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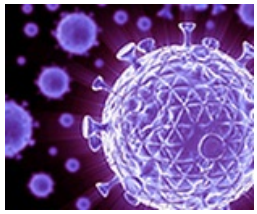

VOLUME 3 - ISSUE 8

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In The Clinic: Improving Outcomes in At-Risk Populations

- Evaluate the specific barriers to testing and entering into care among transgender individuals.
- Evaluate the specific barriers to testing and entering into care migrant and immigrant populations.
- Evaluate the specific barriers to testing and entering into care among adolescents.

Guest Faculty Disclosure
Dr. Agwu has disclosed that she has served on an expert advisory board for Gilead Sciences, Inc.

Unlabeled/Unapproved Uses
Dr. Agwu has indicated that there will be no references to the unlabeled or unapproved uses of any drugs or products.

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Podcast Transcript

BOB BUSKER: Hello and welcome to this *e*HIV Review podcast.

I'm Bob Busker, managing editor of *e*HIV Review. Our guest today is Dr. Allison Agwu — Associate Professor of Pediatrics and Adult Infectious Diseases at the Johns Hopkins University School of Medicine. We're here to follow-up on her recent *e*HIV Review newsletter issue about Improving Outcomes in At-Risk Populations.

***e*HIV Review is jointly presented by the Johns Hopkins University School of Medicine and the Institute for Johns Hopkins Nursing. This program is supported by educational grants from Gilead Sciences, Inc. and ViiV Healthcare.**

Learning objectives for this audio program include:

- **Evaluate the specific barriers to testing and entering into care among transsexual individuals.**
- **Evaluate the specific barriers to testing and entering into care migrant and immigrant populations.**
- **Evaluate the specific barriers to testing and entering into care among adolescents.**

Dr. Agwu has disclosed that she has served on an expert advisory board for Gilead Sciences, Inc. She has also indicated that there will be no references to the unlabeled or unapproved uses of any drugs or products in today's discussion.

Dr. Agwu, thank you for joining us today.

DR. ALLISON AGWU: Thank you, it's my pleasure to be here talking with you today.

MR. BUSKER: As you noted in your newsletter, while overall HIV incidence has remained stable, it's increased in certain populations, specifically transgender people, MSM, and adolescents and young adults. And other populations, like people who inject drugs and immigrants, have shown an increased risk of HIV acquisition. I'd like to focus on how

to translate the research findings reported in your newsletter into clinical practice. So please start with a patient scenario.

DR. AGWU: You're on your way to see your next patient, a 22-year-old named Mike who is here for a routine physical examination. You've seen him once previously for a job physical about two years ago. When you walk in the room, a visibly upset young woman introduces herself as Malia and identifies preferred pronouns of she and hers. She explains that the receptionist at the front desk repeatedly called her Mike despite being corrected. During the interview you apologize to Malia for what has happened and assure her that you will address the issues she has raised with the staff.

You conduct the medical history and interview and make a plan for addressing recommended STI and HIV screening.

MR. BUSKER: So, Mike, Malia — does it really matter? I guess my question is: was it really that important for the provider to apologize and to address the use of the patient's legal name by the staff member?

DR. AGWU: Absolutely. Clearly this young woman has gone through a physical transformation since the last time you've seen her, but she's also gone through multiple levels of transformation and it's very important for not just the physician or the provider, but the entire clinical staff to respect that young woman's presentation in that clinic. You know, the staff member's insistence on using the legal name, which is Mike, which clearly disconnects from how she presents, was stigmatizing to the patient. We know the stigma itself is associated with poor engagement, so it's important to not just apologize but to then address stigma by educating the staff member's medical team. We must also assure that we have practices and procedures that do not unintentionally stigmatize a population.

MR. BUSKER: A very important point; thank you. I'm going to assume you'll be taking a sexual history of this transgender patient. What are the most important things for the clinician to be aware of?

DR. AGWU: It's important to take a normative history, by which I mean asking questions and not making assumptions. It is also important to use the correct terminology to address sexual behaviors, as using the wrong terminology can again be stigmatizing and off-putting. An accurate sexual history allows appropriate determination of which sites you need to screen for STIs and how to counsel on prevention.

MR. BUSKER: Correct terminology to address sexual behaviors — what does that mean? Could you give us some examples?

DR. AGWU: Certainly. I don't mean for providers to go and get a whole crash course on street terms for sexual acts, but some are important to know because they allow the person to feel comfortable in then expressing that act. And example would be using a very medical term like "insertive anal intercourse," which may be very off-putting. You could simply say, "are you a top or a bottom," which would be acceptable terminology that's not stigmatizing and would allow you and the patient to know exactly what you're talking about.

Some really great resources for providers available through some sexual history sites that are referred to in the newsletter can provide a good resource for providers if they want to understand some of the appropriate ways to refer to certain sexual acts that may not be stigmatizing or off-putting.

MR. BUSKER: What about HIV testing? Would you recommend it at this visit?

DR. AGWU: Absolutely. As we know, risk of unidentified HIV infection is high among transgender people, particularly young trans females, for a multitude of reasons. There's risk that she may not return because the visit at this point had been very stigmatizing with the interaction with the staff. This is an opportunity to provide testing, since we know she's at a higher risk as a trans individual, so I definitely would recommend screening. Additionally, routine, universal HIV testing is required or recommended being just by her age and her risk, and every visit is an opportunity to test as well as to educate about risk. For all those reasons I would absolutely recommend HIV testing at this visit.

MR. BUSKER: Are there other recommendations you would make to this patient?

DR. AGWU: She should also be counseled about risk reduction tailored to our identified risk, per her sexual history. We talked about not making assumptions, but knowing or asking what acts and what behaviors she does engage in, because then you can appropriately talk to her about how could she reduce her risk.

There is also a need to plan for follow-up of her results, whether she's positive or negative, and counseling her how to proceed in either case. There is an opportunity to offer PrEP, pre-exposure prophylaxis, based on her risk determination. You may have an opportunity to talk about post-exposure prophylaxis if you discover during that there are challenges. But beyond that there's also planning for just routine engagement and care including trans-specific care. We know that trans-affirmative care — meaning acknowledging the needs of a person who identifies as trans and making sure you provide health care that's related to that — is also known to reduce stigma and ultimately reduce risk.

I think for all those reasons we don't just do HIV testing and move on, but rather it's important to take a comprehensive approach to this young woman.

MR. BUSKER: Thank you for that case and discussion. And we'll return with Dr. Allison Agwu from Johns Hopkins in just a moment.

MR. BOB BUSKER: You've been listening to *e*HIV Review, a combination newsletter and podcast program delivered via email to subscribers.

Newsletters are published every other month. In each issue, an expert author reviews the current literature in an area of specific importance to clinicians treating patients with HIV, including infectious disease specialists, primary care physicians, nurse practitioners, physician assistants, and others.

In the month following each newsletter, the expert author provides a case-based podcast discussion like the one you're listening to now to help translate that new information into clinical practice. These podcasts are also available as downloadable transcripts.

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Thank you.

MR. BUSKER: Welcome back to this *e*HIV Review podcast. We've been talking with Dr. Allison Agwu, Associate Professor of Pediatrics and Adult Infectious Diseases at the Johns Hopkins University School of Medicine, about the clinical aspects of Improving Outcomes in At-Risk Populations. Let's continue with another patient scenario.

DR. AGWU: You are in an urgent care clinic and a 28-year-old woman comes to see you with abdominal discomfort. She reports that the pain, which is increasing in intensity, has been going on for about one week, and she has also noticed some vaginal discharge. She is just coming in to see you as she has not been able to get off of work. The interview is difficult as she is Spanish- speaking with limited English and you speak some but not great Spanish.

She has no medical history to report. Social history, you can decipher she's been in the US for about one year, she's married and joined her husband, who has been in the US for about three years. On physical exam, you notice diffuse abdominal pain and vaginal discharge; additionally, you recognize that she has what appear to be track marks on her arm.

MR. BUSKER: Can we assume, at least for the sake of our discussion, that this patient might be a new immigrant, possibly undocumented?

DR. AGWU: Yes, that would be fair to say.

MR. BUSKER: Please prioritize your specific concerns about this patient.

DR. AGWU: In thinking about this patient, first and foremost with her abdominal pain I'm thinking: is there a sexually transmitted infection that I need to be worried about with the discharge? Is there a pregnancy, potentially an ectopic pregnancy, for example, or a pregnancy that's in the tube? Additionally, I'm thinking about HIV; those are the medical issues. Since I'm noticing track marks, is this someone who has a problem with injection drugs? I know that if I'm thinking about injection drug use as well as immigrant populations, we know there are decreased rates of HIV testing, challenges with engaging both immigrant populations and injection drug users. So several things are intersecting in this one person that raise my concern.

MR. BUSKER: How do you facilitate dealing with everything you've just talked about?

DR. AGWU: First there's a language issue, and while the provider in this scenario speaks some Spanish, it's important to have clear communication. It's trying to make sure you have the right language interpretation or translation to assure that you can appropriately address the young woman's questions, as well as ask the right questions to get the right answers. Trying to bridge the language gap will be important.

We have also seen decreased acceptability of HIV testing when it stands alone, so bundling the HIV test with the STI test and the pregnancy test would be important. And then making sure the several risks we've identified. She's an undocumented person, and she likely has an issue with injection drug use. So we want to make sure we're referring to the appropriate services for her, not just address what's going on acutely, but also provide ongoing support moving forward.

MR. BUSKER: Would you test this woman for HIV?

DR. AGWU: Absolutely. This young woman with two risk factors that we know of — we have the track marks, so let's go with injection drug use first. We know that when HIV is diagnosed in injection drug users, a significant number of them have been seen in medical care of some sort in the previous year. Only about half of them have had HIV testing, so it would be a missed opportunity if we did not test her. Then, because she is likely an undocumented immigrant, and they are often less likely to present for care because they're concerned about their legal status, they're concerned that they would be then reported to law enforcement. They don't present and are less likely to be tested, so it would be another missed opportunity if we don't test this young woman who comes into clinic with those two known risk factors. There's also concern about the STI, and where you have STIs you have an increased risk of HIV. So absolutely I would test for HIV.

We also talk about challenges of following up. We don't know if we'll have another opportunity to test her, so we want to make sure while she's in our presence to test her and refer her to appropriate resources or find a way to make sure that we can have contact with her in the future.

Additionally, this young woman is 28, and younger injection drug users and people who more recently started using have higher risk-taking behaviors, so her risk for HIV may also be increasing. It's an opportunity to test and diagnose, but also potentially to provide some intervention to decrease her risk of acquiring HIV in the future if she's not positive today.

MR. BUSKER: To achieve that risk reduction, what might you suggest for this patient?

DR. AGWU: We know that syringe exchange programs work, so trying to get her to a syringe exchange program would be important. Of course, the primary thing would be to try to get her to stop injecting drugs, but if not, while we're continuing to do that if she has to inject, injecting safely would be important. Suggesting condoms to try to prevent acquisition of HIV and other STIs would also be important. Preexposure prophylaxis has been shown to work for individuals who inject drugs as well as engaging in high-risk sex behaviors would be important, but I think all around it's a complete package of reduced risk, access to care, access to syringe exchange in a way that is culturally appropriate, with language that she can understand to improve the likelihood that she will return.

MR. BUSKER: Let's assume for the sake of our discussion that she tests positive for HIV, and she does return to your clinic. What specific challenges do you face then?

DR. AGWU: There's access. This young woman already said the reason she hadn't presented was because she was working. She has other conflicting interests or the need to survive by working decreased her chance to get there, so transportation and ability to have time off to come to clinic. We talked about the issues of her being undocumented and not necessarily having access to insurance or the things that may be needed. These are not insurmountable, but they certainly increase her risk for falling out of care.

We know that undocumented populations often are highly mobile, and so if we can get her in care, that's great, but can we keep her in care, and what do we need to do and how creative do we need to be to continue to maintain her in care? Language is certainly a challenge, so appropriate language and culturally appropriate services would be important.

And then trying to address her barriers. What are her issues? Is it language, is it insurance, what are they? We would try to address those barriers through social work to decrease the likelihood that she falls out of care.

MR. BUSKER: Thank you for that case and discussion, Dr. Agwu. I think we've got time for one more patient scenario.

DR. AGWU: You are seeing a 17-year-old that you have seen in your practice since he was an infant. As usual, his mother has accompanied him to the appointment. You conduct a history and have informed the mother that you would like to have some time alone with the adolescent. The mother agrees to leave, but then says to the provider, "We will talk about what happened, right?"

MR. BUSKER: That's a difficult situation. How would you handle it?

DR. AGWU: Yes, this is challenging, because particularly as a young person who has been seen at the practice since infancy, there is a level of comfort with the mother being involved. And there is a challenge when parents have to be separated from the adolescent, as the adolescent has to feel confident that they can share what's going on with them without it being shared to their parent.

I think in this case it's important to establish very early, in my own practice I often do this at 10 or 11 years old. I start to give the adolescent time without the parent. I say to the parent, now I'm going to talk to Johnny or Susan alone, and what we talk about is our issues and our business unless there is something that will be harmful. I'm very clear about the guidelines I would require to break that confidentiality.

Now, and this is by law, adolescents are allowed to talk with their providers without the parent involved and without sharing what happens in that encounter unless there is something that has to do with risk, such as whether an adolescent is going to hurt themself or somebody else, they are by law allowed to have that interaction on their own.

In this scenario I'd handle adolescent confidentiality and talk about the importance of giving adolescents their space so they can share things that they then don't feel automatically go back to the parent. I think in that same vein adolescents are less likely to report risk behaviors, sexual behaviors, what have you, if parents are involved. With the parent involved I know automatically that is going to decrease the likelihood of reporting risky behaviors.

In this case I really advocate for the adolescent and talk about the importance of giving them their own time and assure the parents if there is something really concerning, harmful or suicidality or what have you, but assure the adolescent and the parent that this is a confidential encounter and that's just the way it's done at this practice. Make it very normative.

MR. BUSKER: So for clarification: let's say the adolescent patient is sexually active. That's something you are not required to report to the parent. Is that correct?

DR. AGWU: That is correct; no, I'm not required to report. It's important as you talk to young people to gauge what they are comfortable with sharing and not comfortable with sharing, what they have shared with their parents versus not. Disclosure is a good thing for fostering parent/child relationships, but there are times, particularly if kids are LGBTQ or they are exploring their sexual identity, they may not be accepted by their parents, and breaching that confidentiality would be harmful.

I would encourage the patient to share, but if they're not ready to then that's where we are. There's confidentiality of what they've told me, and how I handle that interaction with that adolescent may actually shape how they handle future interactions with providers. So there's a lot of responsibility on the provider, but it really is an opportunity to develop healthy interactions between patients and their providers moving forward.

MR. BUSKER: So again for the purposes of our discussion, what did this 17-year-old reveal about his sex life?

DR. AGWU: In my talk with this young man, he did reveal that he'd been sexually active and had engaged in sexual activity with both males and females.

MR. BUSKER: That's a valuable piece of information. Would that prompt you to test this adolescent for STIs and HIV?

DR. AGWU: Absolutely, and even without that information, the kid is between the ages of 13 and 64, so he meets the guidelines for HIV testing by the CDC anyway, so that's important.

The fact that he does reveal that he's sexually active increases the importance of testing. Asking him about what sites he's engaged in sexual activity is important because then you would be testing not just penile, but also maybe anal, maybe oral, you're checking multiple sites for STIs, and you're testing for HIV. This is all confidential testing of this adolescent, particularly if he has not disclosed activity to the mother.

MR. BUSKER: Is STI and HIV testing without parental consent legal?

DR. AGWU: Adolescents anywhere in the US can access STI testing and treatment without parental consent. For HIV testing a few states have some different laws, so I do encourage the providers to make sure they know what their local guidance is for what their reporting requirements are.

MR. BUSKER: And your suggestions for risk reduction for this patient?

DR. AGWU: Education is very important, particularly if this young man has just started to develop his sexual identity. It's important to establish healthy sexual identity explorations, so talking about risk reduction, negotiation about using condoms are very important, because he may not get that information from anywhere reputable. He may be looking on Google, but here is an opportunity for his provider to provide that information to him.

MR. BUSKER: What about PrEP?

DR. AGWU: PrEP currently is licensed for people 18 and over. The FDA, or the Food and Drug Administration, is currently

reviewing the application for 15- to 17-year-olds. The young man is 17, so not yet, but making sure that he is aware that that resource will be available to him as he turns 18. Additionally, identifying if there's a need for post exposure prophylaxis if he had a particularly high-risk encounter. Post exposure prophylaxis is available regardless of the age, depending on the risk behavior or what happened during an exposure.

MR. BUSKER: So overall, with this adolescent, your task is...?

DR. AGWU: Making sure that this young person understands that sexual exploration is healthy; however, risk reduction is important, pointing him to additional resources, including yourself, this is an opportunity as your provider how you handle this first foray into sexual activity and understanding where he's coming from, making it normative, becoming a resource that he can speak to in the future to provide correct and appropriate information to reduce risk.

MR. BUSKER: Thank you for today's cases and discussion. One more question. In your opinion, what's needed, as the research continues, to help clinicians provide better care for these at-risk populations?

DR. AGWU: We continuously struggle with how to reach at-risk populations, and I think it's an area that we have to continue to explore. When we are able to reach those populations, how do we assure that we employ new modalities to prevent new infections in those populations, how do we maintain vigilance in screening, how do we best educate providers who are encountering patients so they're thinking about HIV risk and thinking about testing and thinking about how they can then reduce risk?

I think what is most needed is to reach populations, maintain contact with high-risk populations and then ultimately reduce risk. What's most important varies by population, but if I had to think about what's needed for how we continue to address at-risk populations, that would be it.

MR. BUSKER: Thank you for sharing your insights, Dr. Agwu. Let's wrap things up now by reviewing today's discussion in light of our learning objectives. So, to begin: addressing the specific barriers to testing and entering into care among transsexual people.

DR. AGWU: For this population, it's important to reduce and minimize stigma. That's probably the number one thing we need to do. Because if we have a stigmatizing environment, we won't see these young trans people come in.

First, we shouldn't make assumptions; we should ask and not assume to make sure that we can appropriately identify people's risk. We should think about what resources are necessary that we can tap into and to help support them and make sure that all staff are educated. That goes to reducing stigma, providing the right combination of tools for this population to make them comfortable, make sure that the appropriate testing and other things are done, and make sure they continue to come back.

MR. BUSKER: And our second learning objective: addressing specific barriers to testing and entry into care among migrant and immigrant populations.

DR. AGWU: There are multiple things. The easy one is language and making sure language is not a major barrier. Providing resources that we can provide in the language that will allow us to most effectively communicate with them. Trying to make sure we have appropriate services to address their barriers, whether it's access, language, transportation, social, legal, or their concerns about legal will be important.

Whenever we can, we should test for HIV within other tests, such as diabetes or other screenings, bundling tests so they are less stigmatizing, and creating an environment so we can reach them again and again and again. We should make things comfortable so they will return to then share their concerns with you with language that's appropriate so we can accurately identify risk and employ testing. Risk reduction should be part of that.

MR. BUSKER: And finally: addressing specific barriers to testing and entry into care among adolescents.

DR. AGWU: For adolescents it is often just getting the person into the clinic. The scenario we presented here had the adolescent coming in, but adolescence tends to be a time when adolescents aren't very present in clinical environments. So when they are present, we should take advantage of that and employ testing as much as we can, assuring confidentiality so that adolescents can express what they are engaging in and ask their questions. Only then can we identify what their risks might be and educate them about risk and risk reduction. We should underscore confidentiality, because if we are unable to provide confidential care to young people in a youth-friendly way, we won't be able to get them to come back and maintain their confidence in terms of their providers. This is key for adolescents.

First we must find them, and when we find them we must make sure we test them and then use the opportunities to define risk and educate them about risk, and then employ risk reductions as an intervention.

MR. BUSKER: Dr. Allison Agwu, from the Johns Hopkins University School of Medicine, thank you for participating in this *e*HIV Review Podcast.

DR. AGWU: Thank you, Bob. It has been my pleasure to discuss this topic today.

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