CT Department of Public Health (DPH)

TB, HIV, STD, & Viral Hepatitis Program

HIV Prevention Program

Beta v1.4

HIV Case Reporting Guidance

October 2015

Introduction

The reporting of newly and previously diagnosed positive cases to the CT DPH is essential in the planning and implementation of HIV prevention and care interventions. This guidance provides CT DPH funded programs with the process on how to accurately report HIV cases in a timely manner. It also includes copies of the required forms necessary for reporting to DPH, and information regarding where and to whom the forms must be sent. We hope that this document will assist you with the necessary information needed to report all newly or previously diagnosed HIV positive cases to the CT DPH HIV Prevention Program.

Respectfully yours,

Marianne Buchelli, MPH, MBA

CT DPH Health Program Supervisor

CT Department of Public Health (DPH)

TB, HIV, STD, & Viral Hepatitis Program

HIV Prevention Program

Procedure for Reporting **Newly or Previously Confirmed HIV Positive Cases to DPH:**

a. Complete **EvaluationWeb 2015 HIV Test Template Forms Parts 1, 2 and 3** for all confirmed HIV positive results (See Appendix A).

b. Submit all completed confirmed **HIV positive EvaluationWeb 2015 HIV Test Template Forms Parts 1, 2 and 3** to the CT DPH HIV Prevention Program.

   i. Outreach, Testing and Linkage (OTL) programs should mail all confirmed HIV positive Test Forms to DPH, attention to Susan Major. A confirmatory email will be sent to programs submitting HIV Test Forms to ensure the receipt of the forms.

   ii. Expanded Testing Initiative (ETI) programs (i.e., directly and non-directly funded) should mail all confirmed positive HIV Test Forms to DPH, attention to Dulce Dones-Mendez. A confirmatory email will be sent to programs submitting HIV Test Forms to ensure the receipt of the forms.

   iii. All programs should contact Partner Services to report HIV Positive case.

c. Report to the CT DPH HIV Surveillance Program all confirmed HIV positive results via:

   1) Phone:

   CT DPH HIV Surveillance Program

   860-509-7900

   OR

   2) Mail:

   Using the **'Adult HIV/AIDS Confidential Case Report Form'**

Instructions on how to complete the Adult HIV/AIDS Confidential Case Report Form

(See Appendix B) and mail it to:
Connecticut Department of Public
Health 410 Capitol Ave MS# 11ASV
P.O Box 340308
Hartford, CT 06134

d. **For HIV Testing sites <u>not using</u> the CT DPH State Laboratory**:

If an Outreach Testing, and Linkage (OTL) or Expanded Testing Initiative (ETI) (directly or non-directly funded) site **<u>is not using</u>** the CT DPH State Laboratory for HIV Testing confirmatory results, providers must submit proof of confirmatory result along with the Adult HIV/AIDS Confidential Case Report Form to the CT DPH HIV Surveillance Program.

e. **For HIV Testing sites <u>using</u> the CT DPH State Laboratory:**

If an Outreach, Testing, and Linkage (OTL) or Expanded Testing Initiative (ETI) (directly or non-directly funded) site **is using** the CT DPH State Laboratory for HIV Testing Confirmatory results, providers must submit one tube of whole blood, serum or plasma. Use of Orasure has been discontinued by the CT DPH Lab.

(See Appendix C)

Note. **Copies of the HIV Test Forms for both positive and negative test events must be kept on file at the site and secured in a locked file cabinet.**

<u>Reporting Do's a nd Don'ts</u>

Do's:

- ✓ Send Parts 1,2, and 3 of the 2015 HIV Test Forms
- ✓ Ensure that forms are completed appropriately
- ✓ Mail forms as soon as possible
- ✓ Include name and return address on envelopes
- ✓ Use the most current HIV Test Forms
- ✓ Make copies of the HIV Test Forms Parts 1, 2 and 3 for your records
- ✓ Contact DPH HIV Prevention and HIV Surveillance Programs, if you have any questions regarding submitting all required information

Don'ts:

- ☒ Mail confidential personal health information (PHI) to the HIV Prevention Program that includes any demographic information such as name, date of birth, address, gender, etc.
- ☒ Wait more than 15 days upon receipt of confirmation to submit HIV Test Forms to DPH
- ☒ Submit any HIV Test Forms without <u>Form ID Labels</u>

APPENDICES

EVALUATIONWEB® 2015 HIV TEST TEMPLATE

PART ONE

Enter or adhere form ID	
Session Date	M M D D Y Y Y Y

Program Announcement (select only one)

- ☐ PS12-1201 Category A
- ☐ PS12-1201 Category B
- ☐ PS12-1201 Category C
- ☐ PS12-1210 CAPUS
- ☐ Other: _____
- ☐ PS11-1113 Category A-YMSM
- ☐ PS11-1113 Category B-YTG
- ☐ PS10-1003
- ☐ PS08-803
- ☐ MSM Testing Initiative

Agency Name/ID Number	
Directly Funded CBO Agency ID (For CDC directly funded CBOs only)	
Site Name/ID Number	
Site Type (enter type code from page 3)	F # # . # #
Site ZIP Code	# # # # #
Site County (enter 3-digit FIPS code)	# # #
Client ID	# # # # # # # # # # # #
Date of Birth (enter 01/01/1800 if unknown)	M M D D Y Y Y Y
Client State (use USPS abbreviation)	
Client County	
Client ZIP Code	# # # # #

Client Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Don't Know
- ☐ Declined
- ☐ Not Asked

Client Race (check all that apply)

- ☐ American IN/AK Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native HI/Pac. Islander
- ☐ White
- ☐ Don't Know
- ☐ Declined
- ☐ Not Asked

Client Assigned Sex at Birth

- ☐ Male
- ☐ Female
- ☐ Declined
- ☐ Not Asked

Client Current Gender Identity

- ☐ Male
- ☐ Female
- ☐ Declined
- ☐ Not Asked
- ☐ Transgender MTF
- ☐ Transgender FTM
- ☐ Transgender Unspecified
- ☐ Additional (specify): _____

Previous HIV Test?

- ☐ No
- ☐ Yes → If Yes, what is the client's self-reported result?
  - ☐ Positive
  - ☐ Negative
  - ☐ Preliminary Positive
  - ☐ Indeterminate
  - ☐ Don't Know
  - ☐ Declined
  - ☐ Not Asked
- ☐ Don't Know
- ☐ Declined
- ☐ Not Asked

	HIV Test 1	HIV Test 2	HIV Test 3
Sample Date	M M D D Y Y Y Y	M M D D Y Y Y Y	M M D D Y Y Y Y
Worker ID			
Test Election	☐ Anonymously ☐ Confidentially ☐ Test Not Offered ☐ Declined Testing	☐ Anonymously ☐ Confidentially ☐ Test Not Offered ☐ Declined Testing	☐ Anonymously ☐ Confidentially ☐ Test Not Offered ☐ Declined Testing
Test Technology	☐ Conventional ☐ Rapid ☐ NAAT/RNA Testing ☐ Other	☐ Conventional ☐ Rapid ☐ NAAT/RNA Testing ☐ Other	☐ Conventional ☐ Rapid ☐ NAAT/RNA Testing ☐ Other
Test Result	☐ Positive/Reactive ☐ Negative ☐ Indeterminate ☐ Invalid ☐ No Result	☐ Positive/Reactive ☐ Negative ☐ Indeterminate ☐ Invalid ☐ No Result	☐ Positive/Reactive ☐ Negative ☐ Indeterminate ☐ Invalid ☐ No Result
Result Provided	☐ No ☐ Yes ☐ Yes, client obtained results from another agency	☐ No ☐ Yes ☐ Yes, client obtained results from another agency	☐ No ☐ Yes ☐ Yes, client obtained results from another agency
If Results NOT provided, why?	☐ Declined Notification ☐ Did Not Return/ Could Not Locate ☐ Other	☐ Declined Notification ☐ Did Not Return/ Could Not Locate ☐ Other	☐ Declined Notification ☐ Did Not Return/ Could Not Locate ☐ Other

Choose status of collection of behavioral risk profile

- ☐ Client completed a behavioral risk profile
- ☐ Client was not asked about behavioral risk factors
- ☐ Client was asked, but no behavioral risks identified
- ☐ Client declined to discuss behavioral risk factors

For clients completing a risk profile, did the client report the following behaviors in the past 12 months? (select all that apply)

	No	Yes	Don't Know
Vaginal or Anal Sex with a male	◯	◯	◯
With a male without using a condom	◯	◯	◯
With a male who is IDU	◯	◯	◯
With a male who is HIV +	◯	◯	◯
Vaginal or Anal Sex with a female	◯	◯	◯
With a female without using a condom	◯	◯	◯
With a female who is IDU	◯	◯	◯
With a female who is HIV +	◯	◯	◯
Vaginal or Anal Sex with a transgender person	◯	◯	◯
With a transgender without using a condom	◯	◯	◯
With a transgender who is IDU	◯	◯	◯
With a transgender who is HIV +	◯	◯	◯
Injection drug use	◯	◯	◯
Share drug injection equipment?	◯	◯	◯
Vaginal or Anal Sex with MSM (female only)	◯	◯	◯

Additional Risk Factors (enter two-digit code from page 3)	1	# #	2	# #	3	# #	4	# #
Session Activities (enter codes from page 3)	1	# #	.	# #	3	# #	.	# #
	2	# #	.	# #	4	# #	.	# #
Local Use Fields	L1	# # # # #	L3	# # # # #
	L2	# # # # #	L4	# # # # #

EVALUATIONWEB® 2015 HIV TEST TEMPLATE

PART TWO

Enter or adhere form ID

CDC requires the following information on all preliminary and confirmed HIV-positive clients:

Was the client referred to HIV medical care?

- ☐ No →
  - Reason the client not referred to HIV Medical Care?
    - ☐ Client Already in Care
    - ☐ Client Declined Care
- ☐ Yes →
  - Did the client attend the first appointment?
    - ☐ Pending
    - ☐ Confirmed: Accessed Service →
      - First medical appointment within 90 days of the HIV test?
        - ☐ No
        - ☐ Yes
        - ☐ Don't Know
    - ☐ Confirmed: Did Not Access Service
    - ☐ Lost to Follow-Up
    - ☐ No Follow-Up
    - ☐ Don't Know
- ☐ Don't Know

Was the client referred to/contacted by Partner Services?

- ☐ No
- ☐ Yes →
  - Was the client interviewed for Partner Services?
    - ☐ No
    - ☐ Yes →
      - Was the client interview within 30 days of receiving their result?
        - ☐ No
        - ☐ Yes
        - ☐ Don't Know
    - ☐ Don't Know
- ☐ Don't Know

Was the client referred to HIV Prevention Services?

- ☐ No
- ☐ Yes →
  - Did the client receive HIV Prevention Services?
    - ☐ No
    - ☐ Yes
    - ☐ Don't Know
- ☐ Don't Know

What was the client's most severe housing status in the past 12 months (check only one)?

- ☐ Literally Homeless
- ☐ Unstably Housed or At Risk of Losing Housing
- ☐ Stably Housed
- ☐ Not Asked
- ☐ Declined to Answer
- ☐ Don't Know

If female, is the client pregnant?

- ☐ No
- ☐ Yes →
  - Is the client in prenatal care?
    - ☐ No
    - ☐ Yes
    - ☐ Don't Know
- ☐ Don't Know
- ☐ Declined
- ☐ Not Asked

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

- ☐ No
- ☐ Yes
- ☐ Don't Know
- ☐ Not Checked

Local Use Fields					
L5	#	#	#	#	#
L6	#	#	#	#	#
L7	#	#	#	#	#
L8	#	#	#	#	#
L9	#	#	#	#	#
L10	#	#	#	#	#
L11	#	#	#	#	#
L12	#	#	#	#	#
L13	#	#	#	#	#
L14	#	#	#	#	#
L15	#	#	#	#	#
L16	#	#	#	#	#
L17	#	#	#	#	#

CDC Use Fields					
C3	#	#	#	#	#
C4	#	#	#	#	#
C5	#	#	#	#	#
C6	#	#	#	#	#
C7	#	#	#	#	#
C8	#	#	#	#	#
C9	#	#	#	#	#

Notes:

EVALUATIONWEB® 2015 HIV TEST TEMPLATE

PART THREE

Enter or adhere form ID	

HIV Incidence (if required by health department)

Date the client reported information	M M D D Y Y Y Y

Has the client ever had a previous positive HIV test?

☐ No
☐ Yes
☐ Don't Know
☐ Declined

Date of first positive HIV test	M M D D Y Y Y Y

Has the client ever had a negative HIV test?

☐ No
☐ Yes
☐ Don't Know
☐ Declined

Date of last negative HIV test	M M D D Y Y Y Y
Number of negative HIV tests within 24 months before the current (or first positive) HIV test	# # # ☐ Don't Know ☐ Declined

Has the client used or is client currently using antiretroviral medication (ARV)?

☐ No
☐ Yes →
☐ Don't Know
☐ Declined

Specify antiretroviral medications

1 # # 2 # # 3 # # 4 # # (see codes from right-hand column)

Date ARV began	M M D D Y Y Y Y
Date of last ARV use	M M D D Y Y Y Y

Notes:

22	Agenerase (amprenavir)
30	Aptivus (tipranavir, TPV)
32	Atripla (efavirenz/emtricitabine/tenofovir DF)
24	Combivir (lamivudine/zidovudine, 3TC/AZT)
38	Complera (emtricitabine, rilpivirine/ tenofovir DF, FTC/RPV/TDF)
06	Crixivan (indinavir, IDV)
37	Edurant (rilpivirine, RPV)
11	Emtriva (emtricitabine, FTC)
03	Epivir (lamivudine, 3TC)
28	Epzicom (abacavir/lamivudine, ABC/3TC)
25	Fortovase (saquinavir, SQV)
10	Fuzeon (enfuvirtide, T20)
19	Hepsera (adefovir)
02	Hivid (zalcitabine, ddC)
23	Hydroxyurea
18	Invirase (saquinavir,SQV)
34	Intelence (etravirine)
36	Isentress (raltegravir)
16	Kaletra (lopinavir, ritonavir)
31	Lexiva (fosamprenavir, 908)
07	Norvir (ritonavir, RTV)
33	Prezista (darunavir,DRV)
09	Rescriptor (delavirdine, DLV)
26	Retrovir (zidovudine, ZDV, AZT)
15	Reyataz (atazanavir, ATV)
08	Saquinavir (Fortavase,Invirase)
35	Selzentry (maraviroc)
39	Stribild (elvitegravir/cobicistat/tenofovir/ emtricitabine)
21	Sustiva (efavirenz, EFV)
40	Tivicay (dolutegravir)
13	Trizivir (abacavir/lamivudine/zidovudine, ABC/3TC, AZT)
27	Truvada (tenofovir DF/emtricitabine, TDF/ FTC)
01	Videx (didanosine, ddI)
14	Videx EC (didanosine, ddI)
17	Viracept (nelfinavir, NFV)
05	Viramune (nevirapine, NVP)
12	Viread (tenofovir DF, TDF)
04	Zerit (stavudine, d4T)
20	Ziagen (abacavir, ABC)
88	Other
99	Unspecified

DPH Keeping Connecticut Healthy

Adult HIV/AIDS Confidential Case Report Form

(Patients ≥13 years of age at time of diagnosis)

DPH USE ONLY

Date of HIV test	Surveillance Method	Source	STATE #	HARMS #	WEEK	YEAR	P	LN
/ /20__	☐A ☐P ☐F ☐U					20__		

1. PATIENT IDENTIFIER INFORMATION MR # SSN #

Patient Name: _____ (LAST, FIRST, MI) Phone: ( ) _____-_____

Address: _____ City: _____ County: _____ State: _____ Zip: _____

2. PROVIDER INFORMATION

Provider's Name: _____ Phone: ( ) _____-_____

Facility: _____ City: _____ State: _____ Zip: _____

3. FORM INFORMATION

Date Completed: ___/___/_____ Person reporting: _____ Phone: ( ) _____-_____

4. DEMOGRAPHIC INFORMATION

Diagnostic Status: ☐ HIV Infection ☐ AIDS	Date of Birth: ____/____/____	Current Status: ☐ Alive ☐ Dead ☐ Unk	Date of Death: ____/____/____	State/Terr Death: _____

Sex: ☐ Male ☐ Female	Ethnicity: (select one) ☐ Hisp/Latino ☐ Unk ☐ Not Hispanic or Latino	Race: (select one or more) ☐ Black or African Am ☐ White ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian or Other Pacific Islander ☐ Unk	Country of Birth: ☐ US ☐ Other_____ ☐ Unk

Residence at Diagnosis: ☐ Same as CURRENT address
City: _____ County: FFLD HTFD LITCH NH NL MDX TLND WIND State: _____ Zip: _____

5. FACILITY OF DIAGNOSIS

Facility Name:

☐ Inpatient ☐ Outpatient ☐ _____

City:

State/Country:

Identification Method:
☐ Lab Report ☐ Lab Audit ☐ ICD-9
☐ Viral Load ☐ Other _____

Report Medium:
☐ Paper, field ☐ Paper, mailed ☐ Disk
☐ Paper, faxed ☐ Phoned ☐ Elec Trans

6. RISK FACTOR HISTORY

Before the 1st positive HIV test, this patient had: (check all that apply)	Y	N	U
• Sex with male			
• Sex with female			
• Injected drugs			
• Rec'd clotting factor			
HETEROsexual relations with the following:			
• IDU			
• Bisexual male (applies to females only)			
• Person with hemophilia/ coagulation disorder			
• Transfusion recipient w/ documented HIV infection			
• Person with AIDS or documented HIV infection, risk unspecified			
Received transfusion Date 1st: Date last:			
Received transplant			
Worked in health-care or clinical lab setting			
NO IDENTIFIED RISK (NIR)			

7. HIV TESTING AND TREATMENT HISTORY

Source: ☐ Patient Interview ☐ Chart abstraction ☐ Provider Report ☐ PEMS ☐ Other

Date patient answered questions: ____/____/____

Ever had a previous *positive* HIV test?
☐YES ☐ NO ☐ REFUSED ☐UNKN

Date of first positive HIV test: ____/____

Has the patient ever had a *negative* HIV test?
☐YES ☐ NO ☐ REFUSED ☐ UNKN

Date of the *last negative* HIV test: ____/____

Number of *negative* HIV tests in the past 2 years: _____

Did the patient ever use antiretrovirals to treat/prevent HIV or HBV? ☐YES ☐ NO ☐ UNKN

If 'YES', list medications here:

First date of ARV use: ____/____/____

Date of last ARV use: ____/____/____

Has the patient received PCP prophylaxis?: ☐YES ☐ NO ☐ UNKN

Why was the patient tested for HIV?
☐ Routine test ☐ Rule out HIV ☐ Symptoms/Dx w/ OI
☐ Partner dx w/ HIV ☐ 'Just checking' ☐ Regular tester
☐ Other: _____

8. LABORATORY DATA

HIV ANTIBODY TESTS AT DIAGNOSIS: (Indicate FIRST test)	RESULT		TEST DATE		
	Pos	Neg	Mo	Day	Yr
HIV-1 EIA	1	0			
HIV1/HIV2 EIA	1	0			
HIV1 Western Blot	1	0			
Other HIV Ab Test	1	0			
SPECIMEN TYPE:		**Oral Fluid**		**Serum**	

VIRAL LOAD TEST: (Record EARLIEST & MOST RECENT)					
Test Type:		**COPIES/mL:**	Mo	Day	Yr
11 NASBA 12 RT-PCR (ST) 12 RT-PCR (UL) 13 bDNA (V2) 13 bDNA (V3)					
Date of 1st Resistance Test: ___/___/_____		**Lab:**			

IMMUNOLOGIC LAB TESTS:			
Closest to current diagnostic status:	Mo	Day	Yr
CD4 count _____ cells/ul (_____%)			
CD4 count _____ cells/ul (_____%)			
FIRST <200 or <14% of total lymphocytes:			
CD4 count _____ cells/ul (_____%)			
CD4 count _____ cells/ul (_____%)			

PHYSICIAN DIAGNOSIS:			
If HIV lab tests were not available, is HIV diagnosis documented by a physician?	Yes	No	Unk
If 'YES', provide date of physician documentation:	Mo	Day	Yr

TB/HIV co-infection is reportable!

Date of last tuberculin skin test: ___/___/_____

Results: ☐ Pos ☐ Neg ☐ Not done

9. CLINICAL STATUS

(check one)

Clinical Record Reviewed?
☐YES ☐ NO

AIDS INDICATOR DISEASES:	Initial Dx Date (mo/day/yr)	Presumptive	Definitive
Candidiasis, bronchi, trachea, or lungs	___/___/___		
Candidiasis, esophageal	___/___/___		
Cervical cancer, invasive	___/___/___		
Coccidioidomycosis, disseminated or extrapulmonary	___/___/___		
Cryptococcosis, extrapulmonary	___/___/___		
Cryptosporidiosis, chronic intestinal	___/___/___		
Cytomegalovirus disease (other than liver, spleen, or nodes)	___/___/___		
Cytomegalovirus retinitis (with loss of vision)	___/___/___		
HIV encephalopathy	___/___/___		
Herpes simplex: chronic ulcers; or bronchitis, pneumonitis, or esophagitis	___/___/___		
Histoplasmosis, diss. or extrapulmonary	___/___/___		
Isosporiasis, chronic intestinal	___/___/___		
Kaposi's sarcoma	___/___/___		
Lymphoma, Burkitt's (or equivalent)	___/___/___		
Lymphoma, immunoblastic (or equivalent)	___/___/___		
Lymphoma, primary in brain	___/___/___		
Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary	___/___/___		
M. tuberculosis, pulmonary	___/___/___		
M. tuberculosis, diss. or extrapulmonary	___/___/___		
Mycobacterium of other or unidentified species, diss. or extrapulmonary	___/___/___		
Pneumocystis carinii pneumonia	___/___/___		
Pneumonia, recurrent	___/___/___		
Progressive multifocal leukoencephalopathy	___/___/___		
Salmonella septicemia, recurrent	___/___/___		
Toxoplasmosis of brain	___/___/___		
Wasting syndrome due to HIV	___/___/___		

10. TREATMENT/SERVICES REFERRAL

Patient informed of his/her infection? ☐YES ☐NO ☐ UNKN

This patient's partners will be notified about their HIV exposure and counseled by:

☐ Physician/provider
☐ Patient
☐ Unknown

Health care providers can request assistance for notification of potentially exposed partners. Would you like this assistance from DPH?

☐ YES PLEASE ☐ NO THANKS

This patient's medical treatment is primarily reimbursed by:

☐ Medicaid
☐ Medicare
☐ Private insurance/HMO
☐ No coverage
☐ Other public funding
☐ Clinic trial/program
☐ Unknown

	Yes	No	Unk
Is patient enrolled in a clinical trial? If 'YES', name: _____			
Is patient receiving or been referred for:			
HIV related medical services:			
Substance abuse treatment services:			

11. FOR WOMEN

Is patient receiving or been referred for OB/GYN services? ☐Y ☐N ☐U

Is this patient currently pregnant? ☐Y ☐N ☐U

If 'YES', when is the due date? ___/___/_____

Has the patient delivered any infants? ☐Y ☐N ☐U

If 'YES', child's date of birth: ___/___/_____

Hospital of birth: _____

City: _____ State: _____

12.COMMENTS: _____

01/2012

APPENDIX C

STATE OF CONNECTICUT
Dr. Katherine A. Kelley Public Health Laboratory
Connecticut Department of Public Health
395 West Street
Rocky Hill, CT 06067

April 20, 2015

To: Users of Connecticut Department of Public Health (CTDPH) HIV Laboratory Testing Services.

Effective April 27, 2015, the Dr. Katherine A. Kelley Public Health Laboratory will implement a new HIV laboratory testing algorithm based on updated recommendations issued by the Centers for Disease Control and Prevention (*Laboratory Testing for the Diagnosis of HIV Infection: Updated Recommendations*). The recommended algorithm has several advantages over previous recommendations, including more accurate laboratory diagnosis of acute HIV-1 infection, equally accurate laboratory diagnosis of established HIV-1 infection, and more accurate laboratory diagnosis of HIV-2 infection, fewer indeterminate results, and faster turnaround time for most test results. Briefly, this test algorithm will include initial testing with an FDA-approved antigen /antibody combination (4th generation) enzyme immunoassay (Genetic Systems HIV-1/HIV-2 Ag/Ab Combo EIA) followed by an antibody differentiation test (the Multispot HIV-1/HIV-2 Rapid Test that can differentiate HIV-1 from HIV-2 antibodies) that is performed when the initial 4th generation EIA is repeatedly reactive. HIV-1 Nucleic Acid testing (HIV-1 NAT) will also be available as a send-out referral test when indicated (e.g. initial 4th generation EIA is repeatedly reactive/Multispot negative or indeterminate). Since the 4th generation antigen/antibody combo EIA detects HIV-1 p24 antigen, in addition to HIV-1 and HIV-2 antibody, the updated algorithm, also utilizing the HIV-1 NAT when indicated, will allow detection of HIV infection earlier during seroconversion.

Please note the following changes associated with the implementation of the updated HIV test algorithm:

- **Testing of oral fluid specimens** (Orasure® HIV-1 Oral Specimen Collection Device) **will be discontinued as of June 1, 2015**. One tube of whole blood, serum or plasma will be the only specimens accepted for testing. Please submit a separate second tube when requesting multiple additional tests (e.g. Syphilis Serology and HCV Antibody). After specimen collection, refrigerate specimens at 2-8°C prior to shipment to the laboratory. Specimens should be received by the laboratory within 7 days of collection.

- **HIV-1 Western blot** testing is no longer part of the recommended algorithm and **will be discontinued.** Supplemental testing will be performed using the Multispot HIV-1/HIV-2 Rapid Test.

- Since no further testing is required for specimens that are nonreactive on the initial 4th generation EIA, supplemental testing with the Multispot HIV-1/HIV-2 Rapid Test will only be performed when the initial 4th generation EIA is found to be repeatedly reactive (presumptive positive) by the CTDPH laboratory.

Please call 860-920-6662 with any questions or concerns as needed.

Sincerely,

Anthony Muyombwe, PhD, HCLD (ABB)
Bioscience Laboratory Division Director
Dr. Katherine A. Kelley Public Health Laboratory
Connecticut Department of Public Health
395 West Street
Rocky Hill, CT 06067
E-mail: anthony.muyombwe@ct.gov

CT Department of Public Health (DPH)

TB, HIV, STD, & Viral Hepatitis Program

HIV Prevention Program

If you have any questions regarding the reporting of HIV positives cases to the CT DPH, please contact:

OTL Forms:

Susan Major, OTL Quality Improvement (QI) Coordinator

Tel: 860-509-7821

Email: susan.major@ct.gov

Routine Testing Forms (ETI Programs):

Dulce Dones-Mendez, Expanded Testing Initiative (ETI) Coordinator

Tel: 860-509-8054

Email: dulce.dones-mendez@ct.gov