NHMA Phoenix Chapter Presents

PrEP for It: Integrating HIV Prevention Into Your Practice Virtual Webinar for Providers

Moderators:

Ricardo Correa, MD, EdD, FACP, FACE, FAPCR, FACMQ, CMQ
President, Maricopa County Medical Society

Petra Fimbres
Director of Marketing and Community Relations, Paloverde Pain Specialists

March 8, 2022

8 p.m. ET | 6 p.m. MT

REGISTER NOW:
bit.ly/PrEPForIt

Speakers:

Melanie Taylor, MD, MPH, CAPT, USPHS
Medical Epidemiologist, Division of HIV Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
U.S. Centers for Disease Control and Prevention

Thanes Vanig, MD, AAHIVS
Chief Medical Officer, Spectrum Medical

Larry York, PharmD, BCIDP, BCPS, AAHIVP
Clinical Pharmacist, Infectious Diseases and HIV/AIDS
UA Petersen HIV Clinics at BUMCTS

NHMA National Hispanic Medical Association

maricopa county medical society

Maricopa County Public Health
WeAreMCPH.org

Ending the HIV Epidemic IN THE U.S.

Opening Remarks

Michelle Sandoval-Rosario, DrPH, MPH, CPH

Prevention through Active Community Engagement (PACT) Region 9 Director

U.S. Department of Health and Human Services

Welcome

Ricardo Correa, MD, EdD, FACP, FACE, FAPCR, FACMQ, CMQ
Board President
Maricopa Medical Society
NHMA Phoenix Chapter Chair

Petra Fimbres
Director of Marking & Community Relations
PaloVerde Pain Specialists

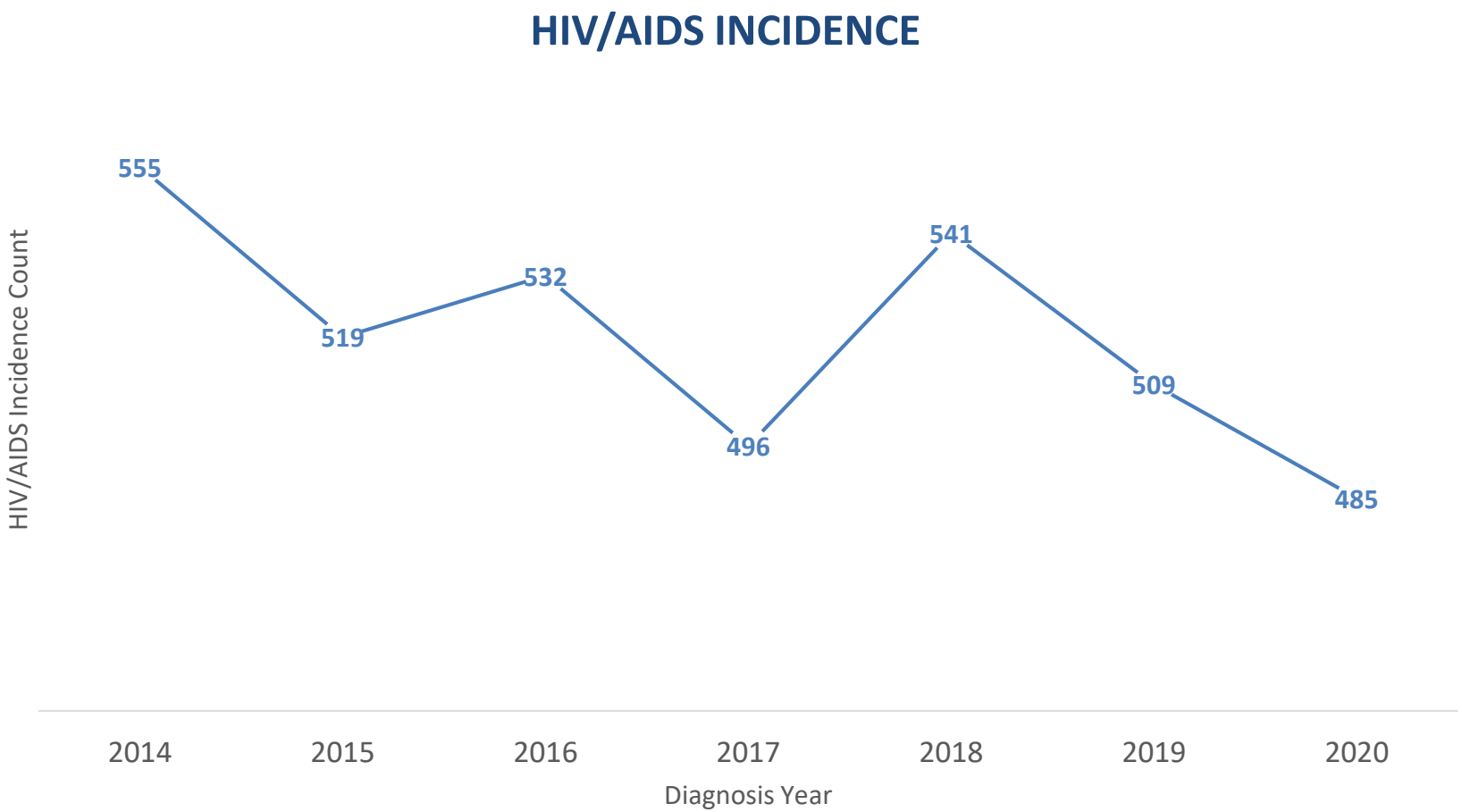
Housekeeping

- Participants will be muted during the presentations, but please feel free to type comments into the chat box throughout the webinar.
- Use the Q & A tab to submit a question for our panelists to address during the Q & session at the end.
- This webinar will be recorded and broadcasted via Facebook Live. The recording and slides will be housed on the NHMAmd.org website one week after the event.

Expanding HIV Pre-Exposure Prophylaxis (PrEP) Services in Maricopa County

Melanie Taylor, MD, MPH
Arizona Department of Health Services
U.S. Centers for Disease Control and Prevention
March 8, 2022

Number of Persons Newly Diagnosed with HIV/AIDS, Maricopa County, 2014-2020*



*The decrease in incident HIV cases in 2020 may be due to the COVID-19 pandemic.

Demographics of Persons Newly Diagnosed with HIV/AIDS, Maricopa County, 2014-2020

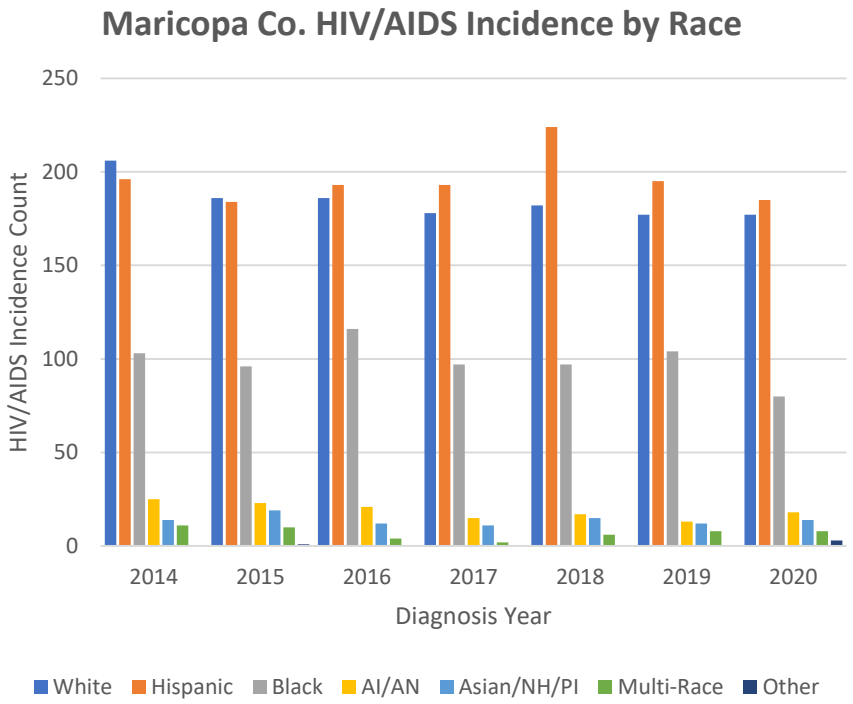


Figure 2: HIV/AIDS incidence count by race in Maricopa County from 2014-2020.

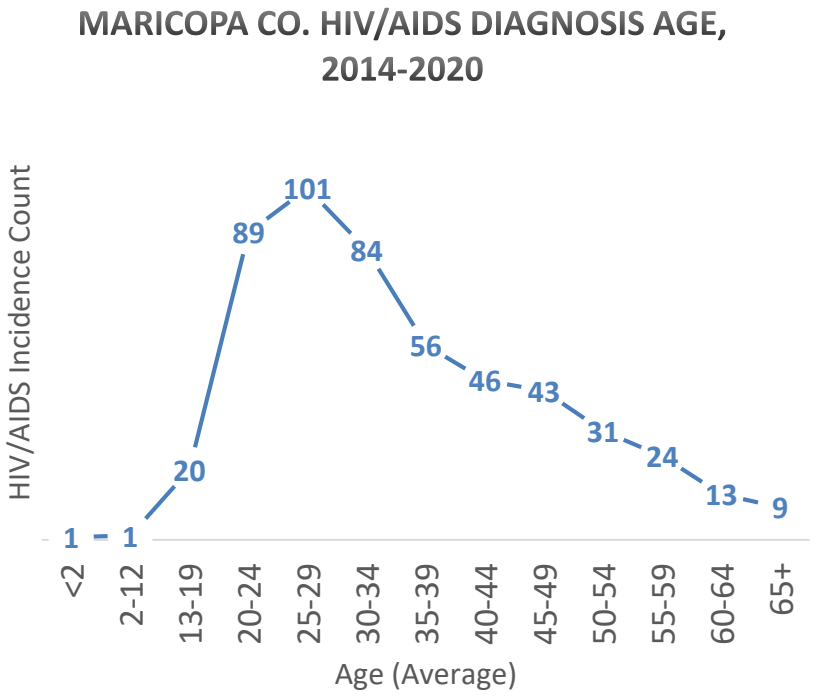


Figure 3: Average HIV/AIDS age diagnosis in Maricopa County from 2014-2020.

Risk Factors and Gender of Persons Newly Diagnosed with HIV/AIDS, Maricopa County, 2014-2020

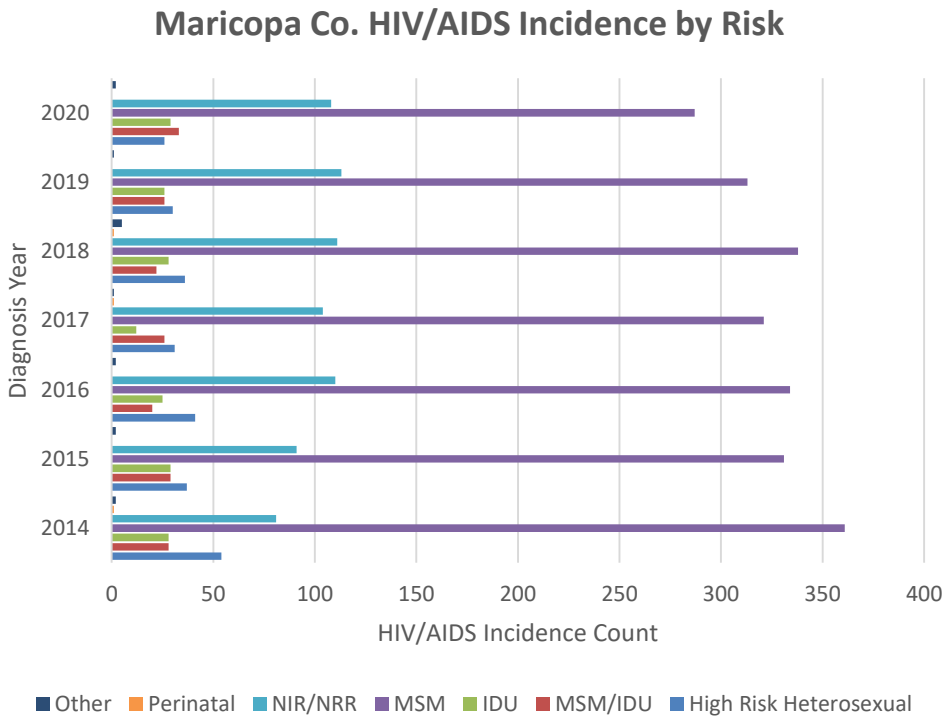


Figure 4: HIV/AIDS incidence count by risk in Maricopa County from 2014-2020.

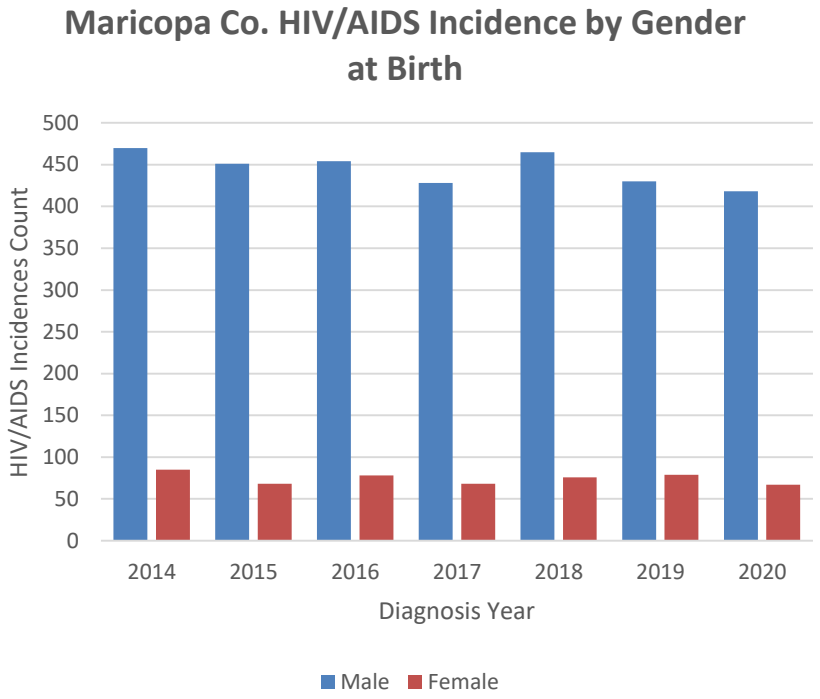


Figure 5: HIV/AIDS incidence count by sex at birth in Maricopa County from 2014-2020.

What is PrEP?

- One method of reducing acquisition of HIV to be used with other prevention practices
- Once-daily oral dosing of a combination pill*:
  - **Tenofovir disoproxil fumarate + emtricitabine (Truvada)**
  - **Tenofovir alafenamide + emtricitabine (Descovy)**
- USPSTF rating of "A" (June 2019)
  - *"When taking PrEP daily or consistently (at least 4 times per week), the risk of acquiring HIV is reduced by about 99%**."*

*Cabotegravir IM injections are now FDA-approved for PrEP

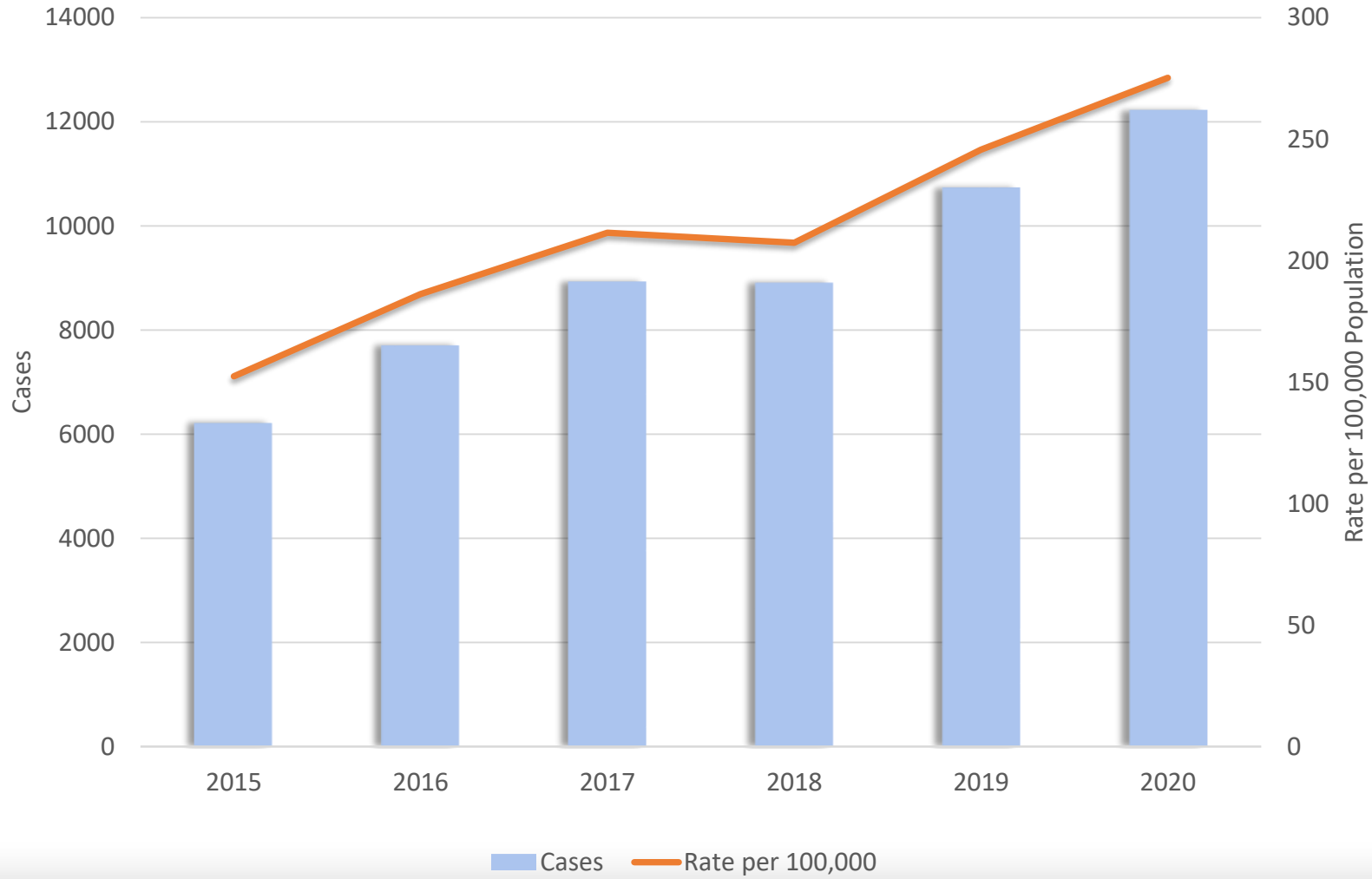
** https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html

Increase Awareness of PrEP as an Option

- **NEW RECOMMENDATION**: *"All sexually active adult and adolescent patients should receive information about PrEP."*
- Encourage providers to offer PrEP as a core primary care service
  - Reduce missed opportunities for PrEP provision and HIV prevention
- Increase knowledge of PrEP among potential users
  - Allow consideration of immediate or future use and PrEP requests
- Increase knowledge of PrEP in the community
  - Recommend PrEP to others or support use by family or friends

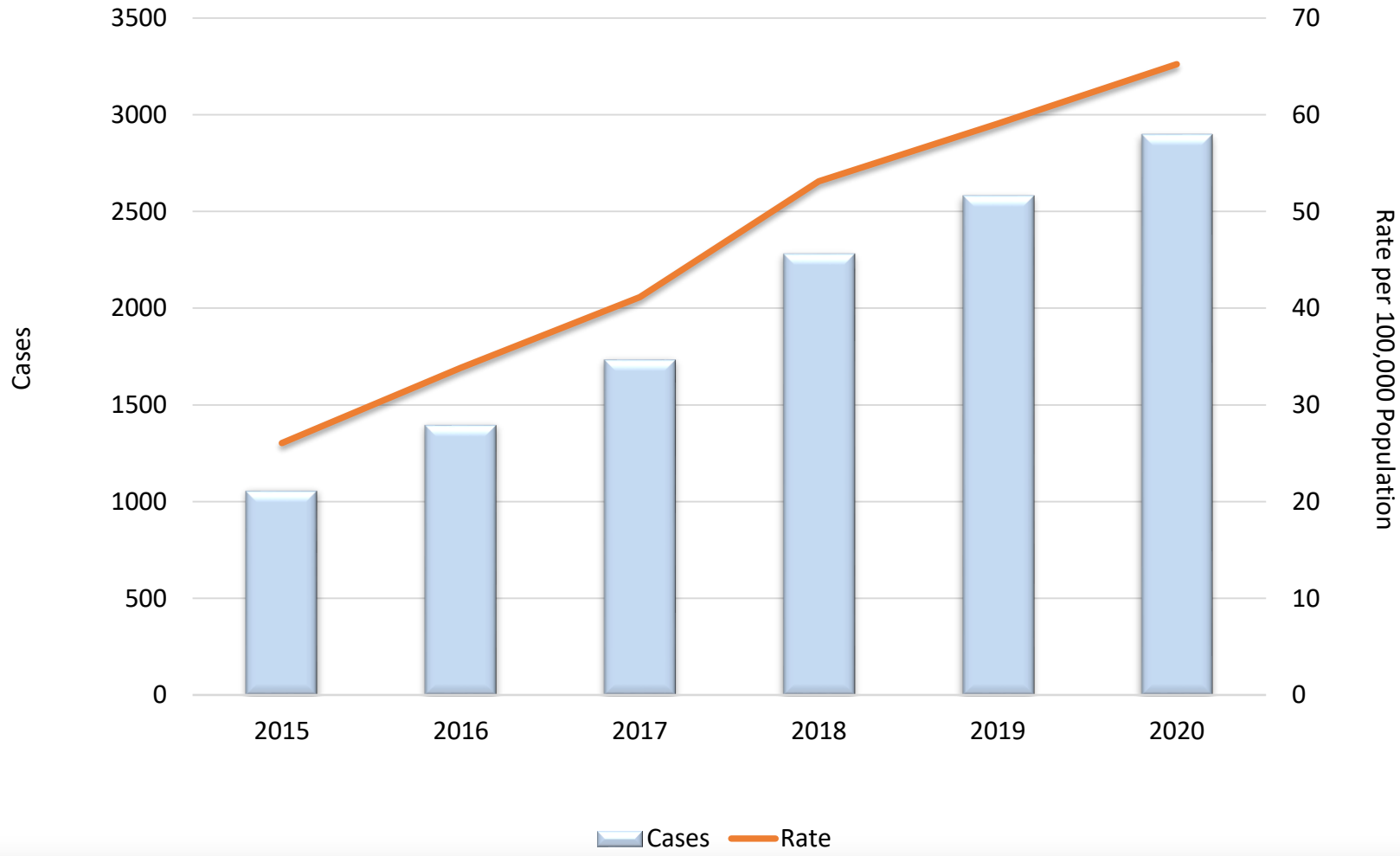
https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf

Temporal Trend of Gonorrhea Cases, Maricopa County, 2015-2020



Source: Arizona Department of Health Services (ADHS) Patient Reporting Surveillance Investigation System (PRISM)

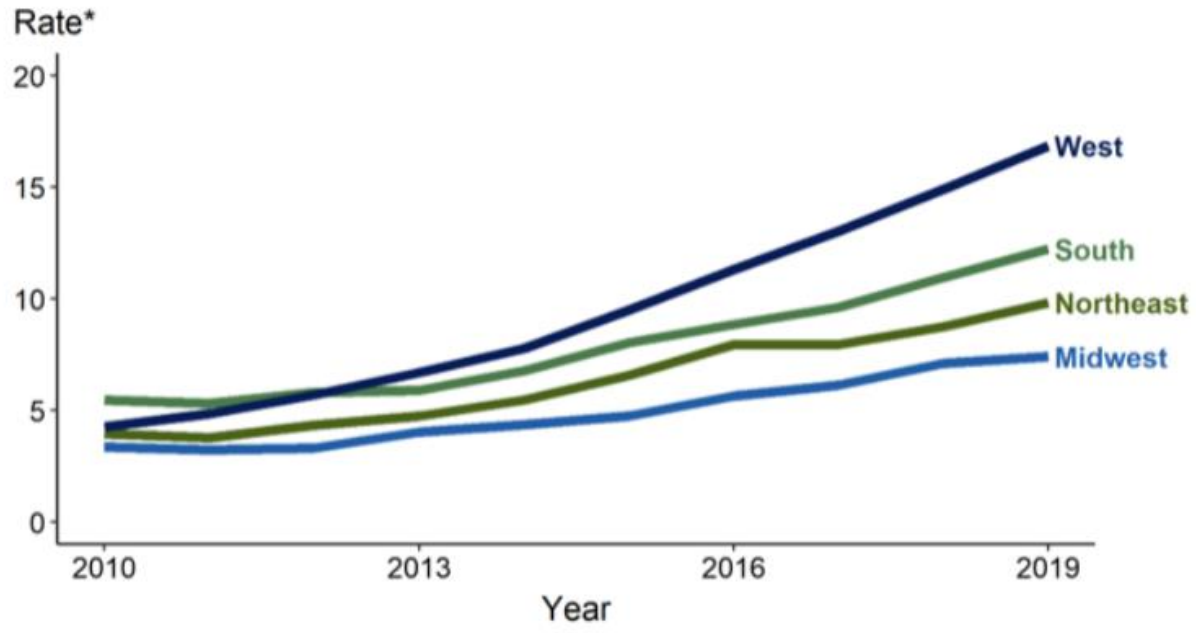
Temporal Trend of Syphilis Cases, Maricopa County, 2015-2020



Stages included - primary, secondary, early latent, late latent, and unknown duration

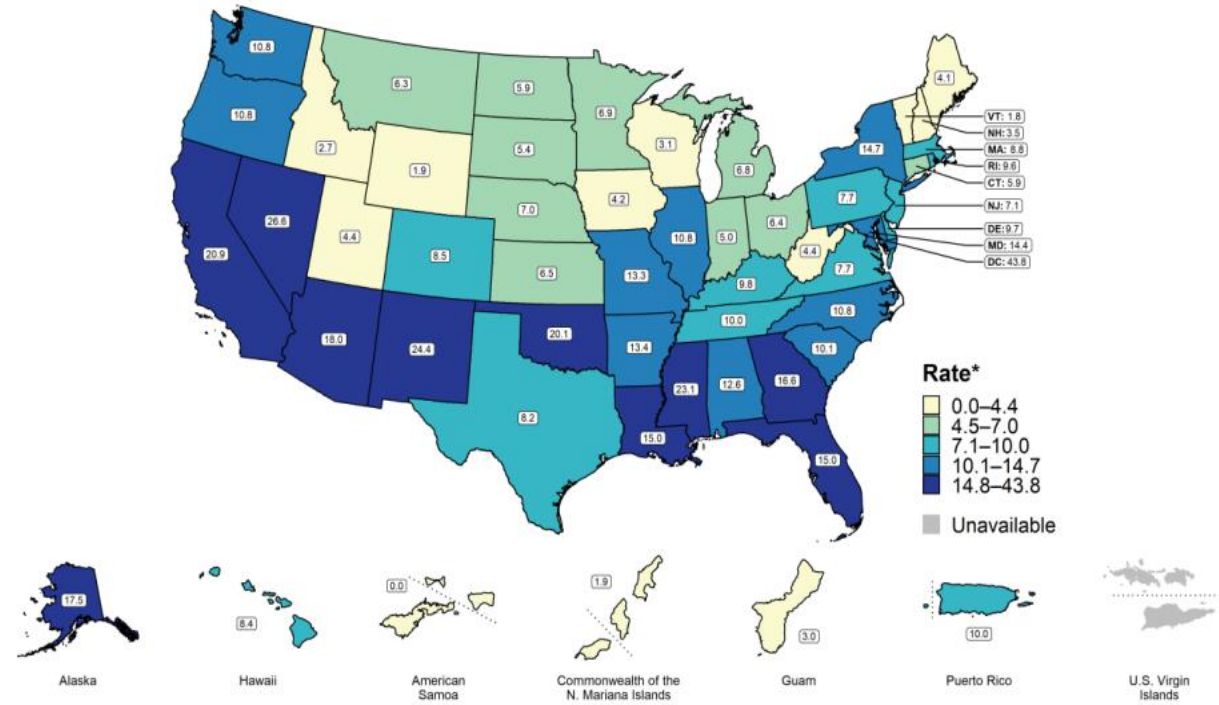
Source: Arizona Department of Health Services (ADHS) Patient Reporting Surveillance Investigation System (PRISM)

Primary and Secondary Syphilis — Rates of Reported Cases by Region, United States, 2010–2019



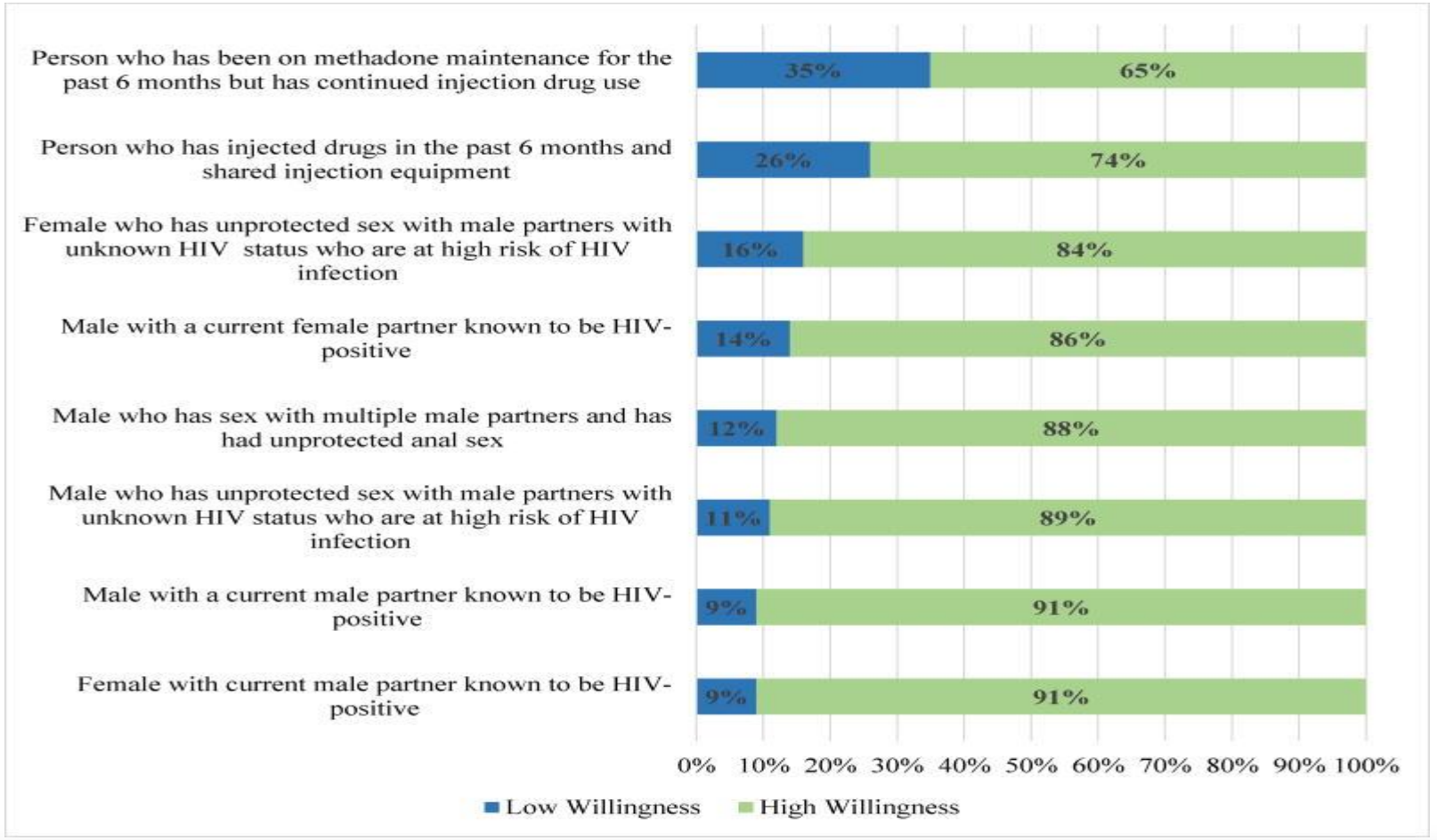
* Per 100,000

Primary and Secondary Syphilis — Rates of Reported Cases by State, United States and Territories, 2019



* Per 100,000

Physician willingness to provide PrEP



Edelman EJ, Moore BA, Calabrese SK, et al. Primary Care Physicians' Willingness to Prescribe HIV Pre-exposure Prophylaxis for People who Inject Drugs. *AIDS Behav*. 2017;21(4):1025-1033. doi:10.1007/s10461-016-1612-6

www.PrEPlocator.org
PrEP Providers in Maricopa County

Planned Parenthood AZ Inc. 4751 N 15th St Phoenix, Arizona 85014 (602) 277-7526	**One Medical** 2201 E Camelback Rd Phoenix, Arizona 85016 (888) 663-6331	**Native Health** 4041 N Central Ave Phoenix, Arizona 85012 (602) 279-5262
Indian Health Service 4212 N 16th St Phoenix, Arizona 85016 (602) 263-1200	**Family Practice Specialists** 4600 E Shea Blvd Phoenix, Arizona 85025 (602) 955-8700	**Camelback Mountain Medical Associates** 120 E Monterey Way Phoenix, Arizona 85012 (602) 266-4383
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Valleywise Health 1101 N Central Ave Phoenix, Arizona 85004 (602) 344-6550		

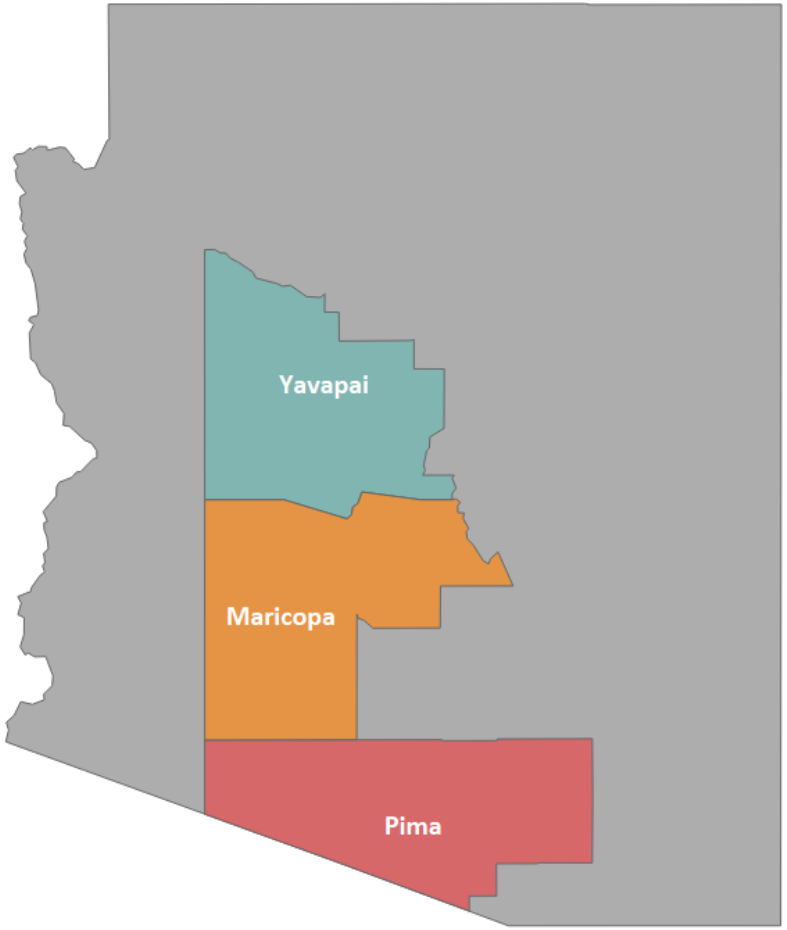
Connecting to PrEP Services in Arizona

Central Navigation Agency (information and referrals statewide):

Area Agency on Aging – Care Directions
602.241.6100
preppep@aaaphx.org

For a Full Directory Visit:

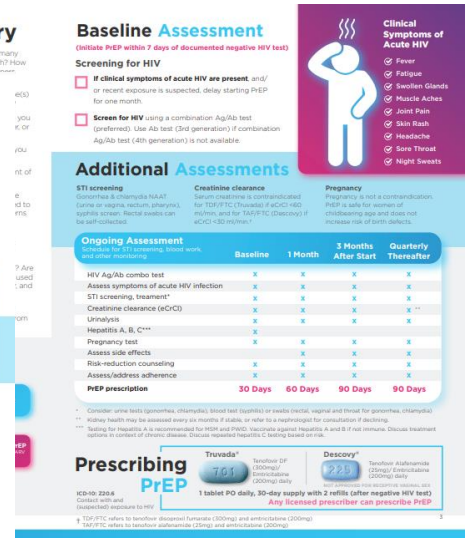
https://HIVaz.org (English)
https://VIH.org (Spanish)



PrEP Champion

Workshops and Trainings on PrEP

- **AIDS Education Training Centers, National Resource Center:**
  http://www.aids-ed.org
- **Academic Detailing in Arizona:**
  Peer-to-Peer Educational Outreach
  For more information, email Christopher.D.Garcia@azdhs.gov
- **Arizona AIDS Education and Training Center (AETC):**
  For more information, visit https://aidsetc.org/aetc-program/paetc-arizona
- **Pacific AIDS Education and Training Center (PAETC):**
  For more information, visit https://paetc.org



PrEP Key Message:

As one method for preventing HIV, talk about PrEP to every patient.

Sexual Health Key Message:

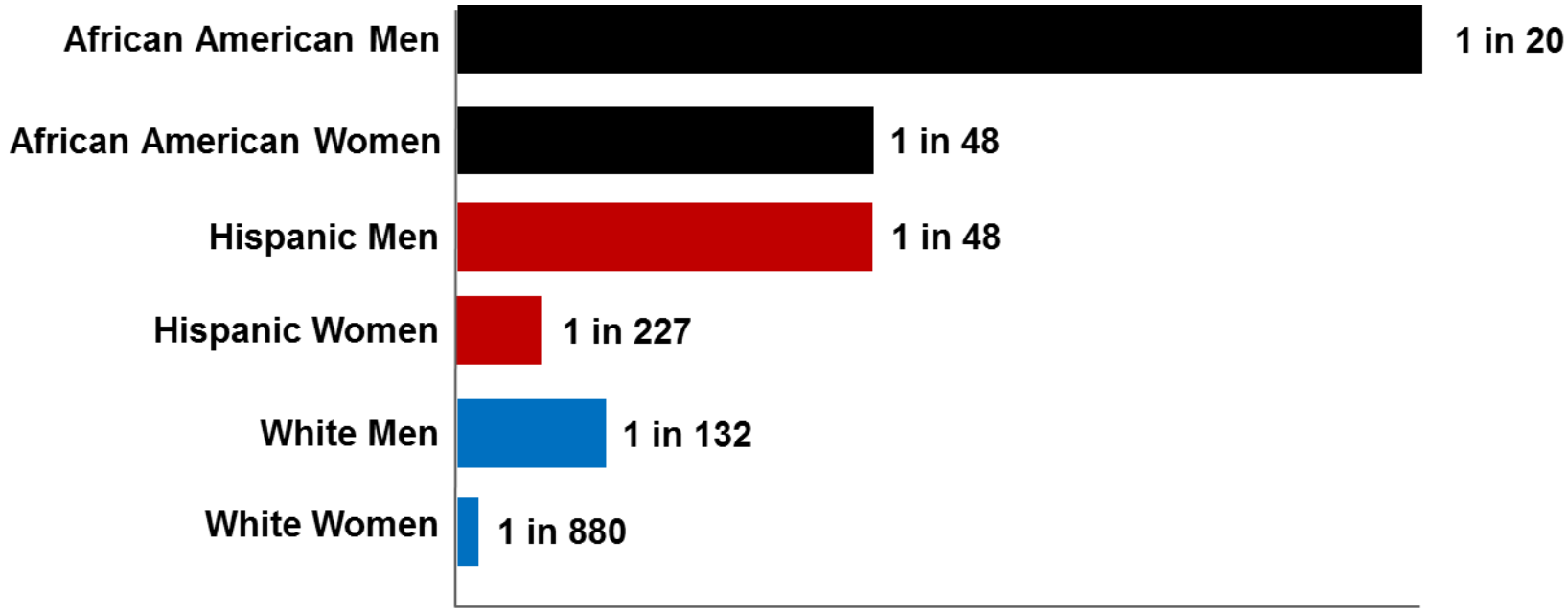
Perform Syphilis and site-specific Gonorrhea and Chlamydia testing, based on sexual exposure.

ARIZONA DEPARTMENT OF HEALTH SERVICES

Health and Wellness for all Arizonans

What is Academic Detailing?

Lifetime Risk of HIV Diagnosis by Race/Ethnicity and Sex



- Lifetime risk for men who have sex with men (MSMs):
  - 1 in 2 black MSM; 1 in 4 Hispanic MSM; 1 in 11 white MSM

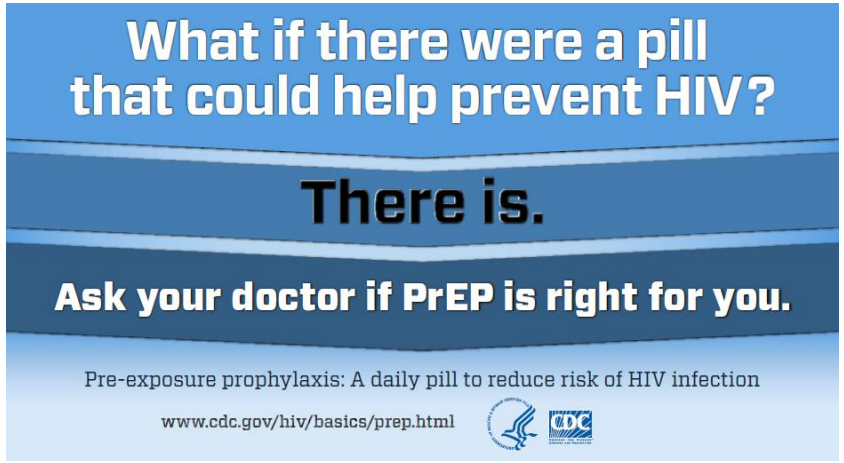
http://www.cdc.gov/nchhstp/newsroom/2016/croi-2016.html#Graphics accessed Sept. 2016

Primary Care Preventive Medications

	Metformin	Tenofovir/Emtricitabine (TDF/FTC)
Indication (package insert)	indicated as an adjunct to diet and exercise to improve glycemic control…	is indicated in combination with safer sex practices …reduce the risk of sexually acquired HIV …
Diagnosis	Impaired fasting glucose (<126 mg/dl) Hemoglobin A1c (5.7-6.4%)	Negative HIV antibody/antigen test Sexual behavior and STI history
Behavioral intervention	Weight loss (at least 7%) Increase physical activity (150 min/wk) Reduce calories and dietary fat intake	Condom use Reduce # of partners Know HIV (and treatment) status of partners
Clinical assessments/follow-up	Renal function, toxicities (ongoing) A1c every 3-6 months Weight	Renal function, toxicities (ongoing) HIV every 3 months STI every 6 months
Adherence	**70%** (at least 80% of doses)	**77%** (4 or more doses/week)

Make it Simple

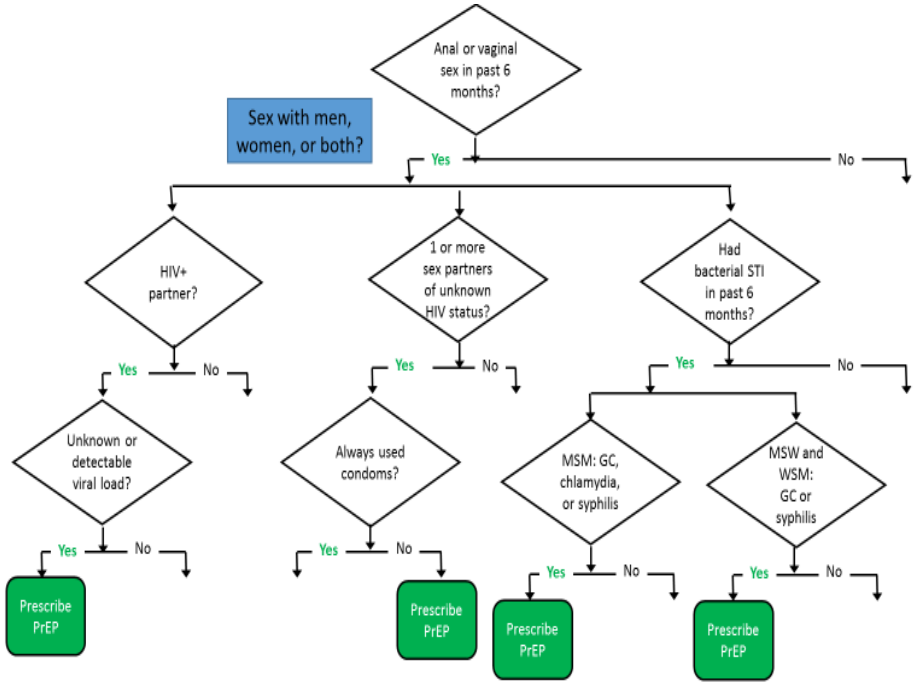
- **Inform all sexually active patients about PrEP availability**
- **Use Electronic Medical Records**
  - Implement routine HIV testing
  - Offer PrEP to all diagnosed with syphilis or gonorrhea
- **Take a team approach**
- **Add select questions to paper or digital health history form**

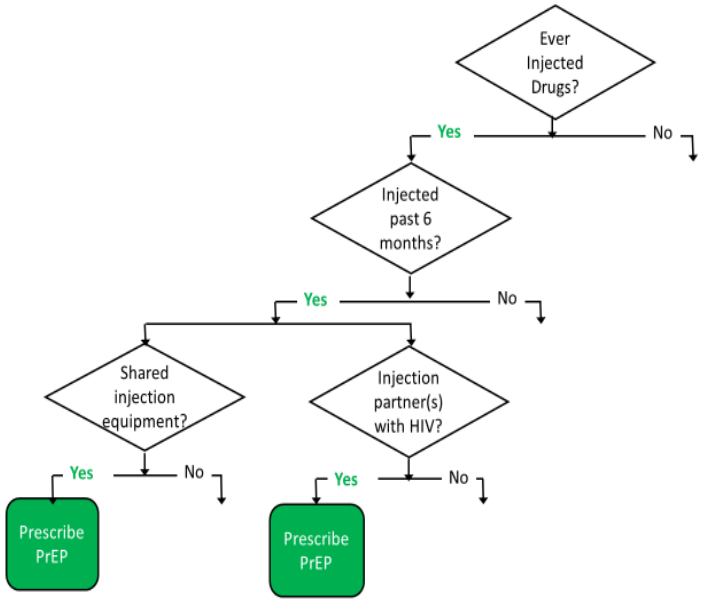


Ask simple questions of *every* patient

1. Are you sexually active?
2. If yes, Do you have sex with men, women or both?
3. Do you have a partner with HIV?
4. Have you recently had sex with one or more partners without using a condom?
5. Have you had a bacterial sexually transmitted infection in the past six months?
6. Do you use or have you recently used injection drugs?

Ask the Least You Need to Know for PrEP





Testing Procedure for Determining HIV Status

- Starting/restarting PrEP for persons with no recent antiretroviral use
  - Lowered HIV-1 RNA threshold for retesting for possible false positive result
- Restarting/continuing PrEP for persons with recent antiretroviral use
  - New algorithm using qualitative or quantitative HIV-1 RNA assays

Providers in Arizona can Receive Free HIV Test Kits

- **Type of Tests: Point-of-Care (POC) Rapid Tests**
  - HIV Antigen/Antibody (Ag/Ab Combo) Test (Results within 20 minutes)
  - HIV Antibody (Ab Test) (Results within 1 minute)

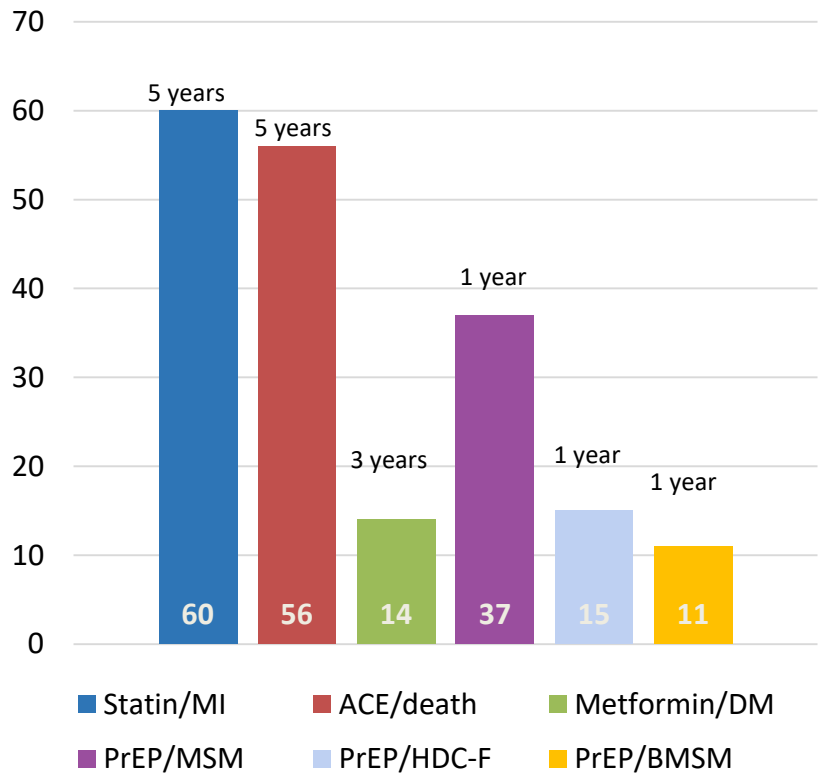
- **POC devices proven to be easy to transport, operate, and maintain.** (Arora, D. R., Maheshwari, M., & Arora, B.,2013)

- **Leads to timely linkage and referral to prevention/ care services.**

- **Contact Deborah.Reardon@azdhs.gov**

Is it Worth It?

Number Needed to Treat



Missed Opportunities

- In NYC, among HIV seroconverters 2012-2017
  - **42%** had a prior negative HIV test visit without provision of PrEP
- In SC, among HIV seroconverters 2013-2016
  - **25%** had a diagnosis of gonorrhea or syphilis at a prior healthcare visit without provision of PrEP
- In the VA, among patients with indications for PrEP,
  - **35%** experienced delays receiving PrEP ranging from six weeks to 16 months.
- In AL, among adolescents at a primary care center
  - **44%** had a PrEP indication. None were offered/prescribed PrEP

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THANK YOU

Melanie Taylor, MD, MPH | Medical Epidemiologist

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facebook.com/azdhs

Ending the HIV Epidemic & PrEP

Thanes Vanig, MD

Spectrum Medical

City of Phoenix Fast-Track Cities Initiative

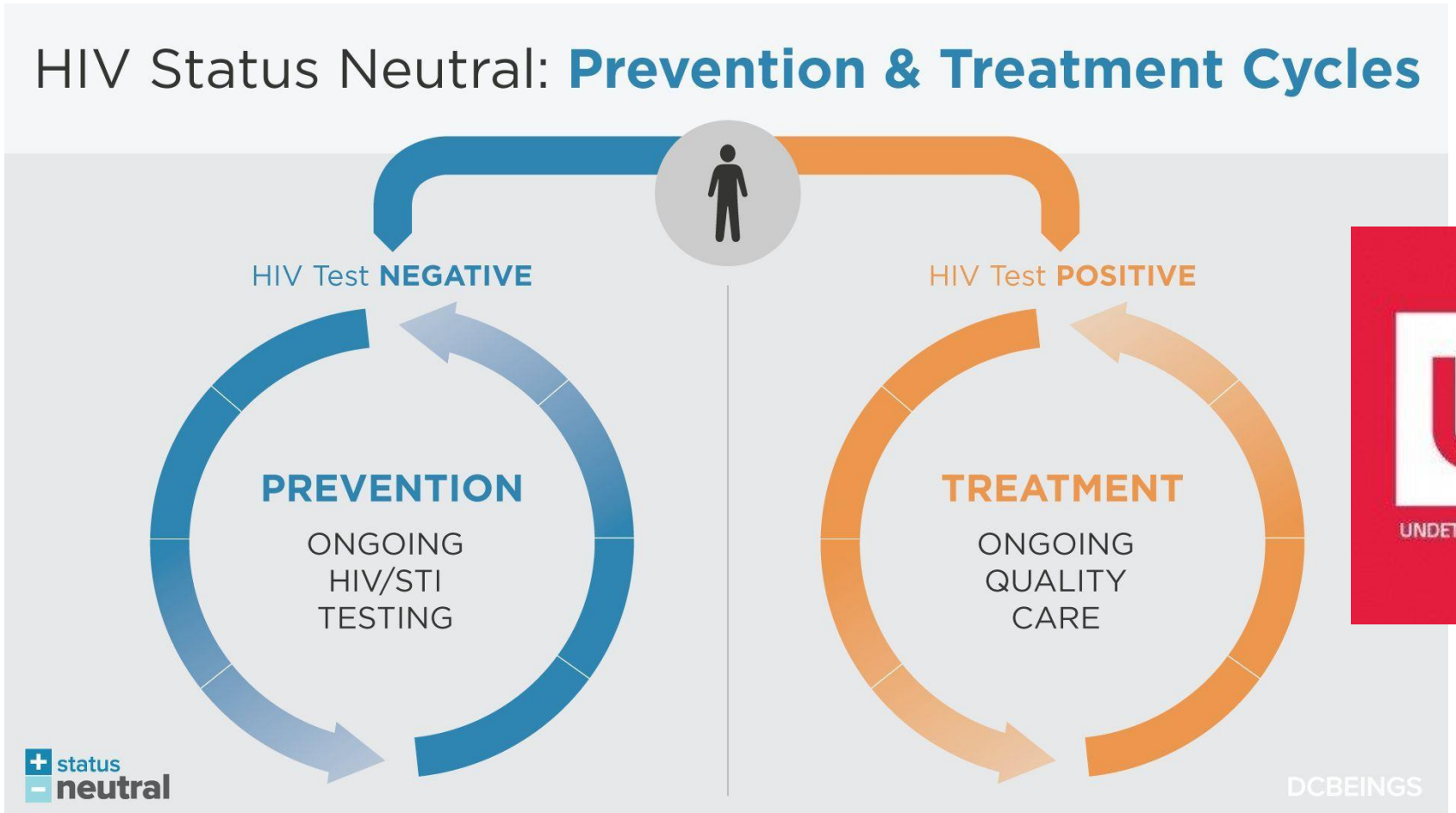
ENDING THE HIV EPIDEMIC

- **UNAIDS 90-90-90**
  - Used as the basis goals for the Fast-Track Cities Initiative

- **EHE: A Plan for America**
  - Test
  - Treat
  - **Prevent**
  - Respond

A Status Neutral Approach:

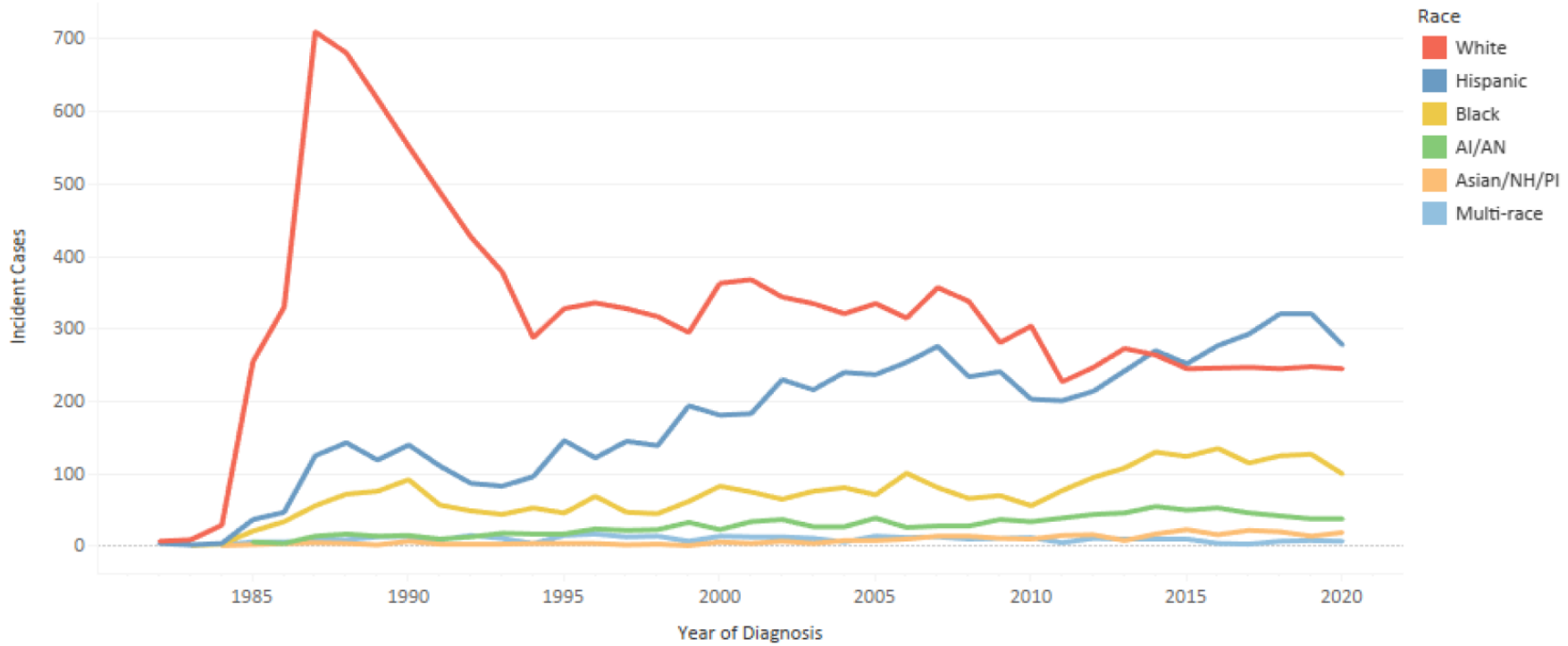
Achieving Together to End the HIV Epidemic



U=U

UNDETECTABLE = UNTRANSMITTABLE

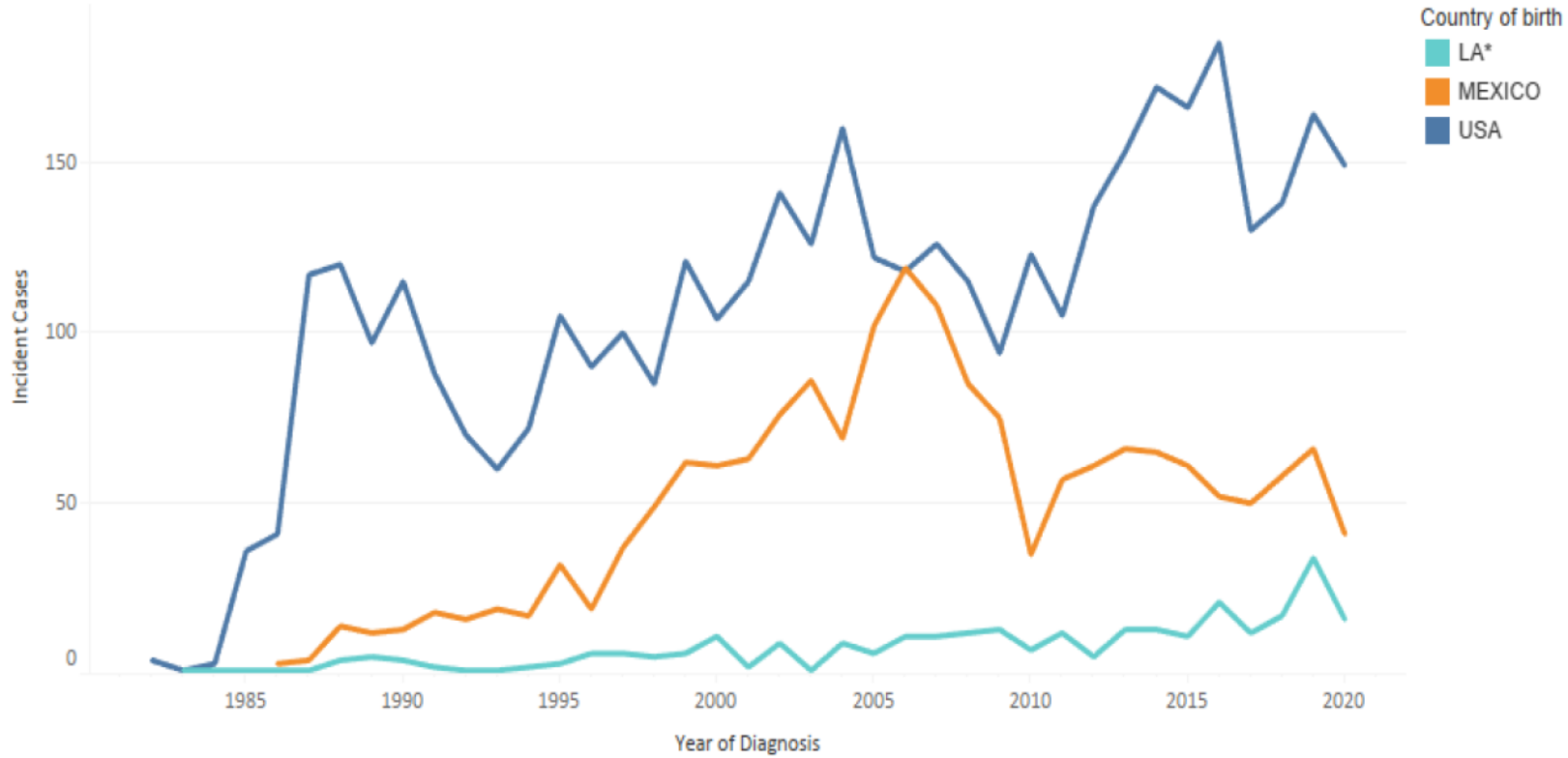
Figure 6: Number of HIV incident cases among persons ≥13 years by race, Arizona 1982 to 2020.



In 1988, 74% of new HIV infections were comprised of White individuals. This population has had a 64% decrease in HIV incidence from 1988 to 2020 whereas Hispanic individuals have had a 49% increase in new infections during the same time period.

In 2020, Hispanic persons accounted for 32% of Arizona's population and 40% of all incident HIV/AIDS cases reported in the state

Figure 7: US Born Compared to Foreign Born, Arizona 1982 to 2020.



* LA includes Bolivia, Colombia, Cuba, Ecuador, Guatemala, Honduras, Nicaragua, Peru, El Salvador, Uruguay, and Venezuela.

The percent of incident HIV/AIDS cases in Hispanic individuals that were born in the U.S has decreased from a high of 87% in 1990, to 72% in 2020. Of the 2020 Hispanic incident HIV/AIDS cases that had complete data for the individual's country of birth, roughly 72% were born in the United States, 20% were born in Mexico and the remaining 8% were born in other countries outside of the U.S.

Recognizing How STIs Can Be an Indicator for HIV Risk

Avoid Missed Opportunities by Having HIV Risk and Prevention Discussions

At the Time of STI Screenings, HIV-Risk Discussions are Critical

5x

- The increased risk of becoming HIV positive associated with genital ulcers[1]

~20%

- The percentage of men with syphilis **who become HIV positive within 10 years**[3]

8x

- The increased risk of becoming HIV positive associated with 2 prior rectal gonorrhea or chlamydia infections in MSM[2]

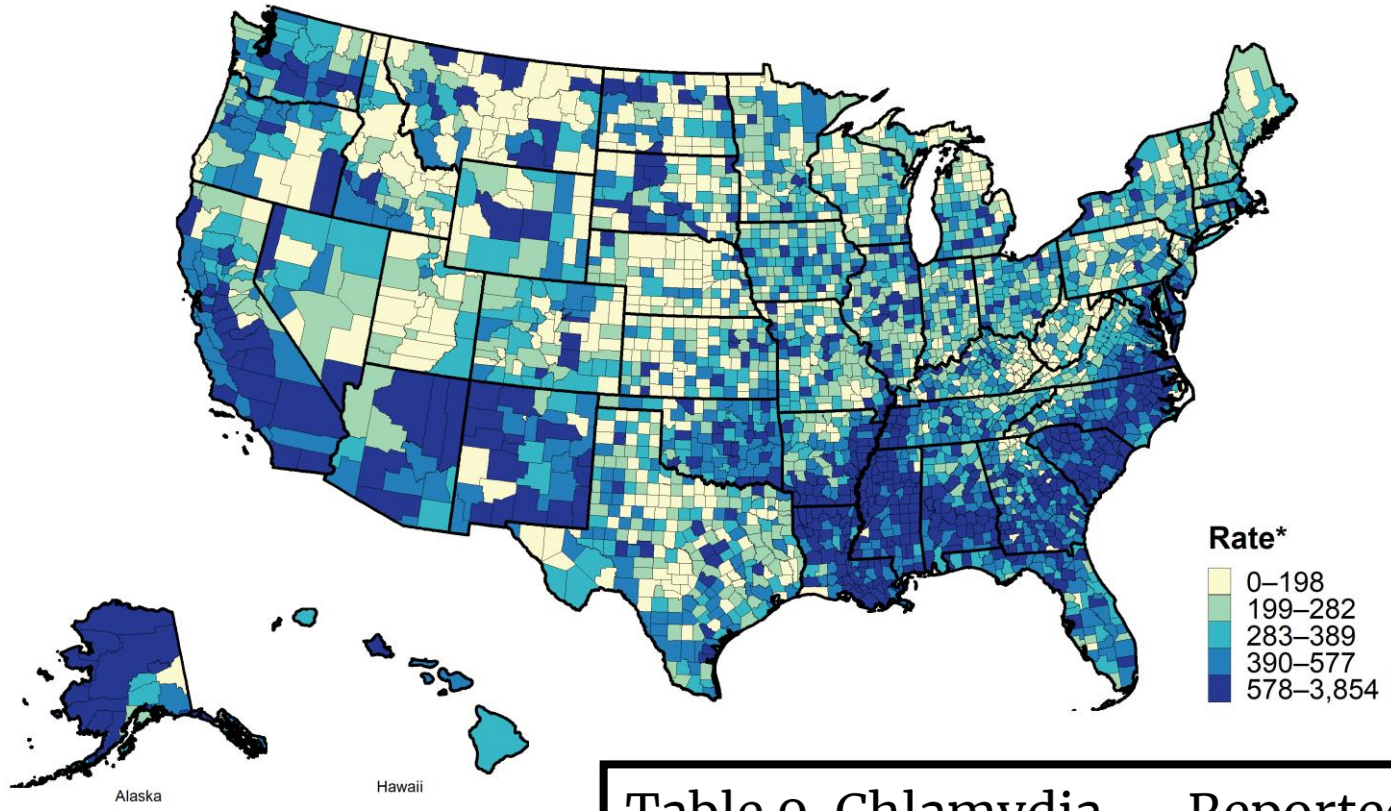
1 in 15

- The proportion of men with a history of rectal gonorrhea or chlamydia **who become HIV positive within 1 year**[4]

Regardless of the outcome, a patient who gets an STI screening should **ALWAYS receive information about their potential HIV risk.**

1. Boily MC, et al. *Lancet Infect Dis.* 2009;9(2):118-129. **2.** Bernstein KT, et al. *J Acquir Immune Defic Syndr*. 2010;53(4):537-543. **3.** Peterman TA, et al. *Public Health Rep*. 2014;129(2):164-169. **4.** Pathela P, et al. *Clin Infect Dis*. 2013;57(8):1203-1209.

Chlamydia — Rates of Reported Cases by County, United States, 2019

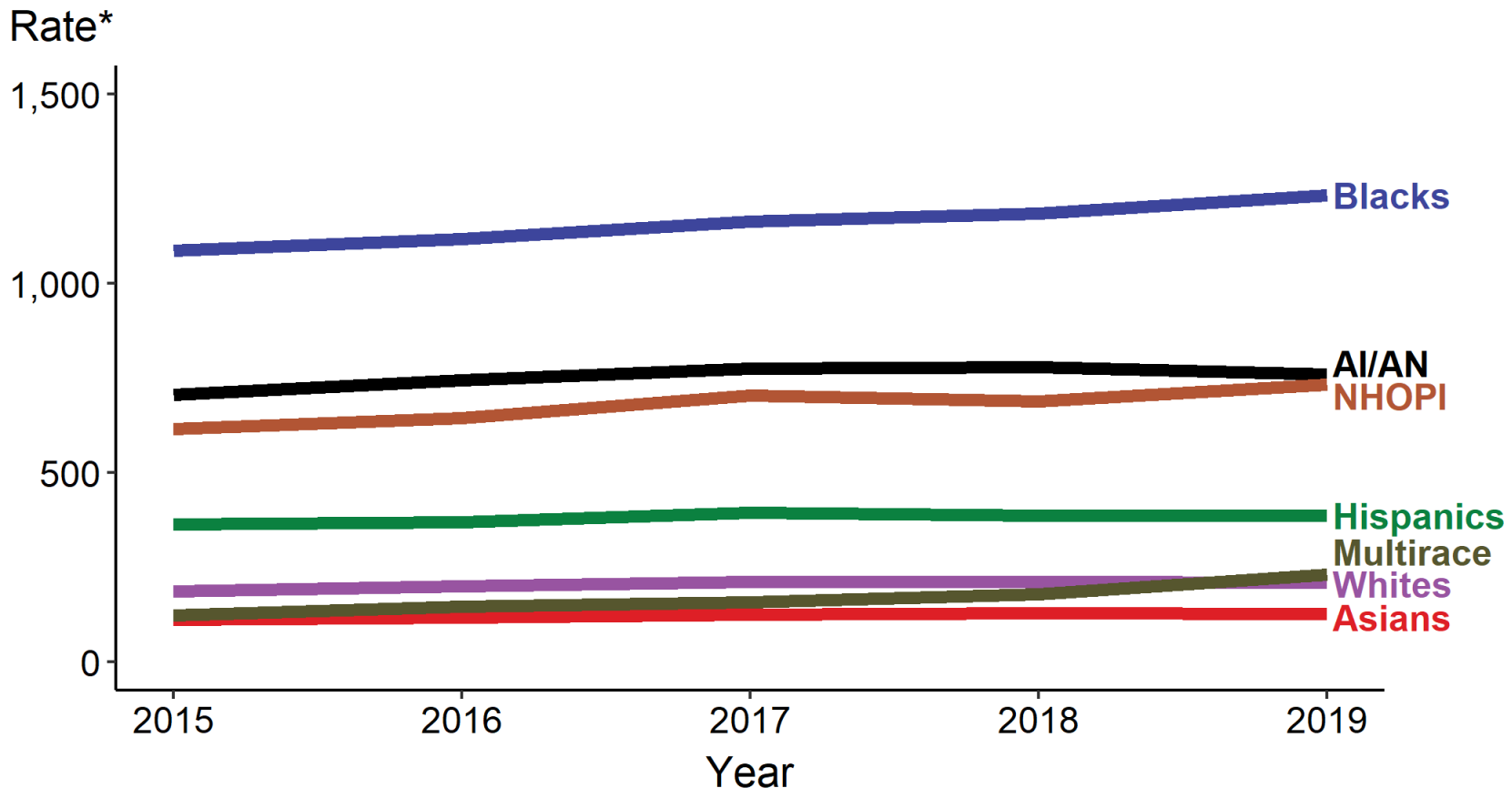


* Per 100,000

Table 9. Chlamydia — Reported Cases and Rates of Reported Cases in Counties and Independent Cities* Ranked by Number of Reported Cases, United States, 2019

Rank*	County/Independent City	Cases	Rate per 100,000 Population	Cumulative Percentage
1	Los Angeles County, CA	69,712	689.8	4
2	Cook County, IL	45,414	876.6	6
3	Maricopa County, AZ	28,375	643.3	8

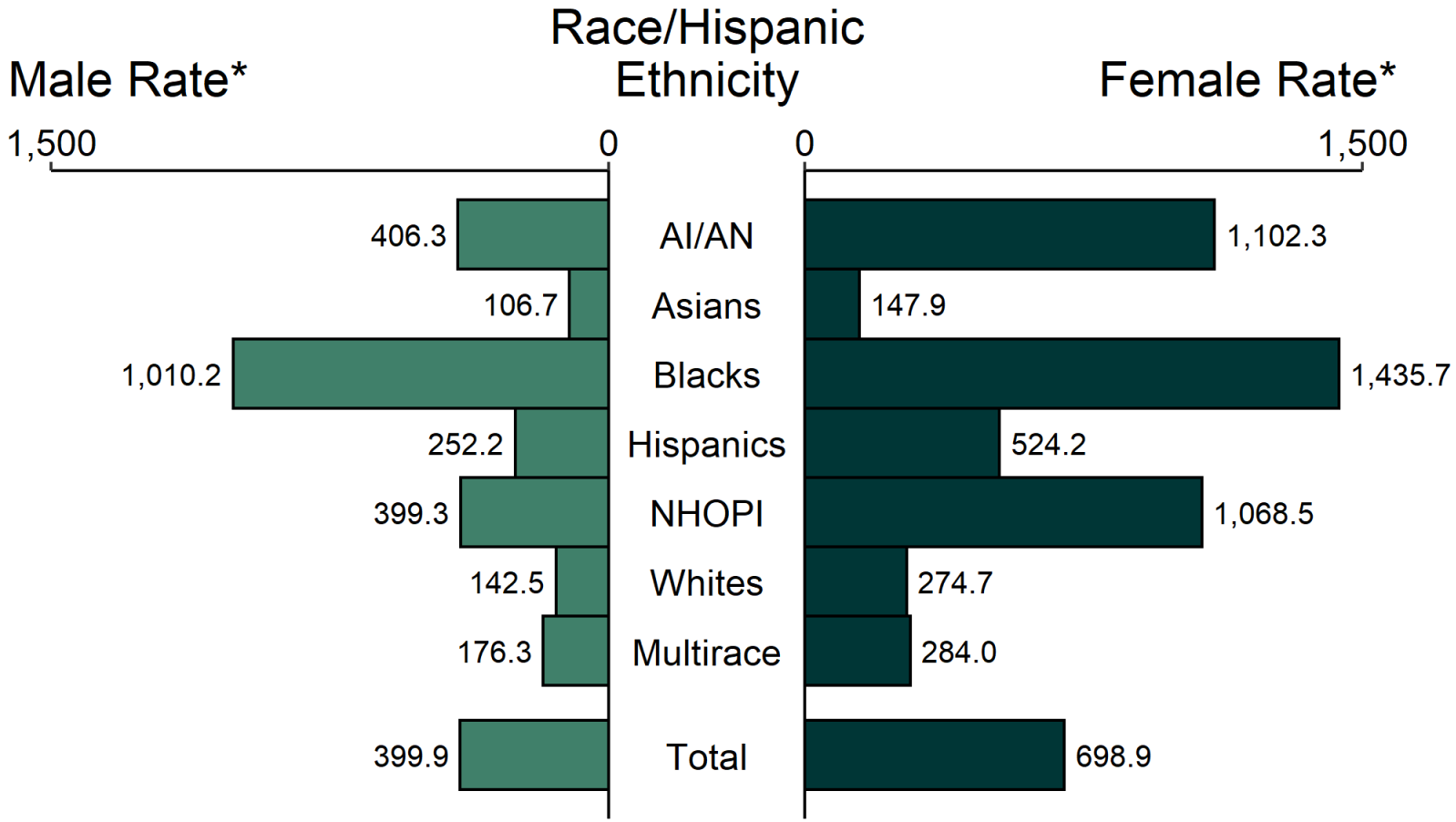
Chlamydia — Rates of Reported Cases by Race/Hispanic Ethnicity, United States, 2015–2019



* Per 100,000

ACRONYMS: AI/AN = American Indians/Alaska Natives; NHOPI = Native Hawaiians/Other Pacific Islanders

Chlamydia — Rates of Reported Cases by Race/Hispanic Ethnicity and Sex, United States, 2019

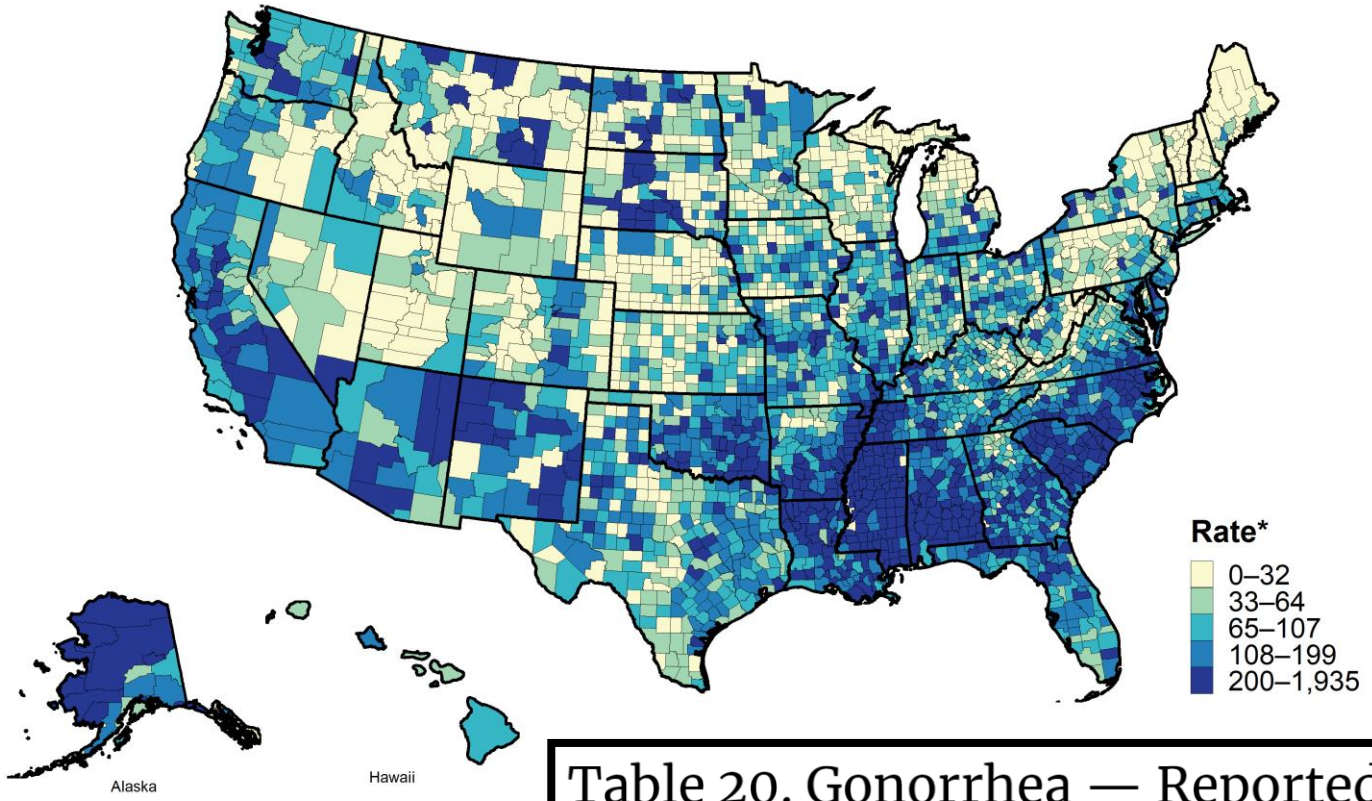


* Per 100,000

ACRONYMS: AI/AN = American Indians/Alaska Natives; NHOPI = Native Hawaiians/Other Pacific Islanders

NOTE: Total includes all cases including those with unknown race/Hispanic ethnicity.

Gonorrhea — Rates of Reported Cases by County, United States, 2019

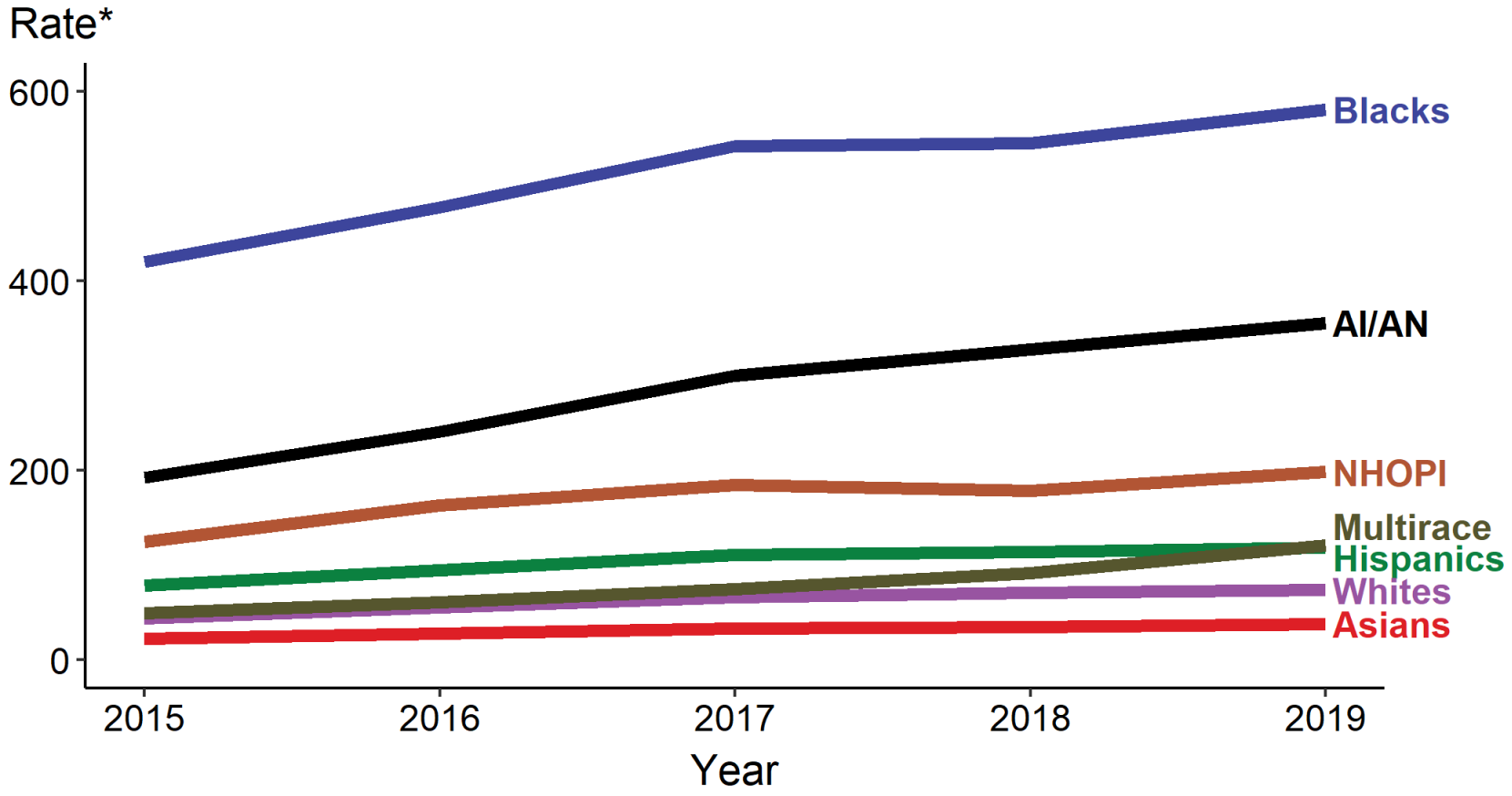


* Per 100,000

Table 20. Gonorrhea — Reported Cases and Rates of Reported Cases in Counties and Independent Cities* Ranked by Number of Reported Cases, United States, 2019

Rank*	County/Independent City	Cases	Rate per 100,000 Population	Cumulative Percentage
1	Los Angeles County, CA	26,195	259.2	4
2	Cook County, IL	18,181	351.0	7
3	Maricopa County, AZ	10,670	241.9	9

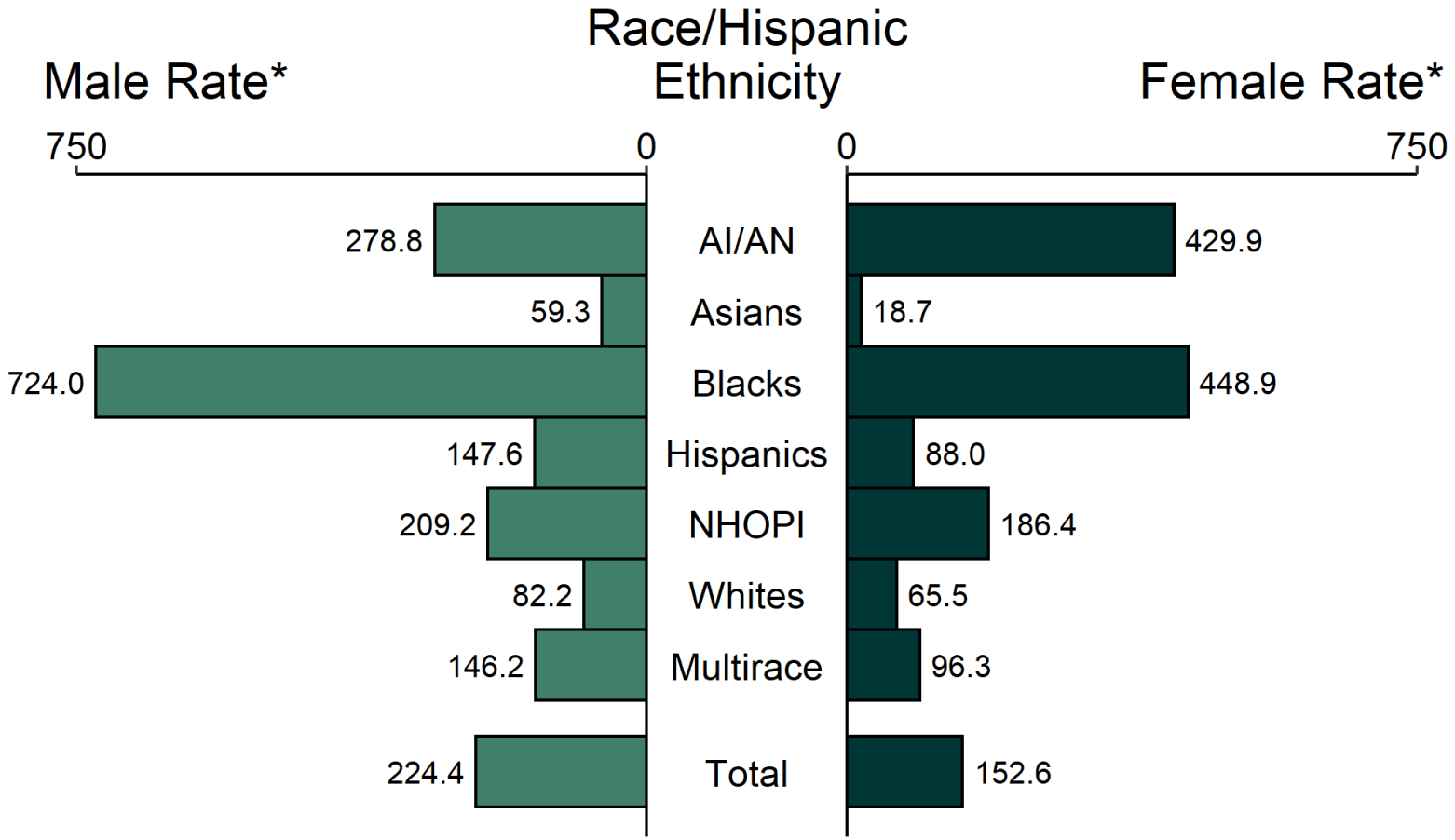
Gonorrhea — Rates of Reported Cases by Race/Hispanic Ethnicity, United States, 2015–2019



* Per 100,000

ACRONYMS: AI/AN = American Indians/Alaska Natives; NHOPI = Native Hawaiians/Other Pacific Islanders

Gonorrhea — Rate of Reported Cases by Race/Hispanic Ethnicity and Sex, United States, 2019

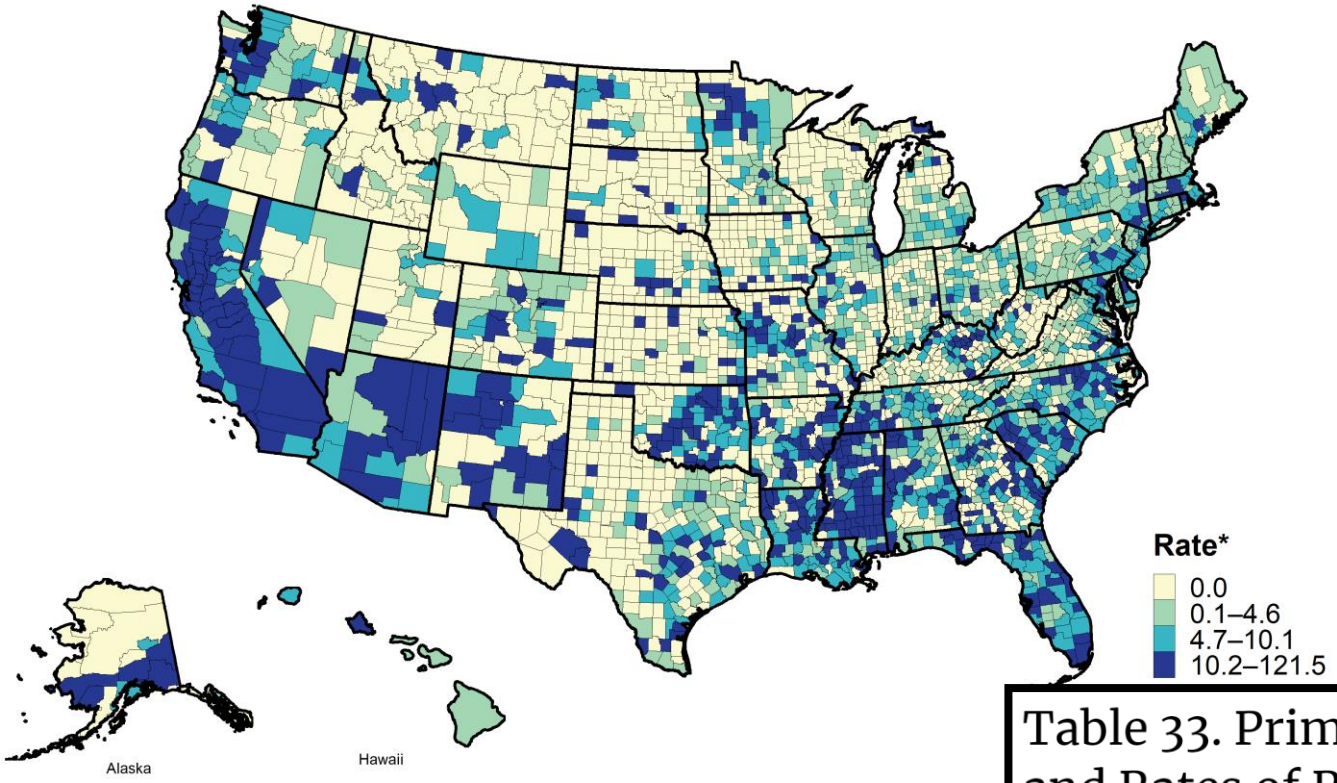


* Per 100,000

ACRONYMS: AI/AN = American Indians/Alaska Natives; NHOPI = Native Hawaiians/Other Pacific Islanders

NOTE: Total includes all cases including those with unknown race/Hispanic ethnicity.

Primary and Secondary Syphilis — Rates of Reported Cases by County, United States, 2019

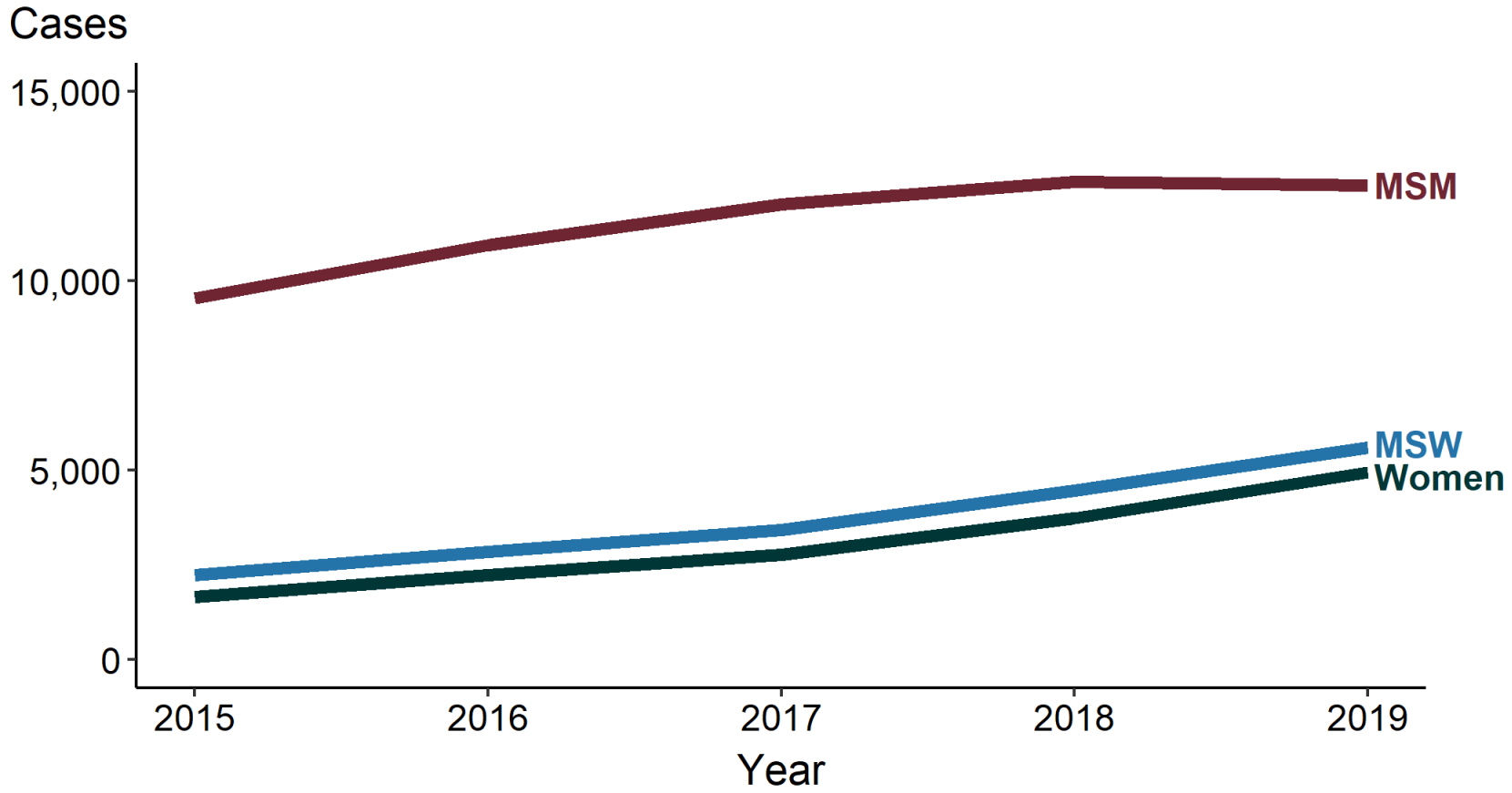


* Per 100,000

Table 33. Primary and Secondary Syphilis — Reported Cases and Rates of Reported Cases in Counties and Independent Cities* Ranked by Number of Reported Cases, United States, 2019

Rank*	County/Independent City	Cases	Rate per 100,000 Population	Cumulative Percentage
1	Los Angeles County, CA	2,550	25.2	7
2	Cook County, IL	1,007	19.4	9
3	Maricopa County, AZ	947	21.5	12

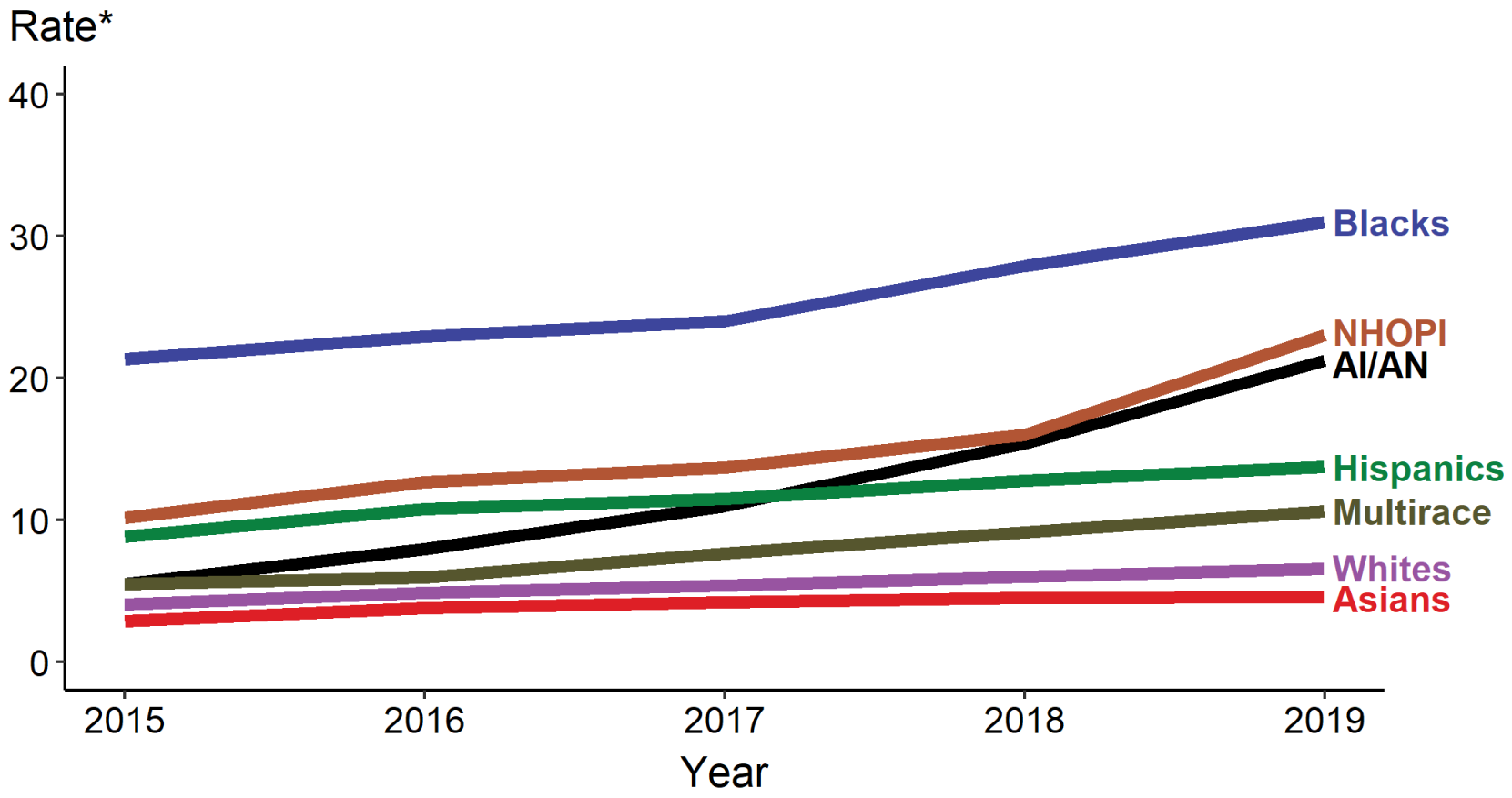
Primary and Secondary Syphilis — Reported Cases by Sex and Sex of Sex Partners, 31 States*, 2015–2019



*31 states were able to classify ≥70% of reported cases of primary and secondary syphilis among males as either MSM or MSW for each year during 2015–2019.

ACRONYMS: MSM = Gay, bisexual, and other men who have sex with men; MSW = Men who have sex with women only

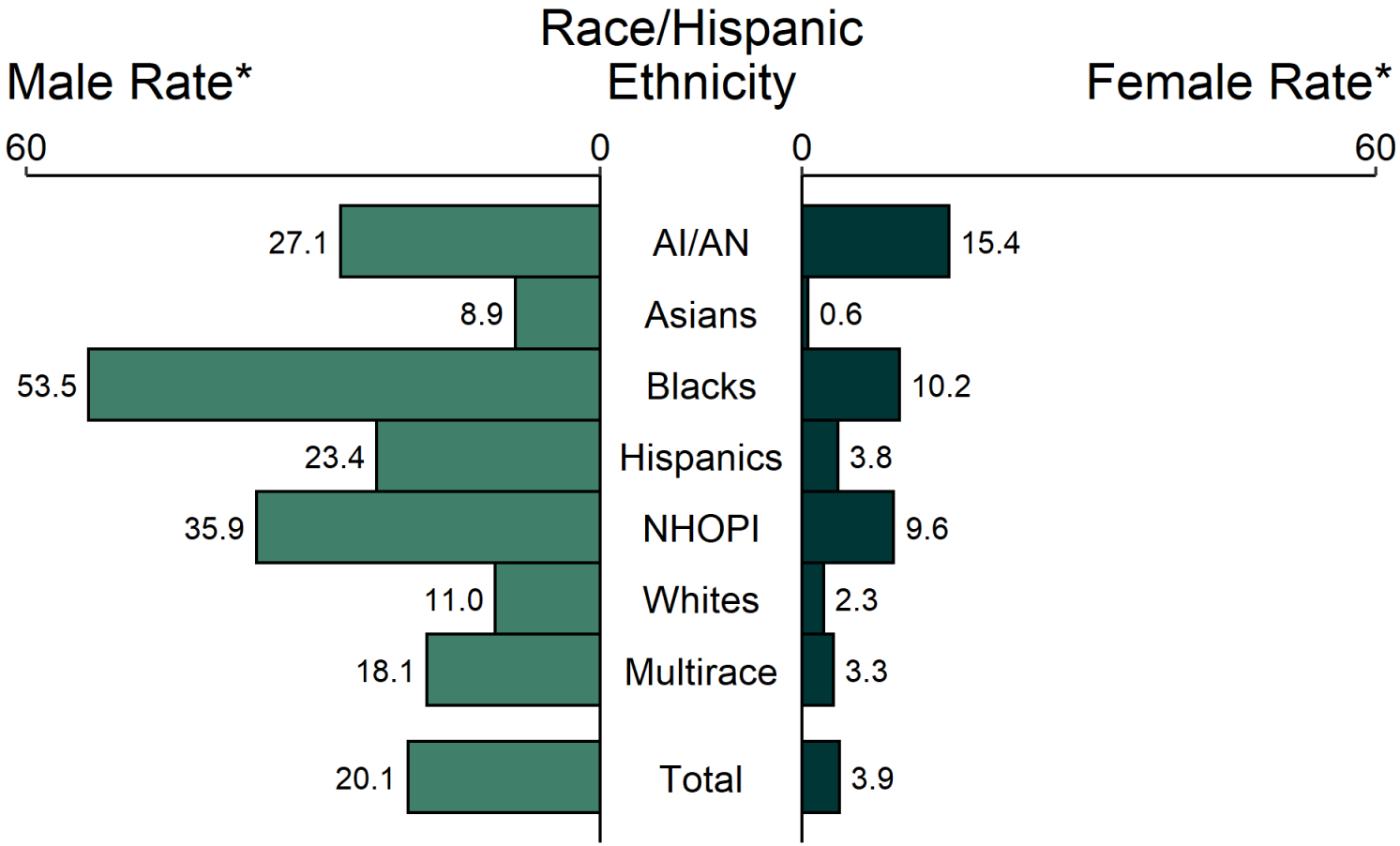
Primary and Secondary Syphilis — Rates of Reported Cases by Race/Hispanic Ethnicity, United States, 2015–2019



* Per 100,000

ACRONYMS: AI/AN = American Indians/Alaska Natives; NHOPI = Native Hawaiians/Other Pacific Islanders

Primary and Secondary Syphilis — Rates of Reported Cases by Race/Hispanic Ethnicity and Sex, United States, 2019



* Per 100,000

ACRONYMS: AI/AN = American Indians/Alaska Natives; NHOPI = Native Hawaiians/Other Pacific Islanders

NOTE: Total includes all cases including those with unknown race/Hispanic ethnicity.

STI in Maricopa County 2021 by Race

Cases by Race/Ethnicity	
Unknown	10,509 (39.9%)
Hispanic/Latino	7,006 (26.6%)
White	4,154 (15.8%)
Black/African American	2,845 (10.8%)
American Indian/Alaskan Native	825 (3.1%)
Multi-Racial/NHPI/Other**	796 (3.0%)
Asian	223 (0.8%)

Chlamydia

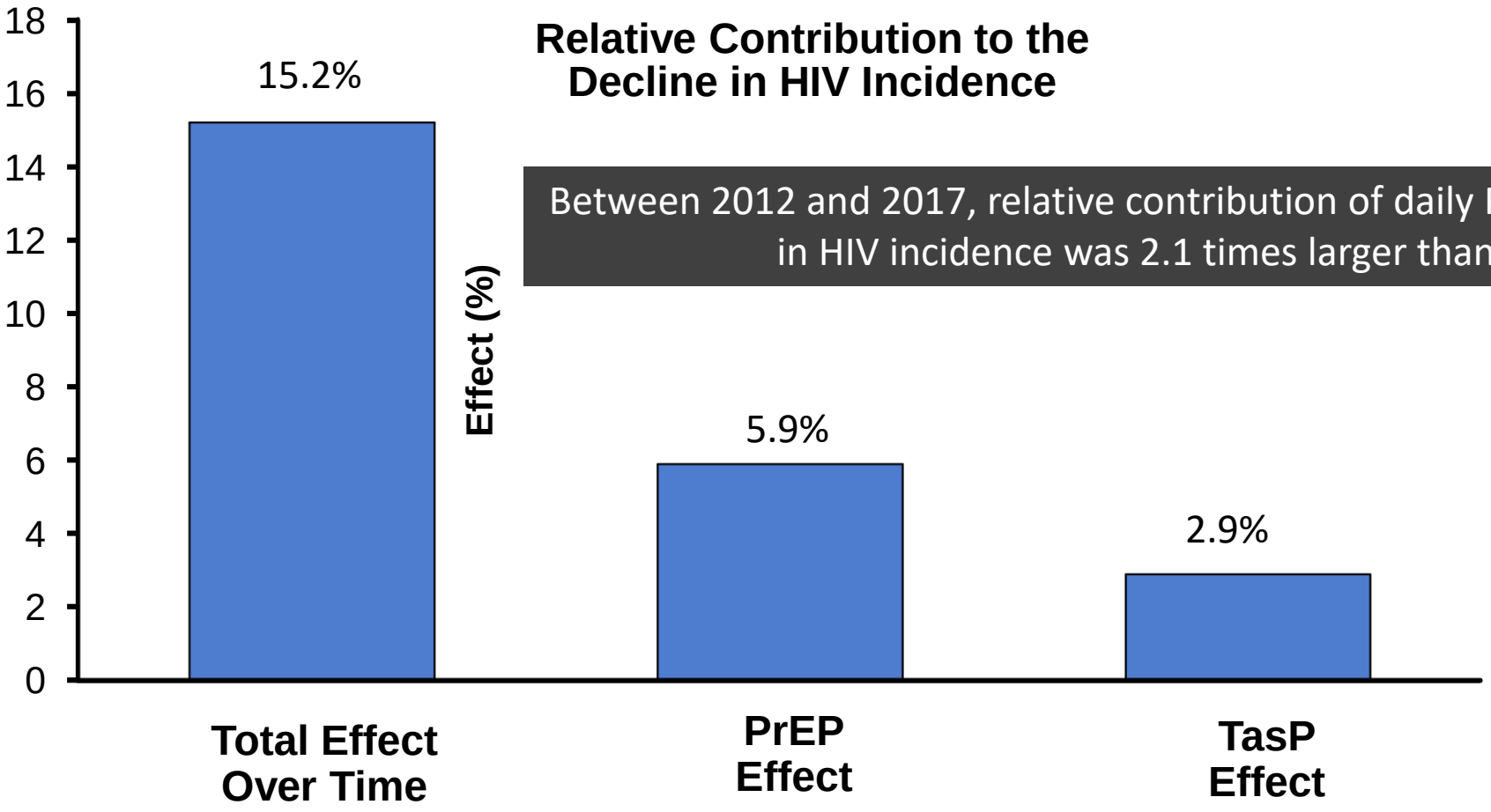
Cases by Race/Ethnicity	
Hispanic/Latino	3,485 (27.1%)
Unknown	3,411 (26.5%)
White	2,657 (20.6%)
Black/African American	2,244 (17.4%)
Multi-Racial/NHPI/Other**	538 (4.2%)
American Indian/Alaskan Native	449 (3.5%)
Asian	87 (0.7%)

Gonorrhea

Cases by Race/Ethnicity	
Hispanic/Latino	841 (41.3%)
White	635 (31.2%)
Black/African American	345 (16.9%)
American Indian/Alaskan Native	112 (5.5%)
Asian	42 (2.1%)
Multi-Racial/NHPI/Other**	37 (1.8%)
Unknown	25 (1.2%)

Syphilis

Daily PrEP Significantly Reduced the Rate of New HIV Diagnoses in US Independent of Treatment as Prevention

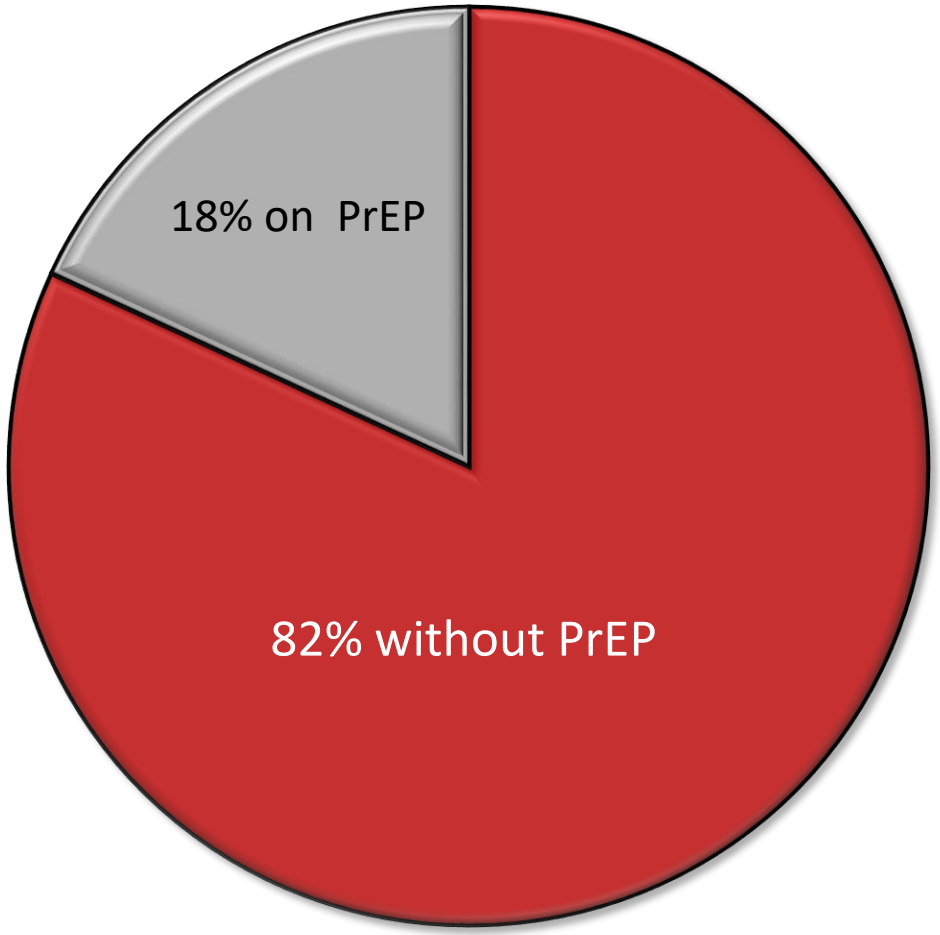


Between 2012 and 2017, relative contribution of daily PrEP to the decline in HIV incidence was 2.1 times larger than TasP

Preventing HIV Transmission: The PrEP Gap in the United States

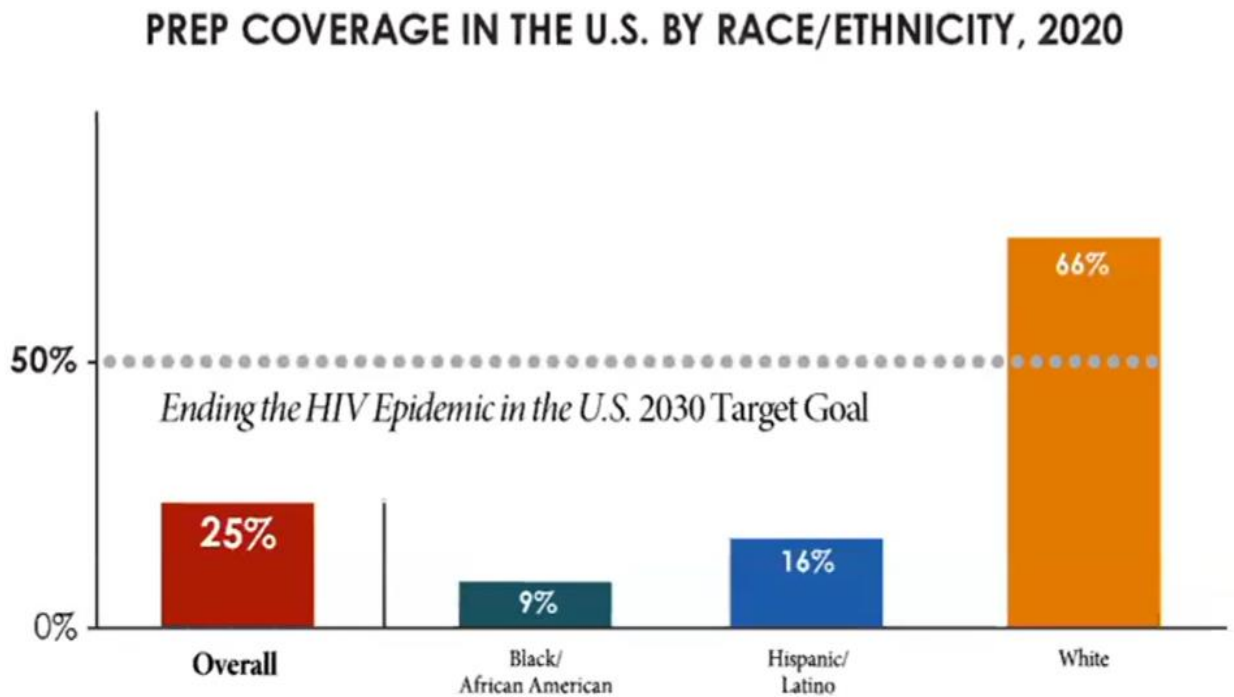
People With an Indication for PrEP (2018)

1.2 Million Americans Are Likely to Benefit From PrEP



Disparities in PrEP Use and Persistence

WHILE 25% OF PEOPLE ELIGIBLE FOR PREP WERE PRESCRIBED IT IN 2020, COVERAGE IS NOT EQUAL



Preventing HIV Transmission: The PrEP Gap in Arizona

- AZ PrEP needs
  - Total 25,300
  - MSM 19,000
    - Hispanic MSM 7,000
    - White MSM 7,200
    - AA MSM 2,500

PrEP to need ratio (PNR)

- Ratio of *PrEP use* to *number of newly Dx*
- PNR of successful cities in the US: 1:20 +
- Maricopa
  - Current PrEP use: 67/100K
  - Current PNR: 1:5.7 (2019)

In Maricopa County, we need to increase PrEP use by 5 fold!

FAST-TRACK CITIES PLAN

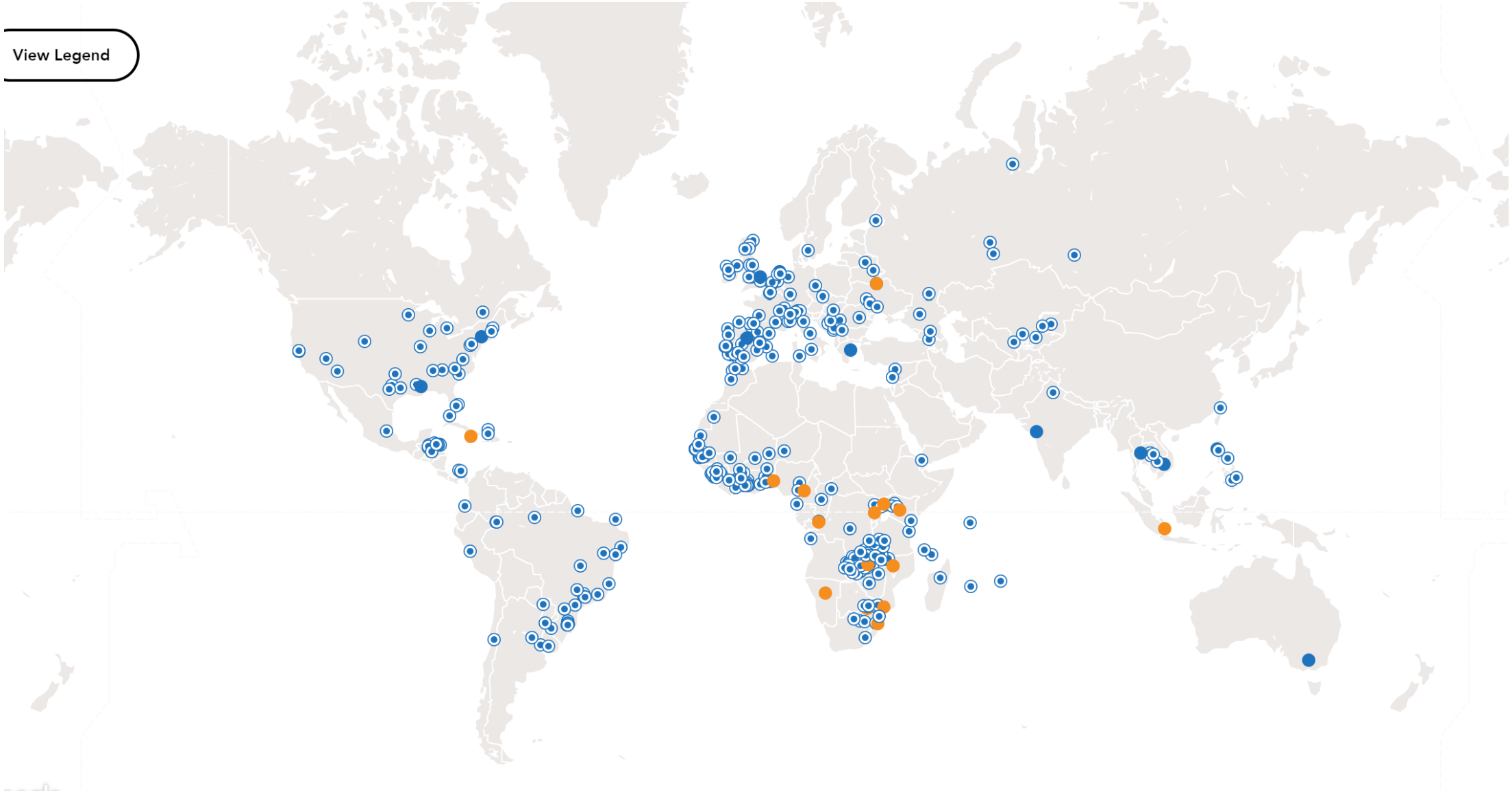
MISSION: To strengthen HIV programs and leverage resources in order to end AIDS by 2030.

FAST-TRACK CITIES

HOME FAS

Select a region ▼ | Select a city ▼ RESET MAP / FILTERS

View Legend



PARIS DECLARATION

We stand at a defining moment in the AIDS response. Thanks to scientific breakthroughs, community activism and political commitment to shared goals, we have a real opportunity to end the AIDS epidemic globally by 2030. Cities have long been at the forefront of responding to AIDS. Cities now are uniquely positioned to lead Fast-Track action towards achieving the 90-90-90 targets by 2020: 90% of people living with HIV knowing their HIV status; 90% of people who know their HIV-positive status on treatment; and 90% of people on treatment with suppressed viral loads.

We can stop all new HIV infections and avert AIDS-related deaths, including deaths caused by tuberculosis. We can end stigma and discrimination. Every person in our cities must have access to life-saving HIV and tuberculosis prevention, treatment, care and support services.

Working together, cities can take local actions for global impact. Leveraging our reach, infrastructure and human capacity, cities will build a more equitable, inclusive, prosperous and sustainable future for all of our residents-regardless of gender, age, social and economic
status or sexual orientation.

WE, THE MAYORS, COMMIT TO:

1 End the AIDS epidemic in cities by 2030

We commit to achieve the 90-90-90 HIV treatment targets by 2020, which will rapidly reduce new HIV infections and AIDS-related deaths-including from tuberculosis-and put us on the Fast-Track to ending AIDS by 2030. We commit to provide sustained access to testing, treatment, and prevention services. We will end stigma and discrimination.

2 Put people at the centre of everything we do

We will focus, especially on people who are vulnerable and marginalized. We will respect human rights and leave no one behind. We will act locally and in partnership with our communities to galvanize global support for healthy and resilient societies and for sustainable development.

3 Address the causes of risk, vulnerability and transmission

We will use all means including municipal ordinances and other tools to address factors that make people vulnerable to HIV, and other diseases. We will work closely with communities, service providers, law enforcement and other partners, and with marginalized and vulnerable populations including slum dwellers, displaced people, young women, sex workers, people who use drugs, migrants, men who have sex with men and transgender people to build and foster tolerance.

4 Use our AIDS response for positive social transformation

Our leadership will leverage innovative social transformation to build societies that are equitable, inclusive, responsive, resilient and sustainable. We will integrate health and social programmes to improve the delivery of services including HIV, tuberculosis and other diseases. We will use advances in science, technology and communication to drive this agenda.

5 Build and accelerate an appropriate response to local needs

We will develop and promote services that are innovative, safe, accessible, equitable and free of stigma and discrimination. We will encourage and foster community leadership and engagement to build demand and to deliver services responsive to local needs.

6 Mobilize resources for integrated public health & development

Investing in the AIDS response together, with a strong commitment to public health, is a sound investment in the future of our cities that fosters productivity, shared prosperity and well-being. We will adapt our city plans and resources for a Fast-Tracked response. We will develop innovative funding and mobilize additional resources and strategies to end the AIDS epidemic by 2030.

7 Unite as leaders

We commit to develop an action plan and join with a network of cities to make this Declaration a reality. Working in broad consultation with everyone concerned, we will regularly measure our results and adjust our responses to be faster, smarter and more effective. We will support other cities and share our experiences, knowledge and data about what works and what can be improved. We will report annually on our progress.

City Phoenix

Signature Greg Stanton

Date 11/29/2016

Anne HIDALGO
Mayor of Paris

Michel SIDIBÉ
UNAIDS

Joan CLOS
UN-Habitat

José M. ZUNIGA
IAPAC

EXECUTIVE SUMMARY

The Fast-Track Cities Initiative (FTCI) is a global partnership between the City of Paris, Joint United Nations Program on HIV/AIDS (UNAIDS), United Nations Human Settlement Program (UN-Habitat), and the International Association of Providers of AIDS Care (IAPAC), in collaboration with the local, national, regional and international partners and stakeholders.

On October 25, 2016, Phoenix Mayor Greg Stanton and the Phoenix City Council authorized the City of Phoenix to join the Fast-Track Cities Initiative. Mayor Stanton appointed Vice-Mayor Laura Pastor and Councilman Daniel Valenzuela to co-chair the initiative. The Mayor appointed a diverse 23-member Ad-Hoc Committee representing people living with HIV, medical providers, community-based organizations, local HIV advocacy groups, and government departments in the HIV field.

There are currently 11 Fast-Track Cities in North America, 10 of which are in the United States. Fast-Track Cities work towards ending AIDS as a public health threat by 2030 by building upon, strengthening and leveraging exciting HIV-related programs and resources. Fast-Track Cities agree to achieve the following 90-90-9-0 targets by 2020.

90%
of people living with the HIV (PLHIV) knowing their HIV status

90%
of PLHIV who know their HIV-positive status on antiretroviral therapy (ART)

90%
of PLHIV on ART achieving viral suppression

0%
Zero discrimination and stigma against people living with HIV

The initiative is framed around a five-element implementation plan, supported by IAPAC, which addresses key aspects necessary for a robust citywide AIDS response that promotes continuum of care of HIV diagnosis to viral suppression:

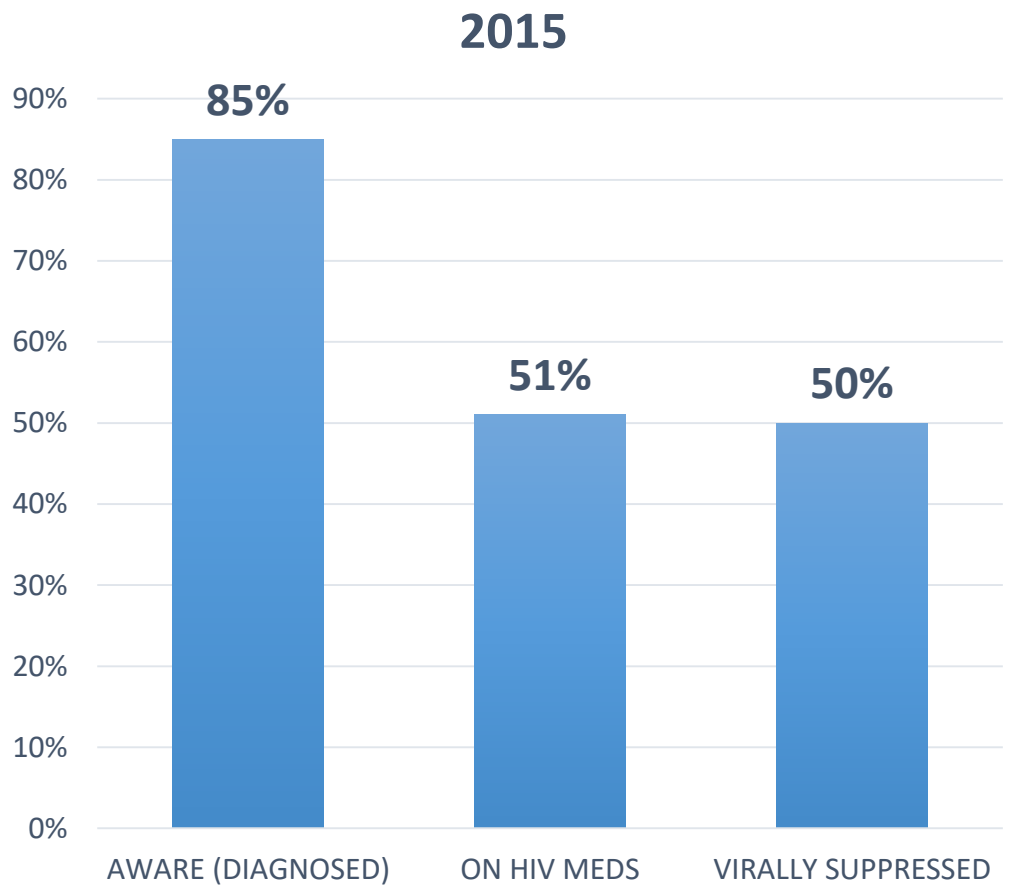
1. Process and Oversight
2. Monitoring and Evaluation
3. Program and Interventions
4. Communications
5. Resource Mobilization

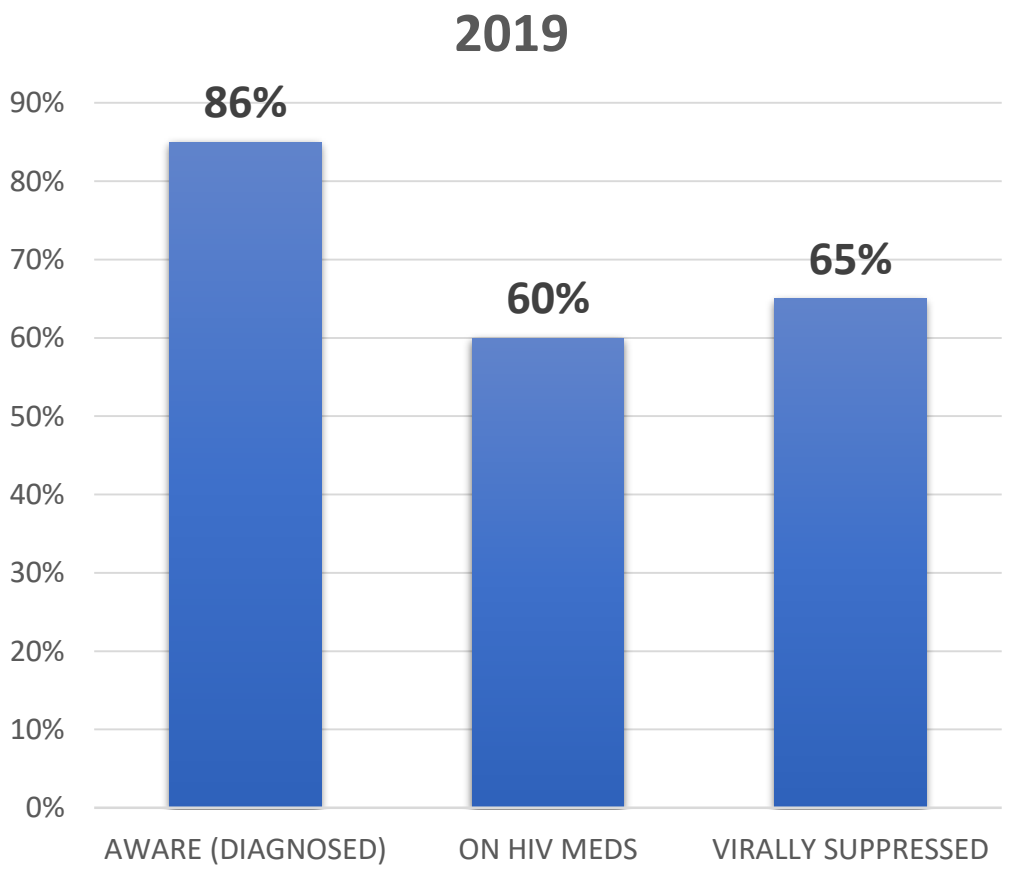
The Ad Hoc Committee has established strong partnerships with the Arizona Department of Health Services, Maricopa Ryan White Part A Program, City of Phoenix programs, and a coalition of community-based organizations. Each entity has pledged resources to support the Fast-Track Cities initiative. Several members of the Ad Hoc Committee are also members of the HIV Statewide Advisory Group, and/or the Phoenix EMA Ryan White Planning Council.

- Citywide Rapid Start Program in Maricopa County
- Launched in September 2018
- Goal: link patient to care within 0 to 5 days
- Inclusion:
  - Newly diagnosed HIV patients
  - Previously diagnosed: treatment naïve or treatment experienced

- START Navigation
  - Apply for health insurance, AHCCCS, Ryan White, ADAP
  - Process paperwork in less than 4 hours
  - Immediate linkage to care and ART
  - Provide case management and other support services
- 7 START Clinics in Maricopa County

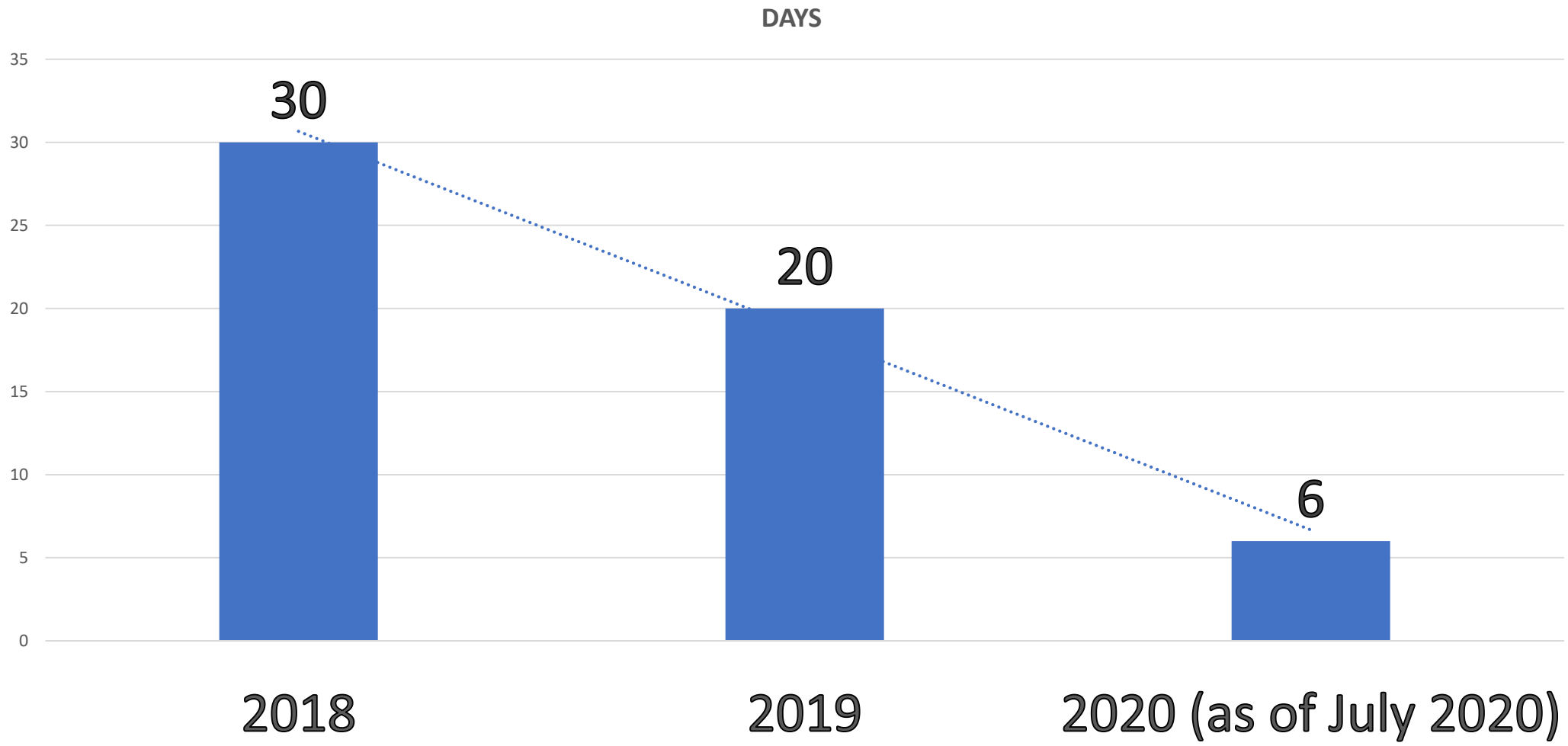
90-90-90 Data 2015/2019





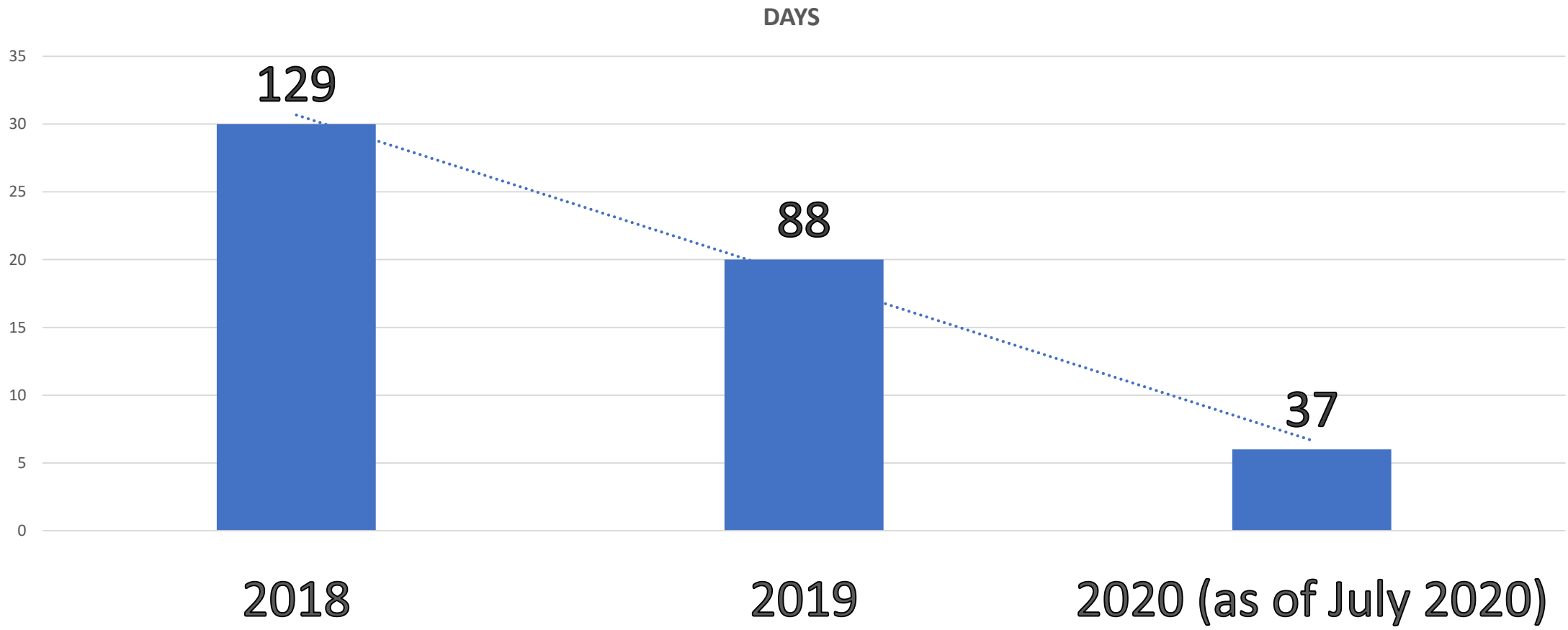
Phoenix.gov/HIVPHX

Preliminary Results of START:
Days from diagnosis to linkage to care in Maricopa County down to 6 days



Phoenix.gov/HIVPHX

Preliminary Results of START:
Days from diagnosis to viral suppression in Maricopa County down to 37 days



Phoenix.gov/HIVPHX

Expansion of PrEP in Maricopa County

- Increase PrEP prescribers among Primary Care Providers
- Expand PrEP program at FQHCs
- Increase opt-out HIV testing in emergency rooms
- Increase utilization of PrEP/PEP navigator

How can you help us end HIV epidemic in our community?

USPSTF Recommendation

HIV testing

Population	Recommendation	Grade
Pregnant persons	The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown.	A
Adolescents and adults aged 15 to 65 years	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened. See the Clinical Considerations section for more information about assessment of risk, screening intervals, and rescreening in pregnancy.	A

PrEP

Population	Recommendation	Grade
Persons at high risk of HIV acquisition	The USPSTF recommends that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. See the Clinical Considerations section for information about identification of persons at high risk and selection of effective antiretroviral therapy.	A

IF YOU HAVE A PATIENT WHO IS

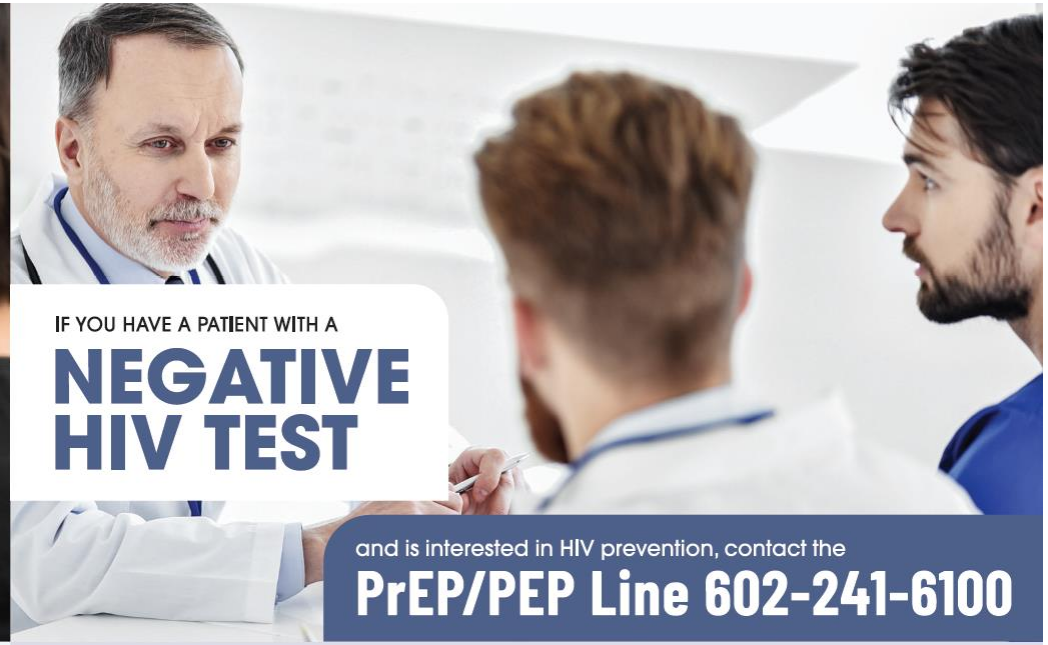
DIAGNOSED WITH HIV

Call the START Line

START STATE OF ARIZONA RAPID TREATMENT **602-212-3788**

- Rapid Access to free or low-cost medical care*
- Rapid Access to free medications*
- Deductible, co-pay and co-insurance financial assistance
- Applying for health insurance
- Case Management
- Other supportive services: dental, nutrition, mental health and substance use treatment and housing referrals

*for those who meet eligibility guidelines



IF YOU HAVE A PATIENT WITH A

NEGATIVE HIV TEST

and is interested in HIV prevention, contact the

PrEP/PEP Line 602-241-6100

PrEP, or pre-exposure prophylaxis, is medicine taken daily that can reduce the chance of getting HIV if exposed sexually.

PEP, or post-exposure prophylaxis, is medicine taken after an exposure to HIV to prevent becoming infected.

PEP must be started within **72 hours (3 days)** after exposure.
But the sooner the better.

The PrEP/PEP Navigator will help your patient:

- Access medication assistance programs
- Apply for health insurance (AHCCCS, Affordable Care Act, etc.)
- Support medication adherence to PrEP/PEP

City of Phoenix

PHOENIX FAST TRACK City

For more information about HIV, visit: www.HIVAZ.org

Thank You!

AETC AIDS Education & Training Center Program Pacific

PEP to PrEP:

A Brief Overview of PEP and Transitioning to PrEP

Larry York, PharmD, BCIDP, BCPS, AAHIVP

Clinical Pharmacist, Petersen HIV Clinics

Objectives

- Review common agents used and workup for HIV post-exposure prophylaxis
- Understand recent changes to STI management
- Explore strategies for initiating PrEP in patients taking PEP

POST EXPOSURE PROPHYLAXIS

What is Post-Exposure Prophylaxis (PEP)?

A 28-day course of antiretroviral medication taken **AFTER** potential HIV exposure.

Consists of **2 pills.** One pill is a combination of two medications.

PEP is an **urgent** request to be handled as soon as possible.

PEP is not effective if initiated after 72 hours

Recommended PEP Regimen

Tenofovir disoproxil + emtricitabine + dolutegravir or raltegravir

- Excellent tolerability
- Proven potency in established HIV infection
- Highly effective in reducing transmission *if taken as prescribed*
- Ease of administration

+

or

= PEP Medications

Dolutegravir

Advantages	Disadvantages
• Well-tolerated • Once-daily dosing • Very high barrier to HIV resistance	• Neural tube defects?

Raltegravir

Advantages	Disadvantages
• Well-tolerated • Data for use in pregnancy • Very low risk of drug interactions	• Twice-daily dosing • Lower barrier to HIV resistance

Dolutegravir and Neural Tube Defects?

- Recent study from Botswana suggested this connection
  - Has not been observed in studies or through US pregnancy registry
- Incidence of NTDs comparatively higher in Botswana
- More recent data from this study did not find a statistically significant increase in neural tube defects

Drug Interactions of INSTI-Based PEP

- DTG and RAL can chelate polyvalent cations and lose efficacy
  - Give 2 hours before or 6 hours after Ca/Mg/Fe/Al/Zn supplements
- Not recommended with select anticonvulsants
  - Phenytoin, phenobarbital, carbamazepine diminish INSTI levels
- DTG can increase metformin levels
  - Monitor closely
  - Consider metformin 1,000 mg/day max during duration

Non-Occupational PEP Testing

Table 2. Recommended schedule of laboratory evaluations of source and exposed persons for providing nPEP with preferred regimens

Test	Source	Exposed persons			
	Baseline	Baseline	4–6 weeks after exposure	3 months after exposure	6 months after exposure
		For all persons considered for or prescribed nPEP for any exposure			
HIV Ag/Ab testing[a] (or antibody testing if Ag/Ab test unavailable)	✓	✓	✓	✓	✓[b]
Hepatitis B serology, including: hepatitis B surface antigen hepatitis B surface antibody hepatitis B core antibody	✓	✓	—	—	✓[c]
Hepatitis C antibody test	✓	✓	—	—	✓[d]
		For all persons considered for or prescribed nPEP for sexual exposure			
Syphilis serology[e]	✓	✓	✓	—	✓
Gonorrhea[f]	✓	✓	✓[g]	—	—
Chlamydia[f]	✓	✓	✓[g]	—	—
Pregnancy[h]	—	✓	✓	—	—
		For persons prescribed tenofovir DF+ emtricitabine + raltegravir or tenofovir DF+ emtricitabine + dolutegravir			
Serum creatinine (for calculating estimated creatinine clearance[i])		✓	✓	—	—
Alanine transaminase, aspartate aminotranferase		✓	✓	—	—
	For all persons with HIV infection confirmed at any visit				
HIV viral load	✓	✓[j]			
HIV genotypic resistance	✓	✓[j]			

Source: https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf

nPEP Testing Footnotes

Abbreviations: Ag/Ab, antigen/antibody combination test; HIV, human immunodeficiency virus; nPEP, nonoccupational postexposure prophylaxis; tenofovir DF, tenofovir disoproxil fumarate.

a. Any positive or indeterminate HIV antibody test should undergo confirmatory testing of HIV infection status.
b. Only if hepatitis C infection was acquired during the original exposure; delayed HIV seroconversion has been seen in persons who simultaneously acquire HIV and hepatitis C infection.
c. If exposed person susceptible to hepatitis B at baseline.
d. If exposed person susceptible to hepatitis C at baseline.
e. If determined to be infected with syphilis and treated, should undergo serologic syphilis testing 6 months after treatment.

https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf

nPEP Testing Footnotes 2

f. Testing for chlamydia and gonorrhea should be performed using nucleic acid amplification tests. For patients diagnosed with a chlamydia or gonorrhea infection, retesting 3 months after treatment is recommended.
   - For men reporting insertive vaginal, anal, or oral sex, a urine specimen should be tested for chlamydia and gonorrhea.
   - For women reporting receptive vaginal sex, a vaginal (preferred) or endocervical swab or urine specimen should be tested for chlamydia and gonorrhea.
   - For men and women reporting receptive anal sex, a rectal swab specimen should be tested for chlamydia and gonorrhea.
   - For men and women reporting receptive oral sex, an oropharyngeal swab should be tested for gonorrhea.
   - (http://www.cdc.gov/std/tg2015/tg-2015-print.pdf)

https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf

nPEP Testing Footnotes 3

g. If not provided presumptive treatment at baseline, or if symptomatic at follow-up visit.
h. If woman of reproductive age, not using effective contraception, and with vaginal exposure to semen.
i. eCrCl = estimated creatinine clearance calculated by the Cockcroft-Gault formula; eCrCl CG = [(140 − age) x ideal body weight] ÷ (serum creatinine x 72) (x 0.85 for females).
j. At first visit where determined to have HIV infection.

https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf

SEXUALLY TRANSMITTED INFECTION UPDATES

Gonorrhea

- Azithromycin no longer recommended with ceftriaxone
  - Very little to no added benefit
  - Unnecessary exposure worsening antimicrobial stewardship
- Ceftriaxone dose increased to 500 mg IM
  - If weight > 150 kg, administer 1 g IM
- Cefixime alternative increased from 400 mg to 800 mg once
- ALWAYS confirm eradication of oropharyngeal gonorrhea
  - Retest with repeat throat swab at least 2 weeks after treatment

Chlamydia

- Doxycycline 100 mg PO BID x 7 days now recommended
  - Azithromycin 1,000 mg PO once now an alternative treatment
- Azithromycin still an option if concerned for follow-up
  - A first line option if individual is pregnant
- Primary concern is around rectal concentrations
  - Azithromycin has great urinary but reduced rectal concentrations
- Doxycycline likely has higher GI adverse effects

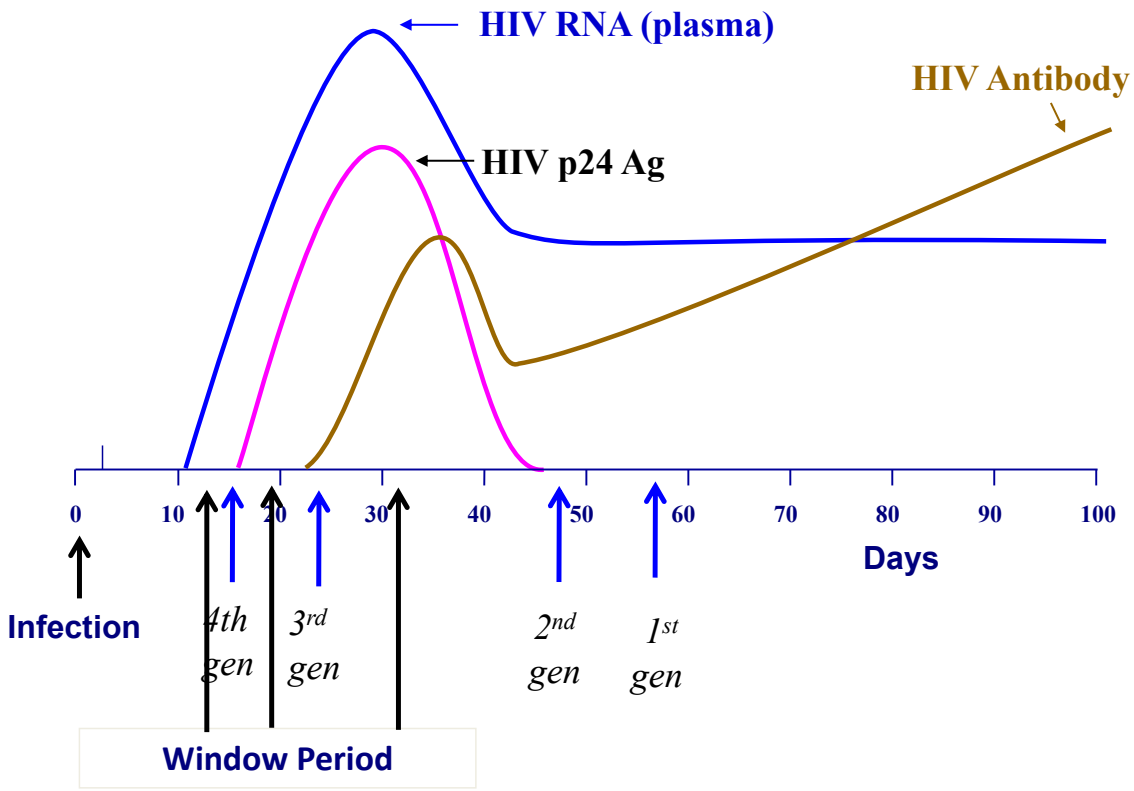
Trichomonas

- Recommended regimen now a longer duration
  - Metronidazole 500 mg PO BID x 7 days
  - Previously 2,000 mg PO once was acceptable for women
    - 50% of women positive at baseline were also positive one month later if given the once daily regimen vs BID x 7 days

- Same concerns for metronidazole and alcohol interaction
  - Avoid alcohol ~12 hours before metronidazole dose
  - Avoid alcohol for ~72 hours after a metronidazole dose

PEP TO PREP

HIV Infection and Laboratory Markers



Modified after Busch et al. Am J Med. 1997

Slide courtesy of Bernard Branson, MD

Transitioning from PEP to PrEP

- Some PrEP counseling provided at initial visit
- We traditionally retest patients at day 25 of 28
- Prescribe PrEP upon receiving lab results
- Ideally see patient at time of transition to review PrEP

Conclusion

- Many individuals who would benefit from PrEP may first be engaged through PEP
- Basic knowledge of PEP management may be useful in PrEP patients who have poor adherence to their regimen and endorse unplanned high risk exposures
- STI management has recently seen a significant overhaul which may drastically change treatment plans/durations

THANK YOU!

National Hispanic Medical Association

Q&A Session:

Upcoming NHMA Events

- **NHMA 25th Annual Conference Mar. 24-27, 2022**
  - Crystal Gateway Marriott, Crystal City, VA
  - Visit nhmamd.org/2022-conference for registration, sponsorship & exhibitor opportunities
- **COVID-19 Virtual Briefing Session #15 on April 27, 2022**
  - Future topics to include:
    - Mental Health
    - Vaccine Rates Updates
    - Child Vaccinations & more
  - Register: https://www.nhmamd.org/covid-19-virtual-briefing-series