Persistence in Care After PrEP Initiation Through a Community-Based Mobile Clinic

01254

A. Johnson, K. King, K. Klose, G. Narcisse, **S. Doblecki-Lewis**

Division of Infectious Diseases, Department of Medicine, University of Miami Miller School of Medicine, Miami, Florida, USA

BACKGROUND

PrEP represents a substantial opportunity for reducing HIV incidence among priority populations and within HIV high-incidence areas. In South Florida, an area of the United States (US) where rates of new HIV infections have been and continue to be particularly high, significant structural, social, and logistic barriers to PrEP care exist. We have established a community-based mobile clinic model for PrEP delivery in five neighborhoods in Miami-Dade County with high rates of new HIV diagnoses. Services are delivered at convenient times and locations on a rotating schedule and at no cost of clients regardless of insurance or immigration status. Data on PrEP persistence with alternative care delivery models is limited.

METHODS

Clients included in this analysis sought PrEP services through one of the five mobile units or the fixed location of the University of Miami PrEP clinic programs between August 2018 and March 2023. We evaluated short term (24 weeks) and long-term (48 weeks) persistence in care in our clinics as well as persistence on PrEP (defined as an appointment resulting in a PrEP prescription). A total of 919 clients were included all of whom had their first appointment before March 31, 2022 and therefore could be evaluated for persistence at 1 year. PrEP persistence was defined as having attended at least 1 follow-up appointment within 24 weeks of their first appointment, having attended a second follow-up appointment within 48 weeks of their first appointment (the follow-up appointment occurring within 24 weeks of their previous appointment). Cox proportional hazards models were used to estimate adjusted Hazard Ratio (aHR) of risk factors for discontinuation of PrEP care at 48 weeks. PrEP discontinuation was examined using client-related data recorded during each visit including demographics, gender, race, ethnicity, insurance status, and location of visit.

Clients initiating PrEP in a mobile clinic had improved persistence compared with those initiating in a fixed clinic, with no difference by race, ethnicity, or insurance status.

	PrEP Persistence				Persistence in Care			
	Adjusted Hazard Ratio (aHR)	Lower C.I.	Upper C.I.	P-value	Adjusted Hazard Ratio (aHR)	Lower C.I.	Upper C.I.	P-value
Mobile vs. Fixed Location	**1.68**	**1.44**	**1.96**	**<0.01**	**2.21**	**1.85**	**2.64**	**<0.01**
Non-Hispanic vs. Hispanic Ethnicity	1.08	0.91	1.29	0.33	0.99	0.81	1.22	0.94
Male vs. Female Gender	**2.02**	**1.54**	**2.65**	**<0.01**	**1.51**	**1.05**	**2.19**	**0.02**
Transgender/ Gender Non-conforming vs. Female Gender	1.17	0.85	1.61	0.32	1.37	0.96	1.93	0.08
White vs. Black Race	1.04	0.83	1.31	0.68	0.95	0.73	1.24	0.72
Uninsured vs. Insured Status	**1.2**	**1.04**	**1.37**	**0.01**	1.12	0.96	1.32	0.13

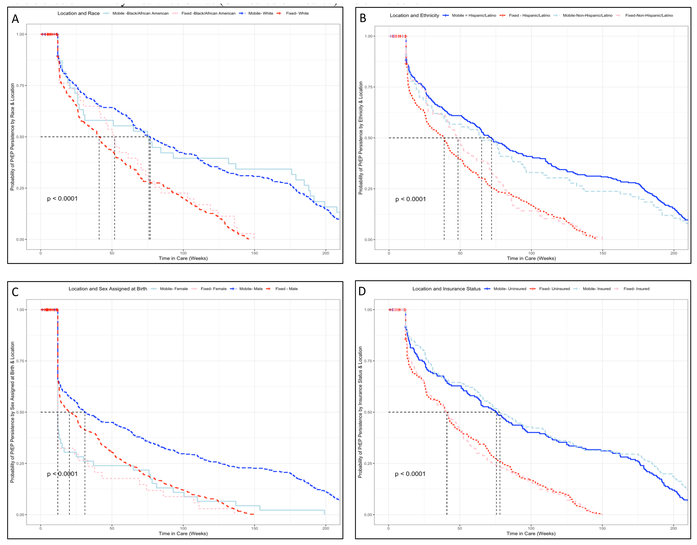
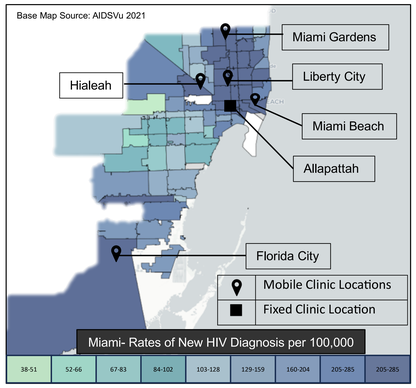


Figure 1 (above). Persistence in PrEP Care for Clients Initiating PrEP in Mobile or Fixed Clinic Setting by Client Characteristics: A) Persistence on PrEP by Race (Black/African American or White) and clinic cohort; B) Persistence on PrEP by Ethnicity (Hispanic/Latino or non-Hispanic/Latino and clinic cohort; C) Persistence on PrEP by Sex Assigned at Birth (Male or Female) and clinic cohort; D) Persistence on PrEP by Insurance Status (Uninsured or Insured) and clinic cohort.



RESULTS

The population was primarily self-reported male (86.8%), white (69.7%), Hispanic/Latino (74.6%), insured at baseline (50.6%), and initiated services at the mobile clinic (52.2%).

Overall, PrEP persistence to 24 weeks was 56.7% and PrEP persistence to 48 weeks was 41.5%. Individuals who were uninsured at baseline, self-identified as male, and initiated services in the mobile clinic were more likely to continue on PrEP than those who were insured at baseline, were white, self-identified as female, and initiated services at the fixed clinic (HR: 1.20, p-value = 0.01; HR: 2.02, p-value <0.01; HR: 1.68, p-value <0.01, respectively). Overall persistence in care (including visits for HIV/STI testing/treatment and other sexual health services) was 76.2% at 24 weeks and 55.7% at 48 weeks. Individuals who self-identified as male, and those who initiated services at the mobile clinic were more likely to continue in care compared with those who self-identified as female, and those who initiated services at the fixed clinic (HR: 1.51, p-value =0.02; HR: 2.21, p-value <0.01, respectively).

CONCLUSIONS

Persistence in PrEP and sexual health care is improved for those initiating services in a community-based mobile clinic compared with a fixed clinic with otherwise identical services, staff, and barrier-lowering strategies. In our analysis, uninsured clients had improved persistence on PrEP compared with those who were insured, suggesting that our no-cost service model with aggressive navigation to available assistance programs can successfully overcome barriers due to insurance coverage. Race and ethnicity were not associated with persistence in our analysis. Persistence among women initiating PrEP in both the mobile and fixed clinics was decreased. Future research to assess the potential role of mobile clinics in PrEP delivery are warranted.



AUTHOR CONTACT INFORMATION

Susanne Doblecki-Lewis, MD, MSPH

sdoblecki@med.miami.edu