

**Recommendations for Conducting  
Integrated Partner Services  
for  
HIV/STD Prevention**

**Division of Health, Wellness and Disease Control  
Michigan Department of Community Health**

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## EXECUTIVE SUMMARY

In October 2008, the Centers for Disease Control and Prevention (CDC) released *Recommendations for Partner Services Programs for HIV Infection, Syphilis, GC, and Chlamydia Infection* (MMWR October 30, 2008 / 57(Early Release); 1-63). The CDC *Recommendations* provide guidance to state health departments to provide effective oversight of integrated partner services (PS) for Human Immunodeficiency Virus (HIV) infection, early syphilis, gonorrhea, and chlamydia.

The Michigan Department of Community Health (MDCH), Division of Health, Wellness and Disease Control (DHWDC) developed the following *Recommendations for Conducting Integrated Partner Services for HIV/STD Prevention* to guide and inform the provision of PS in Michigan by articulating standards for these services. These recommendations address multiple audiences including local health departments (LHDs), community-based organizations (CBOs), and other medical providers, who diagnose, treat and/or provide case management services for HIV and/or other sexually transmitted diseases (STDs). For the purposes of this document, a standard is: 1) any task or activity mandated by local, state, or federal law; or 2) is the policy of the MDCH.

Partner services is an interrelated set of services through which infected persons and their at-risk sex and/or needle-sharing partners receive educational and risk reduction counseling, testing, and treatment, as well as referral to care and other support services. The overarching goal of PS is to maximize the number of partners who are: 1) notified of their exposure to HIV, syphilis, GC, or chlamydia; 2) clinically evaluated; and, 3) treated or linked to medical, prevention, and other services.

Sexually transmitted disease (STD) and HIV prevention and case management share many similarities that allow for one set of recommendations that guide PS. It is, however, important to acknowledge the critical differences in service provision. Two such differences are (1) the legal mandate for HIV PS and (2) the curable nature of STDs. These *Recommendations* address these differences.

Partner services is both effective and cost efficient with respect to the control of disease transmission. Therefore, **the MDCH recommends that all persons with newly diagnosed or reported HIV infection or early syphilis receive PS with active health department involvement.** Persons with a diagnosis of GC or chlamydial infection also benefit from PS. Additionally, because co-infection with HIV and other STDs is common, and rates of co-infection have increased in recent years, all persons diagnosed with HIV should be tested for other STDs, and vice versa.

Program standards for the provision of PS, by disease, are summarized below. Detailed discussion of specific recommendations is also presented and is accompanied by operational guidance and tools designed to support their adoption.

## **Early Syphilis**

In Michigan, state law requires that all positive syphilis serologies be reported to the LHD within 24 hours of specimen finding (*Michigan Compiled Laws (MCL) 333.5111(2)(a), Communicable Disease Administrative Rules 325.172 - 173*). The MDCH PS staff is assigned to LHDs throughout the state and are responsible to review all reports of positive serologies to determine priority investigations.

Determining the stage of syphilis is a highly complex process, as infected individuals can have an indefinite reactive syphilis test. The MDCH PS staff use multiple pieces of information, including historical client data, to identify potential new cases, and work closely with clinicians to assure the timely treatment and investigation of every potential early syphilis case.

Physicians are required to provide all diagnostic, treatment, and demographic information to assist in comprehensive case management (*Communicable Disease Administrative Rule 325.173*). New technologies allow for the reporting of STD cases directly into the Michigan Disease Surveillance System (MDSS), an electronic data system that allows for the collection of STD specific information. Access to this system requires permission from the MDCH.

Once it has been determined that an individual is likely a new case of syphilis, the MDCH PS staff will follow up to ensure treatment as well as interview each client to educate them on their infection, provide referrals, and elicit information on critical period partners. Each partner is contacted, informed of their exposure, and provided with assistance to access services to be evaluated and treated. It is critical that this process happen as rapidly as possible as syphilis infection could be avoided if treated during incubation.

## **Gonorrhea and Chlamydia**

Gonorrhea (GC) and chlamydia (CT) are the most commonly reported diseases in Michigan. The prevalence of these infections presents significant challenges to a public health system with diminishing resources. In Michigan, all cases of GC and CT are reported to the local health jurisdiction within 24 hours of specimen finding, (*MCL§ 333.5111(2)(a), Communicable Disease Administrative Rules 325.172 - 173*), and entered into the MDSS. The MDSS has enhanced local capacity to provide timely follow-up to priority GC and CT cases in that many positive results are reported electronically. The system also includes a case management module that allows immediate transfer of information.

As evidence supports that PS can reduce the burden of GC in a community, it is recommended that all persons with newly diagnosed or reported GC be offered PS. Providers should also consider criteria to prioritize these interviews, such as providing active PS to all pregnant females.

Local health department program managers should consider what resources and services will be devoted to PS for CT. Minimally, each client identified by local health should be offered a partner referral packet containing information for the infected client and their partners, including perforated cards for referring partners to testing and treatment.

Recognizing that limited resources and capacity make delivery of PS for GC and CT challenging, the MDCH has developed several tools to assist in this process. These tools are described in “STD Response” sections of both the *Partner Services Delivery Standards for Medical Providers* and the *Partner Services Delivery Standards for Community Based Organizations* in this document.

## **HIV**

Michigan Compiled laws (MCL) 333.5114 and 333.5114a require that a person or governmental entity that administers a test for HIV refer the tested individual to the appropriate LHD for the purpose of PS if the following conditions apply:

- a. The test results indicate that the individual is HIV infected; and
- b. The entity that administered the test determines that the individual needs assistance with partner notification.

As part of the referral process, testing entities must provide the LHD with information about the infected client that is necessary to carry out partner notification. At a minimum, this information should include (but is not limited to) the name, address and telephone number of the infected individual. PS for HIV is, by law, confidentially administered, and conducted in a direct one-on-one conversation between public health PS staff and the infected individual.

Additionally, MCL 333.5131(5)(b) imposes an affirmative duty of physicians and local health officers to notify a known at-risk contact to an HIV-infected individual of their exposure or refer the contact and/or the infected individual to the LHD for assistance with PS.

Once a LHD receives a request for PS, staff must contact the infected individual within 14 days of the referral and provide counseling, elicit partners, and support linkage with needed prevention, treatment and support services.

Not every case of HIV is or can be referred to the LHD for assistance with PS. Therefore, these *Recommendations* encourage collaborative relationships between medical providers, LHDs, CBOs, and others to ensure that the range of prevention, treatment and support needs of individual clients can be appropriately addressed. Alternative strategies for partner notification are described.

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# **INTRODUCTION**

## INTRODUCTION

The *Recommendations for Conducting Integrated Partner Services for HIV/STD Prevention* provides guidance to LHDs, CBOs, medical providers, and other PS providers to offer PS to individuals diagnosed with HIV and/or syphilis, GC and CT, and to their at-risk sex or needle-sharing partners. PS is one component of a multi-faceted case management program that serves to reduce the transmission of disease, lessen complications, and reduce the disease burden in communities. Through PS, infected persons and their at-risk sex or needle-sharing partners receive educational and risk reduction counseling, testing, and treatment, as well as referral to care and other support services. The goal of PS is to maximize the number of partners who are: 1) notified of their exposure to HIV, syphilis, GC or CT; 2) clinically evaluated; and, 3) treated or linked to medical, prevention, and other services. All PS programs should be able to demonstrate, through monitoring and evaluation, that their programs are effectively striving toward this goal.

These recommendations are designed to strengthen existing PS activities by providing new strategies for working with identified populations, and embracing a more collaborative approach to disease case management. Active health department involvement is essential so that all persons in need of PS have an opportunity to obtain prevention, care and other supportive services. The Centers for Disease Control and Prevention (CDC) strongly recommends, and it is the MDCH's expectation, that all persons with newly diagnosed or reported HIV infection or early syphilis receive PS with active health department involvement. In the past, HIV and STD PS addressed each disease separately, operating under different rules and, to some extent, different philosophies. The goal of these recommendations is to bridge those differences and provide PS in a more consistent manner.

These recommendations support the MDCH's efforts to increase the understanding of PS throughout the Department and statewide; clarify legal statutes that support PS delivery; and detail operational standards. These recommendations also serve to encourage and facilitate collaborative efforts with the private medical community, support PS staff in fulfilling their duties, and enhance accountability for those providing PS. The MDCH-supported HIV/STD prevention and care programs should view these *Recommendations* as a tool to enrich PS delivery. The broad objective for their adoption is to reduce the transmission of disease as part of a comprehensive approach to overall disease case management.

This document is divided into sections to allow for easy reference by physicians, care providers, community-based agencies, and LHD staff involved in PS delivery. Specific contents of the document are either italicized or shaded to draw emphasis to activities required by legal mandate or dictated by program policy or operations.

## **METHODS**

The *Recommendations for Conducting Integrated Partner Services for HIV/STD Prevention* replaces prior recommendations and protocol for the provision of PS. These recommendations provide the tools necessary to integrate disease prevention services provided to both HIV and STD infected clients and their at-risk sex and needle-sharing partners.

Michigan's process for revising its *Partner Counseling and Referral Services Protocol* was a collaborative initiative undertaken with the assistance of key staff from sections and units in the DHWDC (the internal workgroup) and representatives from various community stakeholder groups (the external workgroup). Community stakeholders consisted of staff from community-based agencies, HIV and STD clinics in LHDs, physicians and other providers, social workers, persons living with or affected by HIV/AIDS, and HIV/AIDS surveillance staff. All participants in this collaborative effort were knowledgeable about PS and interested in sharing their experiences and expertise to develop a working document that addressed the needs of identified populations, as well as the staff charged with delivering PS.

During the 2009 calendar year, the DHWDC sought input from both the internal and external workgroups. The workgroups participated in several meetings and an online survey was conducted with medical providers. The group reviewed current program practices against the 2008 CDC *Recommendations* and identified gaps in current PS delivery. The DHWDC also held discussions with three different focus groups (25 people total) living with HIV/AIDS. Fashioned after the collaborative workgroup discussions, the focus groups were designed to identify challenges with receiving PS and their overall impressions and perceptions of the PS process. Information obtained from our internal and external workgroups, the provider survey and the focus groups resulted in the drafting of a Gap Analysis Report.

To help clarify the findings of the Gap Analysis Report, the DHWDC employed a consulting firm to: 1) synthesize the findings; 2) prioritize the findings; and 3) offer recommendations towards an implementation plan based on these findings. While these recommendations serve as the structural basis for PS delivery in Michigan, the DHWDC will continue its efforts toward the development of an implementation plan reflective of Michigan's desire to strengthen PS programming for LHDs, CBOs and medical providers.

## **PURPOSE OF PARTNER SERVICES**

Partner Services includes a broad array of support systems offered to persons diagnosed with HIV, syphilis, GC, or CT infection, and their partners. Components of PS include partner notification, prevention counseling, testing for HIV and other STDs, treatment or linkage to medical care, referral to prevention services, and linkage or referral to other health, prevention and social services (e.g., case management,

reproductive health, prenatal care, substance abuse treatment, housing assistance, legal, hepatitis screening, immunization, and mental health services).

Michigan's PS process is a public health strategy to prevent the spread of HIV and other STDs. Research suggests that the majority of new infections that occur in the United States originate from infected persons who are not aware of their infection.

Introducing clients to PS at the time of testing, and again upon the receipt of a positive result, will help to ensure that they are aware of both the availability and the importance of this service. Through PS, infected individuals/clients receive counseling about their infection, and are provided risk reduction and referral information. Infected clients also receive testing and treatment for other infections and counseling on the importance of notifying their at-risk partners to prevent further transmission and/or re-infection. At-risk partners, once located, receive confidential (one-on-one) notification of their potential exposure, are offered testing for the infection to which they were exposed (and others), are offered prophylactic treatment, if indicated, and are referred to other care and support services. At no time, during the notification process, is information about the infected client shared with the partner.

Partner Services is a tool that is part of a comprehensive program intended to complement other prevention, care, and medical services to ensure that infected and at-risk populations are offered services to meet their health needs. PS assistance is available through LHDs, CBOs, correctional settings, and providers in both public and private medical settings.

The goals of PS for infected persons, their partners, and the community, as outlined by the CDC, are as follows:

#### Infected persons

- Maximize access to PS by providing all infected persons with support to ensure that at-risk partners are confidentially informed of their exposure.
- Maximize effective linkage to medical care, treatment, prevention, and other service interventions to reduce the risk of transmission.

#### Partners of infected persons

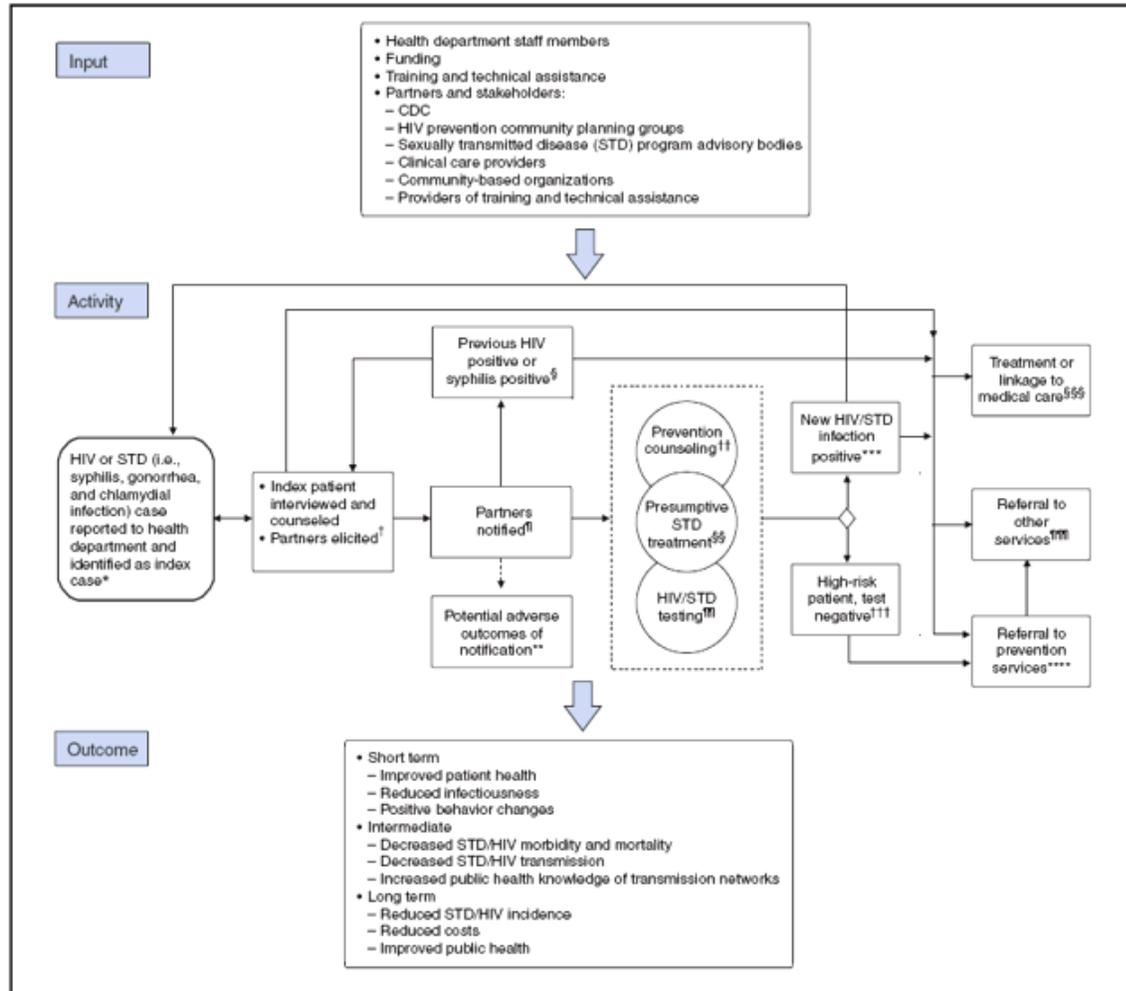
- Maximize the proportion of partners who are identified and notified of their exposure.
- Maximize early linkage of partners to testing, medical care, prevention, and other services.

#### Community

- Reduce future rates of transmission by aiding in early diagnosis and treatment (for STDs), ongoing care (for HIV) and provision of prevention services.

As detailed in the logic model presented below, PS programs have a number of contributing partners, entail numerous activities, and offer substantial benefits to persons infected with HIV infection or other STDs, their partners, and the community.

FIGURE 1. Logic model for partner services programs for human immunodeficiency virus (HIV) infection, syphilis, gonorrhea, and chlamydial infection



\* Cases may be reported to the health department surveillance unit by clinical providers (including STD and other health department clinics), counseling and testing providers, or laboratories. Cases may be reported to the partner services program through the surveillance unit or directly by providers or laboratories.

† Demographic and risk information obtained from interviews can be provided back to the health department surveillance unit through the Health Department Partner Services Program.

‡ Cases of serofast syphilis (i.e., low and stable titers) are closed at this point.

§ Partners may be notified of exposure via provider referral, third-party referral, self-referral, contract referral, or dual referral.

\*\* Adverse outcomes of partner notification include intimate partner violence or relationship dissolution.

†† Client-centered prevention counseling should be available for partners.

‡‡ Treatment for bacterial STDs (e.g., syphilis, gonorrhea, or chlamydial infection) administered presumptively should be available for partners.

‡‡‡ HIV/STD testing should be available for partners.

\*\*\*\* Laboratory results confirm new HIV case, STD case, or both.

†††† Laboratory results are negative for HIV, STDs, or both, but person is at high risk for HIV or STDs.

§§§ Clients who test positive for bacterial STDs (e.g., syphilis, gonorrhea, or chlamydial infection) who were not treated presumptively are treated or referred for treatment. Clients who test positive for HIV are linked to medical care, which includes STD screening, hepatitis B vaccination, and other medical services.

¶¶¶ Clients are referred or directly linked to other services, such as mental health treatment and social services such as housing, case management, and support groups.

\*\*\*\* Clients are referred or directly linked to prevention services, such as comprehensive risk counseling and services and group-level interventions.

## PRINCIPLES OF PARTNER SERVICES

The principles of PS define the foundation for providing services to persons with HIV or STDs and their at-risk partners. Clients receiving PS should clearly understand that it is a support and prevention tool at their disposal to help prevent the further spread of

infection, reduce re-infection, and ensure appropriate linkages to care and treatment. Core elements of PS principles include the following:

**Client-Centered:** PS counseling should be tailored to the behaviors, circumstances and specific needs of each client. Sufficient time during the counseling session should be allowed to ensure the client fully understands the importance of PS and all that it entails. Counselors should be culturally sensitive to the client's needs, and address any communication barriers before introducing PS.

**Confidential:** *It is essential to maintain confidentiality.* At no time should information that identifies an infected client (e.g., demographic information, type of risk encounter, gender, age, or race), be disclosed to the at-risk partner. Similarly, no personal information about the partner, such as test results, should be shared with the infected client. Note: Specific exemptions to MCL 333.5131 allow for the exchange of patient information between local public health and other client support and care facilities for providing PS. See the Legal Authority Section of this document for additional information.

**Voluntary:** *A client has the right to choose participation in PS. Infected clients should not be coerced to participate in PS.* Client contact information should be disclosed to a PS provider who is certified to conduct PS. Participation in PS is also voluntary for at-risk partners. *The offer of PS by health providers, CBOs and public health departments, however, is not voluntary.* When explaining the voluntary nature of PS, it is critical that detailed information about the benefits of active PS participation be provided through the use of persuasive reasoning, which includes a thorough description of PS notification options and a discussion of barriers to PS participation.

**Free:** PS should be available at no cost to all infected clients and their at-risk partners, either directly or by referral to LHDs.

**Evidence-based:** PS staff should use program data to determine the best use of resources to plan and implement effective PS. PS activities require specific knowledge, skill and training offered by the MDCH and the CDC.

**Culturally, linguistically and developmentally appropriate:** PS should be provided in a nonjudgmental manner and be appropriate for the client's culture, language, and level of intellectual development, in compliance with nationally culturally and linguistically appropriate standards. (Note: If necessary, counselors should take advantage of additional resources and/or the MDCH technical assistance to ensure the delivery of PS in this manner.)

**Accessible and available to all:** All infected clients should receive PS as soon as possible after diagnosis, regardless of where they were tested. For HIV, offering PS on an ongoing basis helps clients who may have previously declined PS to access services needed as they progress through the various stages of the care delivery system.

**Comprehensive and integrative:** PS should be part of an array of services that are integrated to the greatest extent possible for persons with HIV, STDs, and their at-risk partners.

**Continuous quality improvement:** Funded HIV/STD programs and medical providers should routinely monitor and evaluate their PS efforts to ensure that program practices comply with recommended standards and meet the ongoing needs of infected clients and at-risk partners.

## **POPULATIONS RECEIVING PARTNER SERVICES**

Providing PS across the full spectrum of communicable diseases is essential to managing the transmission of CT, syphilis, GC and HIV. Acknowledging this, Michigan's PS program extends services to clients diagnosed with HIV and STDs (infected clients) and to their sex and needle-sharing partners at risk of infection. Individuals who have close social relationships with infected persons and/or communities (i.e., social networks) may also benefit from prevention messages and screening because of the frequency with which transmission can occur in these circles. While members of social networks are not necessarily the sexual or needle-sharing partners of infected clients, they can provide valuable information that might enhance disease prevention efforts. Below is a description of PS services provided for each population.

### **Infected Clients:**

Upon receipt of a verified<sup>1</sup> case report for HIV or STDs from a physician, licensed laboratory, or other testing entity, the client is provided with the following:

- Counseling regarding test results
- Risk reduction counseling
- Discussion of PS program, intent, and benefits of service
- Elicitation of partner information
- Treatment for an STD or referral/link to HIV prevention case management/medical care
- Retest 90 days after treatment for GC or CT to assess for re-infection

### **At-Risk Sex and Needle-Sharing Partners:**

Upon receipt of a verified referral from an infected client or care provider, the at-risk partner is provided with the following:

- Confidential notification of exposure
- Disease education
- Access to HIV and STD testing
- Prophylactic treatment for an STD exposure, if indicated
- Elicitation of at-risk or social network partners for investigation
- Referral/linkage to support services

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<sup>1</sup> Verified: disease case report has been authenticated through the MDCH for accuracy of medical and other pertinent information.

**Social Network System/Community:**

Upon receipt of a verified referral from an infected client, partner, or care provider, the social network system/community (SNS) member will be provided with the following:

- Counseling on transmission routes
- Offer of testing, as appropriate
- Elicitation of network partners for follow up

While it is Michigan's goal to maximize the provision of PS to infected clients, at-risk partners, and members of the social network community, we must set realistic goals regarding the provision of these services. In light of diminishing funds and reduced staff in CBOs and LHDs, the MDCH encourages providers to set priorities for the administration of PS.

**SETTING PARTNER SERVICES PRIORITIES**

When setting PS priorities, providers must consider the varying stages of disease and the likelihood of transmission, placing the emphasis on disease reduction and prevention. The CDC recognizes the following populations as high-priority patients regardless of the infection involved:

- Pregnant women and male infected clients with pregnant partners.
- Infected clients suspected of or known to be engaging in behaviors that substantially increase risk for transmission to multiple other persons (e.g., have multiple sex or drug-injection partners).
- Persons co-infected with HIV and one or more other STDs.
- Persons with recurrent STDs.

The CDC also recognizes the following syphilis, GC, and CT infected populations as high priority patients:

- Persons with clinical signs or symptoms suggestive of infection.
- Known partners of confirmed cases.
- Persons from core areas (areas with high concentration of infection).

**Note:** The MDCH uses a syphilis reactor grid<sup>2</sup> to assist with determining investigative priorities for syphilis. Consult your designated MDCH PS staff for additional information.

The CDC recognizes the following HIV infected populations as high priority clients:

- Persons with high HIV viral load (e.g., > 50,000 RNA HIV copies/ml).
- Persons suspected of acute infection (e.g., HIV RNA positive and HIV antibody negative) or recent infection (e.g., current positive HIV antibody test with recent negative HIV antibody test).
- Partners exposed within the past 72 hours.

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<sup>2</sup> Reactor Grid: A table based on age, gender and syphilis serology laboratory results (titers) to determine priority of syphilis investigations

- Candidates for Post-Exposure Prophylaxis (PEP). PEP involves the administration of HIV antiretrovirals following an emergency situation where an HIV exposure may have occurred, e.g., rape, or occupational exposure.
- Partners whose earliest known exposure has been within three months.

## LEGAL AUTHORITY FOR CONDUCTING PARTNER SERVICES

Four provisions within MCL mandate PS as a public health intervention to control the spread of HIV/STDs and to ensure appropriate linkages to care and treatment. These laws provide the legal basis for discharging this public health intervention:

- Confidentiality - HIV Specific: Article 5, Michigan Public Health Code (MCL§333.5101 et seq.), specifically MCL§333.5131 and MCL§333.5114a.
- Court-ordered Testing and Victim Notification: MCL§333.5129

We recommend that all providers of PS become familiar with MCL§333.5114a and MCL§333.5131 to gain a better understanding of the impact that these laws have on PS delivery and other prevention program practices. Summaries of these laws are available at [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd). For an original copy of these specific provisions, view [www.legislature.mi.gov](http://www.legislature.mi.gov).

**Confidentiality:** MCL§333.5131 states the following:

**“All reports, records, and data pertaining to testing, care, treatment, reporting, and research, and information pertaining to partner notification under Section 5114a, that are associated with the serious communicable diseases or infections of HIV infection and acquired immunodeficiency syndrome are confidential.”**

Research has demonstrated that the degree to which confidentiality is maintained by PS programs, is an important determinant of client willingness to participate in and take advantage of PS. Michigan’s confidentiality law (MCL§333.5131) is clear in its outline of measures to protect the confidentiality of persons diagnosed as having a serious communicable disease including HIV and STDs.

The law also defines exceptions to these confidentiality requirements by detailing conditions under which *specific* information about HIV/STD infected clients can be disclosed to the MDCH, a LHD, or other health care provider as one or more of the following:

- 1) To protect the health of an individual;
- 2) To prevent further transmission of disease; or
- 3) To diagnose and care for a patient.

MCL§333.5131(5)(b) also supports PS delivery through the LHD and the private medical community. The law imposes an ***affirmative duty*** upon physicians and local

health officers to either: 1) notify an at-risk sex or needle-sharing partner of a person infected with HIV of their potential exposure to prevent a transmission of HIV or; 2) discharge this notification responsibility to the appropriate LHD for assistance with PS. As part of the discharge of responsibility, physicians and other providers should provide the LHD with the infected client's name, address, and telephone number(s) as well as any other information about the at-risk partner(s) necessary to facilitate notification.

**HIV Partner Services:** MCL§333.5114a states the following:

**“A person or governmental entity that administers a test for HIV or an antibody to HIV to an individual shall refer the individual to the appropriate local health department for assistance with partner notification, if both of the following conditions are met:”**

- (a) The test results indicate that the individual is HIV infected.
- (b) The person or governmental entity that administered the test determines that the individual needs assistance with PS.

This law also requires that persons who make a referral to the LHD also provide the necessary information to carry out PS. This information includes, but is not limited to the client:

- Name
- Address
- Telephone number(s)

Once the client is successfully contacted, the LHD is required by law to inform the client of his or her legal obligation to inform each of his or her future sex partners of their HIV status prior to engaging in sexual relations. HIV infected clients who fail to notify partners may be subject to criminal sanctions.

MCL§333.5114a details:

- How the LHD should conduct PS for HIV infected persons and their at-risk partners and/or parents of a child determined to have been perinatally infected.
- Setting time frames for conducting PS investigations of infected clients and at-risk partners.
- Maintaining the confidentiality of the HIV infected client.
- Obtaining written authorization when the infected client chooses to release case information to a partner.

- Providing an infected client and/or at-risk partner with additional information about strategies for avoiding transmission of HIV and any other information considered appropriate by the LHD.
- Retention of records by LHD for conducting PS investigations.

**Court-Ordered Testing and Victim Notification:** MCL§333.5129 states the following:

Under this law, the LHD and/or the Office of the Prosecutor are **required to provide** victims of certain sex crimes involving penetration with the defendant’s test results for HIV, STDs and other serious communicable diseases. When the LHD is requested to notify the victim, PS staff responds by providing prevention counseling and an opportunity to test or make a referral to testing and other support services.

**HIV and STD Reporting:** MCL§333. 5111 grants the MDCH authority to promulgate rules governing reporting of communicable and related diseases. Specifically the MDCH may:

- a. Designate and classify communicable, serious communicable, chronic, other non-communicable diseases, infections, and disabilities.
- b. Establish requirements for reporting and other surveillance methods for measuring the occurrence of diseases, infections, and disabilities and the potential for epidemics. Rules promulgated under this subdivision may require a licensed health professional or health facility to submit to the department or a LHD, on a form provided by the department, a report of the occurrence of a communicable disease, serious communicable disease or infection, or disability. The rules promulgated under this subdivision may require a report to be submitted to the department not more than 24 hours after a licensed health professional or health facility determines that an individual has a serious communicable disease or infection.

The Administrative Rules are available for download at [www.michigan.gov](http://www.michigan.gov). Click on “Communicable & Chronic Diseases” and then click on “Michigan Disease Surveillance System.” Follow the links to Communicable Disease Reporting in Michigan.

The following rule is a federally required mandate and is supported through program practice:

**Health Insurance Portability and Accountability Act Privacy Protection:**

The privacy rule in the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows for the disclosure of Protected Health Information (PHI), without individual client/patient authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease.

*(Source, Health Care Professional's Guide to Michigan Communicable Disease Rules, 2009.)*

Under Michigan laws and HIPAA rules, state and federally funded HIV and STD prevention programs can legally share PHI about their HIV or STD infected clients with the LHD for the provision of PS. The law **does not** require PS providers to seek the written authorization of infected clients or partners prior to referral for PS. For additional information, view:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>.

The following questions about the interpretation and implementation of some state laws and federal rules affecting PS delivery are often asked.

### **Frequently Asked Questions - HIPAA and State Confidentiality Laws**

#### **1. What is considered PHI under HIPAA?**

- The individual's past, present or future physical or mental health or condition;
- The provision of health care to the individual; or
- The past, present, or future payment for the provision of health care to the individual, and that which identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
- Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, social security number).

#### **2. What type of client or partner information can be shared with a LHD by CBOs or providers for the purpose of PS delivery?**

Information that will aid in the investigation and notification process necessary to carry out public health interventions can be shared with LHDs. Typically, this information consists of an individual's relevant diagnosis and treatment history, name, address, telephone number, and email address. While not specifically referenced in Michigan law, the MDCH requires that any relevant information be released to LHDs that supports the efficient delivery of PS in a safe and secure manner (i.e., with consideration given to living conditions and arrangement, history of violent behavior, threatening or unsafe environmental conditions).

#### **3. What happens to PHI once disclosed to a LHD for the purpose of PS?**

PHI is used to locate and provide PS to infected clients or to an identified at-risk partner. **At no time is infected client information shared with a partner nor is partner**

**information shared with the infected client.** The only exception to this rule is if the client or partner signs a written authorization requesting that PHI be shared. Even then, the information must be specific, and only related to disease management information.

**4. Do HIV/STD prevention counselors, social workers or other non-medical caregivers have a responsibility under MCL 333.5131(5)(b)'s affirmative responsibility (duty) to notify at-risk partners of their exposure to HIV/STD?**

No. Under this law, **only physicians and LHD officers have this legal responsibility.** Other providers who counsel clients diagnosed with HIV or STDs and learn of partners at-risk of infection should immediately refer that information to the LHD for follow up to ensure that appropriate notification and treatment occur.

**Note:** Based on professional licensure requirements, social workers, clinicians and/or therapist may have an **ethical** responsibility to refer at-risk partners to LHDs so they can be notified of a possible HIV/STD exposure. The MDCH recommends that professionals check with their local certification boards for a definitive answer to this question.

**5. Do federal confidentiality laws pertaining to substance abuse treatment and mental health care supersede Michigan's confidentiality laws for PS administration of interviews or treatment for HIV/STDs?**

Possibly. Substance abuse treatment programs and mental health care facilities typically operate under strict confidentiality statutes. For this reason, it is the DHWDCs recommendation that LHDs develop a Memorandum of Agreement (MOA) that stipulates the conditions and type of confidential information that can be shared. A sample MOA is available in the Appendices.

**PARTNER SERVICES DELIVERY  
STANDARDS  
FOR  
MEDICAL PROVIDERS**

## **PARTNER SERVICES DELIVERY STANDARDS FOR MEDICAL PROVIDERS**

Medical providers have a responsibility to determine whether infected clients have notified partners of their potential exposure and to inform clients that the LHD will arrange for partners to be confidentially notified of their exposure. It is important that medical providers who diagnose clients with an STD or HIV have a comprehensive understanding of their role in effectively providing PS or, specifically in the case of HIV exposure, making a referral to PS. **The purpose, benefits, goals and process of PS should be introduced to the client at the time of testing for HIV/STDs.**

### **ENCOURAGING PARTNER SERVICES PARTICIPATION**

Effective PS delivery depends upon the voluntary cooperation of HIV and STD infected clients. Obtaining this cooperation requires that medical providers treat infected clients with respect and understand the possible apprehension to disclose information about partners. Persuasive, yet compassionate, explanation of the following points may help to encourage the infected client's participation in PS:

- The purpose of PS (a systematic process to help prevent and reduce HIV/STD transmission and ensure appropriate linkages to care and treatment).
- Elements of PS (a cooperative relationship between client and PS provider to confidentially notify at-risk partners of their potential exposure to infection so they can receive treatment and referral to support and/or care services).
- Benefits of PS participation for both infected clients, their at-risk partners and the larger community (PS can serve the infected client and partner by providing them the opportunity to learn their status and educating them about the resources available for partner notification, treatment of infection, and assisting the infected client in avoiding re-infection).
- Confidential nature of PS including how privacy and confidentiality are protected.
- Right to decline participation in PS without being denied other services (PS is voluntary; an infected client's lack of participation will not impede access to treatment/care services).
- Legal responsibility of HIV-infected clients to notify partners of their infectious status prior to engaging in sex activities in accordance with MCL§5114a. While not referenced as part of Michigan's legal statute, the MDCH recommends notification of needle-sharing partners prior to engaging in activities that can transmit infection.
- Availability of new technologies (including Internet Notification Service for Partners or Tricks - inSPOT- a web-based partner notification system) to assist

with notifying at-risk partners exposed to certain STDs including GC, CT, non-gonococcal urethritis, scabies/crabs and HIV.

- Availability of tools, including Partner Packets that provide information about STDs and include perforated cards to refer partners to screening.

## **DISEASE REPORTING AND INITIATING A REQUEST FOR PARTNER SERVICES**

Specific forms (outlined below) were created to report cases of STDs or HIV infection. In addition to completion of the form, the LHD should be contacted to request the initiation of PS process. In some cases of STDs (GC and CT), PS initiation is dependant upon local resources and program policy.

### **Case Reporting and Requests for Partner Services - STDs:**

The laboratory processing the specimen initially does reporting of STDs. All reports are received by the local health jurisdiction and are required to be entered into the MDSS.

Several laboratories report via an electronic message directly into MDSS, where local staff are alerted to the report and initiate follow up. Providers also may use the *Confidential Venereal Disease-Chlamydia Case Report and Laboratory Test Results Form* (DCH-0821A) to report a positive test and treatment. A copy of the DCH-0821 and instructions for completion can be obtained from the LHD.

Upon receipt of a GC or CT case report, local staff will follow up according to the jurisdiction's policy and capacity. For a positive syphilis test, the MDCH PS staff will first determine if the person is a potential new infection, then begin the process of disease management by locating the client, providing confidential counseling, and eliciting information on at-risk partners in need of notification and medical evaluation.

### **Case Reporting and Request for Partner Services - HIV:**

The laboratory processing the specimen initially does reporting of positive HIV results. However, testing entities in Michigan are required by law (MCL 333.5114) to submit a completed Michigan Adult HIV/AIDS Care Report Form (DCH-1335) to the LHD. By marking the appropriate box in Section XI of the case report form testing entities, indicate whether or not the client is aware of his or her infection, and who will notify at-risk partners of their potential exposure, the physician, or the LHD. A copy of this form is available on the [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd) website.

Upon receipt of a PS request, the LHD attempts to locate the infected client, counsels him or her about their infection and begins elicitation of information about at-risk partners. Partners, once confidentially notified of their possible exposure, can subsequently receive testing for HIV/STDs, and receive referral information to access prevention and care services.

While Michigan law requires the completion of the DCH-1355 form for all persons diagnosed with HIV or AIDS, it does not provide an avenue for the referral of infected individuals who have requested anonymous reporting (without identifiers), but are in need of assistance with PS. The *Confidential Request for Local Public Health Assistance with Partner Counseling and Referral Services Form (DCH-1221)* is available to refer anonymously reported infected clients as well as their at-risk partners.

A copy of the Confidential Request for Local Public Health Assistance with Partner Services Form (DCH-1221) is available on the [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd) website.

**Note:** When making a **dual diagnosis of syphilis and HIV** infection, the MDCH recommends that providers routinely refer to LHDs for prompt PS delivery following the referral steps outlined above.

The following recommendations are made for PS delivery by medical providers who diagnose persons infected with STDs or as having HIV/AIDS.

## **STANDARDS FOR DISEASE RESPONSE BY MEDICAL PROVIDERS**

### **Standards for STD Diagnosis:**

Medical providers making a diagnosis of STDs are required by law (MCL 333.5111) to report the disease to the LHD via a method approved by the MDCH for the exclusive purpose of disease management within 24 hours of a positive lab result.

For *syphilis*, trained PS staff will conduct an interview with the infected client and elicit partner information for notification. Follow up for GC and CT will vary depending on local jurisdiction capacity.

**Note:** Medical providers should review *Disease Reporting and Initiating a Request for Partner Services* in this section for guidance on this process.

### ***Recommendations for Provider Response:***

The MDCH recommends that medical providers do the following:

- Inform their STD infected clients that the LHD may be contacting them (depending on the specific STD diagnosis) to provide PS in a confidential and secure manner. **Note:** Informing the client of this occurrence can help to mitigate any concerns the client may have about LHD's follow up procedures.
- Inform the client of the importance of assuring that their at-risk partners are notified, so they can receive testing, treatment, and prevention counseling.
- Educate the client on the importance of PS and other strategies for avoiding re-infection.

- Explore/discuss the use of the inSPOT notification system (NOT to be used for syphilis infections).
- Provide treatment for STDs following CDC treatment guidelines. Treatment guidelines can be downloaded at: [www.cdc.gov/std/treatment](http://www.cdc.gov/std/treatment).

When notifying at-risk partners of their exposure to GC and/or CT, physicians may select from *three options* referenced below:

1. **Provider Referral** - infected client is made aware of their infection by their provider, the provider informs the LHD who in turn, notifies the partner(s), depending on their local jurisdiction and staffing capacity.
2. **Self Referral** - infected client chooses to or agrees to inform his/her partner(s); partner referral packet is given to the client, which includes infection information and referral information to access local services.
3. **inSPOT** website notification - infected client utilizes web-based notification system to inform partner(s) about exposure; website sends an electronic notice to the partner(s) with exposure information and referral to local resources. inSPOT is useful for notifying at-risk partners exposed to certain STDs including GC, CT, non-gonococcal urethritis, scabies/crabs and HIV. Information about inSPOT is provided in the Strategies to Enhance Partner Services Section of this document.

Medical providers should document as part of the client's file that PS was provided for their client, or that a referral was made to the LHD, and indicate the date of the referral.

Overall, the best partner notification strategy is the one that results in the partner being notified of their exposure in a timely manner and that moves them to access testing and treatment. More than one strategy may be used to notify different partners of the same infected client.

### **Standards for HIV Diagnosis**

Medical Providers making a diagnosis of HIV are required by law (MCL 333.5114a) to report the infection to the LHD via a method approved by the MDCH for the exclusive purpose of disease management within **seven (7) days** of a positive laboratory result as confirmed by supplemental testing endorsed by the MDCH. It is through this reporting process that the need for PS is determined.

**Note:** Medical providers should review the aforementioned *Disease Reporting and Initiating Request for Partner Services* in this section.

Counsel the client on the meaning of their positive HIV test results, risk reduction information, availability of supportive care and treatment services as well as their legal responsibility to notify any future sex partners of their status prior to engaging in any

sexual activity, or possibly face criminal sanctions. Needle-sharing partners should also be informed of their potential exposure.

Inform the client that assistance to notify at-risk partners is available through the LHD. Unlike providers who diagnosis STDs, medical providers who diagnosis HIV infection must select one of the two following options under pursuant to MCL 333.5131(5)(b):

1. Refer the client or partner(s) to the LHD for assistance with PS (The MDCH recommended approach); or
2. Notify any at-risk partner(s) of their potential exposure to HIV.

### ***Recommendations for PS delivery or referral***

Physicians selecting LHD assistance with notification should discuss with the client:

- The benefits associated with PS provided by local public health, such that notification of partners is prompt, confidential, and partners are offered testing and referral into other care support services.
- Submit DCH-1355 form following directions for making a PS referral to the LHD referenced in the *Disease Reporting and Initiating a Request for Partner Services* section in this document.

**Note:** The MDCH strongly recommends the referral of all newly diagnosed HIV positive individuals to local public health for PS. See the *Setting Partner Services Priorities* section of this document for additional information.

- Document and retain a copy of the DCH-1355 Michigan Adult HIV Case Report form and/or the DCH-1221 Confidential Request for LHD Assistance with PS as part of the client's clinical record and confirmation that PS referral occurred.

Physicians selecting physician notification should follow the process described below:

Encourage PS participation and elicit identifying information about at-risk partners that are in need of notification by doing the following:

- Obtain the name, address, and telephone number of any at-risk sex or needle-sharing partner(s) possibly exposed during the critical period (the period during which the patient could have become infected or transmitted the infection to others)
- Confidentially notify the at-risk partner(s) ***in person*** of their possible exposure, ensuring to protect the confidentiality of the infected client.

- Offer the at-risk partner HIV/STD testing or referral to appropriate testing and care support services.

Assisting the client to participate in PS and begin freely disclosing information about their at-risk partners can be challenging. To assist providers with this process, *PS Counseling Tips* for HIV are offered in this section. Additional assistance is also available by contacting the MDCH at (517) 241-5900.

When selecting physician notification it is expected, from a legal standpoint, that the full scope of PS will be conducted so that any known at-risk partner for whom a name and locating information is available will be notified of their exposure, offered risk reduction information, and HIV testing or test referral. Should physicians encounter difficulty in their efforts to contact at-risk partners, the LHD should be contacted as soon as possible so that assistance may be provided.

- Document and retain a copy of the DCH-1355 Michigan Adult HIV Case Report form and/or the DCH-1221 Confidential Request for LHD Assistance with PS as part of the confidential client file to confirm that PS was provided or referred to the LHD.

Occasionally, medical providers may encounter situations in which HIV-infected clients know of their infection and how it is transmitted, yet they continue to engage in behaviors that expose others to the infection. If this situation occurs, providers should contact their LHD for intervention assistance. Program guidance exists that address this issue in accordance with MCL 333.5201.

## Provider Partner Services Counseling TIPS for HIV

Learning of one's HIV/STD infection can often be traumatic. Assisting the client to process this information and begin to think about who might need to know of their infection because of a possibility of exposure is yet another element of concern confronting the client. Below are helpful counseling tips that medical providers may use to assist clients in disclosing information about partners. Presented below are excerpts from the *National Network of STD/HIV Prevention Training Centers, in conjunction with the AIDS Education Training Center's Ask-Screen-Intervene program*. For additional information on this model view: [www.cdc.gov/std/ptc.htm](http://www.cdc.gov/std/ptc.htm).

### Overview of Disclosure Steps

#### Step 1: Transition to Disclosure

- Bridges to the topic of disclosure
- Draws on the context of the current session or setting
- Checks in with a feeling

Use a simple phrase to transition client into thinking about the need to notify an at-risk partner e.g., *"Now that you know about your infection, what do you think about telling others?"* *"You seem pretty close with your partner, how do you feel about telling him you have HIV?"* **Transition** facilitates the patient's planning for disclosure or serves an invitation to discuss the topic further.

#### Step 2: Discuss Who Client Should Consider Notifying

- Assist client with prioritizing disclosure. *"You keep mentioning Trina, and that she is pregnant, how do you plan to notify Trina of her possible exposure?"*
- Explore issues, benefits of disclosing partner information. *"Who might benefit from knowing you have HIV?"* *"Letting your partner know about their exposure is really a good idea, how do you think they will react?"*
- Discuss how notifying partners can reduce their continued risk, and risk to the client for possible re-infection. *"What do you think your partners will do once they learn of their possible exposure to HIV?"*
- Discuss how the partner may react to being informed of their exposure. *"How do you think your partners will react to learning of their possible exposure to HIV?"*

A discussion of individuals who need to know of their possible exposure based on heightened risk is important. Typically, clients want individuals closest to them to know of their possible exposure, but will need help in ensuring their notification. As part of your conversation with the client, ask simple questions about partners such as a name and the last time the client had sex or shared a needle. Follow up by asking more detailed questions e.g., *"So tell me more about Billy, where did you say he lives?"*

#### Step 3: Coaching Skills

- Discuss how partners will be notified of possible exposure. Give examples of what is said, and consider role playing with the client
- Explain process of how partners will be contacted and how their confidentiality will be protected.
- Explain what will be said and what type of referrals offered.

#### Step 4: Summarize Discussion

- Review what you've talked about (refresh issues discussed and decisions made)
- Validate the client's concerns about disclosure (*offer reassurance that notification is the best alternative to HIV exposure*)
- Leave the door open for continued conversations
- Examples of summary discussions: *"I can see that you are really concerned about not exposing anyone. Letting me notify your partners is a wise thing to do."* *"You've taken a big step today. You should be proud of yourself."*
- Complete the **DCH-1221** for partners, and forward to LHD for follow-up.

## MONITORING, EVALUATION AND QUALITY ASSURANCE FOR PHYSICIANS

This section of the recommendations offers HIV/STD PS providers direction for ensuring effective service delivery. Outlined below is an overview and rationale of the monitoring and evaluation process that should be adopted as part of an overall disease case management plan. PS providers should view the following information and determine the feasibility of implementation based upon the type of service delivery and availability of resources.

### **Overview of Monitoring and Evaluation**

Monitoring and evaluation (M&E) activities are key components of any successful program. M&E helps you to look at the resources that go into your program (e.g., staff, funding); the services provided (e.g., client interviews, referrals); and the results of the program (e.g., linkage to care).

Rationale: All PS activities should be monitored to assess program performance and to identify areas in need of improvement. Applying M&E data to program planning and management can help to refine and strengthen programming by:

- *Describing infected patients and partners* in terms of demographic, geographic, behavioral and other factors. This is important to improving the targeting of screening and prevention activities so that efforts are focused where they will be most effective.
- *Monitoring trends* among infected patients and partners in terms of demographic, geographic, behavioral and other factors. This is important in order to identify potential outbreaks at early stages; assess the extent to which populations are engaged with PS; and to understand whether PS are responsive to community needs.
- *Identifying social networks* that may be facilitating disease transmission. This is important in order to focus PS and other prevention efforts and resources where they will be most effective.
- *Guiding quality assurance* by monitoring program productivity (e.g., number of partners identified and initiated; timeliness of reporting and referral). This will help to focus on program areas and practices that may benefit most from refinement.

Definitions: Monitoring refers to the routine collection and review of data related to program activities and associated outcomes. *Process monitoring* provides descriptive information about services delivered and populations served. In the context of HIV and STD PS, the number of infected clients interviewed and counseled is a process monitoring measure.

*Outcome monitoring* addresses the extent to which the expected program outcomes are achieved. Typically, outcome-monitoring measures are responsive to programmatic standards. In the context of HIV and STD PS, one program standard is that 90 percent of newly diagnosed HIV-infected individuals will be successfully linked to care within

three months of diagnosis. The outcome measure associated with this standard would be the proportion of newly diagnosed individuals successfully linked to care within three months of diagnosis.

All providers of any aspect of PS should conduct both process and outcome monitoring of these services. Monitoring should be ongoing, with data analyzed and reviewed regularly in order to optimize program effectiveness. In the context of PS, providers of HIV and STD PS, should consider several key questions in planning program monitoring activities:

- (1) How completely is the program identifying newly reported cases?
- (2) To what extent is the program identifying, notifying and examining/treating partners?
- (3) What is the yield of PS in identifying new cases of syphilis, GC and CT?<sup>3</sup>
- (4) To what extent is the program providing treatment for syphilis, GC and CT through PS?<sup>4</sup>
- (5) What is the yield of PS in terms of identifying new cases of HIV infection?
- (6) To what extent is the program linking individuals newly diagnosed with HIV to care and treatment?

*Evaluation* refers to activities designed to assess the effectiveness of program activities in facilitating expected program outcomes and in achieving improvements in client health (e.g., decreased morbidity and mortality) and the health of the community (e.g., reductions in disease incidence). In general, evaluation activities require a more rigorous design and analysis and should be undertaken as resources allow. For PS, the kinds of questions that evaluation activities might address, include:

- (1) Which provider type (e.g., clinicians, CBOs, local health, others) is most successful in eliciting partner information?"
- (2) Which providers are most successful in referring infected patients to local health for assistance with PS?
- (3) Compared with other strategies, how effective are PS as a method of identifying new cases?
- (4) Compared with other strategies, how cost-effective are PS as a method of identifying new cases?
- (5) Is certain staff more effective than others in eliciting partners? Locating partners? Encouraging testing and treatment? What possible factors can explain these differences?
- (6) Are there specific populations or communities among whom PS are more successful than others in identifying new infections? In referring and locating partners? What possible factors can explain these differences?

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<sup>3</sup> LHDs conducting PS for GC and CT should conduct monitoring yield of these services as resources allow.

<sup>4</sup> LHDs conducting PS for GC and CT should conduct monitoring of treatment provided to partners as resources allow.

## **Monitoring Partner Services: Key Measures**

For each of the six key monitoring questions described above, the table below provides recommended monitoring measures. Many of the measures apply equally to HIV, syphilis, GC and CT. In these instances, programs should tailor the measures to respond to the infection-specific program standard. For example, monitoring measure 1.c. on the table should be tailored as follows for syphilis “Of the new cases (infected patients) *of syphilis* eligible for PS, number/percent who were interviewed to elicit partner information *within seven days from receipt of positive report.*”

The various measures may not be applicable to every provider type. The provider types(s) to which the measures are applicable are noted in the table. All measures can be addressed with existing data sources, such as patient records. LHDs and CBOs funded by the MDCH for HIV and STD services can obtain needed data from the HIV Event System (HES) and the Michigan Disease Surveillance System (MDSS).

<b>TABLE: Key Monitoring Questions and Associated Measures</b>				
Key Question	Monitoring Measure	Applicability		
		PRO	CBO	LHD
1. How completely is the program identifying newly reported cases?	a. Number of new cases (infected patients) reported to the health department within specified time period associated with each infection.	X	X	X
	b. Of the new cases (infected patients) reported to the health department, number/percent who were eligible for PS (i.e., not deceased, incapacitated or out of jurisdiction at time of report).			X
	c. Of the new cases (infected patients) eligible for PS, number/percent who were interviewed to elicit partner information	X	X	X
2. To what extent is the program identifying, notifying and examining/treating partners?	a. Number of partners claimed per infected patient interviewed		X	X
	b. Number/percent of partners named per infected patient interviewed		X	X
	c. Number/percent of partners named referred to LHD for follow-up	X	X	
	d. Number/percent of named partners initiated (i.e., attempted notification)			X
	e. Number/percent of named partners not previously confirmed HIV infected initiated			X
	f. Number/percent of partners initiated who were successfully notified.			X
	g. Number/percent of partners notified who were examined and/or tested	X		X
3. What is the yield of PS in identifying new cases of syphilis, GC and CT?	a. Number/percent of partners found to be infected, among named partners examined or tested			X
	b. Number/percent of named partners treated to cure (i.e., found to be infected and brought to treatment) [Note: applies to syphilis only]			X

4. To what extent is the program providing treatment for syphilis, GC and CT through PS?	a. Number/percent of named partners treated preventively [Note: for syphilis measure should specify treatment within 30 calendar days from the date of the index interview.]			X
	b. Number of partners brought to treatment (preventively or as a result of exam/testing) per infected patient. [Note: applies to syphilis only]			X
5. What is the yield of PS in terms of identifying new cases of HIV infection?	a. Number/percent of partners found to be infected among partners notified and tested			X
	b. Number/percent of partners newly diagnosed with HIV			X
	c. Number of partners newly diagnosed with HIV per infected patient			X
6. To what extent is the program linking individuals newly diagnosed with HIV to care and treatment?	a. Of the new cases (infected patients) who were interviewed and counseled number/percent successfully linked to medical care for HIV infection	X	X	X
	b. Number/percent of <u>partners</u> newly diagnosed with HIV who learn their test results	X	X	X
	c. Number/percent of <u>partners</u> newly diagnosed with HIV who are successfully linked to medical care for HIV infection (i.e., confirmed attendance at first medical appointment)	X	X	X

### **Overview of Quality Assurance**

Quality assurance is a key component of successful programs. All PS activities should assess the extent to which programming is responsive to community needs and priorities. Gaps in services should be identified as should opportunities for improvement.

**Rationale:** Quality assurance can help to ensure that programs are responsive to program standards and are delivered according to established protocol. Quality assurance activities help to ensure that that programming is responsive and accountable to all stakeholders including funders and, importantly, the communities served.

**Definition:** “Quality Assurance (QA) is a planned and systematic set of activities designed to ensure that requirements are clearly established, standards and procedures are adhered to, and the work products fulfill requirements or expectations.”<sup>5</sup>

### **Components of a Quality Assurance Process:**

1. Identify the product/service that will be examined.
2. Set the standards/expectations for the delivery of the service.
3. Develop policies, protocols, procedures for meeting the standards/expectations
4. Provide training.

<sup>5</sup> Michigan Department of Community Health. HIV/AIDS Prevention and Intervention Section. *Quality Assurance of HIV Prevention Counseling: A Toolbox for Supervisors and Monitors*. May 2007.

5. Measure adherence to established protocols.
6. Strategize for supporting positive work and reducing deficits.

### **Implementation of Quality Assurance**

Quality Assurance activities should be conducted by all providers of any component of HIV and STD PS on a regular and scheduled basis. Agencies should develop a written QA protocol(s) to guide their QA activities. Staff should receive orientation to and training on QA protocol and procedures.

Protocols should address all of the components of the QA process described above. As appropriate, the QA protocol may either specifically detail each component or clearly indicate the sections of referent documents. For example, the protocol may refer to a document that articulates specific standards or outlines a relevant policy.

The QA protocol should clearly describe the method(s) for measuring and supporting adherence to policies, protocols and procedures and/or achieving standards. The QA protocol must specifically describe how the measurement will be carried out and include the frequency of measurement activities, the responsible parties and the manner in which findings will be applied for program improvement.

QA measurement activities should cross multiple domains, consistent with applicable standards. Critical domains are listed below, with sample questions follow each.

- (1) Legal requirements.
  - Are providers delivering PS in ways consistent with the laws governing PS?
- (2) Program/Service requirements.
  - Are providers delivering *all* aspects of PS and *only* those aspects they are expected to by the MDCH standards (e.g., are physicians carrying out their duty to warn or discharging this duty to LHD staff; are CBOs conducting elicitation and referral only)?
  - Are agencies delivering PS in ways consistent with the core elements of PS?
  - Are agencies providing services across clients consistent with program directives (e.g., are they providing services to prioritized populations or providing integrated services as appropriate)?
  - Are referral relationships appropriate to meeting client needs?
  - Are referral relationships appropriately documented?
- (3) Client interface.
  - Are providers delivering PS to individual clients consistent with training?
  - Are providers appropriately documenting PS activities?
  - Are services delivered in a culturally competent and developmentally appropriate manner?
  - Are referrals appropriate to the client identified needs and priorities?

- Are clients provided with integrated screening and prevention services responsive to their particular risk and needs?
- (4) Reporting Requirements.
  - Are providers submitting disease reports within required time frames?
  - Are agencies completing required forms and entering service data appropriately (i.e., complete, accurate and on time)?
- (5) Performance Measures.
  - Are providers achieving internal or the MDCH-provided performance measures (e.g., proportions of clients receiving PS, numbers of partners notified, numbers of clients linked to care)?
  - Are agencies providing services within specified time frames (e.g., initiating or closing cases within required time frames)?

Various strategies can be used to conduct QA and QA of PS can be incorporated into existing routine programmatic QA activities as appropriate. Methods for conducting QA include the following:

- Pouch reviews
- Chart reviews
- Regular team meetings
- Case conferencing sessions
- Client surveys (addressing awareness of, accessibility to, or satisfaction with services)
- Client interviews
- Service data review
- Role plays
- Directly observed counseling sessions, interviews, and/or investigations
- Regularly scheduled reviews of program guidelines, protocols and performance standards
- Regularly scheduled reviews of client materials to assess cultural and developmental appropriateness
- Periodic review and evaluation of referral resources
- Regular review of record keeping to ensure staff are adhering to confidentiality requirements

Providers of HIV and STD PS should implement QA strategies appropriate to their setting.

**PARTNER SERVICES DELIVERY  
STANDARDS  
FOR  
COMMUNITY-BASED ORGANIZATION**

## **PARTNER SERVICES DELIVERY STANDARDS FOR COMMUNITY-BASED ORGANIZATIONS**

The delivery of effective PS is dependent upon both the cooperation of infected clients to share information about their at-risk partners and their overall trust in the PS process. It is important, therefore, that agencies provide clients with a thorough understanding of the principles and elements of PS, and information on how the agency can offer support.

### **ENCOURAGING PARTNER SERVICES PARTICIPATION**

Effective PS delivery depends upon the voluntary cooperation of HIV and STD infected clients. Obtaining this cooperation requires that PS providers treat infected clients with respect and understand the possible apprehension to disclose information about partners. Persuasive, yet compassionate, explanation of the following points may help to encourage the infected client's participation in PS:

- The purpose of PS (a systematic process to help prevent and reduce HIV/STD transmission and ensure appropriate linkages to care and treatment).
- Elements of PS (a confidential process to identify, notify and counsel at-risk partners of their potential exposure to infection so they can receive treatment and referral to support and/or care services).
- Benefits of PS participation for both infected clients, their at-risk partners and the larger community (PS can serve the infected client and partner by providing them the opportunity to learn their status and educating them about the resources available for partner notification, treatment of infection, and assisting the infected client in avoiding re-infection).
- Confidential nature of PS including how privacy and confidentiality are protected.
- Right to decline participation in PS without being denied other services (PS is voluntary; an infected client's lack of participation will not impede access to treatment/care services).
- Legal responsibility of HIV-infected clients to notify partners of their infectious status prior to engaging in sex/needle-sharing activities in accordance with MCL§5114a.
- Availability of new technologies (including inSPOT, Michigan's web-based partner notification system) to assist with notifying at-risk partners exposed to certain STDs including GC, CT, non-gonococcal urethritis, scabies/crabs, and HIV.
- Availability of tools, including Partner Packets, that provide information and perforated cards to refer partners to screening.

## **DISEASE REPORTING AND INITIATING A REQUEST FOR PARTNER SERVICES**

Specific forms are available to report cases of STDs or HIV infection. In addition to completion of the form, LHDs should be contacted to request the initiation of the PS process. Such initiation is dependent upon LHD resources and policy.

### Case Reporting and Requests for Partner Services - STDs:

Reporting of STDs is initially done by the laboratory processing the specimen. Reporting of syphilis serologies, GC and CT infections to LHDs must occur within 24 hours of specimen collection and are required to be entered, by LHDs, into the MDSS.

Several laboratories report via an electronic message directly into MDSS, where local staff is alerted of the report and initiate follow up. Providers also may use the *Confidential Venereal Disease-Chlamydia Case Report and Laboratory Test Results Form* (DCH-0821) to report a positive test and treatment. A copy of the DCH-0821 and instructions for completion are available by contacting the LHD.

Upon receipt of a GC or CT case report, local staff will follow up according to the jurisdiction's policy and capacity. For a positive syphilis test, the MDCH PS staff will first determine if the person is a potential new infection, then begin the process of disease management by locating the client, providing confidential counseling, and eliciting information on at-risk partners in need of notification and medical evaluation.

### Case Reporting and Request for Partner Services - HIV:

The laboratory processing the specimen initially does reporting of positive HIV results. However, testing entities in Michigan are required by law (MCL 333.5114) to submit a completed *Michigan Adult HIV/AIDS Confidential Case Report Form DCH-1355* to the LHD **within 7 days** of the diagnosis. By marking the appropriate box in Section XI of the case report form, testing entities indicate whether or not the client is aware of his or her infection, and who will notify at-risk partners of their potential exposure, the physician, or the LHD. A copy of this form is available online at [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd).

Upon receipt of a PS request, the LHD attempts to locate the infected client, counsels him or her about their exposure and begins elicitation of information about at-risk partners. Partners, once notified of their possible exposure, can subsequently receive testing for HIV, and receive referral information to access prevention and care services.

While Michigan law requires the completion of the DCH-1355 form for all persons diagnosed with HIV or AIDS, it does not provide an avenue for the referral of infected individuals who have requested anonymous reporting, but are in need of assistance with PS. The *Confidential Request for Local Public Health Assistance with Partner Counseling and Referral Services Form* (DCH-1221) is available to refer anonymously

reported infected clients as well as their at-risk partners in need to PS. This form is available for download at [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd).

**Note:** When identifying a dual diagnosis of **syphilis and HIV** infection, the MDCH recommends that providers routinely refer to local public health for prompt PS delivery following the aforementioned steps outlined in this section.

The following recommendations are made for PS delivery by CBOs that identify persons infected with STDs or as having HIV/AIDS.

## **CBO PS RESPONSE TO STD OR HIV DIAGNOSIS**

CBOs significantly contribute to Michigan's PS efforts by providing services to persons who may not seek STD/HIV testing through other venues, and to at-risk partners who might not be aware of their potential risk for infection. Program standards and recommendations provided below help to clarify the role of CBOs in PS delivery.

### **CBO Standards for STD Diagnosis**

The extent of PS delivery can vary based on the disease diagnosed. If a CBO chooses to perform STD screening, it must establish a Memoranda of Agreement (MOA) with the LHD to assure treatment of infected clients. A sample of a MOA is located in the Appendices.

When a diagnosis of syphilis is made, the LHD will provide the full scope of PS. For a diagnosis of GC or CT, PS will be part of the scope of services outlined in the MOA.

Any diagnosis of a reactive STD screening result should be reported to local public health within **24 hours** of specimen collection.

### ***Recommendations for CBO Response to STD***

CBOs should review the following information with clients diagnosed with an STD:

- Inform the client that the LHD may be contacting them.
- Inform the client of the importance of notifying their at-risk partners so they can receive testing and prevention counseling.
- Educate the client on the importance of PS and other strategies for avoiding re-infection and further transmission.
- Assess the client for any partner history of violence or potential violence that could result from learning of an STD exposure. Document this information on the case report form for LHD reference.

- Explore/discuss the use of the inSPOT notification system (**Not to be used for syphilis infections**).
- If the CBO has clinical capacity, provide treatment for STDs following CDC treatment guidelines (<http://www.cdc.gov/std/treatment>).

## Standards for HIV PS Response

CBOs should counsel patients regarding PS; refer patients to local health for assistance in notifying their partners, if appropriate; and conduct partner elicitation.

### **Recommendations**

When providing prevention counseling to positive testers, CBOs should encourage PS participation. Clients who understand the benefits of PS as well as their legal responsibility to notify at-risk partners or seek assistance to do so can help reduce further transmission. CBO PS providers should also do the following:

- Inform the client that a LHD may be contacting them to provide additional PS.
- Explain the reason for collecting partner identifying and demographic information as a tool to assure prompt and accurate notification.
- Elicit partner information. Obtain the name, address, telephone number, email address, physical description (weight, height, gender, age, race and any other demographic information, such as living condition, drug/alcohol abuse issues) of at-risk partners that might facilitate the notification process; also, assess for any history or potential for violence that could result from learning of an exposure. CBO PS counseling tips are provided at the end of this section to offer further assistance.
- Refer partner information to a LHD for notification, testing and referral to other support services using the DCH-1221, Confidential Request for Local Public Health Assistance with Partner Services Form.
- If appropriate, discuss the use of inSPOT for partner notification.

Should at-risk partners present to the CBO on their own volition or are referred by the infected client, provide standard prevention counseling and testing just as you would with any individual expressing an interest in testing.

Occasionally, clients who have received a preliminary reactive test result fail to come back for their confirmatory result. When this occurs, and the confirmatory test result is positive for HIV, CBO prevention staff should follow the recommendations outlined below for addressing PS delivery:

- Refer confidentially tested clients who fail to return for receipt of their HIV confirmatory reactive test result within **two (2) business days** of their missed appointment to LHD for follow up. Use the Confidential Request for Local Public Health Assistance with Partner Services Form DCH-1221 to refer the client. This form is available for download at [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd).

- Anonymous testers should be strongly encouraged to return for their results as additional follow up is hampered by the inability to contact them.

**Note:** Both MCL 333.5131 and HIPAA rules allow CBOs to freely share with LHDs client information such as diagnosis, treatment history, identifying and locating information which can aid in the investigation and notification effort.

***Recommendation:***

CBOs engaged in social networking activities that use infected clients as recruiters to promote HIV testing among their social contacts are encouraged to also utilize the LHD as an alternative testing option to their own agency.

- Inform the LHD of CBO participation in social networking and the possibility of partnering with the LHD to promote HIV testing among network partners.

***Recommendation:***

A variety of strategies can be used to facilitate the linkage of HIV-infected clients to medical care and other support services. One recognized strategy used in Michigan is the Client Authorization for Counselor-Assisted Referral Form (CARF-DCH 1225). This form is available for download at: [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd).

- CBOs should discuss the benefits of early access and linkage to care and support services as an effective tool in possibly delaying the onset of AIDS and attention to psychological needs with their HIV infected clients.

- Routinely document all referrals as part of the client's case file.

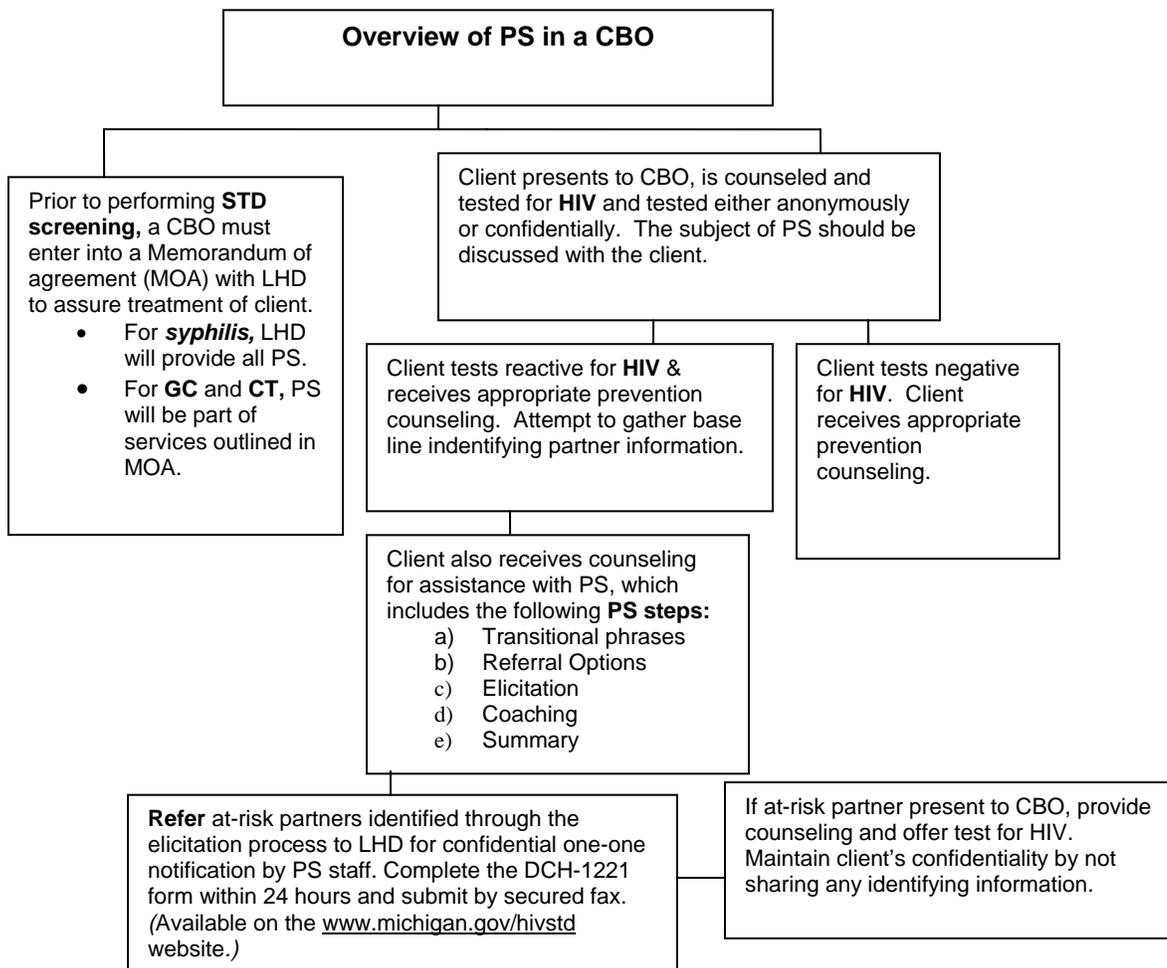
**Note:** CBO prevention and medical case management staff should contact the LHD to seek guidance in addressing HIV-infected clients who intentionally engage in behaviors that continue to put others at risk for HIV infection. Program guidance in accordance with MCL 333.5201 exists that appropriately addresses this issue.

Because of the 'safety net' nature of their business, CBOs often engage clients who may be difficult to reach. These populations frequently seek anonymous testing for HIV. In addition to following the aforementioned recommendations for addressing HIV specific PS, there are several recommendations for PS delivery in these 'safety net' organizations.

- Introduce PS to clients, as appropriate.
- Develop defined strategies for identifying potential infected clients (e.g., clients who may have a new diagnosis, infected clients with new partners or new diagnoses of STDs, persons who declined PS before) and recommended these individuals for PS.
- Ensure and communicate compliance with confidentiality, privacy, and safety expectations.
- Establish consistent testing opportunities and venues to enhance the probability of client re-engagement. Inform the client that your agency will return to this site to provide follow up services (test results, referral to care and support services).
- Establish strong working relationships with the LHD to help facilitate and coordinate joint PS efforts. Contact information for all of Michigan's LHDs is available from the Michigan Association for Local Public Health at [www.malph.org](http://www.malph.org).
- Develop relationships with other providers that support referral and linkages to prevention, care and support services.

## COMMUNITY-BASED ORGANIZATION PARTNER SERVICES COUNSELING TIPS

Learning of one's HIV/STD infection can often be a traumatic event. Assisting the client to process this information and begin to think about who might need to know of their infection because of a possibility of exposure, is yet another element of concern confronting the client. For easy reference, an algorithm highlights the essential responsibilities of CBO prevention counselors in the provision of PS elicitation and referral.



The delivery of PS is essentially a 5-step process that the CDC defines as:

Step 1: **Transitional Phrase:** Counselor use of a simple phrase or sentence that helps to move the HIV-infected client into the discussion of the need to notify at-risk partners. e.g., “With whom would you like to share this information?”

Step 2: **Referral Options:** A discussion of option that the HIV-infected Client may select from to notify at-risk partners: e.g., “Let’s discuss the ways in which your partners may be notified of their exposure to HIV.”

- a. Health department: LHD assumes responsibility for notifying at-risk partners.
- b. Physician: physician assumes responsibility for notifying at-risk partners (not available to CBOs).
- c. Client: HIV-infected client assumes responsibility for notifying at-risk partners.
- d. Combination: HIV-infected client, and/or provider or health department assumes some responsibility for notifying at-risk partner.

Step 3: **Elicitation:** The gathering of identifying and locating information about at-risk partners to facilitate notification by partner services staff from the LHD e.g., “How would you describe this person to me?”

Think about what type of information needed to find someone. This type of information may include:

- a) Exposure Information (e.g., frequency of exposure, type and most recent exposure);
- b) Locating Information (e.g., Name, Home/work address, phone, cell and email address);
- c) Frequent hangouts, Internet/website address;
- d) Identifying Information (e.g., age, gender, race/ethnicity, weight, height, hair type, tattoos, glasses, facial hair, and distinguishing marks or scars).

Step 4: **Coaching:** A discussion and agreement as to who will be notified, who will conduct the notification, and when/where the notification will take place. This step allows for the submission of referral information that may be performed through completion of the *Confidential Request for Assistance with PS form (DCH-1221)*.

Step 5: **Summary:** A conclusion of the PS session that affords an opportunity for the counselor and client to address any concerns raised during the counseling session, and reaffirm roles in the notification process.

## **MONITORING, EVALUATION AND QUALITY ASSURANCE FOR COMMUNITY-BASED ORGANIZATIONS**

This section of the recommendations offers HIV/STD PS providers direction for ensuring effective service delivery. Outlined below is an overview and rationale of the monitoring and evaluation process that should be adopted as part of an overall disease case management plan. PS providers should view the following information and determine the feasibility of implementation based upon the type of service delivery and availability of resources.

### **Overview of Monitoring and Evaluation**

Monitoring and evaluation (M&E) activities are key components of any successful program. M&E helps you to look at the resources that go into your program (e.g., staff, funding); the services provided (e.g., client interviews, referrals); and the results of the program (e.g., linkage to care).

Rationale: All PS activities should be monitored to assess program performance and to identify areas in need of improvement. Applying M&E data to program planning and management can help to refine and strengthen programming by:

- *Describing infected patients and partners* in terms of demographic, geographic, behavioral and other factors. This is important to improving the targeting of screening and prevention activities so that efforts are focused where they will be most effective.
- *Monitoring trends* among infected patients and partners in terms of demographic, geographic, behavioral and other factors. This is important in order to identify potential outbreaks at early stages; assess the extent to which populations are engaged with PS; and to understand whether PS are responsive to community needs.
- *Identifying social networks* that may be facilitating disease transmission. This is important in order to focus PS and other prevention efforts and resources where they will be most effective.
- *Guiding quality assurance* by monitoring program productivity (e.g., number of partners identified and initiated; timeliness of reporting and referral). This will help to focus on program areas and practices that may benefit most from refinement.

Definitions: Monitoring refers to the routine collection and review of data related to program activities and associated outcomes. *Process monitoring* provides descriptive information about services delivered and populations served. In the context of HIV and STD PS, the number of infected clients interviewed and counseled is a process monitoring measure.

*Outcome monitoring* addresses the extent to which the expected program outcomes are achieved. Typically, outcome monitoring measures are responsive to programmatic standards. In the context of HIV and STD PS, one program standard is that 90 percent

of newly diagnosed HIV-infected individuals will be successfully linked to care within three months of diagnosis. The outcome measure associated with this standard would be the proportion of newly diagnosed individuals successfully linked to care within three months of diagnosis.

All providers of any aspect of PS should conduct both process and outcome monitoring of these services. Monitoring should be ongoing, with data analyzed and reviewed regularly in order to optimize program effectiveness. In the context of PS, there are several key questions that program monitoring activities that providers of HIV and STD PS should consider in planning monitoring activities:

- (1) How completely is the program identifying newly reported cases?
- (2) To what extent is the program identifying, notifying and examining/treating partners?
- (3) What is the yield of PS in identifying new cases of syphilis, GC and CT?<sup>6</sup>
- (4) To what extent is the program providing treatment for syphilis, GC and CT through PS?<sup>7</sup>
- (5) What is the yield of PS in terms of identifying new cases of HIV infection?
- (6) To what extent is the program linking individuals newly diagnosed with HIV to care and treatment?

*Evaluation* refers to activities designed to assess the effectiveness of program activities in facilitating expected program outcomes and in achieving improvements in client health (e.g., decreased morbidity and mortality) and the health of the community (e.g., reductions in disease incidence). In general, evaluation activities require a more rigorous design and analysis and should be undertaken as resources allow. For PS, the kinds of questions that evaluation activities might address include:

- (1) Which provider type (e.g., clinicians, CBOs, local health, others) is most successful in eliciting partner information?"
- (2) Which providers are most successful in referring infected patients to local health for assistance with PS?
- (3) Compared with other strategies, how effective are PS as a method of identifying new cases?
- (4) Compared with other strategies, how cost-effective are PS as a method of identifying new case
- (5) Is certain staff more effective than others in eliciting partners? Locating partners? Encouraging testing and treatment? What possible factors can explain these differences?
- (6) Are there specific populations or communities among whom PS are more successful than others in identifying new infections? In referring and locating partners? What possible factors can explain these differences?

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<sup>6</sup> LHDs conducting PS for GC and CT should conduct monitoring yield of these services as resources allow.

<sup>7</sup> LHDs conducting PS for GC and CT should conduct monitoring of treatment provided to partners as resources allow.

## **Monitoring Partner Services: Key Measures**

For each of the six key monitoring questions described above, the table below provides recommended monitoring measures. Many of the measures apply equally to HIV, syphilis, GC and CT. In these instances, programs should tailor the measures to respond to the infection-specific program standard. For example, monitoring measure 1.c. should be tailored as follows for syphilis “Of the new cases (infected patients) of *syphilis* eligible for PS, number/percent who were interviewed to elicit partner information *within seven days from receipt of positive report.*”

The various measures may not be applicable to every provider type. The provider type(s) to which the measures are applicable are noted in the table. All measures can be addressed with existing data sources, such as patient records. LHDs and CBOs funded by the MDCH for HIV and STD services can obtain needed data from the HES and the MDSS.

<b>TABLE: Key Monitoring Questions and Associated Measures</b>				
Key Question	Monitoring Measure	Applicability		
		PRO	CBO	LHD
1. How completely is the program identifying newly reported cases?	a. Number of new cases (infected patients) reported to the health department within specified time period associated with each infection.	X	X	X
	b. Of the new cases (infected patients) reported to the health department, number/percent who were eligible for PS (i.e., not deceased, incapacitated or out of jurisdiction at time of report).			X
	c. Of the new cases (infected patients) eligible for PS, number/percent who were interviewed to elicit partner information	X	X	X
2. To what extent is the program identifying, notifying and examining/treating partners?	a. Number of partners claimed per infected patient interviewed		X	X
	b. Number/percent of partners named per infected patient interviewed		X	X
	c. Number/percent of partners named referred to LHD for follow-up	X	X	
	d. Number/percent of named partners initiated (i.e., attempted notification)			X
	e. Number/percent of named partners not previously confirmed HIV infected initiated			X
	f. Number/percent of partners initiated who were successfully notified.			X
	g. Number/percent of partners notified who were examined and/or tested	X		X
3. What is the yield of PS in identifying new cases of syphilis, GC and CT?	a. Number/percent of partners found to be infected, among named partners examined or tested			X

<b>TABLE: Key Monitoring Questions and Associated Measures</b>				
Key Question	Monitoring Measure	Applicability		
		PRO	CBO	LHD
	b. Number/percent of named partners treated to cure (i.e., found to be infected and brought to treatment) [Note: applies to syphilis only]			X
4. To what extent is the program providing treatment for syphilis, GC and CT through PS?	a. Number/percent of named partners treated preventively [Note: for syphilis measure should specify treatment within 30 calendar days from the date of the index interview.]			X
	b. Number of partners brought to treatment (preventively or as a result of exam/testing) per infected patient. [Note: applies to syphilis only]			X
5. What is the yield of PS in terms of identifying new cases of HIV infection?	a. Number/percent of partners found to be infected among partners notified and tested			X
	b. Number/percent of partners newly diagnosed with HIV			X
	c. Number of partners newly diagnosed with HIV per infected patient			X
6. To what extent is the program linking individuals newly diagnosed with HIV to care and treatment?	a. Of the new cases (infected patients) who were interviewed and counseled number/percent successfully linked to medical care for HIV infection	X	X	X
	b. Number/percent of <u>partners</u> newly diagnosed with HIV who learn their test results	X	X	X
	c. Number/percent of <u>partners</u> newly diagnosed with HIV who are successfully linked to medical care for HIV infection (i.e., confirmed attendance at first medical appointment)	X	X	X

## **Overview of Quality Assurance**

Quality assurance is a key component of successful programs. All PS activities should assess the extent to which programming is responsive to community needs and priorities. Gaps in services should be identified as should opportunities for improvement.

**Rationale:** Quality assurance can help to ensure that programs are responsive to program standards and are delivered according to established protocol. Quality assurance activities help to ensure that that programming is responsive and accountable to all stakeholders including funders and, importantly, the communities served.

Definition “Quality Assurance (QA) is a planned and systematic set of activities designed to ensure that requirements are clearly established, standards and procedures are adhered to, and the work products fulfill requirements or expectations.”<sup>8</sup>

<sup>8</sup> Michigan Department of Community Health. HIV/AIDS Prevention and Intervention Section. *Quality Assurance of HIV Prevention Counseling: A Toolbox for Supervisors and Monitors*. May 2007.

### **Components of a Quality Assurance Process:**

1. Identify the product/service that will be examined.
2. Set the standards/expectations for the delivery of the service.
3. Develop policies, protocols, procedures for meeting the standards/expectations
4. Provide training.
5. Measure adherence to established protocols.
6. Strategize for supporting positive work and reducing deficits.

### **Implementation of Quality Assurance**

QA activities should be conducted by all providers of any component of HIV and STD PS on a regular and scheduled basis. Agencies should develop a written QA protocol(s) to guide their QA activities. Staff should receive orientation to and training on QA protocol and procedures.

Protocols should address all of the components of the QA process described above. As appropriate, the QA protocol may either specifically detail each component or clearly indicate the sections of referent documents. For example, the protocol may refer to a document that articulates specific standards or outlines a relevant policy.

The QA protocol should clearly describe the method(s) for measuring and supporting adherence to policies, protocols and procedures and/or achieving standards. The QA protocol must specifically describe how the measurement will be carried out and include the frequency of measurement activities, the responsible parties and the manner in which findings will be applied for program improvement.

QA measurement activities should cross multiple domains, consistent with applicable standards. Critical domains are listed below, with sample questions following each.

- (1) Legal requirements.
  - Are providers delivering PS in ways consistent with the laws governing PS?
- (2) Program/Service requirements.
  - Are providers delivering *all* aspects of PS and *only* those aspects they are expected to by the MDCH standards (e.g., are physicians carrying out their duty to warn or discharging this duty to LHD staff; are CBOs conducting elicitation and referral only)?
  - Are agencies delivering PS in ways consistent with the core elements of PS?
  - Are agencies providing services across clients consistent with program directives (e.g., are they providing services to prioritized populations or providing integrated services as appropriate)?
  - Are referral relationships appropriate to meeting client needs?
  - Are referral relationships appropriately documented?

- (3) Client interface.
  - Are providers delivering PS to individual clients consistent with training?
  - Are providers appropriately documenting PS activities?
  - Are services delivered in a culturally competent and developmentally appropriate manner?
  - Are referrals appropriate to the client identified needs and priorities?
  - Are clients provided with integrated screening and prevention services responsive to their particular risk and needs?
- (4) Reporting Requirements.
  - Are providers submitting disease reports within required time frames?
  - Are agencies completing required forms and entering service data appropriately (i.e., complete, accurate and on time)?
- (5) Performance Measures.
  - Are providers achieving internal or the MDCH-provided performance measures (e.g., proportions of clients receiving PS, numbers of partners notified, numbers of clients linked to care)?
  - Are agencies providing services within specified time frames (e.g., initiating or closing cases within required time frames)?

Various strategies can be used to conduct QA and QA of PS can be incorporated into existing routine programmatic QA activities as appropriate. Methods for conducting QA include the following:

- Pouch reviews
- Chart reviews
- Regular team meetings
- Case conferencing sessions
- Client surveys (addressing awareness of, accessibility to, or satisfaction with services)
- Client interviews
- Service data review
- Role plays
- Directly observed counseling sessions, interviews, and/or investigations
- Regularly scheduled reviews of program guidelines, protocols and performance standards
- Regularly scheduled reviews of client materials to assess cultural and developmental appropriateness
- Periodic review and evaluation of referral resources
- Regular review of record keeping to ensure staff are adhering to confidentiality requirements

Providers of HIV and STD PS should implement QA strategies appropriate to their setting.

**PARTNER SERVICES DELIVERY  
STANDARDS AND DISEASE CASE  
MANAGEMENT  
FOR  
LOCAL PUBLIC HEALTH**

## **PARTNER SERVICES DELIVERY STANDARDS AND DISEASE CASE MANAGEMENT FOR LHDS**

Certified LHD staff is responsible for providing PS as part of a comprehensive approach to disease case management. Disease case management involves the process of providing counseling, education, treatment (when applicable) and intervention to clients who are infected or potentially exposed to HIV/STDs. Carrying out disease case management requires that PS staff execute a systematic plan to locate, document, and analyze medical and epidemiological case information to deliver timely disease intervention services, and link persons to appropriate care and support services.

PS is available in both clinical settings and in the field. For the purpose of this document, PS staff refers to persons employed by public health to conduct the full scope of PS interventions for STDs and HIV.

### **ENCOURAGING PS DELIVERY**

Effective PS delivery depends upon the voluntary cooperation of HIV and STD infected clients. Obtaining this cooperation requires that PS providers treat infected clients with respect and understand the possible apprehension to disclose information about partners. Persuasive, yet compassionate, explanation of the following points may help to encourage the infected client's participation in PS:

- The purpose of PS (a systematic process to help prevent and reduce HIV/STD transmission and ensure appropriate linkages to care and treatment).
- Elements of PS (a cooperative relationship between client and PS provider to confidentially notify at-risk partners of their potential exposure to infection so they can receive treatment and referral to support and/or care services).
- Benefits of PS participation for both infected clients, their at-risk partners and the larger community (PS can serve the infected client and partner by providing them the opportunity to learn their status and educating them about the resources available for partner notification, treatment of infection, and assisting the infected client in avoiding re-infection).
- Confidential nature of PS including how privacy and confidentiality are protected.
- Right to decline participation in PS without being denied other services (PS is voluntary; an infected client's lack of participation will not impede access to treatment/care services).
- Legal responsibility of HIV-infected clients to notify partners of their infectious status prior to engaging in sex/needle-sharing activities in accordance with MCL§5114a.
- Availability of new technologies (including inSPOT, a web-based partner notification system) to assist with notifying at-risk partners exposed to certain STDs including GC, CT, non-gonococcal urethritis, scabies/crabs and HIV;

- Availability of Partner Packets for GC and CT are available to assist partners with accessing screening and treatment services. These packets including information and perforated cards to refer partners to screening. Additional tools which address HIV and syphilis were under development at the time of publication. GC and CT partner Packets are available from the MDCH by contacting 517.241.5900.

## **DISEASE REPORTING AND INITIATING A REQUEST FOR PARTNER SERVICES**

Specific forms (outlined below) were created to report cases of STDs or HIV infection, and serve as a tool to also request assistance with PS. In addition to completion of the forms, LHD encourages providers to contact the LHD to ensure delivery and initiation of PS where indicated. Based on local resources and public health policy, the initiation of PS for GC and CT may be limited.

### **Case Reporting and Requests for Partner Services - STDs:**

The laboratory processing the specimen initially does reporting of STDs. All reports are received by the local health jurisdiction and are required to be entered into the MDSS.

Several laboratories report via an electronic message directly into MDSS, where local staff are alerted of the report and initiate follow up. Providers also may use the *Confidential Venereal Disease-Chlamydia Case Report and Laboratory Test Results Form* (DCH-0821) to report a positive test and treatment. A copy of the DCH-0821 and instructions for completion are available by contacting the LHD.

Upon receipt of a GC or CT case report, local staff will follow up according to the jurisdiction's policy and capacity. For a positive syphilis test, the MDCH PS staff first determine if the person is a potential new infection, then begin the process of disease management by locating the client, providing confidential counseling, and eliciting information on at-risk partners in need of notification and medical evaluation.

### **Case Reporting and Request for Partner Services - HIV:**

The laboratory processing the specimen initially does reporting of positive HIV. However, Michigan law requires testing entities that administer a test submit a completed Michigan Adult *HIV/AIDS Confidential Case Report Form* (DCH-1355) within **seven (7) days** of receipt of the positive result. By completing section XI of the form, the LHD is notified whether or not the client has received their test results and whether the physician or LHD is to notify partners.

Upon receipt of a PS request, LHD PS staff attempts to locate the infected client, counsel him or her about their exposure, and begin elicitation of information about at-risk partners. Partners, once notified of their possible exposure, can subsequently receive testing for HIV/STDs, and receive referral information to access prevention and care services.

While Michigan law requires the completion of the DCH-1355 form for all persons diagnosed with HIV or AIDS, it does not provide a venue for the referral of infected individuals who have requested anonymous reporting, but are in need of assistance with PS. The *Confidential Request for Local Public Health Assistance with Partner Counseling and Referral Services* form (DCH-1221) is available to refer anonymously reported infected clients as well as their at-risk partners in need of PS. Copies of the HIV/AIDS Confidential Case Report Form (DCH-1355) and the Confidential Request for Local Public Health Assistance with Partner Services Form (DCH-1221) are available on the [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd) website.

**Note:** When working with dually diagnosed (syphilis and HIV) clients, ensure that the client is appropriately treated for syphilis, and receives comprehensive counseling for both disease states and referral into support services

## **STANDARDS FOR CONDUCTING DISEASE CASE MANAGEMENT INVESTIGATIONS**

A comprehensive disease management plan includes conducting field investigations to locate infected clients and at-risk partners. The recommendations below provide guidance and suggestions for both pre-field and field-delivered PS activities, and are present in the POPRCRC format (see below) from the CDC's Introduction to STD Intervention training.

### **POPRCRC:**

- Pre-Interview Analysis
- Original Interview
- Post-Interview Analysis
- Referral
- Cluster Interview
- Re-Interview
- Case Closure

*POPRCRC* is an **integrated** disease case management process and can vary based on the nature of the disease. The following guidance reflects this variance as PS work with persons diagnosed with and/or exposed to HIV, syphilis, GC, or CT

## Pre-Interview Analysis

The process of thoroughly reviewing all available materials related to a case prior to the actual interview with the client.

## Recommendations:

Upon receipt of a case report/referral, PS provider should engage in the following activities:

1. Contact the reporting or referral entity to review and verify case information, and gather any other information necessary to begin investigation.
  - a. Obtain disease history, demographic information as well as any information that may be a barrier to investigation efforts e.g., language, physical limitations, psychosocial issues, and/or environmental/living conditions.
  - b. Even if the physician/provider indicates on the case report form, that they have conducted PS, for HIV infection, the MDCH recommends that the LHD contact the physician/provider to ensure that the provider understands their legal responsibility for conducting the full scope of PS by confidentially notifying at-risk partners of their potential exposure, and offering HIV testing or test referral.
  - c. Conduct internal (MDCH) record search to determine if this is a new or old case/referral, which may or may not necessitate further investigation. Criteria for determining a case as active or inactive will vary based on disease. In the case of *syphilis*, an active case is determined by historical serology results and treatment, as well as symptoms. In cases of *HIV*, an active case of PS is determined if it is newly reported, or PS has not occurred on a previously reported case less than 6-months old.
  - d. Cross check referral information in local directories for possible field investigation e.g.,
    - The white pages
    - District cross directories
    - Web-based residential searches as resources allow such as [infospace.com](http://infospace.com), [peoplefinder.com](http://peoplefinder.com), [switchboard.com](http://switchboard.com). (Note: fees may be associated with the use of these web-based locating systems)
    - Using the search engine Google or Zaba search may also be helpful.
2. Prioritize cases for investigation.
3. Transfer gathered information to appropriate case management forms or electronic case file/record. The DCH-1275 may be used for HIV documentation, or onto any departmentally approved form. A copy of the DCH-1275 form is available on the [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd) website.

**Note:** As part of the pre-interview analysis, PS staff are encouraged to assemble necessary interview tools such as business cards, reference materials, forms, writing materials, and visual aids that may be of assistance in the interview process.

## **Original Interview**

The purpose of the original interview is to ensure that the client (infected individual) understands the seriousness of their infection or exposure, and the importance of their cooperation in the disease prevention process. Interviews should be client-centered to support rapport building and adoption of risk reduction behaviors. A key component of the interview is to elicit identifying and locating information about at-risk partners to support notification efforts.

## **Recommendations**

Original interviews are to be conducted in person for persons who reside in Michigan and based upon epidemiological criteria.

Requirements for syphilis include:

- Serological test
- History
- Symptoms

*HIV* includes:

- Confirmed HIV positive
- Assistance with PS was deemed necessary by the entity who administered test

Original Interviews should be confidential and within specific timeframes:

- Interviews for *syphilis* should occur within **7 days** from date of receipt of positive report. The optimal time for contacting identified at-risk partners for notification of their potential exposure to syphilis or other STDs should occur within **24 hours**.
- Interviews for *HIV* should occur within **14 days** of receipt of positive report.  
**Note:** *Departmental standards* urge that attempts to locate and provide PS to *HIV* infected clients take place within **48-working hours** to expedite PS delivery.

1. Contact the client during the time of day when they are most likely to be available to schedule a face-to-face meeting.

When talking with the client over the phone to schedule an appointment:

- a) Assure privacy and confirm the identity of the client by asking key questions that can help identify the individual (e.g., full name, date of birth, etc.). Limit any shared medical or exposure information to only that which is necessary to arrange a face-to-face appointment.

- b) Upon reasonable certainty of the client's identity, inform the client of the need for a face-to-face meeting to discuss an important health matter. **Due to the sensitive nature of HIV, PS providers cannot discuss any HIV related information over the phone.**
- c) Schedule an appointment within 24 hours of initial contact. Let the client know that the meeting must be private. Request they have some form of identification ready that will confirm their identity, e.g., pictured driver's license, state ID, or a utility bill/letter that confirms their name/address. Assess any language, psychosocial or environmental barriers that might impede a one-on-one conversation. If potential barriers do exist, make appropriate arrangements to address the situation.
- d) If the client is not available for a phone conversation, leave a generic but urgent message with a phone number so the individual may return the call. Be sure to leave a number that omits reference to HIV/STD to help ensure confidentiality.
2. Upon contact with the client, PS staff should progress through the following steps that are outlined in greater detail the *PS Original Interview Guide* in Appendix F of this document:
- *Introduction:* Identify self, where you are from, and affirm why you've come.
  - *Patient Assessment:* Patient concerns, social and medical history, disease comprehension.
  - *Disease Intervention:* Explain rationale for encounter and review risk.
  - *Conclusion:* Address any remaining patient needs or concerns, and reinforce commitments. Leave the door open for continued communication, and schedule a tentative date for a possible re-interview.
  - *Documentation:* Record interview notes (dates, times, persons spoken to, commitments) on designated forms and enter required data into appropriate data management system. Store information in a secure location.
3. Field Safety Precautions: PS staff should embrace the following safety practices when conducting field delivered PS:
- Complete a routing slip of the day's planned field activities and leave it with a designated support staff member or supervisor.
  - Keep a working cell phone on your person at all times.
  - Be aware of your surroundings. Follow your instincts - if they begin to give you warning signals, reschedule the appointment.
  - Drive by the home or site prior to stopping to visually assess environmental conditions.
  - When feasible, call the person you are scheduled to visit prior to your appointment to let them know that you are in route.
  - While conducting the visit, take only materials that are necessary for the visit.
  - Do not bring expensive personal items or a large amount of cash.

- Travel with a co-worker if necessary.
- At the end of your investigations, communicate to your office, either by phone or in person to let them know that you have concluded your field stops.

**Note:** Establishing an interview setting is important and can aid in the successful outcome of PS delivery. Interviews conducted in the clinic setting have certain advantages because it allows for a safe and convenient environment. Clinic interviews allow staff access to records and other materials. Conversely, interviews conducted in the field offer the client familiar surroundings and a level of comfort.

Equally important is establishing *interview periods* (the time the client most likely became infected). Based on the diagnosis of STDs and HIV, and the review of local data, disease trends, and social network analysis, interview periods can range from 15-30 days for GC, 30-60 days for CT, 3-12 months for syphilis, and 1-5 years for HIV.

### **Post-Interview Analysis:**

The process of reviewing case notes to identify any gaps/inconsistencies in information received during the original interview. This activity can be conducted independently, or with the aid of supervisory staff.

### **Recommendations:**

When conducting a post-interview analysis, PS staff should accomplish the following:

- Link associated cases for *syphilis* investigations.
- Identify gaps in time lines for possible exposures.
- Confirm locating information on named partners.
- Identify missing or forgotten information.
- Verify information provided by the client during the original interview, e.g., treatment, counseling, etc.
- Assess barriers that appear to impact patient participation in PS process and strategize ways to effectively address them.
- Record search and prioritize field investigations for identified at-risk partners.
- Perform visual case analysis for *syphilis* cases.
- Complete appropriate paper work and forms.
- Review findings with supervisor for added investigational pointers.
- Implement next action steps toward disease case management.
- Assess linkage to care referrals.

**Note:** The post-interview analysis is an opportune time to look for disease patterns or relationships to other cases. PS staff should consult with colleagues to identify the need for any additional support in case management.

## Referral and Notification

Referral and notification is the process of ensuring that clients are provided the necessary referrals to other medical and support services and that their at-risk partners are notified of their possible exposure and access to care.

As part of comprehensive disease case management, PS staff must remain sensitive to the other psychosocial needs of the HIV or STD infected client. When working with HIV-infected clients who have tested confidentially, partner services staff should promote the use of the Client Authorization for Counselor Assisted Referral Form (CARF) to help expedite referral into HIV/AIDS Case Management. Note: See the [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd) website.

## Recommendations:

1. PS staff is encouraged to maintain active and strong referral relationships with other providers in order to enable and facilitate successful referral<sup>9</sup> to needed services. Following are examples of community resources with which LHDs should develop and maintain referral relationships:

- Substance abuse treatment services
- HIV support groups
- Mental health
- Medical care for treatment
- Intimate or domestic violence
- HIV/AIDS case management services via use of the CARF
- Intercultural/community support groups for persons with language barriers
- Family planning or prenatal care
- Immunization
- Social Security
- Housing
- Legal services
- Rape crisis
- Link to other support services

2. The confidential notification of at-risk partners of their exposure and linkage to testing and treatment is a key PS element.

All notifications should be conducted in a manner such that the person notified:

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<sup>9</sup> Referral: The process by which a client's immediate needs for care, prevention and supportive services are assessed and prioritized. Clients are provided with assistance in accessing referral services. Referral also includes reasonable follow-up efforts necessary to facilitate initial contact with referral services and to solicit client feedback on these services. In an "active referral," clients are escorted to the referral service, regardless of whether the referral is within the initiating agency or at another service provider. See the *HIV Prevention Referral Guidelines and Toolbox*, Michigan Department of Community Health (2007) for additional information.

- Knows the disease for which they are at risk
- Knows the information is valid and the risk is real
- Knows that information is confidential
- Knows the medical options available
- Is sufficiently motivated to act promptly

Similar to the steps outlined in the *'original interview,'* PS staff should progress through those same steps for notifying at-risk partners:

- Introduction
- Notification of potential exposure
- Disease Comprehension
- Risk Reduction Counseling
- Linkage to testing and treatment (this varies by disease and staff capacity, may include field testing, accompanying the patient to the clinic, or referral)
- Stress the importance of receiving test results
- Document case information in electronic and/or paper files as required.

The MDCH supports the use of internet-based partner notification systems, including inSpot, to assist with notifying at-risk partners exposed to GC, CT, non-gonococcal urethritis, scabies/crabs and HIV. The use of the Internet in the case of syphilis or HIV should be limited to making initial contact and setting a time to meet face to face.

1. For victim notification, LHD PS providers may be requested to provide victims of certain sex crimes involving sexual penetration or exposure to a defendant's bodily fluids with the defendant's HIV/Hepatitis B and C test results. Before responding, PS staff must receive the Order for Counseling and testing for Disease Infection form MC-234, and the Verification Regarding Test Results Form DCH-1252 from the courts requesting follow up. Once received, victims or their legal guardian (*in loco parentis*, conservator, and foster parent) confidentially contacted and informed of the information requested. Copies of these forms are available on the [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd) website.

**Note:** Some health jurisdictions utilize a court advocate from the local prosecutor attorney's office to provide victim notification. LHDs should consult their local courts to determine the type of notification services available.

### **Cluster Interviewing:**

The process of selectively interviewing uninfected individuals linked to the infected client, to identify people potentially at risk.

Cluster interviewing is typically performed on a limited basis, following the analysis of a syphilis case, and can be done at any time to expand the base of information not

provided by the original client. Cluster interviewing for HIV is encouraged as resources permit.

### **Recommendations:**

1. The cluster Interview is an intervention strategy intended to identify and gather information about the infected client through others who may be associated with the case. It is also designed to further expedite the disease intervention process by gathering information on high-risk groups associated with the infected client.
2. When conducting cluster interviews, PS staff is reminded to look for the following:
  - Individuals that may benefit from an exam due to social networks or other behavioral risk
  - Individuals with symptoms
  - Individuals exposed to known cases
  - Gain information about known cases
3. Information should be kept current during the investigation process as it is frequently used to identify risk groups for targeted interventions.

### **Re-interview:**

The re-interview is the process of interviewing a client following the initial/original interview. A re-interview can be especially helpful with infected clients who, during the original interview, may have evaded discussion on partner referral or failed to refer partners for testing. The re-interview typically follows the original interview by **2-3 days**, and has set objectives.

### **Recommendations:**

1. When re-interviewing, PS staff should follow a plan designed to accomplish objectives generated from the post interview analysis. The format for initiating a re-interview, and items to cover, are provided below:
  - Introduce/re-introduce yourself and your professional role
  - State the purpose of the session, e.g., problems with comments made in the original interview, and discuss new information
  - Review confidentiality
  - Identify any concerns the patient may have as a result of the original interview
  - Address missing or conflicting information identified through post-interview analysis
  - Address points not covered through the original interview
  - Gather additional locating information on un-located partners and cluster clients

- Support patient initiatives/efforts to locate partners and/or reduce risk
- Document outcome on appropriate case forms.

2. Staff is encouraged to schedule a re-interview at the time of the original interview so that additional information may be secured or provided. Letting the client know this in advance can enhance a “working relationship” and foster a shared responsibility in disease prevention efforts.

### **Case Closure:**

Case closure is the process of reviewing any information obtained and shared during the interview session. PS staff should take this opportunity to reiterate essential information to help ensure a mutual understanding of the next steps in disease case management. A case is considered closed when all reasonable avenues have been taken to locate the client and provide disease case management services.

PS providers are required to document all activities taken as part of the investigation process and record that information onto the appropriate case report record.

Case information should be recorded as soon as possible during the investigational process, and not exceed **48 working** hours following the investigation.

Case closure for HIV and STD investigations should occur within **30 working days** of initiation, unless there are extenuating circumstances and approved by supervisory staff.

Post-case investigation outcome information should be entered into the appropriate module of the HES within **45 days** of case initiation. STD entries must be placed within the MDSS within **24 hours** of case closure.

### **Recommendations:**

PS staff should take the following steps to assure that cases are appropriately closed:

- A thorough review of case to determine that program performance and data needs have been met
- Assure that information is complete and consistent and that results are documented
- When conducted, clear documentation of re-interviews/cluster interviews
- Disposition or outcome of partner investigation efforts is recorded
- In *syphilis* investigations, documentation of source-spread determinations
- Confirmation of linkages to care and support services
- Documentation of supervisory review.

## Investigation Concerns

In the event that HIV-infected individuals are intentionally engaging in behaviors that put others at risk for HIV infection, providers should contact the LHD for guidance in addressing this situation in accordance with Health Threat to Others (HTTO) laws. (MCL§333.5201 et seq.). Contact information for LHDs is available from the Michigan Association for Local Public Health at [www.malph.org](http://www.malph.org).

## REQUIRED RESPONSE TIMEFRAMES IN RESPONDING TO PS REQUEST

Required response timeframes to requests for PS assistance by the LHD vary by disease diagnosis.

### Time Frames for PS Delivery to **STD** Infected Clients and At-Risk Partners

Michigan requires case investigations *for syphilis* begin within **24 hours** of receipt of the case report as evidenced by the completion of the field record. While 72 hours is the expected timeframe, the MDCH is aware that initiating PS for infected clients with diagnoses of GC or CT will vary based on the LHD jurisdiction's resources and staffing. In Michigan, the LHD has the primary responsibility for the follow up of persons diagnosed with GC or CT and to ensure that the infected client and at-risk partners receive appropriate evaluation and treatment.

### Time Frames for PS Delivery to **HIV** Infected Clients

Michigan law (MCL 333.5114a) requires that the LHD attempt to contact and interview the HIV-infected client within **14 days** of receipt of a referral via the *HIV/AIDS Case Report form (DCH-1355)*.

The MDCH recognizes the value of conducting expedient investigations and highly recommends that LHDs begin infected client investigations within **2 business days** after receipt of a request, and complete the investigation within **14 calendar days**. This action enhances the department's ability to locate individuals quickly and elicit information about their at-risk partners.

### Time Frames for PS Delivery to **HIV** At-Risk Partners

Michigan law emphasizes the importance of the LHDs confidentially notifying known partners of their exposure, and providing risk reduction counseling, testing, and/or test referral **within 35 days of receipt of the referral**. In order to facilitate the delivery of prompt PS, the MDCH highly recommends that attempts to notify a known at-risk partner occur within **two business days**, and are completed no later than **35 calendar days**.

LHDs should only initiate paperwork when sufficient locating information (e.g., infected client or partner's name, address and or phone number) is available to begin an

investigation. Additional information, such as age/date of birth or physical description, is always helpful, but the lack of this type of information should not impede investigation attempts.

### **Special Considerations:**

Because there may be situations when testing entities delay referral of client information to the LHD for PS (for example, if client fails to return for results, or are non responsive to notification attempts), the MDCH recommends the following steps that PS providers should take to expedite referrals:

- a. Educate the testing entity on the importance of PS follow up for the client, and the at-risk partner.
- b. Explain the role of public health in the PS process by emphasizing the need to locate clients/partners as soon as possible.
- c. Build a collaborative partnership that allows for the exchange of information that can lead to conducting quality timely investigations.

## **MONITORING, EVALUATION AND QUALITY ASSURANCE FOR LOCAL HEALTH DEPARTMENTS**

This section of the recommendations offers HIV/STD PS providers direction for ensuring effective service delivery. Outlined below is an overview and rationale of the monitoring and evaluation process that should be adopted as part of an overall disease case management plan. PS providers should view the following information and determine the feasibility of implementation based upon the type of service delivery and availability of resources.

### **Overview of Monitoring and Evaluation**

Monitoring and Evaluation activities are key components of any successful program. M&E helps you to look at the resources that go into your program (e.g., staff, funding); the services provided (e.g., client interviews, referrals); and the results of the program (e.g., linkage to care).

**Rationale:** All PS activities should be monitored to assess program performance and to identify areas in need of improvement. Applying M&E data to program planning and management can help to refine and strengthen programming by:

- *Describing infected patients and partners* in terms of demographic, geographic, behavioral and other factors. This is important to improving the targeting of screening and prevention activities so that efforts are focused where they will be most effective.
- *Monitoring trends* among infected patients and partners in terms of demographic, geographic, behavioral and other factors. This is important in order to identify potential outbreaks at early stages; assess the extent to which populations are

engaged with PS; and to understand whether partner services are responsive to community needs.

- *Identifying social networks* that may be facilitating disease transmission. This is important in order to focus PS and other prevention efforts and resources where they will be most effective.
- *Guiding quality assurance* by monitoring program productivity (e.g., number of partners identified and initiated; timeliness of reporting and referral). This will help to focus on program areas and practices that may benefit most from refinement.

Definitions: Monitoring refers to the routine collection and review of data related to program activities and associated outcomes. *Process monitoring* provides descriptive information about services delivered and populations served. In the context of HIV and STD PS, the number of infected clients interviewed and counseled is a process monitoring measure.

*Outcome monitoring* addresses the extent to which the expected program outcomes are achieved. Typically, outcome monitoring measures are responsive to programmatic standards. In the context of HIV and STD PS, one program standard is that 90 percent of newly diagnosed HIV-infected individuals will be successfully linked to care within three months of diagnosis. The outcome measure associated with this standard would be the proportion of newly diagnosed individuals successfully linked to care within three months of diagnosis.

All providers of any aspect of PS should conduct both process and outcome monitoring of these services. Monitoring should be ongoing, with data analyzed and reviewed regularly in order to optimize program effectiveness. In the context of PS, there are several key questions that program monitoring activities that providers of HIV and STD PS should consider in planning monitoring activities:

- (1) How completely is the program identifying newly reported cases?
- (2) To what extent is the program identifying, notifying and examining/treating partners?
- (3) What is the yield of partner services in identifying new cases of syphilis, GC and CT?<sup>10</sup>
- (4) To what extent is the program providing treatment for syphilis, GC and CT through PS?<sup>11</sup>
- (5) What is the yield of PS in terms of identifying new cases of HIV infection?
- (6) To what extent is the program linking individuals newly diagnosed with HIV to care and treatment?

*Evaluation* refers to activities designed to assess the effectiveness of program activities in facilitating expected program outcomes and in achieving improvements in client

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<sup>10</sup> LHDs conducting PS for GC and CT should conduct monitoring yield of these services as resources allow.

<sup>11</sup> LHDs conducting PS for GC and CT should conduct monitoring of treatment provided to partners as resources allow.

health (e.g., decreased morbidity and mortality) and the health of the community (e.g., reductions in disease incidence). In general, evaluation activities require a more rigorous design and analysis and should be undertaken as resources allow. For PS, the kinds of questions that evaluation activities might address include:

- (1) Which provider type (e.g., clinicians, CBOs, local health, others) is most successful in eliciting partner information?”
- (2) Which providers are most successful in referring infected patients to local health for assistance with PS?
- (3) Compared with other strategies, how effective are PS as a method of identifying new cases?
- (4) Compared with other strategies, how cost-effective are PS as a method of identifying new cases?
- (5) Is certain staff more effective than others in eliciting partners? Locating partners? Encouraging testing and treatment? What possible factors can explain these differences?
- (6) Are there specific populations or communities among whom PS are more successful than others in identifying new infections? In referring and locating partners? What possible factors can explain these differences?

### **Monitoring Partner Services: Key Measures**

For each of the six key monitoring questions described above, the table on page 78 provides recommended monitoring measures. Many of the measures apply equally to HIV, syphilis, GC and CT. In these instances, programs should tailor the measures to respond to the infection-specific program standard. For example, monitoring measure 1.c. should be tailored as follows for syphilis “Of the new cases (infected patients) of *syphilis* eligible for PS, number/percent who were interviewed to elicit partner information *within seven days from receipt of positive report.*”

The various measures may not be applicable to every provider type. The provider types(s) to which the measures are applicable is noted in the table. All measures can be addressed with existing data sources, such as patient records. LHDs and CBOs funded by the MDCH for HIV and STD services can obtain needed data from the HES and the MDSS.

<b>TABLE: Key Monitoring Questions and Associated Measures</b>				
Key Question	Monitoring Measure	Applicability		
		PRO	CBO	LHD
1. How completely is the program identifying newly reported cases?	a. Number of new cases (infected patients) reported to the health department within specified time period associated with each infection.	X	X	X
	b. Of the new cases (infected patients) reported to the health department, number/percent who were eligible for PS (i.e., not deceased, incapacitated or out of jurisdiction at time of report).			X

<b>TABLE: Key Monitoring Questions and Associated Measures</b>				
	c. Of the new cases (infected patients) eligible for PS, number/percent who were interviewed to elicit partner information	X	X	X
2. To what extent is the program identifying, notifying and examining/treating partners?	a. Number of partners claimed per infected patient interviewed		X	X
	b. Number/percent of partners named per infected patient interviewed		X	X
	c. Number/percent of partners named referred to LHD for follow-up	X	X	
	d. Number/percent of named partners initiated (i.e., attempted notification)			X
	e. Number/percent of named partners not previously confirmed HIV infected initiated			X
	f. Number/percent of partners initiated who were successfully notified.			X
	g. Number/percent of partners notified who were examined and/or tested	X		X
3. What is the yield of PS in identifying new cases of syphilis, GC and CT?	a. Number/percent of partners found to be infected, among named partners examined or tested			X
	b. Number/percent of named partners treated to cure (i.e., found to be infected and brought to treatment) [Note: applies to syphilis only]			X
4. To what extent is the program providing treatment for syphilis, GC and CT through PS?	a. Number/percent of named partners treated preventively [Note: for syphilis measure should specify treatment within 30 calendar days from the date of the index interview.]			X
	b. Number of partners brought to treatment (preventively or as a result of exam/testing) per infected patient. [Note: applies to syphilis only]			X
5. What is the yield of PS in terms of identifying new cases of HIV infection?	a. Number/percent of partners found to be infected among partners notified and tested			X
	b. Number/percent of partners newly diagnosed with HIV			X
	c. Number of partners newly diagnosed with HIV per infected patient			X
6. To what extent is the program linking individuals newly diagnosed with HIV to care and treatment?	a. Of the new cases (infected patients) who were interviewed and counseled number/percent successfully linked to medical care for HIV infection	X	X	X
	b. Number/percent of <u>partners</u> newly diagnosed with HIV who learn their test results	X	X	X
	c. Number/percent of <u>partners</u> newly diagnosed with HIV who are successfully linked to medical care for HIV infection (i.e., confirmed attendance at first medical appointment)	X	X	X

### **Overview of Quality Assurance**

Quality assurance is a key component of successful programs. All PS activities should assess the extent to which programming is responsive to community needs and priorities. Gaps in services should be identified as should opportunities for improvement.

Rationale: Quality assurance can help to ensure that programs are responsive to program standards and are delivered according to established protocol. Quality assurance activities help to ensure that that programming is responsive and accountable to all stakeholders including funders and, importantly, the communities served.

Definition: “Quality Assurance (QA) is a planned and systematic set of activities designed to ensure that requirements are clearly established, standards and procedures are adhered to, and the work products fulfill requirements or expectations.”<sup>12</sup>

*Components of a Quality Assurance Process:*

1. Identify the product/service that will be examined.
2. Set the standards/expectations for the delivery of the service.
3. Develop policies, protocols, procedures for meeting the standards/expectations
4. Provide training.
5. Measure adherence to established protocols.
6. Strategize for supporting positive work and reducing deficits.

### **Implementation of Quality Assurance**

Quality Assurance activities should be conducted by all providers of any component of HIV and STD PS on a regular and scheduled basis. Agencies should develop a written QA protocol(s) to guide their QA activities. Staff should receive orientation to and training on QA protocol and procedures.

Protocols should address all of the components of the QA process described above. As appropriate, the QA protocol may either specifically detail each component or clearly indicate the sections of referent documents. For example, the protocol may refer to a document that articulates specific standards or outlines a relevant policy.

The QA protocol should clearly describe the method(s) for measuring and supporting adherence to policies, protocols and procedures and/or achieving standards. The QA protocol must specifically describe how the measurement will be carried out and include the frequency of measurement activities, the responsible parties and the manner in which findings will be applied for program improvement.

QA measurement activities should cross multiple domains, consistent with applicable standards. Critical domains are listed below, with sample questions follow each.

- (1) Legal requirements.

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<sup>12</sup> Michigan Department of Community Health. HIV/AIDS Prevention and Intervention Section. *Quality Assurance of HIV Prevention Counseling: A Toolbox for Supervisors and Monitors*. May 2007.

- Are providers delivering PS in ways consistent with the laws governing PS?
- (2) Program/Service requirements.
- Are providers delivering *all* aspects of PS and *only* those aspects they are expected to by the MDCH standards (e.g., are physicians carrying out their duty to warn or discharging this duty to LHD staff; are CBOs conducting elicitation and referral only)?
  - Are agencies delivering PS in ways consistent with the core elements of PS?
  - Are agencies providing services across clients consistent with program directives (e.g., are they providing services to prioritized populations or providing integrated services as appropriate)?
  - Are referral relationships appropriate to meeting client needs?
  - Are referral relationships appropriately documented?
- (3) Client interface.
- Are providers delivering PS to individual clients consistent with training?
  - Are providers appropriately documenting PS activities?
  - Are services delivered in a culturally competent and developmentally appropriate manner?
  - Are referrals appropriate to the client identified needs and priorities?
  - Are clients provided with integrated screening and prevention services responsive to their particular risk and needs?
- (4) Reporting Requirements.
- Are providers submitting disease reports within required time frames?
  - Are agencies completing required forms and entering service data appropriately (i.e., complete, accurate and on time)?
- (5) Performance Measures.
- Are providers achieving internal or the MDCH-provided performance measures (e.g., proportions of clients receiving PS, numbers of partners notified, numbers of clients linked to care)?
  - Are agencies providing services within specified time frames (e.g., initiating or closing cases within required time frames)?

Various strategies can be used to conduct QA and QA of PS can be incorporated into existing routine programmatic QA activities as appropriate. Methods for conducting QA include the following:

- Pouch reviews
- Chart reviews
- Regular team meetings
- Case conferencing sessions
- Client surveys (addressing awareness of, accessibility to, or satisfaction with services)
- Client interviews
- Service data review
- Role plays

- Directly observed counseling sessions, interviews, and/or investigations
- Regularly scheduled reviews of program guidelines, protocols and performance standards
- Regularly scheduled reviews of client materials to assess cultural and developmental appropriateness
- Periodic review and evaluation of referral resources
- Regular review of record keeping to ensure staff are adhering to confidentiality requirements

Providers of HIV and STD PS should implement QA strategies appropriate to their setting.

### PROCEDURES FOR TRANSMITTING PS INFORMATION BETWEEN HEALTH JURISDICTIONS AND AGENCIES

Administering PS frequently requires staff to investigate cases of disease or at-risk partners referred from outside their own health jurisdiction or outside the state of Michigan. In these cases, PS staff should forward case information to the appropriate health jurisdiction responsible for the investigation. Procedures for forwarding PS information are outlined below:

Transmitting PS Information Inside Michigan (Intrastate)		Transmitting PS Information Outside Michigan (Interstate)	
<b>Between LHDs in other health jurisdictions within Michigan</b>	<b>STDs:</b> Enter thorough case information for <i>syphilis, GC and CT</i> investigations into the electronic MDSS. Through this electronic system, PS staff with authorization rights, can forward information to other health jurisdictions inside Michigan for investigation. <b>Do not email case information as confidentiality cannot be ensured.</b>	<b>Between LPH Depts. in jurisdictions outside Michigan</b>	<b>HIV and STD:</b> Provide thorough case information ( <i>investigation specific criteria</i> ) to the STD program liaison via the MDCH at (517) 241-5900. The liaison will contact the health department for that case and provide PS staff with investigation disposition within 14 business days. <b>Do not email case information for syphilis or HIV, as confidentiality of such transmission cannot be ensured.</b>
<b>Correctional Settings (state prisons, county jails)</b>	<b>HIV:</b> Provide thorough case information ( <i>investigation specific criteria</i> ) to the Prison Liaison Consultant at (517) 241-5900. The liaison will contact the health jurisdiction responsible for that case and provide PS staff with investigation disposition information within 14 business days. <b>Do not email case information, as confidentiality cannot be ensured.</b>	<b>Military Branches</b>	Provide thorough case information ( <i>investigation specific criteria</i> ) to the STD program liaison via the Department at (517) 241-5900. The liaison will contact the health department for that case and provide PS staff with investigation disposition within 14 business days. <b>Do not email case information, as confidentiality cannot be ensured.</b>

Transmitting PS Information Inside Michigan (Intrastate)		Transmitting PS Information Outside Michigan (Interstate)	
	<p>Request for follow up of cases for persons residing in county jails should be forwarded to the PS provider of that county health department. <b>Avoid e-mail transmittals, as confidentiality cannot be ensured.</b></p> <p><b>STDs:</b> Provide thorough case information (<i>investigation specific criteria</i>) to the STD program liaison via the Department at (517) 241-5900. The liaison will forward the information to the partner services staff responsible for PS delivery in that county.</p>		
<b>Court Ordered Testing Request for Victim Notification (MCL 333.5129)</b>	<p><b>HIV:</b> For prisoners housed in the Department of Correction (DOC) facilities, send appropriate court forms MC 234, DCH-1252 to the PS prison consultant by calling (517) 241-5900. MC -234, and DCH forms 1252 are located available on the <a href="http://www.michigan.gov/hivstd">www.michigan.gov/hivstd</a> website.</p>		
<b>Other Agencies (Substance Treatment and Mental Health Facilities)</b>	<p>Establish MOA to facilitate the ongoing confidential exchange of specific case information (provided for by HIPAA) and access to the client or partner to provide PS.</p>		

When transmitting referrals between health jurisdictions, disease case management becomes the responsibility of the receiving county. Receiving counties are responsible for recording investigation outcomes into the appropriate program databases.

## SUMMARY OF PARTNER SERVICES ACTIVITIES

Provided below is a summary of community partners that can be involved in the PS process at any given time. Information provided in this chart is indicative of Michigan's collaborative approach to reduce the transmission of HIV/STDs among populations deemed most at risk because of their sex and/or needle-sharing exposure. While PS delivery can vary by degree among our community partners, the overall intent is to link resources and skill sets in effectively designing disease prevention programs. The following sections depict the roles and responsibilities shared by our community partners in PS delivery.

<b>Activities</b>	<b>CBO</b>	<b>LHD</b>	<b>Physician</b>
Counsel client on PS	√	√	√
Counsel client on syphilis, GC & CT and treat infection		√	√
Elicit partner information	√	√	√
Investigate partners		√	√
Refer client or partner to other services	√	√	√
Offer client or partner HIV/STD counseling & testing	√	√	√
Refer at-risk partners to LHD for field investigation	√		√
Request PS assistance from LHD	√		√
Referral to HIV care and treatment	√	√	√

## LINKAGES TO CARE

Linking HIV and/or STD infected clients to appropriate care, prevention and support services is essential to providing optimal disease management. Services such as medical care, mental health, substance abuse and medical case management help infected clients to address their emerging health care needs.

Due to the curative nature of STDs (syphilis, GC and CT) and the availability of treatment upon diagnosis, linking STD infected clients to medical care and recommending that clients return for medical assessments three months after their diagnosis is relatively easy.

When a diagnosis of HIV is made, the linkage with medical providers to clinically evaluate and plan treatment for HIV infection is essential and should be prioritized. Medical case management, which is available in local communities throughout the state, can provide clients with assistance in accessing needed medical care if the patient lacks insurance. Or, in many areas of the state, clinics who receive funding from the Ryan White Treatment Extension Act of 2009, can directly schedule appointments for patients regardless of insurance status and/or ability to pay. Additional information on medical case management is available at [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd) and clicking on the HIV Care and Treatment section.

### **Benefits of Linkages to Care for HIV Infected Clients**

Effective linkage from HIV testing to HIV care ensures that people living with HIV/AIDS receive the services they need to improve their health and enhance their quality of life. Linkage from HIV testing to HIV care is important to:

- Connect more people living with HIV/AIDS with HIV-related medical, prevention and support services to improve their health and overall well-being;
- Reduce HIV transmission by connecting newly diagnosed individuals to medical and mental health care as needed as soon as possible after diagnosis that reduces the chances for further transmission; and
- Ensure a coordinated system of services from HIV prevention and testing to HIV care and treatment.

For clients, linkages help to ensure that they can receive coordinated care. Completed referrals from HIV testing agencies to HIV medical and support services help newly diagnosed HIV positive individuals:

- Access a medical care provider for a medical evaluation, treatment planning and screening for other STDs.
- Receive appropriate medical care and treatment.
- Access other prevention and supportive services.

- Receive assessment for Hepatitis C, Tuberculosis (TB) and current immunizations.
- Receive PS on an ongoing basis.
- Refer identified at-risk partners to the LHD for prevention counseling and HIV/STD testing.

### **Recommendations to Ensure Linkage for HIV**

Ensuring that linkages to core services take place requires that providers identify activities that support linkages for HIV infected clients, and establish measures to determine linkages are successful. In general referral of HIV infected individuals to the continuum of care services includes:

1. Assessment of client referral needs
2. Referral planning
3. Facilitate access to referral services, including providing necessary support to access services (e.g., setting up appointments, arranging for transportation, escorting the patient)
4. Follow-up to assess whether the client has successfully completed the referral and to document the extent to which the referral adequately addressed identified needs.

Additional guidance regarding referral and linkage is available in the *HIV Prevention Referral Guidelines and Toolbox*, Michigan Department of Community Health (2007).

### **Supporting Linkages for STD**

Medical providers and PS staff of LHDs ensure that persons diagnosed as having an STD receive the appropriate care and treatment. Additionally, identified at-risk sex and needle-sharing partners should be notified of their potential exposure, provided information and referrals for free or low cost testing, and treatment.

It is the responsibility of the diagnosing entity to be knowledgeable of the services and organizations to which partners are referred. Providing the name of the LHD as well as the address, hours of STD services, and a specific staff contact is expected.

Listed below, are recommendations expected from both private and public providers that diagnose GC and CT:

#### **Recommendations:**

- Use Partner Packets, coupled with contact information from LHDs.
- Use materials developed by other providers and other LHDs.

Due to the frequency of co-infection across the spectrum of STDs, it is also recommended that partners exposed to one STD be tested for all reportable STDs (GC, CT, syphilis and HIV). Similarly, partners exposed to HIV should be tested for other reportable STDs, as mentioned above. Access to treatment for the provider-confirmed infection to which they were exposed should not be withheld even if the client refuses additional testing.

## COMMUNITY COLLABORATION

The MDCH has prioritized developing and maintaining key partnerships with LHDs, CBOs, medical providers and other providers of prevention and care services to ensure the highest quality and most effective PS engagements possible. The following recommendations may serve to strengthen relationships between providers.

### Organizational Structure

Appropriate organizational structure is critical to effective PS delivery. The following are recommendations for the development of an effective organizational structure:

- Identify a key contact liaison at each organization to facilitate PS referral and follow up processes. This person may also play an important role for clients receiving multiple services within the organization (e.g., from a medical case manager, prevention case manager, mental health therapists, etc.).
- Mutual understanding of state and federal laws, and program policies that support PS referral and delivery.
- Identify and maintain a consistent PS introduction and delivery method and ensure that PS is implemented as an ongoing process (at the intake, assessment, reassessment and monitoring progress points).
- Establish clearly defined roles and responsibilities for each service provider working with the infected client as it relates to PS delivery, reporting, and follow up.
- Develop a client file management system and thorough instruction on how the system can be used to monitor PS referrals.
- Identify external referral sources utilized by the organization in client service provision and their role in PS delivery.

### Relationship Building

Effective PS delivery is dependent upon establishing sound collaborative relationships among medical providers, CBOs, and LHDs. Recommendations for relationship building include:

- Clarify and document roles and responsibilities of agencies engaged in provision of PS using MOAs

*Note: MOAs are not required to release information to LHDs for the purpose of providing PS.*

- Promote continuous education/training among agencies engaged in provision of PS.
- Extend educational opportunities to non-traditional service providers, aimed at building awareness of PS and promoting collaboration.

- Establish standards of communication between CBOs, LHDs, and medical providers (e.g., quarterly, semi-annual face-to-face meetings and conference calls).
- Identify an organizational liaison for direct contact with LHDs for referral and follow up services.
- Develop a mechanism for tracking internal and external PS referral outcomes.

Strategies for relationship building and engaging diverse, and sometimes hard to reach, populations in PS delivery include:

- Ensuring PS delivery is culturally, linguistically and developmentally appropriate.
- Utilizing same-culture providers/counselors (where available) for PS delivery.
- Identifying and educating routine service providers of targeted populations to serve as facilitators of PS delivery.
- Utilizing key-informants/trusted leaders to provide education and promote PS within closed culture social networks.

#### Utilizing Social Networks:

Individuals not identified as a sex or needle-sharing partner are an important link to STD and HIV cases because infection often travels within social networks. As part of effective disease case management, PS providers should assess individuals within a social network that may benefit from testing and risk reduction counseling. Utilizing this prevention tool can identify new cases as well as decrease the facilitation of disease transmission. When interviewing infected clients or partners, PS providers should ask about their social networks and gather key identifying and risk information that may prove useful.

#### Utilizing Community Support Groups

Partner services providers should familiarize themselves with the services that community support groups provide for persons diagnosed with HIV/STDs. These groups may provide assistance in disclosing disease status to partners, and addressing the stigma and discrimination associated with having HIV/STDs. PS providers should contact their LHD or local CBO for additional information on support groups across the State.

#### Sharing Best Practices

A healthy exchange of effective investigative methods used by others can serve to enhance creative ideas and approaches to PS delivery. PS providers are encouraged to visit other agencies to observe different methods to elicit positive client response to PS. Holding periodic regional meetings or conference calls to share information can also serve to improve PS as well as other health outcomes.

## STRATEGIES TO ENHANCE PARTNER SERVICES DELIVERY

Employing effective and innovative strategies to enhance PS delivery is critical to the overall success of disease management of HIV/STDs in Michigan. The MDCH encourages PS providers to consider the following innovative approaches:

### **Internet-Based Partner Services**

Internet-Based Partner Services (IPS) is the process of using the Internet to facilitate notifying a person of their potential exposure to an infectious disease. IPS should supplement, not replace, traditional methods of PS, specifically health department referral. Partner locating information is sometimes limited to an e-mail address or screen name/profile on an Internet site, making such sites the only viable option for contacting that partner.

The CDC encourages the use of the Internet for STD/HIV prevention including PS. See the CDC “Dear Colleague Letter” on the subject, available at <http://www.cdc.gov/std/DearColleague9-13-2005.pdf>.

The National Coalition of STD Directors (NCSDD) and the National Alliance of State and Territorial AIDS Directors (NASTAD) developed *National Guidelines for Internet-based STD and HIV Prevention*, which includes guidelines for internet-based partner notification. This comprehensive resource can be found at [www.ncsddc.org](http://www.ncsddc.org) or [www.nastad.org](http://www.nastad.org).

Due to the omnipresent nature of free e-mail accounts, sending an e-mail carries the same confidentiality risks as leaving a letter on a doorstep. These risks exist for both modes of communication, but the public health benefit of contacting someone outweighs the small possibility that confidentiality will be breached or that the intended recipient does not receive the notice. Like any e-mail correspondence, care should be taken when utilizing this method. PS providers should limit messages to the urgent need for the recipient to contact the LHD; no other information (exposure, infected client identity) should be transmitted. The exception to this rule is the use of the InSPOT system where users may select to self disclose. InSPOT will be addressed later in the document.

### **Access to the Internet and Computer Security**

In order to conduct IPS, employees will need approved access to internet sites that are traditionally blocked including (but not limited to) social networking, dating, or sexually explicit sites. Access to such websites, instant messaging (IM) programs, and other communication technologies is essential. PS staff and their administrators should work in tandem with information technology staff to gain approval to access these sites as well as the skills to use them.

## **IPS via Health Department PS Staff**

This strategy allows for the notification of partners where the only locating information is an e-mail address, screen name, or instant message (IM) account. Messages sent to e-mails or IM accounts should be consistent with traditional partner notification referral letters and should not include specific exposure information. These messages should stress the importance for immediate communication due to “an urgent health matter.” In general, initial IPS messages should consist of a brief message encouraging the partner to contact the PS provider either by e-mail, telephone, or face-to-face. Subsequent attempts to contact the partner may include additional information to increase the sense of urgency.

Other moderately successful partner notification efforts include the use of chat lines. Partners of infected clients are notified of their possible exposure by an electronic mail message sent via their online profile. This method of partner notification for syphilis in men who have sex with men (MSM), has demonstrated high rates of success among notified partners.

## **Implementation of Social Networks Strategy**

Social Networks Strategy (SNS) is a tool employed by some LHDs and community-based agencies to expand their base of information and increase testing for HIV among communities with high risk for HIV and other sexually transmitted diseases. Through SNS, infected clients are selected as ‘*recruiters*’ to work only within their social groups to identify persons who might benefit from testing because of their risk behaviors. Recruiters receive training to how to approach partners and the type of information to share. Referring these persons into testing may be accompanied by a small incentive for the recruiter and tester.

## **Expanding HIV Testing Techniques in the Field-Rapid Testing**

The growth of rapid HIV testing over the last several years has proven to be effective in allowing persons to test and receive preliminary results within a single encounter. Expanding the use of rapid testing in the field by PS staff will help to eliminate the wait time associated with laboratory processing of specimens.

## **Internet-Based Partner Services via Third-Party Sites**

The Internet Notification Service for Partners or Tricks (inSPOT), Michigan is a tool to notify sex partners of their exposure to certain STDs (GC, CT, scabies, crabs, non-gonococcal urethritis and HIV). Websites such as this allow patients to notify their partners anonymously or confidentially of possible exposure to an STD. Although there is limited outcome data available on these third-party notification sites, they have potential to improve PS for certain STDs.

The DHWDC has developed protocols and training that support the use of inSPOT by infected clients and providers who may not be comfortable or are unable (partners are anonymous) to use traditional PS methods. Users of inSPOT can select from an assortment of electronic cards (e-cards) to notify a partner of their exposure to an STD, and send the e-card anonymously or directly, at no cost, from their e-mail address. PS staff and other providers may also use inSPOT to assist clients in notifying their partners. Persons interested in learning more about this service (and the various safeguards) should refer to the current online training calendar for HIV/AIDS – STD, which can be found at [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd).

Additional information on using the Internet as a tool for PS is available at: <http://www.internetinterventions.org/InternetPartnerServices.pdf> and [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd).

### **Working with Medical Professionals**

The CDC research findings of HIV prevention practices of primary care physicians report that 87% indicated that professional training could help “increase their comfort in caring for AIDS patients.” PS providers should work with medical professionals to reinforce the importance of HIV/STD prevention efforts. Informational presentations can outline how they can play an active role in PS delivery and promote the role of public health in PS and disease management. These activities serve a dual purpose: 1) to familiarize PS providers with their care community and 2) enhance communication between PS providers and the medical community. The MDCH has developed awareness programs and provides technical assistance to reach providers through active participation in community forums, and through links to specific websites. Information on working with medical professionals can be accessed at: [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd).

### **Working with Challenging HIV/STD Infected Clients**

On occasion, infected clients may not respond to PS providers or otherwise react adversely to PS attempts. When this occurs, PS providers should strategize with supervisory staff about effective ways to reach clients. Some strategies are listed below:

- a. Identify what barriers may be preventing the client or partner’s willingness to work with the PS provider.
- b. Explore other ways to contact the client or partner (e.g., alternate address, through their physician or case management provider, at alternate times, through e-mail, text messaging, or leaving confidential messages on social network sites indicating that you have important health information to share). Remember: avoid making reference to HIV/STD.
- c. Utilize a different PS provider.

## **Expanding Partner Services Training**

Modifications to current PS trainings offered by the MDCH will emphasize:

- Interview and investigation skill building for PS providers.
- Expanded provider education activities.
- Working with PS providers to enhance communication and PS referral methods.
- Increasing knowledge among PS providers of community resources and PS strategies.
- Use of social networks to optimize the yield of PS activities.

## **Improving and Monitoring Partner Services Quality**

Partner services providers can determine quality improvement strategies/priorities around PS delivery by assessing the needs of their local target population. While extensive monitoring, evaluation and QA measures are provided as part of this document, exploration of other evaluative tools and strategies are also encouraged. Conducting brief surveys or using other client feedback tools can provide the information needed to develop programs to improve PS outcomes.

## **Working with Recalcitrant Clients**

When working with infected clients who intentionally engage in behaviors that expose others to HIV, PS providers should reference Michigan's *Recommendations for Addressing Recalcitrant Behaviors in HIV-infected Populations (2005)* (or subsequent revisions) available for download at [www.michigan.gov/hivstd](http://www.michigan.gov/hivstd). PS providers should also be familiar with Michigan's law that speaks to the illegality of one posing a "health threat to others."

Local health departments that are successfully employing strategies to address recalcitrant behaviors have seen the value of enlisting the assistance of an advisory group (consisting of key LHD staff, along with medical, mental health, drug treatment, and legal professionals) to brainstorm and develop a response to promote behavior change in recalcitrant clients. This system has proven to work well, and avoids imposing upon the court system for resolution.

Additional information and technical assistance on any of these strategies to enhance PS delivery is available by contacting MDCH at (517) 241-5900.

## **Partner Services Support for Special Populations**

Meeting the needs of all clients infected with HIV/STDs is a key goal of disease prevention and management efforts. It is important that PS providers thoroughly assess client needs before initiating PS as part of the comprehensive approach to disease management. Program recommendations offered by the CDC suggest that PS staff recognize the unique characteristics and circumstances of each population. It is important, therefore, that LHD PS staff, together with their supervisor and surveillance

staff, work to identify trends in their jurisdiction as well as those individuals and communities most impacted by disease. To begin carrying out these tasks, PS providers should conduct the following activities:

- Seek guidance from the MDCH and community agencies that target specific risk populations to increase awareness and response to specific PS needs. Examples of unique situations include working with minors, HIV related tissue/organ donation precautions, domestic violence, MSM, LGBTQ, expectant mothers, and incarcerated populations.
- Establish working relationships with the MDCH's disease surveillance program to assist with data analysis and interpretation.
- Examine HIV/STD data through the HES and MDSS and quarterly disease analysis reports regularly.
- Analyze data collected by surveillance staff in local health jurisdictions.
- Assess program services, in conjunction with community partners (*e.g., schools, physicians, CBOs, family planning, clinics, civic organizations*) to determine the effectiveness of current outreach to these populations.
- Once data trends are understood, develop an intervention plan that is culturally and developmentally appropriate for the population.
- Examine research and seek training developed to effectively address disease prevention efforts in populations harshly impacted by HIV/STDs e.g., minors, and teens,

## GLOSSARY

ASO	AIDS Services Organization
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CLAS	Culturally and Linguistically Appropriate Standards
CT	Chlamydia
DHWDC	Division of Health, Wellness and Disease Control
DOC	Department of Corrections
GC	GC
HES	HIV Event System
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HTTO	Health Threat to Others
IM	Instant Messaging
inSPOT	Internet Notification Service for Partners or Tricks
IPS	Internet-based Partner Services
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Questioning
LHD	LHD
MCL	Michigan Combined Laws
MDCH	Michigan Department of Community Health
MDSS	Michigan Disease Surveillance System
MOA	Memorandum of Agreement
MSM	Men Who Have Sex with Men
PEP	Post-Exposure Prophylaxis
PHI	Protected Health Information
PS	Partner Services
QSA	Qualified Services Agreement
STD	Sexually Transmitted Disease
RNA	Ribonucleic Acid

## **APPENDICES**

- A.** PS Original Interview Guide
- B.** Sample Memorandum of Agreement between LHDs and other organizations.

## APPENDIX A PARTNER SERVICES ORIGINAL INTERVIEW GUIDE

This Appendix provides enhanced instruction for PS. Information presented reflects a combination of the *Original Interview* format for the integration of STD/HIV disease case management developed by the CDC and Prevention, and Michigan specific program practices. Key elements of the original interview include instruction on 1) interview structure, 2) patient assessment, 3) disease intervention behaviors, and 4) conclusion. *Tips from the field* also offer guidance from experienced PS staff for addressing situations commonly experienced when providing PS.

The MDCH fully anticipates that information referenced in this appendix will continue to evolve as program areas become more integrated.

### Original STD/HIV Interview Format

**I. Interview Structure:** PS staff is encouraged to apply the following steps to foster a working relationship with clients once physical contact is made. When conducting interviews for syphilis, PS staff should record information obtained onto the appropriate case forms for entry into the MDSS case management module. Likewise, as PS staff conducts interviews for HIV, case information should be entered onto appropriate case forms for entry into the HES.

#### STEPS

- A. Introduce yourself and anyone else present.
- B. Request that the client present some form of identification, especially when you have been unable to confirm their identity, e.g., when in a non-clinical setting. The presentation of a state identification card or a letter/utility bill with their name posted is sufficient. If no identification is available, utilize the physical description provided to confirm match.
- C. Have your identification ready to display if asked.
- D. Thank the client for the anticipated time you will be spending with them during this session.
- E. Explain your professional role (avoiding titles such as PS staff, HIV/STD official).
- F. Ensure privacy (conversation cannot be heard by others).
- G. Explain the purpose of your session.
- H. Explain confidentiality (using brief simple terms, make the explanation pertinent to the patient's situation).
- I. Provide information about the disease diagnosed, or in the case of a partner, the disease exposed to and the necessity for testing/treatment.
- J. Let the client process/assimilate information.
- K. Provide information to help prevent future exposures.
- L. Help the patient know what to do if re-exposed.

***Tips from the field***

*Although arrangements may have been made to meet privately with the patient, others may be present. Should this occur, reaffirm the need for privacy by explaining that you need to discuss a personal matter. Unless the patient authorizes you to disclose confidential (STD/HIV specific) information in writing to a designated individual, all information must remain confidential. If necessary, reschedule to meet when and where privacy can be assured.*

*Establishing an interview setting that is comfortable for the individual may aid in the successful outcome of PS delivery. Clinical settings have certain advantages and allow for a safer and convenient environment. In a clinical setting, PS staff has access to records and other helpful materials. However, interviews in the field may offer the individual a familiar setting and allow for greater comfort.*

**II. Patient Assessment:** PS staff should view this element of the interview as an opportunity to establish sound rapport with the patient. As part of this process, PS staff should do the following:

- Determine what the client knows about their infection.
- Listen, use appropriate verbal and non-verbal communication, and always communicate at the person's knowledge level. Ask open-ended questions.
- Give positive feedback as appropriate.

**A. Address Patient Concerns:** It is important that PS staff identify and resolve the concerns that an individual may have that might serve as a barrier to PS participation. For example:

1. Why treatment was or was not given?
2. How did you get my name?
3. Why do I need to talk to you?
4. Who else knows about my situation?
5. What do I do now?

Close observation of the individual's attitude and needs are important when trying to identify individual barriers.

***Tips from the field***

*Typically, a concern around confidentiality is the number one factor for an individual's refusal to participate in PS. Helping to resolve any concerns around this issue as well as other identified issues can help the individual move forward in the interview process. PS staff should explain why certain information is necessary to collect and discuss how that information will aid in the disease prevention process. PS staff should use a certain amount of discretion while recording information. While it is important to gather and record all the facts, it should be done so that it does not distract from the actual interview. Some PS staff finds it useful to record information on a blank piece of paper, then transfer information onto official forms following the interview.*

**B. Collect Client History:** PS staff should view this element of the interview process as a means to collect personal and medical information that will help to resolve the individual's health issues. PS staff should do the following:

1. Pursue locating information for the individual (address and telephone number, cell phone, e-mail address, alternate locating address).
2. Collect social history as it pertains to the infected patient and the infected patient's social groups/network: lifestyle, travel, school, work, social groups, and recreation (hangouts).

**C. Medical History and Disease Comprehension:** PS staff should take advantage of this opportunity to reinforce the personalization of the interview process by determining what the individual knows about their infection and correct any misinformation. PS staff should do the following:

1. Discuss incubation/window period, transmission and progression of their infection/disease.
2. Discuss history of any STDs, testing for HIV/STDs, and other HIV/STD exposures, incidental treatment, drug use, substance use, and pregnancy.
3. Collect additional medical information as it pertains to the infected individual and to the infected individual's social groups/network, their symptoms, clinic visits etc.

***Tips from the field***

*Clients may not recall specifics about various medical conditions, or events. PS staff might trigger responses by asking about specific timeframes. For example, ask the client about any visits to the doctor or clinic around a certain date/time. Also, review any symptoms indicative of the infection.*

**III. Disease Intervention Behaviors:** As one of the most important elements of the interview process, partner services staff should view this section as an opportunity to reduce the transmission of infection to at-risk sex and needle-sharing partners, and others in their social network.

**A. Partner Elicitation:**

1. Assist the individual in acknowledging that there are partners who may be at risk of exposure through a discussion of the transmission modes.
2. Emphasize the importance of immediate sex or needle-sharing partner referral, emphasizing that one or more may have an STD or be HIV infected which could re-expose the client.

3. Assess the individual's response to information discussed thus far, and determine any concerns that the individual may have. Evaluate problems and use counseling motivations such as:
  - a. Avoiding complications.
  - b. Increased susceptibility to other infections (hepatitis C, HIV, STDs).
  - c. Avoiding asymptomatic nature of infection.
  - d. Avoiding re-infection/exposure.
  - e. Reducing further transmission.

Gather *descriptive* and *demographic* information about each sex or needle-sharing partner.

<b>Name</b>	Full, nick names, prefixes (Jrs/Srs)
<b>Locating</b>	Residential/ mailing address, apartment numbers, alternative address/phone numbers, e-mail address, employer, telephone and cell phone numbers etc. Description of environmental/living conditions, potential contact challenges, e.g., domestic violence, drug use etc.
<b>Exposure</b>	First and last dates of exposure to infection and frequency of exposure
<b>Clustering</b>	Identify others who may be at risk for infection.
<b>Description</b>	Physical characteristics of partner(s) (height, weight, race/ethnicity, gender, hair type/style, other defining physical characteristics, such as tattoos, scars etc.; history of personal or partner pregnancies.

**IV. Partner Services Options:** Determine the capability of the individual's ability and willingness to conduct partner referral of partners exposed to **HIV** through a discussion of PS options (applicable to HIV infection only) which include:

- Health Department Referral (*health department conducts notification of partners.*) Client must provide PS staff with identifying demographic and locating information).
- Provider Referral (*medical provider conducts partner notification*). Medical provider must be willing to conduct one-on-one notification of partners. (See the section of this document, which addresses the role of medical providers).
- Combination Referral (*individual and health department agree to contact respective partners through an agreed upon process and within specific timeframe of 24-48 hours*). PS staff should stress client commitment to ensure notification. As a precaution, PS staff should elicit locating

information on *all* partners in the event the client is unable to notify partners. Under these circumstances, the PS staff can then notify the partners.

- Client Referral (*client assumes responsibility to notify at-risk partners*). partner service staff should coach or role-play with the client on how and what will be said to the at-risk partner about their exposure. The client should be reminded to anticipate the partner's reaction (angry, afraid) upon being informed of their exposure. PS staff should explain ramifications of self-disclosure, and the loss of anonymity. Also, the client should be reminded of the importance of providing referral information to the partner on where counseling and testing is available.

A discussion of the benefits and risk associated with these options is important so that the individual can fully assess which option will work best for him or her, based on their individual situation. PS staff must reiterate Michigan law requiring HIV-infected clients to disclose their status prior to engaging in sexual activity with a partner, and stress the importance of notifying any needle-sharing partners. PS staff are encouraged to review the various methods to notify partners (*e-mail, traditional field*) and identify which method might work best with each partner.

**V. Documentation:** Document this information on the MDCH recognized form for disease specific analysis.

***Tips from the field***

*Explaining the partner notification process for contacting partners through public health can be a helpful tool in alleviating client concerns around disclosure. PS staff should briefly explain the steps taken to ensure confidentiality and notification. Data shows that PS staff are encountering an increase of **dually** infected individuals diagnosed with HIV, STDs and Hepatitis B/C. PS staff are reminded to remain cognizant of the differing variables associated with the case management of these infections, and should seek additional guidance, if necessary, to ensure appropriate and timely case management delivery.*

**VI. Risk Reduction:** PS staff should recognize this section of the original interview as a shift of attention from the individual's current disease to the behaviors that put him or her at risk for all sexually transmitted diseases, including HIV. This section should be individualized and patient-centered, and:

1. Help individual identify risks;
2. Identify and support past successes/behaviors that work;
3. Identify one or two steps to reducing risk;
4. Problem solve for potential barriers to implementing steps;
5. Offer the individual an opportunity to test for HIV as appropriate, or refer them to testing;

6. Link the individual to medical or support services. PS staff conducting HIV case management can utilize the Client Authorization for Counselor-Assisted Referral Form found in Appendix of the tool kit.

**VII. Conclusion:** As PS staff close out the interview, essential elements should be reviewed:

- A. Address any remaining patient needs, questions, or concerns of potential compliance problems.
- B. Reinforce any commitments made by the patient.
- C. Provide handouts, and information as necessary.
- D. Reinforce confidentiality.
- E. Leave the door open to address additional concerns by providing a contact number where you can be reached.
- F. Remember to document information on appropriate case forms and into electronic data systems.

**APPENDIX B**  
**SAMPLE MEMORANDA OF AGREEMENT**

## Memorandum of Agreement

### Between ACME AIDS Services And County Health Department

Effective October 1, 2011 through September 30, 2012, ACME AIDS Services (ACME) agrees to collaborate and coordinate with the County Health Department to ensure provision of medical services for eligible clients in Anytown, Michigan.

Under terms of this agreement, County Health Department agrees to:

1. Accept ACME referrals for STD screening and treatment.
2. Coordinate with ACME regarding partner notification activities such that clients tested at ACME receive their test results and post-test counseling from ACME prior to being contacted by LHD for partner services.
3. Provide on-site STD screening at ACME two days each month, scheduling to be mutually agreed upon.
4. Collaborate with ACME for provision of HIV and STD screening at one outreach event each quarter.
5. Return ACME referral cards on a monthly basis to the ACME Referral Coordinator.
6. Meet with ACME on a quarterly basis to review the collaboration and coordination of services.

Under terms of this agreement, ACME agrees to:

1. Refer clients who test positive for HIV to County Health Department for assistance with partner notification.
2. Refer clients to County Health Department for STD screening and treatment, as needed.
3. Provide confidential space for County Health Department to provide STD screening two days each month, scheduling to be mutually agreed upon.
4. Collaborate with County Health Department for provision of HIV and STD screening at one outreach event each quarter.
5. Provide referred clients with referral forms and copies of their confidential lab results.
6. Meet with County Health Department on a quarterly basis to review the collaboration and coordination of services.

Both agencies agree to secure appropriate authorization for Release of Information from clients prior to sharing client-identifying information.

This agreement does not require financial obligations from either party at this time. Responsibility for coordination of this agreement shall be the parties signed below or her/his designee. This agreement will terminate September 30, 2012 and may be renewed for an additional 12 months upon mutual agreement. Either party may make earlier termination of this agreement with a thirty day written notice.

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Mr. Byron Wigg  
Chief Executive Officer, ACME

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Ms. Delores Honchette  
Health Officer, County HD

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Date

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Date

**For additional information on HIV and STD Partner Services contact:**

**Division of Health, Wellness and Disease Control  
Michigan Department of Community Health  
109 Michigan Avenue, 10<sup>th</sup> Floor  
Lansing, Michigan 48913  
517.241.5900  
[www.michigan.gov/hivstd](http://www.michigan.gov/hivstd)**