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Elora Cortes Date

Using Rapid Qualitative Analysis to Assess PrEP Implementation Strategies in Title X Family Planning Clinics within Metro Atlanta

By

Elora J. Cortes, BS
Master of Public Health

Hubert Department of Global Health

Kate Winskell, PhD, MA, BA
Associate Professor
Hubert Department of Global Health
Committee Chair

Jessica Sales, PhD, MA, BS
Director of Graduate Studies
Associate Professor
Behavioral, Social, and Health Education Sciences
Committee Member

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By

Elora J. Cortes
Bachelor of Science in Public Health
The University of Texas at Austin
2020

Thesis Committee Chair: Kate Winskell, PhD
Associate Professor
Hubert Department of Global Health

Thesis Committee Member: Jessica Sales, PhD
Director of Graduate Studies
Associate Professor
Behavioral, Social, and Health Education Sciences

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Abstract

Using Rapid Qualitative Analysis to Assess PrEP Implementation Strategies in Title X Family Planning Clinics within Metro Atlanta

By Elora Cortes

Background: Over half of all new Human Immunodeficiency Virus (HIV) diagnoses occur in the Southern United States (US). Pre-exposure prophylaxis (PrEP) is a highly effective HIV prevention method that is underutilized by those at risk for HIV in the South. PrEP underutilization is pronounced among women, who represent a small percentage of PrEP users in the South. Title X Family Planning (FP) clinics are funded by Georgia Family Planning System (GFPS) to provide sexual and reproductive services, including HIV testing and PrEP counseling. However, Title X FP clinics in the South experience barriers to adopting evidence-based practices (EBPs) that involve PrEP care delivery. GFPS has deployed tailored PrEP implementation strategies in the form of trainings/technical assistance (TA)/resources with the expectation that clinics will adopt and implement PrEP.

There is a need to conduct ongoing assessments to ensure these PrEP trainings/TA/resources are optimized to meet the needs of Atlanta Title X FP clinics. Rapid Qualitative Analysis (RQA) is one potential strategy to generate actionable results from qualitative data in a timely fashion. The purpose of this study was to describe and assess RQA as a strategy to inform PrEP implementation strategies in Atlanta Title X FP clinics.

Methods: RQA was used to analyze existing data. Title X FP clinics had been recruited at the annual *Ending the HIV Epidemic* (EHE) conference hosted by Georgia Family Planning Services (GFPS) in 2022. Qualitative data from 9 focus group discussions (FGDs) among clinical administrators in Title X FP clinics across Metropolitan (Metro) Atlanta were collected one year after their anniversary date of recruitment (baseline). Each FGD was recorded, transcribed, and de-identified.

Results: Relevant quotes from each clinic extracted from FGD transcripts, were organized into a matrix that was sorted by questions from the FGD interview guide. Quotes were observed for patterns in each key domain from the interview guide using rapid thematic analysis. Lastly, a narrative summary was drafted to further conceptualize major themes emerging across focus groups.

Discussion: Due to the potential need to further tailor and adapt PrEP trainings/TA/resources to meet the evolving needs of Atlanta Title X FP clinics, RQA was used to produce actionable results that will inform potential changes to these strategies. RQA was found to be quick, cost-efficient, and able to produce outputs that respond to the community's needs. If Title X FP clinics update their PrEP care delivery system due to this project's findings, it is expected that cisgender women, especially women of color, will benefit from improved services.

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INTRODUCTION

Human Immunodeficiency Virus (HIV) continues to persist at high rates of diagnoses in the southern region of the United States (US), which accounted for more than half (52%) of new cases in 2021 (CDC, 2023a). In that same year, the State of Georgia ranked 2nd in rates of HIV diagnoses among people ≥13 years of age, just after District of Columbia (DC) (Georgia Department of Public Health, 2023). HIV also disproportionately affects people of color in the south, particularly those who identify as Black/African American or Hispanic/Latino, where their rates of diagnoses are 6.6 and 3.4 times of the rates of White persons, respectively (CDC, 2023a). Georgia's capital city, Atlanta, reported that out of 1,599 new HIV diagnoses, 1,152 cases (72.0%) were in those identifying as Black/Non-Hispanic, and 169 (10.6%) in those identifying as Hispanic/Any Race (Georgia Department of Public Health, 2023). Additionally, cisgender women in Atlanta accounted for ~19% of HIV diagnoses, of whom more than 75% identified as either Black/African American or Hispanic/Latina (Georgia Department of Public Health, 2023 & Malcom et al., 2019).

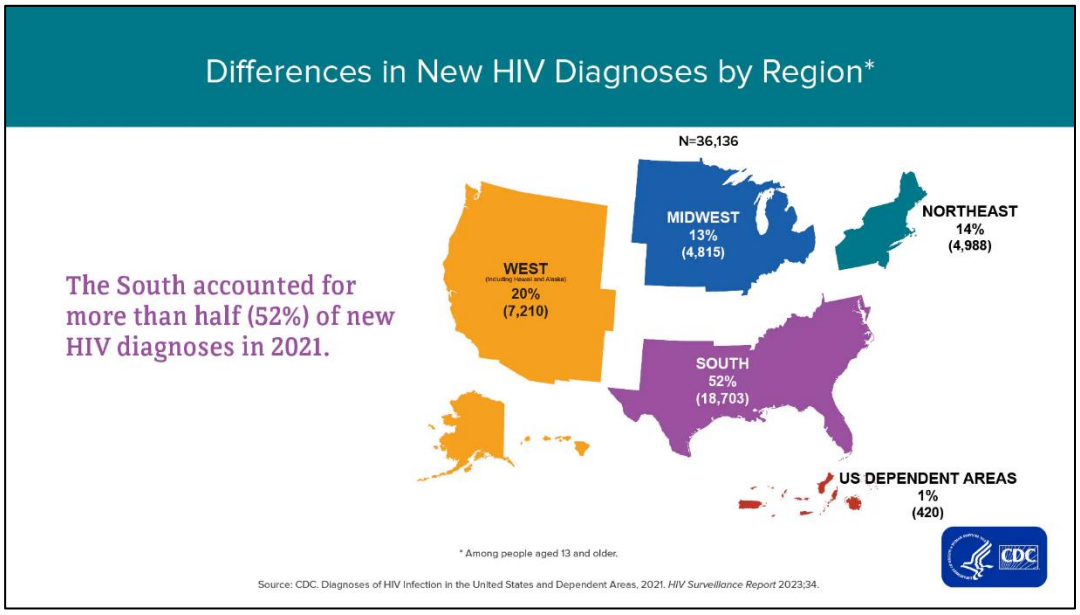

Image from (CDC, 2023a)

Pre-exposure Prophylaxis (PrEP) is a medication taken prior to a potential exposure to HIV, thus reducing the risk of an HIV infection by 74-99% (CDC, 2020 & Sullivan et al. 2018). The Southern United States, though ranking the highest in HIV diagnoses in 2021, only accounts for 39% of the total users of PrEP in the nation (AIDSVu, 2022a). Since the approval of oral PrEP (Truvada) by the Food and Drug Administration (FDA) in 2012, utilization rates among men have increased, but rates among women have shown no growth (CDC, 2023a & Sullivan et al., 2018). Among all PrEP users in the US, 92% are men and 8% are women despite the national average of new HIV diagnoses among women being ~18% (AIDSVu, 2022a). In the context of the recent approval of injectable PrEP (Apretude) in 2021, PrEP uptake among cisgender women remains low (FDA, 2021 & Sales et. al, 2018).

People who identified as Black/African American have represented only 14% of PrEP users, yet in the nation, have accounted for 42% of new HIV diagnoses (AIDSVu, 2022a). Those who identified as Hispanic/Latino have represented 17% of PrEP users, accounting for 27% of new HIV diagnoses in the US (AIDSVu, 2022a). Particularly in the Southern US, Black and Hispanic/Latina women have shown significantly lower rates of PrEP usage, implying that women of color have a higher unmet need for PrEP initiation than their white counterparts (AIDSvu, 2022b, HIV.gov, 2020, & Bush et al., 2016). In addition to race/ethnicity, women who are of low income experience this health disparity of low PrEP utilization (Malcom et al., 2019). This creates patient barriers such as not being able to afford PrEP medications and having limited access to family planning (FP) clinical services that are culturally appropriate (Smit & Masvawure, 2023).

Federally Qualified Health Centers (FQHCs) serve as one of the primary locations for FP services in Georgia, including HIV testing and PrEP counseling (Frost et al., 2019 & Clochard et

al., 2023). FQHCs are known to provide quality, comprehensive care that is accessible, cost-effective, and ultimately centered around community needs (Georgia Department of Community Health, n.d.) In the State of Georgia, FQHCs are one of the main locations that receive funds to provide FP services from Georgia Family Planning System (GFPS), a recipient of the Title X Service Grant. The Office of Population Affairs (OPA), housed under the United States Health and Human Services (HHS), rewards the Title X Service Grant to organizations who meet the criteria of the Title X program. OPA requirements for the program include:

1. Advancing health equity through the delivery of Title X services,
2. Improving and expanding access to Title X services, and
3. Ensuring the delivery of the highest quality of care (OPA, n.d.-a)

FQHCs, which will now be referred to as Title X FP clinics in this paper, have met these criteria. In 2022, patients served in Title X FP clinics were 86% female, 56% were <30 years of age, public (66%) or privately (34%) insured, and 31% were uninsured (Clochard et al., 2023). In addition, 60% of patients identified at or below the federal poverty line for their household income (Clochard et al., 2023). Because Title X FP clinics serve patient populations that may be at high-risk for HIV infection and could benefit from PrEP use, these sites are ideal for PrEP delivery, particularly in the Southern US. (AIDSVu, 2022b, Auerbach et al., 2015, Clochard et al., 2023, Frost et al., 2019, & George et al, 2023).

Problem Statement

Metropolitan (Metro) Atlanta ranks 3rd in rates of new HIV diagnosis compared to other major cities in the US, with women of color being most affected (CDC, 2023a). In a 2018 survey across clinical staff in Title X FP clinics in the South, only 22% of clinics provided services related to PrEP, with the Southeastern region (location of Atlanta, GA) having the fewest clinics offering PrEP (Sales et al, 2021). Atlanta Title X FP clinics are a key source for providing sexual and reproductive health services among cisgender women, yet they underutilize evidence-based practices (EBPs), specifically HIV testing and PrEP implementation (Sales et al., 2021).

In efforts to combat the ongoing HIV epidemic in the United States, Emory University, in partnership with GFPS, launched the Interactive Technologies for Preventing HIV in Title X Services (IT-PHITS) Project, the aims of which included to prepare for (via a package of implementation strategies consisting of trainings, technical assistance (TA), and resources) and evaluate how receipt of these strategies impacts adoption and implementation of HIV testing and PrEP in Atlanta Title X FP clinics. GFPS was responsible for the dissemination of packaged implementation strategies and collaborated with Emory University to collect, analyze, and respond to the findings of the data from Title X FP clinics.

Statement of Purpose

There is a need to conduct ongoing assessments to ensure these PrEP trainings/TA/resources are optimized to meet the needs of Atlanta Title X FP clinics. Rapid Qualitative Analysis (RQA) is one potential strategy to generate actionable results from qualitative data in a timely fashion. The purpose of this study was to describe and assess RQA as a strategy to inform PrEP implementation strategies in Atlanta Title X FP clinics.

Objectives/Aims

An assessment, after one year, using Rapid Qualitative Analysis (RQA) was undertaken to understand the impact of tailored implementation strategies provided by GFPS. The assessment sought to determine whether there are continued or newly identified barriers and/or facilitators to PrEP implementation among Title X FP clinics in Metro Atlanta that could be addressed by further training or other implementation strategies. The objectives of this study were to employ a step-wise RQA approach to uncover if changes were needed with the implementation strategies provided by GFPS and if additional strategies might be needed. Specific aims/steps included:

1. The development of a matrix organized by questions from the focus group discussion (FGD) interview guide and corresponding quotes from the focus group transcripts.
2. The development of summaries using rapid thematic analysis.
3. For illustrative purposes, the creation of a draft narrative summary that presents concise findings to inform potential changes to PrEP implementation strategies.
4. An assessment of the value of RQA to inform PrEP implementation strategies in Atlanta Title X FP clinics.

Significance

Most women trust and choose to receive sexual and reproductive health treatment from FP clinics rather than primary care or STI clinics. Although FP clinics serve as the ideal location to reach cisgender women at risk for HIV, slow PrEP implementation efforts in the clinics hinder this solution (Frost et al., 2019 & Sales et al., 2021). Therefore, establishing PrEP services in Atlanta Title X FP clinics, trusted centers for women's sexual health, is optimal for reaching

cisgender women at risk for HIV. This study describes and presents the findings of an RQA of existing qualitative data to inform PrEP implementation strategies, while also assessing the value of RQA for this purpose.

Definition of Terms

Evidence-Based Interventions/Practices (EBIs/EBPs) - "Programs, practices, principles, procedures, products, pills, and policies" that have been found to be effective at improving health behaviors, health outcomes, or health-related environments." (Brown et al., 2017)

Electronic Health Records (EHRs) – electronic version of a patient's medical history, provider encounters, medical records, and demographics that are managed by healthcare staff (Centers for Medicare & Medicaid Services, 2023)

Ending the HIV Epidemic (EHE) – US Department of Health and Human Services goal to eliminate HIV in the United Stated by 2030, which includes (1) reducing new HIV infections; and (2) advancing health equity by scaling up HIV prevention strategies (CDC, 2023b)

Family Planning (FP) Services – services that treat sexual and reproductive health, including HIV prevention and PrEP counseling (Clochard et al., 2023)

Federally Qualified Health Centers (FQHCs) – federally funded clinics or health centers that provide comprehensive medical care for populations that are underserved (Healthcare.gov, n.d.-a)

Focus Group Discussions (FGD/FGDs) –data collection method used in qualitative research where a selected group of people discuss topics of research interests in depth, which includes probing additional questions to generate data (Kitzinger, 1995)

Georgia Family Planning System (GFPS) – largest and only Title X Family Planning network in the state of Georgia (Georgia Family Planning System, n.d.-a.)

Human Immunodeficiency Virus – a viral disease that attacks the body's immune system and is spread by bodily fluids (blood, semen, vaginal secretions, and breast milk) (HIV.gov, 2023)

In-Depth Interviews (IDIs) – data collection method used in qualitative research where one-on-one conversations between a researcher and a chosen subject speak on individual's experiences on a topic of choice (Taylor, 2023)

Interactive Technologies for Preventing HIV in Title X Services (IT-PHITS) – research project housed under Emory University

Medicaid – an "insurance program that provides free or low-cost health coverage to some low-income people, families and children, pregnant women, the elderly, and people with disabilities." Certain states in the US have expanded this program to reach more people below the poverty line. (Healthcare.gov, n.d.-b)

Office of Population Affairs (OPA) – awards Title X Service grants to state organizations and clinics; housed under United States Health and Human Services (HHS) (OPA, n.d.-a)

Pre-Exposure Prophylaxis (PrEP) – medication that is effective in preventing HIV infection when taken as prescribed (CDC, 2020)

Rapid Qualitative Analysis (RQA) - a fast, cost-effective, and action-oriented approach for qualitative and mixed-methods studies within the research realm to use its findings to quickly inform practice (George et al., 2023 & Nevedal et al., 2021)

Sexually Transmitted Infection/Disease (STI/STD) – an infection with caused bacteria, viruses, or parasites that can be passed from one person to another through blood, semen, vaginal, or other bodily fluids, during oral, anal, or genital sex with an infected partner (National Cancer Institute, 2011)

Title X – established in 1970, this was created to provide affordable sexual and reproductive health care, primarily to people with low incomes (Planned Parenthood, 2016)

LITERATURE REVIEW

PrEP plays an essential role in women's HIV continuum of care in the Southern United States. In 2021, women accounted for 19.8% (6,604) of new HIV diagnoses in the South, yet only 9.7% of women are PrEP users (AIDSvu, 2022b & CDC, 2023a). PrEP is a highly effective, female-controlled form of HIV prevention, but is extremely underused among women in the South (CDC, 2023a & Sales et al., 2018). Title X FP clinics have provided comprehensive healthcare for women's sexual and reproductive health (Frost et al., 2012, Sales et al., & Criniti et al., 2011) and serve over 4 million people of different backgrounds (race/ethnicity, income) each year. Targeting cisgender women for PrEP care delivery aims to meet the goal of the *Ending the HIV Epidemic* initiative (EHE), which is to reduce the number of HIV infections and advance health equity through scaling up HIV prevention strategies (CDC, 2023b & Sales et al., 2021).

HIV testing is a valued form of screening among patients who are at risk of contracting the disease. This allows clinicians to identify individuals who are positive for HIV so they can get treated and thereby also prevent the transmission of disease among sexual

partners (Criniti et al., 2011). HIV testing also allows clinicians to identify patients who test negative for HIV and may therefore be eligible for HIV prevention methods such as PrEP. However, in the US, 1 in 9 women with HIV are unaware they have it (CDC, 2023a). Furthermore, transmission of HIV through heterosexual contact accounted for 86.1% of cases among women, making it a "substantial risk" for women's sexual health in the US (AIDSvu, 2022b, Auerbach et al., 2015, & CDC, 2023a). The current CDC guidelines recommend clinics to utilize routine testing, which performs HIV tests for all adults, male and female, between the ages of 13 – 64. Regardless of an individual's risk, the patient would have to decline the test, otherwise, the test will be performed as part of the treatment regimen of the relevant visit (Criniti et al., 2011). This guideline can also be called "opt-out" or "universal" testing in the medical field.

In one study done in an FP clinic in Pennsylvania, the transition to implement routine testing came with the addition of training more medical staff on HIV screening and counseling (Criniti et al., 2011). This allowed for a larger team to perform tests (medical assistants) and counsel patients (certified nurse midwives, nurse practitioners) as, originally, a dedicated HIV counselor was responsible for treating their patient population (Criniti et al., 2011). This transition allowed the streamlining of routing testing across all patients, ages 13-64, who visit their FP clinic, with a 31% increase (65%) in tests done from the year prior (34% of patients tested). Additionally, an evaluation in the form of a Likert survey was given to staff members, where 100% of clinical staff believed routine testing to be "very important", and 78% believed the integration of routine testing to be "very" or "somewhat successful" (Criniti et al., 2011).

Though the Criniti et al. (2011) study took place before PrEP was accessible to the public in 2012, there are limited studies that have replicated this method, especially in the Southern US,

including Metro Atlanta. Therefore, it is important to engage medical staff in trainings that involve implementing HIV prevention strategies as this increases their awareness of resources available in a clinic and their comfort to refer to services if patients are at risk for HIV (OPA, n.d.-b & Wilbourn et al., 2023). This need is further reinforced in more current literature that highlights clinician-level barriers, as having a climate supportive of HIV prevention practices in the clinic can increase readiness for PrEP implementation among clinical staff as a team (Sales et al., 2021).

Before women can perceive the benefit of taking PrEP as a female-controlled method of HIV prevention, they must be aware of the risk of contracting the disease and where PrEP is accessible in their community (Sales et al., 2021). Women, however, have not been in the limelight for PrEP marketing tactics as men who have sex with men (MSM) are the primary audience for HIV awareness and prevention (Sales et al., 2018 & Smit and Masvawure, 2023). In 2021, the PrEP-to-need ratio (PNR), which is defined as the number of PrEP prescriptions divided by the number of new HIV diagnoses, among adults ages 13 - 64 who identified as Black/African American or Hispanic/Latina is 3.49 and 5.99, respectively, compared to their white counterparts (25.87) (AIDSVu, 2022b). Furthermore, women in the South had a PNR of 4.87 (Ridgeway et al., 2023), compared to the national PNR for males which was 11.36. This indicates an inequity among women of color in Southern US who are not utilizing PrEP, despite the high need for prevention methods to reduce the burden of HIV.

According to multiple studies, having conversations around PrEP during patient-provider visits is a key determining factor in PrEP uptake among women (Ridgway et al., 2023, Smit and Maswawure, 2023, & Wilbourn et al., 2023). This increases PrEP awareness and knowledge among patients who may have been screened at risk for HIV. However, a widely cited clinician-

level barrier is the adequacy of resources, which impacts the standardization of provider trainings for PrEP counseling (Sales et al., 2021 & Ridgway et al., 2023). As mentioned before, comfort to provide HIV prevention counseling, in this case, PrEP counseling, within a team of clinical staff members can impact the readiness of a clinic to implement PrEP (Sales et al., 2021). However, providers in Georgia have shared that speaking on the topic of sex can be uncomfortable for the patient and themselves, thus making it difficult to facilitate dialogue without sounding judgmental (Newton-Livingston et al., 2023 & Wilbourn et al., 2023). Another study's finding has shown that providers in the South are not trained to routinely discuss PrEP with patients, which is further exacerbated among cisgender women of color (Ridgway et al., 2023).

Patients, particularly Black women, have cited medical mistrust due to factors such as experiencing discrimination in the medical space, medical racism, and/or perceiving their providers as unknowledgeable about their health needs (Auerbach et al., 2015 & Ridgway et al., 2023). In addition, there is a stigma related to showing interest in taking PrEP as it insinuates that they are engaging in promiscuous behaviors that put them at risk for HIV (Auerbach et al., 2015 & Smit and Masvawure, 2023). Therefore, in the development of standardizing provider trainings for PrEP counseling, it is important to include the practice of using culturally inclusive and nonjudgmental language that aims to reduce medical mistrust and stigma. Addressing the adequacy of resources may also inform the adaptation of PrEP implementation strategies to meet the needs of PrEP-prescribing providers in terms of the quality of information presented to patients, execution of conversations, and the relevance to their patient population (Newton-Livingston et al., 2023 & Sales et al., 2021).

Title X FP clinics have shown the capacity to provide a full range of care, including patient education, counseling, and social services (Frost et al., 2012). However, in the case of

PrEP care delivery, about one-fifth of 283 Title X FP clinics in the South were providing PrEP counseling and resources to their patients, most of whom identify as female (Sales et al., 2021). Besides promoting PrEP awareness and staff comfortability among clinicians, a larger, more systematic barrier clinics face is the lack of leadership and organizational support to implement PrEP strategies. This leads to the slow adoption of EBPs for HIV prevention as it requires change across a large network, making it challenging to achieve (Sales et al., 2023 & Wilbourn et al., 2023).

Georgia is one of many Southern states that has not expanded Medicaid (Clochard et al., 2023 & Sales et al., 2021), yet Title X FP clinics serve a diverse population, and many patients have varying insurance coverages or low-income levels (Frost et al. 2012 & Criniti et al., 2011). In a study that compared PrEP users in Mississippi, Missouri, and Rhode Island, an individual was found to be 4 times more likely to utilize PrEP if they had insurance coverage versus not being insured (Patel et al., 2017). Being insured versus uninsured also influenced a provider's decision to prescribe PrEP, as sexual health providers cited a worry about their patients' retention of PrEP medications due to out-of-pocket costs (Wilbourn et al., 2023). However, to mitigate these patient-level barriers to insurance and/or medical costs, GFPS, the recipient of OPA's Title X Service Grant, allocates funds across Georgia Title X FP clinics to expand low-cost access to sexual and reproductive health services, including PrEP services. Furthermore, GFPS monitors the progression of FP services and aims to address the individualized needs of these clinics, increasing the support on an organizational level (Newton-Livingston et al., 2023 & Georgia Family Planning System, n.d.-a).

This expansion has led to women entrusting Title X FP clinics with their sexual and reproductive health needs. In a study that assessed US women's reasons for choosing an FP

clinic, 84% mentioned being treated with respect by clinical staff, 82% experienced confidential services, and 80% received free or low-cost services (Frost et al., 2012). Additionally, among Black women in the South, interpersonal-level facilitators to PrEP acceptability and uptake came from healthcare provider encouragement and social support, and societal-level facilitators included PrEP being accessible and affordable (Smit and Masvawure, 2023). This aligns with OPA's Title X service requirements in which GFPS monitors among their main funding recipients, Georgia Title X FP clinics (OPA, n.d.-a). Atlanta, the capital of Georgia, and being identified as an HIV "hot spot" for Black women, makes this location unique for GFPS' monitoring efforts (Sales et al., 2018).

Given that Title X FP clinics operate based upon the needs of the community all while navigating changes in health policy, there is a constant changing landscape that makes PrEP implementation efforts complex to execute (George et al., 2023). FP clinics, by the OPA's Title X service requirements, should strive for health equity, which is defined as "the attainment of the highest level of health for all people," through addressing avoidable inequalities caused by historical and contemporary injustices while eliminating disparities in healthcare (Office of Disease Prevention and Health Promotion, 2020). The health inequity of PrEP underutilization is experienced among cisgender women at risk for HIV, especially in the South, given the statistics (AIDSVu, 2022b). Therefore, in order to address this health inequity experienced among the majority of the patient population in Title X FP clinics, an evaluation of ongoing implementation efforts must be conducted to assess potential barriers and/or facilitators that may inform actionable recommendations to be applied to PrEP implementation efforts (Gale et al., 2019).

Qualitative data provides an "in-depth" look into human experiences and behaviors, evaluating valuable insights that might have been missed in the analysis of quantitative data (Watkins, 2012). However, researchers may find qualitative methods and analysis to be daunting, as the required time-commitment, rigor, and immersion in the data when conducting the processes may be not feasible in the context of their project's timeframe, budget, or resources (Watkins, 2017). However, the development of Rapid Qualitative Analysis (RQA) may provide a fast, cost-effective, and action-oriented approach for qualitative studies (Nevedal et al., 2021). There are different RQA approaches such as rapid assessment procedures (RAP), rapid and rigorous qualitative data analysis (RADaR technique), and rapid ethnographic assessments (REA), but all share a common goal, specifically in implementation projects that utilize qualitative methods, to produce outputs that meet a community's needs.

In one case example, an *EHE* initiative from 2016 – 2017 supplied HIV-prevention resources to rural areas in states that experienced disproportionate rates of HIV diagnoses. The Latino populations are overrepresented among those affected by these HIV rates, which prompted researchers to conduct interviews with nine HIV providers serving the Latino population in these states (George et al., 2023). Using RQA, within 8 months of initiating qualitative data collection (February to June 2021), research findings were generated for dissemination. The healthcare providers noted a lack of readiness of HIV organizations to respond to the COVID-19 pandemic. In addition, providers cited negative experiences in healthcare encounters with patients and their limited knowledge of cultural competency in providing HIV services (George et al., 2023). Researchers were able to rapidly summarize these findings and use their already well-established relationships with the Latino community and HIV service organizations to inform change. These changes included: (1) the implementation of

comprehensive policies for employee safety in the workplace; (2) the increase of funds for resources that transport patients to healthcare facilities; and (3) a training for HIV care providers for the implementation of culturally appropriate services to Latinos disproportionately affected by HIV (George et al., 2023). This case example exhibits similar goals compared to this study, inferring that RQA may benefit cisgender women at risk for HIV through the assessment of tailored PrEP implementation strategies among Title X FP clinics and its output informing actionable recommendations.

In summary, given the gaps between knowledge of EBPs to scale up PrEP and applied practice in Atlanta Title X FP clinics, there is a crucial need to implement tailored PrEP trainings/TA/resources. Additionally, due to the highly evolving needs of healthcare settings, there is a need to conduct ongoing assessments to ensure these PrEP implementation strategies are optimized to meet the needs of Atlanta Title X FP clinics.

To evaluate whether these trainings/TA/resources have been successful, or if revisions are needed, an assessment of the impact of PrEP implementation strategies will be conducted using RQA, specifically the RADaR technique. This analysis will require 5 steps: (Step 1) formatting data transcripts; (Step 2 & 3) matrix of FGD questions and answers; (Step 4) summaries using rapid thematic analysis; and (Step 5) narrative summary. The produced findings will then inform actionable recommendations that further anchor PrEP as an HIV prevention strategy in Title X clinics across Metro Atlanta, making it pivotal in reducing the burden of disease in the South and *EHE* in the US (CDC, 2023b). In addition, this study will assess the value of RQA as a strategy to inform actionable PrEP implementation strategies in Atlanta Title X FP clinics in a timely manner.

METHODS

Study Design

This study used existing qualitative data, described below, and collected as part of the research project, IT-PHITS, of which Dr. Jessica Sales and Dr. Anandi Sheath are the co-principal investigators. This data contributes to the larger research efforts of the IT-PHITS project's Aim 1: Prepare and evaluate adoption and implementation of PrEP care in Atlanta Title X clinics. The activities of this aim consist of (1) Preparing GFPS to provide a menu of tailored PrEP implementation strategies to support Title X clinics (Project Year (PY) 01, Quarter (Q) 1-2), (2) Monitoring Title X clinic use of these tailored implementation strategies offered by GFPS (PY01, Q3 – PY04), and (3) Evaluating the association between clinics' use of tailored PrEP implementation strategies and PrEP reach among cisgender women patients in their clinics (PY01, Q3 – PY04).

For the context of this study, I will be performing the evaluation activity by utilizing RQA to analyze the existing qualitative data from the annual clinic focus groups collected from PY02 (Table 1). Baseline clinic focus groups completed at PY01, patient in-depth interviews, and chart abstractions were not included in this analysis.

Table 1: Evaluation of PrEP implementation and PrEP reach among cisgender women patients (Project Years (PY) 01-04)

Method	**Source**	**Timing (Study Months)**	**Measures**
Clinic focus groups	Clinic admin (Title X coordinators, providers, staff) - per clinical site	Baseline = PY01 starting at GFPS EHE Annual Conference; annually following baseline anniversary date for PY02, PY03 and PY04	Probed about: PrEP adoption and implementation, use and adequacy of GFPS training/ TA resource materials, implementation processes and ongoing barriers/facilitators
Patient In-depth Interviews	Random sample of patients (determined by random days selected for interviews) (n = ~ 40)	Interview cis women patients after clinic visit (Across PY02-PY04)	Receipt of HIV testing, receipt of PrEP counseling, satisfaction with HIV/PrEP conversations, patient- centeredness, awareness about PrEP before visit, interest in PrEP, did

			provider recommend PrEP; decision about PrEP; history of PrEP use
Chart abstraction	Medical records; reported in aggregate to GFPS monthly for FPAR--we will receive data for Atlanta clinics for PY01-PY04	PY01 = baseline PY02 = early implementation PY03 = late implementation PY04= sustainment	Quarterly proportion of women who: receive HIV test, proportion who receive HIV prevention counseling, # of PrEP prescriptions

Geographical Context

Four focal counties with cited high rates of HIV incidence and prevalence among cisgender women, particularly women of color, in the state of Georgia were identified: Cobb, DeKalb, Fulton, and Gwinnett. These 4 counties make up Metro Atlanta, Georgia, which is part of part of Southern United States (Georgia Department of Community Health, 2023).

GFPS, Georgia's Title X grant fund recipient from the OPA, is responsible for integrating Title X FP services in FQHCs (Georgia Family Planning System, n.d.-b & OPA n.d.-a). There are an estimated 31 FQHC sites in the four Metro Atlanta counties, with 6 clinical sites located in Gwinnett, 2 in Cobb, 13 in Fulton (City of Atlanta), and 10 in DeKalb (Georgia Family Planning System, n.d.-b). The primary mission of GFPS is to (1) administer Title X funds to health centers to support the delivery of integrated FP/sexual health services at clinical sites across the state, and (2) build the capacity of these clinical sites to provide comprehensive FP and other sexual health services (HIV testing/ prevention, STI testing, Pap Smears, etc.) through training and TA.

Study Population

Title X FP clinics began recruitment at year-1 (PY01) of the research project, where GFPS and the Emory team met one-on-one with clinic leadership personnel from 31 Metro Atlanta FQHC sites at the 2022 GFPS *EHE* annual conference to share HIV and PrEP- related

statistics and the description of the project. Alongside recruitment, information regarding GFPS's menu of implementation strategies (trainings, TA, and resources) was presented as a solution to support the implementation of PrEP care in clinics that had shown interest (Table 2). Between January 2022 – November 2023, a total of 11 clinics were recruited to participate in the study.

Focus Group Discussions

At that time, GFPS and the Emory team conducted their baseline FGD with each site's clinic leadership personnel and asked to identify any trainings/TA/resources they would like to schedule for their clinic (Table 2). Clinical sites then scheduled their training(s), and monitoring logs were updated to keep track of how many trainings and what type of trainings had been delivered at each participating site between PY01-PY04.

Table 2: Menu of implementation strategies offered by GFPS to facilitate implementation in Title X clinics (Updated as of March 15, 2024)

Trainings		
Description	**Content**	**Audience and Format**
Overview of HIV Testing and PrEP	Overview of PrEP (what it is, how it works, potential benefits); tips for conversations about PrEP; overview of HIV testing (universal, opt-out, routine)	Entire Clinic Staff (30 min)
PrEP care for Clinicians	PrEP care steps: interpret HIV tests, assessing PrEP eligibility, start PrEP, PrEP monitoring & follow-up, women's considerations	Clinicians (1 hour or 2x 30-min)
PrEP Insurance Navigation	Navigate Georgia insurances/drug assistance programs	Insurance, Pharmacy, and/or Admin
PrEP: What's on the Horizon	New products available/ in development (ex., long acting PrEP)	Clinicians
Alternative PrEP Delivery	Overview of PrEP care models (i.e., same-day & telehealth PrEP)	Clinicals and/or Operations Teams
Reporting PrEP Metrics	How to report PrEP metrics for the Title X Family Planning Report	GFPS Quick Tips
Taking a Sexual History	Improving skills in taking a detailed, non-judgmental sexual history	Clinicians (30 minutes) GFPS Quick Tips
STIs (2021 Guidelines)	Review CDC 2021 STI diagnosis and management guidelines	Recorded Lecture Available
Technical Assistance (TA)		

Description	Content
Follow-in support for any PrEP trainings	To provide follow-up, hands on support specific to any of the trainings offered
PrEP implementation planning consult visit	To facilitate the development of a plan for PrEP implementation in your clinic
PrEP and EHR consultation	To provide technical assistance on how to incorporate PrEP care steps into the EHR and/or utilize the EHR to track PrEP metrics
Consultation on alternative PrEP delivery	To assist clinics who want to incorporate novel PrEP delivery models (ex.: same day PrEP & telehealth PrEP)
Resources	
Description	**Content**
Patient-facing PrEP materials	Flyers, handouts, posters including specific content for women (available in both English and Spanish)
Provider-facing materials	Reference sheets on HIV testing, PrEP counseling, and/or PrEP steps, and sexual health assessment
Sexual health assessments	Sexual health assessments that can help identify patients who may most benefit from PrEP, inclusive of unique considerations for women
Opt-out HIV testing consents	Template example of opt-out of HIV testing consents

In preparation for clinical sites' first anniversary of being recruited into the study (PY02), the Emory team prepared a set of questions that were categorized under three key domains for their annual interview in the form of FGDs: (1) HIV Testing; (2) HIV Prevention; and (3) Training Feedback. Each question, including follow-up questions and probing prompts, explicitly asked about the adoption and implementation of EBPs such as HIV routine testing and PrEP counseling. An example of FGD interview guide questions is provided below:

<u>Key Domain 1: HIV Testing</u>

1. Can you please briefly describe how HIV testing is offered at your clinical site(s)?
    i. Follow Up: Do you currently offer HIV testing to all patients 13-64?
        - PROBE about patient perspectives, provider concerns, time.

<u>Key Domain 2: HIV Prevention</u>

2. Since we last met with your clinic on [baseline date], have there been any changes to your clinic's offering for PrEP for HIV Prevention?

ii. Follow Up: Are your clinical sites currently offering PrEP for HIV prevention?

- Follow Up: IF YES, can you briefly describe how PrEP services are currently being implemented in your clinic? Are there any challenges with implementing PrEP at your clinical site(s)?

a. PROBE about PrEP Education and Counseling, prescribing PrEP, etc.

Key Domain 3: Training Feedback

3. What did you think about the PrEP trainings that were offered in your clinic?

iii. PROBE: How did you feel about the format and delivery?

iv. PROBE: What trainings have been most successful at engaging staff?

A total of 9 out of 11 participating clinics had completed their clinical focus group within the time frame of this study (March 2023 -January 2024). One clinical site had not reached their anniversary date from baseline yet (November 2024), and the other clinical site may be lost to follow up due to its temporary closure (due January 2023). Each completed focus group consisted of between 1 and 4 participants. A total of 19 participants were considered either Title X FP coordinators, clinical leadership, or medical staff who specialize in HIV and PrEP counseling.

Each focus group discussion was recorded, with the participants' consent, to allow the Emory research team to transcribe it for data analysis purposes. I was given the task of listening to each audio recording to verify that the transcription of the audio was correct, and de-identifying any names of individuals and/or organizations mentioned throughout. Out of the 9

total recordings, 1 recording was un-transcribable, therefore, the executive decision was made by the Emory research team to utilize the interviewer's notes for analysis.

Procedures

To determine the level of acceptability and appropriateness of trainings/TA/resources in Table 1 that were disseminated, in addition to PrEP adoption and implementation, it was decided that Rapid Qualitative Analysis (RQA) would be best suited for the secondary data analysis of the FGDs. RQA has been developed as a fast and cost-effective approach for qualitative studies within the research realm (Nevedal et al., 2021). In community-based research, RQA has the capacity to address health equity issues by responding to community needs in a quick and timely manner (George et al., 2023). Therefore, due to the high need to adapt PrEP implementation strategies in Atlanta Title X FP clinics, RQA may provide assistance for tailoring to the individual needs of the clinics.

A crucial part in assuring the quality and effectiveness of the RQA process involves employing a dedicated research team throughout the process of qualitative data collection and analysis (George et al., 2023). I, alongside the IT-PHITS team, have been trained on RQA methodologies, particularly the RADaR technique.

In the context of this study, I conducted all 5 steps of the RADaR technique (Image 1), with steps 2, 3, 4, and 5 presented as the objectives of this study: (1) formatting of data transcripts; (2 & 3) matrix development; (4) FGDs summaries using themes; and (5) draft narrative summary.

Image 1: 5 Steps to conduct a Rapid And Rigorous Qualitative Data Analysis (RADaR technique)

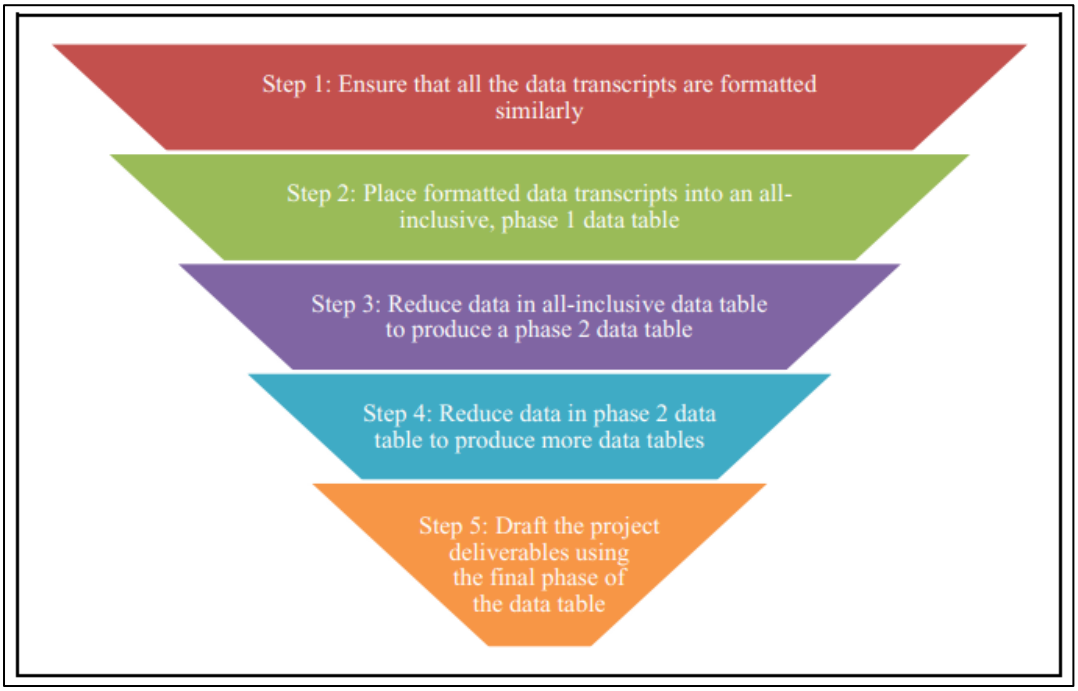

Image from (Watkins, 2017)

Institutional Review Board (IRB) Approval

This project includes human subjects research in the form of a series of FGDs. As the FGDs were recorded, ethics approval was sought and received from the Emory IRB. These recordings have been transcribed, de-identified, and summarized. As I am employed under the IT-PHITS research team, I am on the Emory IRB protocol and approved to use this data for data analysis purposes.

RESULTS

Step 1: Formatted Data Transcripts

Prior to completing the objectives of this study, transcripts, audio files, and interviewer's notes were reviewed for each FGD thoroughly. This included de-identifying names,

organizations, and other identifying factors. This ensured that all transcripts from the FGD were formatted similarly so that they could be copied and pasted into a data table (Watkins, 2017).

Steps 2 and 3: Annual FGD Matrix

The Annual FGD Matrix was developed in Microsoft Excel, where questions, divided by the 3 key domains (HIV Testing, HIV Prevention, Training Feedback), from the FGD interview guide were placed into the columns. Each row was then categorized by each interviewee that participated in their clinic's respective FGD. First, all interviewees/participants' replies to the questions were inputted into the cells of the matrix, making the table inclusive to all answers, regardless of their relevance (Step 2). Next, quotes in each cell that did not help answer the purpose of this study (e.g. interviewer's speech, cross chatter) were removed (Step 3).

Using the RADaR technique, Steps 2 & 3 were undertaken simultaneously to develop a data reduction table that incorporated relevant answers (quotes) from all participants in an Excel sheet, ultimately creating the product of a matrix (Watkins, 2017). An example of the Annual FGD Matrix (Table 3) was further de-identified and provided below:

Table 3: Annual FGD Matrix

		Role Identification	**Key Domain: HIV Testing**	
	Question ⇒	**Can each of you describe your role at the clinic?**	**Since we last met with your clinic, have there been any changes to your clinical site's policies for HIV testing?**	**Do you currently conduct HIV testing annually or more for your patients who are sexually active?**
Focus Group Description: Date and Clinic (De-identified) ⇓				
20230915 Clinic 1: Participant 1		So her role has changed a lot, but I'm a PA.	Yeah, we had two health program coordinators that was really involved	

			with like the HIV grant that have left not too long ago. So there is a new health program special specialist.	
20230327 Clinic 2: Participant 1		So I'm _____ _____ _____ PREP coordinator here at the center. And I worked closely hand-in-hand with [Interviewee #2], and some of the other doctors, but mostly [Interviewee #2].	We tend to refer those STI patients, like [Interviewee #2] was saying, that fit the criteria that they're coming in for the testing. Or if this was their regular physical we do an HIV rapid test. So that's one of the things that _____ _____ _____ talk to you is _____ rapid, we did _____ _____. So we were in the process of getting up and going pretty good.	Yes. And as well as new patients. All new patients are given a rapid as well. Yeah. And they do bloodwork. So they're kind of a double testing.
20230515 Clinic 4: Participant 1		I'm [Interviewee #1] and I'm the chief medical officer at [clinical site], and of course, I oversee all the clinical process and everything else.	No, we still offer it during our clinical physical exams.	

	HIV Testing (cont.)		**Key Domain: HIV Prevention**	
	Do you currently conduct HIV testing on all of your patients who are 13-64 at least once? Do you do opt-out testing in your clinic sites?	**Are there any challenges with implementing HIV testing at your clinic?**	**Since we last me with your clinic, have there been any changes to your clinic's offerings for PrEP for HIV Prevention?**	**Are your clinical sites currently offering PrEP for HIV prevention? IF YES: Can you briefly describe how PrEP services are currently being implemented? Challenges implementing PrEP**
20230915 Clinic 1: Participant 1	So before I joined, universal testing wasn't really happening, like it wasn't really practiced. And we worked really hard to integrate that into the workflow. Getting the buy-on for the nurses and medical assistant was really important. I		There still hasn't been a whole lot of PrEP uptake, to be honest. Yeah. I think part of that is some of the same issue, especially with like timing. And they've also had a lot of changes in staffing and getting through to that, you know, reestablishing that linkage of care was kind of	I think the consensus is if someone is coming in specifically for STD testing, that it is something that we should educate patients on and bring it up. And we strive for that. I don't think it

	think providers, most of the time, already knew, like the guidelines that are changing, but the conversation is really sensitive, like culturally-sensitive in that clinic		like new for both parties again.	happens 100 percent all the time, but we've had discussions about doing that, at least for that patient population as specifically comes in for STD testing. So we've had some talks about integrating the HIV/PrEP conversation into family planning, although it's fairly time-constrained as well. Because half of our patient is uninsured. So getting, even getting them to the pharmacy, and you know, between that can be really hard. [No on-site pharmacy]
20230327 Clinic 2: Participant 1	Yes.	Our biggest challenges is our pediatric department. And there's challenges on both ends with the doctors, as well as patient. But the patient is from the parents...And because it's a parent speaking, there's no. The doctor tends to just kind of go with the flow.	Yes. At their physical, they're getting offered. I want them to be getting offered. [Interviewer: "So it's not based on risk per se, but everyone is offered [PrEP]"]	
20230515 Clinic 4: Participant 1	And, again, it is still an opt-out process. We do ask them specifically if they're interested and what we have learned is we have had so many patients decline the test, but we are encouraging them for sure to get this done at least once a lifetime just for low-risk individuals. But for high-risk, of course, we definitely	The only issue is in actually getting the patients to do the screening test.	Yes, and recently, we have actually started doing some outreach where we let the patients know that we are offering the PrEP services. For 2022, we actually prescribed almost ten scripts, I would say, for four unique patients. Yeah, we are based out of [City] but the number that I just let you know is for organization-wide, yeah, for all the clinics, yes.	Yeah, so for high-risk patients, we definitely, the providers, they do let them know that we offer these services. Of course, just about the medications, how advantageous it is for those patients. So we definitely encourage those patients from the

	encourage them to get this done.			clinical side to think about it. So we do have an in-house pharmacy and since we all work together, the pharmacist and all of us work together, getting access to medications, I think that is taken care of because pharmacy staff, they're really good in being proactively getting these medications for the patients.

	HIV Prevention (cont.)	**Key Domain: Training Feedback**		
	IF NO: What changes or additional assistance might you need to be able to provide PrEP at your clinical sites? Challenges to implementing PrEP	**What was your perception of the clinic's overall readiness to implement PrEP before the trainings?**	**After our PrEP trainings, did your clinic's overall readiness change?**	**What did your think about the PrEP trainings that were offering in your clinic? Did you find the information useful?**
20230915 Clinic 1: Participant 1			I think it really starts internally with the staffing and their perception and understanding of, you know, what we're doing, if it really matters, and how they can convey that to the patient. Because a lot of it depends on our patient navigators as well, and how they translate, you know, what we're asking the patient, when and how their body language is communicating.	Yeah, I absolutely love the training, the sexual history taking. I think it was really important to kind of bridge like that discussion, we wouldn't everybody.
20230327 Clinic 2: Participant 1				
20230515 Clinic 4: Participant 1		Our providers, also, if you remember last year, they were not real comfortable starting on these medications for our patients, but we did	So I think it got all the staff members on board, and then, of course, the clinician training was wonderful. [Clinical Provider] is amazing.	I think it's just giving the overall picture, giving us the birds-eye view of what we are looking at, and then going into drilling down into the basics

		have a training in collaboration with you, with this study, yes, so that training really helped. Yeah, before the training, like I said, most of the staff, they were clueless. Most of the staff, clinical and non-clinical, in the front desk and starting from the schedulers, if you look at when patients call and say, "Hey, do you guys offer PrEP?" They had no clue.	It was really a good training for all of us. And in the future, I think we would love to have more trainings, also. And like I said, we do have a lot more new staff members on board, so we are interested in actually getting more trainings scheduled.	for the clinicians. I think that definitely helped. And the trainings that you guys offered was really good, I should say.

	Training Feedback (cont.)			
	How did you feel about the format and delivery? What trainings have been most successful at engaging staff?	**Beyond meeting with GFPS/Emory team, did you have any additional PrEP trainings, internal meetings or planning sessions to discuss your clinic's PrEP delivery process? IF YES, please describe.**	**What should we consider in terms of training for PrEP implementation moving forward?**	**Comments on Injectable PrEP**
20230915 Clinic 1: Participant 1	Because in our clinic, we actually don't have a whole lot of time where we can sit to talk about this kind of thing. To address it so openly was kind of scary, because you never know how these kind of conversations can go. But I think they took it really well.	We've also had other external trainings with providers and health program specialists with like the Southeast Coalition, of something, like HIV and PrEP, so that that really helped as well. Right now, we are doing universal testing, along with our Hepatitis B and C testing in our [crosstalk] grant.	One thing that I wanted to see more of, I think this is good, because it's an incremental step. You don't want too much change in one setting, but to have like a follow-up talk for all of us and sit down with the staff and the nurses to specifically talk about HIV care, and convey the importance of, you know, the rates, how high it is. So my understanding from that first training was that it wasn't there wasn't very receptive to it, because it was online. There were a lot of signal problems, connection issues, and people	Like, on a side note, I think that, I don't know where, I mean, we're nowhere for our clinic, we're nowhere near along getting the injectable in our clinic. But I think once eventually, if and hopefully, when that happens, I think the delivery would be so much better. Like, I think the uptick would be great, because patients loved getting Depo, like as a preferred method.

			tend to just tune out, like online.	
20230327 Clinic 2: Participant 1	And you know, the best way to do that, and what I found through our last training, when we did the training on cultural sensitivity. That was truly engaging.		[Interviewer: mean, that monthly staff meeting would be a great venue for that, where we could just kind of come in with your already set times. So it wouldn't be something out of the ordinary that you'd have to kind of plan around. But we can work with your schedule for that.] And I can set that up with [clinical staff] and [clinical staff]. She's over HR, which she's normally the person who is over our monthly meetings for, you know, for our staff.	Unfortunately, ViiV is new to the market and this injectable, so not able to give us any free examples. And so right now, for women, you mostly have the APRETUDE, which women love because it's a one-time shot, you know, two months, and it gives them that freedom, which is what a lot of women want. You know, that's why Depo became so popular.
20230515 Clinic 4: Participant 1	Yes, this is good. Correct. So I think this helps because, like you said, we have more locations, six locations, so everybody's spread out all over. So Zoom sessions help and sharing the screen. I think this delivery model is good.		This definitely is a great start with the Zoom sessions, but if you are offering any on-site trainings, in the future, that would be something that would help us	Like I said, we have new providers on board, so we want to make sure that everybody is okay with this process first. And definitely in the future, we will think about the injectables, but at this moment, I would say we are going to stick with the oral preparations. Once we have everyone on board I think and we move forward with looking into injectables and things like that, I think, of course, all the clinicians, we will need the training for that.

	Training Feedback (cont.)
	What additional resources can we provide to assist with PrEP services

	at your clinical sites? What additional PrEP training or technical assistance do you need, if any?
20230915 Clinic 1: Participant 1	I think the biggest things that I can think of is helping us establish some way to get in the clinic, like actually, physically. I think once people see physically, is able to feel it, like, they kind of have to acknowledge that this is something I'm going to have to start doing more. Because it's kind of hard to advocate for something that they don't see impacting them and can't feel.
20230327 Clinic 2: Participant 1	I personally feel like flyer handouts are – they're yesterday. *[Laughter]* I don't – every time we give people, it ends up on the floor in the trash. Especially when I do outreach. Why do that when I can just simply have them hit a QR code. And, you know, people will say, oh, but they don't have phones. We have a person right here on the corner giving out free phones.
20230515 Clinic 4: Participant 1	And in the future, we would like for more trainings. We do have new providers on board, so that'll definitely help. And it all depends on the comfort level of the providers, too, but most of the providers now feel quite comfortable prescribing those medications. It's just a matter of increasing

	these patients more to get started and letting them know of the benefits of the PrEP. Our outreach folks, they are definitely looking into putting it out there in the website, making sure that our patients are aware that we are offering the services. So once the word is out, I think we can draw more patients in.

Step 4: Summaries using Rapid Thematic Analysis

First, each column from the Annual FGD matrix was copied into a Microsoft Word document, making sure to include all participant answers to the one question assigned in that column, if applicable. Next, instead of reducing the data more in a table, I chose to take hand notes on a document to analyze overall themes based on found commonalities and differences – the points of interest that are less common – per question (Watkins, 2017). In other words, a repeat of Step 3, which is the removal of quotes that do not meet the purpose of the study, was done in Microsoft Word instead of Excel. Then, an observation of patterns across the data, focusing on both the commonalities and differences was undertaken for the development of themes. In most RQA methodologies, this action is generally referred to as rapid thematic analysis (George et al., 2023 and Watkins, 2017). It is important to note that this is not a full thematic analysis that utilizes coding throughout; rather, patterns observed with this study's small subset of qualitative data (9 FGD transcripts) allowed the rapid development of themes based on both the patterns and given key domains (Watkins, 2017).

An example of the summaries developed was presented in this format: Key Domain #, Theme #, Question(s) answered, observed pattern (summary):

Key Domain 1: HIV Testing

Theme 1: HIV Testing

Are there any challenges with implementing HIV testing at your clinic?

Following the dissemination of tailored PrEP implementation strategies, some clinics indicated having conversations about the risk of contracting HIV with patients who may opt-out of getting an HIV test.

- "And, again, it is still an opt-out process. We do ask them specifically if they're interested and what we have learned is we have had so many patients decline the test, but we are encouraging them for sure to get this done at least once a lifetime just for low-risk individuals. But for high-risk, of course, we definitely encourage them to get this done."
- "Their usual paperwork that they fill out has an opt-out section on it, but we're finding that a lot of people opt-out, and then once they get in the back and I ask them and explain why we do the testing there, they're like, "Yes, fine, I'll get it." So, we do have that there, but it's still usually a conversation that we [Cross talk] back again."

Key Domain 2: HIV Prevention

Theme 2: Current PrEP Implementation Climate

Are your clinical sites currently offering PrEP for HIV prevention?

Can you briefly describe how PrEP services are currently being implemented in your clinic?

Some clinics have promoted PrEP through outreach efforts and materials, with one citing an increase in PrEP awareness among patients, and another citing success in PrEP prescription uptake.

- "Yeah, we have a lot of MSM, but we're promoting it to everyone, so, that's been—that's definitely been something we're promoting more. We're promoting it a lot more to heterosexual women."
- "So, we have materials. We have—in every room, there's a huge poster that discusses it. I know that when a provider's, when you have those Title X patients that's coming in for an issue, or even if they're just coming for, like, their birth control, they're discussing it."
- "Yes, and recently, we have actually started doing some outreach where we let the patients know that we are offering the PrEP services. For 2022, we actually prescribed almost ten scripts [PrEP medications], I would say, for four unique patients."

Are there any challenges with implementing PrEP at your clinical site(s)?

Some clinics expressed having few patients being prescribed PrEP medications due to staffing shortages.

- "I would say personnel. Like just having the staffing in place to provide services is one of our biggest issues, but I feel like that is an issue kind of across the board."

- "There still hasn't been a whole lot of PrEP uptake, to be honest. Yeah. I think part of that is some of the same issue, especially with like timing. ...And they've also had a lot of changes in staffing and getting through to that, you know, reestablishing that linkage of care was kind of like new for both parties again."
- "I think right now as providers we're just sort of trying to keep our head above water, so it's not top of mind. The main provider who was doing a lot of our reproductive health services – [audio cuts out] – left the organization. So she took a lot of the patient base with her, unfortunately. ...So our other family doc does a lot of chronic care prevention, geriatric care, so he really wasn't doing a lot of the PrEP prevention counseling. ...We have another provider coming full-time in December."

Additionally, two clinics shared issues with patient recruitment.

- "Very overwhelming as well, but I think our organization has been having challenges building our patient base in general. So I don't know if we've made much movement on the PrEP front, because we're just trying to get patients in the door."
- Some of the patients are undocumented so when they go in to ask questions, they are concerned about it impacting their immigration status (i.e. undocumented patient population/confidentiality/cultural barriers + fears) (from interviewer's notes).

Theme 3: PrEP Awareness in the Community

Are there any challenges with implementing PrEP at your clinical site(s)? (cont.)

Some clinics perceive their patients' reluctance regarding the uptake of PrEP due to stigma that exists in the community.

- "I think there definitely needs to be more education. I guess a kind of follow-up to the last question, another barrier may be just time, as far as having the time to really dive into those educational components. I feel like there are some patients who would be great candidates for PrEP, but are just not open. ...So I think some of it may be education. A lot of it could just be stigma. Even though there's a lot more awareness about HIV and AIDS now, there's still a negative stigma, connotation with HIV."
- "Mostly education. Because sometimes people feel as though if they're getting PrEP, then they're doing something they're not supposed to be doing. And so is this about having a conversation, really. And so, so whether you're a man has sex with men, or if you're a female in the Atlanta area, who's actually was at one point, was the highest growing populations for HIV, we understand you have to have the conversation, and say, look, this is what we can do for you to help you not get HIV."

Key Domain 3: Training Feedback

Theme 4: Preferences for Training/Technical Assistance/Resources – PrEP

What was your perception of the clinic's overall readiness to implement PrEP before the trainings?

Some clinics noted a low overall readiness to implement PrEP before the implementation of training(s).

- "Well, I can't recall if I took place in any of the meetings prior, besides the last one that we had in the clinic. But I just, I don't think as like, teamwork-wise, and like, knowledge-wise, they were ready before."
- "Our providers, also, if you remember last year, they were not real comfortable starting on these medications for our patients, but we did have a training in collaboration with you, with this study, yes, so that training really helped. ...Yeah, before the training, like I said, most of the staff, they were clueless. Most of the staff, clinical and non-clinical, in the front desk and starting from the schedulers, if you look at when patients call and say, 'Hey, do you guys offer PrEP?' They had no clue."
- "I think it was pretty low before the training."
- There is a gap in knowledge among providers; Biggest challenges is the providers not knowing the process and dosage (from interviewer's notes).

Though, one clinic believed their staff to be knowledgeable of their site's PrEP care workflow.

- They had talked and knew that it was something at their disposal; staff knew we had PrEP and it was available for some patients (from interviewer's notes).

Theme 5: Injectable PrEP

Comments on Injectable PrEP (Separate column made after patterns were observed in this question: Can you briefly describe how PrEP services are currently being implemented in your clinic? Are there any challenges with implementing PrEP at your clinical site(s)?)

One clinical site mentioned having success prescribing injectable PrEP for their patients, except for those who have Medicaid due to the difficulty of not being able to physically offer injectable PrEP directly from their clinic.

- [Interviewer: ... last time we met, you were doing some PrEP but I don't think that you were doing the injectable PrEP yet. You are, you know, one of the early adopters, I suppose, of injectable PrEP. A lot of clinics have had a lot of obstacles getting the drug and kind of figuring how to navigate through ViiV. So, you are definitely ahead of the game. And so, how has that been going as far as that change?] "**...We've been doing really, really good. A lot of patients want the injectable instead of the oral kind. We have had some difficulty for patients with insurance—Medicaid, specifically—getting Apretude. So, for them, we're pretty much sticking to the oral PrEP.** But that's because we don't buy and build here. If we buy and build here, then, we would be able to get it, but the insurance isn't shipping it directly to us. So, that's our only big obstacle with—with that is Medicaid."

Many of the clinics described not being able to offer injectable PrEP to patients due to a multitude of factors such as low overall readiness, a need for more staffing, or TA in navigating insurance coverage for the medication.

- "We're only doing the pills right now. We have not done—we're not bringing the shot on board right now. We're still just gonna do daily."
- "Like, on a side note, I think that, I don't know where, I mean, **we're nowhere for our clinic, we're nowhere near along getting the injectable in our clinic. But I think once**

eventually, if and hopefully, when that happens, I think the delivery would be so much better. Like, I think the uptick would be great, because patients loved getting Depo, like as a preferred method."

- "Unfortunately, ViiV is new to the market and this injectable, so not able to give us any free [samples] ...And so right now, for women, you mostly have the APRETUDE, which women love because it's a one-time shot, you know, two months, and it gives them that freedom, which is what a lot of women want. You know, that's why Depo became so popular."
- "**Like I said, we have new providers on board, so we want to make sure that everybody is okay with this process first. And definitely in the future, we will think about the injectables, but at this moment, I would say we are going to stick with the oral preparations**. ...Once we have everyone on board I think and we move forward with looking into injectables and things like that, I think, of course, all the clinicians, we will need the training for that."
- [Interviewer: And I know [Interviewee #1] had mentioned that a little bit when she was speaking about, particularly with APRETUDE and getting the insurance coverage, and going through that paperwork process. It sounds like that has also been a challenge.]
- Unable to provide injectable PrEP (from interviewer's notes).

***Bolded and underlined quotes at Step 4 are used in the crafting of the narrative summary (Step 5)**

Step 5: Draft Narrative Summary

The final step in the RADaR technique is to consolidate Step 4's findings into a project's deliverable. A final round of data reduction through the choosing of exemplary quotes under an identified theme was done to develop a narrative summary (Watkins, 2017). The remaining quotes were eliminated due to them having content that seemed repetitive compared to the chosen quote. The development of a narrative summary presents concise findings and evidence traditionally used in qualitative papers, thus drafting a narrative summary may efficiently inform changes, if any, for PrEP implementation strategies applied in Atlanta Title X clinics.

The draft of the narrative summary was provided below, with an illustration of exemplary quotes chosen from Theme 5: Injectable PrEP:

HIV Testing

HIV testing is an initial and desired form of screening to identify patients eligible for PrEP. Among the participating clinics in the study, most have shared that opt-out/universal/routine testing during annual physicals has been successfully implemented in their clinics. In fact, they have observed an increased number of HIV tests being requested and done during visits related to STIs/STDs. One clinical participant said, "No, some even get it more than their annual test. They want it – they think they need it every time. I'm like, no, you don't need it every visit. ...But if they come every six months with a new partner, we do it still," while another has cited how their clinic was referred:

> "... we are doing more general health checks, but then we also have patients frequenting our clinic more for STD testing, because they are hearing from friends, relatives, et

> cetera, so just kind of word of mouth. So we have more patients that are coming in for STD testing, but also doing more annual health checks where we're screening for HIV."

PrEP Awareness in the Community

The PrEP cultural landscape within Metro Atlanta's Title X FP clinics has shifted from medical staff and patients perceiving PrEP medications as being solely for males to being for all sexes, yet the stigmatization of behaviors associated with vulnerability to HIV persists. Many participants have cited stigma as related to low levels of HIV awareness which may impact an individual's decision about receiving any services related to HIV (HIV testing, PrEP). "A lot of it could just be stigma. Even though there's a lot more awareness about HIV and AIDS now, there's still a negative stigma, connotation with HIV," one shared, while another reflected on how they've seen patients decline education on PrEP:

> "I don't feel like we have any barriers as a health system, because I feel like we're giving the education, we're putting the materials out there. We're laying it in their lap, it's just whether or not if they're receptive to it or not. ...I think a lot of it comes with stigma."

Current PrEP Implementation Climate

One major issue that continues to persist is the high staff turnover in Title X FP clinics. In most clinics, particularly in Georgia and in the Southern United States, high staff turnover can be attributed to low salary rates, low job satisfaction, and little to no professional growth within the company (Leider et al., 2021). As a result, the clinics face the threat of losing established-patient satisfaction and relationships, delaying the implementation of trainings (e.g. HIV testing and

PrEP), and potentially compromising HIV prevention and treatment. One clinical participant shared, "...And they've also had a lot of changes in staffing and getting through to that, you know, reestablishing that linkage of care was kind of like new for both parties again," as another cited a specific struggle with staffing shortages that predict an increased pressure to maintain a workforce for their patient population:

> "I think right now as providers we're just sort of trying to keep our head above water, so it's not top of mind. The main provider who was doing a lot of our reproductive health services – [audio cuts out] – left the organization. So she took a lot of the patient base with her, unfortunately. ...So our other family doc does a lot of chronic care prevention, geriatric care, so he really wasn't doing a lot of the PrEP prevention counseling. ...We have another provider coming full-time in December."

The main request made by clinical sites that claimed high staff turnover rates was the need for "refresher" trainings. Noted by an interviewer, a participant mentioned the term "reinforcement," which they defined as repeating the same training. In other words, they are interested in additional trainings that reinforce the knowledge of those who currently work at the clinic while introducing this knowledge to new hires.

Preferences for Trainings/TA/Resources – PrEP

One GFPS training called, "Taking a Sexual History," was mentioned more than a few times by the majority of participants, mostly for being viewed highly favorably by themselves and their clinical staff. "Yeah, I absolutely love the training, the sexual history taking. I think it was really important to kind of bridge like that discussion…," one said. The components of the

training involve practicing skills in non-judgmental conversation, with attention to body language, and trauma-informed care. Cultural competence and inclusive language were likely the overall goal set to be achieved in this training, with one participant personally sharing this sentiment:

> [Interviewer: We talk a little bit about creating that safe space, using correct pronouns, and making sure that people feel comfortable...] "... Exactly. And so, you know, just kind of having that conversation and being comfortable with it, and not making it feel so awkward. And create a relationship where you feel you can go even further, and actually get the truth about what's going on with the patients, and what their perspectives are."

Injectable PrEP

Injectable PrEP, or Apretude, became widely available to Georgia Title X FP Clinics upon its approval for public use on December 2021 (FDA, 2021). From a medical staff's point of view, this provides patients assigned female at birth with an alternative option besides oral/pill form, with the effects lasting about 2 months for each injection. Some participants noticed this was popular and a highly favorable medicinal route for patients. However, the readiness levels among clinics to adopt injectable PrEP varied widely. One clinic, who was considered an early adopter of injectable PrEP, shared this sentiment:

> "We've been doing really, really good. A lot of patients want the injectable instead of the oral kind. We have had some difficulty for patients with insurance—Medicaid, specifically—getting Apretude. So, for them, we're pretty much sticking to the oral PrEP."

On the other hand, participants raised their own barriers to not implementing injectable PrEP in their clinics for a combination of reasons. One participant mentioned, "...we're nowhere near along getting the injectable in our clinic. But I think once eventually, if and hopefully, when that happens, I think the delivery would be so much better. Like, I think the uptick would be great, because patients loved getting Depo [injectable birth control], like as a preferred method," while another shared, "Like I said, we have new providers on board, so we want to make sure that everybody is okay with this process first. And definitely in the future, we will think about the injectables, but at this moment, I would say we are going to stick with the oral preparations."

DISCUSSION

The Annual FGDs Matrix (Steps 2 & 3) served well as a data management tool (Averill et al., 2002), which provided organization and structure for FGD participants' answers to questions from the interview guide. Out of 11 participating clinical sites, 9 were included in this study, with the intent that the 2 remaining sties could be easily added to the matrix. By aligning each participant's answer (if they provided one) under its relevant question, I was able to identify patterns across the different clinical sites by column. Upon first observation, not all cells in the matrix were filled, meaning that not all participants answered the question. However, by looking vertically across columns, I was able to copy and paste multiple cells onto a Word document to quantify how many answered the question and assess if there are any commonalities or points of interest to develop themes (Step 4). It is important to note that the matrix, though serving as a tool to consolidate FGD findings, was crucial to the speed of conducting RQA as identifying

patterns is key to conceptualizing ideas or themes (Watkins, 2017). Often times, resource-strapped environments and community partners cannot afford qualitative software (e.g. NVivo, MAXQDA) whereas the utilization of Microsoft Word and Excel is less costly and allows community partners to easily participate in the RQA process, further enhancing community engagement (Gale et al., 2019 & George et al., 2023).

Creating summaries through rapid thematic analysis (Step 4) involved condensing the data from the matrix further by extracting pertinent quotes from FGD participants that addressed the overall purpose of this study. Though large chunks of participant quotes are eliminated to obtain answers related to the study's purpose, the data can be revisited if or when another research question arises (Watkins, 2017). This action to consolidate the findings allowed me to conceptualize my ideas and generate findings based on the patterns observed across selected quotes (Watkins, 2017).

For example, participants served and operated at different clinics, and though they've cited different experiences, thoughts, and feelings about PrEP trainings, there were commonalities. Though the trainings were enriching, the majority of participants that represented their respective clinics requested more "refresher" trainings as they experienced high staff turnover. This observation is distinctive in that it informs our team that our population of interest (Title X FP clinics) may be challenged with low staff retention, which can hinder the clinic's capacity to implement PrEP.

It is important to note that rapid thematic analysis for the creation of summaries may only be used effectively in small subsets of data, which may not be representative of the whole population of interest. However, given that this study is considered a pilot project for implementing tailored PrEP implementation strategies in Atlanta, GA, among cisgender women,

it is it is appropriate for this purpose so that findings may inform change in PrEP care delivery within Title X clinics (George et al., 2023 & Watkins, 2017).

The narrative summary was intended to concisely share the findings from FGD transcripts based on the study's purpose, which was to assess RQA as a strategy to inform PrEP implementation strategies in Atlanta Title X FP clinics. Since the RADaR technique aims to produce a project deliverable, which provides researchers with a tangible end goal, there is potential to complete a quick and thorough analysis of the qualitative data by removing data that is irrelevant to the study's purpose (Watkins, 2017). By eliminating quotes that seemed repetitive in relation to the selected exemplary quote, I was able to propose the main findings derived from the summaries of Step 4 in paragraph form (Watkins, 2017). This, however, was an incomplete narrative summary, serving more as a draft to explain the processes of how our team plans to deliver our findings once the remaining 2 clinical sites have been interviewed. Additionally, due to the short timeframe of completing this project, only a draft could be offered.

The use of RQA has opened avenues for researchers in qualitative studies, specifically projects aimed at helping vulnerable populations (Averill et al., 2002 & Geroge et al., 2023). In this study's context, conducting RQA using the RADaR technique within 3-4 months has exhibited potential to be a fast, cost-effective approach for researchers and community partners. The turnaround time for this project's deliverable (e.g. draft narrative summary) has also shown promise of being a quick way to inform adaptations needed to further tailor PrEP implementation strategies, if any, given that the need is urgent for Atlanta Title X FP clinics in the context of a rapidly evolving healthcare landscape (Gale et al., 2019 & George et al., 2023).

Limitations

The data used only allowed the analysis of clinician-level experiences, feelings, and perceptions. Another point to note is that participants in this study may also reflect on their experiences in their respective clinics when their agency may have multiple sites in Metro Atlanta. Patient in-depth interviews and electronic health record/chart extraction data were additional means of assessing PrEP adoption and implementation within Atlanta Title X FP clinics. In light of the nature and timing of this project and RQA approach, neither of these data sources were included, and thus the identification of potential barriers and/or facilitators was based on the FGD with clinic staff alone.

My approach to RQA benefited from the support of the project's manuscript team, which is essential to the progression of this study as my team consisted of more skilled qualitative researchers who served as my mentors and collaborators. They also served as my second analysts to validate my findings. In RQA, there is a large emphasis on team collaboration in order to complete a rigorous, yet time-efficient and cost-effective analysis that produces actionable findings and recommendations (Gale et al, 2019 & George et al, 2023).

PUBLIC HEALTH IMPLICATIONS AND RECOMMENDATIONS

Public Health Implications

Particularly for ongoing implementation studies, often real-time results are of greater value to optimize trainings, interventions, or practices. This iterative process is otherwise known as adapting evidence-based practices to the cultural and appropriate context of a population's needs. In real-world clinical settings, adaptations are necessary for increasing the effectiveness and sustainability of a program/intervention that has already been implemented (Miller et al,

2020). It is also important to maintain fidelity, meaning that the core goals of said program/intervention are still being met as ongoing implementation efforts are continuing.

The feasibility of RQA in general provides many researchers and evaluators with a cost-effective and fast methodology to utilize when real-time data is needed to continue a project or intervention. For programs/interventions that are based in the community, RQA may also serve as the methodology to address the urgent needs of communities, ultimately addressing health equity challenges (George et al, 2023). Especially in settings where resources such as time, money, or workforce is low, RQA could be considered more readily available and less resource-intensive (George et al., 2023 & Watkins, 2017).

Recommendations

GFPS serves a crucial role in understanding the individual needs of Title X FP clinics, so, in partnership with Emory University's IT-PHITS research team, these findings may help inform GFPS to further investigate or tailor PrEP implementation strategies to meet the needs of the participating clinics within Metro Atlanta. In the future, more detailed findings as the IT-PHITS project comes to an end may inform GFPS to develop their own set of recommendations that can potentially be applied across all 31 Title X FP clinics.

For the purposes for this project, the IT-PHITS research team should consider these items below:

1. Foreground technical assistance in marketing tactics that incorporate STI/HIV testing and PrEP resources.

- There is a rise in patients coming for HIV testing during STI/STD tests, which also allows the opportunity for clinical staff to engage them in conversation about HIV prevention e.g. PrEP.

2. Continue to offer trainings to Title X clinics who have not received more than two within their annual check-in (focus group interview).
    - With the positive feedback from the trainings, and with high staff turnover, continuing to offer trainings while being aware of the clinics' preferences for scheduling will increase opportunities for positive experiences in professional growth.

3. Collaborate with GFPS to include additional trainings on injectable PrEP.
    - As this is newly on the market, most clinics are currently unable to implement this.

4. Employ a traditional qualitative analysis to further analyze FGD results
    - If the project timeline and budget allow for a traditional qualitative analysis to be conducted, then a more "in-depth" analysis may produce more nuanced and detailed findings.

Conclusion

The majority of new HIV diagnoses among cisgender women occur in the South, with disproportionate rates of HIV infection among women of color (CDC, 2023a). PrEP, though

highly effective, is underutilized by women. Title X FP clinics are one of the prime locations for women in Metro Atlanta to receive HIV testing and PrEP counseling, but previous findings have shown that these clinics experienced barriers to adopting EBPs regarding PrEP. Strategies in the form of trainings/TA/resources were disseminated among Title X FP clinics in Metro Atlanta. Due to the high need to tailor and adapt PrEP implementation strategies to meet the needs of Atlanta Title X FP clinics, RQA was deployed to produce actionable recommendations to inform potential changes to these strategies. These findings include providing technical assistance in PrEP marketing, offering trainings/TA/resources as "refresher" courses, and implementation of a new training that educates on injectable PrEP. RQA, specifically using the RADaR technique, produced fast, real-time data findings that could inform outputs that respond to immediate community needs. In real-world settings, researchers and community partners can utilize RQA as a fast, cost-effective approach, depending on the nature of the project.

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APPENDICIES

A. Interview Guide

IT-PHITS Title X Family Planning Clinic Leadership Focus Group Guide (Annual Review)

Facilitator:	Date:
Note-Taker:	Start Time:
• In-person • Virtual	End Time:

Introduction

Thank you all for agreeing to participate in this follow-up focus group. We appreciate the time you have taken out of your busy schedules to speak with us today. The purpose of this meeting is to get an update on your clinic's current practices for conducting HIV testing and HIV prevention. As a reminder, we are working with Georgia Family Planning System (GFPS) to build comprehensive training and technical assistance resources for your clinical sites specific to HIV testing and PrEP. We'd like to learn which trainings and other resources related to HIV prevention have been most helpful to you and if you'd be interested in having additional trainings offered at your clinics in the future.

I am (introduce facilitator) and this is (introduce note taker). Let me describe myself a bit more and describe the role that I am playing in this process. [Facilitator gives 3-4 sentence description of their professional career]. I will be acting as the facilitator throughout this process. By that, I mean that I will be here to help guide discussions during this process as well as be there as a resource for questions that arise. [Note Taker] will be taking notes today to help us to remember what is said here today.
Before we begin, we would like to encourage everyone to voice their opinion during our discussion. A focus group is a formal discussion among a group on a particular topic. You are the experts here, so we want to learn from you. There are no right or wrong answers and not everyone has to agree. We are trying to understand your individual experiences with PrEP service delivery, so we want to hear from you even if you have differing points of view.

In order to ensure that your rights are protected as a part of this process, we have verbal consent form(s) for each of you describing the study, potential risks and benefits, and the fact that your participation is strictly voluntary. Our discussion will be about thirty to 45 minutes and you will each receive a $50 for your time and participation. [Allow time to read and give verbal consent.]

Before we begin our conversation, please know that everything you say here will be kept confidential. You may skip any questions that you do not want to answer. However, we encourage everyone to voice their opinion about this process. It's also okay to say that you do not know the answer to any question.

So that we can more accurately record your responses we would like to record and take notes on our conversation today. Only our research team will be able to listen to the recordings, and the recording transcripts will be de-identified to exclude your name and affiliation with this clinic. Once the study is completed, the recordings will be destroyed. [Ask if everyone is comfortable with our team recording the conversation.]

Does anyone have questions before we begin?

Focus Group Questions

To get started today let's briefly go around the room and tell the group who we are and what our specific clinic roles are.

1. Can each of you describe your role at the clinic?

Topic 1: HIV Testing

Thank you so much. Now, let's start off with a few questions about HIV Testing at your clinical site(s).

2. Since we last met with your clinic on _____, have there been any changes to your clinical site's policies for HIV testing?

3. Can you please briefly describe how HIV testing is offered at your clinical site(s)?

    a. FU: Do you currently offer HIV testing to all patients 13-64?
        i. FU: What are some of the reasons your clinic doesn't do universal testing?
        Probe about patient perspectives, provider concerns, time.

    b. FU: Do you currently offer opt-out HIV testing? *Opt-out HIV testing is defined by the CDC as performing HIV screening after notifying the patient that 1) the test will be performed and 2) the patient may elect to decline or defer testing. Assent is inferred unless the patient declines testing.*

    c. FU: Do you currently offer routine HIV testing to all patients 13-64 at least **annually** or more often for your patients who are sexually active?

i. FU: What are some of the reasons your clinic doesn't do routine HIV testing? *Probe about patient perspectives, provider concerns, time.*

d. Are there any challenges with implementing HIV testing at your clinic?

Topic 2: HIV Prevention

Thank you, those answers were very helpful in understanding your clinic's offerings. Let's move now from HIV testing practices to focusing on HIV prevention services and providing Pre-exposure prophylaxis (PrEP) at your clinical sites.

4. Since we last met with your clinic on _____, have there been any changes to your clinic's offerings for PrEP for HIV Prevention?

5. PROBE if needed: Are your clinical sites currently offering PrEP for HIV prevention?

6. **IF NO:** What changes or additional assistance might you need to be able to provide PrEP at your clinical sites? Are there any challenges with implementing PrEP at your clinical site(s)?

Briefly go through the steps of PrEP care if more information requested:
*Step 1**, PrEP Education and Counseling**, Educating patients about PrEP and gauging interest in PrEP*
*Step 2, **Assessing Candidacy for PrEP**, procedures can include: a sexual health assessment to assess for HIV risk, review of clinical signs and symptoms of acute HIV infection, screening for sexually transmitted infections, blood work for creatinine levels, and hepatitis screening.*
*Step 3, **Prescribing PrEP**, Patients are good candidates for PrEP if they are HIV negative, have no abnormal laboratory tests, and are interested in taking a daily medication. Prescribe PrEP to these patients, and arrange for follow-up appointments every three months. PrEP procurement may require an insurance or a medication assistance program to ensure the patient can pay for the medication.*
Step 4, ***PrEP Follow-up care**, Recommended follow-up care typically occurs two weeks to a month post the PrEP consultation visit to check for side effects, provide adherence and retention support, and answer patient questions.* Also, PrEP follow up includes visits for adherence support and laboratory testing every 3 months.

IF YES:

a. Can you briefly describe how PrEP services are currently being implemented in your clinic? Are there any challenges with implementing PrEP at your clinical site(s)?

i. Probe about **PrEP Education and Counseling**, educating patients about PrEP and gauging interest in PrEP
ii. **Probe about Candidacy for PrEP**. *Procedures can include: a sexual health assessment to assess for HIV risk, review of clinical signs and symptoms of acute HIV infection, screening for sexually transmitted infections, blood work for creatinine levels, and hepatitis screening.*
iii. **Probe about prescribing PrEP.**
iv. **Probe about PrEP Follow-up Care.**

Topic 3: Training Feedback

The next set of questions will ask you to reflect on the PrEP trainings that we have held at your clinical sites. The last time we talked, we presented several trainings and resources related to HIV prevention and PrEP that we have created. (show table). Of these, we completed _____ training(s) with your clinic on _____. We'd like to get your feedback on these trainings and resources.

10. What was your perception of the clinic's overall readiness to implement PrEP before the trainings?

11. After our PrEP trainings, did your clinic's overall readiness change?

12. What did you think about the PrEP trainings that were offered in your clinic?

PROBE:

a. Did you find the information useful?
b. How did you feel about the format and delivery?
c. What should we consider in terms of training for PrEP implementation moving forward?
d. What trainings have been most successful at engaging staff?

13. Beyond meetings with the GFPS/Emory team, did you have any additional PrEP trainings, internal meetings or planning sessions to discuss your clinic's PrEP delivery process? If yes, please describe.

14. What additional PrEP training or technical assistance do you need, if any?

15. What did you think about the patient and provider resources that we provided?

16. What additional resources can we provide to assist with PrEP services at your clinical sites?

B. Annual Summaries

Key Domain: HIV Testing

Theme 1: HIV Testing

Can you please briefly describe how HIV testing is offered at your clinic?

- *Do you currently offer HIV testing to all patients 13-64?*
- *Do you currently offer opt-out HIV testing?*

The majority of clinics shared that HIV testing, particularly Opt-Out/Universal/Routine testing during patient annual physical visits, have been successfully implemented in their clinics. Furthermore, clinics noted an increased demand for additional HIV tests during visits related to sexually transmitted infections/diseases (STIs/STDs).

- "Yes. And as well as new patients. All new patients are given a rapid as well. Yeah. And they do bloodwork. So they're kind of a double testing."

- "No, some even get it more than their annual test. They want it – they think they need it every time. I'm like, no, you don't need it every visit. But, yeah, we'll go six months. We used to a year, a year, a year. But if they come every six months with a new partner, we do it still."
- "Yeah. We do a—we do a lot. A lot of people, when they come here, they think we're an STD clinic, so that's what we see a lot of."
- "One, we are doing more general health checks, but then we also have patients frequenting our clinic more for STD testing, because they are hearing from friends, relatives, et cetera, so just kind of word of mouth. So we have more patients that are coming in for STD testing, but also doing more annual health checks where we're screening for HIV."
- "If they're coming for, like, a problem visit, something acute—no, maybe not."
- Currently testing all patients, opt out testing (from interviewer's notes)

Are there any challenges with implementing HIV testing at your clinic?

Following the dissemination of tailored PrEP implementation strategies, some clinics indicated having conversations about the risk of contracting HIV with patients who may opt-out of getting an HIV test.

- "And, again, it is still an opt-out process. We do ask them specifically if they're interested and what we have learned is we have had so many patients decline the test, but we are encouraging them for sure to get this done at least once a lifetime just for low-risk individuals. But for high-risk, of course, we definitely encourage them to get this done."
- "Their usual paperwork that they fill out has an opt-out section on it, but we're finding that a lot of people opt-out, and then once they get in the back and I ask them and explain why we do the testing there, they're like, "Yes, fine, I'll get it." So, we do have that there, but it's still usually a conversation that we [Cross talk] back again."

Key Domain 2: HIV Prevention

Theme 2: Current PrEP Implementation Climate

Are your clinical sites current offering PrEP for HIV prevention?
Can you briefly describe how PrEP services are currently being implemented in your clinic?

Some clinics have promoted PrEP through outreach efforts and materials, with one citing an increase in PrEP awareness among patients, and another citing success in PrEP prescription uptake.

- "Yeah, we have a lot of MSM, but we're promoting it to everyone, so, that's been—that's definitely been something we're promoting more. We're promoting it a lot more to heterosexual women."

- "So, we have materials. We have—in every room, there's a huge poster that discusses it. I know that when a provider's, when you have those Title X patients that's coming in for an issue, or even if they're just coming for, like, their birth control, they're discussing it."
- "Yes, and recently, we have actually started doing some outreach where we let the patients know that we are offering the PrEP services. For 2022, we actually prescribed almost ten scripts [PrEP medications], I would say, for four unique patients."

Some clinical sites have access to an in-house or adjacent pharmacy, which allows for easier processing of PrEP prescriptions for the patients they serve.

- "She helps with funding. She's a pharmacist, and so, she helps with different indigent care programs or funding sources and things like that to be able to get the PrEP for as reasonably priced as they can. ...So, we have, like—the providers have, we typed up, [Clinic Staff] typed up, like, a little protocol, per se, on how to handle, you know, this is what we do."
- "Well, I think they did [PrEP] in-house in the hospital, you know. So it's still the same, instead of having a separate clinic. But it's, it's very easy to contact them. So once we call them, they, sometimes, they'll even come up to the clinic if they're still in the building _____ _____ anything. They'll come up to the actual clinic to meet with them. Or they'll just go ahead and contact them right away."
- "So we do have an in-house pharmacy and since we all work together, the pharmacist and all of us work together, getting access to medications, I think that is taken care of because pharmacy staff, they're really good in being proactively getting these medications for the patients."

The majority of clinics shared that they are prompted to mention PrEP to patients at times when STI/STD testing is done during a clinical visit.

- "I think the consensus is if someone is coming in specifically for STD testing, that it is something that we should educate patients on and bring it up. And we strive for that. I don't think it happens 100 percent all the time, but we've had discussions about doing that, at least for that patient population as specifically comes in for STD testing."
- "But PrEP is offered regularly. And what my trigger is, anyone who comes in for STD testing gets asked if they want PrEP. ...But PrEP is offered regularly. And what my trigger is, anyone who comes in for STD testing gets asked if they want PrEP."
- "Yeah, so for high-risk patients, we definitely, the providers, they do let them know that we offer these services. Of course, just about the medications, how advantageous it is for those patients. So we definitely encourage those patients from the clinical side to think about it."
- "...when they're coming in, whether it's for, like, an annual physical or if it's for an STD encounter itself, or something else, or it's kinda related, we always ask about a last menstrual period, and sometimes, it segues into, "Are you sexually active?" And then, I just explain that PrEP is for everyone."

- "It's generally when patients are coming in for a visit for something else, be it a health check or an STD screening, and they kind of meet that criteria for being high-risk. Then there's a discussion that takes place around what is PrEP."

Are there any challenges with implementing PrEP at your clinical site(s)?

Some clinics expressed having few patients being prescribed PrEP medications due to staffing shortages.

- "I would say personnel. Like just having the staffing in place to provide services is one of our biggest issues, but I feel like that is an issue kind of across the board."
- "There still hasn't been a whole lot of PrEP uptake, to be honest. Yeah. I think part of that is some of the same issue, especially with like timing. ...And they've also had a lot of changes in staffing and getting through to that, you know, reestablishing that linkage of care was kind of like new for both parties again."
- "I think right now as providers we're just sort of trying to keep our head above water, so it's not top of mind. The main provider who was doing a lot of our reproductive health services – [audio cuts out] – left the organization. So she took a lot of the patient base with her, unfortunately. ...So our other family doc does a lot of chronic care prevention, geriatric care, so he really wasn't doing a lot of the PrEP prevention counseling. ...We have another provider coming full-time in December."

Additionally, two clinics shared issues with patient recruitment.

- "Very overwhelming as well, but I think our organization has been having challenges building our patient base in general. So I don't know if we've made much movement on the PrEP front, because we're just trying to get patients in the door."
- Some of the patients are undocumented so when they go in to ask questions, they are concerned about it impacting their immigration status (i.e. undocumented patient population/confidentiality/cultural barriers + fears) (from interviewer's notes).

Some clinics have identified financial constraints as a barrier to the adoption and implementation of PrEP in their clinics.

- "...Because half of our patient is uninsured. So getting, even getting them to the pharmacy, and you know, between that can be really hard."
- "Funding is definitely a barrier."
- "We applied for a grant to essentially expand our HIV care services, including testing, PrEP, and just kind of general community outreach. So we will hopefully, if we get approved for the funding from the grant, be doing more rapid testing, and then looking also to partner with organizations, so we can get out into the community and do more rapid HIV testing, but also having testing kits, et cetera, to provide for patients who are – [inaudible]. Then hopefully we have some funding as well to offer PrEP onsite."
- "I think the biggest things that I can think of is helping us establish some way to get in the clinic, like actually, physically. I think once people see physically, is able to feel it, like, they kind of have to acknowledge that this is something I'm going to have to start

doing more. Because it's kind of hard to advocate for something that they don't see impacting them and can't feel." [No on-site pharmacy]

Theme 3: PrEP Awareness in the Community

Are there any challenges with implementing PrEP at your clinical site(s)? (cont.)

Some clinical sites perceive their patients' reluctance regarding the uptake of PrEP due to stigma that exists in the community.

- "So, I feel like we have a really good process in place, it's just the reluctancy of the patient to agree to take the PrEP is kinda the problem, where we have a struggle."
- "I don't feel like we have any barriers as a health system, because I feel like we're giving the education, we're putting the materials out there. We're laying it in their lap, it's just whether or not if they're receptive to it or not. ...I think a lot of it comes with stigma."
- "I think there definitely needs to be more education. I guess a kind of follow-up to the last question, another barrier may be just time, as far as having the time to really dive into those educational components. I feel like there are some patients who would be great candidates for PrEP, but are just not open. ...So I think some of it may be education. A lot of it could just be stigma. Even though there's a lot more awareness about HIV and AIDS now, there's still a negative stigma, connotation with HIV."
- "Mostly education. Because sometimes people feel as though if they're getting PrEP, then they're doing something they're not supposed to be doing. And so is this about having a conversation, really. And so, so whether you're a man has sex with men, or if you're a female in the Atlanta area, who's actually was at one point, was the highest growing populations for HIV, we understand you have to have the conversation, and say, look, this is what we can do for you to help you not get HIV."

Key Domain: Training Feedback

Theme 4: Preferences for Training/Technical Assistance/Resources – PrEP

What was your perception of the clinic's overall readiness to implement PrEP before the trainings?

Some clinics noted a low overall readiness to implement PrEP before the implementation of training(s).

- "Well, I can't recall if I took place in any of the meetings prior, besides the last one that we had in the clinic. But I just, I don't think as like, teamwork-wise, and like, knowledge-wise, they were ready before."
- "Our providers, also, if you remember last year, they were not real comfortable starting on these medications for our patients, but we did have a training in collaboration with you, with this study, yes, so that training really helped. ...Yeah, before the training, like I said, most of the staff, they were clueless. Most of the staff, clinical and non-clinical, in

the front desk and starting from the schedulers, if you look at when patients call and say, 'Hey, do you guys offer PrEP?' They had no clue."
- "I think it was pretty low before the training."
- There is a gap in knowledge among providers; Biggest challenges is the providers not knowing the process and dosage (from interviewer's notes).

Though, 1 clinic believed their clinical staff to be knowledgeable of their site's PrEP care workflow.

- They had talked and knew that it was something at their disposal; staff knew we had PrEP and it was available for some patients (from interviewer's notes).

After our PrEP trainings, did your clinic's overall readiness change?

After the completion training(s), clinics have shown signs of high satisfaction and comfort implementing PrEP.

- "Perhaps, afterwards, they were just because I did start seeing a change in the HIV testing hepatitis A, B, and C testing as well. And the fact that we're trying to promote that into our patients, whether they come for an annual, or just a regular visit."
- "So I think it got all the staff members on board, and then, of course, the clinician training was wonderful. [clinical provider] is amazing. It was really a good training for all of us. And in the future, I think we would love to have more trainings, also."
- "I think it definitely increased with the training, just as far as bringing it to the mind of the staff."
- ...after the training it was cemented and gave a comfort level and gave a much bigger picture for PrEP; it made them feel less alone in providing these services ...It helped reinforce and take it to the next level. (from notes)
- "Hm-mmm. I think it was good."
- "I think it's just giving the overall picture, giving us the birds-eye view of what we are looking at, and then going into drilling down into the basics for the clinicians. I think that definitely helped. And the trainings that you guys offered was really good, I should say."
- "No, it was really informative and more in-depth."
- "I definitely think it was helpful, useful information."
- The unique thing about the training was the data supporting what is happening; to be able to have data to support the prep conversation and to show the actually recommended evidence-based steps was transformational. (from interviewer's notes)
- "Because in our clinic, we actually don't have a whole lot of time where we can sit to talk about this kind of thing. To address it so openly was kind of scary, because you never know how these kind of conversations can go. But I think they took it really well."

What trainings have been most successful at engaging staff?

Some clinics shared their feelings toward certain parts of the trainings that focused on inclusive language and open dialogue about taking note of a patient's sexual history.

- "Yeah, I absolutely love the training, the sexual history taking. I think it was really important to kind of bridge like that discussion, [like] we wouldn't [have with] everybody."
- [Interviewer: We talk a little bit about creating that safe space, using correct pronouns, and making sure that people feel comfortable...] "... Exactly. And so, you know, just kind of having that conversation and being comfortable with it, and not making it feel so awkward. And create a relationship where you feel you can go even further, and actually get the truth about what's going on with the patients, and what their perspectives are. "
- "And you know, the best way to do that, and what I found through our last training, when we did the training on cultural sensitivity. That was truly engaging."
- "But the most important thing is making the staff comfortable with engaging in a conversation. Especially when it comes to sex history, I find that especially our nurses and our MA's, sometimes they're a little bit uncomfortable with having a conversation about, you know, not just do you have sex, but who do you have sex with? What kind of things are you doing? What are your, you know, what things are going on that put you at risk for HIV."

How did you feel about the format and delivery?

Most clinics reported that if in-person training sessions were held, that would lead to greater engagement among clinical staff.

- "So with the training, Zoom is fine, but I actually really, really like the one-on-one... just because we don't have technical difficulties, usually."
- "It's rare that they have one where everyone's in-person. So, we may just at least start with the Lawrenceville office before we try to do one collaboratively."
- "I like to think in person is always good. [Inaudible] – ask questions directly face-to-face. I think we get Zoom fatigue, especially after three year of COVID and virtual meetings. So it's good to be in person."
- "I'm a pretty flexible person. I'm easy to please, so either works for me. I'll say that if it's for more of the staff, it's probably better to be in person. ...the staff or more people take it, a smaller number of people, online is okay, virtual. But if it's more people, the majority of the staff, then I think in person is better. It's more engaging."
- "...So my understanding from that first training was that it wasn't there wasn't very receptive to it, because it was online. There were a lot of signal problems, connection issues, and people tend to just tune out, like online."
- "This definitely is a great start with the Zoom sessions, but if you are offering any on-site trainings, in the future, that would be something that would help us."
- "A little bit of an issue at the Lawrenceville location is, the providers typically don't take the same lunch break, just for various reasons. So, we might would have to block one schedule versus the other for that hour. Or, I mean, if we can't block the schedule, which is not ideal, obviously, we might could hold it twice, even. So—but we definitely we need to get that, hopefully, in within the lunch hour."

However, one clinic shared that given their clinical site's multiple locations, a virtual option works best for the organization's schedule.

- "Yes, this is good. Correct. So I think this helps because, like you said, we have more locations, six locations, so everybody's spread out all over. So Zoom sessions help and sharing the screen. I think this delivery model is good."

What should we consider in terms of training for PrEP implementation moving forward?

Opportunities to schedule trainings should be strategic, as most clinical sites noted the challenge of integrating them into the workday of clinical staff.

- "I have been wanting to get another [training] set up, but I definitely think the PrEP care for clinicians is something that we need. ...An hour would be fine. I was just making sure that we could do this over a lunch break. So, as long as they, you know, brought their lunch. We don't want to block the schedule for too long."
- "We don't do training enough."
- [Interviewer: mean, that monthly staff meeting would be a great venue for that, where we could just kind of come in with your already set times. So it wouldn't be something out of the ordinary that you'd have to kind of plan around. But we can work with your schedule for that.] "...And I can set that up with [FHCGA2 Employee] and [FHCGA2 Employee]. She's over HR, which she's normally the person who is over our monthly meetings for, you know, for our staff."
- Having the entire clinic was valuable for not just providers but also the MA's and the other staff i.e. intake or ancillary are aware of the processes in place; whether it [is] just sharing the information during intake with the patient they now can also be involved ...The training helped complete the full picture (from interviewer's notes).

What additional PrEP training or technical assistance do you need, if any?
What additional resources can we provide to assist with PrEP services at your clinical sites?

The majority of clinics were asked if they wanted to request additional trainings/TA/resources for their clinical sites, with the majority indicating yes.

- "And also just working with some of the 440B pharmacies to get access to patients, so there is a smoother ease of transition, because even with going through the 340B pharmacies, there is a process. It's not as simple as writing the script and then the patient gets the medicine. So I guess just trying to fine tune or smooth that process, so it's more efficient for a patient to get access to PrEP. If that answers your question."
- "One thing that I wanted to see more of, I think this is good, because it's an incremental step. You don't want too much change in one setting, but to have like a follow-up talk for all of us and sit down with the staff and the nurses to specifically talk about HIV care, and convey the importance of, you know, the rates, how high it is."
- "It was very helpful with the medication, the medication options, invitations, you know, the kinds of things patients tend to ask. Just to get that quick review is helpful. I think it

was better for even the medical assistant there as well, so would be able to answer patient questions when they call or things like that."

- "...Definitely PrEP care for clinicians I feel like would be great. Insurance navigation."
- "I think a lot of those things [offered trainings, printed materials, EMR assistance] would definitely be beneficial for us, especially considering the potential for us acquiring these new grant funds. So I think we would definitely look at getting with you in the future to schedule some dates to do some refreshers, and give us some more detailed things specifically for the clinician."
- "So the only thing I could think is, is adding it to that form that they use to fill out for the initial and the follow-up. ... [Interviewer: ...you're just opening the door, and saying this is a universal time point where we are going to mention PrEP, and if they have questions about it, then it would just increase referrals for that.] ...I mean, we could do that. And I can ask [clinical staff]. Because that smart form that we're doing with the ten questions, is part of what family planning is asking us to do. So I can find out from her if she is okay with us. And I can submit a ticket and ask them to add that question to the list of questions, if that's something that you can manipulate."

<u>Some clinical sites specifically shared suggestions of screening or EHR prompts that help further identify/remind them to discuss PrEP with eligible patients.</u>

- The providers need something to flag and then go a little deeper; identifying the risk factors first and then not being judgmental and then digging deeper/how to start the conversation. (from interviewer's notes)
- (Window of Opportunity) Pre-Visit Time: Medical Assistant looking over patient charts, A1C, colorectal cancer screenings, new patient screening etc. Could be a time frame for them to also PrEP eligible patients; how do they determine if this patient would be eligible for PrEP ; Is there a way to flag it for the provider during this time without adding more time; time is a constraint (from interviewer's notes).
- "...It also may be an opportunity to create some more workflows for PrEP. I don't know if we have a template or anything in the EHR, that prompts the provider or the MA to ask so that may be an area of opportunity."
- Scenarios or possible patients who would be eligible can help cement the information and useful in the trainings for staff ...Share eligibility criteria and who would be good candidates for prep; use real life scenarios; share the actual impacts of those who used PrEP and those who sero-converted etc. (from interviewer's notes).

<u>However, a main request for training/TA/resources has come in the form of a refresher course, especially since many of the clinical sites experience high staff turnover.</u>

- "And like I said, we do have a lot more new staff members on board, so we are interested in actually getting more trainings scheduled."
- "But again, with staff turnover it's dropped off again."
- "I think we've had some changes with staff since that time, so I think it would maybe be worthwhile having a refresher or a review of that."
- We know we have a PrEP clinic. But I don't think that because we're not practicing, that that's not part of our, it's really is not part of our everyday to be very honest, I think that

doing the refresher. We rely on our clinicians. I know they may have those conversations in the exam rooms, but not our nursing staff or our health educators.

- "And in the future, we would like for more trainings. We do have new providers on board, so that'll definitely help. And it all depends on the comfort level of the providers, too, but most of the providers now feel quite comfortable prescribing those medications. It's just a matter of increasing these patients more to get started and letting them know of the benefits of the PrEP. ...Our outreach folks, they are definitely looking into putting it out there in the website, making sure that our patients are aware that we are offering the services. So once the word is out, I think we can draw more patients in."
- Reinforcement; even if it's repeating the same training; more data on individuals who started prep and seroconverted and who did not; the impacts of PrEP on an individual ...They are interested in additional trainings; new staff have started so let's reinforce for those who were there; also introduce it again for the new staff (from interviewer's notes)
- "So he may be a person to really hone in on the training, to get them used to having the conversation with patients, as well as a new pediatrician coming onboard pretty soon, too. So it may be an opportunity to do another training later in the year, once we get some new staff in."

<u>TA, specifically about marketing strategies HIV prevention and PrEP, has been highly sought out by the majority of clinics as it is instrumental for patient education in the clinic.</u>

- "We're working on a lot of stuff internally, from signage to marketing and all that. And I would like to kinda see a real marketing firm take over."
- "If there's a QR code that they can scan on their phone while they're sitting in the waiting room that holds up the information. And some people still, like, you know, to have that paper, I think an option for both would be good. ...I feel a starting with a refresher is good."
- "Providing some resources for patients in our waiting areas is good. That would be a good start. Because I don't think we really push that at all. We know it's there."
- "I personally feel like flyer handouts are – they're yesterday. [Laughter] I don't – every time we give people, it ends up on the floor in the trash. Especially when I do outreach. ...Why do that when I can just simply have them hit a QR code. And, you know, people will say, oh, but they don't have phones. We have a person right here on the corner giving out free phones."
- "I think tips for just marketing to the patients, educating patients. How do we let them know this is something that is for them? It's not just something for a certain population, that it's for everybody. ...We're increasing our community outreach programming and our community outreach events."
- "...have more patient-friendly, up-to-date flyers and pamphlets on HIV, like this stuff we had about [crosstalk] some updated material. Even updated material as we _____ _____ _____ _____ _____ _____ education material."
- "Because all the ads and everything, we're focused on that. And they actually, yeah, to a certain degree, I mean, I see more, more ads that are geared towards all, but I feel that that we started out that with that message, and it's just hard to break that. Just like how they are now allowing women with the, you know, to breastfeed that are HIV-positive."

Theme 5: Injectable PrEP

Comments on Injectable PrEP (Separate column made after patterns were observed from this question: Can you briefly describe how PrEP services are currently being implemented in your clinic? Are there any challenges with implementing PrEP at your clinical site(s)?)

Clinical sites vary widely on their adoption of Apretude, the newly released injectable PrEP which has been made available to prescribe for women.

<u>One clinical site mentioned having success prescribing injectable PrEP for their patients, except for those who have Medicaid due to the difficulty of not being able to physically offer injectable PrEP directly from their clinic.</u>

- [Interviewer: ... last time we met, you were doing some PrEP but I don't think that you were doing the injectable PrEP yet. You are, you know, one of the early adopters, I suppose, of injectable PrEP. A lot of clinics have had a lot of obstacles getting the drug and kind of figuring how to navigate through ViiV. So, you are definitely ahead of the game. And so, how has that been going as far as that change?] "...We've been doing really, really good. A lot of patients want the injectable instead of the oral kind. We have had some difficulty for patients with insurance—Medicaid, specifically—getting Apretude. So, for them, we're pretty much sticking to the oral PrEP. But that's because we don't buy and build here. If we buy and build here, then, we would be able to get it, but the insurance isn't shipping it directly to us. So, that's our only big obstacle with—with that is Medicaid."

<u>Many of the clinics described not being able to offer injectable PrEP to patients due to a multitude of factors such as low overall readiness, a need for more staffing, or TA in navigating insurance coverage for the medication.</u>

- "We're only doing the pills right now. We have not done—we're not bringing the shot on board right now. We're still just gonna do daily."
- "Like, on a side note, I think that, I don't know where, I mean, we're nowhere for our clinic, we're nowhere near along getting the injectable in our clinic. But I think once eventually, if and hopefully, when that happens, I think the delivery would be so much better. Like, I think the uptick would be great, because patients loved getting Depo, like as a preferred method."
- "Unfortunately, ViiV is new to the market and this injectable, so not able to give us any free [samples] ...And so right now, for women, you mostly have the APRETUDE, which women love because it's a one-time shot, you know, two months, and it gives them that freedom, which is what a lot of women want. You know, that's why Depo became so popular."
- "Like I said, we have new providers on board, so we want to make sure that everybody is okay with this process first. And definitely in the future, we will think about the injectables, but at this moment, I would say we are going to stick with the oral preparations. ...Once we have everyone on board I think and we move forward with

looking into injectables and things like that, I think, of course, all the clinicians, we will need the training for that."

- [Interviewer: And I know [Interviewee #1] had mentioned that a little bit when she was speaking about, particularly with APRETUDE and getting the insurance coverage, and going through that paperwork process. It sounds like that has also been a challenge.]
- Unable to provide injectable PrEP (from interviewer's notes).

C. Annual FGD Matrix

Table C1: Annual FGD Matrix

			Key Domain: HIV Testing			**Key Domain: HIV Prevention**			
	Question →	*Can each of you describe your role at the clinic?*	*Since we last met with your clinic, have there been any changes to your clinical site's policies for HIV testing?*	*Do you currently conduct HIV testing annually or more for your patients who are sexually active?*	*Do you currently conduct HIV testing on all of your patients who are 13-64 at least once? Do you do opt-out testing in your clinic sites?*	*Are there any challenges with implementing HIV testing at your clinic?*	*Since we last met with your clinic, have there been any changes to your clinic's offerings for PrEP for HIV Prevention?*	*Are your clinical sites currently offering PrEP for HIV prevention? IF YES: Can you briefly describe how PrEP services are currently being implemented? Challenges implementing PrEP*	*IF NO: What changes or additional assistance might you need to be able to provide PrEP at your clinical sites? Challenges to implementing PrEP*
FG Descriptives (date and clinic) ↓									
20230915, Clinic 1, Participant #1		So her role has changed a lot, but I'm a PA.	Yeah, we had two health program coordinators that was really involved with like the HIV grant that have left not too long ago. So there is a new health program special specialist.		So before I joined, universal testing wasn't really happening, like it wasn't really practiced. And we worked really hard to integrate that into the workflow. Getting the buy-on for the nurses and medical assistant was really important. I think providers, most of the time, already knew,		There still hasn't been a whole lot of PrEP uptake, to be honest. Yeah. I think part of that is some of the same issue, especially with like timing. And they've also had a lot of changes in staffing and getting through to that, you know, reestablishing that linkage of care was kind of	I think the consensus is if someone is coming in specifically for STD testing, that it is something that we should educate patients on and bring it up. And we strive for that. I don't think it happens 100 percent all the time, but we've had discussions about doing that, at least for that patient	

					like the guidelines that are changing, but the conversation is really sensitive, like culturally-sensitive in that clinic.		like new for both parties again.	population as specifically comes in for STD testing. So we've had some talks about integrating the HIV/PrEP conversation into family planning, although it's fairly time-constrained as well. Because half of our patient is uninsured. So getting, even getting them to the pharmacy, and you know, between that can be really hard. [No on-site pharmacy]	
20230915, Clinic 1, Participant #2		And I'm just like the family planning coordinator. And I do referrals there as well							
20230327, Clinic #2, Participant #1		So I'm _____ _____ _____ PREP coordinator here at the center. And I worked closely hand-in-hand with [Participant #2], and some of the other doctors, but mostly [Participant #2].	We tend to refer those STI patients, like [Participant #2] was saying, that fit the criteria that they're coming in for the testing. Or if this was their regular physical we do an HIV rapid test. So	Yes. And as well as new patients. All new patients are given a rapid as well. Yeah. And they do bloodwork. So they're kind of a double testing.	Yes.	Our biggest challenges is our pediatric department. And there's challenges on both ends with the doctors, as well as patient. But the patient is from the parents...And because it's a			

			that's one of the things that _____ _____ _____ talk to you is _____ rapid, we did _____ _____. So we were in the process of getting up and going pretty good.			parent speaking, there's no. The doctor tends to just kind of go with the flow.			
20230327, Clinic #2, Participant #2		Well, I'm the clinician, and so I prescribe a lot of the PrEP. I actually talk to the patients who I think are really good candidates for PrEP.					Yes. At their physical, they're getting offered. I want them to be getting offered. [Interviewer: "So it's not based on risk per se, but everyone is offered [PrEP]"]	But PrEP is offered regularly. And what my trigger is, anyone who comes in for STD testing gets asked if they want PrEP.	Mostly education. Because sometimes people feel as though if they're getting PrEP, then they're doing something they're not supposed to be doing. And so is this about having a conversation, really. And so, so whether you're a man has sex with men, or if you're a female in the Atlanta area, who's actually was at one point, was the highest growing populations for HIV, we understand you have to have the conversation, and say, look, this is what we can do for you

									to help you not get HIV.
20210124, Clinic 3, Participant #1		I'm [Participant 1], I'm our clinical coordinator. So, I'm on our clinical support team, and I work in administration. I have been here for a little over three years. And so, I don't actually see patients in the clinic as an R.N. I do a lot of the background work, a lot with grants, a lot of things to support our team of nurses and M.A.s that go out and help support our clinics. So, that's kind of my role here. I kind of stay in the background, but I do a lot of Title X stuff and then we have a couple of different HIV grants that we have been working with lately to try to increase testing and PrEP and just things like that.				No, hm-mmm. We've—it's been a big push. We've had—this is actually, we're going into the third year of one grant and a new grant with HIV. So, it's—we've really, really, really been on the push for the testing over the last couple years.	She helps with funding. She's a pharmacist, and so, she helps with different indigent care programs or funding sources and things like that to be able to get the PrEP for as reasonably priced as they can. So, we have, like—the providers have, we typed up, [clinical staff] typed up, like, a little protocol, per se, on how to handle, you know, this is what we do. Once you do prescribe PrEP, like, this is how often we need to have bloodwork drawn, and then she follows up with them. So, I feel like we have a really good process in place, it's just the reluctancy of the patient to agree to take the PrEP is kinda the problem, where we have a struggle.	We're only doing the pills right now. We have not done—we're not bringing the shot on board right now. We're still just gonna do daily. I think the patients provide their own barrier, honestly. Like, I feel like it—when we talk about barriers, I feel like it's directed very much toward the patient. They don't wanna answer the phone, they don't wanna ask—answer any questions. There may be a language barrier. [Clinical staff don't] speak Spanish, but we're bringing on someone now that's on our team that is bilingual, so, she'll be able to help with those Spanish speaking patients.	

								So, you know, we—I think the patients create their own barriers. I don't feel like we have any barriers as a health system, because I feel like we're giving the education, we're putting the materials out there. We're laying it in their lap, it's just whether or not if they're receptive to it or not. I think a lot of it comes with stigma.	
20210124, Clinic 3, Participant #2		I'm the practice manager here at the [city] location. I've been here just shy of about three years. And so, here is where we will do the testing. I'm not clinical, so, I do not actually perform any of the tests, but we are working with [Participant 1] works with us to make sure that we have everything that we need for the Title X services,	So, the providers, they'll capture those patients that's coming in for their annual physicals. So, that's—I mean, that's a given. If they're coming in for a physical, they're being tested for it. For our Title X patients, depending on the nature of their visit, it's being offered to them, as well	If they're coming for, like, a problem visit, something acute—no, maybe not. [Annual Physicals not asked]	Yeah	And we haven't had patients decline, because they would have to—we don't have patients that have said, "No, I don't wanna do that." We don't really encounter that.	So, we have materials. We have—in every room, there's a huge poster that discusses it. I know that when a provider's, when you have those Title X patients that's coming in for an issue, or even if they're just coming for, like, their birth control, they're discussing it. I don't know exactly what the conversation is, I just know that it's discussed.	Mm-hmm, yeah [In agreement with statements above]	

		able to answer questions for us. We are—we do offer PrEP here. We do testing here. We have in-house testing and, again, we're working with [Participant 1] with the grants to help with that support and the education for the community.							
20230515, Clinic 4, Participant #1		I'm [Participant #1] and I'm the chief medical officer at [clinic], and of course, I oversee all the clinical process and everything else	No, we still offer it during our clinical physical exams.		And, again, it is still an opt-out process. We do ask them specifically if they're interested and what we have learned is we have had so many patients decline the test, but we are encouraging them for sure to get this done at least once a lifetime just for low-risk individuals. But for high-risk, of course, we definitely encourage them to get this done.	The only issue is in actually getting the patients to do the screening test.	Yes, and recently, we have actually started doing some outreach where we let the patients know that we are offering the PrEP services. For 2022, we actually prescribed almost ten scripts, I would say, for four unique patients. Yeah, we are based out of [city] but the number that I just let you know is for organization-wide, yeah, for all the clinics, yes.	Yeah, so for high-risk patients, we definitely, the providers, they do let them know that we offer these services. Of course, just about the medications, how advantageous it is for those patients. So we definitely encourage those patients from the clinical side to think about it. So we do have an in-house pharmacy and since we all work together, the pharmacist and all of us work together, getting access to medications, I	

								think that is taken care of because pharmacy staff, they're really good in being proactively getting these medications for the patients.	
20230515, Clinic 4, Participant #2		My name is [Participant #2]. I'm the quality improvement director and I assist with all of our quality metrics and [Participant #1] with anything that she needs, help coordinate trainings, document this sort of stuff for our organization.							
20230915, Clinic 5, Participant #1		Interim CEO -	No.				Very overwhelming as well, but I think our organization has been having challenges building our patient base in general. So I don't know if we've made much movement on the PrEP front, because we're just trying to get patients in the door.		I think right now as providers we're just sort of trying to keep our head above water, so it's not top of mind. The main provider who was doing a lot of our reproductive health services – *[audio cuts out]* – left the organization. So she took a lot of the patient base with her, unfortunately.

									So our other family doc does a lot of chronic care prevention, geriatric care, so he really wasn't doing a lot of the PrEP prevention counseling. We have another provider coming full-time in December. So he may be a person to really hone in on the training, to get them used to having the conversation with patients, as well as a new pediatrician coming onboard pretty soon, too. So it may be an opportunity to do another training later in the year, once we get some new staff in. It also may be an opportunity to create some more workflows for PrEP. I don't know if we have a template or anything in the EHR, that prompts the provider or the

									MA to ask so that may be an area of opportunity.
20231114, Clinic 6, Participant #1		And I'm a health educator for [clinic] So we provide prevention education, but we do most of the referrals. So if we have a patient that is considered high risk, we will give them the referral information for our PrEP clinic visit here at Grady. And then, you know, allow them to contact the patient that – and we'll order all the lab work as well, too, like the STD screening, just to prepare for PrEP. As health educator, I do a lot of the outreach work. We make sure that the doctor put the referral in properly, and follow up to make sure PrEP is contacted --- .	No.				Well, I think they did it in-house in the hospital, you know. So it's still the same, instead of having a separate clinic. But it's, it's very easy to contact them. So once we call them, they, sometimes, they'll even come up to the clinic if they're still in the building _____ _____ anything. They'll come up to the actual clinic to meet with them. Or they'll just go ahead and contact them right away.	Interviewer: So the procedure is that patients says, yes, I'm interested in PrEP. Then you get their information, and then refer them directly to the PrEP clinic. Yeah, we either call them, or send a chat message, and they'll contact with that. [Challenge] And there was, you know, we switched providers. So I don't know, what happened that they separated it	

		Well, first, we'll make sure their information and the demographic is correct. And follow up to make sure that PrEP has contacted him by this person.							
20231114, Clinic 6, Participant #2				No, some even get it more than their annual test. They want it – they think they need it every time. I'm like, no, you don't need it every visit. But, yeah, we'll go six months. We used to a year, a year, a year. But if they come every six months with a new partner, we do it still.					
20231114, Clinic 6, Participant #3									
20231114, Clinic 6, Participant #4									
20231114, Clinic 6, Participant #5									
20231109, Clinic 7, Participant #1		I'm the new Chief Medical Officer here at [clinic]. I would say the word, but I get it mixed up. And so, I'm over the clinic right now. We're trying to							

		rebuild the clinic. We have new people coming in and streamlining and get SOPs and things like that in the works to build a clinic. I come here from Fulton County Jail, doing stuff with the HIV there.							
20231109, Clinic 7, Participant #2		I'm the QA/QI analyst for the organization. So, I work in quality improvement, but my HIV background, I used to be the Care With person for the state of Georgia Department of Public Health. I did my internship at AID Atlanta for my MPH. Let's see, I've worked at Metro Teen AIDS in D.C. as well as Whitman-Walker. And so, now, I'm here.							
20231109, Clinic 7, Participant #3		I'm a PI, and I see patients here primarily. We do a lot PrEP, or a decent amount of PrEP here. We do—we've been doing a lot	So, we do have rapids available. So, we typically do those on their first visit and then we _____, too, but we have the	Yeah. We do a—we do a lot. A lot of people, when they come here, they think we're an STD clinic, so that's	We try to. Their usual paperwork that they fill out has an opt-out section on it, but we're finding that a lot of people opt-out,		Not—yeah. Yeah, we have a lot of MSM, but we're promoting it to everyone, so, that's been—that's definitely been something	...when they're coming in, whether it's for, like, an annual physical or if it's for an STD encounter itself, or something	

		of the Apretude injections recently. We go through ViiV for them, for uninsured patients. We did that really easily and quickly. And go through AVIDA for some of the oral PrEP for uninsured patients and insureds, with insurance.	negative rapid while we wait for the results from the send out. So, we do the fourth generation antigen antibody and we try and do the viral load, too, sometimes, just to have that. I think it has to be frozen sometimes, but it doesn't come back when they run that. But we typically order the viral load and the fourth generation.	what we see a lot of.	and then once they get in the back and I ask them and explain why we do the testing there, they're like, "Yes, fine, I'll get it." So, we do have that there, but it's still usually a conversation that we *[Cross talk]* back again.		we're promoting more. We're promoting it a lot more to heterosexual women.	else, or it's kinda related, we always ask about a last menstrual period, and sometimes, it segues into, "Are you sexually active?" And then, I just explain that PrEP is for everyone. I ask if they know what it is, if they've heard of it, if they're having unprotected sex or risks. And sometimes, they're interested; sometimes, they're not.	
20230315, Clinic 8, Participant #1		I am the family medicine provider at [clinic]. I supervise two nurse practitioners. I see everyone from adults, up and down, and kids. I'm a family plan lead there as well.	Not as of yet, but there are some changes that will be coming within the next few months, potentially as far as HIV testing and management. Yes. We applied for a grant to essentially expand our HIV care services, including testing, PrEP, and just kind of general	I think a couple reasons. One, we are doing more general health checks, but then we also have patients frequenting our clinic more for STD testing, because they are hearing from friends, relatives, et cetera, so just kind of word of mouth. So we have more patients that are coming in for STD testing, but		Funding is definitely a barrier. I would say personnel. Like just having the staffing in place to provide services is one of our biggest issues, but I feel like that is an issue kind of across the board.		It's generally when patients are coming in for a visit for something else, be it a health check or an STD screening, and they kind of meet that criteria for being high-risk. Then there's a discussion that takes place around what is PrEP. ...there is a family planning template in our	[Challenge] And also just working with some of the 440B pharmacies to get access to patients, so there is a smoother ease of transition, because even with going through the 340B pharmacies, there is a process. It's not as simple as writing the script and then

			community outreach. So we will hopefully, if we get approved for the funding from the grant, be doing more rapid testing, and then looking also to partner with organizations, so we can get out into the community and do more rapid HIV testing, but also having testing kits, et cetera, to provide for patients who are – [inaudible]. Then hopefully we have some funding as well to offer PrEP onsite.	also doing more annual health checks where we're screening for HIV.				EMR that I think might have been created by the Georgia Family Planning that we use, that kind of goes into these – well not necessarily into detail, but to ask some of those questions to help assess which patients might be high-risk.	the patient gets the medicine. So I guess just trying to fine tune or smooth that process, so it's more efficient for a patient to get access to PrEP. If that answers your question. Interviewer: Are you prescribing PrEP at the clinics at all? Not currently, no. I think there definitely needs to be more education. I guess a kind of follow-up to the last question, another barrier may be just time, as far as having the time to really dive into those educational components. I feel like there are some patients who would be great candidates for PrEP, but are just not open. So I think some of it may be education. A lot

									of it could just be stigma. Even though there's a lot more awareness about HIV and AIDS now, there's still a negative stigma, connotation with HIV.
20230915, Clinic 9, Participant #1 [Interviewer's Notes]					Currently testing all patients, opt out testing		Yes, PrEP is now offered, but with challenges.	There is a gap in knowledge among providers; Biggest challenges is the providers not knowing the process and dosage Opportunities are not frequent Some of the patients are undocumented so when they go in to ask questions they are concerned about it impacting their immigration status The providers need something to flag and then go a little deeper; identifying the risk factors first and then not being judgmental and	

								then digging deeper/how to start the conversation. Challenges Summary: fitting it in the providers schedule; providers confidence ; and patient challenges (i.e. undocumented patient population/confidentiality/cultural barriers + fears) (Window of Opportunity)Pre Visit Time: Medical Assistant looking over patient charts, A1C , colorectal cancer screenings, new patient screening etc. Could be a time frame for them to also PrEP eligible patients ; how do they determine if this patient would be eligible for PrEP ; Is there a way to flag it for the provider during this time without adding more time ; time is a constraint	

Table C2: Annual FGD Matrix (cont.)

		Key Domain: Training Feedback				
	Question →	*What was your perception of the clinic's overall readiness to implement PrEP before the trainings?*	*After our PrEP trainings, did your clinic's overall readiness change?*	*What did you think about the PrEP trainings that was offered in your clinic? Did you find the information useful?*	*How did you feel about the format and delivery? What trainings have been most successful at engaging staff?*	*Beyond meeting with the GFPS/Emory team, did you have any additional PrEP trainings, internal meetings, or planning sessions to discuss your clinic's PrEP delivery process? IF YES, please describe.*
FG Descriptives (date and clinic) ↓						
20230915, Clinic 1, Participant #1			I think it really starts internally with the staffing and their perception and understanding of, you know, what we're doing, if it really matters, and how they can convey that to the patient. Because a lot of it depends on our patient navigators as well, and how they translate, you know, what we're asking the patient, when and how their body language	Yeah, I absolutely love the training, the sexual history taking. I think it was really important to kind of bridge like that discussion, we wouldn't everybody.	Because in our clinic, we actually don't have a whole lot of time where we can sit to talk about this kind of thing. To address it so openly was kind of scary, because you never know how these kind of conversations can go. But I think they took it really well.	We've also had other external trainings with providers and health program specialists with like the Southeast Coalition, of something, like HIV and PrEP, so that that really helped as well. Right now, we are doing universal testing, along with our Hepatitis B and C testing in our *[crosstalk]* grant.

			is communicating.			
20230915, Clinic 1, Participant #2		Well, I can't recall if I took place in any of the meetings prior, besides the last one that we had in the clinic. But I just, I don't think as like, teamwork-wise, and like, knowledge-wise, they were ready before.	Perhaps, afterwards, they were just because I did start seeing a change in the HIV testing hepatitis A, B, and C testing as well. And the fact that we're trying to promote that into our patients, whether they come for an annual, or just a regular visit.			
20230327, Clinic #2, Participant #1					And you know, the best way to do that, and what I found through our last training, when we did the training on cultural sensitivity. That was truly engaging.	
20230327, Clinic #2, Participant #2				[Interviewer: We talk a little bit about creating that safe space, using correct pronouns, and making sure that peole feel comfortable...] Excactly. And so, you know, just kind of having that conversation and being	So with the training, Zoom is fine, but I actually really, really like the one-on-one... just because we don't have technical difficulties, usually. But the most important thing is making the staff comfortable	

				comfortable with it, and not making it feel so awkward. And create a relationship where you feel you can go even further, and actually get the truth about what's going on with the patients, and what their perspectives are.	with engaging in a conversation. Especially when it comes to sex history, I find that especially our nurses and our MA's, sometimes they're a little bit uncomfortable with having a conversation about, you know, not just do you have sex, but who do you have sex with? What kind of things are you doing? What are your, you know, what things are going on that put you at risk for HIV.	
20210124, Clinic 3, Participant #1		[Interviewer 1:… it sounds like you all are feeling like you have really good readiness on the clinical side…]		Hm-mmm. I think it was good.	It's rare that they have one where everyone's in-person. So, we may just at least start with the Lawrenceville office before we try to do one collaboratively.	Not that I'm aware of.
20210124, Clinic 3, Participant #2						Hm-mmm.
20230515, Clinic 4, Participant #1		Our providers, also, if you remember last year, they were not real comfortable starting on these	So I think it got all the staff members on board, and then, of course, the clinician training was	I think it's just giving the overall picture, giving us the birds-eye view of what we are looking at, and	Yes, this is good. Correct. So I think this helps because, like you said, we have more locations, six	

		medications for our patients, but we did have a training in collaboration with you, with this study, yes, so that training really helped. Yeah, before the training, like I said, most of the staff, they were clueless. Most of the staff, clinical and non-clinical, in the front desk and starting from the schedulers, if you look at when patients call and say, "Hey, do you guys offer PrEP?" They had no clue.	wonderful. [Clinical Provider] is amazing. It was really a good training for all of us. And in the future, I think we would love to have more trainings, also. And like I said, we do have a lot more new staff members on board, so we are interested in actually getting more trainings scheduled.	then going into drilling down into the basics for the clinicians. I think that definitely helped. And the trainings that you guys offered was really good, I should say.	locations, so everybody's spread out all over. So Zoom sessions help and sharing the screen. I think this delivery model is good.	
20230515, Clinic 4, Participant #2						
20230915, Clinic 5, Participant #1		I think it was pretty low before the training.	I think it definitely increased with the training, just as far as bringing it to the mind of the staff.	But again, with staff turnover it's dropped off again.	I like to think in person is always good. *[Inaudible]* – ask questions directly face-to-face. I think we get Zoom fatigue, especially after three year of COVID and virtual meetings. So it's good to be in person.	

20231114, Clinic 6, Participant #1				Yeah		
20231114, Clinic 6, Participant #2						
20231114, Clinic 6, Participant #3				No, it was really informative and more in-depth. When we first heard about it, it was like, oh, _____. And to me, we're behind. Because I have two friends that work with HIV population. They're like y'all should have been on top of this PrEP _____. _____ _____ one of them just moved to [city], and she went up there. And she's like, yeah, like y'all are behind. Yes, we are.		
20231114, Clinic 6, Participant #4						
20231114, Clinic 6, Participant #5						
20231109, Clinic 7, Participant #1						We're working on a lot of stuff internally, from signage to marketing and all that. And I would like to kinda see a real marketing firm take over.

20231109, Clinic 7, Participant #2						
20231109, Clinic 7, Participant #3						
20230315, Clinic 8, Participant #1			Yes.	I definitely think it was helpful, useful information. I think we've had some changes with staff since that time, so I think it would maybe be worthwhile having a refresher or a review of that.	I'm a pretty flexible person. I'm easy to please, so either works for me. I'll say that if it's for more of the staff, it's probably better to be in person. the staff or more people take it, a smaller number of people, online is okay, virtual. But if it's more people, the majority of the staff, then I think in person is better. It's more engaging.	
20230915, Clinic 9, Participant #1 [Interviewer's Notes]		They had talked and knew that it was something at their disposal; staff knew we had PrEP and it was available for some patients	...after the training it was cemented and gave a comfort level and gave a much bigger picture for PrEP; it made them feel less alone in providing these services It helped reinforce and take it to the next level	The unique thing about the training was the data supporting what is happening; to be able to have data to support the prep conversation and to show the actually recommended evidence-based steps was transformational	Having the entire clinic was valuable for not just providers but also the MA's and the other staff i.e. intake or ancillary are aware of the processes in place; whether it Is just sharing the information during intake with the patient they now can also be	Public health department in [city]; they are doing the opt out testing, so they were willing to offer the rapid tests; so in that perspective They are providing the rapid tests

			It feels less alone and that Emory University is supporting them makes them feel more invigorated		involved The training helped complete the full picture	