Webinar Transcript:
Innovative Models for PrEP Programs in Family Planning Sites

Katie Quimby:

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Hello everyone, and welcome to today's webinar, Innovative Models for PrEP Programs in Family Planning. This is Katie Quimby, from the Title X Family Planning National Training Center, and I'm very pleased that you're here joining us today.

A few quick things before we begin. Everyone on the webinar today is muted, given the large number of participants. We ask that you please use the chat box at the bottom left of your screen to ask questions at any time. We'll address questions at the end of the presentation. Following today's webinar, we will be posting a recording of the webinar, along with the slide deck and a transcript.

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Today, we will discuss the role of Title X Family Planning Clinics in assuring access to PrEP services in their communities. We'll look at various innovative models for implementation of PrEP services at three Title X-funded service sites, and our presenters will share their lessons learned regarding implementing PrEP services.

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We will hear from presenters representing three Title X funded organizations today, who will share their innovative approaches to implementing PrEP services and lessons learned. These organizations are One World Community Health Centers, the Louisiana Department of Health's Bureau of Family Health, and Planned Parenthood of Southeastern Pennsylvania.

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Finally, I'd like to introduce the moderator for today's webinar, Shannon Weber. Shannon is the director of HIVE Online, at the University of California, San Francisco. With that, I will turn it over to Shannon.

Shannon Weber:

Great. Thank you so much, and thank you all for being here. To get us started today, I'm just going to give a few bits of background information, and let's begin by grounding ourselves with what PrEP stands for.

PrEP stands for pre-exposure prophylaxis. PrEP was approved by the FDA in the form of a pill called Truvada, for daily use of HIV prevention, in 2012. PrEP is safe and highly effective, and PrEP works for all people, including youth, and people of all genders, gender identities, and sexual orientations.

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Forty percent of women access reproductive health care only, which makes family planning clinics a logical and an efficient location for offering PrEP to women. Family planning providers are uniquely skilled to offer options within a shared decision-making model, and women want to hear about PrEP from family planning providers. We've heard this over and over in focus groups since 2011.

Prevention of sexually-transmitted infections, including HIV, is a core part of providing quality family planning services. Title X sites have a key opportunity to address gaps in PrEP awareness and access among women by integrating PrEP services into existing HIV prevention services, which can include HIV and STD prevention education, testing and referral, risk reduction counseling, and behavioral interventions, such as condom use and promotion of post-exposure prophylaxis.

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Family planning visits are busy clinical encounters that address multiple health priorities in a limited time. We're well aware that integrating a new service into this environment can feel daunting, particularly when PrEP provision may require some navigation for clients who are underinsured or uninsured, and there is, in fact, more frequent lab testing and follow-up than other family planning services. Even screening for HIV vulnerability can seem like an overwhelming task, given that there are no validated questions that accurately assess a woman's HIV risk.

In addition to these structural challenges, providers and clinic staff require training on both medical provision of PrEP, while it's not overly complicated, it does require some familiarity, and on counseling on a variety of HIV prevention options. While many family planning providers agree that PrEP provision is within their scope of practice, they have indicated that they would like more training.

In recent years, leaders across the U.S. have collaborated to develop clinically sound and widely-available tools to increase PrEP provider knowledge and support implementation of PrEP by family planning clinics. This webinar series is an important part of the tools that have been developed.

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Implementing these innovative models for integrating PrEP services can help reduce some of these implementation challenges that we just identified. We can engage a range of providers, staff, and community partners, and increase access to PrEP for clients. We see health centers offering a range of service models for PrEP, such as weekly after-hours PrEP clinics, doing task-shifting and engaging nurses and community health workers to educate and screen for PrEP, developing relationships with pharmacists who can play an important role, and leveraging online or mobile PrEP delivery or provision options.

Today, we're going to hear from three health centers that are integrating PrEP use using various innovative models. Each of the speakers will share about their PrEP program, and the benefits of the model they're using, the challenges they've encountered, and key lessons learned. Our hope is that through hearing these implementation stories that you'll glean some ideas about how you can integrate PrEP in your setting.

First, we're going to hear from Jessica Downes at the OneWorld Community Health Centers in Omaha, Nebraska, about their pharmacy-based PrEP services. Then, we'll hear from Tammy Bennett about the telehealth services for PrEP at the Bureau of Family Health at the Louisiana Department of Health. Finally, we'll hear from Ama Dankwah at the Planned Parenthood Southeastern Pennsylvania about how their health centers are integrating PrEP and gender-affirming care.

As you listen to each of these presenters, I want you to think about where you're at at your health center, in terms of providing PrEP, and thinking about whether that's offering PrEP, using a referral service, or offering the full range of services on-site, and how these ideas from these innovative implementation models might work in your area.

I also want to make sure folks are aware that this is part of a webinar series. The recordings from the other series are available online. Just to review, we did a nice overview that outlines the background and history of how these various tools supporting family planning providers in offering PrEP have been developed. Then, there was some really specific information shared about how to prescribe PrEP in family planning sites, detailed information about financing and health insurance navigation services at family planning sites, and then today's webinar, which is covering the innovative models of PrEP provision.

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With that, I would like to turn it over to Jessica.

Jessica Downes:

Thank you so much. I'm happy to be here today. As Shannon mentioned, I work at OneWorld Community Health Center, and I'm a clinical pharmacist. Just to give you a quick background as far as OneWorld, we are a federally-qualified health center located in Omaha, Nebraska. We're a patient-centered medical home that offers a range of services, including adult and pediatric medicine, behavioral health, as well as women's health.

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We receive Title X funding through the Family Planning Council of Nebraska. You can see our Title X demographics from last year, with just over 8500 users in 2018, with a majority of those being female, white, and over half of them were 100% or below the federal poverty level.

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We've been offering PrEP at OneWorld for a little over two years now. We offer a full range of services, including counseling, risk-assessment, prescription and monitoring follow-up services, as well.

We really identified a need for this a couple of years ago, when we had some isolated patients come to us, and they would get scheduled with providers, interested in PrEP, and many of our providers weren't familiar with how to go about prescribing this. Often, we were finding that these patients would be referred out to the local Specialty Care Clinic through the University of Nebraska Medical Center, who's also located in Omaha, to provide these services.

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UNMC, the Specialty Care Clinic, is a clinic that offers HIV treatment, and also has a clinical pharmacist embedded in their clinic that was actually in charge of their PrEP services. As they started to see these patients be referred to them from our clinic, they actually became interested in wondering if they could study the role of pharmacists as central PrEP providers potentially in other clinic settings.

We became involved with that. We have myself and another colleague, the two clinical pharmacists at OneWorld Community Health Center. We do have a pharmacy on site, although as clinical pharmacists, we work outside of the pharmacy, and rather in the clinic alongside the providers, the physicians, nurse practitioners, and PAs.

By working with UNMC, we were able to attend some PrEP training from their clinical pharmacist and see how their model works. We really found that we were able to implement that quite seamlessly into our clinic model, as well.

By partnering with them, we were able to have access to their treatment algorithm that they had already established, and with that, we were able to develop a system where the family practice clinicians in our clinic could make an electronic referral to clinical pharmacists for patients who were interested in PrEP.

With that, we would arrange a face-to-face follow-up appointment for the patient with the clinical pharmacist to again conduct risk-assessment; order any potential initial labs that were needed; assess medication accessibility, which I'll talk a little bit more in a couple of minutes; and then schedule follow-up. Whether that follow-up was with the clinical pharmacist, or if they needed to see a provider for additional needs, we could arrange that follow-up that way.

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By offering PrEP, it's really allowed our patients to now access care at our health center without having to refer them outside of our network. I think by having clinical pharmacists as champions for this service, it really initially was intended to help reduce the burden on family practice providers at our clinic.

It gave us the algorithm that we needed to be able to be consistent with how we manage these patients. By having these algorithms in place, and having clinical pharmacists be the champions, it really allowed the family practice providers at our clinic become more comfortable with prescribing it. Oftentimes, we would see patients initially, and maybe refer them back to their provider for follow-up, if they needed additional things addressed outside of PrEP, so these clinicians became comfortable. We're seeing this more frequently prescribed, which really has led to an increase in the family practitioners at our clinic prescribing this initially.

I think before, when we weren't offering this, and we didn't have the treatment algorithms in place, our providers weren't necessarily screening patients, because they weren't as comfortable with what maybe who was appropriate for treatment, or even how they would go about prescribing this medication. But now that we have this process in place, I think that it has actually led to our providers being able to screen patients more appropriately, which has also increased access to PrEP for patients.

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Just to mention a few challenges and opportunities that we've seen over the last couple of years in rolling this out. Again, I've already mentioned that providers weren't necessarily comfortable with providing this. It's not, I think, as Shannon mentioned earlier, it's not difficult, but it's more just making sure that we know exactly what needs to be done, who is at risk, and who would benefit from this; and then what monitoring parameters need to be put in place. By partnering with the local Specialty Care Clinic through the university, we were able to feel more confident in our abilities to do this.

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The second challenge is, obviously, as a federally-qualified health center, many of our patients are uninsured, and so making sure that they had accessibility to the medication was important. I mentioned that our clinic has a pharmacy on site, at its main clinic location, and we're very familiar with the medication assistance programs that are available for a variety of medications.

This is a medication that also has the MAP program. However, that system is not always the speediest, and so sometimes it can take up to a month to get the medication. While starting PrEP is not necessarily urgent, it is timely with respect to when labs are ordered, and when patients need to have labs for follow-up. Initially, when we started this, it was taking patients a month, or maybe even longer, to get access to the medication, which just wasn't ideal.

Again, back to our partnership with the Specialty Care Clinic, we were able to have our MAP coordinator work with their social worker, who was also utilizing the MAP program, and we were able to take away some tips from their experience to make this a more seamless process. Now, I think we're able to get these medications for patients definitely within a week of when patients are seen. I think that that has increased not only patient satisfaction, but obviously just making the whole process a little bit smoother for patients and providers with respect to the labs and follow-ups.

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The third challenge is something that we are still in the process of trying to identify opportunities, and that is just, in general, fewer women are seeking PrEP at our health centers compared to men. I would say that our overall opportunity that we've identified for this is just trying to increase outreach in general and marketing for this.

A couple of things that we have done, on our clinic website, we've included PrEP as a service, along with other chronic disease-state managements, and that sort of thing, so that patients who are maybe not familiar with OneWorld, if they find us online, they can see that we are a PrEP provider. On our website, we have the phone numbers for the clinical pharmacists, so that they know how to go about scheduling that, which I think has been helpful.

Also, if you're not familiar with the PrEP locator, you can type this into Google, and it will pull up a search engine where, essentially, you can type in the ZIP Code that's nearest to you, and identify all of the providers or clinics within that ZIP Code that are offering PrEP. By getting OneWorld on this search engine, this has also, I think, helped patients identify OneWorld as a potential clinic.

I think something that we've found is that many of these patients have done their homework. They've talked with family, or friends, or partners, and they are really seeking a clinic who can help them with this. By making it very visible to the community, I think, has helped us in, again, increasing our outreach to all patients for PrEP.

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Just to recap a few lessons that we've learned. Again, this is just one example of a model where we have clinical pharmacists really as the champions for offering PrEP on-site, but really, that just helped us to streamline the process more, and also be able to be knowledgeable, so that we can provide education to our other clinicians. Which has, again, also trickled down in increasing their overall comfortability in prescribing this and monitoring this.

I think this really was successful because of our initial partnership with the University of Nebraska Medical Center and their Specialty Care Clinic. We were able to go to them for any initial questions that we had, and then if we had specific or unique cases that we needed to bounce around ideas on, they were a great resource for us.

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Please don't hesitate to reach out if there's anything that I can do to help answer questions. I appreciate the time for being able to share this with you all today.

Shannon Weber:

Jessica, this is really great. Before we transition to Tammy, I would like to just ask you a couple of follow-up questions. One, I want to just make a comment. I think it's important to note the beautiful point you

made about the value of the person doing navigation, and when there was high turnover, that you didn't have the same uptake of PrEP. We hear that anecdotally other places, as well. It's a really key, critical role, and something for us to think about is how do we recruit, train, and retain those frontline workers to do this really important work.

I'm loving this pharmacist model. The question I have for you is, you mentioned the screening tool and protocol. I'm wondering if that's something that you developed from scratch on your own? Did you guys look at other programs and adapt something from there? As part of that question about the screening tool and protocols, how did you make sure that this was inclusive of all genders, gender identities, and sexual orientations?

Jessica Downes:

That is something that I really want to make clear, that we did not develop these algorithms from scratch. That was something that I felt was really helpful in our partnership with the UNMC Specialty Care Clinic. They already had this treatment algorithm that they've been using. It really helped us not to have to reinvent the wheel.

It was something, again, that they had been using for quite some time. It helped that it was a clinical pharmacist who was also used to doing that. That just translated really well with the model that we had at OneWorld, but it had a set of questions that we could ask anyone, regardless of gender or sexual orientation, and really was all-inclusive as far as who we could screen for this. I think it, again, helped our clinicians to just be better prepared for screening patients, and gave them the toolkit that they needed to be successful with that.

Shannon Weber:

All right. Great. Fantastic. Do you guys have that online, or does the University of Nebraska have that protocol online, or is it being written up and shared in any way?

Jessica Downes:

That's an excellent question. I am not familiar with it being online, but I can certainly reach out to them and make sure that they are comfortable with me sharing that, and I'd be happy to do that.

Shannon Weber:

Yeah, that would be awesome. I didn't see that yet as a question, but I'm interested in checking it out myself. All right. Thank you so much.

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Now, we're going to transition to Tammy Bennett.

Tammy Bennett:

Hello, everyone. My name is Tammy Bennett. I'm the Reproductive Health Statewide Nurse Consultant for Louisiana. I'm here today to talk to you about our TelePrEP Services in Louisiana. But before we dig in to TelePrEP, I'd like to give you a brief overview of Title X in Louisiana.

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The Bureau of Family Health lies within the Louisiana Department of Health Office of Public Health. That houses our Reproductive Health Program. We provide services both for direct and sub-recipients, who provide those services to men and women for reproductive and sexual health.

We are the sole Title X grantee in Louisiana, and the Reproductive Health Program offers all components of the Quality Family Planning Visits, with the goal to reduce female and infant mortality, morbidity, and teen pregnancy. Another one of our specific goals is to provide individuals and families with information and a means to personally decide the number and spacing of their children.

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In review of our 2018 FPAR data, we saw a total of over 53,000 clients, with 51% of those clients being from the ages of 18-29. 75% were female, and 58% were Black/African-American. 67% of those clients were at 100% of the federal poverty level or below.

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For the TelePrEP Program, the Reproductive Health Program collaborated with other key stakeholders to bring TelePrEP into Louisiana. The collaboration included the STD/HIV Program, Reproductive Health, Bureau of Health Informatics, which is the bureau that assists with our data analysis, and also our electronic health record, and the state pharmacy, who would work directly with insurances and mailing medications to clients.

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There are several ways a client can find out about the TelePrEP Services of Louisiana, but one of those ways is the Reproductive Health Program's website, which is where it links to the STD/HIV Program's website called Louisiana Health Hub.

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This is a picture of the TelePrEP portion on Louisiana Health Hub. The STD/HIV Program goes into a little more detail on TelePrEP Services; what PrEP is; how to effectively maintain a negative HIV status; what telemedicine services involve; and also, it allows the client to self-enroll, or if they want to speak with a live person, then they can call directly to the navigator.

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We've tried to make access to TelePrEP as easy as possible by using a hands-on approach with the PrEP Navigator. When the client clicks "Self-Enroll or Call Navigator," the client fills out basic contact information so that the PrEP Navigator can then contact them within 24 hours. However, I can tell you that our PrEP Navigator is amazing, and he is usually calling the patient within 30 minutes.

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Part of the program's requirements include the client is 18 years of age or older; has a form of Medicaid or insurance; and has access to a computer, smartphone, tablet, some form so that they can have the telemedicine visits.

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We have found that the PrEP Navigator, just as said previously, to be an essential and vital part of our program, as they are the initial contact source for our clients. They give an overview of the program requirements. They verify insurance, identify any barriers to obtaining PrEP, and provide a one-handoff referral to a local PrEP provider, if for some reason the patient would rather have a brick-and-mortar clinic to obtain services instead of doing it the telemedicine way. Also, if they don't meet our eligibility requirements for any reason, then we also provide them a local provider, so that they can still obtain services.

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Labs can be done before or after the initial clinical visit. If the clinician has labs before the visit, then of course they can go ahead and review the labs with the client. Additional components of the visit include a full sexual history; assessing for any recent HIV exposure, which would indicate a need for PEP before PrEP; and assessing for any acute viral syndrome which may indicate new HIV acquisition.

We always review the medical history to make sure that there's no contraindications to PrEP; the review of systems; and a modified exam on telehealth indicators. I would like to just give a shout-out, also, to Maine's and New Mexico's Title X Programs for assisting with the exam requirements for telehealth.

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Our labs are ordered according to the client's insurance requirements, preference, and location. If their insurance requires them to use a certain lab, then we send the orders to that lab. Currently, we're using LabCorp, Quest, and Clinical Pathology Labs, or CPL for short.

The labs are ordered by the clinician, and the frequency for testing follows CDC's guidance on PrEP monitoring. You can see the link below, if you need those guidelines.

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After the initial visit, the clinician will e-prescribe Truvada to either our state pharmacy, or to a specialty pharmacy, depending on the insurance requirements. But if our state pharmacy is used, the pharmacist will directly mail monthly Truvada to an address of the patient's choice. It does not always have to be the address that they live at. It depends on where they would like to pick up that medication.

Critical to the program are follow-up calls made by the PrEP Navigator. The navigator develops a rapport with each patient, and can connect the client to an APRN rapidly if medical questions, or any issues or side effects arise.

After the state pharmacy mails the medication, the navigator will call the client about five to seven days later, just to ensure they received the medication, and they have started taking it. At 30 days, the navigator calls them to ensure compliance with daily medication; side effects; and reinforce risk-reduction education; then the clinician will follow up with them at six months and 12 months.

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Some of the main benefits of the TelePrEP is that it has increased access to PrEP services in rural areas of Louisiana, where there are no PrEP providers. It's also eliminated some travel issues that we have, where the client would usually have to travel into one of the bigger cities to have PrEP prescribed. Now it allows them to have a virtual visit on their lunch break, and they can still obtain the needed services. Due to the success of this virtual platform and compliance of visits, we have very limited no-show visits. Then we're looking also to expand telemedicine to other forms of Title X visits where a physical exam may not be required or needed.

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To increase the referrals of clients for TelePrEP, we have had referrals from all regions of our Parish Health Units. We have 64 Health Units in the state. We also have partnered with community business organizations, private providers, community partners, and of course the patients can also self-enroll after they see advertising on billboards, park benches, buses, social media, which includes Facebook and Instagram.

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Here are some of the public health awareness campaigns for PrEP. You can see this on Facebook, and then here is a picture also of one of our central office staff with the Black Women and PrEP logo.

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With TelePrEP, one of the main challenges is that Louisiana Medicaid does not reimburse for telemedicine services unless both the provider and the client are in a clinic setting. If the client is using their smartphone from work or home, Medicaid will not reimburse for that visit. Currently, we're working with Louisiana Medicaid to change this rule, and allow for the client to choose their location as long as the visit meets the current guidelines for documentation and confidentiality.

Another challenge with identifying the components of a TelePrEP visit is to include the documentation and what is involved in a physical exam. The last challenge involves many rural areas in Louisiana, and the high cost for the provision of those services, due to limited clients. Then you have to pay for the team to travel out to those rural locations. We're actually looking at this as a pilot, so that we can open up telemedicine to all reproductive health clients where a hands-on exam may not be required or needed.

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Lessons learned include to think outside the box and come up with creative methods for offering needed services that will meet our clients' needs. If Medicaid won't reimburse, let's find out why, and let's strive to change those regulations. We need to make sure that we have good, strong partnerships with other programs within our agency, so that we can collaborate to make these services available.

The last thing is to have in place policies and procedures, the job descriptions, along with the goals and expectations, before rolling out a program. That way, everybody is on the same page. The last thing is never give up. If something needs to happen, then keep going until it happens.

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I would like to thank you for allowing me to speak on behalf of Louisiana's TelePrEP Program. You can find all of our contact information below, including Gail Gibson, who is our Clinical Systems Team Lead, Tisha Reed, who is our Program Manager, and myself.

Shannon Weber:

Tammy, this is just so exciting. Really thrilling. I have a couple of questions for you before we go to the next presentation. What made you guys start both thinking about TelePrEP, so what was the impetus for that, and how did you go about thinking about it as a statewide model, rather than piloting in one location?

Tammy Bennett:

This was actually begun in the STD/HIV Program, whenever we were working together with them. Because there are limited providers who do PrEP. I think I'd have to go back to the initial presentation, where you hear about it, but many of those providers don't know how to do PrEP. They're scared of it. They haven't gotten the education. When we realized there were not a lot of providers doing this, and the fact that we have so many rural areas, we needed to figure out a way to increase the access to them.

Shannon Weber:

Fantastic. Can you tell me a little bit...

Gail Gibson:

This is Gail [Gibson]. If I could add, the other component of it is initially the STD/HIV Program had one provider who was able to see patients remotely, but I think teaming up with the Reproductive Health Program allowed access to more providers. That way we could really scale up and see more patients. It was a nice intro for us, as we were trying to examine ways to be able to use this technology for Title X visits, as well. Sorry. I just wanted to add that.

Shannon Weber:

No, super helpful. I'd love to hear a little bit more about how that initial visit works. I'm curious, how long is the initial visit, and the follow-up visit with the clinician? Then, how, in terms of the content with the provider, how integrated is that into the rest of the services I might already be receiving from you? Or does it completely stand alone in terms of the questions that the provider's asking?

Tammy Bennett:

Very good question. Our providers, in the initial visit, usually spend about 45-60 minutes with the client, just making sure that they go through everything. Even though the PrEP Navigator has talked to them about the program, has talked to them about compliance with labs, risk-reduction strategies and all of that, the clinician, as the provider, would like to go through that again, and just make sure that they understand completely what it will entail, being a part of the program. It takes about 45 minutes to an hour. Subsequent visits, if it's a phone call, it can be sometimes 15 minutes. Then the visit at six months and 12 months is about 30 minutes.

Shannon Weber:

Okay, great. Then, my final question before we transition is about the client management. I love hearing also how key the navigator is for your program. Are these visits tracked within its own medical health record, where you're only seeing your TelePrEP patients, and it's being tracked on the back end? And/or is it also part of the electronic medical record for the patient at their primary clinic?

Tammy Bennett:

Good question. All of the patients are patients within our Louisiana Department of Health Electronic Medical Record. What we did for these patients, since they're not under Title X just yet, is we've created a financial group specifically for telehealth. That way, that allows us to pull all of that data just on all of the telehealth visits to determine what we'll do referrals for. Have they ever been on PrEP before? All of these questions are built into our EHR so that when we do pull that data, we're able to get it.

Shannon Weber:

Okay. Super helpful. I see some other questions from the audience that have come in, as well. I'm going to group those together for discussion at the end, but we're going to transition right now to Ama.

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Ama Dankwah:

Hello, my name is Ama, and I'm a nurse practitioner who provides PrEP and gender-affirming hormone therapy for patients at Planned Parenthood Southeastern Pennsylvania, or PPSP. Today, I will be speaking to you on how PPSP integrated PrEP into its gender-affirming care services.

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Firstly, a little bit on PPSP. PPSP is an affiliate of the Planned Parenthood Federation of America, or PPFA, which serves, as its name suggests, patients in Pennsylvania's southeastern counties. However, of note, we do see our fair share of patients from neighboring states, such as New Jersey and Delaware.

PPSP provides services via its eight health centers, two of which currently provide gender-affirming care. As you can see below, PPSP sees a large number of patients through the Title X Program--over 10,000 uninsured patients in fiscal year 2019 alone. Of those 10,000 patients, over 8,000 were female. As you can see, the majority of our Title X users range from about age 18 to 34, and are fairly diverse in terms of race and ethnicity. 20% of our Title X users live at or below the federal poverty level.

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Let's talk about PrEP at PPSP. PPSP officially began offering PrEP services in July of 2018, initially piloting the service at one of our downtown Philadelphia locations. Our program is actually just now celebrating its one-year anniversary, having served 91 patients in fiscal year 2019. Our initiation of the program was heavily supported by Gilead, the makers of Truvada for PrEP, as well as the AIDS Activities Coordinating Office in Philadelphia, who both provided multiple in-services to center staff.

Prior to offering PrEP services at PPSP, patients had to be referred out to other health care centers or providers. Of course, all patients were offered HIV screening, and counseled on safer sex, but PrEP was not always explicitly discussed, unless patients were clearly high risk. I believe that this was a bit of a

disservice to our patients at the time, so I'm happy to now say that PrEP services at PPSP are offered on-site, and with no referral necessary. Patients may either walk in, or schedule appointments online or via phone, to receive PrEP services.

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Before discussing the integration of PrEP with gender-affirming care services, I would first like to provide a brief overview of the process of starting PrEP at PPSP. As you can see listed here, after arriving for their scheduled or walk-in appointment, the patient is first seen by a Center Assistant, or CA, who completes the initial intake.

Of special importance in this intake are the sexual history questions, which help determine the patient's HIV and STI risk, and the baseline labs, which, per PPFA guidelines, must be received and found to be within normal limits prior to the prescription of PrEP. Most lab results are received within four to seven days of being obtained. At this time, we do not offer same-day PrEP prescriptions.

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After the CA intake is completed, the patient is then seen by the clinician, who then determines the patient's medical eligibility for PrEP, and provides counseling on risks, benefits, side effects, importance of medication adherence, and continued safer sex practices. After counseling and medical evaluation, the patient is then discharged, with PrEP electronically prescribed to the patient's pharmacy of choice within seven days, as long as all relevant labs are normal.

Of note, per our guidelines, HIV labs for PrEP are only valid for seven days after the date of collection. If PrEP is not started at that time, unfortunately, labs must be repeated. After prescription, the patient then returns every three months for re-screening to continue PrEP.

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Here, you can see an example of the sexual history questionnaire used. The history is specific to body parts of the patient, body parts of the partners, and the types of sex engaged in, which helps allow for more accurate assessment of risk. Additionally, other questions, such as "Is it possible any of your partners in the last year had sex with someone else while they were in a relationship with you?" helps flag patients who may otherwise have been considered lower risk.

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Given that nearly all patients at PPSP are asked about sexual history, this flag is helpful in even targeting patients who did not initially present for PrEP services. This is especially applicable to our gender-affirming care patients, who may or may not have come in with PrEP on their radar. You can see, outlined here in red, the indicator light or flag that may indicate that someone should be on PrEP, or at least offered it.

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PPSP began offering gender-affirming services in summer of 2017. Like PrEP, the program is still relatively new. However, it has grown rapidly. As of fiscal year 2019, we saw a whopping 494 patients for initial gender-affirming visits at our two participating centers.

In integrating PrEP into gender-affirming care services at PPSP, we were flying by the seat of our pants. We didn't have a specific plan or road map, and integration wasn't exactly always purposeful. In some ways, it seemed to happen organically over time, through a bit of trial and error. Therefore, it is easiest to talk about the integration process as a timeline, as opposed to specific steps.

Firstly, prior to officially offering PrEP at PPSP, all patients, including those receiving gender-affirming care, were provided with standard HIV and STI risk-assessment and counseling. However, PrEP referrals were typically only provided as indicated by either patient interest, or by exceptionally high risk level, such as those with HIV-positive partners.

Once PrEP finally was available at PPSP, we quickly became comfortable with offering it, especially to those in statistically-known higher-risk groups. In the context of gender-affirming care, that may have meant transfeminine folks, transgender persons of color, and transgender sex workers.

However, that obviously neglects a sizable amount of potential at-risk individuals, especially those who don't fit neatly into those categories, such as folks who are transmasculine, or even folks who are white. Clearly, our risk assessment for our trans patients at the time was lacking.

Fortunately, in a lot of ways, this issue was actually rectified by continued staff education, as well as by a subsequent upgrade of our electronic medical records system. Prior to the upgrade, the EMR, which helps facilitate the majority of our visits, had very limited ways to truly assess the nuances of a patient's sexual behaviors.

For example, patients may have been asked if they had sex with men, women, or a very broad, non-specific transgender category. With the upgrade, patients were now being assessed on what specific body parts they had, what specific body parts their partners have, and what specific kinds of sex they were having.

This, of course, was in addition to standard questions, like the number of partners, and condom usage. But having this more accurate information on the who and the how of how our patients were having sex allowed for more accurate assessment of our patients' risk for HIV acquisition.

This helped fill gaps in our previous strategy. For instance, it is a well-known fact that anal sex is riskier than oral sex, in terms of HIV transmission. As such, a transman who engages exclusively in receptive anal sex with male partners may actually be at a higher risk for HIV than a transwoman who only practices oral sex with female partners. With our previous strategies, that transman may not have been offered PrEP. Thus, the EMR upgrade now prompts us to discover and target patients who are candidates for PrEP even more effectively.

It also allows us to more easily explain a patient's specific personal risk factors back to them, as well. Of course, especially with gender-affirming care, talking in terms of specifics helps eliminate any awkward confusion for both the patient and the provider.

Even more recently, another subsequent EMR update, as discussed in that previous slide, flags patients as PrEP candidates for additional risk factors. For example, if their partners are non-monogamous. This really helps to cast a wider net, and change our thinking more liberally on who should be offered PrEP.

I'm happy to say that now most patients at PPSP are offered PrEP if they engage in risky sexual behaviors, regardless of their gender identity or sexual orientation. It is my hope that being able to offer PrEP so universally may actually be helpful in reducing some of the unfortunate stigma surrounding PrEP in the LGBTQ community.

Now that patients receiving gender-affirming services are being adequately risk-assessed and offered PrEP, the next hurdle was how to actually integrate it into their care. Gender-affirming initial visits at PPSP are meaty visits, where patients can spend upwards of two hours meeting with a social worker, center assistant, and then a clinician. It is often too difficult to then incorporate PrEP counseling on top of this, not only due to time constraints, but so as to not overwhelm the patient with too much information.

As such, what is typically done is that the patient who does end up desiring PrEP, PrEP labs are drawn at the gender-affirming initial visit, along with any of the other labs associated with their gender-affirming care, with the plan for the patient to then return within that seven-day timeframe for PrEP counseling and prescription. With follow-up gender-affirming visits, which are much, much shorter, PrEP counseling can often be done the same day, with subsequent e-prescribing after receipt of labs, which eliminates the need for a return visit.

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Now that we've discussed the integration of PrEP into gender-affirming care services, let's discuss some of the challenges and opportunities we have faced in doing so. Naturally, in implementing any new program, educating and training staff is always going to be the first hurdle. PPSP was very, very fortunate in that our staff education process was supported in a multitude of ways, such as by Gilead and the AIDS Activities Coordinating Office in Philadelphia, who provided multiple trainings and education materials.

We were also supported by the explicit medical standards and guidelines put forth by PPFA, as well as numerous cheat sheets posted around the clinic with helpful reminders. We also did have regular clinician conference calls, as well as a pilot lead clinician to help ease initiation and troubleshoot any issues we ran into.

Our second, and possibly biggest challenge, has been time. As stated before, integrating PrEP with gender-affirming initial visits is nearly impossible, given time constraints. So far, having patients have labs drawn, and then return for counseling, has been our way around this. It seems to work, but without stats to verify, it's hard to know if we're losing patients who may not be as highly motivated to return for PrEP services.

The updated sexual history questionnaire is also helpful with regards to time. First off, it provides a structured and brief tool to accurately assess risk in a timely fashion. Secondly, if a patient is flagged, the Center Assistant can then begin the conversation surrounding PrEP, by providing PrEP education materials that the clinician can then more easily build upon. This is opposed to perhaps getting caught off guard at the end of an already long visit with new info that may indicate a patient is at risk for HIV.

The third challenge we face is interest. Some patients are really easy, in that they come in to gender-affirming care knowing that they would like to start PrEP. However, for those who are unsure about it, or maybe were even unaware of PrEP to begin with, cultivating interest can sometimes be a challenge.

Sometimes, that challenge is due to simple misunderstanding, such as, believe it or not, some patients believing Truvada will actually give them HIV. Other times, though, it can be due to stigma. For example, those that are aware of Truvada's use in HIV treatment, as well, may be wary of other people assuming they have HIV, since they would be taking HIV medication.

Breaking that stigma can be difficult, but being able to normalize PrEP, like, "Hey, PrEP is something we're offering nearly everyone, and we thought you might be a good candidate, too, based on some of your answers to the sexual history form," can be a bit helpful in destigmatization. In that way, patients know that they are being offered PrEP because of their specific sexual behaviors, and are not just being targeted because of their gender-identity.

Communicating ease of starting and continuing PrEP is also important for fostering interest. Like, "Did you know that there's a once-daily pill that can reduce your risk of getting HIV through sex? We can probably even get you started within the week." Being able to do that is another way we can and have cultivated interest.

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Through this entire process, the staff at PPSP has learned many valuable lessons. Firstly, that outside resources and supports are invaluable to a successful program. We've also learned that ease of initiation is definitely going to be crucial to success, and that stigma is unfortunately a real and potential barrier to uptake.

Of course, staff and patient education is always going to be key. That's always helped by technology advances, as well. As with everything, metrics will be necessary over time to really evaluate the impact and success of our program.

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I thank you all for your time, and I hope that through our experiences at PPSP, you may have learned something about how to integrate PrEP into your own gender-affirming care services. Above, I have provided my contact info for your reference, and please feel free to contact me with any questions. Enjoy the rest of the presentation.

Shannon Weber:

Ama, thank you so much. This is really beautiful. One of the questions I have for you, so it seems like one of the key changes that you guys made was this screening tool, that's self-administered by the patient. I'm curious if that was updated because of PrEP, or were you in the process of updating that anyway?

Ama Dankwah:

That's something that actually came about more with us initiating gender-affirming care, because it became clear that maybe our language wasn't as inclusive or accurate before, so with starting gender-affirming services, that changed a lot of the ways that we talked about things, and the language we used. Eventually, I feel like the screening tool was born out of that.

Shannon Weber:

Got it. Then, a question for you about staffing. Key for both other models has been the role of a navigator specifically. I'm curious, with your model, are there staff members, or someone playing a navigation role, that are key for holding this whole story together from both your clinic perspective, but as well as the patient experience perspective?

Ama Dankwah:

Yes. I briefly mentioned that we did have a pilot lead when we first started things, and she is the expert on PrEP at our center, so she's a really good point person to go to, so there is someone who keeps everything from falling apart during actual clinical care. As far as the patient experience, it's hard to say. We do get patient feedback through surveys, and things like that, but I don't really have an exact answer for you for that one.

Shannon Weber:

Okay, again, no worries. I'm going to jump over, and take about five, six minutes to look at some of the questions that we've received from the participants. We have a question from Alexandra, that is directed to Louisiana, about "What additional types of MCH services, and whether substance-use services are also being considered?" And Tammy has answered that in the chat, so I'm going to move to the next one.

Two, actually, from Renee. And these are for you, Tammy. "What are the exam requirements for TelePrEP? Anything besides the sexual history and labs? Then, in terms of charges, do you charge patients for the visits and labs, if it's not covered by Medicaid?" I had that specific question, as well. How are you covering those visits right now, that people are doing from home or work, while you're waiting to get the change made with Medicaid? Tammy?

Tammy Bennett:

Okay, so thank you for your question. The first thing I would like to say is right now, I would be happy to share a screenshot of the physical exam questions that we ask on our EHR when we're doing a telemedicine TelePrEP visit. It's actually more questions that you can answer via video than I thought. It's more than just one or two, but I'd be happy to share that with the group, if you'd like.

Shannon Weber:

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I think folks are going to like that, because also, then it can be packaged up. We can chat with folks afterwards, but it could be packaged up, if it was in your slides, and it would be sitting there with the recording, so even people who got access to this later would be able to see that.

Tammy Bennett:

Yes. I would be happy to do that.

The other thing is related to the charges. Currently, right now, we do not charge for the TelePrEP clinic visit. The labs are billed directly to the patient's insurance through LabCorp, Quest, or CPL. Our state pharmacy gets reimbursement whenever they fill the medication for Truvada. Right now, what is not met by the medication, state general fund is assisting with this until we can get Medicaid on-board.

Shannon Weber:

Your state general fund essentially has funded this as a pilot project while you sort out the pieces?

Tammy Bennett:

Correct.

Shannon Weber:

Got it. Okay. Let me review the other questions here. Kirsten asked a great question about wanting to add PrEP to your FQHC, but you're struggling to find education for providers. I know that several folks on this call have mentioned that they'll be adding in resources that can be available as part of the package that will be posted online.

But I think also you are going to want to go to the website, and search for PrEP, because there's been multiple webinars that have been done covering PrEP, including the Prescribing PrEP, that was the third in the series of this webinar series. You can also look at your local AIDS Education and Training Center, and there's also a Capacity Building Assistance Program that's funded by CDC that's free for community-

based organizations, providers, and health clinics, so that they can also be providing PrEP training. You can also look at contacting a Gilead representative to do trainings, as well. I hope that that's helpful.

Then, maybe, Tammy, just in case folks didn't see the answer to the question that Alexandra put up, you could briefly say what types of MCH services are you considering adding to the telehealth, and what you're doing with relation to substance-use services.

Tammy Bennett:

Absolutely. What we are looking at for Title X patients, again, we're not doing that just yet, but we're looking at a clinic-to-clinic model. Because we know that our reproductive health patients are most of the time going to need labs that may or may not be covered, and we would be able to slide those in a sliding-scale down, whereas LabCorp, Quest, they cannot do that.

So, a clinic-to-clinic model. Then for instance if a preventative health care visit for a patient, if they are asymptomatic, they don't have any problems, they don't need a current PAP smear, maybe they had that last year, and they just want a prescription for birth-control, then we can do that all through telemedicine. However, if they are symptomatic, if they need a Pap smear, if they want a LARC device, or procedure, then we would need to see them in the office, one-on-one with the provider.

Shannon Weber:

That was great.

Tammy Bennett:

I hope that answers your question. That's what we're thinking, going forward.

Shannon Weber:

Yes. Very exciting. All right. I am going to transition to the close-out, back to our moderator, to Katie, to finalize the end of this webinar. Thank you all for participating. It's been a really interesting discussion.

Katie Quimby:

Thanks so much.