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Assessment of CDC-Funded Counseling, Testing, Referral, and Partner Notification (CTRPN) Services for Prevention of HIV Transmission

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Table of Contents

I. Introduction
- A. Background of CDC's HIV Counseling and Testing Program
- B. Study Objectives
- C. Methodology

II. Status of CTRPN Services by Site Type

- A. Introduction

- B. Discussion of Each Site Type
  1. Counseling and Testing Sites (CTS)
  2. Sexually Transmitted Disease (STD) Clinics
  3. Drug Treatment Centers
  4. Women's Health and Family Planning Clinics
  5. Tuberculosis (TB) Clinics
  6. Primary Care Facilities
  7. Correctional Institutions

III. Overview of Sites
- A. Introduction
- B. Program Management Issues
- C. Service Delivery Issues
- D. Innovations
- E. Technical Assistance, Infrastructure, and Other Needs

IV. Conclusions and Recommendations

Appendices
- A. Interview Instruments
- B. Clinic and Client Data Request Forms
- C. Document Request Form
- D. Counseling Observation Guidelines and Checklists
- E. Site Visit Agenda and Study Fact Sheet
- F. Client and Risk Profiles

I. Background of CDC's HIV Counseling and Testing Program

The enzyme-linked immunosorbent asay (ELISA), which detects antibodies to HIV, was licensed in 1985 and was used initially to screen potential blood donors and protect the Nation's blood supply. Since then, HIV testing has gradually expanded to include HIV/AIDS risk reduction counseling as well as referrals to needed services and notification of sex and needle-sharing partners who may have been exposed to HIV. funded by the Centers for Disease Control (CDC) programs currently are required to incorporate all these components in the HIV counseling and testing process: pretest counseling, voluntary testing, posttest counseling, referral for monitoring and treatment, and partner notification. The acronym CTRPN reflects this expanded role of counseling and testing programs.

A. CDC's Role in Providing CTRPN Services

Throughout the evolution of this program, CDC has played a pivotal role through funding and administering cooperative agreements with states, providing training, setting standards, and managing national data related to counseling and testing. Currently, CDC funds 65 HIV prevention programs in 50 states, 6 cities, 7 territories, the District of Columbia, and Puerto Rico. Through these 65 programs, CTRPN is provided at more than 7,000 sites in a variety of settings: freestanding sites, sexually transmitted disease clinics, physicians' offices, family planning clinics, correctional institutions, prenatal/obstetric clinics, drug treatment centers, colleges, tuberculosis clinics, primary care facilities, health department clinics, and miscellaneous other types of sites.

The CTRPN program is administered through CDC's National Center for Prevention Services (NCPS), which establishes program guidelines for its cooperative agreement grantees. These guidelines include recommended protocol for laboratory tests, counseling guidelines, and data reporting requirements. NCPS also provides training for state-level trainers and furnishes technical assistance through project officers, who have responsibility for oversight of specific geographic areas, and through other NCPS specialist staff.

B. Evaluation of CTRPN Services: the Context for This Study

As a cornerstone of CDC's HIV/AIDS prevention efforts, CTRPN services have come under increased scrutiny. In 1989, the National Research Council's (NRC) Panel on the Evaluation of AIDS Intervention made a series of recommendations, published in

Evaluating AIDS Prevention Programs.[1] Noting the complexity of assessing various intended outcomes of CTRPN services, the panel recommended that CDC prepare an inventory of services delivered by HIV counseling and testing sites. While recognizing that CDC required quarterly summary data from funded sites, the panel found the available data insufficient to describe the range of testing and counseling activities underway.

As a result of the NRC report, CDC contracted with Macro International Inc. to collect and analyze preliminary information necessary to support development of a comprehensive system to monitor and evaluate CTRPN services. This study was commissioned as an initial step envisioned by the NRC and complements a variety of ongoing and planned CDC evaluation activities.

II. Study Objectives

The purpose of this study is to provide information on the process of service delivery in a wide range of CDC-funded CTRPN sites, to assist CDC in understanding and helping improve service delivery, and to provide information needed to determine areas for additional research. Specific objectives for this study include the following:

- to create an inventory of CTRPN services currently provided at counseling and testing sites funded by CDC;
- to characterize populations seeking and completing these services;
- to identify variables that are most likely to affect the success of CTRPN services;
- to provide CDC with critical information to generate hypotheses for future research to determine the effectiveness of CTRPN services.

Knowledge of the kinds and levels of CTRPN services and the patterns of service delivery is necessary for program monitoring and design of evaluation research, as well as for program development and improvement.

III. Methodology

Study Design. A case study approach to achieving study objectives was selected for several reasons. The preliminary and exploratory nature of the research warranted the depth and qualitative insights offered by case studies. Also, the diversity of clinical settings and patterns of service delivery complicated the selection of a unit of analysis. In selecting the case study approach CDC recognizes that inferences regarding the generalizability of the information are limited.

[1] Coyle, S.L., R.F. Boruch, and C.F. Turner, cds. 1989. Evaluating AIDS Prevention Programs. National Research Council, National Academy Press: Washington, D.C.

Data for the case studies were obtained through interviews with clinic administrators, HIV counselors, and other clinic staff involved in the delivery of HIV counseling and testing services. In addition, site visitors observed both pretest and posttest counseling sessions as well as the clinic process.

Site Selection. Although the influence and relevance of funding programs at the state and county and/or city level are recognized as significant, the focus of this study is on the service delivery, or clinic, level. Five program areas were selected as study localities and, within these, a total of 43 service delivery sites were visited. Pretest site visits were conducted in six sites in two program areas.

Program areas were selected according to the following criteria:

- adequate representation of each site type in which CTRPN services are offered
- AIDS prevalence in the program area
- rate of new AIDS cases in the program area
- geographic diversity

Additional criteria were applied in selecting clinical sites for inclusion in the study:

- funding through CDC's Cooperative Agreements
- adequate client volume to observe counseling and testing
- history of providing CTRPN services
- not included in recent CDC program assessment

Cities considered to be epicenters of the HIV/AIDS epidemic (including New York, San Francisco, and Miami) were excluded from this study because they have been studied repeatedly by CDC staff and other researchers., Program areas with high AIDS prevalence, whose new AIDS case rates indicated a growing problem, were sought.

Using these criteria, the Macro study team, in collaboration with CDC staff, selected the following five study localities: Boston, Massachusetts; Newark and Jersey City, New Jersey; Hartford, New Haven, Bridgeport, and Stamford, Connecticut; Multnomah and Jackson Counties, Oregon; and the Tampa-St. Petersburg area in Florida. Pretest site visits were conducted to three clinics each in two cities: Baltimore, Maryland, and Atlanta, Georgia. Seven types of sites are represented in the study: counseling and testing sites (CT'S); sexually transmitted disease (STD) clinics; women's clinics, incorporating family planning clinics and other setting that primarily serve women; primary care facilities; drug treatment centers; tuberculosis (TB) clinics; and correctional institutions.

Exhibit I-l displays the mix of site types and geographic locations.

Data Collection. The selection of a case study approach created an inevitable tension between obtaining indepth information on a comprehensive list of topics and visiting a large number of sites in each of seven site type categories to observe as many permutations of service delivery as possible. To meet both needs, data collection was

designed so that each site visitor would spend up to one day in a given site. To cover a comprehensive list of topics in that time, site visitors collected as much information as possible ahead of time by contacting clinic staff and requesting copies of relevant clinic documents and specific data on client volume and demographics.

Site visit instruments were developed based on an extensive review of existing research literature and interviews with CDC experts on each element of the CTRPN process. Critical factors identified through the literature review and interviews were used to develop three discussion guides: an administrator interview guide, an HIV coordinator guide, and a counselor interview guide. A flow chart depicting a client's progress through each clinic was also prepared based on interviews and observation.

In addition, clinic and client data request forms, based on the CDC client data record reporting elements, were designed to obtain data on client volume and demographics prior to the site visit so that time on-site could be devoted to interviewing administrators and counselors and observing counseling- sessions. Finally, a set of guidelines for observing counseling sessions and a checklist of key factors were developed to allow site visitors to record the content and duration of observed counseling sessions as objectively as possible. It should be noted that the purpose of observing sessions was to document the various approaches to providing HIV counseling and not to evaluate the quality or effectiveness of counseling.

Site visits were conducted in October and November 1991. In most cases, site visitors were able to spend between half a day and a day in each site, interviewing administrators and counselors. Although counseling sessions were not observed in every site, both pretest and posttest negative sessions were observed in most sites. Only two posttest positive sessions were observed.

Analysis of Site Visit Data. Although the variety of service delivery models and nuances documented during the site visits were helpful in understanding the scope of current services, they made categorization and comparison between sites difficult. Despite the emergence of patterns across site types and across certain elements of the CTRPN process, certain aspects of clinic procedures remain idiosyncratic. The process of interpreting site-level data in order to generate observations and recommendations applicable across programs included the following steps:

1) ***Individual Site Visit Reports: 43 Case Studies.*** Site visitors documented the results of interviews and observations in a site visit report for each of the ***43*** sites and the 6 pretest sites. In addition, a flow chart showing the various steps in the CTRPN process, the duration of each step, and the staff and documentation involved was developed for each site.

2) ***Site Type Summaries. The*** site visit reports from each program area were grouped according to site type. A content analysis was done on each site visit report to glean information on program management and service delivery issues by site type, but across program areas. For example, pretest counseling content was compared for STD clinics

in Boston, Connecticut, Newark, Portland, and Tampa. Each element of program management and service delivery was analyzed in this manner.

3) *Overviews Across Sites and Site Types.* Building on the summaries, overviews of program management and service delivery issues across all site types in all areas were developed. In this section, the analysis required stepping back from the search for patterns within a particular site type to a broader view of issues affecting the provision of HIV counseling and testing, regardless of the clinical setting.

IV. Conclusions and Recommendations

Although the role of this study in CDC's development of an evaluation system was to provide an inventory of the kinds and levels of services currently provided in Federally funded sites, its findings may be useful in assessing the current status of service delivery in context of the current goals of primary and secondary prevention of HIV infection. These findings are summarized below and are followed by specific recommendations that address both primary and secondary prevention efforts.

A. Primary Prevention

Preventing HIV infection can occur only if individuals who are not infected take steps to protect themselves from exposure and if individuals who are infected take similar steps to protect others. For most individuals seen in CTRPN sites included in this study, this process involves initiating and sustaining changes in complex and fundamental sexual and substance-using behaviors that are notoriously difficult to alter. Behavioral research has repeatedly shown that few individuals achieve profound and lasting behavior change on the basis of a single information and counseling session; yet, this is the standard to which counseling and testing programs are held. To achieve lasting change, an individual may go through a lengthy cognitive and behavioral process and a series of attempts with varying success. A recent CDC study conducted by Higgins and colleagues concluded that several sessions of individual, group, or couples counseling and a variety of additional interventions, may be needed for people to achieve substantial behavioral risk reduction.[2]

Evolution of the goals and expectations of CTRPN programs has been accompanied by increasing recognition of the demands placed on the counseling and testing intervention when the expected outcome is sustained behavior change. A panel of technical experts on HIV counseling, convened by CDC's National Center for Prevention Services in late 1991, identified three basic public health prevention functions of HIV counseling and testing programs: (1) to facilitate clients' ability to identify and modify behaviors that may place them at risk, (2) to provide or refer both infected and uninfected individuals to

[2] Higgins, D.L., C. Galavotti, K.R. O'Reilly, D.J. Schnell, M. Moore, D.L. Rugg, R. Johnson. 1991. Evidence for the effects of HIV antibody counseling and testing on risk behaviors. *JAMA*;266(17):2419-2429.

additional prevention services, and (3) to work with infected individuals to help assure these same services are available to their sex and needle-sharing partners?

Facilitating Behavior Change. The sites visited for this study primarily serve client populations at high risk of exposure to HIV. To contribute to the reduction of risk-related behaviors among these individuals, CTRPN programs must assure that opportunity for counseling and testing is readily available and that those who accept the opportunity receive effective counseling with adequate continuing support to make the needed changes.

Opportunities for HIV counseling and testing. Because clients come to some CTRPN sites for services unrelated to HIV risk, CTRPN programs need to integrate discussion of HIV risk and availability of counseling and testing into a variety of clinical encounters. In sites visited for this study, there was a high degree of recognition of this need and significant efforts to assure access to counseling and testing services within the clinic. Among the practices observed were the following:

- Several sites ask clients to complete risk assessment questionnaires during early phases of the visit. Information gathered is used to help clients begin to identify and personalize their own risk, to determine if an HIV counselor should be seen, and to help clinicians and counselors focus discussion of risk exposure.

- The intake process in clinics such as STD, TB, and women's health may introduce discussions of HIV risk as part of routine history-taking, particularly where history is taken by an interview nurse or clinician. Drug treatment clients are usually routed to an HIV counselor as a specific step in the assessment process for admission.

- The clinical examination provides further opportunity to discuss HIV risk, particularly in women's health and STD clinics. In many sites, clinicians are also trained as HIV counselors.

While these practices were widely observed, there is considerable variation in the point at which HIV counseling and testing is offered, the number of opportunities on any given visit, and the extent to which staff who are not HIV specialists are involved in discussion of HIV risk.

Effective Counseling. Expectations of what can and should be achieved in the counseling process have become increasingly sophisticated over the period of this study. Emerging standards for good counseling[4] emphasize several key features of the counseling process that may contribute to its effectiveness:

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[3] CDC. *Technical Guidance on HIV Counseling [Draft].* February *1992.* Centers for Disease Control, National Center for Prevention Services.

[4] Ibid.

- Good HIV counseling is "client centered." It must be tailored to the behaviors, circumstances, and special needs of the individual. This approach requires an interactive process between the counselor and the client and good listening skills, rather than a "lecture" or information-oriented approach.

- HIV counseling should result in an individualized plan to reduce risk of exposure or of transmission. The counselor's role should be to assist the client to consider a variety of options and help select or. negotiate those that are feasible and likely to succeed.

- Risk assessment is the foundation of the individual risk reduction plan and is an essential component of pretest counseling. When properly conducted, risk assessment helps the client to assess and take "ownership" of his or her own individual risk for HIV infection.

The counseling observed during this study was often factually accurate and complete, handled in a professional manner, and included interaction and reflective listening. Of course, there was considerable variation in counseling styles and approaches, professional backgrounds, site and program protocols, and client needs from site to site. However, the development and negotiation of an individual risk reduction plan is not currently part of what most counselors do in pretest and posttest counseling examined for this study. While risk assessment is reported to occur prior to testing in all sites, the extent and quality of discussion of individual risk appear highly inconsistent. Risk exposure categories on standardized data collection forms were frequently used as a trigger for risk assessment; just as frequently, discussion did not go beyond the risk category labels on the form, Where counselors did initiate discussion around risk categories, it was often used to tailor information rather than to explore ongoing behaviors and circumstances and past prevention efforts.

Counselors interviewed for the study consistently expressed a need for additional training in such areas as approaching individuals about sensitive risk behaviors, comfort with cultural and lifestyle differences, and specific aspects of risk such as drug use and women's issues. Moreover, many counselors noted that their clients are well informed, as counselors themselves are, on "AIDS 101" and that more advanced and more accessible training in both counseling practice and HIV/AIDS research and treatment are needed.

Additional Prevention Services. As currently provided in most sites visited in this study, CTRPN services offer a single pretest and a single posttest counseling session to those whose antibody test results are negative. Those found positive are more often provided with continuing support either through contact with the HIV counselor who conducts the posttest session or through referral to other community organizations or both.

The emphasis on HIV prevention in the posttest sessions varied considerably, depending on whether the clients' test results were negative or positive. For those found positive, many sites have referral systems to early medical intervention, psychosocial and other support, and drug treatment. The quality and availability of resources to which HIV-

positive individuals are referred may vary, but CI'RPN sites, for the most part, try to help facilitate clients' obtaining whatever services are available.

For clients whose results are negative, however, quite a different situation exists. Posttest negative counseling sessions average 10 minutes and generally focus on discussing the potential need for retesting, along with admonitions to "stay safe." Condoms are routinely provided to support safe behavior. However, many counselors and administrators interviewed expressed frustration with the lack of resources available for clients whose results are negative. It may be difficult to discuss continued risk reduction in the face of clients' overwhelming relief at receiving negative results. Additional counseling may be needed to help clients realistically confront the risk of HIV to which they are exposing themselves.

Often, specialized HIV staff conduct posttest positive counseling and handle referral, sometimes with additional help of case managers. In these same sites, negative posttest sessions are typically handled by the-regular clinician, often as part of the next routine visit. Where HIV specialists conduct both pre and posttest counseling for all clients, more attention may be provided to risk reduction in the posttest negative session. However, even in these sites, only one posttest session is generally provided, and lasts an average of 20 minutes.

Among the issues to consider in addressing emerging program priorities for additional prevention counseling are the availability of referral resources; staff recognition of the importance of continued support to behavior change in those found negative; and referral support systems that can help identify and manage the referral process.

Assuring Services to Partners. From the earliest stages of CTRPN program development, Federal guidelines and recommendations have presented partner notification as a means of alerting individuals at high risk of their vulnerability and the availability of counseling, testing, and other HIV services. Despite the Federal emphasis on the voluntary and preventive nature of partner notification, however, there persists among many counselors and administrators in sites visited an image of partner notification as a coercive effort to assure identification of all infected individuals. Many staff, particularly in drug treatment and counseling and testing sites (CTS), continue to equate partner notification with provider referral (i.e., clinic or health department staff contacting partners) and resist the idea of pursuing individuals to recruit them into HIV testing.

In general, the importance of counseling and testing partners is discussed during posttest sessions with individuals who are HIV-positive. Some counselors reported introducing in the pretest session the issue of who might need to know about the client's serostatus. As might be expected, STD clinics generally report an emphasis on partner notification and report using both patient and provider referral models. In several sites, counselors involve or refer to trained disease intervention specialists (DIS) from nearby STD clinics for notification assistance, and often for posttest positive counseling and referral.

One counselor who had been trained and had previously worked as a DIS in STD clinics noted that the traditional focus of STD workers on maximizing the number of "contacts" identified and found must give way to a more holistic approach to HIV prevention. In his words, the "epi model" is convenient, but it does not work well to "charge in" and get contact information from those who have just received news of a positive antibody test. He has found it takes several interactions, both for counseling and discussing the importance of notifying partners, to be effective with HIV-positive clients.

Drug treatment and CTS sites, while expressing the strongest reservations about provider referral, report encouraging and helping clients to refer or bring in their own partners. Some drug treatment sites, which provide HIV services only to their own clients in treatment, reported providing HIV counseling and testing specially to partners brought in or referred by clients. The most aggressive partner notification program was observed in Florida sites, where HIV specialists who provide pretest and posttest counseling in public health clinics are trained to elicit names of partners and refer these to DIS for notification assistance.

The extent to which CTRPN sites pursue providing partners with information on HIV exposure and assisting them to obtain HIV services may be related to the image of partner notification as coercive and as synonymous with provider referral. The effectiveness of partner notification activities may be affected by two factors: the extent to which sites that use patient referral actually provide coaching and guidance to clients in doing this, and the extent to which DIS who currently provide most of the notification assistance are trained in the counseling and other support aspects of this role.

B. Secondary Prevention and Early Intervention

With improved medical approaches to delaying onset of symptoms and preventing and treating complications of HIV infection has come increasing emphasis on CTRPN as a means of facilitating access to early intervention services. Continuing improvements expected in treating and managing HIV disease will further highlight the need for a full range of comprehensive and coordinated services.

Among sites visited for this study, referrals are a key focus of the posttest counseling session for HIV-positive clients, particularly HIV medical evaluation and early intervention. There appears to be widespread acceptance of the role of CTRPN in facilitating access to care. One counselor described himself as "very grateful" to have a place to send those with HIV-positive results. However, in some sites, notably in Connecticut and New Jersey, there was limited availability of early intervention services, often necessitating long waits for care and/or traveling to medical centers some distance away from clients' communities. Although the capacity and structure of existing health care services may inhibit ready access to care, acceptance of the role of CTRPN as a gateway to early intervention services seems well established.

While access to early intervention can benefit those with HIV infection and possibly increase the likelihood that clinic staff will introduce and encourage counseling and testing, a recent APHA AIDS working group pointed out additional implications for the continued importance of primary prevention.[5]

- Early intervention may lead to significant increases in longevity and ability to function among HIV infected persons, increasing the importance of continued prevention services to continue to foster and support sustained behavior change.

- Ongoing routine monitoring associated with early intervention offers a unique opportunity to provide continued counseling and education for sustained behavior change.

Indeed, in some sites that have access to primary care and early intervention services through the public health system, HIV counselors reported continuing contact with individuals during the process of medical assessment and availability of continued case management and referral services through HIV clinics.

Failure to Return. Individuals who do not return for their test results, whether positive or negative, lose the opportunity to realize early intervention benefits. Return rates in clinics visited vary greatly.

Given ongoing relationships with their clients, sites like drug treatment and TB clinics may be less concerned if a client does not return specifically for test results. STD staff agree that clients have little incentive to return once an STD is treated and, in one study area, reported that clients know they will be contacted if HIV test results are positive. Some clinics report specific strategies to encourage returns, such as reiterating the confidential nature of test results and the need for divulging both positive and negative results in person.

In most sites, followup efforts are made for those whose results are positive. In clinics that test confidentially, names are often referred to DIS for notification, often following efforts by mail and/or telephone to let individuals know that their results are in. In a few cases, clinic outreach workers may attempt to locate HIV-positive individuals and encourage them to return for results before names are referred to the health department.

Referral Systems. It is increasingly complicated for counselors to keep current on the full range of medical, social, psychosocial and other services needed by HIV-positive clients and to assure that these services meet minimal standards of quality and accessibility.

In many sites visited for this study, individual counselors have the primary responsibility for staying abreast of referral resources. Often, this involves a personal network of

[5] American Public Health Association, Special Initiative on AIDS, AIDS Working Group. 1990. *Public health implications of early intervention in HIV disease.* APHA/SIA Report 7.

contacts and interactions with colleagues. Many counselors are active in community organizations and volunteer groups outside their work roles. In addition, many counselors find themselves involved in case management functions because no one else is available and because they feel a personal commitment to help their clients. This role may include not only facilitating and following up on referrals, but also providing transportation and helping clients with paperwork and applications for financial and social assistance.

The extent to which CTRPN can effectively link HIV-positive individuals with needed services certainly depends on the capacity of the health and social service systems to provide the needed array of services. It depends equally on the capacity of the referral support system available to CTRPN staff to help them keep current on new and existing services and develop referral arrangements and relationships. It also depends upon the availability of CTRPN counselors, case managers, or others to help clients and facilitate obtaining those services.

C. Recommendations

The scope of CTRPN activities and procedures examined in this study is extensive. During the analysis of service delivery by site type and across all sites, a variety of operational refinements and areas for further program and site assessment were evident. Those sections of the report provide a rich source of information on the process of service delivery, potential ways to improve or assist that process, and areas for further exploration in specific sites and study areas.

This section addresses global issues across all areas of study that may affect future program directions and research priorities.

1. Primary Prevention

la. **Prevention services for those who test negative.** There is a clear divergence in recognition of the importance of HIV prevention, depending on whether the client's antibody test is negative or positive. Additional prevention services, beyond a single pretest and posttest counseling session, are minimal or nonexistent for those whose behaviors place them at risk but who are not yet infected.

Recommendation. Further assessment of needs and resources for prevention services for those who are tested and found negative should be undertaken. At a minimum, additional studies should explore the availability of onsite and referral resources and the extent to which programs and sites recognize the importance of ongoing support to facilitate behavior change in those found negative.

lb. Counseling techniques and practices. The counseling process in sites visited is often factually accurate and complete, handled in a professional manner, and involves interaction and reflective listening. However, emerging standards for good

counseling are not evident in current practice in all sites: client-centered counseling tailored to individual circumstances, development of realistic individualized behavior change plans, and use of personal risk assessment as a foundation for determining feasible change.

Recommendation. National program guidelines should clarify the expected outcomes of pre and posttest counseling and specify recommended techniques and practices, based on current behavioral research and counseling expertise.

- A review of risk assessment practices and tools and an assessment of counselors' needs should be conducted and recommended approaches and instruments developed or revised.

- Program guidelines, technical assistance materials, and training programs should clarify the purposes of risk assessment in data collection and counseling and provide recommended approaches to accomplishing these purposes.

- Counselors should receive feedback from supervisors and/or peers to improve counseling and to assess the degree to which program goals are addressed through counseling content and approach.

lc. **Training and continuing education for counselors.** Training for HIV counselors is generally standardized in all sites visited and provided through state- or county-approved channels. However, training programs require 2 to 5 days away from day-to-day responsibilities and generally involve a one-time-only session oriented to basic information for new counselors. Counselors in many areas reported a need for improved training and continuing education that is accessible and systematic. Many reported a need for support beyond "AIDS 101."

Recommendation: Current standardized training provided and sponsored by funded programs should be evaluated to determine the extent to which current content and approach meets emerging counseling demands and expectations.

- A systematic needs assessment should be conducted among program staff and HIV counselors to determine training and continuing education needs in two areas: counseling content and counseling practice. This assessment should include an examination of how initial and ongoing training can meet the different needs of new and experienced counselors.

- An assessment of training content and approach for HIV counselors across the 65 programs currently funded to provide CTRPN services should be undertaken to determine the quality and consistency of counselor preparation and the extent to which current training addresses current program goals.

1d. **Partner Notification.** Despite the Federal emphasis on the voluntary and preventive nature of partner notification, there persists among many counselors and

administrators in sites visited an image of partner notification as a coercive effort to recruit individuals into HIV testing. Staff in many sites continue to equate partner notification with provider referral and often cite STD "contact tracing" as the model. Trained Disease Intervention Specialists from STD clinics provide notification assistance in many sites, and posttest positive counseling and referral as well in many.

Recommendation. Aggressive efforts to detach HIV partner notification assistance from continuing confusion with traditional STD "contact tracing" and to clarify for service delivery staff the importance of partner notification in primary prevention should be undertaken at national and program levels.

- Findings from research in progress on the efficacy of various partner notification models and techniques should be widely disseminated to the service delivery community, as soon as these become available. This may involve developing technical assistance materials in advance of the slower process of publication of research findings.

- Given the key role of STD/DIS as a resource for HIV partner notification assistance, an assessment of training for STD Disease Intervention Specialists should be conducted to determine the extent to which it addresses HIV partner notification issues and objectives. Particular attention should be paid to preparation for counseling and support roles required in providing HIV partner notification assistance and, where applicable, to providing HIV counseling.

- Specific educational efforts should be directed to HIV counseling and administrative staff in clinics which provide CTRPN services. Efforts like those of the New Jersey Partner Notification Assistance program to provide training and technical assistance to sites in understanding and making use of available notification assistance services should be encouraged and supported in all program areas.

le. **Entry into CTRPN services.** CTRPN sites visited for this study are generally providing multiple opportunities to individuals at high risk to obtain HIV counseling and testing services. Discussion of HIV risk and availability of counseling and testing is integrated into clinic operations in a variety of ways.

Recommendation. Data from this study suggests further examination may be needed of several key features of integrated services, including the continued availability of HIV counseling and testing throughout a particular clinic visit and the role of clinic staff in the design and implementation of HIV services.

- In sites that are not providing multiple opportunities for HIV counseling and testing, assessments and technical assistance should explore the nature of existing barriers and ways in which they can be reduced.

- Mechanisms for involving staff in the design, improvement, and provision of HIV-related services should be identified, assessed, and, where appropriate, incorporated into technical assistance and program guidance.

2. Secondary Prevention

2a. **Voluntary return for test results. The** extent to which secondary prevention goals for CTRPN programs can be realized depends largely on the extent to which the needed array of services exists and is accessible. However, operational aspects of CTRPN services can help maximize access for those found HIV-positive. Improvements are needed in efforts made by sites to ensure that individuals return for test results and that referral systems are in place.

Recommendation. Available data, interview, and observation findings from sites included in this study suggest an overall lack of information on the extent to which individuals voluntarily return for test results and their reasons for doing so.

- Data collection procedures should be closely examined to determine the extent to which returns for test results are accurately tracked and reported, and technical assistance provided to improve the accuracy and completeness of currently reported data.

- While test acceptance rates seem a focus of activity in many sites, return rates were rarely discussed by staff as program indicators. Greater emphasis in program guidelines and technical assistance activities should be placed on the significance of voluntary returns for test results for assessing program effectiveness. Clinics should be encouraged and supported in efforts to obtain client feedback on HIV counseling and testing services.

- Additional studies of counseling, clinic practices, and other variables that affect voluntary return should be undertaken to identify the key factors in client decisions to return. Identified factors should be widely disseminated to service delivery staff.

2b. **Referral support systems. The** extent to which CTRPN links HIV-positive individuals with needed early intervention depends on the effectiveness of the referral support system in individual clinics in monitoring availability and accessibility of services, facilitating referrals, and assisting clients to obtain what is needed. In a great many clinics visited for this study, the referral system is the HIV counselor and the network of contacts with colleagues and service agencies that the counselor maintains.

Recommendation. An assessment of the issues and barriers in developing coordinated referral systems at both the clinic and program level should be

undertaken. This should include particular attention to the role of case management and the availability of case management resources in CTRPN sites.

- The importance of referral systems should be emphasized in national program guidelines and technical assistance and support provided in developing effective models.

2c. **Data collection and management.** Despite CDC attempts to enhance the data collection and management efforts of clinics funded under the cooperative agreement, problems persist in data collection, management, and use. Although four of five study areas visited regularly use the CDC client data record for reporting, few report using the data collected for program planning or evaluation purposes.

Recommendation: A system of standardized data collection on the counseling and testing process developed and supported by CDC is increasingly in place, but remaining barriers to using client data to improve program operations should be further examined. These include the variety of service providers conducting data collection, the multiple additional reporting formats and requirements still the rule in many sites, and the lack of clinic-level capability to aggregate and analyze data for internal use.

- A systematic assessment of remaining barriers to consistent data collection and use should be conducted and should include the following:

  - a determination of which staff at the clinic level actually collect data and their training for this function, including a training needs assessment.

    procedures in place for data management and reporting to state and other offices. Since counseling and testing steps occur for any individual client over a period of several weeks, data collection is an ongoing process and may involve several staff and complex procedures for ensuring that all steps are accurately documented and that reporting is completed for individual records.

  - the extent to which aggregated data from individual client data record reporting is available to clinic staff on a regular basis for use at the clinic level, and the various potential uses of aggregate data for setting goals, planning, evaluation, and internal monitoring.

    the extent to which clinic staff have the expertise needed to aggregate, analyze, and apply collected data to program operations.

  - the extent to which clinic administrators and other service delivery staff perceive data currently collected as useful for improving CTRPN services, and which elements they consider of greatest value.

Exhibit I-1
Site Visit and Pretest Clinics

City/Sites	Site Type						
	CTS/ ATS	STD	DTC	FP/ WHC	TB	PHI CARE	PRISON
BOSTON AREA							
• Atlanticare/Lynn Hospital	X	X					
Fenway Community Health Center	X						
• MCI Framingham		X					X
New Bedford-Project CARE	X						
Somerville Portuguese American League (SPAL)	X						
Project TRUST	X						
Boston City Hospital		X					
Dimock Community Health Center	X						
NEWARK/JERSEY CITY AREA							
St. Michael's Medical Center	X						
Newark Community Health Centers Inc.						X	
Newark Department of Health STD Clinic		X					
Spectrum Drug Treatment-Jersey City			X				
Spectrum Drug Treatment-Newark			X				
Essex Planned Parenthood				X			
New Brunswick Counseling Center			X				
CONNECTICUT							
Liberation Program, Inc.			X				
* Stamford Health Department-STD		X		X			
Stamford Health Department-WIC				X			
Hartford Health Department-HIV/AIDS	X						
Regional Network			X				
Webster Correctional Facility							X
Bridgeport Health Department		X					
New Haven Health Department	X						
Yale-New Haven Hospital				X			
Niantic Women's Prison							X
MULTNOMAH AND JACKSON COUNTIES, OREGON							
Westside Health Center CTS	X						
Marlene Clinic	X						
Westside Health Center-STD		x					
I-looper Detox			X				
Westside Health Center-TB					X		
* North Portland Health Center				X		X	
• Southeast Health Center				X		X	
• Fast County Health Center				X		X	
Jackson County Health Department						X	
TAMPA/ST,_ **PETERSBURG AREA**							
Operation PAR			X				
DACCO (Tampa)			X				
Pinellas County Women's Health Center				X			
Lee Davis						X	
Pinellas County Public Health Unit-STD		X					
Hillsborough County Public Health Unit-STD		X					
Hillsborough County Anonymous Test Site	X						
Pinellas County Public Health Unit-TB					X		
Total In **each** category: **Total** Sites: 49	12	9	9	8	2	6	3

City/Sites	Site Type						
	CTS/ ATS	STD	DTC	FP/ WIIC	TB	PRI CARE	PRISON
BALTIMORE (Pretests)							
Chase-Brexton Clinic	X						
Eastern District Chest Clinic					X		
Druid Health District STD Clinic		X					
ATLANTA (Pretests)							
Fulton County Alcohol and Drug Treatment Center			X				
Fulton County Health Department-STD		X					
Cobb County Health Department/Marietta Health Center	X						

- Counted in more than one site type category. Site visits were conducted in 43 sites, excluding pretest sites. Because some sites were included in two categories for analysis purposes, this table shows a total of 49 sites analyzed.

Chapter I. Introduction

A. Background of CDC's HIV Counseling and Testing Program

More than a decade ago, the first cases of an unusual immunologic disease were reported to the Centers for Disease Control (CDC).. As awareness of this phenomenon grew among clinicians and in the public health community, a growing number of related conditions were identified and came to be known as acquired immunodeficiency syndrome (AIDS). The eventual identification of the etiologic agent--the human immunodeficiency virus, or HIV--and understanding of the routes of transmission led to a call for a test that would detect the virus in infected individuals. Licensed in 1985, the enzyme-linked immunosorbent assay (ELISA), which detects antibodies to the HIV, was a major breakthrough in identifying people who could transmit the virus. For that reason, the ELISA test initially was used to screen potential blood donors and protect the Nation's blood supply.

Demand for the test quickly overwhelmed the capacity of blood screening centers, and, in response, CDC established alternate test sites (ATS) through cooperative agreements with state and local health departments. As it became apparent that people at risk for acquiring and transmitting the disease could benefit from risk reduction education, counseling was added as a major component to the process, both before the test and after the test results were known. Counseling and testing came to be viewed as a major opportunity to encourage behavior change related to activities known to be linked to HIV transmission, primarily unprotected sex and sharing drug-injecting needles with infected persons. Reflecting this change in emphasis, the ATS in 1987 were renamed counseling and testing sites (CTS) and were extended into various settings beyond the traditional health department or freestanding clinic site. The objective of the counseling and testing program was 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] At that time, there was no approved therapy to offer a person who was identified as seropositive for HIV.

The situation changed in 1989 as it became clear that zidovudine (AZT) and other antiviral agents could help a person in the early stages of HIV disease. Thus, counseling and testing offered a clear benefit to asymptomatic HIV-positive people by identifying them and helping them enter therapy as quickly as possible. Referral of infected people to appropriate medical and social care became a new component of the Nation's counseling and testing program.

Notifying sex and needle-sharing partners of HIV-infected people has been an important prevention strategy as the program has developed. Clients are encouraged to contact

[1] Rugg, D.L., R.J. MacGowan, KA. Stark, N.M. Swanson. 1991. Evaluating the CDC Program for HIV Counseling and Testing. *Public Health Reports* 106(6):708-713.

partners themselves, but notification assistance is offered by a provider or health department specialist. All CDC-funded programs currently are required to incorporate all these components in the HIV counseling and testing process: pretest counseling, voluntary testing, posttest counseling, referral for monitoring and treatment, and partner notification. The acronym CTRPN reflects this expanded role of counseling and testing programs.

1. CDC's Role in Providing CTRPN Services

Throughout the evolution of this program, CDC has played a pivotal leadership role through funding and administering cooperative agreements with states, providing training, setting standards, and managing national data related to counseling and testing. Currently, CDC funds 65 HIV prevention programs in 50 states, 6 cities, 7 territories, the District of Columbia, and Puerto Rico. Through these 65 programs, CTRPN is provided at more than 7,000 CTRPN sites in a variety of settings. The settings in which CTRPN services are currently delivered include freestanding sites, sexually transmitted disease clinics, physician's offices, family planning clinics, prisons, prenatal/obstetric clinics, drug treatment centers, colleges, tuberculosis clinics, primary care facilities, health department clinics, and miscellaneous other types of sites.

Between 1985, when counseling and testing first became available, and 1991, CDC estimates that about 5.6 million persons have been tested for the AIDS virus and about 265,000 have been found to be infected. In 1991, more than 1.5 million people were tested, and 52,922 or 3.5 percent, were found to be positive.

Supporting CTRPN accounts for a major portion of CDC's prevention budget. In 1990, $117.6 million was allocated to state and local health departments and drug abuse programs for CTRPN activity. This represents 69 percent of funding for the HIV/AIDS cooperative agreements and more than a quarter of CDC's entire HIV/AIDS annual budget.

The CTRPN program is administered through CDC's Center for Preventive Services (CPS), which establishes program guidelines for its cooperative agreement grantees. These guidelines include standard protocol for laboratory tests, counseling guidelines, and data reporting requirements. CPS also provides training for state-level trainers and furnishes technical assistance through project officers, who have responsibility for oversight of specific geographic areas, and other CPS specialist staff.

2. Evaluation of CTRPN Services: the Context for This Study

As a cornerstone of CDC's HIV/AIDS prevention efforts, CTRPN services have come under increased scrutiny. In 1989, the National Research Council's Panel on the Evaluation of AIDS Intervention made a series of recommendations, published in

Evaluating AIDS Prevention Programs. Noting the complexity of assessing various intended outcomes of CTRPN services, the panel made the following recommendation:

> As a first step, the panel believes CDC should prepare an inventory of the various services that are delivered by HIV testing and counseling sites. Although recipients of CDC funding for testing and counseling are required to provide quarterly summary data about their services, we believe these data are insufficient to describe the range of testing and counseling activities now being undertaken at the 1,600 CDC-supported sites across the country?

This study constitutes the first step envisioned by the National Research Council, and complements a variety of ongoing and planned evaluation activities.

B. Study Objectives

In 1989, CDC made a commitment to establish a comprehensive system for continual evaluation of CTRPN services. At that time, the Program Operations Branch (POB) of the Division of STD/HIV Prevention, CPS contracted with Macro International Inc. to collect preliminary information necessary for the development and implementation of a system to monitor and evaluate CTRPN services. The objective of this study is to collect the preliminary, baseline evaluation required by CDC using a qualitative, case study approach. Specific study objectives include:

- to create an inventory of the kinds and levels of CTRPN services currently provided at counseling and testing sites funded by CDC
- to characterize populations seeking and completing these services
- to identify variables that are most likely to affect the success of CTRPN services
- to provide CDC with critical information to generate hypotheses for future research to determine the effectiveness of CTRPN services.

Knowledge of the kinds and levels of CTRPN services and the patterns of service delivery is necessary for program monitoring and design of evaluation research, as well as for program development and improvement.

[2] Coyle, S.L., R.F. Boruch, and C.F. Turner, eds. 1989. *Evaluating AIDS Prevention Programs.* National Research Council, National Academy Press: Washington, D.C., page 105.

C. Methodolonv

1. Study Design

A case study approach to achieving study objectives was selected for several reasons. First, the preliminary, exploratory, and descriptive nature of the research warranted the depth and qualitative insights offered by case studies. The diversity of clinical settings and patterns of service delivery complicated the selection of a unit of analysis and again argued for a case study approach to identify permutations in service delivery. In a discussion of evaluating community-based organization (CBO) projects, which are similar in terms of their variety to the public health clinics in this study, the NRC panel noted that

> Case studies can be immensely helpful in describing an activity and learning about the process involved in conducting it. The major limitation of a case study is that, without a supplemental statistical study of a sample of projects, the generalizability of the information cannot be known. Well-conducted case studies, however, can improve the design of a statistical study of study projects. Indeed, when the universe of projects being studied is diverse or not well understood by researchers, case studies will be a prerequisite for other research (by survey or other methods) since they can identify the questions that ought to be asked.[3]

The case studies constitute an assessment of the process and service delivery issues within sites. Although the influence and relevance of funding programs at the state, county, and/or city level are recognized as significant, the focus of this study is on the site level. In addition, the case studies are not evaluations of the quality of counseling and testing services, nor of the ultimate behavior change outcomes that CTRPN programs seek to achieve.

Data for the case studies were obtained through interviews with clinic administrators, HIV counselors, and other clinic staff involved in the delivery of HIV counseling and testing services. In addition, site visitors observed both pretest and posttest counseling sessions as well as the clinic process. Interviews and observations were conducted in 43 sites in 5 program areas. Pretest site visits were conducted in 6 sites in 2 program areas. Site selection, data collection procedures, and data analysis are described in greater detail below.

[3] Coyle, Boruch, and Turner, 1989, op. cit., page 83.

2. Site Selection

Several criteria were applied in order to select clinical sites for inclusion in the study. These included the following:

- funding through CDC's Cooperative Agreements
- adequate client volume to observe counseling and testing
- history of providing CTRPN services
- not included in recent CDC program review

Program areas were selected according to the following criteria:

- adequate representation of each site type in which CTRPN services are offered
- AIDS prevalence in the program area
- change in AIDS case rate in the program area
- geographic diversity

Cities considered to be epicenters of the HIV/AIDS epidemic (including New York, San Francisco, and Miami) were excluded from this study because they have been studied repeatedly by CDC staff and other researchers.

Using these criteria, the Macro study team, in collaboration with CDC staff, selected 43 sites distributed among five city or state areas: Boston, Newark and Jersey City,. Connecticut, Multnomah and Jackson counties in Oregon, and the Tampa-St. Petersburg area in Florida. Pretest site visits were conducted to clinics in Baltimore, Maryland, and Atlanta, Georgia. Seven types of sites are represented in the study:

- counseling and testing sites (CTS)
- sexually transmitted disease (STD) clinics
- women's clinics, incorporating family planning clinics and other setting that primarily serve women
- primary care facilities
- drug treatment centers
- tuberculosis (TB) clinics
- correctional institutions

Exhibit I-l displays the mix of site types and geographic locations. Several sites are included in more than one category for analysis purposes because they provide multiple services or, as in the case of primary care facilities, their predominantly female clientele and related health needs warrant classification as a women's clinic as well. These sites are marked with an asterisk. Because of this, the 43 sites visited represent 49 sites for analysis purposes. The six pretest site visits are not included in the analysis or in the total number of site visits. Sites visited for pretest purposes appear in the entries for Baltimore, Maryland and Atlanta, Georgia.

3. Data Collection

The selection of a case study approach to data collection created an inevitable tension between obtaining indepth information on a comprehensive list of topics, and visiting a large number of sites in each of seven site type categories in order to observe as many permutations of service delivery as possible. In order to meet both needs, data collection was designed so that each site visitor would spend up to 1 day in a given site. In order to use the scarce time on site to cover a comprehensive list of topics, site visitors collected as much information as possible ahead of time by contacting clinic staff and requesting copies of relevant clinic documents and specific data on client volume and demographics.

Development of Site Visit Instruments. Macro staff conducted an extensive review of existing research literature and interviewed CDC experts on each element of the CTRPN process, including service integration, patient flow, risk assessment, pretest counseling, posttest counseling, referrals, and partner notification. Critical factors identified through the literature review and interviews were used to develop discussion guides for both administrators and counselors. These instruments are included in Appendix A.

Three instruments were ultimately developed: an administrator interview instrument, an HIV coordinator instrument (that could be used as a continuation of the administrator instrument, depending on staff availability), and a counselor interview instrument. The administrator and HIV coordinator instruments jointly covered the integration of CTRPN services into clinic routines, staff training and configurations, and noncounseling aspects of the CTRPN process, including entry, testing, referrals, and partner notification. Administrators were also asked to describe each step in a client's progress through the clinic so that a flow chart could be developed for each clinic. The counselor interview instrument focused on the purpose, duration, and content of pretest counseling (including risk assessment), posttest negative counseling, posttest positive counseling, as well as other relevant issues such as professional background, the availability and adequacy of training, technical assistance needs, and general perspectives on HIV counseling issues.

The site visit instruments were tested in preliminary site visits to CTS, STD clinics, drug treatment facilities, family planning clinics, and TB clinics in Atlanta and Baltimore.

Other Data Collection Took In addition to the site visit instruments, several other data collection tools were developed. Clinic and client data request forms, based on the CDC client data record reporting elements and included in Appendix B, were designed to obtain data on client volume and demographics prior to the site visit, so that time on-site could be devoted to interviewing administrators and counselors and observing counseling sessions. In addition, the fact that most sites were unable to provide these data upon request became an opportunity to discuss data collection issues during the interviews. A document request form (Appendix C) was also sent to clinic staff prior to site visits to obtain background information in preparation for the visit, and to save time on-site. Finally, a set of guidelines for observing counseling sessions and a checklist of key factors were developed to allow site visitors to record the content and duration of observed

counseling sessions as objectively as possible. Copies of the counseling observation guidelines and checklists are included in Appendix D. It should be noted' that the purpose of observing sessions was to document the various approaches to providing HIV counseling and not to evaluate the quality or effectiveness of counseling.

Site visits to 43 sites were conducted in October and November 1991. In most cases, site visitors were able to spend between half a day and a day in each site, interviewing administrators and counselors. Although counseling sessions were not observed in every site, both pretest and posttest negative sessions were observed in most sites. Only two posttest positive sessions were observed.

A proposed site visit agenda, which was sent to clinic administrators prior to the site visits, is attached in Appendix E, along with a study fact sheet and other introductory materials sent to each site.

4. Analysis of Site Visit Data

Data were collected and interpreted with the study's dual goals in mind: an inventory of the kinds and levels of services, and identification of critical factors in the delivery of services. The relationship among study objectives, data collection, and research questions addressed in the data analysis is summarized in Exhibit I-2 (Study Framework).

The richly detailed qualitative data generated by the site visits presented several challenges in terms of analysis. Although the variety of service delivery models and nuances was helpful in understanding the scope of current services, it made categorization and comparison between sites difficult. Despite the emergence of patterns across site types and across certain elements of the CTRPN process, certain aspects of clinic procedures remain idiosyncratic. The process of interpreting site-level data in order to generate observations and recommendations applicable across programs is described below.

Individual Site Visit Reports: 43 Case Studies. Site visitors documented the results of interviews and observations in a site visit report for each of the 43 sites and the 6 pretest sites. In addition, a flow chart showing the various steps in the CTRPN process, the duration of each step, and the staff and documentation involved was developed for each site. Site visit reports and flow charts were returned to the sites for review and comment.

Site Type Summaries. The site visit reports from each program area were grouped according to site type. A content analysis was done on each site visit report to glean information on program management and service delivery issues by site type, but across program areas. For example, pretest counseling content was compared for STD 'clinics in Boston, Hartford, Newark, Portland, and Tampa. Each element of program management and service delivery was analyzed in this manner. Despite the diversity within site types, they were chosen as a unit for analysis because it is more likely that

patterns in service delivery would appear among a particular type of clinic, despite myriad other influences on CTRPN services; this facilitated comparisons across sites. The summaries of site type issues are provided in Chapter II of this report.

Overviews Across Sites and Site Types. Building on the summaries, overviews of program management and service delivery issues across all site types in all areas are provided in Chapter III. In this section, the analysis required stepping back from the search for patterns within a particular site type to a broader view of issues affecting the provision of HIV counseling and testing, regardless of the clinical setting. Integrating HIV counseling and testing into other services and counseling issues were explored across sites, in addition to referral, partner notification, and staff training issues. In addition, this chapter summarizes the innovations and technical assistance needs identified by administrators and counselors.

Data on clinic volume and client demographics were difficult to obtain from the individual sites, pointing to some of the data collection and management issues highlighted later in this report. Instead of relying on inconsistent and incomplete data from individual clinics, aggregate data from the computer-scannable client data record form and reported by the clinics in the study were obtained directly from CDC. These data are displayed and analyzed in Appendix F in a series of charts.

Conclusions and Recommendations for Further Research. As a preliminary, exploratory research effort, this study has raised a variety of issues that warrant further study and/or programmatic attention. While the role of the study in development of a comprehensive evaluation system has been to provide an inventory of services, descriptive information on current operations in funded CTRPN sites yields important information on the status of emerging program goals and directions for primary and secondary prevention. These issues are discussed along with recommendations for future research and program activities in Chapter IV.

Exhibit I-1
Site Visit and Pretest Clinics

City/Sites	Site Type						
	CTS/ ATS	STD	DTC	FP/ WHC	TB	PRI CARE	PRISON
BOSTON AREA							
* Atlanticare/Lynn Hospital	X	X					
Fenway Community Health Center	X						
* MCI Framingham		X					X
New Bedford-Project CARE	X						
Somerville Portuguese American League (SPAL)	X						
Project TRUST	X						
Boston City Hospital		X					
Dimock Community Health Center	X						
NEWARK/JERSEY CITY AREA							
St. Michael's Medical Center	X						
Newark Community Health Centers Inc.						X	
Newark Department of Health STD Clinic		X					
Spectrum Drug Treatment-Jersey City			X				
Spectrum Drug Treatment-Newark			X				
Essex Planned Parenthood				X			
New Brunswick Counseling Center			X				
CONNECTICUT							
Liberation Program, Inc.			X				
* Stamford Health Department-STD		X		X			
Stamford Health Department-WIC				X			
Hartford Health Department-HIV/AIDS	X						
Regional Network			X				
Webster Correctional Facility							X
Bridgeport Health Department		X					
New Haven Health Department	X						
Yale-New Haven Hospital				X			
Niantic Women's Prison							X
MULTNOMAH AND JACKSON COUNTIES, OREGON							
Westside Health Center CTS	x						
Marlene Clinic	X						
Westside Health Center-~		X					
Hooper Detox			X				
Westside Health Center-TB					X		
• North Portland Health Center				X		X	
* Southeast Health Center				X		X	
* East County Health Center				x		X	
Jackson County Health Department						X	
TAMPA/ST. PETERSBURG AREA							
Operation PAR			X				
DACCO (Tampa)			X				
Pinellas County Women's Health Center				X			
Lee Davis						X	
Pinellas County Public Health Unit-STD		X					
Hillsborough County Public Health Unit-STD		X					
Hillsborough County Anonymous Test Site	X						
Pinellas County Public Health Unit-TB					X		
Total in each category: Total Sites: 49	12	9	9	8	2	6	3

City/Sites	Site Type						
	CTS/ ATS	STD	DTC	FP/ WHC	TB	PRI CARE	PRISON
BALTIMORE (Pretests)							
Chase-Brexton Clinic	X						
Eastern District Chest Clinic					X		
Druid Health District STD Clinic		X					
ATLANTA (Pretests)							
Fulton County Alcohol and Drug Treatment Center			X				
Fulton County Health Department-STD		X					
Cobb County Health Department/Marietta Health Center	X						

- Counted in more than one site type category. Site visits were conducted in 43 sites, excluding pretest sites. Because some sites were included in two categories for analysis purposes, this table shows a total of 49 sites analyzed.

Exhibit I-2
Study Framework: Assessment of CTRPN Services
Methods: Interview and Observation
Study Unit: Clinics providing CTRPN services with funding from CDC/CT cooperative agreement
September 11, 1991

Study Aims	Research Questions	Outcomes
1. Describe the kinds, levels and patterns of CTRPN services currently being provided at CDC-funded sites.	What services are provided by clinics funded by the Cooperative Agreement for CTRPN activities in the following categories: • Entry into the CTRPN process • Pretest counseling • Antibody testing • Posttest counseling • Referral to medical and social services • Partner notification How are these services defmed by clinic staff? What is provided in each category of service? How are clinic resources being used to deliver CTRPN services? (e.g. staff allocation, integration of services) What are the structural features of HIV service delivery (e.g. appointments, return procedures) Who is receiving CTRPN services (demographic and risk factor info)? Is the number of individuals served tracked and used?	Description of services in each category. Plow chart of sequence and waiting times for each step in service delivery in each clinic. Summary of data on individuals going through CTRPN process. Summary of data on clients being served by CTRPN services.

Exhibit l-2 (2)

Study Aims	Research Questions	Outcomes
2. Describe the kinds of data collection and evaluation currently underway in CT'RPN sites.	Are data systematically collected on CTRPN services? Which elements? Are demographic and risk factor data systematically collected on clients provided CTRPN services? Are sites participating in seroprevalence studies? How is data stored and managed? To whom are CI'RPN data reported? How? Is CTRPN and seroprevalence data used by study sites? For what purposes (e.g. planning, evaluation)? What are the issues and problems in data collection and reporting? In using data for program planning and evaluation?	Description of kinds of data collected. Description of uses of data. Description of data management forms and practices. Identification of problems in data collection and reporting. Identification of problems in program evaluation.
3. Describe the critical issues and barriers in delivering CTRPN services.	What are the policy factors which facilitate or inhibit effective service delivery? (anonymous vs. confidential, screening vs. universal CT, etc.) What are the administrative issues that facilitate or inhibit effective service delivery? (staff, trainiig, facilities, resources) What are the service deliver-y factors that facilitate or inhibit effective service delivery? (counseling practice, patient flow, waiting times, cultural sensitivity)	Identification of critical issues and barriers to service delivery in areas of • clinic/program policy • administrative and structural features • service delivery practices

Exhibit I-2 (3)

Study Aims	Research Questions	Outcomes
4. Describe innovative approaches to providing CTRPN services.	What innovative approaches are being tried by clinics in each category of service? What are the goals of these efforts? To what extent is data used in planning and evaluating these efforts?	Identification of innovative practices. Description of evaluation activities or reports for identified innovations.
5. Identify technical assistance needs.	Do clinics understand expectations of funding agency(ies) (of CDC?) Do they receive guidance and support in implementing requirements? Is training available? Is it adequate? What guidelines, training or other technical assistance services would be most helpful to service delivery sites?	Identification of technical assistance needs.

Chapter II. Status of CTRPN Services by Site Type

A. Introduction

One of the most difficult challenges in designing this study was to identify a standard unit of analysis. The focus of the study is the current status of counseling, testing, referral, and partner notification (CTRPN) services. However, one of the key features of how these services are currently provided is the diversity of clinical settings in which they are offered. CTRPN services are now available in a wide variety of site types, including the original counseling and testing sites (CTS), sexually transmitted disease (STD) clinics, family planning/women's health centers, primary care facilities, drug treatment clinics, tuberculosis clinics, and prisons, among others. In each of these site types, site-specific factors such as types of other services, history of HIV counseling and testing, clientele, staff configurations, clinic protocols, processes, influence the delivery of CTRPN services. Using site types as a broader unit of analysis allows some standardization and comparison within site types.

In the following sections, data from site visit reports for each site type are summarized, with particular attention to patterns in service delivery. Each site type section also includes tables that summarize staffing, counseling, data collection, referral, and partner notification issues. (In a later section, aspects of service delivery across all site types are explored in greater detail.)

1. Variation Within Site Types

Despite the usefulness of site types as a broader grouping for individual sites, variation within site type categories remains the rule rather than the exception. For example, drug treatment programs include methadone maintenance clinics, residential treatment centers, as well as detox facilities; these have distinctly different features despite their loose affiliation as drug treatment programs. Similarly, some prison HIV programs are based in medical units, while others are adjuncts of STD services. In addition, some sites, because of their range of services and/or clientele, can be classified in more than one site type category. These include the STD/HIV program within a prison described above, as well as a number of primary care facilities whose clientele is comprised mainly of women seeking family planning and prenatal care, A hospital-based clinic in Boston alternated between providing STD and HIV counseling and testing services on different days (but with the same staff). In each of these cases, sites were analyzed in more than one category and therefore appear in two of the site type summaries below.

2. Program Influences

Although service delivery is clearly influenced by the unique setting in which CTRPN services are offered, another important influence is that of the program overseeing service

delivery at the site level. The influence of programs--whether state, city, or county--was not an explicit focus of this study, although its importance as a variable in service delivery is recognized. In addition to general oversight of clinic operations, programs in each area seem to have the greatest influence over the following:

- the type of training required for HIV counseling
- partner notification activities
- data collection

Sites were visited in five program areas: Boston, New Jersey, Connecticut, Hillsborough and Pinellas Counties (Florida), and Multnomah and Jackson Counties (Oregon).

3. Site Type Summaries

Although this study has focused on the kinds and levels of services at the site level, these and other program influences are clearly significant. As sources of both funding and technical assistance, programs shape the content and delivery of services in a variety of ways and help sites target their efforts within the broader fight against HIV/AIDS.

In the following sections, program management and service delivery issues are summarized for each of the following site types: CTS, STD, drug treatment centers, family planning/women's health centers, tuberculosis clinics, primary care facilities, and correctional institutions. A broader discussion of program management and service delivery issues across site types follows the site type summaries.

B. Discussion of Each Site Type

1. Counseling and Testing Sites (CTS)

a. Overview of the Site Type

History

The first blood test for HIV was licensed in 1985 and was used initially to screen the Nation's blood supply, Alternate test sites (ATS) were funded to provide opportunities for HIV testing outside of blood donation centers. In 1987, a new emphasis on providing counseling both before and after testing prompted a name change from ATS to HIV counseling and testing sites (CTS).

In 1991, 45,178 HIV tests were conducted in 1,581 freestanding HIV CTS; of these, 22,770 or 5.0 percent yielded positive results. (The total number of individuals tested is unknown, since some individuals are tested repeatedly.) Although freestanding CTS account for about a fifth of all publicly funded sites providing HIV counseling and testing, they account for 30 percent of all tests and 41 percent of all positive results.

Site Characteristics

A total of *12 CTS* were visited in Boston, Massachusetts; Hartford and New Haven, Connecticut; Newark, New Jersey; Tampa, Florida; and Portland, Oregon. Although all provide HIV counseling and testing as a separate service, some also offer a wider range of services, including primary health care, extended counseling, drug treatment, outreach, and education. Two are hospital-based, three are located within health departments, two are free-standing sites, and five are community-based organizations (CBOs) or community health centers. Of the 12 sites, 5 offer both confidential and anonymous testing and 7 offer only anonymous testing. The sites and locations are as follows:

Name of Site	Location
Project TRUST	Boston, MA
Somerville Portuguese American League (SPAL)	Somerville, MA
New Bedford Center for Human Services/Project CARE	New Bedford, MA
Dimock Community Health Center	Roxbury, MA
Fenway Community Health Center	Boston, MA
Atlanticare/Lynn Hospital	Lynn, MA
Marleen Clinic	Portland, OR
Westside Health Center CTS	Portland, OR
Hartford Health Department HIV/AIDS Program	Hartford, CT
New Haven Health Department	New Haven, CT
St. Michael's Medical Center	Newark, NJ
Hillsborough County Anonymous Test Site	Tampa, FL

Clientele

Many of the CTS visited during this study continue to draw the clientele that initially sought HIV counseling and testing: gay and bisexual Caucasian men. Fenway in Boston has historically provided services for the gay and lesbian community; 65 percent of HIV counseling and testing clients are Caucasian, middle-income men who self-identify as gay/bisexual. A priority for clinic staff is to reach high risk and hard-to-reach subgroups, including transsexuals, individuals involved in S&M culture, and drug users. Onsite drug treatment and detox services have increased the number of both gay and heterosexual drug users seen at the clinic. In addition, there has been a gradual increase in the number of lesbian women, homeless men and women, Latinos, and Portuguese-speaking clients. In 1990, 11 percent of the clinic's HIV counseling and testing clients were people of color.

The Hartford Health Department CTS continues to see mostly gay, Caucasian men, although some are Hispanic and African-American. Clinic staff report seeing drug users and their partners as well. Efforts to reach women included a recent "For Women Only" clinic that featured group educational sessions followed by individual counseling. Staff at the Marleen Clinic in Portland, which has traditionally provided services to gay men, have seen more women and heterosexual men recently. Westside CTS staff in Portland report that gay men account for most repeat tests, but more women and heterosexual men are being seen there as well.

The Hillsborough County CTS sees a diverse clientele that is 60 percent Caucasian, 30 percent Hispanic, and 10 percent African-American, evenly divided between men and women. Sixty percent report gay sexual contact as their primary risk factor; 10 percent of clients who report heterosexual risk are women. Many women at the clinic have moved to Florida from the Northeast and report concern about partners' drug use there, where needle sharing is more common than it is in Florida.

St. Michael's CTS provides HIV counseling and testing to the general population in Newark, but also provides targeting HIV services to persons at risk through several satellite clinics. Individuals in the hospital's inpatient drug treatment program are referred to CTS for HIV services.

CTS that target drug using populations see a more ethnically diverse clientele and benefit from being located within the communities they serve, as opposed to health department sites that are located in health departments along with other clinics. Project CARE is collocated with a methadone maintenance clinic, alcohol/drug treatment program, and youth intervention program in order to reach its target populations: current users as well as former addicts in recovery. Clientele include an equal number of men and women; 84 percent are Caucasian, 19 percent are African-American, and 23 percent are Hispanic, reflecting the demographics of New Bedford. Clinic staff are expanding services to the Hispanic commumty and to county prisons, where disproportionate numbers of inmates are Hispanic.

Project TRUST in Boston also targets current and former drug users. Thirty percent of clients are homeless, and most are either African-American or Hispanic males. Women who present for services tend to be commercial sex workers with a history of drug use. Current outreach efforts seek to recruit more women into the program. Dimock staff see mostly African-American and Hispanic residents from the community, but some Caucasian college students and gay men from other parts of Boston have presented for services. Staff speculate that Dimock is well known outside its neighborhood and may provide an additional measure of anonymity for clients from other areas.

Staff at SPAL continue to try to reach Portuguese-speaking clients with HIV counseling and testing, but are seeing more "Americans" than target populations for this aspect of their services--116 Americans and 25 Portuguese-speaking clients in a recent 6-month period. Seropositivity rates are much higher for Portuguese-speaking clients, many of whom are young, sexually active men in their 20s with multiple partners and no history of condom use. Staff report that the illegal immigration status of many clients may be a barrier to seeking services, and many recent immigrants come from rural areas where attitudes towards health care differ. In addition, misconceptions about risk are common among Portuguese-speaking populations, who have little access to culturally appropriate AIDS education materials and continue to perceive AIDS as a disease affecting gay, Caucasian men. SPAL staff are involved in outreach efforts to Portuguese-speaking clients and are developing appropriate educational materials.

b. Program Management Issues

Integration of Services

Integration of services within a site is less of an issue for CTS that provide only HIV counseling and testing than for other types of sites that offer HIV counseling and testing

as one of many health services. CTS staff generally have not faced the same dilemmas that other sites have faced regarding whether and how to incorporate HIV counseling and testing into existing services. Instead, CTS staff tended to view the integration issue as one of how and where they fit into a broader spectrum of services, which may or may not be provided by the site itself.

Most free-standing CTS have links to other health and human service organizations, either as sources of clients or as referral options for clients. CTS that are collocated in health departments, health centers, or hospitals with other clinics have strengthened linkages to sexually transmitted disease (STD), family planning, drug treatment, and tuberculosis clinics as sources of clients. For example, syphilis patients seen in the Hartford Health Department are routinely referred to the CTS in the same building, and HIV counseling and testing (at the CTS) is offered to all STD patients. (However, staff report that linkages to the health department's family planning clinic have been less successful.) St. Michael's CTS in Newark routinely has patients referred from the hospital's inpatient drug and alcohol treatment program. Project CARE, a Massachusetts program that operates eight counseling and testing sites, deliberately selected locations that provide clients of drug treatment, family planning, prison, and youth programs with HIV services that are convenient and accessible, yet separate from the "host" programs. Counseling and testing in the Project CARE sites is "integrated" into a continuum of services for people who are HIV-positive--including education, outreach, case management, and ongoing medical and psychosocial support--but is separate from other health and human services within each site. At Project CARE and Project TRUST, the focus of these varied services is persons either at risk for HIV/AIDS, or infected with the virus.

In addition to facilitating referrals of clients to and from other health clinics, collocation encourages staff interaction as well. At the Dimock Community Health Center in Roxbury, HIV staff conduct seminars for drug treatment staff, and cross-referrals have been strengthened as a result. In Oregon and Florida health departments, STD clinics are closely linked with CTS through the partner notification and counseling activities of disease intervention specialists (DIS) based in the STD clinics, but active in both the CTS and STD sites. In addition, in Multnomah County, Oregon, the same person manages both the county STD and CTS clinics, which are on different floors of the health department building.

While Project CARE added counseling and testing to a variety of existing HIV/AIDS services it provides to the community, other sites began with counseling and testing and found that they had to expand services in response to community needs and changes in the epidemic. Project TRUST in Boston began as a storefront HIV counseling and testing site targeted to drug users, and now provides case management, onsite primary health care, support groups, advocacy, street outreach, and AIDS education, and plans to add psychiatric care in the future.

Staffing Issues

Staffing issues are summarized in Table 1B, which shows staff roles and backgrounds in outreach/education, counseling and testing, referral, case management, and partner notification. In addition, Table 1B shows HIV counselors' training and whether or not the clinic uses any quality assurance mechanisms to assess counseling quality.

Training. Counselors report varied professional and educational backgrounds. In addition to physicians and nurses who have added HIV counseling to other health activities, therapists, case managers, social workers, drug and alcohol treatment specialists, recovering drug users, phlebotomists, DIS, and health educators provide counseling to CTS clients.

Almost all individuals providing HIV counseling in these sites have completed some type of standardized HIV training provided by the state or county. Additional training includes a 3-day NIDA course attended by Project TRUST staff (whose target population is drug users) and a 2-week course on sexually transmitted diseases attended by staff of St. Michael's HIV program in Newark. Administrators and counselors in Oregon report that the 2-week DIS course does not cover counseling techniques and thus leaves DIS ill-equipped for this aspect of their jobs and for dealing with a fatal diagnosis. In several clinics, new counselors sit in on sessions by more experienced counselors before conducting sessions alone. HIV counselors in Oregon, New Jersey, and Connecticut are also trained phlebotomists, enabling them to draw clients' blood at the conclusion of pretest counseling.

Continuing Education. In many areas, relevant conferences and workshops are available but inaccessible because it is difficult for staff to take time off from their day-to-day duties. Some clinics have tried to provide ongoing in-house training through frequent staff meetings, speakers' bureaus, and circulation of relevant articles. Staff report a need for training that keeps them up-to-date since many CTS clients are well-informed about HIV/AIDS and have more sophisticated information needs, especially regarding treatment issues. In Connecticut, continuing education is required to maintain HIV counseling certification.

Diversity, In addition to professional diversity, staff in most clinics reflect their clientele in terms of gender, racial, and ethnic diversity. This is particularly true of clinics associated with community-based organizations or community health centers who depend on credibility among their target populations in order to be effective. The most frequently reported bilingual/bicultural capabilities are in Spanish, but in Boston several Portuguese counselors and outreach workers serve Portuguese-speaking communities. In addition, staff in many clinics have roots in the community and empathy with client issues--especially drug treatment and recovery, Dimock's director reports that a counselor's two most important qualities are life experience and commitment. In Dimock's case, staff knowledge of and roots in the surrounding neighborhoods were key to community acceptance of the program and its goals. Staff throughout Boston are trying to meet the

special needs of recent immigrants, including different language and cultural norms, fears of accessing health care because of illegal immigrant status, and cultural beliefs and attitudes towards health care.

Training Needs. Feedback on the standardized training is generally positive, but many counselors report that the training they received is insufficient for addressing cultural diversity and drug use issues related to HIV counseling. Counseling techniques--especially how to approach different types of clients about risk behaviors--could be addressed in entry-level as well as advanced training. In addition, as mentioned above, many counselors would welcome information "beyond HIV 101" that helps them stay current as the information about treatment options and implications becomes more complicated.

Counselor Support. Counselors and clinics have devised various ways to manage the stress and emotional burnout that are common byproducts of HIV counseling. Two clinics periodically bring in a trained outside facilitator to lead group discussions with staff. All-day retreats, staff support groups, mental health days, flexible scheduling, regular staff meetings, and balanced distribution of posttest positive sessions are other methods cited by administrators and counselors.

Staff Configurations. Staff configurations vary a great deal. Key influences include program mandates, client volume, resource availability, and clinic history. In two county-led programs--Oregon and Florida--nurses provide HIV pretest counseling, but DIS provide posttest counseling and handle all aspects of partner notification. Several health department sites share staff with other clinics. For example, a counselor in the Hartford Health Department CTS also provides counseling in the health department's STD and family planning clinics. Five of the clinics have social workers on staff to help with referrals and case management for HIV-positive clients. Project CARE has its roots in case management and client advocacy, and its staff reflect this: four of five program case managers share responsibility for providing HIV counseling and testing, dividing their time evenly between case management and HIV counseling and testing. In several clinics, administrators and phlebotomists had received counseling experience or training; this enabled them to step in and provide counseling if warranted by patient flow or scheduling difficulties. Many clinics report full- or part-time outreach workers who combine HIV/AIDS education work with recruitment of clients into the clinic's HIV counseling and testing services.

Confidentiality/Anonymity

Five of the CTS sites provide both. confidential and anonymous testing, while the remaining seven sites offer only anonymous testing, as shown in Table 1A. St. Michael's CTS in Newark, New Jersey currently offers both confidential and anonymous testing but is phasing out anonymous testing in response to state policy. In Connecticut, state HIV/AIDS policy is moving toward providing confidential testing as the standard, with anonymous testing as an alternative. Staff at the New Haven Health Department's CTS expressed concern that the emphasis on confidential testing may drive away potential

clients who come to the clinic (often from outside the New Haven area) because it is perceived as an anonymous test site. The Hillsborough County CTS is the only public site offering anonymous testing. Confidential testing is done in other county public health clinics, which refer clients who wish to be tested anonymously to the CTS.

In sites that offer both types of testing, most clients choose anonymous testing. In every case, clients tested anonymously are identified in clinic records by a unique identifying number that is affixed to blood samples, lab slips, and return appointment cards. Instead of signing informed consent forms, anonymous clients write in their identifying number. Project TRUST staff report that clients who live on the streets often lose the appointment cards with these unique identifying numbers and are therefore unable to obtain their results. In response, staff developed an alternative in which clients create their own code using a combination of their birthdates, initials, and so on.

Many of the anonymous sites encourage clients to reveal their identities once they have tested positive in order to be referred or contacted for followup services and case management, although of course this is never required. In Multnomah County, Oregon, clients who test anonymously are retested confidentially in the county's HIV Wellness Clinic so that an official record of their test results can be included in the client's medical treatment file.

Confidentiality is maintained by keeping HIV records separate from hospital or other medical records, and by keeping HIV records under lock and key with restricted access. Clients must sign a release form in order to have their results released to any other person. At Project TRUST, this includes another health provider.

Data Collection

Data collection methods and uses in each clinic are summarized in Table 1C.

Each of the sites collects data for state reporting purposes using a standardized form. In addition, some sites collect specific demographic information from clients, either by interview or by having clients fill out forms. (At Dimock, in Boston, client forms present difficulties for clients who do not speak English or who have low literacy levels in English, Spanish, or Portuguese.) Another source of data is clinic registration logs, from which data are manually tallied to arrive at aggregate numbers on client volume. Despite these efforts, most information about clientele and volume was anecdotal and very general--e.g., "Recently, we have been seeing more women and minorities." The most recent annual client volume data available for St. Michael's in Newark was from 1989.

The Hartford Health Department CTS was the only site that reported collecting feedback from clients through a questionnaire designed to assess their satisfaction with services. In addition to providing positive feedback, the responses highlighted areas for improvement, including modifications to a phone screening protocol so that it would

provide greater privacy for clients calling from work. (This was accomplished by posing sensitive questions so that they would require only "yes" or "no" answers.)

Although all the sites collect and report various types of data on client volume and demographics, few routinely use these data for program planning, design, or evaluation. At the Hartford Health Department CTS, the administrator described the program as "client-driven, not data driven." At the New Haven Health Department CTS, staff report that they would like to get data back from the state more quickly. In addition, they would like to be able to exchange data with other places and would like a database of all individuals receiving HIV counseling and testing services in New Haven facilities.

Seroprevalence data seem to be used for general information and comparisons, but less frequently for specific purposes such as targeting services. Staff at Hillsborough County CTS in Florida and St. Michael's CTS in Newark do not view seroprevalence data as useful. However, four sites do use seroprevalence and other data to plan and monitor service delivery. Fenway Community Health Center designed an outreach program to recruit more African-Americans and Hispanics in response to demographic data that revealed low numbers of minorities being counseled and tested. Staff at Atlanticare/Lynn Hospital know that they are seeing too many "worried well" clients instead of those who are truly at risk because seroprevalence is not as high as it should be. At the New Haven Health Department site, which is involved in a Centers for Disease Control (CDC) seroprevalence survey, staff are aware that they are not seeing the population most at risk for HIV/AIDS in New Haven: injection drug users, who account for 60 percent of New Haven's AIDS cases. The Connecticut HIV/AIDS program has pressured the clinic to diversify its client profile and meet targets relating to gender, ethnicity, and risk category.

Sites that use seroprevalence and other data are involved in collaborative research with other organizations (such as hospitals and universities) or, as is the case with SPAL, are led by an administrator with a personal background in research and a strong commitment to it.

C. Delivery Issues

Entry

Walk-in/Appointments. Eight sites offered HIV counseling and testing by appointment, while the remaining four offered walk-in services. The Atlanticare/Lynn Hospital site originally offered walk-in services, but staff reported that 10 patients were routinely waiting outside the doors at 8:00 a.m., 1 hour before the clinic opened. This was stressful for both clients and staff, and a decision to switch to appointments was made. Several of the sites that require appointments make an effort to accommodate walk-ins if a counselor is available. Waits for appointments range from 1 to 2 weeks, but delays were experienced in almost all the sites as a result of Magic Johnson's announcement of his serostatus, which dramatically increased demand at the time of the site visits. For

example, at the Hillsborough County CTS, waits for appointments had gone from 1 to 6 weeks as a result of the announcement.

Even before Magic Johnson's announcement, some clinics had experienced more gradual increases in demand for services. Staff at the Westside CTS in Portland noted that 1 year ago, when the wait for an appointment was 1 week, the no show rate was practically zero, In early November (just a few days before the Magic Johnson announcement), the wait for appointments was approximately 2 weeks, and the no-show rate had increased to 20 percent.

Three of the walk-in sites--Dimock, Project TRUST, and Project CARE--specifically target inner city populations and drug users; these sites have chosen a walk-in policy to maintain an informal and accessible atmosphere and to avoid any perceived barriers to access among target populations. Waiting times in walk-in sites varied across clinics and within clinics depending on volume and time of day. At Dimock in Boston, waiting times ranged from 15 minutes to 1-1/2 hours, and this range was typical of other walk-in sites as well. All of the walk-in sites provide appointments for clients returning for test results or move them to the front of the queue.

Hours. Most CTS offer HIV pretest counseling and testing on weekdays, with three sites (Atlanticare/Lynn Hospital, SPAL, and Dimock) seeing clients on 1 day each week. Project CARE services are available in eight separate sites, each offering flexible hours to meet the needs of clientele of host programs. For example, one Project CARE site offers early morning hours, opening at 6:00 a.m. on Tuesdays to match the schedule of the methadone maintenance clinic in the same building and provide access to services for those clients. About half of the CTS offer evening hours to accommodate clients who work. SPAL staff schedule posttest sessions at other less crowded times during the week, as do Atlanticare/Lynn Hospital and New' Haven Health Department staff.

Fees. Only one site (Hillsborough County CTS) charges a fee--in this case, $20--but payment is not required in order to receive HIV counseling and testing services. Staff at each of the Boston sites expressed concern that fees may have to be charged in 1992; this was also a concern at the Westside CTS in Portland, where administrators are contemplating whether or not to ask for donations from clients, if not outright fees. In both Boston and Portland, the potential imposition of fees was of concern because it may constitute a barrier for clients already unsure about whether or not to be tested, and staff at Fenway--a CTS serving the gay and lesbian community--feared that the imposition of fees would be viewed as discriminatory. Project TRUST staff are concerned that their indigent and uninsured clientele will be affected by the charging of fees, even if no one will be denied services because of inability to pay. In addition, other project resources may have to be shifted to accommodate changes in reimbursement for HIV counseling and testing.

Risk Assessment. Features of risk assessment in each clinic are summarized in Table 1E.

Because clients of CTS have self-selected for HIV counseling and testing, risk assessment is rarely used as a screening device for who should or should not be tested. One exception is the Hartford Health Department CTS, where a staff member conducts screening over the telephone when clients call to make appointments. Concerned about the "worried well" overwhelming scarce one-on-one counseling slots, the clinic holds group HIV education sessions twice a month to help interested individuals make better choices about whether or not they should be tested. Typically, heterosexuals with no drug use history are directed to these education sessions. The Hartford CTS receives over 1,000 calls every month, and approximately 10 percent of these result in appointments. At Fenway Community Health Center in Boston, counselors rotate responsibility for telephone coverage and use the initial call to probe for the client's reasons for seeking HIV counseling and testing. In addition to providing some referrals over the phone (such as mental health, substance abuse, or educational workshops), counselors screen for "worried well" and prioritize appointments; for example, physician referrals are always given priority. Hartford Health Department and Fenway Community Health Center were the only two sites in which clinic protocols and staff time specifically include telephone interaction with potential clients and use of this information to make or prioritize appointments.

Even in clinics that have not instituted telephone or other screening, staff in several of the CTS expressed concern about the large number of worried well; this concern was exacerbated in the wake of Magic Johnson's disclosure of his serostatus. Individuals concerned about exposure to HIV were more likely to contact a CTS for HIV testing than any other type of site in this study. At Project TRUST in Boston, staff have noticed that more and more nondrug users have presented for HIV counseling and testing; staff speculate that this may be related to overcrowding and long waits at other Boston counseling and testing sites. Although Project TRUST staff are reluctant to turn away any clients unless the clinic is already at capacity, they are committed to serving injection drug users (IDUs) and do not want the clinic to be perceived as a CTS/ATS. In contrast, staff at the New Haven Health Department CTS were reluctant to dissuade persons at lower risk from receiving HIV counseling and testing, since they see the intervention as an important education and prevention measure that would be valuable for anyone.

Assessing risk to determine types of possible exposure and future risk reduction measures typically occurs in pretest counseling, but often a form or questionnaire is filled out by clients while they are waiting to be seen. In many cases, the forms constitute not only information gathering but also preparation for the content of the session.

Pretest Counseling

Pretest counseling sessions were observed in 6 of the 12 sites. Characteristics of pretest counseling in each site are summarized in Table 1D.

Counselors. As described above, counselors have varied professional backgrounds. In the CTS visited for this study, physicians, nurses, health educators, outreach workers,

phlebotomists, social workers, and recovering addicts all provided counseling. In each of the sites, counselors--regardless of their professional backgrounds--attended some type of standardized state or county course on HIV counseling and testing. In several sites, counselors also sat in on sessions conducted by more experienced counselors before seeing clients alone.

Duration. The duration of pretest counseling sessions ranged from 15 to 45 minutes, with most clinics scheduling between 20 and 30 minutes for these sessions. The longest scheduled sessions were at Hartford Health Department **CTS** (45 minutes), while the shortest were at St. Michael's (15 minutes).

Tools. Almost all the counselors used required data collection forms as guidelines--either to be more efficient about filling out the forms, and/or to prompt the content of the session. Counselors in Boston all used the Health Department form but stressed that the content of individual sessions depends on client needs. In Oregon, the state serology form is similarly used to shape but not necessarily dictate the discussion. However, in an observed session at St. Michael's, the scan form was used to determine risk but the acknowledged risk behavior was not emphasized or discussed more than the others listed on the form. A counselor at the Hillsborough County CTS noted that the scan form would benefit from two additional categories: occupational exposure (typically, needlestick concerns) and child of HIV-positive parent. (These categories are being added to the state lab form.)

Content and Approach. As would be expected, the content of and approach to pretest counseling in these sites is highly variable, influenced not only by differences in protocols but especially by individual interaction between clients and counselors. The following topics are covered in most pretest sessions, according to both observations and interviews:

- the HIV counseling and testing process
- the difference between HIV and AIDS
- meaning of test results and of the "window period"
- transmission routes
- risk reduction
- client's risk factors.

Of these topics, counselors report that the concept of a "window period" is sometimes difficult to get across and is time-consuming, but necessary, to explain. As a SPAL counselor noted, discussion of the window period during pretest counseling is important so that if the client tests negative, he or she will not have a false sense of security about the test results. Only two counselors report that they specifically address obstacles to behavior change. At Dimock, one counselor asks about alcohol use, even though it is not an "official" risk factor.

Risk Perception. Linking general risk to individual risk behaviors is an explicit objective for several of the counselors. Counselors noted that CTS clients--particularly gay clients

(at Marleen and Fenway) and drug users (at Project TRUST)--are generally well-informed about transmission routes and are concerned about specific behaviors that have placed them at risk. Counselors in these sites initiate the discussion of individual risk by asking open-ended questions, such as "Why are you here today?" or "What made you decide to come in?" At Project CARE, clinic protocols provide specific prompts to elicit responses about risk perception, such as "Why are you concerned about AIDS?" or "What makes you believe you have been exposed to the virus?" The counselor at the Marleen Clinic in Portland tries to avoid talking about "high" or "low" risk, fearing that clients are only too willing to find an excuse for denying their risk.

At Fenway, it is not unusual for couples to request a joint appointment. Staff discourage this specifically because it inhibits the counselor's ability to frankly discuss individual risk behaviors with the client. As a compromise, staff offer to schedule back-to-back appointments for partners, with joint counseling after each partner has had an opportunity to receive individual counseling. In many cases, the joint sessions are ideal opportunities to discuss obstacles to condom use with both partners present.

General Goals. At Dimock, counselors see pretest counseling as an opportunity to allay fears about the possibility of positive results; they strive to create an atmosphere of trust that makes it easier for clients to discuss their fears and risk behaviors. At the Westside CTS in Portland, the counselor's goal is to give the client enough information to make an informed choice regarding whether or not to be tested. Another counselor makes a point of noting and encouraging the client's attempt to change behaviors and seek information about HIV.

Preparing for Positive and Negative Results. Most of the counselors address the implications of both positive and negative results during the pretest session. If the results are negative, how will the client maintain or initiate risk reduction measures? If the results are positive, what kind of emotional support is available? At Project TRUST, counselors ask clients, "Who knows that you're here?" as a way to initiate discussions of emotional support. At Dimock, counselors use the pretest session to prepare clients to think about whom they might tell about positive results.

Counselors make a point of discussing the importance of medical care and the availability of services; two counselors specifically ask clients whether or not they have a medical provider. In Multnomah County, counselors feel fortunate to have an HIV Wellness Clinic on the same floor as the CTS (and a short distance from the Marleen Clinic); this allows them not only to refer clients for care but also to offer concrete evidence of an accessible service. The Hillsborough CTS is also located next door to the county HIV Clinic. The Marleen Clinic counselor lets clients know that HIV/AIDS can be viewed as a chronic, manageable disease--not necessarily as an immediate death sentence.

Partner Notification. Several counselors also introduce the concept of partner notification during pretest counseling, to get the client thinking about the possibility that sex and

needle-sharing partners may have to be notified. However, this does not seem to be a routine element of pretest counseling.

Condoms. All but one of the CTS sites provide condoms to clients; the exception is St. Michael's, located in a Catholic hospital. However, St. Michael's does provide brochures about condom use. Only one counselor (at Fenway) consistently demonstrates condoms, noting that often clients are embarrassed to admit that they do not know how to use them. At the Hartford Health Department CTS, counselors demonstrated condom use more frequently in the past, but do not now because of time constraints. However, they do cover the importance of a reservoir tip and of using an appropriate lubricant. With women, counselors at the Hartford CTS make a particular effort to demystify the use of condoms; they discuss how to incorporate condoms into lovemaking and how to avoid the implication that a woman suspects her partner of infidelity if she insists on condom use. The Hillsborough County counselor provides women with printed material suggesting ways to get a partner to use condoms. She also discusses dental dams and routinely recommends that women use foam as well as condoms for safety.

Informed Consent. In nine of the sites, informed consent forms are signed during pretest counseling; anonymous clients enter a bar code identification number that is also used on their blood samples and posttest appointment cards. Bilingual staff are available to clients who need assistance translating the form. At St. Michael's, informed consent forms are available in Spanish. The three exceptions to written informed consent during pretest counseling are the Portland clinics, in which informed consent is obtained verbally, and St. Michael's in Newark, where the receptionist asks the client to sign an informed consent as part of intake.

Other. In the Boston sites, counselors write brief comments about the pretest session on index cards, to which the client's bar code number is affixed. These cards are used to structure the posttest session.

Testing

Testing issues are summarized in Table 1F.

In eight of the sites, counselors draw blood at the end of the session if the client has agreed to be tested. In four of these sites, counselors are trained phlebotomists. One of the nurses at Atlanticare/Lynn Hospital noted that IDUs often have veins that are in poor condition; in these situations, it would be helpful to have a phlebotomist available. At Dimock, counselors who are recovering IDUs find it difficult to draw blood, so other counselors enter the room after their pretest sessions to draw the client's blood. In the remaining sites, blood is drawn in a lab that is in the same building or, in one case, within the site. Waiting times for blood draws are reported to be minimal--less than 15 minutes.

In every case, blood samples are sent to state labs for analysis. Results take between 10 to 14 days.

Return Arrangements

CTS seem to arrange posttest sessions in two ways: clients make an appointment (usually for 2 weeks from the day of the test) on their way out of the clinic, or they are asked to call (in 10 days to 2 weeks) to schedule an appointment. (Even sites that schedule appointments immediately after the pretest session ask the client to call to make sure results are available.) Clients are usually given a card or lap slip with their unique ID# (usually from the scan or another data form), the clinic's telephone number, and either the date of the appointment or the date on which they should call to make an appointment. Clients must present this card or lab slip in order to receive their results. At Project CARE in New Bedford, clients are given a toll-free 800 number to call to check that their results are in; the 800 operator identifies results using the bar code number and site location codes.

At Fenway, New Haven Health Department, SPAL, and Atlanticare/Lynn Hospital, an effort is made to schedule posttest appointments in the evenings or at other times when the clinic is less crowded. At Project TRUST, clients are encouraged to bring someone with them. Most clinics make an effort to schedule posttest sessions with the same counselor who conducted the pretest session. Project CARE staff report that continuity in counselors seems particularly important for Hispanic clients.

In Oregon, clients who do not return receive discreet reminder letters after 3 months. Clients whose results are positive and who can be identified are contacted by a DIS. Clients who do not call for a posttest appointment within 10 weeks receive letters from the Hartford Health Department asking them to call the "Hello Line" for information about test results; these letters are triggered by a tickler file maintained by the receptionist. In the future, the Hartford CTS plans to use outreach workers to contact clients who have not returned. Names of St. Michael's clients who do not return are forwarded to the state's Notification Assistance Program.

Return rates were not available for every site. Staff at the Marleen clinic report that virtually 100 percent of clients return for results. During October, 66 percent of Project CARE clients returned; this rate was similar to SPAL's 65 percent return rate. Eighty percent of Project TRUST clients return for results. At the Hartford Health Department, 86 percent of clients return. At St. Michael's, 37 percent returned, and 70 percent of those who did not return had positive results.

Posttest Counseling

Posttest counseling sessions were observed in four of the sites. Characteristics of posttest counseling across sites are summarized in Table 1G.

Negative Results. Posttest counseling sessions for negative results range from 3 to 4 minutes at Hillsborough to 10 to 20 minutes in the other sites. Many counselors report that clients are so relieved by the news that it is difficult to discuss risk reduction, window

periods, or anything else during the posttest session; the clients are eager to leave. Both counselors and administrators noted that clients whose results are negative often need as much counseling as those who are positive,, but resources are unavailable. Project TRUST tries to provide followup counseling for negative clients on a limited basis; staff are frustrated that negative clients are ineligible for extended services. Staff note that for clients who are negative, the issues raised by the testing process--coming to terms with a lifestyle or behaviors, or having a friend or partner who is positive--are unresolved despite the test results.

In most sites, counselors try to use the posttest negative session to remind clients that their negative results do not necessarily mean that they do not have HIV. Some counselors routinely recommend retesting in 3 months if exposure has occurred, while others recommend 6 months. Depending on the client, some counselors recommend retesting at 3- or 6-month intervals. Retesting recommendations and are listed in Table 1G.

Positive Results. Posttest sessions for positive results are scheduled for between 30 minutes to an 1 hour, with an understanding that some sessions may require more time. Counselors report two main goals for the posttest session: to verify an immediate support system, and to provide referrals to other services. Once they have delivered the results and helped the client with his or her immediate reaction, counselors try to stress the difference between HIV and AIDS. Without giving false hope, the Hillsborough County counselor lets clients know that they can "take control of the disease." This idea was reiterated by other counselors, who stress the importance of medical evaluation, health care, and good nutrition. The Hartford CTS counselor hopes to convey to clients that they can do something about their health status. The Marleen counselor describes the session as an opportunity to set up a plan for living with HIV/AIDS.

Followup sessions are offered in six of the sites; some of these are conducted over the phone. In several of the sites that do offer followup sessions, scarce resources make it difficult to offer these services routinely. At Fenway, counselors make a distinction between the role of an HIV counselor (which is perceived as relaying results, providing immediate emotional support, and connecting the client with ongoing support) and the role of a trained therapist. New Haven Health Department staff would like to be able to offer additional sessions to HIV-positive clients and help them through the transition period while they establish other sources of support. The posttest session alone is considered insufficient to truly help someone undergoing a life-changing experience, and this is a source of frustration for counselors.

Project CARE staff report that delivering positive results in prison settings is particularly difficult because inmates must maintain a facade of strength and toughness, and are unable to reveal the emotional impact of the counseling session once they are among other inmates. As a result, counselors must devote part of the session to helping inmates regain their composure.

Referral

Referral sources, typical onsite and offsite referrals, and gaps in existing services are summarized in Table 1H.

As noted above, referrals are a key focus of the posttest session for HIV-positive clients. Most counselors try to develop an individual package of information for clients, writing down names and phone numbers of appropriate services, ranging from immediate medical evaluations to hotlines and support groups. At Atlanticare/Lynn Hospital, clients' zip codes are used to connect them to local services, although the hospital's Infectious Diseases Clinic and support groups are key referrals. At Project CARE, some counselors are able to prepare referral packages before the client comes in for results. One CARE counselor asks clients to perform a specific action to maintain contact, such as calling on a certain day. Staff carry beepers and are on 24-hour calls; they report that the majority of seropositive clients remain connected to some aspect of Project CARE for services.

Six of the sites have case managers or social workers on site; at Project CARE, counselors themselves function as case managers 50 percent of the time and can take advantage of the project's origins as a case management and advocacy service. SPAL's full-time case manager has strong links to area hospitals and mental health providers. As the program's reputation grows, she has received requests for assistance from AIDS patients who were not originally SPAL clients. This poses a dilemma for staff.

At the Hillsborough County CTS, referrals include medical and some psychosocial services available through county primary care facilities, as well as extensive case management services provided by the Tampa AIDS Network (TAN). TAN case managers assist clients with Medicaid, disability, individual counseling, food banks, support groups, and a variety of social and mental health services. Counselors in Oregon are able to refer (and sometimes walk) clients to the county's HIV Wellness Clinic, where they can receive an immediate medical evaluation and ongoing care. St. Michael's has a Treatment Assistance Program (TAP) within the hospital's HIV clinic that offers case management as well as primary medical care, but clients must wait between 2 weeks and 2 months to receive services.

Fenway staff feel fortunate to have a wide range of services available onsite, including crisis counseling, couples therapy, support groups, outpatient drug treatment, and a triage nurse for initial medical assessments.

Counselors feel that the most immediate need is for a baseline medical evaluation, but unless sites are linked to a specific HIV treatment facility, these referrals are difficult to achieve. Even with an onsite social worker, newly-diagnosed Project TRUST clients take an average of 14 months to present for primary care services at Boston City Hospital's Diagnostic Evaluation Unit. In response, the project now has a nurse conduct an initial medical assessment onsite; the client is then assigned to a primary care physician who monitor's the client's health on an ongoing basis and is responsible for referrals to

specialized care. In New Haven, there is a wait of between 6-7 weeks for medical evaluations.

At SPAL, many Portuguese-speaking clients are recent immigrants from Cape Verde, Mozambique, Angola, Guinea-Bissau, Brazil, and Timor. They tend to be uninsured and without documentation, thus they are afraid to present for medical services and other health care. SPAL staff are concerned about the lack of Portuguese-speaking medical providers and culturally appropriate service delivery models in the Boston area.

In almost every city, dental care for HIV-positive patients was noted as a gap in services. Others included nursing homes, physicians willing to treat HIV-positive patients, housing, and mental health services. In New Haven, staff noted that many local CBOs provide useful support services but are constantly in turmoil, making it difficult to link clients with services.

Partner Notification

Partner notification issues are summarized in Table 11.

At the sites visited for this study, partner notification ranges from nonexistent to aggressive. At Fenway, partner notification is explained but not emphasized; the focus of the session is on linking clients with services. At Dimock, clients are given written information on DIS assistance with partner notification, but again this is not emphasized. Project TRUST staff report that they are uncomfortable with the DIS approach to partner notification, but they do offer clients suggestions on how to approach partners. Stamped envelopes with Project TRUST business cards are offered to clients who would like to notify their partners anonymously through the mail, and the project plans to train outreach workers to conduct partner notification in the future. Similarly, Project CARE offers suggestions as well as direct assistance, if needed.

Atlanticare/Lynn Hospital staff do emphasize partner notification and offer the services of a DIS onsite, but they report that clients prefer to notify partners themselves. The Hillsborough County CTS strongly encourages partner notification by telling clients that their partners have a right to know. Names are elicited by the counselors, when possible, and referred to DIS from the nearby STD clinic for notification.

Innovative Practices

- At the Marleen clinic, a recorded message tells callers clinic hours, bus lines, description of services, and fact that services are free. Clients are invited to hold on if they would like to speak to someone. The recorded message freed up the clerk/receptionist.

- Project CARE offers an 800 telephone number that clients can call if they become anxious while waiting for results. Staff report that many clients use this service.

- Fenway and Dimock have implemented stress reduction measures for staff, including regular meetings to discuss frustrations and solve problems, building administrative time into the work week so staff can complete paperwork without working overtime, distributing positive sessions evenly among staff, groups sessions for staff with clinical psychologist,, providing opportunities to attend training and conferences, periodic all-day retreats, and flexible scheduling/leave policies to allow staff to take mental health days as needed.

- Hartford Health Department CTS designed an exit interview questionnaire for clients to assess quality of services. In addition to positive feedback, comments were used to improve the clinic's phone protocol to give clients calling from work more privacy.

Technical Assistance Needs

- Across-the-board need for advanced. training (beyond "HIV 101"), with more emphasis on counseling techniques, approaching clients, cultural diversity issues, substance abuse, special populations (women, adolescents, minorities), skill building.

- Need for more visual materials for low-literacy and/or non-English speaking clients.

Table 1A
Confidential or Anonymous Testing

CTS Site	Confidential or Anonymous	Informed Consent	Who Has Access to Results
Project Trust	• Anonymous	• Signed (client fill in unique bar code number)	• Results released to outside providers for referral purposes with client's written consent.
Somerville Portuguese-American League (SPAL)	• Anonymous	• Signed (client fills in unique bar code number)	. N/A
Project CARE	• Anonymous	• Signed (client fills in unique bar code number)	• N/A
Dimock Community Health Center	• Anonymous	• Signed (client fills in unique bar code number)	. N/A
Fenway Community Health Center	• Anonymous	• Signed (client fills in unique bar code number)	• N/A
Atlanticare/Lynn Hospital	• Anonymous	• Signed (client fills in unique bar code number)	. N/A
Marleen Clinic	• Confidential and Anonymous	• Verbal	• Clinic manager • HIV counselor
Westside CTS	• Confidential and Anonymous	• Verbal	• Clinic manager • DIS supervisor . DIS . RNs
Hartford Health Department	• Confidential and Anonymous	• Signed	• Clinic staff
St. Michael's Community Health Center	• Confidential and Anonymous	• Signed	• Clinic staff
Hillsborough County Anonymous Test Site	• Anonymous	• Verbal	. N/A
New Haven Health Department	• Confidential and Anonymous	• Signed	• Released only with client's written consent.

Table 1B
Staffing issues

CTS Site	Staff Role/Background: Education/ Outreach*	Counseling and Testing	Referral/ Case Management	Partner Notification	HIV Counselor Training	Quality Assurance
Project TRUST	. 4 outreach workers	• 4 HIV counselors (1 RN) • Project director	• Social worker (onsite)	• DIS	• CDC/DPH training • 3day NIDA training • Phlebotomy	• None
Somerville Portuguese-American League (SPAL)	• 4 outreach workers • 1 health educator	• 2 physicians • 1 outreach worker • 1 phlebotomist	• Social worker	• Counselor discusses but does not contact partners	• CDC/DPH training	• Weekly observation of sessions and team problem-solving discussions to review cases
Project CARE	• HIV health educator	• 5 case managers/ counselors • 4 therapists • Phlebotomist • HIV testing coordinator	• Counselors	• Counselor discusses	• CDC/DPH training	• Counselors observed during initial training
Dimock Community Health Center	• Risk reduction education	• HIV counselors (drug treatment backgrounds) • Clinical supervisor	• Counselors or case manager (onsite)	• Counselors; DIS - assistance offered	• CDC/DPH training • Seminars • Conferences	• DPH staff monitors counseling and training needs
Fenway Community Health Center	• HIV education and outreach	• 4 HIV counselors	• Counselors	• Counselor offers assistance	• CDC/DPH training	• Weekly supervision (may include observations of counseling); -biweekly clinical supervision to review cases
Atlanticare/Lynn Hospital	• N/A	• Public health nurse	• Counselor	• Counselor offers DIS assistance	• CDC/DPH training	• DPH staff observe sessions as part of annual audit
Marleen Clinic	• N/A	• HIV counselor (former drug treatment/outreach worker)	• HIV counselor	• Referred to DIS	• County HIV training course • DIS: 2-week epi course • Phlebotomy	• Supervisor sits in on counseling sessions as part of performance evaluation
Westside CTS	• N/A	• RNs (pretest, posttest negative) • DIS (posttest positive)	• Social worker • DIS	• DIS	• County HIV training course • DIS: 2-week epi course • Phlebotomy	• Supervisors or lead counselors sit in on sessions as part of routine performance evaluation
Hartford Health Department	• AIDS educator (runs group screening sessions)	• 3 HIV counselors; master's in social work, counseling • 1 telephone screener	• HIV counselors	• Counselor discusses; offer care services	• 3day state certification course • Phlebotomy	• Client satisfaction surveys
St. Michael's Medical Center	• Telephone educator, information sessions for inpatient drug treatment program	• 8 HIV counselors • 1 phlebotomist	• Referred to Treatment Assistance Program (TAP) within hospital	• Referred to state Notification Assistance Program	• Z-week STD course • State HIV counseling training (5 day) • Phlebotomy training	• Staff evaluated twice a year, administrator observes counseling sessions
Hillsborough County Anonymous Test Site	• Weekly off-site CT: CBO staff and outreach counselor	. 1 HSR/LPN • 1 community health nurse	. HSR	• HSR elicits names; refers to DIS for notification	• HRS 2-day HIV training course	• Client satisfaction surveys • State QA reviews
New Haven Health Department	• HD outreach staff	• 5 HIV counselors	• HIV counselors	• Referred to state care team	• State counselor certificate training program and continuing education to maintain certification • Phlebotomy	• Chart reviewed by New Haven Health Department AIDS division director

* HIV education and outreach conducted by clinic staffpnor to pretest counsehng (e.g., HIV education incorporated into outreach, group information sessions within the clinic).

Table 1C
Data Collection

CTS Site	Kinds of Data Collected				Forms Used	Use of Data
	Risk Exposure	Demographic Data	CT Steps	Other		
Project TRUST	X	X		• None reported	• State ATS data form	• State reporting • Research
Somerville Portuguese-American League (SPAL)	X	X		• None reported	• State AT'S data form	• State reporting • Program planning
Project CARE	X	X		• None reported	• State ATS data form	• State reporting • Program planning • Target services • Proposal writing
Dimock Community Health Center	X	X		• None reported	• State anonymous data form • Counseling form	• State reporting
Fenway Community Health Center	X	X		• None reported	• DPH ATS data form	• Program planning
Atlanticare/Lynn Hospital	X	X		• Behavioral/epidemiological research studies	• DPH ATS data form	• State reporting • Research • Program planning
Marleen Clinic	X	X		• None reported	• State serology form	• State reporting
Westside CTS	X	x	X	• None reported	• State serology form • Clinic logs	• State reporting • Monitor&/planning
Hartford Health Department	X	x	X	• Client exit interviews	• CDC scan form • Phone activity log • Daily activity log	• State reporting • Program planning monitoring to determine if goals are being met • Program management and planning
St. Michael's Medical Center	X	X	X	• None reported	• CDC scan form • Daily log	• State reporting • Monitor trends • Grant writing • Planning/evaluation
Hillsborough County Anonymous Test Site	X	X	X	• None reported	• CDC scan form • State lab form	• State/county/district reporting • Administrative uses (e.g., trends)
New Haven Health Department	X	X	X	• None reported	• CDC scan form	• State reporting • Program planning

Table 1D
Pretest Counseling

CTS Site	Individual or Group Session	Duration of Pretest Counseling	Condoms Provided/ Demonstrated	Pretest Counseling Observed
Project TRUST	• Individual	• 30 minutes	• Provided	• No
Somerville Portuguese-American League (SPAL)	• Individual	• 25-30 minutes	• Provided	• No
Project CARE	• Individual	• 25 minutes	• Provided	• 1 session
Dimock Community Health Center	• Individual	• 20-45 minutes	• Provided	• 3 sessions
Fenway Community Health Center	• Individual	• 30 minutes	• Provided and demonstrated	. No
Atlanticare/Lynn Hospital	• Individual	• 25 minutes	• Provided	• 3 sessions
Marleen Clinic	• Individual	• 20-45 minutes	• Provided	. No
Westside CTS	• Individual	• 20 minutes	• Provided	• 1 session
Hartford Health Department	• Individual • Group screening sessions for low-risk heterosexuals	• 45 minutes	• Provided; sometimes demonstrated	• Yes
St. Michael's Medical Center	• Individual	• 15 minutes	• Not provided	• 1 pretest session
H&borough County Anonymous Test Site	• Individual	• 30 minutes	• Provided; illustrated materials used	• 2 sessions
New Haven Health Department	• Individual	• 30-45 minutes	• Provided	• 1 session

Table 1E
Risk Assessment

CTS Site	Purpose of Risk Assessment	Risk Assessment Instrument	When Risk Assessment Occurs/By Whom
Project TRUST	• Determine risk(s)	• DPH counseling protocol	• Pretest/counselor
Somerville Portuguese-American League (SPAL)	• Discuss risk behaviors and safer practices	• DPH counseling protocol	• Pretest/counselor
Project CARE	• Identify client risks and risk reduction needs	• DPH and CARE counseling protocols	• Pretest/counselor
Dimock Community Health Center	• Discuss risk behaviors	• DPH protocol	• Pretest/counselor
Fenway Community Health Center	• Telephone screening to prioritize appointments	• Clinic protocol based on DPH	• Counselors (rotate responsibility for phone coverage)
Atlanticare/Lynn Hospital	• Identify risk behaviors	• DPH protocol	• Pretest/counselor
Marleen Clinic	• Review behaviors	• Risk assessment form	• Counselor reviews form with client during pretest
Westside CTS	• Review behaviors	• Risk assessment form	• Review during pretest
Hartford Health Department	• Telephone screening to determine need for CT • Identify individual behavior for education/counseling	• Risk assessment form	• Receptionist/phone • Pretest/counselor
St. Michael's Medical Center	• Identify client's risk(s)	• Scan form categories	• Pretest/counselor
Hillsborough County Anonymous Test Site	• Data collection • Identify individual risk for education/counseling	• CDC scan form categories	• Pretest/counselor
New Haven Health Department	• Identify client's risk(s), personalize risk reduction	• CDC scan form • Checklist	• Pretest/counselor

Table 1F
HIV Testing

CTS Site	When/Where HIV Blood Draw Occurs	Who Draws Blood	Return Arrangements	Follow Up	Lab/Turnaround
Project TRUST	• Pretest	• Counselor	• Present card or code; posttest session scheduled in 2 weeks	• N/A--anonymous testing	• State/2 weeks
Somerville Portuguese-American League (SPAL)	* Lab/AIDS education room (down hall from counseling room)	• Phlebotomist	• Results available in 2 weeks	• N/A--anonymous testing	• State/2 weeks
Project CARE	• Lab (downstairs)	• Phlebotomist	• Call 800 number in 2 weeks to see if results are in (card with # given to client)	• N/A--anonymous testing	• State/2 weeks
Dimock Community Health Center	• Pretest	• Counselor	• Card with appointment date (in 2 weeks) given to client	• N/A--anonymous testing	• State/2 weeks
Fenway Community Health Center	• Lab (on ground floor)	• Lab technician	• Call in 2 weeks to schedule appointment	• N/A--anonymous testing	• State/2 weeks
Atlanticare/Lynn Hospital	• Pretest	• Nurse/counselor	• Card with appointment date (in 2 weeks) given to client	• N/A--anonymous testing	• State/2 weeks
Marleen Clinic	• Pretest	• Counselor (trained phlebotomist)	• Appointment made for 2 weeks from test date	• N/A--mostly anonymous clients	• State/2 weeks
Westside CTS	• Pretest	• Counselor (trained phlebotomist)	• Appointment made for 2 weeks from test date	• DIS attempts to contact HIV positive; Letters sent to HIV negative	• State/2 weeks
Hartford Health Department	• Pretest	• Counselor (trained phlebotomist)	• Call in 10 days to schedule session	• Reminder letter sent to no-shows after 6 weeks	• State/2 weeks
St. Michael's Medical Center	• Most counselors draw blood during pretest counseling session	• Most often counselor, phlebotomist when necessary	• Call in 3 weeks to schedule session	• HIV-positives referred to state NAP	• State/2 weeks
Hillsborough County Anonymous Test Site	• Pretest	• Counselor	• Receptionist gives client appointment for 2 weeks from test date	• None	• State/2 weeks
New Haven Health Department	• Pretest	• Counselor (trained phlebotomist)	• Call in 2 weeks to make sure results are in and schedule appointment	• If tested confidentially, followup letter and phone calls	• State/2 weeks

Table 1G
Posttest Counseling

CTS Site	Same Counselor for Pre and Posttest Counseling	Duration of Posttest Positive Session	Additional Posttest Sessions	Retesting Recommendation	Counseling Observed
Project TRUST	• Always	• Positive: 10-60 minutes • Negative: 10-60 minutes	• Some available	• 6 months	• None
Somerville Portuguese-American League (SPAL)	• Yes	• Positive: 3060 minutes • Negative: 10 minutes	• Some available	• 6 months	• None
Project CARE	• If possible	• Positive: 10-60 minutes • Negative: 10-60 minutes	• Clients encouraged to call counselors if needed	• 6 months	• None
Dimock Community Health Center	• If possible	• Positive: 5-60 minutes • Negative: 5-60 minutes	• Offered if necessary	• 6 months	• None
Fenway Community Health Center	• If possible	• Positive: 45 minutes • Negative: 20 minutes	• Yes	• 6 months	• None
Atlanticare/Lynn Hospital	• Yes	• Positive: 5-60 minutes • Negative: 5-60 minutes	• Yes	• 6 months	• 1 posttest negative session
Marleen Clinic	• Yes	• Positive: 60 minutes • Negative: 10-15 minutes	• No	• 3 months	• 1 posttest negative session
Westside CTS	• If possible	• Positive: 60 minutes • Negative: 15-20 minutes	. No	• 6 months; l-3 if worried	• 1 posttest negative session
Hartford Health Department	• If possible, especially for HIV positive	• Positive: 60 minutes • Negative: 15 minutes	• Clients encouraged to attend at least 1 followup session	• 6 months	• 1 posttest negative session
St. Michael's Medical Center	• If possible	• Positive: 30-45 minutes • Negative: 10 minutes	• Clients encouraged to return for further counseling	• 3 months, 6 months, and 1 year	• 1 posttest negative session
Hillsborough County Anonymous Test Site	• Yes	• Positive: 40+ minutes • Negative: 3-4 minutes	• Clients encouraged to call if help is needed	• 6 months	• None
New Haven Health Department	• If possible	• Positive: 60 minutes • Negative: 20 minutes	. No	• Depends on client's risk	• None

Table 1H
Referrals

CTS Site	Source of Referrals	Services Provided Onsite	Services Offered b Referral Offsite	Maior Gaps
Project TRUST	• On-site social worker	• Case management/advocacy • Primary health care • Support groups • On-site initial medical assessment (RN) • Primary care physician	. Boston City Hospital resources	• Medical services for HIV negative
Somerville Portuguese-American League (SPAL)	• Full-time case manager for HIV positive clients	• Substance abuse • Referrals • Child welfare case management • HIV positive case management	• 2 area hospitals for medical evaluation and care • Mental health referrals	• Lack of Portuguese-speaking medical providers
Project CARE	• Counselors formerly case managers; know client needs and services	• Case management/client advocacy	• Support groups • Medical and social services • Income maintenance	• Transportation • Dental care
Dimock Community Health Center	• Case manager and counselor	• Services provided by in-house Client Services Division: - primary health care - ob/gyn - dental care - case management - mental health - drug treatment - housing - support groups - financial benefits counseling	• Medical, social support services outside of clinic area	• None identified
Fenway Community Health Center	• Case manager and counselor	• primary health care • case management • "Living Well" workshops • mental health • support groups • hotlines • drug treatment • detox • initial medical assessment by triage RN	• Clients referred to medical and social services	• None identified
Atlanticare/Lynn Hospital	• Clinic maintains lists	• Lynn Hospital Infectious Disease Clinic for medical evaluation	• Psychosocial services, support • Visiting Nurses Association support groups	
Marleen Clinic	• Counselors	• County HIV Wellness Clinic for medical evaluation/care	• Support groups • Hotlines • Social services	• Support groups for African-American clients
Westside CTS	• Counselors	• County HIV Wellness Clinic for medical evaluation/care	• Support groups • Social services	• Social services for women, minorities • Mental health counseling
Hartford Health Department	• Counselors	• Within health department: - x-rays, PPD, flu shots • Mt. Sinai outpatient clinic (upstairs) for medical evaluation	• AIDS-related CBOs • Children/family services • Support groups • Mental health	• Dental and medical care
St. Michael's Medical Center	• Hospital Treatment Assistance Program (TAP)	• Within medical center, primary health care	• Social services	• Immediate medical care
Hillsborough County Anonymous Test Site	. HSR	• Through county primary care clinics: - HIV medical evaluation/treatment - Primary care - TB screening - STD services - Family planning	• Drug treatment • Tampa AIDS Network (case management, assistance with Medicaid, support groups)	• Dental care • Nursing homes • Doctors willing to treat HIV positive • Housing
New Haven Health Department	• Clinic/counselor	• Health department STD, TB clinics for screening • Mental health • Medical evaluation	• CBOs • 12-step program	• Delays in obtaining medical evaluation (6-7 weeks)

Table 1l
Partner Notification

CTS Site	Patient Referral	Provider Referral/Who Elicits and Notifies	When Topic is Introduced
Project TRUST	• HIV counselor suggests how to talk to partners; provides stamped envelope and Project TRUST business cards so that clients can notify partners anonymously by mail.	• DIS assistance offered	• Posttest
Somerville Portuguese-American League (SPAL)	• Discussed	• No provider referral	• Pretest
Project CARE	• Suggest how to inform partners	• Counselor offers assistance	• Pretest and posttest
Dimock Community Health Center	• Explained but not emphasized	• Counselor provides written information on DIS service	• Mentioned on handout at entry; discussed during posttest counseling
Fenway Community Health Center	• Assistance offered	• Assistance offered	• Posttest counseling
Atlanticare/Lynn Hospital	• Counselor explains concept	• DIS services (on-site) offered	• Posttest counseling
Marleen Clinic	• Option for "aware" partners	. DIS	• Posttest counseling
Westside CTS	• Option for "aware" partners	. DIS	• Posttest counseling
Hartford Health Department	• Encourages client to contact partners	• State CARE team assistance offered	• Pretest and posttest
St. Michael's Medical Center	• Clients are encouraged to bring partners	• State Notification Assistance Program (NAP)	• Posttest counseling
Hillsborough County Anonymous Test Site	• Tampa AIDS Network provides assistance	• Counselor elicits names and forwards to DIS for notification	• Posttest counseling
New Haven Health Department	• Encourage client to contact partners	• State CARE team assistance offered	• Pretest counseling

B. Discussion of Each Site Type

2. Sexually Transmitted Disease (STD) Clinics

a. Overview of the Site Type

History

Following Centers for Disease Control's (CDC) 1987 recommendations, sexually transmitted disease (STD) clinics were among the first noncounseling and testing (CTS) sites to offer HIV counseling and testing. STD clients have, by definition, participated in an unprotected sexual behavior that may have placed them at risk for HIV/AIDS. In addition, certain STDs--particularly those that result in ulcerative lesions--are associated with more efficient HIV transmission. In 1990, 1,178 STD clinics offered HIV counseling and testing. These STD clinics represented only 16 percent of all testing sites, but yielded high numbers of tests and positive results. The 453,155 HIV tests conducted in these sites accounted for 30 percent of all tests and 24 percent of all positives.

Most of the STD clinics in this study began offering HIV counseling and testing services between 1987 and 1988. The Pinellas County STD clinic began offering services earliest, in 1986, while the Framingham prison clinic opened relatively recently, in May 1991.

Site Characteristics

A total of nine STD clinics were visited. Most were located in health departments; the exceptions were two hospital-based STD clinics at Boston City Hospital and Lynn Hospital, a women's STD clinic in a separate location from the main Stamford Health Department STD clinic, and an STD clinic within the Massachusetts Correctional Institute Awaiting Trial Unit (ATU) at Framingham. The sites and locations are as follows:

Name of Site	Location
Westside STD Clinic	Portland, OR
Atlanticare/Lynn Hospital	Boston, MA
MCI Framingham Awaiting Trial Unit (ATU) STD Clinic	Framingham, MA
Newark STD Clinic	Newark, NJ
Boston City Hospital ACC3 Public Health Clinic	Boston, MA
Pinellas County Public Health Unit STD Clinic	St. Petersburg, FL
Hillsborough County Public Health Department STD Clinic	Tampa, FL
Bridgeport Health Department STD Clinic	Bridgeport, CT
Stamford Health Department Women's STD Clinic	Stamford, CT

Clientele

The clientele of STD clinics is largely urban, ethnic minorities, many of whom are unlikely to seek health care other than STD treatment. Injection drug users who are not in drug treatment and commercial sex workers may seek treatment for STDs but not for other health conditions. Blinded seroprevalence studies have shown consistently that seropositivity is very high in STD clinics. For these reasons, the clientele of STD clinics and their presence in the STD clinic setting may offer the only opportunity to reach clients with risk reduction information, counseling, and HIV testing.

Except for two clinics serving only women (Stamford and Framingham), most clinics report a largely young, minority, male clientele, although gradually increasing numbers of female clients are reported in several clinics. Pinellas County STD clinic reports that half its clients are African-American and the rest are mostly Caucasian, although some Hispanics and Asians are seen. Caucasian men tend to report exposure through gay or bisexual activity, while African-American men report multiple partners and heterosexual risk. More African-American men and women with heterosexual risk are among those testing positive at the clinic. The Hillsborough County STD clinic's clients are mostly African-American men between the ages of 20 and 35.

Clients of the STD clinic at Boston City Hospital are mainly low-income men who are African-American, Hispanic, Haitian, and Cape Verdean. Staff are trying to improve cross-referrals between the hospital's Women's Center and the STD clinic. A blinded seroprevalence study of all hospital inpatients revealed that 9 percent were HIV-positive.

Women at the Framingham prison have been detained on drug and/or prostitution charges. Half the detainees seen in the clinic are Caucasian, 25 percent are African-American, and 25 percent are Hispanic. Many clients of the Stamford Health Department's STD clinic for women are Hispanic. Staff report that high rates of substance abuse as well as emotional problems and homelessness are common, and that women seen at the clinic typically face a variety of social and economic problems in addition to their health care needs. Stamford STD clinic clients are usually referred by the Health Department's regular STD clinic, the women's shelter, or other programs.

b. Program Management Issues

Integration of Services

At about half the STD clinics in this study, staff report that HIV counseling and testing is fully integrated into routine STD activities. At Boston City Hospital, this means that all patients are offered HIV counseling and testing during the STD exam and at each followup treatment session. At Atlanticare/Lynn Hospital, the staffs underlying philosophy is that all clients are at risk and should be tested. This is reinforced by posters in the waiting room, an offer of testing by the intake receptionist (who also gives clients

a packet of HIV literature to review while waiting for the STD exam), and another offer of counseling and testing by the nurse during the STD exam. Each of these is designed to convince clients that HIV prevention is a priority and that they should be tested. At the two Florida sites (Pinellas and Hillsborough), staff see HIV as an STD and therefore as part of the clinic routine. In fact, Hillsborough staff report that HIV is their highest priority. At Pinellas, disease intervention specialist (DIS) interview forms have been redesigned so that they cover all STDs, including HIV. Formerly, a separate interview sheet was used for each STD.

The medical director of Stamford's STD clinic for women noted the distinction between the women's STD clinic, in which HIV counseling and testing is a routine part of STD services, and the main STD clinic, where it is not--in part because of staff resistance. According to the director, staff buy-in is critical to the integration of HIV and STD services, as is the lead physician's outlook. He believes that by giving staff "ownership" of new approaches and tasks, greater enthusiasm and commitment is generated. At the Stamford clinic, HIV testing is discussed at least four times during a client's visit. Outreach workers discuss HIV counseling and testing in the waiting area, the nurse offers HIV testing at intake, the physician discuss HIV exposure and testing during the STD exam and chart review, and the lab director also offers testing if the client has not already accepted it.

Staff resistance to including HIV counseling and testing services was initially a serious problem for Newark's STD clinic. Current staff report that when HIV services were first contemplated, several staff members quit "on the spot." In addition to staff turnover and resistance, adapting clinic protocols and recordkeeping were barriers to incorporating HIV services into the clinic routine. At the Westside CTS in Portland, staff resistance was not identified as a problem, but administrators reported that testing acceptance rates have increased as STD counselors become more comfortable offering the test. HIV counseling and testing skills are considered part of the "core skills" that STD staff must have to perform their duties at Westside STD Clinic.

Confidentiality/Anonymity

Confidentiality issues are summarized in Table 2A.

Two of the nine clinics offer both anonymous and confidential testing; the remaining seven clinics offer only confidential testing. At Stamford STD clinic, which is one of the clinics offering both types of services, confidential testing is strongly supported by staff and 75 percent of clients accept confidential testing. Staff feel that counselors establish a trust relationship with clients, and giving the counselor one's name reflects the client's trust in the counselor. At Atlanticare, staff consider HIV to be an STD and believe that it should be treated according to STD protocols. Because HIV counseling and testing is offered as part of the clinic's STD exam, the patient has already foregone anonymity protection. In other clinics, staff noted that clients are not required to give their real names. In some

clinics, numbers are used as identifiers (for example, when calling patients into the exam room), although clients may use a name at intake.

The confidentiality of HIV and STD records is protected using the same measures in most clinics. Generally STD and HIV files, even if they are kept together, are separate from other medical or hospital records and can't be released to other providers without the patient's written consent. At Boston City Hospital, records indicate whether or not HIV counseling and testing was offered, but not whether or not it was accepted.

Staff at Framingham report particular difficulties in maintaining confidentiality within the prison setting. Although records are not released outside the prison (even to other correctional facilities when an inmate is transferred), guards and other detainees are aware of who seeks services. Staff report that guards recognize AZT medication and therefore know which women are HIV-positive.

Staffing Issues

Staffing issues are summarized in Table 2B.

Staff Background/Training. In most cases, STD clinic staff--nurses, nurse practitioners, and physicians--provide both STD services and HIV counseling and testing. Prior to 1987-1988, HIV counseling and testing in Boston STD clinics was conducted by Department of Health (DPH) AIDS Bureau staff who rotated among the clinics. During 1987-1988, STD staff were trained to provide HIV counseling and testing and currently do so under contract to the Bureau of Communicable Diseases. In Stamford, a nurse from the Health Department's AIDS Program (as opposed to clinic staff) provides HIV counseling and testing. The Bridgeport counselors do only HIV counseling.

In some cases, DIS provide some or all HIV counseling (especially for positive results). This is true at Westside STD, MCI Framingham, Pinellas, and Hillsborough County STD clinics. In Boston, however, DIS do not generally provide HIV counseling. Framingham STD clinic, where the DIS on staff conducts HIV counseling, is considered an exception. In both Oregon and Florida, DIS based in the STD clinics are available to other clinics to provide posttest counseling and partner notification.

In addition to the trained nurses and DIS who provide HIV counseling at both the Westside STD and CTS clinics, the STD clinic has a health educator on staff. She provides HIV pretest counseling before the STD exam for clients who indicate an interest in testing and provides backup for the other counselors. The health educator does not see all patients, only those who self-select while waiting for their STD exams. However, she noted that many of her clients seem to respond to the title of "counselor" and open up more than they would with a clinician in a white coat. At Bridgeport's STD clinic, one HIV counselor has a master's in social work and the other has a master's in counseling.

All staff who provide HIV counseling have taken a standard HIV training course sponsored by the county or state. DIS have also taken the 2-week epi course in addition to state/county HIV training. At Hillsborough County STD, DIS take a special 3-day HIV training course that is more extensive than the standard 2-day HIV course and covers HIV partner notification. In Multnomah County, Oregon, new HIV counselors spend an orientation period observing more experienced counselors, in addition to taking the county training course.

Several clinics have bilingual staff available for Spanish-speaking clients. At Framingham, a bilingual counselor is needed but unavailable, so staff have had to rely on a Spanish speaking detainee to translate counseling for Hispanic detainees seen in the clinic. The shortage of bilingual staff with HIV training is considered a critical problem in Boston. The Hillsborough County STD clinic has one Spanish-speaking DIS but could use two. A bilingual clerk in the clinic's administrative office is occasionally called upon to translate. The Hillsborough clinic also recently recruited five new DIS, all of whom are African-American men.

Continuing Education. Several sites offer ongoing training for staff, either in-house or by encouraging attendance at conferences and workshops. In Connecticut, HIV counselors must participate in continuing education in order to maintain their certification as HIV counselors. At Boston City Hospital, staff have regular access to ongoing training, including weekly inservice training for hospital staff. Limited time is more of an issue for BCH clinic staff than availability of training opportunities. MCI Framingham staff have attended training sessions sponsored by pharmaceutical companies such as Burroughs Welcome. At the Newark STD clinic, ongoing training is provided through videos and conferences. In addition, counselors are observed quarterly by supervisors and receive feedback on their counseling.

Training Needs. MCI Framingham clinic staff report that additional training is needed on special issues for the prison population, substance abuse and HIV, and community resources for HIV positive clients. Although conferences and workshops are useful, they are difficult for many staff to attend. Westside STD staff suggested that good training videos and manuals could provide continuing education without requiring staff to be away from their day-to-day duties. At Hillsborough County STD clinic, staff noted that clients are increasingly well-informed about HIV/AIDS and treatment issues.

Data Collection

Data collection methods and uses are summarized in Table 2C.

Each of the clinics collects data to fulfill state reporting requirements; usually this is accomplished using the scan form or its equivalent. At Westside STD clinic, state reports on HIV activity are released every quarter. Trends and changes in client visits are shared with staff and seroprevalence data are reviewed in terms of whether those at risk are being seen in the clinic. At Boston City Hospital, staff report that monthly summary

reports are available from the state, but it is unclear how these are used at the clinic level. More typically, data from scan forms that are reported to states are not analyzed and reported back to clinics.

At the Pinellas County STD clinic, scan forms are used along with state lab forms. Staff report that it took about 6 months to adjust to the scan forms and they initially required cross checks with the lab forms because of inaccuracies. The clinic used to prepare its own log of HIV activity, but this was considered duplicative and is no longer done. Scan and lab form data are not regularly released by the state, but specific reports can be ordered as needed. The state STD office does release a monthly report on HIV positive results culled from state lab forms and medical records.

At the Hillsborough County STD clinic, scan data are not returned to the clinic but this is not considered a problem. Quarterly STD reports are available. Scan forms, which are filled out for all pretest counseling sessions, are used to monitor acceptance rates for HIV testing throughout the clinic and for individual DIS. Encounter forms (computerized in two clinics) are also used to track client volume and to monitor diagnoses, treatment, tests performed, and DIS information. Client contacts are recorded manually at the Newark STD clinic.

Several clinics are participating in blinded seroprevalence studies. Newark STD clinic is also participating in the family of surveys, and Hillsborough STD is involved in two CDC studies: a partner notification study and a KABB survey. Seroprevalence data are not used at Hillsborough County STD clinic but are available from the county epidemiologist, if needed.

One obstacle to using clinic and state data was noted by Newark STD staff, who would like to have a staff member devoted to research and analysis with a background in these areas. Staff envisioned using data for making programmatic changes, training staff, and educating the community. However, data are not currently used for these purposes.

C. Delivery Issues

Entry

Walk-In/Appointment. Two of the sites offer services by appointment, one offers both walk-in and appointments, and the remaining six accept walk-ins only. Clients of Framingham's STD clinic must schedule an appointment for an STD exam, during which HIV counseling and testing are offered. Clients can see a DIS immediately for pretest counseling or can return later. Appointments were prioritized by pending court date when there was a backlog of clients, but currently counseling and testing are routinely offered at admission. The door to the clinic's administrative office is kept open and clients can stop in to make an appointment during free time or on the way to meals. Staff make an effort to be discreet about appointments, since many clients are concerned about

harassment from other detainees and from guards. Stamford Health Department STD clinic also schedules appointments for clients, although walk-ins are accommodated if staff are available.

Hours. Most clinics are open weekdays. Bridgeport STD clinic is open weekday afternoons, Stamford is open on Tuesdays from 11:00 a.m. to 2:00 p.m., Atlanticare is open Tuesdays and Thursdays from 10:00 a.m. until 6:30 p.m., and the Framingham clinic is open from 6:30 a.m. until 4:40 p.m., reflecting the prison routine. Four of the clinics offer evening hours.

Waiting Time. Waiting times vary within and across clinics. At Westside, clients routinely wait between 1 and 2 hours. Walk-in clients at Newark wait between 30 minutes and 1 hour for services; clients who make appointments can usually be seen the same day. Boston City Hospital clients may be seen in 15 minutes but occasionally have to wait up to 1 hour. At Hillsborough County STD clinic, the loss of one of the clinic's three clinicians and a clerk has extended waiting times from 1-3/4 hours to 4 hours.

Fees. Six of the clinics charge a fee for combined HIV/STD services, but in every case fees are waived if clients are unable to pay. Fees range from $5 at the Westside and Bridgeport STD clinics to $90 at Atlanticare and Boston City Hospital. In Boston clinics, services are automatically free to the homeless and clients under the age of 18. Pinellas County STD clinic charges (but does not require) a $10 fee, which will be increased to the Medicaid allowance of $23.10 in the near future. At the Hillsborough County STD clinic, clients are charged $25 unless they have been referred by a DIS, in which case services are free. Although no one is denied services because of inability to pay this fee, Hillsborough staff fear that clients do not always understand this and may have the impression that coming in for services costs $25. No fee is charged at Newark, MCI Framingham, and Stamford clinics, and there is no additional charge for HIV testing at Westside STD. At Westside, the $5 minimum and sliding scale fee applies only to STD services.

Risk Assessment. The purpose and timing of risk assessment are summarized in Table 2E.

Staff in each of the STD clinics perceive their clients to be at risk for HIV because their STD(s) represent unprotected sexual activity. However, clients do not always share this view. Atlanticare staff report that although many patients have a general understanding of transmission routes, they do not consider themselves to be at risk, despite their STD. In contrast, one of the Westside STD counselors reports that clients want to be assessed and to know and discuss their particular risks.

Risk assessment is not used as a screening device to determine who should or should not receive HIV counseling and testing. In most STD clinics visited, risk assessment occurs during the STD exam when the clinician reviews the client's medical history. Based on

this risk assessment and the client's interest in taking the test, pretest counseling is conducted by either the clinician or a DIS.

At Pinellas County Public Health Unit (PHU) new clients and clients who have not been tested within the past 2 to 3 months are considered eligible for HIV counseling and testing, which is offered in conjunction with the final DIS interview. Testing may be offered to eligible clients during history taking and medical evaluation if the clinician realizes that there is no need for a DIS interview, but some clients leave the clinic between their exam/treatment and the DIS interview and therefore may not be offered HIV counseling and testing. At Boston City Hospital, clients who were not tested during their initial visit are offered counseling and testing during followup visits for treatment. HIV counseling and testing is offered to all clients at Hillsborough County STD clinic. Clients who have not visited the clinic within the past 3 months are routed to HIV pretest counseling first, before the STD exam.

At Westside STD clinic, clients are asked to fill out a risk assessment for while waiting for the STD exam. The form is returned to the intake clerk, who checks to see if the client has answered yes to either of two trigger questions on the back of the form ("Are you interested in learning more about HIV today?" and "Are you interested in being counseled and tested for HIV today?"). If so, a health educator is available to conduct pretest counseling with the client during the wait for an STD exam. Typically, she is able to spend more time discussing HIV with the client than a clinician would during the STD exam. However, even clients who do not indicate an interest in HIV counseling and testing on the risk assessment form are offered these services during the exam.

Pretest Counseling

Pretest counseling issues are summarized in Table 2D. Pretest counseling sessions were observed in eight sites.

Duration. Pretest counseling is often incorporated into the STD exam or the DIS interview. At Atlanticare, the combined STD exam and HIV counseling takes about 25 minutes; at Boston City Hospital, covering both takes between 20 and 45 minutes. At Newark STD clinic, counseling is offered by the nurse/clinician, but the client is forwarded to DIS for both STD and HIV counseling. In these sessions, HIV pretest counseling lasts approximately 10 to 15 minutes. The DIS interview for positive gonorrhea patients requires an additional 15 minutes and 45 minutes for syphilis patients. At Hillsborough County STD clinic, the pretest session is conducted by DIS and takes about 10 to 15 minutes.

Tools, Most counselors use a data collection form or protocol to guide counseling, although many staff stressed that the emphasis differs depending on individual clients' needs, In Boston clinics the DPH protocol is used. At Westside STD clinic, the state serology form and risk assessment form filled out by the client are used. Hillsborough and Newark staff use the scan form.

Content and Approach. Many counselors report that they build on the link between STDs and HIV as a way to discuss individual risk, factual information about transmission, and prevention measures. For examples, most counselors remind clients that condoms protect them from the STDs for which they are being seen in the clinic as well as HIV/AIDS. In an observed pretest session at the Newark STD clinic, abstinence and limiting the number of partners to one were recommended risk reduction strategies, in addition to condom use.

At Boston City Hospital, counselors make an effort to broaden the discussion of STD symptoms and histories to a more general discussion of sexual activity, risk behavior, and HIV transmission before introducing the idea of an HIV test. BCH nurses also find that they often need to spend time discussing basic hygiene and preventative health (including HIV) during the session. Many BCH patients are preoccupied with daily struggles against poverty, unemployment, drug use, and violence, and nurses report that general health status is not a priority. As a result, the nurses use the opportunity of an STD exam to address not only STDs and HIV, but also to try to convince clients that they "have a right to be healthy." The DIS who conducts HIV counseling at Framingham is concerned that for many of the detainees seen in the clinic, she may be the sole source of emotional support.

At the Pinellas County STD clinic, one clinician reports that she sees many patients who are unable to read and finds reasons to read the form to them so that they do not have to admit to literacy problems. For example, in one of the pretest sessions observed at the clinic, the clinician asked an older male client if he would like her to read the form to him, since his eyes seemed to be bothering him; he agreed.

In addition to linking STDs and HIV/AIDS, most counseling sessions provide standard information on the test itself, the "window period" (and its implications for retesting), transmission routes, safe sex, and the importance of routinely and correctly using condoms. At the Bridgeport Health Department STD clinic, one counselors described the main focus of the pretest session as explaining the HIV disease process. Staff report that many clients do not understand the difference between infection and disease and are afraid of AIDS. Another important element of pretest counseling at the Bridgeport clinic is understanding the client's reason(s) for being tested, and using this information to help the client assess his or her own risk and make an informed decision about testing. The HIV component of sessions at Boston City Hospital covers three main topics: an explanation of the test, a discussion of risk behaviors, and a discussion of what the client would do if test results are positive. Atlanticare staff review specific practices and behaviors with the client in addition to reviewing safe sex, discussing how results might be handled, and providing condoms. At Hillsborough, partner notification may be mentioned during the session, but the emphasis is on letting the patient know about "dangers out there" and how to protect oneself.

Framingham staff cover the standard topics and also make a distinction between risk reduction inside and outside the prison setting. Condoms are not allowed within the

prison; staff suggest that clients make dental dams out of pieces of unused plastic trash bags if they plan to engage in oral sex. Except for Framingham, condoms are freely available in each clinic. At the Hillsborough County STD clinic, condom use is demonstrated if staff perceive a problem. Bridgeport staff highlight condom use as a key preventive measure. Condoms are routinely demonstrated and clients are provided with free samples.

At Hillsborough, acceptance of testing is strongly emphasized, since it is a criterion on which DIS are evaluated. Although the purpose of pretest counseling at Hillsborough is described as finding out what's going with the patient, why s/he is at the clinic, and explaining the test and risk reduction measures, staff expressed concern that in some cases the focus of the session may be on acceptance of the test rather than individual risk behaviors and risk reduction measures.

Cultural and language barriers to effective counseling were reported at Boston City Hospital. Translators are needed for Haitian Creole, Portuguese Patois, and Spanish clients. Even when translators are available within the hospital, they may not have received HIV counseling training. Specific issues noted by staff include the fact that Hispanic men are reluctant to discuss sexual behaviors with female nurses and are generally disinterested in condom use. In addition, many Haitian patients seem to prefer traditional healers and mistrust professional medicine and doctors. Staff report that many Haitians believe that AIDS is a curse; this undermines staffs ability to convince clients of the need for prevention.

Testing

Testing issues are summarized in Table 2F.

Blood usually is drawn by the nurse or clinician at the end of the combined STD exam/pretest counseling session, or as part of the STD exam. In each of the sites, blood is only drawn once. At Pinellas County STD clinic, two tubes of blood are automatically drawn with one needlestick and the second tube is sent to the state lab if the client accepts testing.

Two of the clinics--Pinellas and Hillsborough County STD clinics--use onsite labs for drawing blood. All samples are forwarded to state labs and are available within 2 weeks.

Return Arrangements

Clinics are evenly divided between those that schedule appointments for posttest sessions as clients are leaving and those that ask clients to call to schedule appointments. In either case, the date on which a client is to return for results or call the clinic is noted on a card or lab slip, which must be presented in order to receive results. In the walk-in clinics, express services or appointments are available for posttest sessions. One exception to these arrangements is the Pinellas County STD clinic, where DIS may be sent into the

field to locate clients and give them their results before they have had an opportunity to return for their appointments. (Clients are told that results will be available in 2 weeks and to call and make sure they are available before coming in for results. Often, results are available in 10 to 12 days, enabling STD staff to reach most clients in the field before they would present at the clinic for results.) STD staff are expected to locate and counsel 50 to 60 percent of HIV-positive STD clients within 5 days of receiving the results back from the lab; additional posttest sessions in the field are required within 3 to 5 days after the first session to make sure the client is stable and to identify partners, who in turn must be contacted within 3 to 7 days. Staff think that patients know "we'll come and find them if they're positive," which is indeed the case. The same protocol is followed at Hillsborough County STD clinic: DIS go into the field to contact STD patients who are HIV-positive and give them their results before they return for the posttest appointment. Over half of HIV-positive clients are re-interviewed so that partners can be contacted. The focus of this second session is partner notification, but some risk reduction counseling occurs as well. HIV negative clients rarely return specifically for HIV results. At Pinellas, syphilis results are available in 5 to 7 days; returning for HIV results would mean a separate trip.

Return rates are generally low. Staff across sites agree that once an STD is treated, clients have little incentive to return for HIV results, especially when HIV testing wasn't the primary reason for the initial visit. Boston City Hospital has begun sending out reminder letters to clients who do not return, but this strategy has been only marginally successful. Newark STD clinic staff are also beginning to contact clients who do not return, instead of referring them to the state Notification Assistance Program (NAP). Another strategy is to remind clients that they will not have to wait long in the clinic for posttest sessions; most clinics expedite posttest counseling. For example, at Hillsborough County STD clients are told that they may bypass the waiting room and proceed directly to the counseling area when they return for results.

Posttest Counseling

Posttest counseling sessions were observed in three of the sites. Features of posttest counseling across clinics are summarized in Table 2G.

Positive Results. Posttest counseling for HIV-positive clients usually takes up to an hour and sometimes longer. Posttest counseling conducted in the field by STD staff in Florida takes between 30 to 60 minutes.

The immediate goal of posttest positive sessions in most clinics is to stabilize the client and establish a support system through appropriate referrals. Many counselors report that they focus on the need for preventative health care and the importance of taking a "proactive" approach to staying healthy. After calming the client, Hillsborough counselors try to encourage clients to take control of the situation by staying healthy, informing partners, and using condoms. Boston City Hospital counselors review both medical and emotional implications of the diagnosis. Stressing the need for immediate medical

evaluation, BCH counselors tell HIV-positive clients that they need to find a doctor they can trust. The hospital's Diagnostic Evaluation Unit is recommended to clients if they do not already have a provider. Hillsborough County STD staff described partner notification as the principal focus of posttest counseling.

The Bridgeport and Boston City Hospital STD clinics offer additional sessions for HIV-positive clients after the session in which results are given. Staff at both clinics report that most clients to whom these sessions are offered do return for them. (At BCH, additional posttest sessions are offered at the nurse's discretion.) At Hillsborough and Pinellas STD clinics, DIS conduct additional posttest sessions in the field, but these are focused on partner notification. The Pinellas County health servicess representative (HSR), who is a trained DIS, noted that more posttest sessions--perhaps as many as two or three--are really necessary. STD staff are trained to "charge in" and get information about partners; this is a legacy of syphilis and other STDs where speed counts. However, when translated to HIV counseling, the Pinellas clinic HSR is concerned that in some cases the traditional STD "mindset" that focuses on the number of contacts may preclude a more appropriate focus on the individual who has just been diagnosed.

Negative Results. In some cases, negative results are incorporated into the client's next STD visit. Whether they are part of an STD visit or a separate session, they usually take no more than 5 to 15 minutes.

Consistent messages across sites are the need for continued risk reduction to stay negative, and the need for retesting if exposure has occurred or occurs in the future because of the "window period." Retesting is recommended in 6 months for most clients. At Westside STD, the standard retesting recommendation is 6 months. but high risk clients (e.g., IDUs new in recovery, gay/bisexual men, and prostitute contacts) are encouraged to be retested in 3 months. Several counselors make an effort to specifically review risk behaviors discussed during the pretest session. In Boston, clinic protocols facilitate this by requiring clients to write notes about the pretest session on an index card, which is then reviewed in the posttest session.

Referral

Referral sources, options, and key gaps are summarized in Table 2H.

Westside STD, Pinellas County STD, and Bridgeport Health Department have access to a social worker or case manager to assist with referrals. In all the clinics, counselors are responsible for providing clients information on medical and social services available in the community. Stamford STD clinic staff feel that there is a compelling need for case management. The HIV counselors, program coordinator, and health educator all perform case management functions because no one else is available and they are committed to their clients. Staff find that clients depend on the AIDS program staff, who become their "lifelines" in the absence of any other support. Outreach workers sometimes bring in

clients who are known to be HIV-positive (but were not clinic clients) so that the counselors can help them find services.

In most cases, counselors give clients 'materials- with lists of services. At Atlanticare, counselors also make direct referrals on the client's behalf and use the client's zip code to connect with neighborhood services. Hillsborough staff refer clients to primary care facilities within the county health system, but do not have lists of referrals available beyond these. Staff have assembled some materials, but have no support staff available to assist with clients and expressed a need for better referral materials. No referral or followup procedures are in place, but staff feel that ultimately it is up to patients to be responsible for their well-being. The counselors can help in finding resources, but not in assuring that they are used.

Staff view an immediate medical evaluation as the key referral. In many cases, medical evaluations are available either onsite or through the health department. Westside STD staff make appointments for HIV-positive clients at the HIV Wellness Clinic downstairs. Boston City Hospital staff refer clients to the hospital's Diagnostic Evaluation Unit. In Pinellas County, medical evaluations are available at the county HIV clinic, tuberculosis (TB) screening and treatment at the TB clinic, and contraception at the women's health center, all located in the same health center that houses the STD clinic. In Hillsborough County, STD staff refer HIV-positive clients to the nearest primary care facility for medical evaluation and treatment. Symptomatic clients can be referred to the county's HIV clinic across the street. Among the routine referrals for HIV-positive clients at the Bridgeport Health Department clinic are TB and Hepatitis B screening through the health department. Stamford Health Department staff report that early intervention services are not readily available, especially for women, and among those that are, physicians are not equipped to deal with the multiple health and social problems experienced by the clinic's clientele. Newark STD clinic staff routinely refer HIV-positive clients to St. Michael's Medical Center, Newark Health Center, and University Hospital for medical care, case management, and support groups.

Staff at Framingham's Awaiting Trial Unit face a unique referral problem. Although a referral network and medical services are available to women who, are going to be incarcerated within the prison system, these services are unavailable to women who are acquitted and leave the system. Because the program is new, staff have not yet developed extensive contacts in the community. In addition, women who are acquitted do not necessarily stay in the area.

Several staff reported gaps in mental health referrals. Westside STD staff noted that while the availability of medical referrals is excellent due to the. county's HIV wellness clinic, referrals for social services have lagged behind. Gaps include mental health, counseling, and support groups and other services targeted to women, adolescents, and minorities. Hillsborough County staff also noted that few mental health services and psychosocial support services are available for HIV-positive clients who need them. Drug treatment slots are also rare or involve long waits. Newark Health Department staff

expressed concern that indigent clients are unable to obtain medical services because most require payment.

Pinellas County staff occasionally refer HIV-negative clients into drug treatment, if necessary, but this was the only referral reported for negative clients.

Partner Notification

Partner notification features are summarized in Table 21.

Partner notification has been a standard feature of STD control for decades and continues to be central to the HIV activities now assumed by STD staff. In addition to providing both HIV and STD partner notification for clients seen at STD clinics, many DIS also provide assistance with HIV partner notification for clients of other health department clinics.

In cases where the DIS does not conduct posttest counseling, the nurse or HIV counselor usually introduces the concept and answers questions, and then offers the DIS' assistance. At Boston City Hospital, nurses provide clients with a written description of partner notification service with the name of a DIS across the top. If the client is interested, the nurse walks the client down the hall to introduce him or her to the DIS, but clients rarely choose to involve the DIS. Similarly, staff at Atlanticare have a DIS available onsite for partner notification, but most clients choose patient referral. At Newark STD clinic, clients can be referred to the state's Notification Assistance Program (which offers provider referral), but counselors have recently begun notifying partners themselves instead of referring clients to the state program.

Both patient and provider referral are offered at Pinellas County STD clinic. DIS help clients with patient referral by providing coaching and role playing exercises. Clients who choose patient referral are given blue cards that offer a "free exam" to partners. The cards are coded so that clinic staff are alerted that a partner is presenting for an HIV test.

At the Bridgeport Health Department STD clinic, counselors work with the client to develop a plan for contacting sex and needle-sharing partners, going back 1 to 2 years. The counselor coaches the client about how to discuss HIV infection with partners and also encourages clients to contact the state's CARE team and seek their assistance in notifying partners, either instead of or in addition to patient referral.

Partner notification is a major emphasis at Hillsborough County's STD clinic and is the principal focus of both posttest counseling and of followup interviews in the field. The number of partners identified through client interviews is reported and monitored. Although needle sharing is not reported to be a significant source of HIV transmission in Tampa, DIS ask positive clients to identify both needle sharing and sex partners for the past year. As a result of participating in a CDC study of partner notification, staff are

now offering both patient and provider referral. Previously, provider referral was used most frequently, with assistance with patient referral available if necessary.

Oregon state law distinguishes between aware partners (partners of gay men, IDUs, and prostitutes as well as prostitutes themselves) and unaware partners (partners of transfusion recipients, heterosexuals, and partners who are unaware of an index patient's bisexuality injection drug use, or hemophilia). DIS concentrate on getting identifying and locating information for unaware partners and recommend patient referral for aware partners, although DIS assistance is offered for aware partners as well. A Westside STD DIS described her responsibility as notifying partners about the availability of HIV counseling and testing, rather than recruiting them into services.

Innovations

- At Westside STD in Oregon, the waiting time for the STD exam is used to provide more indepth pretest counseling for clients who indicate an interest in either HIV information or testing on the intake/risk assessment form.

- Bridgeport Health Department's STD clinic plays a video in the waiting area that features realistic characters, explicit street language, and rap music; clients observed during the site visit seemed absorbed in the video.

- Hillsborough County STD clinic staff provide monthly blood screening outreach to the community; last month, HIV testing was added. Staff set up in a central location, such as a housing project, and provide blood tests for STDs and HIV. Teams of DIS go door-to-door offering the same services. Privacy and time are obstacles to providing HIV pretest counseling, but 16 people accepted HIV testing last month. None were HIV-positive.

- Physicians assigned to primary care facilities in Tampa receive a week of training in Tampa's STD clinic. This includes half a day spent with a DIS on epidemiology and partner notification.

- The main benefit of targeting Stamford STD clinic services to women is "to get people outside the system wedged into the system" so that they can receive health care, including HIV counseling and testing.

Technical Assistance Needs

- Good training videos and manuals would be useful, since conferences are difficult for staff to attend.

- Staff providing HIV counseling and testing at Framingham feel that training is needed in special issues for prison populations, substance abuse and HIV, and community resources available for HIV-positive clients.

- Framingham staff report a critical need for materials that could be used with Spanish clients, and for teaching aids that could be used with low-literacy clients.
- Continuing education about current HIV/AIDS issues is badly needed.
- Case management services are needed; counselors often do it because no one else is available.
- There is a need for better/expanded capacity to treat the range of complex needs of HIV-positive women. Medical intervention and drug treatment for women are not readily available.
- Hillsborough County DIS report needing more help with locating and staying current on referral sources, and assuring a supply of resource listing is on hand.

Table 2A
Confidential or Anonymous Testing

STD Site	Confidential or Anonymous	Informed Consent	Who Has Access to Results
Westside STD Clinic	• Confidential	• Verbal	• Kept with STD records but no access outside clinic without client's written consent.
Atlanticare/Lynn Hospital	• Confidential	• Signed	• HIV results entered into STD file and kept separate from hospital or general medical records. HIV and STD results cannot be released to other hospital providers without client's written consent.
MCI Framingham	• Confidential	• Signed	• Test results entered into medical record but HIV results are not transferred with medical records. Access is restricted to medical staff only (not prison staff).
Newark STD Clinic	• Confidential	• Signed	• Kept with STD record but no access outside clinic without client's written consent.
Boston City Hospital	• Confidential	• Signed	• HIV and STD results are separate from hospital medical records.
Pinellas County PHU	• Confidential	• Signed	• HIV test results are kept with patient's record.
Hiiborough County PHU	• Confidential	• Signed	• HIV results are included in STD medical record.
Bridgeport Health Department	• Confidential and Anonymous	• Signed confidential or anonymous informed consent form	• HIV counselor • HIV supervisor • Supervisor of communicable disease division
Stamford Health Department	• Confidential and Anonymous	• Signed	• HIV counselor, clinical staff as needed

Table 2B
Staffing Issues

STD Site	Staff Role/Background					
	Education/Outreach*	Counseling and Testing	Referral/ Case Management	Partner Notification	HIV Counselor Training	Quality Assurance
Westside STD	HIV counselor (education)	• 7 nurse clinicians (pretest and posttest negative) • 8 DIS (pretest, all posttest positive) • 1 HIV counselor (pretest and posttest negative)	• DIS	• DIS	• County HIV counselor training • DIS: 2-week epi course • Orientation (observe other counselors)	• Lead DIS sits in on sessions as part of performance appraisal
Atlanticare/Lynn Hospital		• 2 Nurses	• Nurses	• DIS (refer)	• CDC/DPH HIV training	• Visits by state DPH
MCI Framingham	• HIV counselors/DIS (Health Education Seminars)	• 1 DIS (almost all counseling) • 2RNs	• DIS	• DIS	• CDC/DPH training	• No formal QA at this time
Newark STD	no outreach • DIS does education in counseling and testing session	• 9 DIS	• DIS	• Refer to state Notification Assistance Program • DIS beginning to locate HIV-positive clients who do not return for test results	• State HIV training • STD training • Ongoing seminars, conferences, etc.	• DIS supervisor observes and critiques counseling of each DIS once each quarter.
Boston City Hospital		• 4 Nurses • 1 Lab tech	• Nurse	• DIS	• CDC/DPH training and access to ongoing training (e.g., BCH seminars)	• Visits by state DPH
Pinellas County	• N/A	• 4-5 DIS • 1 DIS supervisor • 4 clinicians	• Social worker in health center's HIV clinic	• DIS	• HRS HIV training course	STD Program Guidelines: • STD supervisor sits in on DIS sessions • New DIS monitored for 3 months • Program manager sometimes sits in on sessions
Hillsborough County	• DIS (blood screenings)	• 16 DIS • 5 supervisors	. DIS	• DIS	• HRS HIV training course	• Training programs and HIV counseling guidelines assure quality
Bridgeport Health Department	• HIV counselors (education)	• 2 HIV counselors, masters in social work, counseling	• Referred to case manager	• Counselor (patient referral) or refer to CARE team (provider referral)	• State HIV certification course	• HIV coordinator periodically observes counseling sessions, reviews charts
Stamford Health Department	• Counselor • Health educator	• HIV counselor (RN)	• HIV counselor • Health educator • Program coordinator	• Counselor (patient referral) or refer to CARE team (provider referral)	• State HIV certification course	• HIV coordinator periodically observes counseling sessions, reviews charts

HIV education and outreach conducted by clinic staff prior to pretest counseling (e.g., HIV education incorporated into outreach, group information sessions within the clinic).

Table 2C
Data Collection

STD Site	Kinds of Data				Forms Used	Use of Data
	Risk Exposure	Demographic Data	CT Steps	Other		
Westside STD	X	X	X	• None reported	• County clinic encounter form • State serology form	• State/county reporting • Review seroprevalence data
Atlanticare/Lynn Hospital	X	X		• Blind seroprevalence	• State	• State reporting
MCI Framingham	X	X		• None reported	• State	• State reporting • Program planning
Newark STD	X	X	X	• CDC Family of surveys	. CDC scan form	• Program planning • Staff training • Community education
Boston City Hospital	X	X		• None reported	• State	• State reporting
Pinellas County	X	X	X	• None reported	. CDC scan form • State lab form • clinic logs • Client encounter forms (clinic) • Monthly state STD report	• State/district/county reporting
Hi&borough County	X	X	X	• KABB • Partner notification studies	. CDC scan form • State lab form • Clinic logs	• State/district/county reporting • Test acceptance rates monitored for DIS
Bridgeport Health Department	X	X	X	• None reported	• State form	• State reporting
Stamford Health Department	X	X	X	• None reported	• Scan form	• State reporting; to assess if program meets needs 0 target group

Table 2D
Pretest Counseling

STD Site	Individual or Group Session	Duration of Pretest Counseling	Condoms Provided/ Demonstrated	Pretest Counseling Observed
Westside STD	• Individual	• 20 minutes	• Provided	• None
Atlanticare/Lynn Hospital	• Individual	• 25 minutes (includes STD assessment)	• Provided	• 4 sessions
MCI Framingham	. Individual	• 20-60 minutes	• No--condoms are contraband in prison setting	• 1 session
Newark STD	• Individual	• 10 minutes	• None provided or demonstrated	• 2 sessions
Boston City Hospital	• Individual	• 20-45 minutes (includes STD assessment)	• Provided	• 2 sessions
Pinellas County	• Individual	• 30 minutes (includes STD exam)	• Provided by counselor, prescribed by clinician; illustrated materials accompany each bag of condoms to show use	• 4 sessions
Hillsborough County	• Individual	• 10-15 minutes	• Provided if staff think there is a problem • Demonstrated	• 2 sessions
Bridgeport Health Department	• Individual	• 20-30 minutes	• Provided and demonstrated	• 1 session
Stamford Health Department	• Individual	• 20-30 minutes	• Provided	• 1 session

Table 2E
Risk Assessment

STD Site	Purpose of Risk Assessment	Risk Assessment Instrument	When in Process/By Whom
Westside STD	• Allow clients to self-select for HIV pretest counseling while waiting for STD exam • Identify risk behaviors	• Risk assessment form filled out by client in waiting area • Questions on state serology form	• Client fills out form at intake (while waiting for STD exam) • Counselor reviews risk behaviors and serology form during pretest counseling
Atlanticare/Lynn Hospital	• Identify specific risk behaviors	• DPH counseling protocol	• Pretest/counselor
MCI Framingham	• Identify and discuss client's risk(s)	• DPH counseling protocol	• Pretest /DIS
Newark STD	• "Screen" for HIV risk behaviors	. CDC scan form	• Pretest/DIS
Boston City Hospital	• Discuss risk behaviors and link between STDs and HIV	• DPH counseling protocol	• STD assessment and pretest counseling/counselor
Pinellas County	• Data collection	• CDC scan form categories • State lab form categories • Clinic guidelines for history-taking	• Pretest/DIS or clinician
Hillsborough County	• Data collection • Identify risk behaviors	• CDC scan form categories • State lab form categories	• Pretest/DIS
Bridgeport Health Department	• Empower client to assess own risk and make informed decision about testing	• Health department protocol	• Pretest/counselor
Stamford Health Department	• Tailor prevention message to woman's issues	• State form for risk assessment	• Pretest/counselor

Table 2F
HIV Testing

STD Site	When/Where HIV Blood Draw Occurs	Who Draws Blood	Return Arrangements	Followup	Lab/Turnaround
Westside STD	• Pretest	• Nurse/counselor	• Return in 2 weeks (express line)	. DIS follow up HIV-positive • Negative results kept in STD chart for next visit	• State/2 weeks
Atlanticare/Lynn Hospital	• Pretest	• Nurse/counselor	• Appointment card with session scheduled in 2 weeks	• If clients do not return within 2 weeks of appointment, staff send note that results are available	• State/2 weeks
MCI Framingham	• Either STD exam or pretest counseling	• Nurse	• DIS will find client in ATU or residential unit. If released, client can receive results at local STD clinic.	• DIS contacts women in ATU or residential unit	• State/2 weeks
Newark STD	• Blood is drawn in the clinic lab before pretest counseling. Lab is on main level of clinic, counseling is done on floor below.	• Nurse	• Card with date to call and schedule appointment	• DIS contact HIV-positive in field if they do not return for results	• State/2 weeks
Boston City Hospital	• After STD exam	• Nurse	• Card with posttest session scheduled in 2 weeks		• State/2 weeks
Pinellas County	• Central clinic lab (same floor)	• Lab technician	• Return in 2 weeks	• DIS contact HIV-positive and their partners in field	• State/10-12 days
Hillsborough County	• Clinic lab	• Lab technician	• Return in 2 weeks	• DIS contact HIV-positive and their partners in field	• State/2-3 weeks
Bridgeport Health Department	• STD exam	• Lab technician	• Appointment to call on certain date	• 2 reminder letters • HD contacts HIV positive client in field	• State/2 weeks
Stamford Health Department	• STD exam	• Lab technician	• Appointment for return in 2 weeks	• Reminder letter • Speaks to client in clinic	• State/2 weeks

Table 2G
Posttest Counseling

STD Site	Same Counselor for Pre and Posttest Counseling	Duration of Posttest Session: Positive & Negative	Additional Posttest Sessions	Retesting Recommendation	Counseling Observed
Westside STD	• If possible	• Positive: 45 minutes • Negative: 15 minutes	• No	• 3-6 months	• None
Atlanticare/Lynn Hospital	• Yes	• Positive: 5-60 minutes • Negative: 5-60 minutes	• No	• 6 months	• 1 Posttest negative session
MCI Framingham	• Yes	• Positive: l-l.5 hours • Negative: 10-15 minutes	• Yes	• 6 months	• None
Newark STD	. No	• Positive: 15-20 minutes • Negative: 5 minutes	• By referral	• 6 months	• None
Boston City Hospital	• By request	• Positive: 10-60 minutes • Negative: 10-60 minutes	• Available; offered at nurses' discretion	• 6 months	• 1 Posttest negative session
Pinellas County	. No	• Positive: 45 min-2 hours (in field • Negative: 10-20 minutes	• Additional field session for HIV positive for partner elicitation	• 3 months	• 1 posttest positive session • 1 posttest negative session
Hillsborough County	. No	• Positive: 30-60 minutes (in field) • Negative: 10-15 minutes	• Re-interview HIV-positive for partner elicitation	• 6 months	• 1 posttest negative session
Bridgeport Health Department	• Yes	• Positive: l-2 hours • Negative: 15-20 minutes	• HIV-positive clients encouraged to return for follow up in l-2 weeks	• 3-6 months	• None
Stamford Health Department	• Yes	• Positive: 20-60 minutes • Negative: 15-20 minutes	• Sometimes, varies with client need	• 3 months if client was exposed within past 6 months; note in chart reminds counselor to bring up in posttest	• None

Table 2H
Referrals

STD Site	Sources of Referrals	Services Provided Onsite	Services Offered by Referral Offsite	Major Gaps
Westside STD	• Counselor	• HIV Clinic (same building)	• Support groups • Social services	• Mental health • Social services • Services for women, minorities
Atlanticare/Lynn Hospital	• Counselor and clinic	• STD/DIS • Lynn Hospital Infectious Disease Clinic	• Visiting Nurses Association support groups • Use client's rip code to connect to local services	• None identified
MCI Framingham	• DIS	• Prison Health Services Unit	• Few (new program)	• Support groups only available to inmates (not detainees)
Newark STD	• DIS	• SrD	• St. Michael's and 2 community health centers for medical care	• Free or low-cost medical evaluation and care
Boston City Hospital	• Counselor	• BCH Diagnostic Evaluation Unit for medical evaluation/care	• Support groups	• None identified
Pinellas County	• Counselors	• Same health center: - TB screening - Women's health services - Medical evaluation and treatment	• Support groups • Primary care • Social services • Drug treatment	• Dental care
Hillsborough County	• Counselors	• TB screening	• Drug treatment • Primary care • Medical evaluation and treatment	• Mental health • Psychosocial support
Bridgeport Health Department	• Counselors	• Health department coordinates services: TB screening, Hepatitis B screening	• Refer to case manager	• Housing • Dental care, especially dental surgery
Stamford Health Department	• Counselors • Health educator • Program coordinator	• Family planning • Gynecological exams	• x-rays • Dental clinic • Medical management	• Early intervention • Drug treatment • Providers familiar with women's problems

Table 2l
Partner Notification

STD Site	Patient Referral	Provider Referral/ Who Elicits and Notifies	When Topic is Introduced
Westside STD	• Assistance offered	• DIS	• Posttest counseling
Atlanticare/Lynn Hospital	• Assistance offered	. DIS	• Posttest counseling
MCI Framingham	• Assistance offered	. DIS	• Posttest counseling
Newark STD	• Assistance offered	• DIS (newly implemented)	• Posttest counseling
Boston City Hospital	• Assistance offered	• DIS	• Posttest counseling
Pinellas County	• Role playing, coaching • Blue card offering "free exam" for partners	• DIS	• Introduced briefly in pretest • Discussed in posttest counseling
Hi&borough County	• Assistance offered since CDC partner notification protocol has been in place	• DIS	• Posttest counseling (may be raised briefly in pretest)
Bridgeport Health Department	• Coach client	• Refer to state CARE team	• Pre and posttest counseling
Stamford Health Department	• Coach client	• Refer to state CARE team	• Posttest counseling

B. Discussion of Each Site Type

3. Drug Treatment Centers

a. Overview of the Site Type

A drug treatment program is generally a facility which serves individuals addicted to drugs who are interested in confronting their drug problem. Many types of treatment programs exist including detoxification centers, inpatient and outpatient programs, drug-free living programs, methadone programs. Many specialize in cocaine addiction, alcohol dependence or heroin addiction. Drug treatment programs, along with use of emergency rooms, are major ways these individuals interact with potential sources of health care. Since these facilities usually have recovering addicts among treatment staff, their credibility with the community of drug users may be higher than that of other service providers.

Sharing drug paraphernalia and unprotected sexual activity associated with drug use place addicted individuals at high risk of exposure to HIV. A 1990 summary of data from HIV counseling and testing sites throughout the country showed injection drug users among those with the highest reported rates of seropositivity among individuals tested; 20 percent for homosexual/bisexual injection drug users and 10 percent for heterosexual IDUs. Partners and children of drug users are also at high risk. Therefore, drug treatment programs are uniquely positioned to share HIV information with individuals at risk, offer HIV antibody testing and in some instances provide basic medical care.

The drug treatment centers visited for this study include two each in Connecticut and Florida; four in New Jersey; and one in Portland, Oregon. Although drug treatment centers were also visited in Boston, HIV counseling and testing services in these sites are funded and operated as freestanding counseling and testing sites (CTS). Boston sites are included in the analysis of CTS operations. Site names, locations and kinds of drug treatment services provided by those sites included in this analysis are shown below.

Drug Treatment Site Name and Location	Drug Treatment Services Provided
1. Hooper Detox Center Northeast Portland, OR	Co-ed inpatient facility for medical detoxification of alcohol and drug use.
2. Liberation Programs, Inc. Stamford, CT	Drug treatment agency providing methadone maintenance, inpatient residential treatment, and a drug-free treatment program. HIV staff serving all program components were interviewed.
3. Regional Network of Programs, Inc. Golden Hill Methadone Maintenance Center Bridgeport, CT	Methadone maintenance program.
4. Spectrum Drug Treatment Program Jersey City, NJ	Ambulatory detoxification and methadone maintenance program.
5. Spectrum Drug Treatment Program Newark, NJ	Ambulatory detoxification and methadone maintenance program.
6. Paterson Counseling Center Paterson, NJ	Ambulatory detoxification and methadone maintenance program.
7. New Brunswick Counseling Center New Brunswick, NJ	Short- and long-term detoxification and methadone maintenance; counseling for drug free living; individual and group counseling program for DUIs. HIV staff providing services to methadone clients were interviewed.
8. DACCO/Project HOPE Tampa, FL	Comprehensive substance abuse prevention and treatment program including outpatient, residential treatment, methadone maintenance, and a day treatment for pregnant and postpartum mothers and their infants. HIV staff serving all treatment components were interviewed and the residential treatment facility visited.
9. Operation PAR Methadone Maintenance Clinic St. Petersburg, FL	Comprehensive substance abuse prevention, education and treatment program. The facility visited for this study is a methadone maintenance clinic.

Of the nine drug treatment sites visited, five offer only methadone treatment (New Jersey and Connecticut), three offer methadone as well as other drug prevention and treatment services, and one (in Portland) is an inpatient detoxification facility. A broad array of HIV services is generally provided to clients of drug treatment centers visited, including counseling, case management and assistance' with financial and social services, health education and referral to health care. With Ryan White funding, some are or will soon provide HIV-related health assessments and/or medical care directly. Many drug treatment centers have community outreach workers who contact individuals in "hangouts," crack houses and shooting galleries where HIV education is provided as well as encouragement to become involved in drug treatment. In addition to HIV-related services, New Jersey sites typically offered tuberculosis (TB) and sexually transmitted disease (STD) screening, and one provided family planning. The Florida sites visited were part of comprehensive drug abuse prevention, education and treatment programs.

History

HIV counseling and testing activities in drug treatment sites visited generally began around that time that Federal funding for sites was expanded in 1988. However, several began HIV counseling and testing services in 1987, and one in 1986, the year after the antibody test became available.

Changes in the way HIV services have been provided have been influenced both by the availability of funding and the increasing realization of client needs. For example, early "demonstration" funding from the National Institute on Drug Abuse (NIDA) to two New Jersey sites for HIV outreach, education, and referral to testing was replaced by Centers for Disease Control (CDC) funding and addition of staff for HIV counseling and testing onsite. All sites visited provide HIV counseling and testing on the premises. More recent efforts in most sites have included expanding case management and support groups for those who are HIV positive. Medical evaluation'and treatment are seen as the next level of services which may be made possible by Ryan White funding.

Clientele

Drug treatment centers serve populations at high risk of HIV infection due to drug use as well as unprotected sex. In particular, methadone maintenance clinics reach injection drug users as a primary target population.

Staff at the Spectrum /Jersey City program found it difficult to describe a "typical" client in demographic terms, but noted that staff have distinguished two categories of clients who come to the clinic: productive and nonproductive. Those seen as productive exhibit a consistent attempt to remain clean, attend their weekly groups and have a genuine goal of becoming drug free. Nonproductive clients are not consistent in their participation or in their compliance with treatment guidelines. Staff at the Spectrum program in Newark likewise found difficulty in describing a typical client demographically, but noted that their clients tend to be "treatment-wise and street-wise." In New Brunswick, the "typical" client

was described as an individual who led a delinquent lifestyle prior to heroin use, exhibited antisocial behavior and had some involvement with the justice system.

Seroprevalence data were not readily available to staff in many treatment centers visited. However, those interviewed in New Jersey and Connecticut sites provided very high estimates of HIV infection in their clinic populations. In the Spectrum sites, staff estimated 47 percent and 55 to 60 percent of clients are HIV positive, respectively. Staff in the Spectrum Newark program reported that a CDC seroprevalence study in 1983 found that 67 percent of 300 blood samples obtained were positive for HIV antibodies. Staff in the New Brunswick program estimate that 38 percent of their client population are HIV positive.

Florida drug treatment sites estimated lower proportions of HIV positive clients among those they test: 7.5 percent in Tampa at DACCO and 5 to 10 percent in the Operation PAR methadone maintenance clinic in St. Petersburg. In St. Petersburg, however, the counselor estimates seroprevalence in the clinic as a whole is actually quite a bit higher when those who have been tested and found positive elsewhere are counted. Staff in Florida sites reported that many of those infected have come to the area from the Northeast. One counselor estimates that 60 percent of those who test positive in his Florida clinic come originally from New York or New Jersey. Injection drug users come to Florida, he thinks, partly because there is not a wait for methadone treatment (as there is in the Northeast) and partly because clean needles are readily available in Florida (again unlike the Northeast). Sharing works is much less necessary, Everyone can, and usually does, have his or her own.

Staff in the Liberation program in Connecticut report that more clients entering the program are both accepting testing and receiving positive results. Of 70 percent who accepted testing in the recent past, approximately 30 percent were found positive, reflecting the general seroprevalence of injection drug users in the Stamford area. Recent figures, however, show an increase in both percentage agreeing to be tested (now 76 percent) and in those whose results return positive (50 percent). An increasing number of women in the Liberation program are included in those with positive test results. Staff speculate that the increases may reflect either a real increase in overall seroprevalence among injection drug users, or possibly a self-selection phenomenon among clinic clientele. As the clinic's reputation for providing HIV medical care services becomes known, those who know or suspect they are infected may seek the program.

b. Program Management Issues

Integration of Services

HIV services are a routine part of clinic operations in every drug treatment facility visited for this study. As noted above, the range of HIV services provided by drug treatment facilities is broad and includes community outreach and education, as well as counseling

and testing, referral, case management and extended support for those who are found HIV positive. Administrative and HIV counseling staff interviewed unanimously confirmed the "essential" nature of HIV services for drug treatment clientele. All new intakes are offered counseling and testing; however, this does not extend to existing clients in some New Jersey sites with very heavy caseloads. Most centers offer case management and referral for those whose are HIV positive as part of the overall drug treatment plan. Two have, or anticipate having, Ryan White funding to provide HIV-related care.

All centers have "HIV specialists" who are primarily responsible for HIV services, especially counseling and testing. In only one site (Liberation) do HIV staff double as drug treatment clinicians as well; in others HIV staff are primarily dedicated to HIV services. Usually HIV staff have drug treatment experience and are often certified substance abuse counselors as well.

In one site, HIV counseling and testing are offered during the initial intake interview by intake staff; however, in all other cases clients are routed to an HIV specialist at some point during the intake process for pretest counseling. In all cases pretest counseling and testing are conducted by trained HIV counselors. Administrative staff at the DACCO program in Florida report that initial efforts were made to "integrate" HIV services into the activities of all drug treatment workers; however, maintaining specialized HIV staff has proven a more effective way to provide needed services. Services are integrated, but staff functions may not be. In other centers, staff noted that drug treatment staff appreciate having HIV specialists available as a resource.

Although testing is confidential in all visited sites, the availability of results to other drug treatment staff varies considerably. In one center, the primary drug treatment counselor is invited to participate in posttest positive counseling to assure that all aspects of treatment are coordinated. In another, 'results are now included in the client's general program file. However, in several sites results are kept secure by the HIV counselor. In sites where test results are shared by treatment staff, case management and coordination of care may be handled by staff with broader responsibilities, who are not dedicated to HIV services.

HIV specialist staff are universally involved in consultation and staff development activities within the treatment facility. This may involve formal inservice sessions, or more informal consultation and advice. In some cases, the training function extends to other community agencies outside the drug treatment program. Although the need to educate other drug treatment staff about HIV and allay fears about working with HIV positive clients were reported as early issues in initiating counseling and testing services, this is no longer a major concern in the drug treatment facilities visited for this study. Administrative and counseling staff were unanimous in their belief that HIV services are seen by all staff as essential. In one center, the administrator noted that confronting HIV status can be a "major, traumatic experience" that can galvanize a client into facing a serious drug problem and help turn his or her life around. In another, administrators noted that the initial priority of HIV staff had to be educating fearful drug treatment staff.

Now the situation has been reversed and newly hired drug treatment counselors come into a setting where there is a large, HIV-educated and supportive staff peer group. Staff have learned to accept that substance users are at high risk of HIV infection and that HIV services are critical; they are now confronting the need to handle death and dying issues among clients they serve.

This aspect of integration is notable. While specialized staff provide HIV services and education, other staff (social workers, nurses) have an opportunity to reinforce the importance of HIV in other aspects of the client's total program. Drug treatment sites visited seem to be working toward a system in which all staff see themselves as responsible for addressing HIV during their interactions with the client.

Staffing Issues

Staff roles in providing HIV services are varied and separate in many drug treatment centers visited. In Northeast sites, outreach workers who also provided referral and case management services were common and distinct from HIV counselors who provide pre and posttest counseling. While counseling and testing were made available to partners when clients brought them in, assistance in notifying partners was not a staff role in the drug treatment centers but was universally referred to health department staff.

Table 3B displays the number and backgrounds of staff providing HIV services, as well as the training program required of HIV counselors.

Backgrounds of HIV staff are highly varied, and include many workers without formal educational credentials--particularly in education and outreach jobs. HIV counselors in four centers had nursing backgrounds, and the lead counselor in one site is a physician who also serves as medical director. Substance abuse counseling background for HIV counselors is common; some reported being recovering addicts themselves. All staff providing HIV counseling and testing in all centers were certified either through state-sponsored training programs or through HIV/AIDS training provided by NIDA. In New Jersey sites, HIV counselors are also trained in phlebotomy.

Of the centers visited, only one reported an organized continuing education and support program for HIV staff--the DACCO program in Tampa. This atypically included a continuing education budget for travel to conferences and workshops, as well as inservice training and individual counseling support for staff. Staff in other sites reported informal networking with HIV workers in other agencies, and self-initiated requests for release time and expenses to attend training sessions as the major means of continuing education and development.

Confidential/Anonymous

Drug treatment facilities visited for this study provide confidential testing only. Written informed consent is obtained in all but one site, which accepts verbal consent. Several sites refer individuals seeking anonymous testing to other sites where this is available.

Confidential testing was defined as keeping information "private and between professional staff and the client" or, in another clinic, as "ensuring test results are kept between the counselor and the client unless the client would like the information shared with specific individuals." Anonymous testing was defined as "no personal names used" and as not "eliciting an accurate name from the individual being tested."

In two New Jersey sites, anonymous testing was also offered as recently as a year ago. However staff report anonymous testing' has been discontinued as a result of a state directive. Concern expressed about this change related to the requirement that positive results be sent to the state registry. One counselor noted that his clients do not trust the system and therefore do not want their name, social security number and serostatus sent to the state. Another indicated that one reason for phasing out anonymous testing may be to assure that positive results are only counted once in the state registry.

While only confidential testing is available, access to HIV test results is quite limited in most sites visited. In only two are HIV test results available even to other treatment center staff. In only one of these are the client's results included in the program file. Others restrict access to HIV staff and the medical director, and (in only two cases) the primary substance abuse counselor as well.

Table 3A displays the approach to confidential and anonymous testing in each center, as well as the means by which informed consent is obtained and access to results.

Data Collection

A variety of HIV data collection and reporting activities occur in all sites visited. Data collection is required for reporting counseling and testing activities to the state HIV program in all sites, as well as for the alcohol and drug abuse agency to which many sites also report. Some sites reported collecting risk assessment information from clients for use in counseling those individuals and developing group educational activities. Data collection for seroprevalence and KABB studies was also reported in Northeastern sites. One New Jersey program reported its HIV activities are funded by eight separate grants. Daily logs are used for internal tracking purposes.

Of data collected for state and Federal purposes, seroprevalence data was the only kind of data New Jersey staff reported was returned and used for program planning purposes. The CDC HIV Counseling and Testing Report Form is used in all but one of the program areas visited and is consequently completed in all sites visited. However, few reported obtaining information back from this reporting effort or using the data collected for their

own planning purposes. Connecticut sites reported receiving periodic summaries of scan form data from the state AIDS unit. In Florida, reports on data collected by the CDC form may be requested from the state HIV office, but sites visited did not do this.

In addition to the CDC form, many sites complete state reporting forms for HIV as well. In Florida, risk assessment information is collected on the lab slip used to request HIV testing from the state lab. Like the CDC form, the Florida form is computer scannable and completed for each client. In addition, aggregated information from these forms and internal logs is required monthly for the Florida alcohol and drug abuse office.

While data collection requirements and activities abound, use of collected data for program planning and evaluation is generally not done. One site reported using collected data for grant writing purposes, but noted that of all the data collected little or no feedback comes from the various researchers. In general, current data collection activities are seen as time consuming, duplicative and in need of coordination.

Table 3C displays the kinds of data collected, major reporting forms, and principal uses of data for drug treatment sites visited.

c. Service Delivery Issues

Entry

New intakes are routinely offered HIV counseling and testing as part of the admissions process in all drug treatment facilities visited. However, staff in several New Jersey sites with high seroprevalence report it has been difficult to offer HIV services to clients who have been in the program prior to the time when HIV services were available. These same sites provide HIV counseling and testing for walk-ins who are partners of clients in the program. However this rarely occurs. Sites in other areas serve only those admitted to the drug treatment program, but may also counsel and test partners brought in by clients.

Procedures for including HIV counseling and testing as part of the intake process vary. In methadone clinics, an HIV educator or counselor typically sees the new client after he or she has been seen by other intake staff for psychosocial and medical assessment. This may occur on the first day the patient enters the clinic; however, because the client must come daily for methadone, HIV education and counseling may happen on a subsequent day. At Hooper Detox, the only inpatient detoxification site visited, the HIV counselor generally waits a day or two to allow the client to work through initial detox stages before approaching him or her with HIV information. The Hooper counselor also makes a point of approaching all clients so none feels singled out. Methadone clinics, residential treatment facilities and inpatient detox facilities share a “captive audience” as long as individuals remain in the treatment program.

None of the drug treatment centers visited used assessment of HIV risk to determine whether to offer HIV counseling and testing since the assumption is that drug use places clients at risk. In several sites, information on risk exposure was gathered at various points in the intake process both for data collection purposes and to assist in tailoring group and individual counseling.

Pretest Counseling

In all sites HIV pretest counseling is individually provided by specialized HIV staff trained and certified by state-sponsored or NIDA programs. Sessions may last from a brief 10 minutes in one site which uses preliminary group education sessions extensively to as much as an hour.

Group education sessions are used in many drug treatment facilities to provide "AIDS 101" information. These may be conducted by treatment center staff who are not trained HIV counselors is some sites, but not in most. In one site, group education provided by the HIV counselor is used extensively to help prepare clients for pretest counseling. The DACCO program in Florida has set up a three-tier process which involves two hour-long group sessions for both inpatient and outpatient program clients, followed by briefer individual pretest counseling and testing. Several other programs offer HIV group education sessions, which include discussion of available counseling and testing services, throughout the drug treatment process.

The Spectrum program in Jersey City routes clients to an HIV educator for general information on the disease and risk behaviors before pretest counseling is provided by an HIV counselor.

Table 3D displays key features of pretest counseling in each of the drug treatment sites visited and sites where counseling observation occurred.

Content and Approach. Several counselors interviewed reported individual risk assessment as a major goal or an important part of conducting the pretest counseling session. The intent is to personalize risk both to make clear the need for the HIV antibody test and to discuss ways of minimizing further risk of exposure.

In at least two sites, counselors emphasized the importance of finding out how the client sees his or her risk. One counselor noted that most clients have a succession of people shaking a finger at them, saying "do not do this" and "do not do that," He stressed this is not the way people learn to change their behaviors in any setting. Another comment by this same counselor, reinforced by the pretest session observed in this site, relates to the importance of assessing when an individual is ready to be antibody tested. While the depression or anxiety which may be part of the detoxification process plays a role among clients in the site visited, the counselor emphasized that most counselors do not receive enough training or support in suicide assessment or other ways to gauge a client's ability to handle the test and its results. In another site, staff report that they do not just give

information, but are "less formal" and try to assist clients change behaviors, not just "preach a message."

This cannot be interpreted as a general approach taken by HIV counselors in drug treatment centers visited, however, In two other centers, counselors interviewed reported that they "covered CDC guidelines" in counseling sessions. One reported using these as a checklist. In observed sessions in New Jersey and Florida sites, counselors routinely covered risk exposure categories on the CDC form; however, there was little tailoring of discussion to the responses during the counseling session. In New Jersey sites in particular, counselors spend a great deal of time discussing drug using risk behaviors (although only one discussed cleaning needles) and did not emphasize risks involved in unprotected sexual behavior. In one New Jersey site, the counselor did report increasing discussion of sexual transmission modes due to the high level of knowledge clients already have about injection related transmission.

One HIV counselor in a Florida site reported that discussion of HIV risk with new intakes during pretest sessions tends to focus on dangers of sharing works and the importance of avoiding substances both to decrease HIV risk and reinforce the need to stay in drug treatment. The damage to the immune system caused by drug use and related behaviors is also emphasized. Sexual transmission is covered as needed and condoms are available, but continuing injection drug use is seen as the primary danger. He reports that injection drug use inhibits sexual activity and that many of the clients he sees are monogamous or are minimally sexually active.

Another notable difference between Florida and New Jersey clients, and consequently the focus of counseling sessions, may be the extent to which needle sharing is a risk factor. As noted earlier, clean needles are more readily available to injection drug users in Florida, while they are not in the Northeast.

In a Florida site where multiple pretest sessions were observed, the focus of the session was consistent with what counselors reported: obtaining informed consent for testing, assuring that client's questions about the test are answered, and completing necessary paperwork (including the CDC and state data collection forms). In this site, the pretest session is preceded by group sessions which cover HIV transmission and risk assessment extensively. The sessions occurred in a residential treatment facility where clients receive extensive individual counseling about their drug-related behaviors and lifestyles, Extensive counseling about drug behaviors is also part of other drug treatment programs visited and should be taken into consideration in assessing the. content and extent of such discussion in HIV pretest counseling. As noted earlier, many sites report that staff who are not HIV specialists are oriented to and assist in reinforcing the importance of HIV in other aspects of the client's total treatment program.

Testing

Generally, HIV counselors in drug treatment centers draw blood as part of the pretest counseling session. In more than half the centers visited, HIV testing involves a separate stick. In those using a single stick, the HIV counselor usually draws blood for all clinic purposes, including HIV testing. Table 3F displays the key features of testing in sites visited.

Because of needle use, it may be difficult to find a vein to draw blood from an injection drug user. One site refers difficult cases to a nearby hospital; another uses a trained phlebotomist for all blood work, including HIV testing. In New Jersey and Oregon sites, HIV counselors are also trained as phlebotomists and draw blood at the end of pretest counseling.

In only two sites does someone other than the counselor draw the blood. In one site this is the trained phlebotomist described above who draws blood with a single stick for all clinic needs. Extra vials are drawn for HIV testing and only used if the client consents. In all cases, blood is drawn on the premises and almost always immediately following pretest counseling.

In all sites visited, clients are informed about when results may be expected back at the time of testing. However, the approach to return appointments varies. For methadone clients and those in residential treatment or detoxification, counselors are easily able to find individuals when their results come in. However, even in these settings clients are usually given a date when results are expected back, and often told to call to confirm or to arrange an appointment. Counselors in these settings noted the importance of spending time with clients regularly so it will not be apparent to other clients when a posttest session needs to be conducted.

Sites visited generally make some effort to assure that those with positive results receive posttest counseling. For methadone clients, the chart can be flagged when test results come back so that the client can be routed to the HIV counselor before receiving methadone. In one New Jersey site, the client is required to obtain a signed statement from the counselor that posttest counseling has occurred before methadone is dispensed. In New Jersey sites, names of clients whose test results come back positive may be provided to the state Notification Assistance Program if these individuals leave the program before posttest counseling can be conducted. This is also true in both Oregon and in one Florida site where HIV staff may try to follow up by mail or through use of outreach workers before forwarding names to the health department. In only one Florida site is no follow up attempted. In this methadone clinic, HIV staff do not conduct field contacts and require a signed release from the client to provide information to the health department for follow up of test results. Such permission is rarely given.

Posttest Counseling

Most centers visited have a single HIV counselor who does all pre and posttest counseling. Therefore, the posttest session is usually conducted by the same person who provided pretest counseling. It is also typical that the HIV counselor sees clients over time during their stay in the drug treatment program. For methadone clients, the counselor's contact may be daily. As noted above, in several methadone clinics visited, the client's chart may be "flagged" when HIV test results come back and the individual is sent for posttest counseling before receiving the day's medication.

Posttest counseling sessions are generally reported to last an hour or more for positive results. More variable times are reported for negative sessions, ranging from 15 to 45 minutes. Table 3G displays key feature of posttest counseling. One posttest positive session was observed.

Content and Approach. Posttest positive sessions. Many counselors reported discussing available medical treatment and referral as an important part of the posttest session for those with positive results. As expressed by one counselor, it is important to reassure the client that "it is not the end of the world and treatment is available." Several counselors reported discussing risk reduction to prevent both transmission to others and reinfection. In observed posttest counseling, the counselor spent considerable time discussing what a positive test result means and other details and at times seemed reluctant to allow the client time to express feelings about the news.

One counselor emphasized that his major concern in posttest counseling is keeping clients in the methadone program, not "letting them slip back into the street." In this clinic, the primary substance abuse counselors are also alerted to look for any indications a client may be slipping back and injecting, and will notify the HIV counselor. In another clinic, the primary drug counselor is invited to participate in the posttest session conducted with a client whose results are positive.

Most clinics provided for additional posttest sessions for those with positive results; however, only two schedule followup appointments. One counselor reports "checking in" later the same evening to be sure the client is not feeling suicidal and continuing to phone over several days for clients who remain upset.

Posttest Negative Sessions. The focus of posttest counseling for those with negative results was generally described as "staying negative and using condoms" as well as the importance of retesting if that is warranted. While condoms were available, and condom use was generally felt to be important, counselors did not report discussing ways to introduce them into sexual situations nor demonstrating them routinely. In a pretest session observed at Hooper Detox, the counselor did explore factors which prevented the client's condom use.

The significance of the 'window period" and possible need to retest are prominent in posttest negative discussions described by counselors. One reported that the most important message to get across to the client is that "you didn't have it 6 months ago."

While several counselors noted the general importance of emphasizing continued risk reduction to the client, the counselor at the Hooper clinic in Oregon emphasized the need to get clients to focus on specific ways to stay negative and considered negotiating future behavior change an important part of the posttest negative session. He pointed out that "clients are only human" and that there is a good change they may return to destructive behaviors despite good intentions. His goal is to work on a realistic plan for achieving specific behavior changes. He also noted that for clients in detoxification, receiving negative HIV test results may be "the only good news they have had in years."

Referral

All centers in New Jersey and one in Florida have an additional HIV staff specialist to help the HIV counselor with referral and case management for HIV positive clients. In sites where this is the case, more follow up of referrals and assistance to clients in obtaining services is reported. Where a case management role is not available, as in one of the Florida sites, staff report a great need for this kind of help. The Florida counselor finds himself personally involved in trying to help clients get to the services they need, to the point of providing transportation and helping with paperwork. As HIV progresses, he notes, mental impairment makes these things increasingly difficult for the individual and puts an increasing burden on the counselor.

Referral for medical evaluation and treatment is the rule in all centers visited, with one exception. T-cell counts are performed in, the Operation PAR Methadone Clinic in Florida; treatment is referred. While linkages with medical treatment resources exist for all sites, there are substantial waits for clients of New Jersey sites. In Connecticut, availability of medical care is a problem. However, in both Florida and Oregon, staff noted the "relief' of having good treatment services available through the public health system. This sense of relief may not be shared by all clients; skepticism about availability of the services was evident in the pretest session observed at Hooper.

A wide range of other ancillary services is available onsite in most facilities visited. TB testing and prophylaxis in conjunction with the health department is provided in Connecticut sites. New Jersey sites and one Florida site also provide TB screening. In New Jersey sites, STD screening is conducted in conjunction with routine blood workup.

Overall, counselors and other HIV staff rely on informal networking and contacts with colleagues and other HIV/AIDS service workers to keep them in touch with available referral sources. Many are informed about referrals because they are active in HIV and substance abuse organizations and work with community groups and agencies in addition to their HIV counseling roles.

Key aspects of referral for each site are displayed in Table 3H.

Partner Notification

Partner notification is not an established part of HIV services in the drug treatment centers visited. It is discussed, for the most part, with those whose test results come back positive during the posttest counseling session. In no case does HIV staff assist with provider referral; although counselors in several sites report they offer assistance from health department staff if the client wants it. Two New Jersey sites report they are beginning to elicit partners' names for forwarding to the notification assistance program. At the Hooper Detox center, the HIV counselor invites a trained disease intervention specialist (DIS) from the county's STD clinic to participate in posttest positive sessions to assist with partner notification.

Several sites report urging clients to let partners know or to bring them in to the drug treatment center for counseling and testing. In at least two cases, partners are provided with HIV counseling and testing even though the center does not generally provide HIV services to those who are not existing clients.

Some staff voiced resistance to partner notification, particularly in New Jersey sites where counselors tend to associate this practice with "STD contact tracing." Counselors in these sites were concerned that clients not be forced to receive information they are not yet able to handle. However, the New Jersey state Partner Notification Assistance Program is conducting training at specific sites to inform staff that "people do not have to get their test results if they choose not to."

Key features of partner notification are summarized in Table 31.

Exemplary/Innovative Practices

Notable practices and procedures pointed by staff in drug treatment centers visited include the following:

- A specialized prenatal program for pregnant women who are addicted to heroin. Women in drug treatment are seen by an obstetrician who comes to the clinic one time per week for clinic visits. A pediatrician is also available to assist in following the children who are born during their mother's drug treatment. Nutrition and parenting classes are offered for these participants.

- Services of an acupuncturist who assists in detoxification and cessation of cocaine through a 4-week protocol. Acupuncture services were reported at two sites.

- Support to counseling by offering a weekly parenting group offered weekly to clients. The program has proven effective in enhancing parenting skills and satisfaction with family issues.

- Project Hope thinks one of its major strengths is a holistic approach and strong team orientation. Staff believe an attitude of unconditional positive regard permeates the program--clients are treated with dignity and respect. It is important to be very positive and view the situation as "living with HIV/AIDS."

- The Paterson site has set aside one evening each week where service providers from other organizations come to the clinic to see clients.

Technical Assistance

The following were mentioned as program areas for improvement and further development:

- Providing HIV medical care within the clinic would be a great help, particularly availability of an infectious disease specialist. This would reduce the number of places clients must now go in their efforts to obtain care.

- **A** day care center on site would be beneficial for clients who cannot work but are not too ill to attend a day of activity. This would permit clients to be taken to medical appointments and provided with medications consistently.

- Additional staff are needed to provide the full range of HIV services, In particular there is need for an RN to work evening hours providing counseling and medical management.

- A problem is that some HIV-positive clients are discharged into the community because of noncompliance with the drug treatment program. There is presently no capability to follow up with them for medical and social care or prevention education and counseling.

Table 3A
Confidential/Anonymous

DTC Site	Confidential or Anonymous	Informed Consent	Who Has Access to Results
Hooper Detox Center	• Confidential only • Refer for Anonymous	• Verbal	• HIV counselor and DIS unless released by client to others
Liberation	• Confidential only • Refer for anonymous	• Signed	• HIV staff; medical staff, as needed
Golden Hi	• Confidential only	• Signed	• HIV status included in client's file
Spectrum Drug Treatment Program Jersey City	• Confidential only • Due to recent state directive to phase out anonymous testing	• Signed	• HIV counselor only unless released by client to others. Results kept in separate locked file.
Spectrum Drug Treatment Program Newark	• Confidential only • Refer for anonymous	• Signed	• HIV counselor only unless released by client to others. Results kept in separate file.
Paterson Counseling Center	• Confidential only	• Signed	• HIV counselor only unless released by client to others. Results kept in separate file.
New Brunswick Counseling Center	• Confidential only	• Signed	• HIV counselor only unless released by client to others. Results kept in separate file.
DACCO	• Confidential only	• Signed (refusal also signed)	• HIV staff and medical director only unless released by client to others.
Operation PAR	• Confidential only	• Signed (refusal also signed)	• HIV counselor, primary substance abuse counselor and physician. Client must release results to others.

Table 3B
Staffing Issues

DTC Site	Staff Role/Background				HIV Counselor Training	Quality Assurance
	Education/ Outreach*	Counseling and Testing	Referral/ Case Management	Partner Notification		
ooper Detox Center	• Outreach educators and AOD counselors	• 1 HIV counselor: degrees in social work and counseling	• HIV counselor • DIS	Referred to DIS	• County HIV course; continuing education through seminars, workshops, and conferences	• Supervisor sits in on sessions as part of routine performance evaluation
Liberation	HIV counselors	• 3 HIV counselors: nursing (RNs)	• HIV counselors	Referred	• State training program	• State periodically observes counseling session!
olden Hill	2 outreach workers	• 1 HIV counselor: nursing	• HIV counselor	Referred	• State training program	• State periodically observes counseling session!
pectrum Drug Treatment rogram ersey City	1 HIV coordinator. social work 1 HIV educator 1 outreach worker to be added	• 1 HIV counselor: medical technician & phlebotomist	• HIV coordinator	Referred	• Sday state training (all HIV staff)	• Periodic observations of staff by coworkers and supervisor
pectrum Drug Treatment rogram lewark	1 HIV educator-from community	• 1 HIV counselor. high school, phlebotomist, former drug rehabilitation health educator	• 1 HIV coordinator	Referred	• 5-day state training (HIV counselor only; HIV coordinator to be trained)	• No formal mechanism for assuring quality
aterson Counseling Center	2 HIV outreach/health education workers: community residents	• 1 HIV counselor: nursing (LPN)	• 1 HIV coordinator: BA, vocational rehabilitation (newly hired)	Referred when workload permits	• S-day state training (HIV counselor only)	• No formal mechanism for assuring quality
Jew Brunswick Counseling enter	1 AIDS educator/outreach worker: no formal academic credentials	• 1 social worker/AIDS counselor. certified drug and alcohol counselor, former prison counselor	• 1 AIDS coordinator. BA in education	Referred	• State training program (all HIV Staff)	• Formerly used 2-way mirror • No formal mechanism for assuring quality at this time
)ACCO	4 HIV outreach counselors: community workers	• 1 supervising counselor • 2 HIV counselors: 1 primary substance abuse counselor, 1 nurse (LPN)	• 1 case manager	Referred, if requested	• 2-day NIDA AIDS/HI course (supervising counselor and primary counselor) • 2dayHRS HIV training course (case manager and nurse)	• Program manager spot checks by sitting in on counseling • Periodic case file review
)peration PAR	None	• 1 HIV counselor: certified substance abuse counselor	• HIV counselor	Referred, if requested	• 2-day HRS HIV training course	• Operation PAR monitors monthly reporting data

HIV education and outreac Inducted by clinic staff prior to pretest counseling (e.g., HIV edu tion incorporated into o each, group information se ons within the clinic).

Table 3C
Data Collection

DTC Site	Kinds of Data Collected				Forms Used	Use of Data
	Risk Exposure	Demographic Data	CT Steps	Other		
Hooper Detox Center	X	X	X	• None reported	• County clinic encounter form • State serology form	• State and county reporting • Individual counseling
Liberation	X	X	X	• None reported	• CDCScanForm • State HIV Reporting Form • Monthly Summary report to State Drug Abuse Commission • Clinic logs	• State reporting • Daily logs used for internal tracking
Golden Hill	X	X	X	• Seroprevalence	• CDC Scan For, • Client HIV counseling record • CADAC/DHS seroprevalence questionnaire	• State reporting • Seroprevalence study
Spectrum Drug Treatment Center Jersey City	X	X	X	• None reported	• CDCScanForm • Monthly Summary Report to State Drug Abuse Agency • Monthly Summary report to State Department of Health	• State reporting
Spectrum Drug Treatment Center Newark	X	X	X	• KABB • Seroprevalance	• CDCScanForm • Monthly Summary Report to State Drug Abuse Agency • Monthly Summary report to State Department of Health • Risk Assessment Questionnaire	• State reporting
Paterson Counseling Center	X	X	X	• Seroprevalence • KABB	• CDCScanForm • Funding agency form • Monthly Summary Report to State Drug Abuse Agency • Monthly Summary report to State Department of Health	• Program planning, target group identification • State reporting
New Brunswick Counseling Center	X	X	X	• Seroprevalence data	• CDCScanForm • Monthly Summary Report to State Drug Abuse Agency • Monthly Summary report to State Department of Health	• State reporting
DACCO	X	X	X	• None reported	• CDC Scan Form . State Lab Form • Report to state alcohol and drug office • Internal mcordkeeping	• State reporting • Internal tracking of monthly/ quarterly goals
Operation PAR	X	X	X	• None reported	• CDCScanForm • State Lab Form • Report to State Alcohol and Drug office • Internal logs	• State reporting

Table 3D
Pretest Counseling

DTC Site	Individual or Group Session	Duration of Pretest Counseling	Condoms Provided/ Demonstrated	Blood Drawn During Pretest Session	Pretest Counseling Observed
Hooper Detox Center	• Individual	• 30-40 minutes	• Provided, demonstrated in group education session	• Yes	• 1 session
Liberation	• Individual	• 30-60 minutes	• Provided; films and videos available	• No, central lab used	• None
Golden Hill	• Individual	• 45-60 minutes	• Provided • Demonstrated	• Yes	• None
Spectrum Drug Treatment Program Jersey City	• Individual	• 15-30 minutes	• Not provided	• Yes	• None
Spectrum Drug Treatment Program Newark	• Individual	• 15-30 minutes	• Not provided	• Yes	• None
Paterson Counseling Center	• Individual	• 30 minutes	• Not provided	• Yes	• 1 session
New Brunswick Counseling Center	• Individual	• 45 minutes	• Not provided	• Yes	• None
DACCO	• Individual/Earlier Group Education	• 10-30 minutes	• Provided, demonstrated in group session	• Yes	• Partial group education session . 12 individual counseling sessions
Operation PAR	• Individual	• 30-45 minutes	• Provided	• No, phlebotomist on site	• None

Table 3E
Risk Assessment

DTCSite	Purpose of Risk Assessment	Risk Assessment Instrument	When Risk Assessment Occurs/By Whom
Iooper Detox Center	• Data collection • Identify individual risk behaviors for education/counseling • Initiate dialogue about behavior change	• State risk assessment and serology forms	• Pretest counseling/HIV counselor
.iberation	• Identify individual risk behaviors for education/counseling	• CDC scan form	• General risk assessment at intake/intake worker • During medical assessment/clinician • Specific risk assessment during pretest counseling/HIV counselor
Golden Hill	• Identity individual risk behaviors for education/counseling	• CADAC/DHS HIV intake questionnaire	• Pretest counseling/HIV counselor
ipectrum Drug Treatment Program 'ersey City	• Data collection	• CDC scan form	• Pretest counseling/HIV counselor
ipectrum Drug Treatment Program Newark	• Data collection	• CDC scan form • Risk assessment form	• Separate step during intake process/data collection specialist • Pretest counseling/HIV counselor
Paterson counseling Center	• Identify individual risk behaviors for education/counseling	• Risk assessment form developed by HIV counselor/nurse.	• Pretest counseling/HIV counselor
New Brunswick Counseling Center	• Data collection	• CDC Scan Form	• Pretest counseling/HIV counselor
DACCO	• Data collection • Identify individual risk behaviors for group and individual counseling	• State and CDC scan forms • DACCO questionnaires	• Pretest counseling/HIV counselor • Intake and group education/client self-assessment
Operation PAR	• Data collection • Identify individual risk behaviors for education/counseling	• State and CDC scan forms • Questionnaire developed by HIV counselor	• Pretest counseling/HIV counselor

Table 3F
HIV Testing

DTC Site	When/Where HIV Blood Draw Occurs	Who Draws Blood	Return Arrangements	Follow Up	Lab/Turnaround
Hooper Detox Center	• Pretest counseling separate stick	• HIV counselor	• Return date/call for appointment	• Reminder letter from HIV counselor for negative results	• State/2 weeks
Liberation	• Pretest counseling, separate stick	• HIV counselor, if nurse	• Advised of the 2-3 week interval. Most clients are in-house or return regularly for methadone	• Must return for posttest counseling before methadone is dispensed	• State/2 weeks
Golden Hill	• Pretest counseling, separate stick	• HIV counselor	• Client told of estimated time for results. Note placed on medication chart	• Must return for posttest counseling before methadone is dispensed	• State/2 weeks
Spectrum Drug Treatment Program Jersey City	• Pretest counseling, separate stick	• HIV counselor	• Return appointment made	• Chart may be "flagged" when results return. Client sent for posttest counseling before methadone is dispensed.	• State/2 weeks
Spectrum Drug Treatment Program Newark	• Pretest counseling, single stick for HIV and other needed blood work	• HIV counselor, (draws blood for all clinic purposes)	• Return appointment made	• Chart may be "flagged" when results return. Client sent for posttest counseling before methadone is dispensed.	• State/2 weeks
Paterson Counseling Center	• Single stick for HIV and other needed blood work	• HIV counselor, (draws blood for all clinic purposes)	• Return appointment made	• Chart may be "flagged" to sent client for posttest counseling before methadone is dispensed	• State/2 weeks
New Brunswick Counseling Center	• Separate stick. Client referred to private lab for other blood work.	• HIV counselor	• Return date given/call for appointment	• For positive clients who do not return, names may be forwarded to the state NAP	• State/2 weeks
DACCO	• Pretest counseling or immediately following, separate stick	• HIV counselor or accompanying nurse	• Return date given. Residential clients contacted by counselor when test results return.	• For positive clients who leave the program, HIV staff make an effort to follow up. Names may be referred to the health department if this is unsuccessful.	• State/2 - 3 weeks
Operation PAR	• Single stick for HIV and other blood work	• Phlebotomist on site	• Clients return daily for methadone. Counselor contacts them when results return.	• Clients who leave the program cannot be followed up unless client has signed a release to give information to the health department. HIV staff do not contact in the field.	• State/2 - 4 weeks

Table 3G
Posttest Counseling

DTC Site	Same Counselor for Pre and Posttest Counseling	Duration of Posttest Session	Additional Posttest Sessions	Retesting Recommendations	Counseling Observed
Hooper Detox Center	• Yes, 1 HIV counselor	• Positive: 60 minutes • Negative: 15 minutes	• Available through county HIV wellness clinic or from HIV counselor	• 3 months	• None
Liberation	• If possible	• Positive: 60 minutes • Negative: 15 minutes	• Clients are in continuous contact; additional sessions scheduled as needed	• 6 months	• None
Golden Hill	• Yes, 1 HIV counselor	• Positive: 45-60 minutes • Negative: 30 minutes	• Appointment made for follow up visit 2 days after initial posttest. Additional sessions scheduled ad hoc.	• 3 months	• None
Spectrum Drug Treatment Program Jersey City	• Yes, 1 HIV counselor	• Positive: 60 minutes • Negative: 15 minutes	• Counselor phones clients who are upset same night; may call again over next few days if client remains upset.	• 3-6 months	• None
Spectrum Drug Treatment Program Newark	• Yes, 1 HIV counselor	• Positive: 20-30 minutes • Negative: 15 minutes	• Clients encouraged to return to see counselor if needed. No specific appointments made.	• 3-6 months	• None
Paterson Counseling Center	• Yes, 1 HIV counselor/nurse	• Positive: 45-90 minutes • Negative: 5-10 minutes	• Client is told a return visit is appropriate.	• 3-6 months	• 1 posttest positive session
New Brunswick Counseling Center	• 1 HIV counselor	• Positive: 1 hour 20 minutes • Negative: 40 minutes	• Clients may return to see counselor.	• 3-6 months	• None
DACCO	• Yes, each HIV Counselor is assigned to specific programs	• Positive: 30 minutes and up • Negative: 15-20 minutes	• Second posttest session set within 3 days. Continuing counseling to transition to in-house HIV support group.	• 6 months	• None
Operation PAR	• Yes, 1 HIV counselor	• Positive: 30-45 minutes • Negative: 30-45 minutes	• Counselor sees clients in the methadone program daily; available as needed.	• 6 months	• None

Table 3H
Referrals

DTC Site	Source of Referrals	Services Provided Onsite	Services Offered by Referral Offsite	Major Gaps
Hooper Detox Center	• HIV counselor	• Drug detoxification only	• Medical and psychosocial services • HIV wellness program for HIV positive	• Affordable short-term housing
Liberation	• HIV counselor and other DTC staff	• TB testing • Prophylaxis and treatment • VDRL testing • Contraceptive services • Drug treatment	• Medical evaluation and treatment • Psychosocial support services • TB medication provided by the health department but dispensed by the clinic	• Few providers of HIV medical management • Medical care in the community is not well organized
Golden Hill	• HIV counselor	• TB testing • Prophylaxis and treatment • Women's support group • Counseling • Case management	• Medical evaluation and treatment	• Custodial care for clients with dementia who need 24-hour care
Spectrum Drug Treatment Program Jersey City	• HIV case manager	• TB screening • Social service assistance	• Medical evaluation and treatment • Psychosocial support	• Immediate medical care
Spectrum Drug Treatment Program Newark	• HIV coordinator/case manager	• Referral and follow up with primary centers • Day care program for persons with AIDS • Support group for HIV positive	• Medical services through TAP (wait: 2 weeks to 2 months); also refer to psychosocial, social and support group services	• Immediate medical care • On-site medical care
Paterson Counseling Center	• HIV coordinator/case manager	• HIV positive support groups • Will soon have on-site medical followup	• Medical treatment through TAP (6 week wait), psychosocial support, planned parenthood	• None reported
New Brunswick Counseling Center	• HIV counselor or coordinator	• Case management and support groups	• Medical treatment through TAP (1 week to 4 weeks wait) psychosocial support	• immediate medical assessment and care
DACCO	• HIV case manager	• Medical assessment, psychosocial support including group for HIV positive clients, case management	• Medical treatment • Primary care	• Mental health services
Operation PAR	• HIV counselor	• Medical assessment (cell counts) and evaluation • Psychosocial support • TB screening	• Medical treatment • Primary care	• Case management; transportation and assistance with social services for HIV positive clients

Table 3l
Partner Notification

DTC Site	Patient Referral	Provider Referral/ Who Elicits and Notifies	When Topic is Introduced
Hooper Detox Center	• Clients encouraged to refer partners	• STD DIS participates in posttest positive sessions to assist with partner notification	• Posttest counseling for HIV positive
Liberation	• Clients encouraged to bring in partners	• PN assistance through referral to CARE offered	• Posttest counseling for HIV positive
Golden Hill	• Clients encouraged to refer partners	• PN assistance through referral to CARE offered	• Pretest and posttest
Spectrum Drug Treatment Program Jersey City	• Clients encouraged to bring in partners	• Starting to elicit partners' names to forward to state NAP	• Posttest counseling for HIV positive
Spectrum Drug Treatment Program Newark	• Clients encouraged to bring in partners	• Beginning to elicit names on occasion to forward to state NAP	• Posttest counseling for HIV positive
Paterson Counseling Center	• Clients encouraged to bring in family members and partners	• Assistance offered, beginning to elicit names to forward to NAP	• Pretest counseling • Posttest counseling for HIV positive
New Brunswick Counseling Center	• Clients encouraged to refer partners	• May elicit names to forward to NAP during posttest counseling or in later sessions	• Posttest counseling for HIV positive
DACCO	• Clients encouraged to notify partners	• Assistance offered through the health deuartment. if desired	• Introduced in group education preceding pretest counseling
Operation PAR	• Clients encouraged to bring partners in for CT	• Assistance available through health department, if requested • Names not elicited because of dual confidentiality issues: methadone and HIV	• Posttest counseling for HIV positive

B. Discussion of Each Site Type

4. Family Planning/Women's Health Centers

a. Overview of the Site Type

Issues

HIV disease among women is a mounting concern for those in public health. Worldwide, women constitute about a third of all people estimated to be infected with HIV, according to World Health Organization figures. Although women currently account for only about 10 percent of all reported AIDS cases in this country, the number of cases of women with AIDS is rising at a faster rate than for men (29 percent vs. 18 percent between 1988 and 1989), and women of color are affected disproportionately. In some areas, women represent a much greater proportion of AIDS cases; for example, in Connecticut, one AIDS case in five is a woman. The Centers for Disease Control (CDC) predicts that AIDS will be one of the five leading causes of death among women in 1991.

Two special concerns make it urgent to reach women at risk with counseling and testing. First, the natural history and clinical presentation of HIV disease are not as widely recognized in women as in men; hence, women are more likely to go undiagnosed early in the course of the disease and therefore miss the opportunity for early intervention therapy. Second, because HIV infection can be transmitted perinatally, women of childbearing age present a dual risk: for themselves and for their unborn children.

Nationwide, women account for almost half of all people who receive services at publicly funded HIV counseling -and testing clinics.' Atlanta: U.S. Department of Health and Human Services, 1991;195-203). Minority women are disproportionately represented both among women who are tested and the proportion of those who are found to be HIV seropositive. Risk factors associated with seropositivity include IV drug use (either the woman herself or her partner) and sexually transmitted disease.

Of all women tested at publicly funded sites in 1989 and 1990, about an equal proportion (29 percent) were seen at CT sites, sexually transmitted disease (STD) clinics, and women's clinics (encompassing family planning and prenatal).[2] Many women who sought counseling and testing were at risk for HIV infection, although they were unaware, in

[1] MMWR. 1991. Characteristics of, and HIV Infection among, Women Served by Publicly Funded HIV Counseling and Testing Services--United States, 1989-1990:195-203.

[2] Ibid, p. 196

some cases, of that risk; for example, a high proportion reported no risk behavior, suggesting they were either unaware or unwilling to report it. The MMWR report suggests that "CT sites that serve women in areas of high prevalence of HIV positivity should routinely offer all clients HIV counseling and testing."[3]

Some states have responded to the issue by directing special efforts to women. For example, the Commissioner of the Department of Health Services in Connecticut sent a letter in September 1991 to all physicians, nurses, nurse practitioners, and clinics serving women. The letter reported the state's high rate of AIDS cases among women (20 percent vs. 11 percent nationwide) and recommended routine counseling for all women of childbearing age, noting that "many women who test positive for [HIV] are unaware of their risk of infection because they do not fall into 'high risk' categories." New York and New Jersey have also recommended routine counseling and testing for women of childbearing ages.

Although women receive counseling and testing services in all site types, this section addresses sites that serve women's health needs primarily. Five are women-specific sites and three are primary care facilities whose main clientele are women. The sites visited were the following:

- Connecticut
  - WIC Center in Stamford
  - Women's STD Clinic in Stamford
  - Women's Clinic at Yale-New Haven Hospital in New Haven
- New Jersey
  - Family Planning Clinic at Essex Planned Parenthood in Newark
- Florida
  - Women's Health Clinic at St. Petersburg Health Center in St. Petersburg
- Oregon
  - Three primary care facilities in Portland that mainly serve women:
    - East County Health Center
    - North Portland Health Center
    - Southeast Health Center

Services

The services provided to women at these sites ranged from WIC benefits to family planning and STD care to comprehensive primary health care. Overall, the goal was to

[3] Ibid, p. 203

offer HIV counseling and testing services in a setting that attracts women for health and social services, ideally relating to them in an environment that is supportive and more "user-friendly" than the typical counseling and testing sites (CTS).

Clientele

Women of childbearing age are the main target population, although some sites see adolescents and older women, as well. In some cases, male partners are eligible for counseling and testing in the same setting. The demographics reflect the traditional public clinic population of primarily minority and poor women. In some cases, women bring along their children for health visits, in contrast to other types of CT sites.

b. Program Management Issues

Integration of Services

Successful integration of HIV counseling and testing services with traditional women's health or family planning services seems to depend on several factors: the volume of counseling, the experience of the staff, and the "buy in" of the clinic staff. Clinic staff may be initially resistant about including HIV counseling and testing; it may be seen as too different or challenging or fearful, Staff may resent resources being pulled away from their traditional clinical activities. At one clinic, the emphasis on strict confidentiality initially created a sense of separateness for the HIV counseling component, which worked to the detriment of the overall program. One interviewee said staff education and the physician setting an example of support are the keys to involving the entire staff. Another said that it is crucial for a dedicated HIV counselor to respect the time and space constraints of the clinical staff and remain flexible about when HIV counseling gets scheduled. The personality of the dedicated HIV counselor and his or her efforts to relate to the rest of the staff also affect the successful integration of services.

Staffing Issues

Staffing issues are summarized in Table 4B.

There appear to be three general models for staffing for HIV counseling in women-specific settings.

1. HIV dedicated counselor--All three sites in Connecticut used this model, although at the women's center in Yale-New Haven Hospital, a medical resident takes charge of announcing positive results.

2. Clinical staff (physicians, nurses, nurse-practitioners, nurse-midwives, licensed practical nurses) who receive HIV training and conduct pretest and posttest negative

counseling in addition to other duties, with positive posttests conducted by a specialist, either in-house (St. Petersburg) or by disease intervention specialists who work out of the country health department (Portland).

3. Clinic staff who do HIV counseling in addition to other nonmedical duties. The Essex Planned Parenthood followed this model. The director of social work, the director of special projects, and the substance abuse counselor are certified to conduct HIV counseling; they do most of the pretest counseling and virtually always handle posttest counseling. Five staff social workers also have received HIV training and occasionally do counseling; none of the family planning staff conducts pre or posttest counseling, although they do discuss risk behavior with clients.

Staff in the integrated model (#2) express some frustration about multiple demands and time pressures. They also say that consistent training for all staff is difficult. It is hard enough staying current with a range of issues related to primary care, ob/gyn, or family planning; keeping up with the fast-changing field of HIV/AIDS is a double challenge.

Confidentiality/Anonymity

Confidentiality issues are summarized in Table 4A.

Women who agree to be tested are offered the choice of confidential or anonymous testing in most sites. The St. Petersburg clinic provides only confidential testing, but can refer to a CTS onsite, if the client prefers anonymous testing. Others are typically referred to an anonymous site at a nearby health department. However, women who want to maintain continuity with the health care setting in which they are tested de facto fall into the confidential category. Efforts are made to maintain true confidentiality within the health care setting, but, in actual fact, it is very difficult, given the involvement of several staff in provision of care for these women. Further, the issue of confidentiality doesn't appear to be as much of a crucible as it does with counselors in alternate test sites. In some cases, the counselors and clients forge a bond of trust, rendering anonymity undesirable.

Data Collection

Data collection varies by site, governed. to some extent by state and other jurisdictional reporting requirements and the site's own protocol.

Oregon does not use the scannable form. Multnomah County, in which Portland is located, collects data from "patient encounter forms" from sites throughout the county and uses the state serology form. The patient encounter forms are tabulated and summarized into a quarterly report, which is sent to the clinics. At least two primary care facilities used these results to raise awareness among staff and guide discussions about the extent to which their client populations are affected. One of these clinics developed an internal tracking log for HIV counseling and testing sessions; this form serves as a reminder to

send followup letters to clients who do not return for results and helps ensure that no patient who is tested at the clinic "falls through the cracks."

At the women's clinic in St. Petersburg, the health services representative (HSR) is responsible for assuring quality control of both the CDC and state lab scannable forms and also receives the test results.

Perhaps the most elaborate data collection effort among all the women's center sites takes place at the women's center at Yale New Haven Hospital. Because the hospital's AIDS Care Program is involved in a number of research studies, staff are accustomed to extensive data gathering requirements. The following forms are used to record data from the counseling process:

- Connecticut testing site scannable form (the "green form")
- HIV counseling intake and client record (Women's Center version)
- Informed consent to HIV antibody test--anonymous testing
- HIV test consent form--confidential test
- certification of consent for HIV antibody test
- risk assessment questionnaire (Women's Center)
- risk assessment counseling checklist
- inpatient referral for HIV counselor
- monthly client pretest logs
- monthly client posttest logs

According to the program's policy and procedure manual, each client file includes the following:

- HIV counseling intake and client record (sample included in the site visit report appendix), which is designed to provide a structure to pre and posttest counseling session and also serve as a permanent record of risk and psychosocial assessment;

- Consent form, either signed for confidential testing or numerically coded for anonymous testing;

- The CTS scannable "green form"; and

- Any other pertinent documents.

In the Women's Center, all pretest information is kept in a folder in a locked file cabinet. After the posttest session, additional information is added and the folder is returned to the locked file.

C. Service Delivery Issues

Entry

The topic of HIV counseling and testing typically is raised with the client by clinic staff at one or more points during the clinical encounter. In some cases, the clinician identifies a woman as being at particular risk during the course of a medical history, which includes sexual and drug-using history; at other times, clinical examinations for STDs or other health problems suggest the need for testing. Some clinics use a specific risk assessment form, sometimes a self-assessment, either as part of the entry paperwork (Essex) or as a discussion tool during intake. Typically, testing is offered to all clients and "strongly encouraged" for women who are perceived to be at special risk. Because HIV counseling and testing usually is not the main reason a woman comes to the health center, she may be resistant to initial efforts to partake of those services. Thus, it is important for all clinic staff (intake workers, nurse practitioners, nurses, physicians, lab technicians) to 'buy in" to the need for testing so they will be willing to introduce it to the woman at each step of her clinical encounter.

If a woman accepts HIV counseling and testing, that activity is usually slotted in between other aspects of the clinical visit, the scheduling depending on overall clinic flow. This means that the HIV counselor has to remain flexible and respect the other clinicians' needs to attend to the client. It also speaks to the need for close coordination among staff and education so that all clinic staff are aware of the importance of HIV counseling and testing.

Pretest Counseling

Pretest counseling issues are summarized in Table 4D.

In three sites, counseling is carried out by dedicated HIV staff, and in five sites, clinicians (generally nurses) do counseling in addition to other clinical duties. The amount of time for a pretest counseling session varies from 20 to 45 minutes, and counselors review topics like risk behavior, modes of transmission, the test and its interpretation, and risk prevention.

At the Oregon primary health care sites, women were generally knowledgeable about risk factors for acquiring HIV. At one center, the counselor said women who were counseled "accept the test out of a general concern about HIV, not because of specific risk factors" related to themselves. Some women agree to testing, expressing concern about partners' sexual and/or drug-taking activity. At the two Stamford sites, the counselor was sensitive to her clients' possible lack of power in a relationship and subsequent inability to insist on partners using condoms. She acknowledged the difficulty of such a situation in a nonjudgmental way, mentioning the cultural barriers to condom use among Hispanic men. At the same time, she encouraged the women to take responsibility for their own sexual health, posing the rhetorical question: "Who's going to do it if you do not?"

Counselors who do HIV counseling exclusively appear more likely to be comfortable with discussing sexual issues and risk behavior than their colleagues who are responsible for a wide range of clinical services. That added ease may reflect more indepth training or more experience in HIV counseling. 'Alternatively, it may be simply a matter of self-selection: counselors who are comfortable discussing HIV-related issues are those who become HIV counselors. The two Connecticut counselors, both nurses by professional background, both had a down-to-earth approach to discussing risk behavior and were clear about the need for risk reduction. At the same time, they were empathetic to their clients, culturally sensitive (one was African-American, one was Jamaican), and nonjudgmental.

Connecticut counseling staff also try to elicit information about a client's emotional state, asking questions about the woman's support system, whether she is in therapy, how she would handle positive results. There is special effort to identify clients who are "emotionally fragile" or potentially suicidal; counseling is deferred for these women and they are referred to mental health counseling.

Some clinic staff who take on HIV counseling in addition to other responsibilities (family planning, prenatal care, primary care) express conflict about dividing their attention. Time pressure and competing health care needs can frustrate a clinician's efforts to deliver a "Mercedes-model" of counseling. Also, because clinicians do less HIV counseling than dedicated counselors, their learning curve--and perhaps "comfort curve"--may take longer. Staff often are spread thin, so it is administratively disruptive for the limited staff to take several days off for training. As noted in the St. Petersburg report, "HIV training adds to the overall time they are not fully available for clinic services." In some cases, "territoriality" was an issue, with clinic staff at least initially resistant to involvement with HIV counseling and testing. The emphasis, on "extreme confidentiality" made staff see HIV counseling and testing as something separate. rather than as an integral part of total patient care.

Testing

Testing issues are summarized in Table 4F.

At several sites, women had blood drawn for a variety of lab tests, so there was no need for a separate stick. At other sites, blood was drawn specifically for the HIV test either because a blood sample was not needed for other lab tests at that visit or, in the case of the Women's Center at Yale-New Haven Hospital, ongoing seroprevalence studies required multiple samples from the same blood drawing. Clients at that site also had to go to the phlebotomist at an adjacent building to get blood drawn. At other sites, women had blood drawn in the same clinic where they were counseled, in at least two cases by the nurse who conducted counseling.

In two cases (Yale-New Haven and East County Health Center in Portland), the client's chart is marked in a way to indicate that an HIV test has been given and results should

be discussed on a return clinic visit. At the Portland clinic, a note to the provider to "review lab results" is placed on the top page of the chart. At Yale New-Haven, charts are color coded to identify women who have been tested.

Posttest Counseling

Posttest counseling issues are summarized in Table 4G.

In at least two cases, women's clinics departed from the standard CTS approach of assigning the same counselor for pre and posttest counseling. In these cases, "experts" in HIV counseling or disease intervention were brought in specifically to announce results of a positive test, At Yale-New Haven, a medical resident is the primary "announcer" of positive results, and a hospital social worker is a part of the team. The HIV counselor either joins them or is available later for counseling with the client. In Portland, any positive results are reported to the county health department who then assigns an experienced disease intervention specialist to conduct posttest counseling at the clinic where the woman was pretest counseled and tested. So far, the Portland clinics have had experience with few or no positive clients. At the St. Petersburg clinic, a Health Services Representative (HSR) conducts all posttest sessions. He has spent 4 years working in the field of HIV and is a state-trained disease intervention specialist (DIS). He stated that he does not think the current 2-day HIV training course is sufficient to prepare clinic counselors to deliver positive results.

At the two Stamford sites and at Essex in New Jersey, the same counselor who did pretest counseling also conducted posttest sessions for both negative and positive results. At the Essex site, this is generally contingent upon when the client schedules the return visit. Evening hours are shared among the clinic staff.

Typically, the posttest negative sessions emphasize the need to remain healthy and continue risk protection. Clients are advised to return for retesting if they persist in risky behavior. Negative sessions lasted about 10 to 20 minutes.

Posttest negative sessions within the context of women's clinics were observed in Stamford and Newark. The HIV counselor who conducted a posttest session at the WIC center in Stamford allowed time for the client, a young Hispanic woman, to express relief at the good news. She then gently reviewed the importance of the woman's continuing to use condoms with her partner; the woman was in a monogamous relationship, but thought her partner might have been exposed in the past through drug use or sexual relationships. The client said that her partner was resistant to using condoms, and he thought that, if she insisted, she was doubting his fidelity. The counselor acknowledged that it was a tough situation, but gently insisted that the woman had to look out for her own protection and health through insisting on condoms, and she gave a few suggestions on how the woman could discuss the matter with her partner.

Two posttest sessions were observed at the Essex Planned Parenthood clinic; one lasted 10 minutes and the other, 15 minutes. During the first session, the woman said she and her husband, who might have had sexual encounters with others during their intermittent separations, did not want to use condoms because they were trying to have a baby. The counselor learned that the husband had not had the HIV test; she encouraged the woman to bring her partner in for testing.' In the second session, after being told she was antibody negative, the woman revealed that she was living with a roommate who has AIDS and had some fears about exposure. The counselor did not discuss with the client the foundation of her fears, but did review information about modes of transmission.

Referral

Referral issues are summarized in Table 4H.

Referrals for seropositive women are made to area medical providers, community based organizations, and health departments.

The HSR in St. Petersburg coordinates follow up for seropositive women seen at the women's clinic there. The protocol there involves making an appointment at the health department's HIV clinic for a T-cell count; once the woman's T-cell status is known, the clinic makes a treatment plan and can continue care for those with cell counts under 500. Offering this service is a way to give a woman something besides the bad news of a positive test.

Women at Yale-New Haven are referred to the hospital's high-risk medical clinic, where they get CD-4 cell testing and other appropriate care under the supervision of a physician who is part of the AIDS Care Program that administers the counseling and testing program at the women's center, among other CT-sites. The counselor calls to make an appointment during the posttest session. Psychosocial referrals for a client are coordinated by the clinic's social workers, who assume a case management role.

The case management function is informally assumed in Stamford by the HIV counselor--because no one else is available to do it. She makes appointments for clients and even provides transportation in some cases if the client needs to be seen by a medical provider in another city.

At Essex in Newark, referrals to medical care (the Treatment Assessment Program, or TAP) are done by the social work staff. This site may be receiving funding soon to support a staff member to coordinate medical and psychosocial services for HIV-positive clients.

In Oregon, the DIS would coordinate referrals for any women who tested positive.

Partner Notification

Partner notification issues are summarized in Table 41.

Generally speaking, partner notification does not have the same priority for counselors in women's settings as it might, for example, in an STD clinic. Clients are encouraged to have their partners tested--in some cases, even if they are negative--and are given some support in how to raise the issue. In one case--the WIC clinic in Stamford--partners of women who were tested there did come in for testing at that site, attesting to the feeling of safety and confidence in that environment. More typical is referring matters of partner notification to an outside resource: a disease intervention specialist or a special PN outreach team like CARE in Connecticut.

Table **4A**
Confidential or **Anonymous Testing**

Women's Health Centers	Confidential or Anonymous	Informed Consent	Who Has Access to Results
East County Health Center	• Confidential	• Verbal	• Kept in lab results section of chart; available to providers
Southeast Health Center	• Confidential	• Verbal	• clinic staff
N. Portland Health Center	• Confidential	• Verbal	• clinic staff
Essex Planned Parenthood	• Confidential	• Signed	• Coordinator of special services
Stamford STD	• Confidential or anonymous; confidential stressed	• Signed	• Clinical staff, as needed
Stamford WIC	• Confidential or anonymous; confidential stressed	• Signed	• Clinical staff, as needed
Yale-NH Hospital	• Confidential	• Signed	• Clinical staff, as needed
St. Petersburg Women's Health Center	• Confidential	• Signed	• Results are kept in clients chart; available to providers

Table 4B
Staffing Issues

Women's Health Centers	Staff Role/Background				HIV Counselor Training	Quality Assurance
	Education/Outreach*	Counseling and Testing	Referral/Case Management	Partner Notification		
East County Health Center	• N/A	• 5 RNs with HIV training • Posttest positive counseling by STD/DIS	• DIS	• DIS from STD clinic	• 3 of 5 nurses had county HIV counselor training	• Nursing supervisor observes sessions as part of routine performance evaluation
Southeast Health Center	• N/A	• MDs, NPs, RNs, LPNs • Posttest positive counseling by STD/DIS	• DIS	• DIS from STD clinic	• Staff have had county HIV training to use RA form, not all have indeptl training	• Chart audits • Nursing supervisor observes session
N. Portland Health Center	• N/A	• RNs, LPNs with HIV training	• DIS	• DIS from STD clinic	• County HIV training	• Nursing supervisor observes sessions as part of routine performance evaluation
Essex Planned Parenthood	• Social work director, coordinator of special services, substance abuse counselor, 5 social workers	• Social work director, coordinator of special services, substance abuse counselor	• Staff member conducting counseling and testing makes referral, at present social work staff do general case management	• Coordinator of special services encourages clients to bring partners in for counseling and testing	• All have completed state 5-day training	• Observation of counseling by coordinator of special services twice a year
Stamford STD	• HIV counselor, doctor	• HIV counselor	• HIV counselor	• HIV counselor encourages client; CARE team referral	• State HIV counselor certification course	• Program coordinator periodically observes counseling sessions, reviews charts
Stamford WIC	• HIV counselor	• HIV counselor	• HIV counselor	• HIV counselor encourages client; CARE team referral	• State HIV counselor certification course	• Program coordinator periodically observes counseling sessions, reviews charts
Yale-NH Hosp	• HIV counselor	• HIV counselor	• Social worker at clinic	• HIV counselor encourages client; CARE team referral	• State HIV counselor certification course	• Lead counselor periodically sits in on counseling sessions • Lead counselor reviews client charts
St. Petersburg Women's Health Center	• N/A	• Nursing staff (LPNs, RNs, BSNs) • HSR	• HSR	• HSR elicits names and provides notification assistance	• HRS 2-day HIV training course • HSR has DIS training	• Nursing supervisors observe all practice, including HIV counselin

* HIV education and outreach conducted by clinic staff prior to pretest counseling (e.g., HIV education incorporated i ·o outreach, group information sessions within the clin).

Table 4C
Data Collection

Women's Health Centers	Kinds of Data Collected			Other	Forms Used	Use of Data
	Risk Exposure	Demographic Data	CT Steps			
East County Health Center	X	X	X	• None reported	• Log sheet . Patient encounter form . State serology form	• Check returns for posttest • State/country surveillance data presented at staff meetings
Southeast Health Center	X	X	X	• None reported	• County patient encounter forms • State serology form	. Summary data discussed in staff meetings
N. Portland Health Center	X	X	X	• None reported	• County patient encounter forms • State serology form	• State reporting
Essex Planned Parenthood	X	x	X	• Client satisfaction form	• RA form, scan form, clinic visit record	• Improve services and state reporting
Stamford STD	X	x	X	• None reported	• CDCscan form	• State reporting; to assess if meeting needs of target population
Stamford WIC	X	x	X	• None reported	• CDCscan form	• State reporting to assess if meeting needs of target population
Yale-NH Hospital	X	X	X	. Seroprevalence survey	• CDC scan form, HIV CT intake record, RA questionnaire, RA checklist, inpatients referral form, monthly client logs for pretest and posttest	• Research, state reporting
St. Petersburg Women's Health Center	X	X	X	• None reported	• CDCscan form • State lab form	• State/district/county reporting

Table 4D
Pretest Counseling

Women's Health Centers	Individual or Group Session	Duration of Pretest Counseling	Condoms Provided/ Demonstrated	Pretest Counseling Observed
East County Health Center	• Individual	. 20 minutes	. Provided	• No
Southeast County Health Center	. Individual	. 15 minutes	. Provided	• No
N. Portland Health Center	. Individual	. 20 minutes	. Provided	• No
Essex Planned Parenthood	. Individual	. 20-45 minutes	. Provided, demonstrated	• No
Stamford STD	. Individual	. 20-30 minutes	. Provided	• 1 session
Stamford WIC	• Individual	. 20-30 minutes	. Provided	• 1 session
Yale-NH Hospital	. Individual	. 20-30 minutes	. Provided	• 1 session
St. Petersburg Women's Health Center	. Individual	. 30 minutes total for both history and pretest counseling	• Provided; foam and sponges also provided	• No.

Table 4E
Risk Assessment

Women's Health Centers	Purpose of Risk Assessment	Risk Assessment Instruments	When Risk Assessment Occurs/By Whom
East County Health Center	• Data collection • Determine need for HIV CT and discuss risk behaviors	• County risk assessment form	• During initial history taking exam
Southeast Health Center	• Data collection • Determine need for HIV CT • Identify individual risk	• Risk assessment form	• At entry to clinic; pretest counseling
N. Portland Health Center	• To determine need for HIV CT • Identify individual risk • Data collection	• Risk assessment form	• **Nurse,** during initial clinical assessment
Essex Planned Parenthood	• To determine need for HIV CT	• Risk assessment form	• At intake by FP counselor
Stamford STD	• To direct discussion about individual risks	• State form for risk assessment	• HIV counselor, pretest
Stamford WIC	• To direct discussion about individual risks	• State form for risk assessment	• HIV counselor, pretest
Yale-NH Hospital	• Tailor discussion to individual risk; research purposes	• Risk assessment questionnaire and checklist	• HIV counselor, pretest
St. Petersburg Women's Health Center	• Data collection • Identify individual behaviors for education/counseling	• CDC scan form categories	• History-taking and pretest counseling/nurse

Table 4F
HIV Testing

Women's Health Centers	When/Where HIV Blood Draw Occurs	Who Draws Blood	Return Arrangements	Follow Up	Lab/Turnaround
East County Health Center	• In lab, single stick for all purposes	• Lab tech	• Staff makes appointment in 2 weeks or during next scheduled visit	• Reminder letter sent after 30 days	• State/2 weeks
Southeast County Health Center	• In lab, single stick for all purposes	• Lab tech	• HIV-negative results placed in client's chart to be delivered by provider at next visit. • HIV-positive clients contacted by DIS	• Reminder letter sent after 30 days	• State/2 weeks
N. Portland Health Center	• Nurse draws at end of counseling session	• Nurse	• Client makes appointment in 2 weeks or during next scheduled visit	• Reminder letter sent after 30 days	• State/10 days
Essex Planned Parenthood	• In lab, usually single stick, on occasion a second stick is needed	• Lab tech	• Client told to call in 2 weeks for appointment	• Reminder letter sent at time client misses appointment	• State/2 weeks
Stamford STD	• STD exam	• Nurse	• Appointment made for return in 2 weeks	• Reminder letter • Speaks to client in clinic	• State/2 weeks
Stamford WIC	• At end of counseling session, in office	• HIV counselor	• Appointment made for return in 2 weeks	• Reminder letter • Speaks to client in clinic	• State/2 weeks
Yale-NH Hospital	• After counseling session, in lab in abjacent building	• Phlebotomist	• Results scheduled for next return clinic visit	• HIV counselor collaborates with continuity of care coordinator in women's center to locate no shows	• State/2 weeks
St. Petersburg Women's Health Center	• Central lab, single stick	• Lab tech	• Appointment made for return visit in 2 weeks	• HSR contacts HIV positive in the field	• State/2 weeks

Table 4G
Posttest Counseling

Women's Health Centers	Same Counselor for Pre and Posttest Counseling	Duration of Posttest Session: Positive & Negative	Additional Posttest Sessions	Retesting Recommendation	Counseling Observed
East County Health Center	• Yes for negative; county DIS gives positive results	• Negative: 15 minutes • Positive: 45 minutes	• For HIV positive clients through referral to county HIV wellness clinic	• 6 months	• None
Southeast Health Center	• Yes for negative; county DIS gives positive results	• Negative: 15 minutes • Positive: 45 minutes	• For HIV positive clients through referral to county HIV wellness clinic	• 6 months	• None
N. Portland Health Center	• Yes for negative; county DIS gives positive results	• Negative: 15 minutes • Positive: 40 minutes	• For HIV positive clients through referral to county HIV wellness clinic	• 6 months	• None
Essex Planned Parenthood	• Yes	• Negative:15 minutes • Positive: 45 minutes	• Available upon request	• 6 months	• 3 posttest negative sessions
Stamford STD	• Yes	• Negative: 20 minutes • Positive 30-60 minutes	• Sometimes, varies with client need	• 3 months if client was exposed within past 6 months, note in chart reminds counselor to bring up in posttest	• Yes
itamford WIC	• Yes	• Negative: 20 minutes • Positive: 30-60 minutes	• Sometimes, varies with client need	• 3 months if client was exposed within past 6 months, note in chart reminds counselor to bring up in posttest	• 1 posttest negative session
Yale-NH Hospital	• Yes for negative; medical resident, clinic social worker! join counselor for positive results	• Negative: 20 minutes • Positive: 40-65 minutes	• No	• 3-6 months for clients whose exposure was in "window" period • Periodically for all high-risk women	• None
St. Petersburg Women's Health Center	• Yes for negative; HSR gives positive results	• Negative: 5-10 minutes • Positive: 45-60 minutes	• For HIV positive clients, HSR averages 2-3 additional posttest sessions	• None, unless risk status changes	• 1 posttest negative session

Table 4H
Referral

Women's Health Centers	Source of Referrals	Services Provided Onsite	Services Offered by Referral Offsite	Major Gaps
East County Health Center	• STD/DIS	• Primary care • PNcare	• Mental health counseling • Medical evaluation and treatment through county HIV wellness clinic	• Low-cost inpatient DT for pregnant women or those with children
Southeast County Health Center	. STD/DIS	• Primary care • PNcare	• Mental health counseling . Medical evaluation and treatment through county HIV wellness clinic	• N/A-referrals handled by DIS from STD clinic
N. Portland Health Center	. STD/DIS	• Primary care • PNcare	• Mental health counseling • Medical evaluation and treatment through county HIV wellness clinic	• N/A-referrals handled by DIS from STD clinic
Essex Planned Parenthood	• Case manager at state treatment assistance program	• FP • STD (limited) • Pregnancy care	• Case management • Medical care	• On-site HIV case management
Stamford STD	• HIV counselor	● SID . Ob/gyn • Pregnancy tests	• Medical • Social services • Dental services	• Case management, early intervention (medical) services, especially for women
Stamford WIC	• HIV counselor	• WIC services	. Medical • Social serwices	• Case management, early intervention (medical) services, especially for women
Yale-NH Hospital	• Clinic social worker	• HIV clinic affiliated	• MH • DT • Pediatric care for children of clients	• Affordable, HIV-sensitive mental health services • Housing
St. Petersburg Women's Health Center	. HSR	• HIV medical evaluation and treatment • Primary care • TB screening and treatment • STD screening and treatment • Family planning/maternity	• Drug treatment • Support groups • Social services	• None identified

Table 41
Partner Notification

Women's Health Centers	Patient Referral	Provider Referral/ Who Elicits and Who Notifies	When Topic is Introduced
East County Health Center	• Refer to STD/DIS	• STD/DIS	• Posttest counseling
Southeast County Health Center	• Refer to STD/DIS	• STD/DIS	• Pretest counseling
N. Portland Health Center	• Refer to STD/DIS	• STD/DIS	• Posttest counseling
Essex Planned Parenthood	• Patients encouraged to tell partner	• NAP (referrals made on occasion)	• Posttest counseling
Stamford STD	• Patients encouraged to tell partner; communication skills discussed	• CARE team referral offered	• Pre and posttest counseling
Stamford WIC	• Patients encouraged to tell partner; communication skills discussed	• CARE team referral offered	• Pre and posttest counseling
Yale-NH Hospital	• Patients encouraged to tell partner; communication skills discussed	• CARE team referral offered	• Pre and posttest counseling
St. Petersburg Women's Health Center	• Patients encouraged to tell partner	• HSR	• Posttest counseling

B. Discussion of Each Site Type

5. Tuberculosis (TB) Clinics

a. Overview of the Site Type

Many individuals thought to be at heightened risk for tuberculosis are also at risk for HIV due to high prevalence levels of both infections. Injection drug users (IDUs) and medically underserved low-income groups are among those most at risk for tuberculosis (TB) and HIV.' HIV-positive individuals are more susceptible to TB infection because of their compromised immune systems, and TB screening is routinely recommended for individuals whose HIV test results are positive. For TB clinic staff, knowledge of a TB patient's HIV status influences the therapy for TB treatment and prevention. More recently, concern about the interaction of HIV and TB has grown as more individuals are found to be co-infected. HIV testing in TB clinics has been recommended since 1987.

Two TB clinics were visited for this study: Westside TB Clinic, a county health department clinic in Portland, Oregon, and the Pinellas County Public Health Unit's TB Clinic in St. Petersburg, Florida.

History of Services

Westside TB clinic began offering HIV counseling and testing services in 1988, while the Pinellas County clinic has offered these services. since 1989 to those who come to the clinic for routine screening for school or employment reasons. In response to TB clients' requests for HIV testing, Pinellas TB clinic staff asked the health center's medical director to obtain approval for providing this service within the clinic. Both clinics offer standard TB evaluation and monitoring for active cases and preventive therapy for infected individuals.

Clientele

At the Westside clinic, clientele are divided into three main groups: single males with substance abuse and/or mental illness histories (who are often shelter residents), Southeast Asian and Korean immigrant directed to the clinic by the INS for Class B TB screening, and elderly native-born Americans who were infected in childhood but succumb to TB as their immune systems falter. A few women and children are seen in the clinic, but most clients are male. The group of males with substance abuse and mental illness

[1] CDC. 1990. A strategic plan for the elimination of tuberculosis in the United States. *MMWR* 38(16):269-72.

problems has changed the most over time. Formerly this group consisted almost exclusively of older, late-stage alcoholics, but it now includes growing numbers of younger men with more drug use problems and less alcohol use. Many of the younger men are Hispanic. In response to changes in clientele, a bilingual/bicultural outreach worker now works for the clinic and conducts TB education as well as recruitment.

The Pinellas County clinic's clientele is multi-racial and equally divided among men and women from all age and socioeconomic groups. Many Central American, Southeast Asian, and Eastern European refugees are seen in the clinic and account for many of the 30 to 50 clients seen each day. Clients from higher income brackets are referred by private doctors because TB treatment is free at the health center. Among clients who present for skin testing because of school or job requirements, many are teenagers. Although HIV testing is not routine for routine skin tests, staff try to provide as much AIDS education as possible to teenagers seen in the clinic and make an effort to provide them with condoms.

b. Program Management Issues

Integration of Services

Westside staff recognize that TB patients represent a group at high risk for HIV who wouldn't be identified otherwise, and that HIV potentially affects preventive therapy. Both state and Centers for Disease Control (CDC) guidelines encourage HIV counseling and testing for all TB cases, and these guidelines have been followed at the clinic. However, risk assessments for HIV are offered more frequently now than in the past. Staff report that although the volume of HIV testing in the clinic is low, TB nurses are seeing more and more HIV-positive clients (referred from other clinics or physicians), and every nurse has directly or indirectly come into contact with a patient who is HIV-positive. This has made the existence of HIV more real to them. HIV risk assessment has recently become a more routine part of interviews with preventive therapy clients as well as confirmed cases.

For confirmed TB cases, TB nurses (who have extensive contact with the patient because of their case management function) conduct pretest counseling and draw blood for the HIV test. If confirmed cases are reluctant to discuss HIV issues with the TB nurse, they are referred to the county counseling and testing sites (CTS), located on the same floor as the clinic. All preventive therapy clients are offered HIV counseling and testing, but by referral to the same CTS.

At Pinellas County TB Clinic, HIV counseling and testing are considered essential to TB services because of the strong association between HIV and TB infection. HIV counseling and testing are strongly encouraged for all new TB patients as well as those being treated preventively. HIV lab and scan forms are included in the packet used to open new cases. In particular, staff are committed to offering HIV counseling and testing to clients who come in for routine TB screening, even though they are not "regular" TB patients (i.e., confirmed cases or preventive therapy patients). Staff consider the provision of HIV

counseling and testing to routine screening clients a service that can help prevent future susceptibility to TB.

Staffing Issues

Staffing issues are summarized in Table 5B.

Five nurses act as case managers for confirmed cases at Westside and are trained to conduct counseling and testing. Because the volume of testing is low, nurses report that it is difficult to maintain HIV counseling skills and current levels of information. More systematic refresher courses would be helpful. In addition, staff suggested that specific training regarding how to approach clients about risk behaviors would be helpful. Two additional nurses conduct HIV risk assessments for preventive therapy clients, but not pretest counseling or testing. A bilingual/bicultural outreach worker is also part of the staff and provides TB education as well as recruitment of clients.

One full-time and two part-time senior community health nurses and a full-time LPN staff the Pinellas County TB clinic. The community health nurses provide pretest and posttest negative counseling. In the rare case that HIV results come back positive, the client is seen by the health center's HIV specialist/health services representative (HSR) for posttest counseling and referral. Recently, the clinic lost its only field worker, who had been responsible for monitoring compliance with medication regimens in the field.

Confidentiality/Anonymity

Both clinics offer confidential testing onsite (see Table 5A). Preventive therapy clients at Westside are referred to the CTS on the same floor, where they may choose either confidential or anonymous testing. At Westside, informed consent for onsite testing is obtained verbally, while at Pinellas clients must sign an informed consent form during pretest counseling. Results are kept in the TB chart.

Data Collection

Data collection issues are summarized in Table SC.

The Westside TB clinic is part of a computerized state and county data collection system. Since June 1991, Westside staff have been able to note HIV risk assessment on the county's standard client encounter form, which is then entered into the computerized system. At the county level, data are available on HIV results for TB cases, numbers tested, numbers positive, and numbers negative. Data are also available on the number of TB cases who are HIV-positive and the number who have been diagnosed with AIDS. Staff report that the aggregate data are helpful, but there is currently no way to track outcomes such as whether or not clients kept appointments.

Seroprevalence data are used informally. For example, staff are aware of high seroprevalence rates among IDUS and are concerned that this same community is at risk for TB. Based on seroprevalence trends, staff closely monitor TB cases among IDUs.

At the Pinellas County clinic, scan forms are completed on all clients who accept HIV testing and on confirmed TB cases who refuse HIV counseling and testing. (Scan forms are not completed for patients on preventive therapy who refuse HIV testing.) The state lab form is also completed for clients who accept testing. The lab form is completed while the patient is in the clinic, while the scan form is compiled later using data from the medical record and lab form.

c. Delivery Issues

Entry

Walk-in Services. Both clinics offer services on a walk-in basis, although preventive therapy clients at Westside are seen by appointment. A TB Express room is also available for patients who are currently on preventive medication or case therapy; they can bypass the check-in desk and receive medication without waiting. In both clinics, waiting time for walk-ins is minimal--usually less than 15 minutes.

Fees. At Pinellas County TB clinic there is no additional charge for HIV counseling and testing for TB patients, although some fees apply to other services such as x-rays and skin tests. Although clinic staff do not offer HIV tests to clients who come in for school or work-related screening, they will provide it upon request for about $10. Most are young people with multiple partners, who may not have an obvious risk but state that they "just want to know." Staff speculate that recently increased demand for HIV tests among this group might be a reflection of higher charges elsewhere. For example, HIV testing costs $20 at the sexually transmitted disease (STD) clinic and $30 at the CTS located within the health center. At Westside there is no charge for HIV testing and clients are charged on a sliding scale basis (with a $1 minimum) for other services. No one is denied services because of inability to pay.

Risk Assessment. Risk assessment issues are summarized in Table 5E. At the Pinellas County TB clinic, risk assessment for both TB and HIV is part of the history and interview process. Risk information is obtained through the regular family history for new TB cases, which includes questions about injection drug use. The history form for preventive cases includes a section on HIV status. The TB nurse is able to determine an individual's risk for HIV based on the history, but HIV counseling and testing are encouraged even if there is no apparent risk. Staff use the lab form for risk assessment during pretest counseling, but would like to have a risk assessment instrument that is better suited to interviewing TB clinic clients.

At Westside, risk assessment occurs as part of pretest counseling for confirmed cases, with the TB nurse usually choosing to wait until the patient knows and trusts her before raising

the issue of HIV. She believes that this enables her to get a better, more accurate history. HIV risk assessment for preventive therapy patients occurs in the clinic. Clients are asked to review and (anonymously) fill out a risk assessment form. The nurse who conducts these sessions reported that sometimes clients will admit to a risk behavior such as IV drug use during the risk assessment but not in'other parts of the process. Clients are told that everyone is asked to fill out the risk assessment form; no one is singled out because of appearance, lifestyle, or acknowledged risk behaviors for the HIV risk assessment.

Pretest Counseling

Pretest counseling issues are summarized in Table **5D.**

At the **Pinellas** County TB clinic, pretest counseling occurs during the initial TB assessment for new patients. The TB portion can take up to an hour, and usually another 15 minutes are allotted for HIV pretest counseling. The nurse gives the patient information about HIV/AIDS transmission, establishes the client's level of knowledge about HIV/AIDS, and tries to determine whether or not the client perceives any risk. The test itself is explained, with some discussion of the "window period". Staff recommend that clients be retested in 3 months. Informed consent is obtained in writing if the client chooses to be tested. Once testing has been accepted, the risk categories on the lab form are reviewed. Staff report that reviewing risk categories can "put people off."

During pretest counseling for confirmed TB cases at Westside, the nurse explains how the course of TB can be changed by HIV infection. If the client resists talking about HIV/AIDS, the nurse refers the client to the CTS (located on the same floor). In general, both pre and **posttest** counseling at the CTS are more thorough than the sessions provided by the TB nurses, and referrals to the CTS are cornrnon. Staff suggested that one reason why clients do not accept HIV counseling and testing is their reluctance to face an additional diagnosis, having just been told they have tuberculosis.

Testing

Testing issues are summarized in Table **5F.**

Clients who are tested at **Westside** have their blood drawn by the **TB** nurse in the exam room; samples are then forwarded to the state lab along with a completed serology form. Clients are asked to return in ***2*** weeks to receive their results in person, from the same nurse (who is their TB case manager).

At Pinellas County TB clinic, clients have blood drawn in the health center's lab, along with blood or other lab work required for any other health tests ordered during their visit. Blood samples for HIV tests at all the health center clinics, including the TB clinic, are forwarded to the state by the HSR, who also receives results and then forwards them to the appropriate clinics.

Posttest Counseling

Posttest counseling issues are summarized in Table 5G.

Negative Results. Posttest negative results are given by the same nurse who provided pretest counseling and testing at Westside. County counseling protocols are followed; these include an explanation of the window period and a review of risk reduction measures. Retesting recommendations are not routine.

At Pinellas, posttest negative counseling is scheduled and provided by the TB nurse during the client's next regular visit. Staff report that clients who do not return for treatment (and consequently for HIV results) are a significant problem, especially now that the clinic no longer has field staff available for followup. Clients are seen monthly for medication, but if a client comes in before a regular visit, a nurse pulls the client's chart and gives the results (if they are negative). Generally, it. takes between 2 to 4 weeks for results to be entered into a client's chart because they are sent to the Health Services Representative (HSR) first. During the session, the nurse covers the client's risk behaviors, discusses staying safe, and reviews the meaning of the test. Condoms are discussed and provided, especially when the client is a teenager or an individual at risk because of multiple partners or prostitution.

Positive Results. In Oregon, positive results are usually delivered by an experienced disease intervention specialist (DIS) based in the STD clinic, which is located on the floor above the TB clinic in the county health department offices. Posttest positive results are rare, but DIS follow the county protocol and emphasize referrals to existing services.

In Pinellas County, the health center HSR receives results back from the lab. If the results are positive, the HSR goes into the field to deliver results to the client.

Referral

Referral issues are summarized in Table 5H.

At the Westside TB clinic, the key referral is to the county's HIV Wellness Center, which is located on the same floor as the TB clinic. Medical evaluation and ongoing care is available through the Wellness Center, and DIS can walk HIV-positive clients from the TB clinic directly to the HIV clinic. A variety of hotlines, support groups, and local advocacy organizations are standard referrals; the DIS customizes a list of these depending on client needs.

In Pinellas County, the HSR is responsible for recommending referrals as part of posttest positive counseling in the field. The health center has an HIV clinic onsite (PAMS), and HIV-positive clients identified through any health center clinics are referred there for T-cell counts and treatment. Clients can continue to be treated after their T-cell counts fall below 500.

Several CBOs are closely linked to the health center. These include the Black Nurses Association, People of Color, and the HIVies (an Hispanic community organization), among others. Members of an HIV-positive volunteer group offer moral support and assistance to HIV positive clients through the HIV clinic.

Partner Notification

Partner notification issues are summarized in Table 51.

Oregon law makes a distinction between aware and unaware partners; DIS focus on notifying unaware partners that they may have been exposed to HIV/AIDS and should come in for free HIV counseling and testing. DIS can assist the client if s/he requests assistance with notifying aware partners.

In Pinellas County, counseling and assistance with partner notification are provided by the HSR. The HSR reports that clients seem more able to discuss partner notification during a later session, but not during the initial posttest session when results are first provided.

Technical Assistance/Other Needs

At Westside TB clinic, a bilingual/bicultural outreach worker provides TB education to homeless men, many of whom can be found in shelters and have histories of drug and alcohol use and mental illness. Incorporating HIV education into outreach work is difficult, because there is so little privacy available in shelters and on the street for pretest counseling or risk assessment.

Nurses at the Westside TB clinic would like to have more systematic refresher courses available that would enable them to stay up-to-date on HIV issues in spite of the low volume of HIV activity within the TB clinic.

At Pinellas County TB Clinic, staff are concerned that ventilation and lighting requirements are not met in the clinic's current facilities. In particular, staff are concerned about the danger this represents clients with suppressed immune systems, who are seen in the clinic alongside active TB cases, but it is also dangerous to staff and other clients. In addition, current facilities offer little or no privacy for both HIV and TB interviews and counseling.

Table 5A
Confidential or Anonymous Testing

Tuberculosis Clinics	Confidential or Anonymous	Informed Consent	Who Has Access to Results
Westside TB Clinic	• Confidential • Anonymous available by referral to CTS	• Verbal	• TB nurse and DIS/STD, if positive
Pinellas County TB Clinic	• Confidential	• Signed	• Results are kept in TB chart

Table 5B
Staffing Issues

Tuberculosis Clinics	Staff Role/Background			Partner Notification	HIV Counselor Training	Quality Assurance
	Education/Outreach	Counseling and Testing	Referral/Case Management			
Westside TB Clinic	• 1 bilingual/ bicultural outreach position	• 5 TB nurses (pretest counseling and TB case management) . 2 RNs conduct risk assessments • STD/DIS conducts posttest positive sessions	• TB nurses and STD/DIS	• STD/DIS	• HIV counselor training and conferences	• Lead nurse observes sessions as part of routine evaluation
Pinellas County TB clinic	• No TB clinic worker; but HIV clinic worker does community outreach	• 3 community health nurses . 1 LPN	. HSR . PAMS (HIV clinic) social/case worker	• HSR	. HRS HIV training course	• Initial participation in counseling by other trained nurses . Nursing supervisor observes when possible

Table 5C
Data Collection

Tuberculosis Clinics	Kinds of Data Collected				Forms Used	Use of Data
	Risk Exposure	Demographic Data	CT Steps	Other		
Westside TB Clinic	X	X	X	• None reported	• County patient encounter form • State serology form	• County/state reporting • Monitor seroprevalence rates among persons at risk for TB/HIV
Pinellas County TB Clinic	X	X	X	• None reported	• CDC scan form • State lab form	• State reporting

Table 5D
Pretest Counseling

Tuberculosis Clinics	Individual or Group Session	Duration of Pretest Counseling	Condoms Provided/ Demonstrated	Pretest Counseling Observed
Westside TB Clinic	. Individual	• 20 minutes	• Provided	• None
Pinellas County TB Clinic	. Individual	•15 minutes	• Provided; demonstrated if needed	• None

Table 5E
Risk Assessment

Tuberculosis Clinics	Purpose of Risk Assessment	Risk Assessment Instrument	When Risk Assessment Occurs/By Whom
Westside TB Clinic	• To identify preventive therapy patients who should be referred to CTS on-site and to increase awareness of risk behaviors,	• Risk assessment form	• Routinely conducted during INH appointment for preventive therapy/nurse.
Pinellas County TB Clinic	• Data collection • Screen for HIV testing	• CDC scan form • Section on history form • State lab form	• Part of TB history and interview process/nurse

Table 5F
HIV Testing

Tuberculosis Clinics	When/Where HIV Blood Draw Occurs	Who Draws Blood	Return Arrangements	Follow Up	Lab Turnaround
Westside TB Clinic	• At end of pretest counseling	• Nurse	• Next visit or return in 2 weeks	• Nurse/TB case manager follow up at next session	• State/2 weeks
Pinellas County TB Clinic	• In central lab; single stick	• Lab technician	• Negative results provided by nurse during next regular visit	• HSR contacts HIV positive in field	• State/2 weeks (may take 4 weeks for negative results to reach TB chart and be given to client)

Table 5G
Posttest Counseling

Tuberculosis Clinics	Same Counselor for Pre and Posttest Counseling	Duration of Posttest Session	Additional Posttest Sessions	Retesting Recommendations	Counseling Observed
Westside TB Clinic	• Yes	• Negative: 15 minutes • Positive: 40 minutes	• Through referral to HIV wellness clinic	• None	• None
Pinellas County TB Clinic	• No--HSR conducts all posttest positive counseling	• Negative: 10 minutes • Positive: 45-60 minutes	• Additional sessions for HIV positive by HSR	• 8 weeks after last exposure and retested in 3 months	• None

Table 5H
Referrals

Tuberculosis Clinics	Source of Referrals	Services Provided Onsite	Services Offered by Referral Offsite	Major Gaps
Westside TB Clinic	. STD/DIS • TB nurse	• Immediate referral to HIV wellness clinic on same floor for medical evaluation, treatment, extended counseling	• Support groups • Hotlines	. N/A--DIS typcially handles referrals for HIV positive clients
Pinellas County TB Clinic	. HSR	• HIV clinic for medical evaluation/treatment • Primary care • STD • Family planning/maternity	• Support groups • Mental health services • Drug treatment	• None identified

Table 5I
Partner Notification

Tuberculosis Clinics	Patient Referral	Provider Referral/Who Elicits and Notifies	When Topic is Introduced
Westside TB Clinic	• STD/DIS	• STD/DIS	• Posttest positive counseling session
Pinellas County TB Clinic	• Clients encouraged to tell partners	• HSR	• Posttest positive counseling session

B. Discussion of Each Site Tvpe

6. Primary Care Facilities

a. Overview of the Site Type

Because several of the sites visited for this study described their services as primary care, we have grouped them for purposes of analysis under the heading "primary care facilities."

In Florida, state legislation has mandated that health departments provide primary health care for those who cannot obtain such services due to lack of income or other barriers.

Oregon clinics included in this group are part of a network of county public health departments which have described their function as providing primary care and other services. The Newark Community Health Center is one of five Federally funded primary health care satellite health clinics located throughout the city.

These clinics have been examined as a separate group to provide insight on issues particular to sites in which HIV services constitute one of a wide range of preventive and acute services. The names and locations of sites included in this category are listed below:

Oregon

Southeast Health Center
Portland, OR

North Portland Health Center
Portland, OR

East County Health Center
Gresham, OR

Jackson County Health Department
Medford, OR

Florida

Lee Davis Health Center
Tampa, FL

New Jersey

Newark Community Health Center
Newark, NJ

All clinics visited provide primary care for children and adults, family planning, prenatal and WIC services. Sexually transmitted disease (STD) and tuberculosis (TB) services are provided at both Lee Davis and the Jackson County Health Department in Oregon. In both the Newark and Lee Davis clinics, HIV medical evaluation and treatment are provided onsite. For HIV positive clients, some counseling support is available at Lee Davis and the clinic is co-located with social services. The Newark clinic directly offers case management and other social services such as support groups, drug addiction assessment and advocacy.

Health care services are offered mainly by appointment; however, waits may still be long. Walk-ins are generally accepted if the need is urgent. HIV counseling and testing are included among available services. Of sites visited, only the Florida primary care facility charges a fee ($20) for HIV counseling and testing services, though payment may be waived.

Histo y

Both the Jackson County Health Department and the Newark Community Health Center began offering HIV counseling and testing shortly after the antibody test became available.

The Jackson County Health Department began providing HIV counseling and testing services in 1985 for referrals from the Red Cross. Services were expanded in response to increasing numbers of referrals, as well as assistance from the state. Since 1987, STD and communicable disease clients have been routinely offered HIV counseling and testing services. At present, HIV counseling and testing are available to clients of all clinic services. Other Oregon sites (Multnomah County) have been providing counseling and testing for about 2 years.

The Newark Community Health Center began HIV counseling and testing in 1986 with availability of funding. However, clients were initially referred to test sites at local hospitals.

At present, a comprehensive range of HIV services is available to all clients onsite. Federal and state demonstration projects and programs have influenced this site's ability to provide comprehensive medical and psychosocial services.

The Lee Davis clinic is one of nine primary health care centers located throughout Hillsborough county. HIV counseling and testing have been available since 1989, when the health department made HIV specialists (health services representatives or HSR)

available to neighborhood health centers on a scheduled basis. Since decentralization of comprehensive health care throughout the county began in 1990, the center has had its own full-time HSR to oversee HIV services. Decentralization is considered important for HIV services because neighborhood centers are more accessible to patients, care of asymptomatic HIV infected patients is less costly and the single county HIV clinic is not large enough to serve both asymptomatic and symptomatic patients. HIV services county-wide are conceptualized on a continuum from counseling and testing through specialized medical care. Primary care facilities provide counseling and testing as well as primary medical care for those who are HIV positive but asymptomatic.

Clientele

Many of the sites visited report serving a predominately female client population in which HIV seropositivity is relatively low. The exception is the Newark clinic where the population reflects the areas very high seroprevalence.

In Multnomah County sites, clients are primarily Caucasian women of child-bearing age who come to the clinic for gynecological, family planning, prenatal or WIC services. In Jackson County, clients represent a broader range of age, race/ethnicity and service needs. However, like clients of other Oregon clinics, most offered HIV counseling and testing report heterosexual risk with concerns about multiple partners. This represents a shift from an earlier clientele in Jackson County STD and communicable disease clinics whose exposure was primarily through gay homosexual activity. However a consistent proportion of clients in Jackson County continue to be gay men. An increasing number of clients identified through outreach or other clinic services have injecting drug use histories. Among clients identified through outreach and STD screening, more multiple high risk behaviors are common, e.g. injecting drug use combined with prostitution and high risk partners. Staff note that alcohol and drug use are a factor in risky behavior regardless of whether the clients are addicted or not.

Lee Davis clients are approximately 80 percent female, of whom 75 percent are African-American. However, with the expansion of primary care services staff report an increasing number of men and a wider age range among the population served. Primary care draws older clients; while family planning, maternity and STD continue to draw younger clients. The clinic population is generally a high risk population with a high proportion of individuals with STDs, multiple partners and problems with drug use. However, the overall seropositivity of clients tested at Lee Davis is estimated at 2.5 to 2.8 percent.

The Newark Community Health Center reports a client population which is just over half African-American, with another 40 percent Hispanic and the remainder Caucasian. Because the health center provides ob/gyn and other services for women and pediatric care for children, clients include a large number of low income women who are single heads of households. Injection drug users are sent from local treatment programs for comprehensive medical care, but tend to be HIV antibody tested within the treatment

program. The Spectrum Drug Treatment Program in Newark is within five blocks of the health center.

b. Program Management Issues

Integration of Services

Although counseling and testing are available in all sites visited, only at Lee Davis is this routinely offered to clients who do not request it. In Florida, the state program goal is that HIV counseling and testing be offered to all new clients and that at least 80 percent accept.

At the Newark Community Health Center, all ob/gyn clients are offered counseling and testing; at the East County clinic in Oregon it is routinely offered to those coming in for STDs. Other clients in Newark and East County, and in all the other Oregon sites, are screened for HIV risk before being offered HIV counseling and testing. In two Oregon sites and in the Newark site, a risk assessment questionnaire is completed by the client at intake and reviewed by the interview nurse or clinician to determine the need for HIV services.

At the Southeast Health Center in Portland, those coming for HIV testing only are referred to a freestanding counseling and testing sites (CTS) elsewhere. In Jackson County, HIV services are provided through a freestanding anonymous test site open 2 days a week at the clinic, as well as included with other clinic services on a confidential basis.

HIV staff providing pretest and posttest negative counseling are often public health nurses who have received standard HIV training through state or county-sponsored programs. HIV services are offered in the course of providing other routine services for which the client has come to the clinic. The single exception is the Newark clinic which has a team of HIV specialists. Each department has an assigned HIV counselor who conducts pre and posttest counseling for clients seen there. Initially, when a client needed to be assessed for HIV risk, the medical staff would conduct the assessment. A nurse or a physician would talk with the client about risk behaviors and would determine if an HIV antibody test was necessary. Presently, clients are assessed by the social services staff during their initial visit. Specialized HIV staff conduct pre and posttest counseling for all clients. Nurses and physicians still talk with clients about risk behaviors, however their efforts now focus on the clients' medical management.

Posttest positive counseling is handled by specialized HIV staff in four of the six sites. A disease intervention specialist (DIS) from the STD clinic conduct posttest counseling and followup in two Oregon sites; the trained HIV counselor/HSR does it at Lee Davis; and Newark posttest counseling for both positive and negative clients is conducted by specialized HIV staff who also do pretest counseling. At Lee Davis, Newark and the Jackson County, HIV medical evaluation and treatment are available onsite. Assistance

with notifying partners often involves Disease Intervention Specialists from a nearby STD clinic.

Staffing Issues

For the most part, HIV pretest and posttest negative counseling is being provided by nurses and clinicians who also have other patient care responsibilities in the various clinics within the primary care facilities visited. In one clinic, the lead nurse noted how difficult it is for health assistants, nurses and providers to give HIV issues equal time with other competing tasks that must be completed during the same brief time period. HIV pretest and posttest negative counseling is generally included in routine interactions with clients. Posttest positive counseling and subsequent referral and care, however, are handled by specialized HIV staff in three of the six clinics visited. In two Oregon sites, this function is referred to DIS staff who come from a nearby STD clinic.

Only in the Newark site is there a distinct seven&member HIV team composed of a variety of HIV specialists, some of whom also have other clinic duties. In addition to a team leader, the group consists of an HIV counselor, substance abuse counselor, social worker, nutritionist, health educator and outreach worker. Individual staff are assigned to a specific clinic to provide counseling and testing; however they may substitute for one another in this role. In addition specific staff have been identified as key HIV resources for the center as a whole. The team meets with the clinic physician weekly to review HIV cases.

Quality assurance occurs through chart review in one site. In others occasional observation by the nursing supervisor or HIV specialist is conducted. The Florida HSR keeps an eye on testing acceptance rates for various nursing staff and tries to serve as a resource for those who want some advice and support.

Several issues were identified particularly for nurses providing HIV counseling at Lee Davis. Burnout from the general workload coupled with working with multiproblem HIV positive patients is a problem. Several sites commented on the number of multiproblem clients and the increasing complexity of cases. In addition, some staff have difficulty handling lifestyle differences and in discussing sexual behaviors with comfort. Although training and experience can help, there is a continuing need to deal with this issue.

Among the qualities sought in an HIV counselor in Oregon sites, in addition to an ability to be nonjudgmental, are an open and nonthreatening style, an ability to convey concern about the patient and to make suggestions the patient can accept. An adequate knowledge base was also mentioned as important.

While all staff providing HIV services have received special training to do so, the training varies considerably. Staff in one site noted that it is difficult to provide consistent training for all staff. Finding funds and time for nurses to be away from their duties is hard, and new staff are being oriented to a variety of topics, of which this is only one.

An important support need is one for continuing education. One counselor commented that patients are increasingly well-informed and it is important for counselors to be current. Informal networking, sharing articles and information among staff, and occasional inservice training which includes HIV content are some ways primary care staff try to stay current.

Table 6B displays the number and background of staff providing HIV services, as well as the training required of HIV counselors.

Confidentiality/Anonymity

For the most part, primary care facilities provide confidential HIV testing. Of the two which also offer anonymous testing, one provides this service through a freestanding CTS onsite which is open two afternoons a week. The other reports that anonymous testing is rarely requested. Those who do request anonymous testing must still provide a name and address at intake to obtain other clinic services. In only two clinics, test results are kept in the client's file; others maintain separate files for HIV records.

The table below displays the approach to confidential and anonymous testing in each center, as well as the means by which informed consent is obtained and access to results.

Data Collection

Data collection and reporting on HIV activities is required in all primary care facilities visited. In Oregon sites, individual patient encounter forms are used to report all pretest sessions to the county which returns quarterly summary data to each clinic. In addition, state serology forms are forwarded to the state for each client tested. Sites in Oregon reported more use of data for internal program review and planning than others.

At the Lee Davis clinic, data collection is a prominent part of the job of the HIV specialist/HSR. She has assembled an HIV package to be included in the chart for each new patient. The package includes both Centers for Disease Control (CDC) and state data collection forms, which she has precompleted as much as possible (e.g. "female" is checked for family planning clinic packages). Because a great deal of time may be spent checking and correcting scannable forms so they will not be rejected by the computer, she finds it more efficient to precomplete whatever is possible. Forms remain in the chart, are completed by the regular provider as the patient moves through the clinic, and are collected, checked and sent on by the HSR.

Like others interviewed in these sites, however, the Florida HSR does not receive regular reports back from data collected for state and Federal purposes and relies on internal, manual logs to track acceptance rates and returns of both test results and clients. She may request special reports from the state HIV office, but does not do so.

c. Service Delivery Issues

Entry

In Oregon and Newark primary care facilities, HIV counseling and testing is offered to those who are assessed to be at risk. Pretest counseling is provided to those who request it, if the intake worker notes a test is warranted, or if the provider, through further discussion with the client, thinks a test is needed. At Lee Davis, HIV services are routinely offered to all new intakes and offered annually to regular clients. Risk assessment is conducted as part of pretest counseling for reporting purposes and to assist in focusing the counseling session.

A risk assessment form is used in both Oregon and Newark sites; however administration varies. In Multnomah County sites, a county risk assessment form is administered by the interview nurse or provider to clients coming in for initial family planning visits, prenatal visits and annual exams. This form is sent to the county for reporting purposes. One Oregon site asks clients to complete an HIV questionnaire customized to prenatal, family planning and STD clients. The questionnaires are then reviewed with the client by the provider during the exam and serve as a basis for discussing individual risk. In Newark, clients are also asked to complete a risk assessment form which is reviewed by an intake nurse to determine if the client needs to see the HIV counselor when he or she is forwarded to the appropriate clinic.

Table 6E displays the purposes and instruments used for risk assessment purposes in the clinics visited.

Pretest Counseling

While initial risk exposure information may be obtained by intake workers, HIV pretest counseling is provided by trained HIV counselors in all primary care facilities visited. In Oregon sites this trained counselor is usually the clinician who sees the client for regular clinic services; however in one Oregon site a nurse/HIV counselor is brought in for pretest counseling after the provider has seen the client and established risk. In Florida, interview nurses provide pretest counseling as part of routine procedure. The HSR also conducts pretest counseling if there are walk-ins or overflow clients. Newark, as noted earlier, has HIV specialists assigned to each department to provide pre and posttest counseling.

Pretest counseling is conducted individually in all sites visited and averages 15 to 20 minutes in all but one. Newark counselors report spending as much as 30 minutes in the pretest counseling session. Because few clients are tested in most Oregon sites, observation of pretest counseling occurred in only one. Two pretest sessions were observed at Lee Davis: one conducted by the HIV specialist and one by a family planning nurse. One pretest session conducted by an intake worker was observed in the Newark health center.

Table 6D displays key features of pretest counseling in each of the primary care facilities visited and sites where counseling observation occurred.

Content and Approach. In both Oregon and Florida sites, county or state guidelines are used as a basis for content of the counseling sessions, though the extent to which all elements are covered depends on both time and the client's needs. Information about HIV/AIDS is generally provided and a standard list of risk categories on the state serology form is reviewed.

Counselors in Oregon sites report their clients are generally well informed about HIV transmission, particularly sexual transmission which is a major risk factor for clients of these clinics. This is true of both women who are at risk through heterosexual exposure and men at risk because of gay or bisexual activity. In the pretest session observed in an Oregon site, the client reported using condoms regularly and refused the counselor's offer of condoms, saying he did not need any from the clinic.

Confidentiality protection is also generally reviewed in Oregon pretest sessions; however, in at least one site serving primarily women the counselor reports it does not seem a major concern among clients. This same site reports that condom usage is difficult for many women to discuss, and that many, particularly Hispanic clients, are not interested in using them. Hispanic women report greater resistance by male partners.

Oregon counselors generally try to be sure the pretest counseling session provides clients with enough information about their risk and about the availability of testing to decide whether or not to be tested. Counselors in the Jackson County clinic emphasize the importance of presenting information in a way that is customized to the client's culture, background and gender so it is easily understandable. These pretest sessions also focus on trying to establish the client's specific risk behaviors and risk reduction measures and to reassure clients that a support system is available in the event a positive result comes back.

At Lee Davis, the counselor tries to make sure the patient knows enough to make a decision about his or her risk and understands what the HIV test means. While high acceptance rates for the test are a program goal, the counselor reports that an equally important message to communicate during pretest counseling is that "you can control your risk with some relatively simple actions." Condoms are only demonstrated if the counselor thinks there is a problem or a new user; however, foam and condoms are routinely given to women, even those on birth control pills. There is a clear distinction made between birth control and safety. In the observed pretest counseling session conducted with a female client, the counselor did demonstrate how to use the foam canister but not how to use condoms.

Pretest sessions observed in at Lee Davis differed considerably in amount and quality of information provided. One was conducted by the HIV specialist/HSR and the other by a relatively new family planning nurse. Both, however, focused on completing risk

categories on data collection forms, giving information about HIV and the antibody test, and obtaining signed consent. The HIV specialist asked more open-ended questions about the individual's behavior and attitudes, but did not pursue or confront information provided by the client. Little information was obtained from clients in any session about personal risk. There was little discussion of individual actions to be taken to reduce risk beyond generally recommending use of condoms and foam in the session conducted by the HIV specialist.

There was no discussion of risk reduction in the session conducted by the family planning nurse. In this session, HIV was clearly a relatively minor aspect of general history-taking and lab work requirements. Minimal information on HIV was provided, mainly related to specifics of the test, and no discussion of individual risk occurred.

The Florida counselor definitely believes that pretest counseling affects acceptance rates for HIV testing. Newer nurses who provide pretest counseling at the Lee Davis clinic generally have lower rates of acceptance initially. As they become more comfortable with discussing sexual aspects of risk, accept the value of the test, and realize it is part of the clinic routine, acceptance rates improve.

Testing

In most of the primary care facilities visited, blood is drawn by a lab technician who also draws blood for general clinic purposes with a single stick. At the Lee Davis clinic, STD clients have blood drawn by the STD practitioner.

In Multnomah County, a return appointment for test results is made as part of the routine clinic exit procedure for each client. In Jackson County, clients are asked to call in 2 weeks for an appointment at the onsite CTS for posttest counseling. At Lee Davis and the Newark clinic, a return date is given and the client is asked to call for an appointment. Newark provides a reminder card with the return date.

All clinics follow up on those who do not return if their results are positive. Positive results in Oregon clinics are referred to a Disease Intervention Specialist from the STD clinic for field contact. DIS also follow up on positive results at the Lee Davis clinic.

The Newark clinic makes a series of efforts to reach those whose results return positive. Three letters are sent, followed up by a visit from the clinic's outreach worker. If these efforts are unsuccessful, a certified letter will be sent and the name forwarded to the state Notification Assistance Program for followup.

For negative test results, Oregon clinics generally send a reminder letter within 30 days. At The East County clinic flags the client's chart with a note to "review lab results" so negative results will be provided at the client's next visit. The reminder letter is triggered if this does not occur. At Lee Davis, negative results are provided during the next routine visit to the clinic.

Some staff pointed out that clients may not return for results because they expect to be notified if test results are positive. This is consistent with clinic practice for other kinds of test results. At Lee Davis, the counselor thinks clients have become accustomed to HIV testing as "simply part of the clinic routine" and do not accord it a priority.

Testing issues are summarized in Table 6F.

Posttest Counseling

Posttest counseling sessions for positive and negative results are handled by different staff in all but one of the clinics visited. Negative results are typically given by the regular provider during the next routine visit if the client has not returned specifically for HIV results. Posttest negative sessions are estimated to last about 10 to 15 minutes. However, positive results are handled by more specialized staff. Only posttest negative sessions (one session in each of two clinics) were observed.

In Oregon, three of four clinics call in a Disease Intervention Specialist from the STD clinic to provide positive results. The fourth clinic plans to involve the DIS with the regular provider in giving positive results. To date, the clinic has not had a positive HIV test returned. At the Lee Davis Clinic, the HIV specialist/HSR provides all posttest positive results. Those clinics whose staff conduct posttest positive sessions reported an average duration of 45 minutes, with the Florida site reporting sessions may take as long as 3 hours.

Only at the Newark clinic do the same HIV staff provide both pretest and all posttest counseling. However, as described earlier, Newark HIV staff are specialists assigned to various clinic departments to provide HIV services.

At both Lee Davis and Newark, extended posttest counseling sessions are offered to those who test positive. Table 6G displays key features of posttest counseling in each of the primary care facilities visited.

Content and Approach. Both interview and observation confirmed that posttest negative sessions are brief and focus on discussing the meaning of the antibody test and the possible need for retesting within 6 months of the last exposure. This may translate into a message to the client to be retested within 3 to 6 months. Ideally the benefit of the negative test result is linked to the need to continue risk reduction activities. Condoms were offered or provided in all observed sessions.

The extent to which the need to continue to be protected is discussed varies with the individual being counseled. At the Jackson County clinic, counselors described the basic message of the posttest negative session as "You 're negative now; how will we keep you that way?" At this clinic the counselor reviews the reasons why the client wanted to be tested and discussed which risk factors might still be a problem. As in the pretest session,

clients are asked to describe in their own words what they can do to protect themselves from exposure.

At the Florida clinic where counseling was observed, the counselor asked about exposures subsequent to the test's limit, but accepted at face value the client's assurances that no risk had been incurred during the preceding year. Little information was asked or obtained on individual behaviors. This client had delayed 6 months in returning for results due to being "out of town." The client was advised to seek another HIV test if he thought he needed it and given a generous supply of condoms at his request.

Posttest Positive Counseling

Counselors in sites that provide posttest counseling report that sessions vary greatly depending on the reaction of the client. As noted in Jackson County, some are prepared and have already discussed the possibility with a partner; others are in shock. Overall, counselors report making an effort' to comfort the client, distinguish between HIV infection and AIDS, and assure the client that medical treatment and support is available. The importance of and options for notifying partners are discussed.

At Lee Davis, the counselor says the most important message she communicates is that the client can control what will happen and that a positive attitude can determine the future course. She stresses the benefits of early intervention and makes clear that further counseling is available both from her and from community resources. She usually schedules a second session within a few days, often in conjunction with the client's return visit for medical evaluation. Additional posttest sessions are also provided at the Newark clinic. The Jackson County counselor notes it is important to provide written information because clients often have difficulty absorbing or fully understanding what they are told during the posttest session.

Referral

Multnomah County sites provide only HIV pretest and posttest negative counseling and testing and rely on STD/DIS staff to assist with posttest positive counseling and handle subsequent referrals to needed services. The other three sites visited provide a comprehensive range of HIV and other medical services to those found positive. Mental health services are generally referred out, as are social, legal and financial assistance. Community support groups are also used through referral.

Counselors usually keep track of referral resources through personal initiative and networking with colleagues in other services and agencies.

A variety of services were reported as needed, but not available. In Jackson County an AIDS Task Force meets monthly to identify service gaps and possible solutions. These and other key dimensions of referral services are shown for each site in Table 6H.

Partner Notification

In all but one site, Disease Intervention Specialists are brought in to handle partner notification. Multnomah County sites conduct only HIV pretest and posttest negative counseling and testing and refer posttest positive counseling and all aspects of referral and partner notification to DIS. In one Multnomah County clinic, staff referred to the clinic as providing a "screening step" with referral to more comprehensive programs if HIV test results are positive. This was viewed as a possible weakness since the clinic has never developed its own prevention program.

In the Jackson County clinic, partner notification is handled by a DIS on staff at the health center. Oregon state law forms the basis of the clinic's partner notification policies. Partners are classified as "aware" or "unaware." Aware partners include partners of gay men, IV drug users, and prostitutes as well as prostitutes themselves. Unaware partners include partners of transfusion recipients, heterosexuals and partners who are unaware of an index patient's bisexuality, IV drug use, or hemophilia. It is the client's responsibility to notify aware partners, although the health department will help clients notify their partners if they request assistance. Clients may also notify unaware partners with the understanding that if it cannot be verified that unaware partners have been adequately informed of possible exposure, the health department will notify them of their possible exposure. The DIS summarized the main point of the partner notification discussion as, "It's essentially your choice, but it has to be done." Partners are given either a "Client Managed Partner Referral Card" or a "Provider Managed Referral Card" to present at check-in.

At the Lee Davis clinic, partners' names are elicited by the HIV counselor/ HSR and forwarded to DIS from the downtown STD clinic for notification. Clients may notify partners, however if partners are not referred by an agreed upon date, the names are forwarded to DIS staff.

Only the Newark health center does not refer partner notification to a DIS. Staff report that the clinic conducts its own partner notification through encouraging clients to have partners come in for testing. Counselors assist clients in "how to" tell partners and suggest testing. This assistance is mentioned during pretest counseling. HIV staff recently completed a training program to assist them in collaborating with the state notification assistance program. The program addressed staff concerns that partner notification invaded clients' privacy and forced individuals to be tested.

Partner notification issues are summarized in Table 61.

Exemplary or Innovative Practices

HIV counselors and administrators identified a variety of strengths and effective practices in their programs:

- At the North Portland clinic, the administrator noted the availability of the HIV clinic downtown and all its resources for referral of clients. A "top-notch" staff at the clinic who are comfortable discussing HIV issues with patients was also reported as a major asset.

- Clinic staff in the Jackson County clinic feel that their outreach to high-risk groups has led to better access to counseling and testing services among clients who might not otherwise have sought out these services, The Health Department subcontracts with another community agency for targeted outreach to injecting drug user and gay men. If more than four high-risk people wish to be tested at the same time, the county arranges offsite counseling and testing.

- Staff at Jackson County also recognized that the amount of time they are able to spend with clients is unusual and makes a difference. Other strengths include the dedication and training of staff members. In addition, staff felt that the state AIDS office has provided excellent back-up in terms of training, data, and especially in providing items such as condoms and pamphlets. Staff feel that the county and state administrative offices are strong advocates of the work they do.

- At Newark, staff noted an exceptional primary care physician who provides HIV care on Monday and Friday of each week. Reportedly, clients come and "line up outside her door." The dedication and commitment of this professional is known throughout the community and enhances the clinic's capacity to see individuals returning consistently for care.

- Staff at Newark also consider their ability to perform multiple HIV services a strength. Staff are able to fill in for one another, with the result that "the entire staff serve as the client's case manager."

- Another practice staff identify as a strength of the clinic is the weekly review of clients with staff in a team meeting where all staff have input and influence in decision making.

Technical Assistance and Other Needs

A variety of areas for improvement of practice and procedures were identified by staff as areas for future development and assistance:

- It would be helpful to know more about the effectiveness of services, from the clients' point of view. Although clients are appreciative of services and of the way they are treated in the clinics, there has been no follow up of whether or not the counseling and testing services have had an impact on clients' behaviors.

- It would also be helpful to be able to conduct followup sessions for high-risk individuals who are negative. Staff recognize that a one-time exposure to counseling

may increase awareness, but that more reinforcement is needed to achieve lasting behavior change. Additional sessions would be beneficial for all clients, but seem particularly important for high risk clients who continue to deny their risk.

- Resources to conduct skill-building sessions, especially in correctional and treatment facilities, would allow health department staff to expand the scope and effectiveness of their outreach work. Staff note that risk behaviors often have less to do with knowledge and awareness of the risks than with basic life and relationship skills such as negotiating with a partner or building and maintaining basic self esteem.

- Staff cited a need for more efficient access to current information on treatments and scientific developments. Although staff attend periodic conferences and find these helpful, there is no way to get quick answers to particular questions from clients or find out about relevant journal articles. Local CBOs tend to get information faster than it is filtered through the CDC and state, although state resource people have been responsive to requests for information. It would be helpful to have a media hotline or a resource person available for tracking down information or disseminating it.

- The primary consideration for improving client services and easing staff burden would be to hire an additional social worker, health educator and two physicians. This would assist in "regulating the flow of work on heavy days."

Table 6A
Confidential/Anonymous

Primary Care Sites	Confidential or Anonymous	Informed Consent	Who has access to Results
Southeast Health Center	• Confidential only for existing or new clients • Refer HIV-only to CTS	• Verbal	• Test results included in the client's chart
N. Portland Health Center	• Confidential only	• Verbal	• Providers
East County Health Center	• Confidential only	• Verbal	• Test results kept in lab results portion of chart; providers have access
Jackson County Health Department	• Confidential or anonymous testing at the CTS located onsite • Confidential onlv for clients of other clinic services	• Signed	• Clinicstaff
Lee Davis Health Center	• Confidential only	• Signed	• Test results included in client's chart
Newark Community Health Center	• Confidential and anonymous testing	• Signed	• Test results kept separate from clinic files. For confidential, only social security number and HIV status sent to state registry. For anonymous tests, no identifying information sent to the state. • Test results are released to other agencies only with signed client consent each time.

Table 6B
Staffing Issues

Primary Care Sites	Staff Role/Background				HIV Counselor Training	Quality Assurance
	Education/Outreach*	Counseling and Testing	Referral/Case Management	Partner Notification		
Southeast Health Center	• N/A	• MDs • NPs • RNs • LPNs • Posttest positive counseling by STD/DIS	STD/DIS	• STD/DIS	• County-level HIV training completed or scheduled and "buddy system"- observing more experienced nurses	• Chart audits • Nursing supervisor observes sessions as part of routine performance evaluation
N. Portland Health Center	• N/A	• Nurses with HIV training do pre and posttest counseling and draw blood • NPs • RNs • LPN	Nurse working with STD/DIS and HIV Clink	• Notification assistance referred to STD/DIS	. County sponsored HIV training	• Nursing supervisor observes sessions as part of routine performance evaluation
East County Health Center	• N/A	• Nurses with HIV training: RNs, BSN • Posttest positive counseling by STD/DIS	Nurse working with STD/DIS	• Notification assistance conducted by STD/DIS	• County sponsored HIV training	• Nursing supervisor observes sessions as part of routine performance evaluation
Jackson County Health Department	• HIV outreach workers: community workers	. Nurses with HIV training., RNs	• Nurse/HIV counselor	• Notification assistance provided by onsite DIS	• Miscellaneous local and state-sponsored training as available • Also annual state conference and update sessions	• Nursing supervisor monitors logs and records
Lee Davis Health Center	• No HIV outreach workers, but other clinic outreach workers discuss HIV and distribute condoms in the community	• Nurses with HIV training (RNs, LPNs and BSNs) • HIV specialist health services representative: social work and counseling background . All posttest positive counseling conducted by HSR	• HSR	• Partner's names elicited by HSR; referred to STD/DIS for notification assistance	• HRS 2-day HIV training program	• HSR monitors test acceptance rates
Newark Community Health Center	• 1 outreach worker. community worker • 1 health educator	. HIV Counselor . Substance Abuse Counselor • Social Worker • All have received HIV training	• Social worker • Substance abuse counselor	• HIV counseling staf encourage patient referral • Counselors have been recently traine in notification assistance	• State-sponsored S-day training program	• Counselors are observe by supervisor and peers

HIV education and outreach conducted by clinic staff pr to pretest counseling (e.g., HIV educatton incorporated in outreach, group inform ton sessions within the clinic

Table SC
Data Collection

Primary Care Site	Kinds of Data Collected: Risk Exposure	Demographic Data	CT Steps	Other	Forms Used	Use of Data
Southeast Health Center	X	X	X	• None reported	• County individual patient encounter forms • State serology form	• County and state reporting. Quarterly summaries returned from the county and used by staff for program review.
N. Portland Health Center	X	X	X	• None reported	• County individual patient encounter forms • State serology form	• County and state reporting
East County Health Center	X	X	X	• None reported	• Clinic log • County individual patient encounter forms • State serology form	• State/county staff present summary findings quarterly. Used by clinic staff for program review. • Follow up of clients who don't return
Jackson County Health Department	X	X	X	• None reported	• Clinic log sheet • State serology form	• State reporting • Case manager reviews log for followup of clients
Lee Davis Health Center	X	X	X	• None reported	• CDC Scan Form • State lab form . Clinic logs	• State/district/county reporting • Monitor test acceptance rates and returns
Newark Community Health Center	X	X	X	• Various state and Federal HIV studies	• CDC Scan Form • KABB questionnaire	• Grant writing • Reporting

Table 6D
Pretest Counseling

Primary Care Sites	Individual or Group Session	Duration of Pretest Counseling	Condoms Provided/Demonstrated	Pretest Counseling Observed
Southeast Health Center	• Individual	• 15 minutes	• Provided	• None
N. Portland Health Center	• Individual	• 20 minutes	• Provided	• None
East County Health Center	• Individual	• 20 minutes	• Provided	• None
Jackson County Health Department	• Individual	• 40 minutes for CTS clients • 15-20 for other clinics	• Condoms are provided but not routinely demonstrated	• 1 session
Lee Davis Health Center	• Individual	• 10 minutes if conducted by clinic nurse • 20 minutes if conducted by HSR	• Demonstrated if a problem or new user • Foam and condoms provided	• 2 sessions
Newark Community Health Center	• Individual	• 15 to 30 minutes	• Provided; demonstrated on request	• 1 session

Table 6E
Risk Assessment

Primary Care Sites	Purpose of Risk Assessment	Risk Assessment Instruments	When Risk Assessment Occurs/By Whom
Southeast Health Center	• Data collection • Determine whether HIV counseling and testing should be offered • Identify individual risk	• County risk assessment form	• Intake RN, health assistant or physician's assistant for initial family planning and prenatal visits and annual exams
N. Portland Health Center	• Data collection • Determine whether HIV counseling and testing should be offered • Identify individual risk	• County risk assessment form	• Intake/nurse
East County Health Center	• Data collection • Determine whether HIV counseling and testing should be offered • Identify individual risk	• County risk assessment form	• Intake/provider during exam
Jackson County Health Department	• Determine whether HIV counseling and testing should be offered • Identify individual risk	• Customized risk assessment questionnaires completed by clients in prenatal, family planning and STD clinics	• Completed questionnaires reviewed by provider during exam and test discussed if warranted • If test accepted, pretest counseling conducted by HIV-trained RN
Lee Davis Health Center	• Data collection • Identify individual risk for education/counseling	• CDC scan form categories • State lab form categories	• Pretest counseling/nurse or HSR
Newark Community Health Center	• Determine whether HIV counseling and testing should be offered. All ob/gyn clients receive pretest counseling. • Identify individual risk	• Questionnaire completed by client at intake	• Questionnaire reviewed by HIV counselor in each department to determine whether pretest counseling should be conducted

Table 6F
HIV Testing

Primary Care Sites	When/Where HIV Blood Draw Occurs	Who Draws	Return Arrangements	Follow Up	Lab/Turnaround
Southeast Health Center	. Lab; single stick for all clinic purposes	• Lab tech	• HIV negative results placed in client's chart to be delivered by provider at next visit; HIV positive clients contacted by DIS	• Reminder letter in 30 days if negative • STD/DIS contacts if positive	• State/2 weeks
N. Portland Health Center	• Counseling room	• Counselor	• Appointment to receive results in 2 weeks or during next scheduled visit	• Reminder letter in 30 days if negative • STD/DIS contacts if positive	• State/10 days
East County Health Center	• Lab; single stick for all clinic purposes	• Lab tech	. Checkout staff make return appointment as part of clinic exit procedure	• Reminder letter in 30 days if negative • STD/DIS staff contacts if positive	. State 2 weeks
Jackson County Health Department	. Lab; single stick for ail clinic purposes . For CTS clients, during pretest counseling	• Lab tech	• CTS clients are told to call for an appointment in 10 days • Other clients are asked to make an appointment on the way out to return to the CTS clinic • Exit clerk also reminds clients when they check out	• Serology form forwarded to state if client hasn't returned within 30 days; attempt to contact clients	• State/IO days
Lee Davis Health Center	. Lab; single stick for all clinic purposes	• Lab tech • For STD patients, blood is drawn by the STD practitioner	• Return date given. Client told to walk in or call for appointment.	• Negative results provided during next routine visit • STD/DIS contact those whose results return positive	• State/2-3 weeks
Newark Community Health Center	• Lab, generally single stick. On some occasions the client must receive a second stick for HIV antibody testing	• Lab tech	. Return date given on a reminder card. Client is asked to call to schedule an appointment to return. Client must bring card with test sticker number to receive results.	• For positive results, three letters are sent; then an outreach worker contacts the client • If unsuccessful, a certified letter is sent and the name is forwarded to the state Notification Assistance Program	• State/2 weeks

Table 6G
Posttest Counseling

Primary Care Sites	Same Counselor for Pre and Posttest Counseling	Duration of Posttest Session: Positive & Negative	Additional Posttest Sessions	Retesting Recommendations	Pretest Counseling Observed
Southeast Health Center	• Positive results are given by the STD/DIS . Negative results are given by the regular provider	. Negative sessions: 15 minutes • Positive sessions: 45 minutes	• For HIV-positive clients through referral to HIV wellness clinic	• 6 months	• None
N. Portland Health Center	• Yes, regular provider will conduct posttest session with consultation from STD/DIS. No HIV positive results yet provided at this clinic.	• Negative sessions: 15 minutes • Positive sessions: 45 minutes	• For HIV-positive clients through referral to HIV wellness clinic	• 6 months	• None
East County Health Center	• Positive results given by STD/DIS. Only two HIV positive results have been provided in 2 years. • Negative results handled by the regular provider	. Negative sessions: 1.5 minutes • Positive sessions: 45 minutes	• For HIV-positive clients through referral to HIV wellness clinic	• 6 months	• None
Jackson County Health Department	• If possible	. Negative sessions: 10 minutes • Positive sessions: 40 minutes	• For HIV-positive clients through referral to HIV wellness clinic	• 6 months	• 1 session
Lee Davis Health Center	. Negative results given by the regular provider . Positive results given by the HIV Specialist/HSR	• Negative sessions: 10 minutes • Positive sessions: 30 minutes to 3 hours	• Extended posttest counseling for HIV positive provided by HSR Second session within a few days of initial session when client returns for medical evaluation. Others, as needed.	• 3-6 months	• 1 posttest negative session
Newark Community Health Center	• Posttest results provided by assigned HIV counselor in each department	• Negative sessions: 30 minutes • Positive sessions: 1 hour	• HIV positive clients are invited to return for additional counseling sessions after the initial posttest session. About half do so.	• 6 months	• None

Table 6H
Referrals

Primary Care Sites	Source of Referrals	Services Provided Onsite	Services Offered by Referral Offsite	Major Gaps
Southeast Health Center	• STD/DIS conducts posttest positive counseling and handles referrals	• Only HIV pretest counseling, testing and posttest negative counseling	• Mental health counseling, medical evaluation, and treatment through county HIV wellness clinic	• N/A (referrals handed by DIS from STD clinics)
N. Portland Health Center	. Consultation with the STD/DIS and with the HIV clinic	• Only HIV Pretest counseling, testing and posttest negative counseling	• Mental health counseling, medical evaluation, and treatment through county HIV wellness clinic	• N/A (referrals handed by DIS from STD clinics)
East County Health Center	• STD/DIS conducts posttest positive counseling and handles referrals	• Only HIV pretest counseling, testing and posttest negative counseling	• Mental health counseling, medical evaluation, and treatment through county HIV wellness clinic	• Lack of low cost inpatient drug treatment for pregnant women and for women with children
Jackson County Health Department	. HIV counselor and HIV wellness clinic staff	• Mental health counseling, medical evaluation and treatment through onsite HIV Wellness Program • STD, TE?, and contraception services through the regular clinics	• Community support groups • Information/resource hotlines • Legal services • County mental health services	• Services for those identified early in disease process • Access to dental care • Affordable antiviral drugs • Services for women
Lee Davis Health Center	• H S R	• Medical evaluation and treatment • Primary care • TB screening • STD services • Family planning/maternity	• Mental health services • Drug treatment • Children's care	• Case management • Transportation
Newark Community Health Center	• HIV team maintains linkages through personal contacts • Resource guide: Essex County AIDS Network Rook	• Medical evaluation and treatment • Various other medical and psychosocial services provided by the primary care center	• Adult day care • Homemaker services • Home health care • Drug treatment • Social services and financial assistance	• Housing

Table 6l
Partner Notification

Primary Care Sites	Patient Referral	Provider Referral/Who Elicits and Notifies	Where Topic is Introduced
Southeast Health Center	• All PN referred to STD/DIS	• All PN referred to STD/DIS	• Posttest counseling
N. Portland Health Center	• No HIV positive clients to date • PN approach will be developed with STD/DIS	• PN approach will be developed with STD/DIS	• Posttest counseling
East County Health Center	• All PN referred to STD/DIS	• All PN referred to STD/DIS	• Posttest counseling
Jackson County Health Department	• By state law clients are urged to inform "aware" partners; training is provided • "Unaware" may also be notified by clients if this can be verified	• DIS assist in notifying "awares" if requested • "Unawares" are usually notified by DIS	• Posttest counseling • Also mentioned on risk assessment form reviewed by client before pretest session
Lee Davis Health Center	• Clients must refer partners by an agreed upon date or names are forwarded to STD/DIS for notification	• HIV counselor/HSR elicits names of partners and forwards to STD/DIS for notification	• Posttest counseling
Newark Community Health Center	• Clients are urged to have partners come to the clinic to be tested	• Recent staff training to better collaborate with state Notification Assistance Program	• Posttest counseling

B. Discussion of Each Site Type

7. Correctional Institutions

a. Overview of the Site Type

Issues

The correctional institutional setting presents a number of unique opportunities and challenges for delivery of HIV counseling and testing services. First, it is a closed setting in which restrictions on movement and behavior affect both the capability of providing services and also. the likelihood that the incarcerated population will avail themselves of those services. A prison, in effect, has a "captive audience" for HIV prevention services, and, ideally, can use the opportunity to reach a population who are at high risk for HIV disease because of drug use and/or prostitution. For its part, the incarcerated population has ready access to services and time to take advantage of the services. Second, many prisons provide a level of medical and health care that the inmates would not have easy access to outside the institution, and HIV services typically are linked to the prison's medical unit, thus making integration of care a possibility. Women's correctional settings, in particular, offered opportunities to learn about basic reproductive health issues and develop skills in the area of self-esteem. Furthermore, HIV counseling, at least in the sites visited for this project, also afforded a level of emotional support and therapeutic listening that is a unique experience to many inmates.

However, on the negative side, the institutional setting presents some significant constraints and problems. First, distribution of condoms--a major tool in preventing spread of HIV--is rare in correctional institutions. A 1989 National Institute of Justice survey found that only 5 of 80 state and local jurisdictions had policies that permitted prisoners access to condoms during incarceration.[1] Although staff acknowledge that "situational same-sex encounters" occur during periods of incarceration, such activity generally violates state laws and correctional regulations and thus is not officially sanctioned. Therefore, it follows that distribution of condoms would constitutea priori knowledge of such "illegal" activity, which staff are required to report. This contemporary variation on "the Emperor's new clothes" mitigates against inmates taking seriously AIDS education messages and potentially contributes to the spread of HIV among the incarcerated population.

[1] 1989 Update: AIDS in Correctional Facilities. 1990. National Institute of Justice series on issues and practices. Washington, DC: U.S. Department of Justice, 42-3.

Another barrier is the negative attitudes of some correctional staff toward people with HIV disease, attitudes leading to discriminatory behavior. Considerable education about HIV disease has been provided for many correctional institution staff over the past few years. Virtually all jurisdictions recently surveyed by the National Institute of Justice had some kind of AIDS educational program for staff and inmates. The effectiveness of those educational efforts plays "a major role in determining both inmate and staff attitudes on [AIDS and asymptomatic HIV infection]."[2]

Finally, a potential barrier to acceptance of counseling and testing is the lack of confidentiality in the prison setting. Staff interviewed went to great lengths to assure privacy and confidentiality of clients who came for counseling and testing. But the fact is, in a closed setting where inmates' movements are closely monitored and privacy is a luxury, it is very difficult to keep confidential visits to the counselor or taking of medications for HIV disease. Although not documented as a barrier to counseling and testing, such limited potential for confidentiality may be assumed to have such an effect.

The correctional institutions site visited for this project were the following:

- The Awaiting Trial Unit (ATU) within the Massachusetts Correctional Institute at Framingham, the state women's prison;
- The Webster Correctional Facility, a men's minimum security prison that is part of the Connecticut Department of Corrections; and
- The Connecticut Correctional Institution at Niantic, the state's women's prison.

Services

In the correctional institutions visited, HIV counseling and testing was integrated into the facilities' medical services unit or sexually transmitted disease (STD) clinic. In addition to the CT services provided, any necessary medical service was available in-house. HIV/AIDS education also was provided, typically during the inmates' orientation process and, later, through the counseling and testing experience.

Clientele

The incarcerated and detainee population included people at high risk for acquisition of HIV: drug users and sex workers, many of whom also have histories of drug use. Not surprisingly, the documented rate of HIV in the institutions was high--about 11 percent in Connecticut--and staff estimated the actual rates were much higher. The facilities site visited were minimum security prisons and a detainee center, so many inmates had short sentences and were likely to be released. into the community in a short period of time. Unfortunately, many would return in a short period of time. This "revolving door syndrome" concerned all the staff interviewed. They pointed out that each release--or furlough--offers opportunities for their population to become infected and/or to infect

[2] Update on AIDS in Prisons and Jails. 1990. National Institute of Justice AIDS Bulletin, September 1990. Washington, DC: U.S. Department of Justice, 4.

others. On the other hand, some staff thought that returns to the institution offered additional opportunities for HIV education and risk reduction counseling.

b. Program Management Issues

Integration of Services

In the two Connecticut sites visited, the HIV CTRPN services were provided by an HIV counselor under contract to the Department of Corrections (DOC), which, in turn works under contract to the Connecticut Department of Health Services, AIDS Section. The HIV services were located, organizationally and physically, within the medical units of the correctional institutions. This placement of HIV CTRPN offers several advantages: (1) it enhances communications between medical staff and HIV counselors about needed health services for inmates, (2) it offers convenience (e.g., staff to draw blood, a refrigerator for storage until blood is sent to the lab), and (3) it affords a modicum of privacy for inmates who do not wish to publicize their visits to the HIV counselor.

The Massachusetts site offers STD education and evaluation for detainees in the ATU, as well as HIV counseling and testing, which is provided on 3 of the 5 weekdays when the clinic is open. CTRPN also is provided for prisoners within the context of the prison's Health Services Unit operated through the Massachusetts Department of Corrections; however, since women waiting sentencing were not officially part of the correctional system, they were not eligible for services. The STD clinic was created as a way to reach underserved, at-risk women with HIV education/intervention over an extended period of time.

Interviewees at all three sites underlined the importance of linking CTRPN to access to medical care. Because of court-ordered mandates, many prisons provide a range and quality of medical services that inmates and detainees might not have access to on the "outside."

Staffing Issues

Staffing issues are summarized in Table 7B.

A disease intervention specialist (DIS) from the state Department of Health (DPH), Bureau of Communicable Diseases, provides the HIV counseling at the ATU/STD clinic in Massachusetts. She has received Centers for Disease Control (CDC)/DPH training on HIV counseling and has attended continuing education sponsored by drug companies.

The Connecticut HIV counselors work under contract to the Department of Corrections (DOC), with program oversight from the AIDS Unit in the state Department of Health Services (DHS). One has experience in the correctional field and had worked a number of years in the correctional complex where she is a counselor now. The counselor at

Niantic has a background in social service work; at the time of the site visit, she was just being joined by another counselor who had extensive experience in STD and HIV counseling. Under terms of a 1989 settlement of one aspect of a lawsuit (Doe v. Meachum) in Connecticut, the DOC agreed to hire nine HIV counselors, set minimum standards for counselor training, and establish the content of pre and posttest counseling.[3]

Confidentiality/Anonymity

Confidentiality issues are summarized in Table 7A.

Maintaining confidentiality in a prison setting is extremely difficult. All sites were sensitive to the issue and went to great lengths to maintain privacy of clients to the extent possible. Medical staff are aware of the HIV status of tested inmates because test results become part of the medical records. However, all efforts are made to restrict knowledge of test status to medical staff who "need to know" and not to release any information to prison staff or other inmates. Nevertheless, interviewees cited examples of ways that staff and inmates do learn of a person's HIV status. For example, in Massachusetts, for inmates on any kind of medication, the guards are required to monitor actual ingestion, and they learn to recognize the distinctive shape and color of AZT, thus use this information to identify HIV-positive individuals. In some cases, inmates themselves choose to reveal their seropositive status at a group meeting, for example, NA or AA.

Data Collection

Data collection is summarized in Table 7C.

Data are collected for state reporting purposes. In Connecticut, information goes to the AIDS Unit and is included in the state's HIV/AIDS reports, which present data by site types as well as demographic and risk category.

c. Service **Delivery Issues**

Entry

All inmates and detainees receive AIDS education in a group session when they first enter the institution. At that time, the topic of HIV counseling and testing is raised. Subsequently, the availability of CT is introduced in various ways during informal conversations, clinical staffs mentioning it, and direct recommendation, based on risk factors. In the two Connecticut institutions, the demand is so high that there are waiting lists of prisoners to be seen. Medical and psychiatric referrals get priority. At Framingham, appointments initially had to be prioritized by pending court date because

[3] 1989 Update, op. cit., p. 65.

of the backlog. Currently, all current residents have been served, and the clinic is able to offer HIV CT services to all new admissions.

In one Connecticut facility and the Massachusetts ATU, great efforts are taken to preserve the privacy of the person seeking counseling. However, because of the proximity of the counseling office to the medical corridor where inmates have some access, it would appear more difficult to maintain anonymity at Niantic.

In all cases, appointments are made, either directly with the HIV counselor or through the medical unit or STD clinic.

Pretest Counseling

Pretest counseling issues are summarized in Table 7D.

Pretest counseling in all three institutions reportedly covers the same standard topic areas for such sessions: explanation and meaning of the test, modes of transmission, risk behavior and risk reduction strategies, and anticipated response to positive results. In all three settings, the counselor also was likely to have clinical information on the prisoner related to STDs, tuberculosis (TB) status, or other health-related information that would help assess risk status; in such cases, the counseling was tailored to the specific risk information available in advance or provided by the client during the course of the exam.

Beyond the standard context, though, counseling and testing in the prison and detention center settings carries certain benefits and constraints. Among the constraints are the reluctance of inmates to take away with them any HIV/AIDS brochures or information, out of concern about being identified and labeled HIV-positive. The most notable departure from standard pretest counseling content, though, is the failure to distribute condoms. Connecticut and Massachusetts state laws prohibit distribution of condoms to incarcerated people, on the theory that it would acknowledge that illegal sexual activity occurs in prison settings. In Massachusetts, the counselor had a display board showing various kinds of condoms and also recommended a homemade way for women to craft a dental dam if they planned to engage in oral sex during their stay in prison.

The potential benefit to clients that is unique to a closed setting such as a prison is the continuity of relationship with the counselor. In some cases, the clients maintain contact over several sessions with the counselor, at least raising the possibility of developing a trust relationship that would foster behavior change. At Niantic, for example, the counselor stated that most sessions involve a significant amount of listening and allowing the woman to ventilate a range of emotions related to complex life issues before the issue of HIV infection can be raised. The importance of developing trust and rapport is seen as vital to a counselor's ability to effectively communicate the HIV prevention message to prisoners.

The length of time for a pretest ranged from 20 minutes to 2 hours, depending on the setting and the client's needs, both for information and emotional expression. Sessions at Niantic typically were 1 to 2 hours.

Testing

Testing issues are summarized in Table 7F.

Blood is drawn by clinical staff in all sites. In Connecticut, blood was drawn only on specified days, so it was likely that a person who agreed to testing would have to return to the medical unit on another day for the actual test. At Niantic, such a delay was seen as influencing some women who originally agreed to testing to change their minds between the time of counseling and testing.

Posttest Counseling

Posttesting counseling issues are summarized in Table 7G.

When test results are returned, the clients are contacted and asked to come to the medical unit/STD clinic for posttest counseling and results. The sessions with negative results typically last about 15 to 20 minutes and emphasize the importance of maintaining negative status through prevention of risk behavior. The concept of the "window period" is discussed and retesting considered if there is any chance that risk behavior had occurred during that period or is likely to take place in the future. Clients at Framingham who are released before their results come back are referred to an area STD clinic where results will be forwarded on request. In some cases, the DIS will meet the client in the community to discuss results.

Posttest positive sessions take an hour or more, and followup session are the norm, primarily as a way for the client to gain counseling around the emotional issues. The prison setting mandates certain special considerations, too. For example, positive results at Webster are never given on a Friday when the client would have the whole weekend to react without routine access to a staff counselor. Similarly, the counselor at Niantic underlined the need for appropriate psychiatric backup in case a woman had a strong reaction and threatened violence to herself or others. To help the client and to help maintain the stability of the unit, the counselors said it was important to allow the person adequate time within the safety of the counseling session to ventilate strong feelings.

The counselors also encourage the seropositive patients to take a "proactive" stance toward their own health, recommending that they learn about nutrition, exercise, and stress management. Groups focused around such health promotion issues are offered at Niantic and Framingham.

Clients also are informed about the range of medical care available within the facilities (complete services are available at Niantic and Webster and available at Framingham if

the woman is convicted and joins the regular prison population) and are told that all efforts will be made to maintain confidentiality of their status.

Referral

Referral issues are summarized in Table 7H.

As mentioned, medical care is available to the permanent prison population. Settlement of a Connecticut lawsuit set a precedent for the Nation in mandating that medical care for AIDS patients be brought up to "community standards" (1989 Update, p. 65). Access to care is more difficult for those HIV-positive inmates who are released or, in the case of Framingham, acquitted and return to the community. Referrals are made to the community resources, when the counselor is aware of them, but since the inmates come from all over the state, and even out of state, it is virtually impossible to maintain a personal network of resources. Connecticut prisoners who are released take with them a standard form that lists information about their overall health status (TB results, etc.); their HIV status, if tested; CD-4 cell count, if known; and medications, if any. The released prisoners can take this form to a community health provider to furnish relevant information for treatment. Prisoners also get condoms and a 2-week supply of medications on release.

A common problem is the paucity of community resources to which to refer prisoners and the counselors' lack of time to do the kind of case management needed.

Partner Notification

Partner notification issues are summarized in Table 71.

The DIS offers partner notification services 'to clients in Massachusetts. The DIS doing the counseling will contact partners in the local area or can refer to a DIS in another area of the state, if necessary. In Connecticut, counselors offer partner notification services through the CARE team, a special outreach unit developed to contact sex and needle-sharing partners of HIV-positive clients.

Exemplary Practices/Innovations

Staff at all three sites exhibited a keen sensitivity to the special needs of prisoners and detainees with HIV infection. They were empathetic to the multiple concerns of the clients they counseled and had developed trust relationships which, in many instances, appeared to be rare in that setting. They appreciated the prisoners' needs for confidentiality and tried as much as possible to assure that within the prison setting.

Technical Assistance Needs

The greatest need voiced by Connecticut counselors was for access to continuing education. Because they are contract workers, they do not get paid for their time taken to attend local or area workshops and do not get registration or travel expenses paid. They said such training would make a difference in updating skills and developing a sense of community with other HIV counselors in the state. One counselor said it would be helpful to have special sessions related to HIV counseling and testing in prison settings at regional or national meetings for corrections staff.

Staff at the Framingham facility identified three important gaps affecting their ability to provide ideal CTRPN services for detainees. They said they needs a broader range of low-literacy educational materials, access to counselors with Spanish language proficiency, and a greater emphasis on bicultural counseling capacity.

Table 7A
Confidential or Anonymous Testing

Correctional Institutions	Confidential or Anonymous	Informed Consent	Who Has Access to Results
Niantic Women's Prison (CT)	• Confidential	• Signed	• Restricted to medical staff who need information for treatment
Webster Correctional Facility (CT)	• Confidential	• Signed	• Restricted to medical staff who need information for treatment
Framingham ATU (MA)	• Confidential	• Signed	• Restricted to medical staff within Framingham. HIV test results are entered into medical record but cannot be transferred outside of prison.

Table 7B
Staffing Issues

Correctional Institutions	Staff Role/Background				HIV Counselor Training	Quality Assurance
	Education/Outreach*	Counseling and Testing	Referral/Case Management	Partner Notification		
Niantic Women's Prison (CT)	• HIV counselor, background in social work	• HIV counselor	• HIV counselor	• CARE team	• State HIV counselor certification course	. DOCQA coordinator reviews charts and observes sessions
Webster Correctional Facility (CT)	• HIV counselor, background in correctional work	• HIV counselor	• HIV counselor	• CARE team	• State HIV counselor certification course	. DOCQA coordinator reviews charts and observes sessions
Framingham ATU (MA)	• Nurses, DIS	• DIS	• Nurses, DIS	• DIS in Framingham area or DIS in another part of state	. DIS: CDC/DPH HIV counselor training continuing education via drug company seminars	• No formal QA atthistime

HIV education and outreach conducted by clinic staffprior to pretest counsehng (e.g., HIV education incorporated mto utreach, group mformation sessions within tl clinic).

Table 7C
Data Collection

Correctional Institutions	Kinds of Data Collected				Forms Used	Use of Data
	Risk Exposure	Demographic Data	CT Steps	Other		
Niantic Women's Prison (CT)	X	X	X		. CDC scan form	• State reporting
Webster Correctional Facility (CT)	X	X	X		. Daily log . monthly log sheet . scan form . inmate chart	• State reporting
Framingham ATU (MA)	X	X	X		• STD/HIV data form.	• State reporting

Table 7D
Pretest Counseling

Correctional Institutions	Individual or Group Session	Duration of Pretest Counseling	Condoms Provided/ Demonstrated	Pretest Counseling Observed
Niantic Women's Prison (CT)	• Individual	• 1-2 hours	• No	• No
Webster Correctional Facility(CT)	. Individual	• 20-60 minutes	. No	. No
Framingham ATU (MA)	. Individual	• 20-60 minutes	• No	• Yes

Table 7E
Risk Assessment

Correctional Institutions	Purpose of Risk Assessment	Risk Assessment Instrument	When Risk Assessment Occurs/By Whom
Niantic Women's Prison (CT)	• Determine need for CT • Data collection • Direct pretest discussion	• HIV counseling guidelines and client record	• Screening by clinical staff • During pretest by HIV counselor
Webster Correctional Facility (CT)	• Determine need for CT • Data collection • Direct pretest discussion	• HIV counseling guidelines and client record	• Screening by clinical staff • During pretest by HIV counselor
Framingham ATU (MA)	• Identify client's risk behaviors	. No	• During STD exam and pretest counseling (nurse and DIS)

Table 7F
HIV Testing

Correctional Institutions	When/Where HIV Blood Draw Occurs	Who Draws Blood	Return Arrangements	Follow Up	Lab/ Turnaround
Niantic Women's Prison (CT)	• Phlebotomist in medical unit draws on certain days of week	• Phlebotomist in medical unit	• Inmate is contacted and told to come to medical unit	• N/A	• State/2 weeks
Webster Correctional Facility (CT)	• Nurse in medical unit draws on certain days of week	• Nurse in medical unit	• Inmate is contacted and told to come to medical unit	• N/A	• State/2 weeks
Framingham ATU (MA)	• Blood drawn during STD exam or following HIV counseling session	• Nurse in STD clinic	• DIS contacts woman, who makes appointment; if woman has been released, she is referred to STD clinic in area, where results will be forwarded	• DIS contacts client if still within 'ATU or residential unit	• State/2 weeks

Table 7G
Posttest Counseling

Correctional Institutions	Same Counselor for Pre and Posttest Counseling	Duration of Posttest Session	Additional Posttest Sessions	Testing Recommendations	Counseling Observed
Niantic Women's Prison (CT)	• Yes	• Positive: 45-90 minutes • Negative: 30-60 minutes	• Likely	• 3 months	. No
Webster Correctional Facility (Cl')	• Yes	• Positive: 45-90 minutes • Negative: 30-60 minutes	• Yes	• 3 months	• No
Framingham ATU (MA)	• Yes	• Positive: l-l.5 hours • Negative: 10-15 minutes	• Yes	• 6 months	• Yes

Table 7H
Referrals

Correctional Institutions	Source of Referrals	Services Provided Onsite	Services Offered by Referral Offsite	Major Gaps
Niantic Women's Prison (CT)	• State and national directories, personal network	• Medical • Dental care • AZT • Infectious disease specialist available • MH/psychiatric services • Support groups	• Medical and social services on release from institution • W-10 form and 2 weeks medication provided	• Case managers to help women make transition and gain access services in the community
Webster Correctional Facility (CT)	• State directory	• Medical • Dental care . AZT • MH services	• Medical and social services on release from institution • W-10 form and 2 weeks medication provided	• Case managers to help coordinate services in communities • Community resources for ex-offender population
Framingham ATU (MA)	• Link to health services unit within MCI Framingham	• Mental health and medical services	• Few, new program	• Support groups only serve prison inmate population; unavailable to women awaiting trial

Table 7l
Partner Notification

Correctional Institutions	Patient Referral	Provider Referral/Who Elicits and Notifies	When Topic is Introduced
Niantic Women's Prison (CT)	• Counselor discusses	• CARE team services offered	• Posttest counseling
Webster Correctional Facility (CT)	• Counselor discusses	• CARE team services offered	• Posttest counseling
Framingham ATU (MA)	• DIS discusses	• DIS assistance offered for local area as well as other Parts of state	• Posttest counseling

Chapter III. Overview of the Sites

A. Introduction

The previous chapter has discussed a range of issues by site type, identifying within each type both commonalities and divergent trends. This chapter provides an overview of all the sites visited in connection with this project and examines specific aspects of CTRPN across all site types.

Sections B and C discuss issues related to program management and service delivery across all site types that offer Centers for Disease Control (CDC)-funded counseling and testing services. Finally, a list of innovative practices and technical assistance needs are defined.

B. Program Management Issues

1. Integration of Services

With the exception of freestanding counseling and testing sites, clinics visited for this study have added HIV services to other existing services as a means of reaching individuals at risk of exposure to HIV infection. Initially, staff of many HIV counseling and testing sites did not view HIV as. central to the clinic's mission. Fear or misunderstanding of HIV/AIDS coupled with resistance to adapting staff roles and clinic procedures in a climate of "separateness" have been issues in adopting HIV services.

Initial concerns about whether to incorporate HIV appear largely resolved from the perspectives of staff interviewed during this study. However, the process of integration remains an area of continued attention and effort. Components of the integration process that were observed in sites visited include the following:

- The extent to which HIV counseling and testing are routinely offered to clients;
- The extent to which other clinic services serve as a point of entry to HIV counseling and testing;
- The extent to which HIV counseling and testing serve as a gateway to prevention and early intervention services;
- The use of specialized HIV staff to deliver all or some HIV services.

Integration of HIV services into staff roles and clinic procedures is less an issue for freestanding counseling and testing sites than for others. Instead, counseling and testing sites (CTS) staff tend to view the integration issue as one of how and where their services fit into a broader spectrum of treatment and support services which may or may not be provided by the site itself. Most freestanding CTS have links to other health and human service organizations either as sources of clients or as referral options for clients, or both.

a. Routinely Offering HIV Services

HIV counseling and testing are an established service in sites visited for this study; however, sites vary considerably in the extent to which they actively offer and encourage testing for all clients.

Drug Treatment and Sexually Transmitted Disease (STD) Sites. Staff in STD clinics and drug treatment centers recognize the importance of HIV risk in the sexual and drug using behaviors they treat. Risk is routinely discussed and HIV pretest counseling and testing are routinely offered. The extent to which HIV testing is encouraged, however, appears to vary with locality. Florida sites, for example, have test acceptance goals; while Boston and Oregon sites express more concern with the client's readiness for testing and ability to handle test results.

Tuberculosis (TB) Clinics. Staff of TB clinics visited also recognize the magnitude of HIV risk among their clientele. However, the two sites visited differ in the extent to which TB staff provide HIV counseling and testing. In the Westside clinic, the TB nurse provides pretest counseling and testing for confirmed cases; however, preventative cases are referred to a CTS located down the hall (after a risk assessment session in the TB clinic). At Pinellas County TB clinic, HIV counseling and testing are provided by the TB nurse to all confirmed and preventative clients, as well as at the request of those who come in for routine TB screening for school or employment purposes. Staff consider that providing HIV services during routine TB screening is a service that can help prevent future susceptibility to TB.

Other Clinics. In women's health and primary care facilities visited, risk assessment is more commonly used as a means of determining whether to offer HIV counseling and testing. This is particularly true of sites in Oregon where seroprevalence is low. However, risk may be discussed at several points as the client moves through the clinic process, particularly during initial history taking and during clinical exam. Testing is available to all, but is more strongly encouraged for women perceived to be at risk.

In correctional institutions visited, inmates and detainees receive AIDS education and are told of the availability of HIV counseling and testing in a group session upon entering. HIV services are provided within the medical unit in Connecticut sites visited and through the STD clinic in the Massachusetts Correctional Institute at Framingham. Appointments for counseling and testing must be made directly with the HIV counselor or through the medical unit or STD clinic. In the two Connecticut institutions, the demand is so high that there are waiting lists of prisoners to be seen. Framingham staff have caught up with the backlog and now offer counseling and testing to all new admissions.

b. Clinic Services as a Point of Entry to CTRPN

In all site types, HIV counseling and testing services appear to be readily accessible to clients regardless of the reason for their visit to the clinic. Variation occurs in the point at which services are offered, the number of opportunities a client may have on any given visit, and the extent to which staff who are not HIV specialists participate in discussions of HIV risk.

Drug Treatment Sites: Access to HIV counseling and testing is usually provided during the intake process. This often involves including an HIV educator or counselor as one of the stops the client makes during the process of psychosocial and medical assessment. In some cases, HIV counseling may occur a day or two after other intake steps. Methadone clinics, residential treatment facilities, and inpatient detoxification facilities share a "captive audience" as long as the individual remains in the treatment program.

Other efforts to reinforce the importance of HIV counseling and testing also occur in drug treatment settings. Group HIV/AIDS education sessions often occur throughout the client's participation in the program. The client's primary substance abuse counselor is typically informed about HIV, if not always about the client's status, and able to handle related issues as part of the client's overall treatment program.

STD Clinics. In many STD clinics visited, HIV risk assessment and the need for counseling and testing are initiated during history taking and physical exam by the clinician. Pretest counseling may be conducted either by the clinician, HIV counselor, or by a disease intervention specialist (DIS). In Hillsborough County, clients who have not visited the clinic within the past 3 months are routed to the DIS for pretest counseling first, before the STD exam. At the Westside clinic, clients complete a risk assessment form while waiting for the exam and may be routed to a nurse or health educator for pretest counseling during the wait. Where a DIS or health educator provides pretest counseling, the clinician also discusses HIV and offers counseling and testing during the exam.

Other clinics. In women's health and primary care facilities, HIV risk is often discussed with the client at several points during the clinical encounter. HIV risk may be assessed at intake and discussed again during clinical examination. Depending on whether the HIV counselor is also the clinician or an "HIV specialist," pretest counseling may occur as a separate step. Although testing in these sites may be most strongly encouraged for those who are determined to be at risk, efforts are reported at several points to assure that risk has been ascertained. And all sites provide testing to any client who wants it.

c. CTRPN as Gateway to Prevention and Early Intervention Services

While referring HIV positive clients for further care was an important concern of HIV staff in clinics visited, no efforts to provide further prevention counseling and virtually no

efforts to refer to other risk reduction services (e.g., drug treatment) were reported for those with negative HIV test results.

Medical and psychosocial services for HIV positive clients were available either onsite or through referral to health departments or community organizations in many of the study areas visited, particularly in Oregon and Florida sites. In these areas, several counselors noted the "relief' of having a place to send those with HIV positive results for help. Ready access to early intervention, however, is not assured. Clinics in Boston, Connecticut, and New Jersey program areas reported more difficulty in obtaining medical evaluation and treatment. And there remain important gaps in mental health, dental care and other needed services in most places.

Several sites reported having case managers available either on staff or through referral to health department HIV clinics. Those who did not identified case management as a gap in services that badly needs to be filled. In some cases, notably in some Connecticut sites, HIV counselors acted informally as case managers in addition to their defined role as counselors.

Drug Treatment Centers. Most likely to provide continuing support for risk reduction behavior were drug treatment centers. However, this was not described as HIV risk reduction so much as a comprehensive plan to keep clients in the treatment program and off the streets. Drug treatment and HIV prevention goals may be highly compatible and mutually supportive. One counselor explained that keeping the client in drug treatment was one of the major concerns of posttest positive HIV counseling. A clinic administrator noted that confronting HIV status can be a "major, traumatic experience" that can galvanize a client into facing a serious drug problem and help turn his or her life around.

Drug treatment centers report a variety of HIV staff and a range of ancillary services available onsite. Counseling and support for behavior change are part of the process of drug treatment in most facilities. As noted earlier, drug treatment counselors are often well informed on HIV and recognize its importance in the lives of drug treatment clients. Many clinics have coordinators or case managers to assist in obtaining needed services. Linkages with sources of medical evaluation and treatment are reported for all sites visited; however there are substantial waits for clients of New Jersey sites. In Connecticut, availability of medical care is a problem. TB and STD screening are available in several sites, as is extended psychosocial support.

Correctional Institutions. Like drug treatment staff, HIV counselors in correctional institutions have the opportunity to develop an ongoing relationship with the client and to begin to develop the trust and rapport necessary to foster behavior change. However, risk reduction efforts do not include providing condoms for incarcerated clients. Although unable to provide them, counselors report showing inmates the kinds of condoms available and, in one case, recommending a homemade way to create a dental dam.

In correctional institutions, medical care is available to the permanent prison population. Staff pointed out that access to care is more difficult for those who are released or, in the case of Framingham, acquitted and return to the community. Common problems are the paucity of community resources to which to refer prisoners who are released and the counselors' lack of time to do needed case management when clients make the transition to the community.

STD Clinics. In STD clinics, prevention goals have high priority through partner notification activities that are central to **STD/HIV** staff responsibilities. In addition to providing both HIV and STD partner notification for clients seen at STD clinics, many DIS also provide assistance with HIV partner notification for clients of other health department clinics. Eliciting names of partners of those found HIV positive and alerting them to the possibility of exposure may be viewed as primary prevention for those at high risk. However, assistance with behavior change to prevent or minimize further risk is not well in place in STD sites visited. Those with negative test results are often sent on their way with a pocket full of condoms and a strong admonition to avoid further risk.

For those found positive, the referral system to early intervention services is not well developed in many STD clinics. HIV counselors (DIS and clinicians) are responsible for knowing about and providing information on HIV medical and social services to clients. Only a third of the clinics visited had access to a social worker or case manager to assist with referrals. In many cases, STD counselors provide materials with lists of services. Medical evaluation is considered the key referral and is often available through a health department or hospital clinic. Several clinics reported gaps in mental health referrals, as well as social services, services for women, drug treatment and others.

Limited staff time for referral activities in STD and other clinics may be further affected by the inclusion of individuals who do not come for counseling and testing, but for help in accessing medical and social services. In the Stamford- STD clinic, outreach workers sometimes bring in clients known to be HIV positive so clinic counselors can help them find services. Drug treatment and TB staff also reported that individuals who have been tested elsewhere and found positive come in for referral assistance.

Other Sites. All primary care facilities visited had ready access to medical evaluation and treatment through referral to **onsite** or nearby health department clinics, as did both **TB** clinics visited. Support to those found negative in these clinics, however, was typically limited to a single **posttest** session, often conducted by the regular clinician during the next scheduled visit.

Women's health centers reported similar medical resources through referral, though the Stamford STD clinic reported a major gap in early medical intervention services for women. The clearest illustration of a focus on referring those found positive for care may be the role of Multnomah County, Oregon, women's health/primary care facilities. Staff in one such site report that they serve primarily a "screening" function in assessing risk and providing pretest counseling and testing for those determined to be at risk. In the case

of a negative result, no further services are provided beyond a single posttest counseling session. For positive results, posttest counseling, referral, partner notification, and associated services are handed over to Disease Intervention Specialists from the STD clinic. Despite low seroprevalence rates among women, some staff see this as a weakness and feel that the clinic has not had an incentive to develop a stronger HIV prevention program.

d. Staffing HIV Services

In most sites, clinical staff (nurses and nurse practitioners, sometimes physicians) provide HIV pretest and posttest negative counseling along with other clinic services. This is the case in many women's health and primary care facilities, both TB clinics visited and most STD clinics. However, in Connecticut, dedicated HIV counselors provide CTRPN services exclusively.

For those with positive results; posttest counseling and subsequent referral and partner notification are often referred to more specialized HIV staff. Multnomah County sites refer positive results to Disease Intervention Specialists who handle all steps from the posttest counseling session on. In one Connecticut site, medical residents announce positive test results, but have backup from a social worker and the HIV counselor. In non-STD Florida sites, trained Health Services Representatives handle posttest counseling and elicit names for referral to DIS for partner notification. In STD clinics, DIS generally do some pretest counseling as well as all posttest positive counseling, referral and partner notification. The exception is Boston, where DIS do no HIV counseling at all. (Note: Framingham ATU is an exception--only site in Boston where DIS provides counseling--but this is experimental.)

Drug treatment sites generally have HIV specialist staff providing all HIV services, as do corrections institutions and freestanding CTS. HIV specialists come from a wide variety of backgrounds including nursing, social work, social services, counseling, drug treatment, health education, and others. In many drug treatment sites, a variety of HIV roles are filled by different staff. These include community outreach workers, HIV health educators, HIV counselors, and HIV coordinators/case managers. It is also common in drug treatment sites that HIV specialists have an important role in training and serving as resources to other clinic staff. This may involve inservice sessions for staff within the clinic and in other organizations (see Dimock), as well as consultation and assistance for individual cases.

Training. All staff who provide HIV counseling have taken a standard HIV training course sponsored by the county or state. Some counselors are also trained in phlebotomy, particularly those with nursing backgrounds. Connecticut counselors at CTS sites, who had social services backgrounds, were trained phlebotomists and liked this ability to streamline the CT process for clients. Counselors in New Jersey sites receive additional training to draw blood. DIS have taken an epidemiology course in addition to

state/county HIV training. Boston alternate testing sites (ATS) staff (Dimock, Project TRUST) who see drug using clientele also have taken NIDA S-day course.

In those women's health sites where clinical staff conduct HIV counseling in addition to other duties, multiple demands and time pressures were raised by staff as factors in their effectiveness in providing good services. Consistent training for all staff was also cited as a concern. Staff with multiple duties must stay current with a range of issues related to primary care, ob/gyn, or family planning as well as keeping up with the fast-changing field of HIV/AIDS. The concern for staying current was also reported by TB clinic nurses who provided HIV counseling and testing. Because the volume of testing is low, TB staff at the Westside clinic report difficulty in maintaining counseling skills and current information levels.

An important support need, repeatedly identified by counselors in many sites, is the need for continuing education. Increasingly, counselors encounter clients who are well informed about HIV disease; the counselors believe they themselves must keep current with developments in the field to be credible. In many sites (STD clinics, primary care facilities, and women's health clinics) informal networking, sharing articles and information among staff and occasional inservice training that includes HIV content are the main ways HIV staff stay current. In others, notably some of the Boston and Newark STD sites, staff are offered ongoing training either in-house or by encouraging attendance at conferences and workshops. Yale-New Haven hospital offers a series of lectures on HIV/AIDS topics that is open to any counselor in the area.

Even when training opportunities are available, many staff report difficulty getting away from day-to-day duties to attend. Training videos and manuals to minimize time away from daily work were suggested as ways to help with this problem. Some training topics identified by staff interviewed include ways to approach clients about risk behaviors (both entry level and advanced), cultural diversity; drug use issues, community resources, and treatment options beyond AIDS 101.

2. Confidentiality and Anonymity

Confidential testing predominates among the sites visited. More than half offer confidential testing only; another 28 percent offer both. Connecticut is pressing for confidential testing as the standard with anonymous testing as the option; sites are encouraged to meet concrete goals related to percentage of confidential testing. Among all the sites visited, anonymous testing only is offered only in freestanding CTS sites, and only two-thirds of these do so. Clients who request or seek anonymous testing, however, must eventually agree to confidentiality if medical or other services are needed. In Multnomah County, Oregon, clients who test anonymously are retested confidentially in the county's HIV Wellness Clinic so that an official record of their test results can be included in the medical treatment file.

Though most sites provide mainly confidential testing, access to HIV test results is quite restricted in many. In only two of the nine drug treatment sites visited were results available even to other drug treatment staff without the client's release. In many STD clinics, STD and HIV files are kept separate from other medical or hospital records and cannot be released to other providers without written consent. Atypically, Florida TB, STD, and primary care facilities include HIV results in the client's chart. New Jersey sites are required to report HIV positive results to the state registry.

In corrections institutions, confidentiality is a particular concern. Staff interviewed in these sites were extremely sensitive to the difficulty in maintaining confidentiality and went to great lengths to maintain client privacy as much as possible. Test results are included in the medical record in sites visited; however, efforts are made to restrict knowledge to medical staff who "need to know" and to prevent access to prison staff or other inmates. Nonetheless, true confidentiality is difficult to maintain in such a closed setting. For example, at Framingham, HIV results are not transferred with patient medical records if patients are transferred to a different facility within the prison system. Some drug treatment counselors in methadone and residential programs also reported making efforts to assure confidentiality from other staff and clients. These counselors reported efforts to interact with many clients regularly so that extended counseling time to provide positive results or support would not be so obvious to other clients.

Where confidential testing is performed, written informed consent is obtained in all but the Oregon, sites, which accept verbal consent. In sites which test anonymously, a unique identifying number is affixed to blood samples, lab slips, and return appointment cards to identify the client. Clients may be asked to enter their identifying number on written consent forms in some sites. Often, a card or lab slip with the identifying number must be presented to obtain results. Project TRUST staff report that clients who live on the streets often lose the appointment card with these unique identifiers and therefore may not receive results. Staff there now work with clients to create their own codes using a combination of birth date, initials, and so on.

3. Data Collection

Data collection activities abound in most of the sites visited; however, data are rarely put to use at the site level. The primary purpose for data collection in most sites is reporting, either to funding offices or in conjunction with research projects. Because most data are collected for reporting purposes, many sites were unable to provide data requested prior to site visits. (Clinic data request forms, are provided in Appendix B.) An analysis of available clinic data as well as data provided directly from CDC is provided in Appendix F.

With the exception of Oregon sites, those visited complete the computer scannable CDC HIV Counseling and Testing Report Form, in addition to other state HIV, STD and drug treatment office reporting forms. Oregon sites use a standardized patient encounter form

for the county and a serology form to report HIV testing to the state's HIV program office. Almost all sites maintain separate HIV clinic logs to track who has been counseled and tested, when test results return, and whether posttest counseling has been completed. These are used for internal administrative and management purposes, as well as to help manually assemble the monthly summary data which must be provided to various offices. In Oregon, logs are the basis for reminder letters to HIV clients who have not returned for results within 30 days. Many sites participate in CDC or other research studies, including collecting data on client KABBs, seroprevalence in clinic populations, and such operational issues as partner notification. One New Jersey site reported its HIV activities are funded by eight separate grants.

However, despite extensive data collection activities, most staff interviewed could provide only general and anecdotal information about clientele and volume--e.g., "recently, we have been seeing more women and minorities." In many cases, administrative staff indicated it was possible to obtain requested information from county epidemiology or state office staff, but they did not have it on hand or indicate any regular use of such information. Data requested from sites participating in this study, which mirrored the data elements requested on the CDC scan form completed in most sites, were provided inconsistently and sometimes not at all. In several cases, special effort was required from district or county level administrators to obtain needed data for a specific clinic. Data on client characteristics and testing activity included in this report were obtained from the centralized CDC data base because of the inconsistency of information collected directly from sites.

The data that are collected do not appear to be widely available to or used by staff at the site level. Some exceptions include the Westside STD clinic in Multnomah county, where quarterly reports on HIV activity received by the state are shared with staff and seroprevalence data are reviewed in terms of whether those at risk are being seen in the clinic. Fenway Community Health Center designed an outreach program to recruit more African-Americans and Hispanics in response to demographic data that revealed low numbers of minorities being counseled and tested. Staff at Atlanticare/Lynn Hospital know they are seeing too many "worried well" clients instead of those who are truly at risk because seroprevalence is not as high as it should be. Sites that use seroprevalence and other data appear to be those involved in collaborative research with other organizations (such as hospitals and universities) or may be led by an administrator with a personal background in research and a strong commitment to it.

Use of collected data for program planning and evaluation may be uncommon for several reasons:

1. Sites visited for this study do not generally have internal capability to aggregate and analyze individual data, and do not receive regular reports back from the funding office in most instances. Exceptions include STD sites, which do tend to receive monthly or quarterly feedback from state STD offices. Oregon state HIV program office publishes quarterly surveillance report and annual CT report which are

distributed to all sites. The state HIV office in Florida will provide special reports on request, but requests are rare. The main reasons for data collection at present appear to be participation in a research project or fulfillment of reporting requirements of state or county program offices.

2. Service delivery staff may not see the relevance of statistical data or general trends in their day-to-day work. In a few notable cases, administrative or counseling staff expressed a wish for better data on which to base program assessments and plans. Staff at the Newark STD clinic would like to have a staff member devoted to research and analysis with a background in these areas. However, for the most part staff see completing reporting forms as a chore, albeit a manageable one. Drug treatment center staff, in particular, may perceive data collection activities as time consuming, duplicative, and in need of coordination.

3. The need for reliable and standardized data to help assess the progress of HIV counseling and testing services at state and national levels has increased the level of effort required to assure the quality and consistency of collected data. Given the use of diverse clinical staff to provide HIV counseling in conjunction with other duties, quality control of data collected by various providers is important. In Florida, health services representative (HSR) or DIS are responsible for quality control on both CDC and state computer-scannable forms to avoid their being rejected by the computer. One noted the amount of time which must be spent checking and correcting scannable forms completed by clinicians during patient encounters. She finds it more efficient to precomplete standard sections to minimize things which must be checked afterwards.

An unintended byproduct of current reporting procedures may be a diversion of the counselor's time to data collection at the expense of individualized counseling. One Connecticut counselor reported spending about 30 minutes after each pretest counseling session to handle paperwork for various reporting and research activities. While not recommended as risk assessment tools, the CDC and other standardized report forms were frequently used in observed counseling sessions as a means of assessing individual HIV risk exposure. This is discussed more fully in the section on counseling issues below.

C. Service Delivery Issues

1. Risk Assessment

The extent to which HIV counselors use risk assessment as the basis for counseling depends partly on whether counselors recognize this as an important use of risk information. At least three general purposes for assessing risk were observed in sites visited for this study:

- Identifying exposure categories for data collection and reporting purposes;
- Assessing the presence of HIV risk to determine whether to offer HIV counseling and testing;
- Identifying individual risk behaviors to help tailor educational and counseling sessions.

All sites visited identify exposure categories for reporting purposes. Some sites also determine how strongly to encourage counseling and testing on the basis of identified risk, particularly women's health, primary care facilities and TB clinics serving clientele with lower seroprevalence.

The use of risk information to personalize counseling was less prevalent and appears to reflect individual counseling practice as much as counselor training and guidelines. However, state training and recommended protocol in Connecticut emphasizes risk assessment as a way to target discussions about risk reduction and counselors observed were skilled at incorporating that approach. Overall, among counselors using risk information in counseling, many provide only more tailored information. Fewer work with the client to determine achievable change and craft a personal plan.

a. Risk Assessment Approaches

Risk assessment is conducted both through written self assessment and interview with an intake worker, clinician, or HIV counselor. Frequently, HIV risk will be raised at several points during the client's visit for different reasons.

Self-Assessment. Risk assessment questionnaires are completed by clients during the early phases of their visit in many site types; New intakes at the DACCO drug treatment program complete a general risk assessment questionnaire during intake and a more specific one during group counseling (after admission) where risk exposures are discussed at length. The process assists clients to identify and personalize their own risk and counselors to develop group education and individual counseling approaches. At Operation PAR, the counselor has designed a questionnaire which yields a numerical risk quotient to help focus his interactions with clients.

At the Westside TB clinic, all preventive therapy patients are asked to anonymously complete a risk assessment form. The TB nurse/counselor thinks this helps clients admit to risk behaviors they might not otherwise acknowledge during the interview process. In the St Petersburg TB clinic, the nurse uses a standardized data collection form for risk assessment but would like to have a risk assessment instrument suited to TB clients.

At the Jackson County primary care facility, clients complete an HIV questionnaire customized for prenatal, family planning and STD visits. The questionnaires are reviewed with the client by the provider during the exam and serve as a basis for discussing individual risk. Westside STD clinic patients complete a risk assessment form that can

trigger entry into pretest counseling while patients wait for their STD exams. At the Newark primary care facility, the intake nurse reviews a risk assessment questionnaire completed by the client to determine whether the HIV counselor should be seen.

Several CTS sites ask clients to complete a form or questionnaire while they are waiting to help with routine data collection as well as to help the client and counselor prepare for the counseling session.

Assessment by Clinic Staff. At many sites, risk assessment is part of the initial interview process. In STD, women's health and TB clinics, HIV risk information is discussed as part of standard history-taking. If an interview worker takes the history, the clinician may again bring up issues related to HIV during the examination. TB and family planning clinicians, in particular, point out that HIV must be introduced with sensitivity since clinic patients have come for unrelated reasons. These clinics are more likely to determine the need to offer HIV counseling and testing based on assessment of HIV risk.

STD clients may also be unaware of their HIV risk, though STD staff recognize the importance of unprotected sexual activity and routinely discuss HIV risk and offer counseling and testing. Risk assessment generally occurs during the STD exam when the clinician reviews the client's history. At the Westside STD clinic, a health educator is available to conduct pretest counseling during the wait for the STD exam if the client indicates interest on a preliminary risk assessment form. Typically, she can spend more time discussing HIV than a clinician would during the STD exam.

CDC or other data collection forms may be completed during the initial interview and history, but more typically, data collection forms are completed by the counselor or clinician once the client has accepted pretest counseling. The extent to which data collection forms are used to guide or serve as risk assessment is discussed in the section below.

Screening Potential Clients. While clinics serving women, TB patients, and those presenting for primary health care may use risk assessment as a way to determine the possible need for HIV counseling and testing, some CTS sites find it necessary to use risk assessment to protect scarce resources from unnecessary use by the "worried well."

In both the Hartford and Fenway sites, clinic protocols and staff time specifically include telephone interaction with potential clients and use this information to make or prioritize appointments. The Hartford clinic holds group HIV education sessions twice a month to help interested individuals make better choices about whether or not to be tested. Typically, heterosexuals with no drug use history are directed to these education sessions. After the group sessions, they can opt for a one-on-one counseling session, if desired. Fenway counselors rotate responsibility for telephone coverage and use the initial call to provide referrals, screen for "worried well" and prioritize appointments.

Even in CTS clinics that have not instituted telephone or other screening, several staff have expressed concern about the large number of worried well, particularly in the wake of Magic Johnson's disclosure of his serostatus. At Project TRUST, staff are concerned that more non drug users are coming for HIV services, possibly due to overcrowding and long waits at other sites. While reluctant to turn away clients, staff fear this jeopardizes their commitment and priority in serving injection drug users.

2. Counseling

Counseling was first linked to HIV testing shortly after the HIV antibody test became widely available to the general public in 1985. At that time, alternate test sites (ATS) were funded in anticipation of widespread demand for the test. Free counseling was offered to individuals who sought testing to help them interpret test results accurately and to provide immediate assistance to individuals whose results were positive. By 1987, pretest counseling objectives had expanded to include providing basic HIV information, assessing clients' individual risk, and helping clients determine whether or not testing was appropriate. In addition to providing test results during posttest counseling, clients. received emotional support and, ideally, referrals to appropriate medical and other support services. Reflecting the importance of counseling as an adjunct to the HIV test, ATS were renamed Counseling and Testing Sites (CTS).

The purpose and content of both pretest and posttest counseling have continued to evolve in response to changes in our knowledge about HIV/AIDS, diverse clientele and risk factors, and varied settings in which the test is now offered. HIV counseling objectives have addressed traditional public health goals of both primary and secondary disease prevention as well as medical goals of providing access to early intervention for those who are infected.

The expectation that counseling can play a prevention role is based on the assumption that clients, alerted to the dangers of behaviors that are placing them at risk, will change those behaviors and protect themselves from either exposure to HIV or transmission of the virus to their partners. By identifying persons who would not otherwise learn their positive HIV status, counseling and testing services are also designed to lead to earlier medical interventions as well as referrals to a wide variety of support services within the community.

In both the prevention and early intervention arenas, questions have been raised about the efficacy and efficiency of HIV counseling as a tool for achieving these goals. Behavior change is difficult to achieve in almost any area of life, and particularly so for the sexual and drug using behaviors that place persons at risk for HIV/AIDS. And although early intervention in the disease process has become medically possible, concerns persist about the availability of and access to services.

Chapter III. Overview of the Sites

The purpose of this study is not to evaluate whether or not counseling and testing can achieve or is achieving these and other objectives. These topics, while relevant to this study, are beyond its scope and are the subjects of continued scientific and policy inquiry. Instead, the purpose of this study is to document the kinds and levels of services currently available in a wide variety of sites. The status of counseling, while not the only focus of this study, has been an important one, given its prominence in the counseling and testing process and its potential to affect both long term outcomes (such as behavior change) and short term ones (such as returning for test results).

In order to understand the current status of counseling in these sites, trained site visitors obtained data from a variety of sources. Both administrators and counselors were interviewed in each site to gain insights into which factors, from their perspectives, affect the delivery of HIV counseling. In addition, both pretest and posttest counseling sessions were observed. (Interview instruments and counseling observation checklists are included in Appendix A) Although site visitors did not assess the quality of counseling, they did note and describe in site visit reports'the content, duration, and approach of counseling sessions. Instruments such as data collection forms, counseling protocols, and risk assessment forms used by counselors also were collected onsite.

Not surprisingly, the variation in counseling styles and approaches, counselors' professional backgrounds, HIV-specific training, site and program protocols, and client needs yielded not only rich data but also very little consistency either within site types or across sites. The purpose of this section is not to speculate about causal relationships between any of these factors, but rather to identify issues and trends that have implications for training, guidelines, and/or future research. Findings are reviewed from both interview and observation regarding each type of counseling session--pretest, posttest positive, and posttest negative. In addition, counselor and administrator views on HIV-specific training and other aspects of providing HIV counseling are discussed.

a. Pretest Counseling

Goals of Pretest Counseling

As noted above, HIV counseling has been asked to meet a variety of objectives. Pretest counseling, in particular, seems to follow many and sometimes conflicting models. For example, testing itself is sometimes seen as a goal, either explicitly (as in Florida, where counselors are expected to meet target acceptance rates of 80 percent) or implicitly. When the success of pretest counseling is judged by whether or not a client accepts testing, an emphasis on testing can take precedence over other aspects of pretest counseling, in the view of staff at one Florida site. In two clinics acceptance rates were linked to counselors' longevity in the job; "newer nurses have lower acceptance rates" and "acceptance rates have increased as counselors become more comfortable offering the test."

In contrast, some counselors are unsure of the test's appropriateness for all clients, and state that the goal of pretest counseling is to give clients enough information to make an informed decision about testing. In some cases, this leads to an exploration of risk behaviors and attention to whether or not the client is capable of dealing with test results, but in others, this focus translates into extremely detailed discussions about the accuracy of the test.

In many cases, these approaches can coexist or, if necessary, change depending on the client's needs. But because relatively little time is available for accomplishing a variety of informational, skill building, and data collection tasks during pretest counseling, adherence to different models often determines the content of counseling in such a way that one area of content is emphasized at the expense of others. Risk assessment, for example, is often linked to risk categories on data collection forms, not because it is the most effective way to begin a dialogue about individual risk, but because it is efficient.

General Observations

The average duration of pretest counseling sessions across sites was 20 minutes, with several clinics routinely scheduling 30 minutes or more. Longer sessions--up to 1 or 2 hours--were noted in drug treatment sites and in prisons. In some drug treatment centers, pretest sessions can last up to an hour. In STD clinics, primary care facilities, tuberculosis, and family planning clinics, pretest counseling is often incorporated into the history taking or exam, in which case it is usually shorter than stand-alone sessions. In every case, counselors who conduct pretest counseling sessions have received some type of specialized HIV training. In almost every clinic, counselors follow a protocol for pretest counseling, either using a data collection form to discuss risk or a more generic counseling protocol. Typically, these protocols include an explanation of the test and transmission routes and a discussion of the client's risk behaviors. In many cases where counseling protocols are followed, counselors stress that they use these only as general guides and emphasize different topics, depending on client needs and concerns.

A common element of pretest counseling is discussion of the "window" period. A counselor at Boston's SPAL notes that this is important for subsequent negative sessions, so that clients recognize that they may need to be retested if exposure has occurred. Another topic common to pretest sessions across sites is the distinction between HIV and AIDS. At the Bridgeport Health Department STD clinic, one counselor described this as the main focus of the counseling session, noting that many clients do not understand the difference between infection and AIDS and are afraid of AIDS,

Another common feature of pretest counseling is some exploration of how clients would handle either positive or negative results. In many cases, counselors try to allay fears of positive results by stressing that services are available, Without giving false hope for a cure, one counselor suggests that clients think of HIV as a chronic, manageable disease, not an immediate death sentence.

Client-Centered Counseling

The prevention goals of pretest counseling suggest that risk behaviors, where they exist, should be addressed during the pretest session. The unprotected sexual and drug-using behaviors that place individuals at risk for HIV/AIDS are complex ones, reflecting a context of risk perception, health beliefs, lifestyle, and competing priorities (among many other factors) that is unique for each individual. Because of the complexity of these behaviors, their imperviousness to change, and their intimate (and, in the case of drug use, illegal) nature, the behaviors are often difficult for both counselors and clients to discuss. However, it is crucial that clients receive risk reduction information that is tailored to their behaviors, circumstances, and needs so that it is seen as relevant.

Risk Assessment and Risk Perception

As noted elsewhere in this report, risk assessment means very different things to different people. In the context of pretest counseling, it is, ideally, an interactive process between the counselor and client during which time the client is assisted in identifying and acknowledging risk behaviors so that they can be reduced or minimized in the future. In this sense, risk assessment forms the basis for both perceiving risk and developing a plan to reduce risk(s), making it an essential component of pretest counseling that has prevention of HIV transmission as its goal. In practice, this does occur to an extent, but one or more of these elements--the interactive nature of risk assessment, detailed assessment of risk behaviors, and, most strikingly, discussion of risk reduction measures--often is either limited or absent.

In some clinics, the risk assessment process begins before the pretest counseling session. In these cases, clients are asked to fill out risk assessment forms that are designed to get them thinking about possible exposure while they are waiting to see a counselor. The forms are reviewed with the counselor during the pretest session. Counselors in several clinics open counseling sessions by asking questions such as, “Why are you here today?” or “What made you decide to be tested?” as a way to initiate the discussion of risk. At Project CARE in Boston, clinic protocols prompt counselors to ask questions that are designed to elicit responses about risk perception, including “Why are you concerned about AIDS?” or “What makes you believe you may have been exposed to the virus?”

Several counselors reported that it is important to understand how the client sees his or her risk. In some *STD* clinics, despite accurate knowledge of transmission routes, clients with STDs still did not perceive a personal susceptibility to transmission. At an anonymous test site in Portland, the counselor (who sees mostly gay and bisexual men) tries to avoid discussing “high” or “low” risk, noting that many clients are looking for ways to deny their actual level of risk.

Despite some notable exceptions, most observed risk assessment during pretest counseling was one-sided, rather than interactive, and tended to follow a prescribed format--either from data collection forms or from clinic protocols. While some counselors were

successful in eliciting detailed information on risk behavior using these methods, most identification of risk behaviors seemed to distinguish between aggregate risk categories (such as gay/bisexual, injection drug user, heterosexual with multiple partners), rather than specific activities (for example, type of sex, needle sharing, trading sex for drugs). In addition, very little exploration of circumstances surrounding risk behavior occurred and few counselors followed up on the information given. In an extreme example, a male client in a New Jersey clinic volunteered the fact that he had injected drugs the previous weekend--an admission that not only was ignored by the counselor, but was followed by a detailed explanation of perinatal transmission and a warning that French kissing could be dangerous because of cuts in the mouth.

Counselors and administrators in several clinics expressed frustration that resources are unavailable to provide extended counseling or referrals to individuals who continue to deny their risk for HIV/AIDS. In every STD clinic, for example, staff see some clients returning with repeat STDs. However, few felt that the pretest counseling session itself or other clinic resources would be sufficient to address these clients' risk reduction needs.

Risk reduction measures were largely confined to generously distributing condoms and reminding clients of their importance. Two exceptions are the St. Michael's CTS in New Jersey, which does not distribute condoms because it is a Catholic facility, and the sites within correctional institutions, where condoms are contraband. It should also be noted that in drug treatment facilities, extensive risk reduction counseling may occur outside of the HIV counseling session.

In observed sessions, there was little exploration of why clients did not use condoms or which factors had contributed to failure to use them in the past. One exception was a counseling session in a Portland detox facility. The client, a prostitute, said in answer to the counselor's question that she used condoms about half the time. When he asked what happened on those occasions that she had not used condoms, she replied that sometimes her partners resisted, and other times she didn't have any available. The counselor made some suggestions about negotiating with partners, acknowledging that this was a difficult situation, and reminded her that condoms are always available at the clinic and, after clinic hours, at neighborhood bars. At the Stamford Women's STD Clinic and WIC center, discussions with women about condom use address the difficulties in convincing partners to use them and their implications of suspected infidelity.

Condoms are routinely demonstrated by counselors in two of the clinics; one counselor notes that clients are often too embarrassed to admit that they do not know how to use them. In another Florida clinic, condoms are demonstrated if the counselor perceives a problem or if the client is a new user. At this particular clinic, contraceptive foam is routinely given to women along with condoms; during an observed session, use of the foam canister was demonstrated but the condom was not, (Foam was also recommended to women in some New Jersey clinics.) In this site, counselors make an effort to distinguish between birth control and protection from STDs when discussing foam and condoms. At the Bridgeport STD clinic, counselors routinely demonstrated condoms to

each client in the past, but now find that there isn't enough time to do so. Instead,. they mention specific aspects of condom use such as the reservoir tip and using appropriate lubricants. Other counselors provide very specific information about condom use, but do not necessarily demonstrate their use.

Developing a realistic plan for future risk reduction was also not a notable feature of observed counseling. A Florida counselor told a client, "you can control your risk with a few relatively simple actions." In contrast, the Oregon detox counselor described above noted that clients are only human; some relapse or failure can be expected. Several counselors reinforce the client's decision to be tested as a step towards improving one's health and place risk reduction measures in this context. For example: "you've taken this step; now let's talk about what else you can do." At the Stamford Women's Health Center, counselors try to acknowledge their clients' lack of power in relationships and the difficulties this poses in terms of insisting on condom use. However, they encourage women to take responsibility for their own sexual health, saying "Who's going to do it if you do not?" Staff at the Jackson County Health Center noted that some skill building is needed at more basic levels before condom use or other risk reduction measures can occur. According to staff, this might include self esteem counseling and negotiating skills with partners.

In addition to providing a basis for tailoring risk reduction measures, risk is sometimes assessed in order to screen the "worried well" from the HIV test. Two clinics--Fenway in Boston and Hartford in Connecticut--screen clients by phone when they call for appointments. At the Connecticut clinic, heterosexuals with no drug use histories are usually referred to group education sessions that are held twice a month.

Approaching Clients

Several counselors and administrators noted the importance of accepting client behaviors and remaining nonjudgmental. As one Florida drug treatment counselor said, he tries to do more than "just preach." An Oregon HIV counselor within a detox facility noted that most of his clients have had a succession of people shaking a finger at them all their lives, saying "Do not do this" or "do not do that." He observed that this is not the way people learn in any setting, and there is no reason to expect it to work for HIV risk reduction counseling. A nurse who conducts pretest counseling for TB patients makes a point of telling them that HIV counseling and testing is offered to all clients; they are not being singled out because of their appearance, lifestyle, medical history, drug use, or any other factor.

In many observed sessions, communication with clients was driven by data collection forms. Several counselors noted that the technical phrasing of questions for data collection purposes can be improved; these alterations can play a role in eliciting more accurate information about risk behaviors. For example, a primary care nurse in Oregon reported that she and her colleagues had switched from asking clients, "Have you ever been a prostitute?" (the language on the form) to "Have you ever been in a situation

where you felt you had to trade sex for food, shelter, drugs, or money?" She found the latter version to be less judgmental, and also noted that many women have traded sex for shelter or even money with various partners for extended periods of time, yet do not consider themselves to be prostitutes. Similarly, an HIV counselor specializing in clients of drug treatment centers and correctional facilities always asks, "When was the last time you--?" instead of "Have you ever--?", noting that it "gives permission" to the client to admit to the behavior in question.

At the Pinellas County STD clinic, a clinician reports that she often sees clients who are unable to read. When she suspects that this might be the case, she finds a reason to read the informed consent form to clients. For example, in one observed session, she asked the client if he would like her to read the form for him since his eyes seemed to be bothering him; he agreed.

Multiproblem Clients: Implications for Counseling

Counselors in several sites noted that their clients face a number of health and personal problems in addition to the threat of HIV/AIDS. These include poverty, unemployment, drug use, homelessness, and living amidst personal and community violence. In order to provide HIV information and risk reduction counseling, some counselors feel that they have to address these broader issues first. At Boston City Hospital's STD clinic, nurses report that they spend time discussing basic hygiene and preventive health care during the session. At this site, nurses try to convince clients that they "have a right to be healthy." At Framingham's STD clinic, located within a women's prison, the DIS who conducts HIV counseling is concerned that for many of the detainees seen in the clinic, she is the sole source of emotional support. Similarly, the HIV counselor at Niantic says she has to give women the space to ventilate feelings of anger and helplessness before she can address HIV issues. At the Westside CTS in Portland, one of the nurses who conducts pretest counseling in both the STD and CTS clinics reports that she has been seeing more and more clients with multiple and serious problems, which are difficult to address, let alone resolve, within the pretest counseling session.

Cultural Issues in Counseling

Ideally, the delivery of risk reduction information acknowledges not only differences in risk behaviors and life circumstances but also cultural, developmental, and linguistic differences. Many clinics serve culturally diverse populations and have made efforts to provide a closer match between staff and clients. However, shortages of linguistically and culturally competent staff remain a problem in many clinics. The shortage of Spanish-speaking counselors was particularly acute in Boston and Portland sites, although in both areas some Spanish-speaking counselors are available to meet the needs of Hispanic clients. In Boston, staff are concerned that although translators are available, they have not always been trained in HIV/AIDS issues. At the Framingham Awaiting Trial Unit, a Spanish-speaking detainee translates sessions for her peers. At several Oregon sites, non-Spanish-speaking staff have learned a few key phrases (such as, "someone will be with

you in a few minutes," or "please have a seat"), and some staff are taking Spanish sessions on their own. In two clinics, signs throughout the clinic are in Spanish, providing instructions such as "Please take off your shoes before stepping on the scale," or "Please remove your baby's clothing."

Aside from language, several issues specific to Hispanic clients were reported by clinic staff. At one clinic, staff who see many Hispanic clients report that continuity is important, and they make a special effort to provide the same counselor for both pretest and posttest counseling for Hispanic clients. In several clinics, staff mentioned that Hispanic men are particularly reluctant to use condoms with their wives or steady girlfriends, and that Hispanic women anticipate this resistance. Condoms are strongly associated with prostitution and can be interpreted as an inappropriate suspicion of infidelity. In some cases, counselors address these issues in counseling, acknowledging the difficulties and suggesting ways to discuss and initiate condom use.

In Boston, staff at a variety of clinics 'confront cultural norms specific to the Portuguese and Haitian communities. At the Somerville Portuguese American League (SPAL), a CBO serving the Boston area's Portuguese-speaking community, staff report a dramatic change in the community in the last 5 years. During this period, immigrants from Cape Verde, Brazil, Mozambique, Angola, Guinea-Bissau, Timor, and the Madera Islands have joined the community of European immigrants from Portugal and the Azores. The more recent immigrants include many young, single men in their 20s who, as a group, are likely to be sexually active, have multiple partners, and also have no history of condom use. Cape Verdean immigrants face additional linguistic difficulties even within the Portuguese community, since their dialect is not readily understood by other Portuguese speakers. Many recent immigrants come from rural areas, reflecting traditional health beliefs, and have low literacy rates. SPAL staff noted that visual materials about HIV/AIDS are an important tool for reaching recent immigrants with prevention information.

Staff at Boston City Hospital and Project TRUST, who have been seeing more Haitian immigrants among their clientele, report that this population has specific HIV counseling needs. One issue is that translators with HIV training are needed for Haitian Creole clients. A more complex barrier to service delivery is a set of culturally rooted beliefs about AIDS and the role of traditional healers and medicines. Among these is the belief that AIDS is a curse placed on individuals by supernatural powers. Because of this belief, persons with HIV/AIDS are often ostracized by the Haitian community, and clients are particularly fearful of the stigma that would result if their HIV results became known in the community. Project TRUST initially tried to connect clients with Boston City Hospital staff who were of Haitian descent in order to match clients with culturally appropriate staff, but the strategy backfired when Haitian clients were reluctant to be treated by Haitian staff because they feared their status would become known within the larger Haitian community.

b. Posttest Counseling

Posttest Positive Sessions

Across site types, posttest sessions for clients whose results are positive have two main goals: stabilizing the client, and linking him or her to some sort of ongoing support. Partner notification is a key feature of posttest sessions in several sites, but not across the board. Referrals and partner notification are discussed in greater detail below.

Posttest positive sessions are typically scheduled for between 30 to 60 minutes. In many clinics, DIS provide posttest positive results because of their training and greater experience delivering results and because of the link to partner notification. In other cases, results are provided by the same counselor who conducted the pretest session, if possible, or by the counselor accompanied by a DIS. At the Yale-New Haven Hospital women's health center, positive results are delivered by a medical resident; a hospital social worker and the HIV counselor are available to help the client once she has received her results.

Counselors in a wide variety of sites report that they emphasize the difference between infection and disease, and try to help clients develop a plan for living with HIV/AIDS and taking control of their condition. Counselors review the need for staying healthy through medical evaluation and care, exercise, stress reduction, and proper nutrition. In some cases, risk reduction measures are also reviewed, to prevent both transmission to partners and reinfection. One counselor at a CT in New Haven noted the inherent limitations of trying to deal with such a range of complex issues and a life-changing event in just one session.

A specific concern in drug treatment clinics is that clients will return to drug use in response to HIV positive results. In some clinics, primary substance abuse counselors are aware of results and monitor clients for any signs of drug use. In one clinic, the primary drug counselor is invited to participate in the posttest session. Special issues unique to prisons include the need to give clients enough time within the posttest session to work through strong emotions before returning to a group setting. At the Webster correctional facility in Connecticut, positive results are never given on Fridays because clients might have to spend the weekend without routine access to a counselor. At the Niantic women's facility, the counselor often calls on professionals in the psychiatric unit to help deal with women's strong response to news of a positive test.

Posttest Negative Sessions

Posttest negative sessions are typically the briefest of the three types of counseling sessions, lasting between 10 to 15 minutes in most clinics, Counselors report that clients are so relieved by their results that it is difficult to convey the need for continued risk reduction. As one counselor in a detox facility pointed out, for many clients the negative results may be "the only good news they've had in years."

Many counselors do try to emphasize the need for continued risk reduction by saying, "You're negative now, but what will you do to stay that way?" In Boston sites, counselors jot down notes about the client on index cards immediately after the pretest session; these are reviewed during the posttest session. The HIV counselor at Hooper Detox tries to help clients develop a realistic plan for behavior change, noting that since clients are only human, there is a chance that they will return to destructive behaviors despite their good intentions.

Counselors also try to remind clients that the negative results are meaningless if exposure has occurred. One counselor reports that the most important message to get across to clients in posttest negative sessions is "You didn't have it 6 months ago." Retesting is routinely recommended, usually in 6 months but sometimes in 3 months, and occasionally at regular intervals, as in one Florida site. At one observed session, the client asked for a document "certifying" her negative status.

Several counselors and administrators expressed frustration with the lack of resources available for clients whose results are negative. Many require additional counseling to confront their risk for HIV/AIDS. Extended counseling and other services are usually available for HIV-positive individuals, if at all. Project TRUST staff note that many issues raised by the HIV counseling and testing process remain unresolved for the client whose results are negative. These include coming to term with lifestyle issues and risk behaviors, or, in some cases, dealing with a partner's infection.

Additional Sessions

Additional sessions are available in many of sites. In some cases, these sessions are available if the counselor thinks they are warranted, while in other sites, additional counseling sessions are routine. In residential drug treatment facilities and prisons, continued access to clients (and counselors) facilitates additional sessions and informal monitoring of how clients are doing.

In Hillsborough County, HIV-positive clients have at least two posttest sessions: one to deliver results and a second, separate session to elicit names for partner notification. (Both are conducted in the field.) In other clinics, counselors let clients know they are available by telephone if a need or crisis arises. At Dimock Community Health Center in Boston, counselors carry beepers and are available 24 hours. In Boston, clients are asked to call an 800 toll-free number to arrange a posttest session; operators at the same number are available to talk with clients if they become anxious while waiting for results.

c. Counselor Training Issues

Although HIV counselors reflect a wide variety of professional backgrounds, all have taken some type of HIV-counseling course sponsored by the state, county, or city. Typically, these courses last 2 to 3 days. Staff of some facilities that have a predominantly

drug-using clientele have also taken 3-day NIDA courses on HIV issues. In several program areas, HIV counselors also have phlebotomy training, enabling them to draw blood at the end of the pretest counseling session.

Disease Intervention Specialists have completed a general 2-week training course that includes HIV information, as well as HIV counselor training. A DIS supervisor noted that the DIS course addresses factual information about HIV/AIDS, but does little to explore counseling issues or how to handle the grief and bereavement that are inevitable in dealing with a fatal diagnosis.

While staff were generally satisfied with the training they had received, many expressed a need for more specific and advanced training, now that they have had "HIV 101." Staff of both CTS and STD sites almost unanimously mentioned a need for better training in approaching culturally diverse populations and in dealing with drug use issues. Some nurses in primary care facilities mentioned the difficulties associated with approaching clients about sexual and drug-using behaviors. As clients become better informed about the disease and treatments, many counselors expressed a need for more routine, accessible updates on current information. Because conferences are difficult for many staff to attend, videos, teleconferencing, and newsletters were suggested as possible vehicles for HIV training information without requiring excessive staff time or travel funds.

3. Testing

In the majority of sites visited, blood is drawn for HIV antibody testing by the counselor at the close of the pretest counseling session. This is particularly true of STD, CTS, and drug treatment sites.

In sites that serve injection drug users, a phlebotomist may be needed to assist with clients whose veins are in poor condition. At Dimock, counselors who are recovering IDUs find it difficult to draw blood, so other counselors may be brought in to do this after the counseling session.

Drug treatment sites, in general, were more likely than other site types to draw blood for HIV antibody testing with a separate stick during the counseling session. In those using a 'single stick for all blood work, the HIV counselor usually drew blood for all clinic purposes, including HIV testing.

In primary care facilities and women's health sites, blood was more typically drawn by a lab technician on site who also draws blood for general clinic purposes with a single stick. In one women's health center, ongoing seroprevalence studies required multiple samples from the same blood drawing, necessitating a separate stick. Clients at that site also had to go to the phlebotomist at an adjacent building.

In Connecticut prison sites, blood is drawn only on specified days so clients must often return to the medical unit a second time to have blood drawn.

In the two TB clinics visited, the TB nurse/counselor drew blood at one (Westside), while the client was sent to the health center's central lab for all blood work in the other.

Return Arrangements. For the most part, clinics either schedule a return appointment or provide a date when results are due back and request that clients call to schedule an appointment. An appointment or reminder card may be given to the client. In some sites, the client receives a copy of the lab request form.

The percentage of clients who return for their HIV test results varies widely across clinics, but is generally consistent with national data. Many clinics have made some attempt to address operational barriers such as excessively long waiting times for receiving results. In some walk-in clinics, appointments or express lanes are available for posttest sessions. In others, return appointments are scheduled as the client leaves the pretest session or by phone. In the latter cases, clients are asked to call the clinic (usually in 2 weeks) to check that their results are in and to make an appointment for the posttest session, usually within 1 week. One exception is Florida sites, where trained DIS conduct posttest positive counseling sessions in the field before clients have had a chance to return to the clinic.

Many clients who do not return may not wish to know their results, either because they suspect they are positive or because of more general anxiety. A TB nurse suggested that clients of TB clinics may be reluctant to accept HIV testing in the first place because of the fear of facing another diagnosis, in addition to their diagnosis of tuberculosis. However, there may be a proportion who, despite explanations, misunderstand the process, especially in non-CTS sites where the delivery of HIV test results differs so markedly from others. Nurses in primary care facilities pointed out that in other test result situations (such as Pap smears), providers let clients know if test results are a cause for concern; clients may expect this for their HIV results as well. A counselor at the Lee Davis clinic suggested that clients have become so accustomed to HIV testing as a routine medical service that they do not accord it priority status.

Sites that see clients on an ongoing basis, such as drug treatment centers, prisons, and TB clinics, may be less concerned about poor return rates, since there are continuing opportunities to contact those who are tested. In these clinics, the chart is often flagged when test results return so that the clinician can be sure they are provided to the client on the next visit.

Other sites, such as STD and CTS clinics, are more conscious of the need to encourage returns or ensure follow up, where confidential testing is in place. Project CARE provides a toll-free 800 number so that clients can call to check whether results are in. Fenway tries to schedule posttest appointments in the evening when the clinic is less crowded; Project TRUST staff encourage clients to bring someone with them.

STD staff generally report low return rates and agree that once an STD is treated, clients have little incentive to return for HIV results. Boston City Hospital has begun sending reminder letters to clients who do not return, but reports only marginal success. Another strategy is to remind clients that they will not have to wait long for posttest sessions; most clinics expedite posttest counseling.

Follow Up of Nonreturning Clients. The extent of followup effort is largely dependent on whether test results are negative or positive and whether testing was conducted confidentially or anonymously.

Negative results will generally be provided on the next regular visit, if the client does not come in specifically for HIV results in the interim. In Oregon, clients who do not return receive a discreet reminder letter after 3 months. The Hartford Health Department sends a letter after 10 weeks inviting clients to call the "Hello Line" for information about test results. Hartford plans to use outreach workers in the future to contact clients who do not return.

For positive results, follow up activities are more aggressive. Oregon and Florida sites refer to DIS for contact in the field. In Florida public health sites, particularly, DIS may be sent into the field to contact clients as soon as positive results come back, and before clients have had an opportunity to return. Staff recognize that patients know "we'll come and find them if they are positive" ; which is indeed the case. New Jersey sites may provide names of those who do not return for positive results to the state Notification Assistance Program (NAP). The Newark primary care facilities makes a series of effort to reach these individuals with letters and outreach staff before referring to NAP.

4. Referral

Referrals are a key focus of the posttest' counseling session for HIV positive clients, particularly HIV medical evaluation and early intervention. However, access to needed medical services varies in the study areas visited. Sites in Oregon and Florida have direct access to medical evaluation and treatment through referral to public health HIV clinics and primary care facilities. While there are gaps in available services, staff in these localities generally felt fortunate to have available care.

New Jersey, Connecticut, and Boston sites reported more difficulty accessing HIV early intervention services. New Jersey sites report substantial waits for services. In Connecticut, there appears to be limited early intervention care in some cities like Stamford, sometimes necessitating clients' travel to locations (e.g., New Haven) where specialized HIV care is more readily available. Sites that are not linked to a specific HIV treatment facility may have difficulty finding and making referrals, Project TRUST in Boston reports that HIV-positive clients wait an average of 14 months to be seen for primary care services at Boston City Hospital's Diagnostic Evaluation Unit. Some sites provide initial nursing assessments, and a few provide and assess CD4+ cell counts.

Other health care services often available in-house in sites visited include STD and TB screening, and, to a lesser extent, family planning. While CTS and TB clinics did not report themselves as providing these additional services, these sites were generally housed within public health or community health centers that do so. Drug treatment sites and some CTS sites housed in community based organizations are more likely to provide continuing in-house support groups. For the most part, social, legal, and psychosocial support needs are referred out, frequently to community or volunteer groups.

Dental care, mental health, and social services are among the services often cited as gaps in available resources.

Case Management. In sites that have case management services, more followup of referrals and assistance to clients in obtaining needed help is reported. Where case management support is not available, staff report a great need for this kind of help.

In some sites, social workers or case managers are available onsite to assist with a variety of medical and social service referrals, including assistance with benefits, housing, support groups, therapy, and legal issues. However, even in the sites where staff are available to help with referrals, they may have other non-HIV responsibilities and are sometimes too busy to see all HIV-positive clients. At SPAL in Boston, HIV-positive clients who were not originally tested through the program have asked the case manager for help in finding services. Sites that do not have case managers or social workers on staff cite this as a needed service.

In most cases, counselors seem to be responsible for identifying a wide range of services for clients. Informal networking with colleagues, participation on local AIDS task forces or coalitions, and individual initiative seem to be the source of many referrals, although counselors do build up knowledge of community resources over time. In the absence of other resources or assistance, some counselors show extraordinary personal dedication to their clients. One Florida counselor assists with transportation and paperwork. In Boston, some counselors are able to set up community referrals by linking clients to services closest to their home zip codes.

Problems inherent in this mode of maintaining a referral system are magnified for HIV staff in corrections institutions. For those released from the institution, referrals are made to community resources when the counselor is aware of them. However, since inmates come from all over the state, and some from out of state, it is virtually impossible to maintain a personal network of resources. Connecticut prisoners who are released take with them a standard form listing information about their overall health status, including HIV, and are expected to take this information .to a community provider when seeking care.

Similarly, STD staff in Hillsborough County do not provide referral beyond providing a list of primary care facilities within the county health system. Staff have assembled some

additional educational and resource materials, but have no support staff available to assist clients and expressed a need for better referral materials and support.

HIV clinics to which Oregon and Florida sites refer usually have social work or case management staff to help those referred for medical evaluation with further referrals.

5. Partner Notification

Partner notification has traditionally been a central feature of STD control and remains so for HIV services in STD sites visited for this study. However, in other site types there is wide variation in the extent to which partner notification is encouraged and in the ways assistance is provided. Assumptions about the nature and purpose of partner notification remain an issue. Many staff, particularly in drug treatment and CTS sites, continue to equate partner notification with provider referral and resist the idea of pursuing individuals to recruit them into HIV testing. As one Boston counselor put it, partner notification is "explained, but not emphasized."

While many STD sites report an emphasis on provider referral with assistance by DIS staff, patient referral also appears common. Bridgeport clinic staff report coaching clients to discuss HIV infection with partners as well as offering assistance from the state's CARE team. Pinellas County STD counselors report providing coaching and role playing exercises for those who wish to use patient referral. Clients who choose patient referral are given "blue cards" that offer a free exam to partners. In Oregon, state law distinguishes between aware and unaware partners. STD/DIS concentrate on identifying and locating unaware partners and recommend patient referral for aware partners, though assistance is offered for aware partners as well. The Hillsborough County STD clinic is participating in a CDC study of partner notification which has increased the use of patient referral there. However, the clinic continues to emphasize and monitor the number of partners identified through client interviews and to focus on partner notification in posttest counseling and subsequent field interviews.

Partner notification is not a well established part of services offered in drug treatment centers visited. The importance of notifying partners is usually raised in posttest positive sessions, but offers of assistance are generally low-key and left to the discretion of the client. Many counselors report urging clients to let their own partners know or to bring partners in for counseling and testing, but few described efforts to assist clients to do so. Two New Jersey drug treatment sites report they are beginning to elicit partners names to the state Notification Assistance Program, and have participated in a recent training program to clarify the role and purpose of provider referral. Staff in some sites voiced resistance to partner notification, tending to associate this practice with "STD contact tracing."

Boston CTS sites, which are generally not aggressive about encouraging provider referral, report offering written and verbal suggestions to clients to refer their own partners.

Project TRUST provides clients with stamped envelopes containing Project TRUST business cards for those who wish to notify their partners anonymously through the mail.

The most aggressive partner notification program was observed in Florida sites, where HIV specialists in public health clinics, called Health Services Representatives, are trained to elicit names of partners and to forward these to DIS staff for notification assistance. HSR's provide posttest positive counseling to clients in all Florida clinics visited except STD, including primary care facilities, women's health, TB and CTS sites.

The use of DIS for notification assistance, and often for posttest positive counseling and referral as well, is a common pattern in several study areas. Oregon public health sites refer to DIS for partner notification. Multnomah County sites also refer posttest positive counseling and referral to DIS, along with partner notification services. The DIS at the Framingham women's prison provides counseling and referral, as well as partner notification services. In other Boston sites, DIS provides partner notification assistance but do not conduct any counseling. sessions. In Connecticut partner notification is available through a special state outreach unit called the Companion Awareness and Risk Education (CARE) team, staffed by trained field investigators. However, acceptance of this service remains low, and the state AIDS unit is seeking way to increase utilization of it.

Several Boston sites offer the services of a DIS for notification assistance, but do not encourage provider referral. At Dimock and at the Boston City Hospital STD clinic, clients are provided with written information on DIS assistance with partner notification. Atlanticare/Lynn Hospital staff do emphasize partner notification and offer DIS assistance, but they report that clients prefer to notify clients themselves.

D. Innovative Practices

Administrators and HIV counselors were asked to identify innovative or exemplary practices in their clinics. Several respondents commented that while they did not believe their practices were particularly innovative or exemplary, they had arrived at strategies for improving services that were more like tips or tricks for other providers in the HIV/AIDS field. Their responses are listed below, grouped by site type.

1. Counseling and Testing Sites

- At the Marleen clinic, a recorded message tells callers clinic hours, bus lines, description of services, and the fact that services are free. Clients are invited to hold on if they would like to speak to someone. The recorded message freed up the clerk/receptionist.

- Project CARE offers an 800 telephone number that clients can call if they become anxious while waiting for results. Staff report that many clients use this service.

- Fenway and Dimock have implemented stress reduction measures for staff, including regular meetings to discuss frustrations and solve problems, building administrative time into the work week so staff can complete paperwork without working overtime, distributing positive sessions evenly among staff, group sessions for staff with a clinical psychologist,, providing opportunities to attend training and conferences, periodic all-day retreats, and flexible scheduling/leave policies to allow staff to take mental health days as needed.

- Hartford Health Department CTS designed an exit interview questionnaire for clients to assess quality of services. In addition to positive feedback, comments were used to improve the clinic's phone protocol to give clients calling from work more privacy.

2. STD Clinics

- At Westside STD in Oregon, the waiting time for the STD exam is used to provide more indepth pretest counseling for clients who indicate an interest in either HIV information or testing on the intake/risk assessment form.

- Bridgeport Health Department's STD clinic plays a video in the waiting area that features realistic characters, explicit street language, and rap music; clients observed during the site visit seemed absorbed in the video.

- Hillsborough County STD clinic staff provide monthly blood screening outreach to the community; last month, HIV testing was added. Staff set up in a central location, such as a housing project, and provide blood tests for STDs and HIV. Teams of DIS go door-to-door offering the same services. Privacy and time are obstacles to providing HIV pretest counseling, but 16 people accepted HIV testing last month. None were HIV-positive.

- Physicians assigned to primary care facilities in Tampa receive a week of training in Tampa's STD clinic. This includes half a day spent with a DIS on epidemiology and partner notification.

- The main benefit of targeting Stamford STD clinic services to women is "to get people outside the system wedged into the system" so that they can receive health care, including HIV counseling and testing.

3. Drug Treatment Centers

- A specialized prenatal program for pregnant women who are addicted to heroin. Women in drug treatment are seen by an obstetrician who comes to the clinic one time per week for clinic visits. A pediatrician is also available to assist in following the children who are born during their mother's drug treatment. Nutrition and parenting classes are offered for these participants.

- Services of an acupuncturist who assists in detoxification and cessation of cocaine through a 4-week protocol. Acupuncture services were reported at two sites.

- Support to counseling by offering a weekly parenting group offered weekly to clients. The program has proven effective in enhancing parenting skills and satisfaction with family issues.

- Project Hope thinks one of its major strengths is a holistic approach and strong team orientation. Staff believe an attitude of unconditional positive regard permeates the program--clients are treated with dignity and respect. It is important to be very positive and view the situation as "living with HIV/AIDS."

- The Paterson site has set aside one evening each week where service providers from other organizations come to the clinic to see clients.

4. Women's Health Clinics

- At the East County Health Center in Gresham, Oregon, a nurse who conducts HIV counseling reported that the language on risk assessment forms can seem judgmental. Instead of asking clients, "Have you ever been a prostitute?" she asks them, "Have you ever been in a situation where you felt you had to trade sex for food, shelter, drugs, or money?"

- At the North Portland Health Center, staff see many Hispanic clients, but few staff are fluent in Spanish. As an interim measure, staff have learned a few key phrases in Spanish, such as "Please have a seat; someone will be with you in a few minutes" as a way to make clients feel more comfortable.

5. Primary Care Facilities

- At the North Portland clinic, the administrator noted the availability of the HIV clinic downtown and all its resources for referral of clients. A "top-notch" staff at the clinic who are comfortable discussing HIV issues with patients was also reported as a major asset.

- Clinic staff in the Jackson County clinic feel that their outreach to high-risk groups has led to better access to counseling and testing services among clients who might not otherwise have sought out these services. The Health Department subcontracts with another community agency for targeted outreach to injecting drug users and gay men. If more than four high-risk people wish to be tested at the same time, the county arranges offsite counseling and testing.

- Staff at Jackson County also recognized that the amount of time they are able to spend with clients is unusual and makes a difference. Other strengths include the dedication and training of staff members. In addition, staff felt that the state AIDS office has provided excellent backup in terms of training, data, and especially in providing items such as condoms and pamphlets. Staff feel that the county and state administrative offices are strong advocates of the work they do.

- At Newark, staff noted an exceptional primary care physician who provides HIV care on Monday and Friday of each week. Reportedly, clients come and "line up outside her door." The dedication and commitment of this professional is known throughout the community and enhances the clinic's capacity to see individuals returning consistently for care.

- Staff at Newark also consider their ability to perform multiple HIV services a strength. Staff are able to fill in for one another, with the result that "the entire staff serve as the client's case manager."

- Another practice staff identify as a strength of the clinic is the weekly review of clients with staff in a team meeting where all staff have input and influence in decision making.

6. Correctional Institutions

- Staff at all three sites exhibited a keen sensitivity to the special needs of prisoners and detainees with HIV infection. They were empathetic to the multiple concerns of the clients they counseled and had developed trust relationships which, in many instances, appeared to be rare in that setting. They appreciated the prisoners' needs for confidentiality and tried as much as possible to assure that within the prison setting.

E. Technical Assistance, Infrastructure. and Other Needs

Technical assistance needs identified by both counselors and administrators are listed below, grouped by site type. Responses across sites focused on training needs, particularly advanced or specialized training for counselors.

1. Counseling and Testing Sites

- Staff report a need for advanced training (beyond "HIV 101"), with more emphasis on counseling techniques, approaching clients, cultural diversity issues, substance abuse, special populations (women, adolescents, minorities), and skill building.

- In some clinics there is a need for more visual materials for low-literacy and/or non-English speaking clients.

2. STD Clinics

- Good training videos and manuals would be useful, since conferences are difficult for staff to attend.

- Staff providing HIV counseling and testing at Framingham feel that training is needed in special issues for prison populations, substance abuse and HIV, and community resources available for HIV-positive clients.

- Framingham staff report a critical need for materials that could be used with Spanish clients, and for teaching aids that could be used with low-literacy clients.

- Continuing education about current HIV/AIDS issues is badly needed.

- Case management services are needed; counselors often do it because no one else is available.

- There is a need for better/expanded capacity to treat the range of complex needs of HIV-positive women. Medical intervention and drug treatment for women are not readily available.

- Hillsborough County DIS report needing more help with locating and staying current on referral sources, and assuring a supply of resource listing is on hand.

3. Drug Treatment Programs

- Providing HIV medical care within the clinic would be a great help, particularly availability of an infectious disease specialist. This would reduce the number of places clients must now go in their efforts to obtain care.

- A day care center on site would be beneficial for clients who cannot work but are not too ill to attend a day of activity. This would permit clients to be taken to medical appointments and provided with medications consistently.

- Additional staff are needed to provide the full range of HIV services. In particular there is need for an RN to work evening hours providing counseling and medical management.

- A problem is that some HIV-positive clients are discharged into the community because of noncompliance with the drug treatment program. There is presently no capability to follow up with them for medical and social care or prevention education and counseling.

4. Primary Care

- It would be helpful to know more about the effectiveness of services, from the clients' point of view. Although clients are appreciative of services and of the way they are treated in the clinics, there has been no follow up of whether or not the counseling and testing services have had an impact on clients' behaviors.

- It would also be helpful to be able to conduct followup sessions for high-risk individuals who are negative. Staff recognize that a one-time exposure to counseling may increase awareness, but that more reinforcement is needed to achieve lasting behavior change. Additional sessions would be beneficial for all clients, but seem particularly important for high risk clients who continue to deny their risk.

- Resources to conduct skill-building sessions, especially in correctional and treatment facilities, would allow health department staff to expand the scope and effectiveness of their outreach work. Staff note that risk behaviors often have less to do with knowledge and awareness of the risks than with basic life and relationship skills such as negotiating with a partner or building and maintaining basic self esteem.

- Staff cited a need for more efficient access to current information on treatments and scientific developments. Although staff attend periodic conferences and find these helpful, there is no way to get quick answers to particular questions from clients or find out about relevant journal articles. Local CBOs tend to get information faster than it is filtered through the CDC and state, although state resource people have been responsive to requests for information. It would be helpful to have a media hotline or a resource person available for tracking down information or disseminating it.

- The primary consideration for improving client services and easing staff burden would be to hire an additional social worker, health educator and two physicians. This would assist in "regulating the flow of work on heavy days."

5. Tuberculosis Clinics

- At Westside TB clinic, a bilingual/bicultural outreach worker provides TB education to homeless men, many of whom can be found in shelters and have histories of drug and alcohol use and mental illness. Incorporating HIV education into outreach work is difficult, because there is so little privacy available in shelters and on the street for pretest counseling or risk assessment.

- Nurses at the Westside TB clinic would like to have more systematic refresher courses available that would enable them to stay up-to-date on HIV issues in spite of the low volume of HIV activity within the TB clinic.

- At Pinellas County TB Clinic, staff are concerned that ventilation and lighting requirements are not met in the clinic's current facilities. In particular, staff are concerned about the dahger this represents clients with suppressed immune systems, who are seen in the clinic alongside active TB cases, but it is also dangerous to staff and other clients. In addition, current facilities offer little or no privacy for both HIV and TB interviews and counseling.

6. Correctional Institutions

- The greatest need voiced by Connecticut counselors was for access to continuing education. Because they are contract workers, they do not get paid for their time taken to attend local or area workshops and do not get registration or travel expenses paid. They said such training would make a difference in updating skills and developing a sense of community with other HIV counselors in the state. One counselor said it would be helpful to have special sessions related to HIV counseling and testing in prison settings at regional or national meetings for corrections staff.

- Staff at the Framingham facility identified three important gaps affecting their ability to provide ideal CTRPN services for detainees. They said they needs a broader range of low-literacy educational materials, access to counselors with Spanish language proficiency, and a greater emphasis on bicultural counseling capacity.

Chapter IV. Conclusion and Recommendations

When this study was initiated in early 1990, approximately 3,000 sites across the country were providing Federally funded CTRPN services. These programs were funded through Centers for Disease Control (CDC) cooperative agreements with state programs to achieve the dual objectives of strengthening HIV prevention and surveillance activities. Program guidance for counseling and' testing activities consisted of just over a page of general descriptive information on CTRPN service components. Risk reduction counseling, along with laboratory antibody testing services and referral for medical and psychosocial support, was mentioned only once as a service to be "routinely offered" in sexually transrnitted disease (STD) clinics, drug treatment centers, tuberculosis (TB) treatment clinics and designated counseling and testing sites.'

When site visits for this study were conducted 2 years later, the number of funded sites had more than doubled. The expansion of funded sites included not only STD, tuberculosis (TB), drug treatment and freestanding counseling and testing sites, but also family planning clinics, health department and primary care facilities, prenatal/obstetric clinics, correctional institutions, colleges and others. Program goals outlined in guidelines for 1993 cooperative agreement funding retain a dual focus; however, the two components are primary and secondary prevention of HIV infection.[2]

These prevention goals are to be accomplished through initiating and maintaining behavior change in individuals at risk, improving integration of HIV prevention in health service delivery, and increasing access to early medical intervention and other health, preventive and psychosocial services for those who are infected. Aspects of risk reduction counseling included in 1993 program guidance include the importance of additional prevention counseling (beyond single pre and posttest sessions) for those at high risk of becoming infected or transmitting the virus to others and the need for counseling that is culturally competent, developmentally appropriate, 'and consistent with the client's native language and communication style.

During the interim, when the study approach was being developed and submitted for clearance, evidence was mounting that early medical intervention, including diagnostic monitoring, antiviral therapy, prevention and control of opportunistic infections and management of other aspects of HIV disease could be beneficial for those found positive. In 1990, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was signed into law authorizing Federal funding for comprehensive health and social services for persons with AIDS and HIV disease. Support to CTRPN sites for provision of HIV early intervention services was anticipated, both by CDC and in many state programs, and

[1] CDC. Announcement Number 002. FY 1990 Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) Prevention and Surveillance Cooperative Agreements.

[2] CDC. 1993 HIV Prevention Cooperative Agreement Program Announcement.

efforts to identify and develop early intervention programs were initiated. However, the appropriation of adequate Federal funding for early preventive intervention has yet to be realized.

The expansion of Federally funded CTRPN service sites and program requirements over the 2 years that this study has been in process illustrates the rapidly changing environment in which HIV prevention programs are planned and delivered and the difficulties in designing an approach to evaluating such programs. This study represents one of several initial steps in CDC's commitment to establish a comprehensive and ongoing evaluation system for CTRPN services. Its purpose is to provide information on the process of service delivery in a wide range of CTRPN funded sites, to assist CDC in understanding and helping improve service delivery, and to provide information needed to determine areas for additional research. Simultaneously, CDC has supported and advocated the widespread adoption of uniform data collection and management practices in Federally funded CI'RPN sites and has implemented a variety of evaluation research studies to examine the effect of counseling and- testing on risk-related behaviors. Use of CDC reporting forms and practices is in place-in four of the five metropolitan areas visited for this study.

Although the role of this study in CDC's development of an evaluation system was to provide an inventory of the kinds and levels of services currently provided in Federally funded sites, its findings may be useful in assessing the current status of service delivery in context of the current goals of primary and secondary prevention of HIV infection.

A. Primary Prevention

Preventing HIV infection can occur only if individuals who are not infected take steps to protect themselves from exposure and if individuals who are infected take similar steps to protect others. For most individuals seen in CI'RPN sites included in this study, this process involves initiating and sustaining changes in complex and fundamental sexual and substance using behaviors that are notoriously difficult to alter. As noted by Higgins, et. al., behavioral research has repeatedly shown that few individuals achieve profound and lasting behavior change on the basis of a single information and counseling session; yet, this is the standard to which counseling and testing programs are held. To achieve lasting change, an individual may go through a lengthy cognitive and behavioral process and a series of attempts with varying success. Higgins and colleagues concluded that several sessions of individual, group or couples counseling and a variety of additional interventions may be needed if substantial behavioral risk reduction is to be achieved.[3]

[3] Higgins, D.L., C. Galavotti, K.R. O'Reilly, D.J. Schnell, M. Moore, D.L. Rugg, R. Johnson. 1991. Evidence for the effects of HIV antibody counseling and testing on risk behaviors. *JAMA*;266(17):2419-2429.

Evolution of the goals and expectations of CTRPN programs has been accompanied by increasing recognition of the demands placed on the counseling and testing intervention when the expected outcome is sustained behavior change. A panel of technical experts on HIV counseling, convened by CDC's National Center for Prevention Services in late 1991, identified three basic public health prevention functions of HIV counseling and testing programs: (1) to facilitate clients' ability to identify and modify behaviors that may place them at risk, (2) to provide or refer both infected and uninfected individuals to additional prevention services, and (3) to work with infected individuals to help assure these same services are available to their sex and needle sharing partners!

1. Facilitating Behavior Change

The sites visited for this study primarily serve client populations at high risk of exposure to HIV. To contribute to the reduction of risk-related behaviors among these individuals, CTRPN programs must assure that opportunity for counseling and testing is readily available and that those who accept the opportunity receive effective counseling with adequate continuing support to make the needed changes.

Opportunities for HIV **counseling and testing.** Because clients come to some CTRPN sites for services unrelated to HIV risk, CTRPN programs need to integrate discussion of HIV risk and availability of counseling and testing into a variety of clinical encounters. In sites visited for this study, there was a high degree of recognition of this need and significant efforts to assure access to counseling and testing services within the clinic. Among the practices observed were the following:

- Several sites ask clients to complete risk assessment questionnaires during early phases of the visit. Information gathered is used to help clients begin to identify and personalize their own risk, to determine if an HIV counselor should be seen, and to help clinicians and counselors focus discussion of risk exposure.

- The intake process in clinics such as STD, TB and women's health may introduce discussions of HIV risk as part of routine history-taking, particularly where history is taken by an interview nurse or clinician. Drug treatment clients are usually routed to an HIV counselor as a specific step in the assessment process for admission.

- The clinical examination provides further opportunity to discuss HIV risk, particularly in women's health and STD clinics. In many sites, clinicians are also trained as HIV counselors.

While these practices were widely observed, there is considerable variation in the point at which HIV counseling and testing is offered, the number of opportunities on any given

[4] CDC. *Technical Guidance on HIV Counseling [Draft].* February 1992. Centers for Disease Control, National Center for Prevention Services.

visit, and the extent to which staff who are not HIV specialists are involved in discussion of HIV risk.

Effective Counseling. Expectations of what can and should be achieved in the counseling process have become increasingly sophisticated over the period of this study. Emerging standards for good counseling[5] emphasize several key features of the counseling process that may contribute to its effectiveness:

- Good HIV counseling is "client centered." It must be tailored to the behaviors, circumstances, and special needs of the individual. This approach requires an interactive process between the counselor and the client and good listening skills, rather than a "lecture" or information-oriented approach.

- HIV counseling should result in an individualized plan to reduce risk of exposure or of transmission. The counselor's role should be to assist the client to consider a variety of options and help select or negotiate those that are feasible and likely to succeed.

- Risk assessment is the foundation of the individual risk reduction plan and is an essential component of pretest counseling. When properly conducted, risk assessment helps the client to assess and take "ownership" of his or her own individual risk for HIV infection.

The counseling observed during this study was often factually accurate and complete, handled in a professional manner, and included interaction and reflective listening. Of course, there was considerable variation in counseling styles and approaches, professional backgrounds, site and program protocols, and client needs from site to site. However, the development and negotiation of an individual risk reduction plan is not currently part of what most counselors do in pretest and posttest counseling observed during this study. While risk assessment is reported to occur prior to testing in all sites, the extent and quality of discussion of individual risk appear highly inconsistent. Risk exposure categories on standardized data collection forms were frequently used as a trigger for risk assessment; just as frequently, discussion did not go beyond the risk category labels on the form. Where counselors did initiate discussion around risk categories, it was often used to tailor information rather than to explore ongoing behaviors and circumstances and past prevention efforts.

Counselors interviewed for the study consistently expressed a need for additional training in such areas as approaching individuals about sensitive risk behaviors, comfort with cultural and lifestyle differences, and specific aspects of risk such as drug use and women's issues. Moreover, many counselors noted that their clients are well informed, as

[5] *CDC. Technical Guidance on HIV Counseling [Draft].* February 1992. Centers for Disease Control, Center for Prevention Services.

counselors themselves are, on "AIDS 101" and that more advanced and more accessible training in both counseling practice and HIV/AIDS research and treatment are needed.

2. Additional Prevention Services

As currently provided in most sites visited in this study, CTRPN services offer a single pretest and a single posttest counseling session to those whose antibody test results are negative. Those found positive are more often provided with continuing support either through contact with the HIV counselor who conducts the posttest session or through referral to other community organizations or both.

The emphasis on HIV prevention in the posttest sessions varied considerably depending on whether the client's test results were negative or positive. For those found positive, many sites have referral systems to early medical intervention, psychosocial and other support, and drug treatment. The quality and availability of resources to which HIV-positive individuals are referred may vary, but CTRPN sites, for the most part, try to help facilitate clients' obtaining whatever services are available.

For clients whose results are negative, however, quite a different situation exists. Posttest negative counseling sessions average 10 minutes and generally focus on discussing the potential need for retesting, along with admonitions to "stay safe." Condoms are routinely provided to support safe behavior. However, many counselors and administrators interviewed expressed frustration with the lack of resources available for clients whose results are negative. It may be difficult to discuss continued risk reduction in the face of clients' overwhelming relief at receiving negative results. Additional counseling may be needed to help clients realistically confront the risk of HIV to which they are exposing themselves.

Often, specialized HIV staff conduct posttest positive counseling and handle referral, sometimes with additional help of case managers. In these same sites, negative posttest sessions are typically handled by the regular clinician, often as part of the next routine visit. Where HIV specialists conduct both pre and posttest counseling for all clients, more attention may be provided to risk reduction in the posttest negative session. However, even in these sites, only one posttest session is generally provided, and typically lasts no more than 15 to 20 minutes.

Among the issues to consider in addressing emerging program priorities for additional prevention counseling are the following:

- availability of referral resources
- staff recognition of the importance of continued support to behavior change in those found negative
- referral support systems that can help identify and manage the referral process.

3. Assuring Services to Partners

From the earliest stages of CTRPN program development, Federal guidelines and recommendations have presented partner notification as a means of alerting individuals at high risk of their vulnerability and the availability of counseling, testing, and other HIV services. Despite the Federal emphasis on the voluntary and preventive nature of partner notification, however, there persists among many counselors and administrators in sites visited an image of partner notification as a coercive effort to assure identification of all infected individuals. Many staff, particularly in drug treatment and counseling and testing sites (CTS) sites, continue to equate partner notification with provider referral (i.e., clinic or health department staff contacting partners) and resist the idea of pursuing individuals to recruit them into HIV testing.

In general, the importance of counseling and testing partners is discussed during posttest sessions with individuals who are HIV positive. Some counselors reported introducing in the pretest session the issue of who might need to know about the client's serostatus. As might be expected, STD clinics generally report an emphasis on partner notification and report using both patient and provider referral models. In several sites, counselors involve or refer to trained disease intervention specialists (DIS) from nearby STD clinics for notification assistance, and often for posttest positive counseling and referral.

One counselor who had been trained and had previously worked as a DIS in STD clinics noted that the traditional focus of STD workers on maximizing the number of "contacts" identified and found must give way to a more holistic approach to HIV prevention. In his words, the "epi model" is convenient, but it does not work well to "charge in" and get contact information from those who have just received news of a positive antibody test. He has found it takes several interactions, both for counseling and discussing the importance of notifying partners, to be effective with HIV-positive clients.

Drug treatment and CTS sites, while expressing the strongest reservations about provider referral, report encouraging and helping clients to refer or bring in their own partners. Some drug treatment sites, which provide HIV services only to their own clients in treatment, reported providing HIV counseling and testing specially to partners brought in or referred by clients. The most aggressive partner notification program was observed in Florida sites, where HIV specialists who provide pretest and posttest counseling in public health clinics are trained to elicit names of partners and refer these to DIS for notification assistance.

The extent to which CTRPN sites pursue providing partners with information on HIV exposure and assisting them to obtain HIV services may be related to the image of partner notification as coercive and as synonymous with provider referral. The effectiveness of partner notification activities may be *affected by two factors: the extent to which sites that use patient referral actually provide coaching and guidance to clients in doing this; and the extent to which trained DIS who currently provide most of the notification assistance are trained in the counseling and other support aspects of this role.

B. Secondary Prevention and Early Intervention

With improved medical approaches to delaying onset of symptoms and preventing and treating complications of HIV infection has come increasing emphasis on CTRPN as a means of facilitating access to early intervention services. Continuing improvements expected in treating and managing HIV disease will further highlight the need for a full range of comprehensive and coordinated services.

Among sites visited for this study, referrals are a key focus of the posttest counseling session for HIV positive clients, particularly HIV medical evaluation and early intervention. There appears to be widespread acceptance of the role of CTRPN in facilitating access to care. One counselor described himself as feeling "very grateful" to have a place to send those with HIV positive results. However, in some sites, notably in Connecticut and New Jersey, there was limited availability of early intervention services, often necessitating long waits for care and/or traveling to medical centers some distance away from clients' communities. Although the capacity and structure of existing health care services may inhibit ready access to care, acceptance of the role of CTRPN as a gateway to early intervention services seems well established.

While access to early intervention can benefit those with HIV infection and possibly increase the likelihood that clinic staff will introduce and encourage counseling and testing, a recent APHA AIDS working group pointed out additional implications for the continued importance of primary prevention.[6]

- Early intervention may lead to significant increases in longevity and ability to function among HIV-infected persons, increasing the importance of continued prevention services to continue to foster and support sustained behavior change.

- Ongoing routine monitoring associated with early intervention offers a unique opportunity to provide continued counseling and education for sustained behavior change.

Indeed, in some sites visited that have access to primary care and early intervention services through the public health system, HIV counselors reported continuing contact with individuals during the process of medical assessment and availability of continued case management and referral services through HIV clinics.

Failure to Return. Individuals who do not return -for their- test results, whether positive or negative, lose the opportunity to realize early intervention benefits. Return rates in clinics visited vary greatly.

[6] American Public Health Association, Special Initiative on AIDS, AIDS Working Group. 1990. *Public health implications of early intervention in HIV disease.* APHA/SIA Report 7.

Given ongoing relationships with their clients, sites like drug treatment and TB clinics may be less concerned if a client does not return specifically for test results. STD staff agree that clients have little incentive to return once an STD is treated and, in one study area, reported that clients know they will be contacted if HIV test results are positive. Some clinics report specific strategies to encourage returns, such as reiterating the confidential nature of test results and the need for divulging both positive and negative results in person.

In most sites, followup efforts are made for those whose results are positive. In clinics that test confidentially, names are often referred to DIS for notification, often following efforts by mail and/or telephone to let individuals know results are in. In a few cases, clinic outreach workers may attempt to locate HIV-positive individuals and encourage them to return for results before names are referred to the health department.

Referral Systems. It is increasingly complicated for counselors to keep abreast of the full range of medical, social, psychosocial, 'and other services needed by HIV-positive clients and to assure that these services meet minimal standards of quality and accessibility.

In many sites visited for this study, individual counselors have the primary responsibility for staying abreast of referral resources. Often, this involves a personal network of contacts and interactions with colleagues. Many counselors are active in community organizations and volunteer groups outside their work roles. In addition, many counselors find themselves involved in case management functions because no one else is available and because they feel a personal commitment to help their clients. This may include not only facilitating and following up on referrals, but also providing transportation and helping clients with paperwork and applications for financial and social assistance.

The extent to which CTRPN can effectively link HIV-positive individuals with needed services certainly depends on the capacity of the health and social service systems to provide the needed array of services. It depends equally on the capacity of the referral support system available to CTRPN staff to help them keep current on new and existing services and develop referral arrangements and relationships. It also depends on the availability of CTRPN counselors, case managers, or others to help clients and facilitate obtaining those services.

C. Recommendations

The scope of CTRPN activities and procedures examined in this study is extensive. During the analysis of service delivery by site type and across all sites, a variety of operational refinements and areas for further program and site assessment were evident. Those sections of the report provide a rich source of information on the process of service delivery, potential ways to improve or assist that process, and areas for further exploration in specific sites and study areas.

This section addresses global issues across all areas of study that may affect future program directions and research priorities.

1. Primary Prevention

la. **Prevention services for those who test negative.** There is a clear divergence in recognition of the importance of HIV prevention, depending on whether the client's antibody test is negative or positive. Additional prevention services, beyond a single pretest and posttest counseling session, are minimal or nonexistent for those whose behaviors place them at risk but who are not yet infected.

Recommendation. Further assessment of needs and resources for prevention services for those who are tested and found negative should be undertaken. At a minimum, additional studies should explore the availability of onsite and referral resources and the extent to which programs and sites recognize the importance of ongoing support to facilitate behavior change in those found negative.

lb. **Counseling techniques and practices. The** counseling process in sites visited is often factually accurate and complete, handled in a professional manner, and involves interaction and reflective listening. However, emerging standards for good counseling are not evident in current practice in all sites: client-centered counseling tailored to individual circumstances, development of realistic individualized behavior change plans, and use of personal risk assessment as a foundation for determining feasible change.

Recommendation. National program guidelines should clarify the expected outcomes of pre and posttest counseling and specify recommended techniques and practices, based on current behavioral research and counseling expertise.

- A review of risk assessment practices and tools and an assessment of counselors' needs should be conducted and recommended approaches and instruments developed or revised.

- Program guidelines, technical assistance materials, and training programs should clarify the purposes of risk assessment in data collection and counseling and provide recommended approaches to accomplishing these purposes.

- Counselors should receive feedback from supervisors and/or peers to improve counseling and to assess the degree to which program goals are addressed through counseling content and approach.

lc. **Training and continuing education for counselors.** Training for HIV counselors is generally standardized in all sites visited and provided through state or county

approved channels. However, training programs require 2 to 5 days away from day-to-day responsibilities and generally involve a one-time-only session oriented to basic information for new counselors. Counselors in many areas reported a need for improved training and continuing education that is accessible and systematic. Many reported a need for support beyond "AIDS 101".

Recommendation: Current standardized training provided and sponsored by funded programs should be evaluated to determine the extent to which current content and approach meet emerging counseling demands and expectations.

- A systematic needs assessment should be conducted among program staff and HIV counselors to determine training and continuing education needs in two areas: counseling content and counseling practice. This assessment should include an examination of how initial and ongoing training can meet the different needs of new and experienced counselors.

- An assessment of training content and approach for HIV counselors across the 65 programs currently funded to provide CTRPN services should be undertaken to determine the quality and consistency of counselor preparation and the extent to which current training addresses current program goals.

1d. **Partner notification.** Despite the Federal emphasis on the voluntary and preventive nature of partner notification, there persists among many counselors and administrators in sites visited an image of partner notification as a coercive effort to recruit individuals into HIV testing. Staff in many sites continue to equate partner notification with provider referral and often cite STD "contact tracing" as the model. Trained Disease Intervention Specialists from STD clinics provide notification assistance in many sites, and posttest positive counseling and referral as well in many.

Recommendation. Aggressive efforts to detach HIV partner notification assistance from continuing confusion with traditional STD "contact tracing" and to clarify for service delivery staff the importance of partner notification in primary prevention should be undertaken at national and program levels.

- Findings from research in progress on the efficacy of various partner notification models and techniques should be widely disseminated to the service delivery community, as soon as these become available. This may involve developing technical assistance materials in advance of the slower process of publication of research findings.

- Given the key role of STD/DIS as a resource for HIV partner notification assistance, an assessment of training for STD Disease Intervention Specialists should be conducted to determine the extent to which it addresses HIV partner notification issues and objectives. Particular attention should be paid to preparation for

counseling and support roles required in providing HIV partner notification assistance and, where applicable, to providing HIV counseling.

- Specific educational efforts should be directed to HIV counseling and administrative staff in clinics that provide CTRPN services. Efforts like those of the New Jersey Partner Notification Assistance program to provide training and technical assistance to sites in understanding and making use of available notification assistance services should be encouraged and supported in all program areas.

le. **Entry into CTRPN services.** CTRPN sites visited for this study are generally providing multiple opportunities to individuals at high risk to obtain HIV counseling and testing services. Discussion of HIV risk and availability of counseling and testing is integrated into clinic operations in a variety of ways.

Recommendation. Data from this study suggest several key features of integrated services, including the continued availability of HIV counseling and testing throughout a particular clinic visit and the role of clinic staff in the design and implementation of HIV services.

- In sites that are not providing multiple opportunities for HIV counseling and testing, assessments and technical assistance should explore the nature of existing barriers and ways in which they can be reduced.

- Mechanisms for involving staff in the design, improvement, and provision of HIV-related services should be identified, assessed, and, where appropriate, incorporated into technical assistance and program guidance.

2. Secondary Prevention

2a. **Voluntary return for test results. The** extent to which secondary prevention goals for **CTRPN** programs can be realized depends largely on the extent to which the needed array of services exists and is accessible. However, operational aspects of CTRPN services can help maximize access for those found HIV positive. Improvements are needed in efforts made by sites to **ensure** that individuals return for test results and that referral systems are in place.

Recommendation. Available data, interview, and observation findings from sites included in this study suggest an overall lack of information on the extent to which individuals voluntarily return for test results and their reasons for doing so.

- Data collection procedures should be closely examined to determine the extent to which returns for test results are accurately tracked and reported, and technical assistance provided to improve the accuracy and completeness of currently reported data.

- While test acceptance rates seem a focus of activity in many sites, return rates were rarely discussed by staff as program indicators. Greater emphasis in program guidelines and technical assistance activities should be placed on the significance of voluntary returns for test results for assessing program effectiveness. Clinics should be encouraged and supported in efforts to obtain client feedback on HIV counseling and testing services.

- Additional studies of counseling, clinic practices, and other variables that affect voluntary return should be undertaken to identify the key factors in client decisions to return. Identified factors should be widely disseminated to service delivery staff.

2b. **Referral support systems.** **The** extent to which CTRPN links HIV-positive individuals with needed early intervention depends on the effectiveness of the referral support system in individual clinics in monitoring availability and accessibility of services, facilitating referrals, and assisting clients to obtain what is needed. In a great many clinics visited for this study, the referral system is the HIV counselor and the network of contacts with colleagues and service agencies that the counselor maintains.

Recommendation. **An** assessment of the issues and barriers in developing coordinated referral systems at both the clinic and program level should be undertaken. This should include particular attention to the role of case management and the availability of case management resources in CTRPN sites.

- The importance of referral systems should be emphasized in national program guidelines and technical assistance and support provided in developing effective models.

2c. **Data collection and management.** Despite CDC attempts to enhance the data collection and management efforts of clinics funded under the cooperative agreement, problems persist in data collection, management, and use. Although four of five study areas visited regularly use the CDC client data record for reporting, few report using the data collected for program planning or evaluation purposes.

Recommendation: A system of standardized data collection on the counseling and testing process developed and supported by CDC is increasingly in place, but barriers to using client data to improve program operations remain. These include the variety of service providers conducting data collection, the multiple additional reporting formats and requirements still the rule in many sites, and the lack of clinic-level capability to aggregate and analyze data for internal use.

- A systematic assessment of remaining barriers to consistent data collection and use should be conducted and should include the following:

- a determination of which staff at the clinic level actually collect data and their training for this function, including a training needs assessment.

- procedures in place for data management and reporting to state and other offices. Since counseling and testing steps occur for any individual client over a period. of several weeks, data collection is an ongoing process and may involve several staff and complex procedures for ensuring that all steps are accurately documented and that reporting is completed for individual records.

- the extent to which aggregated data from individual client data record reporting is available to clinic staff on a regular basis for use at the clinic level, and the various potential uses of aggregate data for setting goals, planning, evaluation, and internal monitoring.

- the extent to which clinic staff have the expertise needed to aggregate, analyze and apply collected data to program operations.

- the extent to which clinic administrators and other service delivery staff perceive data currently collected as useful for improving CTRPN services, and which elements they consider of greatest value.

Appendix A

Interview Instruments

Form Approved
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ASSESSMENT OF COUNSELING, TESTING, REFERRAL, AND PARTNER NOTIFICATION (CTRPN) SERVICES

ADMINISTRATOR INTERVIEW INSTRUMENT

ASSESSMENT OF COUNSELING, TESTING, REFERRAL, AND PARTNER NOTIFICATION (CTRPN) SERVICES

ADMINISTRATOR INTERVIEW INSTRUMENT

Introduction:

Thank you again for taking the time to participate in this study. During this interview, we would like to discuss three main topics:

- a profile of your clinic (which covers details about clinic hours, fees, and services);
- the background and development of your clinic's program (how long the clinic has been providing HIV counseling and testing services, and how these services have changed over time);
- policy issues such as confidentiality and informed consent
- administrative issues (how counseling and testing services have been integrated, the staffs background and training, client characteristics, and data collection.)

I will be asking counselors for details and insights about pre- and post-test counseling.

Do you have any questions before we begin?

I. CLINIC PROFILE AND BACKGROUND

1. What kind(s) of patient services are offered at your clinic?

HIV only	Drug Treatment	Primary Care
STD	. Methadone	Health Care for the Homeless
Tuberculosis	. Drug-free	Other _____
Family Planning	. Other drug treatment: _____	

2. What are the clinic's hours and days of operation?

3. Are HIV services offered on a walk-in or appointment basis, or both?

   3A. How long does it take to get an appointment?

   3B. What is the average waiting time (in the clinic) for those with appointments?

   3c. What is the average waiting time for walk-in clients?

4. Are clients charged any fees for services (HIV and/or other)?

   4A. If so, how are these fees determined, and what are they?

5. Are your facilities adequate for the number of clients you see?

   5A. If not, how are services affected?

   . average waiting times
   . clients leaving due to delay

6. Are your staff adequate for the number of clients you see?

   6A. If not, how are services affected?

   . average waiting times
   . clients leaving due to delay

7. How long has this site been providing:

   . HIV counseling and testing services
   • Referrals
   . Partner notification

8. How have HIV CTRPN services at this clinic changed since you first offered them?

II. POLICY ISSUES

9. Does this site provide confidential or anonymous testing, or both?

9A. Why?

9B. What is meant by the term "confidential?"

9C. What is meant by the term "anonymous?"

9D. How is confidentiality maintained?

(List steps taken to protect confidentiality.)

10. *Are* test results kept separately, or included in the patient's medical record?

11. What is your policy on releasing HIV test results?

12. How do you obtain informed consent from clients?

III, ADMINISTRATIVE ISSUES

A. **Integrating** CTRPN

13. What factors led to the inclusion of:

- HIV counseling and testing services
- Referrals
- Partner notification

(Probes: finding, client demand, other)

14. Are HIV CTRPN services incorporated into the clinic routine, or are they a separate track?

15. If integrated with other services, how has CTRPN been integrated into other site activities?

16. What have the issues been in adding HIV services?

- restructuring patient flow
- staff reluctance
- staff training
- general resource constraints
- space constraints
- client resistance (or potential client resistance)
- added managerial or reporting burdens

17. Who is responsible for the clinic's HIV program?

- site administrator
- HIV coordinator
- other

18. How long has this individual administered the program?

19. What is the HIV administrator's background?

20. How much of the administrator's time is spent on HIV activities?

B. **Staff Background and Training**

21. How many clinic staff are involved in delivering HIV services (counseling, testing, referrals, partner notification)?

21A. Who are they? (e.g., clinicians, social worker, nurse, HIV counselor)

21B. What are their responsibilities?

- HIV only
- other tasks/services

21C. (For HIV and other tasks: Approximately what proportion of their time is devoted to HIV duties?)

22. What proportion of the counselor's HIV-related time is spent on:

- pre-test counseling
- post-test counseling
- paperwork
- partner notification
- referrals
- other non-HIV clinic duties

23. What kinds of backgrounds do the HIV counselors have?

Educational degrees
Professional qualifications/background

24. What kind of HIV-specific training do they receive?

- counseling
- partner notification

24A. From whom?

24B. Is ongoing/inservice training provided?

24C. If so, how often?

24D. Is it required?

25. What are the important issues for counselor training and practices that affect HIV counseling?

- stress and burnout
- dealing with cultural diversity among clients
- dealing with clients who deny their risk

26. Do all counselors do both pre- and post-test counseling?

27. Does the clinic sponsor or participate in any support groups for HIV counselors or offer "mental health" days, job rotation, etc. to reduce stress?

28. What kinds of quality control or supervisory mechanisms are in place for assessing counselor performance?

29. What do you consider to be qualities or characteristics of an effective counselor?

C. Client Characteristics

30. Does the clinic have a "typical" client? If so, could you describe him/her?

31. How do you know the composition (in terms of transmission category, race/ethnicity, gender, income level, age) of your client populations?

- data collection
- staff observation
- other

32. Has this profile changed over time?

    32A. If so, what factors do you think contributed to the change?

    32B. If so, has this affected training, counseling, etc. (e.g., hiring Spanish-speaking counselors to reach Hispanic clients)?

D. Data Collection

33. What kinds of data do staff collect?

    33A. On clients (review client data form)

    33B. From clients (e.g., KABB surveys, feedback, exit interviews)

    33C. On CTRPN process (review data request form)

    33D. From staff (formal or informal)

36. Who collects the various types of data?

37. How are data stored and retrieved?

38. Do you collect or have access to any seroprevalence data?

    38A. If so, how do you use it?

    38B. Specifically, do you match any seroprevalence data to data on clients served by the clinic's CTRPN program?

39. Do you identify or track clients who are <u>not</u> being tested for the first time?

39A. If so, how?

40. How do you use the data collected?

- ***Reporting***

  Which types of data?
  To whom?
  What format? (e.g., CDC scannable form)
  Feedback?

- ***Planning***

  Which types of data?
  How are they used for planning purposes?

- ***Evaluation***

  Which types of data?
  How are they used?
  Do you use data to monitor achievement of objectives?

41. What are some of the problems or issues in collecting data and evaluating counseling and testing services?

42. What types of assistance would help you collect useful data and use it (more effectively)?

Other

43. Are there any innovative practices in this clinic which you would like to share with others in the field?

44. What are the strengths and weaknesses of your clinic's operation, in your opinion?

45. What would you change, if you had more resources?

46. Other than additional resources, what types of technical assistance would make your job easier or more effective?

47. What haven’t we asked about or covered that you feel we should know about?

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ASSESSMENT OF COUNSELING, TESTING, REFERRAL, AND PARTNER NOTIFICATION (CTRPN) SERVICES

ADMINISTRATOR/HIV COORDINATOR INTERVIEW INSTRUMENT

ASSESSMENT OF COUNSELING, TESTING, REFERRAL, AND PARTNER NOTIFICATION (CTRPN) SERVICES

ADMINISTRATOR/HIV COORDINATOR/COUNSELOR INTERVIEW INSTRUMENT

Introduction:

Thank you again for taking the time to participate in this study. During this interview, we would like to discuss each step in the counseling and testing process at your clinic. We would also like to ask your help in drawing a flow chart or diagram of a client's progress through the clinic.

Do you have any questions before we begin?

A. ENTRY

1. Is HIV counseling and testing routinely offered to all clients?

   1A. If not, to whom is it offered?

   - as a result of risk assessment
   - by request

   1B. How strongly is testing encouraged? Why or why not?

2. If risk assessments are performed, at what stage in the process do they occur?

   - during entry/intake
   - during pretest counseling
   - during clinical care/assessment

3. What format is used for assessing risk?

   - interview
   - questionnaire
   - other

4. How is the client told about HIV counseling and testing services?

   - first contact (intake)
   - informed consent
   - offer of counseling

5. What happens while a client waits for pretest counseling, or other services?

   - risk assessment (written, or verbal?)
   - HIV/AIDS prevention literature available
   - videos
   - skills training (condom use, bleach use)
   - materials (condoms, bleach)

B. Testing

6. Who draws blood for HIV testing?

7. Where and when is blood drawn?

- on-site
- same floor
- same building
- part of pretest counseling
- part of other blood services
- separate step from other blood services

8. What laboratory services are used?

9. How long does it take for test results to come back from the lab?

   9A. Does this affect the timing of delivering other lab results (such as STD lab work) to the client?

10. How are people notified that their test results are available?

- post-test counseling appointment
- telephone
- other

11. What do you think are the main reasons why people do or do not return for their test results?

(List all that are mentioned, but try to get sense of most important reasons.)

Additional post-test sessions

12. Are further, additional post-test sessions available (i.e., more than one)? To whom?

    12A. If so, how many sessions are usually recommended?

    12B. What percentage of clients who are offered these extended counseling sessions return for them?

13. What is covered in additional post-test sessions?

14. What kinds of services are available in the clinic?

- TB screening
- contraception
- therapy/counseling
- medical exam (physical and blood work)
- treatment (HIV/AIDS)
- other

15. What kinds of services are available through referrals?

- TB screening
- contraception
- therapy/counseling
- other
- medical exam (physical and blood work)
- treatment (HIV/AIDS)
- drug treatment

16. What kinds of services are planned for the future?

- TB screening
- contraception
- therapy/counseling
- case management
- medical exam (physical and blood work)
- treatment (HIV/AIDS)
- drug treatment
- other

17. What are the issues in adding or expanding to include these services?

18. What are the major gaps in available services?

c. **Partner Notification**

19. Does the site participate in partner notification for CTRPN clients?

20. Which partner notification approaches are used?

- provider referrals
- patient referral
- other (referral to health department or STD personnel)
- combination of above (e.g., depends on client preference)

21. Why is this approach to partner notification used at this clinic?

22. What does partner notification involve?

22A. **provider** referral

- who does it (counselors, or other staff?)
- is special training required?
- are both sexual and needle-sharing partners identified?
- how far back in time are clients requested to go in identifying partners?

22B. **patient** referral:

- guidance to client: role playing, videos, written materials?
- are contracts negotiated with clients to ensure that partners are notified?
- are any mechanisms in place to track whether clients present for services as a result of patient referral (such as special cards)?

22C. **follow-up** of either method:

- does it occur?
- who is responsible? (counselors, or other staff?)
- how is follow-up accomplished?
- how many partners are located, as a percentage of those identified by clients?
- of these, how many present for CTRPN services?
- how many complete the process?

23. Does the clinic undertake any "cluster outreach" efforts, such as reaching potential partners in shooting galleries identified by clients, as a way to reach unnamed partners?

24. When in the CTRPN process is the concept of partner notification first introduced to the client?

D. Referrals

25. How long has the clinic been providing referrals for CTRPN clients?

26. Are all HIV-positive clients referred to medical, psychological, social, or other services?

26A. Are HIV-negative clients also referred to other services?

27. Does the clinic have a formal mechanism for ensuring that HIV positive individuals receive a medical evaluation?

28. How is CD-4 cell testing and monitoring done?

- on-site
- agreements with other agencies (list agencies)
- other

29. What is the time frame for medical evaluation?

30. If an individual needs medical treatment, how is this provided?

- on-site
- agreements with other agencies
- other

31. Do you offer a support group for HIV-positive individuals?

E. Flow Chart

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ASSESSMENT OF COUNSELING, TESTING, REFERRAL, AND PARTNER NOTIFICATION (CTRPN) SERVICES

COUNSELOR INTERVIEW INSTRUMENT

ASSESSMENT OF COUNSELING, TESTING, REFERRAL, AND PARTNER NOTIFICATION (CTRPN) SERVICES

COUNSELOR INTERVIEW INSTRUMENT

Introduction:

Thank you for taking the time out of your busy schedule to participate in this study. The purpose of this study is to learn about what is currently happening in the field and about which factors, from the clinic's point of view, affect the delivery of services.

During this interview, I would like to discuss details about the counseling that clients receive during the counseling and testing process.

The interview will take approximately an hour.

Do you have any questions before we begin?

A. Pre-test Counseling

1. What is the purpose of counseling?

   - screening (i.e., eliminating unnecessary tests)
   - prevention

2. How would you describe pre-test counseling at your clinic?

   - one-on-one or group
   - duration
   - content

   2A. (If pre-test counseling is one-on-one): How long do clients usually talk to a counselor before blood is drawn?

   2B. (If pre-test counseling is group): How long does group counseling last? Is there an opportunity to request one-on-one counseling?

3. What is the most important thing to get across in pre-test counseling?

4. What is covered in pre-test counseling?

   - risk reduction
   - risk assessment
   - test procedure
   - meaning/implication of test results
   - partner notification?
   - informed consent
   - benefits of early medical intervention
   - availability of referrals

5. Is condom usage demonstrated during pre-test counseling?

6. Are condoms distributed during pre-test counseling?

7. Do staff use a checklist during pre-test counseling?

8. Do you think pretest counseling affects whether clients accept testing? How?

9. Do you think it affects whether they return for their test results? How?

B. Post-test Counseling

10. **How** is the post-test counseling session arranged?

- call for appointment in x days
- appointment made before client leaves clinic
- walk-in after x days
- other

11. How are test results given to the client?

- Always part of post-test counseling
- If positive, part of post-test counseling
- If negative, part of post-test counseling

12. Do counselors or other staff try to contact clients who haven't returned?

13. Does the same counselor conduct pre- and post-test sessions for an individual client?

    13A. If not, how is the post-test counselor informed about risk information discussed during the pre-test session?

14. What is the most important thing to get across to an HIV-positive client during the post-test session?

15. What is covered in the post-test session, if the client is HIV-positive?

- What results mean
- HIV is not AIDS
- Risk reduction information
- Condom usage (demonstration)
- Condoms distributed
- Partner notification
- Referrals
- Benefits of early medical intervention

    15A. How long does a post-test session usually last, if the client is HIV-positive?

16. What is the most important thing to get across to an HIV-negative client during the post-test session?

17. What is covered in a post-test session, if the client is HIV-negative?

- What results mean
- Continued need for risk reduction
- Condom usage (demonstration)
- Condoms distributed
- Retesting

17A. How long does a post-test session usually last, if the client is HIV-negative?

18. What clients do your recommend get retested?

18A. How often?

19. Are further post-test sessions available? To whom?

19A. If so, how many are usually recommended?

19B. What percentage of clients who are offered these extended counseling sessions return for them?

20. What is covered in additional post-test sessions?

c. **Referrals**

21. How long has the clinic been providing referrals for CTRPN clients?

22. Are all HIV-positive clients referred to medical, psychological, social, or other services?

22A. Are HIV-negative clients also referred to other services?

23. Does the clinic have a formal mechanism for ensuring that HIV positive individuals receive a medical evaluation?

24. How is CD-4 cell testing and monitoring done?

- on-site
- agreements with other agencies (list agencies)
- referrals
- other

25. What is the time frame for medical evaluation?

26. If an individual needs medical treatment, how is this provided?

- on-site
- agreements with other agencies
- referrals
- other

27. Do you offer a support group for HIV-positive individuals?

28. What kinds of services are clients referred to?

- TB screening
- contraception
- therapy/counseling
- clinical trials
- medical exam (physical and blood work)
- treatment (HIV/AIDS)
- drug treatment
- other

29. How is the list of referrals maintained?

30. How current is it?

31. Is there follow-up of whether or not clients access referrals?

31A. Is the follow-up documented?

32. Is feedback solicited from clients regarding the usefulness, cost, etc. of different services on the referral list?

33. What are the major problems in finding referral resources?

34. What are the major gaps in available services?

35. What do you think can be done to address those problems?

D. Other

36. Are there any innovative practices in this clinic which you would like to share with others in the field?

37. What are the strengths and weaknesses of your clinic's operation, in your opinion?

38. What would you change, if you had more resources?

39. Other than additional funding, what kinds of technical assistance would help make your job easier or more effective?

40. What haven't we asked about or covered that you feel we should know about?

Appendix B

Clinic and Client Data Request Forms

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Public reporting burden for this collection of information is &mated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to:

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CLINIC AND CLIENT DATA REQUEST FORMS

Instructions:

Please provide the information requested, if available, by filling in the white blanks in Columns A and B on the Clinic Data Request Form and the “male” and “female” columns on the Client Data Request Form. (On the Clinic Data Request form, the questions in Column B ask for greater detail about numbers provided in Column A.) All estimates should be for a one-month period, if possible. If any of these data are not available, please note "N/A" in the appropriate blank.

If you have any questions about this form, please contact either Coralee Hoffman or Nicole Lezin by calling us collect at **(404) 321-3211.**

Thank you for your help in providing us with this information,

CLINIC DATA REQUEST FORM

COLUMN A	Each Month	COLUMN B	Each Month
1A. Number of clients seen for any reason?		1 B. How many are new clients (not return visits)?	
2A. Number offered HIV counseling & testing?			
3A. Number offered who accept pretest counseling?			
4A. Numb& who have blood drawn?			
5A. Number tested who return for results?		5B. How many return voluntarily?	
		How many return because of follow-up?	
6A. Number returning who are post-test counseled?			
7A. Number returning who are HIV+?		7B. How many HIV+ do not return for results?	
		How many HIV+ non-returners are followed up?	
8A. Number of HIV + who participate in partner notification?		8B. How many participate in provider referral?	
		in patient referral?	
		in a combination ?	
		How manv partners are identified (all models)?	
		How many identified partners are located?	
		How many located partners come for services?	

CLIENT PROFILE DATA

	Males	Females
Number or percentage of clients offered HIV counseling and testing last month:		
Number (or Percentage) who are:		
African-American		
Hispanic		
Native American		
Caucasian		
Asian		
Number (or percentage) who are:		
< 12 years old		
between 13 – 19 years old		
between 20 – 29 years old		
between 30 – 39 years old		
over 40 years old		
Number (or percentage) who are:		
Gay/bisexual male		
Heterosexual IVDU		
Gay/Bisexual IVDU		
Hemophiliac		
Sex partner at risk		
Blood recipient		
Exchange drugs/money		
No acknowledged risk		

Appendix C

Document Request Form

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DOCUMENT CHECKLIST

Instructions:

If your clinic has any of the following documents available, we'd appreciate getting copies ahead of time. This will help us prepare for our visit to your clinic by helping us understand the clinic's operations. We have provided a self-addressed manila envelope for your convenience, and we will be glad to cover your postage expenses.

This is a comprehensive checklist; we realize that not every clinic will maintain each of these documents. We are interested only in blank forms that have <u>not</u> been filled out. (We are not interested in specific data on clients or staff.)

Thank you for your cooperation.

Document Checklist:

- General description of clinic services and your HIV counseling and testing program (e.g., pamphlets/brochures describing your program)
- Registration logs
- Intake forms
- Risk assessment questionnaires or interview guides
- Data collection/reporting forms for HIV counseling and testing activities
- Consent forms
- Pre-test counseling guidelines/checklists used by counselors during sessions with patients
- Post-test counseling guidelines/checklists used by counselors during sessions with patient
- Counseling session record forms
- Referral lists or information given to clients
- Partner notification information given to clients
- Instructions/forms for documenting follow-up of partners
- Plans for/results of any internal studies of patient flow, client satisfaction, counselor attitudes, or any other aspect of the CTRPN process in your clinic
- Annual Report or other description of demographic data on clients

Appendix D

Counseling Observation Guidelines and Checklists

GUIDELINES FOR OBSERVING HIV PRE- AND POST-TEST COUNSELING

During our site visits to clinics providing HIV counseling, testing, referral, and partner notification (CTRPN) services, we plan to observe both pre- and post-test counseling sessions. The purposes of observing counseling sessions include:

- confirming and enhancing information gathered during interviews with site administrators and counselors;
- recording observable activities that are recognized as contributing to more effective counseling (such as demonstrating condom use); and
- noting subjective aspects of counseling practice that are recognized as contributing to more effective counseling (e.g., reflective listening).

Information from observing counseling sessions will be used to describe the status of pre- and post-test counseling activity as it is currently delivered in the sites. The purpose of observing counseling sessions is <u>not</u> to evaluate counselors' performance, or to judge their compliance with any particular counseling protocol.

These guidelines cover both subjective and objective features of HIV counseling. Several key elements of effective counseling are described to help provide focus for observing **subjective** aspects. Worksheets listing activities and topics which can be **objectively** noted during counseling sessions are also included.

Together, these guidelines for observing subjective and objective aspects of HIV counseling should provide a consistent base of information from which to discern the overall status of counseling practice in CTRPN sites.

Subjective Aspects of Counseling

Many experts agree that a counselor's ability to win a client's trust is as important as the content of a counseling session. This is particularly true of HIV/AIDS, where clients are facing not only fears about their mortality, but also concerns about discrimination and the possibility of having infected others with the virus.

As we observe counseling sessions, we can look for aspects of a counselor's approach that signify an effort to customize counseling and make it as relevant for the client as possible. The following list of subjective or descriptive elements of counseling is the result of interviews with counselors, CDC staff and review of relevant counseling literature. It is not meant to be exhaustive; rather, it is a suggested list of the kinds of counseling activities that may make a difference in how receptive clients are to information about HIV infection, and therefore should be noted.

Subjective Elements of Effective Counseling

- *Customizing counseling sessions*

Many counselors are trained to lecture clients about all relevant information, rather than assessing clients' level of knowledge, concerns, behaviors, and so on. Assessing individual risk behaviors, for example, may be used by the counselor to help tailor an individual intervention; or may be handled mainly as a data collection chore. Likewise, discussing the need for retesting may be handled as a routine post-test message or be used by the counselor to explore and reinforce the need for behavior change. By finding out as much as possible about an individual client's behaviors and needs, counselors can make the session more relevant and meaningful, and more efficient.

It is particularly crucial to focus on client beliefs and needs in the early risk assessment phase of a counseling session, because so much of what follows depends on this step. A counselor's view of what constitutes risky behavior is not necessarily the same as a

client's, Therefore, the extent to which a counselor can help a client perceive that he or she is at risk, and understand why particular behaviors are placing him or her at risk, is a key step in the counseling process. In order to achieve this, counselors must be able to get clients to talk about their risk behaviors and then, based on this information, move forward with behavior changes to reduce risk.

- *Negotiating change*

Behavior change is very difficult to achieve; changes in sexual and/or drug-using behaviors are especially difficult. Involving the client as a partner in determining the type of change that is acceptable -- and in determining realistic steps to achieve goals -- may be more effective than a didactic approach.

- *Reflective listening*

Reflective listening is an approach to counseling -- and to communicating in general -- that emphasizes responsiveness to the client. Maintaining eye contact, using supportive body language (smiles, nods), using open-ended questions or phrases ("tell me about X") are elements of reflective listening.

- *Skill building*

Counselors can help "coach" clients through obstacles to behavior change. For example, many clients do not use condoms because they are embarrassed about their lack of expertise. By demonstrating condom usage, rather than handing over a brochure and package of condoms, a counselor may help individual clients overcome these skill-related obstacles. Similarly, counselors may help a client prepare for telling a partner by helping him or her anticipate reactions, and by role playing various scenarios

Objective Aspects of Counseling

From the literature review, interviews with CDC experts, and pre-tests of site visit instruments, we have compiled a list of objective aspects of counseling. This list includes specific activities such as distributing condoms, demonstrating their use, and making a referral appointment for the client. (Some of the subjective elements of counseling are listed as well, but in a way that allows a "Yes/No" answer. We are not trying to evaluate the adequacy of counseling sessions, but we can note the presence or absence of the elements listed on the worksheets.)

The attached worksheets should be used as checklists to help ensure consistency in observing objective aspects of pre-test and post-test counseling. Descriptive observations about these and other aspects of the counseling session should be included in the narrative site visit report.

PRE-TEST COUNSELING WORKSHEET

Individual or group:

Duration of Session:

(Please indicate "Yes," "No," or "N/A")

____ Counselor asks about client's risk behavior(s)

____ Counselor establishes client's self-perception of risk

____ Counselor asks client if s/he has any questions

____ Counselor asks about existing behavior changes and reinforces positive steps

____ Counselor negotiates further change with client

____ Counselor uses checklist

____ Counselor provides:

- condoms;
- demonstration of how to use a condom;
- written materials (pamphlets, brochures);
- other (e.g., bleach)

____ Counselor makes sure client can read and understand written materials;

____ Counselor uses language understandable to the client;

____ Counselor raises issue of partner notification during pre-test session;

____ Counselor obtains client's informed consent for HIV antibody testing;

____ Counselor asks what client will do with results.

POST-TEST COUNSELING WORKSHEET (HIV NEGATIVE)

Duration of session:

____ Counselor reviews meaning of the test results

____ Counselor asks about client's recent risk behavior(s)

____ Counselor discusses possible need for retesting, if risk behaviors are recent

____ Counselor reinforces key areas for risk reduction

____ Counselor asks client if s/he has any questions

____ Counselor uses checklist

____ Counselor provides:

- condoms;
- demonstration of how to use a condom;
- written materials (pamphlets, brochures);
- other (e.g., bleach)

____ Counselor makes sure client can read and understand written materials

____ Counselor uses language understandable to the client.

(Note: Same counselor as pre-test?)

POST-TEST COUNSELING WORKSHEET (HIV POSITIVE)

Duration of Session:

___ Counselor reviews meaning of test results

___ Counselor asks about client's risk behaviors

___ Counselor asks client if s/he has any questions

___ Counselor uses checklist

___ Counselor provides referral information (e.g., hotline numbers, list of referrals/resources in community)

___ Counselor makes appointment for client (note what kind)

___ Counselor offers assistance with partner notification (what types of responses to expect, coaching, provider referral)

___ Counselor provides:

- condoms;
- demonstration of how to use a condom;
- written materials (pamphlets, brochures);
- other (e.g., bleach);

___ Counselor makes sure client can read and understand written materials

___ Counselor reviews client's plans for immediate future: telling partner(s), getting support.

(Note: (Same counselor as pre-test?)

Appendix E

Site Visit Agenda and Fact Sheet

SITE VISIT AGENDA

1. Introductions and Interview with Site Administrator/HIV Coordinator (30-45 minutes)

   - Clinic or Center History and Overview

   - Staff, Clients and Reporting Issues

     We would like to cover kinds and numbers of staff conducting CTRPN services, training and supervision of CTRPN staff, descriptive information about clients receiving HIV services, and what kinds of data collection and evaluation of HIV services are presently underway or envisioned.

2. Interview with Administrator/HIV Program Coordinator (1-1/2 hours)

   - HIV Counseling, Testing, Referral and Partner Notification (CTRPN) Activities

     We would like to discuss the issues and barriers in delivering HIV services, to understand what services are being provided and why, and to prepare a flow chart of a client's progress through each step of the CTRPN process, including entry, pretest counseling, testing, post-test counseling, referral and partner notification.

   - Further Discussion of Staff, Clients, and Reporting Issues

3. Tour Clinic/Center and Observe Patient Flow (1 hour)

4. Interview and Observe Counselor #1 (1 hour)

   We would like to observe a pre- or post-test counseling session. Our purpose is not to evaluate counselor performance,, but to obtain direct information on time available, material covered, and approaches used.

   We would also like to discuss HIV-related responsibilities, issues and concerns in pre- and post-test counseling, referral and partner notification activities,

5. Interview and Observe Counselor #2 (1 hour)

   (Same agenda as for Counselor #1)

6. Interview Other Staff (e.g., Clinician, DIS) (30-45 minutes)

   If other staff who participate in HIV services are available, we would like to interview them about their work and their roles within the clinic.

7. Concluding Discussion with Site Administrator/HIV Coordinator (30 minutes)

   This will provide an opportunity for both site visitors and the administrator to cover any last issues or questions.

FACT SHEET

ASSESSMENT OF COUNSELING, TESTING, REFERRAL, AND PARTNER NOTIFICATION (CTRPN) SERVICES

This study is being conducted by Macro Systems, Inc. and is funded by the Division of STD/HIV Prevention, Center for Prevention Services, Centers for Disease Control (CDC). Participation in the study is voluntary.

Since 1985, HIV counseling and testing programs have been a major focus of CDC prevention efforts. CDC funding for counseling, testing, referral and partner notification (CTRPN) programs is now provided to over 5,000 sites through 63 cooperative agreements with state and local health departments. A wide variety of sites receive funding to provide these services, including: counseling and testing sites (CTSs); sexually transmitted disease (STD) clinics; women's health, family planning, and prenatal care clinics; drug treatment centers (DTCs); and tuberculosis ('IB) clinics.

Purpose

Our objective is to learn, through a combination of observations and interviews, what is currently happening in the field and which factors, from the site's point of view, affect the delivery of services. **This is not an evaluation of whether or not sites are providing services in the "right" way. Instead, we are simply trying to describe the variety of services being provided.** This survey represents the CDC's first effort to describe and document the kinds and levels of CTRPN activities being provided in funded sites. To accomplish this, Macro staff will observe the CTRPN process by visiting sites in Boston, Hartford, New Haven, Newark, New Orleans, and West Palm Beach. The site visits are expected to last either a half or full day, depending on the site.

Reauirements of City/State Program Offices

We hope to receive assistance from the program offices in identifying and contacting individual sites which would be willing to participate.

Reauirements of Site

Prior to the site visit, we hope to contact the site administrator by telephone in order to arrange a time for the visit and to request some information on patient volume and documents (such as protocols, blank registration logs, etc.). These materials will help us prepare for the actual visit.

During the visit, we would like to interview the administrator and counselors about the CTRPN process within the clinic. Most importantly, we would like to observe the CTRPN process. We will do so without intruding on the clinic staffs work, or the client's comfort. We recognize that clients may feel uncomfortable being observed by strangers; we will try to be as unobtrusive as possible. Again, we want to emphasize that this is not an evaluation of whether or not staff are providing services in the "correct" or "wrong" way. Instead, our goal is to describe what is currently occurring in various types of sites.

A copy of the completed site visit report will be returned to the site administrator to confirm accuracy and completeness.

Uses of Findings

Findings will be used to help improve program guidelines and CDC technical assistance efforts, identify areas needing further study, and contribute to establishing a realistic ongoing evaluation system. Results of-the study will be available to both program and site personnel.

Planned Timetable

We plan to be in the field in October and November, 1991.

If you have any questions about the study, we would be glad to talk with you about them. Please call us collect at (404) 321-3211, and ask for Coralee Hoffman or Nicole Lezin.

Appendix F

Client and Risk Factor Profiles

Appendix F: Client and Risk Profiles

A. Populations Served

This section includes comparisons of the characteristics of clients served at study sites are and risk factor profiles by AIDS case rate and estimated seroprevalence of site visit areas.

Currently, four of the five site visit areas report data to Centers for Disease Control (CDC) on client data record forms that can be scanned electronically. (The exception is Oregon, which maintains its own, comparable data collection system and reports to CDC.) Data for this section were collected in two ways. First, clinics were asked to provide data on client volume and demographic characteristics that corresponded to categories reported on the client data record form. Although clinics report these data to state program offices and CDC, our request for recent data revealed that the data are not routinely available once they have been forwarded. Therefore, the data provided by clinics were often incomplete or, in some cases, nonexistent. To augment the information provided by clinics, we obtained data reported by the sites visited for this study directly from the CDC. Data profiled in this section are based on both sources. It should be noted that the 43 sites that participated in the study were selected in a nonrandom fashion. Although we attempted to select sites that would represent the broad distribution of sites and site types nationwide, no claim can be made that the sites selected represent a random selection of all clinics from which reliable estimates of national characteristics or trends can be made.

For reporting of client characteristics, sites are grouped according to the following categories:

- Counseling and Testing Site (CTS)
- Sexually Transmitted Disease Clinic (STD)
- Drug Treatment Center
- Family Planning/Women's Health Clinic
- Tuberculosis Clinic (TB)
- Primary Care Facility
- Prison/Correctional Facility

For reporting of risk features of the population served by the clinics, the clinics were ordered by the estimated seroprevalence of the population served. Using the CDC's HIV Surveillance Report, we identified the AIDS case rate (number of AIDS cases per 100,000 population) for the metropolitan areas of Newark, Tampa-St. Petersburg, Boston, and Hartford, in which most of the sites were located. For 1991, these ranged between a low of 15.3 in Hartford to a high of 51.5 in Newark.

All of the sites are located in metropolitan areas that can be described as having "high" AIDS case rates. Assuming that there is a relationship between the incidence of AIDS in a population and the seroprevalence levels within that same population, we arbitrarily

split the four metropolitan areas into three categories: "Highest," "Mid-level," and "Lowest." The "Highest" category, Newark, has over 40 AIDS cases per 100,000 population and is assumed to have the highest seroprevalence level of the four metropolitan areas. Tampa-St. Petersburg had over 20 AIDS cases per 100,000 population and is assumed to have a 'mid-level" seroprevalence level. Hartford and Boston both had AIDS case rates below 20 per 100,000 population and are assumed to have the "lowest" seroprevalence levels (see Chart 1).

We also compared the AIDS case rates for 1991 to the case rates for 1990. Newark experienced a small decline in the incidence of AIDS cases between 1990 and 1991 (2.6 fewer cases). Newark can be described as a metropolitan area with an extremely high AIDS case rate that appears to be stable. Tampa-St. Petersburg experienced an increase of 5.2 cases (an increase of over 20 percent) and can be described as a metropolitan area with a very high AIDS case rate experiencing a significant increase in the incidence of AIDS. Boston had an increase of 4.5 cases between 1990 and 1991, an increase of over 25 percent. Boston can be described as a metropolitan area with a high AIDS case rate that is undergoing significant increase.' Hartford, with two additional cases, had the smallest absolute increase in the number of cases--a percentage increase less than 20 percent. Hartford can thus be described as a metropolitan area with a high incidence of AIDS that is experiencing moderate growth.

1. Client Profiles

Percentage of Clients Tested and Percentage with Positive Test Results (Chart 2). There are notable differences in the percentage of clients tested. The base for determining this value is the number of clients "offered" testing; thus, the pool represents those clients who accepted the test. Differences in percentage tested among site types represent both differing client motivations for accepting testing and differing levels of "aggressiveness" on the part of clinic staff in attempting to persuade clients to be tested.

Prisons had the lowest testing rate (58 percent) but the highest positive test rate (17 percent). Drug treatment centers had the second lowest testing rate (62 percent) and the second highest positive test rate (14 percent). Although interpretation of these data is difficult, this result may be cause for concern. If the **42** percent of clients not tested in the prison populations and the 38 percent of clients not tested in the drug treatment center populations have the same seroprevalence level as those tested, a significant number of HIV positive individuals have been missed. If this is representative of the situation in prisons and drug treatment centers across the United States, a significant number of HIV positive individuals have not been identified. This is especially disturbing given the high incidence of IDUs in these populations. The rest of the site types approach or exceed an 80 percent tested rate, with the highest tested rate occurring in CTS.

Posttest Counseling and Test Results (Chart 3). Because clients can only receive test results as part of a counseling session, posttest counseling rates also represent return rate

for test results. (However, it should be noted that some returns are the result of follow up.) Prisons and TB clinics have greater return rates than any other site type. This may be due to the fact that clients in prisons can easily be followed up if they do not return voluntarily. In TB clinics, high return rates may be a function of low client volume and of the fact that clients develop an ongoing relationship with the TB nurse, who functions as a case manager. STD clinics have the lowest return rate (32 percent) of all site types. In general, with the exception of prisons and TB clinics, return rates are low.

With the exception of drug treatment centers, no noticeable difference is found between the return rates for clients with positive results and clients with negative results. Almost twice as many clients with positive test results are counseled than clients with negative test results (56 percent vs. 31 percent), although again this may be a result of follow up--especially in Florida sites.

Client Gender (Chart 4). Males are the majority of clients *seen* at CTS, STD clinics, drug treatment centers, and TB clinics. Prisons are segregated by sex and women's health clinics, by definition, see only female clients. It is interesting to note the stability across site types in the distribution of male and female clients (60 percent to 71 percent male).

Client Age (Chart 5). The age of clients varies considerably by site type. Clients of TB clinics typically are older (44 percent are 50 or older), which is consistent with risk factors for tuberculosis. Women's health centers, primary care facilities, and STD clinics are the only site types with a significant number of clients under the age of 19, Prisons and drug treatment centers tend to see clients between the ages of 20 and 39 (92 percent and 81 percent respectively). The variation by age seems to be associated with the characteristics of persons who would seek the services of a particular site type, such as younger women seeking women's health center services.

Client Racial and/or Ethnic Identity (Chart 6). Extreme variations are seen in the racial/ethnic identity of clients served by the different types of sites. African-Americans are the predominant group served by primary care facilities (77 percent), women's health centers (62 percent), and STD clinics (72 percent). TB clinics and CTS serve predominantly Caucasian clients (66 percent and 67 percent respectively). Prisons and drug treatment centers serve approximately the same percentages of African-American and Caucasian clients (43 percent and 40 percent vs. 42 percent and 39 percent). Very few Asian clients are seen by any site type except for TB clinics, which reflects the risk for tuberculosis that many Asians have as a result of immigrating from countries with high tuberculosis rates.

Client Risk Factors for HIV (Chart 7). With the exception of prisons, drug treatment centers, and CTS, the majority of clients report no risk factors for HIV infection. Clients in prisons and drug treatment centers report a significant risk factor for heterosexual IDU (76 percent and 62 percent respectively), a not unexpected result. However, only 62 percent of the drug treatment center clients reported IDU as a risk factor, since most sites visited were methadone treatment facilities, CTS have a significant number of clients (36

percent) who are males who have sex with males. Since CTS have historically served gay/bisexual males, this is not surprising. It is somewhat surprising that 38 percent of CTS clients and 79 percent of STD clinic clients report no risk factors. Interpretation of these results requires further study.

2. Risk Factor Profiles

Risk factor profiles are based on the assumed seroprevalence of the metropolitan area in which clinics are located. As discussed above, the metropolitan areas have been classified as "Highest," "Mid-level," and "Lowest."

Percent of Clients Tested and Percent with Positive Test Results (Chart 8). Although there is an apparent trend in the percentage of clients tested, its direction is opposite of what would be expected. Clinics in the area of highest estimated seroprevalence had the lowest percentage of clients tested of those offered the test (75 percent). Areas with the lowest estimated seroprevalence had the highest test acceptance (93 percent). We cannot assume this difference (18 percent) is significant due to the very small number of clinics involved and due to the very large differences in the absolute number of cases tested in the different clinics. However, we expected the area with the highest estimated seroprevalence to have the highest percentage of clients tested.

The percentage of positive tests by estimated seroprevalence of area follows the expected pattern. The area with the highest estimated seroprevalence had the highest percentage of positive tests (9 percent). The mid-level and lowest areas had lower rates (5 and 6 percent, respectively). The differences between the areas are not considered to be significant.

Posttest Counseling and Test Results (Chart 9). Again, we assume that the posttest counseled percentage is an indicator of the client return rate. The total percentage of clients returning for results and subsequent posttest counseling is highest in areas with the lowest estimated seroprevalence (82 percent). This may be due to the perception of clients that they will receive "good news", i.e., negative test results, when they return for their results or to the fact that counselors have more time/fewer clients. Return rates are considerably lower for the highest and mid-level estimated seroprevalence areas (44 percent for both),

Return rates for clients with positive results is highest among 'mid-level" area clinics (87 percent), followed by the "lowest" areas (80 percent), and is lowest among "highest" area (52 percent). The "highest" area is the Newark, New Jersey metropolitan area and the low return rate seen there may be due to an inability of available resources to deal with the extraordinarily high AIDS case rate and assumed high seroprevalence. Counselors in Newark may not have adequate time to persuade clients to return and followup for positive clients may not be adequate for the demand. The high return rate of the mid-

level area (Tampa-St. Petersburg, Florida) may be a result of the statewide emphasis on follow up and notification of positives.

Client Gender (Chart 10). There is no apparent difference in the gender of clients offered testing between the different estimated seroprevalence level areas, Approximately the same percentages of males and females are seen in the three areas.

Client Age (Chart 11). With the possible exception of the youngest age group (under the age of 19), there seems to be no difference in the age distribution of clients offered testing between the three areas. The highest and mid-level areas have a slightly larger percentage of clients under 19 than does the lowest area (13 percent and 15 percent vs. 6 percent).

Client Racial and/or Ethnic Identity (Chart 12). The highest estimated seroprevalence area, Newark, has the highest percentage of African-American clients offered testing (76 percent). This may reflect the very large number of African-Americans in the population of Newark. The mid-level area, Tampa-St. Petersburg, has almost equal percentages of African-American and Caucasian clients offered testing (50 percent and 44 percent respectively). The lowest areas, Boston and Hartford, have the highest percentage of Caucasian clients offered testing (61 percent). Approximately the same percentage of Hispanic clients are offered testing in the highest and lowest areas (12 percent and 11 percent respectively). The lowest area has the highest percentage of "other" clients (Native American, Asian, other, and unspecified) offered testing (6 percent).

Client Risk Factors for HIV (Chart 13). The lowest estimated seroprevalence areas, Boston and Hartford, have the highest reported percentage of men having sex with men as a risk factor (29 percent). This may be due to the fact that eight CTS sites were visited in these two areas, comprising over half of,, sites visited. In the highest and mid-level areas, the majority of clients offered testing report no risk factors (68 percent and 70 percent respectively). Risk assessment is not occurring in appropriate ways or the clinics in these areas are testing every client regardless of apparent risk. The only other reported risk factor of any apparent significance is heterosexual IDU. Sixteen percent of clients offered testing in the highest area reported this as a risk factor. In the mid-level and lowest areas of estimated seroprevalence, a smaller percentage of clients reported this as a risk factor (11 percent and 13 percent respectively).

3. Summary

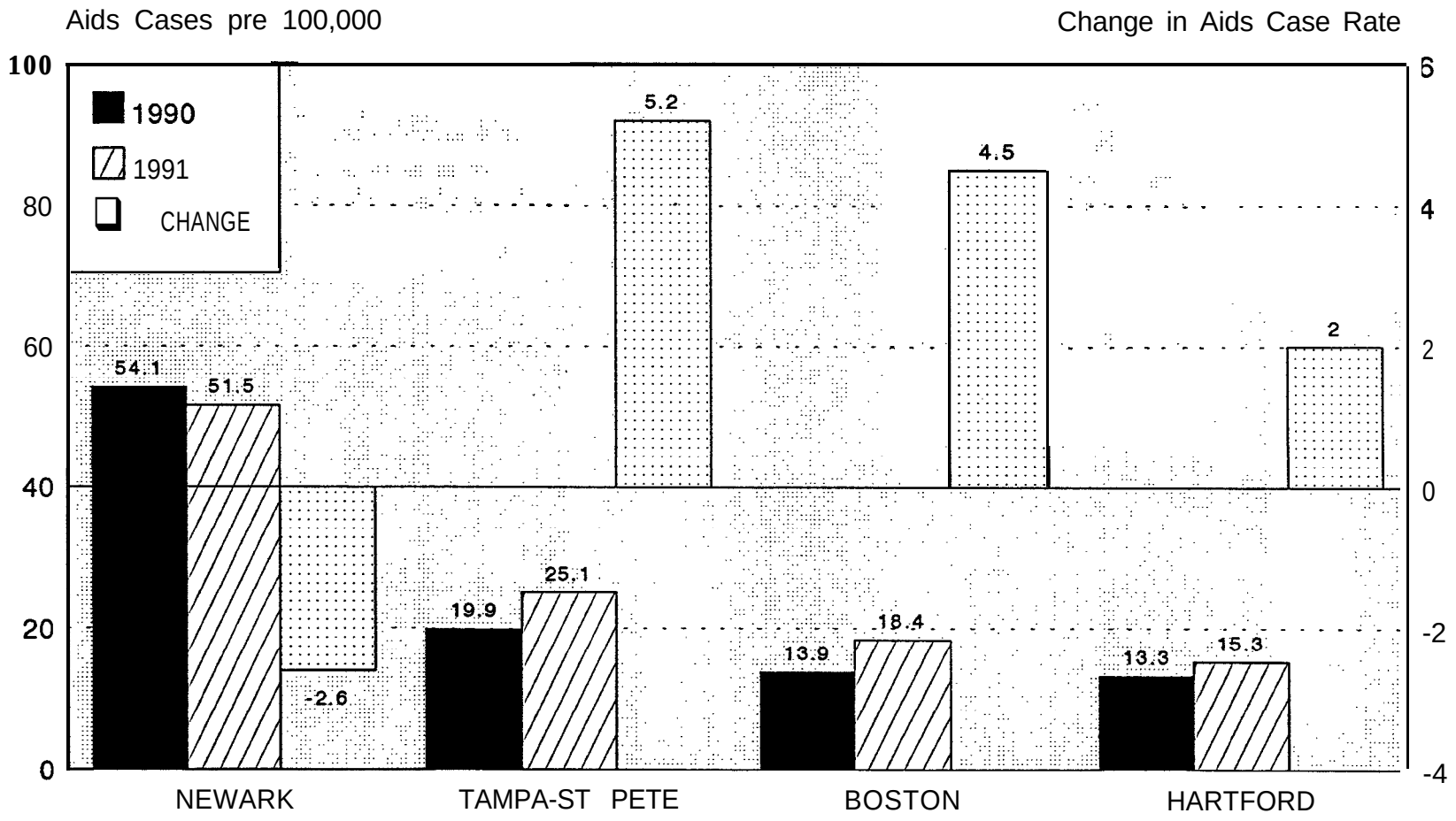
The data presented above for client and risk factor profiles must be interpreted with caution. Only a very small number of sites were selected in a non-random fashion for use in preparing this report, thus any differences noted can not be assumed to be statistically significant nor can it be assumed that these differences reflect the status of all CT sites nationwide. Even so, risk profile and other demographic data examined seem to indicate

that clinics visited are providing HIV counseling and testing services to populations known to be at high risk of exposure to HIV infection.

We attempted to collect these data from each site visited. However, many sites could not provide the data requested. Of those sites that did provide the data, many data elements were unusable. We found numerous errors in the data provided and were reluctant to use what appeared to be unreliable, inaccurate, or incomplete information. It is clear that an effort needs to be made to resolve problems in the collection of data and to provide a mechanism for retention and use of this data at the clinic level. In order to complete an overview of services and populations served, we obtained data directly from CDC, as discussed above. Even though we obtained much of the needed data from CDC, we were unable to obtain an accurate total number of clients and their characteristics from each clinic. These data are not collected on the CDC client data record form. Thus, we do not have a denominator for determining the rate at which differing clinic types offer testing to their clients. Some mechanism for capturing and reporting these data items needs to be developed and implemented.

Chart 1

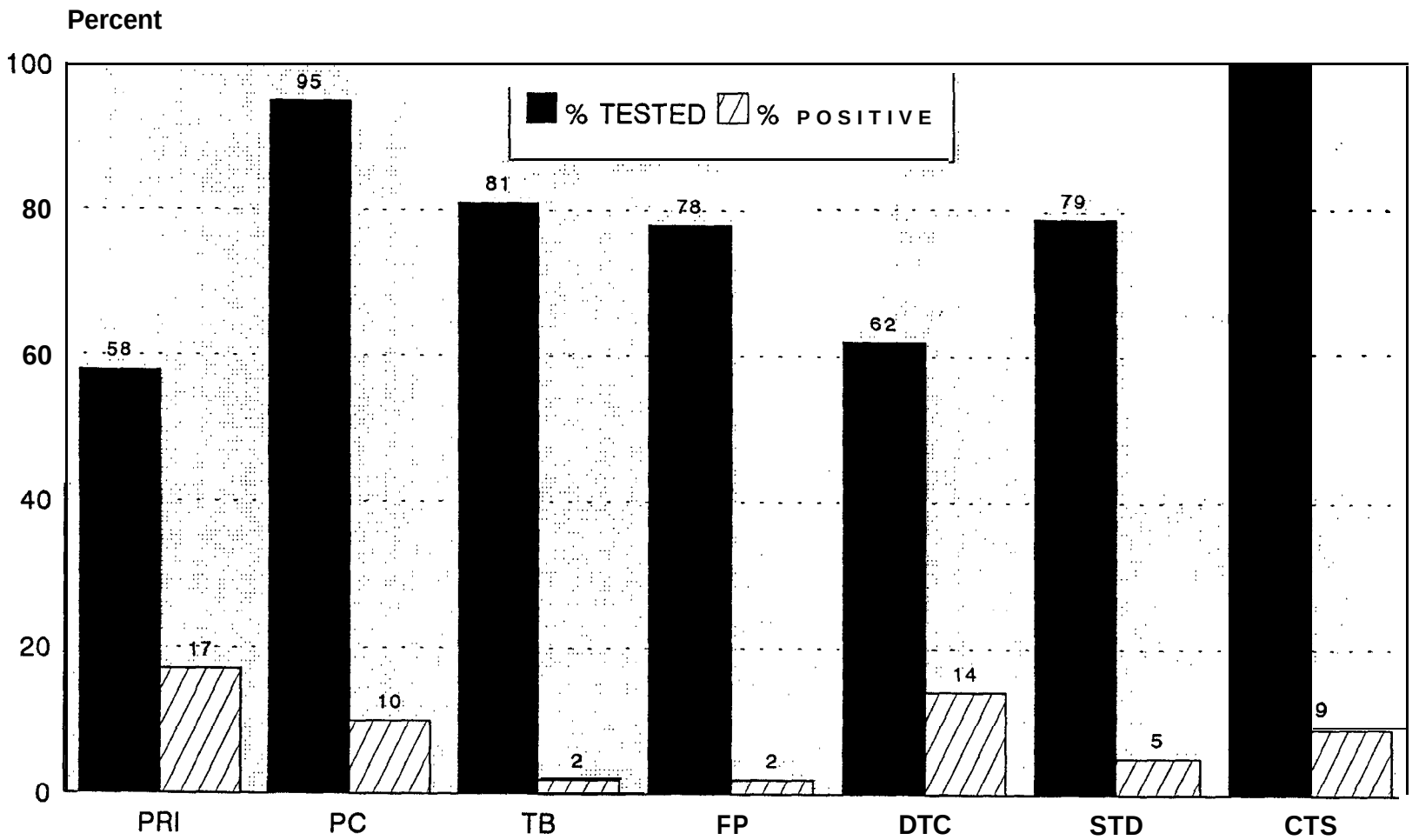
Aids Case Rates For 1990 And 1991 And Change In Rate By Metropolitan Location Of Clinics



	NEWARK	TAMPA-ST PETE	BOSTON	HARTFORD
1990	54.1	19.9	13.9	13.3
1991	51.5	25.1	18.4	15.3
CHANGE	-2.6	5.2	4.5	2

Chart 2

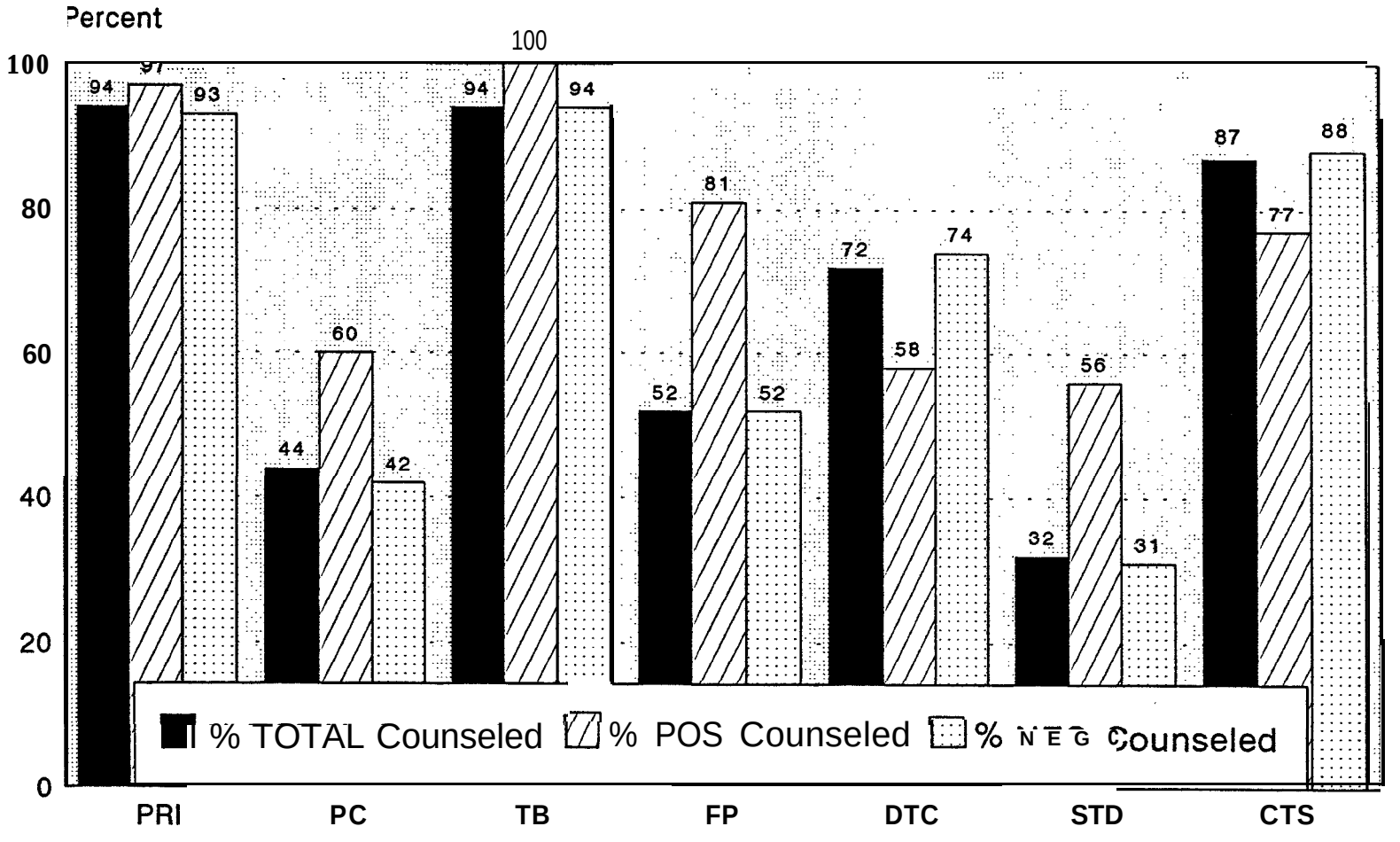
Percent Tested of Clients Offered Testing And Percent Testing Positive By Type Of Site



	PRI	PC	TB	FP	DTC	STD	CTS
% TESTED	58	95	81	78	62	79	98
% POSITIVE	17	10	2	2	14	5	9

Chart 3

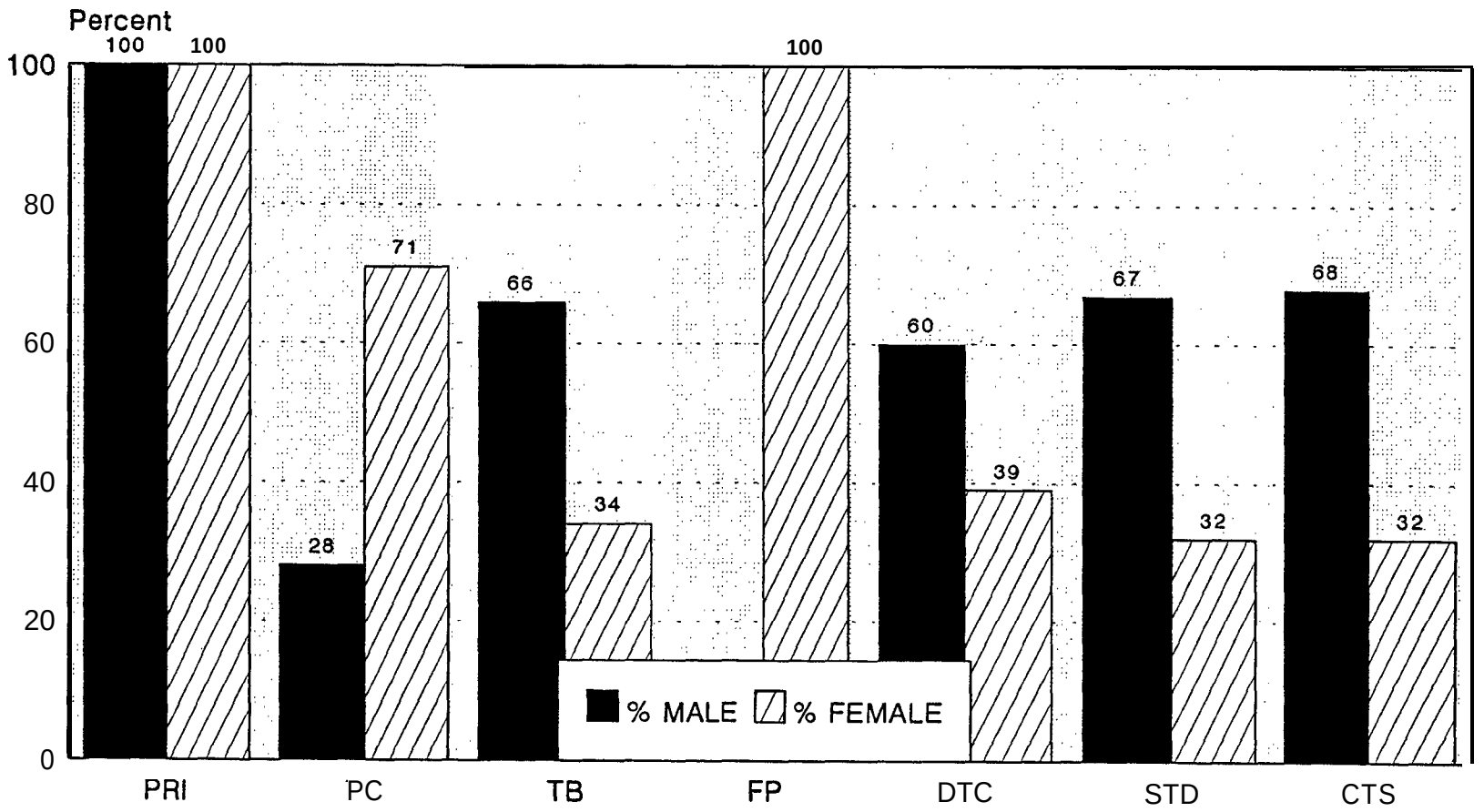
Percent of Total Tested Post-test Counseled, Percent of Positives Post-test Counseled, And Percent of Negatives Post-test Counseled By Type of Site



	PRI	PC	TB	FP	DTC	STD	CTS
% TOTAL Counseled	94	44	94	52	72	32	87
% POS Counseled	97	60	100	81	58	56	77
% NEG Counseled	93	42	94	52	74	31	88

Chart 4

Percent Male And Female Offered Testing By Type of Site

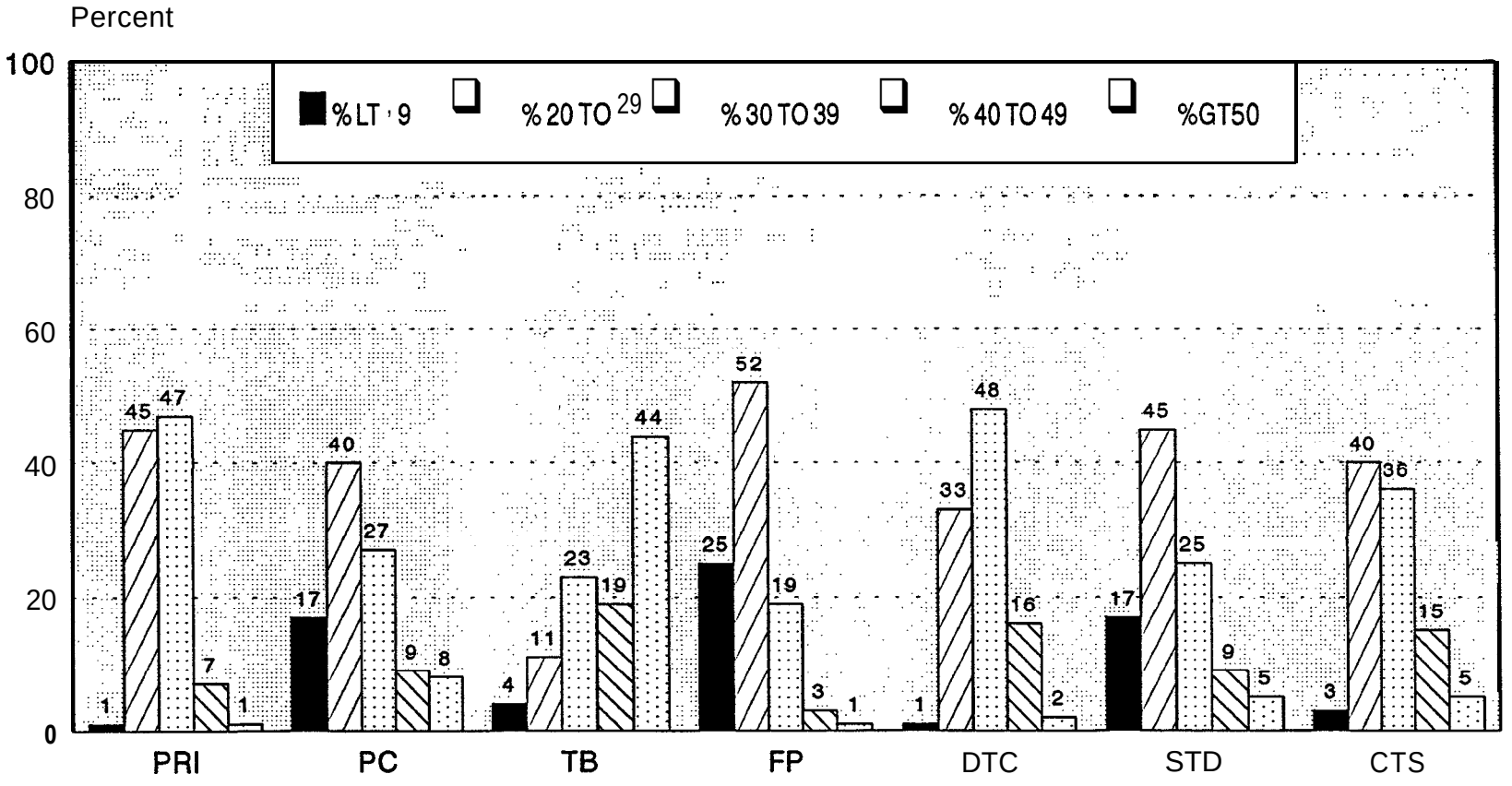


	PRI	PC	TB	FP	DTC	STD	CTS
% MALE	100	26	66		60	67	66
% FEMALE	100	71	34	100	39	32	32

NOTE: Totals do not equal 100% due to some records not indicating the client's gender. PRI site types equal 100 for both genders as prisons are segregated by sex. FP clinics do not serve males.

Chart 5

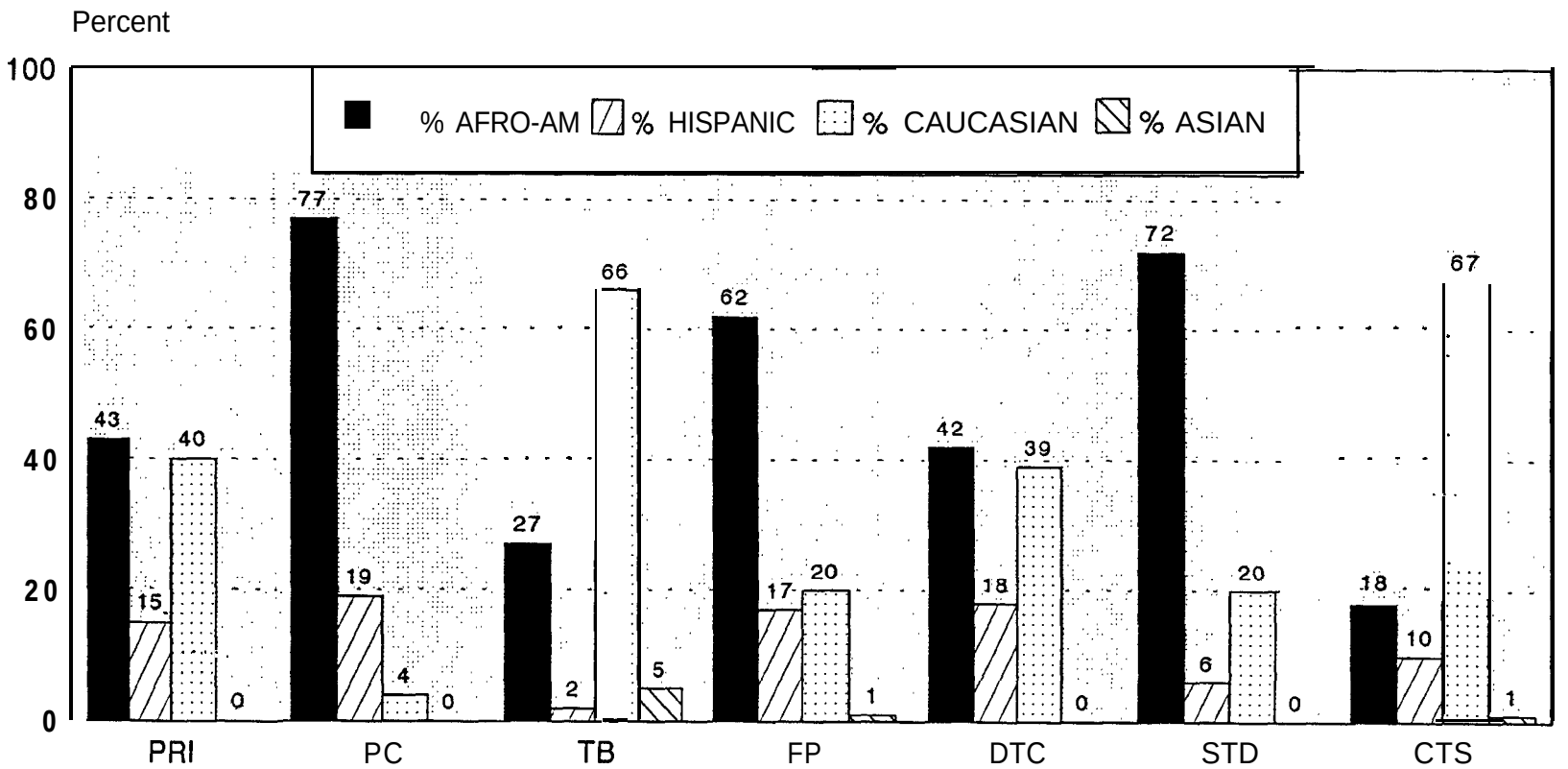
Percent Offered Testing By Age Category And By Type of Site



	PRI	PC	TB	FP	DTC	STD	CTS
% LT 19	1	17	4	25	1	17	3
% 20 TO 29	45	40	11	52	33	45	40
% 30 TO 39	47	27	23	19	48	25	38
% 40 TO 49	7	9	19	3	16	9	15
% GT 50	1	8	44	1	2	5	5

Chart 6

Percent Offered Testing By Racial/Ethnic Group And By Type of Site

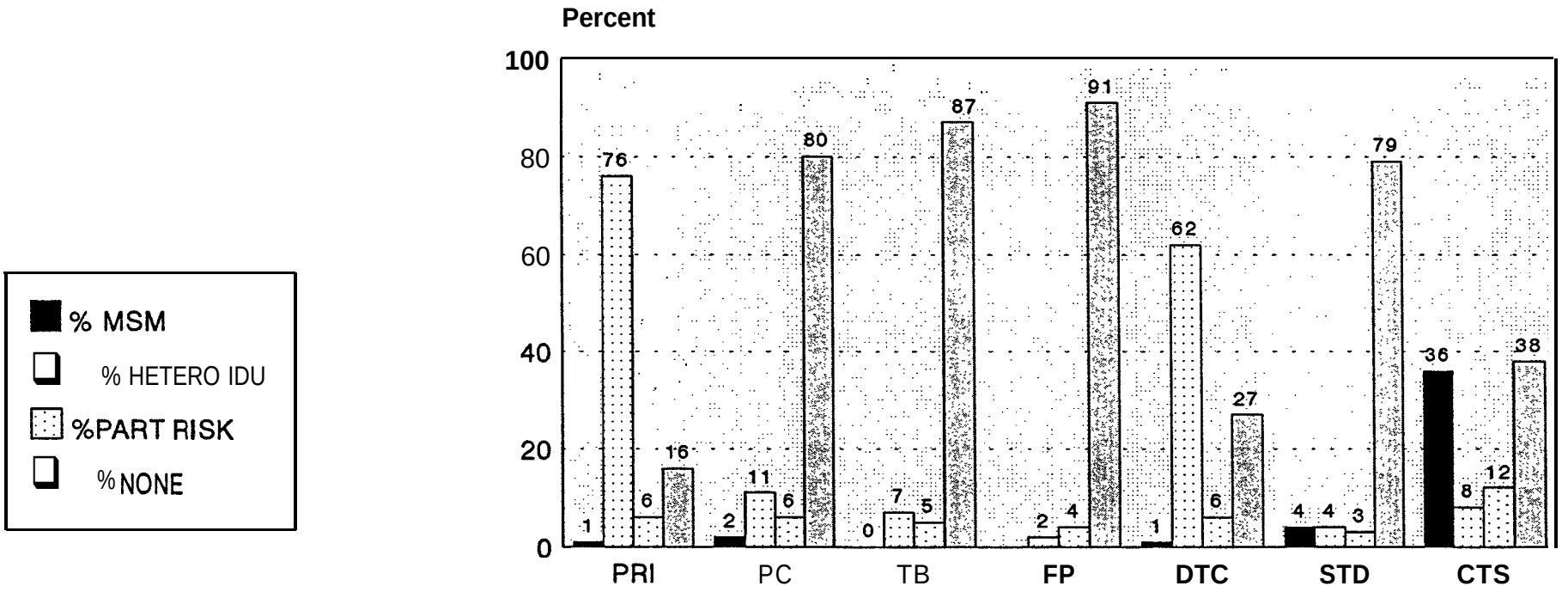


	PRI	PC	TB	FP	DTC	STD	CTS
% AFRO-AM	43	77	27	62	42	72	16
% HISPANIC	15	19	2	17	18	6	10
% CAUCASIAN	40	4	66	20	39	20	67
% ASIAN	0	0	5	1	0	0	1

NOTE: Native American category is not included due to very small number of cases (0% for all site types).

Chart 7

Percent Offered Testing By Acknowledged Risk Factor And By Type Of Site

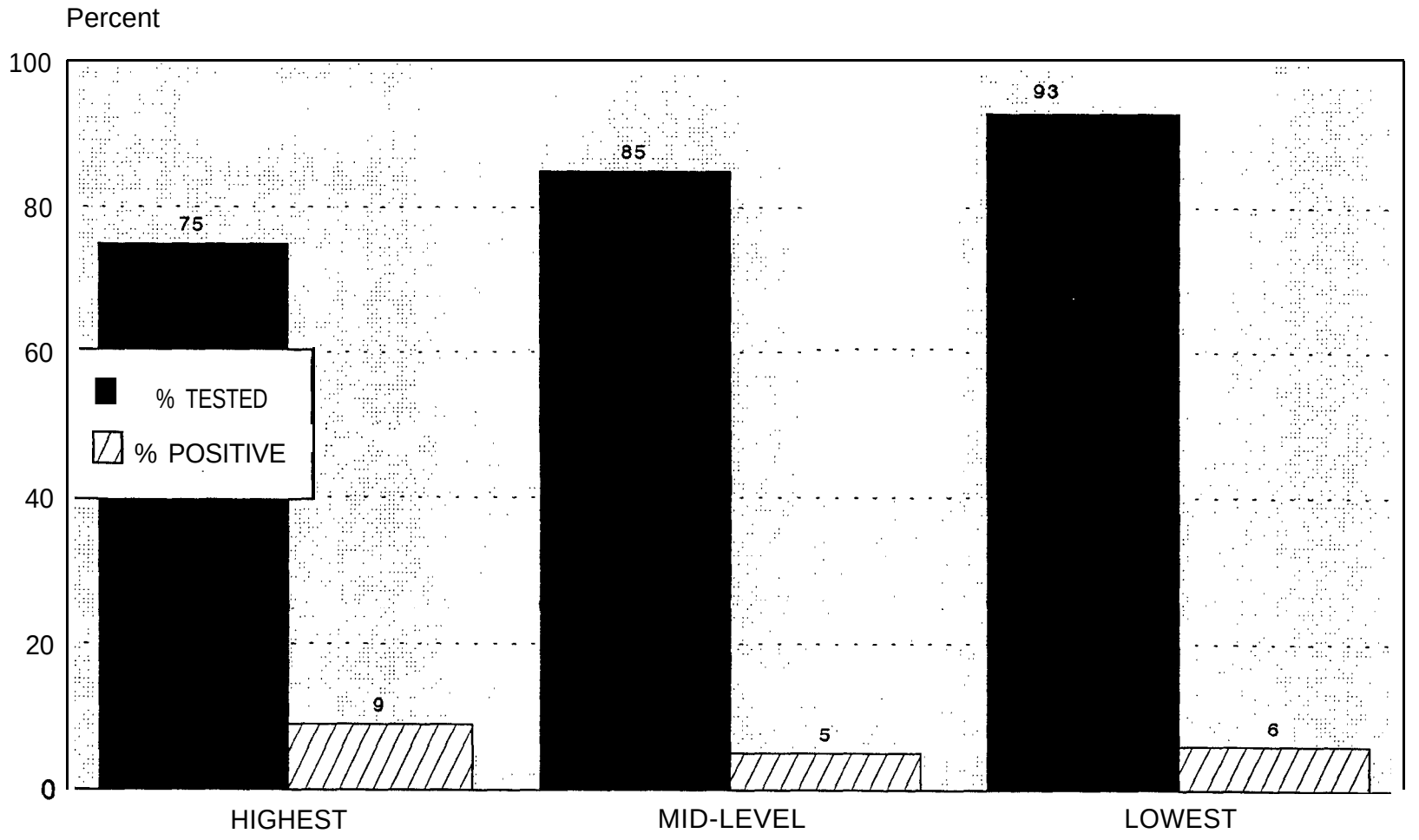


	PRI	PC	TB	FP	DTC	STD	CTS
% MSM	1	2	0		1	4	36
% MSM+IDU	0	1	2	0	1	0	1
% HETERO IDU	78	11	7	2	62	4	8
% HEMOP/BLOOD	0	1	0	2	1	1	1
%PART RISK	8	8	5	4	6	3	12
% EXCH DRUGS/SEX	1	1	0	1	3	8	3
% NONE	18	80	87	91	27	79	38

NOTE: Data for males sex with males and IDU, hemophilia/blood transfusion, and exchanging sex for drugs and/or money is not charted. Data is included in the table below the chart.

Chart 8

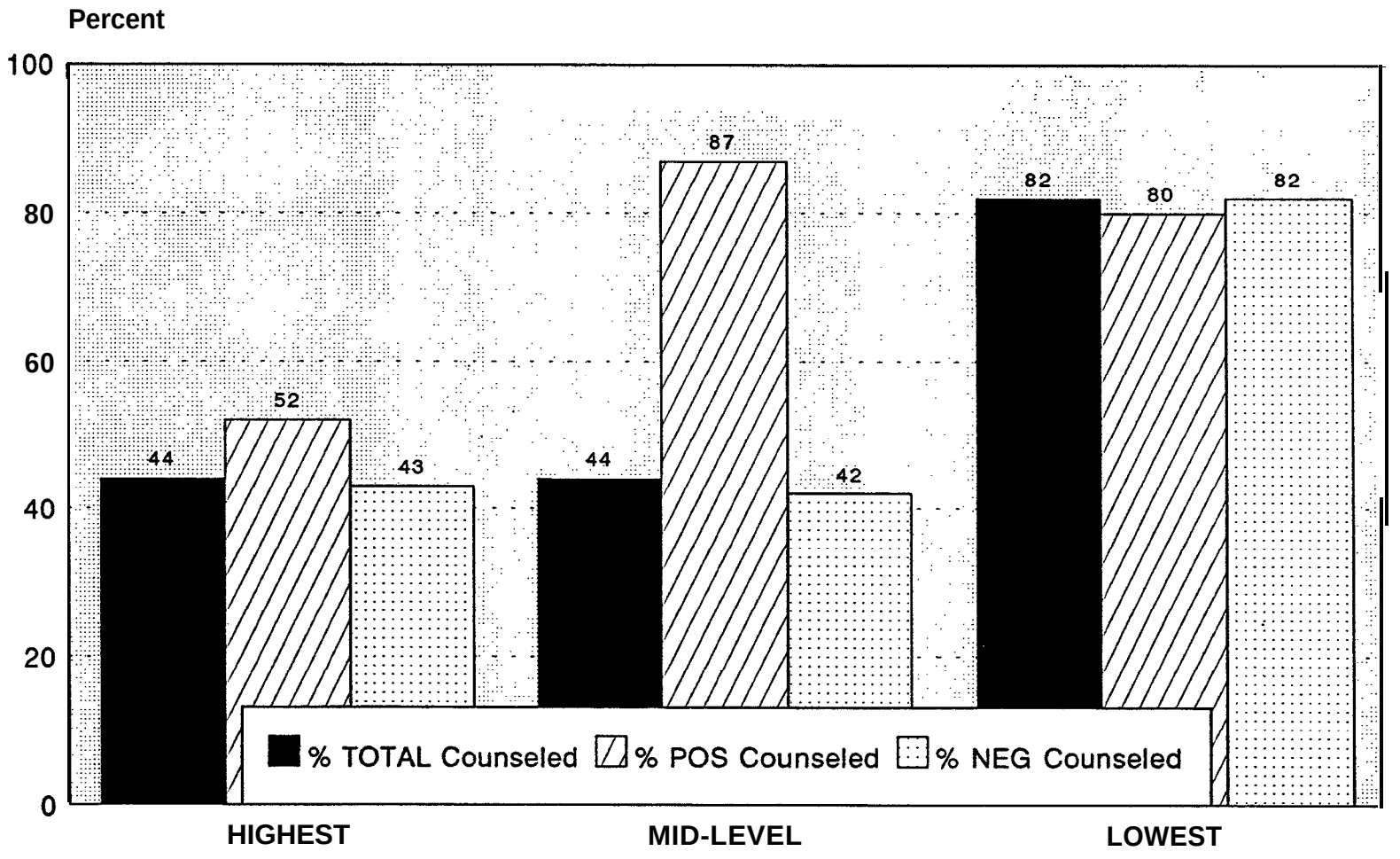
Percent Tested of Clients Offered Testing And Percent Tested Positive By Estimated Seroprevalence of Area



% TESTED	75	85	93
% POSITIVE			

Chart 9

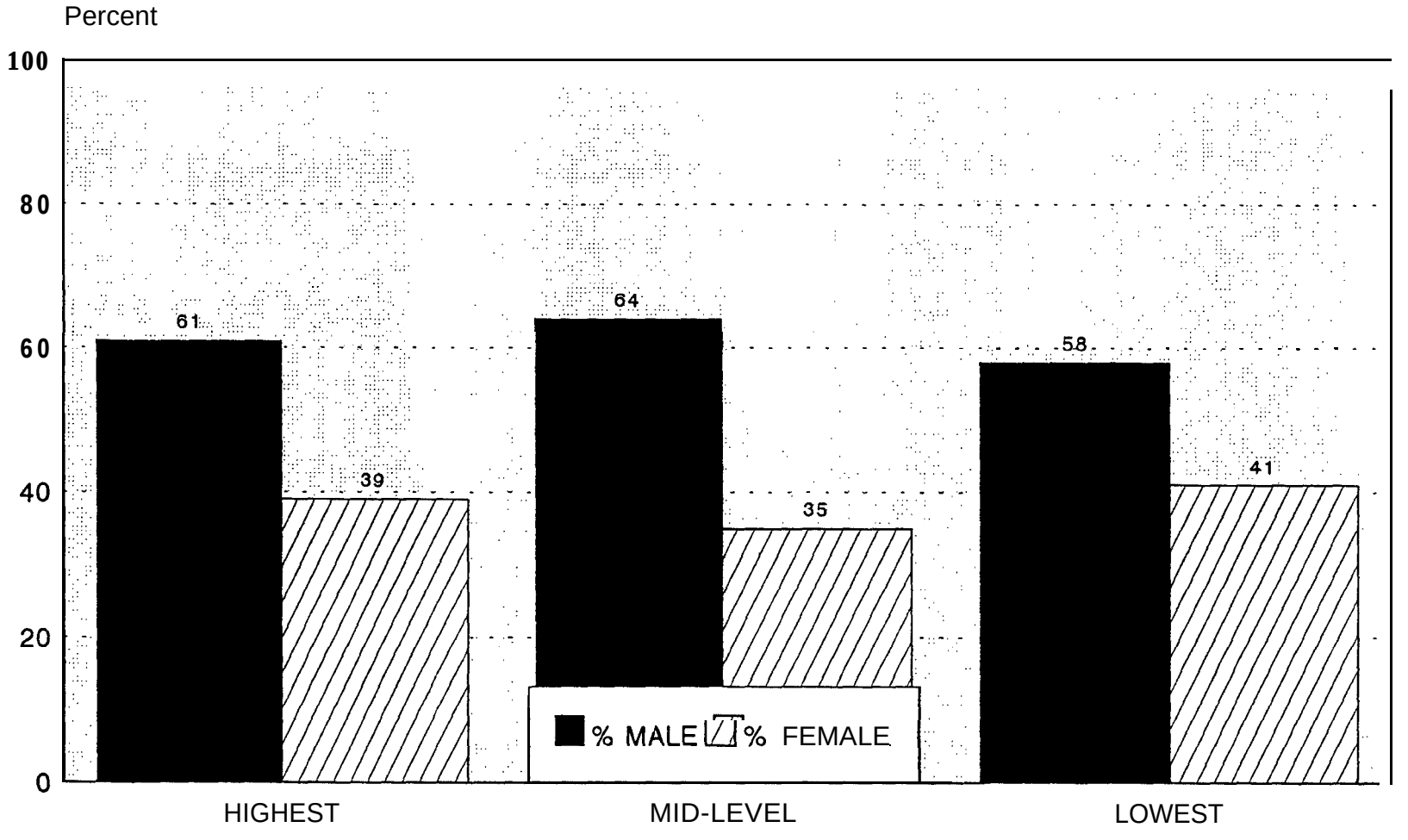
Percent of Total Tested Post-test Counseled, Percent of Positives Post-test Counseled, And Percent of Negatives Post-test Counseled By Estimated Seroprevalence of Area



	HIGHEST	MID-LEVEL	LOWEST
% TOTAL Counseled	44	44	82
% POS Counseled	52	87	80
% NEG Counseled	43	42	82

Chart 10

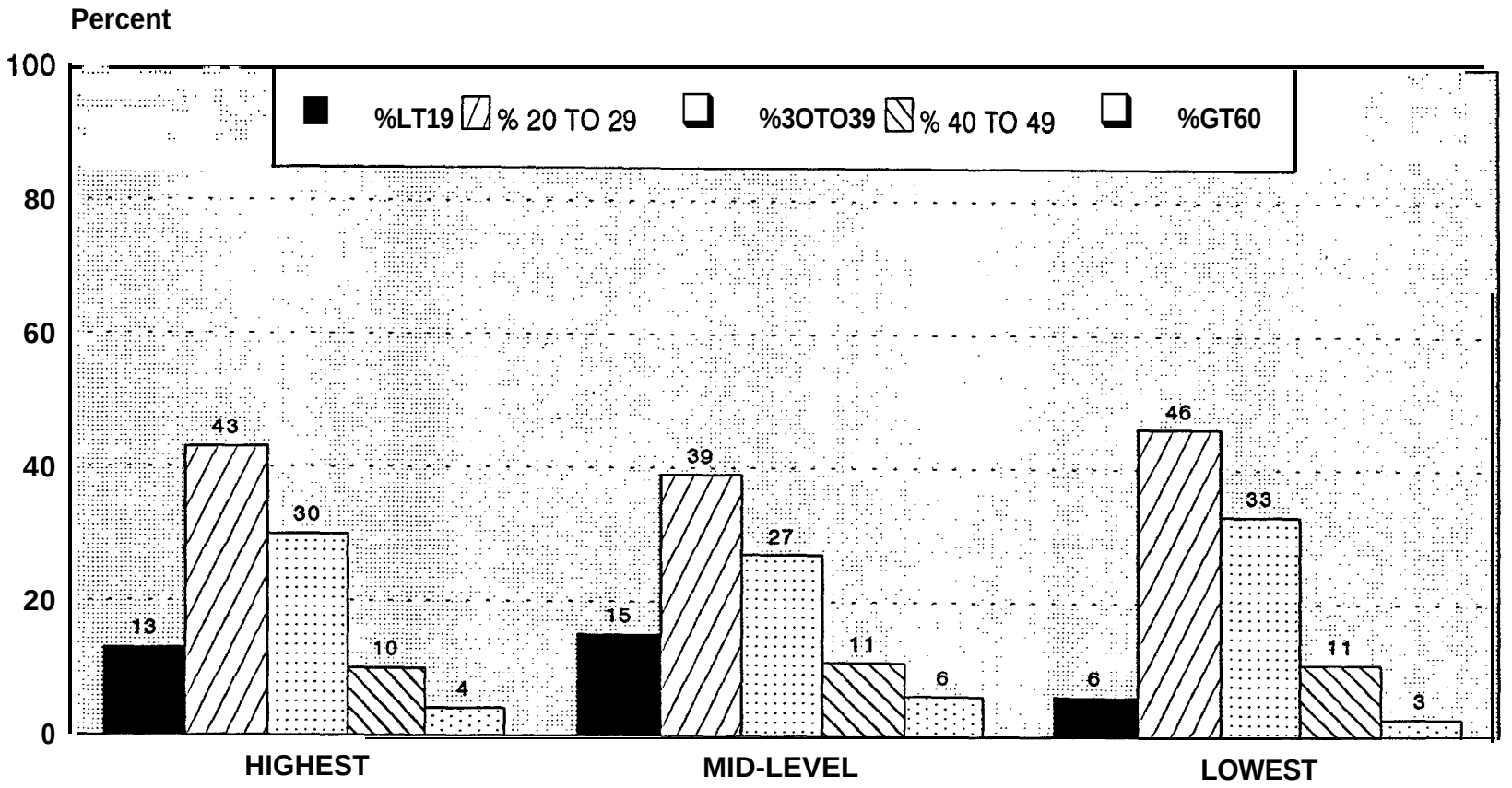
Percent Male And Female Offered Testing By Estimated Seroprevalence of Area



	HIGHEST	MID-LEVEL	LOWEST
% MALE	61	64	58
% FEMALE	39	35	41

Chart 11

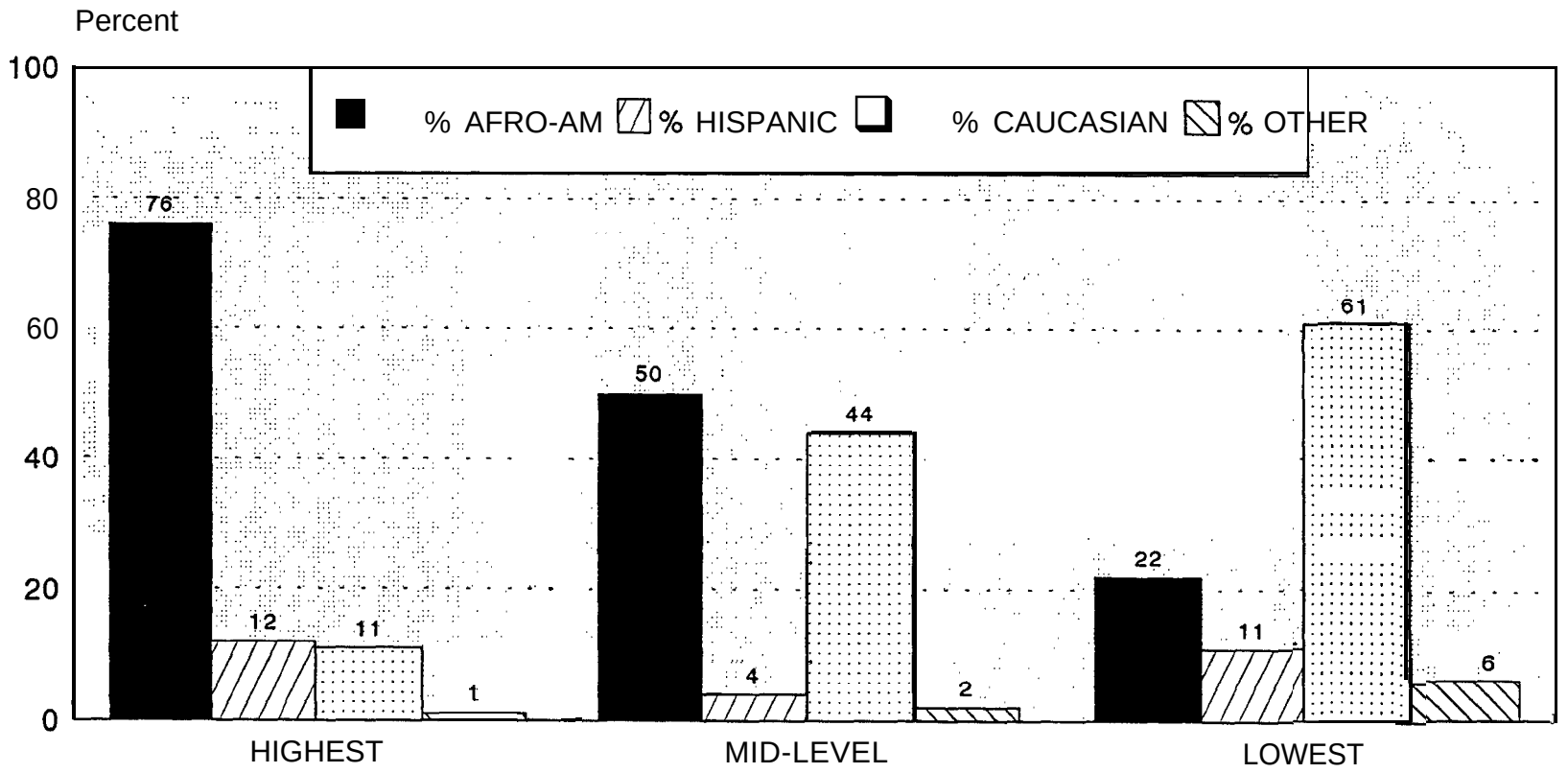
Percent Offered Testing By Age Category And By Estimated Seroprevalence of Area



	HIGHEST	MID-LEVEL	LOWEST
% LT 19	13	15	6
% 20 TO 29	43	39	46
% 30 TO 39	30	27	33
% 40 TO 49	10	11	11
% GT 50	4	6	3

Chart 12

Percent Offered Testing By Racial/Ethnic Group And By Estimated Seroprevalence of Area

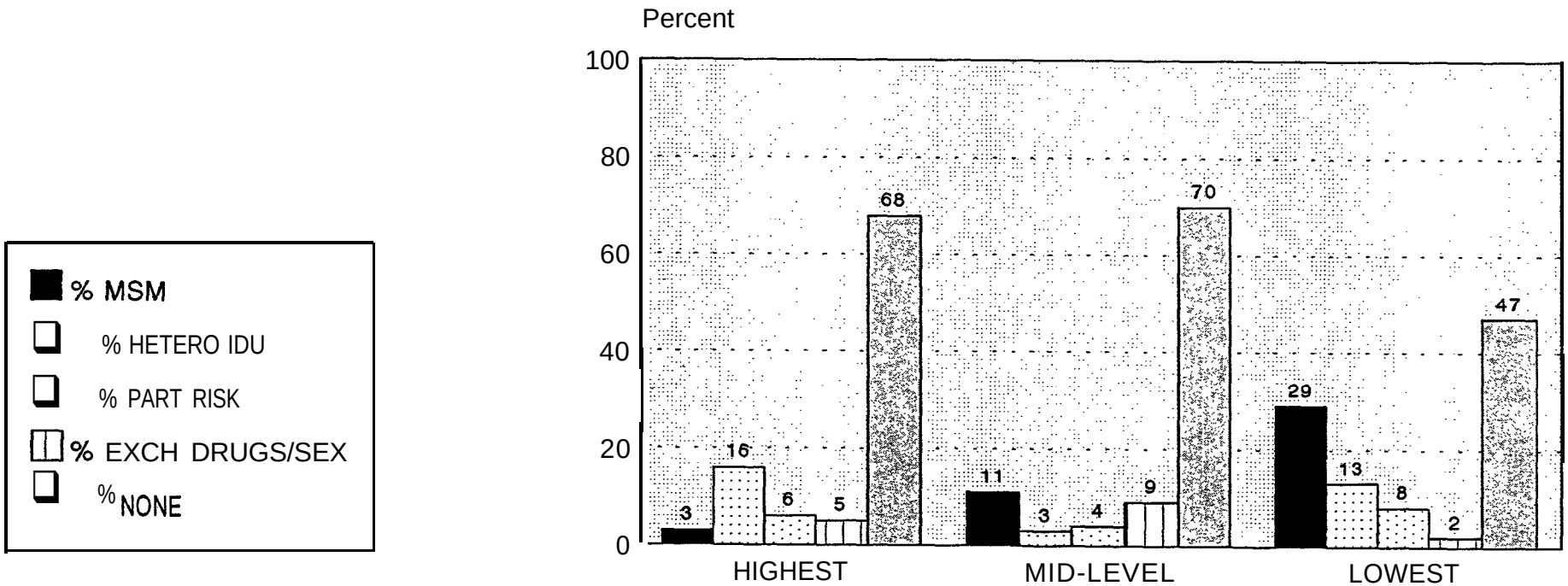


	HIGHEST	MID-LEVEL	LOWEST
% AFRO-AM	76	50	22
% HISPANIC	12	4	11
% CAUCASIAN	11	44	61
% OTHER	1	2	6

NOTE: Native American and Asian category is included in the “Other” category due to the small number of number of cases. “Other” also includes those for whom race/ethnicity is not identified.

Chart 13

Percent Offered Testing By Acknowledged Risk Factor And By Estimated Seroprevalence of Area



	HIGHEST	MID-LEVEL	LOWEST
% MSM	3	11	29
% MSM+IDU	1	1	0
% HETERO IDU	16	3	13
% HEMOP/BLOOD	1	2	1
% PART RISK	6	4	8
% EXCH DRUGS/SEX	5	9	2
% NONE	66	70	47

NOTE: **Data for males sex with males and IDU and hemophilia/blood transfusion is not charted due to small number of cases. Data is included in the table below the chart.**