Early Implementation Experience and Lessons Learned from Eight Diverse Clinics Introducing Long-acting Injectables for HIV Treatment

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ALAI UP

Advancing Long Acting Injectables

For Underserved Populations
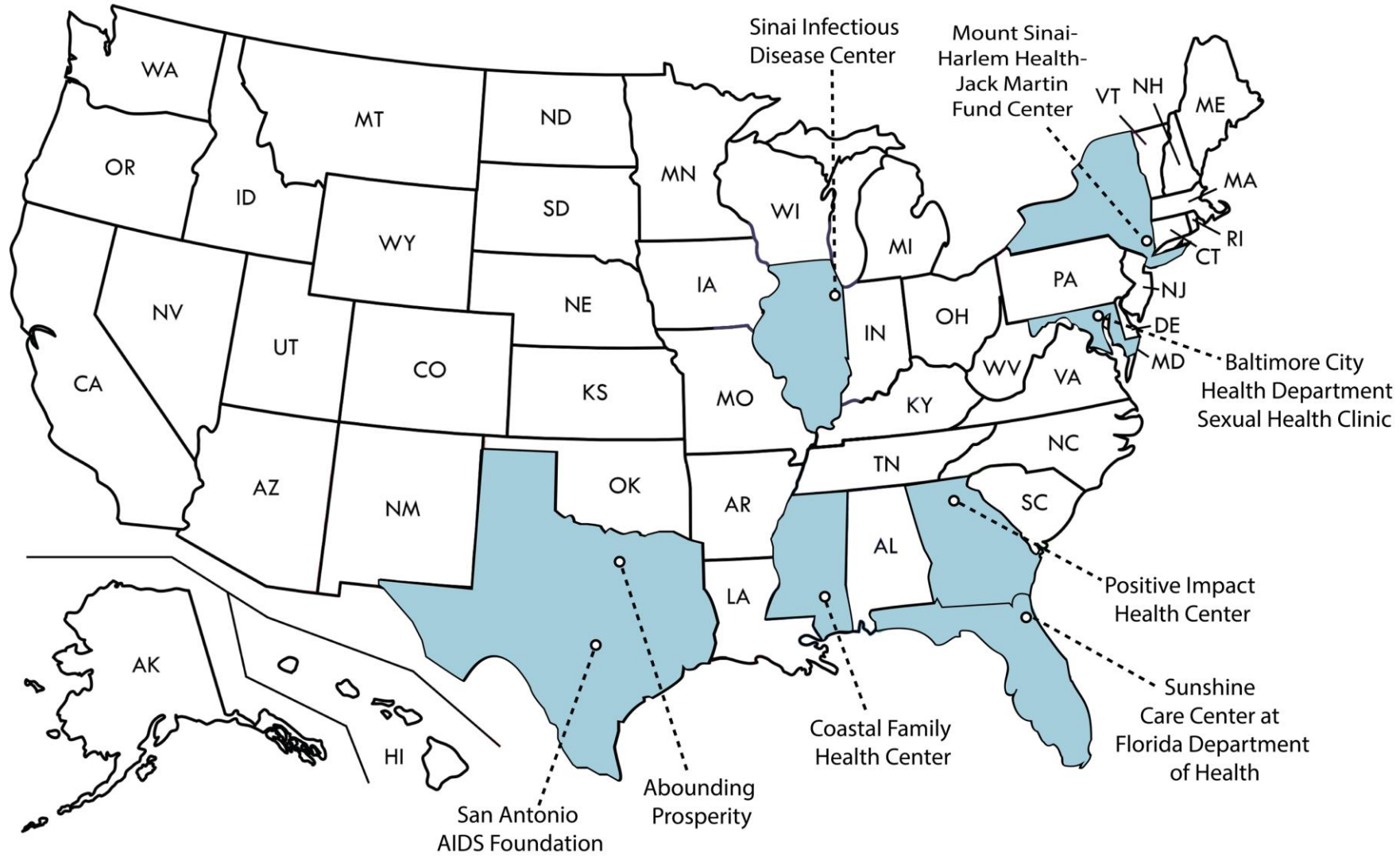
No disclosures to report

1 ALAI UP Overview

ALAI UP Project Goals

Co-develop long-acting injectable HIV treatment programs that **prioritize the needs of underserved populations** and **intentionally implement LAI ART in ways that increase equity in health outcomes**.

Synthesize and disseminate lessons learned from ALAI UP Demonstration Sites to accelerate implementation of LAI ART that prioritizes the needs of underserved populations at other agencies.

ALAI UP is a Special Project of National Significance (SPNS) funded by HRSA HIV/AIDS Bureau and Minority HIV/AIDS Fund

ALAI UP Demonstration Sites

Sinai Infectious Disease Center

Mount Sinai-Harlem Health-Jack Martin Fund Center

Baltimore City Health Department Sexual Health Clinic

Positive Impact Health Center

Sunshine Care Center at Florida Department of Health

Coastal Family Health Center

Abounding Prosperity

San Antonio AIDS Foundation

Six ALAI UP Core Components

Public Health Detailing

Community engagement

Resource Incubator

Technical Assistance

Learning Collaborative

Data reports to monitor equity

Seed Funding: ~$90,000 per year for three years for a total of $270,000

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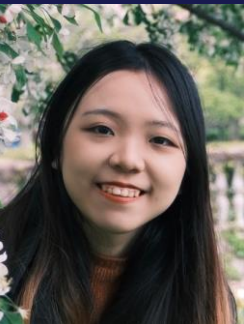
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2 Lessons Learned & Recommendations

Lesson 1: iCAB/RPV is implementable in many different healthcare settings

➢Seven out of eight ALAI UP clinics have successfully initiated and maintained clients on iCAB/RPV, eighth site is weeks away!

➢This includes clinics at ASOs, FQHCs, CBOs, Health Departments, Academic Medical Centers, and Safety-net Hospitals, all of which provide services to underserved populations and some in states with significant structural barriers.

➢All clinics have champions (clinical or non-clinical) but staffing models are diverse.

Rec 1: Don't let perfect be the enemy of the good

➢While the complexities of getting iCAB/RPV for your patients are enormous and daunting, ALAI UP clinic show that it is possible.

➢Different staffing models can work to implement iCAB/RPV.

- 2 clinical pharmacist-led programs
- 1 dedicated coordinator-led program
- 1 MD-led program

- 2 case manager-led programs
- 1 RN-led program
- 1 community health worker-led program

➢Don't reinvent the wheel!
- Reach out to clinics that are similar to yours and ask for advice, workflows, and resources
- Reach out to AETCs or other training entities to provide support

Lesson 2: Universal education is acceptable and feasible in some, but not all clinics

➢Six out of eight clinics have initiated "universal education" approaches so that all people with HIV accessing services at their clinic learn about injectable treatment.

➢Clinics with smaller client populations were earliest adopters of universal education approach.

➢Targeted education introduces opportunities for implicit bias in who hears about injectable treatment and impacts patient experience.

Rec. 2: Consider a universal education approach to LAI ARVs as an equity-enhancing strategy

➤ Clinics are using diverse approaches to educate their clients about LAI ARVs.

➤ Training non-clinical staff to conduct basic education about LAI ARVs works and shifts tasks away from busy clinicians.

➤ Well-trained staff effectively navigate clients' disappointment if they are interested, but not eligible for iCAB/RPV.

Lesson 3: Pharmacy support plays a crucial role in building and expanding an iCAB/RPV program

➤Pharmacy support can take various forms
- 2/8 clinics are using on-site pharmacists, the rest have partnerships

➤Pharmacists own or contribute to the following service components at different clinics:
- Client education and assessment of interest
- Eligibility screening
- Coverage investigation and navigation
- Drug procurement and storage

➤Sites without onsite clinical pharmacy support can be successful in building programs through collaboration with off-site pharmacies.

Rec 3: Access or build pharmacy expertise

At sites with no on-site pharmacy expertise

➢ Identify available staff to cross-train on benefits navigation, procurement, and storage.

➢ Ask for training from AETCs, departments of health, or other entities.

➢ Hire or contract pharmacist or pharmacy technician to support implementation of LAI ART.

➢ Build strong relationships with pharmacist staff at specialty pharmacy.

At sites with on-site pharmacy expertise

➢ Involve pharmacy staff in planning, developing protocols and workflows at minimum.

➢ Identify roles and responsibilities that pharmacy staff can take on.

➢ Engage pharmacy staff for their technical knowledge, even if they cannot fill iCAB/RPV prescriptions.

Conclusion

Long-acting agents are the new frontier in HIV medication and require new ways of working

➢Workflows and staffing plans for oral HIV medications are not optimal for LAIs.

➢Relying solely on clinical staff for the LAI ART limits growth and is unsustainable.

➢To serve patients with HIV in 2024 and beyond, clinics need to find ways to offer long-acting formulations.

➢ Conceptualize injectables as a routine part of HIV clinical services.

Acknowledgement

ALAI UP Information and Resources (coming soon)

targethiv.org/spns/alai-up