TOOLS TO STRENGTHEN ADHERENCE TO CARE AND TREATMENT IN HIV

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HOWARD UNIVERSITY HIV-HCV
CARIBBEAN CLINICIANS
COMMUNITY OF PRACTICE
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Planning Committee And Speaker

Speaker: The following speaker has nothing to disclose in relation to this activity: Monika N. Daftary PharmD, BCPS, AAHIVP

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Goulda A. Downer, PHD, RD, LN, CNS – Principal Investigator/Project Director

CME Disclosures:
Planning Committee And Speaker

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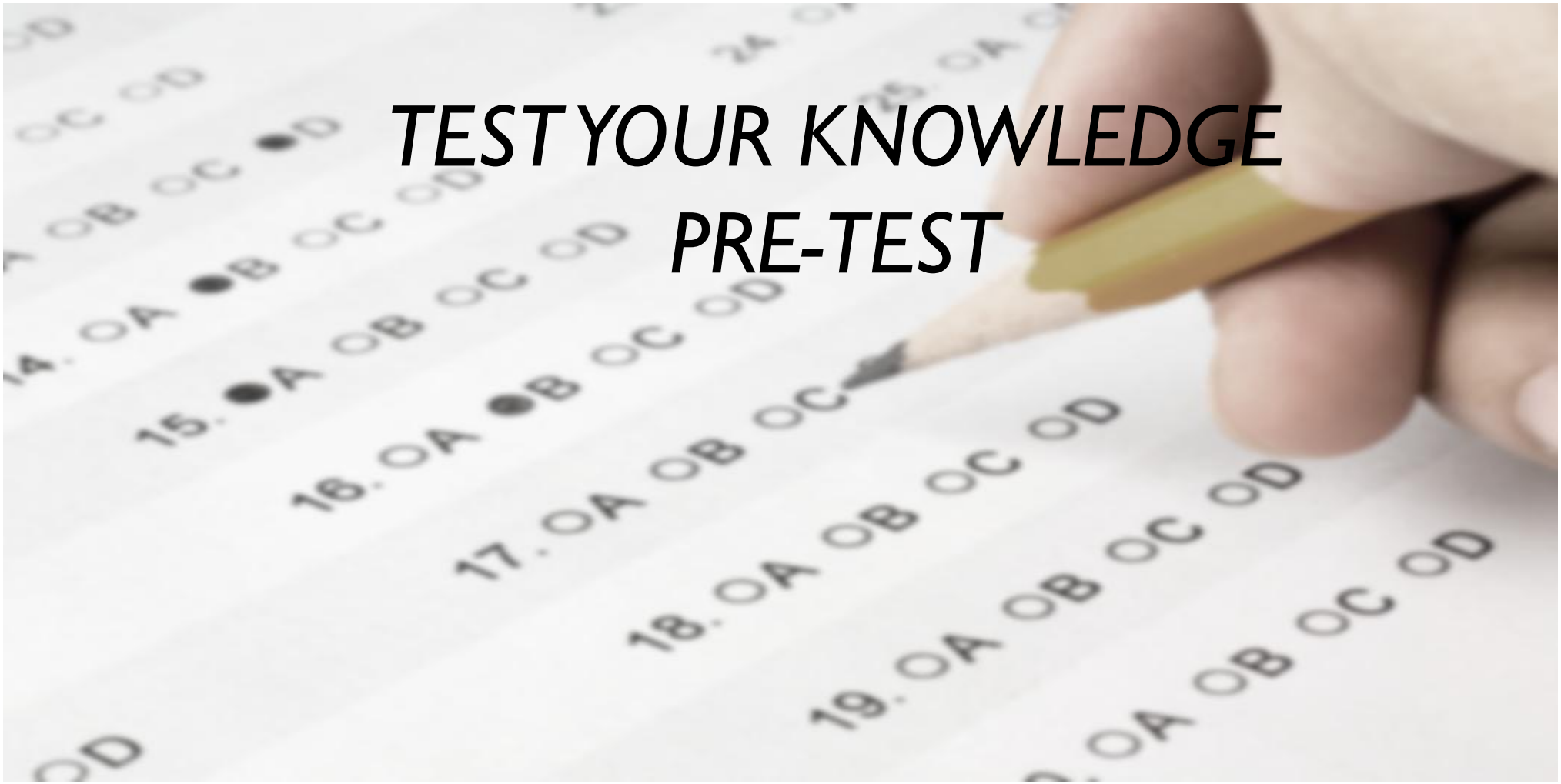
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TEST YOUR KNOWLEDGE
PRE-TEST

Test Your Knowledge
Question #1

The official HIV Care Continuum does not include:

A. Linkage to care

B. Retention in care

C. Prevention of HIV

D. Adherence to care

Test Your Knowledge
Question #2

Please choose the correct statement regarding the UNAIDS 90-90-90 targets:

A. All targets of UNAIDS 90-90-90 were met by 2020

B. Some targets of UNAIDS 90-90-90 were met by 2020

C. Greater than 80% of the UNAIDS 90-90-90 targets were met by 2020

D. Although some goals were met, there is a focus on 95-95-95 targets for eradication of HIV by 2050

Test Your Knowledge
Question #3

A newly diagnosed HIV patient with a history of non-adherence to other chronic care medications (he does not like to swallow pills) presents to your clinic. His HIV VL is 500,000 copies and CD4 300 cells. He is speaking with the medical team and inquires about injectable ART. Choose the correct answer:

A. Since he is non-adherent, injectable ART would be an ideal choice to aid with adherence.

B. Since he is non-adherent, injectable ART would not be an ideal choice to aid with adherence at this time since his HIV VL is detectable.

Test Your Knowledge
Question #4

When assessing adherence at every clinic visit, the following would not be appropriate:

A. Monitor CD4 as a strong biologic measure of adherence

B. Use a simple behavioral rating scale or self-reported assessment

C. Employ a structured format that normalizes or assumes less-than-perfect adherence and minimizes socially desirable or "white-coat adherence" responses

D. Ensure that other members of the health care team also assess and support adherence

TOOLS TO STRENGTHEN ADHERENCE TO CARE AND TREATMENT IN HIV

LEARNING OBJECTIVES

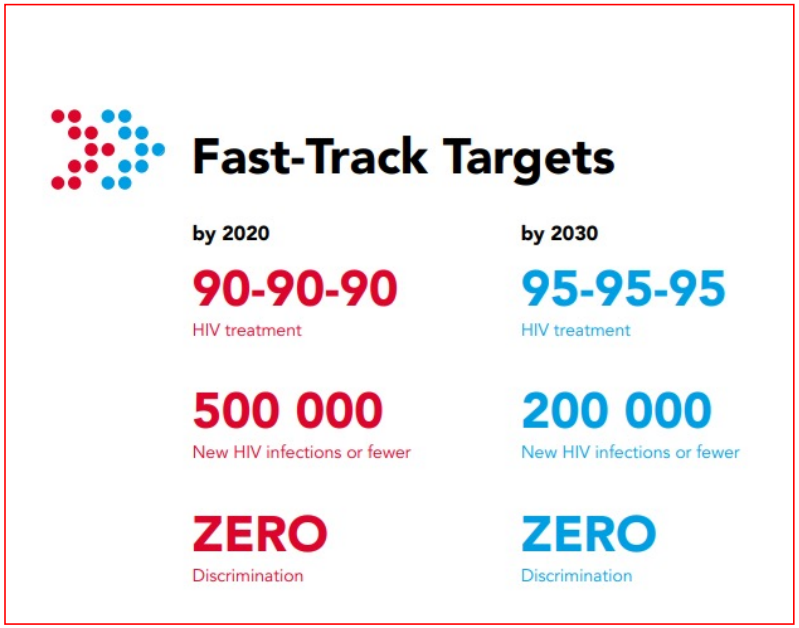
- To define adherence to the HIV Care Continuum
- To review and discuss the HIV data from the Caribbean and the 95-95-95 UNAIDS goals
- To identify approaches to improve adherence to the HIV Care Continuum
- To apply information available to improve the present clinical setting

ADHERENCE TO THE HIV CARE CONTINUUM



Source: HIV.gov. HIV Care Continuum. 2021. Available at: https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum.

ACHIEVING THE 95-95-95 TARGETS FOR ALL: A PATHWAY TO ENDING AIDS



2014: UNAIDS launched new global targets for HIV treatment scale up: 90-90-90
-by 2020, 90% of all people living with HIV will know their HIV status
-by 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART)
-by 2020, 90% of all people receiving ART will have viral suppression)

Targets difficult to achieve

2020: Focus targets for 2030: 95-95-95

Source:
https://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf

GLOBAL HIV DATA

38.4 million people across the globe with HIV in 2021

36.7 million were adults and 1.7 million were children

1.5 million individuals worldwide acquired HIV in 2021, marking a 32% decline in new HIV infections since 2010

85% of people with HIV globally knew their HIV status in 2021

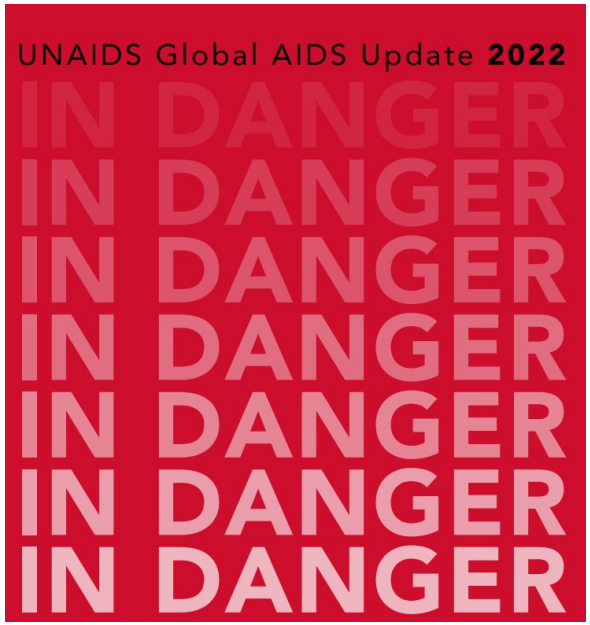
28.7 million people with HIV (75%) were accessing antiretroviral therapy (ART) globally

9.7 million people not receiving treatment

68% were virally suppressed

Source: https://www.hiv.gov/hiv-basics/overview/data-and-trends/global-statistics/

CARIBBEAN HIV DATA UPDATE



The Caribbean has the highest HIV prevalence of any region outside sub-Saharan Africa – the region has made strides

Newly infected with HIV in 2021 (14 000 [9500–18 000]) was 28% lower than in 2010

AIDS-related deaths (5700 [4200–7600] in 2021) have declined by 50%

New HIV infections among children fell by 47% from 2010 to 2021

84% knew their HIV status

83% of people who knew their HIV-positive status were accessing treatment

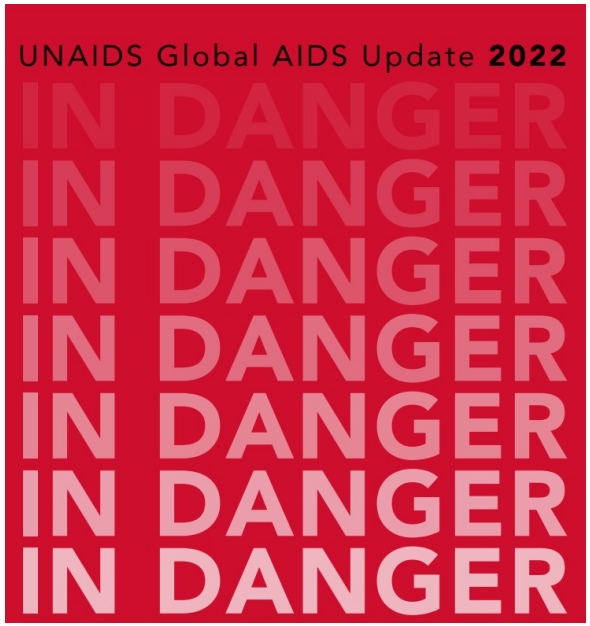
87% had suppressed viral loads (of those on ART)

Diagnosis and treatment coverage remain lower in men than women

Some caveats

Source: IN DANGER: UNAIDS Global AIDS Update 2022. Geneva: Joint United Nations Programme on HIV/ AIDS; 2022. Licence: CC BY-NC-SA 3.0 IGO.

CARIBBEAN HIV DATA UPDATE



There were an estimated 330,000 people living with HIV in the Caribbean in 2021

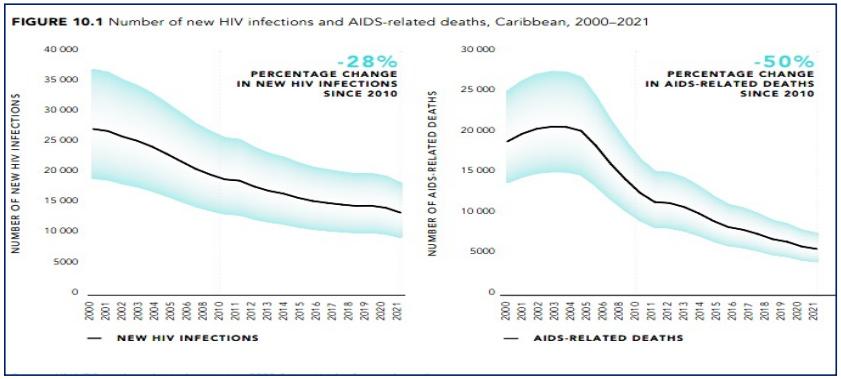
AIDS-related deaths in the region declined by half (50%): *there were 5,700 deaths last year*

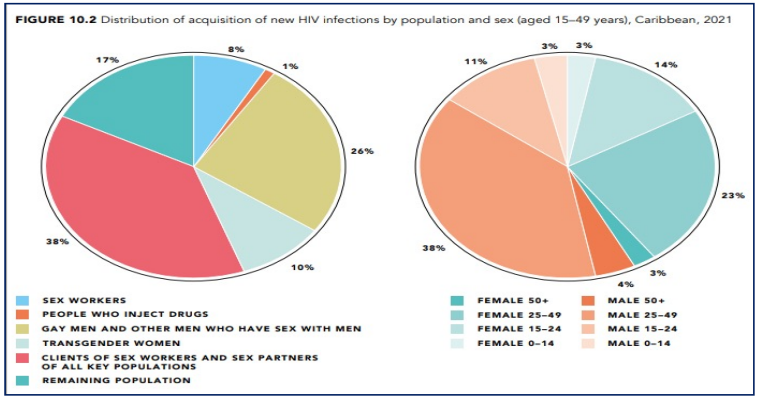
New HIV infections decreased by 28% since 2010: *an estimated 14,000 people contracted HIV during 2021*

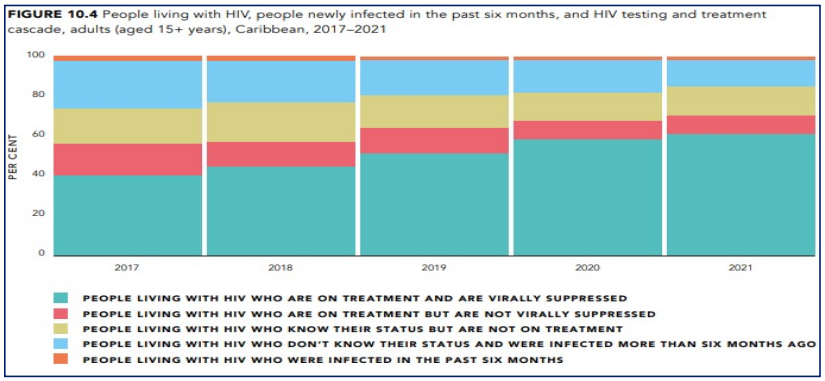
Translation:
270 new HIV infections every week in the Caribbean

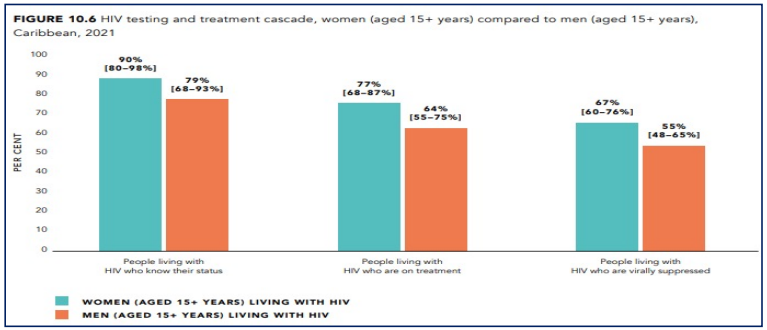
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CARIBBEAN HIV DATA UPDATE



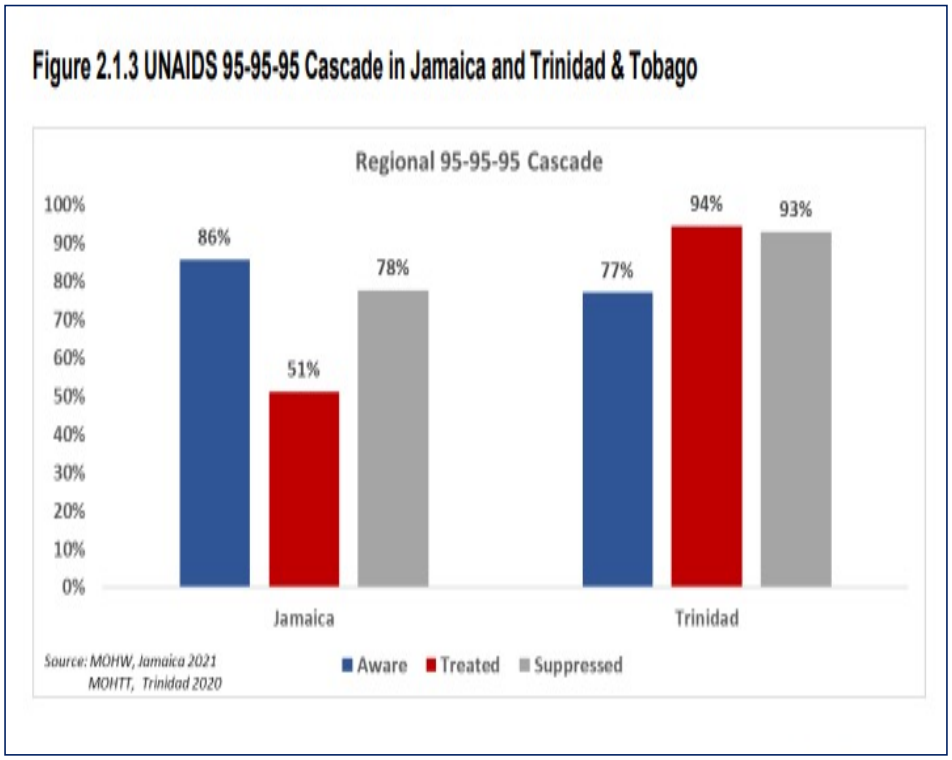






Source: IN DANGER: UNAIDS Global AIDS Update 2022. Geneva: Joint United Nations Programme on HIV/ AIDS; 2022. Licence: CC BY-NC-SA 3.0 IGO.

WHY ADHERENCE TO THE 95-95-95 CASCADE IS NECESSARY?



- Adherence is key

- Awareness of diagnosis
- Treated
- Virologic suppression

- Transmission of disease
- Possibly resistant disease, limits future options

Source: https://www.state.gov/wp-content/uploads/2022/09/Caribbean-ROP22-SDS.pdf

CARIBBEAN HIV DATA – FOCUS AREAS

Only 6 countries included PreP in National Guidelines

- Bahamas
- Barbados
- DR
- Haiti
- Jamaica
- Saint Lucia

Community-led initiatives should be scaled up

Initiatives: HIV testing, treatment initiation, treatment outcomes

Gender equality

Anti-discrimination

Service delivery

Data utilization

Monitoring

Source: IN DANGER: UNAIDS Global AIDS Update 2022. Geneva: Joint United Nations Programme on HIV/ AIDS; 2022. Licence: CC BY-NC-SA 3.0 IGO.

HIV TREATMENT ADHERENCE

- Initiating care with an HIV provider (linkage to care)
- Regularly engaging in appointments (retention in care)
- Adhering to antiretroviral therapy (ART)

It is adhering to the process.

ADHERENCE TO THE HIV CARE CONTINUUM



Source: HIV.gov. HIV Care Continuum. 2021. Available at: https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum.

LINKAGE TO CARE

Receiving a diagnosis of HIV infection can be traumatic	Linkage to care efforts must be delivered with compassion and persistence	May be affected by many factors: socioeconomic, substance abuse, mental health, stigma, etc.
Certain populations may have lower linkage to care	Passive linkage (i.e., passing a name along of a provider) – lower rates of linkage	Active linkage (assistance with appointments, connecting with provider/case management)

Source: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care

ADHERENCE TO THE HIV CARE CONTINUUM



Source: HIV.gov. HIV Care Continuum. 2021. Available at: https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum.

RETENTION IN CARE

Poor retention in HIV care is associated with greater risk of death

Poor retention is common in people who use substances, have serious mental health problems, have unmet socioeconomic needs (e.g., housing, food, transportation)

Also, in patient that lack financial resources or health insurance, have schedules that complicate adherence, have been recently incarcerated, or face stigma

Poor patient–provider relationship

Availability of appointments and timeliness of appointments (and scheduling convenience)

FTF appointments (re-engagement)

Telehealth

Mobile applications

Source: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care

STUDY: VIRAL SUPPRESSION AND RETENTION IN CARE

Description: Positive Health Check is a highly tailored, patient-centered, brief video intervention designed to improve viral load suppression and retention in HIV care for PWH who are newly diagnosed, new to care, or engaged in care but not virally suppressed.

DURATION: 12 months

SETTING: 4 HIV primary care clinics (1 in south central US, 2 in the southeast US, 1 in northeast US)

STUDY YEARS: February 27, 2018 – October 31, 2020

STUDY DESIGN: Type-1 hybrid effectiveness-implementation randomized trial

DELIVERERS: Virtual video nurse and doctor (actors)

DELIVERY METHODS: Digital video counseling tool, Printed materials (patient handout), Tablet

STUDY SAMPLE The analytic study sample of n = 799 was characterized by the following:

- 76% Black or African American persons, Mean age = 44.9 years

Male persons in the intervention group were more likely to have viral suppression at 12 months than male persons in the comparison arm (adjusted risk ratio, aRR [95% CI] = 1.14 [1.00-1.29])

For retention in HIV care, there was a lower risk for a 6-month visit gap in the intervention arm for the youngest (18-29 years old) age group (aRR [95% CI] = 0.55 [0.33-0.92]) and the oldest (61 to 81 years old) age group (aRR [95% CI] = 0.49 [0.30-0.81]) than among those receiving the standard of care.

Bottom line: improved viral suppression and improved retention in care

Lewis, M. A., Harshbarger, C., Bann, C., Marconi, V. C., Somboonwit, C., et al. (2022). Effectiveness of an interactive, highly tailored 'Video Doctor' intervention to suppress viral load and retain patients with HIV in clinical care: A randomized clinical trial. JAIDS Journal of Acquired Immune Deficiency Syndromes, 91(1), 58-67. doi: 10.1097/QAI.0000000000003045

ADHERENCE TO THE HIV CARE CONTINUUM



Source: HIV.gov. HIV Care Continuum. 2021. Available at: https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum.

ADHERENCE TO ANTIRETROVIRAL THERAPY

Can be influence by patient's social situation and clinical conditions

Depression and other mental illnesses

Neurocognitive impairment

Low health literacy

Low levels of social support

Stressful life events including trauma

Busy or unstructured daily routines Active substance use

Homelessness

Poverty

Nondisclosure of HIV serostatus

Denial

Stigma

Inconsistent access to medications due to financial and insurance status

Characteristics of the prescribed regimen: once daily, food requirement, side effect or toxicities

Patient involvement in decision making

Patient education

Source: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care

APPROACH TO IMPROVING ADHERENCE

- Tailor to patient needs and barriers to care
- Changing ART to simplify dosing or to reduce side effects
- Allowing flexible appointment scheduling
- Resources to assist with treatment costs to maintain uninterrupted access to both ART and appointments
- Linking patients to resources to assist with unmet social and economic needs, such as transportation, food, housing, and support services
- Linking patients to counseling to overcome stigma, substance use, or depression

Source: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care

CASE STUDY #1

CASE #1

Background: 64-year-old African American male presents Howard University Hospital (HUH) Clinic – new referral, moved to DC, Maryland and Virginia (DMV) area. Patient is here for management of HIV, non-adherence for last 6 months.

PMH:

- HIV uncontrolled with

  -Lamivudine/Abacavir 300mg/600mg + Efavirenz 600mg

  -HIV VL 120,000 copies/ml, CD4 192 cells/mm^3
- HCV: GT1a, HCV VL 1.8 million copies/ml,F1-F2 (F=0.37)

  -Treatment naïve
- Labs: AST:40 ALT: 30 Scr: 1.1
- Other conditions: Type 2 DM, Peripheral Neuropathy, GERD, HTN
- SH: lives with wife; history of IVDA in 1980s, occasional marijuana, no alcohol use
- Allergies (drug): Penicillin (hives)

CASE #1 : CONT'D -INTERVENTIONS

- Case discussion with medical team: treatment options, HIV genotype results show K103N (resistance to EFV component)
- Change regimen to INSTI-based regimen
- Multi-disciplinary discussion: adherence counseling, HIV 101, patient navigator, case management, nursing, pharmacy
- Patient wife included in discussion, per his request for treatment support

CASE #1 CONT'D – FOLLOW-UP

- Two-week adherence visit: via telehealth – patient doing well.
- 6-week labs: HIV VL 1000 copies/ml, CD4 202
- 8-week FTF visit: medical team follow-up, added to adherence visit to follow

CASE #1 CONT'D
INTERVENTIONS FOR IMPROVE ADHERENCE

- Follows with adherence team – assessed for initial reasons for nonadherence, housing and food stability (referred to case management – both medical and non-medical), telemedicine
- Routine follow-up with medical team

CASE #1 – OUTCOME

- 4-month follow-up with medical team: HIV RNA <20 copies
- Patient continues with adherence team
- Initial discussion with patient regarding injectable ART option

STRATEGIES TO IMPROVE LINKAGE TO CARE, RETENTION IN CARE, ADHERENCE TO APPOINTMENTS, AND ADHERENCE TO ANTIRETROVIRAL THERAPY

Strategies	Examples
Provide an accessible, trustworthy, nonjudgmental multidisciplinary health care team	Include care providers, nurses, social workers, case managers, pharmacists, medication managers, and administrative staff on the care team; train all members on providing compassionate and patient-centered care
Strengthen early linkage to care and retention in care.	• Encourage health care team participation in linkage to and retention in care • Actively support linkage to care with assistance in making appointments and linkage to services to overcome barriers to care

Source: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care

Strategies	Examples
Evaluate the patient's knowledge about HIV infection, prevention, and treatment and based on this assessment, provide HIV-related information.	Keeping the patient's current knowledge base in mind, provide information about HIV, including the natural history of the disease, HIV viral load and CD4 count and expected clinical outcomes according to these parameters, therapeutic and prevention consequences of poor adherence, and importance of staying in HIV care
Provide needed resources	• Provide or refer for mental health and/or substance use treatment • Provide resources about stable housing, social support, transportation assistance, and income and food security

Source: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care

Strategies	Examples
Identify facilitators, potential barriers to adherence, and necessary medication management skills both when starting ART and on an ongoing basis.	• Assess the patient's cognitive competence and impairment. • Assess behavioral and psychosocial challenges, including depression, mental illnesses, trauma, levels of social support, levels of alcohol consumption and current substance use, nondisclosure of HIV serostatus, and stigma • Identify and address language and literacy barriers • Assess beliefs, perceptions, and expectations about taking ART (e.g., impact on health, side effects, disclosure issues, consequences of poor adherence) • Ask about medication-taking skills and foreseeable challenges with adherence (e.g., past difficulty keeping appointments, adverse effects from previous medications, issues managing other chronic medications, need for medication reminders and organizers) • Assess structural issues, including unstable housing, lack of income, unpredictable daily schedule, lack of prescription drug coverage, lack of continuous access to medications, and transportation problems

Source: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care

Strategies	Examples
Involve the patient in ARV regimen selection.	• Review potential side effects, dosing frequency, pill burden, storage requirements, food requirements, and consequences of poor adherence • Assess daily activities and tailor regimen to predictable and routine daily events • Consider preferential use of PI/r-based or DTG-based or BIC-based ART if poor adherence is anticipated • Consider use of STR or fixed-dose-combination formulations to reduce pill burden • Consider use of long-acting injectables in people with suppressed viral load if clinically appropriate. • Assess if the cost or copayment for drugs will affect adherence and access to medications

Source: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care

Strategies	Examples
Assess adherence at every clinic visit	• Monitor viral load as a strong biologic measure of adherence • Use a simple behavioral rating scale or self-reported assessment • Employ a structured format that normalizes or assumes less-than-perfect adherence and minimizes socially desirable or "white-coat adherence" responses • Ensure that other members of the health care team also assess and support adherence

Source: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care

Strategies	Examples
Use positive reinforcement to foster adherence success	• Inform patients of benefits of low or nondetectable levels of HIV viral load (e.g., "Undetectable = Untransmittable") and increases in CD4 cell counts • Thank patients for attending their appointments

Source: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care

Strategies	Examples
Identify the type of and reasons for poor adherence and target ways to improve adherence	• Failure to understand dosing instructions. • Complexity of regimen (e.g., pill burden, size, dosing schedule, food requirements, polypharmacy). • Pill aversion or pill fatigue. • Adverse effects. • Inadequate understanding of drug resistance and its relationship to adherence. • The patient is unaware of appointments, or appointments are not scheduled with proper patient input. • Cost-related issues (e.g., copays for medications or visits, missed work time). • Depression, drug and alcohol use, homelessness, or poverty. • Stigma of taking pills or attending HIV-related appointments. • Nondisclosure of status or privacy concerns leading to missed doses, refills, or appointments.

Source: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care

Strategies	Examples
Select from among available effective adherence and retention interventions.	• Best practice interventions to improve linkage, retention, and adherence • Use adherence-related tools to complement education and counseling interventions (e.g., text messaging, pill box monitors, pill boxes, alarms) • Use community resources to support adherence (e.g., visiting nurses, community workers, family, peer advocates, transportation assistance, pharmacy delivery) • Use patient prescription assistance programs (see above in the table, under "Provide needed resources") • Use motivational interviews • Provide outreach for patients who drop out of care • Use peer or paraprofessional treatment navigators • Recognize positive clinical outcomes resulting from better adherence • Arrange for DOT for persons in substance use treatment (if feasible). • Enhance clinic support and structures to promote linkage and retention (e.g., reminder calls, flexible scheduling, open access, active referrals, improved patient satisfaction) • Offer telehealth services for primary care, as well as supportive services when appropriate

Source: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care

CASE STUDY #2

CASE #2

Background: 24-year-old African American female presents the ambulatory care ID clinic, she is newly diagnosed and distraught over her diagnosis as the test was completed as a part of routine testing. She states she does not like shots and does not want any vaccinations.

PMH:

- Labs:

  -HIV VL 1,300,000 copies/ml, CD4 250 cells/mm^3

  -HIV Genotype S to all

- Labs: AST:20/ ALT: 20 /Scr: 1.1 /RPR: Reactive/Beta HCG: Negative
- Other conditions: Asthma
- SH: lives with grandmother; occasional marijuana, weekly alcohol use
- Allergies (drug): sulfamethoxazole/trimethoprim

CASE #2 -INTERVENTIONS

Case discussion with medical team: engagement in clinic within 3 days of test results, rapid initiation with INSTI-based treatment, IRS possibility, need for HIV 101 patient education, explanation of treatment options, other STI counseling (as RPR is positive), partner notification

Multi-disciplinary discussion: adherence counseling, patient navigator, case management, nursing, pharmacy, support system discussion, housing stability, food stability, insurance

CASE#2-FOLLOW UP

- Two-week adherence visit: onsite – patient not tolerating ART, strategies for adhering to therapy discussed, patient will be placed on every week telehealth visit to ensure adherence, new housing instability as grandmother found out about diagnosis, medical case management (family visit)
- 2-week visit: still not tolerating medication and now missing ART; seen by medical team – addition of anti-nausea medication
- 1-week visit: patient arrived for unscheduled visit, she has stopped ART; new ART options discussed

ADHERENCE

- Follows up with adherence team – new ART started, patient tolerating
- Continues adherence visit via telehealth
- Routine follow-up with medical team

CASE #2-OUTCOME

- 4-month follow-up with medical team: HIV RNA <20 copies
- Patient continues with adherence team

SUMMARY

Linkage to care and adherence to both antiretroviral therapy (ART) and clinic appointments should be regularly assessed

An individual's barriers to adherence to ART and appointments should be assessed before or shortly after the initiation of ART and regularly thereafter

Rapid access to ART – if delayed, this should be addressed

ART adherence problems should be placed on regimens with high genetic barriers to resistance, such as dolutegravir, bictegravir, or boosted darunavir

Adherence to ART should be regularly assessed by self-report at every clinic visit

Difficulties with adherence to appointments or ART should be provided additional adherence support using a constructive, collaborative, nonjudgmental, and problem-solving approach

Source: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care

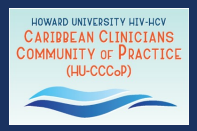


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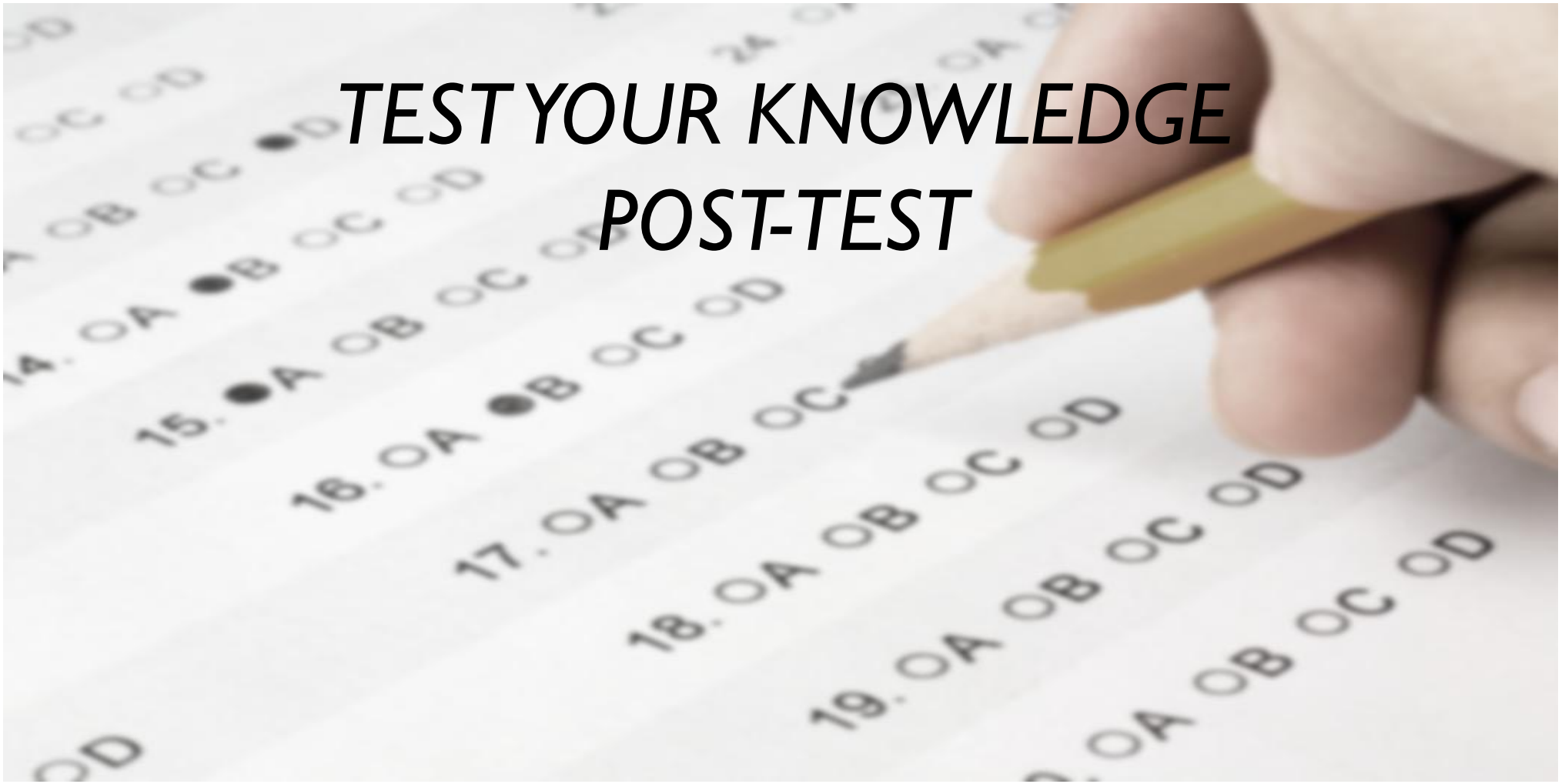
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QUESTION & ANSWER SESSION



Thank You

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TEST YOUR KNOWLEDGE
POST-TEST

Test Your Knowledge
Question #5

The official HIV Care Continuum does not include:

A. Linkage to care

B. Retention in care

C. Prevention of HIV

D. Adherence to care

Test Your Knowledge
Question #6

Please choose the correct statement regarding the UNAIDS 90-90-90 targets:

A. All targets of UNAIDS 90-90-90 were met by 2020

B. Some targets of UNAIDS 90-90-90 were met by 2020

C. Greater than 80% of the UNAIDS 90-90-90 targets were met by 2020

D. Although some goals were met, there is a focus on 95-95-95 targets for eradication of HIV by 2050

Test Your Knowledge
Question #7

A newly diagnosed HIV patient with a history of non-adherence to other chronic care medications (he does not like to swallow pills) presents to your clinic. His HIV VL is 500,000 copies and CD4 300 cells. He is speaking with the medical team and inquires about injectable ART. Choose the correct answer:

A. Since he is non-adherent, injectable ART would be an ideal choice to aid with adherence.

B. Since he is non-adherent, injectable ART would not be an ideal choice to aid with adherence at this time since his HIV VL is detectable.

Test Your Knowledge
Question #8

When assessing adherence at every clinic visit, the following would not be appropriate:

A. Monitor CD4 as a strong biologic measure of adherence

B. Use a simple behavioral rating scale or self-reported assessment

C. Employ a structured format that normalizes or assumes less-than-perfect adherence and minimizes socially desirable or "white-coat adherence" responses

D. Ensure that other members of the health care team also assess and support adherence

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