



AIDS Line

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Save the Date

**HIV Clinical Update
June 10, 2010
Woodbridge, NJ**

(See back cover for more information.)

NJ Ryan White Cross-Part Quality Collaborative Update: PCP and MAC Prophylaxis Lag; STI Screening Improves

*Jane Caruso, MS; NJ Department of Health and Senior Services, Division of HIV/AIDS Services
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The New Jersey Cross Part Collaborative (NJ CPC) has been collecting statewide data on HIV care provided by 40 agencies that provide medical care to HIV patients with Ryan White dollars. All 40 agencies are actively participating in the NJCPC, in a coordinated planning and quality improvement process. The NJCPC has been tracking five medical indicators of HIV care since January 1, 2009. Data are collected every other month, and include a rolling 12 months of information.

Four quality indicators were assigned to the state of NJ by the HRSA HIV/AIDS Bureau (HRSA):

- 1) Two CD4+ tests per year,
- 2) HAART for all patients with AIDS,
- 3) Two HIV medical care visits per year, and
- 4) PCP prophylaxis for all patients with CD4+ level <200.

The fifth indicator, **SYPHILIS SCREENING**, was chosen by the New Jersey Cross Part Collaborative Team as the quality measure which was at highest immediate need of improvement for the state's HIV programs. In the first three quarters of the year, syphilis screening was the primary focus of NJCPC efforts. However, in the process of collecting and analyzing data from this period, it became apparent that PCP prophylaxis lagged far behind the goals, with 52% of patients with CD4+ level <200 recorded as receiving prophylaxis.

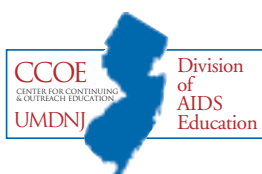
Syphilis Screening: Improvement Well Under Way

INITIAL DATA DEPICTED A STATEWIDE SYPHILIS SCREENING RATE OF 61%.

- The NJCPC set an INTERIM GOAL – **By February 28, 2010, the State of New Jersey will realize a 75% rate for Syphilis screens.** This will be a significant improvement toward the Institute for Healthcare Improvement (IHI) **goal of 90% adherence.**

The first 3 two-month cycles showed stable data, with very little improvement or decline. Cycles 3 through 6 have shown a small upward trend, with a high of 71 percent.

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NJ Ryan White Cross-Part Quality Collaborative Update

(Continued from front page)

The New Jersey Cross Part Collaborative (NJ CPC) has been collecting statewide data on HIV care provided by 40 agencies that provide medical care to HIV patients with Ryan White dollars.

All 40 agencies were asked to submit plans for improving syphilis screening rates. A sample work plan was developed by the NJ CPC Team and distributed to all agencies. Agencies could write their own improvement plan, or use the CPC Team plan as a guide. Agencies began their improvement plans at different times in 2009. Some agencies were able to design and implement PDSA cycles immediately, and other agencies need several more months to craft their projects. Technical assistance through the CPC Team is available to any agency struggling to develop a method for improvement.

PILOT PROJECTS

Two agencies were able to implement PDSA cycles very quickly, and these pilot projects were very successful.



In both of the pilot projects, the new procedures were adopted as their standard of care, and improvements have been maintained.

At the Robert Wood Johnson Medical School in New Brunswick, the initial syphilis screening rate was 25%. Syphilis screening was not routinely ordered by the clinical staff, and it was not a noted priority in annual laboratory assessments.

- To bring the screening to the forefront and promote better screening rates, the RWJ clinic contacted Labcorp to **modify the order forms for blood work**. Syphilis screens were then added to the preprinted list of available tests.
- In addition, **staff education** was conducted so that all clinicians were aware of the additional test available to them on the order form, and were also aware of the need to screen all patients 18 years of age and older for syphilis.
- With the use of the new order form, **syphilis screening rates rose quickly to 53%** and have been rising steadily since their PDSA cycle was implemented.

A second very successful improvement project was implemented at Cooper Hospital in Camden, NJ. The initial syphilis screening rate was 58%. Physicians were not routinely requesting the screen from the phlebotomist.

- The Quality Team at Cooper Hospital decided to make the process simpler for the physician by **generating an electronic list of patients** who were in need of a syphilis screen. As these patients arrived in the clinic, the physician was prompted to request the screen. Although this PDSA cycle showed some initial improvement, it was not sustained. Therefore, a second PDSA cycle was implemented.
- In this second test of change, the same list of patients was generated, but it was **submitted directly to the phlebotomist**. The next measure for syphilis screens showed a rate of 88%, closely approaching the desired rate of 90%.

AS THE CROSS PART COLLABORATIVE WORK CONTINUES TO MOVE FORWARD, the CPC Team hears from other agencies regarding new success stories. A summary of resulting Best Practices will be compiled and distributed to agencies that still struggle with a process for improvement. **One goal of working collaboratively across Ryan White Parts is to share successful strategies across the State so that everyone has access to potential modes for improving the quality of care received by patients in NJ.**

NJ Ryan White Cross-Part Quality Collaborative Update



PCP Prophylaxis: How Can We Improve?

One of the four performance indicators assigned by HRSA to the NJ CPC Team was the use of prophylactic medication when a patient's CD4+ count falls below 200, as measured by prescriptions issued.

IN THE 40 HIV CLINICS participating in the NJCPC, the average result for this indicator over the past five cycles has been 52%. There is an anecdotal assumption that the State of NJ provides better prophylactic care to its HIV-positive patients than is indicated by the CPC results. There are several avenues of investigation that must be taken to understand the actual rate of prophylaxis statewide.

WHY IS PROPHYLAXIS LOW?

Is it knowledge?

- It must first be determined if there are providing agencies who do not understand or are not aware of the need to provide prophylaxis to patients with low CD4+ counts.
- If this is an actual lack of understanding, then technical assistance and educational interventions are available.
- The article in this issue of *NJ AIDSLine* is one resource to help clinicians and administrators understand the need and the guidelines for interventions to prevent and treat PCP among their HIV patients.

Is it in data collection and entry?

- Second, it is possible that the process of moving information from the medical chart into the electronic database is not diligent, and therefore a gap is created between actual prescriptions and documented prescriptions.
- Additionally, it is possible that prophylactic information is entered into databases, but not in a fashion where it can be correctly abstracted.
- There has been much discussion throughout the CPC effort in New Jersey regarding agencies where data managers are not employed, or are employed only part time. It is not uncommon to see providers of care, including nursing and case management staff, directly responsible for the input and output of electronic data.
- Complicating this issue further is the need to for some agencies to enter the same data into several different databases if the agency is funded by multiple sources, and each funder has different reporting requirements.

It must FIRST BE DETERMINED if there are providing agencies who do not understand or are not aware of the need to provide prophylaxis to patients with low CD4+ counts.

NJ Ryan White Cross-Part Quality Collaborative Update

(Continued from page 23)

Next step:

Development of PCP prophylaxis improvement plans

It will take a focused and dedicated effort to identify the underlying causes of low prophylaxis rates at each agency that is experiencing them.

WHY IS PROPHYLAXIS LOW? (Continued)

Is it a gap in the provision of care?

- The rates of PCP have declined over the last decade with the widespread use of HAART. However, **AIDS patients continue to develop PCP**, and HIV care providers must examine how they can reduce incidence of this opportunistic infection.
- HRSA found that **in 2002 only 70% of patients with CD4+ levels <200 received PCP prophylaxis, compared to 80% in 1997**. In New Jersey, the finding of 52% reported prophylaxis raises concerns that there are gaps in care that each program needs to examine and address.
- Some providers explain the lack of prophylaxis as due to **patients who do not adhere to care appointments**. However, data reported to this project was for active patients.

THE IMPROVEMENT PROCESS FOR THIS INTERVENTION, like the other performance measures, begins with awareness and education, and may require:

- Increased and targeted tracking methods
- Revision of clinic protocols and algorithms for care, and
- Teamwork toward the goal of 95% adherence as set by the Institute for Healthcare Improvement (IHI) and the HRSA-HAB national benchmarks.

This goal matches the Healthy People 2010 goal set by the CDC.

- In some agencies, the provision of care may need improvement, and in other agencies the improvement needed may be primarily in data entry and reporting.
- Education and reference materials are readily available to address knowledge deficits.
- If there are data collection and entry problems, then program staff will need to improve their methods of training and staffing for data entry, maintenance, and retrieval.
- As these root causes are identified, the CPC Team is available to help agencies strategize and move towards improvement.

QUALITY MANAGEMENT RESOURCES FOR RYAN WHITE PROGRAMS

HAB/NQC Cross-Part Quality Management Collaborative

New Jersey: Jane Caruso, MS, Ryan White Part D Project Director
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US: National Quality Center website:

<http://nationalqualitycenter.org/index.cfm/5847/19344>

HRSA: Health Resources and Services Administration of the US Department of Health and Human Services: <http://www.hrsa.gov>

HAB: HIV/AIDS Bureau of HRSA: <http://hab.hrsa.gov>

TARGET CENTER:

<http://www.careacttarget.org>

National Quality Center A quality improvement initiative funded through a cooperative agreement with the HRSA HIV/AIDS Bureau
<http://www.nationalqualitycenter.org>

Quality Indicators And Goals For Sexually Transmitted Disease Screening And Treatment

Sexually Transmitted Diseases: Centers for Disease Control and Prevention: <http://www.cdc.gov/std>

Annual STD Report for Fiscal Year 2008: <http://www.cdc.gov/nchhstp/docs/NCHHSTP-Annual-Report-508c.pdf>

Syphilis: <http://www.cdc.gov/std/syphilis>

PDSA

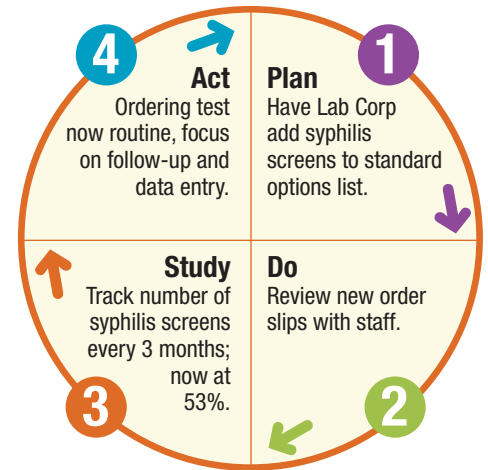
The New Jersey Cross Part Collaborative (NJ CPC) is using the **PDSA (Plan-Do-Study-Act)** process to address the challenges of meeting the goals set by HRSA-HAB. Each site developed goal-specific plans to identify barriers and improve their rate of adherence to the goal.

Robert Wood Johnson Medical Center: Improving syphilis screening rate

Problem Statement: Annual syphilis screening rate for women over 18 is 25%. The clinic's custom Lab Corp form does not list a syphilis test.

Goal: Improve syphilis screening rate to 80%.

Target patients: All HIV+, age 18+

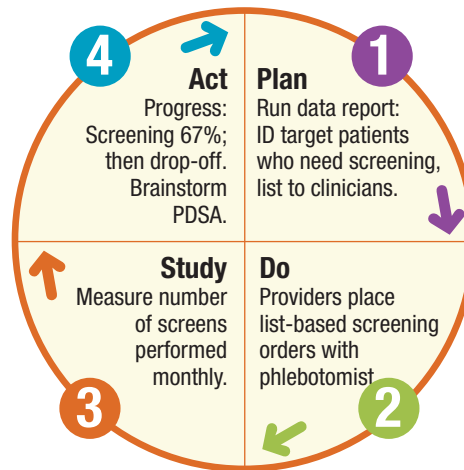


Cooper Medical Center Early Intervention Program (EIP) Improving syphilis screening rate

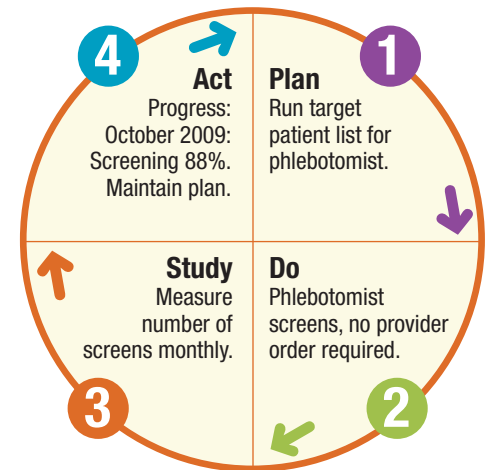
Problem Statement: Initial annual syphilis testing rate is 58%. Data seems inaccurate to staff.

Goal: 95% of EIP patients will receive a syphilis screen during the measurement year.

Target patients: All HIV+, age 18+



CYCLE ONE



CYCLE TWO

The Chandler Clinic was very concerned when they saw a report of their low PCP prophylaxis rates.

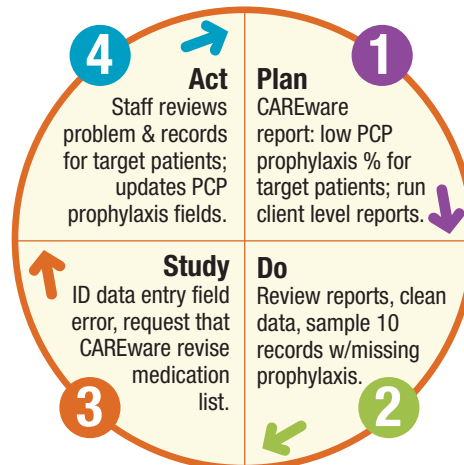
The initial patient list they generated had many errors including inactive patients, and CAREware software did not identify PCP prophylaxis clearly. Nurses trained support staff to understand the significance of prophylaxis and also took a larger role in tracking this patient group including verifying prophylaxis prescriptions. Once inaccurate data was removed, nurses increased targeted outreach to patients who needed hands-on attention to initiate and complete prophylaxis. The data and follow-up changes led to a rise from 40% to 96% PCP prophylaxis in less than a year.

Problem Statement: PCP prophylaxis rates are at 40%, vs. the IHI/HRSA standard of 95%.

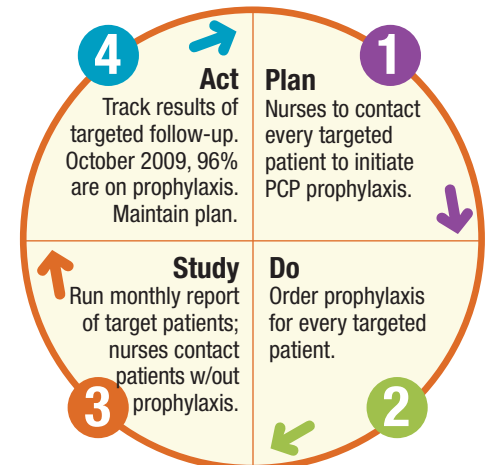
Goal: Investigate data entry/data management errors and address findings.

Target patients: All HIV+, CD4+ <200

Eric B. Chandler Clinic: Improving PCP Prophylaxis



CYCLE ONE



CYCLE TWO

Medication Errors Associated with Antiretroviral Therapy

John J. Faragon, PharmD, BCPS, AAHIVE



BRIEF OVERVIEW

Initial choice of regimens for the treatment of HIV infection in the United States is driven by evidence-based guidelines from the U.S.

Department of Health and Human Services. Current treatment guidelines recommend the use of a ritonavir-boosted protease inhibitor (PI) or a nonnucleoside analogue reverse transcriptase inhibitor (NNRTI) in combination with 2 nucleoside analogue reverse transcriptase inhibitors (NRTIs) for initial treatment.¹ Despite these guidelines for HIV treatment, published studies and case reports continue to alert clinicians to potential medication errors associated with HIV therapy.²⁻¹⁵ This article will focus on types of medication errors and methods of preventing their occurrence.

Types of Medication Errors

Medication prescribing errors associated with HIV therapy have been previously described and can involve:

- the wrong drug due to look-a-like and sound-a-like medications,
- wrong dose or dosing frequency, and
- using drugs together that lead to drug interactions.

Table 2 lists common types of medication errors found in HIV treatment, and several examples of these errors.



Wrong drug

- Name confusion is common in HIV, given that many of the medications used to treat HIV have names that are either similar to other HIV medications or similar to medications used for other conditions or co-morbidities.
 - The **name confusion** has been described in case reports and include examples such as: zidovudine and Zovirax, Viamune and Viracept, nevirapine and nelfinavir, lamivudine and lamotrigine, lexiva and levitra, and more recently, Isentress and Intelence.⁹⁻¹⁵
 - Since many providers may call in prescriptions to pharmacies, it is important for pharmacies and providers to **“read back” prescriptions** when taking verbal orders.
 - Providers may also consider **avoiding three letter abbreviations**, and instead write the full brand and generic names on all prescriptions to avoid confusion with sound-a-like and look-a-like medications.

In one study, overdoses and underdoses of HIV medications occurred in 82% of errors reported.²

Overdose and Underdose

- Perhaps the most concerning medication prescribing error that occurs in HIV treatment involves dosing of HIV medications. In one study, overdoses and underdoses of HIV medications occurred in 82% of errors reported.²
- The reason why these dosing errors occur are numerous, however, failing to dose-adjust medications in the setting of end organ damage is a common cause for overdoses.^{2,4,5,7} Most nucleoside reverse transcriptase inhibitors require dosage adjustment in renal impairment; some protease inhibitors require dosage adjustments in hepatic disease. However, if the dosage or dosage interval is not adjusted in the setting of renal or hepatic impairment, the patient is likely to experience increased toxicity from the HIV medication.
- Similarly, when a patient’s renal or hepatic function improves after an acute illness, providers may need to increase dosages back to normal once the acute issue resolves.
- It is important that pharmacists and other health care providers familiarize themselves with dosing adjustments required in renal and or hepatic impairment, and follow those guidelines when patients are filling their prescriptions.¹ Though less commonly reported, underdoses are also concerning since they may lead to drug resistance and can lead to a negative effect on patient care.

Medication Errors Associated with Antiretroviral Therapy

Drug Interactions

SINCE THE ARRAY OF HIV MEDICATIONS HAS EXPANDED to include protease inhibitors, non-nucleoside reverse transcriptase inhibitors, and the CCR5 inhibitor Maraviroc, and other inhibitors, inducers, or substrates of CYP450, drug interactions have become more likely when combining any of these with other HIV medications or medications used to manage co-morbid conditions.^{1,15}

- Though some medications may be considered contraindicated when used with certain HIV medications, others may simply require a dosage adjustment. For example, when using atazanavir/ritonavir with efavirenz, the recommended dosage for atazanavir needs to be increased from 300mg daily to 400mg daily in combination with ritonavir 100mg.¹⁷

- Some drug interactions can be managed by simply using a different medication. For example, drug levels of the statin medications lovastatin and simvastatin are significantly increased by protease inhibitors and can lead to toxicity including rhabdomyolysis and acute renal failure.^{1,16,18-21}
- As a result, providers may choose to use other statin medications that are less likely to interact, such as pravastatin or atorvastatin.^{1,21} In order to prevent this type of error, HIV care providers and pharmacists need to be aware of potential drug interactions associated with HIV medications, be able to predict drug interactions in the absence of data, and to develop practice-based strategies for preventing their occurrence.

Table 1.
Recommended Components of Initial Antiretroviral Therapy per DHHS Guidelines November 2008

Error Type	Example
Nucleoside Reverse Transcriptase Inhibitor (NRTI)	Tenofovir/Emtricitabine Use of abbreviations
Nonnucleoside Reverse Transcriptase Inhibitor	Efavirenz
Protease Inhibitor	Lopinavir/ritonavir (Once or Twice Daily) Atazanavir/ritonavir Fosamprenavir/ritonavir (Twice Daily) Darunavir/ritonavir (Once Daily)

Table 2.
Examples of Common Medication Errors in HIV

Error Type	Example
Wrong drug	Sound-a-like or look-a-like medications Use of abbreviations
Wrong dose	Overdose Underdose Failing to adjust dosage or frequency due to renal or hepatic impairment
Drug Interactions	Drug-Drug Interactions Drug-Food Interactions Drug-Herbal Interactions

Medication Error Prevention

The most important strategy to prevent medication errors is education.

- Providing periodic updates on HIV regimens for all members of the health care team, including training house-staff, is crucial to avoiding medication errors.
- Some data also suggests that pharmacists working in the hospital setting may help to prevent errors by providing medication and dosing reviews, and writing pharmacy progress notes when HIV infected patients are admitted to the hospital.^{7,22}
- The use of standardized order sheets required for prescribing of ARV medications in the hospital setting may also reduce medication errors.²³
- Finally, the use of accurate internet sources and other technology resources such as Blackberrys and i-Phones may also be helpful for obtaining up to date information on HIV medication dosing, side effects, and drug interactions that are essential for successful care of HIV infection.^{24,25}

Table 3.
Select Medications to Avoid with Protease Inhibitor-Containing Antiretroviral Regimens

DRUG	INTERACTION
Ergot alkaloids	Increased risk of ergotamine toxicity.
Simvastatin Lovastatin	HMG-CoA reductase inhibitor levels markedly increased.
Phenytoin Carbamazepine Phenobarbital	Potential for increased protease inhibitor metabolism leading to virologic failure.
Midazolam Triazolam	Potential for prolonged or increased sedation or respiratory depression.
St John's wort	Substantial decrease in protease inhibitor levels
Rifampin	Substantial decrease in protease inhibitor concentrations
Amiodarone Propafenone Bepridil Quinidine Flecainide	Potential for increased risk of severe cardiac arrhythmias with concurrent ritonavir use
Proton Pump Inhibitors	Substantial reductions in atazanavir plasma concentrations

Adapted from US Department of Health and Human Services, 2008.¹

CONCLUSION

Medication errors are often preventable in the setting of HIV care. With proper education, experience and ongoing training, they can be avoided. Providers are encouraged to identify medication error trends in their own hospital or clinic setting to be sure their entire team remains up to date on HIV medications.

REFERENCES

- Department of Health and Human Services. Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents (Revised November 3, 2008). <http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf>. Accessed October 20, 2009.
- Purdy BD, Raymond AM, Lesar TS. Antiretroviral prescribing errors in hospitalized patients. *Ann Pharmacother*. 2000;34:833-838.
- Edelstein H, Wilson M. Antiretroviral medication errors were universal in hospitalized HIV-seropositive patients at a teaching hospital. *J Acquir Immune Defic Syndr*. 2001;28:496.
- Gray J, Hicks RW, Hutchings C, et al. Antiretroviral medication errors in a national medication error database. *AIDS Patient Care and STDs*. 2005; 19:803-812
- Rastegar DA, Knight AM, Monolakis JS, et al. Antiretroviral medication errors among hospitalized patients with HIV infection. *Clin Infect Dis*. 2006;43:933-938.
- Willig JH, Westfall AO, Allison J, et al. Nucleoside reverse transcriptase inhibitor dosing errors in an outpatient HIV clinic in the electronic medical record era. *Clin Infect Dis*. 2007;45:658-661.
- Heelon M, Skiest D, Tereso G, et al. Effect of a clinical pharmacist's interventions on duration of antiretroviral-related errors in hospitalized patients. *Am J Health Syst Pharm*. 2007; 64:2064-8.
- Pastakia SD, Corbett AH, Raasch RH, Napravnik S, Correll TA. Frequency of HIV-related medication errors and associated risk factors in hospitalized patients. *Ann Pharmacother*. 2008;42:491-97.
- Kakuda TN, Acosta EP, Fletcher CV. Potential confusion with antiretroviral drugs. *Am J Health Syst Pharm*. 1998;55:2639-2640.
- Johnson JT, Dunn EB, Wolfe JJ. Two antiretroviral drugs likely to be confused. *Am J Health Syst Pharm*. 1998;55:1728-1729.
- Max B, Mourikes N. Confusion of nelfinavir and nevirapine. *N Engl J Med*. 1998;338:396-397.
- Raffalli J, Nowakowski J, Wormser GP. "Vira something": a taste of the wrong medicine. *Lancet*. 1997;350:887.
- Cohen MR, Davis NM. AZT is a dangerous abbreviation. *Am Pharm*. 1992;32:26.
- Landis SJ. Azathioprine or azidothymidine. *CMAJ*. 1990;143:611.
- Ambrosini MT, Mandler HD, Wood CA. AZT: zidovudine or azathioprine? *Lancet*. 1992;339:7-18.
- Piscitelli SC, Gallicano KD. Interactions among drugs for HIV and opportunistic infections. *N Engl J Med*. 2001;344:984-996.
- Atazanavir [package insert]. Princeton, NJ: Bristol-Myers Squibb; 2009.
- Cheng CH, Miller C, Lowe C, Pearson VE. Rhabdomyolysis due to probable interaction between simvastatin and ritonavir. *Am J Health Syst Pharm*. 2002;59:728-730.
- Abouafia DM, Johnston R. Simvastatin-induced rhabdomyolysis in an HIV-infected patient with coronary artery disease. *AIDS Patient Care STDS*. 2000;14:13-18.
- Hare CB, Vu MP, Grunfeld C, Lampiris HW. Simvastatin-nelfinavir interaction implicated in rhabdomyolysis and death. *Clin Infect Dis*. 2002;35:e111-e112.
- Fichtenbaum CJ, Gerber JG, Rosenkranz SL, et al. Pharmacokinetic interactions between protease inhibitors and statins in HIV seronegative volunteers: AIDS Clinical Trials Group (ACTG) study A5047. *AIDS*. 2002;16:569-577.
- Segarra-Newnham M. Preventing medication errors with a pharmacy admission note for HIV-positive patients. *Hosp Pharm*. 2002;37:34-37.
- Faragon JJ, Fish DG, Piliero PJ, et al. Development of an antiretroviral prescribing order form in a tertiary care teaching hospital. In: Program and abstracts of the American College of Clinical Pharmacy Meeting; October 20-23, 2002; Albuquerque. Abstract 343.
- Bates DW, Cohen M, Leape LL, et al. Reducing the frequency of errors in medicine using information technology. *J Am Med Inform Assoc*. 2001;8:299-308.
- Bates DW, Teich JM, Lee J, et al. The impact of computerized physician order entry on medication error prevention. *J Am Med Inform Assoc*. 1999;6:313-321.

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DISCLOSURE OF FINANCIAL INTERESTS Dr Faragon has no relevant financial interests to disclose.



Greater Than AIDS: CDC campaign to reduce HIV infection in African-American communities enlists support for prevention, testing, treatment, and community response

Kimi Nakata, MPH, MSW



**The HIV Epidemic Is Real.
We Must Persevere.**



**PREVENTION
TESTING
TREATMENT
Get Involved.**

The Centers for Disease Control and Prevention (CDC), the Department of Health and Human Services and the White House officials launched a new national domestic HIV/AIDS campaign called Act Against AIDS in April 2009.

The Act Against AIDS campaign addresses the disparities in rates of HIV infection and AIDS in gay and bisexual men of all races and African American men and women. Despite more than 25 years of public health awareness campaigns, there has been no reduction in new cases of HIV infection in the United States. International campaigns have expanded their scope and effectiveness in increasing HIV testing and earlier diagnosis, and expanding treatment to a larger proportion of infected individuals.

Americans have ready access to free, confidential HIV testing and to expert HIV care through the Ryan White CARE Act-funded medical and support programs. HIV care professionals have increasingly focused on strategies to increase treatment adherence and continuity in care, with the expectation that antiretroviral treatment and interdisciplinary care can extend life and the quality of life for nearly all of their patients.

However, the HIV/AIDS epidemic continues to expand even as treatment has become more effective and manageable. Public health strategies to bring the epidemic under control have focused on several goals:

- 1) PREVENTION** – Reduce new infections through education and risk reduction interventions focused on behavioral change and awareness of personal risk of infection.
- 2) TESTING** – Expand HIV antibody testing to increase early diagnosis and treatment.
- 3) TREATMENT** – Engage HIV-infected individuals in HIV medical treatment, to improve management of HIV disease and reduce or delay severe illness, reduce medical costs, and reduce transmission of HIV infection to others.
- 4) GET INVOLVED** – Build support for HIV/AIDS awareness and services through expanding the work of community and national organizations committed to prevention, testing, treatment, and advocacy to reduce the impact of the HIV/AIDS epidemic on African-American communities and individuals.

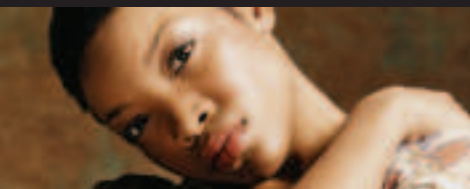
Greater Than AIDS: CDC Campaign to reduce HIV infection in African-American communities

The HIV Epidemic Is Real. Get the Facts.



Take Control of Your Health. Get Tested.

Living with HIV. Delay the Onset of AIDS.



Every 9½ minutes, another person in the United States becomes infected with HIV

PREVENTION: The Act Against AIDS campaign began with the “9½ minutes” slogan, highlighting the continuing urgency to reduce new infections. The CDC reviewed and revised its method of determining the dates and numbers of new infections in 2008, and the estimated incidence, or new cases, rose significantly from the previous estimate of 40,000 per year.

HIV infection and AIDS have disproportionately affected African Americans and Latinos since the beginning of the epidemic. **In 2006, African Americans comprised only 12% of the population of the United States but were 45% of all those newly infected with HIV and half of the AIDS deaths.** Latinos are 15% of the U.S. population, but accounted for 17% of new HIV infections in 2006.

ONE TEST. ONE MILLION PEOPLE. ONE YEAR

TESTING: The Black AIDS Institute is leading a campaign, in partnership with leading Black organizations and other partners, to urge **1 million Black Americans to get an HIV test.** The Black AIDS Media Partnership, as part of the *Greater Than AIDS* campaign, has designed materials to publicize this measurable, challenging goal. The *Greater Than* website features a photo of President Obama after getting an HIV test, and asks visitors to sign a pledge “I pledge to get tested for HIV before June 27, 2010” on the website or on the campaign’s Facebook page.

TREATMENT

After hearing one’s HIV-positive diagnosis, many people are stunned and do not enter medical treatment for months or even years: In 2006, the New Jersey Department of Health and Senior Services-Division of HIV/AIDS Services (NJDHSS-DHAS) and The New Jersey Statewide Coordinated Statement of Need Planning Task Force completed the New Jersey Statewide Coordinated Statement Of Need As Required By The Ryan White Care Act. One of the critical conclusions of this document was that **only 50% of those who knew their HIV-positive status were in HIV medical care.**

Early diagnosis, monitoring, and treatment have become effective and far less difficult to manage than in the early years of the AIDS epidemic. Highly Active Antiretroviral Therapy (HAART) has become the standard of care, and is now shown to improve outcomes when taken well before the development of immune compromise. However, the best HIV care in the world cannot help someone who is not receiving ongoing care. **The Act Against AIDS campaign uses stories of many individuals who are successfully managing their HIV/AIDS to illustrate the benefits and strategies that can extend lives and the quality of live for people living with HIV/AIDS.**

WE  **AIDS****Be a Part of
the Solution.
What You
Can Do.****The message is viral
– from bus ads to
Facebook, from
videos to pledges
to get a million
African Americans
to have HIV tests.**

GET INVOLVED

Partnerships in the African American community: The Act Against AIDS Leadership Initiative

To help ensure the widespread delivery of campaign messages within African American communities, CDC is implementing the Act Against AIDS Leadership Initiative (AAALI). This \$10 million, five-year partnership with 14 of the nation's leading organizations serving the African American community seeks to harness the collective strength and reach of traditional, longstanding African American institutions to increase HIV awareness. While many of the AAALI partners have longstanding commitments to addressing HIV among African Americans, the new initiative will enable each group to **make HIV prevention a core component of its day-to-day activities**. The AAALI is an outgrowth of CDC's prevention philosophy of empowering partners to work within their communities. Religious, political, educational, fraternal, and business groups are all encouraged to develop their own programs, using the materials and slogans developed through this national partnership.

Media is on Board

Because successfully reducing the impact of HIV in the United States will require action from both within and beyond heavily affected African-American communities, CDC will partner with the Kaiser Family Foundation – a leader in health policy and communications – to enlist support from the media and entertainment industries in broadly disseminating these and other HIV prevention messages. CDC and Kaiser will establish a coalition of entertainment, print, online and other media organizations interested in providing support to Act Against AIDS. There will be an emphasis on partnerships with media that are uniquely positioned to reach specific populations starting with African-Americans, given the heavy burden of HIV in this population.

**For more information about the Act Against AIDS campaign
www.nineandahalfminutes.org**

**For information on the 9½ Minutes phase, consumer information
on the epidemic, and tools to participate in this campaign.
<http://www.greaterthan.org> (includes videos, resources)**

Working Toward the HRSA HIV/AIDS Bureau HIV Clinical Performance Measures



The Ryan White Act, recently renewed for another four years, authorizes funding for a significant proportion of HIV/AIDS services in New Jersey and throughout the United States.

The Ryan White legislation includes provisions requiring that HIV services include a quality management component. This issue's cover story and in the continuing education article about prevention and treatment of opportunistic infections both note the uniform performance measures by which all federally-funded HIV services will be evaluated. These measures are designed as objective

benchmarks reflecting the current standards of HIV care established by The U.S. Department of Health and Human Services-Health Resources and Services Administration (HRSA) with the Centers for Disease Prevention and Control (CDC) and the Infectious Disease Society of America.

HRSA has established a series of core HIV/AIDS measures, which are summarized below. The core measures for HIV/AIDS care have been designed for multi-stage implementation.

HAB performance measures fall within the following three groups.

Each group can be used by all programs funded by the Ryan White HIV/AIDS Program, either at the provider or system level.

Tier 1 measures provide an excellent start and can serve as a foundation on which to build, especially if a clinical program has no performance measures.

Tier 2 measures are important measures for a robust clinical management program and should be seriously considered.

Tier 3 measures represent areas of care that are considered "best practice," but may lack written clinical guidelines or rely on data that are difficult to collect.

<http://hab.hrsa.gov/special/habmeasures.htm>

HRSA is requiring that Ryan White services show progress on Tier 1 measures in the coming year. However, measures in all the tiers are considered the standard of care in the latest CDC/IDSA guidelines.

Have you met these measures in your practice?

Tier 1 Performance Measure

Provide Every Year To:

HIV Medical Visits

- Two or more

ALL HIV+ Clients

CD4+ Count

- Two, at least two months apart

ALL HIV+ Clients

PCP Prophylaxis

- Prescriptions(s) in chart

ALL HIV+ Clients with CD4+ <200

HAART prescribed

ALL HIV+ Clients with CD4+ <200 and/or diagnosed with AIDS

Pregnant Women on ARV

- Prescriptions(s) in chart for 2nd and 3rd trimester

ALL HIV+ Pregnant Women

Tier 2 Performance Measure

Provide Every Year To:

Treatment Adherence Assessment & Counseling

- Document at least 2 times per year

ALL HIV+ Clients

Cervical Cancer Screening (Pap)

ALL HIV+ Women

Hepatitis B Vaccination

- Completed the Hepatitis C vaccination series

ALL HIV+ Clients
Exemption: chart documents current or past HBV infection

Hepatitis C Screening

- Performed at least once since HIV+ diagnosis

ALL HIV+ Women

HIV Risk Counseling

ALL HIV+ Clients

Lipid Screening (fasting panel)

ALL HIV+ taking HAART

Oral Exam

ALL HIV+ Clients

Syphilis Screening

ALL HIV+ Clients

TB Screening

- Testing with documented results for latent tuberculosis infection (LTBI) since HIV diagnosis

ALL HIV+ Clients
Exemption: chart documents current or past TB or positive TB test

Have you met these measures in your practice?

Tier 3 Performance Measure	Provide Every Year To:
Chlamydia Screening	ALL HIV+ Clients Exemption: patients <18 and/or deny history of sexual activity
Gonorrhea Screening	ALL HIV+ Clients Exemption: patients <18 and/or deny history of sexual activity
Hepatitis B Screening	ALL HIV+ Clients Exemption: chart documents previously completed HBV series
Influenza Vaccination	ALL HIV+ Clients Exemption: allergic to vaccine component
MAC Prophylaxis	ALL HIV+ Clients with CD4+ <50 Exemption: patient has disseminated MAC
Mental Health Screening	New HIV+ Clients
Pneumococcal Vaccination (ever)	ALL HIV+ Clients
Substance Use (alcohol/drug) Screening	ALL HIV+ Clients
Tobacco Cessation Counseling	ALL HIV+ Clients Exemption: patients who deny tobacco use throughout year
Toxoplasma Screening	ALL HIV+ Clients
• Documented once since HIV+ diagnosis	

FDA: Drug Updates and Cautions

Prior Authorization (NJ ADAP)

Isentress is now FDA approved as a first line antiretroviral agent. Therefore, prior authorization is no longer required for Isentress.

Cautions:

Intelence (etravirine)

[Posted 08/27/2009] Tibotec Therapeutics and FDA notified healthcare professionals of revisions to the WARNINGS AND PRECAUTIONS section of the prescribing information for Intelence (etravirine). There have been postmarketing reports of cases of Stevens-Johnson syndrome, toxic epidermal necrolysis and erythema multiforme, as well as hypersensitivity reactions characterized by rash, constitutional findings, and sometimes organ dysfunction, including hepatic failure. Intelence therapy should be immediately discontinued when signs and symptoms of severe skin or hypersensitivity reactions develop.

FDA MedWatch

Updated reports on medication interactions and warnings:

1-800-FDA-1088; Subscribe to e-bulletin:
<http://www.fda.gov/medwatch/elist.htm>

Guidelines Updates

Recently released guidelines from the U.S. Department of Health and Human Services
For most recent update, always check AIDSinfo:
<http://aidsinfo.nih.gov/guidelines>

Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents / November 3, 2008.
<http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf>

Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection / February 23, 2009
<http://aidsinfo.nih.gov/contentfiles/PediatricGuidelines.pdf>

Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents

 / April 10, 2009

The CDC, with the Infectious Disease Society of America, released this update of the 2002 opportunistic infection guidelines. The new guidelines emphasize the critical role of ART in preventing and treating OIs, especially for infections for which there is no current chemoprophylaxis or treatment.
<http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf>

Public Health Service Task Force Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States

 / April 29, 2009

<http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf>

National HIV/AIDS TREATMENT RESOURCES: Guidelines, Statistics, And Clinician Consultation

Centers for Disease Control (CDC) – Division of HIV/AIDS Prevention

HIV/AIDS research, surveillance reports, funding announcements, research and reporting software, epidemiology slide sets

<http://www.cdc.gov/hiv/hivinfo.htm#WWW>

Rapid Testing: http://www.cdc.gov/hiv/rapid_testing

MMWR [Morbidity and Mortality Weekly reports]:

<http://www.cdc.gov/hiv/pubs/mmwr.htm>

CDC National Prevention Information Network (NPIN)

HIV, STD, and TB news, funding, materials, conference calendars.

<http://www.cdcnpin.org>

US Dept. of Health & Human Services

www.aidsinfo.nih.gov • 1-800-HIV-0440 (1-800-448-0440)

HIV/AIDS treatment guidelines; prevention, treatment, and research.

National Institutes of Health-sponsored searchable

clinical trials database: <http://clinicaltrials.gov>

FDA MedWatch

Updated reports on medication interactions & warnings: 1-800-FDA-1088;

Subscribe to e-bulletin: <http://www.fda.gov/medwatch/elist.htm>

AIDS InfoNet

New Mexico AIDS Education and Training Center-sponsored site provides frequently updated fact sheets on HIV/AIDS services and treatments in both English and Spanish www.aidsinonet.org

National HIV/AIDS Clinicians' Consultation Center

<http://www.nccc.ucsf.edu>

Consultation on antiretroviral therapy, drug resistance, opportunistic infection prophylaxis and treatment, laboratory evaluation; occupational exposure, perinatal intervention.

Warmline: 800-933-3413

National Clinicians' Post-Exposure Prophylaxis Hotline

(PEPline): 888-448-4911 (888-HIV-4911)

National Perinatal HIV Consultation and Referral Service

888-448-8765 (888-HIV-8765)

Ryan White Planning and Coordination Bodies in New Jersey

Ryan White Part A

New Jersey HIV/AIDS Community Planning Group Rutgers, The State University of New Jersey

3 Rutgers Plaza, 2nd Floor

New Brunswick, NJ 08901

Tel: 732-932-3358 x2006 • Fax: 732-932-3357

Website: <http://hpcpsdi.rutgers.edu>

Newark EMA Health Services Planning Council (Essex, Union, Morris, Sussex & Warren Counties)

315 North 6th Street, 2nd Floor

P.O. Box 7007, Newark, NJ 07107

Tel: 973-485-5220 • Fax: (973) 485-5085

Website: www.newarkema.org

Hudson County HIV Health Services Planning Council

574 Summit Avenue, 5th Floor

Jersey City, NJ 07036

Tel: 201-795-4555, ext. 212 • Fax: (201) 795-0204

Contact: Marvin Krieger, Planning Council Chairperson

Email: HcHIVcncl@aol.com

Paterson-Passaic County-Bergen County HIV Health Services Planning Council

c/o Buddies of NJ, Inc.

149 Hudson Street

Hackensack, NJ 07601

Contact: Steven Scheuerman, Planning Council Chairperson

Tel: 201-489-2900

Website: www.aidsnj.org

Ryan White Part A

Middlesex, Somerset, Hunterdon

HIV Health Services Planning Council

Institute for Families, Rutgers University

100 Joyce Kilmer Avenue

Piscataway, NJ 08854

Contact: David Williams

Tel: 732-445-0512 • Fax: (732) 445-4154

Email: dwilliams@ssw.rutgers.edu

Website: www.mshema.org

Philadelphia EMA Ryan White Part A Planning Council

340 N. 12th St., Suite 203

Philadelphia, PA 190117

Tel: 215-574-6760, ext. 104 • Fax: (215) 574-6761

Website: www.hivphilly.org

(includes Camden, Salem, Cumberland Counties in NJ)

Cumberland County HIV Services Planning Council

790 East Commerce Street

Bridgeton, NJ 08302

Tel: 800-870-0568 • Fax: 609-927-7361

Ryan White Part B

New Jersey Department of Health & Senior Services Division of HIV/AIDS Services – Care & Treatment Unit

PO Box 363, Trenton, NJ 08625

Phone: 609-984-6328 • Fax: 609-292-6009

Hotline: 1-800-624-2377

Website: <http://www.state.nj.us/health/aids>

New Jersey Department of Health & Senior Services – Division of HIV/AIDS Services (DHAS)

New web address: <http://www.state.nj.us/health/aids>

- **NJ HIV/AIDS Semi-annual Newsletter**
(statistical report); policies, and guidelines for HIV/AIDS care and services in New Jersey
- **New Jersey rapid testing site:** www.state.nj.us/health/aids/rapidtesting
- **New Jersey HIV (Testing) Helpline:** 1-866-HIV-CHEC
- **New Jersey AIDS/STD Hotline:** (800) 624-2377
–24-hour professionally-staffed service –Consultation, testing referrals, free materials

**New Jersey
HIV (Testing)
Helpline:
1-866-HIV-CHEC**

HIV/AIDS TRAINING & EDUCATION

*University of Medicine & Dentistry of NJ
Center for Continuing & Outreach Education –
Division of AIDS Education
www.umdnj.edu/ccoe/aids*



with funding from the NJ Department of Health & Senior Services, Division of AIDS Education

HIV/AIDS Medical Update Series – FREE ON-SITE TRAINING

To schedule a free 1-hour HIV medical education program at your health care site on any of these topics, contact Michelle Thompson at (973) 972-1293 or ccthomps@umdnj.edu

- HIV in Pregnancy – Preventing Perinatal Transmission:
Implementing the New Jersey Law
- Rapid Diagnostic HIV Testing
- Diagnosis and Initial Management of HIV/AIDS:
What the Primary Care Physician Should Know
- HIV/AIDS and Hepatitis C Co-Infection
- Immunizations for HIV Positive Adults
- Non-Occupational Post-Exposure Prophylaxis
- Prevention and Prophylaxis for Occupational Exposure to HIV and Other Blood Borne Pathogens
- Prophylaxis and Treatment of Opportunistic Infections

*University of Medicine & Dentistry of NJ
Center for Continuing & Outreach Education – Division of AIDS Education*

www.umdnj.edu/ccoe/aids

- Conferences and training for HIV/AIDS health and social service professionals.
- Clinical preceptorships for physicians, nurses, physician assistants, pharmacists, and dentists in:
 - Medical Management of HIV; Co-Management of HIV and Hepatitis C
 - Other topics by arrangement

Free online CME/CE – topics include:

- Women and HIV Treatment: Recently Reported Data
- HIV Testing Update (2009)
- Prevention with Positives in HIV Medical Care
- What is Good Practice? HIV Care Beyond ART
- **Preventing and Treating PCP and MAC:
A Continuing Challenge in HIV/AIDS Care**

Pharmacists:

Check the UMDNJ-CCOE website for certified HIV educational activities, coming soon. Sign up to receive email notices of new activities at www.umdnj.edu/ccoe/aids

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Division of AIDS Education



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Division of HIV/AIDS Services



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For more information see:

<http://ccoe.umdj.edu/catalog/aids>

(973) 972-3690



FOR MORE INFORMATION ON ALL CONFERENCES:

<http://ccoe.umdj.edu/catalog/aids>

or call the UMDNJ-Center for Continuing & Outreach Education, Division of AIDS Education:
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AIDS Line



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