Transcript Details

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Bringing Injectable Treatment to HIV Patients in Atlanta

Dr. Cheeley:

Preexposure prophylaxis, or PrEP, is a safe and effective medication that can help prevent HIV, but unfortunately, inequities to medication access still exist. So to help address this gap, clinicians at Emory University have built a new program to bring PrEP to more patients in the Atlanta area, which is what we're going to talk about today on our program.

Welcome to *Clinician's Roundtable* on ReachMD. I'm your host, Dr. Mary Katherine Cheeley, and joining me today is Dr. Dylan Baker, who is an assistant professor of medicine at Emory University and the associate medical director of the Grady PrEP Clinic.

Dr. Baker, thanks for joining me.

Dr. Baker:

Thank you so much for having me, Dr. Cheeley.

Dr. Cheeley:

Let's jump right in. So I have the distinct pleasure of helping you guys with our PrEP program at Grady. Tell me that transition that we went through when we went from just using tablets for PrEP to now incorporating the injectable therapy.

Dr. Baker:

Yeah. So this program was started about five years ago by my colleague, Dr. Meredith Lora, who's the medical director of the program, and we had been doing oral PrEP for about four years with the addition of an opportunity to do injectable PrEP, which was FDA approved, we were able to start thinking about how we would incorporate an injectable option for our patients into our program.

Our program for the oral side is very much asynchronous, so we're able to do visits on the go with patients, sending them questionnaires to fill out, refilling their meds without necessarily having to call them, and providing an experience that meets the patient where they're at, delivering the exact care that they need in that moment. Obviously, with injectable PrEP, we need a space to do it, we need the medication in hand, we need the staff on-site, so that presented a very different challenge in terms of how to deliver PrEP seamlessly for our patients.

Dr. Cheeley:

Tell me a little bit more about the stigmas that are associated with the oral medication in particular and if this having a long-acting injectable helps with that in making sure that we get more drugs to more patients.

Dr. Baker:

Yeah, so it's not uncommon when I'm having a first discussion about PrEP with a patient that they ask questions, like "Well, does this mean that I have HIV?" Or "Will this medication give me HIV?" Or "What if someone finds the medicine and thinks that I have HIV?" So I think any medicine that you take, patients interpret what that means in very different ways, and it's important to really get at the heart of exactly how they view the therapy in order to make sure that we're counseling them appropriately about what it means to be on PrEP and how it can help them in their lives. So incorporating injectable PrEP is really important for patients who feel stigma with an oral option because they're able to come to appointments on their own time. And then between appointments, between those two months when the medication is active in their system and protecting them from HIV, they're living their normal life, not having to worry about taking a medicine every day, not having to worry about forgetting it while they go on a trip, not having to worry about did they take it before going out on a Friday night and having fun with their friends, so it really presents an opportunity to have medication readily accessible at all times.

Dr. Cheeley:
To those of you listening, we talked about this for a really long time before we actually figured out how to do it—was what happens if patients have difficulty getting to us? Have you guys realized that in the program? What have we done to make sure that folks are staying engaged in care with the injectable option?

Dr. Baker:
Yeah. So when we present the opportunity to get on the injectable PrEP, we definitely have a long conversation with patients about what it looks like for them to come into the clinic every other month. Do they have transportation barriers? Do we need to help with bus fares? Do we need to work with their schedule if they're traveling? And so making sure that we have that conversation up front to figure out how we can best support them in coming to appointments is really important at the outset.

Dr. Cheeley:
What kind of challenges have we had so far with the injectable therapy?

Dr. Baker:
I think a lot of the anxieties that we had at the start are not necessarily the ones that we're encountering. So we thought that we would have a lot of trouble with patients missing appointments, with patients falling out of care, but we find that once patients start the program, we schedule their appointments out a year in advance; they know what their appointments are; we have navigators that remind them of when the appointments are, so we're not having as many patients falling out of care. We're also not having as many patients having side effects as we thought we would have. We have about 54 patients on the therapy now, and we've only had one patient drop out because of bad side effects at this point in time, which is less than we expected, which is great news.

Some of the things that we are experiencing is just how to incorporate this program within the complexities of our current healthcare system with different modes of insurance, different ways of getting reimbursed for the medicine, and how to really integrate it into a large hospital system, into current processes because the process is different than regular visits.

Dr. Cheeley:
So let's take, like 10 steps backwards, and talk about how we lay the groundwork for this. So I feel like oral therapy for PrEP people understand. It's very similar to other processes that we have. But what did the team do to try to build this long injectable cabotegravir program? Who did we engage? What kind of buy-in did we need to get from our health system?

Dr. Baker:
Yeah. So we have a great team that we've put together. I mentioned Dr. Lora, our medical director. We have a program manager. We have a medication access coordinator who helps us secure the medicine. We have a dedicated nurse practitioner, two navigators now that help us. We have a nurse on-site to help give the injections. And so we really need to assemble a full team, especially with the navigational and medication access support in order to make this happen. From there, it was important to identify all of the leaders in their respective areas, so what that looks like is working with nursing leadership to make sure that our nursing protocol was acceptable and could be implemented seamlessly. I'm working with our front desk leadership to make sure that appointment scheduling was appropriate, working with our IT leadership to build the referral program to make sure that the medication can be paid for, working with our pharmacy leadership to make sure that we know exactly how to procure the medicine, how to store it, how to deliver it to the clinic from our medication storeroom, and how to get reimbursed for the medicine. And so identifying all of these key people early on and having meetings early on to get this off the ground was really important. We met for about six months prior to actually doing our first injection just to make sure implementation was smooth.

Dr. Cheeley:
For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Dr. Mary Katherine Cheeley, and I'm speaking with Dr. Dylan Baker about the use of PrEP for HIV.

So, Dr. Baker, you mentioned before about the challenges that we're having, and I think that it's really interesting that what we planned for is not exactly the challenges that we're experiencing. And you mentioned the different insurance landscape, and I think that's something that probably our listeners also feel deeply is just that dichotomy of—I*s it paid for by the pharmacy benefit? Is it paid for by the medical benefit? How do we procure it? Is it buy and bill through the clinic versus is it something that the patient brings in with them* —Can you speak a little bit to that piece? Because I think that's probably the one that frustrates us most as providers.

Dr. Baker:
Definitely. There's two ways of paying for the medicine—pharmacy benefit where we're able to fill it at the pharmacy ahead of time, pharmacy bills the patient's insurance, and then when we inject. We don't bill directly to patient's insurance, medical benefit, we buy the medicine ahead of time, we inject the patient, and then bill for it afterwards.

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The pharmacy benefit does pose a lot less trouble to procure the medicine. We're able to send the medicine to the pharmacy if it's covered under that patient's plan, the prior-auths are a little bit more straightforward, and we're able to get that medicine with a lot less effort so far. There's also patient assistance through ViiV, and we're able to get patients on patient assistance quite easily as well.

For the medical benefit, this is where there's a lot more risk involved for our clinic, because we have to buy the medicine beforehand and make sure we get reimbursed for it afterwards. We also need to involve different teams within the hospital to make sure that it's reimbursed, specifically, our billing department. And so the interlay between the billing department and our clinic has been what's been most challenging. I'm creating a process with IT where we seamlessly send the patient's information to our billing department once we've ordered medicine for them to review, and then send back to us if it's approved through medical or if we need to go through pharmacy. So if we're told that we need to go through pharmacy, we need a process within the IT sphere in order to start the pharmacy process afterwards without having to send back-and-forth e-mails for each patient.

And so that IT interlay has been most challenging on getting this off the ground, and we're looking forward to having it completed in the next month or so in order to get more patients on cabotegravir.

Dr. Cheeley:
Let me just put an exclamation point on that. You would think it's a straight-line process that you order the drug, we see if it's done by the medical side, so will the medical benefit pay for it? We get a denial, and then we say, "Oh, well let's figure out where it can be paid for." It's not a straight line. It's easy to just send an e-mail to someone and say, "Oh, hey, this isn't approved," but that then takes you out of the health record. And as we grow this program to where we want it to be 1,500, 2,000 patients that becomes less and less practical, so that keeping it all within one system is what I think you guys have done an incredible job at doing, and I really commend you guys for making sure that we're staying within one sphere so that we don't have all of these offshoots going in different directions.

What do you see as the future of PrEP in the city of Atlanta?

Dr. Baker:
So right now rates of PrEP uptake in New York City and San Francisco are over a thousand per 100,000 residents. In Atlanta we're currently at about 500 or so. That's about half of what they're at in terms of their rates. They're seeing a precipitous drop-off in their rates of new HIV diagnoses, and I truly believe that high PrEP uptake is one of the ways that they are doing that, so I hope that we can continue to increase access of PrEP in the Atlanta area, get as many patients on PrEP as possible who are at risk of contracting HIV, and reduce our incidence of HIV in this city.

As many of our listeners probably know, Atlanta is at the epicenter of the HIV epidemic. Fulton County has about two percent of its population living with HIV currently, and Georgia has the highest rate of new HIV diagnoses out of any state in the country, and so it's imperative that we make this change now, make this medication more accessible now in order to save future generations from living with HIV.

Dr. Cheeley:
This has been such a fun discussion. I love building this program with you guys and watching you grow. Thank you so much for being here. Thank you for all of the work that you do with PrEP and making sure that our patients get these drugs and making sure that they have access to them. I think that is huge. So thank you to my guest, Dr. Dylan Baker. It was a pleasure hanging out with you today.

Dr. Baker:
Thank you so much, Dr. Cheeley. We really couldn't do it without you, and it's been very fun.

Dr. Cheeley:
For ReachMD, I'm Dr. Mary Katherine Cheeley. To access this and other episodes in our series, visit ReachMD.com/CliniciansRoundtable where you can Be Part of the Knowledge. Thanks for listening.

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