

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



**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 Marketing &
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

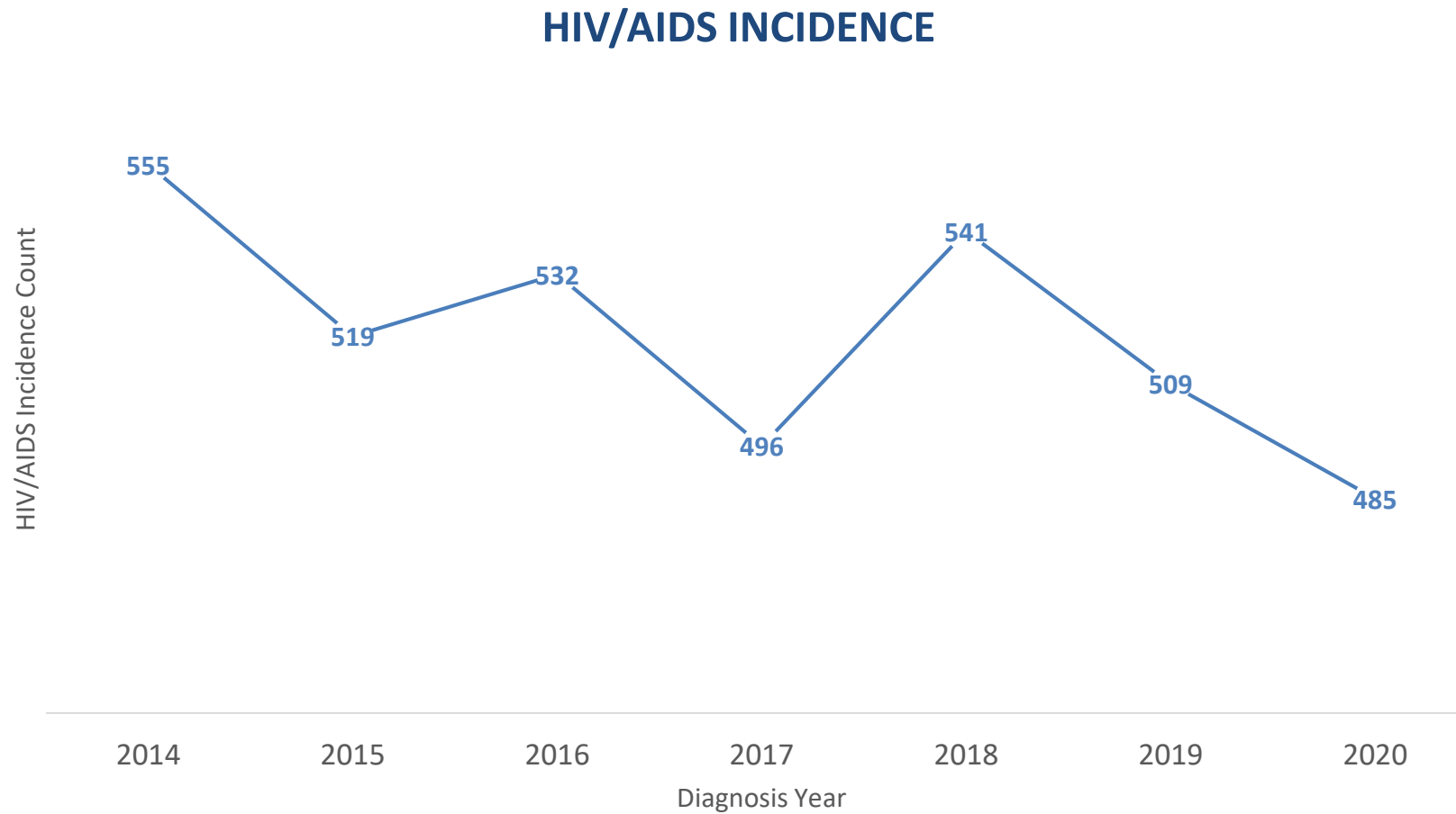
Melanie Taylor, MD, MPH
Arizona Department of Health Services
U.S. Centers for Disease Control and Prevention
March 8, 2022



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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.



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

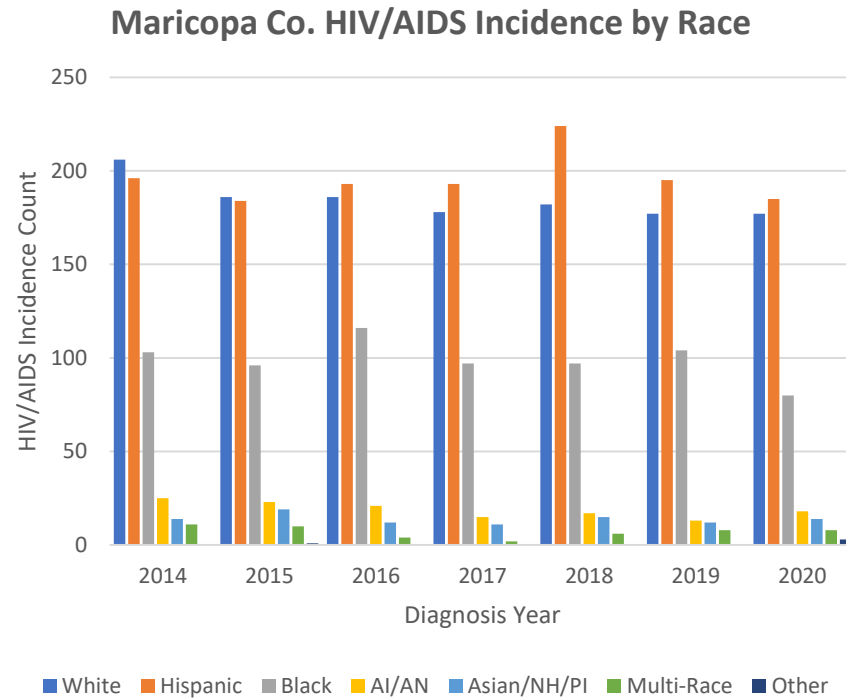


Figure 2: HIV/AIDS incidence count by race in Maricopa County from 2014-2020.

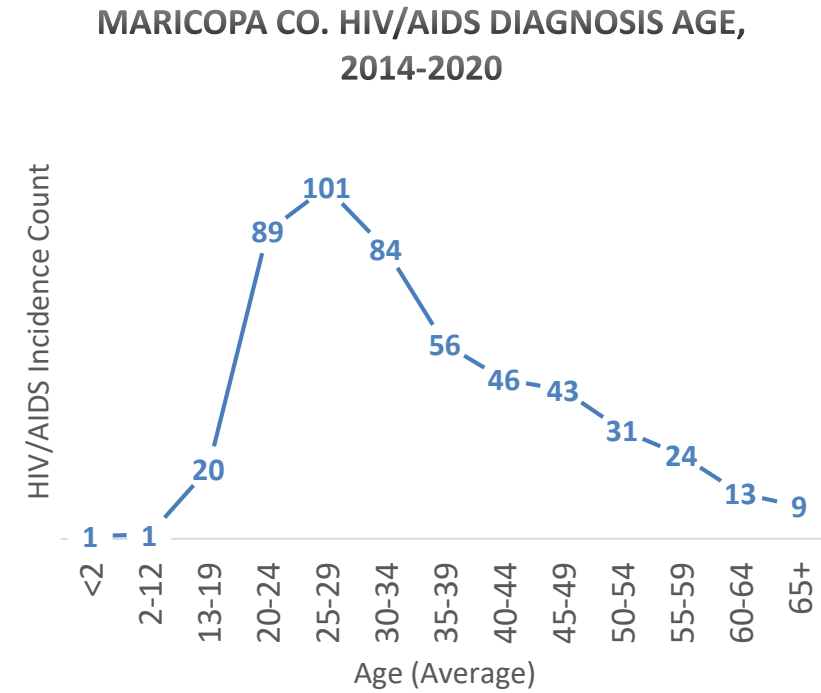


Figure 3: Average HIV/AIDS age diagnosis in Maricopa County from 2014-2020.



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

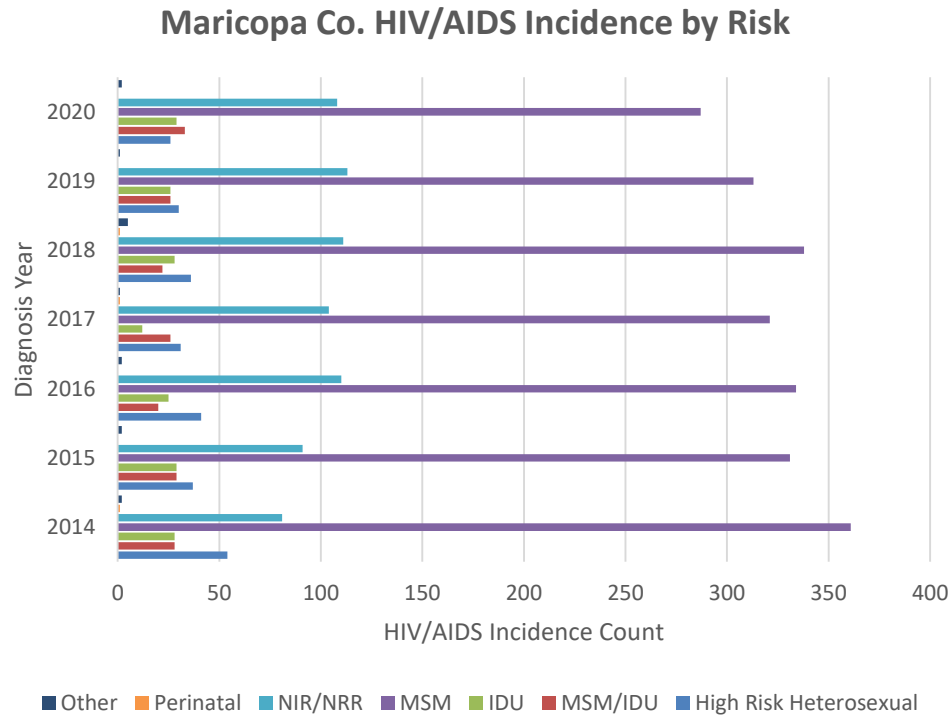


Figure 4: HIV/AIDS incidence count by risk in Maricopa County from 2014-2020.

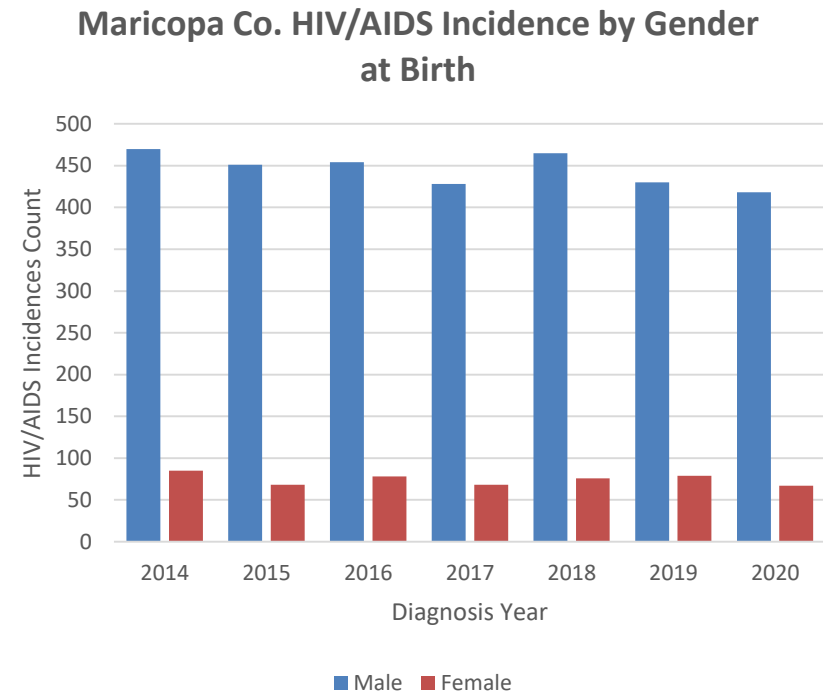


Figure 5: HIV/AIDS incidence count by sex at birth in Maricopa County from 2014-2020.



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%**.”*

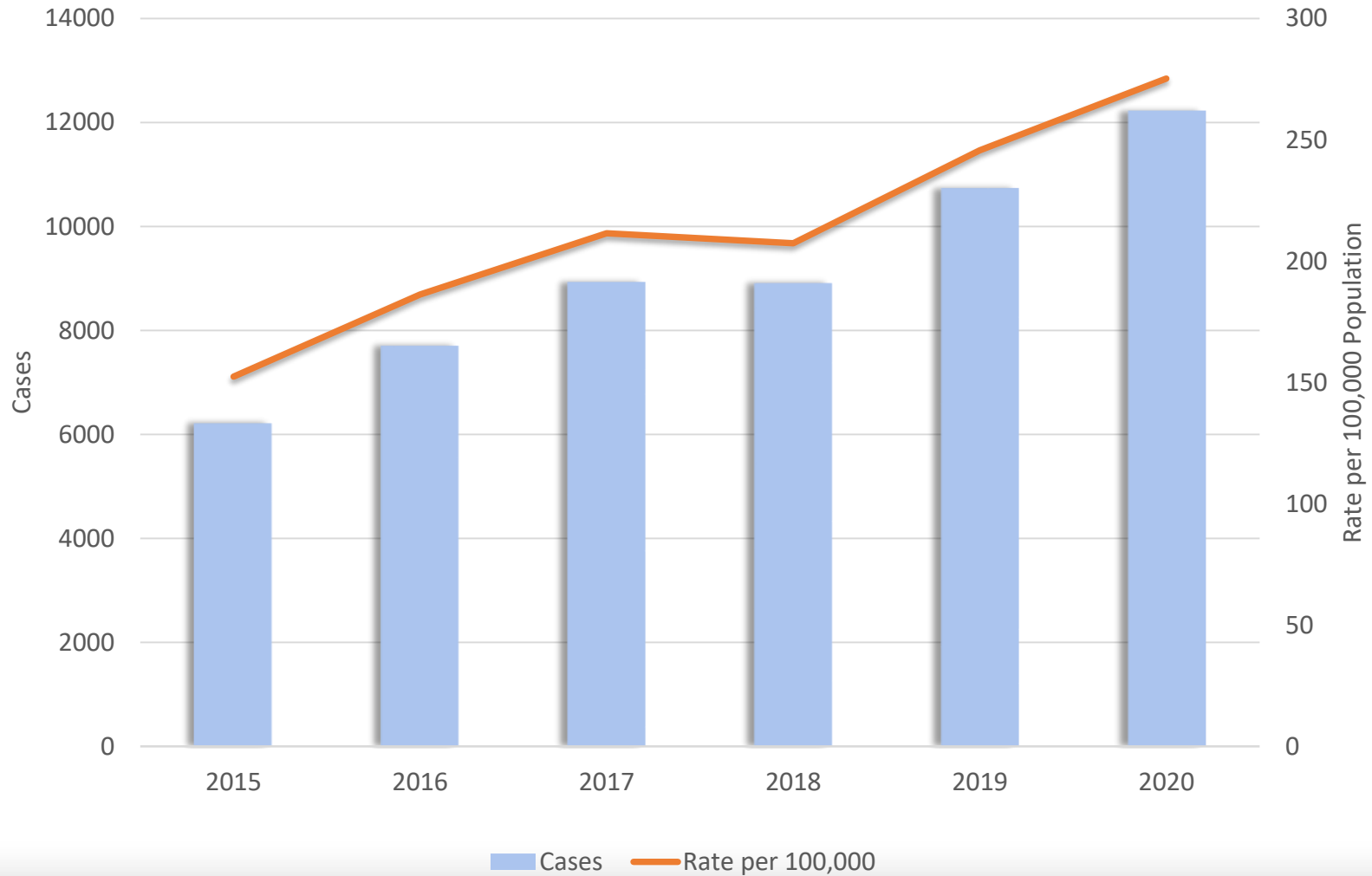


Increase Awareness of PrEP as an Option

- **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



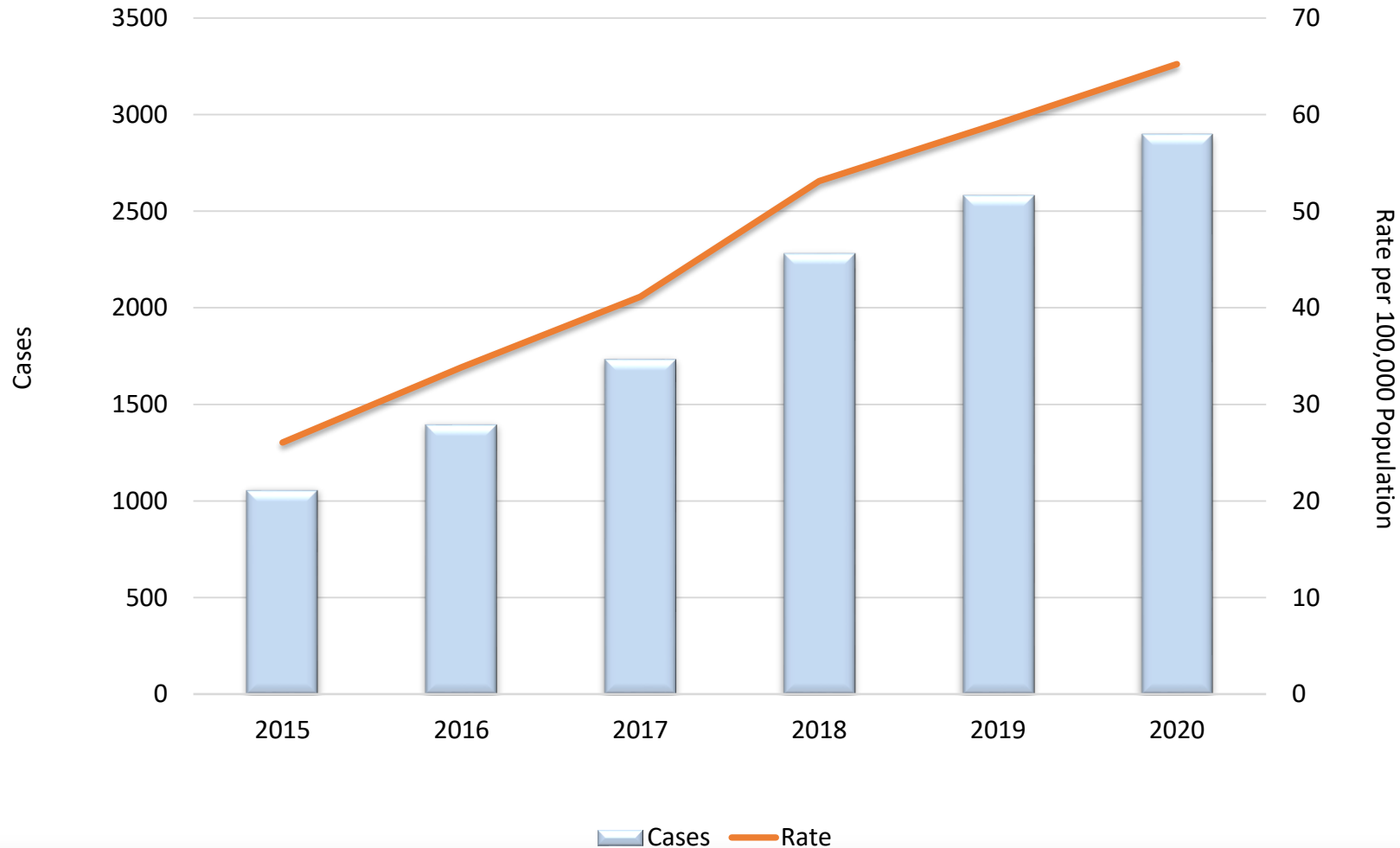
Temporal Trend of Gonorrhea Cases, Maricopa County, 2015-2020



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



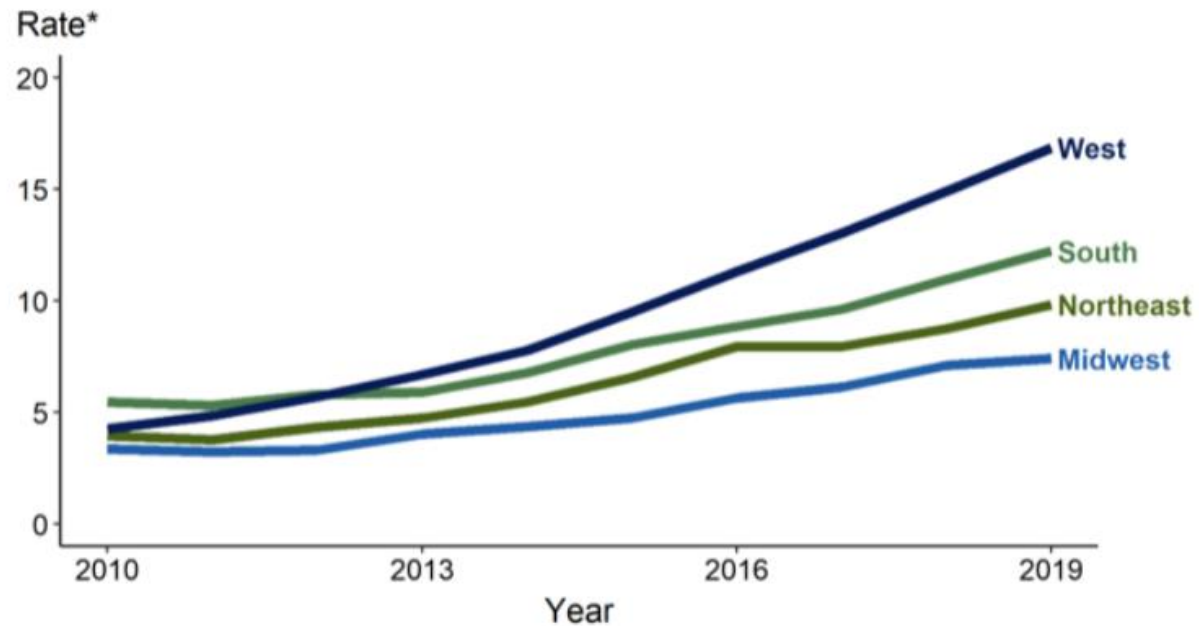
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Stages included - primary, secondary, early latent, late latent, and unknown duration

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

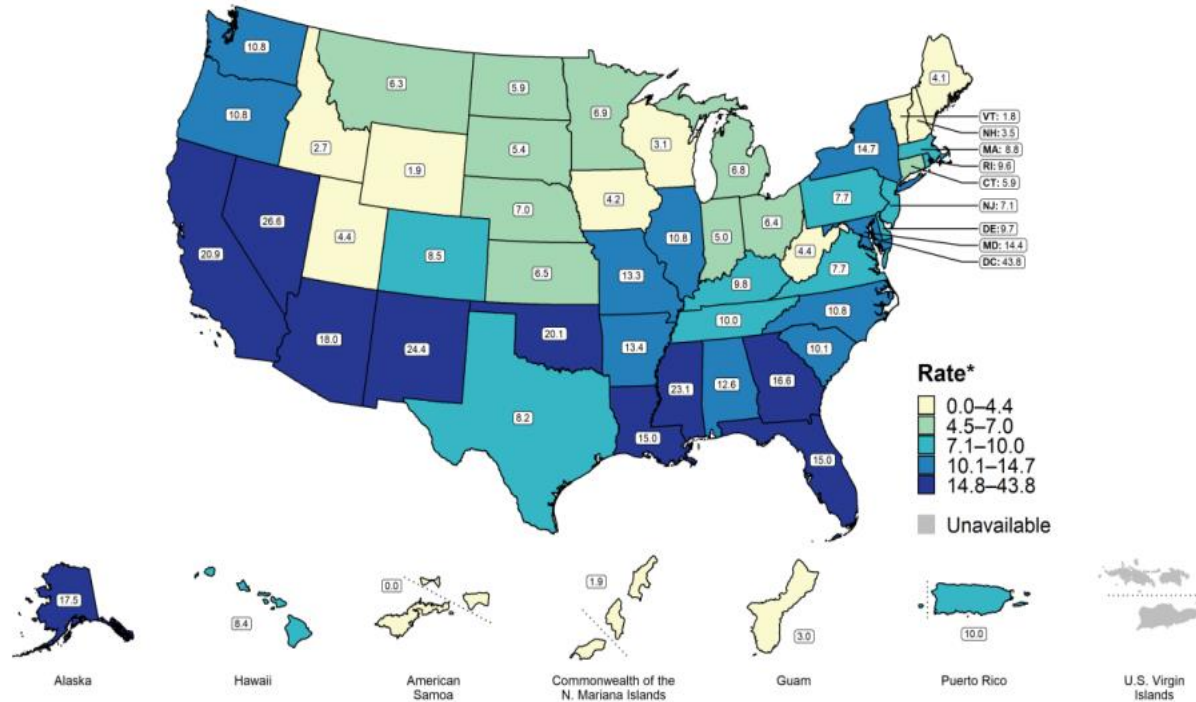
Primary and Secondary Syphilis — Rates of Reported Cases by Region, United States, 2010–2019



* Per 100,000



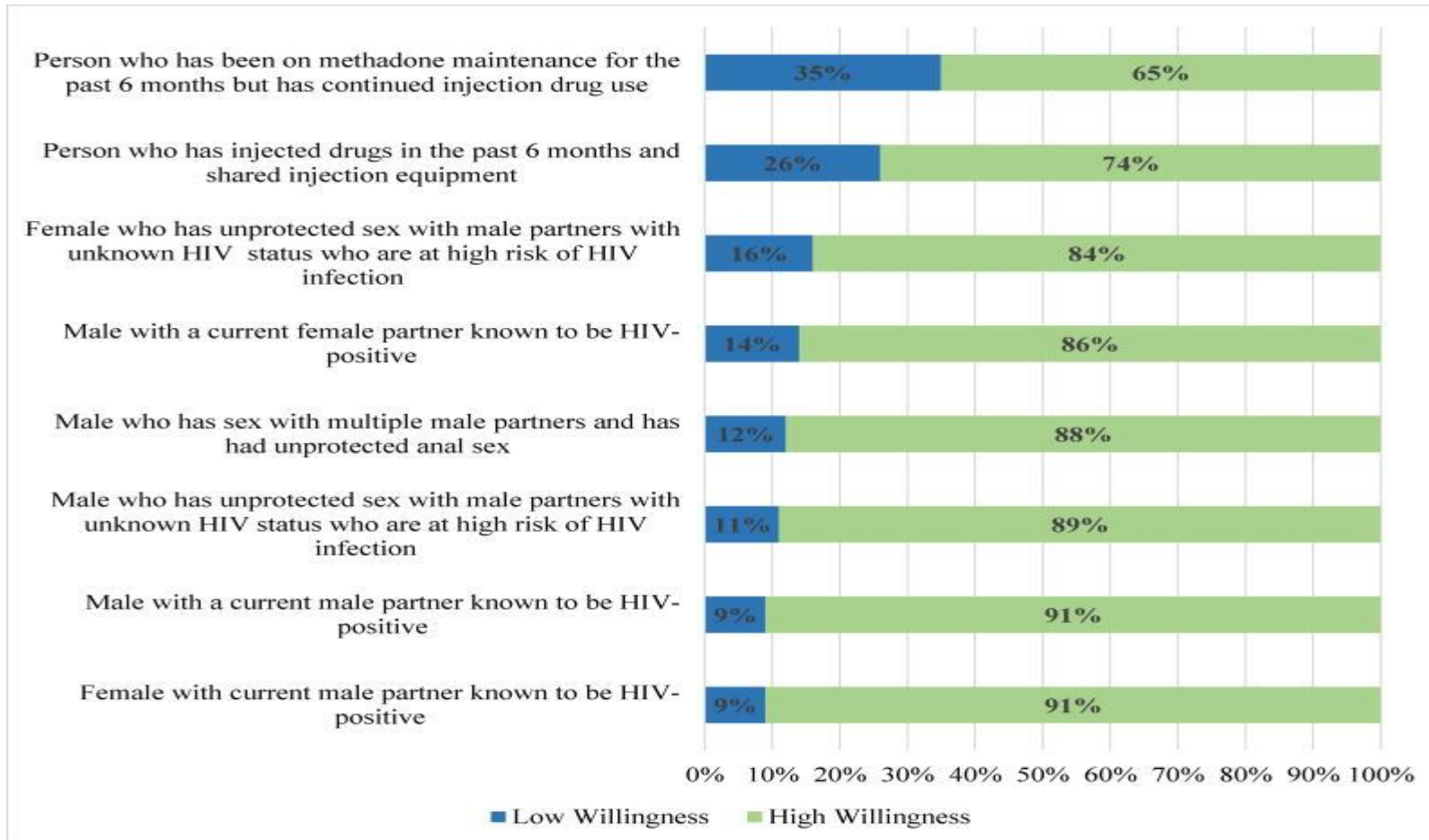
Primary and Secondary Syphilis — Rates of Reported Cases by State, United States and Territories, 2019



* Per 100,000



Physician willingness to provide PrEP



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 |
| Phoenix Children's Hospital 1919 E Thomas Rd Phoenix, Arizona 85016 (602) 933-0955 | Spectrum Medical Group 52 E Monterey Way Phoenix, Arizona 85012 (602) 604-9500 | FIT Health Care 300 W Clarendon Ave Phoenix, Arizona 85013 (602) 279-5049 |
| Arizona Pulmonary Spec. 3330 N 2nd St Phoenix, Arizona 85012 (602) 274-7195 | Your Health and Wellness 3326 N 3rd Ave Phoenix, Arizona 85013 (602) 625-7944 | First Family Medical Group 1444 W Bethany Home Rd Phoenix, Arizona 85013 (602) 242-4843 |
| Pueblo Family Physicians 4350 N 19th Ave Phoenix, Arizona 85015 (602) 264-9191 | CAN Community Health 4350 N 19th Ave Phoenix, Arizona 85015 (602) 661-0666 | Southwest Center for HIV/AIDS 1101 N Central Ave Phoenix, Arizona 85004 (602) 307-5330 |
| Valleywise Health 1101 N Central Ave Phoenix, Arizona 85004 (602) 344-6550 | | |



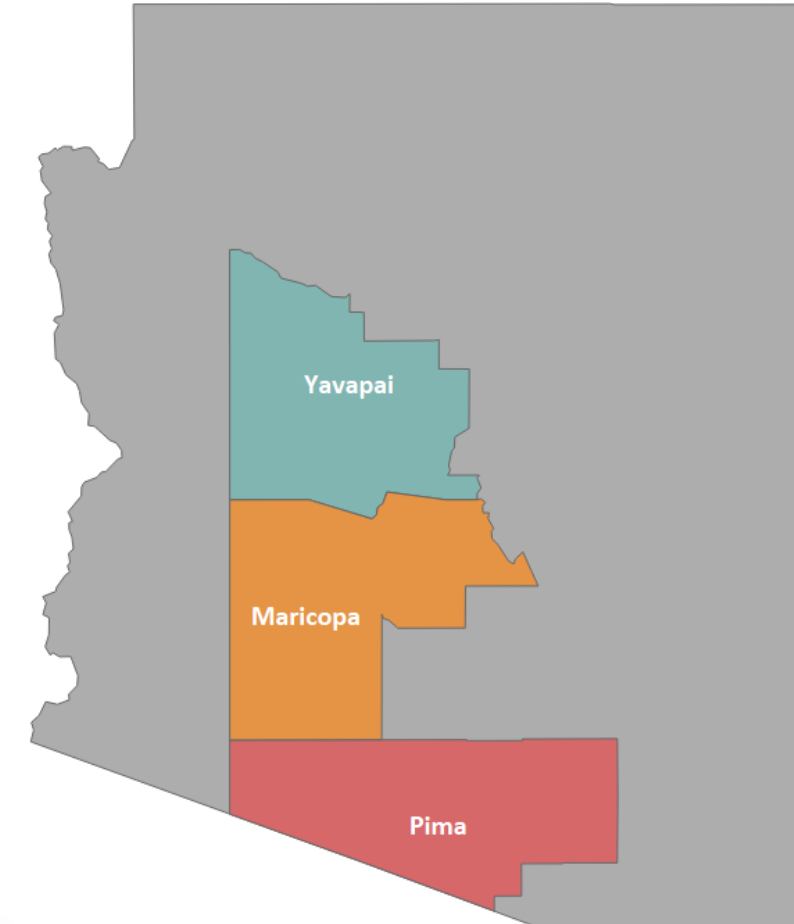
Connecting to PrEP Services in Arizona

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)



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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>



Sexual History

Partners: In the past 12 months, how many men have you had sexual contact with? How

PATIENT COUNSELING

- Daily dosing with excellent adherence is highly effective and strongly correlated with reducing the risk of acquiring HIV. Counsel individuals to strictly adhere to daily dosing instructions.
- PrEP reaches maximum protection in blood after approximately 20 days of daily dosing in people with no sexually transmitted infections (STIs) and in seronegative individuals at approximately 20 days.
- Combining prevention strategies, such as condoms plus PrEP, provides the greatest protection for men and women. Review the need for PrEP and STI testing every 3 months.
- Identify any barriers between to medication adherence.

WHAT IF MY PATIENT HAS A POSITIVE HIV TEST WHILE ON PrEP?

- Discontinue PrEP immediately to avoid potential development of HIV drug resistance.
- Determine the last time PrEP was taken and report pattern of taking PrEP.
- Ensure equipment with HIV primary care that prevent initiation of a full acute HIV treatment regimen and counseling/support services.
- Report a new HIV diagnosis through the Communicable Disease Reporting (CDR) form at cdm.azdhs.gov.

PrEP



RESOURCES

- For Arizona-specific resources regarding PrEP, visit www.azdhs.gov.
- For statewide specific resources regarding PrEP, visit www.azdhs.gov.
- For questions and clinical or research advice on HIV, PrEP, and STI contact experts at the National Clinical Consultation Center at www.nccc.nih.gov.
- CDC PrEP guidelines: www.cdc.gov/hiv/prep/
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SIDE EFFECTS & POTENTIAL RISKS

- PrEP is generally safe and well-tolerated.
- About 50% of adults experience nausea and fatigue in the first month of treatment. This typically resolves after 3-4 weeks.
- Researcher declines in kidney function (glomerular filtration rate) that is rarely clinically significant. Consider more frequent monitoring in patients with kidney disease.
- Researcher declines in bone mineral density. Use caution in those with osteoporosis or history of osteoporotic fracture. Consider baseline bone density measurements for patients with history of or at risk for osteoporosis.
- Contraindications include: HIV infection; use of TDF/FTC (Truvada) and AOC/FTC (Descovy) with other TDF/FTC, AOC/FTC, or AOC/FTC products; use of PrEP within the last 28 hours.

HOW CAN I HELP MY PATIENT PAY FOR PrEP?

- PrEP must provide insurance plans pay for PrEP. Additional assistance is available.
- PrEP is covered by PrEP: www.azdhs.gov
- PrEP is covered by PrEP: www.azdhs.gov
- Patient Assistance Foundation (PAF) www.paf.org
- PAF Foundation (501(c)(3)) www.paf.org

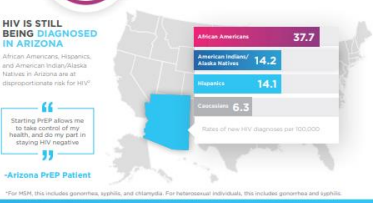
PROVIDERS CAN HELP END HIV IN ARIZONA BY PRESCRIBING PRE-EXPOSURE PROPHYLAXIS (PrEP)

WHAT IS PrEP?

- Any individual and partner(s) is a good fit for PrEP and is confirmed to have a negative test for HIV.
- PrEP is safe. Few adverse effects have been observed.
- PrEP has been FDA approved as the fixed-dose antiretroviral medications Truvada® (2012) and Descovy® (2019).

WHO MAY BENEFIT FROM PrEP?

- Anyone who has had unprotected sex with a sex partner of unknown HIV status in the past 6 months.
- Men who have sex with men (MSM).
- People who inject drugs (PWID).
- People with sexually transmitted infections (STIs).
- Sex partners with HIV risk factors.
- Includes partners of DMSD & female partners of MSM.
- Sexual partners of those living with HIV.



Baseline Assessment

(Initiate PrEP within 7 days of documented negative HIV test)

- Screening for HIV
 - If clinical symptoms of acute HIV are present, and/or an recent exposure is suspected, delay starting PrEP for one month.
 - Screen for HIV using a combination Ag/Ab test (preferred). Use Ab test (3rd generation) if combination Ag/Ab test (4th generation) is not available.



Additional Assessments

| Ongoing Assessment | Baseline | 1 Month | 3 Months After Start | Quarterly Thereafter |
|--|----------|---------|----------------------|----------------------|
| HIV Ag/Ab combo test | X | X | X | X |
| Assess symptoms of acute HIV infection | X | X | X | X |
| STI screening (recommended) | X | X | X | X |
| Creatinine clearance (eGFR) | X | X | X | X |
| Hepatitis A, B, C** | X | X | X | X |
| Urea nitrogen | X | X | X | X |
| Pregnancy test | X | X | X | X |
| Assess side effects | X | X | X | X |
| Risk-reduction counseling | X | X | X | X |
| Assess/advice adherence | X | X | X | X |
| PrEP prescription | 30 Days | 60 Days | 90 Days | 90 Days |

* Consider urine tests (gonorrhea, chlamydia, blood test (syphilis) or serologic testing, vaginal and throat for gonorrhea, chlamydia). ** Urinary health may be assessed every six months if stable, or refer to a nephrologist for consultation of testing.

** Testing for hepatitis A is recommended for MSM and PWID. Vaccinate against hepatitis A and B if not immune. Discuss treatment options in context of chronic disease. Source: www.cdc.gov/hiv/prep/



Sexual Health Key Message: Perform Syphilis and site-specific Gonorrhea and Chlamydia testing, based on sexual exposure.

PRO-TIP! LOOK OUT FOR SYPHILIS AND NEUROSYPHILIS

Think about syphilis whenever you see a sexually symptomatic rash or a sore that does not heal in a sexually active person.

Check a syphilis test when evaluating a genital ulcer and serologic tests.

Check a syphilis test whenever another STI is diagnosed. A patient's past syphilis test and treatment history is essential for determining appropriate treatment. The primary health department can help provide this information.

Check a CSF on the day of treatment-site lab number. The patient's response.

Patients who have a recent sex partner with syphilis should be presumptively treated for early syphilis with penicillin G or doxycycline even if the syphilis test is negative, and can take up to 90 days from time of exposure until test results become positive.

Neurosyphilis can occur during any stage of syphilis. All patients with syphilis should be evaluated for neurologic signs and symptoms. Social and serologic syphilis are manifestations of neurosyphilis.

Patients a better prognosis for patients when there is concern for neurosyphilis such as a positive syphilis serology and neurologic (including visual) symptoms.

For a person living with HIV, the risk for neurosyphilis is substantially higher when their CD4 count is <350 or rapid plasma reagin (RPR) is >1:32.

RESOURCES

- Arizona STD Protocols
- CDC 2015 STD Treatment Guidelines
- STD Clinical Consultation Network
- Free online CDC self-study STD modules
- California STD/HIV Prevention Training Center
- MSM Health
- National LGBT Health Education Center
- Risk assessment tools for clients

(San Francisco City Clinic) (CDC)

ADHS STD Control Program: 602-364-4571

Adapted from the San Francisco Department of Public Health. www.sfdph.org/dph/IDDC/Pages/Neurosyphilis.aspx

Promoting Sexual Health: A Guide for Clinicians

Your patients' sexual history is an important part of their overall health and wellness.

Taking a sexual history will help guide the physical exam, determine sites to screen for sexually transmitted infections (STIs), and establish your patients' STI/HIV risk.

In Arizona, STI cases are increasing even as HIV diagnoses plateau.

Since 2000, STI cases have tripled in Arizona.

Percentage increase in cases from 2018 to 2019*

- Chlamydia 6%
- Gonorrhea 18%
- Syphilis 24%

RESOURCES

Arizona's county health departments use Communicable Disease Report (CDR) forms to track local epidemiological trends and direct services where needed.

The CDR form can be found online at www.azdhs.gov.

Providers can also report using HIDSIS: www.azdhs.gov/hidsis.

For questions or help in completing the report, call 602-364-4571.

*Your county health department can help ensure patients are treated. If you are having trouble following up with a patient, a field worker can help locate them and deliver medications.

For persons newly diagnosed with HIV, assist them to rapidly access antiretroviral therapy (ART) within five days of diagnosis.

STI TREATMENT RECOMMENDATIONS**

| STI | TREATMENT |
|--|---|
| PRIMARY SYPHILIS AND EARLY LATENT SYPHILIS | Benzathine penicillin G (Bicillin L-A), 2.4 million units IM Alternative: Doxycycline 100 mg PO BID x 14 days* |
| LATE LATENT SYPHILIS OR SYPHILIS OF UNKNOWN DURATION | Benzathine penicillin G (Bicillin L-A), 12 million units, administered as 3 doses of 4 million units IM each, at least 3 weeks apart Alternative: Doxycycline 100 mg PO BID x 28 days* |
| CHLAMYDIA (UNTYPED) | Azithromycin 1 gram PO or Doxycycline 100 mg PO BID x 7 days* |
| GONORRHEA (UNTYPED) | Ceftriaxone 500 mg IM |

Discuss a PrEP recommendation with your patient. PrEP is not a recommendation for STI treatment. PrEP is safe for women of childbearing age and does not increase risk of birth defects.

Consult recommendations for neurosyphilis, latent syphilis, or atypical syphilis as supported.

For more information or alternative regimens, please see:

- CDC Treatment Guidelines: www.cdc.gov/std/treatment-guidelines/
- STD Info: www.azdhs.gov/std/

For information on syphilis clinical staging, please see:

- ADHS STD Control webpage: www.azdhs.gov/std/
- www.azdhs.gov/std/

REPORTING STIs

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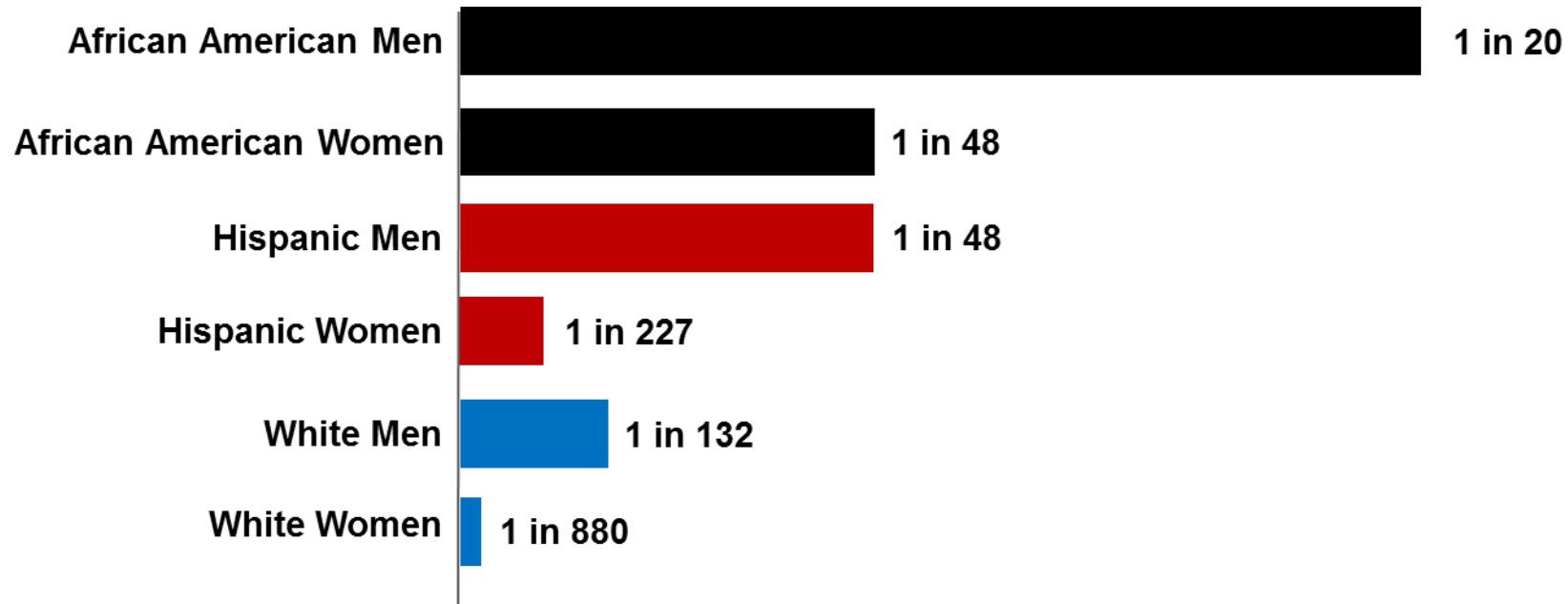
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Lifetime Risk of HIV Diagnosis by Race/Ethnicity and Sex



- 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/nchstp/newsroom/2016/croi-2016.html#Graphics> accessed Sept. 2016



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Primary Care Preventive Medications

| | Metformin | Tenofovir/Emtricitabine (TDF/FTC) |
|--------------------------------|--|---|
| Indication (package insert) | indicated as an <u>adjunct to diet and exercise</u> to improve glycemic control... | is indicated <u>in combination with safer sex practices</u> ...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**



What if there were a pill that could help prevent HIV?

There is.

Ask your doctor if PrEP is right for you.

Pre-exposure prophylaxis: A daily pill to reduce risk of HIV infection

www.cdc.gov/hiv/basics/prep.html

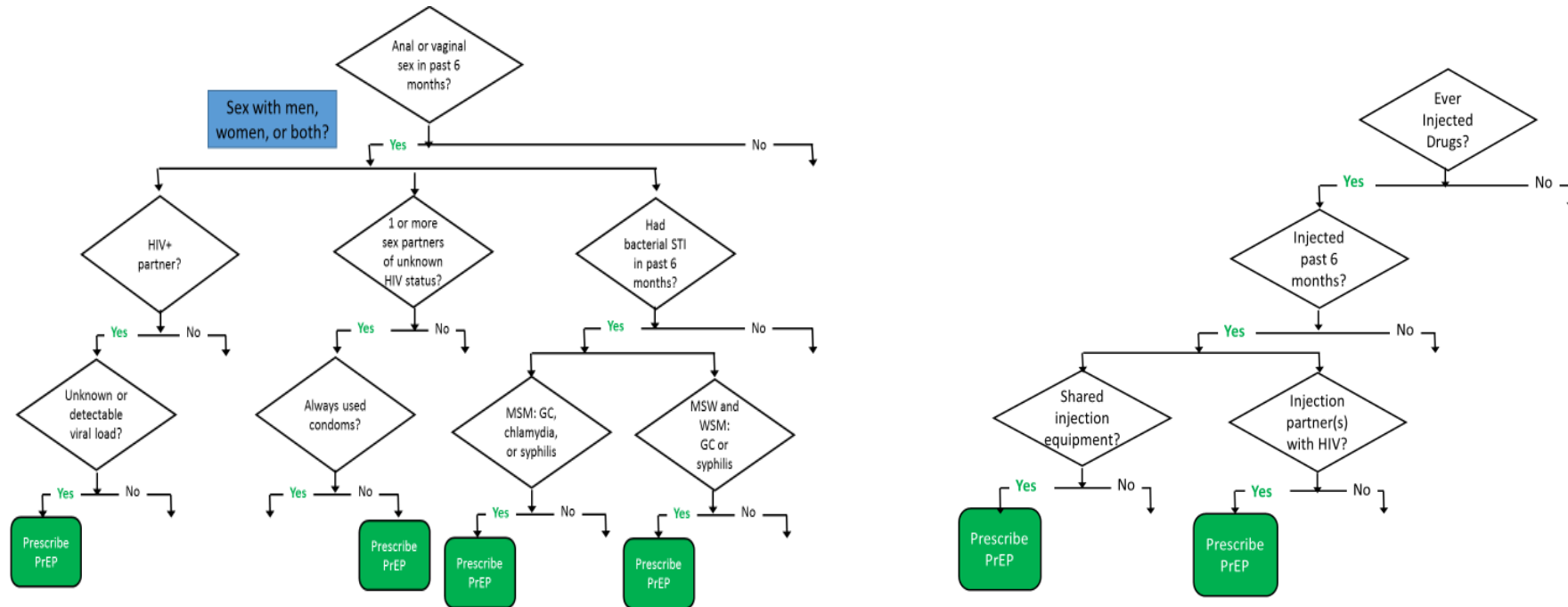


Ask simple questions of *every* patient

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



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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



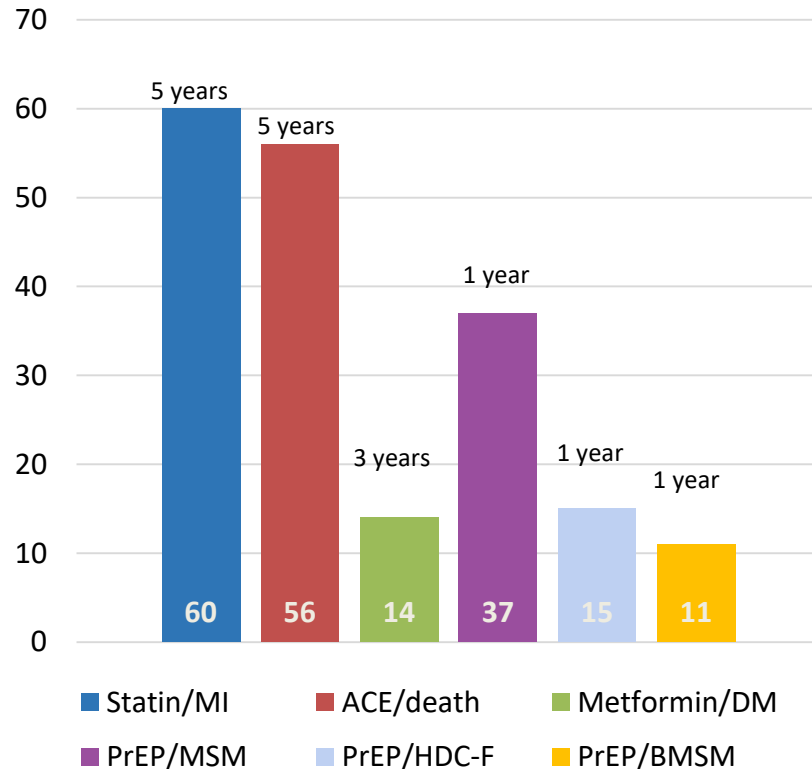
Providers in Arizona can Receive Free HIV Test Kits

- **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



www.PrEPlocator.org
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| | | |
|--|--|--|
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| Valleywise Health 1101 N Central Ave Phoenix, Arizona 85004 (602) 344-6550 | | |



THANK YOU

Melanie Taylor, MD, MPH | Medical Epidemiologist

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azhealth.gov

@azdhs

facebook.com/azdhs



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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

GOAL

75%
reduction
in new HIV
infections
in 5 years
and at least
90%
reduction
in 10 years.



HHS will work with each community to establish local teams on the ground to tailor and implement strategies to:



Diagnose all people with HIV as early as possible.

Treat people with HIV rapidly and effectively to reach sustained viral suppression.



Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).



Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.



A STATUS NEUTRAL APPROACH:



Achieving Together to End the HIV Epidemic

HIV Status Neutral: **Prevention & Treatment Cycles**

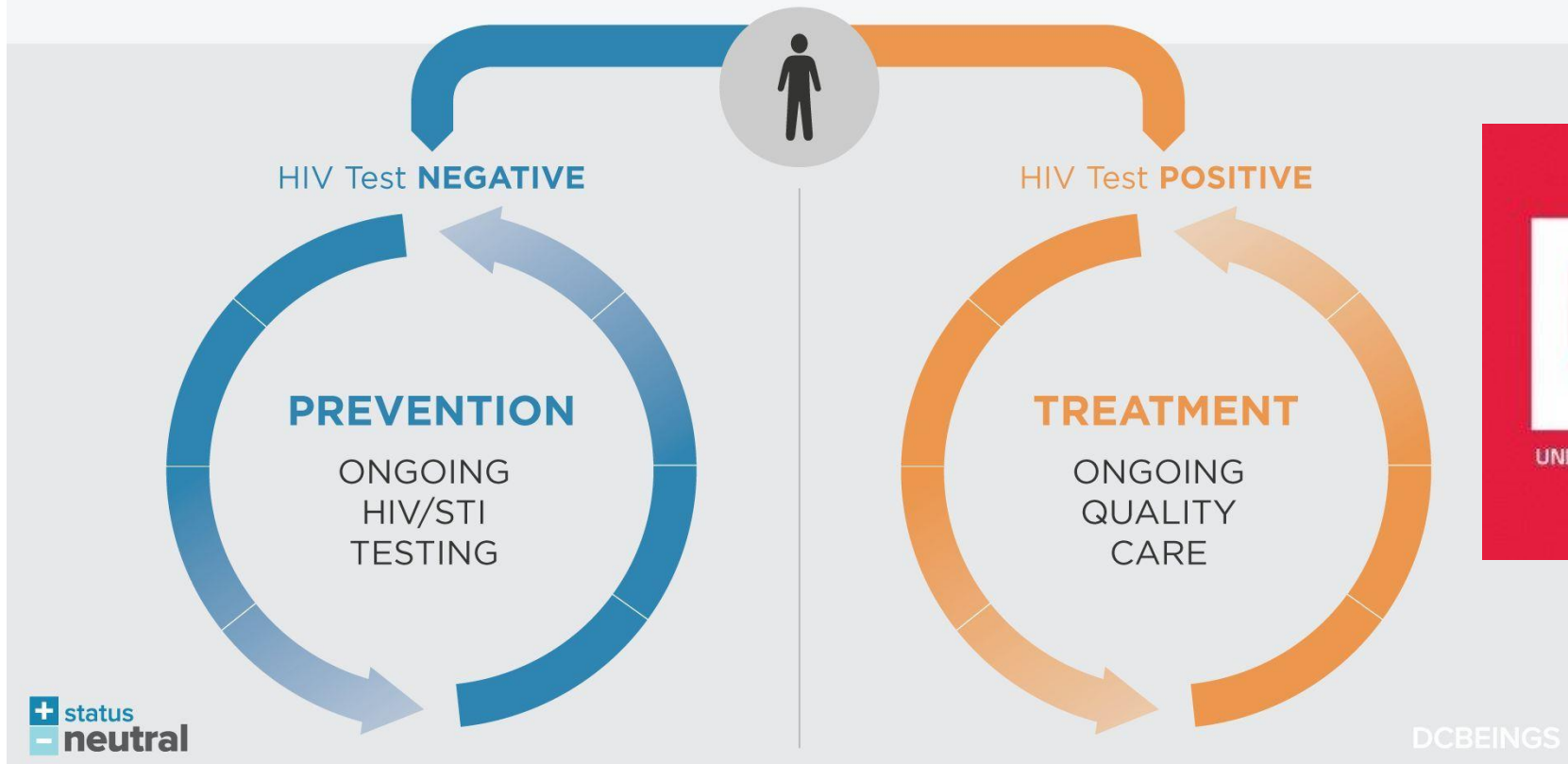
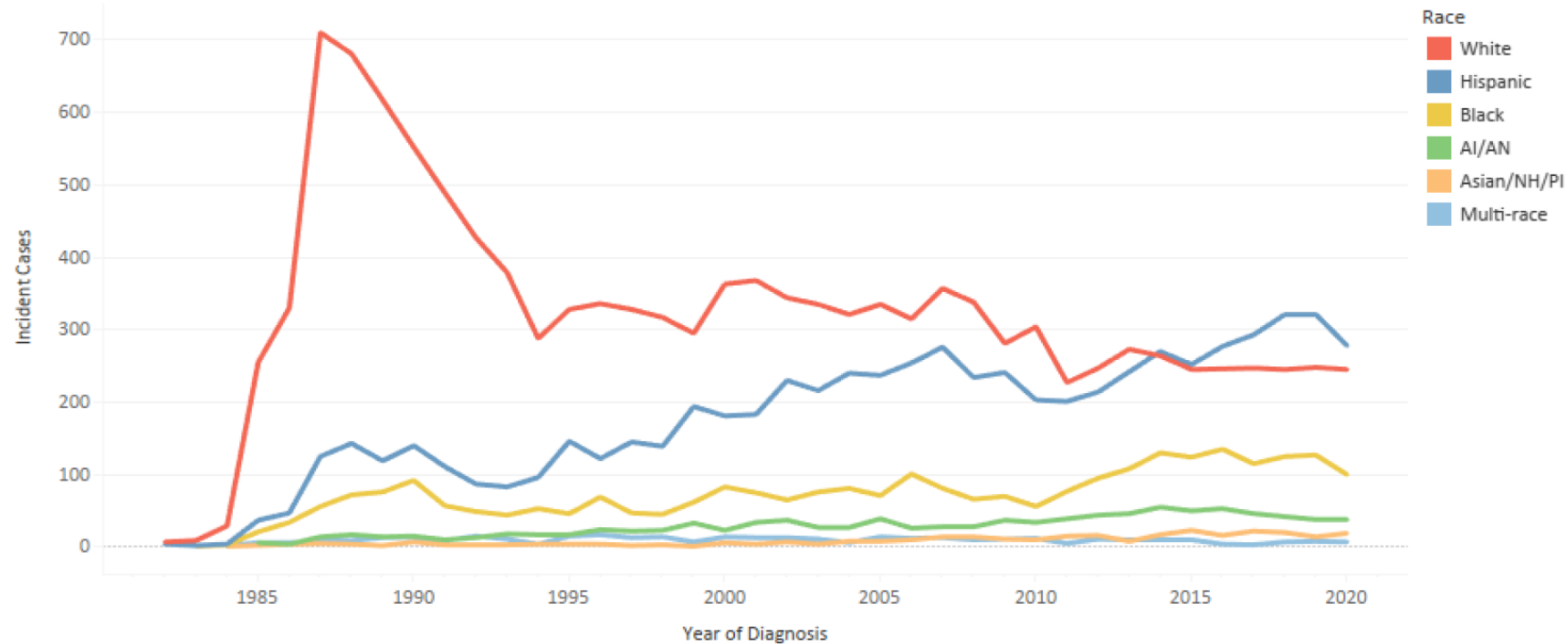


Figure 6: Number of HIV incident cases among persons ≥ 13 years by race, Arizona 1982 to 2020.

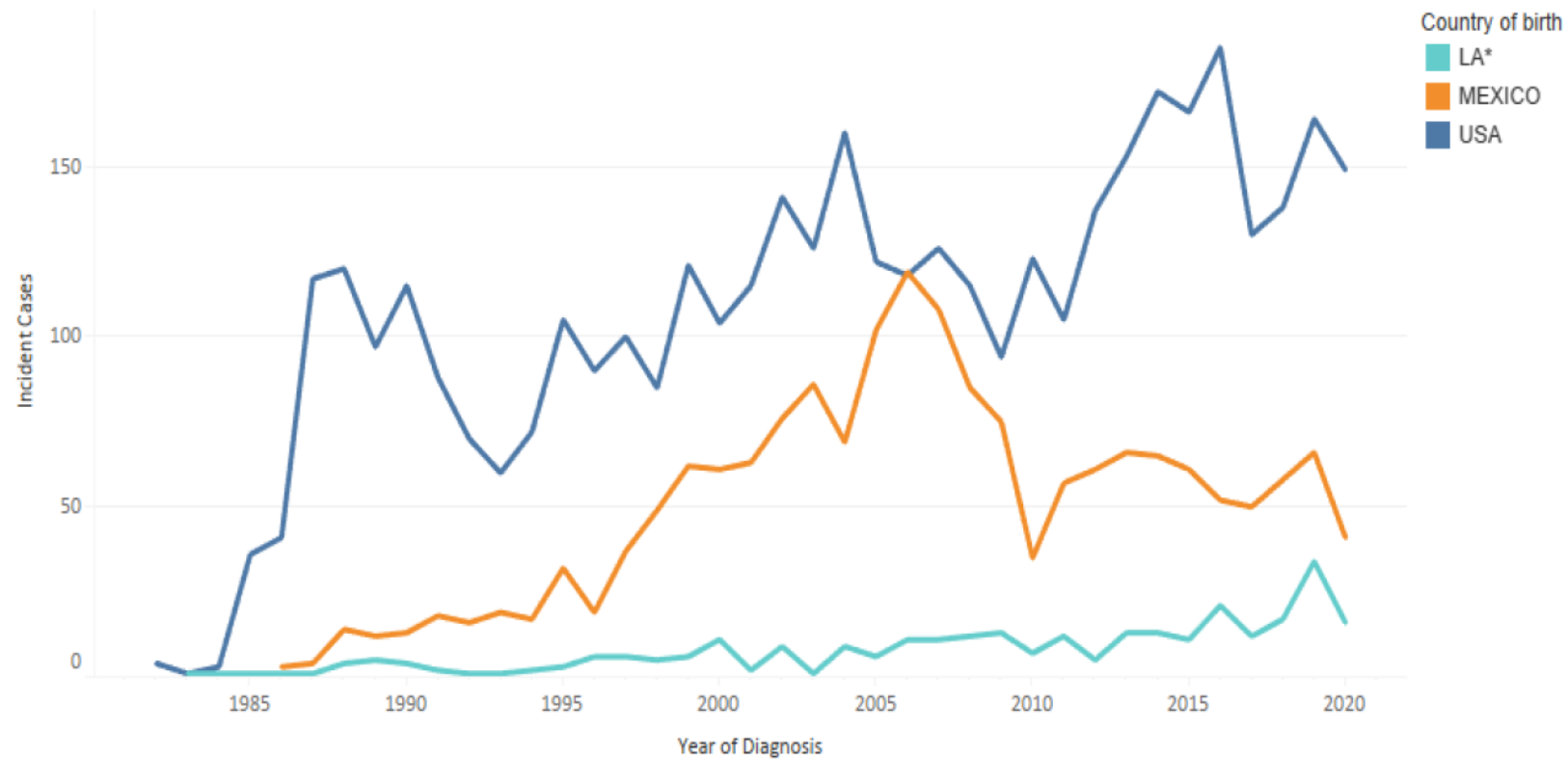


In 1988, 74% of new HIV infections were comprised of White individuals. This population has had a 64% decrease in HIV incidence from 1988 to 2020 whereas Hispanic individuals have had a 49% increase in new infections during the same time period.

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 ulcers¹



~20%

- ▶ The percentage of men with syphilis who become HIV positive within 10 years³

8x

- ▶ The increased risk of becoming HIV positive associated with 2 prior rectal gonorrhea or chlamydia infections in MSM²

1 in 15

- ▶ The proportion of men with a history of rectal gonorrhea or chlamydia who become HIV positive within 1 year⁴

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

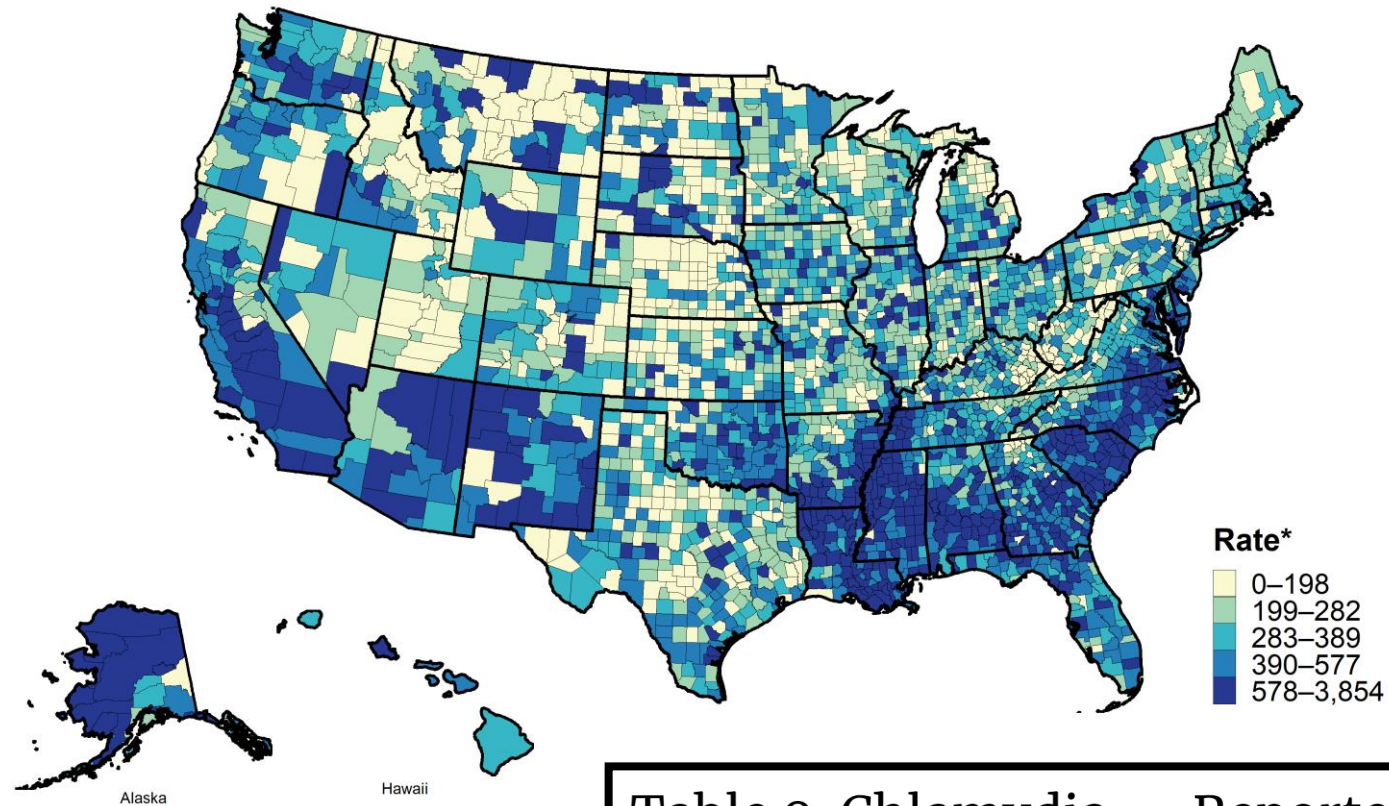
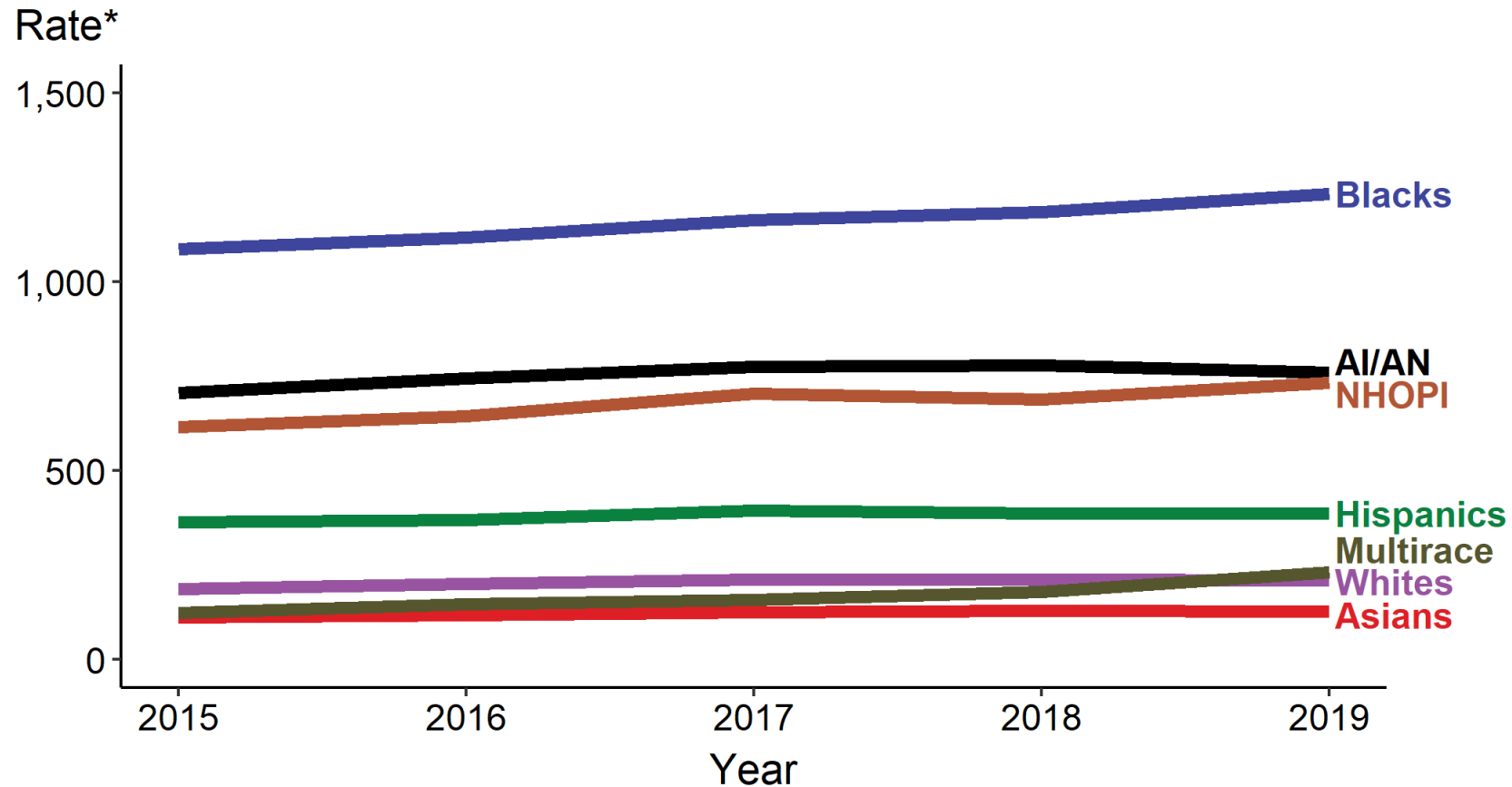


Table 9. Chlamydia — Reported Cases and Rates of Reported Cases in Counties and Independent Cities* Ranked by Number of Reported Cases, United States, 2019

| 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 |

* Per 100,000

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

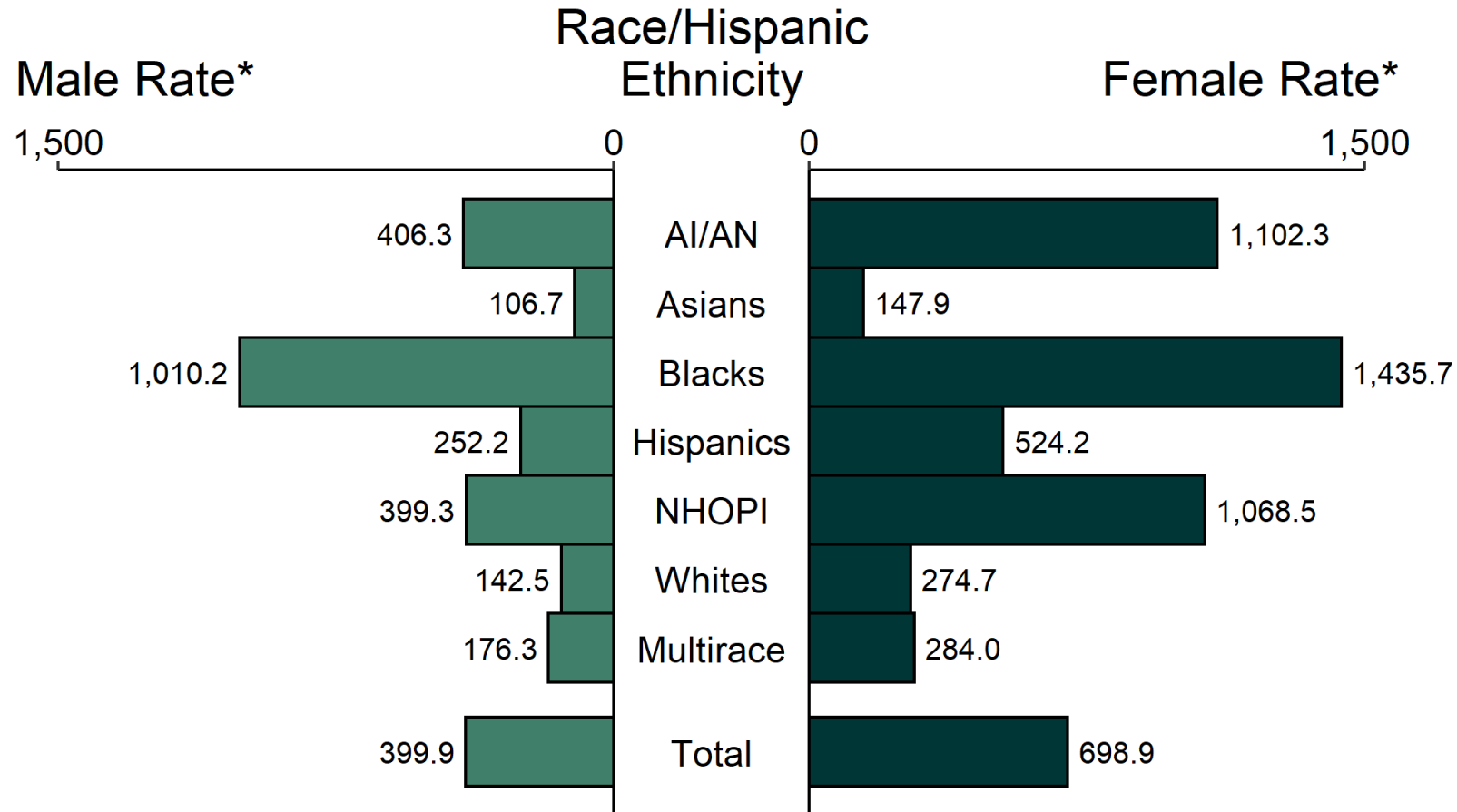


* Per 100,000

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

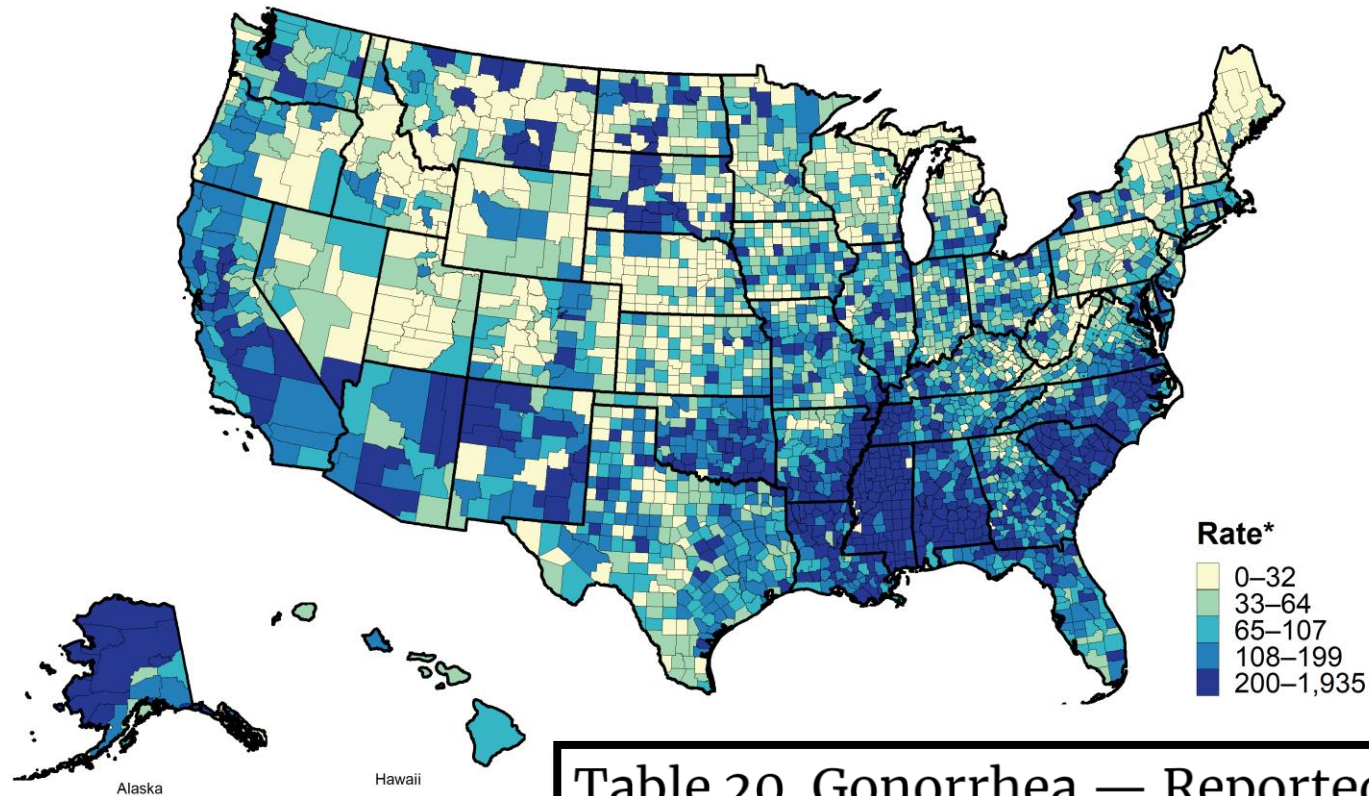


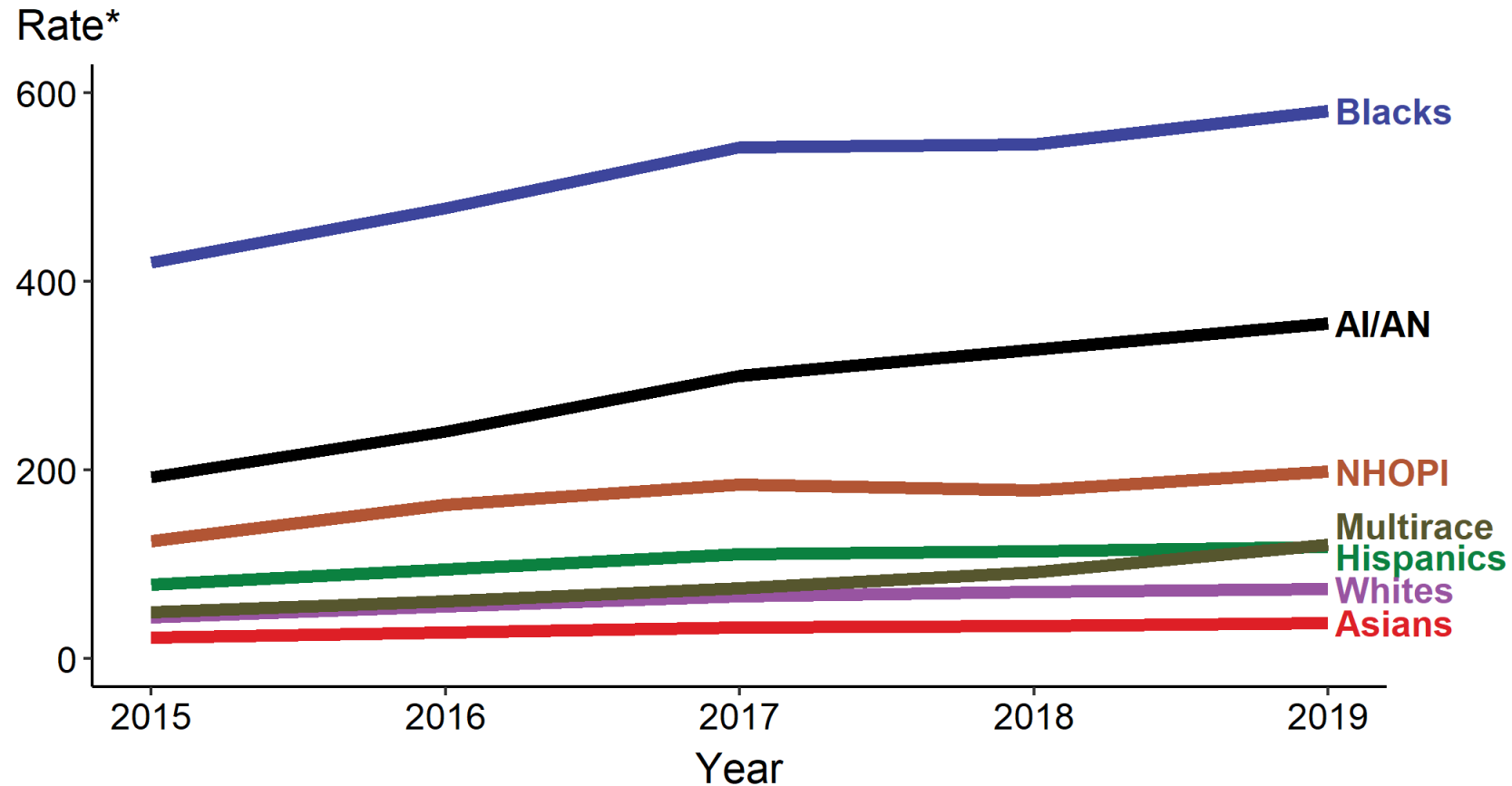
Table 20. Gonorrhea — Reported Cases and Rates of Reported Cases in Counties and Independent Cities* Ranked by Number of Reported Cases, United States, 2019

| 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 |

* Per 100,000



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

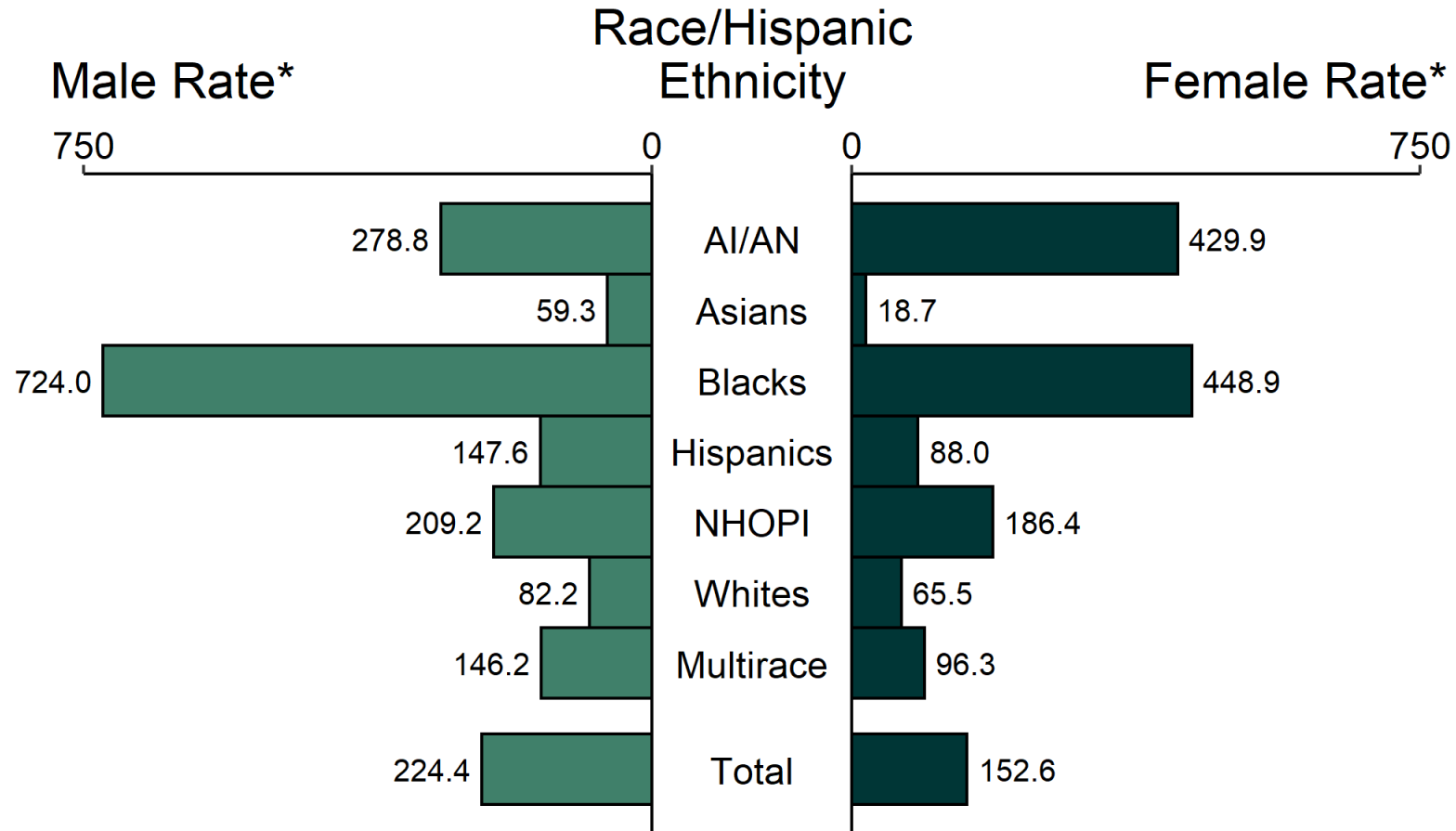


* Per 100,000

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



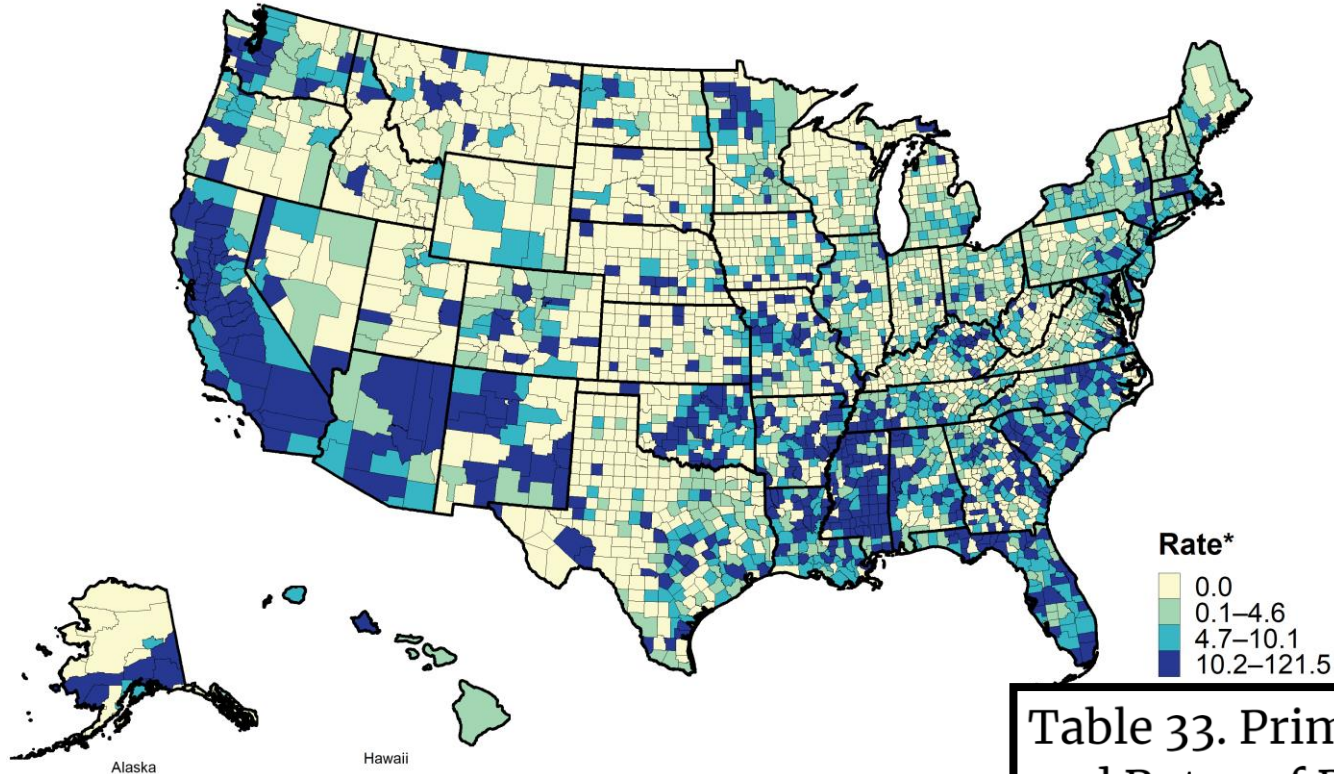
* Per 100,000

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

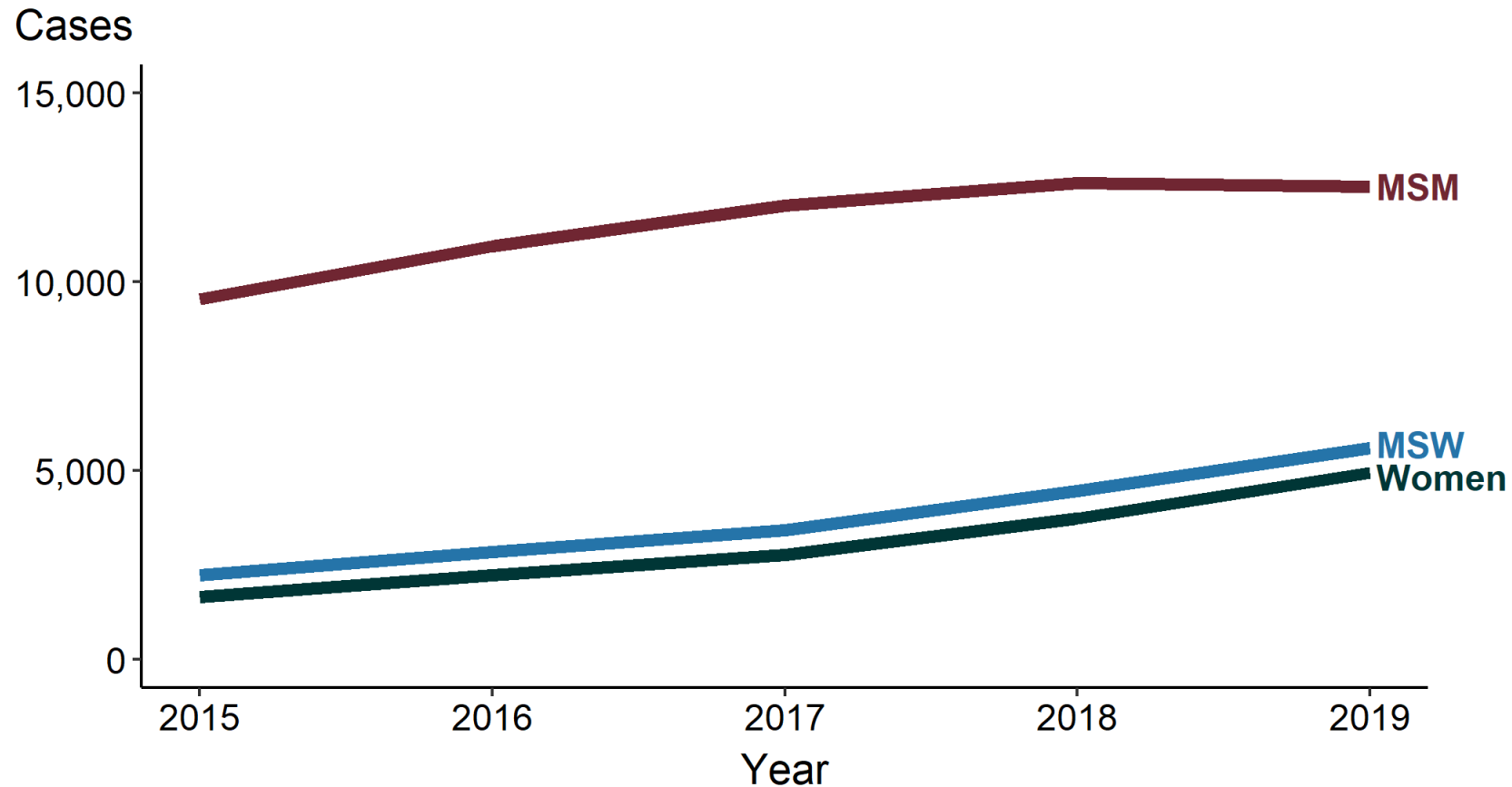


* Per 100,000

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

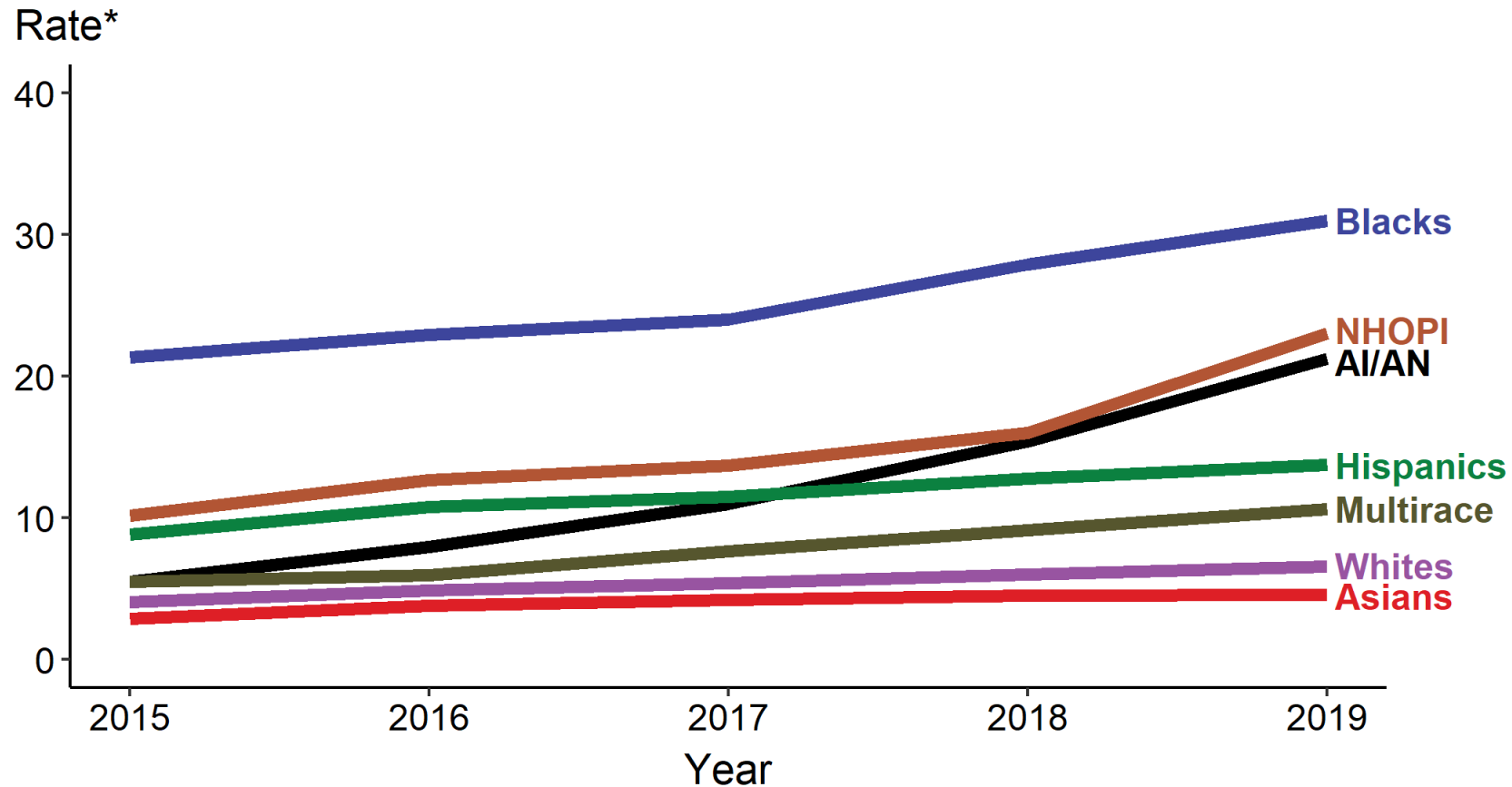


*31 states were able to classify $\geq 70\%$ of reported cases of primary and secondary syphilis among males as either MSM or MSW for each year during 2015–2019.

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

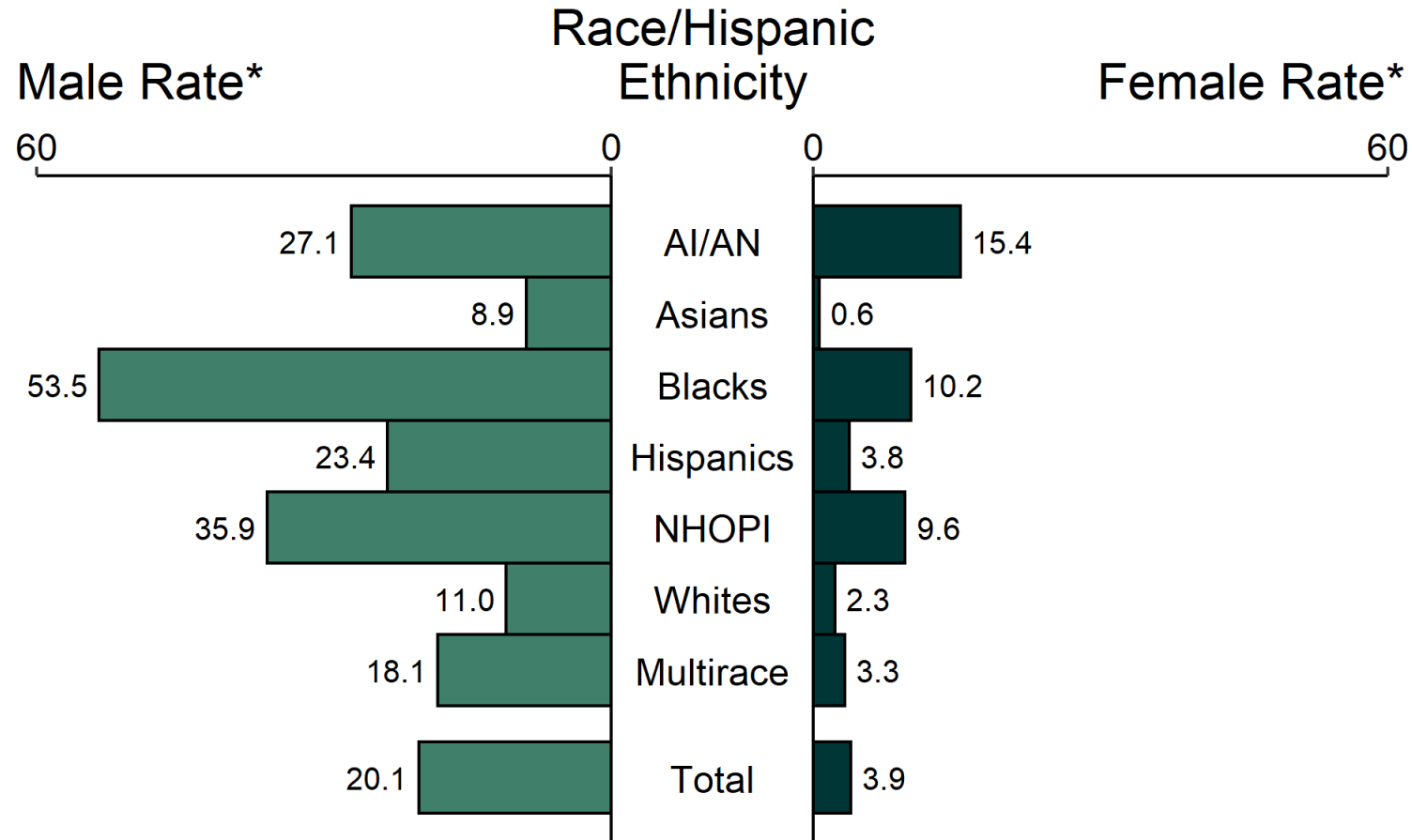


* Per 100,000

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

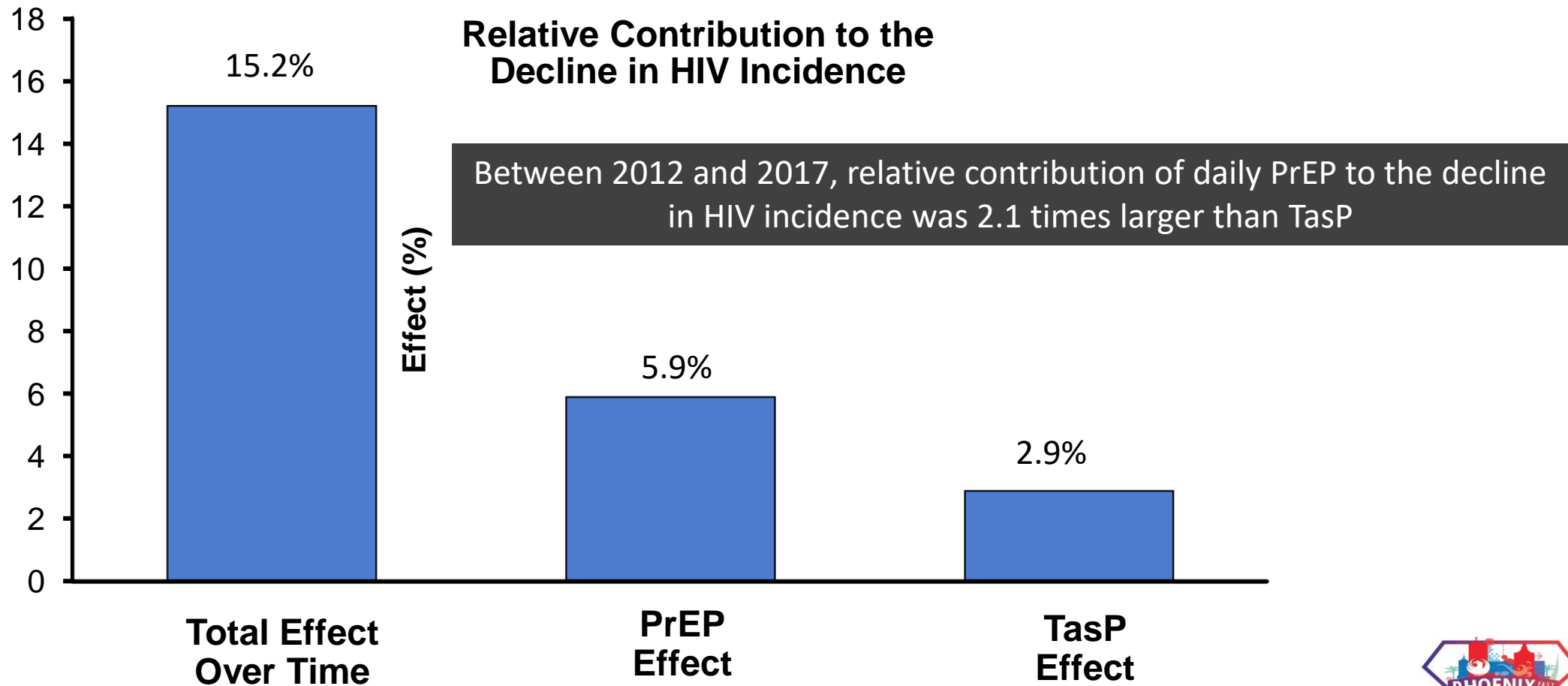


| | |
|--------------------------------|-------------|
| Hispanic/Latino | 841 (41.3%) |
| White | 635 (31.2%) |
| Black/African American | 345 (16.9%) |
| American Indian/Alaskan Native | 112 (5.5%) |
| Asian | 42 (2.1%) |
| Multi-Racial/NHPI/Other** | 37 (1.8%) |
| Unknown | 25 (1.2%) |

Syphilis



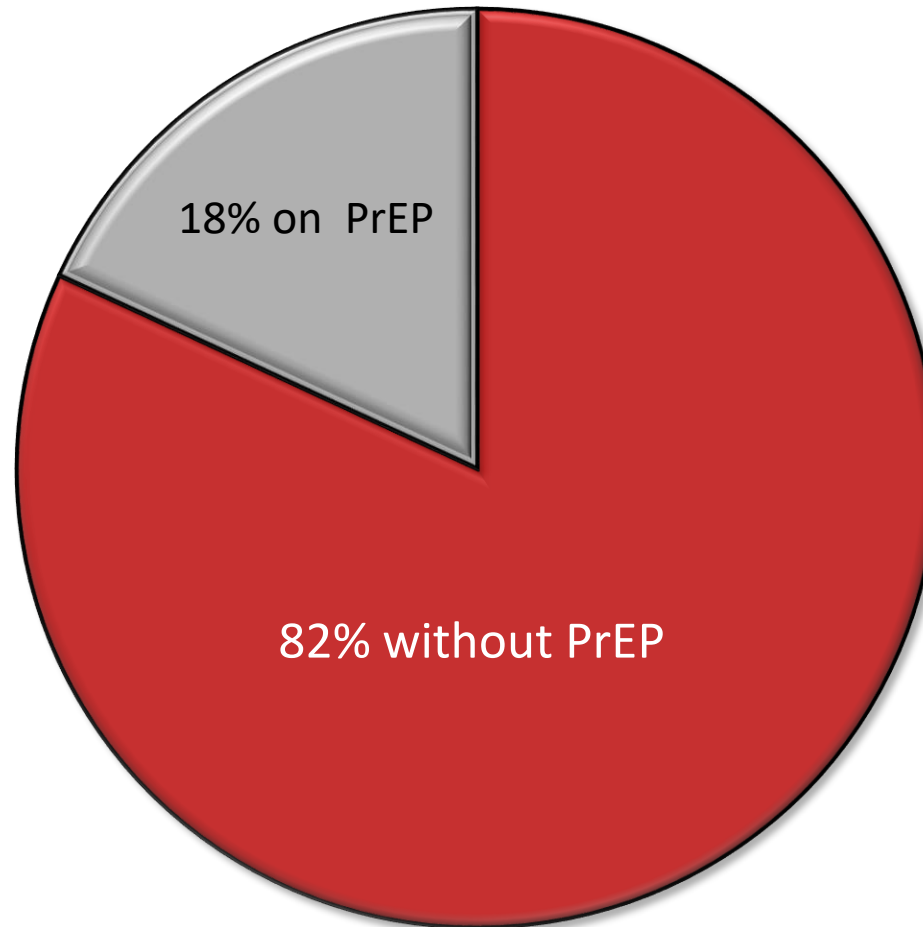
Daily PrEP Significantly Reduced the Rate of New HIV Diagnoses in US Independent of Treatment as Prevention



Preventing HIV Transmission: The PrEP Gap in the United States

People With an Indication for PrEP (2018)

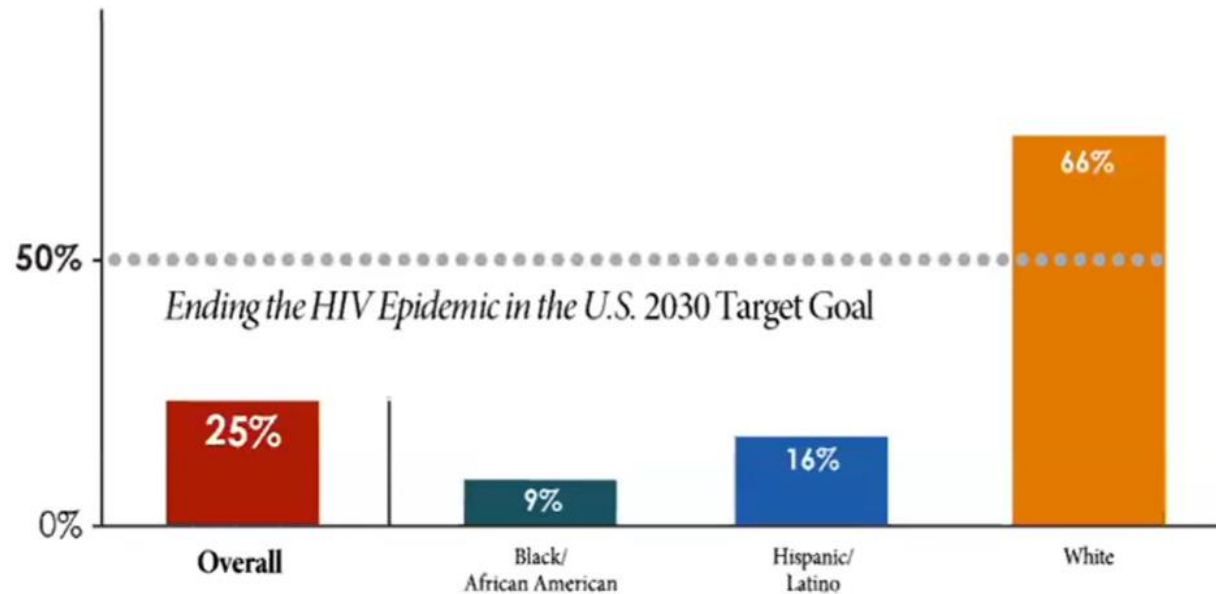
1.2 Million Americans Are
Likely to Benefit From PrEP



Disparities in PrEP Use and Persistence

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

PREP COVERAGE IN THE U.S. BY RACE/ETHNICITY, 2020



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)

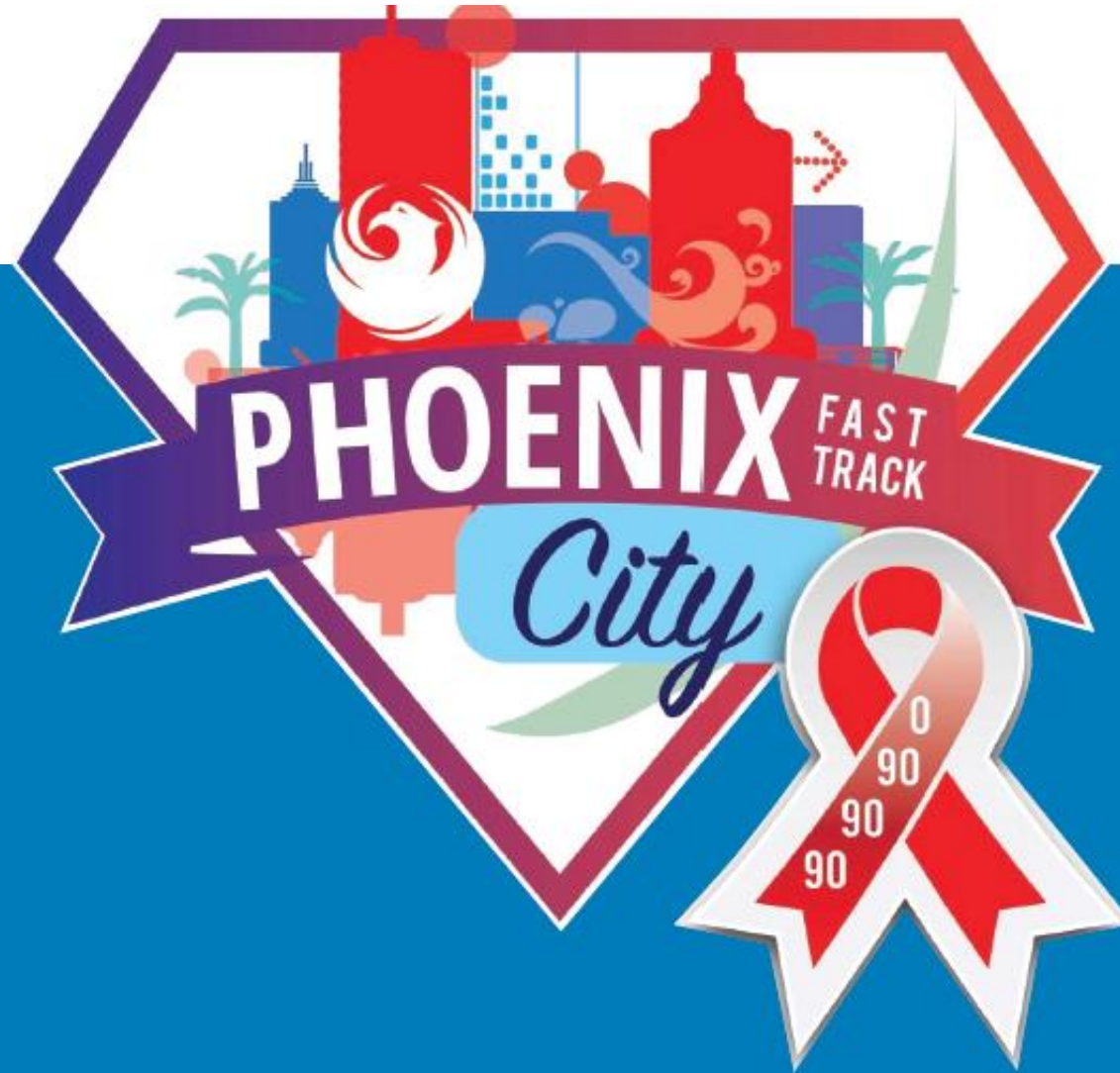
- Ratio of *PrEP use* to *number of newly Dx*
- PNR of successful cities in the US: 1:20 +
- Maricopa
 - Current PrEP use: 67/100K
 - Current PNR: 1:5.7 (2019)

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.

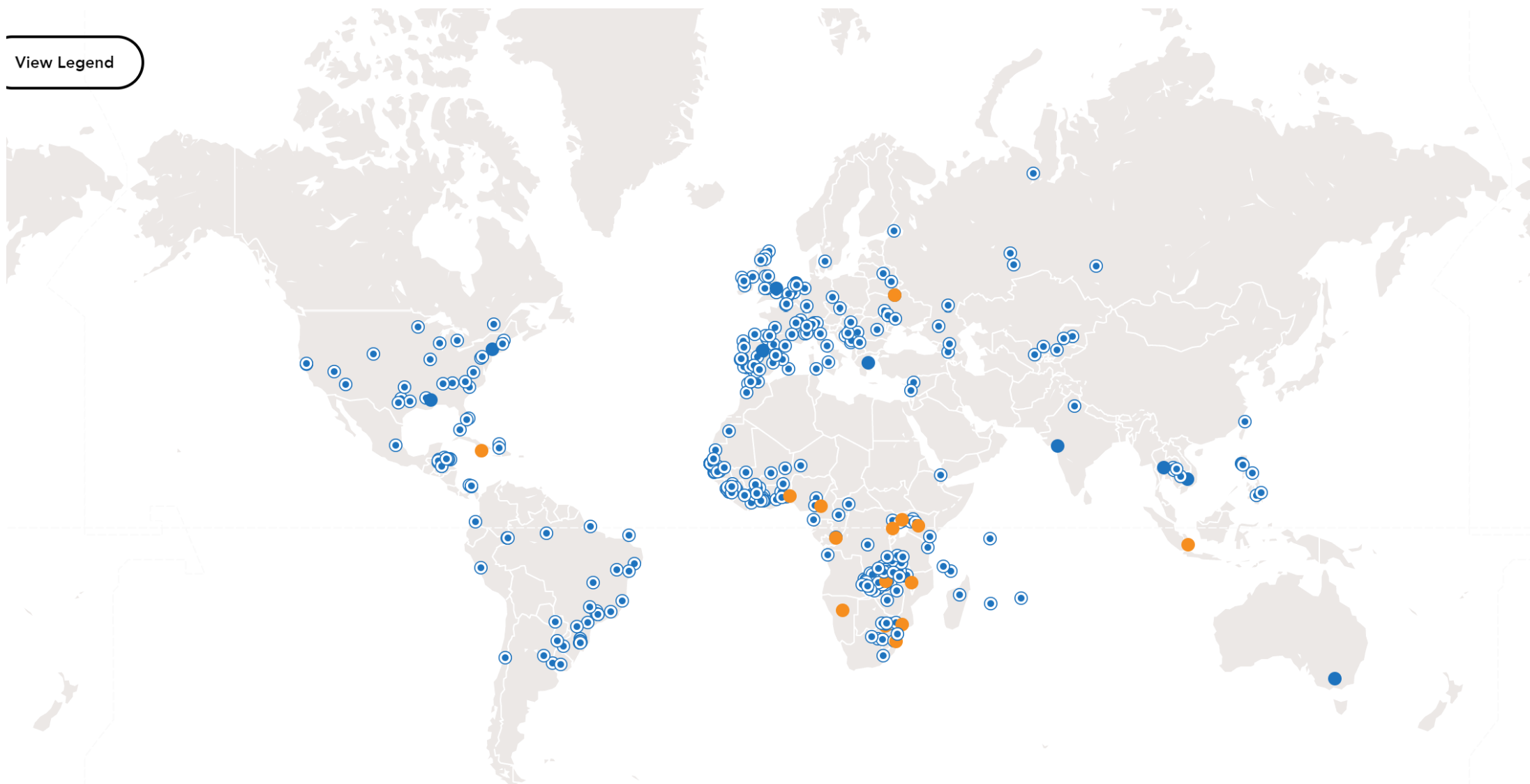


Select a region ▼

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-Track 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 Dreg Stanton
Date 11, 29, 2016

Anne Hidalgo
Anne HIDALGO
Mayor of Paris

Agidiala
MICHEL SIDIBÉ
UNAIDS

Joan Clos
Joan CLOS
UN-Habitat

Jose M. Zuniga
Jose 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.

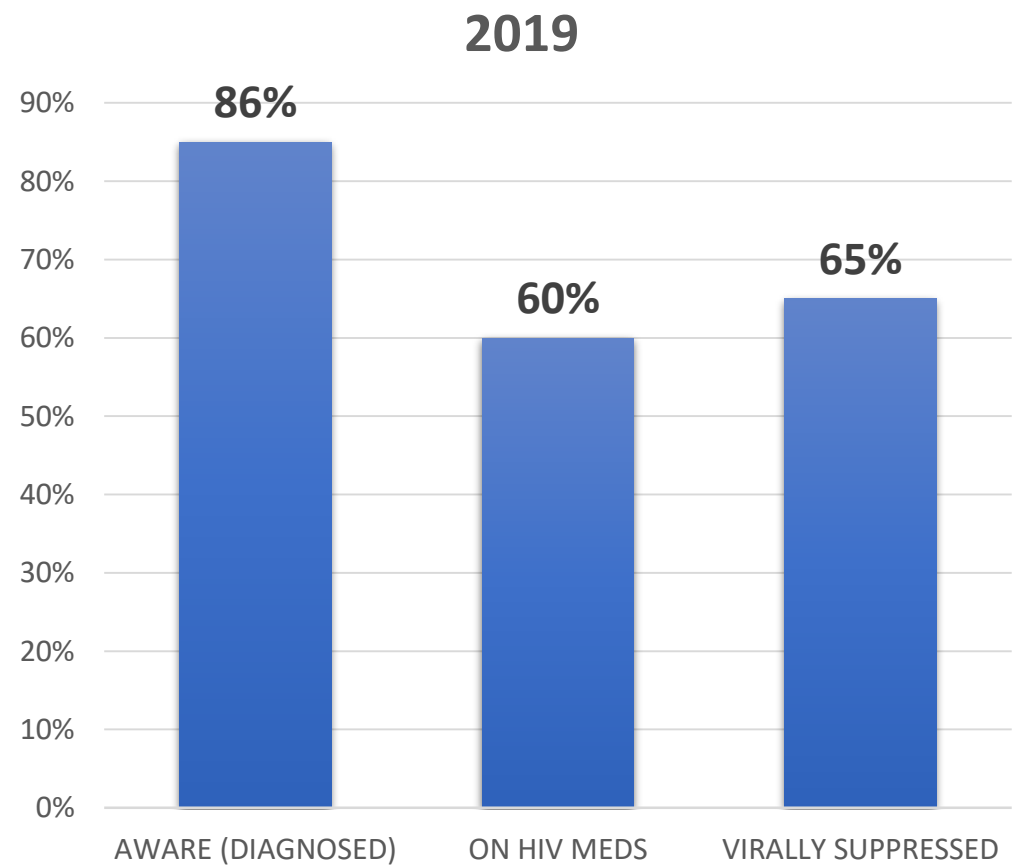
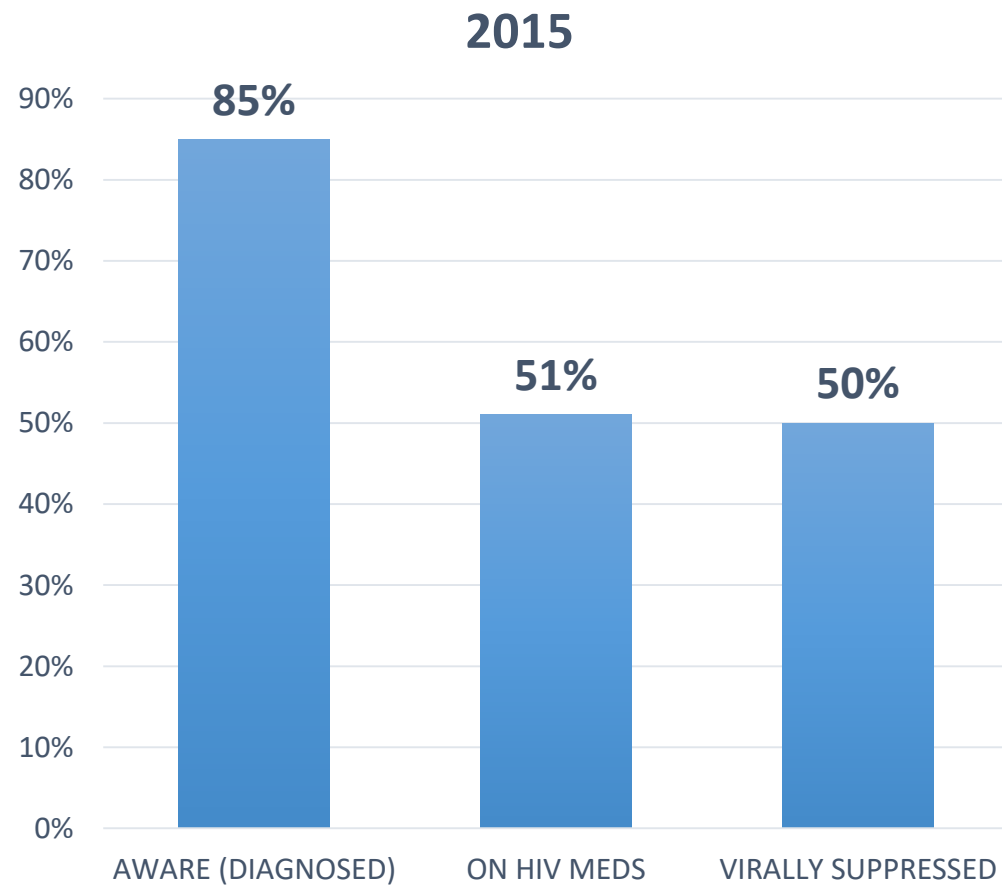


- Citywide Rapid Start Program in Maricopa County
- Launched in September 2018
- Goal: link patient to care within 0 to 5 days
- Inclusion:
 - Newly diagnosed HIV patients
 - Previously diagnosed: treatment naïve or treatment experienced



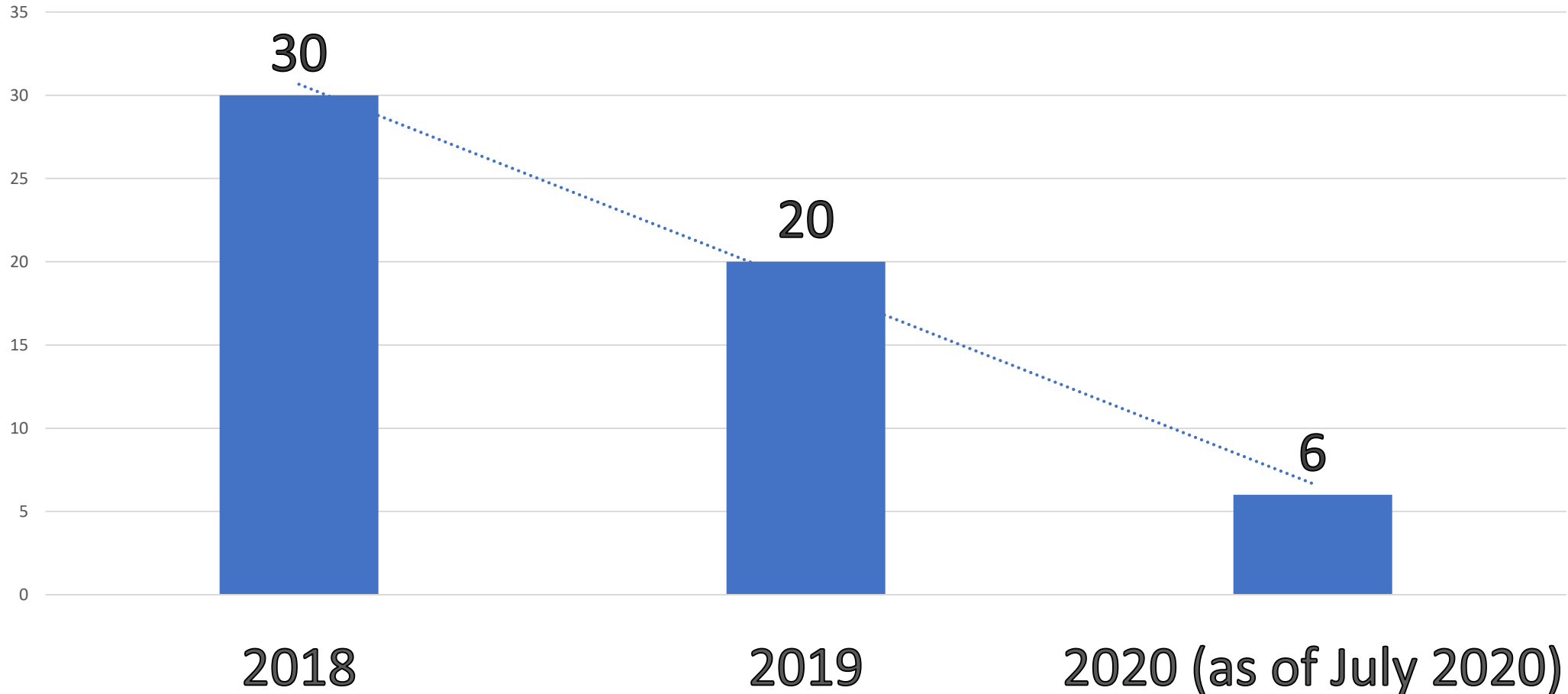
- START Navigation
 - Apply for health insurance, AHCCCS, Ryan White, ADAP
 - Process paperwork in less than 4 hours
 - Immediate linkage to care and ART
 - Provide case management and other support services
- 7 START Clinics in Maricopa County

90-90-90 Data 2015/2019

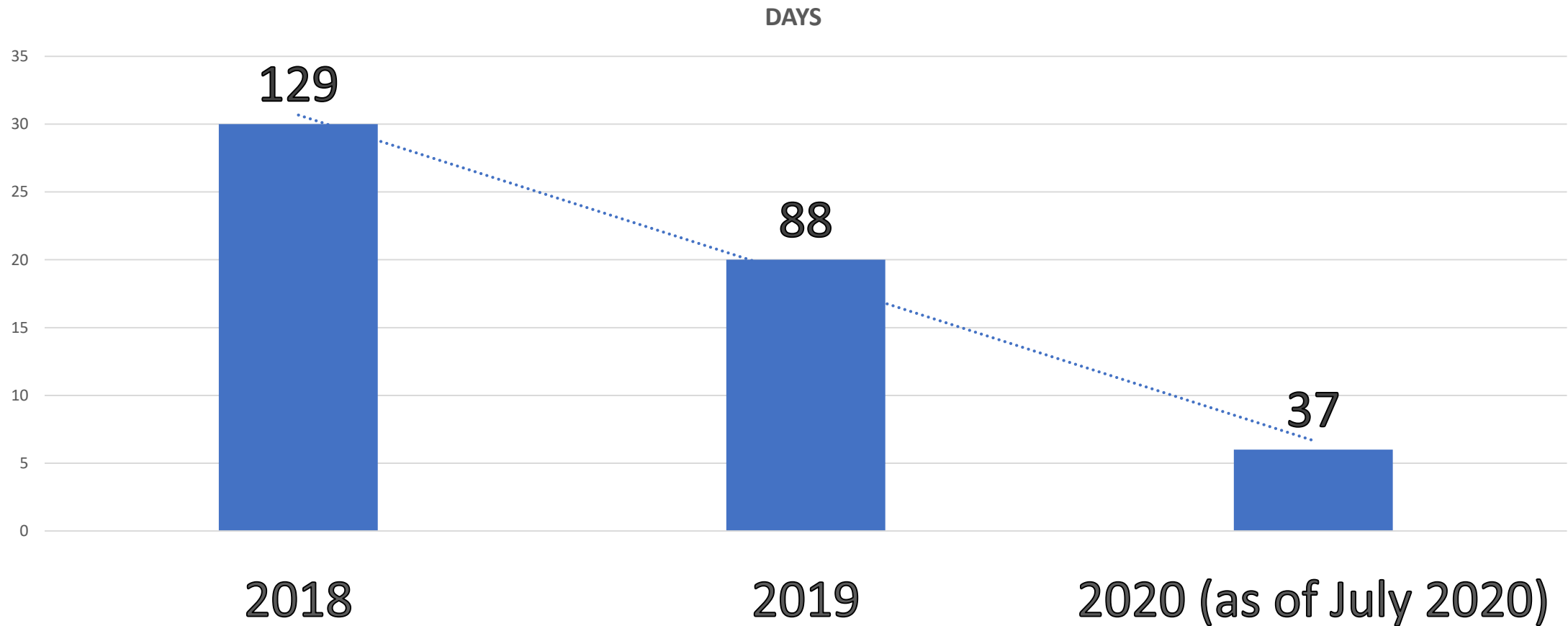


Preliminary Results of START: Days from diagnosis to linkage to care in Maricopa County down to 6 days

DAYS



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



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?



Help Us End HIV by 2030

Phoenix.gov/HIVPHX

get tested • access care • eliminate stigma



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



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

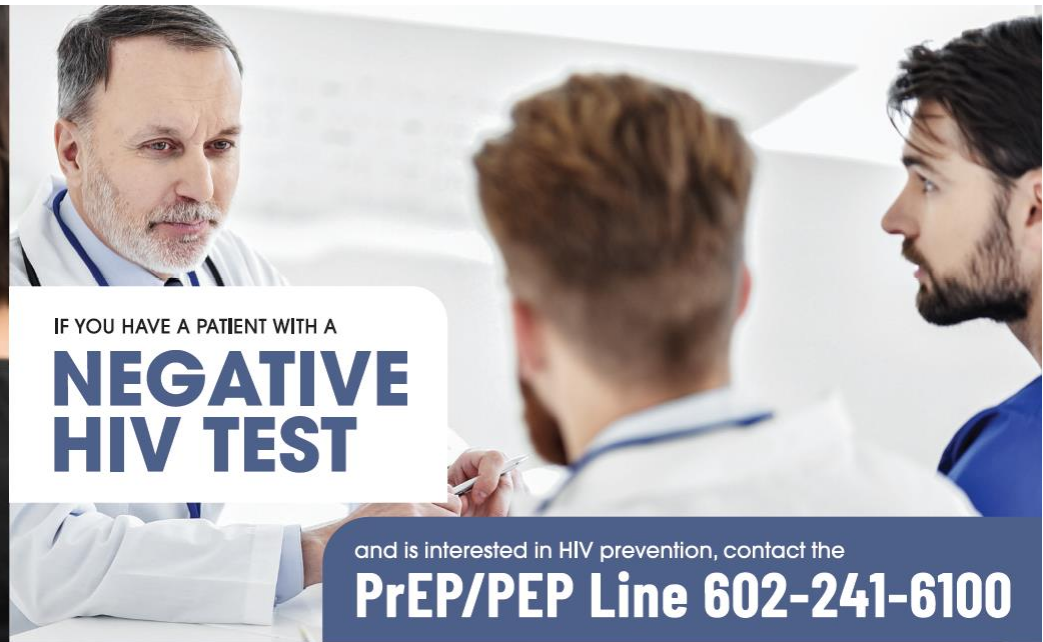


Other supportive services: dental, nutrition, mental health and substance use treatment and housing referrals



City of Phoenix

**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



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

Thank You!

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

- Well-tolerated
- Once-daily dosing
- Very high barrier to HIV resistance

Disadvantages

- Neural tube defects?

Raltegravir

Advantages

- Well-tolerated
- Data for use in pregnancy
- Very low risk of drug interactions

Disadvantages

- 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 aminotransferase | | ✓ | ✓ | — | — |
| | 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

- 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 = $[(140 - \text{age}) \times \text{ideal body weight}] \div (\text{serum creatinine} \times 72)$ (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

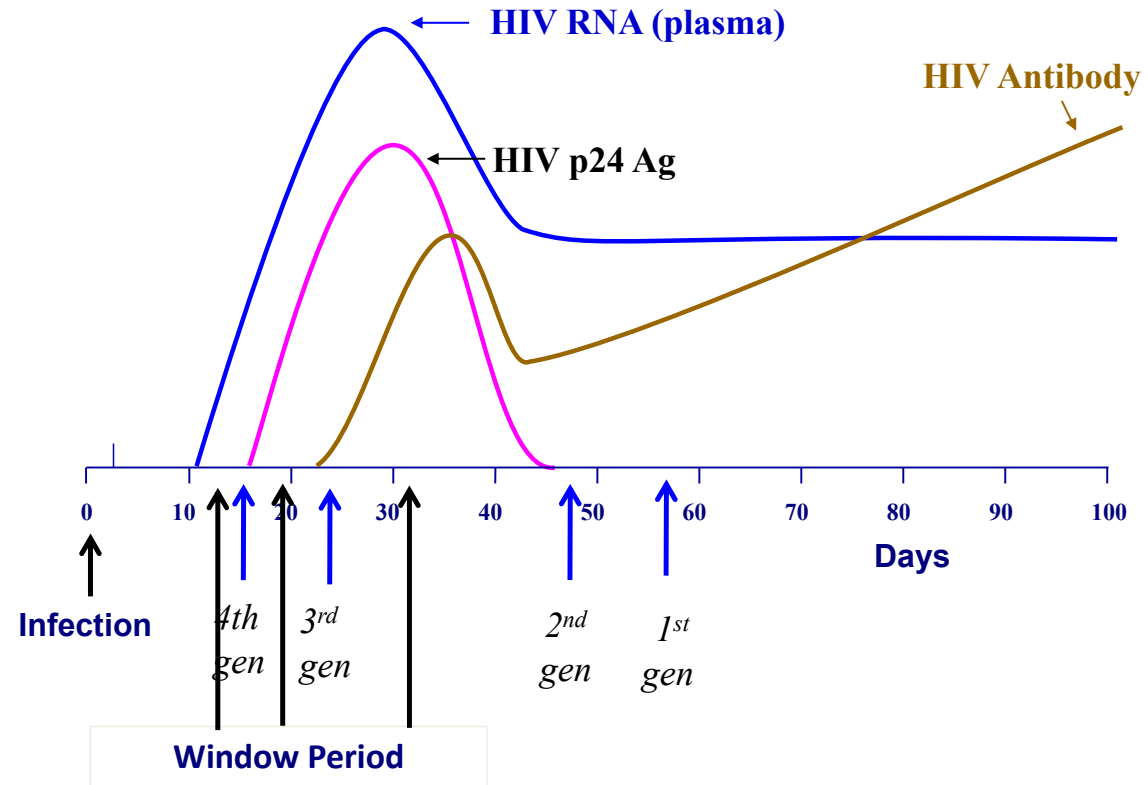
- Doxycycline 100 mg PO BID x 7 days now recommended
 - Azithromycin 1,000 mg PO once now an alternative treatment
- Azithromycin still an option if concerned for follow-up
 - A first line option if individual is pregnant
- Primary concern is around rectal concentrations
 - Azithromycin has great urinary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

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>