Webinar Transcript:
Implementing PrEP Services in Family Planning Sites

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Hello everyone, and welcome to today's webinar, Ready to Offer PrEP? Implementing PrEP Services in Family Planning Sites. This is Katie Quimby from the Title X Family Planning National Training Center. I'm very pleased that you're here joining us today.

A few things before we begin. Everyone on the webinar today is muted, given the number of participants. Please use the chat on the bottom left of your screen to ask questions at any time, and we'll address all questions at the end of the presentation. The recording of today's webinar, along with the slide deck and a transcript, will be posted to fpntc.org within the next few days.

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The objectives of today's webinar are to discuss the role of Title X family planning clinics and ensuring access to PrEP services, to describe the key steps for rolling out PrEP services in family planning settings, and finally to identify resources for implementing PrEP services.

I'm thrilled to announce our speaker today. Erika Aaron is a certified registered adult nurse practitioner, who has worked in the field of HIV for over 25 years. The main emphasis of her work has been on reproductive health in women with HIV.

She's currently the PrEP clinical advisor for the Philadelphia Department of Health in the AIDS Activities Coordinating Office. In this capacity, she educates medical care providers on how to integrate PrEP in their clinical care practice.

She's also an assistant professor at Drexel University College of Medicine, and has served as the Director of Women's Services at the Division of HIV Medicine for 20 years.

With that, I'm going to turn it over to Erika to get started. Erika? Erika? We don't hear you quite yet. Erika, I think you may still be on mute.

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Okay. No, I'm not on mute. Can you hear me now?

We can hear you now.

Okay. I'm so sorry about that. I'm very excited to speak to you all today, those of you on the lines who have joined us are interested in PrEP and family planning settings. That's wonderful. We're really excited

to help provide you some support for getting started. Some of you have already started, so I'm going to address this to all of you.

We're going to talk about establishing protocols, and I'm going to do a brief review of prescribing PrEP. I know that was discussed at the last webinar. But just to review the key points of how we prescribe PrEP. And then how we prepare our clinicians and staff, how we identify key partners. Briefly something about thinking about monitoring and evaluations before you start your program. And then what resources are available to you on line.

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As you know, PrEP is pre-exposure prophylaxis. It's once-a-day pill. Right now, the brand name of the drug is Truvada, and there may be a newer one coming out soon called Descovy, but it hasn't been approved yet by the FDA. Truvada has been demonstrated to reduce the risk of HIV infection up to 92% when taken as directed, which is a very effective medication.

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The OPA has provided a PrEP decision guide, which is online. Actually, all the slides that you have, you can hyperlink to everything that I'll be referring to. This is a great guide you can look through. It gives you very detailed information about how to prescribe PrEP and how to integrate this into your practice.

There have been previous PrEP training webinar series that the OPA has given that's began in April. If you have not had the opportunity to participate in the past webinars, the recordings and the slides are available on the Family Planning National Training Center's website at FPNTC.org.

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When we establish clinical protocols, we need to think about first how we offer PrEP education and counseling, who will be offering this in your clinic. We need to know how to assess risk and how to do this in a non-stigmatizing way; which laboratory tests that we need to get, and to make sure that we confirm negative HIV test results; prescribing PrEP and the tools that providers need to prescribe PrEP; and then what kind of follow-up services we need for people who are on PrEP in our clinics, or if we're referring to a local provider in our area.

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In starting the conversation, it's important to discuss HIV vulnerability with every sexually active woman or man that comes to your clinic. To start integrating universal PrEP education in your clinic, you can start by just addressing this to persons who present for STD treatment, or STD testing, pregnancy testing, and HIV testing. Those would be a great place to start.

I've always said that if we just talk about PrEP to people who come in with STDs, we're going to be covering a lot of people in your clinic who are at risk of getting HIV. This can be done by medical providers, but you also can educate your staff to do the same.

If a person comes in for STD testing, a medical assistant or the lab staff can certainly say to the person, "Hey, you're at risk of getting HIV. Did you know that there's something called PrEP? If you're interested, we'll be happy to refer you to your provider." Or they could be trained to talk a little more detailed about PrEP. Many times that's where lots of education occurs, at the lab, in the lab itself.

We want to make sure that when we do train our staff to do education about PrEP that we focus on positive reasons why persons may want to take PrEP, other than sexual risk. Just because when we talk about sexual risk, it can be very stigmatizing and off-putting to the clients. Words like take control of your sexual health, by taking PrEP it's empowering you, you're taking care of your sexual health, you're taking care of your health.

Also, we know that sometimes taking PrEP increases people's sexual satisfaction and intimacy, because it decreases the stress that someone may be feeling or the worry that someone may be feeling about getting HIV. And to congratulate the person on even thinking about PrEP by staying safe and healthy. These are positive messages that are really important to portray to our clients.

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When we prescribe PrEP, first we want to assess if the patient's a candidate; can they adhere to daily medication regimen? For cisgender women, it's important to take PrEP medication daily. Can they do this? Are they willing to come to clinic every three to six months to get lab tests and to review the need for PrEP?

HIV tests must be negative before starting PrEP. That is a test that we recommend that you do at the time of that appointment where someone is going to be prescribed PrEP. If someone had a test a month ago, that's not good enough. You need to do it that day. You do not want to start someone on PrEP if they already are HIV positive.

The reason for that is that if someone is already HIV positive and they start Truvada, then they can become resistant to Truvada, because they need to be on a stronger medication than just Truvada. We don't want people to get resistant to Truvada if they have HIV, because Truvada is a very important medication in the regimens that are provided for people who are HIV positive. So make sure that test is negative before you even write the prescription.

We also want to do STD screening. This is when we start the initial visit. A creatinine clearance, because tenofovir, which is one of the components of Truvada, has been known to decrease the renal clearance in people who already have compromised renal function. We want to make sure that they have normal renal function, so the creatinine clearance should be above 60 milliliters per minute.

Then Hepatitis B screening: If a patient has chronic Hepatitis B, then tenofovir actually is the treatment, tenofovir or Truvada, which tenofovir is in Truvada, is the treatment for chronic Hepatitis B.

We want to know that before we start or soon after we start, so that if someone has chronic Hepatitis B, we can advise them to continue the Truvada even after they decide to stop the Truvada; that they don't need it anymore for sexual risk, but they still need it for treatment of their chronic Hepatitis B.

Of course, if they're negative without immunities, then we offer vaccinations. Also, testing for Hepatitis C and A is just good primary healthcare.

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If we know the person's negative or their tests are normal, we can write for Truvada, which is tenofovir 300 milligrams, plus emtricitabine, which is 200 milligrams.

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Then we monitor every three months. Every three months we do an HIV test. Of course, the fourth generation is the test that we're recommending, because that has the smallest window period, and it's the best test that we can do for HIV at this time. You can get the results within two days. We want to assess for signs and symptoms of acute HIV infection and talk to the person about their ability to adhere.

When we do STD testing, for people who are more at risk of getting STDs we recommend every three months, but if they're not at an immediate risk of STDs, every six months will suffice.

If someone is having sex in other orifices besides the vagina, then we recommend triple screening. We can do vaginal swabs, rectal swabs and oral swabs for gonorrhea and chlamydia.

If a person desires pregnancy, PrEP is fine to take while pregnancy is being attempted. If the person is not interested in pregnancy of course we talk to them about birth control.

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Then every six months, we do a creatinine clearance to make sure that the renal function is normal, and STD testing and HIV testing. Then we refill the prescription for 90 days.

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When someone decides to stop PrEP, we ask them to come in and talk to us about this so that we can make sure there's a good reason for stopping PrEP. We want to advise them if they ever decide to restart Truvada, that they come back in to get the initial tests again, especially an HIV test.

We don't want someone to stop Truvada if they're at risk of getting HIV, they seroconvert, they don't know that they're HIV positive, and then they have the Truvada in their medicine cabinet and they start taking it again. Then they're at risk of getting resistant to Truvada. We want to just make sure that people know it's important, come back to the clinic before you restart the medication.

If there's any chance that someone seroconverts, so say someone was not adherent, was not taking the medications for two weeks and then restarted, and then they came back for an HIV test and they were HIV positive, they need to have immediate escalations with three drug regimens.

This is information you can get online or by calling the PrEP Hotline, which I will be providing for you, an 800 number where they can talk to you about how to put someone on HIV medicine. Don't wait to get viral loads or resistance results. Start them on a three-drug regimen and refer them to an HIV provider, unless you're doing that in your own setting.

If someone has chronic Hepatitis B when they stop PrEP, it's important to monitor for liver flare. We need to check the LFTs within one month. Of course, we do recommend continuing the Truvada if they have chronic Hepatitis B and not stopping it.

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As I said, during pregnancy, there's no contraindications for PrEP, and breastfeeding there are no contraindications. No evidence of increased congenital anomalies during the first trimester or after. Infants that have been exposed to Truvada through breast milk have a limited drug exposure, and we have not seen side effects.

It's important, if someone becomes pregnant and are on Truvada, that you report this to the Antiretroviral Pregnancy Registry. This is the number: 800-258-4263 [Antiretroviral Pregnancy Registry]. You can also register the patient online. This is the only way we can track the effects of Truvada during pregnancy on the infant.

We certainly do this for women who are HIV positive, but for an HIV negative woman on Truvada while she's pregnant, it's very important so that we can track and make sure that HIV negative women on Truvada don't have any ill effects on the infant. At this point, we're quite secure that there are no ill effects. But this is the only way that we can continue to track this.

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That's a brief review of the guidelines. These guidelines can be found at these hyperlinks. The first one is the CDC guidelines that were updated in 2017. CDC. Preexposure prophylaxis for the prevention of HIV infection in the United States—2017 Update: a clinical practice guideline. https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf.

The second one is the American College of Health Association. I found that these guidelines were really helpful, that you can go here and develop protocols for yourself, for your clinic. You can have people read these who are thinking about starting to write a protocol for PrEP. ACHA Guidelines. https://www.acha.org/documents/resources/guidelines/ACHA_HIV_PrEP_Guidelines_Jan2019.pdf

Then the other is a specific protocol I found online from a place called the Edison Clinic, and it seems to have good protocols in there as well for you to institute. You may be able to institute that in your own site. Providing HIV Pre-Exposure Prophylaxis Protocol for Edison Clinic. https://www.smchealth.org/sites/main/files/file-attachments/prep_protocol_pending_approval_5-27-2015.pdf

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Here's a template, an EMR template from a Planned Parenthood in Philadelphia that I found was helpful. It does a sexual history at the beginning where you just click what type of sexual body part does this person have? Have they had intercourse yet? Do they have any new sexual partners since their last STD test? Is it possible that any of their partners in the last year had sex with someone else? Or, have they had more than one partner in the last 12 months?

These are questions that are really more specific for women who may not recognize that they are at risk of HIV, but it may be their partners who are at risk for HIV. I like these questions for women-centered programs. Don't forget to triple screen, and you can click that you did that or didn't do that.

Then for the initial PrEP visit, this is just some language that covers pretty much everything you would want to have in your note when you start a person on PrEP. You could just copy this into an EMR record and click that you provided this information. Then it just puts less strain on the provider to document in the EMR.

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These are protocols that I got from different sites. This one you could put up in your lab, or you could put it in the provider offices. This is every baseline three months, six months, what labs you need to draw for PrEP.

Sexual Health Assessment and adherence: Baseline, 3m, 6m, 9m, 12m, 15m, 18m, and 24m

HIV Ab/Ag test: Baseline, 3m, 6m, 9m, 12m, 15m, 18m, and 24m

Syphilis serology (Every 6 months if not at risk of STDs, every 3 months if high risk for STD): Baseline, 6m, 12m, and 18m

CT/NG testing (Every 6 months if not at risk of STDs, every 3 months if high risk for STD): Baseline, 6m, 12m, and 18m

Pregnancy test (Every visit if attempting pregnancy or if not using a birth control method): Baseline, 3m, 6m, 9m, 12m, 15m, 18m, and 24m

HBsAG, HBsAb, HBV vaccine status: Baseline only

HCV Ab: Baseline, 12m, and 24m

Serum Creatinine: Baseline, 6m, 12m, and 18m

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This is another protocol that you could use. I don't need to go over this with you. But it's the same protocol that I just discussed with you. It's just written in a way that might be easy for your staff to utilize.

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This is a nice pocket card that was developed by the Drexel College of Medicine in Philadelphia that they handed out to residents and medical students and providers in OBGYN clinics. It's just a quick review of what you need to do to prescribe PrEP, and if you have a PrEP navigator that you refer to or if you have a PrEP clinic that you refer to other than your clinic, you can put phone numbers in here. I'm happy to send a PDF to anyone who may want this for your own use.

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I just want to mention that there is something called PrEP on Demand. The New York City Health Department has recently put out on their website recommendations that this is actually discussed with all patients who are thinking about PrEP. It's not FDA approved at this point. It's not in the CDC guidelines yet. But it's been well researched.

There are three major research studies that have a large amount of patients in them. But only cisgender males are in these studies. This is not recommended for cisgender women. However, I know many of you have seen males.

So this may be something that they know about that they may raise to you. It may be something that you feel comfortable talking to them about. This would be for someone who's not comfortable taking, or not really able to take, a pill every day.

If you take two Truvadas before the HIV exposure or the possible HIV exposure, within two hours and ideally 24 hours before sex, you can also recommend this to your people who inject drugs who may be in your clinic who want to use PrEP prior to unsafe injection, if they're sharing needles. So two to four hours before the HIV exposure. Then one pill 24 hours after the exposure, and one pill 48 hours after the exposure.

This is called 211 dosing, and there is a website here that goes right to the New York City recommendations, and they also have references for the studies that I just referred to.

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How do we prepare clinicians and staff to write for PrEP? First of all, having leadership support is vital for a successful PrEP program.

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Identifying a PrEP champion in the clinic is very helpful. Usually there is one person, at least one person in the clinic who's passionate about this who can really lead this initiative. If you can identify that person ahead of time and engage them, that's very helpful.

Then you want to assess the staff capacity to provide counseling. Is there an HIV testing staff? Are you doing HIV testing comfortable in your clinic? If you have health educators, you can counsel patients about PrEP so that it takes away maybe from clinician time, or patient navigators. Are there financial counselors in your clinic? They should be educated about how to help people get free PrEP, for example, if they have no insurance.

Pharmacists can be very helpful. There are pharmacists that are sometimes co-located in clinics or have very close relationships with the clinic. Those pharmacists may be willing to do HIV testing, or counseling about PrEP, or providing PrEP if they have a protocol with your clinic. Collaborating with pharmacies can be very helpful, and can decrease the burden of the clinical staff.

Then of course staff training needs to be culturally appropriate. We need to destigmatize how we talk to people about their risk. We want to make sure that all non-clinical staff are trained in PrEP, with it being tailored to their individual job function. Billing staff, making sure your staff knows the billing code. The front desk staff, making sure the front desk staff knows how to triage PrEP or PEP calls. And then lab personnel, maybe there's a protocol so that the lab knows for all PrEP visits what they need to draw. That again will take away some clinical time.

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This is just another way of saying what I just said. This is on the OPA website,. Medical assistants or nursing assistants can do PrEP education and counseling. Do you have a PrEP navigator? Do you have health educators that can answer more detailed questions? And again, do you have a pharmacy that you can partner with to help you reduce the burden?

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There are some best practices that the Philadelphia Health Department has developed to help support front desk staff training. As you know, when a patient calls your clinic, they're going to get the front desk. They'll be the first introduction to your clinic. We want to make sure that your front desk or your call centers are very educated about PrEP and PEP, and what to do with PrEP and PEP calls.

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There are some flow charts that we've developed about how to handle calls that we want to make sure that they know what the difference is between PEP, which is that the person had a recent exposure to HIV within the past 72 hours, or are they calling for PrEP? That they haven't had an exposure, but they're interested in preventing exposures.

We want to make sure that for PEP, an appointment should be available within 24 to 72 hour window period, because as you know, PEP has to be given within 72 hours of the exposure.

If it's a PEP call, the front desk should know that they should get transferred to a live person, not a voicemail. Or if the call's going to be returned, we recommend that a call be returned within 90 minutes.

And if you do not offer PEP, that the front desk have a phone number for a local referral clinic, a local clinic that will offer PEP. This is very helpful to people who call, if you're not offering PEP, for your front desk to be able to refer them to a place that does.

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This is just another way of helping the front desk to route the calls and to get information about the patients. If it's a PrEP call, it doesn't have to be done within 72 hours. But a PrEP appointment should be given within a week of the call if you can accommodate that. That's a recommendation that we're making, if it's allowed at the health department, but it depends on your scheduling for PrEP in your office.

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This is a nice video that has been made by the assistant health commissioner of New York City. This is a great two-minute video to show to your providers. The video's message is that HIV prevention is not one size fits all. For some people, 100% condom use works, but for others, it does not.

A PrEP dialog becomes less about prevention and more about sexual pleasure and contentment within one's sexual life. The side effect of a content and anxiety-free sex life is that HIV is prevented better. It's a very positive message to give to patients, and it's also encouraging clinicians to talk about sexual pleasure and not just sexual risk. The hyperlink to this video is provided.

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There are training resources for clinicians and staff. OPA has the webinars that you can connect to that have been given in the past. Your AIDS Education and Training Center Program (AETC) has a series of short training videos on different topics related to PrEP. (https://aidsetc.org/resource/prep-training-videos)

The American Academy of HIV Medicine has CME credits for PrEP Webinars (https://aahivm.org/?s=PrEP). That might be an enticement for some of your providers in order to get trained in PrEP for which they can also get CME credits.

The Family Planning National Training Center website also has links to the previous PrEP webinars that have been offered by OPA.

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Another way that we have to prepare our clinics to offer PrEP is to make sure that financial resources are well known and well versed. Financial counseling and other client resources need to be very easily accessed to prevent barriers to care. Many times patients feel that if they have no insurance or if they can't pay their co-pays, they're not candidates for PrEP. We want to make sure that they know that they are in fact candidates for PrEP.

Some states, such as Washington, New York, and Illinois, have PrEP assistance programs that cover labs and clinical visits. Some also cover some of the cost of the medications.

Gilead, who is the pharmaceutical company that manufactures Truvada, has a very generous Advancing Access Program (https://www.gileadadvancingaccess.com/), which provides free medication for those without insurance, and co-pays up to $7200 a year for those with insurance and have co-pays. It's not that difficult to fill out these forms. They will send monthly bottles of Truvada to either your site or to a patient's residence.

The National Alliance of State & Territorial AIDS Directors (NASTAD) (https://www.nastad.org/resource/billing-coding-guide-hiv-prevention) has a website that also shows billing codes. It's a guide that's very detailed about how you can bill for your services.

Then additionally, there's something called 340B Drug Pricing Program, which you may be familiar with, because Title X programs are eligible to be a 340B drug program. This may assist you with discounted medicine and related medical supplies.

There are certain qualifying safety net providers, including FQHCs, specialized clinics such as STD clinics, and Title X-funded family planning clinics, that are all eligible to participate and receive discounts on outpatient medications.

You can get quite a good amount of reimbursement from prescribing Truvada. This gives your program the ability to supplement costs that may not be covered by insurance that you need to ensure that you have to a robust PrEP program.

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These are some of the ICD-10 codes for PrEP services. Again, you can get that on the NASTAD website.

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Identifying key partners is important, especially if you have decided that you are not going to prescribe PrEP.

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Maybe you're a clinic that wants to screen people, counsel people about PrEP. Maybe you're even willing to do the initial labs, but then you want to refer to a primary care clinic that the patient goes to, or a local or state health department that's offering PrEP, if you don't feel like your site is able to actually prescribe PrEP.

We recommend that your sites do prescribe PrEP. It's not that much of a burden, and you can get reimbursements that can help support your programs. But there are other partners that you can partner with, and they're listed here. I'm sure these are places that you all have relationships with in your settings.

There's also PrEPLocator.org or PleasePrEPMe.org--these both go to the same site--where you can find a PrEP provider. If you have a patient that comes from a distance and does not want to come to you for PrEP but you want to find a provider in their ZIP Code, you put their ZIP Code in and this is a national search that will come up with PrEP providers in their area. This site actually makes sure that these PrEP providers offer very state-of-the-art care for PrEP.

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Some of the key things you can do with your key partners, so for example with your local AIDS Education and Training Centers, you can partner with them to offer trainings to clinicians and staff.

You can also help educate community members about PrEP, because people in the community don't know about PrEP. By educating your community, you will increase your ability to attract people to come to your clinic for PrEP. You can host community outreach events.

The more people in your community who know about PrEP, the safer your community is, the more protected your community will be from getting HIV. It's the only way that we can really end the epidemic, by making sure the people in the community are educated and know what PrEP is.

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This again is another screenshot of the PleasePrEPMe.org or the PrEPLocator.org website.

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If you're going to be starting to do more HIV testing, you'll probably start identifying more persons who are HIV positive. If your clinic can handle treating people with HIV, that's great. Of course, the recommendation is to start ART immediately. Don't wait for an appointment. Have a protocol that you can start ART as soon as someone is diagnosed with HIV.

The reason why we recommend that is there's been a lot of research that has shown that if you start ART immediately in the clinic when someone is diagnosed, they have more hope and more ability to feel

empowered that there's something that they can do about this HIV. We see more success and linkage to care and retention in care.

By starting HIV meds immediately, we see less immunologic dysfunction. There's more of a chance to decrease transmission, and also to engage people in care, to decrease the disparities in care by engaging people in care as soon as their HIV positivity is diagnosed.

It's important for you, if you're not going to provide HIV care in your clinic, to have a clinic in your area that you can refer a patient to. The FindHIVcare.hrsa.gov is a resource that shows all the Ryan White-funded clinics in the United States, to assure that you know one that's near you so you can refer someone immediately to get antiretroviral therapy as soon as they're diagnosed in your clinic is critical.

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Monitoring and Evaluation

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In terms of monitoring and evaluation, this slide is to encourage you to start with thinking about what kind of performance measures you want to measure in your clinic to assess the success of your PrEP clinic.

You can start tracking information about the percentage of clients who receive PrEP counseling and education services; the percentage of clients that are screened for PrEP services, and who are at significant risk for HIV who began medication; percentage of PrEP clients who attended follow-up visits at 3, 6, 9 or 12 months; the percentage who report proper adherence to medication; the number of PrEP clients who may seroconvert; and the percentage of PrEP clients who choose to discontinue medication and the reasons why.

This might be a nice checklist for you to establish before you start your PrEP program, so you can evaluate it.

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Resources

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For the rest of this talk, I wanted to show you some online resources. The CDC guidelines are very helpful, and they also have very good resources on PrEP. CDC HIV Prevention > PrEP (https://www.cdc.gov/hiv/basics/prep.html)

Here's a CDC PrEP video that you can go to and use in your waiting room if you so desire. Video PrEP 101 (https://youtu.be/TR8-3uAuZGo)

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This is a telephone consultation line (1-855-448-7737). It's a clinical consultation service. It's at San Francisco General Hospital at the University of San Francisco. It's open 9:00 AM to 8:00 PM Eastern time, Monday through Friday. The people who answer this line are very smart and know a lot about PrEP. They've helped me a lot with difficult situations. Any time you feel anything uncomfortable as a clinician, this is a great line to call. This is not a patient line; this is for clinicians specifically. PrEP: Pre-Exposure Prophylaxis - Clinically supported advice on PrEP for healthcare providers (http://nccc.ucsf.edu/clinician-consultation/prep-pre-exposure-prophylaxis)

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Here's a site that is more women centered. CDC HIV Risk Reduction Tool (https://www.cdc.gov/hivrisk). That's why I picked this one out. They can assess their risk of being exposed to HIV, and their risk that would lead them to want to start PrEP.

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This site is called PrEPWatch. PrEP Implementation Tools (https://www.prepwatch.org/users-guide-prep-tools-use). It's an AVAC site. AVAC is a wonderful HIV research organization. This gives lots of tools. It's a worldwide site, so it's not just for the United States. But the tools I found on this site are very helpful. There are toolkits that you can use if you want something in addition to what I already showed you at the beginning of this presentation.

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This is called HIVEOnline.org. HIVE Clinical and Training Resources (https://hiveonline.org/old-prep4women). It's a wonderful organization that has lots of resources for women specifically who are HIV positive or who are at risk of getting HIV. This is a good site for you to look at, and also to give to your patients so that they can look at this on their own time.

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There are lots of videos available online, and these are just some that I've enjoyed.

- PrEP: HIV Prevention That Promotes Care – Bridging The Gap (http://immersive.thebodypro.com/LBLN/hiv-prep/?ap=tbptd)
- Powered by PrEP: Keith - Virginia Greater Than AIDS (https://youtu.be/gnvAuNlLMEo)
- Gender Affirming Hormone Therapy (https://www.plannedparenthood.org/planned-parenthood-massachusetts/campaigns/gender-affirming-hormone-therapy)
- PrEP: I Choose Protection, I Choose Control, I Choose My Future. No Apologies. (https://youtu.be/hYJhMm57oHk)

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This video, of a series of five, all based from South Africa, can apply to all of our patient populations. It's called HIV Free Begins With Me.

The message, do not stigmatize me, do not discriminate against me, I am positive, I am powerful. I am HIV free. I choose protection and control for my future. It's a really fun video with young women talking about how they want to protect themselves and their community. I recommend you look at this, as it might be appropriate for some of your waiting rooms.

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These are videos that are on GreaterThanAIDS.org. All of them are empowered messages for women. Videos on HIV Awareness (https://www.greaterthan.org/stories-empowered-women-and-hiv).

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These are also educational videos that you can get. These all have hyperlinks to them.

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One of them is "PrEP." It's a lovely, very short PrEP message for women about the importance of being empowered and doing something for your health. There are many online resources that you can integrate into your site.

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I appreciate your time. We have plenty of time for questions now.

Thank you so much, Erika. We do have some time for questions. For those of you who haven't already typed in your questions, you can do that now. You can navigate to the bottom left of the screen and type in your question. We will take questions via chat.

We have received a few questions to start. The first couple relate to staffing and staff rules. First, you did talk a little bit about the role of front desk staff and frontline staff. I was wondering if you could talk a little bit more about what you see the role of those staff, and specifically this question about what training do you recommend for them?

That's a great question. I think the front desk, as I said previously, is critical for a successful PrEP program. If someone can't get through the front desk to a provider or to an appointment quickly, they may lose their desire to pursue PrEP.

I think we should really provide everything we can to congratulate someone for even thinking about going on PrEP, thinking about protecting themselves and doing something about their health. It really begins with the front desk staff.

Making sure that they know what to say, they can role play together, and you can listen to them if you're supervising them to make sure that during the role play, they're providing positive messages.

But mostly, very important is to make sure if someone calls about PEP, they go directly to a person who can talk to them and assess their need for PEP, and that they get an appointment within a day.

If someone wants PrEP, it's not as urgent. They don't have to talk to someone that day. But it would be very helpful for that person if they could get an appointment within a week so that they don't lose interest in starting PrEP.

I think spending time with your front desk staff will really lead to a much more robust PrEP program. Thank you for that question.

Thank you. Another question around staffing. You mentioned at one point around the importance of leadership support and leadership buy-in for starting to offer PrEP. Can you talk a little bit about the role of a PrEP champion? This is a term that's used quite a bit, a champion. I wonder if you could talk about who could be that champion, and how could a champion be used to support PrEP implementation?

Sure. Usually, there's someone in your staff that's very passionate about this. It really takes someone who has passion and belief that PrEP is important for your population. Even if patients aren't taking PrEP, just that patients are learning about it.

They can also help spread the word about PrEP into their community. If they're not interested in PrEP, maybe their sister is, or their brother, or their friend. There's always someone in the clinic I have found that has a passion for it.

You can sometimes use your 340B funding to maybe supplement that person's salary so that they have some dedicated time to get educated on PrEP, and to maybe educate the staff on PrEP. So you can use that person to do education within your own staff.

You can use that person to look at the monitoring and evaluation tool that I had suggested. There's lots more on the web that you can find. OPA website has tools that you can use. They can maybe champion one of those monitoring and evaluation tools.

That person can make sure that the messages at the front desk or that the lab staff are giving are messages that you approve of and that you're comfortable with. It's not too stigmatizing.

They can kind of monitor the progress of your PrEP program so that it's a real state-of-the-art program. Having one person, giving them some dedicated time to really ensure that you have a robust program, would be highly recommended.

Great. The next question that's come in is about PEP. You've mentioned PEP a couple of times, and began to talk about some of the considerations around offering PEP. But I wonder if you could talk a little bit more about that, and any specific considerations about incorporating PEP into PrEP services?

Sure. PEP, as you start doing HIV testing more, and as you start talking about PrEP, you will start getting more questions about PEP. You really need to be prepared to answer those questions.

Also, to prescribe PEP, prescribing PEP is not hard. We as clinicians do many things that are harder than prescribing PEP. It is something that you can do, and that you don't have to have 24 hour coverage to do this.

You can bring someone back into your clinic who calls about an exposure, as long as they're brought into the clinic within 72 hours, and start using the medications within 72 hours of the exposure. You can make sure you have a couple slots maybe available for that, or use your walk-in slots for someone who has had an HIV exposure.

Truvada is one of the medications that is used in a PEP regimen. We use Truvada, and then we use an integrase inhibitor. It's very easy to get information on this. It's on all kinds of websites. But the CDC has information on post-exposure prophylaxis. Or the phone number that I gave you for the consultation service can help you with that.

The integrase inhibitor that we usually recommend is dolutegravir. One pill once a day has very few side effects. All the side effects we used to see with PEP, which was a lot of nausea and fatigue, diarrhea, we don't see that as much with the new integrase inhibitors that are used for PEP.

It's recommended to give for 28 days. You give an HIV test beforehand to make sure they're negative. If they're positive, it's a regimen that you'd want to start them on. So you would start them on that if they are positive.

But if they had a recent exposure, they wouldn't be positive from that exposure, that wouldn't show up on a test that you did that day that they walked in. They're starting off negative. It's very effective if taken every day. You may want to have some follow-up calls to make sure they're okay, that they're taking it without a problem. Then bring them back in a month and do another HIV test.

If they're negative still, and they're still at risk of being exposed to HIV, then you would want to transfer them right to Truvada. You would take away the integrase inhibitor medication, dolutegravir, and just continue the Truvada. You very seamlessly can go from a PEP regimen to a PrEP regimen.

Again, feel free to call that consultation line if this comes up. They're more than happy to help you with this.

Great. We have one more question. So final call out to our audience, if you do have any more questions, please chat them in now. We'll address this last question. This is a question around clarifying guidance. Can you clarify, if a patient comes in and you're not sure if they've had exposure in the past two weeks, what should you do? Should you start PrEP?

That's an excellent question, and that comes up quite a bit. It's very important to get a good sexual history. All of you know how to do that well, since you're in family planning clinics. But to do a good sexual history to find out if there was any exposure to HIV within the last month.

If there has been exposure, then doing an HIV test that day that they walk in, talking to them about PrEP and the importance of starting PrEP. But telling them to come back in two weeks, have another HIV test, as long as that's negative then you can start PrEP.

And discussing with them the importance of actually having no sex within those two weeks, or using condoms at 100% of the time, so that there's no possible exposure to HIV during those two weeks between the tests.

That would be for someone that you're worried that maybe they had an exposure, and maybe possibly they're HIV positive and don't know it. That test that you do that day, there is a window period for the fourth generation test, it can be as long as 8 to 14 days, the window period. Bring them back in two weeks to make sure that that test is negative. As long as it's negative, then you're good to go.

The other thing you want to assess for is any signs or symptoms of seroconversion, which would be severe viral symptoms. If someone has been complaining to you that they have viral symptoms, upper respiratory or GI, that's pretty severe. That would be the sign of seroconversion. That would be the sign that someone was exposed and actually seroconverting.

If you're assessing for that and you're worried that they may be seroconverting, once again, do the HIV test at that time that you talk to them about PrEP. Then two weeks later do another test.

You can also, some people will draw a viral load. A viral load is a test that's expensive, but it is covered by insurances. If you are worried that they were actually seroconverted, they had signs or symptoms of seroconversion, they had an exposure several weeks ago, so more than within that 72 hour time period that you can start PEP, you can actually do a viral load.

You can find out if they have a high viral load, if the test comes back high, viral load for HIV, then that means that they are in the process of seroconverting. If you have the capacity to do that and you want to know right away, you're afraid this patient may not come back, or you have grave concerns, you can draw that blood test.

Again, you can call the hotline that I gave you in San Francisco and they can help guide you through that process.

Excellent. Thank you so much, Erika. That concludes the questions that we've received. Thank you all for joining us today. As a reminder, we will have a recording of today's session available within the next few days.

If you have any additional questions for us or the speaker about this topic, please don't hesitate to email us or chat us in now, our email is fpntc@jsi.com.

Our final ask is that you please complete the evaluation today. The evaluation will pop up when you exit the session. Please note you have to first log in to fpntc.org in order for you to receive a certificate of completion. We do really love getting your feedback, and we always review your feedback and use it to inform future sessions. Please take a minute and share your feedback with us today.

Again, thank you all for joining us. Hope you have a great day. That concludes today's webinar.