Planning and Implementing HIV Testing and Linkage Programs in Non-Clinical Settings: A Guide for Managers
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To provide direction in the development of the Implementation Guide, an advisory board composed of 18 representatives of health departments and community-based organizations was convened. The advisory board met by conference call 13 times between October 2011 and June 2012, with each call addressing a specific content area of either the Implementation Guide or the Evaluation Guide. A 3-day, face-to-face working session was also held with seven representatives of the advisory board to work through resource gaps and refine the tools included in the guides. Advisory board members were asked to share resources and identify gaps in support necessary for the implementation of HIV testing and linkage, to care as well as to discuss current practices, challenges, and successes in the field.

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Chapter 1. About the Implementation Guide

CHAPTER 1 AT A GLANCE

This chapter provides an overview of the Implementation Guide. In this chapter we do the following:

- Summarize the process for developing the Implementation Guide
- Describe the audience for the Implementation Guide
- Explain the organization and use of the Implementation Guide

The Planning and Implementing HIV Testing and Linkage Programs in Non-Clinical Settings: A Guide for Program Managers (the Implementation Guide) supports implementation, in non-clinical settings, of HIV testing and linkage to care and prevention services. The Implementation Guide and accompanying toolkit is intended to be used in conjunction with the Evaluation Guide for HIV Testing and Linkage Programs in Non-Clinical Settings (hereafter referred to as the Evaluation Guide) for optimal implementation support. The information, tools, and practice examples included in the Implementation Guide are intended to assist organizations such as health departments (HDs) and community-based organizations (CBOs) that operate in non-clinical settings to plan and implement HIV testing and linkage services in these settings. Agencies already providing HIV testing and linkage services in non-clinical settings can strengthen these services by using the information and tools contained in this Implementation Guide.

The Importance of HIV Testing in Non-Clinical Setting

More than 1.2 million people are living with HIV in the United States and approximately 48,000 new infections occur each year. About 70% of sexually transmitted cases of HIV are attributed to persons who are unaware of their HIV-positive status, and nearly 50% of people who test positive for HIV are diagnosed with AIDS within 3 years.

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2 Marks, G., Crepaz, N., & Janssen, R. S. (2006). Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. AIDS, 20(10), 1447–1450.
This indicates persons most at risk for contracting HIV or who may present with early infections are not being reached by the clinical and non-clinical HIV testing approaches used to date.\textsuperscript{4}

Non-clinical settings are settings in which medical, diagnostic, and/or treatment services are not routinely provided. However, non-clinical HIV testing programs provide selected diagnostic services (HIV testing) and selected prevention services (risk-reduction interventions), and can facilitate access to other medical and social services for clients with positive or negative test results. Providing HIV testing services in non-clinical venues facilitates access for individuals who may not access these services through other health care providers, those who may be testing for the first time, or those at highest risk of acquiring HIV who would benefit from repeated testing.\textsuperscript{5}

Examples of non-clinical settings in which HIV testing and linkage services could be provided include mobile testing units, churches, CBOs, bath houses, parks, shelters, syringe services programs, and other social service organizations. Offering testing in these venues allows providers to strategically target their services to individuals at highest risk of becoming HIV infected in their community. By collaborating and building a service network with other local providers, agencies which provide HIV testing in non-clinical settings can facilitate access to a more comprehensive set of prevention and care services in the community.\textsuperscript{5} Provision of HIV testing in non-clinical settings can also play a key role in linking newly diagnosed and previously diagnosed HIV-positive persons to medical care and treatment. This link is critical in increasing access to and utilization of antiretroviral therapy (ART), as well as supporting retention in medical care and good ART adherence. These factors contribute to HIV-positive persons living longer and healthier lives.\textsuperscript{6,7,8}

\textsuperscript{7} Montaner, J. (2006). The case for expanding access to highly active antiretroviral therapy to curb the growth of the HIV epidemic. \textit{The Lancet}, \textit{368}, 531–536.
Purpose of the Implementation Guide

Since the release in 2001 of CDC’s Revised Guidelines for HIV Counseling, Testing, and Referral,⁹ there have been substantial improvements in HIV testing technologies which allow us to identify infection earlier. Approaches to treatment of HIV have continued to evolve and can dramatically improve the health of individuals living with the infection. Research has identified new strategies to locate, engage, and motivate high-risk individuals to accept HIV testing, and to facilitate access to important prevention, medical and social services to clients with positive tests and clients with negative tests. More is now known about strategies that can reduce the risk of infection, and there are many behavioral interventions that are demonstrably effective in promoting safer behaviors.

This Implementation Guide will help non-clinical testing programs implement strategies that are new or have greater emphasis in revised and forthcoming CDC recommendations including:

- Defining and targeting high-risk populations that are likely to have an HIV prevalence of 1% or more.
- Identifying effective recruitment strategies to locate members of these target populations.
- Using streamlined methods to identify members of the target population.
- Using field-tested recruitment methods to motivate members of the target population to accept testing.
- Offering the most sensitive HIV tests that are feasible in the program.
- Assessing the possibility of very recent exposure (≤72 Hours) to make appropriate referrals for non-occupational post-exposure prophylaxis (nPEP).
- Assessing the symptoms of acute antiretroviral infection before testing to determine the need to offer or refer clients for tests that detect acute infection.
- Linking newly identified clients with positive tests to HIV medical care on the basis of either an initial or supplemental HIV test result.
- Providing clients with new positive test results, a basic needs assessment that would guide decisions on the provision/linkage/referral to appropriate medical, prevention, and support services. Providing persons previously diagnosed with HIV with the opportunity to re-test for HIV (e.g., to document HIV status that determines eligibility for medical or social services) and assistance with linkage to or re-engagement in HIV medical care.
- Classifying clients with negative tests into two categories of risk for acquiring infection (elevated vs. not elevated) to identify clients that could most benefit from risk reduction services.

• Providing to all clients with negative test results classified as having “elevated” risk a prevention needs assessment to identify factors that may influence risk of HIV acquisition.

• Providing, linking, or referring all clients with negative tests who are classified as having “elevated” risk to risk-reduction interventions and other medical and social services identified in their prevention needs assessment.

• This Implementation Guide was developed to assist you in implementing an HIV testing and linkage program that makes use of these new insights about effective ways to identify and serve persons at high risk of HIV infection. This Implementation Guide can also assist you in optimizing the effectiveness and efficiency of your HIV testing and linkage program. Systematic and data-driven planning, use of monitoring and evaluation (M&E) data for program improvement, and community engagement and collaboration are critical elements of a successful program and are addressed in detail in this Implementation Guide.

Through adoption of the strategies discussed and tools and samples included in this Implementation Guide, you can strengthen your HIV testing and linkage program. In doing so, you can increase the number of individuals who are aware of their serostatus and provide critical prevention, medical, and social services to clients after they receive their test results.

**Audience for the Implementation Guide**

The information presented within these pages is targeted to program managers, conducting HIV testing, providing risk reduction services, and linkage to care and prevention services in non-clinical settings. Agencies implementing new HIV testing and linkage programs or refining existing programs can benefit from using the information and tools included in this guide. Organizations that fund or provide operational direction to non-clinical HIV testing and linkage services can also use the information and tools to help provide guidance and technical assistance to the programs they support.

The concepts and activities covered in the Implementation Guide are relevant to all non-clinical testing programs, regardless of their funding source, data reporting requirements, or capacity. Each agency has unique needs and priorities when it comes to program planning, delivery, and improvement. This guide presents a comprehensive look at planning and implementation and encourages you to use the concepts and information presented to identify and adopt strategies that are concepts and create a customized approach that is locally relevant, appropriately scaled, and useful.

Throughout this guide, we use the terms “strategy” and “strategies” in relation to the component services of an HIV testing program (e.g., “recruitment strategy”). In this guide, strategy refers to a set of activities (such as risk reduction interventions) and application of tools (such as HIV tests) that are intended to achieve a program goal or objective.
Organization and Use of the Implementation Guide

The Implementation Guide is organized by topic area. Where applicable, accompanying tools and templates are displayed in the text and can be found in Appendices C and D. Readers are encouraged to reference the Evaluation Guide for further guidance on monitoring and evaluation of non-clinical HIV testing and linkage programs.

The following chapters are organized in a way that reflects the natural progression from program planning to evaluation. However, the information in each need not be used in that order. Program planning and implementation is an iterative and ongoing process that must respond to changes in target populations, recruitment strategies, HIV test technologies, and provision of services after clients learn their test results and program goals and capacity. Programs aiming to refine an established program strategy, for example, may find sections on quality improvement more useful than sections on basic program planning.

Likewise, the individual chapters of the Implementation Guide can be used independently. A program that is revising its targeting and recruitment strategy but not its risk reduction services might only consult the targeting and recruitment chapter. To improve the utility and completeness of each chapter to "stand alone", some information is repeated in more than one chapter, (e.g., quality assurance and M&E). Important references to other chapters or sections within the Implementation Guide are noted within each chapter.

How New Programs Can Use the Implementation Guide: The Implementation Guide is designed to assist you in planning your HIV testing and linkage program. The Implementation Guide will take you through the key steps of program implementation, including formative evaluation, planning for delivery of services, as well as M&E of the program. Tools included in the Implementation Guide will help you to plan your program and assess your capacity to implement services.

How Established Programs Can Use the Implementation Guide: If you have already implemented an HIV testing and linkage program, you can use this Implementation Guide to help you to strengthen your program. The information and tools included in the Implementation Guide can help you assess the extent to which your program is meeting the needs of your target population, as well as the kinds of strategies or practices that could help you to better meet community needs and build your capacity to provide these services.

It is good practice to assess your program on a regular basis. Many agencies do this as part of annual or semiannual program planning and improvement activities. It is always a good idea to reassess program practices when substantial changes occur in your agency (e.g., staffing changes) or community (e.g., changes in health and social services in the community). It is also a good idea to reassess program practices in light
of new technologies (e.g., availability of new HIV tests) or advent of new strategies and tools.

Established programs may choose to use the information and tools included in the Implementation Guide to assess the status of an HIV testing and linkage program. In this case, it may be useful to go through the guide chapter by chapter, completing all of the tools. This approach will also result in a baseline inventory of your program and program practices that can serve as a reference and can be updated as needed.

Alternately, established programs may choose to focus on assessing and improving one or two components for the HIV testing and linkage program (e.g., referral and linkage to care). In this case, you may wish to use the chapters and tools that are relevant to that program component.

**How Health Departments and Other Funders Can Use the Implementation Guide:**
Health departments and other funders may wish to use the Implementation Guide in providing training or technical assistance to grantees or contractors. You could use the entire Implementation Guide, individual chapters, and/or selected tools to assist agencies that are just beginning a new program, or for agencies that seem to be struggling with program implementation. Some HDs or other funders may wish to have grantees or contractors complete program planning and implementation on the basis of information and tools included in the Implementation Guide at the beginning of a project (e.g., as a component of a funding proposal) or on a regular basis (e.g., at the beginning of each contract cycle) as a means to assess and monitor capacity to provide HIV testing and linkage services. The Implementation Guide and its tools could also be used as a reference for or foundation of program standards and practices. Health departments and other funders can adapt the information and tools included in the Implementation Guide to suit local needs by adding or adjusting the content to reflect local policies, regulations, or requirements.

**Identifying Helpful Hints**
As we move through concepts and exercises that relate to HIV testing in non-clinical settings, we will pause to highlight helpful hints. The call-out boxes below are examples of the types of information that will be provided.

| **Tip** |
| Tips include “from the field” advice or helpful hints from your HIV prevention colleagues that will help you perform HIV testing and linkage activities. |

| **Recommended Activity** |
| Recommended activities are strategies or practices that reflect the optimal way of providing services. |

| **Tools and Templates** |
Tools and templates will help you construct and document your HIV testing program. They can be tailored by your agency to reflect local needs and will help you determine agency capacity, prevention priorities, services for delivery, and so forth.

Accompanying Resources

A guide to evaluating non-clinical testing programs the Evaluation Guide for HIV Testing and Linkage Programs in Non-Clinical Settings is an essential companion to this Implementation Guide. The Evaluation Guide is consistent with CDC’s Framework for Program Evaluation and provides tools and sample forms to assist agencies in implementing the six steps of comprehensive M&E: engaging stakeholders, describing your program, focusing your evaluation, gathering credible evidence, justifying conclusions, and ensuring use and lessons learned.

Other Resources for HIV Testing

Non-clinical testing programs may receive funding or other operational direction or guidance from one or more sources for your HIV testing and linkage services. These could include Federal agencies such as CDC, foundations, state agencies like HDs, city HDs, or CBOs. These entities often allocate funds to target specific populations, investigate new technologies, or perform special studies that can gauge the effectiveness of interventions. They may require that specific testing strategies or protocols are followed. This guide does not address the specific requirements of these entities; rather, it provides examples and best practices of how one might design and implement a program that may take these requirements into consideration. For more information program design and planning requirements, please contact these entities.

This guide addresses HIV testing and linkage in non-clinical settings, only. Additional information about HIV testing in clinical settings is available from CDC.
Overview of HIV Testing in Non-Clinical Settings

Non-clinical settings provide a key avenue to access HIV testing and linkage services for individuals at greatest risk for HIV. This is particularly true for individuals who do not routinely use health-care facilities. By providing clients access to prevention, medical, and social services on-site or through external agencies, non-clinical testing programs can expand access to a wide range of medical and social services that can help stem HIV transmission, improve health, enhance the quality of life, and prolong life.

Community Readiness Assessment

As the first point of contact to HIV testing and services for many members of your community, non-clinical testing programs have the opportunity to provide services tailored to the unique needs of various target populations. In order to do so successfully, however, they must evaluate the community’s capacity and willingness to use these services.
A community readiness assessment can elucidate how your community currently provides HIV testing and follow-up services to your target population. It can also reveal the extent of awareness about HIV, the value placed on HIV testing and follow-up services; the potential feasibility and acceptability of your program; potential partners and allies that can support your program; and detractors and other obstacles to program implementation.

A community readiness assessment can also identify external stakeholders who can help you to locate and engage your target population, provide prevention, medical and social services to your program’s clients, or assist in evaluating your program. (See Evaluation Guide, Step 1: Engaging Stakeholders.)

Several strategies can be used to collect information for the community readiness assessment. These include review of documents of the communities HIV Planning Group(s), key informant interviews and focus groups or community members who are interested in the target population and/or providing HIV prevention and care services, or discussions at established or specially convened community forums. (See Evaluation Guide, Step 4: Gather Credible Evidence for more data collection strategies.) Examples of the individuals or organizations that can contribute to your readiness assessment include health care providers, social service providers, business owners, faith leaders, government officials (e.g., Mayor’s office, health department), educators, as well as at-large community members.

Interviews, focus groups, and other group discussions with stakeholders and community members are qualitative methods that cannot be standardized and must be tailored to the circumstances of the program and the community. Exhibit 2.1 provides examples of various topics that can be covered in the interviews for the readiness assessment.

### Exhibit 2.1. Key Informant Interview Topics

<table>
<thead>
<tr>
<th>Theme</th>
<th>Question Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge and awareness</td>
<td>• Awareness of the impact of HIV in the community</td>
</tr>
<tr>
<td></td>
<td>• Knowledge and awareness of who is affected by HIV</td>
</tr>
<tr>
<td></td>
<td>• Knowledge of HIV transmission</td>
</tr>
<tr>
<td></td>
<td>• Knowledge of available services</td>
</tr>
<tr>
<td></td>
<td>• Community recognition of the value of HIV testing and services</td>
</tr>
<tr>
<td>Attitudes</td>
<td>• Community attitudes toward health services</td>
</tr>
<tr>
<td></td>
<td>• Community attitudes toward discussing health issues</td>
</tr>
<tr>
<td></td>
<td>• Community attitudes toward HIV</td>
</tr>
<tr>
<td></td>
<td>• Community attitudes toward HIV testing and services</td>
</tr>
<tr>
<td></td>
<td>• Leaders’ attitudes toward HIV testing and services</td>
</tr>
<tr>
<td></td>
<td>• Community attitudes toward discussing sex and drug use</td>
</tr>
<tr>
<td></td>
<td>• Community attitudes toward the target population</td>
</tr>
<tr>
<td>Norms</td>
<td>• Community norms and values regarding behaviors and practices that increase risk for HIV</td>
</tr>
<tr>
<td></td>
<td>• Community norms regarding use of health services, including HIV services</td>
</tr>
<tr>
<td></td>
<td>• Cultural, economic, political, and other issues that impact utilization of HIV services</td>
</tr>
<tr>
<td>Access</td>
<td>• Where members of the community go for health services</td>
</tr>
<tr>
<td></td>
<td>• Who provides health services in the community</td>
</tr>
<tr>
<td></td>
<td>• Acceptable and accessible venues for provision of HIV services</td>
</tr>
<tr>
<td></td>
<td>• Barriers to access</td>
</tr>
</tbody>
</table>
Leveraging the Assessment to Increase Readiness

After collecting information from stakeholders and community members, you can draft a Framework for Assessing Community Readiness that illustrates stages of readiness, program goals suitable for that stage, and strategies to increase a community’s readiness to support and utilize a non-clinical testing program (Exhibit 2.2.)¹ This framework is useful for explaining program issues to stakeholders and can be revised periodically as you collect ongoing feedback from community members.

**Exhibit 2.2. Framework for Assessing Community Readiness for a Non-Clinical HIV Testing Program**

<table>
<thead>
<tr>
<th>Readiness</th>
<th>Stage Description</th>
<th>Stage Goal</th>
<th>Ideas for How to Meet the Goal and Move to</th>
</tr>
</thead>
<tbody>
<tr>
<td>No awareness</td>
<td>Issue is not generally recognized by the community members or leaders as a problem (or it may truly not be an issue).</td>
<td>Raise awareness of issues – regarding impact of HIV and value of testing</td>
<td>• Conduct one-on-one visits with key community members</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Meet with existing and established groups</td>
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<td></td>
<td></td>
<td></td>
<td>• Connect with stakeholders and potential supporters</td>
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<tr>
<td>Denial/resistance</td>
<td>At least some community members recognize that it is a concern, but there is little recognition that HIV might be occurring locally.</td>
<td>Create awareness of the issues regarding the impact of HIV and the value of testing in this community</td>
<td>• Discuss descriptive local incidents related to the issue</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Approach and engage local educational/outreach programs to assist in the effort with flyers, posters, or brochures</td>
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<td></td>
<td></td>
<td></td>
<td>• Prepare and submit articles for church bulletins, local newspapers, club newsletters, and so forth</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Continue strategies from previous stage</td>
</tr>
<tr>
<td>Vague awareness</td>
<td>Most feel that there is a local concern, but there is no immediate motivation to do anything about it.</td>
<td>Raise awareness that the community can make changes</td>
<td>• Share information at local events</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Make presentations on the issue for existing groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Conduct informal surveys to see how people feel about the issue</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Publish newspaper editorials and articles</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Continue strategies from previous stages</td>
</tr>
<tr>
<td>Preplanning</td>
<td>There is clear recognition that something must be done, and there may even be a group addressing the issue. However, efforts are not focused or detailed.</td>
<td>Raise awareness about the impact of HIV and the value of testing with concrete ideas</td>
<td>• Introduce information about the issue through presentations and media</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Review existing efforts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Visit and get investment of community leaders</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Conduct focus groups and make plans</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Increase media exposure through radio and television public service announcements</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Continue strategies from previous stages</td>
</tr>
</tbody>
</table>

## Exhibit 2.2. Framework for Assessing Community Readiness for a Non-Clinical HIV Testing Program (continued)

<table>
<thead>
<tr>
<th>Readiness Stage</th>
<th>Stage Description</th>
<th>Stage Goal</th>
<th>Ideas for How to Meet the Goal and Move to the Next Stage of Readiness</th>
</tr>
</thead>
</table>
| Preparation stage | Active leaders begin planning in earnest. Community offers modest support of efforts. | Gather existing information with which to plan strategies |  • Conduct school surveys  
  • Conduct community surveys  
  • Sponsor a community picnic to kick off the effort  
  • Conduct public forums to develop strategies from the grassroots level  
  • Have key leaders and influential people speak to groups and participate in local radio and television shows  
  • Plan how to evaluate the success of your efforts |
| Initiation stage | Enough information is available to justify efforts. Activities are underway. | Provide community-specific information |  • Conduct in-service training on community readiness for professionals and paraprofessionals  
  • Plan publicity efforts associated with start-up of activity or efforts  
  • Attend meetings to provide updates on progress of the effort  
  • Conduct community interviews to identify service gaps, improve existing services, and identify key places to post information  
  • Begin library or Internet search for additional resources and potential funding  
  • Begin basic evaluation efforts |
| Stabilization stage | Activities are supported by administrators or community decision makers. Staff are trained and experienced. | Stabilize efforts |  • Plan community events to maintain support for the issue  
  • Conduct trainings for community professionals and members  
  • Introduce program evaluation through trainings  
  • Increase media exposure detailing progress  
  • Hold recognition events for local supporters/volunteers  
  • Continue strategies from previous stages |
| Confirmation/expansion | Efforts are in place. Community members feel comfortable using services and they support expansions. Local data are regularly obtained. | Expand and enhance services |  • Formalize the networking with qualified service agreements  
  • Prepare a community risk assessment profile  
  • Publish a localized program services directory  
  • Maintain a comprehensive database available to the public  
  • Develop a local speaker’s bureau  
  • Initiate policy change through support of local city officials  
  • Conduct media outreach on specific data trends related to the issue  
  • Use evaluation data to modify efforts |
### Exhibit 2.2. Framework for Assessing Community Readiness (continued)

<table>
<thead>
<tr>
<th>Readiness Stage</th>
<th>Stage Description</th>
<th>Stage Goal</th>
<th>Ideas for How to Meet the Goal and Move to the Next Stage of Readiness</th>
</tr>
</thead>
</table>
| High level of community ownership      | Detailed and sophisticated knowledge exists about prevalence, causes, and consequences. Effective evaluation guides new directions. Model is applied to other issues. | Maintain momentum and continue growth           | • Maintain local business community support and solicit financial support from them  
• Diversify funding resources  
• Continue more advanced training of professionals and paraprofessionals  
• Continue reassessment of issue and progress made  
• Use external evaluation and use feedback for program modification  
• Track outcome data for use with future funding applications  
• Continue progress reports for benefit of community leaders and local sponsorship; at this stage community has ownership of the efforts and will invest themselves in maintaining the efforts |

### The Agency Readiness Assessment

Before implementing a new HIV testing and linkage program, or making modifications to an established program, it is essential for your agency to conduct a systematic planning process. It is important to understand the basic features of a non-clinical testing program (see Figure 1) and develop a program-specific operational flowchart that specifies your agency’s plan. Thoughtful planning will help to ensure that you are well prepared to implement an HIV testing and linkage program that is both responsive to community needs and delivers evidence-based, high-quality services. In planning for implementation of an HIV testing and linkage program, you will need to take the following steps:

- Draft and refine a prototype program using an operational flowchart that reflects CDC evidence-based recommendations for effective, efficient non-clinical testing programs and input from internal and external stakeholders.
- Select which of the strategies that will be used to implement program activities based on program goals, objectives, resources, and constraints.
- Discuss the operational flowchart with stakeholders and revise accordingly.
- Develop draft policies and procedures for implementing the prototype program.
- Pilot activities where the most effective and feasible methods to deliver an activity remains uncertain.
- Revise the program operational flowchart and policies and procedures based on pilot findings and stakeholder input.
- Identify and form relationships with partner agencies to ensure that a range of client needs are addressed.
• Recruit and train staff and/or volunteers\(^2\) who will provide services
• Secure and/or develop the technologies and materials necessary to deliver services
• Conduct formative evaluation to determine feasibility and effectiveness of program plan
• Develop plans and procedures for QA of the interventions, procedures, and processes
• Develop plans, procedures, and processes for program M&E

A large body of research, programmatic experience, and expert opinion collected over the last decade suggests that non-clinical testing programs can become more effective and efficient if adopt several new strategies. These new strategies represent the key updates in CDC’s forthcoming recommendations on HIV testing in non-clinical settings. Below are listed these strategies and the rationale for this use:

• **Defining and targeting high-risk populations that are likely to have an HIV prevalence of 1% or more.**
  ▪ Rationale: Many non-clinical testing programs have had limited return on investment because they recruited populations with much lower prevalence and identified very few clients with newly diagnosed HIV infection.

• **Identifying effective recruitment strategies to locate members of target populations.**
  ▪ Rationale: Many non-clinical testing programs recruited clients in fixed or outreach venues tied to specific geographic locations. However, many high risk populations are more dispersed and less likely to congregate in specific locales; they may be easier to locate through “virtual locations” such as Internet sites where people find sex partners or scattered rural communities where methamphetamine use is common.

• **Using streamlined methods to identify members of the target population using observation and/or a few simple questions instead of a detailed risk assessment before offering testing.**
  ▪ Rationale: Many non-clinical testing programs conduct extensive risk assessments before offering testing and limited testing to persons who reported risk. Studies indicate that these detailed assessments deter some persons from accepting testing and that self-reported risk may not be as predictive of HIV infection status and population–level characteristics of target populations drawn from epidemiologic and behavioral data.

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\(^2\) We recognize that many HIV testing and linkage programs use volunteers to provide HIV testing and linkage services. Often, volunteers perform the same functions as paid staff. Throughout this guide, for convenience, we use the word “staff” to refer to both paid staff and volunteers.
• Using evidence-based and field-tested methods of client recruitment and engagement to motivate members of the target population to accept HIV testing.
  ▪ Rationale: Using evidence-based methods such as motivational interviewing techniques and incentives can often improve acceptance of testing. However, since not all recruitment methods may work equally well in all populations, they should be field-tested or piloted in the target population before being implemented.

• Offering the most sensitive HIV tests that are feasible in the program, including blood-based tests with appropriate quality assurance.
  ▪ Rationale: Many non-clinical testing programs use HIV tests based on oral fluid, but more sensitive blood-based tests that can detect infection earlier after the point of exposure are now available for use in non-clinical settings.

• Assessing the possibility of very recent exposure before testing to determine whether it is appropriate to refer clients for non-occupational post-exposure prophylaxis (nPEP).
  ▪ Rationale: Evidence suggests that nPEP, the use of antiretroviral medication within 72 hours of a suspected HIV exposure (e.g., ruptured condom worn by a man with HIV or sexual assault by a person who may be infected with HIV), is underutilized in the United States. Non-clinical testing programs are well positioned to facilitate access to this intervention to populations at high risk for acquiring HIV.

• Assessing the symptoms of acute antiretroviral infection before HIV testing to determine the need to offer or refer clients for tests that detect acute infection.
  ▪ Rationale: New tests for acute infection have been developed that expand opportunities to identify persons during the highly infectious stage of acute infection and refer them to risk reduction interventions and early HIV medical care.

• Linking newly identified clients with an HIV-positive test results to HIV medical care on the basis of an initial or supplemental HIV test result.
  ▪ Rationale: Research demonstrates that many clients with an initial positive rapid test result may not return for supplemental test results, thereby missing the opportunity to get linked/referred to HIV medical care, risk-reduction intervention and other services. With the introduction of new, highly sensitive and specific rapid, point-of-care tests, initial results are more predictive of actual infection status so HIV medical providers are more likely to accept clients with initial positive test results while supplemental test results are pending.

• Providing all clients with new HIV-positive test results, a basic needs assessment that would guide decisions on the provision, linkage, or referral to appropriate medical, prevention, and support services.
- **Rationale:** The basic needs assessment is a simple planning tool to assist testing program staff to determine the type, intensity, and the geographic location of the services needed by the client and his/her ability to access them easily.

- **Providing persons previously diagnosed with HIV infection with the opportunity to retest for HIV (e.g., to document HIV status that determines eligibility for medical or social services) and assistance with linkage or re-engagement in HIV medical care if they are not currently receiving HIV care.**
  - **Rationale:** Programmatic evidence indicates that many previously diagnosed HIV infected persons seek retesting for legitimate reasons (i.e., to document their HIV infection when determining eligibility for medical and social services.)

- **Classifying clients with HIV-negative test results into two categories of risk for acquiring infection (elevated vs. not elevated) to determine which clients could benefit from intensive risk-reduction services.**
  - **Rationale:** Programmatic experience indicates that many non-clinical testing programs can have greater impact if they devote less time to prevention services for clients at low risk of HIV acquisition and greater time to high risk clients who warrant intensive, risk-reduction interventions.

- **Providing to all clients with HIV-negative test results identified as having “elevated” risk a prevention needs assessment to identify factors that may influence risk of HIV acquisition.**
  - **Rationale:** Programmatic experience indicates that many non-clinical testing programs can have greater impact if they devote more time to and linkage or referral to medical and social services that may influence risk of HIV acquisition, such as substance use treatment.

- **Providing, linking, or referring all clients with HIV-negative tests as classified as having “elevated” risk to risk-reduction interventions and other medical and social services identified in their prevention needs assessment.**
  - **Rationale:** As noted above.

The flowchart (Figure 1) illustrates the operational flow of activities and outputs for clients targeted by a “generic” non-clinical HIV testing program that features these new strategies.
Figure 1. Operational Flowchart of HIV Testing in Non-Clinical Settings

1. A program may use a combination of different strategies including social networks depending on the program capabilities, resources, and characteristics of the target population. People may become aware of testing by seeing a testing site sign/billboard or interacting with an outreach worker who lacks testing equipment.
2. For persons not seeking testing, asking one to two simple questions to determine if they are members of target population (e.g., MSM, IDU) may be needed in addition to observation. Questions should depend on characteristics of population targeted by testing program and would not be intended to assess risks of HIV infection. However, asking questions to determine if they are members of target population may also be useful in determining test results (e.g., positive test results of test results or a reduction intervention).
3. Persons who decline testing should be offered re-testing in a manner that is consistent with the program's policies and procedures. Re-testing should be offered every six months to one year.

Information collected when documenting provision of this service/option/counterexample, in some cases, the outcome of that service/option/counterexample can be used to evaluate or monitor the testing program.
Figure 1. Operational Flowchart of HIV Testing in Non-Clinical Settings (continued)

HIV Negative

- If suspect recent HIV exposure, provide education and link or refer to nPERI program

- Use triage process to define HIV acquisition risk

- No/low risk
  - Provide condoms and prevention information
  - Advise to test if starting to practice risk behavior

- Moderate/high risk
  - Provide condoms and prevention information
  - Provide advice on HIV testing frequency

HIV Positive (including acute HIV infection)

Minimum services include:
- Link or refer to linkage services staff (may not be same day) for HIV care
- Basic assessment of issues that promote transmission or pose barriers to linkage to care
- Link or refer to support services including risk reduction interventions
- Basic risk reduction messages
- Offer counseling
- Optional if agency resources permit
- More detailed needs assessment
- Linkage or referral to other services defined by more detailed needs assessment
- Provide risk reduction intervention other than basic messages (e.g., DEBIs)

(20) Can be done on same day if feasible

Document

1. Prevention needs assessment: an assessment of factors and behaviors related to HIV acquisition risk
2. Make referrals to other services that may influence HIV acquisition

(21) Can be done off-site or referred to another agency

Document

Is the testing program able to do same day risk reduction intervention on-site?

Yes
- Conduct same day behavioral risk reduction intervention on-site
- Wherever possible, actively link to intensive risk reduction interventions as appropriate

No
- Whenever possible, actively link to evidence-based behavioral risk reduction intervention tailored to client needs, it may be on-site (but outside testing program setting) or off-site and may be appropriate to client characteristics

*Information collected when documenting provision of this service/question/encounter element, and in some cases, the outcome of that service/question/encounter element, can be used to evaluate or monitor the testing program

9. The triage elements are dependent on characteristics of specific population and are used to determine if clients warrant any additional services at the time of testing beyond condoms and information. It is not a detailed risk or needs assessment. If client was offered testing in field and was asked questions to determine if member of a specific target population (e.g., MSM, IVDU), these questions would not need to be repeated if triage done by same person who assessed membership in Target Population.

10. Note, after linkage to care, partner services is urgent for persons diagnosed with HIV acute infection

11. Assuring cannot be provided by agency

12. Terminology is consistent with CDC funding announcements for nonclinical HIV testing

13. May include referral for HCV screening if recommended by CDC at time of guideline release

14. Encourage use of CDC compendium of effective interventions

*Elements of the triage process are found in the “Tools for Flow Chart” document

** Elements of the prevention needs assessment are found in the “Tools for Flow Chart” document.
An important first step in designing or refining a non-clinical testing program is designing a “prototype” program plan that captures program goals, objectives, and strategies that are likely to maximize program effectiveness, efficiency and impact. One way to do this is to create a program-specific operational flowchart based on the “generic” operational flowchart above. Another way that you could do this is to develop a logic model for your HIV testing and linkage program. A detailed discussion of logic models is included in the Evaluation Guide. Including input from internal and external stakeholders of the program will strengthen your program. It is also important to consider several factors unique to your testing program. These include testing program goals, objectives, and target populations defined by funding agencies, authorizing authorities, and community needs assessment (see below).

Testing programs can make different choices how to recruit clients and deliver services. Among the most critical choices are

- which target population to serve,
- which recruitment methods to use,
- which HIV tests to offer,
- how to define clients with HIV-negative tests with elevated risk that warrant more intensive risk-reduction services,
- whether services to clients with HIV-positive tests and clients with HIV-negative tests will be offered onsite, or through linkage or referral assistance to external agencies.

You can revise the program-specific flowchart to reflect initial choices about how the program recruits clients and provide services. By seeking repeated review by internal and external stakeholders, the program can revise the prototype flowchart so it better reflects the program goals, resources, and constraints. It can then serve as a critical blueprint to define how each activity will be provided, the expected outputs of each activity, and the policies and procedures that are needed to operationalize the program.

The tool below is designed as a guide for and a tool to document your program planning efforts. Using this tool will also help you to identify potential challenges to program implementation and strategies to address these challenges.

Before implementing an HIV testing and linkage program, or making modifications to an established program, you will also need to assess the extent to which your agency has the capacity necessary to deliver these services. Tool 1 will assist you in making that assessment.

Tools and Templates: Tool 1—HIV Testing and Linkage Implementation Planning

Tool 1 can assist in the design of your HIV testing program. It will help identify the “who” and “when” for necessary activities, as well as the “how” to overcome challenges.
Tool 1. HIV Testing and Linkage Program Planning and Capacity Assessment

**About Tool 1:** Tool 1 is divided into two parts. Part I: HIV Testing and Linkage Program Planning serves as a guide for and tool to document your program planning process. Part II: HIV Testing and Linkage Capacity Assessment assists you in assessing your capacity for implementing an HIV testing and linkage program. The “Domains of Readiness” presented in Part II correspond to the major implementation activities that need to be completed to prepare you to implement HIV testing and linkage services. The greater the number of domains of readiness completed, the greater your capacity to fully implement HIV testing and linkage services.

Part II is designed to be completed after Part I. If you are planning a new program, it is recommended that you do not begin providing services to clients until you have full capacity to implement HIV testing and linkage services (i.e., all of the boxes on Part II are checked as complete). However, established programs may wish to begin with Part II to identify those domains where program improvement efforts can be concentrated.

This tool should be completed in conjunction with discussion with staff members who provide HIV testing and linkage services, as well as others, such as consumer advisory board members or members of your board of directors. Multiple perspectives will result in richer discussion, a deeper understanding of program planning issues and program operations, as well as better ideas and strategies to ensure a successful program.

Tool 1 presents HIV testing and linkage program planning activities as though they occur in a sequential fashion. It is important to note, however, that some activities may occur at the same time. For example, you may be simultaneously working on developing your recruitment protocol and developing client educational materials. Some activities may reoccur at multiple points in time, such building new partnerships, establishing a new memorandum of agreement (MOA), or hiring new staff members who must be trained.

**How New Programs Can Use This Tool:** This tool is designed to assist you in planning your HIV testing and linkage program. This tool will take you through the key steps of program implementation, including formative evaluation, planning for delivery of HIV testing and linkage services, as well as monitoring, providing QA, and evaluating your program. This tool will help you to assess your capacity and readiness to implement your HIV testing and linkage program. It will help you to identify any gaps in your knowledge or resources that will need to be addressed to ensure that your program will meet the needs of your target population and that you have the knowledge, tools, and resources needed to deliver high-quality services.

**How Established Programs Can Use This Tool:** If you have already implemented an HIV testing and linkage program, you can use this tool to help you to assess whether your program is still meeting the needs of your target population, and if you need to make any changes to strengthen your program. It is good practice to periodically reassess your program to ensure it is still meeting community needs and that you are
using the tools and strategies that help you deliver effective and high-quality HIV testing and linkage services.

Many agencies reassess their programs on an annual basis, as part of a regular program planning and improvement process. Some funders require work plans on a regular (e.g., annual) basis. It is always a good idea to reassess program practices when substantial changes occur in your agency (e.g., staffing changes) or community (e.g., changes in health and social services in the community). It is also a good idea to reassess program practices in light of new technologies (e.g., availability of new HIV tests) or advent of new strategies and tools.

Established programs may find it helpful to use this tool as to take inventory of a program and its capacity. In this case, you could complete the entire tool and update it periodically (e.g., during your annual planning process) or as changes warrant (e.g., when policies and procedures are updated). Alternately, established programs may not need to complete the entire tool, but only sections which are most relevant. For example, if you are considering adopting a new test technology, you may only need to complete the section on testing capacity and QA.

**How Health Departments and Other Funders Can Use This Tool:** Health departments and other funders may find this tool helpful for use with grantees or contractors. You could use this tool in providing technical assistance to agencies that are just beginning a new program, or for agencies that seem to be struggling with program implementation. Some HDs or other funders may wish to have grantees or contractors complete this tool at the beginning of a project (e.g., as a component of a funding proposal) or on a regular basis (e.g., at the beginning of each contract cycle) as a means to assess and monitor capacity to provide HIV testing and linkage services. HDs and other funders can adapt this tool to suit local needs by adding or adjusting the activity fields to reflect local policies, regulations, or requirements, such as specific training or certification requirements for staff providing HIV testing and linkage services.
Instructions for Completing Tool 1. Part I: HIV Testing and Linkage Program Planning

**What is the purpose of this tool?** Tool 1, Part I is used to guide and document your program planning efforts.

**Who should complete this tool?** HIV testing and linkage program managers, in collaboration with staff, consumer advisory board members, and others involved in planning, implementation, and evaluation of the program.

**When should this tool be completed?** Before you implement HIV testing and linkage services or as part of periodic program assessment of established programs.

**How should this tool be completed?** In the top portion of Tool 1, Part I, record the following information in the designated cells:

- **Agency/Program:** Record the name of the agency and/or program completing this tool.
- **Target Population:** Record the target population.
- **Date Completed:** Record the date that the tool was completed or updated, as applicable.
- **Participants:** Record the names and/or positions/roles of the individuals participating in completing this tool.

The left column presents the key activities involved in planning for and implementation of an HIV testing and linkage program. HDs and other funders, in particular, may wish to add, delete, or modify these activities to suit local needs and requirements. For each activity listed, record the following information in the designated column:

- **Last Update:** Enter the date that corresponds to when the activity was completed or last updated.
- **Responsible Individual/Position:** Enter the name of the individual (or title of the position) that has taken responsibility for the activity.
- **Timeline for Completion:** Enter the date by which the activity must be completed.
- **Challenges:** Summarize challenges, if any, which may delay completion of the activity.
- **Strategies:** Summarize strategies that you will use to address the identified challenges in completing the activity.

Tool 1, Part I has been partially completed to illustrate how it may look after completion. The example reflects how an agency developing a new HIV testing and linkage program would use this tool.
### Tool 1. Part I: HIV Testing and Linkage Program Planning

| **Agency/Program:** ACME Prevention Services, Center Point Program | **Participants:**  
| | • ACME executive director  
| | • ACME HIV prevention manager  
| | • ACME board chair  
| | • ACME community advisory board chair |
| **Target Population:** White and African American injection drug users (IDUs) over 30 years of age living in North Center City | **Date Completed:** January 15, 2012 |

<table>
<thead>
<tr>
<th>Activity</th>
<th><strong>Last Update</strong>*</th>
<th><strong>Responsible Individual/Position</strong></th>
<th><strong>Timeline for Completion</strong></th>
<th><strong>Challenges</strong></th>
<th><strong>Strategies to Address Identified Challenges</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct community readiness assessment</td>
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<tr>
<td>Conduct agency readiness assessment</td>
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<tr>
<td>Review applicable State and local laws, regulations, and policies governing HIV testing and linkage</td>
<td>HIV prevention manager</td>
<td>January 2012</td>
<td>Ensuring identification of applicable State and local statutes, regulations, and policies</td>
<td>Consult with Center City Health Department (CCHD) to identify and interpret applicable statutes, regulations</td>
<td></td>
</tr>
<tr>
<td>Identify partner agencies that may refer clients to the testing program or provide medical and social services to tested clients</td>
<td>HIV testing coordinator</td>
<td>June 2012</td>
<td>Gaps in knowledge of and relationships with potential partners</td>
<td>Community advisory board and planning coalition members to assist with identification of and introduction to potential partners</td>
<td></td>
</tr>
<tr>
<td>Obtain input from representatives of the target population in development of plans for implementing HIV testing and linkage services</td>
<td>HIV prevention manager</td>
<td>April 2012</td>
<td>Identifying and engaging gatekeepers</td>
<td>Community advisory board chair and members to assist</td>
<td></td>
</tr>
</tbody>
</table>
| Develop staffing and supervision plan | • HIV prevention manager  
| | • Volunteer coordinator | April 30, 2012 | None identified | Not applicable |

*Existing programs may note the date that the activity was completed or last updated. New programs should leave this column blank.*
### Tool 1. Part I: HIV Testing and Linkage Program Planning (continued)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Last Update*</th>
<th>Responsible Individual/Position</th>
<th>Timeline for Completion</th>
<th>Challenges</th>
<th>Strategies to Address Identified Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Implementation Planning—General (continued)</strong></td>
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<td></td>
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</tr>
<tr>
<td>Hire staff in accordance with staffing and supervision plan</td>
<td></td>
<td>HIV prevention manager</td>
<td>June 30, 2012</td>
<td>• Identifying qualified candidates • Hiring HIV testing coordinator prior to other HIV testing and linkage staff to assist with program implementation planning</td>
<td>Community advisory board and planning coalition members to assist with recruitment</td>
</tr>
<tr>
<td>Develop agency policies for HIV testing and linkage services</td>
<td>HIV prevention manager</td>
<td>May 31, 2012</td>
<td>Identifying sample policies</td>
<td>HIV testing coordinator to consult with CCHD and planning coalition members for sample policies</td>
<td></td>
</tr>
<tr>
<td><strong>Client Targeting and Recruitment</strong></td>
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<tr>
<td>Conduct formative evaluation**</td>
<td>HIV prevention manager</td>
<td>January to March 2012</td>
<td>Expertise and resources to collect and analyze data</td>
<td>• Collaborate with City Center University Social Science Department • In consultation with the City Center planning group, identify and use existing sources of data when possible</td>
<td></td>
</tr>
</tbody>
</table>

**Refer to the section titled Formative Evaluation and Implementation Planning (including Tool 2) in Chapter 2 for additional information on formative evaluation activities.**
### Tool 1. Part I: HIV Testing and Linkage Program Planning (continued)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Last Update*</th>
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<th>Timeline for Completion</th>
<th>Challenges</th>
<th>Strategies to Address Identified Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client Targeting and Recruitment (continued)</strong></td>
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</tbody>
</table>
| • Define the target population and select a targeting strategy|              | HIV prevention manager           | April 2012              | Identifying evidence-based strategies| • HIV testing coordinator will research potential strategies that match with needs identified through formative evaluation  
• Obtain assistance from Center City University Social Science Department (graduate intern) |
| • Select a recruitment strategy                               |              | HIV testing coordinator          |                         |                                     |                                                                                                   |
| Identify recruitment venues                                  |              | HIV testing coordinator          | July 2012               | Gaps in knowledge of appropriate venues | Community advisory board and planning coalition members to assist with identifying venues for recruitment |
| Execute MOA with recruitment partners                         |              | Executive director               | August 2012             | Ensuring recruitment partners will provide data needed for program M&E | Planning coalition members and agency board of directors to assist in negotiating MOA |
| Obtain incentives                                             |              | HIV testing coordinator          | September 2012          | Identifying appropriate incentives with resource limitations | Board of directors will seek donations from local businesses |
| **Testing**                                                   |              |                                 |                         |                                     |                                                                                                   |
| Select HIV tests that will be offered                         |              | HIV testing coordinator          |                         | Ensuring the test is the most sensitive and cost efficient | • Research the most sensitive tests available in one’s jurisdiction  
• Conduct a cost analysis on the tests to offer |
### Tool 1. Part I: HIV Testing and Linkage Program Planning (continued)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Last Update*</th>
<th>Responsible Individual/Position</th>
<th>Timeline for Completion</th>
<th>Challenges</th>
<th>Strategies to Address Identified Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services for HIV-Positive Clients</strong></td>
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<td></td>
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<tr>
<td>• Identify providers of risk reduction and medical and social services of value to clients with positive tests</td>
<td></td>
<td>HIV testing coordinator</td>
<td></td>
<td>• Lack of linkage to care specialists</td>
<td>• Cross train staff to be able to do linkage to care and triaging to other prevention services</td>
</tr>
<tr>
<td>• Decide if will provide these onsite or through external agencies, and if the later, by linkage, referral, or both</td>
<td></td>
<td></td>
<td></td>
<td>• Use evidence-based strategies to coordinate linkage</td>
<td>• Research evidence-based strategies to coordinate linkage</td>
</tr>
<tr>
<td>Execute MOA with health departments for partner services</td>
<td></td>
<td>Executive director</td>
<td></td>
<td>Ensuring confidentiality when passing on client information for partner services</td>
<td>Adhere to privacy and confidentiality laws</td>
</tr>
</tbody>
</table>

| **Services for HIV-Negative Clients** | | | | | |
| Develop a tool to classify clients with negative tests as having elevated risk that can be used to triage these clients to more intensive risk-reduction services | | HIV prevention manager | | Identify tools and resources to adequately categorize and facilitate this process | Research potential tools |
| Decide whether risk-reduction interventions will be provided onsite or through linkage or referral | | HIV testing coordinator HIV prevention manager | | Adequate and competent staff capacity to provide interventions onsite | Develop partnerships with organizations in the community that can help support risk reduction interventions |
### Tool 1. Part I: HIV Testing and Linkage Program Planning (continued)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Last Update*</th>
<th>Responsible Individual/Position</th>
<th>Timeline for Completion</th>
<th>Challenges</th>
<th>Strategies to Address Identified Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Training</strong></td>
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</tbody>
</table>
| Develop written targeting, recruitment, testing, and services for HIV-positive clients and services for HIV-negative clients procedures | | HIV testing coordinator | September 2012 | No existing procedures | • HIV prevention manager will provide assistance in development  
• HIV testing coordinator will research existing procedures that can be adapted |
| Develop (or identify and obtain) marketing materials | | HIV testing coordinator  
Community advisory board | September 2012 | None identified | Not applicable |
| **Training (continued)** | | | | | |
| Train staff on targeting, recruitment, testing and services after testing strategies (e.g., SNS) | | HIV testing coordinator | October 15, 2012 | Two HIV testing and linkage staff members have been waitlisted for the Social Network Strategies (SNS) training | Contact CCHD to identify next training opportunity or alternative strategy for training staff |
| Orient/train staff on targeting, recruitment, testing, services for HIV positives and services for HIV-negative client procedures | | HIV testing coordinator and volunteer coordinator | October 31, 2012 | None identified | Not applicable |
| Train/certify staff as required by statute, regulation, or policy | | HIV testing coordinator | July 2012 | Staff providing HIV testing and linkage staff must complete CCHD’s HIV Basics course and two staff have been waitlisted until December 2012 | Contact Center City HD to explore and negotiate alternative strategy for meeting this requirement |
Instructions for Completing Tool 1. Part II: HIV Testing and Linkage Capacity Assessment

**What is the purpose of this tool?** Tool 1, Part II can be used to assess your capacity to implement an HIV testing and linkage program.

**Who should complete this tool?** Program managers can complete this tool, in collaboration with HIV testing and linkage staff, consumer advisory board members, and others involved in planning, implementation, and evaluation of your program.

**When should this tool be completed?** This tool should be completed before you implement services. It can also be used to assist and document ongoing program assessment and to plan for program enhancements if you have already implemented services.

**How should this tool be completed?** The left column presents the domains of readiness associated with implementing HIV testing and linkage programs. For each of the major program areas included in Part II (e.g., recruitment, testing), there is some overlap in the kinds of activities that must be completed (e.g., development of implementation procedures). These activities are grouped together in Part II and are often developed at the same time.

For each domain of readiness listed, record the following information in the designated column:

- **Complete:** Check the corresponding box if the activities associated with this domain have been completed (or have been updated, if completed by an established program). Leave this box blank if the activities associated with the domain have not been completed or updated.
- **Timeline for Completion:** If the activities have not been completed or updated, enter the date by which the activities associated with the domain must be completed.
- **Strategies to Address Gaps in Capacity:** Summarize the strategies that you will use to address identified gaps. If you are planning a new HIV testing and linkage program, it is recommended that you do not begin providing services to clients until you have full capacity to implement HIV testing and linkage services (i.e., all of the boxes on Part II are checked as complete, and all identified gaps in capacity have been addressed).

Tool 1, Part II has been partially completed to illustrate how it may look after completion. The example reflects how an agency just beginning an HIV testing and linkage program would use the tool.
Tool 1. Part II: HIV Testing and Linkage Capacity Assessment

<table>
<thead>
<tr>
<th>Agency/Program:</th>
<th>ACME Prevention Services, Center Point Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Population:</td>
<td>White and African American IDUs over 30 years of age living in North Center City</td>
</tr>
<tr>
<td>Date Completed:</td>
<td>September 21, 2012</td>
</tr>
</tbody>
</table>

Participants:
- ACME executive director
- ACME HIV prevention manager
- ACME HIV testing and linkage coordinator
- ACME volunteer coordinator
- ACME board chair
- ACME community advisory board chair

<table>
<thead>
<tr>
<th>Domains of Readiness</th>
<th>Complete</th>
<th>Timeline for Completion</th>
<th>Strategies to Address Gaps in Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community readiness assessment</td>
<td>☒</td>
<td></td>
<td></td>
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<tr>
<td>Agency readiness assessment</td>
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<tr>
<td>Formative evaluation</td>
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<tr>
<td>Agency policies</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing plans</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruitment/hiring of staff</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Implementation strategies selected:
- Population targeting
- Client recruitment
- Testing (field—initial test)
- Testing (laboratory for any supplemental testing)
- Linkage to care for HIV-positive clients
- Basic needs assessment for HIV-positive clients
- Partner services for HIV-positive clients
- Triaging HIV-negative clients into highest risk and low/medium risk
## Tool 1. Part II: HIV Testing and Linkage Capacity Assessment (continued)

<table>
<thead>
<tr>
<th>Implementation strategies selected (continued):</th>
<th>Complete</th>
<th>Timeline for Completion</th>
<th>Strategies to Address Gaps in Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Condoms and basic prevention information for low-risk clients</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Prevention needs assessment for highest-risk clients</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Risk reduction interventions for highest-risk clients</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MOA established with partners for the following:**

| a. Population targeting | ☒ | | |
| b. Client recruitment | ☒ | | |
| c. Testing (field – initial test) | ☒ | | |
| d. Testing (laboratory for any supplemental testing) | ☒ | October 31, 2012 | Center City HD public health laboratory does not offer RNA testing. ACME’s executive director and board chair are negotiating the contract with Center City Hospital to process specimens for clients with possible acute infection. |
| e. Linkage to care for HIV-positive clients | ☐ | November 15, 2012 | ACME’s executive director and board chair are negotiating an MOA with Center City Community Clinic to accept referrals for care of clients dually infected with HIV and HCV and for clients co-infected with HCV. |
| f. Basic needs assessment for HIV-positive clients | ☒ | | |
| g. Partner services for HIV-positive clients | ☒ | | |
| h. Triaging HIV-negative clients into highest risk and low/medium risk | ☒ | | |
| i. Condoms and basic prevention information for low-risk clients | ☒ | | |
| j. Prevention needs assessment for highest-risk clients | ☒ | | |
| k. Risk-reduction interventions for highest-risk clients | ☒ | | |
### Tool 1. Part II: HIV Testing and Linkage Capacity Assessment (continued)

<table>
<thead>
<tr>
<th>Domains of Readiness</th>
<th>Complete</th>
<th>Timeline for Completion</th>
<th>Strategies to Address Gaps in Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Written policies and procedures developed for the following:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Population targeting</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Client recruitment</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Testing (field—initial test)</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Testing (laboratory for any supplemental testing)</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Linkage to care for HIV-positive clients</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Basic needs assessment for HIV-positive clients</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Partner services for HIV-positive clients</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Triage process to classify clients with negative clients into those with and without elevated risk of HIV acquisition</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Condoms and basic prevention information for low-risk clients</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Prevention needs assessment for highest-risk clients</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Risk-reduction interventions for highest-risk clients</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Written quality assurance plan developed</strong></td>
<td>☒</td>
<td></td>
<td></td>
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<tr>
<td><strong>Monitoring and evaluation plans developed</strong></td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staff trained/certified to implement:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Population targeting</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Client recruitment</td>
<td>☒</td>
<td>December 15, 2012</td>
<td>Two HIV staff members were waitlisted for the Social Networks Strategy training. CCHD has confirmed that staff are registered for the December training. Until they have completed this training, they will be unable to conduct recruitment activities. Staffing plans and recruitment schedules will be temporarily adjusted.</td>
</tr>
<tr>
<td>c. Testing (field—initial test)</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Tool 1. Part II: HIV Testing and Linkage Capacity Assessment (continued)

<table>
<thead>
<tr>
<th>Domains of Readiness</th>
<th>Complete</th>
<th>Timeline for Completion</th>
<th>Strategies to Address Gaps in Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff trained/certified to implement: (continued)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Testing (laboratory for any supplemental testing)</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Linkage to care for HIV-positive clients</td>
<td>☒</td>
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<td>g. Partner services for HIV-positive clients</td>
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<td>h. Triaging HIV-negative clients into highest risk and low/medium risk</td>
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<td>j. Prevention needs assessment for highest-risk clients</td>
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<td></td>
</tr>
<tr>
<td>k. Risk-reduction interventions for highest-risk clients</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Quality assurance plans and activities</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. M&amp;E plans and activities</td>
<td>☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Other training/certifications required by State or local statute, regulation, or policy</td>
<td>☐</td>
<td>October 11, 2012</td>
<td>Two staff were not able to attend the scheduled July 2012 HIV Basics training. The Center City HD will conduct an in-service training for ACME staff on October 11, 2012.</td>
</tr>
</tbody>
</table>

**Risk-reduction materials secured** ☒

**Client educational materials secured** ☒
Formative Evaluation and Implementation Planning

Before implementing an HIV testing and linkage program, or making modifications to an established program, consider conducting a systematic planning process (see flowchart and Chapter 2, Figure 2.1 for additional discussion about implementation planning). A key part of your planning process is conducting formative evaluation. Through formative evaluation you will explore the need in your community for testing and linkage services and more importantly, identify the strategies needed to target and recruit clients into HIV testing. Continual evaluation of a program’s targeting and recruitment strategy through thorough formative evaluation is a key to successfully accessing your target population for HIV testing and related services. Formative evaluation will help you to decide the following:

- Are the program strategies effective and feasible? Specifically:
  - Targeting, recruitment, and engagement strategies, (i.e., which messages, strategies, and tools will be most successful in engaging the target populations in HIV testing)
  - Selecting the most appropriate HIV testing strategies and technologies based on programmatic and client needs
  - Appropriate linkage and referral strategies for clients with HIV-positive tests
  - Appropriate services for clients with HIV-negative tests based on their individual risk factors

In the context of established HIV testing and linkage programs, formative evaluation can provide information needed to adjust the program to respond to changes in the community, target population(s), and technology.

Good formative evaluation uses mixed methods to collect data. Methods include focus groups, individual interviews with gatekeepers and other community members, ethnographic information, surveys, and review of existing information. You and/or your partner agencies may collect some data expressly for the purpose of planning your program. Other data could be collected by other entities for other purposes but useful to you in planning your program.

Information provided by your staff, volunteers, and partners who serve and/or represent the target population(s), even if not collected systematically (i.e., anecdotal information), can be useful to you in program planning and refinement and may be included in your formative evaluation. It is important to note, however, that anecdotal information should not be the only or the primary source of data that you use to plan implementation of, or adjustments to, your program. If multiple sources of data support a specific finding (e.g., the target population will be unlikely to return to the agency for a second visit to receive HIV test results), you can have greater confidence that the program strategies that you select are the best ones to meet the needs of the target population.

You can obtain additional information and guidance about data sources, including the strengths and weaknesses of each, and guidance for selecting data collection methods.
in Chapter 3 of the Evaluation Guide, Step 4: Gather Credible Evidence (look particularly at the subsection titled Solidifying a Data Collection Plan).

Tool 2 is designed as a guide and a tool for documenting your formative evaluation efforts and findings. Tool 2 is also designed as a guide and a tool for helping you to apply the findings of your formative evaluation to select the most appropriate strategies, messages, and tools for your HIV testing and linkage program.

Tools and Templates: Tool 2—Formative Evaluation and Implementation Planning

The tool that follows can assist you in conducting formative evaluation and applying the findings of your formative evaluation activities to planning your program.

Tool 2. Formative Evaluation and Implementation Planning

About Tool 2: Complete Tool 2 for each of your target population(s). Tool 2 is divided into two parts. Part I: Organizing Your Formative Evaluation Data is intended to provide a guide for the kinds of questions that your formative evaluation efforts should try to answer. It is not intended as a guide on the types of methods you should use or the specific questions that you should include in focus group scripts, interview guides, or survey questionnaires. Before you begin to use this tool, you will need to gather all of the data that you intend to use to plan your program. Part I is also a tool for you to use in compiling and summarizing your data.

Part II: Interpreting and Applying Findings of Your Formative Evaluation is intended to help you and your staff to interpret the data you have compiled for your formative evaluation and apply it to your program plan, including selection of strategies for recruitment, testing, and linkage. It will also help you to identify gaps in your knowledge about the target population and community resources to serve this population. Part II is designed to be completed after Part I. Compile and summarize your data before you begin to process it and decide how to apply it to program planning.

This tool may be completed in conjunction with discussion with staff members who provide HIV testing and linkage services, as well as others, such as community advisory board members or members of your board of directors. Multiple perspectives will result in richer discussion, a deeper understanding of program planning issues and program operations, as well as better ideas and strategies to ensure a successful program. For more information on working with key stakeholders, please refer to Chapter 3, Step 1 in the Evaluation Guide.

How New Programs Can Use This Tool: This tool is designed to assist you in planning your HIV testing and linkage program by providing you with guidance on the kinds of information that you may find useful to collect through your formative evaluation. It will also help you to organize and interpret your data. Working through this tool will help you to plan a program that uses strategies, messages, and tools that are
best suited to meet the needs of your target population(s) and which will successfully engage members of the target population services.

**How Established Programs Can Use This Tool**: If you have already implemented an HIV testing and linkage program, you can use this tool to help you plan for modifications or enhancements to existing services. Conduct formative evaluation if program M&E efforts (see Chapter 2, Tool 1 for additional information about program M&E) suggest that the strategies, messages, or tools you are currently using may not be as successful or well-suited to the target population as they were previously. In addition, before implementing specific changes, such as introducing a new HIV testing technology or adopting a new linkage strategy, you need to understand the extent to which the proposed modification or enhancement is responsive to the needs of your target population(s). Established programs may wish to complete only those sections of the tool relevant to the part of the program for which adjustment or enhancement is being considered, such as where services should be provided.

**How Health Departments and Other Funders Can Use This Tool**: HDs and other funders may find this tool helpful for use with local grantees or contractors. You could use this tool in providing technical assistance to agencies that are just beginning a new program, or agencies that seem to be struggling with program implementation. Some HDs or other funders may wish to have grantees or contractors complete this tool at the beginning of a project (e.g., as a component of a funding proposal) or when they are proposing expanding services to a new target population or adopting new strategies or technologies. HDs or other funders may also wish to adapt this tool for use with other interventions or services.
Instructions for Completing Tool 2. Part I: Organizing Your Formative Evaluation Data

What is the purpose of this tool? Tool 2, Part I is a tool for you to use in framing your formative evaluation and in compiling and summarizing data.

Who should complete this tool? HIV testing and linkage program managers can complete this tool, in collaboration with staff and/or volunteers, consumer advisory board members, and others involved in planning, implementation, and evaluation of your testing and linkage program.

When should this tool be completed? Before you implement services. It can also be used prior to implementing adjustments or enhancements to established programs.

How should this tool be completed? Conduct formative evaluation for each target population you intend to or are serving. You may also want or need to complete formative evaluation for individual programs or funding sources. In the top portion of Tool 2, Part I, record the following information in the designated cells:

- **Agency/Program:** Record the name of the agency and/or program completing this tool.
- **Target Population:** Record the target population for which this tool is to be completed.
- **Date Completed:** Record the date that the tool was completed or updated, as applicable.
- **Participants:** Record the names and/or positions/roles of the individuals participating in completing this tool.

The left column presents evaluation questions related to the kinds of information that you will need to gather in order to plan your HIV testing and linkage program and to help you identify the best strategies for recruitment, testing, and linkage. It is best to use multiple sources of data, including anecdotal sources, to fully answer these questions.

For each evaluation question listed, record the following information in the designated column:

- **Answer to Evaluation Question:** Record a brief summary of available data corresponding to the evaluation question.
- **Information Source and Date of Collection/Publication:** Record the source of the data. This will help you to refer back to the source if more information is needed. Record the date of collection/publication associated with each data source. This will help you to know whether the data is current.

Tool 2, Part I has been completed for you to illustrate how it may look after completion.
### Tool 2. Part I: Organizing Your Formative Evaluation Data

<table>
<thead>
<tr>
<th>Agency/Program: ACME Prevention Services, Center Point Program</th>
<th>Participants:</th>
</tr>
</thead>
</table>
| **Target Population:** White and African American IDUs over 30 years of age living in North Center City | • ACME Prevention Services program director  
• Center Point program coordinator  
• Center Point outreach coordinator  
• Center Point consumer advisory board chair  
• ACME Prevention community coalition chair  
• Center City planning group co-chairs  
• Center City University ethnographers |
| **Date Completed:** May 15, 2012 |

#### Formative Evaluation Questions

<table>
<thead>
<tr>
<th>Formative Evaluation Questions</th>
<th>Answer to Evaluation Question</th>
<th>Information Source and Date of Collection/Report</th>
</tr>
</thead>
</table>
| **Where does the target population live?** | • Abandoned homes in Riverside neighborhood  
• Center City Shelter | • Ethnographic mapping (Center City University Report, August 2011)  
• PS data (Center City HD, October 2011 to March 2012)  
• Outreach staff (Staff meeting minutes, October 2011)  
• Planning coalition members (Coalition meetings minutes, July and September 2011) |
| **Where does the target population socialize?** | Center City Shelter | • Ethnographic mapping (Center City University Report, August 2011)  
• PS data (Center City HD, October 2011 to March 2012)  
• Outreach staff (Staff meeting minutes, October 2011)  
• Planning coalition members (Coalition meetings minutes, July and September 2011) |
| **Where does the target population meet sex partners?** | • Abandoned homes in Riverside neighborhood  
• Riverside Park—especially the old band shell | • PS data (Center City HD, October 2011 to March 2012)  
• Outreach staff (Staff meeting minutes, October 2011)  
• Planning coalition members (Coalition meetings minutes, July and September 2011) |
| **Where does the target population use/share drugs?** | Abandoned homes in Riverside neighborhood | • Ethnographic mapping (Center City University Report, August 2011)  
• Outreach staff (Staff meeting minutes, October 2011)  
• Planning coalition members (Coalition meetings minutes, July and September 2011) |
### Tool 2. Part I: Organizing Your Formative Evaluation Data (continued)

<table>
<thead>
<tr>
<th>Formative Evaluation Questions</th>
<th>Answer to Evaluation Question</th>
<th>Information Source and Date of Collection/Report</th>
</tr>
</thead>
</table>
| Where does the target population get health and dental care?                                   | Center City Hospital emergency room Visiting Nurse mobile outreach ACME syringe services program (SSP) | • Interviews with IDUs in Center City conducted by the HIV planning group (HPG) and Center City University (Report produced by the HPG April 2011)  
• Behavioral Surveillance conducted by State HD (Report, December 2010)  
• Planning coalition members (Coalition meeting minutes, January 2011) |
| Where does the target population get health and dental information?                            | • ACME SSP  
• Friends                                                                                   | • Interviews with IDUs in Center City conducted by the CPG and Center City University (Report produced by the HPPG, April 2011)  
• Planning coalition members (Coalition meeting minutes, January 2011) |
| Who/what does the target population trust for its health information? Why?                     | • Visiting Nurse—nurses are “non-judgmental” and “really care”; provide hygiene kits, socks, blankets, bottled water  
• SSP outreach workers—“they’ve been where we’re at”                                         | • Interviews with IDUs in Center City conducted by the CPG and Center City University (Report produced by the CPG, April 2011)  
• Behavioral Surveillance conducted by State HD (Report, December 2010)  
• Brief interviews with exchangers at ACME SSP (Report, November 2011) |
| What issues or factors are barriers to HIV testing for the target population? Why?            | • HIV is not a health priority; HCV and dental care are priorities  
• Experience with providers “pushing” drug treatment is a deterrent  
• “Judgmental” providers  
• Difficult to get to testing site  
• Too hard to return for results, and the wait is too long  
• Active users do not believe they are eligible for care services  
• Target population believes treatment is too expensive                                         | • Focus group of IDUs (Center City Recovery Alliance, Report, June 2011)  
• Behavioral Surveillance conducted by State HD (Report, December 2010)  
• Brief interviews with exchangers at ACME SSP (Report, November 2011) |
### Tool 2. Part I: Organizing Your Formative Evaluation Data (continued)

<table>
<thead>
<tr>
<th>Formative Evaluation Questions</th>
<th>Answer to Evaluation Question</th>
<th>Information Source and Date of Collection/Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>What other kinds of health or preventive services interest the target population?</td>
<td>• HCV screening and treatment&lt;br&gt;• Dental care</td>
<td>• Brief interviews with exchangers at ACME SSP (Report, November 2011)&lt;br&gt;• Focus group of IDUs (Center City Recovery Alliance Report, June 2011)&lt;br&gt;• Interviews with IDUs in Center City conducted by the CPG and Center City University (Report produced by the HPPG, April 2011)&lt;br&gt;• Referral assessments conducted with ACME clients (Chart reviews: April to June 2011)</td>
</tr>
<tr>
<td>For HIV-positive individuals in the target population, what issues or factors are barriers to linkage to care?</td>
<td>• “Judgmental providers”&lt;br&gt;• HIV care not a priority&lt;br&gt;• Believe not eligible for care services (active users)&lt;br&gt;• Do not want to have to enter drug treatment&lt;br&gt;• Believe treatment too expensive&lt;br&gt;• Difficult to make/keep appointments (scheduling, transportation)</td>
<td>• Interviews with HIV-positive IDU patients at Center City Clinic (Presentation to ACME Board, January 2011)&lt;br&gt;• Focus group of IDUs (Center City Recovery Alliance Report, June 2011)</td>
</tr>
<tr>
<td>For HIV-positive individuals in the target population, what issues or factors are barriers to linkage to PS?</td>
<td>• Believe HD “doesn’t want to help me”&lt;br&gt;• Believe HD working is with law enforcement</td>
<td>• Interviews with HIV-positive IDU patients at Center City Clinic (Presentation to ACME Board, January 2011)&lt;br&gt;• Interviews with IDUs in Center City conducted by the CPG and Center City University (Report produced by the HPPG, April 2011)</td>
</tr>
<tr>
<td>For the target population, what issues or factors are barriers to linkage to risk-reduction services?</td>
<td>Lack of behavioral risk-reduction services (other than substance use disorder treatment) for active IDUs</td>
<td>ACME community resource inventory (Updated April 2012)</td>
</tr>
</tbody>
</table>
Instructions for Completing Tool 2. Part II: Interpreting and Applying Findings of Your Formative Evaluation

What is the purpose of this tool? Tool 2, Part II is designed as a guide and tool to help you to apply the findings of your formative evaluation in order to select the most appropriate strategies, messages, and tools for your HIV testing and linkage program.

Who should complete this tool? Program managers can complete this tool, in collaboration with testing and linkage staff and/or volunteers, consumer advisory board members, and others involved in planning, implementation, and evaluation of your program.

When should this tool be completed? This tool may be completed before you implement HIV testing and linkage services and/or prior to implementing adjustments or enhancements to established programs.

How should this tool be completed? In the top portion of Tool 2, Part II, record the following information in the designated cells:

- **Agency/Program:** Record the name of the agency and/or program completing this tool.
- **Target Population:** Record the target population for which this tool is to be completed.
- **Date Completed:** Record the date that the tool was completed or updated, as applicable.
- **Participants:** Record the names and/or positions/roles of the individuals participating in completing this tool.

Discussion questions are presented in the left column and are segmented by program component: recruitment, testing, and linkage. For each of the discussion questions, record the following information in the designated column:

- **Summary of Formative Evaluation Questions:** Record a summary of the findings of your formative evaluation (as recorded in the Answer column in Part 1. This will help you to draw conclusions about which strategies are appropriate for the target population.
- **Strategies, Gaps, and Next Steps:** Brainstorm about the strategies and practices that could best address your findings and record them in this column. Include gaps in knowledge or resources for which you will need additional information, along with next steps to address these gaps.

Tool 2, Part II has been completed for you to illustrate how it may look when completed.
## Tool 2. Part II: Interpreting and Applying Findings of Your Formative Evaluation

<table>
<thead>
<tr>
<th>Agency/Program:</th>
<th>ACME Prevention Services, Center Point Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Population:</td>
<td>White and African American IDUs over 30 years of age living in North Center City</td>
</tr>
<tr>
<td>Date Completed:</td>
<td>June 5, 2012</td>
</tr>
</tbody>
</table>

### Participants:
- ACME prevention services program director
- Center Point program coordinator
- Center Point outreach coordinator
- Center Point outreach workers
- ACME SSP program coordinator
- Visiting Nurse HIV prevention coordinator
- Center City Hospital HIV clinic manager
- Center Point consumer advisory board chair

<table>
<thead>
<tr>
<th>Discussion Questions for Program Implementation</th>
<th>Summary of Formative Evaluation Findings</th>
<th>Strategies, Gaps, and Next Steps</th>
</tr>
</thead>
</table>
| **Targeting** | • Surveillance data can be limited to ZIP code level  
• Nontraditional data sources might be helpful in addition to surveillance data  
• Risk group defined by funding stream  
• Characteristics and behaviors of the target population define questions | • Collaborate with health departments to obtain prevalence and incidence data  
• Conduct formative research to identify areas where high risk people congregate  
• Nontraditional data sources are helpful in identifying areas where high-risk groups congregate  
• Define characteristics of the target population and develop questions to accompany them |
| • What data sources might be useful to identify areas of high prevalence?  
• Which risk groups should be targeted for testing?  
• Within jurisdictions, where do high-risk groups congregate?  
• How can you determine membership in a target population with a few questions?  
• What additional information is needed? | | |
### Tool 2. Part II: Interpreting and Applying Findings of Your Formative Evaluation (continued)

<table>
<thead>
<tr>
<th>Discussion Questions for Program Implementation</th>
<th>Summary of Formative Evaluation Findings</th>
<th>Strategies, Gaps, and Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment</td>
<td>Depending on the recruitment strategy, lots of staff time needed to locate members of target population, motivate, and engage into testing</td>
<td>- Venue-based recruitment at Center City Shelter and ACME SSP</td>
</tr>
<tr>
<td>- Where should we recruit and offer testing and linkage?</td>
<td>- There are practical barriers to HIV testing (appropriateness of location, hours offered, need for second visit for results)</td>
<td>- Outreach recruitment in Riverside neighborhood</td>
</tr>
<tr>
<td>- How should we recruit for HIV testing?</td>
<td>- HIV not a high priority for target population; HCV testing and dental services are priorities</td>
<td>- Bundle HIV testing with valued health services—partner with visiting nurse to provide outreach testing so HIV and HCV testing can be provided together</td>
</tr>
<tr>
<td>- What recruitment messages will be persuasive?</td>
<td>- HIV retesting can occur at higher rates when incentives are provided</td>
<td>- Recruitment messages should address misconceptions about treatment</td>
</tr>
<tr>
<td>- Who should do the recruiting?</td>
<td>- Depending on the recruitment strategy, lots of staff time needed to locate members of target population, motivate, and engage into testing</td>
<td>- Engage peers as recruiters</td>
</tr>
<tr>
<td>- What additional information is needed?</td>
<td>- Venue-based recruitment at Center City Shelter and ACME SSP</td>
<td>- Providing access to dental services in conjunction with HIV testing may encourage testing</td>
</tr>
<tr>
<td>- How many previously diagnosed positives are recruited for retesting?</td>
<td>- Venue-based recruitment at Center City Shelter and ACME SSP</td>
<td>- We need to find out if it possible/feasible to partner with CCHD on mobile van health service to arrange to provide dental care along with HIV and HCV testing</td>
</tr>
<tr>
<td>- How many previously diagnosed positives that may be encountered during testing efforts have fallen out of care?</td>
<td>- Venue-based recruitment at Center City Shelter and ACME SSP</td>
<td>- Evaluate recruitment strategy if many previously diagnosed HIV persons are retesting</td>
</tr>
<tr>
<td></td>
<td>- Venue-based recruitment at Center City Shelter and ACME SSP</td>
<td>- Reengage previously diagnosed patients to care</td>
</tr>
</tbody>
</table>
## Tool 2. Part II: Interpreting and Applying Findings of Your Formative Evaluation (continued)

<table>
<thead>
<tr>
<th>Discussion Questions for Program Implementation</th>
<th>Summary of Formative Evaluation Findings</th>
<th>Strategies, Gaps, and Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Testing</strong></td>
<td><strong>There are practical barriers to HIV testing (location/hours offered)</strong></td>
<td><strong>Use rapid HIV test</strong></td>
</tr>
<tr>
<td>• Which HIV testing strategy should we use?</td>
<td>• Other health and daily life issues are higher priority than HIV</td>
<td><strong>Venue-based HIV testing at Center City Shelter and ACME SSP</strong></td>
</tr>
<tr>
<td>• Where should HIV testing be provided?</td>
<td>• There are practical barriers to learning result</td>
<td><strong>Conduct outreach HIV testing in Riverside neighborhood</strong></td>
</tr>
<tr>
<td>• What kinds of things might motivate or interest our target population in HIV testing?</td>
<td>• Clinical providers in the community can provide supplemental testing</td>
<td><strong>Use incentives valued by the target population (e.g., blankets, hygiene kits)</strong></td>
</tr>
<tr>
<td>• Who will provide supplemental testing, if the program only offers rapid testing?</td>
<td>• Testing technologies can depend on resource availabilities</td>
<td><strong>Bundle HIV and HCV testing</strong></td>
</tr>
<tr>
<td>• Will the testing program provide blood-based or oral tests?</td>
<td></td>
<td><strong>Explore feasibility of providing HIV testing in conjunction with dental services</strong></td>
</tr>
<tr>
<td>• Does the testing program able to train staff to ask about recent HIV exposure?</td>
<td></td>
<td><strong>We need to find out whether the target population will accept a finger stick rapid test or must oral fluid be used?</strong></td>
</tr>
<tr>
<td>• Does the staff have capacity to evaluate recent infection?</td>
<td></td>
<td><strong>Partnerships need to be developed with clinical providers</strong></td>
</tr>
<tr>
<td>• What additional information is needed?</td>
<td></td>
<td><strong>Staff training on asking about recent exposure can be helpful to provide referrals to non-occupational post-exposure prophylaxis</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Screening for acute infection is useful in helping triage these patients to needed care and alerting health departments for partner services</strong></td>
</tr>
</tbody>
</table>
### Tool 2. Part II: Interpreting and Applying Findings of Your Formative Evaluation (continued)

<table>
<thead>
<tr>
<th>Services for HIV-Positive Clients</th>
<th>Discussion Questions for Program Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>What strategies and resources are required to link HIV-positive individuals in our target population to care?</td>
<td></td>
</tr>
<tr>
<td>What potential barriers are faced by HIV-positive individuals for linkage to care?</td>
<td></td>
</tr>
<tr>
<td>What kinds of practices or things might help HIV-positive individuals in our target population link partner services (PS)?</td>
<td></td>
</tr>
<tr>
<td>Can basic needs assessment be provided onsite following testing?</td>
<td></td>
</tr>
<tr>
<td>What kinds of practices or things might help HIV-positive clients link to risk-reduction services?</td>
<td></td>
</tr>
<tr>
<td>What additional information is needed?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Summary of Formative Evaluation Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target population has misconceptions about HIV treatment (cost, eligibility)</td>
</tr>
<tr>
<td>Practical barriers to HIV care (scheduling, transportation)</td>
</tr>
<tr>
<td>Trust peers for health information and services</td>
</tr>
<tr>
<td>Other health and daily life issues are higher priority than HIV</td>
</tr>
<tr>
<td>Mistrust of HD PS</td>
</tr>
<tr>
<td>Basic needs assessment can inform potential barriers that may prevent linkage to care efforts</td>
</tr>
<tr>
<td>No identified behavioral risk-reduction services for active IDUs available in the community</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies, Gaps, and Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral assessment and planning should address misconceptions about HIV treatment eligibility and cost</td>
</tr>
<tr>
<td>Use peer navigator to facilitate linkage to HIV medical care</td>
</tr>
<tr>
<td>Collaborate with Center City Community Hospital case management program to ensure clients have support to access a range of enabling services</td>
</tr>
<tr>
<td>Collaborate with Center City Community Hospital HIV clinic to identify resources and strategies to provide treatment for HIV-HCV co-infected clients</td>
</tr>
<tr>
<td>What community resources can effectively address the needs of clients with HCV infection, including co-infection?</td>
</tr>
<tr>
<td>Referral assessment and planning should address misconceptions about and value of PS</td>
</tr>
<tr>
<td>Partners will be elicited by peer navigator and referred to the HD</td>
</tr>
<tr>
<td>We need to explore whether it is feasible to provide community-based PS through collaboration with Center City HD</td>
</tr>
<tr>
<td>Basic assessment of needs should address potential barriers to linkage to care or adherence to care</td>
</tr>
<tr>
<td>We must evaluate whether CRCS staff currently have the knowledge and skills necessary to be effective in delivering risk-reduction interventions</td>
</tr>
<tr>
<td>Logan Community Services (LCS) in a neighboring city offers holistic Health Recovery Program; we must determine whether it is feasible to collaborate with LCS to have them provide services to our clients</td>
</tr>
</tbody>
</table>
### Tool 2. Part II: Interpreting and Applying Findings of Your Formative Evaluation (continued)

<table>
<thead>
<tr>
<th>Services for HIV-Negative Clients</th>
<th>Summary of Formative Evaluation Findings</th>
<th>Strategies, Gaps, and Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What strategies can be used to triage the highest-risk persons to prevention services?</td>
<td>• Characteristics of the target population can define whether client is high risk or low/medium risk, if not determined during the targeting phase</td>
<td>• Provide risk-reduction counseling to IDU clients at elevated risk for HIV</td>
</tr>
<tr>
<td>• What kinds of practices or things might help HIV-positive clients link to risk-reduction services?</td>
<td>• No identified behavioral risk-reduction services for active IDUs available in the community</td>
<td>• Assess resources in the program and community that are available, if the client needs to be referred for prevention services</td>
</tr>
<tr>
<td>• What kinds of practices or tools are available to conduct a prevention needs assessment for the highest-risk clients?</td>
<td>• Prevention needs assessment tool can be dependent on the client characteristics and services available in the community</td>
<td>• Factors and behaviors related to HIV acquisition risk should be evaluated during the prevention needs assessment</td>
</tr>
<tr>
<td>• Are there prevention messages or tools available for low-risk clients?</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>• What additional information is needed?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Discussion Questions for Program Implementation**

- What strategies can be used to triage the highest-risk persons to prevention services?
- What kinds of practices or things might help HIV-positive clients link to risk-reduction services?
- What kinds of practices or tools are available to conduct a prevention needs assessment for the highest-risk clients?
- Are there prevention messages or tools available for low-risk clients?
- What additional information is needed?
Practice Example 2.1.
Applying Findings of Formative Evaluation to Program Implementation Planning

The example in Tool 2, Part II, ACME Prevention Services (APS) used formative evaluation to determine which strategies would help them to implement an effective HIV testing and linkage program for their target population, IDUs over the age of 30 years. Tool 2 helped APS organize and apply the findings of their formative evaluation to program planning.

Recruitment and testing will be conducted in the following locations: Center City Shelter, the ACME syringe services program, and through outreach in the Riverside neighborhood. Peers will perform recruitment and recruitment messages will highlight the availability of free HIV care.

APS will partner with the Visiting Nurse Program to provide services in the Riverside neighborhood. APS will use rapid HIV testing. Through targeted interviews with SSP clients, they learned that blood samples obtained through a fingerstick were not a deterrent to testing, and so they will use this method. To encourage testing, they will distribute blankets, hygiene kits, and bottled water. Through partnership with the Visiting Nurse Program, they will be able to offer both HIV and HCV testing through outreach activities.

APS has received training from the CCHD on conducting partner elicitation. They have entered into an MOA with CCHD that ensures that the HD will allow APS 5 business days to elicit and forward to CCHD partner information. After 5 days, if CCHD has not received partner information, PS staff will contact the client.

Referral assessment procedures have been revised to ensure that clients receive information about the availability of HIV medical care, which is free of charge. Peer navigators provide information and support to HIV-positive clients to ensure that clients successfully link with HIV medical care. APS has entered into an MOA with the Center City Community Hospital. This agreement gives APS clients priority for HIV medical care (including same-day appointments), as well as priority for enrollment case management services.

APS CRCS staff has received training to increase their knowledge and skills for working with the target population and will provide risk-reduction counseling to high-risk HIV-negative clients onsite. LCS is interested and willing to provide Holistic Health Recovery Program for APS clients. The two agencies are collaborating in seeking resources to enable this programming.
CHAPTER 3 AT A GLANCE

This chapter addresses targeting HIV testing and linkage services to high-risk populations and recruiting members of these populations into your program. In this chapter we will discuss the following:

- The value of conducting highly targeted HIV testing and linkage services
- The kinds of data that can be used to improve targeting, and where to obtain these data
- Recruitment strategies, including how to select the best strategy for your program
- Incentives for recruitment, including the advantages and disadvantages
- Quality assurance of recruitment activities, including training and assessing staff proficiency
- Monitoring and evaluation of recruitment activities

The tools and examples provided in this chapter will help you to do the following:

- Apply data to decisions about targeting
- Select and implement recruitment strategies
- Monitor the success of your recruitment efforts

What Is Targeting?

Targeting is the practice of directing HIV testing and linkage services to high-risk populations and settings in which high-risk persons can be accessed, with the purpose of ensuring that services are offered to persons who need them (at the place of recruitment or an affiliated nonclinical venue). As an HIV testing and linkage provider, you may find it useful to employ local information and data to identify individuals at highest risk for HIV infection and tailor services to ensure that they are acceptable and accessible to them.

In providing HIV testing in non-clinical settings, it is important to target high-risk individuals who do not access health care services or who otherwise may not have access to HIV testing in clinical settings. This is done by narrowing the focus around specific subsets of a population and tailor programs to provide services that have been proven effective with high-risk populations.
It is important to continually refine your targeting practices and recruit individuals at highest risk for HIV infection. Formative evaluations can provide valuable information refining targeting and recruitment strategies (See Chapter 2 for more details). Continual assessments of these strategies will ensure that your programming has the greatest impact possible and does so with maximum efficiency.

This chapter discusses and provides examples of different data sources useful for targeting, and strategies to help you determine which source(s) will work best for you and for your target populations. It also includes examples of successful targeting practices and suggestions for fine-tuning targeting to better inform recruitment.

**Use of Data in Targeting**

When defining and determining how to most effectively access a target population, it is important to use a variety of data sources. Your agency may find it useful to consider data such as the percentage of individuals infected, the rate of new infections, as well as the profile of risk behaviors present within the community. Typically agencies will rely on State-, city-, and/or county-level disease surveillance data to narrow the scope of their targeting. To gain a more nuanced understanding of where infections are occurring and the behaviors implicated in driving infection, you may want to obtain other sources of data, such as substance abuse treatment admissions or law enforcement data to help identify neighborhood- and street-level profiles of high-risk behaviors, such as sex work or injection drug use. Examples of sources you may use for targeting and recruitment planning are presented in Exhibit 3.1.

**Exhibit 3.1. Sources of Data for Targeting and Recruitment**

<table>
<thead>
<tr>
<th>Characteristic/Factors</th>
<th>Examples</th>
<th>Where to Get Information/Data</th>
</tr>
</thead>
</table>
| Epidemiological        | • HIV prevalence  
                         • Sexually transmitted disease (STD) prevalence  
                         • HIV incidence  | • Disease surveillance data (e.g., HIV, STD, tuberculosis [TB] case registries) (e.g., [CDC’s State and local surveillance reports])  
                            • Serologic Testing Algorithm for Recent HIV Seroconversion HIV incidence reporting  
                            • State/local epidemiologic profiles  
                            • HIV prevention service data  
                            • Medical modeling project  
                            • Substance abuse admissions and treatment |
| Geographic             | • Particular counties in a state  
                         • Particular ZIP codes in a county  
                         • Particular neighborhoods of a city  
                         • Particular venues in a city  | • Geographical information systems (GISs) (e.g., CDC’s [ATLAS](https://www.cdc.gov/atsl) and [AIDSVu](https://www.aidsvu.org))  
                            • Police data  
                            • Disease surveillance data  
                            • State and local health department surveillance data |
### Exhibit 3.1. Sources of Data for Targeting and Recruitment (continued)

<table>
<thead>
<tr>
<th>Characteristic(s)/Factors</th>
<th>Examples</th>
<th>Where to Get Information/Data</th>
</tr>
</thead>
</table>
| Behavioral                | • Sexual behaviors  
• Use of risk-reduction strategies  
• Injection drug use | • Youth Risk Behavior Surveillance System  
• National HIV Behavioral Surveillance  
• Behavioral Risk Factor Surveillance System  
• Community assessments  
• Law enforcement data  
• Substance abuse treatment data  
• Emergency room admissions data  
• Disease surveillance data  
• Members of target population, other stakeholders |
| Social                     | • Social networks  
• Sexual mixing across social groups | • Focus groups  
• Key informant interviews  
• Surveys  
• Cluster analysis of STD data  
• Disease surveillance data  
• Members of target population, other stakeholders |
| Contextual                 | • Poverty  
• Access to care systems  
• Educational attainment  
• Housing stability | • Model-based Small Area Income and Poverty Estimates for school districts, counties, and States  
• Census  
• County and city data  
• National Center for Education Statistics  
• Data from local service providers (homeless shelters, drug treatment sites, etc.)  
• Members of target population, other stakeholders |
| Demographic                | • Gender  
• Age  
• Race  
• Ethnicity  
• Sexual orientation | • Disease surveillance data  
• HIV prevention service data  
• Census  
• State/local correctional system data |

For more information on how to define, locate, and engage high-risk populations, please see the *Public Health Workbook to Define, Locate and Reach Special, Vulnerable, and At-Risk Populations in an Emergency*.

Evaluate each source of data for relevance to your program, as well as the strengths and limitations of each data source. Please reference Chapter 3, Step 4 of the Evaluation Guide (Gather Credible Evidence) for more information about selecting and evaluating data. Some data sources, such as data collected by disease intervention specialists (DIS), may help you to identify networks of partners around individual cases of infection. This method of recruitment, also known as social networking strategy, is effective when HIV transmission is fueled by transmission between friends, acquaintances and colleagues, but may be less effective when transmission is fueled by contact between anonymous, transient, or hard-to-locate persons such as some commercial sex worker, transient MSM, migrants, and immigrants.

Your target population, staff, and other service providers are also an important source of information for you. Members of the target population can help you segment your target
population, thereby increasing the effectiveness of your targeting and informing the selection of recruitment strategies. For example, if you are planning to target men who have sex with men (MSM), try to gain an understanding of subpopulations (e.g., ball or bear communities), as this will help you to select the best recruitment strategies to reach your target population(s). Staff as well as other service providers typically have deep knowledge of a community and may also be able to provide you with needed data.

Other sources, such as data from local service providers, can help to uncover the most appropriate venues and locations for outreach testing. It is important to seek data sources that can also assist you in identifying acute infections, as this is the stage at which individuals are most infectious. If disease surveillance data are not available quickly enough to effectively target local cases of acute infection, your agency may also work with other HIV service providers and clinics to share data to help identify populations where acute infection is likely.

The delay in availability of consolidated, published surveillance data is a common challenge faced by many HIV testing and linkage providers that are trying to use such data for planning and evaluating their programs. Agencies rely on State and local data to the extent that it is available; however, the lag time often hinders their ability to capture the most at-risk groups. For this reason, many organizations build partnerships with other service organizations and gather information from individuals who are familiar with “hot spots” of higher-risk behaviors. For example, some agencies work with local taxi drivers to learn not only where to find sex workers, but also where to provide services to them without interrupting their work.

Working with other service agencies and stakeholders should begin during the community assessment process. Essentially, by assessing the community you can start to identify the target population, as well as uncover challenges that your target population faces in accessing HIV testing and linkage services and strategies on how to recruit high-risk individuals for testing. Community partners can also be involved in identifying locations and venues for testing. By working with local faith leaders or club owners, for example, program staff can gain access to their communities and provide testing at their facilities. For further support on how to identify and engage stakeholders in program planning (i.e., formative evaluation) activities, please refer to Chapter 3 of the Evaluation Guide, Step 1: Engaging Stakeholders.

It is helpful to coordinate or collaborate with the State and/or local HDs to obtain needed data. HDs typically conduct community health assessment activities as part of their ongoing program development and planning activities. Community assessment reports often contain information about specific population groups, community resources, service utilization data, and gaps in services. Contact your State or local HD for additional information.

Work in partnership with State and local HIV/AIDS planning groups to obtain (and plan for) data needed to guide your targeting efforts. HIV/AIDS planning groups and State HDs collaborate in the development of jurisdiction-level epidemiologic profiles (i.e., “epi profiles”). Epi profiles contain a wealth of disease surveillance, behavioral, and other
health indicator data and can be an excellent source of information for HIV testing and linkage providers.

Geo-mapping is increasingly being used for epidemiological surveillance and is growing in importance as a tool for health program planning. Geo-mapping simply means that various data are displayed according to geographic coordinates. Complex data can be presented and integrated in a visual way, which enables users to easily patterns and identify gaps. Geo-mapping can be a useful tool in planning HIV testing and linkage services. Geo-mapping HIV prevalence data can help you quickly discover where the burden of disease occurs and suggest where you might want to focus your program efforts. You can overlay HIV data with other health (e.g., STD prevalence) or demographic data (e.g., race/ethnicity) to get a more precise idea of where program efforts are best focused. Current services can also be geo-mapped so that you can see where there are gaps in services. Geo-mapping typically requires GIS software. Some HDs routinely geo-map HIV and STD data and may be able to easily provide this information. Some HDs work with their HIV/AIDS planning groups or other health assessment processes to prepare health and service data in geo-mapped formats. Contact your State or local HD for additional information. For an example of local-level geomapping, visit the Public Health Institute of Metropolitan Chicago’s Web site.

**Tip**

Check with your county health department to see if they have conducted geomapping to identify clusters of HIV infection. The [AIDSVu Web site](#) provides county and State profiles of infection, and also includes data regarding poverty and STDs.

In the textbox below, Jamie Anderson discusses how to conduct targeting in low-incidence areas where 1% positivity rates are difficult to obtain.

> **In an effort to meet the 1.0% positivity rate for HIV incidence, Kansas Department of Health and Environment (KDHE) will support five CBOs in 2012, with funding directed toward implementing targeted testing with high-risk individuals using Clearview Complete rapid HIV 1/2 test kits. These supported sites will be required by contract to collaborate and recruit for testing efforts with organizations in their communities in order to access populations at highest risk for HIV. Collaborative events include HIV awareness days; community and agency health fairs; bar outreach recruitment activities; pow-wows; church events; and lesbian, gay, bisexual, and transgender (LGBT) community pride events. The five CBOs funded to implement targeted rapid testing will be required to partner with at least one other non-HIV testing organization to provide outreach recruitment or testing on a quarterly basis. These relationships will be established in an effort to target organizations, offer testing, or conduct recruitment efforts where priority populations are. These sites are required to conduct a minimum of three community outreach testing events in venues or settings which reach one or more priority populations.**

- Jamie Anderson
  
  HIV Counseling, Testing, and Linkage Director
  Kansas Department of Health and Environment
What Is Recruitment?

Once your target population has been clearly defined, you must determine how best to locate, engage, and motivate the population to access HIV testing services. There are many different strategies to use when recruiting individuals to HIV testing; typically a combination of approaches works best. No matter what strategies are selected, however, it is critical to engage key informants in the process to ensure that the approach is culturally appropriate and that it will be effective with the target population. (Notice a pattern that engaging the community throughout each step of your program planning and implementation is a priority!)

From working with stakeholders to defining the target population, program staff may already have some insight into what types of recruitment strategies might be successful. With your target population identified, program staff can continue collaboration with informants to tailor recruitment strategies. Formative evaluations can provide valuable information on the best ways to locate, engage, and motivate members of the target population given the dynamics of different communities and strategies that work best with particular high-risk populations.

When planning one’s program strategies, it is important to consider several categories of people that may be naturally encountered during recruitment (see “generic” operational flow-chart in Chapter 2 for details). As a minimum, testing programs are encouraged to recruit and offer testing to persons who fall into the first three core categories. They may also choose to recruit and offer testing persons who fall into the 4th and 5th optional categories:

**Core Categories:**

1. Persons who are members of the target population based on observation or information volunteered by the person without being questioned by the recruiter. For example, recruiters seeking Latino MSM in a specific neighborhood would attempt to recruit Spanish speaking men who congregate at a gay bookstore.

2. Persons who are not a member of the target population based on observation, but recruiters classify them as members of the target population after asking a few questions. For example, recruiters seeking members of a young MSM target population would ask young men if they are gay, bisexual, queer, or have sex with other men.

3. Persons spontaneously seeking testing without having been specifically recruited or offered testing by a recruiter
Optional Categories:

4. Persons who are in a social network (sex or drug) of members of the target population noted in 1 and 2 above if the program opts to use a social network recruitment method.

5. Persons who volunteer individual risk factors for HIV, without being questioned by recruiters.

Thus, persons who do not meet either the core or optional categories would not be offered testing. If an appropriate recruitment strategy is selected, the number of people in this category should be very small. Recruiting a lot of people whom meet neither the core nor optional categories suggests that the recruitment methods need to be refined to better locate or engage members of the target population. Formative evaluation may be conducted to elucidate more precise strategies.

Depending on the type of people encountered, the program will need to develop appropriate messages and procedures to recruit clients, including the characteristics that define membership in the population that can be determined strictly by observation, a limited number of questions that would need to be asked to determine membership in the target population if observation alone does not suffice, and whether the program will offer testing to persons in categories 4 and 5.

Definition

Recruitment is the process by which individuals are located, engaged, and invited to test.¹

The key steps involved in recruitment include the following:

- Precisely identify and describe the target population and actual or “virtual” places (e.g., Internet) to locate the population.
- Develop appropriate messages, tailored to the target population.
- Develop and plan a recruitment strategy (i.e., when, where, how should recruitment be done).
- Pilot the recruitment strategy and refine based on results.
- Use the piloted recruitment strategy for a specific service (i.e., testing).
- Monitor success of recruitment strategies in engaging individuals in the service.
- Refine recruitment strategies, messages, and venues/settings on the basis of M&E data and feedback from the target population.

Each of these steps will be explained in further detail throughout the remainder of the chapter.

Recruitment Strategies

This section will describe the uses of various recruitment strategies and provide support for selecting those that are appropriate for your target population. Once you define your target population, focus on developing messages for and planning your recruitment strategy.

When selecting a recruitment strategy, first and foremost, the strategy must be appropriate to the target community and must facilitate accessing and engaging the target community. If, for example, you are working with homeless IDUs, you will likely need to meet them on the street or in another venue (e.g., a shelter) rather than use the Internet for recruitment, as this population may have limited or no access to the Internet.

Practice Example 3.1: Matching Recruitment Strategies to the Target Population

Acme Prevention Services (APS) provides HIV testing and linkage services in Center City. Their target population is homeless IDUs. APS decides to partner with a homeless shelter and three warming centers to provide HIV testing and linkage. APS also collaborates with CCHD to conduct health screenings using CCHD’s mobile vans (street-based outreach) in the Riverside neighborhood. Formative research identified the Riverside neighborhood as a location where this population congregates, because of the large number of abandoned homes available to use to inject drugs.

In the textbox below, Robin Pearce discusses how the NO/AIDS Task Force uses the Internet to recruit clients.

About 30% of our testing clients visit one of our fixed sites because they did a Google search for free HIV testing in New Orleans, found our Web site, and read our testing hours. We have separate Facebook pages for our satellite prevention offices and we use them to promote events, though clients rarely cite this as the way they find our testing hours.

- Robin Pearce
NO/AIDS Task Force
New Orleans, LA

Below, Jacob Dougherty describes how Diverse and Resilient adopted the use of motivational interviewing to improve recruitment efforts.

We use motivational interviewing as a strategy with our volunteer health promoters that do recruitment out in the field. We chose motivational interviewing because as a strategy it’s relatively easy to train to our health promoters, and it has proven effective at translating issues we hear directly from members of our target population into action. During pride festivals, we deploy many volunteer health promoters throughout the festival to have one-on-one conversations with attendees that fit the target population for our programs. The volunteer health promoters are trained before the
festival on motivational interviewing skills, and the training includes practices, teach-backs, and several field examples from previous years. This way, the volunteer health promoters are able to adapt to different situations they may encounter in the field, and motivate a large number of people to consider getting tested or enrolling in an HIV prevention program.

- Jacob Dougherty
  Data Specialist
  Diverse and Resilient
  Milwaukee, Wisconsin

**Recommended Activity**

Review the following recruitment strategies and select those that are within your agency’s capacity to implement and are appropriate for use with your target population.

Exhibit 3.2 describes the different recruitment strategies employed by HIV testing and linkage providers. If your agency is already using some of the strategies shown here, it is recommended that you evaluate their effectiveness to ensure that you are using appropriate methods. Evaluation of recruitment strategies will be described later in this chapter.
### Exhibit 3.2. Recruitment Strategies

<table>
<thead>
<tr>
<th>Recruitment Strategy</th>
<th>Definition</th>
<th>Uses/Populations</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outreach:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Street-based</td>
<td>Meeting clients in their own environment to engage persons at high risk, often conducted by peers or paraprofessionals</td>
<td>• Mobile testing units • IDUs • Sex workers • High-risk hot spots</td>
<td>• Clients may not want to receive services at the same place where they engage in high-risk behaviors</td>
</tr>
<tr>
<td>• Venue-based</td>
<td></td>
<td></td>
<td>• Street-based services require additional resources (e.g., mobile testing units, additional staff, demonstration materials)</td>
</tr>
<tr>
<td>• Social Marketing</td>
<td></td>
<td></td>
<td>• Additional safety and security protocols</td>
</tr>
<tr>
<td>• Internet</td>
<td>Outreach to clients through online venues such as chat rooms and social networking sites. The Internet can also be used to promote and market program services.</td>
<td>• MSM • IDU • Homeless populations • Recently incarcerated individuals • Useful in places where high-risk groups spend time • Testing may or may not be provided at the venue</td>
<td>• Limits test selection if blood draws are not done onsite</td>
</tr>
<tr>
<td><strong>Social marketing:</strong></td>
<td></td>
<td></td>
<td>• Difficult to evaluate who you are reaching and missing</td>
</tr>
<tr>
<td>• Street-based</td>
<td>The use of media to recruit clients into HIV testing programs, through modes such as the Internet, radio, television, posters, and flyers</td>
<td>• Useful for raising awareness of HIV and HIV testing • Tailor messages to recruit youth, MSM, IDU, and so forth</td>
<td>• Must test messages and seek feedback from clients to make sure marketing is appropriate and effective</td>
</tr>
<tr>
<td>• Venue-based</td>
<td></td>
<td></td>
<td>• Can be expensive</td>
</tr>
<tr>
<td>• Social marketing</td>
<td></td>
<td></td>
<td>• Difficult to evaluate effectiveness other than self-report</td>
</tr>
<tr>
<td>• Internet</td>
<td></td>
<td></td>
<td>• Does not reach those without Internet access such as homeless/transient people</td>
</tr>
<tr>
<td><strong>Internet:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Exhibit 3.2. Recruitment Strategies**

**Outreach:**
- Street-based: Meeting clients in their own environment to engage persons at high risk, often conducted by peers or paraprofessionals.
- Venue-based: Outreach to clients through online venues such as chat rooms and social networking sites.
- Social Marketing: The use of media to recruit clients into HIV testing programs, through modes such as the Internet, radio, television, posters, and flyers.
- Internet: Outreach to clients through online venues such as chat rooms and social networking sites. The Internet can also be used to promote and market program services.

**Social marketing:**
- Street-based: Useful for raising awareness of HIV and HIV testing.
- Venue-based: Can over-test the same people.
- Internet: Difficult to evaluate who you are reaching and missing.

**Limitations:**
- Clients may not want to receive services at the same place where they engage in high-risk behaviors.
- Street-based services require additional resources (e.g., mobile testing units, additional staff, demonstration materials).
- Additional safety and security protocols.
- Limits test selection if blood draws are not done onsite.
- Difficult to evaluate who you are reaching and missing.
- Must test messages and seek feedback from clients to make sure marketing is appropriate and effective.
- Can be expensive.
- Difficult to evaluate effectiveness other than self-report.
- Does not reach those without Internet access such as homeless/transient people.
### Exhibit 3.2. Recruitment Strategies (continued)

<table>
<thead>
<tr>
<th>Recruitment Strategy</th>
<th>Definition</th>
<th>Uses/Populations</th>
<th>Limitations</th>
</tr>
</thead>
</table>
| Internal Referrals   | Accessing clients through other services that are provided within the agency where the testing program resides (e.g., syringe exchange programs, substance abuse programs, mental health services, crisis care) | - Useful for working with groups receiving other services and in correctional facilities  
- Testing can be provided onsite or referrals can be made | - Many high-risk individuals do not access services such as the ones listed here  
- Important to also provide outreach and other services to supplement internal referrals  
- Requires coordination with other agencies |
| External Referrals   | Clients are referred by external agencies to the testing program | - No-cost recruitment  
- Useful for high-risk groups accessing other sites (e.g., syringe exchange, homeless shelters, STD programs, substance abuse programs) | - Must develop relationships with other agencies  
- Provide training/information on how to make appropriate referrals  
- Must make sure referrals truly are high-risk so as not to overwhelm your agency’s testing capacity |
| Social Networking    | A peer-driven approach of identifying HIV-positive or HIV-negative high-risk persons from the community who are able to recruit individuals at high risk from their social, sexual, or drug-using networks; partner referral is a type of social networking which involves members referring their sexual partners to a testing program | - MSM  
- IDUs  
- Sex workers  
- Other high-risk groups | - Recruiters must be provided with coaching and supporting from the implementing agency  
- Staff providing coaching and support must receive training to ensure that they are knowledgeable about the model and have the skills to support recruiters. |
Selecting a Recruitment Strategy

After reviewing the available strategies for recruitment, your agency must decide which methods are appropriate and feasible for working with your target population. It is important to pilot the recruitment strategy to see how well it works and refining as needed. One of the first factors you might consider in piloting/selecting a recruitment strategy is location:

- Where are you planning to access the population?
- Will you reach them in bars?
- Will they come into a social service agency?
- Are they already engaged in other services?
- What time of day do you have the best ability to access them?

By conducting your readiness assessment and formative evaluation, you may have a better idea of where to reach high-risk individuals. For example, if you also offer a syringe services program and your target population is IDU, you can recruit testing clients who are receiving syringe services. Alternately, you may decide that it is better to access the target population in a setting where they congregate, such as a shelter, or where HIV risk behavior occurs, such as a bar. (See Chapter 2: Getting Started—Preparing to Implement HIV Testing and Linkage Services in Nonclinical Settings for more information on formative evaluations. In particular, review the section titled Formative Evaluation and Implementation Planning. Tools that will help you to identify appropriate recruitment strategies are also included in that section.)

Safety: Another factor that must be considered in conjunction with testing venues is safety. If you are trying to reach commercial sex workers, for example, you probably need to conduct outreach. Still, if you try to provide services to commercial sex workers when they are working, you could be costing them clients and disrupting the environment. You could be putting both clients and staff members in danger, so it is important to know the clientele and the location before sending staff out to provide services. Here are a few questions to think through before selecting a recruitment strategy:

- What are the characteristics of the testing environment? Is it closed (e.g., a building) or open (e.g., a street corner)?
- What kind of traffic will be present at the time of testing? Are you testing late at night? Will other people be around?
- How many staff members will you need to have present? Is it safe to have only two or three people onsite? Will you need to have more staff available?
- What type of exit route is available? Are you recruiting in an alley? Can your staff quickly and safely leave the site if necessary?

When testing in an unfamiliar area, it is a good idea to consult with local law enforcement to inform them of your plans. Having a police presence at a testing event would certainly deter many high-risk individuals from testing, so it is important to have police available—should you need them—but not visible to the population.
Another way to increase safety is to enlist a gatekeeper to help you build trust with the community. When clients know your agency and trust that you will not give their names to the police if they are engaging in illegal behavior, they will be more receptive to your services. If you are trying to reach non-gay-identifying MSM, for example, your clients need to trust that you will not out them to the community. A gatekeeper can help establish the necessary rapport and also keep you informed as to where to provide services, as hot spots and popular meeting venues may frequently change. More information on safety is available in Chapter 9: Quality Assurance and Monitoring and Evaluation. For HIV testing conducted in outreach settings, safety considerations for outreach testing are addressed in Chapter 8: HIV Testing in Outreach Settings.

**Agency Capacity:** Consider your agency’s capacity for implementing and sustaining recruitment efforts. Some strategies can be resource intensive and may require hiring additional staff or purchasing new materials. Your agency may wish to use a multipronged approach in which resource intensive recruitment activities are used sparingly. It can also be beneficial to work with partner organizations to combine resources and extend your reach in the community. For example, if your agency does not possess a mobile testing unit, you could partner with other agencies to make use of their mobile units. You might also host an event at which HIV testing is provided alongside non-communicable disease or other health screening to attract more clients and to share the organizational burden with a non-HIV missioned agency. Building such partnerships and collaborating in this way will also help to brand your services and increase name recognition. This can increase the number external referrals made by other organizations for services. Please refer to Chapter 7: Referral and Linkage to Health and Prevention Services for additional information about and discussion of collaboration.

**Practice Example 3.2: Collaboration to Enhance Organizational Capacity for HIV Testing and Linkage**

APS provides HIV testing and linkage services in Center City. Their HIV testing and linkage program offers targeted services for MSM. APS also operates a very successful YouthWorks! program that provides community education and leadership development for low-income minority youth. While APS has been successful in providing services in gay-identified venues, they have been less successful in providing services to MSM who do not self-identify as gay or who do not access gay-identified venues.

CCHD has two large mobile vans that they use to conduct health screenings at various events and as part of their community health outreach program. Nursing staff can perform STD screenings, other health screenings, as well as vaccinations. CCHD has had difficulty in reaching youth, who find it difficult to get to the CCHD clinic during operating hours and fear that their parents will learn about their receiving services.

APS and CCHD decide to collaborate in providing services for their mutual benefit. On two Saturdays each month, APS staff joined CCHD staff on the mobile vans that travel to areas of Center City where the prevalence of HIV and other STDs is relatively high and there are clear gaps in services. APS staff provide HIV testing with a rapid test, offer risk-reduction counseling, and help to refer clients to other risk-reduction services. For clients who are HIV-positive, they provide “concierge” service to link these clients with the HIV client at Center City Hospital. CCHD nursing staff members conduct screening for gonorrhea, chlamydia, and hepatitis C. They also provide vaccination for hepatitis B.
Implementing Recruitment

Implementing new recruitment strategies can be time and resource intensive. A few of the inputs recruitment may require the following:

- Staff training
- Contracting with consultants
- Purchasing new materials
- Cultivating new partnerships
- Developing and testing recruitment messages

Conducting recruitment for testing requires multifaceted training for HIV testing and linkage staff and/or volunteers. If testing is to be conducted at the recruitment site, staff/volunteers need to be trained in HIV testing, and also in how to perform linkage from outreach, external and internal referral venues. Depending on how active your agency's recruitment efforts are, your program manager may decide to hire staff accepted by the target community to specialize in outreach or internal referrals. If staff members/volunteers can interact with clients in their environments as peers, your program may have better recruitment outcomes. Regardless of their specialization, all recruitment personnel must also be trained in cultural competence, as they prepare to enter communities with the objective of recruiting individuals into testing. More information on cultural competency can be found in the section titled Cultural Competence, located in Chapter 9: Quality Assurance and Monitoring and Evaluation.

Obtaining outside expertise, such as a consultant, may be necessary to inform a recruitment strategy and messaging. This is particularly true for efforts in social marketing and Internet recruitment when media advertising is involved, which requires expertise beyond the capacity of many community-based providers. Identifying the most effective Internet recruitment strategy for your organization necessitates pilot testing messages with representatives of the target population. It is important to test messages for reading level to ensure that your target audience comprehends them, for appropriateness to discover how the population perceives them, and for effectiveness to see how the population responds to them.

**Practice Example 3.3: Testing Recruitment Messages**

APS provides HIV testing and linkage services in Center City. Their HIV testing and linkage program targets MSM, some of whom are gay-identifying and some of whom are not. APS has an advisory board with gay-identifying MSM members who provide feedback on the messages developed to target MSM. Still, in order to effectively reach MSM who do not self-identify as gay, APS had to delve deeper into the psychosocial constructs of machismo and internalized homophobia within Center City's Latino community. APS partnered with local men's faith and recreation groups to construct messages that equate testing with masculinity and assert male sexuality. These messages were pilot tested at community testing events to ensure that they were effective in recruiting men into testing without threatening their sexual identities.

Recruitment efforts may also require additional materials and resources. For example, if your program’s scope of service includes street outreach, your agency may need to...
acquire a mobile testing unit. You also might need printed materials to distribute information and provide referrals. When selecting a recruitment strategy, it is important to consider the costs of implementation and weigh them against the projected yield. Surveying members of your target population and interviewing community partners is one way to develop yield expectations, though it is also useful to compare effectiveness of this strategy among other service agencies working with similar populations.

Finally, in order to conduct effective internal referrals, external referrals, and/or social networking, your agency must build partnerships with other service organizations in the community. By building partnerships, your agency can often make inroads in all three of these areas, as the program can provide testing at another agency, receive referrals from other providers, and establish relationships with members of the target population who can recruit others into testing. Make sure to have an updated inventory of local service providers and explore opportunities for new collaborations. Partnerships and collaboration, including strategies for developing and operationalizing them, are discussed in detail in the section titled Community Partnerships and Referral Resources, presented in Chapter 7: Referral and Linkage to Health and Prevention Services.

Once you have trained staff, tested your messages, and gathered all other necessary inputs, you can begin recruiting individuals into testing and other services. You will need to exercise the following steps in order to successfully implement your selected strategies:

- Develop targets for each recruitment site: What are your goals? (Do you hope to provide testing and identify positives? Do you plan to provide referrals? Are you aiming to make your services known to high-risk individuals and to decrease stigma?)
- Based on your targets, select the dates and times for your recruitment activities and coordinate these with all necessary parties (partner organizations, host sites, law enforcement officials, etc.).
- Schedule sufficient staff, volunteers, and supervisors to implement the recruitment effort.
- Prepare and package necessary supplies (pamphlets, appointment cards, referral slips, etc.).
- Pilot test your recruitment efforts at the selected sites to ensure that you are reaching the intended population.
- If referrals are made to your agency or other agencies, follow up with each agency to track referral success.
- Evaluate your efforts: If recruitment efforts do not meet your targets, try to figure out why. (More detail will be provided on evaluation later in this chapter.)
- Refine your messages and alter your efforts as necessary to reach your targets.
- If targets still cannot be met, discontinue recruitment at ineffective sites.
Site Set-Up and Preparation

In getting ready to conduct recruitment efforts, prepare the following:

- Site-specific protocols, including safety procedures
- Messaging guides for engaging clients
- Standards of conduct for specific venues
- Handouts, resources, and/or incentives
- Quality assurance procedures

For more detail about recruitment in outreach venues, along with additional information on site set-up and safety, refer to Chapter 8: HIV Testing in Outreach Settings.

Incentives

Client Incentives

While scientific evidence is inconclusive, program experience suggests incentives can be used in two primary ways to support HIV testing activities. The first and most prevalent usage is to directly incentivize clients. Agencies might offer gift cards, food items, clothing, other goods, and sometimes even cash to motivate clients to accept HIV testing. Typically, incentives are used to reach high-risk individuals who might not otherwise test. If you provide incentives they must be offered equitably, and this effort can pose a substantial resource strain on agencies.

When deciding whether to offer incentives to clients, consider the following factors:

- Are you currently recruiting your target population effectively without incentives? Are you meeting your positivity targets?
- Are other agencies providing similar services in your jurisdiction? Do they offer incentives?
- What is your budget for incentives? How could you ensure sustainability of the program?
- What types of incentives would be appropriate? What would be effective with your target population?
- What policies or regulations (if any) are in place regarding the use of incentives (e.g., is their use allowed by the funder)? Who must approve them? What is allowable? What would be coercive?

Challenges to Using Incentives

Repeat Testers: The use of incentives, while often effective in recruiting people into HIV testing services, can also pose several concerns. By using incentives, your agency may be overwhelmed by repeat testers who are testing primarily to obtain the incentive.
You may need to have a tracking system in place to prevent people from receiving the incentive more frequently than at a predetermined interval. (You might decide that it is beneficial for members of your target population to retest every 3 months and offer incentives at that interval.) Sample procedures for using client incentives are available in as Template 1 Appendix D.

**Interagency Competition:** The use of incentives can also create competition among groups. For example, if your agency provides $25 gift cards to a local grocery store, and another agency provides $25 in cash, clients may be less inclined to test at your agency, as they can shop for services with the best incentives. Similarly, clients may collect on incentives at multiple agencies, thus further draining resources. Your agency may be pressured to use incentives in order to compete with nonservice-delivery organizations. If, for example, you want to provide testing at a health fair, but clients are drawn to an incentive for completing a behavioral risk survey, you may not be able to “buy” their time without offering them something in return. For an example of how this competition can impact testing programs, read the following textbox by Mary Beth Levin.

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Some programs compensated clients $15 to $20 for getting an HIV test. What resulted is that clients visited all of the programs that offered money, making the rounds every 3 to 6 months. In addition, they were less inclined to access services of any kind that did not offer compensation. I also noticed that staff themselves promoted the compensation rather than the service and its benefits. Some programs will financially compensate clients who consent to an HIV test. A guy on the street approached me, asking “How much are you going to pay me to get tested?” I informed him that we weren’t one of those programs. His response: “Well then, why should I get tested with you?” I answered that the important thing wasn’t that he tested with us, but that he test with someone. I reviewed who should get tested and how often, finishing with “If you do decide to test with us, we will be with you every step of the way for as long as you want us.” He took a moment, looked me up and down, shrugged his shoulders, and said “OK, let’s do it.”

- Mary Beth Levin
Associate Professor
Department of Family Medicine and Community Health
Georgetown University School of Medicine
Washington, DC
Testing Program Capacity: Another challenge with the use of incentives relates to organizational capacity. Not only does your agency need to have the resources to provide the incentives, you must also have the capacity to test and link the flow of clients who access your services because of the incentives. If offering incentives at outreach locations, you may run out of incentives and have a crowd of upset clients to address. Such a situation could put your staff in danger if they are unable to provide incentives for everyone. The decision to offer incentives can also have long-term implications for the success of your program if you are unable to sustain them. If you offer incentives because you have a grant to do so this year, but then you will not have the money to offer them next year, you may have more difficulty recruiting clients once the grant ends.

As you can see, incentives can pose unique challenges for your program, and you must carefully think through your process for selecting and distributing them in order to be successful. Some popular alternatives to monetary incentives include giving away small items such as water bottles, t-shirts, or other materials that may be left over from large testing events. You could also enter clients into a raffle or provide compensation for transportation costs in the form of bus tickets or subway fare. Social marketing can also be used to market your services and increase social value of HIV testing. These methods can all help facilitate testing and linkage without draining the resources.

Most importantly, if your agency is reaching its targets without incentives, there is little reason to consider offering them. If, however, you are unable to test and link clients to care because other agencies offer incentives or because HIV testing is not a valued priority of your target population, then you might explore and pilot test their use. Due to their complex challenges, you may consider looking for ways to incentivize clients using limited resources and in sustainable ways.

There may be policies or regulations which prohibit the use of incentives or specific kinds of incentives, such as cash. Check with your State or local HD or your funder to learn about applicable policies or requirements.

Performance-Based Payment

The second kind of use of incentives occurs between funders, such as HDs, and their contractors. Some funders encourage refinement of targeting and recruitment by their contractors through performance-based payment. In this way, contractors may be incentivized to provide services to the highest risk individuals and direct greater effort on recruiting and linking such individuals to services. For community-based and other non-clinical providers, funders typically provide a base amount of funding. Contractors are then eligible to receive additional payment on the basis of the services they provide (e.g., number of tests performed). Sometimes performance-based payment is structured to provide incrementally higher levels of payment for more targeted or more intensive services. For example, a contractor may receive one payment amount for each low-risk individual recruited to testing, and a different, higher amount of payment for recruiting high-risk individuals. Similarly, contractors may be reimbursed one payment amount for
making referrals to HIV medical care and may receive additional payment for confirming that the individual was successfully linked to HIV medical care.

A variation on performance-based payment provides contractors with a payment amount for meeting performance targets. In this scenario, a funder may set aside a maximum amount of funding available to a contractor, provided that performance targets are met. In the case of HIV testing and linkage services, a certain percentage of payment is tied to meeting a specific performance target. If all of the performance targets are met, then the contractor would receive 100% of the payment for which it is eligible. If one or more targets are not met, than the contractor's payment would be reduced proportionately.

**Practice Example 3.4. Performance-Based Payments**

Los Angeles County Health Department has implemented performance-based payment for HIV testing and linkage providers. Providers have two budgets—one is a “base budget” and the second is a “pay for performance budget.” The combination of the two budgets comprises the maximum financial obligation to an individual contractor. Payments from the base budget are made on a cost reimbursement basis. Payments from the performance budget are made based on achievement of specified performance measures: 20% of payment is based on achieving the target for the number of tests conducted; 50% is based on reaching the target HIV seropositivity rate; 15% is based on reaching the target for successful linkage to care, and 15% is based on reaching the target for successful referral to partner services. If providers do not meet a performance target, they are not eligible for receiving payment associated with that measure.

- Sophia F. Rumanes, MPH
  Chief, Prevention Services Division
  Los Angeles County Department of Public Health
  Los Angeles, CA

In this resource-limited climate, performance-based payment may motivate staff to prioritize follow up with clients who need to be linked or to identify new testing sites to increase their yield of new positives. One of the greatest challenges of HIV testing and linkage work is that the target populations are dynamic. Just as the population shifts, so too does the favorite hot spot or the preferred access point for services. Agencies must constantly revisit and refine their practices, though with limited time and resources this can be a difficult task. Performance-based pay is a type of incentive that may help stimulate providers to meeting.

Additional information about use of incentives in conjunction with delivery of test results and linkage to care is available in Chapters 6 and 7.
Quality Assurance of Targeting and Recruitment

Review your practices to ensure that targeting and recruitment is being conducted according to your established procedures and that you are meeting the standards developed for your programs. This means there needs to be written policies and procedures for targeting and recruitment and that you conduct QA activities on a regular basis.

In this section discussion will be limited to QA as it pertains to targeting and recruitment strategies. Additional detailed information on QA, including tools and practice examples, is presented in Chapter 9: Quality Assurance and Monitoring and Evaluation. A few of the major topics for quality assurance in relation to targeting and recruitment are as follows:

- Maintaining effective supervisors and recruiters
- Conducting data-driven targeting
- Ensuring recruitment is conducted according to protocol
- Reaching targets for recruitment

Training

As mentioned earlier in this chapter, additional staff training may be needed in order to conduct effective recruitment. Training alone, however, may not be enough to ensure successful practices. Some agencies choose to use staff or volunteers who are members of the target population for recruitment. This can be helpful in establishing rapport, but it does not negate the need for training and reviewing performance.

Ensure that staff conducting targeting and recruitment have received training appropriate to their responsibilities. It is important for staff performing targeting and recruitment to receive training and education on the following:

- Use of data to inform targeting.
- Recruitment planning and management, including the specific steps in the recruitment process, as defined in agency policies and procedures.
- The recruitment model, if applicable (e.g., social networking).
- Population-specific issues which impact reduction of risk for HIV transmission or acquisition.
- Properly and accurately documenting all aspects of the recruitment process and maintaining confidentiality.

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2 We recognize that many HIV testing and linkage programs enlist volunteers to provide HIV testing and linkage services. Often, volunteers perform the same functions as paid staff. Throughout this guide, for convenience, we use the word "staff" to refer to both paid staff and volunteers.
• Factors that influence a client’s willingness or ability to use referral services.
  ▪ Community resources necessary to meet client needs.
  ▪ Agency policies and procedures regarding recruitment.

It is important that supervisors receive training in the recruitment model to ensure that they possess the knowledge necessary to support staff in implementation and to enable them to effectively assess staff proficiency. Supervisors may find it useful to obtain education and support to work with partner agencies and are encouraged to adjust recruitment practices to the population as necessary.

**Proficiency**

It is important to evaluate staff conducting recruitment to assess their proficiency. Direct observation of sessions with clients is an effective strategy to assess proficiency. It may be useful to observe staff at regular intervals (e.g., quarterly) and more frequently after initial training (e.g., monthly for the first 3 months) or when conducting recruitment in new venues/settings. Additional information on assessment of proficiency is presented in Chapter 9: Quality Assurance and Monitoring and Evaluation.

**Documentation and Record Keeping**

Keep documentation of the following:

• Staff training and proficiency assessments, including orientation to risk-reduction policies and procedures.
• Recruitment activities, including information that helps to explain the productivity of various locations and strategies used for recruitment (e.g., the size of the venue, other activities occurring in the venue).
• Client satisfaction with services.

Additional information on documentation and record keeping is presented in Chapter 9: Quality Assurance and Monitoring and Evaluation.

**Monitoring and Evaluation**

Evaluation of recruitment on an ongoing basis is essential, regardless of whether your agency is already using effective strategies or you are just beginning a testing program. Sometimes efforts that have been effective in the past stop reaching high-risk individuals; through evaluation, you can begin to understand why. Investigate the following:

• Is your program reaching members of the target population?
• Are members of the target population agreeing to HIV testing?
• Is the program reaching your positivity target?
• Have the positivity rates at this site changed significantly in the past several months or years?
If you are just getting started or are trying a new recruitment strategy, evaluate the strategy during the first few months after you implement it.

One way to understand whether your program is doing everything it can to reach the target population is to evaluate how the program recruits for testing and linkage services. This starts with asking clients how they heard about your testing program at the point-of-service. HIV testing staff can ask about this during the testing session and record it into a recruitment logbook or clients can answer questions on an intake and information form. By asking the client directly, you may be able to discover more specific information about the recruitment method rather than simply receiving a form with checked boxes. For example, in conversation staff can uncover what Web site the client visited, what advertisement was seen, as well as the lag time between the client’s receipt of the message and his or her testing visit. The client can also provide feedback and suggestions for where else services should be advertised or where your recruitment efforts are not working.

Exhibit 3.3 provides an example set of questions to ask clients about how they were recruited into testing. This form can be adapted to include each of your program’s current targeting strategies, and questions can be added to gauge the appropriateness of new strategies being considered.

**Exhibit 3.3. Tracking Recruitment Efforts**

Where did you hear about our services? (Please check all that apply)

- [ ] A friend
- [ ] Online
- [ ] Craigslist
- [ ] Facebook
- [ ] Twitter
- [ ] Adam4Adam
- [ ] Referral from another agency
  
  What agency referred you? __________________________________________

- [ ] Advertisement
  
  Where did you see the advertisement? ________________________________

  When did you see the advertisement? ________________________________

- [ ] Saw us providing services elsewhere
  
  Where did you see us providing services? _____________________________

  When did you see us providing services? _____________________________

- [ ] Been here before
If you are recruiting using outreach or social networking strategies, it may not be necessary to collect this kind of information from clients, but you might still find it useful to have a way of keeping track of how individual clients were recruited to your program. Often this is as simple as assigning a specific code associated with each recruitment strategy to client records.

**Practice Example 3.5. Coding Data by Recruitment Source**

APS provides HIV testing and linkage services in Center City. They use venue-based outreach and social networking strategies to recruit clients to their program. Clients can also walk into the APS offices and request a test. APS has a field on their client data collection form (collected by testing and linkage staff) to help them track source of recruitment. Recruitment sources listed on the form include the following:

- Self-referral
- Outreach by APS
- Referred by a partner
- Referred by other
- Social network

Review data regularly (e.g., quarterly) to assess which recruitment strategies are most successful, determine which strategies are most effective in recruiting your target population(s), and suggest areas where program refinement might be needed. Also look closely at the venues in which you are conducting recruitment to assess the extent to which those venues are providing access to your target population(s) and helping you to identify individuals with HIV infection. By evaluating recruitment efforts on an ongoing basis, you will be able to refine practices to keep pace with shifts in your target population. In this way, evaluation becomes an integral part of the recruitment planning process.

The section titled Implementing Monitoring and Evaluation, presented in Chapter 9: Quality Assurance and Monitoring and Evaluation, has additional information and tools to help you to evaluate your targeting and recruitment efforts. Tools to help you conduct a yield analysis to better understand how well your program is working and to guide you in discussions about program improvement are also included in that section.
CHAPTER 4 AT A GLANCE

This chapter addresses risk-reduction services provided in the context of HIV testing and linkage services. In this chapter we discuss the following:

- Various kinds of risk-reduction services for high-risk HIV-negative and HIV-positive persons
- How to assess client need for risk-reduction services
- Providing brief risk-reduction services to the highest-risk individuals
- Quality assurance of risk-reduction activities, including training and assessing staff proficiency
- Monitoring and evaluation of risk-reduction activities

The tools and examples provided in this chapter will help you to do the following:

- Assess clients’ risk level and need for risk-reduction services
- Monitor your success in providing risk-reduction services

What Is Risk Reduction?

Clients receiving HIV testing have a range of prevention, medical, and support needs. Risk-reduction services can help to reduce the likelihood of future infections. Some clients may be at very high risk for becoming infected (if HIV negative) or for transmitting their infection to others (if HIV positive). Other clients may be at relatively low risk for acquiring or transmitting HIV. Clients should be provided with risk-reduction services that address their prevention needs and level of risk for HIV acquisition or transmission. Clients with low or no risk will likely have minimal risk-reduction needs. Develop strategies to provide, onsite or through referral, risk-reduction services that will assist clients in staying negative or from transmitting their infections to others.

Definition

Risk reduction refers to a range of interventions designed to reduce or eliminate the risk for transmission or acquisition of HIV infection. Risk-reduction interventions are listed in Exhibit 4.1.
Exhibit 4.1. Risk-Reduction Interventions

- Screening and treatment for STDs
- Screening for viral hepatitis
- Vaccination for hepatitis B
- Reproductive health services
- Substance abuse treatment
- Non-occupational post-exposure prophylaxis (n-PEP)
- Pre-exposure prophylaxis (PrEP)
- Individual- and group-level behavioral interventions
- Syringe access
- Distribution of risk-reduction supplies (e.g., condoms)

Determining the Need for Risk Reduction

It is essential for all clients tested for HIV to, at minimum, receive information about HIV transmission and prevention, along with condoms and/or other risk-reduction supplies appropriate to the clients’ risk. However, you might find it useful to learn about factors that may be contributing to increasing the client’s risk for acquiring or transmitting HIV. This will help you understand which clients could most benefit from risk-reduction services and which risk-reduction services would help these clients most. Clients who report any of the following may be at high risk for HIV transmission or acquisition and may benefit from risk-reduction services:

- Recent or ongoing unprotected anal and/or vaginal sex with an HIV-positive partner or partner of unknown HIV status
- Recent or ongoing sharing of drug injection equipment with an HIV-positive partner or partner of unknown HIV status
- Current or recent past diagnosis of and/or treatment of an STD in self or partner
- Symptoms of viral illness

Learning when the client was last tested for HIV, and the results of their most recent test, will also help you to gauge clients’ risk for HIV transmission or acquisition. For example, if a client reports a negative HIV test within the past 6 months but also reports using a condom every time he has anal sex, that client is probably not at high risk for HIV. On the other hand, a client who reports a previous negative HIV test result also reports having anal sex with an HIV-positive partner without a condom is at high risk for HIV.

Learning about your clients’ level of risk for HIV does not require a lengthy, in-depth assessment of behaviors and other factors that influence risk (e.g., mental health status). A few brief questions should be able to provide you with this information. Sample questions are included in Exhibit 4.2. Adjust or adapt these questions to suit your target population.
Exhibit 4.2. Sample Questions to Identify High-Risk Clients Who Could Benefit From Risk-Reduction Services

<table>
<thead>
<tr>
<th>Sample Questions to Identify High-Risk Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>• When was the last time that you had anal or vaginal sex with an HIV-positive partner or with a partner whose HIV status you did not know?</td>
</tr>
<tr>
<td>• When was the last time you shared drug injection equipment with an HIV-positive partner or with a partner whose HIV status you did not know?</td>
</tr>
<tr>
<td>• Have you recently been diagnosed with an STD? If yes, are you being (or have you been) treated?</td>
</tr>
<tr>
<td>• Has your sex partner been recently diagnosed with an STD? If yes, is he or she being (or has been) treated?</td>
</tr>
<tr>
<td>• Have you been feeling sick lately? Do you have a fever, sore throat, swollen glands, muscle or joint aches, or any other flu-like symptoms?</td>
</tr>
</tbody>
</table>

There are several ways that you can gather information to gauge clients’ level of risk for HIV transmission or acquisition. Exhibit 4.3 presents various methods, along with the benefits and drawbacks of each.

Exhibit 4.3. Methods to Assess Risk for HIV Transmission or Acquisition

<table>
<thead>
<tr>
<th>Method</th>
<th>Benefits</th>
<th>Drawbacks</th>
</tr>
</thead>
</table>
| Written self-administered questionnaire (paper and computer based) | • Low cost (if done with paper and pencil)  
• Requires little staff time to administer | • Difficult for clients with low literacy levels to complete  
• Translation of questions for non-English-speaking clients  
• Up-front cost for computer programming, purchase of equipment  
• Clients may be reluctant to provide accurate responses and may instead provide socially desirable responses |
| Face-to-face interview | • May help clients with low literacy levels complete risk screening  
• Low cost | • Requires greater staff time to administer  
• Clients may be reluctant to provide accurate responses and may instead provide socially desirable responses if they do not yet know/trust the staff person conducting the interview |
| Audio computer assisted self-interviewing | • Appropriate for clients with low literacy levels  
• Appropriate and reliable with adolescent populations  
• May result in gathering more accurate information than self- or interviewer-administered questionnaires | • Up-front cost for programming and purchase of equipment  
• Programming costs when changes to interview tool needed |
In deciding how you will gather information on client risk, consider the following:

- The literacy level of the target population.
- The developmental level of the target population.
- The venues or settings where testing is to be performed. For example, it may not be desirable or feasible to use computer-assisted methods in some outreach settings.
- Staff time and skills to collect information via interview with clients.
- Staff capacity to provide translation services, if needed.
- Resources to purchase equipment for computer-aided methods for risk screening.

Seek feedback from representatives of the target population and line staff to ensure that you selected a method most appropriate to the target population and within the capacity of your program.

Below, Ben Tsoi describes New York City’s use of personal computers to assist in collecting information and educating clients.

A large hospital in New York City uses tablet personal computers (PCs) to collect information and to provide pre- and post-HIV testing education. These tablet PCs collect patients’ demographic and behavioral information using a computer-assisted self-interview. They also display videos to provide pre- and post-test HIV education. The use of tablet PCs allows a public health advocate (PHA) to educate and test more patients. As one patient is receiving education from a tablet PC, the PHA can be providing an HIV test to another patient.

- Ben Tsoi
  Director of HIV Testing
  Bureau of HIV/AIDS Prevention and Control
  New York City Department of Health and Mental Hygiene
  Queens, NY

Providing Risk-Reduction Services

In the context of HIV testing, focus on addressing clients’ most immediate risk-reduction needs. If clients have multiple and complex needs (e.g., substance use and mental health issues, along with being unstably housed), it is better to refer them to programs (e.g., Comprehensive Risk Counseling and Services (CRCS) or medical case management that are better positioned to identify and facilitate referral and linkage to a variety of risk-reduction and/or support services, and can work with clients over a longer period of time.
Risk Reduction for HIV-Infected Clients

Clients diagnosed with HIV or clients who have a reactive rapid test result will benefit from basic risk-reduction messages and condoms and/or other appropriate risk-reduction supplies.

Many agencies that provide HIV testing and linkage services have staff members that have been trained in risk-reduction counseling or other prevention interventions (e.g., CRCS). These may be the same staff conducting HIV testing. Therefore, it may be feasible for you to provide clients with a positive HIV test result with brief risk-reduction counseling onsite, either in conjunction with results delivery or at a future time. Another option is to refer clients with a positive HIV test result to risk-reduction services suited to clients’ needs. Additional information on behavioral interventions for HIV-positive individuals is available in Appendix B.

As resources permit, conduct a more in-depth assessment of risk with clients with positive test results to identify factors implicated in transmission risk and to help guide referrals to the services (including behavioral interventions) most appropriate to address these factors. It is essential that referrals be responsive to the findings of this assessment as your agency capacity and local resources allow. For additional information on performing referral assessments, please refer to the section titled Implementing Referral and Linkage presented in Chapter 7: Referral and Linkage to Health and Prevention Services.

Risk Reduction for HIV-Negative Clients

Provide condoms to all clients with negative HIV test results. It is essential to provide HIV-negative clients that have been identified as being at high risk for acquiring HIV infection with a brief behavioral risk-reduction intervention during the testing visit, if feasible, or linked to a program that can provide these services.

As resources permit, conduct a more in-depth assessment of risk with HIV-negative clients at high risk for acquiring HIV to identify factors implicated in transmission risk and to help guide referrals to the services (including behavioral interventions) most appropriate to address these factors. Referrals should be responsive to the findings of this assessment, and linkage assistance can be provided as your agency capacity and local resources allow. For additional information on performing referral assessments, please refer to the section titled Implementing Referral and Linkage presented in Chapter 7: Referral and Linkage to Health and Prevention Services.

Brief Behavioral Risk-Reduction Interventions

There are a variety of brief low- to moderate-intensity behavioral risk-reduction interventions that have been demonstrated to be effective with various target populations relative to reducing HIV risk. Some of these interventions are delivered at
an individual level, and some at a group level. Other interventions (e.g., Safe in the City) do not require trained staff to deliver the intervention, and instead rely on passive delivery via video. These interventions can be provided in a variety of settings where HIV testing services are offered. CDC has developed resources to assist providers in implementing these interventions. Additional information about these interventions is available in the Resources section of the Toolkit.

If you make referrals for risk-reduction interventions, it is important that those are relevant to the client’s situation and which address their immediate risk-reduction needs. You should not provide or refer clients to risk-reduction interventions simply because the intervention is available onsite or through referral. A poor match between a risk-reduction intervention and a client’s needs is unlikely to result in the client adopting risk-reduction behaviors and is not an efficient use of agency resources.

Data obtained from formative evaluation, along with HIV testing and linkage service data, can be used to gain an understanding of the types of issues that influence the HIV risk of the target population. This will help you to select the most appropriate brief risk-reduction intervention(s) to offer to clients. For additional information on applying data from formative evaluation activities to program planning, please refer to the section titled Formative Evaluation and Implementation Planning in Chapter 2: Getting Started—Preparing to Implement HIV Testing and Linkage in Non-Clinical Settings. Additional information on training and resources to assist HIV testing and linkage providers in selecting the most appropriate interventions is available in the Resources section of the Toolkit.

**Other Risk-Reduction Interventions**

If the client indicates experiencing signs or symptoms of STDs, provide them with STD screening and/or treatment services. If these are not available at your HIV testing site, make referrals to and provide clients with assistance in accessing STD screening and treatment services.

If your program is unable to offer STD screening, consider partnering with a community health center or HD to offer such services, if feasible. At minimum, develop a strong referral relationship with such agencies to ensure that clients have access to STD screening and treatment.

If a client reports unprotected vaginal/anal sex with an HIV-positive partner or partner of unknown HIV status within 72 hours before being tested, and that client has a negative test result, the client may benefit from n-PEP. You will need to identify providers who can provide n-PEP services and forge partnerships with them to ensure that clients in need of such services are able to access them. The Resources section of the Toolkit includes links to information about n-PEP.

Partnerships and collaboration, including strategies for developing and operationalizing them, are discussed in detail in the section titled Community Partnerships and Referral
Resources, presented in Chapter 7: Referral and Linkage to Health and Prevention Services.

For HIV-negative clients identified as high risk, more in-depth discussion and exploration of client needs relative to risk reduction can occur in the context of referral assessment and planning. Please refer to the section titled Implementing Referral and Linkage presented in Chapter 7: Referral and Linkage to Health and Prevention Services for additional information about referral assessment and planning.

Quality Assurance for Risk-Reduction Services

Develop written policies and procedures for provision of and/or referral to brief risk-reduction services. Ensure that staff members have the training necessary to provide and/or facilitate access to brief risk-reduction interventions. Some State and local HDs provide training on prevention counseling or other brief risk-reduction interventions. Additional information on training and education for brief risk-reduction interventions is available in the Resources section of the Toolkit.

Training

Ensure that staff\(^1\) providing or facilitating access to brief risk-reduction interventions have received training appropriate to their responsibilities:

- It is important that staff providing risk-reduction interventions receive training and education on the following:
- Signs and symptoms of viral illness.
- Behavioral and other (local) factors associated with increased risk for HIV transmission or acquisition (e.g., syphilis co-infection, local trends in new infections).
- Evidence-based risk-reduction interventions (e.g., Personal Cognitive Counseling), as applicable.
- Population-specific issues which impact reduction of risk for HIV transmission or acquisition.
- Properly and accurately documenting all aspects of provision of risk reduction.
- Agency policies and procedures regarding referral assessment and planning (please refer to the section titled Quality Assurance presented in Chapter 7: Referral and Linkage to Health and Prevention Services for additional information regarding recommended training for referral assessment and management).

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\(^1\) We recognize that many HIV testing and linkage programs enlist volunteers to provide HIV testing and linkage services. Often, volunteers perform the same functions as paid staff. Throughout this guide, for convenience, we use the word "staff" to refer to both paid staff and volunteers.
Proficiency

Evaluate staff providing risk-reduction services to assess their proficiency. Direct observation of sessions with clients is an effective strategy to assess proficiency in both areas. If direct observation is not possible, role plays are an alternative strategy for assessing proficiency.

It is useful to observe staff at regular intervals (e.g., annually), and more frequently after initial training (e.g., monthly for the first 3 months). Additional information on assessment of proficiency is presented in Chapter 9: Quality Assurance and Monitoring and Evaluation in the section titled Quality Assurance.

Documentation and Record Keeping

As an HIV testing and linkage provider, you will need to keep documentation of the following:

- Staff training and proficiency assessments, including orientation to risk-reduction policies and procedures.
- Provision of risk-reduction services.
- Referrals made for risk-reduction services, as applicable.
- Authorizations for release of information.
- Client satisfaction with services.

Conduct reviews of client charts (e.g., annually) to evaluate their completeness and accuracy relative to risk reduction. Review of client charts may be conducted more frequently after initial training (e.g., monthly for the first 3 months). Sampling (e.g., a random sample of five charts for each testing staff member) is appropriate if it is not feasible for your agency to review all client charts. Additional information on documentation and record keeping is presented in Chapter 9: Quality Assurance and Monitoring and Evaluation (refer to the section titled Quality Assurance).

Monitoring and Evaluation

It is good practice to review data regularly (e.g., quarterly) to assess the extent to which you are identifying individuals at highest risk for HIV transmission or acquisition and your success in providing and/or linking such individuals with needed risk-reduction services. By evaluating efforts to identify and link high-risk clients to services on a regular basis, you will be able to refine practices to ensure that the needs of your clients are met.

The section titled Implementing Monitoring and Evaluation presented in Chapter 9: Quality Assurance and Monitoring and Evaluation has additional information and tools to help you to evaluate your efforts to identify high-risk individuals. Also included in that section are tools to help you conduct a yield analysis to better understand how well your program is working and to guide you in discussions about program improvement.
CHAPTER 5 AT A GLANCE

This chapter addresses HIV testing strategies. In this chapter we discuss the following:

- The different kinds of tests used to diagnose HIV infection, including test performance
- The window period associated with different kinds of tests
- The benefits and drawbacks of various tests
- Testing for acute HIV infection
- The benefits and drawbacks of different testing strategies
- Testing strategies, including how to select the best testing strategy for your program

The tools and examples provided in this chapter will help you to do the following:

- Select the best testing strategy for your program and clients

HIV Testing Technology

Overview

The overarching goals associated with HIV testing are to identify HIV-infected individuals as early in the course of their infection as possible and to link them to HIV medical care as soon as possible. Early treatment for HIV results in better health outcomes. Most people with HIV receiving care receive antiretroviral therapy (ART) that decreases the amount of the virus (i.e., viral load) in their body. Low viral load is associated with better health outcomes for individuals living with HIV.

Viral load is highest shortly after an individual is infected with HIV. People living with HIV are more likely to transmit HIV to others during this acute phase of infection. Diagnosing individuals during this phase and linking them to medical care is an important prevention strategy, because it reduces the likelihood of transmission of HIV to their partners.
Definitions:
- **Acute HIV Infection**: The highly infectious initial phase of HIV disease, which can last approximately 2 months. It is characterized by a variety of flu-like symptoms such as fever, fatigue, rash, headache, sore throat, swollen tonsils, nausea, vomiting, diarrhea, and joint and muscle aches.
- **Window Period**: The time period between when a person becomes infected with HIV and when a test can detect HIV infection. The window period varies by test.

There are a variety of tests approved by the Food and Drug Administration (FDA) that are used to identify and diagnose HIV infection. HIV tests vary in how soon after infection they can detect HIV infection (i.e., window period). The shorter the window period, the sooner a test can detect HIV after infection. Additional information on HIV tests, including their characteristics, is available on CDC’s Web site.

Available HIV tests are very accurate and give correct results most of the time, given their specified window periods. In other words, some tests are better than others in detecting acute infection. This will be discussed in more detail in the Acute Infection Testing section.

Definitions:
- **Sensitivity** is the ability of a test to correctly identify clients with HIV infection (i.e., “true positives”). A highly sensitive test is unlikely to give a false negative result.
- **Specificity** is the ability of a test to correctly identify clients without HIV infection (i.e., “true negatives”). A highly specific test is unlikely to give a false positive result.

The accuracy of HIV tests is described in terms of sensitivity and specificity. HIV tests vary in their sensitivity and specificity. Tests with higher sensitivity and specificity will give a correct result more times than not, after the window period specified for that test, compared with tests with relatively lower sensitivity and specificity. It is important to note that sensitivity and specificity vary by test type and also by sample type. This will be discussed in more detail later in this chapter.

**Antibody Tests**

HIV screening tests (e.g., enzyme immunoassay [EIA]) and supplemental tests such as the Western blot detect the presence of HIV antibodies. Antibodies are produced by the body in response to infection with HIV.

Antibody tests are often described in terms of “generation.” First- and second-generation tests, including the Western blot, detect only Immunoglobulin G (IgG) antibodies. These antibodies appear later in the course of HIV infection. The window period for first generation antibody tests (including the Western blot) is 6 weeks or more. Second-generation laboratory-based antibody tests have a window period of 4 to 6 weeks. Rapid tests currently used by non-clinical HIV testing programs have window periods that are equivalent to second generation laboratory tests.
More recent third-generation antibody tests detect both IgG and Immunoglobulin M (IgM) antibodies. IgM antibodies appear earlier in the course of infection than IgG. These tests reduce the window period to 3 to 4 weeks.

HIV-2 is uncommon in the United States, but is reported. Most second-generation HIV tests, almost all third generation HIV tests, and all fourth generation tests can detect both HIV-1 and HIV-2. First generation tests, including the Western blot, detect only HIV-1.

Fourth-generation antibody tests detect antibodies (both IgG and IgM), as well as p24 antigens. The p24 antigen is a viral protein of the HIV virus itself that appears before the production of antibodies. Antigens provoke the body’s immune response to produce antibodies. Tests that detect the p24 antigen further reduce the window period to 2 to 3 weeks. Currently, the only fourth-generation antibody tests available require serum or plasma samples and must be performed in a laboratory. There are currently no FDA-approved fourth-generation rapid HIV tests which are waived under Clinical Laboratory Improvement Amendments (CLIA) and available for use in non-clinical settings.

**Nucleic Acid Tests**

Nucleic acid tests detect the presence of the HIV-1 virus itself by testing for its genetic material, ribonucleic acid (RNA). The window period for RNA tests is 7 to 14 days. RNA tests must be performed in a laboratory, as they are highly complex and currently require serum or plasma samples.

Additional information about HIV test technologies is available in Appendix B.

**Overview: Laboratory-Based and Point-of-Care Rapid HIV Testing**

You can conduct HIV testing using laboratory-based technologies (i.e., conventional testing) or at point-of-care, using rapid or conventional HIV tests. In this section we will discuss each of these, including benefits and drawbacks.

**Laboratory Testing**

Laboratory HIV testing involves obtaining a blood sample and sending it to a laboratory (e.g., a public health or commercial laboratory) for testing. Results are typically available a few days after the sample is received. Laboratories conduct HIV testing on serum or plasma samples. Screening tests are typically either third-generation antibody tests or fourth-generation antibody/antigen combination tests. HIV tests used by laboratories also detect HIV-2. Some laboratories conduct HIV testing on oral fluid specimens. Current oral fluid laboratory tests are first- and second-generation HIV-1 antibody tests.

Laboratories typically use combinations of different tests conducted in sequence (called algorithms), to diagnose HIV infection. If the first test used in the algorithm is reactive, subsequent tests are conducted to confirm a diagnosis of HIV. Some algorithms include...
tests that distinguish between HIV-1 and HIV-2. Some algorithms include RNA tests, which allow the confirmation of diagnosis of acute HIV infection. The results of laboratory testing can be considered final unless the client’s most recent exposure occurred during the test’s window period. The algorithms that include RNA tests and tests that differentiate between HIV-1 and HIV-2 infection require blood samples. The abilities of some test algorithms to identify acute HIV infection and to differentiate HIV-1 from HIV-2 infection are key advantages of laboratory testing.

If you choose laboratory testing, you will need some specific equipment and supplies. Most HIV testing done in laboratories is performed on blood samples, collected by venipuncture. Venipuncture simply means drawing blood from a vein in your client’s arm. Depending on State and/or local regulations, your staff may need special training to do venipuncture. You will also need equipment and supplies that will enable you to obtain and process blood samples before sending them to the laboratory, including the following:

- Needle and syringes or other system designed for blood collection
- Tourniquets
- Blood specimen collection tubes
- Personal protective equipment (e.g., lab coat, latex gloves)
- Hazardous waste disposal containers

The red blood cells in the sample you have collected from a client will need to be separated from the serum or plasma to allow testing. For some tests, this must be done before the specimen is transported to the laboratory. Separation requires the use of a centrifuge. Samples may also require refrigeration. Oral fluid testing requires use of a special sample collection device and sample transport vial, but the sample does not require preparation prior to submitting it to a laboratory.

Laboratory testing can be used as the method for initial testing or for supplemental testing, in order to confirm a diagnosis of HIV subsequent to a reactive rapid test result.

**Benefits and Drawbacks of Laboratory HIV Testing:** The benefits and drawbacks of HIV testing conducted in the laboratory are presented in Exhibit 5.1.
Exhibit 5.1. Benefits and Drawbacks of Laboratory HIV Testing

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Drawbacks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population level</strong></td>
<td><strong>Population level</strong></td>
</tr>
<tr>
<td>• Highly accurate</td>
<td>• Test performance varies by product</td>
</tr>
<tr>
<td>• Able to detect acute infection</td>
<td><strong>Client level</strong></td>
</tr>
<tr>
<td>• Can distinguish between HIV-1 and HIV-2</td>
<td>• Wait time for result</td>
</tr>
<tr>
<td><strong>Client level</strong></td>
<td>• May require invasive collection technique</td>
</tr>
<tr>
<td>• Result is final</td>
<td>for blood sample</td>
</tr>
<tr>
<td>• Can be conducted on blood or oral fluid</td>
<td>• Requires second encounter with client to</td>
</tr>
<tr>
<td>• Supplemental testing to confirm diagnosis</td>
<td>provide test results</td>
</tr>
<tr>
<td>• HIV infection can be conducted on single</td>
<td>• May delay linkage with HIV medical care</td>
</tr>
<tr>
<td>sample</td>
<td>• May delay linkage with PS</td>
</tr>
<tr>
<td><strong>Program level</strong></td>
<td><strong>Program level</strong></td>
</tr>
<tr>
<td>• No storage of reagents</td>
<td>• Requires skilled technician for collecting</td>
</tr>
<tr>
<td>• Minimal quality assurance</td>
<td>(e.g., phlebotomist) and processing specimen</td>
</tr>
<tr>
<td>• Ongoing cost to program relatively low</td>
<td>• Requires strategy to ensure clients</td>
</tr>
<tr>
<td>• Minimal staff training for conducting a</td>
<td>receive test results</td>
</tr>
<tr>
<td>test</td>
<td>• May not be appropriate or feasible for some</td>
</tr>
<tr>
<td></td>
<td>settings</td>
</tr>
<tr>
<td></td>
<td>• May require special equipment/supplies</td>
</tr>
<tr>
<td></td>
<td>(e.g., needles, collection tubes)</td>
</tr>
</tbody>
</table>

Consider these benefits and drawbacks when deciding on laboratory HIV testing. Selection of HIV tests is discussed later in this chapter.

**Point-of-Care Rapid HIV Tests**

There are several FDA-approved rapid HIV tests that can be used by HIV testing and linkage providers in non-clinical settings. These tests are categorized as waived under CLIA. CLIA sets Federal regulatory standards that apply to all clinical laboratory testing performed in the United States. Tests categorized as CLIA-waived can be performed outside of a laboratory setting, but testing programs must register and obtain a CLIA certificate of waiver. Waived tests can be performed by anyone who has been trained in their use, but typically no special credentialing is required. More information about obtaining CLIA waivers is available in Appendix B: Resources. Many States have policies or regulations that address rapid HIV testing. Contact your State or city HD to learn more about requirements associated with rapid HIV testing in your jurisdiction.

CLIA-waived rapid tests typically used in non-clinical settings require oral fluid or whole blood samples acquired by a finger stick or venipuncture. Blood samples do not need to be processed further before they are tested. One test can be used with either blood or oral fluid samples, but the sensitivity and specificity of the test is lower when performed with oral fluid compared with whole blood. Most rapid tests detect both HIV-1 and HIV-2. The time to perform the test and obtain results varies by test and ranges from 1 to 60 minutes. This allows you to provide a client with a result immediately after the test is performed. Reactive test results require supplemental testing to confirm a diagnosis of HIV. Supplemental testing can be facilitated by the HIV testing provider or through
referral to another, clinical provider. Using two different rapid HIV tests in sequence can improve the positive predictive value of an initial reactive rapid test result if the results of both tests are reactive.

**Definition:**
Positive predictive value (PPV): The percentage of true positive results among all positive results, (i.e., the number of true positives divided by the number of true positive results added to the number of false positive results). A low PPV (e.g., 50%) indicates that many of the positive test results are false positives. A high PPV (e.g., 98%) indicates that most of the positive test results are true positives.

The use of two rapid HIV tests in sequence is discussed below.

If you choose rapid HIV testing, you will need some specific equipment and supplies. If you are testing using whole blood samples, you will need supplies to conduct sampling either via venipuncture or finger stick, such as lancets, personal protective equipment (e.g., lab coat, latex gloves), and biohazardous waste disposal containers. You will also need equipment, such as refrigerators to store reagents, thermometers to monitor storage and operating temperature, and timers. Additional detail on supplies and material for rapid HIV testing is available in Chapter 6: Implementing HIV Testing.

**Benefits and Drawbacks of Point-of-Care Rapid HIV Testing:** The benefits and drawbacks of rapid HIV testing in non-clinical settings are presented in Exhibit 5.2. Consider these benefits and drawbacks when deciding on implementing point-of-care rapid testing.

**Exhibit 5.2. Benefits and Drawbacks of Point-of-Care Rapid HIV Testing**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Drawbacks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population level</strong></td>
<td><strong>Population level</strong></td>
</tr>
<tr>
<td>Highly accurate relative to the window period</td>
<td>• Decreased sensitivity to detect acute infection</td>
</tr>
<tr>
<td></td>
<td>• Cannot distinguish between HIV-1 and HIV-2</td>
</tr>
<tr>
<td></td>
<td>• Sensitivity and specificity varies with different products and sample types</td>
</tr>
<tr>
<td></td>
<td>• Some reactive test results will be false positive</td>
</tr>
<tr>
<td><strong>Client level</strong></td>
<td><strong>Client level</strong></td>
</tr>
<tr>
<td>• More clients receive their test results without the need for a second encounter</td>
<td>• Supplemental testing must be performed to confirm diagnosis of HIV after a reactive test result</td>
</tr>
<tr>
<td>• Can be conducted on finger stick or oral fluid</td>
<td>• Longer window period compared with most laboratory tests</td>
</tr>
<tr>
<td><strong>Program level</strong></td>
<td><strong>Program level</strong></td>
</tr>
<tr>
<td>• Can be feasibly used in a variety of settings</td>
<td>• Requires strategy to ensure clients receive test results (if supplemental testing is arranged by testing provider)</td>
</tr>
<tr>
<td>• Can be conducted by trained users</td>
<td>• Quality assurance at multiple sites</td>
</tr>
<tr>
<td></td>
<td>• Quality assurance for multiple tests (if different rapid tests in sequence are used)</td>
</tr>
<tr>
<td></td>
<td>• Requires dedicated and temperature-controlled space to store test kits and controls and strategies to store and transport test supplies and to conduct tests</td>
</tr>
<tr>
<td></td>
<td>• May require additional licensing or certification</td>
</tr>
<tr>
<td></td>
<td>• Reader variability in interpreting test results</td>
</tr>
<tr>
<td></td>
<td>• Higher costs for testing program, compared with laboratory testing</td>
</tr>
</tbody>
</table>
You may consider several different strategies for using rapid HIV tests in non-clinical settings. Different strategies include the following.

**Strategy 1—Single Rapid Test Followed by Laboratory-Based Supplemental Testing for Reactive Rapid Test Result:** You can perform a single rapid HIV test on a blood or oral fluid specimen. If the result of this rapid test is reactive (i.e., antibodies have been detected), a sample is obtained for supplemental testing in a laboratory to confirm an HIV diagnosis. It is helpful to notify the laboratory conducting supplemental testing of the previous reactive rapid test result.

You will need to contact the client or have the client return to your agency after several days for the laboratory test results to confirm an HIV diagnosis. Some clients may find it challenging to return to an HIV testing and linkage provider to receive their results, and you will need to have a strategy in place to ensure that clients receive their supplemental test results. Additional discussion of the strategies that you can use to ensure that clients receive test results is included in Chapter 6: Implementing HIV Testing. One alternative is to initiate linkage to HIV medical care, on the basis of the reactive rapid test result, and arrange to have the supplemental test results transmitted to the HIV medical care provider. Obtain an authorization for release of health information from the client if you pursue this option.

The benefits and drawbacks associated with Strategy 1 are summarized in Exhibit 5.3.

<table>
<thead>
<tr>
<th><strong>Recommended Activity</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A blood specimen is recommended for supplemental testing after a reactive rapid HIV test.</td>
</tr>
</tbody>
</table>

**Strategy 2—Single Rapid Test, Immediate Linkage to HIV Care for Reactive Rapid Test Result:** HIV testing and linkage providers also have the option of linking clients to HIV medical care on the basis of a single reactive rapid HIV test result. This strategy facilitates linkage to care and does not require a second visit by the client to the HIV testing provider. In settings that serve high-risk clients, rapid HIV tests have a high positive predictive value for detecting antibodies indicative of established HIV infection. In most cases, a reactive HIV rapid test represents HIV infection. However, supplemental laboratory testing must still be conducted to confirm an HIV diagnosis. Supplemental testing may be conducted by the HIV medical provider rather than the HIV testing and linkage provider.

If you choose this testing strategy, it is important to ensure that HIV care providers are willing and able to accept clients on the basis of a single reactive test result. This may be an important component to address in MOA with HIV care providers. Consult with your State or local HD to determine whether there are any local regulations or policies that prohibit you from making a linkage to care on the basis of a single reactive rapid test result. Submit a completed HIV/AIDS case report to the State/local HD, pursuant to

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1 In the context of HIV testing, “strategy”, as used in this guide, refers to activities and processes associated with employing specific testing technologies to conduct HIV testing with clients.
The benefits and drawbacks associated with Strategy 2 are summarized in Exhibit 5.3.

**Strategy 3—Two Rapid Tests, Immediate Linkage to HIV Care if Both Rapid Tests Reactive; Supplemental Testing if Second Rapid Test Is Nonreactive:** You may consider performing two sequential rapid HIV tests. In this case, a second rapid HIV test is performed if the first rapid HIV test is reactive. If both tests are reactive, this increases the likelihood that the results represent a true positive result (i.e., it increases the positive predictive value of the reactive initial test). If the second rapid HIV test is nonreactive, arrange supplemental testing either by obtaining a specimen for laboratory testing or by linking clients to HIV medical care for supplemental testing. In general, most clients with two reactive rapid HIV test results are infected with HIV, and therefore can benefit from medical evaluation and treatment for HIV infection. Medical providers can perform supplemental testing necessary to confirm an HIV diagnosis. If the first rapid test result is reactive, but the second is negative, the client may have HIV infection. Therefore, it is important to provide or arrange for supplemental testing and/or medical evaluation.

The first test in the sequence must have sensitivity that is equal to or better than the second test used in the sequence. The second HIV rapid test must be conducted with a different test that incorporates different antigens. Usually this is a test from a different manufacturer. Reactive results on both tests improve the positive predictive value of the first test. However, supplemental laboratory testing must still be conducted to confirm an HIV diagnosis. Supplemental testing need not be performed by the HIV testing and linkage provider.

If you choose this testing strategy, ensure that HIV medical providers are willing and able to accept clients on the basis of one or two reactive results. This may be an important component to address in MOAs with HIV medical providers. Consult with your State or local HD to determine whether there are any local regulations or policies that prohibit you from making a linkage to HIV medical care on the basis of reactive rapid test result. Submit a completed HIV/AIDS case report to the State/local HD, pursuant to State statute or regulation. Contact your State or city HD to obtain additional information about HIV disease reporting.

The benefits and drawbacks associated with Strategy 3 are summarized in Exhibit 5.3.
### Exhibit 5.3. Benefits and Drawbacks of Point-of-Care Rapid HIV Test Strategies*

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Benefits</th>
</tr>
</thead>
</table>
| **Strategy 1: Single Rapid Test; Laboratory-Based Supplemental Testing for Reactive Result** | - Clients can be provided with negative test results immediately  
- Identifies clients most likely to be HIV-positive and in need of supplemental testing  
- Suitable for use if there is a high likelihood that clients will receive results of supplemental tests  
- Suitable for use in settings where QA of multiple products not feasible  
- Facilitates linkage with HIV medical care  
- Facilitates linkage with PS | - Clients with acute infection may receive false-negative results  
- Supplemental testing delays linkage with HIV medical care (relative to rapid test strategies 2 and 3)  
- Supplemental testing delays linkage with PS (relative to rapid test strategies 2 and 3)  
- Clients may not receive results of supplemental tests |
| **Strategy 2: Single Rapid Test, Immediate Linkage to HIV Care for Reactive Result** | - Clients can be provided with negative test results immediately  
- Identifies clients most likely to be HIV-positive and in need of supplemental testing  
- Suitable for use in settings where QA of multiple products is not feasible  
- Suitable for use if obtaining specimens for supplemental tests is not feasible  
- Suitable for use if there is a high likelihood that clients will not receive results of supplemental tests  
- Facilitates linkage with HIV medical care  
- Facilitates linkage with PS | - Clients with acute infection may receive false-negative results  
- Some clients with false-positive results will be linked to HIV medical care  
- Clients with reactive rapid test results will still require supplemental testing to confirm diagnosis  
- Some HIV medical providers may not be willing to accept clients on the basis of a single reactive rapid test result |
| **Strategy 3: Two Rapid Tests in Sequence, Immediate Linkage to HIV Care if both test results are reactive** | - Improves positive predictive value when two tests are reactive  
- Identifies clients most likely to be HIV-positive and in need of supplemental testing  
- Facilitates linkage with HIV medical care  
- Facilitates linkage with PS | - Maintaining inventory and conducting QA of multiple rapid tests may be challenging  
- Clients will still require supplemental testing to confirm diagnosis  
- Clients with a nonreactive second test result will require supplemental testing  
- Some HIV medical providers may not be willing to accept clients on the basis of reactive rapid test results alone |


In the following example, Sophia Rumanes of the Los Angeles County Department of Public Health describes the dual rapid algorithm used to facilitate diagnosis and linkage to care.
The County of Los Angeles, Department of Public Health, Division of HIV and STD Programs (DHSP) has adopted and implemented a two-test HIV rapid testing algorithm (RTA) at publically supported HIV testing sites with demonstrated capacity to offer HIV RTA as the standard of care. HIV RTA uses a sequence of up to two different types of HIV rapid tests to provide clients with more definitive information about their HIV status within 1 hour, eliminating the need for laboratory-based supplemental testing, which would require a return visit for results and allowing for immediate referral and linkage to care and treatment services. According to DHSP’s HIV RTA study (funded by CDC 2007 to 2009), 100% of HIV-positive clients at the RTA sites received their results and were referred to care on the same day, compared to 65.4% of clients at regular HIV rapid testing sites who received their confirmed results (with a median of 8 days) and were referred to care and prevention services. DHSP plans to expand RTA to be the standard of care at all funded HIV testing sites to improve disclosure and linkage to prevention and care services.

- Sophia Rumanes, MPH
Chief, Prevention Services Division
Los Angeles County Department of Public Health
Los Angeles, CA

Oral Fluid Testing

Oral fluid HIV testing remains an important tool for HIV prevention programs. However, there are limitations associated with oral fluid testing about which HIV testing and linkage providers must be aware.

The Avioq HIV-1 EIA and OraSure® Western blot are the only two FDA-approved laboratory tests available for oral fluid laboratory testing. Samples for laboratory testing of oral fluid must be collected with the OraSure oral fluid collection device. The sensitivity and specificity of these tests are lower with oral fluid samples when compared with blood specimens, and these tests do not contain antigens that detect HIV-2 antibodies. Laboratory-based oral fluid tests and the Western blot are less sensitive during acute infection than laboratory-based screening tests designed for use with blood and have a longer window period than other blood-based laboratory tests.

The OraQuick ADVANCE® Rapid HIV-1/2 Antibody test is the only FDA-approved rapid test approved for use on either blood or oral fluid samples. The sensitivity and specificity of this test is lower when used with oral fluid when compared with blood specimens.

- Recommended Activity
Blood (whole blood, serum, or plasma) is the preferred specimen for HIV testing because the sensitivity and specificity of tests conducted on blood are higher than those conducted on oral fluid.
In light of advances in technologies for HIV testing, carefully consider the expected benefits of oral fluid testing relative to the drawbacks (summarized in Exhibit 5.4), the needs and preferences of clients, and agency capacity.

### Exhibit 5.4. Benefits and Drawbacks of Oral Fluid Testing

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Drawbacks</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Permits HIV testing in outreach settings or for client populations where collection and processing of blood samples is difficult</td>
<td>• Decreased sensitivity to detect acute infection</td>
</tr>
<tr>
<td>• May facilitate testing if clients would not be tested if venipuncture or finger stick sample collection were required</td>
<td>• Decreased sensitivity and specificity compared with serum or whole blood specimens</td>
</tr>
<tr>
<td>• Does not require trained technician (e.g., phlebotomist) for specimen collection and processing</td>
<td>• Increased indeterminate Western blot results compared with serum or whole blood</td>
</tr>
<tr>
<td>• Decreased risk of occupational exposure to staff performing HIV testing</td>
<td>• Cannot distinguish between HIV-1 and HIV-2</td>
</tr>
<tr>
<td>• Screening and supplemental assay (Western blot) performance is acceptable for established infections</td>
<td>• Western blot is only supplemental test available for use with oral fluid to confirm an HIV diagnosis</td>
</tr>
<tr>
<td></td>
<td>• Higher collection and processing costs for laboratory testing compared with serum or whole blood</td>
</tr>
</tbody>
</table>

There are many circumstances in which oral fluid testing is appropriate to achieve your program objectives. However, contemporary HIV tests improve our ability to diagnose HIV infections earlier, and facilitate earlier entry to care and treatment. In most circumstances, testing blood specimens is preferred because it enables the use of more accurate testing algorithms.

Consult with your State/local HD to identify the technologies and approaches that will most efficiently and effectively address program priorities, respond to the needs of communities, and be feasible within the capacity of your agency.

### Acute Infection Testing

Because viral load is highest shortly after an individual is infected with HIV, people living with HIV are more likely to transmit HIV to others during this acute phase of infection. Therefore, diagnosing individuals with acute infection and linking them to medical care, PS, and other prevention services are important prevention strategies.

If feasible, use a testing strategy that can identify acute infection. Most HIV tests miss much of acute stage of infection. Algorithms which employ fourth-generation antibody/antigen combination tests and which include RNA tests can identify acute infection. If you are using laboratory-based HIV testing, either for initial or for supplemental testing associated with reactive rapid tests, it is essential that you understand the tests and algorithm used by the laboratory.

If the laboratory that performs HIV testing for you does not offer tests that detect acute infection, or if you are not able to conduct laboratory-based HIV testing for all of your
clients, identify and form a partnership with a laboratory or other partner agency that can perform acute HIV testing. It is important to refer clients who are suspected of acute infection for testing for acute HIV infection. Exhibit 5.5 presents the criteria for identifying which clients should receive testing for acute HIV infection. As part of your interaction with clients, you will be gathering information about risk that can help you determine the need for acute infection testing. Please refer to Chapter 4, Exhibit 4.2 for questions that can help in this regard.

### Exhibit 5.5. Criteria for Identifying Clients for Whom Acute HIV Testing Is Recommended

<table>
<thead>
<tr>
<th>Criteria for Acute HIV Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Exposure, through unprotected sex or injection drug use, within the previous 2 weeks, to an individual known to be HIV-positive or whose HIV status is unknown</td>
</tr>
<tr>
<td>• Clinical symptoms of viral illness such as fever, fatigue, rash, headache, sore throat, swollen glands, nausea, vomiting, diarrhea, and joint and muscle aches</td>
</tr>
</tbody>
</table>

If you will be referring clients for acute HIV testing, your process for doing so can be addressed in your policies and procedures.

### Selecting an HIV Testing Strategy

In deciding which testing strategy to use, you will want to consider first, and foremost, performance. Use a strategy which provides accurate results and which can identify HIV as soon as possible after infection. However, you will need to balance performance against other client- and program-level factors, such as client preferences, program capacity, cost, and the settings in which HIV testing will be performed. You may decide to use multiple strategies, because different strategies may be appropriate for different venues or settings, or for individual clients.

You may elect, for example, to use rapid testing in conjunction with outreach testing activities and laboratory-based testing, using blood specimens, for testing performed within your agency. You may decide to provide HIV testing using point-of-care rapid tests for the vast majority of your clients, but for some clients you may recommend and/or provide laboratory testing that can identify acute infection.

### Performance

Laboratory-based tests, using blood specimens, provide more accurate results than rapid tests or tests that use oral fluid specimens. Laboratory-based testing, using blood specimens, also enables the use of more advanced testing algorithms (i.e., those that use third- or fourth-generation tests and may include RNA tests), which allow for earlier detection of HIV infection. Laboratory-based testing also requires only one sample for both screening and supplemental testing and, if blood specimens are used, is typically less costly than other testing strategies.
Client-Level Factors

Client-level factors must also be considered in selecting a testing strategy. The likelihood that the client will receive a test result is of highest importance. If you plan to use laboratory-based testing but clients are unlikely to receive their final test results, you must identify strategies that will ensure that clients receive test results, such as verifying contact and location information to permit follow-up, or making results available by phone.

In highly transient populations, such as homeless individuals, it may be extremely challenging and resource intensive to follow up with clients to ensure that they receive test results. In this case, use of rapid tests may be most appropriate, because it will facilitate receipt of results for the majority of clients, who will be HIV negative. It will also allow you to either concentrate resources on following up on clients with HIV-positive test results (if you have used laboratory testing) or on linking to HIV medical care clients with reactive rapid test results.

Client acceptance of the testing method is also a consideration. Clients may express a preference for immediate test results (i.e., rapid HIV testing, point of care). This expressed need may be outweighed, however, by clients' perception of the accuracy of the test strategy. For example, clients may tell you that they would prefer to have their test results right away. This may suggest that it is appropriate to use rapid HIV testing. However, it may be important to the client that they get a result that is definitive. In this case, it may be better to conduct laboratory testing.

**Recommended Activity**

Explore with the target population, through survey or focus group, different testing methods. This will help them to understand the relative benefits and drawbacks of the various methods and will help you understand which factors are likely to be a barrier or facilitator to using particular testing methods.

The results of your formative evaluation activities should factor into your decisions regarding selection of testing methods, as related to client needs, priorities, and preferences. Additional discussion of formative evaluation is presented in Chapter 2: Getting Started—Preparing to Implement HIV Testing and Linkage in Nonclinical Settings. In particular, review the section titled Formative Evaluation and Implementation Planning.

Program-Level Factors

In selecting a testing method, you must also consider program-level factors. For example, do you have access to a laboratory that can perform third or fourth generation testing? Does the algorithm used by that laboratory include RNA testing? Contact your State or local public health laboratory. Even if they do not perform such testing, they may be able to refer you to a laboratory that does.

The venues or settings in which testing is to be performed will also weigh into your selection of testing methods, particularly as related to the type of sample that must be
collected. If you are testing at your agency, i.e., a “fixed site” it may be very feasible to employ a laboratory-based testing method, using blood samples. If you are testing at an outreach site, such as a park or bar, it may not be possible to employ laboratory-based testing that uses blood because it may not be feasible to collect, prepare, and transport venous blood samples in such settings. In this case, a rapid test that uses finger stick whole blood sampling may be more appropriate. Oral fluid testing, either conventional or point-of-care rapid tests, may also be appropriate in such settings. However, because of the lower sensitivity of oral fluid, testing on blood samples is preferred, unless clients would otherwise not be tested.

Integration of services may also weigh into your decisions regarding selection of testing methods. Many clients who are at risk for HIV infection are also at risk for STDs or infection with viral hepatitis. It may be beneficial for clients, and make your services more valuable to clients to provide testing for STDs and/or viral hepatitis in conjunction with HIV testing. In this situation, it may be more a more efficient use of resources to collect blood samples for laboratory testing for HIV, syphilis, and hepatitis C, as compared with conducting rapid test for HIV and laboratory tests for syphilis and hepatitis.

Your capacity to conduct follow-up on clients who do not receive test results should also be considered. If you perform a high volume of tests and/or have a relatively large number of clients who do not return for their test results, it may not be feasible for you to follow up on all clients. You need a strategy, such as notification of results by phone, to ensure that clients receive their test results, but it must be feasible for your staff and agency to manage. Rapid test strategies also facilitate receipt of results for the vast majority of clients who will be HIV negative. Employing a testing strategy which links clients to HIV medical care after one or two reactive rapid tests is another way to ensure that clients receive results and that program resources are focused on linkage to care, rather than follow-up on clients to ensure that they receive test results.

Consider your capacity as it relates to performing tests (including sample collection and preparation) and QA of testing activities in your selection of a testing strategy. Staff must have the knowledge and skills necessary to collect and prepare samples, as required by the test strategy (e.g., venipuncture for blood-based laboratory testing or finger stick for point-of-care rapid testing). You must have the appropriate equipment and supplies to prepare and transport samples to the laboratory for testing (e.g., centrifuge). Staff must have training and skills necessary to perform tests and conduct required quality controls, if you plan to use rapid testing. If a sequence of rapid tests is to be used, your staff must have the knowledge and skills needed to maintain inventory, proficiency, and QA for both. Your staff must be able to complete any training or certification required by statute, regulation, or policy.

Staff attitudes toward various testing methods will also impact your ability to adopt and use them. For example, staff may be resistant to adopting a new testing strategy. They may hold preconceptions about a variety of factors, such as the accuracy of the test, the ease of specimen collection, or even which methods of specimen collection clients will accept. Concerns or fears that staff have about various test strategies are often
unfounded and can be addressed through discussion and education. It is helpful to have staff members talk to peers from other agencies that have successfully adopted a particular strategy to address such concerns.

**Tip**
Staff conducting HIV testing are often a greater barrier in the adoption of a new testing method than are clients. It is important to educate HIV testing staff on test strategies and learn about their concerns and fears about adopting a new or modified test strategy.

The characteristics of individual products will also influence your choice of test strategy and selection of specific products. Understanding how testing will be integrated into workflow will help you to select the most appropriate products. For example, rapid tests have different minimum read times (ranging from 60 seconds to 20 minutes). The time interval during which test results must be read in order to be valid also varies (ranging from 2 to 20 minutes). It may be desirable to use a product with a longer window during which test results are valid—for example, if you are performing a high volume of tests at a health fair and you have limited staff coverage of the event. In this case, you may want to accommodate staff multitasking and not being able to read the test result at precisely 20 minutes. Operating temperature is another example of a product characteristic that may be important for you to consider. Rapid HIV tests have various operating temperatures. You may, for example, be conducting HIV testing in a on a very hot day. In this case, you would want to have a product that has a high operating temperature range.

Cost is an obvious consideration. Public health laboratories may perform HIV testing at relatively low or no charge, particularly if you receive funding from the State or local HD. You may also be able to purchase rapid test devices at reduced prices, such as through a 340B program. Rapid HIV tests vary widely in their cost, and in selecting one, you may need to trade off desirable characteristics for a more affordable product.

Exhibit 5.6 contains a summary of the factors that your agency may consider relative to selection of HIV testing strategy.

**Exhibit 5.6. Factors to Consider in Selecting HIV Testing Strategy**

<table>
<thead>
<tr>
<th>Performance</th>
<th>Client-Level Factors</th>
<th>Program-Level Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Test sensitivity and specificity (consider specimen type)</td>
<td>• Likelihood of client receiving results</td>
<td>• Access to laboratory testing, including acute HIV testing</td>
</tr>
<tr>
<td>• Ability to detect acute infection (window period)</td>
<td>• Acceptance of method of specimen collection</td>
<td>• Feasibility of use in various settings</td>
</tr>
<tr>
<td>• Ability to detect and/or distinguish HIV-2</td>
<td>• Acceptance of the test method</td>
<td>• Capacity to collect, process, and transport specimens</td>
</tr>
<tr>
<td></td>
<td>• Other factors (e.g., client perception of accuracy of the test method, preferences)</td>
<td>• Integration of services (e.g., provision of STD screening in conjunction with HIV testing)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Capacity to conduct QA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Capacity to conduct follow-up on clients who do not receive test results</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Product characteristics (e.g., shelf-life or time to results of rapid HIV tests)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Other factors (e.g., regulatory or funding requirements)</td>
</tr>
</tbody>
</table>
The practice examples below are presented to illustrate how various factors could come into play in your decisions about which test strategies will work best for you and your clients.

**Practice Example 5.1. Selecting a Testing Strategy for Individual Clients**

Center City Drug User Health Alliance (the Alliance) operates a syringe access program in Center City. The Alliance also provides HIV testing and linkage services. Glenn regularly uses the syringe access program and is also a frequent visitor to the community meals program, but you have not seen him for a couple of weeks. He tells you he has felt too sick to come in. During this visit, you also note that he has not been tested for HIV in over a year and learn that Glenn has shared syringes and other works (e.g., cookers, cottons, wash) with several different people. He has also tricked several times for drugs, and never used a condom. Glenn is currently “couch surfing”. You decide that you will recommend to Glenn that he should be tested for HIV, and because you suspect that Glenn may have acute infection, you draw blood for testing that will be sent to the CCHD laboratory. Even though Glenn is currently homeless, he has been a regular visitor to your program for quite a while, and you believe that he is likely to return to receive his test result.

**Practice Example 5.2. Selecting Testing Strategies for Specific Settings**

ACME Prevention Services targets young men who have sex with men in Center City. HIV testing is currently provided in several venues including bars, public parks, a bathhouse and their agency offices. Many of these men report inconsistent condom use in conjunction with anal sex and there is a relatively high level of drug use in conjunction with sex, particularly methamphetamine. New diagnosis of HIV infection has been rising rapidly in this population in the past two years and nearly one-half of all new syphilis cases among this group are co-infected with HIV. ACME employs several testing strategies.

ACME conducts laboratory-based HIV testing using blood samples for all tests conducted in their agency offices. Because this population is at very high risk for HIV and the likelihood of acute infection is relatively high, ACME wanted to employ a testing strategy that would address acute infection. They can also obtain a specimen for syphilis testing at the same time, which is important given the frequency of syphilis in this population.

ACME uses rapid tests for testing in bars and public parks, because it is very difficult to get clients tested in these venues to return to the agency for test results and because it would be challenging to draw, transport and prepare venous specimens in these settings. Clients with reactive rapid test results receive immediate referrals to HIV medical care. However, clients that have negative rapid test results in these venues, but who may be acutely infected are referred to the agency offices for acute testing. Next day appointments are made at the time of testing. Contact information is obtained from the client and active follow-up is conducted on clients who do not keep their appointments for supplemental testing.

The owners of Steam Pit bathhouse would not allow HIV or syphilis testing to be conducted on-site if blood samples were required. Because the Steam Pit has been identified as a “hub” of a sexual network in the recent syphilis outbreak, ACME wanted to ensure that that the test strategy that they used would address the likelihood of acute infection and also provide an opportunity to conduct syphilis testing. For this reason, ACME decided not to conduct HIV or syphilis testing in the bathhouse, but instead provides education and risk-reduction counseling and supplies, and refers clients to their agency where blood samples are obtained for laboratory-based testing. ACME provides next day appointments and offers incentives to encourage testing.
The example below describes the rationale and process used by Massachusetts Department of Public Health for transitioning non-clinical HIV testing and linkage providers from using point-of-care rapid HIV testing to fourth generation laboratory testing.

Beginning June 2012, the Massachusetts Department of Public Health (MDPH), Office of HIV/AIDS (OHA) implemented 4th generation HIV testing technology and the corresponding CDC-recommended testing algorithm in the Hinton State Laboratory Institute (HSLI). Previously, non-clinical testing grantees primarily conducted rapid HIV tests. Reactive rapid test results requiring a confirmatory test using a blood sample was obtained from clients and submitted to the HSLI for processing by EIA and Western blot.

The State Lab made the transition to fourth generation HIV testing consistent with CDC recommendations. Using the new technology allows clients to learn their HIV status in a shorter period of time, identify infection earlier (within 2 weeks), and link HIV-positive clients to care. This will improve health outcomes for persons living with HIV and their partners, particularly those identified in acute stage of HIV infection. Clients identified in the acute stage of HIV infection have immediate linkage to DIS and assurance of immediate connection to an infectious disease clinician for disease staging and care initiation, as well as HIV partner services for the index client. Integral to supporting persons newly diagnosed is referral to a range of behavioral, positive prevention, and peer support services. HIV testing is provided in the context of integrated communicable disease screening for STDs, hepatitis C, and vaccinations for hepatitis A and B.

MDPH service standards explicitly encourage clients to opt for a blood draw and conventional (i.e., fourth generation) testing if clients report recent or ongoing exposure, and are likely to return for test results. We recommend conventional testing if blood is to be drawn for hepatitis or STD testing. Rapid testing is still available, and we encourage use of rapid testing if the client does not identify recent exposure(s), is unlikely to return for results, and if blood is not being drawn for other tests. Yet because the fourth generation test is better than the rapid test in terms of accuracy, sensitivity, and specificity, and the ability to detect both antigen and antibody, and with a shorter window of detection, in some cases a blood draw is preferred.

MDPH modified our procedures for pre-test sessions to clearly explain to clients the HIV testing process and the options for testing, including the benefits of conventional testing. Risk assessment of the likelihood of client to return for results continues according to established procedures. However, we expect providers to make a specific recommendation to clients regarding type of test (i.e., rapid or conventional) based on assessment of their risk, how recent the exposure may have been, and the likelihood the client will return for results. Results are available to clients within 1 week at the site where HIV testing was conducted.

To prepare non-clinical providers for the shift to fourth generation laboratory-based
testing, all non-clinical providers were required to establish phlebotomy capacity onsite, or to establish new partnerships that provide this capacity. We required grantees to purchase the necessary equipment and support training opportunities for direct service staff. We arranged for daily pick-up of samples from each testing provider to ensure they reached the HSLI within 48 hours using a single method of transport—UPS CampusShip. HIV testing providers are also required to ship hepatitis and STD samples to the laboratory through this method to improve the efficiency of processing and receipt of results.

A series of day-long technical assistance sessions for testing site supervisors and staff providing direct services were delivered. These sessions addressed the rationale for the transition, science of the new technology, new policies and procedures associated with the transition to fourth generation (e.g., preparing samples for submission, shipping), roles and responsibilities of testing site supervisors, assessment of risk for acute infection and making testing recommendations, results delivery procedures, and the importance of linkage to care. Regular monitoring and reinforcing new service policies and procedures will ensure system change and high-quality services.

- Barry P. Callis  
Office of HIV/AIDS, Bureau of Infectious Disease  
Massachusetts Department of Public Health  
Boston, MA

As you can see, there are many factors that can be considered in selecting a testing strategy. No single option is best for all agencies, settings, or clients. Your community may be best served by using multiple testing strategies.
CHAPTER 6 AT A GLANCE

This chapter addresses implementation of HIV testing. In this chapter we discuss the following:

- The legal and regulatory issues associated with HIV testing
- The steps included in the process of testing for HIV
- Informed consent, including strategies for obtaining client consent
- Interpreting test results, including providing clear messages to clients
- Delivery of results, including strategies for delivery of results
- Procedures for site set-up, sample collection, and performing tests
- Universal precautions and exposure control
- Repeat testing
- Incentives to encourage receipt of final test results
- Quality assurance of testing activities, including training and assessing staff proficiency
- Monitoring and evaluation of testing activities

The tools and examples provided in this chapter will help you to do the following:

- Conduct testing in accordance with local, State, and Federal statute and regulation
- Interpret test results and provide clear and accurate messages to clients about the meaning of their test results
- Select strategies to ensure clients receive test results
- Make appropriate recommendations for retesting

Note: Site-specific considerations for HIV testing in outreach settings can be found in Chapter 8.

Legal and Regulatory Considerations for HIV Testing

Before initiating a non-clinical HIV testing and linkage program, you must understand the State and local legal and regulatory requirements and limitations as they apply to HIV testing. Of particular importance is ensuring that your agency has the legal authority to conduct HIV testing.
Authority to Perform HIV Testing: All States have regulations or statutes regarding who may perform HIV testing. In general, testing to diagnose a disease must be performed under the supervision of a physician or other licensed health care professional. Some cities have additional regulations. Contact your State or local HD to learn more.

Policies and Regulations About HIV Testing: All States have policies, regulations, and/or statutes about HIV testing. Many cities have additional policies and regulations. Policies and regulations address issues such as laboratory certifications or licensure, training or credentialing of staff members who perform various aspects of HIV testing, provision of anonymous testing, disease reporting, and consent requirements.

If rapid HIV tests are to be used, you must obtain a certificate of waiver under CLIA. CLIA are Federal regulatory standards that apply to all clinical laboratory testing performed in the United States. If you plan to conduct HIV testing at multiple locations or venues, you may need to obtain CLIA certificates for each of these sites. Additional information about obtaining CLIA certificates of waiver is available in the Resources section of the Toolkit, or you can contact your State or city HD to learn more.

State laws and regulations vary with regard to the age at which minors may consent for HIV testing and treatment without a parent’s or guardian’s consent. Contact your State HD for specific information regarding the age of consent for HIV testing and treatment.

Conducting HIV Testing

Regardless of the setting, preparing to and actually conducting HIV testing involves the same basic set of activities, presented in Exhibit 6.1. This chapter focuses on providing HIV testing. Specifically, this chapter addresses engaging the client, performing testing, and delivering results. Planning for implementation of HIV testing and linkage programs, including selection of recruitment, testing, and linkage strategies, is addressed in other chapters of this manual. Similarly, risk reduction, referral and linkage, and QA are addressed elsewhere in this manual.
### Exhibit 6.1. HIV Testing Activities in Non-Clinical Settings

<table>
<thead>
<tr>
<th>Laboratory Testing</th>
<th>Rapid Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Plan testing and linkage program</td>
<td>• Plan testing and linkage program</td>
</tr>
<tr>
<td>▪ Recruitment strategies</td>
<td>▪ Recruitment strategies</td>
</tr>
<tr>
<td>▪ Testing strategies</td>
<td>▪ Testing strategies</td>
</tr>
<tr>
<td>▪ Venues and settings for testing</td>
<td>▪ Venues and settings for testing</td>
</tr>
<tr>
<td>▪ Linkage strategies</td>
<td>▪ Linkage strategies</td>
</tr>
<tr>
<td>• Engage clients</td>
<td>• Engage clients</td>
</tr>
<tr>
<td>▪ Obtain consent</td>
<td>▪ Obtain consent</td>
</tr>
<tr>
<td>• Conduct testing</td>
<td>• Conduct testing</td>
</tr>
<tr>
<td>▪ Site set-up and preparation</td>
<td>▪ Site set-up and preparation</td>
</tr>
<tr>
<td>▪ Collect specimen</td>
<td>▪ Collect specimen</td>
</tr>
<tr>
<td>▪ Prepare and package specimen for submission to laboratory</td>
<td>▪ Prepare and package specimen for submission to laboratory</td>
</tr>
<tr>
<td>• Deliver results</td>
<td>• Deliver results</td>
</tr>
<tr>
<td>▪ Retesting recommendation, as applicable</td>
<td>▪ Retesting recommendation, as applicable</td>
</tr>
<tr>
<td>▪ Referral assessment and management*</td>
<td>▪ Referral assessment and management***</td>
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<tr>
<td>▪ Risk reduction, as applicable**</td>
<td>▪ Risk reduction, as applicable</td>
</tr>
<tr>
<td>• Reporting</td>
<td>• Reporting</td>
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<tr>
<td>▪ QA, M&amp;E</td>
<td>▪ QA, M&amp;E</td>
</tr>
</tbody>
</table>

*Additional detail on referral assessment and management is provided in Chapter 7: Referral and Linkage to Health and Prevention Services.

**Additional information is provided in Chapter 4: Risk Reduction.

***Additional detail on referral assessment and management is provided in Chapter 7: Referral and Linkage to Health and Prevention Services.

### Before the Test

#### Information About HIV and HIV Testing

Clients should be provided with information about HIV and HIV testing that is sufficient to obtain informed consent for testing. At a minimum, it is suggested that clients be provided with the following information:

- **Overview of HIV testing**
  - What is being tested (e.g., antibodies), based on the test(s) that will be used
  - Testing strategies and client options for testing
  - Procedure for testing
  - Procedure and timeline for obtaining results
  - Next steps and procedure associated with HIV-positive results
  - Next steps and procedure associated with HIV-negative results

- **Benefits of testing**
- **Drawbacks of testing**
- **HIV “basics”** (e.g., transmission, prevention)
• Meaning of test results, especially the window period (relative to last exposure and test strategy used)
• Applicable laws (e.g., disease reporting laws)
• Sources of additional information and support

Inform clients about the tests and testing strategies used by your agency, as well as their options for testing. It is suggested that the information on HIV testing presented to clients represent the tests and testing strategies used by your agency.

☑ **Recommended Activity**
Explore with the client the different tests and test strategies available. Explain the benefits and drawbacks of the tests to help them to help them choose the strategy which will work best for them.

☑ **Recommended Activity**
If you suspect that a client may have acute HIV infection, on the basis of symptoms and/or risk behavior, explain to him or her the process for and benefits of testing for acute infection. Arrange for the client to have acute HIV testing. Please refer to Exhibit 5.5 for the criteria that may be used to identify clients who would benefit from acute testing.

It is important to provide clients with an opportunity to ask and have answered any questions about HIV and the testing process.

You may use one or more modalities to provide clients with this information. Information can be provided verbally, through video, in writing (e.g., brochure or fact sheet), or through use of a computer.

Some States and/or cities have statutory or regulatory requirements related to provision of information in conjunction with HIV testing, including standard required materials that must be distributed to all clients tested for HIV. Some States also have statutes, regulations, or other policies regarding provision of information specific to HIV testing provided in non-clinical settings and/or by CBOs. Contact your State or city HD for information regarding requirements for informed consent for HIV testing. If you will be using rapid HIV tests, be aware that you will be required to distribute to each client a subject information booklet prior to testing. Booklets are provided by the test kit manufacturers.

Select the method for providing information to clients that is most appropriate for the target population. In selecting a method for providing information, consider the literacy level and preferred language of your target population, the developmental level of the target population, and any other culturally relevant factors that inform how health information is understood by members of the target population.
Tip

Use your organization’s consumer advisory board to get input on informational materials and methods. Pilot test materials and methods with community members to ensure that the information is easily understood, culturally relevant, and presented in a manner that is well received by the target population.

Recommended Activity

Know State and/or local statutes, regulations, and policies as they pertain to HIV testing, including requirements regarding informed consent. Contact your State or city HD for additional information.

Consent

It is important to obtain consent from a client prior to performing an HIV test. Consent for HIV testing should be obtained in accordance with State and local laws and regulations. Some States or cities require that consent for HIV testing be in writing, signed by a client. Some States or cities have policies or regulations about consent for testing specific to HIV testing provided in non-clinical settings and/or by community-based providers. There are a variety of approaches that you can take to integrating obtaining consent into your workflow:

- Provide clients with written information and consent forms at intake. Clients can review information prior to being engaged by testing staff. This may help prepare them to ask questions about the test. Clients can sign the consent form at the time of intake or after they have had the opportunity to ask questions about HIV testing.
- Some agencies use computers to gather information from clients at intake. This is referred to as computer-assisted self-interviewing (CASI). Information about HIV testing and information relevant to consent to test can be included in the CASI programming. It may be possible to include consent as part of the CASI programming.
- You could provide clients with information about HIV and HIV testing in your waiting room (or area that you have designated as a waiting area in the case of outreach testing). Information can be provided to clients in written (e.g., a pamphlet), video, or even audio format. You could also choose to present information verbally (or verbally in combination with videos or written material) by, for example, a health educator. Information can be provided to a group or to one client at a time. Some agencies find it most efficient to conduct group education sessions when they have a high volume of clients, such as you might have at a large community event. In this scenario, individuals have the opportunity to ask questions of the health educator, as well as the person performing the test.
- You can also provide information and obtain consent from clients, one client at a time. In this scenario, you would designate one person on staff—it may or may not be the same individual performing the test—to present information to clients, allow them to ask questions, and obtain consent for HIV testing.
Contact your State or city HD for information regarding requirements for informed consent for HIV testing. These requirements may influence your decision about how you approach consent, including how it is integrated into your workflow.

Maintain documentation of consent, whether obtained in writing or verbally, in the client’s chart.

**Recommended Activity**
If oral consent is used, note consent in the client chart or similar documentation associated with provision of HIV testing services. It is important to also note the date and the name of the person who obtained client consent.

If a client elects to be tested on an anonymous basis, his or her name should not be recorded on a written consent to test.

**Tip**
Assign clients who opt to test on an anonymous basis with an alpha and/or numeric code. Record this code on the consent form (if applicable).

**Confidential and Anonymous Testing Options**

Before HIV testing is performed, clearly explain to clients the measures that are in place to protect their confidentiality, including who will know their test results (e.g., PS if the result is HIV positive). If a client is reluctant to provide his or her name, your staff members it may be helpful to explain to the client in simple and clear language the benefits of confidential testing.

**Recommended Activity**
Use simple and clear language to explain confidential testing to clients, such as the following:

“Confidential testing means that your name and other identifying information will be on your test result and other paperwork associated with getting your test. All information given will be held in strict CONFIDENCE according to the laws governing confidentiality. Confidential test results can be released to other people only with your written permission, except for the health department, as required by law. Having your name and contact information is important in case we need to get in touch with you about your test results or to help you to get the health services you need.”

Anonymous testing simply means that an individual is tested for HIV without giving his or her name. Many States and/or cities have statutes, regulations, or other policies regarding the provision of HIV testing on an anonymous basis. Some States require that all clients be advised of their right to be tested without giving their name (i.e., tested anonymously) in advance of administering an HIV test. Contact your State or city HD for information regarding provision of anonymous HIV testing.

If HIV testing is provided on an anonymous basis, it is important that you develop a strategy, such as the use of codes, to ensure that test results are correctly matched to clients.
Assign clients who opt to test on an anonymous basis with an alpha and/or numeric codes. You could use adhesive labels preprinted with codes. Adhesive labels can be purchased with codes printed on sets of labels (e.g., groups of four, six, or eight). This will enable you to label testing specimens, laboratory requisition forms, and results to ensure that they are all correctly linked to the client and that numbers or letters have not been inadvertently transposed.

Use of pseudonyms (e.g., “Jessica Rabbit”) is not recommended because of the potential that multiple clients will use the same pseudonym, increasing the difficulty in correctly matching test results to individual clients and the possibility that clients will not receive the correct results.

If a client receives other services from your agency and elects to be tested for HIV anonymously, it is appropriate to keep HIV testing information separately from any other client records maintained by your agency.

Performing HIV Testing

You can provide HIV testing in a variety of settings, including the office of a CBO, at a community venue (e.g., bar or community center), or in an outreach setting (e.g., health fair, house party). Decisions regarding which settings or venues in which you conduct HIV testing are appropriately informed by your formative evaluation and made in consultation with your staff and other stakeholders including, importantly, members of the target population. Your resources, staff skills and abilities, regulations, community partnerships, and other factors will also influence where HIV testing can be provided.

Site Set-Up and Preparation

Testing Area: Regardless of where HIV testing is to occur, it is of the highest importance that the area where HIV testing is provided is private and ensures client confidentiality. The space used for HIV testing must prevent others from seeing or hearing interactions with the client or observing test processing, in order to ensure that the client’s confidentiality is protected.

It is essential that the space you use to provide testing also have adequate room and seating to comfortably accommodate the clients and staff or volunteers providing HIV testing services. If rapid HIV testing is to be performed, the space must have adequate room to perform tests and controls, adequate lighting to ensure that tests and controls are performed and read accurately, and that the temperature is within the manufacturer’s specifications for operation.¹

¹ Detailed information regarding the space, temperature, and lighting requirements of rapid HIV tests is available on the manufacturer’s package inserts.
Tip

To help ensure privacy, you may consider using a white noise machine or a radio set at a low volume in the vicinity of the space that will be used for HIV testing.

If you are conducting rapid HIV testing, the following conditions must be met:

- **Lighting:** It is important that the lighting in the area where the tests will be performed be adequate to allow you to safely and accurately perform the test and read results. If natural and/or room lighting is not bright enough for safety and to read the results, bring additional lighting (e.g., a lamp) to the outreach site. For outreach conducted in parks or other public settings, consider using a high intensity flashlight. As a rule of thumb, lighting is adequate if standard newsprint held next to the test device can be read without difficulty.

- **Temperature:** Rapid HIV tests must be conducted within the operating temperature specified by the manufacturer on the package insert. Use a thermometer to ensure that the temperature is—and remains—within the proper temperature range. The temperature at which each test was performed should be recorded. Test kits should be stored within the storage temperature range specified by the manufacturer on the package insert. If rapid test kits are to be transported to an outreach site, they must be transported in a manner which will ensure that they remain within the range of the specified storage temperature.

- **Surface Area:** Rapid HIV tests must be performed on a clean and level surface. All testing kit components and controls must be organized. Do not consume food or drink in the area. If rapid tests are to be used at an outreach site, consider carrying a level with you to ensure that you are performing tests on a level surface.

- **Storage and Disposal of Reagents:** If you are using rapid HIV testing, reagents must be stored and disposed of properly. Reagents require refrigeration, and you will need a refrigerator with necessary temperature controls. Maintain an inventory of testing supplies, noting the lot numbers, date of receipt, record of storage temperatures, expiration date, and dates in use. Manufacturer directions should be followed regarding the expiration date of opened reagents. You should not use reagents from kits with different lot numbers interchangeably.

- **Equipment:** If you will be testing using laboratory-based tests, specimens may need to be refrigerated. You will need to obtain a refrigerator with necessary temperature controls, used only for the storage of samples and/or testing supplies. If you will be conducting laboratory testing, you will need to prepare samples for testing. For this, you will need a centrifuge.

- **Supplies and Materials:** Make prevention materials such as condoms, lubricants, bleach kits, and educational materials available to the client in the private space, as well as in the waiting area (or on a display table if in a community venue). Some clients may not want to take condoms or lubricant from the display table where others can see them.
It is essential that your staff have all of the supplies, materials, and reference information necessary to provide HIV testing and linkage services, including the following:

- Forms and logs (e.g., consent forms, referral assessment, referral forms, testing logs)
- Testing supplies and materials (e.g., lancets, bandages, timers, test kits, controls)
- Equipment needed for testing (e.g., centrifuge, lamps, sharps container)
- Risk-reduction supplies (e.g., condoms)
- Educational materials (e.g., brochures)
- Business cards and/or other information about your agency
- Referral and resource information (e.g., HIV medical providers, crisis intervention)
- Incentives (if applicable)
- Client satisfaction or feedback questionnaires

**Recommended Activity**

Provide clients with a business card printed with your agency name and your contact information so that clients have a personal and familiar contact if they have questions or concerns after the testing session.

A sample list of supplies and materials is provided in Template 7 in Appendix D.

**Safety:** Develop procedures to ensure the safety of testing and linkage staff, as well as clients. It is advisable to have a minimum of two staff members on the premises at all times when HIV testing is being provided. Supervisors may find it helpful to schedule after-hours testing in advance, and to be aware of when after-hours testing will be provided. It is advisable that office doors be locked on the occasion that HIV testing and linkage services are provided after hours, and staff should have an emergency contact.

For considerations for implementing HIV testing in community and outreach settings, please see Chapter 8: HIV Testing in Outreach Settings.

**Specimen Collection and Preparation**

Regardless of the HIV testing method used, perform specimen collection and preparation correctly and consistently to ensure accuracy of test results. It is essential that your HIV testing policies and procedures describe the following:

- The materials and equipment required to collect specimens and perform testing
- Steps required to collect the specimen and prepare it for testing
- Steps to perform a test
- Limitations of the procedure
- Cautions to be observed which may affect the test results
- Safety precautions to protect patients and testing personnel
- Quality control procedures
- Plan for remedial or corrective action to be followed in the event that quality control results do not fall within acceptable limits
**Rapid HIV Tests:** For rapid HIV tests, procedures for specimen collection and preparation and procedures for performing tests are provided by the manufacturer and are included with test kits. Many public health laboratories have template specimen collection and test procedures that can be adapted. Please refer to Appendix B: Resources for additional information, including links to online resources.

Many HDs provide training on specimen collection for venipuncture, finger stick, and oral samples. Many also provide training on performing rapid HIV tests. Contact your State or city HD for additional information.

**Laboratory Tests:** If you are conducting laboratory testing on blood samples, consult with the laboratory that will be processing the test for the appropriate sample collection and preparation procedures. The procedure for sample collection and preparation will vary depending on the tests and testing algorithm used by the laboratory, and according to their established procedures. It is very important that you follow these procedures precisely to ensure an accurate test result. Each laboratory has procedures that dictate the following:

- The type and size of sample collection tubes to be used. Different tests require different amounts of sample and different kinds of sample collection tubes. You must use the correct sample collection tubes to ensure that the sample can be tested.
- Preparation of samples. Blood samples must be prepared correctly for testing. You may be required to centrifuge samples prior to shipment to the laboratory.
- Timeframes associated with testing. Depending on the tests used, blood samples must be processed within a short period of time after they are obtained, generally less than 2 days.
- Refrigeration of samples. Depending on how you are required to prepare samples and the tests performed, you may or may not be allowed to refrigerate samples.
- Shipment of samples. You will need to prepare samples for shipment in a way that ensures the integrity of the sample and is appropriate for biohazardous materials. This includes packaging them in the correct containers, labeling samples correctly, and completing the necessary test requisition forms. You may or may not be able to package and ship HIV test samples with samples for other kinds of tests, such as hepatitis or syphilis.
- Reporting of results. You will need to learn about how and in what timeframe results will be reported by the laboratory back to you; this will help you to schedule appointments for results delivery. Laboratories use various ways to report results back to testing providers, including via mail, secure fax, and electronic methods.

Some laboratories may provide training on sample collection and preparation. Some HDs may also provide such training. Consult with the laboratory that will be performing HIV testing.
Testing Procedure

To ensure accuracy of results, it is important that tests be performed correctly and consistently in accordance with written procedures. It is essential that HIV testing procedures describe the following:

- The specific steps required to perform the test correctly
- Performing external quality controls, including frequency or periodicity
- Interpreting patient test results and internal/external control results
- Actions that will be taken if results are not acceptable
- Documentation requirements (e.g., documenting patient results, control results)

Test procedures for rapid HIV tests are available from test manufacturers and are provided along with HIV test kits. Many public health laboratories have template test procedures that can be adapted. Many HDs provide training on testing procedures. Please refer to Appendix B: Resources for additional information, including links to online samples. You may also consider contacting your State or city HD. They may have template procedures that you can use.

Workflow

Examine the setting in which testing is to be performed relative to client flow to determine at which points in the workflow specimen collection and testing are most appropriately performed. Key considerations in determining where in the workflow specimen collection and testing can be performed include maintenance of client confidentiality and adherence to QA procedures.

If you are conducting rapid HIV testing, it may be necessary to perform testing in the same room or area where sample collection occurs. Some testing and linkage providers run the test under a box or behind a screen to prevent the client from watching the test while it is running, as this may create unneeded anxiety of the client and may distract from engaging the client fully in assessing prevention needs or providing risk reduction.

In some settings (e.g., mobile units, community events) space needed to run tests in accordance with QA procedures may be limited. In this circumstance, it may be necessary and more efficient to run all tests in a central area. One staff member can take responsibility for running tests to reduce errors that could compromise the accuracy of test results. If a common area is used to perform tests, measures may be taken to ensure that client confidentiality is maintained. For example, it is important that tests not be run in an area that clients or others pass through. The benefits and drawbacks associated with where sample collection and performing tests are presented in Exhibit 6.2.
Exhibit 6.2. Benefits and Drawbacks of Workflow Configurations for Sample Collection and Performing Tests

<table>
<thead>
<tr>
<th>Configuration</th>
<th>Benefits</th>
<th>Drawbacks</th>
</tr>
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</table>
| Sample collection in same area with client present; if rapid testing is used, test is also processed in same area | • Makes efficient use of limited space  
• Requires fewer staff  
• Maximizes client privacy and confidentiality  
• Feasible in low-volume settings  
• Minimizes change for mixing up client samples or test results | • Staff needs to be trained in all aspects of testing, including specimen collection and performing tests, which can be challenging for QA  
• May be challenging to ensure that area used for multiple uses meets QA standards for safe work practices  
• May increase client and/or counselor anxiety to run test in the same room  
• May reduce the amount of time that staff are able to spend with client on risk reduction  
• May reduce efficiency in high-volume settings |
| Sample collection in central area—client is not present; if rapid testing is used, tests are also processed in central area | • Staff can specialize in tasks, which is beneficial for QA  
• Efficiently uses space and staff resources, particularly in high-volume settings  
• Allows staff to focus time and attention on client engagement, including risk reduction  
• Facilitates compliance with safe work practices when dedicated use of space | • Requires multiple staff  
• May reduce client privacy due to movement of client from one area to another  
• May not be feasible in settings with limited space  
• Increased opportunity for mixing up client samples and test results |

Universal Precautions and Exposure Control

The Occupational Safety and Health Administration (OSHA) has established basic precautions designed to keep employees and consumers safe when there is the potential to come into contact with blood or other body fluids (e.g., saliva, urine). OSHA’s Bloodborne Pathogens standard (29 CFR 1910.1030) requires employers to protect workers occupationally exposed to blood or other body fluids, as defined in the standard. These are often referred to as “universal precautions”. Observing universal precautions means that all human blood and body fluids are considered infectious for bloodborne pathogens, such as HIV, hepatitis B, or hepatitis C.

Pursuant to the OSHA Bloodborne Pathogens standard, your agency must do the following:

- **Establish a written exposure control plan.** The exposure control plan must list all of the job classifications which have occupational exposure, along with specific tasks or procedures performed by employees in these jobs which result in their exposure. It is advisable to update the plan at least annually. The plan may also need to be updated if you make changes to job classifications or procedures. Staff must be given the opportunity to provide input into the exposure control plan, including identifying strategies to eliminate or minimize occupational exposure. Information on obtaining sample exposure control plans is available in Appendix B.
• **Implement the use of universal precautions.** This simply means that all human blood and other body fluids are treated as if they are known to be infectious for bloodborne pathogens, such as HIV.

• **Provide and ensure employees use personal protective equipment.** The first strategy in practicing universal precautions involves using personal protective equipment. Latex gloves and gowns or aprons are two common forms of personal protective equipment used in the context of HIV testing.

• **Identify and ensure use engineering controls.** The second strategy in practicing universal precautions involves using engineering controls. Engineering controls are simply devices (e.g., sharps disposal containers, self-sheathing needles, spring-loaded lancets) that reduce or remove the bloodborne pathogen hazard from the workplace.

• **Identify and ensure use of work practice controls.** Work practice controls simply means keeping a safe work area through practices such as hand washing, cleaning contaminated surfaces, and disposal of hazardous waste.

• **Make hepatitis B vaccinations available to workers with occupational exposure.** Employers must make this vaccination/vaccination series available to all employees with occupational exposure within 10 days of initial assignment to the job with occupational exposure. All vaccinations and medical evaluations are to be provided at no cost to employee.

• **Perform post-exposure evaluation and follow-up to any employee with an exposure incident.** An exposure incident simply refers to blood or other body fluid having come into contact with the eye, mouth, other mucous membrane, or non-intact skin, or through a needle-stick. Evaluation and follow-up involves testing of the source blood, baseline blood testing of the exposed employee, and counseling. Post-exposure prophylaxis may also be appropriate. Incidents must be documented.

• **Affix warning labels and signs to communicate hazards.** Warning labels must be affixed to containers of regulated waste, sharps containers, refrigerators, and other containers used to store, transport, or ship blood or other body fluids.

• **Provide information and training to employees.** Employees must receive regular training on bloodborne pathogens, use of universal precautions, and exposure control and training must be documented.

Additional detail and discussion of universal precautions and exposure control plans are available from **OSHA**.

Staff members who perform HIV testing, including specimen acquisition (e.g., through a finger stick) are occupationally exposed to bloodborne pathogens. Other staff, such as janitorial staff who clean up the areas where testing is conducted, may also be occupationally exposed.

In the context of HIV testing, the most likely occupational exposure will be to blood and through sharps injuries. Common work practices that increase the risk of exposure or sharps injury include recapping needles, such as those used to obtain a sample through venipuncture; failing to dispose of used lancets properly in a sharps container; opening tubes of blood; or transferring blood or body fluids to test devices. Exhibit 6.3 presents
the universal precautions that should be followed by all HIV testing and linkage providers to protect their safety.


- Wash hands or other skin surfaces immediately after before/after handling blood or other body fluids. If soap and water is not available, CDC recommends alcohol-based hand sanitizer.
- Use disposable gloves (preferably latex) and change gloves between clients.
- Do not eat, drink, apply make-up, or handle contact lenses in the work area.
- Do not keep food or drink in refrigerators, containers, shelf, cabinets, or countertops where potentially infectious materials are present.
- Disposal of regulated waste: Dispose of lancets, needles, or other fluid-touched items (e.g., gauze) in proper containers.
- Disinfect all work surfaces and items before and after testing with 10% bleach solution or Environmental Protection Agency-approved disinfectant.
- Report exposure to your supervisor immediately if you come into contact with body fluids.

**Tip**

It may not be feasible to have hand-washing facilities in some HIV testing settings, such as health fairs. In this case, HIV testing staff can be provided with and use either antiseptic hand sanitizer or antiseptic towels.

**Regulated Waste:** The OSHA Bloodborne Pathogens standard uses the term “regulated waste” to refer to waste, including liquid blood or other body fluids, which requires special handling. Consider the following items as regulated waste and dispose of them properly: used rapid HIV test devices or sample collection loops or tubes; used gloves, gauze, bandages; used needles, lancets, or other sharps; and other items that are contaminated with blood or body fluid. Sharps should be disposed of in a container which is closable, leak proof, and labeled as a biohazard. You can dispose of other items in containers which are appropriately marked. Containers can be obtained through medical supply companies and through commercial regulated waste disposal companies.

Twenty-six States operate their own occupational safety and health programs under plans approved by OSHA. These States have standards which are identical or at least as effective as Federal OSHA standards, including bloodborne pathogens and hazardous communications standards. Additional information about State-specific plans is available at OSHA’s Web site or by contacting your State HD. Some States and cities have additional regulations regarding storage and disposal of medical waste. Contact your State or city HD for additional information.
Interpreting HIV Test Results

In order to deliver an accurate message about the meaning of HIV test results, it is essential that your staff be familiar with the test technology used by your agency, relative to the window period, and the timeframe of the last known or possible exposure. See Chapter 5, the section titled Overview of HIV Testing Technologies for additional discussion on the window period, as related to different tests and test strategies.

Laboratory Tests

**Reactive Results:** A test can be considered positive for diagnosis of HIV only after the results of both screening and supplemental tests are reactive. If both the screening and supplemental tests are reactive, the result may be interpreted as HIV positive. It is essential that clients diagnosed with HIV be linked to HIV medical care and referred to PS, and/or other prevention services. In addition, it is beneficial for clients to be counseled to assist them in adopting risk-reduction strategies.

**Recommended Activity**

Use simple and clear language to explain test results clients. For example, “The test result shows that you are infected with HIV.”

If clients are participating in HIV vaccine trials, HIV vaccine–induced antibodies may result in a false-positive test result. Encourage any client with a positive HIV test result who has been identified as a vaccine trial participant to contact the vaccine trial site for evaluation or receive referral to HIV medical care for further evaluation and/or testing.

**Nonreactive Results:** A non-reactive test result indicates no evidence of HIV infection and can be interpreted as HIV negative. Depending on the window period associated with the test that you are using, clients that report recent known or possible exposure to HIV can be advised that they may have been tested before HIV infection could be detected by the test, and recommended retesting at an appropriate interval. Additional discussion regarding recommendations for retesting occurs later in this chapter.

**Recommended Activity**

Use simple language to explain the test results, as related to the window period of the test you are using and recommend retesting, as applicable. For example, “The test result does not show that you have HIV. It may be too early to tell if you are infected. You should be retested in 1 month.”

**Indeterminate Results:** On occasion, testing with the Western blot will yield indeterminate results. Indeterminate test results may be related to recent infection, infection with HIV-2, concurrent infection with other viruses or diseases, vaccination (e.g., HIV vaccine trial participants), or problems with the sample or testing procedure. It is essential for clients who receive an indeterminate HIV test result to be referred for supplemental testing using a testing method that can detect acute infection or other viral infection. Additional information on testing that can detect acute HIV infection is available in Chapter 5, in the section titled Overview of HIV Testing Technologies.
Recommended Activity
Use simple language to explain the test results, as related to the window period and recommend supplemental or retesting, as applicable. For example, “Your test result is indeterminate, which means that the test cannot tell whether or not you have HIV. Because you have been recently exposed to HIV, I am going to refer to you City Hospital for additional testing.”

Rapid Tests

**Reactive Results:** Reactive rapid HIV test results indicate that HIV antibodies have been detected. The result is interpreted as preliminary positive. Supplemental testing is required to confirm a diagnosis of HIV infection. Arrange for supplemental testing by either obtaining a sample or making a referral to a clinical provider that can perform supplemental testing. It is essential that clients with reactive results be linked to HIV medical care and referrals made to PS (if allowed in your jurisdiction). It is also important to counsel clients and to assist them in adopting risk-reduction strategies while awaiting supplemental test results.

Recommended Activity
Use simple language to explain the test results, as related to the testing method you are using. For example, “The test result was positive. It is likely that you are infected and living with HIV. You should have a second test to confirm the results.”

**Nonreactive Results:** If the result of a rapid test is nonreactive, HIV antibodies have not been detected. The test result is interpreted as negative. Arrange for acute HIV testing, if appropriate. If acute infection testing is not available, you can arrange for retesting after an appropriate interval.

Recommended Activity
Use simple language to explain the test results, as related to the window period and recommend retesting, as applicable. For example, “The test result does not show signs of HIV infection. However, you have been having sex without a condom in the past [insert appropriate timeframe]. You should be retested in [insert appropriate amount of time].”

**Invalid Results:** If a rapid test yields an invalid result, it cannot be interpreted. Repeat HIV testing on a new sample obtained from the client. For additional information on invalid rapid test results, refer to the package insert provided with the test kit by the manufacturer.
Delivering Test Results

If rapid HIV testing is performed, the vast majority of clients will receive their test results on the same day, during the testing encounter. However, if you use laboratory testing either as the primary testing method or for supplemental testing conducted in conjunction with reactive rapid tests, a second encounter with the client will be required so that your client receives the final test result. It is essential that your agency have clearly defined strategies for delivery of HIV test results, which can be described in agency policies and procedures for HIV testing and linkage. There are several strategies that you can consider for delivery of test results, including the following:

Face-to-Face Delivery of Results: If you use rapid testing, most test results can be delivered face to face, during the same visit at which the client was tested. If you conduct laboratory-based testing as your primary test strategy or for supplemental testing conducted for reactive rapid test results and plan to deliver test results face to face, an appointment can be made with the client for the follow-up session at the time of the initial test session. Follow-up sessions can be held at the agency offices, the venue where HIV testing was conducted, or some other mutually agreed upon location. Consult with the laboratory that performs your HIV testing to find out how long it will take to receive test results. This will help you to schedule appointments with clients.

Provide clients with an appointment card (or similar means) with the date and time of the follow-up appointment clearly indicated. Asking the client to present identification and/or the appointment card in order to receive test results will help you to that test results are matched correctly to each client.

Tip

Consider using adhesive labels preprinted with random codes. Adhesive labels can be purchased with codes printed on sets of labels (e.g., groups of four, six, or eight). This will enable you to label testing specimens, laboratory requisition forms, results, and client appointment cards with a consistent code and enable you to double check that results are matched correctly to the client.

If a client has tested anonymously, it is important that you give the client a number or unique identifier that can clearly be linked to the test result. The client must present that information in order to receive his or her test results.

If you plan to deliver test results face to face, you will need to identify strategies for following up with clients to ensure that they receive their final test results. Obtain contact information (e.g., telephone number, e-mail address, mailing address) from confidentially tested clients to enable follow-up if they do not keep appointments. Ask clients about how (e.g., in person, via phone), when (e.g., daytime, weekends), and where (e.g., work, home) they prefer to be contacted. Clients may also be advised that if they do not keep follow-up appointments, you will contact them.

It is important that your follow-up procedures protect client confidentiality. Regardless of whether you use mail, telephone, or other electronic means of contacting a client, it is
difficult to ensure that only the client will have access to the communication. Therefore, it is recommended that you do not specifically reference HIV test results.

**Recommended Activity**

To ensure client confidentiality during follow-up by mail, telephone, or other means of contact, avoid referencing HIV test results. Until you can confirm a client’s identity, state that you are contacting the individual with “important health information”. It may also be appropriate to avoid using the name of your agency, particularly if HIV or AIDS is included in the title.

Your agency must determine how many attempts will be made, and in what timeframe, to contact a client who has not kept a follow-up appointment. Factors that are key to consider include the result of the test (i.e., positive or negative) and your agency resources.

It is essential that your agency also emphasize follow-up efforts for clients testing HIV positive, for example, making one or two attempts to follow-up with HIV-positive test results in order to ensure that these clients learn their serostatus and are linked to medical care. If after one or two attempts the client has not been successfully contacted, refer follow-up to public HD PS.

You may decide to give lower priority to follow-up on clients with HIV-negative test results, or may prioritize follow-up on clients who are at elevated risk for HIV or who may be acutely infected. It is important that your agency policies and procedures describe how follow-up is to be conducted.

**Results Delivery by Telephone:** You may consider other strategies for delivery of HIV testing results, including results delivery by telephone. Advise clients of how long the wait period is until results will be available. If your agency uses these strategies, verification of client identity is a primary consideration.

If you will be providing HIV test results via phone, your process for delivery of results may require that the client call in for test results (rather than your agency calling the client). In order to verify the identity of the client, consider use of a code word, agreed upon at the time of the test, or by assigning a number or other code unique to that client.

It is recommended that positive HIV results be delivered face to face. However, it may be necessary or appropriate to deliver positive results via phone. In this situation, counsel the client regarding the benefits of initiating medical care and the importance of risk reduction to protect their health and that of their partners. You can also link the client with HIV medical care. It is important to ensure that the process to link clients to medical care who learn their HIV-positive test results via phone be clearly described in your policies and procedures.
In the textbox, Jamie Anderson describes the process for results delivery by phone in Kansas.

The Kansas Counseling, Testing and Referral program ensures the proper provision of HIV test results by training providers on the delivery of both positive and negative HIV test results. Kansas Department of Health and Environment supervises results delivery efforts by reviewing submitted HIV test forms, rapid test logs, and Kansas Department of Health and Environment Laboratory data.

HIV counseling and testing sites have the option to deliver negative HIV test results from conventional confidential tests either in person or by phone. Sites must provide clients with a unique confidential personal identification number (PIN) and verify the client’s name, date of birth, and PIN before results can be delivered.

KDHE allows for agencies to decide, based on work/clinic flow regarding the delivery of negative HIV test results. Some agencies require clients to call in for results and require the client to provide a PIN to obtain their result. Agencies which have the staffing capacity often choose to call clients directly to deliver results. Agencies calling clients have better posttest counseling rates.

- Jamie Anderson
HIV Counseling, Testing, and Linkage Director
HIV/AIDS Program
Kansas Department of Health and Environment
Topeka, KS

**Results Delivery by Internet:** Your agency may consider delivering test results via a secured Internet Web site. If you use this method, verify client identity not only on the basis of the client name, but also on the basis of a code or number assigned (e.g., PIN) to that client at the time of the test that must be entered in order to receive results.

In conjunction with disclosure of HIV-positive results via a secured Web site, provide clients with a clear message regarding the benefits of initiating medical care and the importance of risk reduction to protect their health and that of their partners. It is important to provide referral resources to facilitate linkage to HIV medical care. Clients can be directed to someone who will provide them with information about test results and to obtain assistance in accessing HIV medical care. This could be done through an online chat application or through video-conferencing.

Video-conferencing is another way that you can use the Internet to deliver HIV test results. Following is a case study from Robin Pearce explaining how her CBO used Skype to initiate linkage to care.
A client recently given a positive test result from a State clinic drove an hour to seek services and a diagnosis from us because the State was not following up. We delivered her result in person and scheduled a subsequent meeting to begin her enrollment paperwork for medical case management services. The client’s current work supervisor had already made it very difficult for her to make time for medical appointments—the supervisor wanted a letter signed by a doctor and more information about the sudden need for important medical appointments. It was hard to find a time to meet with this client, so the linkage coordinator set up a Skype meeting with her. The face-to-face interaction provided by Skype made the appointment more personal and gave the coordinator a better sense of the client’s feelings during this difficult time. Use of this technology worked well for this particular circumstance, but could be used more broadly to feasibly deliver test results, provide counseling to clients and support clients in linkage to care.

- Robin Pearce
  Counseling and Testing Coordinator
  NO/AIDS Task Force
  New Orleans, LA

**Written Results:** Clients sometimes request written copies of their test results. If written results of a negative test are to be provided, it is useful for a clear statement about the meaning of the test results, relative to the window period of the test used, to accompany the result. It is recommended that written test results be provided on your agency letterhead or a similar form and clearly state the following:

- The agency that performed the HIV test
- The date of the test
- The test result (positive or negative)
- Explanation of the result relative to the window period

A sample of a written statement of results provided as Template 2 can be found in Appendix D. It is not recommended that written results be provided in conjunction with anonymous HIV tests. It is important to address provision of written test results in policies and procedures.

**Incentives:** Client incentives may be useful in encouraging clients to return to receive their HIV test results. If your agency decides to use client incentives in conjunction with referral and linkage activities, it is important that the incentives used are appropriate to the client population. Client input regarding incentives, specifically the form of the incentive (e.g., gift card), its value, and when and how it will be provided (e.g., at the completion of the initial medical visit) is useful to helping you make decisions about use of incentives. Your testing policies and procedures can specifically address the use of incentives, including how incentives will be purchased, secured, and tracked. Sample procedures for using client incentives are available in Template 1 in Appendix D.

The results of your formative evaluation activities should factor into your decisions regarding selection of strategies to deliver results. Incentives are discussed in greater
detail in Chapter 3: Targeting and Recruitment. Refer to this section of the Implementation Guide to learn more about different types of incentives and the factors you may consider in determining whether or not to use incentives.

There may be policies or regulations which prohibit the use of incentives or specific kinds of incentives, such as cash. Check with your State, local HD, or funder to learn about applicable policies or requirements.

Recommendations for Repeat Testing

For clients with an HIV-negative test result, recommendations regarding repeat HIV testing can be made on the basis of several factors, including the following:

- The timing of the last known or potential exposure
- The window period associated with the test performed
- Ongoing risk behaviors

In order to make the most appropriate recommendation for retesting, it useful to familiarize yourself with the testing method used by your agency, relative to the window period. If conventional testing is used, it is important to know the window period associated with the tests used by the laboratory that performs testing.

Recent Possible or Known Exposure: Clients with negative results from rapid tests or conventional tests (which do not detect acute infection), but who may be recently infected are recommended for immediate retesting for acute infection. If testing for acute infection is not available, recommend retesting at an interval appropriate to the window period of the test that is used. Clients with very recent or known exposure (within 72 hours) can be offered baseline HIV testing and linked to a provider that can assess eligibility for nPEP.

If conventional testing was performed and the result was negative, you can reasonably deliver a negative result if your laboratory uses an algorithm that can detect acute infection. Recommendations for retesting can be based on ongoing risk. For additional information on identifying clients who should be recommended testing for acute infection, please refer to Chapter 5, in the section titled Acute Infection Testing.

☑ Recommended Activity
Use simple language to recommend retesting associated with a recent exposure. For example,

if acute testing is available, “This test result did not show signs of HIV infection. However, it may be too soon for this test to detect signs of HIV infection. Since you have recently had flu-like symptoms, you should see a doctor who can run a test that will detect signs of infection sooner than this test can.”

Or

if acute testing is not available, “The test result does not show signs of HIV infection. It may be too soon for this test to detect signs of HIV infection. Since you have felt sick over the past 2 weeks, you should be tested again in 1 month to be sure that acute HIV infection is not the cause of your illness.”
Ongoing Exposure: Clients with HIV-negative test results who have ongoing risk can be retested annually. It is appropriate for MSM to retest every 3 to 6 months if they have unprotected sex with multiple partners, anonymous partners, or use drugs in conjunction with sex.

Recommended Activity
Use simple language to explain the test results and recommend retesting. For example, “The test result does not show that you have HIV. If you continue to have sex with anonymous partners without using condoms, you should be tested again in 3 months.”

Disease Reporting

Report reactive test results to the HD, in accordance with State policy and regulation, and complete an HIV Confidential Case Report Form. The Adult Confidential Case Report Form should be completed for clients aged 13 years and older. For clients younger than 13 years, a Pediatric HIV Confidential Case Report form should be completed. In some States, a confidential case report can be completed and submitted electronically. All States have laws regarding the amount of time that HIV testing and linkage providers have to complete and submit an HIV case report. Contact your State or city HD for additional information and instructions regarding completion and submission of HIV case reports.

When conducting a single or dual rapid test, followed by immediate linkage to care (i.e., no supplemental testing is performed), complete the appropriate case report form and submit it to the HD for reactive HIV rapid test results.

If a client with a positive test result was tested anonymously, complete a case report and submit it to the HD. Typically, an HIV testing and linkage provider would complete the case report fully, but would record “anonymous” or something similar in place of the client’s name. Contact your State or city HD to receive specific instructions on completing case reports for clients tested anonymously.

Quality Assurance of HIV Testing

Develop written policies and procedures for HIV testing activities. If rapid HIV testing is used, HIV testing must be performed, at minimum, in accordance with manufacturer instructions and local, State, and Federal regulations. You must have QA practices in place in accordance with the CLIA of 1988 and applicable State local licensing and QA requirements. Many HDs offer QA training for rapid HIV testing; contact your State or city HD for additional information.
Training

Ensure that staff members\(^3\) conducting HIV testing have received training appropriate to their responsibilities in performing HIV testing. It is essential that staff performing HIV testing receive training to do the following:

- Provide accurate and complete information necessary to obtain consent for HIV testing
- Accurately explain confidential and anonymous testing
- Accurately explain testing options, including acute HIV testing
- Assess client need for acute HIV testing
- Collect, prepare, and transport specimens, including appropriately marking specimens and laboratory requisitions to ensure results are accurately matched with clients
- Perform an HIV test, including procedures performed before, during, and after a test (rapid HIV testing)
- Interpret and explain test results to clients
- Adhere to universal precautions and exposure control procedures
- Properly and accurately document all aspects of the testing process (e.g., testing logs, QA logs) and maintain secure documentation
- Ensure their safety, as well as that of clients
- Comply with State and local policies, laws, and regulations governing testing

Proficiency

Evaluate, at least annually, staff conducting rapid HIV testing to ensure proficiency in performing tests and documenting results. If you are using rapid HIV testing, enroll in an external proficiency program. Your testing procedures must address the measures that will be in place for staff who fail proficiency examinations. Many HDs have developed tools and guidelines for assessing the proficiency of staff conducting testing. Please refer to Appendix B for additional resources for assessing proficiency of staff performing HIV tests.

\(^3\) We recognize that many HIV testing and linkage programs enlist volunteers to provide HIV testing and linkage services. Often, volunteers perform the same functions as paid staff. Throughout this guide, for convenience, we use the word “staff” to refer to both paid staff and volunteers.
Regularly evaluate staff conducting HIV testing to demonstrate proficiency in communicating effectively and accurately information about HIV and HIV testing, delivering test results, window period, and so forth. Direct observation of sessions with clients is an effective strategy to assess proficiency. If direct observation is not possible, role-plays are an alternative strategy you can use for assessing proficiency.

**Practice Example 6.1. Quality Assurance of HIV Testing Using Role-Plays**

ACME Prevention Services (APS) provides HIV testing and linkage services in Center City. Every other month, APS sets aside a few hours during which HIV testing staff work together to improve their skills. Before each skill-building session, the testing and linkage program supervisor gathers examples of challenging situations, such as assessing whether a client is too intoxicated to provide consent, delivering an indeterminate test result, or conducting a referral assessment with a teenager, and writes brief client scenarios. Each scenario is presented as a role-play, and the staff takes turns acting as the tester while the supervisor acting as the client. This helps staff learn from each other and keeps their skills sharp. Testing staff observes and critiques each other. A few times each year, the outreach testing staff of the CCHD join them in doing role-plays.

Specific QA strategies are described in Chapter 9: Quality Assurance and Monitoring and Evaluation. Please refer to the section of that chapter titled “The Quality Assurance Plan” for a discussion of how each strategy is most appropriately used. It is important that staff be observed at regular intervals (e.g., annually), and more frequently after initial training (e.g., monthly for the first 3 months).

**Documentation and Record-Keeping**

Client files, testing logs, assessment forms, and any other documents that contain confidential information must be kept secure. Documents containing confidential information may be addressed in your policies and procedures (see the section on Policies and Procedures presented in Chapter 9: Quality Assurance and Monitoring Evaluation for additional discussion).

Rapid HIV tests require that HIV testing linkage providers obtain a CLIA certificate. You may be required to obtain multiple CLIA certificates if you are conducting HIV testing at multiple sites. Additional licensing may be required by State and or local regulation. All licensed laboratories are subject to periodic inspection and review by Federal and/or State authorities. Documentation of HIV testing and associated QA activities, including proficiency reports, will be examined by reviewers. You will need to keep careful documentation of all training, testing, and QA activities, because these documents will be evaluated by reviewers. For rapid HIV testing, your agency will need to keep documentation of the following:

- Staff training and proficiency assessments (for sample collection, test performance, proficiency testing)
- Inventory of test kits and controls (i.e., lot number, dates received/opened)
- Quality control results (i.e., performance of external controls)
- Log of daily tests (i.e., date/time of collection, test run time, read time, results)
- Storage temperature log for tests/reagents
It is essential that the person responsible for supervision of HIV testing activities and who is acting as the laboratory director under CLIA review these documents regularly. Records should be maintained according to the CLIA certificate, or pursuant to State/local policy or regulation (whichever is longer). Many HDs have sample logs and other tools that can be adapted for local use. Contact your State or city HD for additional information. Refer to Appendix B: Resources for links to sites where you can download sample QA logs and quality control procedures.

Keep consent forms (if applicable), test results, referrals, and other information in the client chart. The client chart may be maintained for as long as required by State or local policy or regulation.

Conduct reviews of charts regularly (e.g., annually) to evaluate their completeness and accuracy and more frequently after initial training (e.g., monthly for the first 3 months). Sampling (e.g., a random sample of five charts for each testing staff member) is appropriate if it is not feasible to review all client charts. Specific QA strategies are described in Chapter 9: Quality Assurance and Monitoring and Evaluation. Please refer to The Quality Assurance Plan for a discussion of how each strategy is most appropriately used.

**Monitoring and Evaluation**

It is essential for staff to review data regularly (e.g., quarterly) to assess the extent to which HIV testing strategies help you to identify new infections, help clients learn their HIV test results, and link to care as efficiently as possible. By evaluating, on a regular basis, the extent and ways in which HIV testing strategies and practices help you to achieve program goals and objectives, you will be able to refine practices to ensure that the needs of your clients are met.

The section titled Implementing Monitoring and Evaluation presented in Chapter 9: Quality Assurance and Monitoring and Evaluation has additional information and tools to help you to evaluate HIV testing practices. Tools also included in that section will help you conduct a yield analysis to better understand how well your program is working (including use of various test technologies and practices associated with testing/result deliver) and to guide you in discussions about program improvement.
CHAPTER 7 AT A GLANCE

This chapter addresses referral and linkage from HIV testing services to medical, prevention, and other health services. In this chapter we discuss the following:

- Various kinds of referral services
- The steps involved in referral planning and management
- Strategies for facilitating linkage to services
- Developing and maintaining partnerships for referral services
- Strategies for documenting and monitoring referral and linkage
- Use of incentives to facilitate linkage to HIV medical care
- Quality assurance of referral and linkage activities, including training and assessing staff proficiency
- Monitoring and evaluation of referral and linkage activities

The tools and examples provided in this chapter will help you to do the following:

- Select the best referral and linkage strategies for your program and clients
- Build partnerships to enable you to provide more comprehensive services to meet client needs
- Document and monitor referral and linkage activities

What Is Referral and Linkage?

A primary goal of HIV testing in non-clinical settings is to link clients with HIV infection to HIV medical care as soon as possible. Linkage to HIV medical services facilitates better health outcomes for HIV-infected individuals. Referral and linkage to medical and risk-reduction services is also an important HIV prevention strategy. The risk of acquiring or transmitting HIV infection is influenced by a number of behavioral, physiological, and environmental factors. Addressing these factors through referral to and linkage with risk-reduction and other prevention services can have a significant impact on reducing the likelihood of HIV transmission or acquisition, for both the individual client and the community.

You serve clients who have multiple, and sometimes very complex, needs that challenge them relative to linking with HIV medical care, risk reduction, or support services. Your agency may be able to provide clients with needed medical and risk-reduction services onsite. However, addressing these needs appropriately and effectively may fall outside the expertise
of your program. By working with clients and partner agencies in the community, you can support your clients and give them the best chance for maintaining the behaviors and physical health that can reduce the acquisition and spread of HIV.

**Definition**

The spectrum of definitions for referral and linkage ranges from the relatively simple act of providing information to a more complex process that facilitates and documents a client’s entry to, or engagement with, services.

Referral is the process by which a client’s immediate needs for medical care or risk-reduction services are assessed and prioritized, and the client is provided with information and/or assistance in accessing referral services. A referral may be either passive or active. Linkage takes a further step by ensuring and verifying that the referral was successfully completed.

- **Passive Referral**: In a passive referral, a client is provided with information, such as agency name and location, about one or more referral services. It is then up to the client to make decisions about whether and which services to access and how to access them.

- **Active Referral**: An active referral begins with assessment and prioritization of a client’s immediate needs for medical and/or risk-reduction services. In an active referral, a client is provided with assistance in accessing referral services, such as setting up an appointment or being given transportation.

- **Linkage**: Linkage means that a referral has been verified as having been successfully completed. If a client keeps his or her first appointment or receives the referral service (if the referral requires keeping only a single appointment), the referral can be considered as having been successfully completed. Optimally, feedback on a client’s satisfaction with referral services may be a useful part of the linkage process.

**Practice Example 7.1. Active Versus Passive Referrals**

Peter, an APS test and linkage staff member, has just delivered test results to Simone. She is HIV negative, but her risk screen indicates that Simone has multiple sex partners and was recently treated for chlamydia, suggesting that Simone may be at elevated risk for HIV acquisition. Peter believes that she would benefit from STD screening and possibly some additional risk-reduction services. Peter conducts a referral assessment.

Simone accepts a referral to STD screening and Peter makes an appointment for her at the Center City Community Health Center (C3HC) that afternoon. He provides her with a taxi voucher and gives her a VIP card, which includes his name and contact information along with the name, location, and phone number of C3HC’s clinic supervisor. Giving that card to the receptionist at the health clinic guarantees that Simone will be seen immediately, without a wait. Peter calls the taxi to transport Simone to the health center. Peter provided an active referral to STD screening.

The referral assessment also indicates that Simone often uses alcohol, marijuana, and ecstasy, particularly when she is having sex. Peter suggests to Simone that she might benefit from drug and alcohol addiction services. He tells her about a couple of different programs. Peter gave Simone brochures about both programs, along with contact information. Peter provided Simone with a passive referral to substance use disorder treatment services.
Implementing Referral and Linkage

Regardless of whether a client is newly diagnosed with HIV infection, has been previously diagnosed, or is HIV negative, the steps to making a referral and ensuring linkage to medical, risk-reduction, and/or other services follows the same basic process. When conducting needs assessment and referral planning and management, you will follow these steps:

- **Assess Referral Needs**: Identify the factors that are most important in terms of their influence on a client’s ability or willingness to engage in medical care or risk-reduction services. In assessing referral needs, examine HIV risk behaviors (e.g., sex with anonymous partners, diagnosis with an STD) and prevention practices (e.g., condom use during receptive anal intercourse), environmental factors (e.g., access to sterile syringes, stability of housing), and psychosocial factors (e.g., experience with domestic violence, mental illness). Consider how these factors might be addressed by medical care, risk reduction, or other services.

- **Prioritize Referral Needs**: There are often multiple factors that influence a client’s ability or willingness to reduce risk that influences a client’s health or that impact a client’s ability or willingness to accept and access referral services. In the context of HIV testing and linkage services, it is probably not possible or appropriate to address all of these factors at one time. It is better to focus referral and linkage activities on addressing the factors that can make the greatest impact relative to risk reduction and in keeping a client healthy.

  **Recommended Activity**
  Examine a client’s willingness or ability to accept and complete a referral. If a referral services is not consistent with a client’s interests or priorities, the referral is less likely to be successfully completed.

- **Plan the Referral**: Identify the strategies or methods you will use to facilitate a successful referral. Help the client to identify challenges that he or she may have in completing referrals (e.g., cost, lack of transportation). Identify strategies to overcome these challenges.

- **Facilitate Access to Services**: Provide clients with both information and support necessary to access referrals. Information about the referral can, at minimum, include information about the referral agency (e.g., name, address, telephone number, contact name, hours of service, cost), eligibility, and the processes and timelines for making and getting appointments. Practical support provided to clients can minimally address the identified challenges to accessing referral services.

- **Follow Up and Confirm Linkage**: Assess whether the client successfully completes a referral (i.e., has been linked to the service) and obtain client feedback, if possible. If the client was not successfully linked to services, attempt to determine the reasons for this and provide additional assistance, if appropriate. A client may consent to follow-up, and you can obtain a signed authorization for release of information from the client. The authorization for release of information
can be specific to the referral (i.e., the individual providers with whom client information, including HIV test results, are shared) and may be named on the release. A sample authorization for release of information is included as Template 3 in Appendix D.

**Recommended Activity**

**Obtain feedback from clients about referral services.** Clients who were successfully linked to services can provide valuable information about the referral services, including whether the client received the services they needed, whether these services were satisfactory, and other information about their experience with the referral service or provider of the referral service. This can help a program better support and meet the needs of each client, as well as future clients.

*• Document Referral and Linkage Activities:* It is essential that referrals made and linkage completed be recorded in a client’s file or chart. You may also wish to maintain a referral log to help staff follow up on referrals made and assess their completion. Strategies to monitor the completion of referrals and document linkage are addressed in the section titled Documenting and Monitoring Referrals and Linkage.

Your program may have staff who specialize in referral and linkage or may have linkage programs. In this case, your staff may perform some or all of the steps of the referral and linkage process, particularly for clients with positive test results or diagnosed with HIV infection.

**Referral and Linkage for Clients with a positive HIV Test**

Linkage with HIV medical care, as soon as possible after learning of a positive test result, is an essential outcome of HIV testing services. For individuals with a positive HIV test, early entry into HIV medical care can improve health and quality of life. Viral suppression resulting from use of antiviral medications helps to prevent new infections. Clients with a positive HIV test result can also be referred to PS. PS is a public health strategy in which HD staff notify partners of clients with a positive HIV test result of possible exposure and provide them with opportunities to learn their HIV status.

**Linkage to HIV Medical Care**

In some agencies, HIV testing staff members often provide clients with referrals to and assistance with accessing HIV medical care. These staff may or may not have received training on a specific referral strategy. However, your staff can provide referrals and support linkage to medical care, provided they have adequate knowledge of HIV medical care resources; the skills and resources necessary to assist the client in accessing medical services; and sufficient time and resources to conduct follow-up on referrals to medical care. Recommendations for training for staff performing referral and linkage services is provided in the section in this chapter titled Quality Assurance of Referrals and Linkage. There are a number of specific linkage strategies which have
been evaluated and shown to be effective in facilitating linkage to HIV medical care. Some of these strategies follow a specific protocol or set of procedures. They may also require staff members providing linkage to complete one or more specialized trainings on the protocol or set of procedures, have completed other training as a prerequisite, or possess a specific set of skills and abilities. These strategies may also be useful for improving your agency’s linkage to risk reduction and other services.

- **Linkage Case Management**: Linkage case management involves intensive, short-term assistance to facilitate entry into care. A linkage case manager helps clients to develop a personalized plan to acquire needed services.
  - Antiretroviral Treatment and Access to Services (ARTAS) is one model of linkage case management. ARTAS is for individuals who have recently been diagnosed with HIV. ARTAS consists of up to five sessions with a client within the period of 90 days or until the client is successfully linked to HIV medical care, whichever comes first. A client may be transitioned to a medical case manager for longer-term assistance and support.

In the following example, Ben Tsoi describes how New York City uses ARTAS and Motivational Interviewing to improve linkage rates. Additional information about ARTAS is available in the in Appendix D: Resources.

**ARTAS is a strengths-based case management strategy to enhance linkage of HIV-infected persons to HIV primary care. The New York City Department of Health and Mental Hygiene (NYC DOHMH) provided trainings on ARTAS to its funded testing programs to increase agency capacity to link an HIV-infected client to care. Because familiarity with motivational interviewing techniques, especially responsive listening, is helpful to program staff in building rapport, encouraging communication with the client, and in strengthening the client’s investment in the medical linkage process, the NYC DOHMH also provided training in motivational interviewing to all its funded HIV testing programs. The knowledge learned from these trainings can also be applied to other HIV testing activities, such as recruiting clients, and helping clients reduce activities that expose them to HIV.**

- Ben Tsoi
  Director of HIV Testing
  Bureau of HIV/AIDS Prevention and Control
  New York City Department of Health and Mental Hygiene
  Queens, NY

- **System Navigation**: In system navigation, clients are assisted with navigating the complex health care system, thereby facilitating access to and utilization of medical, risk reduction, and other services. The objectives of system navigation are twofold: (1) to provide direct assistance to the client in accessing services; and (2) support the client in building the knowledge and skills that they need to access and use the health care system on their own. Navigators are sometimes, but not always, peers—people living with HIV who have successfully accessed medical,
risk reduction, and other services. Additional information about systems navigation is available in Appendix B: Resources.

In the examples below, Jon Stockton illustrates how Washington State uses ARTAS to strengthen linkage to care, and Angela Wood describes how a CBO in Washington, DC employs Linkage Navigators to improve linkage and retention rates.

Washington State Department of Health has proposed a model to improve and strengthen active referrals for newly diagnosed clients by integrating the ARTAS intervention into existing testing protocol. Publicly funded sites providing targeted HIV testing services will be expected to ensure that newly diagnosed HIV clients are referred and linked to HIV medical care. Staff providing HIV testing services will be cross trained in the ARTAS intervention and will be able to implement the intervention for newly diagnosed individuals.

Under the existing testing protocol, staff are to ensure that newly diagnosed clients are provided or referred for medical evaluation, including services for other bloodborne pathogens, antiretroviral treatment, HIV prevention, and other support services. The existing results delivery protocol associated with positive results will stay intact, but will be enhanced and expanded to include ARTAS session one activities. ARTAS session one activities will be provided in conjunction with delivery of positive HIV test results, with the overall goal of linking individuals to HIV medical care. Session one activities include the following:

- Introduce the goals of case management and ARTAS
- Discuss client concerns about their HIV diagnosis
- Begin to identify personal strengths, abilities, and skills, and assess others’ role in impeding or promoting access to services
- Encourage linkage to HIV medical care
- Summarize the session, the client’s strengths, and agreed upon next steps
- Plan for next session(s) with the medical care provider and/or tester

It will be the test counselor’s responsibility to ensure that the client is linked to medical care. If the client decides to seek medical case management as their entry point into medical care, then the tester will ensure that a referral is made and tracked to ensure that the client makes an appointment with HIV medical case management. Agencies providing HIV testing services are required to establish a memoranda of understanding and procedures with medical case management programs to ensure that medical case management and testing staff have a communication plan in place to verify that the client has successfully linked to medical care.

- Jon Stockton
  HIV Counseling and Testing Coordinator
  Infectious Disease and Reproductive Health
  Washington State Department of Health
  Olympia, WA
Family and Medical Counseling Service, Inc. (FMCS) employs linkage specialists to ensure that individuals diagnosed with HIV are successfully and expediently linked with HIV medical care in our primary care clinic. Once the linkage specialist connects with the client, the individual receives immediate (same day) access to a new patient appointment that includes the initial intake/assessment, a complete new patient lab panel, and initiation of the treatment plan. The linkage specialist stays with the individual until the appointment is complete, and continues to conduct follow-up activities to ensure successful completion of the first appointment with the assigned primary care provider. For individuals our testers encounter who were previously diagnosed with HIV, the linkage specialist attempts to verify enrollment in care and/or reengage the individual in care and support services. Once connected to services at FMCS, individuals have full access to an array of HIV services, including mental health, substance abuse, medical case management, food bank, nutritional support, and treatment adherence counseling in addition to primary medical care.

- Angela Wood
Chief Operations Officer
Family and Medical Counseling Service, Inc.
Washington, District of Columbia

- Outreach and Peer Support: Outreach and peer support services are linkage services provided by and for individuals living with HIV. Peers can play an integral role in recruiting HIV-positive people into services, particularly individuals from hard-to-reach populations, clients who have been reluctant to enter into HIV medical care, or individuals who have left medical care.
- Peer support can be provided through one-on-one interactions or in groups. Peer support helps HIV-infected individuals to engage in health care through direct support, and build the skills necessary to manage their HIV and obtain needed medical care or other support. Peer support is appropriate for HIV-infected individuals with varying ranges of need for support. Peer support is not necessarily time limited.
- It is not advisable to use peer support as the main strategy for coordinating and facilitating access to HIV medical care, risk reduction, or other services. Peer support can, however, be an important complement to other linkage strategies, such as medical case management. Additional information on outreach and peer support is available in Appendix B: Resources.

You may also use other strategies available to facilitate referral and linkage to HIV medical care. These strategies have not necessarily been formally evaluated, but they are currently being used by HIV testing and linkage providers and appear promising.

- Comprehensive Risk Counseling and Services: CRCS is designed to provide intensive, client-centered risk-reduction counseling to individuals who have more complex needs, such as substance use disorders or mental illness, and who have difficulty in achieving risk reduction. In CRCS, clients receive assistance and support in developing a personalized risk-reduction plan and are also provided with...
support in accessing referral services. CRCS is intended for HIV-positive and high-risk HIV-negative clients. Some HIV testing and linkage providers are using staff trained to provide CRCS to facilitate linkage for all HIV-positive and high-risk negative clients. Additional information on CRCS is available in the Appendix B: Resources.

- **Partner Services**: PS provides an important opportunity for linkage to care. PS staff, often called DIS, can play an important role in linking HIV-positive individuals to HIV medical care, risk reduction, and other services. When conducting interviews with an HIV-infected index client or newly diagnosed partner, it is essential that PS staff assess whether or not the individual is receiving HIV medical care. If not, the client or partner can be referred to or linked with HIV medical care. It is important for PS staff to have up-to-date information about HIV medical care providers and/or linkage resources. In the following text box, Jon Stockton describes how PS staff are trained and employed to support linkage.

> **PS staff in Washington State will be cross-trained in ARTAS intervention and will act as a “backstop” to ensure linkage to medical care for newly diagnosed individuals. In Washington State, it is the responsibility of the HIV tester to ensure that newly diagnosed persons are linked to HIV medical care. PS, however, plays an important role in backstopping testing providers in linking HIV-infected persons to medical care. During the course of providing partner services, PS staff assess whether clients are successfully linked to medical care. If a client has indicated that he or she has not been linked to medical care either through testing services or case management, then PS will initiate linkage using the ARTAS intervention.**

> - Jon Stockton  
> HIV Counseling and Testing Coordinator  
> Infectious Disease and Reproductive Health  
> Washington State Department of Health  
> Olympia, Washington

- **Medical Case Management**: Medical case management has as a primary objective to engage and retain HIV-infected individuals in HIV medical care through coordination of services and follow-up of medical treatments. Some HIV testing and linkage providers also operate medical case management programs, often at the same site where HIV testing is provided, and clients with a positive HIV test result can be easily linked to medical case management programs. Additional information about medical case management is available in Appendix B: Resources.
Referral to Partner Services

A key function of PS is to notify the sex and drug-injecting partners of HIV-positive individuals about their exposure to HIV.¹ PS facilitates HIV testing of exposed partners, as well as linkage to medical and risk-reduction services. Therefore, ensuring HIV-infected individuals are contacted by PS is an important prevention strategy.

Strategies that can be used to help clients with a positive HIV test result access PS include the following:

- **Referral to Public Health:** You can refer a client with a positive HIV test result to the public health agency. PS staff (or DIS) will contact the client and conduct an interview to elicit information necessary to notify his or her partners.

- **Some HIV testing and linkage providers have arrangements with their HD to have PS staff onsite while tests are being conducted.** This may be a useful strategy if your program conducts a high volume of tests and identifies a relatively large number of clients with a positive HIV test result. It may not be feasible to have HD staff “outposted” to your program on a regular basis. However, it may be feasible to have PS staff onsite during special events or attend testing offered in particular venues where it is likely that a relatively large number of clients will be diagnosed.

- **Some HIV testing and linkage providers have arrangements with their local HD to have PS staff on call, such that when an individual is diagnosed with HIV, PS staff can be paged to the testing site relatively quickly.** This approach may be most feasible when the PS service area is relatively small. This may not be feasible, for example, if an HD PS program covers multiple counties. Following you will find an example of how PS staff are posted at targeted testing events in Washington State.

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In Washington State, local health jurisdiction (LHJ) sites include PS staff when planning targeted testing events to ensure newly diagnosed persons are linked to medical care and additional ancillary services as appropriate.

A local HD in Washington State ensures that a worker trained in PS participated in planning and conducting outreach testing events. This approach is intended to ensure timely linkage for individuals testing preliminary positive (i.e., rapid test reactive) during an outreach event. This approach also ensures that clients have an opportunity to talk with someone trained in PS to discuss the goals for and values of PS, as well as the importance of linking to medical care. If PS staff could not be present during an outreach event, then the LHJ would ensure that PS could be available by telephone for persons testing preliminary positive. The goal of outposting PS staff for outreach events was to make certain that the client would be immediately linked to PS and to minimize efforts to locate clients after the testing event. The local HD initiating this strategy experienced great success in initiating contacts and providing PS for newly diagnosed persons.

- Jon Stockton
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Infectious Disease and Reproductive Health
Washington State Department of Health
Olympia, Washington

- Partner Elicitation: In most States, public health agencies have legal authority for conducting partner notification. However, in many States, non-clinical HIV testing and linkage providers may be permitted to elicit partners from HIV-positive clients, and then forward partner contact information to the public HD.

- If you elect to have HIV testing and linkage staff conduct partner elicitation, develop policies and procedures to address this, including the process for forwarding information to the public HD. There may also be training or certification requirements associated with conducting partner elicitation. Contact your State or county public HD for additional information.

Clients Previously Diagnosed With HIV

You may find that you sometimes perform HIV testing for individuals who have already been diagnosed with HIV. Previously diagnosed clients may disclose knowledge of their HIV status to testing staff before or after testing. The strategies described above may also be used to help link previously diagnosed individuals to care.

While ARTAS was specifically designed for and evaluated for use with newly diagnosed individuals, some HIV testing and linkage providers are adapting this for use with previously diagnosed individuals. Carefully evaluate an intervention for suitability in meeting the specific needs of clients and evaluate the adaptations. Information about adapting interventions is available in the Resources section of the Toolkit.
Staff providing services to previously diagnosed individuals might find it useful to assess the specific issues and challenges associated with a client’s willingness or ability to initiate or continue HIV medical care. This will help to ensure that a previously diagnosed client receives the kind of support needed to successfully enter (or reenter) HIV medical care.

Some previously diagnosed clients may be very reluctant to enter care or have particularly complex issues which prevent them from entering or remaining in care. Effectively addressing these issues may be beyond the capacity of your agency. Identify and form relationships with other resources, such as enhanced linkage programs or patient reengagement programs that can provide clients with needed support. Linkage policies and procedures can specifically address linkage for previously diagnosed individuals.

**Pregnant Women**

Pregnant women who are diagnosed with HIV infection can be linked to specialty medical care so that they can receive appropriate HIV medical treatment and obstetrical care and prevent perinatal transmission. Your program, particularly if it targets a population which includes women of childbearing age, might find it useful to identify and form relationships with HIV medical providers who can provide appropriate care to pregnant women, including prenatal care. In some communities, this might include other agencies that have linkage programs specifically for HIV-positive women who are pregnant. Your referral and linkage policies and procedures can address linkage for HIV-infected pregnant women.

**Adolescents**

Adolescents may present a particular challenge with respect to linkage to HIV medical care due to a variety of factors, including limited health literacy, lack of understanding of the health care system, fear of revealing their HIV status to parents or guardians, or lack of health insurance. Both adult and pediatric HIV clinics typically treat HIV-positive adolescents. However, there is some evidence that teens treated at pediatric clinics are more adherent to antiretroviral therapy when compared to teens treated in adult clinics.² Your program, particularly if it targets a population which includes adolescents, might find it useful to identify and form relationships with HIV medical providers who can competently address the HIV medical needs of adolescents. In some communities, this might include other agencies that operate linkage programs specifically for adolescents. Linkage policies and procedures can address linking adolescents to such services.

The following example comes from Los Angeles, where a youth-specific linkage program is in place to improve linkage among youth aged 12 to 24.

The Strategic Multisite Initiative for the Identification, Linkage, and Engagement in Care of Youth with Undiagnosed HIV Infection (SMILE in CARING for YOUTH) is a youth-focused (12 to 24 years of age) collaboration between CDC, National Institute of Child Health and Human Development of the National Institutes of Health, and the Adolescent Trials Network. The Los Angeles County Department of Public Health, Division of HIV and STD Programs, and the local Adolescent Medical Trial Unit, Children’s Hospital of Los Angeles (CHLA), have collaborated to implement this program since 2009.

The department of public health has established an explicit data sharing plan directly with CHLA’s linkage specialist in order for her to follow up with eligible HIV-positive youth through their HIV testing site. The linkage specialist only has access to testing data and is the only individual with access to client-level data (CHLA cannot view the data). The linkage specialists contacts the testing sites to determine the disposition of each youth and offer assistance for linking HIV-positive youth to care if they have not already been linked. In addition, the linkage specialist also developed memoranda of understanding with HIV testing providers so that they can refer HIV-positive youth directly to her for further support and linkage to care activities. The linkage specialist provides client-centered counseling, meets with clients, provides transport, accompanies them to appointments, and provides follow-up services. She links clients to care at youth-friendly and competent HIV specialists in Los Angeles County.

This program has improved linkage to care among youth in large part because of the strong relationship between the hospital, linkage specialist, the public health department, and community-based HIV testing providers. As the program becomes more successful and gains trust in the community, there has been an increase of HIV testing providers referring young HIV-positive clients to the linkage specialist. We look forward to the success of this program and intend to replicate or expand the successful parts of this project with all individuals.

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  Los Angeles County Department of Public Health  
  Los Angeles, CA

Incentives

Client incentives may be useful in encouraging clients with a positive HIV test results to enter or reenter medical care for HIV. The HIV Prevention Trials Network study 065 (HPTN 065) is being conducted to assess the feasibility of a community-level testing, linkage to care, plus treatment strategy (TLC+). Component strategies, including linkage to care, are being evaluated for effectiveness. Included in this study is the evaluation of use of financial incentives to increase successful linkage to care. A newly diagnosed client is given a gift card for completing confirmatory testing at the site where HIV medical care is provided and another gift card at the completion of an initial visit for evaluation with a medical care provider. Anecdotal data from one site suggests that
financial incentives facilitate entry into care. Additional information on HPTN 065 is available on the HPTN Web site.

If your agency decides to use client incentives in conjunction with referral and linkage activities, it is important that the incentives used are appropriate to the client population. Obtain client input regarding incentives, specifically the form of the incentive (e.g., gift card), its value, and when and how it will be provided (e.g., at the completion of the initial medical visit). Your linkage policies and procedures can specifically address use of incentives, including how incentives will be purchased, secured, and tracked. Sample procedures for using client incentives are available as Template 1 in Appendix D.

The results of your formative evaluation activities should factor into your decisions regarding selection of strategies to facilitate linkage to care. Incentives are discussed in greater detail in Chapter 3: Targeting and Recruitment. Refer to this section of the Implementation Guide to learn more about different types of incentives and the factors you may consider in determining whether or not to use incentives.

There may be policies or regulations which prohibit the use of incentives or specific kinds of incentives, such as cash. Check with your State, local HD, or your funder to learn about applicable policies or requirements.

**Referral and Linkage for HIV-Negative Clients**

High-risk HIV-negative clients may benefit from additional risk-reduction services. Provide high-risk HIV-negative clients with a brief behavioral risk-reduction intervention during the testing visit, if feasible. It may be more appropriate to refer them to a program that can provide these services. However, some clients will benefit from additional risk-reduction services, including behavioral interventions. Your agency may or may not be able to provide risk-reduction services onsite.

For high-risk HIV-negative clients, conduct a more in-depth discussion and exploration of client needs relative to risk reduction in the context of referral assessment and planning. The referral assessment is useful for identifying important factors implicated in their HIV acquisition risk and the services most appropriate to address these factors. Referrals can be made in response to the findings of this assessment, and as your agency capacity and local resources allow.

The most important factors implicated in HIV risk will be specific to the target population and individual clients. The capacity to provide services to address these factors will also vary locally.

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Recommended Activity

Focus and prioritize referral and linkage activities: Research conducted by the Center City University indicated that MSM most likely to become HIV infected are those that have HIV-infected sex partners and who rarely/never use condoms. This research also indicated that methamphetamine use was highly correlated with acquisition of HIV.

APS has an MOA with an LGBT outreach program that provides counseling and treatment support for MSM who use methamphetamine. As a result, facilitating access to services to address this need may be prioritized, and agency effort focused on linking such clients to substance use treatment services. Follow-up would be conducted by APS to confirm linkage to treatment.

Referrals could also be made to intensive behavioral interventions (e.g., CRCS provided by the testing and linkage provider) or other risk-reduction services (e.g., PrEP provided by a local health center). However, APS would make referrals but would not follow up to confirm linkage.

Depending on your agency capacity and local resources, you may also provide assistance with linking to these resources. Your staff may or may not have received training on a specific referral strategy (e.g., CRCS). However, your staff can provide referrals and support linkage to risk-reduction services, provided they have adequate knowledge of risk-reduction resources; the skills and resources necessary to assist the client in accessing services; and sufficient time and resources to conduct follow-up on referrals to these services. Your referral and linkage policies and procedures can specifically address linkage for HIV-negative clients.

Choosing a Referral and Linkage Strategy

In choosing a referral and linkage strategy, consider several factors. In this section, we will discuss these factors in detail.

Client Needs and Challenges

In order to identify the strategy that will result in linking clients to services, you must identify the issues and challenges which facilitate or hinder referral and linkage for the target populations. Also, seek to identify the issues and challenges which are unique to the target populations. Addressing identification of client-perceived barriers and facilitators to linkage as part of formative evaluation activities will help you to select the best strategy for their target populations.

Clients with relatively complex needs or multiple challenges that make it difficult to link them with medical care, risk reduction, or other services may benefit from more intensive and longer-term assistance and follow-up. Linkage case management or system navigation may be the best match to client needs. Clients that are reluctant to enter care or who are members of a highly stigmatized population may benefit from peer outreach and support. Some programs successfully enlist clinical staff, such as community health nurses and social workers, in reaching out to and engaging individuals in care. In many areas, there are linkage support services specifically targeted to HIV-infected individuals. However, hospitals, community clinics and
substance use disorder providers often offer such services to help clients, including those who are HIV negative, engage and stay in needed services.

**Agency Capacity**

Some HIV testing and linkage providers also offer other services, such as medical case management or CRCS. If this is the case with your agency, you may be able to leverage those program resources to support referral and linkage of HIV testing clients.

Other testing and linkage providers are colocated with medical or other risk-reduction services. In this case, clients may require less intensive support and assistance to access services. Your HIV testing staff may have the skills and resources necessary to link clients to colocated services.

**Community Resources**

In some communities there may be other resources available to assist your clients in linking to services, such as patient navigators affiliated with HIV medical care programs or outreach and peer support programs offered by another organization in your community. Some communities may also offer population-specific linkage assistance (e.g., formerly incarcerated), which may be of benefit to clients. Become familiar with other referral and linkage resources in the community. This will ensure that your clients have access to the kinds of support and assistance best suited to helping them to successfully link to medical care, risk reduction, and other services. It will also help your HIV testing and linkage providers to make the most effective use of your agency’s resources.

It is unlikely that one single referral and linkage strategy will result in successfully linking all of your clients to needed services because clients have complex and evolving needs and unique challenges. For this reason, consider using a mix of referral and linkage strategies. HIV testing staff or staff members that function specifically as linkage coordinators may successfully deliver some strategies. Other staff within your agency may be able to deliver other strategies, such as medical case management. Partnership with other providers or agencies in the community may be required to deliver other strategies, such as assistance in reengaging individuals who have not been retained in HIV medical care. The following case study details New Jersey’s approach to improving linkage to care and coordination of services through a multiprovider collaborative.

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*The New Jersey Department of Health and Senior Services (NJDOH) has begun implementation of the Patient Navigators Program. The idea for the patient navigation came out of New Jersey’s HIV planning group (HPG). In 2010, the NJ HPG formed the Collaboration and Integration Workgroup, which was charged with identifying strategies to support and encourage program coordination and service integration (PCSI). One of the first issues this workgroup addressed was HIV testing in non-clinical settings. At the time, community-based providers in New Jersey were conducting HIV testing using rapid tests. Clients having a reactive rapid test results*
needed to have confirmatory testing by Western blot, to confirm an HIV diagnosis. This meant that clients had to wait five to seven days for supplemental test results and then had to return to the agency where they were tested to learn their results and receive a referral to HIV medical care. The workgroup realized that many patients were not returning to testing sites to learn their final test results and, as a consequence, were not receiving referrals to or getting linked with HIV medical care.

The HPG Collaboration and Integration Workgroup’s findings resulted in action by NJDOH to breakdown long-standing prevention and care silos and mobilize the State’s HIV Test and Treat initiative. In the same way, the group focused on integrating HIV, STD, TB, and viral hepatitis services and acknowledging HRSA’s and CDC mandates on identifying new positives and linkage to care. The workgroup moved to integrate HIV prevention, care, and support services beyond the planning level into a strategic operational approach. Its vision was to get key stakeholders committing to collaborate on increased access to care. The HPG recommended electing three individuals to represent NJ in the north, central, and southern parts of the State to serve as regional at-large representatives. Ultimately, NJDOH’s goal is to link every non-clinical HIV testing site to a second different rapid test for confirmation of a positive within a clinical site and an immediate linkage to care (same or next business day), promoting unfettered access to HIV care.

Collaboratives formed to make effective linkage a reality on the local level. Each collaborative has among its members diverse representation from service providers in that region, including AIDS service organizations, CBOs providing HIV testing, community health centers, substance abuse prevention and treatment providers, mental health service providers, and other health and social service providers (e.g., food and nutrition services, housing assistance). Diversity in membership in the collaborative ensured coordination and seamless provision of health and other support services needed by clients in each of the regions.

New Jersey’s first regional collaborative was implemented in a three-county area of southeastern New Jersey, anchored by Atlantic City. AtlantiCare, southeastern New Jersey’s largest health care provider, serves as the lead agency and clinical hub for this regional collaborative. Jean Haspel, an advanced practice nurse with AtlantiCare’s Regional Medical Center’s Infectious Disease Services, serves as the lead convener behind this regional collaborative. Haspel led the formative work, beginning in November 2010, inviting and encouraging providers from the surrounding three (Atlantic, Cape May, and Cumberland) counties to participate in the collaborative. She ensured that the appropriate people—decision makers—were invited to and participated in the collaborative enabling the collaborative to act quickly and efficiently in addressing identified issues and challenges.

In addition to AtlantiCare, this regional collaborative includes representation from three federally qualified health centers (FQHCs), all of the CBOs providing HIV testing, drug treatment providers, and community-based providers of food/nutrition services. The collaborative is working actively to expand membership to include two additional FQHCs, mental health service providers, and providers of housing and
NJDOH currently funds six patient navigators statewide. To support the patient navigators, the NJDOH established the regional collaboratives to ensure “no patient would be left behind”, that all individuals living with HIV would have access to and receive support and be engaged in the continuum of services to address their health and psychosocial support needs. Key was eliminating the Western blot confirmatory test that took 5 to 7 days for results, and introducing rapid testing to New Jersey eliminated a major barrier to testing, receiving results and immediate linkage to care. The patient navigator closed the loop with a focus on partner services, engagement, adherence and reengagement through collaboration. Participating agencies sign a single MOA which outlines the goals for the collaborative and participant roles and responsibilities within the collaboratives.

Even while the collaboratives continue to grow and evolve, they have developed an approach to address the linkage to care issue identified by the Collaboration and Integration Workgroup—linkage to and retention in care among individuals living with HIV. The model of care coordination put into use as a result of regional collaboration implementation includes the following:

- Community-based testing providers will refer clients to AtlantiCare for HIV medical care on the basis of an initial, single reactive rapid test result.
- Testing providers will actively assist clients to access care.
- Clients will be provided with “red carpet treatment” at the care facility to expedite entry to care (the goal is same or next business day appointments).
- A patient navigator (who must, minimally, have a bachelor’s degree in social work, psychology, public health, or be a registered nurse) performs a second rapid test. If that second rapid test is reactive, the patient navigator will also arrange for supplemental testing, including CD4 and viral loads, along with screening for gonorrhea and syphilis.
- The patient navigator will link clients with a medical case manager.
- The patient navigator will schedule follow-up patient appointments with physicians. Appointments are typically available within 1 week.
- Because CBOs are critical to ensuring engagement in care, the patient navigator will work with CBOs to follow up on patients who are out of care. Patients will be asked to sign a release of information, which permits participants in the collaborative to share information necessary to facilitate care coordination.

The NJDOH and the HPG are working actively in the remaining clinical sites to get the patient navigators up and running. However, there are important lessons to be learned from the efforts to establish this first patient navigator:

- Have patience and be persistent—building relationships that will be productive and sustainable takes time.
- You must have decision makers at the table in order for the collaborative to work effectively and efficiently.
You must acknowledge turfism and territorialism and address this directly, and probably on an ongoing basis.
You must define procedures, and identify a point person to deal with issues and problems that affect service provision, so that they can be proactively addressed and do not fester.
The HPG is a critical component to the success of the collaborative. The involvement of the HPG helps keep everyone focused on the fact that we are all on the same team and that we share the goal of improving services and ensuring access to care.

The impact of the collaboratives and the patient navigation relative to enhancing linkage and facilitating care coordination will be evaluated. Currently the NJDOH is developing an evaluation plan which is expected to examine initial engagement and retention in care; adherence to ARV; testing of partners and community viral load. Examination of the root causes as to why people drop out of care is also a priority.

- Loretta F. Dutton
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The results of your formative evaluation activities may also factor into your decisions regarding selection of referral and linkage strategies. Additional discussion of formative evaluation is presented in Chapter 2: Getting Started—Preparing to Implement HIV Testing and Linkage in Non-Clinical Settings. In particular, review the section titled Formative Evaluation and Implementation Planning. Tools that will help you to identify and select referral and linkage strategies are also included in that section.

Community Partnerships and Referral Resources

Identify resources and work both within your own agency and with other community partners to ensure that clients have access to and can receive needed services. In order to develop appropriate referral and linkage systems, do the following:

1. **Assess Referral and Linkage Needs:** Identify the referral needs for your target population. Consider the factors most likely to influence the risk for acquiring or transmitting HIV. Identify the specific challenges and issues that impede successful linkage to services. Consider input on referral and linkage needs from
   - consumers, elicited through formative evaluation;
   - current clients;
   - HIV testing and linkage staff;
   - other providers serving the target population(s);
   - funders may also have specific requirements regarding referral and linkage.
2. **Assess Agency Capacity:** Identify services that are or can feasibly be delivered by your agency. Consider if the services that are provided by your agency are appropriate to and can meet client needs, and can effectively address the factors that influence risk for HIV transmission and acquisition. Ease and proximity should not dictate where clients are referred for services.

3. **Identify Referral and Linkage Partners:** Identify appropriate partners to address identified needs. In selecting appropriate partners, consider client acceptability. Clients must find the partner agency and the services that it offers acceptable in terms of
   - accessibility (i.e., location, wait time, availability of appointments, costs),
   - confidentiality,
   - cultural, linguistic, and developmental appropriateness.

Depending on the needs of the clients and the capacity of partners, you may require two or more partners to provide needed referral and linkage services. Input from consumers, clients, and staff aid in assessing acceptability of potential partners.

4. **Establish Partnerships:** Assess partner agency capacity for providing services resulting from referral and linkage activities (i.e., Can they handle an increased volume of clients?). Gauge their willingness to enter into a partnership (e.g., Will they accept appointments from your agency? Are they willing to participate in monitoring the success of referral and linkage activities?)

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**Recommended Activity**

Hold joint program orientations with referral and linkage partners. Include all staff involved in referral and linkage staff, not just supervisors or program managers. This can help ensure that staff providing referral and linkage services have a mutual understanding of available services, expectations for partnership, and can become familiar with each other and can begin to build relationships.

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5. **Operationalize the Partnership:** Regardless of whether partners are internal (i.e., another department in your agency) or external (i.e., another agency in the community), clearly articulate the expectations for the partnership, as well as the processes and procedures that will be used to make referrals and facilitate linkage.

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**Recommended Activity**

Formalize key partnerships with MOA/MOU. MOA/MOU help to ensure that roles and responsibilities of partners are clear and that clients receive needed services. Key partnerships are those that provide essential services for your clients (e.g., HIV medical care) on a regular and ongoing basis; in which each partner has specific responsibilities (e.g., expediting client appointments); or through which resources or information is shared (e.g., data to confirm linkage).

It is important that HIV testing and linkage providers formalize key referral relationships with MOA/MOU. MOAs are statements of commitment between partner agencies or organizations to collaborate or coordinate on a program. This agreement delineates the
expectations for the partnership, along with specific roles and responsibilities of partners. An MOA/MOU for referral and linkage can address the following:

- The specific services to be provided by each partner (e.g., HIV medical care; CRCS)
- How services are to be provided (e.g., referral clients will receive expedited appointments)
- What information/data will be shared and through what mechanisms or processes (e.g., confirmation of linkage by return of referral forms)
- How and when partners will communicate (e.g., monthly meetings)
- Parties responsible for monitoring the partnership for each partner agency

Partnership agreements can be reviewed for renewal at least annually. A sample MOA/MOU is available as Template 4 in Appendix D.

**Referral Resource Guide**

HIV testing and linkage clients may have a wide range of referral needs. Many of these referral needs can probably be addressed through referral and linkage to a small number of main partners. It may be helpful, however, to have information about a variety of community resources, and staff should have knowledge of these resources. A referral resource guide is one tool for organizing and presenting essential information about referral resources.

It is essential that the information contained in the referral resource guide be relevant to addressing client needs. A referral resource guide can include the following:

- Name of provider/agency
- Services provided, including culturally appropriate services
- Populations served
- Culturally specific services
- Location and service area
- Cost of services
- Eligibility requirements
- Appointment procedures
- Hours of operation
- Location/travel instructions, including accessibility by public transportation
- Name of a specific contact person, with telephone, fax, and e-mail address

It is important that the referral resources be kept up to date, and the entire resource guide be reviewed periodically (e.g., biennially) to verify information about referral providers.

It is essential that your referral resource guide be appropriate and accessible to all of your staff. Discourage individual staff from keeping their own repository of resources and contacts. A good referral guide is centralized to the organization and not to individual staff.
**Recommended Activity**

*Keep referral resources up to date and inform all staff about these resources.* It is essential for HIV testing and linkage staff to discuss referrals and share information about referral providers. This will help to ensure that your resources are kept up to date, issues and concerns with partner agencies are identified and addressed proactively, and client needs can be appropriately addressed. Making referral and linkage a regular agenda topic for staff meetings or case conferencing activities can facilitate discussion and sharing information.

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**Documenting and Monitoring Referrals and Linkage**

**Documenting Referrals**

It is important for your staff members to document all referrals made for an individual client. Referrals can be documented in the client chart, and the following information about the referral(s) may be noted:

- Date of referral
- Name of testing and linkage staff making the referral
- Type of referral
- Referral provider
- Assistance and/or incentives provided to help the client complete the referral
- Date of completed referral (i.e., linkage was accomplished), if applicable
- Reasons that the referral did not result in linkage (e.g., client feedback on challenges to accessing services or satisfaction with services), if applicable

If a referral requires follow up to ascertain whether the client was successfully linked to services, a copy of the authorization of release of information may also be included in the client chart.

A referral log is used by some agencies to document, in a centralized tool, referrals made and to track the status of referral completion (i.e., linkage). Instead of—or sometimes in addition to—recording referral information in client charts, referrals made by all testing and linkage staff are recorded in a single location. A referral log can facilitate follow-up of referrals, such as when one staff member contacts a referral provider to follow up on all referrals made to that provider, instead of having individual staff members follow up individually on the referrals they made. If you use a central referral log, use a code or unique identifier instead of a client’s name to ensure confidentiality.
Monitoring Linkage

Your agency will need to confirm completion (i.e., linkage) for some referrals that you make. This is particularly important, as it relates to HIV medical care for clients who are living with HIV. The main strategies for assessing whether clients are linked to services are client self-report and confirmation from referral providers.

**Client Self-Report:** You may sometimes have ongoing contact or interactions with clients, such as if a client is participating in CRCS. The next contact with a client after a referral is made provides an opportunity for asking the client whether he or she was linked to the service. This also provides a good opportunity for obtaining clients' feedback about any challenges they encountered and their satisfaction with the services received. While client self-report is an acceptable means to confirm linkage, clients sometimes tell us what we want to hear rather than what actually happened. For this reason, provider confirmation is a more ideal means to confirm linkage.

**Provider Confirmation:** Provider confirmation of linkage is a more objective way for confirming linkage. There are various options to confirm linkage:

- **Telephone or E-mail Confirmation**—In this case, the referral provider is contacted by your HIV testing and linkage staff and asked to confirm linkage. It is recommended that only specifically authorized staff at the referral agency provide confirmation of linkage. In the case of linkage to medical care, a physician, clinical social worker, or nurse practitioner is the appropriate authorized party.

  **Tip**
  If you intend to confirm linkage via telephone or electronic communications, linkage policies and procedures must specifically address how the confidentiality and security of such transmissions will be ensured in compliance with State/local policies or regulations and the Health Insurance Portability and Accountability Act.

- **Referral Forms**—Referral forms or similar tools, such as “kick-back” cards, can be used so referral providers can confirm that clients received referral services. Staff initiating the referral process may complete the paper form. The referral provider then returns the form (e.g., via mail or secure fax) upon successful linkage. A sample referral form is provided as Template 5 in Appendix D. An advantage of referral forms or similar tools is that they can provide clients with a reminder about the referral, such as the time and date of their appointment. However, such forms can also be easily misplaced by clients.

If any client-identifying information is to be shared between agencies, confidentiality must be observed and a written release of information obtained from the client.

Data from laboratory reporting of CD4 and viral load tests can help to verify entry into HIV medical care. These data can provide useful information for evaluation of the success of referral and linkage activities. These data may not be available to your
agency at the client level due to confidentiality protections. Exceptions may be when clients receive HIV medical care within the same agency that provided testing. Contact the State or city HD for additional information.

**Quality Assurance of Referrals and Linkage**

Develop written policies and procedures for referral and linkage activities and ensure that staff members have the training necessary to perform referral and linkage activities. Some HDs provide training on and/or have tools available for conducting QA of HIV testing and linkage programs.

**Training**

Ensure that staff conducting HIV referral and linkage has received training appropriate to their responsibilities:

- It is important for staff performing referral and linkage to receive training and education on the following:
  - Referral and linkage planning and management, including the specific steps in the referral and linkage process, as defined in agency policies and procedures
  - Evidence-based linkage model (e.g., ARTAS), if applicable
  - Properly and accurately documenting all aspects of the referral and linkage process and maintaining confidentiality
  - Obtaining authorization for release of information
  - Factors that influence a client’s willingness or ability to use referral services
  - Community resources necessary to meet client needs

**Proficiency**

It is important that staff conducting HIV referral and linkage be evaluated to demonstrate proficiency in assessing referral and linkage needs, planning and managing referrals, and conducting follow-up to verify clients successfully completed referrals. Direct observation of sessions with clients is an effective strategy to assess proficiency. If direct observation is not possible, role-plays are an alternative strategy for assessing proficiency. Client charts may also be reviewed to assess the extent to which referrals were appropriate to client needs, whether and what type of assistance was provided, and whether referrals were successful (i.e., the client was linked to services).

Specific QA strategies are described in Chapter 9: Quality Assurance and Monitoring and Evaluation. Please refer to The Quality Assurance Plan for a discussion of how each strategy is most appropriately used. It might be useful for staff to be observed at

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4 We recognize that many HIV testing and linkage programs enlist volunteers to provide HIV testing and linkage services. Often, volunteers perform the same functions as paid staff. Throughout this guide, for convenience, we use the word “staff” to refer to both paid staff and volunteers.
regular intervals (e.g., annually), and more frequently after initial training (e.g., monthly for the first 3 months).

**Documentation and Record-Keeping**

Your agency will need to keep documentation of the following:

- Staff training and proficiency assessments, including orientation to referral and linkage policies and procedures
- Referrals made and linkage verified
- Authorizations for release of information
- Client satisfaction with services to which they were referred/linked
- Incentives, if applicable

Conduct reviews of client charts regularly (e.g., annually) to evaluate their completeness and accuracy relative to referral planning and management and more frequently after initial training (e.g., monthly for the first 3 months). Sampling (e.g., a random sample of five charts for each testing staff member) is appropriate if it is not feasible to review all client charts. Additional information on documentation and record keeping is presented in Chapter 9: Quality Assurance and Monitoring and Evaluation (refer to the section titled The Quality Assurance Plan).

**Monitoring and Evaluation**

It is essential for staff to review data regularly (e.g., quarterly) to assess the extent to which referral and linkage strategies are successful in linking clients with needed services. By evaluating the extent to and ways in which referral and linkage strategies help you to achieve program goals and objectives, you will be able to refine practices to ensure that the needs of your clients are met.

The section titled Implementing Monitoring and Evaluation presented in Chapter 9: Quality Assurance and Monitoring and Evaluation has additional information and tools to help you to evaluate HIV referral and linkage practices. Tools are also included in that section to help you conduct a yield analysis to better understand how well your program is working (including use of various referral and linkage strategies), and to guide you in discussions about program improvement.
CHAPTER 8 AT A GLANCE

This chapter addresses HIV testing and linkage services in outreach settings. In this chapter we discuss the following:

- Overarching considerations associated with providing HIV testing and linkage in outreach settings
- Steps and issues to consider in planning to conduct testing in an outreach setting
- Different kinds of outreach settings and venues, including the benefits and drawbacks of each
- Planning for implementation of HIV testing and linkage in specific kinds of outreach settings, including:
  - Mobile testing units
  - Large community events
  - Other venues such as parks, bars, and bathhouses
- Building relationships with gatekeepers and other partners needed to support HIV testing and linkage services in outreach settings
- Quality assurance of HIV testing and linkage services in outreach settings, including training and assessing staff proficiency
- Monitoring and evaluation of HIV testing and linkage in outreach settings

The tools and examples provided in this chapter will help you to do the following:

- Assess and build community support for HIV testing in outreach settings
- Plan for implementing HIV testing and linkage in outreach settings

Please note: This chapter is designed to complement—but not replace—other chapters of this guide. Refer to other chapters for additional, detailed information on various aspects of HIV testing and linkage.

As a result of your formative evaluation, you will have collected data that you need to identify the specific venues or settings in which to provide non-clinical HIV testing and linkage services to your target population, as well as the recruitment strategies that will most effectively engage your target population. If you are reading this chapter, you have likely decided that using a mobile van or conducting HIV testing in a venue such as bar or club is the best way to reach your target population.
In this chapter we explore and provide guidance for HIV testing in various types of outreach settings, including large venues (e.g., health fairs and gay pride events); mobile units; and other outreach settings such as public sex venues (e.g., bath houses, parks, bars), churches, and shelters. This chapter is designed to complement—but not replace—other chapters of this guide. Refer to other chapters for additional, detailed information on various aspects of HIV testing and linkage, including planning for implementation of HIV testing and linkage programs (Chapter 2); selecting recruitment strategies (Chapter 3); selecting testing strategies (Chapter 5); implementing HIV testing, including procedures for performing testing and universal precautions (Chapter 6); and ensuring quality assurance (Chapter 9). Similarly, the tools included in this chapter are intended to complement—and not replace—tools presented in other chapters. For example, you should not use the planning tool included in this chapter in place of the planning tools included in Chapter 2.

HIV testing and linkage services involve the same basic activities, regardless of the setting or venue in which the services are provided:

- Plan your HIV testing and linkage strategy
- Recruit clients
- Conduct HIV testing
- Deliver results
- Provide referrals/facilitate linkage

**Overarching Considerations for HIV Testing in Outreach Settings**

The way that you conduct these activities in an outreach setting will be a bit different than the way that you conduct these activities in your agency. Conducting testing in outreach settings requires some adjustments in the way that you plan for implementation, such as setting up your site, packing up/breaking down your site, and adjusting QA procedures. Since you will be operationalizing testing and linkage services somewhat differently than you would in your agency, your staff/volunteers may also require a slightly different set of skills or knowledge to conduct services.

Please bear in mind that the information and tools provided in this chapter will likely need to be tailored to the specific settings or venues in which you are providing testing and linkage services. It is highly unlikely, for example, that the implementation plan and associated set of procedures that you develop for testing at a health fair will also work for HIV testing that you conduct at bathhouse. If you are providing services in venues which are similar, such as several bars, each may require a slightly different plan of implementation owing to differences in the physical environment (e.g., size, lighting, number/placement of doors, clientele, flow of patrons).
Planning

If you are conducting HIV testing in an outreach setting, you are providing services in a setting or venue which is owned by someone else, or over which someone other than you has authority. A critical first step in outreach-based testing is establishing trusting relationships with the individuals or entities with the authority to provide you with access to particular venues or settings (i.e., venue gatekeepers). For example, if you want to provide HIV testing and linkage services in a specific bar or club, you will need to obtain the permission of the owner or manager. You will also likely need the cooperation of bartenders, bouncers, or others to conduct HIV testing in that venue. Members of the target population, other service providers, or other stakeholders act as community gatekeepers and may be instrumental in facilitating introductions to and in establishing your credibility with owners or other authorities.

Public environments, such as parks, typically require you to obtain permission from local government authorities, such as a county commission. In working in public venues, it is also important that you establish a relationship with and maintain ongoing cooperation with local law enforcement officials. This is particularly true if you are providing services in an environment in which illegal activities, such as drug selling or sex work, occur. The cooperation of law enforcement will help to ensure that participation in testing services does not put clients at risk for arrest, and it will also ensure the safety of your staff. Public environments may also require that you obtain permission from neighborhood associations or other quasi-governmental entities. In identifying individuals or entities with which you need to establish partnerships, look to your community or consumer advisory board, staff, volunteers, and partner agencies to help you to identify the individuals and entities that you need to target and suggest strategies that will help you to successfully gain access to various settings and venues.

Building relationships needed to gain you access to various settings and venues may often be a long process, requiring months or even years to effect. To gain entry to a particular venue or setting, you need to do the following:

- **Establish your credibility with those individuals or entities that control access:** You need show that you are a trusted partner in the community and that your services will provide a concrete benefit to the community. Members of the target population, staff, and community partners can be instrumental in demonstrating that you are trustworthy and will be a good partner.
- **Persuade venue gatekeepers about the need for HIV testing services and the value of doing so in a particular venue or setting:** Some business owners, community members, or officials may be skeptical that HIV testing services are needed or may not be aware of the impact of HIV in their community. Others may be concerned that providing HIV testing services will drive clients away or interfere with business. Others may hold misconceptions about HIV testing and linkage services, and by consequence, have unfounded fears (e.g., HIV testing services will bring drug users to their neighborhood). Many may not understand what will be
involved in HIV testing in a particular venue and setting, and you will need to explain what those services might look like.

- **Consult with venue gatekeepers in the planning of outreach HIV testing services, and maintain open communication with them before outreach HIV testing activities/events:** Consult with gatekeepers in planning your outreach testing activities. They can help you to understand their particular setting, make suggestions about how and where you HIV testing services can be provided, and facilitate the cooperation of others that will ensure that you have a successful outreach testing event. Gatekeepers may also have conditions for you, such as not conducting HIV testing onsite or not conducting testing with blood samples. It is important that you honor these conditions. Over time, as you gain trust and experience, it may be possible to renegotiate.

- **Follow-up with gatekeepers after an outreach HIV testing event:** Plan on following up with gatekeepers subsequent to outreach testing events, or if outreach testing at a particular venue is ongoing, at regular intervals (e.g., monthly). This will allow you to obtain feedback from gatekeepers about how well the event went, any concerns that they have, and suggestions for improvement. It will also allow you to provide feedback to gatekeepers about the value of HIV testing services in that venue (e.g., the number of high-risk individuals tested or number of new positives identified).

**Recommended Activity**

Write a note of thanks to gatekeepers, event organizers, or managers/owners of venues after outreach events. Expressing your appreciation to gatekeepers and other partners will help them understand how much you value their cooperation and the value of their partnership. You can also use it as an opportunity to share with them what was accomplished through the event and to solicit feedback from them.

- **Review with gatekeepers the need to/value of continuing services in their venue/setting:** Monitor the productivity of HIV testing at individual sites on a regular and ongoing basis (see Chapter 9, the Yield Analysis section for additional information and tools to help you to monitor site productivity) to help you identify the extent to which various HIV testing sites are contributing to achievement of your program objectives in terms of high-risk clients tested, identification of HIV-positives, and linkage to care. If a particular site is productive, this may speak to the need to continue or expand services at that site. Monitoring data may help gain the cooperation of the gatekeeper for this. On the other hand, the site may not be as productive as anticipated. In this case, monitoring will help you to explain to the gatekeeper why you will be discontinuing or scaling back HIV testing services.

In the following textboxes, Ainka Gonzalez describes AID Atlanta’s partnership with a local bathhouse, and José De La Cruz explains how the Desert AIDS Project engages the community to build partnerships, recruit volunteers, and extend organizational reach.
Providing services in bathhouses can be an effective way to reach members of your target population if bathhouses are popular meeting places for high-risk MSM in your community. In planning to provide testing and other prevention services, AID Atlanta found it essential to work with the general manager (GM) of the bathhouse. The management was very supportive of AID Atlanta and of HIV and STD testing and prevention. They strongly encouraged staff and customers to take advantage of the services we offered. The bathhouse already had condoms available, but the management was interested in the information and resources about services that AID Atlanta could provide.

The GM facilitated our accessing the bathhouse and encouraged staff and patrons to take advantage of the services we offered. The GM did, however, give AID Atlanta some specific conditions for providing prevention and testing services. Some of the rules were that all testing must be done by men, as women were not allowed in the club. Because of this, we had to ensure we had enough male staff available before scheduling a testing event. Also, when we used blood testing for HIV or syphilis, we had to deliver results offsite. This was out of consideration for the business and to ensure the safety of all patrons. In some cases, the STD staff would meet with those men who were tested at other locations and give them their HIV test results. When planning to introduce programs in this environment, your agency should work closely with managers and clients in order to ensure appropriate and effective services are provided.

- Ainka Gonzalez
  Prevention Programs Manager
  AID Atlanta
  Atlanta, GA

At Desert AIDS Project (D.A.P.), although we employ several paid staff in our Education, Testing & Prevention Department, we rely on the dedication of between 20 and 25 volunteers to support our efforts. In fact, D.A.P. remains one of the few AIDS Service Organizations in California able to staff its free and confidential testing sites almost exclusively with volunteers. Trained and certified through the California State Office of AIDS, our Testing Program volunteers made a vital contribution to our ability to continue HIV testing free of charge without substantial interruption following the 2009 California State HIV/AIDS Program budget cuts.

Our Volunteer Coordinators leverage many different partnerships to identify volunteers. Knowing the benefits of our services, many of our volunteers are former and current clients, former staff or interns, members of our agency’s target populations, residents of our service area, professionals in the healthcare field, or associated with our clinical and social service collaborators. By building relationships with community partners such as homeless shelter and substance abuse facility case managers, resort managers, leaders of community non-profit organizations, faith-based and other community leaders, we build trust and credibility in the community.
This not only grants us access to provide services at these venues but also introduces us to community members willing to serve as volunteers. The donation of volunteer time represents a significant monetary savings while increasing our ability to serve and interface with the community. In addition, experience teaches us that at-risk individuals are more likely to talk to and take advice from prevention education and testing volunteers who are part of their community rather than “outsiders”. Ultimately, this networking extends our organizational reach despite limited resources while cultivating in volunteers a sense of pride and accomplishment for contributing to their own sense of well-being.

- José De La Cruz
  Community Health Educator
  Desert AIDS Project
  Palm Springs, CA

Implementing HIV Testing in Outreach Settings

Planning HIV Testing in Outreach Settings

If providing HIV testing in a community venue or outreach setting, visit the location in advance of a testing event to do the following:

- **Get a clear picture of the environment in which you will be conducting testing.** This is especially important to do before the first time that you conduct an HIV testing event at a particular venue or setting. It helps you to understand the best way to manage client flow, as well as how and where to engage clients, and identify strategies which will ensure client privacy and confidentiality.

- **Identify appropriate space for HIV testing.** The space in which you will be doing testing must be appropriate to the testing strategy that you will be using. The space must be private and ensure client confidentiality. It might also be useful for you to identify a path by which the client can leave the testing area without having to go back through a public area. For example, a side door of a club which opens into a side parking lot, or a back door on a mobile unit. If you are using a rapid test strategy, you will need to have access to a level surface and an area where food and drink are not being consumed. For mobile units, avoid placing the van on an incline.

- **Understand how procedures and QA practices will need to be modified for the setting.** You will need to determine how you will need to set up for testing to ensure that you are able to provide services that are compliant with program standards and can meet Federal and State regulations. For example, if you are providing rapid HIV testing, you must ensure that the lighting in the area where testing will be performed is adequate. If it is not, you will need to plan for addressing this, such as bringing your own lamps or other light sources. You will also need to determine whether you will need to add the site to your existing CLIA certificate.
Tip
When testing in outdoor venues, bring along fans. The sound generated by the fans will help to block noise and help maintain patient privacy. Fans will also help to circulate air in a tent. If you are performing rapid HIV tests, this may help to regulate the temperature.

- If you are conducting laboratory-based testing, have a plan for sample processing and shipping. If, for example, you are testing late at night, you need to determine how you will store the sample and/or ensure that it is received by the laboratory for processing in accordance with their procedures.
- Ensure that you have the cooperation of others present at the site, such as bartenders or other agencies also providing services at that site, and that everyone understands roles and responsibilities. It is important that you establish rapport with others who will be present at the site or in the venue prior to conducting HIV testing in an outreach site. You may need their assistance in directing clients or in managing difficult situations (e.g., handling an intoxicated client).
- You may also need or want to coordinate services. If you are providing HIV testing and another agency is providing other health or prevention services, such as screening for STDs, clients may get more benefit if you coordinate your services with those of other agencies. It is important that clients know you and others from your agency who will be involved in HIV testing, what they should expect, and who they should come to with questions or concerns. Knowing what services other agencies at the event can offer can help to ensure that your clients receive other services from which they can benefit. In the following textbox, David Ponsart explains how his CBO builds relationships with venue management and community members to grow their collaborative partnerships and increase referrals.
What makes Arab Community Center for Economic and Social Services’ (ACCESS’s) efforts unique is that we do not use display tables, matching outreach shirts, or present ourselves as the agency conducting testing for the evening. We have a long established relationship with venue management and patrons because the staff and volunteers of the project are in and of the community we serve. We frequent the venues sometimes without service provision as the main objective, but rather to build rapport with both venue management and patrons. We offer a very client-centered, nonjudgmental, and sex-positive message and dialogue with our community partners while we make testing and counseling available. This has led to stronger community relationships, enhanced trust, and the ability to test for both STDs and HIV in venues previously thought to be closed to this form of service provision. We provide condom and lube distribution via specially created outreach packs, and written materials are available in both English and Arabic. We have gone to great lengths to create and strengthen relationships with other HIV service providers and frequently provide STD testing services in conjunction with the HIV testing provided by another agency. This collaboration has resulted in an exponential growth in collaborative partnerships and completion of referrals, as well as reduced or eliminated duplication of services in different venues and target populations.

- David Ponsart
  Counseling, Testing and Referral Manager
  Community Health and Research Center,
  Arab Community Center for Economic and Social Services
  Dearborn, MI

- Identify and plan for safety during the outreach HIV testing event. Pay extra attention to ensuring the safety of staff providing services in outreach venues. It may be useful for outreach testing activities to be planned and scheduled well in advance, and supervisors should be aware of the times and locations for HIV testing events as well. As with testing provided in an office, it is encouraged that a minimum of two staff members be at the outreach venue at all times when HIV testing is being provided. If HIV testing is provided in an uncontrolled environment such as a park, staff should never be alone or out of view from other HIV testing and linkage staff while they are with clients.

- Provide cellular phones and emergency contact information to staff testing in outreach settings, and a supervisor should be on call to address emergencies, should they arise. It is essential that staff have identification badges and distinctive articles of clothing, such as project T-shirts, so that they can be easily identified by clients and others, such as law enforcement officials. Additional suggestions for safety procedures are included in Template 6 HIV Testing and Linkage Policies and Procedures, located in Appendix D.

- Plan for dealing with emergency situations. In the event that clients need crisis or emergency services, it might be useful for staff to have information regarding 24-hour crisis intervention services, such as hotlines or contact information of specific individuals they can contact to get immediate assistance for clients.
• **Plan for staffing of the event.** The size of the event and the layout of the venue will impact the number of staff and/or volunteers that you will need for each outreach event. You will need to ensure that your staffing plan is adequate and that you have back-up plans for unforeseen circumstances, such as illness of staff. Outreach events are often conducted after hours, so you may need to make special arrangements regarding staffing. Work with your agency staff to determine who will be able to work an event. Discuss overtime, compensatory time, or flex time for staff.

> **Recommended Activity**
> Ensure that at least one staff person signed up for an outreach event has experience delivering an HIV-positive result and can be on hand to coach other employees.

**Before and After an Outreach Event**

• **Arrival:** For each scheduled testing event, arrive enough in advance of the event to ensure that you have adequate time to properly set up the site, and to identify any potential challenges. When you plan and advertise an outreach testing event, it is important that you show up on time and adequately prepared. You need set up for services early enough that it will not interfere with either your clients’ or gatekeepers’ business, or compromise the safety of your staff. You also need time to adjust your plans to respond to any unanticipated circumstances (e.g., one of your volunteers cancelled at the last minute, the air conditioner on your mobile van is broken).

• **Ordering and Packing Supplies:** It is essential that all of your program staff members who provide HIV testing services receive orientation to where HIV testing supplies and materials are stored. It may also be useful for them to receive instructions on packing supplies and materials needed for HIV testing in community venues and outreach settings, including which supplies and materials are needed for which settings.

> **Recommended Activity**
> If you are conducting rapid HIV testing and will be arranging for supplemental testing for reactive rapid test results, be sure to bring the supplies and equipment necessary to obtain and prepare samples for supplemental testing and to properly train staff ahead of time.

> **Tip**
> When conducting outreach testing on a mobile testing unit (MTU) it is essential that you get out of the van. Set up a table in front of the van. Walk around the block to announce your service. You should not rely on signage. Some agencies offer condoms, lube, magazines, or other items that will attract members of the target population to the MTU.

• **Transport of Supplies and Equipment:** Transport testing supplies and equipment to and from outreach venues in an appropriate manner. If rapid HIV tests are used, the test and control kits can be transported in an insulated bag or cooler to ensure that they remain within the temperature range specified by the
manufacturer. Incentives, if used, may be best transported in a locked box. Take inventory of supplies, including incentives, and equipment at the conclusion of the outreach testing event to ensure that everything is accounted for and nothing is left behind. Please refer to Appendix D, Template 7 for an Outreach Testing Supplies and Materials Checklist.

- **Hazardous Waste Disposal:** You will need to plan for hazardous waste disposal. This includes transporting used sharps or biohazardous waste. It may be necessary for you to transport waste which is soaked in blood or other body fluids back to your agency for proper disposal.

- **Storage and Management of Forms and Paperwork:** Client files, testing logs, assessment forms, and any other documents that contain confidential information created and/or accessed at outreach events must be kept secure during transport to and from these venues. It is essential that documents containing confidential client information be returned to your agency offices and secured as soon as possible after conclusion of the HIV testing event. Such information may not be left in cars or other unsecured locations, unless absolutely necessary. Transport of forms, paperwork, and other documents containing confidential information can be addressed in your implementation procedures (see the section titled Policies and Procedures presented in Chapter 9: Quality Assurance and Monitoring and Evaluation for additional discussion).

**Recommended Activity**

**Use lock boxes or locking brief cases to store confidential documents while being transported to and from outreach sites.** If it is not possible to return confidential documents to your agency immediately at the conclusion of an outreach event, as might be the case with very late night or weekend outreach activities, ensure that a supervisor is aware of and has approved arrangements for temporary storage (e.g., the site supervisor takes possession of the documents and stores them in his home, in a lockbox) and that all confidential documents are returned to your agency as soon as possible. You may wish to consider purchasing a locking file cabinet that is placed in a designated staff person's home or at a particular venue if testing regularly occurs during hours or in locations which make it infeasible to immediately transport confidential documents back to your agency.

- **Supervision:** It is advisable for a single individual participating in the outreach testing event to be named as site supervisor or team lead. It is not at all unusual for unexpected events to occur in conjunction with outreach settings. Clients sometimes become unruly, staff may be unable to interpret rapid test results, or a client may be experiencing a crisis. One person can have authority to make such decisions about how best to deal with such circumstances, rather than the whole group. The person designated as site supervisor may have direct and immediate access, such as via cell phone, to a program manager or supervisor, should they need additional assistance or authorization.

Before implementing HIV testing in an outreach setting, conduct a systematic planning process. Thoughtful planning will help to ensure that you are well prepared to implement outreach testing, and that you can provide services which are quality assured.
Tool 3. Outreach HIV Testing Planning Tool

Tool 3 is designed as a guide for and a tool to document your efforts to plan HIV testing and linkage in outreach settings or venues. Using this tool will also help you to identify potential challenges to implementation and strategies to address these challenges. This tool supplements—but does not replace—other planning tools included in this Implementation Guide.

**About Tool 3:** The Discussion Questions for Program Planning and Implementation correspond to key factors and issues that you need to address in planning to undertake HIV testing in an outreach setting or venue. It is recommended that you do not begin providing outreach HIV testing services until you have completed planning.

This tool should be completed in conjunction with discussion with staff members who provide HIV testing and linkage, as well as others, such as consumer advisory board members or members of your board of directors. Multiple perspectives will result in richer discussion, a deeper understanding of program planning issues and program operations, as well as better ideas and strategies to ensure a successful program.

**How New Programs Can Use This Tool:** This tool is designed to assist you in planning outreach HIV testing and linkage activities. This tool will help you to assess community support and identify key partnerships, assess the feasibility of providing services, and plan for how those services can be delivered. It will help you to identify any gaps in your knowledge or resources that will need to be addressed to ensure the success of your outreach testing program.

**How Established Programs Can Use This Tool:** If you have already implemented HIV testing, or even if you have already implemented outreach-based testing, you can use this tool to help you to plan implementation in new settings or venues or for new target populations.

**How Health Departments and Other Funders Can Use This Tool:** HDs and other funders may find this tool helpful for use with local grantees or contractors. You could use tool in providing technical assistance to agencies that are just beginning to implement HIV testing in outreach settings or for agencies that seem to be struggling with implementing these services. Some HDs or other funders may wish to have grantees or contractors complete this tool at the beginning of a project (e.g., as a component of a funding proposal) or when they add new sites or venues.
Instructions for Completing Tool 3. Outreach HIV Testing Planning Tool

What is the purpose of this tool? Tool 3 guides and documents your planning efforts as they relate to testing in outreach settings.

Who should complete this tool? Managers or coordinators of HIV testing programs can complete this tool, in collaboration with staff and/or volunteers, consumer advisory board members, and others involved in planning, implementation, and evaluation of your program.

When should this tool be completed? Before you implement services in outreach settings or before you begin testing in new venues or with new target populations.

How should this tool be completed? In the top portion of Tool 3, record the following information in the designated cells:

- **Agency/Program**: Record the name of the agency and/or program completing this tool.
- **Target Population**: Record the target population for which this tool is to be completed.
- **Date Completed**: Record the date that the tool was completed or updated, as applicable.
- **Participants**: Record the names and/or positions/roles of the individuals participating in completing this tool.

Discussion questions relevant to planning and implementation of HIV testing and linkage in outreach settings are presented in the left column:

- **Answers to Discussion Questions**: Record a summary of your discussion about each of the corresponding questions in the left column.
- **Strategies, Gaps, and Next Steps**: Brainstorm about the strategies and practices that could best address your findings and record them in this column. Include gaps in knowledge or resources for which you will need additional information, along with next steps to address these gaps.

Tool 3 has been completed to illustrate how the tool may look when completed.
### Tool 3. Outreach Testing Planning Tool

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<th>Participants:</th>
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<td>ACME Prevention Services, Center</td>
<td>• ACME Prevention Services program director</td>
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<td>Point Program</td>
<td>• Center Point program coordinator</td>
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<td></td>
<td>• Center Point outreach coordinator</td>
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<td>• Center Point consumer advisory board chair</td>
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<td><strong>Target Population:</strong> White and</td>
<td><strong>Participants:</strong></td>
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<td>African American IDUs over</td>
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<td>• Center Point consumer advisory board chair</td>
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<td><strong>Date Completed:</strong> May 15, 2012</td>
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</table>

| **Discussion Questions for**     | **Answers to Discussion Questions**                | **Strategies, Gaps, and Next Steps** |
| Program Planning and Implementation |                                                                                       |                                                                                      |
| Who are the gatekeepers to the   | • Neighborhood Association                     | • ACME currently provides outreach in the Riverside neighborhood and will present our plan to the Neighborhood Association at their June meeting. |
| setting or venue?                | • Business Owners Association                   | • Center City Alliance currently partners with us on outreach. They are on board with this plan. |
| From whom or what do we          | • Center City Police                            | Get clarification regarding whether/what authorization is needed from CCHD for us to be able to conduct outreach testing. |
| need to obtain permission to     |                                                                                       |                                                                                      |
| provide HIV testing at the       |                                                                                       |                                                                                      |
| setting or venue?                |                                                                                       |                                                                                      |
| How are we perceived by          | • Positive reputation with the Neighborhood   | • ACME currently provides outreach in the Riverside neighborhood and will present our plan to the Neighborhood Association at their June meeting. Center City Alliance member is on ACME Board. |
| potential partners? By the       | Association and Center City Alliance           | • Board member is also member of Business Owners Association; he will explore the association’s concerns and report back in May. |
| surrounding community?           | • No relationship with Business Owners          | • Executive director, board chair, and chair of Neighborhood Association will meet with police to present plans and discuss concerns. |
|                                  | Association currently                           |                                                                                      |
|                                  | • Police are aware of our outreach efforts      |                                                                                      |
|                                  | and occasionally hassle staff and clients       |                                                                                      |
|                                  | during outreach                                 |                                                                                      |
### Tool 3. Outreach Testing Planning Tool (continued)

<table>
<thead>
<tr>
<th>Discussion Questions for Program Planning and Implementation</th>
<th>Answers to Discussion Questions</th>
<th>Strategies, Gaps, and Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Partnerships and Community Support (continued)</strong></td>
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</tbody>
</table>
| What are the concerns or fears about HIV testing among potential partners? In the surrounding community? | • Business Owners Association does not want “stigma of AIDS” associated with local businesses  
• Center City Police do not want to deal with crowd control | • ACME executive director, ACME board member, and members of our community advisory board (CAB) will provide presentation to Business Owners Association to persuade them of impact of HIV, value of HIV testing, and community support for HIV testing.  
• Executive director, board chair, and chair of Neighborhood Association negotiated “trial period” with police to persuade them that fears are unfounded. |
| **Site/Event Assessment**                                     |                                 |                                  |
| Will the venue or setting attract individuals other than your target population? | • The aquarium in the park is a hangout for teenagers and young adults  
• The band shell is a popular area for public sex | HIV testing will be made available to anyone seeking such services. We will prepare and carry educational materials and referral resources that are appropriate to younger people and MSM. |
| What kind of traffic (e.g., how many people) can you expect in the venue or setting and in what timeframe? | • Drug User Alliance syringe exchange well established and attracts roughly 50 individuals every Tuesday  
• Area is near local businesses, bordered by residential; moderate traffic, except on Friday and Saturday nights when heavily trafficked | • Partnering with the Alliance on Tuesday will allow us to do highly targeted testing.  
• Friday and Saturday nights are too heavily trafficked for our capacity. More difficult to reach members of target population. We should explore partnership with CCHD. |
| Is alcohol or drug use a consideration? | • Active users and secondary exchangers in conjunction with Alliance syringe exchange  
• Friday and Saturday nights alcohol use is high, as there are many bars in the area | Adapt assessment currently used by the Alliance to assess client ability to consent to testing. |
### Site/Event Assessment (continued)

| Will other service providers be working at the setting or venue? At the same time? | Drug User Alliance currently provides syringe exchange  
CCHD periodically conducts outreach  
Visiting Nurse conducts health checks in the area | Currently partner with the Alliance for outreach. Will partner for outreach testing.  
Obtain CCHD schedule and coordinate.  
Contact Visiting Nurse to obtain schedule and discuss plans for HIV testing and to ascertain whether they can also provide hepatitis C testing, which is of high interest to the clients. |
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td>Set up a tent near the old band shell; this would protect client privacy.</td>
<td></td>
</tr>
</tbody>
</table>
| Syringe exchange is currently conducted out in the open in Riverside Park near the old band shell; there are no existing structures that could be used for testing | Set up a tent near the old band shell; this would allow us to set up and perform testing in a more controlled environment. We will also need to bring a level (to make sure that the work surface is flat and level), folding tables, and folding chairs.  
If we conduct testing on Friday or Saturday nights, natural light will not be adequate. We will need high intensity lamps (battery operated) to read rapid test results. |
| There are no existing structures that could be used for testing; the Alliance’s van is too small and will not work for testing | Set up a tent near the old band shell; this would allow us to set up and perform testing in a more controlled environment. We will also need to bring a level (to make sure that the work surface is flat and level), folding tables, and folding chairs.  
If we conduct testing on Friday or Saturday nights, natural light will not be adequate. We will need high intensity lamps (battery operated) to read rapid test results. |
| Are there any restrictions or conditions that impact the kind of samples you can collect or the kind of tests you can run? | No restrictions from gatekeepers  
Temperature control of rapid tests may be difficult during July and August  
Client preferences unknown | Obtain insulated carry-backs for tests and controls; thermometer for use in the field.  
Conduct focus group with CAB to learn whether they will accept finger stick blood collection. |
### Tool 3. Outreach Testing Planning Tool (continued)

<table>
<thead>
<tr>
<th>Discussion Questions for Program Planning and Implementation</th>
<th>Answers to Discussion Questions</th>
<th>Strategies, Gaps, and Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client (continued)</strong></td>
<td></td>
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</tr>
</tbody>
</table>
| Will we need any special supplies and equipment?             | • Need to temperature control rapid tests and controls  
                                                             • Need to provide shelter, work surface, chairs, and so forth | • Purchase thermal insulated carry bags and thermometers.  
                                                             • Rent tent from Events R Us. Look into cost of purchasing for long term after pilot is completed.  
                                                             • Add tables, chairs, thermometers, sharps disposal containers, biohazard bag, and testing supplies (e.g., lancets, bandages) to packing list for outreach. |
| What adjustments will we need to make to our written procedures and quality assurance practices? | • We will need to ensure that the temperature during transport of rapid test kits and controls stay within range as specified by the manufacturer  
                                                             • We will need an alternate plan to ensure temperature control of tests and control kits during July and August  
                                                             • We will need to revise our existing procedures to reflect the procedures that we will use for this outreach site, including client recruitment, transport of supplies, site set-up (to ensure confidentiality and privacy), quality control of rapid testing, delivery of results, referral of clients with reactive results, and transport of confidential client records | • Adjust testing and control logs to allow staff to record temperature before and during transport. Note if temperature falls out of range.  
                                                             • During July and August we will partner with the CCHD for HIV testing events. We will transport testing supplies on the mobile van to ensure that they remain within temperature range.  
                                                             • Consult with the Center City Public Health Laboratory to determine how the Riverside site needs to be added to CLIA certificate.  
                                                             • ACME testing and linkage coordinator will draft procedures. Prevention program manager will review/edit draft and schedule an orientation for all staff/volunteers who will be conducting outreach-based testing. |
## Tool 3. Outreach Testing Planning Tool (continued)

<table>
<thead>
<tr>
<th>Conducting Testing</th>
<th>Discussion Questions for Program Planning and Implementation</th>
<th>Answers to Discussion Questions</th>
<th>Strategies, Gaps, and Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>How will we manage client flow?</td>
<td>• Potential testing clients will be exchanging syringes and getting hygiene packs from Alliance members; Alliance van (i.e., “the love bug”) is parked near the band shell • The tents have only one opening</td>
<td>• ACME outreach staff will approach clients at the point of syringe exchange. Alliance outreach staff will promote testing and refer to ACME outreach staff, stationed nearby. • ACME outreach staff will lead clients to the tent for testing. ACME will set up a table near the tent, and another outreach worker will provide education and risk-reduction supplies for clients waiting to be tested. We will also provide beverages to clients as they wait for testing. Only one client will be allowed to enter the tent at a time. • We will angle the opening of the tent to face away from the syringe exchange so that others are not able to see who goes into or comes out of the tent. • To ensure privacy for clients with reactive test results, the tent will face the south side of the park, which borders Riverside neighborhood. Clients will not need to pass back through the syringe exchange.</td>
<td></td>
</tr>
<tr>
<td>How will clients get test results?</td>
<td>• According to our formative evaluation, this population will have difficulty returning to our agency for test results • Alliance outreach workers tell us that some clients are very regular in coming to the syringe exchange and others are not</td>
<td>We will make referrals to HIV medical care, on the basis of a single reactive result.</td>
<td></td>
</tr>
<tr>
<td>How will clients be linked to HIV medical care?</td>
<td>• We will be referring to care on the basis of reactive rapid test • Center City Hospital currently requires documentation of supplemental tests to confirm HIV infection</td>
<td>• We will contact our linkage coordinator via cell phone to set up an expedited appointment with the Center City Hospital HIV Clinic. • We will provide clients with taxi vouchers and will call for a taxi. • We will negotiate with the Center City Hospital to accept clients on the basis of a reactive rapid test.</td>
<td></td>
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</tbody>
</table>
Quality Assurance and Monitoring and Evaluation

Prior to conducting HIV testing in an outreach venue for the first time, you may find it useful to have developed written policies and procedures for conducting outreach-based HIV testing. Those procedures should address all of the aspects of program operations as with a fixed site, but must be tailored to reflect how services will be adjusted for the outreach venue, including those described in the section above (e.g., transporting confidential client information). Refer to Chapter 9: Quality Assurance and Monitoring and Evaluation for detailed discussion of development of policies and procedures. Sample policies and procedures are available as Template 6, located in Appendix D. You can adjust this sample to reflect your agency’s policies about HIV testing and linkage in outreach settings. Develop policies and procedures specifically for outreach HIV testing, and you may need to develop policies and procedures for each outreach venue.

Training

Ensure that staff members conducting HIV testing in outreach settings have received training appropriate to their responsibilities. Training or orientation may include the following topics:

- HIV/AIDS “basics” (e.g., local epidemiology, transmission, prevention)
- State and local statutes, regulations that govern HIV testing and linkage
- Orientation to site-specific procedures
- Engaging clients
- Providing accurate and complete information necessary to obtain consent for HIV testing
- Explaining accurately confidential and anonymous testing
- Collecting, preparing, and transporting specimens, as applicable
- Performing tests, including procedures performed before, during and after a test is run, if applicable
- Interpreting and explaining test results to clients
- Risk reduction, as applicable
- Referral planning and management
- Adhering to universal precautions and exposure control procedures
- Exposure control policies and procedures
- Properly and accurately documenting all aspects of the testing process (e.g., testing logs, quality assurance logs) and maintaining secure documentation
- Safety procedures, including managing volatile or emergency situations

¹ We recognize that many HIV testing and linkage programs enlist volunteers to provide HIV testing and linkage services. Often, volunteers perform the same functions as paid staff. Throughout this guide, for convenience, we use the word “staff” to refer to both paid staff and volunteers.
Some States or cities have specific requirements for training or certification associated with conducting HIV testing in outreach settings. Staff performing or supervising HIV testing and linkage services in outreach settings may need to complete State- or city-mandated trainings or certifications. Contact your State or local HD for more information about statutes, regulations, and policies associated with provision of HIV testing and linkage services.

**Proficiency**

Evaluate staff conducting HIV testing in outreach settings to demonstrate their proficiency in recruiting clients, communicating information about HIV and HIV testing accurately and effectively, and delivering test results. Staff or others new to HIV testing in outreach settings benefit from “shadowing” more seasoned staff. In this way, they can observe how to approach clients, use messages to engage clients and encourage HIV testing, as well as conduct the testing process itself. Given the generally more public nature of HIV testing in outreach settings, it is generally feasible for the site supervisor to directly observe how staff or others engage clients or provide HIV testing. This is a good way to assess proficiency and allows for relatively immediate feedback to be given.

In the example below, Barry Callis describes how Massachusetts employs field consultants to assess service quality.

`MDPH, OHA, is deeply committed to supporting a highly effective public health system of prevention and integrated communicable disease screening services for HIV, STDs, and viral hepatitis C infections. Two co-administered methods to assess the quality of services are to conduct field observations and service assessments for client engagement and recruitment activities performed by grantees.

Field observation and service assessments provide an opportunity to reinforce performance expectations and recommend adjustments to service delivery. This protocol-driven method of quality assurance is used to objectively verify service availability as scheduled, and to evaluate the performance of direct-care staff, including knowledge, skills, responsiveness to client presentation, and adherence to established standards of care.

In the pilot phase of the quality program, we assembled a group of diverse community representatives who corresponded to client population groups (including persons living with HIV disease) to conduct field observation and service assessments. The field consultants were essentially “secret shoppers” of HIV/AIDS prevention services. The OHA tasked these individuals to assess the availability of services as advertised or described in work plans, as well as the breadth and accuracy of HIV, STD, and viral hepatitis knowledge of direct care staff. All field consultants received 4 hours of orientation and training to the quality management system, and received field supervision from senior staff in the Prevention and Screening Unit of the OHA.`
Field consultants were trained in OHA’s prevention and screening service standards for conducting client engagement and recruitment activities. These service standards include the importance of arriving on time and staying the duration of the session as scheduled. At each visit, field consultants assessed the accuracy of information provided and use of active engagement and health navigation skills and supports (referral and linkage to available screening and care services) as indicated.

After each quality session, field consultants completed standardized reports to summarize impressions and feedback, including action steps to improve services. The written reports were reviewed and approved by supervisors prior to review with the grantees. After three sessions were conducted over the course of 6 months, the pilot was demonstrated to be successful. This function was moved to OHA contract management and technical assistance staff as a component of their routine program monitoring function. Field observation and service assessments are both announced and unannounced based on the nature of the service being assessed.

We have expanded this method of quality assurance by assessing group-level interventions using MDPH program and capacity building staff in order to provide the necessary technical assistance and improve the delivery and quality of prevention services for HIV-positive individuals. Objective feedback has been valuable for grantee program supervisors and MDPH to plan professional development activities for grantee staff and to reinforce and acknowledge excellence. Future field observation and service assessments are planned for HIV, STD, and viral hepatitis screening sessions utilizing the same methodology.

Field observation and service assessments have provided a reliable and constructive strategy to recognize merit of integrated prevention programming, to confirm service quality, address deficiencies, and inform future capacity building and technical assistance opportunities. Creative and diverse program monitoring strategies are essential to ensure excellence in public health practice.

- Barry P. Callis
  Director, Prevention and Screening Unit
  Office of HIV/AIDS, Bureau of Infectious Disease
  Massachusetts Department of Public Health
  Boston, Massachusetts

Debriefing among staff at the conclusion of an outreach testing event can help to identify what worked well and what did not. This can help you to plan for improvements to future outreach events. This strategy can also help staff to learn from each other about which strategies or approaches most successfully engage clients, obtain consent, provide results, and so forth in these types of settings. In this way, staff skills and confidence to provide HIV testing in outreach settings can be improved.
Monitoring and Evaluation

It is essential for staff to review data regularly (e.g., quarterly) to assess the extent to which HIV testing in each outreach venue in which HIV testing is provided is successful in helping achieve program goals and objectives related to testing high-risk populations, identifying new infections, and linking individuals to care.

The section titled Implementing Monitoring and Evaluation presented in Chapter 9: Quality Assurance and Monitoring and Evaluation has additional information and tools to help you to evaluate your performance at individual outreach sites. Specifically, the yield analysis will help you understand how well each site is performing.

Considerations for HIV Testing in Mobile Units

MTUs are typically large vehicles (e.g., large vans, trailers, campers) that have been specifically built for or adapted to provide health services, including testing for HIV. These types of vehicles have become instrumental in providing HIV testing services to high-risk populations (e.g., IDUs), populations difficult to reach through fixed-site testing programs in non-clinical settings, and/or populations who do not access HIV testing in health care settings. Key benefits and drawbacks of HIV testing using MTUs are presented below in Exhibit 8.1.

Exhibit 8.1. Benefits and Drawbacks of HIV Testing Using Mobile Testing Units

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Drawbacks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offers increased mobility to provide HIV testing and linkage to increase access to services in areas of high HIV prevalence, and for hard-to-reach and/or transient populations</td>
<td>Requires establishing and maintaining partnership with law enforcement officials and others (e.g., local businesses) to ensure authority/permission to operate MTU and conduct HIV testing and linkage</td>
</tr>
<tr>
<td>Provides increased privacy and safety when compared to services offered in other outreach settings</td>
<td>Costlier method for outreach HIV testing and linkage due to cost of purchase/rental and maintenance of MTU, staffing, and other costs</td>
</tr>
<tr>
<td>Allows for provision of other screening (e.g., STD testing), clinical services, and other services that could not feasibly be conducted in other outreach settings</td>
<td>Safety of staff and clients is an increased concern compared with most fixed sites</td>
</tr>
<tr>
<td>Allows for use of test strategies that may not be feasible in other outreach settings (e.g., venipuncture for conventional testing)</td>
<td>Must monitor location to ensure that you continue to reach high-risk population</td>
</tr>
<tr>
<td></td>
<td>Requires additional staff, compared with fixed site, in order to appropriately manage client recruitment, client flow, and safety</td>
</tr>
</tbody>
</table>

Tip

Consider developing an MOA with another organization to augment the services that your agency can provide to clients tested for HIV.
Below, Robin Pearce explains how NO/AIDS Task Force uses an MTU to bring testing to people in New Orleans.

Our mobile unit has two private rooms and can bring testing almost anywhere. The driver/coordinator is certified to provide testing and is fluent in Spanish and English. We use this unit for awareness events at universities and community events, and for targeted testing for IDUs, homeless, and migrant day laborers. The van is one of a kind in our region of Louisiana, and we often use it to collaborate with other CBOs. The CareVan has a low positivity rate, but the flexibility and visibility it gives our program is exceptional.

- Robin Pearce
CTR Coordinator
NO/AIDS Task Force
New Orleans, LA

There are a variety of vehicles that you can use as a mobile HIV testing unit. On the basis of your resources, you may consider purchasing a specialty vehicle that is already outfitted to provide health services (e.g., it has multiple rooms or partitions and a bathroom). Alternately, you could adapt a vehicle for use as an MTU by, for example, partitioning the interior to enable increased confidentiality and quality assured testing services. MTUs are designed with various configurations, in terms of size; storage capacity; and the presence of amenities (e.g., a galley with sink, refrigerator, microwave, fresh water tank, air conditioning units) Your agency’s budget for an MTU may dictate what configuration is most feasible for your program. MTUs are available for purchase new or used, and can be found using a quick Internet search. If owning an MTU is not feasible for your agency, consider forming a partnership with another organization, such as a community health clinic or HD that has a mobile van you can rent or borrow. You may also wish to explore partnering with that agency to expand the range of services that can be offered along with HIV testing, or to increase your ability to access your target population.

It is important to calculate the cost and maintenance of your mobile testing unit in your program’s budget, as the MTU will serve as your primary source of transportation and location of services to your target population. Other cost factors to consider include the following:

- Insurance
- Fuel
- Vehicle maintenance (including the generator, plumbing, etc.)
- Licensing
- Storage of vehicle
- Waste disposal
- Permits (parking)
Your agency must also obtain proper parking permits for your vehicle during working hours. A hired driver or qualified staff member may be able to serve as your MTU driver, and it might be useful for these individuals to also possess working knowledge of your mobile units’ maintenance basics. In addition, have policies in place for which staff members have authorization to operate the MTU and appropriate insurance for both personnel and the vehicle. It is important that you address these prior to conducting your first outreach event.

Exhibit 8.2 provides potential questions and solutions you may face with implementing HIV testing in MTUs.

### Exhibit 8.2. Considerations for Mobile Testing Units

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Potential Solutions</th>
</tr>
</thead>
</table>
| How will we recruit clients for testing? | - Station one or two staff members outside of the van to recruit and engage clients and distribute promotional items, educational materials, and risk-reduction supplies to clients. The size and configuration of your MTU will determine the number of individuals (staff and clients) that the MTU can accommodate at any given time.  
- Have your MTU staff team canvass a two- to four-block radius of the community where your target population is found and perform outreach to encourage community members to seek or accept HIV testing.  
- Set up a table with risk-reduction supplies, pamphlets, and promotional materials near the mobile unit to attract potential clients. As individuals approach your table, tell them about your services and refer them to your MTU for HIV testing and others services, as applicable. |
| How will we manage client flow? | You need at least one staff member posted at the door to regulate who enters the MTU. Depending on the size of the event/crowd, it may be helpful to have two staff members regulating entry. |
| How will we ensure privacy and confidentiality? | - Cover windows for areas that will be used for testing to protect the privacy and confidentiality of clients. This can be done using window shades, darkening contact paper, or any other material that prevents anyone outside the mobile unit from perceiving the activities occurring within the van.  
- Route clients into the MTU through one door and route them out of the MTU through another door, if possible. |
| How will clients receive test results? | - Rapid HIV testing: negative results provided same visit.  
- Rapid HIV testing: referral to care on basis of one (or two) reactive results.  
- Return MTU to same location and deliver results at next outreach event.  
- Provide results via phone.  
- Schedule appointment at your agency for results. |
| What arrangements do we need to make to ensure testing is conducted in a quality-assured manner? | - MTU interior temperature must be regulated to ensure that HIV test supplies (kits, controls) remain within operating temperature.  
- Do not store kits and controls on the mobile unit. They should be stored in a temperature-regulated environment.  
- Do not park on an incline. Rapid tests must be performed on a level surface. Carry a level on the MTU. |
| How will we ensure clients are linked to medical care? | - Provide clinical services on MTU (if feasible).  
- Coordinate with mobile early intervention program (if available).  
- Negotiate with HIV medical provider for expedited appointments. |
Exhibit 8.2. Considerations for Mobile Testing Units (continued)

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Potential Solutions</th>
</tr>
</thead>
</table>
| What do we need to do before and after outreach? | - It is essential that the MTU be thoroughly inspected (e.g., tires, lights, compartments, fluid levels, brakes) prior to departure to safeguard against any vehicular issues that may arise during your outreach event.  
- Remove and return to your agency all confidential information (e.g., client files) and store them according to your agency procedures.  
- Take an inventory of supplies and materials on the MTU both before and after outreach activities to ensure that you have adequate supplies and that everything has been returned. |
| How will we address safety? | - Clearly establish who is authorized to use the MTU and for what purposes.  
- Do not allow clients to use the MTU for other purposes (e.g., to use restroom facilities).  
- Park your mobile unit in an area of your target neighborhood where you are least likely to disrupt any community activities or events or interfere with business (either the clients or local businesses). |

Considerations for HIV Testing at Large Events

HIV testing at large events entails testing at community events or high traffic locations such as health fairs, pride festivals, or house balls. Key benefits and drawbacks of HIV testing at large events are presented below in Exhibit 8.3.

Exhibit 8.3. Benefits and Drawbacks of HIV Testing at Large Events

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Drawbacks</th>
</tr>
</thead>
</table>
| • Are often good opportunities to market your agency/services and build relationships with community partners that will enable you to more effectively meet the needs of your target population.  
• Can be useful in building awareness about HIV and your services in the community.  
• Allows for testing large numbers of individuals in a relatively short period of time.  
• May allow you to access new target populations or populations that you have been less successful in engaging.  
• May allow you to leverage the resources of event organizers to promote your agency and your services.  
• May limit the test strategies that can be used (e.g., if temperature cannot be controlled, it is not feasible to collect finger stick or venous samples).  
• May enable the provision of other screening and health services which are of value to your target population (e.g., STD screening) by other participating agencies. | • May result in relatively few high-risk individuals (members of target population) being tested and few HIV-positive individuals (i.e., cost-benefit).  
• May require more staff than fixed site.  
• Privacy/confidentiality may be difficult to ensure compared to services offered in fixed sites.  
• Environment is often not well controlled and may be unpredictable. May be difficult to manage client flow, depending on size and type of event.  
• Clients may be pressured by friends or others to consent to HIV testing.  
• Safety of staff and clients increased concern compared with most fixed sites, particularly if crowd is large and alcohol or drugs are being used.  
• Requires additional staff, compared with fixed site, in order to appropriately manage client recruitment, client flow, and safety. |
There are many factors to consider when selecting and/or deciding to offer testing at a large event. You may be invited by members of the local community or event organizers to provide HIV testing and linkage services at an event that has already been planned, such as a health fair. This may allow you to reach a relatively large number of individuals with HIV testing services, and to do so in a more cost-effective manner than if you were planning a large event on your own. If others are organizing the event, you may be able to leverage their resources for promotion and marketing. For example, you may be able to include information about your agency and its services in marketing materials prepared by the event organizers. You may be able to pool the resources of multiple partner agencies to promote and hold the event, allowing you to have a larger and “splashier” event than if you were to host the event on your own.

Another route to testing in large venues is to develop your own testing event. This can be time and resource intensive. Please see the following example from Jeff Hitt for more information on developing and implementing a large-scale testing event.
The fourth annual HIP HOP for HIV Awareness intervention was held in the City of Houston in July 2010. Persons were offered routine testing for HIV, syphilis, gonorrhea, and chlamydia, but could opt out of one or more tests. Urine specimens were collected for gonorrhea and chlamydia at clinical sites including the Greenspoint Mall location. Over the course of 27 days, a total of 15,460 persons were tested for HIV, with 113 persons identified as HIV-positive (0.73%), 35 of which were newly identified infections; 8,871 persons were tested for syphilis with 209 persons testing positive (2.36%), 52 of which were new cases; 5,755 persons were tested for gonorrhea/chlamydia with 144 persons testing positive for gonorrhea (2.50%), 733 persons testing positive for chlamydia (12.74%), and 105 persons testing positive for both gonorrhea and chlamydia (1.82%). At least 80% of those persons testing positive for HIV, syphilis, and gonorrhea and/or chlamydia were African American.

The success of this intervention is the collaborative efforts of local government, nonprofit and for-profit entities and the number one local hip hop radio station in Houston (97.9 The Box). HIP HOP for HIV is an intervention established as a mechanism to provide free and confidential HIV and STD screening to youth and young adults through a well-planned, well documented, and well executed event. The target population for this intervention is primarily African American youth and young adults. For the past 2 years the intervention has used the Incident Command Structure developed out of the Office of Emergency Management. Persons are tested for HIV, syphilis, gonorrhea and chlamydia. They also are required to participate in a 45-minute educational session that includes interactive games and condom demonstrations. Several immunizations were also offered. Many clients were prophylactically treated onsite by medical staff based on a risk assessment. Counseling specialists provided HIV and syphilis test results. All persons participating received a ticket to the HIP HOP concert that took place on July 31, 2010, where 15,000 young people were entertained by local and national hip hop music’s most stellar performers. In between performances, audience members were provided with alarming statistics about the prevalence of HIV in the African American community on a wide screen hanging overhead. Crystal Jean, an HIV-positive woman, shared her story and HIV status with the concert attendees.

- Jeff Hitt
Manager, HIV/STD Prevention and Intervention
HIV/STD Prevention and Care Branch
Texas Department of State Health Services
Austin, TX
Another example of providing testing in large venues is described below in a case study from Angela Wood of Washington, DC.

Family and Medical Counseling Service, Inc. (FMCS) currently provides HIV testing to individuals accessing services at the Department of Motor Vehicles (DMV) in Washington, DC. This comprehensive program utilizes rapid testing and provides immediate access to follow-up care services for persons with preliminary reactive test results and immediate access to behavior change support services for high-risk HIV-negative individuals.

Washington, DC has an estimated HIV prevalence rate of 3.2%, and only 50% may be aware of their infection. After a review of HIV prevalence data, we determined that the implementation of HIV testing in large public sites may be a feasible strategy to promote and engage individuals in HIV testing services. We identified the DMV, which provides driver’s license and automobile tag services to over 150,000 residents annually, as an ideal location to reach a cross-section of individuals in our target community. We considered the following factors in the selection of our site:

- Location: The DMV office we selected is located in our target community (a high-incidence area) and is in close proximity to our office, which is ideal for facilitating linkage to care.
- Consumer volume and wait time for service: The District of Columbia has a total of six DMV offices. We selected one of the highest volume sites that provides a service package that is accessed by the general public (i.e., driver license and tag renewal). We excluded sites that focus on a specific service (e.g., an inspection center). The center also has an acknowledged wait time greater than 30 minutes.
- Space: Several of the sites that we identified met our first two criteria, but did not have adequate space. We selected a site with the appropriate space to house our testing team.
- Proximity to our primary care office: Critical to the success of our HIV testing strategy is the ability to provide immediate linkage to care for individuals testing reactive. As a result, we selected a DMV site that is within 15 minutes of our primary care office.

Our program model is designed to promote HIV testing and increase the number of DC residents who know their HIV status. FMCS staff promote HIV testing among 100% of consumers accessing services at the Penn Branch DMV, offer 100% of persons receiving services at the Penn Branch DMV access to HIV testing while they wait to receive DMV services, conduct HIV testing for 100% of individuals who volunteer to receive testing, and link 100% of individuals who test preliminary reactive to primary medical care and support services.

Given that this program reaches a diverse group of residents, we decided to implement a testing strategy that builds on an existing HIV campaign in our area. The district’s Ask for the Test campaign is designed to increase the number of residents who receive testing as a part of routine primary care. As such, our testing strategy
includes messaging that is designed to normalize HIV testing, reduce the stigma that is associated with risk-based testing, dispel myths about current HIV testing behavior by primary care physicians, and increase awareness of existing HIV testing services in the district.

Linkage to care for individuals who have a reactive test result is a key component of our program strategy. Our program staff attempt to link people to care on the same day that a reactive test result is received. Individuals with a reactive test result at the Penn Branch DMV are immediately connected to the HIV testing/linkage specialist staff at FMCS. The Penn Branch DMV is located a short drive away from our offices. Our HIV testers can either dispatch a FMCS vehicle to the DMV to escort a client to services at our offices or other community sites or the client can travel to our offices by car or public transportation. Both of these strategies allow for a discrete connection to care while protecting client confidentiality in the DMV. At no time will our linkage specialist and DMV HIV testing staff meet together with a client inside of the DMV.

The inclusion of ongoing program evaluation is critical to the success of any testing program, but is imperative to the implementation of HIV testing in public service venues such as the DMV. FMCS implements a practical program evaluation and continuous quality improvement program that is designed to measure progress toward five selected quality improvement indicators: HIV offer rate, acceptance rate, testing rate, positivity rate, and linkage to care rate for the program in the Department of Motor Vehicles.

On a daily basis our program staff manually collect and report the number of individuals accessing services at the DMV during our hours of operation, the number of individuals who are offered and who accept HIV testing at the DMV, and the number of individuals testing HIV positive. This information is submitted to our program coordinator and is entered into an Excel database that calculates the offer rate, acceptance rate, HIV testing rate, and positivity rate.

- Angela Wood  
  Chief Operating Officer  
  Family and Medical Counseling Service, Inc.  
  Washington, DC

If you have decided to perform HIV testing at a large event, Exhibit 8.4 will provide you with several logistical issues to bear in mind.
### Exhibit 8.4. Considerations for Testing at Large Events

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Potential Solutions</th>
</tr>
</thead>
</table>
| **How will we recruit clients for testing?** | • One to two staff members can “work” the event, promoting your services and directing prospective clients to the area you have set up for testing.  
• Set up a table with risk-reduction supplies, pamphlets, and promotional materials to attract potential clients.  
• Promote your services in the community in advance of the event. Focus on areas of the community and venues which serve members of your target population or people who might be attracted to an event.  
• Ask the event organizers to include your services in any promotional or marketing materials used for the event (e.g., advertise your agency and services on the event Web site). |
| **How will we manage client flow?** | • You need at least one staff member to direct clients, posted at the front of your designated area.  
• Work with the event organizer to determine how large a crowd is expected. Plan your coverage of the event so that you have at least one or two staff members who can promote services and manage client flow, while one or two additional staff members perform testing services. |
| **How will we ensure privacy and confidentiality?** | • Work with the event organizer to place you in a low-traffic area so that clients can have privacy during testing.  
• Often the noise generated from large crowds or music may be adequate to make your conversations with your client more private. However, you may consider bringing in your own white noise machine or radio to keep testing sessions private.  
• Negotiate with the event organizer to be placed in a booth or area where the client will have direct access to an exit, such as the rear door of a club which exits directly into the parking lot. |
| **How will clients receive test results?** | • Rapid HIV testing: negative results provided same visit.  
• Rapid HIV testing: referral to care on basis of one (or two) reactive results.  
• Provide results via phone.  
• Schedule appointment at your agency for results. |
| **What arrangements do we need to make to ensure testing is conducted in a quality-assured manner?** | • You may choose to bring a cooler with you to store reagents or samples during the event. This must be carefully monitored to ensure proper temperatures are kept during the event (especially on hot days).  
• Bring lamps to ensure adequate lighting to read rapid test results. Bring a level to ensure that rapid testing is performed on a level surface.  
• Bring tables and chairs (if not supplied by the event’s organizers) to ensure that you are able to set up an area which provides adequate space and condition for testing. |
| **How will we ensure clients are linked to medical care?** | • Make an appointment for the client while the client is there.  
• Obtain contact information from the client to allow you or someone from your agency (e.g., a linkage specialist) to follow up with them.  
• Provide assistance in keeping a same-day appointment (e.g., taxi voucher). |
| **What do we need to do before and after outreach?** | • Secure confidential information in a lockbox and return to your agency according to your agency procedures.  
• Take an inventory of equipment, supplies, and materials both before and after outreach activities to ensure that you have adequate supplies and that everything has been returned. |
| **How will we address safety?** | • Establish a plan, in advance, for dealing with unruly clients or too large a crowd. In extreme circumstances, you may need to consider shutting down and leaving the event.  
• Establish a plan, in advance, for dealing with clients who are intoxicated or who are being pressured to test. |
Providing HIV testing services in the community is a strategy for increasing education about HIV, and decreasing the stigma about HIV and HIV testing in various communities. However, in a time of shrinking resources and with a focus on reaching the highest risk people within our communities, conducting HIV testing events may not be feasible for every organization. We have received HIV testing requests from large churches in the past that would have a primary focus on members of the church, with very little involvement and participation from the surrounding community, yielding very little, if any, new positive cases. Upon review of the potential event by our staff, we determined that it was more feasible for our agency to focus the majority of our testing resources on those locations and events that were likely to help us identify new positive cases, and if experience suggests that a low turn-out rate, low-risk activities, or low HIV positivity will be found at a location, we may offer to provide information, testing coupons, and other HIV educational resources to that community, and suggest that those who want to be tested for HIV come into the office to get assessed and tested. We have noticed that our HIV testing rate, among all populations of people that we serve, is much higher when they come INTO the office than when we go out into that community, suggesting that sometimes those who come out for community events may not be at the highest risk, even if they are coming from a high-risk area, and those who come into our offices are more at risk.

In planning outreach events, AID Atlanta assesses the feasibility and added value of such events by asking ourselves the following questions:

1. How many people to you expect your event will serve?

2. Who will your event target? (Which target population will be the focus of your event?)

3. Is the community surrounding the organization involved in the effort and invited to participate and access services?

4. How do you plan to promote the testing event?

5. Do you, as an HIV testing organization, have the appropriate resources (staff, test kits, space at the proposed site for confidential services) to effectively manage the proposed event?

6. Has anyone ever conducted HIV testing at that location in the past? What was the positivity rate or level of risk activity of those who came out for testing?

7. Can the people at this location otherwise access HIV testing?

8. Will this be a one-shot testing event, or a regular testing location?
We match our responses to these questions against our available resources to provide HIV testing and ensure that this location meets the needs of AID Atlanta’s testing plan and the goals of our funding source. Although HIV testing is one way to address fear of testing, reduce HIV testing stigma, and provide HIV testing services within a community, other strategies, including providing HIV information, conducting workshops or presentations, providing “FREE” HIV testing coupons, and condom distribution, which includes distribution of HIV and testing information, may also be options that can meet some of the needs of your community partner. You may also suggest another HIV testing organization to the community organization that may have a different target population and has greater ability to serve that organization more effectively.

- Neena Smith-Bankhead
  Director of Education and Volunteer Services
  AID Atlanta
  Atlanta, GA

Ultimately, the decision of whether to offer testing may come down to costs associated with the event relative to the benefits (i.e., the number of high-risk individuals tested and the number of HIV diagnoses made). If you must exhaust your test kit supply and staff resources in order to provide testing, and in doing so you will not identify any new infections or many of the individuals that you test are at low risk for HIV, you may need to decline the event or partner with another agency to share the resource burden.

Rather than performing HIV testing at an event, you may also consider sending a few staff members to the event to provide information and referrals to direct people back to your agency if they would like to be tested. This helps to preserve your resources, but it also allows you to take advantage of an opportunity to increase awareness about the impact of HIV in the community and for you to promote your agency and its services.
Considerations for Testing in Population-Specific Venues

While health fairs and similar events can present opportunities to test large numbers of people, you are more likely to encounter individuals at high risk for HIV, especially your target population, and identify a higher positivity rate at more specialized venues where high-risk individuals congregate and/or where high-risk activities are likely to occur (e.g., parks, bars, shelters, bathhouses). Key benefits and drawbacks of HIV testing in population-specific venues are presented below in Exhibit 8.5.

Exhibit 8.5. Benefits and Drawbacks of HIV Testing in Population-Specific Venues

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Drawbacks</th>
</tr>
</thead>
<tbody>
<tr>
<td>• May result in higher seropositivity compared with other venues/settings</td>
<td>• May result in fewer tests performed compared with other venues/settings</td>
</tr>
<tr>
<td>• May provide access to high-risk populations who do not use other HIV testing services</td>
<td>• Patrons or management may reject HIV testing if it interferes with sex or drug use</td>
</tr>
<tr>
<td>• Is often a good opportunity to raise awareness in the target community about HIV, HIV testing, and your agency</td>
<td>• Requires establishing and maintaining partnership with gatekeeper, venue management, law enforcement, or others to ensure continued access</td>
</tr>
<tr>
<td>• May limit the test strategies that can be used (e.g., not feasible to conduct rapid HIV testing in a very dark environment)</td>
<td>• Privacy/confidentiality may be difficult to ensure compared with services offered in fixed sites</td>
</tr>
<tr>
<td>• May not be feasible to provide other screening services (e.g., syphilis testing)</td>
<td>• Must monitor location to ensure that you continue to reach high-risk population</td>
</tr>
<tr>
<td></td>
<td>• Environment often not well controlled and may be unpredictable; may be difficult to manage client flow, depending on size and type of venue or setting</td>
</tr>
<tr>
<td></td>
<td>• Client consent to test may be challenging (e.g., if alcohol or drugs are being use)</td>
</tr>
<tr>
<td></td>
<td>• Safety of staff and clients increased concern compared with most fixed sites</td>
</tr>
<tr>
<td></td>
<td>• Requires additional staff, compared with fixed site, in order to appropriately manage client recruitment, client flow, and safety</td>
</tr>
<tr>
<td></td>
<td>• Linkage to care may be challenging, particularly if testing is provided after regular business hours</td>
</tr>
</tbody>
</table>

In the following textbox, you will find an example of testing in gay bars from a CBO in New Orleans.

NO/AIDS Task Force offers rapid HIV testing at gay bars (and one bathhouse) in New Orleans every week of the year (Mardi Gras is the only exception). We have established MOUs with the owners/managers to set up testing rooms in the second story or other private space in the bar, such as a dressing room or large storage closet. Per protocol, the Louisiana Office of Public Health approves the site before we can test in the space. Most of the bars offer HIV testing twice a month, though schedules vary depending on special events and holidays. NO/AIDS’ venue testing model uses a “greeter” and one or two certified HIV counselors. The greeter
distributes condom packs (condoms, lube, instructions, and our fixed-site testing hours) and recruits bar patrons for testing. The counselors wait in the private space for clients to come to them to receive the test and counseling services. If a client's test is preliminary positive, the OraSure testing is done onsite. Some patrons are not comfortable getting tested in this environment, but many are. In 2011, 488 people received an HIV test in nine bars and one bathhouse. Of this group, 17 people received a preliminary positive result (a positivity rate of 3.48%). Venue-based testing helps us meet people who wouldn't come to a clinic on their own or who don't think about getting tested. Over time, we've learned that consistency and maintaining a positive relationship with bar owners, bartenders, managers, and the community is key to the success of this testing strategy.

- Robin Pearce
  Counseling and Testing Coordinator
  NO/AIDS Task Force
  New Orleans, LA

Some venues can be difficult to access without a gatekeeper. Therefore, identifying a gatekeeper and using social networking can become essential to the success of your testing program. For example, if your target population is young, African American MSM, try to build relationships with influential members of that community in order to gain access to settings or venues where you can provide HIV testing to the target population. Also note the following considerations found in Exhibit 8.6 when testing at population-specific settings:

**Exhibit 8.6. Considerations for Testing at Population-Specific Settings**

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Potential Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How will we recruit clients for testing?</strong></td>
<td></td>
</tr>
</tbody>
</table>
  • One to two staff can “work” the venue or event promoting your services and directing prospective clients to the area you have set up for testing. Approach individuals and small groups with your “pitch”.  
  • Set up a table with risk-reduction supplies, pamphlets, and promotional materials to attract potential clients.  
  • Promote your services in the community in advance of your outreach testing event. Get gatekeepers to help you (e.g., a bartender or disc jockey).  
  • In some venues where drugs or alcohol are in use and it may be difficult to obtain consent, it may be preferable to set up appointments for testing at a later time rather than conducting testing onsite at the venue. |
| **How will we manage client flow?** |  
  • You need at least one staff member posted at the front of your area where testing is provided to direct clients. Depending on the size of the venue and the size of the crowd, you may need additional staff.  
  • Plan your outreach team so that you have at least one or two staff members who can promote services and manage flow, while one or two additional staff perform testing services. |
### Exhibit 8.6. Considerations for Testing at Population-Specific Settings (continued)

<table>
<thead>
<tr>
<th>Questions to Consider</th>
<th>Potential Solutions</th>
</tr>
</thead>
</table>
| How will we ensure privacy and confidentiality?               | • Ask to set up in a low-traffic area (e.g., a back room of a club) so that clients can have privacy during testing.  
• Find out if you can be placed in a private room. Depending on your venue, loud music and other noises can help keep your conversations with your client more private. If you are unable to be placed in a private room, consider bringing in your own white noise machine to keep testing sessions private. On the other hand, if you are testing in venues, such as nightclubs or bars where loud music is the norm, you will want to ensure that the volume of background noise does not interfere with your interactions with the client.  
• Ask to conduct testing in an area where the client will have direct access to rear door to parking lot or other exit area. If outdoors in particular, set up where clients will not have to walk back through crowds. You may need to check with the owner or other authorities that it is acceptable to designate that door as a private exit and can block off other paths to that door. |
| How will clients receive test results?                        | • Rapid HIV testing: negative results provided same visit.  
• Rapid HIV testing: referral to care on basis of one (or two) reactive results.  
• Provide results via phone.  
• Schedule appointment at your agency for results. |
| What arrangements do we need to make to ensure testing is conducted in a quality-assured manner? | • Bring a cooler with you to store reagents or samples during the event. This must be carefully monitored to ensure proper temperatures are kept during the event (especially on hot days).  
• Bring lamps or flashlights to ensure adequate lighting to read rapid test results. There are good high intensity lamps that are battery operated.  
• If you are providing testing outdoors, you will also need to ensure that testing is conducted in a sheltered area. Consider using a tent or canopy.  
• Bring tables and chairs (if not available onsite) to ensure that you are able to conduct testing an area which provides adequate space and conditions for testing. |
| How will we ensure clients are linked to medical care?         | • Make an appointment for the client while the client is there. Obtain contact information from the client to allow you or someone from your agency (e.g., a linkage specialist) to follow up with them.  
• Provide assistance in keeping a same-day appointment (e.g., taxi voucher). |
| What do we need to do before and after outreach?              | • Secure confidential information in a lockbox and return to your agency according to written procedures.  
• Take an inventory of equipment, supplies, and materials on both before and after outreach activities to ensure that you have adequate supplies and that everything has been returned. |
| How will we address safety?                                   | • Establish a plan, in advance, for dealing with unruly clients or too large a crowd. In extreme circumstances, you may need to consider shutting down and leaving the venue.  
• Establish a plan in advance for dealing with clients who are intoxicated or who are being pressured to test. |
In the following textbox, Jamie Anderson explains how Kansas uses assistance from behavioral intervention specialists to support and expand testing services. Below, Royale Theus describes the Michigan AIDS Coalition’s practices for providing testing in bars.

The Kansas Department of Health and Environment PS Program often assists HIV counseling and testing sites during outreach or testing events. Assistance from behavioral intervention specialists (BIS) comes when a community-based organization or health department may be experiencing staffing shortages for HIV testing. This is an opportunity for BIS staff to offer testing for gonorrhea, chlamydia, and syphilis at the same time they are testing for HIV. Additionally, BIS are often called upon to act as a support for staff not comfortable with delivering their first positive result.

- Jamie Anderson
HIV Counseling, Testing, and Linkage Director
HIV/AIDS Program, Kansas Department of Health and Environment
Topeka, KS

In the bar setting, most clients are going to be under some kind of influence. Our staff tries to get to the bar early to get the clients as they come into the door. This has been a best practice for our agency, and we are usually present from 10 p.m. to 2 a.m. If a client is too inebriated to give consent, we don’t provide a rapid test to the client in the bar. It can be a dangerous situation to test clients in these venues; therefore, staff members must be observant in these types of settings. We also allow clients the option to test in the bars or to come to our agency at a later time. We explain the risks of testing and receiving results in these types of settings.

Since we don’t have a mobile unit, all work is done inside the bar, so we have a great relationship with the bar owners and managers who provide us with a confidential space to test patrons. Bar owners and managers realize the services our agency provides are needed and try to accommodate us as much as possible. They were initially apprehensive about us using the rapid test, with regards to finger stick and blood, but we reassured them of our secure policies and procedures for working in these venues. The DJ also makes announcements to bar patrons that our agency is there and provides the agency contact information via microphone. Our staff has also been consistent and we have not had much turnover, which has helped with client familiarity at these venues.

- Royale Theus
Director of Programs
Michigan AIDS Coalition
Detroit, MI
CHAPTER 9 AT A GLANCE

This chapter addresses quality assurance of HIV testing and linkage services. In this chapter, we discuss the following:

- Quality assurance, including the purpose and rationale for conducting QA
- Standards for HIV testing and linkage services
- Policies and procedures for HIV testing and linkage program
- Strategies for conducting QA
- Cultural competence, including strategies for providing culturally competent services
- Strategies for program improvement

The tools and examples provided in this chapter will help you to do the following:

- Develop and implement a QA plan for your HIV testing and linkage program
- Develop policies and procedures for your HIV testing and linkage program that will help to ensure that you provide high-quality services
- Apply data from monitoring and evaluation activities to program improvement

Please note: The information and tools included in this chapter are designed to complement information and tools presented in other chapters of this Implementation Guide. There are recommendations for training and education, procedures, and QA practices associated with each of the component activities of HIV testing and linkage (e.g., recruitment, testing, linkage). Therefore, in building your QA plan, refer to other chapters in this guide.

In this chapter, we explore and provide guidance for ensuring the quality of your HIV testing and linkage program. This chapter addresses overarching QA issues and practices, including developing a QA plan for your HIV testing and linkage program. The information and tools included in this chapter are designed to complement information and tools presented in other chapters of this Implementation Guide. There are recommendations for training and education, procedures, and QA practices associated with each of the component activities of HIV testing and linkage (e.g., recruitment, testing, linkage). Therefore, in building your QA plan, it is important that you refer to other chapters for additional, detailed information regarding QA of each of the component activities: recruitment strategies (Chapter 3); implementing HIV testing, including procedures for performing testing and universal precautions (Chapter 6); referral and linkage (Chapter 7); and implementing testing and linkage in outreach settings (Chapter 8).
What Is Quality Assurance?

QA is a key aspect of successful programs. It is important for your agency to assess the extent to which the services you provide are responsive to program standards and are delivered according to established procedures. QA activities help to ensure the effectiveness of your HIV testing and linkage program and that services that you provide are responsive to client needs.

Definition

QA is a planned and systematic set of activities designed to ensure that clear expectations for program operations are established, policies and procedures are adhered to, and work products fulfill expectations. The subject of QA, for the purposes of this Implementation Guide, is HIV testing and linkage services.

Implementing Quality Assurance

The process of QA includes six component steps:

1. Identify the products and/or services that will be the subject of QA.
2. Set standards of service.
3. Develop policies and procedures based on meeting the standards.
4. Provide education and training.
5. Assess adherence to established policies and procedures.
6. Develop strategies for supporting adherence.

Standards of Service

Standards of service are evidence-based guidelines about what services may be provided and how those services can be delivered. Suggested standards of service for HIV testing and linkage programs are presented in Exhibit 9.1.
Exhibit 9.1. Suggested Standards of Service for HIV Testing and Linkage in Non-Clinical Settings

Targeting and Recruitment
- Decisions regarding targeting and recruitment should be data-driven and employ epidemiological, geographic, behavioral, social, contextual, and demographic data, as available.
- Employ recruitment strategies appropriate to engaging the target population in HIV testing and linkage services.
- Strive to identify the greatest number of new HIV-positive individuals as possible.

Testing
- Employ a testing strategy that will identify HIV infection as early as possible, and which is responsive to client needs and agency capacity.
- Provide information about HIV testing to all clients.
- Provide information about the availability of anonymous HIV testing services to clients who do not wish to give their names for testing.
- Obtain consent for testing, in accordance with State and local laws and regulations.

Risk Reduction
- Provide clients diagnosed with HIV infection with risk-reduction messages.
- Provide or refer high-risk clients to risk-reduction services responsive to their particular needs and priorities.

Referral and Linkage
- Link clients diagnosed with HIV infection to HIV medical care.
- Refer clients diagnosed with HIV infection to PS.
- Assess client referral needs and provide assistance, as feasible, to access services.
- Employ referral and linkage strategies appropriate to client needs.
- Document referral efforts and their outcome.

Quality Assurance and Evaluation
- Adhere to local, State, and Federal policies, laws, and regulations that govern provision of HIV testing and linkage services.
- Provide services that are culturally, linguistically, and developmentally appropriate.
- Ensure that staff and volunteers have necessary knowledge and skills for their responsibilities.
- Conduct QA and evaluation.
- Apply data from M&E activities to program improvement.

Policies and Procedures

Policies are rules that guide decisions and actions. Procedures are a set of actions or steps to be taken, intended to achieve a described outcome or result. Develop policies and procedures for your program and commit them to writing. It might be useful for all staff, volunteers, and consultants involved in the provision of HIV testing and linkage services to be oriented to the policies and procedures. It is essential that policies and procedures be reviewed periodically (e.g., annually), or as changes warrant, and revised as necessary.
Develop policies that address to whom and under what circumstances HIV testing and linkage services will be provided. It is important that your policies also address confidentiality, conduct, and safety. You can find recommended topics for HIV testing and linkage policies in Exhibit 9.2.

**Exhibit 9.2. Recommended Topics for HIV Testing and Linkage Policies**

- Client eligibility for services
- Service fees (if applicable)
- Provision of services to minors
- Provision of testing to clients who are not competent to provide consent (e.g., due to use of alcohol or other drugs)
- Disclosure of test results, including providing clients with copies of HIV-negative test results
- Confidentiality of client records, including who has access to such information/records and under what circumstances
- Staff conduct (e.g., use of alcohol by staff conducting testing in bars; sexual activity between staff and clients)

Develop procedures that provide a detailed, step-by-step description for each point of the HIV testing and linkage process. You can find recommended components of HIV testing and linkage procedures in Exhibit 9.3.

In the example provided for Tool 2, Part II, ACME Prevention Services (APS) used formative evaluation to determine which strategies would help them to implement an effective HIV testing and linkage program for their target population, IDUs over the age of 30 years. Use of Tool 2 helped APS to organize and apply the findings of their formative evaluation to program planning.

**Exhibit 9.3. Recommended Components of HIV Testing and Linkage Procedures**

- Site set-up and preparation, including provisions to maintain client privacy
- Transport of testing supplies, including devices (if applicable)
- Recruitment of clients
- Engagement of clients
- Consent
- Collecting and preparing samples
- Running HIV tests (preanalytic/analytic/postanalytic phases), as applicable
- Results disclosure
- Risk reduction
- Referral service assessment and planning
- Linkage to HIV medical care for clients with a positive HIV test result (distinguish between newly and previously diagnosed, if applicable), including authorization for release of information
- Referral to PS for clients with a positive HIV test result Referral to risk-reduction and other services
- Record keeping and security of client records (including transport, if applicable)
- Data collection and entry
Many HDs have template policies and procedures for HIV testing and linkage services that can be adapted for use in other programs. Sample policies and procedures are available in as Template 6 in Appendix D. You can use this as the basis for your own policies and procedures, revising it as needed to suit your particular needs. HDs and other agencies often have requirements regarding policies and procedures for HIV testing and linkage programs. They may also provide examples or templates that you can (or must) use. Appendix B: Resources provides information, including links to online resources for policies and procedures for HIV testing and linkage.

Your agency may have only one policy and procedure for HIV testing and linkage services, or you may have multiple policy and procedures, depending on how and where services are provided, who provides services, and workflow. For example, a program may develop one policy and procedure for HIV testing and a separate policy and procedure for linking clients with a positive HIV test to care. Separate policies and procedures are appropriate if you provide HIV testing and linkage services in multiple venues, such as a fixed site and a mobile van.

**Staff Training and Education**

The effectiveness and quality of HIV testing and linkage services is predicated upon having such services provided by qualified and well-trained staff. Some programs use volunteers to provide some or all aspects of HIV testing and linkage services. Anyone who provides HIV testing and linkage services must possess the knowledge, skills, and abilities necessary to perform assigned roles and responsibilities, and should receive appropriate training. It is essential that successful completion of training by staff and/or volunteers be documented.

<table>
<thead>
<tr>
<th><strong>Recommended Activity</strong></th>
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<tbody>
<tr>
<td>Volunteers should possess the knowledge, skills, and training necessary to competently perform their responsibilities. Have volunteers complete any education and training requirements that must be completed by paid staff performing the same roles and functions.</td>
</tr>
</tbody>
</table>

Key topics of training for staff providing HIV testing and linkage services, as well as their supervisors, include the following:

- HIV/AIDS basics (e.g., local epidemiology, transmission, prevention)
- State and local statutes, regulations that govern HIV testing and linkage
- Collecting and preparing samples for testing
- Performing tests, including procedures performed before, during, and after a test is run, if applicable
- Exposure control
- QA activities and processes
- Recruitment strategies
- Risk reduction
- Referral and linkage planning and management
Please refer to the relevant chapters for additional training needs associated with provision of recruitment, testing, and linkage.

It is essential that supervisors and/or program managers receive education and training on testing technologies to facilitate making decisions about which technologies and approach is the best fit for your target population and with the capacity of your agency. This will also help supervisors to evaluate the proficiency of staff in such areas as delivery of test results and making recommendations for retesting. It is also important for supervisors and/or program managers to receive training and education on specific models and/or procedures for conducting recruitment, testing, and linkage. Please refer to the relevant chapters for additional information on training for supervisors.

It may also be useful for supervisors and/or program managers to receive education that assists them in building relationships with other partners, including service providers. Supervisors can benefit from an in-depth understanding of the activities and program components which fall within their purview, regardless of whether they are directly involved in provision of services. Supervisors can benefit from training on techniques for supervision and coaching, particularly to support practice improvement.

Some States or cities have specific requirements for training or certification. Staff or others performing or supervising HIV testing and linkage services at your agency may need to should complete State- or city-mandated trainings or certifications. Contact your State or local HD for more information about statutes, regulations, and policies associated with provision of HIV testing and linkage services.

There are no Federal requirements or regulations regarding the educational attainment or credentialing of staff performing the various components of HIV testing and linkage. However, some States and cities do have statutes or regulations regarding who can perform or oversee certain HIV testing and linkage activities, most notably HIV testing. Contact your State or local HD for more information about statutes and regulations associated with HIV testing and linkage.

There are several key qualities or abilities that are useful for HIV testing and linkage staff and volunteers, including supervisors, to possess:

- **Literacy**: The ability to read and follow procedures is important, particularly with respect to running HIV tests, interpreting results, and keeping accurate records.
- **Organizational Skills**: Strong organizational skills are important, especially if client volume is high, testing and linkage services are being conducted in a busy setting (e.g., a health fair), or when a staff member is responsible for performing or overseeing several tasks or activities simultaneously.
- **Ability to Make Decisions**: Good decision-making skills are important for accurately interpreting test results; successfully linking clients with care, prevention, or other services; and recognizing and handling problems effectively.
- **Communication Skills**: Staff and others providing testing and linkage services must be able to communicate effectively with clients (e.g., meaning of test results),
accurately and clearly convey information to clients, or give clear instructions to staff and others performing HIV testing and linkage services.

**The Quality Assurance Plan**

It is essential that your QA activities be guided by a written plan. The purpose of the QA plan is to provide a roadmap for QA activities. The plan will describe the methods, processes, and timelines for assessing or reviewing adherence to the program’s policies and procedures. Your QA plan can also describe the processes and mechanisms for applying the findings of QA activities to program improvement (i.e., supporting adherence).

Your QA plan and QA activities may address the following domains:

- Responsiveness to needs and priorities of the target population and individual clients, including service accessibility, cultural competence of services/materials, and client satisfaction with services
- Compliance with written policies and procedures
- Staff performance and proficiency
- Supervision of staff
- Responsiveness to program guidelines and performance measures
- Record keeping, including maintenance of confidentiality and security
- Community resources

It is essential that all staff or volunteers receive an orientation to the QA plan and associated processes and procedures.

It is also important that your QA plan clearly describe the method(s) that will be used to assess or review program operations and service provision in each of the domains of QA. Your QA plan may also describe the frequency of assessment, the parties responsible for and/or involved in assessment or review of services, and processes and mechanisms for applying findings to program improvement.

There are a number of strategies or methods that you may use in conjunction with QA activities. Both qualitative and quantitative approaches are appropriate. Strategies and methods for QA include the following:

- **Chart Reviews:** It is important to record relevant and required information about a client (e.g., test results and referrals made) in his/her chart, and that the information is accurate and complete. Periodic review of client charts (usually a sample) will allow supervisors to evaluate this. Supervisors may also use chart review to assess staff performance (e.g., whether information on completed referrals and risk reductions plans has been recorded in client charts).
- **Direct Observation:** Observation of workflow, recruitment, risk-reduction counseling, testing, or other aspects of HIV testing and linkage are useful in assessing compliance with policies and procedures, inefficiencies in workflow, and
staff proficiency in performing particular tasks. Direct observation of HIV testing and linkage activities may be guided by written procedures and findings documented.

- **Role-Plays:** When direct observation of services is not possible or appropriate (e.g., because it would interfere with provision of services), role-plays may be a good alternative. Role-plays provide an opportunity to observe staff skills and performance and provide timely, critical feedback. Role-plays can be conducted among peers or between a supervisor and peers. For a practice example of using role-plays, see Chapter 6, Exhibit 6.1.

- **Team Meetings:** Team meetings can be used to review HIV testing and linkage activities, discuss problems or concerns, and identify solutions. It may be useful for meetings to occur at regular intervals (e.g., monthly); notes, including action items, can be taken and distributed promptly; and follow-up information can be provided on action items.

- **Case Conferencing:** Case conferencing involves discussion of one or more individual clients, typically those that have been challenging. Case conferences are used to identify solutions or strategies to ensure client needs are addressed appropriately and in a timely manner. Case conferences can also aid in identifying areas for program improvement.

- **Client Feedback:** Through surveys (e.g., brief written questionnaires) or interviews, HIV testing and linkage providers can learn about client perception of and satisfaction with services; challenges with accessibility; extent to which services were culturally competent; and other factors. Surveys or interviews can be conducted periodically (e.g., every 6 months for 2 weeks at a time) or on an ongoing basis.

- **Materials Review:** Client educational materials can be reviewed at regular intervals (e.g., annually) to assess cultural, linguistic, and developmental appropriateness. It is appropriate to involve community advisory boards or other representatives of the target population in review of materials.

- **Community Resource Review:** Community referral resources can be reviewed periodically to ensure that referral providers can appropriately address client needs and priorities. Eligibility criteria, fees, and contact information can also be reviewed and updated.

- **Record Review:** It is essential that program records which contain confidential information (e.g., referral logs) be reviewed at regular intervals (e.g., at the end of every month) to ensure staff adhere to confidentiality policies and procedures. The completeness and accuracy of records can also be assessed through record review. Rapid testing also requires regular review of records, such as quality control logs. Please refer to Chapter 6 for additional information on QA of rapid HIV testing, including recordkeeping requirements associated with point-of-care rapid HIV testing.

- **Service Data Review:** It is important that HIV testing and linkage service data be reviewed at regular intervals (e.g., monthly). Service data can help to assess program (e.g., timeliness of return of test results) and staff performance (e.g., success in facilitating linkage) and suggest areas where program improvement efforts may be focused. It is also essential that service data be reviewed with HIV
testing and linkage staff to ensure accurate interpretation and to aid in using data for program improvement. Refer to the section titled Monitoring and Evaluation for Program Improvement for additional information on conducting a yield analysis.

Tip

Use the findings of a review of service data to guide you in deciding which QA strategies to use. This will help you to focus your resources and make the best use of various strategies. For example, review of service data may indicate an unacceptably high proportion of clients with a positive HIV test result that are not successfully engaged in medical care. Reviewing your data may suggest that direct observation of one or two linkage staff, rather than all staff, may be appropriate.

QA activities are most effective and useful when conducted on a regular and scheduled basis. QA of testing and linkage can be incorporated into existing routine programmatic QA activities as appropriate.

The following two examples of QA come from Maryland and the District of Columbia. The former is an overview of the HD’s QA plan, the latter a case study on QA practices from a CBO’s testing program at the Department of Motor Vehicles.

Quality assessment and improvement (QA/I) is a continuous process that examines the activities of Maryland’s HIV Testing Program according to existing or established standards. Program standards and practice recommendations are detailed in the HIV Testing Policies and Procedures Manual produced by Maryland’s Infectious Disease and Environmental Health Administration (IDEHA). The goal of the QA/I process is to increase the quality of outcomes and elevate the level of client satisfaction with HIV testing services.

Maryland’s HIV Testing Program employs multiple strategies and tools to monitor and improve the quality of HIV testing provided in non-clinical and other settings. Included among these strategies are site visits, evaluation of counselor knowledge, observation of staff performing testing and prevention counseling, client satisfaction surveys, and for agencies performing rapid HIV testing, competency, and proficiency examinations. Guidelines and tools for QA/I strategies are included in the HIV Testing Policies and Procedures Manual.

Annually, each agency that provides HIV testing in cooperation with Maryland’s IDEHA receives a site visit. During each site visit, IDEHA program monitors review a range of issues, including staffing, program promotion, and recruitment strategies; compliance with program standards for HIV testing (e.g., confidentiality issues, delivery of results, referral planning and management; record keeping; data security), program evaluation, and fiscal management. Agencies conducting rapid HIV testing also undergo a complete review of their rapid testing program, which includes assessment of compliance with State and Federal regulations; review of rapid testing procedures and quality control practices; record keeping and reporting; and participation in Maryland’s Rapid HIV Testing Competency and Proficiency Program.
The IDEHA requires that every active counselor complete, annually, a Counselor Knowledge Evaluation (CKE) administered by testing site supervisors. In order to pass, test counselors must achieve a score of at least 75%. The CKE consists of questions about basic HIV/AIDS knowledge, HIV antibody testing, HIV testing and counseling skills, Maryland State laws, and standards for giving HIV test results. Individuals that are not successful in meeting the standard must complete remedial steps, which may include retaking the Level 1 Prevention Counselor Training provided by IDEHA.

The Counselor Observation Evaluation is another strategy to ensure that test counselors maintain a high level of competency for conducting prevention counseling associated with HIV testing. Several domains are addressed through the Counselor Observation Evaluation, including professionalism; counseling skills; effectiveness in supporting risk reduction planning; skills in providing results disclosure and associated referral planning and management. Counselor Observation Evaluations are performed by HIV testing site supervisors and according to guidelines issued by the IDEHA.

The Client Satisfaction Survey (CSS) is one of the most important measures of good quality service. The CSS measures client satisfaction with the availability and accessibility of services, the quality of services (e.g., technical competence, complete and accurate information, results), and behavioral elements (e.g., respect, understanding, fairness, confidentiality). Testing providers must administer the survey every other year. Results of this survey are analyzed and returned to each site so that they know what they are doing well and where they need to take measures to improve.

- Jenna McCall  
  Deputy Chief, Center for HIV Prevention  
  Maryland Department of Health and Mental Hygiene  
  Baltimore, MD

FMCS implements a practical program evaluation and continuous quality improvement program that is designed to measure progress toward five selected quality improvement indicators: HIV offer rate, acceptance rate, testing rate, positivity rate, and linkage to care rate for the HIV testing program in the Department of Motor Vehicles. The quality improvement indicators are included in our organizational quality improvement plan.

On a daily basis, our program staff manually collect and report the number of individuals accessing services at the DMV during our hours of operation; the number of individuals who are offered and who accept HIV testing at the DMV; and the number of individuals testing HIV positive. This information is submitted to our program coordinator and is entered into an Excel database that calculates the offer rate, acceptance rate, HIV testing rate, and positivity rate.
Our program design is consistent with the Plan, Do, Study, Act model and emphasizes the importance of consistent measurement of progress toward identified program goals; the identification and implementation of corrective actions when program performance falls below identified goals; and the ongoing monitoring of identified measures to ensure that changes positively impact progress toward identified goals.

The HIV testing manager reviews progress toward the indicators on a monthly basis. When actual performance falls below the identified benchmark/expected goal, our quality improvement and/or quality assurance process is initiated. For example, if our testing rate (testing rate means the client received testing at the DMV/requested testing at the DMV) falls below 80%, the HIV testing manager may conduct further study to identify factors that are contributing to low performance.

The review may include analysis of aggregate and individual performance data, electronic chart audits, and individual and group discussions with staff. If the review reveals a group-level problem, corrective actions target the entire staff. If the review reveals an individual staff issue, the manager may initiate further chart audits, direct observations, or increased supervision until the issue has been resolved and performance reaches the expected level. Hence, in our model, the quality assurance activities are triggered by less than acceptable performance on identified quality improvement indicators.

- Angela Wood
  Chief Operations Officer
  Family and Medical Counseling Service, Inc.
  Washington, DC

Cultural Competence

An individual’s health beliefs and behaviors (including use of health care resources) are influenced and informed by a range of factors, such as race, ethnicity, nationality, language, gender identity, sexual orientation, age, occupation, religion, and economic background. The term culture is often used interchangeably with ethnicity, nationality, or language. It is important to recognize, however, that culture cannot be reduced to a single variable, such as ethnicity. Multiple variables influence and inform how we think of, experience, and feel about various aspects of our lives, including our health and health behaviors. Even within an ethnic or social group, individuals may think about their health and health behaviors very differently because of differences in age, gender, religious beliefs, life experiences, or even personality.

Definition

To help promote health equity in the context of HIV testing and linkage services, it is critical that we provide culturally competent services. Cultural competence can be
broadly defined as the capacity of your staff and your organization to understand and integrate, into provision of HIV testing services, the factors that influence and inform the ways in which your clients understand and feel about HIV and HIV services, such as testing and care. The goal of culturally competent services is to provide the highest quality care to every client that you serve.

There are a number of strategies that you can adopt to ensure provision of culturally competent HIV testing and linkage services. These are summarized in Exhibit 9.4, but also appear throughout this guide.

**Exhibit 9.4. Strategies for Providing Culturally Competent Services**

- Engage members of the target population in the planning, implementation, and evaluation of program services.
- Convene a consumer advisory board to provide ongoing advice and guidance regarding your services.
- Engage gatekeepers to help you build trust and credibility with the community, and also to facilitate access to the target population.
- Address cultural norms, values, and preferences in your formative evaluation. This will help to ensure that you select recruitment, testing, and referral/linkage strategies that are appropriate to your target population.
- Provide interpreter services, preferably onsite, for clients with limited English proficiency.
- Develop collaborative relationships with other community partners that can provide culturally competent services to your clients, in accordance with their needs and priorities.
- Present health information (whether presented in writing, video, in person or other means) at the appropriate language and literacy level for clients. The developmental level and community norms of the target population should be reflected in health information.
- Provide training for staff and volunteers to increase awareness and understanding of the cultural norms and values of the communities that you serve, along with the skills to provide culturally competent services.
- Engage staff and volunteers who represent your target population in delivering services.
- Use community health workers (CHWs) to provide HIV testing and linkage services. CHWs typically reside in the community where services are provided, and are often trusted peers of clients.
- Provide training for staff and volunteers that will help them build the knowledge and skills necessary to interact with clients in a sensitive manner and which will assist them in identifying service needs, priorities, and barriers of individual clients.

In general, if you conduct a thoughtful and systematic planning process that is guided by a well-executed formative evaluation, engage community representatives in planning and implementation of your program, train your staff, and conduct ongoing monitoring and quality assurance of your program activities, you are in all likelihood providing culturally competent services. Even so, there is always room for improvement, and there are some good resources to help you to assess and build your capacity for providing culturally competent services. Please refer to Appendix B for additional resources related to provision of culturally competent services.

If your target population speaks a primary language other than English, it is important for staff providing HIV testing and linkage services to be proficient in that language. If you are unable to provide translation services onsite, explore other arrangements to ensure provision of services in the primary language of your clients. This may involve...
partnership with another agency in your community. Some hospitals and health care systems also provide telephone interpreting services. Contracting with translation services is another option. Some resources for translation services are presented in Appendix B: Resources.

**Recommended Activity**

**Use a professional translator.** Unless a client insists on having a friend or family member act as an interpreter, arrange for and provide translation services, and advise the client of the availability of these services. Never use a minor as an interpreter.

Having peers provide HIV testing and linkage services is often a good way to ensure that the services you provide are culturally competent. However, it is important to ensure that clients find provision of services by peers acceptable. Explore this in your formative evaluation. For example, a program serving young Latino men learned that their clients preferred testing services provided by older women, and preferably women who were nurses. When the program started using only public health nurses to provide testing services for this community, their uptake of testing increased dramatically.

**Tip**

Peers are people in equal standing in a social group, especially based on HIV status, ethnicity, age, or similar characteristics. “Peeress” is the extent to which a person may be considered a peer. In and of itself, peeress is not adequate to ensure provision of culturally competent services. Individuals providing HIV testing and linkage services must also have the knowledge and skills necessary to provide these services and to interact with clients in a meaningful manner.

**What Is Monitoring and Evaluation?**

M&E activities are key components of any successful HIV testing and linkage program. M&E helps you to look at the resources that go into the program (e.g., staff, funding), the services provided (e.g., tests provided), and the results of the program (e.g., successful linkage to care, yield of testing). M&E activities help to ensure the effectiveness of a program and that services provided are responsive to client needs. Monitor and evaluate all HIV testing and linkage activities to assess program performance, identify areas in need of improvement, and ensure accountability to stakeholders. Applying M&E data to program planning and management can help to refine and strengthen programming.

**Definition**

Program evaluation is the “systematic assessment of intervention planning, implementation, and outcomes in order to determine the value and improve program.”

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Monitoring and Evaluation for Program Improvement

Program M&E is an iterative process, and conducting it will help you to have a strong program. Prioritize M&E, ensure that you dedicate adequate resources to M&E activities, and conduct it on a regular basis.

Before you begin providing services, evaluation ensures that your program activities are properly focused and that the strategies that you select are responsive to the needs and priorities of your target population. Using formative evaluation findings before you start providing services helps you to select the strategies that will assist you in achieving your program goals and objectives, and are within the capacity of your agency to implement.

Once you have begun providing services, M&E will help ensure the following:

- Your program stays on track relative to achieving its goals and objectives
- You provide the services that you planned to, and in the way that you intended
- Your recruitment, testing, and linkage strategies are effective
- You identify, in a timely manner, areas of your program that are in need of improvement
- You identify strategies to improve your program
In the text box below, Neena Smith-Bankhead describes the importance of regularly evaluating your program—even ones that are well established.

Many times, the programs that we have cherished for years no longer meet the needs of the community, the populations that we are serving, or the needs of the agency. Although these programs are much loved and sometimes hard to consider getting rid of, shrinking resources sometimes dictate that we reevaluate their effectiveness. Consider the following when rethinking the much-loved program:

- Does the program still meet the need of the target population?
- Have you done an assessment to see what they would like to see remain, and if their needs and interests have changed?
- Is this program still meeting the need that it was originally intended to meet? When was the last time this program was evaluated?
- Is this program in line with what your agency’s mission and goals (i.e., what you are best at and are deeply passionate about)? Does this program either support or enhance the agency mission and goals, or is it disconnected?
- Are there other needs not being met in order to support this project?

Although hard to consider, sometimes it is important to reevaluate your agency’s activities to ensure that the projects and services that you provide are the most beneficial for the resources that you have, as well as meet the needs of the population served. If not, consider eliminating, updating, or changing activities.

- Neena Smith-Bankhead
  Director of Education and Volunteer Services
  AIDS Atlanta
  Atlanta, GA

The Evaluation Guide will provide you with detailed information and tools needed to develop a comprehensive approach to monitoring and evaluating your HIV testing and linkage program. This section focuses on M&E for program improvement. Tool 4, the Yield Analysis, is designed to help you to monitoring your HIV testing and linkage program. Using it will assist you to identify and describe practices or approaches that may benefit from refinement or redirection, and identify strategies to improve your program.
Tools and Templates: The Yield Analysis

Tool 4 will help you to conduct a yield analysis and assist you in applying the results to program improvement.

Tool 4. The Yield Analysis

About Tool 4: Tool 4 is divided into two parts. Yield Analysis Part I: Compilation of Data is a tool for you to use in compiling and organizing the data you will need to conduct a yield analysis. Yield Analysis Part II: Data Interpretation and Program Improvement can be used to assist you in interpreting data, and may be used as a guide in to help to identify and describe the factors that are impacting your program (both negative and positive), and to identify strategies that could be used to improve your program. Part II requires that you have clear program objectives in place. Please refer to the Evaluation Field Manual, Step 2: Describe the Program for additional information about and guidelines for constructing program objectives. Tool 4 addresses the key measures of success of an HIV testing and linkage program operating in non-clinical venues: targeting; recruitment; identification of new HIV positives; ensuring client knowledge of HIV status; and linkage to medical, prevention, and other services. Tool 4 can be easily adjusted to include additional measures of success relevant to your program, such as frequency of retesting.

Tool 4 was designed to be applied to a single target population. However, Tool 4 could easily be adjusted to be used at various levels of program operations:

- **Agency**: The yield analysis would reflect all HIV testing and linkage services delivered by the agency.
- **Program**: The yield analysis would reflect a specific HIV testing and linkage program operated by the agency. Multiple yield analyses could be conducted to compare how well various programs are doing.
- **Grant/Funding Source**: The yield analysis would reflect a specific source of funding. Multiple yield analyses could be conducted by source of funding to compare services across funding sources.
- **Site/Venue**: The yield analysis would reflect HIV testing and linkage services delivered at a single site or venue. Multiple yield analyses could be conducted to compare how well each site is doing.
- **Individual**: The yield analysis would reflect HIV testing and linkage services delivered by a single staff member or volunteer. Multiple yield analysis could be conducted to compare delivery of services across staff and could assist in QA by identifying potential areas where individual staff could benefit from additional education, training, or coaching.

To complete Part I, you will need your program service data for the time period that you wish to review (e.g., the number of tests conducted, client demographics). Part II is designed to be completed after Part I.
This tool, particularly Part II, should be completed in conjunction with staff/volunteers who provide HIV testing and linkage services, as well as others, such as community advisory board members or members of your board of directors. Multiple perspectives will result in richer discussion, a deeper understanding of the issues that are affecting your program, as well as better ideas and strategies to improve your program.

**How New Programs Can Use This Tool:** Monitoring should be an ongoing program activity and evaluation is best done early and often. More often than not, new programs experience “bumps in the road” during early implementation, as new strategies are being used and new procedures are being learned. Staff and volunteers are getting comfortable with their roles, and workflow may need to be adjusted as you gain more practical experience. New programs can benefit from using this tool shortly after implementation (e.g., within the first 3 months), because conducting a yield analysis very soon after you begin providing HIV testing and linkage services can help you to identify areas of your program where refinements or adjustments would be beneficial. During the first year of implementing a new program, consider conducting a yield analysis frequently (e.g., monthly). This will help ensure that your program gets off to a good start and that needed adjustments are made early, and before practices which do not work well become too well established.

**How Established Programs Can Use This Tool:** If you have an established program, using this tool will help you to monitor the performance of your program on an ongoing basis, detect possible problems in a timely manner, and identify strategies that will improve your program. Yield analysis can be conducted on a regular basis, and it is recommended that this occur no less than quarterly for established programs. Consider conducting a yield analysis more frequently in some circumstances, such as when your program appears to be struggling or when you have made some changes to the program, such as adding a new venue, adopting a new testing strategy, or introducing a new linkage procedure.

**How Health Departments and Other Funders Can Use This Tool:** HDs and other funders may find it helpful to use this tool in monitoring grantees or contractors. Staff with responsibility for monitoring contracts or providing technical assistance to local providers can use a yield analysis to help monitor program performance and identify potential technical assistance needs. HDs or other funders may also wish to require grantees or contractors complete a yield analysis on a regular basis as part of required reporting or in conjunction with corrective action for programs that are struggling. HDs and other funders can adapt this tool to reflect local expectations regarding performance or program requirements.
Instructions for Completing Tool 4. Yield Analysis, Part I: Compilation of Data

What is the purpose of this tool? Tool 4, Part I is to be used to compile and organize your program service data.

Who should complete this tool? Non-clinical program managers can complete this tool or others with responsibility for program M&E.

When should this tool be completed? New programs can first complete this within the first 3 months of program implementation and then regularly (e.g., monthly) thereafter. Established programs may complete this regularly (e.g., quarterly), unless the program is experiencing difficulties or there has been some change in the program (e.g., adoption of new HIV testing strategy).

How should this tool be completed? To complete Tool 4, Part I, you will need program service data for the time period that you wish to review (e.g., the number of tests conducted, client demographics, test results, referrals made, and linkage completed).

In the top portion of Tool 4, Part I, record the following information in the designated cells:

- **Agency/Program/Site:** Record the name of your agency, the program, or the site/venue for which this tool is to be completed.
- **Location:** Record the location of the agency, program, or site/venue for which this tool is to be completed.
- **Reporting Period:** Record the time period for which the yield analysis is to be conducted.
- **Funding Source:** Record the source of funding for which the yield analysis is to be conducted, if applicable.
- **Funding Amount:** Record the amount of funding associated with the agency, program, or site for which the yield analysis is to be conducted, if applicable.
- **Target Population:** Record the target population for which this tool is to be completed.
- **Other Information:** Record any other information that may be of interest to you in conducting the yield analysis, such as the number of staff providing services for this program or site, or the number of hours dedicated to HIV testing and linkage services during the review period.

In the bottom portion of Tool 4, Part I, record the specified data in each of the numbered cells and calculate the percentages according to the instructions provided in the column labeled Instructions. Once you have finished compiling your data, you will need to review and interpret it, and try to draw some conclusions from it about how to adjust your program practices (Part II).
Tool 4, Part I has been completed for you to illustrate how it may look when completed. The example reflects how you would complete this tool if for an individual HIV testing site or venue.

**Tool 4. Yield Analysis, Part I: Site Information**

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Agency/Program/Site:</strong> Club Adam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Reporting Period:</strong> April 1, 2012 to June 30, 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. <strong>Target Population:</strong> African American MSM less than 24 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. <strong>Location:</strong> North Center City (ZIP code 50201)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. <strong>Funding Source:</strong> Center City Community Foundation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. <strong>Funding Amount:</strong> $122,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. <strong>Other Information:</strong> Three staff provided HIV testing and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>linkage services at Club Adam during the time period, and 15 HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>testing and linkage events were provided at Club Adam during the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>time period (75 hours).</td>
<td></td>
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</tbody>
</table>

**Yield Analysis, Part I: Compilation of Data**

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. <strong>Number of clients tested for HIV</strong></td>
<td>150</td>
<td>Record the total number of clients tested for HIV during the reporting period.</td>
</tr>
<tr>
<td>9. <strong>Number of clients from the target population tested for HIV</strong></td>
<td>74</td>
<td>Record the total number of clients tested for HIV from the target population</td>
</tr>
<tr>
<td>10. <strong>Recruitment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10a. Clients representing the target population</td>
<td>74</td>
<td>49%</td>
</tr>
<tr>
<td>11. <strong>Testing History</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11a. No previous test</td>
<td>15</td>
<td>10%</td>
</tr>
</tbody>
</table>

**In the column marked #, record the number of clients tested for HIV who were from the target population (from #8, above).**

**In the column marked %, record the percentage of clients tested for HIV who were from the target population. To calculate the percentage, divide the number of clients from the target population by the total number of clients tested (#10a/#9)**

**In the column marked #, record the number of clients who report having never been tested for HIV.**

**In the column marked %, record the percentage of clients who reporting having never been tested for HIV. To calculate the percentage, divide the number of clients who reported no previous HIV test by the total number of clients tested (#11a/#8)**
<table>
<thead>
<tr>
<th>Item</th>
<th>#</th>
<th>%</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 11b. Tested previously negative/unknown results | 110 | 73% | • In the column marked #, record the number of clients who report having a previous test with a negative or unknown result.  
• In the column marked %, record the percentage of clients who reported having been tested previously and who had a negative or unknown result. To calculate the percentage, divide the number of clients who reported being previously tested with a negative or unknown result by the total number of clients tested (#11b/#8). |
| 11c. Previously tested, HIV positive     | 15  | 10% | • In the column marked #, record the number of clients who report having a previous test with a positive results (i.e., previously diagnosed).  
• In the column marked %, record the percentage of clients who reporting having been tested previously and who had a positive result. To calculate the percentage, divide the number of clients who reported being previously tested with a positive result by the total number of clients tested (#11c/#8). |
| 12. Number of clients with HIV-positive test result | 22  |     | Record the total number of clients with an HIV-positive test (newly positive and previously diagnosed) result during the reporting period.                                                                     |
| 13. Number of clients with HIV-negative test result | 128 |     | Record the total number of clients with an HIV-negative test result during the reporting period.                                                                                                             |
| 14. Seropositivity                        |     |     |                                                                                                                                                                                                            |
| 14a. All clients with HIV-positive test result | 22  | 15% | • In the column marked #, record the number of clients with an HIV-positive test result (from #12).  
• In the column marked %, record the percentage of clients found to be HIV positive. To calculate the percentage, divide the number of clients with an HIV-positive test result by the total number of clients tested for HIV (#14a/#8). |
| 14b. Clients with new HIV-positive test result | 7   | 5%  | • In the column marked #, record the number of clients with a new HIV-positive test result.  
• In the column marked %, record the percentage of clients with new HIV-positive test result. To calculate the percentage, divide the number of clients with an HIV-positive test result by the total number of clients tested for HIV (#14b/#8). |
## Tool 4. Yield Analysis, Part I: Site Information (continued)

### Yield Analysis, Part I: Compilation of Data

<table>
<thead>
<tr>
<th>Item</th>
<th>#</th>
<th>%</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>14c. Clients with previous HIV-positive test result</td>
<td>15</td>
<td>10%</td>
<td>• In the column marked #, record the number of clients with an HIV-positive test result who had previously had an HIV-positive test result.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• In the column marked %, record the percentage of clients with an HIV-positive test result who had previously had an HIV-positive test result. To calculate the percentage, divide the number of clients with an HIV-positive test result by the total number of clients tested for HIV (#14c/#8).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Number of clients who received their final HIV test result</td>
<td>135</td>
<td>Record the total number of clients who received their final HIV test result during the reporting period.</td>
</tr>
</tbody>
</table>

### 16. Results receipt

<table>
<thead>
<tr>
<th>Item</th>
<th>#</th>
<th>%</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>16a. All clients who received their final test results</td>
<td>133</td>
<td>90%</td>
<td>• In the column marked #, record the number of clients who received their final HIV test result (from #13).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• In the column marked %, record the percentage of clients who received their final HIV test result. To calculate the percentage, divide the number of clients who received their final test result by the number of clients tested for HIV (#16a/#8).</td>
</tr>
<tr>
<td>16b. HIV-negative clients who received their final test results</td>
<td>128</td>
<td>100%</td>
<td>• In the column marked #, record the number of HIV-negative clients who received their final test results.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• In the column marked %, record the percentage of HIV-negative clients who received their final test results. To calculate the percentage, divide the number of HIV-negative clients who received their test results by the number of clients who tested HIV-negative (#16b/#13).</td>
</tr>
<tr>
<td>16c. New HIV-positive clients who received their final test results</td>
<td>5</td>
<td>71%</td>
<td>• In the column marked #, record the number of clients with a new HIV-positive test result who received their final test results.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• In the column marked %, record the percentage of clients with a new HIV-positive test result who received their final test result. To calculate the percentage, divide the number of new HIV-positive clients who received their final test results by the number of clients newly tested HIV-positive (#16c/#14b).</td>
</tr>
</tbody>
</table>
### Tool 4. Yield Analysis, Part I: Site Information (continued)

#### Yield Analysis, Part I: Compilation of Data

<table>
<thead>
<tr>
<th>Item</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>16d. Previously HIV-positive clients who received their final test results</td>
<td>2</td>
<td>13%</td>
</tr>
<tr>
<td>17. HIV-positive linkage to care and Partner Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17a. New HIV-positive with confirmed linkage to HIV medical care</td>
<td>5</td>
<td>71%</td>
</tr>
<tr>
<td>17b. New HIV-positive with confirmed linkage to HIV medical care within 90 days of test</td>
<td>4</td>
<td>57%</td>
</tr>
<tr>
<td>17c. New HIV-positive with confirmed linkage to HIV PS within 30 days of test</td>
<td>3</td>
<td>43%</td>
</tr>
</tbody>
</table>

**Instructions:***
- In the column marked #, record the number of clients previously diagnosed HIV-positive who received their final test results.
- In the column marked %, record the percentage of clients previously diagnosed HIV-positive who received their final test results. To calculate the percentage, divide the number of clients previously diagnosed who received their final test results by the number of previously diagnosed clients (#16d/#14c).

**17a. New HIV-positive with confirmed linkage to HIV medical care**
- In the column marked #, record the number of clients with a new HIV-positive test result who were successfully linked to HIV medical care.
- In the column marked %, record the percentage of clients with a new HIV-positive test result who were successfully linked to care. To calculate the percentage, divide the number of new HIV-positive clients successfully linked to care by the number of clients with a new HIV-positive test result (#17a/#14b).

**17b. New HIV-positive with confirmed linkage to HIV medical care within 90 days of test**
- In the column marked #, record the number of new HIV-positive clients who were successfully linked to HIV medical care within 90 days of receiving an HIV test.
- In the column marked %, record the percentage of new HIV-positive clients who were successfully linked to HIV medical care. To calculate the percentage, divide the number of new HIV-positive clients successfully linked to care by the number of HIV-positive clients (#17b/#14b).

**17c. New HIV-positive with confirmed linkage to HIV PS within 30 days of test**
- In the column marked #, record the number of HIV-positive clients who were successfully linked to HIV partner services.
- In the column marked %, record the percentage of HIV-positive clients who were successfully linked to HIV Partner Services. To calculate the percentage, divide the number of HIV-positive clients with confirmed linkage to PS by the number of HIV-positive clients (#17c/#14b).
### Tool 4. Yield Analysis, Part I: Site Information (continued)

#### Yield Analysis, Part I: Compilation of Data

| Item                                                                 | Number | Instructions                                                                 |
|                                                                     |        |                                                                             |
| 18. Previously diagnosed HIV-positive out of HIV care at time of HIV test | 11     | Record the number of previously diagnosed HIV-positive clients who were not in HIV medical care at the time of the HIV test. |
| **Item**                                                             | **#**  | **%**                                                                       |
| 18a. Previously diagnosed HIV-positive reengaged in HIV medical care. | 10     | 91%                                                                         |
|                                                                     |        | • In the column marked #, record the number of previously diagnosed clients reengaged with HIV medical care. |
|                                                                     |        | • In the column marked %, record the percentage of previously diagnosed clients reengaged with HIV medical care. To calculate the percentage, divide the number of previously diagnosed clients reengaged with HIV medical care by the total number of previously diagnosed clients who were out of HIV care at the time of HIV testing (#18a/#18). |
| 19. Number of HIV-negative clients at high risk for HIV acquisition  | 44     | Record the number of HIV-negative clients at high risk for HIV acquisition.  |
| **Item**                                                             | **#**  | **%**                                                                       |
| 20a. HIV-negative clients at high risk for HIV acquisition with confirmed linkage to risk-reduction services | 20     | 45%                                                                         |
|                                                                     |        | • In the column marked #, record the number of high-risk HIV-negative clients who were successfully linked to needed risk-reduction services. |
|                                                                     |        | • In the column marked %, record the percentage of HIV-negative clients who were successfully linked to needed risk-reduction services. To calculate the percentage, divide the number of HIV-negative clients successfully linked to risk-reduction services by the number of HIV-negative clients in need of risk-reduction services (#20a/#19). |
Instructions for Completing Tool 4. Yield Analysis, Part II: Data Interpretation and Program Improvement

**What is the purpose of this tool?** Tool 4, Part II will help you understand how successful your recruitment, testing, and linkage strategies are; the factors that might be associated with the effectiveness of these strategies; and strategies that might help you to make program improvements. Tool 4, Part II will also help you to monitor progress toward achieving your program objectives. Please refer to the Evaluation Guide, Step 2: Describe the Program for detailed discussion about construction of program objectives.

**Who should complete this tool?** Program managers, staff, or others with responsibility for program M&E should complete this tool. Also consider inviting members of your community advisory board or other stakeholders to participate in these discussions. Refer to the discussion questions presented in Exhibit 9.5 for additional information to help you complete this tool.

**When should this tool be completed?** New non-clinical HIV testing programs can first complete this within the first 3 months of program implementation, and then regularly (e.g., monthly) thereafter. Established programs may complete this regularly (e.g., quarterly), unless the program is experiencing difficulties or there has been some change in the program (e.g., adoption of new HIV testing strategy). Part II should be completed only after you have completed Part I.

**How should this tool be completed?** In the top portion of Tool 4, Part II, record the following information in the designated cells:

- **Agency/Program/Site:** Record the name of your agency, the program, or the site/venue for which this tool is to be completed.
- **Location:** Record the location of the agency, program, or site/venue for which this tool is to be completed.
- **Reporting Period:** Record the time period for which the yield analysis is to be conducted.
- **Funding Source:** Record the source of funding for which the yield analysis is to be conducted, if applicable.
- **Funding Amount:** Record the amount of funding associated with the agency, program, or site for which the yield analysis is to be conducted, if applicable.
- **Target Population:** Record the target population for which this tool is to be completed.
- **Other Information:** Record any other information that may be of interest to you in conducting the yield analysis, such as the number of staff members providing HIV testing and linkage services for this program or site, or the number of hours dedicated to HIV testing and linkage services during the review period.
In the bottom portion of Tool 4, Part II, key measures of success for your program are presented in the far left column. These should correspond to the goals and objectives that you have established for your program (see the Evaluation Guide, Chapter 3, Step 2: Describing Your HIV Testing and Linkage Program for additional information on writing program goals and objectives). Record the following information in the designated cells:

- **Objective:** Record the objective that you have set for your program corresponding to the measure of success.
- **Summary of Yield Analysis:** Record a brief summary of the data presented in Tool 4, Part I, relevant to the corresponding measure of success.
- **Contributing Factors:** Brainstorm with your group to identify the factors that may be affecting the success of your program. Summarize these factors in the corresponding cells on the table.
- **Strategies:** Brainstorm with your group to identify the strategies that could help you build on your success or could help you to improve your program. Summarize these in the Strategies column.

Tool 4, Part II has been partially completed for you to illustrate how it may look when completed. The example reflects how you would complete this tool for an individual HIV testing site or venue.
Tool 4. Yield Analysis, Part II

1. **Agency/Program/Site:** Club Adam
2. **Reporting Period:** April 1, 2012 to June 30, 2012
3. **Target Population:** African American MSM under 24 years of age, not previously tested
4. **Location:** North Center City (ZIP code 50201)
5. **Funding Source:** Center City Community Foundation
6. **Funding Amount:** $122,000
7. **Other Information:** Three staff provided HIV testing and linkage services at Club Adam during the time period, and 15 HIV testing and linkage events were provided at Club Adam during the time period (75 hours).

### Yield Analysis, Part II: Interpretation of Data and Strategies for Program Improvement

<table>
<thead>
<tr>
<th>Measures of Success</th>
<th>Objective</th>
<th>Summary of Yield Analysis</th>
<th>Contributing Factors</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| How successful were we in engaging members of the target population? | 90% of all clients tested will be of the target population (see # 3, above). | - Only 49% of clients tested at this site were African American MSM 24 years of age or younger. Almost 90% of the clients tested were MSM, but most were 25 years or older.  
- Only 10% had never previously tested. | - Club Adam has raised its cover to $10, which may be prohibitive for younger MSM.  
- Advisory board reports opening of The Hoist, a hot new club in Center City.  
- Citywide testing blitz with large media campaign conducted by CCHD recently completed and may explain why many patrons of Club Adam tested previously. | - Consider reducing the number of testing events at Club Adam, focusing on nights where there is no cover (evaluate whether this attracts younger men).  
- Evaluate feasibility and appropriateness of testing at The Hoist. |
### Tool 4. Yield Analysis, Part II (continued)

<table>
<thead>
<tr>
<th>Measures of Success</th>
<th>Objective</th>
<th>Summary of Yield Analysis</th>
<th>Contributing Factors</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| How successful were we in identifying new infection? | 1% of clients tested will be newly identified HIV positive. | • 5% of all clients tested at Club Adam were newly diagnosed.  
• 10% of all clients tested at Club Adam were previously diagnosed. | • Club Adam appears to be a productive site for identifying new HIV positives.  
The relatively high percentage of previously diagnosed could be attributable to relatively older age of Club Adam patrons. | • Consider continued testing at Club Adam due to yield of positives.  
• Review data more closely to determine the age range of previously diagnosed versus newly diagnosed positives. |
| How successful were we in helping clients learn their test results? | | • 90% of all clients will receive final HIV test results.  
• 100% of newly identified HIV-positive will receive final HIV test results. | | |
| How successful were we in linking newly diagnosed HIV-positive clients to HIV medical care? | 90% of newly identified HIV-positive clients will be linked to HIV medical care. | | | |
| How successful were we in linking newly diagnosed HIV-positive clients to CCHD PS? | 75% of newly identified HIV-positive clients will be linked to the CCHD PS. | | | |
| How successful were we in reengaging previously diagnosed HIV-positive clients with HIV medical care? | 90% of previously diagnosed HIV-positive will be reengaged with HIV medical care. | | | |
| How successful were we in linking high-risk HIV clients to risk-reduction services? | 80% of high-risk HIV clients will be linked to risk-reduction services. | | | |
Exhibit 9.5 provides you with discussion questions that you may use during the process of yield analysis for interpreting data and identifying strategies for program improvement.

### Exhibit 9.5. Discussion Questions for Yield Analysis

<table>
<thead>
<tr>
<th>Level of Success</th>
<th>Summary of Yield Analysis</th>
<th>Contributing Factors</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| How well are we doing for each of the indicators of success—is the number and percentage above or below where we want it? | • What aspects of HIV testing and linkage do we seem to do well at this venue/location?  
• Which aspects of HIV testing and linkage services need improvement? | • What are the possible factors that contribute to what we do well?  
• What are the possible factors that are negatively impacting our services?  
• Is the population still present in the venue?  
• Has something about the venue changed that makes it less likely than before that the population can be reached in this venue?  
• Are there other factors or community issues that make it less likely than before that the population can be reached in this venue?  
• Are staff members able to successfully engage members of the target population? If not, why not?  
• Are there aspects of our workflow that might make testing and linkage easier or more appealing to clients?  
• What factors or community issues might be making it challenging for clients to be successfully linked to:  
  ▪ HIV medical care?  
  ▪ PS?  
  ▪ Risk-reduction services? | • Should testing and linkage at this venue be discontinued or expanded?  
• Are there alternative venues that should be considered?  
• What adjustments can be made to current practice to improve the program?  
• What additional information is needed to make decisions to improve the program? |
Practice Example 9.1. Yield Analysis: Interpretation of Data and Strategies for Program Improvement

In the example yield provided in Tool 4, recruitment efforts at Club Adam were not as successful as ACME staff would have liked. Less than half of all individuals tested were from the target population. The target population for Club Adam was African American MSM, under 24 years old, who had not previously tested for HIV. While most of the clients tested were MSM, less than half were 24 years old or younger and relatively few had never been tested. ACME did not meet their program objective of 90% of all clients tested being from the target population.

The testing and linkage program supervisor presented data from the Part I yield analysis to HIV testing and linkage staff and volunteers and to the agency’s community advisory board. The group discussed the contributing factors. It was learned that the CCHD had recently completed a testing blitz and that Club Adam was included in that blitz. The community advisory board also told staff about a new club in the area, The Hoist, that is attracting a younger crowd. Staff that conducted testing at Club Adam reported that new management at the club had doubled the cover charge on Thursday and Friday nights, which historically have been the most productive nights for testing.

The group brainstormed and discussed possible strategies for program improvement. They decided to approach the management of The Hoist about implementing HIV testing services, in an effort to better reach their target population. The HIV testing and linkage coordinator, along with one of the community advisory board members, agreed to approach the owner of The Hoist to explore the feasibility of offering HIV testing services.

The group also recognized that testing at Club Adam has been productive from the perspective of identifying new HIV positives, ACME established an objective of 1% seropositivity for testing at this venue, and the data show a 5% rate of seropositivity.

A closer look at the data, however, showed that all but one of the clients newly diagnosed was over the age of 24 years, suggesting that there may be an unmet need for HIV testing in this population. The group agreed to discuss whether they can and should expand testing for MSM over age 24 in the future. The HIV testing and linkage coordinator and HIV prevention manager will present these data to the ACME board of directors at its next meeting.

Because testing at Club Adam has helped them to identify new positives, the group agreed that they should maintain some minimum level of effort at Club Adam, at least for the short term. At the same time, because efforts at Club Adam have not been totally successful in reaching the target population, the group agreed that it is important that program effort be redirected to venues/settings where they can more successfully reach the target population.
Appendix A: Glossary

**Algorithm:** The combination and sequence of specific tests used to diagnose HIV.

**Acute:** Acute HIV infection is the highly infectious phase of HIV disease. It can last approximately 2 months. It is characterized by a variety of flu-like symptoms such as fever, fatigue, rash, headache, sore throat, swollen tonsils, nausea, vomiting, diarrhea, and joint and muscle aches.

**Anonymous HIV testing:** HIV testing in which client identifying information is not linked to testing information, including the request for tests or test results.

**Antiretroviral therapy (ART):** Treatment with drugs that inhibit the ability of HIV or other types of retroviruses from replicating in the body.

**Blood:** Blood is a body fluid composed of red and white blood cells suspended in a liquid called blood plasma. Blood carries nutrients and oxygen to cells in the body and carries away waste.

**Capacity building:** Activities that strengthen the core competencies of an organization and contribute to its ability to develop and implement an effective HIV prevention intervention and sustain the infrastructure and resource base necessary to support and maintain the intervention.

**Medical case management:** A service generally provided through an ongoing relationship with a client that includes comprehensive assessment of medical and psychosocial support needs, development of a formal plan to address needs, provision of assistance in accessing services, and monitoring of service delivery.

**Centers for Disease Control and Prevention (CDC):** The lead Federal agency for protecting the health and safety of U.S. citizens providing credible information to enhance health decisions, and promoting health through strong partnerships. Based in Atlanta, Georgia, this agency of the U.S. Department of Health and Human Services serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.

**Client:** Any person served by a health department or other health or social services provider.

**Clinical setting:** A setting in which both medical diagnostic and treatment services are provided.
Cluster interview: An interview with a non-infected partner (or social contact or associate), conducted to elicit information about persons within the social network (e.g., associates) who might benefit from counseling, examination, or testing for HIV and other STDs. Such persons might include persons with symptoms suggestive of disease, partners of other persons known to be infected, or others who might benefit from examination.

Comprehensive Risk Counseling and Services (CRCS): An intensive, individualized, client-centered counseling for adopting and maintaining HIV risk-reduction behaviors.

Confidentiality: Ensuring that information is accessible only to those authorized to have access.

Cultural competence: Cultural competence can be broadly defined as the capacity of your staff and your organization to understand and integrate, into provision services, the factors that influence and inform the ways in which your clients understand and feel about HIV and HIV services, such as testing and care.

Data security: The protection of public health data and information systems in order to prevent unauthorized access or release of identifying information and accidental data loss or damage to the systems. Security measures include measures to detect, document, and counter threats to data confidentiality or the integrity of data systems.

Disease intervention specialist (DIS): A health department staff member who is specially trained to interview persons infected with HIV or another STD (i.e., index patients); elicit information about their partners and associates; notify the partners of their possible exposure; ensure that the partners are offered appropriate services, including examination, treatment and referrals; and provide prevention counseling to index patients, partners, social contacts and associates. Evaluation: The systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and inform decisions about future programming.

External referral: Clients are referred by external agencies to the testing program.

High risk: Clients who report any of the following may be at high risk for HIV transmission or acquisition:

- Recent unprotected anal and/or vaginal sex with an HIV-positive partner or partner of unknown HIV status
- Recent sharing of drug injection equipment with an HIV-positive partner or partner of unknown HIV status
- Current or recent past diagnosis of and/or treatment of a sexually transmitted infection in self or partner
- Symptoms of viral illness

Human Immunodeficiency Virus (HIV): A virus that disables the immune system composed either of two strains of a retrovirus, HIV-1 or HIV-2, and destroys the immune system’s helper T cells, the loss of which causes AIDS.
**Incentive:** Compensation for a person’s time and participation in a particular activity, (e.g., voucher for transportation, food, money, or other small reward).

**Incidence:** The number of new cases in a defined population within a certain time period (often a year). It is important to understand the difference between HIV incidence, which refers to new HIV infections, and new HIV diagnoses. New HIV diagnoses represent persons newly identified as HIV infected, usually through HIV testing. These persons may have been infected recently or at some time in the past.

**Index patient:** The person in whom an index case occurs and who prompts the initiation of an investigation to identify other possibly related cases. Index patients also are sometimes referred to as “original patients” (i.e., the original patient identified in an investigation, not necessarily the original patient in a chain of transmission).

**Informed consent:** An individual receives and understands information sufficient to obtain his/her consent to undergo HIV testing.

**Internal referral:** Accessing clients through other services that are provided within the agency where the testing program resides (e.g., syringe exchange programs, substance abuse programs, mental health services, crisis care).

**Intervention:** A specific activity (or set of related activities) intended to reduce the risk of HIV transmission or acquisition. Interventions may be either biomedical or behavioral and have distinct process and outcome objectives and procedures outlining the steps for implementation.

**Laboratory testing:** Refers to HIV or other testing performed in a public health or clinical laboratory. Sometimes referred to as “conventional” testing.

**Linkage to medical care:** A person is seen by a health-care provider (e.g., physician, physician assistant, nurse practitioner) to receive medical care for his/her HIV infection, usually within a specified time. Linkage to medical care is the outcome of the referral. Linkage can be verified by following up with the provider. This requires a valid release of information form signed by the client in advance of the referral.

**Men who have sex with men (MSM):** Men who report sexual contact with other men and men who report sexual contact with both men and women, whether or not they identify as gay.
**Monitoring**: The regular observation, tracking, and recording of activities taking place in a program or project. It includes the process of systematically observing and routinely gathering information on all aspects of the program. Monitoring also involves providing feedback about the progress of the program to the stakeholders and implementers to be used in making decisions for improving program performance.

**Monitoring and evaluation (M&E) plan**: A comprehensive planning document for all M&E activities. An M&E plan documents the key M&E questions to be addressed, including what indicators are collected; how, how often, from where, and why they will be collected; what baselines, targets, and assumptions will be included; how the indicators are going to be analyzed or interpreted; and how or how often reports will be developed and distributed on these indicators.

**nPEP**: Non-occupational post exposure prophylaxis (n-PEP) refers to the provision of antiretroviral drugs to prevent HIV infection after unanticipated sexual or injection-drug-use exposure.

**Non-clinical setting**: A setting which does not provide medical diagnostic and treatment services.

**Partner**: For persons with HIV infection, partner refers to sex and drug-injection partners (i.e., persons with whom an index client has had sex or shared drug-injection equipment at least once, not just regular or main partners).

**Partner elicitation**: The process of obtaining the names, descriptions and locating information of person who are sex or drug-injection partners.

**Partner Services (PS)**: A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can be offered HIV testing and learn their status, and, if already infected, services to help them prevent transmission to others.

**Plasma**: Plasma is the straw-colored liquid component of blood that holds the red and white blood cells in suspension.

**Positive predictive value (PPV)**: The percentage of true positive results among all positive results, (i.e., the number of true positives divided by the number of true positive results added to the number of false positive results). A low positive predictive value (e.g., 50%) indicates that many of the positive test results are false positives. A high PPV (e.g., 98%) indicates that most of the positive test results are true positives.

**Prevalence**: The total number of cases of a disease in a given population at a particular point in time. HIV/AIDS prevalence refers to persons living with HIV, regardless of time of infection or diagnosis date. Prevalence does not give an indication of how long a person has had a disease and cannot be used to calculate rates of disease. It can provide an estimate of risk that an individual will have a disease at a point in time.
**Privacy:** The right of an individual to keep his or her identity and information concealed or hidden from the unauthorized access and view of others.

**Program:** Collection of services or activities within an agency or jurisdiction designated to meet a social or health services need in a community.

**Program activities:** Specific actions directly related to program objectives that occur, including provision of information, testing, and referral and linkage services.

**Program evaluation:** Program evaluation is the “systematic assessment of intervention planning, implementation and outcomes in order to determine the value and improve program.”

**Program planning:** The process of defining goals, objectives, and activities relevant for specific target populations.

**Process evaluation:** Evaluation that assesses planned versus actual program performance over a period of time for the purpose of program improvement and future planning.

**Qualitative data:** Detailed descriptions of situations, events, people, interactions, and observed behaviors; direct quotations from people about their experiences, attitudes, beliefs, and thoughts; or excerpts or passages from documents, correspondence, records, and case histories. Qualitative data come from open-ended interviews, focus groups, observations, document review, and questionnaires without predetermined, standardized categories.

**Quantitative data:** Numeric information representing predetermined categories that can be treated as ordinal or interval data and subjected to statistical analysis. Quantitative data come from structured questionnaires, tests, standardized observation instruments, and program records.

**Quality assurance:** Quality assurance is a planned and systematic set of activities designed to ensure that clear expectations for program operations are established, policies and procedures are adhered to, and work products fulfill expectations.

**Recruitment:** The process by which individuals are identified and invited to become participants in HIV testing and linkage to care programs.

**Referral:** Referral is the process by which a client’s immediate needs for medical care or risk-reduction services are assessed and prioritized, and the client is provided with information and/or assistance in accessing referral services. A referral may be either passive or active. Linkage takes a further step by verifying that the referral was successfully completed.

- **Passive referral:** In a passive referral, a client is provided with information, such as agency name and location, about one or more referral services. It is then up to the client to make decisions about whether and which services to access.
• **Active referral**: An active referral begins with assessment and prioritization of a client’s immediate needs for medical and/or risk-reduction services. In an active referral, a client is provided with assistance in accessing referral services, such as setting up an appointment or being given transportation.

• **Linkage**: Linkage means that a referral has been verified as having been successfully completed. If a client keeps his or her first appointment or receives the referral service (if the referral requires keeping only a single appointment) the referral can be considered as having been successfully completed. Optimally, it might be valuable to include feedback on a client’s satisfaction with referral services as part of the linkage process.

**Risk reduction**: Risk reduction refers to a range of interventions designed to reduce or eliminate the risk for transmission or acquisition of HIV infection.

**Sensitivity**: Sensitivity is the ability of a test to correctly identify clients with HIV infection (i.e., “true positives”). A highly sensitive test is unlikely to give a false negative result.

**Serum**: Serum is the component of blood from which all red and white blood cells and clotting factors have been removed. Serum contains antibodies and antigens.

**Sexually transmitted diseases (STDs)**: STDs are illnesses that are most often transmitted between people by means of sexual contact, including vaginal intercourse, oral sex, and anal sex. STDs are also referred to as sexually transmitted infections (STIs).

**Social networking**: A peer-driven approach of identifying HIV-positive or HIV-negative high-risk persons from the community who are able to recruit individuals at high risk from their social, sexual, or drug-using networks; partner referral is a type of social networking which involves members referring their sexual partners to a testing program.

**Specificity**: Specificity is the ability of a test to correctly identify clients without HIV infection (i.e., “true negatives”). A highly specific test is unlikely to give a false positive result.

**Stakeholders**: People or organizations that are invested in the program, are interested in the results of the evaluation, and/or have a stake in what will be done with the results of the evaluation.

**Targeting**: Use of data or information to direct HIV testing, linkage and HIV risk-reduction services to high-risk populations, and settings in which high-risk persons can be accessed, with the purpose of ensuring that services are available and accessible by persons who need them.

**Target populations**: The primary groups of people that the program will serve. Target populations are defined by both their risk(s) for HIV infection or transmission as well as their demographic characteristics and the characteristics of the epidemic within this population.
**Testing strategy:** Activities and processes associated with employing specific testing technologies to conduct HIV testing with clients.

**Testing technology:** Type of test used to perform HIV testing on an individual or specimen.

**Whole blood:** Whole blood is liquid plasma in which red and white blood cells are suspended.

**Window period:** A window period is the time period between when a person is infected and when a test can detect HIV infection.
Appendix B: Resources

Chapter 3: Targeting and Recruitment

Social Networks Testing

CDC has produced interim guidance on HIV testing using the social networking strategy. Additional information is available at the link above.

Social Media

CDC has produced a guide for using social media for health communications. The guide is available for download at the link above.

Chapter 4: Risk Reduction

Behavioral Interventions

Effective Interventions

Additional information about brief behavioral interventions for a variety of populations, including training resources, is available at this Web site.

Compendium of HIV Prevention Interventions With Evidence of Effectiveness

CDC maintains a compendium of behavioral interventions effective for different populations, including injecting drug users, adolescents, and other populations at this Web site.

Other Risk-Reduction Interventions

Non-Occupational Post-Exposure Prophylaxis

CDC recommendations regarding nPEP, published in the Morbidity and Mortality Weekly Report are available for download at the link above.

AIDS Education and Training Centers National Resource Network

The AIDS Education and Training Centers conduct targeted, multidisciplinary education and training programs for health care providers treating persons living with HIV/AIDS. They have many resources on nPEP that can help you work with clinical providers to provide this service to your clients.
National Network of STD/HIV Prevention Training Centers

The National Network of STD/HIV Prevention Training Centers is a CDC-funded group of regional centers created in partnership with health departments and universities. The PTCs provide education and training to health professionals in the areas of STD diagnosis and treatment, behavioral interventions, and PS.

Chapter 5: HIV Testing Methods in Non-Clinical Settings

HIV Tests

Overview of Available Tests

HIV InSite, sponsored by the University of California, San Francisco, provides an overview and explanation of the HIV screening tests currently available in the United States available at this Web site.

Rapid Test Considerations

CDC webpage includes a tool describing FDA, CLIA-approved rapid HIV tests.

Acute Infection

Acute Infection Signs

Information about the signs and symptoms associated with acute infection are available at this link.

Clinical Laboratory Improvement Amendments (CLIA) of 1988

CLIA Forms

Information about CLIA, enrollment forms, and fee explanations are available for download from the Centers for Medicaid and Medicare Services at this Web site.

Nonclinical HIV Testing

CDC maintains a webpage on rapid testing and rapid testing guidance. It is available at the link above.
Universal Precautions and Exposure Control

**Universal Precautions and Exposure Control Plans**

OSHA has produced a series of fact sheets on universal precautions and exposure controls and workplace posters in downloadable format. Additional detail and discussion of universal precautions and exposure control plans are available from OSHA at these links:

- [Training resources and materials](#)
- [A sample exposure control plan](#)

**Chapter 6: Implementing HIV Testing**

**Rapid HIV Testing Quality Assurance**

**Quality Assurance Templates**

CDC has produced Quality Assurance Guidelines for Testing Using Rapid HIV Antibody Tests Waived Under the Clinical Laboratory Improvement Amendments of 1988. This document provides guidance on quality assurance practices for sites using or planning to use rapid test kits to detect antibodies to the human immunodeficiency virus (HIV) waived under the CLIA regulations.

The World Health Organization has an [HIV rapid test training package](#) which includes details about setting up QA and log books.

The [Michigan Department of Community Health](#) has developed a comprehensive laboratory quality assurance manual for rapid HIV testing. Templates include sample collection and testing procedures, control logs, and tools for proficiency assessment. Templates are available for download.

New York State’s AIDS Institute has a [Rapid Testing Workbook and Implementation Guidelines](#) which includes information on establishing a QA program, hiring and training personnel, and conducting rapid tests.

The [HIV Early Intervention Services Program of the Division of Addictive Diseases](#), Georgian Department of Behavioral Health and Developmental Disabilities has a variety of templates available, including sample quality assurance procedures and sample forms (e.g., temperature log, consent forms) for rapid HIV testing. These are available for download.
Results Disclosure Procedures

AIDS.gov offers guidance on HIV disclosure to partners, health care providers, family and friends, employers and more.

Chapter 7: Referral and Linkage to Health and Prevention Services

Linkage Case Management

ARTAS Manual: Additional information on ARTAS, including an implementation manual and training resources, is available at the Effective Interventions Web site.

System Navigation

Patient Navigator Programs: This resource describes a variety of patient navigator programs for people living with cancer and other chronic diseases.

Peer Navigator Program: The Peer Education and Evaluation Resource Center (Boston) has produced a toolkit, Building Blocks to Peer Success, to support the training of HIV-positive peers to engage and retain individuals living with HIV into medical care. This site also contains a link to a Health Resources and Services Administration (HRSA)-sponsored Webcast, which provides an overview of the toolkit.

Outreach and Peer Support

Peer Support Services: The Massachusetts Department of Public Health has produced Guidelines for Peer Support Services. This document provides a clear definition of peer support services, describes various methods of delivering peer support, identifies the core competencies of peer leaders, and provides guidance on quality assurance and evaluation of peer outreach and support programs.

Peer Support Tools: The Los Angeles County Commission on AIDS has produced Standards of Care: Peer Support. This document describes the components of peer support services and competencies for peers, and provides sample tools for use in conjunction with peer outreach and support services.

Comprehensive Risk Counseling and Services

CRCS Implementation Manual: CDC has developed an array of resources and tools to support implementation of CRCS, including an implementation manual.

Medical Case Management

Case Management Recommendations: Recommendations for Case Management Collaboration and Coordination in Federally Funded HIV/AIDS Programs were developed jointly by CDC and HRSA to help promote collaboration and coordination.
across various case management systems. The core components of medical case management are identified, and the basic process of medical case management is described.

General Linkage

Best Practices: Project Inform has prepared a summary of best practices from the HPTN 065 study, *TLC+: Best Practices to Implement Enhanced HIV Test, Link-to-Care, Plus Treat (TLC-Plus) Strategies in Four U.S. Cities*. Various linkage strategies currently being evaluated are described.

Adapting Interventions

Evidence-Based Behavioral Interventions: For additional information about behavioral and biomedication intervention implementation support, go to the Effective Intervention’s Web site.

Chapter 9: Quality Assurance and Monitoring and Evaluation

Procedures and Quality Assurance

The CDC has developed *Quality Assurance Guidelines for Testing Using Rapid HIV Antibody Tests* which includes useful information on developing a QA program, testing procedures, and monitoring. Additionally, CDC has resources on how to develop an Individualized Control Plan (IQCP) and waived testing.

The Michigan Department of Community Health has developed a comprehensive laboratory quality assurance manual for rapid HIV testing. Templates include sample collection and testing procedures, control logs, and tools for proficiency assessment, and are available for download.

The Wisconsin Division of Public Health AIDS/HIV Program has a published HIV Counseling, Testing and Referral Services Protocol, which includes a standardized set of quality assurance procedures for HIV rapid testing used by providers in that state. Tools and templates include temperature logs, proficiency checklists, and external control logs. The procedures can be adapted for use elsewhere.

Linkage to Care

Referral and Linkage Procedures: CDC has developed sample procedures for referral and linkage of clients with a positive HIV test for use by HIV testing and linkage providers.
Cultural Competence

Culturally and Linguistically Appropriate Services Standards: In 2001, the Office of Minority Health in the Department of Health and Human Services published national standards for delivering services that reflect a group’s culture and language. This is referred to as culturally and linguistically appropriate services.

Translation Services: The American Translator Association (ATA) maintains an online searchable directories of translation and interpreting services. ATA has also produced a guide titled How Do You Choose the Best Translator for Your Job? that can provide you with information about selecting the right translation services for your organization.

There are many types of organizations that provide telephone interpreting services, including for-profit companies, governmental organizations, and nonprofit groups. Many commercial telephone companies provide interpreting services and can provide interpreting services anytime of the day, sometime on demand. Language Line Solutions is the largest provider of telephone interpreting services in the United States.

Tools and Other Resources for Culturally Competent Services: The National Center for Cultural Competence (NCCC) has a mission to increase the capacity of health care and mental health care programs to design, implement, and evaluate culturally and linguistically competent service delivery systems to address growing diversity, persistent disparities, and to promote health and mental health equity. NCCC has produced a number of training curricula and assessment tools that can assist you with developing your agency’s capacity for providing culturally competent services.

The Gay, Lesbian, Bisexual and Transgender Health Access Project produced Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgendered Clients. The community standards of practices address both agency administrative practices, as well as delivery of services. The standards include recommended practices (e.g., intake assessment, planning services, recruitment, confidentiality) for ensuring culturally competent services for LGBT. The standards are available for download.

The Gay and Lesbian Medical Association has produced Guidelines for Care of Lesbian, Gay, Bisexual, and Transgendered Patients. The recommendations can be adapted for use with HIV testing and linkage programs and are available for download.
Appendix C. Toolkit

The following appendix includes all the tools discussed in the Implementation Guide. Prior to each tool, we provide information on the purpose of the tool, how new and established programs can use the tool, how health departments or funders can use the tool, as well as detailed instructions on who can complete the tool, the timing of completion, and how to complete it.
Tool 1. HIV Testing and Linkage Program Planning and Capacity Assessment

**About Tool 1:** Tool 1 is divided into two parts. Part I: HIV Testing and Linkage Program Planning serves as a guide for and tool to document your program planning process. Part II: HIV Testing and Linkage Capacity Assessment assists you in assessing your capacity for implementing an HIV testing and linkage program. The “Domains of Readiness” presented in Part II correspond to the major implementation activities that need to be completed to prepare you to implement HIV testing and linkage services. The greater the number of domains of readiness completed, the greater your capacity to fully implement HIV testing and linkage services.

Part II is designed to be completed after Part I. If you are planning a new program, it is recommended that you do not begin providing services to clients until you have full capacity to implement HIV testing and linkage services (i.e., all of the boxes on Part II are checked as complete). However, established programs may wish to begin with Part II to identify those domains where program improvement efforts can be concentrated.

This tool should be completed in conjunction with discussion with staff members who provide HIV testing and linkage services, as well as others, such as consumer advisory board members or members of your board of directors. Multiple perspectives will result in richer discussion, a deeper understanding of program planning issues and program operations, as well as better ideas and strategies to ensure a successful program.

Tool 1 presents HIV testing and linkage program planning activities as though they occur in a sequential fashion. It is important to note, however, that some activities may occur at the same time. For example, you may be simultaneously working on developing your recruitment protocol and developing client educational materials. Some activities may reoccur at multiple points in time, such building new partnerships, establishing a new memorandum of agreement (MOA), or hiring new staff members who must be trained.

**How New Programs Can Use This Tool:** This tool is designed to assist you in planning your HIV testing and linkage program. This tool will take you through the key steps of program implementation, including formative evaluation, planning for delivery of HIV testing and linkage services, as well as monitoring, providing QA, and evaluating your program. This tool will help you to assess your capacity and readiness to implement your HIV testing and linkage program. It will help you to identify any gaps in your knowledge or resources that will need to be addressed to ensure that your program will meet the needs of your target population and that you have the knowledge, tools, and resources needed to deliver high-quality services.
**How Established Programs Can Use This Tool:** If you have already implemented an HIV testing and linkage program, you can use this tool to help you to assess whether your program is still meeting the needs of your target population, and if you need to make any changes to strengthen your program. It is good practice to periodically reassess your program to ensure it is still meeting community needs and that you are using the tools and strategies that help you deliver effective and high-quality HIV testing and linkage services.

Many agencies reassess their programs on an annual basis, as part of a regular program planning and improvement process. Some funders require work plans on a regular (e.g., annual) basis. It is always a good idea to reassess program practices when substantial changes occur in your agency (e.g., staffing changes) or community (e.g., changes in health and social services in the community). It is also a good idea to reassess program practices in light of new technologies (e.g., availability of new HIV tests) or advent of new strategies and tools.

Established programs may find it helpful to use this tool as to take inventory of a program and its capacity. In this case, you could complete the entire tool and update it periodically (e.g., during your annual planning process) or as changes warrant (e.g., when policies and procedures are updated). Alternately, established programs may not need to complete the entire tool, but only sections which are most relevant. For example, if you are considering adopting a new test technology, you may only need to complete the section on testing capacity and QA.

**How Health Departments and Other Funders Can Use This Tool:** Health departments and other funders may find this tool helpful for use with grantees or contractors. You could use this tool in providing technical assistance to agencies that are just beginning a new program, or for agencies that seem to be struggling with program implementation. Some HDs or other funders may wish to have grantees or contractors complete this tool at the beginning of a project (e.g., as a component of a funding proposal) or on a regular basis (e.g., at the beginning of each contract cycle) as a means to assess and monitor capacity to provide HIV testing and linkage services. HDs and other funders can adapt this tool to suit local needs by adding or adjusting the activity fields to reflect local policies, regulations, or requirements, such as specific training or certification requirements for staff providing HIV testing and linkage services.
Tool 1. HIV Testing and Linkage Program Planning and Capacity Assessment

**What is the purpose of this tool?** Tool 1, Part I is used to guide and document your program planning efforts.

**Who should complete this tool?** HIV testing and linkage program managers, in collaboration with staff, consumer advisory board members, and others involved in planning, implementation, and evaluation of the program.

**When should this tool be completed?** Before you implement HIV testing and linkage services or as part of periodic program assessment of established programs.

**How should this tool be completed?** In the top portion of Tool 1, Part I, record the following information in the designated cells:

- **Agency/Program:** Record the name of the agency and/or program completing this tool.
- **Target Population:** Record the target population.
- **Date Completed:** Record the date that the tool was completed or updated, as applicable.
- **Participants:** Record the names and/or positions/roles of the individuals participating in completing this tool.

The left column presents the key activities involved in planning for and implementation of an HIV testing and linkage program. HDs and other funders, in particular, may wish to add, delete, or modify these activities to suit local needs and requirements. For each activity listed, record the following information in the designated column:

- **Last Update:** Enter the date that corresponds to when the activity was completed or last updated.
- **Responsible Individual/Position:** Enter the name of the individual (or title of the position) that has taken responsibility for the activity.
- **Timeline for Completion:** Enter the date by which the activity must be completed.
- **Challenges:** Summarize challenges, if any, which may delay completion of the activity.
- **Strategies:** Summarize strategies that you will use to address the identified challenges in completing the activity.
# Tool 1. Part I: HIV Testing and Linkage Program Planning

<table>
<thead>
<tr>
<th>Activity</th>
<th>Last Update*</th>
<th>Responsible Individual/Position</th>
<th>Timeline for Completion</th>
<th>Challenges</th>
<th>Strategies to Address Identified Challenges</th>
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</thead>
<tbody>
<tr>
<td><strong>Implementation Planning – General</strong></td>
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<tr>
<td>Conduct community readiness assessment</td>
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<tr>
<td>Conduct agency readiness assessment</td>
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<tr>
<td>Review applicable State and local laws, regulations, and policies governing HIV testing and linkage</td>
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<tr>
<td>Identify partner agencies that may refer clients to the testing program or provide medical and social services to tested clients</td>
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<tr>
<td><strong>Implementation Planning (continued)</strong></td>
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<tr>
<td>Obtain input from representatives of the target population in development of plans for implementing HIV testing and linkage services</td>
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<td>Develop staffing and supervision plan</td>
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<td>Hire staff in accordance with staffing and supervision plan</td>
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<tr>
<td>Develop agency policies for HIV testing and linkage services</td>
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</table>

*Existing programs may note the date that the activity was completed or last updated. New programs should leave this column blank.*
### Tool 1. Part I: HIV Testing and Linkage Program Planning (continued)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Last Update*</th>
<th>Responsible Individual/Position</th>
<th>Timeline for Completion</th>
<th>Challenges</th>
<th>Strategies to Address Identified Challenges</th>
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<tbody>
<tr>
<td><strong>Client Targeting and Recruitment</strong></td>
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<tr>
<td>Conduct formative evaluation**</td>
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<tr>
<td>- Define the target population and select a targeting strategy</td>
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<tr>
<td>- Select a recruitment strategy</td>
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<tr>
<td>Identify recruitment venues</td>
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<tr>
<td>Execute MOA with recruitment partners</td>
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<tr>
<td>Obtain incentives</td>
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<tr>
<td><strong>Testing</strong></td>
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<tr>
<td>Select HIV tests that will be offered</td>
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<tr>
<td>- Identify providers of risk reduction and medical and social services of value to clients with positive tests.</td>
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<tr>
<td>- Decide if will provide these onsite or through external agencies, and if the later, by linkage, referral, or both</td>
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<tr>
<td>Execute MOA with health departments for partner services</td>
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</table>

**Refer to the section titled Formative Evaluation and Implementation Planning (including Tool 2) in Chapter 2 for additional information on formative evaluation activities.**
### Tool 1. Part I: HIV Testing and Linkage Program Planning (continued)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Last Update*</th>
<th>Responsible Individual/Position</th>
<th>Timeline for Completion</th>
<th>Challenges</th>
<th>Strategies to Address Identified Challenges</th>
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</thead>
<tbody>
<tr>
<td><strong>Services for HIV-Negative Clients</strong></td>
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<tr>
<td>Develop a tool to classify clients with negative tests as having</td>
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<td>elevated risk that can be used to triage these clients to more</td>
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<td>intensive risk-reduction services</td>
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<td>Decide whether risk reduction interventions will be provided</td>
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<td>onsite or through linkage or referral</td>
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<tr>
<td><strong>Training</strong></td>
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<tr>
<td>Develop written targeting, recruitment, testing, and services for</td>
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<td>HIV-positive clients and services for HIV-negative clients procedures</td>
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<td>Develop (or identify and obtain) marketing materials</td>
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<tr>
<td>Train staff on targeting, recruitment, testing, and services after</td>
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<tr>
<td>testing strategies (e.g., SNS)</td>
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<tr>
<td>Orient/train staff on targeting, recruitment, testing, services for HIV</td>
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<tr>
<td>positives and services for HIV-negative client procedures</td>
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<tr>
<td>Train/certify staff as required by statute, regulation, or policy</td>
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</tbody>
</table>
Instructions for Completing Tool 1. Part II: HIV Testing and Linkage Capacity Assessment

What is the purpose of this tool? Tool 1, Part II can be used to assess your capacity to implement an HIV testing and linkage program.

Who should complete this tool? Program managers can complete this tool, in collaboration with HIV testing and linkage staff, consumer advisory board members, and others involved in planning, implementation, and evaluation of your program.

When should this tool be completed? This tool should be completed before you implement services. It can also be used to assist and document ongoing program assessment and to plan for program enhancements if you have already implemented services.

How should this tool be completed? The left column presents the domains of readiness associated with implementing HIV testing and linkage programs. For each of the major program areas included in Part II (e.g., recruitment, testing), there is some overlap in the kinds of activities that must be completed (e.g., development of implementation procedures). These activities are grouped together in Part II and are often developed at the same time.

For each domain of readiness listed, record the following information in the designated column:

- **Complete**: Check the corresponding box if the activities associated with this domain have been completed (or have been updated, if completed by an established program). Leave this box blank if the activities associated with the domain have not been completed or updated.
- **Timeline for Completion**: If the activities have not been completed or updated, enter the date by which the activities associated with the domain must be completed.
- **Strategies to Address Gaps in Capacity**: Summarize the strategies that you will use to address identified gaps. If you are planning a new HIV testing and linkage program, it is recommended that you do not begin providing services to clients until you have full capacity to implement HIV testing and linkage services (i.e., all of the boxes on Part II are checked as complete, and all identified gaps in capacity have been addressed).
## Tool 1. Part II: HIV Testing and Linkage Capacity Assessment

<table>
<thead>
<tr>
<th>Agency/Program:</th>
<th>Participants:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population:</strong></td>
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<tr>
<td><strong>Date Completed:</strong></td>
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</tbody>
</table>

### Domains of Readiness

<table>
<thead>
<tr>
<th>Domains of Readiness</th>
<th>Complete</th>
<th>Timeline for Completion</th>
<th>Strategies to Address Gaps in Capacity</th>
</tr>
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<tbody>
<tr>
<td>Community readiness assessment</td>
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<tr>
<td>Agency readiness assessment</td>
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<td>Formative evaluation</td>
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<td>Agency policies</td>
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<tr>
<td>Staffing plans</td>
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<tr>
<td>Recruitment/hiring of staff</td>
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</table>

### Implementation strategies selected:

1. Population targeting
2. Client recruitment
3. Testing (field—initial test)
4. Testing (laboratory for any supplemental testing)
5. Linkage to care for HIV-positive clients
6. Basic needs assessment for HIV-positive clients
7. Partner services for HIV-positive clients
8. Triaging HIV-negative clients into highest risk and low/medium risk
9. Condoms and basic prevention information for low-risk clients
10. Prevention needs assessment for highest-risk clients
11. Risk reduction interventions for highest-risk clients
### Tool 1. Part II: HIV Testing and Linkage Capacity Assessment (continued)

<table>
<thead>
<tr>
<th>MOA established with partners for the following:</th>
<th>Complete</th>
<th>Timeline for Completion</th>
<th>Strategies to Address Gaps in Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>l. Population targeting</td>
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<tr>
<td>m. Client recruitment</td>
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<tr>
<td>n. Testing (field—initial test)</td>
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<td>o. Testing (laboratory for any supplemental testing)</td>
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<tr>
<td>p. Linkage to care for HIV-positive clients</td>
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<td>q. Basic needs assessment for HIV-positive clients</td>
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<td>r. Partner services for HIV-positive clients</td>
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<td>s. Triaging HIV-negative clients into highest risk and low/medium risk</td>
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<tr>
<td>t. Condoms and basic prevention information for low-risk clients</td>
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<td>u. Prevention needs assessment for highest-risk clients</td>
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<tr>
<td>v. Risk-reduction interventions for highest-risk clients</td>
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<tr>
<td>Written policies and procedures developed for the following:</td>
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<tr>
<td>w. Population targeting</td>
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<td>x. Client recruitment</td>
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<tr>
<td>y. Testing (field—initial test)</td>
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<tr>
<td>z. Testing (laboratory for any supplemental testing)</td>
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<tr>
<td>aa. Linkage to care for HIV-positive clients</td>
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<tr>
<td>bb. Basic needs assessment for HIV-positive clients</td>
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<tr>
<td>cc. Partner services for HIV-positive clients</td>
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<tr>
<td>dd. Triage process to classify clients with negative clients into those with and without elevated risk of HIV acquisition</td>
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</table>
### Tool 1. Part II: HIV Testing and Linkage Capacity Assessment (continued)

<table>
<thead>
<tr>
<th>Domains of Readiness</th>
<th>Complete</th>
<th>Timeline for Completion</th>
<th>Strategies to Address Gaps in Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>ee. Condoms and basic prevention information for low-risk clients</td>
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<tr>
<td>ff. Prevention needs assessment for highest risk clients</td>
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<tr>
<td>gg. Risk reduction interventions for highest risk clients</td>
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<tr>
<td>Written quality assurance plan developed</td>
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<tr>
<td>Monitoring and evaluation plans developed</td>
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<tr>
<td><strong>Staff trained/certified to implement:</strong></td>
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<tr>
<td>hh. Population targeting</td>
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<tr>
<td>ii. Client recruitment</td>
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<td>jj. Testing (field—initial test)</td>
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<td>kk. Testing (laboratory for any supplemental testing)</td>
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<td>ll. Linkage to care for HIV-positive clients</td>
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<td>mm. Basic needs assessment for HIV-positive clients</td>
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<td>nn. Partner services for HIV-positive clients</td>
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<tr>
<td>oo. Triaging HIV-negative clients into highest risk and low/medium risk</td>
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<tr>
<td>pp. Condoms and basic prevention information for low-risk clients</td>
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<tr>
<td>qq. Prevention needs assessment for highest-risk clients</td>
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<tr>
<td>rr. Risk reduction interventions for highest-risk clients</td>
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<td>ss. Quality assurance plans and activities</td>
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<tr>
<td>tt. M&amp;E plans and activities</td>
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<td>uu. Other training/certifications required by State or local statute, regulation, or policy</td>
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<tr>
<td>Risk-reduction materials secured</td>
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<tr>
<td>Client educational materials secured</td>
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Tool 2. Formative Evaluation and Implementation Planning

**About Tool 2:** Complete Tool 2 for each of your target population(s). Tool 2 is divided into two parts. Part I: Organizing Your Formative Evaluation Data is intended to provide a guide for the kinds of questions that your formative evaluation efforts should try to answer. It is not intended as a guide on the types of methods you should use or the specific questions that you should include in focus group scripts, interview guides, or survey questionnaires. Before you begin to use this tool, you will need to gather all of the data that you intend to use to plan your program. Part I is also a tool for you to use in compiling and summarizing your data.

Part II: Interpreting and Applying Findings of Your Formative Evaluation is intended to help you and your staff to interpret the data you have compiled for your formative evaluation and apply it to your program plan, including selection of strategies for recruitment, testing, and linkage. It will also help you to identify gaps in your knowledge about the target population and community resources to serve this population. Part II is designed to be completed after Part I. Compile and summarize your data before you begin to process it and decide how to apply it to program planning.

This tool may be completed in conjunction with discussion with staff members who provide HIV testing and linkage services, as well as others, such as community advisory board members or members of your board of directors. Multiple perspectives will result in richer discussion, a deeper understanding of program planning issues and program operations, as well as better ideas and strategies to ensure a successful program. For more information on working with key stakeholders, please refer to Chapter 3, Step 1 in the Evaluation Guide.

**How New Programs Can Use This Tool:** This tool is designed to assist you in planning your HIV testing and linkage program by providing you with guidance on the kinds of information that you may find useful to collect through your formative evaluation. It will also help you to organize and interpret your data. Working through this tool will help you to plan a program that uses strategies, messages, and tools that are best suited to meet the needs of your target population(s) and which will successfully engage members of the target population services.

**How Established Programs Can Use This Tool:** If you have already implemented an HIV testing and linkage program, you can use this tool to help you plan for modifications or enhancements to existing services. Conduct formative evaluation if program M&E efforts (see Chapter 2, Tool 1 for additional information about program M&E) suggest that the strategies, messages, or tools you are currently using may not be as successful or well-suited to the target population as they were previously. In addition, before implementing specific changes, such as introducing a new HIV testing technology or adopting a new linkage strategy, you need to understand the extent to which the proposed modification or enhancement is responsive to the needs of your target population(s). Established programs may wish to complete only
those sections of the tool relevant to the part of the program for which adjustment or enhancement is being considered, such as where services should be provided.

**How Health Departments and Other Funders Can Use This Tool:** HDs and other funders may find this tool helpful for use with local grantees or contractors. You could use this tool in providing technical assistance to agencies that are just beginning a new program, or agencies that seem to be struggling with program implementation. Some HDs or other funders may wish to have grantees or contractors complete this tool at the beginning of a project (e.g., as a component of a funding proposal) or when they are proposing expanding services to a new target population or adopting new strategies or technologies. HDs or other funders may also wish to adapt this tool for use with other interventions or services.
Instructions for Completing Tool 2. Part I: Organizing Your Formative Evaluation Data

**What is the purpose of this tool?** Tool 2, Part I is a tool for you to use in framing your formative evaluation and in compiling and summarizing data.

**Who should complete this tool?** HIV testing and linkage program managers can complete this tool, in collaboration with staff and/or volunteers, consumer advisory board members, and others involved in planning, implementation, and evaluation of your testing and linkage program.

**When should this tool be completed?** Before you implement services. It can also be used prior to implementing adjustments or enhancements to established programs.

**How should this tool be completed?** Conduct formative evaluation for each target population you intend to or are serving. You may also want or need to complete formative evaluation for individual programs or funding sources. In the top portion of Tool 2, Part I, record the following information in the designated cells:

- **Agency/Program:** Record the name of the agency and/or program completing this tool.
- **Target Population:** Record the target population for which this tool is to be completed.
- **Date Completed:** Record the date that the tool was completed or updated, as applicable.
- **Participants:** Record the names and/or positions/roles of the individuals participating in completing this tool.

The left column presents evaluation questions related to the kinds of information that you will need to gather in order to plan your HIV testing and linkage program and to help you identify the best strategies for recruitment, testing, and linkage. It is best to use multiple sources of data, including anecdotal sources, to fully answer these questions.

For each evaluation question listed, record the following information in the designated column:

- **Answer to Evaluation Question:** Record a brief summary of available data corresponding to the evaluation question.
- **Information Source and Date of Collection/Publication:** Record the source of the data. This will help you to refer back to the source if more information is needed. Record the date of collection/publication associated with each data source. This will help you to know whether the data is current.
### Tool 2. Part I: Organizing Your Formative Evaluation Data

<table>
<thead>
<tr>
<th>Agency/Program:</th>
<th>Participants:</th>
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<td><strong>Target Population:</strong></td>
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<td><strong>Date Completed:</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Formative Evaluation Questions</th>
<th>Answer to Evaluation Question</th>
<th>Information Source and Date of Collection/Report</th>
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<tbody>
<tr>
<td>Where does the target population live?</td>
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<td>Where does the target population socialize?</td>
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<tr>
<td>Where does the target population meet sex partners?</td>
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<td>Where does the target population use/share drugs?</td>
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<tr>
<td>Where does the target population get health and dental care?</td>
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<tr>
<td>Where does the target population get health and dental information?</td>
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<tr>
<td>Who/what does the target population trust for its health information? Why?</td>
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<tr>
<td>What issues or factors are barriers to HIV testing for the target population? Why?</td>
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<tr>
<td>Formative Evaluation Questions</td>
<td>Answer to Evaluation Question</td>
<td>Information Source and Date of Collection/Report</td>
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<tr>
<td>--------------------------------</td>
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<tr>
<td>What other kinds of health or preventive services interest the target population?</td>
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<tr>
<td>For HIV-positive individuals in the target population, what issues or factors are barriers to linkage to care?</td>
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<tr>
<td>For HIV-positive individuals in the target population, what issues or factors are barriers to linkage to PS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For the target population, what issues or factors are barriers to linkage to risk-reduction services?</td>
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</table>
Instructions for Completing Tool 2. Part II: Interpreting and Applying Findings of Your Formative Evaluation

**What is the purpose of this tool?** Tool 2, Part II is designed as a guide and tool to help you to apply the findings of your formative evaluation in order to select the most appropriate strategies, messages, and tools for your HIV testing and linkage program.

**Who should complete this tool?** Program managers can complete this tool, in collaboration with testing and linkage staff and/or volunteers, consumer advisory board members, and others involved in planning, implementation, and evaluation of your program.

**When should this tool be completed?** This tool may be completed before you implement HIV testing and linkage services and/or prior to implementing adjustments or enhancements to established programs.

**How should this tool be completed?** In the top portion of Tool 2, Part II, record the following information in the designated cells:

- **Agency/Program:** Record the name of the agency and/or program completing this tool.
- **Target Population:** Record the target population for which this tool is to be completed.
- **Date Completed:** Record the date that the tool was completed or updated, as applicable.
- **Participants:** Record the names and/or positions/roles of the individuals participating in completing this tool.

Discussion questions are presented in the left column and are segmented by program component: recruitment, testing, and linkage. For each of the discussion questions, record the following information in the designated column:

- **Summary of Formative Evaluation Questions:** Record a summary of the findings of your formative evaluation (as recorded in the Answer column in Part 1. This will help you to draw conclusions about which strategies are appropriate for the target population.
- **Strategies, Gaps, and Next Steps:** Brainstorm about the strategies and practices that could best address your findings and record them in this column. Include gaps in knowledge or resources for which you will need additional information, along with next steps to address these gaps.
## Tool 2. Part II: Interpreting and Applying Findings of Your Formative Evaluation

<table>
<thead>
<tr>
<th>Agency/Program:</th>
<th>Participants:</th>
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<tr>
<td><strong>Target Population:</strong></td>
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<td><strong>Date Completed:</strong></td>
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### Discussion Questions for Program Implementation

**Targeting**
- What data sources might be useful to identify areas of high prevalence?
- Which risk groups should be targeted for testing?
- Within jurisdictions, where do high risk groups congregate?
- How can you determine membership in a target population with a few questions?
- What additional information is needed?

**Recruitment**
- Where should we recruit and offer testing and linkage?
- How should we recruit for HIV testing?
- What recruitment messages will be persuasive?
- Who should do the recruiting?
- What additional information is needed?
- How many previously diagnosed positives are recruited for retesting?
- How many previously diagnosed positives that may be encountered during testing efforts have fallen out of care?

### Summary of Formative Evaluation Findings

<table>
<thead>
<tr>
<th>Strategies, Gaps, and Next Steps</th>
<th></th>
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</table>
## Tool 2. Part II: Interpreting and Applying Findings of Your Formative Evaluation (continued)

<table>
<thead>
<tr>
<th>Discussion Questions for Program Implementation</th>
<th>Summary of Formative Evaluation Findings</th>
<th>Strategies, Gaps, and Next Steps</th>
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<tbody>
<tr>
<td><strong>Testing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Which HIV testing strategy should we use?</td>
<td></td>
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<tr>
<td>• Where should HIV testing be provided?</td>
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<tr>
<td>• What kinds of things might motivate or interest our target population in HIV testing?</td>
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<tr>
<td>• Who will provide supplemental testing, if the program only offers rapid testing?</td>
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<tr>
<td>• Will the testing program provide blood-based or oral tests?</td>
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<tr>
<td>• Does the testing program able to train staff to ask about recent HIV exposure?</td>
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<tr>
<td>• Does the staff have capacity to evaluate recent infection?</td>
<td></td>
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<tr>
<td>• What additional information is needed?</td>
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</tbody>
</table>
### Tool 2. Part II: Interpreting and Applying Findings of Your Formative Evaluation (continued)

<table>
<thead>
<tr>
<th>Discussion Questions for Program Implementation</th>
<th>Summary of Formative Evaluation Findings</th>
<th>Strategies, Gaps, and Next Steps</th>
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</thead>
<tbody>
<tr>
<td><strong>Services for HIV-positive Clients</strong></td>
<td></td>
<td></td>
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<tr>
<td>• What strategies and resources are required to link HIV-positive individuals in our target population to care?</td>
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<tr>
<td>• What potential barriers are faced by HIV-positive individuals for linkage to care?</td>
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<tr>
<td>• What kinds of practices or things might help HIV-positive individuals in our target population link partner services (PS)?</td>
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<tr>
<td>• Can basic needs assessment be provided onsite following testing?</td>
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<tr>
<td>• What kinds of practices or things might help HIV-positive clients link to risk-reduction services?</td>
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<tr>
<td>• What additional information is needed?</td>
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Tool 2. Part II: Interpreting and Applying Findings of Your Formative Evaluation (continued)

<table>
<thead>
<tr>
<th>Services for HIV-Negative Clients</th>
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</thead>
<tbody>
<tr>
<td>• What strategies can be used to triage the highest-risk persons to prevention services?</td>
</tr>
<tr>
<td>• What kinds of practices or things might help HIV-positive clients link to risk-reduction services?</td>
</tr>
<tr>
<td>• What kinds of practices or tools are available to conduct a prevention needs assessment for the highest risk clients?</td>
</tr>
<tr>
<td>• Are there prevention messages or tools available for low-risk clients?</td>
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<tr>
<td>• What additional information is needed?</td>
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<table>
<thead>
<tr>
<th>Discussion Questions for Program Implementation</th>
<th>Summary of Formative Evaluation Findings</th>
<th>Strategies, Gaps, and Next Steps</th>
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Planning and Implementing HIV Testing and Linkage Programs in Non-Clinical Settings
Appendix C • Page 21 of 36
Tool 3. Outreach HIV Testing Planning Tool

About Tool 3: The Discussion Questions for Program Planning and Implementation correspond to key factors and issues that you need to address in planning to undertake HIV testing in an outreach setting or venue. It is recommended that you do not begin providing outreach HIV testing services until you have completed planning.

This tool should be completed in conjunction with discussion with staff members who provide HIV testing and linkage, as well as others, such as consumer advisory board members or members of your board of directors. Multiple perspectives will result in richer discussion, a deeper understanding of program planning issues and program operations, as well as better ideas and strategies to ensure a successful program.

How New Programs Can Use This Tool: This tool is designed to assist you in planning outreach HIV testing and linkage activities. This tool will help you to assess community support and identify key partnerships, assess the feasibility of providing services, and plan for how those services will be delivered. It will help you to identify any gaps in your knowledge or resources that will need to be addressed to ensure the success of your outreach testing program.

How Established Programs Can Use This Tool: If you have already implemented HIV testing, or even if you have already implemented outreach-based testing, you can use this tool to help you to plan implementation in new settings or venues or for new target populations.

How Health Departments and Other Funders Can Use This Tool: HDs and other funders may find this tool helpful for use with local grantees or contractors. You could use tool in providing technical assistance to agencies that are just beginning to implement HIV testing in outreach settings or for agencies that seem to be struggling with implementing these services. Some HDs or other funders may wish to have grantees or contractors complete this tool at the beginning of a project (e.g. as a component of a funding proposal) or when they add new sites or venues.
Instructions for Completing Tool 3. Outreach HIV Testing Planning Tool

**What is the purpose of this tool?** Tool 3 guides and documents your planning efforts as they relate to testing in outreach settings.

**Who should complete this tool?** Managers or coordinators of HIV testing programs can complete this tool, in collaboration with staff and/or volunteers, consumer advisory board members, and others involved in planning, implementation, and evaluation of your program.

**When should this tool be completed?** Before you implement services in outreach settings or before you begin testing in new venues or with new target populations.

**How should this tool be completed?** In the top portion of Tool 3, record the following information in the designated cells:

- **Agency/Program:** Record the name of the agency and/or program completing this tool.
- **Target Population:** Record the target population for which this tool is to be completed.
- **Date Completed:** Record the date that the tool was completed or updated, as applicable.
- **Participants:** Record the names and/or positions/roles of the individuals participating in completing this tool.

Discussion questions relevant to planning and implementation of HIV testing and linkage in outreach settings are presented in the left column:

- **Answers to Discussion Questions:** Record a summary of your discussion about each of the corresponding questions in the left column.
- **Strategies, Gaps, and Next Steps:** Brainstorm about the strategies and practices that could best address your findings and record them in this column. Include gaps in knowledge or resources for which you will need additional information, along with next steps to address these gaps.
## Tool 3. Outreach Testing Planning Tool

<table>
<thead>
<tr>
<th>Agency/Program:</th>
<th>Participants:</th>
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<tbody>
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<td><strong>Target Population:</strong></td>
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<td><strong>Date Completed:</strong></td>
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<table>
<thead>
<tr>
<th>Discussion Questions for Program Planning and Implementation</th>
<th>Answers to Discussion Questions</th>
<th>Strategies, Gaps, and Next Steps</th>
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</thead>
<tbody>
<tr>
<td><strong>Partnerships and Community Support</strong></td>
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<tr>
<td>Who are the gatekeepers to the setting or venue?</td>
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<tr>
<td>From whom or what do we need to obtain permission to provide HIV testing at the setting or venue?</td>
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<tr>
<td>How are we perceived by potential partners? By the surrounding community?</td>
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<tr>
<td>What are the concerns or fears about HIV testing among potential partners? In the surrounding community?</td>
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<tr>
<td><strong>Site/Event Assessment</strong></td>
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<tr>
<td>Will the venue or setting attract individuals other than your target population?</td>
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<tr>
<td>What kind of traffic (e.g., how many people) can you expect in the venue or setting and in what timeframe?</td>
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<td>Is alcohol or drug use a consideration?</td>
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<td>Will other service providers be working at the setting or venue? At the same time?</td>
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### Tool 3. Outreach Testing Planning Tool (continued)

<table>
<thead>
<tr>
<th>Discussion Questions for Program Planning and Implementation</th>
<th>Answers to Discussion Questions</th>
<th>Strategies, Gaps, and Next Steps</th>
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<tbody>
<tr>
<td><strong>Client</strong></td>
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<tr>
<td>Will the venue or setting provide adequate confidentiality?</td>
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<tr>
<td>Will the venue or setting provide adequate and appropriate space for testing?</td>
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<tr>
<td>Are there any restrictions or conditions that impact the kind of samples you can collect or the kind of tests you can run?</td>
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<tr>
<td>Will we need any special supplies and equipment?</td>
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<tr>
<td>What adjustments will we need to make to our written procedures and quality assurance practices?</td>
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<tr>
<td><strong>Conducting Testing</strong></td>
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<tr>
<td>How will we manage client flow?</td>
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<tr>
<td>How will clients get test results?</td>
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<tr>
<td>How will clients be linked to HIV medical care?</td>
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Tool 4. Yield Analysis for Program Improvement

**About Tool 4:** Tool 4 is divided into two parts. Yield Analysis Part I: Compilation of Data is a tool for you to use in compiling and organizing the data you will need to conduct a yield analysis. Yield Analysis Part II: Data Interpretation and Program Improvement can be used to assist you in interpreting data, and may be used as a guide in to help to identify and describe the factors that are impacting your program (both negative and positive), and to identify strategies that could be used to improve your program. Part II requires that you have clear program objectives in place. Please refer to the Evaluation Field Manual, Step 2: Describe the Program for additional information about and guidelines for constructing program objectives. Tool 4 addresses the key measures of success of an HIV testing and linkage program operating in non-clinical venues: targeting; recruitment; identification of new HIV positives; ensuring client knowledge of HIV status; and linkage to medical, prevention, and other services. Tool 4 can be easily adjusted to include additional measures of success relevant to your program, such as frequency of retesting.

Tool 4 was designed to be applied to a single target population. However, Tool 4 could easily be adjusted to be used at various levels of program operations:

- **Agency:** The yield analysis would reflect all HIV testing and linkage services delivered by the agency.
- **Program:** The yield analysis would reflect a specific HIV testing and linkage program operated by the agency. Multiple yield analyses could be conducted to compare how well various programs are doing.
- **Grant/Funding Source:** The yield analysis would reflect a specific source of funding. Multiple yield analyses could be conducted to compare services across funding sources.
- **Site/Venue:** The yield analysis would reflect HIV testing and linkage services delivered at a single site or venue. Multiple yield analyses could be conducted to compare how well each site is doing.
- **Individual:** The yield analysis would reflect HIV testing and linkage services delivered by a single staff member or volunteer. Multiple yield analysis could be conducted to compare delivery of services across staff and could assist in QA by identifying potential areas where individual staff could benefit from additional education, training, or coaching.

To complete Part I, you will need your program service data for the time period that you wish to review (e.g., the number of tests conducted, client demographics). Part II is designed to be completed after Part I.

This tool, particularly Part II, should be completed in conjunction with staff/volunteers who provide HIV testing and linkage services, as well as others, such as community advisory board members or members of your board of directors. Multiple perspectives will result in richer discussion, a deeper understanding of the issues that are affecting your program, as well as better ideas and strategies to improve your program.
How New Programs Can Use This Tool: Monitoring should be an ongoing program activity and evaluation is best done early and often. More often than not, new programs experience “bumps in the road” during early implementation, as new strategies are being used and new procedures are being learned. Staff and volunteers are getting comfortable with their roles, and workflow may need to be adjusted as you gain more practical experience. New programs can benefit from using this tool shortly after implementation (e.g., within the first 3 months), because conducting a yield analysis very soon after you begin providing HIV testing and linkage services can help you to identify areas of your program where refinements or adjustments would be beneficial. During the first year of implementing a new program, consider conducting a yield analysis frequently (e.g., monthly). This will help ensure that your program gets off to a good start and that needed adjustments are made early, and before practices which do not work well become too well established.

How Established Programs Can Use This Tool: If you have an established program, using this tool will help you to monitor the performance of your program on an ongoing basis, detect possible problems in a timely manner, and identify strategies that will improve your program. Yield analysis can be conducted on a regular basis, and it is recommended that this occur no less than quarterly for established programs. Consider conducting a yield analysis more frequently in some circumstances, such as when your program appears to be struggling or when you have made some changes to the program, such as adding a new venue, adopting a new testing strategy, or introducing a new linkage procedure.

How Health Departments and Other Funders Can Use This Tool: HDs and other funders may find it helpful to use this tool in monitoring grantees or contractors. Staff with responsibility for monitoring contracts or providing technical assistance to local providers can use a yield analysis to help monitor program performance and identify potential technical assistance needs. HDs or other funders may also wish to require grantees or contractors complete a yield analysis on a regular basis as part of required reporting or in conjunction with corrective action for programs that are struggling. HDs and other funders can adapt this tool to reflect local expectations regarding performance or program requirements.
Instructions for Completing Tool 4. Yield Analysis Part I: Compilation of Data

What is the purpose of this tool? Tool 4, Part I is to be used to compile and organize your program service data.

Who should complete this tool? Non-clinical program managers can complete this tool or others with responsibility for program M&E.

When should this tool be completed? New programs may first complete this within the first 3 months of program implementation and then regularly (e.g., monthly) thereafter. Established programs may complete this regularly (e.g., quarterly), unless the program is experiencing difficulties or there has been some change in the program (e.g., adoption of new HIV testing strategy).

How should this tool be completed? To complete Tool 4, Part I, you will need program service data for the time period that you wish to review (e.g., the number of tests conducted, client demographics, test results, referrals made, and linkage completed).

In the top portion of Tool 4, Part I, record the following information in the designated cells:

- **Agency/Program/Site:** Record the name of your agency, the program, or the site/venue for which this tool is to be completed.
- **Location:** Record the location of the agency, program, or site/venue for which this tool is to be completed.
- **Reporting Period:** Record the time period for which the yield analysis is to be conducted.
- **Funding Source:** Record the source of funding for which the yield analysis is to be conducted, if applicable.
- **Funding Amount:** Record the amount of funding associated with the agency, program, or site for which the yield analysis is to be conducted, if applicable.
- **Target Population:** Record the target population for which this tool is to be completed.
- **Other Information:** Record any other information that may be of interest to you in conducting the yield analysis, such as the number of staff providing services for this program or site, or the number of hours dedicated to HIV testing and linkage services during the review period.

In the bottom portion of Tool 4, Part 1, record the specified data in each of the numbered cells and calculate the percentages according to the instructions provided in the column labeled Instructions. Once you have finished compiling your data, you will need to review and interpret it, and try to draw some conclusions from it about how to adjust your program practices (Part II).
# Tool 4. Yield Analysis Part I: Site Information

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Agency/Program/Site:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Reporting Period:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Target Population:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Location:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Funding Source:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Funding Amount:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Other Information:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Yield Analysis Part I: Compilation of Data

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Number of clients tested for HIV</td>
<td></td>
<td>Record the total number of clients tested for HIV during the reporting period.</td>
</tr>
<tr>
<td>9. Number of clients from the target population tested for HIV</td>
<td></td>
<td>Record the total number of clients tested for HIV from the target population during the reporting period (see #3, above).</td>
</tr>
</tbody>
</table>

### 10. Recruitment

<table>
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<tr>
<th>Item</th>
<th>#</th>
<th>%</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 10a. Clients representing the target population | | | • In the column marked #, record the number of clients tested for HIV who were from the target population (from #8, above).  
• In the column marked %, record the percentage of clients tested for HIV who were from the target population. To calculate the percentage, divide the number of clients from the target population by the total number of clients tested (#10a/#8). |

### 11. Testing history

<table>
<thead>
<tr>
<th>Item</th>
<th>#</th>
<th>%</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 11a. No previous test | | | • In the column marked #, record the number of clients who report having never been tested for HIV.  
• In the column marked %, record the percentage of clients who reporting having never been tested for HIV. To calculate the percentage, divide the number of clients who reported no previous HIV test by the total number of clients tested (#11a/#8). |
### Tool 4. Yield Analysis Part I: Site Information (continued)

<table>
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<tr>
<th>Item</th>
<th>#</th>
<th>%</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 11b. Tested previously negative/unknown results | | | • In the column marked #, record the number of clients who report having a previous test with a negative or unknown result.  
• In the column marked %, record the percentage of clients who reported having been tested previously and who had a negative or unknown result. To calculate the percentage, divide the number of clients who reported being previously tested with a negative or unknown result by the total number of clients tested (#11b/#8). |
| 11c. Previously tested, HIV positive | | | • In the column marked #, record the number of clients who report having a previous test with a positive result (i.e., previously diagnosed).  
• In the column marked %, record the percentage of clients who reporting having been tested previously and who had a positive result. To calculate the percentage, divide the number of clients who reported being previously tested with a positive result by the total number of clients tested (#11c/#8). |

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Number of clients with HIV-positive test result</td>
<td></td>
<td>Record the total number of clients with an HIV-positive test (newly positive and previously diagnosed) result during the reporting period.</td>
</tr>
<tr>
<td>13. Number of clients with HIV-negative test result</td>
<td></td>
<td>Record the total number of clients with an HIV-negative test result during the reporting period.</td>
</tr>
</tbody>
</table>

### 14. Seropositivity

<table>
<thead>
<tr>
<th>Item</th>
<th>#</th>
<th>%</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 14a. All clients with HIV-positive test result | | | • In the column marked #, record the number of clients with an HIV-positive test result (from #12).  
• In the column marked %, record the percentage of clients found to be HIV positive. To calculate the percentage, divide the number of clients with an HIV-positive test result by the total number of clients tested for HIV (#14a/#8). |
| 14b. Clients with new HIV-positive test result | | | • In the column marked #, record the number of clients with a new HIV-positive test result.  
• In the column marked %, record the percentage of clients with new HIV-positive test result. To calculate the percentage, divide the number of clients with an HIV-positive test result by the total number of clients tested for HIV (#14b/#8). |
### Tool 4. Yield Analysis Part I: Site Information (continued)

<table>
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<th>Item</th>
<th>#</th>
<th>%</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>14c. Clients with previous HIV-positive test result</td>
<td></td>
<td></td>
<td>• In the column marked #, record the number of clients with an HIV-positive test result who had previously had an HIV-positive test result.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• In the column marked %, record the percentage of clients with an HIV-positive test result who had previously had an HIV-positive test result.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>To calculate the percentage, divide the number of clients with an HIV-positive test result by the total number of clients tested for HIV (#14c/#8).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Number of clients who received their final HIV test result</td>
<td></td>
<td>Record the total number of clients who received their final HIV test result during the reporting period.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>#</th>
<th>%</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>16a. All clients who received their final test results</td>
<td></td>
<td></td>
<td>• In the column marked #, record the number of clients who received their final HIV test result (from #13)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• In the column marked %, record the percentage of clients who received their final HIV test result. To calculate the percentage, divide the number of clients who received their final test result by the number of clients tested for HIV (#16a/#8).</td>
</tr>
</tbody>
</table>

| 16b. HIV-negative clients who received their final test results     |       |         | • In the column marked “#,” record the number of HIV-negative clients who received their final test results.                                  |
|                                                                      |       |         | • In the column marked %, record the percentage of HIV-negative clients who received their final test results. To calculate the percentage, divide the number of HIV-negative clients who received their test results by the number of clients who tested HIV-negative (#16b/#13). |

| 16c. New HIV-positive clients who received their final test results |       |         | • In the column marked #, record the number of clients with a new HIV-positive test result who received their final test results.            |
|                                                                      |       |         | • In the column marked %, record the percentage of clients with a new HIV-positive test result who received their final test result. To calculate the percentage, divide the number of new HIV-positive clients who received their final test results by the number of clients newly tested HIV-positive (#16c/#14b). |
## Tool 4. Yield Analysis Part I: Site Information (continued)

### Yield Analysis Part I: Compilation of Data

<table>
<thead>
<tr>
<th>Item</th>
<th>#</th>
<th>%</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 16d. Previously HIV-positive clients who received their final test results | | | • In the column marked #, record the number of clients previously diagnosed HIV-positive who received their final test results.  
• In the column marked %, record the percentage of clients previously diagnosed HIV-positive result who received their final test result. To calculate the percentage, divide the number of clients with a positive HIV test who received their final test results by the number of clients previously tested HIV-positive (#16d/#14c). |
| 17. HIV-positive linkage to care and partner services | | | |
| 17a. New HIV-positive with confirmed linkage to HIV medical care | | | • In the column marked #, record the number of clients with a new HIV-positive test result who were successfully linked to HIV medical care.  
• In the column marked %, record the percentage of clients with a new HIV-positive test result who were successfully linked to care. To calculate the percentage, divide the number of new HIV-positive clients successfully linked to care by the number of clients with a new HIV-positive test result (#17a/#14b). |
| 17b. New HIV-positive with confirmed linkage to HIV medical care within 90 days of test | | | • In the column marked #, record the number of new HIV-positive clients who were successfully linked to HIV medical care within 90 days of receiving an HIV test.  
• In the column marked %, record the percentage of new HIV-positive clients who were successfully linked to HIV medical care. To calculate the percentage, divide the number of new HIV-positive clients with confirmed linkage to HIV medical care by the number of HIV-positive clients (#17b/#14b). |
| 17c. New HIV-positive with confirmed linkage to HIV PS within 30 days of test | | | • In the column marked #, record the number of HIV-positive clients who were successfully linked to HIV PS.  
• In the column marked %, record the percentage of HIV-positive clients who were successfully linked to HIV PS. To calculate the percentage, divide the number of HIV-positive with confirmed linkage to PS by the number of HIV-positive clients (#17c/#14b). |
## Tool 4. Yield Analysis Part I: Site Information (continued)

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Previously diagnosed HIV-positive out of HIV care at time of HIV test</td>
<td>Record the number of previously diagnosed HIV-positive clients who were not in HIV medical care at the time of the HIV test.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>#</th>
<th>%</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>18a. Previously diagnosed HIV-positive reengaged in HIV medical care</td>
<td>• In the column marked #, record the number of previously diagnosed clients reengaged in HIV medical care.  &lt;br&gt;• In the column marked %, record the percentage of previously diagnosed clients reengaged in HIV medical care. To calculate the percentage, divide the number of previously diagnosed clients reengaged in HIV medical care by the total number of previously diagnosed clients who were out of HIV care at the time of HIV testing (#18a/#18).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Number of HIV-negative clients at high risk for HIV acquisition</td>
<td>Record the number of HIV-negative clients at high risk for HIV acquisition.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>#</th>
<th>%</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>20a. HIV-negative clients at high risk for HIV acquisition with confirmed linkage to risk-reduction services</td>
<td>• In the column marked #, record the number of high-risk HIV-negative clients who were successfully linked to needed risk-reduction services.  &lt;br&gt;• In the column marked %, record the percentage of HIV-negative clients who were successfully linked to needed risk-reduction services. To calculate the percentage, divide the number of HIV-negative clients successfully linked to risk-reduction services by the number of HIV-negative clients in need of risk-reduction services (#20a/#19).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Instructions for Completing Tool 4. Yield Analysis, Part II: Data Interpretation and Program Improvement

What is the purpose of this tool? Tool 4, Part II will help you understand how successful your recruitment, testing, and linkage strategies are; the factors that might be associated with the effectiveness of these strategies; and strategies that might help you to make program improvements. Tool 4, Part II will also help you to monitor progress toward achieving your program objectives. Please refer to the Evaluation Guide, Step 2: Describe the Program for detailed discussion about construction of program objectives.

Who should complete this tool? Program managers, staff, or others with responsibility for program M&E can complete this tool. Also consider inviting members of your community advisory board or other stakeholders to participate in these discussions. Refer to the discussion questions presented in Exhibit 9.5 for additional information to help you complete this tool.

When should this tool be completed? New non-clinical HIV testing programs may first complete this within the first 3 months of program implementation, and then regularly (e.g., monthly) thereafter. Established programs may complete this regularly (e.g., quarterly), unless the program is experiencing difficulties or there has been some change in the program (e.g., adoption of new HIV testing strategy). Part II may be completed only after you have completed Part I.

How should this tool be completed? In the top portion of Tool 4, Part II, record the following information in the designated cells:

- **Agency/Program/Site:** Record the name of your agency, the program, or the site/venue for which this tool is to be completed.
- **Location:** Record the location of the agency, program, or site/venue for which this tool is to be completed.
- **Reporting Period:** Record the time period for which the yield analysis is to be conducted.
- **Funding Source:** Record the source of funding for which the yield analysis is to be conducted, if applicable.
- **Funding Amount:** Record the amount of funding associated with the agency, program, or site for which the yield analysis is to be conducted, if applicable.
- **Target Population:** Record the target population for which this tool is to be completed.
- **Other Information:** Record any other information that may be of interest to you in conducting the yield analysis, such as the number of staff members providing HIV testing and linkage services for this program or site, or the number of hours dedicated to HIV testing and linkage services during the review period.
In the bottom portion of Tool 4, Part II, key measures of success for your program are presented in the far left column. These may correspond to the goals and objectives that you have established for your program (see the Evaluation Guide, Chapter 3, Step 2: Describing Your HIV Testing and Linkage Program for additional information on writing program goals and objectives). Record the following information in the designated cells:

- **Objective**: Record the objective that you have set for your program corresponding to the measure of success.
- **Summary of Yield Analysis**: Record a brief summary of the data presented in Tool 4, Part I, relevant to the corresponding measure of success.
- **Contributing Factors**: Brainstorm with your group to identify the factors that may be affecting the success of your program. Summarize these factors in the corresponding cells on the table.
- **Strategies**: Brainstorm with your group to identify the strategies that could help you build on your success or could help you to improve your program. Summarize these in the Strategies column.
## Tool 4. Yield Analysis, Part II: Site Information

<table>
<thead>
<tr>
<th>1. Agency/Program/Site:</th>
<th>4. Location:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Reporting Period:</td>
<td>5. Funding Source:</td>
</tr>
<tr>
<td>3. Target Population:</td>
<td>6. Funding Amount:</td>
</tr>
<tr>
<td></td>
<td>7. Other Information:</td>
</tr>
</tbody>
</table>

### Yield Analysis, Part II: Interpretation of Data and Strategies for Program Improvement

<table>
<thead>
<tr>
<th>Measures of Success</th>
<th>Objective</th>
<th>Summary of Yield</th>
<th>Contributing Factors</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>How successful were we in engaging members of the target population?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How successful were we in identifying new infection?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How successful were we in helping clients learn their test results?</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>How successful were we in linking newly diagnosed HIV-positive clients to HIV medical care?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>How successful were we in linking newly diagnosed HIV-positive clients to HIV PS?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How successful were we in reengaging previously diagnosed HIV-positive clients with HIV medical care?</td>
<td></td>
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</tr>
<tr>
<td>How successful were we in linking high-risk HIV-negative clients to risk-reduction services?</td>
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</tbody>
</table>
Appendix D. Templates

Template 1. Procedures for Use of Incentives and Client Incentive Distribution Log

You can use the example below as a template for your own procedures and distribution log. Adjust the language to align with your organizations policies and procedures regarding the distribution of incentives.

ACME PREVENTION SERVICES

PROCEDURES FOR USE OF INCENTIVES

- Purchase of incentives must be preapproved, in writing, by ACME’s finance manager.
- The finance manager will issue a check made out to the vendor in the appropriate amount. The ACME credit card is not to be used to purchase incentives. Staff who purchase incentives with personal funds will not be reimbursed.
- Original receipts must be submitted to the finance manager.
- Incentives will be stored in a locked filing cabinet in the finance manager’s office.
- The program coordinator will sign out incentives prior to each outreach event.
- The total number and amount (dollar value) of incentives will be recorded on the inventory log. The inventory log will be initialed by the program coordinator.
- Unused incentives will be returned to the finance manager at the conclusion of each outreach event, and the unused number and amount will be recorded on the inventory log. The inventory log will be initialed by the program coordinator.

The following procedures will be observed in distributing incentives to clients:

- The program coordinator will complete the upper portion of the distribution log, with the date and location of the event, along with the number of attendees.
- Clients must initial the distribution log to indicate receipt of incentives. If gift cards are used, the program coordinator must also record the code on the gift card.
- At the conclusion of the event, the program coordinator must record the total number of incentives distributed and initial the distribution log.
- The completed distribution log is to be returned, along with unused incentives, to the finance manager.

### ACME PREVENTION SERVICES
#### INCENTIVE DISTRIBUTION LOG

<table>
<thead>
<tr>
<th>Event Location:</th>
<th>Event Date:</th>
<th>Attendees:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Initial</td>
<td>Inventory #</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

**Incentives Distributed:**

**Incentives Remaining:**

**Total Incentives:**

**Program Coordinator:**
Template 2. Sample Results Letter

You can use the example below as a template for your own letter. It is recommended that you copy this onto your agency letterhead. Adjust the language to comply with State laws and regulations regarding release of protected health information and your agency’s policies regarding release of HIV test results.

Agency Name
Agency Address

________________________________________________________
Neatly print or type client’s name

was tested for HIV on ____________________. The results of that test are NEGATIVE as of this date. A negative test result means that the test did not detect HIV antibodies.

While this test is highly reliable, this result does not guarantee that you are not infected with HIV. Most people who are infected will produce detectable antibodies within about 1 month of infection. However, if you have been recently exposed to HIV, it may be too early to tell if you are infected. This result also does not mean that you will continue to be HIV-negative in the future. You should continue to take steps to avoid becoming infected.

________________________________________________________
Signature and typed name of authorized agency representative  Date
Template 3. Sample Authorization for Release of Information

You can use this sample as a template for your own client authorization for release of information. Adjust the language to comply with State laws and regulations regarding release of protected health information and/or your institutional policies.

Agency Name
Agency Address

Authorization for Release of Information

Client Name: ______________________________________________________________

Neatly print or type client’s name

Client Date of Birth:

I hereby authorize [insert the name of your agency] to release medical and confidential information, including HIV/AIDS status, alcohol or drug use information, and mental health status, to the individual or agency listed below:

The purpose of this disclosure: _________________________

I understand that my records are protected under Federal and State law and cannot be disclosed without my written consent, unless otherwise provided by law.

This authorization is valid for 1 year from today’s date. I understand that I have the right to revoke this consent at any time, but my consent must be revoked in writing.

I hereby release [insert the name of your agency], its employees, staff, and agents, from all legal responsibility or liability that may arise from the disclosure of the information set forth above, related to my files.

________________________________________________________________________
Client and/or authorized signature Date

________________________________________________________________________
Witness Date
Template 4. Sample Memorandum of Agreement

You can use the sample below as a template for your own memoranda of agreement. Adjust the language to reflect the specific terms of your agreement with partner agencies. Please refer to the section titled Community Partnerships and Referral Resources in Chapter 7 for additional detail about constructing memoranda of agreement.

Memorandum of Agreement
Between
ACME Prevention Services
and
Center City Community Health Clinic

Effective January 1, 2012, through December 31, 2012, ACME Prevention Services (APS) and the Center City Community Health Clinic (C3HC) agree to collaborate and coordinate in the provision of services to prevent HIV transmission in the tricounty area and to ensure that individuals identified with HIV infection receive expedited linkage to HIV medical care.

Under terms of this agreement, C3HC agrees to the following:

- Provide expedited access to HIV medical care for clients referred by APS. Clients referred by APS will meet with a C3HC patient navigator and will receive testing to evaluate HIV status (i.e., CD4 and viral load) and STD screening on the same or next business day.
- Provide supplemental testing for clients referred by APS suspected of having acute HIV infection. Clients suspected of having acute HIV infection will be provided with supplemental testing on the same or next business day.
- Provide APS with verification that referred clients have received medical services.
- Provide APS with information regarding clients lost to care to facilitate follow-up on these clients.
- Meet with APS on a quarterly basis to review the collaboration.
- Provide APS with aggregated data on all clients referred by APS regarding retention in care, health status (e.g., viral load), and ARV adherence.

Under terms of this agreement, ACME agrees to the following:

- Refer clients with reactive rapid test result to C3HC for evaluation and treatment of HIV disease.
- Follow up with clients not in care, including those who have dropped out.
- Meet with C3HC on a quarterly basis to review the collaboration.
Under the terms of this agreement, BOTH agencies agree to the following:

- Abide by the terms of the reciprocal data sharing agreement.
- Retain copies of client authorizations for release of information.
- Provide client-level data necessary to monitor the success of program efforts.

This agreement does not require financial obligations from either party at this time. Responsibility for coordination of this agreement shall be the parties signed below or their designees. This agreement will terminate December 31, 2012, and may be renewed for an additional 12 months upon mutual agreement. Either party may make earlier termination of this agreement with a 30-day written notice.

Jamal Jones  
Executive Director  
ACME Prevention Services

__________________________  
Date

Abigale Smith  
Medical Director  
Center City Community Health Clinic

__________________________  
Date
Template 5. Sample Client Referral Form

You can use the sample below as a template for your own referral form. It is recommended that you copy this sample onto your own letterhead. Adjust the language to comply with your agency’s policies and procedures on referral.

Agency Name
Agency Address

Client Referral Form

Today’s Date: _____________________

Client Name: ______________________________________________________

Neatly print or type client’s name

Referred to:

Agency Name: ______________________________________________________

Address: ___________________________________________________________

Contact Name: __________________ Telephone: _________________________

Services Requested/Reason for Referral: __________________________________

Referred By: __________________ Telephone: _________________

Neatly print or type your name

Services Received:

Services Provided: _____________________________________________________

___________________________________________________________

Staff Providing Services: __________________ Date Provided: ___________

Comments: ________________________________________________________

Our client has requested services provided by your agency. Once referral services are rendered, please complete this section of the form and return it to us at [INSERT ADDRESS and CONTACT NAME].

You can use the sample below as a template for your own policies and procedures. Adjust the language to comply with the policies of your agency and the procedures that you will be using to implement HIV testing and linkage.

[Insert Your Agency or Site Name Here]

HIV Testing and Linkage Policies and Procedures

[Insert agency name] provides HIV Testing and Linkage services to [insert target population and or service area, as applicable] HIV Testing and Linkage services provided by [insert agency name] at [insert venue or location (e.g., health fairs or bars, as applicable)] are conducted in accordance with these policies and procedures.

I. POLICIES (add, delete, or modify to reflect the policies of your agency)

HIV testing and linkage services provided by [insert agency name here] are:

A. Confidential: Confidential testing refers to HIV antibody testing services in which personal identifiers are known to persons providing the services, and positive results are reported to the [insert health department name] in accordance with State reporting requirements.

[Insert information regarding your agency- or site-specific policy and procedure related to anonymous testing (e.g., “Agency provides anonymous testing, at clients request,” or “Agency refers to health department all clients requesting anonymous testing).]

B. Voluntary: Client acceptance of HIV testing and linkage services offered by [Agency] are voluntary and clients have the right to decline services.

[Insert information regarding your agency- or site-specific policy and procedure related to the voluntary nature of participation in HIV testing and linkage services (e.g., “Agency reserves the right to refuse testing to clients who are unable to provide consent or who are being coerced to accept services).]

C. Cultural Competence: HIV testing and linkage services provided by [Agency] are culturally competent with respect to the race, ethnicity, gender, sexual orientation, age, language, development level, literacy, and other relevant factors.

[Insert information regarding your agency- or site-specific procedures related to provision of culturally competent services (e.g., translation services, referral of clients, provision of services to clients with low levels of literacy)]
D. Minors: Minors or clients under the age of [insert age at which individuals may consent for HIV testing and/or medical procedures, as defined by statute or other applicable policy] may consent to HIV testing and linkage services.

[Insert information regarding your agency- or site-specific policy for provision of services to minors (e.g., “Agency will not provide HIV testing services to minors contacted through outreach activities conducted by Agency in bars”) as applicable.]

E. Ethical Behavior: [Agency] staff and volunteers will conduct themselves ethically in the provision of HIV testing and linkage services. Consumption of alcohol or drugs during provision of HIV testing and linkage services is prohibited. Sexual or other inappropriate contact with clients is prohibited.

Written Test Results: [Agency] provides written copies of HIV test results only for confidentially tested clients and only to clients for whom testing was conducted.

II. TRAINING

HIV testing and linkage services is to be provided only by individuals who have successfully completed the following training and education requirements: [Insert the training and educational requirements applicable to all staff and volunteers providing HIV testing and linkage service].

HIV tests will be performed only by individuals who have successfully completed the following training and education requirements: [Insert the training and educational requirements applicable to staff and volunteers performing HIV tests, as applicable]

Individuals performing recruitment, linkage, or other aspects of HIV testing and linkage services will complete training and education requirements commensurate with their responsibilities and as required by [insert requirements (e.g., Social Network Training if SNS is used as a recruitment strategy; phlebotomy)].

III. SITE PREPARATION

[For fixed sites, insert description of set-up and preparation for testing, including the following:

- Supplies, materials, and paperwork required
- Where supplies, materials, and paperwork are stored
- Who is responsible to prepare and/or package supplies, materials, and paperwork
- Location where samples are to be obtained and prepared
- Who is responsible for obtaining and preparing samples
- Where testing is performed, as applicable
- Who is responsible for performing testing

Include step-by-step instruction when appropriate (e.g., “Client educational packets are prepared each Monday, by unit administrative assistant”).]
[For outreach sites, include step-by-step instructions for site set-up and preparation, including the following:

- Supplies, materials, and paperwork required, including the following:
  - Educational and risk-reduction supplies and materials
  - Equipment and supplies to perform acquire samples
  - Equipment and supplies to perform testing (e.g., sharps, thermometers, lamps)
  - Promotional materials (e.g., banners, agency brochures, business cards)
  - Equipment and supplies needed to ensure confidential space to perform testing (e.g., white noise machine, curtains, signs)
  - Other equipment and supplies (e.g., display table, chairs)
- Who (title) is responsible for transporting rapid HIV tests (reagents/controls) to and from the outreach site and how will they ensure temperature control, as applicable
- Who (title) is responsible for preparing and packaging supplies, materials, and paperwork and when preparation is to be completed
- Method for securely transporting supplies, materials, and paperwork to and from outreach site
- Set-up and ensuring client privacy:
  - Where clients will receive services (e.g., the VIP room at the back of the club; curtained-off area at northwest corner of convention center)
  - How will privacy be ensured (e.g., a “private” sign will be hung on the door; white noise machine will be used; window shades pulled down)
- Procedures for packing up and returning to your agency, including the following:
  - Who (title) is responsible for packing up materials, equipment and supplies
  - Use of inventory checklist, if applicable
  - Who (title) is responsible for and how will you securely transport confidential paperwork back to the agency (e.g., all client files placed in a locked box that site supervisor returns to agency at close of outreach event)
  - Who (title) is responsible for transporting rapid HIV tests (reagents/controls) to and from the outreach site and how will he or she will ensure temperature control, as applicable
  - Who (title) is responsible for clean-up and what clean-up entails
  - Who (title) is responsible for transporting sharps and biohazardous waste and procedures for transport

IV. CLIENT ENGAGEMENT

[For fixed sites, describe here how you will obtain clients for HIV testing and linkage service. Include the following in your description, as applicable:

- Procedures for client appointments, including who is responsible, times/days of the week when appointments are taken
- Prioritization of internal and/or external referrals to HIV testing and linkage
- Handling of drop-in clients (e.g., are there certain days of the week or hours of the day when services are provided on a drop-in basis?)
- Intake procedures, including who will conduct intake and how intake will be conducted (e.g., pen and paper form or interview with receptionist; which forms are
to be used; what information will be provided to clients at intake, whether consent will be addressed with clients at intake)]

[For outreach sites, describe how client recruitment and engagement will be conducted. Include step-by-step instructions, as applicable:

- Promotion of services (e.g., canvassing the neighborhood; approaching individuals or small groups)
- Engaging clients, including when clients should not be approached (e.g., approaching sex workers when they are trying to work)
- Management of client flow (e.g., who will escort clients to the area where testing is conducted, who will manage access to the area where tests are conducted]
- Intake procedures, including who will conduct intake and how intake will be conducted (e.g., pen and paper form; client self-administered survey on tablet personal computer which forms are to be used; what information will be provided to clients at intake, whether consent will be addressed with clients at intake)]

V. TESTING

A. Information and Consent

Provide Information

Prior to HIV testing, provide clients with information about HIV testing. Each of the following are to be addressed:

- Overview of HIV testing
  - What is being tested (e.g., antibodies)
  - Procedure for testing
  - Procedure and timeline for obtaining results
  - Next steps and procedure associated with HIV-positive results
  - Next steps and procedure associated with HIV-negative results
- Benefits and drawbacks of testing
- HIV basics (e.g., transmission, prevention)
- Meaning of test results, especially the window period (relative to last exposure and test strategy used)
- Applicable laws (e.g., disease reporting laws)

[Insert description, including step-by-step instructions on how information about HIV testing will be provided to clients. In your description, address the method (e.g., brochure, by testing staff that will be used to provide information, who has responsibility for collection of this information, and how it will be documented in the client chart.)

- Provide clients with the opportunity to ask questions.

Explain Confidential Versus Anonymous Testing (as applicable)

- A confidential test requires that a client’s name appear on all laboratory slips and be documented in the client chart. The result is not released without the client’s
written authorization, except for [insert applicable statutes or regulations]. Test results are reported, in accordance with statute for [insert State].

- In an anonymous test, the only identification used on laboratory slips, client charts, and reports to the State is [insert code you will use].

**Explain Test Strategy (and options for testing, as applicable)**

- Rapid HIV test: The test that we use require [insert sample type and describe method for collection]. The result of the test will be available in [insert time to result available to client]. If that test is reactive, another test will need to be performed to definitively determine whether or not you have HIV. [Insert description of supplemental testing and/or referrals, as applicable].
- Laboratory HIV test: This test requires that we obtain [insert sample type and describe method for collection]. The result of the test will be available [insert time to result available to client]. Describe process for client obtaining obtain results.

**Assess Client Sobriety and Ability to Consent**

[Describe the process that you will use to assess client sobriety and ability to consent to HIV testing, for clients who appear to be under the influence of drugs or alcohol. Provide a detailed list of the criteria that testing staff should use to determine whether a client is able to provide consent. Describe what testing staff should do if a client does not appear to be able to consent to HIV testing.]

**Obtain Consent**

All clients tested for HIV must voluntarily consent to HIV testing prior to having a test performed. [Insert description of process for obtaining and documenting consent (e.g., a client must read and sign consent form, or a client reads information sheet, verbally consents, and consent is documented in chart).]

[Describe other circumstances (e.g., a client becomes aggressive or violent) under which testing should not be provided or should be discontinued for a client. Describe what testing staff should do in the event that such a situation arises.]

**Universal Precautions** [(adjust this to reflect your test strategy and site-specific procedures)]

Universal Precautions will be followed at all times during specimen collection and performing HIV tests.

- All samples and materials containing sample (e.g., rapid tests cassettes) must be handled as if they are capable of transmitting an infectious organism. This includes control vials and all rapid test kits.
- Staff collecting samples or performing tests must use protective equipment, including gloves and lab coats.
- Staff collecting samples or performing tests must follow procedures for biohazard safety such as hand washing, use of gloves, sharps and biohazardous waste disposal, and spill containment and disinfections.
Hand washing is a vital component of biohazard control and good laboratory practices. All staff collecting samples or performing tests will do the following:

- Wash hands before and after every client contact; before and after meals, breaks, and using the toilet; and before going home.
- Remove jewelry before washing hands and forearms or using hand sanitizer. Water should be a warm gentle stream and hands and wrists should be made wet.
- Lather hands and wrists using plenty of soap. Hands must be kept lower than elbows so that the water runs from the least contaminated area (forearms) to the most contaminated area (fingers).
- Wash hands, wrists, and between fingers for 15 seconds using friction and rinsing thoroughly.
- Dry hands and wrist with paper towels.
- Turn off the faucet with a paper towel, avoiding direct contact with the contaminated faucet.

**Sample Collection and Preparation**

**Rapid HIV Tests:** [Insert step-by-step procedure for sample collection. Include in the description what type of sample will be collected (e.g., oral or fingerstick whole blood); where the sample will be collected; and by whom (title) (e.g., by the testing program staff in the room with the client; by a technician in the laboratory area).] Note: Step-by-step instructions for sample collection are provided by the manufacturers of each rapid HIV test. These are included in the package inserts for rapid HIV tests. These can be copied into this procedure.

**Supplemental Specimen Collection (if applicable):** [Describe how specimens will be collected following a reactive rapid test. Include in your description the test strategy that will be used (e.g., laboratory or second rapid), as well as the type of sample (e.g., venous blood or oral fluid); who (title) will obtain the specimen, and where the specimen is to be obtained (e.g., is the client brought back to the lab or does a phlebotomist come to the area where the client is seated?). You can refer back to other parts of the procedures (e.g., sample collection for laboratory HIV tests, as applicable).]

**Laboratory HIV Tests:** [Insert step-by-step procedure for oral or venous sample collection and preparation. Include in your description who collects the specimen (title) and how you arrange for phlebotomy, if applicable. Include in your description where the specimen collection is to occur.] Note: Step by-step instructions for oral fluid collection are included with test collection kits and are available from the manufacturer. Step-by-step instructions for preparing, packaging, and submitting oral fluid specimens are specific to individual laboratories. Obtain these from the laboratory that will be processing your samples and insert them into this procedure.

Sample step-by-step instructions for collection and preparation of venous samples are available in the Resources section of the toolkit. The laboratory processing your samples may have specific requirements for preparation. Obtain these from the laboratory and insert them here.
Testing Procedure (Rapid HIV Tests)

[Insert step-by-step procedure for performing rapid HIV test. Include in your description who (title) will perform tests and where test will be performed (e.g., outreach staff will perform the test in the VIP room of the club or testing program staff will perform tests in the lab area of agency). Indicate whether test is run in presence of client and procedures, as applicable, to block client view of test. Indicate who (title) will read the test for results and who (title) will document test results.] Note: Step-by-step instructions for performing rapid tests are provided by the manufacturers of each rapid HIV test. These are included in the package inserts for rapid HIV tests. These can be copied into this procedure.

Results Delivery (address as applicable to the HIV testing strategy you use)

[Describe who (title) will be responsible for results delivery and where results delivery will occur.]

Rapid HIV Tests (Reactive Result)

- Deliver the result to the client.
- Explain the meaning of the result to the client: the test has detected HIV, but supplemental testing will be required to confirm HIV diagnosis.
- Explain supplemental testing [Insert description of method used for supplemental testing (e.g., second rapid, laboratory based with blood sample). Insert step-by-step instruction for supplemental testing (e.g., referral to medical provider, sample obtained onsite) including how the client will receive the test result. Address where the client will go and what he or she will do (e.g., receive risk-reduction counseling) while waiting for a second rapid HIV test result]
- Provide risk-reduction information and messages
- Document results in client chart

Rapid HIV Test (Negative Result)

- Deliver the result to the client.
- Explain the meaning of the result to the client: the test has not detected HIV. Interpret result relative to recent exposure and window period for test used.
- Provide recommendation for retesting, including testing for acute HIV infection, as applicable.
- Provide risk-reduction information and messages.
- Document results in client chart.

Laboratory HIV Tests: [Insert agency name] provides clients with results of laboratory tests only after the final written results are returned to [insert agency name] by the laboratory. [Describe procedure for obtaining results from laboratory, e.g., the supervisor retrieves results from secured fax every morning and records them in the client charts]
Clients may receive results [describe methods that clients may use to obtain results, e.g., phone]. Clients must provide [insert description of identification required] to receive test results. In delivering the results to the client, do the following:

- Deliver the result to the client.
- Explain the meaning of the result to the client.
  - Positive result means that the test has detected HIV.
  - Negative result means that the test has not detected HIV. Interpret result relative to recent exposure and window period for test used.
- Provide recommendation for retesting (if negative).
- Provide risk-reduction information and messages.
- Document results in client chart.

VI. REFERRAL AND LINKAGE

[Insert agency name] provides a variety of prevention and support services for individuals at risk for or living with HIV. If [insert agency name] is unable to provide services that match the clients needs, clients will receive referrals to other agencies.

[Describe who (title) will be responsible for conducting assessment of referral needs, and for planning and managing referrals.]

HIV-Negative Clients: HIV-negative clients at high risk for HIV infection will be provided with risk-reduction services that match their needs. The [insert title of individual(s) providing referral services] will do the following:

- Review risk information provided by client at intake.
- Assess risk-reduction needs and identify barriers to accepting risk-reduction services [insert description of the method that you will use to assess risk-reduction needs (e.g., survey completed by client) and when assessment will be conducted (e.g., while client is waiting for test results).]
- [Insert description of risk-reduction services provided by your agency, as applicable; provide step-by-step instructions of how clients will be offered risk-reduction services (e.g., testing program staff will provide high-risk clients the opportunity to receive Personal Cognitive Counseling). Testing program staff will provide PCC at the time of results disclosure.]
- Make referrals, as applicable [insert description of your process for making referrals, including who is responsible for making the referral and the type of assistance provided to clients in accessing the referral].
- Document risk-reduction services and/or referrals in client chart.

Clients with a Positive HIV Test Result: Clients with a positive HIV test result will be linked to HIV medical care.

- [Insert description of the method that you will use to link clients to medical care and who (title) will be responsible for providing assistance in linkage.]
• Assess barriers to care [insert description of method you will use to assess barriers (e.g., referral specialist will administer service assessment to client)].
• Make referral [insert description of your process for making referral, including who is responsible for making the referral and the type of assistance that will be provided to client].
• Document referral and assistance provided (as applicable) in client chart.

VII. SAFETY (address as applicable to your setting)

The safety of [insert agency name] staff members and volunteers is the highest importance. To ensure safety, the following should be observed:

Fixed Sites:

• Two staff are to be onsite at all times when HIV testing services are offered.
• A supervisor is onsite at all times when HIV testing is provided.
• If testing is provided after hours, a supervisor is to be on call. The schedule for on-call supervisors is posted [insert location] every [insert when schedule posted].
• If testing is provided after hours, all doors are to be locked at all times.
• If testing is provided after hours, staff will contact the on-call supervisor at the conclusion of testing.
• The supervisor is to be notified of difficult situations (e.g., aggressive clients) immediately.
• Staff are not to provide their personal contact information (e.g., cell phone number) to clients.
• Staff are not to provide to clients with rides in their cars.
• [Insert additional safety precautions and procedures]

Outreach Sites (as applicable):

• A minimum of [insert number] of staff are to be onsite at all times when HIV testing services are provided.
• One staff member will be designated as the lead staff.
• Outreach testing is to be provided only at scheduled times and as approved by the program supervisor.
• A supervisor is available at all times via phone during outreach testing events.
• Staff will contact the on-call supervisor at the conclusion of testing.
• Staff are not to provide their personal contact information (e.g., cell phone number) to clients.
• Staff are not to provide to clients with rides in their cars.

Outreach Events:

• Staff must display ID badges at all times.
• Staff should remain in view of each other at all times.
• Staff may not enter a private residence during outreach events.
• Staff may not carry weapons.
• Staff may not buy, receive, or use drugs or alcohol.
• Staff may not buy or receive sexual favors from clients.
• Staff may not participate in illegal activities.
• Staff may not eat or smoke.

[Insert additional safety precautions and procedures]

VIII. Record Keeping

• All client records are kept confidential.
• HIV testing records are [insert whether testing records are kept separate from other client records, if applicable].
• Records of anonymous tests are kept separate from other client records (if applicable).
• Client charts are kept in [insert where client charts are kept, describe who (title) is authorized to access them, and when].
• Client charts are returned to [insert who (title) or where client charts will be kept] when not immediately needed (e.g., for results delivery, or documenting completed referrals). Client charts are never to be left out on desks or stored anywhere other than [insert where charts are to be kept].
• For outreach testing: Client charts and other confidential information are to be transported securely [insert method you will use to transport confidential information] to and from outreach sites. Client information is to be returned to the [insert where client charts are kept], immediately [insert other timeframe, as applicable] after the end of outreach events. Confidential information is not to be taken to or stored in staff homes or cars.
### Template 7. Outreach Testing Supplies and Materials Checklist

This is a sample Outreach Supplies and Materials Checklist. Adjust this checklist to reflect the supplies and materials that you will need for your outreach HIV testing event. Complete this checklist before and after your outreach event to make sure that you do not leave anything behind. Also revise this checklist periodically to reflect any changes needed (e.g., different testing supplies, new brochures).

<table>
<thead>
<tr>
<th>Event/Location:</th>
<th>Site Supervisor:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Site Supervisor:</td>
<td></td>
</tr>
</tbody>
</table>

#### Promotional Materials and General Supplies

- □ Agency brochures
- □ Agency business cards
- □ Pens or markers
- □ Stapler (with staples)
- □ Tape
- □ Scissors
- □ Agency banner
- □ Folding table
- □ Folding chairs
- □ Umbrella/tent
- □ Tablecloth
- □ Drapes/drop cloth

#### Education and Risk-Reduction Supplies

- □ Testing information brochures
- □ Educational/risk-reduction pamphlets
- □ Incentives  Number: 
- □ Condoms (male)  Number: 
- □ Condoms (female)  Number: 
- □ Lubricant

#### Records

- □ Consent forms
- □ Referral forms
- □ Release of information forms
- □ Laboratory requisition forms
- □ Lock box
- □ Client test log
- □ External control log
- □ Temperature log
- □ Incentive distribution log
- □ Testing and referral data collection forms

#### Testing Supplies

- □ Vacuutainers
- □ Tourniquet
- □ Sample collection tubes
- □ Blue absorbent disposable pads
- □ Personal protection gown/lab coat
- □ Latex gloves
- □ Hand sanitizer
- □ Antiseptic wipes
- □ Sterile gauze pads/cotton balls
- □ Sterile lancets
- □ Adhesive bandages
- □ Digital timer or stopwatch
- □ Digital thermometer
- □ Lamp or flashlight
- □ Level
- □ White noise machine
- □ Cooler or insulated bag for storing tests, controls, and/or samples
- □ Red biohazard bags
- □ Sharps containers

#### Uni-Gold

- □ Rapid test kits  Number of kits: 
- □ External controls
- □ Subject information booklets
- □ Wash solution
- □ Collection/transfer pipettes

#### Clearview Complete

- □ Rapid test kits  Number of kits: 
- □ External controls
- □ Subject information booklets
- □ Running buffer
- □ Test stands

#### OraQuick ADVANCE

- □ Rapid test kits  Number of kits: 
- □ External controls
- □ Subject information booklets
- □ Test stands
- □ Specimen collection loops