HIV + COVID Screening & Testing Model

Screening for Preexposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP) for the Prevention of HIV Transmission in the United States, 2021 Guidelines: Policy Background and Recommendations

Abigail Konopasky, Maranda C. Ward, Leah Hoey, Patrick G. Corr

Background

Pre-exposure Prophylaxis (PrEP)

The Centers for Disease Control and Prevention's (CDC) 2021 guide recommends routinely taking a sexual history and **informing all adolescents and adults** who are sexually active or use intravenous drugs about daily use of PrEP and **recommending** it to **those with substantial risk** to help prevent HIV infection. Screening can occur virtually (e.g., phone- or web-based consultations with clinicians).[1]

Post-exposure Prophylaxis (PEP)

The CDC's 2016 guide recommends use of PEP within 72 hours for anyone who has been exposed to HIV to help prevent HIV transmission.[2]

This policy brief reviews current definitions of PrEP and PEP **screening**, outlines the **problems** with current practice around PrEP and PEP screening, and offers specific **policy recommendations** for addressing these problems.

Policy Recommendations

- Licensing bodies should require clinician training
- Insurance compaines should create new billing codes
- Clarify and expand the definition of screening
- Require more frequent discussions with patients
- Include resources for clinicians on not stigmatizing patients

PrEP and PEP Screening, Defined

For PrEP, HHS and the CDC recommend clinicians **initiate a conversation** around HIV transmission in order to determine whether patients have "substantial risk": a sexual partner who is HIV positive, a recent sexually transmitted infection, history of inconsistent condom use, or

School of Medicine & Health Sciences
THE GEORGE WASHINGTON UNIVERSITY

sharing drug injection equipment. If substantial, the next step is to perform a **diagnostic** test for HIV and, if negative, to **recommend** PrEP.

PEP guidance describes how patients must seek care **within 72 hours** of exposure.

A stakeholder group including primary care practitioners (PCPs), policy experts, public health practitioners, and academics vetted the following policy recommendations which address existing problems with the PrEP/PEP Screening Guidelines.

Policy Gaps	Recommendations
PrEP Screening	
• Many clinicians are **hesitant to prescribe PrEP** with only 28% reporting sufficient familiarity with PrEP to recommend it to their patients.[3]	• Licensing bodies for clinicians (e.g., state medical boards) must **require PrEP training/ CME coursework** to inform clinicians about changing guidelines, PrEP indication, and patient counseling skills. **Training programs** must teach sexual history taking (see GOALS framework). • Insurance companies should create an **ICD-10 code, CPT code,** and other **billing codes** for PrEP screening.
• The PrEP guidelines recommend "routinely" taking a sexual history, but there is no **concrete recommendation for how frequently clinicians should be talking about PrEP** and clinicians are already **overwhelmed** by annual visit tasks.	• In order to decrease HIV stigma and transmission, the CDC should create guidelines making annual **consideration of PrEP part of value-based care guidelines,** perhaps through an electronic medical record (EMR) prompt.
PEP Screening	
• PEP is time-sensitive (i.e., a 72-hour window), yet the guidance seems to leave it **up to the patient to initiate the discussion.**	• Licensing bodies for clinicians must **require PEP training**, so clinicians initiate the discussion. • The CDC should create **guidelines recommending annual discussions of PEP** and clinicians should disseminate this information so all patients are aware of it. • Insurance companies should create an **ICD-10 code, CPT code,** and other **billing codes** for PEP screening

Policy Gaps and Recommendations for Both PrEP & PEP Screening Guidelines

Gap 1: Clarify Definition of Screening

The **CDC guidelines do not offer a clear definition of screening**, sometimes using it to mean HIV or other STI testing and, other times, conversations with patients.

Recommendation 1: Use Our Definition

CDC guidelines should **use our screening definition:** Drawing from the guidelines (which do not have an explicit definition of screening), we define PrEP and PEP screening as clinicians: (1) **informing** patients about PrEP and PEP, (2) **asking about** sexual activity or intravenous drug use, (3) **asking about** "substantial risk" factors like partners who are HIV-positive or shared injection equipment, (4) **assessing** for signs of living with HIV infection, (5) offering a **diagnostic test** for HIV.

Gap 2: No Support for Conversations

PrEP and PEP screening (defined above) are complex, yet the 2021 CDC **guidelines do not offer clarity or support on navigating screening conversations.**

Racial, ethnic, sexual, and gender minoritized patients are disproportionately affected by HIV and experience more microaggressions from their clinicians, yet the **CDC guidelines do not offer resources for adapting screening conversations for these patient populations.**

Recommendation 2: Include Resources

Due to the multiple actions asked of clinicians when screening for PrEP/PEP, the CDC guidelines should **include resources**, not just for information to be gathered, but also **for *how* to engage with patients to collect that information and support them** through the screening process, such as the From Risk to Reasons guide.

CDC guidelines should **offer resources** such as our CME bearing culturally responsive communication model and training.

Gap 3: Clinicians Screening Some Patients Disproportionately

Many clinicians are **unaware of the updated CDC guidelines** and perhaps are still influenced by the former guidelines that specifically call out populations like "men who have sex with men" or "transgender persons."[4] Nevertheless, they are **(a) not screening more broadly and (b) still screening some patient groups disproportionately.**

While better, the new guidelines are stigmatizing because they still **distinguish between "high prevalence groups or communities" and others,** even though this distinction does not guide care recommendations.

Recommendation 3: Help Clinicians Screen Broadly

Clinicians must not continue to stigmatize minoritized patients. Instead, CDC guidelines **should provide resources** like our culturally responsive communication model and trainings, so clinicians working with minoritized patients can shift from singling out specific patients to building rapport and trust across all patients.

CDC guidelines should **not mention specific communities** if they are not also offering different recommendations for those communities.

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Gap 4: Structural Inequities Continue

There is currently **no focus on the patient experience** related to screening and counseling present in CDC guidelines. This gap presents ongoing **concerns that emerging policy guidance may continue to perpetuate structural inequities** that contribute to health disparities.

Recommendation 4: Monitor Quality

Accountable Care Organizations must **partner with clinicians and public health practitioners to identify indicators of quality care** for patient engagement. One such example may include patient satisfaction.

GET INVOLVED

JOIN

Join our Mailing List and commit to engaging with our stakeholder network in the coming months to discuss policy design, practice, and health improvement efforts.

ENGAGE

Engage in a collaborative discussion with researchers, advocacy organizations, educational societies, and PCPs in clinical practice to inform policy development.

ATTEND

Plan to attend the GW Two in One Program Policy Summit (details to come in early 2024)!

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For more information, contact us:

twoinone@gwu.edu twoinone.smhs.gwu.edu