WEBVTT

1 00:00:06.690 --> 00:00:07.533 <v ->People join.</v>

2 00:00:09.840 --> 00:00:10.890 We can just let them in.

3 00:00:10.890 --> 00:00:13.170 So I just wanna say good afternoon.

4 00:00:13.170 --> 00:00:14.670 My name is Christine Simon.

5 00:00:14.670 --> 00:00:16.650 I am an associate research scientist

6 00:00:16.650 --> 00:00:19.710 in the Department of Social and Behavioral Sciences,

7 00:00:19.710 --> 00:00:22.380 and at the Center for Methods in Implementation

8 00:00:22.380 --> 00:00:25.920 and Prevention Science here at Yale School of Public Health.

9 00:00:25.920 --> 00:00:28.620 I am delighted to introduce our Ready Hub

10 00:00:28.620 --> 00:00:33.620 webinar presentation and presenter, Dr. LaRon Nelson.

11 00:00:33.630 --> 00:00:36.570 But before I do that, I just wanted give you

12 00:00:36.570 --> 00:00:39.990 a little bit more information about our hub.

13 00:00:39.990 --> 00:00:43.470 Leveraging the expertise of Yale Center for Methods

14 00:00:43.470 --> 00:00:45.630 in Implementation and Prevention Science

15 00:00:45.630 --> 00:00:49.830 and Center for Interdisciplinary Research on AIDS,

16 00:00:49.830 --> 00:00:54.660 Ready, R3EDI, the Rigorous, Rapid and Relevant

17 00:00:54.660 --> 00:00:58.170 Evidence Adaptation and Implementation

18 00:00:58.170 --> 00:01:01.260 to Ending the HIV Epidemic.

19 00:01:01.260 --> 00:01:05.010 Implementation Science Hub provides technical assistance

20 00:01:05.010 --> 00:01:09.000 to more than 10 Ending the HIV Epidemic projects

21 00:01:09.000 --> 00:01:10.980 from around the country.

22 00:01:10.980 --> 00:01:13.350 Ready, we have so many acronyms. (chuckles)

23 00:01:13.350 --> 00:01:15.990 Ready does this in collaboration

24 00:01:15.990 --> 00:01:18.969 with the Implementation Science Coordination,

25 00:01:18.969 --> 00:01:21.600 Consultation and Collaboration Initiative,

26 00:01:21.600 --> 00:01:23.850 also called ISC3I,

27 00:01:23.850 --> 00:01:26.430 creating opportunities to translate local knowledge

28 00:01:26.430 --> 00:01:30.003 into generalizable knowledge whenever possible.

29 00:01:31.200 --> 00:01:33.900 Ready offers comprehensive expertise

30 00:01:33.900 --> 00:01:36.240 in implementation science methods, frameworks

31 00:01:36.240 --> 00:01:39.840 and outcomes in HIV AIDS research.

32 00:01:39.840 --> 00:01:42.720 I just also wanna let everyone know that this event

33 00:01:42.720 --> 00:01:45.510 is co-sponsored by the Yale Center for Methods

34 00:01:45.510 --> 00:01:47.970 in Implementation and Prevention Science,

35 00:01:47.970 --> 00:01:50.700 also known as CMIPS, and Yale Center

36 00:01:50.700 --> 00:01:54.240 for Interdisciplinary Research on AIDS,

37 00:01:54.240 --> 00:01:57.080 CIRA and ISC3I.

38 00:01:57.080 --> 00:01:58.870 So if you would like to know more

39 00:02:01.058 --> 00:02:03.840 about future Ready Hub webinar events,

40 00:02:03.840 --> 00:02:06.840 please notify Dr. Debbie Humphries in the chat,

41 00:02:06.840 --> 00:02:10.080 and she'll make sure that you're added to our email list.

42 00:02:10.080 --> 00:02:15.080 So today's presentation is titled ”No Black Men Left Behind:

43 00:02:17.460 --> 00:02:19.590 Conundrums and Considerations for Designing

44 00:02:19.590 --> 00:02:24.060 a Multi-Level Hybrid HIV Implementation/Efficacy Trial.”

45 00:02:24.060 --> 00:02:28.050 And it is being presented by Dr. LaRon Nelson,

46 00:02:28.050 --> 00:02:30.600 who is the Associate Dean for Global Affairs

47 00:02:30.600 --> 00:02:33.630 and Planetary Health and Independence Foundation

48 00:02:33.630 --> 00:02:36.390 Associate Professor of Nursing.

49 00:02:36.390 --> 00:02:39.870 I just wanted do a quick background on Dr. Nelson.

50 00:02:39.870 --> 00:02:42.363 He has so many accomplishments,

51 00:02:43.620 --> 00:02:46.050 but just to highlight a few.

52 00:02:46.050 --> 00:02:48.570 Dr. Nelson's domestic and international research

53 00:02:48.570 --> 00:02:51.150 investigates the implementation and effectiveness

54 00:02:51.150 --> 00:02:54.030 of multi-level intervention strategies

55 00:02:54.030 --> 00:02:56.850 to reduce race and sexuality-based disparities

56 00:02:56.850 --> 00:02:58.530 in HIV outcomes.

57 00:02:58.530 --> 00:03:01.350 He's recognized as the world's leading authority

58 00:03:01.350 --> 00:03:04.110 on the application of self-determination theory

59 00:03:04.110 --> 00:03:06.270 for HIV prevention and care.

60 00:03:06.270 --> 00:03:09.720 His research also involves identifying interventions

61 00:03:09.720 --> 00:03:13.500 to address intersectional stigma at the organizational level

62 00:03:13.500 --> 00:03:17.340 and treating the traumatic effects of intersectional stigma

63 00:03:17.340 --> 00:03:20.103 that manifests at the individual level.

64 00:03:20.940 --> 00:03:23.370 His work in research and implementation science

65 00:03:23.370 --> 00:03:25.230 spans multiple countries.

66 00:03:25.230 --> 00:03:28.200 He co-founded the Central and West Africa

67 00:03:28.200 --> 00:03:30.450 Implementation Science Alliance,

68 00:03:30.450 --> 00:03:33.030 a collaboration of implementation scientists

69 00:03:33.030 --> 00:03:36.480 in implementing agencies from Cameroon, Congo,

70 00:03:36.480 --> 00:03:41.480 Ghana and Nigeria, aimed to improve HIV-related outcomes

71 00:03:42.030 --> 00:03:44.760 among adolescents in the region.

72 00:03:44.760 --> 00:03:47.370 He is also leading implementation science efforts

73 00:03:47.370 --> 00:03:50.490 to reduce racial disparities in HIV incidence,

74 00:03:50.490 --> 00:03:52.620 treatments and viral suppression

75 00:03:52.620 --> 00:03:56.850 among African, Caribbean and black communities in Canada.

76 00:03:56.850 --> 00:04:00.660 His work in the US focuses on the, excuse me,

77 00:04:00.660 --> 00:04:05.430 his work in the US focuses on the use of multilevel

78 00:04:05.430 --> 00:04:08.100 social, structural, behavioral and clinical interventions

79 00:04:08.100 --> 00:04:12.990 to reduce HIV infections among black MSM.

80 00:04:12.990 --> 00:04:17.010 He's also currently part of a multiple EEG supplement

81 00:04:17.010 --> 00:04:20.520 addressing rapid PrEP and HIV prevention.

82 00:04:20.520 --> 00:04:24.060 It is with great pleasure that I turn this presentation

83 00:04:24.060 --> 00:04:25.590 over to Dr. Nelson.

84 00:04:25.590 --> 00:04:28.350 Thank you so much for doing this.

85 00:04:28.350 --> 00:04:30.330 <v ->Thank you, Chris, for that introduction.</v>

86 00:04:30.330 --> 00:04:31.260 Welcome, everyone.

87 00:04:31.260 --> 00:04:34.920 Thank you for making time with this presentation.

88 00:04:34.920 --> 00:04:38.580 What I'm gonna do today is perhaps a little bit different

89 00:04:38.580 --> 00:04:42.420 because I won't be presenting on outcomes of research,

90 00:04:42.420 --> 00:04:46.203 but this is essentially a presentation

91 00:04:46.203 --> 00:04:49.053 and discussion about research and progress.

92 00:04:50.040 --> 00:04:51.960 Slides are loading in progress.

93 00:04:51.960 --> 00:04:53.793 Let's see if we can get 'em up here.

94 00:04:55.140 --> 00:04:58.207 And so this is the title,

95 00:04:58.207 --> 00:05:00.540 ”No Black Man Left Behind.”

96 00:05:00.540 --> 00:05:04.440 Really thinking about what were some of the conundrums

97 00:05:04.440 --> 00:05:06.480 and things we should be thinking about for designing

98 00:05:06.480 --> 00:05:10.860 a multi-level hybrid HIV implementation/efficacy trial.

99 00:05:10.860 --> 00:05:13.710 And hopefully some of what we're learning,

100 00:05:13.710 --> 00:05:16.710 what we've learned, and what we are learning can help

101 00:05:16.710 --> 00:05:18.781 those of you out there who are thinking

102 00:05:18.781 --> 00:05:23.250 about similar types of work and the opportunities it offers,

103 00:05:23.250 --> 00:05:25.350 but also the challenges that are involved.

104 00:05:27.420 --> 00:05:30.510 The work today I'll talk about was done in collaboration

105 00:05:30.510 --> 00:05:33.960 with a lot of people, but principally with Chris Beyrer

106 00:05:33.960 --> 00:05:35.670 who's at Duke University.

107 00:05:35.670 --> 00:05:39.150 He's the director of Duke Institute for Global Health,

108 00:05:39.150 --> 00:05:40.710 and Bob Remien.

109 00:05:40.710 --> 00:05:42.270 They're not here today presenting today,

110 00:05:42.270 --> 00:05:45.750 but because this webinar we'll talk exclusively

111 00:05:45.750 --> 00:05:48.630 about HPTN 096, it's important for you to know

112 00:05:48.630 --> 00:05:50.780 that three of us are leading that together.

113 00:05:52.020 --> 00:05:55.170 So right now there's still a marked racial disparity

114 00:05:55.170 --> 00:05:57.330 in the coverage of PrEP.

115 00:05:57.330 --> 00:06:00.450 If we look at the most recent data from the CDC,

116 00:06:00.450 --> 00:06:02.520 this is what the slide is showing.

117 00:06:02.520 --> 00:06:04.920 And this is from 2019.

118 00:06:04.920 --> 00:06:09.330 Overall, the nation is still at about a quarter

119 00:06:09.330 --> 00:06:11.830 of people who are eligible for PrEP

120 00:06:13.131 --> 00:06:14.431 have been prescribed PrEP.

121 00:06:15.300 --> 00:06:18.810 So that's about halfway towards the EHE goal

122 00:06:18.810 --> 00:06:21.750 of getting to 50% by 2030.

123 00:06:21.750 --> 00:06:25.470 However, that 23% really is driven principally

124 00:06:25.470 --> 00:06:30.470 by the high degree of PrEP prescription among whites.

125 00:06:31.740 --> 00:06:33.180 So that is 63%.

126 00:06:33.180 --> 00:06:38.130 If you look at Hispanic and Latino, is 14%,

127 00:06:38.130 --> 00:06:40.200 and blacks including African-Americans

128 00:06:40.200 --> 00:06:43.080 are not even 1/10.

129 00:06:43.080 --> 00:06:46.230 And so the large number among whites

130 00:06:46.230 --> 00:06:48.720 mask the disparity that exists,

131 00:06:48.720 --> 00:06:50.620 black folks who are eligible for PrEP

132 00:06:51.530 --> 00:06:54.903 are not being prescribed PrEP and thus black not using PrEP.

133 00:06:56.220 --> 00:07:00.030 We see similar, although not as stark source of patterns

134 00:07:00.030 --> 00:07:05.030 with viral suppression, there are still racial gaps.

135 00:07:05.400 --> 00:07:08.070 You see overall the rate is about,

136 00:07:08.070 --> 00:07:11.700 the proportion is about 66% of people with HIV

137 00:07:11.700 --> 00:07:14.163 being virally suppressed in 2019.

138 00:07:15.360 --> 00:07:18.030 But if you look across three racial groups,

139 00:07:18.030 --> 00:07:20.190 just social groups, mind you,

140 00:07:20.190 --> 00:07:24.720 that blacks and African-Americans represent 61%.

141 00:07:24.720 --> 00:07:28.080 Only 61% of those with HIV are virally suppressed

142 00:07:28.080 --> 00:07:31.740 compared to Hispanics and Latino, which is slightly higher

143 00:07:31.740 --> 00:07:35.913 and then highest among people who are white.

144 00:07:37.650 --> 00:07:40.470 And then the HV epidemic itself is also,

145 00:07:40.470 --> 00:07:42.270 there are disparities geographically.

146 00:07:42.270 --> 00:07:45.540 We know that the epidemic really is concentrated

147 00:07:45.540 --> 00:07:47.790 in southern US states.

148 00:07:47.790 --> 00:07:51.510 Ton of social, structural and behavioral reasons

149 00:07:51.510 --> 00:07:56.460 for that also, but what you see on the map on the left

150 00:07:56.460 --> 00:07:58.740 is the HIV prevalence.

151 00:07:58.740 --> 00:08:02.250 And you can see that it really does pool

152 00:08:02.250 --> 00:08:06.270 along the South Atlantic seaboard,

153 00:08:06.270 --> 00:08:08.220 even Atlantic Coast more generally,

154 00:08:08.220 --> 00:08:11.880 across the Gulf of Mexico states.

155 00:08:11.880 --> 00:08:14.190 The map on the right shows you a similar pattern.

156 00:08:14.190 --> 00:08:17.283 These are HIV diagnoses by US county.

157 00:08:18.360 --> 00:08:21.690 And again, along the southeastern Atlantic coastline

158 00:08:21.690 --> 00:08:22.770 across the Gulf of Mexico,

159 00:08:22.770 --> 00:08:25.983 you see that those where we're having the most cases.

160 00:08:27.570 --> 00:08:30.420 And then if we look more specifically

161 00:08:30.420 --> 00:08:34.050 at black MSM in the South,

162 00:08:34.050 --> 00:08:37.800 you find that they are highly overrepresented

163 00:08:37.800 --> 00:08:40.470 in new HIV cases.

164 00:08:40.470 --> 00:08:44.887 So what you see on this slide are cases of HIV,

165 00:08:46.950 --> 00:08:51.390 new diagnoses of HIV among men who have sex with men,

166 00:08:51.390 --> 00:08:55.713 grouped by region: Northeast, Midwest, South and West.

167 00:08:57.210 --> 00:08:59.910 So you can see clearly that most of the new diagnoses

168 00:08:59.910 --> 00:09:01.833 are happening in the South among MSM.

169 00:09:03.360 --> 00:09:07.140 That accounts for more than all the diagnoses

170 00:09:07.140 --> 00:09:10.140 in other regions put together is in the South.

171 00:09:10.140 --> 00:09:13.980 And if you look specifically in the South among MSM,

172 00:09:13.980 --> 00:09:18.980 black MSM represent the vast majority of the cases

173 00:09:19.380 --> 00:09:21.153 among MSM in that region.

174 00:09:24.120 --> 00:09:28.230 And then this is perhaps one of the most important slides

175 00:09:28.230 --> 00:09:31.470 I'll show you in terms of background,

176 00:09:31.470 --> 00:09:35.190 is that there have been several innovations,

177 00:09:35.190 --> 00:09:38.640 biomedical innovations that should have an impact

178 00:09:38.640 --> 00:09:39.843 on HIV incidence.

179 00:09:41.340 --> 00:09:44.010 There's some things that are done in HPTN,

180 00:09:44.010 --> 00:09:45.990 the HIV Prevention Trials Network.

181 00:09:45.990 --> 00:09:50.220 So in a 052 study, they establish U=U,

182 00:09:50.220 --> 00:09:53.580 that if a person is virally suppressed and undetectable,

183 00:09:53.580 --> 00:09:55.323 they cannot transmit the virus.

184 00:09:56.160 --> 00:10:01.160 There was discovery of the efficacy of oral Truvada for PrEP

185 00:10:03.690 --> 00:10:06.600 and then the introduction of rapid HIV test cases

186 00:10:06.600 --> 00:10:08.000 that could be taken at home.

187 00:10:09.180 --> 00:10:11.013 All very important innovations.

188 00:10:12.210 --> 00:10:17.210 And what you see that between 2010 and 2019,

189 00:10:17.640 --> 00:10:20.190 that those innovations, you know,

190 00:10:20.190 --> 00:10:23.903 we can't say that it was a direct link to it,

191 00:10:25.620 --> 00:10:29.100 but if you just look at how the graph along that timeline,

192 00:10:29.100 --> 00:10:34.100 that you see that the HIV incidence among white MSM declined

193 00:10:34.470 --> 00:10:37.170 over time pretty much corresponding with introduction

194 00:10:37.170 --> 00:10:40.020 of these new innovations.

195 00:10:40.020 --> 00:10:43.980 And that's not unusual, that's not unexpected.

196 00:10:43.980 --> 00:10:45.870 That's the reason why we do,

197 00:10:45.870 --> 00:10:47.250 scientists do this type of research

198 00:10:47.250 --> 00:10:50.343 to have an observable impact.

199 00:10:51.690 --> 00:10:54.180 So you've seen that among white MSM.

200 00:10:54.180 --> 00:10:55.533 But at the same time,

201 00:10:59.374 --> 00:11:03.310 that trend among black MSM from 2010 to 2019

202 00:11:05.040 --> 00:11:07.410 is relatively unchanged.

203 00:11:07.410 --> 00:11:10.620 Even with the evidence of U=U,

204 00:11:10.620 --> 00:11:13.950 even with the introduction of Truvada for PrEP,

205 00:11:13.950 --> 00:11:16.470 even with the introduction of rapid home test kits

206 00:11:16.470 --> 00:11:20.280 that those, the introduction of those innovations

207 00:11:20.280 --> 00:11:23.970 into the health system or the healthcare marketplace

208 00:11:23.970 --> 00:11:26.580 has not seemed to have any impact

209 00:11:26.580 --> 00:11:29.700 on the the HIV incidence among black MSM

210 00:11:29.700 --> 00:11:31.173 in that 10-year time period.

211 00:11:33.090 --> 00:11:36.960 And so there are reasons for that.

212 00:11:36.960 --> 00:11:39.900 And I think in the HIV prevention world,

213 00:11:39.900 --> 00:11:44.460 many of the reasons that we've investigated for many years

214 00:11:44.460 --> 00:11:46.680 have been behavioral reasons

215 00:11:46.680 --> 00:11:50.760 'cause they must be have more sex than the white MSM,

216 00:11:50.760 --> 00:11:53.970 or that's probably the principle reason

217 00:11:53.970 --> 00:11:58.020 that we've investigated and ways to sort of minimize

218 00:11:58.020 --> 00:12:01.263 people's exposure to HIV through sexual behavior.

219 00:12:02.610 --> 00:12:03.600 But through a lot of work,

220 00:12:03.600 --> 00:12:05.220 including some work that's happened at Yale,

221 00:12:05.220 --> 00:12:07.650 we know that there are other factors

222 00:12:07.650 --> 00:12:10.893 that are structural factors and social factors.

223 00:12:13.050 --> 00:12:15.030 I won't even give an examples of them right now,

224 00:12:15.030 --> 00:12:17.880 but, or maybe I will give an example.

225 00:12:17.880 --> 00:12:22.880 So even more recently in the US District Court

226 00:12:23.580 --> 00:12:27.123 out of Tarrant County, Texas, that's Fort Worth,

227 00:12:28.470 --> 00:12:33.000 there was a recent ruling that employers

228 00:12:33.000 --> 00:12:38.000 were no longer obligated to provide coverage

229 00:12:38.280 --> 00:12:40.953 for PrEP as part of their insurance plans.

230 00:12:42.240 --> 00:12:46.620 And so if they're black men, white men, black women,

231 00:12:46.620 --> 00:12:50.853 Hispanic women who wanted to take PrEP,

232 00:12:51.990 --> 00:12:53.520 there will be barriers to taking it

233 00:12:53.520 --> 00:12:55.980 if their employer didn't cover it, right?

234 00:12:55.980 --> 00:12:59.160 That's not a behavioral factor.

235 00:12:59.160 --> 00:13:01.830 That's a structural factor that can impede

236 00:13:01.830 --> 00:13:05.700 the ability for communities to achieve prevention goals.

237 00:13:05.700 --> 00:13:07.860 And so that's just one very recent example.

238 00:13:07.860 --> 00:13:09.660 But there are a number of examples that,

239 00:13:09.660 --> 00:13:12.060 over time, we've come to understand that

240 00:13:12.060 --> 00:13:15.630 the situation is much more complex than getting a person

241 00:13:15.630 --> 00:13:19.830 to do a thing, that the way systems and social norms,

242 00:13:19.830 --> 00:13:23.250 stigmas confront and constrain people's ability

243 00:13:23.250 --> 00:13:25.920 to enact the behavioral goals has an impact

244 00:13:25.920 --> 00:13:26.753 on this epidemic.

245 00:13:26.753 --> 00:13:31.710 And we contend that this is, more than contend,

246 00:13:31.710 --> 00:13:34.890 we understand that this is part of what is happening

247 00:13:34.890 --> 00:13:37.920 with why we can have the development of these types

248 00:13:37.920 --> 00:13:41.100 of innovations and not have an impact on black MSM

249 00:13:41.100 --> 00:13:45.030 in terms of what we see with the viral suppression data

250 00:13:45.030 --> 00:13:48.330 or the incidence data is because there are

251 00:13:48.330 --> 00:13:50.370 structural factors that are making that

252 00:13:50.370 --> 00:13:52.203 very difficult to attain.

253 00:13:53.310 --> 00:13:56.040 So what we decided to do with HPTN 096

254 00:13:56.040 --> 00:13:59.130 was to develop and test an integrated strategy

255 00:13:59.130 --> 00:14:02.220 that dealt both with behavioral factors,

256 00:14:02.220 --> 00:14:03.777 that dealt with social factors,

257 00:14:03.777 --> 00:14:05.730 and that dealt with structural factors.

258 00:14:05.730 --> 00:14:09.390 And so we identified interventions that address

259 00:14:09.390 --> 00:14:10.890 all of those things.

260 00:14:10.890 --> 00:14:12.663 And we're testing this, well,

261 00:14:14.160 --> 00:14:17.190 there are four components of that intervention.

262 00:14:17.190 --> 00:14:22.190 The first is social media influencers.

263 00:14:22.200 --> 00:14:25.470 So I thought was that we have to tackle

264 00:14:25.470 --> 00:14:26.970 this at multiple levels.

265 00:14:26.970 --> 00:14:30.060 We can't just have another study where we enroll a cohort

266 00:14:30.060 --> 00:14:35.060 of black men and zero in an intervention on them

267 00:14:35.460 --> 00:14:37.170 and follow them over time.

268 00:14:37.170 --> 00:14:38.520 Because that that essentially

269 00:14:38.520 --> 00:14:41.190 is a behavioral-focused intervention.

270 00:14:41.190 --> 00:14:43.020 They needed something that addressed these issues

271 00:14:43.020 --> 00:14:44.190 at multiple levels.

272 00:14:44.190 --> 00:14:45.690 And so the first component was to use

273 00:14:45.690 --> 00:14:49.500 social media influencers who could really have an impact

274 00:14:49.500 --> 00:14:52.740 on norms, norms around stigma,

275 00:14:52.740 --> 00:14:56.103 norms around HIV prevention and HIV treatment.

276 00:14:57.180 --> 00:15:01.050 A second component to that was a culturally-responsive

277 00:15:01.050 --> 00:15:04.652 intersectional stigma prevention, or CRISP for short.

278 00:15:04.652 --> 00:15:06.600 That is an intervention that is targeted specifically

279 00:15:06.600 --> 00:15:08.223 at healthcare facilities.

280 00:15:09.780 --> 00:15:14.040 Because the experience that black men have

281 00:15:14.040 --> 00:15:16.530 when they're going to facilities can either optimize

282 00:15:16.530 --> 00:15:19.080 their prevention goals or treatment outcomes

283 00:15:19.080 --> 00:15:20.520 or can undermine it.

284 00:15:20.520 --> 00:15:23.490 And so we thought, beyond doing something

285 00:15:23.490 --> 00:15:26.340 that was at the community level,

286 00:15:26.340 --> 00:15:27.840 that it needed to be something that was focused

287 00:15:27.840 --> 00:15:30.660 at transforming healthcare environments,

288 00:15:30.660 --> 00:15:33.030 so intervention focused at the organizational

289 00:15:33.030 --> 00:15:34.383 or institution level.

290 00:15:35.580 --> 00:15:37.020 There's a peer support component

291 00:15:37.020 --> 00:15:39.900 which is a behavioral-focused intervention

292 00:15:39.900 --> 00:15:42.660 that is targeted towards black men,

293 00:15:42.660 --> 00:15:45.123 black MSM specifically in this study,

294 00:15:46.230 --> 00:15:48.750 that's designed to offer them access to peer support

295 00:15:48.750 --> 00:15:53.750 that's not, doesn't require them to have to meet in person,

296 00:15:54.450 --> 00:15:57.843 which is de facto disclosing people's sexual identity,

297 00:15:58.890 --> 00:16:01.380 which may not be acceptable in some of the places

298 00:16:01.380 --> 00:16:02.640 where the study is happening.

299 00:16:02.640 --> 00:16:04.530 And then the last one is the health equity-focused

300 00:16:04.530 --> 00:16:07.140 intervention, which is the structural intervention.

301 00:16:07.140 --> 00:16:12.140 This is a coalition model where people are coming together,

302 00:16:12.810 --> 00:16:15.630 people, organizations are coming together

303 00:16:15.630 --> 00:16:19.350 and finding different ways to cooperate, right?

304 00:16:19.350 --> 00:16:21.720 The system is the design a particular way,

305 00:16:21.720 --> 00:16:24.630 but we're saying the system's not serving black men,

306 00:16:24.630 --> 00:16:27.450 they're not serving black MSM in particular.

307 00:16:27.450 --> 00:16:31.678 And so how might you cooperate, the church,

308 00:16:31.678 --> 00:16:34.440 the employment agency, the immigration office,

309 00:16:34.440 --> 00:16:38.430 the health department, the police department,

310 00:16:38.430 --> 00:16:42.480 the rape trauma center, how might you, the food bank?

311 00:16:42.480 --> 00:16:45.000 Is there a way to restructure how you work together

312 00:16:45.000 --> 00:16:48.150 that's gonna help bridge these gaps that the men

313 00:16:48.150 --> 00:16:51.060 are falling through and it's contributing to the reason

314 00:16:51.060 --> 00:16:54.210 that we're not seeing incidence decrease

315 00:16:54.210 --> 00:16:57.123 and viral suppression rates increase?

316 00:16:58.050 --> 00:17:00.780 So those are the four components of the intervention.

317 00:17:00.780 --> 00:17:03.060 CRISP, peer support, social media influence

318 00:17:03.060 --> 00:17:03.893 and health equity.

319 00:17:03.893 --> 00:17:07.470 So we said, ”Okay, if we do these four things together,”

320 00:17:07.470 --> 00:17:09.750 right, if we do this multi-level strategy

321 00:17:09.750 --> 00:17:13.800 that are addressing issues that we know are complicating us

322 00:17:13.800 --> 00:17:16.920 achieving this goal with black MSM,

323 00:17:16.920 --> 00:17:18.810 we can increase rates for HIV testing.

324 00:17:18.810 --> 00:17:21.270 And then among those who don't have HIV

325 00:17:21.270 --> 00:17:23.850 increased the use of PrEP.

326 00:17:23.850 --> 00:17:24.987 At the time we only had oral PrEP,

327 00:17:24.987 --> 00:17:26.880 but even with injectable PrEP.

328 00:17:26.880 --> 00:17:29.130 We can increase that and then increase the proportion

329 00:17:29.130 --> 00:17:32.760 of black MSM who are protected from acquiring

330 00:17:32.760 --> 00:17:35.880 an HIV infection if they're exposed.

331 00:17:35.880 --> 00:17:37.440 And then among those who are diagnosed,

332 00:17:37.440 --> 00:17:39.870 we can increase the uptake in adherence to ART

333 00:17:39.870 --> 00:17:42.510 and increase the proportion of those black MSM

334 00:17:42.510 --> 00:17:43.890 who are virally suppressed.

335 00:17:43.890 --> 00:17:46.260 And if we can do these things,

336 00:17:46.260 --> 00:17:48.337 which is consistent with the EHE strategy,

337 00:17:48.337 --> 00:17:50.790 these are three parts of the pillar,

338 00:17:50.790 --> 00:17:53.990 that we can reduce HIV incidence among black MSM

339 00:17:53.990 --> 00:17:56.850 in the South, because that's personally

340 00:17:56.850 --> 00:17:58.050 where it's concentrated.

341 00:18:00.000 --> 00:18:04.200 So we're testing this, the things I described to you.

342 00:18:04.200 --> 00:18:06.450 We don't know that it will work.

343 00:18:06.450 --> 00:18:09.690 We hypothesize that it will work, but we don't know.

344 00:18:09.690 --> 00:18:11.670 How we plan to know what's do testing it

345 00:18:11.670 --> 00:18:14.523 in this cluster randomized controlled trial.

346 00:18:15.420 --> 00:18:17.253 It involves 16 communities.

347 00:18:18.090 --> 00:18:22.222 It involves delivering the integrated strategy

348 00:18:22.222 --> 00:18:23.880 and the intervention communities.

349 00:18:23.880 --> 00:18:26.820 And the communities who are randomized to standard of care

350 00:18:26.820 --> 00:18:28.800 will continue to do whatever it is

351 00:18:28.800 --> 00:18:30.150 that they're doing in their communities

352 00:18:30.150 --> 00:18:33.063 to advance their EEG goals, but without the added,

353 00:18:33.900 --> 00:18:36.093 the addition of the integrated strategy.

354 00:18:37.110 --> 00:18:40.050 And then we're measuring our out points at,

355 00:18:40.050 --> 00:18:43.560 we're measuring out our endpoints in two ways.

356 00:18:43.560 --> 00:18:45.840 The first is we're looking at viral suppression

357 00:18:45.840 --> 00:18:48.330 through partnership with the Centers for Disease Control.

358 00:18:48.330 --> 00:18:51.240 So we'll look at surveillance data to see whether or not

359 00:18:51.240 --> 00:18:53.760 our intervention, the way that is applied,

360 00:18:53.760 --> 00:18:56.070 if can have an impact on CDC surveillance

361 00:18:56.070 --> 00:18:58.800 of HIV viral suppression among black MSM.

362 00:18:58.800 --> 00:19:02.400 And then we are doing an assessment,

363 00:19:02.400 --> 00:19:05.610 a cross-sectional assessment of black MSM sampled

364 00:19:05.610 --> 00:19:08.280 from each community to determine the prevalence

365 00:19:08.280 --> 00:19:10.323 of PrEP uptake in those communities.

366 00:19:11.940 --> 00:19:15.000 So these are the 16 communities.

367 00:19:15.000 --> 00:19:17.100 We group them into pairs,

368 00:19:17.100 --> 00:19:19.443 and we randomized within each pair.

369 00:19:21.990 --> 00:19:23.070 May not be able to see it well,

370 00:19:23.070 --> 00:19:26.400 but the communities that have the stars next to it

371 00:19:26.400 --> 00:19:28.650 are the ones who are randomized

372 00:19:28.650 --> 00:19:32.493 to the intervention community.

373 00:19:34.380 --> 00:19:36.240 And we started this in a pilot.

374 00:19:36.240 --> 00:19:41.240 So we started a pilot maybe earlier 2022,

375 00:19:41.730 --> 00:19:44.040 seems like longer than that.

376 00:19:44.040 --> 00:19:46.680 So we're piloting it and two pairs,

377 00:19:46.680 --> 00:19:49.380 which is about coming to an end of that phase.

378 00:19:49.380 --> 00:19:51.900 That's Dallas and Houston, Texas being one pair,

379 00:19:51.900 --> 00:19:53.697 with Dallas as the intervention community.

380 00:19:53.697 --> 00:19:56.070 And then Montgomery, Alabama and Greenville

381 00:19:56.070 --> 00:19:59.100 being the second pair in Montgomery was the,

382 00:19:59.100 --> 00:20:00.750 or is the intervention community.

383 00:20:01.950 --> 00:20:06.300 I think we developed this beautiful logic model.

384 00:20:06.300 --> 00:20:09.450 This is based on the implementation research logic model

385 00:20:09.450 --> 00:20:12.420 that I think came out of the team at Northwestern,

386 00:20:12.420 --> 00:20:14.400 which is also part of ISC3I.

387 00:20:14.400 --> 00:20:18.363 So we use this to think about how would we implement these,

388 00:20:19.290 --> 00:20:23.250 this intervention strategy given that's gonna be implemented

389 00:20:23.250 --> 00:20:27.630 in places where it requires people who work

390 00:20:27.630 --> 00:20:31.170 in organizations to take the intervention and use it.

391 00:20:31.170 --> 00:20:33.337 So it's not a sort of classic drug trial

392 00:20:33.337 --> 00:20:37.200 where you enroll people, you give them an intervention

393 00:20:37.200 --> 00:20:40.560 or a pill and you see the outcome.

394 00:20:40.560 --> 00:20:44.070 These organizations have some role

395 00:20:44.070 --> 00:20:47.160 in taking these strategies and improving their practice

396 00:20:47.160 --> 00:20:48.240 for us to see the outcomes.

397 00:20:48.240 --> 00:20:49.830 So we need to think about what are the things

398 00:20:49.830 --> 00:20:52.530 that are gonna influence that, what are the determinants?

399 00:20:52.530 --> 00:20:54.270 How might we influence that?

400 00:20:54.270 --> 00:20:56.280 And that's the implementation strategies.

401 00:20:56.280 --> 00:20:58.470 That's what our integrated strategy is,

402 00:20:58.470 --> 00:21:00.393 an integrated implementation strategy.

403 00:21:01.320 --> 00:21:03.630 And then we map the outcomes based on what we think

404 00:21:03.630 --> 00:21:06.300 the mechanism of action will be.

405 00:21:06.300 --> 00:21:07.890 And so again, in this study,

406 00:21:07.890 --> 00:21:10.350 we're not testing the efficacy

407 00:21:10.350 --> 00:21:14.460 of the biomedical innovation.

408 00:21:14.460 --> 00:21:16.260 These clinical interventions exist.

409 00:21:16.260 --> 00:21:19.263 What we're trying to do, in a sense,

410 00:21:20.430 --> 00:21:23.100 is test how can we get them scaled,

411 00:21:23.100 --> 00:21:24.600 taking the scale in these communities,

412 00:21:24.600 --> 00:21:27.780 and can we also observe the impact of scaling

413 00:21:27.780 --> 00:21:30.030 in these communities in our final outcomes

414 00:21:30.030 --> 00:21:33.603 which are viral suppression and PrEP uptake.

415 00:21:34.770 --> 00:21:38.430 So these are the considerations

416 00:21:38.430 --> 00:21:39.630 that I wanted to sort of get into.

417 00:21:39.630 --> 00:21:44.100 So the first thing in doing something complex as this

418 00:21:44.100 --> 00:21:48.093 is community engagement is very important.

419 00:21:49.920 --> 00:21:54.810 Neither Bob or Chris or I live,

420 00:21:54.810 --> 00:21:57.900 Chris lives there now, but live in this place

421 00:21:57.900 --> 00:22:00.300 where we're gonna do this study.

422 00:22:00.300 --> 00:22:03.663 And even if we did, we didn't live in all the places that,

423 00:22:05.280 --> 00:22:06.720 we didn't live in every neighborhood.

424 00:22:06.720 --> 00:22:09.330 We weren't familiar with every place in this region.

425 00:22:09.330 --> 00:22:11.700 And so community engagement was gonna be key.

426 00:22:11.700 --> 00:22:15.960 We needed people who knew what it was to live in the South,

427 00:22:15.960 --> 00:22:20.280 who knew what it was to live the black social experience

428 00:22:20.280 --> 00:22:24.390 in the South, who knew what it was to be a man

429 00:22:24.390 --> 00:22:26.100 who has such desired for other men,

430 00:22:26.100 --> 00:22:28.110 or who engaged in sex with other men,

431 00:22:28.110 --> 00:22:29.760 or who identifies as gay bisexual

432 00:22:29.760 --> 00:22:31.803 in that geographic context.

433 00:22:32.880 --> 00:22:36.060 So we spent a lot of time designing a strategy

434 00:22:36.060 --> 00:22:38.490 that would really infuse community engagement

435 00:22:38.490 --> 00:22:40.946 throughout everything that we did.

436 00:22:40.946 --> 00:22:43.203 It was really a three-level strategy.

437 00:22:44.580 --> 00:22:47.700 The first was helping to raise general awareness

438 00:22:47.700 --> 00:22:50.670 about the study through local stakeholders

439 00:22:50.670 --> 00:22:52.140 and through national stakeholders

440 00:22:52.140 --> 00:22:55.020 who were recognized members of the community.

441 00:22:55.020 --> 00:22:57.723 Then we had a community specific-engagement component,

442 00:23:02.940 --> 00:23:05.090 which is really designed to make sure folks

443 00:23:06.240 --> 00:23:07.680 understood these different elements

444 00:23:07.680 --> 00:23:09.183 of the integrated strategy,

445 00:23:10.530 --> 00:23:13.260 but also that community members could inform

446 00:23:13.260 --> 00:23:15.390 our development of these elements

447 00:23:15.390 --> 00:23:16.920 of the integrated strategy.

448 00:23:16.920 --> 00:23:19.680 And then the third was making sure we could identify people

449 00:23:19.680 --> 00:23:23.130 who could participate in the cross-sectional assessment,

450 00:23:23.130 --> 00:23:25.263 or baseline survey and sampling.

451 00:23:26.490 --> 00:23:31.490 And, initially, we had three types of groups

452 00:23:31.590 --> 00:23:33.990 that we identified or assembled:

453 00:23:33.990 --> 00:23:37.650 a community strategies group which was really a group

454 00:23:37.650 --> 00:23:40.410 that provided strategic guidance to us.

455 00:23:40.410 --> 00:23:44.880 These were folks who were involved in healthcare

456 00:23:44.880 --> 00:23:47.820 and policy and research in different parts of the country,

457 00:23:47.820 --> 00:23:50.470 mostly in the South but not exclusively in the South.

458 00:23:51.330 --> 00:23:53.700 It helped us think about how we were designing this study,

459 00:23:53.700 --> 00:23:57.063 what we should be pursuing, what pitfalls we should avoid.

460 00:23:58.620 --> 00:24:00.000 A community advisory group,

461 00:24:00.000 --> 00:24:03.300 which was our primary advisory body for the study.

462 00:24:03.300 --> 00:24:06.033 These were made up of people who really,

463 00:24:07.080 --> 00:24:08.430 they had to live in the community.

464 00:24:08.430 --> 00:24:11.343 So we had at least two individuals,

465 00:24:12.420 --> 00:24:15.960 not all black men, but mostly black men

466 00:24:15.960 --> 00:24:18.420 who were from each of the 16 communities

467 00:24:18.420 --> 00:24:20.100 where the study was being conducted.

468 00:24:20.100 --> 00:24:21.930 It didn't matter whether it was the intervention community

469 00:24:21.930 --> 00:24:23.250 or standard of care.

470 00:24:23.250 --> 00:24:25.110 We needed people from there who could really help us

471 00:24:25.110 --> 00:24:27.120 understand what we needed to be doing

472 00:24:27.120 --> 00:24:29.610 or be aware of in these communities.

473 00:24:29.610 --> 00:24:32.880 And then finally, we had community liaisons

474 00:24:32.880 --> 00:24:34.140 who really were our gatekeepers.

475 00:24:34.140 --> 00:24:36.360 These were the people, you see them across the bottom

476 00:24:36.360 --> 00:24:41.360 of the screen, who were our connection to the communities,

477 00:24:42.330 --> 00:24:44.670 both me as one of the protocol chairs

478 00:24:44.670 --> 00:24:46.230 and also our senior research managers.

479 00:24:46.230 --> 00:24:48.900 They helped us understand what was going on

480 00:24:48.900 --> 00:24:51.420 and were really the ambassadors, if you will,

481 00:24:51.420 --> 00:24:53.940 for the study in their communities.

482 00:24:53.940 --> 00:24:57.960 These represent Dallas, Texas, Montgomery,

483 00:24:57.960 --> 00:25:00.210 Greenville and Houston, Texas,

484 00:25:00.210 --> 00:25:02.510 Greenville, South Carolina and Houston, Texas.

485 00:25:04.260 --> 00:25:08.340 And we obviously had to do a lot of communications.

486 00:25:08.340 --> 00:25:12.300 And so this is just showing a couple things,

487 00:25:12.300 --> 00:25:14.400 a website was developed to make sure people

488 00:25:14.400 --> 00:25:17.733 could go to it and understand aspects of the study.

489 00:25:18.720 --> 00:25:22.710 We presented at multiple conferences at community events.

490 00:25:22.710 --> 00:25:25.030 And then we had to also in some ways

491 00:25:25.980 --> 00:25:28.260 sponsored community events.

492 00:25:28.260 --> 00:25:32.520 I mean, I think typically,

493 00:25:32.520 --> 00:25:35.400 and I think we suffer from this also in this study,

494 00:25:35.400 --> 00:25:39.630 is we see the community component

495 00:25:39.630 --> 00:25:44.630 as a bit of a added benefit or a luxury.

496 00:25:45.510 --> 00:25:48.840 And what it means is that when we allocate budget,

497 00:25:48.840 --> 00:25:52.380 we allocate it towards the things that are key or important.

498 00:25:52.380 --> 00:25:55.980 And if there's money left over to do the nice-to-have things

499 00:25:55.980 --> 00:25:58.391 but not essential things, then you might sprinkle,

500 00:25:58.391 --> 00:26:01.563 (chuckles) you might put some money in those areas.

501 00:26:02.880 --> 00:26:04.350 But I think that's a mistake.

502 00:26:04.350 --> 00:26:08.160 The community engagement part is essential.

503 00:26:08.160 --> 00:26:11.430 There's no way we could even get to these places

504 00:26:11.430 --> 00:26:13.920 and try to implement half of what we've done

505 00:26:13.920 --> 00:26:15.810 were it not been for our engagement.

506 00:26:15.810 --> 00:26:18.663 And it also can't just be transactional.

507 00:26:20.460 --> 00:26:22.680 And I mentioned this because I mentioned a few moments ago

508 00:26:22.680 --> 00:26:25.530 about the need to sponsor events.

509 00:26:25.530 --> 00:26:29.190 So the trials and investment in the community

510 00:26:29.190 --> 00:26:33.360 had to be more than you being able to bring us participants.

511 00:26:33.360 --> 00:26:36.330 So we had to be there and also show interesting things

512 00:26:36.330 --> 00:26:37.680 that they were doing,

513 00:26:37.680 --> 00:26:40.770 even if it was not directly tied to the study,

514 00:26:40.770 --> 00:26:42.600 that they can be constrained to that,

515 00:26:42.600 --> 00:26:44.340 if your grant funder doesn't approve for you

516 00:26:44.340 --> 00:26:47.580 to do certain things with the fund that promote this.

517 00:26:47.580 --> 00:26:49.200 But had we not done these things,

518 00:26:49.200 --> 00:26:50.920 I think it's quite likely that

519 00:26:52.530 --> 00:26:54.750 we would not have been welcomed or not seen

520 00:26:54.750 --> 00:26:58.830 as serious partners in some of these community areas

521 00:26:58.830 --> 00:26:59.663 where we were.

522 00:26:59.663 --> 00:27:03.720 And so the community investment is a key consideration,

523 00:27:03.720 --> 00:27:08.070 I think is also a common pitfall

524 00:27:08.070 --> 00:27:09.720 that happens when you're designing studies

525 00:27:09.720 --> 00:27:12.783 and particularly how you're resourcing trials.

526 00:27:18.330 --> 00:27:21.630 So we did the baseline cross-sectional assessment

527 00:27:21.630 --> 00:27:23.097 in four communities.

528 00:27:23.097 --> 00:27:25.897 And three of the four, we've already reached our target.

529 00:27:27.090 --> 00:27:30.780 So we did this because the intervention is being applied

530 00:27:30.780 --> 00:27:33.115 at the community level, as I mentioned before,

531 00:27:33.115 --> 00:27:35.433 we're not following a cohort.

532 00:27:36.600 --> 00:27:37.920 So because we're not doing that,

533 00:27:37.920 --> 00:27:40.830 we needed to use a sampling method that we thought

534 00:27:40.830 --> 00:27:42.030 could give us (sneezes),

535 00:27:44.610 --> 00:27:47.530 that we thought could give us a population estimate

536 00:27:48.510 --> 00:27:52.140 that we could sample this way and have a pretty good sense

537 00:27:52.140 --> 00:27:53.820 that this is what's happening in the community,

538 00:27:53.820 --> 00:27:57.570 both that baseline and when we do our follow-up assessment.

539 00:27:57.570 --> 00:28:00.543 And so we use this Starfish sampling method.

540 00:28:02.130 --> 00:28:06.750 And what you'll see, this is data as of Monday

541 00:28:06.750 --> 00:28:08.550 that we've reached our target.

542 00:28:08.550 --> 00:28:11.515 The target is 100 people per community

543 00:28:11.515 --> 00:28:13.590 in the four that were in the pilot.

544 00:28:13.590 --> 00:28:17.763 So we reached our target three of the four communities,

545 00:28:18.600 --> 00:28:20.313 in some ways exceeded the target.

546 00:28:21.510 --> 00:28:22.770 Are there reasons that we had to always (indistinct)

547 00:28:22.770 --> 00:28:24.840 some places, but at least in three,

548 00:28:24.840 --> 00:28:27.840 we have reached at least 100 people that were enrolled.

549 00:28:27.840 --> 00:28:30.690 And in one community we're a little bit ways away

550 00:28:30.690 --> 00:28:34.143 from reaching the 100 'cause we're currently at about 80.

551 00:28:35.730 --> 00:28:37.683 So here is the challenge.

552 00:28:39.240 --> 00:28:44.240 We think there are some assumptions about Starfish sampling

553 00:28:45.420 --> 00:28:48.280 that, not even some assumptions

554 00:28:49.740 --> 00:28:52.140 about that might be cultural that might not really reflect

555 00:28:52.140 --> 00:28:54.930 the way that black communities operate

556 00:28:54.930 --> 00:28:56.940 or move about in the South.

557 00:28:56.940 --> 00:28:58.740 And there are also some constraints.

558 00:28:58.740 --> 00:29:02.430 So for example, in order to try to reach

559 00:29:02.430 --> 00:29:07.410 a representative sample, you can't just go to a party

560 00:29:07.410 --> 00:29:12.180 or event and talk to every person that you encounter, right?

561 00:29:12.180 --> 00:29:15.003 In some sense, that becomes a convenient sample.

562 00:29:16.470 --> 00:29:20.880 And so they've had to space out how many people

563 00:29:20.880 --> 00:29:22.830 they could when they would count a person.

564 00:29:22.830 --> 00:29:25.110 So every third person could be recruited,

565 00:29:25.110 --> 00:29:28.080 and then up to 10 people per event.

566 00:29:28.080 --> 00:29:29.610 And then you would stop recruiting,

567 00:29:29.610 --> 00:29:30.900 and you wait for another event.

568 00:29:30.900 --> 00:29:32.250 You'd approach every third person,

569 00:29:32.250 --> 00:29:35.520 up to a certain number of people at a time.

570 00:29:35.520 --> 00:29:38.910 And so, from a statistical standpoint,

571 00:29:38.910 --> 00:29:41.070 you can understand why that would be important to do

572 00:29:41.070 --> 00:29:43.320 if you're trying to achieve what Starfish

573 00:29:43.320 --> 00:29:46.020 is supposed to provide in terms of representativeness.

574 00:29:47.250 --> 00:29:51.033 But it does create challenges because it does not,

575 00:29:52.689 --> 00:29:55.980 it imposes constraints.

576 00:29:55.980 --> 00:30:00.980 So for example, it takes much longer to recruit people

577 00:30:00.990 --> 00:30:03.540 in these contexts using Starfish

578 00:30:03.540 --> 00:30:05.580 because, especially in COVID,

579 00:30:05.580 --> 00:30:08.580 there are not sort of regular normal places

580 00:30:08.580 --> 00:30:11.310 where black gay men or black MSM

581 00:30:11.310 --> 00:30:15.000 can gather in a place like Montgomery, Alabama

582 00:30:15.000 --> 00:30:17.340 or a place like Greenville, South Carolina,

583 00:30:17.340 --> 00:30:19.533 or even some parts of Texas.

584 00:30:20.469 --> 00:30:23.970 And so the opportunities to recruit become smaller

585 00:30:23.970 --> 00:30:26.460 in places where you don't have an infrastructure

586 00:30:26.460 --> 00:30:29.130 that's set up where there's normal gathering places

587 00:30:29.130 --> 00:30:31.650 for black sexual minority men, right?

588 00:30:31.650 --> 00:30:33.240 So this was a conundrum.

589 00:30:33.240 --> 00:30:35.790 We want to use this strategy because we wanna have

590 00:30:35.790 --> 00:30:38.640 some rigor and understanding that the sample that we got

591 00:30:38.640 --> 00:30:40.773 represents the community overall.

592 00:30:41.760 --> 00:30:43.650 But it's hard to implement this (chuckles)

593 00:30:43.650 --> 00:30:46.050 because of the parameters of how you have to operate it,

594 00:30:46.050 --> 00:30:48.750 which means it's gonna take us a much longer time to do it,

595 00:30:48.750 --> 00:30:50.370 and the studies already started.

596 00:30:50.370 --> 00:30:54.690 And so we don't wanna still be recruiting a baseline sample

597 00:30:54.690 --> 00:30:56.490 at the point that we already had to,

598 00:30:56.490 --> 00:30:59.940 we don't wanna be recruiting the baseline sample

599 00:30:59.940 --> 00:31:01.740 at the point where we've already had to start

600 00:31:01.740 --> 00:31:04.770 implementing the study because it's taking so long

601 00:31:04.770 --> 00:31:07.290 and we can't wait to get the sample

602 00:31:07.290 --> 00:31:09.450 before we can start because of timelines.

603 00:31:09.450 --> 00:31:13.203 So that was a conundrum but something to consider.

604 00:31:14.460 --> 00:31:16.410 For social media influencers,

605 00:31:16.410 --> 00:31:20.280 we had influencers

606 00:31:20.280 --> 00:31:23.163 from at least each community.

607 00:31:24.600 --> 00:31:28.890 This was also very exciting for us

608 00:31:28.890 --> 00:31:31.290 because of the potential impact

609 00:31:31.290 --> 00:31:33.213 and reach of social media influencers.

610 00:31:34.530 --> 00:31:38.610 But it also had some conundrums for us, some challenges.

611 00:31:38.610 --> 00:31:42.180 So the first is that because we are testing this

612 00:31:42.180 --> 00:31:44.853 in a randomized controlled trial,

613 00:31:46.170 --> 00:31:48.810 we were very concerned about contamination,

614 00:31:48.810 --> 00:31:53.810 that we have to find social media influencers

615 00:31:54.780 --> 00:31:58.800 whose influence is really isolated

616 00:31:58.800 --> 00:32:01.140 to the intervention communities,

617 00:32:01.140 --> 00:32:02.910 because we didn't want them influencing people

618 00:32:02.910 --> 00:32:04.710 in our standard of care communities,

619 00:32:05.820 --> 00:32:08.130 not for the intervention component.

620 00:32:08.130 --> 00:32:11.130 And so the first is that is hard to do.

621 00:32:11.130 --> 00:32:14.370 The people that have the most influence,

622 00:32:14.370 --> 00:32:16.290 their influence is not isolated. (chuckles)

623 00:32:16.290 --> 00:32:18.930 Their influence is broad,

624 00:32:18.930 --> 00:32:22.560 and having people like that violates

625 00:32:22.560 --> 00:32:25.680 one of the principles of conducting

626 00:32:25.680 --> 00:32:27.180 a randomized controlled trial.

627 00:32:28.110 --> 00:32:31.740 But if you can identify influencers

628 00:32:31.740 --> 00:32:34.023 who have very limited reach,

629 00:32:34.950 --> 00:32:37.560 which can allow you to have a social media influencer

630 00:32:37.560 --> 00:32:39.720 that will not have such a broad reach

631 00:32:39.720 --> 00:32:42.510 that they would contaminate other communities,

632 00:32:42.510 --> 00:32:44.910 it doesn't really allow you to, (chuckles)

633 00:32:44.910 --> 00:32:47.010 it doesn't really meet the intent

634 00:32:47.010 --> 00:32:49.500 of the social media influence because you need somebody

635 00:32:49.500 --> 00:32:51.900 with limited influence in order to conform

636 00:32:51.900 --> 00:32:53.850 the parameters of a trial.

637 00:32:53.850 --> 00:32:57.240 And if you got influencers who really have broad influence

638 00:32:57.240 --> 00:32:58.623 and people would listen to,

639 00:32:59.580 --> 00:33:01.350 that that would quite easily violate

640 00:33:01.350 --> 00:33:02.790 the parameters of conducting

641 00:33:02.790 --> 00:33:04.500 a randomized controlled problem.

642 00:33:04.500 --> 00:33:07.050 So we've had to learn from this.

643 00:33:07.050 --> 00:33:08.900 One of the ways that we thought about

644 00:33:09.870 --> 00:33:13.510 is that we might have to relax that

645 00:33:16.200 --> 00:33:18.480 and think about, you know, what we would lose

646 00:33:18.480 --> 00:33:21.990 by having a broad influencer who might have influence

647 00:33:21.990 --> 00:33:24.270 in some of the other communities

648 00:33:24.270 --> 00:33:26.910 compared to what we would gain by having an influencer

649 00:33:26.910 --> 00:33:28.680 that could really represent

650 00:33:28.680 --> 00:33:30.730 what this intervention is supposed to be.

651 00:33:32.490 --> 00:33:35.250 For peer support, these are,

652 00:33:35.250 --> 00:33:38.130 the pictures that you're seeing are the people on the team.

653 00:33:38.130 --> 00:33:40.680 And so these are our six peer supporters,

654 00:33:40.680 --> 00:33:44.163 and Antoine Jackson who is their clinical supervisor.

655 00:33:45.424 --> 00:33:48.870 As I mentioned, the peer support is designed for,

656 00:33:48.870 --> 00:33:52.170 it's online, and you don't have to be signed up

657 00:33:52.170 --> 00:33:54.670 with any particular agency to receive the support.

658 00:33:57.180 --> 00:34:01.770 We train them, we train them intensely,

659 00:34:01.770 --> 00:34:03.810 over 40 hours of training.

660 00:34:03.810 --> 00:34:08.810 And we develop a comprehensive promotional program

661 00:34:09.690 --> 00:34:11.643 to get people to participate.

662 00:34:13.200 --> 00:34:14.850 And we didn't have, at least right now,

663 00:34:14.850 --> 00:34:16.353 robust participation.

664 00:34:17.460 --> 00:34:19.770 And we try to understand mostly with the help

665 00:34:19.770 --> 00:34:22.720 of our community advisory group why that might be the case.

666 00:34:25.710 --> 00:34:29.703 And partly because peer support requires trust,

667 00:34:30.900 --> 00:34:33.390 and trust takes time to build.

668 00:34:33.390 --> 00:34:37.770 And that this trust building really was not

669 00:34:37.770 --> 00:34:39.753 aligned with the study timeline.

670 00:34:41.250 --> 00:34:43.680 In some of these places where there's high degrees

671 00:34:43.680 --> 00:34:47.010 of stigma where living as an out black gay man,

672 00:34:47.010 --> 00:34:49.050 or even if you're not out, people finding out

673 00:34:49.050 --> 00:34:52.680 about your sexuality if it's a minoritized sexuality,

674 00:34:52.680 --> 00:34:54.720 can have very serious consequences for people.

675 00:34:54.720 --> 00:34:57.240 And so for folks to access these things,

676 00:34:57.240 --> 00:35:00.360 for even show on their phone as an app,

677 00:35:00.360 --> 00:35:02.670 folks have to trust that it's not gonna get them

678 00:35:02.670 --> 00:35:05.970 in some type of trouble or situation

679 00:35:05.970 --> 00:35:07.227 they don't want to be in.

680 00:35:07.227 --> 00:35:10.263 And that building that type of trust takes time,

681 00:35:11.100 --> 00:35:15.393 and more time than we had (chuckles) for the study timeline.

682 00:35:16.380 --> 00:35:18.270 And so we didn't have great uptake

683 00:35:18.270 --> 00:35:21.150 in this particular component in the timeframe

684 00:35:21.150 --> 00:35:22.200 that we were trying to look for,

685 00:35:22.200 --> 00:35:24.510 which I think it was probably too narrow.

686 00:35:24.510 --> 00:35:26.010 And so one of the things that we considered

687 00:35:26.010 --> 00:35:29.550 is that we probably don't need a centralized

688 00:35:29.550 --> 00:35:32.553 peer support program not connected to an agency.

689 00:35:34.260 --> 00:35:37.410 The reason we had a centralized program

690 00:35:37.410 --> 00:35:40.060 is because people were concerned that in order to get

691 00:35:41.940 --> 00:35:44.310 peer support you had to go to the Spiegelman clinic.

692 00:35:44.310 --> 00:35:45.960 And if you're not a patient at the Spiegelman clinic,

693 00:35:45.960 --> 00:35:49.030 you don't have to become a patient just to get peer support

694 00:35:50.040 --> 00:35:52.080 or go to the Nelson Health Center to get peer support

695 00:35:52.080 --> 00:35:53.130 if you wanted a patient there

696 00:35:53.130 --> 00:35:54.810 or if you didn't like going there.

697 00:35:54.810 --> 00:35:58.710 And so we had that information from the community early on.

698 00:35:58.710 --> 00:36:00.960 So we said we shouldn't anchor it to a clinic

699 00:36:00.960 --> 00:36:03.060 because then that will serve as a barrier.

700 00:36:04.080 --> 00:36:06.630 But, in thinking about that,

701 00:36:06.630 --> 00:36:09.420 we think it may be better to not anchor it

702 00:36:09.420 --> 00:36:12.600 into a particular clinic but to offer the program

703 00:36:12.600 --> 00:36:15.960 to resource multiple organizations in the community

704 00:36:15.960 --> 00:36:18.720 so that people had options so that the peer support program

705 00:36:18.720 --> 00:36:22.590 was not tied to the identity of any one particular clinic.

706 00:36:22.590 --> 00:36:25.920 But because those clinics and organizations were trusted,

707 00:36:25.920 --> 00:36:27.900 hopefully trusted organizations,

708 00:36:27.900 --> 00:36:30.990 that this could facilitate the implementation in ways

709 00:36:30.990 --> 00:36:33.990 that trying to do it centrally from a research site

710 00:36:33.990 --> 00:36:35.460 cannot accomplish in the timeframe

711 00:36:35.460 --> 00:36:38.103 that we needed to accomplish for the trial.

712 00:36:39.810 --> 00:36:43.500 And then this next one is really the CRISP.

713 00:36:43.500 --> 00:36:47.370 And this is the component I spent quite a bit of time on.

714 00:36:47.370 --> 00:36:50.250 Again, CRISP is focused on healthcare facilities,

715 00:36:50.250 --> 00:36:55.250 really to reduce the amount of stigma

716 00:36:56.340 --> 00:36:58.260 that people experience when they go there,

717 00:36:58.260 --> 00:37:00.390 both in interpersonal interactions

718 00:37:00.390 --> 00:37:02.733 but also in how services might be delivered.

719 00:37:03.930 --> 00:37:05.943 And CRISP has these five components:

720 00:37:07.320 --> 00:37:08.490 client observation visits,

721 00:37:08.490 --> 00:37:11.520 which are simulated clients that we train

722 00:37:11.520 --> 00:37:14.520 who go in as patients, simulated patients,

723 00:37:14.520 --> 00:37:16.140 and have an experience in that clinic

724 00:37:16.140 --> 00:37:18.420 and then have the ability to offer feedback

725 00:37:18.420 --> 00:37:21.240 about what it was like to be a black gay man

726 00:37:21.240 --> 00:37:24.810 and playing that character in that clinic space,

727 00:37:24.810 --> 00:37:27.453 or CBO space, but mostly these have been clinics.

728 00:37:28.710 --> 00:37:31.110 Or providing a foundational training

729 00:37:31.110 --> 00:37:34.270 which is basically 12 contact hours of stigma reduction

730 00:37:35.400 --> 00:37:37.110 intervention workshop.

731 00:37:37.110 --> 00:37:39.480 And then quality improvement, which is how we take

732 00:37:39.480 --> 00:37:43.953 what we've learned and translate that into service changes.

733 00:37:46.470 --> 00:37:51.470 So we worked, we tried this with four facilities.

734 00:37:51.870 --> 00:37:53.250 One is Parkland Hospital,

735 00:37:53.250 --> 00:37:57.990 which is a large public safety hospital in Dallas, Texas,

736 00:37:57.990 --> 00:38:01.380 and Abounding Prosperity, which is a community-based clinic,

737 00:38:01.380 --> 00:38:04.320 organization with the clinic in Dallas, Texas,

738 00:38:04.320 --> 00:38:08.100 and then MAO, which is in Montgomery, Alabama.

739 00:38:08.100 --> 00:38:11.400 They have a treatment facility and a prevention facility.

740 00:38:11.400 --> 00:38:14.160 So we were able to, this green that you see is showing

741 00:38:14.160 --> 00:38:16.023 that we completed surveys,

742 00:38:17.070 --> 00:38:18.960 we had simulated client instructors,

743 00:38:18.960 --> 00:38:20.883 observers go in and make those visits.

744 00:38:21.840 --> 00:38:23.490 And we met all our training goals,

745 00:38:23.490 --> 00:38:26.670 which really was that we could get 75% of people

746 00:38:26.670 --> 00:38:30.090 in those facilities who do HIV prevention work

747 00:38:30.090 --> 00:38:33.240 or are along that HIV prevention or treatment pathway,

748 00:38:33.240 --> 00:38:36.690 that we could get at least 75% of those people trained.

749 00:38:36.690 --> 00:38:41.460 And we had as much as 99% coverage in some places.

750 00:38:41.460 --> 00:38:46.460 Parkland was at 77%, and Abounding Prosperity at 83%.

751 00:38:48.180 --> 00:38:50.490 But those are great successes,

752 00:38:50.490 --> 00:38:52.680 but they're also challenges to it.

753 00:38:52.680 --> 00:38:54.580 The first is that

754 00:38:58.950 --> 00:39:03.650 we have to have a pretty strong business case for doing this

755 00:39:03.650 --> 00:39:08.340 in healthcare facilities or a pretty substantial incentive

756 00:39:08.340 --> 00:39:11.100 because the time that the facilities take out

757 00:39:11.100 --> 00:39:14.940 to participate in this, the stigma reduction intervention,

758 00:39:14.940 --> 00:39:18.810 which is important, but it is time that they're not spending

759 00:39:18.810 --> 00:39:21.360 doing things that they could be billing for

760 00:39:21.360 --> 00:39:25.000 and generating revenue, which is not trivial.

761 00:39:27.210 --> 00:39:30.600 So it's something we have to think about to do.

762 00:39:30.600 --> 00:39:35.103 We did provide an intended, which we thought was fair,

763 00:39:36.240 --> 00:39:38.250 in the design.

764 00:39:38.250 --> 00:39:41.100 But in the implementation, it is becoming clear to us

765 00:39:41.100 --> 00:39:44.520 that sites are feeling that they're giving up a bit more

766 00:39:44.520 --> 00:39:48.270 to participate in this than is covered

767 00:39:48.270 --> 00:39:51.270 by the compensation that we provided them for participating.

768 00:39:52.320 --> 00:39:53.970 So it's something to think about because we couldn't do,

769 00:39:53.970 --> 00:39:58.050 we can't force the clinics to do it, to participate in this,

770 00:39:58.050 --> 00:40:03.050 but in order for us to reach black men and black MSM,

771 00:40:03.210 --> 00:40:05.040 we really have to be working in clinics

772 00:40:05.040 --> 00:40:06.570 where we know they'll go,

773 00:40:06.570 --> 00:40:09.453 they'll likely have to pass through to get care.

774 00:40:10.740 --> 00:40:14.280 Related to that is (chuckles)

775 00:40:14.280 --> 00:40:18.543 one of the things that we thought about is how can we,

776 00:40:19.950 --> 00:40:23.020 what number of clinics do we need to target

777 00:40:24.699 --> 00:40:28.020 to maximize the reach that it will get to black MSM?

778 00:40:28.020 --> 00:40:30.753 Is it 10, is it 20, is it 100?

779 00:40:32.010 --> 00:40:33.963 We can't afford 100 in each city,

780 00:40:34.890 --> 00:40:37.200 but we need some way of figuring out how we do that.

781 00:40:37.200 --> 00:40:39.420 For HIV primary care, that's a bit easier

782 00:40:39.420 --> 00:40:43.653 because those sites are relatively few in each city.

783 00:40:44.790 --> 00:40:46.740 So we could essentially target all

784 00:40:46.740 --> 00:40:48.543 HIV primary care facilities.

785 00:40:49.625 --> 00:40:51.960 And this chart here is showing you what we would do.

786 00:40:51.960 --> 00:40:56.960 So there are four facilities, that if we targeted them

787 00:40:57.157 --> 00:40:59.280 and check (indistinct) stigma reduction,

788 00:40:59.280 --> 00:41:02.580 we would be in facilities that had patient volume

789 00:41:02.580 --> 00:41:06.870 that accounted for 65% of the black MSM living with HIV.

790 00:41:06.870 --> 00:41:09.510 This is in Shelby County, Memphis, Tennessee.

791 00:41:09.510 --> 00:41:12.540 So for four clinics we could get 65%.

792 00:41:12.540 --> 00:41:15.750 Those clinics would cover 65% of black MSM.

793 00:41:15.750 --> 00:41:18.227 And then if we get additional four clinics,

794 00:41:18.227 --> 00:41:20.730 we can get as high as 80%.

795 00:41:20.730 --> 00:41:24.690 But then after eight clinics, the additional yield,

796 00:41:24.690 --> 00:41:26.040 the additional coverage we would get

797 00:41:26.040 --> 00:41:27.903 gets smaller and smaller and smaller.

798 00:41:29.430 --> 00:41:31.233 So that's something to think about is how we,

799 00:41:31.233 --> 00:41:35.170 that we're thinking about, is how do we get coverage

800 00:41:36.450 --> 00:41:39.390 in terms of population coverage of black MSM,

801 00:41:39.390 --> 00:41:41.280 but we don't have a lot of time

802 00:41:41.280 --> 00:41:43.770 and we don't have an infinite amount of money to do it.

803 00:41:43.770 --> 00:41:46.740 But we could at least accomplish quite a big yield

804 00:41:46.740 --> 00:41:48.780 in HIV primary care.

805 00:41:48.780 --> 00:41:52.120 The larger challenge for us though is in trying to find

806 00:41:53.550 --> 00:41:57.660 the right coverage, the maximum coverage for facilities

807 00:41:57.660 --> 00:42:01.890 who provide PrEP or who could provide PrEP.

808 00:42:01.890 --> 00:42:05.710 Because essentially that's any primary care facility

809 00:42:06.870 --> 00:42:11.310 anywhere should have the capacity to provide PrEP.

810 00:42:11.310 --> 00:42:15.330 And so we're trying to figure out what that is.

811 00:42:15.330 --> 00:42:18.480 The other challenge in trying to figure out that number,

812 00:42:18.480 --> 00:42:20.493 the imperative, I guess I would say,

813 00:42:21.740 --> 00:42:25.140 is that we can't end up with an intervention strategy

814 00:42:25.140 --> 00:42:29.070 or healthcare facility strategy that can only be done

815 00:42:29.070 --> 00:42:31.293 in the context of a trial like this,

816 00:42:32.130 --> 00:42:33.870 that could never be done.

817 00:42:33.870 --> 00:42:37.530 But the CDC would say there's no way we could support this

818 00:42:37.530 --> 00:42:40.500 in our budget, or that agencies in these communities

819 00:42:40.500 --> 00:42:42.720 across the country with this or get

820 00:42:42.720 --> 00:42:44.370 taken up by the CDC would say,

821 00:42:44.370 --> 00:42:45.930 ”How could we ever lift this up?”

822 00:42:45.930 --> 00:42:49.440 'Cause you have the sample 100, no 100,

823 00:42:49.440 --> 00:42:52.020 let's say 20 facilities in a small community.

824 00:42:52.020 --> 00:42:54.300 There's no way we could do that.

825 00:42:54.300 --> 00:42:57.600 So what we're thinking about now is taking an epi-focused

826 00:42:57.600 --> 00:43:00.840 approach to selecting the healthcare facilities

827 00:43:00.840 --> 00:43:03.483 for the stigma reduction.

828 00:43:04.320 --> 00:43:09.320 That is looking at global information systems data,

829 00:43:10.440 --> 00:43:13.530 or GIS data that should be available

830 00:43:13.530 --> 00:43:15.090 from health departments.

831 00:43:15.090 --> 00:43:20.090 Understanding what are the high STI burden census tracts

832 00:43:20.460 --> 00:43:23.853 in these areas and what clinics are in those areas.

833 00:43:25.140 --> 00:43:28.830 Because the HIV risk, as we saw earlier,

834 00:43:28.830 --> 00:43:32.310 is not evenly distributed, even probably across communities.

835 00:43:32.310 --> 00:43:34.590 There are probably certain communities where STI

836 00:43:34.590 --> 00:43:39.590 as an indicator of risk of acquiring HIV

837 00:43:39.600 --> 00:43:42.810 are more concentrated or more prevalent than other parts.

838 00:43:42.810 --> 00:43:47.310 So we are thinking we should find out where those places are

839 00:43:47.310 --> 00:43:49.710 and what clinics are in those places,

840 00:43:49.710 --> 00:43:54.060 and in what proportion of that census

841 00:43:54.060 --> 00:43:56.370 in those clinics or the patient role

842 00:43:56.370 --> 00:43:58.140 are black men represented?

843 00:43:58.140 --> 00:44:00.900 And I say black men because in many of these places,

844 00:44:00.900 --> 00:44:03.810 we don't have a denominator for black MSM

845 00:44:03.810 --> 00:44:05.100 for a lot of reasons.

846 00:44:05.100 --> 00:44:07.980 Why it doesn't ask question, or they ask the question

847 00:44:07.980 --> 00:44:09.990 and the person is, the man is not comfortable

848 00:44:09.990 --> 00:44:12.900 telling the provider about that aspect of their behavior

849 00:44:12.900 --> 00:44:14.760 for a variety of reasons.

850 00:44:14.760 --> 00:44:17.940 And so we don't have reliable estimates of black MSM

851 00:44:17.940 --> 00:44:22.050 from a prevention side in many of these places

852 00:44:22.050 --> 00:44:23.643 in almost all of these places.

853 00:44:24.762 --> 00:44:28.140 And so, but we do know the number of black men.

854 00:44:28.140 --> 00:44:33.140 And so if we can identify the places,

855 00:44:33.750 --> 00:44:37.020 the highest number of cases of STIs among black men,

856 00:44:37.020 --> 00:44:38.820 if we can reach those black men,

857 00:44:38.820 --> 00:44:41.040 black MSM are a part of that group.

858 00:44:41.040 --> 00:44:44.440 And so we're trying to figure out ways to determine

859 00:44:45.781 --> 00:44:47.720 how can we figure out where the highest need is,

860 00:44:47.720 --> 00:44:51.930 or the biggest impact that does not require us

861 00:44:51.930 --> 00:44:54.960 to try to sample all the clinics, which we cannot do.

862 00:44:54.960 --> 00:44:56.610 And even if we could do it,

863 00:44:56.610 --> 00:44:59.280 it is not a sound public health strategy

864 00:44:59.280 --> 00:45:01.740 because it probably could not be implemented

865 00:45:01.740 --> 00:45:03.690 in most places in the United States

866 00:45:03.690 --> 00:45:07.050 because of the heavy lift and the cost.

867 00:45:07.050 --> 00:45:10.830 And then we also thought about this idea of spillover.

868 00:45:10.830 --> 00:45:14.190 So if we can identify, let's say, index clinics

869 00:45:14.190 --> 00:45:17.103 that are in these places of high STI burden,

870 00:45:18.330 --> 00:45:20.970 then might there be a way to, if we reach those,

871 00:45:20.970 --> 00:45:22.980 that there will be some spillover effect

872 00:45:22.980 --> 00:45:25.230 in other parts of the community which can also help us

873 00:45:25.230 --> 00:45:27.033 reach that coverage.

874 00:45:27.960 --> 00:45:31.710 This is a paper by some of our colleagues at Yale,

875 00:45:31.710 --> 00:45:34.890 including my friend Donna Spiegelman and Sten Vermund

876 00:45:34.890 --> 00:45:37.530 that looked at that in one particular study.

877 00:45:37.530 --> 00:45:39.300 So it is something that we're trying to think about,

878 00:45:39.300 --> 00:45:44.300 is can we look at, can we use a targeted strategy,

879 00:45:45.300 --> 00:45:47.640 identify index healthcare facilities

880 00:45:47.640 --> 00:45:49.470 and then estimate some spillover effect

881 00:45:49.470 --> 00:45:51.870 to other parts of the community,

882 00:45:51.870 --> 00:45:54.750 which I think is likely impossible.

883 00:45:54.750 --> 00:45:58.950 And then the last component is the health equity component.

884 00:45:58.950 --> 00:46:02.013 Again, these are local community coalitions.

885 00:46:03.330 --> 00:46:05.193 They're both local and regional.

886 00:46:06.630 --> 00:46:08.340 In Dallas, we have Abounding Prosperity

887 00:46:08.340 --> 00:46:10.863 as the lead organization.

888 00:46:11.880 --> 00:46:14.760 And in Montgomery with the Medical Advocacy & Outreach,

889 00:46:14.760 --> 00:46:15.593 or MAO.

890 00:46:16.710 --> 00:46:19.080 And then the regional organizing agency,

891 00:46:19.080 --> 00:46:21.703 a coordinating agency is the Southern Black Policy

892 00:46:21.703 --> 00:46:26.100 & Advocacy Network, which is led by a black

893 00:46:26.100 --> 00:46:28.803 openly gay man, open living with HIV.

894 00:46:29.910 --> 00:46:33.000 And next week he might be the first openly black gay man

895 00:46:33.000 --> 00:46:36.450 with HIV serving in the Texas State House.

896 00:46:36.450 --> 00:46:38.600 He's on the ballot, I think he's gonna win.

897 00:46:39.930 --> 00:46:44.790 So this was also not without challenges.

898 00:46:44.790 --> 00:46:47.283 The first is that when we started this,

899 00:46:48.270 --> 00:46:50.010 we used a centralized model,

900 00:46:50.010 --> 00:46:52.410 which was with the Black AIDS Institute,

901 00:46:52.410 --> 00:46:54.210 which is, many of you may know it.

902 00:46:54.210 --> 00:46:58.290 It is a vitally important, famed institution

903 00:46:58.290 --> 00:47:00.453 in the black community and for the country.

904 00:47:01.740 --> 00:47:03.570 That partnership did not work out.

905 00:47:03.570 --> 00:47:08.570 And so the challenge with the centralized model

906 00:47:08.630 --> 00:47:10.710 is that, if the partnership doesn't work out,

907 00:47:10.710 --> 00:47:12.300 you have to start all over

908 00:47:12.300 --> 00:47:14.400 because if you only had one partner.

909 00:47:14.400 --> 00:47:17.040 So we thought that introduced too much instability,

910 00:47:17.040 --> 00:47:22.040 but we thought that made us

911 00:47:22.290 --> 00:47:26.160 too vulnerable to have one implementing partner.

912 00:47:26.160 --> 00:47:27.960 And so we decided to go to a local model,

913 00:47:27.960 --> 00:47:30.900 which I think was more culturally appropriate

914 00:47:30.900 --> 00:47:33.100 in many of these places to do a local model.

915 00:47:34.680 --> 00:47:38.310 So that has worked out well so far.

916 00:47:38.310 --> 00:47:41.610 Another challenge is that Medical Advocacy & Outreach,

917 00:47:41.610 --> 00:47:45.660 they filed for bankruptcy, I don't know,

918 00:47:45.660 --> 00:47:47.463 a week ago, two weeks ago.

919 00:47:48.360 --> 00:47:53.360 And so, we'd already learned from our experience

920 00:47:53.730 --> 00:47:57.930 with having our health equity component

921 00:47:57.930 --> 00:47:59.520 focused in one agency.

922 00:47:59.520 --> 00:48:03.300 And so we expect that for many of these agencies

923 00:48:03.300 --> 00:48:06.240 and many of these areas that we will have

924 00:48:06.240 --> 00:48:10.950 some that struggle and that might cease operations

925 00:48:10.950 --> 00:48:14.490 or change management or change ownership.

926 00:48:14.490 --> 00:48:17.310 So we don't treat this as an isolated incident.

927 00:48:17.310 --> 00:48:19.860 This is one of the structural factors

928 00:48:19.860 --> 00:48:22.980 that impacts HIV prevention goals among black MSM.

929 00:48:22.980 --> 00:48:25.110 What we had to do was figure out how do we build

930 00:48:25.110 --> 00:48:27.420 in some resilience in this model

931 00:48:27.420 --> 00:48:29.460 so that when those changes occur,

932 00:48:29.460 --> 00:48:31.500 which we expect will continue to occur

933 00:48:31.500 --> 00:48:33.783 as we do this in the other cities,

934 00:48:36.959 --> 00:48:38.280 that we don't become so unstable

935 00:48:38.280 --> 00:48:41.130 that we can't complete this intervention in.

936 00:48:41.130 --> 00:48:43.470 So what we did was the coalition

937 00:48:43.470 --> 00:48:46.200 happened to already be built in Montgomery.

938 00:48:46.200 --> 00:48:49.290 MAO had already designed a coalition.

939 00:48:49.290 --> 00:48:52.020 And so we tried to center the intervention

940 00:48:52.020 --> 00:48:55.980 as part of a co-owned community coalition,

941 00:48:55.980 --> 00:48:58.740 that it didn't belong to the organizing agency.

942 00:48:58.740 --> 00:49:01.290 So that if the organizing agency changed hands

943 00:49:01.290 --> 00:49:03.792 or for some reason they decided they didn't want to do it

944 00:49:03.792 --> 00:49:06.570 or they didn't meet grant contract deliverables,

945 00:49:06.570 --> 00:49:10.030 that the coalition could still function

946 00:49:11.310 --> 00:49:13.860 for a time till we found another agency to lead

947 00:49:13.860 --> 00:49:16.953 to serve as the lead organizing agency.

948 00:49:19.500 --> 00:49:22.050 And so just things that consider,

949 00:49:22.050 --> 00:49:24.213 as having gone through all these things.

950 00:49:25.620 --> 00:49:27.030 One thing that we realized,

951 00:49:27.030 --> 00:49:29.880 even though we're conducting a randomized control trial,

952 00:49:29.880 --> 00:49:34.413 that we have to figure out ways to adapt.

953 00:49:35.790 --> 00:49:39.210 We say sometimes, ”We have to bend or we're gonna break.”

954 00:49:39.210 --> 00:49:40.893 And I think we've seen that,

955 00:49:42.184 --> 00:49:44.640 that we try to figure out how we're gonna sort of

956 00:49:44.640 --> 00:49:46.500 adjust as we go along.

957 00:49:46.500 --> 00:49:48.840 So I would consider using a design that will allow you

958 00:49:48.840 --> 00:49:50.793 to adjust as you implement.

959 00:49:51.750 --> 00:49:56.160 What you see on the screen, this is a slide from a talk

960 00:49:56.160 --> 00:50:00.000 I saw Donna Spiegelman give about this approach

961 00:50:00.000 --> 00:50:01.590 that her and her team have come up with

962 00:50:01.590 --> 00:50:03.120 called Learn as You Go.

963 00:50:03.120 --> 00:50:05.640 And so we are looking at how do we implement

964 00:50:05.640 --> 00:50:07.740 this Learn As You Go into the study

965 00:50:07.740 --> 00:50:09.990 that's already been designed.

966 00:50:09.990 --> 00:50:13.170 It would be best to have thought about this to incorporate

967 00:50:13.170 --> 00:50:15.240 this from the beginning when we're designing the study,

968 00:50:15.240 --> 00:50:16.833 but we didn't have that luxury.

969 00:50:17.670 --> 00:50:19.530 We didn't have that foresight, I should say.

970 00:50:19.530 --> 00:50:21.840 So we're looking at how do we do this now

971 00:50:21.840 --> 00:50:25.140 so that we're not just sort of making changes here and there

972 00:50:25.140 --> 00:50:26.820 based on our subjective experience,

973 00:50:26.820 --> 00:50:30.720 but that that we have some data-driven estimates

974 00:50:30.720 --> 00:50:33.120 about where we need to make changes and how much.

975 00:50:33.120 --> 00:50:34.710 So I think this offers great promise

976 00:50:34.710 --> 00:50:36.510 to the work that we're doing.

977 00:50:36.510 --> 00:50:39.300 Community engagement is key, and has to be integrated

978 00:50:39.300 --> 00:50:41.130 with scientific considerations.

979 00:50:41.130 --> 00:50:43.500 You can't do it with just scientific model.

980 00:50:43.500 --> 00:50:46.080 You can't do it with just listening to the community voices

981 00:50:46.080 --> 00:50:48.730 without considering the science, you have to do both.

982 00:50:49.590 --> 00:50:51.600 There really is a need for more implementation

983 00:50:51.600 --> 00:50:53.400 and prevention science methods

984 00:50:53.400 --> 00:50:57.810 that respond to the realities of life for black communities.

985 00:50:57.810 --> 00:51:01.230 I mentioned the challenges of doing Starfish sampling

986 00:51:01.230 --> 00:51:03.980 in some of these places, the challenges of peer support

987 00:51:05.003 --> 00:51:06.720 and social media influence in some of these places.

988 00:51:06.720 --> 00:51:09.780 So our methods need to really be able to respond

989 00:51:09.780 --> 00:51:12.750 to the realities in some of these communities

990 00:51:12.750 --> 00:51:14.790 'cause they're not always designed with

991 00:51:14.790 --> 00:51:17.430 that cultural logic in mind.

992 00:51:17.430 --> 00:51:19.110 And again, it's not trivial.

993 00:51:19.110 --> 00:51:20.370 Might seem so.

994 00:51:20.370 --> 00:51:22.710 When you're trying to do it, you see where it comes out.

995 00:51:22.710 --> 00:51:25.650 And then the last consideration is that we need

996 00:51:25.650 --> 00:51:30.270 more rigorous design options that are not limited

997 00:51:30.270 --> 00:51:33.600 to the RCT or that can at least enhance the RCT.

998 00:51:33.600 --> 00:51:37.650 And I think LAGO might be one thing that could enhance

999 00:51:37.650 --> 00:51:39.870 what we're trying to do with RCTs.

1000 00:51:39.870 --> 00:51:42.750 But if RCTs and some are the only things we have,

1001 00:51:42.750 --> 00:51:45.860 it really is hard for us to test some of these interventions

1002 00:51:45.860 --> 00:51:48.390 in some of these places, given the constraints

1003 00:51:48.390 --> 00:51:50.583 that are already embedded within them.

1004 00:51:51.960 --> 00:51:55.320 So I wanna just acknowledge a lot of people

1005 00:51:55.320 --> 00:51:57.360 involved in this, including the people

1006 00:51:57.360 --> 00:51:58.950 who support this through funding.

1007 00:51:58.950 --> 00:52:00.330 And that's what you see on your screen,

1008 00:52:00.330 --> 00:52:04.083 HPTN and many NIH institutes.

1009 00:52:05.580 --> 00:52:07.600 And then I did want to just say

1010 00:52:08.700 --> 00:52:13.050 sort of in a way of dedication to Dr. Dawn Smith

1011 00:52:13.050 --> 00:52:16.080 who was a very key part of this study

1012 00:52:16.080 --> 00:52:17.130 from the very beginning.

1013 00:52:17.130 --> 00:52:19.860 She is scienced at the CDC.

1014 00:52:19.860 --> 00:52:24.860 She led the development of the PrEP guidelines for the US.

1015 00:52:25.080 --> 00:52:30.030 She died a few days ago, and I will miss her immensely.

1016 00:52:30.030 --> 00:52:31.800 But the work that you see here and the things

1017 00:52:31.800 --> 00:52:35.190 that we're doing really is part of her contribution

1018 00:52:35.190 --> 00:52:39.840 to HIV prevention, practice, but also prevention science.

1019 00:52:39.840 --> 00:52:41.253 And thank you.

1020 00:52:47.400 --> 00:52:49.863 <v ->Thank you so much, Dr. Nelson.</v>

1021 00:52:51.647 --> 00:52:53.400 This is such a great presentation.

1022 00:52:53.400 --> 00:52:57.630 We only have two minutes left, and so I do wanna make sure

1023 00:52:57.630 --> 00:53:01.803 that there are any questions that you're able to answer.

1024 00:53:06.810 --> 00:53:09.760 <v ->Yep, I can stick around and see if there's any questions.</v>

1025 00:53:11.190 --> 00:53:14.519 <v ->Yeah, we're hitting on. Anyone have any questions in that?</v>

1026 00:53:14.519 --> 00:53:17.403 I'm looking. Okay, anyone has any hands up?

1027 00:53:20.490 --> 00:53:23.877 Okay, we are like right at the three o'clock mark,

1028 00:53:23.877 --> 00:53:27.510 but if there are any questions or anything comes up,

1029 00:53:27.510 --> 00:53:31.290 please feel free to email me or, you know,

1030 00:53:31.290 --> 00:53:33.090 and I can pass along to Dr. Nelson

1031 00:53:33.090 --> 00:53:37.020 or email Dr. Nelson directly.

1032 00:53:37.020 --> 00:53:40.893 Just wanna just thank you again so much.

1033 00:53:42.210 --> 00:53:43.680 <v ->Yeah, it's my pleasure.</v>

1034 00:53:43.680 --> 00:53:45.600 It's always a pleasure working with Ready,

1035 00:53:45.600 --> 00:53:47.700 and I appreciate all the work that y'all are doing,

1036 00:53:47.700 --> 00:53:49.140 including helping us.

1037 00:53:49.140 --> 00:53:52.230 I didn't say that we had a Ready consultation,

1038 00:53:52.230 --> 00:53:53.430 and it's been very helpful,

1039 00:53:53.430 --> 00:53:55.650 so thank you again for the opportunity.

1040 00:53:55.650 --> 00:53:57.630 <v ->Yeah, great talk. Great work.</v>

1041 00:53:57.630 --> 00:53:59.553 Really important work, LaRon.