Delivery of a HIV Prevention Counseling Program for Medical Providers: Implementation Process and Lessons Learned

Shilpa N. Patel, MPH; Carol E. Golin, MD
Gary Marks, PhD; Catherine A. Grodensky, MPH
Jo Anne Earp, ScD; Abby Zeveloff, MPH
Christine O'Daniels, RN; Lytt Gardner, PhD
Maureen S. Boland, MPH; Rebecca Davis, MPH
E. Byrd Quinlivan, MD

Urgent Need for Prevention Interventions

- 40,000 new HIV infections in the U.S. each year
- In NC the number of new HIV diagnoses rose annually from 1,480 to 2,073

HYPOTHESIS

HIV medical care settings are highly feasible settings for delivering interventions to a large number of HIV+ persons

MMWR Guidelines

- Structural approaches: posters, brochures
- Screening for HIV transmission risks
- Counseling by providers- brief messages
- Referrals- prevention specialist, other services

Missed Opportunities

- Barriers to prevention counseling were described by 2003.

Need reports describing:

- Actual process of delivering counseling
- Data on prevention program delivery to patients

Barriers include Knowledge, Attitudes and Beliefs

Address

- Administrative and economic barriers
  - ➔ leads to "unfreezing" past behavior
- Exposure to new information and attitudes
  - ➔ allows movement away from the status quo
- Time and practice
  - ➔ Will allow development of skills
- Reinforcing and maintaining support
  - ➔ new behavior will persist

Positive STEPS

- Multi-site intervention funded by CDC from 2004-2006
- Implemented in 7 HIV clinics
- Collected measures of the implementation process
- Sought answers to three questions:
  1. What was the process by which STEPS was integrated?
  2. How often were risk screening and provider counseling delivered to patients?
  3. How did providers and patients respond to integration?

METHODS

The STEPS Program

- Participating clinics: Nashville, Denver, Kansas City, Brooklyn, Atlanta (2)
- Includes FOUR key elements…

(1) Structural Approaches

- Posters
  - “Take Positive STEPS”
- Brochures
- Prescription pads

(2) Routine Risk Screener

- Questions about recent sexual intercourse
- Numbers of sex partners
- Gender and type of partners (primary vs.... casual)
- Placed in the patient's medical chart
  - Prompt to providers
- Providers attempt to discuss HIV prevention with patients quarterly

(3) Provider Counseling

- 4 hour group training session
- Booster training session
- Physician/specialist from Mountain Plains AETC
- Enhance communication skills
- Practice brief prevention counseling
- Provide referrals
- List potential risk-reduction strategies
- Document time spent discussing prevention

(4) Referral Staff - social workers

- Project trainings
- HIV prevention training w/ NC Division of Public Health
- HIV counseling
- Testing
- Partner notification

Patient Population

- 1,200 HIV infected patients:
  - 59% African Am.
  - 44% White
  - 4% Hispanic
  - 1% Native Am.
  - 2% other
- 1/3 patients: women
- Over 50%: between 25-44 y.o.
- Mode of HIV transmission:
  - Hetero sex: 47%
  - MSM: 35%
  - Intravenous drug use: 11%
  - Mother-to-child, other: 7%
- Psychiatric illness:
  - 70% w/ history of mental health and substance use disorders
- Distance:
  - Over 50% patients traveled over 30 miles to clinic

Formative Interviews

- 19 HIV-care providers
- 20 patients living with HIV
- Attitudes toward prevention
- Experiences
- Needs
- Barriers
- Facilitators

Meetings with Stakeholders

- Community advisory board (CAB)
- Associate directors of ID clinic
- Local health department officials

Chart Reviews

- Screening
- Counseling
- Duration of counseling
- 2-3 month intervals for 15 months

Quarterly Patient Exit Surveys

- Offered to all HIV+ patients in survey week
- Perceptions of prevention activities
- Asking and Discussing
  - Asked about safer sex
  - Discussed safer-sex practices
  - Asked about intravenous drug use (IDU)
  - Discussed safer IDU practices
- Discussions -- helpful or not?

Post-implementation Interviews

- 11 of 19 providers interviewed w/ semi-structured guide
- Providers asked again about:
  - Attitudes towards prevention
  - Experiences in providing prevention counseling
  - Needs for program as well as patients

RESULTS

Question 1:

What was the process by which the STEPS program was integrated into an academic infectious diseases clinic?

Opinion Leaders

- ➔Leadership was knowledgeable.
  - ➔Epidemiology, local and global.
  - ➔Need to improve patient counseling.
  - ➔Positive partner had been neglected up to that time.
- ➔Leadership was vocal.
  - ➔Could speak on the issue.
  - ➔Unambiguous with support.
- ➔Leadership was active.
  - ➔Freed fellows and attendings from other responsibilities.
  - ➔Made time in division meetings to address the issue.

Meetings with CAB

- Expressed support for program
- Asked clinic to inform clinic patients STEPS "new culture"
- Importance of not prolonging clinic visits
- Brief, routine, and non-judgmental
- Risk screener would be burdensome for patients due to frequency and private nature and that methods for responding to this be developed.

Interviews with Providers

- Importance of staff to be able to refer complicated prevention cases
- Strategies for dealing with patients seen in clinic
- Strategies for brief HIV education for patients
- Specific techniques for talking about safer sex
- Ongoing feedback

Interview with 20 Patients

- 80% were open to idea of receiving safer sex counseling
- Most preferred to be counseled by medical provider
- Range of topics included:
  - Risks associated w/ different sexual activities
  - Proper use of condoms
  - Sex with other HIV+ partners & reinfection
  - Use of female condoms
  - HIV transmission
  - Sexually transmitted infections (STIs)
  - Disclosure of HIV status to partners
  - Disclosure of HIV status to family and friends
  - Use of common language
  - Supplemental training topics

Meetings with Providers

- All clinic staff to undergo CDC-sponsored prevention counseling training
- Nurses administer risk screener to patients during triage
- Patients to arrive early for risk screener to be completed
- Need for reporting for partner notification purposes vs. need to not report to have meaningful dialogue with patient discussed

Public Health Issues

- NC Public Health reporting laws require attendings to report individuals failing to follow control measures of protection and disclosure
- Providers expressed conflicts betweeen patient advocate and public health roles

Public Health Meetings

- Formal standards of care to address the opposing interests of current state laws
- Counseling and education would be delivered to patients by trained staff at ID clinic FIRST
- Providers reconciled by counseling patients w/o reporting if harm reduction could be achieved
- Care plan would be reported to the Public Health Department if necessary

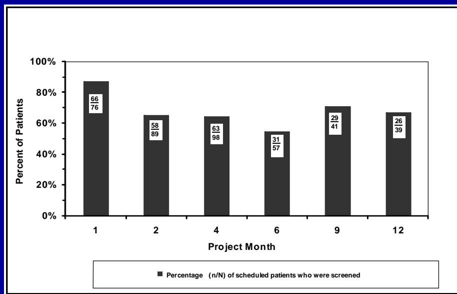
Question 2:

How often were HIV transmission risk screening and provider counseling delivered to patients during routine HIV care?

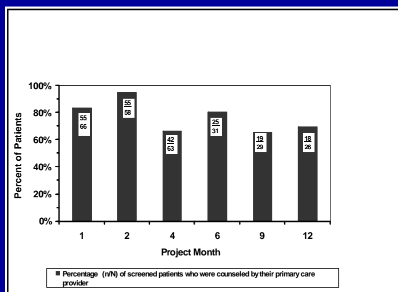
Chart Review

- 80% of scheduled patients were screened for HIV transmission risk behaviors
- Approximately 2 out 3 patients (mean of all remaining time points: 68%) were screened
- Very few patients refused to be screened
- 90% of patients screened during first 2 months received counseling
- 72% (on avg.) of patients screened during remaining period received counseling
- 3.5 minutes per patient=median amount of time spent on counseling
- Prevention specialist counseling services implemented in STEPS
- Referrals to specialists averaged 4 patients per month
  - 1% of 360 pt. visits per month
- Referrals to state health dept. averaged 1 patient per month
  - 50% initiated after diagnosis of STI

Completion of screening form during nurse triage



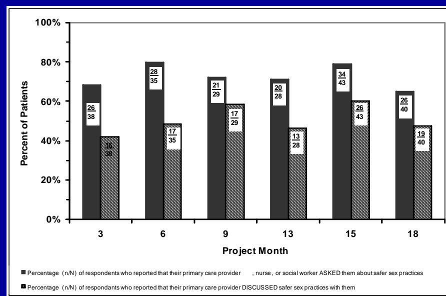
Counseling by provider after screening



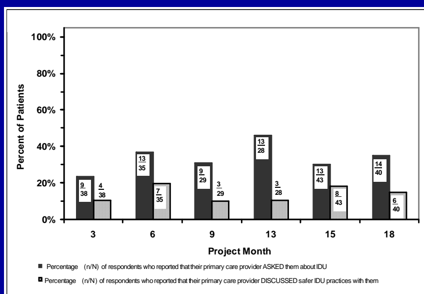
Patient Exit Survey

- 65% Male
- 35% Female
- 62% African American
- 29% White
- 41 y.o.= mean age

Asked about Safer Sex (73%) Discussed Safer sex (51%)



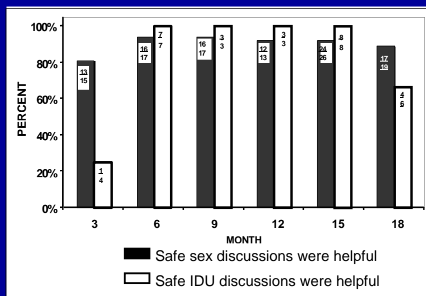
Asked about IDU practices (33%) Discussed IDU practices (15%)



Question 3:

How did patients and providers respond to integrating prevention interventions into the medical care of people living with HIV?

Discussions were "very helpful". (91%)



Provider Response

- Prevention became a "Forefront" issue
- Increased providers' perceptions of risk
- Time was a barrier.
- Counseling remained an add-on.
- Counselor was important- time management for reporting and complicated interventions

Post-implementation Screener

- Risk screener acted as prompt
- Provided structure to the counseling
- Task-oriented could use to "check-off" activity.
- Quarterly may be too frequent.
- Other concerns for low risk individuals.

Lessons Learned

1. Opinion leaders and perception of need are important for change.
2. Screening occurred routinely (70%)
3. Counseling increased
   - 50-60% of all patients
   - 70% after screening
4. Patients and providers indicated similar frequency of counseling.

- Private nature of questions- a barrier for very few
- Screening and counseling documented on same form.
- Medical priorities may have prevented universal counseling.

Sustainability of Screening

- ADD
  - ART adherence,
  - Alcohol use,
  - Patients' concerns (moved to top)
  - Adherence
- REMOVED
  - Risk reduction checklist,
  - Casual vs.... main partner questions

→ Continued at all routine visits

Sustainability

- Important
- No additional staff
- Continued annual local trainings

- Documentation is simpler → only in dictation.
- Ryan White CQI activities → more difficult requires chart abstraction.

CONCLUSIONS

- Similar processes in 2 very different clinics
- Present actual performance data.
- Providers and patients expressed acceptance of the process, finding it helpful.
- Difficulty with continuing performance feedback may result in attrition over time.

Recommendations

- Collect opinion leaders support
- Think about specific barriers
- Think of organizational change principles
- Use consensus and empowerment strategies
- Use existing clinic procedures and resources
- Communicate clear objectives
- Provide feedback- both process and outcome

Please try this at home.

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