



Case Surveillance: Coordinators Meeting Update May 10, 2016

Presenter: Iris Chittams
Coordinator: Karen Robinson

Reporting of Confirmed Positive Cases

- ▶ All reports of positives cases should be sent on a weekly basis
- ▶ Send report by trackable mail (UPS, Fed EX, Etc..)
- ▶ Send completed report to the following addressee:

Ms. Iris R. Ramos Chittams

New Jersey Department of Health

50 East State Street, 4th Floor

Trenton, NJ 08625

Phone: (609) 984-5940

Email: iris.chittam@doh.nj.gov

Reporting A Positive Case

- ▶ Complete / print the Evaluation Web Form
- ▶ Place client identifying information on the Evaluation We Form on the back of Part 3
 - ▶ Name
 - ▶ Date of Birth
 - ▶ Address
 - ▶ Telephone Number
 - ▶ Social Security Number (?)
- ▶ Mail by traceable mail carrier (UPS, Fed EX, Etc..)
- ▶ See next slides for sample forms

Enter or adhere Form ID	
Session Date	M M D D Y Y Y Y
Program Announcement (select only one)	
<input type="checkbox"/> PS12-1201 Category A	<input type="checkbox"/> PS11-1113 Category A-YMSM
<input type="checkbox"/> PS12-1201 Category B	<input type="checkbox"/> PS11-1113 Category B-YTG
<input type="checkbox"/> PS12-1201 Category C	<input type="checkbox"/> PS15-1502 Category A
<input type="checkbox"/> PS12-1210 CAPUS	<input type="checkbox"/> PS15-1502 Category B
<input type="checkbox"/> MSM Testing Initiative	<input type="checkbox"/> PS15-1506 PRIDE
<input type="checkbox"/> OTHER: _____	<input type="checkbox"/> PS15-1509
If PS15-1502 Category A or B are selected, be sure to complete the required supplemental HIV test questions.	
Agency Name/ID Number	
Directly Funded CBO Agency ID (For CDC directly funded CBOs only)	
Site Name/ID Number	
Site Type (enter type code from page 3)	F # # # . # #
Site ZIP Code	# # # # #
Site County (enter 3-digit FIPS code)	# # #
Client ID	# # # # # # # # # # # # # #
Client Record Number (PS15-1502 required. Numeric only)	
Date of Birth (enter 01/01/1800 if unknown)	M M D D Y Y Y Y
Client State (use USPS abbreviation)	
Client County	
Client ZIP Code	# # # # #
Client Ethnicity	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Don't Know
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Declined
	<input type="checkbox"/> Not Asked
Client Race (check all that apply)	
<input type="checkbox"/> American IN/AK Native	<input type="checkbox"/> White
<input type="checkbox"/> Asian	<input type="checkbox"/> Don't Know
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Declined
<input type="checkbox"/> Native HI/Pac. Islander	<input type="checkbox"/> Not Asked
Client Assigned Sex at Birth	
<input type="checkbox"/> Male	<input type="checkbox"/> Declined
<input type="checkbox"/> Female	<input type="checkbox"/> Not Asked
Client Current Gender Identity	
<input type="checkbox"/> Male	<input type="checkbox"/> Transgender MTF
<input type="checkbox"/> Female	<input type="checkbox"/> Transgender FTM
<input type="checkbox"/> Declined	<input type="checkbox"/> Transgender Unspecified
<input type="checkbox"/> Not Asked	
<input type="checkbox"/> Additional (specify): _____	
Previous HIV Test?	
<input type="checkbox"/> No	
<input type="checkbox"/> Yes →	If Yes, what is the client's self-reported result?
<input type="checkbox"/> Don't Know	<input type="checkbox"/> Positive
<input type="checkbox"/> Declined	<input type="checkbox"/> Negative
<input type="checkbox"/> Not Asked	<input type="checkbox"/> Preliminary Positive
	<input type="checkbox"/> Indeterminate
	<input type="checkbox"/> Don't Know
	<input type="checkbox"/> Declined
	<input type="checkbox"/> Not Asked

Sample Date	M M D D Y Y Y Y	M M D D Y Y Y Y	M M D D Y Y Y Y
	HIV Test 1	HIV Test 2	HIV Test 3
Worker ID			
Test Election	<input type="checkbox"/> Anonymously <input type="checkbox"/> Confidentially <input type="checkbox"/> Test Not Offered <input type="checkbox"/> Declined Testing	<input type="checkbox"/> Anonymously <input type="checkbox"/> Confidentially <input type="checkbox"/> Test Not Offered <input type="checkbox"/> Declined Testing	<input type="checkbox"/> Anonymously <input type="checkbox"/> Confidentially <input type="checkbox"/> Test Not Offered <input type="checkbox"/> Declined Testing
Test Technology	<input type="checkbox"/> Conventional <input type="checkbox"/> Rapid <input type="checkbox"/> NAAT/RNA Testing <input type="checkbox"/> Other	<input type="checkbox"/> Conventional <input type="checkbox"/> Rapid <input type="checkbox"/> NAAT/RNA Testing <input type="checkbox"/> Other	<input type="checkbox"/> Conventional <input type="checkbox"/> Rapid <input type="checkbox"/> NAAT/RNA Testing <input type="checkbox"/> Other
Test Result	<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid <input type="checkbox"/> No Result	<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid <input type="checkbox"/> No Result	<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Invalid <input type="checkbox"/> No Result
Result Provided	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes, client obtained results from another agency	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes, client obtained results from another agency	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes, client obtained results from another agency
If results NOT provided, why?	<input type="checkbox"/> Declined Notification <input type="checkbox"/> Did Not Return/ Could Not Locate <input type="checkbox"/> Other	<input type="checkbox"/> Declined Notification <input type="checkbox"/> Did Not Return/ Could Not Locate <input type="checkbox"/> Other	<input type="checkbox"/> Declined Notification <input type="checkbox"/> Did Not Return/ Could Not Locate <input type="checkbox"/> Other
Choose status of collection of behavioral risk profile			
<input type="checkbox"/> Client completed a behavioral risk profile		<input type="checkbox"/> Client was asked, but no behavioral risks identified	
<input type="checkbox"/> Client was not asked about behavioral risk factors		<input type="checkbox"/> Client declined to discuss behavioral risk factors	
For clients completing a risk profile, did the client report the following behaviors in the past 12 months? (select all that apply)			
	No	Yes	Don't Know
Vaginal or Anal Sex with a male			
With a male without using a condom			
With a male who is IDU			
With a male who is HIV +			
Vaginal or Anal Sex with a female			
With a female without using a condom			
With a female who is IDU			
With a female who is HIV +			
Vaginal or Anal Sex with a transgender person			
With a transgender without using a condom			
With a transgender who is IDU			
With a transgender who is HIV +			
Injection drug use			
Share drug injection equipment?			
Vaginal or Anal Sex with MSM (female only)			
Additional Risk Factors (enter two-digit code from page 3)	1 # # 2 # # 3 # # 4 # #		
Session Activities (enter codes from page 3)	1 # # . # # 3 # # . # #		
	2 # # . # # 4 # # . # #		
Local Use Fields	L1 # # # # # L3 # # # # #		
	L2 # # # # # L4 # # # # #		

Adult HIV Confidential Case Report Form

EVALUATIONWEB® 2016 HIV TEST TEMPLATE

PART ONE

Enter or adhere Form ID		Session Date		Sample Date		HIV Test 1		HIV Test 2		HIV Test 3	
Program Announcement (select only one)		Worker ID		Test Election		Test Technology		Test Result		Result Provided	
Agency Name/ID Number		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Directly Funded CBO Agency ID		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Site Name/ID Number		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Site Type		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Site ZIP Code		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Site County		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Client ID		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Client Record Number		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Date of Birth		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Client State		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Client County		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Client ZIP Code		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Client Ethnicity		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Client Race		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Client Assigned Sex at Birth		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Client Current Gender Identity		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Additional (specify):		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Previous HIV Test?		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
If Yes, what is the client's self-reported result?		Test Technology		Test Election		Test Technology		Test Result		Result Provided	
Local Use Fields		Test Technology		Test Election		Test Technology		Test Result		Result Provided	

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type <input type="checkbox"/> HIV <input type="checkbox"/> AIDS (check all that apply to facility below) <input type="checkbox"/> Check if SAME as Facility Providing Information			
Facility Name		*Phone () _____	
*Street Address			
City	County	State/Country	ZIP Code
Facility Type <i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other, specify _____	<i>Outpatient:</i> <input type="checkbox"/> Private Physician's Office <input type="checkbox"/> Adult HIV Clinic <input type="checkbox"/> Other, specify _____	<i>Screening, Diagnostic, Referral Agency:</i> <input type="checkbox"/> CTS <input type="checkbox"/> STD Clinic <input type="checkbox"/> Other, specify _____	<i>Other Facility:</i> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____
*Provider Name		*Provider Phone () _____	*Specialty

Patient History (respond to all questions) (record all dates as mm/dd/yyyy) Pediatric risk (please enter in Comments)

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:		
Sex with male		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sex with female		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Injected non-prescription drugs		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received clotting factor for hemophilia/coagulation disorder	Specify clotting factor: _____ Date received (mm/dd/yyyy): ___/___/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL relations with any of the following:		
HETEROSEXUAL contact with intravenous/injection drug user		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with bisexual male		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with hemophilia / coagulation disorder with documented HIV infection		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
First date received ___/___/_____ Last date received ___/___/_____		
Received transplant of tissue/organs or artificial insemination		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Worked in a healthcare or clinical laboratory setting		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting: _____		
Other documented risk (please include detail in Comments section)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV. Information in CDC's National HIV Surveillance System, that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

Enter or adhere Form ID		
CDC requires the following information on all preliminary and confirmed HIV-positive clients:		
Was the client referred to HIV medical care?		
<input type="checkbox"/> No → <input type="checkbox"/> Yes → <input type="checkbox"/> Don't Know	Reason the client not referred to HIV Medical Care? <input type="checkbox"/> Client Already in Care <input type="checkbox"/> Client Declined Care	
	Did the client attend the first appointment? <input type="checkbox"/> Pending	
	<input type="checkbox"/> Confirmed: Accessed Service → <input type="checkbox"/> Confirmed: Did Not Access Service	First medical appointment within 90 days of the HIV test? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
<input type="checkbox"/> Lost to Follow-Up <input type="checkbox"/> No Follow-Up <input type="checkbox"/> Don't Know		
Was the client referred to/contacted by Partner Services?		
<input type="checkbox"/> No <input type="checkbox"/> Yes → <input type="checkbox"/> Don't Know	Was the client interviewed for Partner Services? <input type="checkbox"/> No <input type="checkbox"/> Yes → <input type="checkbox"/> Don't Know	
	Was the client interview within 30 days of receiving their result? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	
Was the client referred to HIV Prevention Services?		
<input type="checkbox"/> No <input type="checkbox"/> Yes → <input type="checkbox"/> Don't Know	Did the client receive HIV Prevention Services? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	
What was the client's <u>most severe</u> housing status in the past 12 months (check only one)?		
<input type="checkbox"/> Literally Homeless <input type="checkbox"/> Unstably Housed or At Risk of Losing Housing <input type="checkbox"/> Stably Housed		<input type="checkbox"/> Not Asked <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Don't Know
If female, is the client pregnant?		
<input type="checkbox"/> No <input type="checkbox"/> Yes → <input type="checkbox"/> Don't Know <input type="checkbox"/> Declined <input type="checkbox"/> Not Asked	Is the client in prenatal care? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	
	<input type="checkbox"/> Declined <input type="checkbox"/> Not Asked	
Prior to the client testing positive during this testing event, was she/he previously reported to the jurisdiction's surveillance department as being HIV-positive?		
<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> Not Checked

Local Use Fields					
L5	#	#	#	#	#
L6	#	#	#	#	#
L7	#	#	#	#	#
L8	#	#	#	#	#
L9	#	#	#	#	#
L10	#	#	#	#	#
L11	#	#	#	#	#
L12	#	#	#	#	#
L13	#	#	#	#	#
L14	#	#	#	#	#
L15	#	#	#	#	#
L16	#	#	#	#	#
L17	#	#	#	#	#
CDC Use Fields					
C3	#	#	#	#	#
C4	#	#	#	#	#
C5	#	#	#	#	#
C6	#	#	#	#	#
C7	#	#	#	#	#
C8	#	#	#	#	#
C9	#	#	#	#	#

Notes:

2012-2017 Form

ID

Form ID:

Agency

Session Date:

Program Announcement:

Site:

Client

Client ID:

Year of Birth:

Client State:

Client County:

Client Zip Code:

Client Ethnicity:

Client Race (Check all that apply)

Client Assigned Sex at Birth:

Current Gender Identity:

Previous HIV Test?

Client Self Reported HIV Test Result:

HIV Test Information

HIV Test 1

Sample Date:

Worker ID:

Test Election:

Test Technology:

Test Result:

Result Provided:

Show HIV Test 2:

HIV Test 2

Sample Date:

Worker ID:

Test Election:

Test Technology:

Test Result:

Result Provided:

Show HIV Test 3:

Behavioral Risk Factors

Choose one if:

Vaginal or Anal Sex with a Male:

Vaginal or Anal Sex with a Female:

Vaginal or Anal Sex without a Condom with a Female:

Vaginal or Anal Sex with a Female IDU:

Vaginal or Anal Sex with HIV-Positive Female:

Vaginal or Anal Sex with a Transgender Person:

Injection Drug Use:

Additional Client Risk Factors:

Activity

Session Activity 1:

Session Activity 2:
Session Activity 3:
Session Activity 4:

Local

Local Use Field 1 - Site ID of Second testing site:
Local Use Field 2 - Worker ID of Second testing site:
Local Use Field 3 - If partner, Form ID of Index Client:
Local Use Field 4 - Was client referred to PrEP?
(Yes/No):

Referrals

Was client referred to HIV medical care?

If yes, did client attend the first appointment?

If yes, was the first appointment within 90 days of the HIV Test?

Was client referred to Partner Services?

If yes, was client interviewed for Partner Services?

If yes, was client interview within 30 days of receiving their result?

Was client referred to HIV Prevention services?

If yes, did client receive HIV Prevention Services?

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

Prior to the client testing positive during this testing event, was she/he previously reported to the jurisdiction's surveillance department as being HIV-positive?

HIV Incidence

Date client reported information:
Has client ever had a previous positive HIV Test?
Date first positive HIV Test:
Has client ever tested negative?
**Number of negative HIV tests within 24 months
before the current (or first positive) HIV test**
**Has client used or is client currently using
antiretroviral medication (ARV)?**
Medication 1:
Medication 2:
Medication 3:

Medication 4:
Date ARV began?
Date of last ARV use?

Reporting Notes Reminders

- ▶ **If**, only one screening test is performed by the CTS and a referral for confirmation is made
 - ▶ The CTS must obtain final results from the referral site and record the results of the second test in Evaluation Web
 - ▶ Mail to:
 - Ms. Iris R. Ramos Chittams
 - New Jersey Department of Health
 - 50 East State Street, 4th Floor
 - Trenton, NJ 08625
 - Phone: (609) 984-5940
 - Email: iris.chittam@doh.nj.gov
 - ▶ Send completed report by trackable mail
- ▶ **If**, a confirmation test was not offered by the CTS
 - ▶ The CTS must indicate that information in the notes section of the Evaluation Web Form and indicate why follow-up was not performed

Surveillance Processes

- ▶ Facilities should submit forms using the 2016 current version
- ▶ Evaluation Web Form types received
 - ▶ Actual Evaluation Web Form
 - ▶ Photocopy of printed Evaluation Web Forms
 - ▶ Evaluation Web Printout
- ▶ Place client identifying information on the Evaluation Web Form on the back of Part 3
 - ▶ Name
 - ▶ Date of Birth
 - ▶ Address
 - ▶ Telephone Number

Surveillance Processes (Continued)

- ▶ Received Evaluation Web Reports are reviewed for completeness and for errors
 - ▶ Facilities are called to complete missing information
 - ▶ Facilities are called to correct errors entered on the report
- ▶ Checked for both RAPID test results
 - ▶ Completed reports should contain both RAPID test results
 - ▶ If only one test is performed, provide explanation why?
- ▶ Client is checked in the Surveillance Database
 - ▶ New diagnosed clients are entered
 - ▶ Newly identified clients are entered / updated
 - ▶ New facility reports are entered

Surveillance Processes (Continued)

- ▶ Completed Surveillance Processing of Evaluation Web Forms
 - ▶ Entry in Surveillance Database with corresponding NJDOH (prefix) along with CTS number.
 - ▶ Example: NJDOH5115648
 - ▶ Copy of de-identified CTS forms are submitted to Prevention and Education CTS Unit

End of Discussion

Questions or Comments?

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