS): *Rakhmanina, Ferrer, Anderson, Williams, RN Bright and LPN Okumko*
HPTS/SIS Program Perinatal Referrals: 202-476-4732 or 202-476-6629 (M-F daytime, messages returned within 24 hrs)
HPTS/SIS PrEP/New Patient Referral: 202-476-2519 (Red Carpet Coordinator Nara Lee, M-F daytime)
MedStar WHC OB Clinic: 202-877-7101 (request HRSD with Dr. Scott)

University of Maryland:

410-328-8336 (24/7)
HIV specialist: Grant
SPICE Program 410-706-8929

Continuing Education Credit

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