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August 13, 1997

MMCD Policy Letter 97-08

TO:
[X] Prepaid Health Plans
[X] Primary Care Case Management Plans
[X] Geographic Managed Care Plans
[X] County Organized Health Systems

SUBJECT: HIV COUNSELING AND TESTING POLICY

Purpose

The purpose of this policy letter is to clarify Medi-Cal Managed Care Plans' responsibilities in the provision of confidential HIV counseling and testing services to Medi-Cal members. This policy also clarifies requirements for out-of-plan reimbursement of confidential HIV counseling and testing services rendered by Local Health Departments (LHDs) and out-of-plan family planning providers. (MMCD Policy Letters 94-13 and 96-09)

Goals

To maximize the opportunities to prevent and control the transmission of HIV by providing routine risk assessment, counseling, education and testing services to all Medi-Cal Managed Care members, and by establishing effective coordination between Medi-Cal Managed Care Plans and LHDs.

Policy

All contracting health plans [COHS, PHPs, PCCMs, including Plans in GMC and Two-Plan Model (referred to henceforth as the Plans)] are required to follow all State laws

governing consent for testing and disclosure of HIV test results, as well as the latest "HIV Counseling, Testing, and Referral Standards and Guidelines" recommended by the U.S. Public Health Service (USPHS), as published in the Morbidity and Mortality Weekly Report (MMWR) (See Enclosure I). All Plans are required to assess members, including children and adolescents, for risk factors for HIV infection. This assessment includes obtaining a sexual history and inquiring about illicit drug use where applicable.

Access to HIV Counseling and Testing Services

All persons at increased risk for infection or possible transmission of HIV to another person should receive education and counseling and be offered confidential HIV testing services through either the Plan's provider network or through out-of-Plan LHD-funded sites, family planning or sexually transmitted disease (STD) providers. (Please also see MMCD Policy Letter 94-13--Family Planning and MMCD Policy Letter 96-09--STD.) Plans must implement procedures to ensure that adult and/or pregnant members with confirmed HIV positive test results have treatment options explained and treatment offered to them. Infants, children, and adolescents (members under the age of 21 years) who are confirmed HIV positive are CCS eligible and should be referred to CCS (see sections below).

All Plans are required to reimburse out-of-Plan family planning providers for HIV testing and counseling services. In addition, all Two-Plan Model and GMC Plans, are further required by their contracts to reimburse HIV testing and counseling services rendered without prior authorization by out-of-Plan LHD-funded HIV testing and counseling sites, LHDs' STD clinics and other out-of-Plan STD providers. These Plans should maintain a current listing of LHD-funded Confidential and Alternative Test Sites, inform members of their availability and assist members with referrals upon request. These plans are required to execute a subcontract with the LHD covering the provision and reimbursement of HIV counseling, education, and testing services. (Plans other than Two-Plan Model Plans must check their contracts to see if this requirement applies to them.)

Prenatal HIV Counseling, Testing, and Follow-up

Current law (Health and Safety Code, Section 125107) requires that the health care professional primarily responsible for providing prenatal care must offer HIV information and counseling to every pregnant patient, including but not limited to: mode of transmission; risk reduction behavior modification, including methods to reduce the risk of perinatal transmission; and referral to other HIV prevention and psychosocial services. Plans must implement procedures to ensure that all prenatal care providers offer an HIV test to every pregnant woman, unless the patient has a positive test result documented in the medical record or has AIDS as diagnosed by a physician. The prenatal care provider must discuss the purpose of the test; its potential risks and benefits, including treatment to reduce transmission

to the newborn, and its voluntary nature. The provision of information and counseling and the offer of HIV testing must be documented in the member's medical record. If the pregnant woman voluntarily consents to testing, the provider will arrange for the testing to be provided directly or by referral.

For pregnant women who test positive for HIV, Plans must implement procedures which ensure that the prenatal care provider offers treatment to reduce the risk of transmission to the newborn consistent with the most recent PHS guidelines as published in the MMWR. (Note: At the time of publication of this policy letter, the most recent recommendations from the U.S. PHS Task Force on the use of zidovudine to reduce perinatal transmission of HIV was published August 5, 1994, volume 43, Number RR-11.)

HIV Testing and Counseling for Children

Plans must implement procedures which ensure that Plan providers offer HIV counseling to parents or legal guardians and testing (and education and counseling where appropriate) to infants, children, and adolescents in the following categories:

1. Infants and children of HIV seropositive mothers.

2. Infants and children of mothers at high risk for HIV infection with unknown HIV serologic status including:

   a. children born with a positive drug screen;

   b. children born to mothers who admit to present or past use of illicit drugs;

   c. children born with symptoms of drug withdrawal;

   d. children born to mothers who have known arrests for drug related offenses or prostitution;

   e. children born to mothers with any male partners known to be at high risk for HIV; and

   f. any abandoned newborn infant.

3. Sexually abused children and adolescents.

4. Children receiving blood transfusion/blood products between 1977-1985 or symptomatic children receiving blood transfusions since 1985.

5. Adolescents who engage in high risk behavior including unprotected sexual activity, illicit drug use, or who have had sexually transmitted diseases.

6. Other children deemed at high risk by a Plan provider.

It should be noted that infants, children and adolescents who are confirmed HIV positive are CCS eligibles. Plans whose contracts exclude CCS services must refer these members to the CCS program. Plans whose contracts include CCS services must implement procedures to ensure that these infants, children, and adolescents receive care from CCS approved specialists and special care centers.

Out-of-Plan Reimbursement

An out-of-Plan provider is a provider who is not employed by, under contract with, or otherwise affiliated with the Plan for the provision of health services. An out-of-Plan provider who renders HIV testing and counseling must be qualified to do so as part of his/her scope of practice.

1. ALL PLANS:

   An out-of-Plan family planning provider who renders confidential HIV counseling and testing services to a Medi-Cal member during a family planning encounter may bill the Plan. (See MMCD Policy Letter 94-13)

2. TWO-PLAN MODEL AND GMC PLANS:

   LHDs may bill the plan for confidential HIV counseling and testing services provided to a member by any LHD-funded confidential HIV Test Site, including STD and family planning clinics as well as community based organizations. These Plans are also required to reimburse any out-of-plan provider not associated with the LHD who rendered STD services to a Plan member and included HIV counseling and testing services. (See MMCD Policy Letter 96-09)

Conditions for Reimbursement

The following are the conditions under which LHDs and out-of-plan family planning providers will be reimbursed for HIV counseling and testing services:

1. Claims are submitted according to the Plan's specified billing procedures.

2. Appropriate consent for disclosure of medical information must be obtained from the Plan member. Plan members may elect to sign a release of confidential information to the Plan; may allow billing information to be sent to the Plan but refuse to release medical records; or may choose complete anonymity and refuse to sign release of any information.

3. If a Plan member has consented to the release of information to his or her primary care physician (PCP), the out-of-Plan provider must send medical information to the Plan along with the claim and the Plans must assure that the consent and medical documentation is received by the PCP. The medical records must contain sufficient documentation regarding the service rendered to allow the Plan to meet case management responsibilities. Plans may not reimburse the out-of-Plan provider until this condition is met.

If all of the above conditions are met, Plans must assure timely reimbursement for services rendered. For PHPs, including all Two-Plan Model and some GMC Plans, timely reimbursement is defined as payment of a claim within 45 working days of receipt of all necessary documentation. If a Plan determines that a claim is incomplete or is to be contested, the Plan must notify the LHD or out-of-plan family planning provider in writing of this fact within 45 working days. After receipt of the additional information, the Plan has 45 working days to complete reconsideration of the claim. Other Plans should refer to their contracts for timeliness requirements.

Reimbursements will be at the approved Medi-Cal fee-for-service rate(s), appropriate for the provider type, as specified in Title 22, CCR, Section 51501, et seq. unless other rates have been negotiated in the subcontracts.

Plans must have a provider claims appeal system pursuant to the following requirements: Title 22, CCR, Section 56262, for PCCMs; Health and Safety Code Sections 1371 and 1371.1, for PHPs; and provisions of COHS contracts. In the event of disputes, Plans must advise LHDs and out-of-plan family planning providers in writing of the process for claims appeals.

Plans must implement procedures to ensure that PCPs provide timely follow-up care to services rendered by an out-of-Plan provider. The Plans, as well as the LHDs and family planning providers, must educate Plan members regarding the significant positive impact of coordinated care on clinical outcomes, the problems associated with fragmentation of care, and the importance of allowing medical information to be shared between providers.

Subcontract with Local Health Department

Some Plans (e.g., Two-Plan Model and GMC) are contractually required to execute a subcontract with the LHD in the county in which they operate, governing the provision of HIV counseling and testing services. This subcontract must specify the scope of responsibilities of each party including, but not limited to, billing and reimbursement; reporting responsibilities; medical record management to ensure coordinated health care services; claims appeals procedures; and education of Plan members regarding the critical importance of continuity of care and the important role of the member's PCP. All other Plans are encouraged to develop similar working relationships with LHD's in the area of HIV counseling and testing services.

Consent for HIV Testing and Disclosure of HIV Test Results

Plans are required to implement procedures for obtaining member consent for confidential HIV testing. State law (Health and Safety Code, Section 120990) requires that written consent must be secured from a patient prior to an HIV test, except when the test is recommended by a treating physician or surgeon. Under these circumstances, a physician or surgeon can obtain verbal informed consent from the patient. The provider must impart sufficient information to the patient to elicit an informed decision. In the event that a member specifically requests an HIV antibody test which falls outside of his or her treatment regimen, the law requires the completion of a written consent prior to the blood draw.

Plans are required to implement procedures for obtaining consent for the disclosure of a member's HIV test results. It is generally unlawful (exceptions are described in this paragraph) in California to disclose the HIV status of a patient without his or her written consent (Health and Safety Code, Section 120980). Written authorization must be obtained from a patient prior to each separate disclosure of an HIV test result. Under the law, HIV test includes any clinical test, laboratory or otherwise, to determine if a person has or may have HIV. There are circumstances under the laws which permit disclosure without written authorization, but the disclosure is limited to discussions between providers of health care for purposes directly related to the medical care of the member or to persons authorized to make medical decisions for an incompetent person or a minor under the age of 12 (Health and Safety Code, Section 121010).

Under the law, a physician or surgeon may disclose a member's test results to a person reasonably believed to be the spouse, sexual partner or person with whom the member has shared hypodermic needles but only if the physician or surgeon provided education and counseling to the member and attempted to obtain the member's voluntary consent to notify his/her contacts. The physician or surgeon is prohibited from disclosing any identifying information about the member during the notification (Health and Safety Code 121015).

Plans will cooperate with and assist LHDs to identify, educate, counsel, and test non-Plan members who are sex and/or needle sharing partners of HIV positive Plan members.

Medical Records

Plans are required to implement procedures for documenting HIV status in the medical records that ensure member's confidentiality in compliance with State law. (Health and Safety Code, Section 120980; Confidentiality of Medical information Act, Civil Code, Section 56 et seq.)

Reporting

Plans are required to comply with all State disease reporting requirements. Providers are not required to report individuals who test positive for HIV, unless a clinical diagnosis of AIDS can be made. AIDS is a reportable condition under the law and reporting does not require consent from the member (Title 17, CCR, Section 2500). Providers are required to report the names of individuals diagnosed with AIDs to the LHD. The required information includes the diagnosis, name, address, telephone number, occupation, ethnic group, social security number, sex, date of birth, date of diagnosis, date of death of the person, and the name, address, and telephone number of the person making the report.

Plans must implement procedures which ensure that contracted medical laboratories appropriately report HIV test results and that network providers' are in compliance with their responsibilities to report the names of members with a clinical diagnosis of AIDS.

Health Education and Outreach

Plans must implement procedures to ensure that all known HIV infected members are counseled about their responsibility to assure that their sex and needle sharing partners are contacted and informed about their exposure to HIV and the need to seek HIV testing. Providers are responsible for documenting all counseling provided to the member.

Plans must routinely offer education opportunities (classes, videos, etc.) to their members on HIV/AIDS prevention as a component of the required health education services. Plans are also encouraged to participate in LHDs outreach activities and public education campaigns regarding HIV/AIDS prevention.

Provider Training

Plans must ensure that network providers and relevant support staff are knowledgeable about their responsibilities to assess all members for risk factors for HIV infection and to

appropriately counsel and offer HIV testing. Plans are responsible for providing appropriate HIV information and training to their providers, including instruction regarding consent and disclosure issues. Plans may request technical assistance, training, and material related to HIV prevention, education, counseling, and testing from LHDs. Provider certification through an LHD, state, or federal HIV counseling and testing certification program is not required.

Discussion

It is now more imperative than ever to detect HIV infection as early as possible since early detection will enable early intervention and member support activities to begin, and will also allow new and more effective drug treatment options to be offered. Two expert panels were convened recently in response to the rapid advances in the treatment of HIV infection, and the resulting need to provide guidance for treatment decisions at the clinical level. The Office of AIDS Research of the National Institutes of Health (NIH) convened a panel to delineate the scientific principles, based upon the most current understanding of HIV infection and disease, that should guide the most effective use of antiretroviral therapy and viral load testing in clinical practice. The draft "Report of the NIH Panel to Define Principles of Therapy of HIV Infection" was used as the basis for the development of guidelines for the clinical use, by physicians and other health care providers, of antiretroviral agents in the treatment of HIV-infected adults and adolescents. These "Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents" were developed by a second panel convened under the auspices of The Department of Health and Human Services and the Henry J. Kaiser Family Foundation. Both the Report and the Guidelines were released in draft form in June 1997, and are available as a package by calling the HIV/AIDS Treatment Information Service at 1-800-448-0440. Pediatric guidelines will be addressed in the near future. The guidelines generally recommend an aggressive approach to the treatment of HIV-infected adults and adolescents.

In California, testing for HIV can be confidential or anonymous (Alternative Test Site Program). Anonymous testing is free; is administered through LHDs; requires neither a consent form nor formal identification of the patient (a "unique identifier" is used to identify individuals when they return for test results); and emphasizes prevention of HIV transmission. Plans should advise members of the availability of this type of testing.

Responsibilities of LHDs

In addition to administering the local Alternative Test Site Program, LHDs:

- Must ensure that the HIV testing sites implement procedures to identify plan members and to bill services appropriately and comply with all the conditions for reimbursement.

- Must ensure that providers at the HIV testing sites counsel the Plan members to return to the Plan providers for continuity of care. They must educate the Plan members regarding the significant positive impact of coordinated care on clinical outcome, the problems associated with fragmentation of care and the importance of allowing medical information to be shared between providers.

- Must ensure that the HIV testing sites implement procedures to coordinate care and cooperate with the Plans in the timely exchange of medical information. If the Plan member consented to the release of medical information, the HIV testing site must forward medical information to the member's PCP.

- Upon request from the Plan, must assist the Plan in training and educating Plan providers regarding providers' reporting responsibilities and the latest advancements in the field of HIV counseling and testing. The LHD is expected to provide training and educational materials related to HIV testing to Plan providers and members, contingent upon availability of such material.

- Are responsible, as permitted or required in state or federal law, for identification, notification, and follow-up of partners of HIV positive Plan members who are not members of the Plan.

- Are responsible for outreach and public education campaigns regarding HIV/AIDs prevention.

If there are any questions regarding this policy letter, please contact your contract manager.

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Medi-Cal Managed Care Division

Enclosure

Enclosure I

HIV

Counseling, Testing and Referral

STANDARDS & GUIDELINES

May 1994

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

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HIV COUNSELING AND TESTING - OVERVIEW

Historical Perspective

Publicly funded HIV antibody counseling and testing services were initiated in March 1985 to provide an alternative to the donation of blood as a means for high-risk persons to determine their HIV status. At that time, little was known about the prevalence and natural history of HIV infection. Counseling was considered an essential adjunct to HIV testing. The counseling addressed the accuracy and consequences of the test and was designed to help persons interpret the meaning of positive or negative antibody results. HIV counseling was based on the recognition that learning HIV status may be difficult for some clients.

In 1987, with increased understanding about the scope and severity of the HIV epidemic and the predictive value of a positive test, HIV counseling and testing were expanded. Persons seeking care for sexually transmitted infections, family planning, childbirth, or substance abuse were counseled and tested in an attempt to reduce their risk for HIV transmission. "The primary public health purposes of counseling and testing are to help uninfected individuals initiate and sustain behavioral changes that reduce their risk of becoming infected and to assist infected individuals in avoiding infecting others." (1)

Since that time, public awareness about HIV infection has increased, and the reliability and predictive value of the HIV test have been proven. Investigations have demonstrated the benefit of early antiviral and prophylactic treatment for HIV infected persons. These HIV counseling standards and guidelines are the result of increased knowledge about HIV prevention and experience with HIV counseling. Counseling is a direct, personalized, and client-centered intervention designed to help initiate behavior change to avoid infection or, if already infected, to prevent transmission to others, and to obtain referral to additional medical care, preventive, psychosocial and other needed services in order to remain healthy.

Goals of HIV Counseling, Testing, and Referral Services

The current goals of HIV counseling are as follows:

- provide a convenient opportunity for persons to learn their current serostatus;
- allow such persons to receive prevention counseling to help initiate behavior change to prevent the transmission or acquisition of HIV;
- help persons obtain referrals to receive additional medical-care, preventive, psychosocial, and other needed services;
- provide prevention services and referrals for sex and needle sharing partners of HIV-infected persons.

Objectives of HIV Counseling, Testing, and Referral Services

1. Identify persons who are unaware, uninformed, misinformed, or in denial of their risk for HIV infection and facilitate an accurate self-perception of risk.
2. Prepare clients for and provide them with knowledge of their HIV infection status.
3. Negotiate a relevant risk reduction plan and obtain a commitment from clients to reduce their HIV risk.
4. Refer clients to resources that will provide psychosocial support and facilitate desired behavior change.
5. Provide referral to appropriate drug treatment services for clients whose substance abuse problems enhance their HIV risk.
6. Provide information on the increased risk of HIV transmission associated with other sexually transmitted diseases (STDs) and give referrals for STD examination and treatment.
7. Provide family planning information and referrals for women of child bearing age who are infected or at high risk for HIV.
8. Provide referrals to HIV positive and high risk HIV negative persons for necessary medical, preventive, and psychosocial services.
9. Communicate to the client the responsibility for appropriate disclosure including the notification of sex and needle-sharing partners.

Necessary Elements of HIV Counseling, Testing, and Referral Services

- **Maintenance of Confidentiality**
  Strict protection of client confidentiality must be maintained for all persons offered and receiving HIV counseling services.

- **Risk Assessment**
  Risk assessment is the portion of a client-centered discussion that encourages the client to identify, understand, and acknowledge his or her personal risk for acquiring HIV.

- **Prevention Counseling**
  Counseling provides a critical opportunity to assist the client in identifying his or her risk of acquiring or transmitting HIV. It also provides an opportunity to negotiate and

reinforce a plan to reduce or eliminate behavioral risk. Counseling prior to HIV testing (pretest) should prepare the client for receiving, understanding, and managing his or her test result.

- **Providing Test Results**
  Providing HIV antibody test results to a client involves interpretation that is based upon the test result and the client's specific risk for HIV infection. Knowledge of HIV status is important information that a client can use to plan behavior change. Skillful, client-centered counseling is required to reassess behavioral risks which may influence the interpretation of test results. The client will most often focus on the actual result itself rather than behavioral and prevention messages.

- **Provision of Referrals**
  Clients may require referral for physical and psychological evaluations, appropriate therapies (i.e., drug treatment), and support services to enhance or sustain risk reduction behaviors. Each program should maintain complete knowledge of referral resources, including the availability, accessibility, and eligibility criteria for services.

DEFINITIONS

These standards and guidelines on HIV counseling were established after consultation between outside experts and Centers for Disease Control and Prevention (CDC) staff. The document is divided into two sections. The first section addresses program level guidance in establishing policies and procedures which are critical to the development and maintenance of an HIV prevention counseling program. The second section describes guidance for counselors and other providers in the approach to and delivery of HIV prevention counseling services. This document will provide two levels of guidance (2):

- *Standards* in this document are intended to be consistently applied to the delivery of HIV counseling services. They *must* be followed in virtually all cases.

- *Guidelines* are intended to be more flexible. They *should* be followed in *most* cases. However, they recognize that, depending on the client, setting and other factors, guidelines can and should be tailored to fit individual needs.

These standards and guidelines are intended for persons who provide counseling in connection with HIV testing (3) and encompass the following concepts and terminology:

- Triage assessment is the process that determines whether someone should be referred to counseling. Triage assessment facilitates access to prevention counseling services for those persons at increased risk for HIV.

- Risk assessment is the process of assisting the client to identify behaviors that place him or her at risk for HIV. The risk assessment should include: reason for visit and other relevant concerns; personal circumstances; the client's resources and support systems; behavioral and other sources of risk; demographic and epidemiologic factors that influence risk; client's awareness of risk, readiness to change behavior, and receptiveness to available services and referrals. An integral component of HIV prevention, risk assessment is not intended solely as a screening tool for client eligibility for HIV testing. The discussion between the client and counselor should result in a negotiated risk reduction plan. The plan must be a realistic, attainable strategy that is developed with the client to achieve behavior changes to reduce the risk for acquiring or transmitting HIV.

- Client-centered counseling refers to counseling conducted in an interactive manner responsive to individual client needs. This counseling avoids a preconceived set of points to be made by the counselor and encourages the client to do most of the talking. The focus is on developing prevention goals and strategies with the client rather than simply providing information. An understanding of the unique circumstances of the client is required—behaviors, sexual identity, race/ethnicity, culture, knowledge, and social and economic status.

- Appropriate disclosure involves all of the circumstances in which others should be informed of the client's HIV infection status. This determination requires consideration of local and state laws, client confidentiality, and the need to inform others. Disclosure to health care providers and current and subsequent sex and/or drug partners is essential. The client may need guidance and assistance on the methods of informing persons who need to know.

REFERENCES

(1) CDC. Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS. *MMWR* 1987;36:509-515.

(2) Eddy, DM. Designing a Practice Policy, Standards, Guidelines, and Options. *JAMA*. 1990;263:3077-3084.

(3) CDC. Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS. *MMWR* 1987;36:509-515.

HIV COUNSELING, TESTING, AND REFERRAL

Program Standards and Guidelines

Client Eligibility Criteria

Public health agencies that receive federal funds from the National Center for Prevention Services (NCPS) are required to routinely offer, on a voluntary basis with informed consent, HIV prevention counseling and HIV laboratory testing services to persons who are potentially HIV infected, their partners and others who have high risk behaviors (1). Grantees are encouraged to offer services to clients at designated counseling and testing sites, sexually transmitted disease (STD) clinics, drug treatment centers, tuberculosis clinics, criminal justice and correctional systems, women's health clinics, youth and adolescent programs, and other sites which serve persons with risk behaviors for acquiring HIV. To use resources as efficiently as possible, grantees are encouraged to integrate HIV counseling and testing into ongoing operations, especially in STD and substance abuse treatment clinics. HIV Prevention Community Planning provides a forum for priority setting, accomplished through a participatory process, which may guide the targeting of HIV counseling services.

Unless it is prohibited by state law or regulation, clients should be offered reasonable opportunities to receive HIV-antibody counseling and testing services anonymously. The availability of anonymous services may encourage some persons at risk to seek services who would otherwise be reluctant to do so. Grantees who elect to charge for services are strongly encouraged to use a sliding scale, and to provide services regardless of ability to pay. The fact that services will not be denied because of the client's inability to pay should be clearly communicated by the facility by posting signs or providing written materials. Program staff who register clients or collect fees should be familiar with this policy. When a client is identified to be at risk for HIV infection, the health care facility is responsible for providing services or ensuring effective referral for services.

Counseling programs should develop a triage assessment procedure to identify persons at risk for HIV infection. This procedure should consider local circumstances that influence the risk of HIV infection for persons who might not be perceived as being at risk. Health care providers should take advantage of every encounter with a client to reinforce HIV prevention messages (2).

Standards

HIV prevention program managers must accomplish the following:

- Establish systems to ensure that strict confidentiality is maintained for all persons who are assessed for HIV counseling and testing services;
- Seek to ensure that all persons who seek HIV testing are offered counseling relevant to their needs;
- Seek to ensure that persons who are determined to be at risk for HIV infection as a result of sexual or drug using behaviors are routinely counseled;
- Establish that no facility that receives federal funds for HIV counseling and testing services may deny a client services because of that client's inability to pay (3).

SPECIAL CONSIDERATIONS

- Clients who request repeat testing should be managed as indicated in the **"Counseling and Repeat Testing Section."**

REFERENCES

(1) CDC. 1992 HIV Prevention Program Guidance.

(2) CDC. Technical Guidance on HIV Counseling, January 1993.

(3) CDC. 1992 HIV Prevention Program Guidance.

Risk Assessment Development

Program managers, from sites that provide HIV counseling services, should review available data to identify site-specific HIV prevention needs. This review and evaluation should include AIDS case surveillance data, HIV seroprevalence data, STD morbidity, prevention counseling data, and demographic and risk behavior profiles of the population and the catchment community served by each site. Based on analysis of these data, the program should develop policies for each site that address the appropriate provision of primary and secondary HIV prevention services including triage assessment, and targeted or universal risk assessment procedures. For example, if the voluntary HIV testing seropositivity at a site is higher than the blinded seroprevalence, this site may be successfully targeting prevention efforts. However, if the voluntary HIV testing seropositivity is lower than the blinded seroprevalence, this site may not be appropriately targeting assessments, outreach efforts, prevention counseling, and/or provision of voluntary testing services. This information should be used to plan activities and services, redirect efforts and resources to meet current needs, use resources more efficiently, and identify unmet service needs.

Each site that offers HIV testing must provide prevention counseling tailored to individual client needs and should develop an effective method to involve clients in identifying their risk behaviors. This approach should also address local and specific circumstances which might influence the client's perception of risk. Where available, sites should use triage assessment as one of the first efforts to direct persons at risk of HIV infection into prevention counseling. The clinic environment should support the risk assessment process, by involving clients

in identifying their risk behaviors. Strategies to achieve this include group discussions, audiovisual materials, pamphlets, and/or posters. Community based organizations are excellent collaborators in the development and provision of client support services. Educating clients through multiple methods increases the chance that clients will recognize behaviors which place them at risk.

Standards

HIV prevention program managers must make certain that the following are achieved:

- Provision of training and quality assurance to ensure identification of risk behaviors of all clients counseled or tested for HIV;
- Establishment of site-specific demographic and risk profiles, based on analysis of HIV test data;
- Ongoing collection and review of available site-specific data, including AIDS case surveillance data, HIV seroprevalence data, STD morbidity, prevention counseling data, demographic, and risk behavior profiles for targeting of resources and quality assurance of service delivery;
- Determination of appropriate site-specific strategies for risk assessment of clients, based on demographic and risk profiles;
- Procedures to maximize targeting of clients for prevention counseling based on risk profiles.

Guidelines

HIV prevention program managers should do the following:

- Ongoing review and analysis of relevant seroprevalence data, including site specific blinded seroprevalence if available; and
- Analyze, by site, the extent of HIV prevention counseling coverage (number of clients seen, blinded seroprevalence, and number of HIV infected persons identified through prevention counseling).

Referral Service Development

A thorough client assessment often indicates a need for services that cannot be provided by the counselor (e.g. drug treatment, peer support groups, etc.). To ensure that clients receive appropriate care, the program must establish a procedure for referring persons to sites that provide services in a timely, efficient, and professional manner. A collaborative relationship should have already been established with the appropriate representative of the referral site.

Standards

HIV prevention program managers must develop a process for routine referral which include the following:

- A written referral process for identifying, evaluating, and updating referral sources in the site's operations manual;
- A mechanism to provide clients with immediate access to emergency psychological or medical service;
- Appropriate referral resources for;
  - Any client at-risk for HIV infection who may be in need of support to maintain safer behaviors,
  - HIV negative clients who continue to test but are without risk,
  - HIV negative clients who continue to engage in risk behavior,
  - HIV positive clients who continue to engage in risk behavior,
  - HIV positive or high risk HIV negative clients who need STD diagnosis and/or treatment, and
  - HIV positive persons who need a medical assessment.
- Written standards for the follow-up of confidentially tested HIV positive clients who do not return for results and counseling.

Guidelines

HIV prevention program managers should develop a process for routine referral which would accomplish the following:

- Maintains a current list of community and institutional referral resources such as infectious disease specialists and clinics, free clinics, social service agencies, emergency medical services, hospitals, prenatal care clinics, family planning clinics, mental health centers, AIDS service organizations, HIV/AIDS community-based organizations (CBOs), substance abuse treatment facilities, and religious institutions;
- Establishes a liaison at each of these resources; and
- Provides periodic inservices from referral agencies.

Quality Assurance

The objective of quality assurance is to ensure that appropriate, competent, and sensitive methods are used for risk assessments, counseling, and referral of clients. Management staff, contractors, or collaborative agency staff should be trained and able to perform routine objective quality assurance site visits. A minimal level of performance should be determined and agreed upon by the funding agency and the service provider. Less than minimal performance must be remedied, or the site should suspend counseling and testing activities until an acceptable minimal standard of performance can be assured. Counseling programs should develop written quality assurance policies and procedures consistent with these standards and guidelines; these documents should be available to all staff. Client feedback should be routinely used as a factor in assessing the quality assurance of services provided.

Standards

I. Facility

- The site must be geographically accessible to the population it serves.

- The site must operate during appropriate hours and minimize any delay in providing services.
- Counseling rooms must be private to ensure confidentiality of the counseling session.

II. Staff

- Management staff must ensure that necessary resources and systems are available to ensure acceptable job performance.
- The program director must ensure adequate on-site supervision for staff.
- Counselors must meet locally established qualification standards.
- Counselors and other relevant staff must be provided updates at least annually on the scientific/public health aspects of HIV.

III. Educational and Risk Reduction Materials

- Culturally competent, linguistically specific, and developmentally appropriate written HIV information must be available to clients. The National HIV Clearing house is a useful resource to obtain and review a range of HIV education and risk reduction materials.

IV. Records/Forms

- Client records (confidential and anonymous) must contain a copy of the informed consent document, laboratory slip with test results, documentation of prevention counseling, result notification, and formulation of risk-reduction plans.
- Records with patient identifiers must be secured.
- All personal identifying information in connection with the delivery of services provided to any person must not be disclosed unless required by law or unless the person provides written, voluntary informed consent.
- Routine audits of risk assessment questionnaires, counseling and interview forms, and client risk reduction plans must be conducted.

Guidelines _____

I. Facility
- The physical facility should display a level of professionalism and client orientation relevant to the population served.

II. Staff
- A written job description should be provided for all counselors.
- Performance tasks and standards should be established and reviewed with each counselor.
- All counselor and supervisory staff should be familiar with all services connected with the counseling program.
- New counselors should be observed (with client consent) daily until proficiency is assured and periodically thereafter to ensure that proficiency is maintained.
- The supervisor should routinely provide constructive feedback to the counselor based on observations.
- Case presentations should be conducted routinely, using techniques such as team problem solving sessions with medical, supervisory, and counseling staffs.
- Each counselor and supervisor should be provided additional information through training and/or inservices about HIV, STD, TB, immunization, family planning, substance abuse, and early interventions such as antiviral treatments, etc.

III. Educational and Risk Reduction Materials

- Condoms should be available to the client—directly from providers and easily accessible without the client having to ask.
- Current written materials should be prominently displayed in public areas and made available to clients.
- Current written and audiovisual materials should be culturally and linguistically appropriate for the client population. Materials should be sensitive to the reading levels, gender, and ethnicity of the client population.

Publicly Funded Programs – Data Collection and Analysis

Accurate and consistent data collection of HIV prevention counseling, test results, notification of results, referrals, and partner notification activities are critical to the implementation, maintenance, and evaluation of a quality HIV prevention program. Data collection and quality assurance of referrals and partner notification are addressed in the respective guidelines. Analysis of HIV counseling and testing data in combination with seroprevalence and local demographic and STD morbidity data are essential components of prevention program operations. These data should help:

- Identify barriers and gaps in service delivery,
- Plan, refine and target program intervention strategies,
- Analyze resource allocation,
- Provide site specific feedback to clinic staff, and
- Provide specific feedback to counselors.

Standards _____

Publicly funded programs must:
- Utilize a standard data collection tool throughout the project area;
- Collect minimum required variables:
  - Unique record/client identifier;
  - Unique site identifier;
  - Prevention counselor identifier;
  - Date of prevention session;

  - Client demographics (age, sex, race/ethnicity, state, county, and zip code),
  - Client risk behavior (identified through client self-assessment and/or counselor discussion with client during prevention counseling);
  - Final laboratory result/report; and
  - Date of notification of results and prevention counseling.
- Adhere to the NCPS site numbering system criteria:
  - Site number is determined by where the client is tested;
  - Each clinic within a facility has a unique site number;
  - Satellite clinics require a unique site number;
  - Site numbers are not duplicated across counties, districts, or parishes;
  - Site location, not counselor identification number, determines the site number; and
  - Counselor/DIS field services and outreach teams require a unique group site number for field work.
- Conduct routine and systematic review of data for errors and inconsistencies and establish formal mechanisms for corrections.
- Report client record data (with client identifiers removed) to NCPS on a quarterly basis.
- Use the following program indicators to assess HIV testing at individual sites:
  - Number of clinic visits.
  - Number of clients eligible for prevention counseling,
  - Number of clients who received prevention counseling,
  - Number of clients tested for HIV,
  - Number of clients testing positive,
  - Number of positive clients notified of results and provided prevention counseling,
  - Number of clients testing negative,
  - Number of negative clients notified of results and provided prevention counseling, and
  - Other relevant program indicators identified through ongoing quality assurance and data analysis.

Note 1: **The first three indicators provide important denominator data for sites that provide a range of health care services.**

Note 2: **Ongoing consultations are planned and may alter data collection and data analyses standards.**

Guidelines _____

Publicly funded programs should:

- Review site-specific data analysis with appropriate staff at least quarterly.
- Conduct counselor-specific data analysis and provide feed back to the counselor at least twice a year.
- Conduct personnel resource analysis to establish minimum workload guidelines.
- Establish a computerized data system to facilitate data analysis for quality assurance.

HIV COUNSELING, TESTING, AND REFERRAL

Counselor and Provider Standards and Guidelines

Risk Assessment

Risk assessment—an integral component of HIV prevention counseling—is based on the premise that certain behaviors increase risk for infection with HIV. The counselor should engage the client in a discussion which enables the client to recognize and accept personal risk for HIV. Because the risk-assessment process serves as the basis for assisting the client in formulating a plan to reduce risk, it is an essential component of all pretest counseling.

When the counselor assesses a client's risk or reviews risk information previously recorded by the client or a clinician, the approach should be thorough and individualized for each client. The counselor should accept that the client's disclosures concerning risk behaviors correspond to his or her readiness to initiate behavior change. Each counselor should develop effective interactive methods to involve the client in identifying risk behaviors.

Standards

- Assure the client that test results and other information he or she provides will remain confidential.
- Determine the client's prevention and clinical needs by engaging him/her in a discussion that addresses: client's reason for visit and other relevant concerns; other personal circumstances; client's resources and support systems; behavioral and other sources of risk, demographic and epidemiologic factors that influence risk; client awareness of risk; readiness to change behavior; and receptiveness to available services and referrals.
- Listen for and address, as appropriate, information such as the following:
  - Number of sex partners (casual and steady) and sexual activities including vaginal, anal, and oral sex, both receptive and insertive activities;
  - Sex with a person known to be HIV-positive;
  - Sharing needles or having sex with persons who share needles;
  - History of STDs and having sex with persons who have STDs, especially genital lesions;
  - Assessment of current STD symptom status;
  - Sex in exchange for drugs, money, or other inducements;
  - Use of substances such as alcohol, cocaine, etc., in connection with sexual activity;
  - History of HIV antibody testing and results;
  - Condom use; and
  - Birth control—pregnancy prevention methods.
- Document acknowledged risk behavior, decisions about testing, and negotiated risk reduction plans in the client's record.

SPECIAL CONSIDERATIONS

- Risk assessment information may also be obtained by:
  - the clinician during the sexual/drug/medical history prior to or as a component of the counseling session;
  - utilizing a risk assessment tool completed by the client prior to the counseling session.

HIV-Prevention Counseling

Counseling provides a critical opportunity to assist the client in identifying his or her risk of acquiring or transmitting HIV. Counseling also provides an opportunity to negotiate and reinforce a plan to reduce or eliminate the risk. Counseling prior to HIV testing, prevention counseling (pretest counseling), should prepare the client to receive and manage his or her test result. Prevention counseling should also: 1) facilitate an accurate perception of HIV risk for those who are unaware, uninformed, misinformed, or in denial; 2) translate the client's risk perception into a risk reduction plan that may be enhanced by knowledge of HIV infection status; 3) help clients initiate and sustain behavior changes that reduce their risk of acquiring or transmitting HIV. Unless it is prohibited by state law or regulation, clients should be offered reasonable opportunities to receive HIV-antibody counseling and testing services anonymously. The availability of anonymous services may encourage some persons at risk to seek services who would otherwise be reluctant to do so.

Standards

- Assure the client that test results and other information he or she provides will remain confidential.
- Discuss anonymous testing options.
- Provide client-centered counseling to:
  - Establish and/or improve the client's understanding of his/her HIV risk;
  - Assess the client's readiness to adopt safer behaviors by identifying behavior changes the client has already implemented; and
  - Negotiate a realistic and incremental plan for reducing risk.
- Discuss clients history of HIV testing and results.
- Involve the client in an assessment to determine his or her behaviors which result in a risk of acquiring HIV infection.
- Tailor the counseling session to the behaviors, circumstances, and special needs of the client.
- Assist the client in recognizing those behaviors which put him or her at risk for HIV.
- Identify steps already taken by the client to reduce risk and provide positive reinforcement.
- Identify barriers/obstacles to the client's previous efforts to reduce risk.
- Determine one or two behavioral changes the client may be willing to make to reduce risk.

- Discuss the steps necessary to implement these changes.
- Address any difficulties the client anticipates in taking these steps.
- Respond to the client's concerns.
- Provide the client with necessary referrals and a written copy of the risk reduction plan (this plan should not include any personal identifiers). For clients who cannot read, a verbal summary should be provided.
- Assist the client to arrive at an appropriate decision concerning HIV testing.
- Obtain informed consent from the client prior to testing.
- Establish a plan with the client to receive test results.

Guidelines

- Document the risk assessment in the client's record for use during subsequent care.
- Document the risk reduction plan in the client's record.
- Ensure that the client understands the risks and benefits of knowing his or her HIV infection status.
- Discuss the client's expectations of test results.
- Discuss the client's plan to cope while waiting for test results.
- Explore with the client support systems that may be available.
- Ensure that the client understands what will happen during his or her visit to receive test results.
- Discuss the client's responsibility to disclose HIV infection status to sex/needle sharing partners.

SPECIAL CONSIDERATIONS

As part of the assessment, the counselor should ascertain the client's understanding of HIV transmission and the meaning of HIV antibody test results. When appropriate and relevant to the client, the counselor may:

- **Discuss what the virus is and how it is transmitted.**
  Assist the client to comprehend transmission of HIV and the delay between infection and development of a positive test.
- **Discuss what the test results mean and how they are used in medical management.**
  Negative Result - A negative test means that the person is either (1) not infected, or (2) so recently infected that the test could not detect the infection.
  Positive Result - A positive test means that the person is infected with HIV and can transmit it to others.
- **Discuss need for retest.**
  Clients engaging in continued high-risk behavior should be retested 6 months after the last possible exposure to any HIV risk. (See **"Counseling and Repeat Testing"** Section.)
- **Review risk reduction options with the client, for example:**
  - Abstain from sex and injecting street drugs; enroll in a drug treatment program.
  - Practice mutual monogamy between two HIV negative persons.
  - Use condoms to prevent STDs and HIV transmission.
  - Modify sexual practices to low or no risk behaviors.
  - Limit the number of sex partners.
  - Disinfect drug injecting equipment and avoid sharing paraphernalia.
- **Advise persons with behavioral risk for HIV not to donate blood and not to use the blood bank as a means of periodic HIV testing.**
- **Discuss related healthy behaviors, for example:**
  - Limit the use of alcohol and other drugs.
  - Obtain family planning assistance, when appropriate.
  - Obtain early diagnosis and treatment for STDs, when appropriate.
- **Explain authorized disclosures and antidiscrimination protection.**
- **Discuss bringing a support person of the client's choice, at the time of receiving test results.**

Notification of HIV Results and Prevention Counseling

Providing HIV antibody test results to a client involves interpretation that is based on the test result and the person's specific risk for HIV infection and dealing with the client's reaction to his/her test result. The client will most often focus on the result itself. Client-centered counseling is required to reassess behavioral risk that may influence the interpretation. When the client receives HIV test results, the primary public health purposes of counseling are (1) to reinforce perception of risk for those who are unaware or uninformed; (2) to help uninfected persons initiate and sustain behavior changes that reduce their risk of becoming infected; (3) to arrange access to necessary medical, prevention, and case management services for persons with a positive test result; (4) to assist those who may be infected to avoid infecting others and remain healthy; and (5) to support and/or assist infected clients to ensure the referral of as many sex or needle sharing partners as possible.

Knowledge of HIV status is an important piece of information a client can use in planning the scope of behavioral changes. Persons who abstain or have sexual relations with others who are known to be free of HIV infection and who do not use injecting drugs can essentially eliminate their risk of acquiring HIV. However, the consistent and correct use of condoms or the adoption of certain non-insertive sexual activities can greatly reduce the risk of acquiring or transmitting HIV. Although methods may be employed to reduce the risk of HIV from injecting drug use (such as the use of new needles), injecting drug use constitutes a health risk even in the absence of HIV and must be avoided.

The risk assessment and risk reduction plan developed during counseling prior to HIV testing provide a framework for strengthening efforts the client has already taken toward healthier behaviors and for recommending modifications based upon the HIV test result.

Standards

- Review available documentation including the risk assessment, prior to meeting with the client.
- Assure the client that test results and other information he or she provides will remain confidential.
- Provide HIV positive test results only by personal contact, assuring a confidential environment.
- Provide counseling at the time results are given to:
  - Assess the client's readiness to receive HIV test results;
  - Interpret the result for the client, based on his or her risk for HIV infection;
  - Ensure that the client understands what the result means and address immediate emotional concerns; and
  - Renegotiate or reinforce the existing plan for reducing risk considering the client's HIV status.
- Discuss with the client the need to appropriately disclose HIV status.
- Assess the client's need for subsequent counseling or medical services.
- Develop a plan to access necessary resources and appropriate referrals.
- For use during subsequent clinical care, document test results, risk reduction plan, and identified need for any resources and referrals in the client's chart.
- Ensure that confidentially tested HIV infected clients who do not return for results and counseling are provided appropriate follow-up. Document all follow-up. Exhaustive efforts should be made to ensure that confidentially tested HIV infected clients are offered their HIV test results and counseling.

Interpretation of HIV antibody test results depends upon the client's risk behaviors. Some recently infected clients may have negative antibody tests. Indeterminate results may represent a recent HIV infection or a biologic false positive. Eliciting specific information about recent risk behavior is essential to accurate interpretation and counseling.

The client will likely encounter circumstances where it is appropriate to reveal their HIV infection status (e.g., to health care or dental providers; past, present, or potential sex and needle sharing partners). It is important to discuss such situations with the client and assist in developing a plan and skills for appropriate disclosure of HIV infection status.

Guidelines

I. Negative HIV Test Result

- Ensure that the client understands what the test result means including:
  - Limitations of test (i.e., time lag between infection and development of antibodies); and
  - Need for periodic retesting if the client participates in risk behaviors.
- Identify any steps already taken by the client to reduce risk and provide positive reinforcement.
- Encourage the client to continue avoiding risk behaviors.
- Determine one or two behavioral changes the client may be willing to make to reduce risk and discuss steps to implement these changes.
- Assist the client in building skills to negotiate risk reduction activities with current or potential partners through discussion and role plays.
- Offer referral for further assistance in avoiding risk behaviors and maintaining low-risk behaviors.
- Discuss his/her need and ability to help partners realize they are also at risk for HIV infection.
- Reinforce the importance of discussing risk reduction measures with potential partners; identify any difficulties the client perceives.
- Advise client about importance of early STD detection and treatment to reduce HIV risk.
- Advise client to refrain from donating blood, plasma, and organs.
- Advise client on access to other prevention and treatment services (i.e., drug treatment, psychosocial support, etc.)

II. Positive HIV Test Result

Some HIV positive clients may be better prepared to receive positive test results than others. Counseling of patients with positive results must be directed to the client's specific circumstances and may require more than one session. Counselors should recognize that the emotional impact of learning about an HIV positive test result often prevents clients from absorbing other information during this encounter. Counselors may need to arrange additional sessions or provide appropriate referrals to meet the client's needs and accomplish the goals of counseling persons who are HIV positive.

- Allow time for the client's emotional response after learning his or her positive HIV result. A subsequent counseling session or follow-up telephone call may be required.
- Ensure that the client understands what the test result means.
- Assess the client's immediate needs for medical, preventive, and psychosocial support. (e.g., financial, personal, and other)
- Make the client aware of the need for additional medical evaluation and the availability of treatment.
- Establish a plan for continuing medical care and psychological support, including a subsequent prevention counseling session if necessary. As part of the plan, the counselor should:
  - Identify necessary referrals and assist the client with contacting them, and
  - Provide the client with written referral information.
- Reassess the client's risk for transmitting HIV infection.

- Help facilitate behavior change and/or reinforce behaviors that minimize or eliminate risk of transmission.
- Discuss with the client access and availability to ongoing prevention services including psychosocial and support services.
- Discuss with the client the responsibility to assure that sex and/or needle-sharing partners are counseled about their exposure to HIV and the need for them to seek medical evaluation.
- Assist the client in developing a plan which ensures that all partners are counseled about their exposure to HIV.
- Discuss how the client will notify other persons of his or her HIV status including future sex and needle-sharing partners, health care providers, and dental providers.
- Discuss with the client his or her specific plans for the next few days and ensure that the client has access to support systems during this time.
- Advise client to refrain from donating blood, plasma, and organs.

The current testing strategy of two EIA determinations followed by a supplemental test for confirmation, such as the Western blot, makes false positive test results extremely unlikely; however, the possibility of a mislabeled sample or laboratory error must be considered, and for a client with no identifiable risk for HIV infection, a repeat test may be appropriate.

SPECIAL CONSIDERATIONS

- Clients whose results are HIV positive may have specific medical questions. Considering the complexity of medical questions, responses should be left to clinicians to whom the client is referred, or to counselors or case managers with specific expertise in this area.
- Some clients may be at very high risk of transmitting the virus to others. Sites are encouraged to provide, either on-site or through referral, additional prevention counseling (individual, couple, group, or peer), as appropriate to the needs of these clients.
- Counselors should appreciate the complexity of reproductive decision-making for HIV-infected women and must be familiar with the most recent Public Health Service recommendations on antiretroviral therapy to prevent vertical transmission. (1)

III. Indeterminate Test Result

- Explain that the test result is inconclusive and may represent either:
  - a biologic false positive test, or
  - a truly positive test from a recent infection in which antibodies have not yet fully developed.
- Schedule a repeat test approximately 6 weeks after the date of this inconclusive test.
- Emphasize that the client must take the same risk reduction precautions as persons testing HIV positive until the indeterminate finding is resolved.
- Assess the client's concerns and anxieties during the waiting period. If necessary,
  - arrange psychological referral to assist the client with coping while resolving the indeterminate test result,
  - provide a hotline telephone number(s) as a referral option, and
  - provide a subsequent counseling session or follow-up telephone call.

Counseling and Repeat Testing

Situations where clients need repeat HIV counseling or request repeat HIV testing challenge and pose difficult issues for counselors. These situations include previously counseled persons who continue to place themselves or others at risk for infection, persons with indeterminate test results, seronegative persons with no risk who continue to request testing, and persons doubting or disbelieving their seropositive test results. Repeat testing is not advised as a substitute for initiating and maintaining safer behaviors.

Standards

- Assess the reasons the client requests repeat testing or continues risk behaviors.
- Emphasize that repeated testing for HIV will not prevent infection if the client continues to engage in risk behaviors.
- Arrange the specific services to meet the client's needs.
- Document all counseling activities, negotiated plans, and referrals in the client's record.

Guidelines

I. Persons with Continued Risk — Previous HIV Test Negative

The counselor should:

- Review previous risk assessment and risk reduction plan with client.
- Proceed with HIV counseling as outlined in the Section, "HIV Prevention Counseling."
- Provide alternative counseling options (e.g. referral to community based group or individual counseling) to the client to further help him or her understand his or her recidivist risk behavior(s) and modify the behaviors accordingly.
- Acknowledge incremental behavior changes, reinforce those which have reduced risk, and document in the client's chart.
- Identify obstacles which the client encountered in adopting safe behaviors.
- Explain potentially negative impact of HIV reinfection or exposure to other STDs.

II. Persons with Continued Risk—Previous HIV Test Positive

- Explain the continued risk of infecting sex and needle sharing partners.
- Negotiate a plan with the client to prevent HIV transmission.
- Identify resources and alternative counseling options to ensure that the client implements this plan and to reinforce the importance of practicing safer behaviors to protect himself or herself and others.
- Reinforce the importance of informing partners and making risk-reduction decisions with partners.
- Ensure that the client understands the adverse impact of STDs and drug use upon immune function.

III. Persons with Indeterminate Test Results

The counselor should:

- Arrange a repeat test approximately 6 weeks from the date of this current test;
- Assess the client's concerns and level of anxiety during the waiting period. If necessary, arrange psychological referral to assist the client in coping;
- Consider persons to be negative for antibodies to HIV if their Western Blot test results continue to be consistently indeterminate for at least 6 months in the absence of any known risk behaviors, clinical symptoms, or other findings (2);
- Encourage the client to follow guidelines outlined in the **"Notification of HIV Results and Prevention Counseling Section."**

IV. Persons with No Risk—Negative Test Results

The counselor should:

- Counsel the client on modes of HIV transmission and behaviors that place persons at risk for HIV;
- Counsel the client on unwarranted fears;
- Arrange referral for additional counseling for clients who continue to exhibit unfounded anxiety about HIV.

V. Persons Who Doubt Previous Seropositive Test Results

The counselor should:

- Assess why the client doubts the accuracy of the test results;
- Explain the process of multiple tests to confirm a positive result;
- Assist the client in recognizing behaviors that lead to HIV infection.
  - For clients with no acknowledged risk for HIV, repeat the test.
  - For clients with behavioral risk for HIV, arrange for medical referral and repeat test, if necessary.

REFERENCES

1. CDC. Zidovudine for the Prevention of HIV Transmission from Mother to Infant. *MMWR*, 1994;43(16):285-287.
2. CDC. Interpretation and use of the Western Blot Assay for Serodiagnosis of Human Immunodeficiency Virus Type 1 Infections. *MMWR*, 1989;38(S-7):1-7.

Referral Process

A thorough client assessment often indicates a need for services that cannot be provided by the counselor. The counselor has two opportunities to make referrals: (1) the HIV prevention counseling session, and (2) the test notification/prevention counseling session.

Standards

- Provide appropriate referral resources for:
  - Any client who may be in need of support to maintain safer behaviors,
  - HIV negative clients who continue to engage in risk behavior,
  - HIV negative clients who continue to test but are without risk,
  - HIV positive clients who continue to engage in risk behaviors, and
  - HIV positive clients with additional medical, social, or psychological needs.
- Provide the client with a written list of referrals including telephone numbers, addresses, hours of operation, and services provided.
- Document referrals in the client's record. Referrals made during the initial HIV prevention counseling session should be followed-up during the test notification/prevention counseling session.

Guidelines

The counselor should:

- Offer referral to case management provider, if one is available;
- Seek feedback from the client about preferences for referrals, the accessibility of the referral, and the client's intention to follow through with the referral;
- Provide the client with relevant details about referral sites, e.g., the name of a specific contact person.

SPECIAL NOTE

Any HIV positive or negative client who continues to engage in risk behaviors should know where and how to access STD examination and treatment services.

TERMS USED IN HIV PREVENTION

ABSTINENCE: Refraining from participating in something. When talking about HIV, abstinence refers to not engaging in sexual intercourse or injecting drugs.

AIDS: The acronym for acquired immunodeficiency syndrome. AIDS can affect the immune and central nervous systems and can result in neurological problems, infections, or cancers. It is caused by HIV.

ANAL SEX: A type of sexual intercourse in which a man's penis enters his partner's anus.

ANONYMOUS: Without any identification. The term is used in regard to HIV testing when the persons ordering and performing the test do not maintain a record of the name or identity of the person whose blood they are testing.

ANTIBODIES: Proteins that are manufactured by the immune system in response to foreign substances.

ANTIBODY TEST: A laboratory procedure which detects antibodies to specific microorganisms. An HIV antibody test determines if a person's body has produced antibodies to HIV but does not detect the virus itself.

ANTIDISCRIMINATION PROTECTION: Provisions of laws that impose penalties for discrimination because of a person's HIV infection or perceived risk of infection.

ANTIVIRAL: Pertaining to something that inhibits the actions of a virus. Antiviral therapy refers to a treatment that works against the virus itself.

ANUS: The opening of the body through which feces or bowel movements pass. The anus is the part of the body which is penetrated during anal sex.

APPROPRIATE DISCLOSURE: Notifying specific people of a client's HIV risks or infection to other people because of their risk of exposure or their ability to provide medical assistance or support.

ASYMPTOMATIC: Being infected but having no symptoms of infection.

BISEXUAL: A person whose sex partners are both men and women. A bisexual can be a man or a woman.

CD4 TESTING: A laboratory blood test that counts a subset of white blood cells as an aid to determining immune function. Certain counts are indications for starting medications for persons with HIV infection.

CLIENT: A person to whom professional services are rendered.

CLIENT-CENTERED APPROACH: Refers to counseling conducted in an interactive manner responsive to individual client needs. Avoids a preconceived set of points to be made by the counselor and encourages the client to do most of the talking. Focuses on developing goals with the client rather than simply providing information or imposing counselor goals.

CONDOM: Commonly called rubbers, condoms are sheaths that fit over a man's penis or into a woman's vagina to prevent semen from entering the partner's body after ejaculation. Condoms also prevent a man's penis from coming in contact with his partner's body fluids.

CONFIDENTIAL: Kept private. In regard to HIV testing, it means that the results of a test are known only to the person who is being tested and the immediate group of people who provide care and prevention services for that person.

COUNSELING: Helping people plan actions that will benefit themselves or others. Unless designated as group counseling or couple counseling, the word is used here to describe one-on-one discussions.

DISCORDANT: Conflicting. Used to describe the circumstances in which one partner is infected with HIV and the other is not.

EIA: See ELISA.

EARLY INTERVENTION: The set of medical, preventive and psychosocial services provided to persons upon diagnosis of HIV infection. Involves monitoring indicators of immune function as signals to provide interventions to delay the onset of illness, psychosocial support, and measures to prevent transmission.

ELISA: Acronym for enzyme-linked immunosorbent assay. The laboratory test most commonly used to screen for antibodies to HIV. See Positive Test.

FALSE-NEGATIVE: A negative test result for a person who is actually infected.

FALSE-POSITIVE: A positive test result for a person who is actually not infected.

HETEROSEXUAL: A person whose sex partners are exclusively persons of the opposite sex.

HIV: Human immunodeficiency virus; the virus that causes AIDS.

HOMOSEXUAL: A person whose sex partners are exclusively members of the same sex. A homosexual man is called a gay man. A homosexual woman is called a lesbian.

IMMUNE STATUS: The state of the body's natural ability to fight diseases.

IMMUNE SYSTEM: The body's mechanism to identify and fight off infections and other foreign substances.

INJECTED DRUGS: Drugs that are introduced directly into a person's body or bloodstream through a needle. These include cocaine, crack, heroin, and steroids.

INDETERMINATE: Not determined one way or another. Inconclusive test results; the laboratory is unable to state whether antibody is present or not.

INTERVENTION: An action taken to change an outcome.

MASTURBATION: Stimulating a man's penis or a woman's clitoris.

MONOGAMOUS: Having an exclusive sexual relationship with only one partner. Mutual monogamy means neither partner has sex with other people.

MORBIDITY: Illness or disease.

MORTALITY: Death.

NEGOTIATED RISK REDUCTION PLAN: Discussions that result in identifying the steps that a client thinks he or she will take to reduce the chances of acquiring HIV. The counselor's role is to assist the client in developing a realistic plan.

OUTREACH SERVICES: Usually refers to services provided outside the walls of an agency. An outreach worker might go to a client's home or neighborhood.

PARENTERAL: Taken into the body through intravenous or intramuscular injection.

PHLEBOTOMY: Collecting a blood sample for laboratory testing by inserting a needle into a person's vein.

POSITIVE REINFORCEMENT: Acknowledging healthy behaviors or intentions through some mechanism that indicates approval, intended to be perceived as rewarding.

POSITIVE TEST: For HIV, a sample of blood that is reactive on an initial ELISA test, repeatedly reactive on a second ELISA run on the same specimen, and confirmed positive on Western blot or other supplemental test.

PREVALENCE: The total number of persons in a given population with a disease or condition at a given point in time.

PREVENTION COUNSELING: Counseling which is designed to facilitate the client's perception of risk, identify behavior changes that the client has already implemented and barriers to the client's previous efforts to reduce risk, and to assist the client in developing a plan to reduce risk regardless of whether or not he or she takes the test. Prevention counseling that takes place prior to HIV testing should prepare the client for receiving and managing his or her test results.

PROBLEM-SOLVING TECHNIQUES: A process by which a counselor tries to discover the basis of barriers indicated by some verbal or nonverbal communication from the client. After the barriers have been identified, possible solutions are discussed.

PROPHYLACTIC TREATMENT: Medications given to help prevent infection or its consequences.

RETROVIRUS: One of a group of RNA viruses. HIV is a retrovirus.

RISK ASSESSMENT: Used in this document, risk assessment is that portion of a client-centered discussion that encourages the client to identify and acknowledge his or her personal risk for acquiring HIV.

SENSITIVITY: The probability that a test will be positive when infection is present.

SPECIFICITY: The probability that a test will be negative when the infection is not present.

SPERMICIDE: A substance that kills sperm.

TRIAGE ASSESSMENT: The process that determines whether someone should be referred to counseling. Triage assessment facilitates prevention counseling services for those persons at increased risk for HIV.

WESTERN BLOT: A laboratory test that detects specific antibodies to components of a virus. Often used to confirm HIV antibodies in specimens found repeatedly reactive using the ELISA test for HIV antibodies.

HIV COUNSELING, TESTING, AND REFERRAL STANDARDS AND GUIDELINES

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