Category B: Prevention Models

ABSTRACT 90

Near-Perfect Adherence in US iPrEx RCT sites: Frequency and Correlates.

K Amico[1], J Marcus[2], V McMahan[2], P Goicochea[3], K Koester[4], L Vargas[5], K Mayer[6], and A Liu[7]

[1]Applied Health Research; Center for Health Intervention and Prevention, Brighton, MI, United States of America, [2]Gladstone Institute of Virology and Immunology, San Francisco, CA, United States of America, [3]Gladstone Institute of Virology and Immunology; Investigaciones Medicas, San Francisco, CA, United States of America, [4]Gladstone Institute of Virology and Immunology; Center for AIDS Prevent, San Francisco, CA, United States of America, [5]Investigaciones Medicas en Salud, Lima, Peru, [6]Fenway Institute, Brown Medical School, Boston, MA, United States of America, [7]San Francisco Department of Public Health, San Francisco, CA, United States of America

OBJECTIVE: Exposure to daily oral pre-exposure prophylaxis (PrEP) in randomized controlled trials (RCTs) among diverse populations has varied widely (from <26% to >80%), suggesting that adherence to open-label PrEP may also vary by region, community, or cohort. We aimed to characterize adherence amongst US (Boston, San Francisco) participants in the iPrEx RCT among MSM and transgender women.

METHODS: We used drug detection data previously collected for analysis of drug detection at week-24 study visit amongst US participants to estimate the accuracy of self-reported adherence in the US cohort in relation to drug detection, and, given support for accuracy, used self-report data collected during monthly interviews to identify baseline and time-dependent factors associated with near-perfect self-reported adherence.

RESULTS: Drug detection in the sample used to evaluate PrEP exposure suggested that 97% of the US participants included in that substudy had quantifiable levels of drug at their week 24 study visit. Amongst those who had reported using study product on >50% of the days since last study visit [~30 days], 97% had drug detected, suggesting high positive predictive value of self-report, cautioned by overall high rates of drug detection. With evidence of self-report as a valid indicator of drug exposure in the US, we then evaluated 3144 adherence assessments from 223 participants. Near-perfect self-reported adherence (>=90%) in last month was reported on 83% of the assessments, and perfect adherence was reported at 58% of visits. Multivariable adjusted analyses identified older age at enrollment, believing PrEP would be at least 60% effective in preventing HIV, and having reported unprotected receptive anal sex with an HIV-positive partner in the past 3 months as positively associated with adherence. Near-perfect adherence was less likely to be reported if the participant reported gastrointestinal symptoms in the prior month or =5 alcoholic drinks per drinking occasion in the prior month. On longitudinal analysis, adherence was consistently high throughout the study.

CONCLUSIONS: Adherence to blinded study medication was high among US participants throughout their participation in the iPrEx study and was associated with factors similar to those associated with adherence to other medication and prevention regimens. Of the mutable factors identified, side-effects management, exploring impact of alcohol use, and fostering positive beliefs about effects of PrEP and possibly one's sense of risk for infection should be included in PrEP adherence support packages. ***Note: Data from this abstract have also been presented at IAS2012**

ABSTRACT 91

HOME: A Holistic Approach to HIV Prevention and Program Evaluation for Young MSM of Color in New York City

E Aponte[1], S Estabrook[1], D Rodriguez[1], T Howell[1], and B Parker[1]

[1]Harlem United Community AIDS Center, New York, NY, United States of America

OBJECTIVE: HIV/AIDS rates are high and rising fastest among MSM of color. The numbers are even worse for African-American MSM: HIV infection rates rose 66% in just three years between 2004 and 2007. Even in New York City, where transmission is more "diverse," MSM still account for 48% of new HIV infections as of 2010. To address the prevention needs of young MSM of color, Harlem United created HOME, or the "Helping Our Men

Evolve" Program. The purpose of the present study was to design an evaluation approach to assess the needs and outcomes of HOME clients, and provide information integral to continuous program quality improvement.

METHODS: HOME uses multiple behavioral theories and comprehensive HIV/STI prevention strategies in a drop-in space setting. Interventions include but are not limited to: Many Men, Many Voices (3MV), RESPECT, Comprehensive Risk Counseling Services (CRCS) and The Volunteer Leadership Program (VLP). Members also have access to in-house psychological counseling, healthcare, housing, and other supportive services. HOME's health counselors conduct risk assessments on intake and 90 day reassessments to tailor clients' service plans to their needs. In 2010, HOME enrolled 84 members, of which n=25 received a reassessment within the year.

RESULTS: For those members who received reassessments, a paired-samples t-test revealed a statistically significant reduction in reported sexual risk behaviors (t=5.48, p=.00). As a result of these findings, HOME designed an assessment tool, called the Outcomes Matrix, which measures changes in Education, Employment, Income, Housing, HIV Risk, and Mental Health status on a 10-point scale. In a pilot of the Matrix with n=21 clients in 2011, clients evidenced increases in mean scores across 4/5 domains.

CONCLUSIONS: YMCSM who consistently engaged in mental health and risk reduction services for 90 days or more reported reduced HIV-risk factors and improved overall quality of life. HOME's range of services and evaluation capacity support its clients in making informed decisions about their sexual health, with far reaching positive implications for their health, relationships, and community.

ABSTRACT 92

Preparing for and Conducting a Successful HCV Vaccine Trial with Injection Drug Users

A Asher[1], *E Stein*[1], *A Cox*[2], *and K Page*[1]

[1]University of California San Francisco, San Francisco, CA, United States of America, [2]Johns Hopkins University, Baltimore, MD, United States of America

OBJECTIVE: Conducting successful clinical trials of biomedical prevention interventions in high-risk groups, including injection drug users (IDU), requires community involvement and a supportive clinical infrastructure. The Vaccination Is Prevention (VIP) Study is a phase I/II clinical trial testing a preventive HCV vaccine in San Francisco and Baltimore. We discuss preparatory and ongoing work in San Francisco to conduct this study in a population normally excluded from clinical trials.

METHODS: In preliminary work, IDU were surveyed to assess understanding of clinical trials and willingness to participate in a trial testing an experimental HCV vaccine. To meet identified gaps, information sessions with IDU and community-based providers working with IDU were held prior to initiating the trial. Key concepts such as blinding, randomization, the VIP Study objectives and protocol, and the properties of the experimental vaccine were discussed. The teams' experience with conducting research, HCV counseling/ testing, and health care resource/referral networks was also highlighted. Trial staff were trained and sensitized to issues impacting safety monitoring and long-term retention of IDU participants, including psychosocial factors and difficulty with venous access.

RESULTS: Enrollment in the VIP Study is ongoing and IDU are willing to participate. 68 participants are targeted for phase I. Enrollment is meeting targets and has slightly exceeded the projected loss, requiring a minor upward adjustment of sample size. Factors contributing to the early success of the VIP Study include use of an Informed Consent (IC) Comprehension tool reviewed with participants prior to enrollment to ensure that essential trial concepts are understood; a case-management approach to track participants with phone, social media and personal visits that facilitates attendance at study

visits and strengthens relationships between study staff and participants; and a memory aid tool designed for the population, to assist in identification of adverse events. Outreach to local community providers and stakeholders is ongoing; the response has been positive, and many participants come via referrals from community-based providers. The clinical trial site, while a recognized entity of the University, is an outpatient research clinic catering to low-income and marginalized communities. Training for clinical staff has resulted in improved cultural sensitivity, phlebotomy and a referral system that meets the physical and social service needs of IDU.

CONCLUSIONS: Conducting a successful clinical trial for an HCV vaccine with IDU requires strong internal and external support. Essential components include educational activities, community buy-in, a culturally-competent staff, an accessible clinic and aggressive outreach strategies to meet recruitment and retention goals.

ABSTRACT 93

Young Adults at Risk for HCV: Meeting Their Needs through the UFO Model Prevention Program

P DeCarlo[1], N Tilsner[1], A Asher[1], P Simpson[2], B Baxter[3], and K Page[1],

[1]UCSF, San Francisco, CA, United States of America, [2]Harm Reduction Services, Inc, Sacramento, CA, United States of America, [3]North Jersey Community Research Initiative, Newark, NJ, United States of America

OBJECTIVE: High HCV incidence and rapidly increasing HCV prevalence have been observed among young adults who inject drugs. HCV infection most often occurs 2–5 years after initiating injection drug use (IDU). Prevention and education programs must target young people who are most likely to be initiates to IDU and therefore at highest risk for HCV infection.

METHODS: The UFO Model is an HCV prevention strategy based on 15 years of research and services with young adults who inject drugs in San Francisco, CA (UFO Study). With support from the CDC Viral Hepatitis Division, the UFO strategy has been documented and developed into a model HCV education and prevention program that can be adapted by agencies working with young adults at risk for HCV. The UFO Model is informed by the needs of young adults and works on the individual, group and community level to educate and support those most at risk for HCV infection. We have developed a Replication Manual for the UFO Model along with training and technical assistance (TA) products (www.ufomodel.org).

RESULTS: Two agencies are currently testing the usability of UFO Model materials and TA products in Sacramento, CA and Newark, NJ. We conducted site visits at each agency at the beginning and during implementation of the program, and interviewed young adult participants at each site. In addition, we have conducted interviews with organizations across the US who serve young adult IDU. Three common issues have emerged while adapting the UFO Model:1) HCV testing. HCV testing and test counselor training are rare at agencies and local health departments due to lack of funding.2) Hepatitis education. Most agencies are funded through HIV money and knowledge of viral hepatitis transmission is lacking. Many HCV materials available are out of date or inaccurate.3) Outreach. As young adults are a new population for many agencies, conducting effective outreach requires different approaches.

CONCLUSIONS: Young IDU are increasingly emerging as the population at highest risk for HCV, and their service and preventive needs differ from their older counterparts. The UFO Model offers essential information and TA to agencies who want guidance in working with young adults and HCV. Ongoing evaluation of the UFO Model will help identify factors that will increase adaptability and usability of the model. A significant next step will be to assess outcomes, including service access, HCV testing and HCV infection reduction in the growing yet underserved population of young adult IDU.

ABSTRACT 94

Circle of Life – Multimedia Curriculum for Native American Youth

E Bennett-Barnes[1]

[1]Office of Minority Health Resource Center, Rockville, MD, United States of America

OBJECTIVE: The Circle of Life multimedia curriculum draws on American Indian/Alaska Native concepts of the medicine wheel. The curriculum engages youth to make healthy decisions in order to prevent HIV/AIDS/STIs and viral Hepatitis. Requirements of the program included: Integration of health with culture Emphasis on de-linking associations and stereotypes Strong messages about caring, empathy and respect Material and activities enhancing both knowledge and skills of youth, not just didactic content Given this new media rich platform for teaching, the Circle of Life program is flexible and adaptable to different settings and uses repetition through animation to reinforce the content to help reinforce healthy behaviors and decision-making.

METHODS: Pilot study to determine if the curriculum would include knowledge change and behavior change. 18 sites were chosen to participate and each site held a 1–2 day pilot of the curriculum that lasted 1–7 weeks, depending on location and time. Evaluation included surveys, interviews, observation and online metrics (completed and repeated program chapters).

RESULTS: Increased knowledge levels about HIV/AIDS Demonstrated Increased understanding of healthy and risky behaviors Substantial reduction in fears about HIV Teachers responded positively to the materials Curricula seen as culturally appropriate and sensitive to cultural issues

CONCLUSIONS: As a conclusion, the pilots have indicated that the multimedia platform was effective and easy to use. All participants had an increase in HIV knowledge and learned key concepts to preventing HIV/AIDS/STIs and viral Hepatitis.

ABSTRACT 95

How to Implement PrEP

S Cahill[1]

[1]Fenway Institute, Boston, MA, United States of America

OBJECTIVE: Understand implementation and cost effectiveness research on PrEP for HIV prevention in order to guide roll-out by health care providers, community-based organizations, and public health departments.

METHODS: Review published research and interview key stakeholders — researchers, policymakers, providers, advocates, funders.

RESULTS: PrEP must be accompanied by sustained care, regular HIV and STI testing, and behavioral interventions to ensure adherence, minimize risk compensation, and monitor side effects and drug resistance. Modeling of PrEP implementation coupled synergistically with scaled-up treatment — focusing on MSM in San Francisco, adults in Botswana, and serodiscordant couples in South Africa — predicts that PrEP could significantly reduce HIV incidence. If targeted to the highest risk populations — including serodiscordant couples, MSM, sex workers, and young women in hyperendemic countries — and if adherence and efficacy is high enough, PrEP can be cost effective. While clinical settings are the most feasible sites for PrEP implementation, alternative arrangements should be explored, such as substance use treatment sites. Training of health providers and non-clinicians in PrEP delivery is a key component of PrEP scale-up. Research shows widespread willingness to use PrEP among most vulnerable populations, such as MSM in the U.S. and globally. However, concerns are widespread that PrEP may lead to risk compensation, which should be monitored and challenged through social marketing and behavioral interventions. Many gay men are unaware of PrEP. Many confuse PrEP and PEP, or are unaware of either. PrEP offers a teachable moment to increase knowledge of and access to PEP.Among the greatest barriers to accessing PrEP is cost. The CDC estimates TDF-FTC would cost $8,030 a year; generic TDF-FTC is available in the global south for $108 a year. Currently a number of private insurers and some Medicaid programs are covering PrEP for patients. The Affordable Care Act mandates coverage of "Essential

Health Benefits" by insurance offered in state Health Insurance Exchanges; these include prescription drugs and prevention and wellness programs, which could cover PrEP.

CONCLUSIONS: Given approval of TDF-FTC for use as PrEP by the U.S. FDA, and interim guidance by the U.S. CDC and WHO, providers can make PrEP available to highly vulnerable individuals as an additional tool in the fight to stay HIV-uninfected. We know how to make PrEP available in ways that can maximize its effectiveness and minimize risk compensation, poor adherence, and drug resistance. Demonstration projects underway in the U.S. and Africa can increase this knowledge and improve the impact of PrEP in the epidemic.

ABSTRACT 96

Provider Knowledge, Use, and Barriers to the Uptake of PEP and PrEP

A Castel[1], S Willis[1], K Camuso[1], M Kharfen[2], and T West[2]

[1]George Washington University School of Public Health and Health Services, Washington, DC, United States of America, [2]DC Department of Health HIV/AIDS, Hepatitis, STD, TB Administration, Washington, DC, United States of America

OBJECTIVE: Although use of non-occupational post exposure prophylaxis (nPEP) among individuals at high-risk for HIV has been recommended by the Centers for Disease Control and Prevention (CDC) since 2005, this prevention strategy has not been widely implemented in the District of Columbia (DC). More recently, the CDC also issued guidance on the use of pre-exposure prophylaxis (PrEP) as another HIV prevention method. As part of the CDC's Enhanced Comprehensive HIV Prevention Planning Initiative, the DC Department of Health (DOH) will conduct a demonstration project to increase utilization of nPEP as an HIV prevention intervention. In preparation for this project, we sought to determine knowledge, use, and barriers to nPEP and PrEP uptake among healthcare providers in DC.

METHODS: A survey of all licensed infectious disease (ID) and HIV providers in DC was conducted. Provider knowledge, attitudes, use, and perceived barriers to nPEP and PrEP were assessed and descriptive statistics were calculated.

RESULTS: Forty six providers responded to the survey of which 42% were ID physicians. Over 30% had been in practice for at least 20 years and 73% had cared for 20 or more HIV-infected patients in the last three months. Knowledge of CDC recommendations was high with 82% and 59% of providers being aware of the nPEP AND PrEP guidelines, respectively. A majority (64%) of providers had ever prescribed nPEP with 40% prescribing it 10 or more times in the last year. Fewer providers had prescribed PrEP (24%). Providers were more likely to prescribe nPEP and PrEP to persons who had an HIV-infected partner (98% and 95%, respectively) and less likely to prescribe nPEP and PrEP to persons who did not return for medical visits (16% and 34%, respectively) and those with a history of medication non-adherence (27% and 10%, respectively). Eighty six percent and 65% of providers agreed that it was feasible to provide nPEP and PrEP, respectively, in their practice. The greatest barriers to providing nPEP and PrEP were development of HIV resistance (25% and 28%, respectively) and cost reimbursement (21% and 28%, respectively).

CONCLUSIONS: Providers in DC are familiar with and currently prescribing nPEP and PrEP to select high-risk populations. Similar barriers to providing nPEP and implementation of PrEP were identified with HIV resistance and cost reimbursement posing the largest barriers. The DC DOH should focus on patient education and collaborating with health insurers to ensure the maximum uptake and success of implementing these HIV prevention methods in DC.

ABSTRACT 97

Development of a PrEP Candidate Screening Tool: An Assessment of PrEP Knowledge and Health Behaviors Among Individuals at High-Risk for HIV

A Castel[1], A Cates[1], J Peterson[1], R Elion[2], A Charles[3], L D'Angelo[4], and P Poppen[5]

[1]GWU School of Public Health & Health Services, Washington, DC, United States of America, [2]Whitman-Walker Health, Washington, DC, United States of America, [3]DC Department of Health Southeast STD Clinic, Washington, DC, United States of America, [4]Children's National Medical Center, Washington, DC, United States of America, [5]GWU Columbian College of Arts & Sciences, Washington, DC, United States of America

OBJECTIVE: Recent studies have shown that using antiretrovirals as pre-exposure prophylaxis (PrEP) for HIV prevention is effective in reducing HIV incidence among MSM, heterosexuals, and serodiscordant couples. Given the high HIV prevalence in the District of Columbia (DC), PrEP has the potential to make a significant impact in reducing HIV incidence; however, its use will be predicated on adequate knowledge, health care access and use, and optimal adherence. This study's objective was to evaluate PrEP knowledge, experience, acceptability and potential uptake among high-risk populations in DC. This baseline information will be utilized to develop a clinical screening tool to assist health care providers identify potential candidates for PrEP use based on risk, health-seeking behaviors, and potential levels of adherence.

METHODS: A self-administered survey was conducted among high-risk populations attending three DC clinics: the DC Department of Health Southeast STD clinic, the Whitman-Walker Health Gay Men's Health and Wellness Clinic, and the Children's National Medical Center Goldberg Adolescent Clinic. The survey captured information on demographics, HIV risk behaviors, health-seeking behaviors, and PrEP knowledge, experience, and acceptability. Descriptive statistics are reported here.

RESULTS: Between February and June 2012, 293 clinic attendees completed the survey. Participants had a median age of 26 (range: 14–66), were majority non-Hispanic Black (72.4%) and male (56.3%). Few participants (2.4%) had injected drugs in the past year, 48.4% reported frequent condom use with recent sex partners, and 52.9% knew the HIV status of their recent sex partners most or all of the time. Only 61.1% of participants had a regular healthcare provider. Of the 97 participants who were prescribed a daily medication, 65.0% sometimes forgot a dose, and they reported an average of two missed doses in the past two weeks. Few survey participants had heard of either PEP (23.6%) or PrEP (10.6%), but 77.5% said they would take PrEP if it were proven safe and effective. One-fourth (24.9%) thought people would stop using condoms if they were taking PrEP, 72.6% thought they could follow a healthcare provider's instructions regarding PrEP usage, and 82.2% reported they would get HIV-tested regularly.

CONCLUSIONS: Our findings suggest that high-risk populations in DC are generally accepting of PrEP. Potential obstacles for these populations may include low levels of PrEP awareness, lack of a regular healthcare provider, and difficulty taking medications as prescribed. As such, the identification of candidates willing and able to adhere to PrEP requirements remains the most important step in effective PrEP delivery.

ABSTRACT 98

HIV Pre-Exposure Prophylaxis (Prep): Knowledge and Attitudes Among a New York City Emergency Department Patient Population

Y Calderon[1], E Cowan[2], C Brusalis[3], J Mantell[4], T Sandfort[4], and J Leider[2]

[1]Jacobi Medical Center, Einstein Medical Center, Bronx, NY, United States of America, [2]Jacobi Medical Center, Einstein Medical Center, Bronx, NY, United States of America, [3]Jacobi Medical Center, Bronx, NY, United States of America, [4]Columbia University, New York, NY, United States of America

OBJECTIVE: This study assessed knowledge and attitudes towards PrEP within a demographically-mixed community with high HIV prevalence. The study provides information useful for implementing PrEP into existing clinic-based HIV testing and prevention programs.

METHODS: A cross-sectional study was conducted from a sample of Emergency Department (ED) patients at two NYC municipal hospitals. Eligible participants completed an anonymous written survey about knowledge and acceptability of PrEP. Means, standard deviations, and proportions were calculated. Standard bivariate methods were used to compare acceptability and knowledge by race, ethnicity and gender.

RESULTS: The study population (n=474) was 40.9% male, 40.7% Latino and 38.2% non-Hispanic Black. 13.3% reported knowledge of either the term "PrEP" or the use of antiretroviral medications to prevent HIV acquisition. More people indicated they were unlikely or extremely unlikely to use PrEP (40.1%) than indicated they would likely take PrEP if available (32.2%). Many (27.7%) were unsure if they would or would not take PrEP. 44.4% thought that individuals would stop using condoms if on PrEP, while 27.0% thought that individuals would continue using them. Some participants (28.4%) incorrectly thought that PrEP needed to be taken only prior to sex. There were no differences by gender. Latinos were more likely (17.6%) than blacks (8.8%) and others (12.4%) to report knowledge of PrEP.

CONCLUSIONS: Potential providers of PrEP must consider limitations in acceptability to this HIV prevention strategy. Future administration of PrEP must incorporate patient education to ensure user understanding of the technology, its correct usage, and potential limitations.

ABSTRACT 99

A Best-Practice Community-Based Approach to Hepatitis Prevention for At-Risk Immigrant and Refugee Communities

M El-Shamaa[1]

[1]Asian Health Coalition, Chicago, IL, United States of America

OBJECTIVE: Chicago has the largest Asian American population in the Midwest with over 600,000 individuals. More than two-thirds were born outside the United States and come from countries with high hepatitis B (HBV) endemicity. The Chicago Asian American immigrant and refugee (CAAIR) communities make up a vulnerable population for viral hepatitis infections due to the lack of access to adequate health care primarily attributable to low socioeconomic background, limited English proficiency, residential location, and stigma. A fundamental problem exists with the lack of funding for HBV in Illinois and there are presently no core public health services for viral hepatitis nor is there any federally or state funded chronic HBV surveillance system. The Asian Health Coalition initiated the community-based Hepatitis Education and Prevention Program (HEPP) in 1997 with an overall to reduce the morbidity and mortality associated with HBV and liver cancer disparities.

METHODS: The HEPP model's innovation lies in close partnerships that have been developed among community-based organizations (CBOs) and health care providers. This distinguishes HEPP from other community approaches by providing guideline-based, evidence-based education with linkage to care opportunities. Many other community programs fail to utilize a strong collaboration with a physician provider and therefore, misinformation can be communicated. Bilingual bicultural community health workers (CHWs) were recruited from partnering CBOs and trained to conduct culturally sensitive and language-concordant education and outreach using a train-the trainer methodology. CBOs served as central venues for screening events and relationships were further established with providers including local safety-net clinics, hospitals and private physicians to serve as pathways for culturally competent linkage-to-care for those individuals found to be in need of the HBV vaccine series or in need of medical care for chronic infections.

RESULTS: Over a 5-year period, HEPP provided culturally tailored education and outreach to more than 32,000 AAIR community members, and screened 2,500 people for HBV. 1,490 individuals were linked to follow-up care, either to receive the three-series vaccination or medical services for chronic HBV infection.

CONCLUSIONS: HEPP has successfully demonstrated how community–level prevention activities in a non-clinical setting can increase the uptake of testing and improve access to care services to address HBV disparities among vulnerable immigrant and refugee communities.

Our agency has created an easily replicable model for addressing chronic conditions in vulnerable populations by working closely with the community-based organizations to provide culturally tailored outreach and screenings, and health care providers to assure appropriate medical follow-up to the screenings.

ABSTRACT 100

High School Health Education Classes Remain Inadequate in Providing HIV Prevention Information

C Fichtenbaum[1], A Donica[1], and M Zuccarello[1]

[1]University of Cincinnati College of Medicine, Cincinnati, OH, United States of America

OBJECTIVE: While the HIV epidemic has been stable in the United States, increasing numbers of new diagnoses are in persons younger than 30 years of age. The objective of this study was to survey patients, high school students and educators about the utility of health education classes.

METHODS: A knowledge and attitudes survey of HIV risk and prevention behaviors of three populations: HIV-infected persons between the ages of 18–30 (Patients), high school seniors (Students) and health class teachers (Teachers) from area high schools. Standard analytic methods were used with P<0.05 considered significant.

RESULTS: A convenience sample of 79 patients from the waiting room of a large academic HIV practice were surveyed based upon attendance of area high schools: 75% male; 75% African American, 17% White, 8% Other; and 58% were between 18–24 years of age. 124 students, 18 years of age or older, who attended five area high schools were surveyed during lunch: 44% male; 65% African American, 27% White, and 8% Other. Compared to students, fewer patients reported learning about HIV prevention from health class (81% vs. 61%, p=0.002) or their family (52% vs. 29%, p=0.001). There were no significant differences in learning about HIV prevention from a doctor (48% vs. 53%), a friend (27% vs. 19%), or the Internet (27% vs. 19%). Compared to students, fewer patients believed HIV-prevention information from a health class was very useful (59% vs. 33%, p<0.001). Compared to students, more patients reported latex condoms as an effective means of preventing HIV infection (62% vs. 87%, p<0.001). Role-play was infrequently reported as a method of instruction in health class by patients and students (18% vs. 26%, p=ns). 64% of students reported that they were shown how to use a condom in health class compared to 45% of patients (p=0.009). However, only 1 of 16 teachers reported showing how to use a condom in health class. Of 84 area high schools, only 14 schools participated in the health class teacher survey.

CONCLUSIONS: Health class continues to be a primary source of information for adolescents about preventing HIV infection. Reliance on a friend or the Internet as a source of knowledge about HIV remains relatively low. Active learning methods like role-play are rarely used in health classes. Lasting prevention messages are not in place to help protect adolescents. Broader campaigns and re-examination of health class curriculum should be explored to help prevent the spread of HIV infection.

ABSTRACT 101

Comprehensive Community Prevention Models: HIV Prevention on Hispanic Serving Universities in South Texas

E Haggerty[1], E Curet[2], D Brown[3], A Carlon[4], and M Faulkner[5]

[1]Cardea Health Services, Austin, TX, United States of America, [2]The University of Texas at Brownsville, Brownsville, TX, United States of America, [3]Texas A&M University-Kingsville, Kingsville, TX, United States of America, [4]Cardea Health Services, Austin, TX, United States of America, [5]The University of Texas at Austin, Austin, TX, United States of America

OBJECTIVE: The HIV/AIDS Partnership ("Partnership") is a three year demonstration project working with two Hispanic Serving Institutions in South Texas. The primary objective of the partnership is to implement a culturally relevant and community based HIV prevention program to improve HIV knowledge and attitudes among college students. In order to achieve this objective, the partnership employs a three pronged approach that involves fostering

a supportive campus environment; HIV peer education; and targeted outreach.

METHODS: Program evaluation of the Partnership involves a mixed-methods approach to capture the scope of the Partnership's activities. However, this analysis focuses primarily on the impact of HIV peer education on HIV knowledge and student awareness of available services. Change in knowledge is measured through pre and post-test surveys administered to students participating in HIV peer education seminars. HIV knowledge is measured using the HIV Knowledge Questionnaire (HIV-KQ-18) and knowledge of services is measured by three questions asking about awareness of HIV testing on campus, HIV testing in the community and behavioral health services. Descriptive statistics were produced for the entirety of the Partnership's activities. Paired sample t-tests and chi-square tests were used to assess changes in levels of knowledge for those students participating in peer education sessions.

RESULTS: Nearing the end of its second year, the Partnership has reached over 2,175 students through targeted outreach and peer education. The mean age of students is 22.42 (sd=6.97). The majority of participants (62%) were female. Approximately 62% indicated they were single and 54% identified as Hispanic/Latino. For those students who participated in peer led presentations and completed pre and post-test surveys (n=951), significant changes in HIV knowledge is suggested through paired sample t-tests (t=21.915, p<=0.000). Additionally, students who participated in peer led presentations indicated increased knowledge about campus HIV testing services (chi-square=7.440, p=0.010), community HIV testing services (chi-square=31.951, p<=0.00), and behavioral health services available (chi-square=40.042, p<=0.000).

CONCLUSIONS: Comprehensive community prevention models can reach large numbers of Hispanic college students, particularly through peer education. While peer education has been examined with various populations, peer education among Hispanic college students has not been explored. Initial findings from the Partnership suggest peer education is effective at increasing HIV knowledge and awareness of services with this population.

ABSTRACT 102

HIV Providers' Perceived Barriers and Facilitators to Implementing Treatment as Prevention in Clinical Practice: A Qualitative Study

D Krakower[1], J Mitty[1], J Trinidad[2], and K Mayer[3]

[1]Beth Israel Deaconess Medical Center, Boston, MA, United States of America, [2]University of California, San Francisco, San Francisco, CA, United States of America, [3]Fenway Health, Boston, MA, United States of America

OBJECTIVE: Administration of antiretroviral therapy (ART) to HIV-infected persons before immunologic decline reduces HIV transmission to their sexual partners. "Treatment as Prevention," a strategy of prescribing ART to all HIV-infected persons to decrease the spread of HIV, has great potential to impact the HIV epidemic. However, optimizing this strategy in clinical settings will depend on whether HIV providers are willing to prescribe ART to all of their HIV-infected patients. Therefore, it is critical to understand HIV providers' perceived barriers and facilitators to implementing Treatment as Prevention.

METHODS: In May-June 2012, 39 HIV providers from 6 clinics (4 hospital-based practices, 2 community health centers) in Boston participated in focus group discussions centered on perceived barriers and facilitators to prescribing ART to all of their HIV-infected patients. Fifty-six percent of participants were women, 66% were White, 77% were Infectious Diseases specialists, and 62% had > 5 years of experience providing HIV care. Discussions were audio recorded, transcribed, and analyzed for themes relating to provider practices, attitudes, and intentions regarding the implementation of Treatment as Prevention.

RESULTS: Providers expressed positive attitudes towards a policy of prescribing ART to all of their HIV-infected patients. However, they asserted that patient readiness to start treatment and provider perceptions of each patient's capacity to adhere to lifelong therapy would be the strongest determinants of whether providers would actually prescribe ART. Providers believed that some patients would not want to start treatment due to the absence of symptoms, a desire not to be defined as unhealthy, and mistrust of the medical and pharmaceutical communities,

but they anticipated that strong, trusting relationships with their patients could overcome these barriers. Providers believed that initiation of ART before immunologic decline would confer individual health benefits as well as prevent HIV transmission. Additional data to support the individual health benefits of this strategy would encourage them to initiate treatment discussions with patients and would increase their willingness to prescribe ART to all patients. Factors that would further enhance providers' prescribing intentions include long-term data on the safety of ART, perceptions that treating all patients would not divert resources from patients with advanced disease, and guidelines that endorse universal initiation of therapy.

CONCLUSIONS: HIV providers express positive attitudes towards Treatment as Prevention, but they report concerns about the practical aspects of prescribing ART to all of their HIV-infected patients. Understanding ways to address provider concerns will be critical to implement this strategy in clinical settings.

ABSTRACT 103

Sustaining Vital Linkages Between Community and Clinical Settings for MSM

L Thornhill[1], and J Murphy[1]

[1]AIDS Action Committee of Massachusetts, Jamaica Plain, MA, United States of America

OBJECTIVE: The MALE (Men's Action Life Empowerment) Center is a storefront HIV prevention program serving gay, bisexual and other MSM in the South End of Boston, a neighborhood which has the city's highest rates of HIV, syphilis and hepatitis B infection.The program is designed to increase testing among MSM by making it easily accessible in a community setting, ensuring connection to care and treatment for those infected, and engaging those at risk in services that can help prevent new infections.

METHODS: Core strategies currently being implemented at the MALE Center include the following: 1) Create inviting, positive, easily accessible environment for MSM to get tested and connected to care and treatment as necessary. 2) Through clinical partnerships provide integrated STI and viral hepatitis screening and vaccinations by expanded hours of operation to nights and weekend. 3) Immediate on-site linkages to mental health program with no-co pay, flexible meeting times and clinicians specializing in gay and bisexual men's health. 4) Create community support network for high risk MSM who are not consistently engaged in the health care system.

RESULTS: • The MALE Center has the highest seroincidence rate of all Massachusetts Department of Public Health funded community-based and clinical providers. • 1,740 MSM have learned their HIV status at AAC between 2010–2012. 90% of men confirmed positive were linked to medical care and attended their first appointment within three months. • 436 HIV positive MSM have been linked to case management and ancillary support services. 95% of those men have been linked to HIV-related health care.

CONCLUSIONS: Massachusetts has reduced new HIV infections by 54% in the last 10 years, saving $2B in projected health care costs through these combined strategies: 1) Access to care and treatment (HIV as a disability under Medicaid plan and statewide health care reform legislation). 2) A robust community based support service network. 3) Evidence based behavioral intervention programs.The MALE Center implements these strategies by offering easily accessible testing, strong linkages to clinical settings and on-site support services designed to increase the well-being of our clients and reduce risky behaviors. The Center is the link between community and clinical settings for MSM who are not ready, willing, or able to access services in larger healthcare systems and helps reduce new infections and maximize health outcomes. It is also uniquely positioned to increase our understanding of service utilization patterns and preferences among MSM.

ABSTRACT 104

HIV Prevention in Black Churches: The Healing Faith Model

R Newells[1]

[1]Healing Faith, Oakland, CA, United States of America

OBJECTIVE: Healing Faith is the HIV prevention program of the Life Care Ministry at Imani Community Church. The program objective is to increase access to HIV treatment, prevention, care, and support services for all Oakland residents by raising awareness, providing culturally relevant HIV education, and eliminating stigma.

METHODS: Healing Faith works with the congregation, community, and collaborative partners using a combination of engagement methods. (1) Within Imani Community Church, the Life Care Ministry provides comprehensive health education, which includes sexual and mental health, on the fourth Sunday of each month during the worship service. A health information table is maintained in the fellowship hall with male and female condoms, resources, and other material. Weekly bible study has been used as an opportunity to explore how the church addresses gender and sexual identity through a targeted curriculum from the Umoja Project. (2) In the local community, Healing Faith participates alongside the Life Care Ministry as exhibitors at the annual Laurel Street Fair, providing HIV prevention information and general health screenings. (3) In collaboration with other churches, advocates, and AIDS service providers, Healing Faith uses the National Week of Prayer for the Healing of AIDS to engage the faith community in addressing the local epidemic. Through training and advocacy programs with the Black AIDS Institute, AVAC (AIDS Vaccine Advocacy Coalition), and the National Minority AIDS Council, Healing Faith ensures that the most current information is being shared with the community.

RESULTS: After Year One, the congregation of Imani Community Church demonstrated increases in health literacy, HIV literacy, and knowledge of available community resources. After Year Two, there was an increase in collaboration between Healing Faith and community partners. During Year Three, Healing Faith has become a resource used by members of the congregation to locate HIV prevention, treatment, and support services. New volunteers are engaged in HIV prevention activities and have requested training as HIV test counselors.

CONCLUSIONS: Change takes time. More HIV prevention advocates who are also clergy in black churches are needed to engage black faith leaders in open dialogue about the relationship between HIV/AIDS, sexuality, and stigma using a peer-to-peer approach. Incorporating HIV prevention education into comprehensive health education programs and utilizing existing congregational and community events reduces resistance to addressing HIV/AIDS in African American faith communities. Normalizing HIV prevention education within worship services and other church activities increases the overall health literacy and engagement of new HIV advocates and activists.

ABSTRACT 105

Development and Implementation of a Clinic-Based, Provider-Driven Prevention with Positives (PwP) Pilot Program in New York City (NYC)

S Ramachandran[1], J Myers[1], N Mensah[1], K Sepkowitz[1], B Mitts[1], A Andaluz[1], B Cutler[1], and M Sweeney[1]

[1]NYC Department of Health and Mental Hygiene, New York, NY, United States of America

OBJECTIVE: Prevention with positives (PwP) programs attempt to reduce secondary HIV transmission by decreasing ongoing risk behavior. The NYC PwP Pilot, developed by the NYC Department of Health and Mental Hygiene (DOHMH), aims to determine the feasibility and optimal implementation parameters for future citywide scale-up of a clinic-based HIV prevention intervention.

METHODS: Using existing PwP programs as well as models for behavior change related to other diseases, we developed a primary care approach that integrates routine sexual risk screening coupled with evidence-based, ultra-brief provider-delivered risk reduction counseling. We recruited two large HIV primary care clinics to participate; working closely with DOHMH, each pilot site identified a PwP champion, customized their electronic health

records system (EHR) to monitor screening and document counseling, and received on-site training about screening and counseling. Baseline data for the first three months of the pilot were extracted from the EHR of all HIV-positive patients from each site and analyzed to assess completeness of initial implementation. DOHMH staff then used the information to provide data-driven technical assistance and deliver site-specific booster trainings.

RESULTS: In January 2012, two HIV primary care sites (Site A and Site B), serving a total of 1,200 HIV positive patients, began implementation of the pilot program. Over the first quarter, of 836 (70%) patients screened, 207 (25%) reported one or more sexual risk behaviors. Of those with one or more sexual risk behaviors, 90 (43 %) received provider counseling but the counseling rate varied widely between the two sites: 89% for Site A and 21% for site B. Examination of the disparity between sites revealed that documentation of counseling at Site B lagged behind actual provision of counseling, but that counseling was actually being provided.

CONCLUSIONS: Preliminary baseline data suggest that 25% of clients in NYC primary care HIV clinics are engaged in one or more high-risk behaviors. We have demonstrated that our screening and brief clinic-based, provider-counseling model can be operationalized in a busy urban HIV primary care setting. Additional efforts are needed to ensure screening and counseling are appropriately provided and documented. Future pilot data will be analyzed to determine the effectiveness of this model in reducing self-reported sexual risk behaviors among HIV-positive patients. Best practices will be documented to shape and support planned scale-up.

ABSTRACT 106

Project ECHO's (Extension for Community Health Outcomes) Prisoner Health is Community Health: The New Mexico Peer Education Project (NM PEP)

K Thornton[1], *M Haynes*[1], *and S Arora*[1]

[1]University of New Mexico Health Sciences Center, Albuquerque, NM, United States of America

OBJECTIVE: In 2009, over 7.2 million adults were under some form of correctional supervision in the United States. Prisoners have high rates of communicable diseases. The prevalence of hepatitis C (HCV) in the New Mexico Corrections Department (NMCD) is 40% upon entry into prison. It is estimated that persons released from the criminal justice system account for up to 29% to 43% of all persons infected with HCV in the United States. Most prisoners are incarcerated for relatively short periods of time and 95% of prisoners are released back into their communities. Providing health education to inmates before they are released from prison offers an opportunity to establish disease control in the outside community. The purpose of the NM PEP is to increase knowledge of HCV and other relevant health issues in the New Mexico prison population and to help prisoners identify and reduce risk behaviors for HCV and other infectious diseases.

METHODS: Prisoners selected to become peer educators receive a 40-hour intensive training developed using national evidence-based standards, and presented by Project ECHO health experts and training staff. After training, peer educators go on to conduct 10 hour health education sessions with small groups of their fellow inmates. Peer educators attend monthly videoconferences with Project ECHO and peer educators from other sites to receive continuing education. These videoconferences allow peer educators to have training related questions answered, and to address barriers to teaching their own peers.

RESULTS: Since July 2009, a total of 188 peer educators have been trained. These peer educators have facilitated 10-hour health workshops to reach a total of 1,246 inmates. In addition, peer educators have conducted a 2 hour workshop

focusing on HCV and hand-washing for 4,206 recently incarcerated inmates. Thirty videoconferences have been held. A formal evaluation of the project began in January 2012. Questionnaires measuring knowledge, self-efficacy and behavioral intention are given to the peer educators before and after their 40 hour training. Qualitative data is obtained through focus groups and individual interviews. By November 1, 2012, 5 additional training sessions will have been completed.

CONCLUSIONS: The NM PEP is an innovative way to provide high quality health education to a large number of inmates in a short period of time. Peer educators have a unique capacity to deliver factual, relevant information to their peers. Prisons provide a rare opportunity to reach a disenfranchised, at-risk, underserved population and improve public health.