

# HIV COUNSELOR PERSPECTIVES

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## TWO-TIERED HIV COUNSELING AND TESTING

*In 2008, California HIV counseling and testing sites began to implement a new HIV counseling model. The new model attempts to use resources more efficiently by directing clients at the highest risk of contracting HIV to more intensive counseling services while delivering less intensive services to clients at lower risk. This new, “two-tiered” model uses a new instrument, the Client Assessment Questionnaire (CAQ), to assess risk. It also creates a new type of HIV test counselor, the Counselor I, to deliver lower-level interventions. This issue of PERSPECTIVES describes the new model and the opportunities it offers clients, HIV test counselors, and the larger HIV prevention and care system.*

### Research Update

Until 2008, HIV counseling and testing programs funded through the California State Office of AIDS delivered the same kind of intensive one-on-one counseling to every client who received an HIV test. Counselors conducted thorough, personalized risk assessment and disclosure counseling and helped all clients, even those at very low risk for HIV, to develop a personal risk reduction step.

In 2006 and 2007, the Office of AIDS developed a new “two-tiered model” for counseling and testing. The new model distributes funding for counseling and testing based on client risk for HIV. This encourages testing programs to use resources more efficiently, by reserving more intensive services (“high-level interventions”) for clients at higher risk for HIV and less intensive services (“low-level interventions”) for clients at lower risk. In this way, programs can focus most of their

counseling efforts on clients most likely to contract HIV, while still offering HIV testing to all clients.<sup>1</sup>

Counseling and testing programs can conserve program resources in two ways. First, lower-level services do not require a 20-minute counseling session. Instead, clients at lower risk may, for example, receive a brochure or watch a video, thus saving staff time. Second, lower-level services can be delivered by a Counselor I, a new position that requires less training than a Counselor II. While Counselor II’s can deliver both higher-level and lower-level services, Counselor I’s may only deliver lower-level services.<sup>1</sup>

Most counseling and testing sites throughout California are implementing this new model. However, because each area is different, the State Office of AIDS offers some options in applying the new model. Some areas have such a high percentage of clients at “higher risk” that the state has granted them an “exemption” from the new model. These

areas will continue to offer higher-level services to all clients, using the same counseling tools that they have always used.<sup>2</sup> Other service providers are using local variances to deliver higher-level services to certain populations at risk in their communities.<sup>3</sup> These exceptions are discussed below in the section “Exemptions and Local Variances.”

### Goals of the New Approach

The two-tiered model is based on information about HIV prevalence in different populations from the Centers for Disease Control and Prevention (CDC) and the State Office of AIDS. The model has five primary goals:

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*Promote widespread testing so that people know their HIV status.* The CDC estimates that 25 percent of people with HIV do not know that they are HIV-positive.<sup>4</sup> People who do not know that they are HIV-positive do not receive appropriate medical care and can unknowingly transmit HIV to sexual or needle-sharing partners.

In order to encourage more people to learn their HIV status, the CDC now recommends that medical providers routinely test all people between the ages of 13 and 64.<sup>4</sup> The new two-tiered model makes testing more accessible for lower-risk clients, by offering them a simpler, possibly quicker, process. Programs save staff time and program resources by offering lower-risk clients more streamlined services. This means that widespread testing services can still exist, but that more intensive behavioral counseling is reserved for clients at greatest risk.

*Offer prevention services to clients at greatest risk for HIV.* Clients who are at significant risk for HIV infection still receive prevention counseling services based on behavior change theory. These services include a blend of education, exploration of client motivation and capacity to change behavior, and support for realistic steps to reduce future risk of infection.<sup>5</sup>

*Refer clients who test HIV-positive (and hepatitis C-positive) to care.* Early, specialized HIV medical care saves lives. Yet many people newly diagnosed with HIV may have difficulty accessing appropriate medical care. The new model emphasizes the importance of connecting newly diagnosed clients with HIV-specific medical care, and reimburses sites for verifying that clients have followed through with medical care (through a new program called “Verified Medical Visits and Services”).<sup>6</sup> Because many test sites are now offering hepatitis C testing, HIV

test counselors also refer clients with hepatitis C to hepatitis-related care.

*Prevent new HIV infections by promoting disclosure services.* The Partner Counseling and Referral Services (PCRS) program assists HIV-positive clients in disclosing their status to sexual and needle-sharing partners, so that these partners can make informed decisions about testing for HIV. The program has enjoyed great success in reaching some of the people at greatest risk for HIV infection. Under the two-tiered model, delivery of PCRS services is reimbursable.<sup>7</sup>

*Use limited resources efficiently to achieve these goals.* Counselor time and energy and program funding are limited resources. The new model attempts to use these resources to serve the clients at greatest need—clients at higher risk for HIV and clients who test HIV-positive—while still offering services to clients at lower risk for HIV.

### Assessing Risk: The CAQ

In order to determine who will receive higher-level services and who will receive lower-level services, test site staff must first assess the client’s risk for HIV. The State Office of AIDS has created a new tool, the Client Assessment Questionnaire (CAQ),<sup>8</sup> to do this. Clients fill out the front side of the CAQ, answering 20 questions, including questions about the gender of their sexual partners, their sexual and substance-using behaviors, and their history of sexually transmitted diseases.

After the client has responded to these questions, a Client Assessment Staff person, who has been trained to analyze the client responses, reviews the questionnaire, occasionally asks other questions, assesses the client’s level of risk for HIV, and assigns the client to receive either higher-level or lower-level services. The Client Assessment Staff person may be a Counselor I, a

Counselor II, or another staff member who has been trained to analyze the CAQ responses.<sup>1,9</sup>

The table on page 3, “Who Receives Higher-Level Services?” notes several groups of people who receive higher-level interventions based upon their responses to the CAQ. In most cases, people who do not fall into these groups will receive lower-level services (some exceptions are outlined below in “Exemptions and Local Variances”).

### Exemptions and Local Variances

In general, under the new model, test sites use the client’s responses to the CAQ to determine whether the site will offer lower-level or higher-level services to the client. As noted above, however, there are some exceptions that allow for local variations.

*Local Variance Allowances.* Some groups of people in an area may be at high risk for HIV even though they do not fit into one of the groups listed in “Who Receives Higher-Level Services?” For example, suppose that an area’s surveillance data show that a high percentage of recently incarcerated people in that area have tested HIV-positive. In statewide surveillance data, the prevalence of HIV among recently incarcerated people is not high enough for them to be considered a “high-risk” group. But a counseling and testing program serving that area could ask its Local Health Jurisdiction (usually the county) to petition the State Office of AIDS for a Local Variance Allowance (LVA).

If granted, this variance would mean that the program would receive the higher reimbursement rate for delivering higher-level services to recently incarcerated people—until the LVA funds for that LHJ are spent. Programs may choose to modify the CAQ they use to identify the local variance allowance population (for example, “Have

you been in jail or prison in the past year?”), but this is not required by the State Office of AIDS.<sup>3</sup>

*Exemptions.* If at least 85 percent of the clients of a test site, program, or county are people who fit the state’s description of groups at higher risk for HIV, that site has the option of not implementing the two-tiered model. Local Health Jurisdictions determine which sites meet the criteria for exemption. At these sites, the Counseling Information Form (CIF) is used instead of the CAQ to determine a client’s risk level. Services to clients who are considered to be at “lower risk” under the CIF are reimbursed at a lower rate, while services to “higher risk” or HIV-positive clients are reimbursed at a higher rate.<sup>2</sup>

### Lower-Level Services

Clients who do not fit into one of the groups described in “Who Receives Higher-Level Services?” and who are not members of local variance allowance populations are offered less intensive services. These lower-level services include many of the tasks that have always been part of counseling and testing: framing the session, obtaining the client’s informed consent, explaining the types of tests offered (anonymous versus confidential) and the testing process, administering the HIV test, and delivering HIV-negative test results.<sup>1</sup>

Lower-level services do not include a complete risk assessment, or behavior change counseling, since the CAQ results are enough to suggest that the client is at lower risk for HIV. Instead of these services, clients at lower risk receive a low-level intervention, such as a brochure to read or a video to watch during the time that the rapid test is developing a result.<sup>10</sup> Counselors must be familiar with the material presented in the low-level intervention in order to answer any questions from the client.

For clients in lower-level services, the

## Who Receives Higher-Level Services?

Based on their responses on the Client Assessment Questionnaire (CAQ), the following clients would receive higher-level services from a Counselor II:

### A person who ...

- identifies as Transgender or Other in response to Question 1
- has ever injected recreational drugs, if the site offers hepatitis C testing and the person has never received a hepatitis C diagnosis
- has injected recreational drugs in the last year
- has had sex in the last year with someone who injects recreational drugs
- has had sex in the last year with someone HIV-positive
- has exchanged money, drugs, or other goods for sex in the past year
- has had sex, in the past year, with someone who exchanges money, drugs, or other goods for sex
- has received a gonorrhea or syphilis diagnosis in the past year\*
- has used nonprescription stimulant drugs in the past year

### A woman who ...

- has had anal receptive sex with a man in the past year
- has, in the past year, had sex with a man who has sex with men

### A man who ...

- has had anal or oral sex with a man in the past year

In most cases, other clients receive lower-level services unless they are members of a Local Variance Allowance (LVA) population or are being tested at an exempt site.

\* (Gonorrhea and syphilis are associated more strongly with HIV than other sexually transmitted diseases).<sup>5</sup>

Source: Office of AIDS. *Guidance for Completing the Client Assessment Questionnaire (CAQ)*. California Department of Public Health, 2007.

CAQ is the surveillance and service data form. Counselors working with these clients do not have to fill out the more comprehensive CIF.

Lower-level services take less counselor time and training and can be delivered by a new type of counselor, called a Counselor I, who has successfully completed a one-day Counselor I training (versus six days of Counselor II training) plus an annual one-day Continuing Education Training (CET) to maintain certification.<sup>1</sup> Lower-level services may

also be delivered by Counselor II’s.

### Higher-Level Services

Clients whose responses to the CAQ suggest that they may be at higher risk for HIV or who belong to a population covered by a Local Variance Allowance receive higher-level services. In general, “higher-level” services are the same ones that HIV counseling and testing sites have traditionally offered: all of the services described in the “lower-level” section above, plus personalized risk

assessment, client-centered counseling, assistance in developing a realistic risk reduction step, and referral to additional services as necessary.<sup>1,5,11</sup>

Counselor II's deliver all higher-level services. These include disclosing all HIV-positive results. This means that when a client is initially considered to be at "lower risk," but tests preliminary positive or confirmed HIV-positive, the client is immediately transitioned from lower-level services to higher-level services.<sup>11</sup> (See below for more on transitioning.)

Higher-level services also include referrals for HIV-positive clients, including referrals to medical care and PCRS. For sites that offer hepatitis C testing, Counselor II's offer and help administer the hepatitis C test, provide hepatitis C education and counseling, and disclose hepatitis C test results.<sup>1</sup> As noted above, the CIF, updated in 2007, is now used only with clients receiving higher-level services.

Counselors who will deliver higher-level services must attend an initial four-day Counselor II training (very similar to the old "Basic I" training and still called by that name) followed by a two-day enhanced HIV Counselor II training (still called the "Basic II"). Counselor II's must also attend an annual CET.<sup>1</sup>

### Transition Points

Rarely, a client who is receiving lower-level services may reveal additional HIV risk after completing the CAQ. This client would then shift from lower-level services to higher-level services. At many test sites, counselors who are trained as Counselor II's deliver both higher-level and lower-level services. In these cases, any "transition" is virtually invisible to the client: the counselor simply shifts his or her approach from delivering lower-level services to delivering higher-level services.<sup>5</sup>

At sites where Counselor I's deliver

lower-level services, however, there are times when a Counselor I must transition the client to a Counselor II for higher-level services.

If at any time during the lower-level process (before or after the HIV test result has been disclosed) a client reveals a behavior or membership in a population that the CAQ defines as higher risk—for example, sharing needles, being the receptive partner during anal sex, or identifying as a member of a population included in a Local Variance Allowance—the Counselor I would transition the client to a Counselor II.<sup>5</sup> In these cases, the Counselor I might say to the client, "From what you're describing, it sounds like you might benefit from some additional counseling services to help you lower your risk for HIV. I'm going to ask Dave [a Counselor II] to come in to talk with you a little more."

Rarely, a client who has been assessed as at lower risk for HIV tests preliminary positive. In these cases, a Counselor II would step in to deliver the test result and provide additional services such as medical and other referrals and partner disclosure services. To ensure that this transition is seamless, a Counselor I always prepares a client for the fact that a different counselor may be delivering the client's test results, for example, stating: "A counselor will call you when your result is ready."<sup>5</sup>

### Services for HIV-Positive Clients

It is critical that HIV-positive clients receive appropriate primary care and psychosocial services, including services to assist them in disclosing their HIV-positive status to sexual and needle-sharing partners. Although referrals have long been a key service that HIV test counselors provide, the new model places a special emphasis on linkages for HIV-positive clients and now reimburses for the following services:

*Medical Referrals.* When counselors

offer supportive social service or medical referrals to HIV-positive clients, the Office of AIDS will reimburse the test site at a flat rate, no matter how many referrals counselors make.<sup>6</sup>

*Verified Medical Visits.* The two-tier model emphasizes not only referring clients to care, but also ensuring that clients actually access HIV-specific medical services. When test site staff verify and document that an HIV-positive client has seen a medical provider, the test site can be reimbursed. The Office of AIDS will reimburse the test site at one rate based on a client's self-report verifying that he or she went to a medical appointment and will reimburse sites at a higher rate for verifications done by the test site and the medical provider or medical clinic or agency.<sup>6</sup>

*Partner Counseling and Referral Services.* When clients test HIV-positive, they may want to consider informing sexual and needle-sharing partners of their HIV status.<sup>5</sup> The Office of AIDS now reimburses test sites only for the delivery of PCRS, rather than simply for the offer of PCRS alone.<sup>7</sup> Many Counselor II's are trained in how to offer PCRS to clients, and those who are not trained to offer this service should refer HIV-positive clients to providers who can offer the service.

### Conclusion

The new two-tiered model makes changes that are designed to provide the most appropriate level of services to clients—whether they are at higher or lower risk for HIV. These changes, together with local exemptions and variances, allow people at lower risk to test quickly and easily while focusing limited counseling resources on people at greater risk. Emphasizing services to HIV-positive clients and their partners reinforces prevention efforts and strengthens the link between prevention and care services.

## Implications for Counseling

The new two-tiered model of HIV counseling may help agencies use staff time and skills in more efficient, targeted ways. At the same time, the new model challenges counselors by introducing new tools, interventions, and staff roles, and by asking them to make this new testing process as smooth as possible for clients.

### A New Tool: The CAQ

Counselors now have the benefit of the CAQ as they begin sessions with clients. The CAQ identifies groups of people who are likely to be at greater risk for HIV and so might benefit from more intensive counseling services. These “higher-risk” groups are based on analysis of data on the HIV epidemic in California, including a great deal of data from Office of AIDS-funded test sites.<sup>5</sup> These data show that questions like those on the CAQ are generally accurate in predicting which individuals may test HIV-positive.

Using a form to help with triage will be unfamiliar to some counselors. Existing counselors may be used to thinking of the risk-assessment process as an important part of client-centered counseling—and for clients most at risk for HIV, it still is. Counselors delivering higher-level services should use the information on the CAQ to begin a dialogue about risk with their clients. But for clients who are at

lower risk for HIV, creating a streamlined process is even more appropriate.

### Staying Client-Centered

The CAQ categories are part of a screening tool that helps counselors to direct clients quickly and easily to the intervention that will serve them best.<sup>5</sup> But each client is an individual, so it is important to understand the limitations of these categories. Trying to describe a whole person by describing his or her risk behavior or membership in a group would be offensive and incorrect. For this reason, counselors and supervisors use phrases like “risk behavior” and “risk group” only behind the scenes in counseling and testing. These terms are helpful for planning and evaluating services, but can sound impersonal or judgmental when used with clients.<sup>12</sup>

Likewise, it is important for counselors to remember that, within each “risk group,” there is tremendous variety in individual risk behaviors. For example, as a group, men who have sex with men are more likely to have HIV than men who have sex only with women. Yet, many individual men who have sex with men use condoms when having anal sex—or do not have anal sex at all—and, as a result, are at very low risk of contracting HIV. Likewise, many injection drug users clean their needles and works or do not share works, and are at very low risk.

These groups of clients still receive higher-level services, for two main reasons. First, they can receive support in their continued efforts to stay HIV-negative.<sup>12</sup> Second, some clients at high risk do not feel comfortable disclosing their higher-risk behaviors. For example, researchers at the California State Office of AIDS have found that men who have sex with men who report only oral sex on the CIF have a high HIV-positivity rate.<sup>5</sup> Since the HIV

risk from oral sex is very small, one explanation is that some clients are not sharing all of their HIV risk behaviors. While the reasons behind this high positivity rate and reported low-risk activity may not be fully understood, these men receive higher-level services because data suggest that they are indeed at higher risk for HIV. Counselor II's do not need to explain this to clients. Instead, it is helpful to maintain a neutral stance. Third-personing (“Other clients have mentioned...”) is often useful, to normalize the discussion of risk behavior for clients who might otherwise be reticent to disclose.<sup>5</sup>

### Limited Role

The new model challenges both Counselor I's and Counselor II's to understand the functions and limitations of their different roles. It also challenges them to recognize when it is appropriate to transition a client from lower-level services to higher-level services, and to do so smoothly.

Experienced counselors will recognize higher-level services as the same ones that have always been provided to clients. These services include behavior change counseling—a mix of education, exploration of motivations, and realistic support for preventing future infection.<sup>5</sup>

To deliver higher-level services effectively, counselors must be willing to work with clients who are at high risk for HIV and to talk with them in detail about their sexual behaviors and substance use related to HIV risk.<sup>1</sup> During higher-level services, counselors go beyond sharing information with clients in order to help them understand their personal HIV risk and discover their own solutions.

Lower-level services do not include in-depth risk assessment, behavior change counseling, or referrals. By staying within their limited professional role, counselors offering lower-level services make it possible for greater numbers of people to test for HIV without sacrificing more intensive counseling for those at greatest risk.

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### A Counselor's Perspective

“I believe in client-centered counseling. Using the new two-tiered system means we can focus our energy on the clients who need that counseling most.”

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Many people who are trained as Counselor II's will deliver both lower-level and higher-level services, depending on the needs of the client as assessed by the CAQ. In some cases it may be challenging to switch back and forth between delivering intensive client-centered counseling and less intensive lower-level services.

Some counselors who are used to delivering behavior change counseling interventions to every client may have difficulty at first understanding why some clients now receive lower-level services. Yet the funding resources are no longer available to deliver intensive counseling to every client, regardless of his or her risk for HIV. Just as important, it is not clear that clients at lower risk for HIV benefit from such counseling as much as clients at higher risk. Therefore, low-level interventions are a good way to ensure that clients at low risk get the basic HIV information that can help them stay HIV-negative.

### The Art of Transition

Targeting interventions to clients at different levels of risk is client-centered.

It is not necessarily helpful, however, to explain the differences between higher-level and lower-level services to clients. Instead, streamlining the process works best. When services are well-coordinated and transitions are smooth, clients can focus on getting what they need from the session.

The routing of a client to a particular tier is invisible to the client. Clients know only that they are seeing a counselor, not that they are “higher risk” or “lower risk.”<sup>5</sup>

Rarely, a transition from lower-level to higher-level services is necessary. For example, a client might disclose that he had forgotten that he had used cocaine a couple times in the previous year, or that he felt embarrassed to write down that he had had anal sex with another man. Counselors strive to make these transitions as smooth as possible. Smooth transitions happen when all staff know their roles and work within them and when there are adequate numbers of staff to deliver the services needed.

Transitioning a client from lower-level

### A Counselor's Perspective

“It took some time for me to get used to the CAQ, but now I appreciate having that information available at the start of the session.”

to higher-level services happens differently, depending on whether the session is being conducted by a Counselor I or a Counselor II. At many sites, Counselor II's deliver both higher-level and lower-level services. If a client receiving lower-level services from a Counselor II discloses higher risk or tests preliminary positive, the counselor “shifts gears” seamlessly to deliver higher-level services.<sup>5</sup> This requires the counselor to recognize that the client is at higher risk, and then move the session away from simply sharing information and toward client-centered counseling.

If a Counselor I is delivering lower-level

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## Case Example: Transition

*Regina is a 23-year-old White woman who has come in for a rapid test. She fills out the CAQ in the lobby and turns it in. Her counselor, Jenny, who is trained as a Counselor I, directs her to a room. Jenny smiles and motions for Regina to sit down, asking, “What brings you in today?”*

Regina clears her throat and smiles back. “Just wanted to test. I’ve never gotten one before, and I figured it was time.”

“Great,” Jenny says. “And before you get your HIV test today, let’s talk a little about the questionnaire you filled out. I’m wondering if you have any questions about it?”

“No, not really,” Regina replies.

“OK. The reason I ask is because the questionnaire helps us to tailor our services to your specific needs. Also, sometimes people feel differently about answering questions out in the lobby than they do here in private. Do you feel like you have anything to add to your responses on the questionnaire—anything that might reflect your situation more realistically?” Jenny asks.

“Well, there was one question about getting money for sex. I don’t do that a lot, but a few months ago my rent

was due and my landlord said I could ‘work it off.’ So that happened a couple of times with him and a few times with some of his friends.”

Jenny knows that someone who has received money, drugs, or other goods for sex in the last year must be transitioned from lower-level services to higher-level services, and that Susan is the only Counselor II available at the test site tonight. At the same time, Jenny wants Regina to be comfortable and for the session to flow as easily as possible. She responds to Regina: “OK, thanks for telling me that. Knowing that can help us serve your needs better. So we are almost done with our part, and then you’ll be meeting with Susan, who will talk with you about how to reduce your HIV risk. OK?”

Regina nods, and after a few more questions, Jenny excuses herself to get Susan, who completes the session.

services and a client reveals greater HIV risk than initially assessed through the CAQ, the transitioning process is more obvious to the client. In these cases, the Counselor I should inform the client that another counselor will be continuing the session by saying something like, “Now that we’ve had a chance to talk, I think that one of our experienced counselors, Robert, can address your concerns more thoroughly. May I go get Robert?”

The program would also transition a lower-risk client to higher-level services if that client tests preliminary positive: HIV-positive clients receive counseling only from Counselor II’s. Counselor I’s prepare their clients for this possibility, telling every client: “A counselor will call you when your results are ready,” making it clear that the counselor who discloses the test result may or may not be the one the client saw before results disclosure.<sup>5</sup> Counselor II’s then base the disclosure session on the protocol for preliminary positives.

### Assisting Positive Clients

Connecting HIV-positive clients to care and notifying their partners of possible exposure to HIV are vital links in the chain of HIV prevention and care. The new model encourages Counselor II’s to help clients follow through with these referrals—reimbursing sites for medical visits that can be verified and PCRS services that are actually delivered (not just offered).

Whether or not an HIV-positive client has a medical provider already, Counselor II’s should try to help the client make an appointment on the spot. If the client is not interested in medical care, test sites can offer to check in with the client at a later date, to see if there is any additional support—either medical or psychosocial—that interests the client.

Not every client is able to discuss medical care immediately after receiving an HIV diagnosis. Counselors must be sensitive, follow the client’s lead, and support the client in taking whatever next step he

or she feels is most appropriate.<sup>5</sup>

Counselor II’s who are trained to offer PCRS services can refer clients for assistance in informing sexual and needle-sharing partners about their exposure to the virus. PCRS is available to individuals with *confirmed* HIV-positive test results, whether the client tested anonymously or confidentially.

### Conclusion

The new model of two-tiered testing can help test sites respond more efficiently to the needs of both lower-risk and higher-risk testers. Yet, even the labels “lower risk” and “higher risk” have limitations. Clients experience the HIV testing process as individuals, and counselors’ interactions with them should reflect that reality. By understanding and staying within their limited roles, and by flexibly transitioning clients as appropriate, counselors can help clients receive the HIV testing services they need.

## Test Yourself

### Review Questions

1. True or False: All counties in California with a population greater than 78,000 must begin using the two-tiered model of HIV counseling and testing.
2. Which of the following is not a goal of the new two-tiered model? a) to conserve money and other resources; b) to encourage those at both low and high risk for HIV to know their status; c) to ensure that every person who tests receives intensive counseling services; d) to offer prevention services to clients at greatest risk for HIV.
3. True or False: It is important to explain to clients exactly why they have been assigned to either lower-level or higher-level services, so that they can be informed consumers.
4. Which of the following is not an example of a lower-level intervention? a) a brochure; b) a video; c) a client-centered counseling session; d) a group education session.

5. True or False: Gonorrhea and syphilis are more strongly related to HIV than many other sexually transmitted diseases.

6. If she had no other risk for HIV, which of the following women would be directed toward lower-level services? a) a transgender woman; b) a woman who has had unprotected vaginal sex for the last two years; c) a woman who last injected drugs 11 months ago; d) a woman who was diagnosed with gonorrhea two weeks ago.

7. True or False: At many sites, Counselor I's deliver both lower-level and higher-level interventions.

### Discussion Questions

1. How does the shift to two-tiered counseling services affect your agency? If your agency has more than one test site, are different sites implementing the model in different ways?
2. How can a counselor transition a client from lower-level services to higher-level services most smoothly?
3. What do you see as the biggest challenges for Counselor I's under the new

model, and how do those differ from the challenges Counselor II's face?

4. What do you see as the costs and benefits of focusing most counseling and testing resources on people at highest risk for HIV?

5. Suppose a colleague of yours, an experienced test counselor, believes strongly that all clients should receive the same client-centered counseling services. How might you respond?

### Answers to Review Questions

1. *False. A county's population is unrelated to adoption of the new model. While most California sites are using the two-tiered model, some areas or individual sites are not, often because of a local exemption.*
2. *c.*
3. *False. The process of assigning a client to lower- or higher-level services should be invisible to clients.*
4. *c.*
5. *True.*
6. *b.*
7. *False. Counselor I's may only deliver lower-level interventions.*

### Using PERSPECTIVES

**PERSPECTIVES** is an educational resource for HIV test counselors and other health professionals.

Each issue explores a single topic. A **Research Update** reviews recent research related to the topic. **Implications for Counseling** applies the research to the counseling session. Also included are a **Case Study** and two sets of questions for review and discussion.

### HIV Counselor PERSPECTIVES

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