What Happens When PrEP is Implemented? Experiences of a High Volume Community Based LGBTQ Organization in New York City

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Background:

Following the Food and Drug Administration (FDA) approval of Truvada for Pre-Exposure Prophylaxis (PrEP) in July 2012, Callen-Lorde Community Health Center (CLCHC) implemented what would be one of the first and largest PrEP programs in the United States.

Table1. Demographic information of Patients seeking PrEP

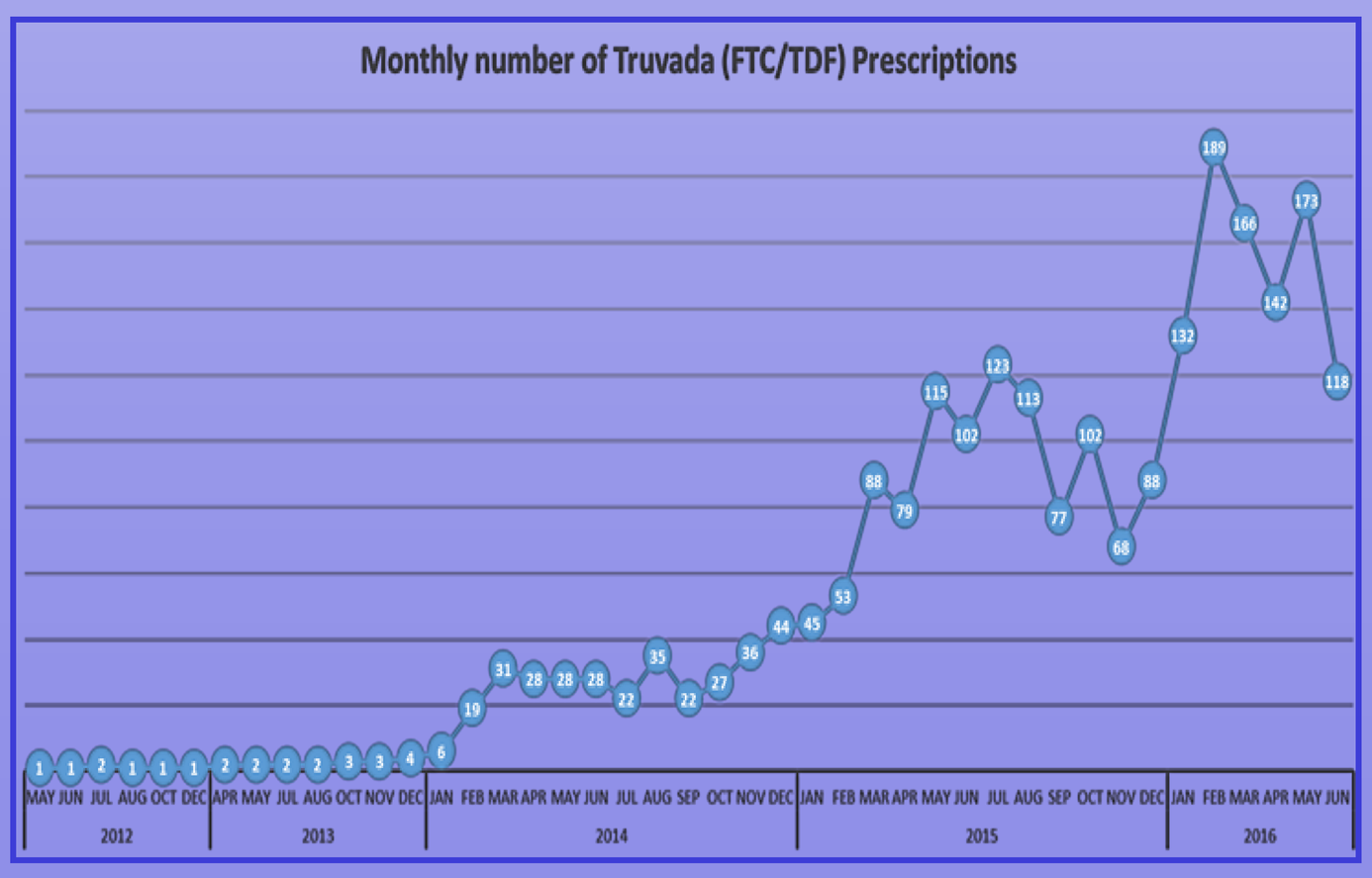
		n	%
Number of Truvada (FTC/TDF) Prescriptions		2324	100%
Ethinicity	Hispanic or Latino	495	21.30%
	Not Hispanic or Latino	1343	57.79%
	Unknown / Not Reported	486	20.91%
Self-Reported Race	American Indian/Alaska Native	11	0.47%
	Asian	138	5.94%
	Black/African American	274	11.79%
	Latino	1	0.04%
	More than one race	125	5.38%
	Native Hawaiian/Other Pacific Islander	15	0.65%
	Unknown / Not Reported	370	15.92%
	White/Caucasian	1390	59.81%
Gender Identity	Cis Female	26	1.12%
	Gender Non- Conforming	33	1.42%
	Cis Male	2093	90.06%
	Trans F	131	5.64%
	Trans M	31	1.33%
	Unknown/Unreported	10	0.43%
Sexual Behavior	Bisexual	68	2.93%
	Declined	78	3.36%
	Gay	1957	84.21%
	Queer/Something Else	101	4.35%
	Straight	120	5.16%
Age group	<= 24	307	13.21%
	25-34	1212	52.15%
	35-44	540	23.24%
	45-54	207	8.91%
	>=55	58	2.50%
Insurance Status	Public Insurance	581	25.00%
	Private Insurance	1345	57.87%
	Uninsured	398	17.13%
Self-Report Reason for Starting PrEP	Serodiscordant	105	4.52%
	Participant in Demonstration Project	147	6.33%
	nPEP to PrEP	305	13.12%
	Open Relationship	14	0.60%
	Self interest	1746	75.13%
	Sex work	1	0.04%
	Unknown/Unreported	6	0.26%
Patients Accessing the Clinic for PrEP Only	PrEP Only	877	37.74%

Description:

From May 2012 through June 2016, CLCHC delivered PrEP to 2,324 unique patients interested in initiating this HIV prevention option. An average of 87 patients were prescribed PrEP each month. 75% of patients self-referred for PrEP, 13% transitioned to PrEP after completing post-exposure prophylaxis, 6% continued PrEP after participation in a demonstration project, and 5% reported being in an open and/or serodiscordant relationship as a reason. PrEP clients were 18-77 years old, with 52% between 25 and 34 years old. The racial distribution was diverse: 59% White, 12% Black and 21% Hispanic/Latino ethnicity. PrEP was accessed via private insurance (57%), public insurance (26%) and by uninsured patients (17%) utilizing medication assistance programs. About 40% of patients seeking PrEP were interested in attending our clinic for PrEP care only.

Lessons learned:

Upon implementation of the program there was high demand for PrEP. Medical staff required dedicated training to manage complex and constantly changing insurance requirements. Uninsured patients had to be linked to medication assistance programs or low/no cost health insurance plans. Insured patients encountered challenges due to high copayments, insurance denials or mandatory mail order delivery programs. Some programs delivered medication to our clinic, which necessitated ongoing tracking and distribution by our staff. The impact on clinic flow was minimized by sharing the tasks of the PrEP visit with a team of providers, testers, nursing and PrEP specialists. New protocols were developed, including one that facilitated patient self-swabs for STD screening. Patient navigation was a key aspect of our program, as was interdepartmental cooperation. The creation of a PrEP-only track of care was needed to fulfil the demand of patients looking to access the clinic for this service only.



Conclusions/Next steps:

As scale-up of PrEP continues, clinics considering implementing PrEP programs need to be prepared for high demand and proactively put systems into place to facilitate patient access, including strategies to deal with complex insurance issues, tracking of patients and quality assurance.

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