Title:
Barriers and Facilitators of Couples' HIV Testing and Counseling: Providers' Perceptions From an HIV Epicenter

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Session Title:
Provider Perceptions of the HIV Patient
Slot:
R 06: Monday, 31 July 2017: 10:15 AM-11:30 AM
Scheduled Time:
10:35 AM

Keywords:
Couples HIV counseling and testing, Primary HIV prevention and Providers perception of couples HIV testing

References:
Please note that there are references included that are greater thanm 5 years however there are more than 3 current references presented here.

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Abstract Summary:
This presentation will describe and synthesize findings from a study among U.S. healthcare providers (N=22) on the perceived barriers to and facilitators of couples HIV testing and counseling (CHTC) in a U.S.-based clinical setting. Providers will offer their perspectives and recommendations for implementation.

Learning Activity:

LEARNING OBJECTIVES	EXPANDED CONTENT OUTLINE
The learner will be able to report U.S. HIV focused healthcare providers who are working in a U.S HIV epicenter perspectives of couples HIV testing and counseling in a U.S. clinical setting.	Interpersonal risk and transmission contributes to high HIV incidence and prevalence globally. HIV primary prevention efforts that address interpersonal risk is underdeveloped in the United States. Couples HIV testing and counseling (CHTC) has been demonstrated to be efficacious to reducing HIV transmission and strengthening linkage to care. Provider perceptions of couples HIV testing and counseling (CHTC) is warranted to establish the strategy in the United States. Providers perceptions of CHTC were generally favorable and providers overall reported a willingness to implement the strategy in their setting.
The learner will be able to examine and explain U.S. HIV healthcare providers perceptions of barriers and facilitators of couples HIV testing and counseling in a U.S. clinical setting.	Providers perceptions of CHTC were generally favorable and providers overall reported a willingness to implement the strategy in their setting. Providers perceived barriers and facilitators at both the provider and institutional level. Providers offered recommendations for making the model of care compatible with the health problem of interpersonal risk.

Abstract Text:

Globally, it is estimated that half of those who are HIV infected are in a relationship with someone who is not (1). Since the beginning of the HIV epidemic the literature has demonstrated that among women, including women of color in the United States, partner attributes heightened risk for infection (2, 3). In the United States, it is estimated that there are ~200,000 heterosexual serodiscordant couples, estimated by the proportion of HIV infected women in a relationship (4). Further modeling studies have identified intimate partnerships as a significant source of infection among gay men (5, 6, 1). These findings warrant HIV prevention in the U.S. to directly address interpersonal risk.

Couples HIV testing and counseling (CHTC) is a dyadic approach to HIV primary prevention that aims to address interpersonal risk for HIV (7, 8). It has been well developed globally, but only recently has been introduced for adoption in the United States (7). The World Health Organization (WHO) has recognized that there is a need to enhance identification of serodiscordant couples to prevent new infections and therefore they have developed guidelines for CHTC. These guidelines recommend that providers' support for CHTC and for HIV prevention in serodiscordant couples will be critical to the success of such services, and that providers' attitudes and views must be considered when planning orientation and training for CHTC (1).

So far, studies which have assessed the acceptance of CHTC in the United States has demonstrated its applicability and feasibility predominantly among male couples (10, 11, 12). The literature is lacking in demonstrating the role of providers in the promotion of CHTC within healthcare facilities and among varying patient populations. Therefore, a need remains to understand provider perspectives that may enhance or impede implementation of CHTC in the U.S. within a clinical setting.

Purpose:

Miami-Dade County is the leading jurisdiction for HIV incidence in the United States, with a rate of 45.3(13). Several factors contribute to this high incidence including state public health and health institutional policy, a large immigrant population, interpersonal risk factors and geographical vulnerability (proximation to high incidence countries and location within a high prevalence US. Region; 13). As part of a broader study to describe healthcare provider knowledge, attitudes and perception of couples' HIV testing and counseling (CHTC) in Miami-Dade County, Florida, a qualitative descriptive design (14) was used to also explore provider's perspectives about CHTC in a clinical setting. The focus of this abstract is to describe provider perceived facilitators and barriers to CHTC implementation.

Methods:

A two-tiered purposive sampling approach was used to recruit providers with experience of engaging people into the HIV care continuum. In-depth, semi-structured interviews among healthcare (clinical and non-clinical) providers (N=22) recruited among 4 healthcare facilities in Miami-Dade County, Florida were conducted from December 2015 to March 2016. Data collection involved use of a topic guide that allowed for open ended responses and that was informed by the literature on provider motivation to engage patients into the HIV care continuum. A content data analysis was conducted to develop codes, categories and themes. This was followed by a thematic analysis to explore more latent content and underlying themes from the narratives (14, 15).

Overall healthcare providers possessed a favorable attitude toward CHTC and believed it to be warranted among their patient population. Content analysis revealed that provider's perceptions were influenced by their personal ethos and experience, their knowledge of the local context including the context of their patient vulnerabilities. A thematic analysis revealed four themes among the narratives: 1) Whom is this strategy for?; 2) Balanced engagement; 3) provider experiences, practices and preferences; and 4) the model of care and the health problem.

Results:

Providers perceived couples' HIV testing and counseling (CHTC) to be for couples who aim to establish commitment or monogamy. They perceived the strategy allowed for the reconceptualization of health promotion within couples and approaches between patients and providers. Providers perceived CHTC to balance engagement between themselves and the individual patient(s) and between partners within the couple. Providers described CHTC as a strategy that allows the couple to avoid any confusion regarding joint results and mitigate any anxiety or potential blame regarding the couple's diagnosis. Adoption of CHTC indicated for some providers not only an evolution in HIV screening approaches, but in how individuals perceived personal well-being to allow for a reconceptualization of individual health.

Current provider practices and preferences were believed to either facilitate or impede CHTC. Many providers spoke of having high levels of comfortability to engage patients in HIV screening, and conversations regarding sexual health. In addition, some of these providers reported experiences engaging couples in a wellness or health visit, or facilitating disclosure between their HIV infected patient/client and their sexual partner. Therefore, to implement CHTC was simply the next step in their personal practice.

Although overall clinical providers reported a willingness to engage couples, some noted that some of their colleagues may not be capable or willing to do so. Some providers reported that the prospect of having a seropositive patient or a serodiscordant couple may be a deterrent for providers. Others perceived some provider's lack of knowledge, training and ultimately capacity to even mange a couple and/or HIV infected patients would make them unwilling to adopt the practice of offering CHTC. It was also believed that some providers are not amendable to having frank with patients about their sexual health.

Provider induced stigma was reported as an important problem. Healthcare providers reported that certain clinical providers possess biases against and can be judgmental toward certain patient populations. This stigma was demonstrated through implicit or explicit biases which potentially deterred patients from screening and engaging into subsequent HIV care for those in which it's indicated.

Some providers also spoke about patient attributes as potential barriers to CHCT. Underlying mental health issues and poor coping skills were salient concerns regarding vulnerability of patients. These concerns dominated all populations discussed in the narratives and by extension perceived to be an important consideration for CHTC. The contexts of patients' lives were also perceived to be potential barriers to uptake. These contexts include concerns regarding insurance, lack of time and transportation or lack of partner willingness to engage in the strategy. Despite this context, prior patient demands and current inquires for CHTC among the patient population and the community were perceived as facilitators to begin offering CHTC at primary care facilities.

Providers perceived that the current U.S. healthcare system does not adequately support HIV primary prevention and therefore this may be a barrier to including partners in HIV screening in a clinical setting. The lack of health insurance among male partners of female index patients within couples, in tandem with provider commitment to the index patient was perceived as a barrier to CHTC. Providers reported that the clinical provider has to be able to bill for their services and delineate who is the patient, in addition to whether the partner of the index patient is registered at the facility, all indicative of perceived barriers.

Providers narratives described the organizational setting and program policies which would facilitate CHTC or was perceived to be potential barriers to CHTC. Providers in favor of clinically-based CHTC noted that federally qualified health centers (FQHC's) and primary care clinics would be best suited to implement CHTC because of the population they serve and the belief that these settings were family/community oriented. Providers used elements of their workplace setting as the model of care that could implement CHTC. Many reported that their organization has the space to accommodate another person in a consultation room to be screened, that they provide free HIV screening on-site, have

personnel who can conduct rapid tests and a model of care that incorporates routinized HIV screening, elements which were all perceived facilitators of CHTC. Providers also identified that the scope of practice within their facility allowed for partners to be screened for sexually transmitted diseases including HIV infection and hence can logistically facilitate CHTC.

Conclusion:

All but one provider expressed their willingness and capability tro implement CHTC. However, providers expressed the need for a multi-level paradigm shift in the U.S. so that the model of care addresses the health problem of interpersonal risk. One level involved a need for clinical providers to be better trained in interpersonal relationships with their patients and improved tolerance for diverse populations. It also involved more cross-training of skills among non-clinical providers and a model of healthcare that was more interdisciplinary to address diverse patient needs. Specific recommendations included the need for provider and patient's education regarding interpersonal health risk and a need to streamline existing health care services so that partners are able to be screened for HIV if present with the index patient.