

TABLE OF CONTENTS

I.	TITLE	2
II.	TYPE OF STANDARD	2
III.	OUTCOME	2
IV.	PERSONNEL	2
V.	COMPETENCIES	2
VI.	Protocols	2
A.	Guiding Principles	2
B.	Administrative Functions	3
C.	HIV Prevention Counseling	6
D.	Partner Services	15
E.	Linkages to Medical Care and Social/Support Services	16
F.	Quality Assurance	17
VII.	Supportive Data	19

TAG 345-9-13

Provision of HIV Prevention Counseling, Testing, and Linkage Services

- I. **Title:** Provision of HIV Prevention Counseling, Testing, and Linkage Services
- II. **Type of Standard:** Service
- III. **Outcome:** To prevent the spread of HIV infection through the following:
 - A. The delivery of science-based, culturally sensitive HIV prevention counseling, testing, and linkage services;
 - B. The provision of linkages and/or referrals to needed medical and psychosocial care regardless of clients' HIV status;
 - C. Successful linkages of HIV-positive clients to partner services and to medical care, as appropriate; and
 - D. The continual enhancement of the quality of counseling, linkage services, knowledge of HIV status, and accessibility of HIV testing.
- IV. **Personnel:** All persons who provide and/or supervise/coordinate HIV prevention counseling, testing, and linkage programs.
- V. **Competencies:** *Technical Assistance Guideline: 345-17-13 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 linkage services.
- VI. **Procedures:**
 - A. **Guiding Principles**
 1. The primary purpose of testing is to diagnose HIV-infected individuals; therefore, every effort should be made to ensure that HIV testing is readily accessible and widely available.
 2. Evaluating an individual's risk for HIV infection and offering testing on a voluntary basis should be a routine part of health care.
 3. HIV prevention counseling, testing, and linkage services should be provided in a manner that is appropriate for the client's culture, language, gender, sexual orientation and age. Technical jargon or terms should be avoided.
 4. All staff of test sites who conduct HIV testing will follow current CDC guidelines, Florida law, and administrative rules, including model protocols for healthcare and non-healthcare settings.

TAG 345-9-13

5. STD Disease Intervention Specialists will follow the CDC's partner services guidelines.
6. When providing HIV testing in healthcare settings, staffs must provide the opportunity for pre-test counseling and face-to-face post-test counseling and obtain informed consent (which does not need to be in writing). Healthcare setting is defined as any setting devoted to both the diagnosis and care of persons, such as county health department (CHD) clinics, hospital emergency departments, urgent care clinics, substance abuse treatment clinics, primary care settings, community clinics, mobile medical clinics, and correctional healthcare facilities.
7. When providing HIV testing in non-healthcare settings, staffs must provide pre-test counseling, face-to-face post-test counseling and obtain informed consent (which must be in writing). Non-healthcare setting is defined as any site that conducts HIV testing for the sole purpose of identifying HIV infection. These settings do not provide any type of medical treatment and include community-based organizations, outreach settings, county health department HIV testing programs, and mobile vans.

B. Administrative Functions

The primary administrative responsibility in an HIV counseling and testing program is to ensure the quality of HIV prevention counseling, testing, and linkage 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 HIV/AIDS and Hepatitis Program 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. HIV testing programs must reregister annually. All registered testing sites have received a *Certificate of Registration* with an expiration date one year from the date of registration. Sites will be sent an application form for reregistration 60 days prior to their expiration date. Sites that fail to reregister with the HIV/AIDS and Hepatitis Program by the expiration date are not authorized to continue operating an HIV counseling and testing program.

TAG 345-9-13

- 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 all medical standards, standard precautions, correct and accurate billing, and meeting protocols.
- d. If the DOH laboratory is used for HIV testing, test sites must use the DOH HIV counseling, testing, and linkage forms, as specified in the *HIV Counseling, Testing, and Linkage Forms Instruction Guide*.
- e. HIV testing staffs as defined in TA: HIV/AIDS 17 must have documentation of approved training in HIV counseling and testing prior to performing counseling sessions. Training includes the HIV/AIDS 500 and 501 courses and 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 registered test site staffs free of charge. The CHD will also provide the applicable forms to the provider free of charge.

2. Confidential and Anonymous Sites

- a. Potential test sites should contact their local Early Intervention Consultant (EIC) or HIV/AIDS Program Coordinator (HAPC) for a new site application packet. The package contains a copy of relevant statutes and administrative rules; the model protocols; a sample Memorandum of Agreement/Memorandum of Understanding (MOA/MOU); and the DH Form 1781 *Application for Registration and Reregistration for HIV Testing Programs*.
- b. Potential test sites must complete the DH Form 1781 *Application for Registration and Reregistration for HIV Testing Programs* and return it to the HIV/AIDS and Hepatitis Program. Non-DOH sites are required to submit the one-time \$100.00 registration fee along with the application.
- c. If DOH is providing any portion of HIV counseling and testing services, including forms, test supplies, and laboratory support to non-DOH test site, a MOA/MOU *must* be negotiated between the local CHD and the provider. The potential test site must agree to follow all DOH security and client confidentiality policies and procedures. This MOA/MOU must state that the potential provider will follow all applicable statutes, rules, policies, and procedures regarding 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 HIV/AIDS and Hepatitis Program staff, following the appropriate model protocol, and following applicable

TAG 345-9-13

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

- d. Upon receipt of the completed DH 1781, a provider site number will be assigned and a certificate issued. The certificate should be posted in a location visible to clients.
- e. Anonymous sites must be approved by the Director of the Division of Disease Control and Health Promotion.
- f. HIV counselors will meet the minimum requirements, as outlined in TA: HIV/AIDS 17 and complete annual HIV/AIDS 501 Updates. HIV counseling and testing should be included in performance standards of all persons providing these services. Qualified staffs should monitor counselors at least annually or as needed and should provide immediate feedback.
- g. Services are provided in accordance with all applicable laws, administrative rules, guidelines, policies and procedures.
- h. DOH staffs should ensure that test sites are supplied with necessary forms and equipment to properly execute HIV prevention counseling, testing, and linkage services.
- i. Services are provided in a manner that is appropriate for the client's culture, language, gender, sexual orientation, and age. All persons providing HIV prevention counseling, testing, and linkage services should receive cultural diversity training.
- j. 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.
- k. HIV/AIDS printed informational materials and condoms with instructions are readily available at test sites.
- l. Counseling is provided in a confidential setting.
- m. 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.)
- n. Documentation of services is conducted as specified in the *HIV Counseling, Testing and Linkage Forms Instruction Guide*. A sampling of records should be randomly chosen and reviewed

TAG 345-9-13

annually by qualified staffs. Qualified staffs may include Prevention section staffs, EICs, clinic supervisors, HAPCs, and others who have been trained in how to review CTL records.

- o. Records are maintained in a secured area with minimal access.
- p. 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.
- q. Relationships with medical and social service providers are established and maintained to facilitate successful linkages.
- r. No client is denied services based on inability to pay. Fees can be charged on a sliding scale or 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(6) 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.

C. HIV Prevention Counseling

1. 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.
2. 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).
3. 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

TAG 345-9-13

nonjudgmental and supportive approach can encourage the client to remain focused on personal HIV risk reduction.

4. 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, Comprehensive Risk Counseling Services (CRCS), 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 who are members of communities with high rates of HIV 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 unless the test site is conducting the couples HIV Counseling and Testing Intervention. 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.

TAG 345-9-13

Refer also to the HIV/AIDS 501 manual. The following should be used for conducting an HIV risk assessment:

- b. Introduction and purpose of the session;
 - 1) Explain confidentiality and the security of confidential information
 - 2) Assess client's reason for testing if requested;
 - 3) Assess client's history of HIV testing:
 - 4) Assess client's knowledge of HIV/AIDS (Clarify any misconceptions.)
 - 5) Assess client's perception of risk;
 - 6) Assess the influence of substance use/abuse on client's HIV risk;
 - 7) Assess client's STD/hepatitis/TB history;
 - 8) Assess client's history of sexual assault/domestic violence;
 - 9) Assess condom use; and
 - 10) Assess partner risk.
- c. 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 Linkage Forms Instruction Guide*.
- d. Clients identified as being at risk should be strongly encouraged to accept testing.
- e. 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.
- f. 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.

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

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

TAG 345-9-13

- 2) Establish and/or improve the client's self-perception of risk;
- 3) Identify and support behavior changes the client has already attempted;
- 4) Explore triggers/situations which increase the likelihood of high-risk behaviors;
- 5) Discuss options for eliminating and/or reducing risk;
- 6) 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;
- 7) Discuss the possible need for retesting. It can take up to three months for HIV antibodies to develop.;
- 8) Discuss the importance of notifying sex and/or needle-sharing partners if test results are positive, the availability of Partner Services (PS) through the CHD STD Program, and how confidentiality is protected if PS is accepted through the CHD STD Program. Clients should be informed that a STD DIS will contact them if they test positive, and that this may occur prior to their scheduled return appointment. 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;
- 9) Discuss the potential social, medical, and economic impact of a positive test result;
- 10) 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.);
- 11) Discuss the importance of returning for test results. Give a return appointment date at least two weeks from the date of the pre-test counseling session. Clients should be given the return appointment card from the DH 1628 Laboratory Request Form and told to bring it to their post-test counseling session, particularly if they test anonymously;
- 12) Make appropriate referrals based on risk assessment and pre-test information and provide literature and condoms as appropriate; and
- 13) 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.
- 14) All pregnant women will be advised of the need to know their HIV status, the risk to unborn children, and treatment

TAG 345-9-13

regimens that are available to reduce the risk of perinatal transmission. Florida law requires that all pregnant women receive opt-out testing for HIV, Chlamydia, gonorrhea, syphilis and hepatitis B at her first prenatal medical appointment and again at 28 to 32 weeks gestation. A DH 1631 Statement of Objection Form must be completed when a pregnant woman declines HIV testing.

- 15) 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.
- 16) 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 Linkage Forms Instruction Guide*.

g. 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. When written informed consent is required, the DH 1818 Consent Form must be used. Specimen collection should only take place after informed consent has been obtained. This will eliminate the possibility of testing clients without consent. See model protocols for healthcare and non-healthcare settings.
- 2) Clients who accept testing will complete the appropriate side of the DH 1818 Consent Form, as specified in the *HIV Counseling, Testing, and Linkage 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 need them.
- 3) When obtaining informed consent from the client, the counselor should explain the following:
- 4) 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;

TAG 345-9-13

- 5) 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 PS.
 - 6) That a list of anonymous test sites is available at the local CHD or at www.floridaaids.org.
- h. 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 tested in healthcare settings should be given the opportunity for a face-to-face HIV post-test counseling session. Clients tested in non-healthcare settings must be provided face-to-face post-test counseling. Test results should remain in the client's record.
 - 2) Although face-to-face post-test counseling is not required in healthcare settings, it is recommended that providers conduct such a session when the individual tests positive.
 - 3) 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 return appointment date card with scan I.D. from the DH 1628 Laboratory Request Form given during pre-test counseling, and the counselor will confirm that race/ethnicity, gender, and age (all on the DH 1628 Laboratory Request Form) correspond with the client who presents for HIV post-test counseling.
 - 4) 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.
 - 5) When face-to-face post-test sessions are required, 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 unless the test site is conducting the Couples HIV Counseling and Testing Intervention. With client permission,

TAG 345-9-13

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.

- 6) 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:
- 7) The meaning of the test results;
- 8) The potential social, medical, and economic effects of a positive test result;
- 9) The possible need for retesting;
- 10) A review of the client's assessment of risk;
- 11) Availability of health care, mental health, social, and other support services;
- 12) 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.; s. 384.34, F.S.]; and
- 13) Other appropriate referrals (e.g., STD, primary care, psychosocial).

i. HIV Negative and Inconclusive Post-Test Session

- 1) The following protocol should be used when giving HIV-negative or inconclusive results (Refer to the HIV/AIDS 501 Manual):
 - a) Introduction and purpose of the session;
 - b) Explain confidentiality and the security of confidential information;
 - c) Provide results clearly and simply. Results should be given right away;
 - d) Explain the meaning of the results;
 - e) Explore the client's reaction to the results;
 - f) Discuss the need for retesting due to recent possible exposure or if result is inconclusive. Most infected persons will develop detectable HIV antibodies within three (3) months of exposure. Persons with initial inconclusive results should be retested immediately. Persons with continued inconclusive results after one

TAG 345-9-13

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*. A specific return date should be given for all retesting;

- g) Reevaluate client's risk;
 - h) Discuss/review risk reduction plan. If client has ongoing risk, convey concern and urgency about client's risk, and refer appropriately; and
 - i) Provide additional referrals, literature, and condoms as needed. Referrals should be documented.
- j. HIV Positive Post-Test Session
- 2) The following protocol should be used when giving HIV-positive results (Refer to the HIV/AIDS 501 Manual):
 - a) Introduction and purpose of the session;
 - b) Explain confidentiality and the security of confidential information;
 - c) Provide results clearly and simply. Results should be given right away;
 - d) Explain the meaning of the results;
 - e) Explore the client's understanding of the results;
 - f) Assess how the client is coping with results;
 - g) Acknowledge the challenges of dealing with an initial positive result and provide appropriate support;
 - h) Assess who the client would like to tell about her/his positive results and who can provide support in dealing with HIV;
 - i) Discuss positive living. If the client is not ready for this discussion, provide her/him with appropriate literature;
 - j) 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, they will need

TAG 345-9-13

- to re-test confidentially to receive additional medical services;
- k) Assess client's willingness to seek support and complete a linkage/referral;
 - l) Evaluate the types of linkages/referrals to which the client would be most receptive. HIV-positive clients must be linked to medical care. 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, Peer Navigation Programs, OB/GYN, family planning, tuberculosis clinic, substance abuse treatment, 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;
 - m) Address the need for healthcare providers to know client's HIV status;
 - n) 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 Targeted Outreach for Pregnant Women Act (TOPWA) program, Healthy Start Coalition, or medical case management. HIV testing should be encouraged for the baby's father and any other of the woman's children, as appropriate;
 - o) 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;
 - p) 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.

TAG 345-9-13

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 PS through the CHD STD program for spouse or former spouse(s) and any sex or needle-sharing partners; and

- q) Explore client's immediate plans after leaving the test site.
- r) 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.

D. Partner Services (PS)

1. Partner Services (PS) is one of the most effective HIV prevention strategies and should always be done by trained staff and in accordance with TAG: STD-2 and STD-30.
2. Due to the sensitive nature involved in the identification and location of partners, PS should be performed by a qualified Disease Intervention Specialist (DIS) who is trained in these techniques. Pursuant to s. 384.26, F.S., only the Department of Health and its authorized representatives may conduct PS. The CHD STD program is responsible for all PS activities, regardless of where the client was originally tested. Other CHD staff may elicit information regarding partners, but only STD 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 PS to clients who test positive.
3. If the client indicates he/she will not participate in PS 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.
4. 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.
5. 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

TAG 345-9-13

sex and/or needle-sharing partner. The counselor should assist the original client in determining the appropriate response.

E. Linkages to Medical Care and Social/Support Services

1. Referral services should be offered to all clients of HIV test sites who are in need of prevention and other supportive services, particularly clients who are HIV infected. Extra efforts should be made to link HIV-infected clients to appropriate medical 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 prevention and other supportive services to reduce the likelihood of these clients acquiring HIV.
2. 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 an agency to make an appointment for the client, a call to the agency to ensure that the appointment was kept, and/or a form that is given to a client with the address and phone number of the agency and a specific contact person. The agency can send a copy of the 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 linkages, and completion of linkages should be verified.
3. Typical referral needs of HIV-infected clients and other clients of HIV test sites may include but are not limited to the following:
 - a. STD Partner Services (PS);
 - b. TB testing;
 - c. Case Management;
 - d. Substance Abuse Prevention and Treatment Programs;
 - e. Medical Evaluation, Care, and Treatment;
 - f. TOPWA and/or Healthy Start;
 - g. Prenatal Care;
 - h. Domestic Violence Counseling;
 - i. Negative Test, Referral for Retest;
 - j. Reproductive Health Services;
 - k. Mental Health Services;

TAG 345-9-13

- I. STD and Viral Hepatitis Screening and Treatment; and
 - m. Behavioral Interventions
- 4. 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:
 - a. Name and address of the referral agency;
 - b. Range of services provided;
 - c. Target population(s);
 - d. Service area(s);
 - e. Contact names and phone (fax and email address, if possible);
 - f. Days and hours of operation;
 - g. Cultural, linguistic, gender, and age competence;
 - h. Cost for services;
 - i. Eligibility;
 - j. Application process;
 - k. Admission policies and procedures; and
 - l. Directions, transportation information, and accessibility to public transportation.
- 5. 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.

F. Quality Assurance

- 1. Documentation
 - a. Proper documentation provides evidence that services were offered and/or provided and that the site is in compliance with Department

TAG 345-9-13

of Health policies. Appropriate documentation can also minimize the risk of future legal action.

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

2. Quality Improvement Reviews

- a. The HIV/AIDS and Hepatitis Program Prevention Section conducts quality improvement site visits to HIV test sites to assess the following:
 - 1) Accessibility of services, including hours of operation, location, availability of supplies and materials such as brochures, posters, forms, condoms, etc.;
 - 2) Compliance with written policies, procedures, protocols, guidelines, rules, regulations, and laws;
 - 3) Cultural, linguistic, gender, and age appropriateness of services and materials;
 - 4) Staff performance/proficiency such as competence, skills, training, etc.;
 - 5) Supervision of staff and their competence, skills, training, etc.;
 - 6) Appropriateness of services to client needs;
 - 7) Documentation in client records;
 - 8) Record keeping procedures, including confidentiality and security;
 - 9) Community resources (availability and collaborative arrangements); and
 - 10) County data review that includes testing trends and comparison of testing population to target population and/or populations with high positivity rates.
- b. Local EICs should also conduct quality improvement reviews on a regular basis and technical assistance visits as needed, or requested.
- c. Test sites should develop their own written quality assurance protocols, and should make them available to all staff providing counseling, testing, and linkage services. Quality assurance

TAG 345-9-13

protocols should include all of the elements of the HIV/AIDS and Hepatitis Program Prevention Section review.

VII. Supportive Data

- A. Section 381.004 Florida Statutes can be found at http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=381.004&URL=0300-0399/0381/Sections/0381.004.html
- B. Chapter 64D-2.004, Florida Administrative Code can be found at: [https://www.flrules.org/gateway/RuleNo.asp?title=HUMAN%20IMMUNODEFICIENCY%20VIRUS%20\(HIV\)&ID=64D-2.004](https://www.flrules.org/gateway/RuleNo.asp?title=HUMAN%20IMMUNODEFICIENCY%20VIRUS%20(HIV)&ID=64D-2.004)
- C. The “HIV Counseling and Testing Forms Instruction Guide” can be found at: http://www.doh.state.fl.us/disease_ctrl/aids/prevention/Counseling_Testing/forms/Guide.pdf
- D. Minimum Standards for HIV Counselors, Trainers, and Early Intervention Consultants Technical Assistance: HIV/AIDS 17 can be found at:
- E. http://www.doh.state.fl.us/Disease_ctrl/aids/prevention/Counseling_Testing/TA_Guidelines/TA-HIV17.pdf
- F. The “National HIV/AIDS Strategy for the United States” can be found at: <http://aids.gov/federal-resources/national-hiv-aids-strategy/nhas.pdf>
- G. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report; Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings; September 22, 2006 / 55(RR14);1-17 can be found at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>
- H. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report; Revised Guidelines for HIV Counseling, Testing, and Referral; November 9, 2001 / 50(RR19);1-58 can be found at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm>
- I. Section 384 Florida Statutes can be found at: http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0300-0399/0384/0384ContentsIndex.html