



**Department  
of Health**

# **Updated Guidance: Implementation of HIV Testing Services**

A webinar for contractors funded by the New York State Department of Health AIDS Institute to conduct HIV Testing services

**Division of HIV/STD/HCV Prevention  
January 13, 2020**



# Objectives

- Provide background & justification for updated guidance from the CDC
- Discuss the domino effect of CDC's modifications for NYSDOH AI-funded contractors
- Highlight indicators for monitoring service provision and progress
- Discuss our next steps
- Answer questions

# Integrated HIV Surveillance and Prevention Funding for Health Departments



A Co

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prograr

- *Ensure that all people living with HIV are aware of their infection and successfully linked to medical care and treatment to achieve viral suppression.* People who take antiretroviral therapy daily as prescribed and achieve and maintain an undetectable viral load have effectively stopped from transmitting the virus to others.

New York City, and San Francisco

Number of awards: 60  
Minimum award amount: \$1 million

Integrating HIV surveillance and prevention programs will help health departments plan and execute more efficient, coordinated, and data-driven prevention efforts, and was strongly supported by stakeholders.

their HIV infections but must be more readily available in the communities most affected by HIV.

These new awards will accelerate the nation's progress toward a goal of no new infections through two central priorities:

- Local health departments serving Baltimore City, Chicago, Houston, Los Angeles County, Philadelphia

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# CDC Guidance



## 2012-2018 (PS12.1201)

- Emphasis on self-reported new diagnosis
- Linkage to HIV Medical Care
- Linkage to Partner Services
- Provision of Prevention Counseling
- Risk Categories

## New Guidance (PS18.1802)

- Emphasis on matching to the NYS Surveillance Registry
  - Previously Known or New Diagnosis
  - Interviewed for Partner Services
  - Linkage to HIV medical care
- PrEP linkages for clients with a negative test result
- Linkages/Provision of Essential Support Services
- Priority Populations





We acknowledge that the CDC's newly required variables change:

1. HIV testing as an intervention
2. Data collection and reporting
  - Funded contractors
  - NYSDOH AI Staff

# Impacts

- Service Provision
- AIRS Modifications
  - Counseling Testing and Referral (CTR) Module
  - Risk History and Priority Populations
  - Forms & Monitoring Reports
- Data Matching Processes with the NYS HIV Surveillance Registry and the NYCDOHMH











# AIRS CTR & Short Intake

1. Intake Information
2. HIV/AIDS Risk History
3. CTR Part A: Client Information
4. CTR Part B: HIV Tests
  - If the Final Result is Negative
5. CTR Part D: If the Final Result is Positive\*



# If the Final Result is Negative

1. Intake Information
2. HIV/AIDS Risk History
3. CTR Part A: Client Information
4. CTR Part B: HIV Tests
  - If the Final Result is Negative





## If the Final Result is Positive

1. Intake Information
2. HIV/AIDS Risk History
3. CTR Part A: Client Information
4. CTR Part B: HIV Tests
5. CTR Part D: If the Final Result is Positive\*\*



\*\*Agencies that refer for confirmatory testing following a rapid reactive point-of-care test are **REQUIRED** to collect information in CTR Part D

INTAKE INFORMATION						
<b>Intake Date:</b>		<b>Client ID:</b>		<b>Date of Birth:</b>		
<b>Last Name:</b>			<b>First Name:</b>			
<b>Address:</b>			<b>City:</b>		<b>State:</b>	<b>Zip:</b>
<b>Current Sexual Orientation:</b>			<b>Current Gender Identity:</b>			
<input type="checkbox"/> Lesbian <input type="checkbox"/> Gay <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual			<input type="checkbox"/> Queer <input type="checkbox"/> Pansexual <input type="checkbox"/> Asexual <input type="checkbox"/> Not Sure/Questioning			
<input type="checkbox"/> Chose Not to Respond <input type="checkbox"/> Sexual Orientation Not Listed <input type="checkbox"/> Write in:						
<b>Gender Pronouns:</b>			<b>Sex Assigned at Birth:</b>			
<input type="checkbox"/> She/her/hers <input type="checkbox"/> He/him/his <input type="checkbox"/> They/them/theirs <input type="checkbox"/> Pronoun not listed / Write-in:			<input type="checkbox"/> Non-Binary Person <input type="checkbox"/> Gender Non-Conforming Person <input type="checkbox"/> Not Sure/Questioning <input type="checkbox"/> Chose not to respond <input type="checkbox"/> Gender not listed/Write-in:			
<b>Primary Language Spoken:</b>			<b>Sex Assigned at Birth:</b>			
<input type="checkbox"/> 01 English <input type="checkbox"/> 02 Spanish <input type="checkbox"/> 03 French <input type="checkbox"/> *Other: Please specify:			<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Chose not to respond			
<b>Housing:</b>			<b>Ethnicity:</b>		<b>Hispanic Details:</b>	
<input type="checkbox"/> 01 Homeless on Street <input type="checkbox"/> 02 Homeless in Shelter <input type="checkbox"/> 03 Transitional Housing <input type="checkbox"/> 04 Residential-Psychiatric <input type="checkbox"/> 05 Residential-Group Home <input type="checkbox"/> 06 Residential-Drug Tx			<input type="checkbox"/> 07 Skilled Nursing Facility or Hospice <input type="checkbox"/> 08 Hospital <input type="checkbox"/> 09 Correctional Facility (Jail/Prison) <input type="checkbox"/> 10 Permanent Housing-Rental <input type="checkbox"/> 11 Permanent Housing-Owns Home <input type="checkbox"/> 12 With Relations/ Friends <input type="checkbox"/> 13 Domestic Violence Situation		<input type="checkbox"/> 35 Central American <input type="checkbox"/> 31 Puerto Rican <input type="checkbox"/> 32 Dominican <input type="checkbox"/> 33 South American <input type="checkbox"/> 34 Mexican/ Mexican-American / Chicano(a)	
<b>Insurance Status:</b>			<b>Race:</b>			
<input type="checkbox"/> Known <input type="checkbox"/> No Insurance If Known, Insurance type: <input type="checkbox"/> Unknown/ Unreported			<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian/ Pacific Islander			
<b>Referral Source:</b>		<b>Type of Referral Source:</b>		<b>HIV Status (at intake):</b>		
<input type="checkbox"/> 658 Self <input type="checkbox"/> Other:		<input type="checkbox"/> External <input type="checkbox"/> Internal		<input type="checkbox"/> 01 HIV-Positive, Not AIDS <input type="checkbox"/> 02 HIV-Positive, AIDS Status Unknown <input type="checkbox"/> 03 HIV-Negative, Unaffected <input type="checkbox"/> 04 Unknown/Unreported <input type="checkbox"/> 08 HIV Negative, Affected <input type="checkbox"/> 10 HIV-Positive, CDC-Defined AIDS		
<b>Counselor:</b>		<b>Program Performing Intake:</b>		<b>Site:</b>		

### HIV/AIDS Risk History

Have you had sex with? (select all that apply)	In the past 5 years:	In the past 6 months:	If yes, select all that apply	Without a condom?
<b>Women</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond	<input type="radio"/> No <input checked="" type="radio"/> Yes <input type="radio"/> Chose not to respond	<input type="radio"/> Vaginal <input type="radio"/> Anal <input type="radio"/> Oral	<input type="radio"/> No <input type="radio"/> Yes
<b>Men</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond	<input type="radio"/> No <input checked="" type="radio"/> Yes <input type="radio"/> Chose not to respond	<input type="radio"/> Vaginal <input type="radio"/> Anal <input type="radio"/> Oral	<input type="radio"/> No <input type="radio"/> Yes
<b>Transgender Women</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond	<input type="radio"/> No <input checked="" type="radio"/> Yes <input type="radio"/> Chose not to respond	<input type="radio"/> Vaginal <input type="radio"/> Anal <input type="radio"/> Oral	<input type="radio"/> No <input type="radio"/> Yes
<b>Transgender Men</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond	<input type="radio"/> No <input checked="" type="radio"/> Yes <input type="radio"/> Chose not to respond	<input type="radio"/> Vaginal <input type="radio"/> Anal <input type="radio"/> Oral	<input type="radio"/> No <input type="radio"/> Yes
<b>Gender non-conforming, non-binary, or questioning persons?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond	<input type="radio"/> No <input checked="" type="radio"/> Yes <input type="radio"/> Chose not to respond	<input type="radio"/> Vaginal <input type="radio"/> Anal <input type="radio"/> Oral	<input type="radio"/> No <input type="radio"/> Yes

#### Were any of your partners in the last 6 months...

A person living with HIV?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond	A person who injects drugs?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond
A person living with HCV?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond	A person who engages in sex in order to get something they need such as money, drugs, food or housing?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond
A person living with an STI?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond		

#### Have you in the last 6 months...

Been diagnosed with an STI?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond	Had sex in order to get something you needed such as money, drugs, food, or housing?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond
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#### Have you ever...

Heard of PrEP?	<input type="radio"/> No <input checked="" type="radio"/> Yes <input type="radio"/> Chose not to respond	If yes - on PrEP the last 12 months	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond
		If yes - currently on PrEP	<input type="radio"/> No <input type="radio"/> Yes

# Have you had sex with?

*Num*                      *Variable Name*

## **Table: G4**                      **Client Characteristics – Priority Populations**

This table is required to be completed by all agencies when data are collected on individual clients as part of HIV testing service delivery.

*Num*                      *Variable Name*

**G400**                      **Sex with a male**                      **XSD (Schema) Name: sexWithMale**

**Value Option: Choose only one**                      **Format Type: Number**                      **Min Length: 1**                      **Max Length: 1**

*Definition:*                      The client/patient self-reported having sex with a male in the past 5 years.

Sex includes oral, anal, or vaginal sex.

*Instructions:*                      Indicate if the client/patient reported having sex in the past 5 years with a male

NYSDOH AIDS Institute  
Provider Guidance: HIV Testing Data Variable Requirements

Variable Category and Label	Required for:		Definition	Value Options
	HIV -	HIV +		
<b>Client Information</b>				
Priority Population Placement [Sex = Oral, Anal, or Vaginal]				
Sex with a male in the past 5 years	●	●	The client self-reports having had sex with a male in the past 5 years.	No Yes
Sex with a female in the past 5 years	●	●	The client self-reports having had sex with a female in the past 5 years.	No Yes
Sex with a transgender woman in the past 5	●	●	The client self-reports having had sex with a transgender woman in the past 5 years.	No





past 3 years		care provider.	Yes
<b>Familiarity with PrEP</b>			
PrEP Awareness	● ●	The client's awareness (ever heard) of PrEP, the medication taken daily to reduce the risk for getting HIV.	No Yes
PrEP use in Last 12 months	● ●	An indication that the client has used PrEP anytime in the last 12 months.	No Yes
PrEP Status	● ●	An indication that the client is currently taking daily PrEP medication.	No Yes





HIV/AIDS Risk History			
<b>Name:</b>		<b>ID:</b>	
<b>Have you ever...</b>			
Had a previous HIV test?	<input type="radio"/> No <input type="radio"/> Yes <b>→</b> <input type="radio"/> Chose not to respond	If yes, date & result   Date: (mm/dd/yyyy)	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Chose not to respond
Injected drugs	<input type="radio"/> No <input type="radio"/> Yes <b>→</b> <input type="radio"/> Chose not to respond	If yes – within the past 5 years?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond
		If yes – within the last 12 months?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond
Been diagnosed with a hemophilia/coagulation disorder?	<input type="radio"/> No <input type="radio"/> Yes <b>→</b> <input type="radio"/> Chose not to respond	If yes, received products prior to 1987?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond
Received a blood product or transplant?	<input type="radio"/> No <input type="radio"/> Yes <b>→</b> <input type="radio"/> Chose not to respond	If yes, prior to 1992?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond
Snorted drugs?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond	Had a tattoo in an unlicensed setting?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond
Had a body piercing in an unlicensed setting?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond	Had chronic hemodialysis?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond
Lived with someone who had Hep C?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond	Been exposed to blood or body fluids while at work?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Chose not to respond



CTR - PART A – Client Info		
<b>Encounter:</b> <input type="checkbox"/> 214 HIV Testing <input type="checkbox"/> 212 HIV Counseling Without Testing	<b>Services/Activities:</b> <input type="checkbox"/> Risk Reduction Services <input type="checkbox"/> HIV Testing Rapid <input type="checkbox"/> HIV Testing Standard (Laboratory Testing)	<b>Was this encounter part of a testing strategy (choose one):</b> <input type="checkbox"/> <b>Social Networking Strategy?</b> → Referred by _____ <input type="checkbox"/> <b>Testing Together?</b> → Testing with _____

CTR - PART B – HIV Tests			
Test 1 (Rapid)		Test 2 (Laboratory Testing)	
<b>Specimen Date:</b>		<b>Specimen Date:</b>	
<b>Test Election:</b> <input type="radio"/> Anonymous <input type="radio"/> Confidential		<b>Test Election:</b> <input type="radio"/> Anonymous <input type="radio"/> Confidential	
<b>Test Results:</b> <input type="radio"/> Preliminary Positive <input type="radio"/> Negative <input type="radio"/> Invalid		<b>Lab-based Test Results:</b> <input type="radio"/> HIV-1 Positive <input type="radio"/> HIV-1 Positive, possibly acute <input type="radio"/> HIV-2 Positive <input type="radio"/> HIV-2 Positive, undifferentiated	
<b>Results Provided?</b> <input type="radio"/> No <input type="radio"/> Yes 		<b>Results Provided?</b> <input type="radio"/> No <input type="radio"/> Yes  <input type="radio"/> Yes, from another agency	
<b>If Yes, Date:</b> (mm/dd/yyyy)		<b>If Yes, Date:</b> (mm/dd/yyyy)	
<b>Test ID/Accession:</b>		<b>Test ID/Accession:</b>	

-  Contact Partner Services as **soon** as you make a **preliminary or confirmed new HIV diagnosis**
-  Rest of state providers: Visit [https://www.health.ny.gov/diseases/communicable/std/partner\\_services/](https://www.health.ny.gov/diseases/communicable/std/partner_services/)
- NYC-based Providers: Call the Field Services Unit at 212-693-1419 or 347-396-7601

# If the Final Result is Negative (Rapid or Laboratory Test)



CTR - PART B – HIV Tests

If the Final Result is Negative (Rapid or Laboratory Test)

For clients who are currently not on PrEP...

Screened for PrEP Eligibility?  No  Yes

Eligible for PrEP?  No  Yes →

*PrEP should be offered to individuals, including adolescents (weighing at least 77 lbs.), that do not have, but are at increased risk of acquiring HIV.*

Referred to a PrEP Provider?  No  Yes

Assistance with Linkage to a PrEP Provider?  No  Yes

Support Services for Clients with a Negative Test Result

	Screened for need	Need Identified	Service Provided	Service Referred
Health benefits navigation and enrollment	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Evidence-based risk reduction intervention	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Behavioral health services (mental health treatment, and substance use treatment)	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

PrEP Eligibility Screening			
Screened for PrEP Eligibility	●	Refers to whether an assessment was conducted to determine if the client meets the appropriate criteria** for using PrEP.	No Yes
Eligible for PrEP Referral	●	An indication of whether the client met the criteria** for receiving a referral for PrEP	No Yes
Referred to a PrEP Provider	●	An indication of whether the client was given a referral to a PrEP provider. PrEP providers are peers, volunteers, and staff members of clinics, health departments, and community-based organizations.	No Yes
Assistance with Linkage to a PrEP Provider	●	An indication of whether the client was provided navigation or linkage services to assist with linkage to a PrEP provider.	No Yes

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# Support Services for Clients with a Negative Test Result



**Essential Support Services** screenings and referrals/linkages are required. These services are intended to aid in the reduction of HIV infections and improve linkages to and retention in care.

CTR - PART B – HIV Tests				
Support Services for Clients with a Negative Test Result				
	Screened for need	Need Identified	Service Provided	Service Referred
Health benefits navigation and enrollment	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Evidence-based risk reduction intervention	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Behavioral health services (mental health treatment, and substance use treatment)	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Social services (housing, transportation, domestic violence intervention and employment)	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

# Essential Support Services



## Behavioral Health Services

- Programs that help clients enroll in public or private programs promoting emotional health and prevention of mental illnesses and substance use disorders
- Services may include, but are not limited to:
  - outreach and education on available behavioral health benefit options (e.g., health maintenance organizations, medication assistance programs),
  - eligibility assessment
  - assistance with enrollment

## Social Services

- Programs that enable and empower people living with HIV to get appropriate treatment and needed care; including food, shelter, medical support and medication adherence.
  - Examples:
    - Housing
    - Transportation
    - domestic violence intervention
    - employment





**DRAFT**

Counseling, Testing & Referrals

Client: **ANewCTRLastNM, ANew**

Form: 8204003738-10/31/2019

**HIV C.T. & R. - Part B: Rapid Testing**

Specimen Date: 10/31/2019 Site: Y1AAC00000 Site\_2  
 Worker: Y1AB800000 LastNm\_64, FirstNm\_64

Technology: POC Rapid Test Election:  Anonymous  Confidential

Test Result:  Preliminary Positive  
 Negative  
 Invalid

Result Provided?  Yes  Yes, from another agency If Yes, Date: 11/14/2019  
 No

Referrals: HCV Diagnostic Testing to Site\_26

**Negative Test Result Assessment...**

Screened for PrEP Eligibility  No  Yes  
 Eligible for PrEP  No  Yes - local  Yes - CDC  
 Referred to PrEP Provider  No  Yes  
 Assistance with Linkage to a PrEP Provider  No  Yes

	Screened for need	Need determined	Service Provided	Service Referred
Health benefits navigation and enrollment	<input type="radio"/> No <input checked="" type="radio"/> Yes	<input type="radio"/> No <input checked="" type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input checked="" type="radio"/> Yes
Evidence-based risk reduction intervention	<input checked="" type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Behavioral health services	<input type="radio"/> No <input checked="" type="radio"/> Yes	<input type="radio"/> No <input checked="" type="radio"/> Yes	<input type="radio"/> No <input checked="" type="radio"/> Yes	<input checked="" type="radio"/> No <input type="radio"/> Yes
Social services	<input type="radio"/> No <input checked="" type="radio"/> Yes	<input type="radio"/> No <input checked="" type="radio"/> Yes	<input type="radio"/> No <input checked="" type="radio"/> Yes	<input checked="" type="radio"/> No <input type="radio"/> Yes

CTR Details...  
 Pre-Test (Part A/Set Header): No  
 Testing (Part B 1 & 2)...  
 - #1 Rapid Testing: Yes  
 - #2 Standard/Conf.: Yes

# If the Final Laboratory Test Result is Positive (AIRS Part D)

# HIV Test Results



## Rapid Test Results

1. **Preliminary positive:** Point-of-care (POC) rapid test was reactive
2. **Negative:** POC rapid test was non-reactive
3. **\*\*Invalid:** A POC rapid test result cannot be confirmed due to conditions related to errors in the testing technology, specimen collection, or transport
  - Requires further medical testing and evaluation
  - All test device package inserts contain next steps for invalid test results (e.g., After two invalid results, call device manufacture)

# HIV Test Results



## Laboratory-based Test Results

- **HIV-1 Positive:** Positive for HIV type 1 infection.
- **HIV-1 Positive, possible acute:** Positive for HIV type 1 infection and is possibly an acute HIV infection. The term “acute” refers to the interval between the appearance of detectable HIV RNA and the first detection of anti-HIV antibodies.
- **HIV-2 Positive:** Positive for HIV type 2 infection.
- **HIV Positive, undifferentiated:** Positive for HIV infection. HIV antibodies could not be differentiated
- **HIV-1 Negative, HIV-2 inconclusive:** Negative for HIV type 1 infection and HIV type 2 antibodies were not confirmed.
- **HIV-1 Negative:** Negative for HIV type 1 infection.
- **HIV Negative:** Negative for HIV infection.
- **Inconclusive, further testing needed:** HIV antibodies were not confirmed; further testing is needed.

If the Final Result is  
Negative, Complete Part B

CTR - PART D: If the Final Laboratory Test Result is Positive

<b>Encounter:</b> <input type="checkbox"/> 211 HIV Counseling (Positive)	<b>Services/Activities:</b> <input type="checkbox"/> Completed and Submitted Provider Report Form (PRF) <input type="checkbox"/> Risk Reduction Services
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If the Final Laboratory Test Result is Positive

Did the client attend an HIV medical care appointment after this positive test?	<input type="radio"/> Yes, confirmed	→	If yes, date attended: (mm/dd/yyyy)
	<input type="radio"/> Yes, client/patient self-report	→	
	<input type="radio"/> No		
	<input type="radio"/> Don't know		

Has the client ever had a positive HIV test?	<input type="radio"/> No	If yes, date of first positive HIV test: (mm/dd/yyyy)	If yes, date attended: (mm/dd/yyyy)
	<input checked="" type="radio"/> Yes		
	<input type="radio"/> Don't know		
		If yes, has the client seen a medical provider for ART in the past 6 months?	<input type="radio"/> No <input type="radio"/> Yes

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

Was the NYS Provider Reporting Form DOH-4189 completed and submitted? (Required)  No  Yes

What was the client's most unstable housing status in the past 12 months?

- Literally homeless
- Unstably housed or at risk of losing housing
- Stably housed
- Declined to answer
- Don't know

If the client is female, is she pregnant?	<input type="radio"/> No	If yes: Is the client in prenatal care?	<input type="radio"/> Yes
	<input type="radio"/> Yes **		<input type="radio"/> No
	<input type="radio"/> Declined to answer		<input type="radio"/> Don't know
	<input type="radio"/> Don't know		<input type="radio"/> Declined to answer

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





CTR - PART D: If the Final Laboratory Test Result is Positive

If the Final Laboratory Test Result is Positive

Did the client attend an HIV medical care appointment after this positive test?	<input type="radio"/> Yes, confirmed	→	If yes, date attended: (mm/dd/yyyy)
	<input type="radio"/> Yes, client/patient self-report	→	
	<input type="radio"/> No		
	<input type="radio"/> Don't know		
Has the client ever had a positive HIV test?	<input type="radio"/> No	If yes, date of first positive HIV test: (mm/dd/yyyy)	If the day is unknown, use the 15 <sup>th</sup> of the month. If the month and day are unknown, use 01/15. If the complete date is unknown, use 01/01/1800.
	<input type="radio"/> Yes		
<input type="radio"/> Don't know		If yes, has the client seen a medical provider for ART in the past 6 months?	<input type="radio"/> No <input type="radio"/> Yes

- Rapid Initiation of Treatment: HIV medical care appointments for clients with confirmed HIV positive test results to occur as soon as possible after diagnosis, preferably same day, but no later than 30 days after the date of diagnosis
- NYSDOH AI Staff will be matching to the NYS HIV Surveillance Registry to promote linkage and retention in care. [Feedback reports are in development.]

\*\*\*DO NOT WAIT TO SUBMIT AIRS EXTRACT\*\*\*



# Importance of Partner Services & Provider Reporting

## NYS Provider Reporting

- Within 14 days of diagnosis complete and submit the Medical Provider Report Form (PRF) (DOH-4189)
  - ePRF using the Provider Portal on the NYSDOH Health Commerce System
- NYC Providers - Contact Notification and Assistance Program (CNAP) by calling 212-693-1419 or 347-396-7601 M-F 9am-5pm

## Partner Services

- Establish collaboration agreements with regional and/or local partner services staff
- PSA for **Patients** <https://www.youtube.com/watch?v=63hsXYucSrs>
- PSA for **Providers** <https://www.youtube.com/watch?v=cumGb4ASugk>





# Housing status in past 12 months

## Value Description

*Literally Homeless*

## Value Definition

*Client has lived in places not designed nor typically used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus/train station or camping ground; or in a shelter or emergency shelter that provides temporary living arrangements.*

*Unstably housed and/or at-risk of losing housing*

*Client has not been homeless, however, client has experienced housing instability as evidenced by frequent moves due to economic reasons, living with others due to economic hardship; eviction from a private dwelling unit (but having another place to go); living in overcrowded housing; or being at risk of having no housing options. This value code includes persons imminently losing housing.*

*Stably housed*

*Persons living in a consistent housing facility that is meant for human habitation and are not at risk of losing housing.*

*Declined to answer*

*Client declined to report housing status in the past 12 months.*

*Don't know*

*Only select 'don't know' if the client states that he or she doesn't know housing status in the past 12 months. Do not select 'don't know' if the client was not asked.*



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## CTR - PART D: If the Final Laboratory Test Result is Positive



## Support Services for Clients with a Confirmed Positive Result

	Screened for Need	Need Identified	Service Provided	Service Referred
Navigation services for linkage to HIV medical care	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Linkage services to HIV medical care	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Medication adherence support	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Health benefits navigation and enrollment	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Evidence-based risk reduction intervention	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Behavioral health services (mental health treatment, and substance use treatment)	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Social services (housing, transportation, domestic violence intervention and employment)	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes



**Essential Support Services** screenings and referrals/linkages are required. These services are intended to aid in the reduction of HIV infections and improve linkages to and retention in care.

- ❖ **Navigation services** refer to assisting clients with locating the right resources so they can be linked to HIV medical care.
- ❖ **Linkage services** are those provided by an agency that actually linked the client to HIV medical care.

# What's Required?

Everything

**AIRS CTR & Short Intake Form** Page 1 of 3

**INTAKE INFORMATION**

Intake Date: \_\_\_\_\_ Client ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Address: \_\_\_\_\_

Current Sexual Orientation:  Lesbian  Gay  Bisexual/Heterosexual  Bisexual  Other: Please specify \_\_\_\_\_

Gender:  She/Her/His  They/Their/Heirs  Pronoun not listed / Write in: \_\_\_\_\_

Current Gender Identity:  Cisgender  Transgender  Gender Not Listed  Write in: \_\_\_\_\_

Primary Language Spoken:  English  Spanish  French  Other: Please specify \_\_\_\_\_

Housing:  Sheltered Nursing Facility or Hospice  Homeless on Street  Homeless in Shelter  Transitional Housing  Residential - Psychiatric  Residential - Group Home  Residential - Drug Tx  Other: Please specify \_\_\_\_\_

Insurance Status:  Known  Unknown  Insurance type: \_\_\_\_\_

Referral Source:  Self  Other: \_\_\_\_\_

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

**HIV/AIDS Risk**

Have you had sex with? (Select all that apply)

Women:  Yes  No  Choose not to respond

Men:  Yes  No  Choose not to respond

Transgender Women:  Yes  No  Choose not to respond

Gender non-conforming, non-binary, or questioning person?  No  Yes  Choose not to respond

Were any of your partners in the last 6 months...  No  Yes  Choose not to respond

Have you in the last 6 months...  No  Yes  Choose not to respond

Have you ever...  No  Yes  Choose not to respond

**AIRS CTR & Short Intake Form** Page 2 of 3

Name: \_\_\_\_\_ ID: \_\_\_\_\_

Have you ever...  No  Yes  Choose not to respond

Had a previous HIV test?  No  Yes  Choose not to respond

Injected drugs  No  Yes  Choose not to respond

Received a blood product or transfused?  No  Yes  Choose not to respond

Used drugs?  No  Yes  Choose not to respond

Had a body piercing in an unlicensed setting?  No  Yes  Choose not to respond

Lived with someone who had Hep C?  No  Yes  Choose not to respond

**CTR - PART A - Client Info**

Encounter:  214 HIV Testing  212 HIV Counseling Without Testing

Services/Activities:  Risk Reduction Services  HIV Testing Rapid  HIV Testing Standard (Laboratory Testing)

Was this encounter part of a testing strategy?  Social Network Strategy  Testing Top

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

Test 1 (Rapid)  Positive  Negative  Unknown

Test 2 (Laboratory)  Positive  Negative  Unknown

Test ID/Accession: \_\_\_\_\_

**Support Services for Clients with a Negative Test Result**

Health benefits navigation and enrollment	Evidence-based risk reduction intervention	Behavioral health services (mental health, substance use treatment)	Social services (housing, transportation, domestic violence intervention and employment)
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Choose not to respond	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Choose not to respond	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Choose not to respond	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Choose not to respond

**AIRS CTR & Short Intake Form** Page 3 of 3

Name: \_\_\_\_\_ ID: \_\_\_\_\_

**CTR - PART D: If the Final Laboratory Test Result is Positive**

Encounter:  211 HIV Counseling (Positive)

Services/Activities:  Completed and Submitted Provider Report Form (PRF)  Risk Reduction Services

**If the Final Laboratory Test Result is 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

Has the client ever had a positive HIV test?  No  Yes  Don't know

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

Was the HIV Provider Reporting Form D0N-4189 completed and submitted? (Required)  No  Yes

Was the client... in the past 12 months?  No  Yes  Choose not to respond

Support Services for Clients with a Positive Test Result

Navigation services for linkage to HIV medical care	Medication adherence support	Health benefits navigation and enrollment	Evidence-based risk reduction intervention	Behavioral health services (mental health, substance use treatment)	Social services (housing, transportation, domestic violence intervention and employment)
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Choose not to respond	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Choose not to respond	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Choose not to respond	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Choose not to respond	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Choose not to respond	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Choose not to respond

**NOTES:**





Counseling, Testing & Referrals

Client: ANewCTRLastNM, ANew

Form: 8204003738-10/31/2019

**HIV C.T.& R. - Part B:Standard / Confirmatory Testing**

Confirmatory Test: Positive Result: Post Test Questionnaire

Attend an HIV medical care appointment after this positive test?  Yes, Confirmed  Yes, client/patient self-reported  No  Don't know **Date Attended** //

Ever have a positive HIV test?  No  Yes  Don't know **Date of HIV test** // **Seen a provider for ART in the past 6 mo?**  No  Yes

Provided with individualized behavioral risk-reduction counseling?  No  Yes

Contact information provided to DOH Partner Services?  No  Yes

Provider Report Form (PRF-4189) submitted to DOH?  No  Yes

Most unstable housing status in the last 12 months?  Literately homeless  Stably housed  Declined to answer  Unstably housed or at risk  Not Asked  Don't know

**Female clients only...**

Is the client 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

	Screened for need	Need determined	Service Provided	Service Referred
Perinatal HIV service coordination	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes		<input type="radio"/> No <input type="radio"/> Yes
<b>All Clients...</b>				
Navigation services for linkage to HIV medical care	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Linkage services to HIV medical care	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Medication adherence support	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Health benefits navigation and enrollment	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Evidence-based risk reduction intervention	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Behavioral health services	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Social services	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

CTR Details...  
 Pre-Test (Part A/Set Header): No  
 Testing (Part B 1 & 2)...  
 - #1 Rapid Testing: Yes  
 - #2 Standard/Conf.: Yes



# CDC Priority Populations



# CDC Guidance on Risk



## Old Guidance (PS12.1201)

### CDC Risk Group

- MSM
- IDU
- High-risk Heterosexual
- MSM/IDU
- Other Risk Category
- Unknown Risk Category

## New Guidance (PS18.1802)

1. Priority populations
2. Allow NYSDOH to define 'at risk for HIV'

# Applying CDC Guidance in NYS



## CDC: Priority Populations

1. MSM/Inject drugs usage (IDU)
2. MSM
3. Transgender/IDU
4. Transgender persons
5. Persons who inject drugs
6. Heterosexual males
7. Heterosexual females
8. Women having sex with women
9. Sex with transgender persons
10. No sex/ no IDU in past 5 years
11. Missing/Invalid

✓ AIRS: MSM At Risk

✓ AIRS: MSM (not at risk)

## NYSDOH: At Risk for HIV

- Had a sexual partner(s) in the last 6 months that:
  - Is living with HIV
  - Is living with/had an STI
  - Is a person who injects drugs
  - Is a person who engages in sex in order to get something they need
- In the last 6 months has:
  - Been diagnosed with an STI
  - Had sex in order to get something they need
  - Had sex without a condom
- Has ever:
  - Injected drugs
  - Been diagnosed with hemophilia /coagulation disorder prior to 1987
  - Received a blood product or transplant prior to 1992



Department  
of Health

AIDS  
Institute



# Indicators for monitoring service provision and progress

# Indicators



- Total # of Clients Tested
- # of 1<sup>st</sup> Time testers
- # Agency Reported Newly Identified HIV Positive Clients
  - # Clients Matched to NYS HIV Surveillance Registry
    - # Newly Diagnosed according to the NYS HIV Surveillance Registry
      - # Newly Diagnosed HIV Positive Clients linked to HIV medical care with HIV-related lab work within 30, 60, and 90 days of HIV diagnosis
    - # Previously Diagnosed according to the NYS HIV Surveillance Registry
      - # Previously Diagnosed HIV Positive Clients linked to HIV medical care with HIV-related lab work within 30, 60, and 90 days of HIV diagnosis
- # Clients with HIV negative results
  - HIV negative clients not already on PrEP at the time of HIV testing that are linked to a PrEP provider
- Total # of Clients receiving Essential Support Services



# Routine Contract Management Report

## Agency Reported Clients with HIV Positive Test Results

Program	Client (TC-ID)	Test Date	Test Result	Client Received HIV test result	Matched to the NYS HIV Surveillance Registry*	New or Previous HIV Diagnosis*	Linked to Medical Care w/in 30 days†	Linked to Medical Care w/in 90 days†

- \* As evidenced by checking the NYS HIV Surveillance Registry
  - New diagnosis: no prior HIV-related lab results (i.e., viral load, CD4 or genotype) were found and there is no indication of a previous diagnosis
  - Previous diagnosis: previous positive HIV test or evidence of a previous positive test was found on review in the NYS HIV Surveillance Registry
- † As evidenced by receipt of HIV-related lab results (i.e., viral load, CD4 or genotype) in the NYS HIV Surveillance Registry AFTER the CTR specimen collection date reported in AIRS

# Next Steps

- NYSDOH will update and distribute AIRS Forms previously sent on January 2, 2020 following this webinar
- Contractors to begin using  AIRS CTR Forms: February 1, 2020
- AIRS Upgrade Tentatively Scheduled for: Early February 2020
- NYSDOH staff have in development
  - AIRS How2 Guides and Data Entry Recording
  - Monitoring and Feedback Reports

# QUESTIONS



Division of HIV/STD/HCV Prevention  
[DOPAI@health.ny.gov](mailto:DOPAI@health.ny.gov)

Begin using



AIRS forms **February 1, 2020**