Editorials

Implementing HIV PrEP in Routine Practice

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HIV continues to have an impact globally. An estimated 1.2 million people in the United States are living with HIV, and there are 38,000 new cases of HIV each year, which has not decreased in the past decade.[1] This is despite the U.S. Food and Drug Administration's approval of oral tenofovir/emtricitabine (Truvada) in 2012 for preexposure prophylaxis (PrEP). It has been shown to be highly effective for preventing HIV acquisition, with an overall relative risk of 0.46 compared with placebo and a lower relative risk of 0.27 in those with 70% or greater adherence.[2] Accordingly, the U.S. Preventive Services Task Force (USPSTF) recommends that physicians offer PrEP to people at high risk of HIV acquisition (grade A recommendation).[2,3] Recent approval of oral tenofovir alafenamide/emtricitabine (Descovy) and injectable cabotegravir (Apretude) has expanded options for HIV prevention.

The Centers for Disease Control and Prevention estimates that only 25% of the 1.2 million people who could have benefited from PrEP received it in 2020.[4] The 2019 initiative, Ending the HIV Epidemic: A Plan for America, set a goal of reducing new infections in the United States by at least 90% by 2030; PrEP use by 50% of those at risk is a key component of this plan.[1] Yet, prescribing rates remain low and are not adequately reaching populations at the greatest risk of HIV acquisition. Although Black and Hispanic patients are disproportionately affected by HIV, they are less likely to be aware of or take PrEP compared with White men who have sex with men.[5] Family physicians are ideally positioned to prevent HIV, improve access to PrEP, and address current health inequities.

One of the first steps in understanding the health needs of our patients is routinely asking for a detailed sexual history that is open and affirming.[6] These conversations are opportunities to eliminate inaccurate assumptions about HIV transmission risk and combat continued stigma related to HIV, intravenous drug use, and various sexual practices. However, despite patients indicating a preference for their physicians to routinely initiate conversations about sexual health, studies show that patients bring up PrEP more often than their physicians.[7-9] This may be due to the physician's lack of knowledge, discomfort, or biases regarding sexual practices and terminology, and may be mitigated by a self-assessment to identify specific knowledge deficits and implicit biases and training on current sexual terminiology.[6] The sexual history of older and established patients, in particular, is more likely to not be consistently obtained or updated.[7] Routinely asking brief, nonjudgmental, open-ended questions can help normalize inclusion of this important aspect of health.

Access to physicians who prescribe PrEP, the need for frequent visits, and cost can be significant barriers to PrEP.[10] Fortunately, the USPSTF grade A recommendation necessitates insurance coverage of medication costs and associated laboratory testing and clinical services. The Centers for Disease Control and Prevention also provides resources for those who are uninsured or underinsured.[11]

Since the FDA approval of PrEP medications, a number of excellent resources on safe PrEP prescribing have been produced, including articles in *American Family Physician*.[3,12-18] In a recent survey of 134 primary care physicians, respondents self-reported high overall knowledge of PrEP, and most thought it was safe and effective.[9] However, respondents reported that they had less specific knowledge of adverse effects, baseline laboratory testing, and ongoing laboratory safety monitoring, which are key pieces and potential barriers to PrEP implementation.

It is time to move beyond training and resources that focus solely on physician attitudes and knowledge and design system-level solutions to current inefficiencies and inequities in delivery of care. Potential solutions include electronic health record (EHR) tools, local champions, and community resources.

A recent study showed that an EHR order set was the most important facilitator for PrEP prescribing, and another study showed an increase in PrEP prescribing in primary care when an EHR template was combined with education.[9,19] Because

family physicians do not have enough hours in the day to address all the recommended preventive health services with patients, EHR templates and order sets can streamline guideline-based care and promote patient adherence and retention.[20] Improved access to physician champions who guide PrEP initiation and handle more complex management and clinical pharmacists who track medication adherence and assist with medication counseling has also been proposed.[9] In addition, identifying and collaborating with local organizations (e.g., LGBTQ+ centers, sexually transmitted infection testing sites, addiction treatment centers, after-school programs) that serve at-risk populations who do not routinely seek traditional medical services is key to addressing health inequity.

As we strive to end the HIV epidemic and implement the USPSTF recommendation to offer PrEP to all people who are at high risk of HIV acquisition, family physicians should consider how patients can best initiate and adhere to treatment. Once PrEP is started, we can anticipate barriers to adherence. For example, scheduled office visits in a busy physician practice may not be the preferred way to get laboratory tests and medication refills, particularly for young, healthy patients. At the first visit, it can be helpful to review local testing options, consider standing laboratory orders, determine frequency of office visits, and discuss the ways that patients can best communicate barriers to care or obtaining refills. What feasible, systems-based solutions might make a difference in your area to promote a patient-centered approach for the prevention and eradication of HIV?

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