### Practice Steps for Implementation of Guidelines Recommendations

The guideline recommendations are shown schematically -

<table>
<thead>
<tr>
<th>ASK</th>
<th>Routinely obtain a thorough sexual history from all patients &gt; 12 years of age to assess risk behaviors and stratify for appropriate testing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCREEN</td>
<td>Routinely screen all patients &gt; 12 years of age for risk behaviors and stratify for appropriate testing.</td>
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<tr>
<td>Test for HIV and STI</td>
<td>Screen all pregnant women for the following:</td>
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<tr>
<td></td>
<td>1. Early during each pregnancy</td>
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<td></td>
<td>2. At risk screening</td>
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<tr>
<td></td>
<td>3. Retest before 36 weeks in women at risk for exposure to HIV and/or any other STIs during the course of pregnancy.</td>
</tr>
</tbody>
</table>

| Human immunodeficiency virus (HIV) | X | X | X | X |
| Syphilis | X | X | X | X |
| Hepatitis B | X | X | X | X |
| Neisseria gonorrhoea | X | X | X | X |
| Chlamydia trachomatis | X | X | X | X |
| Hepatitis C | X | X | X | X |
| Trichomoniasis (for women) | X | X | X | X |

Note: “Risk continuum” (high vs low risk) refers to patients engaging in behaviors that put them at risk for HIV infection and may include: unprotected sex with infected persons; sharing needles with infected people; transmission from HIV-infected mother to child (e.g., in utero or through breast-feeding).

#### Lower Risk

- **RISK CONTINUUM**
  - Higher Risk

#### ADVISE on HIV and STI risk factors and basic prevention messages (See Below)

#### ADVISE on risk of infecting partners while awaiting results

#### Treat diagnosed STI, HIV, (as per regional and national protocol and practice resources), and conditions contributing to high-risk behaviors (substance use/abuse, depression, etc.)

#### Post Test Risk Stratification

<table>
<thead>
<tr>
<th>HIV-Infected</th>
<th>High-risk HIV uninfected</th>
<th>Low Risk HIV-uninfected</th>
</tr>
</thead>
<tbody>
<tr>
<td>- REFER for care as per regional policies and procedures</td>
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<tr>
<td>- ADVISE on risk of infecting partners and prevention of other STI</td>
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<tr>
<td>COUNSEL patients on ways to stay “infection free” &amp; on changing high-risk behavior.</td>
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<tr>
<td>Develop testing schedule to retest for HIV &amp; STI on recurring basis based on risk.</td>
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<tr>
<td>Develop action plan to reduce risk behaviors.</td>
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<tr>
<td>Refer to substance abuse treatment programs.</td>
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<tr>
<td>Treat depression or refer to mental health.</td>
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<tr>
<td>ADVISE patients on ways to stay negative. (Make sure they have understanding of basic prevention messages)</td>
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</tbody>
</table>

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HIV/STI Practice Steps for Implementation Last reviewed/revised 3/11
The practice steps further explained:
1. **ASK**: *It is strongly recommended that clinicians routinely obtain a thorough sexual and substance use history from all patients ≥ 12 years of age to assess risk behaviors and stratify for appropriate testing.*

Regular patient discussions for new and continuing patients under care should include questions about sexual behavior and substance use, including illicit drug use.
   a. Clinicians should use language that reflects culturally competent care to enable appropriate discussion and terms that patients will understand.
   b. Clinicians must inquire about changes in patient’s sexual behavior and substance use, which can change during the course of a patient’s life and experiences.

Effective HIV and STI prevention begins with a full understanding of each member’s substance use and sexual activity and any risks these activities may create. Patient history (past STIs) current clinical signs and symptoms, and sexual and substance use risk assessments must all be combined to evaluate the need for prevention interventions. Risks to be addressed for intervention include, but are not limited to:

- Anyone who acknowledges having had unprotected sexual activity.
- Patients with multiple sexual partners.
- Patients with current or previous STI.
- Patients with sexual partners with current or previous STI.
- Patients with history of recreational or intravenous drug use (IDU), particularly methamphetamines.
- Patients with chronic alcohol abuse.
- Patients with hepatitis B or hepatitis C.
- Men who have exchanged money or drugs for sex, who have been incarcerated, or who have had sex with other men.
- Women who have exchanged money or drugs for sex.

There are many simple and direct questions providers can use for effective risk assessment.

**For all patients:**
“I’d like to ask you some questions related to your sexual health that I ask all my patients.”

1) Are you sexually active? If no, have you ever had sex?
2) How many lifetime sexual partners have you had? Timeframe?
3) Are/were your sexual partners men, women, or both?
4) Did/do you have vaginal, anal, and/or oral sex?
5) Have you ever been diagnosed with an STD or thought you might have one?
   Has your partner?
6) Have you ever been tested for HIV or advised to be tested?
   Has your partner?
7) How do you protect yourself from STIs and HIV?
- **Sexual History for Married Members and Couples**

“I’d like to ask you a few questions related to your sexual health. These are questions that I ask all my patients regardless of the type of relationship they are in.”

1. Do you or your partner have sex with other people outside of your marriage? How do you protect yourself from STDs and HIV?
2. Have you or your partner ever been diagnosed with an STD?
3. Have you or your partner ever been tested for HIV?
4. How long have you been married/together?
5. Before you were a couple did you have sex with other people? If yes, with men, women, or both?
6. Before you were married, did your partner have sex with other people? If yes, with men, women, or both?

(Simple and validated risk assessment tools exist to help the busy clinician conduct effective risk assessments. We will work to employ KP HealthConnect and kp.org to create easy-to-use assessment tools for providers and patients with consistent documentation and monitoring of risks over time with minor impact on clinician workload.)

2. **SCREEN:** It is strongly recommended that patients be appropriately screened for HIV infection and STI based on their individual risk assessment.

The testing recommendations in this guideline demonstrate who should be targeted for HIV/STI screening with appropriate HIV antibody testing and other age and risk-based assessment of other STI laboratory exams. The STI laboratory tests may include: screening for syphilis (RPR or *Treponema pallidum* IgG+IgM), Chlamydia (urine or genital tract swab with Chlamydia PCR amplified probe), Gonorrhea (urine or genital tract swab [and if appropriate anal and throat swab] with gonorrhea PCR amplified probe), Hepatitis B and C antibodies.

**Screen and promptly treat all identified individuals > 12 years of age at risk for the following STIs:**

- Human immunodeficiency virus (HIV)
- Neisseria gonorrhoea
- Chlamydia trachomatis
- Syphilis
- Hepatitis B
- Hepatitis C
- Trichomoniasis (for women)

**NOTE:** Evidence suggests that the presence of other STIs, including herpes simplex, increases the risk of HIV transmission and acquisition.  

* From USPSTF-- ‘Based on a paucity of supporting evidence, herpes simplex virus (HSV) serology testing is not routinely recommended.’
Screen all pregnant women for HIV antibody, syphilis, and hepatitis B early during each pregnancy. Screen at risk* pregnant women for gonorrhea, chlamydia and hepatitis C. Retest before 36 weeks in women at risk for exposure to HIV and/or any other STIs during the course of pregnancy. Risk factors include HIV infected partner or partner at risk for HIV, new or multiple sex partners during pregnancy, illicit drug use, exchanges sex for money or drugs, history of STI during this pregnancy or one year prior to pregnancy, signs or symptoms of acute HIV infection.† Pregnancy risk for exposure may include a newly diagnosed STI during pregnancy, documented or suspected injection drug use, or partner with known HIV infection.

The probability of contracting HIV during a high-risk encounter is significantly higher if an STI is present, including herpes simplex and trichomoniasis (in women). Therefore prompt diagnosis and successful treatment of an STI is an effective prevention strategy and has been shown to reduce transmission of HIV.

3. **INTERVENE:** It is strongly recommended that patients be given brief, evidence-based, and culturally sensitive HIV/STI prevention counseling.
   a. Prevention counseling will be based on the individual patient’s risk and present behaviors.
   b. Follow-up testing and counseling is based on the patient’s ongoing behaviors.

* **Initial HIV Prevention Messages***

An initial screen for HIV infection based on KP Clinical Practice Guidelines can offer an opportunity to educate patients to modify their behavior even before the results are available. There are many “simple” but effective messages clinicians can provide to their patients, including but not limited to:
- Condoms are effective for preventing HIV and most STI.
- Oral contraceptives do not prevent HIV or an STI.
- Substance use during sexual activity can increase risk of contracting HIV or an STI.
- Having an active STI (including herpes) can greatly increase one’s chance of contracting HIV.

If a patient has a higher probability of receiving a positive result for STI or HIV testing, the above messages still apply but can also include advice on risk of infecting partners while waiting for their results.

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* The USPSTF (Recommendations for STI Screening, 2008) recommends that providers determine at risk individuals based on high-risk sexual behavior and age.

Providing Test Results and Post-test Counseling*

CDC Diffusion of Effective Behavioral Interventions Project (DEBI) demonstrates that appropriate follow-up and referral to targeted prevention interventions based on HIV antibody results status and risk behaviors can be very effective in HIV prevention. However, evidence for the effectiveness of post test counseling for behavior change and risk reduction has been mixed, and varied by target population. Meta analysis of post-test counseling interventions have shown that greater reduction in unprotected sex occurred in those receiving positive test results vs. negative, the older vs. younger populations, and those who sought testing vs. being offered by a provider.

Specific follow-up and referral strategies should be tailored to the following groups, based on test results:

I) Diagnosed HIV-infected
   A) With a diagnosed STI
   B) Without a diagnosed STI

Rationale: Identification of a previously undiagnosed HIV positive patient offers several opportunities for prevention. Patients who know they are infected are more likely to adopt behaviors that prevent transmission. Prompt and successful treating of an incident STI prevents transmission. Patients taking effective antiretroviral therapy may be less infectious and transmit HIV less often or possibly not at all.

Recommendation: Prompt treatment of any STI and prompt referral to HIV specialty team (as per regional practices and policies) is essential. Reenforcing prevention messages is useful.

II) Diagnosed HIV-uninfected
   A) Lower Risk (No or past STI, past risk behaviors, and now practicing protected sex).

Rationale: Patients receiving a negative test result with past history of risk behaviors or STI’s need reinforcement to maintain current strategies for prevention. Sexual behavior and substance use can change throughout a patient’s life, and discussion with and counseling patients about these topics is an ongoing process.

Recommendations: Advise patients on ways to stay negative. Reinforce basic prevention messages, and emphasize specific preventative behaviors applicable to the patient. Reassess risk at future visits, and retest if any risk behavior persists.

* Health Education Departments, HIV multi-disciplinary teams and/or other departments can establish programs targeting high-risk patients based on clinician referral and clinicians assessment of patient’s risk. Several medical centers currently offer one-on-one sessions with clinical health educators or other members of an HIV multi-disciplinary team. Further, CMI, HIV Interregional Initiative and kp.org will develop tools and programs to assist with these prevention and counseling efforts. Another excellent evidence-based resource with the CDC DEBI Project, available at: http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm (The CDC DEBI Project offer approaches that are consistent with Kaiser Permanente operations and resources.)
B) Higher Risk with one or more of:
1) Active STI
2) Current History of Unprotected Sexual Activity
3) Alcohol Abuse
4) Non IV Drug Use
5) IV Drug Use

Rationale: Patients engaging in high-risk activities but recently tested negative for HIV are the most important population to target for evidence-based prevention strategies and will yield the greatest impact on HIV transmission rates. Care must be taken to keep the negative test from reinforcing the risk behaviors, or being cited as “proof” by the patient that they are not at risk. Untreated depression has been associated with high-risk behavior in gay men, and persistent substance use contributes to transmission both as a dis-inhibitor to safer practices and as a direct transmission route in inject drug use.

Recommendations: Promptly treat any diagnosed STI. Screen and treat, or refer for possibility of substance use or depression. Stress prevention messages in a culturally appropriate way. Help patient establish a personalized action plan to reduce risk. Establish periodic testing schedule for ongoing HIV and STI testing. Refer to HIV prevention programs at local medical center or to external community resources.

Ways to assist the patient in creating a personalized plan for HIV risk reduction:

- Avoid language that may be insensitive to patient’s background and which may impair further disclosure.
- Motivate patients for behavioral change.
- Offer latex condoms and information on appropriate handling and lubricants to all sexually active persons.
- Counsel regarding drug use, including alcohol, methamphetamine, and injection drug use.
- Remind that Oral contraceptives do not prevent HIV or an STI.
- Advise to seek prompt treatment for any suspected STI or known exposure to an STI even in the absence of symptoms.
  - Reassess sexual practices at future visits and plan for repeat testing as appropriate.
  - Avoid false reassurance.