

CONNECTING CARE PODCAST // EPISODE #10 // TRANSCRIPT

Challenges and Facilitators of ART Initiation in a Substance Use Care Setting

Dr. Alex Walley:

Along with surging opioid overdose deaths and an increase in the number of people with opioid use disorder in the United States, there has also been an increase in the number of new HIV diagnoses among people who inject drugs. For many people, receiving an HIV diagnosis is life-changing news and a person's circumstance can dictate how providers deliver the diagnosis, as well as their approach to initiating HIV treatment, which is referred to as antiretroviral therapy or A-R-T.

Dr. Sim Kimmel:

Choosing the regimens has become easier because of their efficacy and their likelihood of their efficacy and their likelihood of... Basically there's not that much resistance to these newer regimens and that with systems, with some investment in systems, you can really deliver this treatment quickly and hopefully improve people's time to viral suppression.

Dr. Alex Walley:

You're listening to Connecting Care. I'm Alex Walley, an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. I'm joined by my colleagues, Dr. Jessica Taylor and Dr. Sim Kimmel. And today we discuss considerations and best practices for delivering an HIV diagnosis and initiating A-R-T; how COVID 19 has changed the way providers are able to deliver an HIV diagnosis; and how A-R-T and A-R-T initiation has changed over time.

Dr. Alex Walley:

You're listening to Connecting Care, the intersection of HIV and opioid use disorder. I'm Alex Wally, and I'm an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. I'm joined today, again, by my colleagues, Dr. Jessica Taylor and Dr. Sim Kimmel. This podcast series came about because of the surge in HIV clusters and outbreaks, impacting people who inject drugs across the country. We've talked a lot about opportunities for HIV prevention and for many addiction medicine teams this has also meant addressing new HIV infections for the first time, or perhaps for the first time in many years.

Dr. Alex Walley:

Today, we will dig into best practices for sharing a new HIV diagnosis and starting HIV treatment in the setting of active substance use and barriers like homelessness as well as policy changes that can support this work. So Sim, Jess, we all practice in Boston where we have had an HIV outbreak impacting people who inject drugs since at least 2019. And we've all had the experience of sharing a new HIV diagnosis with our patients. What has changed?

Dr. Sim Kimmel:

Well, when we zoom out and look at trends in HIV incidents since really the height of the HIV epidemic, new HIV cases in people who inject drugs have really been declining. So the percentage of new HIV infections that were attributed to injection drug use have gone down considerably. And then more

recently when the opioid supply in the US began to shift towards illicitly manufactured fentanyl and other shorter acting synthetic analogs, those kinds of opioids require more frequent injections, and we start to see an increase in cases.

Dr. Sim Kimmel:

This first received a lot of national attention in 2014, 2015 in Scott County, Indiana. And then there have been several other outbreaks in other parts of the country, some rural and some urban. And so since then, we're seeing more and more infections among people who inject drugs. And this has meant that addiction clinicians who trained after the height of HIV epidemic, but really before the more recent outbreaks have a lot less experience talking to people about HIV and disclosing their new diagnoses.

Dr. Jessica Taylor:

That was a good thing for many years, that we were not seeing the volume of new cases, but our experience in our bridge clinic in Faster Paths has really been exactly what Sim described. We opened in 2016, so that was shortly after fentanyl was hitting the scene in Boston. In our first couple years, we really were not seeing a high volume of new HIV cases in spite of testing increasingly frequently. I think looking back, I can think about three cases in our first couple years in Faster Paths that I heard about that were new diagnoses made in our clinic. And so when 2019, 2020 rolled around and we were seeing more new infections, it really felt different for us. Probably early 2020 was when we had our highest rate of new infections. We had a cluster of about four that were very close together, and that just really brought it home to me that a lot of our team members really fortunately, but had not had the need or opportunity to share a new HIV diagnosis with a patient who's been tested or has not had HIV in the past.

Dr. Jessica Taylor:

And that was something that was honestly intimidating and scary for our providers. And I think the reason that is, is that in usual practice, we work at a great institution with a lot of resources, and that includes a DPH funded public health team. And if you have a low volume of new HIV diagnoses and cases are happening during business hours, it's actually very easy for us to rally resources around a patient and provider that need to have a conversation about a new HIV diagnosis. We have wonderful navigators that actually do a lot of training and have a lot of experience in the specific skill of telling someone about a new HIV diagnosis. And so usually we're spoiled in a sense that we have folks that are comfortable doing this, that have experience doing it, that can very quickly come down to our clinical space and support a patient.

Dr. Jessica Taylor:

And what we've just found is that with the opioid crisis, escalating with COVID interrupting usual scheduling and ability to do in-person visits in some cases and have people on campus, we've just had more scenarios where our providers need to do an HIV diagnosis conversation, really without all of the supports that we would want them to have because it's after hours, because it's early, because someone's walked in unexpectedly. And so that has led to scenarios where we've shared new HIV diagnoses in ways that are different than how we all trained to do it.

Dr. Alex Walley:

I was in medical school in the late 1990s in Baltimore, where there was a lot of new HIV diagnoses in people who used drugs being made every week in inpatient and in outpatient settings. That was in the late '90s, so it was starting. The difference then was that you're delivering or sharing a diagnosis with a

message of hope because we have these new medications that were working at that time to actually transform HIV from a terminal illness to a chronic disease.

Dr. Alex Walley:

And then in residency, I trained in San Francisco in the early 2000s at a time where there were still new diagnoses, but less and less. And then I would say by the time I was in Boston and really for I'd say 2005 to 2015, 16, 17, there really were very few new diagnoses. The new patients that I saw were all transfers from other communities who already had their diagnosis and the issue was trying to piece together what sort of care they had gotten elsewhere. And in the last two years, I've seen multiple new diagnoses in people who inject drugs, just reflecting the story that Sim and Jess were telling, and had to really remember what it was like to give people that new diagnosis. The issues in some ways are the same, but also are also different.

Dr. Alex Walley:

So we're talking about a team with special expertise sharing a new diagnosis. As treatable as HIV is today it's a heavy conversation. So Sim can you share more about how a conversation about a new diagnosis should go?

Dr. Sim Kimmel:

Yeah, so, I think a lot of it depends on the context. So is this somebody who was aware that they had an HIV test that they were waiting on a result for? Was this someone who came into the emergency department and consented to an HIV test, but left before the result came back and now it's several weeks later and they may not even remember that an HIV test was in the works? So I think understanding the expectations matters a lot, but I think there's some principles that regardless of the context of the conversation are important. And the first is to be clear, honest, and direct, to use really simple language, but at the same time, be aware of the power dynamic there between you and the patient and in terms of what the patient's about to face.

Dr. Sim Kimmel:

So I mentioned it's important to understand the expectations both about when the test was performed and what the circumstances are, but also what the patient's expectations are about the result. I've given HIV diagnosis to some people who anticipated that they were going to have a positive test, and they had been kind of avoiding getting a test because they were concerned about finding out that result and other people who really had no idea, that they weren't considering themselves to have any risk factors. They thought that they didn't share syringes or that they only had one partner, but really... And so those are those differences are important and it's important to assess that.

Dr. Sim Kimmel:

I think it's really important to avoid information overload, describing lots and lots of resources that a patient may have, but it's also important to make sure that people understand that this disease is treatable. If people take medications, then they can expect to live a normal life or have a normal life expectancy. And it's also important to make sure people understand that now the treatments are much simpler than they used to be, that for most people, they can take one pill once a day and control this disease. At the same time, you want to get a sense of what people are concerned about. Some people may be particularly concerned about their sexual relationships or their kids or death. And really when you give this information to make sure that you leave space after you have disclosed the result to let people reflect, and then you can really let the patient lead where that conversation will go.

Dr. Alex Walley:

There are three key questions that I like to ask patients after I give them, immediately after I give them the diagnosis. I think your principles that you've mentioned are right on, but these questions, for me, I think are key in figuring out where the patient is at with their diagnosis and the diagnosis can be a shock, and it often is. So a lot of patients are going to be shocked, but there's more specific things that I like to know about where the patient is at. And so these questions have helped me.

Dr. Alex Walley:

The first one is, do you know anyone who has died from HIV or AIDS? And I think it's really important. That question, the answer these days is probably going to be no, because fewer and fewer people are dying from HIV than used to. In the 1990s the answer was probably going to be yes, for most of our patients. So even though the answers have largely changed, if somebody says, "Yeah, my uncle died from HIV." Or "My partner died from HIV." That's very important information to know, to help you support that person going forward. And their outlook on the mortality of HIV is going to be largely informed by the people they know. And whether they've died.

Dr. Alex Walley:

The second question I like to ask is, do you know anyone living with HIV? And then the corollary to that is if they say, yes, do you know if they're on medication? Because if they don't know anyone living with HIV, then this whole thing is way more of a mystery. If they do know someone who's living with HIV, then they're going to have lots of conceptions that are based on the experience of that person that they know or what they think about that person that they know. And that's worth exploring. The person that you know living with HIV, are they able to have a healthy, productive life? If they are, then that's very reinforcing and hopeful for the person that you've just given the diagnosis to. If it's someone who maybe isn't doing well because of HIV or other reasons, that means that's, I think, helpful to know so you understand what the expectations that they're going through.

Dr. Alex Walley:

And then the third question that I like to ask is who in your life can you tell about this diagnosis? And that allows us to really understand what their support network is. Somebody may say, "Oh, well, I'm going to tell my partner, they have HIV." And so then that will push you down one road, or, "I'm going to tell my uncle who's living with HIV. He's been worried about me anyway." So that's good to know because that person has a support network intact. If they say, "It's too early, I'm not going to tell anybody. I don't really know how to process this yet." I think you validate that and say, that's understandable. But then that means that the healthcare providers are literally their only social support around the HIV diagnosis for the time being. And that gives you something really to talk about and work on.

Dr. Alex Walley:

So in the subsequent visits with patients who I've disclosed, or to who I've shared the diagnosis with, I often check in on like how they're doing with sharing their diagnosis with their support network, whether they're finding it supportive, whether they're being stigmatized or not. Because it's possible when they share their diagnosis with others, they could be stigmatized and that's something that we want to help them with, help support them with.

Dr. Alex Walley:

So Sim, the principles that you brought up are such important points. Jess mentioned that the HIV outbreak has not always allowed the time and space for these conversations to happen the way we would like. I have typically had the luxury of giving these diagnoses in person, tried to do that. But we're in the midst of the COVID-19 pandemic and that has made everything more complicated. Jess, how have you in your clinic or not in your clinic worked with giving or sharing diagnoses under these new conditions?

Dr. Jessica Taylor:

I think what you said about doing this in person is incredibly important. And when we think back to several years ago, early on when I was a resident, we would only do an HIV diagnosis conversation in person, that was really considered the best practice. And I think that that is still the case when it's possible, when it's right for the patient. But with the COVID-19 pandemic, with the reality that a lot of people impacted by the current outbreaks may not have phones to schedule visits, may have transportation barriers to coming in, I think we've had to be flexible and really creative and balance getting people the information that they deserve to have about their health and about a condition that can impact people around them, while also making sure that hearing what can still be a very stigmatized condition like you said, and really a life changing condition, is treatable as HIV is, as much as when I give any diagnosis, I see the time period three months from now, when someone's going to be starting to see me less frequently and taking one pill once a day in most cases, and really back to work relationships, all of the things that are important to them, we know that that future can be there for our patients, but in the moment of a new diagnosis, it's really tough.

Dr. Jessica Taylor:

And so, I think we have to balance that with just the logistical challenges that we face and try to make the best choice for the patient in front of us in the moment. I'm going to tell you about a patient. We're going to call him Derek, which is not his name, but he has given us permission to share his story. And he's someone that had a new HIV diagnosis in Faster Paths, our clinic, really recently. And so he's someone that we've worked with for a couple years. Sim and Project Trust have also worked with him, as have several of the collaborators that you've met on our podcast so far. And he's a 40-year-old gentleman that has a history of severe opioid use disorder, crystal methamphetamine use disorder, who has experienced homelessness for many years. He lives at a tent encampment that's fairly close to our hospital and worked with us in our bridge clinic, started buprenorphine, Suboxone, and then was able to graduate from our program to a longer term program in our medical center.

Dr. Jessica Taylor:

But he would always pass by and say, hello and chat, and like to come by and chat with our nurse care manager. And one day came by and shared with our nurse care manager that his partner, a sexual partner, had tested positive for HIV. That was really a surprise, hadn't been expected, and so he was worried about his own risk. And so our nurse was able to coordinate testing. He then went on to an appointment at his new program and came back a little after 5:00 around 5:30. This was on a Friday and his initial HIV test, which had been the antigen antibody test. He had done a blood draw for the laboratory based antigen antibody test that had come back positive. So 5:30 PM, a lot of the teams are out of the hospital. I was out of the hospital and our nurse care manager-

Dr. Sim Kimmel:

5:30 PM on a Friday, no less.

Dr. Jessica Taylor:

On a Friday, yes. So folks that work at hospitals may know that things can clear out and there can be a real difference in some of the services compared to during the week when you get to the weekend. And our nurse who has, I'm sorry to say, has developed a lot of experience with new HIV diagnoses because at the time she was really a main point of contact for a lot of our patients, but still this is something where I think we wanted to really take a team approach. And so she called at 5:30 on a Friday. If you get a call from someone who's in clinic, it's usually something important. And so I picked up and she sort of briefly gave me a rundown and said, "Can I put you on speaker?" And the thought of being on speaker phone to talk about a diagnosis like this is something that when I think back to how I was trained to share a new HIV diagnosis just feels completely out of bounds and really not the ideal scenario or best practice that we want to do for our folks.

Dr. Jessica Taylor:

But I think the reality was that for our patient, he was worried about his diagnosis. And as Sim mentioned, had a sense that his risk was probably high because his partner had tested positive. He doesn't have a phone. We catch him when he passes by, because he's not working with us formally anymore, but realistically, if we didn't share the diagnosis in that moment, it might have been a week or two before we could catch him to really have the conversation again. And then that's a week or two where he's not able to start treatment and also where further transmission could happen. So there's both his personal health to think about as well as the public health implication of missing an opportunity to share a diagnosis.

Dr. Jessica Taylor:

And so, basically we did a disclosure conversation through the speaker phone. Our nurse care manager was sitting with him in the clinic and shared that we thought that even though we just had the prelim result, that most likely it was a true positive and that we could move forward thinking about it as a true positive as we got into the later part of the conversation around starting medication, just because of the challenges with staying in touch. And to be honest, the challenges with walk in access at the time, which did happen during the COVID pandemic, where it's not always as easy to walk into a medical center because of screening protocols and needing to wait in line to be evaluated for COVID symptoms and things like that.

Dr. Alex Walley:

Jess, thanks so much for sharing this. And we're going to talk a little bit more about what you do with initiating A-R-T, but let's just stop for a second. I can hear the sort of hesitancy in your voice about doing this over speaker phone. But I guess I want to point out a couple things about the case that I observe and hear from Sim too, but first of all, this is a guy who came to you. I mean somebody you already, not you actually, to your nurse care manager. Who he had an ongoing trusting relationship with and he found this was an outlet, a safe outlet for him to actually get to tested. There's other places he could have gotten tested, right. But he came to your team specifically to get tested because there was that relationship there.

Dr. Alex Walley:

And then, he got tested because he was really worried. And so I think it would've been in this case, especially now, it would've been awkward not to give him the diagnosis. It's his healthcare, he asked for it, he wanted an answer. And yes, you were on speaker phone, but you had a trusted team member

right there in the room. And so in some ways I think the calling up on speaker phone was a way to kind of marshal a more supportive environment for him in that case.

Dr. Alex Walley:

Anyway, those features I think are important. I guess for me it doesn't mean it's always right to deliver the diagnosis over speaker phone. There have to be other things you need to think about. Like we were discussing, like where the patient is at. So anyway. I don't know, Sim, what your take is on it and what your experience has been in your setting. But this one, I feel like you definitely did the right thing for sure. There's a lot of reasons, but mainly for me, it's about the relationship with the patient, where the patient is at.

Dr. Sim Kimmel:

I agree. And I think this gets at some of the really profound changes around HIV testing and HIV diagnosis that have happened over the last several decades. And some of those are legal changes. That there used to be a requirement for written consent before somebody had an HIV test. Typically, there'd be a visit with just counseling prior to the test. And then the test result would be delivered in person, whether it was positive or negative during a second visit. Some of this is related to how complicated the HIV testing itself was, the window periods where there there'd be this kind of period of early on six weeks, maybe even three months, where the results would only give you information about whether you'd become positive before. And so the testing has gotten better, that now the window period is much shorter.

Dr. Sim Kimmel:

But some of it I think gets at the stigma and there were all these legal protections to protect people with HIV because a HIV diagnosis could result in loss of housing, loss of employment. And some of those things are still the case, but there's been a movement to mainstream HIV care into the rest of medical care. And we wouldn't think so much about disclosing another serious diagnosis over the phone like this, a diabetes diagnosis. We wouldn't have the same kinds of concerns. And so over time there's been an effort to get rid of some of these requirements and make the testing a bit more mainstream. And then the other, I think, big change is just that the treatments are so much better and so much easier. And so the fact that we can offer treatment so readily and people can have an easier time taking it really makes the whole conversation different.

Dr. Alex Walley:

Yeah. There's two ways the treatment is different at least. First of all, the treatment is well tolerated and is so much less burdensome. So very often we're talking about one pill once a day. Whereas in the past, there were regimens with over 12 pills a day in the '90s. So the burden on the patient to take it, it's much more like another convenient medication, like a, for example, blood pressure pill. That's one reason.

Dr. Alex Walley:

The other is, is that the medications are more resilient than they used to be. The pressure to have 90% adherence or higher is less strong. So if you initiate it and the person doesn't have perfect adherence from the outset, that's what we all counsel and we all want our patients to have because we are very worried about resistance, but the fact of the matter is is that the medications that we're using today, the stakes aren't quite as high when it comes to both a, the patient tolerating the medication and b, the medication needing to be taken exactly as directed in order to be effective.

Dr. Sim Kimmel:

The questions that, Alex, that you raised, I love those questions. I'm going to take those and incorporate them into my practice too, because I think they really get at both what people know and have heard about HIV and where they are in terms of the likelihood that they'll experience stigma and kind of what we will anticipate they're going to be facing. And a lot of that has to do with how we disclose this information and how we move forward with a person, so I am going to steal those for sure.

Dr. Alex Walley:

Well, and no matter what we tell them, the messages from physicians can be very powerful, but you have no idea when you talk to the patient whether they're going to believe you or not. So it really helps to know who else in their life is going to be informing their views on this disease. That's really the key because their belief system is going to be much more powerful for them. And that's informed by the people they know more than by us as healthcare providers, I think. At least that's been my experience.

Dr. Jessica Taylor:

I think there's a parallel too, to PrEP public health messaging here, where we've talked on past podcasts about how we haven't done a good enough job as a medical system or providers telling people about the benefits of PrEP, the availability of PrEP. And I think here too, we as a medical system is a public health system we have not gotten the word out about how treatable HIV infection is. And I am always floored, honestly, at how often people tell me that they don't want to test for HIV because they will die if they have it. Or if I'm sharing a new diagnosis and ask a similar question, people are truly afraid that they will die.

Dr. Jessica Taylor:

And sometimes that's informed by family experiences, by knowing someone who died of complications of HIV, but also commonly it may just be informed by stigma and by the way HIV is portrayed in media and in health systems. And by the fact that no one has really had a medically informed conversation with them who's a provider or someone that they work with to explain that the reason we want to test for HIV is that it is incredibly treatable. It is a manageable chronic illness. My patients that are on medication and well controlled see me twice a year and get labs twice a year and take one pill once a day in many cases. And that information is really surprising to people, which I think should cause us to look further upstream as medical and public health systems to really think about how to share that information more broadly so that people have it before the moment of getting a new HIV diagnosis when the conversation is already so heavy and could come to testing or diagnosis with a little bit more, I don't know, more information about what it means to have HIV in 2021.

Dr. Alex Walley:

I'm not a pop culture or Oscar expert, but I think every movie that's ever won an Oscar that was about HIV, and there have been several, including I think Philadelphia and maybe Dallas Buyers Clubs are the ones that come to my mind immediately, they all are set at a time before HIV was a treatable chronic disease. So in the popular culture, it sticks in the mind that it's a terminal diagnosis. And it's not as, I guess, entertaining, while although we, not that we're do our work because we're entertained, but one of the reasons that I became an HIV doctor was because I saw people getting better who didn't expect to get better. So that actually is a very kind of rewarding redemption story that I think a lot of people are attracted to. But I think the way it's conveyed in the popular culture is remains. I totally agree about getting the word out.

Dr. Alex Walley:

Okay. So we should talk about starting A-R-T here. This is an area where our practice has also changed over the years. In the early 2000s when I was a resident in San Francisco, seeing a lot of HIV in the hospital and some in the clinic, we didn't start HIV treatment until people started to show signs of immunosuppression, meaning that their CD4 count had dropped below 350 or even 200, or they had some AIDS defining illness, or they were very motivated to be on medication. The irony also was that for patients with very low CD4 counts in the hospital, we also held off on starting antiretrovirals because we were worried about immune reconstitution syndrome, which is the super charging and overreaching of the immune system when you start antiretroviral therapy in somebody with low T-cells.

Dr. Alex Walley:

And so there was this kind of narrow window of people who we knew to start right away. But over the years there's been many benefits in both groups, those with higher CD4 counts and those at risk for immune reconstitution syndrome for starting A-R-T earlier. There's been, I think in 2015 there were two randomized controlled trials, the START and Temprano trials, both showed morbidity and mortality benefits to early A-R-T initiation with those with the higher CD4 counts greater than 500 compared delaying A-R-T initiation. Sim, you're our resident infectious disease expert here, do you want to give us a little more detail on A-R-T initiation?

Dr. Sim Kimmel:

Yeah. I think the START and Temprano trials led folks to want to start HIV antiretroviral therapy earlier, for sure, and they really changed the way people were thinking about these hospitalizations, even for people who are really sick or the initial outpatient visits, but they were really sort of starting within a couple weeks, was what those trials tested. So outside of people who have certain kinds of infections in the brain and basically we would start antiretroviral therapy within a couple weeks. So that meant, I think, in practice that people who were eager to initiate antiretroviral therapy, that we thought that they would be able to take their medications, the patients thought they'd be able to take their medications, we would start them sometimes in the hospital, but more often we would wait for the genotype to come back and then we would set up a visit after a hospitalization and then start it in a kind of close follow up.

Dr. Sim Kimmel:

But then more evidence came out, there have been several other studies showing that basically same day initiation at the time of diagnosis can improve time to viral suppression. And at BMC, where we practice, I think practice has changed considerably even in the time that I've been there, and from the time that I was a fellow. Some of that has to do with the fact that now the, as we talked already, the antiretroviral therapy has a higher barrier to resistance. It's one pill. And so when you have a single pill with a higher barrier to resistance, that's very likely to be effective without waiting for a genotype, I think people feel much more comfortable starting treatment earlier.

Dr. Sim Kimmel:

And so when a study out of San Francisco General Hospital came out showing that time to viral suppression decreased from about 120 days to around 60 days I believe, it was something around there, that that was pretty compelling. And that felt like that was the San Francisco General Hospital population is comparable to the patients that we're taking care of at BMC. And since then, there've been a lot of efforts to really have early initiation. And so our clinic has developed a same-day initiation protocol. There's nurse practitioners who are prescribing the initial antiretroviral therapy, typically for

people, if they can't get in to see a doctor first, and then they have a close follow up with the doctor who will be taking over their care.

Dr. Sim Kimmel:

I think there's a couple lessons here that choosing the regimens has become easier because of their efficacy and their likelihood of... Basically there's not that much resistance to these newer regimens and that with systems, with some investment in systems, you can really deliver this treatment quickly and hopefully improve people's time to viral suppression.

Dr. Jessica Taylor:

Could you say a little more about the program that supports the nurse practitioners that are doing the work and sort of how that relates to the HIV primary care clinic?

Dr. Sim Kimmel:

Sure. We've talked a bit about how there's a lot of wraparound services in our program. In our HIV clinic there's case managers, and there's a whole team that does intakes. And so when there's somebody who has a new diagnosis, typically they'll have an intake with the intake coordinator, that person will go and meet the patient either in the hospital, or if they have a new diagnosis, there'll be a visit scheduled to have that intake. And then they'll have a visit with the nurse practitioner who will do some of the initial assessments that we've already talked about and typically prescribe antiretroviral therapy. Our clinic, the access to physicians for urgent visits is not as great as it should, so this really provides a way for people to get in to be seen, get started on treatment very quickly, and then they have a follow-up visit with the doctor who will take over their care longitudinally shortly after.

Dr. Alex Walley:

Okay, well, I think we've covered a lot of ground here. Looking back, for each of these podcasts, we come up with learning objectives. And if I look at them, I think we've covered them today. We talked about the initial HIV diagnosis, how to deliver it, how that's changed over the years and our individual approaches and strategies, some key principles. We've talked a little bit about the evidence base for early A-R-T initiation and how the evidence is pointing towards the earlier the better. And then we've talked about some best practices for both the diagnosis sharing and the initiation of A-R-T. Anything either of you'd like to add before we close this down for this month's podcast?

Dr. Sim Kimmel:

Can I just ask what happened to that patient?

Dr. Jessica Taylor:

I will say this is one of the first cases where I have started A-R-T without having the confirmation test back. People that do HIV testing may know that the antigen antibody test is a first test. If it's indeterminate or positive in our hospital it reflexes to a confirmation test. And I knew that that confirmation test probably wouldn't be back until 8:00, 9:00 PM that night just based on the time that the patient was tested. But we had him with us, we talked about his readiness, what he knew. He was really eager to start A-R-T that minute and wanted to do everything possible to get his viral load suppressed, and then really be a resource to his partner who'd also been diagnosed recently and was not on A-R-T yet herself.

Dr. Jessica Taylor:

So we had a risk-benefit discussion and I explained that I did think his test was a true positive, and that on the basis of how, what Sim was saying, how effective the regimens are, and the fact that we luckily are not seeing transmitted resistance to our first line regimens, although we've had a few cases of that, but that I would feel comfortable starting him before getting the genotype, which is the resistance test. And so I prescribed A-R-T, a single pill regimen, sent it to the pharmacy. Our nurse care manager was able to take him upstairs to the cafeteria to get dinner. And then by that point, he got some extra labs, the medication was ready. That really, I have to say, was eye opening to me that even when it's not a perfect scenario, even when we may be physically separated because of all the barriers we discussed, we were able to give him a lot of support and start A-R-T really as soon as that initial HIV screening test came back positive.

Dr. Jessica Taylor:

And he's had a number of challenges that impact patients that we've talked about on this podcast. Holding medication while dealing with homelessness and living outside is an ongoing challenge. His care has been interrupted by incarceration several times, by a couple of hospitalizations for skin and soft tissue infections. And so we tried and did for a while have him come to see us every day. At the time we were open six days a week, so he would come and check in, take his medication with us and then not have to carry the bottle or worry about it. Especially in the time of COVID, but honestly, in any circumstance coming into a hospital every day is not really a desirable routine. And so he transitioned his care to directly observed therapy with one of our colleagues, Megan Sonderegger, who spoke about doing D-O-T for PrEP a couple weeks ago. She's also able to do directly observed therapy for HIV treatment, and so he's worked with her team. He swings by Project Trust, and I think has stored meds at the drop-in center where Sim worked in the past. And he's still on medication.

Dr. Jessica Taylor:

I think a good example, just the reality that there is a lot of stigma against people with ongoing substance use. There are a lot of assumptions that providers and teams make about people not being able to get on or stay on medication, but that is not what we see. It takes a lot of wraparound services. It takes a lot of flexibility, but he's someone who is now on treatment, and when I see him in a couple weeks, I expect his viral load will be suppressed. So I think this case, preventable in a lot of ways, when we think about better PrEP delivery and access to lower barrier HIV testing, I think this could have gone differently. But in spite of that, with wraparound services, with navigation support, with some of the investments that Sim was alluding to, which we can maybe talk more about, I think we're able to deliver care in a way that has made him feel supported and kept him engaged.

Dr. Alex Walley:

Thanks for bringing in the case, Jess, and for your work with him. And thank you both for another great podcast. Look forward to the next one. Take care everybody.

Dr. Alex Walley:

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