Provision of HIV Prevention Counseling, Testing, and Referral Services

I. Authority: Chapters 381 and 384, Florida Statues (F.S.) carefully structures the manner in which health care providers may perform HIV tests. The law requires those who perform HIV tests in county health departments and other registered testing sites to obtain informed consent of the test subject, make private counseling available both before and after the test, and confirm positive preliminary results with a supplemental test before informing the test subject of the result.

II. Title: Provision of HIV prevention counseling, testing and referral services

III. Type of Standard: Service

IV. Objectives: To prevent the spread of HIV infection through the following:

A. The delivery of science-based, culturally competent HIV prevention counseling, testing and referral services;

B. The provision of referrals to needed medical and psychosocial care regardless of clients' HIV status;

C. Successful linkages of HIV-positive clients to partner counseling and referral services and to medical and psychosocial care, as appropriate; and

D. The continual enhancement in quality of counseling, testing technology, knowledge of HIV/AIDS, and documentation of services.

V. Personnel: All persons who provide and/or supervise/coordinate HIV prevention counseling, testing, and referral programs.

VI. Competencies: *Technical Assistance: HIV/AIDS 17 Minimum Standards for HIV Counselors, Trainers and Early Intervention Consultants* (heretofore referred to as the "TA: HIV/AIDS 17") outlines prerequisites, training requisites, and post-requisites for HIV counselors, 501 trainers and Early Intervention Consultants. HIV counselors must also attend annual HIV/AIDS 501 updates to keep abreast of new information and to sharpen their skills in HIV prevention counseling, testing, and referral services.

VII. Guiding Principles:

A. The primary purpose of testing is for clients to know their status; therefore, every effort should be made to ensure that clients return for their results.

B. Evaluating an individual's risk for HIV infection and offering testing on a voluntary basis should be a routine part of health care at all HIV test sites.

C. HIV prevention counseling, testing, and referral information should be provided face-to-face in a manner that is appropriate for the client's culture, language, gender, and age. Technical discussions or terms, such as antibodies or window period, should be avoided.

D. All staff of test sites who perform HIV pre- and/or post-test counseling will use the Centers for Disease Control and Prevention's (CDC) "HIV prevention counseling" model as defined in the manual for the DOH "HIV/AIDS 501 Prevention Counseling, Testing, and Referral Services" course (heretofore referred to as the "HIV/AIDS 501").

E. Department of Health (DOH), STD Disease Intervention Specialists will follow the Centers for Disease Control and Prevention's *Partner Counseling and Referral Services Guidelines*.

F. The CDC revised guidelines for HIV counseling, testing, and referral, as it applies to services provided in Florida should be followed.

G. HIV counseling and testing will be done in accordance with all applicable laws and administrative rules.

VIII. Areas of Responsibilities:

A. Administrative Functions - The primary administrative responsibility in an HIV counseling and testing program is to assure the quality of HIV prevention counseling, testing, and referral services. This includes the following:

1. Registration/Reregistration of Testing Programs

    a. All county health departments (CHDs) and organizations that conduct or advertise as conducting an HIV testing program must register with the Bureau of HIV/AIDS and receive a site number. Please refer to Chapter 64D-2.006, Florida Administrative Code (F.A.C.), for more information. Non-DOH test sites are required to pay a processing fee. Fees established shall be an amount sufficient to meet all costs incurred by the department in carrying out its registration, data collection, complaint monitoring, and administrative responsibilities under s. 381.004 (9)(b) F.S., for all private HIV testing sites, but shall not exceed $100.00. The one-time registration fee of $100.00 can only be waived under the stipulations outlined in the F.A.C.

    b. Effective October 1, 1998, all county health departments and other providers who conduct an HIV testing program, as well as new sites, must reregister annually. All testing sites that have registered since October 1, 1998, have received a *Certificate of Registration* with an expiration date one year from the date of registration. Sites that fail to reregister with the Bureau of HIV/AIDS by the expiration date are not authorized to continue operating an HIV counseling and testing program.

    c. The role of the physician, as it relates to HIV counseling and testing sites, is to ensure the operation of the center and to ensure that the site is adhering to community practice. This includes everything medical, standard precautions, correct and accurate billing, and that protocols are met.

    d. If the DOH laboratory is used for HIV testing, test sites must use the DOH HIV counseling, testing, and referral forms, as specified in the *HIV Counseling, Testing, and Referral Forms Instruction Guide*.

e. Counseling staff must have documentation of approved training in HIV counseling and testing prior to performing counseling sessions. Counselors at test sites must complete the HIV/AIDS 500 and 501 courses and must attend annual HIV/AIDS 501 Updates.

f. The CHD must agree to provide the HIV/AIDS 500 and HIV/AIDS 501 courses and annual HIV/AIDS 501 Updates to test site staff free of charge. The CHD will also provide the applicable forms to the provider free of charge.

g. All registered test sites must reregister annually. These sites will be sent an application form for reregistration 60 days prior to their expiration date. If the application is not completed and returned to the Bureau of HIV/AIDS by the expiration date, the program is not authorized to continue operating.

h. Confidential Sites

(1) Potential test sites should contact their local HIV/AIDS Program Coordinator (HAPC) or Early Intervention Consultant (EIC) for a new site application packet. The package contains a copy of s. 381.004 F.S.; Chapter 64D-2.004 of the Florida Administrative Code; the *Model Protocol for HIV Counseling and Testing Conducted Outside County Health Departments and Registered Testing Programs;* the *DOH Model Protocol for HIV Counseling and Testing for County Health Departments and Registered Testing Programs;* a sample Memorandum of Agreement/Memorandum of Understanding (MOA/MOU); and the DH Form 1781 *Application for Registration and Reregistration for HIV Testing Programs.*

(2) Potential test sites must complete the DH Form 1781 *Application for Registration and Reregistration for HIV Testing Programs* and return it to the Bureau of HIV/AIDS. Non-DOH sites are required to submit the one-time $100.00 registration fee along with the application.

(3) If DOH is providing any portion of HIV counseling and testing services, including forms, OraSure, and technical assistance to non-DOH test site, a MOA/MOU *must* be negotiated between the local CHD and the provider and signed annually by the anniversary date of the beginning of service provision. Referral procedures should be outlined in the MOA/MOU. Any fees charged to clients will be consistent with those charged by the CHD (i.e., they should not charge more than the CHD). The potential test site must agree to follow all security and client confidentiality policies and procedures that apply to the Department of Health, as specified in the *Department of Health Information Security* manual. This MOA/MOU must state that the potential provider will follow all applicable statutes, rules, policies, and procedures regarding confidential HIV counseling and testing. It will be important for the CHD to include what they require of the site in the agreement, such as not turning clients away because of their inability to pay for testing, participation in quality improvement/technical assistance reviews by CHD and/or Bureau of HIV/AIDS staff, following the *DOH Model Protocol for HIV Counseling and Testing for County Health Departments and Registered Testing Programs*, adhering to the *Department of Health Information Security* policies and procedures, and following applicable

technical assistance guidelines. The HAPC and EIC will be available to provide technical assistance on the application process.

(4) When the completed registration form, MOA/MOU (if applicable), and fee (if applicable) are received by the Bureau of HIV/AIDS, a provider profile and site number are generated. The profile and site number are mailed to the provider in order to confirm the information in the profile. The provider is authorized to begin using the site number for HIV laboratory tests and data collection. A certificate is also sent to the provider as proof of registration, and the HAPC and the EIC are copied. The certificate should be posted in a location visible to clients.

i. Anonymous Sites

(1) Only the Department of Health, or organizations authorized by the Department of Health, can perform anonymous HIV counseling and testing. Each county must have at least one site that provides anonymous testing services. The individual county health department may authorize a private provider to perform anonymous counseling, testing, and referral services.

(2) When contacted by a potential test site requesting to be an anonymous site, a registration packet is sent to the contact person by the HAPC or EIC. The package contains a copy of s. 381.004, F.S.; Chapter 64D-2.004 of the Florida Administrative Code; the *Model Protocol for HIV Counseling and Testing Conducted Outside County Health Departments and Registered Testing Programs*, the *DOH Model Protocol for HIV Counseling and Testing for County Health Departments and Registered Testing Programs*; DH Form 1781 *Application for Registration and Reregistration for HIV Testing Programs;* a sample MOA/MOU; and *Interoffice Memorandum: Request for Anonymous HIV Counseling and Testing Site*.

(3) A MOA/MOU *must* be negotiated between the local CHD and the non-DOH provider and signed annually by the anniversary date of the beginning of service provision. Referral procedures should be outlined in the MOA/MOU. Any fees charged to clients will be consistent with those charged by the CHD (i.e., they should not charge more than the CHD). The potential test site must agree to follow all security and client confidentiality policies and procedures that apply to the Department of Health, as specified in the *Department of Health Information Security* manual. This MOA/MOU must state that the potential provider will follow all applicable statutes, rules, policies, and procedures regarding confidential HIV counseling and testing. It will be important for the CHD to include what they require of the site in the agreement, such as not turning clients away because of their inability to pay for testing, participation in quality improvement/technical assistance reviews by CHD and/or Bureau of HIV/AIDS staff, following the *DOH Model Protocol for HIV Counseling and Testing for County Health Departments and Registered Testing Programs*, adhering to the *Department of Health Information Security* policies and procedures, and following applicable technical assistance guidelines. The HAPC and EIC will be available to provide technical assistance on the application process.

(4) The Bureau of HIV/AIDS requires the signed MOA/MOU (if applicable), the completed registration form DH 1781 Application for Registration and Reregistration for HIV Testing Program, *Interoffice Memorandum: Request for Anonymous HIV Counseling and Testing Site* signed by the CHD director/administrator, and *Outline for the Provision of Anonymous HIV Counseling and Testing Services* signed by the provider, CHD director/administrator, area HAPC, and/or EIC, and the one-time $100.00 registration fee (if applicable) in order to assign an anonymous site number and provider profile. Once received, this is forwarded to the Director of Disease Control for final approval. If approved, the final profile and anonymous site number are mailed to the provider in order to confirm the information in the profile. The provider is authorized to begin using the site number for HIV laboratory tests and data collection. A certificate is also sent to the provider as proof of registration. This is copied to the HIV/AIDS Program Coordinator and the Early Intervention Consultant. The certificate should be posted in a location visible to clients. Test sites *cannot* perform anonymous testing without an anonymous site number.

2. HIV counselors will meet the minimum requirements, as outlined in TA: HIV/AIDS 17 and attend annual HIV/AIDS 501 Updates. HIV counseling and testing should be included in performance standards of all persons providing these services. Qualified staff should monitor counselors at least twice annually or as needed and should be provided with immediate feedback.

3. Services are provided in accordance with all applicable laws, administrative rules, guidelines, policies and procedures.

4. Test sites are supplied with necessary forms and equipment to properly execute HIV prevention counseling, testing, and referral services.

5. Services are provided in a manner that is appropriate for the client's culture, language, gender, and age. All persons providing HIV prevention counseling, testing, and referral services should receive cultural diversity training.

6. Barriers to clients' accessing services are assessed, identified, and eliminated or reduced on an ongoing basis. To increase accessibility for clients, HIV testing may be integrated with other clinical/program services. Services should be available on an appointment or walk-in basis. Hours of operation should be based on clients' need for services, staffing levels, and available resources.

7. HIV/AIDS printed informational materials and condoms with instructions are readily available.

8. Counseling is provided in a confidential setting.

9. Every effort is made to ensure that clients who are tested receive their results (e.g., giving post-test appointment at the time of testing, following up with a generic phone call, following up with a letter, and conducting a field visit, etc.).

10. Documentation of services is conducted as specified in the *HIV Counseling, Testing, and Referral Forms Instruction Guide*. A sampling of records should be randomly

chosen and reviewed annually by qualified staff. Qualified staff may include bureau staff, Early Intervention Consultants (EICs), clinic supervisors, HIV/AIDS Program Coordinators (HAPCs), and others who have been trained in how to review CTR records.

11. Records are maintained in a secured area with minimal access.

12. Risk assessment, pre-test counseling, and informed consent are conducted with clients prior to specimen collection to prevent the possibility of clients being tested without their consent.

13. Appointments for anonymous HIV counseling and testing services are *not* scheduled in a way that will identify the client. An alternative system, such as using a numerical appointment system, should be developed. Pseudonyms should not be used to identify clients in anonymous HIV test settings.

14. Relationships with referral agencies are established and maintained to facilitate successful linkages.

15. No client is denied services based on inability to pay. Fees can be charged on a sliding scale or a flat rate. In the case of an anonymous test, the client's verbal declaration of their inability to pay will be sufficient. Please refer to Chapter 64D-2.003(5)(d) F.A.C., Chapter 64F-16.006 F.A.C. (Sliding Fee Scale), and Chapter 64F-16.007 F.A.C. (Waiver of Charges) for more information on fee structure.

IX. Training

A. The Early Intervention Consultant or other HIV/AIDS 501 trainers will provide routine training opportunities to accommodate staff needs. Priority for training will be given to staff who provide HIV prevention counseling, testing, and referral services as a major function of their job duties or as a part of a contractual agreement with the department.

B. To ensure that clients tested for HIV receive the highest quality HIV prevention counseling, testing, and referral services, staff will not perform these services without first meeting the requirements of TA: HIV/AIDS 17, which includes successful completion of the HIV/AIDS 500 and HIV/AIDS 501 courses.

C. HIV counselors at test sites are required to attend yearly HIV/AIDS 501 Updates.

D. The annual HIV/AIDS 501 Update should be tailored for the specific area for which it is being provided and will include counseling, testing, and referral updates; patient care updates; legal updates; data updates; and related local issues. Additional topics may be covered as needed.

X. HIV Prevention Counseling - Since 1993, the Centers for Disease Control and Prevention (CDC) has recommended one interactive counseling approach, client-centered HIV prevention counseling. Client-centered HIV prevention counseling is a process that is aimed at personal risk reduction by helping clients identify and commit to a specific behavior change step. This type of counseling has been shown to be effective in reducing HIV acquisition among high-risk persons with negative or unknown HIV status and transmission from HIV-infected persons. In some HIV test sites, counselors deliver a face-

to-face informational message in response to the checklist of risk behaviors on the DH 1628 Laboratory Request Form or other risk assessment forms. This type of “counseling” is considered to be “information dissemination” and “data collection”, not client-centered HIV prevention counseling.

HIV prevention counseling should be used in HIV risk assessments and in pre-test and post-test counseling sessions. The primary goal of HIV prevention counseling is risk reduction. This is brought about through an in-depth personalized risk assessment and negotiation of an individualized risk-reduction plan that is concrete, acceptable, and achievable. Other elements of HIV prevention counseling include an assessment of the client’s knowledge of HIV/AIDS and clarification of misconceptions about transmission, acknowledgement and support for positive steps that the client has already made, and skills-building exercises (as appropriate).

Counseling sessions should be tailored to address the personal risk of the client rather than providing a predetermined set of information unrelated to the client’s situation or allowing the session to be distracted by the client’s additional problems unrelated to HIV (referrals can be made for these problems). Counseling techniques such as use of open-ended questions and role play scenarios, attentive listening, and maintaining a nonjudgmental and supportive approach can encourage the client to remain focused on personal HIV risk reduction.

Counseling should not be a barrier to HIV testing. Likewise, focusing on increased HIV testing should not be a barrier for the provision of effective HIV counseling services for at-risk clients. Persons seeking repeat HIV testing may need more intensive prevention services, e.g., enhanced prevention counseling, prevention case management, individual level intervention, etc. and should be referred accordingly. Additional information on these services can be obtained in the HIV/AIDS 501 course and update.

A. HIV Risk Assessment – Risk assessment is an essential element of HIV prevention counseling in which the client and counselor work to understand and acknowledge the client’s personal risk(s) for HIV. Risk Assessment is not synonymous with risk screening, which helps determine which individual clients in a population need HIV prevention counseling, testing, and referral services. Risk screening can be used in low prevalence settings (e.g., <1%) and in settings where the client population is generally not at increased risk for acquiring or transmitting HIV infection. Additional information on HIV risk screening can be obtained in the HIV/AIDS 501 course and annual update.

    1. All adult and adolescent clients should be risk assessed for HIV annually, as needed due to medical indications and/or possible recent exposure, or if HIV testing is requested.

    2. When conducting the risk assessment, it is important to assure the client that all information is confidential under Florida law. All HIV counseling sessions should be conducted one-on-one with the client and behind a closed door. If sessions are conducted in an outreach setting, all precautions should be taken to ensure confidentiality. This could include the counselor and client moving away from other individuals and/or encouraging clients to meet with their counselor in the clinic. Partners, spouses, relatives, and others may only be permitted in the room or in the counseling area for translation purposes when no interpreters are available. With client permission, a third party may be allowed in the room for monitoring.

3. Risk assessment allows the counselor and client to identify, acknowledge, and understand the specific details of the client's own HIV risks and the context in which risk occurs. Refer also to the HIV/AIDS 501 manual. The following should be used for conducting an HIV risk assessment:

   a. Introduction and purpose of the session;

   b. Explain confidentiality and the security of confidential information;

   c. Assess client's reason for testing if requested;

   d. Assess client's history of HIV testing;

   e. Assess client's knowledge of HIV/AIDS *(Clarify any misconceptions.)*;

   f. Assess client's perception of risk;

   g. Assess the influence of substance use/abuse on client's HIV risk;

   h. Assess client's STD/hepatitis/TB history;

   i. Assess client's history of transfusions/transplant;

   j. Assess client's history of sexual assault/domestic violence;

   k. Assess client's occupational risk (medical setting/sex worker);

   l. Assess condom use; and

   m. Assess partner risk.

4. Information from the risk assessment should be documented in the client record and on the DH 1628 Laboratory Request Form, as specified in the *HIV Counseling, Testing, and Referral Forms Instruction Guide*.

5. Clients identified as being at risk should receive HIV pre-test counseling and should be strongly encouraged to accept testing. At-risk clients who decline testing should be given information about local anonymous and confidential test sites for future testing. Pre-test counseling and offering of HIV testing should be documented in clients' records and on the DH 1628 Laboratory Request Form, as specified in the *HIV Counseling, Testing, and Referral Forms Instruction Guide*.

6. Clients with no identifiable risk behaviors should be offered HIV pre-test counseling and testing as a part of clinic services. If these clients accept testing, pre-test counseling and testing should be provided and documented accordingly in client record, and on the DH form 1628 Laboratory Request Form, as specified in the *HIV Counseling, Testing, and Referral Forms Instruction Guide*. If these clients refuse HIV pre-test counseling and testing, "refused/declined HIV testing" should be noted in their record.

7. Because clients' HIV risk may not always be identified by HIV counselors or acknowledged by clients, any client who requests a test should be given one.

B. HIV Pre-Test Counseling - Pre-test counseling in the context of HIV prevention counseling is a continuation of the risk assessment that includes an exploration of previous attempts to reduce risk, and identification of successes and challenges in previous risk reduction. Clients should be encouraged to commit to a single, explicit step to reduce their risk. Clients are more likely to take ownership of a concise risk reduction plan that they developed based on risk information that they identified.

1. The following model should be used during the pre-test counseling session (Refer also to the HIV/AIDS 501 manual):

   a. Discuss indications for testing (medical indication and/or information obtained from the risk assessment);

   b. Establish and/or improve the client's self-perception of risk;

   c. Identify and support behavior changes the client has already attempted;

   d. Explore triggers/situations which increase the likelihood of high-risk behaviors;

   e. Discuss options for eliminating and/or reducing risk;

   f. Negotiate a realistic and incremental plan for eliminating and/or reducing risk. Have client commit to at least one concrete, achievable behavior change step. Writing down the agreed upon goal may be useful;

   g. Discuss the possible need for retesting. Most infected persons will develop detectable HIV antibodies within three (3) months of exposure; however, it can take up to six (6) months for these antibodies to develop;

   h. Discuss the importance of notifying sex and/or needle-sharing partners if test results are positive, the availability of Partner Counseling and Referral Services (PCRS) through the CHD STD Program, and how confidentiality is protected if PCRS is accepted through the CHD STD Program. Anonymous clients should be informed that there is a possibility that they will be named as a contact to an infected partner; therefore, they may not remain anonymous;

   i. Discuss the potential social, medical, and economic impact of a positive test result;

   j. Provide information on support services that are available during the wait period for test results (e.g., hotlines, pre-test counselor's name and telephone number, CHD number, etc.);

   k. Discuss the importance of returning for test results, especially since results or any information indicating that clients were tested for HIV *cannot* be given over the telephone. Give a return appointment date at least two weeks from the date of the pre-test counseling session (If results are taking longer than this, please contact the Bureau of HIV/AIDS, Early Intervention Section). Clients should be

asked what problems they might have returning for their appointment or if the date is convenient. Clients should be given the “blue” copy of the DH 1628 Laboratory Request Form and told to bring it to their post-test counseling session, particularly if they test anonymously;

l. Make appropriate referrals based on risk assessment and pre-test information and provide literature and condoms as appropriate; and

m. Inform the client that the counselor who conducts the pre-test counseling session may not be the same for post-test counseling. All efforts are made to ensure that the same counselor is available; however, due to clinic flow and other related issues, this may not be possible.

2. Florida’s Prevention Cooperative Agreement with CDC requires that 90% of clients who test positive for HIV and 75% of clients who test negative for HIV be post-test counseled. Pre-test counseling should be provided in a manner that encourages clients to return for their results. Any barriers related to clients receiving their results should be eliminated or reduced. The primary goal of testing clients is for them to know their HIV status.

3. All pregnant women will be advised of the need to know their HIV status, the risk to unborn children, and treatment regimens that are available to reduce the risk of perinatal transmission. Florida law requires that all pregnant women be counseled and offered HIV testing. A DH 1631 Statement of Objection Form must be completed when a pregnant woman refuses HIV testing.

4. Counselors should also be sensitive to the issue of domestic violence and the effect domestic violence may have on the individual’s ability to negotiate safer sexual practices or willingness to notify partners of possible exposure. Counselors should be aware of local shelters and make referrals as appropriate. The Florida Domestic Violence Hotline (1-800-500-1119) provides information and referrals in English, Spanish, and Creole.

5. Only DOH-approved literature can be offered. A list is available from the Bureau of HIV/AIDS.

6. Information from the pre-test counseling session should be documented in clients’ records and on the DH 1628 Laboratory Request Form, as specified in the *HIV Counseling, Testing, and Referral Forms Instruction Guide*.

C. Informed Consent

1. No person shall perform an HIV antibody test on an individual without first obtaining the consent of the test subject or his/her legal representative. Limited exceptions to obtaining informed consent can be found in s. 381.004 (3) (h), F.S. Written informed consent <u>must</u> be obtained using the DH 1818 Consent Form. Specimen collection should only take place after the pre-test counseling session and informed consent has been obtained. This will eliminate the possibility of testing clients without consent. See *The Model Protocol for HIV Counseling and Testing for County Health Departments and Registered Testing Programs*.

2. Clients who accept testing will complete the appropriate side of the DH 1818 Consent Form, as specified in the *HIV Counseling, Testing, and Referral Forms Instruction Guide*. The counselor will assess the client's ability to read the consent form and will assist the client as needed. Reasonable accommodations should be made for those who are blind, deaf, handicapped, or speak a language other than English.

3. When obtaining informed consent from the client, the counselor should explain the following:

   a. Meaning of "confidential" and the client's right to confidential treatment of information identifying the subject of the test and the results of the test to the extent provided by law, and that Florida law provides penalties for breaches of confidentiality;

   b. The HIV antibody test determines if an individual is infected with the virus that causes AIDS and the potential uses and limitations of the test (the reliability of the results and what positive, negative, and indeterminate results do and do not mean);

   c. Procedures that will be used to collect the specimen for HIV testing and any side effect(s) the client may experience (i.e., possibly bruising when a blood specimen is drawn); and

   d. That HIV antibody testing is voluntary, and consent to be tested can be withdrawn at any time prior to testing;

4. Explain to clients testing confidentially that a positive test result is reported to the local CHD in a way similar to other infection reporting. HIV infection reporting should not be presented in such a way as to deter confidential testing. HIV infection reporting allows DOH staff to offer follow-up activities to those who test positive, including post-test counseling for those who do not return for test results, linkages to medical and psychosocial services, and voluntary PCRS. Confidential testing can more readily facilitate access into medical care for positive clients and can assist medical providers in offering more integrated care with other medical conditions that positive clients may have. Referrals to medical and psychosocial services and PCRS should also be offered to those who test positive anonymously.

5. Information must be given on the availability and location of anonymous test sites. Each CHD shall maintain a list of available anonymous test sites; each counselor should have a current list readily available for distribution upon request.

D. HIV Post-Test Counseling Session

1. The test site staff should ensure that all reasonable efforts are made to notify clients of their test results. All clients should be given the opportunity for a face-to-face HIV post-test counseling session. Clients should be given the client copy of the test results unless refused. The test site copy of test results should remain in the client's record at the test site. HIV test results (positive, negative, or indeterminate) shall not be given over the phone. HIV test sites should discourage clients from calling to inquire whether their HIV test results have returned from the laboratory. Clients

should be reminded that the testing site cannot verify who they may be conversing with on the phone and are required to ensure the client's confidentiality. Florida law imposes strict penalties for breaches of confidentiality.

2. Post-test counseling for clients should take place regardless of test results. The counselor, to the best of his/her ability, will ensure that the person who received the test result is the person who was tested. For anonymous tests, the client will present the blue "client" copy of the DH 1628 Laboratory Request Form given during pre-test counseling. The counselor will confirm that race/ethnicity, gender, and age (all on the "blue" copy of the DH 1628 Laboratory Request Form) correspond with the client who presents for HIV post-test counseling.

3. Counselors should be sensitive to the issue of domestic violence and the effect domestic violence may have on the individual's ability to negotiate safer sexual practices or willingness to notify partners of possible exposure. Counselors should be aware of local shelters and the domestic violence hotline number and make referrals as appropriate.

4. All HIV post-test counseling sessions should be conducted one-on-one with the client behind a closed door. Partners, spouses, relatives, and others may only be permitted in the room or in the counseling area for translation purposes when no interpreters are available. With client permission, a third party may be allowed in the room for monitoring. After the results are given to the client, a third party can be invited into the room if needed for emotional support. At no time should the counselor reveal the HIV test result. It is the client's choice to inform the third party of the HIV result. See the HIV/AIDS 501 manual.

5. During the post-test counseling session, the counselor will ensure that the topics listed below are addressed accurately and take into consideration the client's cultural and ethnic background and education level. Post-test counseling sessions will be client-centered to address the needs of individual clients. HIV post-test counseling shall include:

    a. The meaning of the test results;

    b. The potential social, medical, and economic effects of a positive test result;

    c. The possible need for retesting;

    d. A review of the client's assessment of risk;

    e. Availability of health care, mental health, social, and other support services;

    f. Options for eliminating and/or reducing the transmission of HIV infection to the individual and/or partners. Florida law imposes strict penalties upon those who knowingly transmit HIV infection to others [s. 384.34, F.S.]; and

    g. Other appropriate referrals (e.g., STD, primary care, psychosocial).

6. HIV Negative and Indeterminate Post-Test Session

   a. The following protocol should be used when giving HIV-negative or indeterminate results (Refer to the HIV/AIDS 501 Manual):

      (1) Introduction and purpose of the session;

      (2) Explain confidentiality and the security of confidential information;

      (3) Provide results clearly and simply. Results should be given right away;

      (4) Explain the meaning of the results;

      (5) Explore the client's reaction to the results;

      (6) Discuss the need for retesting due to recent possible exposure or if result is indeterminate. Most infected persons will develop detectable HIV antibodies within three (3) months of exposure; however, it can take up to six (6) months for these antibodies to develop. Persons with initial indeterminate results should be retested after one month. Persons with continued indeterminate results after one month are highly unlikely to be infected and should be counseled as though they are *not* HIV-infected, unless recent exposure is suspected, per the CDC *Revised Counseling, Testing, and Referral Guidelines*. However, clients who request additional evaluation may be offered or referred for Polymerase Chain Reaction (PCR) testing. A specific return date should be given for all retesting;

      (7) Reevaluate client's risk;

      (8) Discuss/review risk reduction plan. If client has ongoing risk, convey concern and urgency about client's risk, and refer appropriately; and

      (9) Provide additional referrals, literature, and condoms as needed. Referrals should be documented on the DH 1628c HIV Post Test (PT) Documentation Form (yellow copy) and mailed to the Bureau of HIV/AIDS, as specified in the *HIV Counseling, Testing, and Referral Forms Instruction Guide*.

7. HIV Positive Post-Test Session

   a. The following protocol should be used when giving HIV-positive results (Refer to the HIV/AIDS 501 Manual):

      (1) Introduction and purpose of the session;

      (2) Explain confidentiality and the security of confidential information;

      (3) Provide results clearly and simply. Results should be given right away;

      (4) Explain the meaning of the results;

      (5) Explore the client's understanding of the results;

(6) Assess how the client is coping with results;

(7) Acknowledge the challenges of dealing with an initial positive result and provide appropriate support;

(8) Assess who the client would like to tell about her/his positive results and who can provide support in dealing with HIV;

(9) Discuss situations in which the client may want to consider protecting her/his confidentiality, e.g., with landlords, realtors, insurance agents, or employers;

(10) Discuss positive living. If the client is not ready for this discussion, provide her/him with appropriate literature;

(11) Explain the purpose and advantages of receiving early intervention services, and how treatment and support may prolong and improve the quality of their life. If the client tested anonymously, the counselor will give the client the option of waiving their anonymity (If receiving treatment services at a CHD, the client does not have to retest as a "confidential" client in order to receive treatment services);

(12) Assess client's willingness to seek support and complete a referral;

(13) Evaluate the types of referrals to which the client would be most receptive. Make linkages as appropriate. Whenever possible, clients should be linked directly with services to ensure referrals are completed. Counselors should assist clients in making appointments or make the appointments for the client with her/his permission. Referrals may include, but not be limited to, OB/GYN, family planning, HIV clinic, tuberculosis clinic, substance abuse treatment, medical case management, STD and hepatitis screening, and domestic violence counseling. The counselor should stress the importance of these follow-up services to the client and provide written referrals whenever possible;

(14) Address the need for health care providers to know client's HIV status;

(15) Inform all pregnant women who test positive for HIV of the benefits of antiretroviral therapy during pregnancy, where she can go to obtain the medications, and that breastfeeding can transmit HIV infection to her baby. In addition, all pregnant women who test positive for HIV antibodies will be referred to the local Healthy Start Coalition and medical case management. HIV testing should be encouraged for the baby's father and any other of the woman's children, as appropriate;

(16) Reevaluate client's risk;

(17) Discuss/review risk reduction plan, including risk of additional infection exposure and transmission to others. The discussion may include abstinence and/or safer sex practices, not sharing needles, proper cleaning of injection materials, condom use/demonstrations, etc. The client will also

be informed of the penalties for criminal transmission of HIV (s. 384.34, F.S.), reasons not to donate blood, blood products, semen, tissues and organs, and the importance of protecting his/her immune system;

(18) Discuss client's past and present sex and/or needle sharing partners who may have been exposed to HIV. All HIV-positive clients must be asked if they have, or have had, a spouse at any time within the ten-year period prior to the diagnosis of HIV infection. If so, the client should be informed of the importance of notifying the spouse or former spouse(s) of the potential exposure to HIV. The client must be informed of the availability of confidential PCRS through the CHD STD program for spouse or former spouse(s) and any sex or needle-sharing partners;

(19) Provide additional referrals, literature, and condoms as needed. Referrals should be documented on the DH 1628c HIV PT Documentation Form (yellow copy) and mailed to the Bureau of HIV/AIDS, as specified in the *Department of Health HIV Counseling, Testing, and Referral Forms Instruction Guide*; and

(20) Explore client's immediate plans after leaving the test site.

b. Notify the CHD STD Program within 24 hours of missed appointment for clients who test positive confidentially and fail to return for post-test counseling.

XI. Partner Counseling and Referral Services (PCRS)

A. Partner Counseling and Referral Services (PCRS) is one of the most effective HIV prevention strategies. There are three methods of follow-up of partners:

1. Client Referral: The HIV-infected individual chooses to inform their partners themselves and refer those partners for HIV counseling and testing;

2. CHD Referral: The HIV-infected individual consents to having the CHD STD Program take responsibility for contacting the partners and referring them to HIV counseling and testing, and other services; and

3. Contract Referral: CHD STD Program does the informing of partners only if the client does not notify the partner within a negotiated time period.

B. Due to the sensitive nature involved in the identification and location of partners, PCRS should be performed by an HIV counselor who is trained in these techniques. Pursuant to s. 384.26, F.S., only the Department of Health and its authorized representatives may conduct PCRS. The CHD STD program is responsible for all PCRS activities, regardless of where the client was originally tested. Other CHD staff may elicit information regarding partners, but only STD Disease Intervention Specialist (DIS) can perform notification of partners. Each test site should establish and maintain a good rapport with their local CHD STD Program to facilitate the provision of PCRS to clients who test positive. Refer to Technical Assistance: STD 15 for additional information on PCRS.

C. If the client indicates he/she will not participate in PCRS and will not self-notify his or her spouse or ex-spouse(s), the counselor has no authority to notify the spouse, former spouse(s), and/or other sex/needle-sharing partners.

D. Pursuant to s. 455.674, F.S., health care practitioners who are regulated through the Division of Medical Quality Assurance of the Department of Health have the privilege to notify sex and/or needle-sharing partners of HIV-positive patients under certain circumstances and if done in compliance with the "Partner Notification Protocol for Practitioners". Liability is not attached to either the practitioner's decision to notify partners or not to notify partners.

E. Clients who test positive for HIV anonymously need to be informed of the possibility that they may be named as a contact to a partner who has tested positive for HIV. This may result in a CHD STD Program staff offering the original client HIV counseling and testing and other services. The client will be informed that the DIS is acting on information obtained from an infected sex and/or needle-sharing partner. The counselor should assist the original client in determining the appropriate response.

XII. Linkages to Medical Care and Social/Support Services

A. Referral services should be offered to all clients of HIV test sites who are in need of medical, prevention, and other supportive services, particularly clients who are HIV-infected. Extra efforts should be made to link HIV-infected clients to appropriate medical, prevention, and other supportive services because such services increase the likelihood of maintaining health, enhancing longevity and quality of life, and reducing the risk of transmission. Reasonable efforts should be made to link high-risk HIV-negative clients to appropriate and available medical, prevention, and other supportive services to reduce the likelihood of these clients acquiring HIV.

B. Linkages differ from referrals because linkages require providers to take whatever steps are necessary to ensure that clients access needed services. This may mean the provider makes a phone call to a referral agency to make an appointment for the client, a call to the referral agency to ensure that the appointment was kept, and/or a referral form that is given to a client with the address and phone number of the referral agency and a specific contact person. The referral agency can send a copy of the referral form back to the provider with documentation that services were/are being provided to the client. In any event, clients should be provided with assistance in accessing and completing referrals, and completion of referrals should be verified.

C. Typical referral needs of HIV-infected clients and other clients of HIV test sites may include but are not limited to the following:

1. STD for Partner Counseling and Referral Services (PCRS);
2. TB for Skin Test;
3. Case Management;
4. Substance Abuse Prevention and Treatment Programs;
5. Medical Evaluation, Care, and Treatment;

6. Healthy Start, Pregnant, HIV-infected;
7. Intervention Therapy, Pregnant, HIV-infected;
8. Prenatal Care;
9. Domestic Violence Counseling;
10. Negative Test, Referral for Retest;
11. Reproductive Health Services;
12. Mental Health Services;
13. STD for screening and treatment;
14. Prevention Case Management; and
15. Screening and Treatment for Viral Hepatitis

D. HIV test sites should maintain current lists or resource guides of local referral agencies and should be familiar with their services. Referral lists or resource guides should include the following:

1. Name and address of the referral agency;
2. Range of services provided;
3. Target population(s);
4. Service area(s);
5. Contact names and phone (fax and email address, if possible);
6. Days and hours of operation;
7. Cultural, linguistic, gender, and age competence;
8. Cost for services;
9. Eligibility;
10. Application process;
11. Admission policies and procedures;
12. Directions, transportation information, and accessibility to public transportation; and
13. Client satisfaction with services.

E. HIV test sites should establish and maintain good working relationships with these agencies, and have a contact person at each agency. Having interagency collaborative agreements/arrangements with referral agencies can help facilitate linkages. Referral agencies should be responsive to clients' needs and service provision should be culturally, linguistically, gender-, and age-appropriate. Test sites should be aware of any barriers to clients' accessing services at referral agencies and should work with these agencies to reduce or eliminate barriers whenever possible. Capacity building should take place with new or developing agencies whenever possible to ensure the availability of various needed services.

XIII. Quality Assurance

A. Documentation

1. Proper documentation provides evidence that services were offered and/or provided and that the site is in compliance with Department of Health policies. Appropriate documentation can also minimize the risk of future legal action.

2. Services should be documented in client records and on HIV counseling and testing forms, as specified in the *HIV Counseling, Testing, and Referral Forms Instruction Guide.*

B. Quality Improvement Reviews

1. The Bureau of HIV/AIDS Early Intervention Section conducts quality improvement site visits to HIV test sites to assess the following:

   a. Accessibility of services, including hours of operation, location, availability of supplies and materials such as brochures, posters, forms, condoms, etc.;

   b. Compliance with written policies, procedures, protocols, guidelines, rules, regulations, and laws;

   c. Cultural, linguistic, gender, and age appropriateness of services and materials;

   d. Staff performance/proficiency such as competence, skills, training, etc.;

   e. Supervision of staff and their competence, skills, training, etc.;

   f. Appropriateness of services to client needs;

   g. Documentation in client records;

   h. Record keeping procedures, including confidentiality and security;

   i. Community resources (availability and collaborative arrangements); and

   j. County data review that includes testing trends and comparison of testing population to target population and/or populations with high positivity rates.

2. Local EICs should also conduct technical assistance visits as needed, or requested.

3. Test sites should develop their own written quality assurance protocols, and should make them available to all staff providing counseling, testing, and referral services. Quality assurance protocol should include all of the elements of the Bureau of HIV/AIDS Early Intervention review. Test sites can develop quality assurance teams to perform this function on a semiannual or annual basis. Local Early Intervention Consultants may assist with these reviews whenever possible.

C. Client Satisfaction Evaluation - Evaluation of client satisfaction can ensure that services meet the client's needs. These evaluations can also provide important feedback to counselors who otherwise may not see the benefits of what they do. Client satisfaction should be assessed at least annually. The information obtained should be used for program enhancement. The Bureau of HIV/AIDS can provide sample client satisfaction surveys.