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Having Productive Conversations with Patients at High Risk for HIV

Announcer:
Welcome to CME on ReachMD. This activity, entitled “Having Productive Conversations with Patients at High Risk for HIV” is provided by Prova Education.

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Dr. Wohl:
This is CME on ReachMD, and I'm Dr. David Wohl. The CDC states that pre-exposure prophylaxis, or PrEP, reduces the risk of HIV infection from sex by about 99% when taken as prescribed. Yet, only about 23% of individuals who are eligible for PrEP in the US receive a prescription for it. And PrEP persistence at 2 years is low at about 40%. So there's a lot of work to be done.

Today, Dr. Lisa Hightow-Weidman and I will be discussing how to discuss PrEP with our patients and implications arising from the 2021 update to the PrEP guidelines.

Dr. Hightow-Weidman, welcome to the show.

Dr. Hightow-Weidman:
Thanks, Dr. Wohl, I'm really happy to be here

Dr. Wohl:
Let's dive right in. In looking at the updated PrEP guidelines, there are revisions to 2 sections that I'd like to hear your thoughts on. First is the recommendation to inform all sexually active adults and adolescents about PrEP. And the second one is the recommendation regarding long-acting injectable PrEP. So let's begin with the first one.

Dr. Hightow-Weidman:
I was really excited to see these new guidelines put forth at the end of last year. And I think in terms of the first point, the big change in these guidelines really put the idea that folks who need PrEP, who want PrEP, should be offered PrEP. And everyone, really, who is sexually active, PrEP should be discussed with them.

And so that really starts with, first, providers taking a good sexual history with, really, everyone and understanding where folks are in terms of their sexual activity and then having a discussion with them as to whether PrEP is right for them.

So regardless of sexual history, though, regardless of the information that's provided, if someone requests PrEP, it really should be offered to them. And that's because we know that some folks aren't comfortable discussing or disclosing their sexual activity with providers, particularly on a first or second visit. And it may take time for them to feel more comfortable. So I think that's the key part of the guidelines in that area.

In terms of long-acting injectable PrEP, I think this is really exciting that we have another option for PrEP for folks who are not really able to take a daily pill. I think there's a lot to talk about when it comes to injectable PrEP, which we'll get to on this podcast. But for now, I

think just saying that having another option is really exciting.

Dr. Wohl:
Yeah, that's really helpful. So in addition to, certainly, adding long-acting injectable PrEP, which they had to do, I think the update also really stresses that we should be talking about PrEP with anyone who's sexually active and prescribe it for those who are at risk. And I think that's really key.

So moving on, the other thing that we really should talk about is persistence. So uptake is one thing; persistence is another. And persistence can be really low in most of the studies that have looked at this. How do you think we can do better, not only with cisgender men and women but with transgender men and women, as well, with getting people to stay on PrEP?

Dr. Hightow-Weidman:
Yeah, that's a great question, and I wish I had the exact right answer. I think the first thing I think about is what have we learned from taking care of folks living with HIV? And what we've learned is that it takes a village. And I know that's kind of a trite saying, but it really does take more than a provider, more than a nurse, more than a social worker, case manager, adherence counselor, navigator, peer support network, etc. It takes an entire village to support that person coming to clinic, getting their meds refilled, taking their medications every day, coming back to clinic, getting labs, etc. And I don't think that we've done as good a job in providing those wraparound services for those who are at risk for HIV as we do for those that are living with HIV.

The other thing is, I think, really kind of starts with the patient-provider relationship and understanding and talking to each individual patient about why they want to use PrEP or why PrEP might be the right option for them at that point in their life. And I think these conversations differ between patients based on sexual and gender identity, as well as other contextual life factors and in terms of where they're living, where they're getting their next meal from, where they're sleeping, all of those things that impact their ability to either take a daily pill or come to the clinic.

I think specifically, as you asked for it, for trans patients I think it's really important to understand their perception of interactions of PrEP with gender-affirming hormones because there's a lot of information out there. And the data does show that tenofovir does not impact gender-affirming hormones. And I think this is a message that needs to be conveyed to transgender women so that they feel confident taking PrEP.

Dr. Wohl:
Yeah, it's really key. So there's lots of things that can influence not only people accepting PrEP into their life, but also staying on it. And you mentioned that this is very individualized, not only for categories of people, but certainly for each individual. And there are many things that could interfere, including their perception of risk, including their concerns about the medication and what it will do for other things like gender-affirming hormones or other medications that they may be on. So it has to really fit. And that takes a lot of thought and a lot of work and delving into each individual person's perceptions and histories. So I think that's really key.

And again, for PrEP, it's a little bit different than HIV therapy, right? Where HIV therapy, you have to be adherent to it long term. With PrEP, there's the matching between periods of risk. If you're not sexually active, do you really feel like you need to take PrEP? So there's a lot of conversations that have to be had regarding how to take PrEP longer term to remain safe.

For those just tuning in, you're listening to CME on ReachMD. I'm Dr. David Wohl. And here with me today is Dr. Lisa Hightow-Weidman. Our discussion today focuses on having productive conversations with our patients at high risk for acquiring HIV, especially in regards to pre-exposure prophylaxis.

So in follow-up, and this is really important, we're also going to talk about successes. You know, how do we learn from what you've accomplished in the clinic and from what others have studied in retaining people in HIV prevention and ongoing and being able to continue PrEP longer term?

Dr. Hightow-Weidman:
It gets back to the point you just made, is that we have to provide individualized, tailored care for each individual patient that's in our clinic, whether or not they're living with HIV or at risk for HIV. And we do that by asking those questions. We do that by understanding more than just what happens in that 15-, 20-minute exam room. We talk to them about their life; we understand what are their kind of current habits. When I'm starting somebody on any type of medication, I try and understand what is their day like? What is a weekday like, and what is the weekend like? And how can we make a daily medication fit into their schedule when sometimes schedules are not the same every day? And so I think that's kind of one of the things that has been successful is creating relationships. And relationships where patients feel comfortable talking about challenges that they have with adherence, because if they aren't willing to kind of express that, and you aren't willing to listen and help them manage it, then you're not going to get very far, and they're just going to not either come back or they're going to tell you they're taking their medicine when they're not.

Again, as I said, more support for those that are living with HIV in terms of prevention, ensuring that prevention for HIV is incorporated into prevention for other types of health conditions and routine exams, I think, is really critical. And thinking about these newer options and if maybe they have a role and a place in promoting longer-term adherence given that they don't require daily therapy, although they do obviously require persistence and engagement in care.

Dr. Wohl:
Yeah, fantastic. I think it's really clear that while there are challenges, from what I hear you saying, this is doable. Clinics can do this. It starts with a provider. It starts with somebody championing this in a primary care clinic or a specialty clinic, but this can be done. Certainly, having a backbench, a deep bench of support, is also really critical.

It's interesting because thinking about what you were talking about, I've also thought about parallels to contraception in women. And 65% of women who are 15 to 49 years of age use some method of birth control. So we've integrated birth control into a population that can benefit from it. And I think there's lessons there for PrEP. And that's a good segue to what you just mentioned, which is formulations and choices.

So let's turn our attention to the relatively very new formulation of long-acting injectable PrEP, or LAI-PrEP. So what's your thoughts about this? Do you think that long-acting PrEP will lead to more people who are possibly at risk of acquiring HIV accepting PrEP beyond what we're achieving now with oral medications?

Dr. Hightow-Weidman:
I think that the analogy to contraception is certainly one that has been kind of put forth. And I hope that we have as much success with PrEP, long-acting PrEP, as we have with kind of the newer or the additional formulations of contraception.

I don't think long-acting PrEP will be the silver bullet in that it will address every issue that we've had which has resulted in lower PrEP uptake than we had hoped for. However, I do think it is the right solution for some patients. I think, similarly, we'll see the same thing with long-acting therapy for those living with HIV. For some people, taking a daily pill is just not possible, not optimal, or just burdensome, and for however long. You know, as you said, PrEP may not be forever, but for some of the younger folks I see, more than a week can sometimes feel like forever. So I think for those folks, it might be a great option.

I think we have to remember that it still does require engagement in care. And specifically, currently coming back to a clinic space for injection every 2 months, as well as labs at that time. So I think it still requires engagement in care even if it doesn't require daily adherence to a pill.

So I do think we will see more people use it once we really get better at providing it. But I don't think that it's going to completely address all of the issues that we've seen with PrEP, because if folks don't know they need PrEP, then it really doesn't matter what the dose formulation is. If they're not talking to a provider, if they're not engaged in care, if they're not discussing their risk, then regardless of how many options we have, they're not going to access them.

Dr. Wohl:
So, clearly, this is not something that's for everyone. But I think on one hand, it gets more attention to PrEP. And now there is another option for people who don't want to take a pill a day and who are willing to come to a clinic a few times a year. But you're right. This does require some testing and some burden on people who are using it and on the clinics. So I think we have to see how this shakes out. But I do think for some people, this could be a game changer, whereas taking a daily pill was not going to work for them. And again, the more options, the better. And the more attention to PrEP, I think, it'll be really helpful for getting more people on PrEP.

But are there any things we haven't touched about with long-acting PrEP that you think people should know about? Maybe specifically around the testing?

Dr. Hightow-Weidman:
Yeah, it certainly is important to recognize that some newer testing recommendations in terms of getting HIV viral loads prior to injections, which is something that's been different in terms of other PrEP and may obviate the ability to do same-day start. Although I think we'll learn more as we start to implement this.

The questions just remain around how we're going to best implement it. And do clinics that are providing PrEP have capacity to deliver this medication every 2 months? Do they have the capacity to follow up people who have missed their appointments? And how will they do that? Or are there other newer or better models? What can be learned from provision of COVID-19 vaccines and testing at sites that are outside of clinical settings like pharmacies or pop-up settings, mobile clinics, etc., that we can use to address provision of another medication that's currently injectable?

And then, as we move forward, perhaps we'll see the ability to self-administer these medicines at home.

I think we have a lot to learn. I'm excited to see PrEP injectable kind of being really used outside of clinical studies. And I agree; it can be a game changer.

Dr. Wohl:
Certainly, it can be a game changer. But there's some trade-offs that you've really nicely articulated that we have to think about. And I really like what you said, as well: We're going to learn a lot about how to do this and how to do it even better.

This has really been fascinating. And before we wrap up, I just want to make sure that any take-home messages that we haven't already articulated that our audience can learn from – what's the final take-home?

Dr. Hightow-Weidman:
The take-home is that with PrEP, it really has changed the face of acquisition of HIV. It works. It prevents HIV if it's taken effectively, regardless if it's taken orally or the injectable PrEP. And so it works; it's effective; it is safe. And we need those that need it the most to get that message.

There's, again, more choices now than there were a year ago. They, again, all require engagement in care. And they all require talking about sexual risk behaviors, sexual behavior history, so that PrEP can be prescribed.

I think the other thing is that until we also address the structural issues that impact and put those populations that we work with more at risk, particularly sexual and gender minority, adolescents, and adults, until we kind of address all of those structural issues and then really kind of increase access to care, decrease poverty, increase access to insurance, all of those other things really are going to be required for us to truly end the epidemic which I think is our goal.

Dr. Wohl:
Yeah, terrific. Every case of newly diagnosed HIV represents a missed opportunity. And everyone listening has to ask themselves, “Do I offer PrEP? If I don't offer PrEP as part of my clinical practice, how can I offer PrEP?” This is for a lot of people out there. It's very relevant. And there's a lot of folks eligible for PrEP. We just have to identify them and talk to them about this. And the CDC update, I think, really makes it clear that we should be having this conversation pretty much with everyone. There's no picking and choosing. So I think that's really, really important.

Well, unfortunately, that's all the time we have today. So I want to thank our audience for listening and thank you, Dr. Lisa Hightow-Weidman, for joining me today and sharing all your valuable insights and experience. It was great talking with you today.

Dr. Hightow-Weidman:
It was super talking with you.

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