The Role of Health Education Specialists in Conducting Rapid HIV Testing

Abstract:

There are over one million people living with HIV in the United States; an estimated 20% are unaware of their status. More innovative testing strategies are needed, as evidence suggests persons most at risk for HIV, or who may present with early infections, are not being reached. Expanding the role of health education specialists can make HIV testing routine and more accessible, and help achieve the national goals of decreasing HIV infection and increasing knowledge of HIV status. This paper focuses on the role of Certified Health Education Specialists (CHES)/Master CHES as being professionally prepared to conduct HIV testing.

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Abstract

There are over one million people living with HIV in the United States; an estimated 20% are unaware of their status. More innovative testing strategies are needed, as evidence suggests persons most at risk for HIV, or who may present with early infections, are not being reached. Expanding the role of health education specialists can make HIV testing routine and more accessible, and help achieve the national goals of decreasing HIV infection and increasing knowledge of HIV status. This paper focuses on the role of Certified Health Education Specialists (CHES)/Master CHES as being professionally prepared to conduct HIV testing.

Introduction

The Centers for Disease Control and Prevention (CDC) estimate that there are approximately 1.1 million people over the age of 13 who are living with Human Immunodeficiency Virus (HIV) in the United States (U.S.).1 In addition, an estimated 20% of HIV-positive individuals are unaware of their status1. Although the overall incidence of HIV has remained stable at approximately 50,000 annual infections since 2006, some risk populations remain disproportionately affected. 2 Men who have sex with men continue to bear the greatest burden of HIV infection, and African Americans continue to be disproportionately affected compared to other racial/ethnic groups.2 Ensuring the availability and access of HIV testing to these high-risk populations is key to controlling the epidemic. One possible solution to this public health problem is to increase the workforce who can conduct rapid HIV testing (RHT). In this paper, we focus on the role of health educators, specifically Certified Health Education Specialists (CHES)/Master CHES, as being professionally prepared to conduct RHT.

Overview of Rapid HIV testing

 There are five tests currently approved by the U.S. Food and Drug Administration for use in non-clinical settings.3 Most RHTs detect HIV antibodies and can be read in 10-20 minutes; they are designed to be screening tests that require venipuncture confirmation if reactive.4 However, a “reactive” test result does not always mean an individual is infected with HIV, as false positive results and reader errors do occur. For detailed information on each test, time to test result, indications for use, sensitivity and specificity, approved specimen types and volumes, and test kit shelf life, please visit <http://www.cdc.gov/hiv/pdf/testing_nonclinical_clia-waived-tests.pdf>

HIV Testing in the United States

According to the Kaiser Family Foundation’s 2011 *Survey of Americans on HIV/AIDS,* 54% of U.S. adults, aged 18–64, report ever having been tested for HIV, including 21% who report being tested in the last year.5 The proportion of the public saying they have ever been tested for HIV increased between 1997 and 2004, but has remained fairly steady since.5 In September 2006, the CDC issued *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings*, which promote HIV testing of all patients ages 13 to 64 in health care settings as part of their routine medical care.6 The U.S. Preventive Services Task Force’s (USPSTF) 2007 *Screening for HIV: Recommendation Statement* strongly recommends that clinicians screen all adolescents and adults at increased risk for HIV infection, and all pregnant women.7 Recommendations were not provided for or against routinely screening asymptomatic adults and adolescents with no identifiable risk factors for HIV. A shift toward a more systematic and routine HIV screening is supported by the Patient Protection and Affordable Care Act (PPACA) which supports the integration of HIV screening into primary care and mandates that HIV testing be available without cost or co-pay, with the intention that screening programs will be better funded and reimbursable.8 In order to meet these goals, the number and type of professionals able to conduct HIV testing will need to expand.

HIV Testing in Non-Clinical Settings

 Due to the high number of undiagnosed persons with HIV in the U.S., more innovative HIV testing strategies are needed. Evidence has demonstrated that persons most at risk for contracting HIV or who may present with early infections are not being reached by the clinical and non-clinical HIV testing approaches used to date. 9 Non-clinical health settings, where you commonly find a CHES/MCHES employed, are settings in which medical, diagnostic, and/or treatment services are not routinely provided. However, non-clinical HIV testing programs provide selected diagnostic services (HIV testing) and selected prevention services (risk-reduction interventions), and can facilitate access to other medical and social services for clients with positive or negative test results. Providing HIV testing services in non-clinical venues facilitates access for individuals who may not access these services through other health care providers, those who may be testing for the first time, or those at highest risk of acquiring HIV who would benefit from repeated testing. 10

National Commission for Health Education Credentialing Responsibilities and Competencies

The National Commission for Health Education Credentialing (NCHEC) is the agency in the U.S. that provides credentialing for Health Education Specialists. Their mission is to “enhance the professional practice of Health Education by promoting and sustaining a credentialed body of Health Education Specialists.”11 NCHEC provides two certifications which are CHES and MCHES. NCHEC designates seven areas of responsibility that identify the role of a health education specialist.11 Additionally, there are competencies and sub-competencies under each responsibility. Although there are no competencies specific to HIV, a number of competencies may be applied to HIV testing and counseling.

Conducting RHT is well-suited to the goals and competencies of the CHES/MCHES. Health Education Specialists are trained to identify high-risk populations and provide educational support and additional resources to improve health. By involving Health Education Specialists in the delivery of RHT services, support, and educational materials and resources can be provided to persons living with HIV who might otherwise not have received such services. Table 1 provides examples of how the various NCHEC Responsibilities can support the role of CHES/MCHES to conduct RHT.

For example, under the Area 1: Assess needs, assets and capacity for health education, a CHES/MCHES could develop and conduct a process and/or outcome evaluation of a RHT program. Additionally, under Area III: Implement health education, a CHES/MCHES can provide clients with test results and tailored, evidence-based post-test risk reduction counseling. Finally, under Area VI: Serve as a health education resource person, a CHES/MCHES will be able to locate or develop HIV prevention materials that are accurate, up-to-date and easy to understand for their clients.

Discussion

Health Education Specialists promote, maintain, and improve individual and community health by assisting individuals and communities to adopt healthy behaviors, 12 There are over 63,000 health educators working in the U.S., and the field is expected to grow by 37% by the year 2020.12 Although some Health Education Specialists focus on health education or community health, most are employed in healthcare and social assistance (51%), and government (23%).12 While the main responsibilities of Health Education Specialists are to develop and implement health education programs, encourage healthy behavior, and refer clients to appropriate resources, there is an opportunity to expand the role of health education specialists to administer screenings and provide counseling for certain public health concerns.

Health Education Specialists have an opportunity to help fill the gap and transition HIV screening to a more universal model. Those working outside of the clinical setting, especially those in local health departments and social service agencies, can also reach people who may not have regular access to medical care because of lack of resources, education or inability to pay. Making testing routine and more accessible would also encourage repeated testing, which will help to achieve the national goals of decreasing HIV infection by 25% and increasing knowledge of HIV status from 70 to 90%.13 Beyond offering HIV screening, Health Education Specialists are a logical resource for increasing awareness and education about HIV prevention and for connecting people to support resources. The 10-20 minutes needed for RHT results provides a window of time ideal for health education and counseling.

 Health education and HIV program planners and administrators should consider utilizing CHES/MCHES-certified health education specialists to conduct and evaluate rapid HIV testing programs. As identified in this article, CHES/MCHES are professional prepared take on this role; especially in working with high-risk and vulnerable populations. Health departments, community-based organizations and other health education organizations that plan, implement and evaluate rapid HIV testing programs should further evaluate the role of CHES/MCHES in being able to apply the NCHEC standards to HIV testing and counseling.

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| Table 1: NCHEC Responsibilities13 and Relationship to Rapid HIV Testing14,15  |
| Responsibility | Relationship to Rapid HIV Testing Programs  |
| Area I: Assess needs, assets and capacity for health education | * Establish appropriate goals, objectives, and activities of targeted rapid HIV testing (RHT) programs;
* Establish community-based support for the proposed RHT activities;
* Identify social/behavioral attitudes, behaviors, and perceptions of the target, high risk communities;
* Provide the basis for evaluation of RHT programs as part of formative and summative studies. 14
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| Area II: Plan health education | * Define and target high-risk populations that would benefit from RHT;
* Identify effective, evidence-based recruitment strategies to locate members of these target populations.15
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| Area III: Implement health education | * Offer the most sensitive RHT that are feasible;
* Provide clients with test results and risk reduction counseling;
* Link newly identified clients with positive tests to HIV medical care and social services.15
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| Area IV: Conduct evaluation and research related to health education | * Use specific, measurable, achievable, realistic, and time-based objectives and a logic model to create an evaluation plan to determine success of RHT programs;
* Document a data collection plan and determining measures of RHT implementation success;
* Determine RHT specific quality assurance measures and data analysis roles and responsibilities;
* Report RHT program findings and progress to organization management, community stakeholders and funders.15
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| Area V: Administer and manage health education | * Identify funding opportunities to expand RHT, submit grant proposals, and maintain relationships with funding agencies;
* Identify and nurture partnerships with appropriate organizations and community groups to increase recognition for RHT;
* Provide staff training and evaluate RHT programs.13
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| Area VI: Serve as a health education resource person | * Be knowledgeable of current information and educational resources regarding RHT;
* Locate or develop education materials that are accurate, up to date, and easy to understand for high risk populations;
* Convey accurate HIV/AIDS prevention information to priority populations and key stakeholders.13
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| Area VII: Communicate and advocate for health and health education | * Promote the role of health educators in RHT;
* Use evaluation and research findings to advocate for policy change to expand RHT to more non-clinical settings;
* Empower stakeholders to engage in advocacy to expand role of CHES/MCHES in conducting RHT.13
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References

1. Centers for Disease Control and Prevention (CDC). Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 U.S. dependent areas—2010. HIV Surveillance Supplemental Report 2012;17(No. 3). Available at http://www.cdc.gov/hiv/pdf/statistics\_2010\_HIV\_Surveillance\_Report\_
vol\_17\_no\_3.pdf. Accessed December 4, 2013.
2. Centers for Disease Control and Prevention (CDC). Estimated HIV incidence in the United States, 2007–2010. HIV Surveillance Supplemental Report 2012;17(No.4). Available at http://www.cdc.gov/hiv/pdf/statistics\_hssr\_vol\_17\_no\_4.pdf. Accessed December 4, 2013.
3. U.S. Food and Drug Administration (FDA). Rapid HIV tests suitable for use in non-clinical settings. Available at http://www.cdc.gov/hiv/pdf/testing\_nonclinical\_clia-waived-tests.pdf. Accessed December 4, 2013.
4. Greenwald JL, Burstein GR, Pincus J, Branson B. A rapid review of rapid HIV antibody tests. *Curr Infect Dis Rep*. 2006;8(2):125-131.
5. Henry J. Kaiser Family Foundation (KFF). HIV Testing in the United States. Available at <http://www.kff.org/hivaids/upload/6094-11.pdf>. Accessed June 12, 2013.
6. Centers for Disease Control and Prevention (CDC). Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR Morb Mortal Wkly Rep*. 2006;55(RR-14):1-24.
7. United States Preventive Services Task Force (USPSTF). Screening for HIV: Recommendation Statement*.* Available at http://www.uspreventiveservicestaskforce.org/
uspstf13/hiv/hivfinalrs.htm. Accessed June 11, 2013.
8. Patient Protection and Affordable Care Act (ACA), 42 USC § 18001 et seq. (2010).
9. Girardi E, Sabin CA, Monforte AD. Late diagnosis of HIV infection: epidemiological features, consequences and strategies to encourage earlier testing. *J Acquir Immune Defic Syndr*. 2007;46(suppl 1):S3-S8.
10. Bowles KE, Clark HA, Tai E, et al. Implementing rapid HIV testing in outreach and community settings: results from an advancing HIV prevention demonstration project conducted in seven U.S. cities. *Public Health Rep*. 2008;123(suppl 3):78-85.
11. Bureau of Labor Statistics (BLS), U.S. Department of Labor. Health Educators. *Occupational Outlook Handbook, 2012-13 ed*. Available at http://www.bls.gov/ooh/
Community-and-Social-Service/Health-educators.htm. Accessed December 4, 2013.
12. White House Office of National AIDS Policy. National HIV/AIDS Strategy for the United States. Washington, DC: White House Office of National AIDS Policy; 2010. Available at http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/nhas.pdf. Accessed December 4, 2013.
13. National Commission for Health Education Credentialing (NCHEC). About NCHEC. Available at http://www.nchec.org/aboutnchec/faq/. Accessed May 28, 2013.
14. Centers for Disease Control and Prevention (CDC). General considerations regarding health education and risk reduction activities. Available at http://wonder.cdc.gov/wonder/
prevguid/p0000389/p0000389.asp. Accessed December 5, 2013.
15. Centers for Disease Control and Prevention (CDC). New resources for HIV testing in non-clinical settings. Available at http://www.cdc.gov/hiv/dhap/eHAP/direct/
013113.html. Accessed December 5, 2013.