Addressing STIs: Ask. Test. Treat. Repeat.

L. Beth Gadkowski, MD, MPH, MS
Jennifer Janelle, MD
University of Florida College of Medicine

Replicating Innovative HIV Care Strategies in the Ryan White HIV/AIDS Program

Innovative HIV Care Strategies to Address HIV and STIs

June 29, 2023

Agenda

- *Project Overview*
  - About the Special Projects of National Significance (SPNS) Program & Integrating HIV Innovative Practices (IHIP) Project – presented by: Shelly Kowalczyk (MayaTech)
- *Intervention Overview*
  - ***Addressing STIs: Ask. Test. Treat. Repeat.*** – presented by: Dr. Jennifer Janelle and Dr. L. Beth Gadkowski, University of Florida College of Medicine
- *Q&A*
- *Participant Feedback*

Project Overview: About the Project

- **Funded By**: The U.S. Department of Health and Human Services, Health Resources and Services Administration's HIV/AIDS Bureau through RWHAP Part F: Special Projects of National Significance.
  - HRSA oversight provided by: Melinda Tinsley and Adan Cajina

- **Awarded To:** The MayaTech Corporation
  - Subcontractor: Impact Marketing + Communications
  - Contract Period of Performance: September 27, 2021 – September 26, 2023

- **Purpose:** To support the coordination, dissemination, and replication of innovative HIV care strategies in the Ryan White HIV/AIDS Program (RWHAP) through the development and dissemination of implementation tools and resources.

Framework for RWHAP SPNS RWHAP

DEMONSTRATE OR IMPLEMENT	EVALUATE & DOCUMENT	COORDINATE, REPLICATE, & INTEGRATE
Fund recipients to respond to emerging needs of people with HIV using evidence-based, evidence-informed, and emerging interventions	Use an implementation science framework to identify effective interventions to improve HIV outcomes among Ryan White HIV/AIDS Program clients	Develop guides and manuals, interactive online tools/toolkits, publications, and instructional materials that describe how to coordinate, replicate, and integrate interventions and strategies for RWHAP providers
Fund special programs to develop a standard electronic client information data system to improve the ability of recipients to report data	Evaluate and document specific strategies for successfully integrating interventions in RWHAP sites	Streamline access to materials and promote replication through the Best Practices Compilation

Key Support to RWHAP Providers

- Implementation tools and resources
  - Featuring interventions implemented by RWHAP grant recipients/subrecipients
- Capacity building TA (CBTA) on featured interventions
  - CBTA webinars
  - Peer-to-peer TA
- Support in the development and dissemination of implementation tools and resources
  - Webinars
  - One-on-one TA
- Helpdesk (ihiphelpdesk@mayatech.com)

Check out TargetHIV.org/IHIP

Disclosures and Disclaimers

Disclosure of Unlabeled Use

This educational activity may contain discussion of published and/or investigational uses of agents that are not indicated by the FDA. The planners of this activity do not recommend the use of any agent outside of the labeled indications. The opinions expressed in the educational activity are those of the faculty and do not necessarily represent the views of the planners. Please refer to the official prescribing information for each product for discussion of approved indications, contraindications, and warnings.

Disclaimer

Participants have an implied responsibility to use the newly acquired information to enhance patient outcomes and their own professional development. The information presented in this activity is not meant to serve as a guideline for patient management. Any procedures, medications, or other courses of diagnosis or treatment discussed or suggested in this activity should not be used by clinicians without evaluation of their patient's conditions and possible contraindications and/or dangers in use, review of any applicable manufacturer's product information, and comparison with recommendations of other authorities.

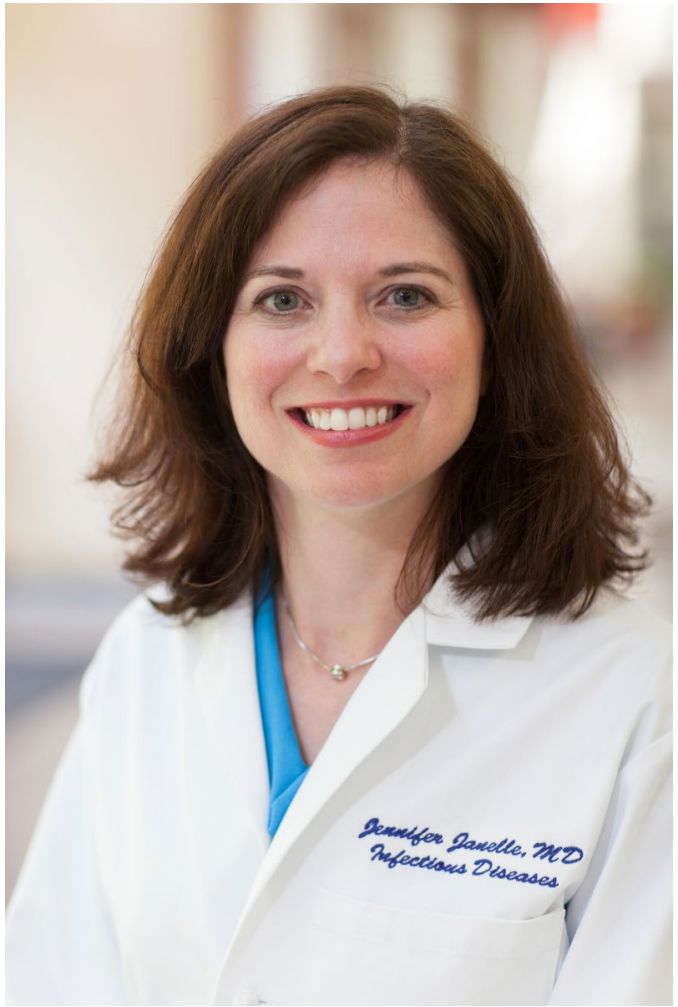
Disclosure of Conflicts of Interest

Postgraduate Institute for Medicine (PIM) faculty, planners, and others in control of educational content to disclose all their financial relationships with ineligible companies. All identified conflicts of interest (COI) are thoroughly vetted and mitigated according to PIM policy. PIM is committed to providing its learners with high quality accredited continuing education activities and related materials that promote improvements or quality in healthcare and not a specific proprietary business interest of an ineligible company.

The faculty reported the following relevant financial relationships with ineligible entities related to the educational content of this CE activity:

L. Beth Gadkowski	Nothing to Disclose
Jennifer Janelle	Nothing to Disclose

Jennifer Janelle, MD



Dr. Jennifer Janelle is an Associate Professor within the Division of Infectious Diseases and Global Medicine in the Department of Medicine at the University of Florida in Gainesville. She currently serves as the UF Adult Infectious Diseases fellowship program director and is a partner in the Southeast AIDS Education and Training Center. Dr. Janelle is board certified in infectious diseases and her clinical interests include HIV, STDs, and other infectious diseases.

L Beth Gadkowski, MD, MPH, MS

Dr. Gadkowski is an Associate Professor at the University of Florida Division of Infectious Diseases and Global Medicine, a role she has held since 2017. At the University of Florida, she helps care for people with HIV at rural health department clinics and has a combined OB/HIV clinic where she helps care for pregnant people with HIV. She is faculty with the Southeast AIDS Education and Training Center and a member of the Florida Department of Health HIV Section Medication Formulary Workgroup, which helps determine the Florida ADAP Formulary.

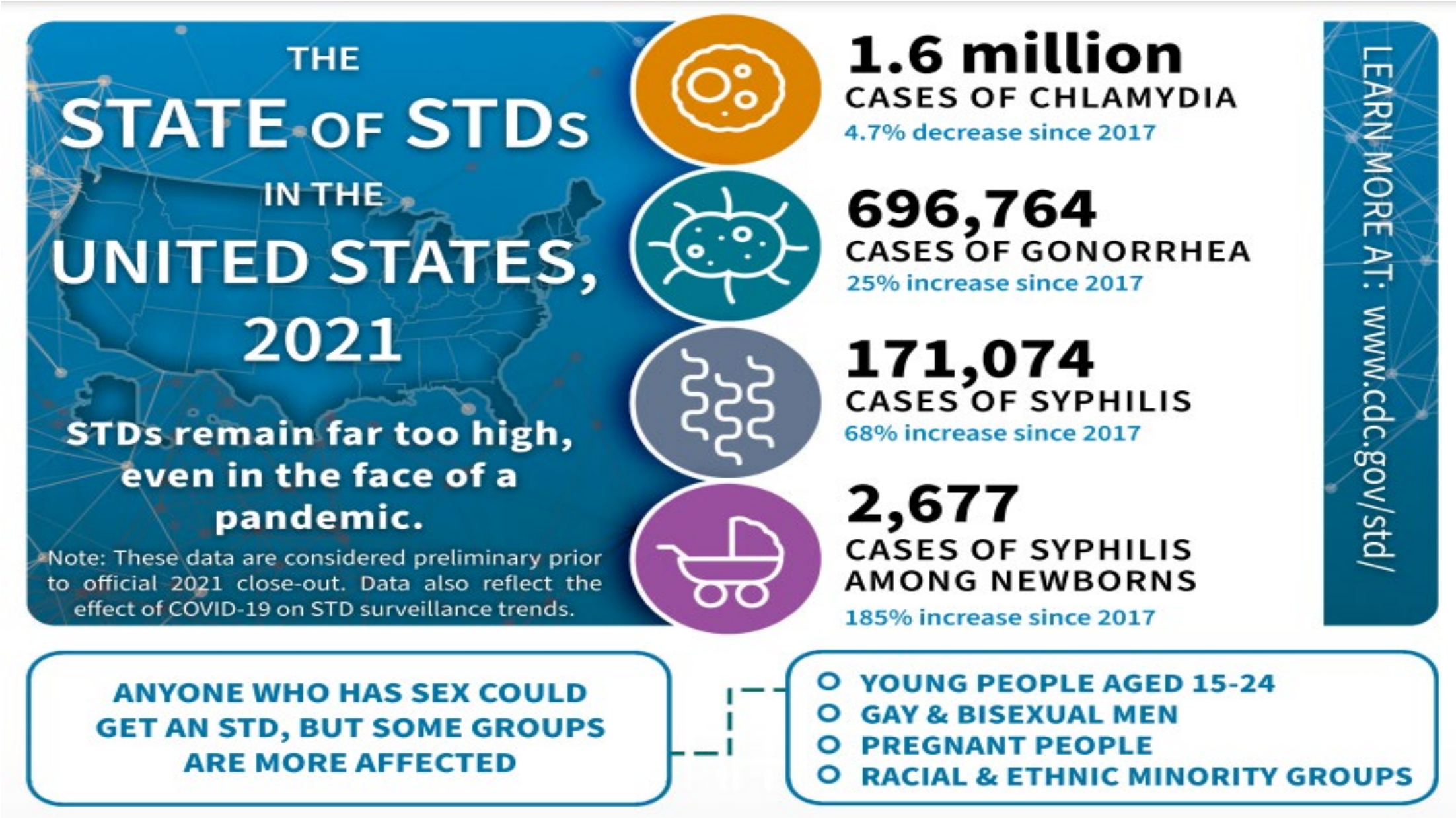
Disclaimer

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U90HA32147-01-00 SPNS Project, awarded at $11,251,973 over 3 years with 0% non-governmental sources used to finance the project. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Overview

- Brief overview of the grant recipient site and funding mechanism for the intervention
- Need addressed, priority population
- Purpose, goals and/or objectives of the intervention

The state of STDs in the US in 2021



Case Study

- Mr. J is a 22 yo man who comes for his annual visit
- You obtain a sexual health history
  - **Partners**: 4 male partners since his last visit with an associated urogenital STI screen
  - **Practices:** oral and anal receptive and insertive sex
  - **Protection from STIs:** not on PrEP, inconsistently uses condoms for anal sex, no condom use for oral sex
  - **Prior STI:** He has had one episode of urogenital gonorrhea at age 20
- He is feeling well

Mr. J Case Study

- Sexual health history suggests risks for syphilis, gonorrhea and chlamydia
- Recommended mucosal sites to be tested for gonorrhea and chlamydia: throat, rectum and urogenital
- Samples collected
- Client-centered STI prevention counselling performed, condoms offered, discussed HIV pre-exposure prophylaxis (PrEP)
- Test results returned:
    - Pharyngeal swab positive for gonorrhea

Addressing The Need For Increased STI Screening

The Problem: Rise of bacterial STIs across the US

- STIs can spread among people who are asymptomatic and can cause serious, long-term health problems if left untreated
- STIs increase the likelihood of HIV acquisition & transmission

The Concern

The Concern: Doing comprehensive sexual histories on each patient, at every visit, will overwhelm the clinical team and the patients; team members not comfortable taking sexual histories; patients don't want this.

Priority Populations

People with or at risk for HIV

- Subpopulations
  - Young adults (ages 18-29)
  - Men who have sex with men
  - Transgender women
  - Racial/ethnic minorities

Addressing STIs: Ask. Test. Treat. Repeat. Video

https://vimeo.com/819141468/b70291df02?share=copy

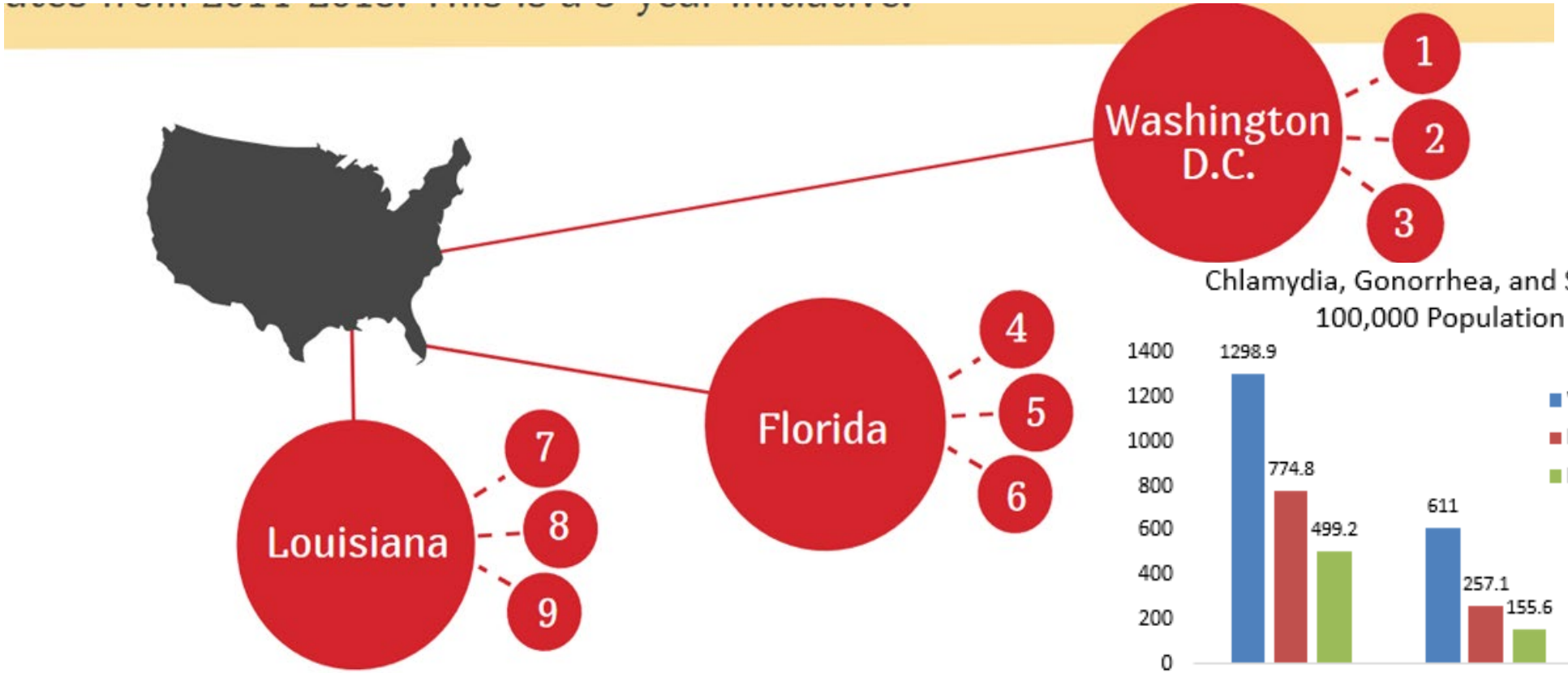
Polling Question

Which is the biggest barrier you face in screening patients for sexually transmitted infections?

1. Time to do a complete sexual health history – **Result: 50%**
2. Comfort talking to patients about their sexual health – **Result: 7%**
3. Concerns about insurance coverage for testing or treatment – **Result: 14%**
4. Lack of access to appropriate testing materials – **Result: 14%**
5. Other (type your answer in the chat!) – **Result: 14%**

Overview of Grant Recipient Sites

François-Xavier Bagnoud Center, Rutgers School of Nursing

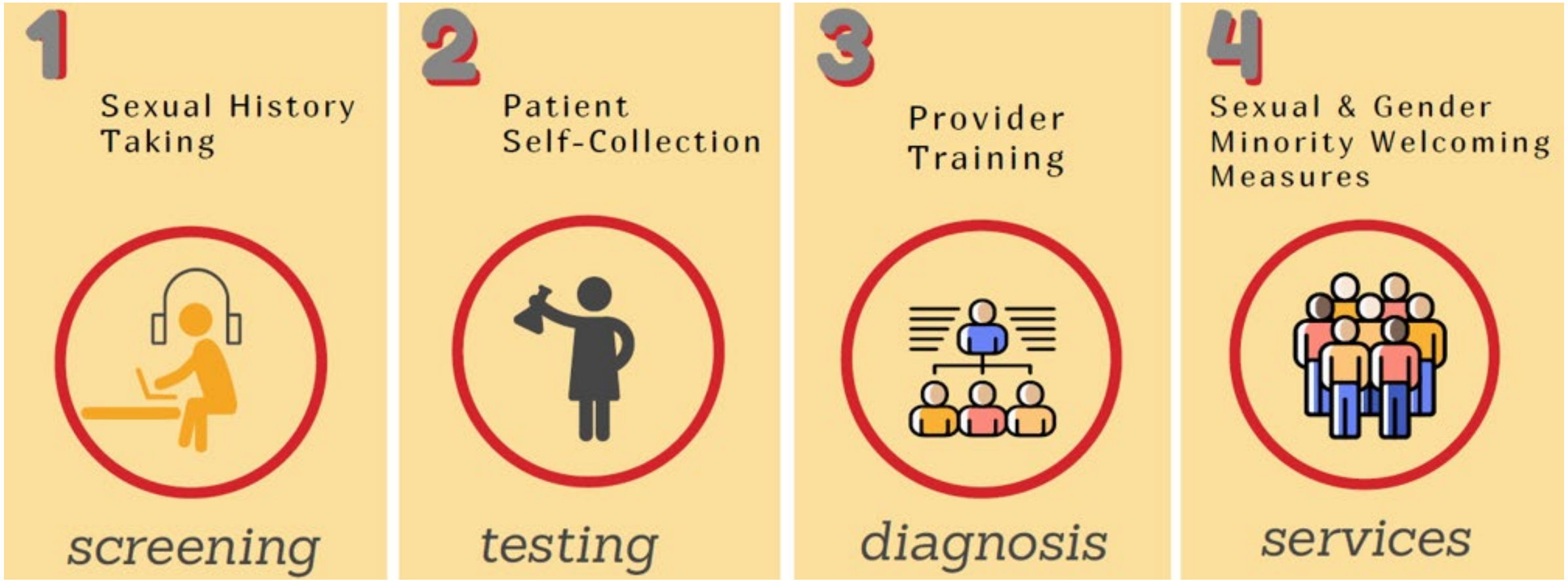


Intervention

9 Clinics

- 9 Ryan White HIV/AIDS Program Clinics
- 2 Bureau of Primary Health Care Health Centers
  - Mix of rural and urban clinics

Four Interventions



Five Components of Sexual Health History Taking

Essential Questions to Ask at Least Annually

Questions:

- Have you been sexually active in the last year?
- Have you ever been sexually active?

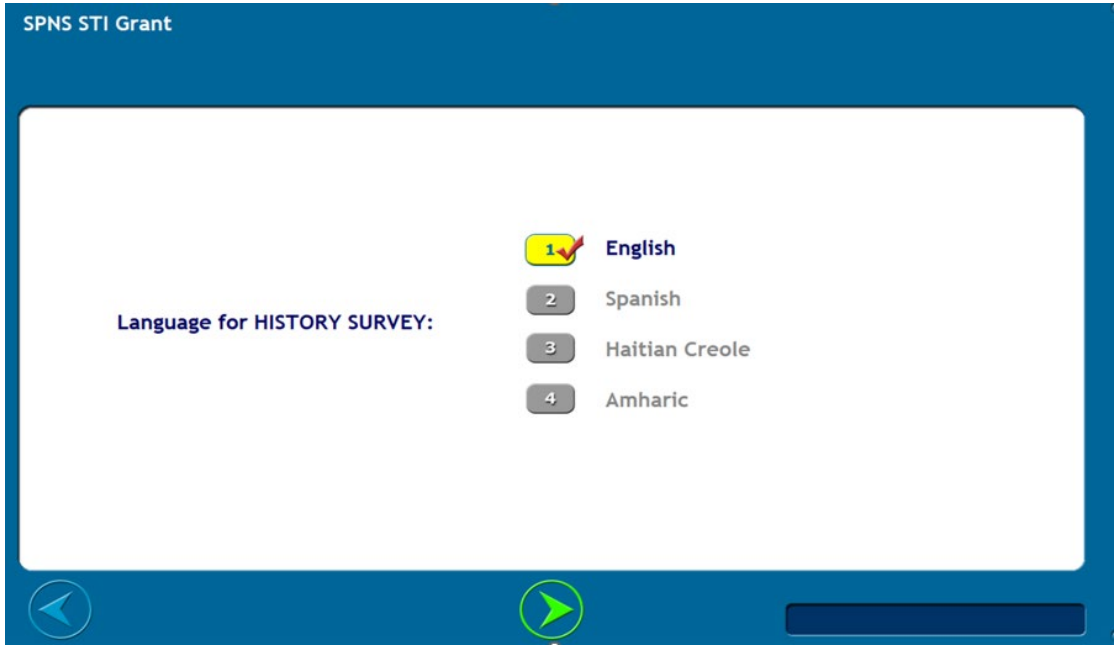
Questions:

- What types of sex do you have (oral, vaginal, anal)?
- With men, women, both, or another?
- How many sexual partners have you had?
- Continue with medical history?

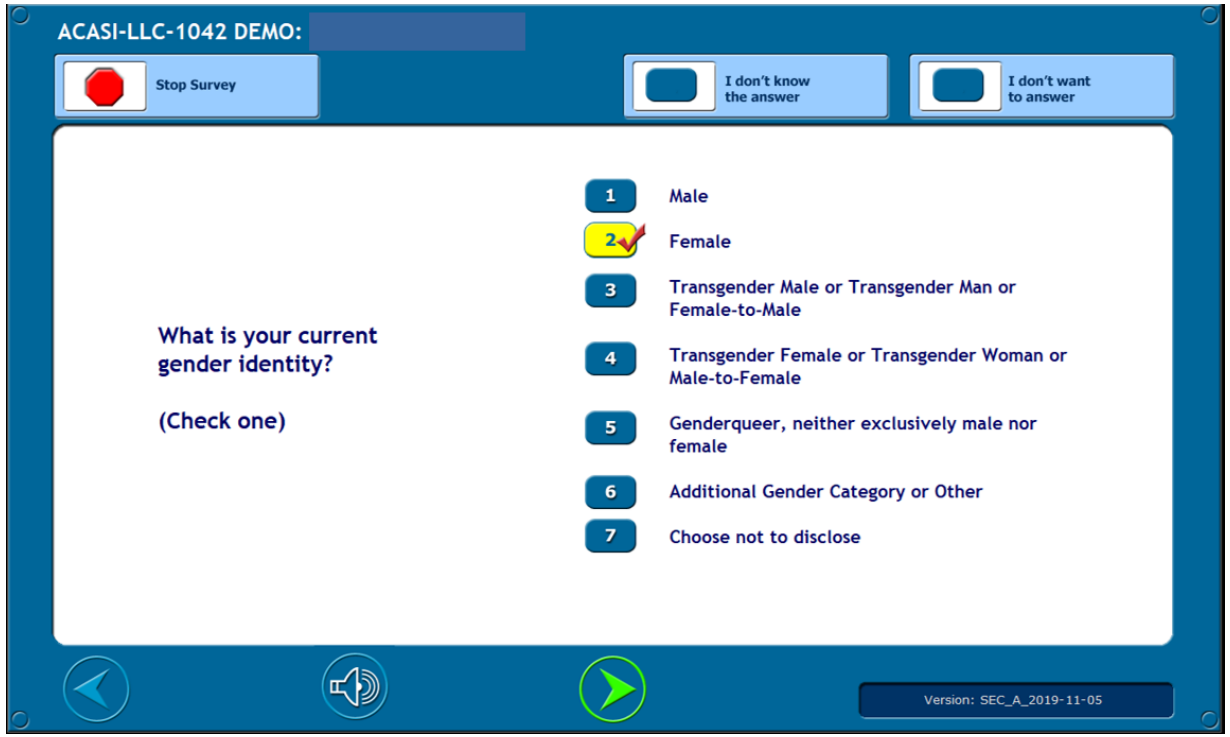
1. **Partners**
2. **Practices**
3. **Prevention of Pregnancy**
4. **Protection from STIs**
5. **Past History of STIs**

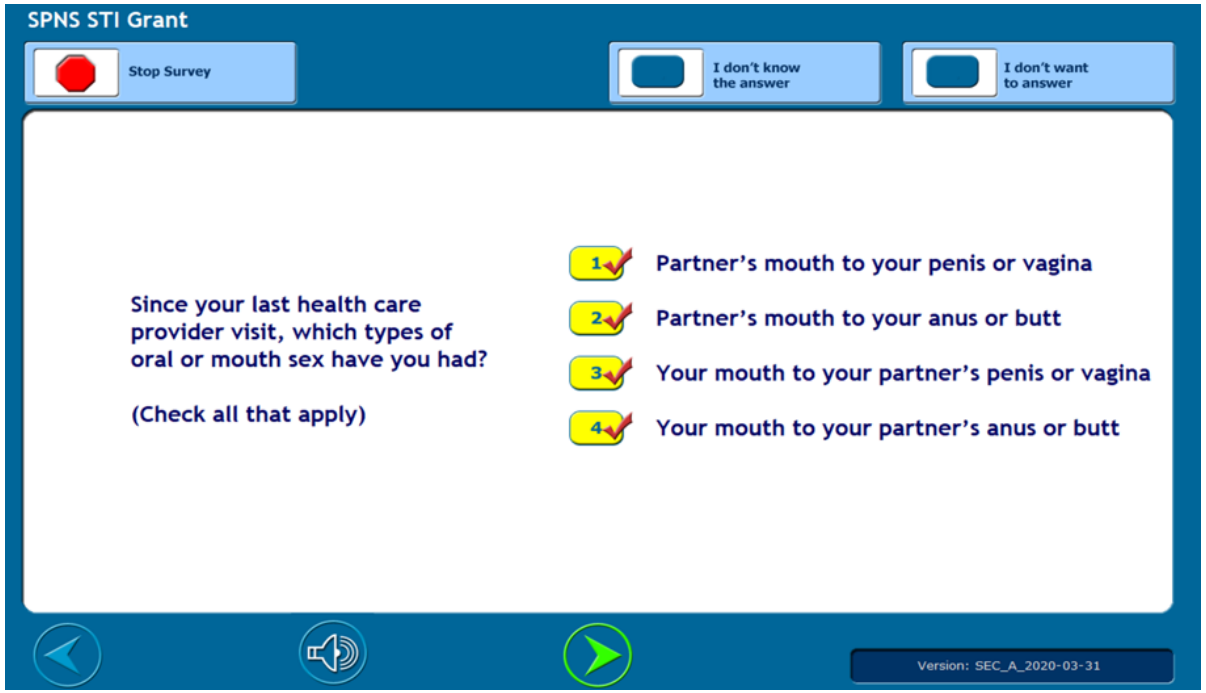
ACASI: Audio Computer-Assisted Self-Interview - 1

- Use of ACASI for STI risk assessment has been associated with:
- Identifying high-risk behaviors
- Less time spent by provider taking a sexual health history
- High acceptability when used by patients
- Potential barriers include:
- Computer literacy
- Implementation expense
- Export of data to EMR when used for clinical care

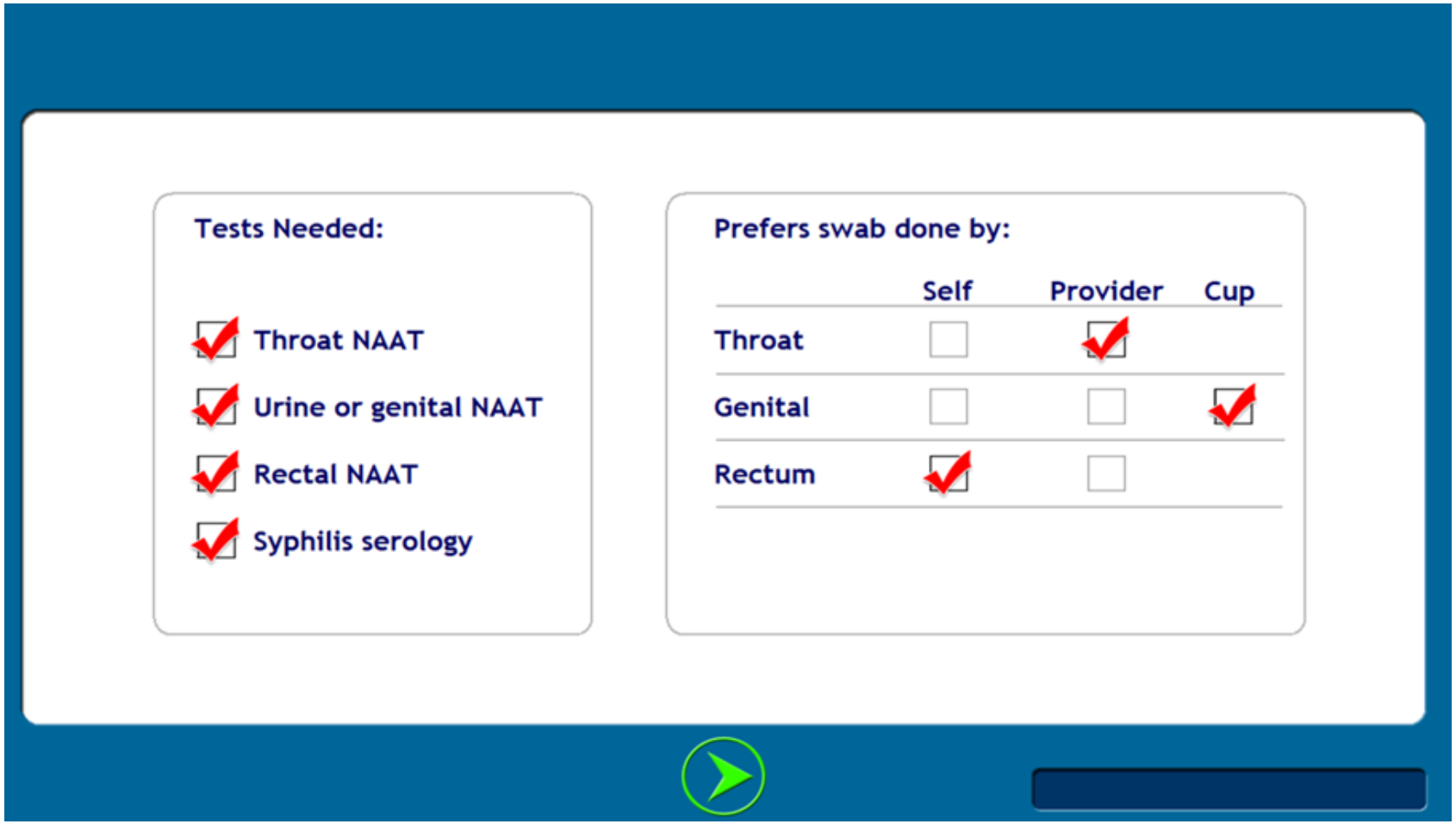


ACASI: Audio Computer-Assisted Self-Interview - 2





ACASI: Audio Computer-Assisted Self-Interview - 3



Sticky Notes

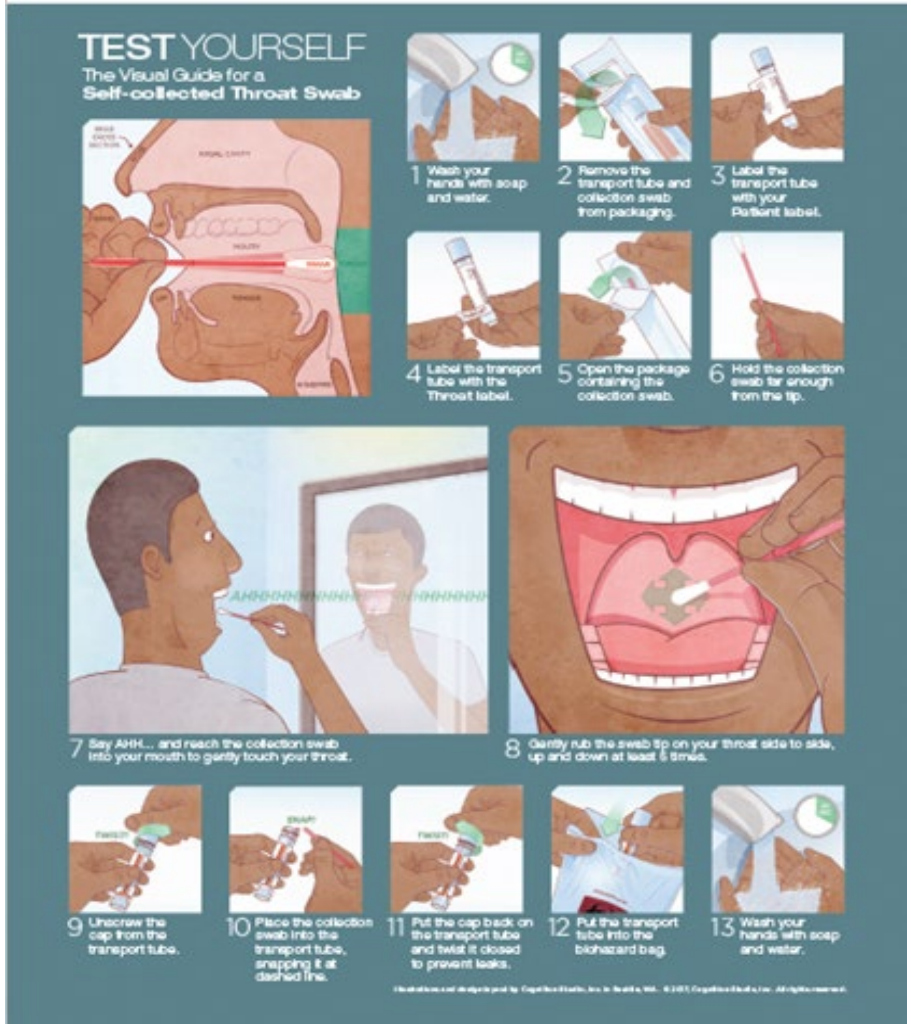
STI Testing Specimens Needed

MRN: **Date:**

	Indication	Self	Staff
Throat NAAT			
GU NAAT Cup or Swab			
Rectal NAAT			
Syphilis Serology			

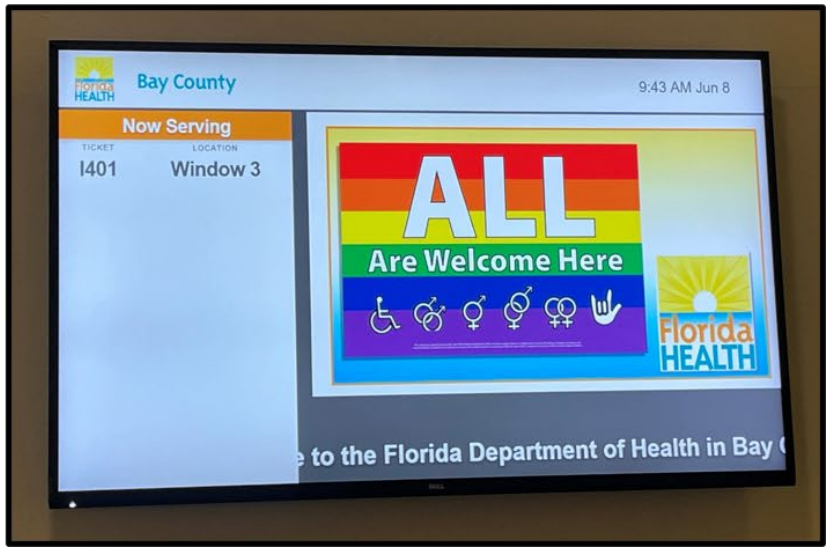
Indications: A = Annual PR = Patient Request
S = Symptoms F/U = Follow-up ID= Identified Factors

Patient Education: Self Collection



Posters courtesy of the University of Washington Prevention Training Center
http://uwptc.org/

Welcoming Indicators



Clinical Team Training Topics

- **STI Epidemiology, Diagnosis & Treatment**
- **Culturally Responsive Care to Reduce Stigma**
- **Taking a Comprehensive Sexual History**
- **Success Stories on Improving STI Care**

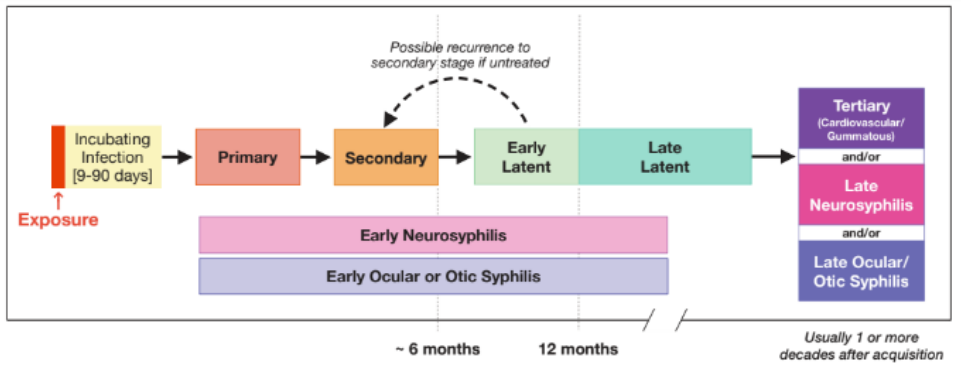
Pocket Guide

The Diagnosis, Management and Prevention of Syphilis Pocket Guide

Adapted from New York City Department of Health and Mental Hygiene Bureau of Sexually Transmitted Infections and the New York City STD Prevention Training Center (2019). The Diagnosis, Management and Prevention of Syphilis — An Update and Review.

National Network of STD Clinical Prevention Training Centers online clinician-to-clinician STD consultation: https://www.stdccn.org/

https://www.nycptc.org/x/Syphilis_Monograph_2019_NYC_PTC_NYC_DOHMH.pdf



Primary and Secondary Syphilis RPR Retesting & Follow-up for People with HIV:

- Every 3 months for 1 year and once again 2 years posttreatment (ie, 3, 6, 9, 12, and 24 months following treatment).

Early Latent, Late Latent, & Latent of Unknown Duration Syphilis RPR Retesting & Follow-up:

- Every 6 months for 2 years posttreatment (ie, 6, 12, 18, and 24 months following treatment).

[1] CDC. Sexually Transmitted Diseases - Summary of 2015 CDC Trearment Guidelines. CDC.gov/std/tg2015/2015-pocket-guide.pdf

This resource is supported by the Health Resources and Services Administration (HRSA) and the U.S. Department of Health and Human Services (HHS) under grant number U9OHA32147. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

Syphilis[1]

	Recommended Rx	Dose/Route	Alternatives
• Primary, secondary, or early latent <1 year	benzathine penicillin G	2.4 million units IM in a single dose	doxycline 100mg 2x/day for 14 days OR tetracycline 500mg orally 4x/day for 14 days
• Latent >1 year, latent of unknown duration	benzathine penicillin G	2.4 million units IM in 3 doses each at 1 week intervals (7.2 million units total)	doxycline 100mg 2x/day for 28 days OR tetracycline 500mg orally 4x/day for 28 days
• Pregnancy	See complete CDC guidelines.		
• Neurosyphilis	aqueous crystalline penicillin G	18-24 million units per day, administered as 3-4 million units IV every 4 hours or continuous infusion, for 10-14 days	procaine penicillin G 2.4 MU IM 1x daily PLUS probenecid 500 mg orally 4x/day, both for 10-14 days
• Congenital syphilis	See complete CDC guidelines.		
• Children: Primary, secondary, or early latent <1year	benzathine penicillin G	50,000 units/kg IM in a single dose (maximum 2.4 million units)	
• Children: Latent >1 year, or unknown duration Latent	benzathine penicillin G	50,000 units/kg IM for 3 doses at 1 week intervals (maximum total 7.2 million units)	

See CDC STD Treatment guidelines for discussion of alternative therapy in patients with penicillin allergy

Clinic Workflows

REMEMBER, patients reporting ANY of the following since last clinic visit or sexual history:

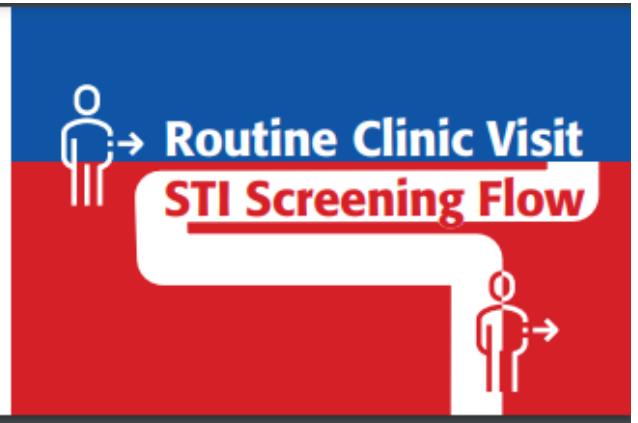
- condomless sex with ≥2 different sexual partners
- exchange sex for commodities
- using drug(s) or alcohol with sex
- partner known by patient to be having sex with others

- a new sexual partner *(since last screening)* need to be tested for GC/CT at each site of reported intercourse (throat, genital, rectal) & syphilis every 3-6 months.
- All pregnant women need vaginal GC/CT & syphilis testing in the 1st trimester & again in the 3rd trimester (as well as throat & rectal GC/CT NAAT if indicated by history).

- All patients diagnosed with GC &/or CT need to be retested 3 months after treatment. People with HIV diagnosed with syphilis should be retested 3 months after treatment. For those without HIV, retest in 6 months.

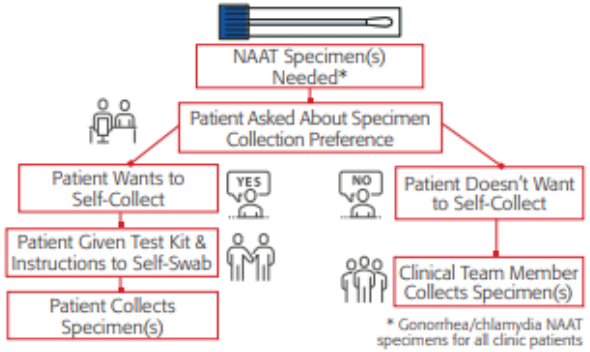
Abbreviations:
ACASI – audio computer-assisted self-interview; CT – chlamydia; GC – gonorrhea; NAAT – nucleic acid amplification test

This product was created through a cooperative agreement supported by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau under grant number U90HA32147.
revised 09-25-2019



- Patient completes sexual history using ACASI
- Clinical team member (RN, LPN, MA, NP, MD, DO, PA) reviews the ACASI sexual history summary page or answers to ACASI sexual history questions to identify needed GC/CT NAATs (oral, genital, rectal) & syphilis testing
- MD/DO/NP/PA places order for needed tests OR RN/MA uses standing order to place order for needed tests

- Patient counseled by RN/LPN/MA on GC/CT NAAT specimen self-collection at each needed anatomical site (throat swab, rectal swab, urine or genital swab) & given test kit(s), one for each anatomical site needed, for collection in bathroom or exam room OR if patient prefers provider to collect, RN/MA/LPN/MD/DO/NP/PA collects specimen



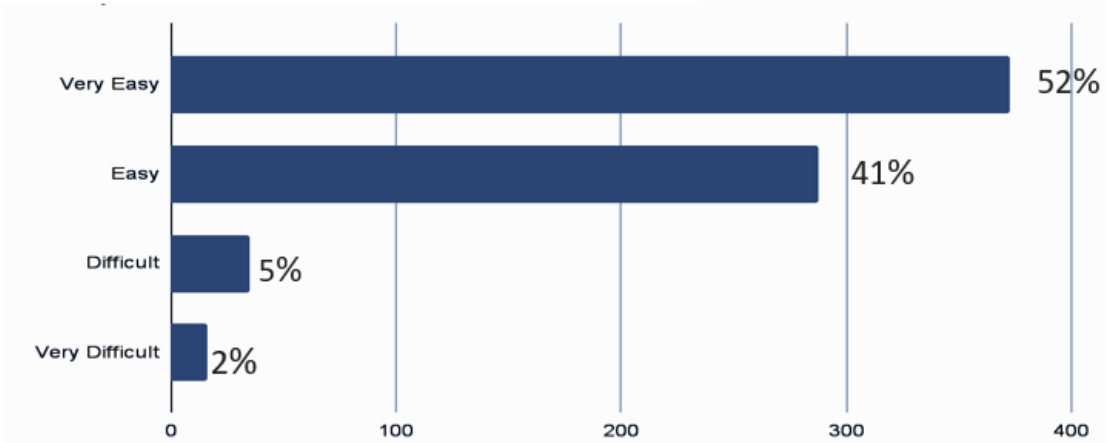
* Gonorrhea/chlamydia NAAT specimens for all clinic patients

- GC/CT specimens are labeled for site of swab, & either urine or site of swab (throat, rectal, urethral, vaginal, or cervical) is written on the lab request
- If indicated in sexual history, blood for syphilis serology is collected along with any other needed blood specimens

Outcomes

Clinic Experience: Answering Questions About Sexual Behaviors on a Computer or Tablet

- Patient Experience



- Providers (*n* = 18) reported that ACASI positively impacted screening (72%), testing (78%), treatment (44%), and follow-up (55%)

Outcomes: ACASI (Florida Experience)

- **Young adults** were most accepting of the ACASI intervention overall
  - Liked privacy of sexual health history taking via a computer
  - More comfortable using technology
- **Women** were less likely to believe that the ACASI assessment was effective for them
  - Some commented that just because they have HIV does not mean they engage in sexual behaviors described in the ACASI
- **Men who have sex with men** were mostly accepting of the intervention, but some felt singled out because of their sexual orientation
- **Older patients** had the most difficulties with technology, vision or hearing impairments and were more likely to require assistance with ACASI surveys

Outcomes: Extragenital Specimen: Patient Satisfaction Responses

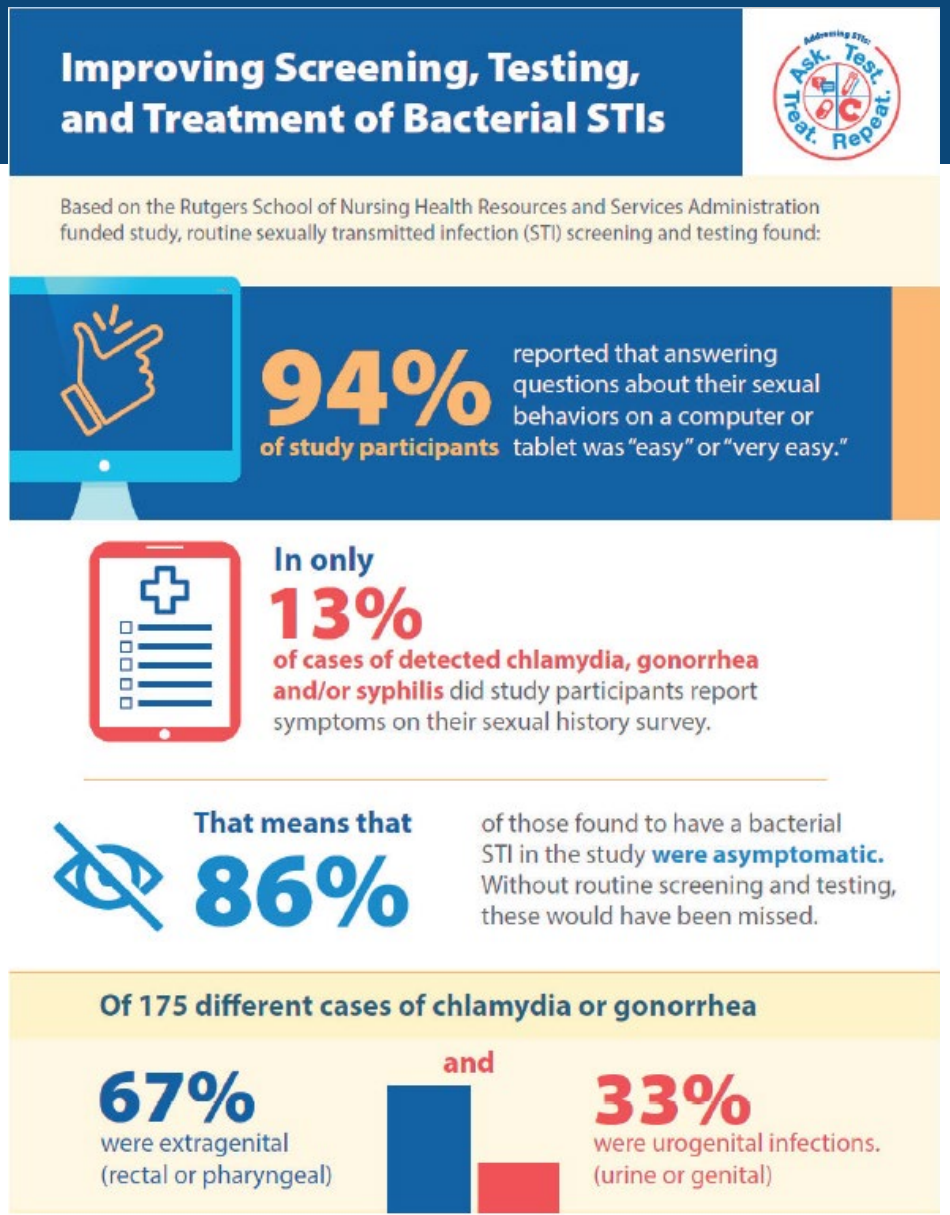
Reasons given for being ***comfortable with self-collection of rectal swabs***	Reasons given for being ***comfortable with self-collection of pharyngeal swabs***	Reasons given for ***NOT being comfortable with self-collection of pharyngeal swabs***
• "I don't feel comfortable with someone I hardly know doing that to me." • "I'm comfortable doing my own rectal swab for Chlamydia and Gonorrhea because this is a private area of my body that not everyone may want to see." • "This is easy and a bit more private." • "It's easy to do and was explained in the poster."	• "I know how it's going to feel, and when it hurts, I can stop." • "It is an easy process with little room for error." • "The method was described to me in an easy way and very understandable." • "It's less invasive/embarrassing." • "No one is in my face breathing and trying to guess if I have the infection or not."	• "I think a professional could do a better job than me." • "Not sure it would be done right." • "I just don't like the feeling of doing it myself."

Patient Satisfaction Survey: LGBTQ+ Welcoming Indicators

LGBTQ+ welcoming clinical space indicator	*Sexual identity*				*Age*		
	Heterosexual respondents "I noticed, and I liked it," n (%)	*LGB[a] respondents "I noticed, and I liked it," n (%)*	*Other respondents "I noticed, and I liked it," n (%)*	p	*Age <50 years respondents "I noticed, and I liked it," n (%)*	*Age ≥50 years respondents "I noticed, and I liked it," n (%)*	p
Gender neutral bathrooms	328 (52.4)	253 (40.4)	45 (7.2)	0.16	259 (69.8)	112 (30.2)	**0.03**
LGBTQ+ inclusive waiting room materials	212 (36.1)	330 (56.2)	45 (7.7)	**<0.001**	281 (74.9)	94 (25.1)	**<0.001**
LGBTQ+ inclusive educational materials	217 (35.4)	352 (57.4)	44 (7.2)	**<0.001**	282 (73.4)	102 (26.6)	**<0.001**
Posted LGBTQ+ nondiscrimination policy	309 (44.9)	331 (48.1)	48 (7.0)	**<0.001**	292 (69.4)	129 (30.6)	**0.03**
Treated with respect by clinic staff	900 (56.3)	597 (37.3)	102 (6.4)	0.06	644 (65)	347 (35)	0.29
Registration selected pronoun question	410 (52.8)	317 (40.8)	50 (6.4)	0.05	345 (69.8)	149 (30.2)	**0.01**
LGBTQ+ supportive organization flyer(s)	285 (42.6)	329 (49.2)	55 (8.2)	**<0.001**	299 (69.9)	129 (30.1)	**0.01**
LGBTQ+ flag	239 (40.6)	301 (51.1)	49 (8.3)	**<0.001**	245 (71)	100 (29)	**0.01**
Transgender flag	188 (39.0)	256 (53.1)	38 (7.9)	**<0.001**	195 (72.2)	75 (27.8)	**0.01**
LGBTQ+ awareness days/events promotion	186 (38.8)	255 (53.2)	38 (7.9)	**<0.001**	223 (73.6)	80 (26.4)	**<0.001**

Source: Nelson JA, et al. AIDS Patient Care STDS. 2022 Nov;36(S2):92-103.

Improving Screening, Testing and Treatment of Bacterial STIs



Challenges

Sexual History Taking
- Provider discomfort with sexual history taking and specimen collection
- Provider Stigma
- Inconsistent and incomplete sexual history by providers

STI Testing and Treatment
- Patient refuses to have provider do NAAT swabbing (oral, anal, genital)
- Patient refuses to provide urine for NAAT
- Patient care/coordination/communication

LGBTQ Welcoming Clinic Space
- Lack of welcomeness to high STI incidence subpopulations (adolescents, young adults, MSM, LGBTQ)

Challenges (con't)

Patient Access
- Patient transportation
- Patient housing instability

Accessible Materials
- Lack of lab, medications, and STI testing supplies on site
- Commercial labs not allowing patient self-collecting extragenital swab GC/CT NAAT specimens
- Laboratory not doing extragenital site GC/CT NAATs (prior to May 2019) – validation study was needed by each lab prior to this approval

Costs and Insurance
- States/jurisdictions ADAP medication coverage program not inclusive of STI treatment medications (i.e., penicillin G benzathine)
- Insurance companies/Medicare restrictions on the number of GC/CT NAATs and syphilis tests done per year
- Community-based pharmacies not stocking penicillin G benzathine because of high cost

Other Challenges Overcome

COVID-19 Pandemic

- Lack of face-to-face encounters
- Challenges with access to lab draw stations
- Shortage of testing supplies as NAAT swabs were also used for COVID testing

Multiple Hurricanes

- Affected Florida and Louisiana

Strengths

Sexual History Taking with Audio-computer Assisted Self-interview

- Patient and provider preferred collection of needed sexual history answers
- Audio component is useful for those with lower reading and/or electronic device literacy
- Provides consistent sexual history questions without reliance on provider comfort in asking the questions

STI Treatment

- Clinics utilizing 340B pharmacy programs or clinics within a department of health were able to obtain STI treatment meds (including penicillin G benzathine) immediately and without as much fiscal burden

LGBTQ Welcoming Clinic Space

- Welcoming measures can be added to clinics to increase the sense of comfort by patients not traditionally feeling “welcome” or emotionally safe in clinics

Strengths (con't)

NAAT Specimen Tool Kits

- FDA approval of extragenital site GC/CT NAAT specimen collection kits
- Routine supplies for bacterial STI testing have long shelf life and do not need refrigeration
- Provider and patient collected NAAT specimens are equally valid and reliable
- Empowerment of patients to collect own NAAT specimen anywhere

Training

- The AIDS Education & Training Center Program (RWHAP Part F HRSA HAB funded) and the National Network of STD/HIV Prevention Training Centers (CDC funded) is available to provide HIV and STI-specific training, TA, and capacity building for free to clinical care sites throughout the US and its territories

Sustainability

Toolkit developed to assist other clinics in implementing the interventions available on TargetHIV (targethiv.org/STIs)

Contents:

- Overview, Fact Sheets, and Infographic
- Sexual History Survey
- Introductions for Specimen Self-Collection
- Workflows
- LGBTQ+ Welcoming Clinic Signs
- Templates
- Publications

Lessons Learned

- Identifying and empowering change champions is critical for guiding implementation in the clinic and to get buy-in from clinic staff
- Creating a clinic flow that engages all appropriate team members facilitates engagement and successful implementation

References

Nelson JA, Zha P, Halawani M, Jones V. Evidence-Based Interventions Implemented into HIV Primary Care Clinics to Make Sexually Transmitted Infection Screening and Testing Routine: Outcomes of a Multi-Site Study. AIDS Patient Care STDs. 2022 Nov;36(S2):92-103.

Target HIV: Tools for HRSA's Ryan White HIV/AIDS Program. Addressing STIs: Ask. Test. Treat. Repeat. Available at https://targethiv.org/STIs

CONTACT US

L Beth Gadkowski MD MPH MS

Beth.Gadkowski@medicine.ufl.edu

Jennifer Janelle MD

Jennifer.janelle@medicine.ufl.edu

Participant Feedback

Please use the following link to give your feedback

https://www.surveymonkey.com/r/R7F79JP

Stay Connected!

Sharing Information & Strategies

CBTA questions, email:

IHIPhelpdesk@mayatech.com

To access IHIP tools/resources and join the IHIP Listserv:

https://targethiv.org/ihip

Contact Information (con't)

Melinda J. Tinsley, MA
Senior Public Health Analyst
Division of Policy & Data (DPD)
HIV/AIDS Bureau (HAB)
Health Resources and Services Administration (HRSA)
Mtinsley1@hrsa.gov
301–443–3496
https://hab.hrsa.gov

Shelly M. Kowalczyk, MSPH, CHES
IHIP Project Director
The MayaTech Corporation
Silver Spring, MD 20910
skowalczyk@mayatech.com
301–587–1600
https://mayatech.com