

**QUALITY ASSURANCE**  
**OF**  
**HIV PREVENTION COUNSELING:**  
**A TOOLBOX FOR SUPERVISORS**

**Michigan Department of Community Health,  
Division of Health, Wellness and Disease Control  
HIV/AIDS Prevention and Intervention Section**

**June 2008**

Revised 06/23/08



# Quality Assurance of HIV Prevention Counseling:

## QA Toolbox



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**Advisory Committee:** The following people have served on an ad hoc advisory committee for the development of the Quality Assurance of HIV Prevention process and toolbox: Nicole Adelman (HARC), Bob Barrie (HAPIS), Crystal Brown-Jenkins (HAPIS—Detroit HD), Denise Bryan (Kent Co HD), Anthony Harden (HAPIS-- Detroit HD), Deanna Hurlbert (HAPIS), Angie Kaiser (MAPP), Amna Osman (Wellness AIDS Services), Amy Peterson (HAPIS), Angela Prince-May (MDCH/STD), Kimberly Snell (HAPIS), Jeanne Sullivan (Ingham Co HD), Lisa Taton-Murphy (HAPIS), Michelle Thorne (Kalamazoo Co HCS)  
Note: the recommendations and materials contained in this Toolbox do not necessarily reflect the opinions of the committee members on all issues.

The work of several other State Health Departments was very useful in creating this Toolbox, in particular— the states of Colorado, Texas, and Connecticut.

Several of the pieces in this Toolbox draw extensively from the work of Joan Garrity and Sally Jones in their training manual, developed for the Centers for Disease Control and Prevention, "Assuring the Quality of HIV Prevention Counseling: A Workshop for Supervisors" (1995)

Supported under a grant from the Michigan Department of Community Health, Division of Health, Wellness and Disease Control, HIV/AIDS Prevention and Intervention Section. Direct correspondence to Liisa Randall, 109 Michigan Avenue, Lansing MI 48913, 517-241-5924. Materials and information may be freely used for HIV/AIDS prevention counseling and testing activities. Appropriate citation is required in publications utilizing this Toolbox.

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# Quality Assurance of HIV Prevention Counseling: Introduction

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## **Background:**

The Michigan Department of Community Health (MDCH), Division of Health, Wellness and Disease Control (DHWDC) maintains an ongoing commitment to expanding its capacity, expertise, and rigor in assuring the quality of the HIV interventions funded by the State. Prevention/test counseling is the HIV prevention service that impacts the greatest number of clients and utilizes the greatest amount of resources. We know, through the national research from Project RESPECT, that prevention counseling conducted according to the CDC standards and guidelines, is effective in assisting clients to reduce their risks. DHWDC has undertaken this project to explore the strengths and weaknesses of HIV prevention counseling in funded sites in Michigan, relative to established standards, and to identify needs for additional training and technical assistance.

## **Goal:**

The goal of the quality assurance (QA) project is to enhance the assessment and feedback process in order to improve the quality and effectiveness of HIV prevention/test counseling in HAPIS-contracted agencies. The key components of the project are:

- To develop written protocols to guide the processes of assessing the quality of counseling and providing useful feedback to agencies and staff.
- To facilitate the use of the protocols by HAPIS staff and by counseling supervisors through training and consultation
- To identify training and technical assistance needs through assessment of HIV prevention counseling skills and practices

This project does not replace or duplicate any existing monitoring or accreditation processes. This project focuses specifically on the interaction between counselor and client, rather than all of the components of an HIV services program (e.g. data collection, laboratory procedures, etc.) This project emphasizes quality assurance as a learning experience for all involved.

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## Process:

In the course of developing the recommendations and strategies for this project, several types of formative research were done. Quality assurance practices and tools from a number of different states were examined, in particular Texas, Connecticut and Colorado, as well as a half dozen other states and several international programs. In addition, field observations and structured interviews with HIV prevention counselors were done in six agencies in Michigan—three community based organizations and three local health departments.

Finally, and very importantly, an ad hoc advisory committee was convened which included HIV prevention counseling supervisors from local health departments and community-based organizations. The committee members were generous with their time and thoughtfulness as they discussed a number of the issues related to quality assurance. Their guidance was invaluable in the development of this Quality Assurance Toolbox and the processes outlined within. At the same time, it should be noted that the participation of these experienced individuals does not necessarily signify their agreement with every recommendation contained in the Toolbox.

## The QA Toolbox:

This QA Toolbox was designed originally for dual purposes: for use by monitors and staff from MDCH/HAPIS and for use by HIV Prevention Counseling supervisors themselves to support both the quality assurance process of HAPIS and agencies' internal QA processes. Every attempt has been made to clearly delineate in this version the recommendations and/or instructions that apply specifically to HIV Prevention Counseling supervisors in their work with their counseling staff. The Toolbox is a "work in progress", and, as such, any and all feedback is welcome. Please direct comments, edits and questions to: Ellen Ives, PO Box 158, East Lansing, MI 48826 or [ellenives@yahoo.com](mailto:ellenives@yahoo.com).

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# Section I:

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### Creating a "Culture of Quality"

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# Quality Assurance of HIV Prevention Counseling



## 1: The Nuts and Bolts of QA!

### QA: Why do it?

- ❑ The quality of HIV prevention counseling matters! HIV prevention counseling that follows the recommended CDC standards and guidelines is **effective** in reducing clients' risk behaviors.
- ❑ HIV prevention counseling is too costly not to take full advantage of the opportunity it presents.

### QA Defined:

Quality Assurance (QA) is a planned and systematic set of activities designed to ensure that requirements are clearly established, standards and procedures are adhered to, and the work products fulfill requirements or expectations.

### QA: There's a lot to it!

There are many components to a quality assurance process:

- ❑ Setting standards/expectations
- ❑ Training
- ❑ Assessing what is happening
- ❑ Providing feedback on assessments
- ❑ Strategizing for supporting positive work and reducing deficits

Much of this process is in place: the document "The Building Blocks of Quality Assurance" provides a quick overview of each component, as related to HIV prevention counseling in Michigan.



# Quality Assurance of HIV Prevention Counseling

## 2: Everyone's a winner!



### Advantages for clients:

- ❑ Makes high-quality counseling a priority
- ❑ Improves service quality and continuity
- ❑ Helps clients reduce their risks of HIV/STD/HepC

### Advantages for counselors:

- ❑ Showcases counselor achievements and strengths
- ❑ Clarifies expectations
- ❑ Provides an opportunity to ask questions, get immediate feedback
- ❑ Provides an opportunity to broaden skills
- ❑ Shows the State the daily challenges/realities of the work

### Advantages for supervisors:

- ❑ Gives supervisor a second opinion; validates/confirms supervisor opinion
- ❑ Gives supervisor concrete tools to use in internal QA processes
- ❑ Feedback from State is a powerful motivator

### Advantages for agencies:

- ❑ Showcases agency strengths
- ❑ Positive feedback from the State is powerful
- ❑ Builds or enhances relationship with State
- ❑ Quality assurance is on broad, transferable counseling skills used in many other (non-HIV) settings that may not be getting QA

### Advantages for the State:

- ❑ Improves the State training program; creates closer links between training and field
- ❑ Builds relationships with agencies, supervisors, counselors
- ❑ Draws on expertise and experience in the field
- ❑ Documents appropriate use of resources
- ❑ Improves outcomes of funded activities



# Quality Assurance of HIV Prevention Counseling:



## 3: The Building Blocks (an overview)

### Standards for HIV Prevention Counseling:

The standards for HIV prevention/test counseling are based on the results of national research, expert opinion, legal requirements, and the experience of agencies and individual counselors and clients. The standards are reflected in a number of documents:

- ❑ Revised Guidelines for HIV Counseling, Testing, and Referral (Centers for Disease Control and Prevention, 1991)  
Available at [www.cdc.gov/hiv/resources/guidelines/index.htm](http://www.cdc.gov/hiv/resources/guidelines/index.htm)
- ❑ Quality Assurance Standards for HIV Prevention and Interventions (MDCH, May 2003) Available at [www.mihivnews.com/hapis/hapis\\_prevention.htm](http://www.mihivnews.com/hapis/hapis_prevention.htm)
- ❑ Individual agency policies and standards
- ❑ "Best practice" guidance shared between agencies

### Training:

Training is the mortar that holds all the rest of the quality assurance process together. Training includes both information and skills-building.

Training in Michigan includes:

- ❑ HIV Counselor certification (Modules 1,2, and 3)
- ❑ HIV Counselor updates
- ❑ Supervisor training
- ❑ On-site orientation/training

### Assessment:

Assessing the quality of HIV prevention counseling may take many forms:

- ❑ Chart reviews
- ❑ Team meetings
- ❑ Case conferencing
- ❑ Case debriefing
- ❑ Client exit interviews
- ❑ Client surveys
- ❑ Audio-taped counseling sessions
- ❑ Role-played counseling sessions
- ❑ Directly observed counseling sessions
- ❑ "Secret shoppers" (trained "clients")



# Quality Assurance of HIV Prevention Counseling

## 4: The Blueprint: Standards for Counseling



### CDC Standards:

"The following elements should be part of all HIV prevention counseling sessions":

- ❑ Keep the session focused on HIV risk reduction
- ❑ Include an in-depth, personalized risk assessment.
- ❑ Acknowledge and provide support for positive steps already made.
- ❑ Clarify critical rather than general misconceptions.
- ❑ Negotiate a concrete, achievable behavior-change step that will reduce HIV risk.
- ❑ Seek flexibility in the prevention approach and counseling process.
- ❑ Provide skill-building opportunities.
- ❑ Use explicit language when providing test results.

### MDCH Standards:

The following are additional key standards related to the provision of HIV prevention counseling in the context of HIV testing:

- ❑ Provide information about HIV testing, including anonymous option
- ❑ Discuss/explain legal issues: confidentiality, anti-discrimination, the disclosure law
- ❑ Explain Partner Counseling and Referral Services (PCRS)
- ❑ Ensure understanding of informed consent
- ❑ Obtain written informed consent
- ❑ Provide appropriate referrals, as needed
- ❑ Provide educational and risk reduction tools
- ❑ Document risk reduction plan and referrals

### References:

- ❑ Revised Guidelines for HIV Counseling, Testing, and Referral (Centers for Disease Control and Prevention, 2001)
- ❑ Quality Assurance Standards for HIV Prevention and Interventions (MDCH, May 2003)



# Quality Assurance of HIV Prevention Counseling:



## 5: What IS "Good Counseling?"

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### Definitions:

"**HIV Prevention Counseling** is a client-centered exchange designed to support individuals in making behavior changes that will reduce their risk of acquiring or transmitting HIV....'Client-centered' means that counseling is tailored to the behavior, circumstances, and special needs of a person...."

"**Counseling** is communication, both verbal and non-verbal, made in response to and in the presence of feelings. It is the work of supporting someone in making decisions when their willingness or ability to act is affected by their feelings. Effective counseling can help a client to explore, express, understand and accept feelings so that she/he can make decisions."

HIV Prevention Specialist Training: Module 2 (CDC adapted by MDCH, revised 01/06)

### Critical Counseling Concepts and Skills:

- ❑ Focus on feelings (address feelings first, reflect feelings)
- ❑ Manage your own discomfort (manage personal issues, self-disclosure)
- ❑ Set boundaries (establish clear roles and responsibilities, practice supportive detachment)
- ❑ Open questioning
- ❑ Attending
- ❑ Paraphrasing
- ❑ Offering options, not directives
- ❑ Reframing
- ❑ Confrontation
- ❑ Giving information simply



## Over-arching Questions:

Here are some sample questions to ask about a counseling session to help determine how well it went:

- ❑ Who did most of the talking—the counselor or the client?
- ❑ How engaged was the client in the counseling process and the development of the risk reduction plan?
- ❑ How does the client feel about, and what does the client understand about, his or her level of risk?
- ❑ What does the counselor understand about the client's risk?
- ❑ Is the client leaving with a clear and incremental plan to reduce their risk of HIV/STD/HepC, which fits with their unique life?
- ❑ How likely is it that the client will be able to follow the risk reduction plan?
- ❑ How supportive was the counselor? What did the counselor do to make the client feel welcome, comfortable, safe and not judged?
- ❑ What went well in this session?
- ❑ What, if anything, about the dynamics or discussion in this session was unsettling?
- ❑ How likely is it that the client will come back?

## What Does Good Counseling Look Like to YOU?

What other questions might you ask? What do YOU look for in a good counseling session?

## Resources:

- ❑ MDCH/HAPIS Trainings and Training Manuals
- ❑ Focus: A Guide to AIDS Research and Counseling (a journal of the University of California San Francisco AIDS Health Project)
- ❑ HIV Prevention Counselor (a newsletter of the UCSFAIDS Health Project)
- ❑ See articles in resource section (Section IV):
  - "The Art of Effective Risk Reduction Counseling," Focus: A Guide to AIDS Research and Counseling (vol.20,no. 7, August 2005)
  - "Approaches to HIV Counseling,"
    - HIV Counselor Perspectives (vol. 13, no.4, October 2004)



# Quality Assurance of HIV Prevention Counseling: 6: Pros and Cons of Assessment Methods



<b>Assessment Method</b>	<b>Description</b>	<b>Pros</b>	<b>Cons</b>
Chart Reviews	Charts are reviewed for inclusion of required elements.	Unobtrusive; quick; impersonal; objective	Charting practices not always standardized; counselors may be deficient in charting but good in counseling or vice versa; chart selection may miss counselors or sites; by necessity charting is usually very brief (doesn't provide a full picture)
Direct observation of counseling sessions	An observer sits in with counselor doing a "live" counseling session	Best view of what is really happening in session; observer can see non-verbals; observer can see entire interaction as it happened (vs. as it is reported by counselor)	Potential for client discomfort; counselor discomfort may negatively impact session; time-consuming; can usually only see small sample of sessions; feedback relies on observer's ability to observe and remember
Observation of role plays	An observer sits in on a role play in which staff play the roles of counselor and client	Doesn't impact real clients; role plays can be scripted to create specific scenarios to observe	Counselor discomfort may negatively impact session; difficulty of maintaining roles to achieve realism; time-consuming for all
Observation of audio-taped counseling session	An observer reviews the audio-tape of a "live" counseling session	Records actual counseling; audio-tape can be stopped and re-played for clarification; provides documentation of session	Potential client concerns about confidentiality; counselor discomfort with audio-tape process



Client surveys	Clients are given written surveys to complete about their experience	Quick; easy; provides written documentation for reporting; can get feedback from large number of clients	Client reactions to counselor and session may not be accurate reflection of quality of counseling; relies on return of survey; self-selected sample
Case conferencing, formal	Staff prepare and discuss specific counseling sessions, following a format for presentation and discussion	Counselors reflect in depth on specific case; guided discussion may facilitate more complete analysis of client situation and counseling response	Relies on counselor to acknowledge and bring up counseling challenges; requires good facilitation questions to draw out issues
Case conferencing, informal	Counselors discuss sessions with peers or supervisors on an as-needed or debriefing basis	Takes advantage of "teachable moments" when counselors are seeking help; is counselor-driven; convenient	Used usually with the most challenging client situations; may not get at routine counseling skills (i.e. focus may be on the client's situation vs. on the counselor's skills)
"Secret Shoppers"	Trained outsiders are used to pose as real clients, experience counseling, and provide detailed feedback on session	Provides unadulterated look at counseling; counselors will not have anxiety of being observed	Expensive-- "shoppers" need to be skilled and trained in both acting in specific client roles as well as observing and providing detailed feedback on counseling skills; counselors may feel "betrayed"; "shoppers" need to keep own issues out of sessions; "shoppers" will be repeatedly tested



# Quality Assurance of HIV Prevention Counseling:



## 7. Addressing Barriers

Counselors (and supervisors) may have concerns about the process and impact of quality assurance practices. It is important to address potential concerns up-front, either through the manner of setting up QA procedures or directly through discussion.

<b>Barriers</b>	<b>Strategies to Surmount</b>
Concern about negative impact on client (both re: counseling experience and re: confidentiality)	Review process to assure confidentiality and obtain client consent. Emphasize voluntary nature and that clients may refuse. Discuss other settings where people experience having observers in room. Emphasize with clients that observers are learning about how staff work.
Counselor anxiety about consequences for themselves	When QA is done as an agency's internal process, supervisors need to be clear that the purpose is improvement of services, not personnel evaluation (unless it IS for evaluation purposes!) In a HAPIS review, observation of counselors is not related to evaluation of individual personnel, but rather to observation of patterns or similarities among counselors within the agency
Time (for preparing counselors, facilitating site visit, doing feedback sessions)	Much of what is done in a quality assurance review may be done anyway—reviewing standards with counselors, reviewing cases, etc. Observations by the supervisor will take time and should be scheduled with an agency or a counselor on a day/date that will minimize inconvenience.
Perception of additional burden (“another hoop to jump through”)	It is an additional burden, yet it is one which gets at the core issues of service provision.



<p>Concern about the supervisor's lack of expertise in doing this kind of evaluation</p>	<p>The QA process is a learning experience for all. Supervisors should have been through the HAPIS counselor certification training, and, in addition, to the HAPIS Supervisor course: Assuring the Quality of HIV Prevention Counseling, which focuses on assessment of counseling.</p>
<p>Concern about negative consequences of a review with other staff (confidentiality of findings, reputation, standing with other staff, impact on funding)</p>	<p>Findings will not be shared with other staff, except as aggregate or generalizable information.</p>
<p>Concern that the process will not be fair</p>	<p>The process has been designed to be as standardized as possible, and is based on existing written standards and guidelines, as well as on the training required for all counselors by MDCH. Counselors should be given the QA assessment tools and information about the process ahead of time.</p>



# Section II:

## Conducting Assessments

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# Quality Assurance of HIV Prevention Counseling:

## 1: QA Assessment Logistics



### Purpose of doing QA

The purpose of engaging in concerted quality assurance assessments is:

- ❑ To enhance the quality of HIV prevention counseling in a MDCH-HAPIS funded or contracted site.

The objectives of the quality assurance process are to:

- ❑ familiarize supervisor and counselors with various quality assurance practices
- ❑ learn more about the nature of client risk and HIV prevention as seen in the field.
- ❑ explore the strengths and challenges of HIV prevention counseling in the agency, and
- ❑ identify needs for additional training and technical assistance.

The primary purpose of quality assurance is not necessarily to conduct individual personnel evaluations, although individual counselors' work will be reviewed and observed, but rather to identify and explore common patterns of counseling issues, and provide support for enhancing the quality of counseling, for individual counselors and in the agency as a whole.

### Advance Preparations:

In advance of setting up formal assessments, it may be helpful for the supervisor to review and print out:

- ❑ **Agency testing data:** total number of tests/year (anonymous and confidential), total number of positives/year, post-test counseling return rates, number of sites, number of tests/site
- ❑ **Agency counselor data:** number of counselors, number of tests/counselor/year, training history of counselors (when trained, when updated.) Certification and update information is available from HAPIS.



This information will give the supervisor an objective picture of the work load of particular sites and counselors and also guide the supervisor in choosing session days/times to observe. Additionally, if there are counselors listed with no tests done in the previous year, then there may need to be a discussion about keeping counselors "on-call" who have inadequate experience in counseling.

### **Advance Communication:**

**Prior** to embarking on formal quality assurance processes, the supervisor should prepare the counselors by distributing and discussing information on quality assurance and sharing the tools which will be used in assessments. The following documents may be helpful to share:

- QA Toolbox documents
  - Section I- 1: Nuts and Bolts
  - Section I-2: Everyone's a Winner!
  - Section I-3: The Building Blocks
  - Section I-4: The Blueprint: Standards for HIV Prevention Counseling
  - Section I-5: What IS Good Counseling? (and associated articles)
  - Section II-2a,b: Chart Review Tools (Section II)
  - Section II-3a,b,c: Direct Observation Tools (Section II)

In addition, the supervisor will want to discuss with counselors:

- The purpose of doing chart reviews, direct observations, and other assessments
- Selection of counselors and sites to observe (need to observe at least 2-3 clients/counselor)
- Scheduling of observations: dates and times
- Observation schedule/process
- Observation venue issues (e.g. # of clients, client flow, observer-client compatibility, room arrangement)
- Potential impact of observations on client flow (providing feedback to counselors after sessions may slow down client flow)
- Suggestion that counselors complete self-assessments using observation tool
- Obtaining client consent (see Section II:18)
- Normality, and ways to cope with, counselor anxiety/discomfort
- Counseling room set-up (seating arrangements etc)



- ❑ Plan for client-observer interactions
- ❑ Plan for possible need for interruptions
- ❑ Chart selection (See Section II:7) to include mix of anonymous and confidential charts; to include mix of charts from different sites—if off-site charts are kept off-site, will need to bring in for review)
- ❑ Feedback and follow-up expectations/process

### **Materials for the Assessments:**

The following items are needed on hand for QA assessments:

- ❑ copies of the chart review tool (Section II)
- ❑ copies of the observation tools (Section II)
- ❑ copies of the quality improvement plan form, if using (Section III)
- ❑ copies of reference materials from "QA Toolbox," to give to counselors, as needed:
  - Frequently Asked Questions (Section IV)
  - Challenging Counseling Situations (Section IV)
  - Articles on counseling (Section IV)

### **Assessment Follow-up:**

**Within one week** of observation and/or chart review, the supervisor should:

- ❑ Meet with the counselor to review findings and develop an improvement plan, if this step was not done at time of the observation.

**Within six weeks after** the assessments, the supervisor should follow-up with the counselor to:

- ❑ Review the quality improvement plan
- ❑ Update counselor on any follow-up actions taken by the supervisor
- ❑ Discuss progress made by the counselor toward completion of the quality improvement plan
- ❑ Respond to any questions, provide technical assistance as needed
- ❑ Discuss on-going timeframe for improvements, as applicable
- ❑ Document, and file appropriately, progress notes on quality improvement plan, along with any additional negotiated plans



# Quality Assurance of HIV Prevention Counseling:

## 2: "Document, document, document!" : Chart Reviews



### Chart Review Rationale:

Documentation of HIV prevention counseling, through charting, is important for several reasons: first, it provides proof of services provided (always important to funders!), second, good documentation allows for better continuity of services, and third, it provides counselors an opportunity to reflect on counseling sessions. Reviewing charts is one relatively unobtrusive method of "seeing" what happens in a counseling session.

The goal of chart review is not necessarily to assess in detail individual counseling sessions, but rather to observe patterns across charts. Reviewing a number of charts can illuminate patterns of service that need to be examined. For example, if all charts simply have "client will use condoms" as the entire risk reduction plan, several explanations could be considered, including:

- 1) counselors don't understand that a risk reduction plan needs to include both a goal (e.g condom use) and action steps to achieve the goal (e.g "discuss with partner", "carry in purse") and back-up actions (e.g. if condom use is not possible);
- 2) counselors have not been instructed on how to chart more completely (i.e. the charts don't really reflect what is going on in counseling);
- 3) counselors are charting what has happened in counseling and are stuck on condoms as the only risk reduction method possible;
- 4) the charting process is form-driven and "use condoms" is a convenient check-box.

The chart review opens the door to discussing all of these issues more thoroughly.



## Technical Review:

In a technical review, charts are checked for completeness and accuracy in record keeping, and fulfillment of contractual requirements regarding documentation. The following are the minimum requirements to observe in a technical review of chart documentation, as stated in the Quality Assurance Standards for HIV Prevention Interventions (MDCH 2003):

- ❑ Chart maintained for each client
- ❑ Anonymous testing record has no link to individual client (i.e. contains no client identifiers such as name, address, phone, or other specific identifiers)
- ❑ A copy of signed/written consent included
- ❑ Documentation of client risk-reduction plan
- ❑ Laboratory HIV test results
- ❑ Documentation of referrals, including signed release forms and follow-up disposition

Additionally, charts may contain:

- ❑ Risk assessment/screening tool, if used
- ❑ Other lab results, if applicable

## Qualitative Review:

In a qualitative review, charts are reviewed as a proxy measure of the quality of counseling; the reviewer asks not just "was it done?", but "how well was it done?" Specifically, a qualitative review would look for:

- clues to the scope and quality of the counselor-client interaction,
- evidence, especially in the required documentation of the risk-reduction plan, that the session had followed the guidelines for HIV prevention counseling as set forth by the CDC and by MDCH
- the quality of the documentation itself, and might ask questions similar to, for example, "Is the documentation legible, with appropriate abbreviations used?"
- completeness, i.e. "Is this session documented well enough that another counselor seeing this client would have a good understanding of this client's unique risks, circumstances, and risk reduction action steps planned?"



## Who Should do Chart Reviews?

Supervisors and/or peers are in the best position to review charts on an on-going basis. Recommendations are given below for regular in-house chart reviews. HAPIS staff will review charts on an annual basis.

## In-house Chart Reviews:

It is recommended that:

- ❑ Supervisors review the first ten charts of each new counselor.
- ❑ On-going, in-house chart reviews be done on a quarterly basis.
- ❑ Each quarter, supervisors review at least two charts for each counselor.
- ❑ Peers should review five charts per quarter, randomly selected (see below)
- ❑ Reviewed charts should be current, no more than one year old.

## Implementing a Chart Review:

- ❑ Review each chart using the chart review tool (attached). For the "Required Contents" section of the tool, simply note whether or not the element is present. Use the comment section to note specific issues. For the qualitative review portion, the key elements of a counseling session are highlighted, with example items of critical documentation for each element listed underneath. Rating is on a scale of 0-3 and is for each element, but not for each specific item. In other words, for example, the element of "negotiate action plan..." is rated as a whole, taking into consideration all four of the items listed underneath. A "0" rating indicates the entire element is missing, not charted at all. A "1" rating indicates that the element is only partially documented. A "2" rating indicates that the element is covered adequately; and a "3" rating indicates excellent, exemplary, thorough charting of all aspects of the element.
- ❑ Note: a "risk reduction plan" includes both a safer goal behavior (e.g. "use condoms") as well as the action steps to achieve the goal. See Section IV, document "Steps in HIV Prevention Counseling Flowchart" for definitions and examples of components of counseling.
- ❑ If a chart is deficient in any area, or excels in any area, use the comment section to discuss. Detailed, specific comments are the most helpful.



### **Additional reviews:**

In some cases, deficiencies found in charts may signal the need for additional reviews. The purpose of pulling and reviewing additional charts would be to see if initial observations reflect a pattern of deficiency in the charting of a particular counselor, or in the agency as a whole. Examples of those deficiencies might include:

- ❑ *Serious client circumstances identified (e.g. domestic violence, medical symptoms, child abuse) with no documentation of referrals, follow-up or discussion noted)*
- ❑ *Risk reduction plans don't seem to match risk history/circumstances*
- ❑ *Risk reduction plans appear to be identical for all clients*

### **Feedback:**

- ❑ If chart review is being done as a routine QA check for the program as a whole provide counselors, as a group, with aggregate observations from the chart reviews (e.g. "I'm noticing that many of the charts are missing information on the clients' most recent potential exposure risks")
- ❑ See the QA Toolbox on Feedback (Section III)

### **Required Follow-up:**

In some cases, deficiencies found in charts may reflect potential legal situations and thus signal a need to discuss specific charts immediately. Examples of those serious deficiencies include:

- ❑ Client name or other identifiers used in an anonymous chart
- ❑ Evidence of a client's suicidal or homicidal intentions with no follow-up plan or referral documented
- ❑ Evidence of child abuse, with no documentation of appropriate follow-up
- ❑ Positive HIV test result not noted as reported
- ❑ Discussion of legal issues for client who has tested positive not documented (e.g. disclosure to future partners, etc.)



### **Random Selection of Charts: Method #1 "Select every X chart"**

- ❑ Determine the number of charts you wish to review
- ❑ Divide total number of charts by the number of charts you want to review to determine what the "X" is. (E.g. there are 637 charts of clients seen in the previous 3 months and you want to review 20 charts, so you will be selecting every 32<sup>nd</sup> chart)
- ❑ Pick a random starting point by having another individual select a number from 1 - total number of charts. In the example, above it would be a number between 1 and 637. Let's say 93 is selected; this will be the first chart reviewed.
- ❑ Select every X chart starting with the number selected by the individual. In the example, you would be reviewing charts 93, 125, 157, etc, in the order they present themselves in the file cabinet. When you reach the end of the cabinet, go back to the beginning and continue counting until all 20 charts are selected.
- ❑ If a chart is pulled and is not within the selection pool (e.g. is not an HIV prevention/test counseling chart, is not within the selected time frame, etc), or the client is known to the observer, do not review it. Put the known chart back and pull the next one.

### **Selection of Charts: Alternate method #1 "Select every X chart"**

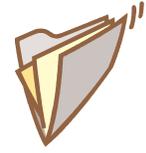
- ❑ As above, determine the total number of charts to review.
- ❑ Using the same selection methods, select chart numbers off of HIV counseling log sheets for the selected time period.
- ❑ Pull charts corresponding to selected numbers

### **Selection of Charts: Method #2 "Call for numbers"**

- ❑ Determine the number of charts to pull.
- ❑ Ask staff available in the office to give you random numbers between 1 and however many charts are available to review (e.g. if reviewing for two months and there are 300 charts, random numbers will be between 1 and 300) You will need as many random numbers as the number of charts to review.
- ❑ Pick a random number yourself.
- ❑ Using your random number as the starting point, use the random numbers of the staff to count to each chart to review, counting either the hard copies of the charts or the log sheets.



# Quality Assurance of HIV Prevention Counseling: 2a: "Document,document,document!": Chart Review Tool



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See attached



## MDCH/HAPIS HIV Prevention and Test Counseling Chart Review

Reviewer: \_\_\_\_\_  
 Client UIN: \_\_\_\_\_  
 Counselor#: \_\_\_\_\_ (pre)  
 Date of Initial Session: \_\_\_\_\_

Review Date: \_\_\_\_\_  
 Site #: \_\_\_\_\_  
 Counselor#: \_\_\_\_\_ (post)  
 Returned for Results: \_\_\_yes \_\_\_no

REQUIRED CONTENTS	Yes	No	N/A	Comments
Agency site number associated with record				
Counselor i.d. associated with record				
Anonymous testing record has no client i.d.				
A copy of signed consent				
Client risk-reduction plan				
Referrals documented, including signed releases and disposition, as appropriate				
Test results (HIV and others, if applicable)				
Risk assessment screening tool included, if used				

INITIAL SESSION: Prevention Counseling	Rating 1-3, N/O,N/A	Comments
<b>Identify HIV/STD/Hep C risk behaviors and circumstances</b>		
Document recent risk/risk incident, including date Pattern of risk behaviors, circumstances and triggers noted		
<b>Establish client specific goal behavior:</b>		
Safer goal behavior is client-specific and realistic for identified risk and RR history		
<b>Negotiate action plan to achieve safer goal behavior:</b>		
Previous/current RR attempts documented, with notable barriers or facilitators Action plan is likely to result in achievement of goal Action plan responds to client's unique risk history Action plan considers potential barriers and facilitators Document distribution of RR materials (condoms, etc.)		

INITIAL SESSION: Referrals and Support	Rating	Comments
<b>Provide and document referrals to support action plan:</b>		
Referral needs assessed and plan documented STD referral made, if applicable HepC referral made, if applicable Referral plan is client-specific		

Rating: 1= partial notation, 2= full notation (another counselor would have full understanding of client's situation), 3= exemplary notations, exceeds expectations, N/O = not observed, N/A = not applicable

Revised 06/23/08

Section II: 10



<b>RESULTS SESSION: General</b>	<b>Rating 1-3, N/A</b>	<b>Comments</b>
Documentation of status of referrals, if applicable/available		
Existing risk reduction reinforced/renegotiated		
<b>RESULTS SESSION: HIV-</b>		
Window period and retesting issues addressed		
<b>RESULTS SESSION: HIV+</b>		
PCRS elicitation/referral documented (DCH 1221)		
Referral to case management documented, CARF used if organization policy		
Case report form submitted (CDC 50.42A)		
Additional referrals assessed, given, facilitated, documented		
If confidential test and client no-shows, referral made to LHD (DCH 1221)		

Rating: 1= partial notation, 2= full notation (another counselor would have full understanding of client's situation), 3= exemplary notations, exceeds expectations, N/O = not observed, N/A = not applicable

**General Comments:**

To what extent would another counselor be able to

- 1) read documentation (documentation is legible and uses appropriate abbreviations)
  
- 2) have a clear picture of the client's risk, risk circumstances and risk reduction plan?

Strengths of documentation:

Areas requiring improvement:

Additional comments:



# Quality Assurance of HIV Prevention Counseling: 2b: "Document,document,document!": Chart Review Tool for Rapid Tests



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See attached



## MDCH/HAPIS HIV Prevention and Test Counseling Chart Review: Rapid Test Charts

Reviewer: \_\_\_\_\_  
 Client UIN: \_\_\_\_\_  
 Counselor#: \_\_\_\_\_ (pre)  
 Date of Initial Session: \_\_\_\_\_

Review Date: \_\_\_\_\_  
 Site #: \_\_\_\_\_  
 Counselor#: \_\_\_\_\_ (post)  
 Returned for Results: \_\_\_yes \_\_\_no

REQUIRED CONTENTS	Yes	No	N/A	Comments
Agency site number associated with record				
Counselor i.d. associated with record				
Anonymous testing record has no client i.d.				
A copy of signed consent				
Client risk-reduction plan				
Referrals documented, including signed releases and disposition, as appropriate				
Test results (HIV and others, if applicable)				
Risk assessment screening tool included, if used				

INITIAL SESSION: Prevention Counseling	Rating 0-3, N/A	Comments
<b>Identify HIV/STD/HepC risk behaviors and circumstances</b>		
Document recent risk/risk incident, including date Pattern of risk behaviors, circumstances and triggers noted		
<b>Establish client specific goal behavior:</b>		
Safer goal behavior is client-specific and realistic for identified risk and RR history		
<b>Negotiate action plan to achieve safer goal behavior:</b>		
Previous/current RR attempts documented, with notable barriers or facilitators Action plan is likely to result in achievement of goal Action plan responds to client's unique risk history Action plan considers potential barriers and facilitators Document distribution of RR materials (condoms, etc.)		

INITIAL SESSION: Referrals and Support	Rating	Comments
<b>Provide and document referrals to support action plan:</b>		
Referral needs assessed and plan documented STD referral made, if applicable HepC referral made, if applicable Referral plan is client-specific		

Rating: 0= absent/missing, 1= partial notation, 2= full notation (another counselor would have full understanding of client's situation), 3= exemplary notations, exceeds expectations, N/A = not applicable



<b>RESULTS SESSION: General</b>	<b>Rating 0-3, N/A</b>	<b>Comments</b>
Documentation of status of referrals, if applicable/available		
Existing risk reduction reinforced/renegotiated		
<b>RESULTS SESSION: HIV-</b>		
Window period and retesting issues addressed		
<b>RESULTS SESSION: HIV+ Preliminary</b>		
HIV+ preliminary results given		
Confirmatory test done/ referred for		
Additional referrals assessed, given, facilitated, documented		
<b>RESULTS SESSION: HIV+ Confirmatory</b>		
PCRS elicitation/referral documented (DCH 1221)		
Referral to case management documented, CARF used if organization policy		
Case report form submitted (CDC 50.42A)		
Additional referrals assessed, given, facilitated, documented		
If confidential test and client no-shows, referral made to LHD (DCH 1221)		

Rating: 0= absent/missing, 1= partial notation, 2= full notation (another counselor would have full understanding of client's situation), 3= exemplary notations, exceeds expectations, N/A = not applicable

**General Comments:**

To what extent would another counselor be able to:

- 1) read documentation (documentation is legible and uses appropriate abbreviations)
  
- 2) have a clear picture of the client's risk, risk circumstances and risk reduction plan?

Strengths of documentation:

Areas requiring improvement:

Additional comments:



# Quality Assurance of HIV Prevention Counseling:

## 3: Surveying the Scene: Direct Observation



### Rationale:

Direct observation of counseling sessions provides an irreplaceable opportunity for the supervisor to learn about the challenges clients face in their lives and those that counselors face in their jobs. Of all assessment methods (chart reviews, client surveys, role plays, etc), direct observation offers the most complete picture of client-counselor interactions, as the supervisor can see and hear language choices, tone of voice, body language and other non-verbals.

### Advance Preparations, Overview:

The following issues need to be reviewed and/or discussed in advance:

- ❑ Review of the purpose of direct observation
- ❑ Scheduling of the observations
- ❑ The observation tool, appropriate QA Toolbox files
- ❑ Preparing the counselors
- ❑ Observation venue and room arrangement issues (see below)
- ❑ Obtaining client consent
- ❑ Confidentiality statement for outside observer
- ❑ Interrupting the session
- ❑ Feedback expectations and process (See QA Toolbox: Feedback)
- ❑ Follow-up expectations and process (See QA Toolbox: Improvement Plan Protocol)



## Direct observation: Who should observe

Observations can be done appropriately both internally (“in-house”), by the supervisor or peers, or externally, by HAPIS staff. Some agencies have had peers from other agencies visit and shadow counselors, as a learning tool for both agencies. In addition, it may be helpful to have counselors use the observation tool to do self-assessment following selected client sessions.

## In-house Observations:

The following are recommendations for observations done internally:

- ❑ Supervisors should observe new counselors at least twice monthly for the first six months of conducting HIV counseling. (MDCH QA Standards for HIV Prevention Counseling)
- ❑ Supervisors should observe at least one counseling session per year for each of their agency's five most active counselors.
- ❑ Peers and/or supervisors may want to observe counselors, using the observation tool, in advance of HAPIS site visit, to help counselors get used to being observed.

## Preparing the Counselor:

It is important that the counselors being observed feel as comfortable as possible about the process—both for their own comfort as well as to minimize the impact on the counseling session and the client. The following are helpful ways to set the counselors at ease, prior to the observation:

- ❑ **Review the purpose** of the observation. The supervisor is there to learn about challenges the counselor faces and strengths he/she brings to the work. If the observation is part of the formal personnel evaluation process, that should be clearly stated.
- ❑ **Acknowledge the challenges** of being observed by reflecting feelings and third-personing (e.g. “most counselors are nervous when someone observes them.”)
- ❑ **Ask** what will help them feel more comfortable.
- ❑ **Review observation criteria.** Review the observation tool, but emphasize that the tool is simply a guide and will not be used during the observation, but only afterward to trigger thoughts. It may helpful to say something like: “I am not so much interested in whether each and every item on the checklist is achieved, but rather in the session's accomplishment as a whole. At the end of



the session, I will ask questions such as: How clear are the client's risk and risk circumstances? What is the immediate action plan? Are the goal and action steps reasonable and feasible for the client? Was the client fully engaged in the conversation or did the counselor do all the talking?"

- ❑ **Review feedback process** and expectations (see Section III). In general, the supervisor can offer at least immediate brief verbal feedback to the counselor, to be followed by more detailed feedback later.
- ❑ **Discuss observation logistics** (see below.)

### Preparing the Observation Logistics:

The following issues should be discussed with the counselors ahead of time:

- ❑ How **client consent** will be obtained (see below)
- ❑ **Room arrangement** (see below)
- ❑ Typical process in terms of **leaving room** to get supplies, etc. The counselor should notify the observer if it is typical in the process to need to leave the room to get supplies or paperwork, and what the observer should do (i.e. follow the counselor or sit alone with the client.)
- ❑ Expectations around **client-observer interactions** (i.e. the expectations if the client seeks to engage the observer or asks the observer questions.) In general, the observer should not answer questions or otherwise interact with the client, beyond polite acknowledgements.
- ❑ Expectations around **counselor-observer interactions**. In general, the counselor and observer should not be interacting once the session starts. The observer should let the counselor know that they will not be giving them any facial cues (frowns, raised eyebrows etc) in response to their counseling.
- ❑ Expectations around necessary **observer interruption of session**. Again, in general, the observer should not interject nor interrupt the session. In some situations however, the observer might be compelled to interrupt a session and the preferred way to handle that should be discussed up front (see below.)



### Room Arrangement:

The arrangement of the counseling room to optimize the comfort of all – client, counselor and observer—will help mitigate the stress of observation. It is helpful to see the counseling room(s) ahead of the observations. Issues to discuss with the counselor(s), ahead of time, include:

- Typical **seating arrangements**: where do the counselor and client usually sit
- **Minimizing the obtrusiveness** of the observer
- **Seating comfort** (if the observer has to sit in a tremendously uncomfortable chair or stool, it will be harder to sit quietly)
- **Line of sight**: in whose line of sight is the observer—the client's or the counselor's? Ideally, neither the client nor the counselor should have to look directly at the observer while looking at each other. The observer should not be seated behind either the client or the counselor, unless it is the counselor's request that the observer sit behind the counselor.

### Obtaining Client Consent:

Observation should be done only with the client's verbal consent. Obtaining client consent may reflect on the feelings of the counselor as well as those of the client, which is another reason to prepare counselors ahead. The observation should be presented to the client in a matter-of-fact fashion; most people are already familiar with having third parties observing in doctors' offices or "monitoring" phone calls to service departments.

The supervisor may be presented as simply as "I have someone following me today to see how I do counseling here. With your permission, s/he would like to sit in on your counseling session. S/he won't be participating or answering questions. Will that be okay with you?" or "... How do you feel about that?"

Even if client consent has been obtained, both counselor and observer should be conscious of the client's comfort level with having a third party in the session. If at any time the client seems unduly uncomfortable, as demonstrated verbally or through non-verbals, the observer should excuse him/herself or the counselor should excuse the observer.



## **Interrupting a Session:**

In general, an observer should not interrupt a counseling session, nor interject remarks or information. In some cases, however, when the observer notices critical steps of the process or critical information are missing, and it is clear that the counselor is not going to achieve them, the observer may feel it important to address them with the counselor. Examples of such situations may include:

- ❑ Counselor starts to take test specimen without having gotten written consent.
- ❑ Client is leaving without information on how to get results.
- ❑ Client has expressed intention to harm self or others or fear of imminent harm from others, and counselor has not addressed.
- ❑ Counselor has given client inaccurate information that could likely cause the client harm, given their unique circumstances: e.g. about condom effectiveness, about the reliability of the test for their particular exposure time-frame, about transmission risks.

The manner in which an observer interrupts the session will depend on the prior agreement with the counselor and on the circumstances and reason for the interruption. It is preferable that interruptions be made in such a manner that doesn't harm the counselor-client relationship, or damage the counselor's credibility.

Observers may choose to:

- ❑ Follow the counselor out of the room (if counselor leaves room to get supplies, for example)
- ❑ Ask the counselor to step out of the room ("Excuse me, I'm wondering if I can ask you something outside?")
- ❑ Try to catch the counselor's attention through non-verbals (catching their eye, clearing throat, etc)
- ❑ Simply interrupt quietly and naturally ("Excuse me, I think you might have forgotten to get the consent signed." "May I add something?...") or "I think there is a new study out which shows...")

## **Observation Criteria:**

The observation criteria are based on the CDC standards for effective HIV prevention counseling, as taught in the MDCH counselor certification modules. The observation tool which follows lists all the standards to be achieved, as well as required individual elements to include, and specific counseling skills and practices to



note. As discussed in Section I, and above in Section II, while the observer may and should, make mental note of very specific details about the counseling session, the observer will not be taking any notes during the counseling session. As a result, some of the more overarching questions about the session—such as those noted on the observation tools (e.g. “at the end of the session, what do we understand about the client’s risk and risk circumstances?”)—will guide the assessment of the counseling session. In addition, observers may wish to review the observation tools in advance of observing, to keep the criteria fresh in their minds.

### **Recording Observations:**

As soon after the counseling session as possible, the supervisor should complete the observation tool. There are four sections to the prevention/test-decision counseling observation tool:

- 1) a section for noting specific counseling concepts or practices observed,
- 2) a section to record general impressions about the strengths/weaknesses of the session and the core content accomplished in the session,
- 3) a section to note how well the counselor achieved the six-steps or standards of a counseling session, and
- 4) a section to note whether or not the elements of informed consent for HIV testing were covered.

The first and fourth sections of the form are simply check-offs, with comments as appropriate.

The second section is a place for written narrative comments.

The third section—on **achievement of the standards**—is to be rated on how well the counselor accomplished each step. In that section, the step is highlighted with various components listed underneath.

**Note on Rapid Testing:** The observation tool for rapid tests combines the prevention/test-decision counseling and results counseling into one tool.



## Ratings:

- **"N/O"** If the counselor missed the step entirely, the rating would be N/O for not observed, and a note should be written in the comments section to clarify that the step was missing (vs. simply that the observer might have missed it.)
- **"1=does not meet expectations"** If there is some work done on the step, but the observer feels it is inadequate or misses too many aspects of a thorough discussion, then the observer would score it a "1= does not meet expectations". An example might be this exchange:  
Counselor: "What do you think you could do to reduce your risk?"  
Client: "I guess I could use condoms."  
Counselor: "That's great! Would you like to take some home?" (moves on into test-decision counseling and informed consent.)

In this scenario, if the counselor never came back to discussing the safer goal behavior more thoroughly—with open questions about how using condoms will fit into the client's life and how the client feels about condoms, what other safer goal behaviors might work for the client, etc—then the observer would give "Establish safer goal behaviors" a rating of "1". (Likewise the next step of "Negotiate action plan..." would also rate a "1", if there were no further discussion of how the client would fit that goal behavior into his/her life.)

- **"2= meets expectations"** If the counselor covers most of the elements for a standard/step, then the observer would rate that step a "2= meets expectations."
- **"3= exceeds expectations"** If the counselor facilitates a really thorough exploration of all aspects of the step, then a rating of "3= exceeds expectations" would be given.

Detailed comments should be included for ratings of "1", "N/O" or "N/A."

## Feedback:

Most counselors will want to get direct feedback on their work after a counseling session. Depending on site flow and scheduling, and the comfort and preferences of the reviewer, there are several ways observations can be recorded and feedback given to the counselor. The supervisor might complete the observation tool alone and



then talk about the session with the counselor, using the completed observation tool as a guide for the discussion. The supervisor might complete the observation tool with the counselor, talking about each item and making notes as they talk. Or the supervisor might offer brief verbal feedback to the counselor and record more detailed notes later. [See Section III]

### **Required Follow-up:**

As with discussions of findings in chart reviews, only observations that reflect potential legal situations or more immediate harm to the client need to be discussed immediately. Examples of this type of observation include:

- Breaches of confidentiality or anonymity
- Failure to follow-up adequately with clients who indicate suicidal or homicidal thoughts or intentions
- Abusive behavior toward clients
- Persistent belief in, and dispensing of, incorrect critical information, despite correction (e.g. an intractable belief that "condoms don't work")



**Quality Assurance of HIV Prevention Counseling:  
3a: Surveying the Scene: Direct Observation  
Elements: Prevention and Test-Decision Counseling**



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**See attached**



**MDCH/HAPIS HIV Prevention Counseling Quality Assurance  
Direct Observation Elements: Prevention and Test Decision Counseling**

Date: \_\_\_\_\_ Agency: \_\_\_\_\_ Counselor: \_\_\_\_\_

Counselor certification date: \_\_\_\_\_ Site: \_\_\_\_\_

Observer: \_\_\_\_ counselor (self) \_\_\_\_ peer \_\_\_\_ supervisor \_\_\_\_ HAPIS(who)\_\_\_\_\_

<b>Counseling Concepts and Counseling Skills</b> Rating: N/O= not observed, √ = observed, N/A = not applicable	<b>Rating:</b> √ , N/O, N/A	<b>Comments</b> Comments required for N/O or N/A ratings.
Reflected feelings, addressed feelings first		
Used open-ended questions, including nth degree questions		
Used active listening skills—verbal and non-verbal attending		
Managed own discomfort/issues		
Offered Buffet of Options, Not Directives		
Provided accurate information		
Gave information simply: Provided information as needed, clarified critical (not general) misconceptions and communicated at appropriate level		
Paraphrased		
Summarized and closed		
Addressed contradictions/conflict between client feelings/statements/behaviors		
Counseling was client-centered		
Session was interactive, not didactic-- Client did most of the talking		
Provided opportunities for skill-building		
Supported client's positive steps		

**General comments on counseling skills:**



<b>Session Goals:</b> <b>Initial Prevention Counseling</b> Rating: N/O=not observed, 1= does not meet expectations, 2=meets expectations, 3= exceeds expectations, N/A = not applicable	<b>Rating</b> <b>1 – 3,</b> <b>N/O,</b> <b>N/A</b>	<b>Comments</b> Comments for rating of 1, N/O or N/A, as needed
<b>Client Introduction and Orientation</b> Established rapport (orient client to session, counselor role, confidentiality, etc.) Explored reason for counseling/testing		
<b>Identify HIV/STD/Hep C risk behavior and circumstances</b> Identified and explored individualized context, circumstances, and triggers of risk behaviors Identified date/timing of most recent exposure Identified and supported client’s attempts to reduce risk Explored need for/enhanced basic knowledge of HIV Assessed communication with partners		
<b>Establish client-specific safer goal behavior</b> Explored safer goal behaviors that client is motivated or capable of adopting Offered “buffet of options”, as needed Explored benefits and risks of new behavior: what behavior will “look” like to client, what factors might affect ability to change, supports		
<b>Negotiate action plan to achieve safer goal behavior</b> Negotiated a realistic, incremental and achievable HIV risk-reduction plan Discussed at least one concrete and specific next step Assessed potential barriers/facilitators to plan and discussed back-up Built on previous successes Solicited client feedback and confirmed that plan is reasonable and acceptable		
<b>Provide and document referrals to support action plan</b> Assessed client’s needs and resources Made and documented appropriate facilitated referrals, as necessary Provided with educational and risk reduction materials, as appropriate Demonstrated male/female condom, other tools, as needed Provided skill-building opportunities (e.g. role plays, use of materials)		
<b>Summary and Closure</b> Summarized and closed: review what’s been covered, what next steps are, make sure client is ready to leave		



<b>Session Goals:</b> <b>Test Decision Counseling</b> Rating: √ = observed, N/O=not observed, N/A = not applicable	<b>Rating</b> √, N/O, N/A	<b>Comments</b> Comments for N/O or N/A rating, as needed
Obtained <b>written informed consent</b> , with signature or anonymous identifier, provided “Important Health Info” booklet		
Discussed <b>appropriate laws</b> : anti-discrimination, felony, confidentiality, reporting, PCRS, right to withdraw consent		
<b>Testing Process:</b>		
Discussed anonymous and confidential testing; offered or referred for both options equally		
Discussed test specimen collection and meaning of test results		
Discussed window period and recommendations for retesting		
Discussed benefits/costs of testing		
<b>Anticipating Results:</b>		
Discussed anticipated feelings regarding test results (+ or -)		
Discussed relationship between testing and behavior-change plan		
Discussed disclosure plans, if result is +, including PCRS		
<b>Plans/ Implementation:</b>		
Assessed waiting period plans, coping/support during wait		
Established plan for receiving results		
Determined testing is appropriate at this time		
Summarized decision and assisted with implementation		

**What is client’s risk?** What partner(s)? When? Circumstances? Partners’ risks? Risk reduction method currently using?

**What is client’s risk reduction plan?** Goal? Previous success/problems achieving goal? With what partners? Realistic? Action steps discussed?

**What did counselor do really well?**

**What is one thing that would have improved the session?**



**Quality Assurance of HIV Prevention Counseling:  
3b: Surveying the Scene: Direct Observation  
Elements: Test Result Counseling**



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**See attached**



**MDCH/HAPIS HIV Prevention Counseling Quality Assurance  
Direct Observation Elements: Test Result Counseling**

Date: \_\_\_\_\_ Counselor: \_\_\_\_\_ Site: \_\_\_\_\_

Observer: \_\_\_\_ counselor (self) \_\_\_\_ peer \_\_\_\_ supervisor \_\_HAPIS(who)\_\_\_\_\_

<b>Counseling Concepts and Counseling Skills</b> Rating: N/O= not observed, √ = observed, N/A = not applicable	<b>Rating:</b> √ , N/O, N/A	<b>Comments</b> Comments for N/O or N/A ratings, as needed
Reflected feelings, addressed feelings first		
Used open-ended questions, including nth degree questions		
Used active listening skills—verbal and non-verbal attending		
Managed own discomfort/issues		
Offered Buffet of Options, Not Directives		
Provided accurate information		
Gave information simply: Provided information as needed, clarified critical (not general) misconceptions and communicated at appropriate level		
Paraphrased		
Summarized and closed		
Addressed contradictions/conflict between client feelings/statements/behaviors		
Counseling was client-centered		
Session was interactive, not didactic-- Client did most of the talking		
Provided opportunities for skill-building		
Supported client's positive steps		

What is client's risk reduction plan? Method? Previous success/problems using method? With what partners? Realistic?

What supports/referrals does the client need? What did counselor do to facilitate them?

What did counselor do really well?

What is one thing that would have improved the session?



<b>Session Goals:</b> <b>Giving Negative Test Results</b> Rating: √ = observed, N/O=not observed, N/A = not applicable	<b>Rating</b> <b>1-3, N/O,</b> <b>N/A</b>	<b>Comments</b>
<b>Giving Results:</b> Assessed client readiness to receive results Sensitively provided results, assess reaction/impact Used explicit language when providing test results Interpreted results and ensure understanding, including discussion of <b>window period</b> as appropriate Discussed re-testing, as appropriate		
<b>Risk Reduction Plan:</b> Reviewed client progress on <b>risk reduction plan</b> Renegotiated/reinforced risk-reduction plan		
<b>Referrals:</b> Assessed status of <b>referrals</b> given, if any As appropriate, discussed referrals for STI/Hep testing Assisted client with additional referrals, as needed		
<b>Session Goals:</b> <b>Giving Positive Test Results</b> Rating: N/O=not observed, 1= does not meet expectations, 2=meets expectations, 3= exceeds expectations, N/A = not applicable	<b>Rating</b> <b>1 – 3,</b> <b>N/O, N/A</b>	<b>Comments</b>
<b>Giving results:</b> Assessed client readiness to receive results Sensitively provided results, assess reaction/impact Used explicit language when providing test results Interpreted results and ensure understanding Discussed re-testing		
<b>Risk Reduction:</b> Reviewed client progress on negotiated risk reduction plan, as possible/appropriate Renegotiated/reinforced risk-reduction plan, as possible		
<b>Referrals:</b> Discussed/ assisted with medical and case management referrals Assessed status of referrals previously given, if any As appropriate, discussed referrals for STI/Hep testing Assisted client with additional referrals, as needed		
<b>Support and Safety:</b> Assessed immediate plans and safety Assessed/discussed available support people		
<b>PCRS:</b> Discussed PCRS options Elicited sex and/or needle-sharing partners for appropriate time frame Negotiated a referral method for each partner Obtained descriptive/locating info for partners referred Coached client on each self-referral		
<b>Paperwork:</b> Completed appropriate paperwork: CARF, PCRS, HIV etc		



# Quality Assurance of HIV Prevention Counseling: 3c: Surveying the Scene: Direct Observation Elements: Rapid Test Counseling



See attached



**MDCH/HAPIS HIV Prevention Counseling Quality Assurance  
Direct Observation Elements: Rapid Test Counseling**

Date: \_\_\_\_\_ Counselor: \_\_\_\_\_  
 Counselor certification date: \_\_\_\_\_ Site: \_\_\_\_\_  
 Observer: \_\_\_\_\_ counselor (self) \_\_\_\_\_ peer \_\_\_\_\_ supervisor \_\_\_\_\_ HAPIS(who) \_\_\_\_\_

<b>Counseling Concepts and Counseling Skills</b> Rating: N/O= not observed, √ = observed, N/A = not applicable	<b>Rating:</b> √ , N/O, N/A	<b>Comments</b> Comments required for N/O or N/A ratings.
Reflected feelings, addressed feelings first		
Used open-ended questions, including nth degree questions		
Used active listening skills—verbal and non-verbal attending		
Managed own discomfort/issues		
Offered Buffet of Options, Not Directives		
Provided accurate information		
Gave information simply: Provided information as needed, clarified critical (not general) misconceptions and communicated at appropriate level		
Paraphrased		
Summarized and closed		
Addressed contradictions/conflict between client feelings/statements/behaviors		
Counseling was client-centered		
Session was interactive, not didactic-- Client did most of the talking		
Provided opportunities for skill-building		
Supported client's positive steps		

**General comments on counseling skills:**



<b>Session Goals:</b> <b>Initial Prevention Counseling</b> Rating: N/O=not observed, 1= does not meet expectations, 2=meets expectations, 3= exceeds expectations, N/A = not applicable	<b>Rating</b> <b>1 – 3,</b> <b>N/O,</b> <b>N/A</b>	<b>Comments</b> Comments for rating of 1, N/O or N/A, as needed
<b>Client Introduction and Orientation</b> Established rapport (orient client to session, counselor role, confidentiality, etc.) Explored reason for counseling/testing		
<b>Identify HIV/STD/Hep C risk behavior and circumstances</b> Identified and explored individualized context, circumstances, and triggers of risk behaviors Identified date/timing of most recent exposure Identified and supported client’s attempts to reduce risk Explored need for/enhanced basic knowledge of HIV Assessed communication with partners		
<b>Establish client-specific safer goal behavior</b> Explored safer goal behaviors that client is motivated or capable of adopting Offered “buffet of options”, as needed Explored benefits and risks of new behavior: what behavior will “look” like to client, what factors might affect ability to change, supports		
<b>Negotiate action plan to achieve safer goal behavior</b> Negotiated a realistic, incremental and achievable HIV risk-reduction plan Discussed at least one concrete and specific next step Assessed potential barriers/facilitators to plan and discussed back-up Built on previous successes Solicited client feedback and confirmed that plan is reasonable and acceptable		
<b>Provide and document referrals to support action plan</b> Assessed client’s needs and resources Made and documented appropriate facilitated referrals, as necessary Provided with educational and risk reduction materials, as appropriate Demonstrated male/female condom, other tools, as needed Provided skill-building opportunities (e.g. role plays, use of materials)		



<b>Session Goals:</b> <b>Test Decision Counseling</b> Rating: √ = observed, N/O=not observed, N/A = not applicable	<b>Rating</b> √, N/O, N/A	<b>Comments</b> Comments for N/O or N/A rating, as needed
Obtained <b>written informed consent</b> , with signature or anonymous identifier, provided "Important Health Info" booklet		
<b>Laws:</b> Discussed appropriate laws: anti-discrimination, felony, confidentiality, reporting, PCRS		
Discussed right to withdraw consent		
<b>Testing Process:</b> Discussed anonymous and confidential testing; offered or referred for both options equally		
Discussed test specimen collection and meaning of test results		
Discussed window period and recommendations for retesting		
Discussed confirmatory retesting for pp or invalid results		
Discussed benefits/costs of testing		
<b>Anticipating results:</b> Discussed anticipated feelings regarding test results (+ or -), feelings if preliminary positive (pp)		
Discussed relationship between testing and risk reduction plan		
Discussed disclosure plans, if result is +, including PCRS		
<b>Implementing test:</b> Assessed waiting period plans, coping/support during wait		
Established plan for receiving results		
Determined testing is appropriate at this time		
Summarized decision and assisted with implementation		



<b>Session Goals: Giving Negative Test Results</b> Rating: √ = observed, N/O=not observed, N/A = not applicable	<b>Rating 1-3 N/A</b>	<b>Comments</b>
<b>Giving Results:</b> Assessed client readiness to receive results Sensitively provided results, allow for and assess reaction/impact Used explicit language when providing test results Interpreted results and ensure understanding, including discussion of window period as appropriate Discussed re-testing, as appropriate		
<b>Risk Reduction:</b> Reviewed client progress on negotiated risk reduction plan, as possible/appropriate Renegotiated/reinforced risk-reduction plan		
<b>Referrals:</b> Reinforced/ discussed other referrals, including STD/Hep C,		

<b>Session Goals: Giving Invalid Test Results</b> Rating: √ = observed, N/O=not observed, N/A = not applicable	<b>Rating 1-3 N/A</b>	<b>Comments</b>
<b>Giving Results:</b> Assessed client readiness to receive results Sensitively provided results, allow for and assess reaction/impact Used explicit language when providing test results Interpreted results and ensure understanding		
<b>Follow-up:</b> Discussed re-testing If Client declines retest, discuss options/provide referrals for retesting at later date/time or other location		



<b>Session Goals:</b> <b>Giving PRELIMINARY Positive Test Results</b> Rating: N/O=not observed, 1= does not meet expectations, 2=meets expectations, 3= exceeds expectations, N/A = not applicable	<b>Rating</b> <b>1 – 3,</b> <b>N/O,</b> <b>N/A</b>	<b>Comments</b>
<b>Giving Results:</b> Assessed client readiness to receive results Sensitively provided results, allow for and assess reaction/impact Used explicit language when providing test results Interpreted results and ensure understanding		
<b>Referrals/ Follow-up:</b> Discussed confirmatory testing options Explained confirmatory testing process, test specimen collection and meaning of results Assessed waiting period plans, coping/support during wait Established plan for receiving results Summarized decision and assisted with implementation		

<b>Session Goals:</b> <b>Giving CONFIRMATORY Positive Test Results</b> Rating: N/O=not observed, 1= does not meet expectations, 2=meets expectations, 3= exceeds expectations, N/A = not applicable	<b>Rating</b> <b>1 – 3,</b> <b>N/O,</b> <b>N/A</b>	<b>Comments</b>
<b>Giving Results:</b> Assessed client readiness to receive results Sensitively provided results, allow for and assess reaction Used explicit language when providing test results Interpreted results and ensure understanding		
<b>Risk Reduction:</b> Reviewed client progress on negotiated risk reduction plan, as possible/appropriate Renegotiated/reinforced risk-reduction plan, as possible		
<b>Referrals:</b> Discussed/ assisted with medical and case mgt referrals Assessed status of referrals given, if any As appropriate, discussed referrals for STI/Hep testing Assisted client with additional referrals, as needed		
<b>Support and Safety:</b> Assessed immediate plans and safety Assessed/discussed available support people		
<b>PCRS:</b> Discussed PCRS options Elicited sex and/or needle-sharing partners for appropriate time frame Negotiated a referral method for each partner Obtained descriptive/locating info for partners referred Coached client on each self-referral		
<b>Paperwork:</b> Completed appropriate paperwork: CARF, PCRS, HIV report, releases		



**What is client's risk?** What partner(s)? When? Circumstances? Partners' risks? Risk reduction method currently using?

**What is client's risk reduction plan?** Goal? Previous success/problems achieving goal? With what partners? Realistic? Action steps discussed?

**What support and/or referrals does the client need?** What did the counselor do to facilitate them?

**What did counselor do really well?**

**What is one thing that would have improved the session?**



# Quality Assurance of HIV Prevention Counseling

## 4. Case Conferencing: A Quality Assurance Tool for Supervisors



### What is Case Conferencing:

Different professions have different definitions for, and protocols on, case conferencing, but basically case conferencing involves discussing client cases with others, in a systematic way. Case conferencing is often used to examine difficult cases in which practitioners (in this case, HIV prevention/test counselors) have been challenged either by a lack of information or resources or a lack of appropriate skills. In this piece, the term case conferencing will refer to supervisors' and/or peers discussing challenging HIV prevention/test counseling sessions and assisting counselors in problem-solving around informational or skill deficits.

Case conferencing activities include:

- describing the counseling session,
- assessing informational and skill needs,
- providing and receiving feedback,
- discussing and reviewing components of the counseling protocol,
- strategizing alternative approaches to enhancing the counseling process,
- role-playing counseling skills,
- sharing information about resources and specific facts,
- discussing needs for on-going or further informational or skill development on the part of the individual or the staff as a whole.

Case conferences can be individual—between a supervisor and an individual counselor—or group—in which other counselors participate as part of a staff meeting, for example. Case conferences can be informal debriefing sessions or intentional, organized sessions. Most of what is written here applies to formal case



conferencing, however many of the considerations also apply to informal case conferencing.

**Pros and Cons of Case Conferencing:**

Pros	Cons
<ul style="list-style-type: none"> <li>• Provides counselors the opportunity to reflect in depth, in an intentional way, on a specific case.</li> <li>• Provides an outlet to counselors for discussing difficult situations and may help prevent burn-out</li> <li>• Guided discussion may facilitate more complete analysis of a client situation and a counseling response.</li> <li>• Validate a counselor's struggles, as well as supports his or her positive efforts in counseling.</li> <li>• Takes advantage of "teachable moments" when counselors are seeking help through acknowledging difficulties.</li> <li>• Allows counselors opportunity to learn from each other.</li> <li>• Provides the supervisor with the opportunity to see and discuss common informational and skill needs for the whole staff</li> <li>• Supports the establishment of group norms around quality of counseling and following protocol</li> </ul>	<ul style="list-style-type: none"> <li>• Relies on counselors to acknowledge and bring up counseling challenges.</li> <li>• Relies on counselors to be prepared for discussion</li> <li>• Requires good facilitation to draw out issues and guide discussion.</li> <li>• Can be difficult to maintain focus on counseling skills, and not let focus get diverted to extremes in client situations.</li> <li>• Facilitators may feel challenged to provide "solutions" versus guiding discussion toward joint exploration of skills.</li> <li>• Formal case conferencing takes time and preparation.</li> </ul>



## Preparing for Case Conferencing:

Counselors should come prepared to discuss a particular client counseling session. It will be helpful if they have thought ahead and are prepared to describe:

- **Setting:** site where counseling took place (e.g. substance abuse treatment program, bar outreach, main office, etc)
- **Client :** demographics
- **Client risk(s):**
- **Risk circumstances:**
- **Client risk reduction plan:** past, current, and intended
- **Relevant client life circumstances:** economic issues, relationship and/or home life issues, etc
- **Referrals needed/made:**
- **Counseling concerns:** what made this a difficult session for the counselor, how the counselor responded to the client, the client's situation, or any session issues

Note: counselors need to present clients in a way which preserves the client's anonymity for the rest of the counselors.

## Case Conferencing Guidelines:

An important part of preparing for effective case conferencing is to develop, in conjunction with staff, some basic guidelines around the process.

Areas to consider in developing the guidelines include:

1. Scheduling: regularly scheduled vs ad hoc case conferencing sessions
2. Purpose and expected outcomes
3. Protocols and tools to be used, including:
  - Standard formats for preparing and presenting cases
  - Guidelines for protecting client confidentiality
  - Process for clarifying and discussing cases
  - Process for offering feedback
4. How the case(s) for conference will be selected. Options include:
  - Rotation among counselors
  - Sessions that went especially well
  - Sessions that a counselor would like retrospective help with
  - Recommendations from the supervisor or request from the counselor to bring a case from individual case conference for group consideration



5. Participation guidelines that may include:
  - Respect for time and task
  - Keeping focus on counseling interaction
  - Focus on constructive feedback
  - Use of "I" statements that take ownership of the content.
  - Equal time consideration for all counselors' participation.
  - Confidentiality issues
6. Paperwork and documentation considerations

### Discussing the Case:

The counselor should be asked to present a brief summary of the client counseling session, following the guideline areas above. The facilitator paraphrases and asks additional clarifying questions, as necessary, to get a full picture of the client, the client's risk situation, and the counseling interaction. In group case-conferencing, the counselor's peers ask clarifying questions as well. The goal is to elicit as much information about the client as the counselor obtained so that everyone has a clear and full picture.

- *Tell us a little more about the client's relationships.*
- *What else can you tell us about the client's risk circumstances?*
- *How did it make you feel when the client revealed their risk?*
- *What other questions did you ask?*

### Assessing the Difficulty:

After the session has been discussed to the fullest extent, the facilitator and/ or the peers, need to assess the source of the difficulty surrounding the session (e.g. *What made this a difficult session for you?*) and determine whether there were informational deficits, skill deficits, or both, on the part of the counselor. Note: it is probably human nature to want to ascribe problems to a particularly difficult client or situation or to a lack of needed information or resources—rather than a lack of skills. It is important to address skills, however, if they are the issue.



### **Addressing the Deficits:**

When deficits are identified, the supervisor has the opportunity to determine if these are deficits for the individual counselor or if the entire staff needs more support in a certain area. The supervisor can also determine if support or technical assistance can be provided simply and immediately or if additional research needs to be done or a separate in-service provided.

### **Case Conferencing Facilitation Skills:**

**In order to facilitate the interaction and mutual support of the staff members, supervisors will need to:**

- Create and maintain a supportive environment free of attack and personal criticism while promoting a lively discussion of the strengths and weaknesses of the client encounter being reviewed
- Assure adherence to the established case conference guidelines
- Encourage and support equal participation by counselors
- Keep the group focused on task and schedule without cutting off discussion
- Keep discussion focused on the counselor's side of the interaction, and not let it side-track into a discussion of the client and other clients like him/her
- Model the skills used in prevention counseling (e.g. open questions, reflecting feelings, reinforcement of successes, paraphrasing etc)
- Reference established standards/protocols for quality assessment
- Not allow herself/himself to become the focus of the discussion
- Reinforce confidentiality

**Note: This piece draws largely from a draft work written for the CDC by Bill Petz from North Carolina.**



# Quality Assurance of HIV Prevention Counseling:

## 5. Client Surveys



A quick proxy for evaluating quality of service is the client survey—variously known as the client satisfaction survey, the client exit survey, etc. Appropriate use of the client survey can yield information related both to the way clients perceive the services they receive and to the quality of those services. Writing effective surveys is not an easy task and can take a significant amount of thought and time. It is really the topic for a whole training in itself. Here are a few considerations to guide you:

### **Purpose:**

What kind of information do you hope to gain? Do you need information on how the site works—e.g. wait times, convenience, location, accessibility? Do you want information about site reputation—perceptions of confidentiality, recommendation by word of mouth, atmosphere of the site, feeling of confidence and comfort in the site? Do you want information about only one aspect or service of the site—e.g. referrals or testing process? Do you want information about how clients react to counselors—feeling respected, feeling understood, not feeling judged? Do you want information about what took place during the counseling session—how much time was spent, whether educational materials were given, what particular issues were discussed, who did most of the talking, what issues the counselor addressed? Do you want information on what effect the counseling had on the client—what they understand as a result of the counseling, how they perceive their risk, what they will do to reduce their risk?

### **Use:**

How will the survey be used? Is it going to be used to report to funders? Will it be used on an on-going basis or intermittently? Is it considered a tool to satisfy funding requirements, or a method to get feedback on services, or a way to empower clients? Will it be used to assess services in the site/agency as a whole or the services of particular counselors? Will it be used as part of performance evaluations?



**Format:**

How long will the survey be? How much time do you expect clients to spend on it? What will be the approximate reading level? What type of questions will you use—yes/no, scaled answers, open-ended, etc.? How will you pre-test your questions for readability, etc.? How will clients who have reading issues (or language issues) complete the survey? Does the method of return of the survey affect the format—e.g. formatted as a self-mailer?

**Administration:**

Will all clients get the survey? If not, what size sample do you need? If you are sampling clients, how will you select which clients get the survey—e.g. random sample of all clients, or all clients on randomly selected days, all clients within a specified time frame, all clients of specified counselors, or some combination of selection methods?

How are they given to clients—by the counselors, by the administrative staff, in packets with other information, in boxes to be picked up?

Where will clients fill them out—in the counseling room, the waiting room, or at home for return by mail?

How will client anonymity be assured?

**Review, Analysis, and Reporting:**

How many completed surveys do you expect/hope to have within a year? Who is going to review the surveys? How often? How will the results be tallied and compiled? How will results be shared with staff, administrators, funders, and clients?

**Resources:**

What can the agency afford for this process? What will be the time impact of this project? Monetary impact? What staff resources and expertise exist in the agency that can be used on this process?



# Quality Assurance of HIV Prevention Counseling:

## 5a. Sample Client Survey Questions



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See attached



# Sample Client Survey Questions

## Suggestions:

- Include a note about not putting name on form.
- Thank client for helping agency to improve, etc.
- Note how/where to return form (e.g. mail in, drop box, etc.)
- Try to keep length of survey to one page, if possible
- Questions below are simply sample ideas
- Open-ended questions would have scaled responses (e.g. "How convenient was this location?" "very" "somewhat" "not very" "not at all" )

## Questions about client/visit (optional):

- Date/location of visit
- Counselor seen
- Client demographics: gender, age, race/ethnicity, sexual orientation

## Questions about the site in general:

- How comfortable did you feel in the test site?
- How pleasant and inviting was the site?
- How were you treated by staff at the site?
- What else would you like to tell us about your experience at the site?
- How long did you have to wait to be seen?

## Questions about accessibility:

- How did you hear about this testing site?
- How convenient was this day and time for you to come in?
- How convenient/ easy to get to was the location?
- How easy was it to find out where to get an HIV test?
- How easy was it to find this HIV testing site?

## Questions about overall perception of counseling:

- How comfortable did you feel with the counselor?
- Overall, how satisfied are you with the counseling you received?
- How likely is it that you would refer someone else here, if they wanted to get an HIV test?
- What else would you like to tell us about your experience with the counselor?



### Questions about counselor-client interaction:

- Who talked more during the counseling session?
- How well did the counselor cover your questions, problems or concerns?
- How well did the counselor help you think about what you are doing that might put you at risk for HIV?
- How well did the counselor help you develop a plan to protect yourself from HIV?
- How well did the counselor provide helpful referrals for your needs?
- Who chose what you would do to reduce your risks, you or the counselor?
- How honest were you with the counselor?
- How much did you share with the counselor about your sex and/or drug using history?
- How well did you think the counselor respected your choices and decisions?
- How safe did you feel sharing your personal information with the counselor?
- What additional questions do you have, that were not discussed in the counseling session?

### Questions about effect of counseling:

- How well do you understand what an HIV test will tell you?
- How sure are you that you will return for your test results?
- How well do you understand what you can do to reduce your risks?
- How helpful was the counseling you received about HIV prevention?
- What is your plan to reduce your risk/stay safe from HIV?
- Which of the following are true for you? (check all that apply)
  - I do not have risk for HIV
  - I do have risk for HIV
  - I want to reduce my risk for HIV
  - I am comfortable with my level of risk for HIV
  - I know what to do to reduce my risk for HIV
  - I have a plan on how I will reduce my risk for HIV
  - I like my plan to reduce my risk
  - I am confident that I can follow my plan



# Quality Assurance of HIV Prevention Counseling:

## 5b. Sample Client Surveys



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See attached



## HIV Test Counseling Client Satisfaction Survey (Sample #1)

**Please help us improve our services by taking a few minutes to answer this survey.  
Do not put your name on this form.**

**1. What type of counseling session did you have this time?** (check only one)

- Pre-test counseling (you'll get your results at next visit)  
 Post-test counseling (you came back today to get your test results)

**2. Overall, how was the counseling you received?**

How informative was it?  Very informative  Informative  Uninformative  Very uninformative  
 How helpful was it?  Very helpful  Helpful  Unhelpful  Very unhelpful

**3. During the counseling session, would you say that, in general:**

- a.  The counselor talked most, and you listened.  
 b.  You talked mostly and the counselor listened.  
 c.  You both talked and listened about the same amount.

**4. How well did your counselor...**

	<b>Extremely</b>	<b>Somewhat</b>	<b>Not at All</b>	<b>Don't Know</b>
Address your questions, problems, or worries about HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ask you to think about what you were doing that puts you at risk for HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Help you develop a plan to protect yourself from HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Help you figure out small steps to make your plan work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provide helpful referrals for your needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5. Which of the following are true for you? (answer each)**

- |  |                              |                             |                                     |   |
|--|------------------------------|-----------------------------|-------------------------------------|---|
| I do not have risk for HIV.                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | <input type="checkbox"/> Does Not Apply |
| I do have risk for HIV.                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | <input type="checkbox"/> Does Not Apply |
| I want to reduce my risk for HIV.            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | <input type="checkbox"/> Does Not Apply |
| I know what to do to reduce my risk for HIV. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | <input type="checkbox"/> Does Not Apply |
| I have a plan on how to reduce my risk.      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | <input type="checkbox"/> Does Not Apply |
| I like my plan to reduce my risk.            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | <input type="checkbox"/> Does Not Apply |
| I am confident that I can follow my plan.    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | <input type="checkbox"/> Does Not Apply |



6. Generally speaking, who chose what you would do, you or the counselor?  I did.  the counselor did.

7. How much help did the counselor give you?  More than enough  Enough  Not enough

8. How much help did you give the counselor?  More than enough  Enough  Not enough

9. How much did you share with the counselor about your sex and/or drug using history?

All of it  Most of it  Some of it  None of it

10. What else would you like to tell us about your experience with the counselor?



**Counseling Testing and Referral Questionnaire (Sample #2)**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>
<b>1. My counselor explains things I do not understand</b>	1	2	3	4
<b>2. My counselor asks me about me needs and wants.</b>	1	2	3	4
<b>3. My counselor respects my choices and decisions.</b>	1	2	3	4
<b>4. My counselor works with me to get the services I need.</b>	1	2	3	4
	Yes	No	Don't Know	Doesn't Apply
<b>5. I have a plan on how I will reduce my risk</b>				
<b>6. I like my plan to reduce my risk</b>				
<b>7. I am confident I can follow my plan</b>				

**8. How much did you share with the counselor about your sex and/or drug using history?**

- All of it
- Most of it
- Some of it
- None of it

**9. How much help did the counselor give you?**

- More than enough
- Enough
- Not enough

**10. How much help did you give the counselor?**

- More than enough
- Enough
- Not enough

**11. Is there any important subject that was not brought up during your test session?**

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## Process Evaluation – 2-Session Prevention Counseling (Sample #3)

As part of this study you have received counseling both before and after taking your HIV test.

**1. Would you say that the counseling you received about HIV and STD prevention was:**

	Extremely	somewhat	somewhat	extremely	
Pleasant	_____	_____	_____	_____	Unpleasant
Informative	_____	_____	_____	_____	Uninformative
Helpful	_____	_____	_____	_____	Useless
Good	_____	_____	_____	_____	Bad

**2. When you first talked to the counselor, during your initial visit (when you agreed to participate in the study), what sexual activities were you doing that put you at risk for AID and other sexually transmitted diseases?**

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**3. During this initial visit, did you and your counselor agree on a specific behavior or action that you would do or try to do?**

\_\_\_\_\_ (1) NO  
\_\_\_\_\_ (2) YES → What did you agree to do?

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**4. Who chose what you would do – you or the counselor?**

\_\_\_\_\_ Me → How much help did the counselor give you?  
(1) Little or none (2) Some (3) A Lot  
\_\_\_\_\_ The Counselor → How much help did you give the Counselor?  
(1) Little or none (2) Some (3) A Lot

**5. In the session you just completed, did you and the counselor agree on a specific behavior or action that you would do or try to do?**

\_\_\_\_\_ (1) NO  
\_\_\_\_\_ (2) YES → What did you agree to do?

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**6. Who chose what you would do – you or the counselor?**



\_\_\_\_\_ Me → How much help did the counselor give you?

(1) Little or none      (2) Some      (3) A Lot

\_\_\_\_\_ The Counselor → How much help did you give the counselor?

(1) Little or none      (2) Some      (3) A Lot

**7. Thinking about both counseling sessions, would you say that, in general:**

- \_\_\_\_\_ (1) The Counselor talked and you listened.
- \_\_\_\_\_ (2) you talked and the Counselor listened.
- \_\_\_\_\_ (3) that you each talked and listened, i.e., that you had a real conversation.

**8. Again, thinking about both counseling sessions, how well did the counselor cover your questions, problems or worries?**

	Very	somewhat	somewhat	very	
Well	_____	_____	_____	_____	Poor

**9. How honest were you with the counselor?**

	Very	Somewhat	Somewhat	Very	
Honest	_____	_____	_____	_____	Dishonest

**10. Do you have anything else you'd like to say about your experience with the counselor?**

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## CTR Client Satisfaction Survey (sample #4)

Date: \_\_\_\_\_

Counselor/Staff contact: \_\_\_\_\_

Your Gender:       male  female

Your age: \_\_\_\_\_

What is your primary ethnic/ cultural/ racial background?

- White/ Caucasian       African-American/ Black  
 Hispanic/ Latino       Asian/ Pacific Islander  
(Other)  \_\_\_\_\_       Native American

How do you identify your sexual orientation?

- Gay       Bisexual  
 Bi-curious       Heterosexual  
 Business Card

How did you hear about our services?

- Flier       Another Community Agency  
 Friend      (Other)  \_\_\_\_\_

1. The overall services provided by this agency are:  
 Excellent       Very Good       Good       Fair       Poor
2. This agency's services are available at times which are convenient to me:  
 Strongly Agree       Agree       Not Sure       Disagree       Strongly Disagree       Not Applicable

*The following questions ask about your perception of the services you have received from this agency. Please mark on the scale from Strongly Agree to Strongly Disagree, your level of agreement with the statement. If the statement is not relevant to the service you received, please mark "not applicable".*

3. The information I receive from staff of this agency has been helpful:  
 strongly agree       agree       not sure       disagree       strongly disagree       not applicable
4. Staff answered my questions:  
 strongly agree       agree       not sure       disagree       strongly disagree       not applicable
5. The staff has made themselves available to answer my questions when I needed them:  
 strongly agree       agree       not sure       disagree       strongly disagree       not applicable
6. I was treated as an individual with unique needs and concerns:  
 strongly agree       agree       not sure       disagree       strongly disagree       not applicable



7. My privacy has been respected:

- strongly agree     agree     not sure     disagree     strongly disagree     not applicable

8. When it comes to testing I felt my privacy rights were explained to me completely:

- strongly agree     agree     not sure     disagree     strongly disagree     not applicable

*The following questions will be used for future program planning and program improvement. Please mark your response to each question on the scale from definitely yes to definitely no.*

9. Would you tell your friends that they should come to us if they have needs like yours?

- definitely yes     probably     probably not     definitely no

10. Do you feel that this agency is addressing the needs of your community?

- definitely yes     probably     probably not     definitely no

11. Are there any services HIV related you need that you wish this agency would provide?

- Yes     No

If yes, please describe those services;

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Any additional comments:

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# Section III:

## Feedback and Follow-up

### ***Section III: Feedback and Follow-up***

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# Quality Assurance of HIV Prevention Counseling:

## 1. Offering Feedback



### Introduction:

Most people have anxiety over getting feedback on their performance. Anxiety about feedback comes from a variety of sources: poor experiences with getting feedback (getting feedback that was harsh or delivered inappropriately), a feeling that, as a professional, one should be "perfect", lack of experience with getting routine feedback, experience getting feedback that wasn't helpful, etc.

Not only is *getting* feedback a source of anxiety, but *giving* feedback can be also. Especially for people in the "helping professions", giving feedback can easily get bogged down by the desire to "take care" of the feedback recipient (i.e. to not say anything negative, etc.) In addition, often not having experienced useful feedback, many people are not familiar with what specific, detailed feedback looks like.

In many ways, the feedback process parallels the counseling process. It is important that the feedback process be framed, much as the counseling process is, in terms of assisting the counselor in identifying their own strengths and deficits, establishing goals for themselves, and facilitating an incremental plan to improve.

### Overarching principles of feedback:

- ❑ Feedback is necessary.
- ❑ Feedback needs to be based on clear guidelines and expectations.
- ❑ Feedback provides the opportunity to hear what's being done well, as well as what needs improvement.
- ❑ Both giving and receiving feedback are gifts and, as such, require appropriate acknowledgement.



### **Timing of Feedback:**

As discussed above, the timing of feedback to counselors on observations of their counseling sessions may vary according to site flow, scheduling, etc. However it is timed, verbal feedback should be given to the counselors observed, using the observation tool as a guide for comments. Feedback may be supplemented with resource articles in Section IV, as appropriate. Feedback on observations should segue naturally into discussion of changes that could be made to improve counseling and a strategy to accomplish those changes.



## 1a. FEEDBACK DO'S AND DON'T'S

### DO's

### DON'T's

<ul style="list-style-type: none"> <li>❑ Do ask for counselor self-assessment first.</li> </ul>	<ul style="list-style-type: none"> <li>❑ Don't charge in with own agenda right away.</li> </ul>
<ul style="list-style-type: none"> <li>❑ Do identify positive qualities first.</li> </ul>	<ul style="list-style-type: none"> <li>❑ Don't start off with negatives.</li> </ul>
<ul style="list-style-type: none"> <li>❑ Do separate positive feedback from constructive criticism.</li> </ul>	<ul style="list-style-type: none"> <li>❑ Don't link negative to positive with "but" or "however".</li> </ul>
<ul style="list-style-type: none"> <li>❑ Do describe specific behaviors noted: e.g. "your use of humor when you explained how to use condoms really put the client at ease."</li> </ul>	<ul style="list-style-type: none"> <li>❑ Don't offer vague comments: "your condom discussion was good."</li> </ul>
<ul style="list-style-type: none"> <li>❑ Do describe behaviors needing adjustment without judgment, using "I" statements. E.g. "I didn't hear you ask about the client's partners."</li> </ul>	<ul style="list-style-type: none"> <li>❑ Don't excuse or accuse the counselor about behaviors needing change. E.g. "I know you wanted to get more information, but this client was so quiet!"</li> </ul>
<ul style="list-style-type: none"> <li>❑ Do talk about things the counselor can change: "When you look over the top of your glasses, it can appear condescending."</li> </ul>	<ul style="list-style-type: none"> <li>❑ Don't talk about things the counselor cannot change: "Wearing glasses makes you look stern."</li> </ul>
<ul style="list-style-type: none"> <li>❑ Do talk about at least one item for improvement.</li> </ul>	<ul style="list-style-type: none"> <li>❑ Don't overwhelm the counselor with a laundry list of changes.</li> </ul>
<ul style="list-style-type: none"> <li>❑ Do give feedback on pre-determined criteria.</li> </ul>	<ul style="list-style-type: none"> <li>❑ Don't give feedback on areas not previously agreed on.</li> </ul>
<ul style="list-style-type: none"> <li>❑ Do invite feedback from the counselor on your own presence.</li> </ul>	<ul style="list-style-type: none"> <li>❑ Don't get defensive about your observation or your feedback.</li> </ul>



# Quality Assurance of HIV Prevention Counseling:

## 1b. Cheat Sheet for Feedback with HIV Prevention Counselors

### Ask for counselor's self-assessment first:

- How did the session feel to you?
- How do you think that went?
- Tell me your thoughts.

### Begin with something positive:

- I noticed when you \_\_\_\_\_, the client \_\_\_\_\_.
- What's one thing you think you did well?
- Here's something I noticed you did that really seemed to help build rapport and trust.

### Discuss one or two areas needing improvement (and strategize):

- What is something you might have handled another way?
- If you could change one thing about the session, what would it be?
- How did the client react when you asked \_\_\_\_\_?
- One thing I noticed was \_\_\_\_\_.
- How did you decide to \_\_\_\_\_?
- What might you do differently in the future? (strategize)
- How could you change that? (strategize)
- What would make it harder (or easier) to change? (strategize)

### Summarize and end on an encouraging note:

- So you are going to \_\_\_\_\_. Please tell me if I can help you with that. Thanks for being open to my comments and suggestions.  
So your plan is to \_\_\_\_\_. I'll check back with you to see how it is going. I look forward to working with you on other interviews.

(Adapted from the CDC curriculum, "Principles of STD Supervision Course," August 2002)



# Quality Assurance of HIV Prevention Counseling:

## 2. Strategizing for Change with Counselors



### Strategizing for Change, Overview:

In the same way that HIV prevention counselors need to work with the client to negotiate a concrete, incremental action plan to reduce risk, strategizing for change with counselors requires "the cooperative development of action plans to address problem areas." (CDC curriculum, "Assuring the Quality of HIV Prevention Counselors", 1995) In fact, the process can be described in the same way we describe the six steps of HIV prevention counseling:

- ❑ Orienting the counselor to the process
- ❑ Identifying the issue (providing detailed feedback) and making sure the counselor owns it
- ❑ Jointly identifying a goal, e.g. alternate counseling approaches to try
- ❑ Developing an action plan to reach the goal
- ❑ Providing resources and referrals for supporting the action plan
- ❑ Summarizing and closing, with agreed upon timeframes for reviewing progress

### Strategies for Change, Outline:

Using the process described above and below, the supervisor should work jointly with the counselor to develop an improvement plan that covers the most critical of any problem areas discussed during feedback. The plan should include clear, specific descriptions of:

- ❑ the problem area(s) identified in feedback
- ❑ the reason(s) those areas were identified as problems (i.e. link to standards/policies)
- ❑ the goal(s) for change
- ❑ the plan to achieve those goals (see the "buffet of options")
- ❑ the timeframe for the plan
- ❑ agreed upon responsibilities of the counselor and the supervisor
- ❑ resources required and to be made available
- ❑ the timeframe for the supervisor to check back on progress



## Strategizing for Change, Key Questions:

The process of moving a counselor through the improvement planning process relies, as does prevention counseling itself, on the use of open questions to assist the counselor in identifying and developing his/her own plan for change. Below are some key questions to help move through the strategizing process:

**Transition Questions:** to move from the identified feedback into identifying a goal

- *How might you do that differently in the future?*
- *What other approaches might you take if faced with a similar situation again?*
- *Examples:*
  - *"Next time you are faced with a client who isn't offering a lot of information, instead of dropping the prevention counseling and focusing on the test, what could you do?"*
  - *"If you have a client who has been through the testing process several times, what might you do to make sure the client has the information needed, without doing a complete mini-AIDS 101?"*

**Cost-benefit Questions:** to explore perceptions about changing an approach

- *What would be hard about doing this differently?*
- *How do you imagine changing your approach might work for your clients?*
- *Example:*
  - *"What would be most difficult about asking a quiet client a few open-ended questions?"*

**Capacity-Building Questions:** to explore counselor's strengths and needed supports for the change discussed

- *What will make it easier to try this new approach?*
- *What do you need to help you with this?*
- *How has this worked when you've done it before?*
- *Example:*
  - *"What would make it easier to get used to asking a quiet client some open-ended questions?"*



**Provisional Try Questions:** to explore process and timeframe for provisional try (the action plan, resources and supports)

- ❑ *When will you plan on trying out this strategy for a new approach?*
- ❑ *How can I help you with this strategy?*
- ❑ *Example:*
  - *"When do you think you will have time to shadow another counselor to watch how she handles this situation?"*
  - *"How can I facilitate other counselors sharing with you their experiences with difficult clients?"*
  - *"When should we plan on checking back in about this?"*
  - *"When should we schedule another observation session to see how this is going?"*

**Strategizing for Change: A "buffet of options":**

The provision of feedback is not inherently useful without developing a realistic, incremental strategy to change. Any action plan for change must be developed in conjunction with, and with the ownership of, those who will carry out the plan (i.e. the plan needs to be acceptable to the participants.) Recommended strategies will be dependent on the issue or situation being addressed, and may include:

- ❑ additional mentoring with a more experienced counselor
- ❑ review of basic standards
- ❑ role-playing with peers or supervisor
- ❑ additional on-site training on specific topics
- ❑ additional training provided by the State
- ❑ regular case reviews with supervisor or peers
- ❑ routine self-assessments

*Resource: "Assuring the Quality of HIV Prevention Counseling: A Workshop for Supervisors" (Centers for Disease Control and Prevention, 1995; primary authors—Joan M. Garrity and Sally J. Jones)*



# Quality Assurance of HIV Prevention Counseling:

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## 2a. Strategizing for Change/ Improvement Plan



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See attached



# Quality Assurance of HIV Prevention Counseling Improvement Plan

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Date: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Site: \_\_\_\_\_ Counselor: \_\_\_\_\_

Area(s) of concern:

1.

2.

Changes Discussed:

1.

2.

Improvement Plan (include dates for completion):

1.

2.

Supervisor Signature: \_\_\_\_\_

Counselor Signature: \_\_\_\_\_



# Quality Assurance of HIV Prevention Counseling:

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## 2b. Strategizing for Change/Sample Improvement Plan



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See attached



# Quality Assurance of HIV Prevention Counseling Improvement Plan

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Date: June 6, 2007

Supervisor: Sally Smith

Site: Acme AIDS Services

Counselor: John Doe

## Area(s) of concern:

1. *Counselor not getting complete risk assessment; missing most recent exposure, clear picture of partners and risks with specific partners, etc*
2. *Documentation too brief, particularly on risk assessment*

## Changes Discussed:

1. *Increase questions asked about risk behaviors and circumstances*
2. *Increase documentation of risk, especially including most recent exposure (when, partner, behavior)*

## Improvement Plan (include dates for completion):

1. *John Doe will shadow Steve Jones twice in next two weeks and observe and discuss use of risk assessment questions*
2. *John Doe will complete self-assessments using observation tool, on three client sessions in next three weeks.*
3. *Sally Smith will look at documentation forms and discuss at next staff meeting on July 2, 2007*
4. *Sally Smith will observe John Doe and review his charts the week of June 25.*

Supervisor Signature: \_\_\_\_\_

Counselor Signature: \_\_\_\_\_



# Quality Assurance of HIV Prevention Counseling:

## 3. Strategizing for Change: Coping with Challenges



Sometimes creating strategies for change or improvement plans does not result in the desired change. Sometimes the strategies or plans are implemented but the outcome does not produce the desired results. Sometimes those strategies or plans are not implemented - either because of a denial for a need to change or a lack of follow-through to do so.

If the strategy for change or improvement plan has been implemented as conceived, and the desired results are not achieved, it is time to review the problem and revise the improvement plan. Go back to the counselor and review the problem—what it is, why it is a problem, why it is important to resolve it. Using open-ended questions, discuss what other approaches might be more helpful. Be careful, however, not to get caught in the trap of working harder than the counselor to creatively solve the problem. As with clients, the counselor has to own the problem and create a workable solution for him/herself.

If the strategy for change has not been implemented or not been implemented effectively, and the problem remains, the supervisor has basically two choices: 1) let it go and watch from a distance or 2) confront the counselor.

### **Confrontation:**

**When to confront:** If you have determined that the change is truly needed and worthy of any potential consequences of confrontation.

**How to confront:** Creating an environment that includes routine meetings and discussions about work performance, helps a meeting to discuss the outcomes of a strategy to change to be less "charged" or less intimidating.



**How to prepare:** If you determine you will have to confront a counselor about not working on an issue, you need to be clear yourself ahead of time about:

1. the required behavior change—be able to articulate what exactly you are looking for (For example, instead of “*better risk assessments*”, you might say “*risk assessments which include the circumstances of risk with each sexual partner.*”)
2. acceptable parameters for change (how much/ by when)
3. consequences (know the parameters of acceptable consequences in terms of personnel policies, contractual limits, etc.)
4. keeping to the agenda of this one issue, and not using the meeting as an opportunity to confront every shortcoming of the counselor.

**What to do in face of resistance:**

1. Empathize and restate needed change (“*It can be uncomfortable to ask clients about intimate parts of their lives. At the same time, in order to be effective in helping clients reduce their risks, it is critical to ask those uncomfortable questions. I need you to ask your clients about their risk and their risk circumstances.*”)
2. Restate needed change -- in the face of resistance, repeat the needed change, “*I need to observe you carrying out complete risk assessments with your clients when I observe you in two weeks.*”
3. Restate needed change with consequences—an “if...then” statement may be helpful here: “*If you want to keep counseling at this agency, then I need to observe you carrying out complete risk assessments with your clients when I observe you in two weeks.*”

The MDCH Supervisors' course “Assuring the Quality of HIV Prevention Counseling” may be really helpful in giving supervisors support for, and practice in, the art of confrontation.

*Resource: “Assuring the Quality of HIV Prevention Counseling: A Workshop for Supervisors” (Centers for Disease Control and Prevention, 1995; primary authors—Joan M. Garrity and Sally J. Jones)*



# Section IV:

## Resources for Counselors

### ***Section IV: Resources for Counselors***

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2. "Approaches to HIV Counseling" .....	6
3. Counseling Skills and Concepts Cheat Sheet .....	15
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4. Steps in HIV Prevention Counseling Flowchart .....	19
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6. Frequently Asked Questions .....	25
7. Counselor Responses to Difficult Situations .....	32
8. Frequently Asked Questions About OraSure .....	38
9. "Risk Reduction: Sex without Condoms". . . . .	40



# 1. "The Art of Effective Risk Reduction Counseling"

Focus: A Guide to AIDS Research and Counseling (vol.20, no. 7, August 2005)

Available on line by using the AIDS Health Project's archived publications search engine: <http://www.ucsf-ahp.org/HTML2/archivesearch.html>

or copying the link below:

[http://128.218.135.89:8080/searchblox/servlet/FileServlet?url=%2FUsers%2Fsweigle%2FDesktop%2FFOCUS\\_PDF%2F2005%2FFOCUS0805.pdf&col=5](http://128.218.135.89:8080/searchblox/servlet/FileServlet?url=%2FUsers%2Fsweigle%2FDesktop%2FFOCUS_PDF%2F2005%2FFOCUS0805.pdf&col=5)



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## 2. "Approaches to HIV Counseling"

HIV Counselor Perspectives (vol. 13, no.4, October 2004)

Available on line by using the AIDS Health Project's archived publications search engine: <http://www.ucsf-ahp.org/HTML2/archivesearch.html>

or copying the link below:

[http://128.218.135.89:8080/searchblox/servlet/FileServlet?url=%2FUsers%2Fsweigle%2FDesktop%2FPerspectives\\_PDF%2F2004%2FPersp1004.pdf.pdf&col=6](http://128.218.135.89:8080/searchblox/servlet/FileServlet?url=%2FUsers%2Fsweigle%2FDesktop%2FPerspectives_PDF%2F2004%2FPersp1004.pdf.pdf&col=6)



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### 3. Counseling Skills and Concepts Cheat Sheet

Developed by MDCH/HAPIS



## Implications of Counseling Concepts and Skills\*\*

### **Essential Concepts:**

- Feelings First**
  - Focus on feelings first
  - You can't take away or fix feelings
  - Articulate the nonverbals
  - Avoid: "I understand/know how you feel..."
- Manage Your Own Discomfort**
- Set Boundaries:**
  - Who's in Charge?**
    - Detachment
    - Rapport-building
    - You are not the target

### **Self-Disclosure**

### **Basic Skills**

- Open Questioning, including nth degree**
  - Avoid: "why?"
- Attending**
- Paraphrasing, including 3<sup>rd</sup> personing**
  - Avoid "..., but..."
- Reflecting Feelings**
- Giving Information Simply**
- Reframing**
- Supportive Confrontation**
- Options vs. Directives**
  - Buffet of options
  - "If . . . , then . . . ."
  - Avoid: "gotta, coulda, woulda, shoulda"s



## 4. HIV Counseling, Testing and Referral Counseling & Documentation Trigger Form



**HIV COUNSELING, TESTING & REFERRAL  
Counseling & Documentation Trigger Form**

**PREVENTION COUNSELING ELEMENTS:**

**Did you:**

- Discuss and document client's risk/potential exposure to HIV**
- Recommend retesting if last risk episode is within window period**
- Discuss barriers/triggers for unsafe behaviors**
- Document barriers/triggers on CTR form**
- Document discussion of risk reduction strategies related to the client's stated risk**

*\* Please document discussion of risk reduction options on Personal Risk Reduction form if client declines to complete*

- Discuss laws related to confidentiality, disclosure of HIV status, HIV non-discrimination**
- Make and/or offer referrals**
- Document referrals on CTR form**
- Distribute materials, if yes, how many:**

\_\_\_ Safer Sex packs            \_\_\_ Male Condoms  
\_\_\_ Female Condoms        \_\_\_ Lube  
\_\_\_ HIV Informational Brochures  
\_\_\_ STI Informational Brochure  
\_\_\_ Other: \_\_\_\_\_

- Review client's chart for all forms.**
- Check or note all appropriate items.**

**Additional Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FOR REFERRALS: UNITED WAY 211 HELP LINE**

**Test Counselors/Clients May Call:**

- **211 from a land phone or AT&T wireless phone,**
- **All others call: 800-552-1183**



# 5. Steps in HIV Prevention Counseling Flowchart

Developed by MDCH/HAPIS



<b>Counseling Steps:</b>	<b>1: Introduction</b>	<b>2: Risk Behavior*</b>  *Behaviors that in and of themselves transmit HIV: Drug Using Behavior: sharing needles/works Sexual Behaviors: unprotected anal intercourse; unprotected vaginal intercourse; unprotected oral sex.			<b>3: Safer Goal Behavior*</b>  **Safer Goal Behavior** Behaviors that in and of themselves eliminate or reduce the risk of HIV transmission.		
<i>Goals of this Step: What the client sees and hears.</i>	<ul style="list-style-type: none"> <li>Introduce client to session</li> <li>Educate and Inform</li> <li>Clarify Roles</li> </ul>	<i>Assist client in identifying the risk behavior the client is engaging in and for which the client focus on reducing risk.</i>			Assist client in identifying the safer goal behavior that they want to achieve that will directly reduce or eliminate the risk of the behavior that they identified in Step 2.		
<i>Intentions of this Step:  What you are attempting to accomplish as the counselor.</i>	<ul style="list-style-type: none"> <li>Establish trust</li> <li>Assure the client understands what will be happening in this session.</li> </ul>	<b>A: Risk Behaviors</b>  Understand what the client is doing that puts him/her at risk for HIV.	<b>B: Risk Behavior Focus</b>  Understand which behavior the client is willing and interested in reducing risk around.	<b>C: Circumstances</b>  Understand the circumstances in which this client participates in this risk behavior.	<b>A: Safer Goal Behavior Options “Smorgasbord”</b>  Understand what options the client is willing to consider.  Provide the client with a smorgasbord of options. Build on previous successes.	<b>B: Safer Goal Behavior Focus</b>  Understand which safer goal behavior the client wants to achieve.  Understand what this new behavior would look like to the client.	<b>C: Circumstances</b> Understand the possible benefits and drawbacks for the client of adopting this new behavior.  Understand the factors that affect this client’s ability to change behavior
		The more clearly you identify the risk behavior, the more clear and appropriate the safer goal behavior will be. This risk behavior must, in and of itself, transmit HIV.			<i>Clearly identifying the circumstances of the risk behavior allows you to assist the client in identifying an appropriate safer goal behavior that will eliminate or reduce the risk of the risk behavior. The Goal behavior must directly reduce or eliminate the risk of the activity identified in Step 2.</i>		
<b>Suggested Questions and Statements:</b>	<p>What would you like me to call you today?</p> <p>What brings you in for an HIV test today?</p> <p>What would you like to know before we are through here today?</p> <p>What have you heard about HIV?</p>	<p>What are you doing that puts you at risk for HIV?</p> <p>What are the riskiest things you are doing?</p> <p>If you were infected, how do you think you may have been infected?</p>	<p>What are you presently doing to protect yourself?</p> <p>How does that work for you?</p> <p>What would you like to do to reduce your risk?</p>	<p>With whom? With which partners?</p> <p>When? During which time periods?</p> <p>Where?</p> <p>Why? Under what circumstances? What frame of mind?</p>	<p>For clients who are stumped and unable to come up with options for reducing risk offer a smorgasbord of options: “Some people use condoms, others lower the number of their partners; some people eliminate anal intercourse and just have oral sex, other people mutually masturbate.”</p>	<p>How would it look for you to do this new behavior?</p> <p>Describe doing this new behavior for me.</p> <p>When would you do it? Where? With whom?</p>	<p>What would be bad for you from doing this new behavior?</p> <p>What would make it more difficult for you to do this new behavior?</p> <p>What would be good for you from doing this new behavior?</p> <p>What would make it easier to do this new behavior?</p>

Re



<b>Counseling Steps:</b>	<b>4: Action Plan*</b> *“Action Plan” Incremental, realistic steps that the client is willing and able to take that will help the client reach the safer goal behavior.	<b>5: Referral and Support</b>	<b>6: Summary and Closure</b>
<i>Goals of this Step:</i> <i>What the client sees and hears.</i>	Assist the client in developing an incremental, realistic plan of small steps to reach the safer goal behavior identified in Step 3.	Provide support and referrals.	<i>Summarize and close the session.</i>
<i>Intentions of this Step:</i>  <i>What you are attempting to accomplish as the counselor.</i>	<p>Support the client to come up with a plan to reduce risk.</p> <ul style="list-style-type: none"> <li>• Identify concrete, incremental steps the client can start to take to achieve his/her goal</li> <li>• Build on previous successes.</li> <li>• Clarify possible challenges, prepare client for success.</li> <li>• If appropriate, role-play possible partner reaction to client’s behavior change.</li> </ul>	<p>Assess the client’s emotional state.</p> <p>Provide active referrals for services and issues the client brought up during the session.</p> <p>Make sure the client has support for their concerns.</p>	<p>Make sure the client understands the next steps.</p> <p>Make sure that you understood and dealt with the concerns of the client.</p> <p>Make sure the client understands the session is over.</p> <p>Make sure the client is ready to leave.</p>
<b>Suggested Questions and Statements:</b>	<p>What would you need to do to be able to (insert goal behavior <i>i.e.</i>: use a condom) next time? What will prepare you to do this? What else?</p> <p>What are the steps you need to take so that you are ready to do this new behavior? What do you need to do so that you can take these steps? What could you do that would make it easier to take these steps? What would be the most difficult part of doing this?</p> <p>How realistic is this plan for you?</p>	<p>Which of the things we’ve talked about would you like more help with?</p> <p>Is there a particular kind of support or service that you are interested in?</p> <p>Would you like to talk to a counselor about (issue that was raised)?</p> <p>Would you be interested in a support group for (issue that was raised).</p> <p>What support do you need? Who would give you that support? What do you need to do to that support?</p>	<p>Identify major points, including feelings, that have been discussed and tie them together.</p> <p>Formulate a concise statement of the client’s issues and decisions. Include the risks discussed, the safer goal behavior, and the action plan to achieve the safer goal behavior. Clearly identify the next steps the client has agreed to take.</p> <p>Check in to see if the client agrees.</p> <p>Check in to see that the client is emotionally ready to leave.</p> <p style="text-align: right;"><b>Section IV: 21</b></p>



Revised 06/23/08

Section IV: 22



## 6. Steps in HIV Test Decision Counseling Flowchart

Developed by MDCH/HAPIS

Revised 06/23/08



Section IV: 23

# 6. Steps in HIV Test Decision Counseling Flowchart

Developed by MDCH/HAPIS



Goals of this Step:	Essential Elements:	Suggested Questions and Statements:
Assure that the client is making a thoughtful-feeling decision about testing	Ask probing questions to help client determine if testing is in best interest	<i>If you decide to test today, how will it affect your life if the test shows that you are infected? Uninfected? How will you feel if you are infected? Uninfected? What is the hardest/easiest part of testing today?</i>  <i>Before you make a final decision about testing today, there is some important information that I need to share with you</i>
Provide information essential to making informed test decision  Component of Informed Consent	Specimen Collection	<i>We collect a sample by _____.</i>
	Getting results	<i>It will take _____ for the results to come back. You will have to _____ to get your test result.</i>
	Window Period	<i>It takes an average of 1 month for signs of infection to show on this test. If you think you may have been exposed to HIV within the last 3 months, you may want to consider being tested again in the future (90 days/3 months from last exposure). How do you feel about this?</i>
	Meaning of Test Results	<i>If the test is reactive, it will mean that you are infected with HIV, you are infectious to others, and you will likely develop symptoms at some time. Help will be available to you to access the services and support that you might need.</i>  <i>If the test is non-reactive, it could mean that you are not infected with HIV <u>or</u> it could mean that you are infected, but your body has not had time to show signs of infection.</i>
	Coping while waiting for result	<i>Your test results will be available (<u>when</u>). In order to get your test result, you will need to _____. How will you deal with the stress of waiting for your test result? Who are people that are supportive to you? Does anyone know what you are going through right now?</i>
	Confidentiality	<i>Our meeting today is confidential. I won't share anything we talk about with anyone. It is important that you know that...continue below</i>
	HIV reporting	<i>If you test using your name today, your name will be reported to the health department if you are infected with HIV. If you do not want your name reported to the health department, let me know now and do not sign the consent form with your real name.</i>
	Right to Anonymity	<i>You have a right to be tested anonymously, or without giving your name of other identifying information, if you prefer. Your name will not be given to the health department if you are infected. If you test anonymously, no one will be able to contact you to give you your test result if you do not return for it.</i>
	PCRS	<i>If you test confidentially (by name) someone from the health department will contact you regarding others who may be infected. You are not required to name any sex or needle sharing partners, however help is available to you through the health department if you would like assistance in notifying others that they may be infected, even if you test anonymously today.</i>
Disclosure Law	<i>if you are infected with HIV you must disclose your infection to anyone that you are going to have sex with before penetration occurs.</i>	

	Discrimination	<i>If you have HIV, you are protected against discrimination in housing and employment.</i>
	Booklet	<i>Here is a booklet for you to read (give Important Health Information).</i>
	Right Withdraw Consent	<i>You have the right to withdraw consent to be tested until the lab processes the result.</i>
	Questions and Answers	<i>What questions do you have about anything we have talked about? How are you feeling about taking the test now?</i>
	Signature or Anonymous ID on Consent Form	Yes, client wants to test: Have client sign consent booklet or alternative.  No, client does not want to test now:  <i>What concerns do you have about testing? (offer clarifying information as needed).</i>  If client <u>still</u> does not want to test today, have client sign to indicate that they have been counseled and have decided NOT to test today.



# Quality Assurance of HIV Prevention Counseling

## 7. Frequently Asked Questions



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**Sources:** *Unless otherwise noted all of the information in this piece is from the Centers for Disease Control and Prevention website (reviewed by CDC 05/05/06)*  
<http://www.cdc.gov/hiv/pubs/faq.htm>

### What is the risk of getting HIV from.....?

**Summary of HIV Transmission Risk by Type of Non-Occupational Exposure**  
(Source: Euro-NONOPEP Project Group)

Type of Exposure (from known HIV+ source)	Risk of HIV transmission per exposure
Accidental needlestick injury	0.2 – 0.4%
Mucosal membrane exposure	0.1%
Receptive oral sex	0 - .04%
Insertive vaginal sex	≤0.1%
Insertive anal sex	≤0.1%
Receptive vaginal sex	0.01% - 0.15%
Receptive anal sex	≤3%
IDUs sharing needle	0.7%
Transfusion	90-100%

### Can I get HIV from oral sex?

Yes, it is possible for either partner to become infected with HIV through performing or receiving oral sex. There have been a few cases of HIV transmission from performing oral sex on a person infected with HIV. While no one knows exactly what the degree of risk is, evidence suggests that the risk is less than that of unprotected anal or vaginal sex.

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If the person performing oral sex has HIV, blood from their mouth may enter the body of the person receiving oral sex through

- the lining of the urethra (the opening at the tip of the penis);
- the lining of the vagina or cervix;
- the lining of the anus; or
- directly into the body through small cuts or open sores.

If the person receiving oral sex has HIV, their blood, semen (cum), pre-seminal fluid (pre-cum), or vaginal fluid may contain the virus. Cells lining the mouth of the person performing oral sex may allow HIV to enter their body.

The risk of HIV transmission increases

- if the person performing oral sex has cuts or sores around or in their mouth or throat;
- if the person receiving oral sex ejaculates in the mouth of the person performing oral sex; or
- if the person receiving oral sex has another sexually transmitted disease (STD).

Although there are very few cases documented of HIV infection in which oral sex was the sole risk for HIV, oral acquisition of other sexually transmitted infections (e.g. gonorrhea, Chlamydia, herpes) is well documented.

## **Can I get HIV from kissing?**

On the Cheek:

HIV is not transmitted casually, so kissing on the cheek is very safe. Even if the other person has the virus, your unbroken skin is a good barrier. No one has become infected from such ordinary social contact as dry kisses, hugs, and handshakes.

Open-Mouth Kissing:

Open-mouth kissing is considered a very low-risk activity for the transmission of HIV. However, prolonged open-mouth kissing could damage the mouth or lips and allow HIV to pass from an infected person to a partner and then enter the body through cuts or sores in the mouth. Because of this possible risk, the CDC recommends against open-mouth kissing with an infected partner.

One case suggests that a woman became infected with HIV from her sex partner through exposure to contaminated blood during open-mouth kissing.



For more information refer to the July 11, 1997, Morbidity and Mortality Weekly Report "Transmission of HIV Possibly Associated with Exposure of Mucous Membrane to Contaminated Blood" located at <ftp://ftp.cdc.gov/pub/Publications/mmwr/wk/mm4627.pdf>.

### **Are "lesbians" or other women who have sex with women at risk for HIV?**

Female-to-female transmission of HIV appears to be a rare occurrence. However, there are case reports of female-to-female transmission of HIV. The well-documented risk of female-to-male transmission of HIV shows that vaginal secretions and menstrual blood may contain the virus and that mucous membrane (e.g., oral, vaginal) exposure to these secretions has the potential to lead to HIV infection.

### **How effective are condoms in preventing HIV/STD?**

Latex condoms, when used consistently and correctly, are highly effective in preventing transmission of HIV, the virus that causes AIDS. In addition, correct and consistent use of latex condoms can reduce the risk of other sexually transmitted diseases (STDs), including discharge and genital ulcer diseases. While the effect of condoms in preventing human papillomavirus (HPV) infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease. (Source: Centers for Disease Control and Prevention, [www.cdc.gov/nchstp/od/condoms](http://www.cdc.gov/nchstp/od/condoms) )

### **How well does HIV survive outside the body?**

Scientists and medical authorities agree that HIV does not survive well outside the body, making the possibility of environmental transmission remote. HIV is found in varying concentrations or amounts in blood, semen, vaginal fluid, breast milk, saliva, and tears. To obtain data on the survival of HIV, laboratory studies have required the use of artificially high concentrations of laboratory-grown virus. Although these unnatural concentrations of HIV can be kept alive for days or even weeks under precisely controlled and limited laboratory conditions, CDC studies have shown that drying of even these high concentrations of HIV reduces the amount of infectious virus by 90 to 99 percent within several hours. Since the HIV concentrations used in laboratory studies are much higher than those actually found in blood or other specimens, drying of HIV-infected human blood or other body fluids reduces the theoretical risk of environmental transmission to that which has been observed - essentially zero. Incorrect interpretations of conclusions drawn from laboratory studies have in some instances caused unnecessary alarm.

Results from laboratory studies should not be used to assess specific personal risk of infection because (1) the amount of virus studied is not found in human specimens or elsewhere in nature, and (2) no one has been identified as infected with HIV due to contact with an environmental surface. Additionally, HIV is unable to reproduce outside



its living host (unlike many bacteria or fungi, which may do so under suitable conditions), except under laboratory conditions; therefore, it does not spread or maintain infectiousness outside its host.

## **How long after a possible exposure should I wait to get tested for HIV?**

It can take some time for the immune system to produce enough antibodies for the antibody test to detect and this time period can vary from person to person. This time period is commonly referred to as the “window period”. Most people will develop detectable antibodies within 2 to 8 weeks (the average is 25 days). Even so, there is a chance that some individuals will take longer to develop detectable antibodies. Therefore, if the initial negative HIV test was conducted within the first 3 months after possible exposure, repeat testing should be considered >3 months after the exposure occurred to account for the possibility of a false-negative result. Ninety seven percent will develop antibodies in the first 3 months following the time of their infection. In very rare cases, it can take up to 6 months to develop antibodies to HIV.

## **What are the different HIV screening tests available in the U.S.?**

In most cases the EIA (enzyme immunoassay), performed on blood drawn from a vein, is the standard screening test used to detect the presence of antibodies to HIV. A reactive EIA must be used with a follow-up confirmatory test such as the Western blot to make a positive diagnosis. There are EIA tests that use other body fluids to screen for antibodies to HIV. These include:

- Oral Fluid Tests – use oral fluid (not saliva) that is collected from the mouth using a special collection device. This is an EIA antibody test similar to the standard blood EIA test and requires a follow-up confirmatory Western Blot using the same oral fluid sample.
- Urine Tests – use urine instead of blood. The sensitivity and specificity (accuracy) are somewhat less than that of the blood and oral fluid tests. This is also an EIA antibody test similar to blood EIA tests and requires a follow-up confirmatory Western Blot using the same urine sample.

### **Rapid Tests:**

A rapid test is a screening test that produces very quick results, in approximately 20-60 minutes. Rapid tests use blood or oral fluid to look for the presence of antibodies to HIV. As is true for all screening tests, a reactive rapid HIV test result must be confirmed with a follow-up confirmatory test before a final diagnosis of infection can be made. These tests have similar accuracy rates as traditional EIA screening tests. Please visit the [rapid HIV testing](#) section of the Divisions of HIV/AIDS Prevention Web site for details.



## Home Testing Kits:

Consumer-controlled test kits (popularly known as "home testing kits") were first licensed in 1997. Although home HIV tests are sometimes advertised through the Internet, currently only the [Home Access HIV-1 Test System](#) is approved by the Food and Drug Administration. (The accuracy of other home test kits cannot be verified). The Home Access HIV-1 Test System can be found at most local drug stores. It is not a true home test, but a home collection kit. The testing procedure involves pricking a finger with a special device, placing drops of blood on a specially treated card, and then mailing the card in to be tested at a licensed laboratory. Customers are given an identification number to use when phoning in for the results. Callers may speak to a counselor before taking the test, while waiting for the test result, and when the results are given. All individuals receiving a positive test result are provided referrals for a follow-up confirmatory test, as well as information and resources on treatment and support services.

There are other tests that are used in screening the blood supply and for rare cases when standard tests are unable to detect antibodies to HIV.

For additional information on the various types of HIV tests, visit the Food and Drug Administration (FDA) Center for Biologics Evaluation and Research at <http://www.fda.gov/cber/products/testkits.htm>.

## Frequently Repeated Rumors about HIV Transmission:

**I got an e-mail warning that a man, who was believed to be HIV-positive, was recently caught placing blood in the ketchup dispenser at a fast food restaurant. Because of the risk of HIV transmission, the e-mail recommended that only individually wrapped packets of ketchup be used. Is there a risk of contracting HIV from ketchup?**

No incidents of ketchup dispensers being contaminated with HIV-infected blood have been reported to CDC. Furthermore, CDC has no reports of HIV infection resulting from eating food, including condiments.

HIV is not an airborne or food-borne virus, and it does not live long outside the body. Even if small amounts of HIV-infected blood were consumed, stomach acid would destroy the virus. Therefore, there is no risk of contracting HIV from eating ketchup.

HIV is most commonly transmitted through specific sexual behaviors (anal, vaginal, or oral sex) or needle sharing with an infected person. An HIV-infected woman can pass



the virus to her baby before or during childbirth or after birth through breastfeeding. Although the risk is extremely low in the United States, it is also possible to acquire HIV through transfusions of infected blood or blood products.

### **Did a Texas child die of a heroin overdose after being stuck by a used needle found on a playground?**

This story was investigated and found to be a hoax. To become overdosed on a drug from a used needle and syringe, a person would have to have a large amount of the drug injected directly into their body. A needle stick injury such as that mentioned in the story would not lead to a large enough injection to cause a drug overdose. In addition, drug users would leave very little drug material in a discarded syringe after they have injected. If such an incident were to happen, there would likely be concerns about possible blood borne infections, such as human immunodeficiency virus and hepatitis B or C. The risk of these infections from an improperly disposed of needle, such as that described in the story, are extremely low.

### **Can HIV be transmitted through contact with unused feminine (sanitary) pads?**

HIV cannot be transmitted through the use of new, unused feminine pads. The human immunodeficiency virus, or HIV, is a virus that is passed from one person to another through blood-to-blood and sexual contact with someone who is infected with HIV. In addition, infected pregnant women can pass HIV to their babies during pregnancy or delivery, as well as through breast feeding. Although some people have been concerned that HIV might be transmitted in other ways, such as through air, water, insects, or common objects, no scientific evidence supports this. Even though no one has gotten HIV from touching used feminine pads, used pads should be wrapped and properly disposed of so no one comes in contact with blood.

### **Is a *Weekly World News* story that claims CDC has discovered a mutated version of HIV that is transmitted through the air true?**

This story is **not** true. It is unfortunate that such stories, which may frighten the public, are being circulated on the Internet.

Human immunodeficiency virus (HIV), the virus that causes AIDS, is spread by sexual contact (anal, vaginal, or oral) or by sharing needles and/or syringes with someone who is infected with HIV.

Babies born to HIV-infected women may become infected before or during birth or through breast feeding.



Many scientific studies have been done to look at all the possible ways that HIV is transmitted. These studies have not shown HIV to be transmitted through air, water, insects, or casual contact.

**I have read stories on the Internet about people getting stuck by needles in phone booth coin returns, movie theater seats, gas pump handles, and other places. One story said that CDC reported similar incidents about improperly discarded needles and syringes. Are these stories true?**

CDC has received inquiries about a variety of reports or warnings about used needles left by HIV-infected injection drug users in coin return slots of pay phones, the underside of gas pump handles, and on movie theater seats. These reports and warnings have been circulated on the Internet and by e-mail and fax. Some reports have falsely indicated that CDC "confirmed" the presence of HIV in the needles. CDC has not tested such needles nor has CDC confirmed the presence or absence of HIV in any sample related to these rumors. The majority of these reports and warnings appear to have no foundation in fact.

CDC was informed of one incident in Virginia of a needle stick from a small-gauge needle (believed to be an insulin needle) in a coin return slot of a pay phone. The incident was investigated by the local police department. Several days later, after a report of this police action appeared in the local newspaper, a needle was found in a vending machine but did not cause a needle-stick injury.

Discarded needles are sometimes found in the community outside of health care settings. These needles are believed to have been discarded by persons who use insulin or are injection drug users. Occasionally the "public" and certain groups of workers (e.g., sanitation workers or housekeeping staff) may sustain needle-stick injuries involving inappropriately discarded needles. Needle-stick injuries can transfer blood and blood-borne pathogens (e.g., hepatitis B, hepatitis C, and HIV), but the risk of transmission from discarded needles is extremely low.

CDC does not recommend testing discarded needles to assess the presence or absence of infectious agents in the needles. Management of exposed persons should be done on a case-by-case evaluation of (1) the risk of a blood-borne pathogen infection in the source and (2) the nature of the injury. Anyone who is injured from a needle stick in a community setting should contact their physician or go to an emergency room as soon as possible. The health care professional should then report the injury to the local or state health department. CDC is not aware of any cases where HIV has been transmitted by a needle-stick injury outside a health care setting.



# Quality Assurance of HIV Prevention Counseling

## 8. Counselor Responses to Difficult Situations



In every situation, the counselor should attempt to identify and acknowledge how a client **feels**. Often, discussing the client's emotional response will assist the counselor in a difficult counseling session.

The situations listed below reflect a few of the more common snags that counselors encounter.

**Client is not willing to commit to doing anything new or different to reduce their risk for HIV after leaving the counseling session.**

The client may not be interested or able to make any changes. Not every counseling session will result in a risk reduction plan in which the client is doing something new and different. The client may already be taking steps that they are comfortable with to reduce their risk.

**Strategy:** The counselor should assure that the client is aware of a variety of other risk reducing options. If the client is still not interested in doing something new to protect themselves further, the counselor can assist the client with problem solving around their current strategy to assure its continuance. If the client is still not able or interested in adopting a new risk reducing behavior or action steps, the counselor should acknowledge the positive steps that this client is taking and document those things in the risk reduction plan. "You said that you have been having only oral sex for the last few months and that is working well for you. Oral sex is less of a risk than vaginal sex, so you are already doing something important to protect your health."



**Client is quiet and withdrawn, is not engaging in dialogue with counselor, answering in mono-syllables or very brief answers.**

There are many reasons why clients may not engage with the counselor. The counselor may not have done an adequate job of building rapport; the counselor is not asking open questions; the client may feel uncomfortable about talking about intimate behaviors in general or may feel uncomfortable with their own behaviors; the client may be mistrustful of the counselor or the agency, etc.

**Strategy:** Begin by acknowledging the client's lack of responses and reflect the client's feelings: for example, "It seems like you don't want to talk much about what is putting you at risk. Many people are uncomfortable talking about intimate personal behaviors. I'm wondering how you feel about it." Reassure the client that they don't have to disclose anything they don't wish to; at the same time, let them know the purpose of the discussion is to make sure they get any help they need in reducing their risk. Emphasize the confidentiality of the process. Try paraphrasing the risk situation as you understand it, and try a few open questions to add more details if possible. If the session still seems bogged down, let go and move on to test decision counseling. Note: if a counselor finds that most of his/her clients "don't want to talk", it may be a counselor issue of discomfort in asking the questions or lack of skillful open questions—rather than a client issue.

**Client actively refuses to disclose risk or discuss prevention and just wants to take the test.**

Clients are not obligated to disclose any information about their risk. Counselors are obligated to provide an opportunity to discuss risk, concerns about risk, and risk-reduction, however, clients are not required to disclose any information about their behaviors in order to be provided the opportunity to test.

**Strategy:** Emphasize that the client's confidentiality will be maintained and provide examples of the steps taken to assure the client privacy. If the



client acknowledges that they are at-risk and steadfastly refuses to acknowledge how, move on to test decision counseling. It may be helpful to try asking a polite imperative, "Please tell me if your concern about HIV is related to sex, sharing needle, or both". This may open the conversation. If the client will not reveal a risk, mark, "No Acknowledged Risk" in the HES system under risk category and "None" under situational cofactors.

#### Client who tests repeatedly and is at very low risk.

Some clients are what are known as "the worried well". These clients test regularly despite being at very low or no risk for HIV. Clients may test repeatedly for a number of reasons. She/he may: misunderstand how HIV is and is not transmitted, may not understand the testing process and the accuracy of the test, may be experiencing extreme guilt about their behaviors and see testing as a way to appease their guilt or justifying the continuance of their behaviors, and many more reasons.

**Strategy:** A counselor may confront the client in a supportive way, for example: *"From what you have told me, you are at almost no risk for HIV, and at the same time, you are very concerned. I am wondering what motivated you to come in for testing today."*

#### Clients who test repeatedly and are at high risk.

Some people will always be at some degree of risk for HIV. Some people will test repeatedly because they do not trust the accuracy of the test. It is important for the counselor to determine the motivation for continued testing to determine how best to proceed. Some clients see testing and getting negative test results as validation for behaviors that they do not want to change or that they may be ashamed of. Other clients see testing as a litmus test of their behavior: if they don't have HIV, then they don't have to make a change. Others see testing simply as an extra precaution beyond what they already do to reduce their risk.



**Strategy:** The counselor may state, *"You said that you get tested every six months. Tell me about your decision to test regularly?"* Clarify any critical misconceptions about the test and testing procedures.

If the client does not have any misconceptions about the test, the counselor may use the client's commitment to regular testing to engage in a discussion around their concerns about infection and what they may be willing to change so that they do not feel compelled to be tested regularly. The counselor may say, *"Your commitment to getting tested reflects that you are a conscientious person who is concerned about what having HIV would mean to your life. What are some things that you might be willing to try to protect yourself from HIV and reduce your need to be tested regularly?"*

If the client expresses or implies that they are not interested or able to reduce their risk for HIV, the counselor may use supportive confrontation: *"If you do not adopt some strategy to reduce your risk further, then you may become infected with HIV"*. This is a fact that the client may have already accepted. It may be helpful to discuss with the client what it will mean for them if they have HIV. This may trigger a renewed interest in prevention and reducing their need to be tested as frequently. *"What will it mean for you if this test result comes back positive,"* or, *"If you had HIV, what would you be willing to do to protect others from your infection?"*

If the client is at high risk, and is already doing what they can to reduce their risk for HIV, support and encourage their decision to test regularly. *"It takes a lot of courage to come in here and get tested. Your commitment to being tested really shows that you are a conscientious person who wants to know what it going on with your health."*

### Client is skeptical of the accuracy or validity of a negative test result.

The client may have anticipated a positive test result, or the client may have misinformation about the test and testing process. Client may also have had a potential exposure to HIV within the last 3 months and be uncertain if a possible infection is detectable yet.



**Strategy:** Review the client's risk history and timeline before the sample was taken for "window period" consideration. Discuss any possible exposures since the sample was taken. Once there is clarity on the window period, it is accurate to state, *"This test is very accurate. As long the sample was taken at least 25 days since your last potential exposure, the test is likely to show infection if you have HIV. There is a small chance that it would take up to three months for the test to react. Knowing this, how do you feel about your test result?"*

If the client is at very low risk and the sample was taken at least 25 days from their last risk incident, the counselor may offer to retest the client at another visit. By offering to retest the client at another visit, in perhaps 2 weeks, the client has an opportunity to think further about whether retesting is necessary.

If the client is at a relatively high risk or the sample was taken within 25 days from when the last possible risk occurred, then discussing with the client retesting at this visit is advisable.

**Client believes that their test result will tell them about their partner's status or behaviors.**

Sometimes clients are fixated on what the test may mean about their partner's behaviors or HIV status.

**Strategy:** Emphasize that the test only tells us if they (the client) have HIV or not. The test cannot tell us who they were infected by, how that person infected them, or how long they have been infected. Redirect the conversation to what the test results may mean to the client: *"How will knowing more about your status for HIV impact your life?"*

**Delivering indeterminate test results.**

An indeterminate test result is an accurate test result. It means that the test cannot tell if the client is or is not infected at this time. It does not mean that the client is "a little bit infected". This client may or may not have HIV.



**Strategy:** When delivering the result, the following language is recommended: *"The test result is uncertain. It was unable to determine if you are infected or not. The only way for you to know if you have HIV or not would be for you to take the test again."*

Reflect and acknowledge the client's feelings. Emphasize that the only way for the client to know if they have HIV or not is to take the test again. The recommendation is that a sample is taken at least 4 weeks from when the first sample was taken.



# Quality Assurance of HIV Prevention Counseling:

## 9. Frequently Asked Questions about OraSure

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### **How does testing using an oral specimen work?**

The OraSure HIV-1 oral collection device consists of an absorbent cotton pad which contains a simple mixture designed to draw oral mucosal transudate or fluid from the lining of the mouth. This fluid contains antibodies, including those that are specific for HIV.

The antibodies collected on the OraSure collection device are tested in a lab, using ELISA and Western Blot testing, similar to the HIV antibody testing process used for blood specimens.

### **How accurate is this collection and testing process?**

This collection and testing process is as accurate as blood testing: study samples give correct results or triggered appropriate follow-up testing 99.97 percent of the time.

### **Do positive tests with the OraSure test need to be confirmed with a blood test?**

Legally, specimens which test positive on the Western Blot are confirmed, valid results. Positive Western Blot results on an OraSure sample are legal results.

### **Can this process be used with ALL clients? (age, risk, etc.)**

This process is not FDA approved for use with clients under age 13. Only specimens from clients aged 13 years and older will be accepted by the MDCH lab.

This process is not approved for HIV-2 testing, so clients whose risk history may indicate a cause for concern about HIV-2 may want to consider blood testing.

### **How is the oral specimen collected?**

See the instructions in the OraSure Training Manual.



### **Is the test unpleasant for the client?**

The solution used to treat the pad is non-toxic, however the collection pad may taste salty, and some clients may experience a dry sensation in the mouth.

### **Does the counselor need to wear gloves to collect the specimen?**

Although HIV is not transmitted by saliva, other bacteria and viruses may be present so the use of gloves is up to the discretion of individual counselors. Hands should be washed after each client.

### **What paperwork needs to be done?**

The same paperwork as with blood specimens:

- Counselors must have the client read the informed consent booklet "Important Health Information" and sign a written informed consent.
- The Microbiology/Virology Test Requisition (DCH-0583) must be filled out and sent with the specimen. **NOTE:** 1) under "Source of Specimen" mark "OMT" and 2) under "Test Requested" mark "HIV-1".
- The Microbiology/Virology Test Requisition (DCH-0583) must also include: Patient Name or Unique Identifier (test label number), date of collection, patient's date of birth, and submitting agency's name and address. Note: The identification (name or unique identifier) on the test requisition must match the identification on the tube.
- Before specimen collection, clients must be given the client information booklet "Subject Information: What You Should Know About the OraSure HIV-1 Oral Specimen Collection Device Prior to Providing an Oral Specimen."

### **What is the shelf life of unused collection devices?**

The expiration date is clearly marked on the package, usually 2 years from the shipment date.

### **Are there special conditions for storage and transport?**

Unused collection devices should be stored at room temperature (64-77 degrees).



Collected specimens may be stored at temperatures between 39 and 98 F for a maximum of 21 days (including the shipping time.)

Specimens should be stored and transported in the OraSure HIV-1 Specimen Vial (included in the Collection Device.)

### **How should specimens be transported to the lab?**

The only State laboratory which runs the OraSure test is the Michigan Department of Community Health Laboratory in Lansing.

Specimens should be transported to the MDCH Lansing laboratory, using the shipping materials provided by the laboratory as "UNIT #4". Up to two, OraSure specimen vials can be placed in the mailing tube provided in Unit #4. . The test requisition(s) is wrapped around the outside of the specimen vial. The vial(s) and test requisitions are placed in a mailing tube. **NOTE:** Postage must be added in order to mail to the laboratory.

### **How can Collection Devices and Shipping Materials be ordered?**

**Collection devices** will be ordered directly from the company, on a master purchase agreement. Speak with your site supervisor for ordering instructions or contact an HIV CTR Program Assistant at the number below.

**Shipping materials** (Unit # 4) are ordered directly from the MDCH Lansing laboratory by faxing your order to (517) 335-9039, phoning your order to (517) 335-9867, or online at [www.Michigan.gov](http://www.Michigan.gov) (enter: "Laboratory Service Guide" into the search field and follow the instructions on the web site for ordering.)

### **Who may use the OraSure oral specimen collection device?**

People administering the OraSure oral specimen collection device in MDCH/HAPIS-funded or designated counseling and testing sites must have been trained and certified HIV Test Counselors **and** must have been trained in the use of the OraSure Collection Devices either by MDCH/HAPIS directly or by someone authorized by MDCH/HAPIS to train other people. Call (517) 241-5903 for information about counselor training or training of trainers.



**IMPORTANT PHONE NUMBERS:**

MDCH HIV/AIDS Prevention and Intervention Section (517) 241-5900

HIV Counseling and Testing Program Assistant  
and OraSure Contact (517) 241-5945

Education Training and Resource Development Unit Secretary:  
Julie Babb (517) 241-5903

MDCH Virology Laboratory: Deborah Stephens (517) 335-8098

MDCH Shipping Materials: (517) 335-9867  
Fax (517) 335-9039

MDCH Data and Specimen Handling Unit, DASH (Test records) (517) 335-8059  
Fax (517) 335-9871



## 10. "Risk Reduction: Sex Without Condoms"

HIV Counselor Perspectives (Vol 10, No. 2,  
March 2001)

Available on line by using the AIDS Health Project's archived publications search engine: <http://www.ucsf-ahp.org/HTML2/archivesearch.html>

or copying the link below:

[http://128.218.135.89:8080/searchblox/servlet/FileServlet?url=%2FUsers%2Fsweigle%2FDesktop%2FPerspectives\\_PDF%2F2001%2FPersp0301.pdf&col=6](http://128.218.135.89:8080/searchblox/servlet/FileServlet?url=%2FUsers%2Fsweigle%2FDesktop%2FPerspectives_PDF%2F2001%2FPersp0301.pdf&col=6)



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# Section V:

## Resources for Supervisors

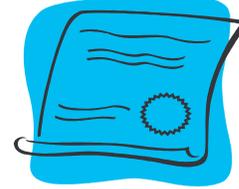
### **Section V: Resources for Supervisors**

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# Quality Assurance of HIV Prevention Counseling

## 1. Counselor Certification Requirements



### Initial Counselor Certification Training:

The HIV Basic Knowledge (Module 1), Prevention Specialist (Module 2) and Test Counselor certification (Module 3) trainings and continuing education are required for individuals who provide HIV test counseling, and who give HIV test results in MDCH funded/designated counseling and testing sites.

**To receive certification, participants must attend each training day in its entirety.** All training days for the modules are from 8 a.m. to 5 p.m. **Participants must also score a minimum of 80% on the exit exams.** In order to receive HIV test counselor certification, the following three trainings must be completed: *Module 1-HIV/AIDS Basic Knowledge Training, Module 2-HIV Prevention Specialist Certification Training, and Module 3-HIV Test Counselor Certification Training.*

### HIV Prevention Specialist and HIV Test Counselor Update Training:

HIV Prevention Specialists and Test Counselors who work in DHWDC-funded agencies and/or designated test sites are required to complete six hours of skills and information enhancement every two years to maintain their certification. **\*There are five options for meeting the update requirement.\***

#### Option 1: One-Day HIV Prevention Specialist/Test Counselor Update

Counselors may attend one of the DHWDC-sponsored one-day HIV Prevention Specialist/Test Counselor Update Trainings.



**Option 2: Specialized HIV Training Courses**

Counselors may attend one of the DHWDC-sponsored Specialized HIV Training courses listed in this calendar.

**Option 3: Partner Counseling and Referral Services (PCRS) Training Courses**

Counselors may attend one of the DHWDC-sponsored PCRS Certification or Recertification trainings listed in this calendar.

**Option 4: Annual Statewide STD/HIV Conference**

Counselors may attend the DHWDC-sponsored Annual STD and HIV Conference that will take place in November/December. Conference announcements will be mailed out during the summer.

**Option 5: Non-DHWDC Sponsored Events**

COUNSELORS DO NOT HAVE TO ATTEND HAPIS TRAININGS FOR UPDATE CREDIT. Counselors may fulfill the update requirement by taking advantage of other HIV-related training opportunities. Many of these opportunities are free or low cost and some do not require travel away from your place of employment. The following are examples of these options:

- HIV/AIDS Regional Training Center Trainings
- HIV Staff In-services
- PRP-Approved HIV Prevention Videos
- HIV-related *MMWR* CME Program Courses
- Web-based CME Opportunities (e.g., Medscape HIV/AIDS CME Center, [www.rn.com](http://www.rn.com), [www.mitrain.com](http://www.mitrain.com))
- Satellite, Web, and TV Broadcasts
- National STD Prevention Conference
- National HIV/AIDS Update Conference
- United States Conference on AIDS
- Community Planning Leadership Summit

Update hours may be obtained at one time (i.e., a one-day workshop) or in smaller segments over the course of two years. Counselors must receive a total of six hours of skills and information enhancement. Counselors will be permitted to use six hours of update training from any of the following categories: a) counseling, psychosocial



issues or issues for special populations (e.g. substance users); and b) HIV epidemiology, biology, testing or treatment.

When counselors have accumulated six hours of update training, they should submit the *Update Documentation Form* to DHWDC. This form is not necessary if updates are completed via options 1-4; HAPIS will update you automatically. For update options that do not provide a certificate or agenda (e.g., HIV prevention video), please submit a brief summary (1/2 page) of the content. Please submit an agenda, conference brochure or other documentation along with the Update Documentation Form. **Documentation must be submitted by December 31<sup>st</sup> of the year in which you wish to receive the update credits.** For more information contact the HAPIS Education, Training, and Resource Development Unit at (517) 241-5900.



# Quality Assurance of HIV Prevention Counseling

## 2. Elements of HIV Prevention Counselor Orientation

(adapted from Texas Department of Health)

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### **Administrative/ Contractual Issues:**

- ❑ HIV Laws, Rules & Regulations - Federal & State (Health & Safety Code)
- ❑ Agency RFP Application/Copy of MDCH Contract
- ❑ Agency Objectives for HIV Counseling and Testing (including e.g. return rates, partner elicitation, successful referral to early intervention)
- ❑ Work Plan and Time Lines
- ❑ Evaluation Plan
- ❑ Programmatic Reporting Requirements
  - Data Collection
  - Documentation Forms
  - Quarterly Reports and Instructions
  - Due Dates/Deadlines
- ❑ Quality Assurance Standards for HIV Prevention Interventions (MDCH, 2003)
- ❑ Revised Guidelines for HIV Counseling, Testing, and Referral (CDC, 2001)

### **Laws, Policies and Procedures (state and local)**

- ❑ Confidentiality
- ❑ Client Consent/Releases
- ❑ Safety (Outreach and in-house)
- ❑ Crisis Intervention Plans
- ❑ Universal Precautions
- ❑ Accidental Exposures/Prophylactic Treatments
- ❑ Mandatory Reporting (CPS/Law Enforcement)
- ❑ Duty to Warn
- ❑ Complaints
- ❑ Grievances
- ❑ Travel/Transportation for Clients
- ❑ Staff Travel Guidelines and Documentation

### **Program Operations & Services**

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- ❑ Staff Responsibilities
- ❑ Site Protocols
- ❑ Standing Delegation Orders

### **General Counseling Issues**

Informational needs re:

- ❑ STD Overview/Facts & Fallacies
- ❑ Syphilis Elimination Overview
- ❑ TB Overview
- ❑ HCV, HBV and HAV Overview
- ❑ Substance Abuse Overview
- ❑ Cultural Issues (e.g. limited English Proficiency Issues, TDD use, race/ethnicity)

Prevention Messages

- ❑ CDC and MDCH notices and announcements
- ❑ Harm Reduction
- ❑ Demonstrations
  - Condoms (male and internal)
  - Cleaning Injection Works
  - Safer Smoking and Injection Kits
- ❑ Other Barrier Methods

HIV Prevention Interventions

- ❑ (referrals available)
- ❑ Client/Staff Boundaries
- ❑ Self Disclosure

**Counselor Quality Assurance:**

- ❑ Standards for HIV Prevention Counseling (MDCH/CDC)
- ❑ QA Toolbox: Direct Observation form
- ❑ QA Toolbox: Chart Review form
- ❑ Supervisory Chart Reviews
- ❑ Observations by supervisor and/or peer mentors
- ❑ Counselor Self-Assessments at 6 weeks post-training, 3 months post-training
- ❑ Observations of Peer Sessions with Feedback and Strategizing Sessions

**Policies and Procedures related to Clients Who Test Positive:**

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- ❑ Case report forms
- ❑ Partner Elicitation Orientation
- ❑ Health Department Notification and Client-Self Notification
- ❑ Forms
- ❑ Meet the local DIS
- ❑ Making and tracking referrals
- ❑ CARF
- ❑ Local referrals
- ❑ Prevention Case Management
- ❑ HIV Case Management

### **Documentation Issues**

- ❑ Counseling Sessions: Risk Assessments and Risk Reduction Plans
- ❑ Anonymous vs. confidential records
- ❑ Informed consent
- ❑ Serology Forms
- ❑ Hepatitis C Forms (if applicable)
- ❑ HERR activities
- ❑ HIV Event System Training
- ❑ Referrals
- ❑ Filing System
- ❑ Record Security
- ❑ Record Retention
- ❑ Destruction of Records

### **Referral Issues**

- ❑ Letters of Agreement/Memoranda of Understanding
- ❑ Memoranda of Understanding with local STD Program
- ❑ Client Consent/Releases
- ❑ Documentation/Tracking of Referrals
- ❑ Referral Resources
- ❑ Community Resource Directory (State and Local)
- ❑ Contact Names
- ❑ Client Eligibility Criteria
- ❑ Follow-up

### **Laboratory Issues (as applicable):**

- ❑ OraSure Training

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- ❑ Rapid Test Training
- ❑ Phlebotomy Training
- ❑ HCV, HIV and syphilis testing
- ❑ Informed Consent
- ❑ Lab Orientation/Protocols of Testing Sites
- ❑ Instruction for Specimen Storage and Submission

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# Quality Assurance of HIV Prevention Counseling

## 3. Considerations for Hiring New Counselors

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### Clarify Job Requirements:

In order to hire counselors who fit best with an agency, supervisors need to start with a clear understanding of what is needed in an HIV prevention counselor, in terms of knowledge, skills, personal qualities and attitudes. Those qualifications need to be included in a clear position description which also clearly outlines the responsibilities, duties and specific tasks of the position. Outlined below are some sample duties and tasks for the position of HIV prevention counselor, along with some examples of the individual qualifications needed for the position. Depending on the agency, counselors may have other roles beyond HIV prevention counseling, that require additional qualifications beyond those outlined here.

### Sample Duties and Tasks

**Responsibility:** assist agency clients and community members with reducing their risk of acquiring and/or transmitting HIV and with learning their HIV serostatus

**Duties:** provide HIV prevention and test counseling to agency clients, according to federal, state, and agency standards and policies, during both walk-in and appointment sessions, 20 hours per week

### Tasks:

- Maintain test site environment, including stocking supplies and educational materials
- Set-up appointments
- Welcome clients and provide with paperwork
- Clarify and enhance clients' understanding of their own risk for HIV/STD/HepC
- Assist clients in development of personal plans to reduce their risks of acquiring and/or transmitting HIV
- Assess and provide referrals
- Obtain informed consent prior to collecting test specimen
- Collect oral HIV-antibody test specimens, package for delivery to lab
- Provide test results
- Complete all necessary paperwork and documentation



**Knowledge:**

Reproductive system  
HIV/AIDS  
Hepatitis C  
Behavior change  
Community resources

Infectious disease (basic)  
STD  
Sexuality  
Culture of clientele

**Skills:**

Communication (verbal and written):

Able to communicate complex information clearly, succinctly and at client's level

Writes legibly

Able to summarize and record sessions thoroughly and accurately

Counseling skills

Organizational skills:

Thorough

Timely

Accurate

Able to manage paperwork of multiple pages

**Personal Qualities:**

Non-judgmental (race, ethnicity, religion, sexual orientation, sexual or drug-use behaviors, etc)

Empathic (able to view world from another's perspective)

Compassionate

Independent (particularly for outreach sites)

Self-starting (has initiative)

Open to learning

Dependable

Capable of personal and professional growth

Able to manage own issues/opinions

Understands and practices confidentiality

Depending on the site, and scope of other job duties to be performed, additional requirements may include educational certificates or degrees, previous similar job experience, etc. Also depending on the site and available pool of appropriate candidates, some agencies may seek candidates with all knowledge and skills in place prior to hiring, while other agencies may have the flexibility or the need to hire

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employees with suitable communication and organizational skills and personal qualities and then train them in the HIV-specific knowledge and skills on the job. Some agencies may require counselors to be certified in HIV prevention/test counseling prior to application; others train new counselors after hiring.

### **Interviewing:**

There are many resources for advice on personnel recruitment and selection, including the readings noted below. Here are just a few general thoughts on interviewing candidates for the position of HIV prevention counselor:

- Ask about previous employment history, especially those positions which included components of in-depth client interactions, talking with people about intimate subjects, using medical knowledge, working independently etc.
- Ask for specific examples of times when the candidate has demonstrated the skills you are looking for (e.g. *"Tell me about a time when you have explained a medical procedure to someone."* It could even be a parent explaining to a child something the doctor is going to do.)
- Ask the candidate to demonstrate, for you, the knowledge or skills you are looking for. The candidate could demonstrate explaining a medical procedure, respond to hypothetical client questions or situations, write sample session notes, etc.
- Look for evidence of the candidate's self-awareness and willingness/ability to grow. Ask about the candidate's deficiencies or challenges, as well as about his or her attributes or strengths. Ask for examples of issues or situations which have been challenging and how they have handled them, what they learned.
- Remember that the whole application and interview process is a demonstration of the candidate's skills and attributes. If the resume or application form is illegible, contains many mistakes or is poorly written, you might have concerns about the same performance on required paperwork. If the candidate is not able to give clear, succinct answers to your questions, they may not be able to do so for clients' questions. While you certainly would expect a candidate to be more nervous in an interview than they would be on the job, how a candidate handles the stress of the interview may give you clues how they would handle stressful situations on the job.

### **Hiring New Counselors:**

When extending an offer of employment to a new counselor, some agencies may be in the position to make the offer provisional. In other words, many agencies have a

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short-term probationary period for both employee and employer to “try-out” the fit between them. Depending on their own individual personnel policies, agencies may make passing of the probationary period contingent on passing the counselor certification training and passing supervisory chart reviews and direct observations.

Whether or not a probationary period is used, new counselors should be observed by their supervisors and have their charts reviewed during their initial months of employment. See Section II, document 2 “Document, document, document: Chart Reviews” and Section II, document 3 “Surveying the Scene: Direct Observations” for recommendations on initial supervisory assessments.

### **A Note about Volunteers:**

Most of what is written about hiring new counselors as employees may apply for volunteer counselors as well. Clearly, training a new volunteer is a big investment for an agency, so it may be useful to have volunteers sign a commitment form, committing to volunteer for a specified length of time or number of hours. See Section V, document

### **Recommended Reading:**

“ Chapter 5: Position Descriptions and Performance Standards” and “Chapter 7: Personnel Recruitment and Selection” in Management Skills for the New Health Care Supervisor, 3<sup>rd</sup> edition by William Umiker (Aspen Publishers, 1998.)



# Quality Assurance of HIV Prevention Counseling

## 4. Sample Volunteer HIV Prevention Test Counselor Commitment Form

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### Policy:

It is the policy of Acme Prevention Michigan (APM) to only permit persons certified by the Michigan Department of Community Health to provide HIV counseling, testing and referral (CTR) services at any of its testing sites or venues. Certification is obtained by completing: **Module 1: HIV Basic Knowledge Training, Module 2: HIV Prevention Specialist Certification and Module 3: HIV Test Counselor and PCRS Certification for Community Based Organizations or Health Departments**

Certification is based upon demonstration of a minimum level of competency, complete attendance of both days, and a minimum score of 80% on the exit examination. HIV Test Counselors must maintain their certification by completing six hours of continuing education every two calendar years. Test counselors who fail to complete their certification update requirements will be decertified and are required to complete Modules 1-3.

Acme Prevention Michigan requires that persons who desire to receive HIV Test Counselor certification as an APM volunteer must to commit to a minimum of at least one year of volunteer service as an HIV Test counselor at any of the organization's test sites or venues. **This expectation is made in exchange of verification that the applicant will be providing HIV test counseling at APM, waiver of the MDCH training fee, as well as on-site HIV CTR skills and training provided by APM.** APM recognizes that circumstances may change in a person's life, that may require a change in the length and time of a volunteer's time commitment, however, our clients and staff deserve competent, dedicated HIV Test Counselors.

THE PREVENTION DIRECTOR MUST APPROVE TIME COMMITMENTS OF LESS THAN ONE YEAR PRIOR TO VERIFICATION OF VOLUNTEER AFFILIATION TO MICHIGAN DEPARTMENT OF COMMUNITY HEALTH.



SAMPLE VOLUNTEER COMMITMENT STATEMENT

I, \_\_\_\_\_ agree to provide a minimum of one year of volunteer service or (from \_\_\_\_\_ to \_\_\_\_\_) following completion of MDCH Test Counselor Certification and other APM required competency and proficiency skills training.

\_\_\_\_\_  
Volunteer' Signature                      Date

\_\_\_\_\_  
Volunteer Coordinator                      Date

\_\_\_\_\_  
Prevention Director                      Date



# Quality Assurance of HIV Prevention Counseling

## 5. Sample Risk Assessment Form(s)

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See attached



# HIV Counseling and Testing Questionnaire

*Welcome to the HIV Counseling and Testing Services provided by XYZ Agency. Knowing your HIV status is very important and you have taken an important step in coming here! Today the counselor will be talking with you about your risks for HIV and what you can do to reduce your risks, as well as taking your test sample. Filing out this questionnaire will help your test counselor with this discussion. Even though some of the questions are very personal, we ask that you answer them as honestly as possible. Your answers are confidential, and the information on this questionnaire is for statistical purposes only. Thank you! DO NOT PUT YOUR NAME ON THIS FORM.*

**Date:** \_\_\_\_\_

## About Me:

<b>My gender is:</b> <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> transgender	<b>My race is:</b> <input type="checkbox"/> African American/Black <input type="checkbox"/> Arab/Chaldean <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/PI <input type="checkbox"/> Native American <input type="checkbox"/> White	<b>I am:</b> <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> partnered <input type="checkbox"/> divorced <input type="checkbox"/> widowed	<b>I live in:</b> State: _____  County: _____  Zip Code: _____
<b>Age:</b> _____  <b>Date of Birth:</b> ____/____/____	<b>Ethnically I am:</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> African born <input type="checkbox"/> Other: _____	<b>I am:</b> <input type="checkbox"/> pregnant <input type="checkbox"/> not pregnant	<b>If pregnant:</b> <input type="checkbox"/> in prenatal care <input type="checkbox"/> not in prenatal care <input type="checkbox"/> N/A

## About my visit:

**I am here to get tested today because:**  
**(check all that apply)**

- The thought of having HIV is very scary to me  
 \_\_\_\_\_)
- I am starting a new relationship
- I test routinely (every \_\_\_\_\_ months)
- I am retesting to confirm a negative result
- I have a possible or recent risk exposure  
 Inconclusive/indeterminate
- I have symptoms that might be HIV
- My partner suggested it
- A friend or family member suggested it
- I was referred by another agency or health care provider
- I have been court-ordered to test
- Other: \_\_\_\_\_

## About Testing:

**I have tested for HIV before**

- No
- Yes (when:

If yes, the results were:

- Negative
- Positive
- 

Did not get results

**I have tested for Hepatitis C:**

- No
- Yes

If yes, the results were:

- Positive
- Negative
- Did not get results



## About my risks:

### I have had sex with:

- Men only
- Women only
- Both men and women

**In the past 3 months, I have had sex with**  
(insert number) \_\_\_\_\_ **partners.**

**In the past year, I have had sex with**  
(insert number) \_\_\_\_\_ **partners.**

### In the past 3 months, I have had the following sexual experiences:

(choose all that apply)

- Oral sex
- Anal sex
- Vaginal sex
- Not applicable

### In the past 3 months, I have used a condom during anal or vaginal sex:

- Always
- Sometimes
- Rarely
- Never
- Not applicable

### In my life or since my last HIV test I have:

- Shared needles or other injection equipment
- Had sex with a person with HIV
- Had sex with someone who injects drugs
- Provided sex for money, drugs, or other things
- Had sex with a man who has had sex with another man
- Had a work exposure to blood or other infectious body fluids

### In the past 3 month, I have:

- Been incarcerated (prison or jail)
- Been homeless
- Experienced domestic violence
- Done migrant work
- Been diagnosed and/or treated for mental illness
- Had sex with someone of unknown HIV status
- Had sex with someone I did not know (anonymous)
- Been forced to have sex

### In the past 3 months, I have had and/or been treated for the following sexually transmitted infections:

- Chlamydia
- Gonorrhea
- Herpes
- HPV/genital warts
- Syphilis
- Hepatitis B
- Hepatitis C
- Other: \_\_\_\_\_

### In the past 3 months, I have had sex while using: (check all that apply)

- Alcohol
- Inhalants
- Amphetamines/Speed
- Marijuana
- Cocaine/Crack
- Crank/Crystal meth
- Heroin
- Club Drugs (ecstasy, GHB, K)
- Sedatives/Downers
- Hallucinogens (LSD, Mushrooms)
- Other: \_\_\_\_\_

### I have the following questions or would like to talk with the counselor about:

---

---

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*Thank you for your assistance!*

# Quality Assurance of HIV Prevention Counseling

## 6. Sample Session Documentation Form(s)

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See attached for blank and sample completed form



## HIV Prevention Counseling Session Summary

Date: \_\_\_\_\_ Client ID#: \_\_\_\_\_ Counselor: \_\_\_\_\_

Current Risk Behavior(s) and Circumstances:

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---

---

Most recent exposure (what/when): \_\_\_\_\_

Safer Goal Behavior(s):

---

---

Personal Action Plan/Steps:

---

---

---

Key Barriers/ Facilitators (including previous successes):

---

---

---

Referrals (note if actively facilitated):

---

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Additional Notes: \_\_\_\_\_

Results Counseling: Date: \_\_\_\_\_ Counselor: \_\_\_\_\_ Result: \_\_\_\_\_

Discussion of retesting: \_\_\_\_\_

Reassessment/renegotiation of risk reduction plan:

---

---

Additional referrals/Notes:



## HIV Prevention Counseling Session Summary

Date: 12/19/06 Client ID#: 123456 Counselor: Mary Doe

### Current Risk Behavior(s) and Circumstances:

Female client has unprotected receptive oral sex with casual male partners twice in past 6 months. Episodes related to alcohol use at bars.

Has unprotected vaginal sex with steady male partner for one year

**Most recent exposure (what/when):** unprotected vaginal sex with steady partner—last week,  
Unprotected oral sex with outside partner 2 months ago

### Safer Goal Behavior(s):

Use condoms with steady partner until test results come back

Abstain from all sex with casual, outside partners

### Personal Action Plan/Steps:

Get tested for HIV today, return next week for results

Take condoms today and tell partner need to use because of possible vaginal infection

Talk to best friend about strategies to not get into hook-up situations and avoid drinking to excess

### Key Barriers/ Facilitators (including previous successes):

Difficult to talk to steady partner about condoms, but has previous history of condom use w/o problems with partner

Binge drinking is episodic part of social life, but best friends don't approve of casual hook-ups so will support attempts to limit

### Referrals (note if actively facilitated):

Planned Parenthood for STD testing

Alcohol counseling—discussed, not desired at this time

### Additional Notes:

**Results Counseling:** Date: 12/27/06 Counselor: Mary Doe Result: non-reactive

**Discussion of retesting:** client wants to retest in one month due to anxiety about last exposure with outside partner (10 weeks ago)

### Reassessment/renegotiation of risk reduction plan:

Client used condoms w/ steady partner this week and will continue until STD aypmt. at Planned Parenthood

Client discussed issues with best friend who agreed to help with reducing alcohol consumption at bars

### Additional referrals/Notes:



# Quality Assurance of HIV Prevention Counseling

## 7. A Quality Assurance Checklist for Supervisors

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**Quality Assurance of HIV Prevention Counseling:  
How Sharp Are Your Tools?  
A Check-list for Supervisors**

- All counselors in this agency are certified by MDCH
- All counselors have completed MDCH-approved certification or update training in the past two years.
- All new counselors receive a thorough orientation on:
  - QA Standards and Guidelines
  - Programmatic Reporting Requirements
  - Agency work plan, time lines, contract
  - HIV Laws—federal and state
  - Confidentiality
  - Client consent and releases
  - Safety
  - Crisis intervention
  - Mandatory reporting
  - Staff responsibilities
  - Site protocols
  - Basic informational needs and resources
  - Prevention messages, supplies, resources
  - Available community referrals/resources
  - Appropriate client-staff boundaries
  - Policy & procedures around positive tests
  - Documentation issues
  - Making an appropriate, effective referral
  - Laboratory protocols, including administering of test
- Counselors receive routine updates on relevant counseling issues through written informational pieces
- New counselors shadow experienced counselors
- New counselors are observed by experienced counselors (peer mentors) and/or supervisor

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- New counselors' charts are reviewed by supervisor and/or peers
- Counselors conduct self-assessments of counseling skills at regular intervals
- Supervisor and/or staff conduct regular chart reviews
- All counselors are periodically observed by supervisor and/or peers
- Counselors receive periodic in-house updates and/or training on relevant topics including: counseling skills, documentation, HIV fact updates, testing issues, client issues, etc
- Supervisor meets with counselors on regular basis to discuss issues related to CTR
- Counselors have opportunity to enhance skills through role-playing with supervisor and/or peers
- Supervisor facilitates regular reviews/explorations of client cases ("case conferencing")
- Agency utilizes client surveys (client satisfaction/feedback surveys)
- Agency evaluates results of client surveys and provides results to counselors.
- Supervisor discusses CTR issues with HAPIS monitors and requests technical assistance as needed
- HAPIS does a QA visit every year
- Supervisor discusses HAPIS QA findings with counselors

