

HIV PREVENTION

THE VA HIV PREVENTION HANDBOOK: A GUIDE FOR CLINICIANS



Department of
Veterans Affairs

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The purpose of *The VA HIV Prevention Handbook: A Guide for Clinicians*

The purpose of the *Handbook* is to assist VA health care providers with translating the findings of HIV prevention research into everyday practice in clinical settings and health care systems. Health care providers include, but are not limited to physicians, nurses, nurse practitioners, physician assistants, psychologists and social workers. The *Handbook* provides basic information, tools, strategies, and recommendations to guide discussions with patients on the prevention of HIV/AIDS. It addresses the sensitive nature of issues like substance use and addiction and sexual practices—behaviors that can make for awkward discussions for both the provider and the patient.

The VA health care system is large with great diversity among its patient population, clinical care models, and health care professionals. Just as no one HIV prevention intervention can meet the needs of *all* individuals at risk for HIV (due to geographic, cultural, gender, and social differences) there isn't any one approach to HIV prevention that will meet the needs of *all* VA health care providers. There are great differences in types of risk behaviors with which veterans may present and great variability in patient and health care provider needs.

The *Handbook* includes references to a variety of VA directives and informational letters that affect HIV/AIDS care in VA medical centers and clinical facilities. These directives and informational letters address topics such as HIV testing and counseling (including informed consent), partner notification, and condom availability through the VHA National Formulary.

The HIV prevention and transmission information provided in the *Handbook* ranges from the basics to tips for the provider who has significant experience in HIV prevention. We encourage you to select and use those sections of the *Handbook* and HIV prevention strategies that work best for your practice and your patients.

I. Introduction

The VA health care system is in a unique position to provide HIV prevention services to more than 3.5 million veterans each year. As the nation's largest single provider of HIV/AIDS care, the VA provided services to almost 19,000 veterans with HIV in 2000. Like other populations in the United States, many veterans may be at risk for HIV/AIDS due to factors such as substance use or abuse and unsafe sexual practices.

Health care providers in many VA clinical settings such as infectious disease clinics, substance abuse treatment programs, domiciliaries, and Vet Centers have been providing HIV prevention services and outreach for years. VA providers in these and other areas have requested help on how best to implement HIV risk assessment and risk reduction interventions for HIV-negative and HIV-positive patients.

Twenty years of HIV prevention research has shown that sustained interventions are needed to create and maintain the behavioral changes that are necessary to prevent transmission of HIV. Fortunately, such interventions have been developed and are available for use in a multitude of settings. HIV prevention activities *are* worth your time and energy and can make a difference.

HIV Prevention Does Work!

Project LIGHT

This intervention took place in primary care and STD clinics and involved a 7-session HIV prevention intervention that focused on attitudes about safer sex, skills building and risk-reduction strategies.

Finding: Participants in the 7-session intervention reported less unprotected sex, increased condom use and were more likely to use condoms consistently over a 1-year period than those individuals who received a 1-hour AIDS education session.§

AIDS and the transition to illicit drug injection—results of a randomized trial prevention program*

The goal of this intervention was to determine the effects of a small group intervention on preventing the transition from sniffing heroin to injecting heroin. The intervention took place in a community storefront and involved four 1-1½ hour sessions over a 2-week period.

Finding: Men and women who participated in the intervention were significantly less likely to inject drugs than those in the comparison condition.‡

Condom skills education and sexually transmitted disease reinfection*

This intervention took place in the waiting room of an STD clinic and involved a 10-15 minute session on effective condom use and a 10-15 minute question and answer period.

Finding: Men and women who participated in the intervention were significantly less likely to return to the STD clinic within the next 12 months with a new STD than those in the comparison condition.‡

Reduction in STD infections subsequent to an STD clinic visit: Using video-based patient education to supplement provider interventions*

This intervention took place in an STD clinic and involved viewing a video, interactive discussions, and free condoms or coupons for free condoms at an area pharmacy.

Finding: Men who participated in the intervention had a significantly lower rate of new STD infections than men in the comparison condition.‡

Adoption of protective behaviors among persons with recent HIV infection and diagnosis --- Alabama, New Jersey, and Tennessee, 1997--1998

“...findings in this study suggest that a high proportion of infected persons adopted safer sexual behaviors following diagnosis of HIV infection and are consistent with other studies showing adoption of safer behaviors after diagnosis in some groups.”†

*These studies meet the CDC’s HIV/AIDS Prevention Research Synthesis Project criteria for relevance and methodological rigor and also have the positive and significant behavior/health findings required for the CDC *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*.

§*Note.* From “*HIV prevention programs with heterosexuals*,” by M. J. Rotheram-Borus, S. Cantwell, & P. A. Newman, 2000, *AIDS*, 14 (Supplement 2), S59-S67.

‡*Note.* From *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*, by CDC’s HIV/AIDS Prevention Research Synthesis Project, 1999.

†*Note.* From “Adoption of Protective Behaviors Among Persons With Recent HIV Infection and Diagnosis --- Alabama, New Jersey, and Tennessee, 1997--1998,” the by Centers for Disease Control and Prevention, 2000, *MMRW*, 49 (23), 512-515.

II. Overview of HIV/AIDS in the United States and in the VA Health Care System

This chapter addresses:

- The HIV/AIDS epidemic in the United States
- Demographics of veterans who access Veterans Health Administration (VHA) care
- Veterans with HIV/AIDS

June 5, 2001 marked the 20-year anniversary of the first U.S. published report on what came to be known as HIV/AIDS.¹ In 1981, the Centers for Disease Control and Prevention (CDC) *Morbidity and Mortality Weekly Report (MMWR)* published a report of five cases of *Pneumocystis carinii* pneumonia (PCP) among previously healthy young men in Los Angeles.² VA has been involved in the fight against HIV since the beginning of the epidemic; among those first reported cases in 1981 were veterans cared for by VA providers.

Almost 20 years later, more than 773,000 people in the United States had been diagnosed with AIDS and 448,060 had died.³ Currently, there are an estimated 800,000-900,000 people infected with HIV living in the United States.⁴ CDC estimates that 300,000 of these individuals do not know they are infected.⁵ These 300,000 individuals may be those who are most at risk for transmitting HIV to others as they are not aware of their serostatus and may not be practicing risk reduction behaviors. That is why risk assessment and HIV testing and counseling both play such a critical role in the prevention and control of HIV.

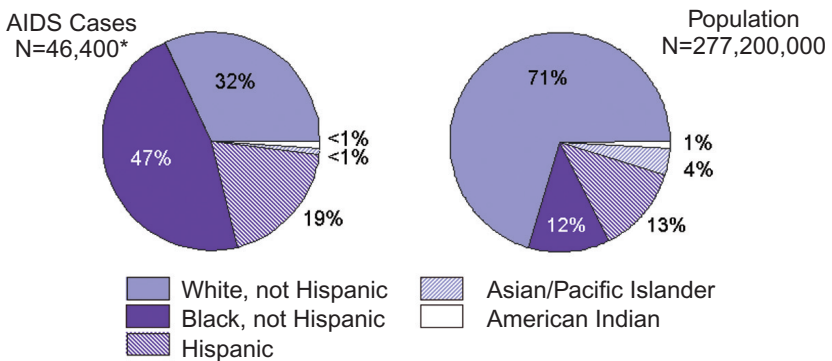
Early testing and detection of HIV helps individuals with HIV enter treatment so that their disease can be monitored and treated appropriately and it also helps individuals begin to learn more about what they can do to prevent transmitting HIV to others. CDC recently implemented a national campaign, SAFE, to increase awareness of these issues and to help increase the numbers of individuals who are tested each year for HIV.⁶

Each year approximately 40,000 people in the United States become infected with HIV.⁷ Concurrently, the number of people living with HIV and AIDS has increased each year while the number of AIDS-related deaths has decreased. This trend is mainly attributable to the use of antiretroviral

therapy, which has effectively slowed the progression of HIV to AIDS. This medical advance has had an incredible impact on the quality of life of those with HIV/AIDS in the United States, but these medications do not serve as a cure, make the management of HIV/AIDS simple or inexpensive, or completely prevent disease transmission from one person to another. Moreover, these medications are not always easily tolerated and it is still unclear how long they will be effective for many patients with HIV.

Of the estimated 40,000 annual new HIV infections in the United States, 70% occur among men.⁸ Forty-two percent of these infections are attributed to men who have sex with men (MSM), 33% to heterosexual activities, and 25% to injection drug use.⁹ Startling is the fact that while African Americans made up 12% of the U.S. population in 1999,¹⁰ by December 2000 they accounted for more than 50% of new HIV cases.¹¹ Of the estimated annual new U.S. HIV cases among women, 64% are among African-American women.¹²

Table 2-1
AIDS Cases Reported in 1999 and Estimated 1999

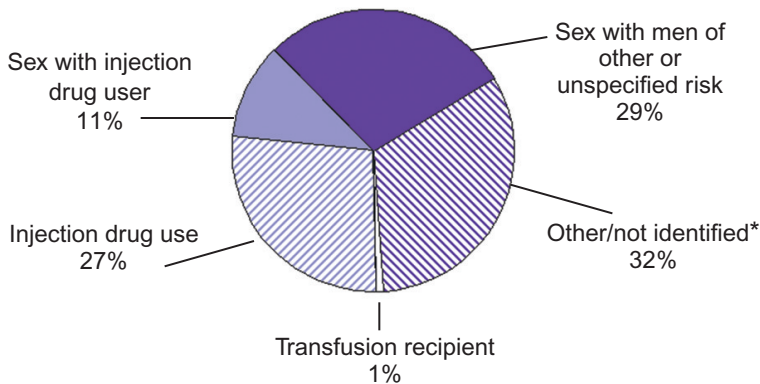


*Includes 120 persons with unknown race/ethnicity

Note. From *HIV/AIDS Surveillance by Race/Ethnicity* (L238 slide series, slide #8), by the Centers for Disease Control and Prevention, 2000. Retrieved June 6, 2001 from <http://www.cdc.gov/hiv/graphics/images/1238-8.htm>

CDC estimates that 120,000-160,000 adult and adolescent females in the United States are living with HIV/AIDS.¹³ Since 1985, the proportion of AIDS cases among adult and adolescent females in the United States has tripled from 7% to 23% (1999).¹⁴ African-American women and Hispanic women make up 77% of reported AIDS cases, yet they represent less than one fourth of the U.S. population.¹⁵

Table 2-2
AIDS in Women, by Exposure Category
Reported in 1999, United States



*Includes sex with a bisexual male, a person with hemophilia, a transfusion recipient with HIV infection, or an HIV-infected and patients with other or undetermined modes of exposure

Note. From *HIV/AIDS Surveillance in Women* (L264 slide series, slide #3), by the Centers for Disease Control and Prevention, 2000. Retrieved August 23, 2001 from <http://www.cdc.gov/hiv/graphics/images/1264/1264-3.htm>

Overview of VHA and the Veterans it Serves

VHA, one of three major branches in the VA, focuses on providing a comprehensive healthcare system for the nation’s veterans. Its four principle missions are to (1) provide medical care to veterans, (2) conduct health professional education and training, (3) conduct health research that benefits veterans, and (4) provide contingency support to the Department of Defense and Public Health Service during times of disaster or national emergency.

As of January 2001, VA had 173 medical centers, 773 clinics, 206 Vet Centers, 135 nursing homes, and 43 domiciliarys.¹⁶ Approximately 3.5 million veterans receive medical care through the VA each year making VA one of the largest health care systems and the largest single provider of substance abuse and mental health services.

Veterans seen in the VA health care system represent a significantly older segment of the population in comparison to the general population. Also, a larger percentage of veterans seen in VA earn low incomes in comparison to the general population and veterans who do not seek care in the VA health care system.

Table 2-3
Characteristics of Veteran VA Health Care Users and Nonusers
Compared with the General Population

Characteristics	Veterans VA User	Veteran non- VA User	General Population
Age 65 and older	35.60%	31.30%	17.00%
Non-Caucasian	25.4	12.5	22.8
Not married	35.7	19.4	39
Education<high school	26	15	24.8
Income<\$20,000	70.5	25.7	32.9
Income<\$10,000	38.5	8.7	14.6

Note. From “The VA Health Care System: An Unrecognized National Safety Net” (p. 202), by N. J. Wilson & K. W. Kizer in *Health Affairs*, 16 (4), July/August 1997.

Veterans with HIV/AIDS

VA is the largest, single provider of HIV/AIDS care in the United States. This comprehensive system of care is supported by a designated HIV coordinator at each VA medical center and the availability of all licensed anti-HIV medications on the VHA National Formulary (male and female condoms are also available on the Formulary).

According to the information available through the VA Immunology Case Registry (ICR), which is a confidential registry, patients with HIV/AIDS seen in the VA health care system are older than the U.S. norm (mean age of 47 years vs. 37 years) and more representative of ethnic/racial minorities (65% of VA HIV/AIDS patients are non-Caucasian vs. 57% of non-VA HIV/AIDS patients are non-Caucasian). Data available from the ICR suggests that VA patients with HIV/AIDS are more likely to report injection drug use as an HIV risk behavior than individuals in the general U.S. population with HIV/AIDS. The reported risk factor information available through the ICR indicates that men who have sex with men account for 34% of VA HIV/AIDS cases, 26% of cases are associated with injection drug use, and 18% report heterosexual transmission as the risk factor. To date, risk information for a significant portion of VA patients with HIV/AIDS is missing and it is important to keep in mind that the stigma associated with men who have sex with men (MSM) and behaviors such as injection drug use may lead to underreporting of these risk factors among veterans.

III. Confidentiality and the VA Health Care System

This chapter addresses:

- VA regulations regarding patient confidentiality
- Release of patient records
- Ways to protect the confidentiality of patients with or at risk for HIV/AIDS

Confidentiality in the health care setting is not only the patient's right but a starting point in which to build an effective provider-patient relationship.

In the VA health care system, "confidential" means that under normal circumstances only health care professionals involved in the patient's care and treatment will have access to information contained in their medical file. This information cannot be released to a third party (e.g., insurance company, potential employer, private practice clinician) unless the patient provides special written consent (VA Form 10-5345) for such a release.

When meeting with a patient for their first visit, it may be good to clarify the patient's confidentiality rights and the circumstances under which a VA provider can disclose a patient's medical information without prior consent. These circumstances involve:

- when it is necessary to protect the life or health of any individual (e.g., homicidal or suicidal intent, sexual or physical abuse of a minor)
- when an employee needs to know the information to perform his/her job
- when it is pursuant to a published routine use in the patient medical records system of records
- when it is pursuant to a request from law enforcement entities
- when requested by a Congressional oversight committee or subcommittee, or
- when it is pursuant to a court order.

In regards to a Congressional request, the VA may disclose information to a Congressional office without prior consent in response to an inquiry from the Congressional office made **at the request of the patient** (not at the request of a third party, such as a family member).

HIV/AIDS information in a patient's VA medical records is formally protected through 38 U.S.C. § 7332. Section 7332 states that any patient's medical record maintained in connection with the performance of any program or activity (including education, training, treatment, rehabilitation, or research) relating to HIV testing and infection, drug abuse, alcoholism and alcohol abuse, or sickle cell anemia can be disclosed only with the specific written consent (VA Form 10-5345) of the individual or as permitted by one of the limited exceptions (see section VA HIV Partner Counseling and Referral Services Guidance, page 63 for further details). Penalties for unauthorized disclosures include a fine of up to \$5,000 for the first offense and up to \$20,000 for a subsequent offense. Unauthorized disclosures also include verbal disclosures.

Should a VA patient request that a facility release their medical record to a third party, you should inform the patient that once the record is released, VA has no control over the information within it. This should be discussed before the patient has signed a consent form for the release of medical records.

As a provider, you can protect the confidentiality of your patients through the manner in which you document HIV risk behaviors in their medical records. Because HIV-related discussions frequently involve activities that are stigmatized and sometimes illegal, it is important to keep medical records as neutral as possible. For instance, if a male patient says he has unprotected sex with multiple men, a statement in his medical record could read "engaging in high-risk sexual activities" as opposed to "engaging in unprotected anal sex with other men." This phrasing will document the patient's risk so that other providers involved in his care will be aware of his risk factors, but it won't disclose personal information that the patient may not want to share with unfamiliar providers.

It is important to understand that even well-intended actions can undermine the confidential relationship you have with your patient. Conversations with colleagues about patient information, including HIV/AIDS status and risk behaviors, should be confined to the appropriate settings.

It is not appropriate to discuss a patient's care or clinical status in public areas in clinical settings such as hallways, nurses' stations, clinical front desks, or elevators. Even though the patient may remain unnamed throughout the conversation, certain identifying information may reveal the identity of the patient.

It may be helpful to provide your patients with information on VHA confidentiality and patient privacy practices. Included in the *Appendices* is an example of a brochure on VA patient confidentiality developed by the VA Puget Sound Health Care System (see *Appendix A*).

IV. Primary and Secondary HIV Prevention

This chapter addresses:

- Opportunities for HIV prevention activities
- HIV primary and secondary prevention activities
- Obstacles to HIV prevention activities in clinical settings

More than 90% of persons in at-risk populations visit their physician each year¹⁷ and many patients believe that information on one's sexual health is an important part of a health evaluation.¹⁸ Yet research indicates that only a small percentage of physicians routinely discuss HIV transmission and prevention with their patients.¹⁹

For many years in the United States, HIV testing and counseling was thought of as the main prevention intervention for people who thought they may be at risk for infection or who tested HIV-negative. Today, comprehensive HIV prevention involves primary and secondary prevention activities. Primary HIV prevention refers to activities directed to keeping an HIV negative person negative and secondary HIV prevention refers to activities for the person who is HIV positive or has AIDS. The goal of secondary HIV prevention is to make sure the infected person (1) does not transmit the virus to others, (2) remains healthy over time, and (3) does not become re-infected with the virus (if the person is reinfected with strains of the virus that are resistant to specific antiretroviral medications, this could have a significant impact on disease treatment).

Primary and secondary HIV prevention activities in VA health care settings enhance the health of veterans and are an effective means in which to decrease the number of new HIV infections.

Primary and secondary HIV prevention activities include:

- HIV risk assessment and risk-reduction counseling,
- HIV testing and counseling,
- partner notification and referral services,
- education on sexual behavior changes and safer sex methods,
- support of medication adherence for those with HIV/AIDS,
- screening for sexually transmitted diseases (STDs),

- education on high-risk substance-use behaviors and harm reduction practices,
- screening for drug and alcohol abuse and when appropriate, referring for substance abuse treatment,
- psycho-educational and support groups, and
- discussing healthy lifestyle choices.

Screening for STDs is a critical HIV prevention intervention as the presence of other STDs indicates that the patient has not been practicing safer sex and may be at risk for HIV. An individual with an ulcerative or nonulcerative STD such as syphilis, chancroid, genital herpes, gonorrhea, chlamydia, and trichomoniasis has a 2-5 times greater risk of becoming infected with HIV.²⁰ Prescribing condoms (available through the VHA National Formulary) is also an excellent prevention activity.

Potential obstacles to HIV prevention activities taking place in clinical settings involve:²¹

- narrow conceptions of medical care and the role of physicians or health care providers in HIV prevention,
- a provider's discomfort with discussing human sexuality and illicit drug use and their attitudes towards persons with HIV or AIDS,
- constraints on time and resources, and
- the ambiguity of HIV prevention messages.

The very nature of HIV transmission involves behaviors not readily discussed in American society. As a health care provider, it is important for you to become comfortable discussing sexual and substance-use activities with your patients. You will need to create an environment of trust for patients so their risk behaviors can be discussed. It is important to assure your patient of the confidential nature of such discussions, as concerns about confidentiality and documentation of such information may prevent some patients from disclosing important information about their risk.

Discussions with patients about HIV/AIDS need not take extensive amounts of time. Findings from a 1995-96 study reported that a comprehensive evaluation of a patient at risk or concerned about HIV took approximately 5-7 minutes.²² Patient-centered approaches to the topic took even less time.²³

There are multiple models and interventions that can help you assess someone's transmission risk and aid him/her in making behavioral changes. Five such models and interventions are (discussed in detail on pages 34-49 of the *Handbook*):

- behavior change counseling,
- use of the Transtheoretical Model of the Stages of Change Theory,
- motivational interviewing,
- a brief intervention for use with HIV-positive patients, and
- practical information on condom use.

V. HIV Transmission and Conditions Associated with Infection

This chapter addresses:

- Bodily fluids proven to spread HIV
- Behaviors associated with a risk for HIV infection
- Frequently asked questions about HIV transmission
- Conditions that may suggest HIV infection

As a VA health care provider conducting HIV prevention activities, it is important to understand the specific risk factors associated with HIV transmission and medical conditions that may indicate infection. A clear understanding of these topics will assist you in providing your patients with the most up-to-date clinical information and conducting appropriate HIV prevention activities.

Bodily fluids that have been proven to spread HIV ²⁴:

- blood
- semen (including pre-seminal fluid)
- vaginal fluid
- breast milk
- other body fluids containing blood
- cerebrospinal fluid surrounding the brain and the spinal cord
- synovial fluid surrounding bone joints
- amniotic fluid surrounding a fetus

Behaviors associated with a risk for HIV infection:

- Unprotected anal and vaginal intercourse
- Unprotected oral sex
- Receipt of blood or blood product transfusions (prior to 1985 of most concern)
- Injection of drugs (including steroid, silicone, and hormone injections) by medical personnel or through illicit means

- Needlestick injuries
- Receipt of tattoos or piercings involving unsterilized needles
- Receipt of acupuncture treatment involving unsterilized needles
- Breastfeeding
- Birthing by an HIV-infected mother (mother-to-child transmission)

Frequently Asked Questions about HIV Transmission

Can I get infected with HIV from mosquitoes?

“No...studies conducted by researchers at CDC and elsewhere have shown no evidence of HIV transmission through insects...”

Can HIV be transmitted through saliva, tears or sweat?

“Contact with saliva, tears, or sweat has never been shown to result in transmission of HIV...”

Can HIV be transmitted by wound-to-wound contact?

“Transmission via wound-to-wound contact, although theoretically possible is highly unlikely given the improbability of such a scenario and the small concentration of virus that is likely to be present...”

Can I get HIV from casual contact (shaking hands, hugging, using a toilet, kissing on the cheek, drinking from the same glass, or the sneezing and coughing of an infected person)?

“No. HIV is not transmitted by day-to-day contact in the workplace, schools, or social settings...HIV is not an airborne or food-borne virus, and it does not live long outside the body...”

Can I get HIV from open-mouth kissing?

“Open-mouth kissing is considered a very low-risk activity for the transmission of HIV. However, prolonged open-mouth

kissing could damage the mouth or lips and allow HIV to pass from an infected person to a partner and then enter the body through cuts or sores in the mouth...”

Can HIV be transmitted in swimming pool water?

“HIV cannot be spread by sharing washing facilities or swimming in the same pool with an HIV-infected person...”

Can HIV be transmitted by aerosol?

“At present time, there are no known instances in which bloodborne pathogens have been transmitted to patients or workers by respirable particles in a clinical setting...”

Are patients in a dentist’s or doctor’s office at risk of getting HIV?

“Although HIV transmission is possible in health care settings, it is extremely rare...”

To learn more information on these questions, go to the CDC web site <http://www.cdcnpin.gov/hiv/faq/transmission.htm>

Note. From *HIV/AIDS resources: Frequently Asked Questions (FAQs) About HIV*, by the Centers for Disease Control and Prevention. Retrieved July 2, 2001 from <http://www.cdcnpin.org/hiv/faq/transmission.htm>

In addition to answering questions on HIV transmission, you should be able to recognize certain medical conditions that may suggest a patient is infected with HIV or has AIDS.

When a patient presents with any one of the conditions listed below, in order to adequately treat the condition you should assess their risk for HIV. If the patient does present with a history of risk factors for HIV, you should discuss HIV testing and seek their consent to proceed with testing and counseling. A list of AIDS-defining conditions can be found in *Appendix B*.

Conditions That May Suggest HIV Infection

- Any AIDS-defining clinical condition (see *Appendix B*)
- Significant, self-limited flu-like illness (especially if associated with rash, sore throat, and lymphadenopathy) in a sexually active or drug-using individual
- Unexplained constitutional symptoms (including weight loss)
- Generalized lymphadenopathy
- Persistent diarrhea
- *M. tuberculosis*
- Unexplained oral thrush
- Sexually transmitted diseases
- Herpes zoster (more the case in younger patients than in older patients)
- Unexplained, recurrent seborrheic dermatitis
- Frequent vaginal candidiasis, particularly in the absence of antibiotic usage or diabetes
- Thrombocytopenia

Note. From *HIV & Primary Care: Putting Prevention into Practice* (p. 10), by the AIDS Institute, New York State Department of Health, 1998. Reprinted with permission.

VI. Conducting HIV Risk Assessment of VA Patients: An Overview

This chapter addresses:

- Behaviors associated with HIV transmission
- An HIV risk assessment questionnaire
- Taking a patient's sexual history
- Taking a patient's substance use/abuse history
- Chart on HIV risk associated with sexual activities
- Guidance for the substance abuse treatment provider
- An infectious disease assessment questionnaire for use in the substance abuse treatment setting
- Guidance for the mental health treatment provider
- HIV prevention activities for homeless populations
- HIV prevention activities in the ER setting

Risk behaviors associated with HIV transmission center on one's exposure to bodily fluids through activities such as sex, the use of needles for injection purposes, childbirth, and breastfeeding.

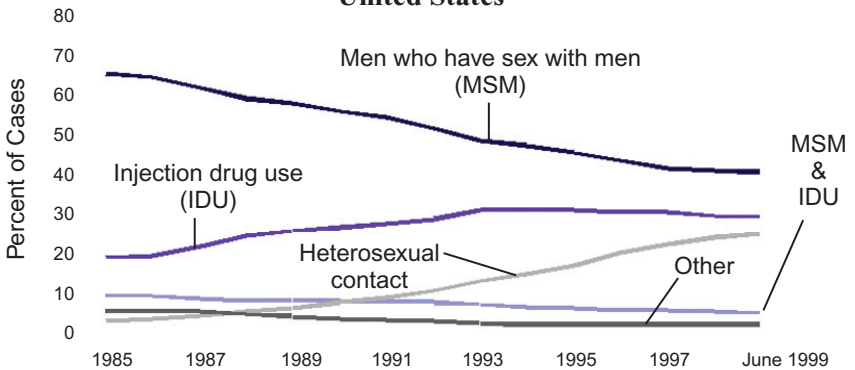
While HIV/AIDS literature frequently categorizes risk for the virus based on "membership" in specific populations (e.g., gay or bisexual men, injection drug users, sex workers), it is sometimes best to think about a patient's risk for HIV in terms of his/her behaviors. For example, the most reported risk behavior among U.S. HIV and AIDS cases are men who have unprotected sex with men (MSM), followed by unprotected heterosexual activity and drug use.²⁵ In reality, it is behaviors associated with unprotected sex and/or substance use that will put anyone at risk for HIV.

Additionally, some people may not identify with a particular population. Not all men who have sex with men identify as gay. So a question such as "When you have sex, is it with women, men or both?" will go much further than "Are you gay?"

In the United States, unprotected heterosexual sexual activity is considered to be one of the fastest growing modes of transmission.²⁶ The AIDS

incidence by risk has increased for heterosexuals approximately 15% each year until 1996.²⁷ It is estimated that in 1999, 62% of new AIDS cases among females were the result of heterosexual contact.²⁸

Table 6-1
Adult/Adolescent AIDS Cases by Exposure Category
and Year of Diagnosis, 1985 - June 1999
United States



Note. From *HIV/AIDS Surveillance - General Epidemiology* (L178 slide series, slide #8), by the Centers for Disease Control and Prevention, 2000. Retrieved August 23, 2001 from <http://www.cdc.gov/hiv/graphics/images/1178/1178-8.htm>

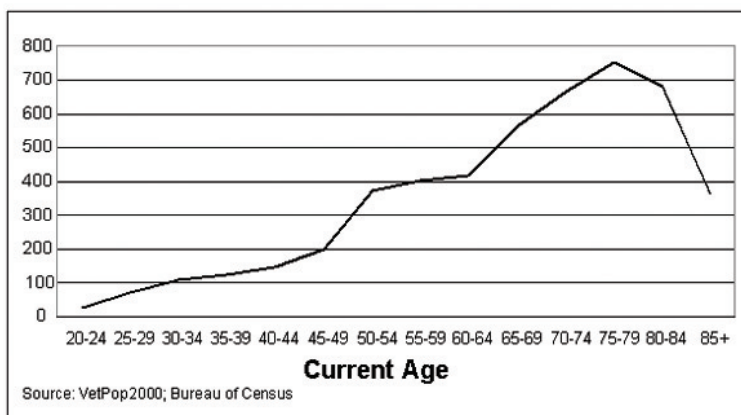
It is noted that the highest reported risk factor for HIV in the United States and VA is still among men having sex with men (MSMs). Recent behavioral and social research has focused on young MSMs who are engaging in unsafe sexual behavior and homophobia faced by African-American MSMs. In some areas of the country there has been a rise in the HIV and STD infection rates among young MSMs. It is suggested that this increase may be related to (1) beliefs that HIV/AIDS medication represent a “cure” and that the disease is easily controlled, (2) complacency about safer sex messages, and (3) little or no experience with seeing friends/family rapidly deteriorate from the virus. African-American MSMs may experience homophobia from the African-American community and racism from the gay white community, thus they may feel like they do not completely belong in either world. Current HIV/AIDS dynamics and trends like these should inform your prevention work.

Health care providers may not believe that certain populations are engaging in behaviors that put them at risk for HIV transmission. If a health care provider makes assumptions that “older” people are not sexually active

or engaging in high-risk substance abuse, a critical discussion on risk behaviors and prevention methods may not take place. As a result, an invaluable opportunity for educating an at-risk patient about HIV may be lost. At the same time, patients over 50 years of age may not see themselves as at risk for HIV even though they are having unprotected sex.²⁹ They may downplay the rate of HIV transmission through heterosexual contact. This age group may include divorced and widowed individuals who are dating for the first time in years.

Ten percent of the people with HIV/AIDS in the United States are age 50 years or older.³⁰ In 1996, 84% of AIDS cases among people 50 years or older were among males.³¹ In the same year, 43% of the cases experienced by this age group were among African Americans.³² People aged 50 years or older were likely than people 13-49 years old to report to a health care provider with an AIDS opportunistic infection.³³ This may suggest that older people are being diagnosed with AIDS later in the course of their infection.

Table 6-2
Number of Elderly Male Veterans per 1000
as of September 30, 2000



Another common assumption is that the HIV risk behaviors of substance users only involve the use of contaminated injection equipment. This narrow definition of a population's risk behaviors ignores that fact that injection drug users may not practice safer sex on a consistent basis, especially when they are high. People with a history of non-injection drug use are more likely to engage in high-risk sexual activities.³⁴ In addition, drug users may be selecting sexual partners from drug networks that have a

higher prevalence of HIV.³⁵ Like drug users, alcohol users also may pick sexual partners from a drug/alcohol network³⁶ and the disinhibiting effect of alcohol can result in unsafe sexual activities.

Take the time to think about your own attitudes and assumptions that may influence your HIV prevention activities. Patients may not be as reluctant to discuss high-risk activities as providers think. Recent research has stated that “patients did not disclose [information] differently whether or not they believed their physician would see their disclosures...Despite physicians’ concerns that patients are uncomfortable being asked about stigmatizing behaviors, data suggest that the majority of patients state they would not be embarrassed by talking with their physician about acquired immunodeficiency syndrome (AIDS), and that they do not mind answering questions about alcohol use and HIV-risk behaviors.”³⁷

It is important to remember that because of their experiences in the military, many veterans may be reluctant to discuss same-gender sexual activities or substance use activities because of unfounded fears that disclosure will jeopardize existing VA benefits. This type of disclosure will not result in a loss of VA benefits.

HIV Risk Assessment Questionnaire for Use in the Health Care Setting

The questionnaire on page 24 can be used to start the HIV assessment process and conversations on risk behaviors. It may help to “normalize” questions about sexual and substance-use histories by introducing these questions with a comment such as “I am interested in all aspects of my patients’ health, so I am asking all my patients these questions to better assess their risk for infectious diseases.” One or more “yes” answers to the questions may indicate some level of risk behaviors and requires provider follow up.

Risk Assessment Questionnaire

1. Have you had two or more sexual partners in the past 10 years?
Yes____ No____
2. Have you had anal sex (a man puts his penis in the anus of other person) with any of your sexual partners during the past 10 years?
Yes____ No____
3. How often have you used a condom when having anal sex in the past 10 years?
Never____ Sometimes____ Always____ Have not had anal sex ____
4. Have you ever had a sexually transmitted disease such as gonorrhea, syphilis, chlamydia, genital warts, or genital herpes?
Yes____ No____
5. At any time in the past 10 years, have you ever given money or drugs to anyone to have sex with you?
Yes____ No____
6. Have you ever had sex with someone so that they would give you money or drugs?
Yes____ No____
7. Have you ever injected street drugs, steroids, or vitamins with a needle?
Yes____ No____
8. Have any of your sexual partners in the past 10 years ever injected street drugs, steroids, or vitamins with a needle?
Yes____ No____
9. Have any of your sexual partners in the past 10 years been men who had sex with other men?
Yes____ No____
10. Have any of your sexual partners in the past 10 years ever had a sexually transmitted disease such as gonorrhea, syphilis, chlamydia, genital warts, or genital herpes?
Yes____ No____

Note. From “Development and Testing of an HIV-risk Screening Instrument for Use in Health Care Settings”, by B. Gerbert, A. Bronstone, S. McPhee, S. Pantilat, & M. Allerton, 1998, *American Journal of Preventive Medicine*, 15 (2), 103-113. Copyright 1998 by Elsevier Science Inc. Reprinted with permission.

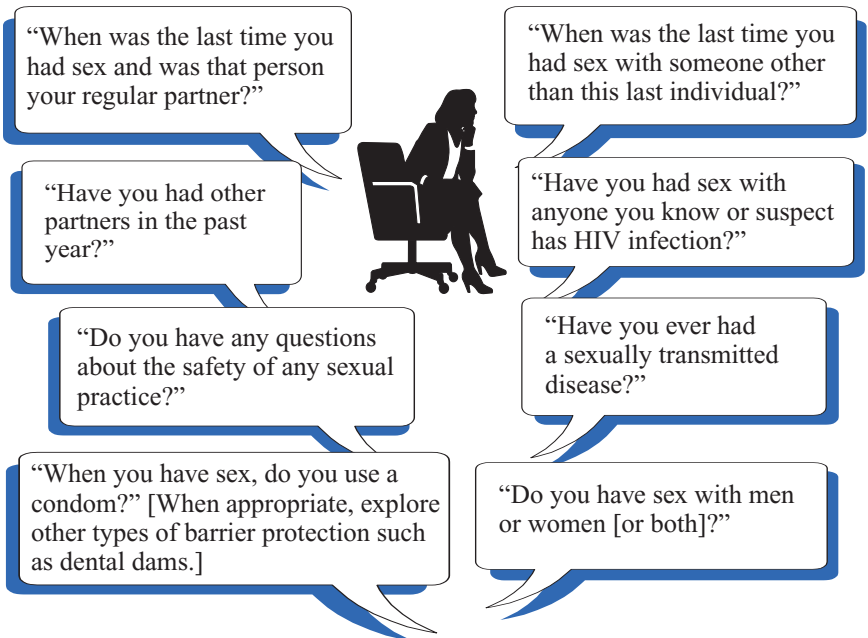
Taking Patients' Sexual and Substance Use Histories

Taking a patient's sexual and substance-use histories allows you to further assess their risk for HIV and their general health status. There are many assessment tools and approaches used in these types of history taking. No one tool or approach is exactly right for all situations and as such, the examples referenced in this section are based on literature reviews, their use of non-confrontational language, and the need for brevity. It is important to take a patient's history in a room or setting where privacy and confidentiality can be ensured.

Taking a Sexual History

Taking a patient's sexual history should be a routine part of a medical exam so let the patient know that you ask these sorts of questions of all of your patients and that they are not being singled out to discuss their sexual history.

Taking a patient's sexual history is like any other type of history; you ask basic questions and build on those questions if necessary. The following sexual history questions can help you branch into a more detailed discussion with your patient:

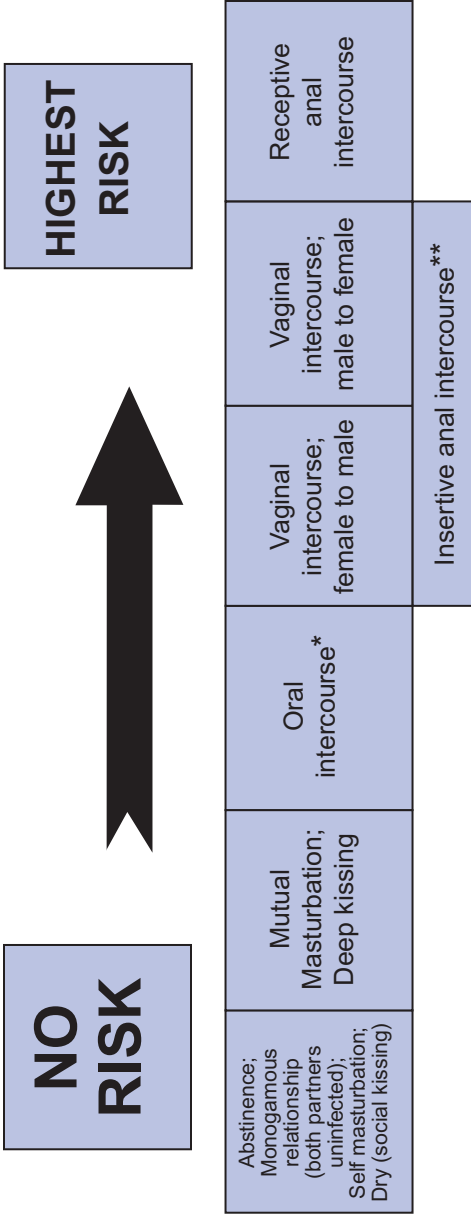


Note. From *HIV & Primary Care: Putting Prevention into Practice* (p. 12), by the AIDS Institute, New York State Department of Health, 1998. Reprinted with permission.

Often, patients will answer “no” to some of these questions because they may feel uncomfortable or embarrassed. A “no”, however, does not eliminate the need for you to review safer sex practices with the patient.³⁸

Some patients want to know the degree of HIV transmission risk associated with specific sexual activities. It may be helpful to use Chart 6-1 to initiate discussions on this topic once your patient has begun to provide you with some information on his or her sexual history or has indicated that they have not routinely practiced safer sex. Chart 6-1 will help patients begin to assess their own relative risk for HIV.

**Chart 6-1
Risk of Sexually Transmitted HIV Infection**



*Risk associated with gender of partners not differentiated due to lack of research.

**Data suggests that HIV transmission through insertive anal intercourse is more efficient than oral intercourse but less efficient than receptive anal intercourse. The relative risk of transmission through insertive anal intercourse compared to vaginal intercourse is unclear.

Note. From *HIV & Primary Care: Putting Prevention into Practice* (p. 55), by the AIDS Institute, New York State Department of Health, 1998. Reprinted with permission.

Taking a Substance-use History in a Primary Care Setting

Epidemiology strongly supports the nexus between substance abuse and the risk for infectious diseases. These risk behaviors include injection drug use, unsafe sexual practices while high or intoxicated, and/or trading sex for drugs or drug money.

Substance use and abuse, especially injection drug use, which may involved the sharing of hypodermic syringes, cottons (material used to filter the drug mixture), or other drug ‘works’, has always been one of the leading risk factors for HIV in the United States.³⁹ CDC reports that injection drug use has accounted for 25% of all cases of AIDS in the United States. This statistic does not include cases of infection experienced by men who have sex with men and inject drugs, and individuals who have heterosexual sex with an injection drug user.

As the nation’s largest single provider of substance abuse treatment, VA sees a large number of veterans who are at risk for HIV because of their current substance abuse or history of injection drug use. Because many of these veterans may not currently be in substance abuse treatment or may not have been identified as drug or alcohol abusers, it is important to integrate routine substance-use histories as part of primary care screening.

The most recent estimates indicate that there were approximately 317,000 veterans with a diagnosis of substance abuse and 540,000 veterans with a psychiatric diagnosis (excluding a substance abuse diagnosis) receiving care in the VA in 1999. The VA has 31 opiate agonist or opiate substitution treatment clinics and provided treatment to 30,000 opiate dependent veterans in 1999.

Health care providers screening for drug and alcohol problems perform a critical function and have the potential to identify many patients who need further assessment or treatment in order to reduce their risk for HIV.

Unfortunately, most medical schools do not include training on how to screen for these problems and many providers may feel uncomfortable or ill equipped to assess for information on as sensitive a topic as substance use. Consequently, many medical care providers have not been very good at identifying active drug and alcohol users.

In approaching substance-use screening in primary care settings, patients must feel comfortable in discussing their use. It may be helpful for providers to:

- ‘normalize’ screenings by prefacing them with a comment that they, the provider, have begun to routinely ask about alcohol and drug use with all their patients to better evaluate their complete health needs,
- conduct screening in a private setting and ask questions and use probes that are non-judgmental,
- use substance abuse screening questions that focus on gaining an accurate assessment of the quantity and frequency of use,
- start substance abuse screening by asking about alcohol and more commonly used substances and then proceed to questions about injection drug use,
- ask about early drug use in a patient’s youth or early adult years and then proceed up to questions about current use,
- ask about illegal drug use during service (especially when coping with combat stressors) when working with combat veterans, and
- perceive substance addiction as any other chronic disease.

There are several self-administered questionnaires that can help the patient and health care provider identify patterns of drug and/or alcohol use that require further assessment or treatment. These include the Michigan Alcohol Screening Test (MAST),⁴⁰ the Drug Abuse Screening Test (DAST),^{41,42} and the Alcohol Use Disorders Identification Test (AUDIT).⁴³ A dual strategy approach such as the use of self-administered questionnaire and a provider-screening interview increases the chance for patient disclosures. It is important to keep in mind that many people are willing to talk about their use but are never asked.

Two initial screening questions that researchers found to be effective in initially screening for alcohol and other drug-use problems in a large primary care setting are:

1. Have you ever felt that you wanted or needed to cut down on your drinking or drug use in the last year?
2. In the last year, have you drunk or used more drugs that you meant to?⁴⁴

It is imperative to note that injection drug use currently accounts for most hepatitis C virus transmission in the United States.⁴⁵ The National Institute on Drug Abuse reports that hepatitis C infection occurs rapidly among new injection drug users as 50-80% become infected with the virus within 6-12 months of injection initiation.⁴⁶ Any patient that reports that they have used injection drug use equipment should be considered at risk the hepatitis C virus.

According to the hepatitis C virus antibody screening flow chart accompanying VA IL 10-2001-009, any individual who presents with an history of injection illicit drug use - past or present - any number of injections - skin or intravenous site, should be counseled and tested for the hepatitis C virus antibody.

Substance Abuse Treatment as HIV Prevention

Substance abuse treatment has been a cornerstone of national HIV prevention efforts.⁴⁷ Substance abuse treatment programs play two critical, yet distinct roles in HIV prevention. First, treatment programs serve to reduce the frequency of high-risk behaviors such as the injection of drugs, aiding in the direct prevention of HIV transmission. But also by gaining access to treatment, injection drug users also gain important access to a broader range of public health interventions such as risk reduction counseling and HIV testing and screening.⁴⁸

Substance abuse treatment programs were the site of the earliest HIV prevention efforts with high-risk populations such as injection drug users and there is a large body of literature that has established an association between participation in treatment and lowering one's risk for HIV.⁴⁹

While substance abuse treatment is a highly effective HIV intervention, limited access to treatment can be a potential barrier for many injection drug users and other high-risk substance-abusing populations. In addition, relapse is a common occurrence so many substance abusers may move in and out of treatment over time. As such, their risk for HIV will likely vary over time, but there still appears to be an overall decline in the frequency of drug use and related risk behaviors even for those who relapse after treatment.⁵⁰

Should you need to provide prevention counseling to patients who continue to inject, CDC recommends that people who inject drugs should be regularly counseled to:

- stop using and injecting drugs or
- to enter and complete substance abuse treatment.

For injection drug users who cannot or will not stop injecting drugs, the following steps may be taken to reduce personal and public health risks:

- never reuse or “share” syringes, water, or drug preparation equipment,
- only use syringes obtained from a reliable source (such as pharmacies or needle exchange programs),
- use a new, sterile syringe to prepare and inject drugs,
- if possible, use sterile water to prepare drugs; otherwise, use clean water from a reliable source (such as fresh tap water),
- use a new or disinfected container (“cooker”) and a new filter (“cotton”) to prepare drugs,
- clean the injection site prior to injection with a new alcohol swab, and
- safely dispose of syringes after one use.⁵¹

Guidance for the Substance Abuse Treatment Provider

The VA HIV and Hepatitis C Prevention Service, the National HIV/Hepatitis C Program, and the Centers of Excellence on Substance Abuse Treatment and Education recently created a joint recommendation regarding hepatitis C and HIV counseling and testing for all veterans receiving specialty care for substance use disorders (SUDs). The recommendation states that upon entry into a VA substance abuse treatment program, patients with SUDs should routinely be (1) tested for hepatitis C and counseled about the testing and results and (2) assessed for HIV risk and receive mandatory pre-test counseling for HIV.

HIV pre-test counseling should include information about risk factors for HIV, the confidential and voluntary nature of the HIV test in VA, the meaning and specificity of the HIV test, and information on measures to be taken for preventing transmission of HIV (for a complete list of information required for pre-test counseling, see page 60). The veteran

should then be asked if he or she wishes to be tested for HIV and their ability to give informed consent should be evaluated.

If the veteran does not wish to be tested for HIV, the counselor or provider should continue ongoing risk assessment and risk reduction counseling. If the veteran does consent to be tested, the provider should proceed with a referral to a HIV test counselor or proceed with counseling and testing according to VA policy.

If a patient in a substance abuse treatment program tests positive for HIV, he or she should be referred to the infectious diseases clinic or their primary care provider in the VA Medical Center in order to receive evaluation and treatment of their HIV. If a patient tests positive for hepatitis C, he or she should also be referred to the identified hepatitis C provider at their facility for further evaluation and management in order to avoid liver damage. If a patient in a substance abuse program has a negative test result on the HIV or hepatitis C test but continues to engage in risk behaviors, he or she should receive risk reduction counseling and be encouraged to continue to be retested every six months until their risk behaviors have stopped.

This handbook contains two screening instruments that can be administered in an alcohol and substance abuse treatment setting. The first instrument, *Simple Screening Instrument for Outreach for Alcohol and Other Drug Abuse and Infectious Disease* (Treatment Improvement Protocol, Series #11) is found on pages 33-34 and the *Risk Assessment Battery* is found in *Appendix C*.

The goal of the *Simple Screening Instrument for Outreach for Alcohol and Other Drug Abuse and Infectious Disease* is to determine the risk for infectious diseases experienced by substance abusers and addicts. To learn more about this instrument and the infectious diseases associated with specific questions, contact SAMHSA's National Clearing House for Alcohol and Drug Information at 1-800-729-6686 or by e-mail at info@health.org and ask for the document.

Screening for Infectious Diseases in the Substance Abuse Service Setting

1. Have you seen a doctor or other health care provider in the past 3 months? (yes/no)
2. a. Do you live on the street or in a shelter? (yes/no)
b. Have you ever been in jail? (yes/no)
3. Have you ever been told you have a positive HIV test [test for the AIDS virus]? (yes/no)
4. Women: Have you missed your last two periods? (yes/no)
5. Have you ever had a positive skin test for TB? I mean a test where you got a shot in the forearm, and a few days later had a hard bump like a blister appear? (yes/no)
6. Have you ever been told you have TB? Has anybody you know or have lived with been diagnosed with TB in the past year? (yes/no)
7. a. Within the last 30 days, have you had any of the following symptoms lasting for more than 2 weeks?
 - Fever
 - Drenching night sweats that were so bad you had to change your clothes or the sheets on the bed
 - Productive cough
 - Coughing up blood
 - Shortness of breath
 - Lumps or swollen glands in the neck or armpits
 - Losing weight without meaning to
 - Diarrhea (runs) lasting more than a week
- b. Do you live with someone who has any of the following symptoms?
 - Coughing up blood
 - Drenching night sweats
- c. Do you know or are you close to anyone with these symptoms? (yes/no)
8. Do you use needles to shoot drugs? (yes/no)
9. Do you use coke or crack? (yes/no)

10. In the last 6 months, have you had any VD[s] [venereal diseases, STDs, sexually transmitted diseases], like syphilis, the clap [gonorrhea], chlamydia, or NGU [nongonococcal urethritis, trichomoniasis, trick]? (yes/no)
11. Have you, or anyone you've had sex with, had any of the following symptoms within the last 30 days?
 - Sore or ulcer on the penis/vagina [“down there”]?
 - Rash, spots, or other skin problems, especially on your palms or the soles of your feet?

Women:

- A vaginal discharge that is different from what you usually have?
- Pain when you have vaginal sex?

Men:

- Discharge from the penis?
12. Have you had sex with more than two people—at different times—in the past 6 months? I mean any type of vaginal, rectal, or oral contact, like you went down on your partner or he/she went down on you, with or without a condom. (yes/no)
 13. Have you used your rectum for sex? (yes/no) [Use regionally appropriate terminology to indicate penile penetration, as opposed to other types of sexual contact.]
 14. In the past 6 months, have you had sex with someone in return for anything, like money, alcohol or other drugs, a place to stay, or just to survive? (yes/no)
 15. Have you ever been forced to have sex against your will? (yes/no)

Note. From *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Disease: Treatment Improvement Protocol Series-11* (DHHS Publication No. {SMA} 94-2094, p. 21), by the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 1994.

Guidance for the Mental Health Treatment Provider

HIV risk assessment and risk reduction counseling can also occur as part of a routine evaluation and treatment in mental health settings such as Vet Centers and psychiatry clinics.

Veterans with chronic mental illnesses may be at greater risk for HIV because of:

- deficits in social skills that are needed to negotiate safer sex with partners,
- sexual disinhibition,
- cognitive impairment or poor judgment,
- hypersexuality or mania, or
- associated substance use.

A 1997 study suggested that U.S. veterans with posttraumatic stress disorder (PTSD) or other mental or emotional problems and substance abuse face a 10-fold increased risk of HIV infection when compared to veterans without either.⁵²

In addition to a link between severe stress exposures and a broad array of diseases,⁵³ PTSD can also be associated with stress-related risk behaviors that may place veterans at risk for HIV. The relationship between PTSD and substance use is well known. In attempting to cope with, self-manage, or ‘numb’ symptoms of PTSD, a veteran may engage in substance use or abuse or associated unprotected sexual behaviors that may place him or her at risk for HIV. If the PTSD is secondary to sexual assault or trauma, it may be much harder to engage in the self-efficacy and interpersonal skills necessary to negotiate safer sex practices such as consistent condom use with a sexual partner.

The seriously and persistently mentally ill are another population at higher risk for HIV and with a higher prevalence of the disease. A review of studies on HIV risk behavior among seriously mentally ill populations found lifetime rates of injection drug use from 4-35%, and higher rates of risky sexual behaviors, including such activities with partners known to be at increased risk for HIV.⁵⁴ It is likely that psychiatric symptoms, substance abuse, and social vulnerability inadvertently contribute to risk in this population.⁵⁵

While a substance-use history is frequently a part of a mental health intake evaluation, sexual history items can also be integrated into routine questions about social relationships. In asking patients in a mental health setting about their medical history, questions about specific sexual activity, the relationship between substance use and sexual risk, use of condoms, and previous diagnoses of STDs can also be included. Again, it is important to emphasize with the patient that you routinely ask these questions of all your patients as you are concerned with all aspects of their health and emphasize the confidentiality policy of VA.

Should your patient present with risk factors for HIV, you should discuss the possible need for HIV testing and counseling. You may want to start the discussion with prompts such as those found on page 58. In addition, you should:

- assess the patient’s ability to provide informed consent,
- refer patients to the HIV test counselor at your facility if they consent to testing and are able to provide informed consent, and
- determine if the patient wants you to accompany them to the testing or provide a time to see them while they are waiting for their result and immediately after receiving the results of their test.

Discussions to evaluate a patient’s readiness to adopt behaviors to reduce their risk as well as general HIV prevention counseling can be integrated into other therapeutic goals. Again, it is important to continue to assess risk for HIV on an ongoing basis for veterans who receive mental health services as their risk for HIV may change in response to changes in their psychological functioning and life events. Factors such as depression, hopelessness, manic presentations, and diminished judgment may increase patients’ risk status, and may have to be addressed before a patient can change his or her risk behaviors.

Mental health settings in VA can make condoms available to patients by leaving them in areas such as restrooms where patients can pick them up unnoticed. Both male and female condoms can also be prescribed to patients through the VHA National Formulary (listed under ‘medical supplies’).

It may also be helpful to provide educational materials on HIV prevention in clinic waiting rooms and examination rooms. Patients can read the material while they are waiting and it provides a cue to patients that this is a topic they can bring up with their mental health services provider.

Guidance for Homeless Care Providers

In March 1990, the U.S. Census counted 39,000 male veterans in emergency homeless shelters. This number underestimates the number of homeless veterans as many homeless individuals do not reside in shelters.⁵⁶ In the same year, there were 149 homeless veterans per 100,000 individuals vs. 126 homeless non-veterans per 100,000 individuals.⁵⁷

Homelessness and HIV/AIDS co-occur at very high rates. Risk factors such as severe mental illness, substance abuse, and a history of injection drug use all occur at higher rates among urban homeless populations, leading to increased risk for HIV. Homeless populations are also likely to have poor access to health care, substance abuse treatment, or condoms—all things that can help prevent HIV and related risk.⁵⁸

VA's proud tradition of Stand Downs for homeless veterans, held each year in cities across the United States, provide excellent opportunities for health screening and support of homeless veterans. Stand Downs are often co-sponsored by VA Medical Centers, Vet Centers, veteran service organizations, and homeless care providers. Many Stand Downs include HIV prevention interventions such as substance abuse screening and treatment referrals, referrals for HIV testing, condom distribution, referrals for HIV treatment, and hepatitis C screening and testing.

Homeless veterans may be reluctant to participate in on-site HIV testing at a Stand Down. Homeless health care providers have reported that they get better participation with HIV testing and risk assessment if homeless veterans at Stand Downs can be given an appointment and seen in a clinic for these services.

HIV Prevention in the Emergency Room Setting

It is important to note that HIV prevention *can* take place in the emergency room (ER) setting. In 1996, 10% of visits to a physician occurred in an ER setting.⁵⁹ While it is highly unlikely that there is adequate time to conduct comprehensive HIV prevention in the ER setting, brief prevention activities can take place. They include:

- asking patients about condom use, number of sexual partners, type of sexual activity, and injection drug use,

- making referrals to VA substance abuse programs, toll-free HIV/AIDS hotlines, VA AIDS/infectious disease clinics, and community organizations,
- recommending HIV testing for patients considered at high risk,
- writing a prescription for condoms for patients who are at risk because of sexual or substance use behaviors, and
- offering HIV prevention reading materials, access to electronic resources, or access to an HIV test counselor during the waiting time.

VII. HIV Prevention Approaches and Strategies

This chapter addresses:

- Behavior change counseling
- Transtheoretical Model of the Stages of Change Theory
- Motivational interviewing
- Partnership for Health: A brief safer sex intervention for health care providers working with HIV-positive patients
- Practical advice on the use of male and female condoms and dental dams

You may have only one opportunity to address HIV/AIDS issues with some patients or multiple opportunities to address it with patients seeking on-going medical treatment. As such, primary and secondary HIV prevention approaches and strategies used in health care settings should be easily administered, effective and brief.

Some models and interventions that can assist you in your approach to primary and secondary HIV prevention include: (1) behavior change counseling, (2) the Transtheoretical Model of the Stages of Change Theory, (3) motivational interviewing, (4) the Partnership for Health intervention for HIV-positive patients, and (5) practical information on condom use. All of these examples contain overlapping themes and activities that are central to helping your patient make and maintain healthy behavior decisions.

Behavior Change Counseling

Behavior change counseling is an “ongoing process through which the patient assumes responsibility for making incremental behavior changes that address the problem.”⁶⁰

The goals of behavior change counseling are to:

- assess each patient’s level of awareness and concern,
- assist the patient in reaching a better understanding of potentially harmful behavior,
- determine the patient’s readiness for change, and

- help the patient bring about the desired change (i.e., suggest options for changing potentially harmful behaviors, help the patient make decisions that promote health, and provide referrals for services beyond the scope of the clinician or the clinical setting).⁶¹

Assess each patient’s level of awareness and concern and assist the patient in reaching a better understanding of potentially harmful behavior

Determining a patient’s level of HIV/AIDS knowledge and their concerns about their behavior is an excellent first step. Patients may be knowledgeable on HIV transmission risk, yet unable to make use of this information in evaluating their own risk. It is through questions that you will determine what types of information you need to share with the patient.

“What are you doing to make sure you don’t get HIV through sex?”

“Under what conditions do you not use a condom?”

“How frequently do you use condoms, and with whom?”

“When do you use condoms and what type of condoms do you use?”

“Do you have any questions about what you can do to prevent HIV?”

“What are any barriers to your protecting your self through HIV?”

“Are you concerned about whether you are putting yourself as risk for HIV through drug use?”

Determine the patient’s readiness for change

This is a process where you determine the patient’s placement on a behavior change continuum. For example, a patient thinking about using barrier protection and a patient who has used barrier protection consistently for the past six months, are at different points of the continuum. A useful model for determining a patient’s readiness to change is the Transtheoretical Model of the Stages of Change Theory (see pages 44-45).

Help the patient bring about the desired change

There are a multitude of activities that can help a patient bring about desired changes—changes that help the patient stay HIV negative or keep the HIV-positive patient from being reinfected or infecting others. Suggested behavior change options (e.g., substance abuse referrals or, if your patient is continuing to use drugs, to not share needles; using a condom) should fit the patient’s circumstances.

Prevention Activities That Help Promote Healthful Changes

- Demonstrating male and female condom use
- Sharing techniques for negotiating condom use
- Sharing techniques that aid in HIV medication adherence
- Providing referrals to substance abuse and mental health services within the VA
- Providing referrals to organizations that offer services not provided by the VA health care system (e.g., harm reduction services*, group therapy sessions for HIV-positive transgender clients, outreach to men who have sex with men in anonymous settings)
- Helping the patient to generate a list of advantages of risk reduction practices, such as substance abuse treatment, safer sex, and not sharing needles
- Helping the patient to identify and begin to address barriers to risk reduction
- Helping the patient understand undertaking risk reduction behaviors as an altruistic measure to help prevent the transmission of HIV to others
- Discussing with a patient how to introduce safer or protected sex with a partner
- Discussing with patients about how and when to disclose their serostatus to a new partner

* Harm reduction is an “approach to treatment that emphasizes incremental decreases in substance abuse or HIV risk behaviors as treatment goals. This method attempts to keep clients in treatment even if complete abstinence is not achieved.” Substance Abuse and Mental Health Services Administration. (2000). *Substance abuse treatment for persons with HIV/AIDS: Treatment improvement protocol (TIP) series 37* (DHHS Publication No. [SMA] 00-3410). Washington, DC: U.S. Government Printing Office.

Transtheoretical Model of the Stages of Change Theory

This theory was developed in 1982 to stage cigarette smokers so that they could be offered an appropriate smoking cessation intervention. The Stages of Change Theory consists of different stages that people face when addressing a behavioral change. These stages do not occur in a linear fashion, but a cyclical one.⁶²

Five Stages of Change

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

Precontemplation: At this stage, the person has no intention of changing the behavior (i.e., never uses condoms) in the near future. Authors of the theory state that many individuals at this stage do not recognize their behavior as a problem. If the person expresses no intention to change their behavior within the next six months, they will be labeled a precontemplator.⁶³

Contemplation: This stage involves identification by the person that they want to change the behavior, but no commitment has been made to this change. An individual could be in this stage for an extended period of time (i.e., 18 months). During this time they may be examining the pros and cons of behavior change and the effort it will take to address it.⁶⁴

Preparation: “is a stage that combines intention and behavioral criteria... Individuals in this stage are intending to take action in the next month and have unsuccessfully taken action in the past year... Although they have made some reductions in their problem behaviors, individuals in the preparation stage have not yet reached a criterion for effective action, such as abstinence from smoking, alcohol abuse, or heroine use.”⁶⁵

Action: “is a stage in which individuals modify their behavior, experiences, or environment in order to overcome their problems. Action involves the most overt behavioral changes and requires considerable commitment of time and energy.”⁶⁶ A person is considered to be in the action stage if they can successfully alter their problem behavior for a period of one day to six months. The hallmarks of the action stage are modification of the target behavior to an acceptable criterion as well as significant overt efforts to change.⁶⁷

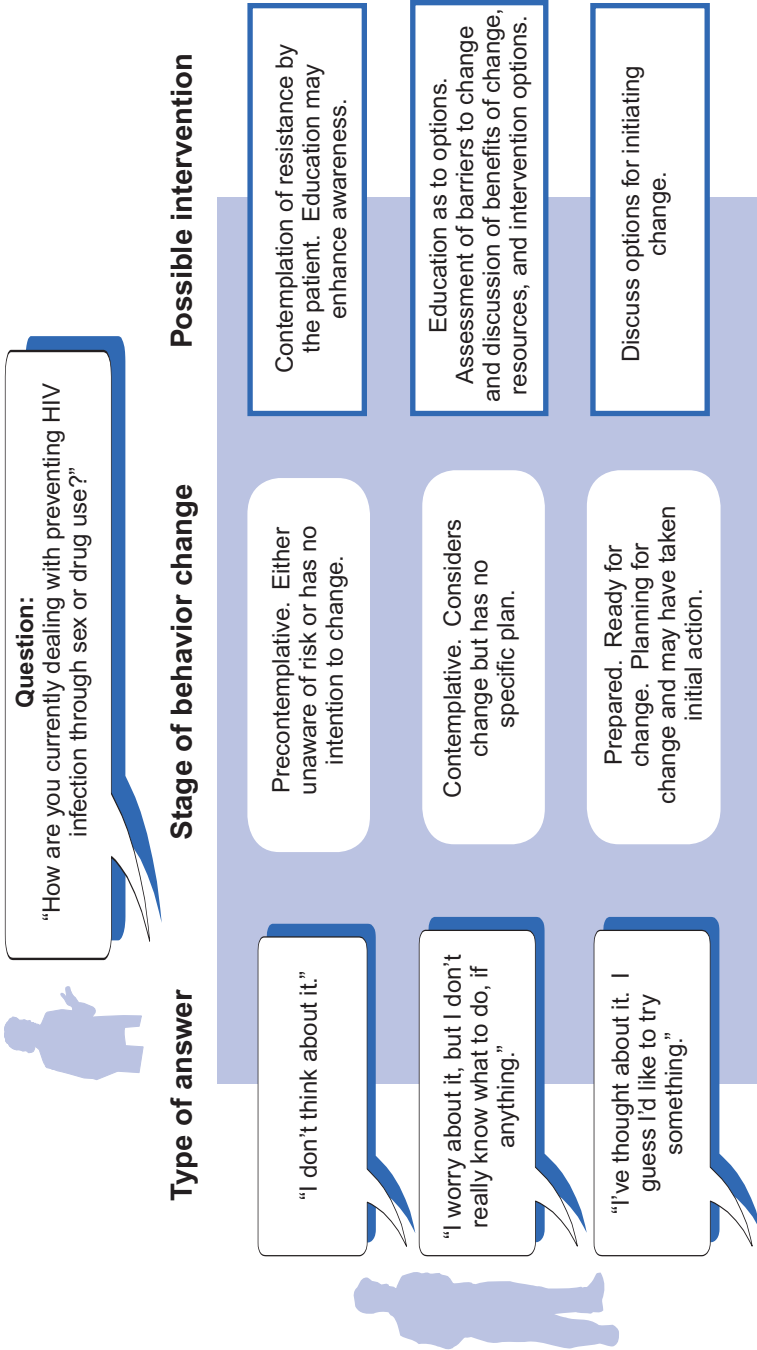
Maintenance: at this stage, an individual should be free of the problem behavior and “be able to consistently engage in a new incompatible behavior for more than six months.”⁶⁸ In the maintenance stage people work to prevent relapse and consolidate the gains attained during action.⁶⁹

While not reflected in all of the literature, termination is considered a sixth stage. In this stage, a person is “presumed to have no temptation to relapse and a complete sense of self-efficacy concerning their ability to maintain health behavior.”⁷⁰

Relapse is the norm for most attempts at behavior change.⁷¹ Relapse is more likely to occur during the action stage than the maintenance stage⁷² although maintainers can experience temptations to relapse for years after being in that stage.⁷³

Being able to determine the stage a patient is in regarding their desire and ability to change a behavior will help you develop HIV prevention strategies. Using the question “How are you currently dealing with preventing HIV infection through sex or drug use?”, Chart 7-1 illustrates statements patients may make and strategies that may prove useful.

CHART 7-1
Responses to Risk-behavior Questions, and Possible Intervention
Corresponding Stages of Behavior Change, and Possible Intervention



"I've started using condoms, but not all the time."
 OR
 "I've started cleaning my works."
 OR
 ["I'm in a treatment program."
 OR
 ["I've been clean for three months."]

"I have been using a condom now for about six months, nearly all the time."
 OR
 "I've started using a syringe exchange program."
 OR
 ["I found out about a drug treatment program."]

"I was really good for a long time, but then I started seeing somebody new and I just stopped.
 I'm not sure it was the right thing to do"
 OR
 "I went cold turkey for a while, but I ran into some old friends who were using and I picked up again."

Action. Initiated change.

Identify and acknowledge successful actions. Explore resources, and referrals. Problem solve to help increase behavior changes.

Maintenance. Adopted a new behavior

Evaluate factors supporting and potentially discouraging maintenance.

Relapse.
 Time or changing factors result in discontinuing adopted behavior.

Evaluate the need for re-initiating behavior.
 Discuss factors influencing cessation of desired behavior.

Note: From HIV & Primary Care: Putting Prevention into Practice (p.55), by the AIDS Institute, New York State Department of Health, 1998. Reprinted with permission. Data from "In search of how people change. Applications to addictive behavior" (p. 1102-1114), by J.O. Prochaska, C. C. DiClemente, & J.C. Norcross, (1992), American Psychologist, 47(9), 1992.

Motivational Interviewing

Motivational interviewing* is another method used to help the patient review and evaluate behaviors that may put him/her at risk for HIV infection or transmission, and help the patient express concerns about the risk behaviors (a characteristic of the contemplation stage) and desires to change the risk behaviors.⁷⁴ Motivational interviewing has been defined as “recognizing a problem, searching for a way to change, and then beginning and sticking with that change strategy.”⁷⁵

Activities Associated with Motivational Interviewing

- Assessing stages of change for risk behavior
- Helping the patient personalize his/her risk
- Negotiating client goals
- Illuminating discrepancies between the patient’s behavior change and existing behaviors (i.e., using clean needles, but not using condoms)
- Discussing the client’s idea of their own longevity (i.e., connecting personal determination to one’s wishes for longevity)
- Providing personal risk feedback
- Encouraging action

Note. From *Motivational Interviewing: Preparing People to Change Addictive Behavior* by W. R. Miller & S. Rollnick, 1991. New York: Guilford Press.

Partnership for Health: A Brief Safer Sex Intervention for Health Care Providers Working with HIV-positive Patients

Partnership for Health (PfH) is an intervention that integrates risk reduction counseling into primary care for individuals who are HIV positive. In this model, health care providers make use of prompts such as educational posters and informational brochures to talk briefly with their HIV-positive patients about the importance of safer sex and disclosure of their HIV status to their sex partner(s).⁷⁶

* To learn more about motivational interviewing, go to the journal of *Behavioural and Cognitive Psychotherapy* (Vol. 23), 1995, S. Rollnick, & W. R. Miller or <http://www.motivationalinterview.org>

The core of the PfH intervention is a 4-hour training program for providers that helps them develop skills to talk with their patients about safer sex during regular office visits. Through these brief patient and provider interactions, the PfH seeks to decrease new infections by emphasizing the importance of patient behavior to protect themselves and their sex partners, and disclosure of their HIV status to their sex partners. In addition to provider counseling at every visit, informational inserts are available for the patients in both English and Spanish. Inserts address the following topics:

- What is safer sex?
- How to tell someone you have sex with that you have HIV
- Answers to your important questions about safer sex and viral load
- With a little creativity, condoms can make sex safer and more sensual
- Building supportive relationships
- What if my sex partner refuses to use a condom?
- Situations that may lead to unsafe sex
- What can I do to help stop the epidemic?

For further PfH information, contact the Partnership for Health, Department of Preventive Medicine, Keck School of Medicine, University of Southern California, 1441 Eastlake Ave., MS44, Los Angeles, CA 90033 or the PfH project manager at 323-865-0345.

Practical Information on Condom Use

In the absence of a vaccine or cure, consistent use of barrier methods such as condoms remains the single best method of preventing sexual transmission of HIV among people who are sexually active. Multiple cohort studies, including those of serodiscordant couples, have demonstrated a strong protective effect of condom use against HIV infection.

Consistent use of condoms has been found to reduce the risk of HIV transmission by 87-95%.⁷⁷

Condoms also play an important role in the prevention of transmission of STDs that are transmitted through genital secretions or genital ulcerative diseases when the ulcers or lesions occur in areas covered or protected by the condom.⁷⁸

It is recommended that VA patients with HIV routinely be asked if they wish to receive a prescription for condoms in order to help prevent transmission of HIV to others through sexual contact. They should then be asked their preference for male or female condoms, or lubricated or non-lubricated condoms. Condoms are usually listed in VHA National Formulary under ‘medical supplies’.

Other patient populations who should be prescribed condoms include patients whom:

- are not HIV+ but who report high-risk activities such as unprotected sex with multiple partners,
- have been diagnosed with an STD,
- have a history of injection drug use or substance abuse, and/or
- have tested positive for hepatitis C or B.

The potential need for condoms should also be discussed with veterans who request Viagra or other treatments for impotency or erectile dysfunction if they also report sexual risk behaviors or multiple sexual partners.

Both male and females condoms are available on the VHA National Formulary. This means that condoms should be available at all VA pharmacies. As stated in VHA Directive 2001-044, “Items listed in the FORMULARY shall be made available throughout the VA health care system and cannot be made non-formulary at the Veterans Integrated Service Network (VISN) or local level. Restrictions can be established at the national, VISN or local level for formulary items that require close monitoring to ensure appropriate use. Restrictions may include evidence-based guidelines and/or prescribing privileges for providers with certain expertise. Restrictions will not be based solely on economic issues and will not be so limited as to prevent patients with legitimate needs from receiving FORMULARY medications.” VHA IL 10-2001-012 addresses the important role that condoms play in the prevention of HIV (see *Appendix D*).

Recent research has examined nonoxynol-9 and personal lubricants, two products often used in conjunction with condoms. After the results of a study that focused on nonoxynol-9 were released at the International AIDS Conference in Durban, South Africa (2000), this spermicide’s effectiveness in preventing HIV transmission has been a debated issue. This study

concluded that nonoxynol-9 is ineffective against HIV transmission and that it may in fact cause vaginal irritation which may facilitate HIV transmission. As such, the CDC recommends that nonoxynol-9 “not be recommended as an effective means of HIV prevention.”⁷⁹

Researchers also examined the use of three personal lubricants (Astroglide, Vagisil and ViAmor) as a means to block the replication of HIV. In the laboratory setting, these non-irritating products were found to be highly active against HIV-infected CEM lymphocytes and also effective against cell-free HIV.⁸⁰

When making condoms available to patients or suggesting their use, the following information on condom type, storage, and use is helpful:

Male Condom Guidance

- Use latex or polyurethane condoms, not natural skin condoms. Research shows that HIV can pass through natural skin condoms.
- Condoms should be stored in a cool dry place, they should not be placed in direct heat or sunlight and should not be put into wallets.
- Condoms should not be used after their expiration date (date printed on individual condom wrapper).
- A condom should be inspected prior to use for damaged packages, and signs of aging such as brittleness, stickiness, and discoloration.
- Put the condom on before sex play begins as pre-ejaculatory fluid, which comes from the penis, may contain HIV.
- Air should be pressed out of the tip of the condom before being placed on the penis.
- When rolling the condom down the base of the penis, leave room at the tip for ejaculate.
- If a lubricant is used, it should be a water-soluble lubricant (e.g., ID Glide, Astroglide) in order to prevent breakdown of the condom. Products like petroleum jelly and lotion are not considered water-soluble lubricants and should not be used.
- After sex, hold on to the base of the condom and pull out while the penis is still erect so the condom doesn't slip off.
- Use a condom only once and properly dispose of it.

Female Condom Guidance

- Condoms should be stored in a cool dry place, they should not be placed in direct heat or sunlight.
- Condoms should not be used after their expiration date (date printed on individual condom wrapper).
- Condoms should be inspected prior to use for damaged packages, and signs of aging such as brittleness, stickiness, and discoloration. The female condom is lubricated so it will be somewhat wet.
- Put the condom in before sex play begins as pre-ejaculatory fluid, which comes from the penis, may contain HIV.
- The condom can be inserted up to eight hours before sex.
- Before inserting the condom, you can squeeze lubricant into the condom pouch and rub the sides together to spread it around.
- The female condom has a firm ring at each end of it. To insert the condom, squeeze the ring at the closed end between the fingers (like a diaphragm), and push it up into the back of the vagina. The open ring must stay outside the vagina at all times, and partly covers the lip area.
- Do not use a male condom with the female condom.
- Do not use a female condom with a diaphragm.
- If the penis is inserted outside the condom pouch or if the outer ring (open ring) slips into the vagina, stop and take the condom out. Use a new condom before you start sex again.
- Don't tear the condom with fingernails or jewelry.
- Use a female condom only once and properly dispose of it in the trash (not the toilet).

Dental Dam Guidance

- A dental dam is a square piece of latex that can help prevent contact with body fluids present during oral sex. An alternative to using a dental dam would be to cut open a male latex condom or a female condom to make a barrier.
- To use a dental dam, first check it visually for any holes.
- If the dental dam has cornstarch on it, rinse this off with water (starch in the vagina can cause an infection).
- Cover the women's genital area with the dental dam.
- For oral-anal sex, cover the opening of the anus with a new dental dam.
- A dental dam should be used for each act of oral sex; it should never be reused.

Note. From *HIV & Primary Care: Putting Prevention into Practice* (p. 152), by the AIDS Institute, New York State Department of Health, 1998. Reprinted with permission.

Both female and male patients may need guidance on condom negotiation skills. Patients should be advised to discuss safer sex and condom use before they find themselves in a sexual situation.

Advise patients to:

- Schedule a time and place outside of the bedroom to talk—condom negotiation is proven to be more difficult when you're in a sexual situation.
- Think about what your boundaries, concerns and desires are before you initiate conversation. Make sure you don't do or agree to do anything that you're not 100% comfortable trying. Remember: it's okay to change your mind.
- Realize that your partner's principles may not match up exactly with your own, and that you may need to work to come up with solutions and alternatives that are acceptable to both of you.⁸¹

Tips for Negotiating Condom Use

- Make sure you clearly state what you want
- Use only “I” statements (e.g., “I want to use a condom when we have sex.”)
- Listen to what your partner is saying
- Be respectful—acknowledge your partner's feelings and opinions
- Be positive
- Use reasons for safer sex that are about you, not your partner⁸²

VIII. HIV Testing and Counseling of VA Patients

This chapter addresses:

- VA policy on confidential HIV testing and counseling
- The informed consent process for HIV testing
- VA staff who can provide HIV pre- and post-test counseling
- Guiding discussions of HIV testing with patients
- Benefits of HIV testing and counseling
- VA HIV pre-test counseling requirements and documentation
- VA HIV post-test counseling requirements and documentation
- Screening tested individuals for domestic violence
- Partner notification and referral guidance
- Reporting of HIV cases to state and local health authorities
- Referrals for primary and secondary prevention services

HIV testing and counseling is an important part of HIV prevention activities. It provides prevention education opportunities for both the person who tests negative and the person who tests positive.

Through pre-testing counseling, a patient can gain an understanding of how certain behaviors put them at risk for infection. Through post-testing counseling, patients are given the test results and thus they become aware of their HIV status. One's knowledge of their serostatus can have an incredible effect on subsequent behaviors and risk reduction techniques.⁸³ In one such study, 90% of the study participants reported that they had changed their sexual behavior since learning of their HIV infection.⁸⁴ Techniques for behavior change can be discussed during HIV pre- and post-test counseling.

VA Policy on Confidential HIV Testing and Counseling

VA HIV testing and counseling for patients is voluntary and confidential and requires written informed consent from the patient. HIV testing in the VA system is not universal (meaning all patients should not be tested) and depends on the identification of risk factors by the provider or veteran or

a veteran's request for testing. As stated in VA Circular 10-88-151 and Circular 10-88-151, Supplement No. 1, the VA makes confidential HIV testing and counseling available to all patients who request it.

For clarification purposes confidential and anonymous testing are defined below:

Confidential HIV testing: The person being tested for HIV will be asked to *provide their name* for testing purposes. The person providing HIV testing and counseling as well as other health and social service providers at the facility who are entitled to review medical records or who are providing care to the patient will have access to the test result. Confidentiality laws and regulations protect this information.

Anonymous HIV testing: The person being tested for HIV *does not provide their name* to the testing counselor and facility/center whom is testing them. The person is assigned a unique identifier that they will use to get their test results. The person being tested and the testing counselor are the only ones to know the test result. Anonymous HIV testing is offered by some public health departments and community-based clinics.

While the VA does not offer anonymous HIV testing and counseling to its patients, VA health care practitioners are encouraged to refer patients wanting such a test to a nearby anonymous testing site. To refer someone to an anonymous testing site in their geographic area, contact the CDC National STD and AIDS Hotlines 24 hours a day, 365 days a year at 1-800-342-AIDS (1-800-342-2437), 1-800-AIDS-TTY (1-800-243-7889) TTY, 1-800-344-SIDA (1-800-344-7432) Spanish, or go to <http://www.hivtest.org/> to locate a testing site.

HIV Testing: Informed Consent

The VA is clear that written informed consent prior to HIV testing is required. Current 38 Code of Federal Regulations Section 17.32 states, "Testing for...HIV must be voluntary and must be conducted only with the prior informed and (written) signature consent of the patient or surrogate. Patients who consent to testing for HIV must sign VA form 10-012, 'Consent for HIV Antibody Testing.' This form must be filed in the patient's medical record. Testing must be accompanied by pre-test and post-test counseling."

It is important to review the consent form (VA Form 10-012) with the patient in order to evaluate whether they have any questions, any difficulty reading or the form, or any difficulty understanding the items.

Examples of patients unable to provide informed consent are:

- a patient who is psychologically unable to cope with the results,
- a patient who is under the influence of a substance or medication that prevents his/her comprehension,
- a patient who has been coerced, and/or
- a patient who cannot communicate with the clinician because of a significant language barrier.⁸⁵

If you suspect your patient has limited comprehension of the significance, meaning and ramification of an HIV test, you should purposely ask the client to repeat his/her understanding of selected concepts you discussed for a broader assessment. You can also ask standard mental status questions to make sure that the patient is well oriented to time and place, such as:

- Tell me where you are?
- Who is the current president?
- Can you tell me today's date?

Should you deem the patient at risk for HIV and unable to provide informed consent, you may want to contact the patient's guardian (if one has been designated) or durable power of attorney. You can discuss your concerns with the guardian and if requested by them, HIV testing and counseling can be performed on the patient after the guardian provides the necessary informed consent. If the patient does not have a legal guardian or a durable power of attorney for health care, then it may be necessary, in limited circumstances, for a court to appoint a guardian.

You will need to assess the urgency of HIV testing. In a patient who is incapacitated and comatose following head trauma, the "need to know" may stem from occupational injury to a health care worker or to aid in the diagnosis or treatment of a condition such as pneumonia.

It is possible that the patient's inability to comprehend the information may be temporary. In some instances, the patient may be stabilized with medication and return for HIV testing and counseling at a later date. If a patient comes to the appointment intoxicated, it is best to reschedule as this person would not be able to provide informed consent.

Types of HIV Testing Methods Available at VA Facilities

At this time, the types of HIV testing methods available at VA facilities vary. This is because the VA does not mandate that all types of FDA-approved HIV tests be made available at each VA facility that offers HIV testing and counseling. As such, facilities may use the regular blood test, the rapid blood test, and/or the oral test. The only VA policy guidance on type of testing method to use involves occupational exposures. IL 10-2001-011 states that the most advanced and rapid HIV detection technologies should be made available in the event of an occupational exposure at a VA facility.

Who in the VA Can Provide HIV Pre- and Post-test Counseling?

VA Circular 10-88-151, Supplement No. 1 states that “[t]he [VA] AIDS Program Office has not identified a single profession to perform counseling but emphasizes the health care professional designation (e.g., one whose profession requires formal academic preparation, standards of practice, and a code of ethics such as nurses, social workers, psychologists) and suggests that individual[s] participate in the national training program.”⁸⁶ Currently, health care providers who have gone through training and are deemed “HIV counselors” and health providers available to do HIV counseling are allowed to conduct HIV pre- and post-test counseling in VA facilities.

Suggestions for Guiding Discussions with Patients on HIV Testing

Opening the discussion of HIV testing—In order to help the patient feel at ease, the health care provider should make it clear that the patient is not being singled out for HIV testing. This can be done in a variety of ways, using statements such as the following:

All patients

“Because of the growing epidemic in our area, all physicians are talking with their patients about HIV and AIDS. I’d like to talk with you about it too. Would it be all right to do that now?”

New patient

“In order to provide the most complete medical picture we can get on all of our patients, I’d like to talk with you about a number of things, including HIV and AIDS. This will help me to provide the best medical care I can for you. Are you familiar with HIV or AIDS? I’d like to give you some information about it. Where should we start?”

Continuing patient

“You have been a patient here for some time. Because of new medical guidelines, I am starting to talk with all of my patients about HIV and AIDS. Have you ever considered the possibility of taking the HIV antibody test?”

Patient with medical indication or risk profile

“Based upon your current medical profile and some of the information you have shared with me, I think we should consider the HIV antibody test at this time. I would like to know your HIV status in order to provide the best medical care for you.”

Pregnant patient or one considering pregnancy

“In light of recent medical development, all physicians are talking with their patients about HIV/AIDS prevention. Can we talk about this now?”

Note. From *HIV & Primary Care: Putting Prevention into Practice* (p. 31-32), by the AIDS Institute, New York State Department of Health, 1998. Reprinted with permission.

Benefits of HIV Testing

- Your health care provider or counselor will tell you how to protect yourself from getting infected with the virus in the future.
- You can end the uncertainty which may come from not knowing if you are infected.
- Your health care provider can give you medical treatment to help you stay healthy and slow down HIV illness. [The VA has every FDA-approved HIV drug on its Formulary]
- Your health care provider can tell you how to prevent passing the virus to others.
- You can learn your status in order to help prevent spreading HIV to others like sex partners who will be at risk if you are positive and don't practice safer sex.
- If you have had a child since you were infected, your child may need additional care and treatment. Your health care provider can tell you about medical care available for children who may be infected with HIV.

If you are a woman who is pregnant or considering a pregnancy and you test positive:

- Your health care provider can tell you about the risk of passing the virus from mother to child.
- Your health care provider can tell you about medication that may reduce the chances of passing the virus from mother to baby.
- You can protect your baby by not breast-feeding. If you have HIV, your breast milk can infect your baby. If you think that you might be at risk for HIV infection, and you do not take the HIV test, you risk passing the virus to your baby if you decide to breast-feed.
- Your health care provider can test your baby to find out if he or she is infected with HIV, and, if so, give the special medical care your baby needs.

Note. From *HIV & Primary Care: Putting Prevention into Practice* (p. 132), by the AIDS Institute, New York State Department of Health, 1998. Reprinted with permission.

Pre-test Counseling: VA Requirements of Pre-test Counseling and Documentation

The VA pre-test counseling requirements were first set forth in VA Circular 10-88-151. That circular established both the counseling requirements and the appropriate documentation of those counseling efforts. Specifically, the 1988 Circular provides that pre-test counseling should include, but not be limited to, the following information:

- the meaning, sensitivity, and specificity of the HIV test;
- the potential social ramifications of a positive test result;
- policies and guidelines for confidentiality of the test results;
- policy on nondiscrimination in health care services for patients with HIV infection and the health care services available in the VA;
- policy and guidelines on disclosure to public health authorities;
- policy on disclosure to spouse and/or sexual partner;
- measures to be taken for prevention of HIV transmission; and
- information relative to authorized disclosures, either with or without consent, of HIV test or treatment records.⁸⁷

In addition to the counseling requirements set forth above, VA Circular 10-88-151 states that all elements of the counseling process should be documented on the progress notes of the medical chart. More specifically, pre-test documentation should include, but not be limited to, the following elements:

- the fact that pre-test counseling was conducted;
- the date and time written consent was given;
- a brief description of the content covered in counseling;
- the patient's response to and participation in the counseling sessions;
- the patient's mental status at the time of counseling;
- a brief assessment of the patient's comprehension of the significance, meaning, and ramifications of the test; and
- the fact that the patient freely consented to testing.⁸⁸

It is important to evaluate whether the patient will need ongoing support while waiting for an HIV test result as this can be a very difficult time. Patients should be provided with a telephone number of a test counselor

or provider whom they can contact if they have questions during the time that they are waiting for their HIV test result. Finally, it is very important to counsel the patient that while waiting for their test result they should practice risk reduction activities such as safer sex and/or not sharing needles or works.

Post-test Counseling: VA Requirements of Post-test Counseling and Documentation

VA Circular 10-88-151 states that post-test counseling should be adapted to both the test result and the particular needs of the individual patient.

- 1) Counseling for a negative result should include, but not be limited to, the validity of the negative result if the patient is in a group at high risk for HIV infection, possible retesting, and reinforcement of risk reduction behaviors.
- 2) If the test results are positive, post-test counseling should include, but not be limited to, reinforcement of the availability of health care services within the VA and community and public health resources; the advantages of notification of spouse or other sexual partners of possible exposure to the HIV and reinforcement of preventative HIV transmission measures to be taken by the patient.⁸⁹

Post-test documentation should include, but not be limited to:

- the results of the test;
- a brief discussion of the content covered in the counseling;
- an assessment of the patient's emotional/mental status; and
- referrals made, if any, and plans for future services.⁹⁰

It is important to realize that discussions of HIV prevention strategies during post-test counseling may not be fully absorbed by the patient. During HIV post-testing counseling, the HIV-negative person may be solely focused on the relief of not testing positive and the HIV-positive person may be trying to process their test result.

Screening for Domestic Violence During Post-test Counseling

Partner or domestic violence is not gender specific and consists of physical, sexual, psychological, and economic abuse occurring in sexual and non-sexual relationships.⁹¹

There may be times when a patient may appear to be fearful for their safety upon learning of a positive HIV test result. In those cases, or if you

have suspected potential abuse, screening for partner or domestic violence should be considered during HIV post-test counseling. It is possible that the patient may be at risk for domestic violence if their partner(s) learns they received HIV testing and counseling and/or the patient tested positive.

Domestic Violence Screening Questions for Use During a Primary Care Visit or During Post-test Counseling

- I'm concerned about prevention and safety, especially in the family. Are you in any relationship where you are afraid for your personal safety, or where someone is threatening you, hurting you, forcing sexual contact, or trying to control your life?
- What happens when you and your partner fight?
- Have you ever been in a relationship where your partner hurt you, threatened you, forced sexual contact, or tried to control your life?

Note. From *Family Peace Project, Family & Community Medicine Medical College of Wisconsin*, by B. Ambuel, B. L. K. Hamberger, 1995. Retrieved July 11, 2001 from <http://www.family.mcw.edu/ClinicalProtocols3.htm>

Should a patient appear at risk for domestic violence, it is important to have a specific plan about what you can do to support them. It is important to talk with them to assess the level of threat to the patient and any children or other vulnerable individuals who live in the home.

If the patient acknowledges current abuse or partner violence, communicate belief, support, and confidentiality. Help the patient assess the current level of danger by asking, "Do you feel safe going home?" Also, assess any indices of lethality such as weapons available and drug or alcohol abuse. Offer the patient telephone numbers such as local shelters, legal advocacy, and the police. Help the patient make an emergency plan, offer follow-up visits or phone contact, and document in the chart.

If you suspect abuse and the patient denies any abuse, tell the patient that you are concerned about their safety and tell them about community resources that they can use if they ever need them. Do not confront or challenge the patient, but offer follow-up and document your concerns.*

VA HIV Partner Counseling and Referral Services Guidance

If you provide HIV pre- and post-testing counseling to VA patients, it is possible that patients who test positive may ask for your advice or assistance with partner notification (also known as partner counseling and referral services [PCRS]). This could involve you giving the patient guidance on disclosure of their HIV status or the patient asking if he/she can have their spouse or sex partner(s) come to the facility and you are present while the partner is told.

Regarding PCRS, patients may need to be coached on:

- the best way to inform each partner,
- how to deal with the psychological and social impact of disclosing one's HIV status to others,
- how to respond to a partner's reaction, including the possibility of personal violence directed toward the client or others, and
- how and where each partner can access HIV prevention counseling and testing.⁹²

The VA defines a partner as the spouse of the patient and/or an individual who has been identified by the patient as a sexual partner during the course of professional counseling or testing. Disclosures may be made where the individual who was tested has provided a specific written consent (VA Form 10-5345) for such disclosure. Should the person being tested die, a disclosure may be made on the request of the next of kin, executor, or personal representative if such disclosure is needed by the survivor to obtain benefits.

Disclosure of a VA patient's HIV-positive test result or status can be made *without* the patient's consent, under specific circumstances. Current 38

*For more information on diagnosis and management of partner violence, contact the Family Peace Project of the Department of Family & Community Medicine, Medical College of Wisconsin, 210 NW Barstow, #201, Waukesha, WI, 53188, (414) 548-6903, <http://www.family.mcw.edu/FamilyPeaceProject.htm>

U.S.C. Section 7332 provides that disclosure without the specific consent of the HIV tested patient may be made under the following circumstances:

1. To medical personnel to the extent necessary to meet a bona fide medical emergency.
2. To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation; however, redisclosure of such data is subject to further restrictions.
3. In response to an appropriate request from a proper federal, state, or local public health authority charged with the protection of the public health and to which federal or state law appropriately requires disclosure of such information, if a qualified representative of such authority has made a written request for that record.
4. Where authorized by an appropriate court order.
5. To the appropriate component of the Armed Forces which is providing health care to the veteran.

In addition to the circumstances set forth above, one more notable exception to the disclosure rule is set forth in 38 U.S.C. Section 7332. More specifically, that section provides that a physician or “professional counselor” may disclose, under certain conditions, *without the patient’s consent*, only under the following conditions:

1. the physician or counselor has made a reasonable effort to counsel and encourage the patient to voluntarily provide this information to the spouse or sexual partner,
2. the physician or counselor reasonably believes the patient will not provide the information to the spouse or sexual partner, and
3. disclosure is necessary to protect the health of the spouse or sexual partner.

Most state public health departments have a PCRS program in place. It is the professional and ethical responsibility of a VA provider to make use of PCRS by contacting the state or local health department in such instances in order to protect the health of the spouse or known sexual partner of a veteran with HIV (see *Appendix E* for a list of PCRS contact information for select states).

VA Policy on HIV Case Reporting to State and Local Health Authorities by VA Facilities and Providers

HIV case reporting is a statistical activity intended to provide for the ongoing systematic collection of HIV information for use in public health practice. Through the reporting of new HIV cases, risk factors, and or outcome specific data, it is possible for the states to provide an ongoing snapshot of the local epidemiology of HIV and assess the efficacy of prevention activities and assist with planning and treatment allocation. Case reporting is *not* partner counseling and referral services activities, which are intended to identify individuals who can benefit from early intervention in the disease process.

As presented in IL 10-2001-002, the VA General Council is of the opinion that the VA is under no legal obligation to comply with a state mandatory-reporting law to report patients' HIV results to state or local health departments, yet supports cooperation. The IL conclusion states:

“VA’s Office of General Counsel Advisory Opinions hold that VA providers are not under legal obligation to comply with a state mandatory HIV reporting law. However, in the spirit of cooperation with state and local health authorities, VA providers are allowed and encouraged to comply with those official requests provided appropriate authorities make written requests, and VA regulations concerning release of medical information are followed.”⁹³

Referrals from VA Clinicians for Primary and Secondary HIV/AIDS Prevention Services

As pointed out earlier, HIV testing is only one example of an HIV prevention activity. When considering interventions to reduce patients' risk for HIV, it is important to consider other referrals that may address behaviors that increase risk for HIV. For example, substance abuse treatment is a highly effective form of HIV prevention as it reduces the incidence of drug-related behaviors that are associated with transmission of HIV.⁹⁴

Referrals to mental health services may help prevent HIV transmission by addressing disinhibition, poor social skills and judgment, hypersexuality, hopelessness, and associated substance use. Mental health referrals are also helpful in treatment of depression and other psychological factors that may contribute to poor adherence with antiretroviral regimens. Dietary or nutritional referrals may also help with nutritional support necessary to address one's general health and adherence to medication.

Ongoing case management, which can be offered by a variety of VA providers, is also highly effective in providing HIV-positive patients or those at risk with the ongoing support needed to develop and maintain behaviors that will reduce their risk for HIV.

Finally, it is important to remember that even the best risk reduction counseling and support may not be effective until more critical underlying conditions such as mental illness, domestic or partner violence, and other acute or chronic conditions can begin to be addressed. Any attempt to reduce risk for a patient who is at high risk for HIV needs to assess and take into consideration all the psychosocial conditions and stressors of a patient as they relate to his or her ability to protect themselves.

IX. HIV/AIDS Issues Affecting the VA Health Care Provider

This chapter addresses:

- Occupational exposures
- Universal precautions
- Provider frustration and burnout
- Challenges of HIV prevention
- Next steps

Issues for VA Providers

Occupational Exposures

In July 2001, VA released IL 10-2001-011, which addressed the guidelines for HIV testing in VA facilities following occupational exposures. This letter addressed a variety of scenarios that may occur during the course of an occupational exposure (i.e., difficulty in testing of source patient, record keeping, and testing methods).

The IL states that the U.S. Public Health Service guidelines for the management of health care worker exposures to HIV and recommendations for post-exposure prophylaxis should be used for general guidance by all VA health care facilities for occupation exposures to HIV. A copy of the IL on occupational exposure can be found in *Appendix F*.

Universal Precautions

Universal precautions, as first defined by CDC, are safety measures taken when providing health care or first aid and are designed to prevent transmission of HIV, hepatitis B, and other bloodborne pathogens. First published in 1987, universal precautions took the place of the need for the isolation category “blood and body fluid precautions” in the 1983 CDC *Guidelines for Isolation Precautions in Hospitals*.^{95, 96, 97}

According to CDC, universal precautions apply to blood, other body fluids containing visible blood, semen, and vaginal secretions. Universal

precautions also apply to tissues and to the following fluids: cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids. Unless they contain visible blood, universal precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, or emesis. Universal precautions do not apply to saliva except when visibly contaminated with blood or in dental settings where blood in saliva is common.

Universal precautions involve the use of protective barriers such as gloves, gowns, aprons, masks, and/or protective eyewear, which reduce the risk of exposure of potentially infectious materials to the health care provider's skin or mucous membranes. In addition, it is recommended that all health care providers take precautions to prevent injuries caused by needles, scalpels, or other sharp instruments. For additional information on universal precautions, please visit the CDC web site at <http://www.cdc.gov/ncidod/hip/Blood/Universa.htm>

Frustration and 'Prevention Burnout' Experienced by Health Care Providers

Because of the nature of HIV/AIDS and the social, emotional, and physical cost of high-risk behaviors, it is only natural for health care providers practicing HIV prevention to experience burnout and frustration. Working with patients to help them develop and maintain safe behaviors can be extremely gratifying and also very difficult at times.

Under the best of circumstances, providers may experience frustration when patients have a hard time adopting new behaviors, whether it is smoking cessation, weight loss or dietary changes. When the behaviors are ones that are necessary and effective in reducing risk for a life threatening, incurable, and transmittable disease like HIV, it can be even more difficult. Providers who have lost patients to HIV/AIDS may find it even more difficult when a patient at high risk is not working to reduce their risk. While it is known what is necessary to reduce risk for HIV, but there is no one "magic" intervention that will get everyone to change his or her risk behaviors.

As a provider, it is important to recognize and monitor your own levels of stress and frustration experienced with this type of work. It is not unheard of to feel anger towards patients who continue high-risk activities despite warnings. Whether it is in an informal or formal setting, it is appropriate for you and colleagues to process these emotions.

Some important questions to ask yourself and your colleagues may include:

- What are some possible obstacles that are keeping this patient from changing his/her behaviors?
- What is this patient's level of readiness to adopt these behavior changes?
- Who else on the clinical team can I enlist to help support the patient in making these changes?
- Why I am working harder than the patient on these changes?
- At what point do I need to refer this patient to another provider to continue work on these issues?

The Challenge of HIV Prevention

It is important to remember that knowledge alone is rarely if ever sufficient to motivate behavior change in those who are at risk for HIV. Individuals who continue to engage in high-risk behaviors may do so for a variety of reasons.⁹⁸ In order to provide the best advice, it is important to understand why risky behaviors are continuing despite attempts to intervene.

First, ask the patients about the circumstances surrounding their most recent high-risk behaviors. On interview, the most likely reasons will be intoxication, unavailability of condoms or a clean needle, or lack of negotiation skills or power in the relationship. Referrals to support services, specialty services, or community agencies to help address these problems will help at-risk patients begin to overcome these obstacles.⁹⁹

Next Steps Following Integration of HIV Prevention Activities

Once you have begun to integrate HIV prevention interventions into your routine clinical care, what are the next steps? As with any other change in clinical practice, steps may be needed to maintain HIV prevention efforts and to evaluate their effectiveness. There are a number of ways to informally evaluate the effects of interventions, in addition to more formal quality assurance approaches. It is important to identify follow-up steps that will work for your clinical setting.

Integration of HIV prevention in clinical settings can be evaluated and supported by:

- providing training in HIV prevention to all new staff,
- monitoring feedback from patients,

- providing ‘refresher’ training to staff periodically,
- allowing time for and encouraging staff training,
- looking at available data on factors such as the number of prescriptions written for condoms,
- reviewing patient charts for documentation of risk assessment or counseling,
- checking in with other providers to monitor their progress in integrating HIV prevention,
- creating local clinical reminders or other prompts for providers,
- making educational materials readily available to patients and staff, and
- making use of technical assistance from community AIDS service organizations and other community organizations.

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APPENDICES

(Appendix A)

Puget Sound, Maine Confidentiality Brochure for Patients

PATIENT MEDICAL INFORMATION - CONFIDENTIALITY AND PRIVACY

Confidentiality of your medical information is important to us. This means that we keep your medical information private - for you and your clinical providers.

Keeping your information private: Good health care depends on a good relationship with your care provider, a relationship based on the trust that we will respect your privacy about the information you provide. We protect your privacy in a number of ways so that you can feel secure.

We protect confidentiality: We protect personal information on our computer network. We have strict policies governing access to, and release of, information. In effect, your medical record is contained within an “electronic” safe-deposit box. All information gathered for treatment is kept secure so that only authorized staff can access your record.

Our staff members have signed an agreement that they will protect your information and respect its confidential nature.

How do we use your medical information?: VA Puget Sound Health Care System uses a state-of-the-art computer system that allows our providers to access your record at the time and place that it is needed, making critical medical information available to our provider almost instantly. This ready access contributes to high quality care for you.

No one can look at your medical information without the appropriate authorization. No one can access your medical data for medical research purposes unless you agree, or unless the information is used in a way that your identity is not known. In order to improve the quality of medical care, we sometimes review medical records to make sure our doctors and nurses are practicing high quality care. In these quality reviews, patient names are not used.

How do we ensure privacy and confidentiality?: Your care is a personal matter, and we know that you want private things to remain private.

We develop and comply with policies to ensure our employees respect confidentiality. We comply with all applicable Federal laws.

We ask your permission before we release your medical record information to someone outside our Medical Center, unless the Privacy Act (5 U.S.C. Sec. 552a) authorizes disclosure without your consent. If we are required by law to release information, we will make a good faith effort to notify you.

If you have questions regarding this important matter, please talk with your caregiver or call us at 1-800-329-VETS (8387) and ask for Terry Liljencrantz, x62144, in the “Release of Information Section.”

(Appendix B)

Conditions Included in the 1993 AIDS Surveillance Case Definition

- Candidiasis of bronchi, trachea, or lungs
- Candidiasis, esophageal
- Cervical cancer, invasive*
- Coccidioidomycosis, disseminated or extrapulmonary
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis, chronic intestinal (>1 month's duration)
- Cytomegalovirus disease (other than liver, spleen, or nodes)
- Cytomegalovirus retinitis (with loss of vision)
- Encephalopathy, HIV-related
- Herpes simplex: chronic ulcer(s) (>1 month's duration); or bronchitis, pneumonia, or esophagitis
- Histoplasmosis, disseminated or extra pulmonary
- Isosporiasis, chronic intestinal (>1 month's duration)
- Kaposii's sarcoma
- Lymphoma, Burkitt's (or equivalent term)
- Lymphoma, primary, of brain
- Mycobacterium avium complex or *M. kansasii*, disseminated or extrapulmonary
- Mycobacterium tuberculosis, any site (pulmonary or extrapulmonary)
- Pneumocystis carinii pneumonia
- Pneumonia, recurrent*
- Progressive multifocal leukoencephalopathy
- Salmonella septicemia, recurrent
- Toxoplasmosis of brain
- Wasting syndrome due to HIV

*Added in the 1993 expansion of the AIDS surveillance case definition.
Note. From "1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults," *MMWR*, 41 (RR-17), 1992, December.

(Appendix C)**Risk Assessment Battery
(R A B)** Check If Asked By Interviewer

ID# _____

DATE: _____

Administered by: _____

Checked by: _____

Please read each of the following questions very carefully. As you will see, many of these questions are personal. We understand this and will make every effort to protect the privacy of your answers.

It is very important that you answer every question honestly. In fact, it's better not to answer a question at all than to tell us something that is not accurate or true. Some questions may not seem to have an answer that is true for you. When this happens, you should simply choose the answer that is most right. Don't spend too much time on any one question.

Remember, always ask for help if you're unsure about what to do.

Thank you for your time and cooperation.

University of Pennsylvania &
Philadelphia Veterans Administration Medical Center
Center for Studies of Addiction
3900 Chestnut Street
Philadelphia, PA 19104

NIDA MDD v. 2.1; 12/21/95

PAST MONTH DRUG AND ALCOHOL USE

A. In the past month, how often have you injected cocaine and heroin together (Speedball)?

- 0. Not at all
- 1. A few times
- 2. A few times each week
- 3. Everyday

B. In the past month, how often have you injected heroin (not mixed)?

- 0. Not at all
- 1. A few times
- 2. A few times each week
- 3. Everyday

C. In the past month, how often have you snorted heroin (not mixed)?

- 0. Not at all
- 1. A few times
- 2. A few times each week
- 3. Everyday

D. In the past month, how often have you smoked heroin?

- 0. Not at all
- 1. A few times
- 2. A few times each week
- 3. Everyday

E. In the past month, how often have you injected cocaine (not mixed)?

- 0. Not at all
- 1. A few times
- 2. A few times each week
- 3. Everyday

- F. In the past month, how often have you snorted cocaine (not mixed)?
0. Not at all
 1. A few times
 2. A few times each week
 3. Everyday
- G. In the past month, how often have you smoked crack, rock, or freebase cocaine?
0. Not at all
 1. A few times
 2. A few times each week
 3. Everyday
- H. In the past month, how often have you injected amphetamines, meth, speed, crank or crystal?
0. Not at all
 1. A few times
 2. A few times each week
 3. Everyday
- I. In the past month, how often have you snorted amphetamines, meth, speed, crank or crystal?
0. Not at all
 1. A few times
 2. A few times each week
 3. Everyday
- J. In the past month, how often have you smoked amphetamines, meth, speed, crank or crystal?
0. Not at all
 1. A few times
 2. A few times each week
 3. Everyday

K. In the past month, how often have you used benzodiazepines (benzos, benzies) such as Xanax, Valium, Klonopin or Ativan?

- 0. Not at all
- 1. A few times
- 2. A few times each week
- 3. Everyday

L. In the past month, how often have you taken painkillers - pills such as Percodan, Percocet, Vicodin, Demerol, Dilaudid, Darvon, Darvocet or syrup (Codeine)?

- 0. Not at all
- 1. A few times
- 2. A few times each week
- 3. Everyday

a. Which types of painkillers did you use?_____

M. In the past month, how often did you inject Dilaudid?

- 0. Not at all
- 1. A few times
- 2. A few times each week
- 3. Everyday

N. In the past month, how often have you used acid, LSD, or other hallucinogens?

- 0. Not at all
- 1. A few times
- 2. A few times each week
- 3. Everyday

O. In the past month, how often have you used marijuana?

- 0. Not at all
- 1. A few times
- 2. A few times each week
- 3. Everyday

- P. In the past month, how often have you used beer, wine or liquor?
0. Not at all
 1. A few times
 2. A few times each week
 3. Everyday

PART I: NEEDLE USE

1. In the past six months, have you injected drugs?
 0. No
 1. Yes
2. In the past six months, have you shared needles or works?
 0. No or I have not shot up in the past six months
 3. Yes
3. With how many different people did you share needles in the past six months?
 0. 0 or I have not shot up in the past six months
 1. 1 other person
 2. 2 or 3 different people
 3. 4 or more different people
4. In the past six months, how often have you used a needle after someone (*with or without cleaning*)?
 0. Never or I have not shot up or shared in the past six months
 1. A few times or less
 2. A few times each month
 3. Once or more each week

5. In the past six months, how often have others used after you (with or without cleaning)?
- 0. Never or I have not shot up or shared in the past six months
 - 1. A few times or less
 - 2. A few times each month
 - 3. Once or more each week
6. In the past six months, how often have you shared needles with someone you knew (or later found out) had AIDS or was positive for HIV, the AIDS virus?
- 0. Never or I have not shot up or shared in the past six months
 - 1. A few times or less
 - 2. A few times each month
 - 3. Once or more each week
7. Where did you get your needles during the past six months? (Check all that apply)
- 0. I have not shot up in the past six months
 - 1. From a diabetic
 - 2. On the street
 - 3. Drugstore
 - 4. Shooting gallery or other place where users go to shoot up
 - 5. Needle Exchange Program
 - 6. Other: _____
8. In the past six months, how often have you been to a shooting gallery/house or other place where users go to shoot-up?
- 0. Never
 - 1. A few times or less
 - 2. A few times each month
 - 3. Once or more each week

9. In the past six months, how often have you been to a Crack House or other place where people go to smoke crack?
0. Never
 1. A few times or less
 2. A few times each month
 3. Once or more each week
10. Which statement best describes the way you cleaned your needles during the past six months? (Please choose one)
0. I have not shot up in the past six months
 1. I always use new needles
 2. I always clean my needle just before I shoot up
 3. After I shoot up, I always clean my needle
 4. Sometimes I clean my needle, sometimes I don't
 5. I never clean my needle
11. If you cleaned your needles and works in the past six months, how did you clean them? (Check all that apply)
0. I have not shot up in the past six months
 1. Soap and water or water only
 2. Alcohol
 3. Bleach
 4. Boiling water
 5. Other: _____
 6. I did not clean my needles in the past six months
 7. I ALWAYS used new needles in the past six months
12. In the past six months, how often have you shared rinse-water?
0. Never or I have not shot up in the past 6 months _____
 1. A few times or less
 2. A few times each month
 3. Once or more each week

13. In the past six months, how often have you shared a cooker?
0. Never or I have not shot up in the past 6 months
 1. A few times or less
 2. A few times each month
 3. Once or more each week
14. In the past six months, how often have you shared a . cotton?
0. Never or I have not shot up in the past 6 months
 1. A few times or less
 2. A few times each month
 3. Once or more each week
15. In the past six months, how often have you divided or shared drugs with others by using one syringe (yours or someone else's) to squirt or load the drugs into the other syringe(s) (backloading, for example)?
0. Never or I have not shot up in the past 6 months
 1. A few times or less
 2. A few times each month
 3. Once or more each week

PART II: SEXUAL PRACTICES

16. How would you describe yourself?
1. Straight
 2. Gay or Homosexual
 3. Bisexual

*Please note: For the following questions, **sex** means any **vaginal intercourse, anal intercourse (in the butt) or oral sex (blowjobs, for example)***

17. With how many men have you had sex in the past six months?
0. 0 men
 1. 1 man
 2. 2 or 3 men
 3. 4 or more men
18. With how many women have you had sex in the past six months?
0. 0 women
 1. 1 woman
 2. 2 or 3 women
 3. 4 or more women
19. In the past six months, how often have you had sex so you could get drugs?
0. Never
 1. A few times or less
 2. A few times each month
 3. Once or more each week
20. In the past six months, how often have you given drugs to someone so you could have sex with them?
0. Never
 1. A few times or less
 2. A few times each month
 3. Once or more each week
21. In the past six months, how often were you paid money to have sex with someone?
0. Never
 1. A few times or less
 2. A few times each month
 3. Once or more each week

22. In the past six months, how often did you give money to someone so you could have sex with them?
- 0. Never
 - 1. A few times or less
 - 2. A few times each month
 - 3. Once or more each week
23. In the past six months, how often have you had sex with someone you knew (or later found out) had AIDS or was positive for HIV, the AIDS virus?
- 0. Never
 - 1. A few times or less
 - 2. A few times each month
 - 3. Once or more each week
24. In the past six months, how often did you use condoms when you had sex?
- 0. I have not had sex in the past 6 months
 - 0. All the time
 - 1. Most of the time
 - 2. Some of the time
 - 3. None of the time

PART III: CONCERNS ABOUT HIV AND TESTING

If you know that you are HIV positive, skip to question # 28.

25. How worried are you about getting HIV or AIDS?
- 0. Not at all
 - 1. Slightly
 - 2. Moderately
 - 3. Considerably
 - 4. Extremely

26. How worried are you that you may have already been exposed to the HIV or AIDS virus?

- 0. Not at all
- 1. Slightly
- 2. Moderately
- 3. Considerably
- 4. Extremely

27. How many times have you had a blood test for the AIDS virus (HIV)? (circle):

0 1 2 3 4 5 6 7 8 9 10 or more times

28. When were you last tested for HIV? On the lines below, please write the month and year of your most recent test.

_____/_____
MONTH YEAR

29. Were you ever told that you had the HIV, the AIDS virus?

- 0. No
- 1. Yes
- 2. I never got the results

Thank You.

Please let the staff person know that you have finished.

(Appendix D)
August 16, 2001

IL 10-2001-012

Under Secretary for Health's information Letter
Access to Condoms as HIV Prevention

1. This Information Letter provides information on the use of condoms in the prevention of human immunodeficiency virus (HIV); provides guidance and further information on the Veterans Health Administration (VHA) existing policy on providing male and female condoms through the National Formulary; and provides recommendations on the prescribing of condoms.

2. Background

a. In the absence of a cure or preventive vaccine, consistent use of barrier methods, such as the condom, remains the single best method of preventing transmission of HIV. Multiple cohort studies, including those of serodiscordant couples, have demonstrated a strong protective effect of condom use against HIV infection. Consistent use of condoms has been found to reduce the risk of HIV transmission by 87 to 95 percent. Condoms also play an important role in the prevention of transmission of sexually transmitted diseases that are transmitted through genital secretions or genital ulcerative diseases when the ulcers or lesions occur in areas covered or protected by the condom. Finally, as the most recent data from the Centers of Disease Control and Prevention have suggested that 10 to 15 percent of cases of hepatitis C may be secondary to sexual transmission, condoms may also play a role in preventing transmission of hepatitis C.

b. Thus, education about risk reduction and access to condoms for male and female veterans is a key component of VHA's program to prevent HIV, hepatitis C and sexually transmitted diseases (STDs) and their impact on veterans and VHA. As the nation's largest single provider of HIV care, it is important that the Department of Veterans Affairs (VA) be a leader in the integration of HIV prevention into clinical care.

c. Findings from a recent national survey conducted by the Pharmacy Benefits Management Strategic Health Care Group suggest that while many pharmacies in the VA health care system routinely stock the male latex condom and the female polyurethane condom, they may be underutilized and are not routinely being prescribed to veterans with HIV, or those at high-risk for HIV.

3. A Reminder of VA Policy on the National Formulary

a. Both male latex and the female polyurethane condoms are currently available on the VHA National Formulary and are classified as a medical supply (VA CLASS XA900). Male and female veterans can be prescribed any type of condom, as best suits their individual prevention needs.

b. As stated in VHA Directive 2001-044, “Items listed in the FORMULARY must be made available throughout the VA health care system and cannot be made non-formulary at the Veterans Integrated Service Network (VISN), or local level. Restrictions can be established at the national, VISN or local level for formulary items that require close monitoring to ensure appropriate use. Restrictions may include evidence-based guidelines and/or prescribing privileges for providers with certain expertise. Restrictions will not be based solely on economic issues and will not be so limited as to prevent patients with legitimate needs from receiving FORMULARY medications.”

4. Recommendations

a. The Public Health Strategic Health Care Group (PHSHG) and the Pharmacy Benefits Management (PMB) Strategic Health Care Group recommend that patients with HIV routinely be asked if they wish to receive a prescription for condoms in order to help prevent transmission of HIV to others through sexual contact. Condom use is to be strongly encouraged for veterans with HIV, as part of their routine care.

b. It is strongly recommended that condom use and the potential need for prescriptions be routinely discussed with patients who:

- (1) Are not HIV positive, but who report high-risk activities such as unprotected sex with multiple sexual partners.
- (2) Have been diagnosed with an STD.
- (3) Have a history or current diagnosis of injection drug use or substance abuse.
- (4) Have tested positive for hepatitis C or hepatitis B.

NOTE: It is also recommended that the potential need for condoms be discussed with veterans who are being evaluated or treated for impotence or erectile dysfunction if they also report high-risk sexual behaviors or multiple sexual partners.

c. VA Pharmacy staff are encouraged to work closely with local providers to ensure that condoms are readily available to patients who require them. To help offset the cost of increased condom dispensing, the PBM and PSHGs have arranged for the availability of male condoms through the Pharmaceutical Prime Vendor (PPV) at a greatly reduced cost. Lubricated male condoms are available through the VA PPV for \$43.75 per 1,008.

NOTE: The PPV Item Number for the reduced price condoms is 4190914.

5. References

a. Centers for Disease Control and Prevention. “Sexually Transmitted Disease Treatment Guidelines,” Morbidity and Mortality Weekly Report (MMWR). 1993; 42 (No. RR-14).

b. Centers for Disease Control and Prevention. Latex Condoms and STDs Prevention Messages, July 2001.

c. Wald, A., Langenberg, A.G.M., Link, K., Izu, A.E., Ashley, R., Warran, T., Tyring, S., Douglas, J.M., and Corey. L. Effect of Condoms Reducing the Transmission of Herpes Simplex Virus Type 2 from Men to Women,” Journal of the American Medical Association (JAMA), 2001; 285:3100-3106.

d. Centers for Disease Control and Prevention. “Recommendations for Prevention and Control of Hepatitis C Virus (HCV) Infection and HCV-Related Chronic Disease” MMWR 1998; 47 (No. RR-19).

6. Questions may be referred to Kim Hamlett-Berry, Ph.D., Director of HIV and Hepatitis C Prevention Service, Public Health Strategic Health Care Group (13B), at (202) 273-8929, or Michael Valentino, R. Ph., MHSA, Associate Chief Consultant, Pharmacy Benefits Management Strategic Health Care Group, at (708) 786-7886.

(Appendix E)

HIV Partner Counseling & Referral Services (HIV partner notification contact information) for Select States

California

Catherine Baker
California Office of AIDS
Prevention Services
California Department of Health Services
916-327-3248

Florida

Partner Counseling and Referral Services
Florida Department of Health
850-245-4303

To obtain information on partner counseling and notification services available in Florida, contact the appropriate county health department or the telephone number above for contact information.

Georgia

Miguel Miranda
Prevention Services: STD/HIV Section
Georgia Dept. of Human Resources, Div. of Public Health
2 Peachtree Street, NW
Suite 12-255
Atlanta, GA 30303
404-657-3100

Illinois

Prevention Counseling Testing Referral/Partner Counseling Referral
Program (PCTR/PCR)
HIV/AIDS Department
Illinois Department of Public Health
217-524-5983

New Jersey

Notification Assistance Program

Department of Health and Senior Services

973-648-7500 (ask for notification assistance)

877-356-8312 (toll-free information line for individuals and providers)

New York

PartNer Assistance Program (for areas outside of NYC)

1-800-541-AIDS or 1-800-872-2777

Contact Notification Assistance Program (for locales within NYC)

212-693-1419 or 212-447-2489

<http://www.health.state.ny.us/nysdoh/hiv aids/hivpartner/infoprov.htm>

Pennsylvania

Partner Counseling and Referrals Services

Division of HIV/AIDS

Bureau of Communicable Disease

Pennsylvania Department of Health

717-783-0572

To obtain information on partner counseling and referral services available in Pennsylvania, contact the appropriate local health department or the telephone number above for contact information.

Texas

Texas HIV-STD Info. Line

Texas Department of Health

1-800-299-2437

To obtain information on partner counseling and referral services available in Texas, contact the appropriate local health department or the telephone number above for contact information.

(Appendix F)**July 18, 2001****IL 10-2001-011****Under Secretary for Health's Information Letter
GUIDELINES FOR HIV TESTING IN VA FACILITIES
FOLLOWING OCCUPATIONAL EXPOSURES**

1. This information letter provides guidance concerning Human Immunodeficiency Virus (HIV) testing in occupational exposure situations; clarifies Department of Veterans Affairs (VA) policy about testing for HIV, and includes a collection of consensus recommendations of a Committee (see subpar. 2b) that included experts in the field of HIV, Acquired Immune Deficiency Syndrome (AIDS), and occupational safety.

2. Background

a. Considerable progress has occurred toward the development of therapeutic agents used to treat HIV infected individuals and significant technical advancement has been made in diagnostic techniques to detect HIV. These recent advancements necessitated a re-examination of VA policies and procedures as related to testing for HIV within the context of potential occupational exposure.

b. A committee was established to review existing VA policies on HIV testing in situations of potential occupational exposure. The Committee was composed of front-line HIV care providers including infectious disease experts, infection control and occupational health experts both from VA Central Office and the field; VA General Counsel's Office; the National Center for Ethics; and a union representative.

c. The guidelines contained in this Information Letter represent a collection of recommendations of the Committee and provide reference to the United States (U.S.) Public Health Service (PHS) guidelines for management of occupational exposures and post-exposure prophylaxis to HIV.

d. The Committee addressed six specific areas. These include:

- (1) VA HIV testing policy in occupational exposures in general;
- (2) Situations where the source patient refuses or is incapable of giving consent or an appropriate authorized surrogate refuses consent;

- (3) Confidentiality issues related to exposed employees' records;
- (4) Exposures during off-duty hours;
- (5) Availability of state-of-the-art diagnostic technologies to detect HIV; and
- (6) Process integrity issues.

3. General Guidance for VA Facilities

a. The U.S. PHS has developed guidelines for the management of occupational exposures to HIV and made recommendations for post-exposure prophylaxis (see subpar. 9a). This information, designed as general guidance, can be used by all VA health care facilities in establishing appropriate programs for the management of health care workers (HCWs) who have occupational exposure to blood and other potentially infectious materials, and for post-exposure prophylaxis. This document is accessible on the web site: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm>.

4. A Reminder of VA Policy on HIV Testing

a. VA policy provides that every patient has the right to informed participation in the patient's health care decisions (see subpar. 9b, VHA Handbook 1104.1, and Title 38 Code of Federal Regulations (CFR) §17.32, regarding Informed Consent). Public Law 100-322 Section 124, as amended, specifies that testing for HIV must be voluntary and requires specific written consent by the patient to be tested (see subpar. 9c). The law also provides that HIV testing be accompanied by documented pre- and post-test counseling.

b. This Information Letter further clarifies VA policy about testing for HIV. A common query is whether specimen left over from other diagnostic or therapeutic tests may be tested for HIV when the source patient cannot be located, is incapacitated, or refuses the HIV test. Current law mandates that VA may administer a test to a patient that would lead to the diagnosis of HIV infection **only** with the prior written consent of the patient, or of an authorized surrogate in accordance with applicable law and regulations. This includes circumstances where occupational exposures have occurred.

c. In situations of occupational exposures, there are instances where testing of the source patient is difficult or impossible. These situations include:

- (1) Source patient or appropriate authorized surrogate refuses consent for HIV test.

Recommendation: Offer exposed employee post-exposure management and anti-retroviral prophylaxis, as warranted by PHS guidelines. The patient, or appropriate authorized surrogate may be re-approached by a different provider, e.g., a counselor, an attending physician or a nurse who is not involved in or affected by the exposure event. Careful attention needs to be taken to ensure that coercion is neither applied nor perceived when a person who initially declined testing is re-approached. If the patient, or appropriate authorized surrogate, still declines, testing may not be performed, even on available residual specimens.

- (2) Source patient left VA medical center before consent was obtained.

Recommendation: Offer exposed employee post-exposure management and anti-retroviral prophylaxis, as warranted according to PHS guidelines. Follow-up with the patient to obtain consent. The source patient's written consent on VA Form 10-5345, Request for and Consent to Release of Medical Records Protected by 38 U.S.C. § 7332, (see subpar. 9d) is also required to disclose the HIV test results to the exposed employee. Provide assistance or support where possible to maximize patient's convenience in the consenting and testing process. A specimen previously collected for other purposes cannot be used for HIV testing without appropriate consent.

- (3) Source patient cannot be located.

Recommendation: Offer exposed employee post-exposure management and anti-retroviral prophylaxis, as warranted according to PHS guidelines. Specimen previously collected for other purposes cannot be used for HIV testing without appropriate prior consent.

- (4) Source patient is incapacitated, incompetent or comatose.

Recommendation: Offer exposed employee post-exposure management and anti-retroviral prophylaxis, as warranted according to PHS guidelines. VA regulations limit diagnostic testing of HIV and the disclosure of information related to HIV infection, when the patient lacks the decision-making capacity (incapacitated, incompetent, or comatose). Testing for HIV, like any other diagnostic or therapeutic procedure, typically requires the patient's (or appropriate authorized surrogate's) informed consent. When the purpose of the test is to confirm the patient's

HIV status following an occupational exposure, a written consent allowing the test for HIV is required. Furthermore, disclosure of the test results to the exposed employee also requires written consent from the patient, or from the patient's legal guardian in instances where the patient lacks the decision-making capacity. Such disclosures require the specific written consent of the patient's court appointed legal guardian on VA Form 10-5345. If the patient is incompetent and there is no consenting court appointed legal guardian, HIV testing and disclosure of the HIV test results are not permitted.

- (5) Source patient is deceased.

Recommendation: *Offer exposed employee post-exposure management and anti-retroviral prophylaxis, as warranted according to PHS guidelines. If the purpose of testing at autopsy is to establish the diagnosis of HIV, then specific consent of the deceased's next-of-kin, or appropriate authorized surrogate, would be required (see subpar. 9e).*

5. Employee Confidentiality and Record Keeping

a. Confidentiality of medical information pertaining to both HCWs and patients is essential. Employee health records should not be accessed by anyone other than Employee Health staff and others who are involved in providing health care to the exposed HCW without the prior written consent of the worker or as otherwise authorized by law. Appropriate security measures and sanctions must be in place to assure the confidentiality of all employees' health records.

b. Medical records and HIV test results of patients who are identified as the potential source of exposure of blood and/or body fluids are subject to confidentiality protections imposed by law (see subpar. 9f). Test results or other information concerning a patient's HIV status may not be disclosed, in most instances, without the patient's specific prior written consent. The source patient's identity and HIV status must not be recorded or reported in HCW's records unless appropriate written permission is obtained.

6. Exposure Management During Non-administrative Work Hours

a. A person can be designated within the facility to deal with issues on occupational exposure to blood and body fluids with coverage provided for off-duty hours.

b. A number of the exposures to blood and body fluids occur off-shifts and during non-administrative hours. The written policies and procedures on the management of the HCW exposed during off-shift and non-administrative duty hours should be uniformly in accordance with the Exposure Control Program of the Occupational Safety and Health Administration (OSHA) (see subpar. 9g).

7. Availability of Most Advanced HIV Testing Technologies

a. The PHS guidelines on evaluation and testing of exposure source should be followed when evaluating for possible HIV infection (see subpar. 9a).

b. The most advanced and rapid HIV detection technologies should be made available (see subpar. 9h). Consideration should be given to using rapid HIV detection tests so that source patients' HIV status can be determined as quickly as possible.

c. In addition to the HIV antibody blood test, the direct HIV detection test, as well as the rapid tests such as urine antibody and oral tests that have the highest degree of sensitivity and specificity, should be made available in appropriate situations along with appropriately trained technicians to perform the test(s).

8. Process Integrity Issues

a. The exposed HCW should never be the one to approach or counsel the source patient about HIV testing.

b. An appropriately trained person should obtain the consent for HIV testing of the source patient, or the HCW, and conduct the counseling and post-exposure management of the exposed HCW. The post-exposure prophylaxis, management and treatment of the exposed HCW, may best be directed by a multidisciplinary team of VA providers who are trained in issues dealing with occupational exposures.

c. A facility multidisciplinary team should be available for consultation during the off-shifts and non-administrative hours.

9. References

a. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to Hepatitis B Virus (HBV), Hepatitis

C Virus (HCV), and HIV and Recommendations for Post-exposure Prophylaxis. Morbidity and Mortality Weekly Report (MMWR) 2001;50 (No. RR-11):1-43. (Web address: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm>)

b. VHA Handbook 1004.1.

c. Title 38 CFR Section 17.32

d. Veterans' Benefits and Services Act of 1988, Public Law No. 100-322, Section 124, 102 Stat. 487 (1988) (38 U.S.C. Section 7333).

e. Title 38 CFR Section 1.460-1.496.

f. Title 38 U.S.C. Section 7332.

g. Office of General Counsel Advisory Opinion VADIGOP 6-8-88. Informed Consent for Testing and Autopsies for AIDS. June 8, 1988.

h. VHA Manual M-1, Part 1, Chapter 9, Release of Medical Information.

g. Occupational Safety and Health Administration's Regulation on Bloodborne Pathogens. (29 CFR Section 1910.1030, Bloodborne pathogens).

h. Holodniy M. "Establishing the Diagnosis of HIV Infection" AIDS Therapy. Dolin, Masur & Saag Eds. Churchill Livingstone Publisher, 1999.

10. Questions may be referred to Abid Rahman, Director, Government Liaison, with the Public Health Strategic Health Care Group (132/13B), at 202-273-8468 or e-mail to: abid.rahman@mail.va.gov.

(Appendix G)

VA HIV/AIDS-related Circulars, Directives & Informational Letters

Circulars

Public Law 100-322, Section 124: Testing for HIV (Human Immunodeficiency Virus) and Informed Consent (Circular 10-88-151, December 14, 1988)

Questions Related to Testing for HIV (Human Immunodeficiency Virus), Informed Consent and Case Reporting in VHS & RA (Veterans Health Services and Research Administration) (Circular 10-88-151, Supplement No. 1, October 18, 1989)

Directives

National Hepatitis C Program (VHA Directive 2001-009, February 27, 2001)
<http://vaww.va.gov/publ/direc/health/direct/12001009.pdf>

Information Letters

Case Reporting of Human Immunodeficiency Virus (HIV) to State and Local Health Authorities by VA Facilities and Providers (IL-10-2001-002, February 13, 2001)
<http://vaww.va.gov/publ/direc/health/infolet/10200102.pdf>

Access to Condoms as HIV Prevention (IL-10-2001-012, August 16, 2001)

Guidelines for HIV Testing in VA Facilities Following Occupational Exposures (IL-10-2001-011, July 18, 2001)
<http://vaww.va.gov/publ/direc/health/infolet/10200111.pdf>

Hepatitis C Testing and Prevention Counseling Guidelines for VA Health Care Practitioners (IL 10-2001-009, June 12, 2001)
<http://www.va.gov/publ/direc/health/infolet/10200109.pdf>

Recommendations for Prevention and Treatment of Opportunistic Infections in HIV and AIDS Patients (IL 10-97-015, March 24, 1997)
<http://vaww.va.gov/publ/direc/health/infolet/109715.doc>

Update On Use of Viral Load Assays, Resistance Assays, and Antiretroviral Agents in HIV Disease (IL 10-98-019, September 9, 1998)
<http://vaww.va.gov/publ/direc/health/infolet/109819.htm>

(Appendix H)

HIV/AIDS Information Resources

American Foundation for AIDS Research (amFAR)

HIV/AIDS Treatment Directory

<http://www.amfar.org/>

amFAR's *HIV/AIDS Treatment Directory* is a comprehensive, continuously updated, searchable database of clinical results for approved and experimental treatments and actively recruiting HIV/AIDS clinical trials. This respected resource includes feature articles, conference reports, and news and analysis on the latest developments in HIV/AIDS research and clinical practice.

The Body

<http://www.thebody.com/index.shtml>

The mission of The Body web site is to use the web to lower barriers between patients and clinicians, demystify HIV/AIDS and its treatment, improve patients' quality of life, and foster community through human connection.

Center for AIDS Prevention Studies

74 New Montgomery, Suite 600

San Francisco, CA 94105

(415) 597-9100; (415) 597-9213 - fax

CAPSWeb@psg.ucsf.edu

<http://www.caps.ucsf.edu/capsweb/FSindex.html>

This web site contains concise, science-supported HIV prevention fact sheets for practitioners and the public in English, Spanish, and Kiswahili (selected sheets).

CDC National Prevention Information Network

<http://www.cdcnpin.org>

This web site is part of the CDC's National Center for HIV, STD, and TB Prevention. It examines the connections among these diseases and provides multiple documents to download and links to related web sites.

ClinicalTrials.gov

<http://www.clinicaltrials.gov/>

The U.S. National Institutes of Health, through its National Library of Medicine, has developed *ClinicalTrials.gov* to provide patients, family members and members of the public current information about clinical research studies. These trials include diseases affecting the immune system such as HIV/AIDS.

HIV/AIDS Treatment Information Services (ATIS)

<http://www.hivatis.org/>

ATIS is the central resource for federally-approved treatment guidelines for HIV and AIDS. You can download current and archived guidelines from this web site.

HIV InSite

<http://hivinsite.ucsf.edu/InSite.jsp>

This web site provides comprehensive, up-to-date information on HIV treatment, prevention, and policy. HIV InSite is a collaborative project of the San Francisco Veterans Affairs Medical Center, the Positive Health Program at San Francisco General Hospital, and the Center for AIDS Prevention Studies.

HIV/AIDS Bureau (HAB)

Health Resources and Services Administration (HRSA)

<http://hab.hrsa.gov/>

HAB, one of four bureaus of HRSA, is the largest single source, next to the Medicaid and Medicare programs, of federal funding for HIV/AIDS care for low-income, and un- and underinsured individuals. HRSA administers the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

National Association of State and Territorial AIDS Directors (NASTAD)

444 North Capitol Street, NW

Suite 339

Washington D.C. 20001

202-434-8090

<http://www.nastad.org>

NASTAD is a non-profit national association of state health department HIV/AIDS program directors who have programmatic responsibility for administering HIV/AIDS health care, prevention, education, and supportive services programs funded by state and federal governments.

Office of AIDS Research (OAR)

National Institutes of Health (NIH)

<http://www.nih.gov/od/oar/>

OAR is located within the Office of the Director of NIH and is responsible for the scientific, budgetary, legislative, and policy elements of the NIH AIDS research program.

Congress has provided broad authority to the OAR to plan, coordinate, evaluate, and fund all NIH AIDS research. The OAR is responsible for the development of an annual comprehensive plan and budget for all NIH AIDS research.

The Substance Abuse and Mental Health Services Administration (SAMHSA)

5600 Fishers Lane

Rockville, MD 20857

info@samhsa.gov

<http://www.samhsa.gov/>

SAMHSA is the federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses. SAMHSA addresses HIV/AIDS issues in the context of substance abuse and mental illness issues.

VA AIDS Information Newsletter

AIDS Information Center

Director, J. Michael Howe, MSLS

Department of Veterans Affairs (13B)

810 Vermont Avenue, NW

Washington, DC 20420

202-273-9206

202-273-6243 (fax)

j.michael.howe@hq.med.va.gov

The *AIDS Information Newsletter* is a biweekly, electronic resource that provides current information to ensure that VA personnel are informed about the latest developments regarding the care of veterans with HIV infection.

VHA Public Health Strategic Health Care Group

Lawrence R. Deyton, MSPH, MD

Chief Consultant

Department of Veterans Affairs (13B)

810 Vermont Avenue, NW

Washington, DC 20420

202-273-8567

202-273-6243 (fax)

<http://vhacoweb1/aidsservice/>

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