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"HIV Testing Enhancement" (Webinar)

National Community Health Partners

2/17/2015

"Participant Resources"

Prepared from Webinar-Based Activities

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<u>Comment</u> in **Times New Roman** (dark) Participant Ideas in **Arial** (blue)

<u>Slide 46</u> [no heading] -What would be appropriate and more effective way to ask whether a client engages in *bisexual* activities? ((Spoken)) A common term in mandatory case reports is “bi-sexual” activities. What is an effective way to collect this information?

<u>Comment</u>: Responses follow pattern that clarify what might be variation (however slight) in case report forms used in different states. This is heartening to find the questions are similar and aim to collect the same strategic information. ((In-person, I would tell the audience, “Give yourselves a round of applause”)) Note the separate questions for distinct data. Congratulations to two persons who recognized the need to include the transgender community in their questioning.

Have you had sex with male, female or both?

Do you ever have sex with men, women or both?

You stated you have many partners, were they male, female of both?

You stated you have many partners, were they male, female of both?

What is your experience in having anal and/or oral sex with men?

Do you have sex with men? -Women? -Or both? -Is it unprotected?

Do you know your last sex partner’s status? Have you engaged with sex with females or males?

To a male, I ask them directly have they ever engaged in sex with another male?

When was the last time you had sex with a man? When was the last time that you had sex with a woman?

What type of sex do you engage in?

What type of sex have you engaged in?

What type of sex are you currently having? ((Wait for answer)) With males? females/?

When you have sex, are you active with males or females?

So, do you go both ways?

Some people engage in sex with people from the opposite sex, while others could also enjoy engaging in sex with people from the same gender. You already told me you have sex with the opposite gender, now I would like to ask you in the past 3 months, have you engage in sex with other person of the same gender?

When you have sex, is it with Men, Women, or Transgender?

I ask "are your partners male, female or both?" then I also ask if they have trans-partners

What is your sexual preference? <u>Comment</u>: “Sexual orientation” is the current term, because “sexual preference” implied ‘choice’ which some people found offensive. Think of Carl Bean’s song (released in 1977) “I was born this way,” a phrase that we still find current today.

Comment in **Times New Roman** (dark) Participant choices in **Arial** (blue)

Slide 47 [no heading]

Place these HIV testing actions in the most logical order. Sort the letters and type them in the QUESTION BOX.

A. Do risk assessment... Emphasize client confidentiality, "same questions for everyone, response is voluntary"
B. Do the HIV test, set the timer
C. Have client complete the Consent Form
D. Prepare envelope with list of resources in case the client decides to leave abruptly...

ANSWER (recommended) is "D" before session, "C" at the beginning, followed by "A" and "B"

Comment: Definitely, this question follows two adages, "There is no right or wrong answer" – "Responses will be highly individualized…" If you read the options above, it makes sense that "D" would be prepared beforehand, possibly several inside a folder that you keep near you. Premature departures however rare can be courteous and some can be abrupt. For some programs "C" would be required before counseling can begin OR in other settings it might be specific to the HIV test, which requires securing a body fluid… This example was adapted from an unnamed manual (we leave it "unnamed," not creators of the training).

Anyway, we sorted responses by chosen options to provide an idea of what participants are currently doing / what they believe to be what a counselor should do in real testing-counseling. For 19 responses, this is the break-down:

N=5 **C, A, B, D**

N=2 **D, C, A, B** N=2 **D, C, B, A** N=2 **C, D, B, A**

N=1 **D, A, C, B**

N=1 **C, A, D, B** N=1 **C, B, A, D** N=1 **C, B, D, A** N=1 **C, D, A, B**

N=1 **A, C, B, D** N=1 **A, C, D, B**

N=1 **C, B, D**

Capital Letters N=14 Small Case N=05

No Spacing N=10 Spacing N=09

Commas N=14 No punctuation N=03 Periods N=01 Hyphens N=01

<u>Comment</u> in **Times New Roman** (dark)   Participant Ideas in **Arial** (blue)

<u>Slide 48</u> Risk Algorithm
O: Oral: receptive is twice as risky as insertion
V: Vaginal: receptive is twice as risky as insertion
A: Anal: receptive is 8X more risky than insertion

((Slide)) How would you phrase one of these in non-numerical plain language?
((Spoken)) Risk varies within the behavioral act. One approach to initiate a conversation on risk is to ask how the client understands risk. Respond to the information-gathering question, again using the QUESTION BOX. Type the letter O or V or A for oral, vaginal, or anal, and describe in non-numerical words how you would explain to a client the magnitude of risk.

<u>Comment</u>: Some participants responded with a brief summation of all three, starting with less to most, or most to least risky. Several mentioned the magnitude of risk for one, two or three modes of transmission, and explained why; and a few extended the discussion. Throughout the activity the choice of "plain language" was clear and to the point:

Less to most (one response) **OVA**   Most to least risky (3 responses) **A-V-O ... A, V, O ... AVO**

V -- Female HIV clients has less chance of transmitting the HIV virus, due to having a shorter urethra. There also is no penetration.

O: When you "receive" oral sex, your risk is greater for contracting HIV than if you are "performing" oral sex.

Two participants identified the continuum of risk >

There is a continuum of risk. Anal sex is the riskiest type of sex, followed by vaginal, and then oral.

Anal sex puts you at a higher risk than Oral or Vaginal sex. Vaginal sex is risky, because of a female physical make-up; she is at risk because of male ejaculation. Oral sex is lowest because there is something in our saliva that attacks the HIV virus.

Someone mentioned (importantly) distinction between "receiving" and "inserting" > **If you are the receiving partner, your risk is increased of being infected with HIV.**

Anal Receptive Sex where you are not the "topper" but the "bottom" (unprotected) is the most risky in terms of the transmission of HIV. Because during sex there may be tearing of the anus; this opens the possibility of more opportunity for the virus to enter the body.

Someone suggested a visual representation, ordered least to most risky > (**draw a line indicating less risky and more risky**) **and put O, V, A in the appropriate spot**

Disclosing when we are unfamiliar is good for learning: I REALLY DON'T KNOW

Comments in **Times New Roman** (dark) Participant question/comment in **Arial** (blue)

(1) What would be the best way to deal with a client who is extremely nervous about their test? What are some comforting types of language or phrases that I can use to settle the client's nerves down?

Comment: As I mentioned when this question was asked, nervousness can occur for various reasons (see my response to the next question on providing a comfortable agency atmosphere, among other dimensions of HIV testing). Techniques of Motivational Interviewing can be helpful for acknowledging what / how the client is feeling. Re-assure the client, consider the client's possible needs, from time to time, but don't persist, expecting it will all go away at once: "I appreciate you're coming in today. This won't take long" ... "Would you like some water?" "Let me know any time you want me to go slower or explain something better..." Nervousness within the context of HIV testing can be related to concerns a client has for their recent / not so recent behavior. Focus on conversational themes where the client is other-than-nervous. For someone from the MSM population, "Personalized Cognitive Counseling" (PCC; see comment on third question) is a tool for dealing with "a memorable event," which becomes evident in relation to a client's nervousness on first entering the room, where you do what you do in testing-counseling with specific PCC techniques.

(2) I have a statement rather than a question, I feel you address each individual client differently most people as soon as you ask what brings them in today will assist you in gathering their risk history and assisting them with risk reduction.

Comment: I wish we had heard this comment for in-person training. This sounds like (reads like) your agency has a rapport with the community – they trust the program and the staff. You must self-present in a way that communicates immediate trust (personal appearance; decorations around the office; manner of speaking), which most likely begins when the client enters the door to your organization. The phrase "address each individual client differently" is true when I recognize variation in concerns and questions ("their risk history"), after we've started. Thanks for supporting the initial phrase, "What brings you in today...?" and for reminding us that the client is the one who can best assist us.

(3) I was hoping that this webinar could have addressed how we reach more MSM population.

Comment: As we mentioned in our immediate response (webinar moderator and myself), one way "to reach more MSM" is through social media. This could be messages posted regularly on an agency's website, or as a special link to the particular program that works directly with MSM. The agency's website is direct and easy-to-access. A special link to a program within the agency provides a sense of community through the (intended) sense of privacy.

Social media can also be engineered through sites utilized by the community of individuals who practice MSM, as well as persons sometimes called MSMW. This would require permission, but some sites permit programs "to belong" to their arena of communications, within good taste and through identification of who someone is representing.

Through these paths into social media, language is important for its immediacy and flavor to let the MSM population (community) know that we respect them, that we can offer care and services that might be of interest / necessity.

More directly to the issue of HIV testing, the behavioral intervention “Personalized Cognitive Counseling” (PCC) is an excellent tool for working with the MSM population. PCC in fact was researched and designed specifically for MSM. Training-of-Facilitators is available. The one that I attended was in another state. Most participants were from the sponsoring organization – which provides a secondary gain in having other perspectives – and a few individuals were from other states (even someone who attended a training that I delivered for his agency and a few others).

Stay posted to announcements for webinars that might cover material on HIV testing for the MSM population. I recently accessed a webinar that described an innovative adaptation for “Social Networks Strategy” (SNS), which brought together community members within a setting that was arranged to make them feel comfortable. SNS is a public health strategy that taps-into MSM networks, once a suitable recruiter is enlisted, consented and coached.

Slide 40 [no heading]
Must a client diagnosed with AIDS have a CD4-cell count of less than 200 (14%)? Choose one:

- Yes, this is proper way to diagnose AIDS
- Yes for "200" but it should be 26% not 14%
- No, a physician may diagnose AIDS by one of the opportunistic infections (OI), regardless of CD4 count

Comment: Either CD4-cell count under 200 copies or AIDS-defining condition, or both, are sufficient to diagnose AIDS. As participants found out (and we found out) this question was not worded in "plain language."

Slide 41 [no heading]
Which is an appropriate reason for "No" to the Question, "Has the patient (case) ever been informed of HIV status?" Check all that apply:

- First-time patient who has never tested
- Patient left before receiving rapid test results
- Patient never returned for confirmatory test results
- Patient took the test but "opted-out" from the results

Comment: First three are common-sense ways that someone might not have "ever been informed of HIV status." The concept of "opt-in" / "opt-out" generally applies to HIV screening where the patient (or client) is told, "We include HIV testing with our screening procedures, unless you decline." The individual must say or sign that they do not wish HIV testing. This has been found to be quicker, less difficult, and it results in more extensive screening for HIV.

Slide 45 Continuing Steps
((spoken)) Which of two items in each pair is more effective, 1 or 2? Make a selection for A and B, or just one…
A1) "What barriers do you find most difficult?"
A2) "Which difficulty should we talk about?"
B1) "I would like to offer a suggestion, if I may?"
B2) "May I provide some information that others have found helpful / useful…?"
Which is more effective 1 or 2 (above)?

((spoken)) Which of two items in each pair is more effective, 1 or 2? Make a selection for A and B, or just one…

Comment: This question has no intended best response. Most participants recognized that "B" was taken from Motivational Interviewing, and "A" moves from open-specific (1) to more general open question (2).

Resources

Recommendations for HIV Testing 2013 > http://www.cdc.gov/hiv/testing/clinical/
Recommendations for HIV Testing 2006 > http://www.cdc.gov/mmwr/pdf/rr/rr5514.pdf

CDC 2011, *Implementation of Routine HIV Testing in Health Care Settings*
NACHC 2008, *CHC Should Include Models for Post-Test Counseling and Linkage to HIV Care*
NASTAD 2011, *Update on Implementation of Rapid Testing in HD-Supported HIV Prevention Programs*

Public Health Strategies > http://www.effectiveinterventions.org
Behavioral Interventions > http://www.effectiveinterventions.org

Program Assistance Letters, National Association of Community Health Centers, Bureau of Primary Care
PAL 2010-09 > http://bphc.hrsa.gov/policiesregulations/policies/pal201309.html
PAL 2010-13 > http://bphc.hrsa.gov/policiesregulations/policies/pal201013.html

Urban Coalition for HIV/AIDS Prevention Services (Ann Ford, Director) "12 Cities, ECHPP, and National HIV/AIDS Strategy Implementation" 4-27-11 > http://www.uchaps.org/assets/FAPP_%2012_Cities_UCHAPS.pdf

R.K. Doshi, J. Milberg, et al 2015 "Viral suppression in United States HIV safety net system," *Clinical Infectious Disease* 60:117-125

David Fawcett 2012 "Spoiled identity," *Positively Aware* 24(7):26-31

M. Isabel Fernández, Robin J. Jacobs, et al 2009 "Drug use and Hispanic men who have sex with men in south Florida: Implications for intervention development," *AIDS Education and Prevention* 21 (Supplement B):45-60

Christopher B. Hurt, Steven Beagle, et al 2012 "Investigating a network of Black men who have sex with men: Implications for transmission and prevention of HIV infection in the United States," *JAIDS* 61(4):515-521

Jeff Levy & Amber Jones 2013 "Nothing small about micro-aggression," *Positively Aware* 25(6):32-35

William Miller and Stephen Rollnick 2013 *Motivational Interviewing: Helping People Change*, Third Edition (Guilford Press) Also available as an e-book

J Blake Scott 2003 *Risky Rhetoric: AIDS and the Cultural Practices of HIV Testing* (Carbondale: Southern Illinois University Press)

Jeffery D. Schulden, Thomas M. Painter, et al 2008 "HIV testing histories and risk factors among migrants and recent immigrants who received rapid HIV testing from three community-based organizations," *Journal of Immigrant and Minority Health* (online)

Teun A. Van Dijk 2006 "Discourse and manipulation," *Discourse and Society* 17(3):359-383

General Information on Testing-Counseling:
https://www.aids.gov/hiv-aids-basics/prevention/hiv-testing/hiv-test-types/index.html
https://www.aids.gov/hiv-aids-basics/prevention/hiv-testing/hiv-testing-frequency/index.html
https://www.aids.gov/hiv-aids-basics/prevention/hiv-testing/confidential-anonymous-testing/index.html
https://www.aids.gov/hiv-aids-basics/prevention/hiv-testing/pre-post-test-counseling/index.html
https://www.aids.gov/hiv-aids-basics/prevention/hiv-testing/post-test-results/index.html
https://www.aids.gov/hiv-aids-basics/prevention/hiv-testing/opt-out-testing/index.html
https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/understand-your-test-results/types-of-lab-tests/
https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/understand-your-test-results/cd4-count/
https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/understand-your-test-results/viral-load/
https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/understand-your-test-results/resistance-test/