Implementation of Project RESPECT in a Busy Primary and HIV Specialty Care Clinic

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Abstract

Background: The University of Pittsburgh HIV/AIDS program provides care to over 1,500 HIV-infected persons. MSM and MSM who use injection drugs (MSM-IDU) represent 58% of the clinic population. Since 2010, there has been a steady increase in new syphilis diagnoses from 1.5% to 4% with the majority of cases representing re-infection. The CDC RESPECT protocol was adapted for implementation with HIV-positive MSM to reduce high-risk sexual behaviors through client-centered discussions.
Methods: This is a longitudinal descriptive research project intended to inform on: (1) the feasibility of implementing RESPECT using a peer counselor; (2) the compendium of client-identified risk reduction strategies, and; (3) the effectiveness of the risk reduction strategies.
Results: Between 9/29/2010 through 7/9/2012,161 non-duplicated clients were referred to RESPECT. Ninety-four (58.4%) clients participated in at least two RESPECT sessions. Unsafe oral sex was the predominant sexual risk category (73.1%) followed by unsafe sex involving friend with benefits, group sex, or sex with a non-primary sexual partner. Approximately 11% of clients reported unsafe anal sex. Nearly 39% of clients agreed to try the female condom for anal sex. 19.2% agreed to maintain their current level of safer behaviors and 11.4% expressed interest in other strategies. Approximately 63% of clients achieved their risk reduction goals, but in nearly 15%, progress toward risk reduction could not be determined.
Conclusions: The findings suggest that it is feasible to implement RESPECT in the HIV primary care setting. Challenges encountered included limited availability of the counselor, lack of buy-in by other providers, follow-up sessions coinciding with regular medical visits where other issues may take precedence and adapting RESPECT for HIV-infected MSM in the context of the continuum of sexual risk taking behaviors. The changing nature of sexual risk-taking behaviors reported by clients over the course of their involvement suggests the need to identify mediators of risk behaviors.

Introduction

In 2003, the Centers for Disease Control and Prevention (CDC) along with the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America published recommendations for incorporating secondary HIV prevention into the routine medical care of all HIV-infected patients regardless of age, gender, or race/ethnicity [1]. At the end of 2006, the CDC determined that men who have sex with men (MSM) accounted for 53% of all new HIV infections in the United States and MSM with a history of injection drug use (MSM-IDU) accounted for an additional 4% of new infections. The CDC also targeted the other major HIV transmission risk groups, specifically IDU, heterosexual contact, and perinatal transmission to receive top priority with regard to HIV prevention strategies [2] . The CDC has a repertoire of evidence-based behavioral interventions (EBI) targeting specific populations engaging in risky behaviors. These EBI are disseminated to community-based providers by the Diffusion of Effective Behavioral Interventions (DEBI) project which attempts to bridge the gap between behavioral research and the clinical practice setting.

Setting and Strategy

Setting: The University of Pittsburgh HIV/AIDS Program (PACT clinic) provides care to over 1,500 HIV-infected persons from an 11-county region of Southwestern Pennsylvania, eastern Ohio, and northern West Virginia. Men represent 76% of the clinic population. The majority of the men identified as white (44.8%), 27.4% as African American/Black, and 1.5% as Latino/Hispanic. MSM and MSM-IDU represent 57% and 2% of the patient population, respectively.

Strategy: The RESPECT intervention is a client-centered, interactive HIV risk reduction counseling model based on Project RESPECT which assessed the efficacy of HIV prevention counseling among persons seen in an STD clinic for treatment.[3] The original study evaluated both 2- and 4-session counseling interventions using the RESPECT protocol. The investigators determined that the 2-session counseling intervention was as effective as the 4-session model. RESPECT is designed to support risk reduction behaviors by increasing awareness of risk and by emphasizing incremental risk-reduction strategies. The intervention's core elements are to:

- conduct one-on-one counseling using the RESPECT protocol
- utilize a "teachable moment" to motivate clients to change risk behavior(s)
- explore circumstances and the context of a recent risk behavior to increase perception of susceptibility
- negotiate an achievable step which supports the larger risk reduction goal
- implement and maintain quality assurance procedures

The RESPECT protocol is structured to help guide the counselor through the intervention and also helps to address barriers to risk reduction with clients. The protocol is interactive and client-centered and is thought to be easily incorporated into other existing programs.

Methods

We selected the 2-session RESPECT protocol for implementation and adaptation in the PACT clinic in order to specifically target HIV-positive MSM. In September 2010, two individuals (ENV, KG) received training in the RESPECT protocol. The model was implemented in the PACT clinic by the end of September and remains ongoing to date.

The RESPECT counselor is a peer advocate in the clinic and is available 12 hours per week. Client referrals originate from providers and social workers. The first session lasts from 15 to 30 minutes during which the client and the counselor explore the particular risk behaviors and develop an achievable step for risk reduction. The counselor maintains detailed notes for each client that serve as the framework for the subsequent session(s) during which the progress towards risk-reduction is reviewed and the client and counselor revise the risk-reduction plan as necessary.

The second session coincides with the client's regularly scheduled clinic appointment and lasts anywhere from 5-7 minutes and up to 15-30 minutes. The counselor reviews the schedule for the clinics that he attends and reminds the providers which clients are due for a follow-up RESPECT session. At both sessions, the counselor provided clients with a "goodie bag" containing male and female condoms and various types of lubricant. At the end of each session, the counselor provided any necessary information that the client may have requested. We adapted the protocol to reflect the ongoing clinical relationship with clients and recognizing the continuum of sexual risk taking behaviors among our MSM clients. Clients' clinic charts and the counselor's notes were reviewed to determine if clients achieved their risk reduction goals.

Results

Refer to the tables at the right for details of the clinic population participating in the RESPECT HIV Prevention counseling.
From September 29, 2010 through July 9, 2012, 161 non-duplicated clients were referred for RESPECT counseling. Ninety-four (58.4%) clients attended at least 2 sessions (range 2 to 5; 1.9 sessions/client).

Among the 161 clients, the spectrum of sexual risk behaviors among these clients ranged from none (no sexual activity of any type) to kinks/fetishes. Both active or passive unsafe oral and anal sex were the predominant sexual risk categories reported by 45.7% and 19.8%, respectively, by the clients referred for counseling. Among the 94 clients that completed at least 2 sessions, the top three risk reduction steps chosen by the clients included: (1) trying the female condom/using condoms for anal sex (38.9%); (2) maintaining current safer behaviors and consistent condom use (19.2%, and; (3) further discussion about other risk/harm reduction strategies (11.4%). 4.2% of clients agreed to limit their sexual networks outside of their primary relationships.

Conclusion

Our findings suggest that (1) it is feasible to implement the RESPECT HIV prevention and sexual risk reduction counseling protocol in the setting of HIV primary care using a peer counselor, and (2) RESPECT is generally acceptable to HIV-infected MSM. The counselor was able to maintain fidelity to the core elements of the RESPECT protocol.

We identified several challenges during the implementation of RESPECT:

- Limited availability of the counselor (12 hours per week)
- Client reluctance to share personal information with a peer
- Limited number of referrals by the majority of the providers
- Inconsistent documentation by providers about clients' risk behaviors
- Lack of buy-in by other providers
- Follow-up sessions coincide with regularly scheduled clinic visits and not within two weeks as per the original RESPECT protocol
- Adapting RESPECT for HIV-infected MSM in the context of the continuum of sexual risk taking behaviors
- Identifying mediators of sexual risk-taking behaviors for clients over the course of their care in the clinic

Table 1. Patient demographic characteristics (N = 161)

Characteristic	Mean (SD) or Number (%)
Age, years	42.8 (11.6)
Age range (median)	19 – 65 (45)
Sex	
Female	2 (1.2)
Male	159 (98.8)
Race/Ethnicity	
White	112 (69.6)
Black	44 (27.3)
Hispanic	3 (1.9)
American Indian	1 (0.6)
Other (not specified)	1 (0.6)
Sexual preference	
Men who have sex with men (MSM)	139 (86.3)
Bisexual	13 (8.1)
Heterosexual	8 (5)
MSM/IDU	1 (0.6)

Table 2. Baseline self-reported sexual behaviors/practices (N=161)

Sexual Behaviors/Practices	Number (%) *(clients reported more then one risk behavior)*
Unsafe oral	90 (40.4)
Unsafe anal	39 (17.5)
Unsafe vaginal	5 (2.2)
Kink, fetish (fisting, watersports, sounding, BDSM)	24 (10.8)
Not sexually active	21 (9.4)
Serosorting	3 (1.3)
"always safe"	25 (11.2)
Unknown (nothing reported, client did not wish to state)	16 (7.2)

Table 3. Risk Reduction Steps (N=94)

Risk Reduction Strategies	Number (%)
Female condom or condoms for anal sex	65 (38.9)
Use condoms consistently/maintain current safer behaviors	38 (22.8)
Discuss risk/harm reduction strategies (serosorting, sexual positioning, dipping, withdrawal)	19 (11.4)
Condoms/barriers for oral sex	15 (9)
Not sexually active/remain celibate	10 (6)
Limit sexual network	7 (4.2)
Negotiate risks with partner(s)	4 2.4)
Disclose HIV status	4 (2.4)
Non-latex condoms	3 (1.8)
Monogamy	2 (1.1)

References

1. Incorporating HIV Prevention into the Medical Care of Persons Living with HIV, Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America, MMWR 2003;52(RR12):1-24.

2. Pennsylvania Department of Health Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania 2009-2010.

3. Mary K. Lamb, Martin Fishbein, John M. Douglas et al. Efficacy of risk-reduction counseling to prevent human immunodeficiency virus and sexually transmitted diseases, a randomized controlled trial. JAMA 1998;280:1161-7.