Ohio Department of Health

HIV Counseling, Testing and Referral & Priority-Based Testing Protocol

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January 2020

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Introduction

This protocol applies to Ohio agencies receiving federal HIV/STI prevention funds and/or materials through the Ohio Department of Health (ODH) HIV/STI Prevention Programs. The protocol is aligned with the National HIV/AIDS Strategy (NHAS) whose three primary goals are: 1.) reducing the number of people who become infected with HIV; 2.) increasing access to care and improving health outcomes for people living with HIV; and 3.) reducing HIV-related health disparities and health inequities.

This document establishes standards for conducting Counseling Testing and Referral (CTR) in an HIV testing session using the Rapid/Rapid (R/R) Testing algorithm. It is designed to be used in conjunction with all other ODH HIV protocols, including the Linkage to Care Protocol, Monitoring & Evaluation Protocol, and Disease Intervention Specialist Protocol.

The protocol ensures the quality and consistency of Priority-Based Testing (PBT) throughout Ohio. It will be used as a guide for funded agencies to focus their activities on priority populations. It will ensure HIV services are directed towards those disproportionately impacted and at highest need throughout the state.

The Ohio Department of Health supports Local Health Districts to oversee prevention efforts within their designated region(s). The HIV Prevention program is available for technical assistance and may request national assistance if needed. Regions may request technical assistance by contacting the HIV Prevention program.

Rapid HIV Testing

With more than 1.1 million people in the US living with HIV, and almost 1 in 6 unaware of their infection, increased opportunities for testing and linkage to medical care and essential services are critical.

In a concerted national effort to expedite client linkage to care and improve health outcomes, Ohio's HIV Prevention program has implemented a dual rapid (Rapid/Rapid) algorithm for HIV testing. Rapid/Rapid testing allow clients who test positive for HIV to be linked to care immediately.

Prompt linkage to HIV treatment (antiretroviral therapy or ART) leads to improved health outcomes and reduction of community viral load, which can reduce the number of new HIV infections.

Dual rapid algorithms:

- Utilize one rapid HIV test to detect antibodies and a second comparable rapid HIV test, from a separate manufacturer, to confirm this detection at a 100% positive-predictive-value (the results are verified to be 100% accurate).
- Allow clients to receive same-day confirmation of their positive HIV test result and further advances the engagement of populations infected with HIV.
- Remove common barriers including the need for additional laboratory testing and losing clients to follow-up.

In a dual rapid algorithm, both confidential and anonymous testing may be offered. Confidential testing should be encouraged as standard practice. **Anonymous testing should never be utilized when conducting the second rapid test.** All paper work needed to make an initial appointment with an infectious disease doctor will be given during the single testing event. No return visit for a confirmatory result will be needed.

All HIV tests are to be conducted with a blood specimen. If your agency needs assistance training employees to conduct HIV test with a blood specimen contact the regional coordinator for your region and training will be arranged.

Laboratory Certification Program

All agencies conducting rapid testing must have a CLIA Waver. The Laboratory Certification Program works to ensure Ohioans receive accurate, cost-effective clinical laboratory testing as a part of their health care. Generally, each separate location or address is required to have a separate CLIA number. There are exceptions for not-for-profit/government-owned laboratories or hospitals. Call us if you think your organization qualifies for one of these exceptions.

Ohio Department of Health 246 North High Street Columbus, OH 43215	Telephone: (614) 644-1845 Fax: (614) 564-2478 E-mail: CLIA@odh.ohio.gov

Test Kits

The State of Ohio HIV Prevention Program has approved two rapid testing technologies for Rapid/Rapid testing. Test kits can be ordered through the HIV Prevention Program: HIVPrevention@odh.ohio.gov.

- **OraQuick**- www.oraquick.com – 20min run time. Please follow manufacturer instructions.
- **Insti**- http://biolytical.com/products/insti-hiv-1hiv-2/ - 1 min run time. Please follow manufacturer instructions.

At-Home Testing

At-home HIV tests can be purchased online or at pharmacies in Ohio and can also be obtained through the Test at Home with OHIV program through Equitas Health (OHIV.org). If testing sites encounter a client who reports having tested positive on an at-home test kit, ODH funded sites should retest using the Rapid/Rapid algorithm. This enables a test counselor to complete an HIV Verification Form, which may only be given when the rapid/rapid algorithm is performed by a certified test counselor, both tests are positive, and HIV test counseling is complete.

PrEP/PEP Testing

If testing sites encounter clients who are currently taking pre-exposure prophylaxis (PrEP), they should perform risk reduction counseling, assess adherence to PrEP, and provide testing if risk is present. CTR testing *does not* count as an HIV test for PrEP care.

If testing sites encounter clients who are currently taking post-exposure prophylaxis (PEP), they should refer clients to a medical provider. Clients taking PEP are at known risk for acute infection and should be tested using RNA tests.

Rapid/Rapid Testing Algorithm

Test 1 - Conduct the initial HIV rapid test (T1) using whole-blood fingerstick method and following manufacturer guidelines of the device. May be confidential or anonymous.

Initial Rapid (Test 1) Negative -

1. Read result of the initial HIV test (T1)
2. Give result to client
    a. In the case of possible acute infection, refer to lab or medical provider for RNA testing.
        i. Questions for acute infection include: When was your last test? What was the result? In the last three months, is there a moment you are concerned about?
    b. In the case of potential exposure within 72 hours, refer for post-exposure prophylaxis (nPEP) and connect to Patient Assistance Programs for payment support.
3. Complete risk reduction plan; provide the client with information on pre-exposure prophylaxis (PrEP), condoms, and other prevention resources.
4. Recommend re-testing based on risk, behaviors, and window period.
5. Re-enforce risk reduction plan.
6. Close session.
7. Record testing information on Opscan. Testing sites mail or fax batches (≥ 50) of Opscan 1s with completed client information to ODH regularly (≤ 1 monthly).
8. Mail to: Ohio Department of Health
   HIV Testing - Data Entry
   35 E. Chestnut St., 6th floor
   Columbus, Ohio 43215

Initial Rapid (Test 1) Positive -

1. Give result of first HIV test (T1) to client, let the client process result as needed.
2. Answer any questions, reminding client that another rapid test will be performed immediately.
3. Take fingerstick blood sample and run second HIV test (T2).
4. Prepare for discussion of rapid linkage to care.

Test 2 - Conduct the second HIV rapid test (T2) using whole-blood fingerstick method and following manufacturer guidelines of the device. T2 should not be offered anonymously.

Second Rapid Positive-

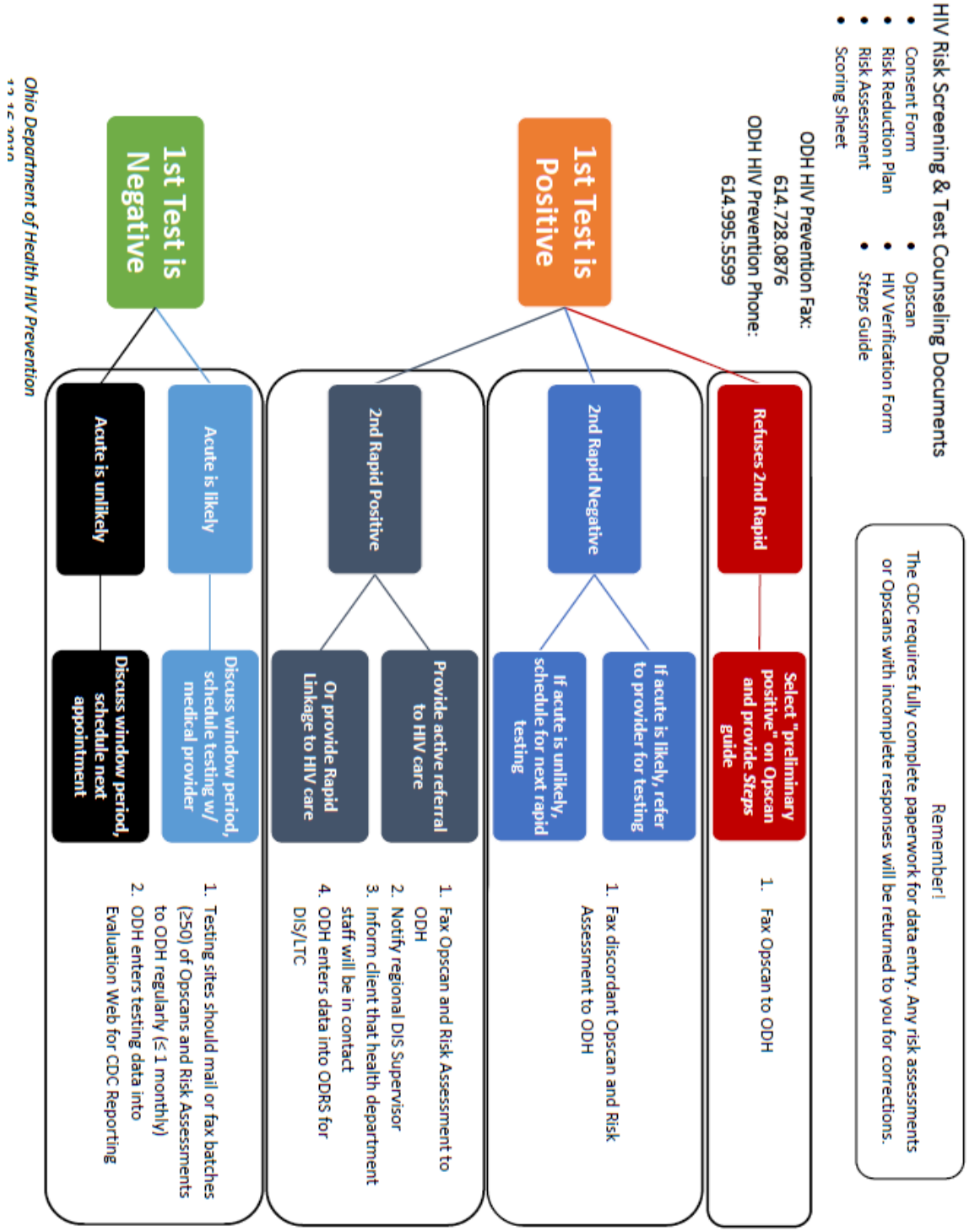
1. Provide the positive test results of T2 to client.
2. Once the positive test results have been disclosed to the client, offer same-day linkage to care or provide an active referral to care.
3. To provide verification of HIV positive test results for a medical provider, complete the ODH HIV Verification Form.
4. To fulfill mandated reporting requirements, complete Opscan with complete information, including the required client contact information.

Second Rapid Negative-

1. If the second rapid test (T2) is negative, this is a discordant result; consider retesting to account for potential test failure.
    a. If acute infection is possible, refer to medical care, third-party lab, or regional Linkage to Care Coordinator for connection to care.
        i. If uninsured, consider Rapid Enrollment into Ryan White. See Linkage Protocols.
    b. If acute infection is unlikely, schedule for additional follow-up testing in 1-2 weeks.
2. To fulfill mandated reporting requirements, complete Opscan with complete information, including the required client contact information.
    a. Select “Discordant” in Section 4

Note: This result should be **rare**. Please notify ODH by emailing the false positive report within 24 hrs. of incident.

HIV Testing Crosswalk - This is a resource that can be used during every testing event that walks HIV test counselors through any potential testing outcome. It also includes reporting requirements for each outcome.



HIV Verification Form - This form is documentation of two positive rapid HIV tests conducted at a testing site.

1. Keep a copy in the client's file and give the client the original form.
2. Notify your regional DIS supervisor of a client with two positive rapid tests.
3. Assist client with rapid linkage.

Ohio Department of Health

Mike DeWine, Governor
Jon Husted, Lt. Governor
Amy Acton, M.D., MPH, Director

HIV VERIFICATION FORM

CONFIDENTIAL

This form should be provided to a medical or service provider chosen, by the client, to verify they have received two reactive rapid HIV test results.

LAST NAME	FIRST NAME	
PHONE	GENDER	D.O.B.
COLLECTION DATE	TIME	

1st Rapid Test OraQuick ☐ Insti ☐	Negative ☐	Positive ☐
2nd Rapid Test OraQuick ☐ Insti ☐	Negative ☐	Positive ☐

TEST SITE	
CITY	PHONE
TESTER NAME	CTR TESTING #
TESTER SIGNATURE	

Rapid HIV testing considerations:

- If the 1st rapid test is **NEGATIVE**, the screen is considered negative for HIV antibodies.
- If the 1st rapid test is **POSITIVE**, confirmatory testing (molecular tests) from an outside laboratory or a second rapid test is recommended.
  - If two different rapid tests have been performed and are **both POSITIVE**:
    - Based on current CDC guidelines, the patient is **considered positive for HIV and has been referred for care.** Additional testing may be performed by the provider to evaluate for treatment options.
  - If two different rapid tests have been performed with the **second test NEGATIVE**:
    - The results are **DISCORDANT** and require further investigation. Refer to an outside laboratory or provider for confirmatory testing; recommend follow-up testing in 1-2 weeks; or provide rapid linkage for confirmatory.

Dear Provider: This information has been disclosed to you from confidential records protected from disclosure by state laws. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or otherwise permitted by state laws. A general authorization for the release of medical or other information is not sufficient for the release of HIV test results or diagnoses

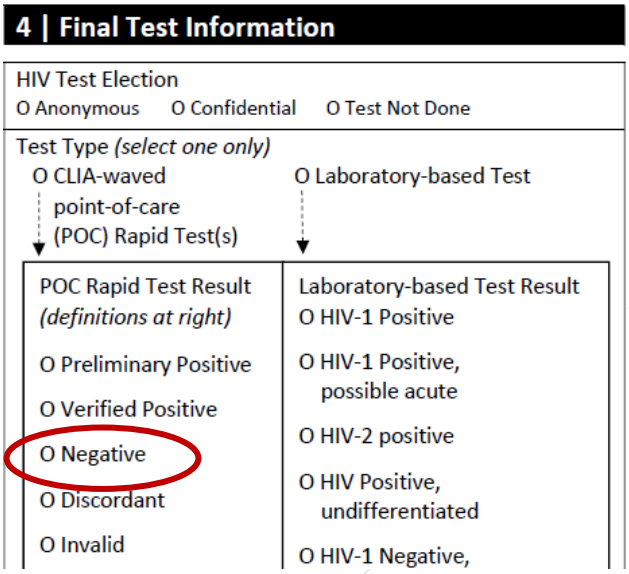
For assistance with test interpretation, contact:
Ohio Department of Health/HIV Prevention
246 North High Street, 6th Floor
Columbus, OH 43215
PHONE: 614.995.5599 FAX: 614.728.0876
HIVPrevention@odh.ohio.gov

HEA#3415 *1.3.20*

Please note that incomplete Opscans will be returned to CTR testing sites for corrections. Testers should ensure that all fields are complete before submission.

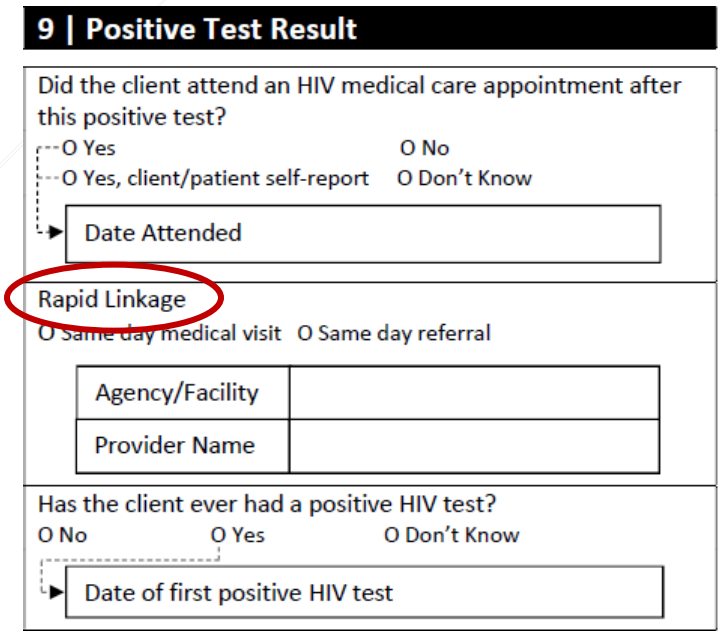
Negative Opscan – Sections 1-8 of the Opscan are completed for every HIV test.

1. Select "Negative" in Section 4
2. Negative test results may be mailed or faxed to ODH in batches at least monthly.
3. Risk Assessments should include the Opscan ID on every page, to account for one-sided printing, and be mailed or faxed with Opscans.



Positive Opscan - Sections 1-10 of the Opscan are completed for every positive HIV test.

1. Include client name and preferred method of contact for DIS/LTC to follow-up.
2. Indicate if client had same-day medical visit (Rapid Linkage), same-day referral, or attended medical visit.
3. Fax Opscan to ODH as soon as possible. Update Section 9 if anything changes; refax to ODH if this occurs.



Assessing Risk

Risk for HIV is affected by both behavioral (i.e., condomless sex, sharing injection drug equipment), and circumstance. Behavioral factors facilitate transmission, while an individual's circumstances (power, privilege, and resources) and geography can determine the odds of infection.

Communities or places with a high incidence of HIV infection are said to have a high community viral load; this means that an individual is more likely to encounter HIV. Community viral load may be high due to factors attributed to the social determinants of health, such as lack of access to resources, systemic racism, provider bias, mass incarceration, or economic inequality. While behavioral interventions may decrease risk, individuals who encounter high community viral loads remain at increased risk of encountering HIV.

While certain racial groups in Ohio experience higher incidence of HIV, it is essential to note that race is socially constructed and is not a biological reality. People of different racial and ethnic groups are not inherently biologically distinct. Racial disparities in HIV incidence are rooted in social determinants of health, not biological difference. Test counselors and program managers must be careful not to conflate the effects of racism with fundamental difference of race/ethnicity. Programs must not reinforce harmful or stigmatizing stereotypes about racial, ethnic, or sexual and gender minority individuals.

Priority Populations

A person who comes from a population with a high concentration of HIV, or who has sexual encounters with these populations should be considered at higher-risk for HIV. Clients from one of Ohio's priority populations will have a higher risk score on the ODH HIV Risk Assessment.

Ohio's statewide priority populations are determined by surveillance data and are reviewed annually. Current priority populations include:

- Young Black/African American men who have sex with men (YBMSM) between the ages of 15-29;
- Men who have sex with men (MSM);
- People who inject drugs (PWID);
- Trans/Nonbinary persons especially Black/African American trans women (TGNC);
- High-risk heterosexuals (HRH) that have/are:
    - Sex partners of persons who inject drugs;
    - Those with a syphilis diagnosis in the last year;

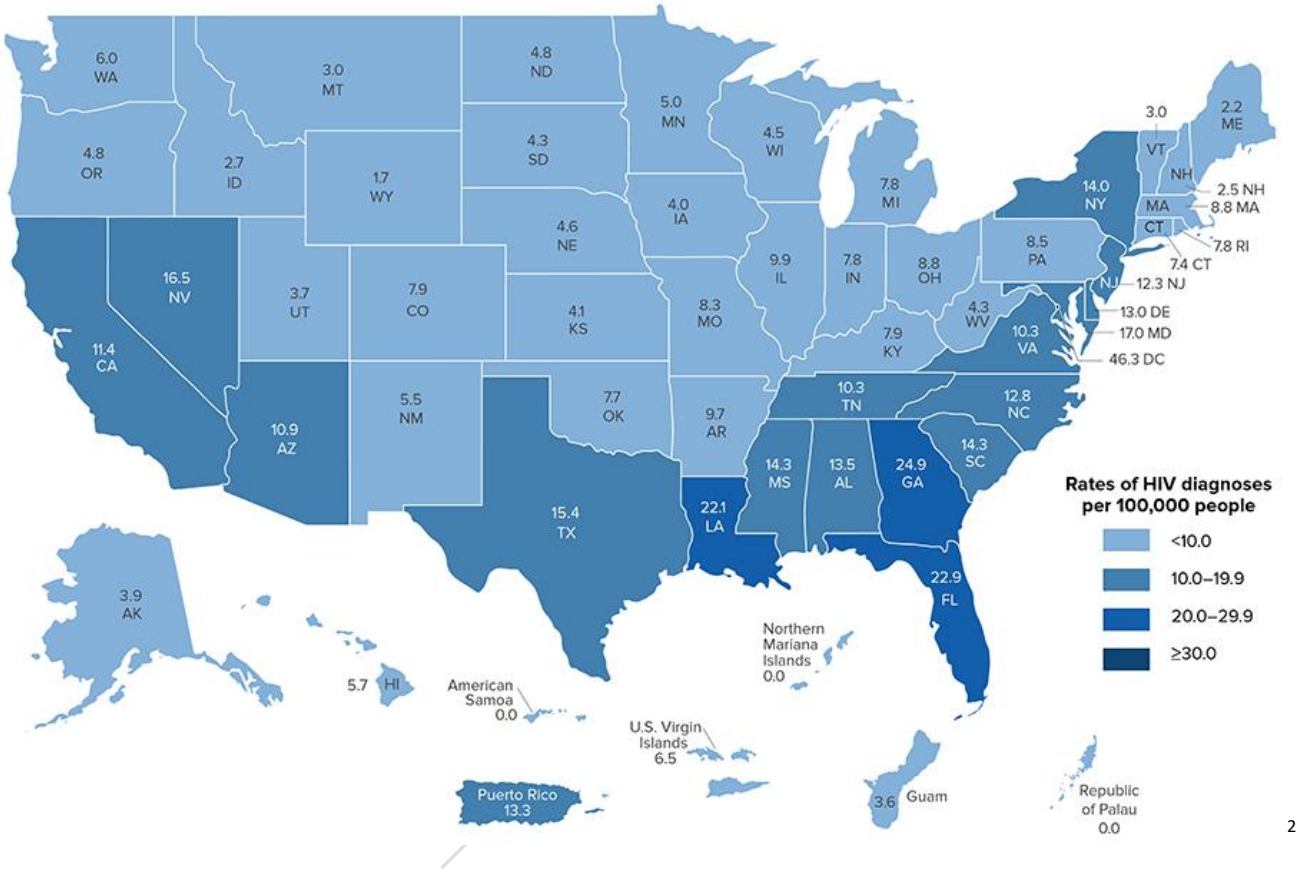
  * People who have visited or moved from the South[1] and haven't been tested since will be prioritized for testing but are not an official priority population.

Program coordinators and testing counselors should use nuanced critical thinking and their best judgment when determining whether someone belongs to a priority population. For example, while the risk assessment asks about behavior during the previous 12 months, a person who injected drugs using shared equipment would still be included in the priority populations if they had last injected 13 months ago and hadn't been tested since.

[1] Defined by the CDC as: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia

Why the South?

Surveillance Data from the US Centers for Disease Control and Prevention (CDC) shows that Americans residing in the South experience heightened incidence of HIV infection. A map of the US showing 2017 rates of diagnosis per 100,000 is shown below. Ohioans who have recently lived in or visited these areas, had sexual or injection drug use encounters, and have not been tested since are at heightened risk as they have encountered an increased community viral load. Testers should use their best judgment in determining clients' relationship to "the South" when determining their score on the risk assessment.



[2]

International Travel

If a client has recently traveled internationally, they may have the resources and/or insurance coverage to test with a medical provider. Testers should ask open ended questions about why they chose a community-based testing site. If they are at moderate risk, have not been tested, travelled to a high prevalence jurisdiction, and expressed concern, then a test could be considered. Regardless, testers should provide counseling on testing with a provider, having difficult or uncomfortable sex conversations, and discuss other discreet testing methods.

Behavioral Risk

According to CDC guidelines, HIV testing should be specifically directed to those who are most at-risk. While our priority populations identify those who come from communities at greatest risk, without accompanying behaviors a client may not be at higher-risk. For example, someone who has recently moved from Miami, but

[2] https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2017-vol-29.pdf

has not had sex in ten years would not be at risk of HIV. The risk assessment will help CTR counselors identify behaviors that put individuals at-risk. Primary risk behaviors include, **within the past twelve months**:

- Having condomless sex with a person who is living with HIV;
- Having condomless sex in exchange for money or drugs;
- Having multiple (greater than five) or anonymous condomless sex partners;
- Sharing injection drug equipment with anyone;
- Having been diagnosed with a rectal/vaginal/urethral STI, especially syphilis.

Risk Assessment

Prior to testing, each client must complete a risk assessment to assess personal risk for HIV infection. This will be followed by a private counseling session between testing counselor and client. Counselors should utilize the assessment tool to calculate a risk score and a recommendation for testing. Testers should avoid completing the risk assessment together with the client, unless requested specifically by the client. It is considered best practice to first allow the client to self-assess their risk.

> **Best Practice!**
> Clients should be allowed to complete the risk assessment on their own. The test counselor can then review it and ask open-ended questions to learn more.

Because no test is guaranteed, ODH HIV counseling sessions should be offered as HIV screenings. Clients who have low- (under 50) or no- risk should not be tested. However, testing may be offered in special circumstances at the sole discretion of the counselor. e.g. If the counselor strongly believes that the client is/may be at risk of HIV but has not been forthcoming with the information necessary for HIV risk determination. *Again, CTR testers should use their best judgment to navigate nuanced situations*.

Testing threshold: 50

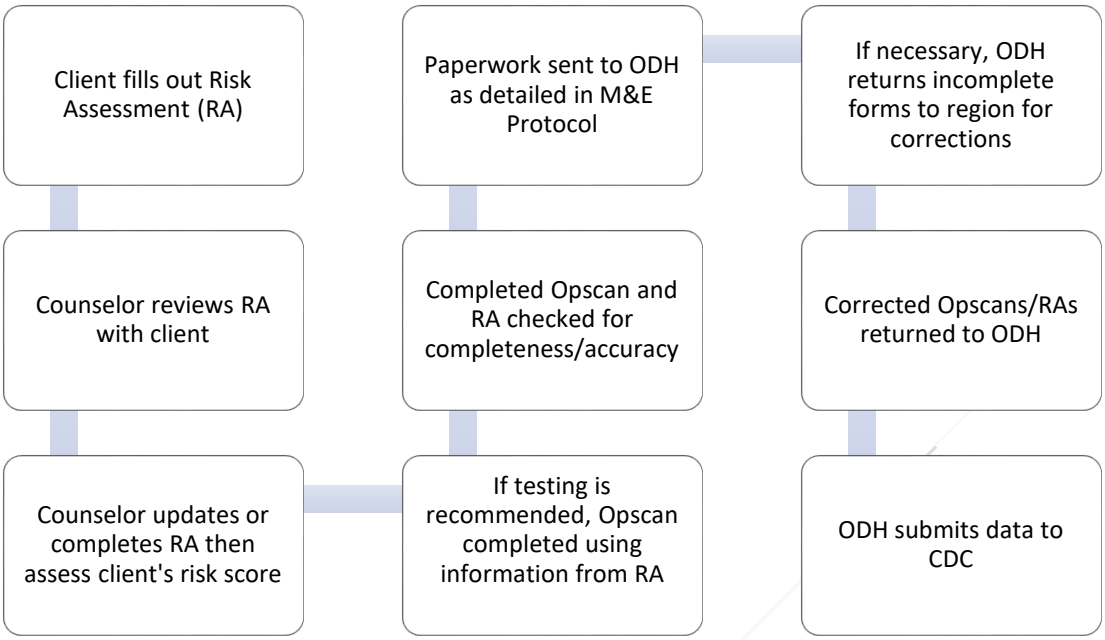
Testers should educate clients regarding risk factors and refer those with no- to low- HIV risk to routine testing with a primary care provider or clinic. To make accurate and complete referrals, testers should have resources for both insured and uninsured clients.

An effective HIV risk assessment tool ensures testing is prioritized to populations at greatest risk. The tool will also refer clients to essential services outlined below:

PrEP	Mental Health Services	Transportation
Health Benefits Navigation	Housing	Employment Services
Linkage to HIV Medical Care	DV/IPV Intervention	Perinatal Support
Medication Adherence Support	Substance Use Treatment	PAPI (PrEP Assistance) Enrollment

Testers and program coordinators should ensure that the HIV risk assessment and Opscan are filled out completely. Only complete Opscan data may be submitted to the CDC. Incomplete data undermines the efforts of test counselors and misrepresents the work done in Ohio. CTR Testers should go over the risk assessment with the client to ensure completeness and accuracy before filling out the Opscan or sending data to ODH. Sites

should keep accurate records of Site IDs and Tester Numbers in the case that documents are returned for corrections or missing data.



HIV Test Counseling Session

All test counselors supported by ODH funds are required to attend ODH CTR Training and maintain a test counselor identification number. CTR trainings occur regularly throughout the year and are communicated to and disseminated by regional coordinators.

Under special circumstances, a temporary test counselor number may be assigned by the state HIV Prevention program. The regional coordinator may request a temporary testing number for a new counselor but is required to provide detailed information regarding how the employee will be trained.

The purpose of HIV counseling is to educate the client on risk, risk behaviors, and transmission to empower them to reduce their risk. All ODH-funded test sites must use Client Centered Counseling. The benefits of Client Centered Counseling depend on the ability of the test counselor to establish an open and non-judgmental environment. The client should guide the session while the tester provides information and resources to empower their decision-making.

The Testing Session

1. Introduce yourself and orient the client to the session
2. Discuss risk screening assessment
3. Run rapid test 1 if assessment and client agree it is appropriate
4. Develop a risk reduction plan
5. Deliver test result(s)
6. Develop or reaffirm a risk reduction plan or discuss linkage plan based on results
7. Refer and link with medical care, social, and behavioral services
8. Summarize and close the session.

8 Steps of HIV Prevention Counseling

The 8 steps provide an outline for the HIV counseling session. Applying the 8 steps can keep the session on track, ensure complete information is shared, and the client's need are met. The content of the session is determined by the client and test counselor and should be guided by the client's responses to the risk assessment. The test counselor should dispel HIV myths, ask open-ended questions, and record information. The risk assessment and risk reduction plan should be used to help the client understand their actual and perceived risk.

1. Introduce yourself and orient the client to the session
   - Introduce yourself and your role.
   - Briefly outline what to expect during the session.
   - Obtain consent to test.
2. Discuss risk and screening assessment
   - Assess knowledge of HIV transmission, signs of infection, and correct any HIV myths.
   - Review Risk Assessment, ask clarifying or open-ended questions as needed.
   - Discuss client's risk and decide if testing is appropriate.
   - If testing is not appropriate, discuss any follow-up information and referrals.
3. Run rapid HIV test 1 if assessment and client agree it is appropriate
   - Explain the process of conducting the test; need for retesting if negative.
   - Educate on Rapid/Rapid testing; need for second test if positive.
   - Run test 1 with fingerstick **blood specimen**.
4. Develop a risk reduction plan
   - Refer to risk assessment to identify indicators of increased risk.
   - Assist client in understanding personal risk, circumstances and skills.
   - Help client identify any risk reduction strategies they would like to implement, including biomedical (PrEP/PEP), behavioral (reduce partners), and barrier methods (condoms).
   - Record risk reduction strategies on the risk reduction plan.
   - Keep a copy for internal records and give client a copy of their plan.
5. Deliver test result(s)
   - Follow manufacturer's instructions on time and interpreting the result.
   - Instruct that the first test is preliminary and must be verified by a follow-up test if positive.
   - Confirm the client's readiness to receive the result.
   - Provide a clear explanation of the result.
   - If positive: allow client to process result, re-explain rapid/rapid testing, and conduct the second test to verify HIV status.
6. Develop or reaffirm a risk reduction plan or discuss linkage plan based on results
   - If negative:
     - Reinforce prevention messages, revisit risk reduction plan and make any necessary changes.
       i. As the first point of contact for many high-risk HIV negative clients, HIV test counselors should not only educate clients about PrEP but should also know and assess for PrEP readiness and refer persons at risk for acquiring HIV to a PrEP navigator or provider.

- Support access to medical, social and behavioral services based on needs and risk profile.
- Review window period and signs/symptoms of acute infection; schedule follow-up testing in 3 months if indicated.

- If positive
  - Wait for client to react and let them initiate conversation; explore client's reaction to result.
  - Inform client about Partner Services; provide *Next Steps* booklet.
  - Complete HIV Verification form and begin linkage to care, following ODH LTC protocols.
    i. Offer rapid linkage if appropriate; if not, explain LTC program.
    ii. Although it might be difficult for clients to grasp everything you are telling them, it is important to discuss and reinforce the importance of accessing care and treatment. Your primary goal should be to link clients with medical care and other necessary follow-up services— either directly or through a patient navigator or linkage coordinator.
    iii. This may also be a good time to discuss navigating disclosure.
  - Notify regional DIS as soon as possible.

7. Refer and link with medical care, social, and behavioral services
   - Throughout the testing session you should receive information that will help you determine what services clients need to stay healthy, safe, and prevent HIV transmission or acquisition. These can be documented on the risk assessment.
   - Identify necessary medical, social, and behavioral referrals.
   - Make referrals as needed; active referrals should always be given when possible.

Referral Guide

- Funded HIV Testing sites are required to maintain a referral guide to ensure HIV Test Counselors can make appropriate and useful referrals to needed services.
- Any services identified through the risk assessment must be documented.
- Referrals and other important information can be found at the Ohio HIV/STI website. www.ohiv.org

Documenting Referrals:

Screening Questions	Counselor Referral Section	Opscan Field
• Do you have health insurance?	Health Benefits Navigation	Health Benefits Navigation and Enrollment
• If you are HIV positive, are you currently seeing a medical provider for treatment?	Linkage to HIV Care	
• Are you pregnant?	Perinatal Support	
• PrEP-related questions (awareness, history)	PrEP Navigation PAPI Enrollment	
• Do you use drugs and alcohol? • Do you inject or shoot-up drugs?	Substance Use Treatment and/or Syringe Service Program	Behavioral Health Services
• Do you have any mental health concerns?	Mental Health Services	
• Do you have reliable transportation?	Transportation	Social Services
• Do you have any immediate housing needs?	Housing	
• Does someone pressure you to have sex? • Do you feel safe in your relationship?	Domestic Violence/IPV Intervention	
• What is your current employment status?	Employment Services	

• Do you have trouble taking a daily medication?	Medication Adherence	Medication Adherence

8. Summarize and close the session.
    - Ensure client is emotionally ready to leave and has had the opportunity to ask all questions.
    - Ensure information is complete for documentation

Paper work required to be kept at testing agency. Record retention should follow the agency's policies. Each site is required to maintain records at their facility. These include:

Test Kit Records	Required Testing Documentation
• Test Kit Log • External Control Log	• Informed Consent • Client Risk Assessment • Risk Reduction Plan • HIV Verification Form (if HIV+) • Opscan

Routine Testing Event

To continue to support large-scale outreach and screening days, and to promote routine HIV testing, we have developed a routine testing event approval process. Under special circumstances (Pride, National Testing Day, World AIDS Day, etc.), it is permissible to suspend Priority Based Testing to promote the importance of routine testing.

- A Routine Testing Request should be sent to the HIV Prevention email. Please ensure enough time for approval before the event. If request is needed in a timely manner, contact the HIV Program Manager for help.
- Routine testing events should obtain consent from the ODH HIV Prevention program and will be considered based on current test kit inventory, anticipated volume, and impact in the community. Requests can be made to the HIV Prevention Manager or the Counseling Testing and Referral Consultant.
- No testing data, including new positive diagnoses, will be counted toward your overall testing numbers. Neither negative nor positive tests will impact your positivity rate.
- Risk Assessments are not required, and the risk threshold is eliminated – counselors should still discuss risk and discuss risk reduction strategies such as PrEP, but a written plan is not required.
- Should a positive be identified, test counselors should complete an Opscan and write "ROUTINE TESTING" at the top.
    - Agency or Region should be included in the Agency box.
- Positive Opscans should be sent to ODH and local DIS Supervisors should be notified for Partner Services. ODH will input results directly into ODRS

A **Routine Testing Request** should be submitted by the Regional Coordinator and must include:

Event name	Priority Pops Reached
Date/Time	Advertising to Priority Pops? Yes ☐ No ☐

Estimated # of attendees and tests	

Testing Toolbox

Testing sessions in Ohio will be done in a variety of settings. Focused on testing in priority populations means there will be more testing outside of the traditional health care offices. The need to be organized and ensure testers have all the materials they need is important. ODH suggest creating a toolbox for testers who are traveling to testing sites or events. The toolbox should be easy to carry and/or have wheels. There also should be a system to restock the toolbox before it is used again. This page is designed to be used as an inventory sheet.

Testing Supplies	
OraQuick Tests (follow OraSure control protocol)	☐
Insti Test Kits (follow Insti control protocol)	☐
Hand sanitizer	☐
Alcohol Wipes	☐
Gauze Pads	☐
Lancets	☐
Band-Aids	☐
Gloves	☐
Disposable blue pad (Chux)	☐
Biohazard sharps containers	☐

Testing Paperwork	
Informed Consent	☐
Demographic form	☐
Risk Assessment	☐
Risk Reduction Plan	☐
Opscan	☐
HIV Verification Form	☐

Other Supplies	
Referral Guide	☐
Steps Books	☐
Important phone numbers (DIS, rapid linkage agencies, PrEP agencies)	☐
Thermometer	☐
Timer	☐
Pens/Pencils for client to use	☐
Folders to keep completed paper work safe	☐
Calculator	☐

Ohio Revised Code – HIV Counseling, Testing, and Referral

	Policy Category	Type	Section Code(s)
PRE-TESTING	Introduction to HIV testing Law	Definitions	ORC 3701.24
	Who may perform an HIV Test	Health care provider within provider's scope of practice	ORC 3701.242 OAC 3701-3-11
	Informed Consent	Consent for medical care required – written or verbal	ORC 3701.242 OAC 3701-3-11
		Minors can give consent (age 13)	ORC 3701.242 OAC 3701-3-11
	Counseling requirements	Pre-test counseling not-required	ORC 3701.242 OAC 3701-3-11
	Anonymous testing	State Department of Health must support counseling and testing programs that offer anonymous testing	ORC 3701.241
		Any individual seeking an HIV test has the right, on the individual's request, to an anonymous test.	ORC 3701.242 OAC 3701-3-11
POST-TESTING	Post-test counseling	The health care provider ordering an HIV test shall provide post-test counseling for an individual who receives an HIV-positive test result.	ORC 3701.242
	Disclosure/confidentiality	Exceptions to confidentiality	ORC 3701.243
		Sexual partner notification	ORC 3701.241
		Court orders may allow access to confidential test results	ORC 3701.243
	Reporting	HIV diagnoses must be reported to designated local health department	ORC 3701.24
OTHER	Testing of minors/adolescents	Minors may consent to HIV testing	ORC 3701.242 OAC 3701-3-11

Purpose of Priority-Based Testing

Effective priority-based testing programs focus on the quality of testing rather than the number of tests conducted. Priority-based testing should be administered in a manner consistent with community and consumer norms. Sites should ensure testing services are culturally and linguistically appropriate to improve accessibility to persons or groups at greatest risk, who may hold varying levels of health literacy.

- Readily accessible HIV screening, counseling, testing, and referral services for individuals at highest risk for HIV;
- HIV testing at no cost to individuals with limited or no access to healthcare, uninsured, and unable to afford testing;
- Anonymous initial testing for persons with confidentiality concerns that might prevent them from seeking services;
- Client-centered risk assessment calculated by behaviors and circumstance;
- Appropriately refer for HIV medical services, case management, partner services, social and emotional support, risk reduction interventions, STI testing, and resources that meet the client's need.

Data-Driven Decision Making

Funded agencies will use testing data combined with state surveillance data to identify populations with the highest number of cases (incidence) in their service areas. Programs will use this data to identify locations for testing and marketing, and to assign resources to reduce new infections across their region. Agencies should incorporate high-impact HIV testing strategies that meet regional and state needs.

Any regional additions to the list of statewide priority populations should be justified with data.

Regional data sources include:

- Counseling, Testing, and Referral (CTR) Program Positivity Reports;
- Linkage to Care and Partner Services Documentation;
- Opscans from CTR Testing;
- Analyses on STI and HIV prevalence from local epidemiologists;
- Overdose Data.

State data sources include:

- ODH HIV Annual Surveillance Statistics;
- Quarterly Reports from ODH Monitoring & Evaluation (M&E);
- ODH HIV Surveillance Zip-code level incidence maps.

Implementing Community Engagement/Outreach:

Beyond not testing those at low-to-no-risk, Priority-Based Testing demands active community engagement. Those at highest risk for HIV may not be aware of CTR testing sites or feel comfortable utilizing them. Funded agencies should not assume that priority population members will come to them but should actively conduct outreach in the community.

Funded agencies must create an outreach and engagement plan for each of their priority populations. The plan should focus on when, where, and how to engage each population identified. Sites should seek innovative delivery methods and messaging strategies that are informed by the community which they seek to engage.

Appropriately engaging priority populations is necessary for maximizing resources, identifying those undiagnosed in need of medical care, treatment. and preventative services, such as PrEP, PEP, and other social and behavioral interventions. To maximize impact, agencies should collaborate with organizations that have a history of working with identified populations and those that address health disparities in their communities. These partners can help construct accurate, clear, effective, and stigma-free (ACES) messages that will increase awareness, reduce stigma, and engage those most at-risk.

Developing culturally, linguistically, and accessible outreach activities that build or strengthen relationships should be primary goal in HIV Prevention. HIV testing and education are secondary to meaningful community engagement. To ensure outreach is culturally responsive, staff must consider:

- Community stakeholders
- Community cultural norms
- Health literacy of community
- Locations where priority populations already seek services
- Location of outreach activities
- History of outreach to population
- Awareness of power dynamics, privilege, and positionality
- Stigma

Ideally, all engagement efforts will start and end with the community. Priority population members should be involved in planning whenever possible and should be compensated fairly for their time.

Below are four effective outreach and engagement strategies sites should consider. 1.) venue-based outreach; 2.) internet outreach; 3.) social networking strategy; 4.) social marketing.

Best Practice!

Engagement efforts should start and end with the community. Priority population members should be involved in planning whenever possible and should be fairly compensated for their time.

Venue-based outreach is done by engaging the priority population in their own environment, such as a neighborhood, hot spot, or venue (e.g., a bar, hotel, or community center). Agencies should identify key messages that are population-focused and effective. Agencies may offer HIV testing services in conjunction with venue-based outreach on-site or by through a mobile testing unit, (e.g. a van or tent).

Appointment-based testing: If it is not possible to test on-site, outreach staff are encouraged to:

1. Schedule a testing appointment with client when they are available.
2. Provide an appointment card with your contact information (also identify any barriers to testing like transportation);
3. Record client's contact information;
4. Follow-up with client to remind and re-engage them before the appointment.

Agencies should consider staff safety, agency capacity, and availability of resources when selecting outreach venues.

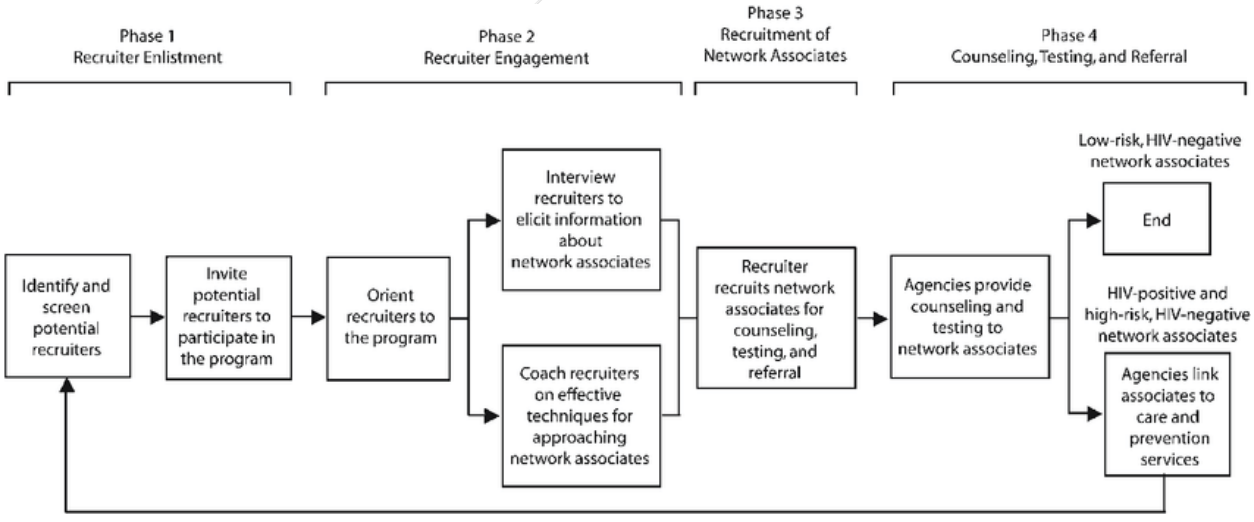
Internet-based outreach Social media is now a primary form and source of communication. Internet-based outreach may be especially useful for reaching young people and MSM who do not identify as gay/bisexual, or those who cannot be found in traditional outreach settings. Dating sites, hookup apps, and social networking sites are all forms of social media and should be utilized to their fullest potential. Funded agencies should use internet-based outreach as an effective outreach method to reach their priority populations. **Internet-based outreach should not replace in-person efforts or be considered an equivalent activity.**

Internet-based outreach may be used to:

- Increase knowledge and dispel myths about HIV and other STIs
- Promote sexual risk reduction techniques, such as PrEP and PEP, condom use, treatment as prevention, regular testing, talking to partners about sexual practices and health, knowing partners names and contact information, etc.
- Encourage harm reduction techniques for individuals that use injection drugs, such as using sterile syringes, unused equipment, clean water, etc.
- Create open discussion about sexual health and sexuality
- Provide referrals for HIV, STI, and Hepatitis testing
- Provide referrals to HIV prevention resources and other social services
- Recruit individuals into additional HIV prevention interventions

Internet-based outreach is easily evaluable through social metrics and data analytics. All internet-based outreach must be evaluated regularly to ensure messages are reaching priority populations with maximum impact. Outreach and engagement plans are required to have an evaluation component and will be monitored by ODH HIV Prevention through regular site visits and in annual and interim reports.

Social Networking Strategy (SNS) is a peer-driven approach that involves identifying HIV positive or high-risk HIV negative persons from the community to serve as "ambassadors" for your agency. Sites recruit members from their priority populations to deliver key messages and encourage testing/wellness among high-risk persons in their social, sexual, or drug-using networks. SNS has four phases outlined below.



SNS utilizes agency ambassadors to deliver key messages and encourage HIV testing among high-risk persons in their social, sexual, or drug-using networks. Ambassadors should be trained on the best approaches to reach their peers, who to approach, and what messages they should use to motivate their peers to be tested. SNS's

impact will plateau once ambassadors have reached saturation within their networks, which is why it is critical to place time-bound limits on participation.

Agencies implementing SNS will have the most success if they:

- Hire and train ambassadors from priority populations for limited engagement periods;
- Constantly recruit new ambassadors to maximize reach;
- Build partnerships in the community to ensure multidirectional referrals and expand ambassador's reach;
- Encourage innovative outreach through internet and social media;
- Provide indirect incentives through peer-driven events to engage new community members or obtain buy-in for testing at high-risk venues where clients might need extra motivation to access HIV testing;
- Find ways to support and encourage ambassadors, through leadership development, stipends (where allowable), or other incentives.

Social marketing

Social marketing strategies have been developed and used at all levels to promote awareness, reduce stigma, and increase engagement. Funded agencies are expected to use media (e.g. print and radio media, transportation media, social/digital media and promotions, dating app messaging, etc) to reach identified priority populations.

Social Marketing/Engagement plans must be:

- Culturally and linguistically appropriate; accessible;
- Assessed for ACES (Accuracy, Clarity, Efficacy, Stigma-free);
- Created for specific audience and purpose;
- Peer- and stakeholder- reviewed through Educational Material Review Process (EMRP);
- Comprehensive to address each aspect of the HIV Care Continuum.

Incentives

Indirect client incentives are an allowable cost to increase community engagement and testing. No direct incentives may be provided, including, but not limited to, exchanging money, goods or services for HIV testing. Direct one-for-one exchange devalues HIV testing; our goal is to make HIV testing accessible and routine in populations most impacted by the epidemic. Examples of indirect incentives include refreshments at testing events, prize raffles, bus passes for SNS ambassadors, etc.

Sites should prioritize incentives for outreach activities that will maximize impact and resources.

Evidence Based Interventions (EBIs)

Funded agencies may incorporate CDC-published evidenced based interventions within their priority population's engagement plan. EBIs are individual, group, couple, and community level risk reduction techniques designed to change behaviors. If EBIs are used, Ohio agencies are encouraged to adapt interventions to maximize impact. Following the spirit and framework of the interventions is often more productive than implementing them as a curriculum.

The EBIs highlighted below (and more) are here: **https://effectiveinterventions.cdc.gov/.** The EBIs highlighted below are those considered most impactful by the ODH HIV Prevention program.

Mpowerment - a community level HIV engagement intervention for young gay and bisexual men. The intervention combines informal and formal discussion groups, creation of safe spaces, social opportunities, and social marketing to reach a broad range of young men with prevention and risk reduction messages.

Funded agencies can use this intervention to develop support groups or drop-in centers for young MSM. They can market the group as a safe space where young gay and questioning individuals can meet and receive support. Community level Mpowerment must have a core group of 10-20 young gay/bisexual men from the community with the support of paid staff and built on the following principles.

- Personal and community empowerment
- Diffusion of new behaviors through social networks
- Peer-influence
- Putting HIV prevention within the context of other compelling issues for young gay/bisexual men
- Community building
- Queer-affirming language and approach

Community PROMISE - is a community-level engagement intervention that relies on peer driven messaging to distribute stories of healthy living to community members. The intervention is based on stages of change and other behavioral theories, and can be implemented with various populations including PWID, MSM, sex workers, and partners of high-risk individuals.

Core Elements of Community PROMISE

- Community identification process
- Role model stories
- Peer advocates
- Evaluation

Agencies can use Community PROMISE to reach their priority populations by using peer advocates. Trained peers can disburse risk-reduction messaging and safe sex kits. PROMISE can also be implemented among PWID, by asking drug users to distribute information on syringe assess programs and treatment services within their social networks. Sites can collect client feedback and use it as a guide when development and enhance their programs. Sites should encourage peers who've adopted healthier living to share their personal stories with their social networks.

Healthy Relationships - is a five-session small group community intervention for men and women living with HIV/AIDS. It is based on social cognitive theory and focuses on developing skills-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills.

Healthy Relationships aims to build skills to reduce stress in the following 3 life areas:

- Disclosing HIV status to family and friends
- Disclosing HIV status to sex partners and needle-sharing partners
- Building healthier and safer relationships

Agencies can use Healthy Relationships to increase clients' decision-making and problem-solving skills. These skills will help clients disclose their HIV status and make empowered decisions. They should incorporate short decision-making stories and popular videos for role-playing scenarios. Healthy Relationships is adaptable to different populations and cultures by varying the choice of videos and providing flexibility in role-playing.

Frequently Asked Questions about the Risk Assessment and CTR Testing

Best Practice!

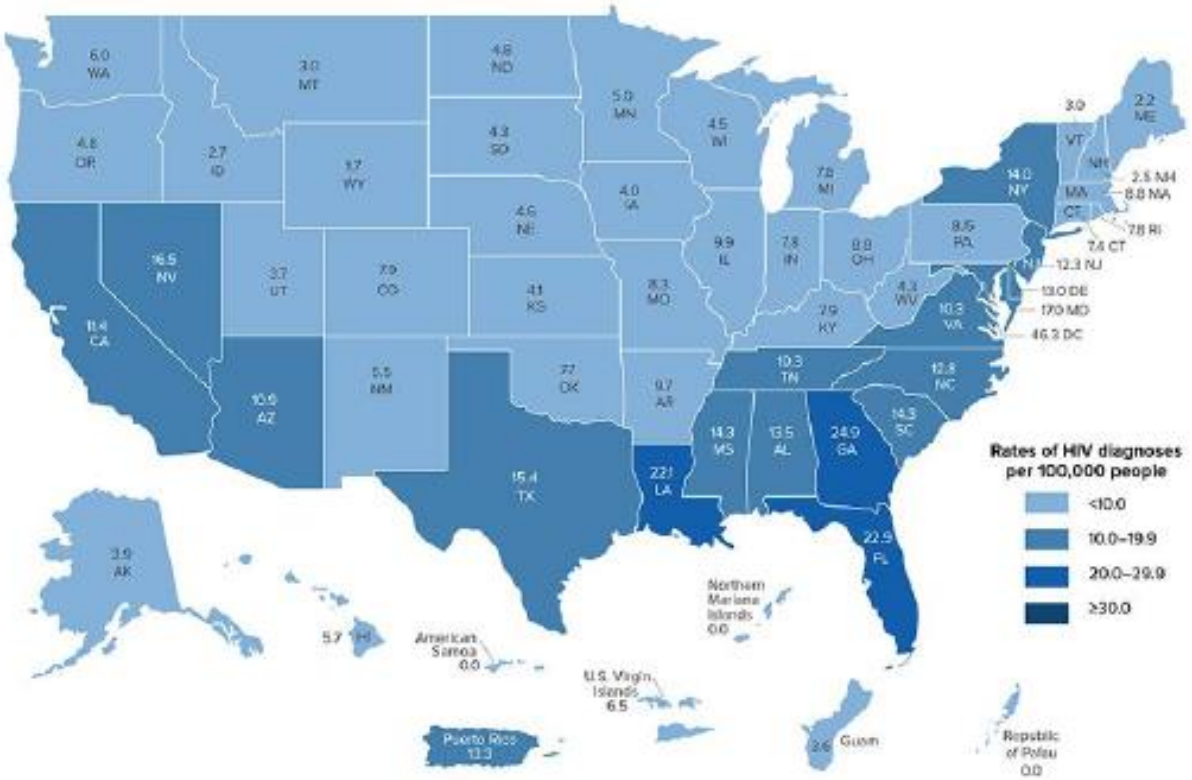
Clients should be allowed to complete the risk assessment on their own. The test counselor can then review it and ask open-ended questions to learn more.

Scoring Responses when More than One Choice is Selected:

Testers should default to the choice with the highest point value. For example, Question 14 (Tell me about your sexual activity for the past 12 months…) allows clients to select multiple types of partners, sex, and frequency of condom use. A "versatile" male client who has both receptive and insertive anal sex should receive 10 points (top), not 15. If this client uses condoms with women sometimes, and never with men, they would receive 10 points (never). Clients should receive a maximum of 45 points for belonging to a population prioritized for testing – no "double dipping."

Why the South?

Surveillance Data from the US Centers for Disease Control and Prevention (CDC) shows that Americans residing in the South experience heightened incidence of HIV infection. A map of the US showing 2017 rates of diagnosis per 100,000 is shown below. Ohioans who have recently lived in or visited these areas, had sexual or injection drug use encounters, and have not been tested since are at heightened risk as they have encountered an increased community viral load. Testers should use their best judgment in determining clients' relationship to "the South" when determining their score on the risk assessment.

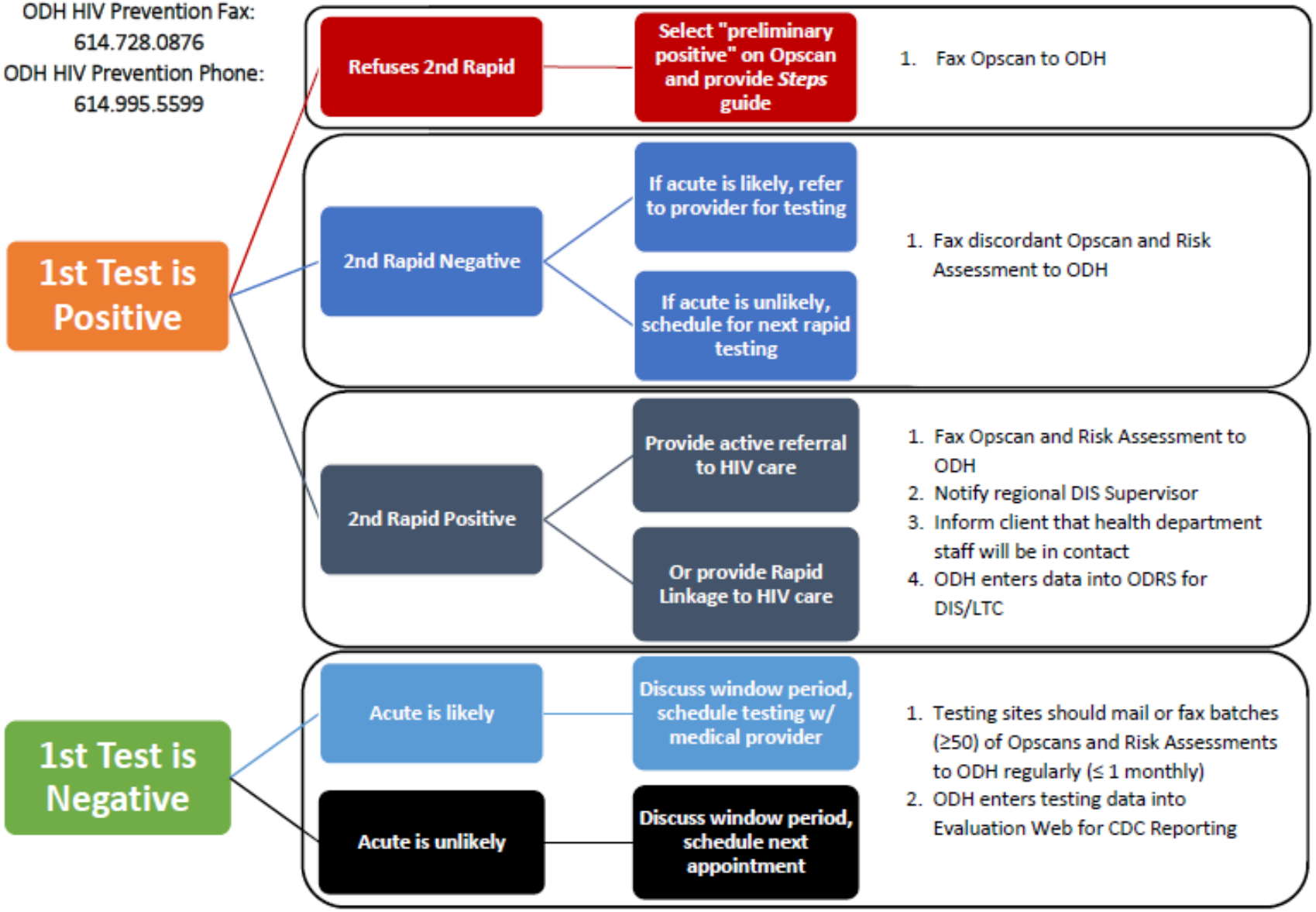


HIV Risk Screening & Test Counseling Documents

- Consent Form
- Risk Reduction Plan
- Risk Assessment
- Scoring Sheet
- Opscan
- HIV Verification Form
- *Steps* Guide

Remember!
The CDC requires fully complete paperwork for data entry. Any risk assessments or Opscans with incomplete responses will be returned to you for corrections.

ODH HIV Prevention Fax:
614.728.0876
ODH HIV Prevention Phone:
614.995.5599



Ohio Department of Health HIV Prevention
12.16.2019

Ohio Department of Health

Mike DeWine, Governor
Jon Husted, Lt. Governor

Amy Acton, M.D., MPH, Director

HIV VERIFICATION FORM

CONFIDENTIAL

This form should be provided to a medical or service provider chosen, by the client, to verify they have received two reactive rapid HIV test results.

LAST NAME	FIRST NAME	
PHONE	GENDER	D.O.B.
COLLECTION DATE	TIME	

1st Rapid Test OraQuick ☐ Insti ☐	Negative ☐	Positive ☐
2nd Rapid Test OraQuick ☐ Insti ☐	Negative ☐	Positive ☐

TEST SITE	
CITY	PHONE
TESTER NAME	CTR TESTING #
TESTER SIGNATURE	

Rapid HIV testing considerations:

- If the 1st rapid test is **NEGATIVE**, the screen is considered negative for HIV antibodies.
- If the 1st rapid test is **POSITIVE**, confirmatory testing (molecular tests) from an outside laboratory or a second rapid test is recommended.
  - If two different rapid tests have been performed and are **both POSITIVE**:
    - Based on current CDC guidelines, the patient is **considered positive for HIV and has been referred for care.** Additional testing may be performed by the provider to evaluate for treatment options.
  - If two different rapid tests have been performed with the **second test NEGATIVE**:
    - The results are **DISCORDANT** and require further investigation. Refer to an outside laboratory or provider for confirmatory testing; recommend follow-up testing in 1-2 weeks; or provide rapid linkage for confirmatory.

Dear Provider: This information has been disclosed to you from confidential records protected from disclosure by state laws. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or otherwise permitted by state laws. A general authorization for the release of medical or other information is not sufficient for the release of HIV test results or diagnoses

For assistance with test interpretation, contact:
Ohio Department of Health/HIV Prevention
246 North High Street, 6th Floor
Columbus, OH 43215
PHONE: 614.995.5599 FAX: 614.728.0876
HIVPrevention@odh.ohio.gov

Ohio Department of Health

Counselor ID #: _____ Site Location: _____ Opscan ID:_____

Today's Date: _____

Please complete this form – it will help your counselor measure your risk for HIV. If you don't know an answer or feel uncomfortable with a question, leave it blank. Your counselor will review this with you during your session.

Personal Information – Please answer the questions below.

Date of Birth: _____ County Where You Live: _____ Zip Code: _____

Age: ☐ 13-19 ☐ 20-24 ☐ 25-34 ☐ 35-49 ☐ 50 or over

Race & Ethnicity: *(Select **ALL** that apply)* ☐ American Indian/Native Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

☐ Hispanic/Latinx ☐ Non-Hispanic/Latinx

Current Gender Identity: ☐ Male ☐ Female ☐ Trans/Nonbinary

Sex at Birth: ☐ Male ☐ Female

Sexual Health Information – Please answer questions 1- 11 below.

1. Are you pregnant? ☐ Yes ☐ No ☐ Don't Know ☐ N/A

2. Have you ever been tested for HIV? ☐ Yes ☐ No ***Date of Last Test***: _____
Result: ☐ Positive ☐ Negative ☐ Don't Know

3. Have you ever heard of PrEP or PEP? ☐ Yes, PrEP ☐ Yes, PEP ☐ No

4. Are you <u>currently</u> taking PrEP or PEP? ☐ Yes, PrEP ☐ Yes, PEP ☐ No

5. Have you taken PrEP <u>in the last year</u>? ☐ Yes ☐ No

6. Were you told by a Local Health Department that you may have been exposed to HIV? ☐ Yes ☐ No ☐ Don't Know

7. Are any of your sex or injection partners HIV+?
☐ Yes ☐ No ☐ Don't Know

8. IF you have a sex or injection partner who is HIV+, are they on treatment?
☐ Yes ☐ Don't Know ☐ N/A (no HIV+ partners)

9. Have you had an STI in the past 12 months?

	Yes	No	Don't Know
Syphilis	☐	☐	☐
Other	☐	☐	☐

10. Have you injected or shot up any drugs in the past 12 months?
☐ Yes, prescribed to me
☐ Yes, drugs not prescribed to me
☐ No

11. <u>IF you've injected or shot up</u>, have you shared needles or equipment?
☐ Yes ☐ No
☐ Don't inject drugs

Sexual Partner History – Please answer questions 12-17 about your sexual partners.

12. About how many partners have you had in the last 12 months? _____

13. Were any anonymous, or someone you didn't know? ☐ Yes ☐ No

14. Tell me about your sexual activity for the past 12 months:

My partners were…		Condom use was…			My position(s) were…		
		Always	Sometimes	Never	Vaginal	Anal (top/giving)	Anal (bottom/taking)
Men	☐	☐	☐	☐	☐	☐	☐
Women	☐	☐	☐	☐	☐	☐	☐
Trans/Nonbinary Individuals	☐	☐	☐	☐	☐	☐	☐

Ohio Department of Health

Counselor ID #: _____ Site Location: _____ Opscan ID:_____

15. Do your partners inject or shoot-up any drugs?

☐ Yes ☐ No ☐ Don't Know

16. Have any of your partners had an STI in the last 12 months?

	Yes	No	Don't Know
Syphilis	☐	☐	☐
Other	☐	☐	☐

17. If your partner(s) have sex with other people, do they have sex with…

☐ Gay/Bi Men ☐ Women ☐ Trans/Nonbinary individuals ☐ Straight Men ☐ N/A (No other Partners) ☐ Don't Know

Additional Information Please answer questions 18-29 about needs you may have.

18. Do you have health insurance?	☐ Yes	☐ No	25. Do you have reliable transportation?	☐ Yes	☐ No
19. If you are HIV positive, are you currently seeing a medical provider for treatment?	☐ Yes	☐ No ☐ N/A	26. Do you have any immediate housing needs?	☐ Yes	☐ No
20. Do you have trouble taking a daily medication?	☐ Yes	☐ No	27. Do you feel safe in your relationship?	☐ Yes	☐ No ☐ N/A
21. Do you have any mental health concerns?	☐ Yes	☐ No	28. Does your partner pressure you into having sex?	☐ Yes	☐ No
22. Do you use drugs or drink alcohol?	☐ Yes	☐ No	29. Do you ever exchange sex for money or drugs or something you need?	☐ Yes	☐ No
23. Do you have any untreated STIs?	☐ Yes	☐ No			

24. What is your current employment status?

☐ Employed, not looking for work ☐ Part-time, seeking full-time work ☐ Unemployed, looking for work

☐ Other: _____

STOP HERE. YOU HAVE REACHED THE END OF THE RISK ASSESSMENT.

Section Only Completed by HIV Test Counselor

Client or partners come from an Ohio population prioritized for testing? (see score sheet for list)		Y ☐
Considered to be at-risk? (circle)	**Y N**	**Total Risk Score:**
If test offered to client with score below 50, justify here:		
OpScan 5 year questions: In past 5 years… had sex with woman? ☐ Y ☐ N with man? ☐ Y ☐ N With trans person? ☐ Y ☐ N Injected drugs? ☐ Y ☐ N		
Referral provided for:	☐ PrEP	☐ Linkage to HIV Medical Care
	☐ Health Benefits Navigation	☐ Medication Adherence Support
	☐ Mental Health Services	☐ Substance Use Treatment
	☐ Housing	☐ Transportation
	☐ DV/IPV Intervention	☐ Employment Services
	☐ Perinatal Support	☐ PAPI Enrollment
Service provided:	☐ Risk Reduction Intervention	☐ Linkage to HIV Medical Care
	☐ PrEP Navigation	☐ Medication Adherence Support
	☐ Health Benefits	☐ PAPI Enrollment

Ohio Department of Health

This scoresheet highlights responses on the HIV Risk Assessment that contribute to or are associated with increased risk (a point value) or lead to key decision points (referral, end counseling session, etc.). The numbers in the left column correspond to the numbered questions on the Risk Assessment.

The score sheet does not need to be submitted to ODH.

2.	Have you ever been tested for HIV?	Positive		STOP – Linkage to Care
4.	Currently taking PrEP or PEP?	Yes, PEP		STOP – refer to provider
		Yes, PrEP		If taken daily, STOP - not at risk for HIV
6.	Were you referred for an HIV test from a Local Health Department? *(DIS contact)*	Yes		+50
7/8.	Are any of your partners HIV positive?	Yes, but not virally suppressed (not on treatment)		+50
		Don't Know		+5
9.	Have you been diagnosed with an STI in the past 12 months?	Yes (any)		+10
		Don't Know		+5
10/11.	Injected/shot-up any drugs in past 12 months? IF YES, NOT PRESCRIBED	Ever share needles or equipment?	Yes	+10
			No	+5
13.	Were any partners anonymous?	Yes		+10
14.	Condom use?	Always / Sometimes		+5
		Never		+10
14.	Type of sex?	Vaginal (if assigned male at birth); Anal (top)		+5
		Vaginal (if assigned female at birth); Anal (bottom)		+10
15.	Do your partners inject/shoot-up any drugs?	Yes		+10
		Don't Know		+5
16.	Have any of your partners had an STI in the last 12 months?	Yes	Syphilis	+10
			Other	+5
		Don't Know		+5
17.	If your partner(s) have sex with other people, do they have sex with…	Gay/Bi men or Trans/nonbinary individuals		+10
		Women or Straight men		+5
		Don't Know		
29.	Do you ever exchange sex for money or drugs or something you need?	Yes		+10
	Is the client from an Ohio population prioritized for testing? *REMINDER: OpScan will ask: In past five years* - Had sex with man - Had sex with woman - Had sex with trans person - Injected drugs	☐ young Black men who have sex with men (YBMSM) ☐ men who have sex with men (MSM) ☐ people who inject drugs (PWID) ☐ trans/nonbinary persons (especially young, Black) ☐ partner of a person living with HIV/AIDS (PLWHA) ☐ partner of PWID ☐ partner of MSM ☐ had a syphilis diagnosis in the last year ☐ have moved from the South and haven't been tested			+45
	Total Risk Score: _____	Test Recommended? (50+)	Y	N

Ohio | Department of Health

Risk Reduction Plan

Mike DeWine, Governor
Jon Husted, Lt. Governor
Amy Acton, M.D., MPH, Director

Last Name: _____ First Name: _____ Date: ____/____/____ Site: _____

RISK AWARENESS

Knowledge Awareness:

- Have you ever been tested before?
- What have you heard about HIV?
  - ...about how people can get HIV?
  - ...about how people can avoid HIV?

Significance to Self:

- What is the reason for getting tested for HIV?
- What if your testing is positive?
- If negative, how will you continue to remain so?

Cost / Benefits Analysis:

- What's working for you with what you are doing now?
- What are you doing now that you would like to change?
- What is the hardest (most difficult) part of changing?
- What might be good about changing?

Capacity Building:

- What will be the most difficult part of this for you?
- How have you handled a similar situation in the past?
- What will you need to do differently?
- When will you do this? What words will you use?

RISK PERCEPTION

Client:	*(high)*	5	4	3	2	1	*(low)*
Counselor:	*(high)*	5	4	3	2	1	*(low)*

RISK REDUCTION PLAN

Plan Process: 1. List steps client is willing to take to reduce risk.
2. Clarify cost and benefits of the plan and adjust as needed.

_____

_____

_____

_____

_____

_____

RISK REDUCTION STRATEGIES

- ☐ Talk to a medical provider about PrEP
- ☐ Try to limit number of partners
- ☐ Ask current or future partner(s) to be tested (a partner who respects you will get tested)
- ☐ Use condoms (or try to increase the frequency of condom use.)
- ☐ Get to know future partners better before having sex
- ☐ Ask partners about sexual history (ex. have you ever had a sexually transmitted disease?)
- ☐ Don't have sex when your judgment could be impaired. (ex. with use of alcohol or drugs)
- ☐ Try not to share drug equipment

EDUCATION, PREVENTION & FOLLOW-UP

Materials Given: ☐ HIV/STI Info ☐ Condoms ☐ ESL HIV/STI Materials ☐ Receptive "Female" Condoms ☐ PrEP Info ☐ Lube ☐ Dental Dams/Misc. ☐ Demonstration

Follow-up Card Given: ☐ Yes ☐ No Referral Made: ☐ Yes ☐ No

Retest Recommended: ☐ Yes ☐ No Retest Date: _____/_____/_____

Counselor Name: _____ #: _____

HIV Antibody Test Results*: _____

A negative HIV test result does **not exclude the possibility of infection with HIV due to the window period.*

Ohio EvaluationWeb 2019 HIV Test Template

Instructions

Within each numbered section, move from top to bottom of column A (on the left), then from top to bottom of column B (on the right).

There are three different response formats that you will use to record data: text boxes (used to write in information like codes and dates), and check boxes.

Six data fields are mandatory for a valid testing event:

- Form ID (write in or adhere a sticker with the Form ID number to each data entry page)
- Session Date
- Program Announcement
- Jurisdiction (populated automatically in EvaluationWeb)
- Agency ID (populated automatically in EvaluationWeb)
- Site ID (populated automatically in EvaluationWeb)

Write in the name of the Agency and Site number on all Opscan forms.

CDC assurance of confidentiality

The CDC Assurance of Confidentiality statement assures clients and agency staff that data collected and recorded on templates will be handled securely and confidentially. All CDC recipients are encouraged to include the CDC Assurance of Confidentiality on all HIV prevention program data collection templates.

Assurance of Confidentiality Statement:

The information in this report to the Centers for Disease Control and Prevention (CDC) is collected under the authority of Sections 304 and 306 of the Public Service Act, 42 USC 242b and 242k. Your cooperation is necessary for the evaluation of the interventions being done to understand and control HIV/AIDS. Information in CDC's HIV/AIDS National HIV Prevention Program Monitoring and Evaluation (NHME) system that would permit identification of any individual on whom a record is maintained, or any health care provider collecting NHMNE information, or any institution with which that health care provider is associated will be protected under Section 308(d) of the Public Health Service Act. This protection for the NHME information includes a guarantee that the information will be held in confidence, will be used only for the purposes stated in the Assurance of Confidentiality on file at CDC, and will not otherwise be disclosed or released without the consent of the individual, health care provider, or institution described herein in accordance with section 308(d) of the Public Health Service Act (42 USC 242m(d)).

This page intentionally left blank.

☐ Referred by DIS for Testing

☐ Opscan Form with Corrections

Ohio Evaluation Web 2019 HIV Test Template

Form ID (*enter or adhere*)

If client tests positive for HIV:
ODRS ID (if applicable) _____
Client Name _____
Client Contact Information

1 | Agency and Client Information *(complete for all persons)*

Session Date

Program Announcement ☒ *PS18-1802*

Agency Name

Site ID Number

Site Zip Code

Site County

Local Client ID *(optional)*

Test Counselor ID

Client Date of Birth *(1/1/1800 if unknown)*

Client State *(USPS abbreviation)*

Client County

Client Zip

Client Ethnicity
☐ Hispanic or Latinx ☐ Don't Know
☐ Not Hispanic or Latinx ☐ Declined to Answer

Client Race
☐ American Indian/Alaska Native ☐ White
☐ Asian ☐ Not Specified
☐ Black or African American ☐ Declined to Answer
☐ Native Hawaiian or Pacific Islander ☐ Don't Know

Client Assigned Sex at Birth
☐ Male ☐ Female ☐ Declined to Answer

Client Current Gender Identity
☐ Male ☐ Transgender Unspecified
☐ Female ☐ Another Gender
☐ Transgender Male to Female ☐ Declined to Answer
☐ Transgender Female to Male

Has the client ever previously been tested for HIV?
☐ No ☐ Yes ☐ Don't Know

2 | PrEP Awareness and Use *(complete for all persons)*

Has the client ever heard of PrEP?
☐ No ☐ Yes

Is the client currently taking daily PrEP medication?
☐ No ☐ Yes

Has the client used PrEP anytime in the last 12 months?
☐ No ☐ Yes

3 | Priority Populations *(complete for all persons)*

In the past five years, has the client had sex with a male?
☐ No ☐ Yes

In the past five years, has the client had sex with a female?
☐ No ☐ Yes

In the past five years, has the client had sex with a transgender person?
☐ No ☐ Yes

In the past five years, has the client injected drugs or other substances?
☐ No ☐ Yes

4 | Final Test Information *(complete for all persons)*

Test Type *(select one only)*

☐ CLIA-waived Point of care (POC) Rapid Test(s)

POC Rapid Test Result
☐ Preliminary Positive
☐ Verified Positive
☐ Negative
☐ Discordant
☐ Invalid

☐ Laboratory-based Test(s)

Lab-based Test Result
☐ HIV-1 Positive
☐ HIV-1 Positive, possible acute
☐ HIV-2 Positive
☐ HIV Positive, undifferentiated
☐ HIV-1 Negative, HIV-2 Inconclusive
☐ HIV-1 Negative
☐ HIV Negative
☐ Inconclusive, further testing needed

Ohio Evaluation Web 2019 HIV Test Template

Form ID (*enter or adhere*)

ODRS ID *(if applicable)* _____

4 | Final Test Information (cont)
(complete for all persons)

HIV Test Election
☐ Anonymous ☐ Confidential ☐ Test Not Done

HIV Test Result Provided to Client?
☐ No ☐ Yes ☐ Yes, client obtained the result from another agency

5 | Additional Tests
(complete for all persons)

Was the client tested for co-infection?
☐ No ☐ Yes

Tested for Syphilis?
☐ No ☐ Yes

Syphilis Test Result
☐ Newly Identified Infection
☐ Not Infected
☐ Not Known

Tested for Gonorrhea?
☐ No ☐ Yes

Gonorrhea Test Result
☐ Positive ☐ Negative
☐ Not Known

Tested for Chlamydial infection?
☐ No ☐ Yes

Chlamydial Infection Test Result
☐ Positive ☐ Negative
☐ Not Known

Tested for Hepatitis C?
☐ No ☐ Yes

Hepatitis C Test Result
☐ Positive ☐ Negative
☐ Not Known

If client tests positive for HIV:
Client Name _____
Client Contact Information _____

6 | Risk Assessment *(complete for persons testing negative)*

Is the client at risk for HIV infection?
☐ No ☐ Yes ☐ Risk Not Known ☐ Not Assessed

7 | PrEP Eligibility and Referral *(complete for persons testing negative)*

Was the client screened for PrEP eligibility?
☐ No ☐ Yes

Is the client eligible for PrEP referral?*
☐ No ☐ Yes

Was the client given a referral to a PrEP provider?
☐ No ☐ Yes

Was the client provided navigation or linkage services to assist with linkage to a PrEP provider?
☐ No ☐ Yes

If the client was not given a referral to a PrEP Navigator or PrEP provider, please explain why:
☐ Client declined ☐ Referral not offered ☐ Services not available
☐ Other: _____

8 | Essential Support Services *(complete for persons testing negative)*

	Screened for need	Need determined	Provided or referred
Health Benefits navigation and enrollment	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Evidence-based risk reduction intervention	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Behavioral health services	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Social services	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Notes *(optional)*

_____
_____

*All clients who test negative for HIV are eligible for PrEP.

Ohio Evaluation Web 2019 HIV Test Template

Form ID (*enter or adhere*)

ODRS ID (*if applicable*) _____

If client tests positive for HIV:
Client Name _____
Client Contact Information _____

9 | Positive Test Result *(complete for persons testing positive)*

Did the client attend an HIV medical care appointment after this positive test?
- ☐ Yes, Confirmed
- ☐ Yes, client/patient self-report
- ☐ No
- ☐ Don't Know

→ Date attended

Rapid Linkage
- ☐ Same day medical visit
- ☐ Same day referral

Agency/Facility	
Provider Name	

Has the client ever had a positive HIV test prior to this event?
- ☐ No
- ☐ Yes
- ☐ Don't Know

→ Date of first positive HIV test

Was the client provided with individualized behavioral risk-reduction counseling?
- ☐ No
- ☐ Yes

Was the client's contact information provided to the health department for Partner Services?
- ☐ No
- ☐ Yes

Client's most unstable housing status in last 12 months?
- ☐ Literally Homeless
- ☐ Unstably Housed or at Risk of Losing Housing
- ☐ Stably Housed
- ☐ Not Asked
- ☐ Declined to Answer
- ☐ Don't Know

If the client is female, is she pregnant?
- ☐ No
- ☐ Yes
- ☐ Declined to Answer
- ☐ Don't Know

→ Is the client in prenatal care?
- ☐ No
- ☐ Not Asked
- ☐ Declined to Answer
- ☐ Yes
- ☐ Don't Know

→ Was the client screened for need of perinatal HIV service coordination?
- ☐ No
- ☐ Yes

→ Does the client need perinatal HIV service coordination?
- ☐ No
- ☐ Yes

→ Was the client referred to perinatal HIV service coordination?
- ☐ No
- ☐ Yes

Was the client interviewed for partner services?
- ☐ Yes, by a health department specialist
- ☐ Yes, by a non-health department person trained by the health department to conduct partner services
- ☐ No
- ☐ Don't know

→ Date of Interview

eHARS State Number *(ODH use only)*

New or Previous Diagnosis *(ODH use only)*
- ☐ New diagnosis, verified
- ☐ New diagnosis, not verified
- ☐ Previous diagnosis
- ☐ Unable to determine

→ Has the client seen a medical care provider in the past six months for HIV treatment?
- ☐ No
- ☐ Yes
- ☐ Don't Know
- ☐ Declined to Answer

Partner Services Case Number *(ODH use only)*

Value Definitions for New or Previous Positives

New Diagnosis, verified – The HIV surveillance system was checked and no prior report was found and there is no indication of a previous diagnosis by either self-report (if the client was asked) or review of other sources (if other sources were checked).

New Diagnosis, not verified – The HIV surveillance system was not checked and the classification of new diagnosis is based only on no indication of a previous positive HIV test by client self-report or review of other data sources.

Previous Diagnosis – Previously reported to the HIV surveillance system or the client reports a previous positive HIV test or evidence of a previous positive test is found on review of other data sources.

Unable to determine – The HIV surveillance system was not checked and no other data sources were reviewed and there is no information from the client about previous test results.

Ohio Evaluation Web 2019 HIV Test Template

Form ID (*enter or adhere*)

ODRS ID *(if applicable)* _____

If client tests positive for HIV:
Client Name _____
Client Contact Information _____

10 | Essential Support Services *(complete for persons testing positive)*

	Screened for need	Need determined	Provided or referred
Navigation services for Linkage to HIV medical Care	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Linkage services to HIV medical care	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Medication adherence Support	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Health Benefits navigation and enrollment	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Evidence-based risk reduction and intervention	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Behavioral health services	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Social services	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Local Use Fields *(optional)*

Local Use Field 1
Local Use Field 2
Local Use Field 3
Local Use Field 4
Local Use Field 5
Local Use Field 6
Local Use Field 7
Local Use Field 8

Notes *(optional)*