IAPAC GUIDELINES FOR OPTIMIZING THE HIV CARE CONTINUUM FOR ADULTS & ADOLESCENTS

(November 2015)

Developed by an Advisory Panel Convened by the International Association of Providers of AIDS Care (IAPAC)

Co-Sponsored by IAPAC and the Office of AIDS Research/National Institutes of Health

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ABOUT THIS PRESENTATION

- This presentation is based on guidelines published in the *Journal for the International Association of Providers of AIDS Care* (*JIAPAC*)*
- The target audience includes care providers, policy-makers, affected communities, organizations, and health systems involved with implementing HIV care
- These slides should be used as prepared, without changes in content or attribution

* IAPAC Guidelines for Optimizing the HIV Care Continuum for Adults and Adolescents. *J Int Assoc Provid AIDS Care*. 2015;14(Suppl 1):S3-S34.

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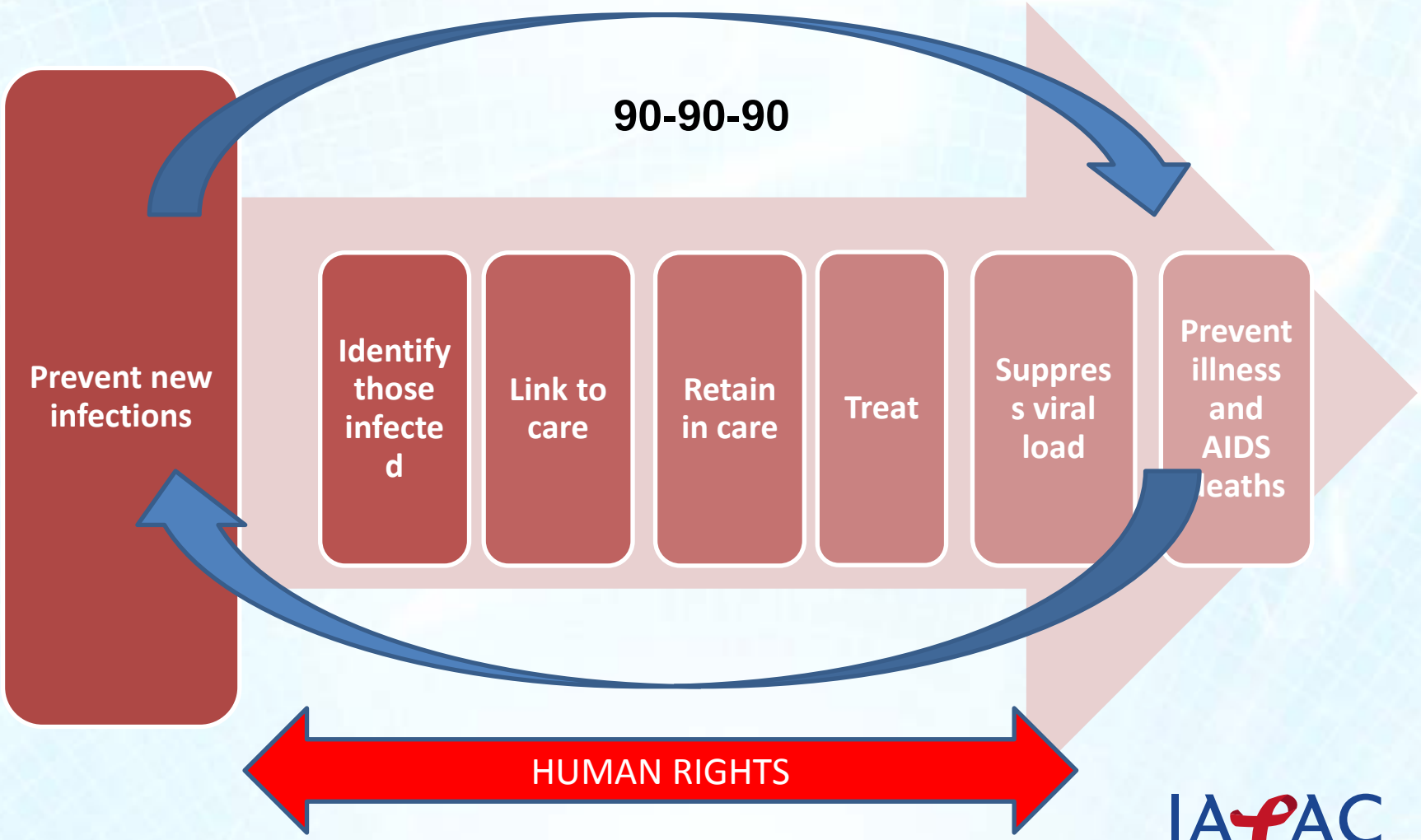
PROMOTING INTERVENTIONS ACROSS THE HIV CARE CONTINUUM



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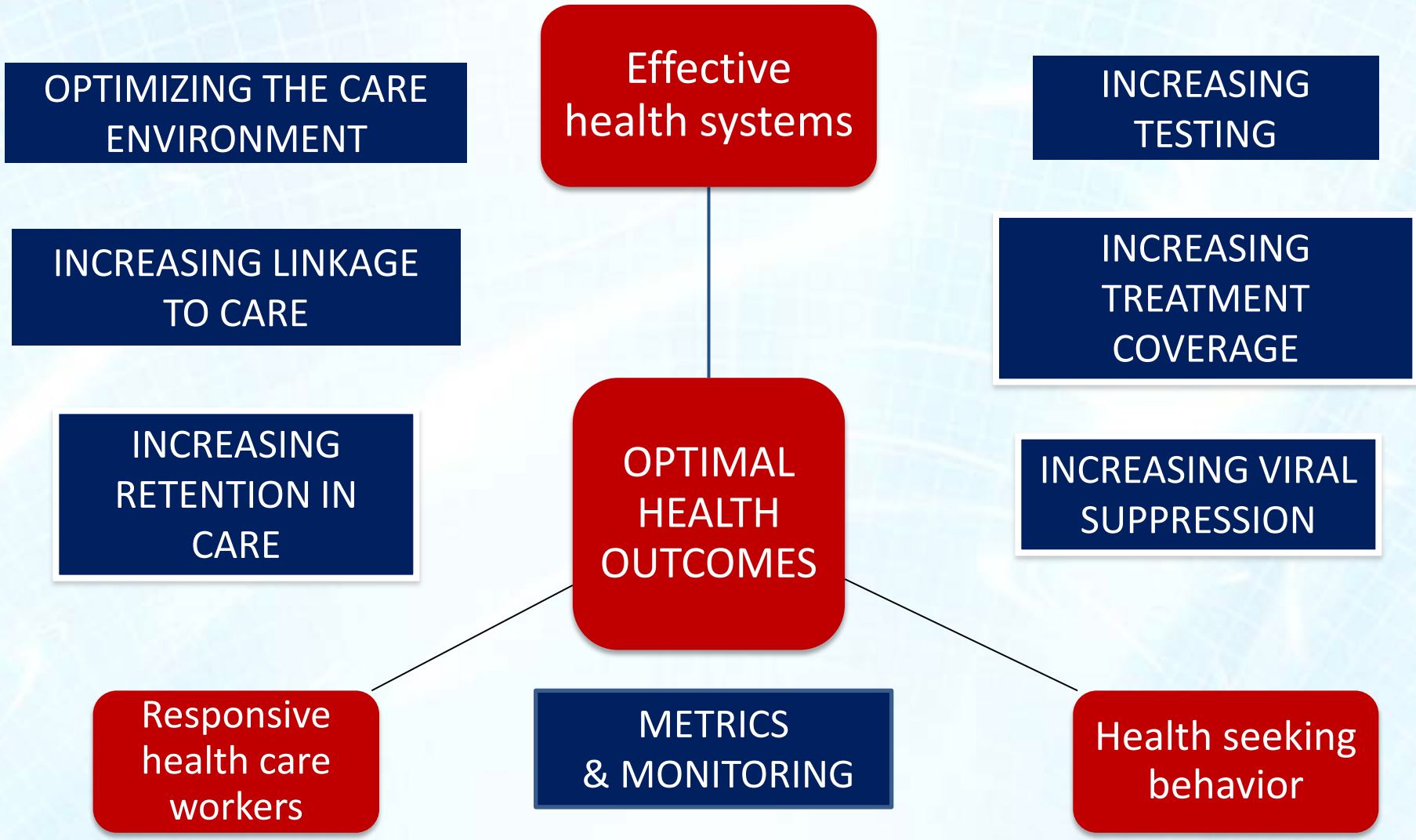
OPTIMAL HIV CARE



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METHODOLOGY

- A systematic literature search was conducted to identify pertinent quantitative evidence, including RCTs, observational studies, and cross-sectional studies
- A total of 6,132 studies met the criteria; 1,047 studies used for evidence-based recommendations
- Jan. 2002-July 2013 + 112 recent “game-changing” papers
- 36 evidence-based recommendations were developed by an international, multidisciplinary IAPAC Advisory Panel
- Recommendations were graded based on the quality of evidence and this informed the strength given to each recommendation

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GRADING SCALES FOR QUALITY OF THE BODY OF EVIDENCE AND STRENGTH OF THE RECOMMENDATIONS

Quality of the Body of Evidence	Interpretation
Excellent (I)	Randomized controlled trial evidence without important limitations; overwhelming evidence from observational studies
High (II)	Randomized controlled trial evidence with important limitations; strong evidence from observational studies
Medium (III)	Randomized controlled trial evidence with critical limitations; observational study without important limitations
Low (IV)	Other evidence, including extrapolations from bench research, usual practice, expert opinion, consensus guidelines; observational study evidence with important or critical limitations

Strength of Recommendation	Interpretation
Strong (A)	Almost all patients should receive the recommended course of action.
Moderate (B)	Most patients should receive the recommended course of action. However, other choices may be appropriate for some patients.
Optional/Conditional (C)	There may be consideration for this recommendation based on individual patient circumstances. Not recommended routinely.

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OPTIMIZING THE HIV CARE ENVIRONMENT

- Laws that criminalize the conduct of MSM, transgender individuals, substance users, and sex workers are not recommended [A IV]
- Laws that criminalize the conduct of PLHIV based on perceived exposure to HIV are not recommended [A IV]
- HIV-related restrictions on entry, stay, and residence in any country for PLHIV are not recommended [A IV]
- Strategies to monitor for/eliminate race-, ethnicity-, gender-, age-, sexual orientation-, and/or behavior-based stigma and discrimination are recommended [B II]

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OPTIMIZING THE CARE ENVIRONMENT (CONTINUED)

- Proactive steps are recommended to identify and manage clinical mental health disorders (e.g., anxiety, depression, traumatic stress), and/or mental health issues related to HIV diagnosis, disclosure of HIV status, and/or HIV treatment [A II]
- Enabling PLHIV to take responsibility for their care (e.g., self-management, user-driven care) is recommended [B I]
- Task-shifting/-sharing from physicians to appropriately trained healthcare providers, including nurses and associate clinicians, is recommended for ART initiation and maintenance [B II]
- Community engagement in every step across the HIV care continuum is recommended [B II]

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INCREASING HIV TESTING COVERAGE & LINKAGE TO CARE

- Routinely offer opt-out HIV testing to all individuals who present at health facilities is recommended [A I]
- Community-based HIV testing is recommended to reach populations less likely to access facility-based testing [A I]
- HIV self-testing is recommended with provision of guidance about proper test administration and direction on what to do once the test result has been obtained [B II]
- Use of epidemiological data is recommended to expedite identification of at-risk individuals for HIV testing purposes [B II]

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INCREASING HIV TESTING COVERAGE & LINKAGE TO CARE
(CONTINUED)

- The offer of HIV testing to partners of newly diagnosed individuals is recommended [A I]
- Immediate referral to HIV care is recommended following an HIV-positive diagnosis to improve linkage to ART [A I]
- For high-risk individuals who test HIV negative, offering PrEP is recommended in addition to free condoms, risk reduction education, and PEP [A I]
- The use of case managers and patient navigators to increase linkage to care is recommended [B II]

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INCREASING HIV TREATMENT COVERAGE

- Offer immediate ART after HIV diagnosis, irrespective of CD4 count [A I]
- First-line ARV regimens with the highest levels of efficacy, lowest adverse event profiles, and delivered in QD fixed-dosed combinations are recommended [B II]
- Viral load testing at least every 6 months is recommended as the preferred metric [B II]
- HIV drug resistance testing is recommended at entry into care or prior to ART initiation, and when virologic failure is confirmed [BI]
- Community-located ART distribution is recommended [A II]

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INCREASING RETENTION IN CARE, ART ADHERENCE & VIRAL SUPPRESSION

Systematic retention monitoring is recommended [A III]

- Quality indicator (measured using EHR, other health data)

Routine adherence monitoring is recommended [A II]

- pVL suppression recommended as primary metric
- Collecting self-reported data from patients recommended
- Pharmacy refill data recommended

Information and communication technologies aimed at supporting patient self-care are recommended [B II]

- mHealth technology using weekly interactive components recommended (e.g., 2-way SMS)
- Alarm devices recommended for PLHIV with memory impairment

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INCREASING RETENTION IN CARE, ART ADHERENCE & VIRAL SUPPRESSION (CONTINUED)

Educating patients about/offering support for ART adherence & keeping clinic appointments is recommended [A I]

Neither DAART nor directly observed ART recommended [A I]

- Community outreach-based DAART recommended for PWID and released prisoners

Proactive engagement/re-engagement of patients who miss clinic appointments and/or are lost to follow-up (e.g., intensive outreach for non-engagement in care within 1 month of diagnosis) is recommended [B II]

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ADOLESCENTS

- Removing adult-assisted consent to HIV testing and counseling is recommended for minor adolescents with capacity to consent [B II]
- Adolescent-centered facility- and community-based services are recommended [A IV]
- Informing adolescents of an HIV-positive diagnosis as soon after testing as feasible is recommended [B II]
- Establishing healthcare transition plans between pediatric and adult care is recommended [B II]

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METRICS & MONITORING

- Jurisdictions should collect a minimum set of 5 indicators:
  - Estimated number of PLHIV (denominator)
  - Number/proportion of PLHIV diagnosed as having HIV
  - Number/proportion PLHIV linked to care
  - Number/proportion of PLHIV on ART
  - Number/proportion of PLHIV on ART & virally suppressed
- Longitudinal cohort monitoring of HIV service utilization and treatment outcomes is recommended to identify means to maximize viral suppression

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NUMERATORS FOR MEASURING THE HIV CARE CONTINUUM

HIV Infected	• **Numerator:** Estimated # PLHIV alive at the end of the calendar year; includes # diagnosed & undiagnosed PLHIV
HIV Diagnosed	• **Numerator:** Total # PLHIV with documented HIV+ status in clinical/administrative health records; diagnosis defined as having at least 1 confirmed HIV+ test
Linked to Care	• **Numerator:** Total # PLHIV linked to care within 3-6 months; could include attending at least 1 clinical care visit, acquiring lab tests and/or prescriptions
On ART	• **Numerator:** Total # PLHIV on ART
Virologically Suppressed	• **Numerator:** # of persons whose last pVL during the measurement period was <200 copies/mL (or lowerst quantifiable level below <1,000 copies/mL)

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GUIDANCE ON KEY POPULATIONS

- Development of evidence-based recommendations specific to key populations is beyond the scope of these guidelines
- However, guidance is provided on issues specific to:
  - Women
  - Men Who Have Sex With Men
  - Transgender Individuals
  - Sex Workers
  - Migrant and Unstably Housed Populations
  - Substance Users
  - Incarcerated Populations

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CONSIDERATIONS FOR WOMEN

- Prioritize and increase women's access to and retention in HIV services along the continuum of HIV care, including through gender-sensitive programming
- Integrate community-based support services for women within HIV care, including peer-based programs and family-based programs that engage partners and family members; at a minimum, offer direct referral to such services for women living with HIV
- Screen for and implement interventions to address food insecurity among women living with HIV
- Screen for physical and emotional abuse and violence (or the risk of experiencing violence) among women across the HIV care continuum

CONSIDERATIONS FOR WOMEN
(CONTINUED)

- Conduct non-stigmatizing discussions of pregnancy and parenting choices and the provision of family planning services to support the full range of sexual and reproductive rights of women living with HIV
- Implement interventions to scale-up access to and retention in HIV care and treatment for pregnant and breastfeeding women living with HIV; such interventions should also include socioeconomic support
- Scale-up pediatric HIV services for infants born to HIV-positive mothers to promote both child and maternal health
- Tailor ART prescribing practices to consider women's use of other medications (e.g., contraceptives), as well as potential side effects in women
- Address the challenges faced by younger women living with HIV across the HIV care continuum

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CONSIDERATIONS FOR MSM

- Develop and adopt standards for the provision of culturally competent care and the dissemination of information/educational materials in clinical programs for all MSM
- Address medical mistrust, promote confidentiality, and minimize stigma, with specific attention to MSM from racial or ethnic minority populations
- Offer supporting services in community-based settings in order to reach MSM who may not access HIV testing services in clinical settings
- Offer screening for syphilis, chlamydia, and gonorrhea in all relevant anatomical sites; screen for viral hepatitis and vaccinate susceptible MSM for HAV and HBV; vaccinate MSM <26 years of age for HPV; provide anal examination for HPV-associated pathology
- Facilitate linkage to care of MSM youth at HIV testing sites through direct referral to MSM peer navigators

CONSIDERATIONS FOR TRANSGENDER INDIVIDUALS

- Develop and adopt standards for the provision of culturally competent care and the dissemination of information/educational materials in clinical programs for transgender individuals
- Address medical mistrust, promote confidentiality, and correct misperceptions regarding HIV treatment and transgender-specific medical care
- Consult with or refer HIV+ transgender individuals on ART who wish to start hormone therapy to a clinician experienced in transgender medical care

CONSIDERATIONS FOR SEX WORKERS

- Tailor HIV prevention, treatment, and care interventions for sex workers, including voluntary HIV, STI, and viral hepatitis (HBV and HCV) screening, condom promotion, and ART access
- Implement programs to scale-up access and address barriers to ART; these programs should ideally be led by and for sex workers living with HIV

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CONSIDERATIONS FOR MIGRANTS & UNSTABLY HOUSED POPULATIONS

- Screen individuals for their housing situation
- Ensure that the basic subsistence needs of unstably housed persons living with HIV are met (e.g., access to housing, food, clothing, hygiene)
- Use evidence-based interventions to address structural barriers to care for unstably housed individuals
- Implement population-tailored strategies to improve engagement and retention in HIV care for migrant and mobile populations

CONSIDERATIONS FOR SUBSTANCE USERS

- Scale-up evidence-based treatment for substance use, in particular opioid substitution therapies
- Implement time-limited DAART with substance users at high risk of ART non-adherence
- Conduct comprehensive and integrated assessments for and provide treatment of co-morbid psychiatric illnesses, in particular depression, among substance users

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CONSIDERATIONS FOR INCARCERATED POPULATIONS

- Offer universal HIV testing, particularly in jurisdictions with hyper-endemic rates of incarceration, so that the offer of HIV testing in correctional healthcare settings mirrors that in community health settings
- Implement interventions to prevent HIV transmission among populations that move into, dwell in, or leave correctional facilities, while delivering general interventions that decrease intimate partner/sexual violence, promote harm reduction, and address substance use
- Ensure that health services in jails and prisons follow international guidelines for HIV care, including for the management of HIV comorbidities that occur at high frequency in incarcerated populations
- Promote 2-way, comprehensive communication between correctional and community HIV providers to ensure that there are no gaps in care, treatment, and support services as people transition to and from their communities and correctional facilities

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MISCELLANEOUS

- To see the full text of the guidelines, visit:
  - http://jia.sagepub.com/content/early/2015/10/23/2325957415613442.abstract (open access); or
  - www.iapac.org for a table summarizing the recommendations.
- Visit the AETC NRC website for the most current version of this presentation: http://www.aidsetc.org
- Visit www.iapac.org to stay up-to-date on guidelines updates and guidelines-related activities, including CME/CE opportunities
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