CUYAHOGA COUNTY BOARD OF HEALTH

YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

5550 Venture Drive Parma, Ohio 44130
216-201-2000 www.ccbh.net

Prevention Region 3
Grant Overview
March 26th 2020

Agenda

- Epidemiological Profile
- Coordination with Ryan White Part A Early Intervention Services
- Program and Fiscal Requirements
- ODH Requirements

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Prevention Region 3 Epidemiology Overview

Vino Panakkal

vpanakkal@ccbh.net

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2018 Region 3 Epidemiology Summary

Incidence/New Cases

- Males made up 88% of new cases in the grant area; more specifically, 51% of new cases were African-American males.
- Highest number of new cases was in the 25-29yrs of age group.
- 66% of new cases were in the Men that have Sex with Men (MSM) exposure category.

2018 Epidemiology
Western Counties: Lorain and Medina

Incidence/New Cases

- In 2018, there were 19 new cases. 74% were male; 42% were White males.
- 26% of cases were in the age 20-24yo age group.
- 43% of cases were in the MSM exposure category.

2018 Epidemiology
Eastern Counties: Lake, Geauga, Ashtabula

Incidence/New Cases

- In 2018, there were 6 new cases in the three counties. 100% were male, more specifically, White males made up 83% of the cases.
- 28% of cases were in the age 35-39yo age group.
- 83% of cases were in the MSM exposure category.

2018 Cuyahoga County Epidemiology

Incidence/New Cases

- Males made up 89% of new cases in the county, specifically African-American males made up 56% of new cases
- Highest number of new cases in county was in the 25-29yrs age group.
- 48% of new cases were below the age of 30.
- 60% of new cases were in the MSM exposure category

Recommended Data-Driven Priority Populations Based on 2018 Epidemiology

Cuyahoga County

- African-American
- Men who have sex with men (MSM)
- Under Age 30

Eastern and Western Counties

- White Males
- 25-29yo Age Group
- MSM

HIV Hot Spots in Cuyahoga County

- Incidence Map
- Prevalence Map

Priority Zip Codes for Testing in Cuyahoga County

- 44102, 44105, 44128 – incidence
- 44102, 44103, 44108, 44113, 44114, 44115, 44117 - prevalence

Testing Ideas/Recommendations for Cuyahoga County

- Working with LGBT Center/LGBT Alliances to offer testing and PrEP options
- Working with Community Development Centers and non-profits in high incidence areas
- Continue HIV testing with STI screening
- Look into ways to test not just partners but social networks of newly diagnosed

Testing Ideas/Recommendations for Outlying Counties

- Working with LGBT Centers/Alliances
- Working with the jails/prisons
- Working in the Hispanic population
- Increase awareness of PrEP in these areas
- Think about how opiate use can impact HIV testing strategies

CTR Testing

ODH Prevention-funded CTR and Priority-Based Testing must reflect epidemiology and hot spots in Region 3

Prevention activities (i.e. campaigns, events, PrEP, condoms, etc.) should reflect priority populations and hot spots.

HIV Community Engagement Coordinator at ODH
Charles Abernathy
Charles.Abernathy@odh.ohio.gov

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Prevention Region 3 Epidemiology Overview

Melissa Kolenz

mkolenz@ccbh.net

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CTR to Care

- What is EIS?
- Referral Process
- Region 3 Care Resources

SERVICE CATEGORY DEFINITION

Early Intervention Services (EIS):

Counseling individuals with respect to HIV/AIDS; testing (not funded through Ryan White Part A); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

RWHAP Part A EIS services must include the following four components:

1) Targeted HIV testing (not funded through Ryan White Part A) to help the unaware learn their HIV status and receive referrals to HIV care and treatment services if found to be HIV infected. Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
2) Referral services to improve HIV care and treatment services at key points of entry
3) Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
4) Outreach services and Health Education / Risk Reduction related to HIV diagnosis

Services should be targeted to the following populations:

- Newly diagnosed
- Receiving other HIV/AIDS services but not in primary care
- Formerly in care – dropped out
- Never in care
- Unaware of HIV status

EIS programs must have signed linkage agreements to work with key points of entry.
Given that EIS leads EIIHA (Early Identification of Individuals with HIV/AIDS) efforts, EIS programs must coordinate with prevention services, counseling and testing centers, as well as other RW Part A providers.

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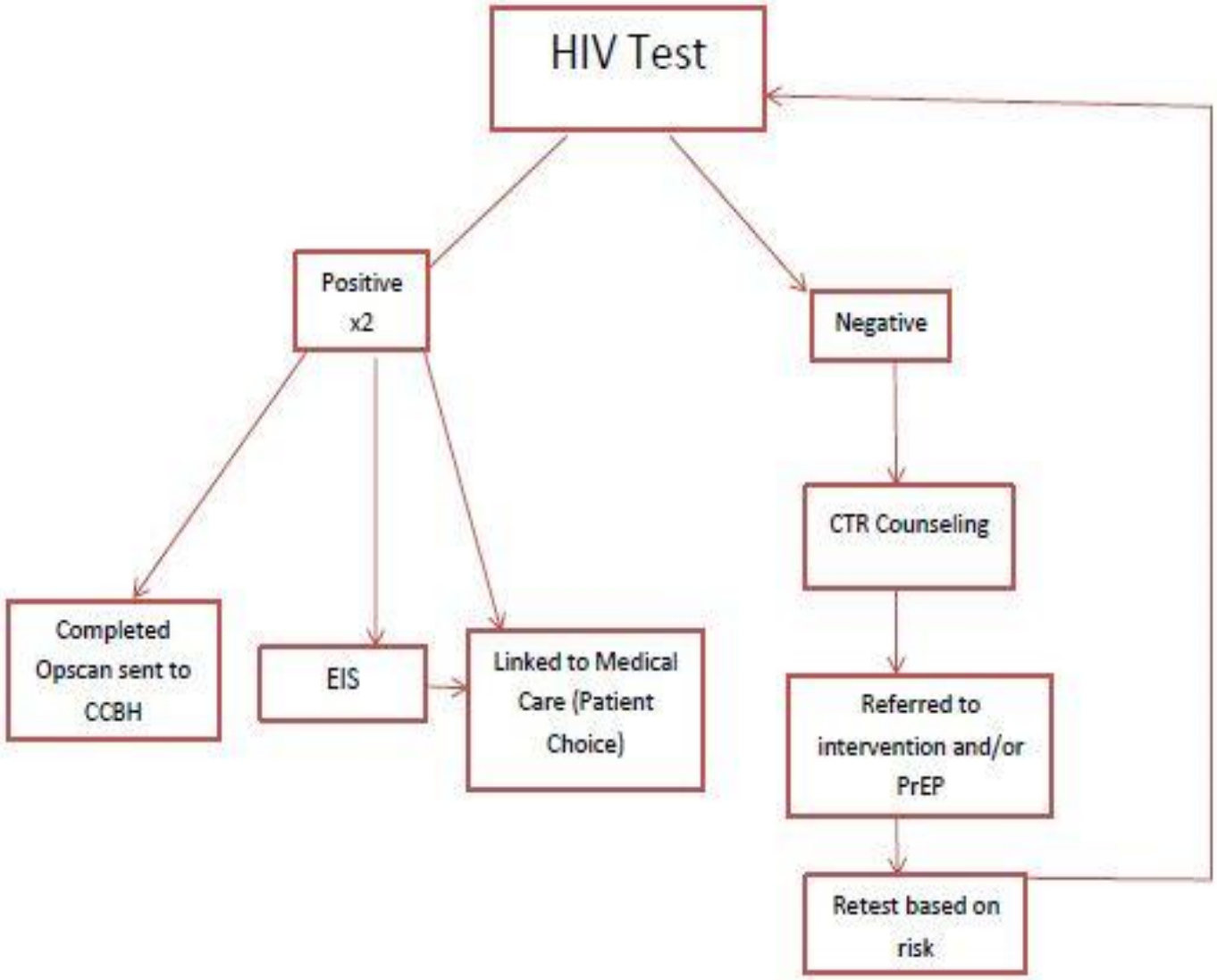
HIV Test
Positive x2
Negative
Completed Opscan sent to CCBH
EIS
Linked to Medical Care (Patient Choice)
CTR Counseling
Referred to intervention and/or PrEP
Retest based on risk

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EIS Contacts by Agency

Circle Health Services:

- Primary: Brenda Glass: 216-707-3452/office and 216-644-5847 Mobile brenda.glass@thecentersohio.org
- Secondary: Adriana Whelan: 216-707-3425/office 216-906-0368/Mobile Adriana.whelan@thecentersohio.org

Cleveland Clinic Foundation:

- Primary: Mary Beth Gramuglia: 216-444-6843; GRAMUGM@ccf.org
- Secondary: Kristen Englund, MD: Office phone 216-444-9159; ewolske@ccf.org (admin assist)

Family Planning Services of Lorain County (Lorain & Medina):

Primary: Jennifer Gosnell: 440-322-7526 ext. 119; Cell: 928-200-5265; jgosnell@fpslc.org

Secondary contact: Pat Berger 440-322-7526 ext. 109 pberger@fpslc.org

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EIS Contacts by Agency

Metro Health Medical Center:

Jennifer McMillan Smith: 216-778-4051(desk) 440-503-5297 (cell) jmsmith@metrohealth.org

Jason McMinn: 216-778-3106 jmcminn@metrohealth.org **Both Jen and Jason can be paged at 216-778-5551*

Signature Health (Lake, Ashtabula, Geauga):

Primary: Brittany Freese- 440-867-5069 bfreese@shinc.org

Secondary: Kristin Ziegler Alban- 440-785-5736; kziegleralban@shinc.org

University Hospitals:

Primary: Carolyn Williams , 216-844-2649 Carolyn.Williams@UHhospitals.org

Secondary: Liz Habat, 216-844 -5316, Elizabeth.Habat@UHhospitals.org

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Medical Provider Contacts (**NOT EIS)

AIDS Healthcare Foundation:

- Brittany Pope: Office: 216.357.3131 x2960; Cell: 216.410.3289; Brittany.Pope@aidshealth.org

Mercy Health:

- Summer Barnett: Office: 440-233-0138, opt 2; Cell: 440-522-3306; SBarnett@mercy.com

Neighborhood Family Practice:

- New provider with multiple locations

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Prevention Region 3 Program and Fiscal Overview

Erik Hamilton – Fiscal

ehamilton@ccbh.net

Melissa Rodrigo – Program

mrodrigo@ccbh.net

CCBH

Program Requirements & Updates

- Ending the HIV Epidemic
- FY2020 Funding Status
- Fiscal Review
- Contracts
- Communication
- Reporting
- Planning Body
- Expectations

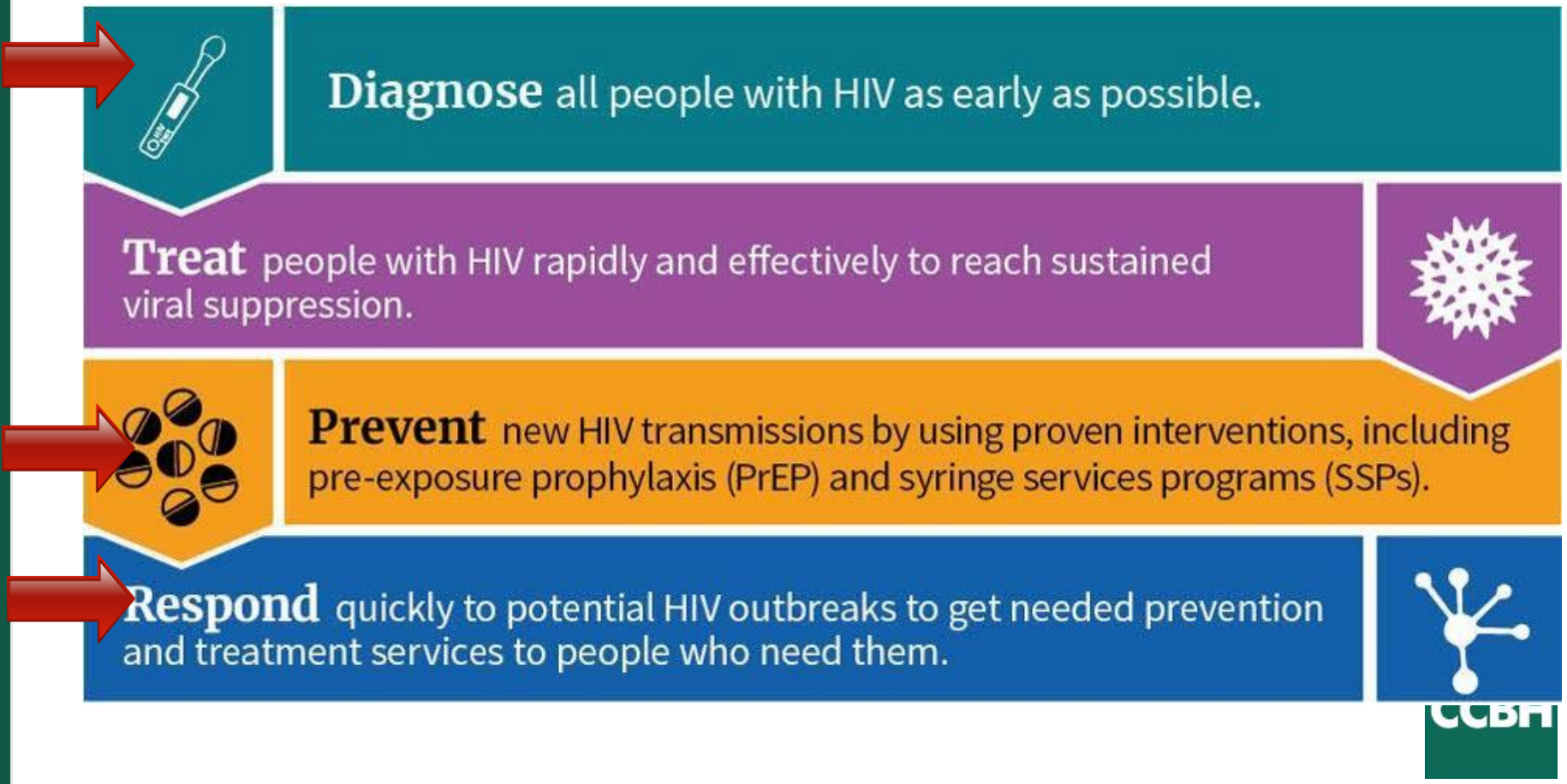
New at CCBH

- As of February 1, 2020 CCBH became the Region 3 STI/HIV Prevention grantee
- Working with ODH to ensure state processes are followed
- CCBH released an RFP for CTR sites (7)
- Staffing the program throughout the 1st 5 months identifying training needs
- Combined EIIHA meetings will continue

Ending the HIV Epidemic Timeline

- Supported ODH RFP to secure a contractor (July 2019)
- Submitted an RFP to HRSA October 2019 for EtHE Care
- Awarded $750,000 (March 1st)
- Contractor Community Solutions was selected as EtHE contactor (March 9th)
- Prevention RFP being submitted in a couple weeks (March 25th) potential June 1st
- Planning April through August 2020

Ryan White HIV/AIDS Program Parts A and B". Cuyahoga County is one of the 48 counties eligible to apply for the funding. The goal is to reduce new HIV infections by 75% within five years, and 90% within 10 years.



FY2020 Funding

- 7 sites funded for CTR within Region 3
- Lorain – Lorain HD
- Medina – Medina HD
- Lake, Geauga, Ashtabula – Signature Heath
- Cuyahoga County – ATF, Care Alliance, Circle Health, Cleveland Treatment Center, and Signature Health

Fiscal Requirements

- Report Budget concerns over and under expenditures
- Invoice late submittal must obtain approval from grantee
- Contract changes = budget changes within 2 weeks
- Cannot pay FTE percentages higher than on the approved budget on invoices submitted
- No FTE should be more than 100% allocated

Fiscal Review

A quick guide to Fiscal Reporting for CCBH

PROGRAM CONTACTS:

Supervisor - program (will change)
mrodrigo@ccbh.net
216-201-2001 x 1507

Business Manager - budget (will change)
ehamilton@ccbh.net
216-201-2001 x 1501

Fiscal Contact - Invoices
hivprevention@ccbh.net
216-201-2001 x1519

Fiscal Report Due Dates

- All Sub-Recipient invoices due on a monthly basis
- Due dates are established in your contract

- CCBH reports quarterly to ODH
- CCBH will stay Subs Invoices Monthly

Expenditure Reports

- Expenditure reports must include the following:
  - Invoice requesting payment on your Agency Letterhead
  - Signed Sub-Recipient Expense Report Form
    - An Excel workbook will be provided to you with payroll and expense reporting
  - Full updated Excel file
  - Backup documentation for all expenses and payroll

  - All requested expenses must be consistent with your most recent approved budget and narrative.

Sample Invoice:

YOUR AGENCY

INVOICE

MUST BE ON AGENCY LETTERHEAD

Your Address
City, State Zip
Phone XXX.XXX.XXXX Fax XXX.XXX.XXXX

DATE: July 2, 2007
INVOICE # 100
FOR:

Bill To:
Attn:
Cuyahoga Cty Bd of Health
5550 Venture Drive
Parma, OH 44130
216.201.2001

DESCRIPTION	AMOUNT
TANF - Comprehensive Sexual Education Program	$ 8,880.74
For services rendered: June 1, 2007 through June 30, 2007	
For classroom curriculum, summits and parent training forum, throughout the Cleveland Communities.	
TOTAL	$ 8,880.74

Make all checks payable to **YOUR AGENCY**
If you have any questions concerning this invoice, contact:

CCBH

Expense Report Form Template

Due Date:		**Project:**	Teen Pregnancy Prevention
Agency:	Center for Community Solutions	**Grantor:**	Cuyahoga County Board of Health
			5550 Venture Drive
Reporting Period:			Parma, OH 44130
Start:			216-201-2001
End:			
		Grantee:	Center for Community Solutions
[ ] Check Box if Final Report for this grant.			0
			0
Payment Request:	$ -	Phone:	0

BUDGET					
Categories:	**Approved Budget**	**Current Request**	**Prior YTD Request**	**Total YTD Request**	**Available Balance**
Salary (Program Staff)	$ -	$ -	$ -	$ -	$ -
Fringe	$ -	$ -	$ -	$ -	$ -
Consultants	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -
Supplies	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -
SUBTOTAL 1	$ -	$ -	$ -	$ -	$ -

Indirect Cost					
Categories:	**Approved Budget**	**Current Request**	**Prior YTD Request**	**Total YTD Request**	**Available Balance**
Indirect Cost	$ -	$ -	$ -	$ -	$ -
SUBTOTAL 2	$ -	$ -	$ -	$ -	$ -
TOTAL AWARD	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

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Expense Categories

- **Salaries & Fringe**
  - CCBH payroll form and back-up documentation to be submitted for agency employees working on project (defined in Budget Narrative)
  - Individuals not included within the Budget Narrative, cannot be supported
  - In order to add or remove staff from budget, requires a budget revision (see budget revision)
- **Consultants/Contracts**
  - Can cover individuals that do not meet the definition of an employee.
  - Need to be outlined in the Budget Narrative
- **Travel**
  - Travel must be in the approved budget and in the contiguous
  - Reimbursement rate is $0.52
  - Reference GSA Pricing and website and info if necessary http://www.gsa.gov/portal/content/104877>>

Expense Categories cont.

- **Supplies**
  - Supplies that will be required to meet the goals of the project must be listed.
  - Office supplies separated from medical/educational purchases
  - Estimated or actual costs.

- **Equipment**
  - An item of tangible property having a useful life of one year or more, costing $1,000 or more for a single item, and is purchased in whole or in part with program funds.

- **Other Costs**
  - Bus tickets, gas cards, postage and printing

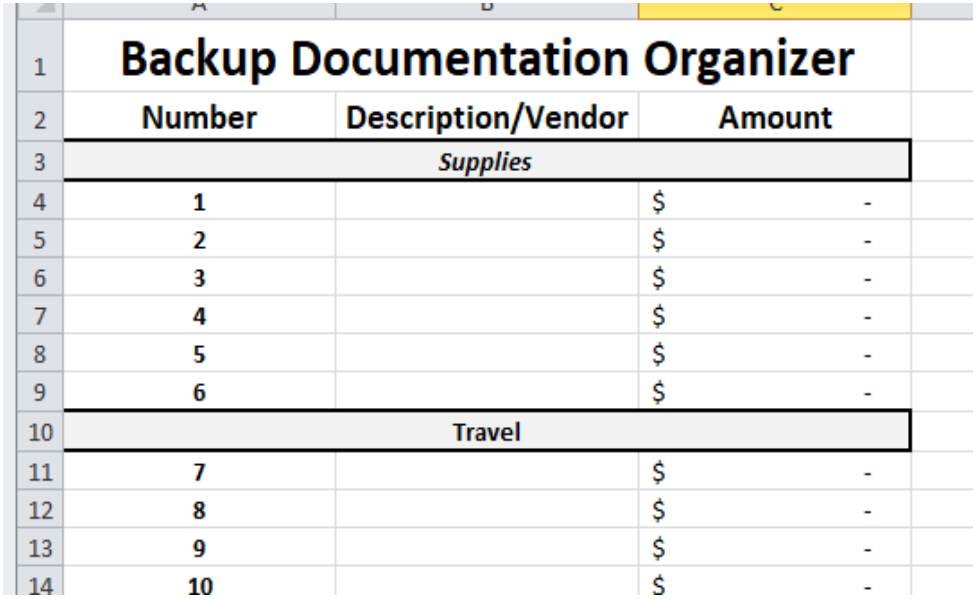
- **Administrative/Indirect Costs**
  - Negotiated Indirect Cost Rate Agreement
  - Cost Allocation
  - 10% de minimis

Backup Documentation

- **Backup Documentation Organization (for large expense reports)**
  - Use a Backup Organizer spreadsheet
  - Organized by budget category
  - Each expense listed and numbered on the receipt and organizer

- Examples include but are not limited to:
  - Invoices, Itemized Receipts, Detailed mileage reports, Cancelled checks, etc.
  - Every expense needs to have backup documentation

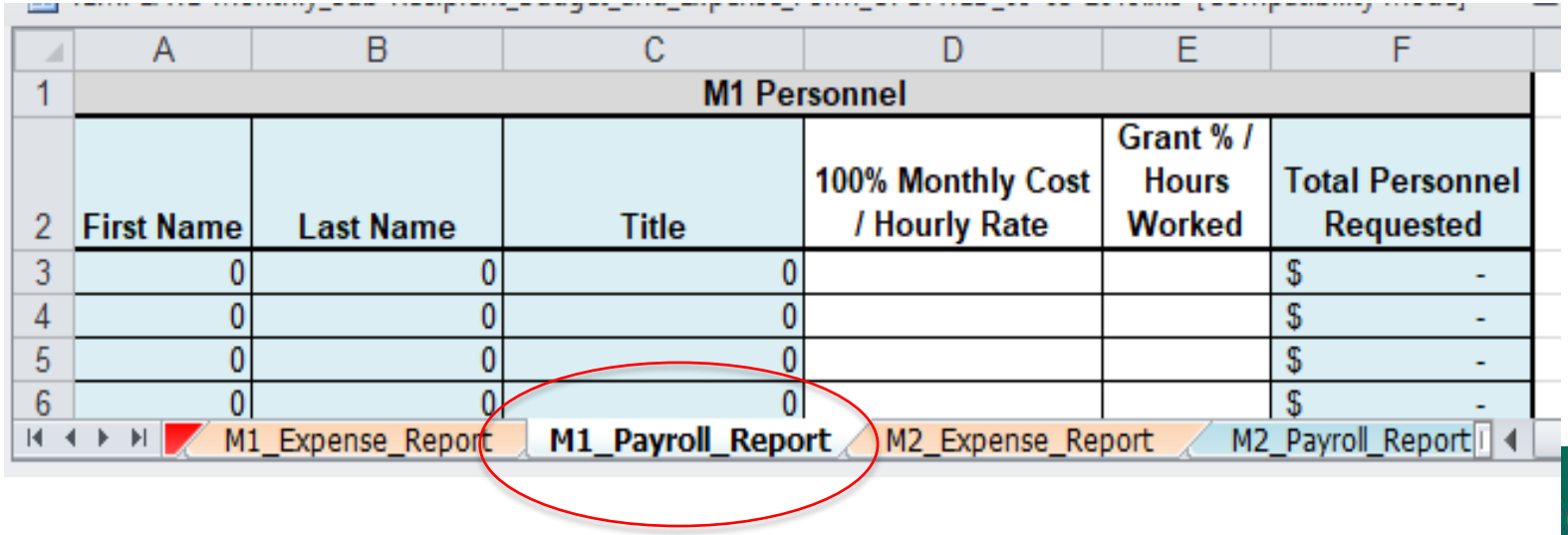
****All backup documentation in order of organizer, numbered, and charges circled and/or highlighted****



	A	B	C
1	Backup Documentation Organizer		
2	Number	Description/Vendor	Amount
3	*Supplies*		
4	1		$ -
5	2		$ -
6	3		$ -
7	4		$ -
8	5		$ -
9	6		$ -
10	Travel		
11	7		$ -
12	8		$ -
13	9		$ -
14	10		$ -

Backup Documentation cont.

- **Payroll Documentation**
  - Payroll ledgers
  - Time Sheets
  - Current and/or Adjusted Distributions
- List all payroll charges on Payroll Report Tab (these will link directly to the Salary line item on your Expense Report tab.)



	A	B	C	D	E	F
1	M1 Personnel					
2	First Name	Last Name	Title	100% Monthly Cost / Hourly Rate	Grant % / Hours Worked	Total Personnel Requested
3	0	0	0			$ -
4	0	0	0			$ -
5	0	0	0			$ -
6	0	0	0			$ -

M1_Expense_Report | M1_Payroll_Report | M2_Expense_Report | M2_Payroll_Report

Budget Revision

- EXAMPLE TEXT: A budget revision is required for any changes in Salary and Fringe OR Movement of funds between budget categories
  - This may include:
    - Adding/removing staff
    - Salary changes
    - Fringe amount changes

- The following Budget Revision forms must be submitted:
  - **Budget Narrative** reflecting written rationale and explanation for changes.
  - **Budget Revision Form** reflecting changes between budget categories amounts.

- A final “spend-down” budget revision must be submitted by September 1st 2020

- This final revision should ensure that all funds will be expended by the end of the grant period.

CCBH

Budget Revision Form Example

(Exhibit B)

SUB-RECIPIENT BUDGET REVISION FORM

Project Name: Teen Pregnancy Prevention **Contract Period:**

Agency Name:

Fiscal Contact Person: 0

Your Increase/Decrease request here.

BASE BUDGET									
Categories:	**Original Approved Budget**	**Revision Request #1**	**Approved Revision #1**	**Revision Request #2**	**Approved Revision #2**	**Revision Request #3**	**Approved Revision #3**	**New Requested Budget**	**Current Approved Budget**
Salaries & Wages	$	$ -	$ -	$ -	$ -	$ -	$ -	$	$
Fringe Benefits	$	$ -	$ -	$ -	$ -	$ -	$ -	$	$
Supplies	$	$ -	$ -	$ -	$ -	$ -	$ -	$	$
Travel	$	$ -	$ -	$ -	$ -	$ -	$ -	$	$
SUBTOTAL 1	$	$ -	$ -	$ -	$ -	$ -	$ -	$	$

DELIVERABLE BUDGET									
Categories:	**Original Approved Budget**	**Revision Request #1**	**Approved Revision #1**	**Revision Request #2**	**Approved Revision #2**	**Revision Request #3**	**Approved Revision #3**	**New Requested Budget**	**Current Approved Budget**
Indirect Cost	$	$ -	$ -	$ -	$ -	$ -	$ -	$	$
SUBTOTAL 2	$	$ -	$ -	$ -	$ -	$ -	$ -	$	$
TOTAL AWARD	$	$ -	$ -	$ -	$ -	$ -	$ -	$	$

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Unallowable Costs

- Tips in excess of 20% of the total bill.
- Receipts not itemized will not be reimbursed.
- Costs in excess of daily per diem (based on destination) for meals, lodging etc. and excess in Federal Mileage Reimbursement Rate (See GSA pricing- http://www.gsa.gov/portal/content/104877)
- Bar/Alcohol expenses
- Equipment costs ($1,000+) that did not seek pre-approval
- Personnel expenses for new staff without completing the proper Budget Revision process.
- in the contract

Project Funding Restrictions

Please review the list included in the RFP and **Exhibit B in the contract**

Some items are:

- To advance political or religious points of view or for fund raising or lobbying;
- To disseminate factually incorrect or deceitful information;
- Consulting fees for salaried program personnel to perform activities related to grant objectives;
- Bad debts of any kind;
- Contributions to a contingency fund;
- Entertainment;
- Fines and penalties;
- Membership fees -- unless related to the program and approved by ODH;

Quarterly Spend Down Plans

- If Sub-Recipient has not spent half of the allotted funding by mid-grant year, a spend down plan will be created by the agency to show how they intend to spend down funds. This also may be a time to consider a budget reduction.

- The plan should clearly reflect the remainder of the funds that need to be expended.

- Mid-Way through grant period, CCBH will schedule a spend down meeting at which time this plan will be due.

Submitting Expenditure Reports

- Double Check:
  - All back up documentation with itemized receipts is provided
  - Everything adds up
  - Invoice has correct amount
  - Forms are signed in ***BLUE INK***!

- Can be e-mailed, mailed or dropped off

Contracts

- Program and Fiscal staff should review
- Insurance certificate holder Budgets should match Exhibit B exactly name CCBH
- Review for allowable costs
- Invoices due by 4:00pm on contract date

Communication

- Designate a Primary Contact for your agency – information from CCBH will be provided to this person and expectation of getting requests from the designee
- This team member is responsible for all requirements of the program being accomplished
- Expectation Communicate Internally
- Best interest, avoid misunderstandings and improve efficiency
- Be responsive to requests timely

Requirements

- Invoices submitted by 4:00pm on contract date
- Completion of a testing plan should reflect back to RFP submission along with target zip codes
- Participate in monthly TA calls or in person meetings with CCBH
- Attend Regional Prevention Planning meetings as structure develops
- Attend required program or fiscal meetings established by CCBH
- Attend required trainings conducted by CCBH
- Site Visits compliance

REPORTING

Due Date	Report	Submitted Via
60 days after NOA	New, non-ODH, Program brochures and educational materials used in program will be submitted for review to CCBH program supervisor	Email or mail
Seventh day of the following month	All CTR data collection forms (“opscans”) submitted to ODH at hivprevention@odh.ohio.gov or Fax Number: **614-728-0876**	Secure fax/email
Established per contract	Monthly expenditure report and supporting documentation submitted to CCBH program supervisor	Email
Fifth day of following month	Monthly testing data and test kit tracking reports submitted to Prevention Supervisor	Email

Expectations

Required activities:

- Staffing vacancies report within 3 days of notification
- New staff require job descriptions, credentials and resumes sent to Grantee –
- Compliance with deliverables in the RFP
- Ensure staff are participating in EHE plan
- New staff training before seeing clients
- EIIHA/Prevention meetings
- Training and Technical Assistance Budget Meetings
- Staff attend required meeting – attendance tracked

REGION 3 PREVENTION

CUYAHOGA COUNTY

BOARD OF HEALTH

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HIV Prevention 1802
Testing Paperwork

Ohio Department of Health

Wendy Adams
Public Health Consultant
Ohio Department of Health

Welcome

This webinar is presented by the Ohio Department of Health (ODH) HIV Prevention Program.

It will review the paperwork process for the HIV Prevention Program

18-1802 grant.

Ohio Department of Health

Record Keeping

All documentation created during a testing session shall be kept in the client record at the testing agency.

Submit original forms for the Opscan and Risk Assessment only to ODH and keep copies for agency records.

Ohio Department of Health

How to Send Forms

The HIV Prevention Monitoring & Evaluation (M&E) Team would prefer to receive forms via FAX.

Fax # 614-728-0876

Use ODH-created fax cover sheet when sending forms.

Ohio Department of Health

HIV-Positive Test Forms

All forms for a positive test are required to be faxed within 24 hours.

Use the appropriate fax cover sheet.

FAX #614-728-0876

Ohio Department of Health

All Opscan forms for persons testing positive for HIV must be faxed or sent via encrypted e-mail to the ODH M&E secure fax line at 614-728-0876, or to

hivprevention@odh.ohio.gov

Ohio Department of Health

Other Ways to Send Forms

Email - HIVPrevention@odh.ohio.gov

Mail - HIV Monitoring & Evaluation
Bureau of Infectious Diseases
ATT: Data Entry
Ohio Department of Health
35 East Chestnut
Columbus, Ohio 43215

Ohio Department of Health

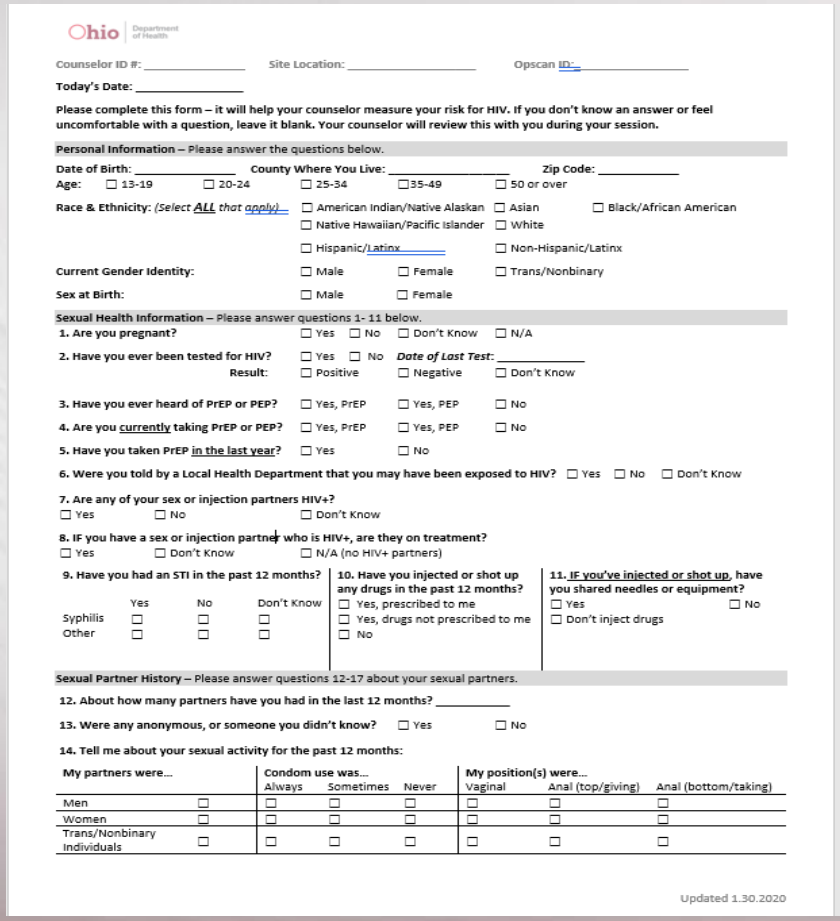
Required Forms for a Testing Session

1. Risk Assessment
2. Risk Assessment Score Sheet
3. Risk Reduction Plan
4. HIV Verification Form
5. Opscan form (Data Collection Form)

Ohio Department of Health

Anyone requesting an HIV Test should be screened for risk, per the Ohio HIV Testing Protocol.

Risk Assessment



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 currently taking PrEP or PEP? ☐ Yes, PrEP ☐ Yes, PEP ☐ No
5. Have you taken PrEP in the last year? ☐ 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

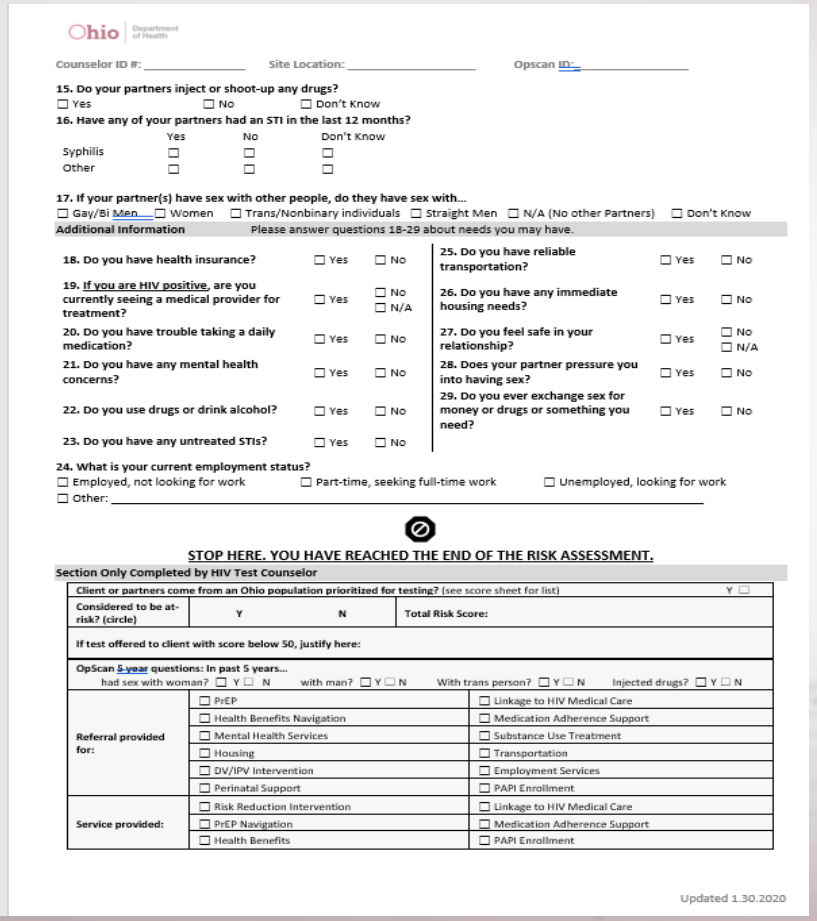
11. IF you've injected or shot up, have you shared needles or equipment? ☐ Yes ☐ No ☐ Don't inject drugs

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… Always	Sometimes	Never	My position(s) were… Vaginal	Anal (top/giving)	Anal (bottom/taking)
Men	☐	☐	☐	☐	☐	☐	☐
Women	☐	☐	☐	☐	☐	☐	☐
Trans/Nonbinary individuals	☐	☐	☐	☐	☐	☐	☐

Updated 1.30.2020



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

Updated 1.30.2020

Ohio Department of Health

Risk Assessment cont.

Ohio Department of Health

Client should be given the opportunity to fill out the Risk Assessment before talking with the test counselor.

HIV Test is Given & Client Tests Negative

The Risk Assessment and Opscan Form from the testing session should be sent together.

(please do not staple or paper clip together)

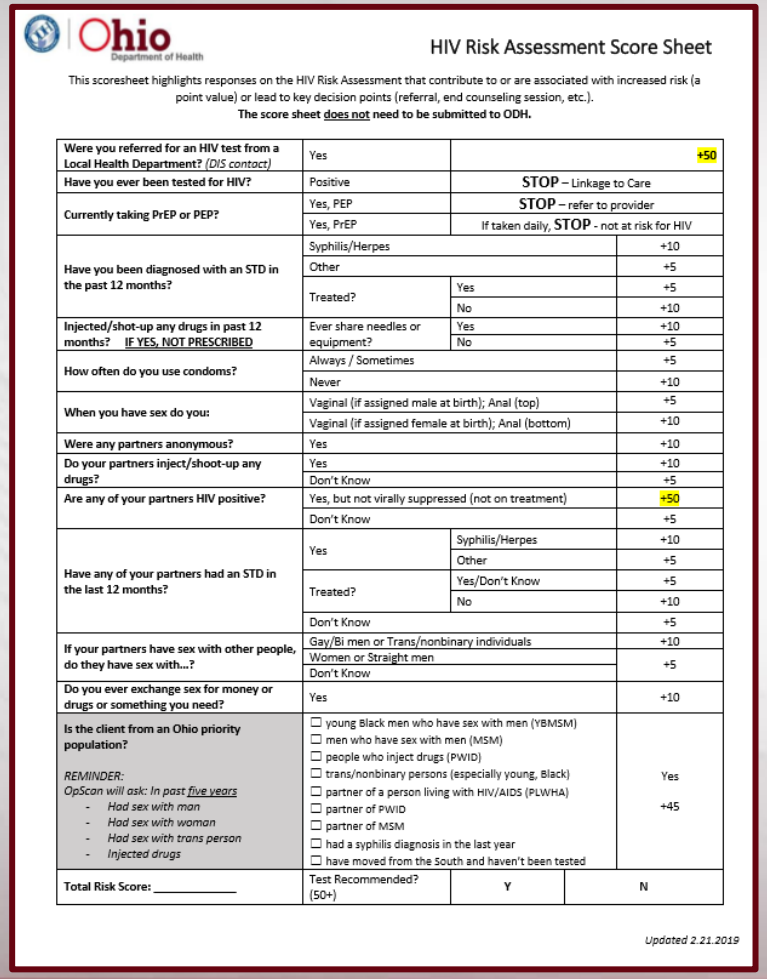
Ohio Department of Health

Client Does Not Receive an HIV Test

The Risk Assessment should be kept in the client record but not sent to ODH.

These forms may be reviewed during a site audit.

Risk Assessment Score Sheet



Ohio Department of Health

HIV Risk Assessment Score Sheet

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 score sheet does not need to be submitted to ODH.

Were you referred for an HIV test from a Local Health Department? *(DIS contact)*	Yes		+50
Have you ever been tested for HIV?	Positive	**STOP** – Linkage to Care	
Currently taking PrEP or PEP?	Yes, PEP	**STOP** – refer to provider	
	Yes, PrEP	If taken daily, **STOP** - not at risk for HIV	
Have you been diagnosed with an STD in the past 12 months?	Syphilis/Herpes		+10
	Other		+5
	Treated?	Yes	+5
		No	+10
Injected/shot-up any drugs in past 12 months? IF YES, NOT PRESCRIBED	Ever share needles or equipment?	Yes	+10
		No	+5
How often do you use condoms?	Always / Sometimes		+5
	Never		+10
When you have sex do you:	Vaginal (if assigned male at birth); Anal (top)		+5
	Vaginal (if assigned female at birth); Anal (bottom)		+10
Were any partners anonymous?	Yes		+10
Do your partners inject/shoot-up any drugs?	Yes		+10
	Don't Know		+5
Are any of your partners HIV positive?	Yes, but not virally suppressed (not on treatment)		+50
	Don't Know		+5
Have any of your partners had an STD in the last 12 months?	Yes	Syphilis/Herpes	+10
		Other	+5
	Treated?	Yes/Don't Know	+5
		No	+10
	Don't Know		+5
If your partners 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		
Do you ever exchange sex for money or drugs or something you need?	Yes		+10
Is the client from an Ohio priority population? *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		Yes +45
Total Risk Score: _____	Test Recommended? (50+)	Y	N

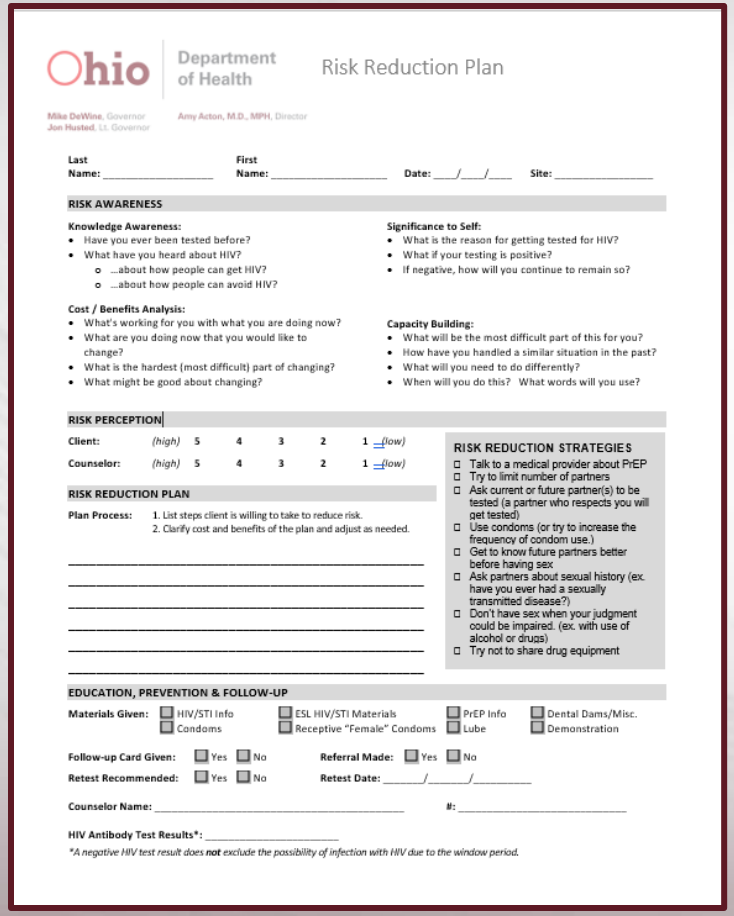
Updated 2.21.2019

The Risk Assessment SCORE SHEET Is for the tester to use to score the assessment.

It is not sent to ODH.

Ohio Department of Health

Risk Reduction Plan



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*: _____

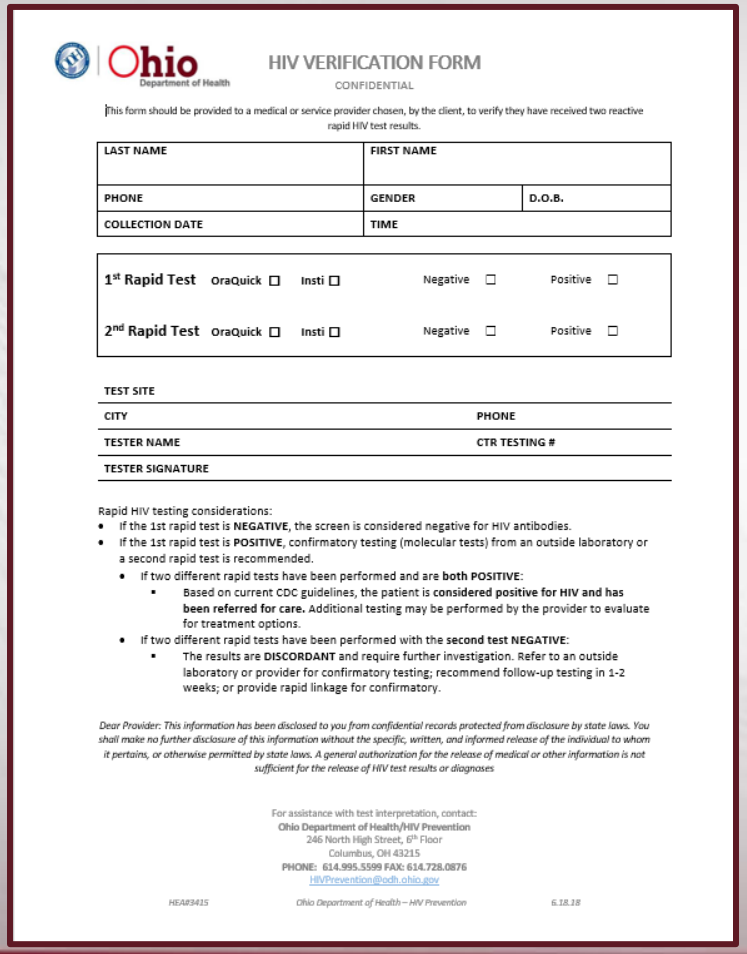
A negative HIV test result does **not exclude the possibility of infection with HIV due to the window period.*

Risk Reduction plan should be developed by the tester and the client.

This Form is NOT sent to ODH.

Ohio Department of Health

HIV Verification Form



Ohio Department of Health

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 *Ohio Department of Health – HIV Prevention* *6.18.18*

Once HIV is verified, client receives a Verification Form.

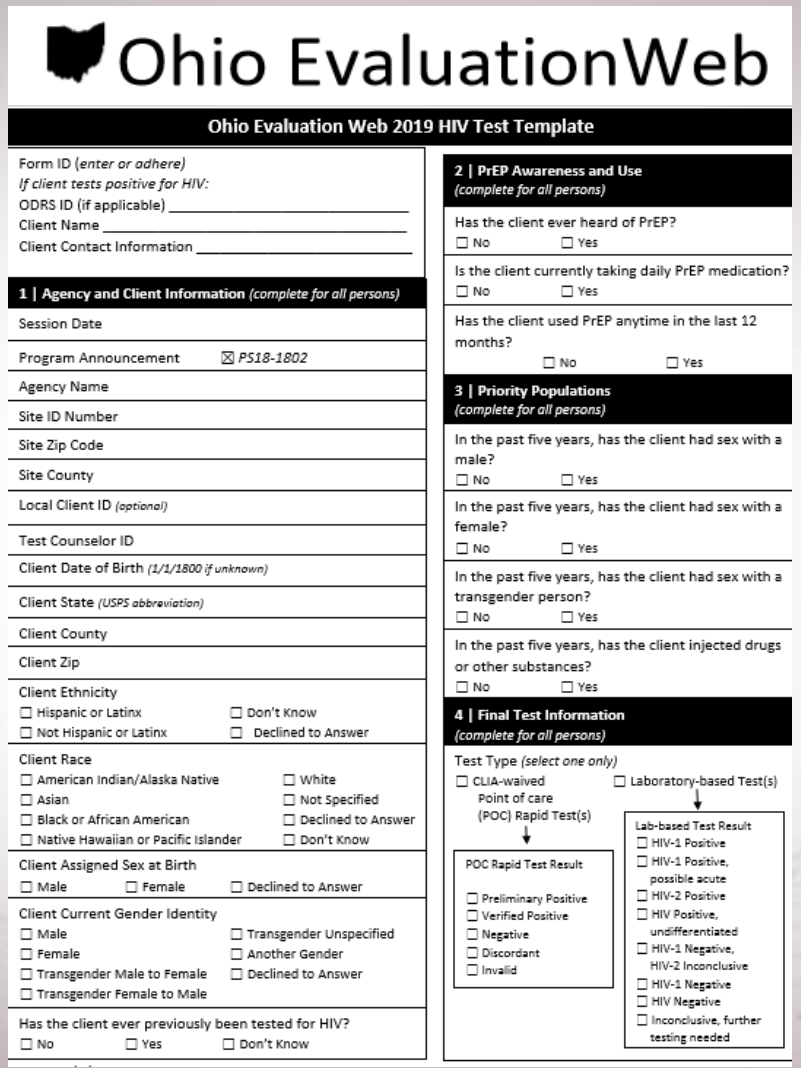
Keep a copy in the client records.

Form is NOT sent to ODH.

Ohio Department of Health

Data Collection

- The Evaluation Web Data Collection form known as an Opscan Form should be sent with the Risk Assessment.
- Forms from the testing session should be sent together.



Ohio EvaluationWeb

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

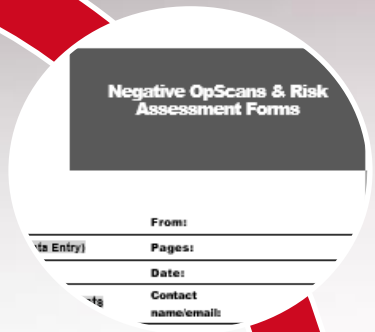
Ohio Department of Health

Opscan Form

- The HIV Prevention Monitoring and Evaluation (M&E) team has a step-by-step webinar for filling out the Opscan form that can be requested.
- Contact your regional coordinator if you would like access to that webinar.
- Please refer to the Opscan Test Form Manual for definitions of variables and values on the Opscan form.

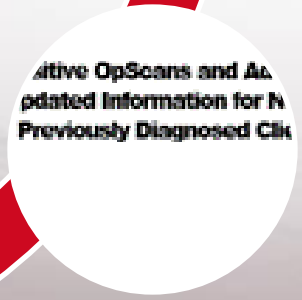
When sending forms by FAX-

Please use the fax cover sheets supplied by ODH



1.1) Negative Opscan and Risk Assessment

2) Opscan Corrections



3) Information for New or Previously Diagnosed Clients

Ohio Department of Health

Data Collection Quality

The Opscan form should be filled out completely and accurately.

If any variable is left blank or filled out incorrectly the CDC system will not continue with the form, making the data impossible to enter.

Every testing site should have a quality assurance person who reviews forms for complete information before sending this form to ODH.

Ohio Department of Health

Data Quality Assurance

Opscan forms submitted to ODH with QA issues will be returned to the Regional Coordinator. The Regional Coordinator is responsible for obtaining corrections and must resubmit forms to ODH M&E within 5 business days.

Opscan Quality Assurance

Such issues are:

- Opscan with no Risk Assessment and vice versa.
- Fields left blank
- Opscan ID Number (i.e. the same Opscan ID number used for more than one client)
- Incorrect Data (i.e. testing date recorded as date of birth).
- Illegible writing

Ohio Department of Health

Review

Forms to be sent to ODH

Risk Assessment

- when client receives a test

Data Collection Form (Opscan)

- Evaluation Web

Forms to keep in client record

- Risk Assessment
  - Copy if client was tested and send original to ODH
  - Original copy if client was not tested
- Risk Reduction Plan client can receive a copy.
- Data Collection Form (Opscan)
- HIV Verification Form if needed

THANK YOU

For more information on filling the forms out or on test counseling, contact the HIV Prevention Coordinator in your region.

Ohio Department of Health

Contact Information

Wendy Adams
Public Health Consultant,
Ohio Department of Health

Wendy.Adams@odh.ohio.gov

Ohio Department of Health