HIV and Diabetes Care

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What we’ll talk about today

- Challenges to managing diabetes and HIV concurrently
- Existing treatment standards and protocols for three populations of patients with co-occurring diabetes & HIV
- HIV and diabetes care demonstration project
Why is this an issue?

- PLWH are living longer - meaning they, too, are at risk for age-related chronic conditions like Type 2 diabetes.
- While the exact prevalence rates for diabetes among PLWH are unknown, national estimates indicate that up to 14% of people who are in care for HIV also have diabetes.
- PLWH have increased risk for Type 2 diabetes for two reasons:
  - Chronic inflammation caused by HIV infection
  - Some antiretroviral (ART) medications, which have a metabolic impact
Challenges

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Diagnosis

- HIV can impact the HbA1c results, underestimating the patient’s level of hyperglycemia – which makes it inappropriate to use as a diagnostic tool.
- For the same reason, the A1c is problematic when used to track blood glucose over time.
Medication regimen

- PLWH are already living with a sometimes complex medication regimen.
  - Beginning ART usually involves three drugs from at least two different drug classes.
  - Impacted by cost, coverage, patient’s health, side effects, drug resistance and convenience.
HIV is rightly the priority of infectious disease care providers, and of PLWH – but the presence of an urgent condition tends to push other health issues to the back burner.
Social Determinants of Health

- HIV disproportionately impacts people of color, those with lower levels of education, and lower socioeconomic status.
- Health equity issues create barriers that make it difficult to manage diabetes, such as inconsistent access to:
  - Medical care
  - Healthy food
  - Safe physical activity options
  - Transportation
Stigma

- Stigma: negative attitudes or beliefs about a certain group.
- Both people with Type 2 diabetes (especially those with obesity) and PLWH experience stigma and misunderstandings:
  - People make moral judgments about those who have it
  - Think only certain groups get the disease
  - May think those who have the condition, deserve it

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Criminalization contributes to the stigma surrounding HIV. Laws in Michigan and throughout the US date from a time when HIV was a fatal and poorly understood disease:

- It is a felony for a PLWH to engage in penetrative sex without disclosing their status to the partner.
- PLWH can be subject to bioterrorism laws.
- HIV status can be considered a factor in criminal sentencing.
- PLWN can be subject to examination, treatment of commitment by the Department of Health if they are determined to be a ‘health threat’ to others.

These laws have not been updated in light of current knowledge.
U=U: What is it?

There is now research-based confirmation that people who take ART as prescribed, and have an undetectable viral load, cannot transmit the disease to a sexual partner.

www.preventionaccess.org/about
U=U: Why is it important?

- Reduces shame and fear of sexual transmission, and opens possibilities for conceiving children without alternative insemination.
- Dismantles stigma surrounding HIV on a personal, clinical, and community level.
- Encourages PLWH to start and stay on treatment, to keep both themselves and their partners healthy.
- Strengthens advocacy efforts for universal access to treatment, care and diagnostics – and brings us closer to ending HIV.

https://www.preventionaccess.org/about
Standards and Protocols

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Three subgroups to consider

- People with preexisting diabetes who acquire HIV
- People who are diagnosed with diabetes and HIV concurrently
- People who develop hyperglycemia after the start of HIV therapy.

Each has a slightly different treatment protocol.

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Pre-existing diabetes

- Test fasting glucose levels prior to starting HIV medications.
- Reference drug interaction table in Integrated Management of HIV and Type 2 Diabetes.
- Prescribe ART drugs with safer metabolic profile.
- Monitor fasting glucose levels 3 months after start of ART drugs and every 3-6 months thereafter if impaired fasting glucose is present.
HIV & diabetes concurrent diagnoses

- Test fasting glucose levels prior to starting concurrent anti-diabetic and HIV medications.
- Reference drug interaction table in Integrated Management of HIV and Type 2 Diabetes.
- Prescribe HIV drugs with safer metabolic profile.
- Collaborate with or refer to PCP and/or endocrinologist for prescribing of anti-diabetic agents, and to DSMES.
- Monitor fasting glucose levels 3 months after start of ART drugs, and every 3-6 months thereafter if impaired fasting glucose is present.
Develop diabetes after start of ART

- Test fasting glucose levels prior to switching ART regimen.
- Reference drug interaction table in Integrated Management of HIV and Type 2 Diabetes.
- If possible, switch to drugs with safer metabolic profile.
- Monitor fasting glucose 3 months after switching ART, and every 3-6 months thereafter if impaired fasting glucose is present.
- Collaborate with/refer to PCP and/or endocrinologist, and to DSMES.
Barriers to using current protocols

- Testing for diabetes before starting ART sometimes isn’t workable.
- Link between infectious disease and primary care.
- Access to care.
HIV and Diabetes Care project
Four phases of the project

- Identify diabetes prevalence and patterns among PLWH.
- Engage healthcare providers in screening for diabetes & referral to DSMES.
- Increase LGBTQ+ and HIV cultural competency among DSMES professionals.
- Create an innovative, culturally competent diabetes wellness program for delivery at outpatient ambulatory care clinics.

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Thank you!

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