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 Web 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
# Evaluation Web Forms Page 1

## EvaluationWeb 2016 HIV Test Template

### PART ONE

<table>
<thead>
<tr>
<th>Sample Date</th>
<th>M D Y Y Y Y</th>
<th>M D Y Y Y Y</th>
<th>M D Y Y Y Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Test 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Test 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Test 3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Worker ID
- Anonymously
- Confidentially
- Test Not Offered
- Declined Testing
- Conventional Testing
- Rapid HIV Testing
- Other

#### Test Technology
- Conventional
- Rapid
- HAV/RTA Testing
- Other

#### Test Result
- Positive/Reactive
- Negative
- Indeterminate
- Invalid
- No Result

<table>
<thead>
<tr>
<th>Result Provided</th>
<th>M D Y Y Y Y</th>
<th>M D Y Y Y Y</th>
<th>M D Y Y Y Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Test 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Test 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Test 3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### If Results NOT provided, why?
- Declined
- Notification
- Could Not Locate
- Other

#### Choose status of collection of behavioral risk profile
- Client completed a behavioral risk profile
- Client was asked, but no behavioral risk factors identified
- 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)

<table>
<thead>
<tr>
<th>Vaginal or Anal Sex with a male</th>
</tr>
</thead>
<tbody>
<tr>
<td>With a male without using a condom</td>
</tr>
<tr>
<td>With a male who is HIV +</td>
</tr>
<tr>
<td>With a female without using a condom</td>
</tr>
<tr>
<td>With a female who is HIV +</td>
</tr>
<tr>
<td>With a transgender person</td>
</tr>
<tr>
<td>With a transgender who is HIV +</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Injection drug use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share drug injection equipment?</td>
</tr>
</tbody>
</table>

### Additional Risk Factors

<table>
<thead>
<tr>
<th>Enter two-digit code from page 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

### Session Activities

<table>
<thead>
<tr>
<th>Enter two-digit code from page 3</th>
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</thead>
<tbody>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

### Local Use Fields

<table>
<thead>
<tr>
<th>L1</th>
<th>L2</th>
</tr>
</thead>
<tbody>
<tr>
<td>L1</td>
<td>L2</td>
</tr>
</tbody>
</table>

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Adult HIV Confidential Case Report Form

Facility of Diagnosis (add additional facilities in Comments)

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

After 1977 and the earliest known diagnosis of HIV infection, this patient had:

Sex with male

Sex with female

Injected non-prescription drugs

Receiving clotting factor for hemophilia/Coagulopathy disorder

HETEROSEXUAL relatives with the following:

HETEROSEXUAL contact with intravenous/injection drug user

HETEROSEXUAL contact with bisexual mate

HETEROSEXUAL contact with person with hemophilia / coagulopathy disorder with documented HIV infection

HETEROSEXUAL contact with transfusion recipient with documented HIV infection

HETEROSEXUAL contact with transplant recipient with documented HIV infection

HETEROSEXUAL contact with person documented HIV infection, risk not specified

Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments section)

Worked in a healthcare or laboratory setting

Other documented risk (please include detail in Comments section)

This report is to the Centers for Disease Control and Prevention (CDC) is authorized by laws (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 243c). Response to this is voluntary for Federal government employees, 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 will permit identification of any individual on whom is recorded, is collected with a guarantee that will not 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 309(b) of the Public Health Service Act (42 USC 243c).
**Evaluation Web Forms Page 2**

**PART TWO**

**Enter or Adhere Form ID**

**CDC Requires the Following Information on All Preliminary and Confirmed HIV-Positive Clients:**

1. **Was the client referred to HIV medical care?**
   - [ ] No
   - [ ] Yes
   - [ ] Don’t Know

   - Reason the client not referred to HIV Medical Care?
     - [ ] Client Already in Care
     - [ ] Client Declined Care

   - Did the client attend the first appointment?
     - [ ] Pending
     - [ ] Confirmed: Access Service
     - [ ] Confirmed: Did Not Access Service

   - First medical appointment within 90 days of the HIV test?
     - [ ] No
     - [ ] Yes
     - [ ] Don’t Know

2. **Was the client referred to/contacted by Partner Services?**
   - [ ] No
   - [ ] Yes
   - [ ] Don’t Know

3. **Was the client interviewed for Partner Services?**
   - [ ] No
   - [ ] Yes
   - [ ] Don’t Know

4. **Was the client referred to HIV Prevention Services?**
   - [ ] No
   - [ ] Yes
   - [ ] Don’t Know

   - Did the client receive HIV Prevention Services?
     - [ ] No
     - [ ] Yes
     - [ ] Don’t Know

5. **What was the client’s most severe housing status in the past 12 months (check only one)?**
   - [ ] Literally Homeless
   - [ ] Unstably Housed or At Risk of Losing Housing
   - [ ] Stably Housed

   - Not Asked
   - Declined to Answer
   - Don’t Know

6. **If female, is the client pregnant?**
   - [ ] No
   - [ ] Yes
   - [ ] Don’t Know

   - Is the client in prenatal care?
     - [ ] No
     - [ ] Declined
     - [ ] Not Asked

   - [ ] No
     - [ ] Yes
     - [ ] Don’t Know

7. **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?**
   - [ ] No
   - [ ] Yes
   - [ ] Not Checked

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**Notes:**

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## Evaluation Web Forms Page 3

### EVALUATIONWEB® 2016 HIV TEST TEMPLATE

**PART THREE**

<table>
<thead>
<tr>
<th>Code</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Ageronae (amprenavir)</td>
</tr>
<tr>
<td>30</td>
<td>Apithus (tipranavir, TPV)</td>
</tr>
<tr>
<td>32</td>
<td>Atipra (efavirenz/emtricitabine/tenofovir DF)</td>
</tr>
<tr>
<td>24</td>
<td>Comblav (lamivudine/zidovudine, 3TC/AZT)</td>
</tr>
<tr>
<td>38</td>
<td>Compleria (emtricitabine, rilpivirine/tenofovir DF, FTC/RPV/TFD)</td>
</tr>
<tr>
<td>06</td>
<td>Crithnav (indinavir, DRV)</td>
</tr>
<tr>
<td>17</td>
<td>Eduvix (rilmipavir, RVP)</td>
</tr>
<tr>
<td>11</td>
<td>Emtriex (emtricitabine, FTC)</td>
</tr>
<tr>
<td>03</td>
<td>Epivir (lamivudine, FTC)</td>
</tr>
<tr>
<td>28</td>
<td>Epixar (abacavir/lamivudine, ABC/3TC)</td>
</tr>
<tr>
<td>25</td>
<td>Forivox (saquinavir, SQV)</td>
</tr>
<tr>
<td>10</td>
<td>Fuzex (enfuvritide, T20)</td>
</tr>
<tr>
<td>19</td>
<td>Hepsera (adezavir)</td>
</tr>
<tr>
<td>02</td>
<td>Hfml (zalcitabine, dDC)</td>
</tr>
<tr>
<td>23</td>
<td>Hydorgynes</td>
</tr>
<tr>
<td>18</td>
<td>Invirase (saquinavir, SQV)</td>
</tr>
<tr>
<td>34</td>
<td>Intence (zidovudine)</td>
</tr>
<tr>
<td>36</td>
<td>Ixentress (raltegravir)</td>
</tr>
<tr>
<td>16</td>
<td>Kalteza (tibivir, ritalnavir)</td>
</tr>
<tr>
<td>31</td>
<td>Lexvia (fosamprenavir, 90B)</td>
</tr>
<tr>
<td>07</td>
<td>Nolvir (zidovudine, RTV)</td>
</tr>
<tr>
<td>33</td>
<td>Puzinexx (zidovudine, ORV)</td>
</tr>
<tr>
<td>09</td>
<td>Rector (didavir, dLV)</td>
</tr>
<tr>
<td>26</td>
<td>Retron (zidovudine, ZDV, AZT)</td>
</tr>
<tr>
<td>15</td>
<td>Reyataz (azanavir, ATY)</td>
</tr>
<tr>
<td>08</td>
<td>Saquinavir (Fortavase, Invirase)</td>
</tr>
<tr>
<td>35</td>
<td>Seltenity (maraviric)</td>
</tr>
<tr>
<td>39</td>
<td>Strivid (abacavir/lamivudine, 3TC/AZT)</td>
</tr>
<tr>
<td>21</td>
<td>Sustiva (efavirenz, EFV)</td>
</tr>
<tr>
<td>40</td>
<td>Thivcay (dolutegravir)</td>
</tr>
<tr>
<td>13</td>
<td>Truvada (abacavir/lamivudine/zidovudine, ABC/3TC, AZT)</td>
</tr>
<tr>
<td>27</td>
<td>Truvada (tenofovir DF/emtricitabine, TDF/FTC)</td>
</tr>
<tr>
<td>01</td>
<td>Videx (didanosine, ddl)</td>
</tr>
<tr>
<td>14</td>
<td>Videx EC (didanosine, ddl)</td>
</tr>
<tr>
<td>17</td>
<td>Viracept (nevirapine, NVP)</td>
</tr>
<tr>
<td>09</td>
<td>Viramune (nevirapine, NVP)</td>
</tr>
<tr>
<td>12</td>
<td>Virohe (tenofovir DF, TDF)</td>
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<tr>
<td>04</td>
<td>Zerit (stavudine, d4T)</td>
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<tr>
<td>20</td>
<td>Zidov (abacavir, ABC)</td>
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<tr>
<td>88</td>
<td>Other</td>
</tr>
<tr>
<td>99</td>
<td>Unspecified</td>
</tr>
</tbody>
</table>

**Enter or adhere Form ID**

**HIV Incidence (if required by health department)**

**Date the client reported information**

**Has the client ever had a previous positive HIV test?**
- No
- Yes
- Don't Know
- Declined

**Date of First positive HIV test**

**Has the client ever had a negative HIV test?**
- Yes
- Don't Know
- Declined

**Date of last negative HIV test**

**Number of negative HIV tests within 24 months before the current (or first positive) HIV test**

**Has the client used or is client currently using antiretroviral medication (ARV)?**
- No
- Yes
- Don't Know
- Declined

**Specify antiretroviral medications**

**Date ARV began**

**Date of last ARV use**

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<table>
<thead>
<tr>
<th><strong>2012-2017 Form</strong></th>
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<table>
<thead>
<tr>
<th><strong>ID</strong></th>
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<tbody>
<tr>
<td>Form ID:</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Agency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Date:</td>
</tr>
<tr>
<td>Program Announcement:</td>
</tr>
<tr>
<td>Site:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Client</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Client ID:</td>
</tr>
<tr>
<td><strong>Year of Birth:</strong></td>
</tr>
<tr>
<td>Client State:</td>
</tr>
<tr>
<td>Client County:</td>
</tr>
<tr>
<td>Client Zip Code:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Client Ethnicity:</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Client Race (Check all that apply):</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Client Assigned Sex at Birth:</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Current Gender Identity:</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Previous HIV Test?</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Client Self Reported HIV Test Result:</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>HIV Test Information</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>HIV Test 1</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Date:</td>
</tr>
<tr>
<td>Worker ID:</td>
</tr>
<tr>
<td>Test Election:</td>
</tr>
<tr>
<td>Test Technology:</td>
</tr>
<tr>
<td>Test Result:</td>
</tr>
</tbody>
</table>

**https://cdc2-ew.lutherconsulting.com/evaluationWebV6/cfm/exportPDF.cfm**
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?

Iris R Ramos Chittams
Email: iris.chittams@doh.nj.gov
Phone: (609) 984-5940