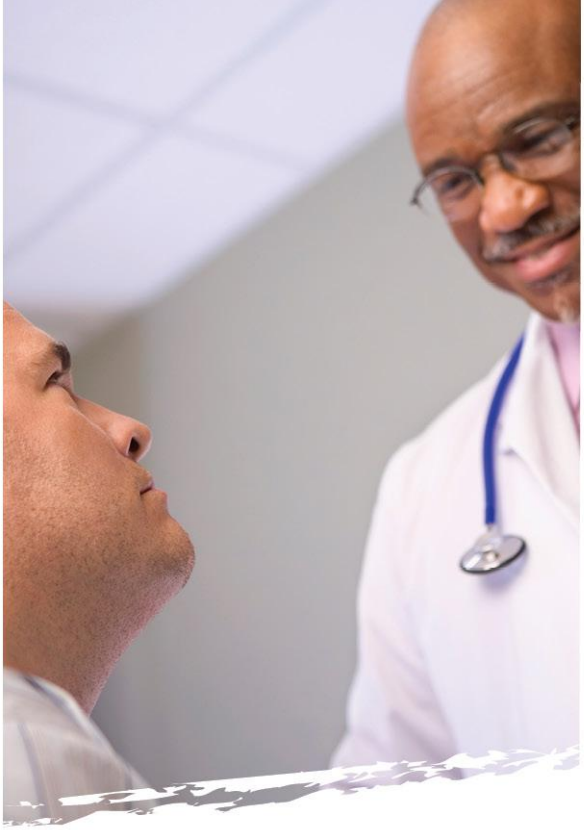


YOUR LOVE. YOUR HEALTH. OUR HELP.

Reproductive and Sexual Health

# HIV-STI Prevention: Sexual Partner Services

revised 4 January 2013

NAVY AND MARINE CORPS PUBLIC HEALTH CENTER

PREVENTION AND PROTECTION START HERE

# Foreword

This document does not establish Navy policy.

The purpose of this document is to provide recommended procedural details and guidance to Navy medical professionals serving Department of Defense health care beneficiaries regarding the notification and counseling of sexual partners of patients who have been diagnosed with sexually transmitted infections, including HIV.

This document is derived in large part from guidance and training documents developed by the Centers for Disease Control and Prevention (CDC), National Center for HIV, STD, and TB Prevention, Atlanta, GA, to whom SHARP is greatly indebted. The primary reference is:

> Centers for Disease Prevention and Control (2008). MMWR, Vol 57. Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydia Infection. CDC, National Center for HIV, STD and TB Prevention, Atlanta, GA. 30 Oct 2008 http://www.cdc.gov/mmwr/PDF/rr/rr57e1030.pdf

This document may be downloaded from the NMCPHC website.

Comments on this document are encouraged and may be forwarded to:

Navy and Marine Corps Public Health Center
Sexual Health and Responsibility Program (SHARP)
620 John Paul Jones Circle, Suite 1100, Portsmouth VA 23708
www-nehc.med.navy.mil/hp/sharp
voice: (757) 953-0974; [DSN 377]
fax: (757) 953-0705; [DSN 377]

**Views and opinions expressed are not necessarily those of the Department of the Navy**

# Table of Contents

Forward……. 3

Table of Contents…… 4

Summary of Changes..……. 6

Learning Objectives……. 7

Continuing Education Credit…… 8

Terminology……. 9

Purpose of Partner Services….……. 9

Benefits of Partner Services ……..……. 10

Deciding Which Partners Should Be Referred…… 11
Table 1 – Contact Tracing Periods…….. 12

Partner Services concepts…… 14

Partner Services Options…….……. 18
Table 2 – Partner Services Options……. 23-24

Special Issues:
Potential for Discovery of the Original Patient's Identity…….. 25
Duty and Privilege to Warn Partners…….. 25
Child Abuse; Threats to Harm…… 26
Potential for Violence……. 26
Youth…….. 26
Collaboration Between Field Preventive Medicine and Navy HIV Evaluation and Treatment Units (HETUs) Regarding HIV Partner Services……. 27

Recommendations for Monitoring Processes and Outcomes……. 31

Coordination with Public Health Authorities…… 32

Partner Services Steps…….……. 33

Working with Clients (steps 1-5)……. 33
Locating Partners (step 6)……..……. 39
Working with Partners (steps 7-11)…… 40
Record Keeping……. 45

Bibliography…… 46

Examination…… 48

Answer Sheet and Critique……. 53

## Summary of Changes

To NEHC-HP-TM 6100.02 dated December 2013

- Updated references to DoD HIV instructions and HIV spouse notification and clarified spouse notification practices
- Revised “Forward”

# Cognitive Learning Objectives

**Sexual Partner Services**

Upon completion, the student will be able to **identify** and **discuss** basic facts concerning:

- ✓ Partner Services purpose
- ✓ Contact tracing periods
- ✓ Partner Services concepts
  - voluntary
  - confidentiality
  - Client-centered counseling
  - on-going
- ✓ Partner Services options
  - Provider Referral
  - Client Referral
  - Dual Referral
  - Contract Referral
- ✓ Partner Services steps
  - Transition
  - Offer options
  - Elicitation
  - Coaching
  - Summarize
  - Investigate
  - Notify
  - Prevention Counseling
  - HIV test decision
  - Link to other services
  - Follow-up

Achievement of these learning objectives is measured by scoring not less than 80% correct on the 35-question written examination included herein.

## Continuing Education Credit

Students are responsible for contacting their own respective professional organizations to determine appropriate category and documentation requirements.

# Sexual Partner Services

## Terminology

"Partner Services" is a new term in use since October 2008 when the CDC published its latest guidance on the subject. Terms used previously were "Partner counseling and referral services" (since the early 1990's); "partner notification" (1980's) and "contact tracing" (1920's). For the purpose of this document, a "**provider**" is any health care worker (doctor, nurse, Independent Duty Corpsman, Preventive Medicine Technician, etc.) tasked to conduct Partner Services activities. A "**client**" is the person or patient infected with a sexually transmitted infection (STI) whose sexual or needle-sharing partners may have been exposed to the infection. The provider and client terminology has been adopted here because it is used in the current national guidelines.

## Purpose of Sexual Partner Services

Sexual Partner Services is a set of activities intended to alert people exposed to STIs and facilitate appropriate counseling, testing, and treatment. It is Navy Medicine policy (BUMEDINST 6222.10) that each patient infected with an STI shall be informed of the importance of notifying their sexual partners and encouraging them to promptly seek medical evaluation for the exposure.

Recent research (St Lawrence, et al 2002) demonstrates that "few physicians engage in partner notification, and most instruct patients to self-report to the health department or notify partners themselves. This reliance on partner notification represents a gap between common practice and our knowledge of its effectiveness".

Sexual Partner Services is only one element of a comprehensive STI/HIV prevention effort. Sexual Partner Services is typically provided in conjunction with other essential STI prevention services. A comprehensive STI prevention effort includes:

- Education and prevention counseling of those at risk on ways to reduce risk
- Detection of asymptomatically infected individuals
- Effective diagnosis and treatment of infected individuals
- Sexual Partner Services
- Immunization of persons at risk for vaccine-preventable STIs

For example, Sexual Partner Services is typically conducted in conjunction with **risk reduction counseling**. By using a **client-centered** approach, providers can help clients reduce their future risk of infection and negotiate a plan to facilitate counseling, testing, and treatment of their partners. Studies have shown that a client-centered counseling approach can result in behavior change, thereby decreasing the likelihood of future infection. In a study by Hoxworth et al (2002) partner notification was associated with increased condom use by index clients and partners.

## Benefits of Sexual Partner Services

**The client** (i.e. original or index patient **)** benefits from counseling and treatment. He/she also is given an opportunity to gain peace of mind by fulfilling responsibility to partners without revealing his/her own infection status. The client may also reduce their risk of re-infection (Whittington et al, 2001).

**Partners** benefits by learning about their real risk (which partners may underestimate, misunderstand, deny or be unaware of). They also receive the impetus for entering counseling and/or testing (where partners may learn of own infection for first time). They receive referral to counseling and support services (e.g., family planning and related decisions; emotional problems; addictions; other issues) and opportunity for behavior change (due to prevention counseling and increased awareness of risk). This can help them reduce the likelihood of acquiring or transmitting infections in future. For partners who are already HIV-infected and unaware of their status, they have the opportunity to enter prevention case management or other needed services and to avoid inadvertent transmission to partners or unborn children.

In addition to the benefits realized by exposed and potentially infected partners, Partner Services may also have prevention benefits at the **community** level in reducing STI transmission by identifying sexual networks at high risk. Interventions may then be more effectively directed, and risks within the network reduced. According the CDC (2008): "On the basis of evidence of the effectiveness and cost-effectiveness of partner services, CDC strongly recommends that all persons with newly diagnosed or reported HIV infection or early syphilis receive partner services with active health department involvement. All persons who receive a diagnosis of or who are reported with gonorrhea or chlamydial infection also are suitable candidates for partner services."

For example of cost effectiveness, a study by Cohen, Wu and Farley (2005) estimated the cost of preventing one new case of HIV infection through Sexual Partner Services to be $6,100. Although this figure may strike one as surprisingly high, the authors conclude that Partner Services is a more cost-effective strategy for HIV prevention than any other they evaluated, with the sole exception of "single session videos in STD clinics". Compared to their estimate of $20,000 for the annual care of one HIV infected person, the cost-effectiveness of Partner Services becomes obvious.

In 2010, the Institute of Medicine Committee on HIV Screening and Access to Care, in HIV Screening and Access to Care: *Exploring Barriers and Facilitators to Expanded HIV Testing* found:

"Partner notification has been found to be effective for identification of persons with previously undiagnosed HIV infection (CDC, 2008d, 2010). Partner notification is a key component of partner services20 that involves confidential notification of the sexual and needle sharing partners of HIV infected individuals of possible exposure. A systematic review of studies conducted among a variety of populations for the Task Force on Community Preventive Services showed that between 14 and 26 percent of tested partners of individuals with HIV were found to have undiagnosed HIV (Hogben et al., 2007). Based on these findings, the Task Force currently classifies the evidence as sufficient to recommend provider referral partner notification (CDC,

2010). Partner services, including partner notification, also have the benefit of providing an opportunity to reach persons who are HIV-negative but who are at very high risk for HIV (such as sex and drug-injection partners of persons with HIV) to make them aware of their risk and offer prevention services (Dooley et al., 2007)."

## Deciding which partners should be referred

It is not usually necessary or fruitful to notify every sexual partner of every client. Deciding which partners should be notified is based upon the STI, the client's sexual history, and the likelihood of reaching the partner.

- STI and the client's sexual history. Of primary concern are those partners which may have transmitted the disease to the index patient or who may have been exposed to infection by the index patient. Hence, the important time periods are the incubation period and the infectious period (i.e. "spread" period). Combined, these are referred to as the **Interview Period**. Table 1 contains a summary of recommendations and requirements for Interview Periods for selected STIs. In addition to the guidelines in the Table, providers are strongly encouraged to determine and comply with partner notification requirements of their locality and state.

Likelihood of reaching the partner. Regarding the likelihood of reaching the partner, two conditions should be considered when prioritizing the investment of healthcare resources in partner notification efforts.

(1) The first condition is the **quality of the information** about the partner. For example, partners for whom the client cannot or does not provide adequate identifying or locating details will not likely be found. Certainly, identifying information must be of sufficient quality to ensure the *right person* is notified. Providers must determine whether a notification effort is worthwhile in cases where partner information lacks quality.

NOTE: Partner referral reports **sent to other public health agencies** should contain at least 2 pieces of identifying information. "Home address" and "home phone" are considered to be 1 piece of information. Other useful identifying information includes place of work; work phone; beeper; hangouts; make of car, etc.

(2) The second condition involves the **policies and practices of the cognizant public health authority**. Some public health authorities must prioritize their work due to resource constraints. For example, it may not be cost-effective to notify your local civil public health authority of people exposed to chlamydia if the local authority has a policy of following up on only syphilis and HIV cases. Providers are strongly encouraged to contact and closely network with local and state public health authorities to determine and comply with appropriate laws and policies. One study found that public health departments provided Sexual Partner Services services to only 12% of chlamydia patients and only 17% of gonorrhea patients (Golden et al, 2003)

NOTE: Military public health authorities who are informed about named partners who are DoD health care beneficiaries assigned within their jurisdiction will always attempt notification (if appropriate according to the parameters of Table 1, Interview Periods).

## Table 1 - Interview Periods

based on
CDC STD Treatment Guidelines 2010; MMWR 59; RR-12
CDC Partner Services Guide 2008; MMWR 57; 30 Oct 2008
CDC Partner Counseling and Referral Services Trainers Manual, 2002, page T4-17,18
SECNAVINST 5300.30E, Management of HIV in the Navy and Marine Corps, Aug 2012

| | |
|---|---|
| Chancroid | 10 days preceding onset |
| Chlamydia | 60 days before onset (or date of specimen collection if asymptomatic); or most recent partner if >60 days |
| Genital Herpes | current sex partners can benefit from evaluation and counseling |
| Gonorrhea | 60 days before onset (or date of specimen collection if asymptomatic); or most recent partner if >60 days |
| Granuloma Inguinale | 60 days |
| Hepatitis B, acute | Vaccinate partners if within 14 days after the sexual exposure. The interval during which post-sexual-exposure prophylactic vaccination is effective is unlikely to exceed 14 days. |
| Hepatitis B, chronic | No contact time period specified. Minimally, current sexual partners, needle-sharing partners and non-sexual household contacts should be offered hepatitis B vaccine. |
| Hepatitis C | Patient should discuss the low but present risk of sexual transmission with their partners and discuss the need for counseling and testing. |
| HIV | 1 or 2 years before date of first positive HIV test through date of interview; might be mitigated by evidence of recent infection or availability of verified previous negative test results.<br>Spouses: SECNACVINST 5300.30E requires that spouses of HIV positive reserve compoent members be provided notification, counseling, and testing. |
| Human Papillomavirus (genital warts) | Patients with genital warts should inform current sex partners because the warts can be transmitted to other partners. |
| PID | 60 days or most recent partner if >60 days |
| Pubic lice | one month |
| Lymphogranuloma Venereum | 60 days |
| Nongonococcal Urethritis | 60 days |
| Scabies | one month |
| Syphilis, primary | 3 months plus duration of symptoms |
| Syphilis, secondary | 6 months plus duration of symptoms |
| Syphilis, early latent | 1 year before start of treatment |
| Trichomoniasis | “sex partners should be treated” |

HIV and Spouse Notification.

Information about potential HIV exposure must be disclosed to the HIV-positive member's **spouse.**

In military policy, the notification of spouses of reserve component members is given in SECNAVINST 5300.30E (Aug 2012); and for spouses of active duty and reserve component members in Army regulation 600-110, and Air Force Instruction 48-135.

In civilian settings, the Ryan White CARE Act Amendments of 1996 (Pub. L. No. 104-146 [May, 2, 1996]) require that states receiving funds under part B of title XXVI of the Public Health Service Act (42 U.S.C. Sect. 300ff-27a [1996]) take "administrative or legislative action to require that a good faith effort be made to notify a spouse of a known HIV-infected patient that such spouse might have been exposed to the human immunodeficiency virus and should seek testing." A spouse is defined as any person who is the marriage partner of an HIV-infected patient or has been the marriage partner of that patient at any time within the 10-year period before the diagnosis of HIV infection.

Although the Ryan White Act does not apply to Navy Medicine, there is a long precedent within U.S. public health practice for the notification of the spouse/former spouse of patients diagnosed with HIV.

Recommended guidelines for Navy providers who are considering spouse notification:

- Fully comply with the letter of military policies.
- Manage the notification of the spouses of active and reserve members identically.
- Strive to arrange face-to-face notification.
- Since the spouse may reside in a different State than the provider, consider partnering with other Navy medicine providers in the spouse's location of residence.
- The identity of the HIV-positive member is not disclosed to the spouse during the notification process.
- The decision of whether to notify the former spouse and the 10-year interview period might be modified if a confirmed history of a negative HIV test or other laboratory testing indicates that the index patient was infected more recently.
- Ensure a good faith effort is made to notify spouses. The CDC describes a good-faith effort as:
    - asking all HIV-infected clients if they have a current or past marriage partner(s)
    - notifying these partners of their possible exposure to HIV, except in situations when, in the judgment of public health officials, there has been no sexual exposure of a spouse to the known HIV-infected individual during the relevant time frame
    - referring them to appropriate prevention services
    - documenting these efforts.

Potential partners that are not named.

In rare cases, the provider may know of a partner at risk even though the client has not identified that partner. Within DoD regulations, the compilers of this document are aware of only one definitive circumstance in which a provider has a definitive duty to inform an unnamed potential partner of a potential exposure to an STI – the HIV-infection spouse notification mentioned above. However, other circumstances may arise which involve a duty or privilege to warn. Information about "duty-to-warn" is included in the "Special Issues" section of this document.

In addition to HIV-spouses and "duty to warn", there is another precedent for notifying "unnamed" people. The concept of "**clustering**" has been used in STI control programs for many decades to find people who may be at high risk of **syphilis** infection, but are not specifically named as partners. Clustering involves eliciting information from index patients about persons in their social networks, other than partners, who might benefit from counseling, testing, and other services. These persons, referred to as **social contacts** (and referred to as suspects in previous guidelines) and **associates**, might include persons with symptoms suggestive of disease, partners of other persons known to be infected, or others who might benefit from examination (e.g., pregnant females). Clustering also might include eliciting information about venues in which the index patients and their social contacts interact socially (e.g., bars or clubs). Clustering differs from cluster interviewing, which involves asking uninfected partners or social contacts of index patients about their own social networks. Data on the effectiveness of clustering for case finding are limited, but suggests that the case-finding yield is substantially lower than that of partner notification. For example, unnamed spouses and roommates of patients infected with early syphilis might be considered for notification as "associates". Such consideration should account for the possibility that the spouse or roommate was truly not exposed, the potential for relationship consequences, and the provider's duty to protect the privacy of the original patient.

If the provider suspects that a there is a person who may have been exposed but has not been "named" as a partner, the provider should discuss that person with the index patient. For example, the provider might ask "we haven't talked about your spouse/roommate yet – how should we make sure that person is OK?"

The original patient could also be recruited to encourage associates and social contacts to seek testing (Peer Referral).

## Sexual Partner Services Concepts

Partner Services is voluntary.

No person can be forced to disclose the names of his/her partners. Sexual Partner Services relies on the willing participation of the client and their partners. It can never be made mandatory or coercive. Attempts at coercion are unethical and generally impractical. Coercive strategies erode trust and cooperation. Anecdotes occasionally circulate regarding the use of discipline or quarantine as a method of STI prevention. An example might be the Sailor denied a liberty port call because he became infected. Providers are reminded that the use of discipline or quarantine may have negative effects on healthcare-seeking behavior. The infected patient that fears the healthcare provider may avoid or delay treatment or self-treat, leading, in some cases, to asymptomatic carrier states and serious disease sequelae. Policies of discipline, quarantine or restriction of liberty for the purpose of STI prevention may be counterproductive and are strongly discouraged.

The provider should explain that participation is voluntary.

Providers can encourage clients to participate in Sexual Partner Services by fostering rapport and an atmosphere of trust and mutual respect. People are most likely to willingly participate in Sexual Partner Services when they understand the process and appreciate the benefits to themselves and their partners. Sexual Partner Services efforts are more successful when providers communicate a genuine concern for the overall well-being of the client and their partners. Client-centered counseling techniques are highly recommended for developing this relationship.

The provider should **explain** how privacy is protected to encourage participation by the client who is initially unwilling or resistant to engage in a conversation about partners.

Providers must protect confidentiality.

Some clients may be reluctant to participate in partner referral because of concerns over the ability of the health system to maintain their confidentiality. It is natural for a client to be sensitive about his or her personal sexual health information. This sensitivity may be heightened for military members who fear workplace implications of their infection. People who may be especially concerned about the privacy of their information include those who are in sensitive occupations or leadership positions, married patients, and those who fear their behavior may be a violation of laws or regulations. The provider should ensure clients that their privacy will be strictly protected.

Health information privacy regulations have been designed to protect patient confidentiality. For example, the privacy and use of information obtained from a service member during the HIV epidemiologic interview is protected by SECNAVINST 5300.30D, Management of HIV in the Navy and Marine Corps. Medical records are protected by the provisions of BUMED Manual of Medicine (Section VI, Medico-Legal Issues, Articles 16-35 through 16-41), and information about partner identity is not recorded in patient medical records. In some cases, the provider may need to explain these regulations and processes to encourage participation by the client who seems reluctant to discuss partners because of privacy concerns.

All attempts to make contact with a partner should be confidential. This is often difficult because other community members might ask the purpose of the provider's call or visit and why he or she is attempting to make contact. Nevertheless, providers should not reveal to others why they are trying to find a particular person. Likewise, providers should never leave a note or message that mentions an STI exposure as the reason for attempting to make contact. In addition, no other information should be revealed that might lead to others learning the reason for the contact or that might otherwise lead to disclosure of sensitive information or to a breach of confidentiality. As each partner is located, he or she should be informed privately and face-to-face, if at all possible. However, if the person refuses to meet with the provider, informing a partner by telephone might become necessary if no reasonable alternative exists, with strict safeguards to verify the identity of the person being spoken with and ensure that privacy and confidentiality are protected. Regarding HIV, informing a spouse by telephone should only be done as defined in SECNAVINST 5300.30D and by state and local jurisdictions, and after every step has been taken to ensure that the correct person has been located, is on the telephone, and others are not listening. Further attempts should be made to arrange a meeting in person.

The original infected client will sometimes inquire about the results of the Sexual Partner Services provider's activities regarding his or her partners. The provider, when requested, can reveal whether a particular partner has been informed of his or her exposure, but must not reveal any confidential information about that partner, including whether the partner decided to be tested or whether he or she is infected. Of equal importance is not revealing any identifying information about the original client to the partner, including the person's sex, name or physical description, or time, type, or frequency of exposure.

Suggestions for protecting confidentiality under a variety of circumstances are given in Figure 1.

Although the Sexual Partner Services provider may need to document the results of his or her activities, confidentiality must still be maintained for all persons involved. Information that identifies partners should be kept locked in a secure location. SECNAV M-5210.1 (December 2005) states that "communicable disease case files" should be destroyed when 5 years old (formal reports) while "working files" should be destroyed when data is summarized in formal reports. Therefore, client and partner information, other than the official record, should be destroyed when current Sexual Partner Services activities are concluded (unless otherwise required by DoN practice).

Figure 1 - Methods to Protect Confidentiality
adapted from CDC 1999, PCRS Training Participant's Manual, Handout 3-1

When talking with the STI-infected client:
- Never reveal whether a partner decided to be tested.
- Never tell the client the partners' test results.
- You may reveal whether a particular partner has been informed of his or her exposure.

When talking with partners:
- Always confirm identity of partner.
- Always find a private site and, only then, notify them of the possible exposure.
- Never identify the client by name, gender, physical description, race, age, type of exposure (sex or needle-sharing), dates of exposure, or location of exposure.

When talking with "third parties" (such as roommates, parents, neighbors, spouses):
- Never give information about why you're looking for the person.
- Limit your remarks to, "This is about a health matter," or "This is personal and important."

When leaving written messages, especially while seeking partners:
- Leave message in a sealed envelope – you may write "confidential and urgent" on the envelope.
- In the letter or notice, write only, "This is an urgent health matter."
- Never leave your business card if it suggests you are in preventive medicine or disease control.

When using the telephone:
- Always ensure that you are speaking with the correct person.
- Always verify that the person is in a private setting.
- Always ensure that no one can overhear your end of the conversation.

When handling written records:
- Keep partner names and identifying information locked up.
- Refer requests for client or partner information to appropriate medicolegal authorities.
- Never take records out to the field.
- Never leave notes or papers in your car, home, or other unsafe place.

When talking with your own work colleagues:
- Never discuss clients or partners unless there is pressing need to do so.
- Always protect the identity of clients and partners during case reviews.

When talking with your family, friends, or others outside the workplace:
- Keep work discussions to a minimum.
- Never reveal any identifying features of a client or partner.

Client-centered communication is most effective. Client-centered communication means that the interaction between the provider and the client is focused on the client's issues and circumstances. This interaction differs from "canned" information-giving and advice-giving. Provider skills that are useful in this regard include:

*Focus on feelings*. To be successful, the provider should determine and acknowledge the client's relevant feelings about the issues surrounding referral of their sexual partners. Minimizing the client's feelings or failing to understand them may hinder effective communication and referral. An effective interaction requires the candor and active involvement of the client. The provider must seek to understand what issues may motivate or inhibit the client in successful partner referral. To accomplish this, the provider must be willing to ask about and listen to the client's concerns and beliefs and respond effectively to them.

*Manage your own discomfort*. The Sexual Partner Services task requires providers and clients to discuss issues that may be very personal and even painful. Both the provider and client enter the interaction with their own set of values, biases and beliefs. It is expected that some clients will disclose behavior, values, or circumstances that cause discomfort in the provider. This discomfort is natural and expected. But, if the provider reacts adversely, communication with the client may be hindered and partner referral efforts may suffer. An uncomfortable provider may react by avoiding difficult issues, hurrying the session, or dictating referral options. These reactions will not likely result in successful partner referrals. Providers should manage their discomfort and avoid verbal and non-verbal reactions that may shut down communication. A non-judgmental and empathetic attitude is helpful. At the end of an effective session, the client should have no idea what the provider's biases are. Providers might remind themselves that they can effectively help clients even though they may hold different values, biases and beliefs.

*Set boundaries*. Providers seek to positively influence the attitudes and actions of their clients, but intuitively know they do not control the client's behavior at any time – before or after the interaction. Just as the provider should not accept responsibility for client choices, providers must acknowledge that clients may not choose the referral options and plans the provider would prefer. Providers care about their clients and may be frustrated by their attitudes and actions. In some cases, providers may have to "let go". The provider should not measure their success based on client actions, since these are not within the provider's control. Rather, the provider should measure success based on whether he/she helped the client to understand the importance of partner referral, the options available, and helped them develop a realistic partner referral plan.

Using **open-ended questions** is an effective strategy for gaining a great deal of information in a short time, for uncovering relevant feelings, issues, and circumstances, and for engaging the client in the conversation. Good open-ended questions begin with "who", "what", "when", "where", and "how". **Polite imperatives** such as "give me", "tell me", "explain to me", and "describe" are also effective. "Why" questions should be avoided because they may communicate disapproval and inhibit open discussions, such as "Why did you do that?"

Some Navy providers have expressed concerns about their ability to effectively counsel clients of the **opposite sex**. However, research has demonstrated that there appears to be no correlation

between the gender or ethnicity of the provider and success in partner notification programs (Hennessy, et al 2002).

There have also been concerns that Sexual Partner Services for HIV infected clients may actually be counter-productive because Sexual Partner Services may result in **broken relationships** and the formation of new relationships (exposures of new / more people). These concerns seem unfounded based on studies by Hoxworth et al (2003) and Kissinger et al (2002).

Partner Services is ongoing.

It may be unrealistic for providers to assume they can solve all the issues surrounding effective Sexual Partner Services in one session. For example, providers may feel pressure to "get all the names" right now. But Sexual Partner Services need not be a single event. Follow-up sessions can be scheduled. It can also be helpful for providers to remember that the session is just one of many opportunities clients have to access their services and those of others. Providers should continue to support client referral and risk reduction plans during return visits.

On-going Sexual Partner Services for patients infected with HIV should be offered at every HIV-reevaluation visit, because risk (and transmission) may be on-going. New HIV infections have been detected via Partner Services programs for people with long-standing HIV infection (Ahrens et al 2007).

## Partner Referral Options

Recognizing that the client's participation is voluntary, the provider seeks to determine what might motivate the client to participate, and to help the client select appropriate referral options.

It is tempting – and less time-consuming – for a provider to simply inform the patient about Partner Sevices responsibilities and options, then leave the patient to digest the information and apply it to their partners as they see fit. However, recent research (Niccolai at al, 2006) indicates that patients will notify a larger proportion of past and present partners when the provider and the patient take the time to discuss and focus on the characteristics of each sex partner, and use this information to develop a specific approach to notification of each partner.

There are two basic approaches or options for reaching partners. **Client Referral** is used when infected individuals choose to inform their partners themselves and refer those partners to counseling and testing. **Provider Referral** is when the Partner Services provider, with the consent of the infected client, takes the responsibility for contacting the partners and referring them to counseling, testing, and other support services.

Sometimes a combination of the two approaches is used. With the **Dual Referral** approach, the infected client informs the partner of his/her infection in the presence of the Sexual Partner Services provider. By having a professional provider present, this approach supports the client and reduces other potential risks. With the **Contract Referral** approach, the Sexual Partner Services provider notifies the partner only if the client does not notify the partner within a negotiated time period. These four options are summarized in Table 2.

Client Referral

In the case of HIV infection, findings clearly indicate that fewer partners are actually informed of their possible exposure when the client-referral approach is used (versus Provider Referral). However, because Sexual Partner Services is a voluntary process, clients should be able to choose this approach.

When clients choose to inform their partners themselves, they usually need some help to succeed. The provider should be prepared to assess the situation and the client's readiness and ability to succeed. Although most clients do not experience negative consequences when notifying partners, the provider can help the client minimize the potential for these consequences. For example, clients might need to be coached on:

(1) the best ways to inform each partner;
(2) how to deal with the psychological and social impact of disclosing one's status to others, particularly in the case of HIV infection;
(3) how to respond to a partner's reactions, including the possibility of personal violence; and
(4) how and where each partner can access counseling, testing, and treatment.

Because partners may react by stating "You didn't get it from me" or "I feel fine". The client should be instructed, when speaking with partners, to

(1) tell the partner the actual **name of the infection** the client has,
(2) emphasize the importance of the partner seeking medical care **promptly**, even if they don't feel ill, and
(3) emphasize the importance of the partner telling their doctor the **name of the infection** they were exposed to – partners should not make their doctor guess why they're seeking care or just ask for a "check-up" hoping to avoid embarrassment.

A disadvantage of Client Referral is that the client might unintentionally convey incorrect information about transmission, available support services, confidentiality protections, or other issues. Also, the client forfeits anonymity to partners, increasing the potential for disclosure of the client's infection status to third parties, subsequent discrimination, or partner repercussion. Despite its drawbacks, Client Referral is frequently chosen, and it can have some advantages. Because the client is usually more familiar with the identity and location of the partner, this approach can allow some partners to be referred for counseling and testing more promptly. Also, some clients choose this approach because they feel the best way to preserve a current relationship. Another obvious advantage is that when client referral is successful, fewer staff are used and fewer resources are consumed than with the provider-referral approach, so the financial burden for prevention programs is reduced.

The provider should, if at all possible, permit the patient to use the office phone or computer at the time of the original interview to immediately notify those partners chosen by the patient for Client Referral.

Provider Referral

When the client chooses provider referral, the provider will also need to assess the situation regarding each partner, including the best ways to inform them, how to locate and contact them, and how to respond to partners' reactions. Research indicates that provider referral is more effective in serving partners than client referral. Some of the advantages of using the Provider Referral approach:

-The provider is able to readily verify that partners have been confidentially informed and have received client-centered counseling, testing, and treatment.

-The provider can better protect the infected client's anonymity since no information about the client is disclosed to his or her partners.

-A well-trained provider is better able to defuse the partner's potential anger and blame reactions as well as accurately and more comprehensively respond to the partner's questions and concerns.

-Provider referral better facilitates learning about sexual networks, thus potentially enhancing overall STI prevention efforts in affected communities.

One disadvantage of the provider-referral approach is the fact that providers are not always able to locate partners. Since providers are less familiar with the partners, actually locating them can be more difficult than it might be for clients. The provider-referral approach may also entail substantial financial costs.

Regarding HIV infection, providers should keep in mind that some clients who choose provider referral might still notify some partners about their status and will thus need relevant counseling.

If the provider has an indication of a potentially violent situation for the client or others, the provider must make an assessment prior to notifying the partner and seek expert consultation before proceeding.

Third-Party Referral is a variation of Provider Referral in which partner notification is completed by the attending health care provider without the assistance or involvement of their preventive medicine department. This is the option of the attending health care provider, who is in the best position to understand the patients' unique needs and circumstances. The preventive medicine department serves as an ancillary service. Because preventive medicine often learns about STI cases a day or more after treatment, and because the attending clinician may have elected to manage partner services him or herself (i.e. Third Party Referral), preventive medicine should consult the attending clinician before contacting the STI patient to offer partner services.

Dual Referral

Some clients prefer to have the provider present when they inform their partner. This is an option that can be easily employed when the partner is in the waiting room. The dual approach allows the client to receive direct support in the notification process. The provider is in a position to provide immediate counseling, answer questions, address concerns, provide referrals

to other services, and in some cases potentially minimize partner repercussions. Dual-referral enables the provider to know which partners have been served, and to some extent, learn about sexual networks. Whether the client or provider will take the lead in informing the partner should be worked out in advance of the notification. The provider still needs to coach and support the client as with the Client Referral approach. The provider and the client need to consider, in particular, the partner's possible concerns about having his or her relationship with the client revealed to the provider. By considering this issue in advance, the client and the provider can anticipate the partner's possible reactions and discuss how to respond appropriately.

Contract Referral

This approach requires more negotiation skill on the provider's part and a relationship of trust between the provider and client. The provider and client decide on a time frame during which the client will contact and refer their partners. If the client is unable to complete the task within that agreed-upon time period, the provider then has the permission and information necessary to inform the partner. The provider must also have agreement with the client about how to confirm that partners were notified. For example, the provider should negotiate a provision with the client whereby the partner confirms in some way (e.g., telephone call, appointment for services) to the provider that he or she has been informed. Otherwise, the provider may have difficulty knowing which partners have been informed and whether or not provider referral or some other assistance is now needed.

INSPOT

Another mechanism for Client Referral is the INSPOT.ORG "e-card". INSPOT is a website which enables the patient to send an anonymous e-mail to a partner. This method of partner notification is not ideal because the patient never really knows if the partner receives the message, because anyone with access to the partner's e-mail account may see the message, and because the partner and patient have no personal interaction (which might serve to motivate the partner to seek treatment). E-cards also suffer from the same weaknesses of all other forms of Client Referral. Scientific data regarding INSPOT as an effective partner referral intervention is sparse. What has been written suggests low levels of awareness and appeal among studied populations (Rietmeijer, et al 2011). However, INSPOT may be the best option for some partners of some patients. It is arguably better than no notification at all. Providers should consider informing some patients about INSPOT -- for example, patients who seem reluctant to disclose partner information to the provider and who seem reluctant to participate in standard client referral and patients who say that the only identifying information they have is a partners e-mail address.

Expedited Partner Therapy

Expedited partner Therapy is the delivery of medications or prescriptions by the patient to their sex partners without clinical assessment of the partners. Clinicians provide patients with sufficient medications directly or via separate prescriptions for the patients and their partners, plus written materials with instructions on drug administration, warnings about possible side effects and allergic reactions, fact sheets about gonorrhea and/or chlamydia infection, and a list of clinics where cost-free STI care is available. In some cases, EPT proved more effective than traditional sexual partner referral. Some States feature one or more laws that permit or facilitate

certain health care practitioners to practice EPT. Some states feature one or more laws that may limit the ability of some health care practitioners to conduct EPT, and other states feature one or more judicial decisions that disallow prescriptions to persons without a physical examination or physician-patient relationship. A State-by-State analysis completed by the CDC is available on-line at http://www.cdc.gov/std/ept/legal/default.htm

The standard (and preferred) method of sexual partner referral calls for the clinician to refer the patient to their local military preventive medicine or military public health department. Ideally, each partner should be tested and treated for the infection to which exposed, counseled about risk reduction, and be offered HIV testing and Hepatitis A and/or B vaccination. This standard approach represents the best method of ensuring the notification and care of partners. Also, because a partner's test may indeed be positive for the infection, this standard approach may lead to the treatment of other potentially exposed people.

The reality is that standard partner referral, which requires the voluntary participation of the patient and partner, is not always successful. Patients and partners may resist or refuse participation in the standard referral process, and partners may deny sexual involvement with the original patient or refuse care for a variety of understandably sensitive reasons.

Though EPT is not the ideal process for sexual partner referral, it is a potentially effective option in cases where the clinician, working in partnership with the patient, determines that EPT is more likely than standard partner referral to bring a partner to treatment. In such cases, EPT may increase the likelihood of prompt treatment of those partners whose therapy might otherwise be significantly delayed, decrease risk of patient re-infection, and enable discreet management of sensitive cases. The CDC has concluded that clinicians are in the best position to determine, in cooperation with the patient, the most efficacious method for achieving treatment of each partner.

WHEN EPT IS NOT APPROPRIATE

- EPT is not appropriate in cases of suspected sexual assault or abuse; or a situation in which the patient's safety is in doubt.
- EPT is not appropriate for patients co-infected with STIs not covered by EPT medication.
- Providers should assess the partner's symptom status, particularly symptoms indicative of a complicated infection. Partners who have symptoms of a more serious infection (e.g., pelvic pain in women, testicular pain in men, or fever in women or men) are not appropriate candidates for EPT.
- EPT should not be used for partners with known severe allergies to antibiotics.
- EPT is not recommended for men that have sex with men.

There is no definitive Navy Medicine policy regarding EPT. However, Navy Partner Services providers should be aware of EPT and whether patients or partners may access EPT from their local health departments or local private clinicians.

## Table 2 - Partner Referral Options

adapted from

CDC Partner Services Guidance; MMWR Vol 57; 30 Oct 2008

Partner Counseling and Referral Services Training Participant Manual (CDC, 2002, page H4-4, P4-7)

| Options | Who notifies and refers the partners? | Does the provider "coach" the client? | Does the provider collect full exposure, identifying, and locating information about partners? | description | advantages | disadvantages |
|---|---|---|---|---|---|---|
| **"Client Referral"** | client | yes | no | The client informs partners that he/she has the STI and they may also have it. The client uses the name of the disease, and emphasizes that it is very important the partner sees a doctor promptly, even if they don't think they are infected. When speaking with partners, a caring attitude is helpful, while a blaming attitude is not. The counselor helps the client keep in mind that his/her partner, even if infected, may not know it. Some people may have some sexually transmitted infections for long periods without having symptoms. | -Client's familiarity with identity and location of partner can result in prompt referral.<br>-Client preserves relationship with partner. Requires little in way of staff or resources. | -Client needs assistance.<br>-Client lacks counseling skills and experience.<br>-Client may unintentionally convey incorrect information about HIV transmission, available support services, confidentiality questions, etc.<br>-Fewer partners are informed.<br>-Client forfeits anonymity to partner.<br>-Client may face embarrassment, shame, or even violence.<br>-Potential for disclosure of serostatus to third parties, subsequent discrimination, or partner repercussion. |
| **"Provider Referral"** | provider | no | yes | With the client's permission, the provider informs the partner that someone with the disease has named them as a contact. This information is ideally shared face-to-face. The provider never discloses the client's name, but says only that a person who cares enough about them gave their name to ensure they receive appropriate care. The provider helps the partner access medical treatment and testing. | -Provider is able to verify that partners have been confidentially informed and have received client-centered counseling and testing in a timely fashion.<br>-Provider ensures client's anonymity.<br>-Well-trained provider helps defuse partner's potential anger and blame.<br>-Results in greater numbers of partners informed than does Client Referral. | -Provider not always able to readily locate and identify partner.<br>-Provider less familiar with lifestyles or problems of partner, therefore informing of exposure can be more difficult.<br>-High cost. |

## Table 2 - Partner Referral Options

adapted from

CDC Partner Services Guidance; MMWR Vol 57; 30 Oct 2008

Partner Counseling and Referral Services Training Participant Manual (CDC, 2002, page H4-4, P4-7)

| Options | Who notifies and refers the partners? | Does the provider "coach" the client? | Does the provider collect full exposure, identifying, and locating information about partners? | description | advantages | disadvantages |
|---|---|---|---|---|---|---|
| **"Dual Referral"** | client discloses with provider present | yes | no | This option is generally used when the client's partner is in the waiting room. The dual referral involves the client's notifying the partner in the presence of the provider; the provider is then available to address partner concerns and questions. Under no circumstances should the provider notify the partner of the original client's infection status, because this would be a breach of confidentiality. The provider plans with the client for how the session may go and, if needed, coaches the client on what to say. This option supports the client and ensures the partner receives prompt and complete information and medical care. | -All the advantages of Client Referral, plus the provider can give immediate counseling, answer questions, allay concerns, refer partner to other services.<br>-Client can notify partner in safe environment; provider's presence may temper partner reactions.<br>-Provider can ensure that partner has been informed and counseled. | -Client requires coaching.<br>-Client forfeits anonymity to partner.<br>-Client loses intimacy when notifying (bringing stranger in).<br>-Often little time for client or partner to prepare.<br>-May set up an emotional triangle.<br>-Provider often will not have established rapport with partner. |
| **"Contract Referral"** | client makes initial attempt; if unsuccessful, provider conducts referral | yes | yes | This is a negotiated agreement between the client and provider. The client agrees to inform the partner and, if that partner does not call or visit the provider a given date, then the provider notifies the partner. | -Depending on the situation, may include many of the advantages of a Provider Referral and/or a Client Referral, plus, the client has the option to back out of notifying partner, and partner will still be notified. | -Depending on the situation, may include many of the disadvantages of a Provider Referral and/or a Client Referral, plus, the provider and client must negotiate clearly to ensure partner is notified. |

## Special Issues

Limits to Privacy

In general, the Partner Services provider must avoid disclosing the name of the index patient and must protect the private medical information of the patient. However, there may be circumstances which require **a breech of this confidentiality** between the patient and provider**.**

Disclosure of limited health information – to protect a person from a communicable disease, to comply with certain law enforcement rules, and in cases of criminal activity is authorized - see DoD(HA) Military Health System Notice of Privacy Practices at http://www.tricare.mil/hipaa/downloads/Notice-of-Privacy-Practice-FINAL-FOR-PRINTING-10_21_02.pdf .

*Potential for Discovery of the Original Patient's Identity*. In some cases, a sexual partner, upon learning of their potential exposure, may be able to guess the identity of the original (infected) patient. This potential does not obviate the need for the provider to notify this partner. Of course, if the partner inquires about the identity of the original patient (even if they guess correctly), the Sexual Partner Services provider does not divulge, but rather explains the requirement to protect the medical information of the original patient.

*Duty and Privilege to Warn Partners.*

**Duty to Warn** is "a legal concept that a healthcare provider who learns that an HIV-infected client is likely to transmit the virus to another identifiable person must take steps to warn that person. State laws determine which circumstances constitute a duty to warn." (CDC, 2008)

**Privilege to Warn** is "the legal concept that a healthcare worker is legally permitted to warn partners of an HIV-infected person of the risk of past or future exposure to HIV". (CDC, 2008)

Information about an HIV-infected patient must be disclosed to that person's **spouse** (or former spouse in the past 10 years) when potential exposure of the spouse cannot be reasonably ruled out. This duty-to-warn requirement is established in SECNAVINST 5300.30D (Jan 2006); Army regulation 600-110 (15 Jul 2005), para 6-8 and 6-9 and Air Force Instruction 48-135 (12 May 2004), para 1.1, 1.2, 1.3, 3.5, and A12.3. These DoD requirements are similar to the procedures followed by civilian public health agencies operating under Public Law 104-146 (Ryan White Care Act Amendments of 1996 – see Section 8 at ftp://ftp.hrsa.gov/hab/amend.pdf) which requires States that receive Ryan White Care Act funding to make a good faith effort to notify current and previous spouses (married within the previous 10 years of the date of diagnosis). The CDC describes a good-faith effort as (1) asking all HIV-infected clients if they have a current or past marriage partner(s), (2) notifying these partners of their possible exposure to HIV, except in situations when, in the judgment of public health officials, there has been no sexual exposure of a spouse to the known HIV-infected individual during the relevant time frame; (3) referring them to appropriate prevention services; and (4) documenting these efforts.

A Partner Services provider may have concerns about an **identifiable partner** at risk of **future** exposure. If the partner is unaware of the HIV-infection status of the original patient and is unlikely to learn of the original patient's HIV-positive status from the original patient, the

provider should confront the patient with this concern. If, after confronting the patient, the provider remains unconvinced the identifiable partner will be informed by the patient, the provider may perceive a duty or privilege to warn. The Sexual Partner Services provider must comply with DoD and DoN policies and host-state laws. State laws vary on this matter. The Sexual Partner Service provider should seek guidance from a supervisor or the local medico-legal officer in these cases.

The provider may also be concerned about an HIV-infected patient who **persistently engages in behavior** that places others at risk of infection. Such behavior may constitute criminal behavior (depending on State law) and may violate the Uniform Code of Military Justice. In such cases, the CDC recommends (CDC, 2008) "initiating increasingly intensive prevention interventions (e.g. comprehensive risk counseling and services)", or referral to "substance abuse treatment, mental health services or other relevant services", and "seeking legal advice when public health interventions are not sufficient or appropriate. Determining the most appropriate course of action requires consideration of the details of the specific situation; every case must be managed carefully and confidentially". The Sexual Partner Services provider must comply with DoD and DoN policies and host-State laws. State laws vary on this matter. The Sexual Partner Service provider should seek guidance from a supervisor or the local medico-legal officer in these cases.

*Child Abuse; Threats to Harm*

Disclosure of the original patient's health information may be required when the patient divulges child abuse, sex between adults and minors, threats to do harm to another identifiable individual, and threats to harm themselves. The Sexual Partner Services provider must comply with DoD and DoN policies and host-State laws. State laws vary on this matter. The Sexual Partner Service provider should seek guidance from a supervisor or the local medico-legal officer in these cases.

Potential for Violence

The limited data available suggests that the rate of violence attributed to partner notification is likely to be low, but screening for potential violence is important. If the provider concludes that potential exists for violence against the patient by the partner, the provider should refer the patient to a domestic violence prevention specialist and coordinate a plan for partner notification in collaboration with that specialist and the patient.

Youth

The unique biological and cognitive developmental characteristics of young people infected with or named as partners of people infected with an STI require services for them to be developmentally appropriate and seem-less. Therefore, pediatric health care providers should be relied upon to manage these cases whenever possible.

Approaching youths who have received a recent diagnosis of HIV or any other type of STI can be challenging. Before broaching the subject of partner elicitation with a young patient, assessing immediate needs is important. Youths might have many misperceptions and information gaps about partner services that need to be addressed, such as understanding that partner services are voluntary and that they have the right to decline participation. They also

should understand the concept of confidentiality and that it includes not reporting to their parents unless the youth requests parent or guardian involvement. In addition, specific counseling skills might be necessary, especially for youths with a recent diagnosis of HIV, to ensure that they understand the ramifications of the diagnosis and how to prevent future acquisition of HIV and other types of STIs and transmission to others.

Counseling skills of providers are especially important when partners are very young or immature. Developing simple and clear messages regarding the STI and HIV notification process is needed to ensure that youths are able to understand the purpose of notification and the urgency of getting tested. Being able to assess the maturity of the partner is essential to ensure that an appropriate plan of action is developed.

Youths who fear losing partners and friends might find it especially difficult disclosing information about sexual or injection-drug partners and other social contacts. In addition, youths might be reluctant to provide information about adult partners because of fear of legal repercussions related to sex between an adult and a youth. In addition, fear of partner violence might prevent partner identification; therefore, assessing the potential for partner violence is essential for each partner identified. Assessing other potential violence or maltreatment situations that might occur involving parents, guardians, or friends also is critical. Finally, providers should be sure to discuss the topic of sexual abuse with their clients; if sexual abuse is suspected, they should notify the appropriate authorities in accordance with applicable laws and regulations.

Although the process of notifying partners named by youths and named by adults is the same, legal concerns might exist in situations with youths, especially when an adult partner is named. Knowledge of state laws is essential; if sexual abuse or statutory rape is suspected, the provider must be prepared to report to the appropriate agency.

Young partners might also require specific types of assistance to obtain testing. For example, the provider should be prepared to call previously identified testing sites, make an appointment for testing, and then follow up with the youths to verify that they received the test. Youths might be reluctant to access services because of financial and transportation limitations and because of fears that parents must give permission or be informed. Youths must understand that, with a few exceptions, all adolescents in the United States can legally consent to receiving a confidential diagnosis and treatment of STIs. In all 50 states and DC, medical care for STIs can be provided to adolescents without parental consent or knowledge. In addition, in the majority of states, adolescents can consent to HIV counseling and testing. Consent laws for vaccination of adolescents differ by state. Several states consider provision of vaccine similar to treatment of STIs and provide vaccination services without parental consent. Because confidentiality is crucial, health-care providers should follow policies that provide confidentiality and comply with state laws for STI services. Providers should remain knowledgeable and updated on related state and local laws and regulations.

Because youths often are a medically underserved population compared with persons in other age groups, they might be less likely to receive office-based medical care or to use primary care services. Reasons for this include concerns about confidentiality, lack of health insurance, lack of adolescent-specific services including health-care providers with adolescent health experience, and appointment times that conflict with school schedules. HIV-infected youths might face

additional challenges, and health care providers serving HIV-infected youths report that acceptance of HIV diagnosis and return for care and treatment can take many months. Programs might be able to increase the likelihood of successfully linking adolescents to care and treatment by developing relationships with medical facilities that are sensitive to youth concerns and that have a strong case-management component.

Collaboration Between Field Preventive Medicine and Navy HIV Evaluation and Treatment Units (HETUs) Regarding **HIV** Partner Services.

Ideally, persons who test positive for HIV should be contacted and offered partner services as soon as possible, ideally within a few days.

Every active duty sailor or marine newly identified with HIV is referred to one of the three Navy HETUs for an initial evaluation (Bethesda, Portsmouth or San Diego Naval Medical Centers). This evaluation includes partner services. The **primary responsibility** for completing partner services for these newly diagnosed active duty members falls to the HETU preventive medicine staff member, although that interaction rarely occurs within a few days of the positive test. The HETU is in the best position to offer initial partner services for active duty patients because these patients may not yet be emotionally prepared to productively discuss this subject (perhaps in part because of UCMJ concerns), and pressing them prematurely by untrained staff may be extremely counterproductive in the long run.

For non-active duty patients, responsibility for partner services resides with the attending health care provider and his/her supporting Navy preventive medicine department. Local civilian health departments may be consulted for support.

> NOTE: The CDC recommends these partners be placed at the **highest priority for notification** of exposure to HIV:
>
> - Partners who have been exposed within the past 72 hours and might be candidates for nonoccupational postexposure prophylaxis (PEP), if available. PEP is intended to be initiated within 72 hours of exposure to HIV, and antiretroviral medications must be taken for 28 days. Partners who have been exposed and can be notified within this time frame might be candidates for PEP (3). Because PEP is only intended for persons who are HIV negative and because partners might not be aware of their HIV status, access to rapid testing is necessary for this option to be offered.
>
> - Partners who are more likely to have become infected with HIV:
> -- Partners of index patients who are known (e.g., via review of medical records) to have a high HIV viral load (e.g., >50,000 HIV RNA copies/ml), which significantly increases the risk for HIV transmission. High viral load often is associated with acute infection but also can occur at different points during the course of the disease.
> -- Partners of index patients who are known (e.g., via review of medical records) to have acute HIV infection (e.g., presence of HIV RNA with negative HIV antibody test results) or recent infection (e.g., current positive HIV antibody test with recent negative HIV antibody test). Rapid follow-up of persons in networks with evidence of active, ongoing transmission might offer an opportunity to interrupt chains of transmission.
> -- Partners of index patients who had another STI at the time of exposure or partners who might have had another STI themselves at that time. Evidence suggests that STI infection (both ulcerative and nonulcerative) might increase HIV viral load in genital secretions and facilitate transmission and acquisition of HIV, increasing the likelihood that the partner might have become infected.

- Partners who, if infected, are more likely to transmit HIV to others include partners whose earliest known exposure has been within the past 3 months. Studies suggest that the incubation period for HIV infection (time from infection to acute retroviral syndrome) ranges from 5 to 75 days, that serum viral load is likely to be highest in the month after infection, and that viral load in seminal and cervicovaginal fluid is likely to be highest in the first 2 months after infection. Therefore, partners who are likely to have been infected within the previous 3 months might be more likely to spread HIV to others.

***HIV Partner Services by Field Preventive Medicine / Medical Treatment Facilities (MTF) / Medical Department*:**

**Prior** to referring the newly HIV-positive active duty member to the HETU, the medical treatment facility (MTF) or medical department which ordered the HIV test **may learn** about the HIV-positive result and **may elect** to offer partner services. However, this field or MTF provider should **not** conduct a lengthy sexual partner interview immediately after notification, especially without adequate training. Any initial offer of partner services by the MTF should be conducted with the goal of introducing the importance of partner notification. MTFs are reminded that a detailed conversation about partner referral with a well-trained specialist will take place at the HETU.

**If** the patient does reveal partner information to the MTF:

1. The MTF or local medical department shall directly notify all named partners/spouses who are DoD health care beneficiaries and who reside and/or receive care within the MTF's local public health jurisdiction. Notification shall be conducted face-to-face whenever possible, not by phone. However, if the person refuses to meet with the provider, informing a partner by telephone might become necessary if no reasonable alternative exists, with strict safeguards to verify the identity of the person being spoken with and ensure that privacy and confidentiality are protected. If attempts to arrange face-to-face notification of the partner are unsuccessful, MTFs may enlist the assistance of their local state or municipal HIV/AIDS partner notification agency. If desired by the MTF's host state HIV/AIDS surveillance coordinator, information about named sexual partners will be shared with the MTF's host state (which may elect to also contact these partners).

2. For named partners/spouses who are DoD health care beneficiaries but do not reside within the local public health jurisdiction, the MTF or local medical department shall phone the military preventive medicine/military public health office or local medical department which does have jurisdiction and will send them the field records (partner reports). That military preventive medicine/military public health office shall manage notification of the potentially exposed beneficiary. "Local" means where the partner resides.

3. For named partners/spouses who are NOT DoD health care beneficiaries, the MTF or local medical department shall telephone the MTF's host state/territory and shall mail field records to the MTF's host state/territory for action, following the host state's/territory's HIV/AIDS PCRS reporting procedures.

4. Partner information obtained by the MTF or local medical department should be **shared with the HETU** so partners are not notified twice.

5. When the MTF or local medical department receives partner information from HETUs, the **MTF should inform the HETU** when partner notification is complete. This will aid HETUs when they conduct on-going partner referral discussions with patients.

***HIV Partner Services at the HETU.*** HETUs or the HETU-supporting preventive medicine department should afford initial and on-going partner referral services to every HIV positive patient at every visit.

1. The HETU (or HETU-supporting Preventive Medicine Department) should directly notify all named partners/spouses who are DoD health care beneficiaries and who reside and/or receive care within the HETU's local public health jurisdiction. Notification should be conducted face-to-face if possible, not by phone. If attempts to arrange face-to-face notification of the partner are unsuccessful, HETUs may enlist the assistance of their local state or municipal HIV/AIDS partner notification agency. If desired by the HETU's host state HIV/AIDS surveillance coordinator, information about named sexual partners should be shared with the HETU's host State (which may elect to also contact these partners).

2. For named partners/spouses who are DoD health care beneficiaries, but do not reside within the local public health jurisdiction, the HETU (or HETU-supporting preventive medicine department) should phone the appropriate military preventive medicine/military public health office which does have jurisdiction and should send them the field records (partner reports). The military preventive medicine/military public health office should manage notification of the potentially exposed beneficiary. The HETU, when relaying partner information to appropriate military preventive medicine/military public health office, should request verification (via return of a copy of the field record) that the partner was notified. "Local" means where the partner resides.

3. For named partners/spouses who are NOT DoD health care beneficiaries, the HETU or HETU-supporting preventive medicine department should contact by phone and should mail field records to the HETU's host state for action, following the host state's HIV/AIDS PCRS reporting procedures.

## Monitoring Program Processes and Outcomes

The CDC recommends that program managers review partner services data at least quarterly to assure quality and assess effectiveness. Questions which might be asked and answered:

1. How completely is the program identifying newly reported cases and interviewing patients for partner services? For example,

- Number of new STI cases reported to the preventive medicine department, including cases identified through surveillance activities (lab reports, etc)
- Of new cases reported to the preventive medicine department, the number and proportion of index patients who were eligible for partner services (i.e., not out of jurisdiction at the time of report)
- Of new patients eligible for partner services (i.e., index patients), the number and proportion who were interviewed to elicit partner information

2. How effectively is the program identifying partners, notifying them of their risk, and examining or testing them for infection? For example,

- Number of named partners elicited per index patient interviewed
- Of named partners for which Provider Referral, Third-Party Referral, Contract Referral or Dual Referral was chosen by the index patient:
  - -- the number and proportion initiated (i.e., attempted to notify)
  - -- the number and proportion actually notified
  - -- the number and proportion examined, tested and treated
  - -- the number of partners preventively treated within 7, 14, and 30 calendar days from day of interview of index patient

3. Do patient and partner data reveal variations by age, race/ethnicity, sex, or risk behavior and can this information be applied to community prevention efforts?

4. Are Partner Services providers trained and skilled? For example:

- Have all Partner Services providers completed the self-study or classroom version of the SHARP course “Sexual Partner Services”?
- Have all Partner Services providers been directly observed and evaluated by a trained supervisor, trainer or peer while conducting “live” interviews?

5. Are Partner Services correctly documented; are records protected; are official documents maintained for 5 years and “working files” destroyed (shredded) when the information has been summarized in formal reports per SECNAV M-5210.1?

## Coordination with Public Health Authorities

These are some questions a Sexual Partner Services provider might ask of their cognizant Preventive Medicine Officer and local and state public health authorities:

-HIV and STI control program contact information (names, phone, address, fax, e-mail)

- Local STI clinic hours, locations and fees (if any)

-Reportable disease program contact information and process

-Partner notification processes:
Which exposures will be followed-up by them, which will not?
What is the partner reporting process? (local forms, phone calls, etc.)

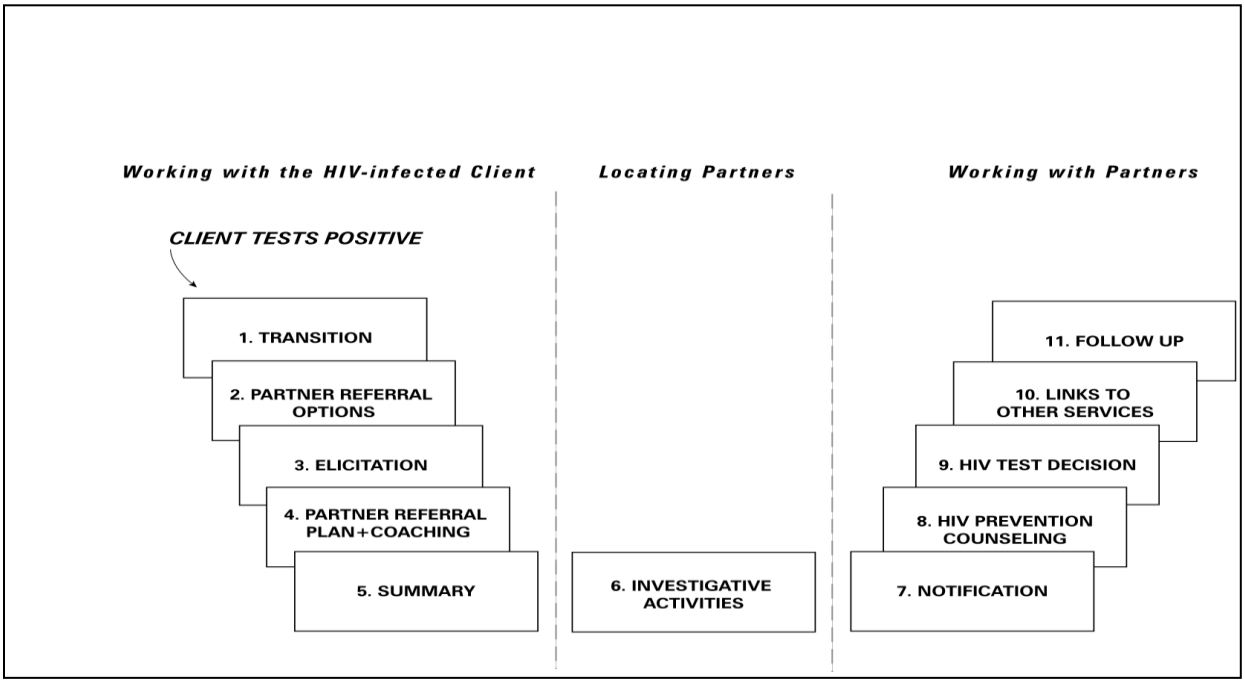
-Local and state laws affecting:
Sexual Partner Services activity record keeping
HIV spouse notification
Other obligatory notifications such as "duty to warn"
Reporting violence/threats of violence
Reporting child abuse

**Providers should always consult their medicolegal advisor regarding the applicability of local and state laws to Navy medical operations.**

## Sexual Partner Services: Steps

The CDC describes a five-step process for working with HIV-infected infected clients. This model may be adapted to serve clients and partners infected and exposed to other STIs. These five steps do **not** necessarily occur in order. These steps are followed by investigation activities (step 6), and five additional steps involved in working with named partners (steps 7-11). These are shown in Figure 2.

Figure 2 – HIV PCRS Steps
from CDC 1999, PCRS Training Participant's Manual, page P1-9




## Working with Clients

Step 1 – Transition.

Sexual Partner Services rarely occurs as a single-purpose session. More often, clients are also receiving risk reduction counseling and may also be receiving testing and/or treatment in the same session. Client reactions vary significantly to learning about their STI, so the provider must gauge the appropriate point at which to initiate the discussion about the Partner Services plan. In fact, other critical issues might need to be resolved first. For example, the client might express fear of a violent reaction from a partner. Resolving problems through role-playing, for example, might help clients overcome barriers to participating in Partner Services and help them better prepare for their part in those activities.

Moving from discussions about treatment, testing, or personal risk reduction into the Sexual Partner Services plan may occur at any opportune point during the session. A **transitional**

**statement** is one way to redirect the conversation to a discussion of sexual partners. Some sample transitional phrases:

Figure 3 - Sample Transitions
Adapted from CDC 1999, PCRS Training Participant's Manual, handout 4-1

*Let's talk a little about your partners, who probably are not aware of their risk, and how we can ensure that they're OK.*

or

*How do you feel about your partners being told they may have been exposed to* (the STI)?

or

*What are your feelings about telling your partners they may have been exposed to* (the STI)?

or

*What have you thought about your partners who need to know they've been exposed?*

or

*Now that we have talked about the various ways to keep you healthy, let's talk about ways we can keep your partners healthy. How do you feel about talking to your partners?*

or

*As we discussed, the earlier people know if they have (*the STI*), the sooner they can see a doctor in case they are also infected. How would you feel about talking to your sexual partners who may also have this infection?*

or

*About how many people do you think you have had sex with in the past (*contract tracing period for the STI*)? Let's talk about them. How would you feel about telling me their names?*

Notice many of these questions elicit the client's feelings about Sexual Partner Services, since knowing these can be helpful to the provider. If the client seems reluctant to discuss partners, the provider could ask some open-ended questions to determine what benefit the client perceives in helping their partners receive testing and treatment. The provider can then address those things that would motivate the client, such as benefits to themselves (avoiding re-infection), benefits to their partners, and benefits to the community.

Step 2 – Offer Options

In some cases infected clients initially will not want their partners notified. For example, they might fear loss of anonymity, the breakup of a relationship, or other adverse consequences. Clients might say that partners have already been informed about their risks or that partners would not be interested in counseling, testing, or other support services. Providers can encourage a client's participation by explaining that the partner benefits by knowing his or her infection status and being able to seek immediate treatment if infected. Also, if infected, the partner can avoid transmitting the infection to others. However, when a client is determined not to disclose partner names, the Sexual Partner Services provider should counsel the client as if he or she has chosen the Client Referral approach. Describe the four options to the client, including the advantages and disadvantages (see Table 2). Then, check again on the client's feelings. Some of the client's concerns about their anonymity or other issues may have been assuaged by learning about the options. When describing the options, it is helpful to the client for the provider to also describe how the process works. Some sample scripts are included in Figure 4.

Figure 4 - Sample Script to Describe Referral Options
Adapted from CDC 1999, PCRS Training Participant's Manual, handout 4-3

*One of the best ways to get help to your friends, ease your mind, and remain anonymous is to get in touch with your partners. Let me explain what I mean and what your partners would be told.*

*I would make sure I have the right person, tell that person that I have something important to talk about, and ensure we were speaking privately. I would then tell the person that he or she has been exposed to (*the STI*). We would immediately provide your partner with the kind of counseling that you have received and offer him or her a chance to be tested.*

*I would not mention your name or anything about you that would tip your partner off to who gave us his or her name. I would not say anything about your gender, your physical description, your age, whether the exposure was sexual or through shared needles, the dates of the exposure or your location. This is the best way of notifying your partners when you want to remain anonymous. (*Provider Referral*)*

*On the other hand, for the partners with whom you have an ongoing relationship that's important for you to maintain, you will probably want to tell them yourself. In this case, I can help you think through the best way to do this for each partner — and the best things to say. We could even practice a bit to build your confidence.* (Client Referral)

*I can also work with you so that you and I can tell a partner together*. (Dual Referral)

*If you try, but end up not being able to tell your partner, I'll get in touch with him or her. I would not mention your name or anything about you that would tip the partner off to who gave us his or her name.* (Contract Referral)

*You can pick a different way of handling each partner, depending on your relationship with that person. What questions or concerns do you have about any of these approaches?*

Step 3 – Elicitation

**Information to collect**. In the elicitation step, the provider helps the client name all their partners during a discrete time period. For each partner you will gather information on:

-How the exposure occurred (sex or needle-sharing)
-How to locate the partner
-How to identify the partner
-Is the partner a DoD health care beneficiary?

**Motivate clients** to participate in partner notification with timely and appropriate cues such as:

-mode of transmission
-confidentiality protection
-asymptomatic nature of diseases
-risk of reinfection
-social responsibility
-increased risk of acquiring and transmitting HIV if infected with another STI
-complications and consequences of untreated infections, including the impact on pregnancy and children

**Helping clients remember** and identify partners, you may need to use all your creative resources:

-Reassure clients of the ways in which their **confidentiality** will be protected
**-Challenge** conflicting information
**-Address** sensitive topics
-Encourage clients by helping them to consider the **benefits** — both to themselves and their partners — of participating in PARTNER SERVICES
-Stimulate clients memory through the use of existing tools, such as calendars, address books, diaries.

You will want to be client-centered when eliciting partner information. That means paying attention to the client's feelings and starting where they're willing to start. Some providers have found that it works best to create a fairly complete list of partners for the entire contract tracing period, before proceeding with collecting details about each. Some of the advantages of collecting all partners' names (or identifiers) before proceeding with detailed information on each include:

-Starting with a list of names, even just first names, can ease the client into giving more specific information later.

-The list of partners gives you a point of reference to help with coaching.

-Starting first with a list of names puts less pressure on the client to come up with a lot of details "on the spot."

-Creating a list of names may help jog the client's memory and gives the client some time to think of more specific details.

-Providing just names (and not other identifying information) makes him/her feel less threatened by the whole elicitation process.

In some cases, you may see disadvantages to starting with the full list of names. For example, if a client has had a lot of partners, she or he might not want to reveal that fact. Starting first with one name and accompanying information might be a more successful way to ease the client into the conversation. There is not a hard and fast rule about the order in which to work.

One study (Brewer et al, 2005) found that additional partner names may be elicited (3-5%) by **non-specific prompting** and **"reading back the list".**

- After the patient reports he/she can recall no other partners, the provider prompts the patients by asking "***Who else can you think of that you had sex with*** (during the contact tracing period)".

- The provider then slowly reads aloud back the list of partner names, prompts again "***Who else can you think of that you had sex with between ____ and today***?

**Collect exposure, identifying and locating information**.

Collecting detailed exposure information is important to Sexual Partner Services. It helps the provider set priorities among partners for notification — those most likely to be infected or to transmit.

Collecting detailed location information helps investigators find partners more easily and helps them better maintain the partner's confidentiality (because they will go directly to the partner and not through intermediaries). Locating information may include home and work addresses and phone numbers, school attended, and hangouts.

Most of the identifying information needed may be elicited by asking a broad, open-ended question or polite imperative such as "***How would I know this person***?" or "***Describe this person to me***."

A useful **Partner information form** for recording relevant information about partners during the session is included as an appendix to this document. After the session is complete, the counselor should transfer this information to a "**field record**" or similar form. Complete one "field record" for each partner. A copy of the CDC Field Record is included as an appendix to this document

Step 4 – Partner Referral Plan and Coaching

The client will decide which options are best for each partner. For client's that elect the Client Referral, Dual Referral, or Contract Referral options, the provider will want to provide "coaching". The provider should assess the client's willingness and ability to:

-Contact partners promptly
-Find a private place for discussion
-Disclose their own STI status
-Help their partners understand the seriousness of the STI
-Accept that their partner is not bound to protect the client's confidentiality
-Refer the partner for services
-Anticipate and handle partner's reactions

Ask the client how soon they will speak with each partner, where they will meet, and what they will say. The provider should role-play as the client, while the client plays the role of the partner. This demonstration can help clients see a model notification and recognize whether or

not they're ready to take on this responsibility. It also gives the provider a chance to see how the partner may react. As stated previously, the provider should demonstrate how the client could

(1) tell the partner the actual **name of the infection** the client has,
(2) emphasize the importance of the partner seeking medical care **promptly**, even if they don't feel ill, and
(3) emphasize the importance of the partner telling their doctor the **name of the infection** they were exposed to – partners should not make their doctor guess why they're seeking care or just ask for a "check-up" hoping to avoid embarrassment.

A fact sheet entitled How Do I Tell My Partner..?, designed to help clients understand the partner notification options and processes is included as an appendix to this document and is available on the website of the Navy and Marine Corps Public Health Center (NMCPHC) Sexual Health and Responsibility Program (SHARP) at http://www-nehc.med.navy.mil/downloads/hp/contact.pdf.

Providers may consider creating an "I care card" to give to patients – 1 card for each partner (plus a couple extra cards for partners the patient may not have mentioned). The card, which may be created and printed on business card stock, contains an "I care" message, the name and phone number of the provider, and a case number. By giving this card to a partner, the patient communicates who the partner can call for an STI evaluation of referral, and communicates to the provider the identify (i.e diagnosis) of the index patient. The template for the "I care" card shown here may be downloaded from the SHARP website http://www-nehc.med.navy.mil/downloads/hp/sharp_I_care_card.doc or the SHARP Toolbox compact disk.

Step 5 – Summarize

The summary step may have a significant influence of the ultimate success of the referral process. Important aspects of this step include:

-Review referral plans. Summarize the referral plan for each partner and check for agreement.

-Reemphasize confidentiality. Remind the client of how you will protect their identity.

-Ask client if he/she has any other questions.

-Offer your card and phone number. Leave the "door open" for them to return with any questions and requests for support.

-Transition back to the counseling session. Summarize any personal prevention plan made with the client, and give them condoms and appropriate brochures, etc.

**Finding partners**

Step 6 – Investigate

Navy providers will attempt to find, or request local Navy Preventive Medicine notification, of all named partners who (a) were exposed during the appropriate contact tracing period, (b) were included in the Provider Referral or Contract Referral plan of the client, (c) are DoD health care beneficiaries and (d) reside within the preventive medicine jurisdiction of the provider.

Locating and exposure information of **non-DoD healthcare beneficiary** partners will be reported to the cognizant public health authority. Although client information may also be reported to local or state health authorities, providers are reminded that these reporting systems are separate and that the name of the original client is never linked to the partner in such reports. Providers should follow local guidance for local reporting of partners. This may entail locally-designated forms and procedures. For partners located outside the local area, partner identification information may be sent to the State public health authority (who will forward the report to the cognizant State or local health authority) using a State-specific form and process or using CDC Form 73.2936S - Field Record (a sample of this form is included as an appendix).

With the exception of HETUs, which will receive feedback from field medical departments and MTFs, providers should not expect confirmation of receipt or a disposition report. If a disposition report is desired, the provider should so state on the Field Record, and provide a statement of justification and return address/phone information. Providers are encouraged to be familiar with the addresses, phone numbers, forms, and processes for the local or state in which they are located.

Locating and exposure information of **DoD healthcare beneficiary** partners will be reported to the cognizant local military public health authority using any locally (i.e. Preventive Medicine) approved form or CDC Form 73.2936S - Field Record. Providers may receive telephone numbers and mailing addresses for local military public health and preventive medicine offices from:

-Army: Center for Health Promotion and Preventive Medicine, (Aberdeen Proving Ground, MD), **(**410) 436-4312 [DSN 584]

-Air Force: HQ Air Force Medical Operations Agency, Public Health (Bolling AFB, Washington D.C.), (202) 767-1839 [DSN 297]

-Navy and Marine Corps Public Health Center (Portsmouth. VA.), (757) 953-0700 [DSN 377]

-Coast Guard Headquarters, Clinical and Operational Medicine - CG-1121 (Washington, DC), (202) 267-0845

**Working with Partners**

Step 7 – Notification

Notifying partners can be challenging. Providers may be concerned about informing the right person, how the partner may react, preventing adverse consequences to the original client, and avoiding breeches of confidentiality, among other issues. It may be helpful to providers to know that, in a study in South Carolina (Jones et al 1990, page R-54), most partners notified felt the health department did the right thing in telling them (87%) and felt the health department should continue to notify people exposed to HIV (92%). When the notification is handled professionally, named partners often respond positively to the notification and seek medical evaluation.

As previously mentioned, spouses of HIV-infected military reservists must be notified in accordance with SECNAVINST 5300.30D. Other partners of HIV-infected clients should be notified face-to face if at all possible.

Two important issues for partner notification are:

(1) Make sure you have the right person
(2) Protect the confidentiality of the original client

When notifying partners by telephone, first ensure you have the right person. Then, ask to ensure you are speaking privately (not on speaker phone or in busy place where they cannot speak privately). Ask the partner to come in to your office to discuss a personal medical issue and arrange an appointment or meeting. If the partner insists on first knowing the purpose of the appointment, the provider may inform the partner over the phone. Otherwise, face-to-face

notification is preferred. As previously mentioned, providers should not reveal to others why they are trying to find a particular person. Likewise, providers should never leave a note or message that mentions an STI exposure as the reason for attempting to make contact.

Sample scripts of notification conversations are offered in Figure 5.

Figure 5 - Sample Script to Notify and Respond to Partners

*Hello. Am I speaking with (*partner name*)? Are you the same (*partner name*) that (works at __, or is assigned to ___?* - insert identifying details that will confirm you have the right person but will not link the client to the partner)

*I'm (*HM2 Smith*) from (*Naval medical facility*). Are we speaking privately? I'd like to speak with you about a personal medical matter. Can you come in to see me? It's not an emergency, but I would like to speak with you soon. I think it would be best if we spoke about this in person. Is that alright with you?*

*You have been named as a sexual partner of a person who has been diagnosed with* (infection name*). It's important you receive (*the recommended testing and/or treatment*) to ensure that you're OK.*

In response to that partner's statement "I feel fine" or other denial of the need for testing/treatment – *Some people who have this infection are completely unaware of it. But the infection can cause health problems if untreated and the infection may also be spread to other people. It's important that anyone who may have been exposed to this infection receives prompt (*appropriate testing and/or treatment*).*

If asked "Who gave you my name" – *I'm obligated to protect the privacy of every patient. I can tell you that the person who told us about you was a person who cares enough about you to make sure you're OK.*

Step 8 - Counseling

The partner notification event provides an opportunity for providers to assess the partner's sexual risk behavior and to help the partner reduce future risks. Sample scripts for this process are found in Figure 6.

Provider training in client-centered prevention counseling and in sexual risk assessment skills is available. Details are included later in this document.

Figure 6 - Sample Script to Assess and Respond to Risk Behavior

*How many people have you had sex with over the past 6 months or so?*

*What is the riskiest thing you're doing in your life that could expose you to (*the infection*) or to HIV or an unplanned pregnancy?*

*What have you done in the past to protect yourself from (*the infection*) or HIV or an unplanned pregnancy?*

*What would you like to do in the future to protect yourself?* Note: to help the partner understand their options, see the attached SHARPFact fact sheet entitled "Choosing safer Options Reduces Risk"

*What do you see as the advantages to doing (*the safer behavior the partner wants to adopt*)?*

*What will be the hardest thing about doing (*the safer behavior the partner wants to adopt*)?*

*How will you incorporate this plan into your life?*

Step 9 – HIV Test Decision

HIV testing should be offered to all named sexual partners. Testing under these circumstances is the option of the named partner. Providers are reminded to complete the locally-approved informed consent form for any HIV testing of non-active duty members.

When offering the test, providers are encouraged to determine if there are any local or state guidelines or laws for pre or post-test HIV counseling.

The provider should explain the HIV test and the meaning of a negative and positive result, and how the partner will be informed of the test results.

Step 10 – Link to Other Services

Partners may need to be referred to other professionals to complete the Sexual Partner Services process or to support some other identified need.

For example, the provider may need to arrange **testing, treatment and Hepatitis B vaccination**. Providers are strongly encouraged to make these arrangements while the partner is in their office – and it is certainly preferable to provide these services in the same building and during the same visit if possible. This "**one-stop**" or comprehensive service setting inhibits losing partners to follow-up and minimizes patient/customer inconvenience. Sexual Partner Services providers who do not have working space in the same building where testing and treatment services are offered operate at a disadvantage and are encouraged to reconsider their operating location.

Partners may also express a desire for access to other services, such a those of the chaplain or family service. These referrals, and the personal issues involved, may be very important to the ultimate success or failure of Sexual Partner Services and risk reduction. Again, providers are strongly encouraged to make these arrangements while the partner is in their office. Referral services to consider include:

- domestic violence prevention;
- crisis intervention;
- rape crisis intervention;
- legal services;
- child or adult protective services;
- intensive HIV prevention intervention;
- mental health counseling;
- substance abuse treatment;
- prenatal care;
- reproductive health assistance;
- social services (e.g., assistance with housing);
- screening and treatment for other STIs;
- hepatitis screening or vaccination (recommended for all persons being evaluated for an STI)
- TB screening.

Sexual Partner Services providers should actively learn about the availability and referral processes for local referral services.

Step 11 – Follow-up

The provider should check to ensure the partner completed the agreed-upon referrals for testing, treatment, and other services and seek to assist the partner where needed. Providers are encouraged to ask partners (and clients) for their permission to follow-up or "check in to see how things are going".

A re-interview is recommended for all patients with primary or secondary syphilis to follow up on the status of partners the patient chose to notify themselves and to elicit further partner information.

A re-interview should be scheduled within 2 weeks for patients who were not ready to discuss partners during the initial interview.

HIV Retesting. Partners might be infected with HIV but test negative because of the window period between infection and development of detectable levels of HIV antibodies. With recent EIA tests (e.g., second-generation IgG-sensitive tests and third-generation IgG/IgM-sensitive tests), most infected persons develop detectable antibody within 3 months of infection. Therefore, partners who test negative might be advised to be retested 3 months after the date of last known exposure. In partner services, suggestions for retesting are complicated because reference to any date might compromise the index patient's identity. For this reason, routinely suggesting that partners be retested 3 months later might be the best course of action.

## Record Keeping

Providers should keep a record of their attempts to notify partners. This record should document each phone call and other attempts to notify partners, and the outcome of these efforts such as the interview date and the test, treatment and vaccination dates of the partners. This record may be important later if a coworker takes over a case, to explain your efforts to program evaluators, to answer any concerns that patients or partners may raise, and to demonstrate a good faith effort to find partners. No specific forms for this are specified in Navy directives. Internal-office case management of STI patients and notification of their partners may be documented on a host-State form or on these CDC interview forms:

- HIV / Syphilis Interview Record
  http://www.cdc.gov/std/Program/forms/EIR_03_07_2008.pdf
- Gonorrhea / Chlamydia Interview Record
  http://www.cdc.gov/std/Program/forms/GC_CT_IR_6_05_2008.pdf

Providers should keep a file copy of any partner notification form sent to another public health agency. Again, while no Navy directives specify a form for this purpose, Partner Services providers might notify other agencies using a locally approved form (such as their host-State form) or CDC Form 73.2936S - Field Record (http://www-nmcphc.med.navy.mil/downloads/hp/cdc_field_record.pdf).

Providers are encouraged to seek local (i.e. Preventive Medicine or MTF) guidance for specific documentation requirements or policies, if any.

To preserve patient privacy, records of Partner Services activities should be kept locked and inaccessible to unauthorized view.

Testing, treatment, vaccination and counseling of a each partner should be recorded in that person's official medical record.

Partner identity is not documented in patient medical records. In general, partner names and patient names are recorded on separate documents, with only a case number or code linking the two. The CDC Interview forms listed above contain both identities (patient and partners) but not on the same page.

SECNAV M-5210.1 requires communicable disease official documents to be maintained for 5 years and "working files" to be destroyed (CDC recommends shredding) when the information has been summarized in formal reports.

Note for Coast Guard: COMDTINST M6000.1C, Chapter 7.B at http://www.uscg.mil/directives/cim/6000-6999/CIM_6000_1C.pdf specifies the use of CDC 73.54, Contact Interview Record and provides detailed instructions on completion and distribution.

## Bibliography


Ahrens K, Kent C, Kohn R, Nieri G, Reynolds A, Philip S, Klausner J (2007). HIV partner notification outcomes for HIV infected patients by duration of infection, San Franscisco, 2004 to 2006. J AIDS 46;4:479-484. Dec 1, 2007

Brewer D, Potterat BA, Muth S, Malone P, Montoya P, Green D, Rogers H, Cox P (2005). Randomized trial of supplementary recall of sexual partners in contact interviews. *Sex Tran Dis* 32:3;189-193

Centers for Disease Prevention and Control (1999). *PCRS Trainer's Manual* and *PARTNER SERVICES Training Participant's Manual*. CDC, National Center for HIV, STD and TB Prevention, Atlanta, GA.

Centers for Disease Prevention and Control (2008). MMWR, Vol 57. Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydia Infection. CDC, National Center for HIV, STD and TB Prevention, Atlanta, GA. 30 Oct 2008 http://www.cdc.gov/mmwr/PDF/rr/rr57e1030.pdf

CDC. 2008d. *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2008*. http://www.cdc.gov/nchs/data/series/sr_10/sr10_242.pdf (accessed June 9, 2010).

CDC. 2010. *Interventions to identify HIV-positive people through partner counseling and referral services*. http://www.thecommunityguide.org/hiv/partnercounseling.html (accessed May 13, 2010).

Centers for Disease Prevention and Control (2010). *MMWR* Vol 59; No RR-12. Guidelines for Treatment of STDs 2010. http://www.cdc.gov/std/treatment/2010/default.htm?s_cid=stdtreat_9

Cohen D, Wu S, Farley T (2005) Cost effective allocation of government funds to prevent HIV infection. Health Affairs 24;4:915-926.

Department of Defense (1991). DoD Instruction 6485.1, *HIV-1*. March 19, 1991 <http://www-nehc.med.navy.mil/downloads/hp/6485_1.pdf>

Department of the Navy (2002). Bureau of Medicine and Surgery (BUMED) *Manual of Medicine.* <http://vnh.org/Admin/MMD/001Contents.html>

Department of the Navy (1999). Bureau of Medicine and Surgery. BUMEDINST 6222.10A *STD Clinical Management Guidelines.* 21 June 1999. http://www-nehc.med.navy.mil/downloads/hp/6222_10a.pdf>

Department of the Navy (1990). SECNAVINST 5300.30C, *Management of HIV-1 in the Navy and Marine Corps.* March 14, 1990 http://www-nehc.med.navy.mil/downloads/hp/5300_30C.pdf>

Dooley, S., J. Douglas, and R. Janssen. 2007. Partner counseling and referral services for HIV infection. *Am J Prev Med* 33(2S):S81-S83.

Golden MR, Hogben M, Handsfield HH, St Lawrence JS, Poteratt JJ, Holmes KK (2003). Partner notification for HIV and STD in the United States: low coverage for gonorrhea and chlmydial infection, and HIV. Sex Trans Dis 30;490-6

Hennessy, M., Williams, S., Mercier M., Malotte, K. (2002). Designing partner notification programs to maximize client participation. *Sexually Transmitted Diseases,*29:2;92-99, Feb 2002

Hogben, M., T. McNally, M. McPheeters, and A. B. Hutchinson. 2007. The effectiveness of HIV partner counseling and referral services in increasing identification of HIV-positive individuals a systematic review. *Am J Prev Med* 33(2 Suppl):S89-100.

Hoxworth H., Spencer N., Peterman T., Craig T., Johnson S., Maher J. (2003). Changes in Partnerships and HIV Risk Behaviors After Partner Notification. STDs 30(1)83-88, Jan 2003

Jones at al (1990). Partner acceptance of health department notification of HIV exposure - South Carolina. *JAMA*, 264:10;R53-56

Kissinger P., Niccolai L., Manya M., Farley T., Maher J., Richardson-Altson G., Dorst D., Myers L., Peterman T. (2003). Partner Notification for HIV and Sypilis. STDs 30(1)75-82, Jan 2003

Niccolai L, King L, Dentremont D, Pritchett E (2006). Disclosure of HIV serostatus to sex partners: a new approach to measurement. STDs, Feb 2006, 33:2;102-105

Rietmeijer C, Westergaard B, Mickiewicz T, Richardson D, Ling S, Sapp T, Jordan R, Wilmoth R, Kachur R, McFarlane M (2011). Evaluation of an Online Partner Notification Program, Sexually Transmitted Diseases Vol. 38; No. 5: P. 359-364 (05.11)

St Lawrence J., et al (2002). STD screening, testing, case reporting, and clinical partner notification practices: a national survey of US physicians. Am J of Public Health 92(11);1784-1788

US Congress (1996). Public Law 104-106 (Ryan White Care Act Amendments of 1996), Section 8[a]. May 20, 1996

Whittington WL, Kent C, Kissinger P, Oh MK, Fortenberry JD, Hillis SE, Litchfield B, Bolan GA, St Louis ME, Farley TA, Handsfield HH.(2001). Determinants of persistent and recurrent Chlamydia trachomatis infection in young women: results of a multicenter cohort study. Sex Transm Dis 2001 Feb;28(2):117-23

## SHARP Sexual Partner Services - Examination

1) The purpose of Sexual Partner Services is to
   a) Get all the names of sexual contacts
   b) Determine if any laws have been broken
   c) Alert people exposed to sexually transmitted infections (STI) and facilitate appropriate counseling, testing, and treatment
   d) None of the above

2) Sexual Partner Services is often accompanied by
   a) Risk-reduction counseling
   b) Core-values training
   c) Religious instruction
   d) Criminal investigation

3) An effective strategy for gaining a great deal of information in a short time, for uncovering relevant feelings, issues, and circumstances, and for engaging the client in the conversation is the use of
   a) A checklist
   b) A patient brochure
   c) Open-ended questions
   d) Closed-ended questions

4) Studies have shown that providers can be effective even if they are not of the same gender as the client
   a) True
   b) False

5) The decision about which partners should be notified depends upon
   a) The STI
   b) When the last sexual contact occurred
   c) The likelihood of the partner being notified
   d) All the above

6) Two conditions that should be considered when prioritizing the investment of healthcare resources in partner notification efforts include
   a) The quality of the information about the partner
   b) The policies and practices of the cognizant public health authority
   c) Both a and b
   d) Neither a nor b

7) Which partners of a client diagnosed with gonorrhea should be notified of their exposure?
   a) All named sexual partners and the spouse even if not named
   b) All named or suspected sexual partners
   c) All named sexual partners within the 60 days preceding the onset of symptoms or the most recent partner if >60 days
   d) None of the above

8) For clients diagnosed with Hepatitis C, which partners should be informed of the low but present risk of transmission?
   a) All partners during the past 10 years
   b) All partners during the past 1 year
   c) All partners within the past 14 days
   d) The patient should be instructed to discuss the low but present risk of sexual transmission with their partners discuss the need for counseling and testing.

9) For partners of clients diagnosed with genital warts
   a) Notification of partners by medical authorities is not necessary
   b) Patients with genital warts should inform current sex partners because the warts can be transmitted to other partners.
   c) Both a and b
   d) Neither a nor b

10) Which of the following statements are true?
   a) No person can be forced to disclose the names of his/her partners
   b) Partner Services relies on the willing participation of the client and their partners
   c) Both a and b
   d) Neither a nor b

11) The counseling concept that is helpful for uncovering underlying feelings and motivations is called
   a) Focus on feelings
   b) Manage your own discomfort
   c) Set boundaries
   d) None of the above

12) The counseling concept that recognizes that the provider and client enter the interaction with their own set of values, biases, and beliefs is called
   a) Focus on feelings
   b) Manage your own discomfort
   c) Set boundaries
   d) None of the above

13) The counseling concept that based on the fact that providers must acknowledge that clients may not choose the referral options and plans the provider would prefer is called
   a) Focus on feelings
   b) Manage your own discomfort
   c) Set boundaries
   d) None of the above

14) The two basic approaches or options for reaching partners are “client referral” and “provider referral”
   a) True
   b) False

15) Who chooses the referral option to be used?
   a) The provider
   b) The client
   c) The partner
   d) None of the above

16) A different referral option may be chosen for different partners of the same client
   a) True
   b) False

17) The referral option(s) that enable the client to remain anonymous is/are
   a) Client Referral
   b) Provider Referral
   c) Dual Referral
   d) None of the above

18) For Client Referrals, the provider should discuss with the client
   a) How to deal with the psychological and social impact of disclosing one's status to others
   b) How to respond to a partner's reactions, including the possibility of personal violence
   c) How and where partners may access counseling, testing, and treatment
   d) All the above

19) For Client Referrals, the provider should instruct the client, when notifying his/her partner, to
   a) The infected client should tell the partner that the client has the infection and that the partner may also have it
   b) The client should state actual name of the infection they have
   c) The partner should see a doctor promptly, even if the partner does not feel ill, and tell the doctor the name of the infection they were exposed to
   d) All the above

20) Among the advantages of Client Referral are
   a) The client's familiarity with the partner can result is prompt referral
   b) The client may consider self-disclosure the best way of maintaining the relationship
   c) This option requires little in terms of provider staff resources
   d) All the above

21) One of the advantages of Provider Referral is that the client's anonymity is preserved
   a) True
   b) False

22) A disadvantage of Provider Referral is
   a) Provider is not always able to locate the partner
   b) High cost
   c) Both a and b
   d) Neither a nor b

23) The option generally used when the partner is in the waiting room is called
   a) Client Referral
   b) Provider Referral
   c) Dual Referral
   d) Contract Referral

24) The option which gives the client an opportunity to notify the partner within an agreed upon time frame with the provider initiating notification after that period is called
   a) Client Referral
   b) Provider Referral
   c) Dual Referral
   d) Contract Referral

25) This referral option includes many of the advantages of Provider Referral and/or Client Referral, plus the client has the option to back out of notifying the partner, yet the partner will still be notified
   a) Client Referral
   b) Provider Referral
   c) Dual Referral
   d) Contract Referral

26) Moving from discussions about treatment, testing, or personal risk reduction into the Partner Services plan may occur at any opportune point during the session. One way to redirect the conversation is known as
   a) Transitional statement
   b) Shock therapy
   c) Investigation
   d) None of the above

27) In the elicitation step, the provider helps the client name all their partners from a discrete time period. For each partner you will gather information on
   a) How exposure occurred (sex or needle-sharing)
   b) How to locate the partner
   c) How to identify the partner
   d) All the above

28) When eliciting partner information, providers should
   a) Reassure clients of the ways in which their confidentiality will be protected
   b) Challenge conflicting information
   c) Encourage participation by reminding clients of the benefits
   d) All the above

29) Some providers collect all partners' first names (or identifiers) before proceeding with detailed information. An advantage(s) of this strategy is/are
   a) Starting first with a list of names puts less pressure on the client to come up with a lot of details "on the spot"
   b) Creating a list of names may help jog the client's memory and gives him or her some time to think of more specific details
   c) Providing just names (and not other identifying information) makes the client feel less threatened by the whole elicitation process
   d) All the above

30) A rule of thumb for partner notification is
   a) Make sure you have the right person
   b) Protect the confidentiality of the original client
   c) Both a and b
   d) Neither a nor b

31) The process of informing people that they have been named as partners is an opportunity to assess their sexual risk behavior and help them reduce future risk
   a) True
   b) False

32) HIV testing is mandatory for named partners of people who have an STI
   a) True
   b) False

33) Providers are strongly encouraged to make follow-up arrangements while the partner is in their office
   a) True
   b) False

34) Regarding partner follow-up (step 11), the following are true:
   a) A re-interview is recommended for all patients with primary or secondary syphilis to follow up on the status of partners the patient chose to notify themselves and to elicit further partner information.
   b) A re-interview should be scheduled within 2 weeks for patients who were not ready to discuss partners during the initial interview.
   c) When partners of HIV patients test HIV negative, the provider should recommend HIV retesting in 3 months.
   d) All the above.

35) The person who has primary responsibility for interviewing active duty members newly infected with HIV is
   a) The PMT at one of the Navy HETUs
   b) The doctor, corpsman, PMT or EHO at the facility which ordered the HIV test
   c) The members Commanding Officer
   d) The local civilian public health office

36) When an active duty member is newly identified HIV positive, the field or MTF provider (doctor, corpsman, PMT or EHO) should **not** conduct lengthy sexual contact interviews immediately after notification, especially without adequate training. Any initial offer of partner services by the MTF should be conducted with the goal of introducing the importance of partner notification because:
   a) Patients may not yet be emotionally prepared to productively discuss this subject
   b) Pressing them prematurely by untrained staff may be extremely counterproductive in the long run
   c) Only the PMT at the HETU should know about their partners
   d) A and B above

End of Examination

**NMCPHC SHARP course: Sexual Partner Services**

Navy and Marine Corps Public Health Center - SHARP
620 John Paul Jones Circle, Suite 1100
Portsmoth VA 23708
Fax 757-953-0705 [DSN 377]

| | |
|---|---|
| date | SSAN or certification # or Member # |
| name | |
| email | |
| address | |
| professional / affiliation AMA ANA CEHS CEHT | other: |

**Answer Sheet**

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | a | b | c | d | e | 14 | a | b | c | d | e | 27 | a | b | c | d | e |
| 2 | a | b | c | d | e | 15 | a | b | c | d | e | 28 | a | b | c | d | e |
| 3 | a | b | c | d | e | 16 | a | b | c | d | e | 29 | a | b | c | d | e |
| 4 | a | b | c | d | e | 17 | a | b | c | d | e | 30 | a | b | c | d | e |
| 5 | a | b | c | d | e | 18 | a | b | c | d | e | 31 | a | b | c | d | e |
| 6 | a | b | c | d | e | 19 | a | b | c | d | e | 32 | a | b | c | d | e |
| 7 | a | b | c | d | e | 20 | a | b | c | d | e | 33 | a | b | c | d | e |
| 8 | a | b | c | d | e | 21 | a | b | c | d | e | 34 | a | b | c | d | e |
| 9 | a | b | c | d | e | 22 | a | b | c | d | e | 35 | a | b | c | d | e |
| 10 | a | b | c | d | e | 23 | a | b | c | d | e | 36 | a | b | c | d | e |
| 11 | a | b | c | d | e | 24 | a | b | c | d | e | | | | | | |
| 12 | a | b | c | d | e | 25 | a | b | c | d | e | | | | | | |
| 13 | a | b | c | d | e | 26 | a | b | c | d | e | | | | | | |

**Course Critque**

| How effectively did the material help you identify and discuss basic facts concerning: | not helpful | helpful | very helpful |
|---|---|---|---|
| 1. PCRS purpose | | | |
| 2. contact tracing periods | | | |
| 3. PCRS concept | | | |
| 4. PCRS options | | | |
| 5. PCRS steps | | | |

| | excellent | very good | good | fair | poor | n/a |
|---|---|---|---|---|---|---|
| Usefulness | | | | | | |
| Quality | | | | | | |
| Facilities/Management | | | | | | |
| Registration | | | | | | |
| Environment | | | | | | |
| Audiovisuals | | | | | | |

| | yes | no |
|---|---|---|
| Do you feel the course was fair, balanced, and free from commercial bias? | | |
| Was there any information regarding unapproved or off-label use of products? | | |

This Educational activity has contributed to my professional effectiveness and improved my ability to:

| | strongly agree | agree | disagree | strongly disagree | n/a |
|---|---|---|---|---|---|
| Treat/manage patients | | | | | |
| Communicate with patients | | | | | |
| Manage my medical practice | | | | | |
| Other: | | | | | |

# Interview Record

Patient ID | Condition(s) 1 2 | Case ID 1 2 | Lot # | Interview Record ID

Neurological Involvement? C P N U

900 Site Type | 900 Site Zip Code | 900 Agency ID

Patient Name

Case ID

Lot #

## Name

Last Name | First Name | Middle Name

Preferred Name / AKA | Maiden Name

## Phone/Contact

Home Phone

Work Phone

Cellular Phone

Pager

E-Mail Address(es)

Emergency Contact Name

Emergency Contact Phone

Emergency Contact Relationship

## Address

Residence Street | (Apt. #) | City

State | Zip | County | District | Country

Living With | Residence Type

Time At Address W M Y | Time In State W M Y | Time In Country W M Y

Currently Institutionalized? Y N U | Name of Institution | Institution Type

## Demographics

Date of Birth / / | Sex at Birth M F | Current Gender M F MTF FTM U R | If additional Gender, Specify:

English Speaking? Y N U

Age | Marital Status S M Sep D W C U R | Race AI/AN A B NH/PI W U R | Hispanic/ Latino? Y N U R | Primary Language

## Pregnancy

Pregnant at Exam? Y N U R # Weeks | Pregnant at Interview? Y N U R # Weeks | Currently in Prenatal Care? Y N U R | Pregnant in Last 12 Mos? Y N U R | Pregnancy Outcome D S M A U

## Condition 1 Reporting Information

**Method of Case Detection** | Other

OP Condition | OP Case ID

### Facility First Tested

If Other, Describe | Laboratory Report Date / /

Interviewed? Y N | If not, why not? | If Other, Describe | Interview Period (mos.)

Place of Interview: | If Other, Describe | PEMS Site ID

Date First Assigned for Interview / / | DIS # | Date Reassigned for Interview / / | DIS #

Date Original Interview / / | DIS # | Date First Re-Interview / / | DIS #

Date Case Closed / / | DIS # | Supervisor #

**Imported Case?** N C S J D U | Import Location

## Condition 2 Reporting Information

**Method of Case Detection** | Other

OP Condition | OP Case ID

### Facility First Tested

If Other, Describe | Laboratory Report Date / /

Interviewed? Y N | If not, why not? | If Other, Describe | Interview Period (mos.)

Place of Interview: | If Other, Describe | PEMS Site ID

Date First Assigned for Interview / / | DIS # | Date Reassigned for Interview / / | DIS #

Date Original Interview / / | DIS # | Date First Re-Interview / / | DIS #

Date Case Closed / / | DIS # | Supervisor #

**Imported Case?** N C S J D U | Import Location

Case ID

## RISK FACTORS

**Y**-Yes, Anal or Vaginal Intercourse (with or without Oral Sex) **O**-Yes, Oral Sex Only **U**-Unspecified Type of Sex
**N**-No **R**-Refused to Answer **D**-Did Not Ask

**Within the past 12 months has the patient:**

1. Had sex with a male? ☐
2. Had sex with a female? ☐
3. Had sex with a transgender person? ☐
4. Had sex with an anonymous partner? ☐
5. Had sex without using a condom? ☐
6. Had sex while intoxicated and/or high on drugs? ☐
7. Exchanged drugs/money for sex? ☐
8. **[Females only]** Had sex with a person who is known to her to be an MSM? ☐
9. Had sex with a person known to him/her to be an IDU? ☐

**Y**- Yes **N**-No **R**-Refused to Answer **D**-Did Not Ask

**Within the past 12 months has the patient:**

| | Y/N/R/D |
|---|---|
| 10. Been incarcerated? | ☐ |
| 11. Engaged in injection drug use? | ☐ |
| 12. Shared injection drug equipment? | ☐ |

13. During the past 12 months, which of the following injection or non-injection drugs have been used? (Y/N/R/D)

- ☐ None
- ☐ Crack
- ☐ Cocaine
- ☐ Heroin
- ☐ Methamphetamines
- ☐ Nitrates/Poppers
- ☐ Erectile dysfunction medications (e.g., Viagra)
- ☐ Other, specify: _____

14. Other Risk, Specify: _____

## Social History

**Places Met Partners**

| Type | Name |
|---|---|
| ☐ | _____ |
| ☐ | _____ |
| ☐ | _____ |
| ☐ | _____ |
| ☐ | _____ |
| ☐ | Did not ask |
| ☐ | Refused to answer |

**Places Had Sex**

| Type | Name |
|---|---|
| ☐ | _____ |
| ☐ | _____ |
| ☐ | _____ |
| ☐ | _____ |
| ☐ | _____ |
| ☐ | Did not ask |
| ☐ | Refused to answer |

**Partners in Last 12 Months**

| | | Unknown | Refused |
|---|---|---|---|
| Female | ☐☐☐ | U | R |
| Male | ☐☐☐ | U | R |
| Transgender | ☐☐☐ | U | R |

**Interview Period Partners**

| | Condition 1 | Unknown | Refused | Condition 2 | Unknown | Refused |
|---|---|---|---|---|---|---|
| Female | ☐☐☐ | U | R | ☐☐☐ | U | R |
| Male | ☐☐☐ | U | R | ☐☐☐ | U | R |
| Transgender | ☐☐☐ | U | R | ☐☐☐ | U | R |

**Additional Social History Comments**

_____

**Local Use:** A B C D E F G H I J K L

Case ID

## STD Testing

| Date Collected | Provider | Test | Specimen Source | Qualitative Result | Quantitative Result |
|---|---|---|---|---|---|
| / / | | | | P N I U Q C | 1: |
| / / | | | | P N I U Q C | 1: |
| / / | | | | P N I U Q C | 1: |
| / / | | | | P N I U Q C | 1: |

## HIV Testing

**Tested for HIV at this event?** Y N U R Not Asked **Previously Tested for HIV?** Y N U R Not Asked

**Self Reported HIV Test Result:** 01 02 03 04 66 77 99 **Date of Self Reported Test:** / /

| Date Collected | Provider | Test | Specimen Source | Qualitative Result | Provider Confirmed |
|---|---|---|---|---|---|
| / / | | | | P N I U Q C | |
| / / | | | | P N I U Q C | |
| / / | | | | P N I U Q C | |

## Signs and Symptoms

| | Signs/ Symptoms | Earliest Observation Date | Anatomic Site | Clinician Observed? | Patient Described? | Duration (Days) |
|---|---|---|---|---|---|---|
| 1. | | / / | | | | |
| 2. | | / / | | | | |
| 3. | | / / | | | | |

If Other, Please Describe:

## STD History

Previous STD History? Y N U R

| | Condition | Dx Date (mm/yyyy) | Rx Date (mm/yyyy) | Confirmed? |
|---|---|---|---|---|
| 1. | | / | / | |
| 2. | | / | / | |
| 3. | | / | / | |

## STD/HIV Treatment/Counseling

| Treatment Date | Provider | Drug and Dosage |
|---|---|---|
| / / | | |
| / / | | |
| / / | | |

**Treatment Comments:**

**Incidental Antibiotic Treatment in Last 12 Months?** Y N U

| **Rx Date** (mm/yyyy) | **Drug/Dosage/Duration** | **Condition** |
|---|---|---|
| / | | |
| / | | |

**Anti-Retroviral Therapy for Diagnosed HIV Infection?** In Last 12 Months? Y N U R Ever? Y N U R

**Results Provided:** Y N

**900+ Only:**

**Referred to Medical Care:** Y N

**If Yes, did Client Attend First Appt.:**

Case ID

## Partner, Social Contact, & Associate Information

| 1 | Last Name | First Name | AKA | Jurisdiction |
|---|---|---|---|---|
| | Referral Basis / First Exposure ___/___/___ | Freq. / Last Exposure ___/___/___ | Gender: M F T U R / Pregnant: Y N U R | Spouse: Y N U R |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Condition 1 | ___/___/___ Ix Date | ___/___/___ Init. Date | Ix DIS # | Ix Type | Type Ref. | FR# | Dispo | ___/___/___ Dispo Date | Cond. | DIS # | SO/SP |
| Condition 2 | ___/___/___ Ix Date | ___/___/___ Init. Date | Ix DIS # | Ix Type | Type Ref. | FR# | Dispo | ___/___/___ Dispo Date | Cond. | DIS # | SO/SP |

| 2 | Last Name | First Name | AKA | Jurisdiction |
|---|---|---|---|---|
| | Referral Basis / First Exposure ___/___/___ | Freq. / Last Exposure ___/___/___ | Gender: M F T U R / Pregnant: Y N U R | Spouse: Y N U R |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Condition 1 | ___/___/___ Ix Date | ___/___/___ Init. Date | Ix DIS # | Ix Type | Type Ref. | FR# | Dispo | ___/___/___ Dispo Date | Cond. | DIS # | SO/SP |
| Condition 2 | ___/___/___ Ix Date | ___/___/___ Init. Date | Ix DIS # | Ix Type | Type Ref. | FR# | Dispo | ___/___/___ Dispo Date | Cond. | DIS # | SO/SP |

| 3 | Last Name | First Name | AKA | Jurisdiction |
|---|---|---|---|---|
| | Referral Basis / First Exposure ___/___/___ | Freq. / Last Exposure ___/___/___ | Gender: M F T U R / Pregnant: Y N U R | Spouse: Y N U R |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Condition 1 | ___/___/___ Ix Date | ___/___/___ Init. Date | Ix DIS # | Ix Type | Type Ref. | FR# | Dispo | ___/___/___ Dispo Date | Cond. | DIS # | SO/SP |
| Condition 2 | ___/___/___ Ix Date | ___/___/___ Init. Date | Ix DIS # | Ix Type | Type Ref. | FR# | Dispo | ___/___/___ Dispo Date | Cond. | DIS # | SO/SP |

| 4 | Last Name | First Name | AKA | Jurisdiction |
|---|---|---|---|---|
| | Referral Basis / First Exposure ___/___/___ | Freq. / Last Exposure ___/___/___ | Gender: M F T U R / Pregnant: Y N U R | Spouse: Y N U R |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Condition 1 | ___/___/___ Ix Date | ___/___/___ Init. Date | Ix DIS # | Ix Type | Type Ref. | FR# | Dispo | ___/___/___ Dispo Date | Cond. | DIS # | SO/SP |
| Condition 2 | ___/___/___ Ix Date | ___/___/___ Init. Date | Ix DIS # | Ix Type | Type Ref. | FR# | Dispo | ___/___/___ Dispo Date | Cond. | DIS # | SO/SP |

| 5 | Last Name | First Name | AKA | Jurisdiction |
|---|---|---|---|---|
| | Referral Basis / First Exposure ___/___/___ | Freq. / Last Exposure ___/___/___ | Gender: M F T U R / Pregnant: Y N U R | Spouse: Y N U R |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Condition 1 | ___/___/___ Ix Date | ___/___/___ Init. Date | Ix DIS # | Ix Type | Type Ref. | FR# | Dispo | ___/___/___ Dispo Date | Cond. | DIS # | SO/SP |
| Condition 2 | ___/___/___ Ix Date | ___/___/___ Init. Date | Ix DIS # | Ix Type | Type Ref. | FR# | Dispo | ___/___/___ Dispo Date | Cond. | DIS # | SO/SP |

## Marginal Partners, Social Contacts, & Associates

| | Name | Sex | Age | Race | Height | Weight | Hair | Exposure | Locating Information |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |

Case ID

## Interview / Investigation Comments

## Travel History and Internet Use

Case ID

# Investigation Plans & Supervisory Review

**Date Submitted:** _____ **Initial Review Date:** _____

| Date | DIS # | DIS Investigation Plans | Date | Sup # | Supervisory Comments |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| Last Name | First (& Nickname) |
|---|---|
| Address (Street) | (Apt. #) |
| City, State, & Zip Code | Telephone Number |

| Age/D.O.B. | Race | Hispanic |
|---|---|---|
| / / | AI/AN \| A \| B \| NH/PI \| W \| U \| R | Y \| N \| U \| R |

| Gender | Marital Status |
|---|---|
| M \| F \| MTF \| FTM \| U \| R | S \| M \| Sep \| D \| W \| C \| U \| R |

| Internet Alias/E-mail Address | Internet Site/System |
|---|---|
| | |

| Height | Size/Build | Hair | Complexion |
|---|---|---|---|
| | | | |

Place of Employment/Hours/Phone

Other Identifying, Locating, or Medical Information

| FR Number | OOJ No. | OOJ Area | Due Date |
|---|---|---|---|
| | | | / / |

Ix Only FR: Yes ☐ No ☐

| Referral Basis: | Disease 1 | Disease 2 |
|---|---|---|
| ☐ **Partner** _____ | | |
| ☐ **S/A** _____ | | |
| ☐ **Positive Lab Test** | | |
| ☐ **OOJ/ICCR** _____ | | |

Pregnant? Y _____ Wks. N U

900 Case Status:

Original Patient ID. Number:

**Exposure:** First Freq. Last

| Date | Test | Result | Provider |
|---|---|---|---|
| | | | |

| Date | Drugs | Dosage | Provider |
|---|---|---|---|
| | | | |

| Initiating Agency | Invest. Agency | Clinic Code |
|---|---|---|
| | | |

Disease 1

Interviewer Number:

Date Initiated: / /

Type Interview: Type Referral:

Dispo:

Date: / /

New Case #:

DX: Worker:

Disease 2

Interviewer Number:

Date Initiated: / /

Type Interview: Type Referral:

Dispo:

Date: / /

New Case #:

DX: Worker:

Internet Outcome: Post-test Counseled: Yes No

**900 PS Information** **(Complete on all 900 Sexual Contacts)**

Interviewed? ☐☐ 900 PS Interview Date ___/___/___

Sex at Birth: M F additional, Specify: _____

Notifiability: ☐☐ Plan: ☐☐ Actual Method: ☐☐

Self-Reported Results: ☐☐ Date of Last 900 ___/___/___

Referral 1: ☐ Referral Date ___/___/___ Test: ☐ Result: ☐

Post: ☐ **900+ Only:** Referral 2: ☐ First Appt.: ☐☐

**FACTORS** **Optional for 900 negative sexual & social contacts, associates, or cohorts.**

| | Y/O/U/N/R/D | | Y/N/R/D |
|---|---|---|---|
| Male | ☐ | IDU | ☐ |
| Female | ☐ | Share Equipment | ☐ |
| Transgender | ☐ | NIR | ☐ |
| Condom | ☐ | Other | ☐ |

Other (Specify): _____

**Standard Documentation Abbreviations**

**Bic** - Bicillin
**C/B** - Call back/Called back
**CLIX** - Cluster Interview
**CX** - Contact
**CL** - Cluster
**CSW** - Commercial Sex Worker
**FB** - Field Blood
**FR** - Field Record
**FV** - Field Visit
**HX** - History
**IM** - Intramuscular
**IP** - Index Patient
**IX** - Interview
**LX** – Lesion
**MSM** - Men who have Sex with Men
**OI** - Original Interview
**OP** - Original Patient
**P/C** - Phone Call
**Pt** - Patient
**RI** - Reinterview
**RS** - Record Search
**SX** - Symptoms
**TX** - Treatment
**PTC** - Post-test counsel
**W/** - With
**WBI** - Will be in
**W/O** - Without

Navy and Marine Corps Public Health Center; Sexual Health and Responsibility Program (SHARP); www-nehc.med.navy.mil/hp/sharp

**Sexual Partner Services – Desktop Assistant**

**NOTE: THIS IS NOT AN OFFICIAL NAVY FORM. IT IS FOR INSTRUCTIONAL PURPOSES ONLY**

**Partners of case#** _____ **Case diagnosis** _____ **Date of Diagnosis** _____ **Date this form initiated:** _____

| Partner Info | Date of last contact and place | Within tracing period? | Exposure type | DoD healthcare eligible? | Notification option selected | Identifying, locating, and "contract" info | Disposition |
|---|---|---|---|---|---|---|---|
| Name:<br><br>Relationship:<br>(check one)<br>□ spouse<br>□ other main<br>□ casual or periodic<br>□ anonymous<br>□ CSW<br>□ unknown<br>□ refused<br><br>Gender: | Date:<br><br>Place:<br>(check all that apply):<br><br>□ home station<br>□ underway<br>□ on leave / liberty<br>□ deployed<br>□ prior to enlistment<br>□ CONUS<br>□ OCONUS<br>□ other: _____ | Yes<br><br>No | Sex<br><br>Needle-sharing<br><br>both | Yes<br><br>No | Provider<br><br>Client<br><br>Dual<br><br>Contract<br><br>Other: | | Notified? Date: _____<br><br>Testing and Treatment Confirmed?<br>Date: _____<br><br>Confirmed infected? Yes / No<br><br>Date case closed: _____<br><br>Final Disposition Code: _____ |
| Name:<br><br>Relationship:<br>(check one)<br>□ spouse<br>□ other main<br>□ casual or periodic<br>□ anonymous<br>□ CSW<br>□ unknown<br>□ refused<br><br>Gender: | Date:<br><br>Place:<br>(check all that apply):<br><br>□ home station<br>□ underway<br>□ on leave / liberty<br>□ deployed<br>□ prior to enlistment<br>□ CONUS<br>□ OCONUS<br>□ other: _____ | Yes<br><br>No | Sex<br><br>Needle-sharing<br><br>both | Yes<br><br>No | Provider<br><br>Client<br><br>Dual<br><br>Contract | | Notified? Date: _____<br><br>Testing and Treatment Confirmed?<br>Date: _____<br><br>Confirmed infected? Yes / No<br><br>Date case closed: _____<br><br>Final Disposition Code: _____ |

Disposition Codes:
A-preventive treatment B-refused preventive treatment C-infected and brought to treatment D-Infected-not treated E-previously treated for this infection
F-not infected G-insufficient info to begin investigation H-unable to locate J-located and refused exam and treatment K-out of jurisdiction L-other

| MOTIVATION – Points to encourage clients to participate in PCRS | | |
|---|---|---|
| **Benefits to Client:** | **Benefits to Partners:** | **Benefits to Community:** |
| **Protects privacy and anonymity.**<br><br>**Relieves client of responsibility to inform partners.**<br><br>**Offers peace of mind to client by fulfilling ethical responsibility to partners.**<br><br>**Reduced risk of re-infection from same partners and others "in the circle".** | **Prompt treatment for infection.**<br><br>**Information about real risk (which partners may underestimate, misunderstand, deny or be unaware of).**<br><br>**Access to testing (where partners may learn of own infection for first time).**<br><br>**Referral to counseling and support services (e.g., family planning and related decisions; emotional problems; addictions; other issues).**<br><br>**Opportunity for behavior change (due to prevention counseling and increased awareness of risk).**<br><br>**Reduced likelihood of acquiring or transmitting infection in future.** | **Earlier identification and treatment of previously undiagnosed HIV infections.**<br><br>**Reduced transmission within community.**<br><br>**Improved surveillance and identification of disease networks.**<br><br>**Increased dissemination of HIV/STD prevention information.**<br><br>**Improved understanding of HIV/AIDS/STDs in the community.**<br><br>**Reduced stigma on infected individuals.** |

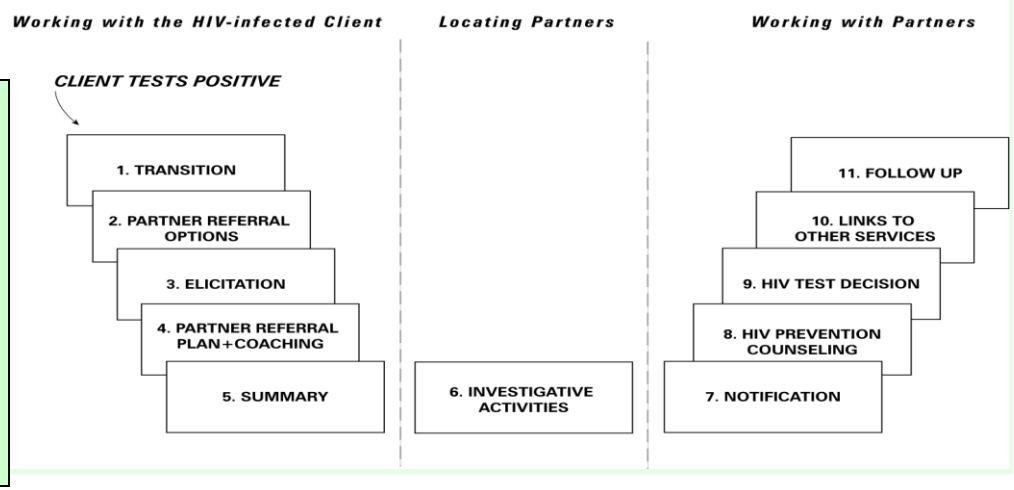
## COACHING – Key Points to Communicate

***When speaking with partners, <u>the client</u> should:***

**- tell the partner the actual <u>name of the infection</u> the client has,**

**- emphasize the importance of the partner seeking medical care <u>promptly</u>, even if they don't feel ill**

**- emphasize the importance partner telling their doctor the <u>name of the infection</u> to which they were exposed**



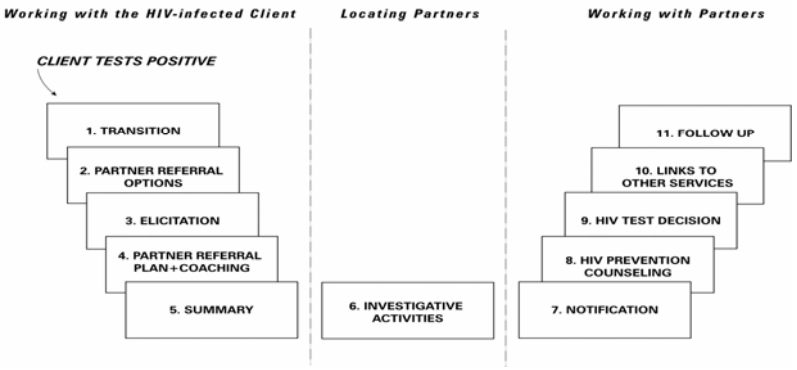
# Sexual Partner Counseling and Referral - Provider Role-Play Feedback Form

| **Provider's Name** | **Observer's name** |
|---|---|
| | |

| ***Did the counselor adhere to the 3 counseling concepts?*** | **yes** | **no** | ***Did the counselor positively demonstrate the 4 counseling skills?*** | **yes** | **no** |
|---|---|---|---|---|---|
| - PCRS is voluntary | | | - Open-ending Questions | | |
| - Providers must protect confidentiality | | | - Focus on Feelings | | |
| - PCRS is on-going | | | - Manage Discomfort | | |
| | | | - Set Boundaries | | |

| ***Did the Counselor cover the 5 steps of "Working with Clients"?*** | **yes** | **no** |
|---|---|---|
| **- Transition**<br>Transition statement was: _____ | | |
| **- Partner Referral Options**<br>Benefits of participating in PCRS explained?<br>Options that were explained were: _____<br>Options selected by the client were: _____ | | |
| **- Elicit Partner Information**<br>Names of partners were:_____<br>Identifying info gained?<br>Exposure type and period info gained?<br>Locating info gained? | | |
| **- Referral Plan and Coaching**<br>Provider helped patient plan for notifying every partner?<br>Client knows to use STI name; stress importance of prompt care; encourage partner to tell doctor the STI name?<br>Client knows how partners can access testing and treatment? | | |
| **- Summarize**<br>Provider restated notification plans?<br>Provider gave his/her contact info?<br>Provider scheduled/tried to schedule follow-up?<br>Provider left the "door open" to future conversations about PCRS? | | |

**Constructive Comments:**



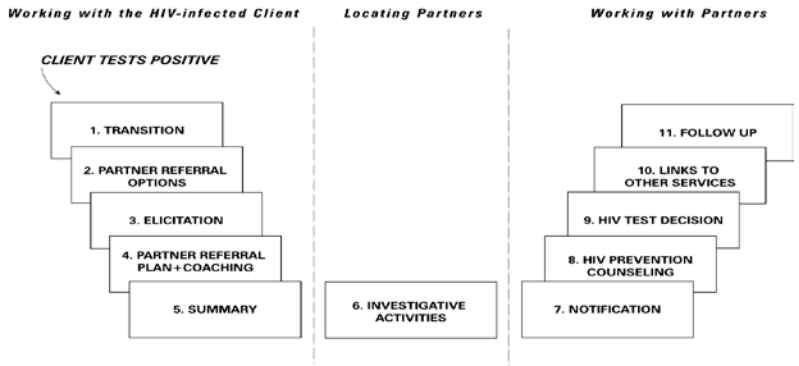



(pcrs_feedback.xls)

Dear Supervisor/Trainer,
Your subordinate has completed the SHARP course "Sexual Partner Counseling and Referral".
To validate these new skills, provide helpful feedback, and ensure quality in this task, we encourage you to observe a counseling session. Use this form (and the PCRS *Desktop Assistant*) to conduct and document your evaluation of the first 5 (of 11) steps in the process.
When you are satisfied the counselor has demonstrated competence, sign and send the form to NMCPHC-HP-SHARP. Your subordinate will receive a SHARP lapel pin as certification of their skills. We also encourage periodic supervisory evaluations to ensure continuous improvement and quality, as recommended by the CDC.

| **Supervisor/Trainer name and command:** | **Counselor name and mailing address:** |
|---|---|
| **Date:** | **Supervisor/Trainer signature:** |

| ***Did the counselor adhere to the 3 counseling concepts?*** | **yes** | **no** | ***Did the counselor positively demonstrate the 4 counseling skills?*** | **yes** | **no** |
|---|---|---|---|---|---|
| - PCRS is voluntary | | | - Open-ending Questions | | |
| - Providers must protect confidentialty | | | - Focus on Feelings | | |
| - PCRS is on-going | | | - Manage Discomfort | | |
| | | | - Set Boundaries | | |

| ***Did the Counselor cover the 5 steps of "Working with Clients"?*** | | **yes** | **no** |
|---|---|---|---|
| **- Transition** | Did the counselor transition into partner notification appropriately and effectively? | | |
| **- Partner Referral Options** | Did the counselor explain the 4 options and ask how the client/patient wants to notify partners?<br>Options: Provider referral; Client referral; Dual Referral; Contract Referral | | |
| **- Elicit Partner Information** | Did the counselor effectly elicit all partners and gather identifying, exposure and locating information? | | |
| **- Referral Plan and Coaching** | Did the counselor prepare the client/patient to accurately and effectively inform their partners? | | |
| **- Summarize** | Did the counselor summarize the referral plans, offer and arrange follow-up, and keep the door open to further discussion? | | |

**PCRS 11-Step Model**