WELCOME to the

PEP Talk: HIV Post Exposure Prophylaxis ECHO

AETC AIDS Education & Training Center Program New England

Introduction to AETC

About the AETC Program:

A national program of leading HIV experts, provides locally based, tailored education and technical assistance to healthcare teams and systems to integrate comprehensive care for those living with or affected by HIV.
The AETC Program transforms HIV care by building the capacity to provide accessible, high-quality treatment and services throughout the United States and its territories.

AETC Program Mission:

To increase the number of health care providers who are effectively educated and motivated to counsel, diagnose, treat, and medically manage people with HIV disease, and to help prevent high-risk behaviors that lead to HIV transmission.

Acknowledgement

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Series Learning Objectives

- Manage HIV PEP for individuals at risk for HIV infection in accordance with current clinical guidelines.
- Describe the psychosocial, legal, and financial components of providing holistic care to those at risk for HIV infection.
- Identify state and national resources available to support providers

Schedule

Date	Session Title
4/7/2026	nPEP background and introduction
4/21/2026	Adult physical and psychosocial assessment
5/5/2026	Pediatric physical and psychosocial assessment
5/19/2026	Trauma informed care
6/2/2026	Medical management
6/16/2026	Follow up testing
6/30/2026	Processing vicarious trauma

nPEP Background and Introduction

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Dartmouth Health

AETC AIDS Education & Training Center Program New England

Project ECHO

Content warning: Sexual Assault

What is nPEP?

- Non-occupational post-exposure prophylaxis (nPEP)
  - Antiretroviral medication (and other care) given after sexual, injection drug use, or other non-occupational exposure to HIV

- Occupational post-exposure prophylaxis (oPEP)
  - Healthcare workers, first responders…who are exposed to HIV through needlesticks or splashes with certain body fluids
  - Same medication management but different population and separate guidelines (not discussed here)

HIV (human immunodeficiency virus)

- Virus that attacks the immune system and can lead to AIDS if not treated
- Spreads via blood and certain body fluids
- Most people get infected through sex, sharing needles or drug injection equipment
- No cure
- No vaccine

Table 1.
Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act*

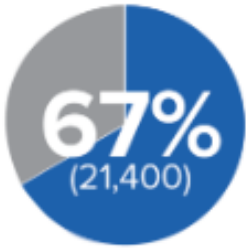
Exposure Type	Rate for HIV Acquisition per 10,000 Exposures
Parenteral	
Blood transfusion	9,250
Needle sharing during injection drug use	63
Percutaneous (needlestick)	23
Sexual	
Receptive anal intercourse	138
Insertive anal intercourse	11
Receptive penile-vaginal intercourse	8
Insertive penile-vaginal intercourse	4
Receptive oral intercourse	Low
Insertive oral intercourse	Low
Other^	
Biting	Negligible
Spitting	Negligible
Throwing body fluids (including semen or saliva)	Negligible
Sharing sex toys	Negligible

*Factors that may increase the risk of HIV transmission include sexually transmitted infections, acute and late-stage HIV, and high plasma HIV RNA levels. Factors that may decrease the risk include condom use, male circumcision, antiretroviral treatment, and HIV preexposure prophylaxis (PrEP). None of these factors are accounted for in the estimates presented in the table.
^HIV transmission through these exposure routes is technically possible but unlikely and not well documented.

Source: Dominguez KL, Smith DK, Thomas V, et al. Updated guidelines for antiretroviral postexposure prophylaxis after sexual, injection drug use, or other nonoccupational exposure to HIV—United States, 2016. Atlanta, GA: US Department of Health and Human Services, CDC; 2016. [CDC]

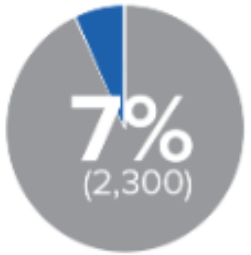
Estimated HIV infections in the US by transmission category, 2022

There were **31,800 estimated new HIV infections** in the US in 2022. Of those:



were among gay, bisexual, and other men who reported male-to-male sexual contact*

were among people who reported heterosexual contact



were among people who inject drugs

* Includes infections attributed to male-to-male sexual contact *and* injection drug use (men who reported both risk factors).

Source: CDC. Estimated HIV incidence and prevalence in the United States, 2018–2022. *HIV Surveillance Supplemental Report*, 2024; 29(1).

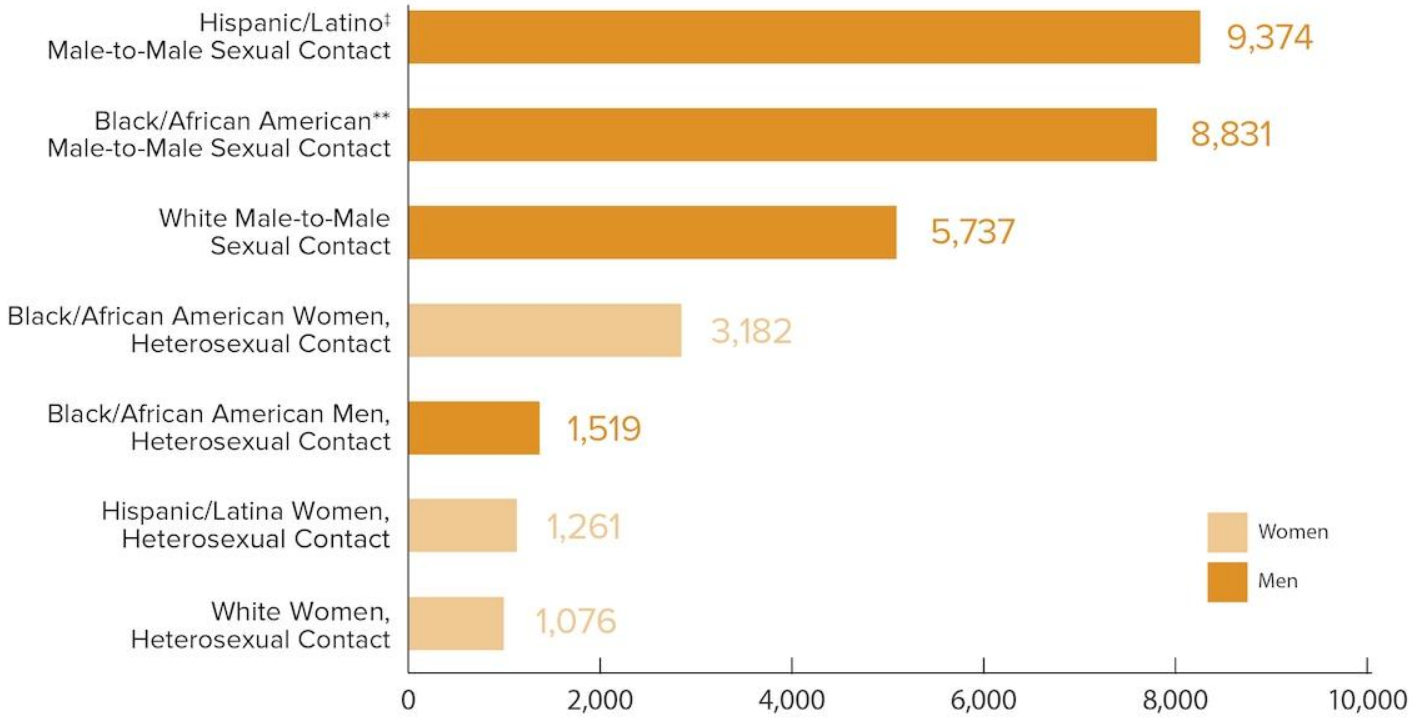
Ending the HIV Epidemic

Overall Goal: Decrease the estimated number of new HIV infections to 9,300 by 2025 and 3,000 by 2030.

[Fast Facts: HIV in the United States | HIV | CDC]

HIV diagnoses in the US and 6 territories and freely associated states for the most-affected subpopulations, 2022*†

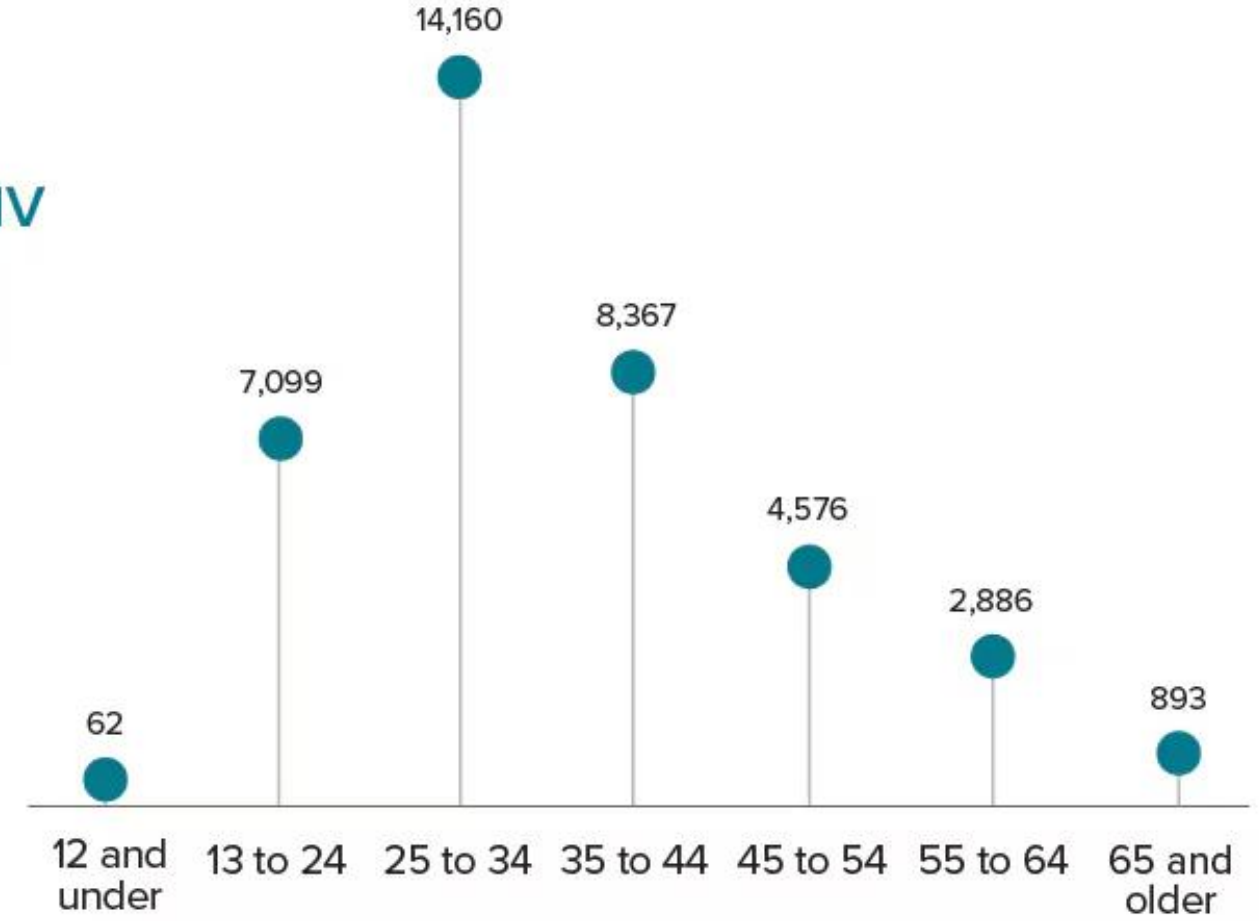
Gay and bisexual men are the population most affected by HIV.



[Fast Facts: HIV in the United States | HIV | CDC]

HIV diagnoses in the US and 6 territories and freely associated states by age, 2022

In 2022, 37,981 people received an HIV diagnosis in the US and 6 territories and freely associated states. People aged 13 to 34 accounted for more than half (56%) of new HIV diagnoses in 2022.



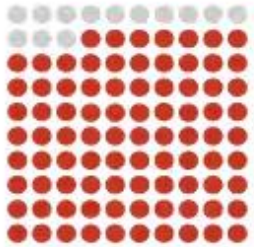
Source: CDC. Diagnoses, deaths, and prevalence of HIV in the United States and 6 territories and freely associated states, 2022. *HIV Surveillance Report*, 2022;35.

[Fast Facts: HIV in the United States | HIV | CDC]

Knowledge of HIV status in the US, 2022*

In 2022, an estimated **1.2 million people** had HIV.

For every 100 people with HIV



87 knew their HIV status.

* Among people aged 13 and older.

Source: CDC. Estimated HIV incidence and prevalence in the United States, 2018–2022. *HIV Surveillance Supplemental Report*, 2024; 29(1).

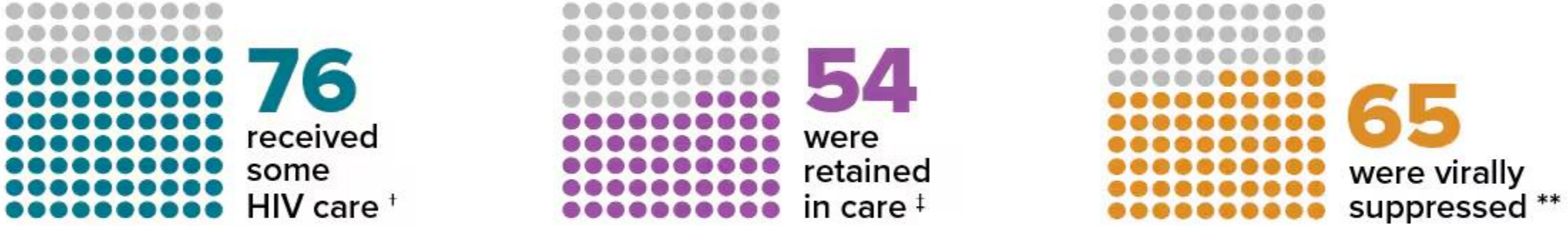
Ending the HIV Epidemic

Overall Goal: Increase the estimated percentage of people with HIV who have received an HIV diagnosis to at least 95% by 2025 and remain at 95% by 2030.

[Fast Facts: HIV in the United States | HIV | CDC]

HIV care continuum among people with diagnosed HIV in 48 states and the District of Columbia, 2022*

More than half of people with diagnosed HIV are virally suppressed. For every **100 people overall with diagnosed HIV**:



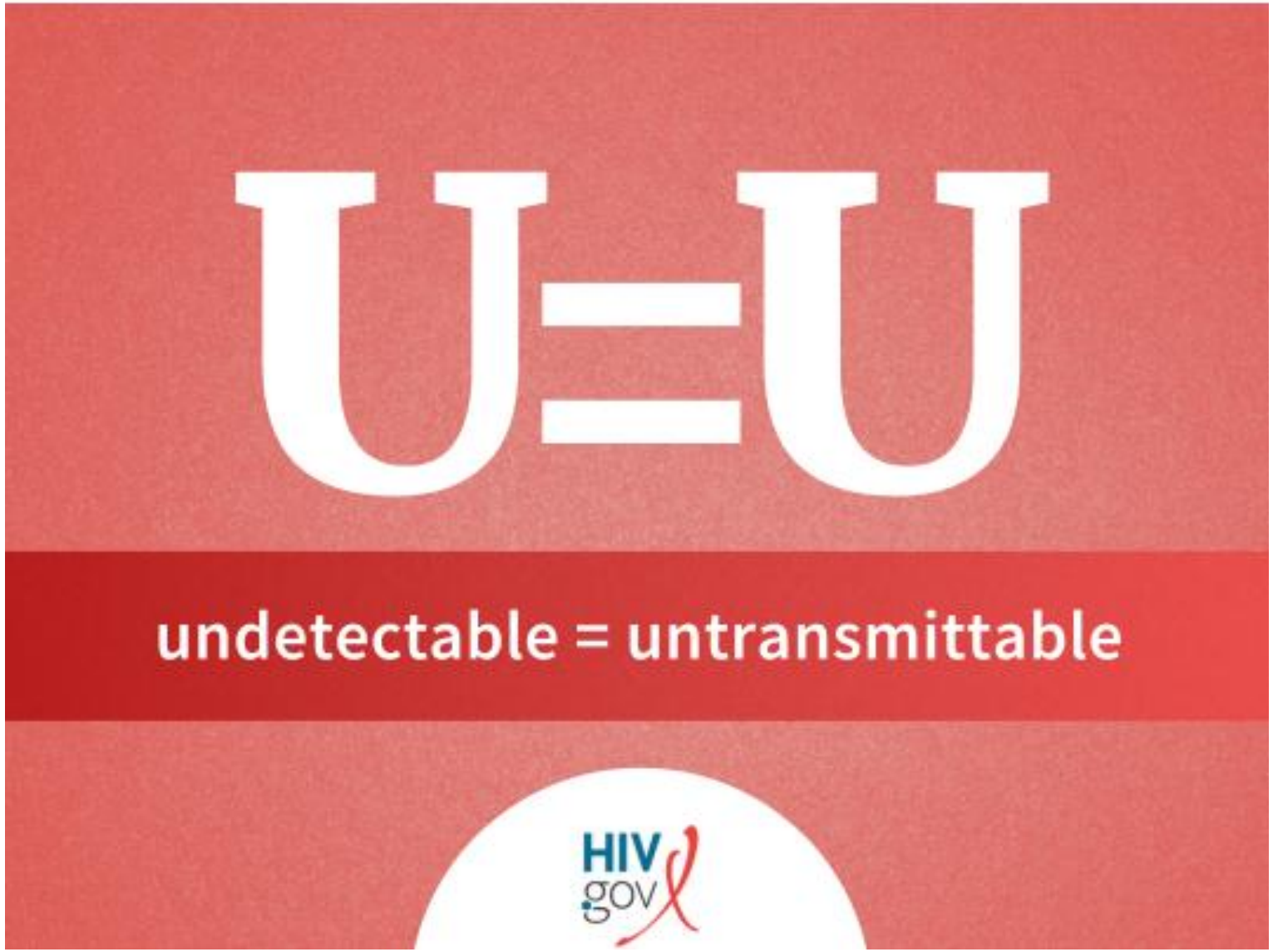
* Among people aged 13 and older.
†At least 1 viral load or CD4 test.
‡Had 2 viral load or CD4 tests at least 3 months apart in a year.
**Based on most recent viral load test.

Source: CDC. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 territories and freely associated states, 2022. *HIV Surveillance Supplemental Report* 2024;29(2).

Ending the HIV Epidemic

Overall Goal: Increase the percentage of people with diagnosed HIV who are virally suppressed to at least 95% by 2025 and remain at 95% by 2030.

Fast Facts: HIV in the United States | HIV | CDC


U=U
undetectable = untransmittable
HIV.gov

Why is HIV nPEP important?

It is one of several strategies used to prevent the spread of HIV and end the HIV epidemic, and timing is everything!

Ending the HIV Epidemic

Diagnose all people with HIV as early as possible.

Treat people with HIV rapidly and effectively to reach sustained viral suppression.

Prevent new HIV transmissions by using proven interventions, including PrEP and syringe services programs (SSPs).

Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

How are we doing?

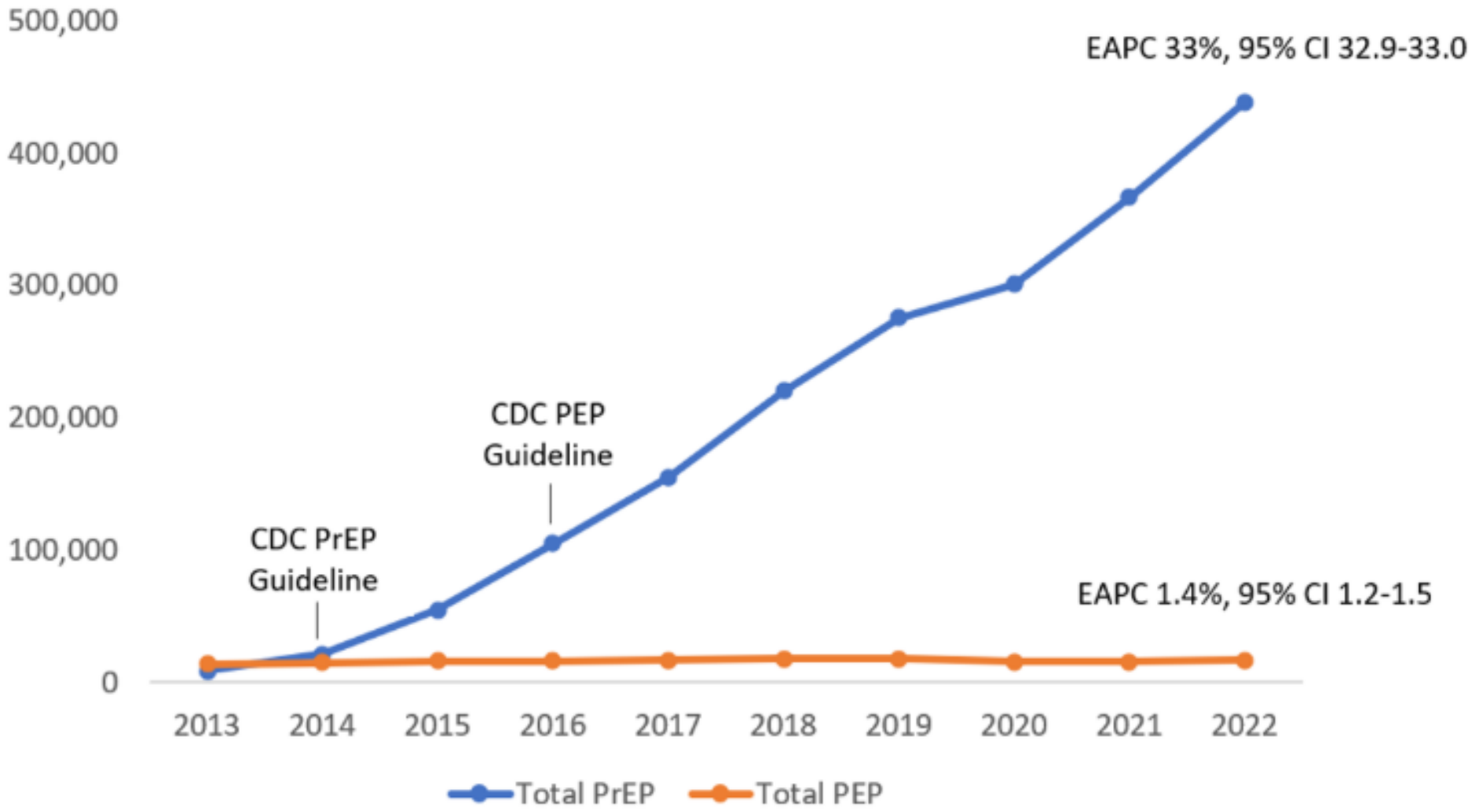
Persons aged ≥16 years

Annual PEP rx ranged from 13,999-17,996

2022 PEP user data
- 51.2% women
- 60.1% age 25-44

EAPC = estimated annual percentage change

Figure. HIV PEP and PrEP Prescription Trends in the United States, 2013-2022



CROI abstract 2024

Assumptions and Limitations

- “Due to ethical and logistical reasons, it is highly unlikely that a prospective, randomized, placebo-controlled trial to evaluate HIV nonoccupational PEP in humans will ever take place.”
- Rationale for providing HIV nPEP is based on extrapolation from
  - HIV PEP in other settings
  - Animal studies
  - Retrospective reviews
  - Observational HIV nonoccupational PEP reports
  - Expert opinion

Core Concepts - Nonoccupational Postexposure Prophylaxis - Prevention of HIV - National HIV Curriculum

HIV PEP Guidance

- 1997 oPEP was recognized to be safe and effective (81% reduction in HIV if given within 4 hours of exposure) and CDC issued guidance for oPEP, which was recently update in 2025 (oPEP Guidelines)

- 2005 CDC extended these recommendations to the nonoccupational setting and this has since been updated in 2016 and 2025
  - Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV — CDC Recommendations, United States, 2025 | MMWR

HIV nPEP Big Picture

- nPEP is recommended following exposure that has substantial risk for HIV acquisition
- Start nPEP ASAP after exposure (optimally within 24 hours and no later than 72 hours)
- 28-day course of 3-drug antiretroviral therapy
- Safe, effective and well tolerated
- Baseline and follow up testing required to rule out infection
- Consider transition to PrEP (pre-exposure prophylaxis)

Other infectious considerations

- Hepatitis B
- Hepatitis C
- Gonorrhea
- Chlamydia
- Syphilis
- Trichomonas
- HPV

Hepatitis B

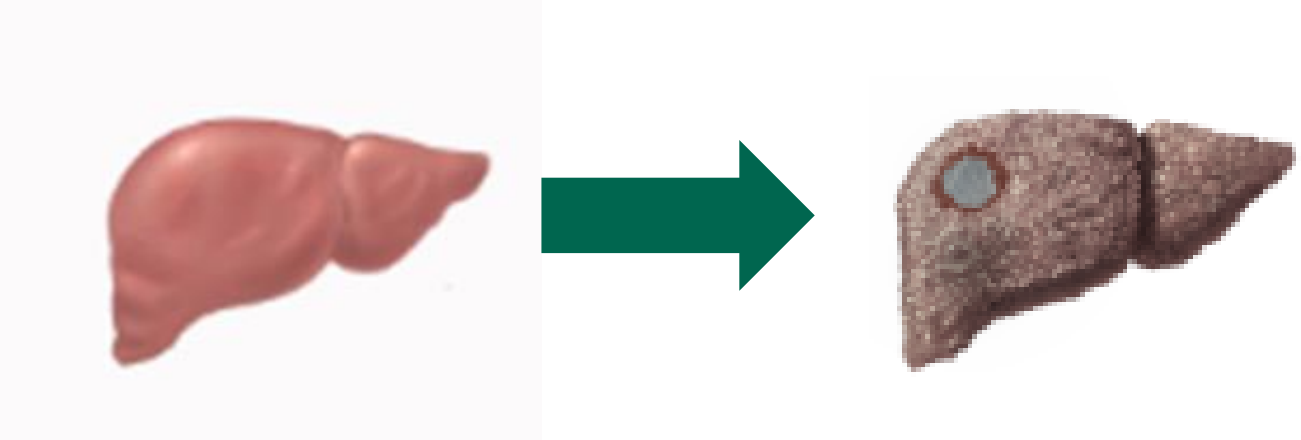
Reported cases of hepatitis B in 2023

2,214

In 2023, a total of 2,214 cases of hepatitis B were reported in the US, but experts estimate the actual number is likely around 14,400.

- Virus that infects the liver
- Transmitted through exposure to infectious blood or body fluids
- 100x more infectious than HIV
- Vaccine preventable
- No cure
- Post-exposure interventions available

- Highest rate of infection
  - Persons aged 40-59 years
  - Non-Hispanic Black
  - Eastern and Southeastern states



[Hepatitis B Surveillance | 2023 Hepatitis Surveillance | CDC]

Hepatitis C

- Virus that infects the liver
- Transmitted through exposure to infectious blood or body fluids that contain blood
- 10x more infectious than HIV
- Curative treatment available
- No vaccine or other preventive options

Reported cases of hepatitis C in 2023

4,966

In 2023, there were 4,966 reported cases of acute hepatitis C, but CDC believes the actual number of acute hepatitis C cases in 2023 was probably closer to 69,000.

- 2.4 to 4 million people had Hepatitis C in the US (2017-2020)
- Rates of acute hepatitis C highest among males, those aged 30-39 years, non-Hispanic American Indian/Alaska Natives, and those living in the Eastern and Southeastern states
- Most common risk factor was injection drug use

Clinical Overview of Hepatitis C | Hepatitis C | CDC

WELCOME to the

PEP Talk: HIV Post Exposure Prophylaxis ECHO

Session 2, Adult Physical and Psychosocial Assessment,
April 21, 2026

Forensic Nursing Overview For Infectious Disease

JANET CARROLL RN, CEN, SANE-A, SANE-P
NH SANE PROGRAM DIRECTOR

What is a Forensic Nurse?

Sexual Assault Nurse Examiner (SANE)

- **An RN who:**
  - Has been specially trained to provide comprehensive care to sexual assault patients
  - Demonstrates competency in conducting a medical/forensic examination.
  - Has the potential ability to be an expert witness.

- Also called a Forensic Nurse Examiner (FNE) when caring for additional populations

- Other states: SAFE, ANE, etc

Possible SA Cases:

- Injury not consistent with history provided
- Found unresponsive without clothing on or found with others in the act of violence
- Genital or anal injury upon arrival without specific cause
- Overly controlling partner
- Bruising to inner thighs without explanation
- Family/Friend concerns
- Question of Drug-Facilitated Sexual Assault

Or they might present with:

- Patient may make statements of sexual assault:
  - Statements of full disclosure: " I was raped last night"
  - "I feel like I had sex last night"
  - "I can only remember snippets of last night"
  - "I woke up without any clothes on" or "I woke naked in my car"
  - "My underwear is missing" or "My underwear is on backwards"
- EMS may state:
  - "We found her outside, she/he was half naked"
  - "When we got there, she was passed out and two guys were having sex with her"
  - "Something wasn't right about this scene call…."
- There are many, many more things that may bring a patient in!
  Remember to ask: What happened? Can you tell me more about that?

SANE Responsibilities

- Medical/forensic evaluation and treatment
- Evidence collection
- Documentation of injury or lack thereof
- Comprehension of what the findings mean
- The ability to testify to those findings as a fact or expert witness

Age Groups- Sexual Assault

- Adolescent/Adult

- Pediatric: Pts Under age 18
  - ED Visits
  - Child Abuse Clinics/Child Advocacy Centers
  - PCP Office

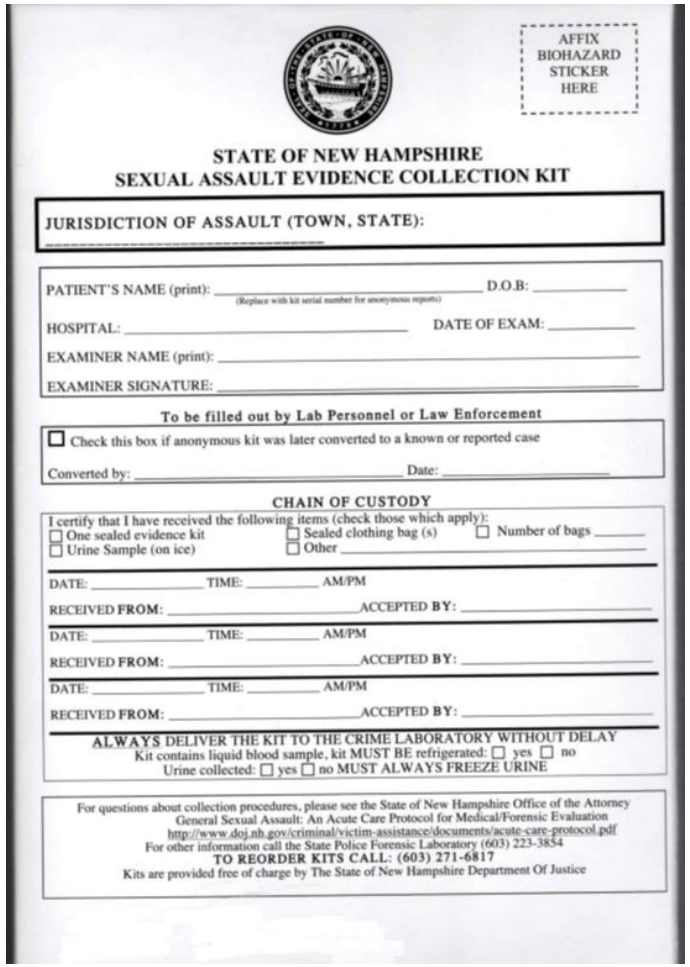
Medical Forensic Exams

- Screening and Health!
  - Long-term & Short-Term health consequences
    - Improved patient outcomes
  - Resources (hospital & community) available
  - Healthcare costs- decrease

Timeframes Matter

- Evidence Collection Kits:
  - Adolescents/Adults: 120 Hours
  - Pre-Pubescent: 96 hours, unless drugged (120 hours w/drugging)
- HIV Prophylaxis:
  - 72 hours
- Pregnancy Prophylaxis:
  - 120 Hours
- DFSA: Sooner is best

Evidence Collection



AFFIX BIOHAZARD STICKER HERE

STATE OF NEW HAMPSHIRE
SEXUAL ASSAULT EVIDENCE COLLECTION KIT

JURISDICTION OF ASSAULT (TOWN, STATE): _____

PATIENT'S NAME (print): _____ D.O.B: _____
(Replace with kit serial number for anonymous reports)

HOSPITAL: _____ DATE OF EXAM: _____

EXAMINER NAME (print): _____

EXAMINER SIGNATURE: _____

To be filled out by Lab Personnel or Law Enforcement

☐ Check this box if anonymous kit was later converted to a known or reported case

Converted by: _____ Date: _____

CHAIN OF CUSTODY

I certify that I have received the following items (check those which apply):
☐ One sealed evidence kit ☐ Sealed clothing bag (s) ☐ Number of bags _____
☐ Urine Sample (on ice) ☐ Other _____

DATE: _____ TIME: _____ AM/PM
RECEIVED **FROM:** _____ ACCEPTED **BY:** _____

DATE: _____ TIME: _____ AM/PM
RECEIVED **FROM:** _____ ACCEPTED **BY:** _____

DATE: _____ TIME: _____ AM/PM
RECEIVED **FROM:** _____ ACCEPTED **BY:** _____

ALWAYS DELIVER THE KIT TO THE CRIME LABORATORY WITHOUT DELAY
Kit contains liquid blood sample, kit MUST BE refrigerated: ☐ yes ☐ no
Urine collected: ☐ yes ☐ no MUST ALWAYS FREEZE URINE

For questions about collection procedures, please see the State of New Hampshire Office of the Attorney General Sexual Assault: An Acute Care Protocol for Medical/Forensic Evaluation
http://www.doj.nh.gov/criminal/victim-assistance/documents/acute-care-protocol.pdf
For other information call the State Police Forensic Laboratory (603) 223-3854
TO REORDER KITS CALL: (603) 271-6817
Kits are provided free of charge by The State of New Hampshire Department Of Justice

EVERY Patient Should be **OFFERED** the Following:

- Documentation of the History of Event
- Comprehensive Physical Exam for Injury/Disease Identification.
  - Photography if requested
  - Pediatrics: Videography of ano-genital exam
- Prophylaxis Medications: (If appropriate)
  - Pregnancy
  - Sexually Transmitted Infections
  - HIV
- Crisis Center Advocate
- Mental Health Evaluation

Options of Medical Forensic Exams

- Sexual Assault:
  1. Eval without evidence collection
  2. Eval w/reported evidence collection
  3. Eval w/anonymous evidence collection

     -Not an option if a mandatory report

- All other forensic populations:
  - Eval with or w/o photography, evidence only if warranted

Mandatory Reporting Requirements of **Healthcare** Providers

1. Minors: CPS

2. Vulnerable Adults: APS

3. GSW & Serious Bodily Injury: Law Enforcement

***NOTE: Varies by state, however very similar!

The Incapacitated or Unable to Consent Patient:

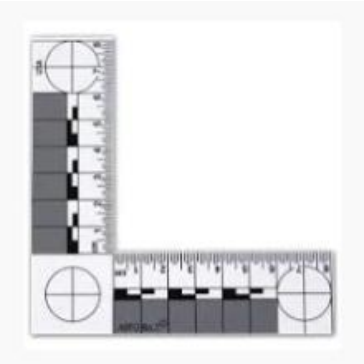
- Policy in place
- Next of Kin: if possible
- Court order

DFSA: Drugged

- “date- rape” drugs: Rhoypnol, GHB, Ketamine, Ectasy(MDMA), etc
  - What's the Biggest? Lets name a few!
- Signs:
  - Unexplained memory loss, or “memory flashes”
  - Statements of: “ I feel like I had sex, but I don’t remember it”, “ I normally drink, but this time was different”.
  - Missing clothes without explanation
  - Injuries with no memory of it
- Some drugs have a life span of 4 hours

Forensic Photography

- “one picture equals a thousand words”
- Are part of the MEDICAL RECORD, not the kit
- Photographs should not be taken in place of diagrams and written descriptions
- Serves to visually document the actual physical appearance of an injury to preserve it



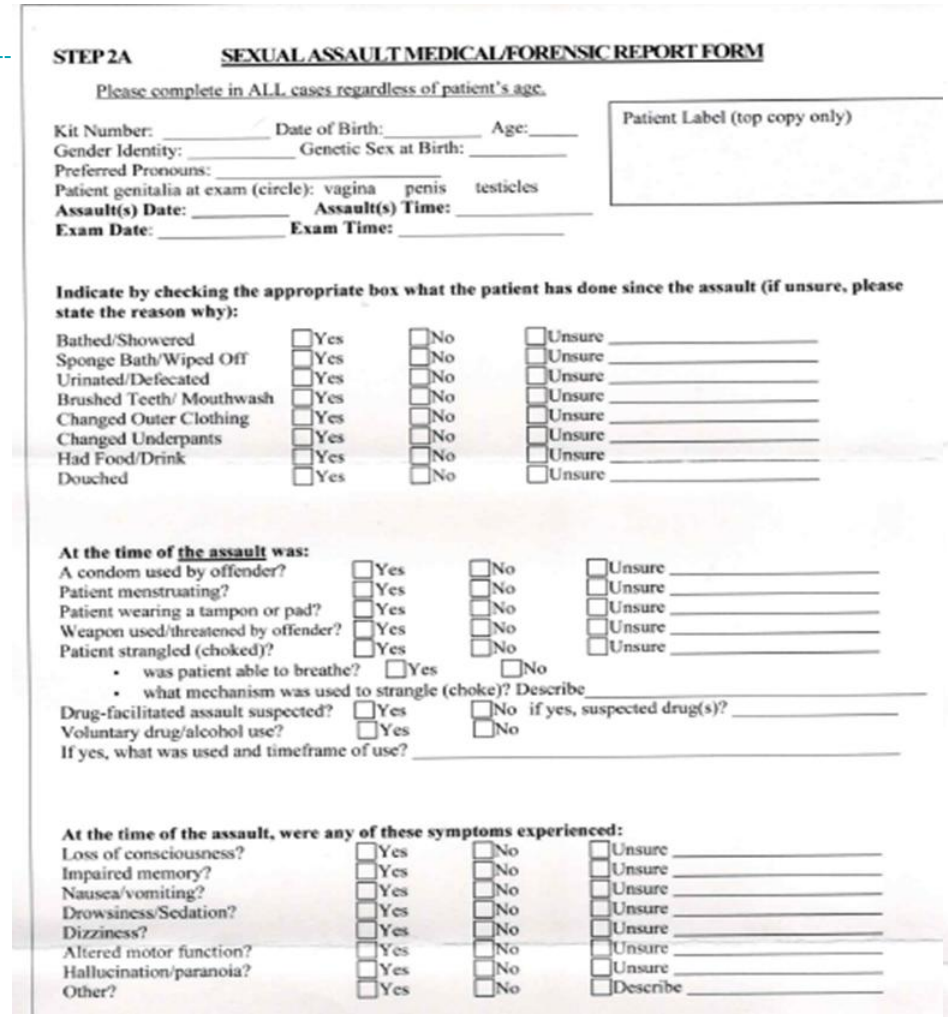
Ano-Genital Images

- Will not release
  - Unless search warrant or other legal authorization
  - Serves mostly for peer review and secondary medical opinion
  - May be used for defense medical expert review

Strangulation

- Is now a FELONY
  - NH SANE protocol: Tool for strangulation assessment and documentation.

Kit: History Taking



STEP 2A **SEXUAL ASSAULT MEDICAL/FORENSIC REPORT FORM**

Please complete in ALL cases regardless of patient's age.

Kit Number: _____ Date of Birth: _____ Age: _____
Gender Identity: _____ Genetic Sex at Birth: _____
Preferred Pronouns: _____
Patient genitalia at exam (circle): vagina penis testicles
Assault(s) Date: _____ **Assault(s) Time:** _____
Exam Date: _____ **Exam Time:** _____

Patient Label (top copy only)

Indicate by checking the appropriate box what the patient has done since the assault (if unsure, please state the reason why):

Bathed/Showered	☐Yes	☐No	☐Unsure _____
Sponge Bath/Wiped Off	☐Yes	☐No	☐Unsure _____
Urinated/Defecated	☐Yes	☐No	☐Unsure _____
Brushed Teeth/ Mouthwash	☐Yes	☐No	☐Unsure _____
Changed Outer Clothing	☐Yes	☐No	☐Unsure _____
Changed Underpants	☐Yes	☐No	☐Unsure _____
Had Food/Drink	☐Yes	☐No	☐Unsure _____
Douched	☐Yes	☐No	☐Unsure _____

At the time of the assault was:

A condom used by offender?	☐Yes	☐No	☐Unsure _____
Patient menstruating?	☐Yes	☐No	☐Unsure _____
Patient wearing a tampon or pad?	☐Yes	☐No	☐Unsure _____
Weapon used/threatened by offender?	☐Yes	☐No	☐Unsure _____
Patient strangled (choked)?	☐Yes	☐No	☐Unsure _____

- was patient able to breathe? ☐Yes ☐No
- what mechanism was used to strangle (choke)? Describe _____

Drug-facilitated assault suspected? ☐Yes ☐No if yes, suspected drug(s)? _____
Voluntary drug/alcohol use? ☐Yes ☐No
If yes, what was used and timeframe of use? _____

At the time of the assault, were any of these symptoms experienced:

Loss of consciousness?	☐Yes	☐No	☐Unsure _____
Impaired memory?	☐Yes	☐No	☐Unsure _____
Nausea/vomiting?	☐Yes	☐No	☐Unsure _____
Drowsiness/Sedation?	☐Yes	☐No	☐Unsure _____
Dizziness?	☐Yes	☐No	☐Unsure _____
Altered motor function?	☐Yes	☐No	☐Unsure _____
Hallucination/paranoia?	☐Yes	☐No	☐Unsure _____
Other?	☐Yes	☐No	☐Describe _____

STEP 2B **SEXUAL ASSAULT MEDICAL/FORENSIC REPORT FORM**

Please complete in ALL cases regardless of patient's age.

Kit Number: _____

Number of Offenders: _____ Sex of Offender(s): _____

Patient Label (top copy only)

Prior to exam:
Was patient given any medication at the hospital prior to the exam? ☐Yes ☐No
If yes, list medications: _____

At the time of the exam was:

Patient menstruating?	☐Yes	☐No	☐Unsure _____
Patient wearing a tampon or pad?	☐Yes	☐No	☐Unsure _____

Within the past five days has the patient engaged in consensual sexual activity? ☐Yes ☐No
If yes, on the following date(s): _____

Was a condom used	☐Yes	☐No
Was the consensual partner also the offender?	☐Yes	☐No

Details of the assault obtained by patient (check all that apply):

☐ Patient was unable to provide history of assault at this time

During the assault, were photos or video taken? ☐Yes ☐No ☐Unknown
Please describe: _____

Penetration performed **by** offender:
☐ penile/oral ☐ penile/genital ☐ penile/anal
☐ oral /anal ☐ oral/genital ☐ digital/genital ☐ digital/anal
☐ other (please describe) _____
☐ foreign object (please describe) _____
☐ other oral contact by offender (please describe) _____
☐ other oral contact by patient (please describe) _____
☐ ejaculation deposited on patient's body (please identify location and swab area): _____

Describe the details of the assault specifically related to the samples that have been collected: _____

STEP 12

SEXUAL ASSAULT EVIDENCE COLLECTION KIT INVENTORY FORM

Patient Label:

Kit Number #: _____

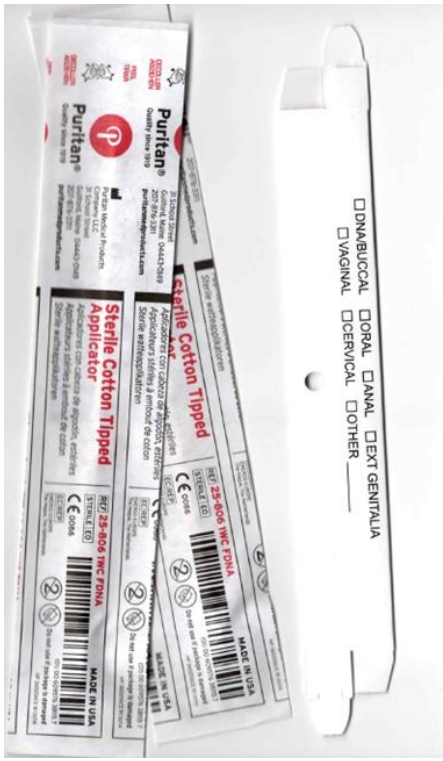
Check collected or not collected as appropriate

	Collected	Not Collected	Form completed
Step 1: Authorization			*Always complete*
Step 2A: Medical/Forensic Report Form			*Always complete*
Step 2B: Medical/Forensic Report Form			*Always complete*
Step 3A: Blood Toxicology Sample *			
Step 3B: Urine Toxicology Sample *			
Step 4: Outer Clothing Number of Bags _____			
Step 5: Underpants/Diaper			
Step 6: Oral Swabs and Smear			
Step 7: DNA Sample/ Buccal Swabs			
Step 8: Foreign Material			
Step 8: Pubic Hair Combings*			
Step 9: Anal Swabs and Smear			
Step 10: External Genitalia/Penile Swabs			
Step 11: Vaginal/Cervical Swabs and Vaginal Smear *			
Step 12: Sexual Assault Evidence Collection Kit Inventory Form			*Always complete*
Step 13: Medical/Forensic Examination Forms			*Always complete*
Step 14: Patient Information Form			*Always complete*
Step 15: Patient Forms			
a. HIVnPEP Patient Information Form			*Always when giving nPEP*
b. Follow Up Examination Voucher Form			*Give to PT*
c. Sexual Assault Crisis Center List			*Give to PT*
d. NH Crime Victims Bill of Rights			*Give to PT*
e. Financial Assistance for Victims Card			*Give to PT*
Step 16: Postcard (Provider **MUST** complete and mail)			*Always complete*
Step 16A: Forensic Sexual Assault Examination Billing Form			*Always complete*
Additional Evidence: please list: _____			
Additional Evidence: please list: _____			

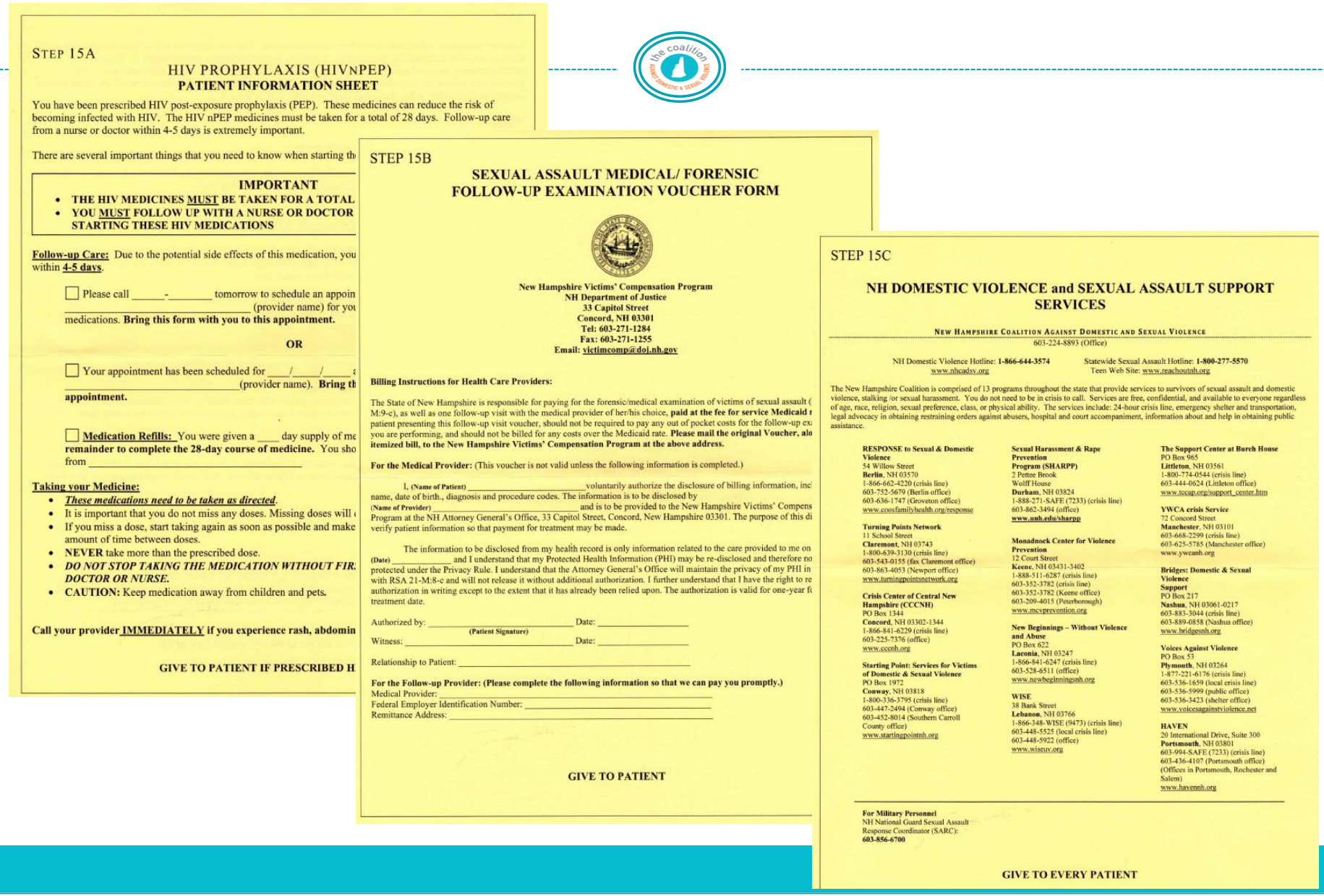
***Any step with an asterisk is NOT routinely required with a pre-pubertal child.**

Date _____ Signature of Examiner _____

Retain for Medical Records



Sample Resource Papers



STEP 15A

HIV PROPHYLAXIS (HIVnPEP)
PATIENT INFORMATION SHEET

You have been prescribed HIV post-exposure prophylaxis (PEP). These medicines can reduce the risk of becoming infected with HIV. The HIV nPEP medicines must be taken for a total of 28 days. Follow-up care from a nurse or doctor within 4-5 days is extremely important.

There are several important things that you need to know when starting th

IMPORTANT
- **THE HIV MEDICINES MUST BE TAKEN FOR A TOTAL**
- **YOU MUST FOLLOW UP WITH A NURSE OR DOCTOR STARTING THESE HIV MEDICATIONS**

Follow-up Care: Due to the potential side effects of this medication, you within **4-5 days**.

☐ Please call _____-_____ tomorrow to schedule an appoin _____ (provider name) for yo medications. **Bring this form with you to this appointment.**

OR

☐ Your appointment has been scheduled for ___/___/___ _____(provider name). **Bring th appointment.**

☐ **Medication Refills:** You were given a ____ day supply of me **remainder to complete the 28-day course of medicine.** You sho from _____

Taking your Medicine:
- ***These medications need to be taken as directed.***
- It is important that you do not miss any doses. Missing doses will
- If you miss a dose, start taking again as soon as possible and make amount of time between doses.
- **NEVER** take more than the prescribed dose.
- ***DO NOT STOP TAKING THE MEDICATION WITHOUT FIR. DOCTOR OR NURSE.***
- **CAUTION:** Keep medication away from children and pets.

Call your provider IMMEDIATELY if you experience rash, abdomin

GIVE TO PATIENT IF PRESCRIBED H

STEP 15B

SEXUAL ASSAULT MEDICAL/ FORENSIC FOLLOW-UP EXAMINATION VOUCHER FORM

New Hampshire Victims' Compensation Program
NH Department of Justice
33 Capitol Street
Concord, NH 03301
Tel: 603-271-1284
Fax: 603-271-1255
Email: victimcomp@doj.nh.gov

Billing Instructions for Health Care Providers:

The State of New Hampshire is responsible for paying for the forensic/medical examination of victims of sexual assault (M:9-c), as well as one follow-up visit with the medical provider of her/his choice, **paid at the fee for service Medicaid r** patient presenting this follow-up visit voucher, should not be required to pay any out of pocket costs for the follow-up ex you are performing, and should not be billed for any costs over the Medicaid rate. **Please mail the original Voucher, alo itemized bill, to the New Hampshire Victims' Compensation Program at the above address.**

For the Medical Provider: (This voucher is not valid unless the following information is completed.)

I, **(Name of Patient)** _____ voluntarily authorize the disclosure of billing information, incl name, date of birth., diagnosis and procedure codes. The information is to be disclosed by **(Name of Provider)** _____ and is to be provided to the New Hampshire Victims' Compens Program at the NH Attorney General's Office, 33 Capitol Street, Concord, New Hampshire 03301. The purpose of this di verify patient information so that payment for treatment may be made.

The information to be disclosed from my health record is only information related to the care provided to me on **(Date)** _____ and I understand that my Protected Health Information (PHI) may be re-disclosed and therefore no protected under the Privacy Rule. I understand that the Attorney General's Office will maintain the privacy of my PHI in with RSA 21-M:8-c and will not release it without additional authorization. I further understand that I have the right to re authorization in writing except to the extent that it has already been relied upon. The authorization is valid for one-year fr treatment date.

Authorized by: _____ Date: _____
(Patient Signature)

Witness: _____ Date: _____

Relationship to Patient: _____

For the Follow-up Provider: (Please complete the following information so that we can pay you promptly.)
Medical Provider: _____
Federal Employer Identification Number: _____
Remittance Address: _____

GIVE TO PATIENT

STEP 15C

NH DOMESTIC VIOLENCE and SEXUAL ASSAULT SUPPORT SERVICES

NEW HAMPSHIRE COALITION AGAINST DOMESTIC AND SEXUAL VIOLENCE
603-224-8893 (Office)

NH Domestic Violence Hotline: **1-866-644-3574**
www.nhcadsv.org

Statewide Sexual Assault Hotline: **1-800-277-5570**
Teen Web Site: www.reachoutnh.org

The New Hampshire Coalition is comprised of 13 programs throughout the state that provide services to survivors of sexual assault and domestic violence, stalking /or sexual harassment. You do not need to be in crisis to call. Services are free, confidential, and available to everyone regardless of age, race, religion, sexual preference, class, or physical ability. The services include: 24-hour crisis line, emergency shelter and transportation, legal advocacy in obtaining restraining orders against abusers, hospital and court accompaniment, information about and help in obtaining public assistance.

RESPONSE to Sexual & Domestic Violence
54 Willow Street
Berlin, NH 03570
1-866-662-4220 (crisis line)
603-752-5679 (Berlin office)
603-636-1747 (Groveton office)
www.coosfamilyhealth.org/response

Turning Points Network
11 School Street
Claremont, NH 03743
1-800-639-3130 (crisis line)
603-543-0155 (fax Claremont office)
603-863-4053 (Newport office)
www.turningpointsnetwork.org

Crisis Center of Central New Hampshire (CCCNH)
PO Box 1344
Concord, NH 03302-1344
1-866-841-6229 (crisis line)
603-225-7376 (office)
www.cccnh.org

Starting Point: Services for Victims of Domestic & Sexual Violence
PO Box 1972
Conway, NH 03818
1-800-336-3795 (crisis line)
603-447-2494 (Conway office)
603-452-8014 (Southern Carroll County office)
www.startingpointnh.org

Sexual Harassment & Rape Prevention Program (SHARPP)
2 Pettee Brook
Wolff House
Durham, NH 03824
1-888-271-SAFE (7233) (crisis line)
603-862-3494 (office)
www.unh.edu/sharpp

Monadnock Center for Violence Prevention
12 Court Street
Keene, NH 03431-3402
1-888-511-6287 (crisis line)
603-352-3782 (crisis line)
603-352-3782 (Keene office)
603-209-4015 (Peterborough)
www.mcvprevention.org

New Beginnings – Without Violence and Abuse
PO Box 622
Laconia, NH 03247
1-866-841-6247 (crisis line)
603-528-6511 (office)
www.newbeginningsnh.org

WISE
38 Bank Street
Lebanon, NH 03766
1-866-348-WISE (9473) (crisis line)
603-448-5525 (local crisis line)
603-448-5922 (office)
www.wiseuv.org

The Support Center at Burch House
PO Box 965
Littleton, NH 03561
1-800-774-0544 (crisis line)
603-444-0624 (Littleton office)
www.tecap.org/support_center.htm

YWCA crisis Service
72 Concord Street
Manchester, NH 03101
603-668-2299 (crisis line)
603-625-5785 (Manchester office)
www.ywcanh.org

Bridges: Domestic & Sexual Violence Support
PO Box 217
Nashua, NH 03061-0217
603-883-3044 (crisis line)
603-889-0858 (Nashua office)
www.bridgesnh.org

Voices Against Violence
PO Box 53
Plymouth, NH 03264
1-877-221-6176 (crisis line)
603-536-1659 (local crisis line)
603-536-5999 (public office)
603-536-3423 (shelter office)
www.voicesagainstviolence.net

HAVEN
20 International Drive, Suite 300
Portsmouth, NH 03801
603-994-SAFE (7233) (crisis line)
603-436-4107 (Portsmouth office)
(Offices in Portsmouth, Rochester and Salem)
www.havennh.org

For Military Personnel
NH National Guard Sexual Assault Response Coordinator (SARC):
603-856-6700

GIVE TO EVERY PATIENT

Sexual Assault: Prophylaxis

- Prophylaxis Options
  - Pregnancy
  - STI's- Dispensing
  - HIVnPEP

- Procedure

HIV Prophylaxis Coverage by State:

- Connecticut: Dispense minimum 3-5 days; Fill RX at Walgreens
- Maine: Dispensed 3–5 day supply & given Rx to fill. Barriers to accessing Rx at Pharmacy. Must bill insurance or pay out of pocket
- Massachusetts: Covered in Full, can now dispense directly from ED, all 28-day supply
- New Hampshire: Covered in Full, can dispense up to 28-day supply under Pharmacy Rule.
- Rhode Island: Covered in Full
- Vermont: Covered in Full, can dispense up to 28-day supply; have voucher form if Rx given.

Example: Billing Form

Victim Comp Auto Pays:

- Hospital Visit
- Prophylaxis Meds
- Assoc. Lab Testing
- First 24 hours of hosp.

STEP 16A

Hospital Label

STATE OF NEW HAMPSHIRE VICTIMS' COMPENSATION
FORENSIC SEXUAL ASSAULT EXAMINATION
BILLING FORM

_____(name of patient or "anonymous") has been informed that the NH Victims' Compensation Program can provide payment for the examination, collection of evidence, and treatment related to this sexual assault visit; including HIV Post Exposure Prophylaxis, if necessary. It is the intent of this form to allow the patient to make an informed decision concerning the method of payment she/he chooses.

Please choose an option:

- _____Patient does not have insurance that would cover this treatment.
- _____Patient does have insurance or Medicaid which will be billed. Patient will not be charged for any co-payments or deductibles associated with this treatment.
- _____Patient does have insurance that would cover this treatment but does not want insurance carrier billed.

This section must be completed by the SANE provider or treating physician:

Forensic Sexual Assault Examination Kit #_____ Patient's Account #_____

Patient's Date of Birth **(REQUIRED)**_____ RX (for HIV nPEP medications ONLY):_____

Were HIV nPEP medications dispensed in ED? **Yes No** (circle one) # of days HIV nPEP medications dispensed:_____

The City/State/County where assault occurred:_____

(NH Victims' Compensation Program can only provide payment for assaults occurring in NH. If assault occurred in another state, please contact the Victims' Compensation Program of that state.)

HIV POST EXPOSURE PROPHYLAXIS PRESCRIPTION MEDICATIONS WILL BE PAID TO THE HOSPITAL/FACILITY AT MEDICAID RATE BY THE NH VICTIMS' COMPENSATION PROGRAM.

SANE or Attending Physician (please print)	Signature of SANE or Attending Physician	Telephone

Name of Facility	Name of Billing Contact Person	Telephone	Date of Service

Please use the universal UB invoice with back up documentation, including the services provided, medical record and appropriate medical coding. This form must be attached to UB invoice. Failure to provide all requested information will result in denial of payment. When completed, please mail these documents to:

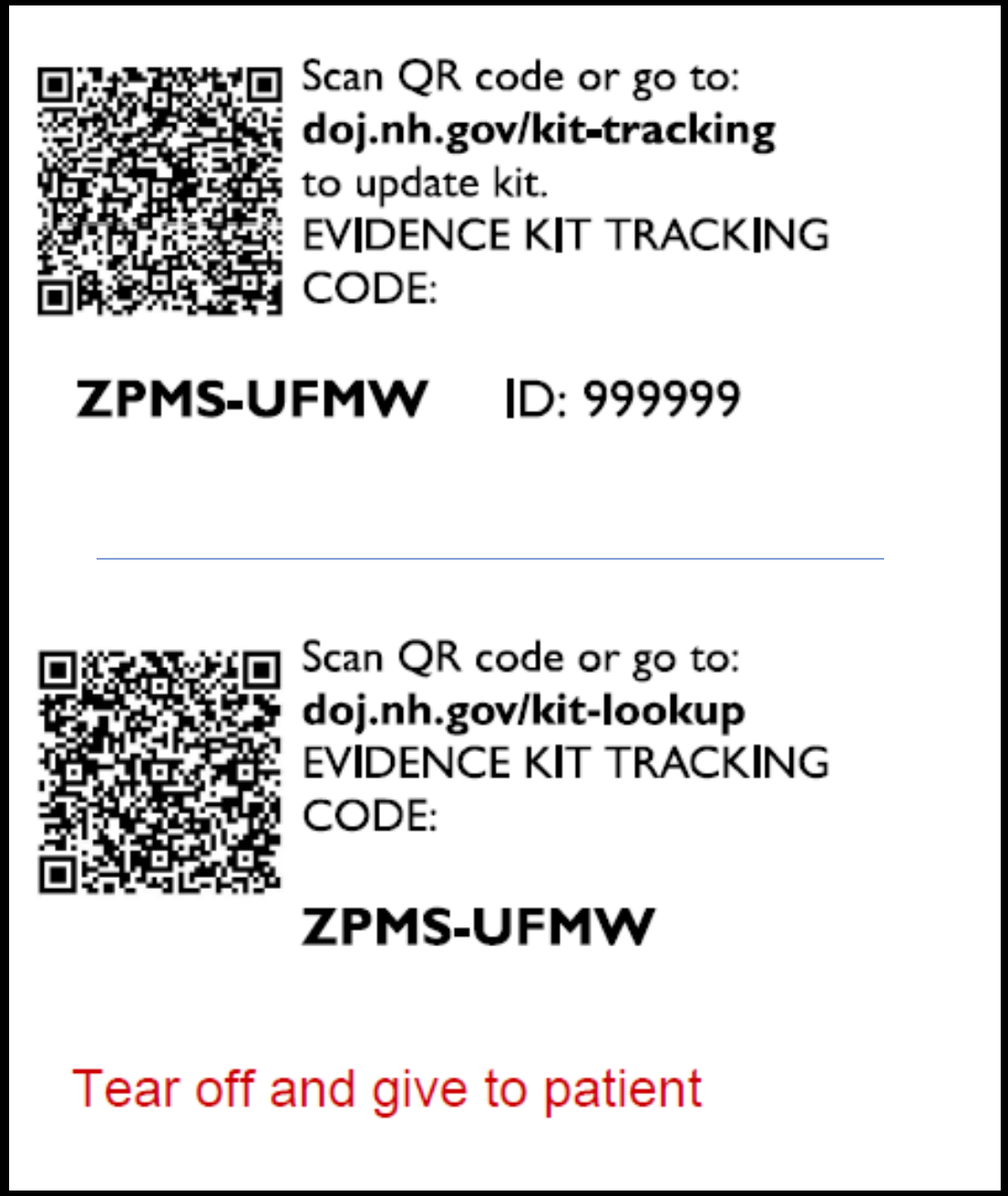
New Hampshire Victims' Compensation Program
Office of the Attorney General
33 Capitol Street
Concord, NH 033301
Telephone: 603-271-1284
victimcomp@doj.nh.gov

Note to provider: Be sure that your billing department has a copy of this completed Billing Form and Instructions.

08/2020

Kit Tracking System

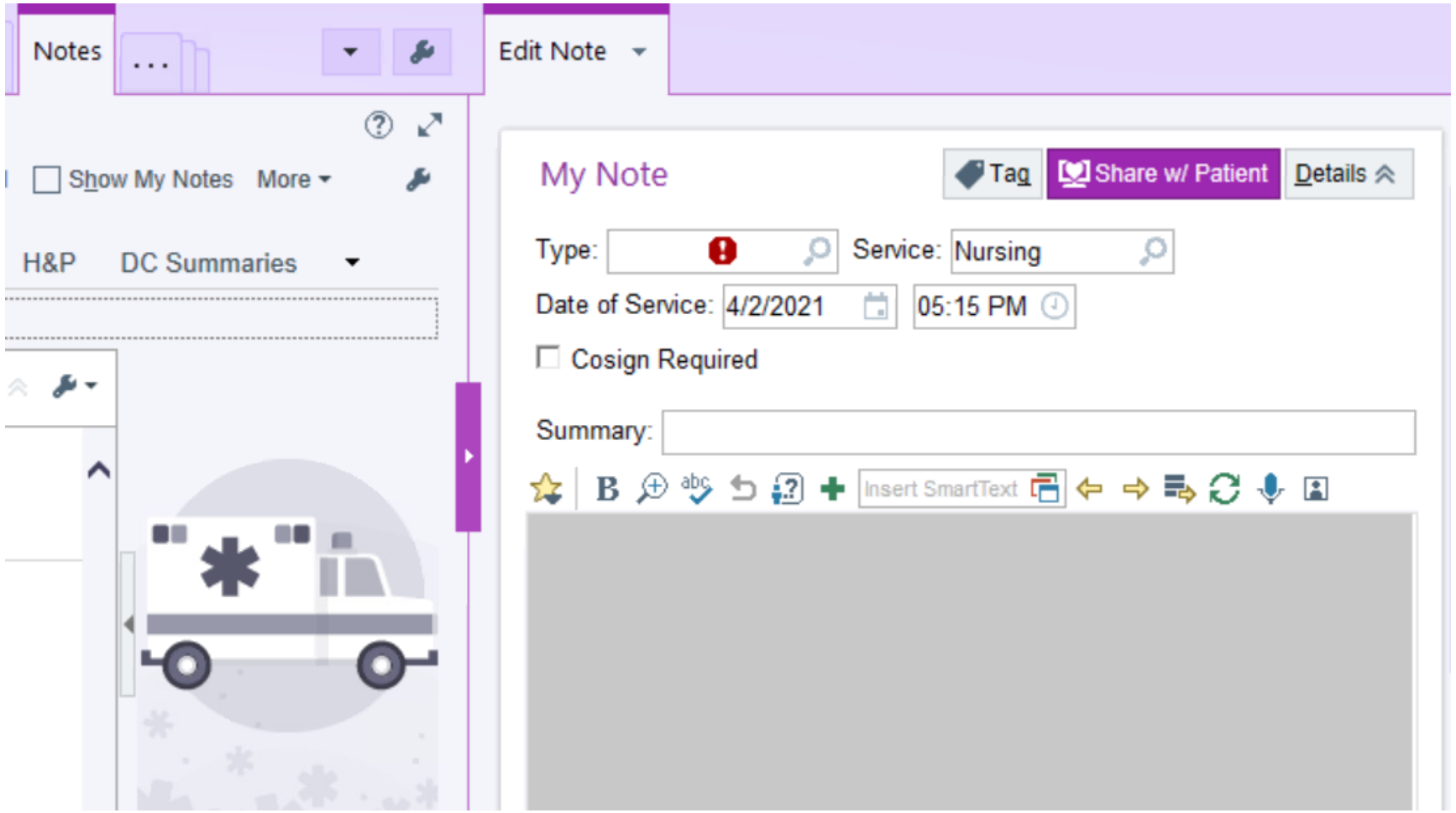
EXAMPLE



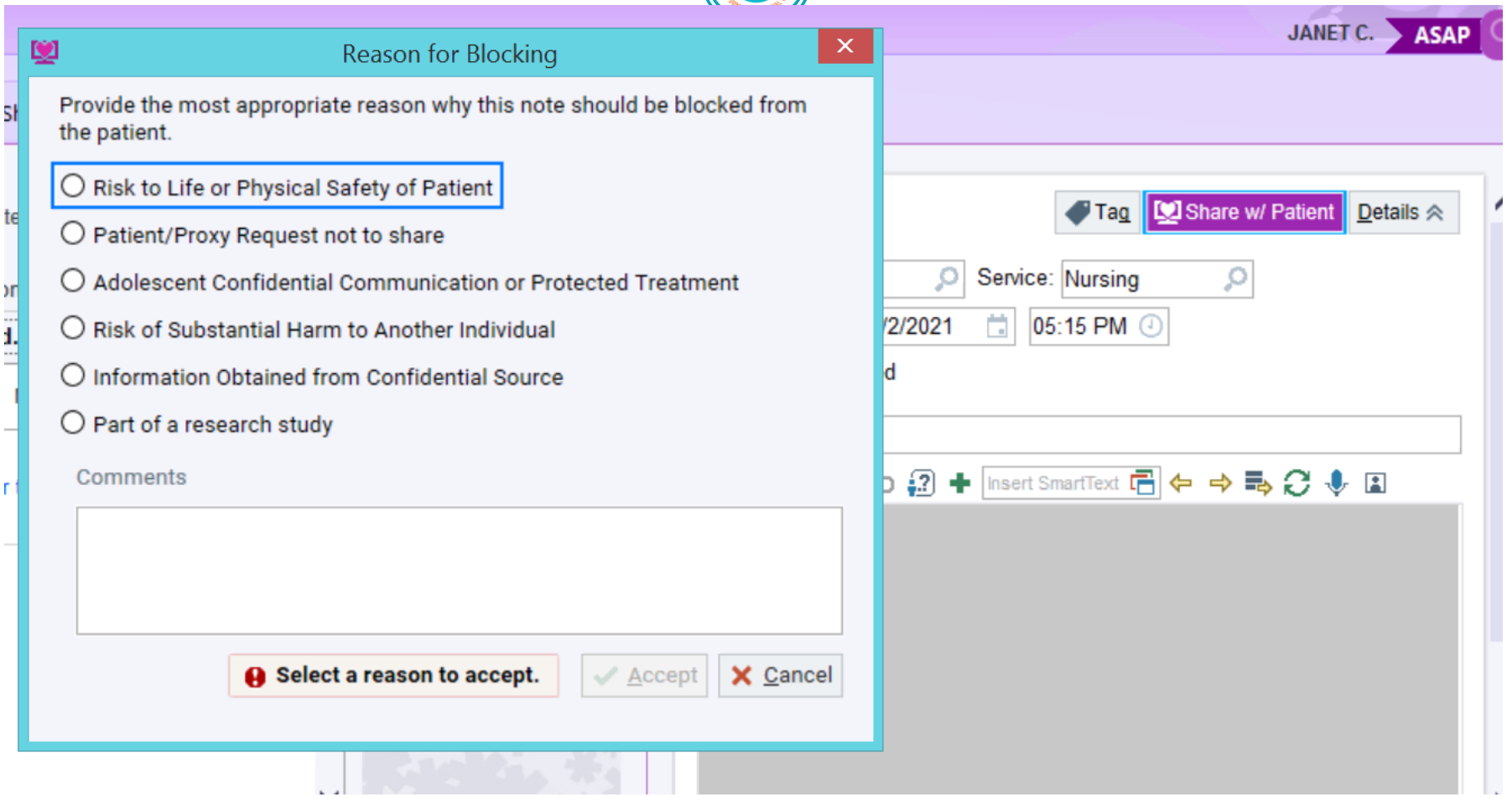
Privacy

- Forensic Nurses: Paper Documentation, ROI flag
- EMR: “Unshare” note
- If safety issue at work: FYI “restricted encounter”

“Unshare” notes for safety! - EPIC EMR Example



EPIC EMR Example



Crisis Center Advocates

- ✓ Complement the effective intervention of health care.
- ✓ Are victim-centered in everything they do.
- ✓ Brainstorm and provide options available and do safety planning based on the individual's choices/situation.
- ✓ Provide access to advocacy, support, and resources.
- ✓ Are CONFIDENTIAL.

Crisis Center advocates can not acknowledge that they are providing services to any victims of domestic or sexual violence without a release by that victim. (NH RSA 173-C)

Crisis Center Advocate

- 24-hour access to shelter
- 24-hour accompaniment to hospital & police
- 24-hour support and information hotline
- Assistance in obtaining protective orders
- Advocacy in systems and support in their navigation
- Help creating a safety plan for the family
- One-to-one support and support groups
- Professional training and educational programs
- Confidential consultation
- Systems work in communities

National Hotlines

- National Sexual Assault Hotline:
  - 800-656-4673

- National Domestic Violence Hotline:
  - 800-799-7233

- Connecticut: CT Alliance to End Sexual Violence 888-999-5545
- Maine: ME Coalition to End Domestic Violence 866-834-4357
- Massachusetts: https://www.mass.gov/doc/find-a-rape-crisis-center/download
- New Hampshire: NH Coalition Against Domestic & Sexual Violence 866-644-3574
- Rhode Island: RI Coalition Against Domestic Violence 800-494-8100
- Vermont: VT Network 800-489-7273

Victims Compensation

- Varies by state: If eligible & how much
- Patient needs to apply
- Assists with paying for out-of-pocket costs associated with the assault.

Follow-Up

- Crisis center advocate
- PCP or provider of choice
- If on nPEP: hopefully an ID provider
- Mental health counseling is encouraged
- SANE Repeat evaluation PRN
- Call 911 if feeling unsafe or in danger
- How to report if anonymous

Joke Time

Two peanuts went walking down the street. One was assaulted.

My toddler is refusing to nap. He’s guilty of resisting a rest.

Thank you!

JANET CARROLL RN, CEN, SANE-A, SANE-P

JANET@NHCADSV.ORG

(603) 715-8804 WORK CELL

WELCOME to the

PEP Talk: HIV Post Exposure Prophylaxis ECHO

Session 3, Pediatric Physical and Psychosocial Assessment,
May 5, 2026

Pediatric Physical and Psychosocial Assessment

Dr. Patrick Passarelli – DHMC Infectious Disease

Dr. Amy Roy – DHMC Child Advocacy and Protection Program

Anna Marsh, APRN – DHMC Child Advocacy and Protection Program

Tory Emery, LICSW – DHMC Child Advocacy and Protection Program

Objectives

- Understand differences in pediatric vs adult sexual abuse/assault examinations.
- Understand the options available for specialized medical examinations in regards to pediatric sexual abuse.
- Understand when and what to consider testing in pediatrics.
- Understand when to consider prophylactic medications in pediatrics.

Child Sexual Abuse

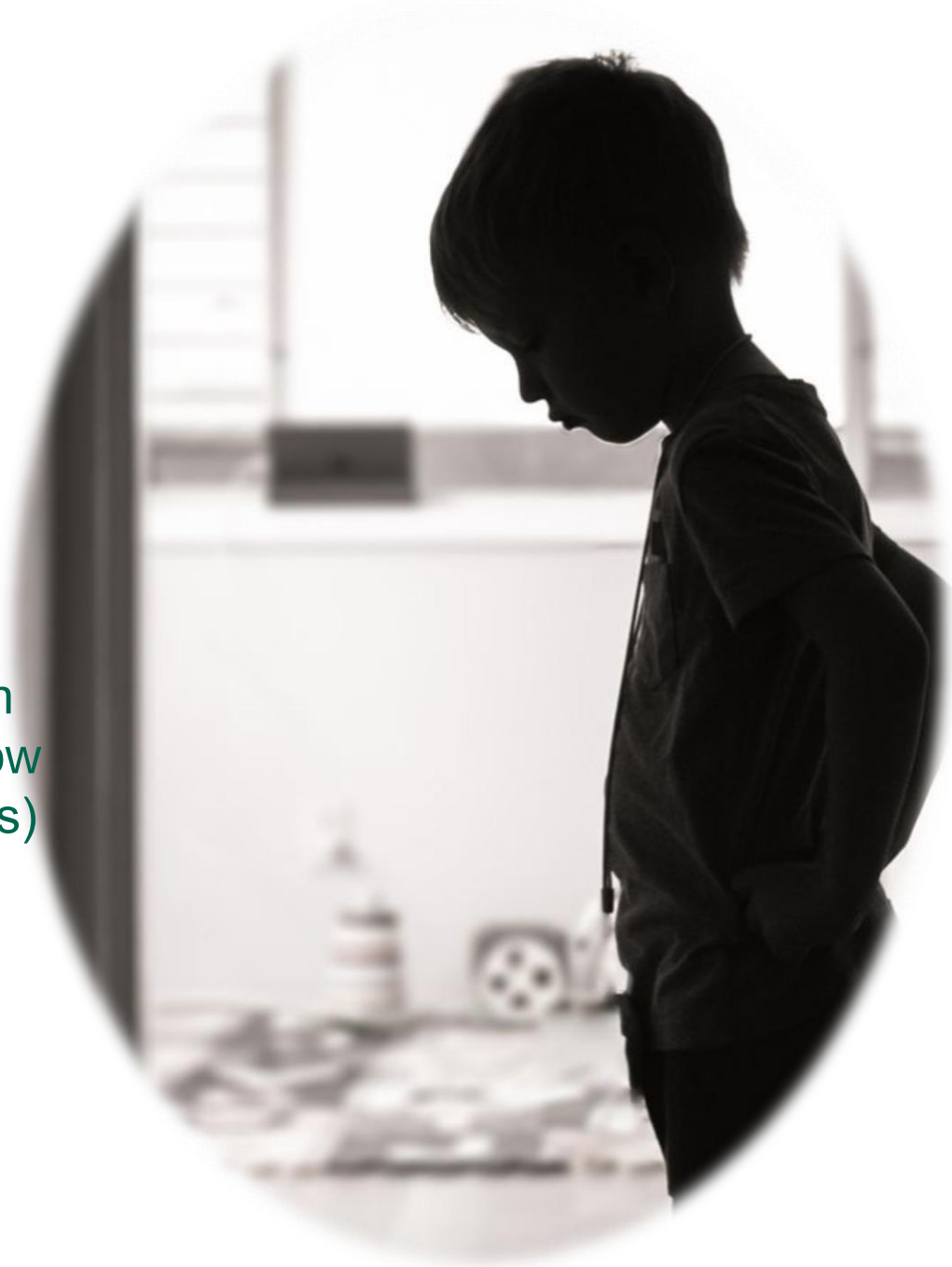
- CDC definition: *"The involvement of a minor in sexual activity that violates the laws or social taboos of society and that the child:*
  - *Does not fully comprehend.*
  - *Does not consent to or is unable to give informed consent to.*
  - *Is not developmentally prepared for and cannot give consent to."*
- Between an adult and a minor.
- Between two minors when one exerts power over the other.
  - Examples include fondling, penetration, exhibitionism, voyeurism, intercourse, and exposing a child to other sexual activities

Child Sexual Abuse

- Recognition of possible abuse
  - Behavioral concerns
  - Symptoms
  - **Disclosure**
- Evaluation
  - Physical findings
  - In select cases
    - Test for STIs, pregnancy, and evidence collection

When to seek emergency medical evaluation:

- Acute sexual assault
  - Evidence collection within 120 hrs (know your state's policies)
- Injuries
- Concern for trafficking



Specialized Medical Evaluation – Child Sexual Abuse

- Child Abuse Pediatrics Clinic (DHMC CAPP)
  - Acute sexual abuse SANE exams
  - Non acute sexual abuse exams

Medical providers

Nurses

Social workers

Child life specialists

Why are these important?

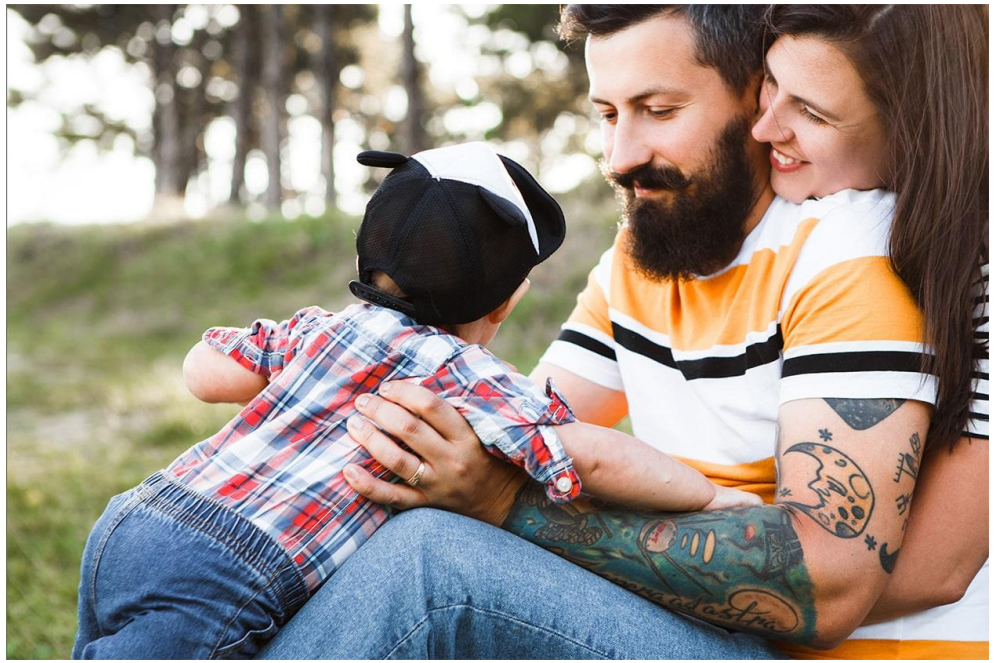
- Opportunity to determine if a child's medical problem is the likely result of maltreatment
- Opportunity for a child and family to evaluate the child's health after a traumatic event
  - Model conversations about body autonomy
  - Relieve distress

What happens at these appointments?

- Perform a complete medical assessment
  - History
  - Physical exam
  - Photo documentation of skin findings, anogenital exam
  - Order diagnostic tests
    - lab tests
- A LOT of communicating
  - Talk to kids about their bodies
  - Talk to parents/caregivers about their kids
    - Not always easy
  - Communicate with other medical professionals
  - Communicate with non-medical professions

Goals of a specialized medical exam?

- Address specific medical needs
  - Diagnosis and treatment of STI's
  - Referrals for other care
- Assign some level of certainty to the likelihood of sexual abuse
- Address mental health needs
- Provide family support
- Restore some sense of control and autonomy to children and families
  - We give a lot of choices



Other important stuff?

- Place for parents to fall apart
  - Parents feel guilty
- Kids can address their worries
  - “I think it made me sick. I been sneezin’ a lot.”
- Children can say what happened
  - Some won’t talk at the CAC
  - Medical exception to hearsay

- EDUCATION
  - Misconceptions/myths
  - Parents on talking to kids about body safety and sexual abuse
    - Use real words!!!
  - Kids on body safety
    - Chance to say “ don’t touch my body!” and have an adult listen

What DOESN’T happen at these visits?

- We don’t “rule out” abuse
  - Most children who have been sexually abused will not have physical exam findings!
  - It is normal to be normal.
- ONLY diagnose abuse
  - Consider all possibilities
  - Can help resolve concerns
  - Address MEDICAL problems

- A forced exam, especially a forced genital exam
  - Model respectful and appropriate conversations about body touching.
- An internal vaginal exam for pre-pubertal girls
  - Never ever ever ever ever.
  - Emphasis on ever.

Reporting to Child Protective Services

- Expected part of clinical practice
- Important part of evaluating children with concerns for maltreatment
  - Sexual abuse
  - Physical abuse
  - Neglect
- Decisions around reporting often complex

CPS: A Critical But Imperfect System

- Mandated reporting laws are necessarily broad
  - “If concerned, report…”
- An overwhelmed CPS system isn’t a better system
  - Over 50% of CPS reports are screened out
- Disproportionality and bias in reporting
  - Persists through the CPS process
  - Harm to families in over reporting
- Mismatch between provider’s concern and the tool
  - Treatment for poor hygiene is access to soap and water
  - NOT a CPS report

A Paradigm Shift

Reflexive Reporting

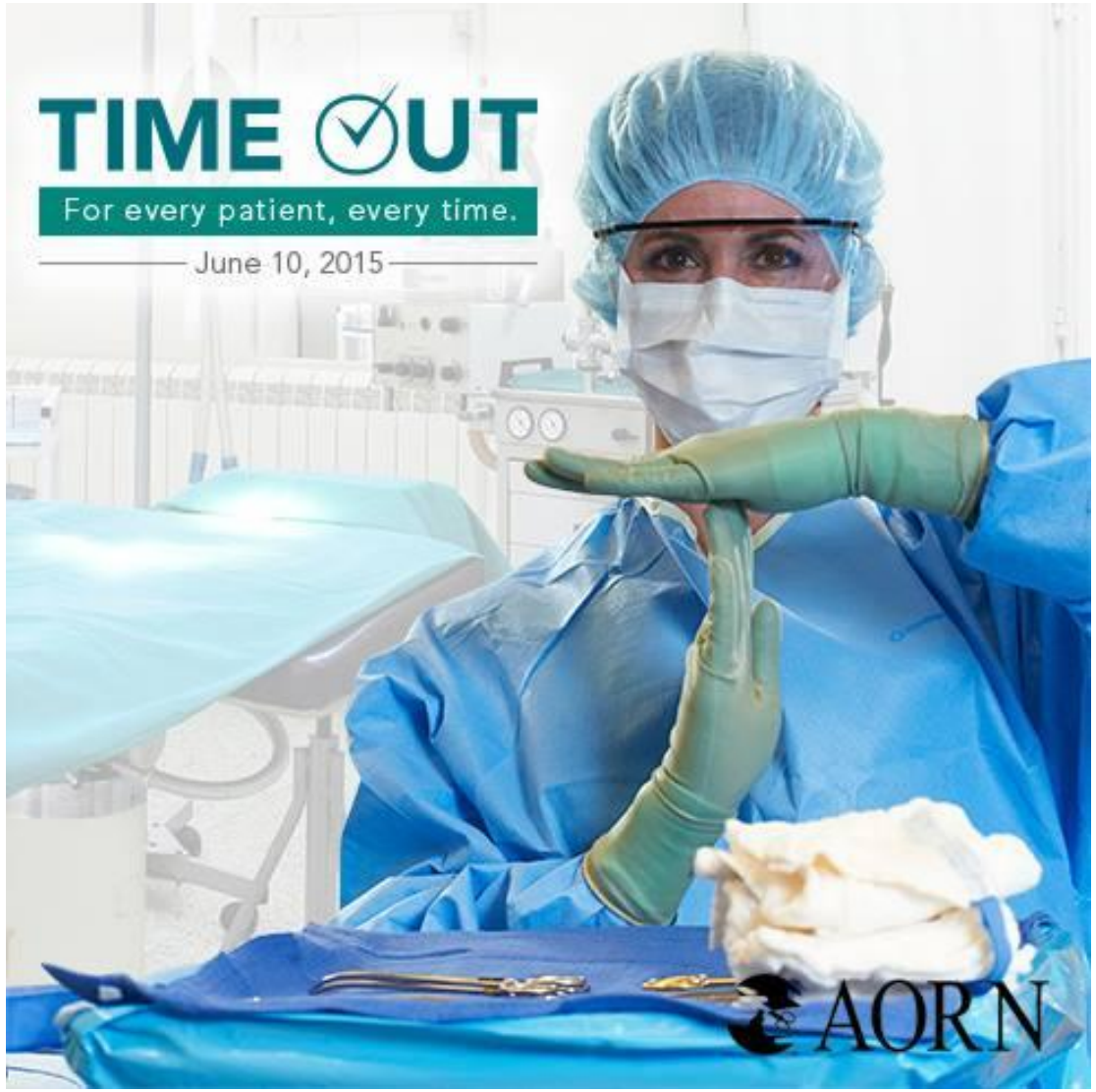
I'm worried so I must report

Structured Thinking

I'm concerned, does a report make sense?

The Surgical Timeout

- The operating room team reviews:
  - Patient's identity
  - The procedure
  - The surgical site
- Time for team members to voice any concerns about the patient's safety or the procedure



The BEST Timeout Model

PRE-Reporting Time-Out

The care team reviews **BEST** practices:

- **Biases**
- **Education & support**
- **Situational awareness**
- **Transparent**

Time for a provider or team to verify that a CPS report makes sense and that we have the necessary information to make a

good report

Key Components of BEST

- **B**ias Mitigation:
  - Actively questioning if a report is based on objective evidence or influenced by bias
- **E**ducation and Support:
  - Recognizing that CPS often does not provide needed resources; clinicians should prioritize connecting families to community support or hospital services instead of relying on reports for help.
- **S**ituational Awareness:
  - Making a reasonable effort to obtain the appropriate information from the relevant caregivers
- **T**ransparency:
  - Engaging with families about concerns and being honest about the reporting process, rather than filing anonymously without warning, when safety permits

Indications for STI Testing in Prepubertal Child after Possible Sexual Assault

- Child reports sexual abuse, regardless of the acts involved
- Child has a sibling, other relative, or another person in the household with an STI
- Child has signs or symptoms (e.g. vaginal discharge or pain, genital itching or odor, urinary symptoms, genital lesions or ulcers)
- Child or parent requests STI testing
- Child is unable to verbalize details of assault

STI Testing in Prepubertal Child after Possible Sexual Assault

- Symptoms are uncommon even in children with proven STIs; therefore, testing all sites for all pathogens is standard of care
- Empiric treatment is NOT recommended for prepubertal children
  - Incidence of STIs is low in this population
  - Risk of ascending infection of uterus, fallopian tubes, and ovaries is low
  - Follow-up can usually be ensured
- Given low prevalence, positive result for GC, chlamydia, or trichomonas should be confirmed either via repeat testing on original specimen or repeat sample prior to treatment

Table 2.5. Implications of Commonly Encountered Sexually Transmitted (ST) or Sexually Associated (SA) Infections for Diagnosis and Reporting of Sexual Abuse Among Infants and Prepubertal Children

ST/SA Confirmed	Evidence for Sexual Abuse	Suggested Action
Neisseria gonorrhoeae[a]	Diagnostic	Report[b]
Syphilis[a]	Diagnostic	Report[b]
Human immunodeficiency virus[c]	Diagnostic	Report[b]
Chlamydia trachomatis[a]	Diagnostic	Report[b]
Trichomonas vaginalis[a]	Diagnostic	Report[b]
Anogenital herpes	Suspicious	Consider report[b,d]
Condylomata acuminata (anogenital warts)[a]	Suspicious	Consider report[b,d,e]
Anogenital molluscum contagiosum	Inconclusive	Medical follow-up
Bacterial vaginosis	Inconclusive	Medical follow-up

[a] If not likely to be perinatally acquired and rare vertical transmission is excluded.
[b] Reports should be made to the local or state agency mandated to receive reports of suspected child abuse or neglect.
[c] If not likely to be acquired perinatally or through transfusion.
[d] Unless a clear history of autoinoculation exists.
[e] Report if evidence exists to suspect abuse, including history, physical examination, or other identified infections. Lesions appearing for first time in child >5 years of age are more likely attributable to sexual transmission.

STI Testing in Prepubertal Child after Possible Sexual Assault

- *N gonorrhea* and *C trachomatis*
  - Culture or NAAT/PCR
  - Pharynx, anus, vagina, urine (from penile urethra)
  - If urethral discharge present, superficial is swab adequate (vs intraurethral swab)
  - Cervical specimens are NOT recommended
  - Gram stain NOT recommended to diagnose or exclude gonorrhea
  - NAAT can cross-react with nongonococcal commensals
    - *Neisseria meningitidis, N. sicca, N. lactamica, N. cinerea; Moraxella catarrhalis*

STI Testing in Prepubertal Child after Possible Sexual Assault

- *Trichomonas vaginalis*
  - Testing should not be limited to patients with vaginal discharge, because there is some evidence that asymptomatic sexually abused children could be infected and may benefit from treatment
  - Culture and wet mount of vaginal specimens and/or NAAT
  - Point of care tests not validated in prepubertal children

STI Testing in Prepubertal Child after Possible Sexual Assault

- *Herpes simplex virus*
  - Any vesicular or ulcerative genital or perianal lesions should be sent for NAAT or viral culture
- Bacterial vaginosis
  - Wet mount or NAAT of a vaginal swab specimen should be performed if discharge present
- Syphilis
  - Treponemal and nontreponemal testing of child at time of abuse, then ~6 weeks, and ~3 months after exposure

STI Testing and Empiric Treatment in Postpubertal Child or Adolescents

- Aligns with adult guidance
  - Ceftriaxone 500 mg x 1 dose PLUS
  - Doxycycline 100 mg PO BID x 7 days PLUS
  - Metronidazole 500 mg PO BID x 7 days
- HPV vaccine series should be initiated at >/= 9 years if not already begun or completely immunized

Hepatitis B Testing and Management in Children and Adolescents after Possible Sexual Assault

- Fully vaccinated against Hepatitis B
  - Give Hepatitis B booster dose
- Unvaccinated or incompletely vaccinated
  - Serum hepatitis B surface antigen testing of abuser – or – hepatitis B surface antibody testing of child
  - Give HBIG and initiate hepatitis B vaccine series

HIV Testing and Management in Children and Adolescents after Possible Sexual Assault

- Testing:
  - Fourth generation HIV ab/ag testing of abuser if possible
  - Testing of child at time of abuse, then ~6 weeks, and ~3 months after exposure
- nPEP recommended if <72 hours after exposure, abuser known to be HIV-positive, and there is exposure of mucous membrane, nonintact skin, or percutaneous contact with blood, semen, vaginal or rectal secretions, breast milk, or body fluid visibly contaminated with blood
- Negligible risk: urine, nasal secretions, saliva, sweat, or tears if not visibly contaminated with blood
- nPEP in other situations <72 hours after exposure, depends on risk determined by local epidemiology, risk factors of abuser (e.g. injection drug use, MSM, multiple partners, history of STI)

HIV nPEP in Children and Adolescents

- As in adults, 28 day course of Biktarvy (bictegravir/emtricitabine/tenofovir alafenamide) now first line treatment for most children
  - Adult dose for 25 kg and above (55 lbs; 6-9 year old)
  - Lower dose for 14-25 kg (30 lbs; 2-3 year old)
  - <14 kg → call pediatric ID and/or national hotline National Clinician Consultation Center for guidance

References

Adams, J. A., Farst, K. J., & Kellogg, N. D. (2018). Interpretation of medical findings in suspected child sexual abuse: an update for 2018. *Journal of Pediatric and Adolescent Gynecology*, *31*(3). 225-231. Doi: 10.1016/j.jpag.2017.12.011

Kimberlin, D. W., Banerjee, R., Barnett, E. D., Lynfield, R., & Sawyer, M. H. (Eds.). (2024). Red Book: 2024–2027 Report of the Committee on Infectious Diseases (33rd ed.). American Academy of Pediatrics.

U.S. Centers for Disease Control and Prevention (CDC) (2024, May 16). *About child abuse and neglect.* Child Abuse and Neglect Prevention. https://www.cdc.gov/child-abuse-neglect/about/index.html#print

WELCOME to the

PEP Talk: HIV Post Exposure Prophylaxis ECHO

Session 4, Trauma Informed Care,
May 19, 2026

Session 4:
Trauma-Informed Care

Christina Minasian Hunt, PsyD, MLADC

May 19, 2026

Disclosures

- No relevant financial disclosures

Content Warning for Sexual Violence

Objectives

- Describe trauma-related risks specific to individuals who seek nPEP
- Explore factors that impact treatment adherence for survivors of trauma
- Identify 6 guiding principles of TIC
- Illustrate some examples of TIC in practice across the continuum of care

Who Seeks nPEP?

- Survivors of Sexual Assault and Rape
- People who inject drugs and/or share equipment
- People in serodiscordant relationships
- Individuals who have sexual contact with other individuals who may be at high-risk of acquiring HIV

Treatment Adherence

Factors associated with nPEP nonadherence/disengagement:

- Sexual assault
- Shame and/or stigma
- Medication side-effects
- Too busy
- Lack of education/understanding

Factors associated with nPEP adherence/completion:

- Health care provider encouragement
- Monetary support for transportation
- Reminders from family/peers to take PEP
- Offering PEP at initial consultation/ testing site/ “one-stop” services
- Provision of nPEP in-hand (remaining 27 days)
- Nurse-centered post-assault care, including comprehensive education
- Perpetrator known to be HIV-positive
- Survivor of assault attending counseling

Core Principles of Trauma-Informed Care

(SAMHSA)

Safety

Demonstrate physical and psychological safety throughout all aspects of care

Trustworthiness & Transparency

Establish and reinforce clear expectations, maintain consistency, & reassure patient that they are in charge

Peer Support

Connect patients with individuals with lived experience to support navigation and access to community resources

Collaboration & Mutuality

Work alongside patient and minimize power differential through shared decision-making

Empowerment

Provide patient with options, rather than directives; reinforce personal sense of agency and self-efficacy; take opportunities to praise growth

Cultural, Historic, & Gender Issues

Seek to understand, acknowledge, and address systemic barriers related to identity, bias, and systemic inequities

TIC Across the Continuum of Care

1. First Contact & Triage	2. History & Assessment	3. Medication & Counseling	4. Follow-Up & Adherence
• Non-judgmental intake language • Offer private, safe space immediately • Warm handoffs at every transition and include an identified staff to remain with patient throughout first contact • Prevent repeat storytelling	• Trauma-sensitive questioning • Use affirming language and praise • Offer choice of clinician gender • Normalize disclosure and make it clear that they are not required to disclose anything that they are not ready to disclose	• Explain PEP clearly and calmly • Use a multi-modal/multimedia approach • Address stigma proactively • Discuss side effects without alarm and provide examples of how to manage them	• Check-in on safety at home • Offer multiple means of connecting (phone, text, portal, etc.) • Be familiar with the mental health resources in your community and offer to connect them • Flexible appointment options • Address potential barriers (transportation, insurance, etc.)
1	2	3	4

A Word on Words

❌ Avoid language that is accusatory, judgmental, and/or patronizing	✓ Instead, use language that is supportive, nonjudgmental, and respectful
Why didn't you use a condom? How did you get into this mess?	How can I support you right now? Would you be open to discussing options for preventing transmission/retransmission?
You should have come in sooner. I can't believe you waited so long.	I'm glad you're here. Would you be okay with us getting started? What questions can I answer?
This medication needs to be taken every day.	Let's work together to figure out a routine that works for you. What do you need to make this work?
Do you do drugs? *Your drug screen came back dirty/clean.* *Are you an addict?*	What in your daily life might affect taking your medication? Your labs indicated recent use of [substance]. We want to make sure we set you up with the best care possible. Would you be interested in exploring those options?
You need to tell your partners.	There are options for notifying partners — would you like to talk through them? Do any sound like they would work for you? If not, would you be open to us figuring out a plan that would work for you?

Self-Care as an Ethical Imperative

Thoughts? Questions?

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WELCOME to the

PEP Talk: HIV Post Exposure Prophylaxis ECHO

Session 5, Medical Management,
June 2, 2026

Dartmouth Health

AETC AIDS Education & Training Center Program New England

Project ECHO®

Session 5:
Medical Management

Bryan J. Marsh, MD

Craig Worby, PharmD

What is the rationale for nPEP?

- Randomized clinical trial of nPEP or of different regimens? None.
- Occupational PEP trial
  - 1997 case-control study of HCWs with needlestick injuries from source with known HIV
    - Oral AZT started within 4 hours reduced risk of HIV infection by 81%
- Perinatal prevention
  - Several studies of PEP administered to mother in labor and/or the baby after birth demonstrated reduced risk of infection
- Animal PEP studies
  - Multiple macaque studies demonstrated close to 100% protection with TFV given soon (<36 hours) after exposure and continued for 28 days
- Observational studies
  - Many low quality and often small

What are the indications for nPEP after sexual exposure?

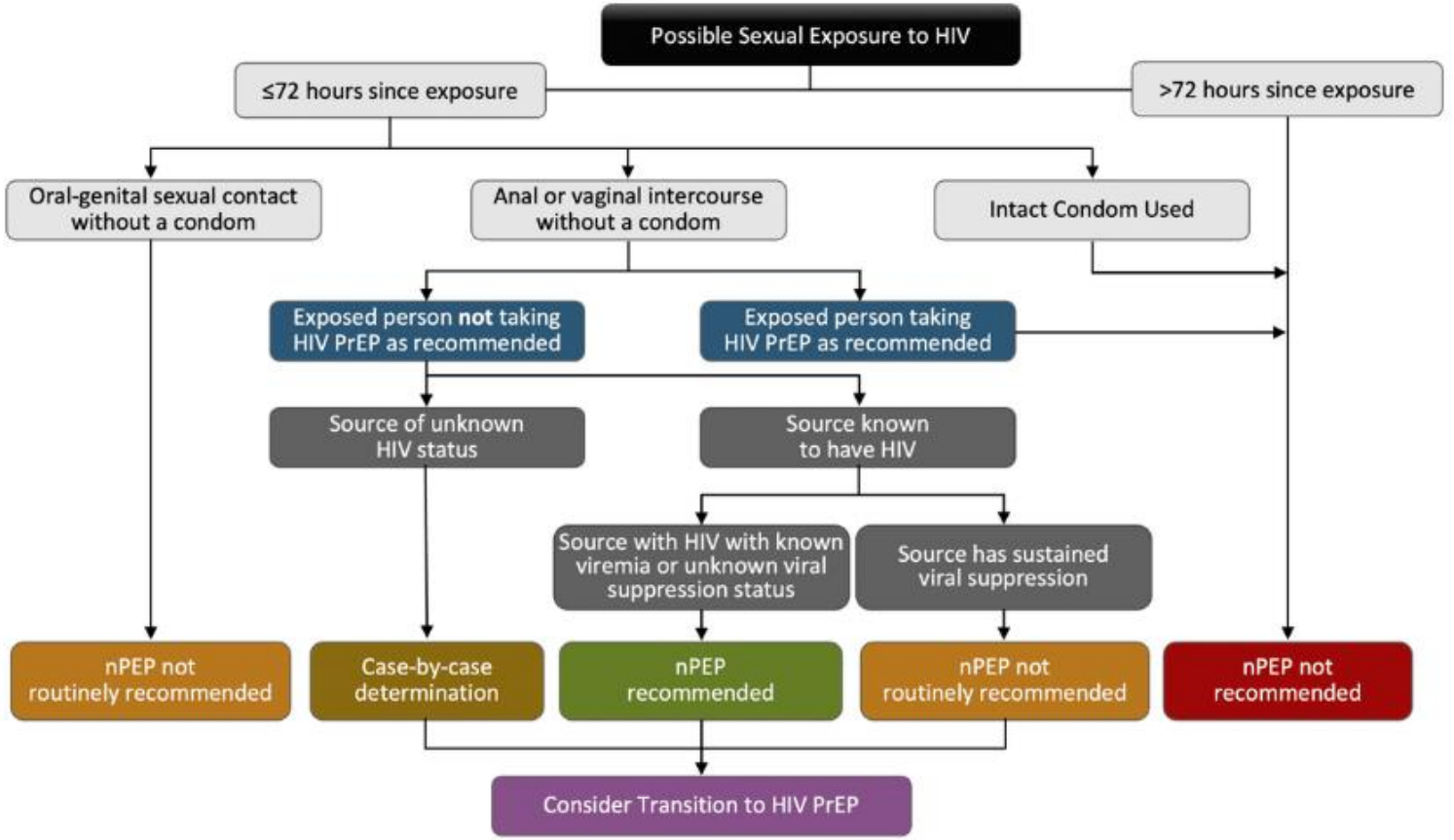

Figure 2. Algorithm for HIV Nonoccupational PEP Use after Possible Sexual Exposure to HIV

Abbreviations: PrEP = preexposure prophylaxis; nPEP= nonoccupational postexposure prophylaxis

Source: Tanner MR, O'Shea JG, Byrd KM, et al. Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV - CDC Recommendations, United States, 2025. MMWR Recomm Rep. 2025;74:1-56.

What are the indications for nPEP after injection drug exposure?

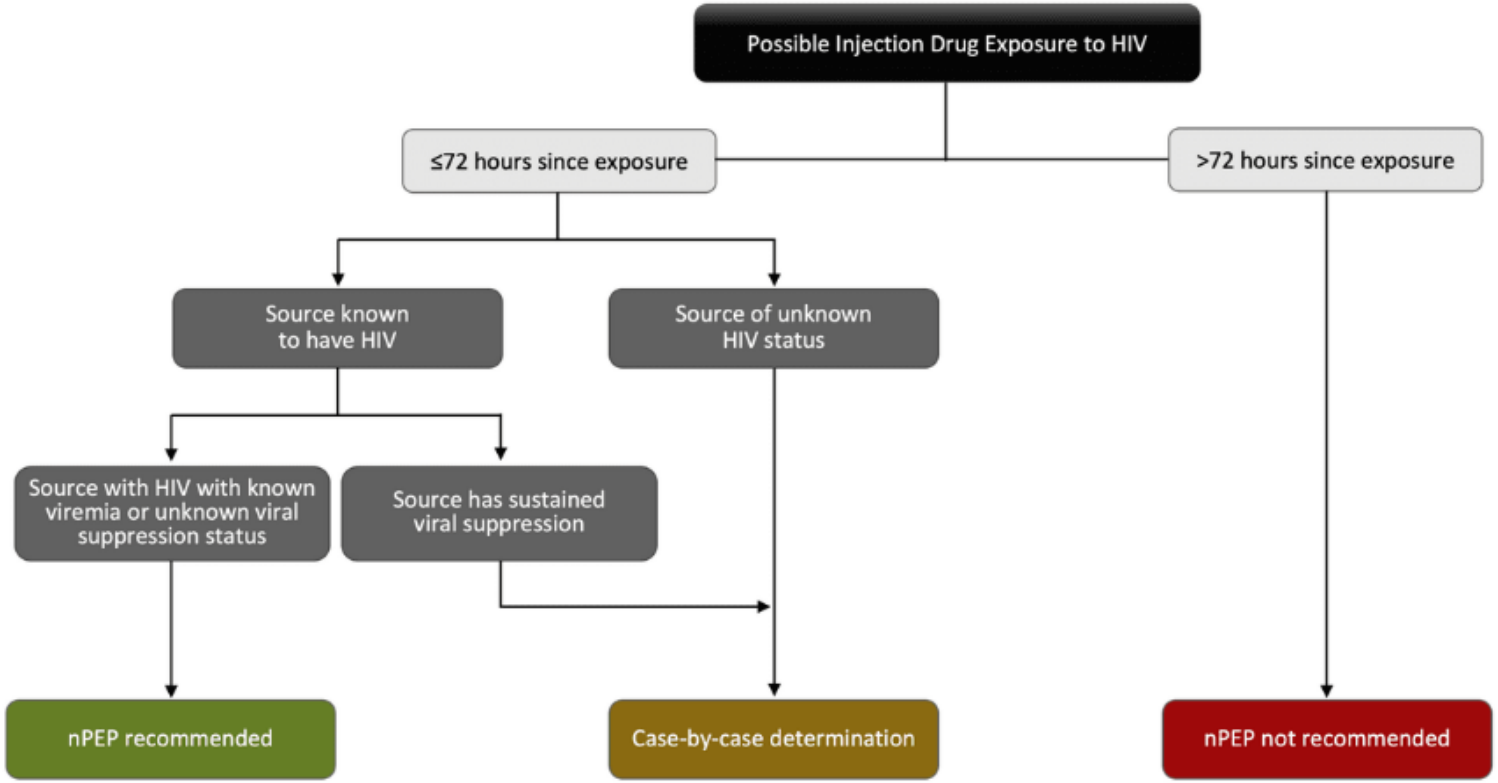

Figure 3. Algorithm for HIV Nonoccupational PEP Use after Possible Injection Drug Use Exposure to HIV

Abbreviation: nPEP = nonoccupational postexposure prophylaxis

Source: Tanner MR, O'Shea JG, Byrd KM, et al. Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV - CDC Recommendations, United States, 2025. MMWR Recomm Rep. 2025;74:1-56.

What are the indications for nPEP after possible other exposures?

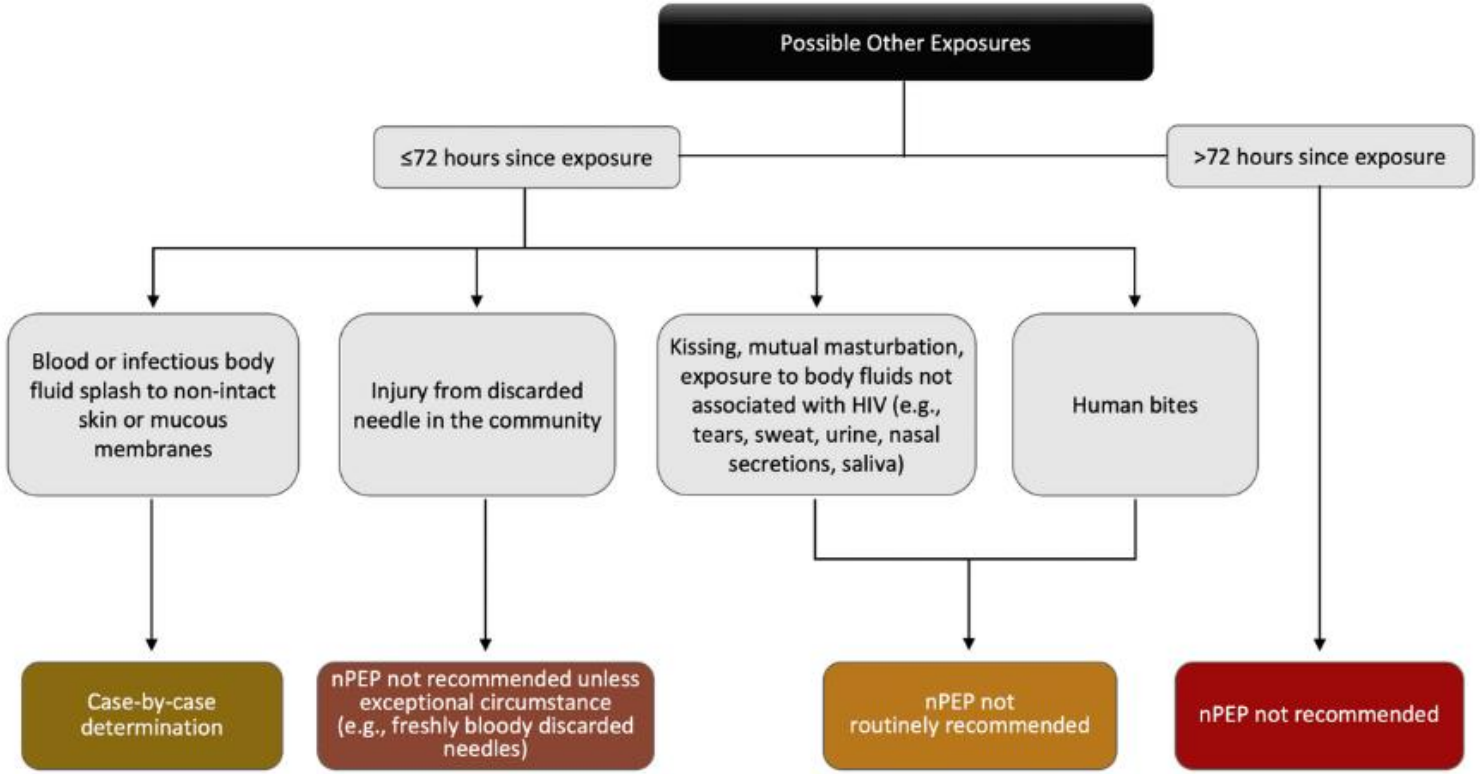

Figure 4. Algorithm for HIV Nonoccupational PEP Use after Other Possible Injection Drug in the Setting of Infective Fluid Splash or Exposure, Needle Injury, or

Abbreviation: nPEP= nonoccupational postexposure prophylaxis

Source: Tanner MR, O'Shea JG, Byrd KM, et al. Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV - CDC Recommendations, United States, 2025. MMWR Recomm Rep. 2025;74:1-56.

What baseline testing is recommended?

Table 7. Recommended Laboratory Monitoring of Source Persons and Exposed Persons Following Nonoccupational Exposure to HIV

Table 7.
HIV Nonoccupational PEP: Recommended Laboratory Monitoring of Source and Exposed Persons

	Source	Person Exposed to HIV			
	Baseline	Baseline	4–6 weeks after exposure	12 weeks after exposure	6 months after exposure
Test		All persons evaluated for HIV nPEP			
Rapid (point-of-care) or laboratory-based HIV Ag/Ab test)[†]	√	√	√[§]	√	—
HIV diagnostic NAT[¶]	√[**]	√[**]	√[§]	√	—
HBV serology, including: HBsAg, HBsAb, and HBcAb	√	√[††]	—	—	If HBV nonimmune at baseline
HCV antibody testing	—	√[§§]	—	—	If follow-up testing recommended[¶¶]
HCV RNA NAT	√[···]	—	If follow-up testing recommended[†††]	—	—
Syphilis serology[§§§]	√	√	√[§§§]	√[§§§]	—
Gonorrhea NAAT[····]	√	√	—	—	—
Chlamydia NAAT[····]	√	√	—	—	—
Pregnancy test[††††]	—	√	√	—	—
	All persons considered for or prescribed nPEP				
Serum creatinine		√	Only if abnormalities at baseline	—	—
Alanine aminotransferase and aspartate aminotransferase		√	Only if abnormalities at baseline or symptomatic	—	—

What additional clinical assessment is recommended before starting nPEP?

- Person exposed
  - Medical comorbidities
    - Kidney or liver disease
    - HBV infection
    - Pregnancy or breast feeding
  - Medications
    - Drug interactions, including with OTC medications (e.g. polyvalent cations)
  - Allergies
  - Challenges to adherence to nPEP and f/u (e.g. housing, SUD, psychiatric illness, etc.)
- Source person
  - If HIV+ and HIV isn't suppressed on ART, then known ARV resistance

What treatment is recommended to prevent bacterial and protozoal STIs?

- Gonorrhea
  - IM ceftriaxone 500 mg if <150 kg, 1,000 mg if >/= 150 kg
- Chlamydia
  - Doxycycline 100 mg po bid x 7 days
  - Azithromycin if pregnant
- Trichomonas vaginalis (women only)
  - Metronidazole (Flagyl) 500 mg po bid x 7 days
- Syphilis
  - Not recommended

https://www.cdc.gov/std/treatment-guidelines/sexual-assault-adults.htm

What treatment is recommended to prevent other viral STIs?

- HBV
  - Determined by HBV status of the source and the person exposed
  - TFV and FTC/3TC (in Truvada, Descovy and Biktarvy) are used for treatment of HBV, but efficacy for PEP is unknown
- HPV
  - HPV vaccine (3 doses if > 14 years old) offered if unvaccinated
  - Efficacy for PEP unknown
- HCV
  - Sexual transmission largely with receptive anal sex
  - No empiric treatment
- HSV
  - No recommendation for screening or treatment

https://www.cdc.gov/std/treatment-guidelines/sexual-assault-adults.htm

What treatment is recommended to prevent HBV infection?

Table 9.

HBV Postexposure Prophylaxis Following Nonoccupational Exposure to HBV*

HBV Status of Person Exposed	HBsAg Status of Source		
	HBsAg Positive	**HBsAg Status Unknown**	**HBsAg Negative**
Unvaccinated	HBIG x 1, and HBV vaccine series (first dose now)	HBV vaccine series (first dose now)	HBV vaccine series (first dose now)
Partially vaccinated	HBIG x 1, and complete HBV vaccine series	Complete HBV vaccine series (give next dose in series now)	Complete HBV vaccine series (give next dose in series now)
Fully vaccinated but response to vaccine unknown	HBV vaccine booster dose x 1 (give dose now)	HBV vaccine booster dose x 1 (give dose now)	No treatment
Fully vaccinated with documented response to vaccine†	No treatment	No treatment	No treatment
Vaccine nonresponder^	HBIG x 2 (separated by 1 month)	HBIG x 2 (separated by 1 month)	No treatment

Abbreviations: HBV = hepatitis B virus; HBsAg = hepatitis B surface antigen; HBIG = hepatitis B immune globulin

*Exposures include percutaneous (e.g., bite or needlestick) or mucosal exposure to blood or body fluids, sex or needle-sharing contact, or victim of sexual assault/abuse.

†HBV vaccine response is defined as a person with anti-HBs ≥10 mIU/mL after completing a HBV vaccine series.

^HBV vaccine nonresponder is defined as a person with anti-HBs <10 mIU/mL after ≥6 doses of HBV vaccine.

Source: Schillie S, Vellozzi C, Reingold A, et al. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices. MMWR Recomm Rep. 2018;67:1-31. [PubMed Abstract]

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What other treatments are recommended?

- Emergency contraception
- Antiemetic
  - E.g. ondansetron
  - Take 30 minutes before the culprit medication

HIV nPEP Regimens

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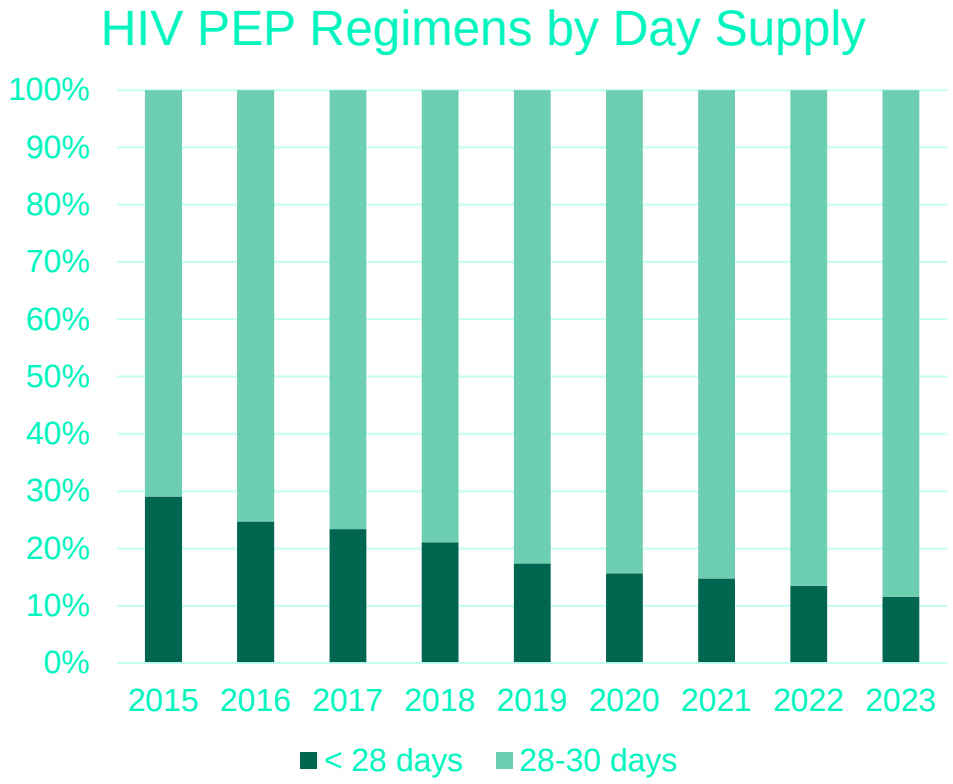
Trends in ART Prescribing for PEP



- Bictegravir accounted for 16.8% of PEP regimens as of 2023
- Bictegravir-based ART was associated with higher completion rate (92.3%) compared to other CDC recommended PEP ART (87.6%)

*Data derived from prescriptions claims from retail pharmacy

CDC 2025 nPEP Guidelines

Preferred Regimens

- Bictegravir/Tenofovir Alafenamide/Emtricitabine (Biktarvy)
- Dolutegravir (Tivicay) + (TdF or TAF) + (3TC or FTC)

Alternative Regimens

- Raltegravir + (TdF or TAF) + (3TC or FTC)
- Darunavir/ritonavir + (TdF or TAF) + (3TC or FTC)
- Darunavir/cobicistat + (TdF or TAF) + (3TC or FTC)

Considerations in selection to nPEP

Clinical Considerations	Possible Barriers
Efficacy of regimen/high barrier to resistance	Adverse effects
Timing	Pill burden
Impaired hepatic/renal function	Local rules/regulations
Exposure to previous ART regimens or long-acting injectable ART	Operational Considerations
Drug-drug interactions	Cost/Reimbursement

Data Supporting Use

- No randomized, placebo controlled trials
- Evidence supporting use is very low quality
  - Bictegravir – 2 non-randomized open label study (n=164)
    - Effective with higher completion rates (90-96%) than historical regimens
  - Dolutegravir – 2 cohort and 1 open label study (n=1134)
    - No HIV seroconversions, completion rates 64-94%
  - Raltegravir – 14 studies (n=3101)
    - Limited studies report at least 1 seroconversion, mitigating factors exist
    - Completion rates 32-96%
  - Darunavir – 12 studies (n=14,398) involving boosted lopinavir or boosted darunavir
    - 18 seroconversions, 9 attributed to nPEP failure

Regimen	Dose	Pills per day	DDIs	Renal Adjustments	Hepatic Adjustments
Bictegravir/ TAF/FTC (Biktarvy)	50 mg/25 mg/200 mg	1	Polyvalent cations MATE1/2 inhibitor OCT2 inhibitor 3A4, UGT1A1 substrate	Contraindicated if CrCl < 15 mL/min not on dialysis	Not recommended Child-Pugh class C
Dolutegravir (Tivicay) **PLUS**	50 mg	2	Polyvalent cations MATE1/2 inhibitor OCT2 inhibitor 3A4, UGT1A1 substrate	None	Not recommended Child-Pugh class C
TAF/FTC (Descovy) or TDF/FTC (Truvada)	TAF: 25 mg/200 mg TDF: 300 mg/25 mg		BCRP, OAT1/3, p-gp substrate	TAF: Contraindicated CrCL < 15 mL/min not on dialysis TDF: Not recommended CrCL < 10 mL/min not on dialsysis 3TC/FTC: Renal dose adjustments available	

Regimen	Dose	Pills per day	DDIs	Renal Adjustments	Hepatic Adjustments
Raltegravir **PLUS** TAF/FTC (Descovy) or TDF/FTC (Truvada)	400 mg TAF: 25 mg/200 mg TDF: 300 mg/25 mg	2 AM 1 PM	UGT1A1 substrate BCRP, OAT1/3, p-gp substrate	TAF: Not recommended CrCL < 15 mL/min not on dialysis TDF: Not recommended CrCL < 10 mL/min not on dialysis 3TC/FTC: Renal dose adjustments available	Not recommended Child-Pugh class C
Darunavir/ cobicistat/ TAF/FTC (Symtuza)	800 mg/150mg/10 mg 200 mg	1	Strong 3A4 inhibition TAF: BCRP, OAT1/3, p-gp substrate	Not recommended CrCL < 30 mL/min not on dialysis	Not recommended Child-Pugh class C
Darunavir (Prezista) **PLUS** Ritonavir (Norvir) **PLUS** TAF/FTC (Descovy) or TDF/FTC (Truvada)	800 mg 100 mg TAF: 25 mg/200 mg TDF: 300 mg/200 mg	3	Strong 3A4 inhibition BCRP, OAT1/3, p-gp substrate	No dose adjustments needed for darunavir/ritonavir TAF: Contraindicated CrCL < 15 mL/min not on dialysis TDF: Not recommended CrCL < 10 mL/min not on dialysis 3TC/FTC: Renal dose adjustments available	Not recommended Child-Pugh class C

Operational Considerations

- "Dispense in original bottle" – some pharmacies not amenable to partial fill
  - Cannot repackage into blister packs (30 day expiration)
  - Unit dose packaging now available for select ARTs (ex: bictegravir, TAF/FTC, TDF/FTC)
  - Dispense full 30 day bottle

- Supply at point of care vs. send prescription to retail pharmacy
  - Adds additional healthcare touchpoints to obtain therapy
  - Common HIV regimens should be available, but not guaranteed

Our Approach

- Utilizing INSTI-based nPEP
  - High barrier to resistance, minimal adverse effects, minimal drug-drug interactions

- Bictegravir/TAF/FTC x28 days
  - 1 tab once a day to improve patient compliance
    - Standard dosing can be used down to children as young as 2 years old (over 25kg)

  - Dispense 7 day unit dose cards x4. Remaining 2 tabs saved for inpatient use.
    - Other affiliates within DH system use remaining 2 tabs for a needle stick kit

Our Approach

- Bictegravir/TAF/FTC x28 days
  - Prepackaged kits dispensed by ED to ensure acquisition, reduce need to additionally go to outpatient pharmacy
    - First dose administered in ED by SANE RN
  - Reimbursed by NH state for dispensing in sexual assault patients
  - Ignoring renal function, our assessment limited risk with only 28 days of therapy
    - If concerned about renal function, ID specialist may change at follow-up appt

References

1. Tanner MR, O'Shea JG, Byrd KM, et al. Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV — CDC Recommendations, United States, 2025. MMWR Recomm Rep 2025;74(No. RR-1):1–56. DOI: http://dx.doi.org/10.15585/mmwr.rr7401a1.
2. John N Le, Weiming Zhu, Ya-Lin A Huang, Wei Wei, Jesse O'Shea, Laura M Mann, Mary R Tanner, Athena P Kourtis, Karen W Hoover, Trends in Persons Prescribed HIV Postexposure Prophylaxis in the United States, 2015–2023, *Clinical Infectious Diseases*, Volume 82, Issue 2, 15 February 2026, Pages e286–e295, https://doi.org/10.1093/cid/ciaf581