Optimizing Care in Underserved Patients Living with HIV

Faculty:
Melissa Badowski, PharmD, MPH, FCCP, BCIDP, BCPS, AAHIVP
Milena Murray, PharmD, MSc, BCIDP, AAHIVP

Moderator:
Jason J. Schafer, PharmD, MPH, BCPS AQ-ID, BCIDP, AAHIVP

A Virtual Satellite Symposium conducted at the 2020 ASHP Midyear Clinical Meeting and Exhibition
About the Faculty

Melissa Badowski, PharmD, MPH, FCCP, BCIDP, BCPS, AAHIVP

Dr. Badowski received her doctorate of pharmacy degree from Midwestern University, Chicago College of Pharmacy, Downers Grove, Illinois and her Masters in Public Health from the University of Illinois at Chicago School of Public Health. She completed her PGY-1 pharmacy practice and PGY-2 pharmacotherapy residencies at the University of Maryland Medical Center and the University of Maryland College of Pharmacy, Baltimore, Maryland. Her specialties and research interests include HIV and Infectious Diseases.

Upon completion of her residencies, Dr. Badowski was an assistant professor at the University of Maryland College of Pharmacy, Baltimore, Maryland. In 2010, Dr. Badowski joined the University of Illinois at Chicago, College of Pharmacy. She currently manages patients with HIV in the Illinois Department of Corrections through telemedicine services. In 2014, Dr. Badowski became the founding chair of the American College of Clinical Pharmacy HIV Practice and Research Network. In addition, she was appointed as a Pharmacotherapy Specialist Council Member to the Board of Pharmacy Specialties. She has been the recipient of the American Academy of HIV Medicine / Institute of Technology Technology Award, the Gita Patel Best Practice Recognition Award from the Society of Infectious Diseases Pharmacists, the and Distinguished Clinical Practitioner Award from ACCP’s HIV PRN.

Milena Murray, PharmD, MSc, BCIDP, AAHIVP

Milena Murray is an Associate Professor of Pharmacy Practice at Midwestern University College of Pharmacy and an HIV/ID Clinical Pharmacist at Northwestern Memorial Hospital. She completed her Doctor of Pharmacy degree at the Philadelphia College of Pharmacy and her Masters of Science in Clinical Investigation at Northwestern University. Her post-graduate training consisted of a PGY-1 Pharmacy Residency at Maimonides Medical Center in Brooklyn, New York and an Infectious Diseases Pharmacotherapy Fellowship at Northwestern Memorial Hospital through Midwestern University. Her primary research interests are drug shortages and HIV/Hepatitis C pharmacotherapy. Dr Murray is a Board Certified Infectious Diseases Pharmacist and an AAHIVM HIV Pharmacist.
Dr. Jason Schafer is a Professor and Vice Chair in the Department of Pharmacy Practice at the Jefferson College of Pharmacy in Philadelphia, Pennsylvania. He also currently practices as an HIV clinical pharmacy specialist in the Division of Infectious Diseases at Thomas Jefferson University. Dr. Schafer received his Doctor of Pharmacy degree from Duquesne University and completed a pharmacy practice residency at UPMC Mercy Hospital of Pittsburgh and a second residency specializing in infectious diseases at the Ohio State University Wexner Medical Center. He received his Master of Public Health degree from the Jefferson College of Population Health. He is board-certified in pharmacotherapy (BCPS) and infectious diseases (BCIDP) and is credentialed by the American Academy of HIV Medicine as an HIV Pharmacist (AAHIVP). Dr. Schafer has published numerous peer-reviewed articles, abstracts and book chapters on HIV medicine and infectious diseases pharmacotherapy. These include the *Guidelines on Pharmacist Involvement in HIV Care* published by the American Society of Health System Pharmacists and endorsed by the American Academy of HIV Medicine and *HIV Pharmacotherapy, The Pharmacist’s Role in Care and Treatment*. 
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Funding:
This CE activity is supported by an educational grant from Merck

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- Deadline: January 8, 2021
- Pharmacists: CE credit uploaded to CPE Monitor
  - user must complete the “claim credit” step

Attendance Code
Code will be provided at the end of today’s activity
How to Ask a Question

- Locate menu bar on your computer desktop
- Click orange arrow button to open menu box
- Type question into question box
- Click Send
- Do not close menu box
  - This will disconnect you from the Webcast
- Please submit questions throughout presentation

Accessing PDF Handout

- Click the hyperlink that is located directly above the question box
- Do not close menu box
  - This will disconnect you from the Webcast
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Professor and Vice Chair
Department of Pharmacy Practice
Jefferson College of Pharmacy
Thomas Jefferson University
Philadelphia, Pennsylvania

Melissa Badowski, PharmD, MPH, FCCP, BCIDP, BCPS, AAHIVP
Clinical Associate Professor
Section of Infectious Diseases Pharmacotherapy, Dept. of Pharmacy Practice
University of Illinois at Chicago, College of Pharmacy
Chicago, Illinois

Milena Murray, PharmD, MSc, BCIDP, AAHIVP
Associate Professor of Pharmacy Practice
Midwestern University College of Pharmacy, Downers Grove, Illinois
HIV/ID Clinical Pharmacist
Northwestern Memorial Hospital
Chicago, Illinois

Dr. Badowski has no relevant commercial or financial relationships to disclose. Dr. Murray has received honorarium as a speaker for Merck and as an advisory board member for Theratechnologies. Dr. Schafer has received a consulting fee as an advisory board member from Merck and Viiv, and a research grant as investigator for Merck and Gilead.
Objectives

• Examine the importance of a culturally competent framework to optimize care in underserved HIV populations.
• Describe cultural and social context for medical mistrust in underserved patients living with HIV.
• Recognize potential ways to optimize adherence in patients with misconceptions regarding antiretrovirals.
• Discuss innovative tools for retention in care in patients living with HIV.
Patient Case #1

MW is a 43-year-old African American female newly diagnosed with HIV and is antiretroviral treatment naïve. She was initiated on a once daily antiretroviral therapy. She was very surprised by her diagnosis and, at times, is still in disbelief. For most medical conditions, she prefers natural remedies or herbal supplements.
Optimizing Care in Underserved Patients Living with HIV

**Annual HIV Infection in the U.S 2014 – 2018**

![Graph showing annual HIV infections in the U.S. from 2014 to 2018.](image)


**New Infections by Race and Transmission Group**

![Bar chart showing new infections by race and transmission group.](image)

Rates of New HIV Diagnoses – 2018

Viral Suppression Across the United States

About 80% of people in HIV care were virally suppressed at their last test.

About 2/3 of people in HIV care maintain viral suppression over a year.

Abbreviation: DC = District of Columbia.


CDC. Evidence of HIV Treatment and Viral Suppression in Preventing the Sexual Transmission of HIV. 2018.
Underserved Populations: Homeless

- **Boston**
  - On ART
    - Homeless 86%
    - Incomplete VS = 47%
    - Housed 89% (p=0.02)
      - Incomplete VS = 47% (p=0.008)
  - Overall incomplete VS
    - Homeless 48%
    - Housed 26% (p=0.02)

- **San Francisco**
  - POP-UP intervention in homeless
  - 92% (59/64) restarted ART (most at enrollment; range 0-12 days) and returned for follow-up within 90-days
  - VS at 6-months
    - 60% (95% CI 47 to 74%)

**ART** = antiretroviral therapy; **VS** = virologic suppression


Underserved Populations: Incarcerated

- People in prison are 5 – 7 times more likely to be living with HIV

- Prevalence of HIV in 2015 in correctional facilities ~ 1.3%
  - Higher than the 0.3 – 0.4% HIV prevalence in US population

- New York, Louisiana, and Florida had the highest prevalence (>3.0%)

### Success of ART During Incarceration: Illinois

<table>
<thead>
<tr>
<th>CD4 Count (cells/mm³)</th>
<th>Outcome</th>
<th>Pre-telemedicine (%)</th>
<th>Telemedicine (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 350</td>
<td>1</td>
<td>59.2</td>
<td>92.8*</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>28.6</td>
<td>83.7*</td>
</tr>
<tr>
<td>351 – 500</td>
<td>1</td>
<td>49.1</td>
<td>95.8*</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>19.4</td>
<td>89.1*</td>
</tr>
<tr>
<td>&gt; 500</td>
<td>1</td>
<td>64.4</td>
<td>87.6*</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>17.8</td>
<td>59.1*</td>
</tr>
</tbody>
</table>

Outcome 1 = first 6 visits
Outcome 2 = visits 2 – 6 (viral load not suppressed at first visit)
*p-value < 0.001 compared to pre-telemedicine


### Medicaid Eligibility Suspended for Enrollees Who Become Incarcerated

- **JAILS**
- **PRISONS**

Corrections and Medicaid Agencies Have Electronic, Automated Data Exchange Processes to Facilitate Suspension/Reinstatement of Enrollment

KFF, State Health Facts 2020. https://www.kff.org/medicaid/state-indicator/states-reporting-corrections-related-medicaid-enrollment-policies-in-place-for-prisons-jails/activeTab=map&currentTimeframe=0&selectedDistributions=medicaid-suspended-rather-than-terminated-for-enrollees-who-become-incarcerated-jails%&sortModel%3D%7b%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7d

Ending the HIV Epidemic

Optimizing Care in Underserved Patients Living with HIV

Strategies to End the 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 pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
- **Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.


America’s HIV Epidemic Analysis Dashboard (AHEAD): Viral Suppression

- **Overall**
  - Viral Suppression: 61.1% in 2017, 64.7% in 2018, 95.0% in 2025 and 2030 targets.

America’s HIV Epidemic Analysis Dashboard (AHEAD): Linkage to Care

Overall

<table>
<thead>
<tr>
<th>Year</th>
<th>Linkage to HIV Medical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>77.8%</td>
</tr>
<tr>
<td>2018</td>
<td>80.2%</td>
</tr>
<tr>
<td>2019 PRELIM</td>
<td>81.6%</td>
</tr>
<tr>
<td>2020 PRELIM</td>
<td>81.1%</td>
</tr>
<tr>
<td>2025 TARGET</td>
<td>95.0%</td>
</tr>
<tr>
<td>2030 TARGET</td>
<td>95.0%</td>
</tr>
</tbody>
</table>


Role of the Pharmacist in HIV Care
### Rapid Initiation of ART

<table>
<thead>
<tr>
<th>Antiretroviral</th>
<th>Prescribing Considerations</th>
<th>Food Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rapid Start Options</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bictegravir/tenofovir alafenamide/emtricitabine</td>
<td>• High genetic barrier to resistance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Minimal risk of transmitted drug resistance (TDR)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Potential for weight gain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Single tablet regimen (STR)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Activity against Hepatitis B Virus (HBV)</td>
<td></td>
</tr>
<tr>
<td>Darunavir/cobicistat/tenofovir alafenamide/emtricitabine</td>
<td>• High genetic barrier to resistance</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>• Minimal risk of TDR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• STR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Potential for many drug interactions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Activity against HBV</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

### Initial Regimens for Most People with HIV

<table>
<thead>
<tr>
<th>Antiretroviral</th>
<th>Prescribing Considerations</th>
<th>Food Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bictegravir*/tenofovir alafenamide*/emtricitabine</td>
<td>• See previous slide</td>
<td>None</td>
</tr>
<tr>
<td>Dolutegravir*/abacavir/lamivudine [Triumeq™]</td>
<td>• High genetic barrier to resistance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Only initiate if HLA-B*5701 negative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• STR</td>
<td></td>
</tr>
<tr>
<td>Dolutegravir* plus (emtricitabine or lamivudine) plus (tenofovir alafenamide* or tenofovir disoproxil fumarate)</td>
<td>• Multi-tablet regimen</td>
<td>None</td>
</tr>
<tr>
<td>Dolutegravir*/lamivudine [Dovato™]</td>
<td>• HIV-1 viral load &lt; 500,000 copies/mL</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• HBsAg negative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HIV genotype must be evaluated prior to start</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• First two-drug regimen (2DR) considered for initiation</td>
<td></td>
</tr>
<tr>
<td>Raltegravir* plus (emtricitabine or lamivudine) plus (tenofovir alafenamide [TAF] or tenofovir disoproxil fumarate [TDF])</td>
<td>• Multi-tablet regimen</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Lower genetic barrier to resistance when compared to dolutegravir and bictegravir</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- *Potential for weight gain

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### Additional Single Tablet Regimens to Consider

<table>
<thead>
<tr>
<th>Antiretroviral</th>
<th>Prescribing Considerations</th>
<th>Food Requirements</th>
</tr>
</thead>
</table>
| Elvitegravir*/cobicistat/tenofovir alafenamide*/emtricitabine [Genvoya™] | • Lower genetic barrier to resistance when compared to dolutegravir and bictegravir  
• Potential for many drug interactions                       | With food         |
| Rilpivirine/tenofovir alafenamide*/emtricitabine [Odefsey™]  | • Not recommended for HIV-1 VL > 100,000 copies/mL or CD4 < 200 cells/mm³  
• Contraindicated with proton pump inhibitors (PPIs)           | With a meal       |
| Rilpivirine/dolutegravir* [Juluca™]                        | • 2DR used only for switches in virologically suppressed  
• Contraindicated with proton pump inhibitors (PPIs)          | With a meal       |
| Doravirine/tenofovir disoproxil fumarate/lamivudine [Delstrigo™] | • Potential alternative in patients with INSTI-based weight gain? | None              |
| Rilpivirine/tenofovir disoproxil fumarate/emtricitabine [Complera™] | • Rarely used  
• Not recommended for HIV-1 VL > 100,000 copies/mL or CD4 < 200 cells/mm³ | With a meal       |
| Elvitegravir*/cobicistat/tenofovir disoproxil fumarate/emtricitabine [Stribild™] | • Rarely used  
• Not recommended for HIV-1 VL > 100,000 copies/mL or CD4 < 200 cells/mm³ | With food         |
| Efavirenz/tenofovir disoproxil fumarate/emtricitabine or lamivudine [Atripla™] | • Rarely used  |

### ART Considerations in Underserved Populations

- Often unaware of the need for prior authorizations, availability of co-pay cards or drug company assistance, accessibility of AIDS Drug Assistance Program (ADAP)
- Food insecurities (especially if ART requires food)
- Weight gain due to ART?
  - Many lack resources to eat healthy and exercise
  - Unable to achieve weight loss → potential for development of comorbid conditions?
Considerations for HIV Care during SARS-CoV-2

- Maintain at least a 30-day supply—and ideally a 90-day supply—of ART and other medications
- Expedite additional drug refills as needed
- Consider changing to mail order delivery of medications, where possible
- Consider delaying ART switch until close follow-up and monitoring are possible
- Persons with HIV should not switch their ARV regimens or add ARV drugs to their regimens for the purpose of preventing or treating SARS-CoV-2 infection despite some ARVs being evaluated for treatment
- Consider need for in-person versus virtual appointment and need for labs
- Telephone or virtual visits for routine or non-urgent care and adherence counseling may replace face-to-face encounters
- For persons who have a suppressed HIV viral load and are in stable health, routine medical and laboratory visits should be postponed to the extent possible


Milena Murray, PharmD, MSc, BCIDP, AAHIVP
Objective #1

- Examine the importance of a culturally competent framework to optimize care in underserved HIV populations.

What should be considered when providing culturally competent care?

A. Bridge gaps in culture or religion
B. Sociocultural differences lead to medication adherence
C. Use of assumptions can lead to better HIV outcomes
D. Cultural norms are similar among patients living with HIV
What is Culture?

- Shared system of values
- Learned patterns of behavior
- Influenced by sex, gender, education, etc.
- Includes “medical culture”

What is Cultural Competency?

- Understanding of patient’s beliefs, concerns, and expectations regarding medical encounter
- Affects communication and relationships
- Sociocultural differences lead to barriers

Laying the Groundwork

- Cultural norms vary
- Assess for predominant cultural beliefs and practices
- Bridge gaps in culture or religion


Laying the Groundwork

AVOID
Stereotypes Assumptions Labels

Assess the Individual Patient

Questions

What do you believe is the problem?
What is causing the problem?
How do you treat the disease aside from medications?
What is the most important aspect of the disease?
How do you want to be helped?
Who else do you speak with for health information?
Who else knows about your diagnosis?

Aside from medication, what is another factor to promote medication adherence?

A. Ensure health literacy by patient nodding in agreement
B. Recommending provider-centered decisions
C. Place medications in context of professional situation
D. Involve the patient in the management of their HIV care
Moving Beyond Medication

- Place medications in context of social situation
- Entire social context affects patient’s ability to adhere to medication

Strengthen Relationships

- Involve patient in the formulation of management plans
- Verbal acceptance of plan by patient

Language matters!
Objective #2

- Describe cultural and social context for medical mistrust in underserved patients living with HIV.

Which of the following regarding medical mistrust is true?

A. Present only in specific ethnicities
B. Bias is not related to mistrust
C. Related to historical experiences
D. Results in delays in care
Medical Mistrust

- Historical events fuel current mistrust
- Minority patients might miss out on advances in care
- Mistrust and past experiences delay routine care
- Biases can lead to populations mistrusting healthcare providers
- Work has to be done to actively win back trust

Roots of Medical Mistrust

- Language barriers
- Cultural misunderstandings
- Previous patient interactions


Medical Mistrust in PLWH

- Diagnosis as “punishment”
- HIV targeting minority communities
- Withheld HIV care

Which of the following is true regarding provider relationships and mistrust?

A. Decreased trust results in less frequent visits to clinicians
B. Poor outcomes are related to the providers specialty
C. Mistrust is easily overcome with extra communication
D. Patient will be forward about unfair treatment concerns
Relation with Patient Linked to Mistrust

- Mistrust and poor communication negatively associated with various HIV-related and psychosocial outcomes among men of color living with HIV who have sex with women.
- Patient-provider relationship quality associated with poor HIV-related and psychosocial outcomes in men of color living with HIV who have sex with women.
- Among individuals with uncontrolled HIV who use drugs:
  - Higher level of physician mistrust was associated with longer time since the individual’s last visit to an HIV provider.
  - Longer time since seeing an HIV care provider was associated with higher HIV RNA.

Medical Mistrust Cycle

- Medical professional frustration of trying to treat without “entire picture”
- Patient perception of unfair treatment
- Patient declines to disclose important information

Sources:
Objective #3

- Recognize potential ways to optimize adherence in patients with misconceptions regarding antiretrovirals.

Which of the following adherence interventions would best combat medication misconceptions?

A. Explain the suggested treatment is the newest available
B. Ask questions regarding need for treatment
C. Provide pillboxes to the patient for organization
D. Give written education materials each year
Medication Adherence

- Higher levels of race-based medical mistrust predicted lower medication adherence
- Trust in person’s own physician predicted medication necessity beliefs which predicted adherence


Treatment Perception

- Higher scores on a treatment necessity scale were associated with high adherence at 12-month follow-up point
- Higher scores on a treatment concern scale associated with low adherence
- Approximately 30% rejected initial offer for antiretroviral treatment

Optimizing Care in Underserved Patients Living with HIV

Need for Treatment

Patients “feel well” early in HIV disease course
Long term adverse effect concern versus benefits of treatment

Combatting Misconceptions

• Assess patient beliefs for misconceptions regarding antiretroviral treatment
• Adherence will be non-starter if patient does not believe antiretrovirals will treat HIV

Support groups
Peer educators
Treatment buddy

Patient Education

- Provide in patient friendly terms
- Preferred media
- Reaffirm education at regular intervals

How to Avoid Mistrust

- Avoid use of “persuasion”
- “New” treatments may be seen with different perspective

References:
Interventions

- Simplify regimen if appropriate
- Digital applications
- Directly Observed Therapy
- Smoking cessation programs
- Referrals as appropriate


Melissa Badowski, PharmD, MPH, FCCP, BCIDP, BCPS, AAHIVP
Objective #4

• Discuss innovative tools for retention in care in patients living with HIV.
**What intervention can promote retention in HIV care?**

A. Long conversations about HIV at each clinic visit  
B. Expecting a patient to obtain insurance without assistance  
C. Providing a prescription for ART upon hospital discharge  
D. Ensuring ART is covered prior to leaving clinic

---

**Patient Case**

| History of Present Illness | • 57-year-old Spanish-speaking female patient admitted to the hospital for dyspnea on exertion while walking up the stairs and generalized malaise over the last month  
|                           | • Denies any known medical conditions or allergies  
|                           | • Chest X-ray concerning for PCP and patient started on treatment |
| Past Medical History      | • Hypertension  
|                           | • Depression |
| Social History            | • Lives with her son  
|                           | • Uninsured  
|                           | • Immigrated from Guatemala 5 years ago |
| Medications (prior to admission) | None |
| Pertinent Labs and Imaging | CD4: 61 cells/mm$^3$  
|                           | HIV-1 RNA: 89,096 copies/mL  
|                           | 4th generation HIV test (+)  
|                           | HIV genotype: pending  
|                           | Scr 1.1 mg/dL  
|                           | AST/ALT: 18/12 Units/L  
|                           | Hepatitis B and C: negative |
| Assessment/Plan           | Medical team put an order in to start antiretroviral therapy |
**HIV Care Continuum**

- **Diagnosed with HIV**
- **Engaged or Retained in Care**
- **Linked to Care**
- **Prescribed Antiretroviral Therapy**
- **Achieved Viral Suppression**

**Medical Care and Viral Suppression – 2016**

![Graph showing data on medical care and viral suppression among persons aged ≥13 years living with diagnosed HIV infection, by sex, 2016 - 41 states and the District of Columbia.](https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-national-hiv-care-outcomes.pdf)

**Note:** Receipt of medical care was defined as ≥1 test (CD4 or VL) in 2015. Retained in continuous medical care was defined as ≥2 tests (CD4 or VL) ≥3 months apart in 2015. Viral suppression was defined as <200 copies/mL, on the most recent test in 2016.
### Retention in Care and Viral Suppression post-release from prison, stratified by whether individuals were re-incarcerated (recidivist) during the follow-up period

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Years 1 – 2</th>
<th>Years 1 – 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individuals retained in HIV care (n, %)</strong></td>
<td>Overall: 711/1059 (67%)</td>
<td>Overall: 528/1029 (51%)</td>
<td>Overall: 415/1001 (41%)</td>
</tr>
<tr>
<td></td>
<td>Recidivists: 279/344 (81%)*</td>
<td>Recidivists: 275/460 (60%)*</td>
<td>Recidivists: 246/508 (48%)*</td>
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<tr>
<td></td>
<td>Non-recidivists: 432/715 (60%)*</td>
<td>Non-recidivists: 235/569 (45%)*</td>
<td>Non-recidivists: 169/493 (34%)*</td>
</tr>
<tr>
<td><strong>Virologic Suppression (n, %)</strong></td>
<td>Overall: 465/711 (65%)</td>
<td>Overall: 380/528 (72%)</td>
<td>Overall: 313/415 (75%)</td>
</tr>
<tr>
<td></td>
<td>Recidivists: 168/279 (60%)*</td>
<td>Recidivists: 188/275 (68%)</td>
<td>Recidivists: 177/246 (72%)*</td>
</tr>
<tr>
<td></td>
<td>Non-recidivists: 297/432 (69%)*</td>
<td>Non-recidivists: 192/253 (75%)</td>
<td>Non-recidivists: 136/169 (81%)*</td>
</tr>
</tbody>
</table>

* Statistically significant


### Factors Associated with Linkage to Care (LTC)

**Positive Association**
- Intermediate incarceration (31 – 364 days)
- Transitional case management
- ART during incarceration
- Older age
- ≥ 2 medical comorbidities
- Early linkage to care post-release
- Health insurance

**Negative Association**
- Reincarceration
- Conditional release

Barriers to Retention in Care

- Personal or cultural beliefs
- Cognitive abilities
- Health status and medical comorbidities
- Poor mental health or substance use
- Poor transitions in care
- Unable to access/afford treatments
- Structural issues
  - Housing, job, transportation, childcare, health insurance

Breaking Down the Barriers for Retention in Care

- New to HIV care
  - “It’s important that you come to your medical appointments regularly so I can monitor your progress and help you stay healthy. Let’s talk about what that means.”
  - “I know it can be difficult to keep all your appointments, but it’s very important. What can we do to make sure you keep your next appointment?”
  - “I’m looking forward to seeing you on a regular basis.”

- Brief conversations at each visit build relationships and keep patients engaged in their own care
  - Short, direct, nonjudgmental, and supportive
  - Teachable moments to motivate patients to continue care and make positive changes
  - Highlight goals of therapy so patients can self-monitor (i.e. increase CD4, become and remain undetectable)
Retention in Care Tools: STEPS to Care

- Intensive one-on-one case management improves linkage, engagement and retention in care
- One-on-one education sessions empower clients to manage their own health and adhere to their treatment plans
- Interdisciplinary teams establish and maintain care plans that adapt to changing client needs
- Care Team Coordination
- HIV Self Management
- Patient Navigation


Retention in Care Techniques

- Data to care
- Enhanced personal contact
- Culturally competent care
- Medical case management
- Patient navigation interventions
- Walk-in, incentivized care model
Patient Case #2

| History of Present Illness | 57-year-old Spanish-speaking female patient admitted to the hospital for dyspnea on exertion while walking up the stairs and generalized malaise over the last month  
| Past Medical History | Hypertension  
| Social History | Lives with her son  
| Medications (prior to admission) | None  
| Pertinent Labs and Imaging | CD4: 61 cells/mm³  
| HIV-1 RNA: 89,096 copies/mL  
| 4th generation HIV test (+)  
| HIV genotype: pending  
| Assessment/Plan | Medical team put an order in to start antiretroviral therapy  

Where Does Rapid Start Fit in the Care Continuum?

Same-day ART increases rates of retention in care and sustained viral suppression in HIV patients

New Orleans

Jason Halperin,1,2 Katherine Conner,1 Isolde Butler,1 Pu Zeng,1 Leann Myers,1 Rebecca Clark,1 and Nicholas Van Sickels1,2

1CrescentCare, New Orleans, Louisiana; 2Infectious Diseases Section, Tulane University School of Medicine, New Orleans, Louisiana; Global Biostatistics and Data Science, School of Public Health and Tropical Medicine, Tulane University New Orleans, New Orleans, Louisiana

Summary

• Questions beyond those related to medications are needed to uncover medical mistrust
• Optimizing adherence requires building a relationship with the patient to understand their healthcare model
• Retention in HIV care relies on interdisciplinary care

Thank you!
CE Credit Instructions

Optimizing Care in Underserved Patients Living with HIV

December 8, 2020

1. To receive CE credit for this activity, you must complete the post-test and activity evaluation online no later than Friday, January 8, 2021.


3. Click on the Evaluation button which is listed with the Optimizing Care in Underserved Patients Living with HIV - December 8, 2020 CE activity.

4. Login to the ProCE Center. Note: You will need to sign up for a new account if you have not previously used the ProCE Center.

5. Enroll in the CE activity, then enter the Attendance Code: ________________.
   
   Note: the attendance code will be announced at the conclusion of the CE activity.

6. Take the post-test, complete the evaluation, and claim CE credit.

7. If you need assistance or have questions, please contact ProCE at 630.540.2848 or via email at info@proce.com.

Note: It is ProCE policy that CE requirements (i.e. post-test, if applicable for the specific CE activity, and evaluation) be completed within 30 days of the live activity date to ensure an on-time submission to your CPE Monitor account.

PDF version of the handout is located at: www.ProCE.com/res/pdf/HIV2020Dec8.pdf