ATTACHMENT 23
LIST OF MINIMUM QUALITY STANDARDS
FOR HIV PREVENTION AND HIV TESTING PROGRAMS

GEORGIA DEPARTMENT OF
COMMUNITY HEALTH
Division of Public Health

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List of Minimum Quality Standards for HIV Prevention and HIV Testing Programs

HIV Unit ▪ Division of Public Health
Georgia Department of Community Health

Introduction.

The purpose of this document is to provide a written list of Minimum Quality Standards for the provision of HIV prevention services and HIV testing services by organizations working in partnership with the HIV Unit of the Division of Public Health, Georgia Department of Community Health (DCH).

The HIV Unit receives federal funds for HIV prevention and HIV testing, as part of a cooperative agreement between the State of Georgia and the Centers for Disease Control and Prevention (CDC) primarily for the purpose of reducing Georgia's HIV incidence rate. Key activities as part of this cooperative agreement are listed below.

- The State of Georgia will ensure the delivery of targeted, sustained and evidence-based HIV prevention interventions, including prevention of perinatal HIV transmission;
- The State of Georgia will ensure the implementation of proven public health strategies such as HIV/STD partner services;
- The State of Georgia will ensure the development of systems and relationships to ensure clients are linked to appropriate prevention, care, and treatment services; and,
- The State of Georgia will ensure the development and implementation of capacity-building, program monitoring and quality assurance policies and procedures to support continuous program improvement.

In support of these activities, the HIV Unit works in partnership with a broad range of community-based organizations, local health districts, health departments, clinics and other organizations. This list of Minimum Quality Standards is aimed at ensuring procedural clarity and consistency.

Definition of "Contractor."

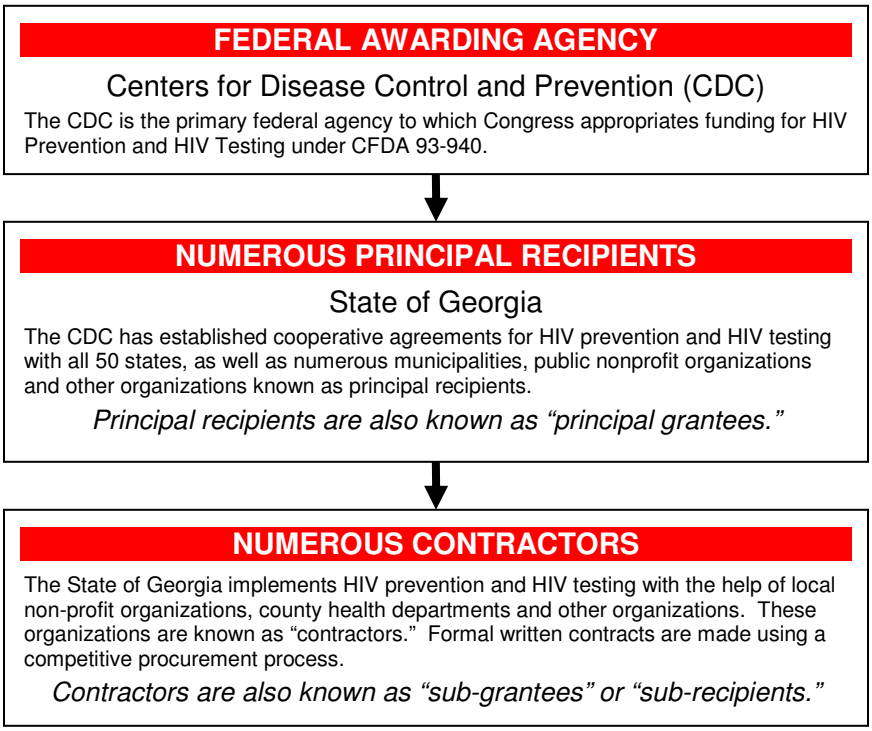
As used in this document, the term "contractor" refers to any organization that receives payment or in-kind support from the HIV Unit for the purpose of implementing activities that are directly related to the HIV prevention goals of the HIV Unit. The following list provides examples of "contractors."

- Community-based organizations (CBO's) that receive grant funding from the HIV Unit
- Local health departments and health districts that receive Grant-In-Aid (GIA) funds from the HIV Unit
- Any organizations that receive in-kind support from the HIV Unit, such as HIV testing kits (even if no money is exchanged)

The terms of the working relationship between the HIV Unit and the contractor must be in the form of a written contract, Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU).

In casual conversation, it is common to use the terms “contractor” and “grantee” interchangeably. However, these terms actually do not mean the same thing.

The following chart illustrates this distinction.



Distinction between “Should / Must” and Equivalents.

Throughout this document, terms such as “must” and “should” are used carefully.

- Should: This word means the standard is suggested, encouraged and highly recommended. However, valid reasons may exist to justify ignoring the standard because of specific extenuating circumstances. Contractors will not be penalized by the HIV Unit for failure to abide by the standard, especially if the contractor is working in good faith toward future compliance with the standard.

  - **Other Similar Words:**
  - **May**
  - **Might**
  - **Recommended**
  - **Suggested**
  - **Encouraged**

- Must: This word means the standard is an absolute requirement and is not negotiable.

  - **Other Similar Words:**
  - **Shall**
  - **Required**
  - **Will**

Future Revisions.

Readers should note the revision date shown below. The format and content of this document may be modified from time to time. Visit the web site of the HIV Unit periodically to check that you have the most current version: www.health.state.ga.us/programs/stdhiv/

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	ADMINISTRATIVE STANDARDS
A1	**Attainment of Contract Deliverables** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must demonstrate adequate ongoing progress toward achieving the goal of deliverables listed in the contract "Statement of Work." If a contractor experiences difficulty reaching monthly targets for a particular deliverable, the contractor must show that significant progress was made toward reaching that deliverable and that an action plan is in place for correcting the situation effectively.
A2	**Narrative Reports** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must submit program narrative reports with complete, clear, specific and detailed information describing the activities of the contract during the stated period and progress toward goals. Reports (and all required attachments) must be submitted in a timely fashion. The frequency and due date for narrative reports will vary, however, depending on the contract.
A3	**Informed Consent** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must have written procedures requiring documentation of voluntary and informed consent from a client before he or she participates in any HIV prevention intervention. At a minimum, the informed consent must address the following topics and answer the following questions. • What is the purpose, expected duration and general content of the intervention? • The client's right to decline to participate and to withdraw from the intervention once participation has begun. • What types of information will be collected about the client, if any? • How will client data be stored? How long will the information be archived? • In general, what does the organization do to protect client confidentiality? • What types of information will be shared with the HIV Unit or other organizations, if any? • Will the program be free of cost to the client? If not, what specific fees will be charged? • General client responsibilities such as arriving at a certain time, and participating for a certain minimum amount of time. • The privacy of personal information disclosed by other clients. • Will the contractor need to contact the client at a future date? Why? • Will photographs be taken? If so, how they will be utilized? • Will video or audio recordings be made? If so, how they will be utilized? • Will any incentives be provided? If so, what is the monetary value of those incentives? • Whom should the client contact for questions about the intervention and clients' rights? • Where can the client obtain a copy of the contractor's grievance procedures, if desired? The informed consent must be written using language that is reasonably understandable to the client.

A4	**PEMS Data Reporting** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must utilize the online PEMS tool for manually entering all required PEMS program variables for each of the following types of program activities. • Any behavioral intervention with an individual client (individual-level) • Any behavioral intervention with a group of clients (group-level) The following forms have been created to help contractors collect the required PEMS variables for each of the above types of activities. • Form HIV510: Participant Sign-In Sheet • Form HIV520: Behavioral Risk Assessment Tool (Client-Level Data for Individual-Level Interventions) • Form HIV530: Aggregate-Level Form for Outreach and Group Interventions In addition to these forms, contractors are also required to submit a report of aggregate program-level data using "Form HIV531: Process Monitoring Aggregate Form" each month. Contractors must ensure data entry is completed in a timely fashion, such no later than 30 days after each program activity.
A5	**Review Panel** REQUIRED In accordance with CDC requirements, all educational materials utilized in federally-funded HIV prevention programs must be reviewed and approved by a local review panel. All contractors funded to implement behavioral interventions for HIV prevention must utilize the Georgia Materials Review Committee for this purpose or another local review panel formed in accordance with CDC requirements. Contractors must have documentation on file to show compliance with this CDC requirement. See 57 Federal Register 26742 (1992).
A6	**Acknowledgement of DCH Sponsorship** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must include the following statement in each of the following types of printed materials created by the contractor for the funded HIV prevention program: brochures, flyers, press releases, posters and banners. • This program was made possible in part by a grant from the Georgia Department of Community Health, Division of Public Health, HIV Unit with funding from the Centers for Disease Control and Prevention (CDC). In addition, if the organization provides information about its funded intervention on a particular page of its web site, the acknowledgement should appear on that particular page. A link to the HIV Unit web site should also be included. This standard does not require including the DCH logo as part of this acknowledgement of sponsorship. However, if a contractor wishes to include the DCH logo, an authorization must be obtained beforehand from the DCH Director of Communications. The contractor may be required to provide samples of such publicity materials for examination.

A7	**Cultural Competence** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must strive to offer culturally competent services by ensuring all volunteers and employees are aware of the demographic, cultural, and epidemiologic aspects of their communities. Contractors should dedicate time and resources for paid and volunteer personnel to receive education aimed at building awareness of these aspects, as well as training aimed at building skills for serving clients of diverse backgrounds. Contractors should recruit, train and promote a team of paid and volunteer personnel representative of and sensitive to the various different cultures served in the contractor's local community. Contractors should make reasonable accommodations to offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. Contractors should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated and addressed. Contractors should provide opportunities for all paid and volunteer personnel to develop an understanding of how stigma, culture, race, ethnicity, discrimination, gender identity, sexual orientation, violence, substance use, economic status, educational attainment and other factors impact health outcomes. The Office of Minority Health of the U.S. Department of Health and Human Services has published the National Standards for Culturally and Linguistically Appropriate Services in Health Care, which may be utilized as a guide for ensuring cultural competence in the delivery of programs and services.
A8	**Documentation of Training in HIV Prevention Intervention** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must be able to produce documentation showing that each volunteer and/or employee whose position is funded in whole or in part by the contract has been trained in proper program implementation procedures. In addition, contractors must have plans in place to ensure the ongoing assessment of staff and volunteer training needs and the provision of training for volunteers and staff members as needed and appropriate.
A9	**Volunteers** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must ensure that volunteers receive training in proper program implementation procedures. Volunteers should be held to the same performance standards as employees. Contractors should know and disclose how their liability insurance and worker's compensation applies to volunteers. Contractors are encouraged by the HIV Unit to develop and maintain a "Manual of Standard Operating Procedures for the Management of Volunteers" or other similar document.
A10	**Criminal History Documentation** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must have on file a criminal history report for 1) each employee whose position is funded in whole or in part by the contract and 2) volunteer staff members who are actively involved in the implementation of the program.

A11	**Confidentiality** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must have a system in place to ensure that confidentiality is maintained for all participants in the program. Client-level data should be kept in a secure, locked place that is accessible only to appropriate staff at their work place. Provisions should be made to ensure security and confidentiality whenever file transport is necessary. Before sharing any information with another agency to which a client is referred, signed authorization from the client (or his/her legal guardian) must be obtained. Employees must be trained to comply with the contractor's system of confidentiality. If a contractor experiences a breach of confidentiality involving one or more clients, the contractor must report the breach to the HIV Unit within 14 days of learning about the occurrence. The contractor must also conduct a prompt investigation of the breach and provide a preliminary or final report to the HIV Unit regarding the findings of the investigation within 30 days of learning about the occurrence.
A12	**Safety Protocol** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must have a safety protocol to help ensure the safety of paid and volunteer personnel, especially if the contract involves conducting off-site outreach and recruitment of clients. The safety protocol must include no drug or alcohol use, appropriate professional behavior with minors and their parents and no loaning or borrowing of money. Plans for dealing with medical or psychological emergencies must also be included.
A13(a)	**Contractor Policies for Grievances and Whistleblower Protection** All contractors funded to implement behavioral interventions for HIV prevention are encouraged by the HIV Unit (but not required) to have a system and policy to receive and respond to internal and external complaints from clients, employees and board members regarding violations of the law, ethics violations, violations of organizational policy or other misconduct. At a minimum, it is recommended (but not required) that the written policy should include the following components. • a system for submitting complaints and reporting related factual information • a procedure for investigating the allegations • a procedure for reporting the investigation findings • a procedure for reporting decisions made as a result of the investigation • a procedure for clients to request an appeal if unsatisfied with the investigation outcome • a prohibition against retaliatory action against those who make good faith complaints Sample whistleblower policies are available from organizations like the Georgia Center for Nonprofits and the National Council of Nonprofits.

A13(b)	**Contractor Policy on Conflict of Interest** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must have a written conflict of interest policy. The Panel on the Nonprofit Sector, Interim Report, Section 4, Conflict of Interest Policy Disclosure contains a useful description of the Conflict of Interest issue. References to the Internal Revenue Code note that the Code defines a conflict of interest and that: "All states mandate that directors and officers owe a duty of loyalty to the organization, and improperly benefiting from a transaction involving a conflict of interest more than likely involves a violation of the duty of loyalty. Some state statutes specifically penalize participation in transactions involving conflicts of interests unless the organization follows certain prescribed procedures." At a minimum, the contractor's conflict of interest policy must include the following components. • It must be tailored to the organization's specific needs and characteristics. • It must define the term "conflict of interest". • It must identify groups of individuals within the organization covered by the policy. • It must address transactions between governing body members, advisory group members, owners, staff, and the organization. • It must include provisions for policy enforcement. • It must provide a framework for evaluating situations that may constitute a conflict. The policy should ensure that governing body or advisory group members who are employees (or relatives of employees) must excuse themselves on matters where their objectivity would be compromised, such as promotions, salaries and specific benefit packages. The standard does not require an exhaustive list of conflict situations, but the policy should provide a framework for determining when a situation constitutes conflict.
A14	**Contractor Posting of DHHS Flyer** All contractors funded to implement behavioral interventions for HIV prevention are encouraged by the HIV Unit (but not required) to post copies of the *"Report Fraud"* poster of the US Department of Health and Human Services, Office of Inspector General, in prominent areas that are visible to clients and employees. This may include areas such as waiting rooms, lobby areas, employee break rooms or other areas visible to clients and employees. This poster is also known as the DHHS "Contractor Code of Ethics and Business Conduct Poster." It encourages persons to call the Fraud Hotline of the US Department of Health and Human Services (1-800-447-8477) for reporting fraud or misconduct relating to the receipt or expenditure of DHHS contract funds. The HIV Unit of the Division of Public Health, Georgia Department of Community Health, receives funding for HIV prevention and HIV testing through a cooperative agreement with the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services.
A15	**Prohibition Against Use of HIV Prevention Funding for Research** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must not conduct research using any of the individual-level data or group-level data obtained from clients during the course of the contract unless the contract states explicitly that the data may be utilized for such purposes. This includes any data obtained about a client, his or her participation in an intervention or other identifiable private information. As defined in the Code of Federal Regulations (Title 45, Part 46) the term 'research' means "a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge."
A16	**List of Board Members** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must submit to the HIV Unit an updated list of board members including name, title, mailing address and telephone number no later than January 15 each year.

A17	**Transparency and Annual Report or Equivalent** By making full and accurate information about its mission, activities, finance and governance publicly available, a charity encourages transparency and accountability to its constituents. The Internal Revenue Code requires a charity to make its Form 1023 exemption application, Form 990, and Form 990-T, available for public inspection. The Internal Revenue Service encourages every charity to adopt and monitor procedures to ensure that its Form 1023, Form 990, Form 990-T, annual reports, and financial statements, are complete and accurate, are posted on its public website, and are made available to the public upon request. Organizations that file Form 990 will find that Part VI, Section C, Lines 18 and 19, ask whether and how an organization makes its Form 1023, Form 990 and Form 990-T, governing documents, conflict of interest policy, and financial statements available to the public. All contractors funded to implement behavioral interventions for HIV prevention are encouraged by the HIV Unit (but not required) to create an annual report (or equivalent) along with a dissemination plan for the annual report. At a minimum, it is recommended (but not required) that the annual report should include a description of the contractor's mission, a list of activities, successes and accomplishments and financial statements reflective of the contractor's financial condition during its 12-month fiscal year. Contractors are encouraged by the HIV Unit to maintain evidence of the wide distribution and/or broad availability of their annual reports to the public.
A18	**Critical Incident Reporting Procedure** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must have adequate procedures for critical incident reporting. A "Notice Concerning Critical Incident Reporting" must be posted in a conspicuous, common area accessible to clients and the general public. The signage must conform in content to the sample provided by the Georgia Department of Community Health (see contract attachments). During the period of contract, if a contractor experiences a critical incident it must notify the appropriate DCH staff (Office of Inspector General) regarding the critical incident and the results of any immediate action taken. During the period of contract, if a contractor experiences a potential violation of criminal law it should notify local law enforcement authorities regarding the matter. Each contractor should also document the matter and notify the HIV Unit.
A19	**Evidence of Compliance with Insurance Requirements** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must provide evidence of compliance with the provisions of the contract section titled "Insurance." The contractor must submit such evidence of compliance to the HIV Unit no later than January 15 each year. Insurance certificates showing coverage to be currently in force and listing the State of Georgia as certificate holder shall be maintained in the contract file for each of the types of insurance required by the contract.
A20	**Audits and Financial Reporting Requirements** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must provide evidence of compliance with the provisions of the contract section titled "Audits and Financial Reporting." Contractors must submit such evidence of compliance to the HIV Unit for each year of funding received under the contract. Contractors must submit such evidence of compliance within 180 days after the close of the contractor's fiscal year. As evidence of compliance, contractors may complete, sign and submit the "Statement of Compliance with Contract Requirements for Audits and Financial Reporting" form for each year of funding received under the contract.
A21	**Internal Control** REQUIRED Note: The following text is copied from "Fiscal Management" (Unit 5: Audits and Internal Control, Section IV), a publication of the National Minority AIDS Council Technical Assistance, Training and Treatment Division, funded by the Centers for Disease Control and Prevention, grants U22/CCU318121 and U22/CCU318525, and the Health Resources and Services Administration, grant number 2U69HA0034. Federal regulations require grantees to have appropriate fiscal management systems that

provide for internal control. Internal control comprises those measures and methods adopted within the organization to safeguard the cash and other assets of the organization, check the accuracy and reliability of the accounting data, promote operational efficiency and encourage adherence to management policies. A system of internal control includes:

- Processes designed to provide reasonable assurance regarding achievement of management objectives.
- A plan of organization that provides appropriate segregation of functional responsibilities. That is, no single individual is responsible for an entire transaction. An example is the person who writes checks but does not reconcile the bank statement.
- A system of authorization and procedures adequate to provide reasonable control over assets, liabilities, revenues and expenses.
- A degree of quality of personnel commensurate with responsibilities.

Procedures for internal control may vary, depending on the size of the organization and other factors. Usually, an organization that can answer "Yes" to most of the following questions has adequate internal control.

- Does the board of directors authorize bank accounts and signers on the bank accounts?
- Does the board of directors approve and monitor the budget?
- Are employees who handle cash bonded?
- Is incoming mail opened and are cash receipts listed in duplicate by two or more people having no access to cash receipts or accounts receivable records?
- Are receipts deposited on a daily basis?
- Are checks required to be countersigned?
- Is signing blank checks prohibited?
- Are bank accounts reconciled by someone other than the persons participating in the receipt or disbursement of cash?
- Does a responsible individual receive the bank statements unopened from the bank?
- Are fees charged for services approved by the board of directors and publicly announced in fee schedules, bulletins and other announcements?
- Does an accounting manual detail account coding of expenditures in compliance with funding and organization accounting requirements (e.g., program and other functional bases)?
- Do procurement policies govern purchases of equipment, supplies and other items?
- Are authorizations for new hires, terminations and changes to salaries authorized by someone other than the person responsible for processing the payroll?
- Are timesheets or timecards prepared by employees who identify the amount of time spent in each program area or functional unit?
- Does a responsible person periodically review classes of position and pay rates for compliance with the provisions of the personnel practices or other documents designating rates of pay for employees?
- Are payrolls prepared by an outside service center?
- Do accounting procedures, charts of accounts and other tracking devices provide for identifying receipts and expenditures of program funds separately for each award or grant?
- Does the organization account for unused vacation and sick leave time?

Separation of Duties
As the series of internal control questions illustrates, separation of duties is a key mechanism to have in place. For example, one person prepares the checks, one or more persons sign the check and another person reconciles the bank statements. If a single individual were responsible for all these tasks, the internal control would not be adequate.

Non-profit organizations, particularly small ones, have some difficulty assigning tasks to employees in a manner that provides sufficient internal control, which also accommodates the size of the organization.

Assignment of Tasks
In some small nonprofit organizations, the executive director or another key staff member is responsible for all fiscal management, with no oversight or review by any other party. This

	person prepares the budget, authorizes purchases, hires employees, approves timesheets, calculates the payroll, writes and signs checks, receives payments for services, makes bank deposits, reconciles bank statements, prepares fiscal reports for the board of directors and handles other tasks. This practice is not acceptable for grantees receiving federal funds. It is expected that the program will have adequate stewardship of federal grant funds through sound fiscal management systems. In practical terms, this means that the executive director concentrates on achieving the program objectives: he/she has overall responsibility for the organization and its fiscal management; and oversees the work of staff members responsible for maintaining accounts, writing checks, preparing reports and other tasks. The executive director may handle some tasks personally, but they are usually related to the leadership role, such as ensuring that the budget provides resources consistent with the needs of the program or reviewing others' work (e.g., reconciling the bank statement). Equally important, grantees must assign responsibilities for sets of transactions to more than one person. No individual should be allowed to execute all transactions within the set. For example, the same person should not authorize a payment and write the check. Separation of duties is a critical element of internal control. Small organizations may need to rely on one person to do the tasks and have the work reviewed by another person. In other instances, board members may take some responsibility (e.g., in some small nonprofit organizations, the board treasurer reviews the monthly bank reconciliation). Each grantee must decide how to assign duties and how to establish internal control. The federal agencies will not prescribe that duties must be assigned in a particular way.
A22	**Contract Monitoring** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must cooperate with the contract monitoring process set forth by the HIV Unit. HIV prevention projects are monitored throughout the year in a variety of ways. At the start of each contract year, the assigned contract monitor will meet with the contractor to complete a Tailored Contract Monitoring Plan (Form HIV-610). The contractor will be asked for input in finalizing the performance indicators, measurement principles and the monitoring schedule for the Tailored Contract Monitoring Plan. The contractor's written work plan and list of measurable objectives will also be included as part of the Tailored Contract Monitoring Plan. Official monitoring visits will be made at least once each year for on-site assessment of the compliance with these standards. On-site assessment visits will be scheduled by the contract monitor in coordination with the contractor. The duration of an on-site assessment may range from a few hours to several days, depending on the circumstances. Prior to the scheduled visit, the contractor will receive a copy of the agenda and monitoring tool for the assessment for review. On-site assessment visits may include the following. • an opening meeting to review the agenda for the monitoring visit • an audit and/or review of program records and documents • a review of compliance with administrative requirements of the contract • a detailed assessment of progress toward program goals and objectives • an observation of the implementation of one or more of the contracted services • other components as deemed necessary by the Department If, as determined by the monitoring process, the contract standards are not being met, the department will determine the amount of time the contractor will be given to achieve compliance with the standards, up to a maximum of six (6) months.

A23	**Technical Assistance** The HIV Unit is available to provide capacity building assistance to support continuous program improvement. All contractors funded to implement behavioral interventions for HIV prevention are encouraged to participate in the capacity building program set forth by the HIV Unit. Depending on the specific needs of the organization and the availability of resources, capacity building services may be available to address the following topics. • Recruitment and retention of clients of high risk behavior • Recruitment and retention of qualified volunteers • Writing intervention protocols • Writing quality assurance plans • Implementing DEBI's with fidelity to core elements • Adapting DEBI's • Identifying evidence-based interventions to meet the needs of a local target population • Writing SMART objectives • Organizational finances, internal controls, budget, financial policies and procedures • Program monitoring and evaluation • Data submission • Number of FTE / dedicated staff • Effective staff management, supervision, coaching and evaluation • Addressing staff turnover • Board development • Long-term strategic planning • Developing your communication and marketing plan • Cultural competency • Information technology • Other topics as needed Agencies are encouraged to consider their needs for technical assistance capacity building services on an ongoing basis.
A24	**Encouraged Attendance at Georgia Community Planning Group Meetings** All contractors funded to implement behavioral interventions for HIV prevention are encouraged to participate in the Georgia HIV Prevention Community Planning Group (CPG) and the ongoing process of community planning. Contractors are encouraged (but not required) to attend at least two CPG meetings each year. Membership is not required for attendance, as CPG meetings are open to the public. Contractors are encouraged to solicit CPG membership applications from among their constituents to represent the population(s) served by the agency.
A25	**Updating Agency Information in the Georgia HIV/AIDS/STD Infoline** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must provide updated information to the Georgia HIV/AIDS/STD Infoline (1-800-551-2728) at least once each year. This includes current agency contact information, upcoming HIV prevention events and a current list of HIV prevention programs and services offered by the contractor. In addition, changes in agency contact information and/or services must be communicated to the Georgia HIV/AIDS/STD Infoline as they occur.

PROGRAM-RELATED STANDARDS

P1

Written Work Plans for Behavioral Interventions REQUIRED

All contractors funded to implement behavioral interventions for HIV prevention must have a written work plan describing in detail the steps and activities for implementation of the intervention. The HIV Unit does not prescribe a form template for work plans. Contractors have leeway to develop their own work plan templates. At a minimum, the work plan must address the following topics and answer the following questions.

- "SMART" goals and objectives (specific, measurable, attainable, realistic and time-oriented)
- For each objective:
  - Detailed description of the specific tasks and activities to be accomplished.
  - Name of person responsible for ensuring implementation of each task.
  - Start date and "due date" for each task (and date actually accomplished)
- Budget for planning costs and resources needed to implement the plan.
- Plans for monitoring, supervising and evaluating progress toward goals and objectives.
- Plans for updating and revising the plan during the year.
- Any other details necessary for ensuring the plan is clear.

Contractors implementing any of the interventions in the CDC Diffusion of Effective Behavioral Interventions Project (also known as DEBI's) must ensure that the work plan includes each of the tasks and activities listed in the corresponding "Implementation Planning Worksheet" for that specific intervention.

These "Implementation Planning Worksheets" are available at www.EffectiveInterventions.org for each of the featured evidence-based interventions under the category of "Implementation Planning Tool and M&E Key Activities."

P2

Fidelity to Core Elements REQUIRED

All contractors funded to implement behavioral interventions for HIV prevention must do so in accordance with the stated core elements and key characteristics of the intervention as described in the CDC Provisional Procedural Guidance for Community Based Organizations (http://www.cdc.gov/hiv/topics/prev_prog/ahp/resources/guidelines/pro_guidance/).

This includes any of the interventions included in the CDC Diffusion of Effective Behavioral Interventions Project (also known as DEBI's) as well as the following interventions, activities and strategies.

- Outreach
- Comprehensive Risk Counseling and Services (CRCS)
- HIV Counseling, Testing, and Referral (CTR)
- Incorporating HIV Prevention into the Medical Care of Persons Living with HIV
- Partner Counseling and Referral Services (PCRS, formerly known as partner notification services)
- Rapid HIV Testing in Nonclinical Settings
- Routine HIV Testing of Inmates in Correctional Facilities
- Universal HIV Testing of Pregnant Women at Very High Risk for HIV

It shall be the responsibility of the contractor to adequately supervise all paid and volunteer personnel responsible for implementing HIV prevention interventions to ensure fidelity to core elements. This may be accomplished as part of the contractor's Quality Improvement Plan, using any number of various different tools for monitoring and evaluation, such as client satisfaction surveys, fidelity forms, quality assurance checklists and facilitator observation forms.

As part of the process of ensuring fidelity to core elements, contractors must be willing to submit to an observation of the intervention as implemented by the contractor's personnel. Observations will be conducted by trained personnel from the HIV Unit. Observations may be announced or unannounced.

P3	**Referrals** REQUIRED
	All contractors funded to implement behavioral interventions for HIV prevention must have written procedures for referring clients to needed services. At a minimum, the procedures must address the following topics and answer the following questions.
	
	• How does the contractor refer clients to needed services?
	• A distinction between the following types of referrals.
	  ○ Referrals that do not require contractor follow-up for the purpose of determining the outcome of the referral. Some contractors consider referrals of this type to be "passive" referrals or "information referrals."
	  ○ Referrals that do require contractor follow-up. Referrals of this type are usually for high-priority programs and services. For example, all newly diagnosed HIV-positive clients must receive a referral to primary care and the contractor must conduct follow-up to check if the client attended the first appointment.
	• For referrals that require contractor follow-up, what steps does the contractor require for follow-up? How are the referrals tracked and logged?
	(Especially referrals to primary care, for clients living with HIV who are not receiving care.)
	• The contractor must maintain a current list of private and public sources for referrals.
	• The contractor must ensure the list is readily accessible to staff and clients.
	• At a minimum, the list should state where and how to access the following services.
	  ○ HIV care, mental health, housing, food, transportation, reproductive health
	  ○ screening and treatment for Syphilis and other STDs
	  ○ viral hepatitis screening, treatment and vaccination
	  ○ legal services, domestic violence, chemical dependency treatment
	  ○ programs for HIV risk reduction and skill-building
	  ○ mental health service providers
	
	The following referrals are mandatory.
	
	• All MSM who are sexually active must receive a referral for Hepatitis A & B vaccination, Syphilis screening and screening for other STDs.
	• All clients whose HIV status is unknown must be referred to HIV testing services (CTR).
	• All persons living with HIV who are not in care must be referred to HIV care and prevention services.

P4	**Plans for Client Recruitment: HIV Prevention Behavioral Interventions** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must have a written plan for ensuring effective recruitment of participants. At a minimum, the plan must address the following topics and answer the following questions. • Plans for locating members of the defined target population. • Recruitment strategies appropriate to the target population. • Effective and culturally-appropriate recruitment messages. • Appropriate venues for recruitment. • Staffing plans (including the use and training of employees and/or volunteers). • Steps for documentation of recruitment activities. • The use of data to assess and improve the effectiveness of recruitment activities. • Plans for recruiting persons with recent High Risk Behavior (HRB) Because resources for outreach are limited, contractors must ensure their outreach plan is strategic and targeted. Contractors should focus their recruitment efforts to maximize the likelihood of reaching persons of high risk for acquiring (or transmitting) HIV. High Risk Behavior (HRB) is defined as having either of the following activities with a person of unknown or serodiscordant HIV status. • Having unprotected anal or vaginal intercourse (UAVI) • Sharing needles or injection drug works Contractors shall not utilize HIV prevention funds (including HIV test kits received from the

Department of Community Health through an in-kind grant) for any of the following types of activities.

- Indiscriminate, mass HIV testing performed at schools, worksites and health fairs
- Indiscriminate, mass HIV testing to canvass a residential neighborhood
- Repeat testing of an HIV-positive person who already knows his HIV-positive status*
- Repeat testing of an HIV-negative person who technically does not need to be re-tested

In conducting outreach to recruit persons of High Risk Behavior (HRB) for HIV testing or HIV prevention services, many contractors have reported great success at venues such as:

- Clinics for STD treatment
- Homeless shelters
- Drug shooting galleries
- Emergency rooms
- Bars, nightclubs and raves
- Street hangout spots
- Methadone clinics
- Adult video stores
- Areas where sex workers do business
- Bathhouses, sex clubs and sex parties
- Online chat rooms
- Places known as cruising areas

Each of these types of venues has the potential to yield excellent results for recruiting persons of High Risk Behavior for acquiring or transmitting HIV. Of course, other types of venues may also be excellent for recruitment purposes.

As part of the process of selecting venues for conducting outreach, contractors should ask the following question.

- What is the relative likelihood of recruiting persons of Highest Risk Behavior (HRB) at this venue, as opposed to other venues?

The answer to this question may be based on factors such as knowledge of the venue, past experience with similar venues and knowledge of the demographics of the surrounding area (unemployment rates, poverty rates, high school completion rates, racial/ethnic breakdown, etc.).

Finally, in conducting recruiting potential clients for HIV prevention services, efforts should be made to avoid enrolling clients of low risk for acquiring or transmitting HIV. To accomplish this, some contractors may wish to create a brief survey for screening potential clients based on the number of risk behaviors self-reported by clients during the 90 days, 6 months or 12 months immediately prior to the date of recruitment. If such an approach is utilized, the contractor might wish to accept only clients with a certain minimum level of risk. In turn, clients with “little or no risk” might be politely “screened-out” and not enrolled in the HIV prevention intervention (for example, clients who self-report that they had abstained from any and all risk during the survey time frame). However, clients with “little or no risk” may still receive other services such as general literature, supportive messages and information about appropriate programs, services and volunteer opportunities that might of interest.

*NOTE RE TESTING PERSONS WHO ALREADY KNOW THEIR HIV-POSITIVE STATUS:
If a client is in need of HIV care services but does not have health insurance or any alternative recourse for obtaining HIV care, he must be referred to a primary care facility that receives Ryan White funding. Of course, he will be required to present evidence of his HIV-positive status (such as a Western Blot test result) in order to enroll as a new patient. Primary care facilities that receive Ryan White funding are authorized by HRSA to order HIV diagnostic testing in these and other situations. The facility may pay for the cost of HIV diagnostic testing with Ryan White funds. HIV prevention funds and resources (including test kits) should never be utilized to pay for HIV diagnostic testing for clients who already know their HIV-positive status.

P5	**Incentives and Promotional Items Utilized for Client Recruitment** Contractors implementing HIV prevention activities may utilize funds for client recruitment and retention incentives (such as coupons, food, refreshments, clothing, free condoms, transportation) to encourage client enrollment and participation. To be appropriate, a recruitment incentive must encourage but not compel participation. Incentives should not make clients feel pressured to participate. Of course, care should be taken to ensure incentives are of sufficient worth to ensure participation. If potential program participants perceive the incentives of the program to be of insufficient worth for them, low participation may result. On the other hand, the use of extravagant incentives can compromise the integrity of the program with the attempt by some clients to enroll more than once; the coercion of peers to participate; and the selling, trading, duplication or forging of recruitment coupons. If incentives are mentioned in recruitment materials (such as flyers, posters, letters or other recruitment materials) the communication should be straightforward and honest. Recruitment materials should not imply that an incentive is more valuable than it really is. Also, recruitment materials should not imply that every participant will receive an incentive if in reality the contractor only intends to conduct a drawing. Incentives may be monetary or non-monetary. Monetary incentives are cash or cash equivalents such as gift certificates and gift cards. Non-monetary incentives are goods or services that are not easily exchanged for cash. Technically, no limits exist on the dollar amount of each individual incentive or the total dollar amount of all incentives. Nevertheless, contractors must obtain written approval from the HIV Unit before deciding to purchase or distribute incentives if the dollar amount of each individual incentive will exceed $25.00 and/or if the total dollar amount of all incentives to be purchased during the grant year will exceed $2,000.00. In an attempt to minimize the likelihood of fraud, waste, abuse, mismanagement and theft, the grantee should develop and implement procedures and internal controls for the purchase, storage, tracking, distribution and accounting of all incentives. Such procedures should be in writing. Depending on how the organization is structured, the organization's governing body, board of directors, treasurer, accounting or bookkeeping department may be involved in the development of such procedures. At a minimum, these written procedures must address the following topics and answer the following questions. • Periodic accounting of all monetary incentives by a staff member segregated from the functions of program implementation. • A master log for recording the purchase of monetary incentives including the serial number of each gift card or gift certificate purchased, date purchased, date when the item was entrusted to a staff member for program use and the name of the person who eventually received the incentive. • A requirement that an original store receipt must be attached to the master log for purchased incentives. The store receipt must have a description of the purpose of the purchase noted directly on the receipt and must be signed by the person who made the purchase. For example: “Gift cards for client shoes in ABCD Program.” • A form for clients to sign when they receive an incentive to document the distribution of the incentive. The form must include the following statement: “By signing this document, I affirm that I have received the following incentive item: _____. I also affirm that I received this incentive item free of cost to me, and directly as a result of my voluntary participation in the following activity: _____. I also affirm that my contact information (shown below) is correct. I hereby grant permission for a member of the Georgia Department of Community Health to contact me by telephone, regular U.S. mail or e-mail for the purpose of confirming my signature on this document.”

P6	**Collaboration with the Local Health District** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must have a "Memorandum of Agreement" with the corresponding local health district. It should be signed by the contractor's executive director or chief executive officer and the health district director. At a minimum, the Memorandum of Agreement must address the following topics and answer the following questions. • How does the contractor collaborate with the local health district? • Who are the principal points of contact for the contractor and the health district? • Quality assurance of HIV testing counselors • Procedures to ensure the "HIV/AIDS Case Report Form" is submitted for every HIV case • Procedures to ensure the ongoing training of staff members regarding linking HIV-positive clients to HIV care and treatment, early intervention services, ADAP, HICP, PCRS and other HIV-related educational topics for staff members • Who will be responsible for ensuring all HIV-positive clients receive a formal invitation to participate in PCRS? What specific steps will be taken to ensure the invitations are made? How will the invitations (and the clients' responses) be documented? • Who will be responsible for providing PCRS to clients who agree to participate? What specific steps will be taken to ensure this person is informed whenever a client expresses willingness to participate? How will the PCRS sessions be documented? • Training of staff on proper procedures for PCRS • Data collection and reporting • Confidentiality • Local laws and regulations • Target population to be served • Referral networks • Expiration date of the Memorandum of Agreement • Other topics
P7	**Collaboration with Other Organizations** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must have working relationships with other organizations that serve the target population. Some examples may include substance abuse and treatment centers, detention centers, clinics, DFACS and other social service agencies. Contractors are encouraged by the HIV Unit to have written documentation of such working relationships in the form of a letter or "Memorandum of Agreement." At a minimum, it is recommended that the Memorandum of Agreement should address the following topics and answer the following questions. • How do the two organizations collaborate? • Who are the principal points of contact for the two organizations? • Procedures for the referral of clients • Data collection and reporting • Confidentiality • Other topics
P8	**Review of Randomly-Selected Prevention Records** REQUIRED All contractors funded to implement behavioral interventions for HIV prevention must be willing to submit to an audit review of program records to be conducted by the HIV Unit of the Georgia Department of Community Health. An audit review may be announced or unannounced. During an audit review, a member of the HIV Unit will specify the time period ("date frame") for the audit review and generate various lists of randomly-selected program sessions within this date frame. Simple random sampling will be utilized. Typically, separate lists of randomly-selected sessions will be created so that each funded intervention may be audited separately. • Every list of randomly-selected session numbers will be based on a master list of the

program sessions conducted by the contractor within the date frame. This list will have 30 random numbers, or 10% of the total number of program sessions within the date frame (whichever is greater). If less than 30 random numbers are generated using this method, the date frame should be expanded.

- Example: Suppose that between January 1 and June 30, the "ABCD Community Center" implemented 29 cycles of an intervention and the intervention has 11 consecutive program sessions. Thus, a total of 319 program sessions were implemented (29 x 11 = 319). As shown in the following diagram, each of the sessions can be assigned a number in sequential order. Next, a random number generator can be utilized to create a list of 32 session numbers (since 32 is approximately 10% of the total number of sessions). The red sessions shown in the diagram represent the 32 program sessions to be audited. These 32 sessions were selected using a random number generator.

During an on-site assessment visit, the contractor will be given a copy of the list of session numbers that were randomly generated. Of course, this list will not be given to the contractor beforehand. The contractor will be asked to provide each of the requested test records immediately. A member of the HIV Unit will examine each record to determine whether all of the required forms are completed correctly and attached to the corresponding test record.

- All fields on the CDC HIV Test Form "Part 1" must be completed correctly.
- The barcode serial number must appear on every document as a barcode sticker (or hand-printed number if all stickers have been used).
- Informed consent must be on file. Documentation of verbal consent is acceptable. In addition, a general consent is also acceptable, meaning there is no need to have an HIV test consent form separate from the agency's general consent form.
- A copy of the OraSure test form must be attached (if an OraSure Western Blot was requested from the state lab).

If the test result is confirmed HIV-positive, the following items must be documented.

- If test result is confirmed HIV positive and the client has <u>not</u> <u>yet</u> returned to receive the results, the file <u>must</u> contain documentation of attempts to reach the client on separate dates and the outcome of each attempt. At least 4 attempts to locate the client are suggested before closing any such case.
- All fields on the CDC HIV Test Form "Part 2" must be completed correctly.
- Linkage to care must be documented. The date when the client attended his or her first medical care appointment must also be documented. The "notes" section of the "Part 2" form may be used for this purpose, if desired.
- If known, the name of the client's medical care provider should be documented.

		Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 7	Session 8	Session 9	Session 10	Session 11
Cycle 1	Jan 5	1	2	3	4	5	6	7	8	9	10	11
Cycle 2	Jan 17	12	13	14	15	16	17	18	19	20	21	22
Cycle 3	Jan 29	23	24	25	26	27	28	29	30	31	32	33
Cycle 4	Feb 7	34	35	36	37	38	39	40	41	42	43	44
Cycle 5	Feb 16	45	46	47	48	49	50	51	52	53	54	55
Cycle 6	Feb 27	56	57	58	59	60	61	62	63	64	65	66
Cycle 7	Mar 6	67	68	69	70	71	72	73	74	75	76	77
Cycle 8	Mar 9	78	79	80	81	82	83	84	85	86	87	88
Cycle 9	Mar 13	89	90	91	92	93	94	95	96	97	98	99
Cycle 10	Mar 19	100	101	102	103	104	105	106	107	108	109	110
Cycle 11	Mar 29	111	112	113	114	115	116	117	118	119	120	121
Cycle 12	Mar 30	122	123	124	125	126	127	128	129	130	131	132
Cycle 13	Apr 8	133	134	135	136	137	138	139	140	141	142	143
Cycle 14	Apr 11	144	145	146	147	148	149	150	151	152	153	154
Cycle 15	Apr 20	155	156	157	158	159	160	161	162	163	164	165
Cycle 16	May 2	166	167	168	169	170	171	172	173	174	175	176
Cycle 17	May 13	177	178	179	180	181	182	183	184	185	186	187
Cycle 18	May 16	188	189	190	191	192	193	194	195	196	197	198
Cycle 19	May 27	199	200	201	202	203	204	205	206	207	208	209
Cycle 20	Jun 6	210	211	212	213	214	215	216	217	218	219	220
Cycle 21	Jun 13	221	222	223	224	225	226	227	228	229	230	231
Cycle 22	Jun 19	232	233	234	235	236	237	238	239	240	241	242
Cycle 23	Jun 29	243	244	245	246	247	248	249	250	251	252	253
Cycle 24	Jun 29	254	255	256	257	258	259	260	261	262	263	264
Cycle 25	Jul 12	265	266	267	268	269	270	271	272	273	274	275
Cycle 26	Jul 18	276	277	278	279	280	281	282	283	284	285	286
Cycle 27	Jul 29	287	288	289	290	291	292	293	294	295	296	297
Cycle 28	Aug 3	298	299	300	301	302	303	304	305	306	307	308
Cycle 29	Aug 6	309	310	311	312	313	314	315	316	317	318	319

List of 32 randomly-generated numbers from 1 to 319:
4, 40, 44, 49, 61, 87, 100, 103, 109, 134, 142, 144, 158, 163, 171, 172, 176, 188, 198, 203, 210, 238, 247, 248, 249, 269, 273, 276, 278, 284, 312, 318

Diagram: Example of selection of 32 program sessions for program auditing purposes, using a random number generator.

P9	**Quality Improvement for HIV Prevention Services** All contractors funded to implement behavioral interventions for HIV prevention should have a written plan for the continual use of data to assess and improve HIV prevention activities. An effective quality improvement program includes the following components. • It should address infrastructure, performance measurement, annual quality goals, engagement of stakeholders and evaluation. • It should have a quality management committee responsible for quality planning, allocating resources for quality management, establishing and supporting a culture of innovation and change and providing guidance. • It should require ongoing quality improvement activities that are carried out by quality improvement teams. Contractors are encouraged by the HIV Unit to develop and maintain a written quality management plan. As a resource, contractors may wish to consider "Quality Improvement for Non-Clinical Services: Quality Academy Tutorial 22" (www.NationalQualityCenter.org). Contractors implementing any of the interventions included in the CDC Diffusion of Effective Behavioral Interventions Project (also known as DEBI's) may wish to include in their written quality management plan a list of quality management instruments (such as quality assurance forms and checklists) and procedures for the periodic use of those instruments. An "Evaluation Field Guide" has been created for each of the interventions in the in the CDC Diffusion of Effective Behavioral Interventions Project (also known as DEBI's). These "Evaluation Field Guides" offer useful instruments for monitoring and evaluation such as client satisfaction surveys, fidelity forms, quality assurance checklists and facilitator observation forms. Each intervention has its own "Evaluation Field Guide," which can be downloaded at www.EffectiveInterventions.org under the category of "Resources & Tools."
	STANDARDS PERTAINING TO HIV TESTING SERVICES
T1	**Standard Operating Procedures for HIV Rapid Testing and Counseling** REQUIRED All contractors funded to implement HIV testing must have written procedures for HIV rapid testing and counseling. At a minimum, the procedures must address the following topics and answer the following questions. • One person must be designated as being responsible for overseeing the HIV testing program and communicating with DCH regarding HIV testing matters. • The procedures must address the manufacturer's instructions for use of HIV testing kits (setup, cleanliness, materials required, handling of biohazard items, external controls, etc.) and proper conditions for storage of HIV testing kits (including temperature and security requirements). • Filing of confidential test records • Correct use of forms • Use of logs for recording control kit results • Use of logs for recording temperatures in storage rooms and testing areas • Reporting of confirmed positives to the Georgia Department of Community Health • Reporting false reactive test results to the HIV test kit manufacturer Pursuant to FDA regulations, a quality assurance plan must be in place for HIV testing. The plan must include step-by-step activities to ensure mistakes are found and corrected.
T2	**CLIA Certification or CLIA Waiver** REQUIRED All contractors funded to implement HIV testing must have documentation of either a CLIA waiver or CLIA certification.

T3	**Follow-Up Procedures for HIV-positive test results** REQUIRED All contractors funded to implement HIV testing must maintain a secure and confidential log for tracking all HIV-positive test results and ensuring confirmation of linkage to care. Procedures should be in place to ensure thorough outreach and follow-up in the event a client does not return for his or her confirmatory results within 15 business days. At the end of every quarter, the contractor must calculate the percentage of confirmed HIV-positive clients that have no confirmed linkage to care. Efforts should be taken to ensure a low percentage. It is recommended (although not required) that this percentage be less than 10%. A percentage of 3% or lower is considered excellent.
T4	**Partner Counseling and Referral Services for HIV-Positive Clients, Especially All Newly-Diagnosed Clients** REQUIRED All contractors funded to implement HIV testing must ensure that all newly-diagnosed HIV-positive clients receive information about the availability of services for Partner Counseling and Referral Services (PCRS, formerly known as partner notification). If the Contractor does not provide this service, the contractor must have an MOU with an organization willing to accept responsibility for this role. PCRS is a voluntary and confidential service that involves interviewing all clients who are HIV-positive, contacting their current and past partners and informing them that someone living with HIV has identified them as a sex partner (or partner who shares injection drug paraphernalia). Notified partners are encouraged by the HIV Unit (but not required) to seek HIV counseling and testing. The contractor must have PCRS documentation for all newly-diagnosed HIV+ clients. This documentation must include evidence that PCRS has been offered and evidence of the client's decision to voluntarily accept or refuse the offered services.
T5	**Documentation of Training in HIV Prevention Counseling and HIV Rapid Testing** REQUIRED All contractors funded to implement HIV testing must be able to produce documentation showing that all HIV testing workers have been trained in HIV rapid testing procedures and skills for client-centered HIV risk reduction and prevention counseling. Examples include: • training in rapid test procedures • regular observation of workers for quality control purposes • annual check of each worker's test result interpretation skills (annual proficiency test) • training covering the content of "CDC Fundamentals of HIV Prevention Counseling"

T6	**Review of Randomly-Selected HIV Test Records** REQUIRED All contractors funded to implement HIV testing must be willing to submit to an audit review of HIV test records to be conducted by the HIV Unit of the Georgia Department of Community Health. An audit review may be announced or unannounced. During an audit review, a member of the HIV Unit will specify the time period ("date frame") for the audit review and generate two lists of randomly-selected unique test numbers within this date frame. Because the number of HIV-positive test results is much smaller than the number of HIV-negative test results, stratified sampling will be utilized to ensure an adequate review of HIV-positive test results. • The first list will be based on a master list of all HIV-negative test results within the date frame. This list will have 30 test numbers, or 10% of the total number of HIV-negative test results from within the date frame (whichever is greater). If less than 30 test results are available using this method, the date frame should be expanded. • The second list will be based on a master list of all HIV-positive (confirmed) test results within the date frame. It will have 6 test numbers, or 10% of the total number of HIV-positive test results from within the date frame (whichever is greater). If less than 6 test results are available using this method, the date frame should be expanded. During an on-site assessment visit, the contractor will be given a copy of the list of test numbers that were randomly generated. Of course, this list will not be given to the contractor beforehand. The contractor will be asked to provide each of the requested test records immediately. A member of the HIV Unit will examine each record to determine whether all of the required forms are completed correctly and attached to the corresponding test record. • All fields on the CDC HIV Test Form "Part 1" must be completed correctly. • The barcode serial number must appear on every document as a barcode sticker (or hand-printed number if all stickers have been used). • Informed consent must be on file. Documentation of verbal consent is acceptable. In addition, a general consent is also acceptable, meaning there is no need to have an HIV test consent form separate from the agency's general consent form. • A copy of the OraSure test form must be attached (if an OraSure Western Blot was requested from the state lab). If the test result is confirmed HIV-positive, the following items must be documented. • If test result is confirmed HIV positive and the client has <u>not</u> <u>yet</u> returned to receive the results, the file <u>must</u> contain documentation of attempts to reach the client on separate dates and the outcome of each attempt. At least 4 attempts to locate the client are suggested before closing any such case. • All fields on the CDC HIV Test Form "Part 2" must be completed correctly. • Linkage to care must be documented. The date when the client attended his or her first medical care appointment must also be documented. The "notes" section of the "Part 2" form may be used for this purpose, if desired. • If known, the name of the client's medical care provider should be documented.