

Gay Men's Sexual Health Think Tank Meeting

December 16 – 17, 2013

San Francisco, CA



Purpose

In order to determine the best recommendations for how to improve provider-client communications around HIV prevention strategies (especially within the context of PrEP), San Francisco AIDS Foundation, with financial support from Gilead Sciences, brought together more than 20 thought leaders and experts from around the country on December 16 and 17, 2013, to convene a gay men's sexual health think tank. Attendees included primary care doctors, infectious disease specialists, community service providers, public health officials, government representatives, researchers, and HIV prevention research advocates. This report provides an overview and highlights of the discussion, along with the group's recommendations for how to use PrEP as an opportunity to better address gay men's sexual health for provider-client communications.

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Background

Research reveals that there are substantial gaps in cultural competency in serving the health needs of gay and bisexual men when it comes to provider-client communication.

The existing literature suggests most providers are not proactive in initiating sexual health conversations, or do so in ways impaired by assumption and judgment that miss crucial opportunities relevant to comprehensive health care for gay and bisexual men. Major themes include provider assumption of client heterosexuality and client sexual orientation/identity as indicative of sexual behavior. These assumptions are conveyed through the provider's non-gender-neutral language, closed-ended questions, and verbal and nonverbal cues in the office environment. Also, many providers are either unaware of or choose not to implement the Centers for Disease Control and Prevention's (CDC) updated sexually transmitted infection (STI) testing guidelines, which further compromises appropriate sexual health care for gay and bisexual men.

By improving the quality of provider-patient communications, we will be able to improve health outcomes and prevent new HIV infections among gay and bisexual men. Many researchers in the field have cited the "sexual *health*" framework as critical in addressing gay men's sexual risk-taking and HIV prevention. This holistic and sexuality-affirming approach breaks the mold of "safe sex" and "condoms-only" messaging that has dominated HIV prevention efforts for the past thirty years. It also moves beyond sexual health definitions used by other public health agencies and normative bodies, like the World Health Organization and CDC, whose definitions mention sexual pleasure and well-being but also suggest political and moral subtexts that are less than affirming. The framework we propose goes beyond the presence and absence of STIs and incorporates the physical, emotional, mental, and social well-being of the patient, as well as recognition that sexual experiences should be pleasurable.

There are limited available resources outlining best practices for communication between providers and gay and bisexual men specific to HIV prevention strategies within this type of sexual health framework. The recent U.S. Food and Drug Administration's (FDA) approval of Truvada for pre-exposure prophylaxis (PrEP) presents us with the opportunity to redress this gap. Currently, there is little consensus or apparent progress with engaging providers on how to appropriately implement this newest HIV prevention strategy. Provider knowledge and readiness varies greatly, and the current models of care are not well suited for PrEP delivery.

By focusing on PrEP as an opportunity to advance the discussion around gay men's sexual health, we will be able to increase instances in which culturally competent conversations about Truvada for PrEP are initiated between providers and gay and bisexual men in community health settings.

Day One: Opening Remarks and Presentations

The gay men's sexual health think tank commenced with welcoming remarks by Neil Giuliano, San Francisco AIDS Foundation's chief executive officer. After group introductions, Megan Canon from San Francisco AIDS Foundation presented the meeting's background, goal, and objectives, with foundation consultant Dr. Judith D. Auerbach serving as facilitator.

The goal of the meeting was to identify how best to increase instances in which appropriate conversations about Truvada for PrEP are initiated between providers and gay and bisexual men in community health settings.

The objectives were to discuss how we can use the emergence of PrEP to advance the discourse around gay men's sexual health, comprehensive HIV prevention, and advances in biomedical technologies; to define the ideal conversation about PrEP between providers and clients; and to identify the most effective strategy and output(s) for improving the quality and effectiveness of conversations between providers and clients around PrEP, gay men's sexual health, and comprehensive HIV prevention.

Dr. Auerbach presented four framing questions to focus the day's discussion. These were:

- *What is our concept of sexual health for gay men?*
- *How, if at all, does PrEP fit into this concept?*
- *What do we need to know about our clients and providers for developing optimal sexual health and HIV prevention communications in the context of PrEP?*
- *How will we know that our vision of sexual health is achieved, e.g., as a result of improved client-provider communication?*

She then introduced four presenters to the group to help shape the discussion: Dr. Wayne Steward from the University of California, San Francisco; Dr. Dawn Smith from the Centers for Disease Control and Prevention; Rodney Vanderwarker from Fenway Health; and Jim Pickett from AIDS Foundation of Chicago. The presentations are summarized below.

Sexual Health Care Preferences among Gay and Bisexual Men Wayne Steward, PhD, MPH (University of California, San Francisco)

Dr. Steward reported on findings from an evaluation of Magnet, the gay men's health center in the heart of the Castro neighborhood, which offers an array of free sexual health services for HIV-negative and HIV-positive men. Magnet has been a program of San Francisco AIDS Foundation since 2007. The study broadly examined the men's choices around sexual health care services through in-depth qualitative interviews with 32 self-identified gay or bisexual, English-speaking males aged 18 and over. Participants lived, worked, and/or socialized in San Francisco at least once a week and also sought sexual health services within the larger San Francisco Bay Area.

The researchers used a framing analysis method to analyze data from the interviews. The results showed that men fell along a continuum in their sexual health care-seeking behavior. At one end of the spectrum were *consolidators*, mostly HIV-positive men who met all their health care needs through their primary care provider (PCP). At the other end were *fragmenters*, mostly HIV-negative men who intentionally sought sexual health care independent of their PCP. Between these two particular groups were those who received sexual health care services from a PCP only when and if they were offered (*opportunistic integrators*) and those who interfaced with the health care system exclusively for sexual health needs (*single-issue sexual health consumers*). These last two groups were also comprised of exclusively HIV-negative men.

The study demonstrated there is no one-size-fits-all model of how gay men access sexual health care. Different gay men need different services in different venues, depending on HIV status, health insurance status, provider setting, perception of health needs, and other motivating factors. As a main takeaway point for the think tank discussion, the finding that the majority of HIV-negative men are less likely to consolidate their sexual health care services in one primary care location is highly relevant for HIV testing, STI testing, and PrEP program implementation, especially as current efforts to scale up PrEP are currently specifically focused on PCP settings.

The main drivers that lead HIV-negative gay men to actively seek sexual health care outside of their PCP included fear and stigma in talking about their sexual health with their PCP, and a belief that stand-alone sexual health centers provide more competent sexual health care. Sexual health clinics are perceived to have more culturally relevant and non-judgmental providers, more advanced screening technologies, greater convenience, and the ability to see clients at free or reduced cost regardless of health insurance status.

The discussion also focused around how fragmentation of sexual health care services is reinforced by some PCPs who proactively opt-out of providing sexual health care services and encourage their clients to use stand-alone sexual health centers even if they have health insurance, due to complicated medical billing processes, providers' limited time, and/or Magnet staff's reputation as STI management experts. Fragmentation is even reinforced by the existing local institutional system of care, in which the San Francisco Department of Public Health prioritizes funding stand-alone sexual health centers like Magnet, which is a gay men's sexual health center, and San Francisco City Clinic, which is a municipally funded STI clinic for a broader population, thereby encouraging people to visit these locations for just their sexual health care needs. Insurance companies play a role, too, as reimbursement for STI services is not lucrative and/or is administratively cumbersome. For example, even though the CDC's latest STI treatment guidelines include rectal and pharyngeal gonorrhea and chlamydia screening, these specific tests are not approved by the FDA and thus not billable by some private insurance companies.

These factors suggest primary care settings may not be ideal for combination HIV prevention strategies such as PrEP for HIV-negative gay and bisexual men. This population rarely uses their PCP for their sexual health care needs, the study suggests; therefore implementing and accessing PrEP through PCPs has some significant barriers and might not be very efficient.

Other settings, like sexual health care clinics, should be explored as part of PrEP implementation. It is also imperative for PCPs to improve their knowledge and confidence in serving gay men and their sexual health needs.

Best Practices for Patient-Provider Communication: The Case of Medication Adherence **Dawn K. Smith, MD, MS, MPH (Centers for Disease Control and Prevention)**

Dr. Smith used the example of medication adherence to present a model of how PCP services related to lifestyle risk factors are influenced by the receptiveness of the patient, the perception of how the service aligns with the provider's job description, and whether the provider feels that service implementation will make a positive difference for the client.

Capacity, Dr. Smith explained, is influenced by the alignment of the service with the organization's protocol, and the extent to which the provider has the information and knowledge, as well as the organizational support, to render it. With these preconditions met, the provider then determines what screening and intervention strategies to implement. Finally, informed by past success or failure, the provider decides whether the results are worth the effort.

The above model becomes more complex when applying it to service delivery for PrEP medication adherence. Whereas many components are within the provider's scope, specificities around adherence exceed what is standard for most providers. Adding to this complexity are the many nuances surrounding communication and even the ideal candidate. Whereas a provider may be an effective communicator in general, s/he can be ineffective in relating condition-specific information. Dr. Smith presented data indicating that PrEP decreases HIV risk for all *except* consistent condom users who stop using condoms *and* use PrEP inconsistently. While PrEP is a proven HIV risk reduction strategy, it is difficult to communicate these nuances. This communication barrier to giving contextually relevant and culturally appropriate information is further nuanced by the patient's race/ethnicity, as evidenced by studies showing African-American patients in particular are less satisfied with their provider's condition-specific communication than are other ethnic groups.

Given the disproportionate HIV epidemic among African-Americans, the gaps in knowledge affecting patient-provider communication are particularly concerning. In the United States in 2013, more African-American men who have sex with men (MSM) were diagnosed with HIV than their white counterparts. In the PrEP study in Chicago, adherence to PrEP among this population was also seen to be poorer than among whites at every age level.

The above findings point to the need for further research in preventive sexual health interventions that is congruent with existing health care delivery systems. In addition, studies are needed surrounding best practices for preventive sexual health service delivery. Lastly, research should include patient-provider communication as well as meaningful inclusion of youth and adult minority participants, particularly African-Americans, within preventative sexual health service studies.

Best Practices of Sexual Health Care

Rodney VanDerwarker, MPH (Fenway Health)

Mr. VanDerwarker discussed Fenway Health's integrated delivery of sexual health care services within a patient-centered medical home. For context, Fenway Health is a federally qualified community health center located in Boston, Massachusetts, and provides a wide variety of medical, mental health, and specialty services for the LGBT community, people living with HIV/AIDS, and individuals who live and work in Boston. It is important to note that Massachusetts was one of the first states to implement health care insurance reform and historically is on the cutting edge of the gay rights movement, including approving gay marriage and transgender civil liberties.

At Fenway Health, continuity and convenience of care are facilitated using technology as well as a team-based approach. These methods work to ensure multiple points of access are created to assist patients in meeting their needs in immediate ways. Fenway Health uses electronic medical records to issue prompts and appointment reminders. iPads are also used to support providers in performing required screenings and to make a broad array of sexual health information readily available. To achieve a team-based approach, Fenway Health has trained medical assistants to conduct rapid HIV testing. Highly trained sexual health counselors are also readily available, with flexible schedules in order to meet with clients for extended periods of time. Lastly, Fenway Health provides drop-in hours, same-day appointments, and opportunities for comprehensive phone counseling. By expanding the patient relationship to a broad range of providers, Fenway Health's unique, integrated model ensures that there are multiple points of entry to access one system, making connection with health care easy.

This approach is conducive to effective PrEP delivery, for which Fenway Health is experiencing a growing demand that is increasingly initiated by clients, who are learning about PrEP as a result of recent community education efforts to increase PrEP knowledge. Awareness is also elevated because Boston was one of the sites for the iPrEx study. When brought up in provider-client communications, PrEP is typically presented as an option among other strategies in the HIV prevention toolkit. Although providers are talking about PrEP with their clients, to date, there is no formal PrEP protocol prompting providers to initiate these discussions.

As public funding continues to shrink, Fenway Health is keen to ensure its integrated model remains sustainable for future years. Fenway Health is taking steps now to encourage and empower those clients who have their own private insurance to proactively seek culturally competent health care in their own individual systems of care. As such, it already has developed several training tools and educational brochures, geared toward PCPs and clients, about PrEP, taking a sexual history, and coming out to your provider. These resources may be found at <http://www.lgbthealtheducation.org/>.

Best Practices of Gay Men’s Sexual Health Messaging

Jim Pickett (AIDS Foundation of Chicago)

Mr. Pickett focused on the principles, ideals, and ideas around the framing and messaging of gay men’s sexual health. He explained how these remain heavily and negatively embedded within the disease paradigm, and how prevention strategies such as PrEP have further fueled perceptions of gay men engaging in condomless sex as irresponsible, reckless, and selfish.

Instead of scare tactics, sexual health messaging must exit the crisis paradigm of HIV infection. It must embody the principles set forth by the gay men’s health movement and be holistic, asset driven, multicultural, relationally focused, informative, empowering, and celebratory. PrEP allows the opportunity to advance this agenda and to reframe sexual health as more than the absence or presence of disease.

To this end, Mr. Pickett encouraged the gay community to take the lead in educating providers about PrEP and reframing the meaning of safe and protected sex. He noted condoms must also be reframed as an imperfect strategy and not mythologized as a gold standard. HIV counseling and testing should be viewed as a gateway to talk about PrEP. Through education, empowerment, and mobilization, gay men can take back the pleasure, intimacy, connection, emotion, and love that their sexual health agenda historically has been denied.

AIDS Foundation of Chicago has led national efforts on this front by creating the My PrEP Experience blog, which features real stories from people who have chosen to use PrEP as one way to protect themselves from HIV. As demonstrated by Mr. Pickett’s case study of an individual seeking a prescription for Truvada as PrEP, the blog has become an important platform to connect users, potential users, and providers and enable them to learn more and support each other around PrEP. The blog may be viewed here:
<http://myprepexperience.blogspot.com/>.

Day One: Discussion

Dr. Auerbach facilitated a wide-ranging discussion based on the framing questions that were introduced to the group earlier and reflective of the presentations, as summarized below.

What is our concept of sexual health for gay men?

“Gay men’s health isn’t what happens between the knee and navel but also what’s between our ears and in our heart.” – Dr. Ron Stall, University of Pittsburgh

Given the diversity of the people around the table and the complexity of the topic at hand, the group had difficulty conceptualizing gay men’s sexual health in its broadest terms. The group eventually did reach consensus that gay men’s sexual health should move beyond a disease focus and instead be more holistic. This whole-body model recognizes the role that syndemics of substance use, mental health, and victimization play for gay men. Notwithstanding these negative experiences, sexual health promotion should take a more asset-based approach by

tapping into resiliency, and it should recognize the social benefits of sexuality, like pleasure, orgasm, and perhaps most importantly, intimacy.

The lack of intimacy felt by individuals in the community is deeply rooted in stigma. Using intimacy as the goal for gay men's sexual health would provide a positive framework and would imbue gay men with agency to be more proactive in actualizing their sexual health, and for making informed choices around their health-seeking behaviors for themselves and the community. Incorporating a life-course approach would also afford greater recognition that the sex lives of gay men are fluid and go through "seasons" of high risk. Services reflecting this concept of gay men's sexual health would be convenient, sensitive, and culturally appropriate. While there was a strong desire from the group to normalize gay men's sexual health and universally adopt this concept, it is clear that the field has yet to make this paradigm shift.

How, if at all, does PrEP fit in to this concept?

"We need to address PrEP as a vehicle for people who knowingly don't use condoms."
— Michael Cowing, amfAR

"PrEP gives us an entry point to talk about raw sex in a way that's helpful. We can talk about effectiveness and reframe condoms. We can reframe how we talk about protection and safer sex." — Jim Pickett, AIDS Foundation of Chicago

There was much debate on PrEP's potential role in the larger gay men's sexual health conversation. While PrEP messaging has evolved with more research and resources, negative messaging from the early days of PrEP research—related to concerns about limited efficacy, adverse side effects, and resistance—still dominates community conversations and are proving difficult to reverse. Even today there is confusion about how to message around PrEP's efficacy and safety. To further complicate this issue, PrEP is often framed within the gay community itself through the lens of promiscuity and held against the "condoms-only" gold standard, which fuels stigma and shame among individuals, providers, and the very community that may stand to benefit most from this HIV prevention strategy.

From a gay men's sexual health perspective, PrEP offers protection for "bottoms" (receptive anal sex partners) and/or men who do not or cannot use condoms. It gives gay men the opportunity to talk about sexual expression, pleasure, raw sex, negotiation, and condom use, which are core elements of the collective concept of gay men's sexual health defined above. Talking about PrEP allows a reframing of what "safer sex" means. Thus individuals who do not consistently use condoms and decide to use PrEP are not reckless and irresponsible. Rather, PrEP is a tool that empowers individuals to be proactive, take control, and plan ahead for the type of sex that they want. Yet awareness and uptake of this new HIV prevention strategy is low in the gay community.

For providers, there is the opportunity to bring up PrEP with clients and have a really rich conversation around gay men's sexual health that has been largely absent up to now. Whether that conversation includes all the currently available options in the HIV prevention toolbox, or looks ahead to other options potentially coming down the research pipeline (i.e., microbicides,

non-daily PrEP), talking about PrEP is still an advantageous way to bring up the larger concept of gay men's sexual health. As an added bonus for providers, PrEP encourages clients to be more engaged in care and have more routine HIV/STI testing, which is particularly helpful for young gay men who would not access sexual health services otherwise.

What do we need to know about our clients and providers for developing optimal sexual health and HIV prevention communications in the context of PrEP?

There are many relevant factors and characteristics to consider in determining if individuals would be ideal PrEP candidates. While individual behavioral and physical factors for HIV acquisition risk are important, so is the background HIV prevalence of the individual's environment and sexual network. The frequency, spacing, and periodicity of sexual activity are key to assess, along with a detailed sexual history. This sexual history narrative would ideally include sexual debut, number of partners, seasons of risk, role of drugs and alcohol in sexual activities, and patterns of partnering, falling in love, falling out of love, and rebounding. Current HIV and STI prevention strategies must be taken into account, as well as syndemic indicators.

It is very important for providers, health educators, and treatment advocates to figure out where clients are learning about PrEP, which may be from local community education outreach efforts, other peers, and their providers. Identifying influential, trusted sources is key. Since providers are often not forthcoming about discussing comprehensive gay men's sexual health, there is a lot of pressure for clients to advocate for themselves and request PrEP from their providers.

Providers' attitudes toward HIV, STIs, sex, and gay men is indicative of their interest, intent, tone, and comfort level in talking about gay men's sexual health with their clients. Because a provider identifies as gay does not necessarily mean that provider would be more likely to support PrEP than would a heterosexual provider. Upstream factors like sexual health training and organizational culture all connect to providers' openness and willingness to talk about PrEP. Type of medical practice and setting, such as primary care or community-based health clinic, are important contextual factors. Many in the group agreed that talking about sexual health with clients is really difficult for some providers, whether or not they understand that prescribing PrEP is easy and not the same as treating HIV with antiretrovirals.

Some providers have a difficult time gathering needed information about their clients in a way that is non-judgmental and easy to understand. The life-course approach and "seasons of risk" concept of gay men's sexual health are sometimes difficult to explain. The need to simplify messages was continually emphasized throughout the discussion. For example, Dr. Stephanie Cohen from San Francisco City Clinic suggested "What are you *already* doing?" as a helpful baseline question to start the conversation about clients' HIV prevention practices. In order to normalize and validate known non-condom use, Dr. Malcom John from University of California, San Francisco, offered this example question: "When do you *not* use condoms?"

For those providers who are uncomfortable about taking a detailed sexual history, Dr. Susan Buchbinder from San Francisco Department of Public Health developed a simple three-question

risk assessment tool based on iPrEx data. She offered these three key questions that providers can use in the context of PrEP as an entrée into a broader conversation about gay men's sexual health with their clients.

1. Do you have sex with men, women, or both?
2. How many sex partners have you had in the past 3 months?
3. Have you been an unprotected bottom in the past 3 months?

Given the limited time that medical providers have with clients in an individual visit, these simplified examples can go a long way for providers to help establish trust and credibility in their relationships with clients. While these are examples of how some of the experts in the room handle these gaps in provider-clients communications around gay men's sexual health and PrEP, currently there is no universally approved PrEP risk assessment tool for providers.

How will we know that our vision of sexual health is achieved, e.g., as a result of improved client-provider communication?

The group identified these outcomes and measures as optimal for evaluating progress in achieving our vision of gay men's sexual health:

Individual level

- Increased percentage of providers who document sexual orientation; answers to Dr. Susan Buchbinder's three key questions in medical chart [*Note, there was concern within the group about what should and should not be charted to maintain patient confidentiality*]
- Increased disclosure by gay men of their homosexuality to providers
- Good PrEP adherence plan and execution
- Increased satisfaction around sex life
- Increased self-care, pride, and comfort around sexual health

Community level

- Decreased HIV and STI incidence (from local surveillance data)
- Increased rates of STI/HIV testing and linkage to appropriate care
- Decreased rates of syndemic conditions, e.g., alcohol and drug consumption, depression, violence victimization (from population-based surveys)
- Decreased internalized homophobia (using [Dr. Greg Herek's measures of stigma](#))

For these data to be useful, it is important to collect them over time and evaluate for patterns. Of note, during this part of the discussion, there was a lot of concern around STI incidence and whether rates of syphilis and gonorrhea would rise along with PrEP uptake since PrEP does not reduce risk for STIs.

Day Two: Discussion

The theoretical framing questions of Day One's discussion set the stage for Day Two's discussion, which concentrated more on program implementation issues. With the more finely tuned goal of increasing PrEP literacy among providers and clients, the discussion focused on what is needed by each sector, and on identifying who is responsible for filling those gaps. The framing questions charged to the group and the resulting discussion are detailed below.

What is required/needed for both providers and clients to have this conversation?

The group agreed that the current national policy and community discourse around PrEP is largely negative. The paradigm shift needed to talk about PrEP using a more holistic concept of gay men's sexual health is difficult for both providers and clients to conceptualize and operationalize. Current misconceptions and pessimistic attitudes around PrEP are a result of negative messaging from the nascent days of PrEP research and implementation and have unfortunately carried over to present day. Fortunately, thanks to the growing body of PrEP research, there are enough data about PrEP efficacy, safety, and resistance to now counteract the negativity surrounding PrEP, enabling people to make well-informed decisions about PrEP and their sexual health.

While a better framing of the positive aspects of PrEP is obviously required and needed for providers and clients to constructively talk about it as part of gay men's sexual health, providers struggle with how to simplify PrEP messages without overpromising this HIV prevention strategy as a "silver bullet." For example, when describing PrEP efficacy, is it better to message that PrEP is more than 90% effective in reducing HIV risk, or use the latest iPrEx data that indicates participants who took PrEP consistently as prescribed were protected by up to 99%? The challenge of identifying a concise message that resonates with the community cannot be overstated, especially as application of research data from randomized controlled clinical trials and PrEP modeling may not translate in real-world settings. Current demonstration projects being conducted across the country and internationally in various cities will help researchers, providers and public health officials understand how PrEP can be implemented and sustained outside of clinical trials.

Many stakeholders will need to be involved in order to facilitate appropriate conversations around PrEP between providers and clients. To achieve prevention synergy, all of these audiences must be approached simultaneously to create the optimal environment. There is a need for policy makers and advocates to champion PrEP legislation to pivot how PrEP is operationalized. These policy changes would ensure that the appropriate infrastructure is in place to facilitate and motivate providers and clients to talk about PrEP. With respect to engaging providers and individuals, much emphasis was placed on adopting a diffusion of innovation model to facilitate effective peer-to-peer communications. By leveraging key influencers who support PrEP, information about PrEP can diffuse and spread more easily through various social networks. To better engage the community, the group highlighted the need for outreach education efforts to increase PrEP literacy to create "demand," and the need

to create resources to facilitate clients accessing PrEP, such as a PrEP provider registry, to address the “supply” side of the equation.

What do providers need and who is responsible for providing what is needed?

Given the diversity of the health care workforce, “providers” were loosely defined as anyone who provides health services. This includes physicians, nurse practitioners, and physician assistants who have prescribing authority for PrEP. This broad definition also includes medical assistants, case managers, and HIV test counselors who constitute the HIV health workforce and who interact with clients in primary care and/or community health settings. With the goal of helping identify which providers need to be able to talk with their clients about sexual health, be able to identify PrEP candidates, and be interested in and comfortable with prescribing PrEP, the group came up with a wish list and identified who ideally would be responsible for providing those items.

Most of the suggestions revolved around the need for setting up national and local infrastructure to encourage and support providers to be more PrEP friendly. As pointed out by many of the providers in the meeting, providers will not or cannot adopt new approaches to gay men’s sexual health if those approaches feel burdensome, so the simpler, the better. The group tasked CDC, as the leading federal public health agency, with the responsibility to create final PrEP guidelines, additional support tools describing PrEP and its administration, comprehensive HIV/STI screening and treatment algorithms, specific risk criteria for specific populations, and a PrEP-specific consultative warm-line. The group felt that there is a huge need for doctors to use formal PrEP codes for medical reimbursements, but without final PrEP guidelines, insurance companies are unable to create payer guidelines and PrEP-specific billing codes.

There was also a desire for influential medical organizations and other normative bodies, such as the U.S. Preventive Services Task Force, HIV Medical Association, American Academy of Family Medicine, National Association of Community Health Centers, and other non-HIV professional associations, to determine and endorse a standard of care for discussing PrEP. Non-HIV specialists may be hesitant to prescribe PrEP because they do not feel qualified to prescribe HIV drugs, so an endorsement or “permission” from HIV specialists for non-HIV providers to prescribe this class of drugs may be key.

Also, by working with already existing professional networks, it would be to our advantage to engage providers within the systems and structures currently in place and keep those systems up-to-date by disseminating and distributing materials on those channels. For local infrastructure, AIDS Foundation of Chicago already provides a 3.5-hour community training for the city’s HIV workforce to learn more about PrEP, and the group expressed interest in making this training more widely available across the country. Related slides are available here: <http://www.slideshare.net/JimPickett/project-rsp-training-on-prep-for-hiv-prevention-22798530>.

To improve actual provider-client communications, health communication specialists and providers need to employ positive analogies for messaging about PrEP, such as anti-malaria

pills prior to possible exposure. Also, the group expressed a need for a screening instrument to identify ideal PrEP candidates, similar to the CAGE questionnaire used for identifying issues related to alcohol use. It would be the responsibility of gay community centers, like Magnet and Fenway Health, to increase cultural competency and literacy about gay men among providers by providing educational materials around sexual practices, language usage, sexual identities, sero-adaptive positioning, etc.

What do clients/communities need and who is responsible for providing what is needed?

The group defined potential candidates for PrEP use as HIV-negative gay men at risk for infection. The ultimate goal is to empower HIV-negative gay men with information to increase their PrEP awareness, identify themselves as at risk and as potential PrEP users, and then go to their provider to advocate for their own health needs and ask for this medication. The group brainstormed about how best to address opportunities and gaps in this regard, recognizing that clients' needs differ from providers' and focus more on peer-to-peer education.

Community-based organizations should strategically target their education outreach efforts to include traditional media blitzes in prominent gay and HIV magazines, such as POZ Magazine, to include articles about PrEP, and/or even to approach non-traditional media, such as condomless porn producers, to include PrEP in a storyline. This same line of thinking extends to reaching out to key social institutions that may not necessarily be involved with HIV to get the word out. For African-American populations specifically, these organizations could include the NAACP, 100 Black Women, and prominent faith-based organizations.

Knowing that young people are disproportionately affected by the HIV epidemic, more efforts should be done to reach out to young adults under the age of 23, who may not be on their parents' health insurance, as well as those in the House Ball community, who may be at elevated HIV risk. In general, moving beyond social marketing efforts, peer-to-peer interaction was emphasized as a strategy, for example by setting up town hall meetings or even patient navigators to bolster education efforts with hard-to-reach populations and increase awareness and interest in PrEP. More effort is needed at the grassroots level to get the word out about PrEP to clients and their communities.

What role does San Francisco AIDS Foundation have in this conversation? What can San Francisco AIDS Foundation do and/or make happen to fill identified needs?

While the list of provider and client needs is extensive, there are opportunities for San Francisco AIDS Foundation to take ownership of and to fill identified needs. The group agreed that the think tank meeting was useful and helpful in facilitating dialogue around such an important topic and encouraged the foundation to continue the momentum and host more meetings of this nature. As a next step, they suggested convening providers from clinical, community, and hepatitis C backgrounds to loop them into the dialogue. Also, they would like a think tank meeting to crystalize and develop PrEP tools and instruments.

In addition, the group identified advocacy areas that the foundation could take the lead on, including encouraging the CDC to release final PrEP guidelines, investigating how to get PrEP reviewed by the U.S. Preventative Services Task Force, and ensuring state-level “explanation of benefits” and patient privacy for youth who are covered under their parents’ health insurance.

On a local level, the group expressed an interest in the foundation developing a list of local service providers in a PrEP registry, as well as increasing its collaborative work with Oakland and other East Bay HIV/AIDS service organizations.

Internally, the group wanted the foundation to explore the organization’s produced materials and events and take advantage of all opportunities to message about PrEP at various locations and events, whether they are development- or program-related.

Conclusion and Next Steps

San Francisco AIDS Foundation will disseminate these findings and take the group’s targeted recommendations into consideration. Clearly, there is a great need to educate and support providers in their conversations with clients about gay men’s sexual health and PrEP. At the same time, more is needed to educate and empower clients to advocate for their own health needs and have these conversations with their providers. Given the needs of both providers and clients identified during the meeting, it is imperative to simplify processes but not oversimplify information. Understanding the environmental context and the respective motivations of providers and clients is important for improving PrEP literacy across the board.

This think tank meeting was a successful first step in an important, ongoing process. The foundation recognizes the opportunity to continue this conversation and the responsibility to engage more stakeholders, especially as the momentum around PrEP continues to build. As a next step, the foundation hopes to convene a follow-up think tank meeting just with providers with the goal of creating PrEP support tools and instruments to assist them in their conversations around gay men’s sexual health and PrEP. An additional aim is to consider how to address the think tank’s priority of creating a clearinghouse PrEP registry.

The foundation greatly appreciates the financial support provided by Gilead, which enabled us to convene this meeting.

APPENDIX A: PARTICIPANTS

Participants included thought leaders and experts in the gay men's sexual health field across many disciplines. Asterisks by names denote participants who were also part of the meeting planning committee.

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APPENDIX B: REFERENCES

In preparation for the gay men's sexual health think tank meeting, Megan Canon and Emily Claymore of San Francisco AIDS Foundation prepared two research briefs focusing on patient-provider communication and provider provision of PrEP in clinical settings. The content of those research briefs is summarized in the background section of this report. The articles referenced in those research briefs are listed below, as are all the studies referenced throughout the meeting's discussion.

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