

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF HEALTH, WELLNESS & DISEASE CONTROL
HIV/AIDS PREVENTION & INTERVENTION SECTION**

**STRATEGIES TO IMPROVE CLIENT RETURN
RATES FOR RECEIVING HIV TEST RESULTS**

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STRATEGIES TO IMPROVE CLIENT RETURN RATES FOR HIV TEST RESULTS

I. INTRODUCTION

Client failure to return for HIV test results is a key issue in the provision of quality assured counseling, testing, and referral (CTR) services. Since 1992, the Division of Health, Wellness & Disease Control (DHWDC) has developed recommendations and strategies to assist local providers of CTR services with improving rates of client return. Data obtained from the DHWDC's HIV Event System (HES) revealed an overall return rate of 82 percent during calendar year 2006. Clients with positive test results returned at a rate of 80 percent. Both of these are significant improvements over the past decade, among both local health department and community based organizations. In 2001, the Centers for Disease Control & Prevention (CDC) lowered return rate standards for clients testing negative from 75% to 70%. For clients whose test results are positive, the standard was increased from 90% to 95%. Although return rates have improved in many agencies, there is still need for further improvement.

To receive the full benefit of counseling and testing as a prevention intervention and to assist them in the adoption and maintenance of HIV-risk reducing behaviors, clients need to know their HIV infection status. Moreover, to ensure that individuals who are tested for HIV learn their test results and receive appropriate prevention counseling and referral to care and supportive services, it is essential that barriers to receipt of HIV test results be removed.

This revised document is intended to serve as a tool for program managers and supervisors to use in developing plans to improve rates of return for HIV test results and counseling. This document updates a technical assistance document previously released in 1998 and again in 2002. Most of the strategies described below have been suggested by staff working at HIV CTR agencies in Michigan.

II. BACKGROUND

During 2006, DHWDC surveyed several of its contractual HIV counseling and testing programs to determine reasons for client failure-to-return (FTR) for HIV test results. DHWDC also requested that agencies submit strategies which might be useful for increasing client return rates; many of the strategies listed in this document have been derived from policies which have been implemented in Michigan's HIV counseling and testing programs.

HIV program staff should review these strategies, select those which can be tailored to individual programs, and implement these over the course of six to twelve months. Each agency knows its clientele best, so staff should select **ONLY** those procedures which are most appropriate for

improving their own rates. After implementation of strategies, staff should evaluate the results, and take appropriate steps to modify the selected strategies, if necessary.

III. TERMINOLOGY

The following abbreviations and references are used in this document:

- | | | |
|----|-------|--|
| a. | CBO | Community-based organization |
| b. | CDC | Centers for Disease Control & Prevention |
| c. | CTR | Counseling, testing and referral |
| d. | DHWDC | Division of Health, Wellness & Disease Control |
| e. | FTR | Failure to return (for HIV test results) |
| f. | HAPIS | HIV/AIDS Prevention & Intervention Section |
| g. | HES | HIV Event System |
| h. | LHD | Local health department |
| i. | MDCH | Michigan Department of Community Health |
| j. | NGO | Non-governmental organization |
| k. | PCRS | Partner Counseling & Referral Services |

Also please note the following definitions:

- | | |
|----|---|
| a. | Test-decision counseling = pre-test, or initial, prevention counseling |
| b. | Test-results counseling = post-test, or test-results, delivery counseling |

IV. INITIAL PROGRAM ASSESSMENT

The actions listed below describe methods of assessing agency protocols which might inhibit clients from returning for HIV test results. Agency data are available from the HIV Event System (HES).

Strategies to consider:

1. Compare return rates among various client populations/sites or other CTR programs within the agency's region/jurisdiction (See Appendix A: Agency Self Assessment, revised January 2007).
2. Measure/compare return rates among sites within a program, such as clients who come in for (and receive) only STD services with those who come in and receive both STD and HIV services.
3. Implement and use the findings from client surveys and other feedback mechanisms, including suggestions from other CTR programs and/or DHWDC, to identify barriers to service and to help determine reasons clients

might not be returning for test results.

4. Examine the return rate within programs among counselors and among risk populations (e.g., MSM, IDU, sex with IDU) and with demographics such as gender, race and age.
5. Seek feedback from agencies to which clients are referred in order to monitor client satisfaction with the program.
6. Conduct periodic evaluation of physical space, client flow, and time concerns (refer to CDC Quality Assurance Standards for HIV Prevention Interventions, May 2003).

V. STRATEGIES TO IMPROVE RETURN RATES

A. PURPOSE OF VISIT

Persons accessing services specifically for the purpose of HIV counseling and testing tend to return for their test results. However, when clients visit a sexually transmitted disease, or family planning clinic, they usually have a reason other than HIV testing for accessing services. Although clients in these settings are frequently offered an HIV test, they may have less interest in obtaining HIV test results than in obtaining the desired STD or family planning service.

Strategies to Consider:

1. Assess every client's motivation to return for results. Ask clients explicitly during test-decision (pre-test) counseling about their willingness to return for test results. Provide extra motivation during this session to increase their willingness to return for test results, regardless of other tests provided during their visit to the clinic.

SPECIAL NOTE: This strategy has been found to be one of the most effective and certainly one of the least expensive ways of improving rates of return for HIV test results.

It may be appropriate to NOT offer testing to clients who indicate that they might not or will not return for test results.

2. Survey clients through one-on-one exit interviews, or anonymous written feedback forms/surveys, to determine the reason for their visit, intention to return for results, and satisfaction with service.
3. Determine if HIV services should be offered separately from STD and other non-

HIV services. Although it has been recommended that STD and HIV services be integrated, each agency should examine whether separating these services into distinct clinics will improve client return rates for HIV test results.

For example, if services are set up so that all clients in need of HIV testing can only obtain them through STD or family planning clinics, and return rates are below the established state standards, then it may be advisable to set up a separate HIV clinic. If the agency already has an HIV clinic, but return rates for HIV through the STD or family planning clinic are below the return rates for the HIV clinic, then it may be advisable to refer all clients needing HIV tests to the HIV clinic.

4. Develop a client profile, based on local CTR data, which clearly describes those most likely not to return and then use this data to tailor counseling messages.
5. Consider offering clients non-cash incentives to return for results, such as movie passes, bus passes, discount coupons to local groceries and/or pharmacies, and gift certificates such as “free sandwich” coupons to local fast-food restaurants.
6. Print a "To Do" checklist of a few key items (e.g., three safer sex messages) on a card with the site phone number to give to the client in the pre-test/test-decision session. Include the date of return for posttest/test-results counseling.
7. For clients tested anonymously, include the pseudonym or test number on the same or a separate card, as a reminder.
8. As appropriate, remind clients coming in for other services of the need to return for HIV test results.
9. Combine return visits for other services with HIV test-results counseling appointments.
10. "Flag" the charts of clients not returning for test-results counseling, so that when they return for another reason, HIV post-test counseling/results can be delivered.
11. For clients who have tested confidentially and who have not returned for HIV test results, make a phone call or send a letter reminding them to return. The counselor who provided the pretest counseling should make the initial phone call or send the letter. If the client does not respond within five to ten business days, AND the test results were positive, the file should be referred to PCRS staff for follow-up.

NOTE: Staff who are certified to provide PCRS may be the most appropriate to provide such follow-up. It is imperative to discuss this strategy with the client in advance of actually making the call or sending the letter. Another useful strategy to consider would be making a field visit to the client’s residence (again, set this up with the client in advance of actually

doing so). Note that DHWDC requires that agencies provide written documentation on all follow-up efforts for clients whose test results are positive.

B. WAITING ROOM SETTING

Persons who are seeking only HIV services may be anxious or apprehensive about the entire process of counseling and testing. Eliminate any possibility of stigmatizing your clients. If any client can ascertain that another client is in the clinic for HIV counseling/ services, either or both clients may experience embarrassment or unnecessary concern because they have been “identified” as an HIV client. Additionally, clients of particular sexual, ethnic or racial groups may feel uncomfortable if they perceive that the clinic staff and/or environment is not sensitive to their needs.

Strategies to Consider:

1. Plan for clients to wait for clinic services in one large waiting room, where a mix of clients (and reasons for visits) are present (e.g., family planning, STD, and HIV). Several agencies in Michigan have tried this modification with good results.
2. Use each examining room or clinic area for more than just HIV services, so that clients have a sense that each area has multiple purposes and none are identified as "AIDS" rooms. This would hold true for STD clients and services as well.
3. Eliminate signs which explicitly indicate HIV, AIDS, or STD services. While these may be convenient for staff, such signs stigmatize clients. Consider changing signs to read “Adult Clinic” or “Personal Health.” These changes have also been tried and found to be successful with several DHWDC contractual agencies.
4. Omit group presentations, such as group videos or talks on HIV in public areas. Many clients report that they want as little contact as possible with other clients.
5. Display culturally sensitive posters and brochures. Such displays promote client acceptance of staff who may not reflect their race/ethnicity and/or sexual orientation. Post these displays in both waiting and examination/counseling rooms.

C. ACCESS

The distance traveled for services may be perceived as being a barrier. Many clients travel to a site outside their county to assure confidentiality and/or anonymity. In addition, the client may lack adequate transportation, bus fare, or have difficulty getting child care or a sitter.

Strategies to Consider:

1. Refer the client to a health department or clinic nearer to home, if appropriate, for test-decision and test-results counseling.
2. Provide CTR in other community sites, such as churches, homeless shelters, and other community-based organizations (CBOs).
3. Set up a van shuttle, or consider setting up a satellite clinic in targeted neighborhoods. Coordinate a shuttle service with other local agencies, such as hospitals, the Department of Human Services, or other CBOs.
4. Provide bus tickets or discount coupons for city transportation.
5. Provide child care at the clinic site.
6. Provide reimbursement for parking, or provide free parking nearby.

D. HOURS OF OPERATION

If daily hours of operation for counseling and testing are limited, clients may be unable to get into the clinic or return because of work or family activity schedules. If counseling sessions are scheduled at 20- or 30-minute intervals, there may be insufficient time to provide all the needed information and counseling.

Strategies to Consider:

1. Provide clinic services one night per week or once every two weeks. For example, on one day, open at 10:00 a.m., and then stay open until 8:00 p.m. that night.
2. Combine HIV clinic with other late night clinics, such as family planning or STD. For security reasons, ensure that the HIV clinic is not staffed by just one person at night.
3. Ensure that counseling staff are available for special requested appointments.
4. Schedule appointment times with clients at 30 to 45 minute intervals to assure that clients receive all the necessary information on testing and that their questions and concerns are addressed. Let clients know that they may return for repeat visits for counseling and to have questions answered.
5. Stagger HIV testing throughout the month so that different days are HIV testing days, while offering other clinic services on these days as well (such as family

planning clinics and HIV testing on the second and fourth Tuesdays). This helps protect client anonymity, and makes it difficult to identify any particular day as an "AIDS day." This, however, may make it difficult for clients to walk in, so be sure to promote changes in service in local newspapers and in other appropriate media.

6. For outreach-based CTR services, return to the same location at the same time on an established schedule.

E. PROVISION OF INCENTIVES

Several clinics in Michigan have found that providing incentives and/or more direct client involvement with their appointment have increased client return rates.

Strategies to Consider:

1. Provide coffee, bus passes, hot lunches, sandwiches, or food stamps as added incentives to return for test results.
2. Go with the client, after pre-test/test-decision counseling, to the front desk to schedule test-results counseling appointment. Participation of clients in their own health care may increase the likelihood of their return.
3. If appropriate, have the front desk clerk come directly to the counseling room and consult with the client to schedule the test-results counseling session.
4. Finally, consider having each counselor schedule appointments with the client in the counseling room.

F. FEAR & ANXIETY

Clients often have fears or anxiety about receiving their test results.

Strategies to Consider:

1. Make sure during the test-decision counseling session that the client's fears and anxieties are addressed. Ask specifically what fears or concerns might inhibit the client from returning for test results and post-test counseling. Use current scientific data to dispel myths and misinformation.
2. Address the benefits of returning for test results, such as the health benefits of early knowledge of HIV positive status to facilitate early medical intervention, and client management of their health. Knowledge of one's HIV status can also enable the

client to assist previous and current sex and/or needle-sharing partners to improve their health status as well.

3. Let the client know that the counselor is available to answer questions during the interval between the test-decision and test-results counseling sessions. Give clients both the counselor's and the AIDS Hotline telephone numbers.
4. Use open-ended questions to determine specific points of anxiety/concern and then ensure each point is resolved before the client leaves.
5. Explore with anxious clients their available support system, and identify persons, in the clinic, the community, and in the client's own network, for support and communication.

G. PERCEPTION OF SERVICE BARRIERS

Clients often have concerns about anonymous or confidential testing, as well as protection of their own confidentiality on site. Clients who test anonymously have moderately higher return rates than those who test confidentially in Michigan (86% vs 80%). Concerns about on-site confidentiality may be the result of an interaction with a counselor, front desk staff, other staff, or because of the structure of the setting (record keeping/security, counseling site/privacy). Clients sometimes experience frustration with long waits in the clinic prior to seeing a counselor, and have other concerns about the agency's services which may put them ill at ease. Finally, clients who speak foreign languages or who have hearing impairments may not know that the agency has counselors and/or services to accommodate such individuals.

Strategies to Consider:

1. Consider providing referral to agencies which provide anonymous testing if the agency has limited opportunities for anonymous testing. Note that Michigan law requires that an anonymous option be made available, either on site or through a referral.
2. Review on-site procedures for protection of client confidentiality, including privacy in counseling and testing areas. Ensure that all staff, regardless of position or responsibility, are thoroughly familiar with the agency's procedures regarding client and medical record confidentiality. Explain these procedures to clients as needed.
3. Advise clients of longer than expected waiting times when the clinic is overloaded or there are insufficient numbers of counselors available.
4. Use local media (newspapers, radio, and television), as well as advertising, to

actively promote the agency's positive image in the community. Include personal stories from clients, with their (written) permission. This should help improve the community's confidence in the HIV services offered.

5. Use local media to promote the need for clients to return for HIV test results. Too often, ads promote the need to be tested, but rarely emphasize the need to return for results.
6. If possible, ensure that counselors are associated with more than just the HIV program, so that clients visiting a particular counselor (i.e., the "AIDS" nurse) do not experience embarrassment or undue concern.
7. Ensure that all staff at the agency are aware of on-site and local HIV/AIDS services, CTR sites and hours. If possible, provide each staff with a brochure/flyer listing such information.
8. Provide the client with the same counselor for test-results counseling as he/she had during the test-decision session, which will help ensure consistency. Conversely, change counselors if the client reports discomfort with a particular counselor.
9. Ensure that the agency has access to bilingual counselors or interpreters to work with clients who do not understand or speak English. The AT&T telephone company has access to a "black box" interpreting service which, for a modest fee, can translate, with confidentiality assured, foreign languages from most countries. If staff determine that AT&T's black box is the strategy they are considering, it is highly advisable to discuss the confidentiality measures in place to protect the client(s).
10. Ensure that clients are aware that the agency is in compliance with the federal Rehabilitation Act of 1973. This Act requires that all agencies receiving federal monies, directly or indirectly, provide an interpreter or help arrange appropriate services so that persons with physical disabilities, including hearing impairments, are provided with a reasonable accommodation.

SPECIAL NOTE: Please contact Bob Barrie or Jeanine Hernandez, DHWDC/HAPIS staff at (517) 241-5900, if you have questions about #9-#10.

H. TURN-AROUND TIME

This section focuses on HIV test results which take more than two weeks to get back to the client, i.e., from the time of the specimen collection to the return of results to the clinic/site.

Strategies to Consider:

1. Verify that the courier service is efficient, given the short turn-around time for actual HIV testing at MDCH and MDCH-sanctioned laboratories.
2. Verify that clients are given accurate information about turn-around time so that their expectations are not unrealistic.
3. Maintain ongoing specimen logs to document turn-around time, to give clients a realistic date for return and to assure clients that their sample was not lost or misplaced. It is critical that this information be documented in a log or a notebook.
4. Determine if HIV test results should be faxed to the agency from MDCH laboratories. Ascertain that the agency can put the fax machine in a secured area, i.e., in a room or area which has secured access for staff and is also beyond the view of the agency's clients.

SPECIAL NOTE: Contact Jeanine Hernandez, HAPIS Counseling & Testing Coordinator, to verify that your agency's fax set-up meets state requirements for confidentiality. She may be reached at (517) 241-5900.

I. RESULTS BY TELEPHONE

Clients often assume that their test results will be telephoned to them if their results come back HIV-positive, especially if they have initially come to the clinic for family planning, treatment of an STD, or other non-HIV services. In many other clinic settings, other laboratory results are given over the phone.

Strategies to Consider:

Review this point with all counseling staff, and with clients as needed. Explain that HIV test results are not usually provided over the phone, and that positive results are never given by phone. Ensure that staff know the rationale for face-to-face counseling, including the need for re-emphasizing each client's risk reduction plans.

NOTE: Effective June 2002, DHWDC changed its policy about providing HIV negative test results by telephone. This may be considered for agencies serving a low risk and low seroprevalence population. Agencies must submit a plan to DHWDC which addresses how they will provide test results by phone. Approval to implement telephone test results counseling must be given by DHWDC before the agency may proceed with this option.

J. ADOLESCENTS

Adolescents often have lower return rates for test-results counseling.

Strategies to Consider:

1. Obtain training for counselors on dealing with the special psychosocial needs of adolescents.
2. If needed, refer adolescent and even younger clients to sites/programs experienced in providing developmentally competent services to adolescents and children.
3. Ascertain that the client hasn't been sexually abused. If abuse is suspected, contact child protective services or a social worker through the Department of Human Services.
4. Provide appropriate referrals for adolescents who are dealing with transgender/transsexual, gay, lesbian, or bisexual issues. There are much higher rates of substance abuse, mental health problems, and/or suicide attempts among these youth, and greater sensitivity and discretion are required to help ensure their return for test results.

K. RACE/ETHNICITY

African Americans and other people of color often have lower return rates for HIV test-results counseling.

Strategies to Consider:

1. Ascertain that counseling staff have been trained in the cultural sensitivities and needs of various people of color (African Nationals, African and Native Americans, Arab-Chaldeans, Hispanics, Asians, etc).
2. Maintain a diverse and multi-cultural staff, which gives the agency the ability to offer clients a counselor of their preference.
3. If resources are limited, train volunteers of color to work with people of color.
4. Maintain a "presence" (i.e., public presentations, workshops, etc.) in communities of color and other targeted populations, to promote services.
5. Collaborate with other agencies within your jurisdiction to coordinate prevention and care services, especially those that deal with diverse populations.
6. Display posters and brochures which feature persons of color.

L. INJECTING DRUG USERS (IDUs)

IDUs have lower return rates, on average, for test-results counseling. Many are indigent and thus may not have telephones, a fixed place of residence/address, and may be more concerned about immediate matters such as obtaining their next hit, fix, or high. IDUs may live on the streets and so are unable to maintain a regular schedule to return to a mobile clinic for test results. They may be suspicious of government-sponsored agencies, services, and staff, and so may have strong concerns about confidentiality/anonymity. Typically, IDUs are, or have been, involved in illegal activities, such as injecting illegal drugs and possessing drug paraphernalia.

Strategies to Consider:

1. Encourage or arrange for clients to get into drug treatment. Studies show clients in drug programs have higher return rates than those who are not in these programs.
2. Reassure the client of the agency's protocol regarding confidentiality and/or anonymity.
3. Provide training and updates to substance abuse treatment staff. Visit treatment facilities to conduct risk reduction presentations and offer information on testing.
4. Increase street outreach in IDU communities to promote harm reduction and safer sex, and provide information on counseling and testing services. Provide mobile services, as resources permit.
5. Collaborate with local agencies to arrange for drug treatment assistance, as well as referral for health care and early medical intervention, food, financial help, housing, clothing, and other social services.

M. INCARCERATED CLIENTS

Clients who have been incarcerated and tested for HIV/STDs are less likely to return for test results for several reasons. Transfers to other facilities, early release, or reluctance to spend limited personal time for HIV test results counseling may increase the likelihood of not returning for test results. Additionally, HIV counselors may have to face problems with the physical layout of each county jail. Many do not have private rooms available for counseling and testing, and jails often cannot guarantee an inmate will still be on site when test results become available.

Strategies to consider:

1. Consider making appointments for test results counseling at correctional facilities for incarcerated clients, informing both the client and the facility of the need for an appointment.
2. Consider bringing the test results directly to the client in the jail, preferably in a room which has as much privacy as possible, and yet is still not a security or safety risk for the counselor (or inmate/client). In some jails, the best site is in an area as close to the inmate's cell as possible.
3. Avoid providing test results on visiting day, as many inmates are reluctant to spend time with HIV counseling when family and friends are a priority.
4. Consider having the client contacted by the medical unit, and then provide CTR in that unit to help ensure confidentiality.

N. COUNSELOR SKILLS & TRAINING

Counselors need periodic training to ensure the highest quality of services for HIV clients. Strategies to consider:

1. Cross-train counselors and other appropriate staff about HIV, STD, family planning, and other services, so that returning for test results may be emphasized for all clients.
2. Provide cultural sensitivity training for all staff. Work to improve the agency's relationship with a diverse client population. Develop procedures for dealing with clients who come to the agency for counseling and testing, as well as for follow-up for high risk seronegative and HIV-infected clients.
3. Have counselors train other staff on HIV client confidentiality procedures, local regulations, and state and federal laws. Ensure that all staff, regardless of position, are trained about the need for strict observance of confidentiality requirements.
4. Ensure that all counselors have been trained in client-centered counseling, and that they are able to attend updates, as required, at two-year intervals.
5. Ensure that counselors attend other HIV and related updates as resources permit.
6. Work with the counseling staff at regular intervals on key counseling issues, such as being non-judgmental, providing support when clients show signs of being anxious, etc. Provide or have counselors attend updates, procedure/protocol review sessions, and encourage staff discussions of problems encountered.

NOTE: DHWDC requires that HIV counselors attend approved update trainings every two years for recertification.

O. RISK REDUCTION PLANS

DHWDC requires that all funded CTR staff develop and document a written plan for clients to reduce their risk of becoming infected or re-infected with HIV. Such plans must be individually negotiated with the client so that they are appropriate to the client's individual risk behaviors. Risk reduction plans enable clients to feel that they have increased control over whether they will become infected or re-infected in the future, and thus may increase the likelihood that clients return for their test results.

Strategies to consider:

1. Address the issue of how knowledge of one's HIV status is essential to present and future health, and that it may be valuable to seek repeat testing if the client continues to participate in risk-taking behavior;
2. Offer the client a written copy of his/her own risk reduction plan, with the date and time of the appointment to obtain test results.

VI. DHWDC CONTACT

If your agency's staff have questions about client failure to return for HIV test results, or about implementing assessment and/or improvement strategies, contact Bob Barrie, Quality Assurance Coordinator, at (517) 241-5934, or contact your agency's designated Contract Monitor/Quality Assurance Consultant, at (517) 241-5900.

APPENDIX A

AGENCY SELF-ASSESSMENT Failure To Return (FTR) Rates

INTRODUCTION

In order to assure the highest quality services for all HIV counseling and testing clients, HAPIS has designed a series of questions which measure success with respect to client return rates for HIV test results. It is essential that all agencies strive to meet and exceed CDC's standards of 70% return rate for clients whose test results are negative, and 95% for HIV positive clients.

The following assessment tool is divided into four sections:

- Part I consists of basic agency information;
- Part II provides space for the agency to list current strategies being used to improve return rates;
- Part III consists of tables where staff can fill in the blanks with appropriate data;
- Part IV is a series of questions that agencies can answer regarding their return rates.

Your responses on the assessment tool will help your agency to diagnose FTR problems and also help to find solutions. Additionally, for those agencies which are meeting and/or exceeding the standards listed above, it would be useful to document reasons your agency is doing so well. This survey should be kept on file within your agency to be reviewed by quality assurance and contract monitor staff during site visits.

Please use data from your agency, as well as data from MDCH/DHWDC, to determine trends in client return rates. In assessing your agency's success, it may also be useful to compare your program with other collaborative agencies within your counseling and testing jurisdiction. These initial measurements may be useful for comparison of your agency's progress at a later date, as discussed below. Note that comparing data among agencies is voluntary, not mandatory.

INITIAL PROGRAM ASSESSMENT

The following actions describe how to measure FTR in your area and among your clients.

1. Compare return rates among various client populations/sites within the agency's jurisdiction. For example, if your agency has four sites in your county, then compare how each is doing relative to the others. Additionally, agencies with sites in different counties should do the same.

It also might be useful to compare your agency's return rates with the rates of a similar agency, such as another local health department, or another community based organization providing similar services (e.g., street outreach, or visits to camps of migrant farm workers).

2. Measure/compare return rates among sites within a program at your agency, such as clients who come in for (and receive) only STD services with those who come in and receive both STD and HIV.
3. Examine the return rate within programs among counselors and determine the differences for clients with various risks, such as injection drug use, sexual activity, sex with an injection drug user, infected mother/infant, etc.
4. Use client surveys and other feedback to address barriers to service and to help determine reasons clients might not be returning for test results.

Different agencies have handled this by developing a variety of surveys. Some agencies have clients mail back questionnaires anonymously, or have left the surveys at the front desk on their way out, with no client identifiers used. One local health department has developed a postcard size survey, which can be mailed back.

5. Seek feedback from agencies where clients are referred in order to monitor client satisfaction with the program.

This arrangement should be set up ahead of time, either with a collaborative agency, or with one where your agency seeks to develop collaboration. It is recommended that a written agreement be developed where services and/or referrals are exchanged.

PART I.

SELF ASSESSMENT SURVEY

AGENCY INFORMATION

Agency: _____

Address: _____

Contact Person: _____

Phone Number: _____

TIME PERIOD OF REPORT: Comparison Periods & Number of Tests

Current Year: _____	Previous Year: _____
___ HIV tests: January – March	___ HIV tests: January - March
___ HIV tests: April - June	___ HIV tests: April - June
___ HIV tests: July - September	___ HIV tests: July - September
___ HIV tests: October - December	___ HIV tests: October - December

Part II. CURRENT STRATEGIES IN PLACE TO INCREASE CLIENT RETURN RATES FOR HIV TEST RESULTS

List three of your top strategies which are currently being used to improve return rates.

1. First Strategy:

2. Second Strategy:

3. Third Strategy:

After these strategies have been implemented and been in use for six to twelve months, staff should revisit these and determine how and if they should be modified to further improve client return rates. Review the strategies with other staff and compare the agency's current successes and failures with the strategies listed in the first fifteen pages of this document.

PART III. RETURN RATES - PROGRESS TABLES

Please fill in the following tables which will help you determine differences in return rates by gender, race, risk exposure, program or site type, counselor, type of test, and age of client. Analyses of these tables will help pinpoint areas that need improvement with return rates.

NOTE: The “Current Rate” refers to the time period for the most recent quarter. The “Previous Rate” refers to the time period of the most recent quarter before the Current Rate period.

A. RETURN RATES BY GENDER Current Period: _____ Previous Period: _____

GENDER	NEGATIVE TESTERS		POSITIVE TESTERS		OVERALL RATE	
	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %
Males						
Females						

B. RETURN RATES BY RACE

Current Period: _____ Previous Period: _____

RACE	NEGATIVE TESTERS		POSITIVE TESTERS		OVERALL RATE	
	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %
African Am						
Asian Am						
Caucasian						
Hispanic						
Native Am						
Arab-Chaldean						
Other						

C. RETURN RATES BY RISK EXPOSURE

Current Period: _____ Previous Period: _____

RISK	NEGATIVE TESTERS		POSITIVE TESTERS		OVERALL RATE	
	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %
MSM/IDU						
MSM						
Hetero IDU						
Sex Partner at Risk						
Child of HIV+ Woman						
STD Diagnosis						
Sex for Drugs/ Money						
Sex while using drugs						
Hemoph/Bld Recipient						
Victim of Sex Assault						

C. Return Rates by Risk Exposure (continued)

	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %
Health Care Exposure						
No Acknowledged Risk						
Other						
Not Specified						

D. RETURN RATES BY PROGRAM/SITE TYPE

Current Period: _____ Previous Period: _____

PROGRAM / SITE TYPE	NEGATIVE TESTERS		POSITIVE TESTERS		OVERALL RATE	
	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %
HIV						
STD						
Family Planning						
Off-Site Satellite Clinic						
Mobile Van						
Other						

E. RETURN RATES BY COUNSELOR**

Current Period: _____ Previous Period: _____

COUNSELOR	ID NUMBER	NEGATIVE TESTERS		POSITIVE TESTERS		OVERALL RATE	
		Current Rate %	Previous Rate %	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %
Counselor	#						
Counselor	#						
Counselor	#						
Counselor	#						
Counselor	#						
Counselor	#						
Counselor	#						
Counselor	#						

** Attach more sheets as needed.

F. RETURN RATES BY TYPE OF TEST

Current Period: _____ Previous Period: _____

TYPE OF TEST	NEGATIVE TESTERS		POSITIVE TESTERS		OVERALL RATE	
	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %
Anonymous						
Confidential						

G. RETURN RATES BY AGE OF CLIENT

Current Period: _____ Previous Period: _____

CLIENT AGE	NEGATIVE TESTERS		POSITIVE TESTERS		OVERALL RATE	
	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %	Current Rate %	Previous Rate %
< 5						
5-12						
13-19						
20-29						
30-39						
40-49						
>= 50						
Unknown						
Not Specified						

PART IV. SELF ASSESSMENT QUESTIONS

1. Has the agency's overall return rate for this quarter:

Increased Decreased

Please describe possible reasons for the increase/decrease:

2. Has the agency's overall return rate for positive testers for this quarter:

Increased Decreased

Please describe possible reasons for the increase/decrease:

3. Has the agency's return rate for negative testers for this quarter:

Increased Decreased

Please explain possible reasons for this increase or decrease:

4. If the agency's rate has improved or stayed the same, list strategies that will be used to maintain or increase this rate:

5. If the agency's rate has decreased, list strategies that will be used to improve this rate:

6. If the agency's rates of return are lower than the standards established by CDC*, what are the factors affecting the rate that need to be looked at more closely:

- | | |
|---|--|
| a. <input type="checkbox"/> Gender | e. <input type="checkbox"/> Counselor(s) Skills/Training |
| b. <input type="checkbox"/> Race | f. <input type="checkbox"/> Type of Test (Anonymous vs Confidential) |
| c. <input type="checkbox"/> Risk Exposure | g. <input type="checkbox"/> Age of Client |
| d. <input type="checkbox"/> Program/Site Type | h. <input type="checkbox"/> Other: _____ |

* CDC Standards: 95% return for HIV infected clients, 70% for HIV negative clients.