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Replicating Effective Behavioral Interventions: RESPECT HIV Prevention Counseling

Final Report

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Contents

Exhibits

Introduction

Despite advances in the treatment of human immunodeficiency virus (HIV) infection, there is still no cure. Programs that reduce unprotected sex, the sharing of used syringes and works, and other risky behaviors will remain the best way to control the spread of HIV. A great deal of progress has been made in the development and testing of programs to reduce risky behaviors.

These efforts have produced a number of effective, evidence-based interventions, including the 2-Session and 4-Session RESPECT HIV Prevention Counseling models. The RESPECT counseling models were developed in a randomized controlled trial called Project RESPECT. The study was conducted in five, public, sexually transmitted disease (STD) clinics in Baltimore, Maryland; Denver, Colorado; Long Beach, California; Newark, New Jersey; and San Francisco, California. In this study, the effectiveness of 2-session and 4-session, client-focused counseling models was evaluated against an informational message model.

Project RESPECT research produced two, effective, evidence-based HIV prevention counseling models: the 2-session model, which consists of two brief (about 10 to 28 minutes) one-on-one counseling sessions; and the 4-session model, consisting of one brief (about 20 minutes) and three longer (about 60 minutes) one-on-one counseling sessions.

To capitalize on this critical work, the Centers for Disease Control and Prevention (CDC) have incorporated many of the core principles into their revised HIV Counseling and Testing recommendations as well as provided technical assistance to facilities, including staff training and quality assurance. Most recently, CDC contracted with RTI International to translate the

RESPECT intervention into clear, easy-to-use materials under the Replicating Effective Programs (REP) initiative. As part of this process, CDC also contracted with RTI to pilot test the 2-session model and conduct a process evaluation.

OVERVIEW OF THE REPORT

This report summarizes RTI's work on the project, focusing on the process evaluation, including its methodology and major findings, providing recommendations for easing implementation of the RESPECT Counseling intervention in real-world settings, and suggesting possible next steps.

Detailed Description of Accomplishments

The replication of the 2-Session and 4-Session RESPECT interventions involved a number of critical tasks including

- *Forming an advisory group.* RTI recruited a community advisory board that included representatives from several local HIV prevention agencies to review materials and provide feedback on RESPECT materials. Additionally, RTI and CDC staff identified several original researchers that provided information and guidance about the context, purpose, and integrity of the 2- and 4-Session RESPECT models.

- *Developing the intervention portion of the prevention package.* RTI worked closely with CDC, the original researchers, and the community advisory board to develop intervention materials that maintained the integrity of the counseling interventions while formatting it in a way that is understandable, attractive, and user-friendly to HIV/STD direct service providers.

- *Developing the training portion of the prevention package.* In collaboration with the original researchers, CDC training staff, and the California STD/HIV Prevention Center (CA PTC), RTI developed training curricula and materials that emphasized adult experiential learning and skill building. The materials include a training video with sample counseling sessions inspired by transcripts from the original RESPECT study.

- *Identifying organizations to implement the translated RESPECT materials and evaluating the replication process.* RTI first developed a strategy to market the package for implementation. RTI's criterion was that the organization must provide voluntary HIV testing. RTI contacted a number of local community-based HIV

prevention organizations within a 150-mile radius of RTI and assessed interest in implementing the 2-Session RESPECT counseling intervention and participating in a process evaluation of that implementation. Initially, the Forsyth County Department of Public Health (FCDPH) and the Craven County Health Department (CCHD) agreed to participate. However, staffing changes and resource limitations prevented FCDPH from implementing the intervention (although they did participate in training). Additional information regarding the 2-Session RESPECT model implementation is included in the next section of this report.

- *Conducting orientation and training with implementing agencies.* RTI worked closely with CDC staff to train staff members at the implementing agencies. These trainings included teaching the technical skills needed to conduct the 2-Session RESPECT model counseling as well as quality assurance methods and procedures necessary to ensure that intervention fidelity was maintained.

- *Providing technical assistance during implementation.* In addition to the initial training, RTI provided ongoing technical assistance through on-site visits and regular conference calls.

- *Developing a plan to evaluate implementation.* Using cross-site measures, RTI measured how well each site was able to implement the intervention. See the results section for more information.

- *Developing a final RESPECT package.* The final RESPECT package contains a number of components designed to facilitate the training and implementation of the RESPECT HIV Prevention Counseling model. These components include

  - Overview
  - 2-session manual
  - 2-session Counselor Cards and Prompt Sheets
  - Video demonstrating the 2-Session RESPECT model
  - 4-Session manual
  - 4-session Counselor Cards and Prompt Sheets
  - RESPECT attaché
  - Session-specific materials

Exhibit 1 shows RTI's deliverables by activity and date.

Exhibit 1. RTI Deliverables

Activity	Date
Task 1: Form Advisory Group	
Initial e-mail to original RESPECT researchers	9/27/2001
Recruiting plan for community advisory board (CAB) to CDC	10/10/2001
Proposed LAM list to CDC	11/9/2001
Local advisory kickoff meeting	1/30/2002
"Study Guide" sent to LAM to assist in review of materials	2/15/2002
CAB sent draft 2-session manual and first two sessions of 4-session intervention for review	4/10/2002
RTI project director met with Dr. Mary Spink-Neumann and Dr. Mary Kamb	4/26/2002
RTI staff met with HIV counselors in Wake and Durham Counties to discuss common HIV counseling situations	5/24/2002
Revised 2-session manual to CAB	6/6/2002
Revised 2-session manual sent to original researchers	6/24/2002
Conference call with CDC and original researchers	8/7/2002
Conference call with Kevin Malotte regarding 4-session intervention	9/18/2002
Revised 4-session intervention sent to Kevin Malotte for review	1/26/2003
Overview sent to LAM for review	9/29/2003
Task 2: Develop the Intervention Portion of the Prevention Package	
Draft replication package to CDC	12/7/2001
Revised draft replication package to CDC	2/15/2002
Draft intervention package sent to CDC	4/10/2002
Revised 2-session manual to CDC	6/6/2002
Outline of 4-session intervention to CDC	6/12/2002
Revised 4-session intervention outline sent to CDC	6/20/2002
Revised 2-session manual sent to CDC	8/20/2002
2-session manual quality assurance materials sent to CDC	9/18/2002
Revised 2-session manual sent to CDC	11/18/2002
Revised project timeline sent to CDC	11/27/2002
Revised 4-session intervention sent to CDC	12/16/2002
Revised 2-session manual sent to CDC	1/10/2003
Draft HIV positive protocol to CDC	2/20/2003
2-Session manual quality assurance materials sent to CDC	2/24/2003
Revised 4-session manual sent to CDC	1/26/2003
Document design for 2-session manual sent to CDC	3/15/2003

Activity	Date
Task 2: (continued)	5/16/2003
Revised 2-session manual sent to CDC	7/16/2003
Revised 2-session manual sent to CDC	7/28/2003
Revised 2-session manual sent to CDC	8/19/2003
Revised overview sent to CDC	9/15/2003
Revised quality assurance materials sent to CDC	9/17/2003
4-Session manual sent to CDC	12/19/2003
Final HIV positive protocol sent to CDC	12/19/2003
Revised 2-session manual sent to CDC	1/27/2004
Task 3: Develop the Training Portion of the Prevention Package	
Draft Training Manual sent to CDC	2/15/2002
Revised training materials sent to CDC	5/10/2002
Draft video script to CDC	5/17/2002
Overview of training materials, including outline of activities, sent to CDC	5/24/2002
Revised video script to CDC	8/15/2002
Sample logos sent to CDC	3/13/2003
Training materials sent to CDC	3/13/2003
Revised video script to CDC	3/17/2003
Training Unit 1 overheads sent to CDC	4/21/2003
Training Unit 2 overheads sent to CDC	4/30/2003
Revised training materials sent to CDC	7/28/2003
Revised video script to CDC	8/14/2003
Training video taping	9/8/2003
Revised training materials sent to CDC	1/14/2004
Task 4: Develop the Technical Assistance Portion of the Prevention Package	
Draft technical assistance plan sent to CDC	5/24/2002
Task 5: Produce a Limited Number of Prototype Intervention Packages	
List of package contents sent to CDC	1/14/2003
Several sample package components sent to CDC	
Formatted protocol script	4/4/2003
Quality assurance for 2-session	4/17/2003
Two examples of page formatting	4/24/2003
Three examples of cover designs	4/24/2003
Sample cover and back design for 2-session	4/25/2003
Revised version of HIV positive protocol	4/28/2003

Activity	Date
Task 6: Identify Organizations or Field Settings for the Trial Run of the Intervention Packages	
RTI staff met with Durham County Health Department representative	6/3/2002
Recruitment plan sent to CDC	6/10/2002
RTI staff met with Wake County Health Department representative	7/24/2002
Additional information about potential sites sent to CDC	8/9/2002
RTI sent recruitment letter to all health departments within 150-mile radius of RTI	7/15/2002
RTI staff met with Cumberland County Health Department	12/2/2002
RTI staff met with Forsyth County Health Department	12/11/2002
RTI staff met with Craven County Health Department	2/27/2003
Memorandum of Agreements sent to Forsyth and Craven County Health Departments	5/20/2003
Task 7: Develop an Evaluation Plan	
Draft evaluation plan sent to CDC	5/10/2002
Decision by RTI IRB that, given the nature of the work, the project does not require RTI IRB approval	7/24/2002
Evaluation plan sent to CDC	8/1/2003
Task 8: Conduct Orientation and Training	
Training for implementing agencies	6/5/2003
On-site training itinerary sent to CDC	7/31/2003
On-site visits by RTI and CDC staff	8/5/2003
Final meeting with Craven County site	1/13/2004
Task 9: Provide Technical Assistance During Implementation	
RTI held conference call with Forsyth County to address implementation concerns	10/29/2003
On-site visit to Craven County	11/3/2003
Forsyth site withdrew from the project	12/15/2003
Task 10: Monitor Program Implementation	
Monitored sites 9/1/03 – 12/31/03	12/31/03
Task 11: Track Intervention Costs	
Evaluated costs throughout implementation	12/31/03
Task 12: Finalize Intervention	
Final job was sent for printing	03/15/04
Task 13: Develop Technical Assistance Guidelines	
Draft Technical Assistance Guide sent to CDC	1/30/2004

Activity	Date
Task 14: Develop Fact Sheet	
Draft fact sheet sent to CDC	6/27/2002
Revised fact sheet sent to CDC	3/3/2003
Task 15: Meet with CDC	
RTI meeting with CDC, Boston Massachusetts	10/28/2001
RTI meeting with CDC, Research Triangle Park, North Carolina	1/15/2002
RTI meeting with CDC, Atlanta, GA	4/26/2002
RTI staff attended RESPECT training and met with CDC staff, Atlanta, GA	10/23/2002
RTI staff attended REP meeting, Atlanta, GA	10/30/2002
RTI meeting with CDC, Research Triangle Park, North Carolina	5/6/2003
RTI meeting with CDC, Atlanta, GA	8/20/2003
RTI Staff attended REP meeting, Atlanta, GA	11/6/2003
RTI Staff attended pilot training, San Francisco, CA	3/22/2004

Process Evaluation

PROCESS EVALUATION METHODS

This evaluation was designed to assess how well the 2-session RESPECT intervention worked, how the intervention functioned, how congruous the use of the intervention was with the goals of the intervention, whether the intervention was delivered as intended to appropriate recipients, how well the manual was organized, the use of program resources, and other related questions (Rossi, Freeman, and Lipsey, 1999).[1] Process data, both qualitative and quantitative, were collected to identify barriers to implementation, potential solutions to these barriers, and costs strategies where applicable.

Recruitment

RTI developed a strategy to market the package for implementation. The two main criteria were that participating organizations must already provide voluntary counseling, testing, and referral, and they must be interested in carrying out the intervention. Further, sites must be willing to implement the intervention and participate in the process evaluation. RTI contacted many health departments local to RTI. RTI also sent letters to health departments and some other community-based organizations within a 150-mile radius of Research Triangle Park, North Carolina, where RTI is located.

[1]Rossi, Peter H., Howard E. Freeman, and Mark W. Lipsey. (1999). *Evaluation: A Systematic Approach,* sixth edition. Thousand Oaks, CA: Sage Publications, Inc., p. 67.

Participating Sites

Two sites initially agreed to participate in the process evaluation: the Craven County Health Department (CCHD) and the Forsyth County Department of Public Health (FCDPH). CCHD is located in New Bern, North Carolina (NC), which is a small town in eastern NC. The 2-Session RESPECT model was implemented in CCHD's STD clinic and HIV counseling and testing site (CTS), which are housed in the same building. FCDPH is located in Winston-Salem, NC, an urban city in the Piedmont or central region of the state. The evaluation was going to be implemented in their HIV CTS, which resides at the main facility. Further, for the training(s), several representatives from health departments and prevention training centers attended the training and provided input.

Methodology

To evaluate the intervention, RTI conducted site visits, asked the sites to send information on the demographics of their clients (Documentation of Intervention Episodes form, **Appendix A**), reviewed the training evaluation forms, evaluated the technical assistance calls, and asked the sites to fill out a few other forms related to the intervention.

RTI conducted a site visit with each county a few months after the initial training. RTI conducted another one with CCHD a few months later, followed by a final phone call with the staff and CDC representatives. RTI also conducted a final call with the FCDPH.

Instruments

The following outline describes the key topics RTI examined as part of the process evaluation. RTI examined these issues through site visits, Documentation of Intervention Episodes forms (**Appendix A**), technical assistance calls, and training evaluations.

RTI examined the following domains for the process evaluation.

- Description of the environment in which the intervention was implemented
- Description of supervisor and counselor characteristics.
- Description of intervention episodes
- Implementation

  - Description of implementing the 2-session model in existing HIV and STD programs
  - Modifications to the 2-session model
  - Quality assurance
  - Barriers to implementation
  - Staff reaction to the 2-session model
  - Client reaction to the 2-session model
- Cost effectiveness
  - Start-up and maintenance costs
  - Program session labor costs
  - Quality assurance and evaluation costs
  - Total costs
  - Sources of cost variations

Analysis

Using the data from forms sent by the sites, training evaluation forms, and site visits, RTI qualitatively analyzed the process of implementing the intervention.

PROCESS EVALUATION RESULTS

The process evaluation, which integrated qualitative and quantitative data collection methods, took place from September 1 to December 31, 2003. Participating sites included the Craven County Health Department (CCHD) in New Bern, North Carolina (NC), and Forsyth County Department of Public Health (FCDPH) in Winston-Salem, NC. FCDPH was unable to participate fully in the process evaluation because it did not implement the intervention; thus, the findings described below are for CCHD only unless otherwise indicated.

Environment in which the Intervention was Conducted

The 2-session RESPECT HIV Prevention Counseling model was conducted at the Craven County Health Department located in a relatively small town. HIV counseling is confidential, not anonymous.

At CCHD, clients are typically given 30 minutes, whether the appointment is for HIV counseling and testing or if it also includes STD testing or other clinical examination. All testing is done at the CCHD. The outreach worker talks with people and motivates them to come in for testing. Typically, when someone comes in for an STD screening, the staff tries to motivate the client to consider an HIV test and, as a result, it can take up to 45 minutes to see a client. For a positive test result, staff may meet with a client up to an hour. At the time of the intervention, Craven County had a 120 percent increase in HIV-positive rates (27 positives in 2002). At that time, the CCHD was divided into family planning and adult services, although there is sometimes crossover between the two services. As a result, all participants who came in, came in for STD and/or HIV counseling or were motivated to come in by the outreach worker.

Training for CCHD clinical staff usually consists of a 2-month training at the University of North Carolina followed by a 6-month clinical training prior to working in the clinic.

At FCDPH, two staff are in the field providing HIV testing and counseling. During a typical month, approximately 55 to 80 pretest and posttest counseling sessions are provided. Testing is done in the field at a number of locations including the jail or detention authority, the transit authority (bus station), a nearby school of the arts, addiction recovery care association, the Winston-Salem state authority for the care of homeless individuals, and Hope Education and Outreach. Typically, HIV outreach obtains about 2 to 3 HIV-positive test results a year, but in 2002 the number was up to 8. The majority of clients they see have used crack and/or alcohol and have multiple sex partners. Sexual abuse is an issue for some clients. The male-to-female ratio is even. The majority of clients are African-American, although Winston-Salem is only about 12 to 13 percent African-American.

Training for FCDPH staff includes a state training on an HIV counseling, testing, and referral model similar to the 2-session model.

At both sites, testing is confidential and the HIV tests are paid for by the state and typically involve a standard blood draw.

However, the outreach worker at CCHD was working on obtaining a grant to pay for Oraquick tests.

Supervisor and Counselor Characteristics

The CCHD supervisor is a nurse (BSN and RN) who sees clients in the STD clinic. She did not have HIV prevention experience prior to 2003 when she took the position at CCHD. The 2-Session RESPECT model is the only HIV counseling and testing model she has used. During the training, an additional counselor was trained, but did not take part in the implementation because she changed jobs. The other counselor at CCHD is a health educator who works primarily in the HIV CTS, although he spends quite a bit of time conducting community outreach and education activities. He started working at CCHD in 1999, but had previous HIV counseling and testing experience and has also trained others in HIV counseling and testing. The CCHD supervisor and counselor participated in the initial training at RTI and received continuing education about providing HIV-positive test results at their site.

The FCDPH supervisor has worked in HIV prevention for less than 1 year. The supervisor participated in the initial the 2-Session RESPECT model training at RTI. Through continuing education at their facility, one counselor who did not participate in the initial training received training (2 full days) on implementing the intervention. FCDPH did not participate in the implementation. The supervisor later reported to RTI that the challenges FCDPH experienced in implementing the 2-session intervention were internal and were in no way related to the training and materials or the intervention itself. She cited the time involved with hiring and orienting new staff and other internal pressures (grant writing, progress reports, etc) as the major stumbling blocks. All items that took precedence over the 2-Session RESPECT model were essential to the maintenance of FCDPH's program funding. Specifically, the implementation proved difficult for the following internal reasons:

- Hiring and training of new staff.
- Involvement in planning and implementing a legislative conference.
- Dismantling of a community-based organization.

- Other internal responsibilities that were a higher priority.

Although the site was unable to implement the 2-Session RESPECT model, the supervisor provided input based on the training process:

Positives

- Provides a concrete foundation for risk reduction.
- Enables the clients to problem-solve and develop negotiation skills.
- Provides a compassionate and effective mechanism for delivering a positive result.

Negatives

- Time consuming for the counselor because of the amount of open-ended questions.
- Very script-oriented, which feels unnatural and does not allow for easy conversation. (This was modified as a result of the training.)
- Not applicable in large testing venues.
- Difficult to implement in certain populations such as the incarcerated and the mentally challenged.

Intervention Episodes

We gathered weekly quantitative data on intervention episodes using the form shown in **Appendix A**. An intervention episode was defined as an HIV counseling and testing session involving Session 1 or 2 of the 2-Session RESPECT model. The total number of intervention episodes included clients who participated in Session 1 only, Session 2 only, or both Session 1 and 2. For each intervention episode, we collected data on

- Contact type (Session 1 or 2)
- English or Spanish language used for the session
- Setting in which the intervention was conducted
- Sex or gender of participants
- Age, race/ethnicity, risk characteristic(s), and sexual orientation of participants
- Type of HIV test

CCHD administered the Session 1 intervention to 90 clients and the Session 2 intervention to 65 clients, for a total of 155 intervention episodes. The majority of intervention episodes were conducted in English and all were conducted at the health department. More than half of the episodes were with females. Forty percent of episodes involved persons aged 20 to 29, and 70 percent involved whites. Nearly 80 percent of episodes were conducted with heterosexuals, and 75 percent of episodes reported multiple sex partners as a risk factor. The characteristics of clients who participated in intervention episodes in Craven County are shown in **Exhibit 2**.

IMPLEMENTATION

The sections below describe findings related to the implementation of the 2-Session RESPECT model. The sections cover the following: CCHD's experiences implementing the 2-Session RESPECT model in its STD clinic and HIV counseling and testing program, modifications CCHD made to the 2-Session RESPECT model protocol and reasons for these changes, the quality assurance and control practices adopted by CCHD staff, the barriers staff encountered in implementing the 2-Session RESPECT model, and staff reactions to the intervention at both CCHD and FCDPH. Finally, reactions of HIV prevention trainers who attended a 2-day training are discussed.

Implementing the 2-Session Model in Existing HIV and STD Programs

When FCDPH staff were asked about how decisions were made to implement an intervention, the supervisor stated that she and the medical director make the decision. FCDPH attempts to update the policies and procedures manual every other year, but it had been 3 years since the agency had last updated its policies and procedures. When asked about implementing the 2-Session RESPECT HIV Prevention Counseling model, the supervisor did not consult the medical director because it was not a significant time commitment and it was similar to the organization's current procedures. Had it been unique, she would have had to speak with the medical director.

Exhibit 2. Characteristics of Intervention Episodes in Craven County, NC: September 1–December 31, 2003 (N = 155)

Characteristic	Number (%) of Intervention Episodes
Gender	
Male	69 (44.5)
Female	85 (54.8)
Undetermined	1 (<1.0)
Age	
19 or younger	32 (20.6)
20 to 29	64 (41.3)
30 to 39	39 (25.2)
40 to 49	12 (7.7)
50 or older	8 (5.2)
Race/Ethnicity	
White	78 (50.3)
African American	70 (45.2)
Hispanic	6 (3.9)
American Indian/Alaska Native	1 (<1.0)
Sexual Orientation	
Heterosexual	123 (79.4)
Gay/lesbian	14 (9.0)
Bisexual	11 (7.1)
Not determined	7 (4.5)
Risk Factor*	
Multiple sex partners	117 (75.5)
Alcohol or drug user	67 (43.2)
Sex partner of IDU	20 (12.9)
Men who have sex with men (MSM)	18 (11.6)
Intravenous drug user (IDU)	13 (8.4)
Sex worker	13 (8.4)
Public sex environment (PSE) user	13 (8.4)
Inmates	3 (1.9)
Homeless	2 (1.3)
Other**	9 (5.8)
Not determined	22 (14.2)

*Risk factors are not mutually exclusive.
**Other includes sexual assault/rape, occupational exposure, women who have sex with women, sex with someone who is HIV-positive.

When CCHD staff were asked about the implementation, staff reported that at the time of the training, the supervisor (who was new to HIV CTR) did not have a good understanding of the intervention until after the training. The decision to implement the 2-Session RESPECT model was unusual in that the decision was made by the outreach worker, as a result of lack of supervisory staff at the time to make the decision.

CCHD integrated the 2-Session RESPECT model within their STD clinic and their HIV counseling and testing site (HIV CTS). They have also had opportunities to incorporate some aspects of the 2-Session RESPECT model with outreach activities, with emphasis on getting clients to come into the clinic for counseling and testing services. Overall, staff at CCHD did not have difficultly implementing the 2-Session RESPECT model and noted that it became easier to administer the model over time. However, implementing the 2-Session RESPECT model in an STD clinic may be more challenging than implementing it in an HIV CTS, mainly because the primary reason for the visit differs. For instance, most HIV CTS clients go there specifically for HIV testing services and are thereby aware of HIV and are motivated to be tested. On the other hand, STD clinic clients mainly seek diagnostic and treatment services because they are symptomatic; thus, they may be less immediately concerned about HIV or motivated to be tested. In the latter case, it is incumbent on the provider conducting the STD exam to open a dialogue about HIV testing. Although this is easily accomplished according to one of the CCHD counselors, the entire session may take more time to conduct because counselors spend additional time educating clients about HIV testing, conducting additional clinical responsibilities, and completing additional paperwork.

Although each session generally takes between 20 and 30 minutes to complete, length may vary depending on numerous factors. As mentioned above, the setting in which the intervention is conducted may have implications for session length. Additionally, clients' familiarity with HIV and HIV testing may affect session length. For example, counselors may need to spend time informing and motivating clients about HIV and receiving the HIV test if they have not been tested before. Likewise, counselors at CCHD reported that Sessions 1 and 2 may be lengthier with less educated clients because of the need to explain more about HIV and what each test result means.

Likewise, the extensiveness of clients' individual risk histories may also affect session length. It may take counselors additional time to summarize risk patterns of clients who engage in multiple HIV risk behaviors and to develop their risk reduction step.

The length of Session 2 also depends on whether counselors are providing HIV-positive or HIV-negative test results. Most counselors realize that it is difficult to predict how clients will react to hearing a positive test result and that it could take up to an hour to provide the result and counsel a client. For example, some clients might have difficulty understanding the meaning of a positive result or may take more time absorbing its meaning, particularly if they were anticipating testing negative. Thus, the counselor may have to take more time to explain the meaning of test results or deal with the emotional and psychological issues that may arise. Additionally, providing the positive test result may run slightly longer depending on states' partner notification and referral system requirements.

2-Session Model Modifications

Although the 2-Session RESPECT model was initially found to be effective with HIV-negative heterosexual persons who sought STD testing and whose main risk for HIV was through sexual transmission, CCHD staff involved with the intervention administered it to all persons they saw in the STD clinic and HIV CTS, with some exceptions. For example, they did not administer the intervention to persons who sought STD or HIV services related to sexual assault or rape.

CCHD counselors reported that, although they covered all of the model's core elements, they found the protocol prompt order "awkward" and felt it was necessary to adapt the order of protocol prompts to meet their clients' needs. For example, to break the ice with a particularly shy client, counselors at CCHD may have asked them what brought them in for testing before orienting them to the session. As one counselor stated, "The key is to make sure [the client] understands that you are interested in them." CCHD staff felt strongly that reordering the protocol prompts in this way increased clients' comfort level, which ultimately led to more honest sharing during counseling sessions.

CCHD staff also modified Session 2 if staff who were not implementing the 2-session model conducted the pretest counseling session. If staff who were not implementing the 2-session model (non-RESPECT staff) conducted the pretest counseling session but the posttest counseling session was

scheduled with staff trained in the 2-session model, the "RESPECT" staff spent more time at the beginning of Session 2 getting to know the client and their risk patterns before implementing the intervention.

Quality Assurance (QA)

CCHD staff participated in formal and informal QA activities. Their formal QA activities included participating in training and continuing education, observing counseling sessions 1 day per week, and completing QA forms. Both CCHD and FCDPH participated in the initial 2-day training. RTI provided CCHD with on-site continuing education on delivering test results to HIV-positive persons during Session 2. RTI also provided on-site training to one FCDPH staff person who was unable to attend the initial training. CCHD intervention staff observed each other conduct counseling sessions once per week, and they routinely completed the QA checklists for Sessions 1 and 2 (See **Appendix B**).

CCHD staff also reported that they met daily for informal debriefing sessions throughout the evaluation period. They used this daily meeting time to discuss any issues that arose during the day and to problem-solve as necessary.

Barriers to Implementation

As mentioned previously, one barrier CCHD experienced occurred when non-RESPECT staff conducted the pretest counseling session and RESPECT staff conducted the posttest counseling session. CCHD RESPECT counselors compensated for this by spending the first few minutes of the posttest counseling session getting to know the client and their risk histories before implementing Session 2. Although this now occurs less frequently, this example illustrates the importance of widespread adoption of the intervention by an agency or program for it to be delivered efficiently.

FCDPH experienced a range of barriers as they prepared to launch the 2-Session RESPECT model, including hiring and training new staff, their involvement with planning and implementing a legislative conference, the recent dismantling of a key community-based organization, and other internal responsibilities.

CCHD encountered some situations in which the intervention took longer than anticipated, but overall, the intervention could be conducted within 20 to 30 minutes. Additionally, CCHD staff reported that, as they gained familiarity with the intervention, they were able to move through it more quickly.

Another concern expressed by FCDPH was that the intervention was "very script oriented, which feels unnatural and does not allow for easy conversation." CCDH staff felt similarly about the flow of the intervention initially, but with minor adjustments to the order of protocol prompts, they became more comfortable with the format and relied less and less on the script as their comfort level with the intervention increased.

Both CCHD and FCDPH staff also questioned whether the 2-Session RESPECT model could be successfully implemented in a large HIV CTS, particularly because it may take more time to conduct the 2-Session RESPECT model than a standard HIV CT session. For example, CCHD noted that the intervention worked well for them because their caseloads were light enough to accommodate sessions that ran over their allotted time.

Staff Reaction to 2-Session RESPECT Model

In general, CCHD staff were very positive about the intervention and indicated their preference for 2-Session RESPECT model in lieu of the traditional counseling, testing, and referral training. Both counselors agreed that the counselor cards and script were very useful and that the counselor cards were an effective and unobtrusive means of ensuring that they covered all of the core elements during sessions. The supervisor in particular was a strong proponent of the counselor cards because she had not conducted HIV counseling and testing prior to implementing the 2-Session RESPECT model. As they told us, "RESPECT is an invaluable resource" and "offers a safety net so all important issues are covered."

Although they did not implement the intervention, FCDPH staff were also positive about the intervention. They agreed that the 2-Session RESPECT model "provides a solid foundation for risk reduction," and they planned to implement the intervention once their staffing issues were resolved. Further, the supervisor reported that she believes the intervention enables clients to

problem-solve and to develop partner negotiation skills and facilitates a compassionate and effective posttest counseling milieu for providing HIV-positive test results, as did CCHD staff.

Client Reaction to 2-Session RESPECT Model

CCHD staff reported that roughly 55 to 60 percent of clients receiving Session 1 returned for their test results, and 85 percent of those who returned carried out their risk reduction step. Additionally, staff noted that more people have asked for condoms since they began implementing the 2-Session RESPECT model. CCHD counselors told us that clients have been very responsive to the 2-Session RESPECT model, perhaps because the model makes them feel more cared about and engenders greater trust between the client and the counselor, thereby facilitating more open sharing about risk behaviors.

Health Department and Prevention Training Center Representative Reactions to the Pilot Training

Several trainers from state health departments and Prevention Training Centers (PTCs) attended the 2-day training in May, 2003. Through their comments, the following suggestions were provided for the training manual and the training:

- Include in the introductory information on the 2-Session RESPECT model information on adapting the model to state, local, and agency requirements and how the model fits in with other HIV CTR activities.
- Provide more information on how the 2-session model may benefit agencies and clients.
- Provide more guidance and training on quality assurance.
- Discuss the core elements throughout.
- Review basic counseling concepts and skills.
- Use a script from the original Project RESPECT research to demonstrate the counseling method.
- Model the counseling in sections.
- In both the manual and the training, discuss the differences between traditional counseling and the RESPECT model of counseling.

- Add the positive protocol into the training and allow time to model it.

Additionally, after revising the training with assistance from the California Prevention Training Center in March 2004, another pilot training was conducted and the following suggestions were made:

- Focus the training on the manual's guidance sections to describe each component.
- Provide more guidance for framing the video as a learning tool.
- Develop prompt sheets for counselors to follow as an option to the counselor cards.
- Allow agencies to adapt the model with more flexibility.
- Discuss embedding the intervention towards the end after participants have discussed the model in-depth.
- Focus the training on the content of the model and less on the research.
- Define client-centered versus client-focused.

COST-EFFECTIVENESS

Because the 2-Session RESPECT model is a replacement intervention, designed to supplant existing counseling and testing protocols, its replication costs depend in large part on the type of program that is replaced. If a center is currently using a labor-intensive, lengthy counseling and testing protocol, the cost of the 2-Session RESPECT model may be lower. Conversely, the 2-Session RESPECT model may be relatively more costly in counseling and testing centers that routinely administer quick test results with less emphasis on counseling.

To enhance the usefulness of this cost analysis, costs are presented in terms of start-up and maintenance costs, program intervention costs, and quality assurance and evaluation costs. Where possible, costs are presented in terms of per session costs. These costs should be compared to the costs of any existing counseling protocol to determine the marginal (relative) cost of the 2-Session RESPECT model.

Start-Up and Maintenance Costs

Start-up costs for the 2-Session RESPECT model in Craven County were very low. The 2-Session RESPECT model's start-up costs consisted of obtaining two of the 2-Session RESPECT model packages, a video, and the time for staff to familiarize themselves with these materials. The economic cost of the packages was $173.70 per package for a total of $347.40. For Craven County, these materials were provided by CDC, so the cost to the health department for these materials was $0.

Other costs of the 2-Session RESPECT model intervention in Craven County involved expenses that were diverted from former interventions, rather than newly allocated to the 2-Session RESPECT model. Craven County used the same examination and counseling rooms used for existing counseling and testing interventions. Some of the 2-Session interventions took place in Craven's STD clinic examination room, while others took place in Craven's existing counseling and testing office. In both instances, no new space resources were allocated for the 2-session model that were not already in use for counseling and testing purposes.

The 2-Session RESPECT model did not require the use of additional telephone and mail services above and beyond the normal services used by the clinic prior to implementing the 2-Session RESPECT model.

Program Session Labor Costs

In total, CCHD administered 155 intervention episodes (90 Session 1 and 65 Session 2 sessions). CCHD staff devoted 93 total hours to the 2-Session RESPECT model counseling and testing sessions; 22 hours by the supervising nurse and 71 by the counselor. On average, each session required 36 minutes of staff time to complete. The supervising nurse conducted 36 sessions, and the counselor conducted the remaining 118. Due to data limitations, for this analysis we have assumed that the time required for the 2-Session RESPECT model sessions required did not vary by personnel type.

Assuming an average hourly wage for counselors in Craven County, NC, of $15.24 and a wage of $21.07 for supervisory

nurses,[2] the total labor cost of the 2-Session RESPECT model was $1,683 for 155 sessions during a 4-month period (**Exhibit 3**). Applying a fringe benefit rate of 25 percent, the full labor cost of the 2-Session RESPECT sessions was $2,103 for the four month period, or $13.57 per session.

Exhibit 3. Per Session RESPECT Intervention Labor Costs Per Session

	Hourly Wage	Average Minutes per Session	Cost per Session	Cost per Session + Benefits*
Supervisor	21.07	36	12.64	15.80
Counselor	15.24	36	9.14	11.43
Total**	18.10	36	10.86	13.57

*Assumes a fringe benefit rate of 25%
**Total hourly wage is the weighted average of the cost of supervisor and counselor time

Quality Assurance and Evaluation Costs

CCHD also incurred costs related to quality assurance and evaluation activities. Over the 4-month period, the counselor and supervisor devoted a total of 34.65 hours to quality assurance and evaluation—approximately one half day's work per employee per month. The number of hours devoted to these activities was similar between the supervisor (18) and the counselor (16.65). Because the supervisor conducted fewer 2-Session RESPECT sessions than the counselor, we assume the quality assurance and evaluation tasks completed by each were different. Given this assumption, it makes sense to present the work each devoted to quality assurance and evaluation in terms of minutes per session, with the session denominator being the total number of intervention episodes (155). The supervisor spent an average of 6.96 minutes per session on quality assurance and evaluation, compared to 6.44 minutes by the counselor.

Because the share of this work was more heavily weighted toward the supervisor, the weighted hourly cost for quality assurance and evaluation ($18.27) was slightly higher than the weighted hourly cost for counseling ($18.10) (**Exhibit 4**). Multiplying the average hourly wage by the 34.65 total hours spent on quality assurance and applying a 25 percent fringe benefit rate, the total labor cost to Craven County for these efforts was $791; a cost of $5.11 per session.

[2]U.S. Bureau of Labor Statistics, www.bls.gov.

Exhibit 4. Monthly Quality Assurance and Evaluation Costs for the 2-Session RESPECT Model

	Hourly Wage	Minutes per Session	Cost per Session	Cost per Session + Benefits*
Supervisor	21.07	6.96	2.44	3.05
Counselor	15.24	6.44	1.64	2.06
Total**	18.27	13.4	4.08	5.11

*Assumes a fringe benefit rate of 25 percent
**Total hourly wage is the weighted average of the cost of supervisor and counselor time

Total Costs

Total costs for the intervention were calculated simply by summing the totals from the different components (**Exhibit 5**). These costs are presented in terms of costs per the 2-Session RESPECT model session and client. Overall, the 2-Session RESPECT model in Craven County cost $3,252 over 4 months; a cost of $20.99 per session, or $36.14 per client. Of these costs, 65 percent were labor costs spent on direct patient counseling session, 24 percent were labor costs spent on quality assurance and evaluation, and 11 percent was the cost of startup materials (paid for by CDC).

Exhibit 5. Total Costs of the Craven County the 2-Session RESPECT Model

Type of Cost	Total Craven County Cost	Per Session Costs (N = 155)
Start-Up and Maintenance	357	2.31
2-Session RESPECT Sessions	2,103	13.57
Q&A and Evaluation	791	5.11
Start-Up and Maintenance	357	2.31

Sources of Cost Variations

It is important to emphasize that the costs presented represent those found in one public health clinic in Craven County, North Carolina. Costs of implementing the 2-Session RESPECT model in other areas of the country may vary based on regional and facility differences. Some of the potential sources of variation are listed below.

Labor Costs: The hourly wage estimates used for the supervisory nurse and the counselor were drawn from the Bureau of Labor Statistics information for eastern North Carolina (**Exhibit 6**). The national average for these positions is higher than that used in the analysis, and labor costs vary widely nationally. In addition, costs in Craven County were estimated using a registered nurse as the supervisor and a public health social worker as the counselor. Local variations in costs will be driven by the use of more or less skilled labor, for example the substitution of higher-cost physicians for supervisors or lower-cost counselors for social workers.

Exhibit 6. National Hourly Wages for Positions Compared to Those in Craven County

	National 10th Percentile	Craven County	National Median (50%)	National 90th Percentile
Registered Nurses	16.33	21.07	23.12	33.50
Medical and Public Health Social Workers	11.46	15.24	17.97	27.08

Facility Space: This analysis did not include facility costs because at CCHD, the 2-Session RESPECT model was replacing an existing counseling session. The space used for the intervention at CCHD was used for HIV counseling and testing and STD diagnostic and treatment purposes prior to implementing the 2-Session RESPECT model. Thus, the intervention did not require any new facility costs. It is possible that in other settings, the 2-Session RESPECT model might be added in addition to existing counseling sessions or require additional space in which to conduct the intervention. In these instances, the regional cost of the number of counseling rooms needed to meet the demand of the center should be included to obtain an accurate estimate of program costs.

HIV Prevalence: In 2003, Craven County reported a population rate of previously undetected HIV diagnoses of 28.3 per 100,000. HIV prevalence among a facility's clients will likely influence the cost of the 2-Session RESPECT model. For example, sessions in which clients are informed that they are HIV-positive may take longer than sessions in which patients are informed of negative results. Therefore, the higher the HIV prevalence in a facility, the

higher both the average session and client cost of the 2-Session RESPECT model is likely to be.

Size of Intervention: HIV counseling and testing comprises a relatively small proportion of services delivered at CCHD, with the intervention delivered to approximately 22 clients a month. Many counseling and testing facilities operate on a much larger scale than this and may see that number of clients (or more) in a single day. The greater the demand for counseling and testing services in a center, the more experienced staff will become with the 2-Session RESPECT model, and the more efficiently the 2-Session RESPECT model will be conducted. In larger centers with higher demand, the costs of the 2-Session RESPECT model per client should decrease over time.

Age of the Intervention: Longer-duration interventions are likely to experience lower costs than shorter-duration interventions. The longer an intervention is in operation, the more clients it sees, and reducing the proportion of cost that startup materials represent. The startup costs at CCHD represented 11 percent of total costs. Assuming that the number of clients seen remains stable and the same labor costs for the length of an entire year, the startup costs drops to 3.5 percent of total costs. In addition, much of the administrative Quality Assurance and Evaluation costs of the 2-Session RESPECT model were incurred early in the process. The longer an intervention is in operation, the lower these costs should be.

This cost analysis is limited by the following factors:

1. Estimated wages from the bureau of labor statistics were used in place of actual salary figures from Craven County.
2. Because the 2-Session RESPECT model is a behavioral intervention to be used with an existing HIV testing program, no costs of HIV testing were included.
3. Because of data limitations, we assumed that the 2-Session RESPECT model sessions conducted by the supervisor took the same amount of time as those conducted by the counselor. Because the supervisor's time is more costly than the counselors, longer sessions by the supervisor relative to the

counselor could be expected to increase the cost estimates in this analysis.

4. Because of data analysis, we were not able to distinguish between the length of first and second sessions, nor between second sessions where the patient was HIV-positive verses HIV-negative. Our inability to calculate this information does not affect the cost results for Craven County, but does hinder efforts to exactly translate these results to other settings.

Changes to the Final Package

As a result of piloting the package at the two sites, review by the original researchers, the pilot training feedback, and feedback from the community advisory board, the following changes were made to the manual:

1. The 2-session manual used the most recent version of the protocol from the RESPECT-2 study. RTI incorporated some of the modifications made to the 2-session manual to the 4-session manual. Specifically, RTI developed of protocol prompts and example dialogue for the 4-session manual.
2. The 2-session model includes information for discussing HIV risk with people who inject illicit drugs.
3. The introductory section of the manual contains more information on how to imbed the model into an organization's other services.
4. We revised the core elements slightly. Specifically, in the initial training, one of the core elements stated that counselors should follow the protocol script. Counselors found this too difficult to follow and focus on the client's needs at the same time. The manual was modified to distinguish between the example dialogue (example dialogue the counselors can use if they choose to), the protocol prompts (key points to discuss that a counselor should review), and the protocol components (overarching topics the counselor must review). Eventually, it was agreed that the core element was to follow the protocol components.

5. At the suggestion of CDC, RTI included a protocol for providing the HIV-positive test result and training materials for the positive test result.

6. RTI substantially modified the training with direction from the California Prevention Training Center and CDC. RTI modified the training in the following ways:

   6.1. The approach is more interactive for participants as a result of suggestions from multiple training participants and the California Prevention Training Center.

   6.2. As appropriate, we included reviews of counseling concepts and skills as suggested by CDC.

   6.3. RTI increased the time and guidance on quality assurance. The original 2-day training did not provide enough time to review quality assurance well enough for supervisors and counselors.

   6.4. RTI modified the introduction of the RESPECT model to better frame the RESPECT model for participants. Many are counseling in a similar, but not the same manner. Participants in the original training reported resistance to the focus on following the protocol as it was researched.

   6.5. Demonstration of the model is conducted by sections, the first three components, the second three, and the last two for Session 1. The first three components for Session 2 were demonstrated together. Participants had difficulty reviewing one component at a time and wanted to continue further into the demonstration and as a result, we modified it to be demonstrated in sections.

   6.6. RTI with assistance from CDC and the California Prevention Training Center changed the script for the demonstration. At the suggestion of CDC, a script from the RESPECT-2 study's research was used. It is a mock session between two trained counselors.

   6.7. At the suggestion of CDC, RTI modified the example dialogue in the counselor cards and manual to include selected dialogue from the demonstration script. The

purpose of this change was to facilitate learning the protocol by following the video with the counselor cards.

6.8. RTI added additional training and information on providing the HIV-positive test result to the training curriculum. Additionally, the training also includes modeling the positive test result. A script demonstrating the HIV-positive protocol was added at the suggestion of CDC. The HIV-positive protocol script came from a site in Texas.

Recommendations

TYPES OF AGENCIES AND TARGET POPULATIONS FOR WHICH THE RESPECT PACKAGE WOULD BE APPROPRIATE

The RESPECT HIV Prevention Counseling models were effective for HIV-negative heterosexuals who came to a clinic for STD testing and whose main risk for HIV was sexual transmission. These counseling models have not been studied in other populations. However, because they use a client-focused counseling approach and include a personalized risk assessment and development of a personalized risk-reduction step, they can be easily adapted and tailored to different HIV testing settings for a variety of populations. In other words, the RESPECT models can be offered to all persons at risk for HIV who seek testing in any setting, including traditional clinic settings and nontraditional settings, such as community-based or outreach venues. Similarly, because each model includes a protocol with specific prompts, it helps the counselor cover all important pieces of the protocol while ensuring that the counseling will be acceptable to target populations.

The counseling models can be effective with all people at risk for HIV through sexual transmission and/or injection drug use. Further, although the effectiveness of the intervention for use with HIV-positive persons has not been studied, the 2-session and the 4-session manuals include counseling protocols for delivering positive test results to clients. Finally, the 4-session protocol can be tailored to clients whose test result is positive.

The RESPECT intervention can also be used in field settings, by community-based organizations and local health departments alike.

TAILORING THE RESPECT PACKAGE FOR OTHER AGENCIES AND POPULATIONS

Because the RESPECT counseling models are intended to be offered along with HIV testing, they are often imbedded within a service called "counseling and testing." As recommended by CDC guidelines, these services often include additional components such as consenting processes, referral processes, partner notification services, and individual or group education programs. In addition, local laws and organizational policies regulate provider programs. To effectively use the 2-session and 4-session models, providers are encouraged to imbed the counseling protocol within their service or program in a way that minimizes disruption of services and changes to the protocol.

Agency and clinic environments may differ from the research conditions under which the RESPECT models were tested. Therefore, providers may need to adapt the counseling model to meet client and agency needs, while keeping the core elements of the model intact.

Lessons Learned

During the process of developing the intervention package, training, and implementation of the intervention, RTI learned the following lessons.

1. The replication of research may benefit from using the same team of original researchers to perform the replication of the package. If the original researchers replicate the project, the team already has a substantial amount of knowledge about the intervention, thereby saving time and misunderstandings about the intervention.

2. The replication of the research may benefit from using parties other than the original researchers. An outside organization may consider new issues that the original researchers would not have considered because of being intimately involved. For example, the definition of how much to follow the protocol needed to be clarified during the development of the package. While the original researchers had a specific idea, it was never described until later in the process. As another example, original researchers may not have an understanding of the real-life constraints that community-based organizations and health departments have. In some cases, changes needed to be made to the protocol to allow for more flexibility.

3. If an outside agency or organization replicates another researcher's research, it is helpful to have strong connections between the two. Ideally, the original researchers should be added as consultants or subcontractors prior to beginning the project.

4. Ensure that the pilot sites' state approves of the study. While RTI was conducting several research studies relating to HIV in the State of North Carolina, it wasn't until after the initial pilot training that RTI discovered the need for state approval for piloting RESPECT.

5. Piloting the training improves the final training curricula. Each of the iterations of piloting the training provided valuable information about what needed to be changed to the final curricula.

6. Involve organizations with experience in dissemination to the target audience from the beginning of the project. If the focus of the project is to replicate effective interventions, it may be helpful to work with organizations who train in the substantive area regularly, such as prevention training centers. These organizations typically have a good understanding of issues that agencies may have with an intervention, which original researchers may not have or may not attend to. By working with a prevention training center, original researchers or other entities may receive and be able to resolve a wider variety of implementation issues than issues brought up from the few and usually local pilot sites.

7. Depending on the type of replication package, it may be helpful to include meetings with state departments of health which are often responsible for disseminating interventions. As an alternative, it may facilitate the dissemination if replicating organizations or CDC provided information on upcoming replicated interventions to state departments of health.

8. Include more in-person meetings with the technical monitor and other appropriate CDC team members. To ensure that the intervention package follows CDC guidelines for replication and other CDC policy guidelines, it may help the replicating organization to increase the number of in-person meetings. RTI found the in-person meetings useful for clarifying CDC policies and how they corresponded with the original intent of the research protocol.

9. Finalize the format of the deliverables at the end of product development to decrease costs. Costs were incurred as a result of changing back and forth from Word and Quark. It may be helpful to develop all initial deliverables in Word or some other similar word processing package and, 3 months prior to the end of the project, have the products formatted in a design software package for production. Products in color are far more costly to reproduce in Word than in designing software such as Quark, which allows colors to be layered.

10. Consider using the video as a marketing tool. While the overview provides some information about the model, it may be helpful for potential users to see the counseling in action to understand it better.

11. Increase access to the package by placing it on the CDC website. The overview provides a general outline and it may be helpful for potential agencies if supervisors and/or staff review the manuals to gain a better understanding of the model. Training supervisors and counselors in the models is important to the fidelity of the intervention, by placing it on-line, potential or current providers can access it easily. For potential providers, easy access to the package may motivate them to have their staff trained in the model(s). For current supervisors, if there is staff turnover, this would allow them to obtain information on RESPECT that they may not be immediately able to receive.

Appendix A: Documentation of Intervention Episodes Form

Documentation of Intervention Episodes*

DATE _____ **Are you (check one):** ☐ **Volunteer** ☐ **Paid Staff**

SITE _____ **ZIP CODE** _____

CONTACT TYPE
(Total number of sessions)

_____ Brief Intervention Session 1

_____ Brief Intervention Session 2

Other _____

SETTING
How many counseling sessions took place in:

Health Department Setting _____

Field Setting _____

(Please Specify _____)

Other _____

LANGUAGE
(mark all that apply)

❑ English

❑ Spanish

Other _____

Other _____

SEX/GENDER

Total Participants = _____

Females= _____

Males= _____

Not determined= _____

❑ Actual Counts ❑ Estimate

ESTIMATED # TRANSGENDER= _____

AGE
(Total should equal "Total Participants" in Sex/Gender section.)

19 and younger _____

20–29 years _____

30–39 years _____

40–49 years _____

50 and older _____

not determined _____

❑ Actual Counts ❑ Estimate

*** To be faxed to RTI each week. Please direct fax to Lori Hill, telephone (919) 541-1288, fax (919) 541-6683, email lch@rti.org. Thank you.**

Documentation of Intervention Episodes* (continued)

RACE/ETHNICITY ***(Fill in number of participants in the space provided.*** ***Total should equal "Total Participants" in Sex/Gender Section.)***	**TARGET CHARACTERISTICS** ***(Fill in number of participants in the space provided.*** ***Clients may be counted under more than one heading.)***
AFRICAN AMERICAN= _____ AMER. IND./ALEUT/ESK.= _____ ASIAN/ASIAN AMERICAN= _____ LATINO= _____ WHITE= _____ OTHER= _____ OTHER= _____ ❑ Actual Counts ❑ Estimate	IDU= _____ MSM= _____ MULTIPLE SEX PARTNERS= _____ SEX PARTNER OF IDU= _____ ALCOHOL/DRUG USERS=_____ HOMELESS= _____ INMATES= _____ PROSTITUTES= _____ PSE USER= _____ NOT DETERMINED= _____ OTHER 1= _____ OTHER 2= _____ ❑ Actual Counts ❑ Estimate
SEXUAL ORIENTATION ***(Fill in number of participants in the space provided. Total should equal "Total Participants" in Sex/Gender section.)*** BISEXUAL= _____ HETEROSEXUAL= _____ GAY/LESBIAN= _____ NOT DETERMINED= _____ ❑ Actual Counts ❑ Estimate	**TYPE OF HIV TEST** ***(Please enter the number of each type of HIV test used with RESPECT participants)*** STANDARD BLOOD DRAWN= _____ ORASURE= _____ RAPID= _____ OTHER= _____ ❑ Actual Counts ❑ Estimate

LABOR HOURS

Use the table below to report an estimate of the labor time devoted to RESPECT for all employees, contract providers, and volunteers who worked on RESPECT during the week.

Job Title	**Total Hours** worked on RESPECT per week	**Quality Assurance Hours** Of Total Hours, number of hours spent on RESPECT Quality Assurance activities per week	**Process Evaluation Hours** Of Total Hours, number of hours spent on RTI Process Evaluation Activities (such as completing this form) per week
(Example) Counselor	*35*	*5*	*1.5*

Appendix B: Quality Assurance Forms

Quality Assurance Form for RESPECT Session 1

Counselor Name _____ **Type of QA**: Tape Observation

Reviewer Name _____

Date of Observation _____ **Session Start Time** _____

Client ID _____ **Session End Time** _____

Session 1 Protocol Activities	Not Achieved	Achieved	N/A
Introduce and orient client to the session			
Introduce yourself to client			
Explain role of counselor			
Indicate the duration of session			
Outline content of session			
Provide referrals			
Discuss activities (lab work) with client			
Address immediate questions and concerns			
Enhance the client's sense of self-risk			
Find out why client has come for HIV testing			
Listen for and identify behaviors that put client at risk			
Assess client's level of concern for getting/having HIV			
Discuss client's HIV test history and prior behavior changes			
Assess whether client is engaging in risky behavior because of previous HIV negative test result			
Direct the client's attention toward risk behavior			
Discuss examples of conflicts between beliefs and behavior			
Explore the specifics of most recent risk incident			
Explore the who, what, when, where, how of recent risk incident			
Assess level of risk acceptable to client			
Assess communication about HIV with partner(s)			
Identify circumstances or situations that contributed to risk incident			
Identify risk vulnerabilities and triggers to the risk behavior incident			
Discuss examples of conflicts between client's beliefs and behavior			
Review previous risk reduction experience(s)			
Assess the client's pattern of risk behavior			
Identify successful attempts at practicing safer sex			
Identify obstacles to risk reduction			
Explore triggers and situations that increase the likelihood of high-risk behavior			
Assess client's communications about risk with friends and partners			
Discuss the client's level of acceptable risk			
Discuss examples of conflicts between client's beliefs and behavior			

Quality Assurance Form for RESPECT Session 1 (cont.)

Session 1 Protocol Activities (cont.)	Not Achieved	Achieved	N/A
Summarize risk incident and risk patterns			
Provide feedback about client's risk for HIV			
Summarize the information the client has provided			
Note the pattern of risk behavior			
Identify triggers and things that make the client vulnerable			
Discuss examples of conflicts between beliefs and behavior			
Convey concern and urgency about the client's risks			
Support and encourage client in addressing risk issues			
Negotiate risk-reduction step			
Prioritize risk-reduction behavior			
Explore behavior(s) that client will be most motivated about or capable of achieving			
Identify a reasonable, yet challenging, step toward changing the behavior			
Break down the risk step into specific, concrete actions			
Problem-solve obstacles to step			
Role-play the step (if applicable)			
Identify support for risk-reduction step			
Confirm with the client that the step is reasonable and acceptable			
Acknowledge that the step is a challenge. Inform client the step will be reviewed/revised at the next session			
Ask client to be aware of strengths and weaknesses in the step			
Document the risk-reduction step, keeping a copy for yourself			
Identify sources of support and provide referrals			
Assess the client's support system			
Address the long-standing or tough-to-manage issues that contribute to risk			
Assessed client's willingness to seek professional help or use a referral			
Evaluate the types of referral the client would be most receptive to			
Provide appropriate referrals			
Close the session			
Review follow-up schedule			
Identify ways for the client to remember follow-up appointment			
Review contact information for the client and the counselor			
Proceed with organization's guidelines to obtain specimen for HIV test			

Quality Assurance Form for RESPECT Session 1 (cont.)

Comment on counselor's maintenance of core elements and items checked as "Not Achieved."

Quality Assurance Form for RESPECT Session 2: Negative Test Result

Counselor Name _____ **Type of QA**: Tape Observation

Observer Name _____

Date of Observation _____ **Session Start Time** _____

Client Number _____**Session End Time** _____

Session II Protocol Activities	**Not Achieved**	**Achieved**	**N/A**
Provide negative test result			
Welcome the client back			
State result clearly and simply			
Review meaning of the result			
Assess client's reaction to result			
Note the need to consider test result in terms of the most recent exposure			
Review the risk-reduction step			
Assess client's efforts to try out the risk-reduction step			
Provide encouragement and support for client's risk-reduction efforts			
Identify supports for and barriers to risk-reduction step			
Problem-solve issues with step			
Revise the risk-reduction step			
Revise or develop a new risk-reduction step			
Discuss a more challenging step or revise previous step			
Identify or clarify actions to achieve the step			
Confirm with the client that the step is reasonable and achievable			
Document the revised risk-reduction step and give copy to client			
Identify sources of support for the risk-reduction step			
Emphasize importance of client discussing with a trusted friend/relative the intention and content of step			
Identify a person to whom the client could comfortably disclose the step			
Establish a concrete, specific approach for client to use in sharing the step with friend/relative			
Ask client be aware of strengths/weaknesses when trying it out			
Let client know you have confidence in his or her ability to complete the step			
Provide referral and end session			
If a referral was provided in previous session, follow up on the client's completion			
Address long-standing or hard-to-manage issues that contribute to risk			
Assess the client's willingness to seek professional help and use a referral			
Evaluate types of referral			
Provide appropriate referral			
Provide closure			

Quality Assurance Form for RESPECT Session 2: Negative Test Result (cont.)

Comment on counselor's maintenance of core elements and items checked as "Not Achieved."

Quality Assurance Form for RESPECT Session 2: Positive Test Result

Counselor Name _____ **Type of QA**: Tape Observation

Observer Name _____

Date of Observation _____ **Session Start Time** _____

Client Number _____ **Session End Time** _____

Session II Protocol Activities	**Not Achieved**	**Achieved**	**N/A**
Provide positive test result			
Welcome the client back			
Re-explain confidentiality			
Verify the result belongs to the client			
Assess the client's readiness to receive the result			
Provide the result clearly and simply			
Allow client time to absorb meaning of test result			
Explore client's understanding of the meaning of the result			
Assess how client is coping with result			
Address immediate concerns and fears			
Acknowledge the challenge of dealing with a positive result			
Identify sources of support and provide referrals			
Assess whom client would like to tell about his/her positive test result.			
Identify person, family member or friend to help the client through the process of dealing with HIV (coping and support, planning for the future, medical follow-up)			
Discuss wellness strategies			
Identify current health care resources			
Address the need for health care providers to know client's test result			
Explore client's access to medical services (STD exam, routine medical care, TB screening)			
Identify needed medical referrals			
Assess client's receptiveness to referral			
Help client access referral services			
Address risk-reduction issues			
Refer to client's risk-reduction step.			
Assess client's plan to reduce risk of transmission to current partners			
Explore client's plan for reducing the risk of transmission to future partners			
Address disclosure of HIV status to current and future partners			
Encourage the client to protect others from HIV			
Summarize and close the session			
Validate client feelings			
Summarize key issues addressed			
Review contact information and arrange for follow-up			
Get the client's plans for the next step			
Close session			

Quality Assurance Form for RESPECT Session 2: Positive Test Result (cont.)

Comment on counselor's maintenance of core elements and items checked as "Not Achieved."