CONNECTING CARE PODCAST // EPIDSODE #1 // TRANSCRIPTS

The intersection of HIV and OUD in the time of COVID-19

Dr. Alex Walley :

For Dr. Taylor, an HIV doctor and addiction specialist in Boston, COVID-19 has meant a lot of changes to how and where she treats her patients.

Dr. Jessica Taylor:
In the early days of March, mid-March, late March, we were really scrambling to figure out what that would look like for our patients and how we could continue to provide access, recognizing that many people that need to access medications for opioid use disorder like buprenorphine may not have access to a telephone, a video enabled phone, other devices, or even private spaces to have a visit with a provider.

Dr. Alex Walley:

COVID-19 has changed the way society operates in countless ways. For our team of addiction specialists and HIV providers, COVID-19 has not only increased vulnerability among our patient population, it has challenged us to innovate and safely provide services. You're listening to Connecting Care, a podcast of the HRSA-funded initiative Strengthening Systems of Care for People with HIV and Opioid Use Disorder.

Dr. Alex Walley:

I'm Alex Walley. I'm a general internist, primary care doctor, and addiction medicine specialist in Boston, Massachusetts. During this episode, we'll discuss the intersection of HIV and opioid use disorder in the time of COVID.

Dr. Jessica Taylor:

I'm Jessica Taylor. I am an HIV primary care doctor and an addiction medicine specialist. I'm the medical director at our at Bridge Clinic and the HIV Prevention Programs at Boston Medical Center.

Dr. Sim Kimmel:

I'm Sim Kimmel. I'm an HIV primary care provider, an addiction medicine specialist, and an infectious disease specialist. And I'm the medical director for addiction services and HIV prevention programs.

Dr. Alex Walley:

Well, guys, this is our first podcast where we're going to focus on issues around HIV, HIV prevention, opioid use disorder, overdose prevention. I hope our audience will be forgiving as we're novices at this, but we hope to share some really important information. How do you guys feel about doing our first podcast?

Dr. Jessica Taylor:

Excited. This is a great opportunity to share a lot about what we've been seeing on the ground during the last nine, 10 months during the pandemic and also talk about some really important issues that are impacting our patients, including HIV transmission, and just challenges with accessing treatment related to COVID-19 changes.

Dr. Alex Walley:

Sim, how are you feeling?

Dr. Sim Kimmel:

I'm a little nervous, a little nervous for the podcast, but ready for the discussion. And I'm excited to have a chance to talk with both of you. We don't always get to have a conversation in this kind of forum, so I'm excited to learn and to share ideas.

Dr. Alex Walley:

Yes, I agree with that. I'm a big podcast fan. I've always dreamed of being a podcaster and excited about this opportunity. Sim, do you want to read our learning objectives so we're oriented before we dive into the case today?

Dr. Sim Kimmel:

Definitely. The first learning objective is to describe the role for medications for opioid use disorder, such as buprenorphine and methadone, in HIV prevention among people who inject drugs. The second learning objective is to outline the regulatory changes during the COVID-19 public health emergency that facilitated medication for opioid use disorder access to populations at higher risk of HIV acquisition and other complications of substance use disorder.

Dr. Sim Kimmel:

And our third learning objective is to describe barriers and facilitators of opiod use disorder and HIV care during the pandemic.

Dr. Alex Walley:

Thanks. So here's how this is going to work. Jessica has a case for us that I think is going to really bring out and highlight a number of these learning objectives. We're going to stop along the way of the case to discuss some of the key aspects. And then at the end, we're going to sum things up and go back over learning objectives to make sure we covered what we were hoping to cover. I'm going to turn it over to Jess to tell us about this case.

Dr. Jessica Taylor:

Sure. One of the major changes that happened during the early days of the pandemic is a regulatory change that allowed us to be able to start buprenorphine by telephone or telemedicine for the first time. So pre-pandemic, in order to start a controlled substance medication with a patient, you had to establish a patient-provider relationship with an in person visit.

Dr. Jessica Taylor:

But because of the COVID-19 public health emergency, we had a couple of changes related to the COVID-19 public health emergency that allowed us to start to do buprenorphine visits by telemedicine. First, in January 31st, a public health emergency was declared related to the COVID-19 pandemic. And

then at the end of March, March 31st, the DEA clarified that because of the COVID public health emergency, we would be allowed to start medications like buprenorphine by telemedicine without the requirement for that in person visit.

Dr. Jessica Taylor:

In the early days of March, mid March, late March, we were really scrambling to figure out what that would look like for our patients and how we could continue to provide access, recognizing that many people that need to access medications for opioid use disorder like buprenorphine may not have access to a telephone, a video enabled phone, other devices, or even private spaces to have a visit with a provider. The case I'm going to tell you about is one of the first ones that we did by telemedicine, trying to overcome some of these barriers for our patients.

Dr. Jessica Taylor:

I was working in our bridge clinic one day and received a call from a colleague across the street at one of our harm reduction sites that Dr. Kimmel was talking about and told me that she was with a patient, 30 year old gentlemen who has a history of severe opioid use disorder, as well as stimulant use disorder, and was interested in talking about medications.

Dr. Alex Walley:

Jess, could you tell us a little bit more about what... When you say bridge clinic, describe what that is so people understand what a bridge clinic is.

Dr. Jessica Taylor:

Sure. Bridge clinics are a relatively new way to take care of people with substance use disorders that really stemmed from the opioid overdose crisis and the fact that people were really being put on long waiting lists. That was driving increases in overdose and mortality. Bridge clinics came about in order to decrease wait times for medications, which are lifesaving for people with opioid use disorder, and really provide rapid access and stabilization to people that may need some added support before they are able to go on to a traditional outpatient setting where it can be a little bit less flexible.

Dr. Jessica Taylor:

So for example, in a Bridge clinic, in our program, we try to see people if they arrive late for their appointments. We provide same day service. So if someone comes in as a new patient, we try to offer buprenorphine that same day, and we try to offer access, stabilization, flexibility so that when people move on to a long-term, for example, primary care-based addiction treatment site, they're really ready to take that on and have already been stabilized on a medication.

Dr. Alex Walley:

Great. You're trying to bridge them from a setting where they're not accessing care or it's hard for them to access care, stabilizing them, and then optimally transitioning them to some community-based longitudinal program.

Dr. Jessica Taylor:

I think bridge clinics fill some other healthcare gaps for people with unstable substance use disorder. In our program, for example, we offer vaccinations. We offer STD testing and treatment. We offer HIV prevention services, which we'll be able to delve into a little bit later in the podcast. But what we know is that people with unstable substance use disorders can have a very difficult time with treatment entry.

Sometimes they've just come out of a hospitalization and aren't yet connected to a community site for long-term care.

Dr. Jessica Taylor:

And we're able to fill that gap. Sometimes they need the flexibility that I mentioned. It's been interesting. We're in our fifth year, and it's been interesting to see how over time we have expanded our scope to take on more of these other medical needs and other psychosocial needs in addition to that rapid access to medication piece.

Dr. Alex Walley:

Great. What were the initial adaptations that you guys made when the COVID pandemic first started in March and April?

Dr. Jessica Taylor:

Sure. In our program, we did make the decision to remain open in person throughout the pandemic and throughout the surge, which is one that we made after a lot of discussion. But just recognizing that a lot of our population does depend on demand, walk-in access, we decided to keep the doors open. We also did offer telemedicine visits, which for us was completely new.

Dr. Jessica Taylor:

Because like I mentioned, prior to this public health emergency, it was not permitted to start buprenorphine by telemedicine without first having an in person visit to establish that patient-provider relationship. So that for us was a big change. And we really had to get creative to make sure that in transitioning many of our visits to telemedicine, we didn't worsen disparities that we know already exist in terms of access to care.

Dr. Jessica Taylor:

We know that people who use substances and people who inject drugs experienced many structural barriers to getting treatment. And if now people were going to be required to have telephone access or smartphone access or tech access, we were really nervous that some people who may have been at the highest risk in terms of overdose and HIV acquisition risk could be completely excluded from the healthcare system.

Dr. Jessica Taylor:

To prevent that, we really reached out to our colleagues that were doing street-based outreach and our harm reductionists colleagues and tried to be creative about ways that they could use their own devices or work phones, work devices, to connect patients that did not have phones of their own to providers who were available and interested and ready to do phone-based buprenorphine assessments and starts.

Dr. Jessica Taylor:

And I would say that was our major adaptation. Several others included changes to the way that we staffed our program in terms of having providers do a longer stretch at a time so that we didn't get into the situation of our entire staff getting sick at the same time. We had a lot of adjustments on that front. We certainly had a lot of focus on infection prevention and personal protective equipment that was new and different for us, and we really tried to engage new partners.

Dr. Jessica Taylor:

In addition to street outreach teams, harm reduction workers, we tried to build bridges with local syringe service programs with recovery programs that might not have been comfortable having patients leave to come into an appointment and then return because of the COVID risk. We started doing phone-based consults with, for example, patients in residential treatment programs that ordinarily would have been transported to us to see us in person. We were able to handle that by telemedicine.

Dr. Alex Walley:

Great. Sim, you work with an HIV prevention program that does street-based outreach and has a drop-in center. Can you paint a little bit more detailed picture and then talk about how COVID impacted that program?

Dr. Sim Kimmel:

Yeah, absolutely. The program that we run, instead of a kind of medical model where there's appointments and a visit with a doctor, it's really a peer outreach worker model. There's a physical space, and in that space, people can sit and hang out and relax. There's coffee and snacks. It's just a place for people who might be experiencing homelessness or not have a safe place to go to come and kind of feel safe for a little bit.

Dr. Sim Kimmel:

We give out various kinds of supplies for people, ranging from sleeping bags and warm coats to what really is driving the program is syringe distribution. To try to prevent transmission of HIV and other bacterial infections, we do teaching and education and syringe distribution. We also distribute naloxone to help people reduce overdose risk and rescue their friends and loved ones and other people that they might encounter who are using. And this program also offers HIV testing and hepatitis C testing in a kind of low barrier way that doesn't have the feel of a medical system.

Dr. Sim Kimmel:

And then wrapped around that, we have a nurse practitioner and then me as a physician kind of backing up the outreach staff and providing clinical care as needed, so abcess and wound care, HIV care, HIV prevention care, and a lot of case management services. A lot of the patients we see are people who are trying to navigate really complicated social situations, trying to decide whether they should enter into the hospital or not to get infection managed. We help people navigate those difficult and tricky decisions in the context of substance use.

Dr. Sim Kimmel:

When COVID hit, our space is a really small space and people come in and they will often stay for hours. And that didn't really seem feasible with the COVID risk for our staff and for other clients and patients that might be getting services to expose everybody. So around when COVID first hit and there were changes really throughout all of the services at the hospital, we really shut down the drop-in space for our program, and we kind of doubled down on the outreach services that we were providing.

Dr. Sim Kimmel:

Our staff would basically go to where people spend their time, where they might be using, where they might be sleeping and try to find people and engage people and deliver the resources, the HIV testing, hepatitis C testing, connect to care from the street. And then additionally, we ended up setting up a tent outside of our drop-in, where we provided the kind of same sort of services, but outside. It really changed the feel of the program.

Dr. Sim Kimmel:

And in some ways, it expanded access to people who might just be walking by on the street and might not have kind of taken the step to go inside. It increased I think the number of encounters we maybe had with people, but there wasn't the extended time that you might have with someone where they're drinking a cup of coffee and you get to talk to them and really build a relationship.

Dr. Alex Walley:

Great. Hopefully folks have a picture of the care settings that we're operating in here and how they've adapted in the setting of COVID. We should get back to the case, which Jessica was telling us about. It's really the first person I think they treated using telemedicine at the bridge clinic that they connected with through this HIV prevention and outreach services program. So why don't you take us back to the case and tell us what happened, Jessica?

Dr. Jessica Taylor:

Sure. One of our colleagues, who's a harm reductionist in the drop-in center, sent me a text and said, "I have this patient here, this 30 year old gentlemen, who is interested in buprenorphine. Can I put you on speaker? Can I put you on video?" And at that point, we really were under the impression still that we needed to use video or some sort of audio visual combined platform to be compliant. Later on, we had clarification from the federal government that audio only methods would be acceptable for telemedicine. My colleague said, "Can I put you on FaceTime?"

Dr. Jessica Taylor:

And there actually had also been federal guidance that because of the public health emergency, providers that acted in good faith using sort of everyday technology such as FaceTime, which is not HIPAA compliant, would not be subject to penalties under HIPAA because things were changing so rapidly and we had not yet stood up HIPAA compliant platforms, which we did over the following weeks. My colleague put me on FaceTime.

Dr. Jessica Taylor:

I was in our bridge clinic and I did a video-based visit with this patient, who I mentioned is a young man with opioid and stimulant use disorders. He also has a severe benzodiazepine use disorder, and he told me a history that is I would say very typical in the population that we serve. He'd been using about two grams of heroin per day.

Dr. Jessica Taylor:

In our context in Boston, when I say heroin, I really mean a combination of potentially some heroin, but largely illicitly manufactured fentanyl, which is an opioid that can be extraordinarily potent and one where the potency can be very variable, so overdose risk is quite high. His use was intravenous, and he was also using non-prescribed benzodiazepines every day.

Dr. Jessica Taylor:

The last time he used was about an hour before our visit, and he said that he sometimes used stimulants often to wake himself up if he had been using opioids and needed to get going or get rolling, but went on to tell me a little bit more about his history with substances. It'd been going on for about a decade, his heavy substance use, and he just described a really long list of personal, professional, family consequences related to substance use, including a history of several incarcerations.

Dr. Jessica Taylor:

And he told me a little bit about his treatment history, so he had done time in methadone treatment programs or opioid treatment programs on methadone, which had sometimes been an effective treatment for him in the past.

Dr. Jessica Taylor:

He had also tried buprenorphine-naloxone in the past, and he was really the most interested in restarting buprenorphine or suboxone in large part because he was worried that if he restarted methadone and was incarcerated again, he would be forced to go through abrupt withdrawal, which is a really traumatic and uncomfortable thing to go through that many of our patients are forced to do if they are incarcerated and don't receive evidence-based medication treatment.

Dr. Alex Walley:

I'm going to pause you just for a second to just make one regulatory point, which is that we're not going to talk in detail about methadone today, but there have been liberalizations with methadone as there are with buprenorphine. But one of the key pieces that distinguishes them is that initiating methadone still requires an in person visit from the federal regulatory perspective. If this fellow did want to get methadone, he would have had to present in person to a methadone clinic.

Dr. Alex Walley:

Whereas because he wanted buprenorphine, this could be done through a telemedicine visit. Jess, can you paint a picture for us here? Where was the patient? What was the setting like?

Dr. Jessica Taylor:

Yeah. This visit started where our harm reduction outreach worker was outside with the patient on Massachusetts Avenue in Boston, which is a very busy street. High traffic busy main street. And as we started to talk, the visit was moved because we're on FaceTime so that the patient was brought inside to a small area in the drop-in center. Like you'd mentioned, the drop-in center was not open for clients to come in and use the usual services like sitting and getting coffee. The patient was the only person in there with the harm reduction worker.

Dr. Jessica Taylor::

I was across the street in our bridge clinic, and we had fair connectivity. We could mostly see each other and had a reasonable connection. But yeah, it was a totally new experience, because I didn't have experience using video for visits like this, and we'd never started someone that we hadn't seen in person. It was interesting. I have to give the patient credit. He was completely game for talking to me and answering what are really personal questions by video and with someone else present in the room.

Dr. Jessica Taylor:

And I think that really spoke to the trust in the harm reduction worker that he was game to try this new pathway and engage with a provider that he'd never met by video in this sort of setup that was admittedly a little bit of a rough run at the time, because this was the first time we tried it. So yeah, that was what it was looking like from my end.

Dr. Alex Walley:

So it sounds like the patient was most interested in buprenorphine and his concerns were really that the lockdown that was happening around COVID would make it really harder for him to get access to the drugs that he had been using, and he was worried about going into withdrawal.

Dr. Jessica Taylor:

Yeah. And I'll say that that was a really interesting part of it for me because we as a bridge clinic, we are always trying to reach patients who may not be fully ready to start medication and enter recovery. We always want to be serving people who are earlier on in the care cascade, because that's where we can do the most important work around HIV prevention and overdose prevention. But we sometimes don't reach that population as much as we'd like.

Dr. Jessica Taylor:

Because for us in the bridge clinic, we're based in a hospital, and so people do have to walk in the front door of a hospital, past a security desk, through hallways that are busy to get to us. And we try to have a therapeutic space where we also offer things for patients. We can get people coffee, things like that, but there is a bar to get into our bridge clinic. For me, it was really exciting to connect to a patient who was very candid that he wasn't sure.

Dr. Jessica Taylor:

He was planning to be on recovery long-term, but was coming to us because he was afraid about not having access to heroin, fentanyl, interruptions in supply, interruptions and access to his dealer, and wanted to make sure that he did not go into opioid withdrawal without way to manage that. It was a very exciting visit for us that way, because we really feel like that's the work we want to be doing. But sometimes as low barrier as we try to be, we understand that we aren't as low barrier as we may need to be to reach people at the highest risk.

Dr. Alex Walley:

Has this concern have been a common motivation of patients during the pandemic, or are there other things that have undermined the patient's motivation?

Dr. Jessica Taylor:

I would say we heard about this a lot in terms of concern about interruptions in supply, and with that comes concerns about having to get heroin, fentanyl from new sources or new dealers where the supply may be less predictable or different than what people are used to. We took care of a patient who we've known for several years who described having 11 overdoses in about a two week period, because the supply that she was able to access was just completely unpredictable for her and different than what it normally had become accustomed to.

Dr. Jessica Taylor:

We certainly heard a lot about this. A lot of our patients also left the area suddenly, so we were working with some people by phone who typically stay either outside or in shelter in our neighborhood. But because of the pandemic, we're allowed to go home to stay with family temporarily or to stay with a partner temporarily. There were a lot of changes that way. And likewise, we saw a lot of people that were new to the area who may have been told that they could not stay with family because of ongoing substance use.

Dr. Jessica Taylor:

It felt like a lot of turn in our population and a lot of people seeking care for different reasons.

Dr. Alex Walley:

Sim, how about you as far as your team and the folks that you've been seeing? How's their motivation or interest in treatment or other services been impacted by COVID?

Dr. Sim Kimmel:

Yeah. I think that my experience echoes a lot of what Jess described, that initially there was a lot of concern about what kind of supply people will be able to access. I think shortly after the kind of initial lockdown policies, when it became clear that this was not just going to be a short-term experience, people who may have been able to go back to their families, I think some of those relationships became more strained and then people came back to the area. And then I think it became clear that there was going to continue to be drugs available for people.

Dr. Sim Kimmel:

I think that stopped being a huge driver, that fear of lack of access than it was at the beginning. There's a famous opioid drought that occurred in Australia in 1999, which hasn't fully been explained. And following that opioid drought, not only was there a decrease in opioid use in Australia, there was also a dramatic decrease in overdoses.

Dr. Sim Kimmel:

I was really thinking that that was going to happen with the pandemic, that just this whole like slowdown of the economy and of transportation, that it was going to be harder for drugs to get distributed and that we would see a similar opioid drought. And I think at this stage we can say that that definitely didn't happen. In fact, we're recording this on December 18th and just yesterday, the CDC released an alert that is making the case that overdoses have really surged.

Dr. Alex Walley:

They were surging before COVID hit, and then they have continued to surge in many parts of the country since. There are other issues that I think have come up during the pandemic. So pretty obviously and already sort of alluded to, but social distancing leads to more people using alone, which that I think was also an immediate concern of mine and I think that's been realized. Then there's also the other side to that, which is that people who are desperate and don't have resources don't really have the privilege to isolate.

Dr. Sim Kimmel:

You both have too much using alone and then you also have too much congregation that allows for the rapid spread of COVID. Our folks are seeing both of these things. The residential treatment programs have de-densified in order to try to handle COVID, which that really decreases access to residential care. There just aren't as many beds because they can't offer the same density under sort of COVID best practices.

Dr. Alex Walley:

On the one hand, there's just an economic downturn that I think everybody has noticed, but there were also these stimulus checks and unemployment access that a lot of our patients hadn't previously had access to. There was an increase in money in the economy at some levels, which I know for some, not all, but some patients has been a trigger too... Especially with the drug market actually not being that dramatically changed, but remaining stable.

Dr. Jessica Taylor:

I was going to amplify something you said about the issue of using alone versus congregation, because I think that became a really key tension in the way that we counsel patients. I learned from Alex, but when I counsel about overdose prevention, I say to patients, "Look, if you are using to avoid overdose, to stay as safe as possible, we recommend having someone in the room with you who is looking at you, not upstairs or downstairs, and has a cell phone in one hand to call 911 and naloxone or Narcan in the other hand to reverse overdose."

Dr. Jessica Taylor:

And I've learned that script from Alex. I use it all the time, and really emphasize that because of the illicitly manufactured fentanyl that is on the street right now, we're seeing overdoses that progress over seconds to minutes, not minutes to hours. So having people around you monitoring you is a key way to stay safe. And then all of a sudden, we had this new public health messaging to distance, to not be in congregate settings. And as someone that gives harm reduction counseling, I found that to be a real tension.

Dr. Jessica Taylor:

On an individual patient level, I had to think through kind of how to tailor the relative risk of COVID acquisition compared to the relative risk of using alone, which is really high. That was just a tough thing for our patients to navigate and I think tough for our providers to make sure we were giving accurate and thoughtful public health messaging that actually applied to people who are at very high risk from being alone.

Dr. Alex Walley:

We should get back to the case, Jess. You left off with your assessment of his substance use and his prior treatment experience and his interest in buprenorphine. And then painted a picture of the physical settings that you guys were both in. So why don't you fill us in from there?

Dr. Jessica Taylor:

Sure. So we talked about the pros and cons of buprenorphine. He was interested. He was a good candidate. And next, we talked about how to start buprenorphine. So if folks on the call may know that buprenorphine is a partial opioid agonist, and that means that if you have heroin or fentanyl or another opioid in your system and you start buprenorphine right away, you can give yourself what we call precipitated withdrawal or you can put yourself into withdrawal.

Dr. Jessica Taylor:

This patient was really experienced with switching from heroin, fentanyl to buprenorphine on his own. He felt very comfortable, and we talked through how he typically waits 12 to 24 hours to make that transition. Just as an aside, a lot of our patients are having to wait longer these days because of the fentanyl analogs on the street, but he was experienced with the transition, felt very strongly that he could do it in the community. I prescribed electronically a one week supply.

Dr. Jessica Taylor:

The other difference for us, in this case, was that typically we do get labs or potentially check a urine drug screen before we start buprenorphine. And because of the setup where the patient wasn't physically in my location, we decided that we would defer urine testing. And I think that has really moved me along as a provider in terms of my perspective of the role for urine drug testing. In a case like this, the patient was able to be extremely candid about his substance use. And I felt like I had a very accurate picture of how he was doing.

Dr. Jessica Taylor:

Also, I had him on video, so I was able to see that he was alert. He was interacting with me. He was not too impaired to do a visit. And that made me feel comfortable that we were having a good conversation and that he was ready to do the buprenorphine induction that evening.

Dr. Alex Walley:

Jess, I want to stop you there and get Sim's input on that in a lower barrier relationship or a different setting than a medical setting that the patient's openness about their substance use may be different. I wanted to know what your thoughts are on that, if that's also been your experience.

Dr. Sim Kimmel:

Yeah. I think that's a really important question. The harm reduction workers and the outreach workers I think often... They often get very different stories about what people's plans are than the medical providers that most patients, clients have experienced coming through the healthcare system. They've been through methadone clinics. They know the kinds of questions that we ask, and they know what kinds of answers we want to hear. Somebody who wants to get started on buprenorphine kind of knows the routine about what they're supposed to say.

Dr. Sim Kimmel:

And I think they may be more apt to share their ambivalence to a harm reduction worker about their future plans. They may be more likely to share riskier behaviors where they feel like they're not going to be shamed, but they're actually going to get resources or support to reduce those risks. I think often times clinicians are able to gather this kind of information and partner with patients.

Dr. Sim Kimmel:

But I think there is a different dynamic when it's somebody who's a peer or who's an average worker and doesn't have the kind of authority and there's not the kind of power hierarchy in the same way that there is with doctors and other prescribers.

Dr. Alex Walley:

Thanks, Sim. Just take us back to the case and where you went from there.

Dr. Jessica Taylor:

Sure. So I prescribed a week of buprenorphine. And because the patient didn't have a phone or access to devices, we made a plan for the harm reduction outreach workers to find him in a week and said to him, "Look, come by, pass by, next Wednesday morning. I'm in clinic. We'll get you on the phone, and we'll do this again." And that worked. That was a plan that as a provider felt a little bit less guaranteed than perhaps some of the plans that we would have made in the past for a scheduled in person visit, but that went well.

Dr. Jessica Taylor:

We also talked a lot about HIV prevention. And I think earlier we were talking about physical or geographic changes and where patients were and where dealers were and how that impacted substance use, as well as access to treatment.

Dr. Jessica Taylor:

I think the other thing that was really weighing on us in the early days of the pandemic was the separation of people who inject drugs from HIV prevention services like syringe service programs, access to clean needles, access to HIV pre and post-exposure prophylaxis, because a lot of harm reduction organizations and syringe service programs across the state and across the country really had to rapidly modify operations and that led to some access interruptions.

Dr. Jessica Taylor:

I think what we saw is that in our programs, we were trying to give people larger supplies at a time of safe injection equipment, for example. So that if someone was out of the area, couldn't get back to a harm reductionist for a week or two weeks, they would have more clean equipment up front, more sterile equipment up front, I should say, to avoid being in a position of having to share a needle. But that was really weighing on us, so we talked about ways to prevent HIV. We talked about getting some labs for eligibility for HIV pre-exposure prophylaxis or PrEP.

Dr. Jessica Taylor:

And during this visit, our patient, he wasn't ready to do that, but we had a good conversation about ways to reduce risk of HIV. And then he worked with the harm reductionist to get his prescription, and we have buprenorphine in his hand an hour after I got that initial text message. And so here I am thinking, my bridge clinic has done this amazing service. We've connected with a high risk patient. And I said to my harm reduction colleague, "This is fantastic. You called me an hour ago and the patient already has his buprenorphine."

Dr. Jessica Taylor:

And she said, "Jess, it was terrible. This was way too long. This won't work. People who are at really high risk who are potentially withdrawing or under the influence are not going to be able to tolerate this type of a wait." That was such an important conversation for me that just still really stands out in terms of the importance of keeping the patient perspective in mind and just the value that having an interdisciplinary team has in advocating for patients and making sure that we think through not just the systems issues from a provider standpoint or a system standpoint, but actually what is the experience of a patient who has a lot of barriers and is struggling.

Dr. Jessica Taylor:

That was very humbling that I was so excited about this interaction and got feedback that we need to be faster and better next time. We did get faster and have tried to provide much more rapid on demand access over the last nine to 10 months. But yeah, I mentioned that because it really stood out and was a very humbling experience for me as someone that runs a low barrier program.

Dr. Alex Walley:

That's a good example of what Sim was talking about earlier. I want to ask you specifically about HIV testing in this patient. You mentioned risk reduction counseling. You mentioned PrEP and PEP. One of the things that has dramatically dropped off during the pandemic is HIV testing that has to happen in person. You can't do that over the phone. Were you guys able to test this guy?

Dr. Jessica Taylor:

So through my program, we were not able to test. And my program was offering laboratory-based or phlebotomy-based HIV testing, which involves a blood draw and involves coming into our hospital and going to a phlebotomy station where you have to wait in the waiting room and you might have a 10, 15 minute wait. The reason that many programs like ours prioritize phlebotomy-based testing is that it lets

us do fourth generation antigen antibody testing, which is much more accurate and early infection. So it is a more sensitive test for new HIV.

Dr. Jessica Taylor:

It's a very accurate test. It's the gold standard. And when patients are willing and able to get it, that is what we should do. What we see though in our patient population is that many people either are not able to tolerate the added weight of getting a blood draw. People might have difficult venous access related to a history of injection use, and so it's really uncomfortable to get frequent blood draws. And it just may not be something that can be on the agenda on a given day.

Dr. Jessica Taylor:

When you have multiple competing priorities, adding that weight and the phlebotomy piece can be really difficult when people are in crisis. So for that reason, we also partner with our harm reductions around rapid testing. And I think we've really had a perspective change, or at least I can say I have, where I know the fourth generation test is the best test that requires the blood draw and I like to use it when I can, but a rapid test is dramatically better than no test at all.

Dr. Jessica Taylor:

This patient declined to come in for phlebotomy, but had been able to recently get tested with a rapid test at a local drop-in center. During this visit, he didn't want to retest, and we talked about that a lot. Because in our context near Boston Medical Center, I'm having my patients who inject drugs test once a month because we have an HIV outbreak in our neighborhood. By September of 2020, we had seen three times more new HIV infections among people who inject drugs from January to September at our institution than the prior two years.

Dr. Jessica Taylor:

Just a dramatic increase in new infections among people with injection as a risk factor and additionally sexual risk factors in many cases. We certainly had that conversation and talked about retesting, but this day, it was not something that we were able to accomplish, which I think just speaks to the need to incorporate HIV prevention in every visit and bring it up in a way that keeps the door open to revisit HIV prevention next time.

Dr. Alex Walley:

Sim, you're an infectious disease expert. Anything you want to add to this issue around HIV prevention, HIV testing?

Dr. Sim Kimmel:

I think what Jess said that a not perfect test is better than no test at all I think is a really important point. I think the concern is that people could be falsely reassured that they could think that they're HIV negative based on the negative test, because there's a window period with the rapid test that's longer than if you get a phlebotomy, a whole blood sample test. So as long as people understand that, I think that it really gives us a lot more information than we would otherwise have.

Dr. Sim Kimmel:

And we're seeing a lot of people who have ambivalence about getting tested, about getting into care. To the extent that we can lower those barriers, just as an hour feels like a success for a clinician prescribing buprenorphine, I think with rapid testing, you can deliver people the information that they want much more quickly, even if it's not as perfect of information.

Dr. Alex Walley:

Well, I want to thank you both. We I think covered a lot. Jess, you took us through your first patient who you treated with telemedicine in collaboration with an HIV prevention and outreach program. It really has become a model for, I think, how your clinic and others are caring for these patients. You demonstrated both the challenges and the new tools that we have at our disposal. We want to review the learning objectives just to make sure that we hit on what we were hoping to hit on.

Dr. Alex Walley:

Learning objective one, describe the role of medications for opioid use disorders, such as buprenorphine and methadone and HIV prevention among people who inject drugs. Learning objective two, outline regulatory changes during the COVID-19 public health emergency that facilitated medication for opioid use disorder, access to populations at high risk of HIV acquisition, and other complications of substance use disorder. And learning objective three, describe barriers and facilitators of opioid use disorder in HIV care during the pandemic.

Dr. Alex Walley:

Those are all big topics. I don't think we are ever going to comprehensively address all three of those, but I'm hopeful that we gave people some insight direct from the front lines. I want to encourage our listeners to provide us with feedback and other topics that touch on HIV and opioid use disorder that we could address in future podcasts. We're looking forward to the series. Thank you very much. Any final thoughts or comments from Jess or from Sim?

Dr. Sim Kimmel:

Thanks so much for the opportunity to talk with you all today.

Dr. Jessica Taylor:

Yeah. We're really excited to have this platform and to get to share some of what we've learned from our patients and colleagues.

Dr. Alex Walley:

You're listening to Connecting Care. Our program was produced today by JSI and Boston Medical Center. Connecting Care is supported by the HRSA-funded project Strengthening Systems of Care for People with HIV and Opioid Use Disorder. The project aims to enhance level coordination and networks of care among Ryan White HIV/AIDS program recipients and other federal, state, and local entities. You can learn more about the project and find resources at www.ssc.jsi.com. I'm Alex Walley. Join us next time for more from Connecting Care.

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