



Ryan White Clinical Conference, October 3-6, 2021: Key takeaways and slides

Compiled by ([send feedback to](#)):

Sophy S. Wong, MD, HIV ACCESS Medical Director

Click for: [PDF handouts of slides](#), [PowerPoint slide decks](#).

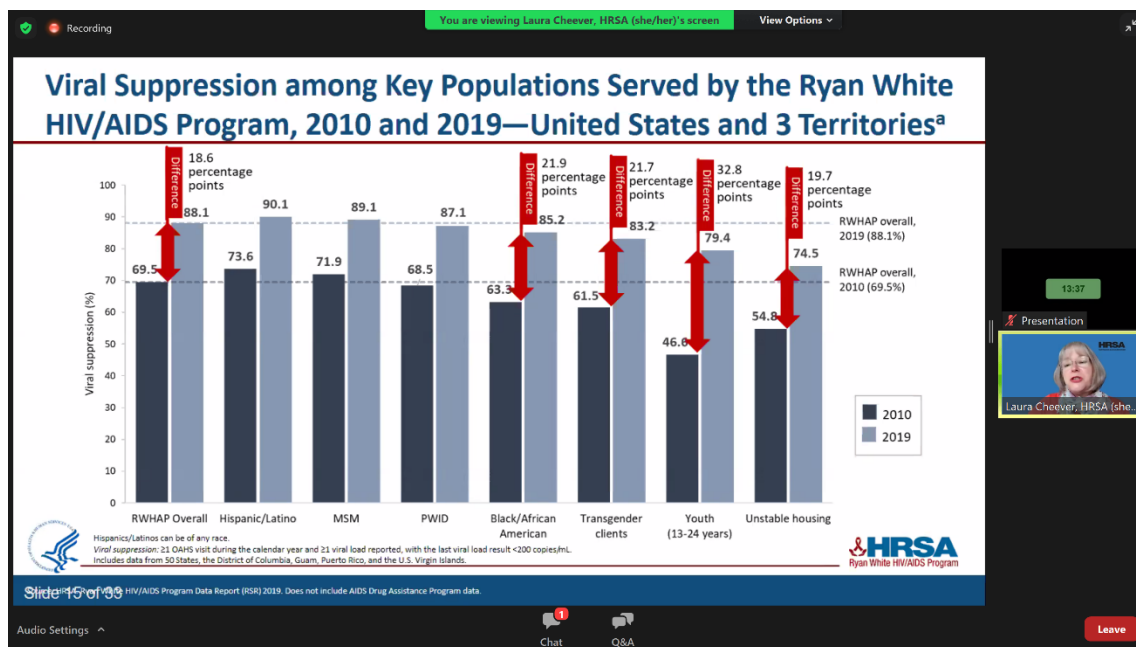
Key takeaways:

- **New Ryan White resources:** [HIV care best practices compilation](#), [HIV/AIDS Compass Dashboard](#).
- **New ART in development** include candidates with reduced frequency of dosing: [Islatravir](#) for qmonth oral PrEP, [Lenacapravir](#) for q6 month ART and for MDR HIV, broadly neutralizing antibody infusions to be used with long-acting CAB or oral regimens.
- **CAB-RPV LA** studies have shown non-inferiority with q8 week dosing (CROI 2021), and Europe has approved q8 week dosing. Studies are on-going for direct-to-inject for treatment naïve and without oral lead-in (LATTITUDE study), plus in adolescents (MOCHA study).
- **PLWH and COVID vax:** CDC [clarified](#) that third Pfizer or Moderna doses are for CD4 <200, hx of AIDS OI without immune recovery, symptomatic HIV, or untreated HIV. Pfizer boosters are permitted for all PLWH but not all may be at higher risk. [HIVMA](#) has updated guidance.
- **New ART and weight gain:** significant weight gain seen: 3-6 kg for INSTIs and 2-4.5 kg for switching from TDF to TAF, mostly within the first year, and highest for women and Black and African American people. INSTI and TAF combo with highest weight gain. Exercise and caloric restriction can reduce weight gain by 30%.
- **Drug-drug interactions (DDI):** try to reduce polypharmacy and use the [Liverpool Drug Checker](#) when starting new meds, especially if using ritonavir, cobicistat, statins, anticoags, antacids.
- Remember that INSTIs (Biktarvy, dolutegravir/Tivicay, CAB oral) need to be taken 2 hours before or 6 hours after multivitamins and antacids (cations reduce INSTI absorption).
- **HIV and aging:** assess frailty and fall risk with chair-to-stand observation, screen for HIV-associated neuro-cognitive disorder (HAND) using [MOCA](#) ([PDF in English](#)), and assess loneliness with [UCLA loneliness scale](#).
- [The Friendship hotline](#) provides 24/7 crisis help for elders to talk to someone: 1-888-670-1360.
- **ART panel:** Updated data presented in October from the [STAT RCT](#) on the DTG/3TC single-pill 2-drug rapid ART regimen showed non-inferiority to other ART regimens at 48 weeks; panelists want to see long-term data around durability of viral load suppression.
- **Young PLWH:** "I am more than my viral load!" Feedback from young PLWH is for providers to see them as whole people and more than just their ART and viral loads.
- **INSTIs cause an artificial increase in A1C**, so it's not as reliable for diagnosis for people on INSTI regimens. Use fasting glucose instead to screen for diabetes.
- **Lung cancer** rates are 2x higher among PLWH, and viral cancers are 5x higher among PLWH. Remember to screen with low-dose CT for people ages 50-80 who have a 20-pack-year smoking history and currently smoke or quit in the past 15 years. ([USPSTF grade B](#))
- **Hot off the press! Anal cancer screening results from the [ANCHOR study](#)** show that removing HSIL with electrocautery significantly reduced the rates of progression to anal cancer, compared to active monitoring without treatment. Stay tuned for data to inform our anal pap practices.
- **Depression in PLWH** is very common, about 30-40% in HIV clinics. Screen with PHQ2 or 9 with form they fill out themselves or by someone who cares. Distinguish from bipolar. Treatment is trial and error: use usual meds, check for DDI, go up to max dose for 6-8 weeks before switching. With 2 med trials, 2 out of 3 will achieve acute remission. If no remission, refer to psychiatry.

- **Pregnant PLWH:** PCPs can continue to take care of them w/o specialty OB! Generally, continue ART if it's working (except cobi and check if you need to adjust dosages). For newly dx'ed pregnant PLWH, DTG+TDF/FTC is preferred, or DTG/ABC/3TC if HLAB5701 neg (but don't delay).
- **Breastfeeding for PLWH in the US:** guidelines for people who don't want to formula feed: it's acceptable to exclusively breastfeed during the first 6 months, then introduce complementary foods and gradually wean from breastfeeding. Avoid rapid weaning due to ☐ viral shedding.
- **Addressing burnout:** recognize the emotional exhaustion, depersonalization (cynicism), and feeling of diminished personal accomplishment. Take time off for self-care. Organizations need to ask "How do we prioritize what really matters? Is what we make people do really necessary?"
- **Re-engaging PLWH in care:** when reaching out to people, use intentional messaging: "We missed you. We care about you. We'd love to see you again. Call today and make an appointment or drop by." Text messaging can be used with patient permission (document it).
- **2021 CDC STI treatment guidelines:** Please download the updated [wall chart summary here](#).
- **Gonorrhea treatment update:** The treatment of uncomplicated gonorrhea is now 500 mg of intramuscular ceftriaxone; if chlamydia is present or is not ruled out, add one week of 100 mg of oral doxycycline taken twice daily. Patients with pharyngeal gonorrhea should have a test-of-cure 1-2 weeks later. Everyone with gonorrhea should be re-screened 3 months after treatment.
- **Chlamydia treatment update:** Doxycycline 100mg orally twice daily is the preferred option. Asymptomatic or mild infections or proctitis: treat for 7 days. Moderate-severe: 21 days.
- **PrEP data-free zone:** please see Dr. Landovitz's slides ([PDF](#), [PPT](#)), and see Dr. Landovitz's amazing PrEP RCT effectiveness summary infographic on the last page of this document.

October 3, 2021 sessions

- **HIV/AIDS Bureau Updates, Laura W. Cheever, MD, ScM**
 - Mr. Harold Phillips is leading the reconstituted Office of National AIDS Policy (ONAP) and will be working on an update to the National HIV/AIDS Strategy (NHAS) for 2022, which will incorporate public comments, the latest surveillance data, more on quality of life and aging with HIV.
 - The first national STI strategic plan and updated viral hepatitis strategic plan were also released this year.
 - The new Ryan White HIV/AIDS Compass Dashboard includes nationwide outcomes by demographic groups (age, gender identity, race/ethnicity, risk) and by jurisdictions, including the Oakland TGA (Alameda and Contra Costa Counties), which shows us with:
 - Above national average viral load suppression rates overall, for Black and Latinx MSM, and youth,
 - Average for people with unstable housing, and
 - Below average for Black ciswomen, transgender women, people 50 and older, and people who inject drugs in 2019. 2020 data is not yet available.
 - The data dashboard shows us below average in all groups for retention in care, but may be more reflective of data completion problems in ARIES.
 - Disparity gaps in viral load suppression decreased among clients served nationwide RW programs and in particular among youth, Black clients, transgender clients, and clients with unstable housing (see slide below).
 - Despite the pandemic, between March and August 2020, 6,300 new clients were enrolled in Ryan White and 3,596 were re-engaged in care nationwide.
 - Burnout has increased among the US health care workforce from 35-54% in 2019 to 76% in September 2020. HRSA has invested \$103 million into health worker resilience and mental health programs (mostly for trainings and a TA provider).
 - There is a new HIV best practices compilation of care strategies used in RW settings.



- **New Investigational ART Drugs and Strategies, Judith S. Currier, MD**

- New ART under study:

- Islatravir is new nucleoside reverse transcriptase translocation inhibitors (NRTTI, which blocks reverse transcriptase in multiple ways) in Phase 3 development for HIV treatment (with doravirine in a fixed-dose oral tablet) and PrEP (once monthly oral dosing).
- Lenacapravir is a q6 month injectable capsid inhibitor in Phase 2/3 trials for treatment for people with multidrug resistant HIV in combination with an oral background regimen (CAPELLA trial), showing 81% virologic suppression and mean increase of 81 CD4 cells at week 26. Phase 2 trial for treatment naïve PLWH (LEN + FTC/TAF vs. BIK) show
- GSK'254 is a maturation inhibitor under study; resistance is a problem with this class.
- Broadly neutralizing antibodies (infusions): several are being studied in combination with long-acting CAB and oral regimens.

- CAB-RPV injectable:

- Data presented at CROI 2021 showed that q8 week dosing was non-inferior to q4 week dosing. Europe has approved q8 week dosing but it's not yet approved in the US.
- The MOCHA trial is studying CAB-RPV LA in adolescents.
- The LATTITUDE study is looking at CAB-RPV LA in treatment naïve without VLS and without oral lead-in.

Recording You are viewing Judith S. Currier, MD's screen View Options

Summary

- New drugs with novel mechanisms of action and less frequent dosing are progressing in development.
 - Islatravir
 - Lenacapravir
 - GSK'254
 - Broadly neutralizing antibodies
- Use of approved combination of long acting cabotegravir/rilpivirine slowly being rolled out
 - Investigational approaches with q 8 week dosing, combination with other agents and use in populations that have struggled with adherence in progress.

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1:44

Presentation

2021 Ryan White HIV/AIDS Program NATIONAL CONFERENCE

Judith S. Currier, MD

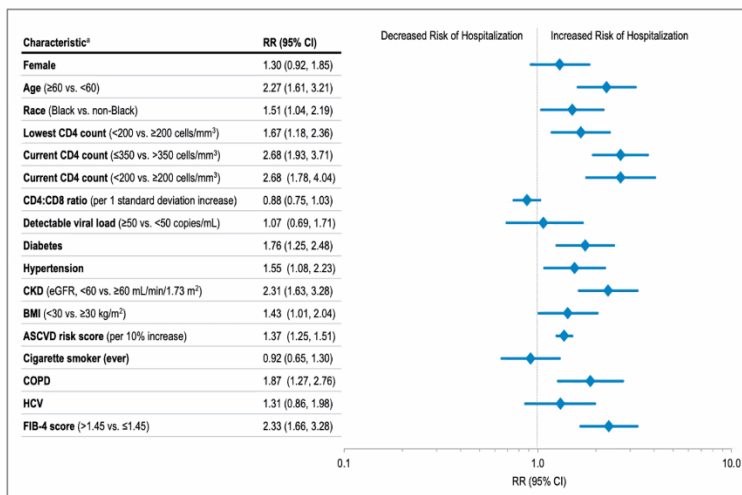
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- **An Update on COVID-19, Rachel Bender Ignacio, MD, MPH**
 - PLWH and COVID risk
 - Shapiro and Bender study (under review) showed that COVID-19 severity was worse with CD4 <350 and history of CD4 <200 in the 13k PLWH CNICS cohort.
 - Hx of CD4<200 RR 1.67 and current CD4<350 RR 2.68. See data slides below.
 - The COVID pandemic also disrupted care, attention and funding for HIV and share common disparities among communities of color, requiring underlying structural change (Millet).
 - Combined COVID vax updates from Dr. Bender Ignacio and Sophy:
 - Third Pfizer or Moderna vaccine doses are *recommended* for people with immunocompromising conditions who received the first two Pfizer or Moderna doses. This includes PLWH with “advanced and untreated HIV.” This is because people with certain immunocompromising conditions don’t respond well enough to the first 2 doses as others but do appear to respond to a third dose.
 - Published guidance: the CDC, CDPH and HIVMA (for PLWH).
 - It’s best to stay with the same mRNA vaccine (Pfizer or Moderna) for the third dose simply because we have more data on that, but if the same one is not readily available, it’s OK to give a third dose with the other mRNA vaccine.
 - The CDC has since clarified that “advanced HIV” means:
 - CD4 cell counts less than 200/mm3
 - A history of an AIDS-defining illness without immune reconstitution
 - Clinical manifestations of symptomatic HIV infection
 - People who got the J&J vaccine have not gotten authorization for additional doses yet (but hopefully will on Oct 15).
 - Pfizer boosters are available for people who received two Pfizer vaccine doses 6 or more months ago who are ages 65 and over, and ages 18-64 with underlying conditions

(including PLWH considered at risk), living in long-term care facilities, and with high-risk work exposures, such as frontline health care workers, first responders and teachers.

- Published guidance: [the CDC](#) and [HIVMA \(for PLWH\)](#).
- Technically, since HIV is an included “underlying condition,” Pfizer boosters are permitted for all PLWH, but not all PLWH are *recommended* to get Pfizer boosters. For example, an otherwise very healthy 30-year-old undetectable on ART who lives alone and does not have significant workplace exposures would be lower risk for severe COVID-19 and transmission. (Granted, this is not many of our patients!)
- People who got the J&J vaccine have not gotten authorization for booster doses yet (but hopefully will on Oct 15).
- Fluvax can be given with COVID vaccines ([updated CDC guidance](#)).

Risk Factors for COVID Severity among PWH



Most studies recapitulate non-HIV specific risks in PWH:

- HTN
- DM
- Age
- BMI

Shapiro & Bender Ignacio et al, CROI 2021 and manuscript under review
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COVID Severity risk: CD4 & VL

- Across cohorts from early pandemic through the present, clear trends toward increased risk of severe outcomes with low CD4
- Some cohorts suggest current CD4 <350 as threshold, others at 200, but analysis dependent
- Concern for confounding by test date & SARS CoV-2 effect on lymphopenia (eg WCDPH used data from hospitalization)
- Most large non-HIV specific datasets lack specificity on parameters of HIV treatment
- Most PWH on ART in these cohorts
- CNICS: History of CD4 <200 RR 1.67 and current CD4 <350 RR 2.68 for hospitalization, low CD4/CD8 ratio increases risk

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WCDPH CID 2020; Vizcarra Lancet HIV 2020; Shapiro & Bender Ignacio, under review

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Covid-19 Vaccines for PWH

hivma
hiv medicine association

COVID-19 Vaccines and People with HIV
Frequently Asked Questions

WHICH VACCINES: Vaccine with any EUA or approved vaccine (globally, WHO endorses + ChAdOx1 + Sinopharm, Sinovac)
-Preference for mRNA vaccine if possible given multiple doses likely more important if compromised response

SAFETY: No evidence of safety concerns with mRNA or inactivated viral-vector vaccines for PWH

EFFECTIVENESS: small studies show adequate response to mRNA and ChAdOx1 vaccines

10-11

- **Challenges and Opportunities for Telemedicine, Wendy Armstrong, MD**
 - Telehealth is a useful and important tool but it's not for everyone. About 50% prefer in-person visits when there's a choice.
 - Digital divide is a major barrier with unequal access to broadband internet, smartphones, computers, language access, private spaces and headphones.
 - Telehealth coverage post-pandemic is still unknown: states regulate Medicaid coverage, individual insurance providers vary in their reimbursement schemes, CMS may or may not extend Medicare coverage to 2023.
- **40 Years of Progress: Looking Back at the Beginning of the HIV/AIDS Epidemic in the Bay Area. [Watch here.](#)** *This special panel features a moderated discussion of those that were involved at the very start of the HIV/AIDS epidemic in the San Francisco Bay Area.*
 - East Bay OG clinicians Dr. Kathleen Clanon and Dr. Michael Reyes spoke on this special panel and described how we learned to listen and center community voices and input in care and service delivery through the HIV epidemic and applied some of those learnings to the COVID pandemic response.

SPECIAL SESSION NOW AVAILABLE ON-DEMAND TO THE PUBLIC
40 Years of Progress: Looking Back at the Beginning of the HIV/AIDS Epidemic

Moderated by Laura W. Cheever, MD, ScM, and Michael S. Saag, MD

Special Session Panelists



Marcus Conant, MD
Co-Founder, San Francisco
AIDS Foundation



Kathleen A.
Clanon, MD
Alameda Care Connect



Alison Moed, RN
San Francisco General
Hospital



Michael Reyes, MD
University of California
San Francisco



Paul A. Volberding, MD
University of California
San Francisco



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October 4, 2021 sessions

- **Antiretroviral Therapy and Weight Gain, Roger J. Bedimo, MD, MS**
 - Significant weight gain seen: 3-6 kg for INSTIs and 2-4.5 kg for switching from TDF to TAF
 - Mostly within the first year.
 - Highest for women and Black and African American people.
 - INSTI and TAF combo with highest weight gain.
 - Exercise and caloric restriction can reduce weight gain by 30%.

Zoom Webinar Participant ID: 5054311 You are viewing Roger J. Bedimo, MD, MS' screen View Options

Recording

Summary: Magnitude and Determinants of Weight Gain with ART Initiation in Naïve Patients

- INSTI: Significant weight gain. Greater magnitude of weight gain in people of African descent and women: Probably greater with DTG and BIC than RAL.^{4,5,6} Low baseline CD4 counts and high VL predictive
 - Possible mechanism(s): INSTIs induce adipocyte dysfunction: adipogenesis, lipogenesis, oxidative stress, fibrosis, and insulin resistance.⁷
- NRTIs: Greater weight gain with TAF vs. ABC and TDF;^{5,6} and greater weight gain with INSTI in conjunction with TAF.¹
- NNRTI less conducive to weight gain.^{5,6,8,9}
- Balance the benefits of INSTIs and TAF with risk of weight gain!

1. Venter. NEJM 2019; 2. Hill. IAS 2019; 3. Bedimo. ID Week 2018; 4. Bourgi. CROI 2019; 5. Bedimo. CROI 2019; 6. Sax. CID 2019; 7. Gorwood. CID 2020; 8. Orkin. EACS 2019; 9. Moestrup. EACS 2019.

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9:16 AM

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Recording

Management of Weight Gain and Metabolic Risk in PLWH

- Moderate intensity aerobic exercise *plus* nutritional optimization recommended for all
- No good evidence for ARV switch to non-INSTI, non-TAF (Case reports)
- ≥ 150 min of moderate intensity aerobic exercise over ≥ 3 days a week¹
- Calorie guideline options for weight loss.^{2,3}
 1. 1200–1500 calories/day for women or 1500–1800 calories/day for men
 2. An energy deficit of 500-750 calories per day
 3. An evidence-based diet that restricts a certain food type (e.g., high-carbohydrate foods) to create an energy deficit
- **Improved Diet Assoc. with Lower ART-Related Weight Gain⁴**
 - **Diet decreased odds of gaining at least 5 kg by 30%**

1. ADA. Diabetes Care. 2020;43(Suppl 1):S48-s65; 2. Knowler et al, NEJM, 2002; 3. Monroe et al, CID, 2014; 4. Patel. IDWeek 2021, Abstract 835

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9:24 AM

Zoom Webinar Participant ID: 5054311 You are viewing Roger J. Bedimo, MD, MS' screen View Options

Recording

Summary

- Accumulating data that INSTI- and TAF-based regimens are associated with greater weight gain than other regimens (also, PIs to some extent)
 - Increases in weight on DTG are higher in women, Blacks (and Hispanics?)
- Initial data on patterns and mechanism of weight gain: mostly fat, with INSTI. Need to evaluate effect on appetite, caloric intake, energy expenditure
- Metabolic Complications: Increased lipids and with TAF; probably metabolic syndrome and insulin resistance with TAF and INSTI
- In patients with significant weight gain: does changing to non-INSTI or non-TAF regimen help?

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9:25 AM

- Managing Polypharmacy and Drug-Drug Interactions**
Jennifer J. Kiser, PharmD, PhD
 - Try to reduce polypharmacy and use the Liverpool Drug Checker when starting new meds, especially if using ritonavir, cobicistat, statins, anticoags, antacids.
 - Remember that INSTIs (Biktarvy, dolutegravir/Tivicay, CAB oral) need to be taken 2 hours before or 6 hours after multivitamins and antacids (cations reduce INSTI absorption).

Zoom Webinar Participant ID: 5054311 You are viewing Jennifer J. Kiser, PharmD, PhD's screen View Options

Recording

Resources

Resources	Use	Access
Drug-Drug Interaction Management		
University of Liverpool HIV Drug Interaction Checker	This website/app provides current and evidence-based information on HIV drug interactions with recommendations and references. Users can switch to table view to see summary table of interactions. There are separate websites for HCV drug interactions and COVID-19 drug interactions with comedications	https://www.hiv-druginteractions.org
University Health Network HIV/HCV Drug Therapy Guide	This website/app provides up-to-date and evidence-based data on both HIV and HCV drug interactions with recommendations and references. It also provides a link to interaction checks with medications from similar classes	https://hivclinic.ca/wp-content/plugins/php/app.php
Interaction Tables within the Department of Health and Human Services HIV Treatment Guidelines	This website/app provides evidence-based guidelines regarding the management of people living with HIV with a section on useful HIV drug interactions	https://clinicalinfo.hiv.gov/en/guidelines

Nhean S, Tseng A, Back D. Curr Opin HIV AIDS 2021 Epub

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10:08 AM

- **Managing Aging and HIV, Meredith Greene, MD**
 - Video telehealth visits: observe sitting in chair-to-stand, observe gait at home, see home environment, ask them to pull all their pills and do a full medication review.
 - Assess frailty and fall risk with chair-to-stand observation and ask: Have you fallen in the last year?
 - Screen for HIV-associated neuro-cognitive disorder (HAND) using MOCA (PDF in English).
 - MOCA has been studied in diverse groups and is multilingual.
 - But developed first in Montreal with mostly a white population.
 - Consider routine screening annually for people ages 50+.
 - Assess loneliness with UCLA loneliness scale.
 - The Friendship hotline provides 24/7 crisis help for elders to talk to someone: 1-888-670-1360.

Zoom Webinar Participant ID: 5381132 You are viewing Meredith Greene (she/her/hers)'s screen View Options

Recording

Summary

- 5Ms of Geriatrics Approach can help improve care & address **Multi-complexity** many Older PWH experience
- **Mobility:** Ask about function (ADL, IADL) and falls
--Objective assessments --SPPB, TUG complementary
- **Mind:** Assess mental health and cognition
-- MOCA may be best clinic based tool for HAND, cognitive symptoms
- **Matters most:** Ask about loneliness & social isolation (normalize!)
--UCLA loneliness scale

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3:20
#2021RWOC
Presentation
Meredith Greene (she/her/hers)...

2021 RWOC
Meredith Greene (she/her/hers)...

11:03 AM

- **Cases From the Clinic(ians): Antiretroviral Therapy Cases and Panel Discussion, Michael S. Saag, MD and panelists**
 - **Serum CrAg with baseline labs:** Consider checking a serum CrAg (cryptococcal antigen) for people with CD4<100 to screen for disseminated cryptococcus. If it's positive, get an LP to check CSF and treat accordingly. It's not in current DHHS guidelines and is a "consider" lab in IDSA 2020 guidelines.
 - **DTG+3TC for rapid ART:** Updated data presented at IDWeek (Oct 2021) from the STAT RCT on the DTG/3TC single-pill, 2-drug rapid ART regimen showed non-inferiority to other ART regimens.
 - 97% VLS in both study groups at 48 weeks for those who followed-up, 82% in ITT analysis including those missing lab data and LTFU.
 - The panelists were excited by this but also concerned about long-term efficacy and potential resistance with adherence gaps. See data slides below.
 - **Treating elite controllers:** most participants and panelists would start ART and a few panelists would recommend but not push it as hard as people with higher

viral loads. Elite controllers still have evidence of increased T-cell activation and inflammation, so lean towards treatment. See slide below.

- o **Patients with chronically low CD4 counts despite virologic suppression on ART:** Some people (~10-15%) don't get strong CD4 recovery, and it might be related to how low and damaged their CD4 reservoirs are.
- o Lots of interventions have been studied, and no meds changes or additions have been seen to help.
- o Panelists would keep them on the tolerated suppressive ART regimen, check for coinfections and screen for cancers (Sophy's addition).

Zoom Webinar Participant ID: 5381132 You are viewing Michael S. Saag, MD's screen View Options

Recording

STAT Is a Phase IIb, Multicenter, Open-label, Single-Arm, Pilot Study Evaluating DTG/3TC as a Rapid Test-and-Treat Intervention

- In the primary analysis of STAT (ClinicalTrials.gov, NCT03945981) at Week 24, 78% (102/131) of all participants and 92% (102/111) of those with data available irrespective of ART achieved HIV-1 RNA <50 c/mL
- Here we show results from the key secondary efficacy analyses through Week 48 of the STAT study, including among participants with high baseline viral load ($\geq 500,000$ c/mL)

Participants newly diagnosed with HIV-1

Screening and Day 1 must be the same day (before safety and resistance labs available)

All participants undergoing ART modification were allowed to remain on study

DTG/3TC FDC (N=131)

Screening/Day 1 Week 1 Review BL safety labs Week 4 Review BL resistance Week 8 Week 12 Week 24 Week 48 End of study analysis Week 52 Last visit Follow-up/End of study

Eligibility criteria

- Adults ≥ 18 years of age
- ART naïve
- Newly confirmed diagnosis of HIV-1 (within 14 days of initial diagnosis)

Baseline criteria to switch from DTG/3TC

- Creatinine clearance <30 mL/min/1.73 m²
- Grade 3-4 lab abnormality
- Chronic HBV infection
- Transmitted resistance mutations (eg, M184V/I)

Primary efficacy analysis

ITT-E missing = failure

- HIV-1 RNA <50 c/mL (irrespective of treatment)
- HIV-1 RNA ≤ 50 c/mL
 - Includes missing data while on study or missing data due to study withdrawal

Other key efficacy analyses

- Observed analysis
- Snapshot analysis

Role et al. AIDS 2021;35:1957-1965.

IDWeek™ 2021, September 26-October 3, 2021, Virtual

Role et al. IDWeek 2021™, Virtual, Slides 75.

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Chat Q&A

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29:53

#2021RWCC

Presentation

Allison L. Agwu, MD, ScM

Michael S. Saag, MD

James Raper, PhD, DSN, CRNP, JD

Judith S. Currier, MD

Meredith Greene (she/her/hers)

Roger J. Bedimo, MD, MS

Laura Cheever, HRSA (she/her)

2021 Ryan White HIV Clinical Conference

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Recording

High Rates of Virologic Suppression Were Observed Across All Efficacy Analyses at Week 48

Group	HIV-1 RNA <50 c/mL	HIV-1 RNA ≥50 c/mL
Observed (N=110, on any ART regimen)*	97/110	3/110
Observed (N=103, on DTG/3TC)	97/103	3/103
ITT-E missing = failure (N=131, on any ART regimen)*	82/131	18/131
FDA Snapshot (N=131, on DTG/3TC)	76/131	15/131

Participants, %

ITTE non-suppression rates were driven by non-virologic factors (ie, high withdrawal rate)

Snapshot non-suppression rates were driven by study withdrawals and ART modifications

*The observed analysis included all participants with available HIV-1 RNA data, regardless of ART regimen. The ITTE missing = failure analysis included all participants in the ITTE population, regardless of ART regimen. Of the 24 participants classified as HIV-1 RNA ≥50 c/mL, 3 had HIV-1 RNA ≥50 c/mL, 3 were on study but missing data at Week 48 (1 due to COVID-19), and 18 discontinued from study for non-treatment-related reasons (eg, withdrawal consent, lost to follow-up). In the Snapshot analysis (missing data or switch considered failures), the 103 participants with HIV-1 RNA <50 c/mL were all on DTG/3TC; of the 19 participants classified as HIV-1 RNA ≥50 c/mL, 3 had HIV-1 RNA ≥50 c/mL (all under DTG/3TC), 10 modified ART, and 6 discontinued from study for non-treatment-related reasons (eg, withdrawal consent, lost to follow-up) and had HIV-1 RNA ≥50 c/mL. 12/131 had no virologic data at Week 48.

Role et al. IAS 2021; Virtual. Poster PEB162

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Recording

Elite controllers have higher levels of CD8 “activation” than other aviremic groups, including those on HAART and HIV negatives

Group	% CD38+ HLA-DR+ CD8+ T cells
HIV negative (n=84)	~8
HAART VL < 50 (n=139)	~12
Elite controllers (n=67)	~18
Non-controllers (n=160)	~42

P<0.0001

P=0.01

Activation higher in elites than other “aviremic” groups even after adjustment of CD4, age and other factors

Hunt JID 2008 (see also Lopez Abstract 366)

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October 5, 2021 sessions

- Preventing HIV-Related Comorbidities in Adolescents, Allison L. Agwu, MD, ScM
 - “I am more than my viral load!”
 - Feedback from young PLWH is for providers to see and hear them as more than their ART and viral loads.
 - See images below.
- See slides below on preventive health assessments and interventions.

- PLWH adolescents have STD rates similar to the general population, have increased overall from 2017, with highest increase among females.
- Perinatal PLWH may be more likely to use condoms, but most people use inconsistently.
- Ask about and focus on modifiable risk factors
 - Young PLWH: 40% use tobacco products, 49% overweight/obese
 - Young PLWH and INSTIs: still emerging but trending towards some weight gain.
 - INSTIs cause an artificial increase in A1C, so it's not as reliable for diagnosis for people on INSTI regimens. Use fasting glucose instead to screen for diabetes.
 - For young people with IGT/diabetes, Dr. Agwu leans on lifestyle change over meds.
- For ART, Dr. Agwu aims for the smallest, least frequent pills with the fewest side effects. We forget that kids don't feel comfortable swallowing pills, and some benefit from pill swallowing training.



Zoom Webinar Participant ID: 3975184 You are viewing Allison L. Agwu, MD, ScM's screen View Options

Recording

2021 Ryan White Clinical Conference

What can you do?

- Take a good history
- Assess risk factors
 - Tobacco
 - Substances
 - Sex
 - Activities
 - Helmets, firearms
- Detailed family history
- Physical examination

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Chat Q&A

9:23 AM

9:45

#2021RWCC

Presentation

Allison L. Agwu, MD, ScM

JOHNS HOPKINS MEDICINE

Leading Cause of Death in the United States for Select Age Groups (2019)
Data Courtesy of CDC

Rank	10-14	15-24	25-34	35-44	45-54	55-64	All Ages
1	Unintentional Injury 779	Unintentional Injury 11,755	Unintentional Injury 24,516	Unintentional Injury 24,270	Malignant Neoplasms 35,587	Malignant Neoplasms 111,765	Heart Disease 659,041
2	Suicide 534	Suicide 9,954	Suicide 8,099	Malignant Neoplasms 10,695	Heart Disease 31,138	Heart Disease 80,837	Malignant Neoplasms 595,401
3	Malignant Neoplasms 404	Homicide 4,774	Homicide 5,341	Heart Disease 10,499	Unintentional Injury 23,359	Unintentional Injury 24,892	Unintentional Injury 173,040
4	Homicide 191	Malignant Neoplasms 1,368	Malignant Neoplasms 5,577	Suicide 7,525	Liver Disease 8,098	CLRD 18,743	CLRD 156,979
5	Congenital Anomalies 189	Heart Disease 872	Heart Disease 3,495	Homicide 3,446	Diabetes Mellitus 15,508	Diabetes Mellitus 14,385	Cerebrovascular Disease 150,005
6	Heart Disease 87	Congenital Anomalies 390	Diabetes Mellitus 1,112	Liver Disease 3,417	Diabetes Mellitus 6,348	Liver Disease 14,385	Alzheimer's Disease 121,499
7	CLRD 81	Diabetes Mellitus 248	Diabetes Mellitus 887	Diabetes Mellitus 2,228	Cerebrovascular Disease 5,153	Cerebrovascular Disease 12,931	Diabetes Mellitus 87,647
8	Influenza & Pneumonia 71	Influenza & Pneumonia 175	Cerebrovascular Disease 585	Cerebrovascular Disease 1,741	CLRD 3,592	Suicide 8,258	Nephritis 51,565
9	Cerebrovascular Disease 48	CLRD 168	Complicated Pregnancy 532	Influenza & Pneumonia 951	Nephritis 2,269	Nephritis 5,857	Influenza & Pneumonia 49,789
10	Benign Neoplasms 35	Cerebrovascular Disease 158	HIV 486	Septicemia 812	Septicemia 2,176	Septicemia 5,672	Suicide 47,511

CLRD: Chronic Lower Respiratory Disease

Note: Suicide is not among the ten leading causes of death among children in the 0-9 year age group nor in adults in the age group 65 years and older.

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Recording

2021 Ryan White Clinical Conference

What can you do?

- Actions:**
 - Smoking cessation
 - Lifestyle modification
 - Treatment
 - HTN (<130/80 goal) or <90th percentile
 - Hyperlipidemia: ?? (benefit for older youth with clear abnormal)
 - Weight loss
 - hyperlipidemia
 - Substance use treatment
 - STI counseling, screening, and treatment; family planning
 - Immunizations

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Chat Q&A

9:30 AM

2:42

#2021RWCC

Presentation

Allison L. Agwu, MD, ScM

JOHNS HOPKINS MEDICINE

Immunizations for Adolescents and Young Adults

Human Papilloma (HPV)
Hepatitis A
Hepatitis B
Tdap
MCV
Flu
COVID
PCV & PS23
Others as indicated

Percentage of adolescents who are up to date on HPV vaccination

www.cdc.gov/hpv

USPSTF

- Non-AIDS Cancers, Timothy J. Wilkin, MD**

- Cancer risk is higher among PLWH, now non-AIDS related cancers are a leading cause of death.
- Higher risk of mortality for PLWH who have cancer diagnoses overall; Dr. Wilkin is not sure if it's an issue with less access to care or poorer response to treatment.
- PLWH have significantly more viral cancers (5x higher) and AIDS-related cancers.
- Lung cancer is 2x more among PLWH, while rates of other non-viral cancers are less.

- USPSTF recommends lung cancer screening with low-dose CT for people ages 50-80 who have a 20-pack-year smoking history and currently smoke or quit in the past 15 years.
- The guidelines were updated in March 2021 to go down to age 50 from 55, and down to 20+ pack years rather than 30+ pack years.
- Colorectal cancer screening down to age 45: in May 2021 USPSTF gave a grade B recommendation for colorectal cancer screening in all people ages 45-49, in addition to their grade A recommendation for all people ages 50-75.
- HPV and anal cancer are very elevated among PLWH
 - HPV vax: for ages 9-26, and 24-45 with shared decision-making.
 - Efficacy decreases after sexual activity, only prevents new infection.
 - 90% less oral cancer in trials too.
 - Seeing less morbidity with areas of high and organized vax programs, like Australia.
 - Screen for anal cancer with anal cytology (anal pap).
 - Evaluate any abnormalities with HRA.
 - Treat HSIL with ablation or topical therapy.
 - ANCHOR trial: done enrolling, done with f/u, results not yet released, press release might be this week! Designed to find out if treating HSIL will reduce morbidity.
 - October 7 update: here is the UCSF press release on the ANCHOR trial findings!

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However, cancer risk remains elevated in people living with HIV (PLWH)

Standardized Incidence Ratios (SIRs) for cancer in PLWH (1996-2012), compared to the general U.S. population

Cancer Types	Observed Cases	SIR (95% CI)*
All cancers	21,294	1.69 (1.67-1.72)
AIDS-defining cancers	6,384	14.0 (13.6-14.3)
Kaposi sarcoma	2,269	498 (478-519)
AIDS-defining NHLs	3,687	11.5 (11.1-11.9)
Cervical cancer	428	3.24 (2.94-3.56)
Non-AIDS cancers (NADCs)	14,344	1.21 (1.19-1.23)
Non-viral NADC	10,200	0.92 (0.90-0.94)
Viral NADCs	4,144	5.39 (5.23-5.55)
HPV-related oral cavity pharynx	297	1.64 (1.46-1.84)
Anus	1,568	19.1 (18.1-20.0)
Liver	1,104	3.21 (3.02-3.41)
Merkel cell carcinoma	10	2.58 (1.24-4.74)
Vagina	25	3.55 (2.36-5.24)
Vulva	151	9.35 (7.91-11.0)
Penis	114	5.33 (4.39-6.40)
Hodgkin lymphoma	875	7.70 (7.20-8.23)

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Hernandez-Ramirez Lancet HIV 2017

Viral NADCs are increased 5 fold in PLWH (e.g. HPV, HBV, HCV and EBV cancers)

Non-viral NADCs are not increased in HIV (e.g. breast, colorectal, prostate)

Exception: Lung cancer is increased 2 fold in PLWH

22:05
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Presentation
Timothy J. Wilkin, MD, MPH

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9:49 AM

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Other cancer prevention activities per USPTH/ACIP

- Hepatocellular carcinoma
 - Vaccination against hepatitis B and other prevention practices
 - Treatment of hepatitis B and C
 - Screening for hepatocellular carcinoma
- Human papillomavirus-related cancers
 - 9-valent HPV vaccination for prevention of anal, cervical, oropharyngeal, penile, vaginal and vulvar cancers
- Smoking cessation
- Aspirin use for prevention of colorectal cancer in those with >10% ASCVD risk for MI
- Breast CA medication, BRCA screening in selected groups

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10:01 AM

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Timothy J. Wilkin, MD, MPH

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Summary: Reducing NADC in PLWH

- Implement screening for NADC
 - Breast, cervical, colorectal, lung
 - Lung cancer screening identifies cancer at earlier stages where treatment is curative
- Evolving data on screening for anal cancer will say whether this should be standard of care.
- HPV vaccination for prevention of HPV-associated cancers
 - Prevents anal, cervical, penile, vaginal, vulvar cancers
 - Existing data suggests preventions against HPV-associated oropharyngeal cancer

Acknowledgements: I would like to thank **Anna Coghill, PhD, MPH** (Moffitt Cancer Center) and **Elizabeth Chiao, MD MPH** (MD Anderson Cancer Center) for their input

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Chat Q&A

10:09 AM

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2:54
#2021RWCC
Presentation
Timothy J. Wilkin, MD, MPH

- **Addressing Depression in Patients with HIV, Francine Cournos, MD**
 - MDD among PLWH is very high, about 30-40% in HIV clinics
 - Associated with mortality and worse care continuum outcomes
 - One of the most disabling and frightening of all illnesses.
 - Treating is giving people their lives back!
 - Worse during pandemic for everyone and also especially among HCWs.
 - Treatment is trial and error
 - Distinguish between mild and moderate and severe: mostly impact on function.

- PHQ2 and PHQ9 are simple tools
 - Not likely to get honest answers when we are not really interested in dx and tx.
 - Need to want to hear what the person says to screen properly.
 - Distinguish between MDD and bipolar because antidepressant can precipitate mania.
 - 3 in 20 people in primary care dx with MDD have bipolar.
 - Ask the 3 screening questions below.
 - Anti-stigma: bipolar people are often very creative and productive when they can harness their hypomanic states, like Alvin Ailey, but also suffer tremendously, especially in the depressive states.
- Aim for remission:
 - Reduce suffering and cog dysfunction and mortality, increase quality of life, VLS.
 - Antidepressive meds: 1 in 3 acute remission. Use usual meds, check for DDI/tox.
 - Go up to max dose before switching. Many PCPs don't do this and it's a mistake.
 - Switch after 6-8 weeks if it doesn't work.
 - Doesn't matter what that something else is.
 - Ultimately with 2 trials, 2 out of 3 will achieve acute remission.
 - After 2 trials and still no remission, refer to psychotherapy.
- Elders: start low and go slow.
 - Siloed SUD and MH treatment is a major barrier! Also stigma!
 - SUD among PLWH is very poorly studied.
 - 40% EtOH use among people with bipolar.
 - Need to treat MDD and SUD both... one does not treat the other.
 - When you can't get specialty BH care
 - Self-care
 - Community supports

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Recording

The Two Most Commonly Used Screening Tools Used to Assess for Depressive Symptoms

- The Patient Health Questionnaire-2 (PHQ-2): Two questions
- The Patient Health Questionnaire-9 (PHQ-9): Nine questions
- A combination of the PHQ-2 and PHQ-9
- The PHQ-2 and PHQ-9 are:
 - Quick to complete
 - Free of charge to use and/or reproduce
 - Well-studied
 - Available in multiple languages
- The PHQ-2 and PHQ-9 can be accessed via the National HIV Curriculum and scored at that site using automatic calculators (Tools and Calculators); This site also offers extensive information about the sensitivity and specificity of these tools (Module 2, Lesson 5). Access these materials at www.aidsctc.org/nhc

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17:56
#2021RWCC
Presentation
Francine Courmos, MD

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10:48 AM

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Recording

Aim to Achieve Remission of Depressive Illness, Not Just Improvement

- Because there's no "penicillin" for depression, we largely treat patients by trial and error, monitoring tolerability to side effects and degree of improvement.
- Response to treatment (>50% reduction of symptoms) is a much less desirable outcome than remission from depressive illness (few or no symptoms); persistent symptoms pose a risk for relapse.
- Our best evidence suggests the first trial of an antidepressant has a 1 in 3 chance of achieving acute remission. If the first trial at an adequate dose doesn't work, switching to a different antidepressant also has about a 1 in 3 chance of achieving acute remission.
- Therefore, about 2 in 3 patients will achieve acute remission with two antidepressant trials.

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14:42 #2021RWCC Presentation Francine Cournois, MD

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Recording

Diagnosing Bipolar Disorder

- There are no brief screens for bipolar disorder. The Mood Disorders Questionnaire (MDQ) is available but has 13 items.
- Ask if the patient or a close relative has ever been told s/he has manic-depressive illness or bipolar disorder?"
- Consider a few questions from the MDQ (based on the DSM-5):
 - Has there ever been a period of time when you were not your usual self, and you had much more energy than usual?"
 - Has there ever been a period of time when you got much less sleep than usual and found you didn't really miss it?
- If you get yes answers to any of the above questions, you might consider completing the MDQ (www.aidsctc.org/nhc) and/or referring the patient for a diagnostic evaluation.

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11:26 #2021RWCC Presentation Francine Cournois, MD

- **Perinatal HIV Care and Prevention: A Case-Based Panel Discussion, Susan Cu-Uvin, MD and panelists**
- PMTCT has reduced perinatal transmissions <1% in high income countries and ~4% in low to middle countries. Huge success!
- ART in a newly diagnosed pregnant person:
 - Participant poll: 68% chose DTG/TDF/F.
 - Dr. Cu-Uvin also chooses DTG/TDF/F.

- INSTI regimens are important for reducing viral load rapidly to reduce risk of transmission to the fetus/baby.
- Avoid: BIK (not enough data yet; will have in 2026), coBI regimens (don't work with metabolic changes in pregnancy), also avoid RPV with high VL >100k.
- TAF is alternative now, new guidelines will be released in 2022. If already on TAF, then OK to stay.
- Preferred regimens in pregnancy, see below
- PCPs can take care of pregnant patients! Don't need to pass them off.
- ART in PLWH already stably suppressed who get pregnant.
 - Continue the ART regimen if it's working, except switch off coBI, and adjust dosage if needed.
- PLWH desiring pregnancy with HIV-negative partner: counsel and support around U=U and the importance of and efficacy of viral load suppression on ART for preventing sexual transmissions. No need for all the complex sperm washing and IUI, etc. that we used to do.
- Breastfeeding for PLWH in the US: recent data from Africa showing ~1% risk of transmission through breastfeeding when on ART. See slide below.
 - US guidelines are for people who don't want to formula feed, it's acceptable to exclusively breastfeed during the first 6 months, then introduce complementary foods and gradually wean from breastfeeding. Avoid rapid weaning due to increased HIV shedding and transmission observed with rapid weaning in studies.

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Recording

Preferred Initial Regimens in Pregnancy

NRTIs Backbones	ABC/3TC (not to be used in persons positive for HLA B-5701) TDF/FTC or TDF/3TC (potential renal toxicity of TDF)
INSTIs	DTG/ABC/3TC (FDC) (requires HLA B-5701 testing) DTG plus a Preferred Dual-NRTI Backbone RAL plus a Preferred Dual-NRTI Backbone (RAL has to be given twice daily)
Protease Inhibitors	ATV/r plus a Preferred Dual-NRTI Backbone DRV/r plus a Preferred Dual-NRTI Backbone

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38:13 #2021RWCC Presentation Allison L. Agwu, MD, S... Susan Cu-Uvin, MD Ronald Wilcox (HRSA H&B) 2021 Ryan White Conference Jodie Dionne, MD

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ART Regimen Component	ART for Pregnant People Who Have Never Received ARV Drugs and Who Are Initiating ART for the First Time	Continuing ART for People Who Become Pregnant on a Fully Suppressive, Well-Tolerated Regimen	ART for Pregnant People Who Have Received ARV Drugs in the Past and Who Are Restarting ART ^a	New ART Regimen for Pregnant People Whose Current Regimen Is Not Well Tolerated and/or Is Not Fully Suppressive ^a	ART for Nonpregnant People Who Are Trying to Conceive ^{a,b}
Integrase Strand Transfer Inhibitor (INSTI) Drugs Used in combination with a dual-nucleoside reverse transcriptase inhibitor (NRTI) backbone ^c					
DTG	Preferred	Continue	Preferred	Preferred	Preferred
RAL	Preferred	Continue	Preferred	Preferred	Preferred
BIC	Insufficient data	Continue with frequent viral load monitoring or consider switching	Insufficient data	Insufficient data	Insufficient data
EVG/c ^d	Not recommended	Continue with frequent viral load monitoring or consider switching	Not recommended	Not recommended	Not recommended
Protease Inhibitor (PI) Drugs Used in combination with a dual-NRTI backbone ^c					
ATV/r	Preferred	Continue	Preferred	Preferred	Preferred
DRV/r	Preferred	Continue	Preferred	Preferred	Preferred
LPV/r	Not recommended, except in special circumstances	Continue	Not recommended, except in special circumstances	Not recommended, except in special circumstances	Not recommended, except in special circumstances
ATV/c ^d	Not recommended	Continue with frequent viral load monitoring or consider switching	Not recommended	Not recommended	Not recommended
DRV/c ^d	Not recommended	Continue with frequent viral load monitoring or consider switching	Not recommended	Not recommended	Not recommended

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Recording

Breastfeeding in the US:

Prior to the accessibility of ART in low-income countries, studies demonstrated that **exclusive breastfeeding during the first 6 months** of life is associated with lower rates of HIV transmission than mixed feeding (a term used to describe infant fed breast milk plus other liquids or solid foods, including formula). After 6 months, when complementary foods are required for adequate infant nutrition, demand for breast milk decreases and **gradual weaning** can occur. **Rapid weaning over several days is not recommended**, because increased HIV shedding in breast milk and an increased rate of HIV transmission during rapid weaning were observed in studies from low-income countries that were conducted before ART was widely accessible for breastfeeding women. Currently, not enough data exist to determine whether exclusive breastfeeding or mixed feeding has an impact on perinatal transmission in the context of effective ART.

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October 6, 2021 sessions

- **Addressing HIV Practitioner and Staff Burnout in the COVID-19 Era, Nadine J. Kaslow, PhD**
 - Recognize the emotional exhaustion, depersonalization (cynicism), and feeling of diminished personal accomplishment.
 - Take time off for self-care.

- o Organizations need to ask “How do we prioritize what really matters? Is what we make people do really necessary?”
- o See slides below for more details.

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Recording

What is Burnout?

- Syndrome characterized by
 - Emotional exhaustion – loss of interest and enthusiasm for work
 - Depersonalization – poor attitude with cynicism and treating others as objects
 - Diminished personal accomplishment– reduced effectiveness and sense of personal accomplishment, low self-value

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9:11 AM

#2021RWCC Presentation Nadine J. Kaslow, PhD

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Recording

Burnout

- Risk factors
 - Difficult situations
 - Workplace violence
 - Excessive workload
 - Inadequate resources or inefficient processes
 - Galian-Munoz, 2014; O'Connor et al., 2018 ; Silva et al., 2015; West, 2018

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9:13 AM

#2021RWCC Presentation Nadine J. Kaslow, PhD

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Recording

BURNOUT – SIGNS

- ▶ Poor self-care
- ▶ Weight changes
- ▶ Frequent headaches
- ▶ Tired, overwhelmed
- ▶ Irritable, frustrated
- ▶ Apathetic, dissociated
- ▶ Negative, cynical, angry
- ▶ Sad, depressed, helpless
- ▶ Critical of self and others
- ▶ Low professional-efficacy
- ▶ Isolated, disconnected
- ▶ Use negative coping strategies
- ▶ Queen & Harding, 2020; Rakofsky et al., 2018

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18:46 #2021RWCC Presentation Nadine J. Kaslow, PhD

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Recording

Burnout

- Emerges gradually over time
- Can be mitigated by
 - Role clarity
 - Professional autonomy
 - Fair treatment
 - Support
- Can be remedied through a change of circumstances or changes in the environment
 - O'Connor et al., 2018; Simionato & Simpson, 2018

Slide 8 of 36

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20:56 #2021RWCC Presentation Nadine J. Kaslow, PhD

- **Engaging Out-of-Care Patients, James Raper, PhD, DSN, CRNP, JD**
 - CDC D2C activities:
 - Out of care patient lists
 - Prioritize patients to contact, phone, email, mail, home visits
 - Tracking contacts
 - Road map: see slide below

- Intentional messaging: “We missed you. We care about you. We’d love to see you again. Call today and make an appointment or drop by.”
- Text messaging and HIPAA problems
 - TigerConnect is a HIPAA compliant messaging app.
 - UAB compliance and Dr. Raper (who is also a lawyer) have this protocol:
 - Ask patients how they want to be communicated with.
 - What you work out with the patient, sign forms.
 - Privacy is an issue, and you can do it as long as you have documented permission from the patient.
 - Dr. Cheever: ask patients how they want to be contacted, be clear about what will be communicated on that platform and sign permission for that.
- People who get refills but don’t come in?
 - Dr. Raper: refilling without visits and labs is medical malpractice, so UAB policy is they can get 6 months of refill, 1 month bridge, and after that they must come in for labs and a visit to get more medications.

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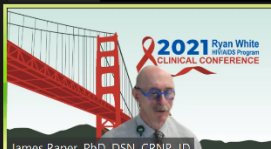
Local roadmap to patient re-engagement

1. Identify the patient group
2. Export the group’s email addresses
3. Create email messaging
 - Customize copy so it’s relevant – “We’ve missed you”
4. Influence action within the email – Recommend that patients schedule or request an appointment
5. Make it easy to book an appointment
 - Prioritize online scheduling
 - Let patients know if you have expanded or new flexible hours
6. Send appointment reminders

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15:14
#2021RWCC

Presentation



James Raper, PhD, DSN, CRNP, JD

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9:58 AM

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Recording

Local plan for re-engaging patients

- Create a list of patients seen within the last 24 months but not within the past 12 months
- Select the group or groups of patients you want to re-engage right away. Consider patients who are likely to have the greatest need for care — this can be based on the date of their last visit, acuity/patient condition (CD4 or vRNA), or simply a history of cancellations and no-shows.
- Develop tracking activities (e.g. making telephone calls and sending letters/emails, making home visits to the patient's last known address)

Slide 11 of 19

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16:56 #2021RWCC Presentation 2021 San Francisco Conference James Raper, PhD, DSN, C...

- **Diagnosing and Managing Sexually Transmitted Infections, Khalil G. Ghanem, MD, PhD**
 - I did not participate in this session; please see the slides ([PDF](#), [PPT](#)).
 - Please see the updated [2021 CDC STI Treatment Guidelines here](#).
 - Updates include:
 - 1) updated recommendations for treatment of *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, and *Trichomonas vaginalis*;
 - 2) addition of metronidazole to the recommended treatment regimen for pelvic inflammatory disease;
 - 3) alternative treatment options for bacterial vaginosis;
 - 4) management of *Mycoplasma genitalium*;
 - 5) human papillomavirus vaccine recommendations and counseling messages;
 - 6) expanded risk factors for syphilis testing among pregnant women;
 - 7) one-time testing for hepatitis C infection;
 - 8) evaluation of men who have sex with men after sexual assault; and
 - 9) two-step testing for serologic diagnosis of genital herpes simplex virus.
 - **Gonorrhea treatment update:** The treatment of uncomplicated gonorrhea is now 500 mg of intramuscular ceftriaxone; if chlamydia is present or is not ruled out, add one week of 100 mg of oral doxycycline taken twice daily. Patients with pharyngeal gonorrhea should have a test-of-cure 1-2 weeks later. Everyone with gonorrhea should be re-screened 3 months after treatment.
 - **Chlamydia treatment update:** Doxycycline 100mg orally twice daily is the preferred option.
 - Asymptomatic or mild infections or proctitis: treat for 7 days.
 - Moderate-severe proctitis: treat for 21 days.

- ### **Effectiveness of PrEP in Randomized Clinical Trials**



ASPIRE
(Dapivirine)

27%

31%

CI: 1 – 46

CI: 1 – 51

DISCOVER
(TDF/FTC) (TAF/FTC)

Incidence rate 0.30%

Incidence rate 0.16%