WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Pre-Exposure Prophylaxis, Session #2, Community of Practice

9 August 2016

STEVE LUCKABAUGH: Good afternoon. My name is the Steve Luckabaugh, and I'd like to welcome you to the Pre-Exposure Prophylaxis, Session #2, Community of Practice webinar. This webinar is brought to you by the Partnerships for Care, HIV Training, Technical Assistance and Collaborations Center, HIV TAC. The Partnerships for Care project is a three-year multi-agency project, funded by the Secretary's Minority AIDS Initiative Fund, and the Affordable Care Act.

The goals of the project are to one, expand prevention of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV. Two, to build sustainable partnerships between health centers and their state health department. And three, to improve health outcomes among people living with HIV, especially among racial and ethnic minorities.

The project is supported by the HIV Training, Technical Assistance, and Collaboration Center, HIV TAC. We have three speakers today. Amir Dickson is the program manager for Connected Boston, which is a program of the Multicultural Aids Coalition. Connected Boston's aim is to address health disparities and advance health equity in the lives of black and Latino gay and bisexual men, and other MSM in the greater Boston area to reduce stigma related to sexual orientation, gender expression, and HIV status.

Mike Yepes, our next speaker, who grew up between Boston and Providence, Rhode Island to Colombian immigrant parents. Identifying as Latino gay and gender queer, and living in primarily Spanish-speaking neighborhoods, he has navigated his life at the intersection of various identities, and experienced firsthand the obstacles in accessing health care faced by individuals at the intersection of various disenfranchised communities. As a result, he has focused his work on identifying the focal points at which health disparities begin, and the cascading systems which amplify them.

After graduating from Brown University with a BSC in Neuroscience, Mike spent several years working in the medical field, studying things such as asthma and diabetes. Now Mike finds himself at Fenway Health, where he functions as one of the bilingual health navigators on the prevention and screening team, which works to identify and ameliorate STI infections in the greater Boston communities with particular focus on communities of color.

While his experiences vary in the context of the conditions being studied, the foundational focus has and continues to be the goal of obtaining and understanding of where health disparities begin and how to effectively counter and resolve them.

And our first speaker today is Dr. Douglas Krakower. Dr. Krakower is an attending physician in the Division of Infectious Diseases at Beth Israel Deaconess Medical Center in Boston, adjunct faculty at the Fenway Institute, and assistant professor of medicine at Harvard Medical School. His research focuses on ways to optimize HIV prevention in care settings.

Currently he is conducting studies with funding from the National Institutes of Health to enhance patient-provider communication in clinical decision-making regarding the use of pre-exposure prophylaxis. He's also affiliated faculty at the Ratelle STD/HIV Prevention Training Center of the Massachusetts Department of Public Health.

His clinical practice encompasses general infectious diseases, and HIV treatment and prevention. Please join me in welcoming Dr. Krakower.

DOUGLAS KRAKOWER: Thank you very much for the introduction. It's really an absolute pleasure to be here to talk about implementing pre-exposure prophylaxis in the clinical care settings. I think it's a very exciting time to talk about how health care organizations can do this in their local environments. And so this webinar hopefully will address some of the building blocks and steps that clinics can take to organize PrEP care in their settings. And then we'll hear some wonderful talks from Mike and Amir afterwards about the importance to have specialized staff members.

So I wanted to start by talking about some of the very important evidence that PrEP can be highly effective in a routine clinical care setting as a motivator for why organizations, they want to do this in their settings.

This is a slide from an observational study published in the fall of last year, looking at a health care organization in California called Kaiser Permanente's experience with using PrEP as part of their routine care settings. And the graph, if you look at horizontal axis, looks at time. On the left-hand is July of 2012. On the right is February of 2015. And the vertical axis looks at the number of individual who were referred for PrEP care, or who initiated PrEP at Kaiser Permanente over that time period.

And you can see that there was a steep increase over the course of the time of the study. And the really important data from the study is they had about 677 individuals who were prescribed PrEP in their care setting over the course of the study. And these are almost all men who have sex with men, or MSM. And they found that there were no new HIV infections among people who were prescribed PrEP.

And given the historical data in this population, they would have expected some new HIV infections. So this was very important data that in a real-world care setting, PrEP can actually be

highly effective at decreasing HIV incidence, and it's a motivator for clinics to think about establishing a similar program in their local settings.

The CDC has looked at what's the scope in the US population of people who may benefit from something like PrEP. And using nationally representative probability surveys, they've estimated that there are probably about 1.2 million Americans who may benefit from PrEP.

And they broke it down a little bit by important populations. And of that 1.2 million they estimate about one in four sexually active MSM, or almost half a million such individuals, may benefit from PrEP and meet clinical indications. About one in five persons who inject drugs, over 100,000, and about one to 200 heterosexual adults or over 600,000. And the important thing about these data is that they speak to a very large scope of scale up that would be needed to implement PrEP and meet CDC goals, what we think are most effective ways to use this on a population scale.

However, as of July of 2016, there were some important data presented at the International AIDS Conference that they estimated in the United States that there are probably about 80,000 individuals who have been prescribed PrEP since 2012 when it was FDA approved. So if you look at the numbers, there are probably only about 6% or 7% of the goal of people who may benefit from PrEP who have actually been prescribed it. So there's a lot of work that needs to be done in scaling this up.

And I think it speaks to the fact that primary care and other health care organizations that may see people who don't see HIV specialty care, can play a leadership role in implementing PrEP on a national level. So I wanted review some of the steps that a health care organization or a clinic site might need to consider in getting ready to prescribe PrEP to their patients.

So the steps may include being able to identify potential candidates for PrEP. And this may include incorporating routine risk assessments into general primary care. And many people who may benefit from PrEP who are at increased risk for HIV acquisition will not see HIV specialist care or STI specialists, but will see a primary care generalist. So a generalist can routinely assess whether someone's at increased risk for HIV infection, and therefore whether they may benefit from PrEP. That can be a very powerful way to be prepared to find people who make benefit from PrEP.

They should also be prepared as organizations to respond to requests for PrEP from patients who may be empowered and knowledgeable and may seek out PrEP. Finally, they may get referrals from HIV testing programs or STI sites that may provide care to populations enriched with at-risk individuals who may show up as referred patients. And so then being prepared to provide PrEP care to them is also a way to scale up the program.

Another step will be training providers to be able to support informed decision-making about PrEP. PrEP is something that may not be right for everyone. And so having providers with the skills and educational tools to have culturally competent discussions with their patient on an

individualized level about whether PrEP is right for them, will be something that's important to figure out for organizations who provide PrEP.

And then PrEP in terms of the medications and some of the follow-up care is expensive if people are going to pay completely out of pocket. The medications alone are over $10,000 per year per person. So there may be significant financial and insurance barriers that we'll need to be prepared to address for some patients who may be either uninsured or under-insured, and need help with things like co-pays, for example.

Organizations and [INAUDIBLE] providers who are ready to prescribe PrEP medications in terms of clinical skills, and having clinical-wide protocols can be helpful in this manner. And I'll show you an example of a clinical protocol from an organization that's been prescribing PrEP for a few years, to give you an example of what that might look like.

And then in terms of the long-term care associated with PrEP use, clinics will need to provide monitoring, counseling, and ongoing support as PrEP is a longitudinal intervention for some patients.

Here is an example of the PrEP clinical protocol from Fenway Health, which is where I do some of my research. And it's an organization that specializes in the health care of gender and sexual minorities. It's a community health center in Boston.

And as of now they've prescribed PrEP to well over 1,000 unique individuals over the past few years. So they have a lot of experience as a primary care site. They've been doing PrEP at a pretty high rate for a number of years.

So if you look at some of the steps that are part of their general protocol, I won't go through all the details. But note that there are steps including HIV testing, STI testing, the need for safety lab monitoring at baseline and at followup. Discussions in terms of informed verbal consent, figuring out if PrEP is right for someone, making sure they understand the risks, benefits and alternative approaches to HIV prevention and sexual health, counseling around adherence, sexual risk reduction, and also drug and alcohol use. Those can be important comorbidities in terms of people who may benefit from PrEP, and can also affect adherence to PrEP.

And then finally reassessments, over time PrEP may not be something someone needs to use every day for the rest of their life. So if their risk patterns change, providers should be prepared to counsel people that they can also stop PrEP for periods of time.

So this is a summary of clinical protocol at Fenway. And it's an example of what you might have at your organization if you decide to prescribe PrEP. But I think it also highlights that there are a number of steps where different staff members with different trainings could contribute to PrEP care. So for example, HIV testing and counseling is something that clinical prescribing providers could do as part of their care.

But you could also have specialists in HIV testing and counseling who provide that role, or who provide a supportive role. And the moral of the story for this whole talk is really one size may not fit all. And local resources and staffing availability are really going to dictate the best approach to PrEP care for particular organization.

So there are a number of different models of PrEP integration. And I've been focusing on this idea of primary care at Fenway Health, where primary care generalists are prescribing PrEP to their patients as part of routine care.

But let me walk you through three major models that have been introduced so far at different sites in the US. Looking at the first row of this table, you can see that municipal STI clinics, where they may take care of patients who have increased risk for HIV as a population, is one way to find a high percentage of patients who present to care who may benefit from PrEP.

And San Francisco City Clinic has had a PrEP demonstration project, as has had the Miami-Dade County Health Department PrEP demo project. And those are great examples of where PrEP was successfully delivered through STI municipal clinics.

Now some STI sites may not have the infrastructure to provide longitudinal care. So it'll be important to figure out, if you are an STI clinic, if you have the capacity to do that or not.

The next row looks at a different approach than STI clinics. It looks at organizations that may have lots of primary care providers, and may have local HIV specialists, such as infectious disease specialists.

And here, this is sort of the Kaiser Permanente model that I mentioned in the first slide. Here you would have a primary care providers who can refer to HIV specialists locally. So the idea would be that primary care providers identify people who may benefit from PrEP. And then they refer patients to specialists who can actually enact prescribing, or patients can be referred-- can help refer to the specialists within the organization.

And finally, the last row includes other primary care organizations besides Fenway Health, such as Whitman Walker Health in DC, which is also a community health center with specialty care for LGBTQ patients. And these are great examples of how community health centers that are staffed by generalists can learn the skills and structure themselves to provide PrEP to large numbers of patients coming in for primary care.

I think in the ideal world where there were sufficient resources and staffing, a multidisciplinary team-based approach to PrEP care would be the strongest approach. And it's something that has worked very well at Fenway Health, for example. In this idea you have a primary care provider who can prescribe PrEP, such as the physician or physician assistant, or advanced nurse practitioner.

You may have a team nurse, a team medical assistant, team behavioral health specialists. As I mentioned before, mental health and behavioral comorbidities such as depression, anxiety, and substance use issues are important comorbidities in terms of PrEP care that need to be addressed. And behavioral health specialists can be ideal for supporting that part of PrEP care.

There may be team case managers, clinical pharmacists who help with adherence counseling or side-effect management. And then finally PrEP specialists or health system navigators, if resources allow, can be an absolutely fantastic addition to a team. And we'll hear more about that from my colleagues after this talk.

One example of an organization that has used several different approaches to multidisciplinary PrEP care is Trillium Health, which is an organization in Rochester, New York. And this slide shows on the left half, how between July of 2012 and March of 2015, they had 126 individuals screened for PrEP, and almost 100 who actively were using PrEP.

And to enact PrEP care, they had multidisciplinary team that had a clinical provider, a clinical pharmacist, and an HIV test counselor. After that period as of April 2015, they shifted to a slightly different model where they had a clinical provider working in conjunction with a PrEP specialist or health system navigator who performed multiple different roles that had been performed by the clinical pharmacist and the HIV test counselor.

And I use this as an example of adaptive organizational change, where the organization looked hard at the resources that they had, and the staffing capabilities. And over time figured out that plan B versus plan A was probably a more effective approach. And I point this out as a way of highlighting that idea again that one size may not fit all. And also over time one size may not fit all.

Organizations may need to change and adapt, depending on the staffing, expertise they have, the interest in becoming PrEP providers within their staffing, [INAUDIBLE], and also in terms of the volume of care that they may provide. So as you can see, over time they moved up from 92 active PrEP patients to over 150 active PrEP patients, and going. So adapting as you go is probably something that can be wise for organizations, and something that is happening in primary care in general in PrEP care is probably no different in that regard.

Just to look a little bit more at some of the financial barriers that people who are either under or uninsured may face, we did a survey of the 32 primary care providers at Fenway Health last year to ask them if they had had financial barriers interrupt either initiation of PrEP or continuation of PrEP for any of their patients. And 31 of the 32 generalist primary care providers that we interviewed had actually prescribed PrEP to median of 20 patients. So as I was saying before, this is an organization with lots of experience providing PrEP. And about 48% of the providers surveyed said they'd had at least one patient with a lack of insurance coverage that got in the way of PrEP care.

About 45% had a patient who was unable to pay out-of-pocket costs even if they had insurance. And then only 39% said they really hadn't had any financial issues with providing PrEP care.

So this is a moving target over time. And also certainly there's lots of heterogeneity in terms of different states and different organizations in terms of the insurance of the patients, insurance [INAUDIBLE] of the patients to whom they provide care.

So this is just one example in a clinic in Massachusetts where there's lots of resources for health care insurance, and for health care assistance and assistance with co-pays that there's still maybe financial barriers. So the clinical organization, being prepared with resources to address these is going to be really important.

And I highlight that there are some patient assistant programs that are up and running that can be very useful in real-world care. Gilead, who makes Truvada for PrEP has a website that has some resources in terms of patient assistance for getting insurance or for getting support with paying for PrEP, including copay assistance.

The Patient Advocate Foundation is one of a few advocate foundations who have also offered copay assistance. And I would encourage you to ask for more details from Amir and Mike in terms of their experience with helping people to navigate some of the challenges with accessing PrEP.

Any organization that's going to provide clinical care may want to consider whether or not this is care for which they can be reimbursed. And this slide shows some of the ICD-10 codes that can be utilized as part of appropriate billing and coding. And I just want to highlight that organizations can be reimbursed for the PrEP care they deliver. And this is not an exhaustive list by any means. But these are some codes that may be helpful as part of appropriate billing and coding for PrEP care so that organizations can have sustainable financial models for delivering PrEP care.

So the last point I want to make is this idea of which providers and which organizations are going to be able and poised and interested in engaging in PrEP care. And I highlighted the Kaiser Permanente experience, which is a large organization with lots of primary care providers, but also lots of HIV specialists embedded throughout their organization who can be receptive to PrEP referrals, and who can enact PrEP care.

They also highlighted that STI clinics, such as municipal clinics in San Francisco and Miami-Dade may be poised to provide PrEP. But there may be STI clinics that don't have the infrastructure to provide the longitudinal care that is required of PrEP care.

So I want to put in a plug for primary care providers in generalist organizations as having an opportunity to be true leaders in scaling up PrEP on a national level. And we did some qualitative research interviews with generalist primary care providers at an academic medical

center in Boston to ask them about reasons they thought they could or could not provide PrEP care, or reasons they thought they should or should not.

And this highlights one theme that emerged from that study, which is that generalists may consider themselves as experts in preventive medicine in many areas of medicine, including sexual health care around contraception, or cardiovascular preventive disease, and in a number of other very important areas of preventive medicine. And I would say as the cheerleader of generalists, they're probably the best providers to provide preventive care in many regards.

And so this primary care provider has offered a quote that I think encapsulated some of the sentiment that they were feeling about this ownership over preventive care. And the quote is, "As a primary care provider, I hope that it's my job to do a range of things that are important for health maintenance and prevention. It's a conversation that I would be willing and happy to do. I would have to do it once or twice. I don't think I need a week long CME course about it. It's safe, effective, clear cut guidelines. It's sort of like Plan B."

So not every generalist is going to be interested in engaging in PrEP care to this degree, or feel exactly like this person did. But I think it highlights that for some generalists this is an opportunity to provide excellent preventive care to their patients. So to summarize my thoughts on some of the main domains for implementing primary care-- excuse me-- PrEP in a primary care or other health care organization.

There's a really great need to increase access to PrEP in primary care settings on a national level, to meet some of the need and access needs for people who may benefit from PrEP nationally, and the CDC will open to a million people who may benefit from PrEP is something that's still a long way off. PrEP provision has been shown to be feasible in real-world care settings. And there are multiple delivery models that exists from primary care to STI care and others.

And the is key is really to identify local needs, interests, and staffing resources. And then structure PrEP care teams accordingly. If outside resources are needed, either accessing local expert colleagues, which is an excellent way to find trusted colleagues in their communities who can support you with questions about implementing PrEP in your own care setting, or for nationally available resources. For example, UCSF has a Clinical Consultation Center, kind of a warm line. And the number is here. You can call them and ask them any aspects of PrEP clinical care.

And then finally again, put in a plug for the rich opportunity for primary care providers who are just superb clinicians in many areas of prevention and preventive medicine, to become leaders in PrEP care where appropriate. Thank you for your time. And I'll turn the talk over to Amir and Mike.

STEVE LUCKABAUGH: Did we want to take a couple questions here?

DOUGLAS KRAKOWER: Absolutely. That would be great.

STEVE LUCKABAUGH: OK. We did get a couple that came in. The first one is aside from HIV positive persons and obvious medical condition contraindications, for whom is PrEP not appropriate?

DOUGLAS KRAKOWER: It's a important question. So I might turn it a little bit on who is PrEP most appropriate for, kind of framing it as a way to think about what are the aspects of a patient's history that may suggest PrEP is a benefit. And the people for whom it may be a benefit is really anyone who has increased risk for HIV acquisition.

The CDC highlights some criteria in terms of men who have sex with men and transgender women in terms of populations that have high HIV prevalence and high HIV incidence in this country. So not everyone who belongs to those populations is someone who is engaging in risky behaviors that would mean that PrEP was beneficial.

But I think it suggests that at least having culturally competent discussions with every individual to figure out if it is right for a particular person at that point in their lives is really important. And it's incumbent upon providers and counselors to think about that. People who inject drugs are also an important population in this country in terms of new HIV infections. And then heterosexuals, including women who make up probably about somewhere between 10%, 15%, or 20% of new infections on a national level, and depending on the locale are also people who may benefit.

So questions including has the person engaged in non-condom sex with partners of other HIV positive status or HIV unknown status, multiple partnerships, people who are exchanging sex for money, drugs, or other goods or services, people who have had sexually transmitted infections in the past, and who may be at risk for acquiring bacterial sexually transmitted infections that may he predictive risk factors for HIV acquisition. For example, people who have had a rectal sexually transmitted infection such as gonorrhea or chlamydia, or who have had a syphilis diagnosis, we know from epidemiological data, are at increased risk for becoming infected with HIV.

So it sounds like a long list of criteria to think about. But I might encourage you to review the CDC guidelines. And the guidelines themselves are quite large, at over 100 pages. So that's not really realistic for every provider to sit down and read them cover to cover. But they have a couple of boxes, kind of like box one, box two, box three that go through in a snapshot bullet-point form some of the CDC recommended indications for PrEP. So that can be one approach.

There are other kind of summary approaches where clinical providers can look on the web, or through CDC's website in terms of snapshots about patient indications for PrEP. And I would encourage you to look at those.

In terms of people who wouldn't benefit from PrEP who have met criteria otherwise, I think thinking about some of the psychosocial challenges to adhering to PrEP are important, as the more people can adhere to PrEP, the more efficacious it will be. So if someone is having a lot of trouble adhering to care, and adhering to other medical plans that may be something to consider in terms of prescribing PrEP.

On the other hand, that can be overemphasized in that providers-- other studies are showing may not be perfectly able to predict who will and who will not adhere to a particular medication. So even if someone has a chaotic life with lots of psychosocial challenges to adhere, it doesn't mean that PrEP may not be right for them at this point in time. So the bottom line is for providers, ideally is to engage in a culturally competent and comprehensive psychosocial and sexual history. And then try and come up with an individualized idea of whether a particular patient may benefit from PrEP.

STEVE LUCKABAUGH: OK, thank you. And do you think PrEP Plan B at Trillium became more effective as word of PrEP got out into the community? And adding a PrEP specialist was a result of this, rather than the other way around? I.e, was the PrEP specialist put in place first, causing the increase? Or did the increase in interest in PrEP call for a PrEP specialist?

DOUGLAS KRAKOWER: I'm so glad that you asked that question. Because I don't know. And the data from Trillium come from a great presentation that they gave earlier this year at a National Association for Providers in AIDS Care conference. So we could explore that. But I will say there are definitely secular trends that are behind the scenes in some of these increases in PrEP use.

For example, at Kaiser and probably at Trillium where other surveys in urban centers, for example, among MSM populations, have found that PrEP awareness, familiarity, and use has increased in some urban centers over time. So there probably has been more requests for PrEP of providers, and therefore more need to address PrEP care by integrating PrEP specialists.

Again, I don't know for Trillium, a percentage. But what I will say is that I think regardless, the PrEP specialist, if that can be integrated into a care setting if resources allow, is going to be remarkable at either addressing demand or potentially motivating increasing demand because of the excellent care they can provide, particularly for populations in patients who may have lower health care literacy, and may have trouble navigating health care organizations.

STEVE LUCKABAUGH: Thanks. It's all we have for now. I guess we can move on.

DOUGLAS KRAKOWER: Thank you.

MIKE YEPES: Welcome everyone. So we're going to switch over to a discussion on what PrEP navigation currently looks like. What are the current trends, obstacles, and so forth. It's going to be led by myself, Mike Yepes, and my colleague, Amir. I'm going to have Amir start off, and we'll go from there to transition halfway through, and I'll take lead.

AMIR DIXON: Hello, everyone. I first want to say thank you to all for having us today. So my name is Amir Dixon. I'm with Multicultural AIDS Coalition. And like Mike said, we're going to talk through what PrEP navigation on the front line looks like, and the work that we're doing.

So the objectives are we want to identify and define what our target population is. And talk through what do the day-to-day health navigation operations look like, the current steps to assist in PrEP navigation, and some of the current obstacles in care negotiation and retention; and also future plans and potential action steps.

So our target population, in Massachusetts, currently we see approximately 600 to 700 new HIV infections annually. The communities most impacted are MSM and transgender women of color. According to the CDC, one in two black MSM, and one in four Latino MSM will become HIV positive if prevention efforts are not implemented.

So just running through the daily operation, so we do counseling and testing with clients, risk assessment, and risk reduction planning, serum testing for HIV, HCV and syphilis, and making appropriate referrals for clients. So thinking through housing, and health insurance, some mental health services and behavioral health services as well.

Delivering results, scheduling regular follow-ups. So what the current PrEP navigation looks like, the navigators assess current knowledge of PrEP and PEP during counseling. Answering any questions that folks may have, and sort of gauging where the knowledge is, giving them the knowledge that they need around PrEP and PEP. So they need to know how it works, where to obtain it, the benefits and side effects, costs, and the resources as well.

So for also for current PrEP navigation, addressing additional information barriers. So talking through stigma of PrEP, and teaching about how PrEP reacts to hormone therapy. We get a lot of those questions from trans clients. Concerns of PrEP leading to increased STI rate, access to bilingual staff to address language barriers.

Also if considering PrEP, provide clients with resources on data and information. And if wanting to start on PrEP, referring the client to a provider.

So also for PrEP navigation what we like to do is navigate also to our network of care, to those of community health centers that we work with, outside of either from where AIDS actions who are also part of the network of care, who have culturally competent, and regionally competent providers who are able to provide this service for them.

And also those providers will provide wrap-around services, so behavioral health, PrEP, mental health services, et cetera. So PrEP services, so what we like to also do is link clients on PrEP with other clients on PrEP who act and support one another in adhering to the med.

Building and having regular follow-ups, and check-ins with clients, building off that relationship. Creating a schedule for repeat testing as well. So some of the obstacles that have to be

navigated is limited long-term follow up, clients do not attend medical appointments, limited internal communication, and then limited staff and resources.

So here we're talking about and speaking about how do we build up capacity. So what does capacity look like? Dr. Krakower talked about a multidisciplinary theme, of hope that act as a team in being able to navigate the client through the appropriate services. So building on how providers talk back and forth with one another. Also who's the person that is going to be doing the follow-up with clients, and building out and maintaining that relationship?

Also looking at are the clinic hours appropriate for clients. So how can we create a system that works specifically for clients?

MIKE YEPES: All right. So Amir talked a little bit about what PrEP navigation as a process looks like, what are the concerns or obstacles from a provider or a navigator concept in the health care setting? Where we want to shift next is talking about what the obstacles are for clients.

Which oftentimes, intentional or not, is a dialogue that doesn't always can address to the maximum potential in a clinical setting. Some of the concerns of clients can include things like intergenerational trauma. We think of distrust of Western medicine, the Tuskagee Syphilis Study, sterilizations of indigenous populations. These are things that may have affected prior generations. But that fear, that anxiety, that trauma, that stress that's ignited by hearing of Western medicine, being in the presence of Western medicine is carried on generation to generation.

So even if someone didn't live through that narrative, they might have heard about it through their father, or grandmother, or aunt. And it's important to be culturally sensitive of that trauma.

One of the bigger obstacle clients face is the hierarchy of needs. Oftentimes as questioners or navigators we become very fixated on you need to take this medication. It's good for you. Take it. You'll feel better.

But what are the concerns that happen before that clinical appointment? What are the concerns after that clinical appointment? So in the case of hierarchy of needs, is how are they concerned? Is food scarcity an issue? Is there violence in the home? What else is more pressing? What is on the radar of immediate survival versus long-term care?

And then we also want to look at how those issues are exacerbating health disparity. Interestingly, Gilead recently shared some statistics that showed over 50% of HIV infections happen in communities of color. But over 50% of PrEP users are Cis white gay men. Why is that? Are communities of color engaging in activity that might exacerbate health disparity? The brief answer is yes. We're often engaging in survival work, sex work for immediate income. That might lead to concerns involving sexual violence, assault, and so forth.

And then these are important matters to be aware of. Are we engaging in high-risk behavior because we're looking for ways to find housing, and feeding our families, and so forth?

Additionally, just a generic lack of information of resources. Time and again, I'll here clients who come into my services and say, they only knew about it because of a friend or because a relative who had been shown [INAUDIBLE] before. We often find that there's not a lot of information online. When it does exist, it's not readily accessible. You might have to click on four tabs or five tabs to figure out how to get the number you need, or the directions you need, or the instructions you need.

There's scarcity of testing centers, or a poor awareness of where they're located. There isn't heavy discussions in community areas about sexual health products and how to maintain safety. And there's not a lot of awareness about medication options.

Oftentimes someone might not come in for PrEP initially. But when I first bring it up, they say what's that. And we go into a discussion about what its purpose is, how it's effective, what concerns to be worried about. So making sure that we're disseminating that information on a mass scale is very important.

And also STI transmission information, a lot of my clients I'll ask them do you know about sexual health during my STI and type of practice. And oftentimes they obtain information from other resources that may not be the most effective. So are we doing our job to disseminate that to the maximum potential? What are we putting online? What are we putting in local letters or brochures around hospital settings? What are we saying during the clinical appointments?

Additional obstacles, communication fatigue. I can't count the number of times that someone says, I've been tossed around from department to department to department, and I'm getting very frustrated. So I think we collectively need to make sure that we're trying to avoid that as much as possible. It can be very time consuming. It might sacrifice the slot that the person had available to come in for an appointment. They may get miscommunication or the wrong information.

So as I talk a little bit about hierarchy of needs, direct communication fatigue, traumas and the impact of intergenerational narratives. So how do we solve these things, or how do we bring solutions to the table. I think the big takeaway today is I want the implementation of tangible small steps to improve access to PrEP to [INAUDIBLE] the right capacity, increase staff size to amplify the number of patients that can be seen.

That can be done in a myriad of ways. It doesn't mean you have to hire staff. It could be you get interns to handle more of the day-to-day work. So the actual trained counselors have more time to counsel clients. It might be that if you have the funding, and you do actually hire additional personnel. But if you do engage in those steps, make sure that you're reflecting the communities you're aimed to serve. Get bilingual or trilingual staff members. Encourage people to learn new skills sets.

If someone doesn't speak English, and speaks Spanish instead, it is not appropriate to give them a provider who had took one semester of Spanish in college. We wouldn't do that to an English-speaking patient. Why do the contrary?

We want to make sure we create a databases to follow patients in the long term, whether that's in Excel, Microsoft Access, SPSS. You name the software. There is a capacity to form systems to track long-term care. Implement call back systems to follow up with no shows. That might be the intern's role. It might be a special staff member who handles communications in the long term.

But make sure someone is responsible and accountable for ensuring that when people do not arrive, we are calling. We are asking, what was the complexity. Why couldn't they make it? How can we remedy that in the future?

Additionally, create staff and team training and seminars. Oftentimes when we talk about the hierarchy of needs that is new information to many of our personnel. And oftentimes unintentionally we may [INAUDIBLE] to the patient's needs. So let's become more aware of cultural perceptions to Western medicine, more aware of housing circumstances, income levels, family sizes, which employment systems ensures [INAUDIBLE] income than others. Because that tool doesn't know why we're engaging in behaviors xyz.

If a single mother if engaging in sex work, because that ensures a lot of income to feed her family that information, to make sure that we're navigating that in an appropriate and culturally competent manner is appropriate. Because it allows us to know, OK, so maybe the questions we should be addressing first are the housing concerns, or the domestic violence concerns. What are the power dynamics to work with their partners? Is there enforcement of no condoms, or what's the situation?

When we address those more immediate needs, the patient becomes much more respective, much more accommodative, and more likely to share about how other interventions become more impactful in the long term.

And again, ensure on the facility level, ensure all staff have general knowledge of who to refer patients for specific services. And making sure that they have a really solid idea of what that means.

So for example, if you have a free clinic that offers care for five specific STIs, make sure your team knows what those are. Because if they hear STIs, and transfer the client over, and you say, oh we actually offer services for herpes or HPV or so forth. Now you've just aggravated and disgruntled a client because you didn't actually take the time to find out what their needs were, relayed them to the wrong department, and now they're getting upset and frustrated, and so forth.

So making sure we have a good synopsis of where our services lie, and in what capacity, and making sure that either we transfer accordingly. Or if we don't know what those services are, saying, can I put you on hold for a quick second? I'm just going to get that information for you to make sure that you have it. Because now you save the patient from the process of being tossed around department from department. And also you've now learned where those services are located, for a more streamlined process of future clients.

Additionally, we've talked a lot about end multidisciplinary teams. So creating pods or units that work in close proximity. That could be a nurse practitioner, or a primary care physician, or a specialist in conjunction with a case manager, a specific PrEP navigator, a social worker. Figure out what it is the team that is most impactful and effective in your local facility, and making sure that you're communicating amongst each other what status is your client.

And also organizing who is going to be speaking to who. The last thing a client wants is a bombardment of six phone calls, one from their physician about the prescription, one [INAUDIBLE] about housing, one from xyz. So first say, OK, what is our first and most important need? Who is going to speak on that need? Once that's addressed, who is the next person to speak to that client, and in what context? Organize the flow of communication into a more streamlined process for the facility, but also for the clients to ensure optimal and efficient care.

And again, accommodate community means-- Amir made a great point. We need to make sure that are the hours and services impactful to our community. To be frank, in communities of color which often are in a lower socioeconomic bracket, they might be engaging in jobs that don't have benefits. So they can't just leave on a Wednesday at 12:00 knowing that benefits are covering payments so they can go to their appointment.

It might be they're working at Burger King, or Home Depot, or so forth, and think, I can't miss this shift because I need to put food on the table. So do we offer evening clinic hours? Do we offer weekend clinic hours? Do we need to implement incentives to encourage staff to work those kind of hours? But we can't say we're doing our optimal job if we're only providing hours from 12:00 to 2:00 on a Wednesday, which are hours our clients can't come in.

And additionally, provide information that work with patient's needs. For example, don't just go with the generalist that [INAUDIBLE] who tells him to use more condoms, use more condoms, use more condoms. For some clients that maybe be effective. For others it may not. For both PrEP and condoms, may be the optimal solution.

Think of sexual health products as a toolbox. And think, what is the assortment that is most impactful for this client versus creating a one-dimensional approach. We want to encourage patient-centered care, and the special concerns, risks, interests of each client will vary significantly.

And additionally, make sure that we're looking at ways that we can provide assistance or care outside of the clinical setting. I talked again and again about the hierarchy of needs. So we need

to look at housing programs, EBT or WIC programs, childcare programs, increased communication with social workers or case management. And that can manifest itself in various ways.

If a facility is large enough and has the capacity, we can implement them internally. For example, Fenway has case management workers who can see a client after the medical appointment to address non-physiological needs, so to speak, in the acute setting. But if that's not feasible, maybe it means creating a strong relationship with the an outside agency that does provide those services.

Oftentimes when we find that maybe we don't provide a certain service, we have strong ties with the AIDS Action Committee, the Multicultural AIDS Coalition, and we communicate amongst each other to ensure that if the needs are met at one institution, they can be met elsewhere with our awareness and making sure that we're on top of that here.

And that goes for everything, not only [INAUDIBLE] housing, but also childcare programs. You're a single parent. And you can't go to your appointment because somebody needs to watch your kid. Is that daycare facilities, is there an internal department that can watch some other children at the hospital?

Look at the other concerns for the client. I cannot stress enough. The hierarchy of needs is a very real concern, and particularly important within disenfranchised communities. So we need to address it 24/7 at all times. Remember, the care happens during the appointment, but also before and after.

Cultural competency, cultural competency, cultural competency, I cannot stress is enough. That is an ongoing learning basis. It cannot be condensed to a one-day seminar. That is a good initial step. But I encourage that people who want to work in a clinical setting become exposed to the humanities and social sciences during their academic learning that they make the effort to go to the communities where most of their clients originate from. So you have an idea of what are the other circumstances impacting those individuals.

That you regularly ask your patients, what do you need. What are your interests? Don't just speak for what you think. But ask them, what is their major concern. Only when you know that you have actually provided critical and effective care.

Ask about additional factors like transportation assistance. Is it difficult to get to our facility? Is that why you have a lot of no shows? Can we use The Ride, the MBTA? How do we circumnavigate that? Increase resource availability. Like I said, if information is not there, disseminate it. If it is there, but not accessible, find out how to make it more transferable and accessible. Those are critical action steps.

So that really wraps up our presentation. Just to reiterate what we mentioned, you want to be cognizant of what are the concerns on the professional level. What are the limitations to the

navigator or the providers? What are the concerns or limitations for the client? What are tangible actions steps that can be implemented? It doesn't have to be an overhaul, unless you have the capacity for it. But it can be used to eventually get to that point.

But the key is making tangible steps. That is what I want everyone to take away today. Come back to your facilities, and ask yourself, what can I do to change the status quo and improve the care of our clients, particularly disenfranchised communities such as MSM of color, transgender of color, low-income communities, undocumented immigrant communities, and so forth. Thank you.

STEVE LUCKABAUGH: All right. Thank you. We have some time here to take some questions if anyone happens to have any questions. Please enter them into the Questions pane on the Go-to-Webinar toolbar, and we will address those now. I don't have any questions currently.

DOUGLAS KRAKOWER: If any of the participants feel like they might be willing to comment, I'd be curious to know if any of them have had experiences with implementing PrEP in their settings. And if so, could people throw out some of the major barriers that they have faced, so we can troubleshoot or crowdsource a solution together today?

STEVE LUCKABAUGH: OK. If anyone would like to speak, I can unmute your phone. Just use the Raise-your-Hand feature. And raise your hand, and I'll unmute you.

DOUGLAS KRAKOWER: Alternatively, if people haven't had experience trying to implement it yet, then I wonder if people are in the stage where they're considering this, but they have obstacles in mind for why they may not be able to initiate PrEP care at their sites. And we can also chat about that.

STEVE LUCKABAUGH: OK. We have one person, Cindy Cabales, I will unmute you. Go ahead.

CINDY CABALES: Hi. I work for Health Care for the Homeless in Maryland. And we-- I guess what I find the question challenging, have you implemented PrEP yet. When I talk to our organization, as PrEP as a program, there's a lot of resistance to kind of formalizing as a program, per se. Because there's so many competing priorities that are going on right now. There's a lot of administrative changes going on. And what I have found when I try to talk to providers about PrEP, the medical providers tend to say, yeah, I already know about that. I already have clients or patients who are on PrEP.

And then when I talk to the non-medical staff, there's interest in it. But it's really hard to get buy-in to prioritize education and training on it. And we were working through a huge PCMH transformation right now. I even tried to think about how can I make this part of one of the care team's specific training. And it's just really hard finding a way to make this a program, per se.

But I do find that medical providers are feeling pretty comfortable giving it to-- prescribing and managing clients who are on it. I just find it challenging because it seems to me that our biggest opportunity is to make sure non-medical providers know about it. So they can appropriately screen and refer people at risk to the medical providers, so they can get started on PrEP.

So I guess my challenge is how do you get organizational buy-in when there are so many competing priorities? And what are some good ways to really get buy-in from the non-medical providers to see this as value in dealing with a very high-risk complex population?

DOUGLAS KRAKOWER: Well, thank you for sharing your experience. And I think, as I was saying before, it's one size may not fit all. It sounds like it's a start to have clinical providers-- and a very good start, I will say-- to have clinical providers who feel like they have enough information, familiarity, and clinical skills to get this done in individual clients who they take care of.

And a transformation as large as the one you're describing to us, patient-centered medical home and all the other competing interests in health care in general is a huge wave or tsunami to try to overcome with this one voice in the crowd about how PrEP and sexual health care is important. And of course, it's just one voice in many.

So I don't have a single best solution. But I think trying to continually advocate for this as an important part of the comprehensive primary care is one approach. And it's not a silver bullet to get this front and center in an organization overnight. But I think that there-- there may not be the perception that sexual health care is part of a comprehensive primary care for people, and that people think more about cancer screenings, high blood pressure screenings, et cetera, which are all absolutely critical general primary care issues.

And part of this is engaging both the leadership, the clinicians and the non-clinical staff who work with the leadership and clinicians to see this as such. As to say, if we're not addressing comprehensive sexual health care, it's like we didn't take someone's blood pressure. I don't mean to over-emphasize it and dramatize it, and put it at odds with the other important [INAUDIBLE] in health care.

But to start to change people's perception about how PrEP is one form of sexual health care and HIV preventive care. But it's on a spectrum of different options, including condoms and HIV/STI testing and a whole host of different approaches to this. And this is just one option. But I think step one might be to change the perception of how if fits into what we should be delivering to really every primary care patient.

I don't know if Amir and Mike have other thoughts in their experience working with staff members to try and influence people's perception of the importance of this topic.

AMIR DIXON: I totally agree with Dr. Krakower about how making sure that we shift sort of narrative to making sure that PrEP is part of a comprehensive health screening. So, I think that's

a definite shift and approach I will take to ensuring that PrEP is a part of regular sexual health screening, counseling and testing, and are part of the conversation.

MIKE YEPES: And just to add on to that, it's extremely important that we change the language, so that this is not a sub-specialty of treatment, but part of the primary care. But as far as immediate action steps, I think questions to look at are, are surrounding organizations implementing something similar, and have they seen a drastic change in the care of their clients.

Because oftentimes providers and administrative personnel respond to data and evidence. So who is doing it already? What has the change been? Looking at your own internal staff and saying, who has concerns about this? Buy-in comes in to the masses too. So is this is a concern being raised by multiple staff, so some more willingness there to listen.

So it's a really organized front. So who inside your team or your organization has these same concerns? Are there any upper-level staff who carry more leverage or weight in these communications? Can they function as representatives for advocacy? And maybe even have a presentation where you [INAUDIBLE] the ideas, and then bring that data and evidence from adjacent units to kind emphasize the importance of this and the impactfulness of this. I think that's very critical. And I think oftentimes here in Boston we find that when we provide statistics about what's going on at Fenway, or AAC, or the multi-cultural AIDS Coalition, other organizations are more likely to follow suit.

STEVE LUCKABAUGH: All right. Thank you. We had a comment that came in. I've had clients say that their PCP didn't know about PrEP, and where to refer the client.

MIKE YEPES: I'm happy to take that front. I as an actual consumer of PrEP had the same predicament at a larger hospital here in the area. My provider was not too informed about PrEP. They didn't comfortable prescribing it. And I had to do the research myself, and be my own advocate. So in an effort to address that for other individuals who might have that capacity, I think part of it is seeing within your organizations, are there ways to encourage education on PrEP.

I found that at many hospitals doing a continuing education course is certainly impactful. Because there's only so many meetings and so many events that a provider can attend. Is there a direct benefit to me? And if they know they can get continuing education credits out of it, there's a larger willingness to come in and become informed about it. Additionally, if you do any presentations within your own institution encouraging internal providers who do specialize on PrEP to provide a baseline of education for other providers who may not have that sub focus.

As far as navigating the individual, I encourage that each institution kind of build their own internal database of other additional areas, like I mentioned earlier. For example, at my own clinic where I do HIV/STI testing. We also cover chlamydia, gonorrhea, syphilis and Hepatitis C.

When someone has a concern outside of that spectrum, I ask, what is the need? How urgent do you need it?

And I have a list of other institutions that may be more appropriate for that concern. And that it ensures the patients the needs. So that way A, we're creating incentives to educate our own internal staff. And while as on ongoing basis, we have backup resources in the intermittent period.

STEVE LUCKABAUGH: OK. Thank you. That's all the questions I have right now. Thank you again for participating in today's webinar. And thank you to our speakers for those excellent presentations. If you have any additional questions for the P4C project or for our speakers, please email us at P4CHIVTAC@mayatech.com. Take care, everybody. And we'll see you next time.