WEBINAR VIDEO TRANSCRIPT

DHHS / Health Resources and Services Administration (HRSA)

Addressing STIs: Ask. Test. Treat. Repeat.

29 June 2023

ANGEL JOHNSON: Good afternoon or good morning, depending on where you are today. Welcome to the Integrating HIV Innovative Practices webinar on replicating innovative HIV care strategies and the Ryan White HIV/AIDS program.

Today's webinar features only one intervention, which focuses on innovative HIV care strategies to address HIV and STIs. I'm Angel Johnson with the MayaTech Corporation. I'll be moderating this webinar. Before we meet the presenters, we'll review some housekeeping guidance and go over the webinar logistics and the agenda and get a brief overview of the SPNS IHIP project from our project director Shelly Kowalczyk.

So before we hear from our speakers, Shelly will give a brief overview about the SPNS IHIP had project. Next, our presenters will talk about their intervention. Following the presentation, we'll do a Q&A. And then finally, I'll give more detail and how to give your feedback on today's presentation.

Shelly?

SHELLY KOWALCZYK: Great. Thanks, Angel. Hi, everyone. I'm Shelly Kowalczyk. Thanks for joining today's webinar sponsored by the Ryan White HIV/AIDS program. The integrating HIV Innovative Practices, or IHIP project, supports the coordination, dissemination, and replication of innovative HIV care strategies in the Ryan White HIV/AIDS program. And this project is in this last component of the SPNS framework as we are developing implementation tools, resources and facilitating the delivery of capacity-building technical assistance.

IHIP is also meant to align with HRSA's Best Practices compilation. So you'll find that many of the interventions that we highlight through, IHIP. You can find our resources on the Best Practices website. And if you go to the Best Practices Compilation website, you can also find that there tools and resources are also linked back to the IHIP page. So you can find them in either place.

So key support that we provide includes, as I said, we develop intervention implementation guides. We have fact sheets, frequently asked questions. And we're also doing video spotlights this project. So you can find all of those on our website. Today's webinar is part of TA provision in which we use our peer-to-peer TA, having the interventionists themselves talk about the interventions.

We also support providers in the development and dissemination of their own tools and resources. So we have facilitated some webinars. And we have one more coming up at the end of July. And then we also offer one--on-one support. So any of our tools and resources can be found on TargetHIV.org/IHIP. And that includes all of the webinars that are recorded.

And then if you need assistance or have more questions for us, feel free to email IHIP helpdesk at Mayatech.com.

ANGEL JOHNSON: Please note that the opinions expressed during this presentation are those of the presenters and do not necessarily represent the views of the webinar sponsors and planners. And information presented is not meant to serve as a guideline for patient management. Additionally, our presenters have nothing to disclose and no conflicts of interest.

So now it's time to meet our presenters. Our presenters for today's webinar are Dr. Beth Gadkowski and Dr. Jennifer Janelle with the University of Florida College of Medicine. Dr. Janelle is an associate professor within the Division of Infectious Disease and Global Medicine and the Department of Medicine at the University of Florida in Gainesville. She currently serves as the University of Florida Adult Infectious Disease Fellowship program director and is a partner in the Southeast AIDS Education and Training Center.

Jennifer is board certified in infectious diseases. And her clinical interests include HIV, STDs, and other infectious diseases. Dr. Gadkowski is an associate professor at the University of Florida Division of Infectious Diseases and Global Medicine. In this role, she helps care for people with HIV at rural health department clinics and has a combined OB/HIV clinic where she helps care for pregnant people with HIV.

Beth is faculty with the Southeast AIDS Education and Training Center and a member of the Florida Department of Health HIV Section Medication Formulary Workgroup, which helps determine the Florida ADAP formulary. Now we're going to hear from Jennifer and Beth.

JENNIFER JANELLE: Dr. Gadkowski and I are both delighted to be here today to talk about a project that we were involved in. And the title of our presentation today goes with our project, which is addressing STIs-- Ask, Test, Treat, Repeat.

This project was supported by the Health Resources and Services Administration, or HRSA, of the US Department of Health and Human Services. In overview, we are going to be discussing the grant recipient sites and funding mechanism for the intervention. We're going to be addressing the needs and some priority populations that we considered in the study as well as going over the purpose, goals, and/or objectives of our intervention. And we're also going to be discussing our outcomes.

There is a huge epidemic of sexually transmitted infections that's been going on really worldwide. Over nearly for about the past decade, people who acquire sexually transmitted infections are at risk of acquiring HIV. And STIs can be markers of unsafe sexual practices.

So it's very important that we address sexually transmitted infections that we get good sexual health histories, test appropriately, make diagnoses when they're present, and treat and follow up not only to avoid the complications of the sexually transmitted infection that's being diagnosed, but also to address sexual health behaviors that could put people at risk of recurrent infections or HIV infection.

And this is from the CDC. And you can see that they have some priority populations, young people age 15 to 24, gay and bisexual men, pregnant people, and racial and ethnic minority groups. And you'll see in a few slides that these were also priority populations for our project. So we'll start with a case.

This case is of Mr. J, a 22-year-old man who comes in for his annual visit. As part of his annual visit, you obtain a sexual health history. You base your sexual health questions on the CDC's 5P approach which explores partners, practices, past histories of STIs, protection, and if there's a chance of pregnancy, the pregnancy and reproductive life plan.

So for Mr. J, you do obtain a sexual health history that shows that he has had four male partners since his last visit with an associated urogenital STI screen. He practices oral and anal receptive and insertive sex. Mr. J is not currently known to be HIV infected and is not on PrEP and inconsistently uses condoms for anal sex and does not use condoms for oral sex either.

And in terms of prior STIs, he had one episode of urogenital gonorrhea at age 20. Today, he comes in and he's feeling well. He's having no symptoms suggestive of a sexually transmitted infection. However, your sexual health history suggests risk for syphilis, gonorrhea, and chlamydia. We're thinking about bacterial sexually-transmitted infections. But you're also worried about the possibility of HIV infection.

In terms of testing, you're going to obtain an HIV test. And then in terms of testing for bacterial sexually transmitted infections, the recommended mucosal sites to be tested based on the sexual health history are the throat, rectum, and urogenital region. So you collect your samples. And you provide client-centered STI prevention counseling. Condoms are offered. And you discuss HIV pre-exposure prophylaxis. But you wait. Because this person could be at risk for HIV infection. And you indicate that you're going to discuss this further once the test results come back.

The test returns. And the oropharyngeal swab is positive for gonorrhea despite Mr. J having absolutely no symptoms to suggest infection in this region. And he also tests positive for HIV infection. He is treated with ceftriaxone, 500 intramuscularly. And antiretroviral therapy for HIV is immediately begun.

I think that this case really represents the concerns that we have with this increase in sexually transmitted infections putting people at risk for acquiring HIV and the importance of appropriate screening and testing regardless of symptoms. So we really want to be addressing the need for increased STI screening.

This rise of bacterial STIs across the United States is very concerning. And we have to remember that sexually transmitted infections can spread among people who are completely asymptomatic and can cause serious long-term health problems if left untreated. And sexually transmitted infections do increase the likelihood of HIV acquisition and transmission. So this is very important for both our patients who are at risk for HIV and those who actually have HIV infection.

When providers think about incorporating sexual health history, taking and appropriate testing into their clinical encounters, they often have a lot of concerns. We have a short time in the clinic to address many different components of that patient's health, not the least of which is their sexual health.

And so they have concerns about the amount of time it takes to obtain a good sexual health history, challenges efficiently obtaining the needed specimens. Some people have discomfort with addressing personal and sexual health topics. And some people are concerned that patients really don't want this. And bringing this up in clinic encounters is not going to be very welcome.

So our project really sought to determine if we can package some previously-proven strategies that have been shown to be effective in diagnosing and treating people for sexually-transmitted infections and if

they could be combined in a way that promoted acceptance of testing by clinic staff providers and patients with the flow that maintained clinic efficiency.

This study was done in Ryan White and Bureau of Primary Care Clinics and really focused on patients with or at risk for HIV. We did have priority populations. Our defined priority populations were young adults aged 18 to 29, men who have sex with men, transgender women, and racial and ethnic minorities as these populations are overrepresented in the HIV epidemic.

So we wanted to give you a quick overview of our project. We have a fantastic video that was created. And then we'll go back to some detail about the project and address some things that are not covered in the video.

[VIDEO PLAYBACK]

- When addressing Sexually Transmitted Infections, or STIs, Ask, Test, Treat, Repeat. It's a new campaign for health care providers to improve and make routine assessing, testing, treating, and following up with recommended STI screening and testing. Why? The incidences of bacterial STIs continue to increase. Since 2018, 1 in 5 Americans have had an STI on any one day.

According to the US Centers for Disease Control and Prevention, there are approximately 20 million new cases of STIs each year. Many people with STIs are asymptomatic. Why does this matter? Patients may not have symptoms to report. Providers may equate no symptoms with no STIs. STIs are spread without even knowing it. And having an STI may increase the risk of acquiring HIV.

But there is a solution. Ask, test, treat, repeat. How? Make your clinic a welcoming environment for people of all sexual and gender identities. Ask patients discreetly to share their gender and sexual identities and their sexual histories since their prior visits. Allow patients to collect their own extra genital chlamydia and gonorrhea test specimens since urine testing may not be enough. Train health care providers to make this the norm.

How do we know this works? We have the evidence. The results-- increased patient comfort and satisfaction, extragenital sites testing, asymptomatic STI identification, provider knowledge, and healthier patients and communities. Replicate what works. Ask, Test, Treat, Repeat. Visit targetHIV.org/STIs. Download materials and get started today.

[END VIDEO PLAYBACK]

JENNIFER JANELLE: So I thought it would be interesting to see what you guys think are the biggest barriers you face in screening patients for sexually transmitted infections. So we have a poll. So pick which answer kind of fits your barriers that you might face in screening for sexually transmitted infections. Is it the time to do a complete sexual health history? Is it comfort talking to patients about their sexual health, or concerns about insurance coverage for testing or treatment, or lack of access to appropriate testing materials or some other reason?

I've got my eye on the chat. So if you want to type something in there, that's fine. We'll see it. All right. I think most people agreed with some of the concerns that we had with this project and that was voiced by our project providers-- is the time to do a complete sexual health history. We really focused on that. And one of our interventions using an audio computer-assisted self-interview was very helpful in addressing that concern. Because they were able to do it kind of on their own independently.

Some people say concerns about insurance coverage for testing or treatment. And I know it's very challenging to do the tests in three-month increments and get that covered by insurance for our folks that are at risk for sexually transmitted infections.

So I think a lot of you guys had some of the same concerns. And then I see some things in the chat box. I see clients don't feel comfortable or find it necessary to receive services. And I think that's very true.

And one of the things that we can do as providers is really highlight that even asymptomatic people could have sexually transmitted infections. And those infections may not have been recently acquired they may have been around for a long time. So getting screened and tested, even if they believe themselves to not be at risk anymore, is very important.

Yeah, I see a comment that some people may get confused with terminology when asking them about their sex or sexual orientation, which doesn't necessarily answer who they have sex with. I think that's very true. So hopefully, as we look at some of the questions that we use through our ACASE, you can see kind of the words that we used in our project to address some of those issues.

So I wanted to give a brief overview of the grant and recipient sites. This project was HRSA-funded. It's a special project of national significance, the primary funding recipient was the Rutgers School of Nursing. They identified three jurisdictions which have a higher than average rate of sexually transmitted infections. So they reached out to Louisiana, Florida, and Washington DC as what they call their convener sites. And the convener sites selected three clinics that were either Bureau of Primary Health Care or were Ryan White-funded clinics in which to do the interventions.

So our nine clinics-- nine clinics were Ryan White HIV program clinics. We had some Bureau of Primary Health Care clinics. And these were a mix of rural and urban clinics. Some were in bigger cities. And some were in rural areas. Because we really wanted to make sure that we were able to implement and identify interventions that would be useful at a variety of practice sites.

So we had four interventions. The first intervention involved sexual history taking. So that was the screening part of our STIs or STDs intervention. So that screening was done through an ACASI system, which I'll demonstrate in a few minutes. We also encouraged patients to self-collect their samples if they did not want to have providers collect those samples. And that gave patients some privacy and control over the testing.

We did provider trainings. Because some providers really feel very uncomfortable discussing personal sexual behaviors. And so we did provider trainings about the importance of that, went through some modeling of how that sexual history taking can be done, the proper diagnosis and treatment as well as follow up.

And then we focused on services. Sexual and gender minority welcoming measures were implemented in the hope that this would appeal to these populations that sometimes feel unwelcome in the regular clinic practices.

We obtained sexual health histories, basically focusing on the five P's, the Partners, Practices. Prevention of Pregnancy, Protection from STIs and Past history of STIs. But it was very simple to start the questioning. The first question was, have you been sexually active in the last year? And if they said yes, you go through the sexual health history.

If they said no, then the next question is, have you ever been sexually active? And if yes, then you go through the sexual health history. If the answer was no to both questions, you just continued on to the medical history. Sexual health histories in this project were obtained through ACASI, which is an Audio Computer-Assisted Self-Interview. The use of this ACAI allows patients to have some privacy when answering these questions.

They basically have a private space. They wear headphones if they need to have assistance with having the information read to them. They can also see the questions on the screen. And here, you can see we had four choices for the language-- English, Spanish, Haitian, Creole, or Amharic. And these were the languages that were most common in the different clinics that we used.

The use of ACASI has been associated with identifying high-risk behaviors, less time spent by providers taking a sexual health history, and high acceptability when used by patients. But there are some potential barriers.

Some patients lack adequate computer literacy to be able to maneuver this. And in our study, we had research coordinators that were able to assist in that situation. There is an implementation expense. And there was a challenge because ACASI data did not export to the EMRs that our clinics were using.

I wanted to walk you through some of the questions that we used to identify gender identity. So people had a wide variety of options. Or they could choose not to disclose at all. And so we tried to make a lot of options for how people might be able to identify which gender identity most matched with their gender identity. We also asked questions about the type of sexual activity that the patient may have had. You can see options here.

And then at the end of that, they went through a whole battery of questions. And then the ACASI would generate a result showing which tests were needed and whether the patient preferred swabs to be done by themselves, by the provider, or in the case of your urogenital testing, whether they would want a cup to provide their own urine sample. Because the ACASI results did not import directly into the EMRs used by the intervention clinics, some sites utilized sticky notes to ensure proper testing was done based on the sexual health history results.

And these sticky notes are actually part of a starter pack that Dr. Gadkowski will be describing a little bit later that you can order if you think this would be helpful for your clinic. We also provided patient education on self-collection of mucosal swabs. So here, you can see the poster that came from the University of Washington Prevention Training Center showing how to obtain a pharyngeal swab for patients.

There's also swab posters for urogenital and anal swabs as well as posters in Spanish for all three sites. Here, you can see some of the welcoming indicators that were used in our various clinics to ensure that people who are of the LGBTQ+ community will know that they're welcome in these clinics.

Other indicators that were used in clinics were LGBTQ flags and unisex bathrooms. We also had clinical team trainings. And this included all members of the clinical team so that everyone knew the purpose of this project, interventions that were being done, and had a background in sexually transmitted infection epidemiology diagnosis and treatment, culturally-responsive care to reduce stigma, taking a comprehensive sexual health history. And the final one was really fun.

This was where each clinic each intervention site had the opportunity to present their success stories on improving STI care. So they were able to actually talk about the interventions in their clinics, the strategies that they found were helpful or not helpful.

In order to facilitate appropriate and treatment, we did create some pocket guides. Here, you can see the pocket guide that was used for diagnosis and treatment of syphilis. And it had some reminders of the fact that early-- neurosyphilis can be present at any stage. And we also need to be looking out for ocular and otic syphilis as well as the treatments. And then there were clinic workflows also for the routine clinic visit STI screening flow.

So this is kind of the outline of the interventions. It's some ideas of things that we were able to develop that the clinics found useful for improving sexually transmitted infection screening, diagnosis, and treatment. And now I'm going to turn this over to Dr. Gadkowski who's going to be discussing some of the outcomes.

BETH GADKOWSKI: So I'm going to review the outcomes of three of the interventions that we talked about. And the first is the ACASI, the clinic experience of patients answering questions about their sexual behaviors on a computer or tablet that Dr. Janelle just described. And at the end of participating in these interventions, patients and providers were actually given a survey about how they felt about their experience. And this is the results from that.

So as you can see, when asked how easy it was to answer a sexual health history on a computer or a tablet, the majority of patients here, 52%, found it very easy. 41% found it easy. 7% found it difficult or very difficult. But as you can see the, majority of the folks found it to be a good experience.

Providers, you'll notice that not that many providers responded. But remember, we only had nine clinics that we were working with. So 18 is not too terrible. But they reported that the ACASI also positively-impacted their screening tests and treatment and follow up. So overall, patients and providers felt that they had a good experience using the ACASI to do a sexual health history.

So what were some of our experiences in Florida? And as we were really looking at some priority populations and who the ACASI worked best for, we wanted to just give some comments from some of the folks that did participate in the study in Florida sites. And so young adults, and these are folks between 18 and 29, were most accepting of the ACASI intervention.

Overall, they like the privacy of taking a sexual health history on a computer. And they are very comfortable using the technology. Women, however, were less likely to believe that the ACASI assessment was effective for them. And as you can, see Dr. Janelle had just reviewed some of the questions that are posed on the ACASI And there are very specific in asking sexual practices. And some folks found that those, perhaps, didn't necessarily apply to them.

And a lot of women felt that just because they had HIV did not mean that they engaged in some of the sexual behaviors that were described in the ACASI. The way that those sexual behaviors are described are to capture everyone and everyone's sexual preferences. And that may not appeal to-- or be applicable to everyone who is taking the sexual health history. Men who have sex with men were most accepting of the intervention. But some felt singled out because of their sexual orientation.

And older patients had the most difficulties with some of the technology or vision or hearing impairment that could be involved with the ACASI. That's one of the reasons why it is such a great intervention.

Because there is a hearing aspect to it. But some of these folks were more likely to require assistance with the ACASI surveys.

Some of the outcomes for our next intervention, which was patient self-collection of extragenital specimens for gonorrhea and chlamydia. So this included pharyngeal or oral specimens as well as anal specimens. And as Dr. Janelle showed you, patients were presented with instructions and visual cues on how to collect these specimens themselves. And overall, participants were very comfortable with self-collection of both rectal swabs and pharyngeal swabs.

As you can imagine, more were comfortable with self-collecting rectal swabs and pharyngeal swabs. And I'll go through some of the comments that we had from our participants in Florida. So some of the reasons given for being comfortable with self-collection of rectal swab, I don't feel comfortable with someone I hardly know doing that to me.

I'm comfortable doing my own rectal swab for chlamydia and gonorrhea, because it's a private area of my body that not everyone may want to see. This is easy and a bit more private. And another participant said, it's easy to do and is explained in the poster.

What's really great is that-- and these responses are part of the patient survey that they took at the end of participating. So some reasons given for being comfortable with self-collection pharyngeal swabs, I know how it's going to feel. And when it hurts, I can stop. It's an easy process with little room for error. The method was described to me in an easy way and was very understandable. It's less invasive or embarrassing.

And then no one is in my face breathing and trying to guess if I have the infection or not. And then some reasons given for not being comfortable with self-collection of a pharyngeal swab, I think a professional could do a better job than me. Not sure it would be done right. And I just don't like the feeling of doing it myself.

We're very fortunate that these participants were really open and honest with their responses. This is the results of the patient satisfaction survey with regards to LGBTQ+ welcoming indicators. And this represents results from the entire study.

And as Dr. Janelle indicated, LGBTQ+ welcoming indicators were put in place in each of the clinics. And there were basically 12 indicators. For the most part, at least 10 were able to be set up in all of the clinics. And again, these included things like gender neutral bathrooms, having LGBTQ+ inclusive waiting room materials and educational materials and a non-discrimination policy.

And again, we were trying to help make clinic waiting rooms a welcoming place, a place where folks who may not normally want to be there feel a little bit more welcome and want to get their care there. And when trying to determine how people responded to these, the way that we decided to go about doing it was seeing if people noticed these indicators and whether they liked them or not. Because the big thing is you first have to notice them. And not everybody notices things. But some people do.

And so with these responses, we split it up into some of the populations that we were really trying to capture and hopefully make an impact on that they would like this and that they want to come back and get their care there. And so this included folks who identified as LGB respondents and then those folks based on age with us wanting to capture more of a younger population, especially those who are young adults between the ages of 18 and 29.

And as you can see in these results, individuals who identified as LGB, most of them noticed and liked these clinic space indicators. And that was in comparison to folks who identified as heterosexual. And the same basic result was for folks who were less than 50 versus those older than 50.

Importantly, this doesn't necessarily mean that they were more likely to necessarily engage in care. We didn't measure that. But we wanted to at least show, perhaps, that there was a positive response in some way. And perhaps, that would affect behavior. And we do see that they responded positively for the most part. And importantly, most people, regardless of sexual identity or age, responded positively to these welcoming indicators.

So this is an infographic that you saw briefly in the video that basically sums up the study results. And just to give the highlights, 94% of the study participants reported that answering questions about their sexual behaviors on a computer or tablet was easy or very easy. And as Dr. Jill had indicated before-- and as this is a common problem in why we, perhaps, don't do enough STI screening-- is that in only 13% of the cases of chlamydia, gonorrhea, syphilis did the study participants report symptoms on their sexual history survey.

So that means that about 86% of those found to have a bacterial STI were asymptomatic. And we would have missed it if we hadn't done routine screening based on their sexual health history. And really interestingly, and this goes with a lot of other data that we've seen lately, is that of the 175 different cases of chlamydia and gonorrhea, 67% of those were extragenital, which meant they were rectal or pharyngeal. And only 33% were urogenital. So again, if we didn't perform a sexual health history and do site-specific testing based on that result, we would have missed these infections.

So briefly, I want to talk about some of the challenges that we wanted to address and that we faced in doing this study in the first place. And some of these, we've already talked about. And some of you had mentioned that these are things that you face as well with regards to a sexual health history. A lot of times, there's provider discomfort or stigma with this.

And there's often an inconsistent and incomplete sexual history that's done by providers usually due to lack of time or comfort. With regards to STI testing and treatment, a lot of times a patient, again, doesn't want to have a provider do the swabbing. Or they don't provide a urine sample. Or they go to the bathroom before you get the urine sample that you needed.

And that falls into coordination and communication and patient care. And it's sort of funny. Because you think, why do I have a syphilis test? Well, because I was drawing blood for something else. To get these other tests, you have to do something else. So it requires a little more effort on everyone's part.

With regards to the LGBTQ welcoming clinic space, if we want folks, especially those in our priority populations, adolescents, adults, and LGBTQ to be feel welcome in these spaces, we want patients to have access to these things. Transportation and housing instability are a chronic problem. Accessing materials, sometimes folks don't have a lab or medications or STI testing supplies on site.

A lot of commercial labs don't actually let patients self-collect extragenital samples. It's not allowed at the VA hospitals either. And labs prior to 2019 were not even processing extragenital GC chlamydia NAATs.

And then with regards to cost and insurance, we've mentioned this briefly already, that some insurance companies and Medicare may restrict the number of STI tests that can be done a year. And that actually

during our study, we found that some states and ADAP jurisdictions didn't include STI treatment medication coverage. And then community-based pharmacies were also not stocking penicillin because of the high cost.

So what are some of the other challenges? So as if that wasn't enough, when we were starting to do our-- basically roll out our studies and to do patient recruitment, COVID happened. And this presented us with a how-do-we-do-this scenario. We weren't seeing patients in real life. Nobody was seeing patients in real life. So Zoom had to be learned in how to diagnose. And see folks over Zoom presented its own problems.

Lab draw stations were now hard to find. And you needed an appointment. And you had to go to-- a lot of times patients had to go someplace else other than their clinic in order to get labs. And then there was a shortage of testing supplies. Because the NAAT swabs were also used for COVID testing.

Mother nature didn't help. We had multiple hurricanes during that time period, also, that affected Florida and Louisiana. There was an ice storm in Washington DC that knocked out electricity. There was a lot. There was a lot happening.

So what are some of the strengths of this study? Hopefully, you've already seen these. So when you take a sexual history with the ACASI, most importantly, it provides a consistent sexual history questions without reliance on the provider. For STI treatment, we did this study in a lot of health departments that already had penicillin in stock. And some clinics utilized 340B pharmacy programs to access those.

The LBGTQ welcoming clinic space, when we added these, there was an increased sense of comfort by the patients not traditionally feeling welcome or perhaps emotionally-safe in clinics. With regards to the NAAT specimen toolkits, as we're starting this study, the FDA did approve the extragenital sites specimen collection. And what's important to remember is that these supplies have a long shelf life. They don't need refrigeration. Whether a provider or patient collects the NAAT specimen, they're equally valid and reliable. And this also empowers patients to collect their own NAAT specimen anywhere, meaning physically on their body, and then anywhere.

And then with regards to training, we didn't talk about training as much. But I do want folks to know that training is available through the AIDS Education and Training Center programs, which is part of HRSA-funded and also the National Network of STD/HIV prevention training centers which is CDC-funded.

And they can provide HIV and STI-specific training, technical assistance, and capacity-building for free to clinical care sites. It's just a matter of reaching out to them. And they are who helped us.

So with regards to sustainability, this is your big opportunity to scan the QR code on this slide to access the toolkit that we developed as part of-- or that was developed as a result of this study. And this is available also at TargetHIV.org/STIs. And the contents includes many of the products that you saw Dr. Janelle present earlier.

And so what are some of the lessons learned? I think it's really important to identify and empower change champions people who are excited about this. In the clinic, helping to get buy-in and to guide implementation in the clinic so that everyone's on the same page and excited about this. Because that excitement is contagious and can help you really present something great to your patients, and also creating a clinic flow that engages all the appropriate team members. And this facilitates engagement,

and then successful implementation. Everyone likes to be part of something a little bigger than themselves.

So those are some of the lessons that we learned. These are our references. The first paper is by Nelson, et al and discusses this project and the results that we've presented. And please don't forget about the TargetHIV website with these tools that we've presented. And then these are our contacts. So please feel to reach out. And I'll turn it back over to Angel. Thank you.

ANGEL JOHNSON: Thank you. Thank you both, Beth and Janelle. That was great. We now going to open it up, take a few questions. We did have a question that came through the Q&A that asked about, since the ACASI is digital, for the older population would it be effective to provide a questionnaire on paper? I know medical paperwork is going digital as well. But as clinics with their physical paperwork, that they could fill out. And this is from Shannon Adair.

JENNIFER JANELLE: Yeah. And, Shannon, we actually have a paper copy of the ACASI questionnaire in the packet that's in that starter kit. So we definitely have that available. We use printed ones at our clinics, sometimes Dr. Gadkowsi and I do. Yeah, for sure.

And if you cannot afford the ACASI, if that's not something your clinic is ready to do, we actually, during the course of this, found that the North Dakota Department of Health has a fantastic risk assessment online. And we loved it. Because it actually has a lot of patient education about why certain questions are being asked.

And it goes through hepatitis C, risk for gonorrhea, chlamydia, syphilis, HIV. It's really a fantastic resource. Yeah, I think that is something you may want to look at. I actually don't know the estimated cost of the ACASI software. Do you know that, Beth?

BETH GADKOWSKI: I do not. It's proprietary. Unfortunately, you'd have to reach out to them. Am I able to put the North Dakota link in the chat, Angel, for their resource?

ANGEL JOHNSON: Yes. You can do that.

BETH GADKOWSKI: OK. Let me go ahead and do that.

ANGEL JOHNSON: And if you have additional questions, please feel free to type them into the chat or the Q&A. Raise your hand. And you can ask them directly. In the meantime, we would appreciate if you would give us your feedback on the presentation. This is the link that you can use to do that. You can copy and save the link. I will send it out in an email following the webinar.

But if you want to go ahead and do that now, that'll be great. Do we have any other questions?

BETH GADKOWSKI: Angel, Is it possible to go back to just the slide that shows what's involved, what's part of the STI toolkit. Since we have two seconds, I just want to make sure that everyone sees what's available in there and can go back to that. There you go. OK.

And so just, again, this free starter kit. It has an overview of the study, some fact sheets, that infographic. It gives you that sexual history survey. And you can use it however you use it. A lot of folks do not have the funds to do an ACASI. And that's also where the paper may come in and also the North Dakota Know Your Risk as well.

We've had providers at other clinics that don't have an ACASI pull-up that the North Dakota Know Your Risk score and do it with a patient sitting next to them in the clinic as someone who can't read. Or you can pull it up for the patient. And they can go through it basically themselves.

Again, there's then, going back to the toolkit, there's introductions for how to self-collect, some of those workflows that Dr. Janelle showed, some other templates, some publications, and then some LGBTQ welcoming clinic slides. And I believe they have-- there are pronoun pins in there as well.

JENNIFER JANELLE: And there's flags as well as the self-testing posters that we used.

ANGEL JOHNSON: Great. So we have a couple more questions. Someone wanted to know, what is the estimated cost of the ACASI software?

BETH GADKOWSKI: We do not know that unfortunately.

ANGEL JOHNSON: OK. And thought there was another question. But it seems to have disappeared. OK. Any other questions? And Beth did drop that link into the chat box if you want to get that. So if there are no other questions or any closing remarks from our presenters, if you like please feel free to do so.

Yeah, we just want to thank everyone for attending this webinar and all the webinars that we have done through this series and to actually to be on the lookout for any information for future webinars. And to remember to access the IHIP tools and resources and to join the IHIP listserv, please go to https://www.TargetHIV.org/IHIP.

Anything else, ladies? Any closing remarks?

JENNIFER JANELLE: No. We're just thrilled to have the opportunity to talk about this project. I think it's really important to find some tools that could work for your clinics. And I think it's sometimes challenging. So I love that this study looked at things that had already been assessed and put them together as a package. I think that was useful.

ANGEL JOHNSON: Well, we want to thank you so much for your time and for that great presentation. And we want to thank everyone for joining today's webinar.

BETH GADKOWSKI: Thank you.

JENNIFER JANELLE: Thank you.

ANGEL JOHNSON: Have a great rest of your day.