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Provider perceptions on HIV risk and prevention services within permanent supportive housing

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ABSTRACT

Permanent supportive housing (PSH) is an evidence-based solution to homelessness for persons experiencing chronic or long-term homelessness and one or more physical or behavioral health problems. Health services through PSH typically focus on physical and behavioral health. With the exception of programs specifically designed for persons living with HIV/AIDS, little attention has focused on services through PSH to prevent transmission of HIV or other sexually transmitted infections (STIs), yet sexual risk behavior continues after homeless persons move into PSH. The purpose of this study was to investigate how PSH providers approach HIV prevention and the challenges they perceive surrounding HIV prevention in PSH. Results serve as a critical first step toward addressing the acceptability and feasibility of providing HIV/STI prevention services to PSH residents. As part of a longitudinal mixed methods study examining HIV risk and prevention behavior among homeless unaccompanied adults moving into PSH in Los Angeles, we conducted eleven focus groups with a total of 60 frontline staff across 10 PSH agencies. Thirty-three percent of focus group participants were African American, 32% were Hispanic, and 55% were women. Results suggest that provider awareness and knowledge of PrEP is very limited, and provision of formal HIV prevention programing for residents is perceived as challenging. Informal, ad hoc conversations with residents about sexual risk and HIV prevention do occur when providers have rapport with clients and perceive risk. There are significant gaps in HIV prevention services through PSH but also opportunities to enhance providers' efforts to promote the health of residents through prevention.

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Introduction

HIV has increasingly become a disease of indigent and homeless persons (Culhane, Gollub, Kuhn, & Shpaner, 2001; National Coalition for the Homeless, 2009; National Health Care for the Homeless Council, 2012; Shubert & Bernstine, 2007; Wenzel et al., 2016), with prevalence rates among homeless urban community samples as high as 10% (Caton et al., 2013; Robertson et al., 2004; Wenzel et al., 2016), compared to a U.S. population prevalence of less than one half of 1% (Hall et al., 2015). High rates among homeless persons persist despite the existence of several effective HIV prevention tools, including condoms (Centers for Disease Control and Prevention (CDC), 2013; Joint United Nations Programme on HIV/AIDS, 2015; World Health Organization, 2009–2016), HIV testing as prevention/treatment (Sood, Wagner, Jaycocks, Drabo, & Vardavas, 2013; Walensky et al., 2010; White House Office of National AIDS Policy, 2015), and pre-exposure prophylaxis (PrEP) (CDC, 2016; National Center for HIV/AIDS, 2014; Service, 2014; United States Department of Health & Human Services, 2016).

Permanent supportive housing (PSH) is an evidence-based solution for persons experiencing chronic or long term homelessness and physical or behavioral health problems (Byrne, Fargo, Montgomery, Munley, & Culhane, 2014; Rog et al., 2014; Smelson et al., 2016). As the term suggests, housing provided to individuals through PSH is not time limited. Additionally, case management and other services are made available to support retention and address health needs (Byrne et al., 2014; Rog et al., 2014). However, with the exception of programs specifically designed for persons living with HIV/AIDS (Buchanan, Kee, Sadowski, & Garcia, 2009; Dobbins et al., 2016; Wolitski et al., 2010), there has been little attention on PSH as a locus for HIV prevention services (Sikkema et al., 2007).

The purpose of this study is to investigate how PSH providers approach HIV prevention and the challenges they perceive surrounding HIV prevention in PSH.

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The results will serve as a critical first step toward addressing the acceptability and feasibility of providing HIV/STI prevention services to PSH residents.

Methods

As part of a larger, longitudinal mixed methods study examining HIV risk and prevention behavior among homeless adults moving into PSH in the Los Angeles area (Wenzel, 2014), focus groups were conducted with staff at 10 PSH partner agencies to better understand the landscape of HIV/STI prevention services and how these services are (or are not) integrated into PSH for formerly homeless persons. In total, 11 focus groups were conducted across 10 agencies with a total of 60 frontline staff (1 agency had 2 focus groups). Each group included a range of frontline staff positions, including program managers, case managers, and outreach workers, with an average of 5 providers (range: 3–11) per group. Thirty-three percent of focus group participants were African American, 32% were Hispanic, and 55% were women. Two study staff served as moderators of each group; staff obtained verbal consent from all participants and recorded data on perceived race/ethnicity and genders of participants. All participants were offered a $20 cash incentive.

Groups lasted approximately one hour, were conducted in private spaces at the agencies, and were audio-recorded. Groups assessed topics relevant to general healthcare and, specifically, HIV prevention and services within the context of PSH. Audio recordings were transcribed, entered into ATLAS.ti qualitative software (Scientific Software Development GmbH, 2015), and analyzed thematically using coding procedures that involved both independent and co-coding for purposes of rigor. For this study, codes were reviewed by the lead author to develop an initial set of themes related to providers' views on HIV prevention services. These themes were then reviewed and finalized through team discussion.

Results

The focus groups revealed that formal HIV prevention efforts are not prioritized and are rarely provided in PSH, and that knowledge is lacking among PSH providers on how to provide HIV prevention services.

Formal HIV prevention efforts are not prioritized and rarely provided

With a few notable exceptions in which PSH programs occasionally brought in HIV prevention services, PSH staff largely articulated that the priority of the program was housing retention: "We're not aiming to reduce Hepatitis C or HIV or things like that. Our priority is, get people housed and keep them housed." Another noted that "We don't have bowls of condoms … . We're not proactive in those ways … ." In a few cases, formal prevention programing had previously been provided, "but we haven't had that in years," and "abstinence-only education didn't work."

In some cases, providers were uncertain who should have responsibility for HIV prevention. An exemplar of this uncertainty is a question posed by a participant: "Who should talk about it [HIV and STI prevention]? Should I, … or the clinic nurse?" Because of this uncertainty, discussions with residents regarding HIV were "ad hoc" and seen as dependent upon individual rapport. As one participant explained, "it depends on the case manager/client relationship," and, "It's just how comfortable they feel with me." Some providers made decisions based on perceived client risk since " … not everybody needs to hear safe sex practices." Yet as a program policy or practice, "The conversation around it [HIV prevention] is not happening."

Lack of knowledge on how to provide HIV prevention services

Providers expressed awareness of the importance of HIV prevention but seemed to lack tools to provide it, as captured in one participant's question, "How do we address that?" Participants mentioned numerous trainings but none that addressed HIV prevention: "Harm reduction trainings just talk about drugs the whole time," and "You go to trainings on personality disorders at least 10 times a week, right? … But we have to sit and talk about it [HIV prevention] because we don't do it now."

Focus group questions about PrEP, in particular, revealed limited familiarity with this medication, and a perception of resident unawareness and lack of access. As participants noted, "Most of them [staff and residents] don't know," and "I don't think we have folks that have access to [PrEP], or doctors that have prescribed [PrEP]." There were some expressions of interest in PrEP; for example, at one program, "the staff is learning about it." Even among those who did know about PrEP as "the hottest thing right now … .", it was deemed expensive and that "The County's not going to pay, politicians are not going to pay, so you can have jollies." There was uncertainty about coverage of the medication through Medi-Cal (i.e., California's Medicaid program) and worries that clients might sell the medication. Concerns were also raised about side effects and monitoring requirements, prompting statements such as, "we need a designated nurse just to do that," which was also related

to concerns that clients might be incapable of self-administering PrEP as prescribed.

Discussion

Although we found that formal HIV prevention programing in PSH is rarely provided and knowledge about prevention is limited, informal interactions transpiring between providers and residents in PSH suggest a bridge to more formal HIV prevention efforts. Evidence-based efforts to prevent HIV should be prioritized and integrated more systematically within the supportive services offered through PSH (Henwood et al., under review). The only randomized controlled trial investigating unprotected sex in PSH clients versus clients in a treatment-as-usual condition found no differences after two years, suggesting that PSH in itself is not effective in changing HIV risk behavior (Parpouchi, Moniruzzaman, McCandless, & Somers, 2016). Rather, PSH may provide an appropriate foundation for implementing evidence-based programing to reduce risk for HIV and other STIs.

Feasibility of routine implementation of HIV prevention programing in PSH may be challenged by limitations in staff capacity to serve multiple high-need clients while also promoting housing retention and medical and psychiatric services. Provision of PrEP through PSH represents a particular challenge given limited knowledge of this medication among providers and expressed concerns about close monitoring of clients prescribed this medication. Of note, PrEP is covered by Medi-Cal (California Department of Health Care Services, 2016), and some Los Angeles County clinics provide no-cost PrEP even for uninsured patients (County of Los Angeles Department of Public Health, 2016).

There are several opportunities to explore for advancing HIV prevention to residents in PSH. Content and format of existing evidence-based HIV prevention interventions (e.g., the CDC's Effective Interventions (2015)) might be adapted through close collaboration with residents and providers to ensure acceptability and feasibility (Cederbaum, Song, Hsu, Tucker, & Wenzel, 2014). Research has previously demonstrated acceptability of HIV prevention programing among homeless persons (Cederbaum et al., 2014; Wenzel et al., 2016; Wenzel, D'Amico, Barnes, & Gilbert, 2009). It would be advisable for PSH providers to enhance linkages with HIV/AIDS organizations, which could provide education to staff and clients on harm reduction, HIV testing and counseling, and PrEP. Regarding PrEP, PSH providers and client case managers might benefit from education to understand the costs and benefits of PrEP for individuals at high risk of HIV infection. Clients at high risk would benefit from greater access to HIV and other STI testing and counseling, as well as PrEP prescriptions, counseling, and medication monitoring that are provided through HIV/AIDS organizations or Federally Qualified Health Centers. Local community-based organizations, clinics, and health departments might be engaged to coordinate existing services in the community, such as on-site delivery of prevention services to clients in PSH sites. The integration of prevention services may confer many benefits and prove to be an effective, replicable, and sustainable approach for prevention of HIV transmission and infection.

PSH provides a foundation for promoting health of individuals who have endured long bouts of homelessness and who have physical or behavioral health challenges. HIV risk and prevention, however, has received limited consideration in the context of PSH thus far, despite the potential threat that HIV poses to resident health. In this study, one of very few to have investigated HIV prevention in PSH, we learned that there are significant gaps in services but also opportunities to enhance efforts in promoting health of residents through prevention.

Disclosure statement

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