

SENO- OPTIONS



Getting Started with Options



Implementation Manual
for HIV Care Clinics

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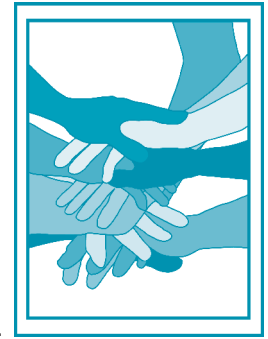
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Part 1



Options Overview



A. Why Integrate Prevention into Healthcare for Persons Living with HIV?

Despite the significant improvements made in the prevention and treatment of HIV, the annual rate of new infections in the U.S. has not decreased over the past decade (CDC, 2004). It has become clear that traditional models of HIV prevention that had focused primarily on uninfected populations are not enough to stem the HIV epidemic. To be most effective, prevention efforts need to be focused not only on uninfected at-risk populations, but also on those individuals already infected with HIV.

With a growing number of people living longer with HIV, it is critical to implement prevention programs that help HIV+ individuals adopt and maintain healthy behaviors. By addressing HIV prevention in care, People Living With HIV/AIDS (PLWHA) can avoid:

1. The transmission of HIV to uninfected individuals.
2. The acquisition of incident sexually transmitted infections (STIs) and other pathogens such as hepatitis, which are associated with substantial morbidity, rapid HIV disease progression, and increased rates of HIV transmission.
3. The potential acquisition of antiretroviral-resistant HIV from engaging in risk behavior with seroconcordant partners receiving ARVs but without complete viral suppression.
4. The possibility that HIV superinfection or viral recombination may occur when concordantly HIV-infected individuals engage in risk behavior.

Because a high viral load has been shown to be a contributing factor to the transmission of HIV (Gray et al., 2001; Quinn et al., 2000), adherence to antiretroviral medications is a potentially important prevention strategy. However, an undetectable viral load is not sufficient to prevent HIV transmission. HIV has been detected in the semen and vaginal secretions of many PLWHA with undetectable viral loads. Thus, it is critical to provide effective HIV risk reduction interventions in tandem with adherence counseling as part of a quality care approach.

Evidence-based interventions that are proven to reduce risk behavior among PLWHA can be deployed to decrease the incidence of new HIV infections among the general population. Such activities (referred to as “Prevention with Positives” or PwP) have been prioritized by CDC, HRSA, NIH, HIVMA/IDSA, WHO, and UNAIDS as part of the standard of care for PLWHA.

In July 2003, CDC (Centers for Disease Control), HRSA (Health Resources and Service Administration), NIH (National Institutes of Health), and HIVMA/IDSA (HIV Medicine Association / Infectious Diseases Society of America) collaboratively authored a document entitled, *Incorporating HIV Prevention into the Medical Care of Persons Living with HIV*, in which they stated that the elements of a comprehensive PwP approach include:

- Screening for HIV transmission risk behaviors and STIs on a routine basis during clinical care visits.
- Providing brief behavioral risk reduction interventions in the clinic and referrals when needed.
- Facilitating HIV serostatus disclosure and the notification and counseling of partners of HIV-infected individuals.


The unique characteristics of the healthcare provider-patient relationship and the repetitive nature of HIV care suggest that the clinical care site can serve as an important setting to implement interventions that reduce HIV risk behaviors among PLWHA. This potential can be realized by working to retain patients in care and by allowing sufficient time during routine visits to address issues such as HIV risk reduction and adherence.

B. **What is Options?**

Intervention Description

The Options intervention was designed to help PLWHA engage in safer sexual and drug use behavior and maintain such behaviors over time in order to maximize their own health and the health of their partners. The intervention builds on the supportive relationship and trust that typically develops between healthcare providers and their HIV+ patients, and it provides a framework that providers can use to initiate and maintain brief discussions about HIV risk reduction (e.g., condom use, clean needle use) with their patients on an ongoing basis. These discussions, which are designed to be incorporated into patients’ routine clinical visits, consist of the following provider-delivered steps:

1. **Set the agenda for discussion.**
2. **Identify the patient's current HIV transmission risk behaviors.**
3. **If the patient reports multiple risk behaviors, ask the patient to choose one on which to focus during the current visit.**
4. **Evaluate the patient's readiness to change their risk behavior (or maintain their safer behavior).**
 - a. Ask the patient to rate the **Importance** of changing their behavior on a scale from 1 to 10, where 1 is "not at all important" and 10 is "extremely important."
 - b. Ask the patient to rate their **Confidence** that they can change their behavior if they so choose, on a scale from 1 to 10, where 1 is "not at all confident" and 10 is "extremely confident."
5. **Based on the patient's Importance and Confidence ratings, decide whether to focus on Importance or Confidence.**
 - a. If **Importance** and **Confidence** are both 9 or 10, skip the remaining discussion on **Importance** and **Confidence**, and discuss barriers to change.
 - b. If **Importance** < 7, focus on **Importance**.
 - c. If **Importance** ≥ 7, focus on whichever one (**Importance** or **Confidence**) is rated lower.
6. **Focusing on Importance OR Confidence, identify the patient's barriers to changing their risk behavior (or maintaining their safer behavior).**
 - a. If the patient's **Importance/Confidence** rating > 1, ask the patient to explain why they did not give a **lower** rating.
 - b. Ask the patient to explain what would need to happen in order for their **Importance/Confidence** rating to **increase**.
7. **Briefly summarize the patient's responses, and then discuss specific strategies for raising their Importance or Confidence rating.**
8. **Negotiate a goal or plan of action with the patient.** Ask the patient to select a goal or action plan that they would be willing to work on between now and their next clinic visit.
9. **Document the negotiated goal or action plan on the *Options Prescription* pad and the *Patient Record Form* (PRF), give the *Options Prescription* to the patient, and file the PRF in the patient's medical record.** (Note: Use of the *Options Prescription* is optional. Many providers choose not to use it with their patients.)



The intervention is based on the Information-Motivation-Behavioral Skills (IMB) model of HIV prevention (J. Fisher & Fisher, 1992, 2000, 2002; W. Fisher & Fisher, 1993; W. Fisher, Fisher & Harman, 2003), which asserts that HIV prevention information, motivation, and behavioral skills are the fundamental determinants of HIV preventive behavior. **HIV prevention information** includes *facts about how HIV is transmitted and prevented* (e.g., “oral sex is safer than vaginal sex”), *HIV prevention heuristics* (e.g., “any woman who is not married must be HIV-negative”), and *implicit theories of HIV risk*, which hold that one can detect and avoid HIV by assessing a partner’s dress, demeanor, and social associations. **HIV prevention motivation** includes *personal motivation* to practice HIV preventive behaviors (e.g., attitudes towards personally performing specific HIV preventive acts; Ajzen & Fishbein, 1980), *social motivation* to engage in HIV prevention (e.g., perceptions of social support for performing HIV preventive acts; Ajzen & Fishbein, 1980), and *behavioral intentions* to engage in HIV preventive actions (Ajzen & Fishbein, 1980). The **behavioral skills** component of the model is composed of an individual’s objective ability and perceived self-efficacy for the performance of HIV-preventive behaviors (Bandura, 1989, 1994; J. Fisher & Fisher, 1992; W. Fisher & Fisher, 1993; Kelly & St. Lawrence, 1988). This model has been extensively validated in over 15 years of correlational and experimental intervention research with diverse populations in multiple cultural settings worldwide (see J. Fisher & Fisher, 2000).

The intervention uses motivational interviewing (MI) techniques (Miller et al., 1991; Rollnick, Mason & Butler, 1999) to first identify the informational, motivational, and behavioral skills barriers to consistent safer sex and drug practices, and then deliver critical informational, motivational, and behavioral skills content to patients to address their specific risk reduction needs. During the first Options visit, about 5 to 10 minutes are spent in a dialogue between the patient and healthcare provider about the patient’s risky behavior, the dynamics of their behavior, and individually-tailored goals to help move the patient in the direction of safer behavior. On subsequent visits, about 5 minutes are spent discussing these issues as well as any progress that the patient has made since the previous visit toward achieving their goals.

Unless other more pressing issues take precedence, it is anticipated that a patient receives the intervention at each routine clinic visit. Provider-patient discussions of HIV risk reduction are *individualized* for each patient based on the patient’s current readiness to change their risky behavior or maintain their safer behavior. For example, HIV+ individuals who have not yet begun to think about changing their behavior will focus on different issues and goals than those who periodically or routinely practice safer behavior. For patients who report no risk behavior (the majority of PLWHA in clinical care), the focus of the intervention is on reinforcing and maintaining their safer behavior and preventing lapse or relapse into risky behavior. Consequently, conducting Options with patients who report no risk usually takes less time than conducting it with those patients who report risk behavior.

The Options intervention provides healthcare providers with the necessary training and skills to perform effective, theory-based risk reduction counseling with their patients on an ongoing basis during routine care. To date, the Options intervention is one of the few evidence-based HIV risk reduction interventions developed for HIV+ patients in clinical care.

The core elements of the Options intervention consist of the following:

- **Assessing the patient's risk behavior.** Each Options intervention visit includes a brief and thorough assessment of any current HIV transmission risk behavior and conditions under which the risk behavior may occur.
- **Identifying the barrier(s) to the consistent practice of safer behavior.** The healthcare provider seeks to understand the patient's ambivalence, if any, about engaging in safer sex and drug use practices, and the specific barriers to consistently being safe. Although the Importance and Confidence questions are a relatively quick and efficient way to identify barriers, there are other ways in which to do so. Providers must choose the method that works most effectively for them.
- **Developing strategies for overcoming the barrier(s) to safer behavior.** During the Options visit, the healthcare provider and patient discuss strategies for reducing HIV risk behavior or maintaining safer behavior.
- **Negotiating a goal or action plan.** The healthcare provider and patient negotiate a mutually agreed-upon behavior change goal that the patient will work on between the current visit and their next scheduled visit. Ideally, each Options intervention visit results in a goal that both the provider and patient agree is realistic and achievable. When the patient returns for a follow-up visit, their progress toward the previously established behavioral goal is assessed.

Modifying the Options Intervention Protocol for Use in Busy Clinical Care Settings with Limited Time

Some clinical care settings may have insufficient time (appointment slots < 20 minutes) to deploy Options as the standard of care during routine visits. In these settings, it is recommended that healthcare providers:

- Conduct annual to bi-annual assessments of risk behavior with all their patients.
- Target ongoing Options visits with those patients who present with risk behavior.

- Have less frequent Options visits with patients who consistently demonstrate safer behavior during routine assessments and report no foreseeable contexts or situations (e.g., risk triggers) where the practice of safer behaviors would be difficult.

In clinical care settings with limited time, it may be best to adapt the protocol to prioritize routine Options visits with those patients who are practicing *unsafe* behavior, while conducting limited Options visits with those who are consistently practicing safer behavior.

In settings with extremely limited resources and time, it may be necessary to prioritize having risk reduction discussions with those patients who report risk, while conducting less frequent Options follow-up visits with those who continuously report no risk behavior. Although some patients who practice safer behavior may eventually lapse into unsafe behavior, it may be the most time- and cost-effective to target HIV prevention efforts towards those who currently present with risky sexual or drug use behavior. Because risk is dynamic and can change over time, brief ongoing reassessments of risk behavior (which will be much shorter than initial assessments and can be quite informal) should be included in all follow-up visits, if possible.

Training Other Staff Members to Deliver the Options Intervention

When Options was first developed, healthcare providers were selected to deliver the intervention because they meet with PLWHA on an ongoing basis, and the majority of them have positive and trusting relationships with their patients. Capitalizing on existing meetings between providers and patients is believed to be a time- and cost-effective way to do risk reduction counseling with PLWHA. Alternative models of Options have been proposed, such as utilizing members of the clinical care team other than healthcare providers to deliver Options intervention sessions (e.g., nurses, social workers, counselors, or case managers). There is no doubt that many of these staff members have very strong relationships with their patients and may be excellent alternative sources for risk reduction counseling, especially in those clinics with medical appointments under 20 minutes. HIV adherence counselors have in fact been successfully used in South Africa to conduct risk reduction discussions with HIV+ patients (Cornman et al., submitted for publication).

Whichever staff member meets with the patient needs to do so on a regular basis, must have sufficient time (at least 5 to 10 minutes) to conduct an Options discussion, and must have a confidential space in which to conduct the

discussion. Since the discussion involves extremely sensitive topics (HIV, sex, and drug use), it is preferable that the same staff member meet with the patient each time that the patient comes to the clinic. If more than one staff member is going to have Options discussions with the patient, it is critical that there be extremely good communication between those staff members so that the patient gets a clear, consistent message and does not get frustrated because they have to “tell their story” multiple times.

The Options intervention has been shown to be effective at reducing risky sexual behavior among PLWHA when delivered by healthcare providers in the U.S. and by HIV adherence counselors in Durban, South Africa (see following section). Although the Options intervention has not been evaluated with other staff members as “interveners,” it is anticipated that when the protocol is followed and the clinic is adequately prepared for Options implementation (as detailed in *Criteria for Successful Program Implementation* in Section D), a trained nurse, social worker, or case manager could effectively deliver the Options intervention during routine clinical care appointments.

Advantages of the Options Intervention Approach

Based in Behavioral Science

- Is guided by the Information-Motivation-Behavioral Skills (IMB) model of HIV prevention.
- Uses motivational interviewing as the delivery system.
- Has been shown in randomized controlled trials in the U.S. and South Africa, to be effective at reducing sexual risk behaviors among PLWHA in clinical care.

Integrated into Routine Delivery of HIV Care

- Capitalizes on existing healthcare provider-patient relationships.
- Has the capacity to reach large numbers of patients.
- Consists of brief 5- to 10-minute discussions about risk reduction that can be readily integrated into clinical care appointments.
- Is designed to be implemented on repeat occasions on an ongoing basis and to provide reinforcement to sustain behavior change over time.
- Involves a team approach where the healthcare provider acts as the gatekeeper and utilizes resources available in the clinic (e.g., case management, mental health services, social services).

Patient-Centered

- Provides a framework that can be readily adapted and tailored to the individual needs of each patient.
- Encourages patients to produce the arguments for change and concrete strategies for achieving it.
- Helps patients improve their decision-making skills and determine their own course for behavior change.
- Builds rapport and trust between the healthcare provider and patient.

Versatile

- Can be used to help patients reduce their risky behavior and maintain their safer behavior.
- Can be used with patients who are ready to change their behavior as well as with patients who deny that they have a problem and are not yet ready to consider change.
- Addresses both sexual and substance use risk behaviors.
- Provides a framework and set of skills that healthcare providers can use to motivate patients to adopt and maintain a wide range of health behaviors (e.g., smoking cessation, exercise, healthy eating).

For more information on the Options intervention, refer to:

Fisher JD, Cornman DH, Osborn CY, Amico KR, Fisher WA, Friedland G. Healthcare provider-initiated HIV-risk reduction intervention for HIV+ persons: formative research, acceptability, and fidelity of the Options Project. *J Acquir Immune Defic Syndr.* 2004;37(Suppl 2):S78–S87.

Fisher JD, Fisher WA, Cornman DH, Amico KR, Bryan A, Friedland GH. Healthcare provider-delivered intervention during routine clinical care reduces unprotected sexual behavior among HIV-infected patients. *J Acquir Immune Defic Syndr.* 2006;41:44–52.

C. How was Options Developed and Evaluated?

The U.S. Options Project, Funded by the National Institutes of Health (NIH)

In 1999, NIH funded the Center for Health, Intervention, and Prevention (CHIP) at the University of Connecticut to develop a healthcare provider-delivered intervention that decreases HIV-infected patients' risky sexual and drug use practices. This intervention is based on the Information-Motivation-Behavioral Skills (IMB) model of HIV prevention, which asserts that HIV risk behavior is caused by deficits in individuals' levels of HIV prevention information (I), motivation (M), and behavioral skills (B). HIV care providers deliver the intervention using brief motivational interviewing (MI) techniques that identify IMB deficits and can be used to assess individual patients' readiness to change. The intervention capitalizes on the importance of the healthcare provider-patient relationship and the repeated encounters over time that characterize HIV care. The intervention incorporates brief (5- to 10-minute) individualized discussions of HIV risk reduction into patients' regularly scheduled clinic visits.

► Evaluation of the Options Intervention

The NIH-funded Options Project was conducted in 2 HIV care clinics in Connecticut that are the largest providers of HIV care in the state. Physicians, physician assistants, and nurse practitioners implemented the intervention with enrolled HIV+ patients.

Computer-administered self-interviews (CASI) assessed patients' sexual and injection drug use behaviors at baseline and then at 6-month intervals for a follow-up period of about 18 months (4 assessments). The surveys were administered in either English or Spanish, depending on the patient's preference, with an accompanying audio track to assist those who had difficulty reading.

Outcome research demonstrated that Options is a feasible and practical intervention that busy healthcare providers are able to implement on an ongoing basis and that is effective at decreasing risky sexual behavior in HIV+ patients over the course of an 18-month follow-up.

Baseline Characteristics of the PLWHA Sample: Out of 484 study participants, the majority (77%) reported no risk behavior in the previous 3 months when assessed at baseline. Specifically, 27% (54% of sexually active participants) reported consistent condom use when engaging in vaginal, anal, and insertive oral sex, and 50% reported abstaining from sex altogether. **A significant level of risky sexual behavior was reported by PLWHA at baseline, with 46% of sexually active participants reporting unprotected anal, vaginal, or insertive oral intercourse in the last 3 months (23% of the total sample).**

A total of 2,408 sexual events reportedly occurred in the previous 3 months among study participants, with 47% (1,126) of these events being unprotected. A total of 514 partners were potentially exposed to HIV during these unprotected sex events, with 351 partners (68% of all partners exposed) believed to be HIV-negative or of unknown serostatus, according to study participants.

With regard to injection drug use, 55 study participants (11.4%) reported using injection drugs in the past month. Of these 55, 40% reported sharing needles or works in the past month. This resulted in 128 sharing events with 284 sharing partners. It should be noted that 95% of these partners were believed to be HIV-negative or of unknown serostatus according to study participants. This highlights the fact that sharing events among injection drug users often involve more than one sharing partner, with a high risk of transmitting the virus to previously uninfected individuals.

Feasibility, Fidelity, and Acceptability: On average, healthcare providers who were trained in the Options protocol implemented 7 out of 9 suggested protocol steps and implemented the protocol in 73% of routine medical visits over the course of the study. On average, patients received one dose of the Options intervention about every 4 months for an average of 5.4 intervention doses during the 18-month period (Fisher et al., 2006).

Research on the acceptability of the Options intervention suggests that the intervention was well-accepted as a component of routine HIV care by both healthcare providers and patients. Patient refusal to participate in the Options intervention during their clinic appointments was extremely rare (in only 3% of study visits). Furthermore, patients seemed pleased with the integration of the intervention into their routine care; exit questionnaires revealed that patients reported positive experiences with the Options intervention, rating their healthcare providers as very helpful (a 9.1 out of 10 on average) and understanding (a 9.3 out of 10 on average).

Intervention Effectiveness: At 18-month follow-up, the Options study found that a brief, risk reduction counseling intervention delivered by healthcare providers during routine clinical consultations was feasible to implement and effective at reducing sexual risk behavior among PLWHA.

- In terms of overall sexual risk, there was a significant 79% reduction in

the estimated mean number of unprotected vaginal, anal, and insertive oral sexual events over the 18-month study period for participants in the intervention group. Sexual risk events in the control group, however, increased approximately fourfold over the study period.

- Focusing on unprotected sex events with partners believed to be HIV-negative or unknown status, there was a 46% decrease in the mean number of risky sexual events reported by those in the intervention group (a finding that approached significance). In contrast, those in the control group reported a significant increase in unprotected sex with HIV-negative and unknown status partners.
 - Using a more conservative measure of risk behavior (unprotected anal and vaginal sex events), there was a substantial decrease in risk in the intervention group that approached significance. Intervention group participants reported a 70% reduction in the estimated mean number of unprotected anal and vaginal sex events, whereas participants in the control group reported a significant increase in those events.
 - Among PLWHA who received the Options intervention, there was a reduction in the number of HIV-negative or unknown status sexual partners over time, while there was no change in the number of these sexual partners for PLWHA in the control group.
 - Although the number of IDUs in the study was too small to detect intervention effects, the high rates of needle sharing among those IDUs suggest that there is a *need for prevention interventions that address risky drug use as well as risky sexual behaviors*.

The Options New York Demonstration Project Funded by the NYS AIDS Institute

In 2003, the NYS Department of Health AIDS Institute funded a demonstration project with the Options intervention in 3 clinical sites in the state of New York. A total of 423 patients were enrolled in the study across the 3 sites, and over 30 healthcare providers were trained in the intervention. Findings demonstrated that this intervention was (1) feasible to implement in clinic settings as part of primary HIV care, (2) acceptable to patients and clinic staff, and (3) able to be implemented with fidelity. More importantly, there was a significant reduction in the number of unprotected sexual events among PLWHA as well as in the number of HIV-negative and unknown status partners with whom PLWHA had unprotected sex.

Based on feedback from the providers, it became clear that a flexible model for implementation was critical for getting buy-in from providers. Consequently,

modifications were made to the protocol to make it easier to use with and adapt to different types of patients. The demonstration project also identified *Criteria for Successful Program Implementation*, which are described Section D.

Options Replication Evaluation Project Funded by the Health Resources and Services Administration (HRSA)

Beginning in September of 2005, HRSA funded 15 diverse clinical care sites under its Special Projects of National Significance (SPNS) Program to replicate the Options intervention. The feasibility, fidelity, and impact of Options were evaluated across these sites with 1368 HIV+ patients. Findings revealed that the intervention was implemented with fidelity at 14 of the 15 sites. The follow-up assessment was brief (3 months), but it indicated a trend toward decreased use of recreational drugs and alcohol, a trend toward decreased sex when high, and a significant increase in patients' condom use with main sex partners, casual sex partners, and HIV-negative and unknown status partners. Lastly, this project demonstrated that the healthcare providers trained in Options by University of Connecticut trainers were able to successfully train other providers at their clinics when provided with the necessary training materials.

Izindlela Zokuphila/Options for Health in South Africa

In 2003–04, an adapted model of the Options intervention was piloted with 152 HIV+ patients at McCord Hospital's Sinikithemba HIV Care Clinic in Durban, South Africa. The “Izindlela Zokuphila/Options for Health” intervention was delivered by HIV adherence counselors who met with HIV+ patients on a routine basis during regularly scheduled clinic visits and did risk reduction counseling with them. Analyses of the data indicated that the intervention was feasible to implement, acceptable to patients, able to be delivered with fidelity, and effective at reducing sexual risk behavior among intervention participants (Cornman et al., under review).

The Izindlela Zokuphila/Options for Health intervention was delivered in 99% of routine patient medical visits, with an average of 2 intervention visits per patient over a 6-month interval. Data indicated that the intervention was delivered with considerable fidelity and included all requisite intervention steps (i.e., a modal 8 of 8 steps were delivered). Exit interviews and focus groups with intervention patients indicated that counselors implemented the intervention in the context of a supportive, helpful, nonjudgmental atmosphere.

Analysis of intervention impact on the number of unprotected vaginal and anal sexual events revealed a significant condition x time interaction. Specifically, whereas patients in the standard-of-care control condition reported an *increase* over a 6-month period of time in the mean number of unprotected sex events,

those in the intervention condition reported a significant *reduction* in those events. This reduction in risky behavior occurred despite the fact that PLWHA in both the intervention and control conditions increased their sexual activity over the course of the study. The increase across conditions in sexual activity is not surprising considering that most patients were newly prescribed ARV medications and likely experienced improvements in objective and subjective health, increasing their interest in and ability to have sex. The fact that those in the intervention condition became more sexually active but reduced their risky behavior strongly supports the potential effectiveness of this intervention approach.

D. **Is Options Right for You?**

Criteria for Successful Program Implementation:

Preparing for Options

The New York-based Options demonstration project revealed a set of criteria for successful program implementation. These criteria have been incorporated into a screening tool that was developed to assess whether Options is appropriate for your clinic setting (see *Options Tool Kit* in Part 3).

Eleven Criteria for Successful Program Implementation Include:

1. Leadership
2. Healthcare provider buy-in
3. Interdisciplinary team
4. Drawing on strengths and local resources
5. Continuity of care
6. Appointment duration of sufficient length
7. Minimal documentation requirements
8. Setting realistic goals and expectations
9. Training
10. Ongoing communication between healthcare providers, clinic staff, and trainers
11. Ongoing program evaluation

1. Leadership

To successfully integrate prevention into the context of care for patients living with HIV/AIDS (PLWHA), leadership must be present at the clinic site to:

- Endorse the practice of prevention with PLWHA.
- Outline clear expectations for providers and staff during implementation.
- Address concerns and questions from providers.
- Prioritize program implementation as standard practice.

Ideally, this leadership should be provided by one of the healthcare providers who is well-respected and in a position of influence. This provider acts as a “champion” for the Options intervention and serves as a role model for implementation.

2. Healthcare Provider Buy-In

Prevention with positives can seem like just another demand on already overburdened providers who have an ever-growing checklist of quality care initiatives for their patients living with HIV. Acknowledging the commitment and time it will take to integrate prevention into care, and developing a realistic phase-in plan, will help to ease healthcare providers’ concerns about demands on their time.

The vast majority of healthcare providers who have implemented Options have had a positive experience when initiating these conversations with patients, and have come to value the importance of prevention with positives. Healthcare providers have reported improved relationships with their patients including greater openness from them. In addition, many healthcare providers have applied the skills that they learned during the Options training (i.e., motivational interviewing techniques) to other health promotion behaviors, such as smoking cessation and weight loss. Since initially it can be challenging to integrate risk reduction discussions into HIV care visits, it is extremely important that providers feel supported in this endeavor. One way to do this is to ensure that there is a multidisciplinary team available to help the healthcare provider address the multitude of HIV prevention needs that may exist among the clinic population, and that there is a clear channel for referrals for any issues that may emerge. In addition, it is critical to engage healthcare providers in the development of the phase-in and implementation plan. The more opportunities that they have to provide input and to brainstorm possible solutions to the potential challenges of Options implementation, the greater the likelihood that they will be motivated to participate and that implementation will be successful.

3. Interdisciplinary Team Approach

The Options protocol has the greatest potential for success if the clinical care support staff functions as a team with the healthcare providers being the

gatekeepers to HIV prevention services. Healthcare providers are extremely busy and have limited time in which to discuss prevention issues with their HIV+ patients. Their role as gatekeeper is to identify the prevention needs of the patients and then, if necessary, to refer the patients to other members of the clinic staff (e.g., nurse, psychiatrist, social worker, case manager) to ensure that the patients' needs are met.

This means that all staff should learn about the Options protocol, attend the trainings if possible, and have clearly defined roles in its implementation. For example:

- Nurses can teach patients how to correctly use male and female condoms and other barrier methods.
- Psychiatrists can evaluate patients for mental health issues (e.g., depression) that may be contributing to risky behavior.
- Case managers can assist patients with housing and substance abuse issues that pose barriers to practicing safer behavior.
- Health educators can distribute patient resource materials.
- Peer educators can assemble support groups to address HIV transmission and prevention concerns among PLWHA.

It is important to acknowledge that prevention with PLWHA is a clinic-wide priority, and making Options the standard of care involves all levels of staff. Clear, consistent messages about prevention with PLWHA and support from every staff member will foster a collaborative, supportive environment for the patients receiving the program and for the providers implementing it.

4. Drawing on Strengths and Local Resources

It is critically important that the clinic have the ability to address a variety of patient needs within the clinic itself or through referrals to local agencies in the community. The clinic should draw on its existing strengths and also do an inventory of local resources that can be used to address patients' needs. Specifically, the clinic should be able to provide the following:

- Referrals to case management, substance abuse treatment, domestic violence programs, support groups, social services, and mental health services.
- Access to male and female condoms and training in how to use them.
- Access to clean syringes and other drug paraphernalia.
- Access to prevention literature.
- Access to a partner notification program.
- Access to a post-exposure prophylaxis program for potentially exposed partners.

Note: Baseline assessments of risk behavior among PLWHA served by the clinic may help to identify gaps in services and alert staff to issues that may need to be addressed once Options is implemented.

5. Continuity of Care

Continuity of care with a dedicated healthcare provider is critical for Options to work in a busy clinic setting. For Options discussions to be most productive, a level of trust should exist between the patient and healthcare provider. This trust is maximized when the patient meets with the same provider on an ongoing basis. Frequently changing providers can be disruptive to the patient-provider relationship and thus potentially limit the effectiveness of the Options discussions. Consequently, this protocol may not be ideal for teaching hospitals where patients are meeting with a series of short-term residents or fellows (**Note:** An alternative implementation plan in this setting may include delivery of the Options intervention by consistent, non-rotating members of the clinic staff, such as nurses).

6. Appointment Duration of Sufficient Length

The initial Options discussion typically takes about 10 minutes to complete, but it can be longer depending on the complexity of the risk reduction issues being addressed and the patient's motivation to change their behavior. Healthcare providers who schedule appointments for *20 minutes or less* may struggle initially to incorporate the Options intervention into a patient's regularly scheduled appointment unless an appointment is specifically dedicated to the intervention. Subsequent intervention sessions are typically 5 minutes or less depending on the patient's risk behavior, so time constraints should be less of a concern for implementation of the protocol on subsequent visits.

Some clinics have come up with creative solutions to the problem of limited time. For example, some clinics have staff other than the healthcare providers (e.g., counselors) conduct the initial Options discussions, and then the providers follow up with the patients at subsequent visits. For this to be effective, there must be exceptionally good communication between the provider and the staff person conducting the initial visit. At other clinics, providers break up the initial discussion into two discussions. During the first discussion, they identify the patient's risk behaviors and the barriers to practicing safer behavior. And then during the second discussion, they discuss possible strategies for overcoming these barriers and agree upon a goal or action plan that the patient can work on between the current visit and the next visit. There are still other clinics where providers conduct an initial risk assessment with every patient but only have regular Options follow-up discussions with those patients who report risk behavior. Those patients who report no risk are reassessed on an annual basis.

7. Minimal Documentation Requirements

Because healthcare providers are inundated with required paperwork, keeping

Options documentation requirements to a minimum facilitates implementation of the intervention. The method of documentation typically used for Options is a one-page *Patient Record Form* with checkboxes and spaces for comments that facilitate ease of use and guide the healthcare provider through the steps of the intervention. This form serves as a record of the Options encounter and assists with healthcare provider recall during follow-up visits. It can be modified for paper or electronic medical record systems.

It should be noted that if providers find the documentation difficult to access or complete, this can serve as a major barrier to Options implementation. A brief tutorial on how to use the forms prior to implementation is useful for providers. And conducting interim assessments with the providers to evaluate whether the forms need to be modified or adapted for ease of use enables real-time modifications to be made before documentation becomes an obstacle.

8. Setting Realistic Goals and Expectations

Establishing clear, realistic goals for program implementation will encourage healthcare provider participation and promote buy-in. These goals include:

- Informing healthcare providers ahead of time that they will need to commit time to the training sessions and to learning the protocol.
- Establishing realistic expectations for providers regarding the amount of time that these discussions (particularly *initial* Options discussions) may add to patient visits. Providers also need to understand that these discussions are intended to take place on an ongoing basis at every routine clinical care visit with a patient.
- Enabling a staggered start for implementation so that providers are not overwhelmed at the prospect of implementing Options with every patient at every visit.
- Developing a specific phase-in plan where providers conduct initial Options discussions with 1 to 2 patients per clinic session. Ideally, providers should look at their patient roster at the beginning of the day and decide which patient(s) they will have an Options risk reduction discussion with that day. If they do not plan ahead, they are likely to finish the day without having had any discussions. Also, if they wait until the end of the day, they are likely to feel under too much pressure or be too tired to do it. Until providers become facile with the protocol and make it part of their routine, it can be easy to forget to do it or not prioritize it.

When working with healthcare providers who already routinely conduct risk reduction discussions with their HIV+ patients, it is important to acknowledge how Options will fit into their standard practice. Providers who have an established counseling protocol may be hesitant to attempt a new protocol. Therefore, it is recommended that providers who are well-versed in risk reduction counseling participate in the training sessions, and then supplement and/or modify their current protocol with any useful information gathered from the trainings.

Regardless of which risk reduction protocol they use, it is important that providers document their interactions with their patients. If the *Patient Record Form* is used for documentation purposes, providers should record their discussions on that form even if they are not using the Options protocol. Surveying providers on their current practices prior to implementation will help establish a baseline to see how providers improve their standard practice over the course of implementation. For more information, see *Planning Steps* in Part 2.

9. Training

In order for healthcare providers to effectively implement Options with their HIV+ patients, they must be sufficiently trained in the intervention protocol. Training can be provided as a one-day workshop or as 2 half-day workshops. To maximize the coordination and delivery of prevention services, it is recommended that all clinic staff be trained in the intervention. This means that the clinic must be willing to close for a day (or 2 half-days) in order for the training to take place. **Note:** Clinics interested in being trained in Options should contact their project officer at HRSA to determine when trainings are available in their area.

Training is also available online to individuals at www.optionstraining.org. This is recommended for those individuals who are unable to attend the group training workshops or for those who want to supplement the training that they received in the group workshops.

10. Ongoing Communication between Healthcare Providers, Clinic Staff, and Trainers

It is critical that healthcare providers have support during implementation of the Options intervention and that two-way communication exist between providers and trainers for feedback, troubleshooting, and specific questions. This can be achieved by phone, e-mail, or in-person during booster discussions. Clinicians must have opportunities to voice their concerns and to elicit suggestions during routine case conferencing and staff meetings. Likewise, trainers should have access to participating providers to provide feedback, updates, and encouragement. In addition, trainers should be available to clinic staff to assist with any logistical issues that may arise (e.g., issues around documentation, patient educational materials), so that the clinic can smoothly integrate Options into its daily routine.

11. Ongoing Program Evaluation

When integrating HIV prevention into standard of care for PLWHA, it is critically important to continuously monitor and improve the quality of services provided. Ongoing program evaluation allows the clinic to evaluate the frequency with which Options is being delivered, the fidelity of the intervention being delivered, and the intervention's effectiveness at reducing risky sex

and drug use behavior. It can also determine whether implementation and maintenance are being bogged down by burdensome documentation systems, reporting requirements, or unattainable objectives. If clinicians feel constricted by the program or by the documentation systems, they can become frustrated and less willing to implement the intervention. Clinics need to be able to identify problems as soon as they develop and to act quickly to resolve them.

Staffing Needs

The Options intervention is designed to be delivered during routine clinical visits by healthcare providers who provide primary care to patients living with HIV (i.e., physicians, nurse practitioners, and physician assistants). While it does not require the hiring of additional providers or other clinic staff, it does require one of the existing clinic staff (ideally, a healthcare provider) to be a “champion” for the Options intervention prior to, at the inception of, and throughout implementation (see *Leadership* under *Criteria for Successful Program Implementation*). This “champion” must be a member of the clinic staff who is well-respected by the providers, has authority and influence over the providers, and will serve as a role model for Options implementation and maintenance.

Healthcare providers who will be responsible for conducting the Options intervention with their HIV+ patients should anticipate spending about 5 to 10 minutes during routine clinical consultations for initial Options discussions, and 5 minutes or less for follow-up Options discussions. It is strongly recommended that when HIV clinical care providers first begin integrating these discussions into their routine care, they do so gradually, starting with 1 to 2 patients per clinic session and increasing that number over time. The first Options discussion with each patient takes the longest to implement, so trying to have these initial discussions with all of one’s patients that come in on a particular day, would not be feasible; the provider would likely fall behind in their schedule and end up with frustrated patients in the waiting room. Thus, a staggered start is recommended for successful integration of this intervention into the clinic routine.

Although the intervention is designed to be delivered by HIV clinical care providers, clinic staff are critical in supporting the behavior change goals that are negotiated with PLWHA during the Options discussions. Specifically, they can provide important services and resources that will help patients to achieve their goals (see *Interdisciplinary Team Approach* in Section D for examples).

Prior to training and implementation, the clinic should assemble and conduct a pre-implementation meeting with clinic leadership and key stakeholders for the purpose of describing the Options intervention, outlining the time expectations and anticipated roles and responsibilities for clinic staff during training and implementation, and allowing attendees to ask questions. Key stakeholders are the senior-level members of the clinic staff and can include HIV clinical care providers, nursing staff, social

services staff, and administrative staff. If there is a community advisory board, representatives from that board can also be included. Ideally, an Options trainer should be available to present the information and answer questions.

It is critical to address concerns and troubleshoot potential issues during an open forum so that key staff members do not feel pressured into providing services without having input. It is also important to understand potential pitfalls and obstacles *prior to implementation* rather than during it. This process promotes buy-in and support for Options implementation across the range of clinic staff. The pre-implementation meeting typically takes about an hour and can occur during a regularly scheduled staff meeting.

Costs to Clinic

The Options intervention was designed to be seamlessly integrated into the standard of care for PLWHA. Because the intervention utilizes the existing staff and resources that are available at the clinic, few additional resources are needed to make it part of PLWHA's routine care.

- Whereas the costs to the clinic are considered minimal, the benefits are potentially quite substantial. Specifically, Options discussions can lead to reductions in risky sexual and drug use behavior, which can not only decrease the likelihood of transmission of HIV to others, they can contribute to a decreased incidence of sexually transmitted infections and Hepatitis C virus, reinfection with resistant HIV virus, and unplanned pregnancies. It is unfortunate that the Options risk reduction discussions themselves are not yet reimbursable. However, by capitalizing on the services provided by the clinic and enabling those services to function at a fuller capacity, there is the potential for higher returns on the services that are reimbursable.
- The major challenge for the clinic is to integrate Options discussions into the current clinic visits without extending the duration of the appointments. This is particularly difficult if the appointments are of short duration (< 20 minutes). This task becomes more manageable if Options discussions are transitioned into routine clinical care visits over time (e.g., initial Options discussions with 1 to 2 patients per session per provider).
- Staff time to attend the training sessions and prepare for Options implementation and maintenance is one of the major costs to the clinic. Orientation, training modules, and booster sessions will involve time and effort for all levels of clinic staff. However, time for training is well spent, as participants will be learning how to effectively provide risk reduction counseling to PLWHA, which will impart important health benefits to those living with HIV, and also reduce HIV transmission to those uninfected. In addition, CEI/CME credits may be provided for some of the training activities.
- Ideally, one staff member should be designated to be the onsite Options

coordinator, whose responsibility it is to work closely with the trainer to coordinate the logistics of the training, the implementation, and the evaluation.

- All training materials are available in electronic form, with the exception of the book *Health Behavior Change* by Mason and Rollnick (1999). It is helpful to have at least one copy of this book available to clinic staff as a resource on motivational interviewing. The cost of the book is approximately \$30.
- A final cost includes providing a meal or snacks during training sessions. Although this is not required, it is strongly recommended because it promotes attendance and participation.

E. The Options Package

The Options Package consists of training workshops and technical assistance resources. Each workshop described below has a complement of materials, including training materials, patient handouts, and video demonstrations. The training workshops are available in a group format with trained facilitators, and they are also offered online to individuals at www.optionstraining.org. Technical assistance resources can be purchased in hard copy form from University of Connecticut's Center for Health, Intervention, and Prevention (CHIP), or they can be downloaded free-of-charge from the Options website.

If you are interested in implementing Options at your clinic, contact your project officer at HRSA.

Training and Technical Assistance

► Orientation with All Staff (1 hour)

The onsite Options coordinator works with the trainer to schedule the orientation meeting, which is typically held during a regularly occurring staff meeting. All clinic staff should be invited to attend this one-hour meeting and given sufficient notice to be available for it. The orientation is facilitated by an Options trainer, and attendees are encouraged to ask questions during the session. The purpose of the orientation is to:

- Briefly introduce the Options intervention to providers and other clinic staff.
- Describe how the Options intervention was developed, evaluated, and refined for use in the clinical care setting.
- Review the advantages of the Options intervention and the rationale for providing HIV prevention services to PLWHA.
- Cultivate an environment in the clinic where providing HIV prevention services to PLWHA is seen as an important and necessary part of HIV care.

The primary objective of the orientation session is to provide the opportunity for all staff members to learn about the Options intervention, ask questions, and give feedback. Ideally, all levels of staff should be invited to participate in the orientation session so that they can understand their roles and the expectations in relation to Options implementation.

During the orientation:

- The trainer reviews the expectations for rolling out the Options intervention—specifically, the schedule and duration of training sessions, Options intervention objectives, and staff roles in relation to implementation.
- The clinical care team that is responsible for spearheading the Options intervention (i.e., the onsite Options coordinator, the “champion,” and other multidisciplinary team members) are introduced so that questions and suggestions can be routed accordingly.
- Clinic-wide buy-in is promoted by highlighting the important benefits of providing prevention services to PLWHA and by demonstrating the ease and efficiency of the Options approach as a framework for integrating HIV prevention services into HIV care.

It is recommended that, following the orientation session, the onsite coordinator and key clinic leaders conduct a debriefing session with the Options trainer to review next steps and address any issues or concerns that emerged during the orientation session with clinic staff.

Materials:

During the orientation session, the following materials are distributed (see sample agenda and fact sheet in the *Options Tool Kit* section of this manual):

- Options Implementation Manual (this manual)
- Options Orientation Agenda
- Options Intervention Fact Sheet

▶ **Options Training: Options Intervention Protocol Workshop (4 hours with breaks) and HIV Risk Reduction Strategies Workshop (3 hours with breaks) = TOTAL 8 hours with lunch and breaks**

The Options training includes both the Options Intervention Protocol Workshop and the HIV Risk Reduction Strategies Workshop. If both

workshops are provided in a single day, it takes 8 hours to complete them (7 hours plus an hour for lunch). Or the workshops can be conducted in 2 separate half-day sessions, if preferred. It is critical that the training workshops be scheduled when healthcare providers and other staff are available, which may mean that the clinic has to close for a day. The onsite coordinator should alert all staff members who are required to participate well in advance of the training date, and should remind participating staff as the training date nears. The workshops, which are facilitated by an Options trainer, are fun, fast-paced, and interactive.

The goals of the Options Intervention Protocol Workshop and the HIV Risk Reduction Strategies Workshop are (1) to train healthcare providers in the Options risk reduction counseling intervention, and (2) to give healthcare providers risk reduction strategies that they can offer their HIV+ patients to minimize the health risks associated with sex and drug use behaviors.

The information in these training workshops is presented in didactic lecture format with interactive exercises, PowerPoint slides, video demonstrations, role-plays, and live demonstrations of how to most safely use male and female condoms, lubricants, oral barriers, syringes, and other drug paraphernalia.

Materials:

Training materials that are distributed during the training workshops include:

- Options Intervention Protocol Manual: An intervention protocol training manual, which details the steps of the intervention, and provides examples of scripts, case studies, and sample forms (i.e., *Patient Record Form* and *Options Prescription* pad).
- Options Risk Reduction Strategies Manual: A risk reduction strategies workbook that includes strategies healthcare providers can offer their patients to minimize the health risks of various sexual and drug use behaviors.
- An instructional DVD that demonstrates simulated Options provider-patient discussions.
- Patient handouts that provide information on a range of relevant risk reduction topics.
- *Health Behavior Change*: A book on Motivational Interviewing by Mason and Rollnick (1999). (This is optional.)
- Quick reference guides for providers that summarize the steps of the Options intervention.

Prior to the training, the onsite coordinator should arrange for the following space and equipment to be available for the training workshops:

- A room to accommodate all of the attendees and the trainer(s).

- Space to break out into small groups of 2 to 3 people.
- LCD projector and projection screen.
- DVD player and TV, or DVD-compatible laptop and speakers.
- Laptop with PowerPoint software.
- Large table for displaying educational materials (at least one 6' x 3' table).
- Adhesive tape for the training activities.
- Pens for completing evaluations.

▶ **Booster Training Sessions (1 to 2 hours)**

Booster training sessions address issues that typically emerge once Options has been implemented at a site, such as how to conduct Options discussions on an ongoing basis with patients who consistently report no risk behavior. These sessions also provide an opportunity for providers to discuss difficult cases and problem-solve ways to deal with patients who present with challenging barriers to HIV prevention. In addition, these sessions are useful for identifying and addressing any technical or logistical needs that emerge during implementation; this allows issues to be dealt with expeditiously so that Options implementation is minimally affected.

To minimize disruption to clinic routine, booster training sessions can be scheduled during regular clinic meetings. Facilitated by an Options trainer, these sessions are typically conducted 1 to 2 months after a clinic begins implementing the Options intervention.

The content of booster sessions often varies from clinic to clinic as a function of the particular challenges that clinic staff face with respect to Options implementation and maintenance. Prior to conducting a booster session, it is often a good idea to survey the providers and other clinic staff to determine what issues they would like addressed during the session. A booster session may focus on any one or more of the following issues:

- The degree of progress made by healthcare providers in implementing Options. This should include a discussion of what has worked and not worked, and the specific challenges to implementation.
- The specific support that providers need to effectively integrate Options into routine clinical care and address patients' issues and concerns. Are certain services needed to augment the Options discussions and make them more impactful?
- Patients' reactions to having these discussions during routine clinic visits. Have they been forthcoming, and do they appear to be comfortable talking about sex and drug use?
- The predominant HIV prevention issues faced by the clinic population, and how to address those issues.

- Challenging patient cases (e.g., patients who are engaging in risk behavior but refuse to change), and potential strategies and solutions for moving those patients in the direction of behavior change.
- How to conduct follow-up Options visits, including how to do ongoing risk reduction counseling and relapse prevention with patients who report no risk over time.
- The navigability, time efficiency, and usefulness of the documentation, and how it should be modified, if at all.

▶ **Ongoing Technical Assistance**

In addition to booster sessions, technical assistance (TA) will be provided on an ongoing basis, as needed, by an Options trainer. This includes assistance with both program implementation and evaluation. Given that multiple providers may be struggling with the same issues, a clinic may wish to schedule TA meetings so that issues can be addressed in a group setting. Using staff meetings to do case conferencing around Options patients can be a way to engage staff from multiple disciplines in problem-solving.

In addition to in-person TA meetings, an Options trainer will also be available to address emergent issues and provide resource materials, as needed, via e-mail. The onsite coordinator should be the person responsible for working directly with the Options trainer and presenting technical assistance requests.

▶ **www.optionstraining.org**

Web-based training materials are available for use, including training lectures, interactive role-plays, and video demonstrations of Options protocol delivery, at **www.optionstraining.org**. Training manuals and patient handouts can be downloaded from this site as well.



Part 2



Integrating Options into Clinical Care

PREPARATION

Getting Started—Making Prevention with PLWHA a Priority

The first step in planning for implementation of the Options intervention as a part of clinical practice is to *recognize the importance of addressing the prevention needs of PLWHA as standard of care*. This includes believing that the role of HIV care providers should include talking with HIV+ patients about their sexual and drug use risk behavior on a routine basis, and identifying and addressing patients' risk reduction needs in order to help them practice safer behavior. Ideally, this should involve a multidisciplinary team approach in which all of the local resources are poised to address the risk reduction needs of PLWHA, including clinic staff, case management, community-based organizations, and referral systems.

Prior to implementation, the multidisciplinary team should develop a detailed phase-in plan that outlines the expectations for participating providers and the methods for monitoring and assessing progress using quality improvement measures and quality care indicators. It is recommended that site-specific tools that support implementation and monitoring be created for use in the clinic setting to ensure the ability to evaluate progress.

Planning Steps

- 1. Form a multidisciplinary implementation team, which includes the medical director, onsite Options coordinator, and members from the nursing, social services, and health education teams.** Each discipline has skills to contribute to HIV prevention. Developing this team will aid in informing staff of their roles in launching, implementing, and maintaining the Options intervention, and will contribute to buy-in among all levels of staff. Examples of roles and responsibilities for these team members are as follows:

Medical Director and Clinical Care Team

- Implement the intervention with patients according to the phase-in plan.
- Provide input on how the intervention can best be integrated into standard of care and implemented clinic-wide, based on their initial

implementation experiences.

- Report on case studies during staff meetings.
- Foster collaborative relationships with staff to ensure that patients can access services and referrals.

Onsite Options Coordinator

- Assemble the implementation team.
- Assess the current HIV risk reduction counseling practices of providers and other clinic staff, and the HIV prevention needs of the HIV+ patient population.
- Modify tools for use in the clinic setting, with input from the medical director and clinical care team.
- Schedule trainings.
- Monitor progress on a routine basis, and request technical assistance when needed.

The onsite Options coordinator continuously evaluates program delivery to determine whether staff are using the tools and phase-in targets for implementation are being met. Routine and ongoing assessment ensure that any barriers to successful intervention implementation and delivery are addressed in a timely and responsive manner. The onsite coordinator should report on progress during routine staff meetings.

Nursing Team

- Teach patients how to access and correctly use male and female condoms.
- Inform patients of the clinical risks associated with unprotected sexual behavior and unsafe injection drug use.
- Maintain an open, nonjudgmental environment that facilitates patients' exploration of their sexual and drug use behaviors.

Social Services Team

- Access appropriate services and make referrals to local agencies for assistance if patients indicate that homelessness, domestic violence, or inability to disclose one's serostatus is a barrier to practicing safer behaviors.
- Make referrals to psychiatric care, rehabilitation facilities, 12-step programs, methadone maintenance programs, or other appropriate services if patients are clinically depressed or addicted to substances.

- Provide more intensive counseling to patients who have issues that require additional attention beyond the limited time available to healthcare providers.

The social services team provides an essential bridge to services for patients.

Health Educators

- Work with the social services team to identify patients' specific needs and then address those needs by setting up appropriate support groups and collaborating with local organizations.
- Provide patients with handouts on specific HIV prevention topics.
- Educate patients about the health risks involved with unprotected sex and drug use.

Peer Advocates

- Serve as role models for HIV prevention.
- Talk about HIV prevention from the perspective of someone living with HIV.
- Inform patients of available HIV prevention services in the community.
- Advocate for additional services for HIV+ patients.

2. Establish a baseline and assess needs. Prior to implementation, it is advisable that clinics assess the HIV prevention needs of the HIV+ patients served, the current HIV prevention resources and services available to patients, and the standard of care provided by healthcare providers with respect to HIV prevention. There are several ways to address these questions, and clinics can decide what works best for them within the context of time and available resources.

To understand the specific HIV prevention needs of one's HIV+ patients, clinics can:

- Conduct focus groups with HIV+ patients to understand the current HIV risk behaviors among the clinic population and the services that would best assist them with risk reduction (see sample protocol in *Options Tool Kit*).
- Review available patient satisfaction survey results, or query patients on their satisfaction with and confidence in their healthcare provider discussing HIV prevention issues with them (see sample survey in *Options Tool Kit*).
- Conduct a confidential survey of patient's current risk behaviors with a subset of the clinic population. Determine the level of their risky sexual and drug use behaviors, and how Options could best address the needs of the patients at the clinic, based on the responses to the survey

(see shorter and longer versions of the *HIV Risk Behavior Survey* in the *Options Tool Kit*).

To understand what services patients are currently receiving in terms of standard of care for HIV prevention and what services may be lacking, clinics can:

- Assess current HIV risk reduction counseling practices among HIV care providers via questionnaires or chart reviews. Questionnaires can be administered pre- and post-implementation to assess providers' current risk reduction counseling practices and how they improve over time following training in the Options intervention. Chart reviews can elucidate what current forms of documentation exist to monitor counseling practices and how these forms can be modified to monitor Options implementation.
- Review referral networks for mental health services, substance abuse treatment, individual and group-level HIV prevention programs, support groups, and other available resources, either on- or offsite.

Patients may report a range of issues that are potential barriers to practicing safer sex and safer drug use. The onsite Options coordinator should do an inventory of available services and delineate each team member's role with respect to addressing the HIV prevention needs of patients (see sample screening tool in *Options Tool Kit*). This is critical because the healthcare provider will not only conduct the Options intervention but also serve as the gatekeeper to HIV prevention services for their patients. Healthcare providers who are implementing Options should know the answers to the following questions or at least know who at the clinic can provide the answers:

- Where can patients learn how to correctly use male and female condoms?
- What local organizations provide free condoms?
- What support groups are available, and where are they located?
- Where can patients go for help with mental health issues?
- What local organization(s) provide domestic violence services?
- Where can patients go for assistance with alcohol problems?
- What treatment programs are available for drug users?
- What methadone maintenance programs are available for patients seeking treatment for heroin addiction?
- Where can patients get clean syringes and works? Are there syringe exchange programs available in the area, and if so, where are they located?

Prior to implementing Options, assess the clinic's and surrounding area's capacity to address the range of patients' HIV prevention needs. Knowing the resources currently available will assist providers in offering patients strategies for change.

3. Select quality indicators, and develop site-specific tools for implementation and integration into medical records. Sample evaluation tools are included in the *Options Tool Kit*. Potential quality indicators include:

Frequency of documentation of intervention

- During the planning phase, tools can be developed to assess the frequency of intervention delivery, to document the specific protocol steps implemented (or adherence to core elements), and to monitor overall progress with respect to integrating Options into routine clinical care. For an example of a form that has been used to monitor intervention implementation, see the sample *Patient Record Form* in the *Options Tool Kit*.

Patient satisfaction

- Assessment of patient satisfaction with Options discussions can serve as an important indicator of whether patients find the discussions useful. If the findings are positive, they can be a powerful incentive for providers to continue implementation of the Options intervention. See the sample *Patient Satisfaction Survey* in the *Options Tool Kit*.

Decline in risk behavior (long-term)

- Risk behavior can be assessed over time using information from *Patient Record Forms* or from behavioral surveys with patients. Surveys of risky sexual and drug use behaviors can be administered before and after Options implementation to determine whether risk behavior declines over time. See sample surveys and the *Patient Record Form* in the *Options Tool Kit*. *It is important to be aware that any surveys administered to patients will need to be approved by the Institutional Review Board.*

Decline in incidence of sexually transmitted infections (STIs)

- A potential indicator of intervention effectiveness is an overall decline in the incidence of sexually transmitted infections among the clinic population. Chart reviews can be conducted periodically to track the incidence of STIs over time. See the sample *Chart Review Form* in the *Options Tool Kit*. *This may require patient consent, and if so, would require approval from the Institutional Review Board.* (Please note that this measure was not used in the evaluation of the original Options Project because of an insufficient number of patients with STIs to detect reliable differences over time.)

4. **Develop a phase-in plan.** A phase-in plan should take into account the duration of appointment times, clinic caseload, and number of providers available to implement the intervention.
- **It is recommended that healthcare providers commit to starting Options with 1 to 2 patients per clinic session.** Clinics with appointments scheduled for 30 minutes or more may be able to commit to more per session. After a month of implementation, the Medical Director and onsite Options coordinator should meet with the providers and have a structured discussion about whether the enrollment targets and documentation systems are adequate, acceptable, and feasible. Modifications should be made accordingly, and retraining in new documentation systems provided, if necessary. Real-time improvements are essential to sustaining buy-in and implementation.
 - **One way to ensure that the entire clinic population will have at least one Options discussion within the year is to link first Options visits to annual psychosocial assessments.** Incorporating Options discussions into the annual assessments during the phase-in period guarantees that implementation targets are feasible and acceptable to participating providers and that tools are appropriate for uptake.
 - **OPTIONAL: Identify a core group of healthcare providers for phase-in.** Some sites may find it helpful to identify a core group of providers to pilot test the intervention, critically assess documentation systems and implementation targets, and then revise measures and enrollment schedules accordingly, prior to clinic-wide implementation. The core group can become potential champions for the program and can also serve as a technical resource for other providers initiating the program.
5. **Train providers.** In-person training is available through HRSA (interested parties should contact their project officer for more information), and Web-based training can be obtained at www.optionstraining.org. For a detailed description of the training and available training materials, see Part 1E, *The Options Package*. For sample agendas for each training module, see the *Options Tool Kit*.

IMPLEMENTATION

1. Phase in according to plan.

Implementation of the Options intervention during routine clinical care visits should be gradual, with a target of 1 to 2 Options visits per clinic session per healthcare provider. The more often providers do the intervention, the more comfortable and adept they will become at implementing Options as standard of care. Providers who have limited prior experience or training in addressing risky sexual and drug use behavior with their patients may find it challenging and need to be supported as they adjust to this new role. On the other hand, providers who have substantial

prior experience with or training in these issues may be reluctant to learn a new protocol and may need encouragement to integrate it into their current, ongoing discussions of risk behavior with their patients.

2. Integrate monitoring into case conferencing and self-management plans.

Frequent check-ins and ongoing technical assistance with participating providers will ensure that any obstacles or barriers to Options implementation are addressed in a timely manner. Monitoring can be conducted at routine intervals at multiple levels, with status reports distributed to the implementation team and appropriate staff. Case studies where providers discuss common issues and concerns that emerge from Options discussions with their patients can help providers learn how to work more effectively with their patients.

3. Report at staff and quality improvement meetings, troubleshoot, and problem-solve.

It is recommended that the team receive weekly to monthly reports that summarize the progress made on reaching the Options implementation targets as specified in the phase-in plan. All evaluation and quality improvement findings, including patient feedback, should be presented to the team at regular intervals, to foster teamwork, provide support, and encourage mutual problem-solving.

The onsite Options coordinator and the “champion” should acknowledge the substantial contributions of participating providers with ongoing feedback and support. Small token rewards for providers who consistently achieve their implementation targets will boost morale. Acknowledgment during staff meetings of the team’s contributions to prevention-with-positives, with specific examples of success with patients, will promote collaboration and teamwork.

4. Conduct booster training sessions.

As issues emerge during case conferencing, quality improvement meetings, and through ongoing review of *Patient Record Forms*, a booster training session for healthcare providers doing the Options intervention may be helpful for addressing challenges and sharing potential solutions. The onsite Options coordinator can identify issues of common concern that need to be discussed during the booster session. Ideally, these sessions should be facilitated by an Options trainer, but they can be fairly informal and relatively short in duration (30 minutes to 1.5 hours). Historically, these sessions have been extremely helpful to those providers who face challenges in implementation.

PROGRAM EVALUATION

Program Evaluation

1. Monitor progress, and identify challenges and lessons learned.

Once the phase-in plan has been developed and quality indicators selected, the onsite Options coordinator should monitor implementation progress and identify potential challenges/issues with documentation systems and program uptake. This includes reviewing all available data (including effectiveness data, if that is collected) and regularly presenting the findings to the multidisciplinary team during phase-in (for example, at case conferencing meetings). The implementation team should have an opportunity to give feedback on the findings and convey lessons learned. This process facilitates issues with implementation being addressed and resolved on a routine basis.

If the clinic opts to have a core group of providers implement Options (see *PREPARATION*), these providers should be interviewed as a group about what modifications should be made to the program prior to clinic-wide dissemination, based on their practical experience with the Options protocol. Adapted models that are consistent with the clinic culture and the time constraints are recommended as long as the core elements of the intervention are maintained.

2. Conduct rapid improvement projects to address issues and lessons learned.

After the team and participating providers review the data and provide feedback, they should propose and enact improvement projects that respond to common challenges and barriers to Options implementation. To enact those improvements in a timely manner, the team should develop an action plan and timeline that details how each barrier and challenge will be addressed for future delivery of Options. This approach helps sustain the momentum for integrating prevention-with-positives into standard HIV care.

MAINTENANCE

1. Make prevention part of quality HIV care programs.

Once a clinic has integrated Options into standard practice for healthcare providers who treat PLWHA, efforts should be made to explicitly recognize that HIV prevention services *are* an integral part of HIV care. For healthcare providers to stay motivated to continue implementing the Options protocol, they need to realize the benefits of the service they provide, through either direct experience with patients or through a detailed evaluation. To be sustained over time, prevention with PLWHA needs to be regarded as having the same weight and import as treatment adherence and nutrition. Routine monitoring and ongoing feedback helps ensure that the Options intervention will have staying power with participating providers.

2. Monitor quality indicators for HIV prevention services.

Because of the complex nature of behavior change, it is difficult to set benchmarks for HIV prevention. Since every individual patient presents with a unique set of HIV risk behaviors and HIV prevention needs, it is challenging to measure success in the way a clinic would routinely assess a new program or intervention (e.g., improvement in the appointment show rate or increases in the number of patients who get flu vaccines). At a minimum, the onsite Options coordinator should be able to determine the proportion of patients who have had Options visits, and the proportion of those patients who have had more than one Options visit. After a year of implementation, all patients in a given clinic should have had at least one Options visit. Each provider should be able to initiate the Options protocol with one to two patients per clinic session and conduct Options follow-up visits regularly during routine clinical consultations with all patients who have already had their first Options visit.

As services evolve and data are collected, it is critical to continually reassess goals and progress towards those goals with respect to Options implementation. Questions to consider are the following:

- How have HIV prevention services for PLWHA changed since Options implementation?
- How have HIV prevention needs changed for PLWHA, and are the available services still responsive to those needs?
- Are the quality indicators and measures adequate and appropriate for ongoing program evaluation and monitoring?
- Have process improvements been adequate to address common issues and improve service delivery?
- Are implementation targets still feasible with the competing demands of HIV care?

Monitoring results, identifying common problems and solutions to those problems, implementing the solutions, and studying the resulting impact will ensure that the program remains responsive to the realities of and demands on healthcare providers, and that it continues to benefit the patients it is designed to serve.



Part 3



Options Tool Kit



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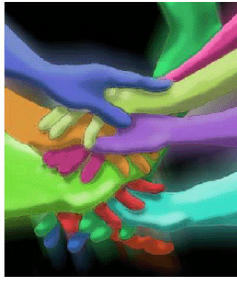
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Options Orientation Agenda

I. Rationale for providing prevention services to PLWHA in clinical care

- a. Reduces the incidence of sexually transmitted infections and possible reinfection with resistant strains of HIV virus.
- b. Reduces HIV transmission to uninfected partners of PLWHA.
- c. Draws upon the unique strengths of the clinical care setting as the ideal environment to promote HIV risk reduction with PLWHA.
 1. Supportive relationships exist between healthcare providers and their HIV+ patients.
 2. HIV care is characterized by repeat clinical encounters on an ongoing basis.

II. Overview and brief description of the Options intervention

- a. Based on the Information-Motivation-Behavioral Skills (IMB) model of behavior change.
- b. Uses motivational interviewing (MI) as the delivery system.
- c. Involves brief, provider-initiated discussions with patients to assess risk behavior, identify barriers to safer sexual and drug use behavior, explore strategies for overcoming barriers, and negotiate an agreed upon behavior change goal or action plan.

III. Outcome findings from the Options Project: feasibility, fidelity, and efficacy

- a. Feasible to implement in the clinical care setting.
- b. Able to be delivered with fidelity.
- c. Effective at reducing unprotected sexual behavior.

IV. Advantages of the Options intervention

- a. Based in behavioral science.
- b. Integrated into routine delivery of HIV care.
- c. Patient-centered.
- d. Versatile.

V. Expectations for healthcare providers and staff

- a. Training sessions.
- b. Options implementation and maintenance.

VI. Questions

VII. Contact Information





The Options Project

A Healthcare Provider-initiated HIV Risk Reduction Intervention for People Living with HIV/AIDS (PLWHA)

FACT SHEET

Program Overview

The Options Project is a theoretically-based, healthcare provider-initiated intervention to help PLWHA in primary care practice safer sexual and drug use behaviors on an ongoing basis. It is based on the Information-Motivation-Behavioral Skills (IMB) model of health behavior change and uses Motivational Interviewing (MI) techniques to convey critical HIV risk reduction information, motivation, and behavioral skills content to people living with HIV. Essentially, the intervention consists of a collaborative, patient-centered discussion between the healthcare provider and the patient in which the provider uses MI techniques to:

- (1) Introduce the discussion of safer sex and drug use.
- (2) Assess the patient's risk behaviors.
- (3) Evaluate their readiness to change (or maintain) safer behaviors.
- (4) Understand their ambivalence about changing by identifying the informational, motivational, and behavioral skills barriers to changing.
- (5) Elicit strategies from the patient for overcoming those barriers and moving towards (or maintaining) change.
- (6) Negotiate an individually-tailored risk reduction behavior change goal or plan of action.

These discussions of HIV risk reduction are *individualized* for each patient based on the patient's risk assessment and current readiness to change their risk behavior, and they are designed to be brief (5 to 10 minutes) and to occur on an ongoing basis during regularly scheduled medical visits with providers.

Target Populations

Options targets men and women living with HIV/AIDS.

Program Materials

- Options Implementation Manual
- Options Intervention Protocol Manual
- Options Risk Reduction Strategies Manual (for sexual behavior and drug use)
- Instructional DVD
- Informational patient handouts
- Pocket guide for providers
- *Health Behavior Change* by Mason and Rollnick (1999)

Research Results

Implementation of Options produced the following results:

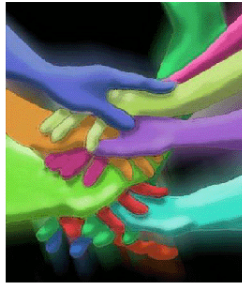
- Participants reported overall decreased rates of unprotected vaginal, anal, and insertive oral sexual events over the 18-month follow-up period.
- Participants also reported decreased rates of unprotected vaginal, anal, and insertive oral sexual events specifically with HIV-negative and HIV status-unknown partners.
- In contrast, standard-of-care control patients showed increases in unprotected sexual behavior over the 18-month follow-up.

For more information on Options, contact Deborah H. Cornman, Ph.D. at 860-486-4645 or at deborah.cornman@uconn.edu.

Core Intervention Elements

- Each Options intervention visit includes a brief and thorough assessment of any current HIV transmission risk behaviors and the conditions under which the risk behaviors occur.
- Providers work with patients to identify the barrier(s) to patients' consistent practice of safer behavior.
- Strategies for overcoming the identified barrier(s) and reducing HIV risk behavior (or maintaining safer behavior) are discussed.
- Patients and providers negotiate a mutually agreed-upon behavior change goal that patients attempt before their next scheduled visit. The goal must be one that is realistic and achievable.
- When patients return for follow-up visits, progress made toward the previously established behavioral goal is assessed.





Options Training Agenda

- Brief Overview of Options Intervention Development and Evaluation
- Introduction to Motivational Interviewing
- Step-by-Step Review of Options Intervention
- Using Options Intervention at Follow-Up Visits
- Working with Patients at Different Stages of Change
- Video Demonstrations of Options Intervention
- Role-Play and Rehearsal of Options Intervention
- Overview of Sexual Behavior and Strategies for Safer Sex
- Overview of Drug Use Behavior and Strategies for Safer Drug Use



Options Planning Tools: Overview

The planning tools provided in the following pages can help clinics determine if Options is a good fit for them and the patients they serve.

Screening Tool and Request Form for Options Training

Prior to implementing Options, it is important to assess the feasibility of implementing this intervention at your clinic, based on the criteria described in Part 1D, *Is Options Right for You?* The following form consists of a brief screening tool to determine whether Options will be a good fit for your clinic and a registration form to request training.

Sample Protocol for Focus Groups with HIV+ Patients in Clinical Care

One of the recommended planning steps for Options implementation is to determine the current HIV risk behaviors among the clinic population and which HIV prevention services PLWHA need and want. This can be accomplished by conducting focus groups with representative groups of patients at your clinic. A sample focus group protocol follows.

Conducting focus groups with HIV+ patients in care, which would require IRB approval, is not a required preliminary step for Options implementation.



Screening Tool and Request Form for Options Training

Site Name: _____

Address: _____

Primary Contact Person: _____

Phone: _____ Fax: _____ E-mail: _____

Percentage of patients that are HIV+: _____

Total # of HIV+ patients in care: _____

Clinic Appointment Duration (length of time provider meets with HIV+ patient): _____

Format of Medical Record Systems: Hard Copy Electronic/Computer-based

Current HIV prevention-with-positives (PwP) activities (*please describe*): _____

Number of providers (e.g., MDs, PAs, NPs) managing HIV+ patients: _____

How frequently, on average, do HIV+ patients come in for care? _____

What is your appointment no-show rate? _____

Is there continuity of care (i.e., do the same providers see the same patients over time)? Yes No

Are you a teaching hospital where short-term fellows or residents (<1 year tenure) are responsible for providing HIV care? Yes No

Do you have an interest in having an onsite Options training session and implementing Options as part of your PwP program? Yes No

Sites must commit to a 1- to 1½-hour Orientation Session for all staff (prior to Options training and implementation) and a one-day Options Training Workshop for all HIV care providers.

Are there routine seminars/staff meetings when we can schedule an orientation session? Yes No

What days and time would work best for an orientation session? _____

What days and times would work best for a one-day training session with HIV care providers? _____

Please identify a planning group for Options, including, at a minimum, the Clinical Director, an onsite Options coordinator, and another member of your team. Use additional pages if necessary.

Name: _____ Title: ***Clinical Director*** Phone: _____ E-mail: _____

Name: _____ Title: ***Options Coordinator*** Phone: _____ E-mail: _____

Name: _____ Title: _____ Phone: _____ E-mail: _____

Name: _____ Title: _____ Phone: _____ E-mail: _____

Screening Tool and Request Form for Options Training (continued)

Checklist:

- Can you identify a healthcare provider to provide leadership in Options implementation?
- Can you identify a multidisciplinary team to address Options implementation and maintenance?
- Are the providers at your clinic supportive of implementing Options?
- Do the same providers see the same patients over time?
- Are your appointments at least 20 minutes in duration?

If you answered yes to the above questions, Options could be right for you. For information on Options, contact:

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Associate Director
Center for Health, Intervention, and Prevention (CHIP)
2006 Hillside Road, Unit 1248
University of Connecticut
Storrs, CT 06269-1248
Phone: 860-486-4645
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E-mail: deborah.cornman@uconn.edu

Protocol for Focus Groups with HIV+ Patients in Clinical Care

Each focus group will take approximately 60 to 90 minutes to conduct and will consist of approximately eight participants of the same risk group or ethnic group (e.g., gay men, heterosexual women, IDUs, African-American men).

The group facilitator will introduce him/herself and convey the following information:

- The reason for conducting this focus group is to find out about the sex and drug use behavior of HIV+ adults so that we can develop programs to help them stay healthy and also avoid transmitting HIV to others.
- No one should respond to any questions that they don't feel comfortable answering, and they can leave the discussion at any time if they would like.
- There are no right or wrong answers.
- This group is not trying to reach an agreement; we are trying to learn about the different perspectives that people have.
- If it is acceptable to everyone, the group discussion is being audiotaped so that we will be able to refer back to it and not miss any of the information conveyed to us. All names will be deleted from the recording and the accompanying transcript. Only the group in charge of this focus group will have access to the recording or the transcript. All data will be presented to others in summary form with no names or identifying information being revealed.
- During the group discussion, it is important that people speak one at a time, so that when we listen to the tape we can understand what everyone has said.
- Everything said in the room is confidential and should not be repeated outside of this discussion group. No one should reveal who participated in the group or the fact that they are HIV+. Whatever we talk about will not be revealed to the doctors or clinic staff.
- While no names will be associated with peoples' comments, because there are other people in the group, anything a participant says could become public information.
- It is important that people not say anything during the discussion that they would be uncomfortable having associated with themselves.

Note to Facilitators

The questions on the following pages address the issues that should be covered when talking with the participants. Feel free to phrase the questions any way you like, but please try to cover all of the issues, and make sure that every participant gets a chance to respond. If you would like participants to introduce themselves, that should happen before the tape recorder is turned on.

Please note that some items involve injection drug use. Only include these items in the focus groups conducted with injection drug users, and eliminate them in the focus groups with gay men and non-IDU heterosexual women.

Sex and Drug Use Behaviors

Let's start with some questions about sex and drug use behavior.

- We know that when people first get diagnosed with HIV, they often get nervous about having sex. What percentage of HIV+ people do you think are having sex?
- What percentage of HIV+ people who are having sex are doing it safely?
 - How would you define safer sex? What is it?
 - How often do you think HIV+ individuals choose a less risky behavior (like oral sex) in place of a riskier behavior (like anal or vaginal sex) in order to decrease the risk?
 - How often do you think HIV+ individuals choose to have sex with HIV+ partners so that they can avoid using condoms?
- What are the greatest barriers to HIV+ people practicing safer sexual behavior?
 - How large a role does alcohol and recreational drug use play in unprotected sex?
 - What role does crystal methamphetamine play?
 - What role does Viagra play?

MSM Questions:

- How many HIV+ gay men are meeting men online? Are they more likely to have unprotected sex with men they meet online? If so, why?
- Are there certain settings where risky behavior is more likely to occur than others? At bathhouses? At bars?
- How popular are barebacking parties among HIV+ gay men?

IDU Questions:

- What percentage of HIV+ injection drug users do you think inject drugs safely?
 - What does it mean to inject drugs safely?
 - How often do you think that HIV-infected people who inject drugs share needles and works?
- What percentage of HIV+ injection drug users do you think participate in the syringe exchange program?
- What percentage of HIV+ injection drug users clean their needles with bleach?
- What are the greatest barriers to HIV+ injection drug users using clean needles and works?

HIV Transmission Information

We're going to talk for a few minutes about information and misinformation that people have about sex (and drugs).

- What misinformation, if any, exists out there about HIV and sex? What do some HIV+ people believe that isn't correct?
- What education needs to be provided to those living with the virus about HIV and sex?
- How do you think people infected with HIV decide whether or not to use a condom when having sex?
 - Does it depend on the type of sex?
 - Does it depend on the serostatus of the partner?
- What role does viral load play in people's decisions about sex and whether or not to use condoms?

IDU Questions:

- What misinformation, if any, exists out there about HIV and injection drug use? What do some HIV+ injection drug users believe that isn't correct?
- What education needs to be provided to HIV+ injection drug users?
- How does someone who injects drugs decide whether or not to share needles or works with someone?

Attitudes about HIV Risk Behaviors

Let's talk now about people's motivation to practice safer behavior.

- What are the main reasons that HIV+ people practice safer sex?
- What is the best way to motivate HIV+ people to practice safer sex?
- How do most people who are infected with HIV feel about condoms? Do they like them? Do they hate them?
 - What do they like about condoms, and what do they dislike about them?
- How tired are people of hearing prevention messages? If they are tired of them, what needs to be done differently?

IDU Questions:

- What are the main reasons that HIV+ people don't share their needles and works?
- What is the best way to motivate HIV+ people to not share their needles and works?
- What do most HIV+ injection drug users think about the syringe exchange program? Do they think it's helpful in preventing the spread of HIV?

- What do most HIV+ injection drug users think about bleaching needles? Do they think it is helpful in preventing the spread of HIV?
- How difficult is it to talk with people that you inject with about not sharing needles or works?

Norms about HIV Risk Behaviors

Now I'm going to ask you some questions about the way your friends and others feel about sexual and drug use behavior, and about making these behaviors safer.

- What do your friends think about HIV+ people having sex?
- What do your friends think about HIV+ people using condoms? Do they believe that condoms should be used all of the time, some of the time, or never?
 - **MSM Question:** What do most HIV+ gay men think about using condoms during oral sex?
- What do most HIV+ individuals think about disclosing their HIV status to their sexual partners? Is it something that they should or should not do?
 - **MSM Question:** Do most HIV+ gay men believe that as long as they have disclosed their status to their partner, it is okay to have unprotected sex?

IDU Questions:

- What would your friends think about HIV+ individuals sharing their needles or works with others?
- What do your friends think about the syringe exchange program?

Skills for HIV Risk Reduction

Next we're going to talk about the skills that are involved in HIV prevention and how difficult it may be to do them.

- What percentage of HIV+ individuals know how to use condoms properly?
 - For those who don't know how to use them correctly, where would be the best place for them to learn?
- What is the greatest challenge of talking to a sexual partner about safer sex? What would make it easier?
- What is the greatest challenge of disclosing your HIV status to a sexual partner?

IDU Questions:

- What percentage of HIV+ injection drug users know how to clean needles with bleach?
 - For those who don't know how to bleach them, where would be the best place for them to learn?
- How many HIV+ injection drug users know about the syringe exchange program?

- Why don't some HIV+ injection drug users it?
- What would make it easier to use?

Risk Reduction Counseling

We are developing a program where healthcare providers will do brief risk reduction counseling with their HIV+ patients as part of the regular medical visit. We want to know what you think about this type of program, but first we want to understand what currently happens between you and your healthcare provider with respect to discussions about sex and drug use.

- How often, if ever, does your healthcare provider talk to you about your sexual and drug use behavior?
- Does your healthcare provider try to help you to be safer in your behavior? If so, how do they try to help you, and are they effective at it?
- Does your healthcare provider know a lot about sex and drug use behavior? What training, if any, do they need?
- Who else at the clinic, if anyone, talks to you about your sexual and drug use behavior? A nurse? A counselor?
- If you were going to talk with someone about your sex and drug use behavior at the clinic, who would you choose to talk with? Your healthcare provider? A nurse? A counselor? Someone else at the clinic?
- How comfortable would you be talking about safer sex and safer drug use with your healthcare provider as part of your regular clinic visits?
- How comfortable do you think your healthcare provider would be having these discussions?
- What would make it easier to talk about sexual and drug use behavior with your healthcare provider?
- Do you think most HIV+ people would be comfortable talking to their healthcare providers about sexual and drug use behavior?
- How helpful would it be to HIV+ people if healthcare providers had brief discussions with them about safer sex and drug use behaviors on a regular basis? Why or why not?

Questions

Do you have any questions you'd like to ask us?

Thank the participants for their help.



Patient Record Form

The *Patient Record Form* is an example of a standardized form on which the healthcare provider can document what transpired during an Options visit, including the risk behaviors identified (*if any*), the conditions under which the risk behaviors occur, **Importance** and **Confidence** ratings, and the agreed-upon goal or action plan. Once completed by the provider, the *Patient Record Form* is filed in the patient's medical record. At the subsequent visit, the provider reviews the *Patient Record Form* as a reminder of what occurred at the last visit. The form thus serves multiple purposes; besides providing intervention prompts to the provider, it is a measure of intervention fidelity and implementation frequency, and it contains patient information that the provider needs to be able to effectively implement the intervention from one clinic visit to the next.

Versions of this form have been successfully used in over 25 clinics throughout the United States and Africa. It can be tailored to the needs of a clinic, and with the assistance of IT staff, it can be modified for use in electronic medical records.

When providers first begin implementing the Options intervention, they sometimes need assistance in remembering the steps of the protocol. They can either use the *Patient Record Form* as a prompt, or a *Quick Reference Guide for the Options Intervention* can be made available to them. If they use a paper copy of the *Patient Record Form*, they can put the *Reference Guide* on the back of that form. If instead, they have electronic medical records, a copy of the guide can be incorporated into the electronic records. A third option is to use a palm-sized version of the guide (*Options Pocket Guide*), which the provider can carry in their pocket.

The *Patient Record Form*, the *Quick Reference Guide*, and the *Options Pocket Card* can be obtained from this manual or from the Options website (www.optionstraining.org).



OPTIONS



OPTIONS PROJECT Patient Record Form

Patient Name: _____ MR#: _____

Appointment Date: ____/____/____ Provider: _____

I. Did you implement the Options protocol during this visit?

Yes No (patient refused) No (other issues took precedence)

II. Patient's progress on previous goal:

N/A: Today is first Options visit No goal set at last visit No progress on goal Partially achieved goal Fully achieved goal

Barriers to Achieving Goal: _____

III. Risk behavior assessment: *Check all risky and safer sex/drug use behaviors in which patient is now engaging.*

a. Vaginal sex without a condom f. Sharing injection drug needles or works (e.g., water, cooker, cotton, spoon)

b. Anal sex without a condom g. Injection drug use but no sharing of needles or works

c. Oral sex without a condom h. No injection drug use

d. Sexual activity but always with condoms i. Other: _____

e. No sexual activity

IV. Sexual or drug use behavior focused on: *(Write in behavior, or choose letter from above):* **a b c d e f g h i**

Was relapse prevention of risky behavior worked on? Yes No

V. Conditions under which specified sexual/drug use behavior occurs: (e.g., doesn't use condoms with HIV+ partners, injects with used needles when dope sick, or doesn't have sex because too depressed. If worked on relapse prevention, please specify situations that are challenging for patient.) _____

VI. Behavior for which Importance and Confidence were rated: _____

VII. Importance score: *Circle one.* 0 1 2 3 4 5 6 7 8 9 10 Didn't have patient rate IMPORTANCE

Not at all Important Somewhat Important Extremely Important

VIII. Confidence score: *Circle one.* 0 1 2 3 4 5 6 7 8 9 10 Didn't have patient rate CONFIDENCE

Not at all Confident Somewhat Confident Extremely Confident

IX. Did you discuss strategies for increasing the patient's Importance/Confidence score, for helping the patient to be safer, or for helping the patient to continue to be safe in their sexual and/or drug use behavior?

Yes No

X. Goal / plan that patient agreed to for next visit _____

XI. Comments _____

Quick Reference Guide for the Options Intervention

1. Set the Agenda.

“There are a couple of things that I talk about with all of my patients—sex and drug use. I would like to spend a few minutes talking about these issues, if that is okay with you.”...

2. Assess Risk Behavior.

“Many of my patients are finding it challenging to practice safer sex and safer drug use on a day-to-day basis... Now, I don’t know if these are issues for you, but if they are, I would appreciate it if you would help me understand what this struggle is like for you ... What works for you and what doesn’t, when it comes to safer sex... What works for you and what doesn’t, when it comes to safer drug use?”

3. Summarize risky behaviors, and ask patient to choose one on which to focus.

“You said that you are doing [risk behavior x] and [risk behavior y]. Let’s just focus on one of these areas for today. Which one would you prefer to talk about?”

4. Assess Importance and then Confidence.

“I would like to better understand how you feel about [changing behavior]. Can you help me by answering a couple of questions?”...

1) *“On a scale from 0 to 10 where 0 is ‘not at all important’ and 10 is ‘extremely important,’ how important is it to you to [change this behavior]?”...*

(2) *“On a scale from 0 to 10 where 0 is ‘not at all confident’ and 10 is ‘extremely confident,’ how confident are you that you can [change this behavior]?”*

Algorithm:

- If both IMPORTANCE and CONFIDENCE = 9 OR 10, explore with the patient any barriers to change.
- If the rating of IMPORTANCE < 7, explore IMPORTANCE and ignore CONFIDENCE for the time being.
- If the rating of IMPORTANCE ≥7, explore the one with the lower rating.

5. Based on the algorithm, further explore Importance OR Confidence.

(1) *“You gave yourself a score of [#] for [importance/confidence]. Why did you give yourself a [#] and not a lower score?”*

(2) *“What would have to happen in order for your [importance/confidence] score to increase?”*

6. Briefly summarize patient’s responses, and then discuss specific strategies for raising patient’s score. If patient does not offer any strategies, ask permission to provide strategies, and then provide a menu of strategies.

“You said that your [importance/confidence] score would increase if [x]. Would you be interested in hearing about [x]? or Would you be interested in learning about ways to [x]?”

7. Negotiate a Goal or Action Plan with the patient: Have the patient select a goal from a menu of goals for the next clinic visit.

“You have talked today about some possible ways to [x]. Would you be willing to try any of these alternatives between now and our next visit?”

Optional: Document the agreed-upon goal or action plan on the Prevention Prescription or Action Plan, and hand it to the patient.

8. Document Goal or Action Plan on the Patient Record Form and file it in the patient’s medical record.

Options Intervention Steps

- STEP 1:** Set the agenda for the discussion.
- STEP 2:** Identify patient's current HIV risk behavior(s).
- STEP 3:** If patient reports multiple risk behaviors, ask patient to choose ONE to focus on today.
- STEP 4:** Use Importance and Confidence ratings (0-10) to assess patient's readiness to change.
- STEP 5:** Decide whether to focus on Importance or Confidence:
- If both are 9 or 10, discuss barriers to change.
 - If Importance < 7, focus on Importance.
 - If Importance ≥ 7, focus on the lower rating.
- STEP 6:** Identify barriers to consistently practicing safer sex or drug use.
- If Importance/Confidence rating > 1, ask patient to explain why did not give a lower rating. If rating ≤ 1, skip this question.
 - Ask patient what would need to happen for rating to increase.
- STEP 7:** Summarize patient's responses, and discuss strategies for changing risky behavior.
- STEP 8:** Negotiate realistic/attainable goal with patient to address risk behavior. **OPTIONAL:** Write it on *Options Prescription* pad, and give to patient.
- STEP 9:** Document Options discussion on *Patient Record Form*, and file it in patient's medical record.



Options Prescription / Options Action Plan

At the end of each Options discussion, the healthcare provider can document the agreed-upon goal or action plan on one of two documents: *Options Prescription* or *Options Action Plan*. The provider, or the provider and patient together, can sign the form, indicating their commitment to working together toward this goal. The provider then gives the *Prescription* or *Action Plan* to the patient to take with them. This document can function as a mini-contract, or agreement, between the provider and patient, indicating the specific goal that the patient will try to accomplish between now and the next clinic visit. It can also serve as a form of reinforcement for the patient who is practicing safer behaviors, acknowledging the good work that the patient is doing in protecting their own health and the health of others. Lastly, it serves to convey the importance of following through on the goal. When a healthcare provider writes a medication prescription for a patient, the provider is acknowledging the importance of the patient taking their medications. When a provider writes a behavior change prescription, the provider is conveying that working on the behavior change goal is as important as taking one's medications.

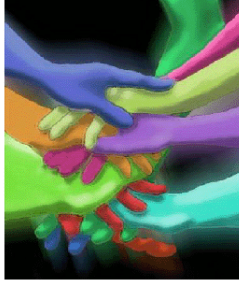
In practice, use of the *Options Prescription / Action Plan* has been quite variable. The majority of healthcare providers have preferred to create a verbal agreement between themselves and the patients. Only a minority of providers have chosen to create a paper form of agreement.

The *Options Prescription* and the *Options Action Plan* can be obtained from this manual or from the Options website (www.optionstraining.org).



OPTIONS

**P
P
C
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N
E
S**



Prevention
Prescription

Date: _____

Name: _____

Plan: _____

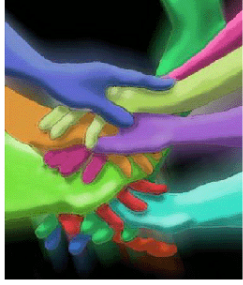
Signature





OPTIONS

PRINCIPLES



Action Plan

Date: _____

Name: _____

Plan: _____

Signature

Signature



Options Evaluation Tools: Overview

The Options intervention has been rigorously evaluated for effectiveness, feasibility, and fidelity as well as acceptability among patients and providers. See Part 1C, *How was Options developed and evaluated?* While it is unlikely that clinics will have the resources or the need to rigorously evaluate the Options intervention, they can use certain tools to monitor the Options intervention's uptake, effectiveness, and overall impact on patients' clinical care experience as part of quality of care.

Quality Improvement

Quality improvement indicators, such as the feasibility of the intervention in the clinic setting, acceptability to patients and providers, and the extent to which healthcare providers adhere to the protocol and its core elements, are important to assess over time.

Feasibility and Protocol Uptake

To monitor protocol uptake, clinics implementing Options can compare the target number of completed Options visits with the number of visits in which the protocol was actually administered. This can be accomplished through a review of the *Patient Record Forms* (PRFs)—the forms on which healthcare providers document whether they implemented the Options intervention.

Intervention uptake (i.e., the extent to which healthcare providers adhere to the protocol) can be assessed by reviewing PRFs for the specific steps implemented by providers. Most critical for providers to implement are the core elements of the intervention, which consist of the following:

1. Assessing the patient's risk behavior.
2. Identifying the barrier(s) to the consistent practice of safer behavior.
4. Developing strategies for overcoming the barrier(s) to safer behavior.
4. Negotiating a goal or action plan.

Patient Record Forms can provide gross estimates of risk behavior in the patient population as well as indicate strategies that have been effective at motivating behavior change in patients. PRFs can also be useful for tracking referrals and whether patients used them. (See sample *Patient Record Form* preceding this section).

Maintain the core elements of the Options intervention to maximize intervention effectiveness.

Patient Satisfaction and Service Ratings

Clinics may also choose to assess patient perceptions of and satisfaction with HIV prevention services both prior to and after implementation of the Options intervention. Such a measure used pre-Options implementation, can help identify gaps in HIV prevention services and highlight HIV prevention needs among patients in the clinic. Follow-up surveys can serve as a measure of quality improvement, and can be used to determine how well the protocol is being implemented and whether patients find it helpful. (See sample *Patient Satisfaction Survey* following this section.)

Patient surveys can also be useful for assessing intervention fidelity and acceptability. For example, surveys can assess what their provider talked about during the Options discussion, and they can also assess how nonjudgmental, understanding, and knowledgeable about sexual and drug use behavior their provider was during the discussion.

Chart Reviews

Clinics may conduct chart reviews to determine (1) how many patients have initial and follow-up Options visits, (2) how frequently, on average, patients are having an Options discussion with their provider, and (3) how often Options discussions are *not* occurring because other issues (e.g., acute illness) took precedence. Further, the clinic may decide to conduct chart reviews to see if the incidence of sexually transmitted infections decreases over time, once the Options protocol is implemented. (See sample *Chart Review Form* following this section.)

Intervention Effectiveness

The measures that can be used to rigorously evaluate the effectiveness of Options are beyond the scope of typical quality indicators. This kind of an evaluation requires that a clinic conduct a baseline assessment to characterize the levels of risk behavior and the dynamics of risk among their patient population. Following a baseline assessment (pre-Options implementation), risk then needs to be assessed at some time point, or at multiple time points, following initial implementation of the Options intervention. Comparisons between baseline and follow-up measures of risk behaviors can be used to establish the efficacy of the intervention at reducing risky behavior and maintaining safer behavior over time. The baseline survey also provides useful data on the risk behaviors that are prevalent among the target population, which can be used to adapt and tailor the Options intervention content as well as to develop and modify patient resource materials. (See sample *HIV Risk Behavior Surveys* following this section.)

Each clinic can decide if they want to monitor the intervention's effectiveness at reducing risky sex and drug use behaviors, and if so, how extensively they wish to assess specific risk behaviors. As detailed in the Fisher et al. (2006) article

reporting on the findings from the Options evaluation study, several measures of risk behavior can be used to assess the effectiveness of the intervention:

- Total number of unprotected vaginal (receptive and insertive), anal (receptive and insertive), and insertive oral sexual events during the previous 3 months. Assessed with all partners, and also with HIV-negative and unknown status partners only.
- Total number of unprotected vaginal and anal sexual events only (as a more conservative measure of transmission risk).
- Total number of HIV-negative and unknown status partners with whom participants had unprotected sex during the previous 3 months.

This level of specificity in assessing sexual behavior may be more detailed than desired by a given clinic and may require too much patient and/or clinic staff time. A clinic may decide that a briefer, more general measure of risk behavior is more practical to use as an indicator of intervention effectiveness. (See a shorter version and a longer version of the *HIV Risk Behavior Survey* on the following pages.)

Using either version of the HIV Risk Behavior Survey will likely require review and approval by an Institutional Review Board (IRB). Patients will need to give consent and understand the risks involved with completing this type of survey (e.g., discomfort with answering questions about their sexual and drug use behavior). Patients will also need to be assured that their individual responses are confidential and will not be shared with the clinic staff or their healthcare provider. Additional staff or consultants will be required to obtain informed consent, administer the survey, enter the data, and analyze the results. All information, including the informed consents, will need to be stored in a secure location. Finally, clinics may want to offer a small incentive to patients for completing these measures. If a clinic decides to evaluate the effectiveness of Options at reducing risky behavior, it is important to consider the additional time and resources involved.



8. How **comfortable** do you feel discussing sex and/or drug use with your healthcare provider?

_____ Not at all comfortable

_____ Somewhat comfortable

_____ Very comfortable

9. How **helpful** was your healthcare provider today when talking about ways to be safer in your sex or drug use (or when talking about ways to continue your safer behavior if you are already being safe)?

_____ Not at all helpful

_____ Somewhat helpful

_____ Very helpful

_____ Not applicable. My provider did **not** talk about sex or drug use today

10. How **understanding** was your healthcare provider of your feelings and concerns during your discussion today about sex or drug use?

_____ Not at all understanding

_____ Somewhat understanding

_____ Very understanding

_____ Not applicable. My provider did **not** talk about sex or drug use today

11. How **knowledgeable** is your healthcare provider about **sex**?

_____ Not at all knowledgeable

_____ Somewhat knowledgeable

_____ Very knowledgeable

_____ Don't know

12. How **knowledgeable** is your healthcare provider about **recreational drug use**?

_____ Not at all knowledgeable

_____ Somewhat knowledgeable

_____ Very knowledgeable

_____ Don't know

13. What suggestions do you have for improving the discussions between you and your healthcare provider about sex and drug use? _____

14. What other comments do you have? _____

OPTIONS PROJECT Chart Review Form

Review period: _____ / _____ / _____ to _____ / _____ / _____
month day year month day year

Reviewer initials: _____

Date of chart review: _____ / _____ / _____ (month/day/year)

Patient ID: _____

Date of birth: _____ / _____ / _____ (month/day/year)

Date of HIV diagnosis: _____ / _____ / _____ (month/day/year)

Date HIV care initiated at clinic: _____ / _____ / _____ (month/day/year)

Date of first Options visit: _____ / _____ / _____ (month/day/year)

Date of first Options visit with current HIV care provider: _____ / _____ / _____ (month/day/year)

Date of first medical visit with current HIV care provider: _____ / _____ / _____ (month/day/year)

Provider code for HIV care provider: _____

Visits During Options Implementation

Date month/day/year	Routine Visit? (i.e., not sick, urgent, or other visit) Yes / No		Options Intervention Done? Yes / No		If Not Done, Indicate Reason(s)*	Describe Other Risk Reduction Done

*** Code:**

1. Not a routine visit
2. Not an Options provider
3. Other issues took precedence
4. Other (describe reason, including if could not determine it)

(Continued on next page.)

HIV Risk Behavior Survey (shorter version)

Please answer the following questions about your sexual behavior and condom use. (Condom use refers to the use of the male condom or the female condom.)

Vaginal sex = sex where a penis is put into a vagina.
Anal sex = sex where a penis is put into a butt or anus

1. Did you have vaginal or anal sex **in the last 3 months**?

_____ Yes (*If Yes, skip to Question 4.*)

_____ No

▶ **Only answer the next 2 questions if you have *not* had vaginal or anal sex in the last 3 months.**

2. When was the last time that you had vaginal or anal sex?

_____ About 4 to 6 months ago

_____ About 7 to 12 months ago

_____ More than a year ago

3. You said that you have not had vaginal or anal sex **in the last 3 months**. Which of the following statements best describes the reason that you have not had vaginal or anal sex? *Please check only one.*

_____ I have no desire to have sex right now.

_____ I have no partner to have sex with.

_____ My partner(s) has been unwilling/unable to have sex with me.

_____ I am abstaining from sex in order to prevent anyone else from getting HIV.

_____ I am only having oral sex right now.

_____ Other—*Please specify:* _____

▶ **If you have not had anal or vaginal sex in the last 3 months, skip to Question 13.**

4. **In the last 3 months**, with how many different sex partners did you have vaginal or anal sex? *Please make your best guess.* _____

5. How many of these partners were **HIV-negative** or had **unknown HIV status** (in other words, you did not know if they had HIV)? *Please make your best guess.* _____

6. **In the last 3 months**, how often did you have vaginal or anal sex with partners who were **HIV-negative** or **whose HIV status you did not know**?

_____ 1 to 4 times

_____ 5 to 10 times

_____ 11 to 20 times

_____ 21 to 30 times

_____ Over 30 times

_____ I have not had sex **in the last 3 months** with someone who was HIV-negative or whose HIV status was unknown to me.

(Continued on next page.)

7. **In the last 3 months**, how often did you **use a condom** when having vaginal or anal sex with someone who is **HIV-negative** or whose **HIV status you did not know**?
- Never
 - Rarely
 - Some of the time
 - Most of the time
 - Always
 - I did not have sex in **the last 3 months** with someone who was HIV-negative or whose HIV status I did not know.
8. **In the last 3 months**, how often did you **use a condom** when having vaginal or anal sex with someone who you knew to be **HIV-positive**?
- Never
 - Rarely
 - Some of the time
 - Most of the time
 - Always
 - I did not have sex **in the last 3 months** with someone who was HIV-positive.
9. **In the last 3 months**, how often did you **use a condom** when having vaginal or anal sex with your **main sex partner**? (*A **main sex partner** is a person you have lived with or seen a lot, and to whom you have felt a special emotional commitment. If you had more than one main sex partner in the last 3 months, please choose the one you had sex with most recently when completing these questions.*)
- Never
 - Rarely
 - Some of the time
 - Most of the time
 - Always
 - I did not have a main sex partner **in the last 3 months** (*If no main sex partner, skip to Question 11*)
10. Which of the following statements describes how you feel about **using condoms every time** with your **main sex partner** when you have either vaginal or anal sex?
- I don't see the need to use condoms every time with my **main sex partner**
 - I do see the need to use condoms every time with my **main sex partner**, but I can't right now
 - I have been using condoms every time with my **main sex partner** for **less** than 3 months
 - I have been using condoms every time with my **main sex partner** for **more** than 3 months

(Continued on next page.)

11. **In the last 3 months**, how often did you **use a condom** when having vaginal or anal sex with your **casual sex partner**? (*A **casual sex partner** is someone you have sex with only once or more often, but that you do not think of as your “main sex partner.” This includes friends, acquaintances, “one night stands,” or other.*)

_____ Never

_____ Rarely

_____ Some of the time

_____ Most of the time

_____ Always

_____ I did not have any casual sex partners **in the last 3 months** (*If no casual sex partners, skip to Question 13*)

12. Which of the following statements describes how you feel about **using condoms every time** with your **casual sex partners**, when you have vaginal or anal sex?

_____ I don't see the need to use condoms every time with my **casual sex partners**

_____ I do see the need to use condoms every time with my **casual sex partners**, but I can't right now

_____ I have been using condoms every time with my **casual sex partners** for **less** than 3 months

_____ I have been using condoms every time with my **casual sex partners** for **more** than 3 months

▶ **The next set of questions ask about your drug and alcohol use. This refers to drugs that were not prescribed by your doctor.**

13. Place a checkmark next to all of the drugs and alcohol that you used **in the last 3 months** without a prescription from your doctor.

_____ Amphetamine, methamphetamine (speed, crystal, crank, etc.)

_____ Cocaine (including crack)

_____ Downers (e.g., valium, Ativan, Xanax)

_____ Pain killers (e.g., Oxycontin, Percocet)

_____ Hallucinogens (e.g., LSD)

_____ Ecstasy

_____ Club drugs (e.g., GHB, ketamine)

_____ Heroin

_____ Marijuana

_____ Poppers (amyl nitrate)

_____ Alcohol

_____ Other—Please specify: _____

_____ None—**If None, you are finished with this survey. THANK YOU!**

(Continued on next page.)

14. **In the last 3 months**, about how often did you have sex when you were high or drunk on alcohol or any of the drugs listed above?
- Never
 - Rarely
 - Some of the time
 - Most of the time
 - Always
 - I did not have sex **in the last 3 months**
15. Have you ever injected drugs?
- Yes
 - No—**If No, you are finished with this survey. THANK YOU!**
16. Did you inject drugs **in the last 3 months**?
- Yes
 - No—**If No, you are finished with this survey, THANK YOU!**
17. **In the last 3 months**, how often did **you** share needles or works with someone else (*either you used a needle or works after someone else used them, or someone else used your needle or works*)?
- Never
 - Rarely
 - Some of the time
 - Most of the time
 - Always
18. When was the last time you shared needles or works?
- In the last 3 months
 - 4 to 6 months ago
 - 7 to 12 months ago
 - More than one year ago
 - Never

Thank you for completing this survey!

HIV Risk Behavior Survey (longer version)

Please answer the following questions about your sexual behavior and condom use. (Condom refers to the male condom or the female condom.)

1. Did you have vaginal, anal, or oral sex **in the last 3 months**?

_____ Yes (*If Yes, skip to question 4*) _____ No

▶ **Only answer the next 2 questions if you have not had sex in the last 3 months.**

2. When was the last time you had vaginal, anal, or oral sex?

_____ About 4 to 6 months ago

_____ About 7 to 12 months ago

_____ More than a year ago

3. On the first question you said that you did not have sex **in the last 3 months**. Which of the following statements best describes the reason why you did not have sex? If more than one applies, **please select the one that is the best description of your situation**.

_____ Sex is not a priority for me right now; other things are more important.

_____ There has not been anyone I want to have sex with.

_____ I have not had the opportunity to have sex with anyone.

_____ My partner(s) has been unwilling/unable to have sex with me.

_____ I am too scared of my HIV to have sex.

_____ I am abstaining from sex in order to prevent anyone else from getting HIV.

_____ Since starting my medications, my sex drive has decreased.

_____ I have been too depressed to want to have sex.

_____ I haven't felt well enough physically to have sex.

_____ Other (*please specify*) _____

▶ **If you did not have sex in the last 3 months, skip to Question 24.**

The next set of questions asks about vaginal sex (sex where a penis is put into a vagina) and anal sex (sex where a penis is put into a butt or anus).

4. Did you have **vaginal or anal** sex **in the last 3 months**?

_____ Yes _____ No (*If No, skip to Question 14.*)

5. **In the last 3 months**, with how many partners did you have **vaginal or anal** sex? (*Write in a number for your answer.*)

_____ partners

(Continued on next page.)

6. **In the last 3 months**, about how many times did you have **vaginal or anal** sex?

____ Once

____ Twice

____ Once a month (or 3 times in 3 months)

____ Twice a month or every other week (or 6 times in 3 months)

____ Once a week (or 12 times in 3 months)

____ Twice a week (or 24 times in 3 months)

____ Three times a week (or 36 times in 3 months)

____ Four times a week (or 48 times in 3 months)

____ Five times a week (or 60 times in 3 months)

____ Six times a week (or 72 times in 3 months)

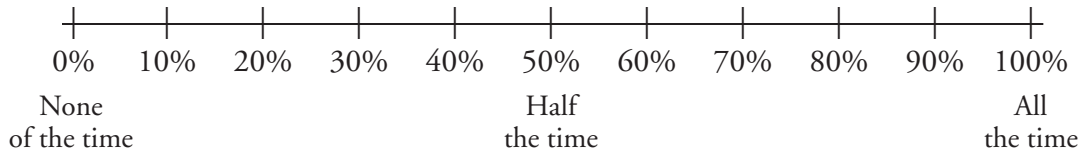
____ Every day (or 90 times in 3 months)

____ Twice a day (or 180 times in 3 months)

____ Three times a day (or 270 times in 3 months)

____ Other (*please specify*) _____

7. When you had **vaginal or anal** sex **in the last 3 months**, about what percentage of the time did you and/or your partner(s) use a condom? (*Circle your answer.*)



8. **In the last 3 months**, with how many **HIV-positive partners** did you have **vaginal or anal** sex? (*Write in a number for your answer.*)

____ partners (*If you had No HIV+ partners, skip to Question 11.*)

9. **In the last 3 months**, about how many times did you have **vaginal or anal** sex with an **HIV-positive partner(s)**?

____ Once

____ Twice

____ Once a month (or 3 times in 3 months)

____ Twice a month or every other week (or 6 times in 3 months)

____ Once a week (or 12 times in 3 months)

____ Twice a week (or 24 times in 3 months)

____ Three times a week (or 36 times in 3 months)

____ Four times a week (or 48 times in 3 months)

____ Five times a week (or 60 times in 3 months)

____ Six times a week (or 72 times in 3 months)

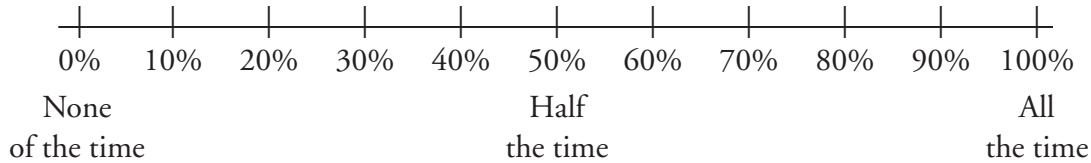
____ Every day (or 90 times in 3 months)

____ Twice a day (or 180 times in 3 months)

____ Three times a day (or 270 times in 3 months)

____ Other (*please specify*) _____

10. When you had **vaginal or anal** sex with an **HIV-positive partner(s) in the last 3 months**, about what percentage of the time did you and/or your partner(s) use a condom? *(Circle your answer.)*



11. **In the last 3 months**, with how many **HIV-negative partners** or **partners whose HIV status you didn't know** did you have **vaginal or anal** sex? *(Write in a number for your answer.)*

_____ partners *(If you had No HIV- negative or status unknown partners, skip to Question 14.)*

12. **In the last 3 months**, about how many times did you have **vaginal or anal** sex with an **HIV-negative or status unknown partner(s)**?

_____ Once

_____ Twice

_____ Once a month (or 3 times in 3 months)

_____ Twice a month or every other week (or 6 times in 3 months)

_____ Once a week (or 12 times in 3 months)

_____ Twice a week (or 24 times in 3 months)

_____ Three times a week (or 36 times in 3 months)

_____ Four times a week (or 48 times in 3 months)

_____ Five times a week (or 60 times in 3 months)

_____ Six times a week (or 72 times in 3 months)

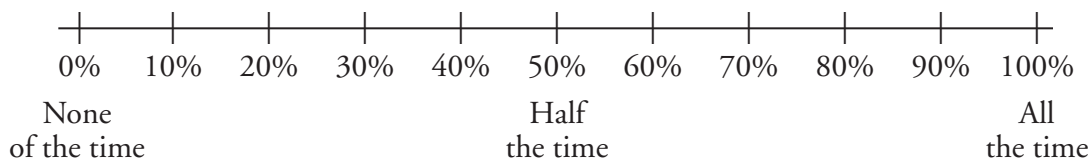
_____ Every day (or 90 times in 3 months)

_____ Twice a day (or 180 times in 3 months)

_____ Three times a day (or 270 times in 3 months)

_____ Other *(please specify)* _____

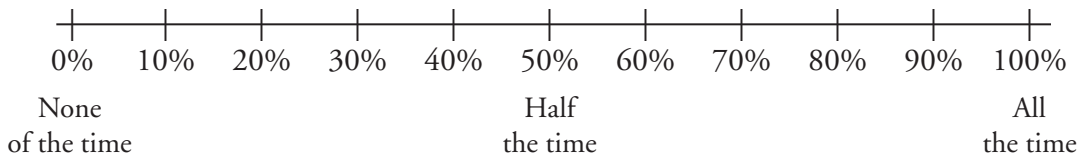
13. When you had **vaginal or anal** sex with an **HIV-negative or status unknown partner(s) in the last 3 months**, about what percentage of the time did you and/or your partner(s) use a condom? *(Circle your answer.)*



19. In the last 3 months, about how many times did you have **insertive oral** sex with an **HIV-positive partner**?

- ___ Once
- ___ Twice
- ___ Once a month (or 3 times in 3 months)
- ___ Twice a month or every other week (or 6 times in 3 months)
- ___ Once a week (or 12 times in 3 months)
- ___ Twice a week (or 24 times in 3 months)
- ___ Three times a week (or 36 times in 3 months)
- ___ Four times a week (or 48 times in 3 months)
- ___ Five times a week (or 60 times in 3 months)
- ___ Six times a week (or 72 times in 3 months)
- ___ Every day (or 90 times in 3 months)
- ___ Twice a day (or 180 times in 3 months)
- ___ Three times a day (or 270 times in 3 months)
- ___ Other (*please specify*) _____

20. When you had **insertive oral** sex with an **HIV-positive partner in the last 3 months**, about what percentage of the time did you use a condom? (*Circle your answer.*)



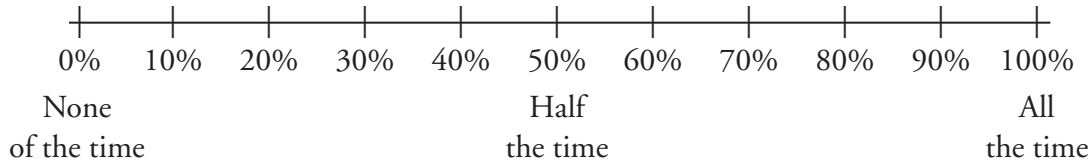
21. In the last 3 months, with how many **HIV-negative or status unknown partners** did you have **insertive oral** sex? (*Write in a number for your answer.*)

___ partners (*If you had No HIV- or status unknown partners, skip to Question 24.*)

22. In the last 3 months, about how many times did you have **insertive oral** sex with an **HIV-negative or status unknown partner**?

- ___ Once
- ___ Twice
- ___ Once a month (or 3 times in 3 months)
- ___ Twice a month or every other week (or 6 times in 3 months)
- ___ Once a week (or 12 times in 3 months)
- ___ Twice a week (or 24 times in 3 months)
- ___ Three times a week (or 36 times in 3 months)
- ___ Four times a week (or 48 times in 3 months)
- ___ Five times a week (or 60 times in 3 months)
- ___ Six times a week (or 72 times in 3 months)
- ___ Every day (or 90 times in 3 months)
- ___ Twice a day (or 180 times in 3 months)
- ___ Three times a day (or 270 times in 3 months)
- ___ Other (*please specify*) _____

23. When you had **insertive oral** sex with an **HIV-negative or unknown status partner in the last 3 months**, about what percentage of the time did you use a condom? *(Circle your answer.)*



The following questions ask about drug and alcohol use. This refers to drugs that were not prescribed by your doctor.

Please answer as honestly as possible, and remember that your answers are private and confidential.

24. Place a checkmark next to all of the drugs and alcohol that you used **in the last 3 months** without a prescription from your doctor.

___ Amphetamine, methamphetamine (speed, crystal, crank, etc.)

___ Cocaine (including crack)

___ Downers (e.g., valium, Ativan, Xanax)

___ Pain killers (e.g., Oxycontin, Percocet)

___ Hallucinogens (e.g., LSD)

___ Ecstasy

___ Club drugs (e.g., GHB, ketamine)

___ Heroin

___ Marijuana

___ Poppers (amyl nitrate)

___ Alcohol

___ Other—Please specify: _____

___ None—**If None, you are finished with this survey. THANK YOU!**

25. **In the last 3 months**, about how often did you have sex when you were high or drunk on alcohol or any of the drugs listed above?

___ Never

___ Rarely

___ Some of the time

___ Most of the time

___ Always

___ I did not have sex **in the last 3 months**

26. Have you ever injected drugs?

___ Yes

___ No—**If No, you are finished with this survey. THANK YOU!**

(Continued on next page.)

27. Did you inject drugs **in the last 3 months**?

_____ Yes

_____ No—**If No, you are finished with this survey, THANK YOU!**

28. **In the last 3 months**, how often did **you** share needles or works with someone else (either you used a needle or works after someone else used them, or someone else used your needle or works)?

_____ Never

_____ Rarely

_____ Some of the time

_____ Most of the time

_____ Always

29. When was the last time you shared needles or works?

_____ In the last 3 months

_____ 3 to 6 months ago

_____ 7 to 12 months ago

_____ More than one year ago

_____ Never

Thank you for completing this survey!



Part 4



Questions and Answers About Options



1. What is Motivational Interviewing (MI)?

"Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence about behavior change. The patient is intimately involved in every step of the process, especially in the selection of the goals. The relationship between the patient and the healthcare provider is thus a collaboration—one in which the patient and healthcare provider work together to negotiate an individualized plan for positive change."

Rollnick and Miller, 1999

Motivational Interviewing (MI) consists of a set of interpersonal communication techniques designed to produce changes in health-related behaviors in individuals. It is a patient-centered approach to enhancing individuals' motivation to change, and one of its main underlying principles is that people cannot be forced to change their behavior if they are not ready. It is critical to work collaboratively with patients in a supportive, nonjudgmental way to help them explore, understand, and resolve their ambivalence toward behavior change by identifying and addressing their individually-relevant obstacles to such change. Equally important, MI recognizes that each individual patient is potentially the best source of information about the particular barriers that they may face to behavior change or maintenance of safer behavior. The MI strategy seeks patient insight on this issue, and then uses it as the basis for collaboratively formulating individually-tailored strategies for change or maintenance. These techniques have been used with a variety of health behaviors.

The Options intervention uses Motivational Interviewing techniques to deliver HIV risk reduction information, motivation, and behavioral skills content in a way that maximizes patient "buy-in," minimizes resistance, and has an empirically-supported likelihood of eliciting safer sexual and drug use behavior.

2. Why is it important for healthcare providers to conduct the Options discussions?

The Options intervention was developed in collaboration with healthcare providers, patients, and behavioral scientists, to build on the caring and trusting

relationship that exists between providers and their patients, and to make use of the resources available in the clinical care setting. The intervention and training materials were developed to be responsive to the demands of healthcare providers within a busy clinical care environment. While the intervention has only been evaluated with providers as the implementers, other staff members can conduct the Options visits provided that they have ongoing contact with patients, have the time to devote to these discussions, and are adequately trained.

3. Does the entire clinic need to attend the Orientation and Training Sessions?

It is important that the entire clinical care team who are involved with routine patient care (e.g., nurses, healthcare providers, case managers, social workers, peer educators) attend the Orientation Session so that they can learn about Options, understand their role in Options implementation, and become committed to the approach. To maximize the coordination and delivery of prevention services, it is strongly recommended that clinic staff also attend the Training Sessions.

4. What additional staffing and resources will Options implementation involve?

The Options intervention was designed to be seamlessly integrated into the standard of care for PLWHA using existing staff and resources. Prior to implementation, it is important to identify an onsite Options coordinator to facilitate the scheduling of trainings, prepare documentation and evaluation tools, if appropriate, and assist the providers with their technical assistance needs. The coordinator can also help identify HIV prevention needs within the clinic population and locate relevant resources and referrals. An existing team member can assume these responsibilities. It is also important to have a “champion” (ideally, a healthcare provider) to provide leadership and promote buy-in to the idea of implementing a healthcare provider-delivered PwP program. Once buy-in occurs, the “champion’s” role is to provide encouragement to healthcare providers so that they continue to implement the Options intervention with their patients over time.

5. How many HIV healthcare providers have used this model, and what were their experiences?

“Options has created a whole new series of opportunities for me to improve the way I practice medicine. I think Options has given me, as a practitioner, skills to address issues of risk, both sexual and substance abuse, in my patients. And that, actually, I believe is a very, very important part of comprehensive HIV care...”

Gerald Friedland, M.D., Director, AIDS Program, Yale University

As of May 2006, over 200 healthcare providers and healthcare professionals had been trained in the Options intervention. The intervention is being

implemented as the standard of care in multiple clinical care settings in the United States, and the feedback from healthcare providers and patients has been extremely positive. Healthcare providers have indicated that integrating Options discussions into routine clinical care is the most challenging in the beginning, when they have not yet developed a level of comfort with the intervention and dialogue. The more Options discussions that they have, though, the more skilled they become in the intervention and the more useful that they find it to be.

6. How do patients respond to these discussions during routine clinical care visits?

The Options intervention was developed in collaboration with healthcare providers and patients to be responsive to the needs of PLWHA. Patients have responded well to these discussions, and refusal rates to engage in these discussions were exceedingly low during the evaluation study. Furthermore, providers who have conducted the Options intervention with their patients have consistently reported that the patients look forward to having these discussions at each visit and are disappointed if they do not occur.

7. We need additional materials that specifically address unique risk behaviors among PLWHA at our clinic, such as the use of crystal methamphetamine among MSM. What information is available through Options?

A number of patient handouts and other resource materials are provided as part of the training materials. These materials cover a range of topics, from HIV disclosure to club drugs to safer sex communication skills. They can also be downloaded from www.optionstraining.org.

8. Can the Options intervention be used for health behaviors other than HIV risk reduction?

Motivational interviewing (MI) techniques, which comprise the delivery system for the Options intervention, have been shown to be effective in motivating patients to practice a range of safer health behaviors, including smoking cessation, and drug and alcohol abstinence. The IMB theory which forms the basis of the Options intervention has been used as an explanatory model for numerous health behaviors, such as antiretroviral medication adherence and breast self-examination. While the Options protocol was developed specifically for HIV risk reduction, it appears that it can be generalized across a number of different health behaviors and domains. Anecdotally, healthcare providers have indicated that they have successfully adapted and used Options with a variety of health behaviors. Prior to using it for other health behaviors, ideally one should first establish its efficacy for those particular health behaviors and anchor it within the needs and culture of the specific population of interest.

9. Can you conduct only part of the Options protocol? What if you run out of time before implementing all of the steps?

Because the Options intervention was designed to be implemented on repeat occasions over time during regularly scheduled clinical care visits, if a healthcare provider cannot complete all of the steps during one visit, they will have the opportunity to revisit the protocol at the next visit and continue where they left off. What is most important is to maintain the core elements of the intervention even if it takes multiple visits to get through all of the steps. The core elements are the following: (1) assessing the patient's risk behavior, (2) identifying the barrier(s) to the consistent practice of safer behavior, (3) developing strategies for overcoming the barrier(s) to safer behavior, and (4) negotiating a goal or action plan.

10. What topics are best to address at booster sessions?

Topics that are good for booster training sessions include the common challenges that providers face when implementing the Options protocol, such as how to work with patients who resist changing their HIV risk behavior, or how to structure Options visits for patients who report no risk behavior. It is important to conduct a preliminary assessment of what topics providers would *like* to have reviewed during the booster session. Booster sessions are also an excellent opportunity for providers to share their Options “success stories,” which can help motivate and encourage other providers.

11. How can you keep healthcare providers and staff motivated after the initial trainings and booster session?

Providing ongoing feedback and regular opportunities for providers and staff to share their experiences (e.g., during regular staff meetings) can help to motivate them to continue implementing Options at their clinic. This means acknowledging the contributions of all staff during implementation, not just the providers. It also means being responsive to the challenges that providers and staff encounter when integrating Options into their clinic routine. This may require modifying certain aspects of how Options is implemented such as how visits are documented or the target date for completing at least one Options discussion with every patient.

12. Do we have to use the forms provided in this manual?

It is not necessary to use the forms provided in the *Options Tool Kit*. These forms can be adapted to meet the needs of your clinic or entirely new forms can be created. The sample forms provided in this manual were created specifically for use in busy clinical care environments, where providers are already overburdened with documentation demands. The *Patient Record Form* was designed to help providers follow the steps of the Options intervention and to help them recall what occurred during previous Options visits; it can be modified for use in any medical documentation system.

13. Do we have to evaluate Options?

The Options intervention has already been rigorously evaluated and found to be feasible to implement in a range of clinical care settings and effective at reducing risky sexual behavior. Thus, it is not necessary to conduct an outcome evaluation in your clinic. However, to maximize intervention effectiveness, the core elements of the Options intervention must be maintained.

If you have the necessary resources, evaluation of the Options intervention within your clinical setting can help motivate providers to initiate, implement, and maintain Options as the standard of care. Specifically, understanding the risk dynamics and levels of sexual and drug use risk behavior among your clinic population serves as an important basis for implementing Options. Further, demonstrating that Options is effective and feasible in your clinic setting provides a valuable incentive for healthcare providers to continue implementing Options on a routine basis. However, you should be aware that evaluating Options may entail significant staff time and resources, which may outweigh these benefits. In addition, any surveys administered to patients will need to be approved by the Institutional Review Board, and all resultant data will need to be analyzed. The time required to administer pre-intervention measures to patients can also delay Options protocol implementation.



Part 5



OPTIONS TIMELINE





Options Timeline

Stages of Project	Time Frame for Activity	Activity	Person/Team Responsible
<p>PREPARATION: Pre-Implementation</p>	<p>1–2 months before Implementation</p>	<p>1. Form a multidisciplinary implementation team, which could include the medical director, onsite Options coordinator, and members from the nursing, social services, and health education teams.</p> <p>2. Assemble and schedule a meeting with senior leadership and key personnel to clearly outline the time expectations and anticipated roles and responsibilities for clinic staff during Options training and implementation, and allow attendees to ask questions.</p> <p>3. Identify an onsite Options coordinator to schedule the orientation and training sessions, and to conduct an inventory of current services provided by the clinic.</p> <p>4. Identify a “champion” to promote HIV prevention with PLWHA as standard of care, to motivate individual healthcare providers to implement Options, and to provide leadership around the integration of the Options intervention into the clinic routine.</p> <p>5. Establish a baseline. Review existing services, available resources, and patient educational materials. Using the screening tool, evaluate the clinic’s capacity for implementing Options. If possible, conduct a brief assessment of patients’ prevention needs, and determine the availability of local resources for addressing those needs.</p> <p>6. Select quality indicators to evaluate the clinic’s progress on integrating Options discussions into routine clinical care. Indicators may include frequency of intervention delivery, adherence to protocol steps, patient satisfaction, decrease in risk behavior, and decrease in incidence of STIs.</p>	<p>Medical Director Options Coordinator</p> <p>Medical Director Options Coordinator</p> <p>Medical Director Options Coordinator</p> <p>Medical Director</p> <p>Options Coordinator Case Management Team</p> <p>Implementation Team Medical Director Options Coordinator</p>

Options Timeline *(continued)*

Stages of Project	Time Frame for Activity	Activity	Person/Team Responsible
<p>PREPARATION: Pre-Implementation (cont.)</p>	<p>1–2 months before Implementation (cont.)</p>	<p>7. Develop site-specific tools to evaluate the clinic’s progress in implementing Options. Determine how Options intervention sessions will be monitored and recorded using the <i>Patient Record Form</i> or within existing medical documentation systems, and how providers will be reminded to implement Options during routine visits with patients (stickers on patients’ medical records, etc.). A sample <i>Patient Record Form</i> is provided in the <i>Options Tool Kit</i>.</p> <p>8. Assess whether evaluation tools are required to be submitted to the local Institutional Review Board for approval, and whether all documentation is in compliance with HIPAA standards.</p> <p>9. Develop a phase-in plan. Phase-in plans should take into consideration the duration of appointment times, the clinic caseload, and the number of providers available to implement the intervention. Recommendations for phase-in include healthcare providers implementing Options with 1-2 patients per clinic session and linking first Options visits to annual psychosocial assessments to ensure that the entire clinic population has at least one Options session per year. Some sites may find it helpful to identify a core group of providers to pilot test the intervention.</p>	<p>Implementation Team Participating Providers Options Coordinator</p> <p>Options Coordinator</p> <p>Implementation Team Participating Providers Options Coordinator</p>
<p>PREPARATION: Orientation and Training Preparation</p>	<p>2–4 weeks before training</p>	<p>1. Invite all staff to the orientation meeting to introduce Options, solicit feedback, and outline expectations for staff for implementation. It is recommended that lunch (or refreshments) be provided and that the onsite Options coordinator encourage all staff to attend. All key stakeholders and senior clinical staff should attend. This meeting should be held in a large conference room that allows for PowerPoint presentations. The onsite Options coordinator will need to duplicate materials for distribution, but the Options trainer will lead the discussion.</p>	<p>Medical Director Options Coordinator</p>

Options Timeline *(continued)*

Stages of Project	Time Frame for Activity	Activity	Person/Team Responsible
<p>PREPARATION: Orientation and Training Preparation (cont.)</p>	<p>2–4 weeks before training (cont.)</p>	<p>2. During the orientation, announce the proposed training date(s) for the Options Intervention Training Workshop and HIV Risk Reduction Strategies Workshop.</p> <p>3. Review training expectations and time commitments for staff to participate in the training. Remind staff on multiple occasions of the date(s) and time(s) of the training sessions.</p> <p>4. Make the necessary arrangements for the training session. A large conference room should be made available, where training participants can break into small groups. Audio-visual equipment such as an LCD projector and a DVD player are needed to display the training presentations. A meal or refreshments should be arranged in advance for training participants, as an incentive to attend. A head count should be provided to the Options trainer in advance, so that an adequate number of training materials are available for distribution to the participants on the day of training.</p>	<p>Options Trainer Options Coordinator</p> <p>Options Trainer Options Coordinator</p> <p>Options Coordinator</p>
<p>TRAINING</p>	<p>2–4 weeks following orientation meeting</p>	<p>1. Train the providers. The clinic should plan on devoting a full day or 2 half days to the training, which will consist of the Options Intervention Protocol Workshop and the HIV Risk Reduction Strategies Workshop (7 hours with breaks; 8 hours with breaks and lunch). All healthcare providers should be required to attend this training session; it is recommended that all clinic staff attend as well. Multiple reminders should be used to ensure attendance. Availability of meeting space, food, and equipment should be confirmed in advance. The Options trainer will lead the training and bring training materials for distribution.</p>	<p>Options Trainer Options Coordinator Participating Providers All Interested Staff</p>

Options Timeline *(continued)*

Stages of Project	Time Frame for Activity	Activity	Person/Team Responsible
TRAINING (cont.)	2–4 weeks following orientation meeting (cont.)	<p>2. At the end of the training, provide a brief tutorial on how Options will be documented in the patients’ medical records, proposed targets for Options implementation (i.e., number of patients per period of time), and how providers will be reminded to implement Options during routine consultations. The onsite Options coordinator and Options trainer will conduct this tutorial.</p>	Options Coordinator Options Trainer
IMPLEMENTATION	Immediately following training	<p>1. Phase in Options according to plan, with providers meeting their target of 1-2 Options visits per clinic session. Provide support to providers with limited experience or training in addressing risky sexual and drug use behavior as they adjust to this new role. Encourage providers with substantial prior experience doing risk reduction counseling to integrate the protocol into their current discussions with patients.</p> <p>2. To help providers when they first start implementing the protocol, provide them with a copy of the <i>Quick Reference Guide</i>, or with the <i>Options Pocket Guide</i>, both of which describe the steps of the protocol. This <i>Quick Reference Guide</i> can be placed on the back of the <i>Patient Record Form</i>. The <i>Pocket Guide</i> can be carried by providers in their pockets.</p> <p>3. Give healthcare providers <i>Patient Record Forms</i> to document each Options encounter (to be filed in the patient’s medical record) and <i>Options Prescription pads</i> to document behavior change goals (use of <i>Options Prescription pads</i> is optional). Also provide stickers to flag charts for those patients who have had Options visits, as a reminder to do follow-up Options visits.</p>	<p>Implementation Team Medical Director Options Coordinator</p> <p>Options Coordinator Participating Providers</p> <p>Options Coordinator</p>

Options Timeline *(continued)*

Stages of Project	Time Frame for Activity	Activity	Person/Team Responsible
IMPLEMENTATION (cont.)	Immediately following training (cont.)	<p>4. Track the use of <i>Patient Record Forms</i>, and provide monthly updates to providers on their progress in implementing Options. Communicate regularly with the Options trainer during implementation for ongoing technical assistance.</p>	Options Coordinator
		<p>5. Integrate monitoring into case-conferencing and self-management plans. Conduct monitoring at routine intervals and at multiple levels, and provide status reports. Frequent monitoring will ensure that any obstacles or barriers to Options implementation are addressed in a timely manner.</p>	Options Coordinator
		<p>6. Report at staff and quality improvement meetings, troubleshoot, and problem-solve. Hold team meetings with participating providers, case management staff, nursing staff and other relevant team members to discuss challenging patients with respect to HIV prevention, and how to most effectively work with these patients.</p>	Medical Director/ Options “Champion” Options Coordinator
		<p>7. During staff meetings, acknowledge the team’s contributions toward providing HIV prevention services to PLWHA. Promote collaboration and teamwork by describing successful referrals and case studies.</p>	Medical Director/ Options “Champion” Options Coordinator
		<p>8. Ask participating healthcare providers to make suggestions for the upcoming booster session. Provide all suggestions to the Options trainer <i>prior</i> to the booster session. The trainer will integrate the suggestions into the booster session.</p>	Options Coordinator Implementation Team

Options Timeline *(continued)*

Stages of Project	Time Frame for Activity	Activity	Person/Team Responsible
IMPLEMENTATION: Booster Session	Within 4–8 weeks after implementation	<p>1. Hold booster training sessions. Based on feedback from participating healthcare providers, the onsite Options coordinator, and the Options “champion,” conduct a booster session to address implementation issues and logistical obstacles, and to share experiences with implementing the intervention. Schedule the booster session for at least one hour up to a maximum of two hours, and ask all participating healthcare providers to attend. Confirm the availability of meeting space, food, and equipment in advance of the session. The Options trainer will lead the booster session and bring applicable training materials for distribution.</p> <p>2. If necessary, modify the <i>Patient Record Form</i>, documentation systems, and target numbers during the booster session in order to address emergent implementation issues.</p>	<p>Options Trainer Participating Providers Options Coordinator Medical Director/ Options “Champion”</p> <p>Options Coordinator</p>
PROGRAM EVALUATION	Ongoing after implementation	<p>1. Monitor progress, and identify issues and lessons learned. Review all available data (including outcome data, if collected) to determine implementation progress, and to identify potential issues with documentation and program uptake. Present findings during case conference meetings.</p> <p>2. If the clinic implements Options with a core group of participating providers, interview the providers as a group to get feedback, and make needed modifications prior to clinic-wide dissemination.</p>	<p>Implementation Team Options Coordinator</p> <p>Implementation Team Options Coordinator</p>

Options Timeline *(continued)*

Stages of Project	Time Frame for Activity	Activity	Person/Team Responsible
PROGRAM EVALUATION (cont.)	Ongoing after implementation (cont.)	<p>3. Conduct rapid improvement projects to address issues and lessons learned. Improvement projects that respond to common challenges and barriers to Options implementation should be proposed and enacted based on data and feedback provided by the multidisciplinary implementation team.</p>	Implementation Team Options Coordinator
MAINTENANCE	Ongoing after implementation	<p>1. Make prevention part of quality care programs. Efforts should be made to explicitly recognize that HIV prevention services are an integral part of HIV care. The “champion” for the Options intervention will continue to encourage providers to implement the protocol, be available for consultation and questions, and remind providers of Options implementation targets during scheduled staff meetings.</p> <p>2. Monitor quality indicators for HIV prevention service. Routine monitoring and ongoing feedback will ensure that the Options intervention has staying power with participating providers. Monitor quality indicators to track the progress of Options. Specifically, determine the proportion of patients who have participated in Options discussions and the proportion of patients who have had more than one Options visit.</p> <p>3. Track the use of <i>Patient Record Forms</i>, and provide monthly updates to providers on their progress in implementing Options. Communicate regularly with the Options trainer during implementation for ongoing technical assistance.</p>	<p>Options Coordinator Medical Director/ Options “Champion” All Staff</p> <p>Implementation Team Participating Providers Options Coordinator</p> <p>Options Coordinator</p>

Options Timeline *(continued)*

Stages of Project	Time Frame for Activity	Activity	Person/Team Responsible
<p>MAINTENANCE</p>	<p>Within 12 months of implementation, the clinic site should be implementing Options as standard of care.</p>	<p>1. Continually reassess goals and progress towards those goals in terms of Options implementation.</p> <p>2. Monitor results and make adjustments that address common problems. Implement necessary changes and study the results so that the program remains responsive to the realities and demands of providers and continues to benefit the patients that it intends to serve.</p> <p>3. Update and assess available resources, patient handouts, and services, in order to meet the changing HIV prevention needs of PLWHA. A stock of <i>Patient Record Forms</i>, patient handouts, prescription pads and other resource materials will be available for providers' use.</p>	<p>Implementation Team Participating Providers Options Coordinator</p> <p>Implementation Team Participating Providers Options Coordinator</p> <p>Options Coordinator</p>

References

- Anzala AO, Simonsen JN, Kimani J, et al. Acute sexually transmitted infections increase human immunodeficiency virus type 1 plasma viremia, increase plasma type 2 cytokines, and decrease CD4 cell counts. *J Infect Dis.* 2000;182:459-466.
- Ajzen I, Fishbein M. *Understanding attitudes and predicting social behavior.* Englewood Cliffs, NJ: Prentice-Hall; 1980.
- Bandura A. Perceived self-efficacy in the exercise of control over AIDS infection. In: Mays VM, Albee GW, Schneider SM, eds. *Primary prevention of AIDS.* Newbury Park, CA: Sage; 1989:128-141.
- Bandura A. Social cognitive theory and exercise of control over HIV infection. In: DiClemente RJ, Peterson JL, eds. *Preventing AIDS: Theories and methods of behavioral interventions.* New York: Plenum Press; 1994:25-59.
- Blackard JT, Mayer KH. HIV superinfection in the era of increased sexual risk-taking. *Sex Trans Dis.* 2004;31:201-204.
- Centers for Disease Control and Prevention. Incorporating HIV prevention into the medical care of persons living with HIV: Recommendations of CDC, the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and the HIV Medicine Associations of the Infectious Diseases Society of America (IDSA). *MMWR.* 2003;52:1-24.
- Fisher JD, Cornman DH, Osborn CY, Amico KR, Fisher WA, Friedland GA. Healthcare provider-initiated HIV risk reduction intervention for HIV-positive persons: formative research, acceptability, and fidelity of the Options Project. *J Acq Imm Def Synd.* 2004;37:S78-S87.
- Fisher JD, Fisher WA, Cornman DH, Amico RK, Bryan A, Friedland GH. Healthcare provider-delivered intervention during routine clinical care reduces unprotected sexual behavior among HIV-infected patients. *J Acq Imm Def Syndr.* 2006;41:44-52.
- Fisher JD, Fisher WA. Changing AIDS risk behavior. *Psych Bull.* 1992; 111:455-474.
- Fisher JD, Fisher WA. Theoretical approaches to individual-level change in HIV risk behavior. In: Peterson JL, DiClemente R, eds. *HIV Prevention Handbook.* New York: Kluwer Academic; 2000:3-55.
- Fisher JD, Fisher WA. The information-motivation-behavioral skills model. In: DiClemente R, Crosby R, Kegler R, editors. *Emerging Promotion Research and Practice.* San Francisco, CA: Josey Bass Publishers; 2002.
- Fisher WA, Fisher JD. Understanding and promoting AIDS preventive behavior: A conceptual model and educational tools. *Can J Hum Sex.* 1993;1:99-106.

- Fisher WA, Fisher JD, Harman JJ. The information-motivation-behavioral skills model: A general social psychological approach to understanding and promoting health behavior. In: Suls J, Wallston KA, eds. *Social Psychological Foundations of Health and Illness*. Malden, MA: Blackwell Publishing; 2003:82-106.
- Grant RM, Hecht FM, Warmerdam M, et al. Time trends in primary HIV-1 drug resistance among recently infected persons. *JAMA*. 2002;288:181-188.
- Gray RH, Wawer MJ, Brookmeyer R, et al. Probability of HIV-1 transmission per coital act in monogamous, heterosexual, HIV-1-discordant couples in Rakai, Uganda. *Lancet*. 2001;357:1149-1153.
- Holmes KK, Mardh P, Sparling PF, et al., eds. *Sexually transmitted diseases, 3rd ed.* New York: McGraw-Hill; 1999.
- Kelly JA, St. Lawrence JS. AIDS prevention and treatment: Psychology's role in the health crisis. *Clin Psychol Rev*. 1988;8:255-284.
- Klausner JD, Kent CK. HIV and sexually transmitted diseases. Latest views on synergy, treatment, and screening. *Postgrad Med*. 2004;115:79-84.
- Kozal MJ, Amico KR, Chiarella J, et al. Antiretroviral resistance and high-risk transmission behavior among HIV-positive patients in clinical care. *AIDS*. 2004;18:2185-2189.
- Miller WR, Rollnick S. *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press; 1991.
- Quinn TC, Wawer MJ, Sewankambo N, et al. Viral load and heterosexual transmission of human immunodeficiency virus type 1. Rakai Project Study Group. *N Engl J Med*. 2000;342(13):921-929
- Reynolds SJ, Risbud AR, Shepherd ME, et al. Recent herpes simplex virus type 2 infection and the risk of human immunodeficiency virus type 1 acquisition in India. *J Infect Dis*. 2003;187:1513-1521.
- Rollnick S, Mason P, Butler C. *Health behavior change: A guide for practitioners*. Edinburgh: Churchill Livingstone; 1999.
- Serwadda D, Gray RH, Sewankambo NK, et al. Human immunodeficiency virus acquisition associated with genital ulcer disease and herpes simplex virus type 2 infection: A nested case-control study in Rakai, Uganda. *J Infect Dis*. 2003;188:1492-1497.
- Simon V, Vanderhoeven J, Hurley A, et al. Evolving patterns of HIV-1 resistance to antiretroviral agents in newly infected individuals. *AIDS*. 2002;16:1511-1519.
- Wright PW, Hoesley CJ, Squires KE, Croom-Rivers A, Weiss HL, Gnann JW. A prospective study of genital herpes simplex virus type 2 infection in human immunodeficiency virus type 1 (HIV-1)-seropositive women: correlations with CD4 cell count and plasma HIV-1 RNA level. *Clin Infect Dis*. 2003;36:207-211.