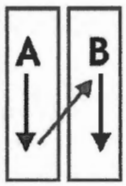
Georgia Department of Public Health 2020 HIV Test Template Guidance

This HIV testing data collection template is provided to assist CDC-funded recipients who are collecting National HIV Prevention Program Monitoring and Evaluation (NHME) HIV testing data. This template is not mandated for use in the field, and it may be customized to best fit your agency's needs. Contact the NHME Service Center (1-855-374-7310 or NHMEservice@cdc.gov) to receive a Microsoft Publisher version of this template that can be edited.

The fields on this form reflect data requirements as described in the most current NHME Data Variable Set. This template is designed for direct data entry into EvaluationWeb; however, it is not intended for use as an Optical Character Recognition (OCR) document.



Flow of Data Entry

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), **fill-in ovals** (used to select only one response), and **check boxes** (used to select as many responses that apply).

Six data fields are mandatory for a valid testing event:

- Form ID (write in or adhere a sticker with the Form ID bar code 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)

For agencies entering data directly into EvaluationWeb, it may not be necessary to complete the following fields (they will be pre-loaded by the system administrator): **Agency Name or Agency ID, Site Type, Site County**, and **Site ZIP code.**

Depending on your jurisdiction, you will either write in the name **or** the ID for the Agency and Site. In these instances, you will want to follow the convention of your jurisdiction. Do not write both the name and the ID for these fields.

For assistance with data reporting and submissions: contact the Georgia DPH HIV Data Team at HIV.Data@dph.ga.gov or 404-657-3100.

To add new sites: contact the Georgia DPH HIV Data Team at HIV.Data@dph.ga.gov or 404-657-3100.

For questions about NHME data elements: contact the NHME Service Center at NHMEservice@cdc.gov or 1-855-374-7310.

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 Statement 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 Health Service Act, 42 USC 242b and 242k. Your cooperation is necessary for 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 NHME 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 Confidentially 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)).

Georgia Department of Public Health 2020 HIV Test Template Definitions

Value Definitions for New or Previous Diagnosis

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 client selfreport (if the client was asked) or review of other data sources (if other data 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 not checked and no other data sources were reviewed and there is no information from the client about previous HIV test results.

Value Definitions for POC Rapid Test Results

Preliminary positive - One or more of the same point-of-care rapid tests were reactive and none are non-reactive and no supplemental testing was done at your agency.

Positive - Two or more different (orthogonal) point-of-care rapid tests are reactive and none are non-reactive and no laboratory-based supplemental testing was done.

Negative - One or more point-of-care rapid tests are non- reactive and none are reactive and no supplemental testing was done.

Discordant - One or more point-of-care rapid tests are reactive and one or more are non-reactive and no laboratory-based supplemental testing was done.

Invalid - A CLIA-waived POC rapid test result cannot be confirmed due to conditions related to errors in the testing technology, specimen collection, or transport.

Site Types: Clinical

- F01.01 - Inpatient hospital
- F02.12 - TB clinic
- F02.19 - Substance abuse treatment facility
- F02.51 - Community health center
- F03 - Emergency department
- F08 - Primary care clinic (other than CHC)
- F09 - Pharmacy or other retail-based clinic
- F10 - STD clinic
- F11 - Dental clinic
- F12 - Correctional facility clinic
- F13 - Other

Site Types: Mobile

- F40 - Mobile Unit

Site Types: Non-clinical

- F04.05 - HIV testing site
- F06.02 - Community setting - School/educational facility
- F06.03 - Community setting - Church/mosque/synagogue/temple
- F06.04 - Community Setting - Shelter/transitional housing
- F06.05 - Community setting - Commercial facility
- F06.07 - Community setting - Bar/club/adult entertainment
- F06.08 - Community setting - Public area
- F06.12 - Community setting - Individual residence
- F06.88 - Community setting - Other
- F07 - Correctional facility - Non-healthcare
- F14 - Health department - Field visit
- F15 - Community Setting - Syringe exchange program
- F88 - Other

Form Approved: OMB No. 0920-0696, Exp. 02/28/2019. Public reporting burden of this collection of information is estimated to average 8 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-79, Atlanta, Georgia, 30333, ATTN: PRA 0920-0696. CDC 50.135b(E),10/2007

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Georgia Department of Public Health 2020 HIV Test Template

Form ID *(enter or adhere)* A30000890000

1 | Agency and Client Information

Session Date 01/01/2023

Program Announcement
- ○ PS15-1506 PrIDE
- ○ PS15-1509 THRIVE
- ○ PS17-1711
- ○ PS18-1802
- ○ PS18-1802 Demonstration Projects
- ○ PS19-1901 CDC STD
- ○ Other CDC funded
- ● Other non-CDC funded

Specify Other *(optional)* PS24-0047

Agency Name or ID Agency Name

Site Name or ID

Site Type *(codes on page 2)* F02.19

Site ZIP Code Agency Zip Code

Site County *(3-digit FIPS code)*

Local Client ID *(optional)* either crack and peel or internal ID

Year of Birth *(1800 if unknown)* 01/01/1999

Client State *(USPS abbreviation)* GA

Client County *(3-digit FIPS code)*

Client ZIP Code

Client Ethnicity
- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Don't know
- ○ Declined to Answer

Client Race *(select all that apply)*
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Not Specified
- ☐ Declined to Answer
- ☐ Don't Know

Client Assigned Sex at Birth
- ○ Male
- ○ Female
- ○ Declined to Answer

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

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

2 | Final Test Information

HIV Test Election
- ○ Anonymous
- ● Confidential
- ○ Test Not Done

Test Type *(select one only)*
- ● CLIA-waived point-of-care (POC) Rapid Test(s) — Non-Reactive Only
- ● Laboratory-based Test — Positive only

POC Rapid Test Result *(definitions on page 2)*
- ○ Preliminary Positive
- ○ Positive
- ● Negative
- ○ Discordant
- ○ Invalid

Laboratory-based Tests
- ○ HIV-1 Positive
- ○ HIV-1 Positive, possibly acute
- ○ HIV-2 Positive
- ○ HIV Positive, undifferentiated
- ○ HIV-1 Negative, HIV-2 Inconclusive
- ○ HIV-1 Negative
- ○ HIV Negative
- ○ Inconclusive, further testing needed

Result provided to client?
- ○ No
- ● Yes
- ○ Yes, Client obtained the results from another agency

Complete sections 3-4 for persons testing NEGATIVE for HIV

3 | Risk Assessment

Is the client at risk for HIV infection? *(optional)*
- ○ No
- ● Yes
- ○ Risk Not Known
- ○ Not Assessed

4 | PrEP Eligibility and Referral

Was the client screened for PrEP eligibility?
- ● No
- ○ Yes

we don't train on this so No is the default

Is the client eligible for PrEP referral?
- ○ No
- ○ Yes, by CDC criteria
- ○ Yes, by local criteria or protocol

Was the client given a referral to a PrEP provider?
- ● No
- ○ Yes

Was the client provided with services to assist with linkage to a PrEP provider?
- ● No
- ○ Yes

Georgia Department of Public Health 2020 HIV Test Template

Complete sections 5-8 for ALL persons

Form ID *(enter or adhere)* A30000890000

5 | Additional Tests

Was the client tested for other STIs?

○ No ○ Yes

- Tested for Syphilis? ○ No ○ Yes
  - Syphilis Test Result *(optional)*
    - ○ Newly Identified infection
    - ○ Not Infected
    - ○ Not known
- Tested for Gonorrhea? ○ No ○ Yes
  - Gonorrhea Test Result *(optional)* ○ Positive ○ Negative ○ Not known
- Tested for Chlamydial infection? ○ No ○ Yes
  - Chlamydial infection Test Result *(optional)* ○ Positive ○ Negative ○ Not known
- Tested for Hepatitis C? ○ No ○ Yes
  - Hepatitis C Test Result *(optional)* ○ Positive ○ Negative ○ Not known

6 | PrEP Awareness and Use

Has the client ever heard of PrEP (Pre-Exposure Propholaxis)? ○ 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

7 | Priority Populations

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 substances? ○ No ○ Yes

8 | Essential Support Services

	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

Local Use Fields

Local Use Field 1 *(Worker ID)*

Local Use Field 2

check local use field form

Local Use Field 3

Local Use Field 4

Notes *(optional)*

Forms due on the 15th of every month

Georgia Department of Public Health 2020 HIV Test Template

Complete section 9-10 for persons testing POSITIVE for HIV

Form ID *(enter or adhere)* A30000890000

Client Name *(Last Name, First Name)*

Last Name, First Name

9 | Positive Test Result

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

Has the client ever had a positive HIV test?

- ○ 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

What was the client's most severe housing status in the last 12 months?

- ○ Literally homeless
- ○ Unstably house 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
- ○ Yes
- ○ Not asked
- ○ Declined to Answer
- ○ 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 for perinatal HIV service coordination?

- ○ No
- ○ Yes

eHARS State Number

eHARS City/County Number

New or Previous diagnosis?

- ○ 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
- ○ Declined to Answer
- Yes
- Don't Know

Partner Services Case Number

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

10 | Essential Support Services

	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