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HIV PREVENTION ACROSS THE LIFESPAN: ENGAGING EVERYONE IN PREP FROM YOUTH TO ELDERS: THE NYS HIV PRIMARY CARE AND PREVENTION ANNUAL CONFERENCE

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[video transcript]

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I'm delighted to introduce our speakers today Dr. Jeffrey Birnbaum and Dr. Jeffrey Kwong.

00:13
Dr. Jeffrey Birnbaum is an associate professor of pediatrics and public health at SUNY Downstate Medical Center, an adolescent medicine specialist and board-certified pediatrician who has devoted most of his professional career to working with HIV positive youth. He currently serves as the principal investigator and executive director of the health and education alternatives for teens or heat program. Heat is the only program of its kind in Brooklyn to offer comprehensive medical and mental health care, supportive services and access to clinical research for HIV positive and at-risk youth. Dr. Birnbaum has built the heat program into a system of care that provides age and developmentally appropriate culturally competent care for heterosexual, lesbian, gay, bisexual and transgender youth who are living with or at risk for contracting HIV. Today, he operates as a one-stop full-service clinic offering a full range of medical, mental health and supportive services that are tailored to meet the specific health needs of young people.

01:08
And Dr. Jeffery Kwong is a professor and certified adult Gerontology primary care nurse practitioner in the division of advanced practice at Rutgers School of Nursing. He is also a practicing HIV primary care provider at Gotland medical group in New York City, where he specializes in providing HIV prevention and treatment. He is the former director of the HIV specialty track at Columbia University School of Nursing and the immediate past president of the National Association of nurses and AIDS care. Dr. Kwong serves as an expert faculty member for CEI HIV Project ECHO is on the advisory panel for the HIV AIDS clinical guidelines group and a member of ANNEX HIV and aging expert panel. He is certified as an HIV specialist by the American Academy of HIV medicine. Thank you for being with us today, both doctors, Birnbaum and Kwong. And now to begin the program. I will turn it over to Dr. Birnbaum.

02:03
Okay, thank you. It's kind of fun to be a pair of Dr. Jeff's at opposite ends of the age spectrum here. Although I think I'm older. And I just wanted to thank everyone had CEI for putting this conference together. It's really been a really great conference always great presentations put on by CEI. So, as both of us have nothing to disclose, there are our learning objectives, we're going to be looking at models of care and different considerations for both younger and older adults in prescribing PrEP and looking at barriers and facilitators. So, starting off with the adolescents and young adults, just to review, some of this has been mentioned already the end of the epidemic and the epidemic plan that had been put in force by Governor Cuomo in 2014. And in red at the bottom, you see highlighted keeping HIV negative folks negative by providing PrEP were indicated. So, this particular slide shows, you know, there was a lot of discussion

before about racial and ethnic disparities. I want to show in the context of, of all of those ethnic and ethnic and racial disparities there are, it's compounded by age disparities. So, what you'll see from where I've put some of the arrows at least, the arrows on top looking at the, at the red lines, this is in New York City in New York State, although across the state, HIV is decreasing in incidence, we still have a 20- to 29-year-old age group, probably the highest incidence age group for all HIV infections, all new HIV infections. Just counting that down a little bit in New York City, you could see among MSM, just about half of all new infections, although coming down for all age groups, half of them are in young men below the age of 30. Among young women, you can see the red line also is that 20- to 29-year-old, we still have a very high incident group in terms of relative to other age groups, and as well, for women, when you break this down among different ethnic and racial groups, you could see that it's still younger women disproportionately among black and Latino women in particular. Among transgender women, if you look at the upper left the red bar 20- to 29-year-old are the largest group getting new infections of HIV and as well, ethnic minorities as well black and transgender, black and Latina transgender women are the ones who are getting infected. So, not to point out who's getting infected, but who we need to focus our, our PrEP efforts on. So, just really going over this PrEP timeline, I want you to draw your attention to the red line in the middle, which separates the pre-youth era from the youth era. There were some things which occurred starting in 2017, were two landmark studies, which I won't go into, other than to say these were a specific adolescent trials network studies, which showed that in the first ATN 110 study that young, primarily young men ages 18 to 22 could be engaged in a PrEP protocol. And the ATN 113 study in May 2017, was published showing that 13 to 17 year olds could be engaged in a PrEP protocol. Underneath the purple lines, April 2017, where New York State Public Health law was amended to allow minors to consent for PrEP. This was the game changer, which made life easier for those of us providing PrEP services to young people in prior to that we were unable to prescribe PrEP without having to go through all kinds of machinations without getting parental consent. There were ways to get around the law without necessarily breaking it. But to be able to just allow a minor to consent for PrEP, for that matter for HIV care, a real game changer for those of us in the field.

And then you can see when FDA approved PrEP for both formulations of tenofovir in a 15- to 17-year-olds as well as for the new medication, the Alafenamide. So, getting a little bit further into the current era with injectable Cabotegravir the two studies that we really focus on that allow us to go ahead and start providing injectable PrEP, or the HPTN 083 study which was done in MSM and transgender women only. This was a global study, and then following up that a few months later, HPTN 084, was a study that showed that injectable cabotegravir could be used in cisgendered women. And in both studies, the injectable form of PrEP, cabotegravir was superior to oral medication. So, obviously, there are some issues that I won't go into relating to giving the medication with as far as resistance, and so on. But at the bottom, you could see that there's a possibility that injectable PrEP may be a good option. As this slide says in the not-too-distant future, but we've just started doing it in my clinic for adolescents and young adults. There are concerns about adherence to both showing up for the injections that are equal to the concerns we have for oral PrEP regimens. And so those are things that we need to consider. Having said that, I would say having had about amount of experience of trying to provide injectable PrEP in my own clinic. I'll give a little personal editorializing is that the whole for me as

a provider, the prior authorization process is a real nightmare. It's a real deterrent to providers wanting to prescribe injectable PrEP. I think some of the other issues around having patients show up on the assigned day and getting the medication into the clinic. Those are bearable, but having to learn the difference between getting prior authorization between a managed care plan straight Medicaid versus private insurance versus a pharmacy benefit versus a medical benefit. Trying to navigate this is a huge waste of time and a real deterrent to promoting injectable PrEP and if there are folks from the agents to listening, please do something about it. Some other things from the end the epidemic plan from Governor Cuomo. Some just to highlight some of the things in red that we need to focus on programs that will target sexually active young people, especially minors. In getting to zero recommendation seven one of those has already been achieved. If which is guarantees minors the rights to consent, they need to have some level of competency. More importantly, providers need to understand that a minor can consent to getting PrEP services as well as HIV care services without parental knowledge or consent. And so, getting providers to know that and getting youth to know that they can present for the services without parental knowledge or consent is extremely important. So, there are other issues. I'll draw your attention to, not the bottom three bullets, but everything above that, again, HIV care and HIV prophylaxis real game changer when the New York State Public health laws were amended in 2017, allowing minors to consent along with STD treatment, screening and treatment, family planning, prenatal care, termination of pregnancy will be one of those that laments the loss of Roe v Wade, like everyone else has today, as well as consenting for their own HIV counseling and testing. The issues at the bottom are still issues that we get faced with every single day providing clinical care. And we still do not have a minor, right to consent for substance use, treatment, mental health services or transgender care, which works against some of the epidemiology slides I showed you for transgender young women in particular.

11:31
So, what are some of the unique developmental issues that put minors and youth, minors and youth at risk for HIV infection? Young people have a sense of immortality, risk taking is normative behavior, having unprotected sex may not be safe, but it's normative. It's normal at that age, just figuring out who you are with this emerging sense of identity or autonomy and independence, challenging authority figures, he told me not to have sex, so, I'm going to go out and have sex without a condom, that sort of thing. And then experimentation with just what somebody's sexual preferences and identity is figuring out who you are. So, these are all things that have to be considered if you are working with adolescents and young adults that need to provide care and developmental context. And that with respect to PrEP, understand that adherence although adult adherence may not be that great. Adolescents are notorious for being poorly adherence to medication. So, you need to work in that context if you're going to promote any sort of PrEP. So, why do we need to have specialized PrEP services for youth, you need to have places where young people, different sectors of the at-risk population, LGBT youth, heterosexual young women, partners of perinatally infected youth can come for care and have their risk issues addressed in a more adolescent and youth focused manner. And the clinical culture in an Adolescent Clinic is very different from what you will find in an adult clinic. Even though you may be prescribing the same exact type of care, the way in which it's delivered is very different. Having to have the expertise in navigating consent confidentiality, and how do you obtain your minors insurance information when it's in the parent's possession. This requires

having PrEP specialists and case managers who understand how to navigate around these issues, and makes having adolescent focus services that much more important. So, what does that adolescent PrEP care model mean? So, we have youth centered, family centered, non-adult centered multidisciplinary care, having little to no contact with a parent or care provider, although that's not 100% true in all cases, usually, it usually is the case, having their PrEP services integrated into a one stop shopping model where you can address some of the barriers such as housing, insurance, partner violence, and so on abuse at home, being able to integrate PrEP into a one stop shop model. You usually don't disclose to their families that they're getting any health care or for that matter, young people are very private about their sexuality, whether they're sexually active, or whether they are, you know, young, young male, having sex with other males, and so on. So, they don't disclose any of this to their families. And that's an important thing to consider in the adolescent care model. Again, confidentiality and consent, and that teen and youth services are core to the clinic and a lot of that it, most of it, I would say is either sexual health services or for that matter, mental health services, all integrated and are core to how the clinic may function. So, so somewhat disparate from the higher incidence in young people you could see in New York state through 2020, at least for 20, to 24-year-old 13- to 19-year-old as well but definitely for the 20- to 24-year-old, it's had very high incidence of HIV, across all the different groups I showed PEP uptake is not that great compared to other age groups. So, we have our work cut out for us in promoting PrEP to young people.

15:44
Some of the challenges that are out there for PrEP implementation to adolescents and young adults, there aren't a lot of adolescent friendly clinics, the insurance issues, it's all over the place. And in particular, when young people cannot access their insurance information from parents or guardians, that's a major, major issue. We need to have expertise on how to apply for PrEP-AP or treatment assistance plan for young people who may be minors. There's also a lack of confidentiality around explanation of benefit letters for people up to age 26 years old. If a young person is on their parent's insurance, that EOB letter goes to the parents not to the person. So, you really need to make phone calls to the insurers and have the EOB letter sent to an alternative address, they're required by law to send a letter out. But they don't have to send it to the owner of the policy. And a lot of young people just don't know about PrEP, don't know where to go. And again, there's the general stigma around HIV. So, having all sorts of alternate addresses in the in the electronic medical record, and so on, these are all issues that that PrEP specialists need to have expertise in. And I'm trying to keep to time. So, I'm just jumping ahead a bit. So, some of the outreach suggestions, let it be known that your clinic is a safe environment to come to, for young people and provide the PrEP services right there. Have networks with referral programs, community-based agencies that work with young people, in particular LGBT, young folks, and so on agencies that serve young women, and offer PrEP along with transgender services as appropriate. If you're providing transgender care, and your partner is known to be negative, PrEP needs to be integrated into that hormonal therapy talk that you're having with them. Get to know your high schools in college health services, family planning clinics, we work a lot with the house ball community. For those of you don't know what the House ball community is, look up the show pose on FX effects network, watch the first episode, you'll know what you need to know about that. And again, social networks word of mouth is some of the best form of outreach for young people. Some of the images that we use,

the one on the left is promoting PrEP to the house ball community if you don't know what vogueing is. And that's what it looks like when you have a really good graphic artist. Images that have same sex behavior for men, images that promote PrEP to women, images that promote PrEP to transgender individuals all essentially important, if people don't see themselves in the images that are promoting it, they're not going to go and seek PrEP services.

19:02
I'm going to jump ahead to my case discussions and save time for Jeff number two to do his presentation. So, JJ is a 24-year-old young man who have sex with men who presented to my clinic at age 19, seeking out PrEP services. At the time, 43 different male sex partners in the past three months. He hooked up with them through sex apps such as Grindr. He was unaware of their HIV status and didn't really feel like talking about HIV in sexual situations with his partners, and he said I'd rather take PrEP and not to talk about this. He started in 2017. He took it on and off. So due parent's issues were on and off for three years. And but he would come in for care every three months. He would take it for a while and then stop it because he said he was not sexually active so he would stop taking the PrEP, and then he'd become sexually active again without restarting it. In February 2018, he had rectal gonorrhea. We treated him and restarted PrEP at that time after testing negative for HIV. A few months later, he had pharyngeal chlamydia. Again, he had stopped taking PrEP prior to this, and then he restarted PrEP again after testing negative for HIV. Happened again in July 2019, with rectal and pharyngeal Gonorrhea. Each time we talked to him about partner treatment, he didn't keep any of his partner's contact information after having sex with them, he would delete their profile from his Grindr app. And in July 2019, he also reported occasional crystal meth use, and then we lost track of them because his phone service was no longer active.

20:54
Then comes along COVID beginning of April 2019, he shows up, he had a penile chancre and tested positive for syphilis with an RPR of 164. He also had rectal gonorrhea and chlamydia at that time. His HIV test was interestingly enough, negative at the time. But he also reported that since a year before, when he told us about the crystal meth use, he had upped his use of crystal meth, and he was part of a group of five men who would intermittently come to some tent in the middle of a public park, in a forested part of the park. And they would share crystal meth in exchange for sex. And he was going there twice a week. And he was in denial about crystal meth use being a problem. He also had a boyfriend who was also part of this group of young men coming to this tent, who he was involved in a domestic violence situation with the boyfriend. At the time, the best we could do was harm reduction counseling. And then his insurance somehow got deactivated and he couldn't refill his PrEP script at that time. And he was it was difficult to get him back in to work with him on getting the insurance reactivated but he showed up a month or so later, he was interested in restarting PrEP when we finally got his insurance turned back on, but he tested HIV positive at the time. So, there are so many barriers for this young guy. Although, since he tested positive, he stopped using drugs, he remains undetectable. His partner started on PrEP. He disclosed his HIV status. So, if you want to call that a silver lining, there's a little bit of it. But this was something that we were unable to address all of his barriers and these are things that we need to consider with young people.

22:54
Moving on to my second case. So, MH entered care in the clinic at age 13 and early 2018. She started in our HIV negative program for high-risk youth. She reported being sexually active from age 12. She had a history of poor relationship with her mother. And running away ACS became involved for neglect and abuse reports and family therapy was mandated. She did report having a series of monogamous relationship with older teenage boys between the ages of 17 and 19. And then during one of the periods where she ran away, she was engaged in survival sex for food and shelter. She takes, she was starting on oral contraception, she had poor adherence. And she was treated for gonorrhea and chlamydia after being sexually assaulted when she was 14 years old. And she got started on PEP post exposure prophylaxis and was referred for PrEP services at that time as well. She was a marijuana user at one point she was cutting herself she had some inpatient psych hospitalizations and she was actually reporting auditory and visual hallucinations. And she was discharged and then she had a psych decompensation before she could even enter outpatient psych follow up, she was readmitted a second time for a psych ward for a month that stabilized on fluoxetine, which remains on today. And she came back to the PrEP program after she was discharged and was able to access outpatient psychotherapy in the same clinic where she's receiving her PrEP. But now she's 17 years old. I have to say she showed up for a therapy appointment yesterday but forgot she had a PrEP visit with me but I know she's still taking it. But she's become strongly adherent to her visits. She takes her PrEP, she switched from oral contraceptives to injectable contraception, all within the PrEP program. She still lives with her mother. She's back in school. And she's actually brought her boyfriend into clinic when in December of last year, she tested positive for chlamydia. So, I'm going to stop there and see the rest of the time to Jeff Kwong.

25:33
All right, well, thank you so much Dr. Birnbaum. Hello, everybody, and thank you, again for, to CEI for allowing me to participate in today's conference. So, I'm going to take things from a slightly different angle and from the other end of the aging continuum or the life continuum. So, I'm going to start with just a quick case here. So, a 67-year-old cisgender female with a past medical history of hyperlipidemia, type II diabetes, hypertension. She has various medications as listed there. And she reports in terms of her social history. She consumes alcohol socially, apparently divorced and does report having sex with male partners only every once in a while. She has lab work done as part of her routine physical, and her HIV test comes back negative she has antibodies for Hepatitis B, syphilis test is negative. Her GFR is 79 and her cholesterol profile is noted there with an LDL of 98 and HDL of 39. So, I'm going to give you based on this history and this case profile. Just a quick little question here. And there is a polling opportunity here. So, which of the following would be recommended? she should be offered PrEP with monthly Cabotegravir, she should be informed about PrEP with TDF FTC. c) TAF/FTC is recommended because of her renal function. d) She is not a candidate for TDF/FTC because for diabetes and hypertension. The correct answer here is actually B. She should be informed about with TDF/FTC.

27:32
So, let's talk a little bit about PrEP and offering PEP. So, if you look at the newest guidelines, the most recent guidelines developed and released by the Centers for Disease Control, what

are the recommendations. In terms of informing and educating individuals about the availability of PrEP. The current guidelines do recommend that all sexually active adults, and adolescents should be informed about PrEP. So, there's there are no age limits here. Anybody who reports having any sexual activity, young adults, middle aged adult or older adults, should be at least informed about the availability of this biomedical intervention. In terms of offering it really simplified, who should be offered PrEP. The new guideline says anybody who asks for it. So, when we think about older adults specifically, we know that in terms of new HIV infections, in general, which were covered throughout your different conferences today in Dr. Birnbaum presentation earlier, we know that the bulk of new HIV infections are occurring in younger adults, typically those under 25. However, it's important to realize that about a quarter percent of the new infections are occurring in people 50 years or older. So, although the bulk of new infections are currently in younger adults, there's still a percentage of people who are becoming infected or acquiring HIV over the age of 50. And so that is something to be cognizant of when we're thinking about prevention. Now, the great thing is when we look at trends in terms of PrEP use in individuals over 50. We see that in New York State, the number of PrEP prescriptions in this age population 50 to 59, has increased nicely over the last six years or so. And if we look at those 60 and over, we also see a rise in uptake as well. So, we are seeing trends or shifts towards increased uptake in persons over 50. But I think we still have more to go. Now when we know, when we think about the options for PrEP this too much but we know that there are two FDA approved oral formulations as well as the injectable option. And we know that there are pluses and minuses for each of these options. Some options such as TDF/FTC may be limited by renal function. Some options may increase or result in increased lipids, weight gain issues and so. Although there are benefits, there are also things that we need to consider in terms of potential side effects. And when we think about consider use of medications, such as PrEP, we need to really think about the context of older adults and the different issues that are important to consider in providing comprehensive care. And one of the things that comes up, really, when we think about care of older adults is the issue of comorbidities. And so, I think, although comorbidities are important across age, and they really play a significant role in aging individuals, and just in general for the nature of chronic disease, we know that as people age, we do see just a rise of comorbidities, such as renal disease, such as cardiovascular disease, which can play a role in terms of which PrEP options may or may not be appropriate. Additionally, we know that issues such as side effects, adherence play a role. But also, polypharmacy is a significant issue, especially in the setting of older adults who may be taking other concurrent medications to help manage their comorbidities. We know that as people add more medications to their regimens, there's the risk of drug-drug interactions, as well as increasing the risk for non-adherence.

31:31
But let's take a look for a moment when we think about the data. So, we know that these are FDA approved options, right? We have two oral formulations one injectable option. We talked about evidence-based medicine, but when we think about the data, specifically in older individuals, and here when I say older individuals, I will say 50 years or older, you know, what is the data and what information has been made available? Well, this is a list I put on here, the left-hand side all of the major registrational trials for the different TDF FTC, TAF FTC and Cabotegravir, and you can see here that the percentage of the patient population in this

registration older is relatively small. So, in some of the earlier studies with both the iPREX products, and in the DISCOVER trials, that's with the TDF FTC, and the TAF FTC, you can see here, very small percentage up to 11% of people were 40 years or older. In the DISCOVER trial, the mean age was in their 40s. Some of the newer trials such as HPTN 083 and o84 for trials, which are the cabotegravir trials, do handle combinations for older adults, but the boy through 083 trial 0.3% of individuals for 60 years or older, and the HPTN 084 for trial, which is the trial in cisgender women, the upper age limit was 45, though. So, you know, when we think about how much data and evidence is there available, there really is just a very limited amount. And I think that's one of the things that we need to consider or potentially look at further as we move forward in terms of real-world use of Pre-Exposure Prophylaxis. Now there have been a couple of studies. One, this is just a small report out of the VA, looking at in their patient population, PEP use in patients 45 and older, and again, the percentage was relatively small, mostly males.

33:38

And you can see just in terms of things such as renal issues or other complications, that really there was not a significant change in GFR proteinuria between baseline and more than three months for these individuals. Again, this was a very small sample size. We know in terms of the benefits, so what are the true benefits with regards to say the oral options of TAF FTC versus TDF FTC. This is information from the Discover trial showing that yes, indeed, we know that TAF FTC, a little less renal impact than TDF FTC. Other, this is a systematic review looking at the overall decline and renal function on people using TDF FTC. And one of the biggest factors in this analysis are people experiencing changes in renal function was age so 50 years or older was associated with a higher incidence of Creatinine clearance changes. So, what are the guidelines recommendations for renal monitoring in the setting of PrEP? This is again from the 2021 CDC guidelines which states that you should at least get baseline creatinine clearance. And then at least every six months for people 50 years or older, whose baseline GFR is less than nine, right? What about bone mineral density changes, this is something also that has been well documented in terms of a less bone mineral density changes in people who use TAF FTC versus TDF FTC. The important thing here is to note that although there are changes in bone mineral density, there were no differences in terms of fragility fractures. So, that's important to know with regards to this situation. But what are the recommendations in terms of monitoring patients who may be at risk for osteopenia or may who may have osteopenia or osteoporosis. So, DEXA scans are not recommended before the initiation of PrEP. If somebody has a fragility fracture or risk of osteoporosis, then they should be referred, quote, unquote, for consultations is according again to the guidelines. I think it's really a case-by-case basis in terms of clinical decision making of whether or not to incorporate or use DEXA scanning as a means of monitoring patients who may be older who may be at risk for potentially fractures or osteoporosis injury. And just a brief review or refresher here, you know, what are some of the risk factors for osteopenia, osteoporosis, thinning of the bone or right pendula. So, being postmenopausal long term, corticosteroid use, Vitamin D deficiency, some inflammatory conditions use of PPIs. And some other chronic conditions such as congestive heart failure, liver disease and renal disease, all can contribute to osteopenia, osteoporosis. And so, in our older adult patients who may have any of these risk factors or other concurrent conditions, it's important to consider and use that as part of your clinical decision making. What about metabolic changes? Well, we know that TAF FTC, for compared to TDF FTC, we do see some

changes in terms of cholesterol and we know that atherosclerotic heart disease, one of the major leading causes of chronic disease in adults, regardless of HIV status, or other things, one of the biggest causes of chronic disease in morbidity and mortality is CVD, right CVD issues cardiovascular disease issues. So, we know that, indeed people who have or are on TAF may experience some changes in their lipid profile, in terms of increases in their triglycerides and potentially increases in their LDL, as well. So, what are the recommendations for monitoring on patients with regards to lipid so all persons prescribed TAF FDC for PrEP should have their triglycerides and cholesterol levels measured at least annually, so every 12 months, and statins should be prescribed if indicated. So again, you wouldn't base that on some of these ACC ha risk score, if they would benefit from a statin.

38:18

Now, I know in our case study, we had a situation where it was a 60s 60 plus year old cisgender woman. So, what is the data or what information is there on regards to use of TDF FTC and postmenopausal women? Well, there isn't a lot of data, but there was one study looking at postmenopausal explants, tissue explants, and they found that the active metabolite of tenofovir was more than nine-fold lower in postmenopausal explants compared to pre-menopausal so when we think about protection, again, this is the issue of, do we have enough data in older adults? This is something that I think needs to be explored further, so in fact, you know, when we think about protection in the cervical vaginal lining, for postmenopausal women, are they getting sufficient levels of TDF in those tissues? So, you know, based on this probably not, but again, we don't have enough data to say, do we need to make any changes, but something again to consider as you move forward. I talked a little bit about polypharmacy as an issue when we think about care for older adults. And we know that polypharmacy can lead to things such as non-adherence, but there are also other things as well. So, there's data that shows that, like pharmacy increases the risk for unintentional falls, drug-drug interactions, and ultimately The increased mortality as well. So, how can you address polypharmacy? Well, you know, TAF FTC TDF FTC both one time what once a day? Well, we do have non pill options, right? So, there are there's Cabotegravir. So, this is something where you might say, Oh, well for some individuals where polypharmacy is an issue, maybe an injectable or long-acting option is something to consider. And here you can see in terms of side effects and have Cabotegravir versus the comparator arm of TDF FTC that some of the most common side effects of cabotegravir are typically injection site reaction on changes in creatinine and not significant for are significantly different in these situations. However, I know this was covered in the previous session. Right before this one we're talking about cabotegravir. But some of the changes that we do see because of cabotegravir being an integrase inhibitor, we know that one of the side effects is weight gain. So, there was differential weight gain in the 083 versus 084 trial, there was about two kilograms seen in the 083 trial, which was in men have sex with men and transgender women. For cisgender women, there was about a four-kilogram weight change. Also, some changes in cholesterol, as noted here. So, again, you know, we think about pros and cons, these are all things that we need to think about when deciding on what's the best, what are the best options to offer, our patients who are over 50.

41:42

Now, one of the other things that we think about when we think about older adults, and HIV and STI risk is, is just in terms of protection. So, this is a great campaign, believe this is through a Korea, it is not a condom when we think about barrier use and protective barriers between individuals who may engage in vaginal, you know, vaginal - anal, penis-anal sex, right. We know that in terms of older adults, that STI infections are much higher in 60, in person 65 and older, and that those rates of STIs especially cases of syphilis and gonorrhea, increasing dramatically in this population. But, you know, when we think about HIV prevention, what are some of the barriers? Well, there are multiple barriers that come up in terms of having patients who may benefit from PrEP, from getting them, from getting PrEP. So, some of these barriers include the providers just don't talk about sex. There's this stigma of, of sex in itself in terms of older adults, there's stigma associated with HIV, there's a stigma associated with STIs, that all sort of play a role in terms of access, and uptake of PrEP in this population. There's, again, lack of knowledge, patients may not be aware that this is an option that's available to them, they may see it or view it as something for younger people, or for hetero men, or for populations other than themselves. And so, there's this misconception about risk. There's also when we think about HIV prevention, and just STI prevention in general, with older adults, their issues and concerns about insurance cost, and also physical challenges of just having mobility and issues with function that may cause or be a barrier in terms of prevention. And when we think about older adults, and sex, so this is just a study or survey that was done among older adults, and they did find that actually, adults 65 to 80, about 1000, people who are part of this survey, did report having sexual activity. So, about a third of the women and more than half of men recorded being sexually active on a regular basis. And in terms of talking about sex, this is one of the things that came up, which I think is an important message for all of us on this call, or on this conference, which is that 17% of older adults talk about sex with a health care provider. However, of those people who actually had the opportunity to have a conversation about sex, more than half of the discussions had to be initiated by the patients themselves because the providers just didn't talk about it. So, you know, when we think about talking about sex, talking about HIV prevention, it's really important for us to normalize this conversation and really make it part of routine primary care. The other thing that I think might help facilitate that discussion is when we think about testing. And, you know, I really must applaud New York State for modifying and changing the language in terms of testing recommendations. If you look at the USPSTF for the US Preventive Services, Task Force recommendations for testing, they do put an age bracket or age limitation here 15 to 65. And in New York state, if you're not aware, the way that our language is written, it says that routine opt-out testing should be offered to individuals 13 years or older. So, in 2017, that upper age limit was removed. And I think that really helps open up the thinking of providers to think Oh, yes, you know, somebody who's sitting in front of me, who's 66, 67, 68, 75. This is something that we should be offering as part of routine primary care.

45:59

But what are some of the other conditions or some of the other factors that come up in terms of sex and prevention and considerations for older adults, it's the psychosocial issues. So, we know that ageism is something that is pervasive in our culture, in many different facets of the way that we interact, and we care for and treat and communicate with our older adults, patients or older adults in general. And, you know, this is something that has many lasting, or long-

lasting impacts on someone's ability have an interpretation of themselves, of them of themselves as a sexual being. And I think that's something that we need to really think about and address, as we think about providing care for our older adult populations. We also know that individuals who may be LGBTQ identified as an older adult, may have other issues layered on top of ageism issues. And it, the you know, there is a lack of providers who have a sensitivity to care for and recognize the needs of those of the LGBTQ population and something that I think we really need to make greater efforts at in terms of making care accessible.

47:28
One of the big issues that comes up both the younger or youth spectrum, the issue of payment and access, well, the same issues come up for older adults. But the good thing is that Medicare, Medicaid, and most private insurance plans cover PrEP, and there are assistance programs that are available for people without insurance. So, just to close out and make sure we have some time for questions, just some key points here. HIV infection remains an issue for older adults, clinicians should consider not only comorbidities, but other psychosocial issues when prescribing PrEP, and normalizing conversations about sexual health should be a part of routine care for older adults. And here's some resources if you aren't familiar with the great SAGE is an organization, their home bases here in New York City, but they have affiliate affiliates across the United States. And they are a wonderful resource for LGBTQ older adults. They provide support groups, sexual wellness groups, PrEP seminars, case management options, social events. And there's also the GMHC hotline, as well as for people in New York City or for individuals in New York City or there is a program called service program for older people or spot which provides mental health services and other care management services for older adults, and they are an organization that is very LGBTQ affirming. So, that's a great opportunity or resource as well for people in this area. So, that is conclusion. I think we have time for some questions. I'm going to stop sharing my screen.

49:23
We do, yes! And we have some comments here in the chat box about how in Florida parental consent is a huge barrier for minors and PrEP. And this person has found that cover my meds is a very helpful site. However, they've not used it for cabotegravir, only oral PrEP. And also, Ready Set PrEP is an excellent resource for uninsured folks. And it's very easy to use. So, thank you for that information. Yeah, so yeah, we can open it up to any questions at this time or our audience.

50:01
There was a question from an earlier presentation that I think could apply here as well, and it was, what happens if you are talking with the person or the patient, and either, you know, you, as the clinician realize that PrEP might be right for them, but they're kind of like in denial about it. Could you either speak to if you've ever had a patient like that, where, you know, their values, maybe are at odds with what you're feeling on that issue?

50:32
Want to go first? Or?

50:34
Sure. So, you know, I think it's, it's one of those things where, how I might handle that situation, you know, try to use some of the mode of motivational interviewing techniques or strategies to sort of get them to, you know, articulate some rationale or reasoning that, to help them sort of see that, yes, maybe this is a benefit. But, you know, I think, what I'll say or, you know, sometimes what I'll do is that people go, Well, that's not right. For me, well, I'm like, Well, alright, well, you know, I just want to share this information with you. And, you know, it may not may not be right for you right now, but you might be able to use it in the future, or somebody else might be could benefit from this information. And what I'll do is, I'll, you know, I'll bring it up every time just to see, you know, check in see how they're doing, but sometimes it'll move the needle or hit you have to sort of start where the patient is, but yeah,

51:39
I would say that it's kind of routine with adolescents. You know, there's not always a connection between cause and effect. And, you know, their thinking may not be abstract thinking about some things down the line that might happen to them. It's like that, you know, with contraception, well, I can't get pregnant, it hasn't happened yet. And things like that. So, you know, I just think it's important, not only to use some of the techniques that Jeff said, but even equally as important, if not more important, just keeping them in care, keeping them in the door, so that you can have just general conversations about health and finding the opportunities to, you know, use things like motivational interviewing, but it's with young people and the way that they engage with care, it's, it's just getting them to show up. And to be able to have a general conversation about them before you start getting into specific techniques.

53:03
We have a question here for Dr. Kwong. Do you see the same potential applications of injectable PrEP for older adults as for younger adults and adolescents?

53:13
Guys, do I see Sorry?

53:15
It's in the Q&A chat down at the bottom, if you want to read it, it says potential applications of injectable PrEP for older adults as younger adults.

53:28
Yeah, you know, again, I think, in terms of for injectable, PrEP options for older adults, you know, they're the same issues of needing to come in to the clinic to get the medication, which, you know, as I tried to allude to, in my presentation, every formulation, or every option of PrEP is it has its pros and cons. So, you know, for an older adult, it may not necessarily be that they have issues with, you know, keeping their appointments, because they have, you know, multiple things that they can't remember their, you know, their appointments or whatever. But I mean, it could be something as simple as mobility issues and transportation issues to the to getting to a clinic every two months, and maybe that's just not as a feasible option for somebody who, you know, needs and needs extra assistance, just in terms of transportation, or are those things but

I don't, but you know, but for somebody who has issues with, you know, taking pills or they can't open the pill bottle or they can't, you know, manipulate, manipulate things with fine, fine motor movements, and yes and injectable options, fantastic, because they don't have to worry about it. So, I don't know. Don't answer the question.

54:56
I believe so. Yes. And there is another question here for you Dr Kwong around, it says there was you mentioned that there's an increase in STI is among the older population, I would think that older folks would have less risky sexual behaviors. You may have mentioned this during the presentation, so forgive me if I missed it. But can you please speak to what may be the reason for this increase in STIs?

55:19
Sure, so part of the reason why we're seeing or why there is a rise in STIs is because when we think about, you know, ways to prevent STIs barrier methods come up as our, our recommended way to help prevent or reduce STI, STI transmission. And older adults may not necessarily use barrier methods, because in for heterosexual individuals, we typically think of barrier methods as a means of preventing consumption, but may not be relevant for somebody who, you know, is older, so they don't think why need to use a barrier. method. So, then they don't, everything is, again, because people don't talk about sex people, we know that many STDs are asymptomatic, and people can be passing, transmitting STIs asymptomatically. And if their providers and talk to them about it, or they may not necessarily be aware that they have, you know, Chlamydia or gonorrhea, then it can be transmitted that way.

56:32
So, there's a significant focus on socio economic barriers to PrEP. But we know administrative barriers exist everywhere. What are those the decreased access to PrEP? And how can we address them?

56:45
Yeah, I think. And this wouldn't be unique to adolescents but some of the issues, in particular around the injectables, I could focus on that, again, I've just had to learn by trial and error, just seems like it's unbelievable myriad of administrative barriers to accessing the medication. Separate from some of the logistical issues, storage and delivery and things like that. The way I've addressed on that front, is just by trial and error, having to learn the rules of all the different types of coverage. And that each one follows a different set of rules. And having to figure out the difference between a medical benefit and a pharmacy benefit on someone's plan, and developing relationships with pharmacists that both in house at my hospital, there's an inpatient pharmacy, and then there's an outpatient pharmacy and developing relationships with them to try and smooth out some of those administrative barriers and really learning from them that what these barriers are and how to get around them. The other place, I can't I mean, I kind of railed on, on, on all the prior authorization issues before but I'll repeat, do away with them, the world would be a better place. And I don't think we're saving any money by putting those prior offs in place. What we're doing, every time I yell at someone from an insurance company on the phone, I said, you're killing people with HIV every time they say, Well, you know, they, this guy's

a madman. But the other area where it's important to address with youth specifically, is how to deal again, it's insurance. So, it's administrative, but how to learn to navigate around how to access parent's insurance information when the minor can't get it, get to it without saying Hey, Mom, can I have the insurance card and I'm having sex without your knowledge. Oh, by the way, I'm gay also. Those are not easy conversations, or impossible conversations. So, learning some of the ways around to get that information without having to put the minor in the path of you know, such a difficult situation. And there are ways to do it. You just have to learn them as you go along that those are actually barriers and one of the pasts around them. So, I don't know, Jeff, whether you have your own things to add to that.

59:56
No, you said it perfectly. You know, I would say the PA process, their prior approval process is the biggest challenge. And you know, I mean, this just happened today, actually. One of our patients was starting or trying to start on Cabotegravir. Paperwork went in, I think it was second week of May and we got it approved in finally, but it took until now. So, you know, that's a long time. So anyway.

1:00:39
Thank you once again to both doctors Jeffery Birnbaum and Dr. Jeffrey Kwong.
[End]