



NATIONAL ASSOCIATION OF
Community Health Centers®

Monkeypox Vaccination, New Types of PrEP, Injectable HIV Care: Emerging Topics in LGBTQ Care

Wednesday, November 16 | 8:15 – 9:45am

Atlantic 5-6, The Westin Fort Lauderdale Hotel

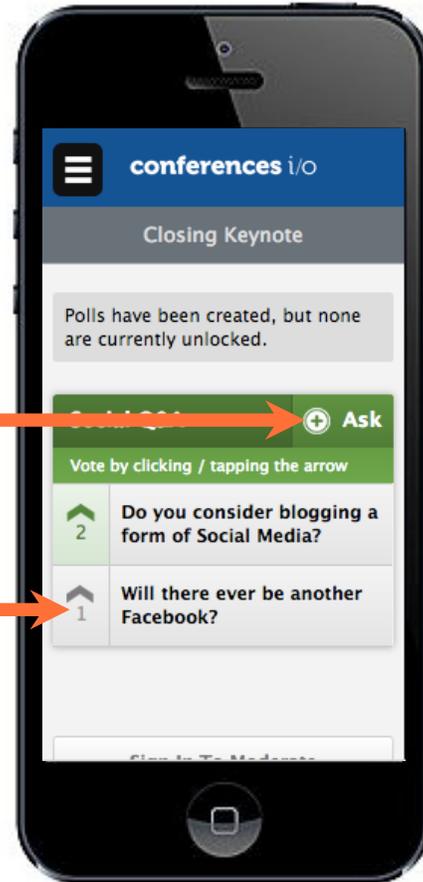
Fort Lauderdale, FL



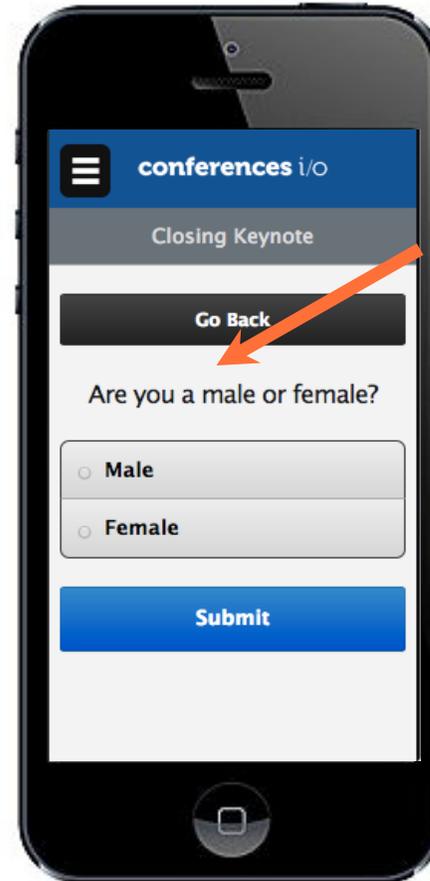
Vote / Give Feedback/ Respond to Polls

**Give us
Feedback**

**Up-Vote a
Comment**



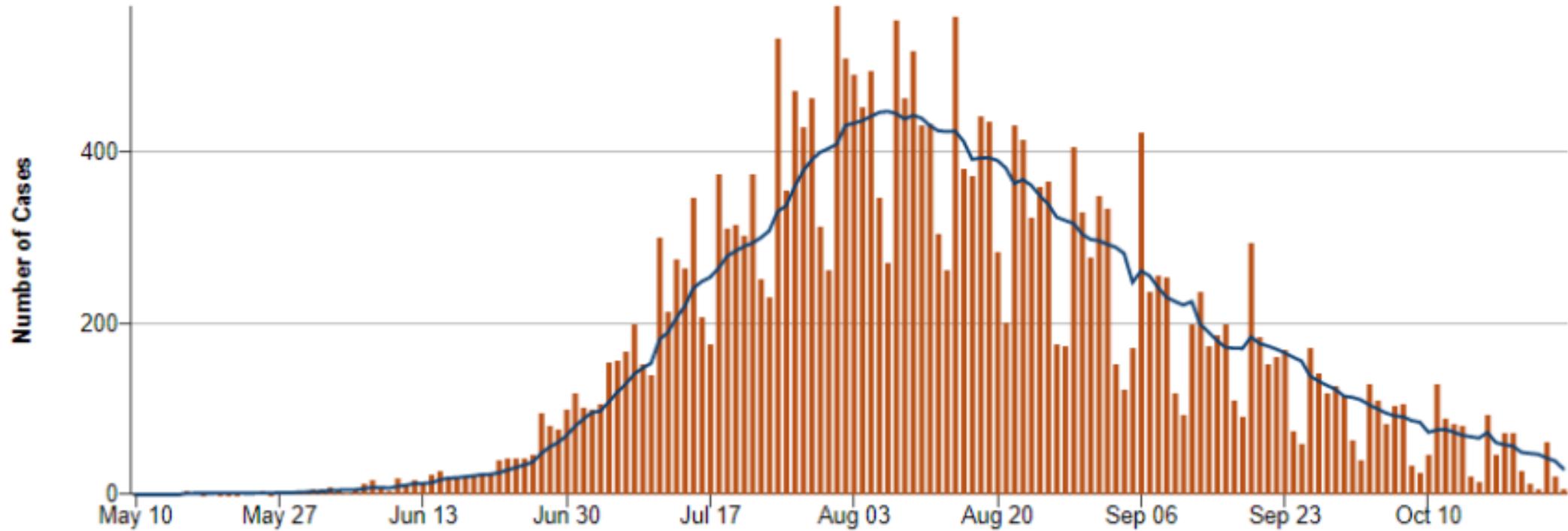
**Click on
question and
then
Respond to
Polls when
they appear**



Monkeypox Updates

*Slides adapted from White House NACHC presentation

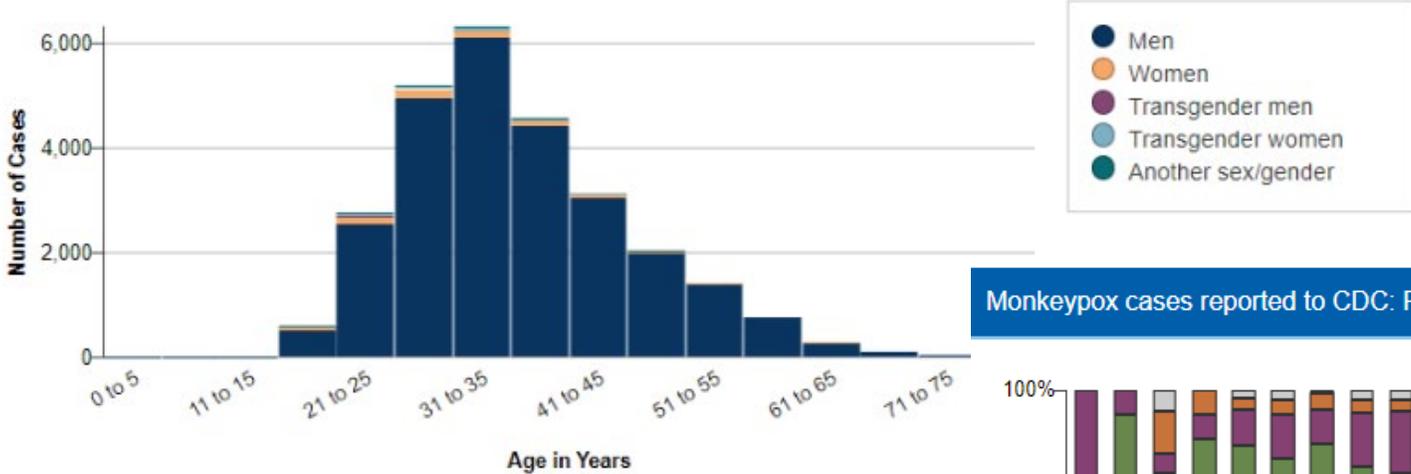
Daily Monkeypox Cases Reported and 7-day daily average



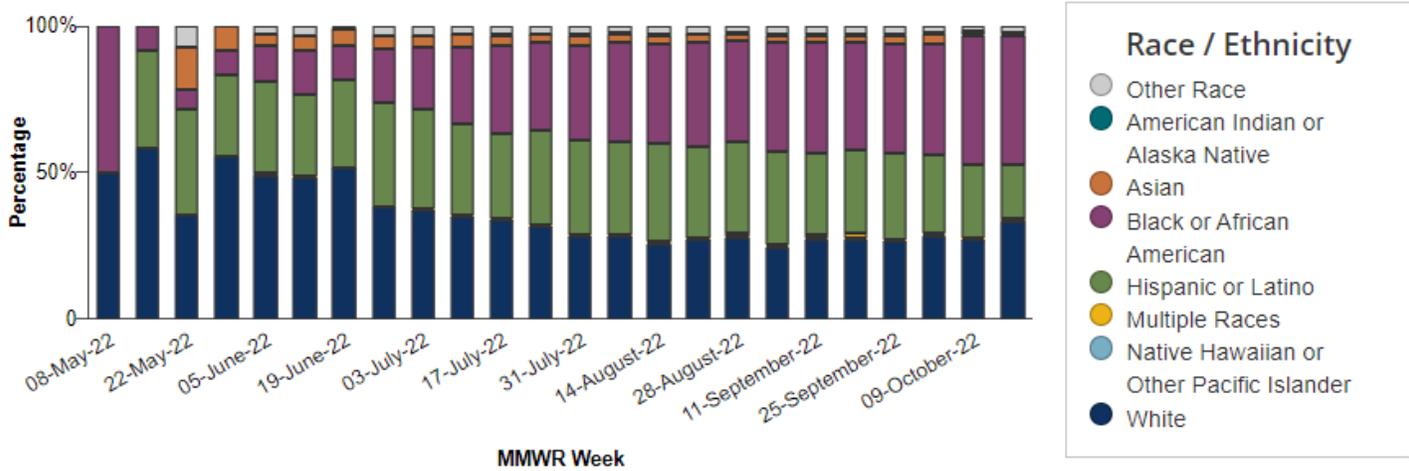
Epidemic Demographics

Data as of October 26, 2022

Monkeypox cases reported to CDC: Age and Gender



Monkeypox cases reported to CDC: Race/Ethnicity by Week



CDC Message

In the U.S., HIV or recent sexually transmitted infections (STIs)* are common among people with monkeypox

Among nearly 2,000 people with monkeypox:†

Condition	Percentage
had HIV	38%
had an STI in the past year	41%
had either HIV or an STI	61%

It is important to

- Prioritize people with HIV and STIs for monkeypox vaccination
- Offer HIV and STI screening for people evaluated for monkeypox



*Diagnosed with an STI other than HIV in the past year
† People diagnosed with monkeypox in eight jurisdictions during May 17–July 22, 2022

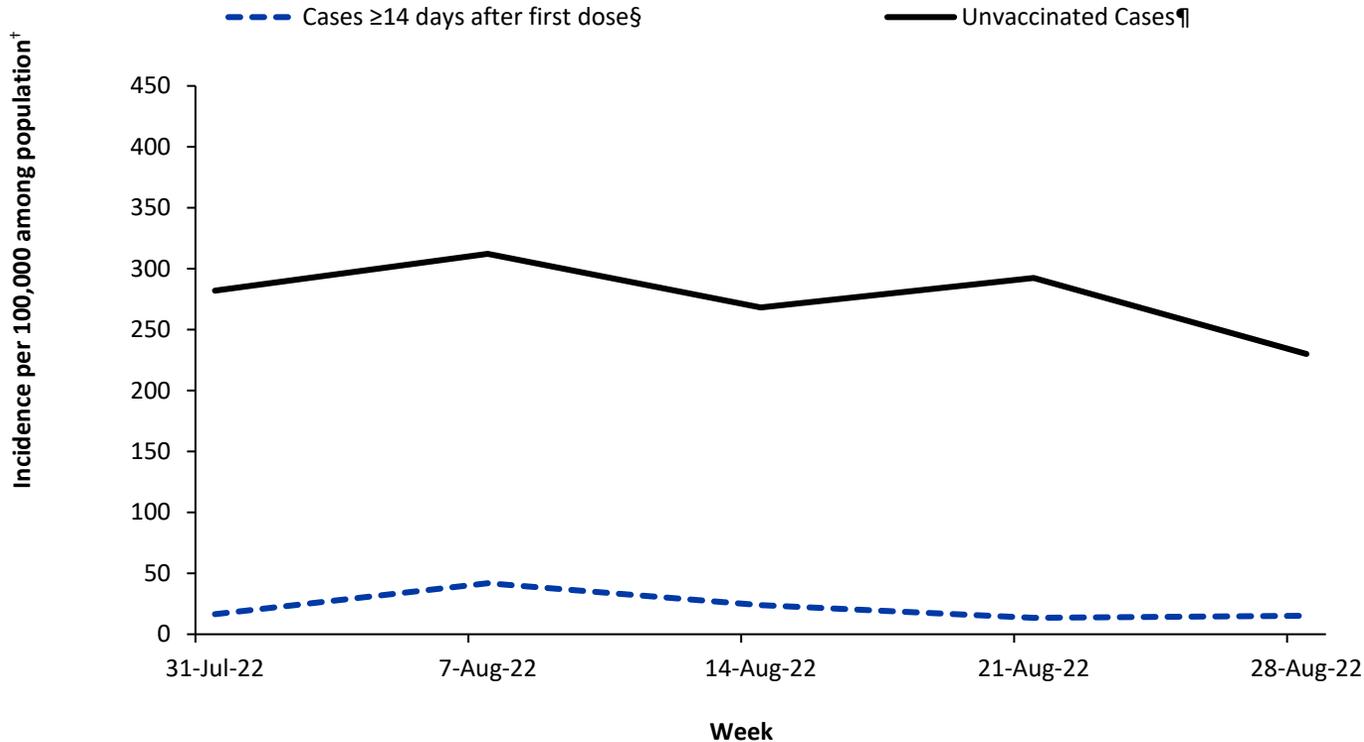
bit.ly/mm7136a1

SEPTEMBER 9, 2022

MMWR

Rates of Monkeypox Cases* by Vaccination Status

July 31, 2022 – September 3, 2022



People eligible for monkeypox vaccination should get vaccinated as soon as possible

Study of males ages 18–49 years eligible for vaccination*

Vaccination Status	Infection Rate
RECEIVED NO DOSES	14 infections per 100,000 people
RECEIVED ONE DOSE*	1 infection per 100,000 people

It's important to get both doses for best protection

CDC MMWR

*Unvaccinated, July 21, 2022 – September 3, 2022
 †Received first dose of vaccine 14 days or more earlier
 MMWR 2022;71(14):e1

HIV Prevention

*Slides adapted from Dr. Uri Belkind and Dr Asa Radix

PrEP: Pre-exposure Prophylaxis for HIV Prevention

- The use of anti-retroviral (ARV) medications to reduce the risk of infection in people who are HIV-negative, before exposure
- It can be oral, injectable, intravaginal, rectal...
- Available regimens:
 - Tenofovir disoproxil fumarate (TDF) 300mg/emtricitabine (FTC) 200mg PO daily or on-demand (usually in a fixed-dose combination tablet) **(TDF/FTC)**
 - Tenofovir alafenamide fumarate (TAF) 25mg/emtricitabine (FTC) 200mg PO daily* (usually in a fixed-dose combination tablet) **(TAF/FTC)**
 - Cabotegravir 30mg PO daily x 5 weeks, followed by 600mg IM q4wks x 2, followed by 600mg IM q8wks

Old Guidance

New Guidance

Table 1: Summary of Guidance for PrEP Use

	Men Who Have Sex with Men	Heterosexual Women and Men	Injection Drug Users
Detecting substantial risk of acquiring HIV infection	HIV-positive sexual partner Recent bacterial STI High number of sex partners History of inconsistent or no condom use Commercial sex work	HIV-positive sexual partner Recent bacterial STI High number of sex partners History of inconsistent or no condom use Commercial sex work In high-prevalence area or network	HIV-positive injecting partner Sharing injection equipment Recent drug treatment (but currently injecting)
Clinically eligible	Documented negative HIV test result before prescribing PrEP No signs/symptoms of acute HIV infection Normal renal function; no contraindicated medications Documented hepatitis B virus infection and vaccination status		
Prescription	Daily, continuing, oral doses of TDF/FTC (Truvada), ≤90-day supply		
Other services	Follow-up visits at least every 3 months to provide the following: HIV test, medication adherence counseling, behavioral risk reduction support, side effect assessment, STI symptom assessment At 3 months and every 6 months thereafter, assess renal function Every 6 months, test for bacterial STIs		
	Do oral/rectal STI testing	Assess pregnancy intent Pregnancy test every 3 months	Access to clean needles/syringes and drug treatment services

STI: sexually transmitted infection

	Sexually-Active Adults and Adolescents ¹	Persons Who Inject Drug ²
Identifying substantial risk of acquiring HIV infection	Anal or vaginal sex in past 6 months AND any of the following: <ul style="list-style-type: none"> HIV-positive sexual partner (especially if partner has an unknown or detectable viral load) Bacterial STI in past 6 months³ History of inconsistent or no condom use with sexual partner(s) 	HIV-positive injecting partner OR Sharing injection equipment

PrEP 2-1-1

- CDC currently only recommends daily PrEP
- Event-driven PrEP (ED-PrEP) is an option for some patients (off-label)
 - MSM
 - Sexual transmission
- Also called PrEP On-demand, intermittent PrEP, or 2 - 1 - 1 PrEP

For whom is ED-PrEP appropriate?	For whom is ED-PrEP NOT appropriate?
<ul style="list-style-type: none">• a man who has sex with another man:<ul style="list-style-type: none">– who would find ED-PrEP more effective and convenient– who has infrequent sex (for example, sex less than 2 times per week on average)– who is able to plan for sex at least 2 hours in advance, or who can delay sex for at least 2 hours	<ul style="list-style-type: none">• cisgender women or transgender women• transgender men having vaginal/frontal sex• men having vaginal or anal sex with women• people with chronic hepatitis B infection.

Injectable PrEP

Apretude (Cabotegravir)

PROS, although not many, are really important

NO PILLS, increased adherence and protection
from HIV

Decreased disclosure concerns

Decreased oral medication toxicities including bone, renal and certain metabolic concerns

***MOST IMPORTANT, increases access, if we can get it to people who need it

Injectable PrEP

Apretude (Cabotegravir)

- Expensive (compared to TDF/FTC)
- Injection Site Reactions
- More Frequent Clinic Visits
- Medication “tail” after discontinuation
- Cannot administer if history of silicone or fillers in buttocks
- No protection against Hepatitis B
- Delayed HIV Ag/Ab conversion
- Requires 4th gen and viral load every 2 months
- Access issues at every level

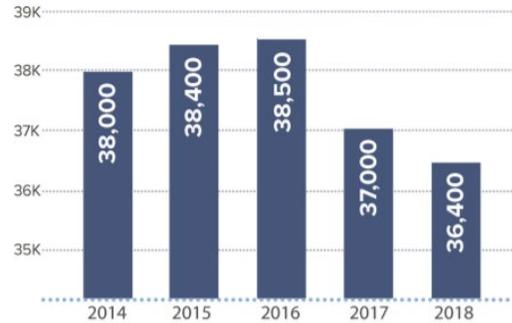


PrEP in the US

Challenges with Uptake and Persistence

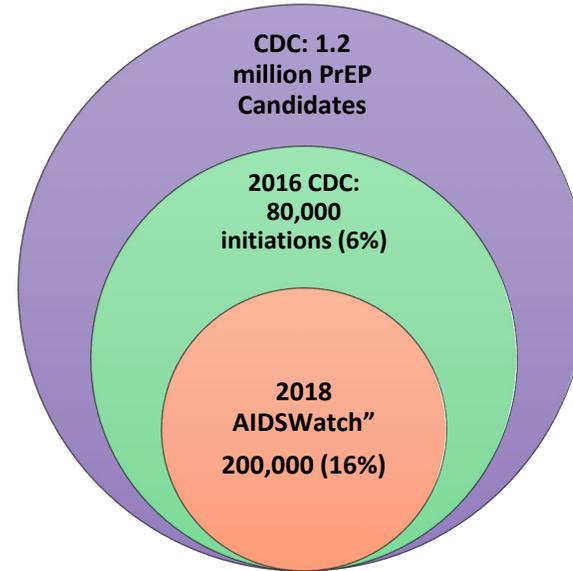
• A little about HIV in the US* ...

~37,000 annual new cases
2014 - 2018



60%
among Black and
Latinx

PrEP uptake in US



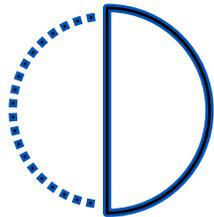
- 1% and 3% of Black and Latinx candidates
- Additional challenges with persistence



1 in 2 lifetime HIV risk Black MSM



1 in 4 lifetime HIV risk Latinx MSM



50% of New HIV infections are transmitted by individuals who are unaware of their HIV status



1 in 7 individuals living with HIV are not aware of their Serostatus

PrEP uptake in US

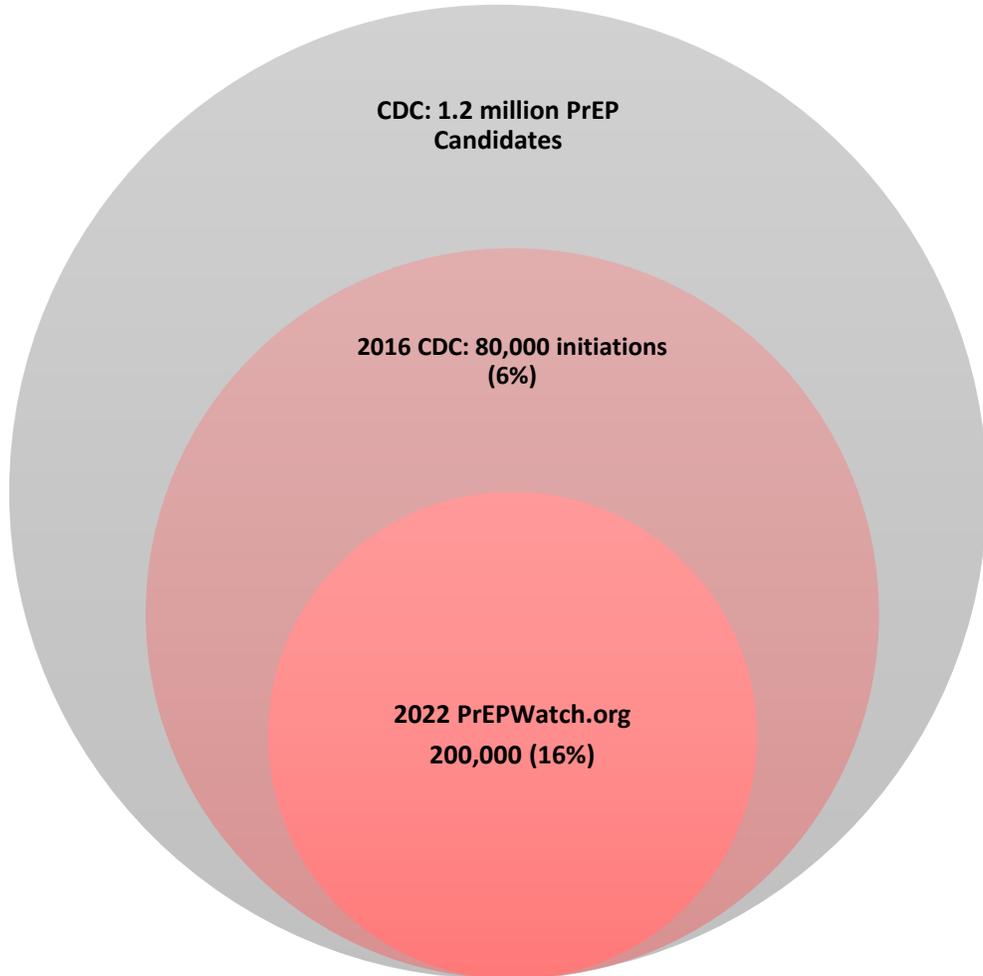


TABLE 2. Estimated percentages and numbers of adults with indications for preexposure prophylaxis (PrEP), by transmission risk group – United States, 2015

Transmission risk group	% with PrEP indications*	Estimated no.	(95% CI)
Men who have sex with men, aged 18–59 yrs [†]	24.7	492,000	(212,000–772,000)
Adults who inject drugs, aged ≥18 yrs [§]	18.5	115,000	(45,000–185,000)
Heterosexually active adults, aged 18–59 yrs [¶]	0.4	624,000	(404,000–846,000)
Men**	0.2	157,000	(62,000–252,000)
Women	0.6	468,000	(274,000–662,000)
Total	—	1,232,000	(661,000–1,803,000)

TABLE 1. Annual number of persons aged ≥16 years prescribed HIV preexposure prophylaxis, by selected characteristics — IQVIA* Longitudinal Prescription Database, United States, 2014–2016

Characteristic	Year no (%)		
	2014	2015	2016
Total	13,748 (100)	38,879 (100)	78,360 (100)
Sex			
Male	12,624 (91.8)	36,845 (94.8)	74,639 (95.3)
Female	1,110 (8.1)	2,012 (5.2)	3,678 (4.7)
Unknown/Missing	14 (0.1)	22 (0.1)	43 (0.1)
Age group (yrs)			
16–17	22 (0.2)	29 (0.1)	64 (0.1)
18–24	953 (6.9)	3,223 (8.3)	7,382 (9.4)
25–34	4,687 (34.1)	14,766 (38.0)	30,959 (39.5)
35–44	3,825 (27.8)	10,156 (26.1)	19,989 (25.5)
45–54	2,845 (20.7)	7,564 (19.5)	13,913 (17.8)
55–64	1,080 (7.9)	2,543 (6.5)	5,046 (6.4)
≥65	336 (2.4)	598 (1.5)	1,007 (1.3)
Census region			
Northeast	3,411 (24.8)	10,110 (26.0)	20,909 (26.7)
Midwest	2,330 (17.0)	6,350 (16.3)	12,748 (16.3)
South	3,562 (25.9)	10,223 (26.3)	21,335 (27.2)
West	4,420 (32.2)	12,169 (31.3)	23,306 (29.7)
Other [†]	22 (0.2)	22 (0.1)	55 (0.1)
Unknown/Missing	3 (0.0)	5 (0.0)	7 (0.0)
Payer type[§]			
Medicaid/CHIP	1,430 (10.4)	4,547 (11.7)	9,542 (12.2)
Medicare	488 (3.6)	968 (2.5)	1,832 (2.3)
Commercial	9,980 (72.6)	31,993 (82.3)	63,430 (81.0)
Cash	163 (1.2)	262 (0.7)	732 (0.9)
Other [¶]	356 (2.6)	1,080 (2.8)	2,705 (3.5)
Unknown/Missing	1,331 (9.7)	29 (0.1)	119 (0.2)

United States

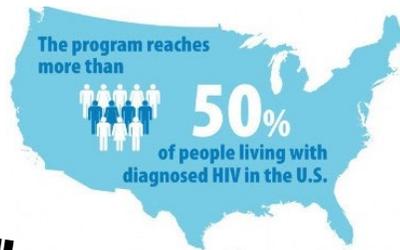
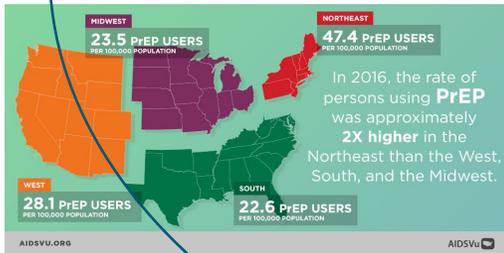
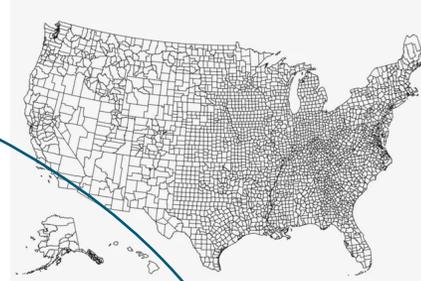
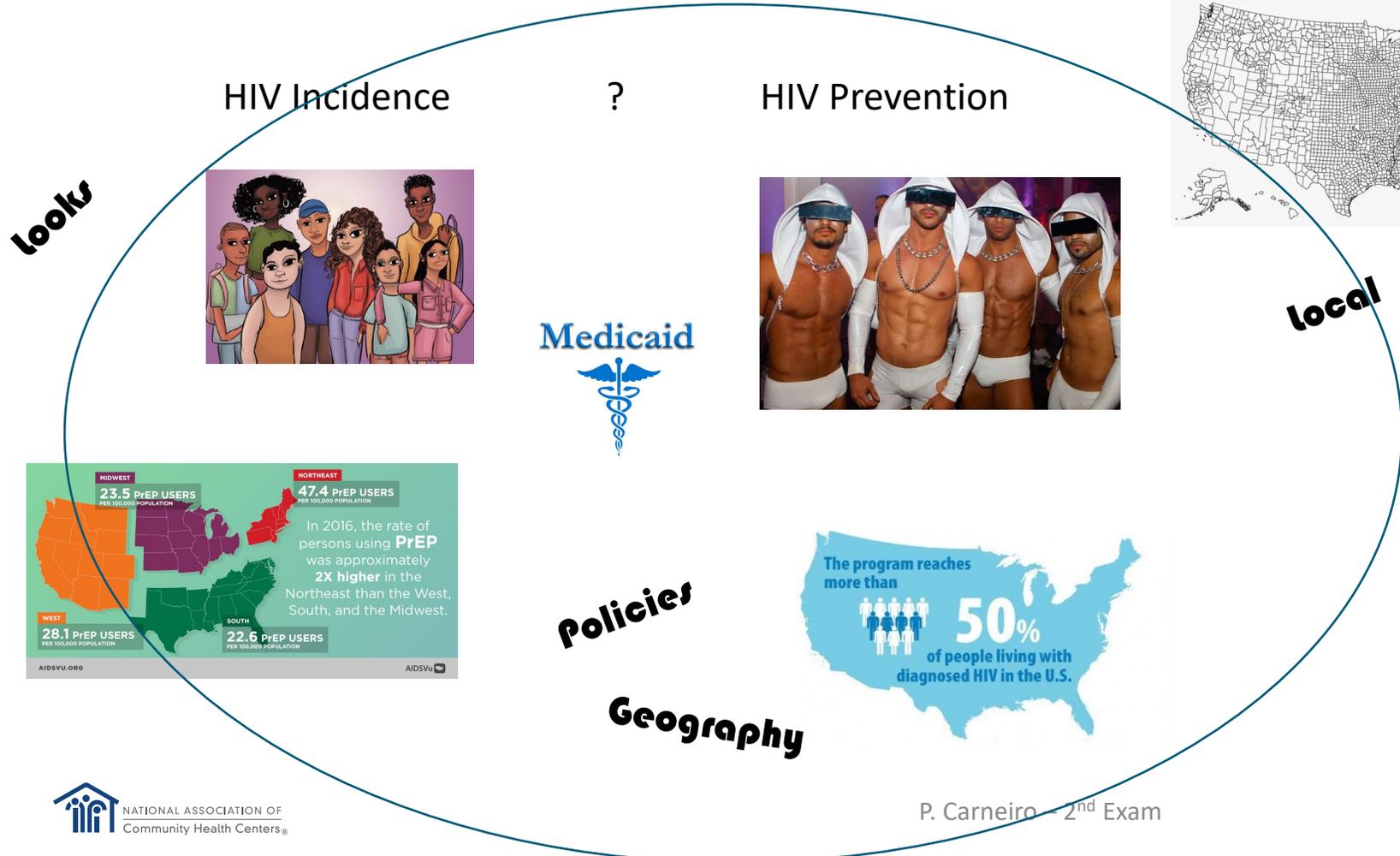
A snapshot of PrEP scale-up, registration and resources for the United States.

227,000–228,000

Estimated Cumulative Number of People Initiating PrEP **i**

Data Updated: April 11, 2022

HIV Prevention individuals and Structural Issues



Challenges with PrEP uptake

Initiation

Who is a good candidate?
How to talk to them?
Getting the medication at pharmacy

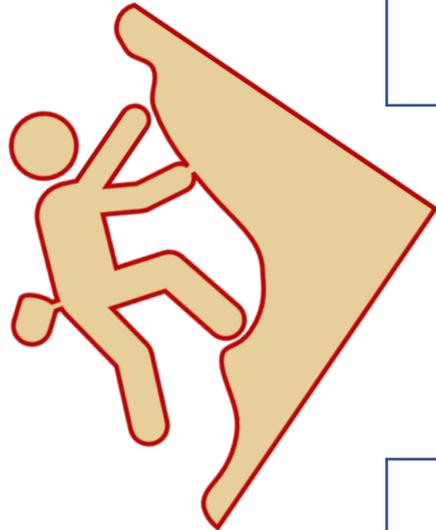
Adherence

How well are patients doing?
What modality of PrEP is best?
Side effects concerns
Misconceptions

Persistence

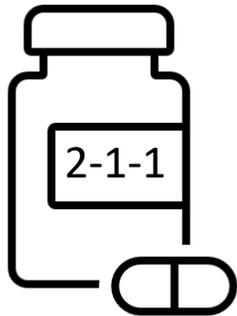
How to stay engaged?
Long term care plan
3-month f/u forever?

- Psychosocial factors
 - Initiative
 - Stigma
 - Shame
- Primary Care factors
 - Lack of time
 - Provider discomfort
 - Unawareness
 - Lack of competency
 - “purview paradox”

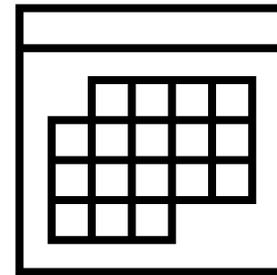


How is PrEP prescribed?

- Only Medical Providers can prescribe daily oral PrEP
- New PrEP guidelines add more options.... And more are coming



Long Acting
injectable



Monthly PrEP



... Implants.... douches...

Together 5,000

- Internet-based national cohort of cisgender men and transgender people who have sex with men
 - All participants met clinical guideline criteria for PrEP
 - Recently diagnosed with an STI
 - Recently used PEP
 - Had condomless anal sex with a man
 - Share needles or used Crystal meth recently
 - Our analysis sample $n=6264$

Who spoke to the provider about PrEP

Communication with a medical provider about PrEP

- Have you ever spoken to a medical provider about starting PrEP?
 - No, I have not ever spoken to a provider about starting PrEP
 - Yes, and we both decided it was a good option for me and I should start PrEP
 - Yes, and we both decided it might be a good option but to wait before beginning PrEP
 - Yes, and we both decided it was not a good option for me
 - Yes, and the provider was not comfortable prescribing PrEP for me
 - Yes, and the provider thought it was a good option, but I chose not to do it

Who answered each of the potential answers

Who spoke to the provider about PrEP?

- Only **31%**

Moral of the story:

Less than half of one third (~12%) of respondents may go into taking PrEP soon

How were their answers?

- Yes, and we both decided it was a good option for me and I should start PrEP (**45%**)
- Yes, and we both decided it might be a good option but to wait before beginning PrEP (**16%**)
- Yes, and we both decided it was not a good option for me (**7%**)
- Yes, and the provider was not comfortable prescribing PrEP for me (**15%**)
- Yes, and the provider thought it was a good option, but I chose not to do it (**17%**)



Structural Barriers to HIV Prevention and (Some) Solutions

Challenges implementing PrEP services

- Low PrEP awareness by prescriber and potential PrEP users
- Misperceptions about and around PrEP use
- Systems/programs/work-flows that identify people at risk for HIV are lacking
- Prescribing PrEP may seem complicated
- (Cost)
- HIV/PrEP Stigma

Low PrEP awareness

- **Medical provider gaps** (Petroll, 2017):
 - 76% of PCPs had heard about it
 - 28% felt familiar with prescribing it
 - 17% had prescribed it
- **Community awareness**
 - 64% of MSM had heard about it (Iniesta, 2018)
 - <10% of women at risk for HIV knew about it (Auerbach, 2015)
 - 96% of MSM and TGW C.M. users heard about, 3.3% had ever used PrEP (McMahan, 2017)
 - 28% of urban AYA knew about it (Caves, 2019)
 - 3-65% of TGW had knowledge of PrEP (Sevelius, 2015. Wood, 2018)
 - 68% of 13-18y.o. YMSM had heard of PrEP (Gordian-Arroyo, 2020)

Misperceptions about PrEP

- **Among medical providers** (Petroll, 2017)
 - It results in risk compensation
 - People should use condoms instead of PrEP
 - It will increase resistance
 - PrEP users are not likely to adhere
- **Among patients**
 - It is not effective
 - Interferes with hormones (GA-HT)
 - Bad side effects

Identifying those at risk for HIV – Reframing it

WE NEED TO TALK ABOUT SEX AND DRUGS!

- Validating and encouraging, not judgmental
- Less about eligibility criteria and more about the desire to remain healthy and not worry about HIV
- Less about number of partners and more about sexual health ideals
- Less about “high-risk behaviors” and more about community-level prevalence and social contexts

Not all HIV prevention is created equal

SOCIALLY ACCEPTABLE AND CONVENTIONAL HIV PREVENTION:

- Limiting sexual activity
- Limiting number of sexual partners
- Consistent condom use

LESS SOCIALLY ACCEPTABLE (albeit probably more effective) HIV PREVENTION:

- PrEP

There is a perception that PrEP (a highly-effective HIV prevention strategy) is an "excuse" from adherence to other HIV prevention strategies (which may be less effective)

Institutional PrEP stigma

- Language suggesting that PrEP is only for those at “very high risk” of infection
- PrEP eligibility assessments that provide mixed messages about the definition of “high-risk” behavior
 - *The man who had condomless sex once with a regular well-known male partner*

Is as good a candidate for PrEP as

- *The man who had condomless encounters with multiple casual/anonymous partners while intoxicated with CM and sharing needles*

Revisit messaging

- Instead of relying on traditional risk assessments
- Ask patients about their own HIV and STI concerns: **“What are your concerns about your sexual health? How much do you worry about HIV and other STIs and why?”**
 - ❖ Providers will learn more about patients’ true behavior, attitudes, and risk perception
 - ❖ Asking patients about their sexual goals (“What’s your ideal for your own sexual health? What would you need to improve your sexual health?”) helps patients feel that providers are trying to give them what they need rather than judge
 - ❖ This would also identify PrEP candidates because of future or anticipated behavior

Monkeypox and HIV

ONE HEALTH CENTER'S
PERSPECTIVE



Johann Torres, MD

Chief Medical Information Officer

Senior Medical Director

Medical Director of HIV/AIDS Services

Miami Beach Community Health Center

Miami Beach Community Health Center



- Serving Southeast Florida area since 1977
- 3 Physical locations (South Beach, North Beach and North Miami)
- Served 58,506 Patients in 2021 (1023 Persons with HIV)
- 50+ Medical providers across about a dozen specialties
 - 8 HIV Providers with more in training
 - 4 Dentists, 2 Dental Hygienists
 - 1 Registered Dietitian, 1 Ryan White Nutritionist
 - 2 Clinical Psychologists
 - 2 Endocrinology Providers and 1 in training
 - 2 Optometrists
- 400+ Employees
 - 8 Ryan White Case Managers, 3 Peer Educators
 - 10 Population Health Specialists
 - 3 Health Promotion Navigators
 - 1 Clinical Pharmacist, 5 Medical Preauthorization Assistants
- Joint Commission, PCMH and URAC Specialty Pharmacy Certified
- 340B Pharmacy
- On-site laboratory (specimen collection and POC testing)
- Dental Imaging, RetineVue, FibroScan®

Patient Centered



High Quality



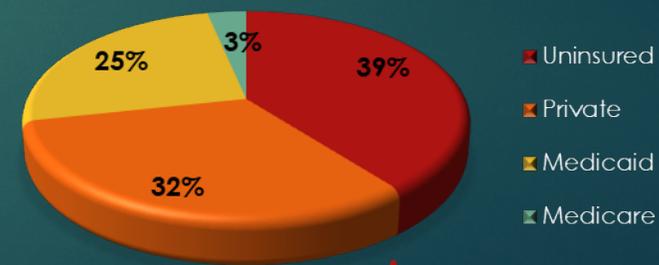
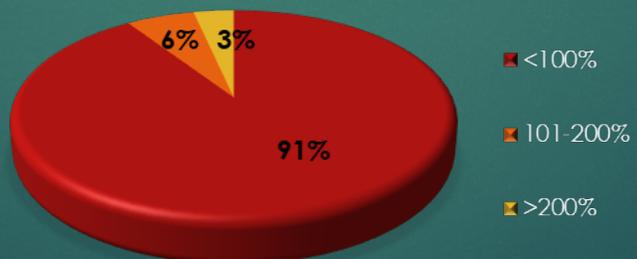
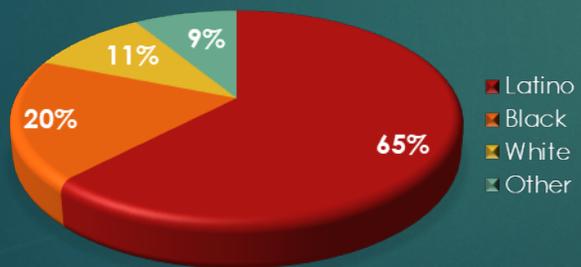
Primary Care



Specialty Services



Who We Are





Monkeypox Diagnosis and Treatment Response Plan

- ▶ July 2022 – First Case of Monkeypox referred to MBCHC
- ▶ Identified Treating Medical Providers – at least 2 at each site
- ▶ Set aside “Isolation Rooms” where patients can be treated
- ▶ Set up a Fast Track process
- ▶ Provider and Staff Education
 - ▶ Monkeypox Education at Bimonthly Provider Meeting
 - ▶ CDC and FDOH Treatment Protocols reviewed with treating staff
- ▶ Total of 28 Confirmed Cases since July (4 cases in November)
 - ▶ Tecovirmat – antiviral therapy
 - ▶ EA-IND Expanded Access of an Investigational New Drug (“Compassionate Use”)
 - ▶ Strategic National Stockpile
 - ▶ Coordinated via FDOH (Miami Dade County – ADAP pharmacy)

Monkeypox Vaccine

- ▶ Late July – 200 doses distributed from FDOH in coordination with MDC Ryan White Program
- ▶ August – 400 vials from HRSA and 200 more vials from FDOH
- ▶ 431 1st Doses and 333 2nd Doses (764 total)
- ▶ Initially Campaigned using our Population Health Team to our patients at risk (HIV positive, MSM, Staff)
- ▶ Currently open to public
- ▶ Lessons and processes from COVID vaccine roll out



State of Florida's EHE (Ending the HIV Epidemic Plan) MBCHC's Implementation

Implement Routine Screening

Screening Policy

- **Create a Culture of Routine Screening**
- Opt-Out
- Standing Order
- POC Rapid Testing via RW Test Counsellors
- Mail Out OraQuick kits

Data-Driven

UDS Data to Create Registry

- EHR Reminders
- Provider Report Cards
- Frequent and Targeted Re-Education
- Population Health Team to Close Gaps

Provide Rapid Access Ensure Retention-In-Care

Rapid Access

- Monitor HIV Test Results Through Reporting
- Increase HIV Provider Base
- Provide Immediate Access to HIV Care via Telemedicine or Warm Handoff
- Pharmacy Maintains Ready-To-Go 30-Day Supplies of Common RA Medications (e.g. Biktarvy)
- Ryan White Case Managers On-Site for Expedited Registration

Retention-In-Care

- Maintain a Registry
- Weekly Meetings to Monitor and Troubleshoot Progress
- Use both RW Case Management and Population Health Team

Improve and Promote Medical Prevention

PrEP



Create a Culture of HIV Prevention via Medication

- Provider Education (and Re-Education)
- Multidisciplinary Approach (e.g. Behavioral Health, OB-Gyn)
- Data-Driven **Proactive** Approach
- PrEP Protocol
- Same-Day PrEP
 - POC Rapid HIV
 - Pharmacy Maintains Ready-to-Go 7-Day Supplies
- Health Promotion Navigators

nPEP

- Referred to Health Promotion Navigators
- Same Day or Next Day Appointments with HIV Providers
- nPEP Protocol

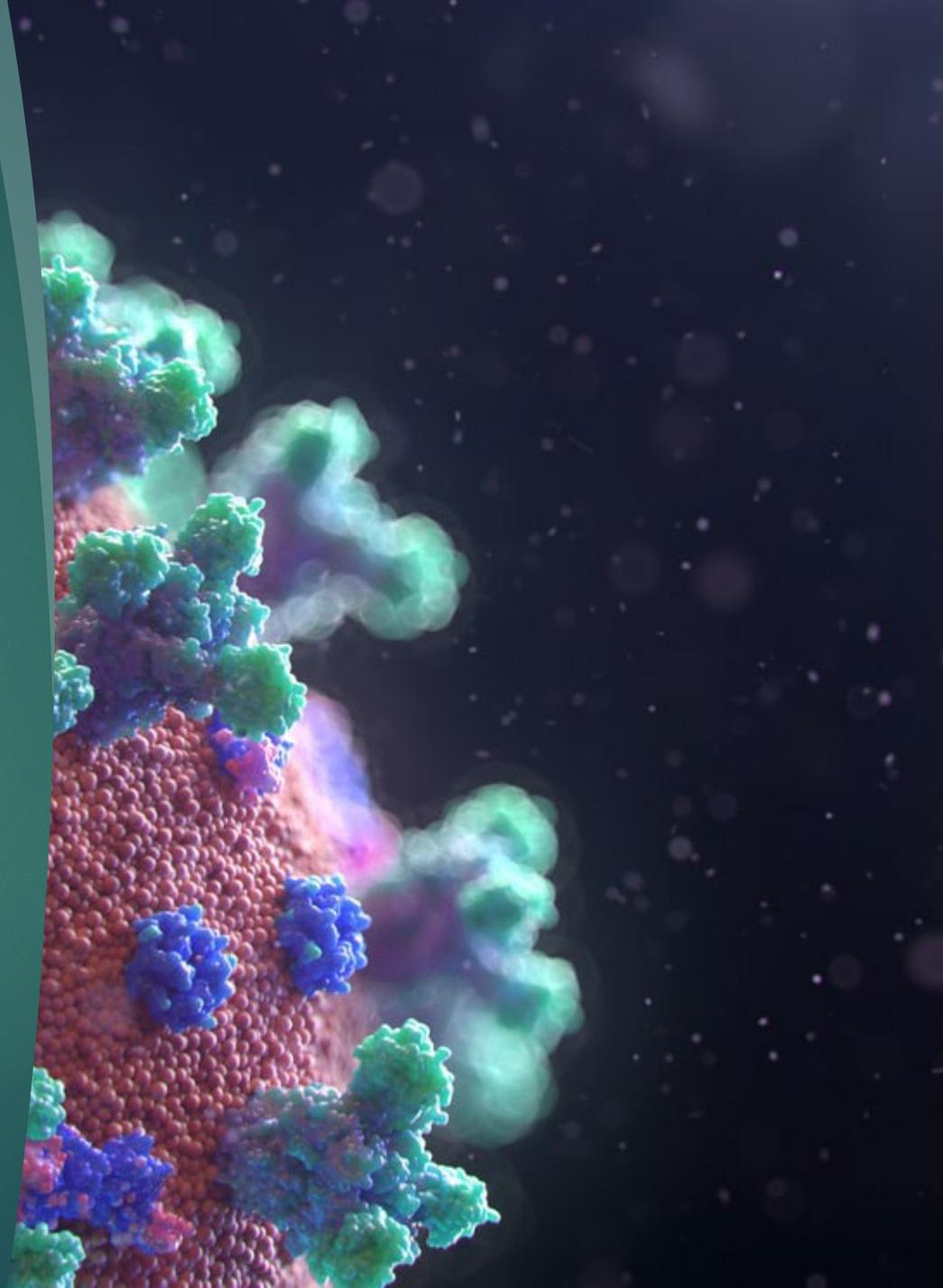
Increase HIV Awareness

UNDER CONSTRUCTION



PrEP: Lemonade from Lemons A Story of Telehealth

- ▶ The MBCHC Telehealth Story: Origins
- ▶ 2020 Pandemic Shut Down Lessons
- ▶ Health Promotion Navigators as Care Coordinators
- ▶ Leverage Telehealth for to minimize barriers to care
- ▶ Utilize Commercial Lab Patient Service Centers
- ▶ Delivery Service for Medications
- ▶ (Future: Home Self-Testing Kits)



PrEP: Importance of 340B

- ▶ 340 Savings could be redirected towards:
 - ▶ Cost of lab work and follow up visits
 - ▶ Health Navigator and Population Health Teams
 - ▶ Clinical Analytics Time to find new patients
- ▶ Challenges
 - ▶ Truvada (tenofovir disoproxil fumarate) went generic in March 2021
 - ▶ Descovy (tenofovir alafenamide)
 - ▶ Not approved on all plans without prior authorization
 - ▶ Occasionally managed by PBM's
 - ▶ Apreture (cabotegravir)
 - ▶ Early (just became available Feb 14, 2022)
 - ▶ Special issues with an injectible



PrEP: Apretude Revolutionary New Tool

- ▶ Bi-monthly injection
 - ▶ Pro: Convenience, Discretion, No Pills
 - ▶ Cons: Must come to office, Injection, Cost (staff, supplies, medication)
- ▶ Superior Efficacy compared to TDF
 - ▶ HPTN 083: MSM/TGW – 66% Risk Reduction
 - ▶ HPTN 084: CGW – 90% Risk Reduction
- ▶ Why is this revolutionary
 - ▶ PrEP is like birth control/family planning
 - ▶ Discretion
 - ▶ Reduces barriers to care



PARTING GIFTS

- ▶ No HIV Specialists, No Problem!
 - ▶ THE POWER OF THE HEALTH CENTER CONTROLLED NETWORK
 - ▶ HIV “Specialty” Care is the Realm of the PCP
 - ▶ AAHIVM Mentor Program, National HIV Curriculum
 - ▶ Take advantage of Telehealth, ECHO
- ▶ Identify a Champion(s) **AND** Do not be afraid to change
- ▶ Patient-Centered Care: Minimizing Barriers
- ▶ The Value of the Pilot – Convincing the C-Suite
- ▶ Repetition Nurtures the Mission: “Turning the Tanker”
- ▶ ***Inspiration vs. Emulation***



Thank You



QUESTIONS?



THANK YOU!

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Community Health Centers®

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