A Qualitative Assessment of Facilitators and Barriers to HIV Testing Initiatives in the District of Columbia

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BACKGROUND

- The District of Columbia has a severe and generalized HIV/AIDS epidemic with a prevalence of 2.7%.
- Since the release of the 2006 CDC HIV testing recommendations, the District of Columbia Department of Health (DC DOH) has supported the implementation of routine HIV testing in addition to more targeted strategies.
- Despite these efforts and increasing testing rates in DC, between one-half to one-third of residents remain unaware of their HIV status resulting in missed opportunities for testing and a high percentage of late testing.

OBJECTIVES

- To assess HIV testing initiatives to date in DC and to explore gaps that may contribute to missed opportunities for testing.

METHODS

- Reviewed DC DOH programming and policies portfolio.
- Conducted semi-structured interviews with:
  - o Testing coordinators and directors from DC DOH-supported testing sites, n=7, including:
    - Community-based organizations (CBO), n=2;
    - Health clinics, n=3; and
    - Hospital emergency departments (ED), n=2.
  - o HAHSTA staff, n=4.

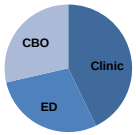

Figure 1: Sample by Organization Type

- Utilized purposeful sampling strategies to select sites based on organizational type, volume of testing, and diversity in client demographics.
- Used Atlas.ti 7.0 software for content analysis to identify relevant themes and patters.

RESULTS

Organization and Client Characteristics

- Sampled sites primarily provided services to underserved, minority populations. To varying degrees, the sites provided comprehensive, wrap-around services to meet diverse client needs.

"…As the face of the infections changes in DC so is our clientele. So now it's…predominantly minority and we have more males. And as far as MSM versus heterosexual [we] may be teetering somewhere in the fifty-fifty range at this point…They usually come from the Wards… six, seven, eight."

Understanding of HIV Testing

- Key informants had a good understanding of HIV testing and had favorable perceptions of the importance of testing.

"[Routine testing is] not necessarily based on risk factors so to speak, which is you know just like we all go to the doctor and get our blood sugar tested or our blood pressure tested at least once a year, HIV being part of that. I feel that it definitely assists the community on a whole. I mean with the HIV rate being what it is in DC…it's really prevalent here in DC."

Testing Implementation Strategies

- Clinics, EDs, and CBOs exhibited a variety of implementation strategies including differences in context for testing, staffing models, and testing technologies used.

"They [patients] come in they said they're here for their [health care] appointment …The provider sees the client for whatever they're presenting for that day and also tells them along with any other labs that they may run …"I'm [going to] set you up for this HIV test. And then they will make us [peer testing staff] aware…and [we] will explain the [rapid] testing [procedure]."

RESULTS

Testing Practices

- Variation was evident in regards to opt-out and consent practices, education and pre/post test counseling, confirmatory testing, and linkage to care strategies between sites.

- Opt-out and consent practices

"It's opt-out consent…and that's the way that I present it...We're going to, we routinely screen everybody that comes through the emergency department… unless you decline."

"The provider says you know you're here for a routine physical do you want to do STD screening…? And, then the provider says now this includes, you know we'll screen you for gonorrhea and Chlamydia, HIV, syphilis….[consent is] oral, yeah."

- Education and counseling

"We do a personalized risk assessment for every client and give them feedback based on their personal risk assessment and give them ways and ideas to be able to reduce their risk…So we're really, really, really big on education."

- Confirmatory testing and linkage to care

"Another thing that we do that's kind of different than most we're going to offer that person immediate escort, immediate transportation to a care provider right then and there."

"So, you just need to walk into our front door and say you're here for Red Carpet [linkage service] and then we'd get you through the process that day…We get them hooked up with a nurse case manager. They get their first set of labs drawn and they'll usually meet with [a] provider…as well as if they don't have insurance they meet with our public benefits department."

RESULTS

Barriers

- Sites reported barriers to the further scale up or sustainability of testing programs largely having to do with the availability of resources.

- Limited funding and resources

"…One of the most difficult problems we have is the lack of funding….I mean at the end of the day it's really never enough money cause it's just so many people and so many things."

- Third party reimbursement

"So, my team for lack of a better word probably would be considered peers. They're not credentialed. They're…not you know Medical Assistants or Nurses. So, under most insurances they would not be able to bill . While there are ICD 9 codes or CBT codes for charging rapid testing it needs to be under the auspices of a provider."

- Reporting requirements

"To be quite honest at the end of the day it's a lot of paperwork. And you know HAHSTA has made efforts before to try to minimize it but even eternally we have our own paperwork on top of what they require so it can be a little daunting."

Facilitators

- Sites reported facilitators to current testing programs having to do with DC DOH support and staff commitment at their organizations.

- Support from DC DOH

"…[DC DOH staff] are the monitors for the grant, so financially that's one. Two, they offer safer sex products. Three, we get our tests from them. Four, they've had a myriad of trainings that were brought in for HIV counseling and testing…Any type of technical assistance that we need from them we can always go to them."

RESULTS

- Testing staff commitment

"They [patients] kind of look at this as a second home….They build relationships with their providers, whether it be their case manager or their medical provider or even still me [testing staff]. ..my department might have been the first one of contact through testing…we [strive to] keep a good strong rapport going."

LIMITATIONS

- There may be possible bias due to convenience sampling techniques used in the recruiting of sites and study participants.
- The methods used in this study are not conducive to generalizing study findings.

CONCLUSIONS

- Variation was evident between sites in how they understood and implemented testing.
- Testing implementation strategies were found to be diverse and appropriate given the testing context. Clinics had the most diversified testing portfolio.
- Barriers faced by sites included funding and resource constraints and concerns about the sustainability of their testing programs.
- Third party reimbursement, particularly for rapid testing, was identified as a major challenge for the clinical sites.
- Strong testing staff commitment in terms of dedication, commitment, and energy was exhibited at all sites and was a strong facilitating factor across sites and testing programs.

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