CONNECTING CARE PODCAST // EPISODE #3 // TRANSCRIPT

Reaching those who need it most: HIV prevention for people who inject drugs

Alex Walley:

We need to strive for everyone to have equitable access to care and prevention.

Dr. Jessica Taylor:

We know that approximately one in seven Black women who inject drugs in the United States will go on to contract HIV in her lifetime, and that compares to one in 26 women who inject drugs overall and one in 42 men who inject drugs overall. Many people listening today care for, know, provide services to more than seven Black women.

Alex Walley:

And not only do we care for more than seven Black women, we care about them. There are so many factors, race being one of them, that impact PrEP, adherence and health outcomes. You are listening to Connecting Care. I'm Alex Walley. I'm an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. This is the second of a two-part series about HIV pre-exposure prophylaxis, or PrEP, among people who inject drugs. During today's podcast, we'll take a deeper dive into how systemic barriers contribute when things go wrong with PrEP adherence.

I'm joined again today by my colleagues, Dr. Jessica Taylor and Dr. Sim Kimmel. Today is the second part of our discussion about PrEP among people who inject drugs. In part one, we reviewed a successful case of engaging someone who injects drugs in PrEP by starting with PEP, we discussed the nuances and benefits of PEP to PrEP strategies among people with ongoing regular sexual and injection risk. We reviewed that people who inject drugs are eligible for PrEP In the CDC guidelines. We discussed the challenges and opportunities of PEP and PrEP among people who inject drugs. Today in part two, we will review a challenging case of a patient who was initiated on PrEP. We hope to consider and emphasize promising ways to improve access to PrEP for people who inject drugs. Okay, so welcome back Jess and Sim, who's going to present the case today?

Dr. Sim Kimmel:

I'm going to present the case today. It's a challenging case that I think brings up some of the issues that we've been talking about and will help us think through some of the solutions. The case I want to talk about is a Black woman who's in her mid 30s with a past medical history of multiple issues. She has addiction, an opioid use disorder, cocaine use disorder, she has a methamphetamine use disorder and also has a history of alcohol use disorder that's fairly severe with a history of fairly recent withdrawal seizures. She also has a history of trauma and a diagnosis of PTSD, Post-Traumatic Stress Disorder, and bipolar disorder. And then she also has hepatitis C, so she's got multiple comorbidities that are kind of overlapping. And she engages in transactional sex without condoms. She has a regular partner who she uses condoms with. She's lost children due to DCF involvement. She's homeless, currently, experiencing homelessness, and she presents to the emergency department.

Alex Walley:

So DCF, for people who are aren't in Massachusetts, I think most people know what it is, but can you explain what that is, DCF?

Dr. Sim Kimmel:

So DCF is the Department for Children and Families, I believe is the acronym. And they're charged with investigating cases of abuse and neglect, or concerns about abuse and neglect, and she had several children who she had lost custody of and had been placed I believe in foster families. So she comes to the emergency department seeking care for abscesses on her arms. So she's been injecting substances, a mixture of fentanyl, methamphetamine, cocaine, and she has multiple abscesses on her arms. So she comes in with fevers and she's in pain and she's seeking care related to that. And while she's in the hospital, she's admitted to the hospital and she receives a IND or a drainage procedure by surgeons of the abscess, she gets antibiotics. And there's this period in the hospital where she's getting treated, she's starting to feel a little bit better and multiple kind of services reach out to her.

So the Addiction Consult Service is asked to see her and she expresses interest in getting some help with her substance use disorder. Oftentimes patients in the hospital, these are opportunities, people are motivated, they're very reflective due to the concerns about their health. In consultation with the Addiction Consult Service, she was started on methadone for treatment of our opioid use disorder, and there was a plan to link to a methadone clinic as an outpatient. And she gets screening laboratory tests for HIV, for syphilis, given her history, and those tests come back and she's found to have syphilis and her HIV test is negative. And so the combination of those things demonstrate her extremely high risk of contracting HIV, and in coordination with the emergency department and the inpatient team and the addiction constant service, the decision is that she should be started on pre-exposure prophylaxis.

Alex Walley:

So Jessica, this is an inpatient in a general hospital who has an infection, who uses substances, the infection is probably a complication from injecting, and this person was started on PrEP, or the decision was made to start this person on PrEP. And so I want to give my initial thoughts to this and then hear your thoughts. So I'll just say that I have been, I guess, working with patients who are hospitalized like this for over 20 years and for much of that 20 years we've known that PrEP has worked, not all of it, but much of it we've known that PrEP works. But it is quite unusual in my experience for us to actually start PrEP in a hospitalized patient until recently, and I think we talked about that maybe in the last podcast, but what are your thoughts about the eligibility of this person being started on PrEP and what are the things that you would be thinking about if you were taking care of her in the hospital?

Dr. Jessica Taylor:

I agree. I think we have really turned a corner in terms of thinking about HIV prevention at these really acute touchpoints like emergency department visits and inpatient hospitalizations, and I think it's really critical. We know that a lot of people at the highest risk of HIV acquisition are not coming into the primary care clinic, they're not going to an outpatient urgent care clinic, for example. And we know that when we actually do a look back after people who inject drugs are diagnosed with HIV, we see a whole number of missed opportunities. That's certainly true at our institution. At a recent look back of the current HIV outbreak cluster at our institution among people who inject drugs, we saw the people had an average of 11 ED contacts, a median of four, in the six months leading up to their diagnosis.

So I think what we're learning is that we have to capitalize on the touchpoints that we have and that they are in settings where we just historically have not really focused on HIV prevention and other

preventive services. Based on what Sim is telling us about this case, I completely agree with using this moment and this opportunity to talk about HIV prevention and start PrEP. We heard that the patient that we're talking about today has sex with multiple partners without condoms and transactional sex, which can be a higher risk scenario for HIV acquisition. We heard about injection drug use. I actually can't remember, Sim, if you mentioned shared injection equipment?

Dr. Sim Kimmel:

She says that she doesn't share her syringes, but she does share the cottons.

Dr. Jessica Taylor:

Great. And so that's actually very common. And I just want to highlight one thing Sim did that's really important, which is ask about all injection practices. So very commonly people might say, "Oh, do you share syringes?" Or worse, they might ask in a way that really doesn't create a safe space for people to disclose what they do. We hear language like, "You don't share needles, do you?" And then of course, who would say yes to that question, right? It's important to ask open-ended questions and ask not just about the syringe itself, but also about injection equipment. It is pretty common for people to share cottons or to reuse cottons if they're not able to access drugs in a given moment because there's sometimes some residual drug left behind that can be accessed, and that is a pretty high risk practice in terms of risk for infections. So really great to ask about all types of injection practices and the entire injection sequence to have that information.

Alex Walley:

I have another question for you. So Sim described her as a Black woman from the top, and I'd like us to take a moment to reflect on the role of race in this case, how it's specific to HIV risk and transmission and PrEP, as well as access to equitable access to care in our system. Jess, why don't we start with you and then Sim can have a chance to reflect on it.

Dr. Jessica Taylor:

Thanks for bringing that up, Alex. I think we're in a moment where we are really reflecting critically on when and how we include race when we talk about patients, and so this is a really timely topic. In this case, what stands out to me, knowing that she is a Black woman, is that her risk of HIV is substantially higher than a white woman who injects drugs, for example, and higher still than a white man who injects drugs. And we can talk about reasons for that in a minute, but just to put a number to it, we know that approximately one in seven Black women who inject drugs in the United States will go on to contract HIV in her lifetime, and that compares to one in 26 women who inject drugs overall and one in 42 men who inject drugs overall.

So that's really staggering. One in seven Black women who inject drugs is expected to contract HIV. Many people listening today care for, know, provide services to more than seven Black women who inject drugs and so I think that that stat can be really grounding in terms of helping providers and care teams understand the degree of risk and the degree of urgency we have when we talk about HIV prevention. I think this is an important conversation to have. The reasons that we see these disparities, I think we should do an entire podcast...

Dr. Jessica Taylor:

Have, the reasons that we see these disparities, I think we should do an entire podcast on. That they relate to systemic racism, to barriers, to accessing services, to mass incarceration. That is an entire topic

in and of itself. And I think for providers, the important takeaway here is that if you're caring for a Black woman who injects drugs, HIV prevention should be very high on your list based on risk factors that she may share with you, that it might be sexual risk factors, injection risk factors, or both, depending on the circumstance. But it is our responsibility to talk to our patients about ways to keep themselves safe from HIV. And I think, historically, the medical system has not done a good job serving our patients of color in terms of addressing HIV prevention.

Alex Walley:

Great. I hope we get to some of the possible solutions. I'm not sure we know them all, but Sim, do you want to add anything?

Dr. Sim Kimmel:

I think Jess is absolutely right. We should be thinking critically about when we include that piece of information, people's racial backgrounds, when we're describing cases clinically. In this case, I decide to include it, in part because we're having this conversation and in part, because of the increased risk. But I think also her racial background, her experiences with racism, her personal experience with the Department of Children and Families, family services, her experience with incarceration. I didn't actually get into that, but her mother also had a substance use disorder and she was raised by a foster family. Her relative isolation is related to legacies of racism, and her lack of social support is also related to the history of racism in Boston. That was why I brought that up.

Alex Walley:

Great, thank you. We're at the point here where... How did you say it? She was offered prep?

Dr. Sim Kimmel:

I may have said that the decision was made to offer her prep, which is probably not the best way to describe it. Really, it should be a conversation with the patient about their risks. But I think oftentimes, clinical teams are having conversations about what kinds of treatments to offer people and how to present that information to people. So she was offered prep, and I think she understood her risks and she was concerned about HIV acquisition, and so she decided that she would want to start prep. And the encouraging thing is she also, at the same time, was seeking concurrent treatment for her opioid use disorder. She has multiple other conditions that make even her opioid use disorder treatment a little bit more challenging, concurrent methamphetamine use and cocaine use, alcohol use as well. But she was quite motivated at this point.

Alex Walley:

That's great. And I will say, again, reflecting on my historical experience, when we have started to bring up prep in the past, many times patients weren't aware of what it was and it was hard to describe. I wasn't taught the language in medical school on how to describe it. And do you want to say anything about why you think she was motivated or how it was presented to her that may have at least not discouraged her from engaging in prep or taking them up on it?

Dr. Sim Kimmel:

I think in this circumstance, the patient understood that particularly, because of transactional sex work and having unprotected sex with multiple partners, that she was more aware of the risk of infection. I think oftentimes, at least until fairly recently, people seem to think that the rates of HIV were low

enough that even if they shared syringes every once in a while, their risk of HIV was not so high. And I think she understood based on prior knowledge and prior experiences with people with HIV, that she was at high risk.

Alex Walley:

Great. I think that one thing that we know from the literature is that there's intersecting risk for people who inject and people who have a sexual risk. And people who also have sexual risk may be more motivated to engage in prep. Okay. Do you want to take it from here, what happened next?

Dr. Sim Kimmel:

Because she had these abscesses and required ongoing wound care and didn't have any place to stay, she was eligible to be placed in a respite facility where she could get nursing support, nursing care. And in that setting, there's daily administration of medication. So she was initiated on prep. She completed her antibiotics in a respite facility and received her daily prep. She stayed at that facility for some period of time, and then ultimately left and ended up going back to the street.

Alex Walley:

She left the respite facility. Did she continue on her addiction treatment? Did she continue on her prep?

Dr. Sim Kimmel:

She left the respite facility. She remained on methadone. She was out on the street. She continued to inject drugs and returned to some transactional sex work. And about a month later she presented again and actually had a rapid HIV test that was negative, and then shortly thereafter, had a viral load that was positive. Which means that she had had an acute infection.

Dr. Jessica Taylor:

What prompted the team to send both a rapid test and a viral load at the same time?

Dr. Sim Kimmel:

There's concern that when people get blood tests performed with phlebotomy, that we won't be able to actually reach out to them and find them with the results. And so a rapid test gives you an opportunity to deliver some information about people's HIV status right there. So if she had a rapid test, she found out that as of several weeks ago, which is essentially what the result of a rapid test would show, she was HIV negative. But that she still could be HIV positive due to HIV infection in the past couple weeks, in the last two weeks. She wanted that information. We wanted to deliver that information to her more quickly.

Alex Walley:

Jess, do you want to talk a little bit about the pluses and minuses of the various testing strategies and maybe explain what you think happened here?

Dr. Jessica Taylor:

This is really on my mind because we just implemented rapid testing in my program, Faster Pass. Project Trust has had it for some time. Essentially, the most accurate screening test is the fourth generation HIV antigen and antibody test. It's the most accurate in early infection, which we might call acute HIV infection, basically recent HIV infection. Unfortunately though, it requires phlebotomy, a blood draw,

and that's challenging for a whole bunch of reasons that I think we covered in our last podcast. So a lot of places are implementing rapid testing as well. I'm a huge proponent of rapid testing when someone either cannot or will not get a blood draw. And the truth is in Boston right now, where we have an HIV outbreak among people who inject drugs, I think the people who are injecting or have sexual partners who are injecting should test once a month.

Getting phlebotomy done once a month is a very high bar that even working in a hospital would be a challenge for me to schedule myself. I think we really need to be thoughtful about what is the test that the patient is willing and able to get that the system can deliver to them if they might be on the street or in the community, not coming into the medical center. I like the approach that was taken in this case. So someone who is at high risk of HIV infection, very interested in understanding her status. It sounds like she had a rapid test and a phlebotomy based HIV test concurrently at the same time to give her some preliminary information in the office before she leaves. But also to make sure that that more accurate test. And I'm curious if you know anything about whether they also did a fourth generation at the same time, because we would typically do a fourth generation phlebotomy test and a rapid at the same time.

There are cases though, if you're really worried, if someone might have symptoms of acute HIV that you would also do that viral load, the RNA test. The one that we use is not FDA approved for diagnosing acute HIV infection. Although a viral load test has recently been FDA approved for that reason. But yeah, anyway, I think this just highlights the way that the system falls short for our patients where we have a lot of patients that want to be tested we want to test, but our systems make it really challenging to get the most accurate test.

Dr. Sim Kimmel:

One thing I just want to add here is, I didn't specifically mention what was going on with her prep medications when I described this case. So when she came in to get her test again a month later, she said that she had been taking her prep medications. And I think patients want to convey to their clinicians that they're doing what we've asked them to do or that they're doing the best they can. I think probably what was really happening is after she left the time in the respite facility where she was really getting the medications every day, she was likely not taking the medications at the time that she was at risk and contracted acute HIV at that time.

Alex Walley:

The rapid test in this case was negative because it wasn't sensitive enough to pick up acute HIV. There is a window that exists, however, the backup test, the RNA, which required a blood draw was positive. And that can be more sensitive in acute HIV. Okay. So this is not the outcome that we were hoping for when she was in the hospital and we offered her prep, and were excited that she was motivated to engage. I think we need to take a little time to think about how this could have gone better and what sort of things we could improve things for her. Sim, why don't you start with some of your reflections on how you think this could have gone better or what maybe we could have done differently here?

Dr. Sim Kimmel:

It seems to me like she made use and the system delivered in the acute hospitalization. The system delivered a lot of effective interventions. The methadone, the prep, there was a linkage to care to an outpatient respite facility that she qualified for because of her need for wound care. But after that, there's very few resources to help support her. So she's a woman who's experiencing homelessness. It's very challenging to adhere to medications if you are not sure how you're going to keep the medication safe, if you're concerned about how you're going to have enough food or how you're going to get to your next opioid. I think all of that makes it really hard. Had she had an opportunity to go to some sort

of residential... I mean if she had an opportunity to go to some sort of residential, I mean of housing, housing would make things a lot easier, I think is one of the big things that we're learning as we think about who's at highest risk for HIV acquisition.

I think also she had multiple risk factors. She has multiple comorbidity, she has multiple social risk factors. They really all multiply. So it wasn't just that she has one substance use disorder, but she also has difficult mental illness. She has multiple substance use disorders. She has homelessness. And all of those things multiply. So we need to think about how we can deliver resources to people.

Alex Walley:

Great. Jess, what are some options here on how we could create a system or improve things for her?

Dr. Jessica Taylor:

One that we wanted to bring up today because it's new and really exciting is the option of long-acting injectable prep. A couple of really landmark clinical trials came out looking at long-acting cabotegravir, which is an HIV medication that can be dosed every two months to prevent HIV infection and people at high risk.

So we had these two trials, they're HIV prevention trials network, trials 083 and 084 that looked at HIV prevention in cisgender men who have sex with men and transgender women as well as cisgender women at risk of HIV, and compared long-acting injectable prep to a daily oral medication for prep.

And essentially these trials showed a phenomenal risk reduction, just really, really impressive data where, in men who have sex with men and transgender women, the long-acting injectable reduced HIV transmission by 66% compared to oral daily prep. And among cisgender women, the rate of HIV acquisition actually came down by almost 90%.

We almost never see effect sizes that big in clinical trial work and particularly in an HIV prevention space where we have not had very many recent randomized control trials. These are really, really exciting in terms of new drug trials coming on the scene.

But what's disappointing is that we hear about these long-acting injectables. And to me, hearing about Sim's case, I think what a great opportunity. What if we could have provided this patient with a long-acting injectable form of prep on her way out the door from the hospital or from the respite facility, which is really a transition point when risk increased significantly, and just provide a few months of coverage so that other factors can stabilize, get into place to really reduce risk.

Unfortunately, where we are is that the trials of this long-acting injectable medication systematically excluded people who inject drugs. And that was done both explicitly by excluding people who had, for example, substance use that investigators judge to be potentially problematic, but also in more of a subtle way. So, for example, people who are hepatitis C antibody-positive were excluded from trials. And hepatitis C is incredibly prevalent among people who inject drugs as well as people who have had substance use disorder in the past. A hepatitis C antibody is expected to stay positive lifelong after a hepatitis C infection.

So the result is that the trial populations really don't reflect the community in terms of inclusiveness of people who use substances. And I think that is a huge gap and really a serious problem. It stems from making assumptions about people who inject drugs and their ability to take an oral daily medication or adhere to study protocols. And we know that people who inject drugs and people who use substances in general can be very successful in clinical trials as well as with adherence to daily medications. We have a large body of data from HIV work, from hepatitis C work that really speaks to that.

And we also have some implementation science data that shows that with the appropriate navigation supports and community-based supports in place, people who inject drugs can adhere to daily oral prep at the same rate as other populations. As an addiction doc, as an HIV doc, it really upsets me to see our patients systematically excluded from something that is a breakthrough in HIV prevention where they really stand to benefit, even though they're not necessarily... So the patients we're talking about might have more instability in their lives than the patients who are enrolled in the trial.

I think the application to me is the most exciting for people who have the most barriers. I'd really like to see more work done in this area and a trial of long-acting prep among people who inject drugs.

Alex Walley:

Yeah, so for an intervention that the primary promising piece of it, and I'm sure it's going to be expensive, long-acting cabotegravir, the way they're going to justify the expense is by saying that it promotes adherence and that's what the trial data shows. And so excluding people who use drugs because you don't think they're going to be adherent, that's kind of an ironic exclusion for a drug that's designed to promote adherence.

So I hope we're not in a place where the practical application of this medication is held to the same standard, really what appears, at least from my addiction perspective, to be a discriminatory standard of exclusion. I hope that's not how it'll come out in practice. But it's possible because people will argue about the generalizability to populations that weren't necessarily studied.

Dr. Jessica Taylor:

Alex, I think at a systems level, the other thing that I worry about is coverage. You mentioned that the cost of medications like long-acting cabotegravir are expected to be high. That's true. And when we look to payers, to state Medicaids to cover these medications, they sometimes look to the evidence body. And if the body of evidence that we have is for preventing sexual exposure, sexual HIV risk acquisition, and we're looking at a population that has both sexual and injection risk, we could be in a dicey situation where payers don't want to provide coverage for our population who, again, is at extraordinarily high risk and really stands to benefit.

Alex Walley:

So this was a person who started on prep, motivated, had lots of challenges, also started on methadone and engaged. And despite prep and medication for opioid use disorder, still had a HIV infection. We talked about long-acting medications. What are some of the other potential opportunities for people like this patient?

Dr. Jessica Taylor:

One type of programming that I am very excited about is the option for medication storage and directly observed therapy, or I guess maybe better said, facilitated dosing on a daily basis, which in Boston is available through our colleagues at an organization that serves people experiencing homelessness and can provide daily dosing, can help track people down to get them their daily prep dose, can provide a place to store medications and really do, as we've talked about, essentially directly through therapy, but in a patient-centered way.

I think that's incredibly important because the barriers that Sim mentioned around keeping medications safe, avoiding medication theft, which is incredibly prevalent on the street, just having a place to put possessions. These are real, very concrete barriers that directly impact some people's ability to stay on medications. Not all, but they are very real barriers. And so I think opportunities like that to get your

medication in the same place every day, where you can also receive other services that people who inject drugs are interested in receiving, like syringe services, coffee, housing enrollment, things like that, to me is really exciting and I think helps mitigate some of the challenges that feel like really big structural problems to solve.

Alex Walley:

I think there's other windows of hope here that reveal themselves to me, at least in the case, which didn't turn out as we had hoped. It takes a lot for someone like this patient to seek care, to seek help. And I think when she came in, she must have been hurting from her infection and really feeling like it was something that she couldn't manage on her own.

But I think it's important to recognize that most people who use drugs are in a network of other people who use drugs as well as people who don't and families that care about them, even if they're homeless. And really leveraging that network or using that network or even a better term would be partnering with that network to get the word out about HIV prevention and overdose prevention is really a crucial place where we are right now.

And so we've seen that historically, whether it is syringe service distribution, whether it's Naloxone distribution. Remember that the great success of overdose prevention with Naloxone is really about people who use drugs rescuing each other with Naloxone. So I don't think yet we're at a place where people who use drugs have enough trust or diffusion of understanding or experience around prep. I think we're headed in that direction.

But when an individual decides to engage and use prep, they need other social supports. It needs to be more acceptable among their group. And I think that really means efforts to demedicalize prep to the best we can. It is a medical intervention, it's medicine, and we need to have healthcare involved. But we really do need to work more on how to reduce the barriers that healthcare brings in. And we've talked about a lot of those today with testing, et cetera.

Dr. Jessica Taylor:

I think there's a nice parallel to be made too with monthly injectable buprenorphine as we talk about injectables and just strategies that reduce barriers by mitigating the need to take a daily medication, mitigating the need to go to a pharmacy every day. These can be really challenging interactions where we know that every time our patients go to the pharmacy, they may experience stigma. Availability of a long-acting injectable can really take a lot of that off the table.

And that's been the story that we've seen for monthly injectable buprenorphine, which is why I think I'm really excited about the opportunity to pair these interventions. We know that medications for opioid use disorder are one of our most potent and most important HIV prevention tools, in addition to preventing overdose. And here we have an opportunity, if we can get enough data to feel comfortable using these interventions in our population, we have an opportunity to really pair those two things and think about reducing the number of times that patients do have to go into that medicalized.

Dr. Jessica Taylor:

About reducing the number of times that patients do have to go into that medicalized setting that can be really challenging.

Alex Walley:

Sim, you work in a program where you are the only doctor, or you maybe have a nurse practitioner who works with you, but most of the staff are not healthcare providers. Can you talk a little bit about what

advantage they may have or strengths that they may have or how they build on the strengths of the people that you guys are trying to help?

Dr. Sim Kimmel:

I think the programs that are rooted in peer support in harm reduction that are not medicalized, my experience is that people are much more honest about their experiences. They're much more willing to come and seek support and care when they're not doing well. They develop relationships with people that really mean a lot to them that are real sources of support, and they also can utilize resources that are more flexible, that don't require specific appointments, don't require making phone calls to see your clinician, that they can just kind of walk in. And the kinds of things that they're seeking out can be more flexible. So people come to the program that I work in oftentimes because their shoes are wet. They've been out on the street and they really are looking for a new pair of shoes. And then when they're there, they start having a conversation with one of the outreach workers and it turns out that maybe, "Hey, do you need some syringes? Oh, hey, when was the last time you were tested for HIV? Is that something that you'd be interested in doing?"

And those kinds of relationships and experiences, conversations can happen more organically. The other thing I wanted to just reflect on for a minute about this case is certainly every HIV infection is a failure of our system, but this is a patient whose HIV was diagnosed essentially at the exact same time that she acquired the infection. In some ways, she was connected enough to care and trusted the services even though she was kind of intermittently connected to different kinds of services. She came back to get tested again. She was aware of her risks. She wanted to know and she wanted to try to protect herself and ultimately to start treatment if she were to be infected. I think there is something about that too that we need to be thinking about both prevention and engagement, about early diagnosis and all of that is linked together with making sure that these services are delivered in locations where people are accessing resources that they need.

Alex Walley:

We really do need to tune in and engage with the people that we're trying to help. I think that probably goes without saying, but the research on PrEP in people who inject drugs actually shows that the people who are at the highest risk are the ones who are most aware and most motivated to engage in PrEP. So that's not always something that occurs in the setting of prevention interventions where the people who are actually at the highest risk are the ones who want that prevention intervention. And so that's another piece I think that this case illustrates and that we really need to capitalize on. So Sim you mentioned, is there any further updates you can give on her and how she's doing? Have we been able to engage her further in care and what's the latest that we know?

Dr. Sim Kimmel:

Yeah. After she had her diagnosis, she was quite upset about the diagnosis, but entered into a respite program again essentially for stabilization and medication initiation, and was linked again to methadone, started on antiretroviral therapy and put together several weeks where she was doing quite well. And then since then, unfortunately, has not been doing quite as well and came off of her medications and is no longer being treated with methadone. And she's had some ups and downs, but I think she knows where she can get help and where there are resources. So I'm hopeful that we'll be able to better engage her in the coming weeks.

Alex Walley:

The next time around. That has a lot of parallels to what we see in addiction with relapse and remission. Okay. Well, we should wrap up. Are there final thoughts on what to take away from this case?

Dr. Jessica Taylor:

I was just reflecting as you were talking Sim about how we're talking about a case of a patient who was started on PrEP, ultimately contracted HIV. And one thing that makes me nervous when we talk about these cases is that I would never want someone to have the takeaway from this podcast that it's too risky to start PrEP in people who inject drugs. And I really want to say I think this was a perfect case to start PrEP. I think the team did everything right. The patient was interested, she met criteria for PrEP. Lots of systems resources were available in the inpatient setting and less in the outpatient setting, but this was the right case to start PrEP. I always think back to being taught as a medical student. I don't know if this is still true these days with the use of antibiotics, but I was told if you don't take someone to the operating room to take out their appendix and every once in a while it's a normal appendix, you're not taking enough people to the operating room.

Basically, if we only prescribe PrEP to people who never go on to acquire HIV, we are not getting PrEP to the populations who are at highest risk. In a good quality PrEP program that is serving people with active substance use every once in a while there may be adherence challenges, someone may seroconvert, and I think that is an outcome we never want to see for our individual patient or at a population level. But what we need to do is think through how we can do better next time, what additional supports we can rally and also just really reflect as Sim was doing on the fact that PrEP got to the right patient in this case. We have other things we can and should do better, but if we never talk about a case like this, we're probably not reaching the people that need it the most. So I'm really glad to hear that the patient's risk was identified, she was engaged, and I think it had tremendous benefits for her, like you mentioned in terms of early diagnosis, linkage to your team, connection and ongoing care.

Alex Walley:

Great. Okay. Thanks guys. I look forward to the next time. 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 system 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. Until next time, I'm Alex Walley.