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The United States Conference of Mayors

Local HIV Policies Resource Guide

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The United States Conference of Mayors

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OVERVIEW

More than ten years into the epidemic, communities continue to struggle as they face the demands and needs created by HIV / AIDS. While federal legislation such as the Americans with Disabilities Act (ADA) has addressed some of the policy-related issues created by the disease and states have implemented HIV-related policies in certain areas, many issues remain that require action at the local level.

Leadership by local policy makers is important as communities grapple with the many complex issues created by the HIV epidemic. Policy makers must be proactive in identifying potential problems, standardizing and increasing the effectiveness of services, and coordinating the community's response to HIV in order to assure the optimal use of resources. The process for addressing HIV-related concerns varies from community to community, depending on the structure of local government, the political climate, and local traditions. Policies can be in the form of mayoral executive orders, resolutions passed by the city council or regulations and protocols developed at the agency level.

The Local HIV Policy Resource Guide will assist local officials in the development of appropriate responses by providing working examples of locally-utilized policies and protocols. By developing policies before difficult-to-address situations arise, communities can avoid management by crisis and ensure the delivery of services and the optimal utilization of resources.

Policies in this resource guide are reprinted exactly as submitted by respondents with no editing by USCM staff. For additional information on specific policies contact the respondents directly. A listing of respondents is included on the last page of the resource guide.

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Introduction

The Local HIV Policy Resource Guide is the third collection of local policies compiled by The U.S. Conference of Mayors (USCM) / U.S. Conference of Local Health Officers (USCLHO). Past guides have provided local policy makers with examples of HIV-related policies adopted by other communities pertaining to correctional facilities, health care workers, discrimination, schools, and HIV antibody testing. Policies collected for this guide address the following areas:

* Monitoring and assuring quality of services provided by organizations funded by the locality or local government agencies;

* Early Intervention, referral and follow-up;

* Voluntary partner notification services;

* Coordination between HIV prevention and STD services;

* Tuberculosis prevention and control measures for HIV-infected individuals; and

* HIV prevention efforts targeting drug users.

These areas represent a "second phase" of local response to the HIV epidemic. Earlier resource guides primarily presented policies designed to ensure appropriate precautions were implemented to protect against the further spread of the disease (e.g., the use of universal precautions by health care providers and first responders) and to stem unwarranted fear of contagion (e.g., anti-discrimination and employment policies).

The policies collected for this guide demonstrate a coordination of HIV-related activities with a broad spectrum of services. The guide examines integration with STD services and TB prevention and control activities, the delivery of services in response to HIV-related scientific developments, early intervention activities, the efficacy of needle exchange programs and the adoption of quality assurance measures.

For the development of this document, USCM/USCLHO collected surveys from 94 local health departments. As could be expected, responses varied greatly. Some communities had no HIV-specific policies in place in the requested areas, others operate under state policies, and still others have adopted local policies. The policies presented in this publication are not necessarily intended to serve as "model policies," but as examples of the types of actions local government has seen necessary to take in response to the continuing AIDS epidemic.

Quality Assurance Monitoring for HIV-related Activities

In the face of ever increasing demand for services and limited resources to meet needs, public and private funders are demanding that service providers monitor and assess the effectiveness of their efforts. Service-providing local government agencies and community based organizations can utilize a variety of measures to help ensure that services are responsive to a community's needs. It is imperative that funders develop standards to assess the effectiveness of grantees so that programs can be compared to ensure that services are reaching those in need and modifications can be made to increase program effectiveness.

Santa Clara County, California
Kansas City, Missouri

SANTA CLARA COUNTY, CALIFORNIA

SANTA CLARA COUNTY HEALTH DEPARTMENT

AIDS EDUCATION PROGRAM

SUBVENTION CONTRACTORS MONITORING PLAN

I. PROGRAM DELIVERABLES

A. Reaching Targeted Population

1. Do monthly reports match people being targeted in work plan?
2. Are access points appropriate for reaching target population?
3. Are there appropriate outreach or recruitment strategies for reaching target population place?

B. Numbers of Clients/Participants being Delivered

1. Do monthly reports indicate that year end totals will be reached?
2. Are plans in place to reach appropriate totals if projects are behind schedule of delivery?

C. Quality of Educational Messages being Delivered

1. Are curriculums, and work plans appropriate in both message and educational approach to target population?
2. Is evaluation criteria as outlined in work plan being met?
3. If evaluation criteria's not being satisfied, is there a plan to increase success rate or modify evaluation plan to more accurately evaluate effectiveness of overall educational activities?
4. Is feedback solicited from participants as to effectiveness and benefits of educational programs? Is client participant feedback utilized in modification of program content or delivery?
5. Are educational activities observed and evaluated by independent experts (i.e. monitoring agency, subvention colleagues or other independent experts)? Is feedback favorable and is there a method of evaluating and incorporating any changes recommended into educational plans?
6. Is education delivered in a culturally competent manner? Are educators familiar with and sensitive to ethnic, sexual preference and lifestyles of the target population and able to take such factors into account in delivering educational services?
7. Do project staff have language capability to provide services for target population? Are educational materials available in appropriate languages?

8. Is there overall community support for your educational activities? Do you receive letters or phone calls supporting or questioning educational activities? Do you solicit community input or comment and incorporate feedback into educational plans?

II. PROGRAM MANAGEMENT AND STAFF

A. Overall Agency Goals

1. Does your agency evaluate the AIDS education project in light of the agency's overall goal or mission? Do educational interventions reflect that mission?

2. Are plans made on an agency level to expand or re-target educational activities? Are these efforts being made on the basis of community need? Are efforts being made to secure funding for new or expanded activities?

B. Cultural Competency

1. Does the agency accept and respect differences in ethnicity, sexual preferences and life-styles and pay attention to how such factors influence the delivery of education services?

2. Does the agency have in place a system of recruitment and employment that ensures the hiring of unbiased employees capable of dealing in an effective and understanding manner with the cultural communities represented in the agency's target population?

3. Are cross-cultural trainings either providedor made available to educational staff?

4. Does the agency consult with the community being targeted regarding service provisions and delivery? How is feedback incorporated into educational plans?

C. Fiscal Management

1. Does the budget reflect the actual staff and material needed to reach contract objectives? Are AIDS educational activities supported by funds apart from subvention subtract?

2. Are fiscal reports prepared and forwarded to the County in a timely manner?

3. Do expenditures reflect actual work preformed as described in monthly reports?

4. Are reports prepared accurately?

5. Are problems of over and under expenditures identified and plans to deal with the above formulated and appropriate to the situation?

D. Staffing

1. Are staff qualifications appropriate for educational activities being carried out? Do staff meet educational and experience requirements for the job? How does the agency insure that staff will be able to deal with the cultural diversity represented in the target population.

2. Is current staffing level adequate to meet contract objectives? If not, are appropriate efforts being made to recruit additional staff?

3. Are staff appropriately oriented and trained? How does the agency ensure that staff have adequate AIDS knowledge and appropriate educational skills? Is there any ongoing training and if so, how is this done and of what type?

4. How is the educational staff evaluated? What factors are looked at? How and how often is evaluation done?

5. How is agency staff supported? If burn out or low staff moral is an issue, how are these issues handled?

III. COMMUNITY INTERACTIONS

A. Relationship With Community and Other Programs

1. Do you inform, consult or provide education to the community about your programs or any other subvention AIDS programs? If so, how is this done?

2. Do you maintain relationships with other HIV/AIDS programs other than those under subvention? If so, what kinds of contacts do you have?

3. Do you maintain relationships with other service agencies which have an interest in HIV/AIDS prevention such as substance abuse, mental health or social service programs? What kinds of relationships do you have?

B. County AIDS Program/Subvention Agencies

1. Does the agency interact with other subvention agencies?Do you attend joint meetings? Consult with each other? Engage in joint educational activites?

2. Are relationships with subvention agencies positive? What areas of conflict exist? How are conflicts resolved?

3. Is relationship with County AIDS Program positive? What areas of conflict exist? How are conflicts resolved?

KANSAS CITY, MISSOURI

HEALTH EDUCATION AND RISK REDUCTION
QUALITY ASSURANCE PLAN

PROGRAM OVERVIEW:

The Health Education and Risk Reduction segment of the Kansas City Missouri Health Department, HIV/AIDS Program contracts with eight different community based organizations to provide HIV/AIDS educational programs for specific target groups. Each community based organization's contract has a defined scope of work that includes provisions for a monthly report. We work very closely with the different community based organizations building a level of trust that is unique in the field of HIV/AIDS Education. The City Health Department is regarded as partners and often is involved in the planning stages of many of the community based organizations educational programs. This partnership has made quality assurance of Health Education and Risk Reduction programs a cooperative effort.

QUALITY ASSURANCE:

To assure the quality of the material and the information disseminated by the community based organizations that currently contract with the City for Health Education and Risk Reduction, we have broken the quality assurance into three parts; 1) monthly reporting based on contract provisions; 2) site visits including visits to presentations; 3) community based literature review of all material used in Health Education and Risk Reduction activities. The following is a detailed explanation of each of the three parts of our quality assurance plan:

1. Monthly Reporting

   Monthly reports are to be submitted via a specific format that is provided as an attachment to the Health Education and Risk Reduction contracts at the beginning of the contract period. Each monthly report form consists of a billing statement and a written report form that is based upon the contracts "scope of work" segment. This form makes it easy to assess what contract provisions are being fulfilled and which needs extra work. These program assessments are made on a monthly basis and any action necessary would begin in the following month.

   The HIV/AIDS Education Coordinator would conduct a site visit to assess the lack of compliance with the contracted obligation. This assessment is made with cooperation of the community based organization's HIV/AIDS Educator. We discuss the difficulties and try to find workable solutions.

2. Site Visits

   Site visits are conducted periodically to maintain the working relationship of the Kansas City Health Department, HIV/AIDS Program and the community based organization. These visits are just part of a working relationship that has been nurtured over the lifetime of this program. The HIV/AIDS Program is an integral part of the Health Education and Risk Reduction resource community. Each organization provides assistance to others when necessary.

The site visit includes attending an HIV/AIDS presentation conducted by each community based organization. These presentations vary from booths at ethnic festivals to lectures to high risk populations. The site visit can be a cooperative effort, manning a booth or assisting with a lecture/ presentation. This involvement could also be in the planning stages of an event or presentation.

During these site visits observation and questioning are the most frequently used tools for quality control. We can make suggestions and solicit opinions from the community based organization's educator creating a dialogue from which to assess their level of expertise. The use of surveys and pre-test and post-test questions are helpful to assess the level of audience understanding. Ultimately the assessment of behavior change is subjective and limited to the audience's willingness to practice what they have heard.

The Missouri Department of Health also supplies pre-test and post-test evaluations as well as a fact sheet, to each of our Health Education and Risk Reduction sites. The community based organizations use these to evaluate their audiences knowledge base and their presentation. The community based organizations send the completed evaluations with any specific instructions to the Missouri Department of Health where they are processed. The community based organization then receives a report once a quarter providing the demographics of the audience, knowledge level and audience retention level for each separate presentation. A copy of each evaluation and a copy of the fact sheet is attached.

3. Literature Review

The power of the media the printed word, audio and video has long been known. We have begun a community literature review to insure that the quality of the educational material used in our Health Education and Risk Reduction Program is appropriate, accurate, effective and in compliance with the Centers for Disease Control's standards. Controlling the type of message you provide and the consistency of the message is vital to a quality educational program intent on behavior change. Attached is a copy of the policies and procedures of the literature review process.

The Kansas City Missouri Health Department and the community based organizations that contract with the City have attempted to provide a quality HIV/AIDS education program for the Kansas City metropolitan area. We are constantly seeking new ways to evaluate our programs in effort to increase their effectiveness. The Kansas City Missouri, HIV/AIDS Program has developed several forms that help us assess our level of involvement and the type of involvement. A copy of these forms to this report is attached.

(Revised 10/11/90)

Early Intervention Referral and Services

Ever since the development of successful early medical intervention drugs, providers have been struggling to meet demand for effective and cost efficient services. Important issues to be addressed in providing early intervention services include: access to CD4 testing for HIV-infected individuals; the establishment of standards of care for HIV-infected individuals; and the development of referral networks to other services.

Pinellas County, Florida
Tulsa, Oklahoma

CD4 Lymphocyte Assay Policy

Background

The CD4 (T4, Helper Cell) lymphocyte assay is the most important guideline that we now have to assess the progress of HIV disease in HIV antibody positive clients. It is an informal policy within this agency that clients who test positive for HIV in any other clinic may be referred to the HIV/AIDS Patient Care Clinic (PAMS) for assessment and consultation. It has been recognized by clinic staff that these consultations consume a significant amount of clinic time. Given the limited clinic time and space available, it appears to be cost-effective to provide a T4 lymphocyte assay to HIV positive clients. These clients may then be triaged appropriately based upon CD4 level.

Policy

Any enrolled client who undergoes HIV antibody testing in a Health Unit clinic may be offered consultation through the PAMS Clinic. This consultation will consist at a minimum of a CD4 lymphocyte assay. If the client is found to have a T4 count of over 500, they will be referred elsewhere for medical care. If the count is 500 or under, they will be offered enrollment in PAMS for further evaluation.

TULSA, OKLAHOMA

PROCEDURES FOR HEALTH MAINTENANCE CLINIC (HMC)

Background

Human immunodeficiency virus (HIV) infection is a chronic condition which results in progressive impairment of the immune system through destruction of CD4+ lymphocytes and by other less well defined mechanisms. While the infection cannot be cured, there are preventive measures including vaccinations, medications, and lifestyle recommendations which can potentially slow the progress of immune system dysfunction and prevent secondary morbidity. In order to determine the need for preventive measures such as AZT (zidovudine; formerly azidothymidine) or prophylaxis for Pneumocystis carinii pneumonia, the Centers for Disease Control has recommended that persons with HIV infection who have not developed AIDS have regular monitoring of immune system function using helper-inducer (T4 or CD4+) lymphocyte counts as an indicator. The purpose of this protocol is to describe how the Tulsa City-County Health Department (TCCHD) will offer preventative services including routine monitoring of CD4+ lymphocyte counts for persons who are HIV-infected but have not developed severe illness.

Access

Patients referred to the HMC are routed through the disease intervention specialist (DIS) staff who obtain HMC appointments after offering partner notification assistance and providing confirmation of positive HIV antibody status, along with routine counseling regarding HIV testing and prevention.

Admission

Patients are admitted to the HMC by appointment. Admission requirements include: a positive HIV antibody test; a CD4+ (T4) lymphocyte count, if known, above 200 per cubic millimeter; not receiving treatment to prevent Pneumocystic carinii pneumonia (PCP) and use of the patient's name. This service is highly confidential, but not anonymous. Those who have had a CD4+ lymphocyte count within the previous 6 months will not be tested, except in special circumstances.

Service Limitations

The clinic does not provide diagnosis or evaluation for illness; patients are encouraged to establish a care relationship with a personal physician. Except for tuberculosis or sexually transmitted disease, no treatment is provided. No HIV medications are provided. The clinic does not offer a "drop-in" service for CD4+ lymphocyte counts; CD4+ lymphocyte counts are only part of a health maintenance "package". The clinic does not provide disability evaluation for Social Security or other programs.

Except in special circumstances, CD4+ lymphocyte testing will be provided only every 6 months.

Patients are referred to their personal physician for any illness and for any medications related to their HIV infection. Services are discontinued when the CD4+ lymphocyte count is below 200 per cubic millimeter or when the patient is started on PCP prevention.

INITIAL CLINIC VISIT

A. OBTAIN HISTORY

1. Epidemiologic and past medical history (Baseline Information Form).
2. Current HIV-related symptoms (Clinic Visit Record).

B. PHYSICAL EXAMINATION - if not under the care of personal physician

1. Vital signs

   a. Pulse, if indicated
   b. Blood pressure
   c. Temperature, if indicated
   d. Weight

2. General appearance
3. Skin - observe for rashes and lesions
4. Lymph nodes - cervical, post-auricular, mandibular, supraclavicular, axillary, femoral
5. Mouth - examine for periodontitis, candidiasis, "hairy" leukoplakia, herpes, Kaposi's sarcoma.
6. Chest

   a. Inspect rate, rhythm and effort of breathing
   b. Percuss-consolidation, diaphragmatic excursion.
   c. Auscultate - note presence of normal breath sounds, or crackles, wheezes, etc.

7. Neurological Assessment

   a. Mental processes: assess use of language, short term memory, serial subtraction of 7. (These should be assessed carefully if client reports mood changes, memory loss, confusion, declining intellectual function.)
   b. Motor - assess for weakness, reflexes, spasticity, gait (These should be evaluated if client reports loss of strength or coordination)
   c. Sensory changes - assess pinprick, vibration or proprioception if client describes pain or burning in distal extremities or other changes.

8. Other

C. LABORATORY

1. Complete blood count (CBC), including white blood cell count (WBC) and differential, hemoglobin, hematocrit, mean corpuscular volume of red cells (MCV), platelets, absolute lymphocytes.
2. CD4+ lymphocyte count

   a. If "borderline" near 500 or 200 per cubic millimeter, may repeat in 1-2 months.
   b. Refer for consideration of AZT therapy if less than500 and for PCP prophy laxis if less than 200.

3. Rapid Plasma Reagin (RPR) test for syphilis.
4. HIV, if positive status not previously confirmed through TCCHD.

D. TUBERCULOSIS (TB) SCREENING

1. At TCCHD Tuberculosis clinic.
2. Mantoux skin test - (patient must return 48-72 hours for reading) with skin test control with tetanus and mumps antigens.

a. Procedure, PPD

(1) Purified protein derivative (PPD), 5 tuberculin units, is the recom mended antigen.
(2) 0.1 ml. of PPD is injected intracutaneously on the ventral surface of the left forearm.
(a) Skin test should be given within one hour after TB syringe is filled.
(b) Using a tuberculin syringe, keep bevel upward and make injection beneath surface of the skin.
(c) A discrete, pale, elevation of the skin - a wheal - 6mm to 10mm in diameter should be produced.

b. Reading a PPD skin test

(1) Ideally should be read 48-72 hours after injection.
(2) However, little change in the size of reaction occurs before the fifth day and large reactions will still be evident at least 7 days later.
(3) Make the reading in good light with forearm slightly flexed at elbow.
(4) By inspection and palpation determine the presence or absence of induration.
(5) Measure the diameter of the induration transversely to the long axis of the arm.
(6) Erythema without induration is not considered evidence of tuberculous infection
(7) Record size of reaction in millimeters of induration.

c. Tetanus skin test

(1) Antigen — 1:5 dilution of fluid tetanus toxoid.
(2) Procedure — same as with PPD except:

(a) Site—upper right ventral forearm
(b) Have epinephrine available

(3) Interpretation—Induration greater than 2 mm indicates reaction

d. Mumps skin test

(1) Antigen—commercially prepared mumps skin test antigen, a sterile suspension of killed mumps viruses.
(2) Procedure—same as with PPD, except:

(a) Site—right ventral forearm, below and at least 2-1/2 inches from site of tetanus test
(b) Do not give without physician approval if allergic to eggs or

egg products
(c) Have epinephrine available

(3) Interpretation—More than 2 mm induration indicates reaction.

3. Baseline Chest x-ray.

E. ASSESSMENT

1. HIV classification (to extent possible, based on information obtained).
2. Other

F. PLAN

1. When to return
2. Recommended course of action to be followed, such as referral or particular behaviors for patient emphasis
3. Participation in research project(s)

G. IMMUNIZATIONS - at TCCHD immunization clinic

1. Pneumococcal - administered one time only
2. Influenza - administered yearly during the fall or early winter.
3. Hemophilus influenza b - administered one time only
4. Tetanus-diphtheria - once every ten years

H. EDUCATION (History and Counseling form)

1. Factual review of disease
2. Assessment of status, lifestyle, "co-factors"
3. Patient duties

   a. Nutrition
   b. Rest
   c. General health maintenance including smoking cessation, and reduction of alcohol intake, reduction/elimination of recreational drug use, reduction of other co-factors
   d. Prevention of transmission

ROUTINE CLINIC VISIT

A. INTERIM HISTORY, including:

1. New symptoms
2. Current medications
3. Recent exposure to TB

B. PHYSICAL EXAMINATION - if not under care of personal physician, as done on initial visit.

C. LABORATORY - CBC and CD4+ lymphocytes as under initial visit.

D. TB SCREENING

1. If symptoms or exposure.
2. Routinely, every 12 months—if not already PPD positive or treated.

E. ASSESSMENT - includes HIV classification, as possible, and other health needs.

F. PLAN - Similar to primary visit and follow-up from "E".

G. IMMUNIZATIONS - If not given on prior visit, or completion of the series.

H. EDUCATION AND COUNSELING

1. Review of any problem areas from prior visit or developing in interim.
2. DIS Interview if needed (e.g. not compliant regarding prevention)

IMMUNIZATIONS

Many possible complications of HIV infection are potentially preventable with current vaccines. Live virus vaccines are not to be given without written request from a physician. If patient brings such a request, it should be included in the immunization record.

"KILLED" vaccines to be offered

1. Pneumococcal (administered one time only)
2. Influenza (administered yearly during the fall or early winter)
3. Hemophilus influenza b (administered one time only)
4. Td - once every ten years

LABORATORY - HMC

A. RPR (RAPID PLASMA REAGIN)

Syphilis infection frequently accompanies and is a risk factor for HIV infection. Recent case reports indicate that syphilis can have an atypical course in persons infected with HIV. HIV-infected persons should be screened for syphilis with an RPR and, if RPR+, a confirmatory fluorescent treponema antibody (FTA) test. Treatment should be initiated according to standard guidelines if client if found to be infected.

B. A low or declining CD4+ lymphocyte count or CD4 percentage are the best-accepted laboratory predictors of declining health status for HIV-infected persons. A normal CD4+ lymphocyte count is between 400-1100/mm3, although this range may vary among different laboratories. HIV-infected persons with CD4+ lymphocyte counts less than 500/mm3 should be encouraged to receive anti-HIV therapy. Institution of zidovudine as soon as CD4+ counts fall below 500/mm3 has been proven beneficial in slowing the progression of HIV-related effects upon the infected person. HIV-infected persons with CD4+ lymphocyte counts less than 200/mm3 are at greatly increased risk of developing medical complications of Acquired Immune Deficiency Syndrome (AIDS) (30% per year) and should be encouraged to consider prophylaxis for PCP.

Although CD4+ lymphocyte counts have been shown to generally decline over the course of HIV infection (average expected decline of 80/mm3/year), counts may increase or decrease by 10-25% from one measurement to the next for reasons that are unclear. Repeat testing at shorter intervals (1-5 months may be indicated when the CD4+ lymphocyte count is near the 200 or 500/mm3 level or appears to be falling rapidly.)

The TCCHD will offer CD4+ lymphocyte counts to HIV-infected persons to assist them in monitoring their health status and determining when referral for preventative therapies such as PCP prophylaxis is necessary. The following guidelines are to be used in requesting CD4+ lymphocyte counts:

1. Clients should have documentation of HIV infection before CD4+ lympho cyte counts are performed.
2. CD4+ lymphocyte counts should be performed at 6 month intervals. As indicated above, there are situations in which it may be desirable to perform follow-up counts sooner than 6 months. CD4+ lymphocyte counts are expensive and the clinic physician will take this into consideration when repeating the county prior to 6 months.
3. Once a patient has a CD4+ lymphocyte count of 500/mm3 or less, every effort should be made to refer him/her to a physician or clinic and probably begin zidovudine therapy. In some cases, the clinic physician may elect to repeat the count before referral when it is near the 500 level. Such referred patients may continue to receive follow-up at this clinic for periodic re-evaluation until CD4+ lymphocyte counts decline to 200/mm3. Results of periodic lab testing here can be forwarded to the physician or clinic at the patient's request.

TUBERCULOSIS SCREENING

A. RATIONALE:

Persons with HIV infections who have been exposed to tuberculosis are at increased risk for developing active and disseminated tuberculous infection. For this reason, all HMC patients are routed through the TB clinic.

B. POLICY:

1. Regardless of skin test results, HIV-infected persons with history of recent TB exposure receive prompt referral to the TB Clinic physician.

2. Patient history includes, among other inquiry, questions regarding:

    a. Previous TB infection
    b. Contact to TB case
    c. Previous TB skin testing, including any positive or negative tests, both before and after known to be infected with HIV
    d. Areas of previous residence that may suggest high risk of exposure

        (1) Foreign residence
        (2) High rate areas of United States

    e. Other factors which indicate high risk ($\geq$ 10%) such as:

        (1) Drug injection
        (2) Homeless

3. Administer Mantoux skin test—5 tuberculin units (5TU) of purified protein deriva tive of TB organism (PPD) in left forearm. Screening questions-which should delay or eliminate skin testing.

    a. Fever in last 24 hours?

b. Live virus vaccination—measles, mumps, rubella (MMR), or oral polio vaccine (OPV) in last 6 weeks?
c. Immung globulin (IG) in last 6 weeks?
d. Previous + test since known positive HIV infection?

4. Administer mumps and tetanus antigen control tests in right forearm.
5. Return in 48-72 hours to have skin tests read.
6. Interpretation of skin test reactions.

For one who is HIV positive, a reaction of 5 millimeters (mm) of induration with 5TU PPD is significant, and the patient is seen by the TB clinic physician for further evaluation and, if indicated, therapy. Those with negative initial PPD, and positive mumps and/or tetanus test receive repeat test with 5TU PPD to check for booster response. Those who are anergic (all skin tests negative) are referred to the TB clinic physician. See summary chart on next page.

NOTE:

Absence of a reaction to PPD tuberculin (5TU) does not exclude diagnosis of TB. Reasons tuberculin reactions may decrease or disappear temporarily:

1. Febrile illness
2. Severe illness
3. Measles or other exanthemas
4. Live virus vaccination (recent)
5. Hodgkins' disease or other lymphoma
6. Sarcoidosis (a pulmonary or systemic disease)
7. Overwhelming miliary or pulmonary tuberculosis
8. Adrenal corticosteroid hormones
9. Immunosuppressive drugs such as cancer chemotherapy agents
10. Inherited or acquired diseases which are characterized by immunologic dysfunc tion (including advanced HIV infection)

C. REFERRAL

While the delivery of preventative services and the monitoring of asymptomatically infected persons are within the capabilities of the TCCHD, the treatment of HIV related illness currently is not. It is therefore imperative that every HIV-infected client be advised to establish or maintain a relationship with a physician who can care for the person should medical complications develop. All testing and preventative treatment performed by the health department can be communicated to the patient's physician if the patient desires, according to the confidentiality requirements of Oklahoma law.

Since the development of debilitating disease can result in loss of income and medical insurance, it is also important that HIV-infected persons be referred to Department of Human Services HIV case managers so that they may be informed regarding the availability of this service and provided a list of other resources for HIV infected persons during the initial evaluation.

HIV-infected individuals often have multiple problems. During counseling, they are advised of the availability of the HIV Resource Center, especially if they have psychological or social problems. In addition to providing direct assistance, the Resource Center which was created by a coalition of community agencies, organizations and individuals interested in HIV-related service, has referral linkage with most of the related resource in Tulsa.

Prevention Counseling

Regular interaction with HIV-infected persons for medical monitoring provides an opportunity for reviewing and emphasizing measures which can prevent additional transmission of HIV. HIV-infected clients coming for CD4+ lymphocyte counts and other services initially meet with a DIS staff member to review HIV prevention guidelines, to be provided with condoms and discuss their use, and to be offered partner notification services. Thereafter, they are referred to the DIS staff as needed.

Voluntary Partner Notification Services

Considered controversial by many activists and a key prevention strategy by health departments, partner notification has continually sparked debate throughout the HIV epidemic. Opponents contend that partner notification is an expensive, time-intensive process that identifies a relatively small number of at-risk individuals and that other prevention activities are just as effective and less expensive. Health departments view partner notification (both sexual and needle sharing) as a voluntary service offered to clients to assist them in informing their former contacts who may have been exposed to HIV and go on to infect others unknowingly .

Prince George's County, Maryland

Office on AIDS
Counseling and Testing Services

Process Objections

Pre- test Counseling

1. All HIV Counselors will have HIV counseling training and be knowledgeable about the HIV antibody testing, interpretation of the results, modes of transmission, methods of prevention as well as counseling skills appropriate for identifying risk factors and initiating behavior modification and HIV antibody test results.

2. All HIV Counselors will be client sensitive, culturally competent, developmentally appropriate with the instructions and linguistically specific whenever possible to those individuals accessing care through the CTS.

3. The counselors through active listening will be able to create an emotional space that ensures the client the opportunity to evaluate their risk factors (behavior) for possible behavior change. These changes will be necessary regardless of the test results.

4. The counselor will provide individualized and realistic specific recommendations/suggestion to the client to reduce the potential for exposure to the HIV infection. The client through an interactive process will develop a beginning plan to reduce risks to possible HIV infection and transmission.

5. The counselor will assist the client in deciding to have the HIV antibody test done. The counselor will stress the benefits of being tested. The counselor will explain the testing procedure.

6. The client will have an understanding of the difference between anonymous and confidential testing as well as the advantages and disadvantages of each. The client will understand if treatment is necessary and selected through the Health Department, the client's record will be changed from anonymous to confidential.

7. The counselor will explain to the client the difference between HIV infection and being diagnosed as having AIDS.

8. The counselor will provide sufficient information to ensure the client has a general understanding that early treatment is available for HIV infected individuals.

9. The client will have an understanding that if the HIV antibody test results indicate the client is HIV infected, partner notification will be initiated. The client will understand the purpose of partner notification is to prevent the spread of the disease. Individuals who may have been exposed will be identified and contacted for HIV counseling and testing and if necessary assisted in accessing medical treatment. The client will understand, that their name will be kept confidential throughout the partner notification process.

10. The counselor will assess the client for areas that additional referrals may be necessary, e.g. medical care, or substance abuse counseling.

11. The counselor will use universal precautions when conducting the HIV antibody test.

12. The counselor will complete the questionnaire, labeling, scheduling in accordance to the established procedure.

13. The counselor will complete the monthly statistical log at the assigned test site.

Post-test Counseling

1. The client will receive the test results in a positive, therapeutic environment.

2. The client will have a firm understanding of the test results as well as the accuracy of the exams:

   a. Negative results with no high risk behavior in the past six (6) months indicates no need for further testing.

   b. Negative results with high-risk behavior less than six (6) months prior to testing means retesting must occur within three (3) months. The client will also understand the need for the elimination of high risk behavior during this period, to avoid transmission of the disease in case they sero-convert.

   c. Indeterminant: The client may be in the process of sero converting, therefore an additional test in six (6) weeks will be necessary.

   d. Positive: The client is HIV infected a second text will be done for quality control of the laboratory doing the tests. The client must begin to access health care.

3. The client will be able to verbalize an awareness of the type and necessity of behavior change to reduce the risk to or transmission of HIV disease. The individual's risk reduction plan (developed during pre-counseling session) will be further explored. Modifications on the plan will be made to increase the probability of implementation. The counselor will stress a negative test result does not mean the risk reduction plan does not have to be implemented.

4. Secondary post-counseling sessions on the reduction of risk behaviors will be conducted when appropriate.

5. Referrals for primary and secondary HIV prevention services, e.g. substance abuse counseling, Maternal Health, Family Planning will be made.

6. The client will be provided prompt crisis-intervention counseling if necessary as a result of the HIV antibody test.

7. During the obtaining of blood for the HIV antibody re-test, the counselor will use universal precautions. The counselor will follow the procedure for obtaining the re-test.

Early Intervention

1. The client will be provided information re: the need for and benefits of early access to medical treatment. The Early Intervention Coordinator will stress the benefits of the individual knowing their sero status as well as being screened for STD, especially syphilis, tuberculosis and hepatitis B. The format will be individualized to identify those areas that the client needs to access for treatment.

2. The EIC will discuss the option's available for health care through the Health Department and the private sector. Support services that are geographically group will be explored for possible inclusion in an health care access plan. It is the intent after this information is given the client will access health care.

3. The EIC will stress care through the Health Department will not be denied because of the

clients inability to pay for services selected.

4. Should the client select the private sector for health care, the EIC will assist the client in accessing health care. The EIC will explore the feasibility of maintaining contact with the client to ensure entry into the health care system.

5. The EIC will assist the client in exploring and identifying individuals who "need to know" their diagnosis. The focus will be client driven, with the EIC suggesting time sequence and the commitment of the counseling staff to assist the client in this endeavor.

6. The risk reduction plan will be discussed in more detail to assess client's understanding of the transmission of HIV infection and their role in the prevention of the spread of the disease. The EIC will assess ownership of the risk behavior and reduction plan.

Partner Notification

1. Through the pre- and post-test counseling sessions, the client who is HIV positive will understand and accept the public health goals of the prevention the spread of the HIV infection and accessing medical treatment for the infected individual.

2. The client will be receptive in the partner notification process.

3. The client, if willing, will notify immediate partners. Through the STD/PHA and approach and time frame will be established. If the client is unable or does not want this responsibility the Health Department will do the notification.

4. The partner notification interview will be conducted by a STD/PHA that is knowledgeable about the HIV disease process. The PHA will provide a reassuring and open environment that enhances the client's self-esteem and willingness to assist in this endeavor.

5. The PHA/STD will be client sensitive, culturally competent and developmentally appropriate with instruction.

6. The PHA/STD will be sensitive, understanding and acceptance of the ramifications of being diagnosed with the HIV infection.

7. The referral protocol established will be adhered to be both the EIC and the PHA.

Evaluation

1. DATA will be collected in the following areas:

   a. Rate of return for testing results: The data will be evaluated to determine what influences the return rate, e.g. risk factors, site of testing [location and type of primary health care being provided] type of testing and type of counselor conducting the pre-counselor [primary vs secondary responsibility]

   b. Partner notification: Education will include e.g. factors that influence client's receptiveness to partner notifications, the reliability of the client notifying their partner(s) and follow-up HIV testing of partner(s) the result [number] of clients identified as drug or sexual contacts through partner notification, the number of clients STD is able to contact for HIV testing, the number tested and seropositive rate of contacts.

   c. Access to health care: Evaluations will be done to determine rate of accessing care, factors that influence the decision, type and reasons for services selected, barriers to

accessing care, ability to monitor continuation of health care selected, especially in the private sector.

2. Barriers to meeting the objectives in these areas will be identified, evaluated for feasibility of elimination. Future CTS/Early Intervention Plans will incorporate these finding's as well as positive influences for meeting those objectives.

Office on AIDS
Counseling and Testing Service
Partner Notification/Early Intervention Procedure

Purpose: The following procedure has been developed to ensure a comprehensive effective partner notification process that is client-sensitive yet responsive to the public health concerns of HIV infections: prevention of the spread of the HIV infection and access to health care for the infected individual.

Personnel	Procedure
HIV Counselor	**Pre-test HIV Counseling and Testing Service**

In addition to what is currently included in the pre-test CTS interview, partner notification will be discussed. The partner notification discussion will include:

1. purpose: prevention of the spread of the disease and the identification of individuals who are at risk for infection so that counseling, testing and medical services can be provided

2. responsibility of the client to notify present and former sex or needle sharing partners

3. responsibility of the health department

4. procedure for partner notification

   a. if the client if HIV positive an appointment will be scheduled with the Public Health Advisor to discuss partner notification

   b. the client will be encouraged to discuss with the P.H.A. their sexual and/or needle sharing partner(s)

   c. the Health Department through the STD Clinic will advise contacts of the exposure to HIV infection while keeping client's name confidential

Secretary — **Individual has been identified as HIV positive**

1. the client's identifying number will be coded as mt [more time]

2. when the client calls for a post-test CTS appointment, the secretary will:

   a. schedule the client in a "mt" slot

   b. notify the Early Intervention Coordinator and STD of the client's scheduled appointment

   c. place a "B" by the appointment slot when the EIC has

been notified

d. place a "S" by the appointment slot when STD has been notified

1st Post - HIV Positive Counseling and Testing Session

Secretary — EIC and STD/PHA will be notified of the client's arrival

HIV Counselor — In addition to what is currently included in the first post-HIV positive CTS counseling session, the HIV Counselor will review the public health concerns: prevention of the spread of the disease and access to early treatment. Partner notification will be re-explained as one of the processes to meet those concerns

The HIV counselor will notify the EIC after phase one (1) of the counseling session is completed. The counselor will give the EIC an assessment of the client's response to being told they are HIV infected and their receptiveness to partner notification and possible medical intervention.

EARLY INTERVENTION COORDINATION

Early Intervention Coordinator — The EIC prime purpose is to explain and encourage early access to health care for all those who are HIV infected. The EIC does this by:

1. education re: need for benefits and early medical treatment

   a. screening for TB, STD's, and Hepatitis B

   b. discuss variety of evaluative, treatment and supportive services available through the Health Department. The EIC will explain that the client may choose to select only some services, rather than all the services

2. counseled on the prevention/spread HIV infection and client's role

3. importance of partner notification

   a. prevention of the spread of HIV infection

   b. ensure early access to health care for others who might be infected

Early Intervention Coordinator — If the client selects to use the Health Department services at this time, the intake process and appointments will be scheduled.

HIV Counselor- to Draw Blood — 1. The second HIV antibody test, plus all blood samples required for the DES will be drawn at this time: CD4, CBC and differential, Hepatitis, Serology, Blood Chemistry x2. (See SPC Protocol)

HIV Counselor- Draw 2nd HIV Blood Only — If the client does not select to use Health Department Services or wishes to to further evaluate medical care options, the EIC will attempt to establish a relationship with the client that will facilitate on-going communication.

1. referral list will be given to the client

2. client will be encouraged to contact EIC to advise of medical care arrangements and maintain supportive contact.

HIV Counselor/ Early Intervention Coordinatior

Two (2) RD-52 requesting (Inter and Intra Agency Referral Form) will be completed.

1. EIC will complete a RS-52 referral form to STD.
   The following information will be included:

   a. Date of positive HIV antibody test. Indicate if this is the first positive HIV test, if not, date of first HIV positive

   b. Identified high risk behavior

   c. Client's response to knowledge of being HIV positive

   d. Client's openness to partner notification.

2. The pink copy of the RS-52 partner notification referral will be kept with the CTS file.

3. The pink copy of the RS-52 DEU referral will be kept with the CTS file. All other copies will be forwarded to the DEU through the EIC.

PARTNER NOTIFICATION

Public Health Advisor/STD Department

Partner Notification interview will be done in the Office on AIDS by STD/PHA immediately following the EIC intervention.

1. PHA will complete the RS-52 referral with pertinent information such as, but not limited to:

   a. number and type of contacts

   b. any children (under the age of 6 years) that may be involved because of an HIV infected mother

   c. current steady partner - name if possible — to ensure comprehensive health care of a couple

   d. response of client to partner notification

   e. concerns of PHA from the STD clinic

   f. recommendations of PHA including need for further intervention

2. The completed partner notification referral will be given to EIC, in the Office on AIDS for filing and future evaluation

2nd HIV retest Post - Counseling and Testing Service Session/Early Intervention Coordinator

Early Intervention Coordinator

In addition to what is currently included in the second post-test CTS session:

1. For the client who has previously selected to use the Health Department Services, the EIC will:

   a. discuss the 2nd HIV test result

   b. re-emphasize prevention counseling

   c. continue the intake process and schedule appointments

   d. draw all DES bloods if the specimen were drawn previously

2. For the client who previously chose not to use Health Department Services for further medical intervention, the EIC will:

   a. determine what service of health care will be/was selected. If needed a review of available options will be discussed

   b. ascertain the client's willingness to have EIC periodically contact client as to progress in health care if health care is to be provided by outside sources

   c. if the client has decided to use Health Department Services, the intake process and scheduling of appointments will be done. All blood required for the DES will be done at this time: CD4, CBC and differential, Hepatitis, Serology, Blood Chemistry x2, Anergy panel and ppd test will also be done at this time

   d. EIC will stress that the client may select any available services he/she may wish, even if the medical care component is not selected

   e. the results of the 2nd HIV tests will be discussed; prevention counseling will be re-emphasized

The EIC will contact STD for a public health advisor if further partner notification is needed. This would have been previously discussed and decided by the EIC and the PHA who had done the initial partner notification.

Public Health Advisor

A follow-up, 2nd partner notification session will be conducted if appropri ate after the 2nd HIV post counseling session.

Partner Notification-Client entry Outside CTS/Office on AIDS

Designated Person eg. HIV Coordinator CTS Counselor Other Health Departments

1. Clients who tested positive in Health Department sites other than the

Office on AIDS, will notify STD department for partner notification on their clients.

2. All partner notification ideally will occur in the department that the client obtained the HIV Counseling and Testing

3. The program will refer the client through RS-52 referral form to the Early Intervention Coordinator EIC. The referral will include:

   a. HIV test date, with copy of the HIV antibody test results

   b. brief listing of identified risk factors

   c. date partner notification done

   d. client's receptiveness to initiating medical treatment

   4. The EIC will contact STD to confirm partner notification completed.

Partner Notification: Client Accessing Service

1. As part of the early intervention the client will meet with the EIC. The EIC will discuss partner notification as part of the intake process. The partner notification discussion will include:

   a. purpose: prevention of the spread of the disease and the identification of individuals who are at risk for infection so that counseling, testing and medical services can be provided

   b. responsibility of the client to notify present and former sex or needle sharing partners

   c. responsibility of the health department

   d. procedure for partner notification

1. if the client is HIV positive an appointment will be scheduled with the Public Health Advisor to discuss partner notification

2. the client will be encouraged to discuss with the PHA their sexual and/or needle sharing partner(s)

3. the Health Department through the STD Clinic will advise contacts of the exposure to HIV infection while keeping client's name confidential

2. The EIC will complete a RD-52 Referral Form to STD. The following information will be included:

   a. date of the positive HIV antibody test

   b. identified high risk behavior

   c. client's response to knowledge of being HIV positive

   d. client's openness to partner notification

e. approvement date and time for partner notification.

3. The EIC will forward the referral form to STD

Public Health Advisor/STD Department

Partner Notification interview will be done in the Office on AIDS by STD/ PHA immediately following the EIC intervention.

1. PHA will complete the RS-52 referral with pertinent information such as, but not limited to:

   a. number and type of contacts

   b. any children (under the age of 6 years) that may be involved because of a HIV infected mother

   c. current steady partner—name if possible—to ensure comprehensive health care of a couple

   d. response of client to partner notification

   e. concerns of PHA from the STD clinic

   f. recommendations of PHA including need for further intervention

2. The completed partner notification referral will be given to EIC, in the Office on AIDS for filing and future evaluation.

Office on AIDS
Counseling and Testing Service

Goals:

1. The entire HIV counseling and testing process will be client centered. The session will be individualized to the behaviors, circumstances and special needs of the person being served.

2. Individuals seeking HIV antibody testing will understand the CTS program is an entry source for the identification and treatment of the HIV disease. CTS may serve as entry to other services such as substance abuse treatment, STD treatment and family planning that the client may require.

3. Individuals will institute behavior modifications as a result of the preventative risk reduction counseling during the CTS pre-counseling and post-counseling sessions.

Objectives:

Pre-Counseling Session

1. All counseling sessions will be client sensitive, developmentally and culturally appropriate and linguistically specific. The counselors will be culturally sensitive.

2. The client seeking CTS services will evaluate their risk factors. Through active interaction with the counselor, a risk reduction plan will be developed. The client will understand that the plan will assist them in the prevention and/or spread of the disease. Appropriate referrals will be made to assist the client in meeting the goals of their risk reduction plan. Client approval for the referral(s) will be done before any referrals are initiated.

3. The client's understanding of HIV and their related risk factor will result in the individual selecting to be tested.

4. Partner notification will be presented as a major component in the prevention of the spread of the HIV infection. The counselor will clarify the role and responsibility of the client as well as the Health Department in partner notification. The client will understand partner notification will be necessary if the client's HIV antibody test results are positive.

Post-Counseling Session

1. The client will receive the test results in a positive and therapeutic environment.

2. The client will understand and be able to verbalize the meaning of the test results, the reason for retesting if necessary and the impact of their risk factors on the test results.

3. The risk reduction plan will be reassessed for modification to ensure successful implementation. The client will be able to verbalize how their risk behavior impacts on prevention or transmission of their HIV infection to others. If necessary additional referrals will be made.

4. If necessary, as a result of a positive HIV test result, the client will be provided prompt crisis-intervention counseling by a qualified counselor from the Office on AIDS.

5. The client will understand the importance of early medical treatment and how to access medical care.

Early Intervention

1. Through the Early Intervention Coordinator, the client will have a greater understanding of the importance and benefits of prompt and early medical treatment. After medical treatment has been obtained the client will know their sero status [CD4 count etc.] whether or not they have been exposed to tuberculosis, hepatitis, STD and the appropriate medical care necessary to maintain wellness. The options available through the Health Department and private sector will be discussed; the client will select the option most ideal for them. The client will be willing to have the Office on AIDS monitor their access to and continued follow-up of private medical care.

2. Any financial barriers to care will be discussed and minimized by encouraging the client to request a case manager to assist in obtaining entitlements and other necessary resources.

3. The client will assume responsibility for their behavior. The client if necessary will be encouraged to have additional counseling for risk reduction behavior.

4. The client will accept the importance of and understand their role and the Health Departments role in partner notification.

Partner Notification

1. All partner notification reviews will be sensitive to the client's diagnoses and its impact on his/her status.

2. All clients who test positive through the CTS program will have a partner notification interview by Public Health Advisor of the STD clinic.

3. The client's desire to notify immediate and/or recent partners will be honored. A mutually acceptable approach will be developed by the client and Public Health Advisor. This approach will include a time frame for notification and a procedure for having the partner tested.

Quality Assurance

1. The CTS program will assist the state in laboratory reliability and accuracy of the HIV antibody test by retesting all HIV positive clients and following established protocol for HIV 2 testing.

2. The CTS program will collect demographic and epidemiological data to assess success of CTS program as well as develop further CTS plans.

3. Data will be collected to evaluate 1) the rate of return for testing results; 2) success of the implementation of the behavior risk reduction plan by the client; 3)success of the partner notification in identifying contacts and accessing HIV testing and health care for seropositive individuals; 4) the timeframe, rate, and type of health services selected by seropositive clients and; 5) the effectiveness in monitoring continuation of health care selected in the public and private sector. Future and current services will then reflect the conclusion of the evaluation.

4. Continued education of the CTS staff will be established, maintained and evaluated for appropriateness and effectiveness on testing methods and interpretation of results, counseling that is culturally sensitive, risk reduction, and treatment of HIV disease.

Integrating HIV Counseling and Testing and STD Services

The incidence of STDs, especially among teens, has increased significantly in recent years—an indication that many are not practicing safer sex. Coordinating HIV prevention activities with STD services provides access to a high risk, difficult to reach population. The similarity of the prevention messages (reducing number of sexual partners, using condoms, abstinence) make it practical to integrate these activities.

Maricopa County, Arizona
Cincinnati, Ohio

MARICOPA COUNTY, ARIZONA

MARICOPA COUNTY DEPARTMENT OF PUBLIC HEALTH
PUBLIC HEALTH CLINIC
HIV COUNSELING AND TESTING PROTOCOL FOR
SEXUALLY TRANSMITTED DISEASE SERVICES PERSONNEL

This protocol applies to Maricopa County Public Health Clinic (MCPHC) STD Communicable Disease Investigators (CDI's) who provide HIV counseling and testing services to clients who attend the Public Health Clinic (PHC) for sexually transmitted diseases. Pre-test and post-test counseling, as well as partner notification services for HIV seropositive clients must be offered to all individuals requesting HIV testing in the appropriate language.

It shall be discussed with each individual that HIV testing is confidential and **voluntary**. Each client shall be informed of anonymous and confidential testing options, given a description of each, and offered his/her choice of options.

Listed below are the policies and procedures pursuant to this protocol.

PERSONNEL

All PHC STD CDI's providing HIV counseling and testing services shall be qualified to provide services through appropriate in-house training, ADHS training and certification, education, and experience.

Training will include, but not be limited to: Each STD CDI will observe three HIV pre-test counseling sessions provided by HIV staff, as well as conduct three HIV staff observed pre-test counseling sessions. Role-plays will be conducted by HIV staff with the STD CDI's as part of the post-test counseling training.

Initially, the HIV supervisory staff will provide quality assurance with each employee through process audits and/or role plays. The STD supervisors, in cooperation with the HIV Services Coordinator and/or the HIV Counseling and Testing Coordinator, will assume the role after an agreeable time period.

FACILITY AND SETTING

All HIV pre- and post-test counseling shall be conducted in a private, confidential setting unless there are extenuating circumstances such as the need for a translator.

EDUCATION/INFORMATION

Pamphlets and other handouts regarding HIV information will be available for each PHC client. Furthermore, ongoing STD/HIV/AIDS-related videos will be played continuously during clinic hours in the PHC front lobby area.

PRE-TEST COUNSELING

STD CDI's will **offer** HIV pre-test counseling and testing to individuals who present for sexually transmitted disease testing at the completion of the STD interview.

Each client shall be informed that HIV testing is **voluntary**. If a client elects to have HIV testing, an explanation of the anonymous and confidential test options shall be discussed in the appropriate language and the ADHS handout explaining these options shall be shown to each individual (Attachment I). When explaining the confidential test option, the client will be informed that if he/

she opts for confidential testing, names elicited for STD contacts will be available to the STD CDI for partner notification if the person tests positive for HIV, but that the client still has the option of notifying partners of possible exposure and the need for testing.

Each STD client desiring HIV antibody testing will receive pre-test counseling as outlined in the attached Maricopa County HIV Pre-Test Counseling and Testing Guidelines (Attachments II, III, IV).

During pre-test counseling, demographic data on each client will be entered on the ADHS HIV Counseling and Testing Report Form (scan form) (Attachment V) and on a Daily Activity Log (Attachment VI) which will be coded appropriately (Attachment VII) for each CDI providing HIV counseling and testing.

Consent Form

If the client chooses confidential testing, the client will be informed that at the end of the counseling session, he/she will be asked to sign a consent form (Attachment VIII). At the end of the session, the consent form will be read to the client before the client signs it. The CDI will then sign the form as a witness and be sure the form is dated. This consent form stays with other testing forms pending post-test counseling, after which it will be stored in a separate confidential file or kept with other notes not maintained in medical file.

Lab Slips and Client Identification Numbers

The code for the PHC (STD-A) and the address will be written on the top part of each lab slip. The Lab Slip ID Number will also be written on the left side of the lower part of the slip.

Each STD client desiring HIV testing will be given an identification number in addition to the lab slip number. This number will be written on both top and bottom parts of the lab slip. (Attachment IX)

The client identification number will consist of the number 99 with an A for anonymous or C for confidential, month and day of the month, the assigned STD CDI's number with an additional letter which will be unduplicated in any day. (99A-Month & day-CDI Number and letter)

Example for anonymous testing: 99A-901-199B (Sept. 1)
Example for confidential testing: 99C-1209-199G (December 9)

On the lower part of the lab slip if the person test confidentially name, address, telephone (or message phone) and date of birth are to be written under "Mail To:" A return date and time in two weeks (or longer if necessary for client) for the client to be counseled by a **STD CDI** should also be written on the lower part of the lab slip.

On the lower part of the lab slip if the person tests anonymously, the word "Anonymous" is to be written in the section under "Mail To." A return date in two weeks (or longer if necessary for client) for the client to be post-test counseled by an **HIV Counselor** should also be written on the lower part of the lab slip. Client should be instructed to walk in on the morning of that date or given a specific appointment time in the afternoon of that date (on the 30 or 45-minute interval). It should further be explained to the client that he/she will be seeing another counselor for results.

The CDI will give the bottom copy of the lab slip packet to the client with instructions to bring it back when returning for post-test counseling. **Educate each client on the importance of returning with the copy of the lab slip. If the client tests anonymously and fails to bring in the copy of the lab slip given at time of pre-test, results cannot be given and client will need to be tested**

again. This is the only way to assure both client identify an confidentiality.

FAMILY OF SURVEYS

Each STD client choosing HIV testing shall be offered participation in the Family of Surveys if the attached inclusion and exclusion protocol is met (Attachment X). If the client declines, the top part of the survey is to be completed.

The completed survey forms or the top page are to be given to the HFS Administrative Assistant upon completion.

TESTING

A blood specimen shall be drawn on all clients requesting HIV antibody testing. If the blood has previously been drawn by the clinician, the STD CDI shall verify with the client, using the client's yellow slip, that the blood retrieved from the lab with the chart number is that client's blood before removing the STD label from the blood and replacing it with a label which has the HIV Lab ID number in large numbers and the client ID number in small numbers above it. The labeled blood is then placed in a falcon tube, the top two copies of the lab slip (which do not contain lower part of lab slip) are wrapped around the falcon tube with a rubber band, and the blood is placed in the plastic container in the phlebotomy room.

If the client participates in the Family of Surveys, the survey label is **also** placed on the blood specimen, on the lab slip which goes with the blood and on the office copy of the lab slip. The survey lab slip is stapled to the lab slip going to the lab for testing.

The final copy of the lab slip is paper-clipped to the ADHS scan form and:

If the client tested confidentially, kept in a designated folder for that STD CDI and then placed in a locked file cabinet.

If the client tested anonymously, it is put in the middle drawer of the middle HIV file cabinet in a file folder labeled "STD CDI RETURNS".

UNIVERSAL PRECAUTIONS SHALL BE FOLLOWED AT ALL TIMES.

TEST RESULTS

When test results arrive, the results for clients testing confidentially with an STD CDI will be given to the STD Supervisor for distribution to STD staff. Each CDI will then place the lab results with the scan form and copy of the lab slip and shall indicate the result on the scan form.

If a result is both EIA and Western Blot reactive, the lab number and result are to be recorded on a Daily Log Sheet for the day the results are received. Then the assigned STD CDI number, lab number and pre-test counsel date are also placed on the HIV Positive/Partner Notification Log (Attachment XI) which is to be kept in a centrally located area for use by all STD CDI's HIV performing counseling and testing. In addition, three copies of the lab slip with the positive results shall be made: one copy will be placed in a folder in the third drawer of the middle file cabinet in the HIV file area labeled "STD CDI Positive - Year." The two remaining copies will remain with the scan form, original results and lab slip awaiting return of the client.

POST-TEST COUNSELING

STD CDI's will provide post-test counseling to individuals testing confidentially. HIV counselor will provide post-test counseling to individuals testing anonymously.

At the time of client return for results, the front desk person will look at the lab slip. If there is a 99C and a name on the slip, the STD CDI who has the assigned number also on the slip, is paged to the front. If there is a 99A and "Anonymous" written on the slip, a check-in call slip will be written and placed in the STD referral slot and page "99 Counselor to the front". The first available HIV counselor will then see that client and provide post-test counseling.

All post-test counseling shall be conducted in private, confidential setting, except in the case of extenuating circumstances as described in "Facility and Setting".

The post-test counselor shall review each laboratory test result and ascertain needed client follow-up. Indeterminate tests shall be redrawn and resubmitted for additional testing.

Each individual returning for test results shall receive appropriate post-test counseling as outlined in the attached Maricopa County HIV Post-Test HIV Seronegative and HIV Seropositive Counseling and Testing Guidelines (Attachment III & IV).

The STD CDI's shall include post-test counseling or no-show information for individuals not keeping return appointments on the Daily Activity Logs turned in at the end of the day.

If the confidentially testing post-test counseled client tested HIV seropositive, the original results as well as one copy will be provided to the client (the copy should indicate "Educated", the date and your initials and is given to client to give to doctor or clinic. The other copy of the results is to be attached to the completed Surveillance form (Attachment XI) and given to the Surveillance Coordinator at the end of the post-test counseling session.

If the HIV positive client participated in the HFS survey, the post-test part of the survey must be completed or the top page completed as a denial of participation.

If the confidentially testing client's result is positive and the client fails to return for results within two days of his/her scheduled return appointment, three good faith attempts shall be made to reach the client to schedule the post-test visit. These attempts may include but are not limited to phone attempts both during and after normal work hours, a confidential letter, or field visit.

PARTNER NOTIFICATION

The importance of partner notification activities and obligation of the HIV antibody positive client to inform all sex and/or needle-sharing partners shall be discussed. County partner notification services shall be offered to all individuals testing HIV antibody positive. The clients' rights to inform their own partners shall be respected and assistance given in form of role plays. A second post test counseling appointment should be made for a time within the next week. A contract can be negotiated with the client that if at the second appointment partner notification has not been completed, the CDI will assist and the importance of notification of partners will be reviewed at that time.

When County partner notification activities are requested, notification of contacts shall occur in person **only** and must include all information as listed in the Maricopa County HIV Pre-Test Counseling Guidelines (Attachment II).

The <u>HIV Counseling and Testing Program Procedure for Record Management of HIV Partner Referral Services</u> (Attachment XIII) should be followed for all partner notification activities.

Under **no** circumstances should the partner (contact) be given the identity of the index case or information that could lead to the discovery of the identity of the index case.

DOCUMENTATION-FORMS-LOGS

The Daily Activity Log is to be maintained by each STD CDI providing pre-and post-test counseling. Lab number, demographic data, test results and status of post-test counseling activities, TB testing, referrals, etc. shall be indicated and turned in to the HIV Counseling and Testing Coordinator at the end of the day. One copy may be kept by the CDI for future reference.

The ADHS Client Report Form (scan form) is also to be kept on each client pre-test counseled regarding HIV. If the client is not tested, this form is turned in at the end of the day. If the client is tested, the form is kept with the lab slip copy until the client returns for post-test counseling. If the client does not return for post-test counseling on the date scheduled, the client is listed as a no-show on the Daily Activity log, and the large page of the scan form completed and turned in. The narrow page is separated, lab number placed on it and this narrow page is then kept with the lab slip and result pending future post-test counseling of the client, at which time it is turned in also.

At the end of each day, any STD CDI providing HIV pre-test or post-test counseling is to be sure the following is done:

For anonymous testing clients - Turn in daily activity log to the HIV Counseling and Testing Coordinator. Place lab slips with attached scan forms in the second drawer of the middle HIV file cabinet in a file folder labeled "STD CDE RETURNS".

For confidentially testing clients - Be sure all pre-test and post-test counseling data, positive test results, and no-show return-client data have been entered on daily activity log. Turn in daily activity log to the HIV Counseling and Testing Coordinator. Also turn in to HIV Counseling and Testing Coordinator completed scan forms for individuals receiving post-test counseling or who did not keep the scheduled return appointment (keep narrow copy of scan form with label slip for future post-test counseling). Keep lab slip with attached scan form in a folder in a locked filing cabinet.

When results come back for clients testing confidentially, indicate results on scan form, make three copies of lab slip with results for any HIV positive clients, record positive on daily activity log as well as on the HIV Positive/Partner Notification Log, prepare positive packet and partner notification forms.

Efforts to contact confidentially-testing HIV positive clients who fail to keep post-test counseling appointments shall be documented on the log.

Partner notification forms and the partner notification log shall be completed and updated as indicated in the protocol for same.

CINCINNATI, OHIO

PROCEDURE FOR CONFIDENTIAL HIV TESTING IN THE STD CLINIC

I. Targeted Pre-test Counseling

The rationale for targeted pre-test counselling is to seek out those STD patients who are most likely to be infected with HIV. Our goal in HIV prevention is to identify those individuals who practice "risky behavior" and "empower" them with the knowledge necessary to prolong their health and prevent other's from infection.

II. Registration/Clinic Flow

- After each client has been registered, he/she will be given the booklet "Your STD Clinic Visit" which includes information about test ramifications.
- Although all counselors have been trained by ODH the Cincinnati Health Department will require a written consent form from all clients who agree to confidential testing.
- Clinicians will assess all patients for HIV risk and will recommend HIV testing for all clinic patients. The clinician will document risk status on the STD medical record.
- Clinicians will inform patients that we routinely perform confidential HIV testing, but they have the option to refuse the test or have it performed anonymously.
- If a client chooses to be tested confidentially, the clinician will have him sign a consent form prior to having the blood drawn.
- The lab technician will draw the HIV serology along with any other serologies that need to be obtained (syphilis, serosurvey).
- The HIV serology will be labeled with the bar code number attached to the HIV counseling Op-Scan form. The Op-Scan form and bar coded appointment card will be placed in the chart and forward to the DIS for pre-test counseling after completion of examination and treatment.
- If the client decides to be tested anonymously, the lab technician will draw and label the HIV serology with the bar code number attached to the HIV Op-Scan form. After completion of the examination and/or treatment the client will be given the bar coded appointment card and referred to the counselor without his/her chart.
- Patients whose risk determinants are included on the list below should always be referred for pre-test counseling to a DIS regardless of his/her decision to be tested.

Persons Targeted for Pre-Test Counseling:

a. contact to positive HIV (partner who is notified of exposure and referred for HIV testing)
b. substance abusers (IVDU's or crack/cocaine users)
c. bisexual males
d. Prostitutes (males or females)
e. Lesion infected STD patients (syphilis, chancroid, herpes and others)
f. gay males

III. Pre-Test Counseling

- The HIV op-Scan form should not be completed while the client is present. The form should be completed after the counseling session using the medical chart and interview notes.

A. Non-Targeted Clients

- All clients whose risk determinants are not listed above, will be counseled in accordance to current ODH guidelines.
- All clients will be informed that testing is voluntary.
- Anonymous versus confidential testing will again be explained to the client. This will include

a discussion about test ramifications.

B. Targeted Clients

- All clients will be advised that testing is voluntary.
- Anonymous versus confidential testing options will again be explained. This will include a discussion about test ramifications.
- Targeted pre-test counselling will be focused on persuading the client to believe that their risky behavior puts them at risk for HIV infection.
- Each DIS will conduct an individualized discussion with each client about what he does, how he does it, and with whom and how often to assist in the determination of each client's true risk.
- All pre-test counselling sessions will include a discussion of safer sex practices.
- partner notification will be introduced at the pre-test counselling session.
- Each person pre-test counselled will be given appropriate HIV/AIDS written material.
- All clients who are pre-test counselled will be advised of the critical importance of their returning for test results.
- All clients will be given a return appointment for a minimum of 10 days from the date of the pre-test counselling session.
- All clients will be informed that HIV test results will not be given out over the telephone.

IV. Test Results/Follow-Up

- The CTS clerk will be responsible for maintaining the confidential log.
- Test results will be recorded in the log when received
- The CTS clerk will inform the first line epi supervisor of all positive test results received. This will include bar code number, counselor number and date of test result appointment.
- Once the first line epi supervisor has been notified of a positive test result, he/she will inform the counselor - If the client does not return one week after the expected in date, a ERF will be initiated for DIS follow-up.
- Follow-up will only be performed if the test result is positive.
  ERF's initiated for follow-up will be assigned to the DIS who performed the pre-test counseling.
- Documented information about the client such as name, address, phone number, risk determination and STD status will be obtained from the medical record.
- Dispositions will be completed per HIV Records Procedures.
- The dispositions per the HIV Records Procedures define the extent of staff effort expected to complete follow-up.
- After two patient encounters and no satisfactory response for disposition is obtained, the DIS can close the ERF.
- Post-test counseling and positive test results can be given in the field only by an experienced DIS, at the clients request, if the client is determined to be a stable individual who is prepared to deal with the result in a rational manner, if the environs can be assured to be kept private, and only if the client absolutely refuses to come to the testing site. ALL of the above conditions must be met, otherwise post test counselling and test results may not be given anywhere other than at the STD clinic.

V. Post-Test Counseling

A. - Post-test Negative

Counseling will be done in accordance to current ODH guidelines. Clients will be informed that if any risky behavior has occurred in the last 3 months, they could become infected but not yet develop measurable HIV antibodies and should return for another test 3 months after risky behavior has stopped.

B. - Post-test Indeterminate

Any client whose initial Western Blot test result is indeterminate should be re-tested at the time of the post-test counselling session. If the second specimen is also indeterminate, the client should be referred to a physician or clinic through the Support Services Coordinator for further testing and evaluation.

C. - Post-test Positive

- Whenever possible, the DIS who did the pre-test counselling on a client whose test is positive, will also do the post-test counselling.
- Counselling will be performed in accordance with current ODH guidelines.
- At the conclusion of the initial post-test counselling session the DIS will inform the nurse when his/her client agrees to a mantoux skin test.
- A return appointment should be made for 48 to 72 hours for the reading of the mantoux skin test and a second post-test session.
- At the initial and/or the second post-test session the DIS should:

1. discuss partner notification informing the client that notification is voluntary.

2. a list of all sex/needle sharing partners within the past year should be obtained.

3. Agreement should be reached as to who (client or counselor) will notify each partner.

4. HIV positive clients who want to inform their own partners must be coached concerning how this should be done, what to expect, and give an expected in date for counselling and testing for each partner referred.

5. Clients will be informed that their decision to inform their partner constitutes a "contract" and if the referred partner does not come in for counselling and testing, the counselor shares the responsibility and will follow-up with the client and/or the partner to resolve the disposition of each partner who needs to be notified.

6. All clients will be given a referral card to give each partner he/she decides to contact. The back of the referral card will be coded with the original patient's bar code number.

7. All partners will be documented on ERF's with special care given to obtain an accurate physical description.

8. Appropriate written information about AIDS/HIV will be provided for each positive client to give to all partners he/she decides to notify.

9. The DIS will make every effort to introduce the HIV positive client to the Support Services Coordinator.

Tuberculosis Prevention and Control Measures for HIV-infected Individuals

During the 1980s, tuberculosis reemerged as a major health problem in the United States, especially in the cities hardest hit by the HIV epidemic. Cutbacks in federal funding for TB control, the rise of multidrug resistant TB (MDRTB), the growing number of homeless, and ongoing poverty and substance abuse are contributing to the sp`read of TB. An additional factor is the HIV epidemic. HIV-infected individuals are especially susceptible to infection with TB. Important issues for consideration include: implementing infection control measures in facilities providing services to people with HIV infection; implementing infection control measures to protect HIV-infected employees; and ensuring people at increased risk of TB are screened and treated appropriately.

Boston, Massachusetts
New Hanover County, North Carolina

BOSTON, MASSACHUSETTS

HUMAN IMMUNODEFICIENCY VIRUS (HIV) POLICIES

HIV TESTING POLICY

PURPOSE:
To offer appropriate counselling and testing for Human Immunodeficiency Virus (HIV) infection to BCH tuberculosis (TB) Clinic attendees.

1. In accordance with Centers for Disease Control (CDC) guidelines, all persons with known or suspected TB should be counselled regarding HIV infection and offered confidential HIV testing (1).

2. Persons with Class 2 TB should be questioned regarding risk factors for HIV infection. Risk factors include IV drug use; male homosexual contact; adults having received flood or clotting factor concentrate between 1978 and 1985; adults having had sexual relations at any time since 1978 with a) persons known to be infected with HIV or to have AIDS, b) a man who has had sexual contact with another man, c) prostitutes, d) IVDU's, or e) persons born in countries where most transmission of HIV is thought to occur through heterosexual sexual contact. Risk factors in infants and children include a) parents, especially the mother, with HIV infection or any of the adult risk factors, and b) receipt of blood or clotting factor concentrates between 1978 and 1985. Persons with an identified risk factor should receive counselling and be offered confidential HIV testing.

3. HIV test results should be entered in the patient's TB Clinic chart on a separate sheet (not on the Interagency forms). When forwarding medical records, HIV information should not be forwarded from the TB Clinic chart unless the patient has specifically authorized release of HIV information.

4. TB Control nurses who have received training regarding HIV and TB and TB Clinic physicians should offer HIV testing to persons as outlined above.

5. HIV testing should be done in accordance with applicable BDHH policy.

6. Persons found to be HIV positive should be referred to their primary care provider for medical follow-up. Patients should be encouraged to share their HIV results with their primary health care provider.

7. Tuberculin testing for patients with known HIV infection or for patients engaging in high risk behaviors for HIV.

PURPOSE:
Tuberculosis remains a significant and stubborn health problem in the U.S. Recent increases in TB have been associated with co-infection with HIV.

The goal in TB treatment is to provide medications and close follow-up care and this is particularly important in person with or at risk for HIV infection.

PPD skin testing (Mantoux) should be done in all those at risk for TB, including the following:

- Persons who are immuno-suppressed, especially persons infected with HIV, or persons at risk for HIV infection.

- Recent contacts of known or suspected TB patients.

- Persons with abnormal chest radiographs suggesting past TB infection.
- Persons exhibiting signs and symptoms of current TB infection (i.e. fatigue, malaise, weight loss, fever or night sweats).
- Foreign-born persons from high tuberculosis prevalence countries such as Asia, Africa and Latin America.
- Persons from low income populations (including homeless).
- Substance abusers (especially IVDU's).
- Residents of institutions (especially correctional facilities and nursing homes).
- Employees who treat persons listed above.
- Persons with medical risk factors known to increase the risk of tuberculosis (such as diabetes mellitus, prolonged corticosteroid therapy, hematologic diseases, post-gastrectomy, being 10% or more below ideal body weight).

PROCEDURE:

1) Interview patients to find out their TB status.

2) If they have never been tested for TB, or if the test performed more than 3 months ago was documented to be negative, patients should be offered TB skin testing with control antigens.

3) Patients to be tested will receive a PPD (5TU) 0.1-ml on the left forearm intrader mally. (See "How to administer the Mantoux test" in Manual).

4) Controls using two of the following will be planted on the right forearm.

Tetanus Toxoid	0.1 ml. (1:5 -buffered diluent)
Mumps	0.1 ml.
Candida	0.02 ml.

5) Skin test should be read 48-72 hours after placement. A positive (ie: significant) reading among our patient population for PPD is >5mm induration for known HIV + or IVDU's with unknown HIV status. For other groups, induration >10mm at 48-72 hours is considered significant. For Mumps, Candida or Tetanus, a positive test is >2mm induration or >2mm erythema (Mumps only) at 48-72 hours. (See "How to read the Mantoux test").

6) All information, including size of skin test reading must be documented in a medical record.

7) Patients on the following categories should be referred for physician evaluation.

   a) Those with significant (positive) PPD reaction.
   b) Those with a history of prior positive PPD and no history of previous adequate INH therapy.
   c) Those with no response to both PPD and control antigens.
   d) Those with known close contact with active TB case, regardless of current PD status.

8) A chest X-RAY will be taken using the TB (free care) billing number. Patients with a normal chest X-RAY will be medically evaluated and advised to start preventive therapy if indicated.

9) If CXR is abnormal, sputum will be collected, and the patient evaluated for therapy.

10) Patients will be asked about their HIV status. If HIV status is unknown patients will be offered HIV counselling and testing, if appropriate. Patients engaged in high risk activities who have previously tested negative (over 6 months ago) will be advised to retest. All patients who test positive for both HIV and TB will be started on preventive therapy.

NEW HANOVER COUNTY, NORTH CAROLINA

HIV and TB

Recommendations for HIV Testing for TB Cases, Recent

Contacts of TB Cases and Individuals with Positive

TB Skin Test

1. TB cases, recent contacts of TB cases, and individuals with positive TB skin test will be given written information about AIDS (AE-1).

2. Provide pre-test counseling to inform patient of high risk factors. High risk patients will be given the option for confidential (recommended), anonymous or refusal for HIV testing.

3. If a patient agrees to confidential testing, obtain written consent form (DHS-3482).

4. If a patient refuses to sign written consent form (DHS-3482), offer anonymous testing.

5. If patient consents to HIV testing, refer to lab with completed forms (DHS-3445 and DHS-T3439-High Risk Factor Data). Advise patient to return to Chest Clinic in two weeks for HIV test results.

6. When patient returns to Chest Clinic for test results, nurse provides post-test counseling and refers to appropriate health care provider.

7. Those individuals who test HIV seropositive are advised to notify their personal health care providers and their sexual and needle sharing partners. Partners should be encouraged to obtain HIV testing and of the availability of testing through the Health Department's HIV counselor.

8. Explain that individuals who test positive for the AIDS virus and TB germ are more likely

to develop active TB and that preventive TB treatment may be initiated.

Recommendations for AIDS Antibody Positive Individuals Identified in Anonymous Testing

I. <u>Anonymous Testing</u>

A. Provide usual post-test counseling.

B. Explain that individuals who are infected with both the AIDS virus and TB are more likely to develop active TB and that preventive treatment may decrease that risk.

C. HIV counselor will refer by giving a yellow card to attend Chest Clinic for TB skin testing, chest x-ray and clinical evaluation.

D. Advise patient of importance of attending Chest Clinic.

E. Advise patient that a medical record will be initiated with patient's name, however, patient may choose not to have HIV testing or results documented in record.

II. <u>Chest Clinic</u>

A. Nurses in Chest Clinic will counsel and recommend that HIV antibody test results be recorded in patient's medical record.

B. Nurse will obtain written informed consent for documentation (DHS-3482).

C. If the Antibody-positive patient refuses to have antibody results recorded in the patient's medical record, advise them to verbally inform their medical care provider of their test result and their wish not to have it documented in their record.

D. Patient will receive skin test, chest x-ray and clinical evaluation by physician.

E. Patient management will be according to CDC guidelines for TB preventive therapy in HIV seropositive persons.

HIV Prevention Efforts Targeting Drug Users

The unique issues in working with illicit drug users create additional challenges for HIV prevention programs. HIV prevention activities by outreach workers can be hindered by highly visible police presence or confiscation of prevention materials such as bleach. Outreach workers must also rely on the police for security since they frequently work in high-risk areas. Because of these concerns, many communities with outreach programs targeting drug users have developed policies for interaction on the street.

New Haven, Connecticut

NEW HAVEN, CONNECTICUT

Demonstration Needle Exchange Program Protocol (Excerpt)

Security

NEP (needle exchange program) staff members will never conduct the exchange service individually. The van will always be occupied by two (2) staff when the exchange is in operation. Exchange will occur only in the van.

NEP staff will rely on their good judgement and expertise in working with the IV drug user population, and in areas of dense drug activity, to detect and avoid situations that could place them at risk of personal harm. Communication with the police department will be ongoing to remain informed of sites that present unusual risk and should be avoided.

The van will be equipped with a silent "panic" alarm system enabling staff to alert police to emergency situations and summon help by pressing a button discreetly placed beneath the exchange/interviewing desk. A phone will also be available in the van for security and operational purposes. The NEP van will be locked each night and parked at the City Department of Public Works under tight security.

Needles/syringes will be stored in locked cabinets at the NHHD AIDS office. Staff will determine the number of needles/syringes needed for each exchange shift and place that amount in locked, portable file drawers to be kept in the van when the exchange is in operation. At the end of each shift NEP staff will return surplus needles/syringes to the AIDS office.

Only NEP staff and other designated NHHD personnel will have access to the key for the cabinet containing the needles/syringe. An inventory of needles/syringes in stock will be maintained by the New Haven Health Department.

Policy on Use of Elicit Drugs in Presence of NEP Staff

The use or distribution of illicit drugs will not be permitted in the presence of NEP staff or the immediate vicinity where the van is stationed. All NEP participants will be informed of this policy during the initial encounter and reminded at repeat visits as necessary. A sign stating this policy will be prominently displayed in the van and noted on handouts given to exchangers that describes how the program works. If this policy is violated involved staff will instruct the person(s) to stop. If the person(s) refuse to cease their behavior they will be denied services and asked to leave the premises. In cases where the person(s) refuse to stop the behavior or leave, staff will summon the police using the alarm system or the phone in the van.

Agreement With New Haven Police Department

The Police Department will work in cooperation with the NHHD to ensure that the program is allowed to operate without interference and is recognized as a legally sanctioned initiative. All police officers will receive a briefing on the rationale of the NEP, the law authorizing the program, and how it works. A photo of the NEP van will be disseminated to police officers.

Police will not arrest IV drug users found to be in possession of needles/syringes who are participants of the NEP. NEP participants may be identified by their program ID card, if they are carrying it at the time of the police encounter, and by the special marking and tracking number on the needles/syringes they are carrying.

If a drug dealer who is also an NEP participant is arrested for possession of needles/syringes the Police Chief will intervene to judge whether the charges should be dropped and discuss the case

with the prosecutor. The NHHD will verify the person's involvement in the NEP by checking the program ID presented by the individual and the syringes found in his/her possession.

The NHHD will inform the police department of the NEP site schedule and apprise the appointed contact person within the department of significant changes that occur in the schedule.

The police chief or his designee will serve on the NEP advisory council to help monitor the progress of the program and resolve problems that arise in the process.

The police will respond to calls from NEP staff in emergency situations but will otherwise attempt to maintain a low profile in the vicinity where the exchange is operating (to the extend that this does not interfere with their normal duties). NEP staff will be trained to determine true "emergency situations" by the NHPD.

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