Healthcare Provider's Perceptions of Couples HIV Testing in South Florida (PRELIMINARY FINDINGS)

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Outline

- Background on HIV screening
- Challenges
- Facilitators and barriers to HIV screening: A qualitative metasynthesis
- Couples HIV Testing and Counseling (CHCT)
- Healthcare providers perceptions of CHCT in South Florida
- Summary
- Potential next steps
Background

- HIV testing/screening remains THE primary prevention strategy.
- Globally, HIV testing has increased by 33% from 2009 to 2013.
- Availability of different modalities has contributed to increase of HIV screening.
  - PITC (provider initiated testing) significantly increased testing offers
  - Rapid testing significantly increased testing two-fold
- Improvement in diagnostics and treatment has shifted perception of the disease.

Wang, 2015; WHO, 2012
Domestic Healthcare Priority

President Obama’s HIV Care Continuum Initiative directed Federal departments to increase the number of people with HIV who are:

- **diagnosed** with HIV
- **linked** to HIV care
- **retained** in HIV care
- **prescribed** HIV treatment

**virally suppressed** (having very low levels of HIV in their body).

Learn more about the National HIV/AIDS Strategy: Updated to 2020 at AIDS.gov/2020 #HIV2020
As of 2012, 54% of U.S. adults reported ever having tested for HIV.

Over the past decade, the percentage of adults who tested in the past year has not changed.

85% of HIV testing occur in clinical settings.

~40% of hospitals (> .01% prevalence) in a national survey conducted universal screening.

CDC, 2013; Herrin, 2012
Challenges Remain

- Provider offer is based on perceived patient risk
  - Missed opportunities to capture HIV infected patients who undiagnosed or not in care
- Weaknesses in partner based approaches
  - Challenges in HIV partner services
    - Providers preference for patients to self disclose
    - Disclosure of serostatus is less than optimal
  - Men involvement in testing in general and in ANC has structural and pyscho social barriers
- 92% of new HIV infections are attributable to those not in care.
Partner-based considerations

- Globally, half of those HIV infected are in a long term sexual relationship w/ someone who is not.
- Early U.S. studies (‘90’s) and current epidemiology demonstrate couple based risks/ relationship factors remain to be important causes of transmission.
  - Models have estimated 39% - 65% of HIV incidence among U.S. MSM to be from main partners.
  - 84% of U.S. women acquire HIV through heterosexual transmission.
  - Relationships factors have been documented to override engagement in “safer sex behaviors”.
  - Couple based approaches have been documented to be effective in reducing sexual and drug using risks.

Bowleg et al., 2013; CDC, 2015; El-Bassel et al., 2009; Goodreau et al., 2012; Ivy et al., 2014; Wingood & DiClemente, 1998; Marks et al., 2006; McMahon et al., 2013; Sullivan et al., 2009; WHO, 2012; Wilson et al., 2003; Wyatt et al. 2001
Current Challenges ……

• Demonstrate a need to enhance testing strategies
  • Men are less likely to test than women.
  • Non-pregnant women are less likely to be screened.
  • HIV testing remains primarily individually focused.

• Has led to interests in couple based approaches to HIV prevention with specific focus to
  • Identify serodiscordant couples.
  • Strategize to minimize transmission.
  • Optimize availability of newer treatment (i.e. PReP).

Cherutich et al., 2013; Medley et al., 2012; WHO, 2012
Challenges Remain

HIV Care Continuum Shows Where Improvements are Needed

In the US, 1.2 million people are living with HIV. Of those:

- **Diagnosed**: 86%
- **Engaged in Care**: 40%
- **Prescribed ART**: 37%
- **Virally Suppressed**: 30%

Sources: CDC National HIV Surveillance System and Medical Monitoring Project, 2011.

*Antiretroviral therapy*

http://kff.org/hiv/aids/fact-sheet/hiv-testing-in-the-united-states/
Facilitators and Barriers to HIV Screening: A Qualitative Metasynthesis

- Focuses on the first 2 parts of the HIV treatment cascade:
  - screening uptake
  - receipt of test results or serostatus awareness
- Aims were to identify qualitative studies that addressed how do we get:
  - people to screen for HIV infection?
  - the results of those tests to people?
- Approach:
  - Reciprocal translation (Sandelowski & Barroso, 2007)

Levels of Influence to HIV Screening

- Broader Patterns of Influence
  - Policy
  - Modality

- Interpersonal Attributes
  - Location of service
  - Partner-based considerations

- Individual Attributes
  - Attitude
  - Processes
  - Self-concepts
  - Awareness

- Healthcare provider attributes
Interpersonal Attributes

• Partner-based considerations
  – Partner risk
  – Partner serostatus as proxy
  – Couple’s testing

• Healthcare provider attributes
  – Impediment and motivator
  – Provider personal attributes
    • Perceived barriers
    • Practitioner’s ethos
    • Patient motivators
    • Practitioner skills
  – Provider-patient interactions
    • Communication
    • Interpersonal skills
Couples HIV Testing and Counseling (CHTC) is a dyadic approach to HIV prevention.

CHTC Protocol

<table>
<thead>
<tr>
<th></th>
<th>Introduce CHTC and Obtain Concurrence</th>
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<tbody>
<tr>
<td>2</td>
<td>Prepare For and Conduct HIV Test</td>
</tr>
<tr>
<td>3</td>
<td>Explore Couple’s Relationship</td>
</tr>
<tr>
<td>4</td>
<td>Discuss HIV Risk Concerns and Reasons for Seeking CHTC</td>
</tr>
<tr>
<td>5</td>
<td>Discuss Couple’s Agreement</td>
</tr>
<tr>
<td>6</td>
<td>Provide Results</td>
</tr>
<tr>
<td>7</td>
<td>Develop Care, Treatment, and Prevention Plan Based on Results</td>
</tr>
<tr>
<td>8</td>
<td>Link with Follow-up Services</td>
</tr>
</tbody>
</table>

CHTC

- Client & partner learn of status jointly
- Immediate provider facilitated joint disclosure
- Provider eases tension & diffuse blame
- Focus on couple communication & agreements
- Shared understanding of risk & health information
- Counseling & linkage are tailored to joint results

CDC, 2012; WHO, 2012
Couples testing has been shown to:

Decrease:
- Risk behaviors
- Seroconversion within discordant couples
- Number of extra-dyadic partners
- Illicit drug use

Improve/enhance:
- Sexual safety & HIV knowledge
- Willingness to test and testing
- Condom use
- Partner disclosure
- Sustained linkage to medical care for those who are seropositive

(Jiwatram-Negron & El-Bassel, 2014; WHO, 2012)
• Guidelines based on experiences in low-mid income countries.

• Providers’ support for CHTC and for HIV prevention in serodiscordant couples will be critical to the success of such services.

• Providers’ attitudes and views must be considered when planning orientation and training for CHTC.
Research Questions

• What are U.S. healthcare providers’ perception of couples HIV testing and counseling?

• What are U.S. based providers recommendations for implementing CHTC?
Integrated Literature Review: Providers perception of CHTC

- Six studies:
  - Concentrated in sub-Saharan Africa
  - One study included two U.S. settings and perspectives on male couples
- Entire protocol not reported
- CHTC terminology not consistent
- Providers definition not consistent
- Providers perception:
  - Overall highly endorsed
  - Favorable opinions toward improving HIV prevention
  - Acknowledged potential challenges
  - Supported implementation
Healthcare Provider's Perceptions of Couples HIV Testing in South Florida: A Qualitative Study

- **Context**
  - 5,377 new dx, 2013
  - HIV-specific criminal laws
  - HB 321
  - EPT is prohibited in FL
  - Changed July 2016
  - Miami-Dade CHCT Pilot
Purpose: To explore health providers’ perceptions of couples HIV testing.

AIM 1: Ascertain clinical provider knowledge about and attitudes toward CHTC as an HIV testing strategy.

AIM 2: Examine provider perceptions about CHTC.

AIM 3: Identify provider perceived challenges and facilitators of CHTC in a clinical setting.
Methodology: Setting and Sampling

- **Setting**
  - Miami, Fl
  - 2 FQHCs,
  - 2 hospital based HIV care clinics

- **Design**
  - Purposive sampling
    - Practiced for > 1 yr., N=22
    - HIV testing and/or care
**Sample demographics:**

HIV prevention and care providers

<table>
<thead>
<tr>
<th>Demographics Variable</th>
<th>Frequency</th>
<th>Provider Variable</th>
<th>Frequency</th>
</tr>
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<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td>Years in practice</td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>7</td>
<td>&lt;5</td>
<td>2</td>
</tr>
<tr>
<td>40-49</td>
<td>8</td>
<td>5-10</td>
<td>5</td>
</tr>
<tr>
<td>&gt;50</td>
<td>7</td>
<td>11-19</td>
<td>9</td>
</tr>
<tr>
<td>Race (self-identified)</td>
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<td>Licensed Practitioner type*</td>
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<tr>
<td>Black</td>
<td>9</td>
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<tr>
<td>White</td>
<td>11</td>
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<tr>
<td>Hispanic/Latino</td>
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<td>1</td>
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<tr>
<td>Foreign-born</td>
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<td>Mental health provider</td>
<td>4</td>
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<tr>
<td>Yes</td>
<td>8</td>
<td>Other non-clinical provider</td>
<td>4</td>
</tr>
<tr>
<td>No</td>
<td>14</td>
<td>Program managers</td>
<td>4</td>
</tr>
<tr>
<td>Nationality (self-identified)</td>
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<td>Testers/Counselors</td>
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<tr>
<td>American</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latino</td>
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<td></td>
<td></td>
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<td>Haitian</td>
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</tr>
<tr>
<td>Hispanic</td>
<td>1</td>
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</tr>
</tbody>
</table>
Methodology: Orientation, Collection & Analysis

• Orientation
  – Health inequity, primary prevention lens
  – Interactive-Integrative paradigm
  – Post-modernism philosophy

• Collection
  – In-depth semi-structure interviews (30 minutes – 1.5 hours)
  – December 2015 to March 2016
  – Data saturation

• Qualitative description approach  (Sandelowski, 2000 & 2010)
  – Non-specific typology, atheoretical
  – Content analysis approach
  – Thematic exploration
Safety and Quality Assurance

• Subject & data protection:
  – UM IRB approval
  – Informed consent
  – Provider demographic information and interviews are stored separately.
  – Identification of provider via study ID
Interview Guide Domains

• Professional history:
  – HIV testing
  – HIV infected patient care
  – Partner engagement
• Knowledge about CHTC
• Perceptions about CHTC
• Attitude about CHTC
• Recommendations for CHTC
Provider current practice:
Using Peplau’s Theory of Interpersonal Relations

Nurse-client interaction
dynamic, trust and communication

Patient personal goals
anxiety → problem solving energy

Orientation
Introduction
Purpose
Interviewing
Assessment

Working
Understanding disease/illness context

Termination
Closure
Self-reflect
Discharge planning

Nursing role — continually self-reflecting
stranger-resource-teacher-leader-surrogate-counselor

Health outcome/goal
Provider knowledge of CHCT

“... Of course I know about CT, you know I’m in the field of HIV, so I should be aware. But you know I know studies and PrEP all these things so it's not that I just heard about it, we are very familiar with CT.”

“... well I did not necessarily know they were doing it in this clinic until I seen the flyer and when I seen the flyer well, they were kind of like putting it more directly towards homosexual couples, but I think heterosexual couples need to do the same.”

“...it is a new service that we offer, I did not know that it originated in Africa. I am so surprised and impressed with that. I am embarrassed by that personally we’re supposed to be the forefront of medical technology and that includes the way we approach our clients.”

“... the health department was offering the training and...I encourage some of our counselors to get that training.”

“...I have to say I don't know much, so it's not something I do currently. I don't know much about it.”

“...I don't know who spearheaded it. I don't know if this is an idea from the health department or the University of Miami or where it began, but I remember it was all starting at the same time at the different sites.”
Provider perceptions of CHTC

- Perception of CHCT
  - Provider knowledge of local context
    - Jurisdictional context
      - Patient vulnerabilities
    - HIV testing
      - Sexual health
      - Increase awareness
      - Structural & policy
  - Provider ethos & experience
  - Context of patient vulnerabilities
    - Psycho-social Partner-based
      - Socially-based
Provider perceptions of CHTC

“...I think people who are together should be tested for HIV.”

“...I know too many people who have become infected by their steady partner because their steady partner did not tell them or was afraid to tell them. But if I got a couple who were willing to discuss this and they're not afraid to tell...I would think it would be easier...”

“... there are places in this country like Minnesota or Michigan or somewhere where this would not apply at all, but here I think in this situation here...I would advise someone that way.”

“... There is a need to target the population. Even though this is catered for MSM I don’t know why it is not catered to heterosexual women as well because there is a need and there is a risk from the male partner.

...we had a couple of cases in the past...where people are saying we want to get tested together and the protocol of the health department back then was, ‘no, it had to be individual, it has to be separate’ and people actually got upset about that...sometimes people did not understand why and often times to be honest, the counselor did not know what to say...so when that came about I was happy...
Healthcare Provider Attitude: Thematic Framework

- Provider perceived challenges & facilitators
  - Patient attributes
  - Operational consideration
  - Provider engagement

- Nuanced

- Healthcare Provider Attitude
  - Couples considerations
    - Who is a couple?
    - Couple’s motivation
    - Balanced engagement
    - Whom is this for?

- Testing technology implementation documentation
  - Response to protocol

Clinical setting
Couples considerations:
Who is a couple / Who is this for?

“I wonder how many real relationships there are any more, you have hookups and baby daddies...couples should get tested, once they decide to be couples, but you see I don't know what a couple is anymore. I don’t even know if a traditional relationship is even out there anymore. I see a majority of I think non-traditional relationships, they're not living together. I don't know maybe those are traditional now.”

“I define a couple by the person who you are talking to. So it is not my definition that I go by. I define it by whether a person believes that they are a couple”

“...it is an opportunity for couples, I would not say just for two people who are having sex or hooking up, but people who are in a relationship to establish goals and common goals on how they will make sure that they will remain negative...or how they would deal with a potential infection if anything happens.”

“I think it is a great thing because me personally, if I was single and I was going to go into a relationship and my partner said, my partner being male or female or transgender said, ‘nah, I am not into that,’ then I am not into you because that’s telling me, I don’t really matter.”

“...Even though this is catered for MSM I don’t know why it is not catered to heterosexual women as well because there is a need and there is a risk from the male partner. Heterosexual relationships we see are more stable and not as versatile or volatile as male couples and therefore if you are establishing relationship goals, it seems that it would make sense with couples who have a more long term mind set and not a casual set-up...”
“...the benefit that I will always assume is the peace of mind, there is no deception through the process, there's no lies, there’s really no room for that. So people get the benefit of truth being established.”

“.... I love it...you come with your husband to be tested with you and he knows that you're going to be tested...and you agree to use protection...if you want to be negative, whenever he wants to cheat he is either not going to cheat or he is going to use condoms...either way he is going to protect you.”

“it's almost like a two for one, you know if you want to be in this relationship with me I strongly urge you to do this, so you already have one person interested in their health now you're going to bring in the other person who is not as interested in their health...I think it is a great idea, I think it is wonderful.”

“...it shows that both partners in the couple understand the risk...It shows that there is commitment to health for both parties. If they know at the same time I think it is easier for them to understand. In most cases it will not be clear who got it from who which is always the case where one test first and the other one test other later on...they go through getting engaged in care and getting medication at the same time.”

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Provider attitudes: Balanced engagement

“I like the idea because it takes off the blame of the couple. Sometimes if the woman have first the test she feels that, ‘I am guilty’, and if they do it at the same time it is hard for them to know who had it first and I think it would make it easy for them.”

“...the partner is just as aware of it as you are because obviously you all are together and the partner realizes the problem.”

“...sometimes they need a jumping off point for trust to be developed...”

“...it is easier to know the status of both and again if they are both with the disease and with the infection to support each other. That way it is easier to get more adherence to the medications, to the appointment.”

“...it shows that both partners in the couple understand the risk...It shows that there is commitment to health for both parties. If they know at the same time I think it is easier for them to understand. In most cases it will not be clear who got it from who which is always the case where one test first and the other one test other later on...they go through getting engaged in care and getting medication at the same time.”
“... If you don't address your past you're due to repeat it. Now you're in a couple and you are forming a couple ...and he doesn't know your past and you don't know his past and okay so you don't know what you're getting yourself into. So in order to, let's lay it all out on the table. This is where I come from, this is where I’ve been, and this is where I am at today. Are you okay with that? Now we can make an agreement. Okay, so you can have other guys, but emotionally you are mine. Okay but you know what I did before so okay it's time to change.”

“... people have partners but they have partners for different reasons and they may not want that moment to be shared with someone else I mean like whatever that experience entails, the grief, the disappointments and all of that, I don't know if that somebody would be comfortable having another person on their side to experience that so I try to reserve that for that individual. You know obviously you seek out support appropriately as you deem necessary but I am a not sure, I am a person who is you know a proponent for couples testing or whatever you know.”

“... it is already difficult alone just to get people alone to submit to the testing on a personal level and now you're asking them to bring their partner in, I'm not sure if everybody is ready to take that leap.”
Provider perceived challenges and facilitators of CHTC in a clinical setting

- Provider engagement
- Patient attributes
- Operational considerations
- The clinical setting

“You will be surprised how hard it is for physicians to ask patients. Some of the problems are from the physician, they are uncomfortable talking about these issues which I never understood and I still don't understand. They think if you are a clean person, it is really remarkable, and that you are smart that you should be able to know those things and so they don't have to talk about it with them and they are afraid of losing patients. So it is a fascinating thing talking to people that practices.”

“Those of us who deal with the poor, our conversations are very clear, you know. These are having conversations about sex, obesity, whatever it's not a deterrent for us, but testing is a big issue in the normal practices. Physicians lack of comfort is a considerable problem.”

“...we are already comfortable with you doing HIV testing and counseling for high-risk behavior and all that so I think my response may be a little bit skewed because it's kind of like we are okay, we are fine, because it’s like what we do everyday. So um you know I think for us it's a little bit different in comparison to other primary care clinics because it's kind of what we do all the time.”
Provider perceived challenges of CHTC in a clinical setting

“...fear, transportation, time, taking time off from work, refusal of the partner, more times than not the partner is the one that has gave it to them and they have refused to acknowledge that they have the disease, again fear not just of the other person, but fear of being reported and somebody will come looking for them, the fear of the healthcare system or dislike of the healthcare system, distrust of the healthcare system, work, children, the feeling that most women have...their needs are not as important as their children’s or the rest of the families and of course the male feeling of invincibility and denial that they can’t get it.”

“...patients don't want to know that they have HIV.“...

“...they give us like 15 minutes time slot for extremely complicated patients. I mean the HIV is usually not the issue...it's all the other stuff on top of it because what HIV does is accelerate all of these other conditions... the medical system is so complicated with these stupid insurance companies in all the stuff that those tasks, those task of housekeeping are overwhelming. there's no time to even really, I spend more time at the computer than with the patient.”
Provider perceived facilitators of CHTC in a clinical setting

"...I think the patients will motivate, when your patients come in and start asking for things and are unhappy when you don't, the provider will start asking. I think making things non-stigma...if you make it like an everyday thing..."

"...it has to be supported from the top down. That kind of initiative has to be supported from the top down because...if the head doctor does not like, does not approve of people making that offer in the waiting room or if the head office manager does not like it, it's not going to happen."

"...they see them together sometimes like a couple come in together because they have the same provider or doctor and they come to the room with the doctor together so basically that is basically couples counseling, couples testing."

"...the best motivation is an education...I think a lot of it comes down to teaching residents and health staff early on and getting them more comfortable...it doesn't have to be HIV it's the use of electronic medical records all these things and you can see that the younger people are better at certain things than senior individuals and it's not that they have been motivated, it is that they have been educated and this is what their norm [is] and so I think what is going to be in large part is making sure that the youth in medicine come up understanding these things and accept them and feel comfortable with them. And it's much harder to change behavior than to instill a behavior."
What are providers recommendations?

- Paradigm shift
  - Provider characteristics
  - Patient education
    - “how healthy are WE?”
  - Organizational
    - Concordance b/w model of care and health problem
    - Streamline existing services

- Refine strategy protocol
Summary

• Overall - favorable perception of CHCT
• Most perceive a need & are willing to implement
• Perceived challenges
  – Based on current challenges with HIV screening and healthcare in general
  – Systemic organizational factors & patient vulnerability
• Perceived facilitators
  – Patient/community demand
  – Provider existing comfortability with the population and couples
What’s Next?

• Assess
  – Current practices to partner approaches
  – Haitian population vulnerabilities
  – Perception of PrEP

• IMPLEMENT!
  – Tool development(?)
  – Protocol(?)
  – Pilot (?)
### Potential Implications

- Inform health centers plans for enhancing their HIV prevention programs.
- Inform CHTC implementation – in a U.S. clinical setting.
- Enhance provider ability/identify provider considerations to promote HIV prevention dyadic-based strategies.
- Provide foundation for further research on this and related topics.
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• Julie Barroso, PhD, RN, FAAN

• Community/patient populations in South Florida
Thank you

Questions?

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