Quality Assurance Standards for HIV Prevention Interventions

HIV/AIDS PREVENTION AND INTERVENTION SECTION
DIVISION OF HIV/AIDS-STD
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

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INTRODUCTION

This document defines and describes the HIV/AIDS Prevention & Intervention Section, Division of HIV/AIDS - STD (HAPIS/DHAS) standards for HIV prevention services. These standards were developed by HAPIS/DHAS after careful review of existing federal guidelines and standards, state and federal statute and policy, published literature regarding effective interventions, and current “best practices” in HIV prevention programs. Grantees were asked to provide feedback on draft standards. HAPIS/DHAS made adjustments and refinements to the standards based on provider feedback. Based on HAPIS/DHAS’ experience with initial implementation of quality assurance activities associated with these standards as well as changes to state and federal policy, the standards have been further revised.

All providers under contract with HAPIS/DHAS for provision of HIV prevention services, including local public health agencies, are expected to adopt the program practices described in these standards. Responsiveness to these program standards will be assessed through routine contract monitoring and quality assurance activities.

With implementation of these standards it is not HAPIS/DHAS’ intention to create undue burden on service providers. Rather, the implementation of these standards and the associated monitoring and assurance activities are intended to facilitate the provision of high quality HIV prevention services which are responsive to community needs and priorities.

The Quality Assurance Process. As recipients of public funds, both HAPIS/DHAS and its grantees must be accountable for how prevention resources are used. HAPIS/DHAS does not, however, view quality assurance as program “auditing”. It is not intended to be punitive. Rather, it is intended to be helpful to both the grantee and HAPIS/DHAS. HAPIS/DHAS views quality assurance as a mechanism by which to:

C Aid in understanding the type and range of services supported by MDCH.
C Assess the extent to which such services are responsive to needs and priorities.
C Assess grantee responsiveness to established program standards.
C Identify technical assistance and capacity development needs and priorities of grantees.
C Identify “best practices” to share with other providers.
C Build local agency capacity to conduct quality assurance and program monitoring.

Quality assurance activities are not intended to be burdensome to grantees. HAPIS/DHAS’ priority is on ensuring high quality and sustainable services. The grantee’s first responsibility is to the community that it serves. To that end, the HAPIS/DHAS’ quality assurance process will be characterized by the following:

C A consistent, standardized approach to quality assurance. Standard assessment and reporting tools will be used by program consultants engaged in quality assurance activities.
C Findings of quality assurance consultations, including recommendations and/or requirements for program redirection or refinement, will be communicated to grantees in a timely manner, via a formal report.
C At least one on-site intensive consultation will be conducted each fiscal year with
representative(s) of HAPIS/DHAS. Additional on-site consultations will be conducted at the discretion of HAPIS/DHAS as dictated by agency need, findings of contract monitoring activities, request of the grantee or other factors.

C Formal, quality assurance consultations will be complemented by routine and ongoing contact with HAPIS/DHAS program consultants for the purposes of contract monitoring, technical assistance, and information dissemination.

C Formal quality assurance consultations may be accompanied by and/or complemented by direct observation of prevention services, when appropriate and feasible.

The process and protocol by which quality assurance activities will be conducted are described in separate documents.

NOTE: Assessment and assurance of counseling, testing and referral (CTR) and partner counseling and referral services (PCRS) in local public health agencies are addressed through a Department-wide accreditation process. The frequency with which on-site consultations occur and the specific format for assessment and assurance of CTR and PCRS activities in local public health agencies is dictated by the protocol associated with the accreditation process.

**Roles and Responsibilities in Quality Assurance.** The following roles and responsibilities have been identified in relation to quality assurance of HIV prevention services:

HAPIS/DHAS will:

C Communicate program standards and other expectations to grantees clearly and in a timely manner.

C Provide grantees with the information and tools necessary to facilitate responsiveness to program standards.

C Conduct quality assurance and contract monitoring activities pursuant to established protocol.

C Facilitate identification and provision of technical assistance necessary to ensure responsiveness to program standards.

C Communicate clear and reasonable expectations for program refinement and redirection.

HIV prevention service providers will:

C Provide prevention services which are responsive to program standards and contractual requirements.

C Seek the information and tools appropriate to responding to program standards.

C Seek technical assistance and support necessary to facilitate responsiveness to program standards.

C Provide HAPIS/DHAS with documentation and materials necessary to conduct quality assurance activities, as required and/or requested.

C Participate fully in quality assurance and contract monitoring activities.

C Respond in a timely and appropriate manner to recommendations or requirements related to program refinement or redirection.

**Organization of this Document.** In the sections that follow, HAPIS/DHAS has described, very
specifically, standards for HIV prevention services. This document includes one section for each
type of prevention intervention. For each intervention, the following are described:

- Definition of the intervention
- Goals for the intervention
- Standards for the intervention
- Standards associated with staff training and development
- Standards associated with the agency quality assurance protocol or procedures
- Standards associated with data collection and program evaluation

In addition, the first section of the document describes overarching quality assurance standards. These standards apply to all agencies, across all intervention types. Questions and concerns related to these program standards or quality assurance activities should be directed to the HAPIS/DHAS program consultant assigned to your agency.
1. OVERARCHING QUALITY ASSURANCE STANDARDS

1.0 Definition
Quality assurance is a systematic assessment of the extent to which services have been delivered pursuant to a program plan approved by HAPIS/DHAS, and in accordance with relevant programmatic guidelines and standards.

1.1 Goal
To ensure provision of high-quality prevention services which are responsive to client- and community-identified needs and priorities.

1.2 Standards
This section addresses overarching quality assurance standards. These standards apply to all prevention programs regardless of intervention type. Quality assurance standards unique to specific intervention types are described in the subsequent sections of this document.

Agency Capacity. Agencies under contract with MDCH for provision of HIV prevention services are expected to maintain the organizational, administrative, fiscal and programmatic capacity necessary to deliver high quality prevention services.

C Governance: Agencies under contract with MDCH for provision of HIV prevention services must establish and maintain an appropriate mechanism for organizational governance. Written by-laws must be developed, implemented and adhered to.

C Board of Directors. Agencies under contract with MDCH for provision of HIV prevention services must establish and maintain a Board of Directors. Board members must possess the expertise and experience necessary and appropriate to provide general oversight, develop organizational policy, and work in partnership with the Executive Director to ensure achievement of the agency’s mission.

C Financial Operations. Agencies under contract with MDCH for provision of HIV prevention services must establish and maintain appropriate mechanisms for fiscal management of the agency which are consistent with standard accounting principles. Written policies and procedures must be developed, implemented and adhered to.

C Personnel. Agencies under contract with MDCH for provision of HIV prevention services must ensure that all staff possess the knowledge, skills, abilities and credentials essential to assigned responsibilities. Staff must be hired, evaluated and discharged through fair and objective processes, which are appropriately documented.

Confidentiality and Privacy. Personal identifying information about a client, including information about HIV serostatus, is not to be divulged to others in ways which are inconsistent with a client’s written consent (MCL 333.5131). Outreach-based prevention efforts may require special considerations to ensure that a client’s privacy and confidentiality are assured. Staff and volunteers must sign a Confidentiality Statement.
Adherence to Federal, State, Local Regulations and Statutes. Providers of HIV prevention services must adhere to federal, state, and local regulations and statutes. Michigan regulations and statutes are summarized in the document entitled *Michigan HIV Laws: How They Affect Physicians and Other Health Care Providers, September 2002* (www.michigan.gov/mdch)

Cultural Competence. A client’s culture, language, gender, sexual orientation, age, and/or developmental level influence how a client seeks, accepts, and accesses HIV services. Providers should address these factors in program development and implementation.

Services Accessibility and Acceptability. Services must be provided through methods and in venues which facilitate access to and acceptability of services.

- HIV prevention services must be geographically accessible to the target population.
- HIV prevention services must be offered during hours appropriate to the target population.
- HIV prevention services must be offered in settings which are acceptable and appropriate to the target population.
- HIV prevention services must be provided by staff who are culturally and linguistically competent.

Coordination and Collaboration. Strong networks of providers are essential to ensuring that the range of client needs can be appropriately and efficiently addressed. Mechanisms for ensuring effective coordination and collaboration must be developed (e.g., agency cross-trainings; joint regular staff meetings). Collaborative relationships must be formally documented in memoranda of agreement (MOA).

Educational Materials. Pursuant to federal funding requirements:

- Educational materials must be culturally, linguistically, and developmentally appropriate to the client population.
- Educational materials must be current and scientifically accurate.
- Educational materials (e.g., brochures, posters, videos) used for HIV prevention activities must be reviewed and approved by the MDCH Program Review Panel prior to their use.

Risk Reduction Tools and Materials. For clients at increased risk for HIV due to their own and/or their partners’ sexual behavior, condoms must be made available to the client, without the client having to request them. Other risk reduction tools appropriate to a client’s risk (e.g., bleach kits) should be made available as allowed under local, state and/or federal policy and/or statute.

Staff Training and Development. Staff responsible for providing direct prevention services must receive appropriate training and education to ensure that they have the knowledge, skills, and abilities necessary to deliver high quality prevention services. Specifically:

- Staff must successfully complete all training, certifications, and updates relevant and/or required to perform roles and responsibilities associated with their position. Training and certification requirements are described in the relevant sections of this document.
• Staff must be provided with copies of relevant programmatic guidelines and standards and receive training appropriate to implementation of the intervention(s).

• Staff must be provided with, and oriented to, program plans, including objectives, work plans, and time lines. Opportunities to periodically review and discuss progress toward meeting objectives should be provided.

• Staff must be provided with, and oriented to, all forms (e.g., consent forms), data collection tools, agency-specific procedural documents (e.g., record keeping, referral protocol), and data management systems (e.g., HIV Event System) and trained regarding their use.

• Staff must be provided with regular educational and skills-enhancement opportunities, appropriate to performing roles and responsibilities associated with their position.

• Staff must be knowledgeable about confidentiality laws and agency-specific confidentiality policies and procedures.

**Staff Performance and Proficiency Assessment.** Regular assessment of staff performance and proficiency in adhering to programmatic guidelines is essential to ensuring high quality prevention services.

• Written job descriptions are to be developed for all positions; these should include minimum experience and/or education requirements. Job descriptions should be reviewed with staff periodically.

• Specific criteria and a process for assessment of staff performance and proficiency are to be developed and maintained. Staff should be oriented to these.

**Supervision.** Supervisors must have the knowledge, skills, and ability to administer an intervention and/or program.

• Supervisors must have basic knowledge of the medical/scientific facts of HIV transmission, prevention, natural history and epidemiology.

• Supervisors must have knowledge and understanding of relevant programmatic guidelines and standards as well as applicable laws.

• Supervisors must have familiarity with applicable reporting forms and protocols.

• On-site supervision must be provided.

• An agency Code of Ethics must be developed and maintained. All staff are to be provided with an orientation to the Code of Ethics.

**Client Satisfaction.** To ensure that services are responsive to community- and client-identified needs and priorities, regular assessments of client satisfaction are essential. A mechanism for assessing client satisfaction with services, including accessibility and acceptability of services, must be developed, implemented and maintained. This must included formal grievance procedures.

**Provider Safety.** Agencies must develop protocols and strategies to ensure the safety of staff and volunteers providing HIV prevention services.

**Evaluation.** Evaluation of prevention services is an essential and on-going activity. Evaluation assists an agency in assessing the extent to which program objectives are being
met and the extent to which services are reaching the intended target. Evaluation also serves to identify areas for program refinement and improvement.

All agencies under contract with MDCH for provision of HIV prevention services must:
- Submit statistical data using the HIV Event System. Specific technical and reporting requirements are described in technical manuals developed and disseminated by HAPIS/DHAS.
- Submit required programmatic data in a timely manner and according to the format established by HAPIS/DHAS. Reporting formats and time lines are described in the agreement between agencies and MDCH and associated technical guidance documents.
In addition,
- The agency must develop, implement, and maintain a procedure for collection and management of the required data.
- The agency must develop, implement and maintain a procedure for review of data to ensure accuracy.
- The agency must develop, implement and maintain procedures for using evaluation data to refine or redirect programming.

**Record-Keeping.** The agency must maintain accurate and complete records. Accurate and complete records will ensure that client needs are addressed and will also assist in program evaluation.
- All personal identifying information obtained in connection with delivery of services must not be disclosed unless required by law or unless the client provides specific, written consent allowing disclosure.
- Records must be appropriate to the relevant programmatic guidelines and standards. Required records are unique to specific intervention types. Details associated with each intervention type are described in the relevant sections of this document.
- The agency must establish, implement and maintain policies and procedures to ensure the security of client records, including identifying information.
- The agency’s record-keeping policy and procedures must address retention and storage of records. Applicable federal or state law and programmatic standards should be reflected in this policy.

NOTE: Special consideration may be required for record-keeping associated with outreach-based prevention activities to ensure the confidentiality and security of client records. Protocol for record keeping associated with outreach-based activities should describe such strategies.

### 1.3 Agency Quality Assurance Protocol
To ensure that clients receive high quality HIV prevention services, all agencies under contract with MDCH are expected to develop written quality assurance protocol and implement quality assurance activities. It is expected that written protocol address each intervention type offered by the agency. The quality assurance protocol must be provided to, and/or be accessible to, staff involved in provision or supervision of direct prevention services. Orientation to the protocol must be provided to staff engaged in direct prevention services. The following are key components of a quality assurance protocol:
Compliance with Program Standards and Guidelines. (e.g., counseling protocol, failure to return protocol, referral protocol). The written quality assurance protocol must describe the methods for delivering prevention services and must be specific to each intervention type. Protocol must be responsive to programmatic guidelines and standards established by MDCH.

Cultural, Linguistic, and Developmental Competence of Services and Materials. The quality assurance protocol must describe the methods for obtaining consumer input into development, implementation and evaluation of services and associated tools (e.g., pamphlets, promotional materials, surveys).

Staff Training and Development. The quality assurance protocol should describe the methods for:

- training and education of staff to ensure that staff have and maintain essential knowledge, skills and abilities.
- recording and monitoring of all staff training and education. Documentation should include employee name, date, type, source, and duration of training. Copies of relevant certificates should be kept.
- training/orienting staff to programmatic guidelines, program plans, and reporting requirements.

Staff Performance and Proficiency Assessment. A mechanism for evaluating staff performance and proficiency must be developed, implemented and maintained, and described in a written protocol. The written protocol must describe:

- The protocol for reviewing and modifying job descriptions. Job descriptions should be included as appendices.
- Specific criteria and processes for assessment of staff performance. The methods used to orient staff to these criteria and processes should be described.

Supervision. The quality assurance protocol should describe:

- Supervisory and reporting relationships.
- The processes and methods used to orient staff to the Agency Code of Ethics and Confidentiality Statements. A copy of the Code of Ethics and Sample Confidentiality Statements should be included as an appendix.

Client Satisfaction. The quality assurance protocol must describe the mechanisms for assessing client satisfaction with services and the methods by which the findings from such efforts are to be incorporated into program refinement.

Evaluation and Data Collection. The quality assurance protocol should describe:

- The process associated with collection and management of data.
- The protocol for reviewing data for errors and inconsistencies.
- The methods used to review data and apply it to program refinement and/or redirection.
- Mechanisms by which staff, directly responsible for providing services, are provided with data analysis and evaluation findings. In addition, their involvement in program refinement must be described.
• Mechanisms by which consumers are provided with data analysis and evaluation findings, as well as their involvement in program refinement, are to be described.

**Record-Keeping.** The quality assurance protocol should describe the record-keeping policies and procedures, including:

• The process by which the accuracy and completeness of records is assessed.
• The methods used to ensure the confidentiality and security of client records. This policy should reflect applicable federal/state statutes and programmatic standards.
• Procedures for records retention and storage, reflective of state/federal law and/or programmatic standards.
• As applicable, specific record-keeping policies and procedures associated with provision of outreach-based services.
2. HIV COUNSELING, TESTING AND REFERRAL

2.0 Definition
HIV counseling, testing and referral (CTR) involves three specific interventions delivered as a set. Counseling and referral may be provided without testing; testing, however, may not be provided without counseling and referral.

The definitions and goals for each of these three specific interventions are provided in subsequent sections.

2.1 Goals
HIV counseling, testing and referral are intended to ensure that HIV-infected individuals and individuals at increased behavioral risk for HIV:
- receive high-quality HIV prevention counseling intended to facilitate adoption and maintenance of behavior to reduce risk for transmission and/or acquisition of HIV.
- have early knowledge of their HIV serostatus.
- have access to appropriate medical, prevention and psychosocial support services.

HIV counseling, testing and referral services are also intended to ensure that those individuals who wish to learn their HIV serostatus through HIV testing are provided with information about transmission modes, prevention strategies, legal issues, and information related to the test, including the meaning of test results.

2.2 Standards
This section addresses overarching quality assurance standards for HIV counseling, testing and referral services. Program and quality assurance standards, specific to each component intervention of CTR, are detailed in subsequent sections of this document.

Targeted Services. Counseling, testing and referral services should be targeted to those individuals and communities at increased risk for transmission and/or acquisition of HIV. Providers are to target services:
- to those individuals and communities identified through the community planning process as priority populations for such services.
- on the basis of review and analysis of site-specific data including: HIV/AIDS surveillance data; HIV seroprevalence data; sexually transmitted disease morbidity, and other relevant health indicator data.
- based on risk-screening conducted with clients. Risk screening is defined by both the client’s self-reported risk behavior and clinical symptoms suggestive of increased risk for HIV (i.e. presence of a sexually transmitted disease, acute retroviral symptoms or opportunistic infections). Risk screening is not risk assessment, which is part of prevention counseling.

Agencies are to develop strategies and procedures which maximize provision of services to targeted communities.
**Client Eligibility.** All individuals seeking HIV counseling, testing and referral services are to be provided with HIV testing, upon request. Agencies which receive funding from MDCH for HIV CTR services may not charge a fee for these services. Agencies under contract with MDCH which are not funded for CTR may charge a fee for counseling and referral services only, provided that fee is on a sliding scale basis. *Reference: MCL 333.5923.*

Reasonable accommodations must be made for individuals with disabilities, including the provision of interpreters for hearing impaired individuals.

**Confidentiality and Privacy.** Ensuring a client’s privacy and confidentiality is essential. The agency must develop, implement and maintain strategies which ensure that confidentiality and privacy are maintained during the counseling, testing and referral process. Outreach-based counseling, testing and referral services require special considerations.

**Informed Consent.** Pursuant to Michigan law, HIV testing must be preceded by written informed consent.

- C The booklet “Important Health Information” (DCH 0675) must be provided to the client. This booklet includes an informed consent form.
- C A copy of the signed consent is to be included in the client record.
- C When testing is performed on an anonymous basis, consent must be documented using a system which preserves the anonymity of the client.
- C Consent of a parent or guardian is not required to test an adolescent for HIV. The adolescent’s consent is valid and binding as if the adolescent had achieved the age of majority. *Reference: MCL 333.5127*
- C Written informed consent of a legally authorized representative or guardian is required to test an individual who is unable to understand or provide informed consent. *Reference: MCL 333.5133.*

Outreach-based counseling, testing and referral services may require special considerations to ensure that “true” informed consent has been obtained.

**Anonymous Testing.** Anonymous testing means that a client’s personal identifying information (i.e. name, address, phone number) is not included on laboratory requests, informed consent, medical records, or reports of HIV test results. There can be no possible link to an individual client. Pursuant to Michigan law, anonymous HIV testing must be made available to a client, upon request. *Reference: MCL 333.*

**Notification of HIV Test Results and Prevention Counseling.** Provision of test results and associated prevention counseling are essential to ensuring the effectiveness of counseling, testing and referral services. All agencies under contract with MDCH for providing CTR services, must ensure that at least 95 percent of clients found to be HIV seropositive will receive their test results and post-test counseling. At least 70 percent of clients found to be HIV seronegative must receive their test results and associated prevention counseling. *Reference: Strategies to Improve Client Failure to Return for HIV Test Results, MDCH, 2002.*
**Reporting.** Pursuant to state law, HIV positive tests results are to be reported to the local health department within seven (7) days after receiving the test result from the laboratory. Information is to be submitted on the Adult HIV/AIDS Confidential Case Report (CDC 50.42C, CDC 50.42B). *Reference: Act 489 of 1988, MCL 333.5114.*

**Risk Reduction Tools.** Provision of risk reduction tools appropriate to a client’s behavioral risk are a critical element of counseling, testing and referral effectiveness. For clients who participate in HIV CTR, condoms are to be made easily available. (See Section 1.2)

**Physical Space, Client Flow and Time Issues.** Agencies must periodically assess the efficiency and appropriateness of these factors and the extent to which they facilitate high quality counseling, testing and referral services, including client access and acceptability.

**Record-Keeping.** Accurate and complete record keeping is essential to quality assured services. Client records are to be maintained for each individual participating in CTR. For the purpose of CTR, client records must include the following:

**For confidentially-tested clients, at minimum:**
- Copy of signed informed consent form
- Documentation of client risk-reduction plan
- Laboratory test result
- Documentation of referrals, including signed release forms and disposition

Client records may also include:
- Client risk assessment.
- Client demographic information.
- Clinical records (e.g., STD, family planning)

**For anonymously-tested clients, at minimum:**
- Copy of completed informed consent form
- Documentation of client risk-reduction plan
- Laboratory test result
- Documentation of referrals, including disposition when available

*Client names or other personal identifying information cannot be connected with any form in the record.*

Client records may also include:
- Client risk assessment.
- Client demographic information, excluding identifying information.

**Other Considerations:**
- Client records must be stored in a locked file. *Reference: MCL 333.5114*
- Lists of HIV seropositive clients cannot be kept. *Reference: MCL 333.5114*
- Records should be destroyed in an appropriate time frame.

2.3 **Agency Quality Assurance Protocol**
Each agency must develop a written protocol which addresses HIV counseling, testing and referral services. In addition to the standard components of quality assurance protocol identified in Section 1 of this document and the intervention-specific quality assurance components described in Sections 3-5 of this document, the following are to be addressed in this protocol:

**Targeted Services.** The quality assurance protocol must address:

- the procedure for identifying appropriate targeting of services, including sources of data used.
- the process and procedure used to assess the extent to which services are reaching intended targets.
- strategies and procedures used by the agency in maximizing provision of services to targeted communities.

**Confidentiality and Privacy.** The quality assurance protocol must describe the strategies used to ensure that confidentiality and privacy are maintained during the counseling, testing and referral process. If counseling, testing and referral services are provided in outreach settings, the protocol must specifically address strategies and protocol used to ensure confidentiality and privacy in such settings.

**Informed Consent.** If counseling, testing and referral services are provided in outreach settings, the protocol must specifically address strategies used to ensure that true informed consent is obtained, if, for example, the client is intoxicated or mentally impaired.

**Notification of HIV Test Results and Prevention Counseling.** The quality assurance protocol is to describe:

- the process and procedures for ensuring provision of test results and prevention counseling.
- specific strategies to provide results and counseling to clients who do not return for their post-test counseling and provision of test results.

**Record-Keeping.** If CTR services are provided in outreach settings, the protocol must address for record-keeping procedures appropriate to such settings.

### 2.4 Evaluation and Data Collection

Standards associated with evaluation and data collection are described in Section 1 of this document.

- Agencies are to obtain and use a site number/numbers from HAPIS/DHAS.
- Agencies are to obtain and use counselor identification numbers from HAPIS/DHAS for all certified counselors. Each counselor must have their own counselor identification number. Counselor identification numbers may not be transferred between counselors.

### 3. HIV PREVENTION COUNSELING IN ASSOCIATION WITH HIV TESTING
3.0 Definition
HIV prevention counseling is an interactive process whereby clients are assisted in identifying the specific behaviors and context of those behaviors which place them at increased risk for acquiring or transmitting HIV. The process of counseling also assists a client in identifying and committing to specific strategies designed to reduce the risk for HIV transmission or acquisition.

In the context of HIV testing, clients are also provided with information about HIV transmission and prevention strategies as well as information about the HIV test, legal issues, and the meaning of results.

3.1 Goals
Ensure that HIV-infected individuals and individuals at increased behavioral risk for HIV receive education and counseling to assist them in adopting and maintaining behaviors which reduce risk for transmission or acquisition of HIV.

3.2 Standards
All agencies providing HIV counseling under contract with MDCH must use the HIV Prevention and Test Decision Counseling Model endorsed by MDCH. This applies to counseling provided in association with HIV testing as well as individual level prevention counseling.

The Counseling Process. The MDCH “Client-Centered” HIV Prevention and Test Decision Counseling Model must be followed by agencies under contract with MDCH. Key steps in this counseling model include the following:

Initial Counseling Session
C Provide information regarding the HIV test including benefits and consequences.
C Discuss availability and meaning of anonymous testing, pursuant to Michigan law.
C Discuss and provide assurance of confidentiality, pursuant to Michigan law, as well as anti-discrimination law for people with HIV.
C Explain that the client has a legal obligation, if found to be HIV infected, to inform each sexual partner of the client’s infection prior to engaging in sexual relations with that partner, and that the client may be subject to criminal sanctions for failure to inform the partner. Reference: MCL 333.5114a. and MCL 333.5210
C Provide client-centered counseling in accordance with MDCH curriculum. The following are key steps:
* Introduce/orient client to session
* Identify risk behaviors
* Identify safer goal behavior
* Identify action steps
* Provide referrals and support
* Summarize/close
C Explain partner counseling and referral service options.
C A counselor must ensure that a client fully understands information contained in the “Important Health Information” booklet (DCH 0675).
C Obtain written informed consent for HIV testing.
C Provide referrals for appropriate medical, prevention and supportive services.
C Provide educational materials and risk reduction tools.
C Document risk reduction plan and referrals.

Result Delivery Session
C Assess readiness to receive results.
C Provide test results.
C Explain the meaning of test results.
C Provide client-centered counseling to re-negotiate or support client’s risk reduction plan.
C Provide referrals for appropriate medical, prevention and supportive services.
C Provide educational materials and risk reduction tools.
C Document risk reduction plan and referrals.

Counseling Format. Prevention/test-decision and test results counseling must be provided face-to-face and to one individual at a time. Group counseling associated with HIV testing is not endorsed by MDCH. Group education sessions (AIDS 101) which precede individual-level prevention counseling are acceptable.

MDCH does not routinely endorse provision of HIV test results and associated prevention counseling via telephone. However, it may be appropriate for agencies or settings with relatively low HIV prevalence, that serve clients at relatively low risk for HIV and that have sub-optimal rates of return for test results. Telephone counseling must adhere to the following parameters:
C Telephone counseling may be used only to provide HIV negative test results.
C HIV test results must not be provided without appropriate prevention counseling.
C Only MDCH-certified counselors may provide test results and associated prevention counseling.
C Only MDCH-funded or designated HIV CTR sites will be authorized to provide HIV test results and associated prevention counseling via the telephone.

Any agency wishing to adopt telephone counseling must submit to HAPIS/DHAS, for review and approval, a written protocol for telephone counseling. The written protocol must be responsive to the MDCH “Policy for Provision of HIV Test Results and Associated Prevention Counseling” (October 2002). This policy requires that written protocol describe:
C Procedures to ensure client confidentiality.
C Procedures to verify the identity of the person receiving the test result, such as the use of a code-word.
C The protocol by which clients will be required to call back for test results. This protocol must specify that clients will randomly returned to the test site for test results and associated HIV prevention counseling. This will ensure
that all clients testing positive and randomly selected HIV negative clients receive their results and prevention counseling face-to-face. The protocol must provide assurances that this will be communicated to clients during the prevention/test decision counseling.

C A randomization process for selecting HIV-negative clients to return for face-to-face prevention counseling and provision of test results.

C Follow-up methods used for contacting HIV-infected individuals to provide HIV test results, prevention counseling, and provision of referrals.

C Procedures to ensure that all HIV positive clients are referred to partner counseling and referral services.

Community-based organizations and local public health agencies authorized by MDCH to use rapid HIV testing technologies must provide HIV prevention counseling pursuant to procedures established by HAPIS/DHAS. These procedures are described in the document entitled *HIV Prevention Counseling Using Rapid Testing*.

**Staff Performance and Proficiency Assessment.** Regular assessment of the skills and abilities of counseling staff is essential to ensuring high quality counseling. In addition to the overarching standards included in Section 1, agencies are to establish protocols for assessing the proficiency of counseling staff. The protocol should describe the methods and criteria used for the assessment, frequency of assessment, the method of feedback, and mechanisms for ensuring improvement. Assessment of counseling skills can be achieved through direct observation of counseling sessions, review of audio-taped sessions, or through role-play scenarios between the counselor and supervisor. Observation and feedback should be conducted on a regular basis. A suggested time frame for direct observation of an HIV prevention counselor by the supervisor is twice monthly for the first 6 months of conducting HIV counseling, monthly for the second 6 months, quarterly for the second and third year, and annually for counselors with more than 3 years of experience. Other assessments can be done through routine case conferencing and random chart audits.

### 3.3 Staff Training and Development

In addition to the standards associated with staff training and development described in Section 1 of this document, staff providing HIV counseling must:

C Successfully complete the MDCH HIV Counselor Certification course, including the MDCH Basic Knowledge course.

C Participate in MDCH-endorsed updates related to the scientific and public health aspects of HIV, counseling techniques and special topics at least every two years.

C Successfully complete the MDCH Rapid HIV Test Counselor course (for agencies authorized to provide rapid HIV testing).

**NOTE:** Staff may NOT begin providing HIV prevention counseling services prior to successfully completing the MDCH HIV Counselor Certification Course. In addition, any previously certified counselor who has not completed an update for four or more years must again successfully complete the MDCH HIV Counselor Certification Course prior to providing services and receiving a counselor identification number from HAPIS/DHAS.
Supervisors of HIV counselors must:
- successfully complete the MDCH HIV Counselor Certification course (5 day).
- successfully complete the MDCH Supervisor Course.
- participate in MDCH-endorsed updates related to the scientific and public health aspects of HIV, counseling techniques and special topics at least every two years.

### 3.4 Agency Quality Assurance Protocol
Each agency must develop a written protocol which addresses HIV counseling. In addition to the standard components of quality assurance described in Section 1 of this document, the protocol must address:
- The process and procedures associated with assessing counselor proficiency.
- Data collection and record-keeping. Specific strategies to ensure that counselors have adequate time for data collection and record keeping, outside of counseling sessions should be described.

### 3.5 Evaluation and Data Collection
Standards associated with evaluation and data collection are described in Section 1 of this document. In addition:
- Data collection is not to interfere with prevention counseling. Counselors are strongly discouraged from completing data collection forms during counseling sessions.
4. HIV TESTING

4.0 Definition
HIV testing is the process through which a client’s HIV infection status is determined.

4.1 Goal
Promote early knowledge of HIV status.

4.2 Standards

Test Technologies. The MDCH endorses conventional HIV testing using a specimen obtained through venipuncture or finger stick (i.e., “blood spot”) and HIV testing using a specimen obtained using an oral swab (i.e., OraSure). The decision as to which method(s) to adopt should be guided by several factors including client preferences and acceptability, ease of sample collection, complexity of laboratory services, availability of trained personnel and cost/resource availability.

MDCH recognizes that use of home collection devices in specific circumstances may facilitate acceptance of HIV testing among hard to reach populations.

The MDCH endorses a limited application of rapid testing technologies. Rapid testing is best used in settings where return rates for HIV test results fall below acceptable thresholds and where clients are at increased risk for HIV and/or have relatively high seroprevalence. Agencies under contract with the MDCH cannot adopt rapid HIV testing without prior authorization from MDCH. Reference: MDCH Position Statement on Rapid HIV Testing (September 2001).

Screening. The MDCH laboratories routinely screen for HIV-1 and HIV-2. HIV-1 is screened from either serum or Oral Mucosal Transudate (OMT); HIV-2 can only be screened from a serum specimen. Providers should request HIV-2 testing for West African immigrants, for individuals who have traveled in West Africa and had an exposure, or for sex and needle-sharing partners of these individuals.

Confidentiality. Test results may be provided to an agency through a secure fax. Agencies wishing to receive test results must request authorization to do so and provide documentation as to the security of the fax.

Interpreting HIV Test Results. Clients are to be provided a clear and simple statement of HIV test results. Laboratory reports of HIV tests will provide one of three results:

• Positive (Reactive) HIV Test Results. If a test result has been confirmed by Western Blot the test is to be considered a valid positive result. There is no need to repeat the test except under conditions outlined under Repeat Testing.

• Negative (Non- Reactive) HIV Test Results. A negative test result usually indicates that a person is not infected with HIV. There is no need to repeat the test except under conditions outlined under Repeat Testing.

• Indeterminate HIV Test Results. A test result is considered indeterminate if the confirmatory (Western blot) which follows a repeatedly reactive screening (ELISA) is indeterminate. Clients with an initial indeterminate Western blot
result should be retested for HIV infection at least one month later. If client has a second indeterminate result, they should be referred for medical evaluation.

- **Inconclusive HIV Test Results.** A test result is considered inconclusive due to a compromised sample or insufficient quantity of specimen for screening or confirmatory testing.

NOTE: Interpretation of results associated with rapid HIV testing are described in the document entitled *HIV Prevention Counseling Using Rapid Testing.*

**Repeat Testing.** A client should be repeat tested if any of the following occurs:

- An initial Western Blot positive test result. The repeat test is for the purpose of medical evaluation, not to confirm the initial test which is a legal, valid result. The repeat test should be performed at the time of clinical evaluation for medical management of HIV.
- An Indeterminate Western blot.
- A negative test result and:
  - an exposure so recent that the client may not yet have developed detectable antibodies; or
  - a single possible or known exposure to an HIV infected person, with an HIV test less than three months after that exposure; or
  - ongoing risk behaviors and possible or known exposures to HIV-infected individuals; or
  - known infection with Hepatitis C (HCV).

HIV testing, accompanied by prevention counseling and appropriate referral must always be provided upon client request.

**Providing Test Results by Telephone.** HIV positive test results are not to be given by telephone. Provision of negative test results by telephone must be accompanied by prevention counseling. See Section 3.2.

**Clients Who Fail to Return for Test Results.** If a client who has tested confidentially tests positive for HIV and fails to return for his/her test results, associated prevention counseling and referral, the agency must refer this client to the appropriate local public health agency for follow-up, notification of results and prevention counseling. The “Confidential Request for Health Department Assistance with Partner Counseling Testing and Referral Services (Form HP-1221) must be used.

**Laboratory, Universal Precautions and Related Procedures.**

- Staff providing HIV testing must be familiar with, and use, universal precautions, particularly those staff who collect and prepare specimens.
- Appropriate protective devices must be available.
- The agency must develop a plan for management and must make appropriate arrangements for disposal of medical waste.
- Biohazard containers must be available for disposal of medical waste, including sharps.
NOTE: Laboratory procedures associated with rapid HIV testing are described in a document entitled: *Rapid HIV Testing Using OraQuick* (April 2003).

### 4.3 Staff Training and Development

In addition to the standards associated with staff training and development described in Section 1 of this document:

- Staff using OMT testing must successfully complete an MDCH-endorsed training on use of OMT testing.
- Staff using other methods of collection must have appropriate training.
- Staff (including supervisors) using rapid HIV tests must successfully complete the MDCH training on rapid HIV testing. Ongoing proficiency testing is also required.

### 4.4 Agency Quality Assurance Protocol

Each agency must develop a written protocol which addresses testing services. In addition to the standard components of a quality assurance protocol described in Section 1 of this document, the protocol must describe:

- The procedures which will be used to ensure a secure fax.
- Orientation and training to universal precautions for staff conducting HIV testing.
- The methods used to ensure provision of protective devices to ensure appropriate use of universal precautions.
- Management and disposal of medical waste.

### 4.5 Evaluation and Data Collection

Standards associated with evaluation and data collection are described in Section 1 of this document.
5. REFERRAL

5.0 Definition
Referral is the process by which a client’s immediate needs for care, prevention and supportive services are assessed and prioritized. Clients are provided with assistance in accessing referral services. Referral also includes reasonable follow-up efforts necessary to facilitate initial contact with prevention, care and psychosocial services.

In the context of HIV prevention counseling and testing, referral does not include ongoing support or management of the referral.

5.1 Goal
To assist a client in accessing appropriate medical, prevention and psychosocial support services.

5.2 Standards
The following key steps in referrals must be followed:

Assess Client Referral Needs
C Identify key factors which influence the client’s ability to adopt/sustain risk reducing behaviors or which promote health and prevent disease progression.
C Examine client’s willingness and ability to accept and complete a referral.
C For HIV infected clients, referrals must be made for appropriate medical care and for partner counseling and referral services.
C Document referral needs and priorities in client record.

Referral Planning
C Assess factors which might make it difficult for the client to complete a referral (e.g., lack of transportation, client work schedule, cost of services, cultural competency of agency).
C Identify strategies to facilitate a successful referral.
C Document referral plan in client record.

Facilitating Access to Referral Services
C Provide the client with necessary information to enable client to access the referral service (e.g., contact name, eligibility requirements, location, hours of operation, telephone number).
C As needed and appropriate, provide the client with assistance for completing the referral (e.g., set appointment, provide or facilitate transportation).
C Document assistance, if any, provided in client record.
C If client identifying information is to be shared between providers, written consent must be obtained from the client. Consent must be specific to each referral. Reference: MCL 333.5131.

Documenting Referral and Referral Follow-Up
Assess whether client has accessed referral services and any difficulty in accessing them.

Document status of referral in client record.

**Referral Resource Guide**

Agencies are to maintain an accurate and current referral “resource guide”. The information contained in the referral resource guide should be relevant to the needs of the agency’s clients and to the interagency agreements. For each agency included, the resource guide should indicate:

- Name of provider or agency.
- Types of services provided.
- Populations served by the provider/agency.
- Service area.
- Name of primary contact person, with telephone, fax and email address.
- Hours of operation.
- Location.
- Cultural, linguistic and developmental competence.
- Cost of services.
- Eligibility requirements.
- Admission policies and procedures.
- Directions, transportation information and accessibility to public transportation.

All referral resource guides must include:

- Local health department PCRS coordinator contact information.
- Providers of HIV case management services.
- Resources for the diagnosis and treatment of sexually transmitted diseases as well as other relevant infectious diseases (e.g. viral hepatitis, tuberculosis).
- Drug or alcohol prevention and treatment facilities.

**5.3 Staff Training and Development**

In addition to the standards associated with staff training and development described in Section 1 of this document, staff providing referrals must receive adequate training and continuing education on issues essential to implement and manage referrals.

Staff providing referrals must have successfully completed the Basic Knowledge Course offered by MDCH. In addition, staff providing referrals must be provided with information on and orientation to:

- Referral resources.
- Protocol for referral management, including obtaining client authorization for release of information, communication with referral agencies, follow-up with referrals and documenting completion of referrals.
- Policies and procedures associated with maintenance of client confidentiality.

**5.4 Provider Coordination and Collaboration**
Strong working relationships among providers are especially critical in ensuring the responsiveness and effectiveness of referral services. Standards associated with facilitating coordination and collaboration are described in Section 1 of this document.

5.5 **Agency Quality Assurance Protocol**

Each agency must develop a written protocol which addresses referral services. In addition to the standard components of a quality assurance protocol described in Section 1 of this document, the protocol must describe:

- **C** The policy and procedures for training and updating staff on referral resources, including collaborative relationships with other service providers.
- **C** The process and procedures associated with updating and ensuring the accuracy of the resource guide.
- **C** The methods associated with facilitating coordination with relevant service providers.
- **C** Policies and procedures associated with reviewing and updating memoranda of agreement.
- **C** Policies and procedures associated with providing clients with immediate access to emergency medical and psychological services.
- **C** Methods for assessing and documenting completed referrals.

5.6 **Evaluation and Data Collection**

Standards associated with evaluation and data collection are described in Section 1 of this document.
6. PARTNER COUNSELING AND REFERRAL SERVICES

6.0 Definition
Partner Counseling and Referral Services (PCRS) includes two component interventions: (1) elicitation of sex and needle-sharing partners of HIV-infected individuals and (2) notifying these partners as to their exposure and offering HIV prevention services including HIV CTR.

6.1 Goal
The goal of PCRS is to help clients notify their sex and needle-sharing partners and to assist clients and partners to gain early access to HIV counseling, testing and referral services.

6.2 Standards
Community-based and other non-governmental organizations providing care to HIV-infected clients, CTR or other prevention services can only elicit sex and needle-sharing partners and refer of those partners to local health agencies (i.e. partner elicitation and referral) for investigation and notification. Investigation and notification of partners is an activity conducted only by certified staff of local public health agencies or physicians. Procedures for investigation and notification are described in the document entitled, Guidelines for Partner Counseling and Referral Services (May 2001) available by contacting HAPIS/DHAS.

Partner Elicitation and Referral (PER) Process. Key steps in the PER process include:
• HIV-infected client is counseled regarding PCRS, including legal responsibility to notify all sex partners prior to engaging in sexual relations.
• Counselor presents and discusses methods for notifying partners.
• Counselor collects identifying and contact information for partners for whom the client requests assistance in notifying.
• Identifying and contact information is forwarded to the appropriate local public health agency. Information must be received by the local health agency within 72 hours using form HP-1221 (Confidential Request for Health Department Assistance with Partner Counseling Testing and Referral Services).
• Counselor refers client to other appropriate medical, prevention and psychosocial support services.

6.3 Staff Training and Development
In addition to the standards associated with staff training and development described in Section 1, staff conducting PER must:
C Successfully complete the MDCH HIV Counselor Certification Course (5 day).
C Successfully complete either the PCRS Training for CBOs or the PCRS certification training for local health department staff.
C Participate in MDCH-endorsed updates related to the scientific and public health aspects of HIV, counseling techniques, PCRS updates and special topics at least every two years.
6.4 Agency Quality Assurance Protocol

In addition to the standard components of quality assurance described in Section 1 of this document, the protocol must address the process and procedures associated with PCRS.

6.5 Evaluation and Data Collection

Standards associated with evaluation and data collection are described in Section 1 of this document.
7. INDIVIDUAL-LEVEL PREVENTION COUNSELING

7.0 Definition

Individual-level HIV prevention counseling is an interactive process whereby clients are assisted in identifying the specific behaviors, and context of those behaviors, which place them at increased risk for acquiring or transmitting HIV. The process of counseling also aids a client in identifying and committing to specific strategies designed to reduce the risk for HIV transmission or acquisition.

Individual-level prevention counseling differs from HIV prevention counseling provided in the context of HIV testing in that the counseling session is not leading to HIV testing. It differs from prevention case management in that it is less intensive and is of shorter duration. It differs from outreach in that an individual risk reduction plan is developed.

7.1 Goals

Ensure that HIV-infected individuals and individuals at increased behavioral risk for HIV receive education and counseling to assist them in adopting and maintaining behaviors which reduce risk for transmission or acquisition of HIV.

7.2 Standards

All agencies providing HIV counseling under contract with MDCH must use the HIV Prevention Model endorsed by MDCH. This applies to counseling provided in the context of HIV testing as well as to individual level risk reduction counseling.

The Counseling Process. The MDCH “Client-Centered” HIV Prevention Counseling Model must be followed by agencies under contract with MDCH. Key steps in this counseling model:

- Introduce/orient client to session.
- Discuss and provide assurance of confidentiality, pursuant to Michigan law.
- Identify risk behavior(s).
- Identify safer goal behavior(s).
- Identify action steps.
- Provide referrals for appropriate medical, prevention and support services.
- Provide educational materials and risk reduction tools.
- Summarize/close.
- Document risk reduction plan and referrals.
**Setting.** The space for the individual counseling must be private and conducive to private/personal discussion. Ensuring a client’s privacy and confidentiality is essential. (See Section 1.2)

**Counseling Format.** Individual counseling must be provided face-to-face and to one individual at a time.

**Record-Keeping.** Client files are to be maintained for each client participating in individual-level HIV prevention counseling. Client files must contain:
- Client risk reduction plan, with documentation of progress.
- Documentation of referrals, including signed release forms and disposition.

Client files may also contain:
- Client risk assessment forms or other intake forms.

### 7.3 Staff Training and Development

In addition to the standards associated with staff training and development described in Section 1 of this document, staff providing HIV counseling must:

- Successfully complete the MDCH HIV Counselor Certification course, including successfully completing the MDCH Basic Knowledge course.
- Participate in MDCH-endorsed updates related to the scientific and public health aspects of HIV, counseling techniques and special topics at least every two years.

**NOTE:** Staff may **NOT** begin providing HIV prevention counseling services prior to successfully completing the MDCH HIV Counselor Certification Course. In addition, any previously certified counselor who has not completed an update for four or more years must successfully complete the MDCH HIV Counselor Certification Course prior to providing services and receiving a counselor identification number from HAPIS/DHAS.

Supervisors of HIV counselors must:

- successfully complete the MDCH HIV Counselor Certification course (5 day).
- successfully complete the MDCH Supervisor Course.
- participate in MDCH-endorsed updates related to the scientific and public health aspects of HIV, counseling techniques and special topics at least every two years.
7.4 **Agency Quality Assurance Protocol**

Each agency must develop a written protocol which addresses individual-level HIV prevention counseling. In addition to the standard components of quality assurance described in Section I of this document, the protocol must address documenting risk reduction plans and referrals.

7.5 **Evaluation and Data Collection**

Standards associated with evaluation and data collection are described in Section 1 of this document.
8. PREVENTION CASE MANAGEMENT

8.0 Definition
Prevention case management (PCM) is an intensive, multi-session individual level intervention. It targets individuals who are at highest risk for HIV transmission or acquisition because of multiple and complex needs.

PCM acknowledges the relationship between HIV risk and other issues (i.e., substance abuse, STD treatment, mental health, and social and cultural factors). It integrates the strategies of prevention counseling and service brokerage to assist clients in adopting and sustaining behaviors which reduce the risk for transmission or acquisition of HIV.

PCM involves the identification of HIV risk behaviors and medical and psychosocial needs that influence HIV risk taking followed by the development of a client-centered prevention plan with specific behavioral objectives for HIV risk reduction. It is different from individual-level HIV prevention counseling in that PCM is longer term and intensive in nature and involves brokerage to supportive services. PCM is different from care case management in that PCM involves negotiation of behavioral risk reduction plans.

8.1 Goal
To assist those at highest risk of HIV transmission or acquisition to identify, adopt, and maintain behaviors which reduce their risk of acquiring or transmitting HIV infection.

8.2 Standards
**Targeted Services.** Prevention case management services are to be targeted to HIV-infected persons or persons who are HIV-uninfected but who engage in ongoing HIV-related risk behaviors (e.g. sex partner to HIV-infected person) and who have attempted without success to adopt and maintain behaviors to reduce their risk for transmission/acquisition of HIV and who experience situational factors which influence their HIV-related risk behaviors (e.g. chronic mental illness, homelessness).

**The Prevention Case Management Process.** All agencies providing Prevention Case Management under contract with MDCH must provide incorporate the following critical elements into PCM services:

*Client Recruitment.*

*Client Engagement.*

*Screening for Eligibility.* A written screening tool must be utilized to identify persons at highest risk for acquiring or transmitting HIV, and to determine who is appropriate and eligible client for PCM services. All persons screened for PCM, including those who are not considered to be appropriate for PCM, must be offered counseling by the prevention case manager or other appropriate agency staff, and referrals relevant to their needs should be made.
Assessment. All PCM clients must participate in a thorough assessment of their HIV, STD, and substance abuse risks and their medical, prevention and psychosocial needs. At a minimum, the following items must be included in the assessment:

- Health status
- Adherence to HIV-related treatment (if relevant)
- STD history
- Drug and alcohol use
- Mental health issues and treatment history
- Sexual history
- Social and environmental support
- Risk reduction skills
- Barriers to risk reduction
- Protective factors, strengths and competencies in the client’s life related to HIV risk reduction. (Specific content of these areas can be found in the CDC HIV Prevention Case Management Guidance, September 1997.)

Prevention case managers must provide clients with an informed consent document for signature at the time of assessment. This document must assure the client of confidentiality, and must lay out the client and agency roles and responsibilities in prevention case management (e.g., time commitment of client, services of the agency, guidelines for discharge and grounds for termination of service if appropriate.)

Development of a Prevention Plan. For each client, a written client-centered prevention plan must be developed with client participation. The plan must define HIV risk-reduction behavioral objectives and strategies for change that are time-phased and achievable.

- Each prevention plan must be client-specific and responsive to the individual client’s needs and circumstances.
- The prevention plan must be signed by both the client and the prevention case manager.
- The prevention plan should specify who is responsible for what and by when.
- The plan should specify when counseling to support adherence to treatment should be provided, if appropriate.
- The prevention plan should describe specific referral needs and priorities.

Monitoring and Reassessment of Client’s Needs and Progress

- Prevention case managers must meet on a regular basis with clients to monitor their changing needs and their progress in meeting behavioral objectives. Progress must be documented in the client’s confidential file.
C A protocol must be established defining minimum, active efforts to retain clients. The protocol should specify when clients are to be made “inactive,” and this term must be defined.

C All attempts/efforts to retain clients in the PCM program must be documented in the client file.

Discharge from PCM. A protocol for client discharge must be established. This protocol should include an after care plan and “relapse protocol” so that the client understands that PCM is available as needed.

Case Load. The case load of an individual prevention case manager is not to exceed 20 active clients.

Coordination of Services/Referrals. Coordination of services and completion of referrals are essential to the success of PCM services. To that end:

C Memoranda of Agreement must be established with relevant service providers to ensure availability and access to key service referrals.

C Communication about a client with other providers must not occur without first obtaining signed, informed consent from the client. Consent must be specific to each provider with whom communication occurs.

PCM must not duplicate care case management for persons living with HIV, but PCM may be integrated into these services.

Record Keeping. Accurate and complete record keeping is essential to quality assured services. Client files are to be maintained for each client participating in prevention case management. Client files must contain:

C a copy of the signed informed consent document

C the negotiated prevention plan with the client’s signature

C documentation of progress toward meeting behavioral objectives

C documentation of referrals made and the status of referrals

C documentation of discharge plans

C copies of referral documents

Risk Reduction Tools. Provision of risk reduction tools appropriate to a client’s behavioral risk are a critical element of PCM effectiveness. Condoms must be made easily available to all clients at risk for sexual transmission/acquisition of HIV.

8.3 Staff Training and Development
In addition to the standards associated with staff training and development described in Section 1 of this document, staff providing Prevention Case Management Services must:

- Successfully complete the MDCH HIV Counselor Certification Course (5 day).
- Successfully complete a HAPIS/DHAS-approved PCM training.
- Participate in MDCH-endorsed updates related to the scientific and public health aspects of HIV, counseling techniques and special topics at least every two years.

NOTE: Staff may NOT begin providing prevention case management services prior to successfully completing the MDCH HIV Counselor Certification Course and a HAPIS/DHAS-approved training in prevention case management.

8.4 Agency Quality Assurance Protocol

Each agency must develop a written protocol which addresses quality assurance in their PCM program. In addition to the standard components of quality assurance described in Section 1 of this document the protocol must address:

**Recruitment.** The protocol must describe methods that will be used to recruit clients for PCM services.

**Engagement.** The protocol must describe the frequency, number and time frame of contacts associated with client engagement.

**Confidentiality and Privacy.** The protocol must describe the strategies used to ensure that client confidentiality is maintained.

**Referral.** The protocol must describe the methods to:

- assist clients to access referrals to needed services
- ensure coordination with relevant service providers
- assess and document referrals

**Record Keeping.** The protocol must describe record keeping policies and procedures, including documentation of risk reduction plans, referrals and client progress toward meeting prevention goals and objectives.

**Coordination with Care Case Management.** An explicit protocol for structuring relationship with care case management providers must be developed, implemented and maintained. It must describe how to transfer and/or share clients.
8.5 Evaluation and Data Collection

Standards associated with evaluation and data collection are described in Section 1 of this document. In addition,

C A system to measure client progress toward achievement of HIV prevention related goals and objectives must be developed, implemented and maintained to demonstrate program effectiveness.

C A system must be developed, implemented and maintained to monitor client utilization and satisfaction with referrals.
9. GROUP-LEVEL HIV PREVENTION COUNSELING

9.0 Definition
Group-level HIV prevention counseling is an interactive process whereby clients are assisted in identifying the specific behaviors which place them at risk for acquiring or transmitting HIV and in making plans for individual behavior change. Group-level HIV prevention counseling can also assist clients in obtaining access to other needed prevention services in clinical and community settings (e.g., referrals).

Group-level HIV prevention counseling is offered over multiple sessions convened during a specific and limited period of time (e.g. one session per week for each of six weeks). Participation in group-level HIV prevention counseling is generally “closed” to other participants at the time of the first session. Optimally, each participant attends every session and groups have a relatively small number of participants.

Group-level HIV prevention counseling differs from support groups in that sessions are structured according to a pre-established curriculum, and specific behavioral outcomes are developed and monitored. Support groups may or may not be “closed” to new members and generally do not have a specified end date.

Group-level HIV prevention counseling differs from “AIDS 101” or group education activities in that multiple sessions are delivered, pursuant to a pre-established curriculum, and specific behavioral outcomes are developed and monitored.

9.1 Goal
Ensure that HIV-infected individuals, and individuals at increased behavioral risk for HIV receive education and counseling to assist them in adopting and maintaining behaviors which reduce risk for transmission or acquisition of HIV.

9.2 Standards
All agencies providing group counseling under contract with MDCH must use the HIV Client-Centered Counseling Model endorsed by MDCH.

The groups must have a time limit set on their existence as a group and should have the same individuals attending every session if multi-session. This “close-ended” model is more suitable to the establishment of client-specific outcome objectives that can be monitored over time (e.g., self-reported reduction in number of sex partners at the end of 8 weeks of group attendance).

The Counseling Process. The following are key steps in client-centered group counseling:
C Introduce/orient clients to session.
C Provide assurance of confidentiality, pursuant to Michigan law.
C Help clients identify risk behavior(s).
C Help clients identify safer goal behavior(s).
C Help clients identify action steps.
C Provide information about appropriate medical, prevention and support services.
C Provide educational materials and risk reduction tools.
C Demonstration from each participant of skills acquired.
C Document risk reduction plan and referrals.

**Setting.** The space for group counseling must be private and conducive to private/personal discussion. Ensuring a client's privacy and confidentiality are essential.

**Counseling Format.** Group counseling must be provided face-to-face to a group of individuals.

### 9.3 Staff Training and Development

In addition to the standards associated with staff training and development described in Section 1 of this document, staff providing HIV counseling must:

- C Successfully complete the MDCH Basic Knowledge course.
- C Successfully complete the MDCH HIV Counselor Certification course (5 day).
- C Participate in MDCH-endorsed updates related to the scientific and public health aspects of HIV, counseling techniques and special topics at least every two years.

Supervisors of counseling staff must be credentialed by MDCH. This includes:

- C Successful completion of the MDCH HIV Counselor Certification (5 day).
- C Successful completion of the MDCH Supervisor Course.
- C Participate in MDCH-endorsed updates related to the scientific and public health aspects of HIV, counseling techniques and special topics at least every two years.

Agencies that provide group counseling must be facilitated by persons who meet the following criteria:
Professional Facilitator/Educator: A person who has experience in facilitation of groups and an understanding of group dynamics and processes. This individual may include (but is not limited to) an HIV educator, licensed therapist or other counseling professional.

Or

Peer Facilitator/Educator: a peer is a person who has a shared identity with the targeted community or group. Peer facilitators/educators must have training and/or experience in facilitation of groups and an understanding of group dynamics and processes.

9.4 Agency Quality Assurance

Each agency must develop a written protocol which addresses group-level HIV prevention counseling. In addition to the standard components of quality assurance described in Section 1 of this document, the protocol must address mechanisms for documenting client risk reduction plan and referrals.

9.5 Evaluation and Data Collection

Standards associated with evaluation and data collection are described in Section 1 of this document.
10. SUPPORT GROUPS

10.0 Definition
Support groups are a gathering of individuals with like needs who offer support to one another through sharing, discussion and empathy. Support groups are convened over multiple sessions to groups of varying sizes (two or more participants) with a focus of providing social support for participants, including support for the adoption and maintenance of HIV-related risk reducing behaviors as well as psychosocial support related to HIV or associated issues. Support groups are generally not guided by a pre-established curriculum and do not have specific behavioral outcomes associated with them. Support groups generally have “open” membership and do not usually have a specified end date.

A support group differs from group-level HIV prevention counseling in that group-level HIV prevention counseling is guided by a pre-established curriculum, is associated with specific behavior objectives, membership is “closed” after the first session, and meetings occur over a pre-determined number of sessions over a relatively short period of time.

10.1 Goals
To encourage development of supportive norms that facilitate adoption and maintenance of behaviors that reduce the risk for transmission and/or acquisition of HIV.

10.2 Standards

Support Group Setting and Format. Support groups must:
  C Be provided in an environment which ensures participant confidentiality.
  C Be held at an agreed upon time, date and location that is accessible to the individuals it serves.

Support Group Content. Support groups must:
  • Include referral to mental health services, if appropriate. Immediate referral for crisis counseling must be made available.
  • Include provision of educational materials, referrals and information to substantiate discussion.

Support Group Facilitation.
Facilitator Knowledge and Skills. Facilitators of support groups must possess the knowledge and skills to:
  • Manage group dynamics, including conflict.
  • Act as a resource for group members.
Facilitate the group appropriately, including ensuring that all members are able to actively participate and that the group remains focused.

Monitor and document group participation.

Confidentiality Statements. Support group facilitators and participants should sign confidentiality statements. Since support groups are ongoing and new members may join at any time, confidentiality should always be discussed when new members enter the group.

Ground Rules/Rules of Conduct. Support group activities should be guided by Ground Rules or Rules of Conduct.

10.3 Staff Training and Development

In addition to the standards associated with staff training and development described in Section 1 of this document, staff providing support groups must:

- Successfully complete the MDCH Basic Knowledge course.
- Participate in MDCH-endorsed updates related to the scientific and public health aspects of HIV, counseling techniques and special topics at least every two years.

Agencies that provide support groups must be facilitated by persons who meet the following criteria:

C Professional Facilitator/Educator: A person who has experience in facilitation of groups and an understanding of group dynamics and processes. This individual may include (but are not limited to) an HIV educator, licensed therapist or other counseling professional. Note: training described above is strongly recommended, but not required, for credentialed therapists and counseling professionals.

Or

C Peer Facilitator/Educator: A peer is a person who has a shared identity with the targeted community or group. Peer facilitators/educators must have training and/or experience in facilitation of groups and an understanding of group dynamics and processes.

10.4 Agency Quality Assurance

Each agency must develop a written protocol which addresses support group activities. In addition to the standard components of quality assurance described in Section I of this document, the protocol must address:

Confidentiality. The protocol must describe the strategies used to ensure that client confidentiality is maintained.
**Record Keeping.** The protocol must describe the methods used to document and monitor support groups including participant attendance, issues addressed by the group during each session, referrals made, as well as any outstanding issues.

**Client Safety.** The protocol must describe the methods used for crisis intervention.

**Barriers to Participation.** The protocol must describe the methods by which barriers to participation are addressed (e.g. transportation vouchers, child care reimbursement).

### 10.5 Evaluation and Data Collection

Standards associated with evaluation and data collection are described in Section 1 of this document.
11. SKILLS-BUILDING WORKSHOPS

11.0 Definition
Skills-building workshops are single-session health education interventions designed to assist participants to develop one or more specific HIV-related risk reducing behaviors. Each participant in a skills-building workshop is expected to demonstrate attainment of these skills. Role playing or other participant demonstrations of skills must be included and assessed in skills-building workshops.

11.1 Goal
To ensure that all participants learn or enhance their abilities to engage in one or more specific HIV-related risk reducing behaviors. Secondarily, participants will increase self-efficacy (e.g., I can do it) and behavioral intent toward adoption of an HIV-related risk reduction behavior (e.g., condom use).

11.2 Standards
All agencies providing skills-building sessions under contract with MDCH must have each participant demonstrate attainment of one or more skills. Workshops must be interactive structured with specific learning objectives and defined activities. Ample time must be allowed for discussion and participant demonstration of skills. Educational materials to substantiate discussion must be provided. Examples of skills-building workshops include the following:

Condom Demonstration. Demonstrate, and have each participant demonstrate the correct way to use a condom. The following must be addressed:

- Expiration date.
- How the condom is to be stored.
- Description of the correct types of lubricant.
- How to open the package correctly.
- Proper placement of the condom.
- Proper removal of the condom.
- Proper disposal of the condom.

Dental Dam Demonstration. Demonstrate, and have each participant demonstrate the correct way to use a dental dam or an alternative latex barrier. The following must be addressed:

- How the dental dam is to be stored.
- Where the dental dam is to be placed.
- Description of the correct types of lubricant.
• Description of alternative barriers.

Negotiation - Safer Sex/Abstinence. Safer sex negotiation skills, safer sex negotiation with examples and modeling, and sexual abstinence as an effective HIV prevention method must be presented during a group session.

One or more of the following must be discussed and demonstrated by each participant (for example, through role plays):

• Assertiveness.
• Communication skills.
• Refusal Skills.
• Decision-making skills.

Needle Use/Abstinence from Use of Drugs. The need for safer needle use and abstinence from use of drugs as an effective HIV prevention method must be presented during a group session. The intervention must include detailed information on disinfection techniques. Each participant must demonstrate these techniques. Other information must include risks associated with sharing needles and equipment for any use (e.g., tattoos, piercing, injecting drugs) and proper disposal of injection equipment. The staff should discourage the reuse of needles, cookers and other possibly contaminated items. Staff should have information available to facilitate referral to medical, prevention, and support services.

11.3 Staff Training and Development

In addition to the standards associated with staff training and development described in Section 1 of this document, staff providing skills-building workshops must possess:

• Scientifically accurate and current information related to HIV/AIDS (e.g. etiology, transmission, prevention, etc.)
• Knowledge of relevant community resources, including how to access them.
• Ability to present information in language the audience can understand.

In addition, the following areas of knowledge and skills are strongly recommended for all staff facilitating skills-building workshops:

• STD/HIV/TB interaction.
• Viral hepatitis.
• Group facilitation.

In addition, the following knowledge and skills may be appropriate:

• Assessment and evaluation skills.
• Presentation skills.
• Communication/engagement skills.
• Substance use issues.
• Sexuality (human growth and development and sexual orientation).
• Cultural issues, including training in cultural competence.
• HIV counseling, testing and referral.
• Psycho-social aspects of HIV.
• Domestic violence.
• Parental/child health issues.
• Stress/burnout reduction.
• HIV reporting.

All staff providing skills-building workshops must participate in relevant educational updates at least every two years.

11.4 Agency Quality Assurance Protocol

Each agency must develop a written protocol which addresses skills-building workshops. The standard components of quality assurance are described in Section 1 of this document.

11.5 Evaluation and Data Collection

Standards associated with evaluation and data collection are described in Section 1 of this document.
12. INFORMATIONAL SESSIONS

12.0 Definition
Informational sessions (e.g., AIDS 101, Safer Sex Presentations, PLWH/A Speakers) are one-time educational presentations covering topics such as: HIV/AIDS, STDs, Substance Use/Abuse, Safer Sex and Viral Hepatitis. Informational Sessions do not include a skills-building component, that is, there is no participant demonstration of skills. Although the staff conducting the informational session may demonstrate a skill (e.g., how to put on a condom), this intervention is not intended to have all participants learn and demonstrate specific skills. Informational sessions should be tailored to the unique needs of the target audience.

12.1 Goal
To raise awareness about HIV/AIDS-related issues, promote supportive attitudes and social norms, and to increase knowledge of modes of HIV/AIDS transmission and prevention strategies.

12.2 Standards
The content of the informational session must:

- Be scientifically accurate and current
- Be appropriate to the target population

Educational materials to substantiate discussion must be provided and information to facilitate referrals must be available. Appropriate risk reduction tools should be made available to participants.

12.3 Staff Training and Development
In addition to the standards associated with staff training and development described in Section 1 of this document, staff providing informational sessions must possess:

- Scientifically accurate and current information related to HIV/AIDS (e.g. etiology, transmission, prevention, etc.)
- Knowledge of relevant community resources, including how to access them.
- Ability to present information in language the audience can understand.

The following areas of knowledge and skills are strongly recommended for all staff presenting informational sessions:

- HIV epidemiology and etiology.
- HIV prevention/risk reduction.
- STD/HIV/TB interaction.
• Viral hepatitis.
• Presentation skills.

In addition, the following knowledge and skills may be appropriate:
• Communication/engagement skills.
• Substance use issues.
• Sexuality (human growth and development and sexual orientation).
• Cultural issues, including training in cultural competence.
• HIV counseling, testing and referral.
• Psycho-social aspects of HIV.
• Domestic violence.
• Parental/child health issues.
• Stress/burnout reduction.
• HIV reporting.

All staff providing informational session must participate in relevant educational updates at least every two years.

12.4 Agency Quality Assurance Protocol
Each agency must develop a written protocol which addresses informational sessions. The standard components of quality assurance are described in Section 1 of this document.

12.5 Evaluation and Data Collection
Standards associated with evaluation and data collection are described in Section 1 of this document.
13. OUTREACH

13.0 Definition
Outreach is a relatively brief intervention conducted one-to-one with individuals at increased risk for transmission or acquisition of HIV/AIDS, in settings where they socialize or congregate. Outreach includes exchange of information designed to provide each individual contacted with information on their personal risk for transmission/acquisition of HIV/AIDS, risk reduction strategies and information on medical, prevention and supportive services. Outreach is usually accompanied by the distribution of condoms, bleach, safer sex kits, and educational materials (brochures). Outreach differs from individual-level HIV prevention counseling in that it is a relatively brief intervention and an individualized risk reduction plan is not developed.

13.1 Goal
To increase knowledge and awareness of HIV/AIDS issues, personal risk for HIV/AIDS, preventive strategies and relevant community resources.

13.2 Standards
Outreach activities must:

- Be provided to one individual at a time.
- Include individualized risk and risk reduction information.
- Be provided in settings and during times appropriate to the target population. Venues may include: bars/clubs, beauty salons/barber shops, shelters, parks, soup kitchens, migrant camps, street, highway rest areas, and shooting galleries.
- Be accompanied by distribution of risk reduction tools and educational materials (e.g. condoms, brochures).
- Present scientifically accurate and current information.
- Provide information to facilitate access to medical, prevention and support services.

In addition to “street” outreach, this intervention can be delivered in the form of:

Bar and Home Parties. Bar Parties are one form of outreach conducted in bars, clubs or similar venues. The feature that distinguishes bar parties from outreach at bars is that bar parties are centered around a particular theme or activity. Home Parties are an outreach intervention conducted in a private home. This is an informal activity that provides basic HIV information regarding transmission, prevention, and safer sex options.
13.3 Staff Training and Development

In addition to the standards associated with staff training and development described in Section 1 of this document, staff providing outreach must possess:

- Scientifically accurate and current information related to HIV/AIDS (e.g., etiology, transmission, prevention, etc.)
- Knowledge of relevant community resources, including how to access them.
- Ability to present information in language the audience can understand.

In addition, the following areas of knowledge and skills are strongly recommended for all staff providing outreach:

- STD/HIV/TB interaction.
- Viral hepatitis.
- Communication/engagement skills.
- Presentation skills.

The following knowledge and skills may be appropriate:

- Substance use issues.
- Sexuality (human growth and development and sexual orientation).
- Cultural issues, including training in cultural competence.
- HIV counseling, testing and referral.
- Psycho-social aspects of HIV.
- Domestic violence.
- Parental/child health issues.
- Stress/burnout reduction.
- HIV reporting.

Supervisors and staff who provide outreach as their primary job responsibility (greater than 51% of their time) are strongly encouraged to complete a specialized training in outreach worker skills and strategies. All staff providing outreach services must participate in relevant educational updates at least every two years.

13.4 Agency Quality Assurance Protocol

Each agency must develop a written protocol to address outreach activities. In addition to the standard components of quality assurance described in Section 1 of this document, the quality assurance protocol must address:

- Methods used to determine the locations, times of day, and the day of the week that are most productive for reaching the target population.
- Safety of outreach workers.
C Adherence to established schedule and locations for outreach activities.
C Client confidentiality.
C Relapse prevention plan for staff who are recovering substance abusers.

13.5 Evaluation and Data Collection
Standards associated with evaluation and data collection are described in Section 1 of this document.
14. COMMUNITY LEVEL INTERVENTIONS

14.0 Definition

Community level interventions seek to influence attitudes, knowledge and awareness about HIV/AIDS issues. The focus of community level interventions are on the community as a whole, rather than on individuals or small groups. Community may be defined as “general public” or some specific sub-population (e.g. racial/ethnic communities). Community level interventions include community-wide events and community mobilization activities. These events may include walks, health fairs, ethnic fairs, and gospel festivals.

Community level interventions do not include events organized by other agencies. All the components of the event must be developed by the agency from the beginning to the end, including evaluation and/or follow-up.

14.1 Goal

The goal of community level interventions is to raise community awareness about HIV/AIDS prevention issues and to influence community norms and values.

14.2 Standards

All agencies providing Community Level Interventions under contract with MDCH must:

- Hold the event in a space that is easily accessible to the community.
- Provide scientifically accurate and current information about HIV/AIDS, including etiology, transmission modes and prevention strategies.
- Provide information to facilitate access to medical, prevention and support services, including counseling, testing and referral.
- Be staffed by individuals who are knowledgeable about HIV/AIDS and the agency’s services.
- Provide appropriate risk-reduction educational materials and brochures.

In addition, the agency may provide risk-reduction supplies (e.g., condoms, safer sex kits, hygiene kits, bleach kits)

14.3 Staff Training and Development

In addition to the standards associated with staff training and development described in Section 1 of this document, staff participating in community level interventions must possess:
• Scientifically accurate and current information related to HIV/AIDS (e.g. etiology, transmission, prevention, etc.).
• Knowledge of relevant community resources, including how to access them.
• Ability to present information in language the audience can understand.

In addition, the following areas of knowledge and skills are **strongly recommended** for all staff participating in community level interventions:

• STD/HIV/TB interaction.
• Viral hepatitis.
• Communication/engagement skills.

The following knowledge and skills may be appropriate:

• Substance use issues.
• Sexuality (human growth and development and sexual orientation).
• Cultural issues, including training in cultural competence.
• HIV counseling, testing and referral.
• Psycho-social aspects of HIV.
• Domestic violence.
• Parental/child health issues.
• Stress/burnout reduction.
• HIV reporting.

All staff participating in community level interventions must participate in relevant educational updates at least every two years.

### 14.4 Agency Quality Assurance Protocol

Each agency must develop a written protocol which addresses Community Level Interventions. The standard components of quality assurance described in Section 1 of this document.

### 14.5 Evaluation and Data Collection

Standards associated with evaluation and data collection are described in Section 1 of this document.
15. DISPLAY TABLE AT EVENT

15.0 Definition
Display tables are informational displays set up at events that provide HIV information and materials in order to raise awareness about prevention issues and community resources. Venues may include walks, health fairs, ethnic fairs, etc. and are usually events organized by other agencies. **Display tables cannot be funded as a stand-alone intervention, and must be coupled with one or more MDCH-approved interventions (e.g., Individual, Group, PCM, or CTR).** This does not include tables set up at events that your agency has organized (see Section 14, Community Level Interventions).

15.1 Goal
To raise community awareness about HIV/AIDS prevention issues; to introduce the agency to interested community members and to provide educational information, risk-reduction supplies and resource information, as needed.

15.2 Standards
This section addresses overarching quality assurance standards for display tables. Display tables must:

- Be placed in a setting that is accessible to the targeted community.
- Provide scientifically accurate and current information about HIV/AIDS, including etiology, transmission modes and prevention strategies.
- Provide information to facilitate access to medical, prevention and support services, including counseling, testing and referral.
- Be staffed by individuals who are knowledgeable about HIV/AIDS and the agency’s services.
- Provide appropriate risk-reduction educational materials and brochures.

15.3 Staff Training and Development
In addition to the standards associated with staff training and development described in Section 1 of this document, staff or volunteers participating in display table activities must complete an orientation to the agency’s services.

15.4 Agency Quality Assurance Protocol
Each agency must develop a written protocol which describes the orientation to the agency’s services. The standard components of quality assurance described in Section 1 of this document.

15.5 Evaluation and Data Collection
Standards associated with evaluation and data collection are described in Section 1 of this document.
16. MATERIALS DISTRIBUTION

The distribution of educational and risk reduction materials is an important part of HIV/AIDS prevention services. Materials which may be distributed include agency brochures, educational materials approved by the MDCH Program Review Panel, safer sex kits, hygiene kits, bleach and condoms. All educational and informational materials must be approved by the MDCH Program Review Panel and contain scientifically accurate and current information.

NOTE: MDCH does not support materials distribution as a “stand-alone” intervention.