A National Training Program to Improve HIV/STD Prevention into the Care of Persons Living with HIV

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Background

- Sexually Transmitted Diseases (STDs) can increase the risk of HIV infection and transmission. It is crucial for providers to ask all HIV+ patients about behaviors related to HIV transmission and STD acquisition.

- The Ask, Screen, Intervene (ASI) curriculum was developed to increase provider knowledge, skills, and motivation to incorporate risk assessment and prevention services into the care of People Living with HIV (PLWH).

Objectives

- Determine if a nationally coordinated training program can reach providers who care for PLWH and increase perceived knowledge, skills, and motivation needed to implement recommended prevention practices.

- Report trainee implementation of recommended practices in the workplace 3–6 months after training and identify barriers to implementation.

Methods

- The National Network of STD/HIV Prevention Training Centers (NNPTC) recruited HIV-care providers in geographic areas with high incidence and prevalence of HIV among racial and ethnic minorities through emails, at conferences, and through direct outreach to HIV clinics.

- The NNPTC developed ASI to disseminate the guidelines *Incorporating HIV Prevention into the Medical Care of PLWH,* presented in MMWR in June 2003.

- Immediately after training, participants completed a post-course evaluation to: self-assess their confidence to demonstrate ASI knowledge and skills and identify barriers to implementation. Three to six months after training, participants with active email addresses were invited to complete a follow-up survey.

- Descriptive statistics summarized demographic, occupational, and satisfaction data. Likert scale confidence levels demonstrate ASI learning objectives; means were calculated to measure pre to post course changes and pre to 3-6 month follow-up; and paired two-tailed Student's t-test was used to test significance.

Results

The ASI curriculum was delivered to 2,558 HIV-care providers (61.4% were clinical providers and 33.6% were non-clinical providers) at 137 sites between September 30, 2007 and December 31, 2010.

Retrospective Self-Reported Frequency of Practicing ASI Skills in the Workplace Before and 3-6 Months After ASI Training
(1=Never, 2=Rarely, 3=Sometimes, 4=Almost Always, 5= Always)
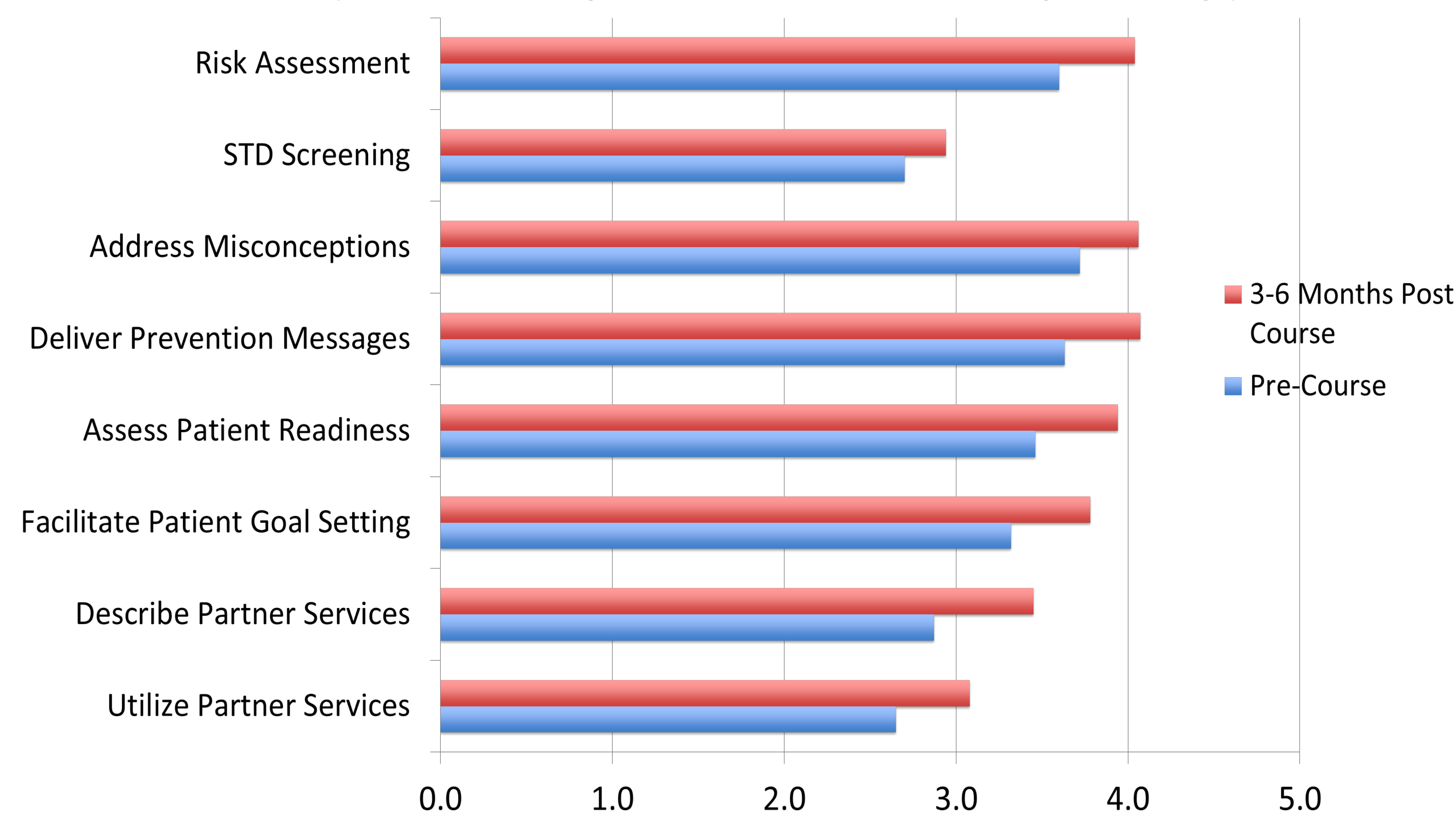
3-6 months after training, 320 responders self-reported significant increases in the frequency of performing all 8 ASI skills (p<.001). Respondents reported greatest gains in confidence in describing partner services to all your HIV+ patients (+.58 change), assessing HIV+ patients' readiness to make behavior changes to reduce risk of transmitting HIV or acquiring an STD (+.48 change), and asking all HIV+ patients about behaviors that can place them at risk for transmitting HIV or acquiring an STD (+.45 change).

Self-Reported Anticipated Barriers and Actual Barriers to Implementing ASI Practices
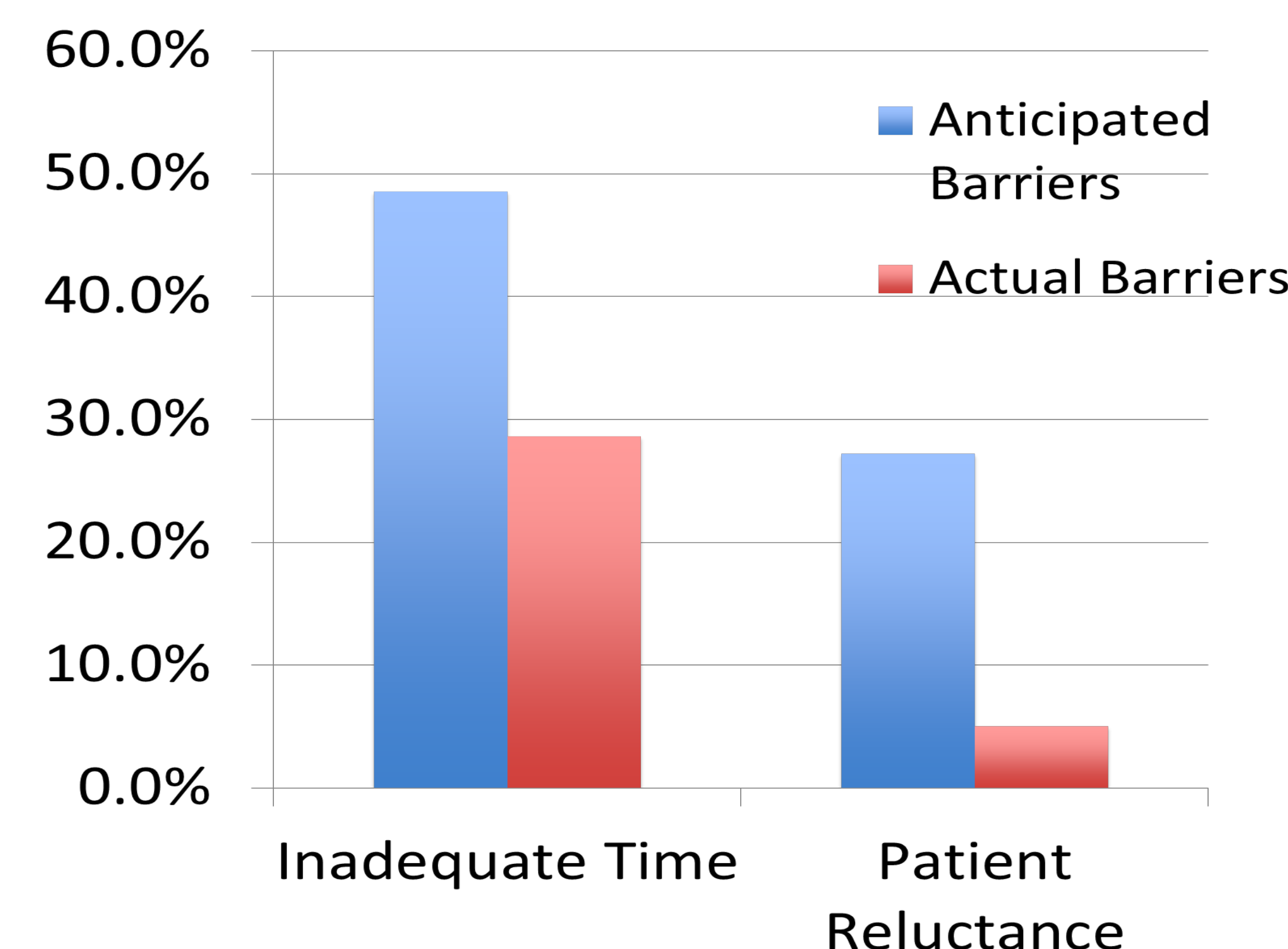
Immediately after training participants anticipated barriers in implementing ASI, and 3-6 months after training participants reported actual barriers to implementing ASI in their workplace.

Conclusions

- ASI was equally valuable for both clinical and non-clinical health care providers, particularly around assessing risk behavior, assessing patient readiness to change behavior, and communicating about Partner Services.

- ASI training increased perceived confidence to demonstrate ASI knowledge and skills and contributed to more frequent use of ASI skills 3-6 months post-training for all healthcare providers.

- This supports a multi-disciplinary team approach to increase the frequency of ASI practices and reinforce prevention messages in clinical settings.

- 50% of follow-up survey responders faced barriers to implementing ASI practices. Barriers mirrored anticipated obstacles with time constraints mentioned most often. Although providers expected patient reluctance to interfere, few found this to be true.

Limitations

- Without a randomly assigned control group, we cannot demonstrate that training is solely responsible for the changes in confidence reported.

- Most participants volunteered to attend the training which might have biased the sample toward those already motivated to improve their HIV prevention practices.

- Confidence ratings and frequency of implementing ASI practices are self-reported estimates.

Implications

- A well-coordinated training program can reach a national audience of HIV-care providers, significantly increase self-reported capacity to incorporate HIV/STD prevention into the care of PLWH, widely disseminate federally recommended practices through training, and increase self-reported frequency of using recommended practices.

- Training alone is not sufficient to ensure recommended practices become fully integrated into HIV care. Barriers, specifically time constraints, must be addressed before prevention can be maximized in clinical settings.