

Northwest HIV, Hepatitis C and STI Treatment Practices and Training Needs Assessment Summary

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Executive Summary

In October 2014, the Northwest Portland Area Indian Health Board (NPAIHB) partnered with the Northwest Education and Training Center (NW AETC) to carry out a needs assessment to better understand the HIV, Hepatitis C and Sexually Transmitted Infection (STI) treatment practices and training needs in American Indian and Alaska Native (AI/AN) communities. The survey was completed by 60 healthcare providers at IHS, Tribal, and Urban Indian (I/T/U) healthcare facilities located in Alaska, Idaho, Montana, Oregon and Washington.

Key survey findings include:

- A great deal remains to be done in I/T/U healthcare facilities, to reach recommended HIV/HCV/STI screening levels. Only 18% of participating clinicians reported that over half of their eligible patients had been screened for HIV, and less than 15% reported that over half of their eligible patients had been screened for HCV.
- Most I/T/U clinicians in the region do not feel confident treating HIV/HCV infections. Only 12% of the providers surveyed felt “extremely prepared” or “very prepared” to treat a patient for HIV/AIDS, and 16% felt similarly prepared to treat someone for HCV.
- Most I/T/U clinicians in the region refer their HIV/HCV positive patients to specialists for follow-up treatment and care, or co-manage their patients with an expert.
- On the whole, I/T/U providers in the region do not feel that HIV, HCV, or STIs are a priority health concern for their community.
- There are many provider-perceived barriers to HIV/HCV/STI prevention that could be addressed to improve HIV/HCV/STI rates in the region, including barriers associated with clinical systems, patient norms and community awareness.

Based on these findings, the NPAIHB offers the following recommendation to the NW AETC:

- Offer training and technical assistance on clinical strategies that have been shown to improve HIV/HCV/STI screening rates (including systems redesign using EHR reminders, removing payment barriers, offering non-invasive screening methods, ensuring patient privacy/confidentiality), and ways to overcome patients’ resistance to screening.
- Offer trainings on: Counseling & Testing, Emerging Issues in HCV Treatment, Substance Use and HIV/HCV, Managing a new HCV Diagnosis, and provider-perceived barriers to HIV/HCV/STI prevention, tailored to the unique I/T/U clinical context.
- Offer trainings using a variety of methods, including conferences, on-site trainings, self-directed studies, and live webinars.
- Support referral networks and under-utilized tele-health options for HIV/HCV.

It is our hope that this report will help guide the design and selection of future trainings provided by the NW AETC to I/T/U clinicians in Alaska and the Pacific Northwest.

Introduction

Over 300,000 American Indians and Alaska Natives (AI/AN) receive health services at Indian Health Service (IHS), Tribal, and Urban Indian (I/T/U) clinics located in Alaska, Idaho, Montana, Oregon and Washington. The Portland Area IHS provides access to health care for an estimated 150,000 AI/AN residents of Oregon, Washington, and Idaho. The Billings Area IHS provides access to care for over 70,000 AI/AN. And the Alaska Native Tribal Health Consortium (ANTHC) provides healthcare for an estimated 143,078 AI/AN.

The Portland Area Indian Health Service operates 6 federal clinics, and there are an additional 24 compacted tribal clinics in Idaho, Oregon and Washington. The Billings Area IHS operates 6 federal clinics, 2 tribal health departments, and 5 urban health facilities. In Alaska, there are 44 tribal health centers, 160 tribal community health aide clinics, five residential substance abuse treatment centers, and a tertiary hospital located in Anchorage.

Recent surveillance reports indicate that AI/ANs in the region experience elevated rates of HIV/AIDS and Sexually Transmitted Infections (STIs), and that HIV/AIDS, chlamydia, gonorrhea and Hepatitis C continue to disproportionately effect AI/AN in Alaska, Idaho, Montana, Oregon and Washington (Appendix A).

Given these trends, it is critical that clinicians in I/T/U settings utilize available policies and practices to maximize the identification and treatment of new HIV/HCV/STI cases, feel confident carrying out CDC and USPSTF recommendations, and establish well-functioning referral networks to ensure AI/AN patients receive the best possible follow-up and care.

By better understanding the screening and treatment practices currently used in I/T/U settings, barriers that hinder optimal prevention and care, and the HIV/HCV/STI training priorities and preferences of I/T/U providers, the *Northwest AIDS Education and Training Center* can better align its services to the capacity and needs of AI/AN communities in the region.

Needs Assessment Results

The needs assessment included 6 topical domains:

- Provider Demographics
- HIV/AIDS Screening and Treatment
- Hepatitis C Screening and Treatment
- STI Screening and Treatment
- Prevention and Training needs
- 2015 HIV/HCV/STI Update

Provider Demographics

The survey was completed by 60 staff at IHS, Tribal, and Urban Indian (I/T/U) healthcare facilities, by at least 5 personnel in Alaska, 3 in Idaho, 18 in Montana, 14 in Oregon, and 13 in Washington (n=53). The vast majority of respondents were physicians (35%, n=18), followed by clinic administrators (19%, n=10). Another 19% were nurses, nurse practitioners, or public health nurses (n=10). Nearly 40% of respondents had worked at their facility between 1 and 5 years. Twenty-five percent had been at their facility 6-10 years, and almost 20% had worked at their facility for 11 or more years.

HIV/AIDS Screening and Treatment

Over 77% of respondents reported that they were familiar with the current recommendations for HIV screening in healthcare settings (n=45). Five respondents were not familiar with the recommendations, and 8 were only somewhat familiar.

Nearly 88% of respondents indicated that their practice setting provides HIV screening (n=51). 25% of respondents believed that 1-25% of their patients 13-64 years old had been screened for HIV to date (n=11). Nine percent reported that 26-50% of their eligible patients had been screened (n=4), 9% reported 51-75% (n=4), and 9% reported 76-100% of their eligible patients had been screened (n=4). Nearly half (48%) of respondents did not know.

Nearly 48% of respondents indicated that their practice setting uses an electronic health record reminder system to prompt orders for HIV testing (n=21); 43% of the clinics did not (n=19). Nearly 70% of respondents felt that HIV screening rates should be increased in their facility (n=38); almost one-quarter did not believe it was necessary (n=13).

Most respondents felt “somewhat prepared” (40%, n=20) or “not prepared” (29%, n=14) to treat a patient for HIV/AIDS. Only 12% felt “extremely prepared” or “very prepared” (n=6). Most respondents believed they had treated a patient who had HIV (61%, n=35). Over 17% were not sure (n=10), and 21% thought they had “probably” or “definitely” not treated a patient with HIV (n=12).

Nearly 75% of practitioners reported that they see 1-5 patients with HIV on average per year. One practitioner reported seeing 6-10 patients, and one reported seeing 16-20 patients. Nearly 20% were not sure (n=7). Less than half of the responding practitioners (49%) had ever personally treated a person for HIV/AIDS (n=17); 51% had not (n=18). Of those who had treated a patient for HIV, over 72% reported that they treated 1-5 patients with HIV on average per year (n=13) and nearly 28% were not sure (n=5).

Most I/T/U practitioners (44%) reported that they “provide primary care to patients with HIV/AIDS, but refer to an HIV expert for all HIV-related health issues” (n=8). And nearly 39% reported that they “co-manage patients with HIV/AIDS with an HIV care expert” (n=7). None reported providing “all HIV/AIDS care throughout the course of the disease” (n=0). About 1/3 of providers reported having HIV+ patients who were also dealing with substance abuse, mental health conditions, homelessness, or were uninsured or underinsured.

Relatively few I/T/U providers felt that HIV/AIDS was an “extremely serious” or “very serious” issue for their community (17%, n=9). Most reported it was a “somewhat serious” issue (42%, n=23), and 29% felt that HIV/AIDS was not a serious issue for their community.

When asked what the most significant barrier to providing HIV prevention, screening or treatment in their professional settings there was a wide array of answers, from prevention (7), social norms (5), patient (5), clinical practice (12), training (3) and cost (3). A breakdown of their answers is included in Figure 1.

Figure 1. Barriers to providing HIV prevention, screening or treatment

	Count
Prevention	8
<ul style="list-style-type: none"> • Lack of education/understanding (n=2) • Lack of condom use (n=2); The government issue condoms are lousy; buying them is expensive and embarrassing. • Intoxicated sexual relations results in increased risk of HIV transmission. • Widespread IV drug use also puts users at a high risk. • Inconsistent school-based sex education is a barrier. I would love to see sexual health beginning in 7th grade. 	
Social Norms	5
<ul style="list-style-type: none"> • Stigma associated with HIV • Lack of community support • Community resistance to discussing sexually-related topics. • The perception that there are many more pressing issues that must be addressed. • Belief that no one has it because it is rare. However, especially with the return of heroin as a substance of abuse, it will be greater in our community in the future. 	
Patients	6
<ul style="list-style-type: none"> • Getting at-risk patients to the clinic • Many patients decline recommended screening (n=2); Most offers for screening are declined, even when offered with other STD screening, prior to contraceptive rx. • Patient not wanting it in the medical record • Reluctance of patients to be tested here in a small community due to privacy issues. 	
Clinical Practice	12
<ul style="list-style-type: none"> • Time and productivity • Universal precautions (n=2) • Remembering to see if HIV screening is done (n=2) • Getting the screening at time of visit • Following the "Treatment Plan" • Overscreening is an issue, consumes valuable resources. • Treatment is well-established elsewhere, so we refer patients there • No visible indication to screen (I don't see patients with HIV, if I do screen it is always negative, I don't hear about HIV in the community); I screen pregnant women and high risk individuals (IV drug users, multiple sex partners, sex with people they did not know) • We continually have new doctors rotating through our clinic. Some are better at preventive health than others. • Work is itinerant, dependent upon resources / facilities available in remote communities 	
Training	2
<ul style="list-style-type: none"> • Need better training • Lack of education re: standards 	
Cost	3
<ul style="list-style-type: none"> • Payment for HIV screening for Direct Care patients as HIV testing is not performed within our clinic but is instead sent out. • Lack of money • Cost of testing to uninsured populations 	
Other	1
<ul style="list-style-type: none"> • Not sure 	
No Barriers	3

Hepatitis C Screening and Treatment

Over 66% of respondents reported that they were familiar with the current recommendations for Hepatitis C screening in healthcare settings (n=36). Nine respondents were not familiar with the recommendations, and 9 were somewhat familiar. 80% of respondents indicated that their practice setting provides HCV screening (n=44).

Nearly 21% of respondents believed that 1-25% of their patients born between 1945 and 1965 had been screened for Hepatitis C (HCV) to date (n=8). Over 15% indicated that 26-50% of their eligible patients had been screened (n=6), 11% reported 51-75% (n=4), and 3% reported that 76-100% of their eligible patients had been screened for HCV (n=1). Half (50%) of respondents did not know. Nearly 42% of respondents indicated that their practice setting uses an electronic health record reminder system to prompt orders for HCV testing (n=16); 47% do not (n=18). Nearly 70% of respondents felt that HCV screening should be increased in their facility (n=38); 20% did not believe it was necessary (n=11).

Most respondents felt “somewhat prepared” (26%, n=14) or “not prepared” (32%, n=17) to treat a patient for HCV. Only 16% felt “extremely prepared” or “very prepared” (n=9). Most I/T/U providers had treated a patient who had HCV (62%, n=34). Nearly 13% were not sure (n=7), and 25% thought they had “probably” or “definitely” not treated a patient with HCV (n=14).

Nearly half of the practitioners reported that they see 1-10 patients with HCV on average per year (50%, n=15). Two practitioners reported seeing 11-15 patients, and two reported seeing 16-20 patients per year. 23% reported seeing more than 20 patients per year with HCV (n=7). Over 13% were not sure (n=4).

Among those who reported having seen patients with HCV (n=34), over 75% reported never having treated any patients for their Hep C infection (n=26). Of those who had treated a patient for Hepatitis C (n=8), most reported that they treat 1-5 patients with HCV on average per year (n=7, 88%). Only one practitioner wasn't sure how many patients they treat for HCV per year (12%).

Most I/T/U practitioners reported that they “Provide primary care to patients with HCV, but refer to an HCV expert for all HCV-related health issues” (n=3), or that they “Co-manage patients with HCV with an HCV care expert” (n=3). One reported “Provide[ing] all HIV/AIDS care throughout the course of the disease,” and one reported “Refer[ing] patients with HCV to a specialist when they fail treatment.”

Nearly 80% of providers reported having HCV+ patients who were also dealing with substance abuse, mental health conditions, homelessness, or were uninsured/underinsured.

Few I/T/U providers felt that Hepatitis C was an “extremely serious” issue for their community (8%, n=4). Most reported that it was a “very serious” or “somewhat serious” issue (34% and 40% respectively). Three providers felt that HCV was not a serious issue for their community (6%).

When asked what the most significant barrier to providing HCV prevention, screening or treatment in their professional settings there was a wide array of answers, from prevention (5), social norms (8), clinical practice (9), training (5), and cost (8). A breakdown of answers can be seen in Figure 2.

Figure 2. Barriers to providing HCV prevention, screening or treatment

	Count
Prevention	5
<ul style="list-style-type: none"> • Lack of condom use • Many patients and their partners do not like condoms • People not getting screened and spreading the communicable disease • Lack of education/understanding • Lack of interest in the issue by policy makers, and the community 	
Social Norms	8
<ul style="list-style-type: none"> • Need more awareness brought to the attention of the community • Alcohol and drugs • Community support • Getting patients to access the clinic • Itinerant, dependent upon resources and facilities available in remote communities • Stigma attached to hepatitis C • Getting those at risk into the clinic • Getting patients to have their blood drawn 	
Clinical Practice	9
<ul style="list-style-type: none"> • Wearing gloves • Universal precautions • Remembering to do the screening • Not screening adequately • Rotating providers. • Not adequately staffed to provide care, • Difficulty obtaining Hepatitis C screening test for Direct Care patients as this is not yet performed within out clinic, but is instead sent out (soon to be implemented in-house within a couple of months). • It appears we have a fairly high percentage and should be doing better at screening and helping to identify risk factors. Most pt are unaware that they are at risk • Treatment is often delayed or contraindicated due to comorbid disease states 	
Training	5
<ul style="list-style-type: none"> • We need supplies and more training. • Need further education in treatment (n=3) • Lack of education re: standards 	
Cost	8
<ul style="list-style-type: none"> • All medications must be requested from Drug companies as there are no federal funds available. • Cost of treatment (n=5) • Meds have to be paid for by outside funding. • Lack of coverage for evaluation and treatment of HCV. • The cost for uninsured patients of obtaining entry labs to see a hepatologist regionally- getting viral loads for example 	
Other	3
<ul style="list-style-type: none"> • Our disbelief that everyone should be screened in the first place..... CDC is baseline data gathering by their mandate. I won't play along 	
No Barriers	0

STI Screening and Treatment

Over 83% of respondents reported that they were familiar with the current recommendations for chlamydia screening in healthcare settings (n=46). Six respondents were not familiar with the recommendations, and 3 were somewhat familiar.

Over 92% of I/T/U respondents reported that their practice setting provides chlamydia screening (n=51).

Nearly 14% of respondents believed that 1-25% of their sexually active female patients under 25 had been screened to date (n=6), 16% indicated that 26-50% of their eligible patients had been screened (n=7), 11% reported 51-75% (n=5), and nearly 21% reported that 76-100% of their eligible patients had been screened for chlamydia (n=16). Almost 40% of respondents did not know.

44% of respondents indicated that their practice setting uses an electronic health record reminder system to prompt orders for chlamydia testing (n=19); 44% do not (n=19).

Nearly 40% of respondents always offered EPT to STI+ patients (n=17), 27% of respondents usually offered (n=12), 9% occasionally offered EPT (n=4). Only 2% never offered EPT and 21% of respondents did not know (n=9).

Only 16% of respondents always screened STI+ patients for HIV (n=7), 44% usually screened (n=19), 13% occasionally screened (n=6), 5% never screened STI+ patients for HIV. Almost 21% of respondents stated that screening did not fall into their scope of work (n=9).

When asked what the most significant barrier to providing STI prevention, screening or treatment in their professional settings there was a wide array of answers, from prevention (8), social norms (7), clinical practice (11), training (5), and cost (3). A breakdown of answers can be seen in Figure 3.

Figure 3. Barriers to providing STI prevention, screening or treatment

	Count
Prevention	8
<ul style="list-style-type: none"> • Lack of condom use • Many patients and their partners do not like condoms • Getting patients to access the clinic (n=3) • Patient adherence to treatment recommendations (n=2) • Getting partners in - getting follow up testing completed 	
Social Norms	7
<ul style="list-style-type: none"> • Stigma, community bias (n=2) • Lack of community support • Folks are willing to pee in a cup, but not willing to do blood testing • Screening acceptance decided by patient when offered • Patient compliance with recommended screening, likely due to patient concerns for being seen in tribal setting vs more anonymous setting (ie planned parenthood) 	
Clinical Practice	11
<ul style="list-style-type: none"> • Wearing gloves • Universal precautions • Remembering • Rotating providers who vary in their preventive health measures • Providers should be routinely screening all teens and young adults - not just symptomatic • I always recommend and order for subsequent HIV/RPR testing be done when +CT or + GC, but do not follow patient to lab, and sometimes they "forget" to go once ordered....or they may refuse to be tested. • Poor provider communication • People don't always present to the clinic every year (they are healthy and don't come in for annual health checks) so it is difficult to screen them if they are not presenting to the clinic • Variables for self swab vs. urines vs. pelvic exams for women to get testing done- nursing protocols inconsistent • Screening is good. Some people get care outside of facility for confidentiality reasons but then partner notification and treatment are more difficult. • Time 	
Training	5
<ul style="list-style-type: none"> • Trained knowledgeable staff to get into the community to do it • No training (n=2) • Finding contacts • Lack of understanding re: HIV test along with + ch 	
Cost	3
<ul style="list-style-type: none"> • Lack of resource or adequate facility in remote communities • Other than syphilis testing, we do not provide STI testing in-house, so most Direct Care patients do not receive this as these are send out tests that would cost them • Cost of testing for uninsured populations • Cost of treatment (n=2) • Cost of testing for uninsured populations 	
Other	1
<ul style="list-style-type: none"> • Stupidity 	
No Barriers	1

Prevention and Training Needs

Over 45% of respondents (n=24) regularly provide education about HIV, STI and HCV. Almost 40% of respondents (n=21) occasionally provide education about HIV, STI and HCV, and 15% (n=8) never provide education.

Almost 38% of respondents reported that “lack of community awareness” was the most significant barrier to STI/HIV/HCV prevention in their community (n=17). “Stigma” was reported by 18% of respondents (n=8).

When asked to select 5 topics that would best meet their educational needs, respondents selected: Counseling & Testing, Emerging Issues in HCV Treatment, Substance Use and HIV/HCV, and Managing patients with a new HCV diagnosis. A list of all responses can be seen in Figure 4.

When asked to rank their preferred training modalities, I/T/U providers in Alaska and the Pacific Northwest most frequently selected in-person conferences, on-site trainings, self-directed studies, and live webinars. Preceptorships and telemedicine were their least preferred training methods.

Figure 4. Preferred HIV/HCV training topics

	Count
Counseling & Testing	22
Emerging Issues in HCV Treatment	17
Substance Use and HIV/HCV	16
Managing Patients with a New Hep C Diagnosis	13
CDC Recommendations for Hepatitis C Testing	10
Maternal and Child health and HIV/HCV	10
Mental Health Disorders and HIV /HCV	10
Providing HCV Care in the Primary Care Setting	10
Risk (Harm) Reduction	10
Risk Assessment including Sexual History Taking	10
Emerging Issues in HIV Treatment	9
Historical Trauma and risk	9
HIV Prevention Update	9
Post-Exposure Prophylaxis including PrEP	9
Antiretroviral Therapies for treating HIV	8
CDC Recommendations for Routine HIV Testing	8
Managing Patients with a New HIV Diagnosis	8
Opportunistic Infections	7
Stigma and HIV/AIDS	7
HCV 101: An Introduction to HCV	6
Providing HIV Care in the Primary Care Setting	6
HIV & Other Sexually Transmitted Infections (STIs)	5
Psychosocial Implications of HIV and HCV	5
HIV 101: An Introduction to HIV/AIDS	4
Metabolic Complications in HIV	4
Primary HIV Infection	4
Oral Manifestations of HIV	3
TB and HIV/HCV	2
Adverse Effects of Antiretroviral Therapy	1
HIV Resistance Testing and Salvage Therapy	1
HIV/Hepatitis Co-Infection	1
Providing care in Correctional Settings	1
Other: HIV in pediatrics	1
Other: Ocular symptoms associated with STIs	1
Other: None	1
Other: Whatcom county/local information that is relevant to the scope of problem here	1
Other: How STI affects vision and the retina	1
Other: Guidance as insurance plans change to ensure coverage of medications and referrals for GI/HIV clinics	1

2015 HIV/HCV/STI Update

Among those who lived in Oregon or Washington, several additional questions were asked to identify training preferences associated with attending a 2015 *HIV/HCV/STI Clinical Update Training*.

Most expressed interest in workshops focusing on: cultural competency in addressing HIV/STI/Hepatitis in AI/AN populations, clinical updates of Hepatitis C, case management of HIV and Hepatitis C patients, clinical updates on HIV, clinical updates on STI and how to take sexual history.

Fewer expressed interest in sessions covering: local organizations that support HIV/STI/Hepatitis, local systems improvement for HIV/STI and Hepatitis screening and perspectives from positive patients. (Figure 5)

Figure 5. Preferred 2015 Training Topics

	Count
Cultural competency in addressing HIV/STI/Hepatitis in AI/AN populations	16
Clinical update on Hepatitis C (current recommendations, treatment and case studies)	15
Case management of HIV and Hepatitis C patients	14
Patient assistance programs for HIV and Hepatitis C	14
Clinical update on HIV (current recommendations, treatment and case studies)	12
Clinical update on STI (current recommendations, treatment and case studies)	12
How to take the best sexual history you can from a patient	11
Local organizations that support HIV/STI and Hepatitis (state, local, non-profit, NWAETC, NPAIHB)	7
Local systems improvement for HIV/STI and Hepatitis screening (Best Practices)	7
Perspectives from positive patients	5
Other (please specify)	0

Over 80% of respondents indicated that CMEs would be important for them to attend such a training. A total of 15 people, 57% of respondents, reported that travel scholarships would be important for them to attend a 2015 training.

Only 22% (n=6) of respondents answered that they would not be likely to participate in an Adobe Connect webinar, if they were not available to participate in an in-person training. The remainder, 44% (n=12) and 33% (n=9), reported that they would be “somewhat likely” or “very likely” to attend a virtual Adobe Connect webinar.

Survey Findings and Recommendations

HIV

- While most participants (77%) were aware of the HIV screening recommendations set forth by the Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force (USPSTF), only 18% of respondents believed that over 50% of their patient population had been screened according to the guidelines.
- 70% of respondents felt that HIV screening should be increased at their facility.
- Only 12% of clinicians felt “prepared” or “very prepared” to treat someone for HIV.
- Approximately 60% of the responding clinicians at I/T/U clinics in Alaska and the Pacific Northwest had ever treated a patient who had HIV; only half (50%) had ever treated a patient for their HIV infection (i.e. provided their HIV medications and/or managed complications from their disease or their medications).
- According to respondents, the most pronounced barriers to HIV prevention, screening, and treatment were due to issues related to clinical practice, lack of community-based prevention efforts, and patient reluctance to get screened.

Hepatitis C

- Two thirds of the survey’s respondents were familiar with the new Hepatitis C screening recommendations for people born between 1945 and 1965; the remaining were somewhat or not familiar with the CDC and USPSTF’s latest recommendations.
- 70% of respondents felt that Hepatitis C screening should be increased at their facility.
- Most clinicians felt “somewhat prepared” (26%) or “not prepared” (32%) to treat a patient for HCV. Only 16% felt “extremely prepared” or “very prepared.”
- Most clinicians (75%) had not treated a patient for their Hepatitis C infection.
- Few I/T/U providers felt that Hepatitis C was an “extremely serious” issue for their community (8%, n=4). Most reported that it was a “very serious” or “somewhat serious” issue (34% and 40% respectively).

Sexually Transmitted Infections

- Over 80% of respondents were familiar with the chlamydia screening recommendations for young women.
- Less than half of respondents use an EHR reminder to prompt screening for chlamydia.
- Only 40% of clinicians “always screened” STI+ patients for HIV.
- According to respondents, the most pronounced barriers to STI prevention, screening, and treatment were related to clinical practice, patient resistance to condom use, and patient reluctance to get screened.

Prevention and Training Needs

- Over 80% of respondents regularly or occasionally provide education about HIV, HCV and STI prevention strategies.
- Nearly 40% of respondents felt that insufficient “community awareness” was the most significant barrier to STI/HIV/HCV prevention in their community, followed by “stigma associated with sexual health,” reported by 18% of respondents.
- The most frequently selected training topics included: Counseling & Testing, Emerging Issues in HCV Treatment, Substance Use and HIV/HCV, and Managing patients with a new HCV diagnosis.
- When asked to rank their preferred training modalities, I/T/U providers selected in-person conferences, on-site trainings, self-directed studies, and live webinars.

NW AETC Recommendations

- Offer training and technical assistance on clinical strategies that have been shown to improve HIV/HCV/STI screening rates (including systems redesign using EHR reminders, removing payment barriers, offering non-invasive screening methods, ensuring patient privacy/confidentiality), and ways to overcome patients’ resistance to screening.
- Offer trainings on: Counseling & Testing, Emerging Issues in HCV Treatment, Substance Use and HIV/HCV, Managing a new HCV Diagnosis, and provider-perceived barriers to HIV/HCV/STI prevention, tailored to the unique I/T/U clinical context.
- Offer trainings using a variety of methods, including conferences, on-site trainings, self-directed studies, and live webinars.
- Support referral networks and under-utilized tele-health options for HIV/HCV.

2015 Prevention and Training Needs

Most respondents in Oregon and Washington expressed interested in a one- or two-day training on: cultural competency in addressing HIV/STI/Hepatitis in AI/AN populations, clinical updates on Hepatitis C, case management of HIV and Hepatitis C patients, clinical updates on HIV, clinical updates on STI, and how to take sexual history.

Per respondent feedback, a proposed 2015 Clinical Update Training would include CME credits, with a pre- half-day session on cultural competency, followed by a full-day training on:

- Clinical Update on Hepatitis C (1.5 hours),
- Case management of HIV and Hepatitis C patients (2 hour hands-on),
- Patient assistance program navigation (45 min),
- Clinical Update on HIV (1.5 hours)
- Clinical Update on STI (1.5 hours)

Ten to fifteen travel scholarships would be needed to maximize in-person participation. And having the option call-in for topics of interested would likely increase participation, for those unable to travel.

Appendix A: HIV/HCV/STI Surveillance

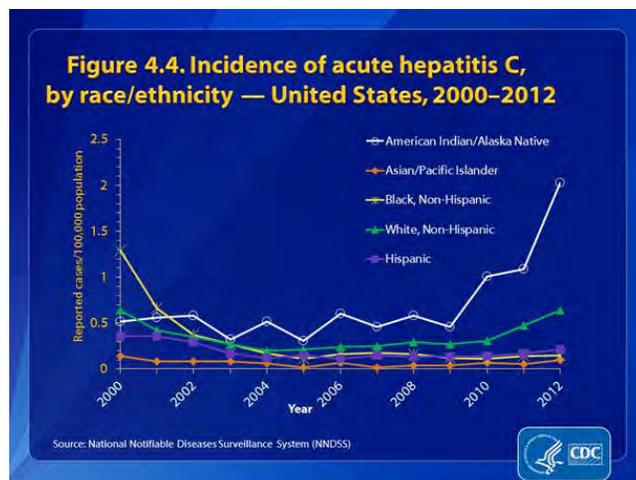
Figure 1. HIV diagnoses | American Indian/Alaska Native | Both sexes | 2012 | Adults and adolescents | All transmission categories | By State¹

Area	Population	Cases	Rate
United States	1,852,842	228	12.3
Alaska	80,277	6	7.7
Idaho	14,485	0	0.0
Montana	45,538	2	4.5
Oregon	36,355	2	5.7
Washington	74,005	6	8.3

Figure 2. Chlamydia | American Indian/Alaska Native | Both sexes | 2012 | All age groups | By State

Area	Population	Cases	Rate
United States	2,598,792	18,093	696.2
Alaska	116,457	2,556	2,194.8
Idaho	20,617	110	533.5
Montana	65,615	970	1,478.3
Oregon	53,572	242	451.7
Washington	107,317	581	541.4

According to CDC surveillance, from 2002–2010 the incidence rate of acute hepatitis C remained below 0.5 cases per 100,000 for all racial/ethnic populations except AI/AN people. Rates for AI/AN people have been historically higher than for other race/ethnicities, especially in recent surveillance.²



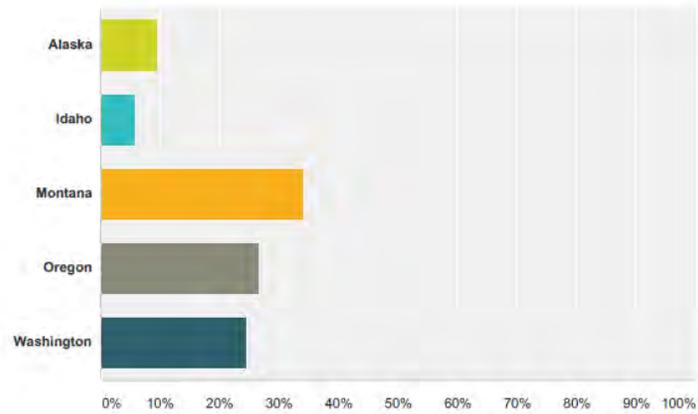
¹ CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas: <http://www.cdc.gov/nchhstp/Atlas/>

² Centers for Disease Control and Prevention. (2011) Incidence of acute, hepatitis C, by race/ethnicity — United States, 2000-2012. Retrieved December 1, 2014 from <http://www.cdc.gov/hepatitis/Statistics/2012Surveillance/Slide4.4.htm>

Appendix B: Survey Questions and Selected Responses

Provider Demographics

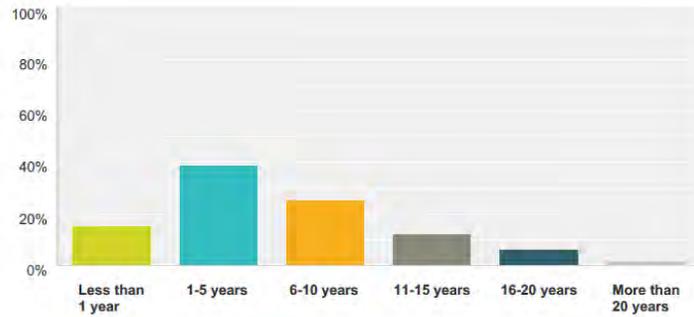
1. What state do you work in?



2. What is your primary occupation?

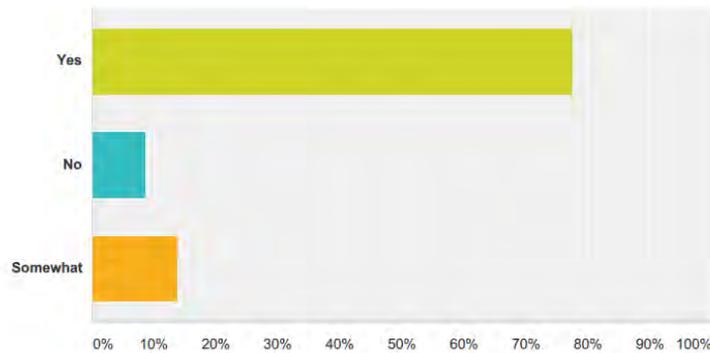
	Response Percent	Response Count
Physician	35%	18
Administrator, Clinic manager	19%	10
Health educator	8%	4
Nurse Practitioner	8%	4
Advanced Practice Nurse	6%	3
Dentist, Dental professional	4%	2
Optometrist	4%	2
Physician's Assistant	4%	2
Public Health Nurse	4%	2
Nurse	2%	1
Social Worker	2%	1
Case Manager		0
Chemical dependency/treatment professional		0
Counselor		0
Nutritionist		0
Pharmacist		0
Psychologist		0
Other: Tribal council member, Technical Assist. Provider, CBC	6%	3

3. How long have you worked at your current facility?

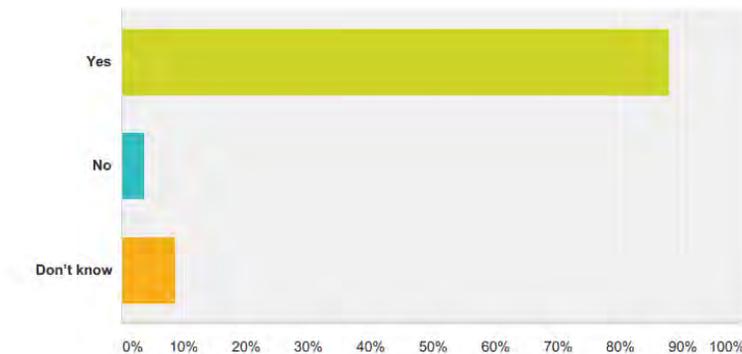


HIV/AIDS Screening and Treatment

4. Are you familiar with the current recommendations for HIV screening in healthcare settings, that every person be screened for HIV at least once between the ages of 13 and 64, issued by the Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force (USPSTF)?

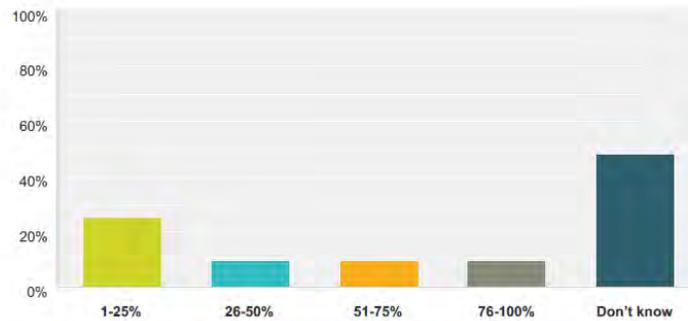


5. Does your practice setting provide HIV screening?



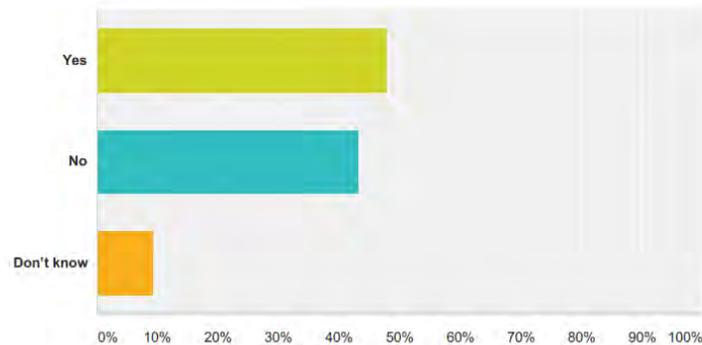
6. Among those who responded “yes” (n=51) to Question #5:

To date, what percentage of your patients between the ages of 13 and 64 have been screened for HIV?

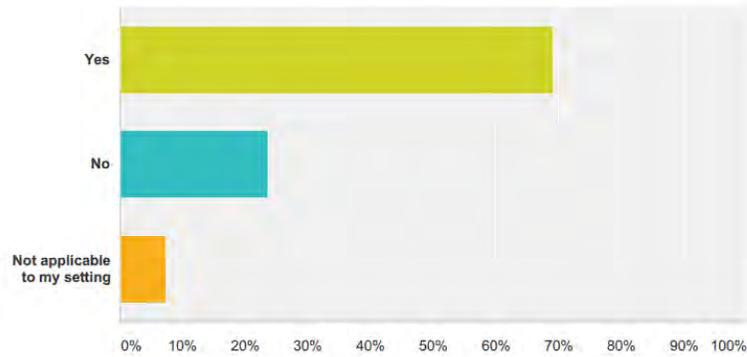


7. Among those who responded “yes” (n=51) to Question #5:

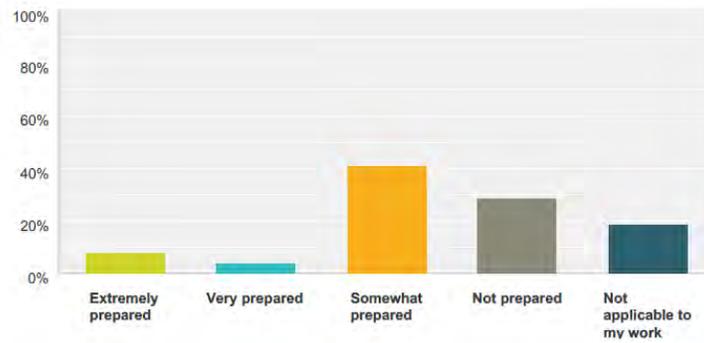
Does your practice setting use an electronic health record reminder system to prompt orders for HIV testing?



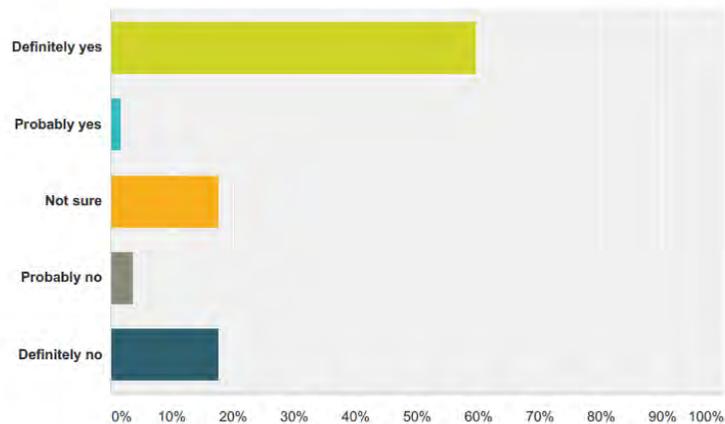
8. In your opinion, should HIV screening be increased in your facility?



9. How prepared do you feel to treat a person for HIV/AIDS? (i.e. provide their HIV medications and/or manage complications from their disease or their medications)

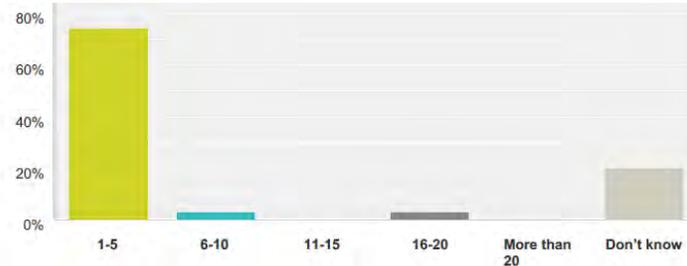


10. Have you ever personally treated a patient for *any* condition, who also had HIV/AIDS?



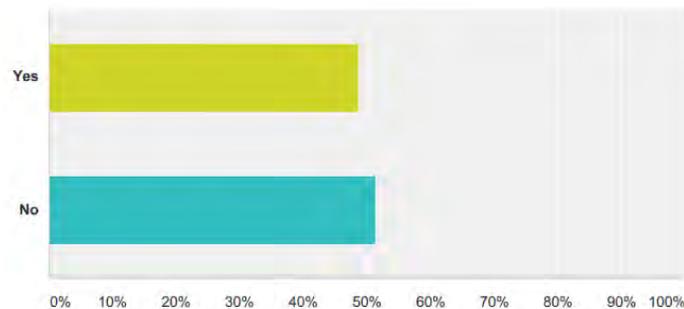
11. Among those who responded “Definitely yes” (n=34) or “Probably yes” (n=1) to Question #10:

On average, how many HIV+ patients do you treat for *any* condition, on an annual basis?



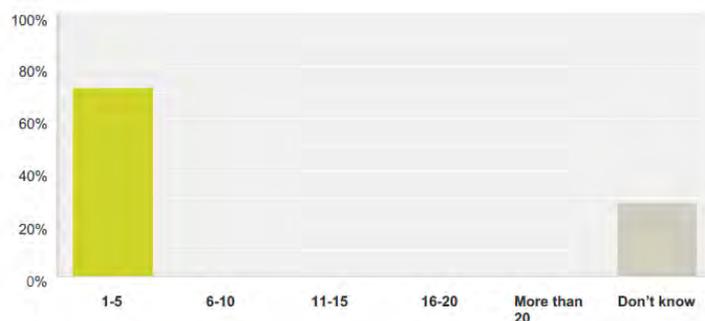
12. Among those who responded “Definitely yes” (n=34) or “Probably yes” (n=1) to Question #10:

Have you ever personally treated a person *for* HIV/AIDS (i.e. provided their HIV medications and/or managed complications from their disease or their medications)?



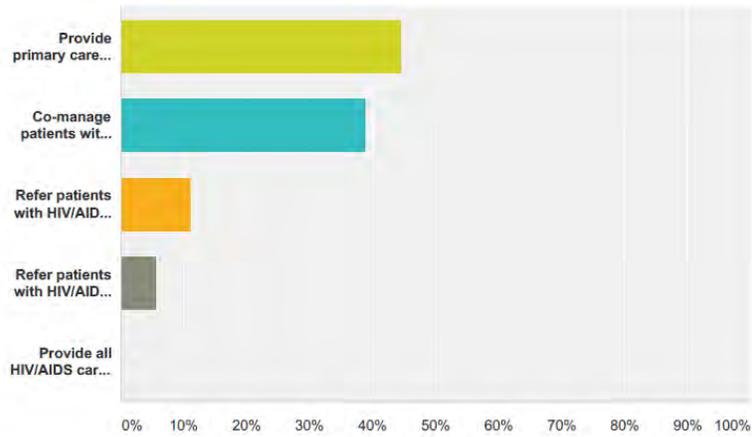
13. Among those who responded “Definitely yes” (n=34) or “Probably yes” (n=1) to Question #10:

On average, how many patients do you treat *for* HIV/AIDS on an annual basis?



14. Among those who responded “Definitely yes” (n=34) or “Probably yes” (n=1) to Question #10:

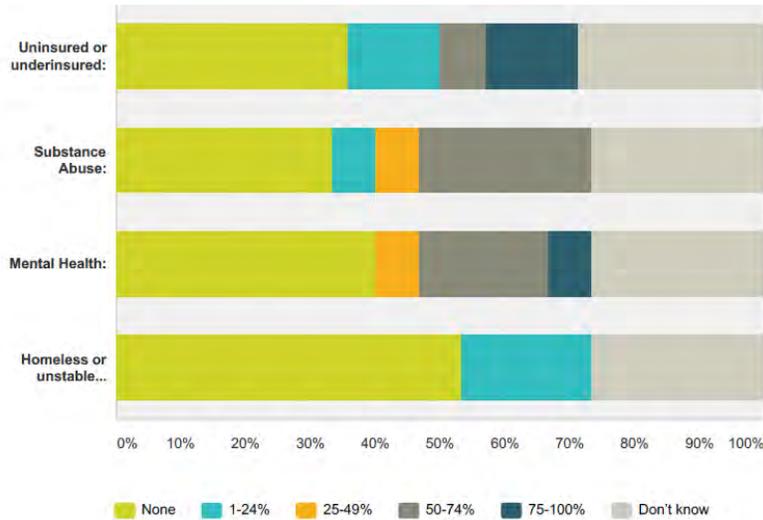
Please describe the way in which you most often provide HIV/AIDS care (select one):



Answer Choices	Responses
Provide primary care to patients with HIV/AIDS, but refer to an HIV expert for all HIV-related health issues	44.44% 8
Co-manage patients with HIV/AIDS with an HIV care expert	38.89% 7
Refer patients with HIV/AIDS when they need antiretroviral treatment (ART)	11.11% 2
Refer patients with HIV/AIDS to a specialist when they fail ART	5.56% 1
Provide all HIV/AIDS care throughout the course of the disease	0.00% 0
Total	18

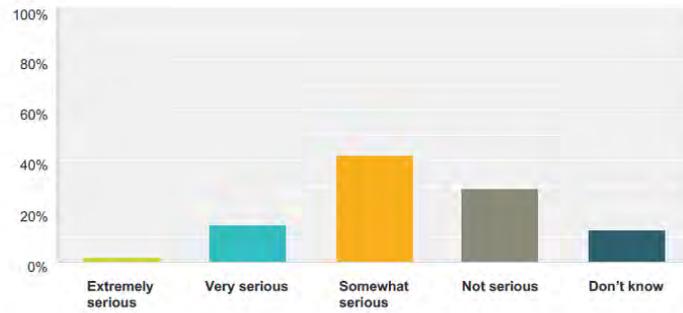
15. Among those who responded “Definitely yes” (n=34) or “Probably yes” (n=1) to Question #10:

For what percentage of your HIV+ patients/clients did you need to address the following issues in the past year:



	None	1-24%	25-49%	50-74%	75-100%	Don't know	Total
Uninsured or underinsured:	35.71% 5	14.29% 2	0.00% 0	7.14% 1	14.29% 2	28.57% 4	14
Substance Abuse:	33.33% 5	6.67% 1	6.67% 1	26.67% 4	0.00% 0	26.67% 4	15
Mental Health:	40.00% 6	0.00% 0	6.67% 1	20.00% 3	6.67% 1	26.67% 4	15
Homeless or unstable housing:	53.33% 8	20.00% 3	0.00% 0	0.00% 0	0.00% 0	26.67% 4	15

16. In your opinion, how serious a health issue is HIV/AIDS in your community?



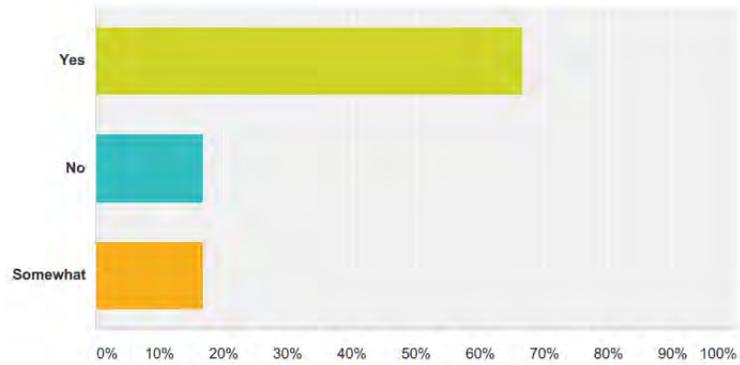
Answer Choices	Responses	
Extremely serious	1.82%	1
Very serious	14.55%	8
Somewhat serious	41.82%	23
Not serious	29.09%	16
Don't know	12.73%	7
Total		55

17. What is your most significant barrier to providing HIV prevention, screening or treatment in your professional setting?

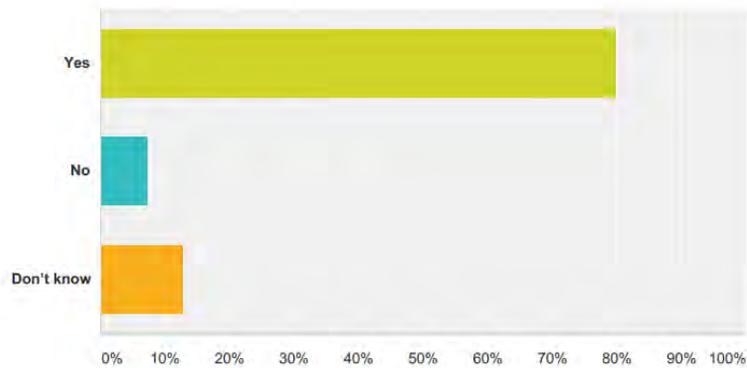
See page 7.

Hepatitis C Screening and Treatment

18. Are you familiar with the current recommendations for Hepatitis C screening, that every person born between 1945 and 1965 be screened for Hepatitis C, issued by the Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force (USPSTF)?

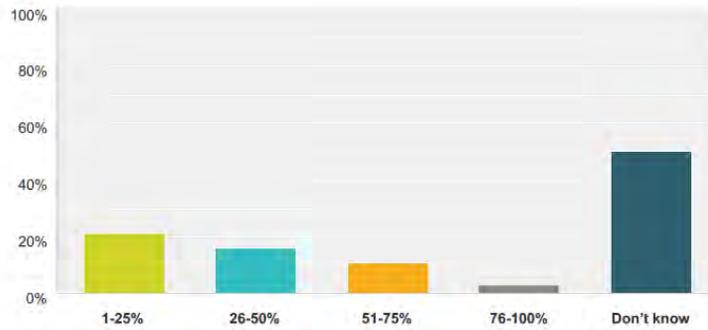


19. Does your practice setting provide Hepatitis C (HCV) screening?



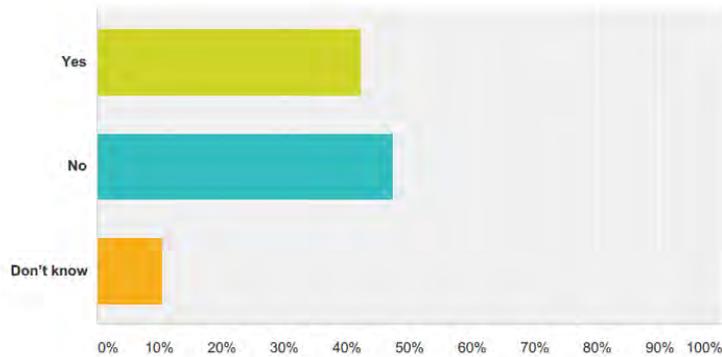
20. Among those who responded “yes” (n=44) to Question #19:

To date, what percentage of your patients born between 1945 and 1965 have been screened for Hepatitis C (HCV)?

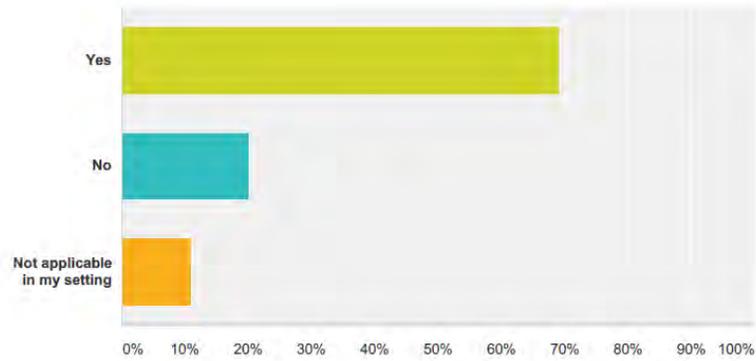


21. Among those who responded “yes” (n=44) to Question #19:

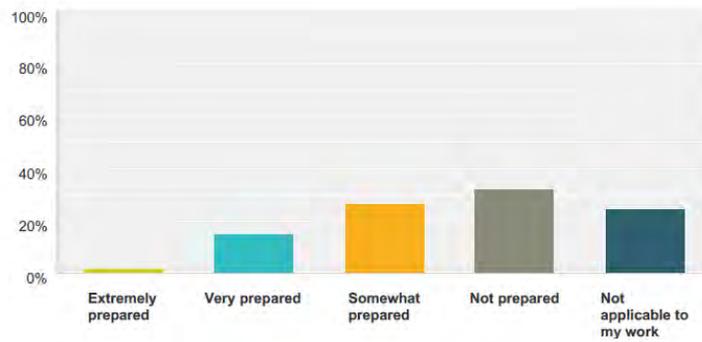
Does your practice setting use an electronic health record reminder system to prompt orders for Hepatitis C (HCV) testing?



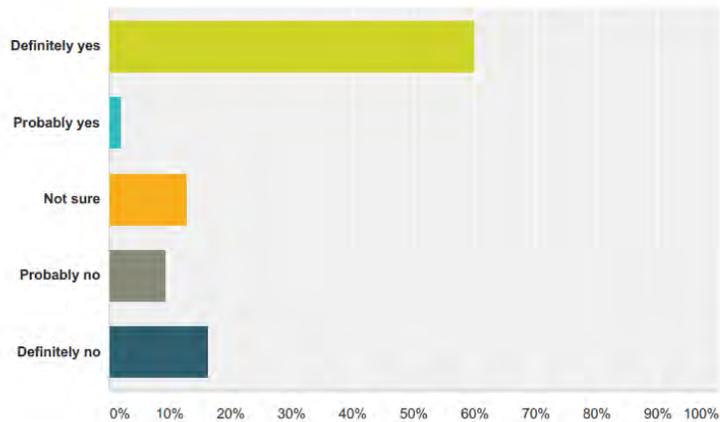
22. In your opinion, should Hepatitis C (HCV) screening be increased in your facility?



23. How prepared do you feel to treat a person for HCV? (i.e. provide medications to treat their HCV infection)

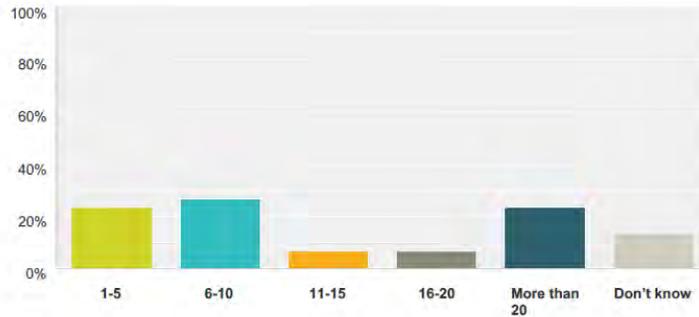


24. Have you ever personally treated a patient for *any* condition, who also had Hepatitis C (HCV)?



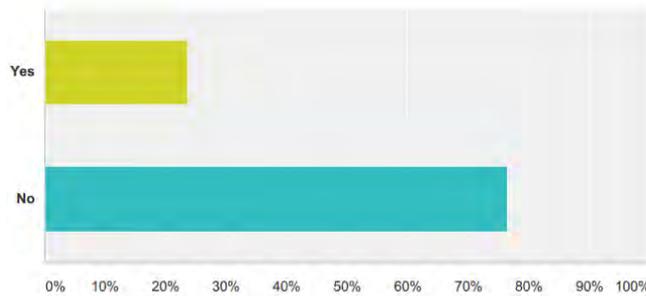
25. Among those who responded “Definitely yes” (n=33) or “Probably yes” (n=1) to Question #24:

On average, how many HCV+ patients do you treat for *any* condition on an annual basis?



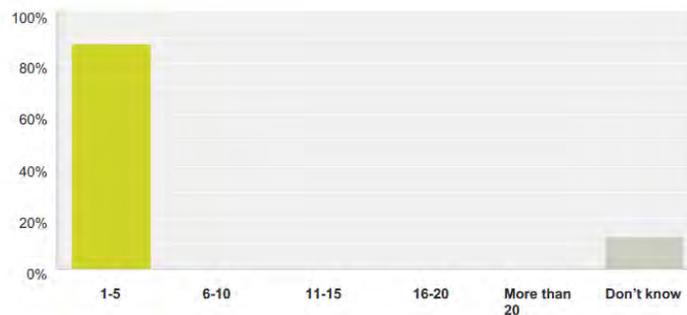
26. Among those who responded “Definitely yes” (n=33) or “Probably yes” (n=1) to Question #24:

Have you ever personally treated a person *for* Hepatitis C (HCV) (i.e. provided medications to treat their HCV infection)?



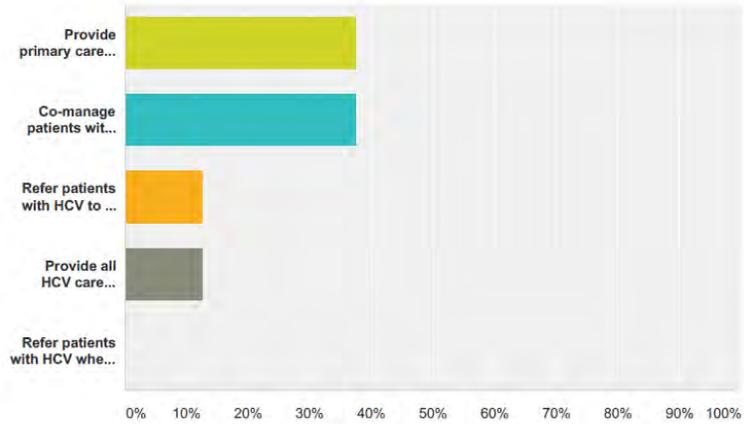
27. Among those who responded “yes” (n=8) to Question #26:

On average, how many patients do you treat *for* Hepatitis C (HCV) on an annual basis?



28. Among those who responded “yes” (n=8) to Question #26:

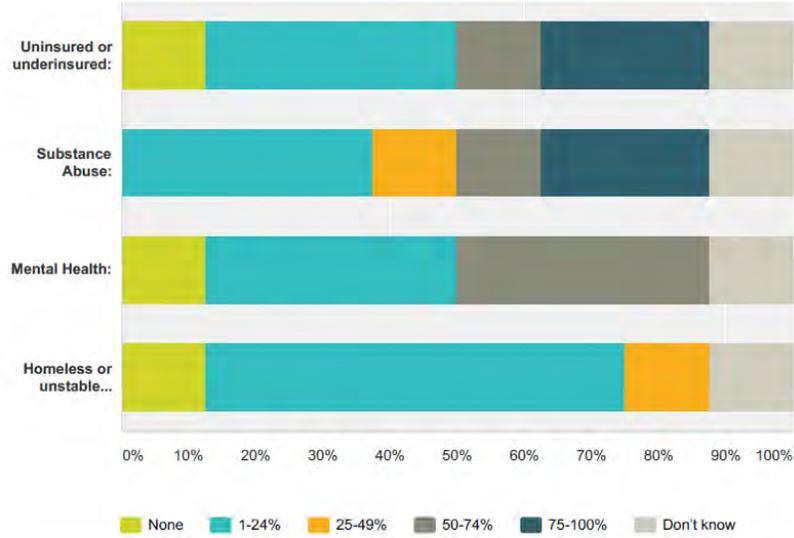
Please describe the way in which you most often provide HCV care (select one):



Answer Choices	Responses
Provide primary care to patients with HCV, but refer to an HCV expert for HCV-related health issues	37.50% 3
Co-manage patients with HCV with an HCV care expert	37.50% 3
Refer patients with HCV to a specialist when they fail treatment	12.50% 1
Provide all HCV care throughout the course of the disease	12.50% 1
Refer patients with HCV when they need treatment	0.00% 0
Total	8

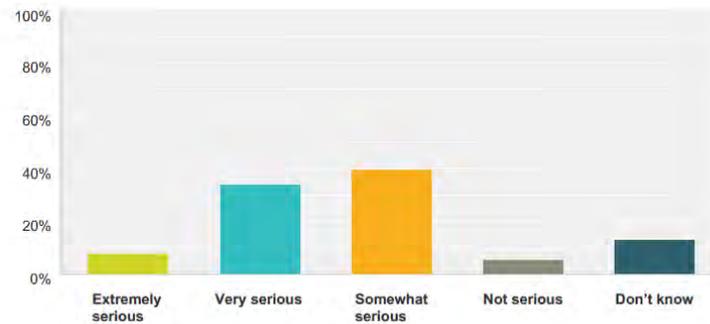
29. Among those who responded “yes” (n=8) to Question #26:

For what percentage of your HCV+ patients/clients did you need to address the following issues in the past year:



	None	1-24%	25-49%	50-74%	75-100%	Don't know	Total
Uninsured or underinsured:	12.50% 1	37.50% 3	0.00% 0	12.50% 1	25.00% 2	12.50% 1	8
Substance Abuse:	0.00% 0	37.50% 3	12.50% 1	12.50% 1	25.00% 2	12.50% 1	8
Mental Health:	12.50% 1	37.50% 3	0.00% 0	37.50% 3	0.00% 0	12.50% 1	8
Homeless or unstable housing:	12.50% 1	62.50% 5	12.50% 1	0.00% 0	0.00% 0	12.50% 1	8

30. In your opinion, how serious a health issue is Hepatitis C (HCV) in your community?

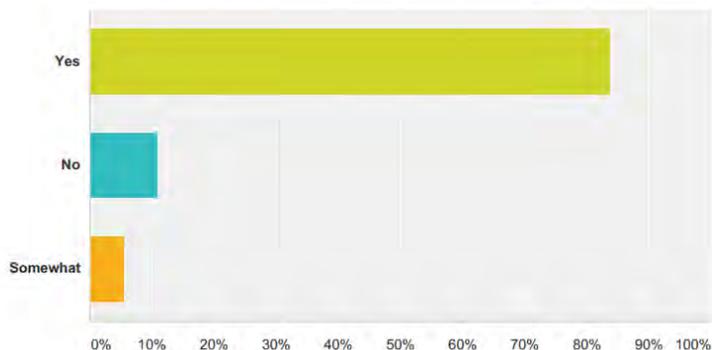


31. What is your most significant barrier to providing HCV prevention, screening or treatment in your professional setting?

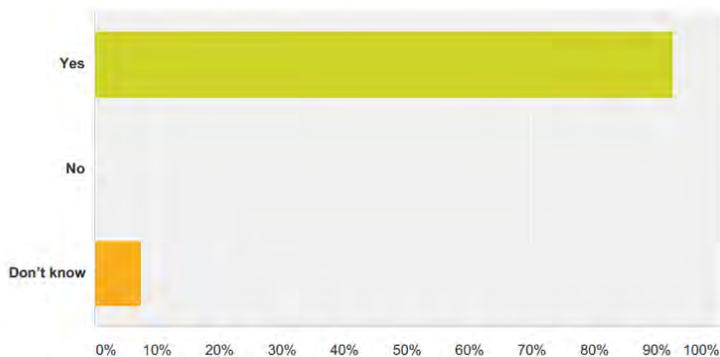
See page 10.

STI Screening and Treatment

32. Are you familiar with the current recommendations for chlamydia screening, that every sexually active female 25 years of age and under be screened annually for chlamydia, issued by the Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force (USPSTF)?

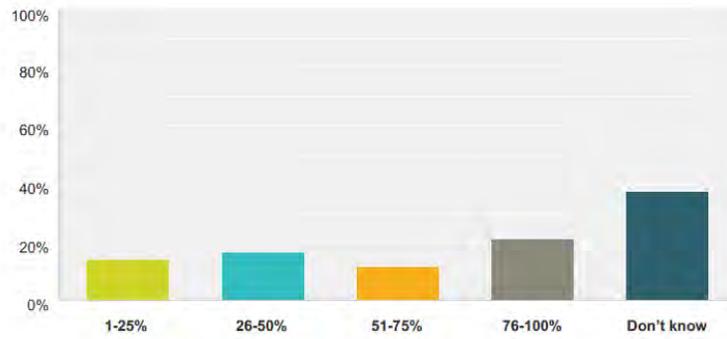


33. Does your practice setting provide screening for sexually transmitted infections (STI), including chlamydia screening?



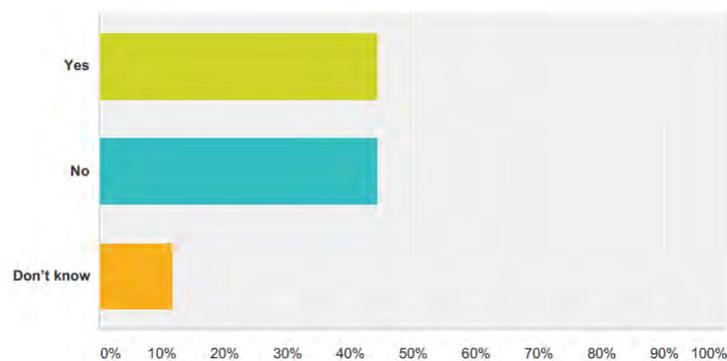
34. Among those who responded “yes” (n=51) to Question #33:

In the past year, what percentage of your sexually active female patients 25 years old and under was screened for chlamydia?



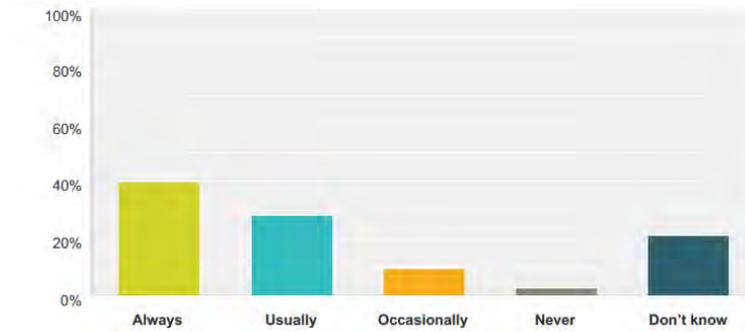
35. Among those who responded “yes” (n=51) to Question #33:

Does your practice setting use an electronic health record reminder system to prompt orders for sexually transmitted infection (STI) tests?



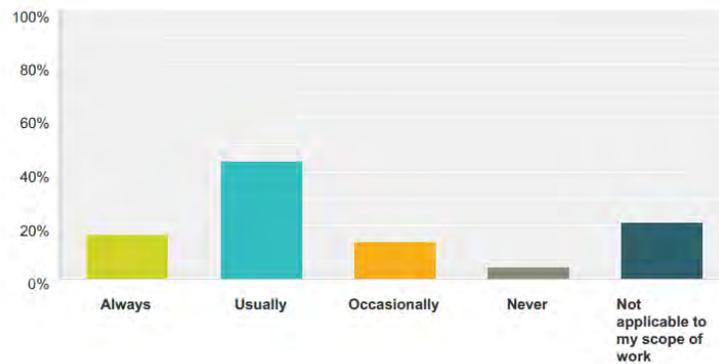
36. Among those who responded “yes” (n=51) to Question #33:

How often does your practice setting offer expedited partner therapy to treat the partners of someone who is STI+?



37. Among those who responded “yes” (n=51) to Question #33:

How often do you test STI+ patients for HIV?

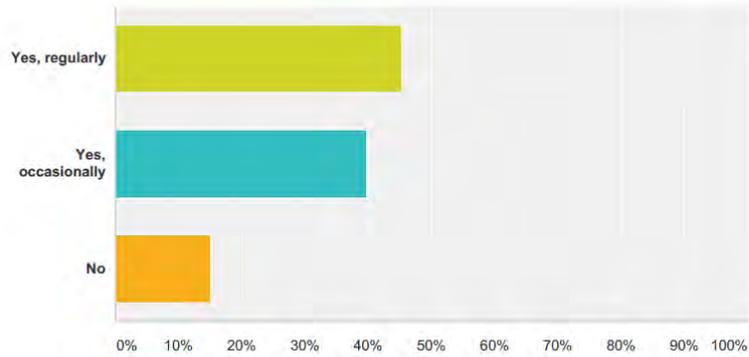


38. What is your most significant barrier to providing STI prevention, screening or treatment in your professional setting?

See page 12.

Prevention and Training Needs

39. Do you provide education about HIV, sexually transmitted infections, or Hepatitis C (HIV/STI/HCV) prevention strategies or risk reduction strategies to patients or community members?

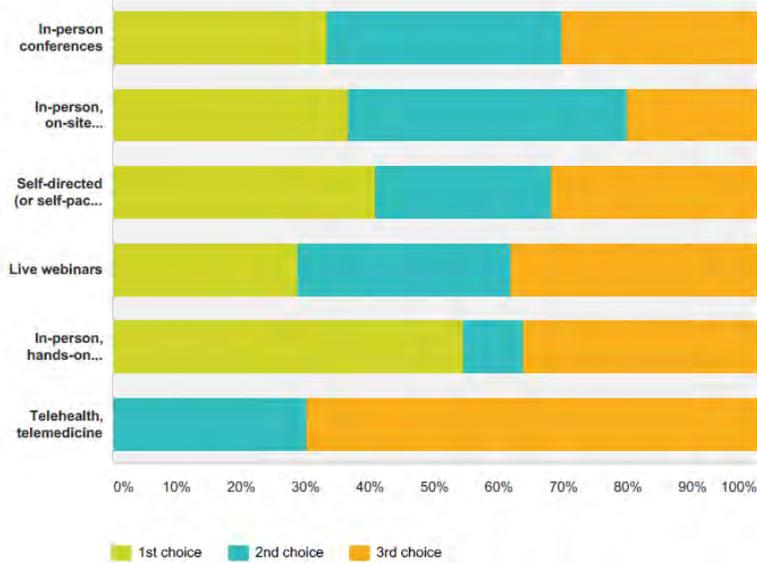


40. In your opinion, what is the most important barrier or gap in the prevention of HIV, HCV, and STIs in your community?

Answer Choices	Responses
Lack of community awareness	37.78% 17
Stigma associated with sexual health	17.78% 8
Insufficient clinical services	11.11% 5
Lack of prevention infrastructure: funding, staffing, capacity, time	11.11% 5
Insufficient staff training	8.89% 4
Lack of culturally appropriate interventions	8.89% 4
Insufficient partner services: contact tracing, expedited partner therapy, etc.	4.44% 2
Stigma associated with LGBT or Two Spirit identity/health	0.00% 0
Total	45

41. Please select 5 of the following topics that would best meet your educational needs around HIV/HCV:

42. Which of the following training modalities would you prefer most? (rank your top 3)



	1st choice	2nd choice	3rd choice	Total
In-person conferences	33.33% 11	36.36% 12	30.30% 10	33
In-person, on-site trainings with clinic staff	36.67% 11	43.33% 13	20.00% 6	30
Self-directed (or self-paced) study (e.g., via web sites, written materials)	40.91% 9	27.27% 6	31.82% 7	22
Live webinars	28.57% 6	33.33% 7	38.10% 8	21
In-person, hands-on clinical observation (preceptorship)	54.55% 6	9.09% 1	36.36% 4	11
Telehealth, telemedicine	0.00% 0	30.00% 3	70.00% 7	10

2015 HIV/HCV/STI Update

1. Which sessions you are most interested in attending (mark all that apply):

	Count
Cultural competency in addressing HIV/STI/Hepatitis in AI/AN populations	16
Clinical update on Hepatitis C (current recommendations, treatment and case studies)	15
Case management of HIV and Hepatitis C patients	14
Patient assistance programs for HIV and Hepatitis C	14
Clinical update on HIV (current recommendations, treatment and case studies)	12
Clinical update on STI (current recommendations, treatment and case studies)	12
How to take the best sexual history you can from a patient	11
Local organizations that support HIV/STI and Hepatitis (state, local, non-profit, NWAETC, NPAIHB)	7
Local systems improvement for HIV/STI and Hepatitis screening (Best Practices)	7
Perspectives from positive patients	5
Other (please specify)	0

2. If the availability of continuing education credits would be important for you to attend such a training, please specify which you would need:

Answer Choices	Responses	
CME	81.48%	22
Not important for me to attend	18.52%	5
CEU	3.70%	1
Social Work	3.70%	1
Pharm	3.70%	1
CNE	0.00%	0
Other (please specify)	0.00%	0
Total Respondents: 27		

3. Would the availability of travel scholarships be important for you to attend such a training?

Answer Choices	Responses	
Yes	57.69%	15
No	11.54%	3
No, I am employed by IHS and am unable to accept travel scholarships	30.77%	8
Total		26

4. How likely would you participate via an Adobe Connect webinar, if you were not available to participate in person?

Answer Choices	Responses	
Very likely	33.33%	9
Somewhat likely	44.44%	12
Not likely	22.22%	6
Total		27