PrEP, PEP, Rapid ART, & ED Testing

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Objectives

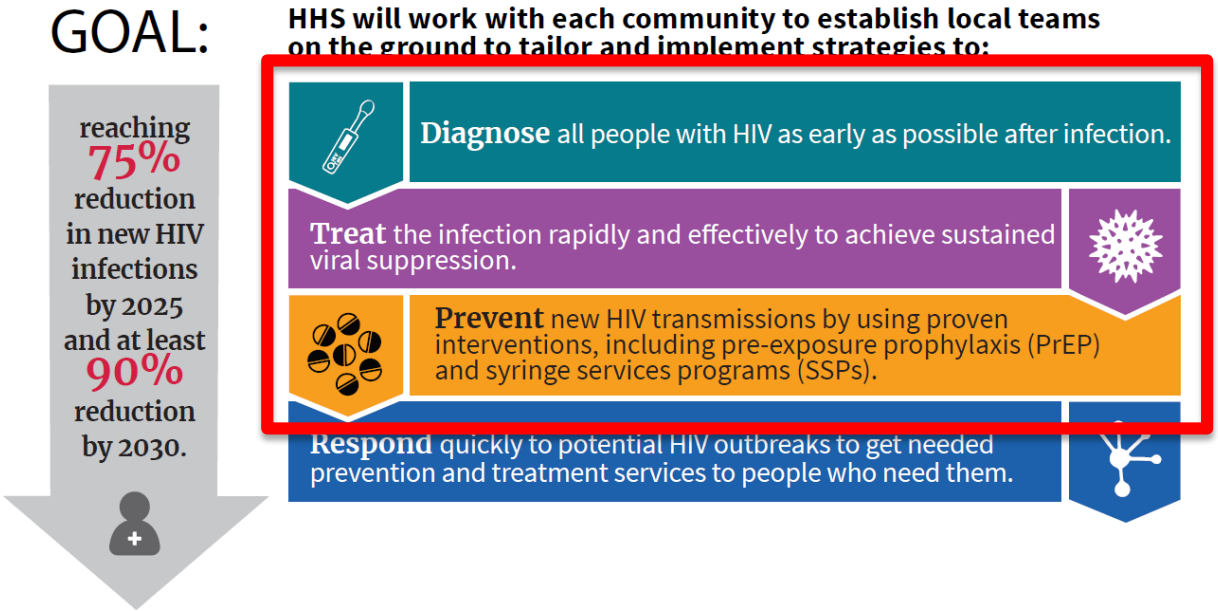
- Review fundamentals of PrEP, PEP, rapid initiation of ART, and emergency department HIV testing

IU Health LifeCare

- Hospital-based HIV treatment and prevention provider, with multidisciplinary services
- HIV primary care services & chronic disease state management, medical- & non-medical case management (Care Coordination), multidisciplinary behavioral health team, clinical pharmacy team, dietitian, Rapid Start program (rapid ART initiation), biomedical prevention services (PrEP, PEP), rapid HIV testing, etc.
- Social Work and Clinical Pharmacy services for the Riley Hospital for Children HIV Clinic (approx. 70 patients)
- Methodist Emergency Department HIV & HCV testing (Gilead FOCUS)

- 1,497 PLWHA seen in the past 12 months
- Viral load suppression: 91.7% [<200 copies/mL]
- 85% of patients receive primary Care Coordination at LifeCare

Ending the HIV Epidemic Strategies



cdc.gov/endhiv/docs/ending-HIV-epidemic-overview-508.pdf

Pre-Exposure Prophylaxis [PrEP]

- All patients see a Nurse Practitioner and Social Worker (PrEP Navigator) at first appointment
  - Subsequent Navigator involvement is determined based off of need (insurance, adherence, psychosocial needs, etc.)

- Nothing new here, but where do we have room for improvement?
  - For LifeCare, it's making meaningful connections with individuals who identify as non-white, transgender, sex workers, etc.
- How do you expand PrEP outside of the ASO community?
  - FQHCs? Primary care? Linkage from emergency departments? Partner with online providers somehow?

LifeCare PrEP patients	LifeCare	TGA
White (non-Hispanic)	66%	71%
Black	19%	16%
Asian	8%	4%
Hispanic	5%	7%
Other	2%	2%
Male	88%	49%
Female	12%	51%
Transgender	0%	

ryanwhiteindytga.org/Resources – Epidemiology of HIV in the Indianapolis Transitional Grant Area: 2019

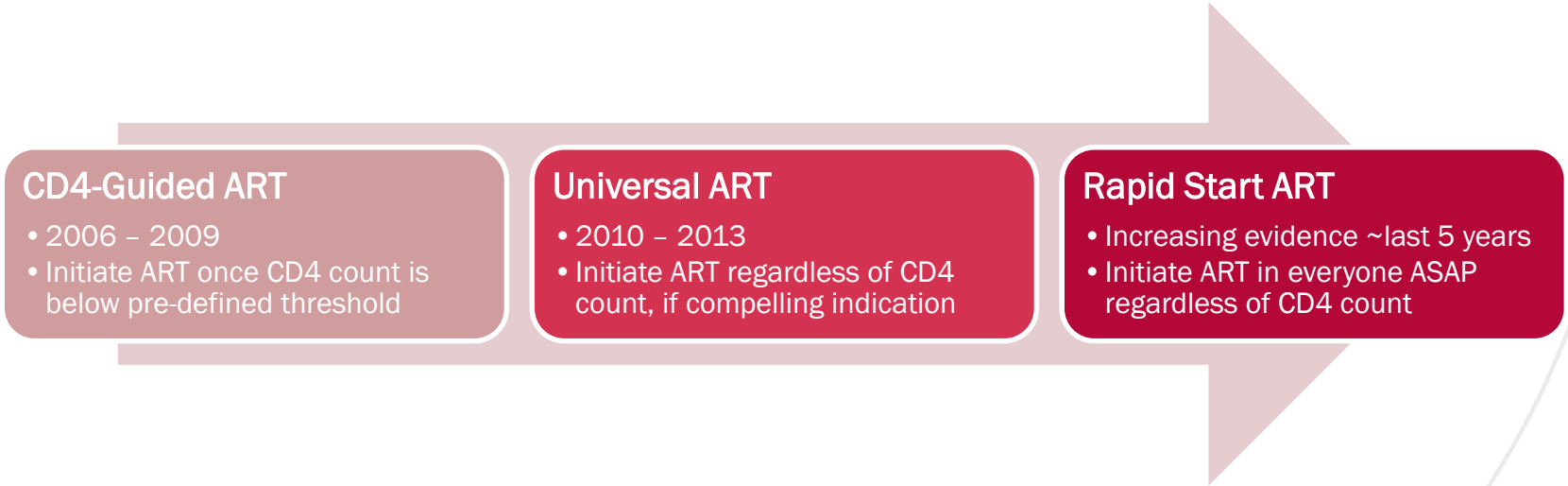
Post-Exposure Prophylaxis [PEP]

- Non-occupational
- Non-sexual assault

- Via LifeCare directly (during business hours) or through Methodist Emergency Department (24/7 access)
  - Patients who start at Methodist ED are provided enough medication to last until next business day, at which patient is seen by LifeCare for all follow-up care

- Goes hand-in-hand with PrEP. Essential to educate those seeking PEP about PrEP.
- If you're providing PrEP but not PEP, ask yourself and your colleagues why not

Evolution of Treatment Initiation



Richardson E, et al. Antiviral Res. 2014;103:88–93.

Rapid Linkage & Treatment

- START & TEMPRANO trials, as well as multiple other studies from around the world and within the United States (UCSF, Grady Health System, etc.) show that rapid linkage and treatment in individuals with HIV can lead to:
  - Decreased time to medical appointment, initiation of ART
  - Decreased time to virologic suppression
  - Fewer significant health events (overall better health outcomes)

INSIGHT START Study Group, Lundgren JD, Babiker AG, et al. *N Engl J Med*. 2015;373(9):795-807.
TEMPRANO ANRS Study Group, Danel C, Moh R, et al. *N Engl J Med*. 2015;373(9):808-822.

LifeCare: “Rapid Start”

- From receipt of referral to meds-in-hand in less than 72 hours
- Inclusion criteria: ART-naïve individuals with ability to pay for visits/labs/medication (insurance, RW, etc.)
- First Rapid Start patient June 2019
- To date, 42 patients referred to LifeCare that meet criteria for Rapid Start
  - 27 [64.3%] of those were seen in clinic and left with ART same-day, within 72hrs of receiving referral

- Wins:
  - Patient reactive HIV screen at Methodist ED in February. Reactive screen to HIV diagnosis to meds-in-hand in 5 calendar days. HIV VL decreased from 99,200 to 21 copies in 6 weeks.
  - Patient reactive HIV screen at LifeCare in June. Staff in place and prepared to provide immediate Rapid Start appointment. Patient chose to leave that day, but came back for Rapid Start intake two calendar days later. Reactive screen to HIV diagnosis to meds-in-hand in less than 48hrs.

Rapid: Real-World Tips and Tricks

- Define what “rapid” means for your setting. What is feasible?
- Establish a standard procedure and re-evaluate as needed
- Ensure patients are aware of documents needed for benefit enrollment
- If on parent’s insurance, assess if parent is aware of diagnosis
- Review only necessary information at initial appointment
- Hand deliver medicine to patient in clinic, if possible
- Utilize all available co-pay cards and pharmaceutical patient assistance programs
- Be flexible. Start small and expand.

- “Don’t let perfect be the enemy of good.”

Richardson E, et al. Antiviral Res. 2014;103:88–93.

Emergency Department [ED] HIV Testing

- Identification of new HIV diagnoses in high-volume areas
- 24/7 access
- Linkage
  - Newly-diagnosed with HIV
  - Known diagnoses but who are out of care
  - PrEP
- Gilead FOCUS Program
  - Public health initiative that encourages routine HIV & HCV testing in emergency departments
- Opt-out testing model, using existing ED staff
  - “You will receive an HIV and a Hepatitis C test today as a standard of care at this facility, unless you decline.”

Emergency Department [ED] HIV Testing

- Working to iron-out process at Methodist (90-100k ED visits/yr) with hopes of expanding to all EDs across the IU Health system (450k ED visits/yr) in near future
- **HIV screening** [2/24/20 – 7/9/20]
  - 1,043 screens completed
  - New diagnoses: 3 (0.3% positivity)
- **HCV screening** [2/24/20 – 7/9/20]
  - 1,033 screens completed
  - Ab positive: 103 (10.0% positivity)
    - New diagnoses: 21 (2.0% positivity)
    - 59 of those already known to have HCV never started care or were never linked to care
    - 23 already completed HCV treatment
- Again…. “Don’t let perfect be the enemy of good.”

...so what?

- These interventions don't require large sums of money to implement or major infrastructure shifts. They require planning and coordination.
  - Particularly for agencies with access to medical providers (inside or outside of the existing ASO network), implementation should be relatively straightforward with thoughtful planning.
  - Site-specific constraints may make implementation harder (rapid, for example, if you don't have access to clinic space the entire time an agency is open), but how can you improve upon your current state?
- Remain data-driven
- We do a good job with those in care and virally suppressed, but how do we succeed with those who aren't in care, aren't suppressed, or aren't on PrEP yet?
- Community-wide interventions instead of agency-specific programs? Agency strength assessments?

- **How to we move forward with a plan that creates measurable impact?**

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