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Moderator: Miguel Gomez
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2:50 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are on a listen-only mode until the question and answer session of today's conference. At that time to ask a question press Star 1 on your phone and record your name at the prompt.

This call is being recorded. If you have any objections you may disconnect at this time. I would now like to turn the call over to Dr. Tim Harrison. Sir, you may begin.

Dr. Harrison: Thank you. Good afternoon and to our west coast listeners good morning. Thank you for joining us for this webinar titled Moving Black MSM along the HIV Care Continuum, Challenges, Opportunities, and Emerging Practices.

I'm Timothy Harrison, Senior Policy Advisor in the U.S. Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy.

I have just a few administrative items to cover to begin with. Due to the high listener participation and capacity limits of this hosting platform, some

listeners may have phone access only. I want to remind those listeners that they are able to access today's slides by going to the webinar section on aids.gov.

Next we have reserved time for Q&A following the speakers' presentations. At that time the operator will instruct listeners how to ask questions. Finally, I want you to know that today's webinar event is not for media reporting.

With that said I would like to introduce our opening speaker, Dr. Ron Valdiserri, Deputy Assistant Secretary for Health, Infectious Diseases, and Director of the Office of HIV/AIDS and Infectious Disease Policy at the U.S. Department of Health and Human Services. Ron?

Dr. Valdiserri: Thanks Tim and welcome to all of you. As Tim mentioned I am Dr. Ron Valdiserri, Deputy Assistant Secretary for Health, Infectious Diseases and run the office of HIV/AIDS and Infectious Disease Policy here at HHS.

I thank you all for your interest and participation in today's webinar. If the numbers of registrants for this webinar -- nearly 1300 -- is any indication, there are quite a number of you who believe as we do that today's conversation on black, gay, bisexual and other men who have sex with men and the HIV care continuum is critically important.

Making a positive difference in the health of Americans who are at risk for or living with HIV/AIDS is an important goal for all of us. As outlined in the national HIV/AIDS strategy, a large part of that job is addressing the HIV related disparities that persist among black, gay, bisexual, and other men who have sex with men both in terms of HIV prevention as well as care.

And remember it was only last July that the president released an executive order calling on all of us to accelerate our efforts to improve gaps along the continuum of HIV care.

Along those lines, our speakers today will share what we know about the day to day challenges faced by black MSM as they navigate the HIV care continuum and more to the point what we are learning about emerging practices and promising strategies that offer feasible solutions to improve health outcomes.

Please keep in mind that today's conversation is not meant to be an exhaustive detailing of all known HIV care and treatment interventions that might benefit the health of black MSM.

But we do hope that today's webinar will highlight promising ideas, raise important questions, and suggest new areas and avenues for research and policy development that will help to improve the HIV related health outcomes of black, gay, bisexual, and other men who have sex with men. And now it is my pleasure to turn the microphone back to Tim who is going to moderate our webinar this afternoon. Tim?

Dr. Harrison: Thank you Dr. Valdiserri. I would now like to introduce Dr. Omar Whiteside, Division of HIV/AIDS Prevention, and the National Center for HIV/AIDS, Viral Hepatitis, STD and TD Prevention at the Centers for Disease Control and Prevention. Dr. Whiteside?

Dr. Whiteside: Thank you for the introduction Dr. Harrison. Today my presentation will focus on the HIV epidemiological profile and the continuum of care for black MSM. Next slide please.

The presentation will cover recent data CDC has published describing HIV morbidity among black MSM. It will also include information from a report and a recent CDC MMWR which described the continuum of care for blacks in the U.S. and in doing so also provided information on the continuum of care for black MSM. Next slide please.

As of 2010, the year which the most recent data is available for new HIV infections, 10,600 or 36% of all new HIV infections occurred among black MSM; 11,200 or 38% of all new HIV infections occurred among white MSM; and 6700 or 22% of all new HIV infections occurred among Hispanic or Latino MSM.

Black MSM aged 13-24 accounted for 4800 new HIV infections. This was twice as many estimated new infections as young white MSM or young Hispanic/Latino MSM. The number of new infections among black MSM aged 13-24 was higher than the number in any other age group of black MSM and higher than the number in any age group in white or Hispanic/Latino MSM. Next slide.

As of 2011, the year which the most recent data is available for HIV infection diagnoses, black MSM accounted for the largest estimated number and percentage of diagnoses of HIV infection at 11,805 diagnoses or 39% of all HIV infection diagnoses among MSM. 10,375 or 34% of all HIV infection diagnoses that occurred in MSM took place in white MSM while 6949 or 23% of all new HIV infections among MSM occurred among Hispanic/Latino MSM.

As of 2010, the year which the most recent data is available for individuals living with HIV infection, there were an estimated 440,408 MSM living with diagnosed HIV infection. Of those, 134,746 or 31% were African American,

205,000 or 47% were white and approximately 85,000 or 19% were Hispanic/Latino. Next slide.

On February 7, 2014 which was also National Black HIV/AIDS Awareness Day, the CDC published the progress along the continuum of HIV care among blacks with diagnosed HIV in an MMWR. In it the CDC described linkage to care and retention in care for blacks using data from 19 jurisdictions which represented 44% of all blacks living with diagnosed HIV as of December 31, 2010.

The results of the analysis indicate that 71% of black MSM were linked to care within three months which is a lower linkage rate to care than blacks in any other transmission category. It also indicated that 46.3% of black MSM were retained in care which is lower than the overall average for blacks which was 48% and well below the national HIV/AIDS strategy goal of 80%. Next slide.

Data on antiretroviral therapy and viral suppression were derived from the medical monitoring project using estimates from the United States and Puerto Rico. Based on this analysis 47% of black MSM were prescribed ART and 37.1% were virally suppressed. The percentages for ART prescription and viral suppression were higher than the overall average for blacks which was 46% and 35% respectively. Next slide.

The CDC's approach to addressing the HIV epidemic among black MSM involves three areas of commitment. One, engaging African American MSM communities and strategic partners; two, expanding and focusing on the prevention strategies and programs with the greatest impact; and three, evaluating and disseminating information on strategies and programs.

CDC has used this approach to fund state and local health departments and community based organizations to support HIV prevention services for MSM. We have also used it to expand HIV prevention services for young gay and bisexual men of color, transgender youth of color, and their partners.

The CDC awarded $55 million to 34 CBOs with strong links to these populations. This funding is being used to provide HIV testing to more than 90,000 young MSM and transgender youth of color with the goal of identifying more than 3500 previously unrecognized HIV infections and linking those who have an HIV infection to care and prevention services.

This approach was also used to fund the national capacity building assistance for high impact prevention which addresses gaps in each step of the HIV care continuum by providing training and technical assistance for staff of health departments, CBOs, and healthcare organizations. The estimated annual funding will be $22 million. Next slide.

Through its Act Against AIDS campaign CDC aims to provide gay and bisexual men with effective and cultural appropriate messages about HIV prevention. The Testing Makes Us Stronger campaign for example encourages African American MSM and bisexual men aged 18-44 to get tested for HIV.

Due to diffusion of effective behavioral intervention projects the CDC supports programs for MSM most at risk of acquiring or transmitting HIV. The MSM testing initiative will establish and evaluate an HIV testing and linkage to care program to identify MSM with HIV who were previously unaware of their infection and link them to HIV medical care. Next slide please. And thank you very much for your time.

Dr. Harrison: Great, thank you Dr. Whiteside. I would now like to introduce Dr. Ann Robbins, Senior Public Health Advisor TB, HIV/STD and Viral Hepatitis Unit, Texas Department of State Health Services. Dr. Robbins?

Dr. Robbins: Good afternoon. Thank you Dr. Harrison and just thank you to the distinguished panel. This is going to be quite a discussion. So I'm going to talk to you a little bit about what state health departments are looking at and doing with black MSM gay men, bisexual men, transgender women, and other groups.

And as Dr. Valdiserri pointed out, this is by no means an exhaustive detailing of everything they're doing. Just going to try to hit some general things that I hope will be helpful. Next slide please.

So it was very helpful to hear a national profile of what is going on with black MSM and African American blacks in general but everybody knows all politics in epidemiology are local and I did want to give you a picture of what is going on in Texas.

As you can see, MSM were 57% of the persons living with HIV in 2012. And because we have been doing some work on estimating the number of black gay men, white gay men, and Hispanic gay men, the population size, then we can estimate that 15% -- and that's about one in seven -- of black MSM in Texas were living with a diagnosed infection. That's a little bit different way of looking at the impact.

MSM were more than two out of three of the new diagnoses in Texas in 2012 and black MSM represented 21%. Now keep in mind this is in a state with about 10% to 11% overall African American population. So you can see the very real impact that HIV and AIDS are having in this community. Next slide.

I wanted to give you a little flavor of linkage and retention in care for MSM in Texas. You can make some comparisons across MSM group but I'm going to hone in on black MSM.

When we look at persons diagnosed in 2012, more than 1/4 of the black MSM were not linked into care within three months of their diagnosis. This is more than double the rate for white MSM and quite a bit much higher than the rate for Hispanic MSM.

When we look at continuous participation in care across more than one year which I think is a very interesting and novel way to look at this, then what we can see is across the years 2008-2012 for black MSM no care at all was observed for about 12% of these men. About almost 50% were in and out of care across the years. Some years we saw them, some years we didn't. And only 1% remained in care consistently between 2008 and 2012. Next slide please.

So when we pull it all together in the care cascade we can see that about 41% of black MSM living with diagnosed HIV infections were virally suppressed and this can be contrasted with 62% of the white MSM and 54% of the Hispanic MSM.

And by the way, the overall viral suppression for the whole state among people with any kind of diagnosis or among diagnosis is more than 50% so this is quite a disparity for black MSM. The other MSM racial ethic groups are actually achieving much greater shares of viral suppression than the state overall. Next slide please.

So what are state health departments doing to respond? What are their challenges and what opportunities are afforded to address these issues that are with black MSM? A lot of my talk is going to be drawn from these two very fine publications. You can find them at nastad.org.

And they are the result of members dialog, careful study, and participation in a gay men's health equity work group that has been established to build capacity of state and local health departments, creating integrated and coordinated responses across infectious disease, behavioral health, and substance abuse, improve data collection systems, and create comprehensive strategies to better address both the social and medical environments and systems in which black MSM live to come up with some better, more appropriate, more effective solutions. Next slide.

So the responses of course across different health departments across different communities are going to be varied but these are some common themes that we have seen in health department responses.

Health departments are doing things with data that were illustrated with the kinds of statistics that I started off with to develop really sort of locally applicable detailed data stories, more than just statistics, but stories about how the care continuum is expressed in a community and what the challenges may be for a particular community or group of people.

Health departments are also reaching out to new sources of information, electronic health records, other sources of information so that we can get a more enriched understanding of the social and medical environment that these gay men and other people living with HIV, you know, do their daily life, work their daily life in.

These health departments have also organized planning and evaluation using the continuum which sort of gives a uniform theme to our discussion. And now let's get into the real meat of what you might notice on the ground differently.

A recent inventory of HIV prevention activities at state health departments indicate that there has been a shift in resources towards MSM and black and Latino MSM in particular in terms of greater resources placed, you know, focus on doing testing in these groups, and more attention towards linkage to care and especially maintenance into care for these groups who have special challenges and needs.

Health departments have also focused on coordinating across different types of providers -- behavioral health providers and substance abuse providers as well as social service providers into sort of the systems that are focused on prevention and care. So that's coordination of prevention and care but also integration of other types of social and medical services.

One of the most important responses has been an intensified community dialog and consultation. We can look at development of advisory groups or community conversations in states like Maryland, Michigan, Florida, Texas has one too.

Looking for ways and stories from the community, insights and the needs expressed by the community to build that into HIV prevention and care programming but also to learn more about the general social environment and the needs of these men.

Our next response that is very promising is work on enriching community building. A lot of the challenges that black men face or Latino men face is - come from a lack of a supportive community.

Health departments can provide support along the way for communities to organize and be able to support each other and provide a vibrant source of information for healthcare systems and social service systems so it doesn't come from a third party, it comes from the men themselves.

Finally there has been a great deal of interest and uptake in targeted social marketing and social media. The CDC talked a little bit about Act Against AIDS. But there are also a lot of states with home grown sorts of social media or targeted social marketing that is developed in collaboration with the community.

And finally, guidance and training for health and social service system providers, not traditional HIV providers. And if we'll go to the next slide we can see an example of this.

These two pieces of literature were developed in consultation with blue ribbon panels developed by NASTAD and they're focused on care providers to look at the optimal care of for MSM in terms of health status checks that are important for MSM. Also a brochure that is focused on raising levels of understanding about sexual health needs of MSM, encouraging dialog with providers.

Now what this doesn't show is also a lot of focused effort on creating culturally respectful environments both in physical health but it is also needed in behavioral health settings as well as substance abuse treatment. The lack of

a respectful and affirming environment can keep men from accessing the services that they need. That has an impact on participation. Next slide please.

So the challenges and opportunities very briefly. We need tri-directional or quad-directional capacity building for health departments, community based organizations, and health systems where we can learn from each other, where we can connect more experienced agencies with agencies that may not have serving black MSM as a part of their stated mission but are, you know, trying their best to serve that community, you know, on a daily basis.

So capacity sharing between CBOs, capacity lessons passed on, the community talking to health departments about what is needed, and health departments providing support and structure to build the bridges that we need to develop new leaders and strengthen the system.

I have talked about increased system participation. I want to place a special emphasis on social services. Those services are really needed for issues like job training, issues on transition from incarceration, and housing issues.

And finally the kind of boring IT and data challenges. But, you know, we really look forward to strengthening capacity in the future to integrate more information about other social markers of distress such as crime, dropout rates, pregnancy rates, life expectancy, and so on to really add urgency to the message of what is going on with black MSM. Next slide please.

So moving forward, the bar before the bars. Next slide. Where health departments are headed, where we should be headed, and where we know we ought to be headed and okay, let’s just say where we are headed is working on the bars before the bars in collaboration with the community.

While we can look at mechanical fixes to our systems to increase the number of people in care or retained in care, really what we also need to be addressing or perhaps what is more pressing is understand why men become infected in the first place.

And those answers are embedded in the bar before the bar. Stigma, homophobia, racism, poverty, violence, homelessness, marginalization. Those are not necessarily health problems but they are the conditions which lead to vulnerability to HIV. Next slide.

Since these are societal issues we need multiple levels of action. Health departments can operate at the level of individual services but they also have an obligation to address interpersonal and organizational community and societal levels of intervention. If we want to address the bars before the bars we have to get outside of just individual interventions and move into the public arena and policy arena where those changes can be made. Next slide.

And I wanted to draw your attention to another document very hot off the press, also available at NASTAD that contains 17 recommendations for directly addressing stigma in the domains of prevention to treatment adherence.

And that's the end, that's the last slide there. So that was a very rapid overview of what is going on with health departments and their response to HIV. Thank you for the opportunity to share.

Dr. Harrison: Thank you, thank you very much Dr. Robbins. Before we move to our next speaker I just want to remind our listeners that we have set aside time at the end of the presentation for Q&A. But if you have questions in mind you may

email those questions to contact@aids.gov and we will address them at the end of the conversation.

Our next speaker, I now would like to introduce Dr. Andres F. Camacho-Gonzalez, Assistant Professor of Pediatrics, Division of Pediatric Infectious Diseases, Emory University and Grady Health System Ponce de Leon Center. Dr. Camacho-Gonzalez?

Dr. Camacho-Gonzalez: Thank you Dr. Harrison. Good afternoon. Today I will be discussing the challenges, opportunities, and emerging practices from the HIV care continuum among black MSM from the clinical perspective. In addition I will share some interventions that we have developed at the Pediatric and Youth Clinic at Grady IDP Infectious Disease Program in Atlanta to improve gaps with the HIV continuum of care.

So in 2011 the HPTN-052 trial kind of generalized the concept of treatment as prevention among the scientific community bringing an exciting new chapter in HIV prevention.

Although the use of antiretrovirals to prevent transmission was already implemented for many years in the mother through child transmission prevention program, we had in our hands a tool that would not only benefit the patient but that will also have a significant public health impact. Next slide.

However, in order for this intervention to work HIV infected patients needed to achieve proper immunologic and virologic control and reach undetectable levels of the virus.

The HIV treatment cascade opened our eyes and we knew how far we were from achieving that goal and the daunting task we had ahead of us but it also gave us a clear route for improvement. CDC revealed that from around a million or so people infected with HIV in the U.S. only 82% knew their diagnosis and around 25% had achieved virologic control. In order to benefit from treatment as prevention we had a lot to do in each step along the cascade. Next slide.

So opportunities along the HIV care continuum are numerous. Scientific advances and policy changes have given tools to clinicians to help improve different aspects of the cascade.

National guidelines have changed to address the importance of generalized HIV testing throughout the population, decreasing the number of asymptomatic patients that did not know they were infected. Scientific advances have also allowed us to determine if early treatment improves patient outcomes by decreasing the direct and indirect effects of the virus in the body and controlling the inflammatory response.

In addition to public health implications of decreasing transmission, HIV medical regimens have become more potent, less toxic, and easier to take and with higher threshold for resistance. However we are still struggling in identifying infected patients in the community, keeping them engaged in care, and placing them in optimal antiretroviral care. Next slide.

This is because the medical care of HIV infected individuals as we heard before goes beyond the disease process. It encompasses the social, cultural, and economic aspects of the patient. The individual behaviors along with the stigma of the disease, the lack of education, abundant social inequalities, and a

costly healthcare system among other are layers influencing the engagement in care of HIV infected individuals. Slide.

Therefore the bad news is that we have challenges along each of the steps of the HIV care continuum but the good news is that throughout the years of this epidemic there has been evidence based interventions that have been developed that can serve and are serving as framework for future efforts. Next slide.

You see here there are a number of interventions that alone have proven to be effective in decreasing linkage and retention in care -- I'm sorry, in increasing linkage and retention in care. The majority of them tried to address factors along those layers that we discussed before but we need to broaden our arsenal and identify newer strategies or combine strategies addressing specific populations. This is a good way to start. Next slide.

Let's look at the different components of the cascade pointing out from the clinical standpoint some challenges, new endeavors, and opportunities. If we start at the first step of the cascade, one of the obvious challenges is that we need to expand our capability of testing people.

Although challenging and sometimes technically difficult, we need to perform target testing in specific populations where the incidence is increasing and we need to have the capability of repeating testing to those high risk populations.

We have seen how the younger population is getting infected and how they have the worst numbers along the treatment cascade. Therefore we need to start testing the younger populations as well as addressing the education around sex, STIs, and HIV.

In addition in order to really expand testing we need to decentralize care and involve the primary care practitioners, pediatricians, family practitioners, internal medicine doctors, adolescent specialists among others because they are the primary contact when it comes to the high risk individuals. Next slide.

In terms of linkage and enrollment in care, the U.S. HIV Care Continuum Initiative has set the goal of linkage to at least 85% of the positive individuals. And challenges that we have at this moment include among others the issue that testing and clinical care are usually done by two independent entities.

Although this has started to change, improvement in communication and partnerships between the two entities needed to facilitate an easy enrollment of the positive individual.

We need to simplify and develop protocols to streamline enrollment in care. Social disparities and psychological problems are usually experienced by HIV infected patients bringing with them a big group of logistical issues that affect linkage and enrollment in care. Transportation, food insecurity, homelessness, and drug abuse among others need to be strongly addressed in order to keep patients in care.

Good friendly clinics are necessary. Adolescents and young adults have their own way of doing things as we know and we need to understand them in order to provide excellent care. Expansion of clinic hours to more friendly schedules as well as walk-in capacity is essential for the younger population. Next slide.

In terms of retention in care we also have significant challenges and needs. Trusting the health system and coping with new diagnosis is a difficult area and requires continuing support from the time of diagnosis to way past the linkage visit.

Patients at this time are very vulnerable and require a lot of support. Peer support groups and accessible health systems with personnel that are well trained and well versed in HIV management and care. Personnel that are open, friendly, and engaging are essential components to retention in care.

Intensive case management will help patients prioritize taking care of their health despite the numerous social disparities. Using technology to expand the clinical care beyond the clinic walls will also serve in supporting these patients along the way. Next slide.

To increase ARV initiation and viral suppression we need to be able to increase ARV coverage for HIV infected patients as the guidelines are recommending. We are also struggling to find practitioners that are trained to deal with HIV management patients and their complications. Therefore we need to expand and train personnel so they can feel comfortable prescribing ARV regimens.

We need to get a better hold of concomitant health issues such as drug addiction and psychiatric problems. In adolescents we have the challenge of dealing with the latency period of disease which for concrete thinkers as the adolescents are will drive them away from the treatment if they don’t feel safe. In addition, for some of them it’s very challenging to take medications in a non-disclosure environment. Slide.

Let’s look at some of the emerging practices trying to decrease gaps in the HIV care continuum. Home based testing, although it has shown to be effective in other countries the out take of home based testing in the U.S. has not been ideal. Increasing efforts are being done in this area and research is

required to understand if increased home testing will translate into effective linkage to care.

Fear, stigma, transportation and communication barriers among others have led to some innovative approaches such as using the Internet for identification of certain populations and enrollment of for example rapid testing initiatives or other behavioral modification therapies.

However, significant interventions are still required such as educating and addressing people's beliefs and concerns about HIV. If we do not address this issue it will be very difficult for at risk individuals to seek testing and if positive to link into care.

Emerging practices to improve linkage and retention include a variety of behavioral interventions, some of who are validated or they need validation. Protocols looking at monetary incentives for enrollment have also shown some promising results outside the United States. Next slide.

In terms of interventions to improve retention, implementation of text messaging technology to deliver behavioral and psychological interventions, expansion of telemedicine programs to facilitate medical visits and improve retention, test and treat strategies and financial incentives to follow medical care.

ARV - and in terms of ARV initiation and suppression, hopefully the Affordable Care Act will help us expand the pool of people who are receiving antiretroviral therapy. There are foundations who are helping cover some of the Affordable Care Act premiums and pharmaceutical companies have developed certain plans to decrease the co-pays of their medications. Next slide.

At the Grady infectious disease program we are doing different programs to help HIV infected patients move along the cascade. First of all we are funded to implement ARTAS intervention, that as you recall from my previous slides is one of the evidence based approach to improve linkage in care. ARTAS populations are lost to care, new diagnosis, and need support. They need support as well and heavily rely on peer counselors and navigators.

MACARTI intervention stands for Metropolitan Atlanta Community Rapid Testing Initiative. It was a mixed method intervention that was funded by the CDC where we applied venue testing, motivational, interviewing, and intensive care management support that was initiated prior to the HIV testing.

In the initial phase of this intervention we consulted and interviewed a group of infected and non-infected youth to understand better potential sites for venue testing as well as potential testing barriers, ways of approaching youth for testing, and disclosure of diagnosis.

Now during the second phase we have conducted testing events in venues identified in the first phase and this year so far we have tested 359 individuals between 18-24 and we have identified 32 infected patients for a positivity rate of 8.9%.

Twenty seven of those patients have been linked so far. There was three that were identified as weakened so we haven’t linked them but we are working on performing confirmatory testing. There was one that was lost to care and he is - but he was into the correctional system.

In addition we have been able through this program to collaborate with multiple testing agencies in the metro area helping them link and engage their identified patient into care. Next slide.

In the near future we will be receiving funding from the state for the development of a mobile application which will allow us to expand clinical care beyond the clinicals.

This ambition is a tool that will not only remind patients of their appointments and when to take their medication, but will have the capability of allowing real time interaction with the clinical staff if they so desire and having the option of asking for refills, medical questions among others.

We will allow patient intervention in the initial phase of the development of the application to tell us what they think the application should have to make it versatile and useful for them. We have also developed a peer mentoring program to ease the transition and continuation of care. We are in the process of creating a space where patients receive life skills that will help them address some of their social issues and insecurities. Next slide.

I just wanted to end with this phrase from a recent article in the Clinical Infectious Disease Journal which I think we should all aim for. “Ideally interventions will be designed to facilitate seamless progression from diagnosis to suppression through collaboration among services, agencies, care providers, and researchers.” Thank you very much.

Dr. Harrison: Thank you very much Dr. Camacho-Gonzalez, very nice. I would now like to introduce Dylan Orr, Chief of Staff, Office of Disability Employment Policy, U.S. Department of Labor. Mr. Orr?

Dylan Orr: Good afternoon and good morning everyone. Thank you Dr. Harrison and thank you to the previous speakers. I am very happy to be joining you today on this important webinar.

As mentioned I serve as Chief of Staff in the Office of Disability Employment Policy at the U.S. Department of Labor. I am also the Department of Labor's federal representative on the national HIV/AIDS strategy.

I am here to talk about the importance of employment and training as part of the larger toolkit to address the HIV epidemic and improve the lives of people living with HIV including black MSM. Next slide please.

So why is employment important in the conversation? We know that unemployment and poverty are structural barriers that increase the risk of HIV/AIDS infections. Therefore it makes sense that training and employment services be a part of what is offered to communities at highest risk including black MSM.

Research also indicates that employment has the potential to improve health outcomes and improve the overall quality of life of individuals living with HIV.

One of the first studies in this area was an early qualitative study conducted in the early 1990s at Multitasking Systems of New York, one of the first HIV employment programs funded by the National Institute on Disability and Rehabilitation. This study was conducted after two physicians noticed their patients with HIV who continued to work were less susceptible to depression and lived longer than those who disengaged from work.

Another more recent study looked specifically at comparisons of disparities and risks in HIV infection in black and other men who have sex with men in Canada, the UK, and the U.S. This study showed that U.S. black MSM had a twofold greater odds of having a structural barrier that increases HIV risk than other U.S. MSM including unemployment, low income, previous incarceration, or less education.

This study also noted that low income, unemployment, incarceration, and low education are not only interrelated but also independently associated with HIV infections and recommended that social and economic environments should be considered and addressed to successfully stem disparities in HIV infection among black MSM. Next slide.

Another important study was conducted in 2008, 2009 by Dr. (Liza Conyers) from Penn State University in collaboration with the National Working Positive Coalition and the New York State Department of Health AIDS Institute. Among other findings, this study suggested that work positively impacts individuals' health and reduces health risk behaviors.

Among employed participants who were unemployed prior to their current job, 49% reported that their self-care increased since their current job, 46% reported an increase in CD4 counts, 21% reported an increase in medication adherence, 34% reported a decrease in alcohol and drug use, and 30% reported a decrease in unprotected sex.

It is also true that a smaller percentage reported negative health outcomes, highlighting the need for more research to better understand what characteristics may contribute to both positive and negative outcomes.

This study also showed than when unemployment - unemployed participants were asked if they could work, only 1/4 of men and 1/3 of women reported that they could not work signaling an increased need for employment services to help people living with HIV address barriers that are impeding their engagement in the workforce.

Also conducted in 2008, the HOPE pilot program was a community based participatory research project conducted by research at George Washington University in partnership with Whitman Walker Health with a focus on mental health and employment outcomes of African American gay men living with HIV. It involved the use of HOPE interventions over seven weeks.

During each of these three group sessions, participants learned various skills such as problem solving, job seeking skills such as how to create a resume, and how better to communicate with healthcare providers.

At the time of the interventions not all of the men were working but after three months follow-up three were enrolled in college, one had obtained employment, and three were actively seeking employment. There were significant decreases in depression and anxiety and increases in self-efficacy, self-esteem, medication compliance, and job seeking skills. Next slide please.

Most recently in 2013 the International Labor Organization conducted an international study on the subject of HIV and employment and issued a report that analyzed the findings of 23 studies on the relationship between employment and HIV treatment covering more than 6500 people living with HIV across the world. The ILO report found that people living with HIV who were employed are almost 40% more likely to stick to HIV treatment than those without a job.

For those interested in additional research in this area, please go to DOL's HIV employment page which includes the research compendium compiled for the Institute on HIV and Employment that we held along with the National Working Positive Coalition in 2012. Next slide please.

We of course know that employment has intrinsic value for individuals, families, and communities. I have heard it described as the single most normative activity in our society.

On a personal side, employment can provide us a sense of purpose and meaning in addition to income and independence. Employment also offers one of the only routes out of poverty.

When we help people enter or reenter the workforce we also help our communities and our economies. And in a world of limited HIV/AIDS resources helping one person obtain employment can also open up a space for others in greater need of services and support. Next slide please.

Importantly, the national HIV/AIDS strategy also included specific goals around increasing job skills and employment for individuals living with HIV, increasing support for employers, integrating people living with HIV into broader employment initiatives for people with disabilities, and addressing HIV stigma and discrimination.

With advances in treatment we also know that people can and are living long and full lives with HIV. While employment will not be an option for all, it can be an option for many.

The Affordable Care Act of course also presents new opportunities and options for people with respect to healthcare coverage which can impact employment possibilities for this community as well. Next slide please.

Now I would like to turn to some resources for HIV and employment. First, there are many public services available for employment and training including those in your local area. The first are American Job Centers which are funded by the Department of Labor. There are thousands of these across the country though they are called different things in different communities.

They provide job seekers both those with and without disabilities with services like training referrals, career counseling, job listings, and other employment related services.

Also while center programs are generally administered locally by community agencies, American Job Center staff will know about these programs and anyone seeking information on resources should also contact - ask the local agency staff about job search assistance, federal bonding, employer tax incentives, education and training. To find your local center go to servicelocator.org.

Every state also has one or two vocational rehabilitation agencies. These are funded through the U.S. Department of Education and provide counseling, medical and psychological services, job training, and other individualized services specific for individuals with disabilities and these can be an important resource to individuals living with HIV.

Vocational rehabilitation agencies also accept tickets under the Ticket to Work program. To find your state VR agency, go to 1.usa.gov/ncvvvr. Next slide please.

Ticket to Work employment networks are entities that contract with the Social Security Administration to accept tickets and provide employment and training services to people with disabilities as part of the Ticket to Work program. This is a program for individuals who are currently receiving SSI or SSDI benefits.

To find an EN in your area you can go to www.yourtickettowork.com and you should also look for Workforce Incentive Planning and Assistance or WIPA in your area. The SSA WIPAs offer benefit planning and assistant services to all SSA beneficiaries with disabilities who are over the age of 18.

When it comes to going back to work or going to work for the first time, one of the first concerns can be about benefits and potential loss of benefits. So it's important to know that there are safeguards in place that allow people to keep their benefits while they try out work and also to quickly return to benefits if employment doesn't work out. For more information about those work incentives and safeguards go to www.socialsecurity.gov.

The Job Accommodation Network is another important resource to know about. This is a free service offered through my agency ODEP that provides free expert and confidential consultation to employers and employees on job accommodations as well as other resources for people with disabilities including people living with HIV. You can learn more at www.askjan.org or call 1-800-526-7234 or 1-877-781-8403 on TTY.

I am also proud to announce that on March 24 a historic rule was issued by the Department of Labor updating the regulations under Section 503 of the Rehabilitation Act. Section 503 covers non-discrimination and affirmative

action obligations for federal contractors as it relates to the employment of people with disabilities.

This new Section 503 rule establishes a 7% goal for the employment of people with disabilities in every job group of a contractor's workforce. This is an important regulation for people to know about as people living with HIV can certainly benefit.

We also know that the African American community experiences disproportionate incarceration rates so when we talk about employment services for the communities specifically black MSM, it is also good to be aware of resources related to reentry.

There are numerous resources in this area and I do want to mention that DOL has a reentry program which includes a training to work adult reentry competitive grant program that helps men and women participating in a state or local prison work release program gain the job skills necessary to succeed in an in-demand occupation upon release.

Funding for this program is $30 million this year. It is typically announced in February. You can find out through announcements about grants and contracts out of DOL on www.dol.gov/email.

There is also a federal reentry council, a collaborative initiative supported by numerous agencies that has worked to address these issues and provides resources including the results of transitional job reentry programs, research, and a helpful series of reentry myth busters, all of which can be found at csgjusticecenter.org. Next slide please.

I also want to direct you to ODEP's HIV web page that includes numerous resources on HIV and employment, www.dol.gov/odep/topics/hivaids. This is a great resource if you're looking for a deeper dive into the research in this area, effective practices among HIV service providers, and an overview of resources such as the Institute on HIV and Employment Report.

As we speak DOL and HUD are also working on an online Getting to Work training curriculum for HIV service providers and this curriculum will incorporate the lessons learned from HUD's Getting to Work initiative, DOL's work in this area, as well as the research, success stories, resources, etc. from our partners like the National Working Positive Coalition and stakeholders across the country who have incorporated employment and training into the services they provide the HIV community and with great results. Next slide please.

I would like to end with some ideas of things you can do today to impact this area. One of course and probably the easiest is to start a conversation at your agency or organization around employment and training -- what has been done in the past, what can be done going forward.

One of the ideas is to establish a partnership with one of the public resources I mentioned before, a local American Job Center, your state VR agency, an employment network, or a community organization that may already provide employment services that you could partner with in your area.

One idea is to send someone from your agency or organization to talk to them about the community you work with and how you're working with them and how you can partner together or invite someone from their side to come speak to you about the services they offer.

Learning about how other service providers have established programs in their organizations or agencies is another great way to start. The Institute report I mentioned has some tips there as well as the web page lists a list of HIV service providers that have developed programs with successful outcomes.

Other ideas are peer-to-peer support groups for people to discuss their employment histories and goals and resources dedicated to skill building or job searching such as a computer room, computer lab.

Other changes could include adding questions on an intake form related to employment status, employment history, or employment goals. In general adding questions around employment status to other solicitations for information related to HIV can help us better understand what the employment gaps and needs are going forward.

Of course another option is to acquire dedicated staff funding and build an internal program yourselves around employment and training with regular evaluation of results. Next slide please.

This quote from a former board member of the National Working Positive Coalition has stayed with me since it was first shared. “The first 15 years of the epidemic were about dying -- first quickly, then a little more slowly, but it was all about dying. The next five years were about not dying. It is my hope and belief that the next era of HIV/AIDS epidemic is about living, really learning to live fully with HIV.” Thank you very much.

Dr. Harrison: Thank you Mr. Orr. I would now like to introduce Dr. LaRon Nelson, Dean’s Endowed Fellow in Health Disparities, Assistant Professor of Nursing, and Associate Director of International Research, Center for AIDS Research, University of Rochester Medical Center.

Dr. Nelson is joining us from overseas and in the event that he is not able to maintain a phone connection, we pray that does not happen, we will move into the Q&A. Dr. Nelson you may begin.

Dr. Nelson: Yes hello, can you hear me?

Dr. Harrison: Yes.

Dr. Nelson: Okay good. So that slip up we hoped wouldn't happen actually already happened. So luckily we planned for this and I'm calling back in on my cell phone. I don't have access to the slide webinar so I'm just using the slides on my laptop so I'll just ask the operator to go to the next slide.

Okay, so I'll talk to you today, first of all I'm glad to be able to be here to talk about this topic. I live in the United States and am a black MSM so this appeals to me personally, clinically, and scientifically. I will talk about improving the HIV care continuum for black MSM from a variety of perspectives including a research perspective. Next slide.

I will focus on three areas. One will be the role of the primary prevention in the HIV care continuum, the use of HIV and STI surveillance data (unintelligible) outcomes and also directions for future research. Next slide.

So the first thing we'll talk is a little bit about primary prevention and the HIV care continuum. What I would like us to think about is the time to start thinking about linkage and retention is not at diagnosis but it's actually pre-diagnosis.

If you think about making a diagnosis as a downstream event, what we need to really be focused on is upstream interventions and what activities need to be done to prepare people for that downstream event, the diagnoses and what can we do to support people to have successful kind of outcomes if they actually do have HIV.

So when you think about that from an approach of HIV cascade of care but that is really in supporting housekeeping behaviors or patterns that support HIV care cascade.

So when we think of routine testing not just focusing on HIV testing but also focusing on STI testing which is a behavior that we look for from the people who (unintelligible).

Also if we think about not just as a primary prevention tool but potentially powerful primary prevention tool but also engagement as an opportunity for negative MSM to get experience in HIV antiretroviral medication, having explained to being engaged in some related clinical procedures and processes which might if in fact some of them (unintelligible) may be mystified in HIV care which could be engaged in HIV care. So establishing positive healthcare experiences upstream could help black MSM if they find themselves diagnosed with HIV downstream. Next slide.

Also think about HIV testing not just as sort of activities for someone to know their status but really thinking about an entry point into the care continuum. Looking at strategies for targeting black MSM who are at the highest risk for infection.

I have a slide at the moment saying that it’s at risk but focusing on those that are at highest risk and using HIV testing as an opportunity to support more

frequent HIV testing, frequent rapid HIV testing for that matter communities of care.

So really thinking about testing not just as a way to know people's status but to really target MSM who are most likely to care convert and use it as an opportunity to support early detection and linkage to care.

(Unintelligible) around the country, a lot of them are being disseminated through the process. The opportunity is there to not just focus on behavior outcomes but also healthcare engagement outcomes. This includes being engaged with clinical partners to support some of the programming using other opportunities to get people linked to insurance access, whether (unintelligible) opportunities.

And also giving a link to primary care homes. These are things that are necessary to establish behavior patterns and (unintelligible) prior to that diagnosis that have a bit more sense of coherence about the systems if they do find themselves diagnosed with HIV. Next slide.

We'll talk a bit about using HIV and STI surveillance data. This is - we talked about (unintelligible) before but (unintelligible) we use the patterns to support the care continuum through the ability to access surveillance data.

(Unintelligible) CDC which one thing to talk about is establish protocol to share data between programs whether it's the STD program or TD program, they could be on a case and maybe look at that person (unintelligible) but they could set up protocols that would allow them to contact and use that opportunity to get that person back into a system, back into care.

(Unintelligible). And from jurisdiction, I'm not sure if this is all over the country, but can access regional health information networks through a particular (unintelligible) departments can access data called public health (unintelligible) diagnostic data, laboratory data, health department would need to access that and notice the better support care. Next slide.

Another way to use local data, I should say HIV data, it could be local, it could be statewide, is to use it to identify high risk HIV negative black MSM. So Dr. Robbins earlier talked about our epidemics being local, this is exactly the point here.

There may be local (unintelligible) conversion but we should be thinking about trying to identify what black MSM would be most likely to convert and then focusing on them (unintelligible) activities to support linkage to care is to be (unintelligible) regional health information exchanges in part to manage HIV testing for people who are (unintelligible) who are testing less frequently than recommended to support more frequent testing and early detection.

(Unintelligible) engagement, again that's the idea that more frequent (unintelligible) pre-diagnosis that these processes won't be so unfamiliar to them. Next slide.

(Unintelligible) can also be used to support retention and care. So possibly to monitor trends and what labs are being done, how to identify black MSM who are having less than - less frequently than what is recommended. Those would be at risk (unintelligible).

This is an opportunity for (unintelligible). That could also be a capacity to do field work to support clinics to engage black MSM that may not have the same expertise and capacity that (unintelligible). Next slide.

And so now my focus is on future (unintelligible). So just a few ideas to show these. Next slide. So the first thing is I think you have heard this throughout this webinar today that there really is a need for collaboration between PDA clinics, health departments, and black communities or interventions designed to support HIV care continuum.

(Unintelligible) using home grown access for engaging black MSM and actually work with them on a basis. Sometimes (unintelligible) primary care providers test providers can activate (unintelligible) and care coalition systems work with identifying patients who may be at high risk for infection. So engage an HIV care continuum (unintelligible) with HIV and also provide medical homes for black MSM. Next slide.

And as we mentioned before health departments are an important role too for including the surveillance data capacity. It can be clinics that are run, it can be (unintelligible), capacity to do field work for client follow-up.

So ways to really not just think about, you know, how we may have health department partnerships that support (unintelligible) that involve these stakeholders and figure out how to best construct and again (unintelligible) systems designed to (unintelligible). Next slide.

The next thing is really to develop and test new service delivery models. It is true that one size doesn’t fit all when it comes to service models in communities. I have heard this before but it has really been a problem for (unintelligible) local innovation and local relevance.

I think what we need to know is what models that address the factors impacting epidemiology with MSM, what models best harness the assets of

CBOs or health and human service systems, what fits with local social, cultural, and political realities (unintelligible) complex, and then how to test new ways of using private health information.

Our focus is for region health information innovations but those are relatively recent phenomena. You don't know how that can be leveraged for improving HIV care continuum (unintelligible) especially more focus on that. Next slide. Next slide.

One example, I guess (unintelligible) in Rochester (unintelligible) model. So this model was conceptualized from the current model used in the county health department. This is a partnership between the Monroe County Department of Public Health and the University of Rochester Medical Center including the School of Nursing how they did the training.

So in this model we used surveillance data to identify MSM at the highest ongoing risk for infection including black MSM. This includes MSM with recent diagnoses with gonorrhea, Chlamydia, syphilis, and (unintelligible).

And so the new model is to be tested is instead of having a black MSM or MSM in general come to the clinic for a routine test and see a public health nurse, they would go to them or to some other place with the nurse and the client eventually together for HIV testing and then using social media to maintain regular contact with the MSM with the goal (unintelligible) this model can support (unintelligible) for frequent HIV testing for high risk. Next slide.

Okay so care coordination is something that is not recorded on time but (unintelligible). But what is central under the Affordable Care Act (unintelligible) but across many health diagnoses and maybe health in general,

it is a deliberate organization of healthcare activities that are non-duplicative, repetition of information and testing procedures and communication and really utilize patient preferences in how the care is organized and delivered.

It does require collaboration between agencies. And I think possibly the question is how are different models with care coordination's related to the HIV care cascade outlines. I think this requires people to use some of the current models that are conceptualized, different models that make more sense for their jurisdiction and for the population. Next slide.

There was a study of HIV Prevention Trials Network, study that Dr. (Unintelligible) and Dr. (Unintelligible). It actually does use the care coordination model that is (unintelligible) behavior counseling component.

The focus of this is really on looking at whether and how care coordination can support Prep initiation and Prep adherence among black MSM. But it does have implications for I think the HIV care continuum. It does simulate things like talk about in this presentation in terms of (unintelligible) support behavior pattern for (unintelligible). And they some of the antiretroviral lab work and procedures (unintelligible).

So I think looking at some of these models as in HPTN 073, thinking about how some of these models support or impact outcome of the (unintelligible) infections. Next slide.

And then the final one is really thinking about providers in a healthcare settings and structure intervention targets. The challenges in care is not just about black MSM attitudes and behaviors but is also about healthcare provider attitudes and behaviors.

And I know I'm a clinical provider myself. I know a lot of us believe that our practices are safe and welcoming. But it's not enough that we think we are safe and welcoming to black MSM but to actually engage and remain in care. Next slide. Next slide.

So this is the final slide, some of the interventions I think we should think about is targeted healthcare is things like anti-racism, anti-oppression frameworks, anti-stigma interventions that includes anti-stigma, anti-homophobia, and that environment or encourage support. You have (unintelligible) and how it is structured and delivered.

And then the evaluation really has to be different from other things that I have typically seen. It's more - it can't just be about increases in competencies or skills or knowledge. We really have to understand how these impact perceptions and how it actually impacts on their linkage to care and their willingness to be retained in care. And then some feedback that allow you to reassess and make changes as necessary. Next slide. Okay thank you for your time.

Dr. Harrison: Wonderful, thank you Dr. Nelson. At this point I would like to thank all of our speakers for their very thoughtful presentations and inform listeners that we will now begin our question and answer period.

We have our speakers available to answer your questions. Please if you can keep your questions brief and that will allow us to answer as many questions as possible.

In a moment the operator will give you instructions for asking a question live. But if you're not able to do so you may also email contact@aids.gov where we will be able to respond to you as well. Operator, you may continue.

Coordinator: Yes thank you. And to ask a question please press Star 1 on your phone, unmute your phone, and record your name clearly when prompted. Again to ask a question press Star 1 on your phone and record your name when prompted. One moment please for any incoming questions. And we have a question from (Brian Bob Goldman). Your line is open.

(Brian Bob Goldman): Well two quick questions. One, when can we expect maybe a copy of these awesome slides. And two, for the last speaker, the mention of a possible like a station healthcare worker in the field to reach all the young MSM by social media means and being able to meet them in their community, is that a position that you guys have created and piloted or is that just a suggestion possibly something that we're looking for funding for by the CDC? Because that seems like an interesting direction to take.

Dr. Harrison: I can answer the first question, the first part of the question, this is Tim Harrison. The slides are already available on aids.gov. If you go through the webinar section of the site you can already find the slides. And Dr. Nelson, your response? He may be talking on mute. Dr. Nelson? Oh we can come back to that. We'll find a response to that question.

Dr. Camacho-Gonzalez: Dr. Harrison if I can try to answer that question, this is Andres Camacho.

Dr. Harrison: Sure, please Dr. Camacho.

Dr. Camacho-Gonzalez: With the MACARTI - what we do with the MACARTI trial is - I'm sort of the PI of that intervention and I am available and I have been actually in testing events where patients have been identified. Once they identify the patient they usually call me and I go to the venue and start the

linkage process from the venue from a clinical standpoint. And then we sort of drive the patient towards the clinic and we continue the intervention there.

But I'm - as a provider I think sometimes the patient feels very comfortable when the physician gets to the testing event or the testing venue where - and kind of feels that first contact with what is going to be their clinical care from later on.

(Brian Bob Goldman): Okay thank you. It sounds like a model we use here for, you know, on call physician as well as social workers if we're ever testing out in the community. Maybe my question wasn't specific enough.

Has there ever been a model like this used for just young black MSM in general whether they have been confirmed positive or at a testing event period? Are they able to request maybe a healthcare worker come out and talk to maybe two or three of their friends or maybe if they have questions in general or possibly even I don't know, like doing lab work on a, you know, sort of meeting the patient who isn't able to attend their appointments at the healthcare facility.

Dr. Camacho-Gonzalez: That I know of no. When I go to testing events there's people that they want to talk to me either they are positive or negative and we discuss things with them. But I don't think it's a standardized practice yet.

(Brian Bob Goldman): Okay.

Dr. Valdiserri: This is Dr. Valdiserri. The closest that I know, and it's not exactly what you're asking but I know that in one of our state health department programs they have provided their disease intervention specialist, the DIS, with

specialty training. This isn't just for black MSM but really for all vulnerable populations who they know are positive but have fallen out of care.

And they - we just heard about this program this past week. So it is kind of related. It's not exactly what you're talking about but I think it really gets to the issue of reaching out to clients.

And the other point that the health department program made is that they really take pains to identify candidates who have the kind of social work skill set and can be really, you know, that have a good rapport that can reach out to all clients who they know are infected but haven't for whatever reason have fallen out of care. But that's the closest that I know that some states are trying to implement that kind of model.

(Brian Bob Goldman): Okay that's great, thank you.

Dr. Harrison: Do we have another question Operator?

Coordinator: Yes we have one more question, they did not record their name. If you pressed Star 1 your line is open.

Woman: Yes hello. I'm calling - somebody did ask the question about the slides and I'm glad that we can download those from the website. In our demographic we are seeing a great rise in syphilis infection in most young MSM that are testing. They're testing positive for syphilis and then coming in with a secondary HIV, you know, a positive result.

So if anybody would want to speak with - speak to that, we're seeing a lot of between 18 and probably 24 there has been a great increase in our program within the last 6 months where in the previous years we haven't been seeing

that many new infections in that demographic for MSM. So I know the social media was really one of the ways that we were trying to, you know, address it but if anybody has any other comments or statements.

Dr. Robbins: This is Ann, can I attempt to answer or comment on it?

Dr. Harrison: Yes go ahead.

Dr. Robbins: Okay great. You know, one of the things that all the presenters talked about in some way was using the information you have to try to get in front of things. And so I'm glad you mentioned co-infection because it does present an opportunity.

Unfortunately what you're talking about is a trend I think that most communities have seen where we have a simultaneous diagnosis or even a syphilis diagnosis that comes in after the HIV diagnosis has been made.

What we have also noticed as a result of doing, you know, some provider interviews and also matching our data across STD and HIV is that the presence of a gonorrheal infection in men is an event that can really predict, you know, someone becoming positive.

So one of the things that we're trying to do with this is work with providers to have them understand the importance of recognizing, you know, this as a sentinel sort of event and a chance for intervention and referral and work and counseling for the client who has just been diagnosed with gonorrhea to do the appropriate testing in terms of not just getting a genital sample.

But also to work with providers more broadly to make them aware of the issue, to make - to work with providers and provide them support about, you

know, what they might need to do to make their practice more welcoming, and share information with community members and have them really drive the way that they want to get the word out about that.

We have had several different communities in Texas face this challenge and each one of them has designed their own sort of step forward advocacy, this is how I'm going to let my community know what is going on.

And we have been able to be there to say provide support for both social media or targeted media and to do the typical health department provider alert type of things. But it really does take the three part collaboration with the health department, the health systems, and the community systems.

Dr. Harrison: Great, thank you. I'm going to read a question that came in through our aids.gov website. This is for Dylan Orr. He says he spoke very eloquently about the impact of employment initiatives on the lives of PLWH. Can he also talk more about any models of employment interventions as part of a comprehensive HIV prevention approach for black MSM?

Dylan Orr: You know, the answer to that question would be quite lengthy so the thing that I would do is direct you to that Institute report that I mentioned which does compile a number of HIV service providers and practices that they have used in terms of employment as an intervention among other services that they are providing.

Dr. Harrison: Okay thank you. And Operator do we have additional questions online?

Coordinator: Yes I'm showing three questions in the queue. The next one is from (Sudha Sharma) from New York State Department of Health. Your line is open.

(Sudha Sharma): Yes I would like to just ask, could you please repeat the website again for these presentations?

Dr. Harrison: Sure, that is aids.gov/webinar.

Coordinator: Okay thank you and we have (Derrick Wilson), your line is open.

(Derrick Wilson): Good afternoon and thank you for the presentations. My question is particularly for our panelist from Texas. I'm wondering in all of the work and the research that you have done, very often when we work with providers here in Philadelphia the providers tend to look at interventions and that are geared towards black MSM that are gay identified. You can find them in the clubs or in the ball community, wherever it may be.

But I'm really - we have really been pushing our providers to move beyond what can be termed low hanging fruit and to really work with non-gay identified black MSM.

And I'm wondering is there anything happening particularly in Houston where there is, you know, a large community of black gay men? I mean, it's kind of a hub for black gay men in this country. Is there anything that you're looking at that is effective in terms of reaching non-gay identified black MSM?

Dr. Robbins: So in terms of sort of community outreach and in terms of clinical practices?

(Derrick Wilson): Yes and retention as well, yes.

Dr. Robbins: And retention. Okay wow. You know, the most effective way and, you know, Houston is a good example of this also but, you know, there are examples of

this all over the country. Really it takes going deep into networks and sort of snowballing your way through, again that idea of community building.

But I also think another key - so that's not a really great answer but I think in terms of trying to build a sort of safe space for that. But I think even more important in terms of reaching non-gay identified men is that we need to do a much better job in the United States of doing sexual health assessments across the board.

Our sexual history taking practices are really poor. And at that point if you have that welcoming, comfortable environment and you do a good comprehensive sexual history just in terms of primary care, that creates an opportunity for a patient to talk about stuff that's not about orientation focused but more about how to stay healthy in relationships physically, mentally, so on and so forth. Does that kind of get at a little bit of your question?

(Derrick Wilson): Oh a little bit. I was really more looking at any models that may be out there that really speak to just effective work in reaching out to non-gay identified black MSM.

Dr. Robbins: You know, I would have to go through and I would want to talk with more colleagues. At this time I'm sorry, I'm pulling a blank. Maybe the other participants about a particular detail of an intervention.

Dr. Harrison: Dr. Nelson or Dr. Whiteside, do you have any thoughts on this?

Dr. Nelson: This is Dr. Nelson. I really - my comment is going to be what Ann said that's really about creating environments where people are able to talk more about their behavior and not their orientation.

And I don't think that's not a practice anywhere but I'm in Ghana right now and most MSM in Ghana don't identify as gay. So it creates a particular challenge because most you try to find is people who may be at risk for based on their behavior but who don't identify as gay.

And some providers here, a few of them have figured out a very interesting way about how they take sexual and social histories that can sort of pinpoint people who may be without necessarily disclosing immediately that they have sex with other men. But somehow they get there.

And I don't know if that is written down, formalized anywhere. I could try to find that out. But there are ways that providers have been able to get people - to identify those men in a context where almost nobody - there is no gay club to go to find people. So I think you'll be interested in possible models happening in other places that could be useful possibly for what you're trying to do in Philadelphia.

Dr. Harrison: Great, thank you. I have one question here coming in from our aids.gov site and this is for Dr. Whiteside. You referenced a CDC supported HIV testing initiative for black MSM. Is this a new initiative? If so, is a funding announcement forthcoming or are these grants already in the field?

Dr. Whiteside: To my understanding - the information that I provided folks with was available on the CDC website. We actually have a website that specifically speaks to - it's a fact sheet for black MSM.

From my understanding that initiative, I think it may be currently going on but before I actually say that I probably - the best thing for me to do would be to find out. So that's a question that I could provide later for individuals who are on the call.

Dr. Harrison: Fair enough, thank you Dr. Whiteside. Operator are there additional calls?

Coordinator: Yes we have two in the queue right now. (Marcus Stanley), your line is open.

(Marcus Stanley): Hello everyone. I had a couple of quick - just two quick questions for you. The first question I had was how was linkage to care defined? How is linkage to care defined? Was it going to the initial, just making your first initial medical appointment? Or basically just how was it defined?

Dr. Harrison: I'll turn that to both Ann Robbins and to Dr. Camacho-Gonzalez.

Dr. Robbins: I'm sorry, I was busy taking mute off. Do you want me to try to answer this question?

Dr. Harrison: Sure, in Texas how do they define linkage?

Dr. Robbins: In Texas. Well we kind of follow the - everybody kind of does it the same way. We're looking for evidence of sort of a kept medical appointment in the first 90 days after the date of diagnosis.

So we're going to look at things like laboratory results, we're going to look for, you know, evidence of a clinical visit through provider records and Medicaid records and insurance records. And we're also going to look for evidence of a filled prescription. And those are nice proxies.

Dr. Camacho-Gonzalez: The same way in Atlanta, we look for an appointment with a physician in the first 90 days after diagnosis. That will kind of be reflected by what Ann just said, like labs being obtained and medical history being completed.

(Marcus Stanley): Okay and my second question goes back to ecological framework. As it relates to the interpersonal factors, the black MSM, you know, the intimate partners, family members, and such. Like what kind of interventions out there that targeted, that was the most effective that actually took that approach and tried to increase black MSM proportions of (unintelligible)?

Dr. Harrison: Dr. Camacho-Gonzalez, do you want to take this one on?

Dr. Camacho-Gonzalez: I didn't hear it well. Can you repeat the question for me again, I'm sorry?

(Marcus Stanley): Going back to the socio ecological framework where we were talking about the interpersonal factors like the intimate partners, family members, friends; social network. What interventions are out there that was most effective in taking that approach to increase the proportion of black MSM being linked to care?

Dr. Camacho-Gonzalez: Well I think part of what I think needs to happen is sort of at the beginning the patient needs a lot of support. So kind of having someone at least interventions either through a peer navigator or through out of the clinic support needs to happen in order for the patient to be - for it to be easier for the patient to be retaining care.

Sometimes patients who are newly diagnosed and especially in the adolescent population, they don't have - they are either away from their houses or in schools out of where they normally live and they have no one to help them maintain their linkage and retention in care.

And so what I found and kind of the clinical practice is if you are able to establish some sort of support for that patient either through family members, through friends, or through a peer navigator, those patients usually tend to do a lot better than if they're on their own.

(Marcus Stanley): Okay so there has been no intervention to actually target those relationships in trying to strengthen the care continuum?

Dr. Camacho-Gonzalez: No there is some interventions with peer navigators that have shown to be effective. In terms of social networks I think a lot of work has been done to try to identify other patients in those networks that are positive and trying to link those patients as well in care.

Because a lot of our own patient networks you will find a lot of positive patients. So there's interventions looking at those networks trying to sort of test and bring those patients into care as well among the social networks.

Dr. Valdiserri: This is Dr. Valdiserri. Just to also briefly add to that, I think it's fair to say that the - when we're talking about what works and what evidence do we have that something works, it's important to recognize that there are still a number of gaps particularly when we're considering specific populations like for instance young gay black men.

And one of the, you know, ideas behind this call also is to try to raise up and identify areas where further whether it's operational research or clinical research could take place. And I think Dr. Nelson touched upon that very nicely.

I would say that in other disease conditions, particularly other chronic disease conditions, there is a fair amount of work showing generally that family

involvement or involvement of a significant other generally improves outcomes, adherence outcomes, keeping appointments, etc.

So, you know, I think there are some lessons learned that can be taken from what we know about other disease states that could be applied to HIV. But clearly I think your question identifies that, you know, there is still some pretty significant gaps when we look at implementation science or trying to kind of understand from an operational point of view what works best for particular populations.

Dr. Robbins: And can I add something to that as well, this is Ann Robbins.

Dr. Henderson: Sure please, go ahead.

Dr. Robbins: Yes so in addition to that sort of immediate identification of a support network which routinely happens through counseling and testing if it is done well, and also through public health follow-up if it is done well. That's a best practice. You know, let's name a few people that can help you.

There are lots of examples maybe not in the literature but out there, you know, in practice that encourage family members, significant other participation doing education sessions, including them in some counseling and planning and things like that.

But I also want to point out that beyond that initial encounter and retention we need to do work on the larger environmental scale to create - to increase the number of people that would be supportive of these young men.

And part of that has to do with the stigma and the fear and anxiety that people may have about disclosing their sexual identity, disclosing their HIV to the

people that might be very supportive of them or have been supportive in other aspects of their life.

So in addition to work that we do with individuals always keeping our mind on the fact that working in the broader environment to decrease homophobia and to decrease stigma is going to enhance the support of persons in HIV care whether they're at the beginning or middle of their encounter with the system.

Dr. Henderson: Thank you Ann. Is there another question in the queue?

Coordinator: Yes there's just one more from (Brian Goings). Your line is open.

(Brian Goings): Hello, can you hear me?

Dr. Henderson: Yes.

(Brian Goings): Okay, one of my questions was kind hit on and hit around but I wanted to know how do we or what are some of the suggestions that I guess you'd say the government want us to do as far as reaching the younger teens.

Because I know for a fact in my state of North Carolina that there are teenagers who are sexually active but we can't reach them because of their - one way that we can reach them is through the school but when we go to the school we are limited to what we can talk to them about and there is limited information that a school will allow inside of the school.

The next time that we see them are when they are hitting their numbers as in, you know, HIV positive or having syphilis or some kind of other STI, STD. And so then this is like well how do we reach them if we keep running into barriers, you know, that everybody - the state may have put up.

And most of the time these younger teens, they're being sexually active because they get online, they get on these dating sites/sex sites, they lie about their ages, they meet up with people, and they have sex not even thinking about the consequences.

And of course, you know, if somebody is already HIV positive and they're talking to someone who is younger than them, they're going to use their being naive and just use it against them. So how do we kind of block that or address that? And my next question is if there was more information on the Internet based testing that I saw. I was kind of interested in that.

Dr. Henderson: Okay I put that to the panel, particularly Dr. Nelson. Do you have the first part of his first question, reaching the younger folks?

Dr. Nelson: Yes, I think the - it's an important question. There may be two things here. One is I think young people have a lot of ideas. I mean, they can tell you how to reach them. So I would say really talking to them.

I know the challenge then is the young folks will get ideas that won't be acceptable to the people who make decisions about how you reach people. So one is really reach out to young folks and really find out what - they will tell you what are the best ways to access - to get to them.

And I think the second part is really a public advocacy component because it sounds like, you know, the challenge is the folks who I don't know, organize and make regulations about your programs have particular restrictions.

So I think there needs to be some advocacy around really taking what young people tell you what needs to happen to get to them and making sure people

who make policy or who have authority over these issues hear from the community. But they need to change to be more responsive to this epidemic particularly based on the feedback you get from the youth in the community.

Dr. Harrison: Great, and I have a related question here that came through aids.gov and it's from the president of the National Association of Advancement of Colored People College Chapter.

And he wants to know can anyone give advice or provide information about past successes that help make people particularly in the 18-25 age range more comfortable to participate in HIV related events. And he noted that there was a problem, that it's hard to solicit participation for events with this topic. It's still very taboo. And so the issue of stigma sort of resonates particularly in this college campus setting. Does anybody want to address that?

Dr. Robbins: So is the stigma - well of course it was sent in but it's, you know, the type of stigma, that's not uncommon, the feeling that I want to shy away from something where I'm not sure how I will be welcomed.

One of the best approaches to that as the previous respondent indicated is to ask your target population what is the best way to do this. But I think the other thing that we have learned through lessons is not branding something as an HIV event can go a long way towards allowing people to sort of participate a little bit more comfortably. Casting it in terms of a broader topic like men's health or sexual health even, you know, can be very helpful.

Dr. Camacho-Gonzalez: My advice also would be persistence.

Dr. Robbins: Yes there you go.

Dr. Camacho-Gonzalez: I think as you approach people with sort of this kind of topics will make some of them uncomfortable but if they - if you continue pursuing this and kind of explaining your reasoning behind and kind of backing it up with the data of your state or wherever you are, I think that will help open some eyes and you can slowly get in.

But it's a difficult task and it's just a matter of not kind of - not giving up in the first attempt. And as time goes by and people understand that you're really invested in what you are trying to do I think they will - they are more open minded and they allow you to start going in.

I think for the other person that was asking about the younger population, I think you're right. It's very difficult especially in the southern states to get into areas where we can kind of get hold of teenagers. And as you said schools are sort of closed and are difficult to get in.

And I think one of the approaches would be more not I'm going to go there and do HIV testing in the school population but we're going to do a health assessment I think in school and the school I think that's important just to make it more generalized. Because there is no school that wants to be identified as a school that has HIV; that they are finding HIV infected patients in their school. So that's one approach, to do it more as a health intervention.

And then also getting the parent association in your pocket so they can kind of help you in getting to the schools as well and do it like in - not in one school, do it in multiple schools so they're not like targeting one school. I think that is an approach that may help.

Dr. Robbins: You know, if I can just - I'm sorry, just chime in one more thing to understand. When you talk to adolescents about where they like to get their

information, not necessarily where they get it but where they would like to get it, they mention their parents. And so again a focus on, you know, PTA meetings and parent association meetings, you know, can be a great place to have parents be more comfortable with that.

But, you know, kids are interested, teenagers are interested. They may not act interested but they are interested in what their parents have to say or what their parents, you know, can relate to. So, you know, they may get more of their information from the Internet but they really like to be able to get more information from their parents too.

And also to keep in mind, school may be not the best place to get open dialog. We have had good open dialogs at churches, we've had good open dialogs in community centers; we've had good open dialogs in coffeehouses. Again, getting some advisors from that age group to tell you how to set it up and what they want to talk about is the greatest guide that you can get.

Dr. Harrison: Great, thank you Ann. We have certainly gone over our prescheduled time but we'll take one more question if there is one in the queue. If not we'll take one from aids.gov.

Coordinator: I'm showing no questions in the phone queue.

Dr. Harrison: Okay then I'll go with the question that we got from aids.gov and it has to do with policy level interventions. Are there those that have shown some effectiveness and what is needed? And I'll put this question to any of the panel who may have some ideas about policy level interventions. No takers?

Dr. Nelson: This is Dr. Nelson. I'm not an expert on policy but I will say one thing that I heard coming up recently was about Medicaid expansion in some states

particularly in the south. And that has come up to be a major barrier for care. And I think it will significantly impact black MSM.

So I think one policy would be for folks to talk to people in their state houses around how to get Medicaid expanded in some states that aren't doing so. I think because you can find that black MSM falls between the gap of those who don't qualify for care under the Affordable Care Act and who may not be able to benefit from Medicaid. So that could be a policy that could have a significant impact on black MSM. I think they may be more likely to fall within that gap, particularly poor ones.

Dr. Harrison: Great. Anyone else want to respond to this question? No, great. Well we have had a great round of presentations and conversation and Q&A. And I just want to thank our speakers and our listeners for staying for nearly two hours for participating in this very important webinar.

I hope it has touched on some important questions and issues and has been sort of food for thought so we understand that this is really an opportunity to engage more further, more deeply into this issue.

As I mentioned earlier, the speaker slides are currently available on aids.gov and a recording of this call will be available within a week on aids.gov. Thank you all for your participation in this call and this call will now be ended.

Coordinator: Thank you for your participation. This concludes today's conference call. You may disconnect at this time.

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