# Prevention Summit notes from Round Table on PBC

**How do you fit into the Philosophy shift?**
**What new strategies have you tried?**
**How are they working?**
**How do you determine where to test?**
**What shapes your testing model?**
**How do you fit into the Philosophy shift?**
**What new strategies have you tried?**
**How are they working?**
**How do you determine where to test?**
**What shapes your testing model?**

**Philosophy shift:**
We have found we are missing the mark
More condom education, more condom dispensing needed
Policy barriers with agencies we partner with.

Attitude of clients that HIV disease is manageable
Needs to be explored with better out reach to youth
Better needs assessment of youth

- SHAC collaboration to get focus on sexual health
- Be on a committee
- Lobby effort with SHAC by district and advocacy with school boards

40 year old and above are often high risk, using Tw/oC for health fairs to target older adults

Using community incentives to hit the target populations
Developing “mini” counseling
Jail and Treatment centers have too many people to do full PBC sessions

Targeted use of test type and model
PBC in Health Centers, recent STI DX., in house testing
Need freedom to be logical about what works with client
Ability to use education that may not result in test.
Internet recruitment.

**Brief Assessment in 3 components**

1. PBC
2. Mini-PBC
    - Screening
    - Ambivalence
    - Risk Reduction Step
3. Testing without Counseling
    - Jails'
    - Fairs
    - People in a hurry

**Shift in Philosophy:**

Counselors like having a choice (PBC vs Testing without Counseling)
Prefer results giving options
Question objectives and how they should change to better reflect the work done

Ideas:

- When testing without counseling, some basic questions should be asked
- ½ page risk assessment used for TwoC and Testing with counseling as well
- Supervision of counselor decisions with guidance
- Flexibility in different situations
- If Testing without counseling with high risk flexibility, option to use PBC should be made by each counselor
- Want flexibility to give negative results by phone
- Use of DIS and use of rapid tests in walk in clinic.
- Testing results availability
- Networking to find MSM, social network sites
- Quick PBC, few questions to be determined: If high risk, ask more
- Staff has a quota of # of PBC sessions
- Gay bars provide the possibility of more positives
- Short streamlined approach
- Nervousness about only becoming testing without counseling sites

**Needs:**

Need outreach to include providing education to targeted persons
Productivity: Make assessments easier, more accessible.
Assess where target pops are being reached by other programs, share information

**Wishes:**

1. Not adhere to number of tests and how to get them.
2. See new testing technology available now for early diagnosis
3. Inflexibility of monitoring success, redefine success
4. Offer flexibility and options
5. DSHS offering specific information on encouraging change
6. Encouraging change
7. Rapid RPR testing