Integrating Self-Testing for PrEP with Providers and Partners

January 13, 2020

PARTICIPANT QUESTIONS

The following questions were posed by participants during the "Self-Testing Strategies for HIV Testing and PrEP Access" hosted on Jan. 13, 2020.

Q: What does low barrier HIV/STI testing look like?

A: This is a sliding scale, fee-for-service model that slides down to zero for all STI and HIV services. Low barrier could also refer to services that are funded through safety net programs, which do not allow the service provider to bill the client or the client's insurance. Barriers can also go beyond cost – and could include home testing, local lab options, or critically distant lab options.

Q: What are some strategies to limit dating profile deletion if used for a marketing strategy for outreach? When using, dating apps delete the profile if used for marketing.

A: To prevent the deletion of the profile, utilizing the photos of a PrEP Navigation Specialist (usually someone who volunteers to use their photo) is helpful. We found that using a person's picture compared to a pill provides more transparency as someone who works for the agency and may potentially work with the client if they come into the clinic.

In addition, profiles are usually flagged and deleted if you (the organization) are messaging others on apps, specifically asking for their information. We recommend allowing patrons on the app to message the organization first before responding. Instead of asking for contact information in the app, we provide a link to our Healthvana platform which provides a more secure platform to begin building the relationship.

Q: Have you considered using a telehealth tool to conduct an HIV testing event which encompasses collecting the client-level data and working with clients on reading the result and conducting essential service referrals as needed?

A: This option was explored in the beginning of our Phase 1 pilot with rapid HIV testing. Equipment for participating agencies was purchased (Zoom licenses) and flexibility was given to the agencies to utilize this service, but clients declined this type of service. Clients preferred to talk over the phone and were not interested in having face-to-face visits. We have

continued to offer phone or video-based support to individuals conducting the test at home once the test is received, but clients have not utilized this service offering.

Q: How do you get a photo of the result from the client and how do you verify the identity of the individual who sent the photo? Based on phone number? I assume you are not getting PII via email or text message.

A: PII (Personally Identifiable Information) is collected in a secured system once the test is ordered and individuals are provided a test ID number which is used to track test events into testing database. Individuals are then able to take a photo of their test with the assigned test ID when returned by text or email to the issuing agency.

Q: Would you be able to talk a bit about the different screening devices/ technologies that will be part of the kit?

A: Initially, the lab explored microcontainer blood collection compared to dry blood spot (DBS) collection for syphilis, HIV, and Hepatitis C. We learned from our home-test kit evaluation that blood returns were challenging for some individuals who received the capillary microcontainer, so we are now exploring potential DBS options. The same swabs, which are used for in person 3-site STI screening, are currently undergoing validation.

Q: Do consumers photograph the test result and send it in, or do consumers phone results in? What is your rate of returned results?

A: Our preference is for clients to take a photo of the results and either text or email the agency utilizing the phone number the client provided. We have had instances where some individuals have verbally confirmed results, but the preferred method is to see the result, interpret and verify for the patient via photo.

We have only had one client be issued a test kit and not report the result to the issuing agency. We conduct a lot of relationship building with the phone call and assessment, creating a client to counselor relationship by exploring risks and providing supportive services as a part of the process compared to having this done independent of the counselor.

Q: Curious to know if a cross match using self-test kit data and running this against other in-house databases (i.e. eHARS) has been considered?

A: A couple of health departments have entered their self-testing data into their HIV surveillance system to understand linkage and retention in care later or other indicators in terms of outcome.