

KNOW YOUR STATUS

A large red awareness ribbon is positioned behind the text 'KNOW YOUR STATUS'. The ribbon starts from the top right, loops around the word 'KNOW', goes down behind 'YOUR', loops around the word 'STATUS', and ends with a pointed tail at the bottom left.

**A Tool Kit for HIV Programs in
Saskatchewan First Nations**

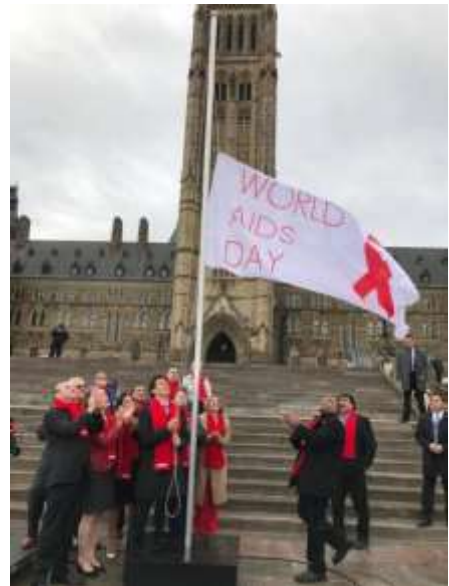
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“Good things happen when First Nation communities gather to share experiences and knowledge. HIV is only one of the major health concerns we as First Nation people face. We need to work together and create sustainable programs for our people. Creating better health for our people involves a strong cultural approach. Our Know Your Status Program, which was developed in 2009 is community-based and community driven. We strive daily to create an environment that meets the needs of all our clients and band members.” – Chief Bruce Morin

“The Know your Status program has helped to save lives and provide hope for those living with HIV in our community. We highly recommend that other communities adopt the program. We are extremely proud of our health care workers and community members for embracing this life saving program.” - Chief Larry Ahenakew



“As a collective, we want to share successes and help any community combat HIV/AIDS. As First Nations, it’s time that we come together to drive the development, expansion and implementation of HIV programs by our people, for our people.” – Tribal Chief Felix Thomas

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Special thanks to the members of the HIV Technical Working Group for sharing their knowledge, skills and expertise.

Introduction to Know Your Status: Model for HIV programming in First Nations Communities

Over the last few years, high HIV rates in Saskatchewan have received local, provincial, national and international attention with very little coverage of the hard work and successes of the many groups throughout the province in addressing HIV. Big River First Nation (BRFN) and Ahtahkakoop Cree Nation (ACN) started their Know Your Status (KYS) programs in 2011, and are now considered world leaders in the fields of HIV and Hepatitis C in First Nations communities. The Saskatoon Tribal Council (STC) has demonstrated excellence in this field through the SHARP harm reduction program in Saskatoon and its 20th St Health Centre, and its rural and on-reserve programming.

The Know Your Status HIV programs developed by Big River First Nation and adopted by Ahtahkakoop Cree Nation, and the STC SHARP program have seen significant successes in increasing community awareness and decreasing stigma around HIV. The groups have implemented culturally grounded programs, supported by Elders, community members and volunteers that support people at risk and people living with HIV and Hepatitis C. As a result, people with HIV and Hepatitis C are now living in their community and receiving the care they need and deserve.

There are high rates of HIV in Saskatchewan, especially in First Nations Communities, but some Saskatchewan First Nations communities have been tackling this head-on, and with great success.

Know Your Status

'Know Your Status' has been around for some time as an HIV prevention and education tag line for numerous HIV campaigns around the world. Most references to 'Know Your Status' are connected to testing and awareness campaigns. We consider Know Your Status to encompass: community engagement and readiness; prevention through education and harm reduction; testing for HIV and other STBBIs; treatment as prevention; client support and case management; and surveillance and evaluation. What distinguishes the Know Your Status programs in BRFN and ACN is that they are community led and community driven. They built on the community's readiness to increase awareness and gain support to implement programs that include education, prevention, testing, treatment, and linkage to supports to help manage their HIV and Hepatitis C. It is a continuum of care necessary to ensure people are retained in care.

Know Your Status (KYS) is more than getting testing for HIV and knowing if you are positive or negative.

It is also about education, harm reduction, treatment & support for people who are positive, & surveillance of the disease.

As BRFN, ACN, and STC can attest, finding success in addressing HIV requires a great deal more than a testing awareness campaign. It requires a Leadership-led and Leadership-driven community effort that ensures those at risk feel comfortable accessing testing and using prevention services and that those who are HIV/Hepatitis C positive will find safety and support in their communities and achieve optimal health.

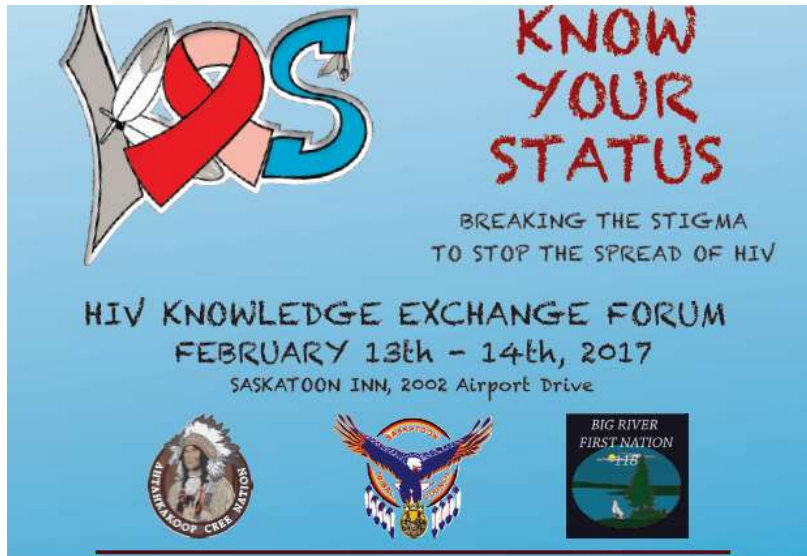
Collaborating to Share Success

In December, 2015 the Chiefs of STC, BRFN, and can and the Saskatchewan Regional Executive of Health Canada, First Nations Inuit Health Branch met to discuss HIV in Saskatchewan. Through this meeting, the HIV Steering Committee and HIV Technical Working Group were formed to begin work to more efficiently support First Nations communities in HIV programming through the development of knowledge sharing tools and activities. The groups' terms of reference state

- Their purpose is to expand the successful Know Your Status model in First Nation communities.
- The purpose of the Steering Committee is to provide oversight and direction in the development and implementation of a First Nation HIV Strategic Action Plan for sustaining and developing programs and services; and to collaborate across First Nation, federal and provincial governments. Collaboration will be promoted with interrelated programs and services such as Hepatitis C and other sexually transmitted or blood-borne infections (STBBI).
- The purpose of the Technical Working Group will be to present recommendations to the HIV Steering Committee regarding the development, resourcing and implementation of HIV, Hepatitis C, and other STBBI prevention, care, treatment and support strategies. These recommendations will include the broad range of social determinants of health with an emphasis on the importance of culture.
- Key activities of the groups will be to increase knowledge sharing and best practices around HIV/ Hepatitis C and other STBBIs in First Nation communities.

First Nation Leaders are working together, to prevent HIV transmission, and to improve the lives of people living with HIV, and the lives of their families.

In an effort to share knowledge, the committees decided in 2016 to focus on developing a tool kit and holding the first annual forum.



The forum poster.

The Tool Kit

The following tool kit is by no means an inclusive manual for HIV programming. The members of the Steering Committee and Technical Working Group have used these tools in the implementation of Know your Status.

It is the hope of the HIV Steering Committee and the HIV Technical Working Group that other First Nations will be able to realize their own successes through using the KYS Toolkit, to expand their activities. This toolkit includes tools to help you with:

community engagement and determining community readiness to increase HIV services in the community,

prevention through education and harm reduction, testing in your community,

understanding HIV treatment and being able to provide treatment in your community,

creating what you need for client support and case management, and,

surveillance and evaluation.

Community Engagement and Readiness

What is community readiness?

The first and very crucial step is to engage with your community to determine how ready they are for adding to your current HIV programming, at whatever stage they are at. The definition of community readiness is the degree to which a community is prepared to take action on an issue. Whether you are a leader, staff member or citizen we are all aware of different times or situations in our communities when we have sensed that it is the right time to act, or not, based on the support or resistance from the people around us. This is community readiness. Matching an intervention to a community's level of readiness is absolutely essential for success. Action on an issue must be challenging enough to move a community forward but not too overly ambitious that you risk failing because community members are not ready or able to support the action (Plested, Jumper-Thurman, & Edwards, 2016).

Measuring Community Readiness

Most of us have a pretty good idea where our own community might stand on a particular issue, but those who study community readiness say that every community sees some surprises when they complete a community readiness assessment. Sometimes communities are more ready, sometimes less and this informs leadership and staff of where to start and where resources are best directed.

We have referenced a model (see Appendix A) that you may want to consider using to determine your community's overall community readiness. The Steering Committee and Technical Working Group may also be able to assist you in this determination. This model may be used to consider community readiness for having HIV testing available in your community, but also for the implementation of a harm reduction (needle distribution) program.

The first and very crucial step is to engage with your community to determine how ready they are to add to your current HIV programming.

How do we build community readiness?

Awareness that a problem or issue exists is essential to gaining the support of leadership and community members to allocate resources. Building community readiness about HIV can start anywhere – with youth, a concerned community member, an Elder, Leader or a group of people who can initiate readiness by bringing to light factual information that local people can relate to and tell them why they should care about the issue. Awareness information shouldn't create panic or fear, and should be presented with some suggestion for ideas or solutions to the problem.

As with any community initiative communities generally see greater success if it is Leadership driven and supported. The successes in BRFN, ACN, and STC began with informed leaders acting. In BRFN, Chief Morin held a community meeting on HIV and set a tone and direction of tolerance, acceptance and perseverance to address HIV while supporting those affected by it.

We have provided the “Checklist for communities to use before initiating HIV testing” (see Appendix A). Few checklists are ever complete, and implementing a new program in a community is never as easy as going through a list and checking off when you have completed each task. However, our hope is that this checklist will provide you with a basic idea of the components you will need to consider before beginning HIV testing for other sexually transmitted and/or blood borne infections. Most programs that offer HIV testing also offer other testing.

Communities see greater success if KYS is not only leadership supported, but also leadership driven.

Therefore, Chiefs and Councils need to understand HIV transmission, care for people who are positive, and how to prevent and tackle the stigma associated with HIV.

Education

Education is a key component throughout the continuum of the Know Your Status program right from building community readiness to supporting clients and family members.

Community-Wide Education

The previous section has outlined the role of education in community readiness to create a general awareness and understanding of HIV thereby reducing stigma and preparing the community and staff to support the KYS program. There are many resources available that can support Leadership and staff to provide basic HIV 101 facts and information. These include brochures and pamphlets, the internet and social media, and health professionals.

The CATIE website is an excellent source of up-to date information that ranges from HIV and STI basics to new releases and briefings on the latest HIV, Hepatitis C and STI treatment and research. Their site is easy to navigate and includes resources from other HIV organizations such as the Canadian HIV/AIDS Legal Network and

the Canadian Aboriginal AIDS Network. Communities can order pamphlets, brochures, posters, fact-sheets, books and more at no cost from their web site at <http://www.catie.ca/en/home>.

Information pamphlet
from CATIE website



Other great sites include the United Nations AIDS web site that houses the UNAIDS Strategy, resources and reports at <http://www.unaids.org/>.

Education sessions and presentations can be provided to students, community members and staff at little to no cost to health or community programs. Community health nurses can be an excellent resource to provide HIV education just as addictions and mental health workers can provide harm reduction, illicit drug and injection drug use information. Many Tribal Councils have nursing support positions such as clinical supervisors who can also provide communities with education resources or presentations.

Excellent, including culturally appropriate educational resources available from:

***Canadian AIDS Treatment and Information Exchange
Canadian Aboriginal AIDS Network
Canadian HIV AIDS Legal Network
United Nations AIDS***

HIV, Hepatitis C and STI Education in Schools

The KYS programs in ACN and BRFN emphasize the importance of educating youth on HIV, Hepatitis C and STIs. Nursing staff are regularly in the school providing education to students in addition to the sexual health curriculum already in place.

HIV, Hepatitis C and STI Education for Staff

All staff who provide support services to people living at risk or people who are living with HIV or Hepatitis C should have a basic knowledge such as how the virus are contracted, signs and symptoms, needle safety, what testing is and where to get tested, and others within the community that can help. Some individuals may prefer to access some or all services by external providers. It's a good idea for staff such as the income assistance worker, teachers, principals, housing and public works staff, child and family services, youth, recreation and justice workers to also be trained.

HIV, Hepatitis C, and STI education is essential education in schools.

All health, social, & addictions staff need at least basic HIV education.

Harm Reduction

What is Harm Reduction?

Harm reduction is a concept we commonly apply in our daily lives but generally take for granted. For example, we might indulge in a high calorie meal but might exercise more to keep the weight off and our hearts healthy. Another example is that there are many accidents involving driving in motor vehicles, and rather than choosing not to be in a vehicle, we wear seat belts to minimize harm should we get into an accident. These examples show how in our daily lives we engage in behaviors that create potential risks to our health and that we acknowledge and accept the risks and then do extra to prevent or reduce harm to ourselves and others.

The BC Centre for Disease Control in their harm reduction training manual defined harm reduction as:

Harm reduction involves taking action through policy and programming to reduce the harmful effects of behavior. It involves a range of non-judgmental approaches and strategies aimed at providing and enhancing the knowledge, skills resources and supports for individuals, their families and communities to make informed decisions to be safer and healthier.

We know that as human beings the vast majority of us have or will in our lifetimes engage in at least one behavior that potentially puts us at risk of contracting HIV, Hepatitis C or an STI. Harm reduction programs operate on the same principles as seat belts – we accept that people are going to be at risk of harm when we drive and some (most) of us will speed regardless of the consequences of law enforcement penalties or worse. The same concept applies to harm reduction in HIV, Hepatitis C and STI's - we accept that people are going to engage in risky behaviors such as unsafe sex and injection drug use regardless of the consequences and that through harm reduction principles, we can work to reduce harms to themselves and others.

Harm reduction is an essential service and approach that is not about enabling people to use drugs, rather, it is about respecting that people have a right to choice; and also to respect and dignity, even if that current choice is drug use. People are people first.

This acceptance of the broad range of human behaviors is one of the core principles of harm reduction - pragmatism. Harm reduction respects human dignity and the rights of individuals while focusing on strategies that will decrease the negative consequences of high risk behaviors through interventions. These interventions can include: education, clean needle distribution, HIV, Hepatitis C and STI testing, methadone or opioid substitution therapy, addictions and mental health supports, counselling, treatment and advocacy and supports to reduce the impact of social determinants of health.

Successful harm reduction programs are characterized by having low barriers to care – ie: clients do not have to give a lot of personal information or show government issued identification to access. They are high access – the program meets clients when and where they are at. ‘Meeting clients where they are at’ means a great deal more than in locations, times and with suitable programs. It also recognizes what stage a client is at in their readiness to reduce or eliminate their risks and offering appropriate support, education and services.

Assessing clients and providing education

No harm reduction program can be effective without educating people engaging in high risk behaviors about how to minimize risk to themselves and to others. Although individuals may access a harm reduction program for the sole purpose of obtaining clean needles, staff are responsible for engaging clients, doing informal, basic assessments (ie: general appearance, signs of poor health, mental health issues, changes from last visit, housing situation, etc) and

providing appropriate, accurate and relevant information.



Staff should be comfortable and well-versed in sharing information with clients on: safe injection practices (ie: not sharing needles/equip, injection drug use (IDU) tips, hygiene when using), safe sex practices (use of condoms, dental dams, lube), signs and symptoms of HIV/AIDS, Hepatitis C, STI's and common injection drug use illnesses (abscesses, chalk lung, endocarditis), testing practices (ie: what an HIV point of care test entails), illicit drugs and their risks/effects, new drug trends and their risks (ie: crystal meth, fentanyl), signs of an overdose, methadone therapies, and more.

The CATIE web site also offers pamphlets, brochures and other mediums (at www.CATIE.ca/en/home). These resources are an excellent way to provide clients with additional and more specific information on how to prevent the transmission of HIV, Hepatitis C and STIs.

Education after a positive diagnosis

Staff play a key role in providing support to clients and their families especially after a positive HIV or Hepatitis C diagnosis. At the time of diagnosis, clients and their families have many questions that range from “Can HIV get passed on through mosquito bites or kissing?” “If I don’t tell a future partner, will I go to jail?” to “When can I get on medications and what are they?” that are best answered by a nurse, physician or well-trained peer who can give correct information and refer people to professionals and community supports. As mentioned above, CATIE has a large inventory of information and pamphlets that include resources for people who are positive such as a nutrition guide, information for positive pregnant mothers, and a monthly newsletter that a KYS program can have on hand.



Pamphlets available from CATIE

It is essential that at the time of an HIV or Hepatitis C diagnosis, that people are educated on their illness, and get their questions answered, by someone they can trust. Trust is number one.

Harm Reduction Programming – Needle Distribution

Currently in Saskatchewan, injection drug use is the primary mode of transmission for both HIV and Hepatitis C. Needle exchanges have decades of research to support that they are one of the most effective and cost-efficient ways to reduce the number of new HIV and Hepatitis C infections.

Over the last several years, public health policies and programs have caught up to best practices around providing clean needles to people who use drugs from “needle exchange” to “needle distribution” policies. Needle distribution is considered best practice since although it emphasizes the importance of needle returns, it recognizes people may not always be able to return the same amount they picked up each time. By not enforcing a strict “one for one” policy it ensures people can always access clean needles.

Harm reduction programs typically offer a 1CC 28 gauge insulin syringe along with tourniquets (elastic ties), cotton dental filters, alcohol swabs, metal spoons or steri-cups, and sterile waters. Additional supplies may include band aids, polysporin, Vaseline, and hygiene items such as shampoo, soap and hand sanitizers.

Along with supplies, clients should be given information about how to inject more safely to prevent HIV and Hepatitis C transmissions and other illnesses caused by injection drug use. Refer to the CATIE website for excellent resource materials.

All First Nations communities in Saskatchewan can receive needle distribution supplies through the First Nations and Inuit Health Branch. Prior to receiving supplies, communities need to contact Brett Dow (brett.dow@canada.ca) to discuss process and support available. The supply request form is included in Appendix B.

For more information on Canadian best practices in harm reduction, see <http://www.catie.ca/sites/default/files/bestpractice-harmreduction.pdf> for *Best Practice Recommendations for Canadian Harm Reduction Programs that provide service to people who use drugs and are at harm for HIV, HCV, and other harms: Part 1 and 2.*

The Prairie North Health Region published a needle safety manual that can be accessed at http://www.pnrha.ca/bins/doc.asp?rdc_id=4324.

Harm Reduction is about more than giving needles, but the provision of needles is crucial to prevent the spread of HIV and Hepatitis C.

Harm Reduction Programming - Condom Distribution

Harm reduction programs also offer free access to male and female condoms, dental dams and lubricant. Along with condoms, clients should be given information about how to protect themselves and others from HIV, Hepatitis C and STI infections. ALL clients should be offered testing or information on where to get tested.

Harm Reduction Programming – Opioid Substitution Therapy (OST)

For clients using opioid-based substances or “down” such as hydromorphone, fentanyl, and heroin an opioid substitution therapy can reduce health and social risks associated with injection drug use. By engaging and referring a client in OST, clients’ risks are reduced by preventing them from using substances that may be cut with other harmful substances that cause injury or death. It also reduces their need to engage in drug-seeking behaviors such as drug-dealing, street-work or other illegal or harmful activities.

With OST, the client is engaged with a methadone counselor and physician to formulate a plan to reduce or eliminate their dependence on opioids. The 2016 Guidelines for OST programs in Saskatchewan can be found on the College of Physicians and Surgeons web site at: <https://www.cps.sk.ca/iMIS/Documents/Legislation/Policies/STANDARD%20-%20SK%20OST%20Therapy%20Guidelines.pdf>.

Harm Reduction Programming – Referrals and Advocacy

A key activity of a harm reduction program is referring clients to services and supports that will assist them in reducing their risky behaviors. Many people struggle with multiple issues including homelessness or unstable housing, food security, education, employment, justice, addictions and mental health, family issues, and issues accessing health and social services due to stigma and discrimination.

Harm reduction staff need to be able to informally assess a client based on information gathered during regular interactions. This includes information the client discloses about themselves and changes in their appearance or demeanor or use of the program. Based on this informal assessment, staff need to be knowledgeable about what services are available in and around the community and ensure the client is connected to care.

Harm Reduction Programming – Data Collection

Before deciding what information a harm reduction program should collect, it is important to ask why it is needed. For example, at one time STC's SHARP program was documenting how many spoons each individual was given. This was inefficient use of staff resources to collect and input data when 1) the number of spoons an individual takes has had little value for STC in evaluating and improving their programs and 2) it can be easily calculated how many spoons were used by simply reviewing supply orders. STC now focuses on collecting data that will demonstrate the program is fulfilling the purpose of the program – to educate clients on their risks, link them to services and reduce their risk.

HIV and other STBBI Testing

Careful planning and preparation is essential prior to beginning testing in community. Experience has taught us that prior to offering testing:

1. Your level of community readiness needs to be able to support the program;
2. You will need to know if your current health programs (especially nursing) have the capacity, skills and resources necessary to offer testing;
3. Your staff need to be trained to offer and administer testing;
4. Your health centre must be appropriately licensed to ensure the quality control for specimen collection; and
5. MOST important is that there is an established referral processes to people and professionals to support individuals who are positive.

Some questions to answer in planning can include: Which type of blood testing is more suitable for our community? How will we get specimens to the lab – who will transport them? What is the best way to ensure people from our community who want to get tested can be assured privacy and confidentiality? What do we do if we have a positive test: What physician or specialist do we have a relationship with that we can connect people who are positive to? How and when will people who are newly positive see an infectious disease doctor? Who in our community can provide people with counselling and support?

As you can see, successful testing in community is based on good planning, decisions, resources and relationships. When testing we need to know where to link positive cases to good medical care.

A sample of clinical policy and form templates is available in Appendix C (documents 1 to 14).

Community Capacity and Resources

Each community will have unique strengths and challenges when implementing testing. Some will benefit from having existing staff with HIV, Hepatitis C and STI experience or be geographically located near a lab or have strong professional relationships and peers in communities that can support a complete Know Your Status program.

For many communities the majority of the workload will fall on the community health nurse and/or the health director initially but communities are encouraged to explore resources available within and to your communities in your regions.

Offering Rapid Point of Care HIV Testing and/or Blood Draw Testing

The Rapid HIV Point of Care (POC) test is a screening test for HIV that uses a very small amount of blood (a finger prick of blood). Results happen in minutes and can be analyzed by a nurse. The Rapid POC HIV test can only **screen** people for HIV and is over 99% accurate (<http://www.catie.ca/en/pif/spring-2015/rapid-point-care-hiv-testing-review-evidence>). If the screening test comes back 'reactive' (most likely HIV positive), additional blood samples are required to confirm an HIV infection. These samples can be collected by a nurse with phlebotomy training or a phlebotomist and need to be sent to the provincial lab for analysis. It takes 5-10 business days for the results which are sent back to the nurse and physician to inform the patient.

The benefits of the Rapid POC test are that it is relatively painless, it doesn't take very long to do, the results of the test are almost immediate, it doesn't require nurses to have phlebotomy training and skills, it is a reliable and accurate test, and is generally preferred by people who use drugs (often their veins are in poor condition and make blood draws difficult and painful).



Photo of a POC test from the BC Centre for Disease Control

Although quick and convenient, the Rapid test can pose challenges. Since the results are almost immediate, a nurse will have to ensure prior to testing that the individual is mentally/cognitively able to give informed consent (ie: is not under the influence of drugs and alcohol) and that they are prepared to get the results of the test (ie: they won't pose a danger to themselves or others if the test is reactive). If the Rapid test is given in a rural or remote location and the test is reactive, the nurse may not be trained in phlebotomy and will need to refer the person for blood work to the nearest lab or hospital. With a reactive Rapid POC test there is also an immediate need for the nurse to ensure the individual leaves the clinic with adequate support as they begin living with the diagnosis.

Staff Training

In order to offer the Rapid HIV POC test in community, your community health nurse needs specific training. Nursing staff can also take training to be certified in phlebotomy but this is a skill that requires more frequent use to maintain their clinical competency. Community nursing staff can consult with their clinical supervisor or health director for training options in their region.

An essential component of training for the Rapid Test is the pre and post test counselling which trains staff to assess a client's risk factors, ability to give informed consent, and education and referral needs in the event of a reactive test. Saskatoon Tribal Council has developed a training module for pre and post test counselling and has trained mental health and addictions, prevention, and community health staff to be able to support the nurse in preparing and debriefing individuals. This training can be provided to interested communities.

Pre & Post Test Counselling

Before testing, nurses have to provide adequate pretest counselling – testing MUST not happen unless pre-test counselling has been completed. As mentioned above, testing for HIV should always be voluntary and carried out only after the client has given informed consent. Conversely, post-test counselling is equally important in regards to communicating the test result, assessing the client's understanding of the test results and providing them with education to reduce any risks identified during pre-test counselling or link them to care if the test is reactive.

HIV testing is not compulsory in Canada but it is encouraged that any one engaging in high-risk behaviors—including unprotected sex of any type should be tested annually as part of a yearly physical. The BC Centre for Excellence encourages everyone to get tested regardless of their lifestyle (ie: Know Your Status – positive or negative).

Tips for Testing:

- A sample form has been included in Appendix D however, communities will need to develop their own policies and adapt forms based on their situation and needs (ie: intake forms, care flow sheets, and reporting forms).
- Having an intake process may take a few visits and will give an opportunity to build rapport with the individual to assist you in providing them with knowledge and support to get tested.
- Ensure you have a private area and discuss with the client how you will maintain confidentiality.
- Nursing staff will need to work with their clinical supervisors to determine reporting processes for testing and positive cases.
- Support programs for newly diagnosed patients require different forms and paperwork within each health region. You will need to contact your local health region to find what is expected.

An example of a form used ACN has been attached in Appendix D.

Phlebotomy and Lab Licensing:

Each site providing the Point of Care test and/or phlebotomy requires a lab license.

Treatment as Prevention

As mentioned in the previous section, communities MUST assess and plan for what community resources are required to support people living with HIV and Hepatitis C. Once an individual has been diagnosed as positive with HIV or Hepatitis C as a reportable communicable disease, health professionals are required to work with the Regional Medical Health Officer of FNIHB to collect and provide information on treating a new infection. Most importantly, community staff must follow up with the individual to link them with the family physician, or infectious disease specialist for treatment, and medications as well as other essential care providers such as addictions and mental health workers, outreach supports, nutritionists, Elders and peers.

Treatment

Prior to a physician prescribing a medication to treat HIV, additional blood work may be needed to determine the strain of HIV or Hepatitis C. Currently, there are a limited number of medications to treat HIV and Hepatitis C, some of which best suit certain strains (genotypes) of the viruses.

Additional bloodwork will also test whether or not the type of virus the person has is resistant to any medications. Drug resistance can happen when someone who has HIV starts and stops taking their medication. Stopping and starting a medication can result in the virus becoming immune to the medication. In other words, it becomes resistant to the drug. If this person transmits their HIV to someone else, their drug resistance can be passed on through that virus and that drug may also not be effective for the next person. It is important for physicians to know the genotype and if there is drug resistance prior to prescribing a medication.

Client Support and Case Management

We know that when HIV is left untreated, as an individual's viral load increases, so does the likelihood of transmitting the virus when engaging in risk behaviors. In the past, individuals were not offered treatment until their viral loads exceeded a limit where they were deemed sick enough to require it. The BC Centre for Excellence has proven that the Treatment as Prevention (TasP) strategy which offers medications to all people living with HIV, regardless of their viral load, is the most effective for individuals, and for prevention. This strategy creates public health benefits by targeting resources to reduce viral loads thereby reducing new HIV transmissions and costs of new infections to the health system.

Clinical management is therefore much more than just doctors prescribing medications. It is about supporting the individual's right to choose if and when they start medications while supporting their holistic needs.

The continuum of care should include additional supports such as case managers and counselors to support people who may be experiencing difficult life circumstances that may prevent them from taking their medications and are therefore at risk of developing drug resistance. Case managers help people to address basic needs such as housing, getting nutritious and regular meals, receiving income supports and to overcome other barriers such as addictions and mental health issues, transportation to medical appointments, and involvement in the justice system.

An important factor to consider in supporting someone with a new HIV or Hepatitis C diagnosis is the flurry of emotions, questions and uncertainties upon learning of a new HIV diagnosis and thereafter, living with it in a healthy manner. The patient may already be struggling with any number of social issues and/or some form of addiction. The entire care team needs to support and encourage patients to seek help and offer them appropriate resources by referring them to available support services. BRFN and ACN have found success in running programs and supports within their health centres that can also provide incentives for people to stay engaged in care such as:

- Good Food Box Certificates (GFBC): given to clients who come in for their blood draws or immunizations when due and a monthly draw for needle exchange clients and needle sweeps.
- Phone program: clients are given a phone and monthly top-up minutes to stay connected to their care providers.
- Set up appointments for x-rays, ultrasounds, scans, TB clinics and other specialists. Arrange for medical transportation to appointments or by staff if need be.
- Home visit if needed to give reminders about appointment dates and new medication orders.

- Physician and specialist clinics in community - pick up and drop off clients.
- Deliver medication to client's home if requested.
- Baby Formula Program: HIV positive mothers who have infants can receive four cases of formula monthly until baby is one year old.
- Assessing and supporting clients' during crisis situations by helping find housing or when warranted give bi-weekly Good Food Boxes.
- Assist clients to get Social Assistance Medical Reports completed by doctors and specialists which entitles them to extra diet or disability assistance.
- HIV Peer Support Groups.

Enclosed are some documents which include forms and information on treatment services:

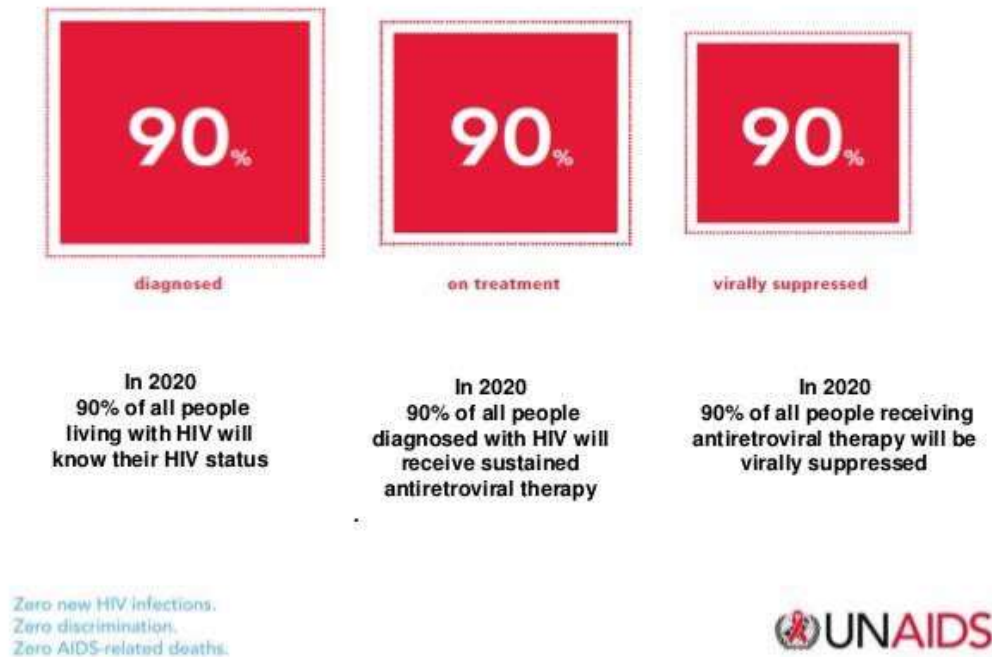
- Listing of Saskatchewan in-patient and out-patient treatment centers operating under National Native Alcohol & Drug Abuse Program (NNADAP) treatment services (Appendix E)
- Income Assistance Medical Report Form and Instructions(Appendix F)

Surveillance

UNAIDS 90-90-90 TARGETS

The Joint United Nations Programme on HIV/AIDS (UNAIDS) set a global goal to end the AIDS epidemic by 2030. To monitor progress towards this goal, UNAIDS established “90-90-90” treatment targets for 2020. The aim being to ensure that 90% of HIV positive people will know their status, that 90% of those who know their status receive treatment, and that 90% of those on treatment will have a suppressed viral load. Three documents are enclosed that help to clarify 90-90-90.

«90-90-90» - ambitious target aimed at ending AIDS



1. Appendix G- Provincial document - “The UNAIDS 90-90-90 Targets; Saskatchewan and National Indicators for 2014” explains how the provinces and territories, including Saskatchewan, contributed data to the initiative of the Public Health Agency of Canada (PHAC) to monitor Canada’s progress in achieving the UNAIDS goal. It describes the estimation of the 90-90-90 for Saskatchewan and Canada for 2014.

Table 1 of this document uses an estimation and a range. The first line estimates 2,309 people in Saskatchewan are living with HIV and 65,040 in Canada based on PHAC modelling (the attached PHAC document titled “Canada’s 90-90-90 measures” is the model used). The second line shows that of those 2,309 there are 1,588 (69%) that have

been diagnosed in Saskatchewan and 52,220 (80%) in Canada. The next line then uses that estimate to show the number (percentage) of people being treated. From this estimate, the number (percentage) of people who have suppressed Viral Loads can be determined.

2. Appendix H - List of nine indicator categories from the UN AIDS Monitoring and Evaluation Reference Group and Indicators Technical Working Group to be monitored by community health centers that provide HIV testing and treatment to First Nations in FNIHB-SK areas.
3. Appendix I - The template in Appendix I was developed for the purpose of providing First Nations communities confidential reports of HIV, Hepatitis C and STI'. The template shows case counts and diagnosis rates within a specified period of time (the sample shows five years); results of said community in comparison to Saskatchewan and Canada's rates. The template also allows for communities to input information on Harm Reduction programs and services such as Needle Exchange, Methadone or Suboxone Maintenance Treatment into the template. The final area of the template is on HIV testing and treatment indicators that could be used to evaluate HIV testing and treatment services; thereby developing an estimate of our own 90-90-90.

Conclusion

HIV, Hepatitis C and STI information is rapidly changing as new treatments, programs and ideas are brought online. As with any document, the information included is recognized as a snap shot of current knowledge and experience of implementing the Know Your Status HIV program in First Nations communities by the Saskatoon Tribal Council, Ahtahkakoop Cree Nation, and Big River First Nation. This tool kit has built on the knowledge of many that came before and is one of many sources and ways for us to share best practices with each other. The writers acknowledge the hard work, dedication, knowledge and experience of the many communities, Tribal Councils and organizations working in Saskatchewan to address HIV.

As we move forward in supporting our communities, Leaders, staff, people living with HIV, and each other, we ask that the information outlined be shared in a good way and that we share and support each other in ensuring a healthy future for our children.

Appendix A – Community Readiness

Checklist for communities to use before initiating HIV testing

This is a document written by front-line community health nurses, including those who have worked in Know Your Status programs in Big River and Ahtahkakoop First Nations.

√	Checklist
	Involve community leaders such as Chief and Council and Elders. It is essential that community leadership (formal and informal) support HIV testing and follow-up being provided in the community.
	Assess overall community readiness. This may involve a formal process. See page 2 of this document for references for two community readiness models.
	Assess the capacity of your community health care staff to add on this program to their existing roles, and also whether you would need additional staff.
	Community awareness and education (including schools) on HIV prevention, infection, stigma, etc. is in place and planned to be ongoing.
	Policies and procedures are in place for HIV testing and follow-up (see page 2 of this document).
	Determine who will be the health care provider who is ordering the testing. This may be the Medical Health Officer, but it does not have to be.
	Obtain a lab license from Laboratory Licensing (required for most testing), Saskatchewan Disease Control Laboratory (see procedures 3.0 and 3.0a from FNIHB Sexual Health Guidelines and Procedures).
	Partner with local lab. Typically, staff from the community will transport specimens to a local lab and the local lab will then send specimens on for analyzing. Discussions regarding best times to have specimens to the local lab will need to occur, and also whether they have a limit on their capacity to receive specimens.
	Mental Health and Addictions supports in place as needed, including plans for who will provide ongoing support for clients who are HIV positive.
	Inform the Positive Living Program/ HIV Clinic/Infectious Disease Specialist closest to you that your community will be starting testing because if people test positive, these agencies and people will be involved in the follow-up.
	Nurses from Health Canada First Nations Inuit Health Branch (FNIHB) may be able to help you with testing initially, so have discussions with that team if you want them involved.
	Community health nurse orientation (See procedures 4-0 and 4-0a from FNIHB Sexual Health Program Guidelines and Procedures).

Policies and Procedures may include the following:

- All documents in the FNIHB Sexual Health Program Guidelines and Procedures (1-0 to 14-0).
- Other:

Overarching RN Specialty Practice Policy

Infection Prevention and Control: Specimen Collection

Blood Borne Pathogen (BBP) Exposures: Employees

Roles and Responsibilities of Health Care Personnel

Confidentiality

Linking with MHO/Primary Care Provider with interpretation of results

Follow-up and linking clients to care and support

Prevention education

Management and treatment of acute HIV infection

Managing HIV Non-Disclosure in Refusing (Unwilling or Unable) Clients

HIV Outbreak Management

HIV in Pregnancy

HIV Case Management

Documentation

References for Community Readiness models:

Canadian Aboriginal AIDS Network (CAAN), 2012, Assessing Community Readiness and Implementing Risk Reduction Strategies: Workbook.

Plested, B.A., Jumper-Thurman, P., & Edwards, R.W (2016, March). Community Readiness Manual, The National Center for Community Readiness, Colorado State University, Fort Collins, Colorado

Source: http://www.bccdc.ca/resource-gallery/Documents/Communicable-Disease-Manual/Chapter%205%20-%20STI/HIV_Guidelines_Testing_FollowUp_Prevention.pdf retrieved on [October 12](#), 2016

Appendix B – Health Canada Harm Reduction Supply Request Form

HARM REDUCTION SUPPLIES-REQUEST FORM

This form is only for Harm Reduction sites recognized by Health Canada, Sask.Region
FAX to: 306-780-5107 Attention: HIV Admin Support

Advanced ordering is recommended to avoid running out of stock

Please allow ample time for delivery of supplies

Product Description	Notes	Qty./Request
"One"-Male condoms	Lubricated 1000/ case Min. order 1 case	
Female condoms(insertive)	4/bag Min. order 1 bag	
Aqua Lube	2ml packet 500/case Min. order 1 case	
Dental Dams	100/box. Min. order 1 box	
Alcohol Prep wipes	4000/case Min. order 1 case	
Tourniquet	10 rolls/box 4boxes/case Min. order 1 box	
Mini sharps Collector (Black container)	100/case Min. order 1 case	
Cotton Pellets #2	2550/box 6boxes/case Min. order 1 case	
Cotton Pellets #3	2500/box 12boxes/case Min. order 1 case	
Syringe & Needle 1cc-U-100-28G1/2	100/box 5boxes/case Min. order 1 case	
Steri-cups Disposable cookers with filter	1000/case Min. order 1 case	
Tablespoons	3 doz /box Min. order 1 box	
Sterile Water (3ml vial)	1000 vials/case Min. order 1 case	
Vitamin C Ascorbic Acid BP	1000x100 mg strips/box Min. order 1 box	

Contact Name: _____

Contact Phone No. _____

Contact Email Address : _____

Organization Name: _____

Appendix C

Appendix C – Health Canada First Nations and Inuit Health Branch, Saskatchewan Region

Sexual Health Program Guidelines and Procedures (November, 2016)

Health Canada First Nations and Inuit Health Branch (FNIHB) Saskatchewan Region

Sexual Health Program Guidelines and Procedures (November, 2016)

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Refer to existing documents in Nursing Practice Administrative Guidelines (NPAG) manual:

Overarching RN Specialty Practice Policy

Infection Prevention and Control: Specimen Collection

Spills (Blood and Body Fluids)

Blood Borne Pathogen (BBP) Exposures: Employees

RN Specialty Practice in Sexual Health Programs

Document 1-0

Date: November 2016

Developed by the RN Specialty Practice Working Group November 2016

Background:

The registered nurse (RN) may be required to learn specialized competencies in order to provide client care that is unique to a practice setting. The Saskatchewan Registered Nurses Association (SRNA) states these specialized competencies, which allow the RN to perform specialty practices, are beyond the foundational competencies obtained in an entry to practice RN education program. RN Specialty Practices include skills, treatments, or interventions within the scope of the general practice RN. The document “Standards for RN Specialty Practice” replaces the previous SRNA document “Transfer of Medical Function and Special Nursing Procedures”. Health Canada First Nations Inuit Health Branch Saskatchewan Region (FNIHB-SK) will follow the guidelines of the SRNA outlined in the document Standards for RN Specialty Practice to support RN specialty practice and ensure client safety. Refer to FNIHB Nursing Practice Administrative Guidelines overarching policy on RN Specialty Practice for more information.

Purpose:

A Medical Directive and RN Clinical Protocol provide the authority and direction for the RN to perform Specialty Practices such as Phlebotomy in Sexual Health Programs. RN Specialty Practice Procedures not authorized by a Medical Directive and RN Clinical Protocol require a client specific order.

Procedure:

1. The most current Saskatchewan Ministry of Health Communicable Disease Manual, Guidelines for the use of Point of Care (POC) HIV test kits in Saskatchewan, the Canadian STI Guidelines, and other guidelines issued by MHO (i.e. FNIHB or NITHA) may be used to inform the development of clinical protocols.
2. As part of a Sexual Health Program, the RN will provide testing in the health centre as per a Medical Directive and RN Clinical Protocol. This may include phlebotomy, finger stick sampling and urine testing.
3. Management of Chlamydial and Gonococcal infections may be provided in accordance with a Medical Directive and RN Clinical Protocol. Further treatment and management not covered in the Medical Directive and RN Clinical Protocol may be provided only through direct consultation with the Regional MHO or the Primary Care Provider/Infectious Disease Specialist.
4. The RN may participate in the case management of clients with HIV and Hep C and their families/support system. Any follow up bloodwork must have a client specific order from the Primary Care Provider/Infectious Disease Specialist.

References:

Battlefords Sexual Health Clinic. (2000). Procedure manual. Scope of Battlefords sexual health clinic STD diagnostic and treatment services.

Saskatchewan Registered Nurses Association. (2015) Standards for RN Specialty Practices. Regina, SK

Saskatchewan Registered Nurses Association. (2016) RN Specialty Practices: Employer Guidelines. Regina, SK.

Saskatchewan Registered Nurses Association. (2016) RN Specialty Practices: RN Guidelines. Regina, SK

Lab Processes

Purpose:

There are several components to this lab processes procedure. The components covered within this procedure are communicating with the ordering health care provider and communicable disease coordinator, communicating with the lab you are taking specimens to, how to label specimens and requisitions, SDCL sample tote packing guidelines, and ordering supplies for testing. Note that there are separate procedures for the specifics about blood and urine collection; 7-0 and 8-0 respectively.

Procedure:

1. Communicating with the ordering health care provider

If Health Canada FNIHB MHO:

Have a conversation with the Health Canada FNIHB MHO first to discuss your intention to begin testing. You will need to obtain the MHO's full information to put on the requisitions.

A study number might be used on the requisitions, and that number would be unique to each community. The purpose of the study number is that when results are received at Regional Office, it will be absolutely clear where the client is from and where they were tested.

Otherwise, the results may not get back to regional office and/or regional office may be uncertain who tested them, even though the MHO is the ordering physician as the MHO gets cc'd on client results for First Nation clients. Results will be received at Regional Office and you would communicate with Regional Office to discuss the best way for you to receive them (Communicable Disease Coordinator).

If other ordering physicians/NP:

Have a conversation first to discuss your intention to begin testing. You will need to obtain the physician's full information to put on the requisitions.

All results will be received by the ordering physician or designate. Positive results will also be received by Regional Office.

2. Communicating with the lab you are taking the specimens to

You will need to find out local lab hours and specifically when they will receive specimens from you and when they will not.

They will typically want to be notified when you expect to have higher volumes of testing such as testing days because it could overload their capacity.

3. How to label specimens and requisitions

See SDCL Test Request & Sample Requirements Poster (see attached 2-0a).

4. SDCL Sample tote packing guidelines (see attached 2-0b).

5. Ordering supplies for testing

Supplies may be ordered from:

- Health Canada Drug Distribution Centre (DDC) 780-495-2200
- Saskatchewan Disease Control Lab (SDCL) 306-787-3131
- Stevens company
- Schaan Healthcare Products Inc.
- Local pharmacy or hospital

SAMPLE Phlebotomy and Urine Collection Supply List
Blood Collection set winged safe luer lock 21G x 3/4" (butterfly)
Bag TDG Biohazard small
Vacutainer EDTA holder
Alcohol swabs
Gloves (latex free)
Band-aids (latex free)
Cotton balls
Blue pads
Tourniquets (latex free)
Sharps container
Tube EDTA yellow 5 mL (may need lavender or green tubes for other testing)
TDG SAFTPAK small 1B ship kit
Sterile orange top 70mL urine containers
Gen-Probe Aptima urine collection kit for Chlamydia and Neisseria gonorrhoeae NAAT (From SDCL)
Lab requisitions: The requisition for urine for NAAT is the microbiology req, and the requisition for blood for HIV, hepatitis, and syphilis is the Chemistry and Immunoserology req. (From SDCL)

SDCL Test Request & Sample Requirements Poster

The quality and accuracy of laboratory results can only be assured when samples and test requests meet specific criteria for collection, labeling and sample integrity. The following are Saskatchewan Disease Control Laboratory's requirements:

1.1 Test Requests - The laboratory requires a written or an electronic request for all patient tests requests from an authorized person. An oral request can be accepted, but requires that a written authorization follow before the results are released by the laboratory.

The **requisition** must include the following information:-

- Ordering **Provider's Full Name** (Last Name, First Name & Initials) & **Address** (include MSB# & Clinic#)
- **Patient's Full Name** (Last Name, First Name & Initials) & **Address**
- **Unique Patient Identifiers** (i.e. HSN, Sex and date of birth)
- **Sample Information** including source (or type), date and time of collection, and additional relevant information as necessary for specific test to ensure accurate and timely testing and reporting of results (e.g. antibiotic therapy, clinical history)

If the laboratory transcribes or enters test requisition or authorization information, the laboratory needs to ensure that the information is transcribed or entered accurately (& attach original).

2.1 Samples – Refer to the collection information as given in the *SDCL Compendium of Tests* and the pictorial *Sample Transport Containers Available at the SDCL* on the website at www.health.gov.sk.ca/compendium.


Label the **sample** with the following information:

- **Patient's Full Name** (Last Name, First Name & Initials)
- **Unique Patient Identifiers** (i.e. HSN, date of birth)
- **Collection Information** (e.g. date and time of collection, initials of person who collected the sample)

3.1 Sample Rejection Criteria - Samples **will be rejected** for the following reasons: -

- Samples that **cannot be safely processed** by SDCL staff (e.g. container is cracked or broken or has leaked in transit)
- Samples that have been **improperly transported or packaged**
- Samples that have **improper collection or handling** (e.g. incorrect container or transport medium)
- **Missing information** as required to identify the patient and provider accurately

In the event that rejecting the sample could compromise patient care or the recollection of the sample causes the patient undue hardship, the laboratory will attempt to resolve any discrepancy within a reasonable confidence level. The laboratory would then require a signed waiver verifying the correct information be faxed to SDCL by the submitter.



The image shows an open sample tote. The top compartment contains a clear plastic sleeve with a paper clip. The bottom compartment contains a pink foam rack, a blue foam rack, and a yellow stopper. A red plastic tamper-proof fastener is also visible. Three text boxes provide instructions: 'Paper clip corresponding requisitions in same order as specimens in racks', 'Use Pink Foam Racks for all tests highlighted in pink', and 'Place all other specimens in Blue Foam Racks. Swabs in bags can be laid flat on top of foam blocks.'

SDCL Sample Tote Packing Guidelines

1. Do not place any labels on clear sleeves on tote
2. Ensure adequate amount of absorbent material
3. Locate first sample in lower left corner of rack and fill sequentially left to right, front to back
4. Paper clip requisitions in same order as samples
5. Place requisitions in waterproof bags
6. Group samples for the same patient
7. Ensure stoppers are above foam
8. Urines/swabs should be placed in suitable rack (Swabs in bags can be laid on top of foam blocks)
9. Use biohazard bags for sputum samples
10. Limit of 6 swabs per biohazard bag with requisitions in pouch
11. Fasten closed zipper with red plastic tamper proof "cynch lok®" on the exterior of the tote
12. Ensure if tote contains Outbreak/STAT/time sensitive samples it is fastened with yellow "cynch lok®" on the exterior of the tote
13. Please submit frozen samples separately in foam racks and send in suitable packaging

Procedure for Obtaining a Medical Lab License

Document 3-0

Date: November 2016

Developed by the STI Project Committee June 2012. Revised November 2016 by the RN Specialty Practice Working Group.

Purpose:

In Saskatchewan, the *Medical Laboratory Licensing Act* and Regulations require a license “where a test is performed or where a specimen is taken or collected” (Saskatchewan Ministry of Health, 2009). Therefore, to be able to provide lab services, a Medical Lab Licence must first be obtained from Laboratory Licensing, Saskatchewan Disease Control Laboratory. It is the employer’s responsibility to obtain and renew a lab license and the Community Health Nurse may be involved in the process.

Procedure:

1. Complete the lab licence application form *Application/Renewal for a Licence to Operate a Medical Laboratory* (Document 3-0a) and fax back to (306) 787-1525. Phone (306)787-3130 if you require further assistance. Renewals are completed on an annual basis. A renewal reminder is sent out approximately one month before renewal is due.
2. If the intent of the license is to provide outreach testing, specify “Outreach testing at ____” on the first page in the “type of licensee” section under Other.
3. Saskatchewan Ministry of Health Lab Licencing will review the application, and if approved the license and information will be sent back to the applicant. See attached samples of letter, license terms and conditions, and license (Document 3-0b).
4. The list of staff providing testing may be added to as needed.

Reference Documents:

Link to *The Medical Laboratory Licensing Act and Regulations*: <http://www.publications.gov.sk.ca/details.cfm?p=730>

APPLICATION/RENEWAL FOR A LICENCE TO OPERATE A MEDICAL LABORATORY
All sections of the application form are required to be completed prior to submission to the Ministry

New Application Date of Application/Renewal: ____/____/____
Renewal Licence # _____ MM DD YEAR

Laboratory Facility

Name of Facility _____ Telephone # _____
Street Address _____ Fax # _____
City _____ Postal Code _____ Email _____
Mailing Address (if different than above) _____
City _____ Postal Code _____
Regional Health Authority physically located in: _____

Type of Licensee

Individual Corporation Partnership
Regional Health Authority Provincial Government Canadian Blood Services
Hospital Other (please specify) _____

Licensee Information

Name _____ Telephone # _____
Mailing Address _____ Fax # _____
City _____ Postal Code _____ Email _____

If partnership or corporation - partners or directors:

Name _____ Title or Position _____
Mailing Address _____ Telephone # _____
City _____ Postal Code _____ Email _____

Name _____ Title or Position _____
Mailing Address _____ Telephone # _____
City _____ Postal Code _____ Email _____

Name _____ Title or Position _____
Mailing Address _____ Telephone # _____
City _____ Postal Code _____ Email _____

Ownership of Facility Premises

Does the Licensee own the premises? Yes No

If Licensee **does not** own the laboratory premises:

Lease expiry date: _____/_____/_____
MM DD YEAR

Premises Owner's:

Name _____ Telephone # _____
Mailing Address _____ Fax # _____
City _____ Postal Code _____ Email _____

Qualified Professional: (See Appendix A)

Name _____
Professional Qualification _____ Telephone # _____
Mailing Address _____ Fax # _____
City _____ Postal Code _____ Email _____

Main Laboratory Contact:

Name _____ Telephone # _____
Mailing Address _____ Fax # _____
City _____ Postal Code _____ Email _____

Signatures:

I/We, in applying for a licence to operate a medical laboratory, state that the information and data contained herein is correct.

I/We hereby authorize the Ministry of Health and the Accreditation Program to share, one with the other, any information possessed by the Ministry or the Program in relation to my/our provision of medical services in the past and future.

Signature	Name & Title (please print)	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Updated January 2013

IMPORTANT:

1. Complete the attached List of Tests.
2. Complete the attached List of Staff.

Licence # _____

Licence # _____

List of Staff

Last Name	First Name	Employment Start (MM/DD/YEAR)	Position <small>Location in laboratory/clinic</small>	Designation <small>Professional Qualification</small>	Cert. Year <small>Professional Qualification Year</small>	Educational Upgrades

Updated January 2013

Procedure for Sexual health program Orientation and Continuing Competency

Document 4-0

Date: November 2016

Developed by the STI Project Committee June 2012. Revised November 2016 by the RN Specialty Practice Working Group

Purpose:

Orientation for RNs who will be providing testing for STBBIs (sexually transmitted and blood borne infections) involves the provision of information and training on: assessment, education & counselling, testing procedures, lab protocols, partner notification, treatment and documentation.

Minimum requirements for RNs in Sexual Health Programs include annual SRNA licensure, certification in Transportation of Dangerous Goods every 3 years, CPR, and Phlebotomy training with an annual review.

Procedure:

1. The Nursing Supervisor/Manager or Designate reviews with the orientating nurse the content in the attached *RN Sexual Health Competency Program Checklist (5-0a)* and documents dates taught and dates observed. The RN Sexual Health Competency Program Checklist contains the minimum competencies that should be assessed. Employers may choose to adapt and add additional competencies if required.
2. The *RN Sexual Health Competency Program Checklist* is to be signed off by the Nursing Supervisor or Designate upon successful completion of content review/skills sessions with the nurse. The number of times a RN is to be observed performing skills depends on skill comfort and proficiency, but a minimum of three times is required.
3. The Nursing Supervisor or Designate will review nurse competency annually according to the Checklist.
4. RNs are also expected to read memos for updates to programming as they emerge and refer to the Saskatchewan CD Manual and Canadian Guidelines on Sexually Transmitted Infections for the most up to date and current guidelines.

References:

Battlefords Sexual Health Clinic. (2000). Procedure manual. Sexual health clinic orientation and certification.

Sexual Health Competency Checklist

For CHNs who are testing, treating, and providing contact tracing

(adapted from the BRT6 STI Clinic 2016 Competency checklist)

Registered Nurse: _____

Nursing Supervisor/Practice Evaluator(s): _____

Activity	Dates taught	Dates observed	Dates observed	Dates observed
General				
<input type="checkbox"/> Infection Control Guidelines <input type="checkbox"/> Transportation of Dangerous Goods certification <input type="checkbox"/> Confidentiality <input type="checkbox"/> Charting Laboratory Results		n/a	n/a	n/a
Client History & STI Risk Assessment				
<input type="checkbox"/> Obtains appropriate client history and assesses STI Risk: Last known date of STI testing? Positive for any? Any risk factors? Timeframe? Symptoms?				
Client Education and Counselling				
Client centered education and counselling: <input type="checkbox"/> Pre-test counselling <input type="checkbox"/> STI modes of transmission <input type="checkbox"/> Safer Sex <input type="checkbox"/> Harm reduction if applicable <input type="checkbox"/> Documentation on appropriate records				
Collection of Urine Specimens for Chlamydia, Gonorrhea, and other if required.				
Demonstrates correct techniques for urine specimen collection & transport: <input type="checkbox"/> Obtains informed verbal consent <input type="checkbox"/> Instructs clients on how to obtain a specimen <input type="checkbox"/> Documentation – specimen label, lab requisition, client forms & record <input type="checkbox"/> Referrals if symptomatic <input type="checkbox"/> Stores & Transports in accordance with SDCL/local lab policy and TDG guidelines				
Venipuncture & Blood Collection for Syphilis, HIV, Hep B & C, and other if required				
Demonstrates correct techniques for blood collection and transport: <input type="checkbox"/> Obtains informed verbal consent <input type="checkbox"/> Performs proper venipuncture for blood collection <input type="checkbox"/> Documentation - specimen label, lab requisition, client forms & record <input type="checkbox"/> Troubleshooting				

<ul style="list-style-type: none"> <input type="checkbox"/> Centrifugation if applicable <input type="checkbox"/> Stores & transports in accordance with SDCL/local lab policy and TDG guidelines <input type="checkbox"/> Referrals to lab if cannot obtain specimen <input type="checkbox"/> Completes a recognized course such as Saskatchewan Polytechnic Nursing 1681 Venipuncture <input type="checkbox"/> Completes "Blood Collection Competence Checklist" (document 6-0a) 				
HIV Rapid Point of Care (POC) Testing: When applicable				
<p>Demonstrates proper procedure for POC Testing:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pre and Post-test counselling <input type="checkbox"/> Quality control: performs controls, documents <input type="checkbox"/> Documentation: controls, kit inventory, testing log, specimens, client forms & record <input type="checkbox"/> Participates in Capillary Collection Training <input type="checkbox"/> Stores & Transports in accordance with SDCL/local lab policy and TDG guidelines <input type="checkbox"/> Collects confirmatory sample at the same time <input type="checkbox"/> Referrals <input type="checkbox"/> Completes 'Point of Care Orientation: Initial Competency Checklist & Annual Skills Review' (includes supervised performance) 				
Treatment and follow-up of Case and Contacts:				
<p>Provides appropriate counseling and treatment:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Post-test counseling <input type="checkbox"/> Verify contacts <input type="checkbox"/> Pregnancy testing if needed <input type="checkbox"/> Medical directives and RN clinical protocols for Treatment of Chlamydial and Gonococcal infections <input type="checkbox"/> Follow MHO direction for Syphilis treatment and follow-up if applicable <input type="checkbox"/> Referrals if needed <input type="checkbox"/> Documentation: client record, appropriate investigation form <p>Proceeds through partner notification process:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Informs a Contact of Exposure <input type="checkbox"/> Education, counselling and follow-up including treatment <input type="checkbox"/> Documentation: client record, appropriate contact referral form 				
Knowledge Check:				
<p>Public Health Agency of Canada: Canadian Guidelines on Sexually Transmitted Infections</p>		n/a	n/a	n/ah

Completion Date: _____
(YYYY/MM/DD)

Signature of CHN/PHN: _____

Signature of Nurse Supervisor/Evaluator: _____

Date of Review	Signature of Nursing Supervisor/Evaluator

Pre- and Post-test counselling

Document 5-0

Date: November 2016

Developed by the STI Project Committee June 2012. Revised November 2016 by the RN Specialty Practice Working Group

Purpose:

To provide parameters for consistent, comprehensive pre and post-test counselling for clients undergoing HIV testing.

Procedure:

1. RN's in Sexual Health programs shall be trained in pre and post-test HIV counselling. RNs will follow the most current pre and post-test counselling guidelines for HIV Testing. Refer to "Saskatchewan HIV Testing Policy In-Depth HIV Pre and Post-Test Counselling, Government of Saskatchewan, March 2015" (Document 6-0a), and "Saskatchewan HIV Testing Policy Routine Testing Quick Guide, Government of Saskatchewan, March 2015" (Document 6-0b).
2. For information on the current HIV test provided in Saskatchewan, nurses may read "Saskatchewan HIV Testing Policy HIV Diagnostic Lab Testing Flow Chart, Government of Saskatchewan, July 2016" (Document 6-0c).
3. Nurses wanting additional information regarding pre and post test counselling may read "HIV Screening and Testing Guide, Public Health Agency of Canada, 2012" which can be found at <http://www.phac-aspc.gc.ca/aids-sida/guide/hivstg-vihgdd-eng.php> and may attend the Saskatchewan HIV Collaborative course.
4. Nurses must document relevant information from pre and post test counselling sessions. Refer to sample STBBI Testing Form for pre test counselling (Document 5-0d).

References:

- Saskatchewan HIV Testing Policy. In-Depth HIV Pre and Post-Test Counseling. Government of Saskatchewan. March 2015.
- Saskatchewan HIV Testing Policy. Routine Testing Quick Guide. Government of Saskatchewan. March 2015.
- Saskatchewan HIV Testing Policy. HIV Diagnostic Lab Testing Flow Chart. Government of Saskatchewan, July 2016.
- Human Immunodeficiency Virus. HIV Screening and Testing Guide. Public Health Agency of Canada. 2012.

In-depth counselling is **not** required in all settings but **should** be offered when risk factors are identified and in settings with a broader Sexually Transmitted Infection (STI) mandate e.g. Sexual Health Clinics, youth settings, outreach clinics, etc.

Refer to Routine Testing Quick Guide for minimum pre-test counselling requirements - adequate in most settings.

Pre-test counselling - must include the 3 C's:

● **Confidentiality** ● **Counselling** – dependent on setting ● **Consent** – informed & voluntary

- **CONFIDENTIALITY:**

- **Nominal** (recommended), Non-nominal (use of code if client expresses concerns re: Nominal) and anonymous testing (available through Public Health in Prince Albert, Regina, and Saskatoon).
- HIV, like other communicable infections (Measles, Tuberculosis [TB], Chlamydia) is **reportable** to the regional Medical Health Officer.
- **Requirements** under *The Public Health Act, 1994*:
 - Completion of **Case Report Form**.
 - Assistance to ensure **notification of sexual and drug use partners** while maintaining confidentiality.
 - Assistance to address **disclosure** to future sexual partners.
- **Results** must be given in person except by prior arrangement in exceptional circumstances.

- **COUNSELLING: Pre-test education**

- **Testing Process:**
 - HIV basics - refer to Client Information Sheet.
 - **Routine testing complemented by Risk Based testing:**
 - unprotected sex (vaginal, anal and sometimes oral) with a high risk partner.
 - blood contact when sharing needles and other drug use equipment.
 - blood contact when sharing equipment used for tattooing, piercing or acupuncture.
 - Window Period (minimum 2 wks. but up to 3 mos. for 4th Generation Enzyme Immunoassay and Antigen [EIA]) - refer to Lab Testing Flow Chart.
 - Meaning of Positive/Indeterminate/Negative results.
 - Need for further testing.
- **Reasons** to be tested:
 - Allows earlier access to **services and care**.
 - Helps people to **live longer, healthier** lives with treatment.
 - Helps people become actively **involved** in their own care.
 - **Decreases worry** about possible infection.
 - Helps **prevent spread of HIV** to others.
 - **Decreases discrimination**.
 - **Avoids the need to identify risks** or exposures.
- **Potential risks** – inability to cope/suicide potential, risk of **violence/harm**.
“Is there any reason that it wouldn't be a good idea for you to get tested?”
- Develop plan to address concerns and plan for test in future.
- **Support, assistance, care and treatment options** are available and will be offered.
- When to return for results/**how client can be found** when results are ready.
- Assess **risk factors** and develop plan to **minimize potential for transmission** while awaiting results.

- Exploration of **supports** and ability to cope with a Positive result.
- **CONSENT**
 - **Verbal. Informed. Voluntary. Documented.**
 - Written consent not required. **Must document on patient record that consent was obtained or that client refused.**

The ability of a person (including a minor) to provide informed consent is determined by the extent to which the person's physical, mental, and emotional development will allow for a full understanding of the test, including the right to refuse. Refer to the College of Physicians and Surgeons of Saskatchewan's Policy on Determining Capacity to Consent at: <http://www.cps.sk.ca/Documents/Legislation/Policies/GUIDELINE%20-%20Determining%20Capacity%20to%20Consent.pdf>

Post-test counseling

NEGATIVE RESULT

- Give **result**.
- Review **risks, suspected/known exposures and time frames**.
- Review **need for further testing**:
 - At 4 weeks and 3 months after a known/suspected exposure.
 - Every 3-6 months for clients with on-going high-risk activities (above).
 - Every 12 months for clients who are sexually active.
- Reinforce **prevention and risk reduction (Harm Reduction)**.
- Provide prevention and risk reduction supplies as available.
- **Referrals** for support services/programs when needed.

POSITIVE RESULT

- **Prepare** before giving result (urgent but not emergent).
- Healthcare providers may choose to give the result to a client themselves or they may **contact Public Health** (or the Infectious Disease Clinic for In-Patients) to discuss:
 - **How** to give result to client.
 - Potential to have Public Health staff present/available.
 - Coordination of **referral** to Infectious Disease Clinic.
 - Specific **client needs/situations** eg. pregnant, addictions.
 - Coordination of **contact tracing** eg. sexual/drug use partners, children, anonymous contacts.
 - Assistance to complete **Notification Form**.
 - Plan to link to **support, care and treatment** services.
 - **What to say**:
 - **"You have tested positive for HIV."**
 - Answer unspoken question "Am I going to die?" **Provide hope**.
 - Address issues that are **priority to client** e.g. children, partners, job.
 - Get permission for referral to the Infectious Disease Clinic.

For more detailed information, including **SAMPLE SCRIPTS**, see BCCDC Communicable Disease Control Manual. Appendix 2, Chapter 5. Sexually Transmitted Infections. HIV Pre and Post Test Guidelines. September 2011. http://www.bccdc.ca/NR/rdonlyres/C0486576-7398-4630-B71C-31A0D5EAEBDC/0/STI_HIV_PrePost_Guidelines_20110923.pdf.

To access assistance with issues related to HIV testing or to reach your local Public Health/ Infectious Disease resources, call:

Insert Local Contact Information

WHY? 26% of HIV positive people are **unaware** of their status.¹

- In spite of The Joint United Nations Programme on HIV and AIDS (UNAIDS)/WHO 2004 recommendations, **people who should be tested are still being missed.**
- **Missed testing opportunities** when providers are required to determine need for testing based on risk.
- **Missed testing opportunities** when testing is mainly client-initiated.
- **Stigma and discrimination** will lessen when testing is routine.
- **To increase rate of testing, promote earlier diagnosis, improve treatment outcomes & reduce transmission.**

WHO?

- All patients aged 13 to 70 receiving primary or emergency health care who do not know their HIV status.
- All persons who are **sexually active with multiple/successive long-term partners** and have not had an HIV test in the last 12 months.
- All patients who have requested an HIV test.
- All **pregnant women**. HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women (Society of Obstetricians and Gynecologists of Canada [SOGC] , 2006). Repeat screening in the third trimester may be indicated based on clinical assessment and labor and delivery guidelines. (Morbidity and Mortality Weekly Report [MMWR] Recommendations and Reports, 2006) (SOGC , 2006).
- All patients **assessed in a sexually transmitted infection (STI) clinic** or seen in any health care setting for an STI or Hepatitis B or C.
- All persons with **current or past history of illicit drug use.**
- All persons **from endemic² countries.**
- All **tuberculosis (TB) patients (active and latent)** and contacts as indicated.
- All patients **showing signs/symptoms that may be consistent with HIV-related disease.**³

WHEN?

- Consider at least once every 5 years in all adults.
- Part of an annual exam.
- Whenever a risk is discussed.
- On a regular basis or with other blood work. Refer to time frames in "Negative Result" section.

¹ Public Health Agency of Canada, HIV/AIDS Epi Updates - July 2010, www.phac-aspc.gc.ca/aids-sida/publication/epi/2010/2-eng.php

² The Public Health Agency of Canada defines countries where HIV is endemic as those where the prevalence of HIV among people ages 15 to 49 years is 1.0% or greater and one of the following:

- 50% or more of HIV cases are attributed to heterosexual transmission;
- a male to female ratio of 2:1 or less among prevalent infections; or
- HIV prevalence greater than or equal to 2% among women receiving prenatal care.

³ https://www.escmid.org/fileadmin/src/media/PDFs/4ESCMID_Library/2Medical_Guidelines/ESCMID_Guidelines/2012_HIV_Indicator_Conditions_-_Guidance_for_Implementing_HIV_Testing_in_Adults_in_Health_Care_Settings_FINAL_version_2012-10-26.pdf

HOW?

Confidentiality Counselling – dependent on setting Consent – informed and voluntary

Written, signed consent is not required; however verbal, informed consent must be obtained and all care providers must document on patient record that verbal consent was/was not obtained.

Minimum information for consent:

- **Benefits** of testing.
- **Right to refuse.**
- **Availability of support, assistance, care and effective treatment options.**
- Information is kept strictly **confidential** throughout the testing process.
- HIV is **reportable** to the regional Medical Health Officer, who will assist with **partner/contact follow-up** and with responsibilities under *The Public Health Act* regarding **disclosure** to future partners.

The ability of a person (including a minor) to provide informed consent is determined by the extent to which the person's physical, mental, and emotional development will allow for a full understanding of the test, including the right to refuse. Refer to the College of Physicians and Surgeons of Saskatchewan's Policy on Determining Capacity to Consent at: <http://www.cps.sk.ca/Documents/Legislation/Policies/GUIDELINE%20%20-%20Determining%20Capacity%20to%20Consent.pdf>

HIV Client Information Sheet may be used to provide the above information. The practitioner simply confirms that the client understands the information, discusses any client concerns, obtains verbal consent and documents.

“Did you have a chance to look over the Information Sheet? Unless you'd like to discuss any questions first, I'm going to include a routine HIV test with your blood work today. HIV testing is now recommended for people 13 years and older, so I ask everyone.”

See In-depth HIV Pre- and Post-Test Counselling Guide for situations requiring more detailed information.



ORDER HIV SCREENING TEST

NEGATIVE RESULT

- Discuss result.
- Review **need for further testing:**
 - At 4 weeks and 3 months after a known/suspected exposure.
 - Every 3-6 months for clients with on-going high-risk activities.
 - Every 12 months for clients who are sexually active.
- Reinforce prevention and **risk reduction.**
- Offer **referrals** for support services e.g. prevention and risk reduction programs, addiction services, mental health services.

POSITIVE RESULT

- **Prepare** before giving result (urgent but not emergent).
- Protect the patient's **privacy** and **confidentiality.**
- Provide sufficient time to discuss the **impact of the positive result** and **ask questions.**
- Arrange for a **follow-up appointment.**
- Provide **risk reduction information** to prevent transmission of the virus.
- Work with the patient to discuss when, how and with whom to **disclose the positive test result** and develop a **partner notification strategy.** Contact Public Health to assist with **partner/contact follow-up.**
- Providers may also **contact Population/Public Health** (or the Infectious Disease Clinic for In-Patients) to assist with:
 - **Finding** patient.
 - **Referral** to Infectious Disease Clinic.
 - Specific patient needs/**situations** e.g. pregnant, addictions.
 - Completion of **HIV Case Report Form.**
 - **Linkage** to care, treatment and support services.

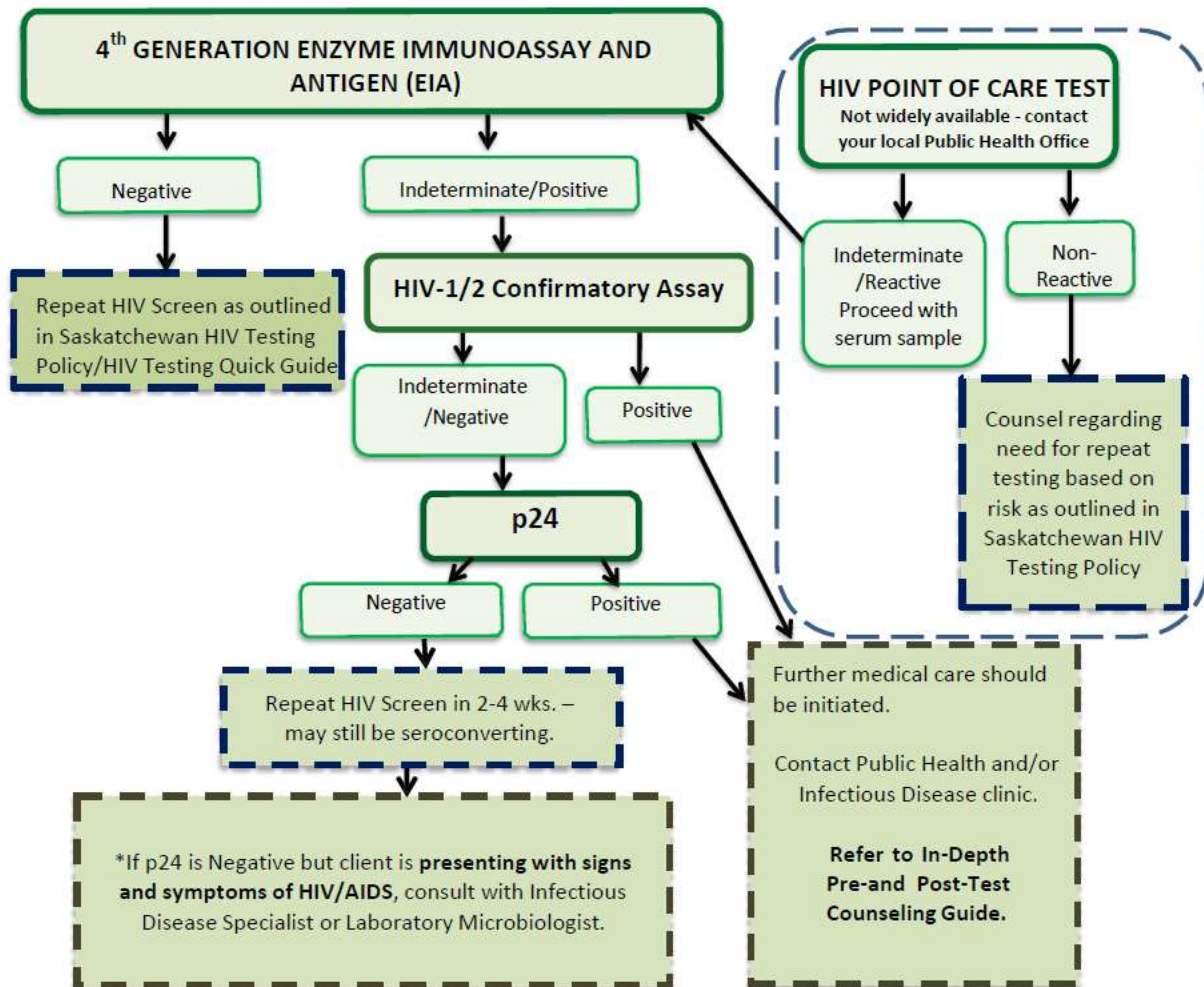
INDETERMINATE RESULT

Repeat test in 2-4 weeks, or consult with Infectious Disease Specialist or Microbiologist if client has signs and symptoms consistent with HIV infection.

Supplemental Information

Confirmatory testing is done automatically by Saskatchewan Disease Control Laboratory. Test providers are not expected to order or determine the need for confirmatory testing.

Test providers are expected to order repeat HIV Screen, Consult or Refer as indicated in the dotted boxes below.



For assistance with HIV testing or to reach your local Public Health/Infectious Disease resources, call HealthLine at 811.

HIV Testing in BC Resource Document for Health Professionals, June 2010.
Saskatchewan Disease Control Laboratory Newsletter, November 2012, Volume 1, Number 2

4TH GENERATION EIA TEST - COMBINATION (HIV 1 and 2) ENZYME IMMUNOASSAY and p24 ANTIGEN

- The basic screening test for HIV in Saskatchewan. **All further confirmatory testing is done automatically** by Saskatchewan Disease Control Laboratory as per Flow Chart.
- On **lab requisition, select "HIV Screen"**.
- p24 antigen component **may reduce the minimum** window period to 2 weeks post-exposure in some cases.
- p24 antigen component appears before antibodies, but **may not always be detectable**.
- For this reason, **A CLIENT WITH DEFINITIVE EXPOSURE TO HIV AND A NEGATIVE SCREEN AT 2-4 WEEKS MUST CONTINUE TESTING TO THE END OF THE 3 MONTH ANTIBODY WINDOW PERIOD** (or until positive, whichever comes first).

HIV-1/2 CONFIRMATORY ASSAY

- First confirmatory test to be run.
- Is considered "confirmatory" due to high specificity.

P24 ANTIGEN TEST

- A more specific version of the P24 test done as part of the EIA screen.

POINT OF CARE TESTING (POCT) USING INSTITEST

- POCT using InstiTest has been available at select sites in Saskatchewan since 2011.
 - Contact the local public health office in your area for more information.
- STAT Testing
 - In **Regina and Saskatoon** hospitals, STAT HIV Testing is run using **4th Generation EIA**.
 - In **other regional labs**, STAT HIV Testing is run using **InstiTest**.
 - In **some cases**, 4th Generation EIA (p24 antigen component) may detect new infections up to 2 weeks earlier than antibody test alone (e.g. InstiTest).

CLIENT IDENTIFICATION

- **NOMINAL**
 - Client's **full name and Health Services Number (HSN)** are on requisition.
- **NON-NOMINAL**
 - Optional method of client identification **if client has concerns**.
 - Includes first 2 initials of first name and first 2 initials of last name (**code**).
 - Must include **HSN and Date of Birth** to ensure correct identity. Will not be run without both.
- **ANONYMOUS**
 - Available in **Prince Albert, Regina and Saskatoon** through Public Health/Sexual Health Clinic.
 - Clients with **positive results must re-test** under name or code.

Date and location of testing:

Client name

Date of birth

SK health card number

Live on reserve? If yes, which one? House number?

Mailing address

Cell phone number

Other phone

Email

Tests we offer: HIV, Hepatitis B, Hepatitis C, Syphilis, Chlamydia, Gonorrhea.

Confidentiality: results known by testing physician/NP, MHO, public health (if positive)

How they are transmitted: All can be sexually transmitted, and HIV, hepatitis B and C can also be through blood, especially IDU.

Last tests for these?

Positive for any?

Is there any risk they are worried about? When was it?

Symptoms?

Condom useage? IDU?

What they would do if a positive result? What might you need from us?

Window Periods: 1-3 months HIV, Hep B/C 2-4 weeks, Syph 4 weeks, CT/GC 2wk, therefore re-testing may be required.

Process to receive results if negative, and if positive

Educate about ongoing safer sex and/or drug use, especially if they had a risk. Encourage them to tell their partners to get tested.

If positive Chlamydia, gonorrhea, syphilis all treatable. Free immediate treatment. We can have your results sent to physician or NP of your choice. Your sexual partners would need to be treated too. We would have to get names of contacts if positive for any of the tests so that they could be followed. Your name not used. Doing them a favor. HCV can be cured and HIV can be managed well and people can lead long healthy lives. Not death sentences. It is best to know your diagnoses. We would make referrals for you. And help guide you through those dx.

Did client consent to testing? Client has right to decline.

Tests done, Notes, and signature of health care provider

Venipuncture, blood collection, and centrifugation

Document 6-0

Date: November 2016

Developed by the STI Project Committee June 2012. Revised November 2016 by the RN Specialty Practice Working Group

Purpose:

To ensure proper collection and transportation of venous blood specimens.

Procedure for Venipuncture and Blood Collection:

Equipment

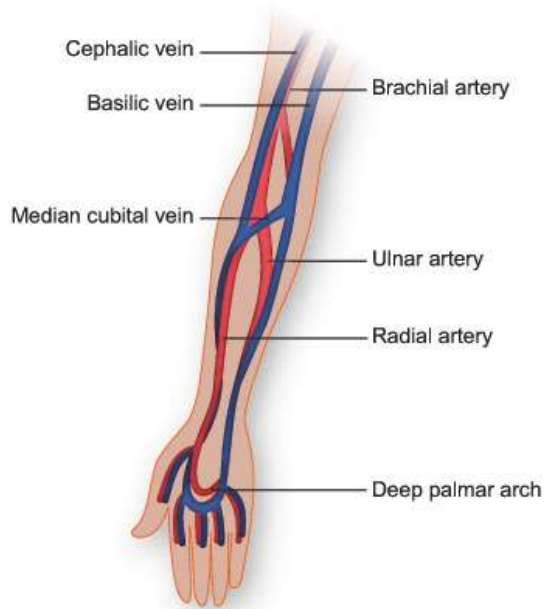
- Hand sanitizer
- Sharps container
- Disposable gloves and protective eyewear
- Vacutainer equipment: Vacutainer tubes, needle holder, sterile double needles (20-21 gauge for adults)*
- Alcohol swabs
- Rubber Tourniquet
- Cotton balls
- band-aid
- labels for each collection tube with the appropriate client information included
- lab requisition forms
- small pillow or folded towel to support the extremity, if needed

***Vacutainer Blood Collection System**

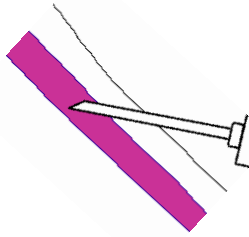
The Vacutainer system consists of a double-pointed needle, a plastic holder or adapter, and a series of vacuum tubes with rubber stoppers of various colors. The stopper colors indicate the type of additive present. The blood goes from the Client directly into the appropriate test tube.

Procedure

1. Properly identify and reassure client.
2. Perform hand hygiene & don gloves.
3. Prepare needle and vacutainer according to the procedure for currently used equipment (have extra vacutainer tubes at hand in case you have problems with original tubes). Check expiry date on vacutubes.
4. Client can be sitting or in supine position. Position client's arm: extend arm to form a straight line from shoulder to wrist. Place pillow or towel under upper arm to enhance extensions.
5. Select venipuncture site. The preferred site is the anecubital fossa—vein of choice is the median cubital vein. The cephalic vein has a tendency to roll and the basilica vein lies close to brachial nerve & artery so should be avoided. Determine the best puncture site by palpating the vein.



6. Check chosen vessel for a pulse. If a pulse is present, the vessel is an artery-DO NOT USE. Choose another site.
7. Apply clean tourniquet 7.5 cm (3 in.) above the elbow, or midway between the elbow and shoulder. Apply it with enough tension to compress the vein but not the artery.
8. Check for the radial pulse to make sure the arterial flow is not impeded. If no pulse is felt, release the tourniquet and reapply using less tension.
 - * Do not leave the tourniquet on for more than 1 minute while you search for a vein. If more than one minute passes, release the tourniquet for at least 3 minutes, then re-apply. If on too long, some blood test results may be altered.
9. Have client form a fist to make the veins more prominent.
 - * Do not have them “pump” their fist as it can alter blood sample results.
10. Feel for the vein. It will feel like an elastic tube that “gives” under the pressure of your finger. If it pulsates, then it is an artery so do not use.
11. Cleanse puncture site with alcohol swab using a circular motion (centre to outward) for about 5-7.5 cm from insertion site, and allow to air dry.
12. Not allowing enough time to air dry can cause client more pain after insertion and hemolysis (the destruction of red blood cells) due to residual alcohol).
13. Hold vein taut during the procedure.
 - Place your thumb about 2.5 cm below insertion site, press down on the arm, and at the same time pull the skin toward the hand.
 - The fingers of your hand should be around and underneath the client’s arm as you stretch the skin and vein taut.
14. Insert needle into vein with bevel up at about 15-degree angle to the skin, in a smooth motion. Do not hesitate.



15. As the needle enters the vein, you will feel a little “give”. Now decrease the angle of the needle and slide it further into the vein.
16. When in place, advance Vacutainer tube to puncture rubber stopper, keeping the needle as stable as possible.
17. Loosen tourniquet and have client relax fist. You should only have the tourniquet on for one minute total time.
18. Fill tube(s) – quantity depends on test(s).
19. Remove tube from holder to break the “vacuum”.
20. Invert (turn upside down and then to upright) BD SST tube 5 times according to BD Vacutainer Collection Tube Product Insert.
21. Remove needle and holder from client and dispose of needle in sharps container.
22. Apply pressure to vein with dry cotton ball as needle is removed. Apply pressure until bleeding stops.
23. Assess puncture site for clotting and apply band-aid over site.
24. Label the vacutubes, matching labels to requisition(s).
25. Sign requisition.
26. Allow blood to clot thoroughly before centrifugation, and centrifuge according to pages 7 & 8 of *BD Vacutainer Evacuated Blood Collection System Product Insert*.
27. Bag vacutubes & requisition.
28. Remove and dispose of gloves. Perform hand hygiene.
29. Document procedure in client record in the progress notes. Record the date and time of venipuncture, the site used for the procedure, any complications, and the tests obtained. Note the client’s reaction to the procedure and when specimen transport occurred. Document on appropriate flow sheet, if available.

Procedure for Centrifugation of Blood Samples:

1. Use a tiger top SST (serum separator tube) for obtaining specimens that require centrifugation (these are the samples being sent to virology).
2. Allow the specimen to clot by waiting 30 minutes. Specimens are centrifuged a minimum of 30 minutes after collection up to a maximum of 8 hours after collection.
3. Open the centrifuge by turning the latch counter-clockwise.
4. Insert the specimens in the appropriate blood tube holders and place the clear tube cap over the holder.
5. Balance the specimens by ensuring the specimens are placed across from each other. In the event of an unequal number of specimens, fill an empty tube with water to the level of the sample that is not balanced. Recap the tube and place it across from the specimen not balanced.

6. Turn the latch of the centrifuge lid clockwise to close.
7. Turn the time to 10 minutes. Centrifuge rotor speed is 3,500 rpm. The centrifuge will begin operation. Once the timer reaches zero, an audible bell will sound and the power will be cut to the motor and the rotor will coast to a stop. Do not open the lid until the rotor has come to a complete stop.
8. Remove the samples and place them in the refrigerator.
9. Notify the Nursing Supervisor in the event of any operation abnormalities, if a tube breaks or if there is any specimen leakage.
10. Provide maintenance and cleaning to the centrifuge as per operating manual.

References:

BD Vacutainer Collection Tube Product Insert.

Jantzen, D., & Molzan, A. (2009). In. P. A. Potter, A. G. Perry, J. C. Ross-Kerr, & M. J. Wood (Eds.), *Canadian fundamentals of nursing* (4th ed.). Toronto, Ontario, Canada: Harcourt Canada.

Kiechle, F. L. (2010). So you're going to collect a blood specimen: An introduction to Phlebotomy. 13th Edition. College of American Pathologists.

Regina Qu'Appelle Health Region Sexual Health Manual.

Saskatoon Health Region (2011). Sexual Health-Street Health Programs Policy & Practice Standards Manual. Centrifugation of Blood Samples. Policy number 80-40.

SKILL LEVEL	Comments:
VEIN ASSESSMENT	Comments:

_____ has met the above criteria attempts at venipuncture as determined and is deemed competent to perform phlebotomy.

Lab Phlebotomist Name: _____ Organization: _____ Signature: _____ Date: _____

Nurse Supervisor Name: _____ Nurse Supervisor Signature: _____
Date: _____

Collection and transportation of urine specimens

Document 7-0

Date: November 2016

Developed by the STI Project Committee June 2012. Revised November 2016 by the RN Specialty Practice Working Group

Purpose:

To ensure proper collection and transportation of urine specimens for Chlamydia trachomatis, and Neisseria gonorrhoeae. The specimens are collected in accordance with the most current procedures recommended by the Saskatchewan Disease Control Laboratory (SDCL) Compendium of Tests. SDCL performs Nucleic Acid Amplification Tests (NAAT) on the specimens.

Procedure:

Equipment

Urine container, Atima urine collection container, and pipette.

Procedure

1. Ideally, the client should not have voided for at least 1 hour prior to specimen collection. Recent voiding does not preclude testing. Instruct client not to cleanse area before voiding.
2. Ask client to collect only the first 20-30 mL of urine into the container and to cap it tightly. The urine collection cup should be free of any preservatives.
3. Wash hands and don gloves. Label urine container.
4. Transfer 2 ml of urine into Aptima collection tube and fill between the black lines only. Recap tube tightly. This must be done within 24 hours of specimen collection.
5. Label urine collection tube.
6. Store specimens between 2° and 30° C (room temperature) until time of transport to lab. Once in the transport tubes, specimens are stable at room temperature.
7. Ensure that the specimen label and the lab requisition have the correct information on them and are ready for transport. Include client's symptoms and date of illness onset (if relevant) on the requisition.
8. Specimens will be delivered using totes (provided by the lab) to the appropriate lab or hospital and then to SDCL. When using the SDCL specimen tote system, place the specimen urine tube into the foam racks. Specimens may also be placed in their own biohazard bag, separate from blood, with the requisition in the bag pouch, and then placed in packaging according to Transportation of Dangerous Goods procedure (hard sided cooler labeled appropriately).
9. Document procedure in client record in the progress notes. Record the date and time of urine collection, the tests obtained. Document on appropriate flow sheet, if available.

References:

Gen-Probe Aptima urine specimen collection kit package information (2016)

Saskatchewan Health (2016). Saskatchewan Disease Control Laboratory Compendium of Tests. Section: Virology. Chlamydia trachomatis Nucleic Acid Amplification Test (NAAT) Retrieved from <http://sdcl-testviewer.ehealthsask.ca/Home/Details?id=267>

Processing and transporting HIV and Hep C viral loads, CD4 and CD8 specimens

Document 8-0

Date: November 2016

Developed by the STI Project Committee June 2012. Revised November 2016 by the RN Specialty Practice Working Group

Purpose:

It is recognized that clients with HIV and Hepatitis C requiring ongoing follow-up will face barriers in relation to obtaining blood work. Follow-up blood work may be done in the community. However, to obtain reliable test results, there are specific guidelines with the collection and transportation of viral load specimens and for CD4/CD8 specimens. Following this procedure in conjunction with Transportation of Dangerous Goods (TDG) guidelines will ensure access to quality and safe ongoing follow-up bloodwork.

Procedure for HIV and Hepatitis C Viral load samples:

1. Collect blood in two vacutainers (may vary according to local lab) containing EDTA (lavender stopper). Ensure labels and requisitions are completed. Provide complete client information including Saskatchewan Health Services number and birthdate.
2. Communication with the nearest lab facility must be initiated to ensure time frames are met and to decide who will centrifuge the specimens.

Procedure for CD4/CD8 specimens:

1. Communication with the nearest lab facility must be initiated to ensure time frames are met. For example, days and hours that samples are accepted may vary. Ensure labels and requisitions are completed. Must provide complete client information including Saskatchewan Health Services number and birthdate.
2. Collect blood in 2 vacutainers (may vary according to receiving lab) containing EDTA (lavender stopper).
3. CD4/CD8 samples are not centrifuged; a whole blood sample is required.
4. Follow Transportation of Dangerous Good (TDG) Guidelines for transportation.

References:

Levett, P. & Kirsch, J. (May 7, 2012). Personal communication, e-mail.

Minielly, Della (2012). Lab supervisor for St. Paul's Hospital Lab. Personal communication, January 12, 2012.

Public Health Agency of Canada (2012). Pathogen Safety Data Sheets and Risk Assessment. Retrieved from <http://www.phac-aspc.gc.ca/lab-bio/res/psds-ftss/index-eng.php#h>

Saskatchewan Health (2011). Saskatchewan Disease Control Laboratory Compendium of Tests. HIV Viral Load, p. I 37, Hepatitis C Viral Load p. I 32.

Saskatoon Health Region. (2011). Centrifugation of blood samples. 80-40. Sexual Health-Street Health Programs Policy and Practice Standards Manual.

Saskatoon Health Region. (2011). Specimen transport to local laboratories. 80-50. Sexual Health-Street Health Programs Policy and Practice Standards Manual.

Saskatchewan Disease Control Lab (November 29, 2011). Personal communication with Nicki Coffin, Director of Immunology and Virology.

Spiritwood and District Health Complex Lab personnel (November 2011). Personal communication.

Transportation of Dangerous Goods Nurses Manual. Version 10, 2008. Office of Laboratory Security, Public Health Agency of Canada.

HIV Point of Care (rapid) testing

Document 9-0

Date: November 2016

Developed by the STI Project Committee June 2012. Revised November 2016 by the RN Specialty Practice Working Group

Background:

Point of care (POC) Rapid Testing of HIV refers to the practice undertaken by health care professionals of providing pre-test counselling, post-test counselling and a preliminary HIV antibody result within minutes, outside of a designated laboratory. The current standard method of HIV diagnosis (Genieus confirmatory assay or p24 antigen) can take several days for result availability. The use of the POC Rapid Testing of HIV attempts to address this delay by providing preliminary antibody results in minutes. This test is beneficial in situations where immediate knowledge of patient's HIV status is considered important, and where the client chooses this method of testing following adequate counselling.

HIV POC Rapid Tests are not reliable for those individuals who are in the HIV seroconversion stage (window period). HIV POC Rapid testing in Saskatchewan currently utilizes a test kit (INSTI HIV-1 Rapid Antibody Test) licensed by Health Canada. All test results are considered preliminary. HIV POC Rapid testing is not designed for screening the general population; it is to be used to screen patients at high risk for HIV.

Point of Care Rapid Testing for HIV can contribute to: preventing new HIV infections; reducing the number of HIV individuals who are unaware of their status; and promoting linkage of HIV positive individuals to care.

Purpose:

To provide a guideline for health centres who will be carrying out HIV Point of Care (POC) Rapid Testing.

Procedure:

1. The health centre staff should follow the steps as outlined in the Saskatchewan Disease Control Lab (SDCL) document called "Instructions on how to set up an HIV Point of Care (POC) Site in Saskatchewan (SDCL, 2016)". Those steps are integrated into this procedure.
2. Facilities providing HIV POC testing require a qualified professional (QP) who oversees:
 - Pre and post test counselling
 - Training
 - Competence
 - Quality control
 - External quality assessment (EQA)
 - Documentation

3. HIV POC sites should be able to support the administration of HIV POC testing and need a Standard Operation Procedure (SOP); a set of instructions that describe the entire HIV POC testing process. Help developing your SOP is available at <http://sdcl-testviewer.ehealthsask.ca> – under Requisition click on Generic format for INSTI HIV-1-HIV-2 Antibody Test Kit BioLytical Laboratories August 2016.
4. A medical laboratory license is required from the Ministry of Health (MOH). To obtain or add to a current license, complete the online application at:
<http://www.publications.gov.sk.ca/details.cfm?p=68452&cl=2>.
5. The medical laboratory license must be approved by the MOH prior to testing and obtaining the HIV POC testing kits from the Saskatchewan Disease Control Laboratory (SDCL).
6. Call SDCL 306-787-3192 to receive a supply requisition for ordering HIV POC testing kits and controls. A copy of your approved medical laboratory license must accompany the requisition to SDCL. A document is provided for the facility records that the kits have been validated by the SDCL.
7. For training, consider making arrangements with the nearest HIV POC site, or STI clinic, or with Biolytic directly.

Nurses who will be administering HIV POC Rapid tests must complete the attached *Point of Care Rapid Test Orientation: Initial Competency Checklist & Annual Skills Review (10-0a)*. Once the checklist is completed and the nurse is deemed competent to perform POC testing independently, the Nursing Supervisor or Designate will sign.

8. The nurse is required to complete the *Point of Care Rapid Test Orientation: Initial Competency Checklist & Annual Skills Review* on an annual basis.
9. The most current Saskatchewan Ministry of Health Guidelines, *Guidelines for the Use of HIV Point of Care (POC) Test Kits in Saskatchewan* (March 2014) are to be used for clinic protocol for HIV POC rapid testing procedure, pre- and post-test counselling, and quality control. In addition, the nurse should refer to the INSTI HIV-1 Antibody Test Kit product insert and the Biolytical online training video at <http://www.biolyticalcanada.com/>
10. Once training is complete contact SDCL for an evaluation panel.
11. Upon successful completion of the evaluation, results are shared with the Laboratory Quality Assurance Program (LQAP), College of Physicians and Surgeons of Saskatchewan (CPSS).
12. LQAP will contact the QP to arrange EQA (the site is responsible for the cost of the EQA).
13. For additional information access the CPSS General Policy #7, Point of Care Testing Policy #1 and Point of Care Testing Policy #2 found on pages 6-9 at:
<http://www.cps.sk.ca/imis/Documents/2016%20Laboratory%20QA%20Policy%20Manual.pdf>

14. All sites will be using HIV POC kits with the same lot number. SDCL provides each site with documentation that the HIV POC lot number has been validated for your records. You must notify the Immunoserology Section of SDCL of invalid kit results.
15. HIV POC Rapid testing sites MUST submit both positive and negative samples to Saskatchewan Disease Control Laboratory for confirmatory testing.
16. The use of HIV POC Rapid test kits must include pre- and post-test counselling, and should only be implemented after informed consent has been obtained from the client.
17. The nurse must document in the client record and on the appropriate forms (see above 3.0 SOP for online forms).

References:

Saskatchewan Ministry of health. (2014). Guidelines for the use of point of care (POC) HIV test kits in Saskatchewan.

Saskatchewan Disease Control Lab (2016). Instructions on How to Set Up an HIV Point of Care (POC) Site in Saskatchewan.

Biolytical Laboratories. Online training video at <http://www.biolyticalcanada.com/>

Pregnancy testing and counselling

Document 10-0

Date: November 2016

Developed by the STI Project Committee June 2012. Revised November 2016 by the RN Specialty Practice Working Group

Purpose:

To offer and provide pregnancy testing and counselling in a consistent and comprehensive manner for clients that present to the Sexual Health Program.

Procedure:

1. Before testing, counsel client on potential outcomes of test results.
2. The pregnancy test is performed using a urine sample according to the product monogram. To improve the accuracy of the test, it should ideally be performed on a specimen collected with the first void of the day (morning), at least one day after missed period.
3. Counselling should be provided to inform client of options and explore support system.
4. Document appropriately.
5. Refer to appropriate agency and health care provider if follow up care is required.

References:

Battlefords Sexual Health Clinic. (2000). Procedure manual. Pregnancy testing and counselling and Pregnancy testing & counselling form.

Condom distribution

Document 11-0

Date: November 2016

Developed by the STI Project Committee June 2012. Revised November 2016 by the RN Specialty Practice Working Group

Purpose:

To define the parameters of condom distribution.

Procedure:

1. Nursing staff may distribute a variety of condom supplies upon client request.
2. This is done in conjunction with information and education on safer sexual practices.
3. Condoms are distributed directly to the client or indirectly through an intermediary person.

References:

Battlefords Sexual Health Clinic. (2000). Procedure manual. Condom distribution

Fibroscan

Document 12-0

Date: November 2016

Developed by the RN Specialty Practice Working Group November 2016

Purpose:

To outline guidelines regarding the use of Fibroscan.

Procedure:

1. Fibroscan is a RN Specialty Practice Procedure which requires a client specific order (if not included in a Medical Directive and RN Clinical Protocol) and additional education.
2. In order to operate Fibroscan, RNs must receive training and certification from the Fibroscan manufacturer and follow procedure as per manufacturer.
3. Fibroscan results must be interpreted by the ordering Primary Care Provider/Infectious Disease Specialist.

References:

Echosens (Fibroscan manufacturer) website: <http://www.myliverexam.com/en/lexamen-fibroscan.html>

Mobile Clinics

Document 14-0

Date: November 2016

Developed by the STI Project Committee June 2012. Revised November 2016 by the RN Specialty Practice Working Group

Purpose:

To make services available to those unable to access the clinic site.

Procedure:

1. Mobile clinics to be held as needed under the direction of the FNIHB Medical Health Officer (MHO).
2. Lab license must be obtained as per Lab Process 3.0.
3. Community Health Nurses (CHNs) in sexual health programs may offer urine and blood testing for STBBIs, treatment for STIs, condom distribution, counselling, and pregnancy testing in mobile clinics.
4. See Procedure 2.0 for a list of suggested supplies and equipment.
5. Other CHN activities such as immunization may be provided in mobile clinics. An anaphylaxis kit must be readily available.
6. Personnel transporting samples must have Transportation of Dangerous Goods certificate and appropriate containers for transport.
7. CHNs in the community may assist with follow up of results.

Appendix D – Know Your Status Clinical Form



Client Care Flow Sheet

	Allergies:				
HIV HISTORY					
Risk Factors: <input type="checkbox"/> IDU <input type="checkbox"/> Heterosexual <input type="checkbox"/> MSM <input type="checkbox"/> Other					
HIV POC Testing date:			<input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive <input type="checkbox"/> Indeterminate		
Date of HIV Confirmation Dx:			Confirmation on File: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of Hep C Confirmation Dx:			Confirmation on File: <input type="checkbox"/> Yes <input type="checkbox"/> No		
HIV Laboratory Testing (CD4 & VL q3-4 months or as indicated)					
DATE TEST					
CD4					
CD4%					
VL					
ANTIRETROVIRAL (ARV) THERAPY HISTORY					
ARV Medication	Start Date	Stop Date	Reason for Discontinuation		
BASELINE BLOOD WORK/SEROLOGY TESTS					
TEST	DATE	RESULT	TEST	DATE	RESULT
HBsAg			CMV		
HBsAb			TOXO		
Hep A IgM			HSV-1		
Hep A IgG			HSV-2		
Hep C Ab			VZV		
Hep C PCR			MAC		
Hep C GT			SYPHILLIS		
TEST	DATE	RESULT	Other TEST	DATE	RESULT
HIV Ab			CXR		
HIV GT			PAP Test		
HLA-B*5701			Liver U/S		
			Liver Fibroscan		



Client Care Flow Sheet

IMMUNIZATION (Determine use of immunization in relation to CD4 count, refer to SIM)			
Vaccines	Guidelines	Date	Notes (e.g. Immune, Declined etc...)
Hep A - #1	For those susceptible 3 doses required		
Hep A - #2			
Hep A - #3			
Hep A titre			
Hep B - #1	For those susceptible. Double regular dose for each vaccine. Refer to SIM Guidelines.		
Hep B - #2			
Hep B - #3			
Hep B Titre			
Pneumovax	All at baseline & repeat once after 5 years	#1	
		#2	
Tdap (Boostrix)	Routine booster q 10 years	#1	
		#2	
Influenza	Annually		
TST	Annually		
OTHER MEDICAL/SIGNIFICANT CO-MORBIDITIES			
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Bone Disease	<input type="checkbox"/> COPD/Asthma	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Depression	<input type="checkbox"/> Psychiatric Dx	<input type="checkbox"/> Other _____	
CURRENT COMPLAINTS			
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Headaches	<input type="checkbox"/> Falls	
<input type="checkbox"/> Change in eating habits	<input type="checkbox"/> Fever	<input type="checkbox"/> Changes in Strength	
<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Chills	<input type="checkbox"/> Numbness	
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Pain	
<input type="checkbox"/> Unexplained Weight Loss	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Chest Pain	
<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Swollen Lymph Glands	<input type="checkbox"/> Cough	
<input type="checkbox"/> Sores in Throat or Mouth	<input type="checkbox"/> Seizures/Tremors	<input type="checkbox"/> Shortness of Breath	
<input type="checkbox"/> Changes in Hearing	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Skin Changes/Rashes	
<input type="checkbox"/> Change in Vision	<input type="checkbox"/> Change in Balance	<input type="checkbox"/> Edema	
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Gums Bleeding	<input type="checkbox"/> Other	
Comments: _____			

Appendix E

**Appendix E – Listing of Saskatchewan National Native Alcohol and Drug Abuse Program
(NNADAP) In-Patient Treatment Services**

Saskatchewan NNADAP Treatment Services

Armand Bekkata Treatment Centre
Box 5010 Clearwater River, SK S0M 3H0
Phone: 306-822-2033
Fax: 306-822-2750
Email: crdntc@sasktel.net

Athabasca Health Authority Outpatient Program
Box 162 Black Lake, SK S0J 0H0
Phone: 306-284-2124
Fax: 306-284-2173
www.athabascahealthauthority.ca

Cree Nations Treatment Haven
Box 340 Canwood, SK S0J 0K0
Phone: 306-468-2072
Fax: 306-468-2758
Email: cree.nations@sasktel.net

Ekweskeet Healing Lodge
Box 280 Onion Lake, SK S0M 2E0
Phone: 306-344-2054/2380
Fax: 306-344-4805
Email: ekweskeet@sasktel.net

Mistahey Musqua
Box 404 Loon Lake, SK S0M 1V0
Phone: 306-837-2184
Fax: 306-837-4414
Email: mistahey.musqua@sasktel.net

Sakwatamo Lodge
Box 3917 Melfort, SK S0E 1A0
Phone: 306-864-3631
Fax: 306-864-2204
Email: sakwatamo@sasktel.net

Saulteaux Healing and Wellness Centre
Box 868 Kamsack, SK S0A 1S0
Phone : 306-542-4110
Fax: 306-542-3241

Appendix F – Income Assistance Medical Report Form and Instructions



Indigenous and Northern Affairs Canada / Affaires autochtones et du Nord Canada

Medical Report

Notes to Examining Medical Practitioner or Health Care Professional

1. Unless specifically requested by Indigenous and Northern Affairs Canada, via an Income Assistance Administrator, the cost of this examination is the responsibility of the applicant/client.
2. Please return the completed form to: _____

Date issued: ▶

Year	Month	Day
------	-------	-----

 IA Administrator to provide name above (▲) and indicate on (◀) the left the date this form was issued to the client.

Client Consent:

I hereby authorize any health care professional who has observed or attended me, to give full information regarding my condition including history, consultation reports, and diagnosis, to Indigenous and Northern Affairs Canada and the individual identified above (note #2), for the purpose of determining my eligibility for federally-funded IA benefits.

Date: ▶

Year	Month	Day
------	-------	-----

 ▲ Signature of Client ▲ ▲ Trustee (where applicable) ▲

▲ Name of Patient ▲		▲ Age ▲	▲ Sex ▲
Date of Birth		Year	Month Day
▲ Address of Patient ▲		▲ Examining Medical Practitioner ▲	
How long has this patient been under your care? ▲		▲	

SAMPLE ONLY

Diagnosis and History

1. Does this patient have a **short term** illness or condition (under 12 months)? Yes No

Diagnosis: _____
OR

2. Does this patient have a **prolonged** physical or mental condition (over 12 months) as defined in Chapter 7, Section 7.7.2 a) of the Social Programs Policy Manual? Yes No

If YES to either question above, please explain below.

3. Does the patient's condition limit employment or training capacity? Yes No

Treatment: _____

Prognosis: _____

4. Present medication: _____
If any of the above medications affect the patient's activities, please explain below:

SUBJECT: Instructions: Medical Report

APPENDIX
5

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2

5. If the patient is not able to work at this time, when can he/she be expected to be ready for work? (Approximate number of days, weeks, or months) _____.

Can the patient return to former occupation? Yes No

If Yes, are there any restrictions? Please describe below:

If No, please indicate the reason below:

6. Is the patient capable of any other work? Yes No

If Yes, what type of work?

If No, why is the patient not capable of work?

7. Does the patient have an addiction problem? Yes No

Do you believe the patient would benefit from addiction treatment? Yes No

If Yes, please indicate where you will be referring him/her: _____

SAMPLE ONLY

Special Diet

8. If the patient is pregnant, expected birth date: _____

9. Does the patient's child require infant formula? Yes No

If Yes, name of formula: _____ Number of months required: _____

If No, does the patient require a lactation diet: Yes No

10. The following list includes commonly prescribed special diets where expenses exceed normal food costs.

If a special diet is required, please check **one** of the following:

High Protein for **acute conditions where treatment is intensive** and for a specific time period.

Number of months required: _____

Caloric Level (**Please circle reason**) diabetes, weight reduction, modified fats.

Daily Calories: 1900 - 2499 2500 - 2999 3000 + **Length of time required** _____

Food Supplement (Boost, Ensure, etc.) **for specific condition and time period.**

Name of supplement: _____

Number of cans/day: _____ Length of time required: _____

Dialysis

Chronic Disease – includes Hepatitis C, HIV, AIDS, Sickle Cell Anemia, Cystic Fibrosis.

Other (describe) _____

I _____ am a _____ licensed to practice in Saskatchewan.
(print health professional's name) (professional discipline)

Address: _____

This report contains my clinical assessment and considered opinion at this time.

Signature: _____

INDIGENOUS & NORTHERN AFFAIRS CANADA - SASKATCHEWAN REGION		FEDERALLY-FUNDED INCOME ASSISTANCE	
SUBJECT:	Instructions: Medical Report	APPENDIX 5	PAGE 3

MEDICAL REPORT

This report is to be **fully completed** by a Medical Practitioner in order to assist with verifying a client's eligibility for federally-funded IA due to medical reasons which are of a long-standing nature. In this case, a *Medical Report* is to be obtained at least once every twelve (12) months.

This report is also used:

- When an applicant is applying for IA in situations of temporary illness or injury (the illness or injury must be identified with a time frame of when the applicant can be expected to return to his/her normal occupation or other employment);
- To verify pregnancy;
- To verify a client's need for a lactation diet;
- To verify special diet requirements;
- To verify any other special medical circumstances;
- To verify a client's disability status.

When a client is diagnosed by a Medical Practitioner as having a permanent disability, ongoing medical reports are not required (see Chapter 2, Section 2.1.7 e)).

It is the applicant's/client's responsibility to have the form fully completed, signed and dated by his/her Medical Practitioner.

Instructions for completing a *Medical Report* form:

The IA Administrator is to provide his/her name in the space provided beside note #2 at the top of the form. The date on which this document was provided to the client is indicated by the IA Administrator in the space labeled "Date issued".

The IA applicant/client must read and understand the consent statement and provide his/her signature and date in the space provided indicating his/her agreement to releasing the requested medical information.

The Medical Practitioner or Health Professional completes the remaining portion of the form with appropriate responses.

To assist the Medical Practitioner or Health Professional with accurately completing this form, the following excerpt is replicated here from Chapter 7 of the Social Programs Policy Manual:

INDIGENOUS & NORTHERN AFFAIRS CANADA - SASKATCHEWAN REGION		FEDERALLY-FUNDED INCOME ASSISTANCE	
SUBJECT:	Instructions: Medical Report	APPENDIX 5	PAGE 4

7.8.1 Granting Criteria

- a) Monthly allowances over and above the Adult Allowance may be approved for a special diet only on the written recommendation of a physician (i.e. Medical Doctor; General Practitioner) or a medical practitioner or a health professional (dietitian; nutritionist; community health nurse; other medical specialist) as specified in e), f) and g) below:
- b) A parent caring for a dependent child is eligible to receive a special diet rate for the child when it has been medically determined that the child requires a special diet.
- c) **The nature and duration of the special diet must be specified on a *Medical Report* (See Appendix 5) unless indicated otherwise below.**
- d) Special diet allowances may be paid according to the rate schedule in Section 7.8.2 or as per actual costs established by a dietitian or nutritionist. In cases where actual costs are paid, receipts must be provided by the client within thirty (30) days of issuance.
- e) A dietitian or nutritionist may identify a client's diet needs upon the recommendation of a physician. In situations where client access to a physician is limited or non-existent (i.e. in northern remote communities), the client's diet needs may be identified by a medical practitioner or other health professional.
- f) Pregnancy diet may be provided based on the written recommendation by a physician or other health professional (not necessary to use *Medical Report* for verification). Pregnancy must be verified in writing in order to be acceptable.
- g) Lactation diet may be provided based on the written recommendation of a physician or other health professional (not necessary to use *Medical Report* for verification).

7.8.2 Special Diets Rates

- a) The following rates are provided for commonly prescribed special diets where the expenses exceed ordinary food costs and the actual costs are not know.

Special Diet Rates	Cost Per Month
Calories (all age groups) – for diabetes, weight reduction and modified fats (low cholesterol)	
1900 – 2499	\$27.00
2500 – 2999	\$42.00
3000 +	\$75.00
Dialysis – for persons receiving regular dialysis treatments	\$35.00
High Protein - for acute conditions where the treatment is intensive and for a specified period of time	\$53.00

September 2016

INDIGENOUS & NORTHERN AFFAIRS CANADA - SASKATCHEWAN REGION		FEDERALLY-FUNDED INCOME ASSISTANCE	
SUBJECT:	Instructions: Medical Report	APPENDIX 5	PAGE 5

Pregnancy - may be provided as soon as pregnancy is verified by a physician or health professional	\$48.00
Lactation - may be provided upon verification by a physician or health professional	
Chronic Disease (includes food supplements)	\$140.00

- b) Chronic disease includes but is not limited to: Hepatitis C; Human Immunodeficiency Virus (HIV); Acquired Immune Deficiency Syndrome (AIDS); Sickle Cell Anemia; and Cystic Fibrosis.
- c) Clients diagnosed with a chronic disease and identified as requiring a special diet can be issued the actual costs for bottled water in addition to the special diet rate.
- d) When more than one diet is prescribed, only the higher cost diet is provided.
- e) Funds for a special diet are not provided to a client in a hotel or emergency shelter, except when food supplements are medically required.
- f) Funds for a special diet are not provided to a client receiving a LOC allowance, except when tube feeding is medically required. For these clients, the actual cost for food used for tube feeding products minus \$120.00 is provided.
- g) For a client in a Community Living Service Delivery (CLSD) group home, the total amount for the special diet minus \$140.00 is provided.

7.8.3 Special Diets for Those Unable to Eat Solid Food

- a) The following deductions are made for infants, children and adults who require special products as they are unable to eat solid food:
 - i) **Child(ren) Special Diet**
The actual cost of the special diet (including infant formula) in excess of \$70.00 per month is provided. Receipts must be provided to the IA Administrator identifying \$70.00 was exceeded.
 - ii) **Adult Special Diet**
The actual cost of the special diet in excess of \$120.00 per month is provided in addition to the Adult Allowance. Receipts must be provided to the IA Administrator identifying \$120.00 was exceeded.

7.8.4 Food Supplements

- a) Food supplements (e.g. Boost, Ensure) are enriched food products prescribed by a physician for a specific condition for a specific time period (e.g. Crohn's

INDIGENOUS & NORTHERN AFFAIRS CANADA - SASKATCHEWAN REGION		FEDERALLY-FUNDED INCOME ASSISTANCE	
SUBJECT:	Instructions: Medical Report	APPENDIX 5	PAGE 6

disease, malabsorption problems, etc). Supplements are considered a special diet.

- b) The actual verified cost of food supplements may be provided to a client if:
 - i) The above mentioned enriched food products have been prescribed by a physician or a dietitian/nutritionist on the recommendation of a physician;
 - ii) The specific condition is identified on a *Medical Report*;
 - iii) The time-period this diet is required is specified on a *Medical Report*.

Appendix G – 90-90-90 Surveillance

The UNAIDS 90-90-90 Targets Saskatchewan and National Indicators for 2014

December, 2016

The Joint United Nations Programme on HIV/AIDS (UNAIDS) has set a global goal to end the AIDS epidemic as a public health threat by 2030. To monitor progress towards this goal, UNAIDS established “90-90-90” treatment targets for 2020:

- 90% of people living with HIV are diagnosed;
- 90% of those diagnosed are on treatment; and
- 90% of those on treatment are virally suppressed.

Saskatchewan’s and Canada’s Progress Toward Reaching the UNAIDS Targets

Provinces and territories, including Saskatchewan, contributed data to the initiative of the Public Health Agency of Canada (PHAC) to monitor Canada’s progress in achieving the UNAIDS global goal. PHAC released a public report on December 1, 2016 that provided national results on the 90-90-90 targets for 2014. **Table 1** provides the 90-90-90 indicators for Saskatchewan and Canada for 2014.

Table 1: Provincial and National 90-90-90 Indicators for 2014

	Saskatchewan		Canada ¹	
	Estimate	Range ²	Estimate	Range ²
Number of people living with HIV ³	2,309	2,000 – 2,600	65,040	53,980 – 76,100
Number of people living with HIV who are diagnosed ⁴	1,588	1,491 – 1,685	52,220	47,230 – 57,440
First 90: Proportion of people living with HIV who are diagnosed ⁴	69%	61% – 79%	80%	73% – 87%
Number of people diagnosed with HIV who are on treatment ⁵	1,237	N/A	39,790	36,470 – 43,140
Second 90: Proportion of people diagnosed with HIV who are on treatment ⁶	78%	73% – 83%	76%	70% – 82%
Number of people on treatment with a suppressed Viral Load ⁷	981	N/A	35,350	32,430 – 38,260
Third 90: Proportion of people on treatment who have suppressed Viral Load ⁸	79%	70% – 88%	89%	84 – 93%

¹ <http://www.healthycanadians.gc.ca/publications/diseases-conditions-maladies-affections/hiv-90-90-90-vih/index-eng.php>

² The provincial reportable disease system, similar to most other jurisdictions, does not record previously diagnosed HIV positive individuals who move into the province. Similarly, HIV positive residents who move out of the province are also not tracked. Although deaths from HIV and AIDS tend to be reported to the province, mandatory reporting of deaths due to notifiable diseases did not come into effect until 2015. For these reasons, an actual number for those living with HIV or diagnosed to have HIV cannot be obtained; a range was estimated and the midpoint used for the indicator calculations

³ Calculations are based on PHAC modeling for the period ending December 31, 2014.

⁴ Calculation: $\frac{\text{Number of persons living with HIV who are diagnosed}}{\text{Number of persons living with HIV}}$ X 100 (based on PHAC estimates)

⁵ Number of people diagnosed with HIV with at least one prescription filled for HIV medications in 2014 (*Drug Plan and Extended Benefits Branch*)

⁶ Calculation: $\frac{\text{Number of persons diagnosed with HIV on treatment}}{\text{Number of persons living with HIV who are diagnosed}}$ X 100

⁷ Number of people with at least one prescription filled for HIV medications with Viral Load considered to be suppressed (no longer or unlikely to transmit HIV) in 2014 (*Saskatchewan Disease Control Lab data*)

⁸ Calculation: $\frac{\text{Number of persons with a suppressed HIV viral load}}{\text{Number of persons diagnosed with HIV on treatment}}$ X 100

The national results should be interpreted with caution as data completeness, data sources, methods and definitions differ from province to province, as well as from country to country. These indicators are a starting point to monitor our progress, recognizing that the data and methods used to calculate the indicators will be refined and improved in the future.

The ranges of Saskatchewan's 90-90-90 indicators and the national indicators overlap, making it difficult to determine if Saskatchewan's indicators are lower than the national indicators. However, we know that Saskatchewan faces risk factors and circumstances that create barriers for individuals to access HIV testing, care and treatment. These risk factors and circumstances include:

- high rates of HIV transmission amongst those who self-report Aboriginal ethnicity and the stigma and discrimination that prevent and delay these individuals from accessing services;
- high rates of drug addiction that contribute to transmission through injection drug use;
- geographical challenges for rural and remote residents to access services; and
- mobility, which leads to individuals being "lost to follow up".

Provincial Efforts to Reach the 90-90-90 Targets

Initiatives to increase awareness of HIV and to increase testing will continue to be key interventions to improving our provincial indicators. It is important for individuals to know their HIV status in order to make informed choices about what is best for their health. Injection drug use is a primary driver of HIV transmission in Saskatchewan. The complex issues faced by many individuals who inject drugs means that it is more challenging for these individuals to access and remain in HIV treatment.

Efforts continue – in conjunction with federal, provincial, community and Indigenous partners – to improve access to testing and clinical interventions in alignment with best practices and the UNAIDS 90-90-90 targets. In addition, with our partners, we will continue our efforts to engage, educate and support individuals and communities to prevent transmission of HIV.

Appendix H – UNAIDS Monitoring and Evaluation Indicators

The UN AIDS Monitoring and Evaluation Reference Group and Indicators Technical Working Group have created *Indicator Standards: Operational Guidelines for Selecting Indicators for the HIV Response*. The following is a list of nine indicator categories that were developed to be monitored by community health centres that provide HIV testing and treatment to First Nations in FNIHB-SK areas.

Indicator	Measures
1. Number of First Nations persons diagnosed with HIV living in the community on (date)	<ul style="list-style-type: none"> Number of First Nations persons diagnosed with HIV who are living in the community on (date)
2. Number of First Nations person newly diagnosed with HIV, by age and gender	<ul style="list-style-type: none"> Number of First Nations persons in the community who are diagnosed with HIV in one calendar year, by age and gender
3. HIV diagnoses by risk factor	<ul style="list-style-type: none"> Number of First Nations persons in the community diagnosed with HIV in (calendar year) in each exposure/risk factor category (IDU, heterosexual contact...), by category chosen as highest in exposure hierarchy
4. Number of First Nations persons currently diagnosed with HIV, TB & STBBI co-infections in the community	<ul style="list-style-type: none"> (a) Number of First Nations persons living in the community who have diagnosed HIV and HCV on (date) (b) Number of First Nations persons living in the community who have diagnosed HIV and TB on (date) (c) Number of diagnosed HIV positive First Nations persons living in the community who were diagnosed with an STI during (calendar year of STI diagnosis)
5. Number of HIV tests and persons tested	<ul style="list-style-type: none"> (a) Number of HIV tests (standard tests and POC tests combined) done in the previous calendar year by the (health centre) among individuals living in (main community served by health centre) (b) Number of distinct individuals living in (main community served by health centre) tested for HIV in one calendar year, by sex and age group (c) Number of distinct individuals who lived in other/surrounding communities who were tested for HIV by (health centre) in one calendar year
6. Late stage HIV diagnosis	<ul style="list-style-type: none"> Of those persons in the community who were diagnosed with HIV in (calendar year) (indicator 2), how many had an initial CD4 cell count under 200* OR were diagnosed with AIDS within a year of HIV diagnosis? <p>*Ideally, cases in the acute stage of HIV at diagnosis should be excluded, however proceeding without information on the acute stage is recommended at this time</p>
7. Cascade of Care indicators*	<ul style="list-style-type: none"> (a) Of those persons living in the community who

	<p>were diagnosed as HIV positive in (calendar year diagnosed), how many were linked to care? Of those linked to care, how many were linked to care within 3 months?</p> <ul style="list-style-type: none"> • (b) Percentage of people of living in the community who were diagnosed with HIV in (calendar year) who were: <ul style="list-style-type: none"> i) engaged in ID care ii) retained in ID care iii) retained in care broadly (including nurse care) iv) on ART v) adherent to ART vi) suppressed: undetectable viral load <p>*Only 7 (a) is sought from community health centres that provide HIV care</p>
8. Contact Tracing indicators (HIV)	<p><u>To be reported by health centres/nurses:</u></p> <ul style="list-style-type: none"> • (a) Number of unique* HIV contacts in (calendar year) • (b) Of the unique HIV contacts named in (calendar year), how many were notified? • (c) Of the unique HIV contacts named in (calendar year) who were notified, how many got tested for HIV? • (d) Of the unique HIV contacts named in (calendar year) who were notified and got tested for HIV, how many tested HIV positive? • (e) Number of (calendar year during which contacts were named) contacts who had already been diagnosed as HIV positive before they were notified of being a contact <p>*unique contact refers to a unique individual names as a contact, for example where a person has been named twice as a contact, the person would be counted once</p>
9. Mortality	<p>Possible measures:</p> <ul style="list-style-type: none"> • Of those First Nations persons diagnosed as HIV positive between (dates) in the community, how many are known to be deceased as of (date)? <p>OR</p> <ul style="list-style-type: none"> • HIV related mortality: How many HIV related deaths occurred among First Nations persons living in (specific First Nation community OR FNIHB-SK area First Nations) in (calendar year)?

Appendix I – FN Epidemiology Summary Template

(Community Name) First Nation

Epidemiology of HIV, Hepatitis-C, Chlamydia and Gonorrhoea – 2011 to 2015

This document provides a summary of newly diagnosed Human Immunodeficiency Virus (HIV), Hepatitis-C, Chlamydia and Gonorrhoea cases in _____ First Nation. The newly diagnosed cases are pertaining to only newly reported cases in _____ First Nation in a given year and do not include cases diagnosed in other regions.

Disease counts and diagnosis rates

<p>HIV</p> <ul style="list-style-type: none"> Between 2011 and 2015 there were 37 newly diagnosed HIV cases in _____ First Nation. The HIV diagnosis rate in 2015 was 0 because there were no new HIV cases diagnosed in the community that year. Etc... 	<p>Hepatitis-C</p> <ul style="list-style-type: none"> Between 2011 and 2015 there were 49 newly diagnosed Hepatitis-C cases in _____ First Nation. The Hepatitis-C diagnosis rate in 2015 was 324.3 per 100,000. Etc..
<p>Chlamydia</p> <ul style="list-style-type: none"> Between 2011 and 2015 there were 102 newly diagnosed Chlamydia cases in _____ First Nation. The Chlamydia diagnosis rate in 2015 was 1459.5 per 100,000. Etc... 	<p>Gonorrhoea</p> <ul style="list-style-type: none"> Between 2011 and 2015 there were 16 newly diagnosed Gonorrhoea cases in _____ First Nation. The Gonorrhoea diagnosis rate in 2015 was 324.3 per 100,000. Etc...

Harm Reduction Programs and Services

The following indicators are available for _____ First Nation is available at the community:

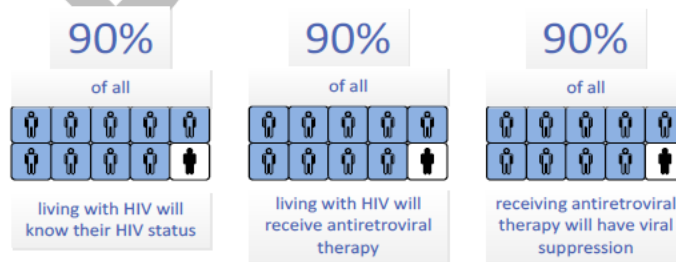
- The volume of needles given to clients: _____
- The number of clients accessing the needle exchange program: _____
- The number of clients on methadone maintenance treatment program or Suboxone : _____

HIV tests

- The volume of HIV tests conducted in _____ First Nation is available at the community.

HIV Testing and Treatment Indicators (including CASCADE)

Note: Please see the supplementary attached document for a list of indicators that could be used at communities to evaluate HIV testing and treatment services.



Appendix

Table 1. _____ First Nation case counts and diagnosis rates for HIV, Hepatitis-C, Chlamydia and Gonorrhea (2011 to 2015).

Year	HIV		Hepatitis-C		Chlamydia		Gonorrhea	
	Cases	Diagnosis rates Per 100,000	Cases	Diagnosis rates Per 100,000	Cases	Diagnosis rates Per 100,000	Cases	Diagnosis rates Per 100,000
2011	16	927.5	19	1101.4	20	1159.4	2	115.9
2012	11	630.7	9	516.1	20	1146.8	1	57.3
2013	4	224.1	6	336.1	18	1008.4	2	112.0
2014	6	330.0	9	495.0	17	935.1	5	275.0
2015	0	0.0	6	324.3	27	1459.5	6	324.3

Figure 1. Comparison of _____ First Nation diagnosis rates for HIV and Hepatitis-C to other jurisdictions (2011 to 2015).

