

Red Ribbon Campaign

Uniting American Indian and Alaska Native
Communities to Eliminate HIV-AIDS

Strengthening the Ribbon

A Primary Care Approach to Eliminating
HIV/AIDS in Indian Country

June 14, 2022 | 2-3 p.m. EST

Broadening the Ribbon

Innovative Resources and Effective Strategies
to Eliminate HIV/AIDS in Indian Country

July 14, 2022 | 2-3 p.m. EST

Sharing the Ribbon

Best Practices from the Frontlines

July 26, 2022 | 3:30-4:30 p.m. EST





Strengthening the Ribbon: A Primary Care Approach to Eliminating HIV/AIDS in Indian Country

Tuesday, June 14, 2022 | 2:00 PM – 3:00 PM EDT

PRESENTERS:

Dr. Jorge Mera, Director of Infectious Diseases | Cherokee Nation Health Services (CNHS)

Jessica Leston, Clinical Programs Director | Northwest Portland Area Indian Health Board (NPAIHB)

David Stephens, BSN, RN, ECHO Clinic Director | Northwest Portland Area Indian Health Board (NPAIHB)



DISCLAIMER

This event is made possible by the Minority
HIV/AIDS Fund through the Indian Health
Service



AGENDA

TIME ALLOCATED	TOPIC	PRESENTER(S)
2:00 p.m. EST	Welcome	Divya Nanduri
2:02 p.m. EST	<ul style="list-style-type: none">• About NCUIH• Zoom Etiquette• Introduction of Presenters	Divya Nanduri
2:05 p.m. EST	Presentation	Dr. Jorge Mera
2:45 p.m. EST	Q&A Session	
3:00 p.m. EST	Adjourn	Divya Nanduri



ABOUT



NATIONAL COUNCIL *of* URBAN INDIAN HEALTH

The National Council of Urban Indian Health (NCUIH) is the national non-profit organization devoted to the support and development of quality, accessible, and culturally-competent health and public health services for American Indians and Alaska Natives (AI/ANs) living in urban areas.

NCUIH is the only national representative of the 41 Title V Urban Indian Organizations (UIOs) under the Indian Health Service (IHS) in the Indian Health Care Improvement Act (IHCA). NCUIH strives to improve the health of the over 70% of the AI/AN population that lives in urban areas, supported by quality health care centers.



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ECHO Clinic Director |
Northwest Portland Area
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Clinical Programs Director |
Northwest Portland Area Indian
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INDIAN + COUNTRY
ECHO
LEADING THE WAY **▶▶▶**

*Growing the Ability to Deliver Quality Healthcare to
American Indian and Alaska Native People.*

Strengthening the Ribbon: A Primary Care Approach to Eliminating HIV/AIDS in Indian Country

June 14, 2022

Jessica Leston, MPH | Clinical Programs Director |
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Jorge Mera, MD, FACP | ECHO Medical Director |
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jorge-mera@cherokee.org

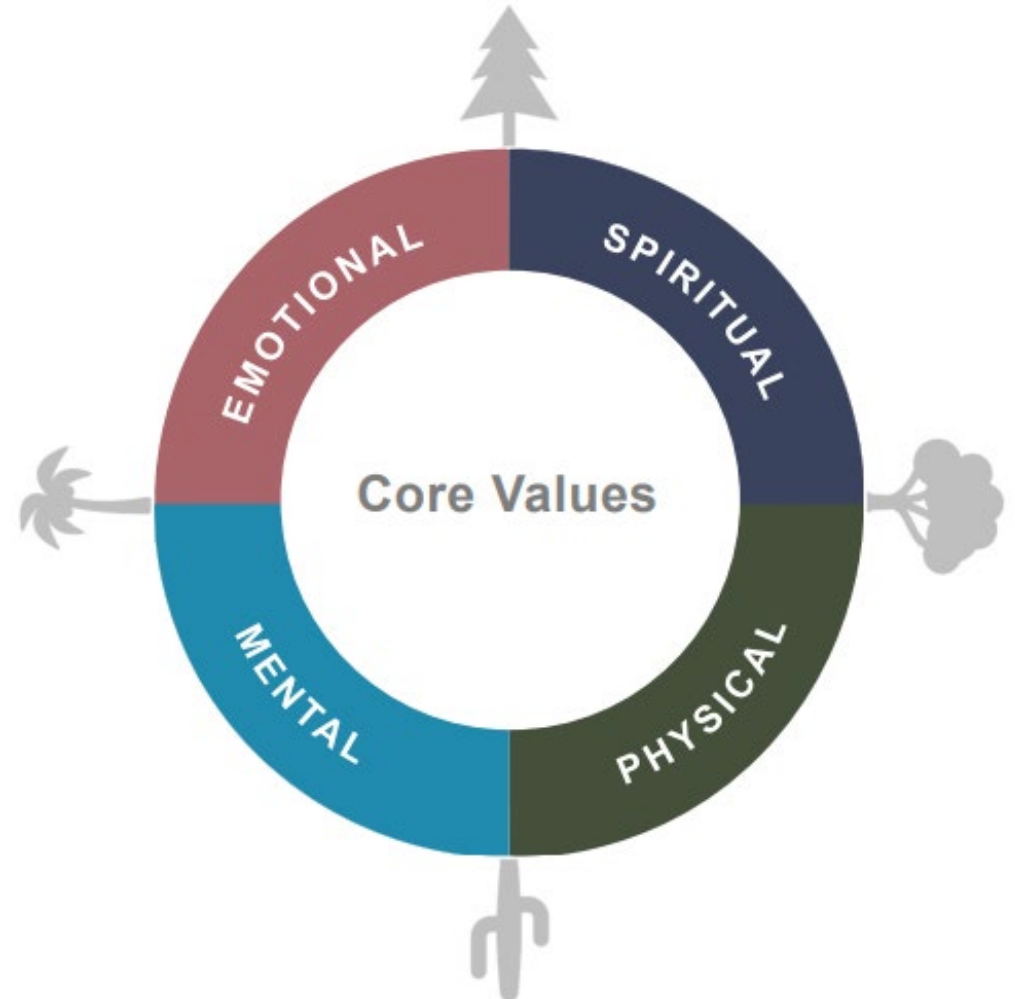
David Stephens, BSN, RN | ECHO Clinic Director |
Northwest Portland Area Indian Health Board |
dstephens@npaih.org

HIV slides adapted from Dr Jonathan Iralu

Indigenous HIV/HCV/STI Elimination Strategy

Core Values and Principals

- Storytelling, wisdom
- Community, family, taking care of family, interconnectedness, relationships to each other, the land, all beings, and reciprocity
- Balance, harmony, healing, holistic care
- Affirmation, community strength, hard work, humor
- Courage, diversity, equity, justice
- Honesty, truth, trustworthiness
- Overarching: love, respect, responsibility, reverence



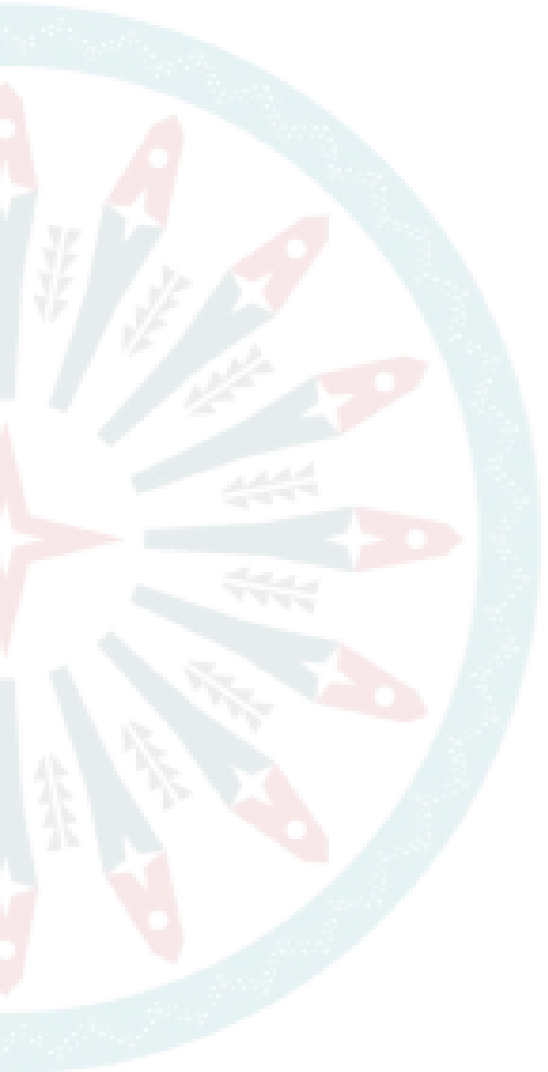
Indigenous HIV/HCV/STI Elimination Strategy

Key Learnings

- **Sovereignty:** Respect Indigenous sovereignty in the design and delivery of services
- **Cultural Responsiveness:** Ensure delivery of culturally responsive services
- **Partnerships:** Strengthen partnerships to improve systems of care
- **Awareness:** Increase community awareness of the relationship between sexual health and overall health and well-being to support prevention of HIV/HCV/STIs
- **Capacity:** Address capacity to support provision of care
- **Clinical Resources and Services:** Increase accessible, available and sustainable resources and services
- **Addressing Stigma:** Implement strategies that address stigma
- **Data Systems:** Enhance data systems, research, and evaluation to address information gaps

Outline

- **Clinical Case**
- **The SUD | HCV | HIV | STI Syndemic**
 - Example: Scott County, Indiana
- **The SUD | HCV | HIV | STI Syndemic in Indian Country**
- **What Should the PCP Know about HIV**
- **Interventions to Mitigate the Syndemic:**
 - Societal (Macro), Health System (Micro), Health Professional (Individual)
- **Conclusions**



Clinical Case: Mr. S

- **Mr. S** is a 24-year-old American Indian/Alaskan Native (I/AN) male who suffered a right femur fracture (MVA) **6 years ago**. **Unfortunately, pain management training or policies were not available** in the institution, and he was discharge from the hospital with oxycodone hydrochloride for pain control.
- **Two years ago**, his new medical provider refused to refill the oxycodone. **Unfortunately, the provider was not trained in screening for substance use disorders (SUDs) nor did he have an MAT waiver**. The patient then turned to his friends who gave him oxycodone, but later he had to purchase it in the streets.
- **One year ago, he started injecting heroin** since it was cheaper. **Unfortunately syringe service programs are not available** where he lives, and he has been sharing needles and syringes.
- **Three days ago**, he presented to the Emergency Department (ED) with opioid withdrawal symptoms (Nausea, vomiting, diarrhea, restlessness, abdominal pain). **Fortunately, the ED medical provider was trained in SUD management** and induced him with Buprenorphine/Naloxone and gave him a 3-day prescription, enough until he could be evaluated and placed on Medication Assisted Treatment (MAT). **In addition, the provider was also trained in screening for HIV, STIs, HCV, and HIV PrEP**, during the ED visit he was screened and tested positive for HIV. HCV and other STIs screens were negative and was referred to the Primary Care clinic for HIV evaluation and treatment.

Missed Opportunities

Individual Provider

- Orthopedic surgeon did not recognize that opioids are not the first line of treatment for management of pain in the outpatient setting
- The patient's PCP did not recognize that the patient has an SUD

Health System

- Should have had guidelines/policies in place for pain management
- Should have policies in place for Medication Assisted Treatment
- Should have policies in place for screening for SUD, HIV, HCV and STIs

Society

- Should recognize the syringe service programs are evidence-based practices

We Should Not be Relying on Luck for Patient Care

What can we do for Mr. S?



**AS A PRIMARY CARE HEALTH WORKER?
(INDIVIDUAL)**



**AS HEALTH SYSTEM LEADERSHIP?
(MICRO)**

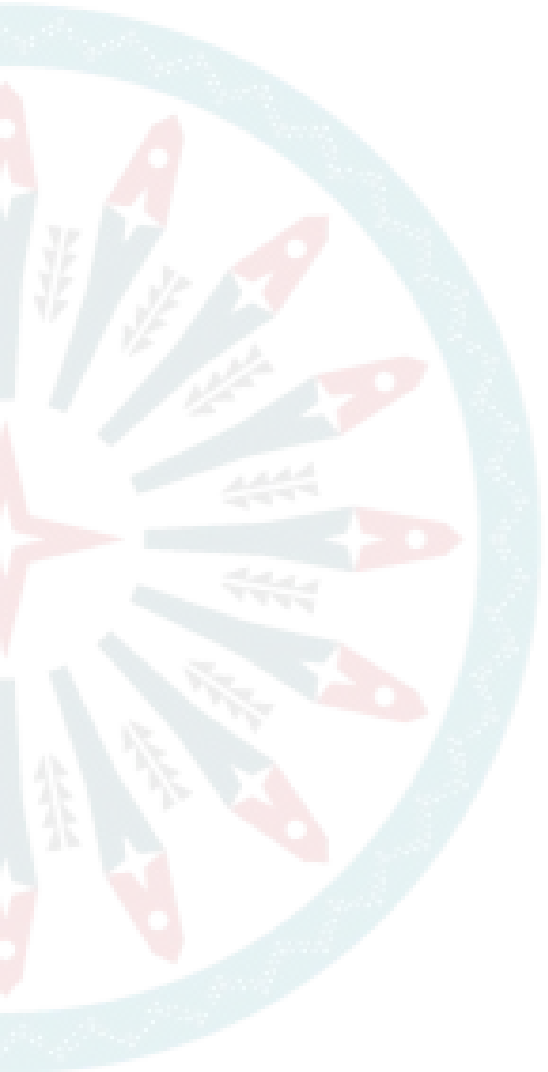


**AS A SOCIETY
(MACRO)**



Outline

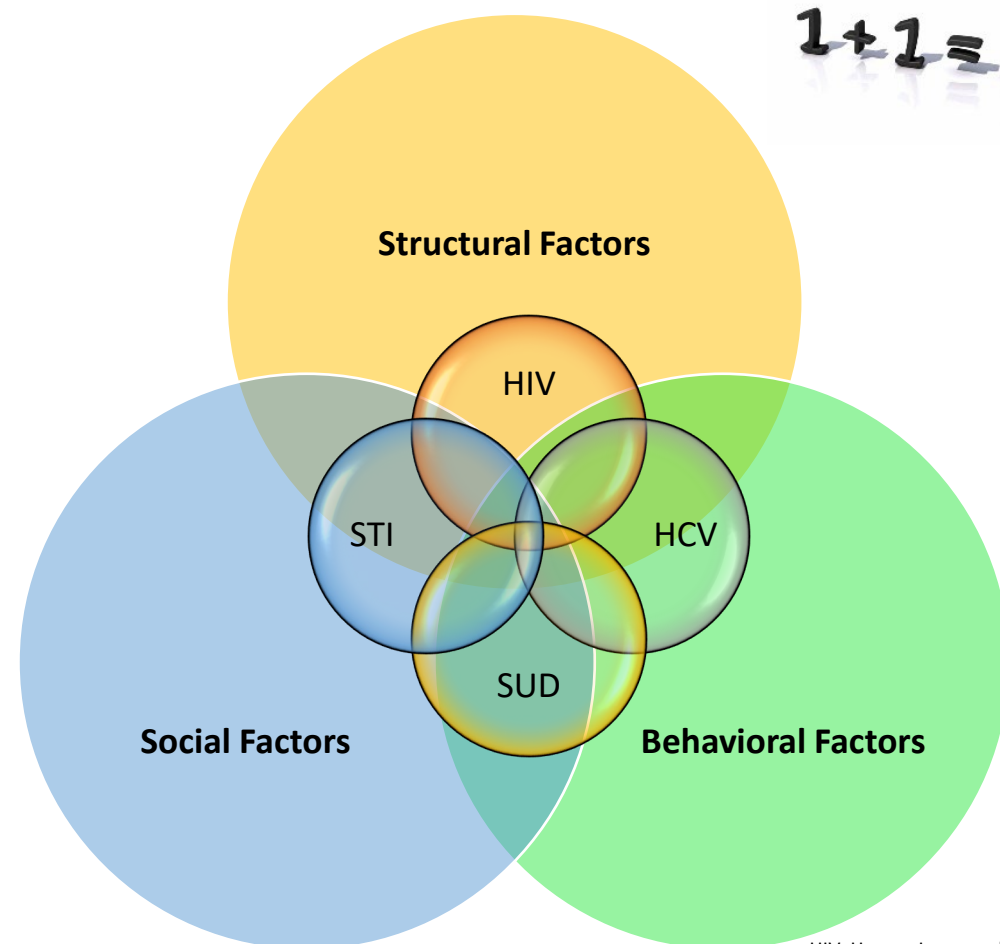
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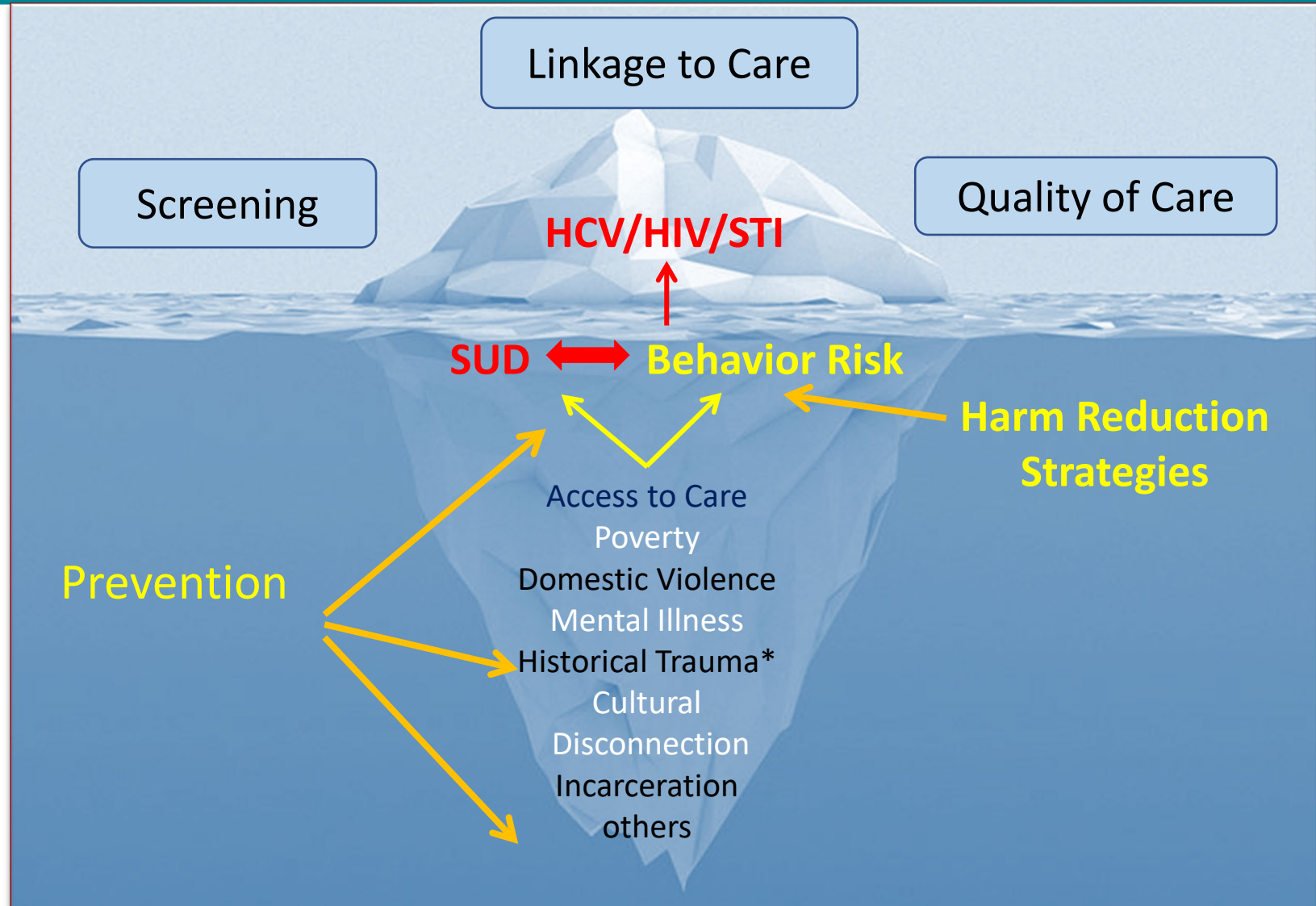
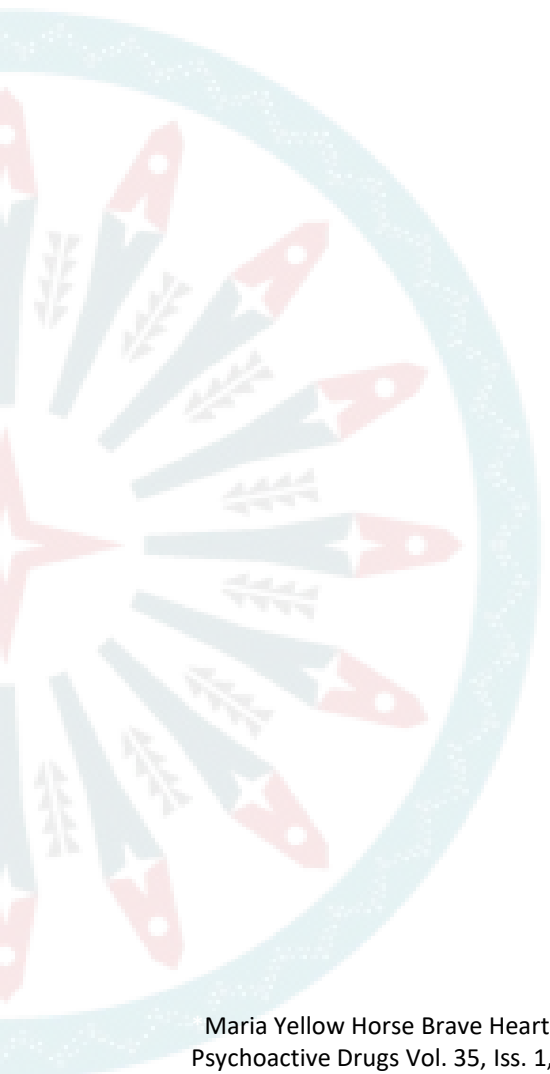
Syndemic

Core principles:

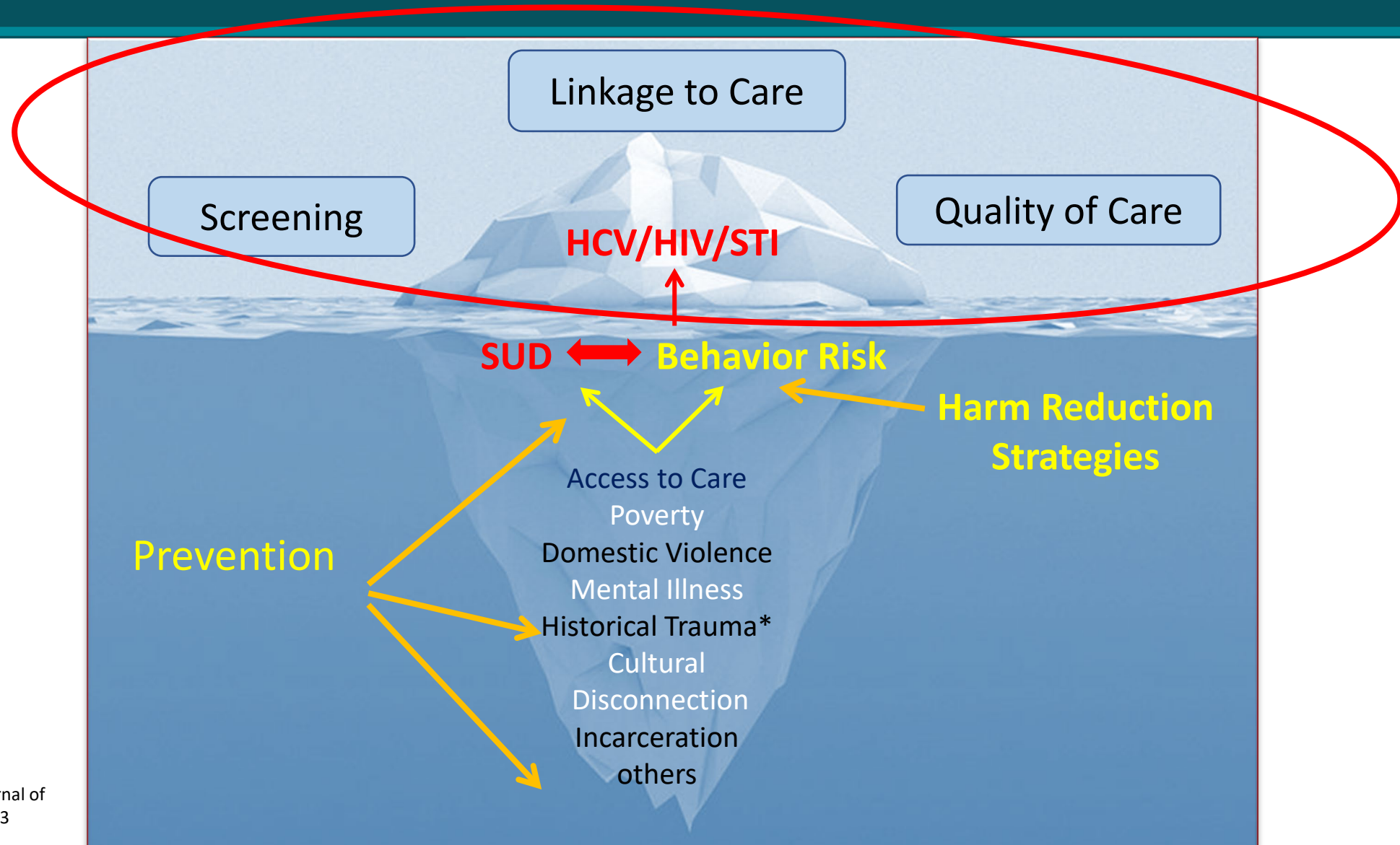
- **Clustering** of two or more conditions in a specific population
- Their **synergism** in producing excess burden of disease in a population
- **Precipitation and propagation** by large scale behavioral, structural and social forces



Syndemic



Syndemic



Indiana HIV Outbreak

From 2004-2013

- < 5 HIV infections reported annually in Austin, Indiana

In late 2014

- 3 new HIV diagnoses in Austin IN, 2 of them had shared needles

By mid-January 2015

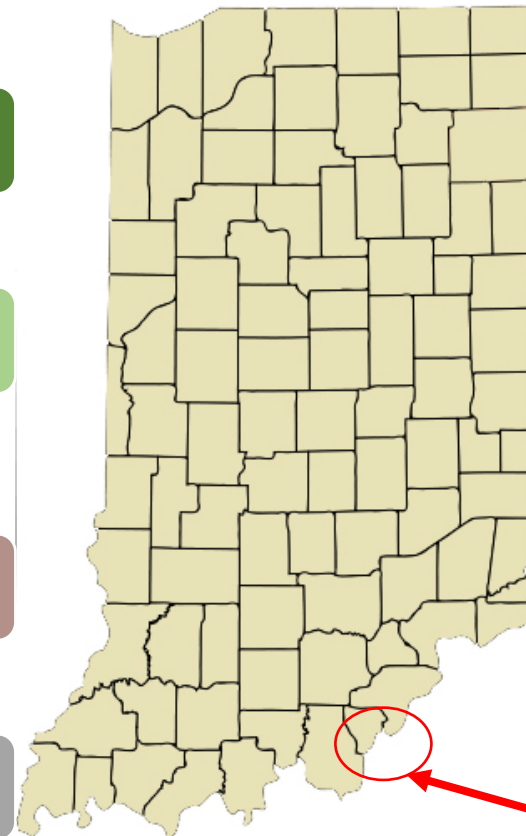
- Through contact tracing ISHD identified 8 more new infections
- The source of infection: Injection of the opioid oxymorphone (semi-synthetic opioid analgesic)

As of June 14, 2015:

- 170 new HIV infections and 115 co-infected with HCV in a Community of 4200 people

All epidemiologically linked to Austin, IN

- Infections were recent and from a single HIV strain



Scott County: Among the state's 92 counties, ranked 92nd in a variety of health and social indicators, including life expectancy

Indiana HIV/HCV Outbreak: Syndemic Risk Factors in Austin County

High poverty (19.0%)

Unemployment (8.9%)

- Few affected persons were employed or insured

Education

- Low educational attainment (21.3% no high school)
- Little HIV awareness in the general population
- Unaware of transmission risks and treatment benefits
- No routine HIV education in schools (abstinence only)

Ranked lowest in the State for health indicators and life expectancy

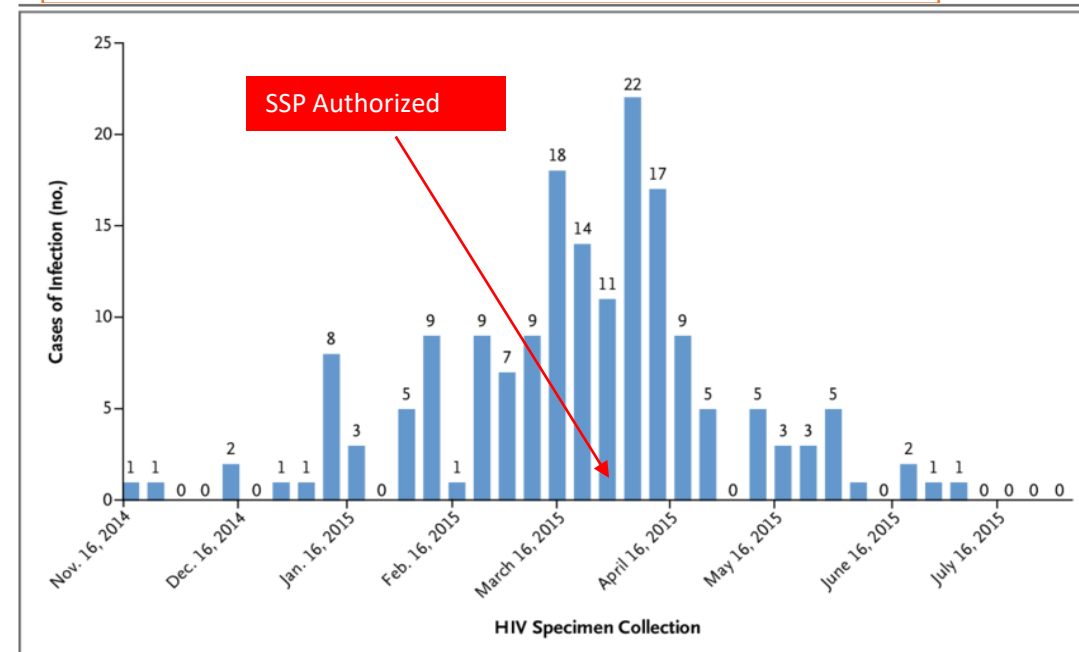
SSP program not permitted by state law

No outpatient HIV/HCV care available

Limited addiction services, including MAT

How Was the Outbreak Controlled?

- **One stop shop**
 - Behavioral health treatment
 - HCV/HIV/MAT treatment provided
- **SSP emergency authorization**



Actions That Can Help Prevent HIV Outbreaks among People Who Inject Drugs

Physician Actions

1. Screening patients for substance-use disorders and mental health disorders.
2. Testing patients and their sexual and drug-injection partners for HIV, HCV, and sexually transmitted infections, with appropriate pre- and post-test counseling.
3. For patients testing positive for HIV and HCV, offering immediate treatment according to established guidelines.
4. Providing HBV vaccination; even one dose can be effective.
5. Providing naloxone to opioid users and their families and partners to prevent fatal overdoses.
6. Offering immediate referrals to substance-use treatment programs that provide opioid-agonist therapy.
7. Becoming licensed to provide opioid agonist therapy.
8. Supporting injection-drug users by providing them with sterile syringes or referring them to places where they can obtain them.
9. Supporting legislative reforms to expand Medicaid and to allow federal funds to support needle-exchange programs.
10. Using prescription-drug monitoring programs in clinical decision making involving opiate prescribing.



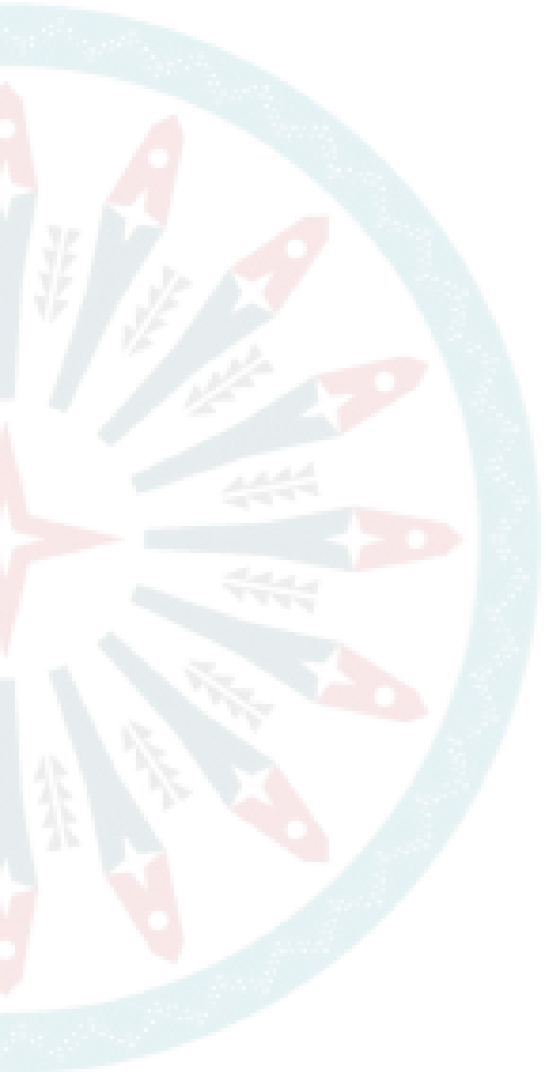
- “Four years after the United States received a wake-up call about the importance of harm reduction, the most vulnerable areas of the country remain asleep.
- Despite the federal government’s goal of ending the HIV epidemic in the United States, it’s not clear that it will do what is necessary to address the spread of HIV and HCV in rural America. Health professionals can advocate for legal changes that authorize syringe-exchange programs and other lifesaving interventions.”

Threading the Needle — How to Stop the HIV Outbreak in Rural Indiana Steffanie A. Strathdee, Ph.D., and Chris Beyrer, M.D., M.P.H. NEJM 373;5 nejm.org july 30, 2015

N Engl J Med 2019; 380:1988-1990
DOI: 10.1056/NEJMp1901276

Outline

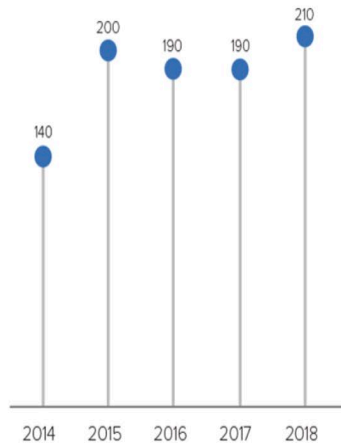
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HIV in American Indian/Alaska Native Populations

Estimated HIV Infections Among AI/AN People in the US, 2014-2018

HIV infections have increased since 2014.

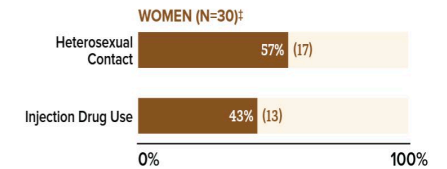
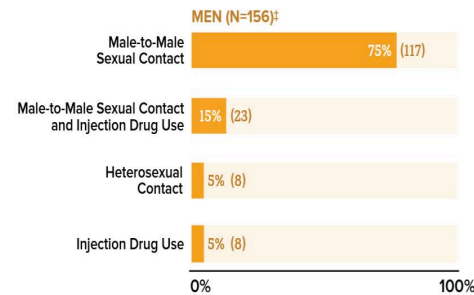


Source: CDC. Estimated HIV incidence and prevalence in the United States, 2014–2018. *HIV Surveillance Supplemental Report 2020*;25(1).

<1%

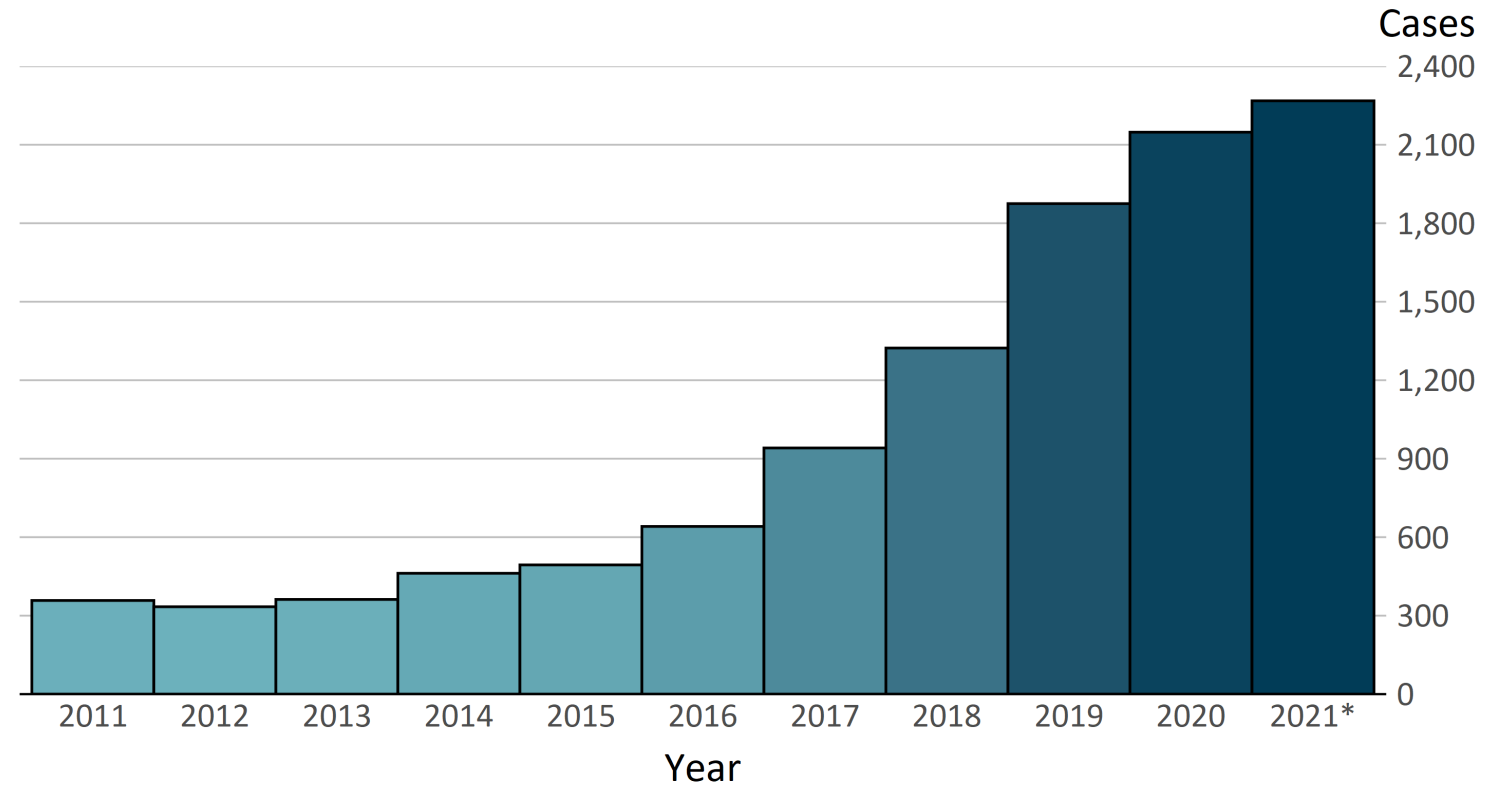
Of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas* in 2018, less than 1% (186) were among American Indian/Alaska Native (AI/AN) people.

Most new HIV diagnoses were among AI/AN gay and bisexual men.†



- In the U.S. in 2018, both male and female AI/AN had the highest percent of estimated diagnoses of HIV infection attributed to injection drug use, compared with all races/ethnicities.
- Among men, 15% (23) of new HIV diagnoses were attributed to injection drug use, and 11% (21) were attributed to both male-to-male sex and injection drug use.
- Among women, 43% (13) of new HIV diagnoses were attributed to injection drug use.

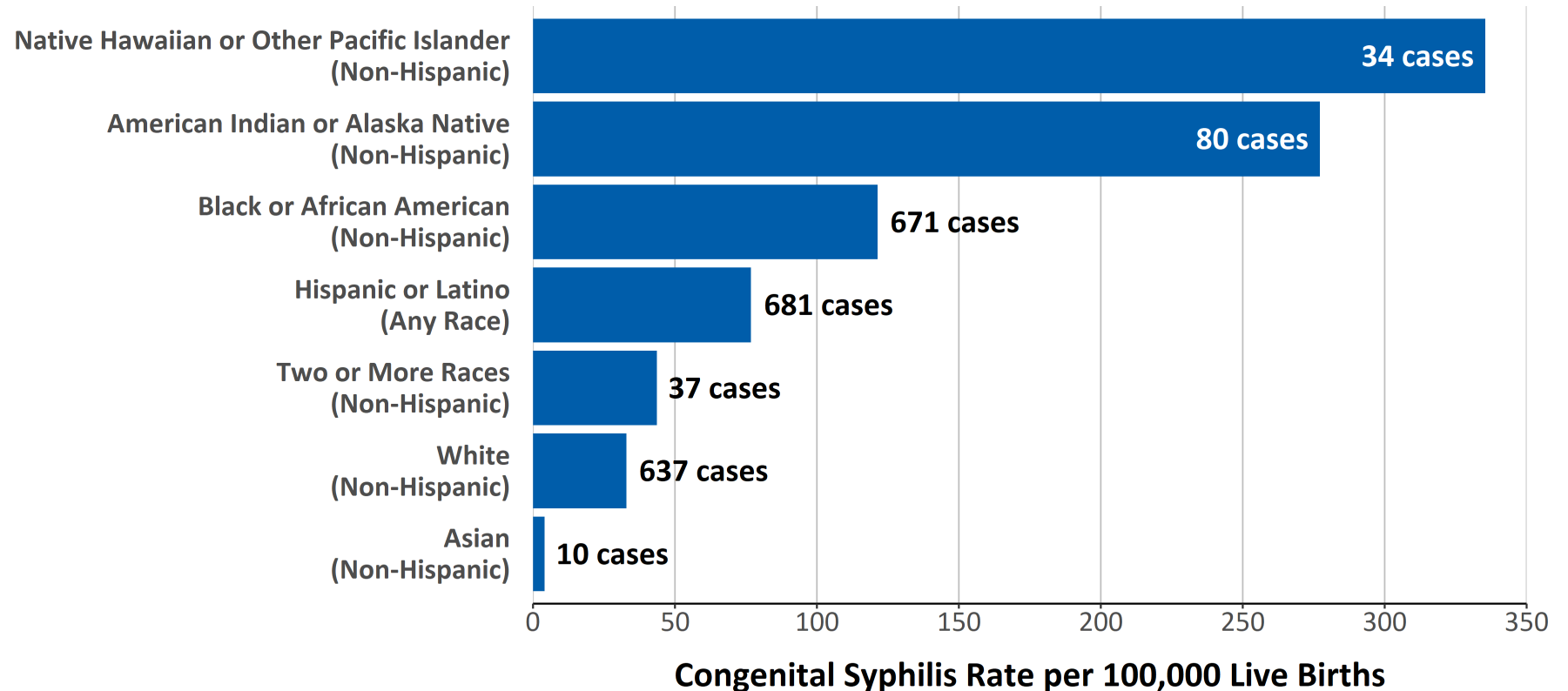
In the United States, 2,268 infants born in 2021* have already been reported as cases of congenital syphilis



* Reported 2021 congenital syphilis data are preliminary as of March 9, 2022.

Congenital Syphilis — Reported Cases by Year of Birth, United States, 2011–2021*

Racial and ethnic disparities in rates of reported congenital syphilis continued to persist in 2021*



* Reported 2021 congenital syphilis data are preliminary as of March 9, 2022.

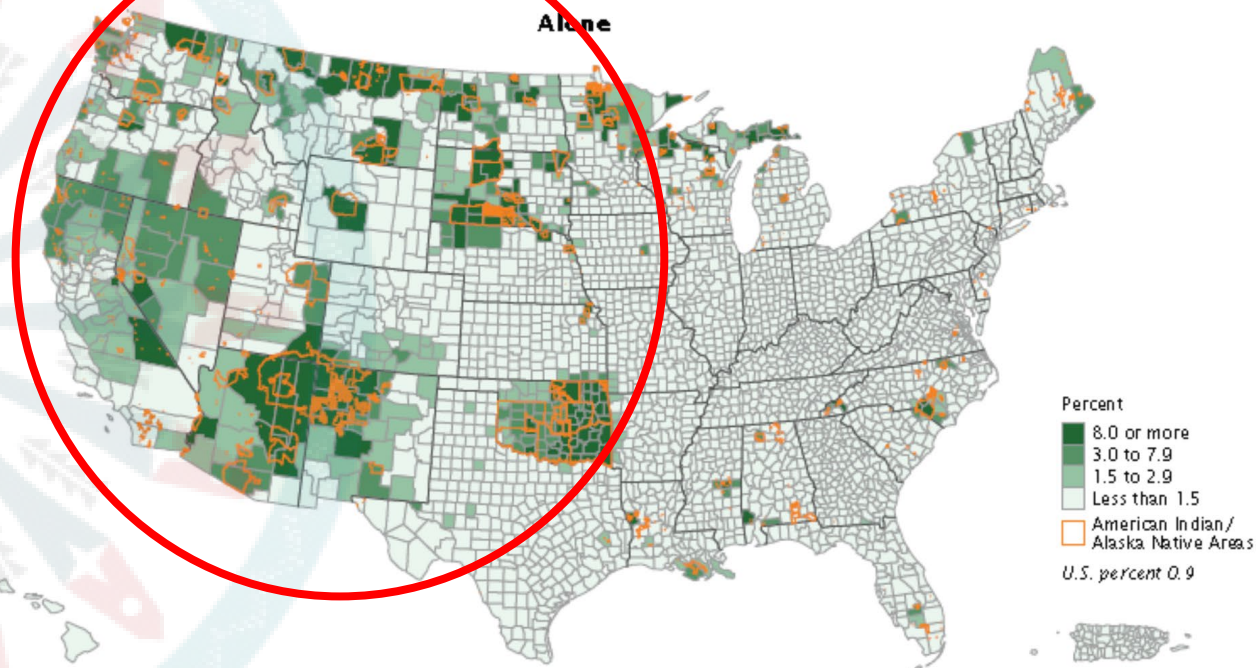
NOTE: In 2021, 118 cases (5.2%) were missing reported race and/or hispanic ethnicity.

- **Congenital Syphilis — Case Counts and Rates of Reported Cases by Race and Hispanic Ethnicity, United States, 2021***

American Indian/Alaska Native (AI/AN) Statistics in the United States

Figure 4.
American Indian and Alaska Native as a Percentage of County Population: 2010

For information on confidentiality protection, nonsampling error, and definitions, see www.census.gov/prod/cen2010/doc/pi94-171.pdf



- 573 Federally recognized tribes
 - 5.2 million AI/AN alone or in combination
 - California and Oklahoma have the highest rate of AI/AN population
- **Hepatitis C in AI/AN in the US**
 - HCV disproportionately affects AI/AN^{1,2}
 - The AI/AN HCV **mortality** rate is 10.8 deaths per 100,000, compared to 4.5 per 100,000 nationally.
 - From 2015 to 2016, **incidence** rates of acute HCV among AI/ANs rose from 1.8 to 3.1 cases per 100,000.
 - Rates of **chronic liver disease** and cirrhosis deaths are 2.3 times higher among AI/ANs than Whites.

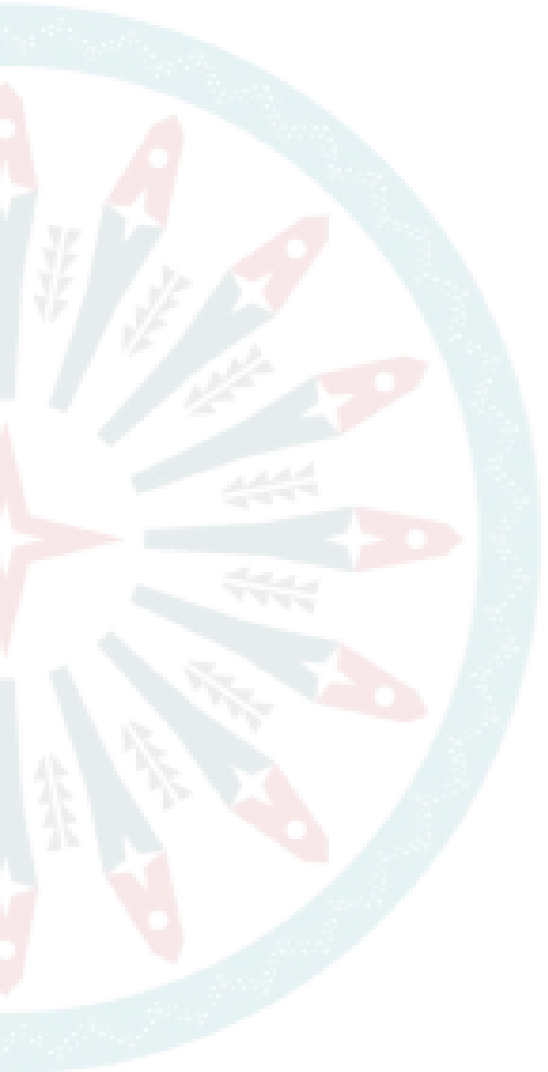
1. Centers for Disease Control and Prevention. Surveillance for Viral Hepatitis: United States, 2016. Retrieved from <https://www.cdc.gov/hepatitis/statistics/2016surveillance/commentary.htm>

2. Center for Disease Control and Prevention. Deaths: Final Data for 2014. http://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf

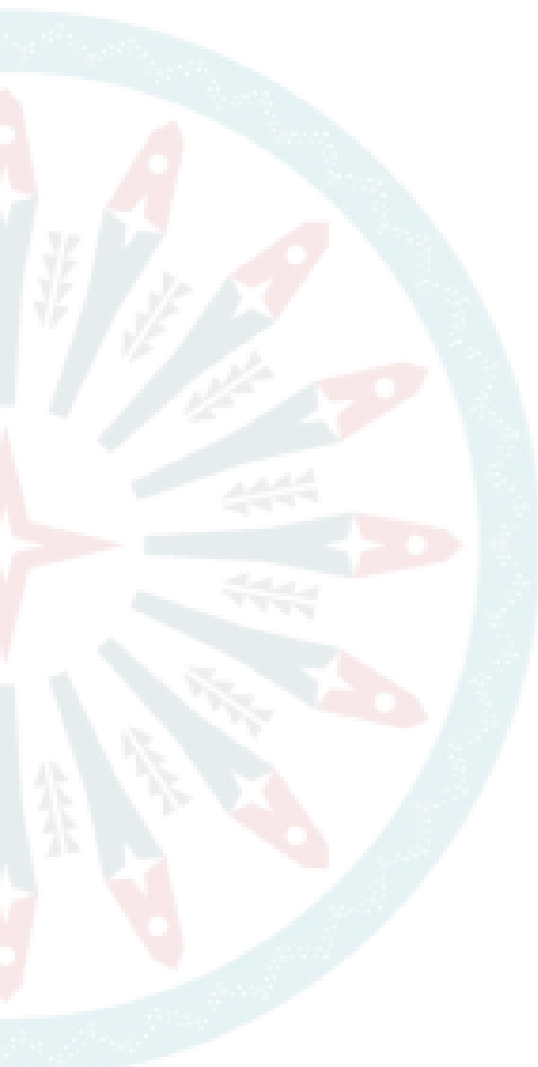
3. US Census Bureau. <https://www.census.gov/www>. Accessed Nov 2, 2019

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What Should the PCP Know about HIV



HIV 101

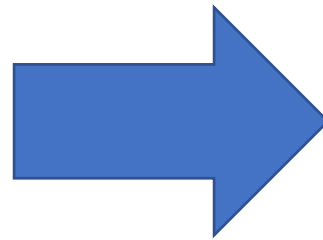
Prevention: Patient education and HIV PrEP

Screening

Early treatment of newly diagnosed patients

HIV Transmission

- Blood
- Semen
- Vaginal Secretions
- Breast milk

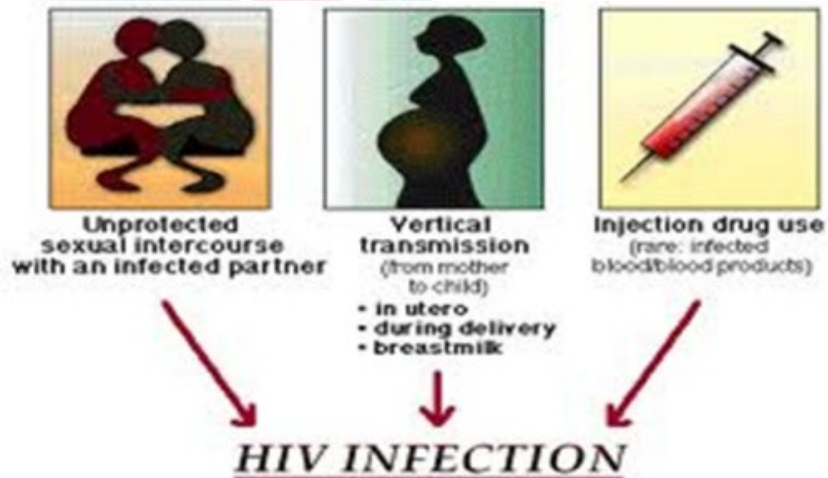


Comes into contact with:

- Mucous membranes
- Damaged tissue
- Is injected into the body

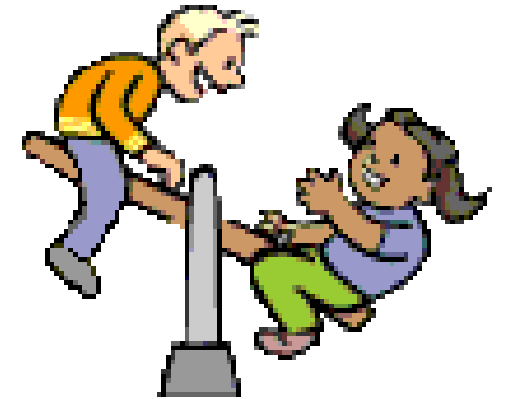
Through:

- Vaginal, anal, or oral sex
- Contaminated needles
- IV drug use
- Transplacental



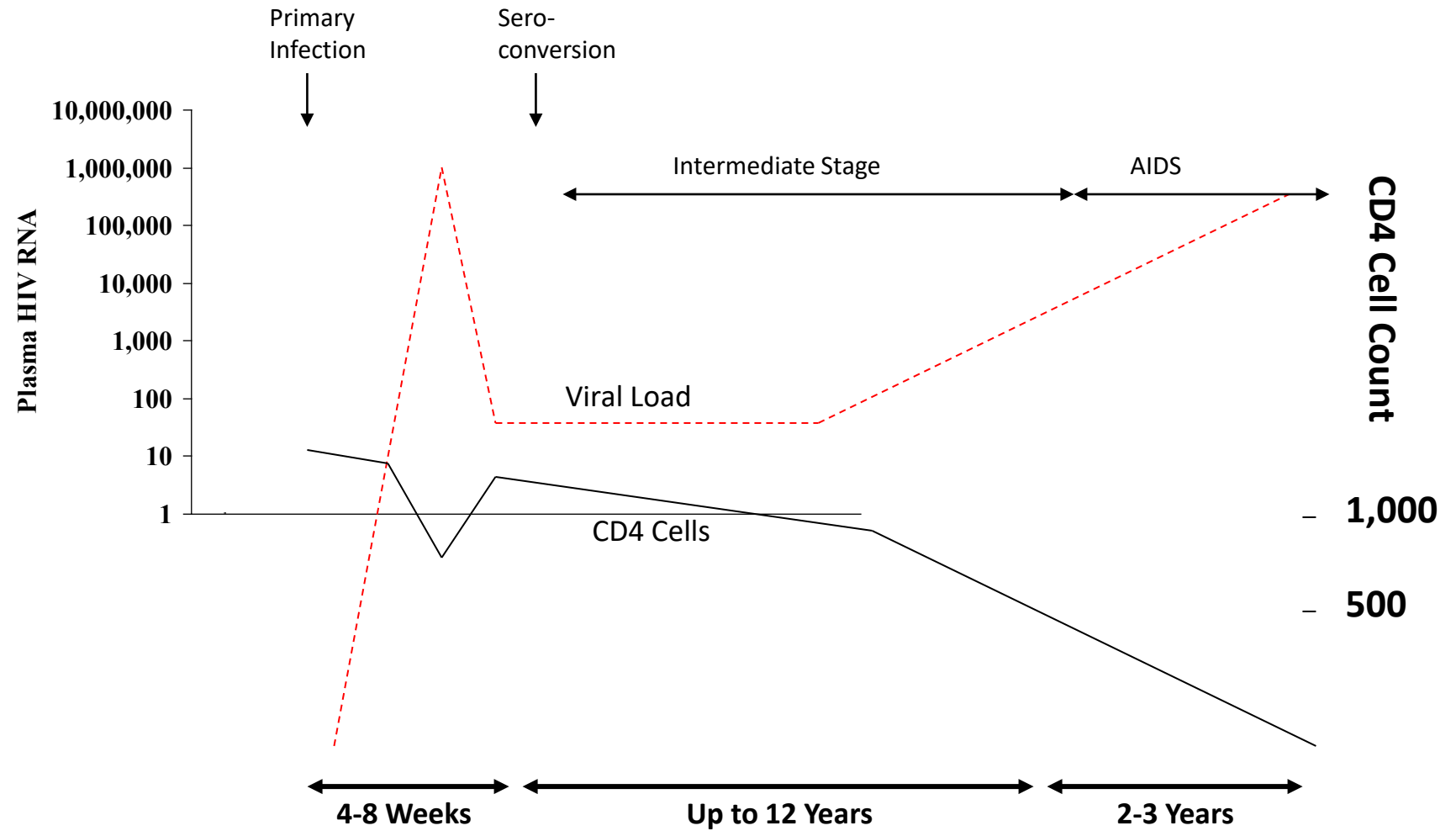
HIV Is Not Transmitted By

- Casual contact
- Working or playing with an HIV positive person
- Closed mouth kissing
- Shaking hands
- Public pools
- Hugging
- Public toilet
- Air, food, or mosquitos

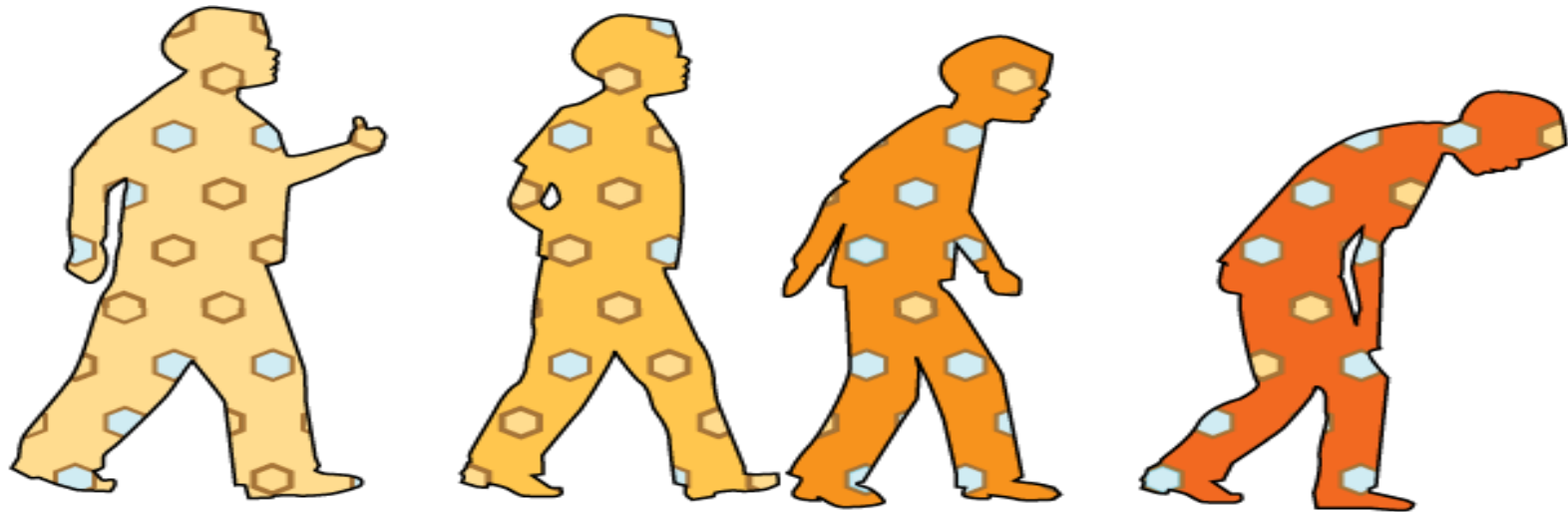


If an HIV + person is on ART and virally suppressed: U=U

HIV RNA and CD4 kinetics



Clinical Progression



Beginning:

No symptoms,
no weight loss.

After few years:

Mild weight loss,
mouth ulcers, itching,
skin disease.

After several years:

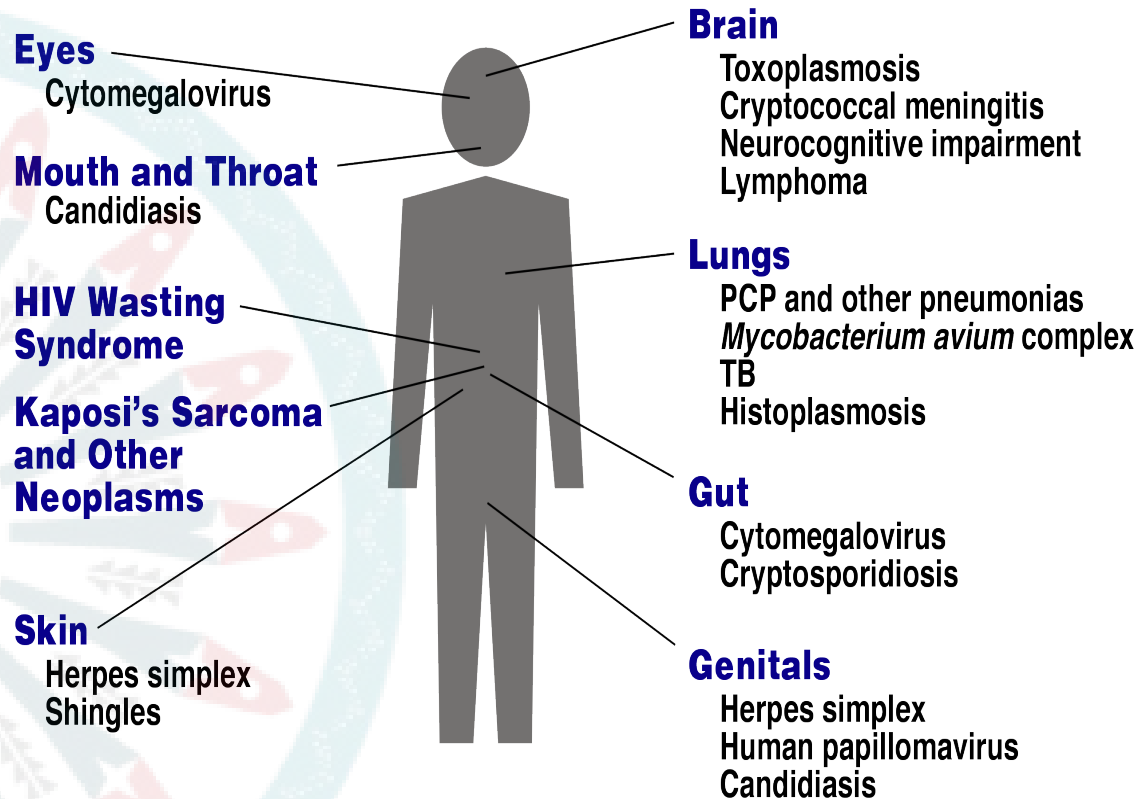
Important weight
loss, thrush, TB,
fever.

After 10 years:

Wasting syndrome, chronic
herpes, simplex ulcerations,
extrapulmonary TB

5–10 YEARS

Consequences of CD4 Depletion: Opportunistic Infections and Cancers



- CD4 > 500
 - Tuberculosis (TB)
- CD4 200-500
 - TB, Oral Candidiasis
- CD4 150- 200
 - TB, Candida esophagitis (CE), Pneumocystis,
- CD4 < 100
 - TB, CE, Pneumocystis, MAC, Cryptococcus, Histoplasmosis, Lymphoma
- CD4 < 50
 - TB, CE, Pneumocystis, MAC, Cryptococcus, Histoplasmosis, Cytomegalovirus

Opportunistic infections are infections that take advantage of a weakened immune system

Primary HIV Infection

Symptomatic illness in 40-90%

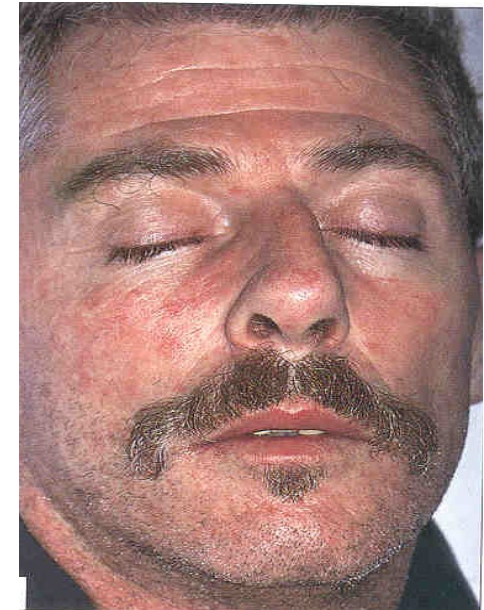
Illness is nonspecific and mononucleosis-like

Appears 2-4 weeks after exposure

Clinical illness lasts 1-4 weeks

Primary HIV Infection Symptoms

Fever	96%
Lymphadenopathy	74%
Pharyngitis	70%
Rash	70%
Myalgias	54%
GI complaints	30%
Encephalopathy	6%



- Maculopapular rash affecting face, neck and trunk
- Usually, individual lesions <1cm
- Confluence rare

What Should the PCP Know about HIV



HIV 101

Prevention: Patient education and HIV PrEP

Screening

Early treatment of newly diagnosed patients

What is HIV **Pre Exposure Prophylaxis**?

HIV PrEP is when HIV negative people at very high risk for acquiring HIV take one pill daily (tenofovir/emtricitabine) to lower their chances of getting infected when exposed sexually or through injection drug use.

- **Taken daily PrEP** can lower the risk of getting HIV from sex by more than 90% and from injection drug use by more than 70%

PrEP is not a substitution for other HIV prevention interventions such

- Condoms
- Behavioral risk reduction

PrEP does not protect against other sexually transmitted infections

PrEP is different from PEP (Post Exposure Prophylaxis)

Taking a Sexual History

Sexual health can greatly impact overall quality of life, it allows you to:

- Identify those individuals at risk for sexually transmitted infections (STIs), including HIV,
- Identify appropriate anatomical sites for certain STIs tests

It Provides an opportunity for risk-reduction and counseling

- Sharing information about behaviors that may place your patient at risk of contracting STIs

Many ways to illicit the necessary information!

- Some may prefer open dialogue
- Others may prefer written response to predetermined questions
- This applies to patients and providers

Either way, let the patient know that you ask these questions to all teenage and adult patients

- Regardless of age, gender, gender identity, or marital status

CNHS: Basic Sexual History for PrEP Evaluation

Have you injected drugs in the last 6 months

- **Yes:** NEEDS PrEP Evaluation
- **No:** Go to next question

Do you have sex with women, men or both?

- **No:** You are done !!!!
- **Yes:** Go to next question

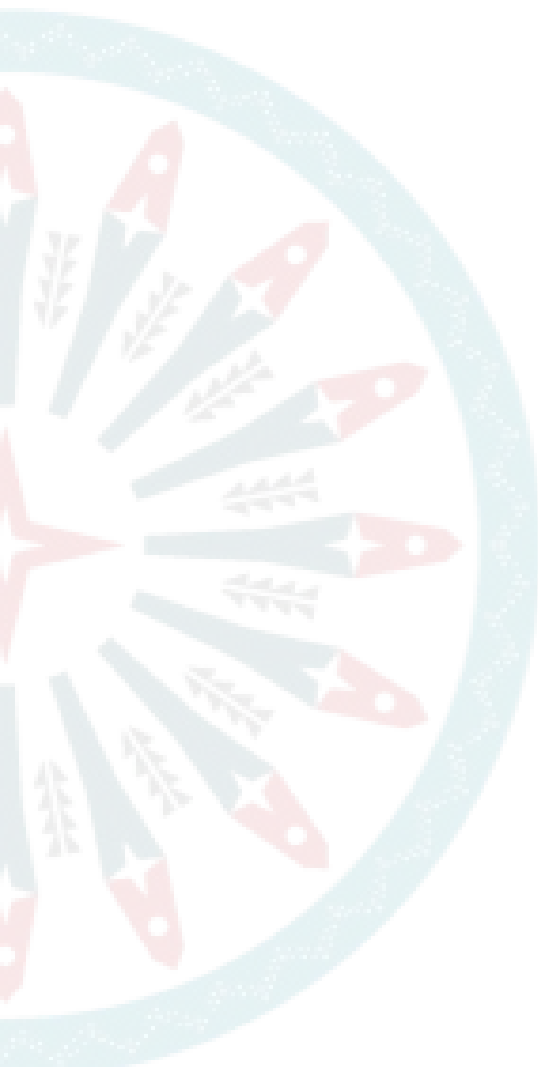
During sex do you use condoms?

- All the time: You are done !!!!
- Sometimes: Go to next question
- Never: Go to next question

How many sexual partners do you have

- One partner and they know their HIV status to be negative: You are done!!!
- One or more without knowing their HIV status: NEEDS PrEP Evaluation

What Should the PCP Know about HIV



HIV 101

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Early treatment of newly diagnosed patients

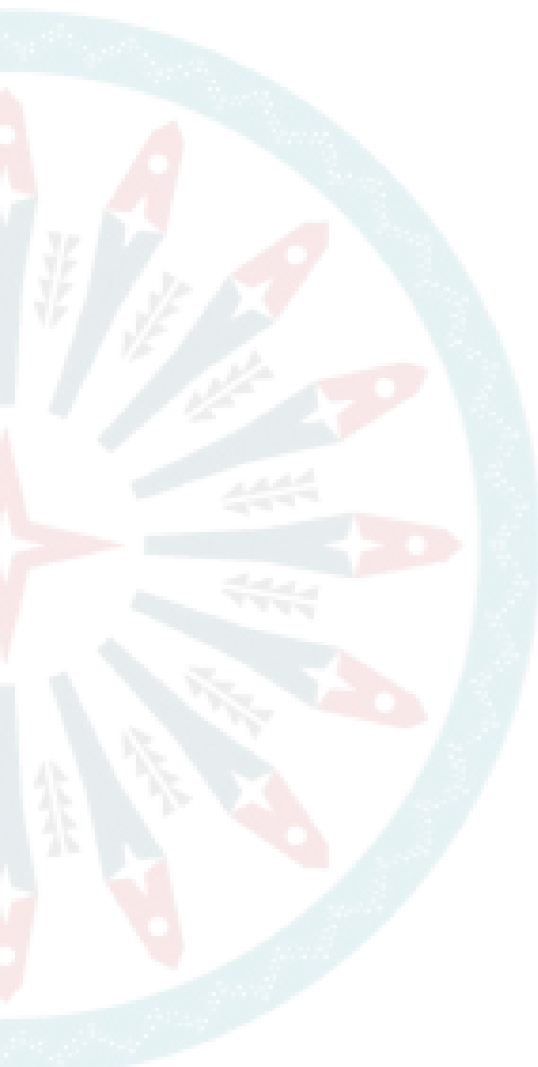
Screening: Our Current Goal



Offer HIV screening to every American Indian and Alaskan Native patient at least once in their life... and more often based on risk.

Screening: Strategies

- 1. Electronic health record reminders**
- 2. Lab triggered screening**
- 3. Community outreach**
 - a) SSP programs
 - b) MAT services
 - c) Food distribution sites
 - d) Mobile Units
 - e) Incarcerated persons



“Reflex Lab-triggered” HCV/HIV Screening

Patient presents to lab for routine/other phlebotomy

- Example: Emergency department visit for pneumonia, sent for CBC and CMP, extra tube drawn for HCV antibody

Process Completed by Hand
(not an automated process)

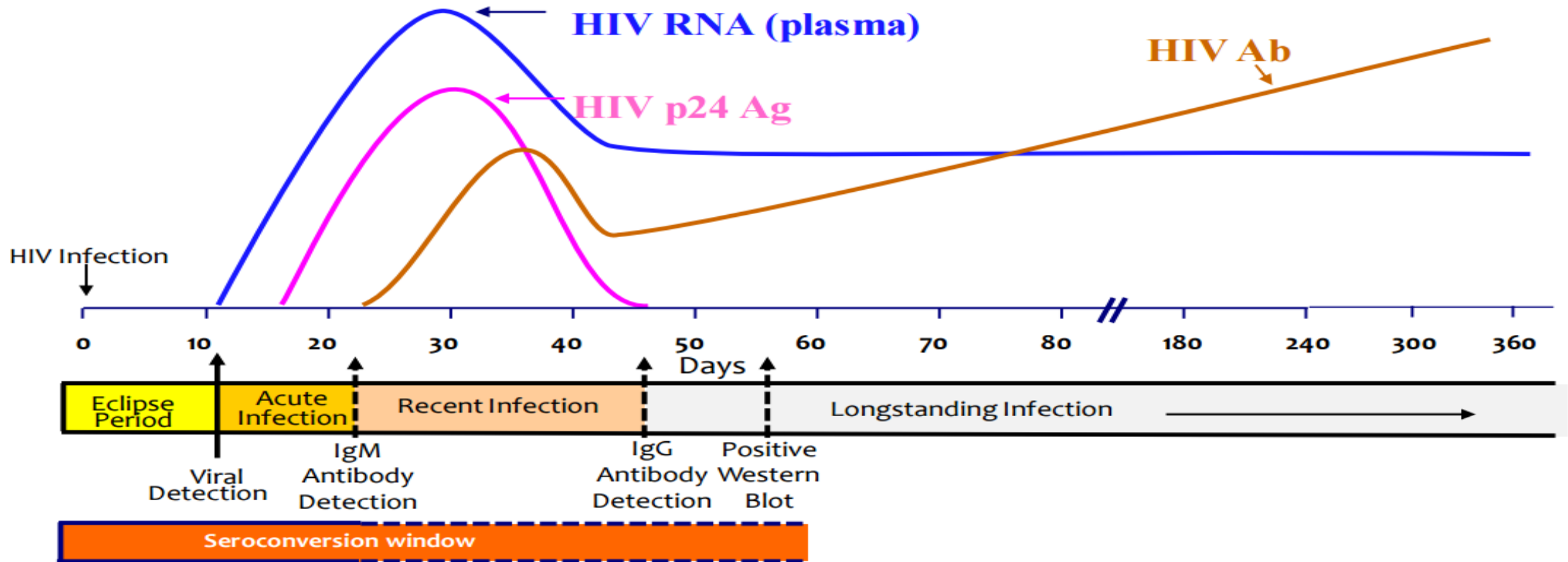
- Results Sent Directly to HCV Program Staff

Order for HIV antibody is added-on post phlebotomy if criteria met for screening

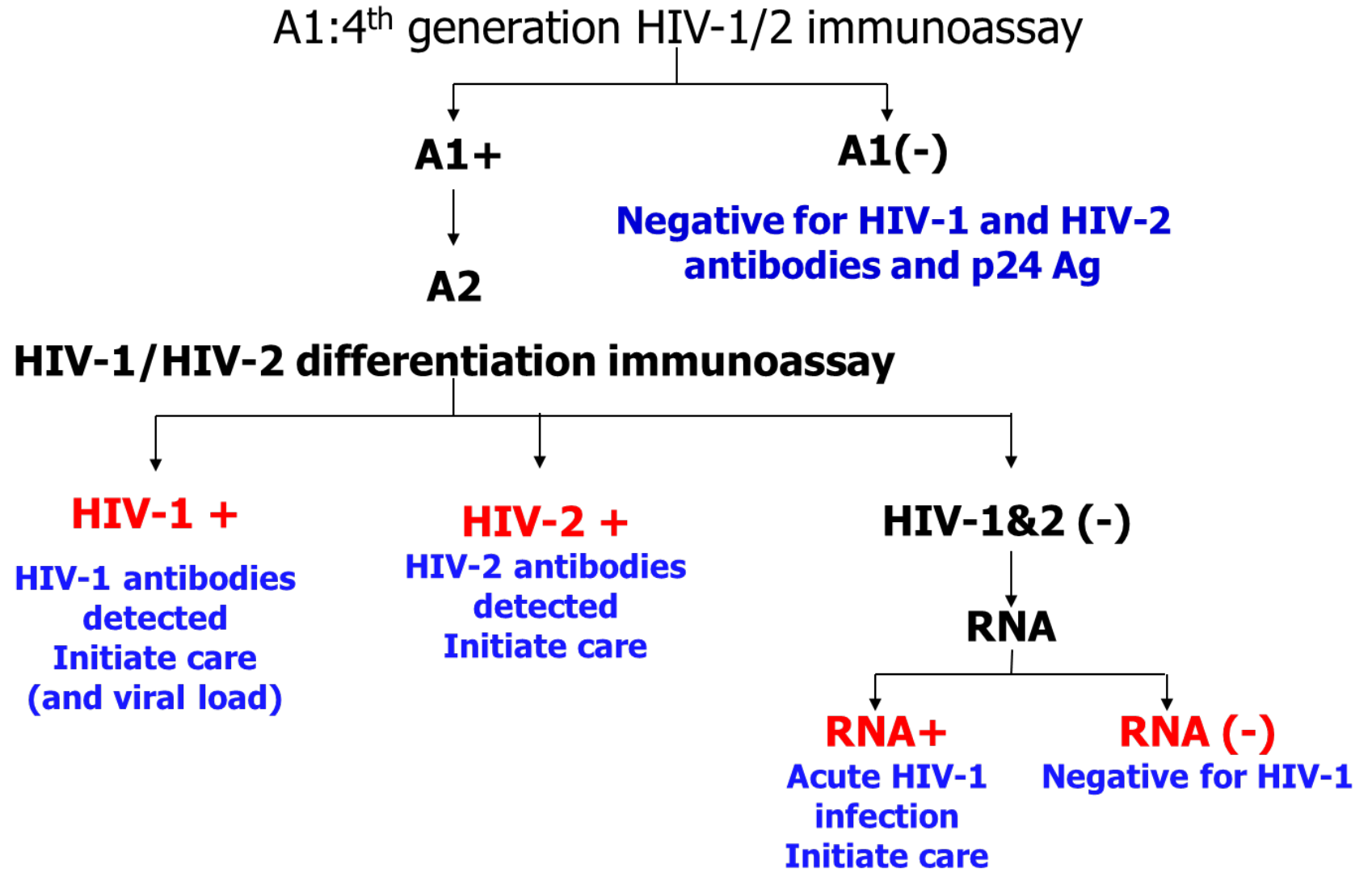
- If screening is due
- If there is signed informed consent in EHR



Interpretation of HIV Testing

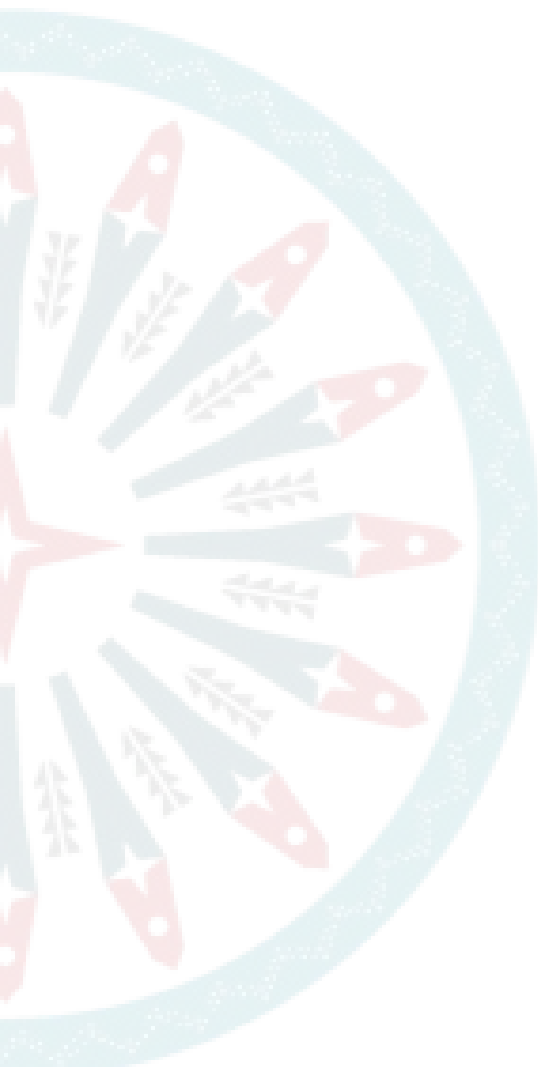


HIV Diagnostic Testing Algorithm: Fourth Generation Test



https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUK EwiFkfak1OT2AhX1lWoFHT3 5B4kQFnoECAMQAQ&url=https%3A%2F%2Fwww.cdc.gov%2Ffactgainst aids%2Fppt%2Fcme-slide-deck.pptx&usg=AOvVaw3_-2UN7vXNDRB4ZoJFJie-

What Should the PCP Know about HIV



HIV 101

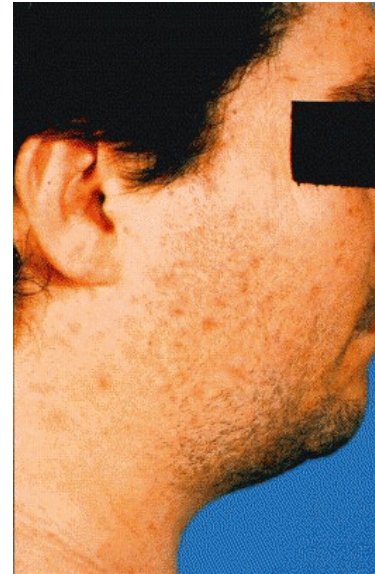
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Early Treatment of Patients Diagnosed with HIV

- **Asymptomatic patient screened positive**
- **Symptomatic patient**
 - **Lymphadenopathy**
 - Cervical
 - Epitrochlear
 - **Oral Hairy Leukoplakia**
 - **Oral Thrush**
 - **Splenomegaly**
 - **Rashes**
 - Acute HIV rash
 - Syphilis



What tests would you order?

CD4, viral load and HIV Resistance panel

- Genotypic or phenotypic

CBC w/ differential and a Comprehensive metabolic panel

HLA B* 5701

- Screening for Abacavir hypersensitivity

Hepatitis panel (hepatitis A, B, C)

- Other serologies such as Toxoplasmosis, Cytomegalovirus, Varicella/Zoster

Screening for other sexually transmitted infections (STIs):

- Oral, rectal, urethral GC and urethral CT as indicated

PPD at entry into care

- Treatment of LTBI warranted for:
- ≥ 5 mm of induration on PPD

Chest X ray

Antiretroviral Therapy

Recommended for all HIV-positive people

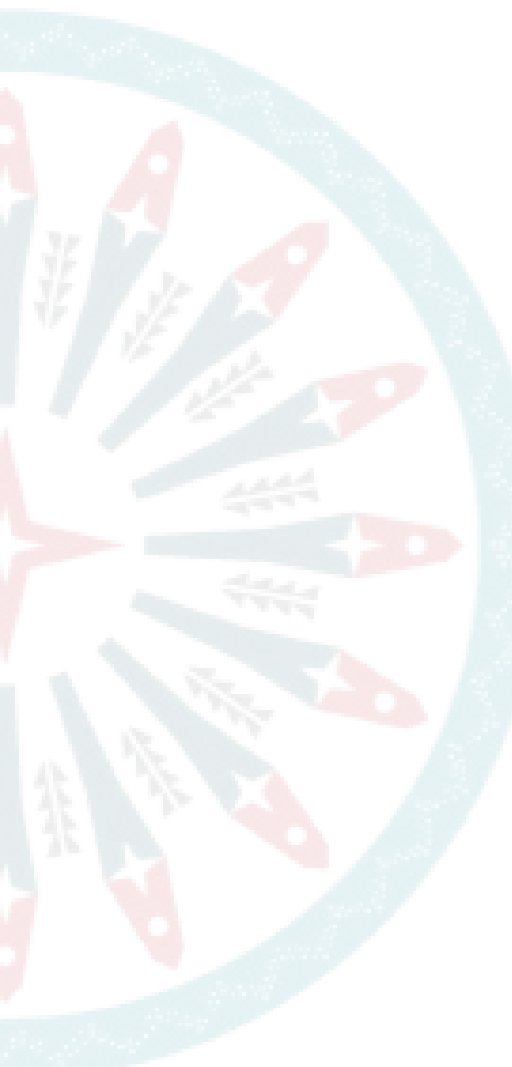
- To prevent disease progression
- To prevent transmission of HIV: **U = U**
 - **Undetectable = Untransmissible**

Goals of Therapy

- Durable suppression of HIV viral load to less than 50 copies/mL
- Restoration of immune function (as indicated by the CD4 cell count)
- Prevention of drug resistance
- **Improvement in quality of life**

See *Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents*: aidsinfo.nih.gov

The Panel on Antiretroviral Guidelines for Adults and Adolescents classifies the following regimens as Recommended Initial Regimens for Most People with HIV (in alphabetical order):

- 
- Bictegravir/tenofovir alafenamide/emtricitabine (AI)
 - Dolutegravir/abacavir/lamivudine—only for individuals who are HLA-B*5701 negative and without chronic hepatitis B virus (HBV) coinfection (AI)
 - Dolutegravir plus (emtricitabine or lamivudine) plus (tenofovir alafenamide [TAF] or tenofovir disoproxil fumarate [TDF])b (AI)
 - Dolutegravir/lamivudine (AI)—except for individuals with HIV RNA >500,000 copies/mL, HBV coinfection, or when ART is to be started before the results of HIV genotypic resistance testing for reverse transcriptase or HBV testing are available.

Health Care Maintenance



Tobacco cessation is critical

Cancer Screening

- Pap smears
 - Cervical Every 6 months initially, then yearly if negative and anal Pap for males (MSM) and females
- Breast, Lung, prostate, colorectal cancer screening, etc. (same as for HIV (-) people)

Cardiovascular Risk Assessment

- Check baseline lipids before treatment and periodically after initiation of treatment
- Calculate CVC risk

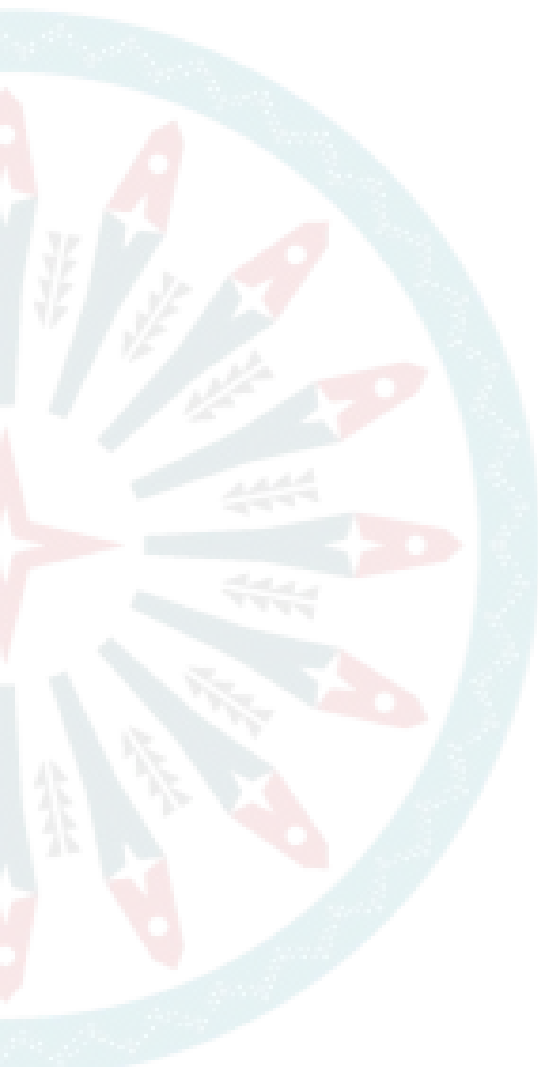
Vaccines

- Hepatitis A, hepatitis B (if not immune), Pneumococcal, Influenza every year, Tdap, Meningococcal, VZV, COVID-19

Behavioral Health Evaluation

- Screen and treat for anxiety, depression, PTSD and substance use disorder

Four Pillars of Ending the HIV Epidemic in the US

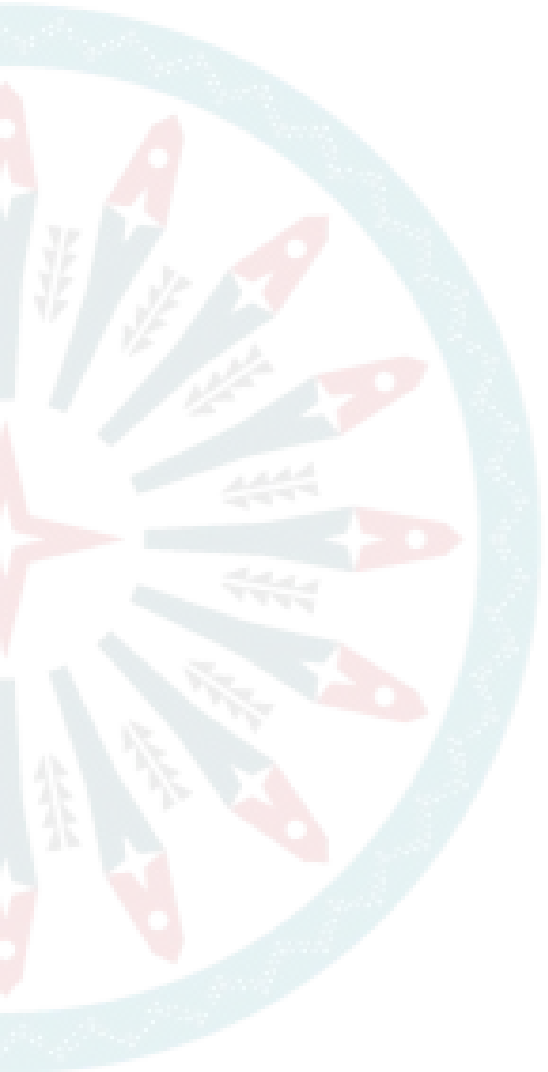


The efforts will focus on four key strategies that together can end the HIV epidemic in the U.S.

1. Diagnose all people with HIV as early as possible.
2. Treat people with HIV rapidly and effectively to reach sustained viral suppression.
3. Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
4. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Outline

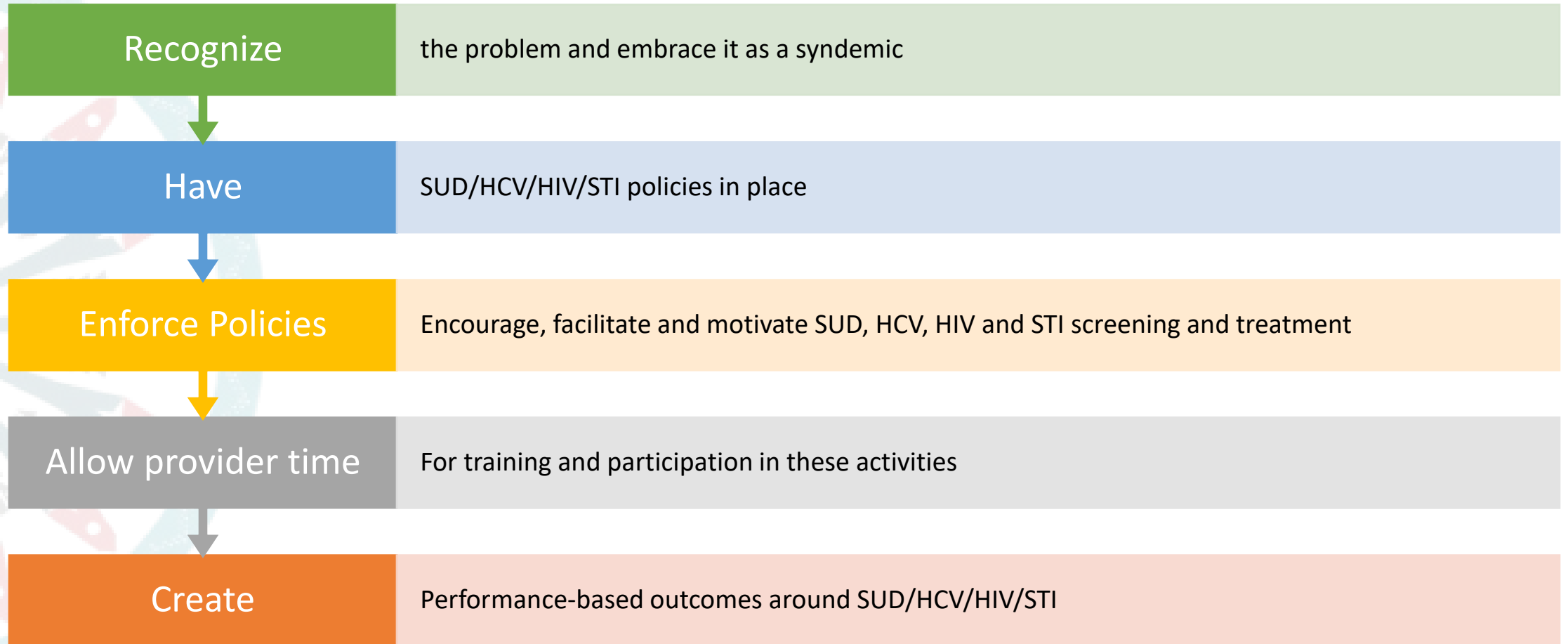
- **Clinical Case**
- **The SUD | HCV | HIV | STI Syndemic**
 - Example: Scott County, Indiana
- **The SUD | HCV | HIV | STI Syndemic in Indian Country**
- **What Should the PCP Know about HIV**
- **Interventions to Mitigate the Syndemic:**
 - **Societal (Macro), Health System (Micro), Health Professional (Individual)**
- **Conclusions**



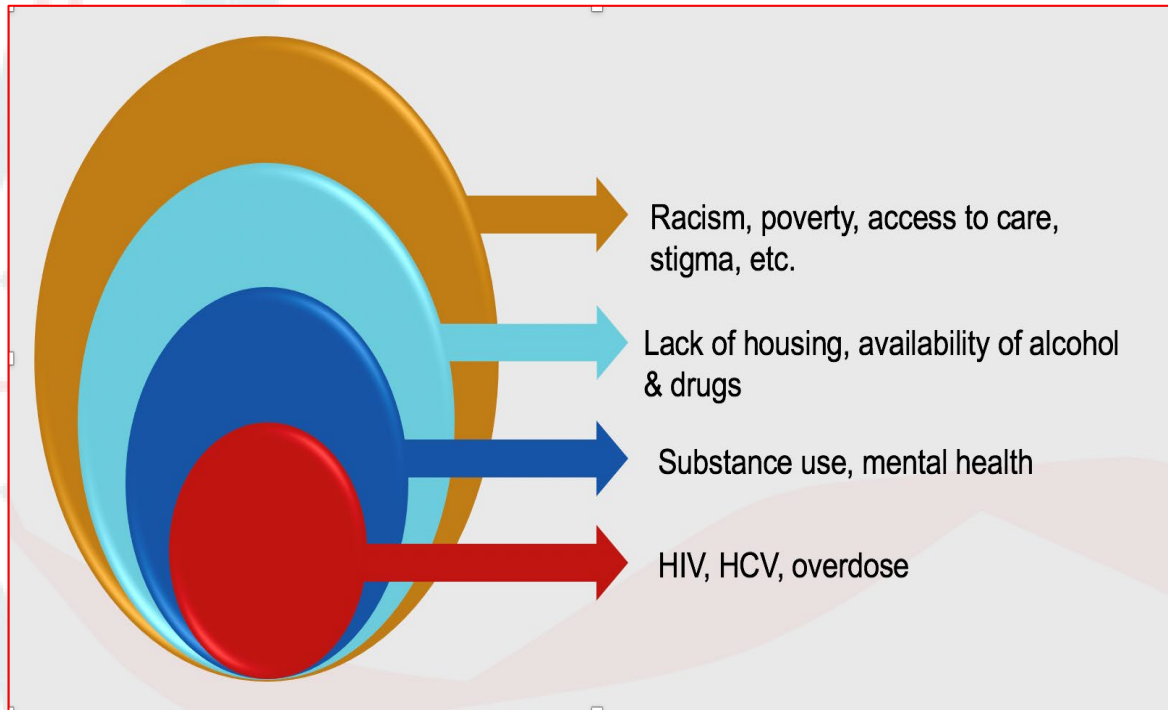
Clinical Case: Mr. S

- **Mr. S** is a 24-year-old American Indian/Alaskan Native (I/AN) male who suffered a right femur fracture (MVA) **6 years ago**. **Unfortunately, pain management training or policies were not available** in the institution, and he was discharge from the hospital with oxycodone hydrochloride for pain control.
- **Two years ago**, his new medical provider refused to refill the oxycodone. **Unfortunately, the provider was not trained in screening for substance use disorders (SUDs) nor did he have an MAT waiver**. The patient then turned to his friends who gave him oxycodone, but later he had to purchase it in the streets.
- **One year ago, he started injecting heroin** since it was cheaper. **Unfortunately syringe service programs are not available** where he lives, and he has been sharing needles and syringes.
- **Three days ago**, he presented to the Emergency Department (ED) with opioid withdrawal symptoms (Nausea, vomiting, diarrhea, restlessness, abdominal pain). **Fortunately, the ED medical provider was trained in SUD management** and induced him with Buprenorphine/Naloxone and gave him a 3-day prescription, enough until he could be evaluated and placed on Medication Assisted Treatment (MAT). **In addition, the provider was also trained in screening for STIs, HCV, HIV, and HIV PrEP**, during the ED visit he was screened and tested positive for HIV. HCV and other STIs screens were negative and was referred to the Pirmary Care clinic for HIV evaluation and treatment.

What can Leadership in the Health System do for Mr. S



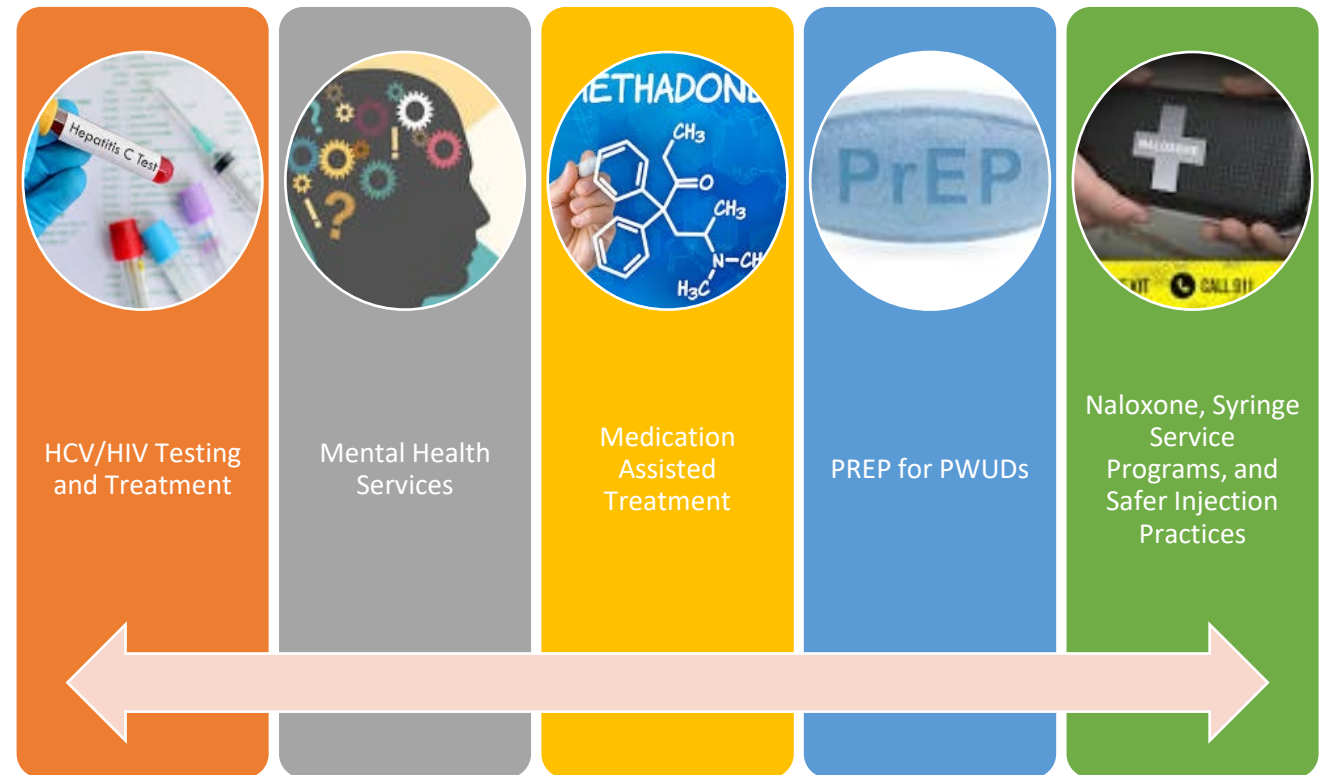
What Can Society Do For Mr. S?



- Addressing the root of the problem is critical for the elimination of present SUD/HCV/HIV/STI syndemic and the prevention of future ones
- A coordinated approach between society, government, public health will be needed

What can the Healthcare Worker do for Mr. S?

- Vaccinate him for hepatitis A and B
- Have an MAT license and continue buprenorphine/naloxone
- Be comfortable prescribing HIV treatment; if Mr S. was negative for HIV, be comfortable prescribing HIV PrEP
- Be comfortable prescribing HCV treatment if Mr S. was positive for HCV
- Educate your patient on safe injection practices
- Refer to or advocate for Syringe Service Programs



Recognize and Understand

The HIV disparities in racial and ethnic minorities are not only driven by behavior

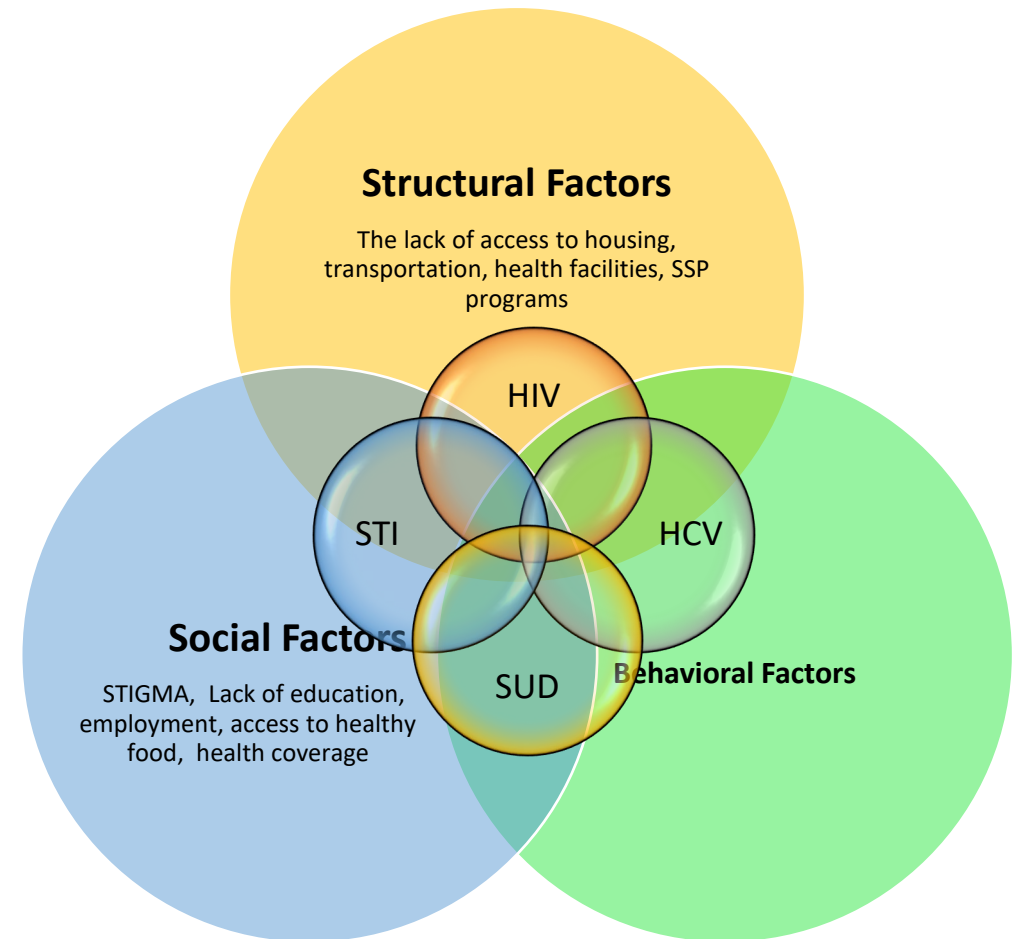
- Structural and Socioeconomic factors play a major role

When people are unable to seek or receive care because of socioeconomic barriers

- Treatable diseases, like syphilis, HIV or HCV, persist at higher rates.
- With a higher baseline rate of transmissible infections, it is more likely that those in the community will be exposed to the infection.

Respond to HIV, STIs, HCV and SUD

- By ensuring that the resources go to the communities in highest need in a timely and efficient way.



Conclusions

Ending the HIV/SUD/HCV/STI epidemics will be difficult if not embraced as a syndemic

- Structural, Social and Behavioral factors need to be addressed

Ending the SUD/HCV/HIV/STI HIV/HCV/SUD syndemic will require a multipronged approach

- Political will and leadership support are essential
- SUD services should be integrated into primary care and barriers for harm reduction services should be removed
- The efficacy of PrEP and HIV treatment has been established, access to the most vulnerable populations is critical
- Everyone with HCV mono-infected or Co-infected with HIV should be treated
- Syphilis is taking a toll in AI/AN communities, zero tolerance for congenital syphilis should be the standard of care

Primary care providers should be at the forefront of harm reduction, STI, PrEP, HIV and HCV treatment. If they are not, nobody will.

Resources: Indian Country ECHO



People need access to quality care for their complex health conditions.



There aren't enough specialists in Indian Country for everyone who needs care.



Indian Country ECHO trains clinicians to provide high quality care.

Patients get the right care, in the right place, at the right time. This improves outcomes.



Clinicians are connected to a learning community of peers and experts.



Resources: Indian Country ECHO

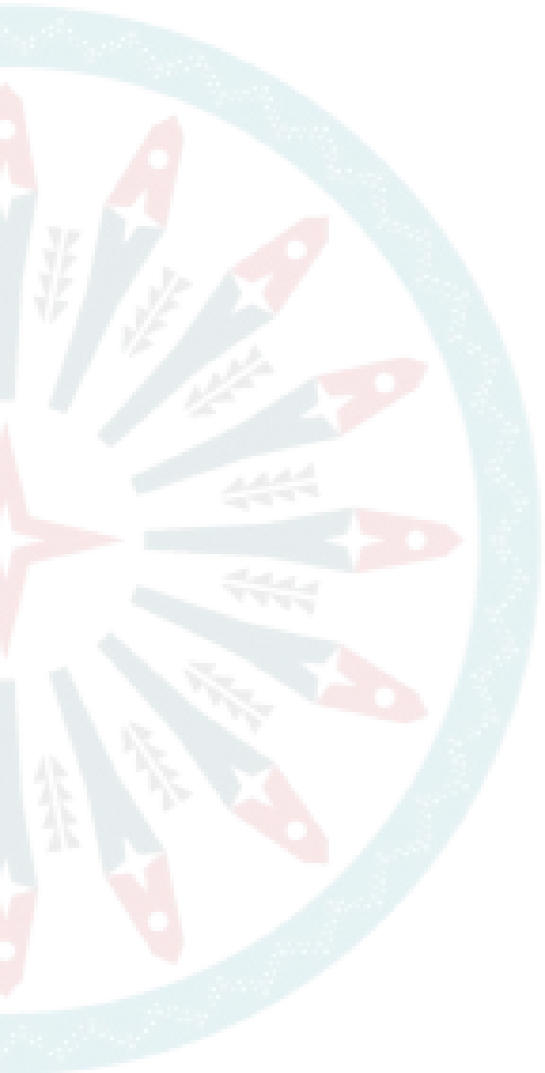
DESIGNED FOR

I/T/U clinicians and staff serving American Indian and Alaska Native people throughout Indian Country, and all those who are interested in providing high quality care to patients with infectious diseases are invited to attend.

DESCRIPTION

Each month, ECHO offers an ECHO session with infectious disease experts focusing on the latest emerging topics, including the screening, management and treatment of patients with infectious diseases. The 1-hour long clinics include an opportunity to present cases, receive recommendations from specialists and peers, engage in a didactic session and become part of a learning community. Together, we will manage patient cases so that every patient gets the care that they need.

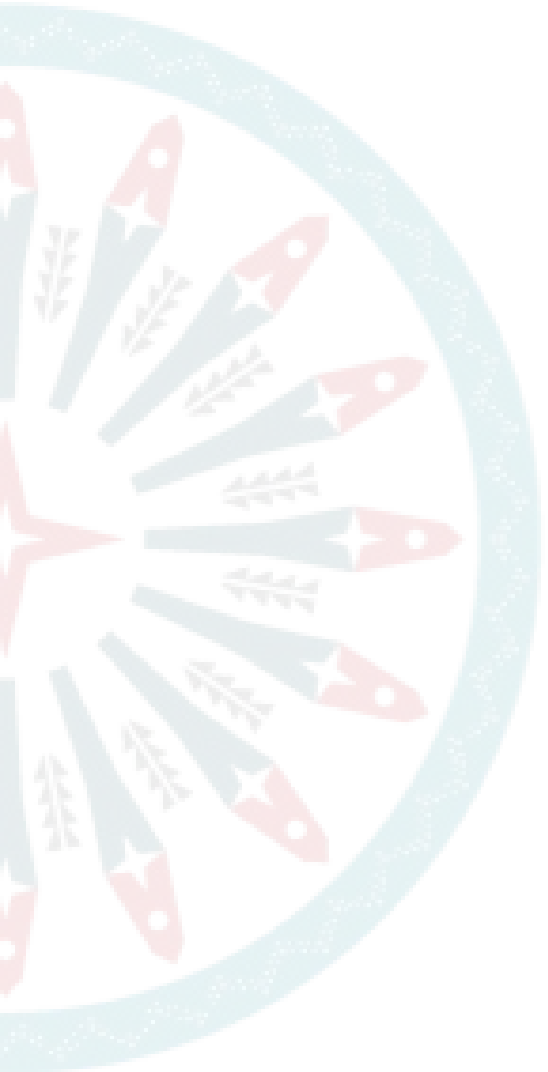
TO LEARN MORE, VISIT: [HTTPS://WWW.INDIANCOUNTRYECHO.ORG](https://www.indiancountryecho.org)



Questions?

Thank You
G&V (Wado)

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