TAKING A HISTORY OF SEXUAL HEALTH: OPENING THE DOOR TO EFFECTIVE HIV AND STI PREVENTION

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LEARNING OBJECTIVES

At the end of this webinar, participants should be able to:

1. Identify strategies for taking a history of sexual health
2. Access sample questions that clinicians can use in asking about sexual health with all adult patients
3. Explain the role of routine sexual health histories in HIV/STI prevention
BACKGROUND ISSUES

- What people do and want
- What clinicians say
WHAT PATIENTS WANT

- Survey of 500 men and women over 25
- 85% expressed an interest in talking to their doctors about sexual concerns
- 71% thought their provider would likely dismiss their concerns
- A history of sexual health followed by appropriate, targeted discussion can enhance the patient-provider relationship
PROPORTION OF PHYSICIANS DISCUSSING TOPICS WITH HIV-POSITIVE PATIENTS

<table>
<thead>
<tr>
<th>Topic</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence to ART</td>
<td>84%</td>
</tr>
<tr>
<td>Condom use</td>
<td>16%</td>
</tr>
<tr>
<td>HIV transmission and/or risk reduction</td>
<td>14%</td>
</tr>
</tbody>
</table>

(Adherence to ART: 84% [AmJPublicHealth. 2004;94:1186-92])
DISCOMFORT AS A BARRIER

“Ironically, it may require greater intimacy to discuss sex than to engage in it.”

The Hidden Epidemic
Institute of Medicine, 1997
## Sexual Behavior Among Massachusetts High School Students by Gender, 2009

<table>
<thead>
<tr>
<th>Affirmative Responses</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Respondents: All Students</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime sexual intercourse</td>
<td>48.0%</td>
<td>44.6%</td>
</tr>
<tr>
<td>Sexual intercourse before age 13</td>
<td>8.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Four or more lifetime sexual partners</td>
<td>15.2%</td>
<td>10.6%</td>
</tr>
<tr>
<td><strong>Respondents: Students having sexual intercourse in past three months</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom use at last sexual intercourse</td>
<td>65.7%</td>
<td>50.6%</td>
</tr>
<tr>
<td>Substance use at last sexual intercourse</td>
<td>27.6%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Taught in school about AIDS or HIV</td>
<td>87.2%</td>
<td>87.6%</td>
</tr>
</tbody>
</table>

Youth Risk Behavior Surveillance System, *MMWR*, 2010
WHEN WE TALK ABOUT THE ELDERLY WHAT COMES TO MIND?
## Percent Having Sex

<table>
<thead>
<tr>
<th>Age</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>57-64</td>
<td>84%</td>
<td>62%</td>
</tr>
<tr>
<td>65-74</td>
<td>67%</td>
<td>40%</td>
</tr>
<tr>
<td>75-85</td>
<td>38%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Lindau, *NEJM*, 2007
GETTING TO KNOW PATIENTS IN CLINICAL SETTINGS
TAKING A HISTORY

- Get to know your patient as a person (e.g., partners, children, jobs, identity, living circumstances)
- Use inclusive and neutral language
  - Instead of: “Do you have a wife/husband or boy/girlfriend?”
  - Ask: “Do you have a partner?” or “Are you in a relationship?” “What do you call your partner?”
- If you slip up, apologize and ask the patient what term is preferred
- For all patients
  - Make it routine
  - Make no assumptions
The Centers for Disease Control and Prevention (CDC) has developed a simple categorization of sexual history questions to help focus on key issues.

http://www.cdc.gov/lgbthealth/
CREATING SYSTEMS

- **When?** Taken at initial visit and annual prevention visits
- **How?** Taken directly by the provider, or filled out by patient on paper or electronic form in advance of visit (at home or in waiting room)
- **Considerations:** privacy concerns; time; protection of data; health literacy level
- **Making it routine:** reminders in EHRs, staff training
“I am going to ask you a few questions about your sexual health and sexual practices. I understand these are very personal, but also important for your overall health.”

“I ask these questions of all my adult patients. Like the rest of our visit, everything we discuss is confidential.”

“Do you have any questions?”
SAMPLE QUESTIONS
PARTNERS

- Have you been sexually active in the last year?
- Do you have sex with men only, women only, or both?
- How many people have you had sex with in the past year?
PRACTICES AND PROTECTION

- What kinds of sex are you having? (e.g., oral, vaginal, anal, sharing sex toys)
- What do you do to protect yourself from HIV and STDs?
- How often do you use protection?
  - If sometimes, when, why and with whom?
PRACTICES AND PROTECTION

- Do you or your partner(s) use alcohol or drugs when you have sex?
- Have you or your partner(s) ever had sex in exchange for drugs, money, shelter, food, or other necessities?
- Have you ever had sex with someone you didn’t know or just met?
HISTORY OF STD’S (STI’S)

- Have you ever had a sexually transmitted disease?
  - When, What kind?; How were you treated?
- Have you ever been tested for any STD’s or HIV?
  - If yes, when and what were results?
- Has your current, or any former, partners been diagnosed with an STD?
  - Were you evaluated for the same?
  - Were you treated and with what?
PREGNANCY PROTECTION AND DESIRES

- Are you trying to conceive or parent a child?
- Are you concerned about getting pregnant or getting your partner pregnant?
- Are you using contraception or any form of birth control?
- Do you want to discuss challenges regarding having children?
PARTNER VIOLENCE, TRAUMA

• Have you ever experienced physical or emotional violence with someone you were involved with?
SEXUAL AND GENDER IDENTITY, DESIRE, SEXUAL HEALTH

- Assess comfort with sexual and gender identity
  - *Do you want to talk about your sexuality, sexual identity, gender identity, or sexual desires?*

- Ask about sexual health
  - *Do you have any concerns about your sexual function or satisfaction?*
FOLLOW-UP AS APPROPRIATE

- Screening and testing
- Counseling and education
- Referrals (behavioral, etc.)
- Is there anything else you want to discuss about your sexual health?
SEXUAL HEALTH: OPENING DOORS TO EFFECTIVE HIV AND STI PREVENTION
PEOPLE, PRACTICES, OUTCOMES:

- MSM
- Pregnant Women
- Trans Men
- STIs
- Trans Women
- HIV
- WSW
- Adolescents
- Hep C

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HIV/AIDS IN THE UNITED STATES
HIV IN THE UNITED STATES

- Approximately 1.2 million people are living with HIV
- There are ~50,000 new cases of HIV diagnosed every year
HIV INCIDENCE BY TRANSMISSION CATEGORY, UNITED STATES, 2011

- Male-to-Male Sexual Contact (MSM): 64%
- Injection Drug Use (IDU): 6%
- Heterosexual Contact: 17%
- MSM/IDU: 3%
- Other: 10%

There are approximately 50,000 new HIV diagnoses each year in the US.

Incidence among MSM and MSM/IDU increased 15% from 2008 to 2011. Young black MSM accounted for more than half of new infections among MSM aged 13-24 over this time.
WHY IS HIV INCIDENCE HIGHEST AMONG BLACK MSM?

- Sexual risk behaviors and substance use do not explain the differences in HIV infection between Black and white MSM.
- The most likely causes of disproportionate HIV infection rates are:
  - Barriers to access health care
  - Less awareness of HIV status
  - Delayed treatment of STI’s which facilitate HIV transmission
  - High HIV prevalence in Black MSM networks especially among those who identify as gay.
TRANSGENDER WOMEN ARE ALSO AT HIGH RISK

- Estimated HIV prevalence in trans women
  - 28% in US (Herbst, 2008)
  - 56% in African-Americans (Herbst, 2008)
  - 18-22% worldwide (Baral, 2013)
Vision: The United States will become a place where new HIV infections are rare and when the do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance will have unfettered access to high quality, life-extending care, free from stigma and discrimination.
THE NATIONAL HIV/AIDS STRATEGY

Goals:

- Reduce the number of people who become infected with HIV
- Increase access to care and optimize health outcomes for people living with HIV
- Reduce HIV-related health disparities
- Achieve a more coordinated national response to the HIV epidemic
NATIONAL HIV/AIDS STRATEGY
2015 TARGETS

- **Reducing new infections**
  - Lower annual number of new infections by 25%
  - Reduce transmission rate by 30%
  - Increase from 79% to 90% the percentage of people living with HIV who know their status

- **Increasing access to care and improving health outcomes**
  - Increase the proportion of newly diagnosed patients linked to care within 3 months of diagnosis from 65% to 85%
  - Increase proportion of Ryan White clients who are engaged in care from 73% to 80%
  - Increase number of Ryan White clients with permanent housing from 82% to 86%

- **Reducing HIV-related health disparities and health inequities**
  - Increase the proportion of diagnosed gay and bisexual men with undetectable viral load by 20%
  - Increase the proportion of Black Americans with undetectable viral load by 20%
  - Increase the proportion of Latinos with undetectable viral load by 20%
OPPORTUNITIES ALONG THE HIV CONTINUUM

- Outreach: 100%
- Counseling and Testing: 82%
- Linkage to Care: 66%
- Retained in HIV Care: 37%
- On ART: 33%
- Suppressed Viral Load: 25%

Adapted from CDC, “HIV in the US-The Stages of Care” July 2012
CASE DISCUSSION

- 28-year-old male who reports unprotected, receptive anal sex yesterday
- Learned afterwards that his partner is HIV-infected and taking ART
- Has no chronic medical problems
- Has been treated for syphilis, gonorrhea, LGV, and genital HSV in the past
- Has had 3 similar exposures to HIV in the past year
QUESTIONS

- Is he HIV-infected at baseline?
- How should his recent, high risk exposure be managed?
- How should his long-term risk of HIV infection be managed?
IS HE HIV INFECTED AT BASELINE?

Universal HIV Screening

- HIV Positive
  - HIV care / antiretroviral therapy/
  - Counseling/Adherence
  - Reduce HIV Incidence

- HIV Negative
  - Safer sex
  - Address STIs
  - PEP or PrEP
  - Counseling/Adherence
  - Reduce HIV Incidence
MORE TESTING IS NEEDED

- 20% of those with HIV do not know they are infected.

- 32% receive an AIDS diagnosis within one year of HIV diagnosis.

MMWR, 2010
BARRIERS TO HIV TESTING

- Only 61% of general internists offer HIV testing regardless of risk.
- 50% of EDs are aware of CDC’s guidelines, and only 56% offer HIV testing.
- HHS interviewed a sample of health centers in 2011 to see if following CDC’s HIV testing guidelines:
  - Only 20% of sites were testing all patients 13-64 y/o
  - Remaining sites only tested high-risk patients or those who asked

Haukoos, 2011; Korthuis, 2011
Screening and testing are prevention interventions

- USPSTF Grade A Recommendation: Test all once
- Those who test positive need evaluation and treatment.
- People who are negative but at high risk need ongoing testing
- Testing is a pre-requisite for:
  - Treatment as prevention
  - Pre-exposure prophylaxis

Weinhardt, 1999
WHAT’S NEW IN HIV TESTING?

- Newer testing algorithms which use successive immunoassays to **eliminate the Western blot** have been proposed.
- “Fourth generation” antibody/antigen tests shorten the window period by ~7 days.
- **Home HIV tests** may increase testing but raise concerns about cost, appropriate use, and follow-up.

Branson, 2010
QUESTIONS

▪ Is he HIV-infected at baseline?

→ No, but his partner is.....

▪ How should his recent, high risk exposure be managed?
  ▪ How is Partner’s Treatment Relevant?
  ▪ What Should patient do?

▪ How should his long-term risk of HIV infection be managed?
IS HE HIV INFECTED AT BASELINE?

Universal HIV Screening

HIV Positive

HIV care / antiretroviral therapy/ Counseling/ Adherence

Reduce HIV Incidence

HIV Negative

Safer sex Address STIs PEP or PrEP Counseling/ Adherence
EARLY ANTIRETROVIRAL THERAPY DECREASES HIV TRANSMISSION (TASP)

- 1763 stable, healthy, serodiscordant couples, sexually active
- CD4 count: 350 to 550 cells/mm³

Randomization

Early antiretroviral therapy
CD4 350-550

Delayed antiretroviral therapy
CD4 ≤250

Cohen, 2011

Courtesy of Doug Krakower, Ken Mayer
EARLY ANTIRETROVIRAL THERAPY DECREASES HIV TRANSMISSION

1763 stable, healthy, serodiscordant couples, sexually active
CD4 count: 350 to 550 cells/mm³

Randomization

Early antiretroviral therapy
CD4 350-550

4 infections
1 linked, 3 unlinked

Delayed antiretroviral therapy
CD4 ≤250

35 infections
27 linked, 8 unlinked

96% relative risk reduction in linked transmissions

Courtesy of Doug Krakower, Ken Mayer
IS HE HIV INFECTED AT BASELINE?

Universal HIV Screening

HIV Positive
- HIV care / antiretroviral therapy/
  Counseling/Adherence

HIV Negative
- Safer sex
- Address STIs
- PEP or PrEP
- Counseling/Adherence

Reduce HIV Incidence
POST-EXPOSURE PROPHYLAXIS (PEP)

- Indicated for high-risk exposures to HIV-infected individuals
- Consists of 28 days of antiretrovirals (usually tenofovir-emtricitabine +/- others, often raltegravir)
- Earlier initiation = better efficacy (likely not useful after 72 hours)
- HIV testing at baseline, 1, and 3 months
QUESTIONS

▪ Is he HIV-infected at baseline?
  → No

▪ How should his recent, high risk exposure be managed?
  → PEP (and partner’s ART may help)

▪ How should his long-term risk of HIV infection be managed?
CONTRIBUTION OF STD’S TO HIV TRANSMISSION

- Augmentation of HIV infectiousness and susceptibility via a variety of biological mechanisms from both ulcerative and non-ulcerative STD’s
- Among MSM infected with rectal GC or CT, a history of 2 additional prior rectal infections was associated with an 8 fold increased risk of HIV infection.
PRIMARY AND SECONDARY SYPHILIS—BY SEX AND SEXUAL BEHAVIOR, 33 AREAS*, 2007-2012

![Graph showing cases of primary and secondary syphilis by sex and sexual behavior from 2007 to 2012.](image)

- **MSM** (men who have sex with men)
- **MSW** (men who have sex with women)
- **Women**

32 states and Washington, DC reported sex of partner data for ≥70% of cases of P&S syphilis for each year during 2007-2012.

†MSM = men who have sex with men; MSW = men who have sex with women only
TRANSGENDER MEN AND WOMEN

- STI/STD screening and counseling based on behavior and anatomy
  - Many trans women have a functional penis
  - Many trans men have a vagina and cervix
PREP: CAN A PILL PREVENT HIV?
**Oral Prep is Safe and Efficacious; Efficacy is Dependent Upon Adherence**

<table>
<thead>
<tr>
<th>Study</th>
<th>Efficacy overall</th>
<th>Drug detected overall</th>
<th>Estimated Risk reduction with drug detection</th>
</tr>
</thead>
<tbody>
<tr>
<td>iPrEx</td>
<td>42%</td>
<td>~50%</td>
<td>92%</td>
</tr>
<tr>
<td>Partners PrEP</td>
<td>67-75%</td>
<td>82%</td>
<td>86% (TDF) 90% (FTC/TDF)</td>
</tr>
<tr>
<td>TDF-2</td>
<td>62%</td>
<td>80%</td>
<td>78%</td>
</tr>
<tr>
<td>Fem-PrEP</td>
<td>No efficacy</td>
<td>26%</td>
<td>“adherence too low to assess efficacy”</td>
</tr>
<tr>
<td>VOICE</td>
<td>No efficacy</td>
<td>29%</td>
<td>“adherence too low to assess efficacy”</td>
</tr>
<tr>
<td>Thai IDU</td>
<td>49%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

CDC GUIDANCE ON PRESCRIBING PREP

- Determine Eligibility (negative HIV test, at high-risk for HIV acquisition, screen/treat for STDs, screen/vaccinate for Hep B; pregnancy test)
- Prescribe tenofovir-emtricitabine 1 tablet by mouth daily
- Provide condoms and risk-reduction counseling
- Monitor closely (at 1 month, then q 2-3 months: HIV testing, follow BUN/Cr, repeated risk assessment and counseling)
THE PREP PACKAGE

INTRODUCING THE "PrEP PACKAGE" FOR ENHANCED HIV PREVENTION:
A Practical Guide for Clinicians
October, 2012

THE FENWAY INSTITUTE

PROTECTING YOURSELF FROM HIV THROUGH PRE-EXPOSURE PROPHYLAXIS (PrEP):
What You Need to Know
October, 2012

THE FENWAY INSTITUTE

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QUESTIONS

▪ Is he HIV-infected at baseline?
  → No

▪ How should his recent, high risk exposure be managed?
  → PEP (and partner’s ART may help)

▪ How should his long-term risk of HIV infection be managed?
  → PrEP + condoms + safer sex + STI treatment
EXPANDING THE CARE CONTINUUM TO OPTIMIZE EFFECTIVE HIV CARE IN CLINICAL PRACTICE
HIV PREVENTION IN PATIENT-CENTERED MEDICAL HOMES

- Comprehensive Care
  - Testing, counseling, linkage to care, treatment, and PrEP at the same health center
  - Linking behavioral and biomedical care
- Patient-Centered
  - Addressing stigma and homophobia in healthcare
  - Understanding the social determinants of health

- Coordinated Care
  - Case management to ensure linkage to/retention in care for those with HIV
  - Linkage of high-risk individuals to the PrEP package

- Quality and Safety
  - Collecting information on SO/GI in the EMR
  - Electronic decision support for HIV testing
SUMMARY

- HIV disproportionately affects MSM and transgender individuals.
- HIV testing is the cornerstone of most prevention interventions.
- Treatment-as-prevention, PEP, and PrEP are powerful bio-behavioral tools to decrease HIV incidence.
- Health centers have opportunities to create and improve HIV prevention programs.
http://www.lgbthealtheducation.org/training/online-courses/BestPracticesinHIVPrevention/
QUESTIONS?
WE ARE HERE TO HELP YOU!

Adrianna Sicari, Hilary Goldhammer, Harvey Makadon

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艅 www.lgbthealtheducation.org
RECOMMENDATIONS FOR USE OF ART FROM THE CDC

- Antiretroviral therapy (ART) is recommended for all HIV-infected individuals to reduce the risk of disease progression.
  - The strength and evidence for this recommendation vary by pretreatment CD4 cell count: CD4 count <350 cells/mm³ (AI); CD4 count 350 cells/mm³ to 500 cells/mm³ (AII); CD4 count >500 cells/mm³ (BIII).

- ART also is recommended for HIV-infected individuals for the prevention of transmission of HIV.
  - The strength and evidence for this recommendation vary by transmission risks: perinatal transmission (AI); heterosexual transmission (AI); other transmission risk groups (AIII).

- Patients starting ART should be willing and able to commit to treatment and understand the benefits and risks of therapy and the importance of adherence (AIII). Patients may choose to postpone therapy, and providers, on a case-by-case basis, may elect to defer therapy on the basis of clinical and/or psychosocial factors.
FIGURE 1. Algorithm for evaluation and treatment of possible nonoccupational HIV exposures

Substantial exposure risk

≤72 Hours since exposure

Source patient known to be HIV positive

nPEP recommended

Source patient of unknown HIV status

Case-by-case determination

>72 Hours since exposure

Negligible exposure risk

nPEP not recommended

Substantial Risk for HIV Exposure

*Exposure of* vagina, rectum, eye, mouth, or other mucous membrane, nonintact skin, or percutaneous contact

*With* blood, semen, vaginal secretions, rectal secretions, breast milk, or any body fluid that is visibly contaminated with blood

*When* the source is known to be HIV-infected

Negligible Risk for HIV Exposure

*Exposure of* vagina, rectum, eye, mouth, or other mucous membrane, intact or nonintact skin, or percutaneous contact

*With* urine, nasal secretions, saliva, sweat, or tears if not visibly contaminated with blood

*Regardless* of the known or suspected HIV status of the source

Smith, 2005