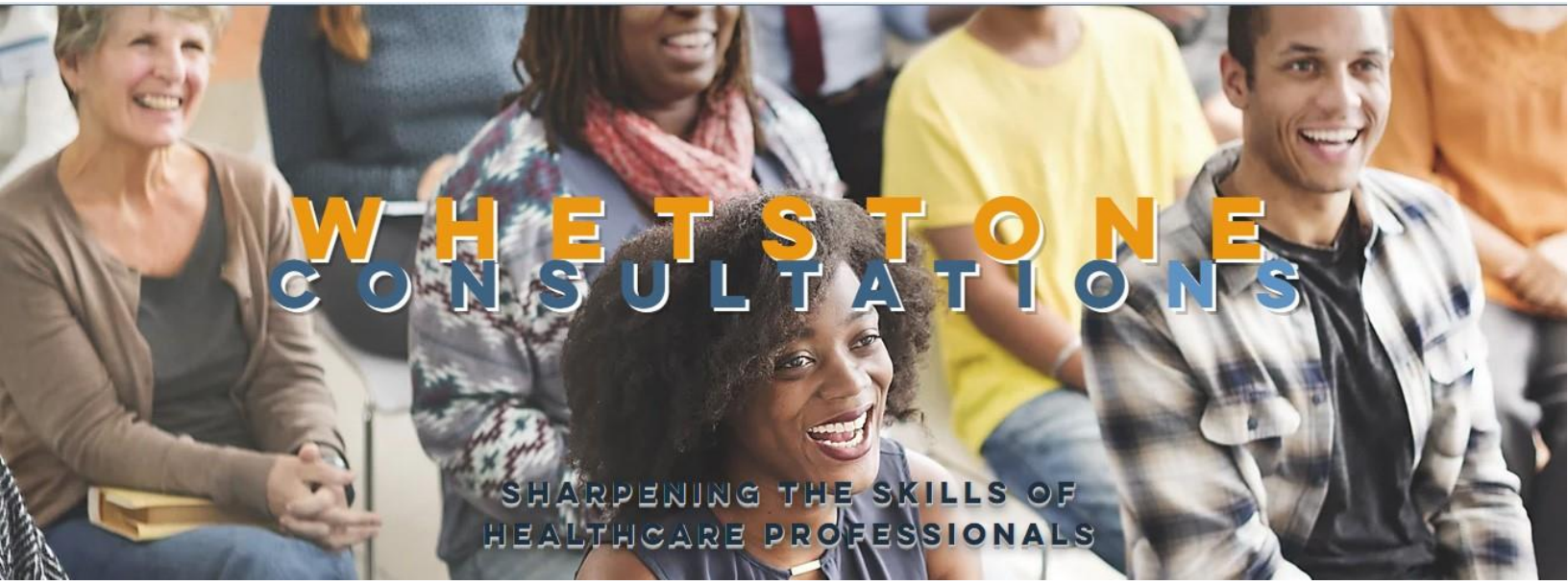
HIV Counseling, Testing & Referral Training
Participant Manual

NC DHHS HIV/STD Prevention and Care Branch
Whetstone Consultations Major Revision 2019



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Agenda

Day 1	Day 2	Day 3
Welcome & Getting Started	Reentry	Reentry
Purpose Question	Treasure Hunt	Guest Speaker: Gender Equity
Participant Introduction	Guest Speaker: Harm Reduction & Needle Exchange	NC Public Health Law
Privacy Squares	Review of Day 1	Role of the Disease Intervention Specialist
Personalizing Risk Activity	Task: Introduction	Task: Giving Negative Test Results
Counseling Skills	Task: Education	Role-Play Demonstration: Giving Test Results
HIV Education	Task: Assess	Role-Play Number 2 in Duos or Trios
The Test: Antibody & Antigen	Task: Prevention	HIV Counseling in Varied Situations
Counseling Skills	Task: Referral	Wrap -Up
Offering Options	Role-Play of "Peter"	
CTR Priorities & Continuum	Stereotyping vs Common Behaviors	
Pluses and Wishes	Role-Play Duos/Trios	
Day 1 Wrap Up	Day 2 Wrap Up	

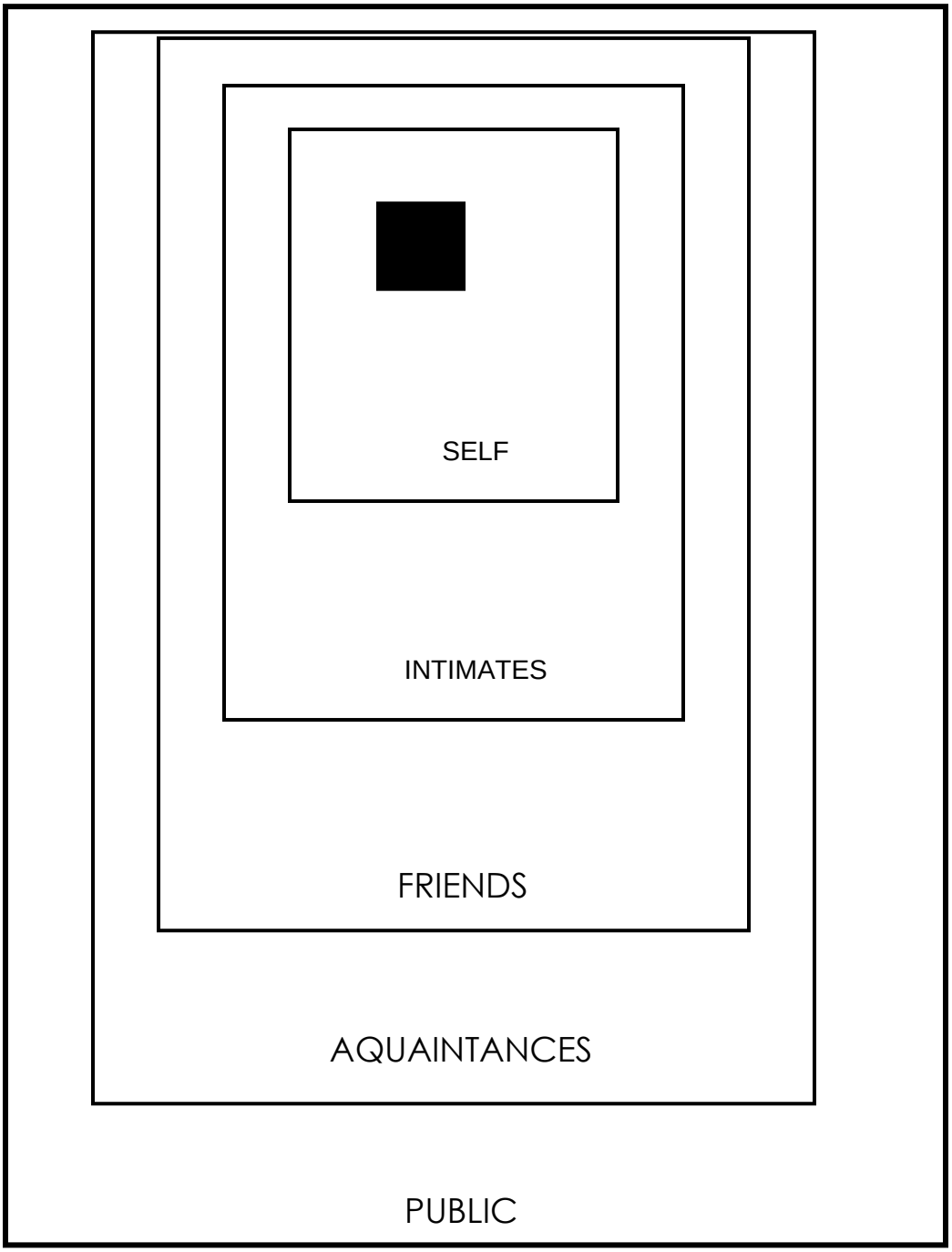
HIV CTR TRAINING OBJECTIVES

- Clarify their communication boundaries and address issues of privacy and openness in sexual and drug use communication.
- Discuss the subjective nature of risk-taking.
- Learn the various attributes of a quality HIV CTR session.
- Learn the basics about Hepatitis A, B and C and how they relate to HIV infection.
- Learn a model to help clients identify risk, set goals, and take the necessary action.
- Learn criteria for making effective referrals.
- Identify counseling skills useful in HIV prevention counseling.
- Learn the major points of the Public Health Code and Law related to HIV counseling, testing and referral.
- Explain the concepts and process of various HIV testing technologies.
- Learn and practice giving HIV test results.
- Learn ways to customize the CTR process to specific situations.

Ideas, Questions and Action Items

During training you may get specific ideas of how you can apply the concepts or skills discussed to your work or personal life. Record them here so you don't forget the insight.

PRIVACY SQUARES



CTR PRIORITIES

The current CDC and NC goal is to widely implement opt-out testing and to deemphasize pretest counseling in most clinic setting. The goals of this opt-out initiative are to …

- Reduce barriers to testing
- De-stigmatize HIV testing
- Identify infection earlier in cases of disease
- Reduce the number of new infections

Definitions

Opt-Out Testing – All clinic patients, without regard to risk, ages 13-64, will be tested unless they decline; consent is still required.

Client Centered Prevention Counseling – Should be available to high-risk patients, HIV positive patients, and patients who request this service.

NOTES:

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HIV COUNSELING CONTINUMM

TASKS	Opt Out to Specific Counseling		
INTRODUCTION	No Intro	→	Explain the Process
EDUCATE	No Education	General Disease Education	Specific Disease Education
ASSESS	No Assessment	Risk Screening	Personalized Risk Assessment
PREVENTION	No Prevention	General Prevention Messages	Goal Setting & Action Plan
TEST	No Information	Basic Explanation	Discussion of Test
REFER	No Referral	Resources	Active Referral
CLOSE	End Session	→	Further Instructions
GIVE TEST RESULTS	No Results Given	Informed of Results	Counseled on Results

COUNSELING SKILLS

Attending

Attending Skills refers to the different ways we use our body to communicate to our client. Some important points to keep in mind are…

Facial Express/ Smile:_____

Eye Contact: _____

Attentiveness: _____

Voice Quality: _____

Paperwork/Computer Work:_____

Using Simple Language

To be best understood by our clients, we must strive to…

- Clarify the client's question or point of misinformation when we are uncertain what they mean.
- Provide a precise, tailored response using simple, non-technical words. Be brief and to the point and say "I don't know" when you don't know something.

Word	How It can be confusing	Say instead
Abstinence		
Body Fluids		
Exposure or exposed		
Monogamous		
Multiple Partners		
Negative or Positive		
Partner		
Protection		
Risk factors		
Sex		
Sexually Active		

Open-Ended Questioning

Open questions allow for explanation and elaboration of the client's answers. They usually are answered with more than a yes/no or single word response.

- 5Ws & an H: W____, W____, W____, W____, W____ & H_____
- Use Polite Imperatives _____
- Allow Silence: _____
- The Nth Degree: _____

SAMPLE Open-Ended Questions

Do you use condoms?
- How often do you use condoms?
- When was the last time you used a condom?
- What type of condoms do you use?

Would you like to find out if you are infected?
- What do you think about finding out if you have HIV?
- When would you like to know if you are infected with HIV?
- How interested are you in learning if you are infected?

Do you shoot drugs?
- How often do you inject drugs?
- When was the last time you shared a needle with someone?
- When was the last time you shot drugs?
- Tell me about the last time you injected drugs.

Do you know how someone can get HIV?
- Tell me what you know about HIV.
- What do you know about how HIV is transmitted?
- Tell me how someone can get HIV.

Do you think you can talk to your partner about protecting yourselves?
- What do you think you will say to your partner about protecting yourselves from HIV?
- What do you think your partner will say when you tell him/her that you want to be safer?

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Reflection

Reflection is stating back to the client in fewer, often more concise words, something that the client just expressed. These paraphrased words can recapture either…

- Content i.e., what is going on, events, timelines, persons, etc.
- Feelings i.e., happiness, fear, anger, etc

Proper reflecting takes the skill of active listening to identify what the client is expressing. To "hear" feelings requires listening with our hearts and guts, as well as with our ears and eyes.

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Third Personing

Third Personing is making statements that acknowledge and normalize feelings expressed by a client by referring to others in similar situations.

Examples:

Many people have…

A lot of my clients say…

Several people I've spoken with have…

I've heard other people…

NOTES:

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TASK: INTRODUCTION

INTRODUCTION

Elements of a good orientation…

- The counselor's full name (both first and last)
- The counselor's function at the present time. i.e. HIV counselor, STD nurse, outreach worker, etc.)
- Clarification on what the client would like to be called.
- Confidentiality: State that the session will be confidential. We recommend that each patient simply be told that the counseling session is confidential and then ask the client if s/he has any questions. Clients should NOT be told that "No one else will know what you tell me" or "What's said in here, stays in here" or similar statements.
- In some cases, where rapid testing is an option, it may be necessary to describe the testing options in the orientation portion. This will vary from site to site.

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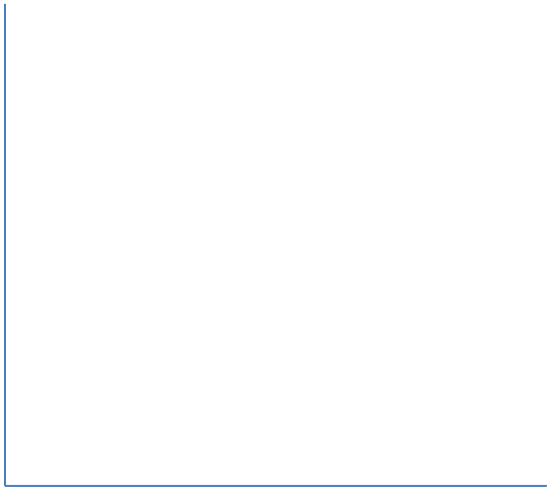
TASK: EDUCATE

HIV Facts

HIV is found in

It is primarily spread in our country by

When HIV enters a person's body it



The HIV window period is

Treatment is

TASK: EDUCATE (pg 2)

Hepatitis Facts

A: Found in Feces

Contracted by:

- Contaminated food
- Getting virus in mouth during oral-anal contact with an infected person

Symptoms:

Feeling tired, joint pain, sick stomach and yellowish eyes and skin.

Vaccination: YES Tx/Cure: No

B: Found in Blood and Sexual Fluids

Contracted by exposure to:

- Unprotected sex with an infected person
- Sharing needles or other drug equipment with an infected person

Symptoms:

Only about half who have Hep B have symptoms which can be feeling tired, joint pain, sick stomach and yellowish eyes and skin.

Vaccination: YES TX/Cure: No

C: Found in Blood & <u>Possibly</u> Sexual Fluids

Contracted by exposure to:

- Sharing needles or other drug equipment with an infected person
- Rarely people get it from unprotected sex with an infected person

Symptoms:

Often symptom free at first but may eventually develop severe liver disease.

Vaccination: No Tx/Cure: Yes

THE ABCS OF HEPATITIS

	HEPATITIS A is caused by the Hepatitis A virus (HAV)	**HEPATITIS B** is caused by the Hepatitis B virus (HBV)	**HEPATITIS C** is caused by the Hepatitis C virus (HCV)
U.S. Statistics	• Estimated 2,500 new infections in 2014	• Estimated 19,200 new infections in 2014 • Estimated 850,000–2.2 million people with chronic HBV infection	• Estimated 30,500 new infections in 2014 • Estimated 2.7–3.9 million people with chronic HCV infection
Routes of Transmission	Ingestion of fecal matter, even in microscopic amounts, from: • Close person-to-person contact with an infected person • Sexual contact with an infected person • Ingestion of contaminated food or drinks	Contact with infectious blood, semen, and other body fluids primarily through: • Birth to an infected mother • Sexual contact with an infected person • Sharing of contaminated needles, syringes, or other injection drug equipment • Needlesticks or other sharp instrument injuries	Contact with blood of an infected person primarily through: • Sharing of contaminated needles, syringes, or other injection drug equipment Less commonly through: • Sexual contact with an infected person • Birth to an infected mother • Needlestick or other sharp instrument injuries
Persons at Risk	• Travelers to regions with intermediate or high rates of Hepatitis A • Sex contacts of infected persons • Household members or caregivers of infected persons • Men who have sex with men • Users of certain illegal drugs (injection and non-injection) • Persons with clotting-factor disorders	• Infants born to infected mothers • Sex partners of infected persons • Persons with multiple sex partners • Persons with a sexually transmitted disease (STD) • Men who have sex with men • Injection drug users • Household contacts of infected persons • Healthcare and public safety workers exposed to blood on the job • Hemodialysis patients • Residents and staff of facilities for developmentally disabled persons • Travelers to regions with intermediate or high rates of Hepatitis B (HBsAg prevalence of ≥2%)	• Current or former injection drug users • Recipients of clotting factor concentrates before 1987 • Recipients of blood transfusions or donated organs before July 1992 • Long-term hemodialysis patients • Persons with known exposures to HCV (e.g., healthcare workers after needlesticks, recipients of blood or organs from a donor who later tested positive for HCV) • HIV-infected persons • Infants born to infected mothers

Incubation Period	15 to 50 days (average: 28 days)	45 to 160 days (average: 120 days)	14 to 180 days (average: 45 days)
Symptoms of Acute Infection	**Symptoms of all types of viral hepatitis are similar and can include one or more of the following:** • Fever • Fatigue • Loss of appetite • Nausea • Vomiting • Abdominal pain • Gray-colored bowel movements • Joint pain • Jaundice		
Likelihood of Symptomatic Acute infection	• < 10% of children < 6 years have jaundice • 40%–50% of children age 6–14 years have jaundice • 70%–80% of persons > 14 years have jaundice	• < 1% of infants < 1 year develop symptoms • 5%–15% of children age 1-5 years develop symptoms • 30%–50% of persons > 5 years develop symptoms **Note:** Symptoms appear in 5%–15% of newly infected adults who are immunosuppressed	• 20%–30% of newly infected persons develop symptoms of acute disease
Potential for Chronic Infection	None	• Among unimmunized persons, chronic infection occurs in >90% of infants, 25%–50% of children aged 1–5 years, and 6%–10% of older children and adults	• 75%–85% of newly infected persons develop chronic infection • 15%–25% of newly infected persons clear the virus
Severity	Most persons with acute disease recover with no lasting liver damage; rarely fatal	• Most persons with acute disease recover with no lasting liver damage; acute illness is rarely fatal • 15%–25% of chronically infected persons develop chronic liver disease, including cirrhosis, liver failure, or liver cancer • 1,800 persons in the United States die with HBV- related liver disease as documented from death certificates	• Acute illness is uncommon. Those who do develop acute illness recover with no lasting liver damage. • 60%–70% of chronically infected persons develop chronic liver disease • 5%–20% develop cirrhosis over a period of 20–30 years • 1%–5% will die from cirrhosis or liver cancer • 19,600 deaths in 2014
Serologic Tests for Acute Infection	• IgM anti-HAV	• HBsAg in acute and chronic infection • IgM anti-HBc is positive in acute infection only	• No serologic marker for acute infection
Serologic Tests for Chronic Infection	• Not applicable—no chronic infection	• HBsAg (and additional markers as needed)	• Screening assay (EIA or CIA) for anti-HCV • Verification by an additional, more specific assay (e.g., nucleic acid testing (NAT) for HCV RNA)

Screening Recommendations for Chronic Infection	• Not applicable—no chronic infection Note: Screening for past acute infection is generally not recommended	Testing is recommended for: • All pregnant women • Persons born in regions with intermediate or high rates of Hepatitis B (HBsAg prevalence of ≥2%) • U.S.–born persons not vaccinated as infants whose parents were born in regions with high rates of Hepatitis B (HBsAg prevalence of ≥8%) • Infants born to HBsAg-positive mothers • Household, needle-sharing, or sex contacts of HBsAg-positive persons • Men who have sex with men • Injection drug users • Patients with elevated liver enzymes (ALT/AST) of unknown etiology • Hemodialysis patients • Persons needing immunosuppressive or cytotoxic therapy • HIV-infected persons • Donors of blood, plasma, organs, tissues, or semen	Testing is recommended for: • Persons born from 1945–1965 • Persons who currently inject drugs or who have injected drugs in the past, even if once or many years ago • Recipients of clotting factor concentrates before 1987 • Recipients of blood transfusions or donated organs before July 1992 • Long-term hemodialysis patients • Persons with known exposures to HCV (e.g., healthcare workers after needlesticks, recipients of blood or organs from a donor who later tested positive for HCV) • HIV-infected persons • Children born to infected mothers (do not test before age 18 mos.) • Patients with signs or symptoms of liver disease (e.g., abnormal liver enzyme tests) • Donors of blood, plasma, organs, tissues, or semen
Treatment	• No medication available • Best addressed through supportive treatment	• Acute: No medication available; best addressed through supportive treatment • Chronic: Regular monitoring for signs of liver disease progression; some patients are treated with antiviral drugs	• New direct acting antiviral medications offer shorter durations of treatment and increased effectiveness, including over 90% of patients who complete treatment are cured

Vaccination Recommendations	Hepatitis A vaccine is recommended for: • All children at age 1 year • Travelers to regions with intermediate or high rates of Hepatitis A • Men who have sex with men • Users of certain illegal drugs (injection and non-injection) • Persons with clotting-factor disorders • Persons who work with HAV- infected primates or with HAV in a research laboratory • Persons with chronic liver disease, including HBV- and HCV-infected persons with chronic liver disease • Family and care givers of recent adoptees from countries where Hepatitis A is common • Anyone else seeking long-term protection	Hepatitis B vaccine is recommended for: • All infants at birth • Older children who have not previously been vaccinated • Susceptible sex partners of infected persons • Persons with multiple sex partners • Persons seeking evaluation or treatment for an STD • Men who have sex with men • Injection drug users • Susceptible household contacts of infected persons • Healthcare and public safety workers exposed to blood on the job • Persons with chronic liver disease, including HCV-infected persons with chronic liver disease • Persons with HIV infection • Persons with end-stage renal disease, including predialysis, hemodialysis, peritoneal dialysis, and home dialysis patients • Residents and staff of facilities for developmentally disabled persons • Travelers to regions with intermediate or high rates of Hepatitis B (HBsAg prevalence of ≥2%) • Unvaccinated adults with diabetes mellitus 19–59 (for those aged ≥60 years, at the discretion of clinician) • Anyone else seeking long-term protection	There is no Hepatitis C vaccine
Vaccination Schedule	2 doses given 6 months apart	• Infants and children: 3 to 4 doses given over a 6- to 18-month period depending on vaccine type and schedule • Adults: 3 doses given over a 6-month period (most common schedule)	No vaccine available

CDC Updated 2016

TASK: ASSESS

Risk Behaviors

Definition: These are the sex or drug-use activities that in and of themselves can result in the transmission of HIV.

Examples may include: Having sex without a condom, getting semen or vaginal fluids in your mouth, sharing a needle, etc.

Risk Screening

Definition: A means to determine what a client/patient has done that could cause HIV infection

Risk Screening can be done in a variety of ways…

- Self-Administered Questionnaire
- History Taking
- Conversation with the Client
- Or a combination of these

TASK: ASSESS (pg 2)

Personalized Risk Assessment

The Set Up:

Ask: "Tell me what you know about how someone gets HIV." Make sure to determine that HIV is transmitted primarily through sex and sharing needles.

"Since sex and sharing needles are the two primary ways HIV is transmitted, those are the things we have to talk about with our clients. I am going to ask some important, but personal, questions so I can understand your risks and help you keep from becoming infected."

1. What kind of sex do you have: oral (your mouth on someone's genitals or someone's mouth on your genitals) or vaginal (penis inserted into a vagina) or anal (penis in an anus or butt)?

2. Do you have sex with people who have a penis or who have a vagina or can have either? (What is the sex of the people you have sex with?)

3. How many people have you had sex with in the past 6 months?

4. When was the last time you put something in your body with a needle?

   OR

   What experience have you had with drugs and needles?
   Then . . . How do you get high? Stoned? Altered?

TASK: PREVENTION

Harm Reduction Messages

Definition: Informing clients what they can do to eliminate or reduce the risk of becoming HIV infected.

Basic Information

1. Do not have oral, vaginal or anal sex.
    - If having sex, use condoms and limit the number of people you have sex with.
2. Do not share needles
    - If sharing needles, clean them before use.

Method:

- Provide a brochure or show a video in waiting room
- Verbally inform clients
- Link risk assessment to specific harm reduction strategies
- Counsel client on individualized strategies

OFFERING OPTIONS: The Buffet

Risk Elimination: Behaviors that essentially eliminate all possibility of becoming HIV infected.

Harm Reduction: Reducing the likelihood that a person will become HIV infected by choosing behaviors that are less likely to cause infection but do not eliminate risk.

What are the 2 most widely promoted strategies put forth by Public Health to prevent becoming infected with HIV (and other STDs)?

1._____ **2.**_____

BUT WAIT…. There are more!
We need to create a BUFFET.

_____ _____

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HARM REDUCTION TECHNIQUES

Using a Condom

Step 1: Check the expiration date. You don't want to use an expired condom that may break. Also, make sure it's stated on the packaging that it meets Australian standards.

Step 2: Open the packet carefully; don't use your teeth as you don't want to tear the condom.

Step 3: Hold the tip of the condom to remove any air and then roll it down to the base of the erect penis. Make sure the condom isn't inside out before attempting to roll it on. If you do roll it on inside out there's a possibility it could have some sexual fluids on it (like pre cum). The best thing to do here is to grab another one and start again.

Step 4: Put some water-based lubricant on the outside of the condom. This will reduce the risk of the condom breaking and even increase pleasure. Do not use oil-based lubricants such as Vaseline; these can sometimes cause the condom to break.

Step 5: After ejaculation, make sure the penis is withdrawn while still erect. Make sure you hold onto the base of the condom while you're withdrawing. You don't want it to slip off.

Step 6: Remove the condom, tie a knot in the end, wrap it in a tissue and put it in the trash Here's a tip: If you are using sex toys, like dildos, it's also a good idea to use condoms on these, as sexual fluids and STIs can be transmitted between partners if you are sharing.

Cleaning Needles

1. Fill the used syringe with clean water.
2. Shake up the water-filled syringe.
3. Squirt the water out. Repeat steps one through three until you no longer see blood in the syringe.
4. Fill the entire syringe with undiluted bleach and leave it in there for 30 seconds or more (try humming the "Happy Birthday to You" song all the way through, three times over).
5. Squirt all the bleach out.
6. Fill the syringe with clean water *again*, shake it up, and squirt the water out. Repeat this step a few times to avoid injecting bleach into the body.

NC SYRINGE EXCHANGE PROGRAMS

Needle Exchange is now legal in North Carolina. There are many agencies and individuals who are working with the needle using population. While there are slight variations among all of the program, the majority disperse clean needles and equipment to anyone who uses a needle for drug use. Some programs collect old needles, although turning in used needles is not a prerequisite to getting clean works.

To get an up-to-date list of programs across NC who do needle exchange, go to the website below. You may want to check back often, as new programs are beginning all the time.

https://www.ncdhhs.gov/divisions/public-health/north-carolina-safer-syringe-initiative/syringe-services-program-north

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PrEP: PRE-EXPOSURE PROPHYLAXIS

www.med.unc.edu/ncaidstraining/prep/PrEP-for-consumers

What is PrEP? :

- Pre-exposure prophylaxis (or PrEP) is a pill that can be prescribed to people who are at significant risk of getting HIV. Most commonly this is a person in a sexual relationship with an HIV positive person.
- This pill is very effective if taken correctly. Taken daily, PrEP reduces the risk of getting HIV from sex by more than 90%. Among people who inject drugs, it reduces the risk by more than 70%. Your risk of getting HIV from sex can be even lower if you combine PrEP with condoms and other prevention methods.
- PrEP can delay the development of antibodies among persons who do become HIV-positive. It is important for people on PrEP to receive regular HIV screening using tests that can detect viral antigens or RNA.

Role of the HIV Counselor:

Increasing the number of people in our communities who take PrEP will decrease the spread of the virus. Therefore, counselors should strive to:

1. Identify people who are good candidates for taking PreP.
2. Help find providers in their community who are willing to administer PrEP.

PrEP Information:

PrEP providers can be found at the website below. Anyone who is willing to become a provider would also go to this website and learn what needs to be done to bring PrEP to their community.

PEP: POST EXPOSURE PROPHYLAXIS

PEP:

- PEP stands for post-exposure prophylaxis. It means taking antiretroviral medicines (ART) after being potentially exposed to HIV to prevent becoming infected.
- PEP must be started within 72 hours after a recent possible exposure to HIV, but the sooner you start PEP, the better. Every hour counts. If you're prescribed PEP, you'll need to take it once or twice daily for 28 days. PEP is effective in preventing HIV when administered correctly, but not 100%.
- PEP is safe but may cause side effects like nausea in some people. These side effects can be treated and aren't life-threatening.
- Your health care provider or an emergency room doctor can prescribe PEP. Talk to them right away if you think you've recently been exposed to HIV.

TASK: PREVENTION (pg 2)

Goals Setting & Action Plans

GOAL SETTING: Establishing specific goal/s that the client wants to adopt that will directly prevent or greatly reduce HIV transmission.

Examples: Knowing the HIV status of your partners, using a condom with anal and vaginal sex, not sharing needles, etc.

ACTION PLAN: Steps that need to be made to achieve the goal. Some example question to ask clients are, "What actions do you have to take to reach your goal?", "What changes have to be made?", "What small changes can you make that will result in less risk?", "What bigger shifts are you willing to try?"
Examples: carrying condoms, talking with your partner, don't get drunk, etc.

Note: For many HIV infected clients, "compliance" with control measures will be a difficult transition. We cannot give them permission to neglect protecting others, so our effort is focused on developing a plan for how to comply.

Examples:

- Eliminate sex with partners who clearly will not use condoms.
- Discuss condoms use with steady partner
- Develop strategies for disclosing HIV status.

HIV TESTING TECHNOLOGIES

Current Testing Technology

It is now common for HIV test to test for antigens as well as antibodies. These tests are sometimes referred to as 4th generation tests or combined antibody/antigen (Ag/Ab) tests.

A reactive result (or a positive) from a fourth generation HIV test means that HIV antigens, HIV-1 antibodies, and/or HIV-2 antibodies were detected.

The window period for the 4th Generation test is 3 weeks.

Specimen Collection

Currently there are three ways to collect a specimen for HIV Testing:

- Blood draw (recommended because other tests such as syphilis can be done)
- Finger Stick
- Oral Swab

Rapid Testing

There are many different brands of HIV test which can be conducted and give a result on the same day. These are called rapid tests. The collection method of rapid test can be either an oral swab or a finger stick. The state recommends that we use a window period of all of these tests as 3 months.

Notes on Testing

NC PUBLIC HEALTH CODE & LAW

The Public Health Law has recently been changed to reflect new advances in treatment. Below are the six disease control measures all HIV positive persons in NC must be told and follow.

All person with HIV must:

1. Use a condom
    a. Exceptions to this CM are:

        - the person living with HIV is **in HIV care**, is **adherent with the treatment plan** of the attending physician, and had been **virally suppressed for at least 6 months** (HIV levels below 200 copies per milliliter) at the time of sexual intercourse;

        - the sexual intercourse partner is HIV positive;

        - the sexual intercourse partner is taking (PrEP) – antiretroviral medication used to prevent HIV infection as directed by an attending physician; or

        - the sexual intercourse occurred in the context of a sexual assault in which the person living with HIV was the victim;

2. Not share needles or any part of the works.

3. Not donate blood, plasma, semen, etc. (unless the person donating is part of a clinical trial).

4. Have a skin test for tuberculosis.

5. Notify current and future sex partners of their HIV test results (unless they meet the exceptions mentions in 1.)

6. Notify past sexual and needle-sharing partners of the past 12 months or so.

10A NCAC 41A .0202 CONTROL MEASURES – HIV

The following are the control measures for the Human Immunodeficiency Virus (HIV) infection:

(1) Persons diagnosed with HIV infection (hereafter "person living with HIV") shall:

(a) refrain from sexual intercourse unless condoms are used except when:

(i) the person living with HIV is in HIV care, is adherent with the treatment plan of the attending physician, and had been virally suppressed for at least 6 months (HIV levels below 200 copies per milliliter) at the time of sexual intercourse;

(ii) the sexual intercourse partner is HIV positive;

(iii) the sexual intercourse partner is taking HIV Pre-Exposure Prophylaxis (PrEP) – antiretroviral medication used to prevent HIV infection as directed by an attending physician; or

(iv) the sexual intercourse occurred in the context of a sexual assault in which the person living with HIV was the victim;

(b) not share needles or syringes, or any other drug-related equipment, paraphernalia, or works that may be contaminated with blood through previous use;

(c) not donate or sell blood, plasma, platelets, other blood products, semen, ova, tissues, organs, or breast milk, except when:

(i) The person living with HIV is donating organs as part of a clinical research study that has been approved by an institutional review board under the criteria, standards, and regulations described in 42 USC 274f-5(a) and (b);

or, if the United States Secretary of Health and Human Services determines under USC 274f-5(c) that participation in this clinical research is no longer warranted as a requirement for transplants, and the organ recipient is receiving the transplant under the criteria, standards, and regulations of USC 274f-5(c); or

(ii) Sperm or ova are harvested under the supervision of an attending physician to be used by the person's spouse or partner for the purpose of achieving pregnancy.

(d) have a test for tuberculosis;

(e) notify future sexual intercourse partners of the infection, unless the person living with HIV meets the criteria listed in Sub-item (1)(a)(i) of this Rule. If the person living with HIV is the victim of a sexual assault, there is no requirement to notify the assailant;

(f) if the time of initial infection is known, notify persons who have been sexual intercourse or needle-sharing partners since the date of infection or give the names to a disease intervention specialist employed by the local health department or by the Division of Public Health for contact tracing and notification; and

(g) if the date of initial infection is unknown, notify persons who have been sexual intercourse or needle-sharing partners for the previous 12 months or give names to a disease intervention specialist employed by the local health department or by the Division of Public Health for contact tracing of all sexual and needle-sharing partners for the preceding 12 months.

(2) The attending physician shall:

(a) give the control measures in Item (1) of this Rule to patients living with HIV in accordance with 10A NCAC 41A .0210;

(b) advise persons living with HIV to notify all future sexual partners of infection;

(c) If the attending physician knows the identity of the spouse of the person living with HIV and has not, with the consent of the person living with HIV, notified and counseled the spouse, the physician shall list the spouse on a form provided by the Division of Public Health and shall send the form to the Division by secure transmission, required by 45 CFR 164.312(e)(1), secure fax at (919) 715-4699. The Division shall undertake to counsel the spouse and the attending physician's responsibility to notify exposed and potentially exposed persons shall be satisfied by fulfilling the requirements of Sub-Items (2)(a) and (c) of this Rule;

(d) advise persons living with HIV concerning proper methods for the clean-up of blood and other body fluids;

(e) advise persons living with HIV concerning the risk of perinatal transmission and transmission by breastfeeding.

(3) The attending physician of a child living with HIV who may pose a significant risk of transmission in the school or day care setting because of open, oozing wounds or because of behavioral abnormalities shall notify the local health director. The local health director shall consult with the attending physician and investigate the following circumstances:

(a) If the child is in school or scheduled for admission and the local health director determines that there may be a significant risk of transmission, the local health director shall consult with an interdisciplinary committee, which shall include school personnel, a medical expert, and the child's parents or legal guardians to assist in the investigation and determination of risk. The local health director shall notify the superintendent or private school director of the need to appoint this interdisciplinary committee. Significant risk of transmission shall be determined in accordance with the HIV Risk and Prevention Estimates published by the Centers for Disease Control and Prevention, which are hereby incorporated by reference including subsequent amendments and editions. A copy of this publication can be accessed at no cost online at https://www.cdc.gov/hiv/risk/estimates/riskbehaviors.html.

(i) If the superintendent or private school director establishes this committee within three days of notification, the local health director shall consult with this committee.

(ii) If the superintendent or private school director does not establish this committee within three days of notification, the local health director shall establish this committee.

(b) If the child is in school or scheduled for admission and the local health director determines, after consultation with the committee, that a significant risk of transmission exists, the local health director shall:

(i) notify the parents or legal guardians;

(ii) notify the committee;

(iii) assist the committee in determining whether an adjustment can be made to the student's school program to eliminate significant risks of transmission;

(iv) determine if an alternative educational setting is necessary to protect the public health;

(v) instruct the superintendent or private school director concerning protective measures to be implemented in the alternative educational setting developed by school personnel; and

(vi) consult with the superintendent or private school director to determine which school personnel directly involved with the child need to be notified of the HIV infection in order to prevent transmission and ensure that these persons are instructed regarding the necessity for protecting confidentiality.

(c) If the child is in day care and the local health director determines that there is a significant risk of transmission, the local health director shall notify the parents or legal guardians that the child must be placed in an alternate child care setting that eliminates the significant risk of transmission.

(4) When health care workers or other persons have a needlestick or nonsexual non-intact skin or mucous membrane exposure to blood or body fluids that, if the source were HIV positive, would pose a significant risk of HIV transmission, the following shall apply:

(a) When the source person is known:

(i) The attending physician or occupational health care provider responsible for the exposed person, if other than the attending physician of the person whose blood or body fluids is the source of the exposure, shall notify the attending physician of the source that an exposure has occurred. The attending physician of the source

person shall discuss the exposure with the source and, unless the source is already known to be living with HIV, shall test the source for HIV infection with or without consent unless it reasonably appears that the test cannot be performed without endangering the safety of the source person or the person administering the test. If the source person cannot be tested, any existing specimen shall be tested. The attending physician of the source person shall notify the attending physician of the exposed person of the infection status of the source.

(ii) The attending physician of the exposed person shall inform the exposed person about the infection status of the source, offer testing for HIV infection as soon as possible after exposure and at reasonable intervals until the interval since last exposure is sufficient to assure detection using current CDC HIV testing guidelines, and, if the source person was HIV positive, give the exposed person the control measures listed in Sub-Items (1)(a) through (c) of this Rule. The CDC HIV testing guidelines are hereby incorporated by reference including subsequent amendments and editions. The CDC HIV testing guidelines can be accessed at no cost online at https://www.cdc.gov/hiv/guidelines/testing.html, with the most current updates found at https://stacks.cdc.gov/view/cdc/23447. The attending physician of the exposed person shall instruct the exposed person regarding the necessity for protecting confidentiality of the source person's HIV status.

(b) When the source person is unknown, the attending physician of the exposed persons shall inform the exposed person of the risk of transmission and offer testing for HIV infection as soon as possible after exposure and at reasonable intervals until the interval since the last exposure is sufficient to assure detection using the current CDC HIV testing guidelines.

(c) A health care facility may release the name of the attending physician of a source person upon request of the attending physician of an exposed person.

(5) The attending physician shall notify the local health director when the physician has cause to suspect a patient living with HIV is not following or cannot follow control measures and is thereby causing a significant risk of transmission. Any other person may notify the local health director when the person has cause to suspect a person living with HIV is not following control measures and is thereby causing a significant risk of transmission.

(6) When the local health director is notified pursuant to Item (5) of this Rule of a person who is mentally ill or intellectually impaired, the local health director shall confer with the attending mental health physician or Local Management Entity/Managed Care Organization and the physician, if any, who notified the local health director to develop a plan to prevent transmission.

(7) The Division of Public Health shall notify the Director of Health Services of the North Carolina Department of Public Safety and the prison facility administrator when any person confined in a state prison is determined to be living with HIV. If the prison facility administrator, in consultation with the Director of Health Services, determines that a confined person living with HIV is not following or cannot follow prescribed control measures, thereby presenting a significant risk of HIV transmission, the administrator and the Director shall develop and implement jointly a plan to prevent transmission, including making recommendations to the unit housing classification committee.

(8) The local health director shall ensure that the health plan for local jails include education of jail staff and prisoners about HIV, how it is transmitted, and how to avoid acquiring or transmitting this infection.

(9) Local health departments shall provide counseling and testing for HIV infection at no charge to the patient. Third party payers may be billed for HIV counseling and testing when such services are provided and the patient provides written consent.

(10) HIV pre-test counseling is not required. Post-test counseling for persons living with HIV is required, must be individualized, and shall include referrals for medical and psychosocial services and control measures counseling.

(11) Notwithstanding Rule .0201(d) of this Section, a local or state health director may require, as a part of an isolation order issued in accordance with G.S. 130A-145, compliance with a plan to assist the individual to comply with control measures. The plan shall be designed to meet the specific needs of the individual including linkage to care and may include referral to one or more of the following available and appropriate services:

(a) substance abuse counseling and treatment;

(b) harm reduction services;

(c) mental health counseling and treatment required to prevent transmission;

(d) education and counseling sessions about HIV, HIV transmission, and behavior change required to prevent transmission; and

(e) intimate partner violence intervention services.

(12) The Division of Public Health shall conduct a partner notification program to assist in the notification and counseling of partners of persons living with HIV.

(13) Every pregnant woman shall be offered HIV testing by her attending physician at her first prenatal visit and in the third trimester. The attending physician shall test the pregnant woman for HIV infection, unless the pregnant woman refuses to provide informed consent pursuant to G.S. 130A-148(h). If there is no record at labor and delivery of an HIV test result during the current pregnancy for the pregnant woman, the attending physician shall inform the pregnant woman that an HIV test will be performed, explain the reasons for testing, and the woman shall be tested for HIV without consent using a rapid HIV test unless it reasonably appears to the clinician that the test cannot be performed without endangering the safety of the pregnant woman or the person administering the test. If the pregnant woman cannot be tested, an existing specimen, if one exists that was collected within the last 24 hours, shall be tested using a rapid HIV test. The attending physician must provide the woman with the test results as soon as possible.

(14) If an infant is delivered by a woman with no record of the result of an HIV test conducted during the pregnancy and if the woman was not tested for HIV during labor and delivery, the fact that the mother has not been tested creates a reasonable suspicion pursuant to G.S. 130A-148(h) that the newborn has HIV infection and the infant shall be tested for HIV. An infant born in the previous 12 hours shall be tested using a rapid HIV test

(15) Testing for HIV may be offered as part of routine laboratory testing panels using a general consent that is obtained from the patient for treatment and routine laboratory testing, so long as the patient is notified that they are being tested for HIV and given the opportunity to refuse.

History Note:
Authority G.S. 130A-135; 130A-144; 130A-145; 130A-148(h);
Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988;
Eff. March 1, 1988;
Amended Eff. February 1, 1990; November 1, 1989; June 1, 1989;
Temporary Amendment Eff. January 7, 1991 for a period of 180 days to expire on July 6, 1991;
Amended Eff. May 1, 1991;
Recodified from 15A NCAC 19A .0201 (d) and (e) Eff. June 11, 1991;
Amended Eff. August 1, 1995; October 1, 1994; January 4, 1994; October 1, 1992;
Temporary Amendment Eff. February 18, 2002; June 1, 2001;
Amended Eff. January 1, 2018; November 1, 2007; April 1, 2005; April 1, 2003.

NOTES from Legal Lecture:

TASK: TESTING

Explanation of the HIV Test

Point to Discuss:

- How the specimen will be collected.
- How and when the result will be given.
- What the test results will mean.
- The need for a second test due to risk within the past 3 weeks.
- What happens when a test is positive (a great detail of discussion about this is not necessary unless the client has specific questions)

Sample questions to help clients determine if they are ready to know their status:

- What will you do if your test comes back positive?
- What will you do if your test comes back negative?
- Who knows you're here today? / Who knows you're getting an HIV test?

TASK: REFER

Effective Referrals

Definition of Referral: an assessment and prioritization of the client's need for care and supportive services and a link to those services.

Referral can be as simple as providing the client with a list of community resources or as complex (active referral) as direct assistance, support and follow up of the link of client and resources.

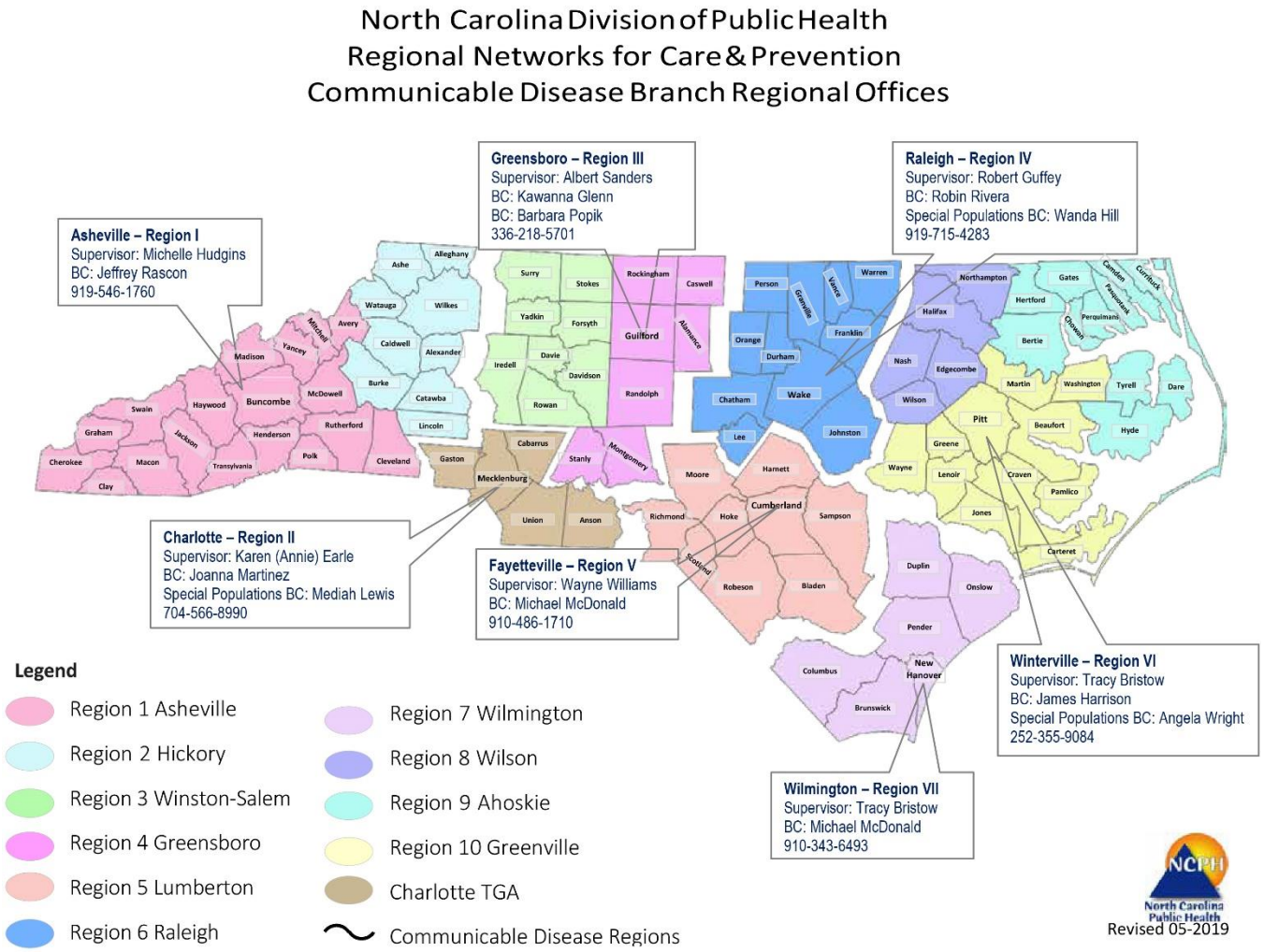
- Help client define priorities
- Discuss and brainstorm options
- Sell the service then offer the referral
- Refer to known and trusted services
- Assess the client's response to a referral
- Facilitate an active referral
- Develop a follow-up plan
- Be aware of confidentiality issues

REGIONAL MAP & PATIENT CARE PROVIDERS

For an updated list of NC HIV Patient Management Providers go to:

www.epi.dph.ncdhhs.gov/cd/hiv/docs/HIVPatientManagementNetworks_062519.pdf

REGIONAL OFFICES



TASK: CLOSE

Summarizing & Closing

Summarizing: Formulating & giving the client a concise statement that briefly describes what has been discussed and decided. It also lists the contracts or commitments for harm reduction, referrals, and next steps.

Example of summarizing:

- *"So, we've talked about how having sex without a condom could cause infection. And we've talked about how you plan to carry condoms with you when you go out."*
- *So, you've told me that you plan to talk to your partner Patricia about coming in together for counseling."*

Closing: Closure creates a confirming and supportive reminder and validation of the work between client and counselor.

Examples of Closure:

- *"Do you have any questions?"*
- *"What else can I do for you today?"*

TASK: GIVING NEGATIVE TEST RESULTS

Test Result Counseling: Negative

- Be sure that the client matches the name and other information on the lab sheet/chart.

- Give the test results immediately. Avoid chit-chatting with the client.

- Do not say, "You do not have HIV". Instead say "Your test came back negative. This means that HIV was not detected." Explain that a negative test means that the client was not infected with HIV three months prior to taking the test. Link your client's actual situation to their need to be retested.

- Discuss the need for a second antibody test. This is necessary when the client has had risk (i.e. unprotected sex or needle sharing, etc.) within 3 weeks of the last test.

- Review the clients personal risk behaviors and circumstances.

- Discuss the client's successes or failures in practicing harm reduction.

- Adjust the harm reduction plan if need be.

- Make appropriate referrals.

TASK: GIVING POSITIVE TEST RESULTS

- Be sure that the client matches the name and other information on the lab/test results.

- Give the test results immediately. Say very clearly, "Your test is positive. This means that you have HIV infection." Do not say, "I'm sorry."

- Allow silence. Do not rush the client.

- Assess the client's understanding of the results including the ability to transmit the virus to others.

- Ask, "Who have you told about getting your results today?" This may be a clue to a person who will provide support.

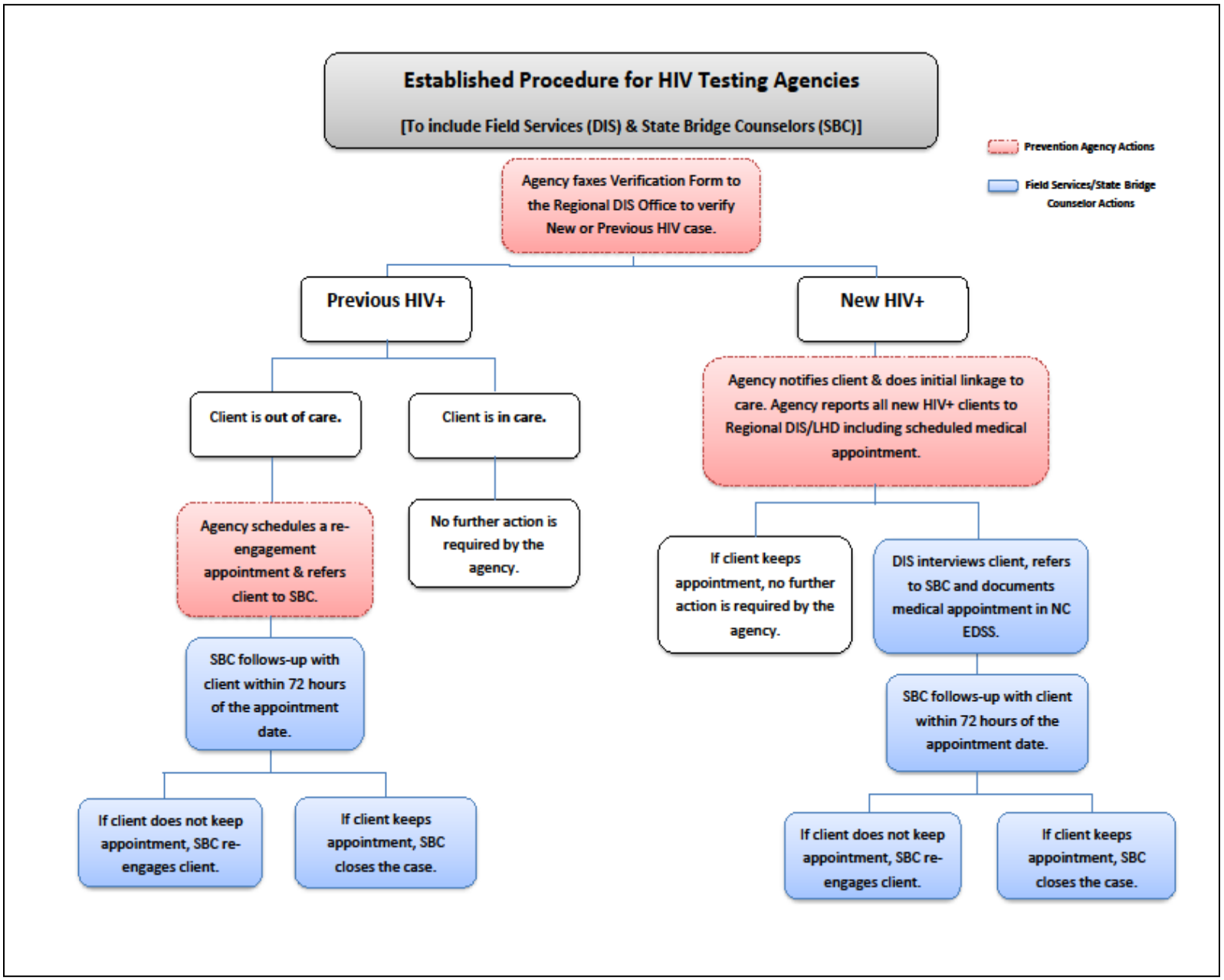
- Legal Requirements:
    - Give client Disease Control Measures. Some agencies have clients sign that Control Measures were given.
    - Complete spousal notification (if applicable)
    - Advise client on procedure for cleaning blood spills
    - Advise client of risk of perinatal transmission and transmission by breast feeding

- Tell the client that a Disease Intervention Specialist (DIS) will be in contact with him or her in the near future. Explain the DIS's function (i.e. follow-up counseling and to help notify their past partners) and their willingness to be of service.

- Refer them to a Health Care Provider asap.

ALGORITHM FOR HIV LINKAGE TO CARE

It is largely the role of the DIS to make sure the HIV person is linked to care, however the HIV counselor plays an important role. As a counselor it is critical to **confirm the patient's locating information** (i.e. address, phone, etc.) and to mention the importance of early treatment. In some cases, it may be advantageous to **make the client an appointment with a provider** on the day their test results are given.



VARIED SCENARIOS FOR CTR PROCESS

Example #1:

Setting: Outreach testing with OraQuick in a bar on a Friday night with the goal of testing as many people as possible or a local health department STD clinic with the same goal.

TASK	Method/Task Content
Educate	A Brochure with disease information…
Prevention	…and prevention information
Assess	Risk screening tool
Introduction	Get consent
Test	Brochure: how the test works and what it means
Give Results	Give results - Negative
Refer	Resource List
Close	"Thanks for Coming"
OR	
Give Results	Give results – Positive Give control measures, action plan, etc.
Refer	…to DIS and case manager
Close	Support encourage & restate plans

Example #2:

Setting: Outreach testing in a community center during the day using OraQuick with a goal to offer testing to as many people as possible and get each client to commit to one risk reducing behavior change

TASK	Method/Task Content
Educate	A Brochure with disease nformation
Assess	Risk screening tool
Introduction	Brief conversation
Test	Explain test procedure & the meaning of the results; get consent
Give Results	Give results - Negative
Prevention	Based on risk screening, help he client commit to one thing hey can change to reduce heir risk.
Refer	Provide information on esources linked to risk creening.
Close	Support, encourage & restate plan
OR	
Give Results	Give results – Positive Give control measures, action plan, etc.
Refer	…to DIS and case manager
Close	Support encourage & restate plans

Example #3:

Setting: Testing up on request at a fixed community based organization site using conventional testing with goal to help clients understand their risk and develop a plan to reduce or eliminate their risk.

Initial Visit

TASK	Method/Task Content		
Introduction	Conversation		
Assess	4 questions and exploration		
Educate	Link disease information to risk		
If a low-risk client…		*If a high-risk client.*	
Prevention	Brochure with harm reduction messages	**Prevention**	Goal setting & Action Plan
Test	Test and explain process & meaning of result	**Test**	Testing process & meaning of results
Close	Instruct to return for results	**Refer**	Link resources to risk
		Close	"Thanks" and "done good work", restate plan; instruct to return for results

Return Visit Low Risk

TASK	Method/Task Content
Introduction	Welcome back
Give Results	Give results - Negative
Prevention	Link risk & results and make a plan to stay that way.
Refer	Provide resources linked to risk assessment & action plan
Close	Use "good news" to say negative

Return Visit High Risk

TASK	Method/Task Content
Introduction	Welcome back
Give Results	Give results - Negative
Prevention	Review Action Plan
Refer	Review/Adjust/add referrals
Close	"thanks" and "good work; instruct to return for 2nd test

ADDITIONAL RESOURCES

NATIONAL AND STATE INFORMATION

- CDC HIV Fact Sheets: www.cdc.gov/hiv/pubs/facts.htm#Role
- Revised Guidelines for HIV Counseling, Testing and Referral: www.cdc.gov/mmwr/PDF/rr/rr5019.pdf
- North Carolina State Facts: HIV/AIDS in North Carolina: www.aidsaction.org/communications/publications/statefactsheets/pdfs/northcarolina_2003.pdf
- Planned Parenthood Federation of America: www.ppfa.org
- Sexuality Information and Education Counsel of the US (SIECUS) www.,seicus.org
- HIV and It's Treatment: What You Should Know: www.aidsinfo.nih.gov/other/cbrochure/english/cbrochure_en.pdf

HOTLINES

- National STD/AIDS Hotline
  (800) 227-8922 or (800) 342-2437
  En Español (800) 344-7432
  www.ashatd.org
- National Herpes Hotline: 919-361-8488

MISC. SERVICES

- Project Access: www.aegis.com/factshts/network/access/index.html
- Project Inform: www.projinf.org/org/Regionrsrc/NC.html
- Center for AIDS Research: www.cfar.unc.edu
- HIV Glossary of Terms: www.aidsinfo.nih.gov/ed_resources/glossary/

HEPATITIS

- http://www.cdc.gov/ncidod/diseases/hepatitis/
- http://www.hepfi.org/
- http://hepatitis-central.com/
- http://www.immunize.org/

Lab Procedures	
HIV, syphilis, hepatitis gonorrhea/chlamydia testing	Myra Brinson: 919-807-8835
Reportability	
New cases of HIV, syphilis, GC/CT, acute HCV	Your Local Health Department
Reportability Disease rules for the Branch	Vanessa Greene: 919-546-1658
Public Health Law	
	Chris Hoke: 919-707-5006 Dr. Victoria Mobley: 919-546-1639
Role of Disease Intervention Specialist	
	Dr. Victoria Mobley: 919-546-1639 Todd Vanhoy: 336-218-5708 ext. 204 Regional Office DIS Supervisors
Giving HIV Results	
HIV Counseling Procedures	Cheri Britton: 828-225-8522 Ron Higginbotham : 919-755-3139
Accessing HIV test results through SLPH	Myra Brinson: 919-807-8835
DIS role in case notification and partner notification	Dr. Victoria Mobley: 919-546-1639 Todd Vanhoy: 336-218-5708 ext. 204
Non-Traditional Test Sites	
Outreach Testing Sites	Marti Eisenberg : 919-755-3145
Substance abuse testing sites	Kristena Clay-James : 919-755-3150
Jail Testing	Ron Higginbotham : 919-755-3139
Rapid Testing Sites	Carlotta McNeil: 919-755-3148
Supervisor	Pete Moore : 919-755-3140
Opt Out Testing	
	Ron Higginbotham : 919-755-3139 Pete Moore : 919-755-3140
Rapid HIV Testing	
	Carlotta McNeil: 919-755-3148
Hepatitis	
Clinical aspects of Viral Hepatitis	Christina Caputo : 919-546-1634
HCV Testing	Marti Eisenberg : 919-755-3145
Syphilis	
Clinical Aspects	Dr. Victoria Mobley: 919-546-1639
Partner services and case notification	Todd Vanhoy: 336-218-5708 ext. 204 Regional DIS field offices

CaseManagement	
Ryan White Care Providers & Services	Bob Winstead: 919-755-3122
Regional Networks of Care	Bob Winstead: 919-755-3122
AIDS Drug Assistance Program	Amanda Greene: 919-546-1691
State Bridge Counselors and Linking and re-engaging HIV cases to care	Dr. Victoria Mobley: 919-546-1639