

Tennessee Department of Health

HIV/ STD Prevention Program
Manual

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I. Introduction

The Tennessee Department of Health HIV/STD Program assembled this manual to assist public health department staff in both the metropolitan and rural regions with STD prevention and intervention efforts. The information found in these guidelines comes from state and local STD programs across the country and in Tennessee. Many of the strategies and recommendations have been proven effective over time in STD intervention efforts.

This manual is intended to provide a consolidated collection of HIV/STD Program policies, standards, roles and responsibilities. It is not intended to replace the *Centers for Disease Control and Prevention Passport to Partner Services Training (PPS)*, *The State Nursing Protocol Manual*, the PRISM Manual, or other manuals that give information on specific subjects. When appropriate, the user of this manual will be referred to the appropriate resource. However, it does replace the previous STD Program Guidelines and all policy memos previously issued.

While there are obvious differences among rural and metropolitan regions in Tennessee in terms of morbidity, staffing and clinic organizational structures, these guidelines should provide a ***fundamental framework*** for the management of STD intervention and prevention. Many of the recommendations, schedules and forms found herein, may be modified to meet regional/local operations. However, all programs in the state must adhere to the program standards and strive to meet the goals and objectives of the federal cooperative agreements which fund the HIV/STD Prevention Program.

The Field Services Division will modify these guidelines as changes occur in order for the document to transcend inevitable fluctuations, such as funding and morbidity levels, as well as staff turnover, both in the field and the Central Office (CO). In order to assure that your guidelines remain current, it is imperative that you include updates in your local copy. Also, if you identify any major modifications to these guidelines or needs for which written guidelines do not presently exist, we would like to discuss those with you.

The Tennessee HIV/STD Prevention Program is a combined program at all levels; HIV Prevention, HIV Care and STD Care and Prevention. All programs across the state are required to meet the combined program standards. Clinical issues are more appropriately covered in the *Tennessee State Nursing Protocol Manual*. HIV Care policies and procedures fall under the *Ryan White and the Centers of Excellence Protocols*. This manual specifically addresses the standards of HIV and STD Prevention, which include HIV Prevention, STD Prevention and HIV/STD Field Services.

II. Program Components

The Tennessee HIV/STD Prevention Program is a combined program at all levels; HIV Prevention, HIV care and STD Care and Prevention. All programs across the state are required to meet the combined program standards. Clinical issues are more appropriately covered in the *Tennessee State Nursing Protocol Manual*. HIV Care policies and procedures fall under the Ryan White and the Centers of Excellence Protocol. This manual specifically addresses the standards of HIV and STD Prevention programs, which include HIV Prevention, STD Prevention and HIV/STD Field Services.

A. HIV Prevention

The HIV Prevention Program in many states is a separate program from the STD Prevention Program. In Tennessee, the programs are fully integrated. However, at the federal level, they remain separate with separate goals and objectives on which all states must report. The following is a brief description of the components of the federal program.

HIV Prevention Grant- Tennessee receives federal grant funds for prevention services in the CO, in health departments and in Community Based Organizations (CBO) across the state. The basic components are: Community Planning; Counseling; Testing and Referral (CTR); Partner Services (PS); Prevention for HIV-Infected Persons; Health Education and Risk Reduction Services; Public Information Services; Perinatal HIV Transmission Prevention; Program Monitoring and Quality Assurance; STD Prevention; Collaboration and Coordination; Laboratory Support and HIV/AIDS Epidemiologic and Behavioral Surveillance.

Every state must have a community planning group. The group must be comprised of individuals who reflect the epidemic in the state. In Tennessee, the community planning activities are conducted at two levels; state and regional. Regional Community Planning Groups (RCPGs) consists of health department staff, HIV activists, CBO staff, and of people living with AIDS in the area served by one of the five Consortia Regions. The Tennessee Community Planning Group (TCPG) is comprised of individuals elected from the RCPG to serve 2 -year commitments. The group meets and develops target populations¹, and from which the HIV Prevention Plan for the state is developed. All HIV prevention activities must include the TCPG in the decision process and the cooperative agreement between the State and CDC must be approved by the TCPG.

Expanded HIV Testing/CAPUS/PrEP – These are separate programs in addition to the base HIV Prevention grant. These programs are designed to expand and improve case identification, linkage and reengagement to care, and provide current scientifically proven methods of HIV prevention through pre-exposure prophylaxis.

B. STD Prevention & Field Services

Within CDC, STD prevention is a separate program from HIV Prevention. The cooperative agreement that funds the STD Prevention Program is titled “Improving Sexually

¹ Target populations are the risk groups on which each state concentrates their activities. The groups must be epidemiologically valid.

Transmitted Disease Programs through Assessment, Assurance, Policy development, and Prevention Strategies (STD AAPPS)". Within STD AAPPS, programs are directed to 1) conduct assessments of STD surveillance processes, case finding and treatment, and partner services processes and activities. 2) assure priority populations have access to screening and treatment, 3) evaluate existing program policies, update those policies as needed, and educate key community on STD public health policies, and 4) create and develop STD prevention strategies through community engagement with private providers, family planning clinics, Federally Qualified Health Care Centers, HIV care providers, and civic organizations.

STD Prevention-Tennessee works with county, regional, and metropolitan health departments to improve STD case finding, treatment, partner services, and case reporting by providing administrative and programmatic support, and training. Areas of emphasis include: Surveillance and Data Management, Outbreak Response Plan, Medical and Laboratory Services, Partner Services, Community and Individual Behavior Change Services, Program Evaluation, Leadership and Program Management, and Training and Professional Development.

C. HIV/STD Surveillance

Tennessee has a cooperative agreement with CDC for HIV/STD Surveillance. The HIV/STD Surveillance Section is housed within the HIV/STD/Viral Hepatitis Program within TDH Communicable and Environmental Disease and Emergency Preparedness Program. The Surveillance Cooperative Agreement provides funding for regional and metropolitan HIV Surveillance staff, regional and CO Epidemiologists, and related program support. The HIV/STD Surveillance Section monitors data quality and completeness, and provides analysis, and program support for the many reports required by federal funding.

III. Professional Conduct, Confidentiality & Security

A. Professional Conduct

Each person belongs to an established personnel system (federal, state, local) and must observe the codes of conduct established by his/her employer regarding punctuality, substance abuse, political activity, conflicts of interest, and other personnel policies. All personnel represent both the Tennessee Department of Health and the local health department in the performance of daily activities. In general, the more stringent requirements among these agencies are the ones to which all personnel should conform regarding professional conduct. The following basic standards will help to foster successful working relationships:

1. Conduct all activities with honesty and integrity.
2. Manage interactions with health officials and other local professionals with tact and diplomacy. Be professional and treat all individuals with respect.
3. Treat clients, co-workers, and the general public with courtesy, dignity, and respect.
4. Observe operational policies regarding lines of authority and communication and use of resources, facilities, and equipment.
5. Inform management at the earliest opportunity of any actual, potential, or perceived conflicts which may arise and that could have a negative influence on program activities.

B. Confidentiality/HIPAA

Confidentiality refers to keeping information obtained from or about patients, partners, social contacts, and associates in confidence. Information is not divulged to others or obtained or maintained in a way that makes it accessible to others. When a person agrees to disclose private information, especially in the context of a service aimed at helping others, such information should be held in strict confidence, both because of its private nature and as a sign of respect for the person who is volunteering to share the information.

Real or perceived breaches of confidentiality can endanger persons being served, who might face stereotyping, social isolation, loss of social or financial support, barriers to accessing housing, employment, and various social and medical services and physical or emotional abuse. Such breaches also can undermine community trust in and access to essential public health programs and services. For these reasons, policies and procedures for protecting confidentiality are critical. State law protects the confidentiality of all STD patients and information. Although confidentiality is a central principle of partner services, partner services programs cannot absolutely guarantee patient or partner anonymity. Health officials must make all reasonable attempts to ensure that the confidential nature of communication with a Disease Intervention Specialist (DIS) is respected and protected to the fullest extent allowed by law. All staff must sign a confidentiality statement upon hire.

All staff members who are authorized to access partner services information and data must be responsible for reporting suspected security breaches. Any breach of protocol or procedures, regardless of whether personal information was released, must be reported

immediately to the supervisor and will be investigated to assess causes and implement remedies. Penalties exist for confidentiality breaches.

1. Health Information Portability and Accountability Act (HIPAA)
 - a. **HIPAA** is the federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of healthcare information and help the health care industry control administrative costs.
 - b. **HIPAA** is divided into different titles or sections that address a unique aspect of health insurance reform. Two main sections are Title I which deals with Portability and Title II that focuses on Administrative Simplification.
 - c. For more information please refer to the HIPAA web site:
<http://www.hhs.gov/ocr/privacy/>
2. **Privacy-HIPAA** provides for the protection of individually identifiable health information that is transmitted or maintained in any form or medium. The privacy rules affect the day-to-day business operations of all organizations that provide medical care and maintain personal health information.
3. What health information is protected?
 - a. **HIPAA** protects an individual's health information and his/her demographic information. This is called "protected health information" or "PHI".
 - b. Information meets the definition of PHI even without the patient's name, if you look at certain information and you can tell who the person is, then it is PHI.
 - c. The PHI can relate to past, present or future physical or mental health of the individual. PHI describes a disease, diagnosis, procedure, prognosis, or condition of the individual and can exist in any medium – written or printed files, voice mail, email, fax, or verbal communications.
 - d. **HIPAA** defines information as protected health information if it contains any of the following information about the patient, the patient's household members, or the patient's employers:
 - 1) Names
 - 2) Dates relating to a patient, i.e. birthdates, dates of medical treatment, admission and discharge dates, and dates of death
 - 3) Telephone numbers, addresses (including city, county, or zip code) fax numbers and other contact information
 - 4) Social Security numbers
 - 5) Medical records numbers

- 6) Photographs
 - 7) Finger and voice prints
 - 8) Any other unique identifying number
- e. Information on how to file a complaint can be found at The US Department of Health and Human Services, Office of Civil Rights, www.hhs.gov/ocr/hipaa

C. Security

The Tennessee Department of Health (TDH) is granted statutory authority to make rules and regulations for the control of sexually transmitted diseases (STDs) (Tennessee Code Annotated 68-10-109). Control measures involve many activities including disease surveillance, reporting, and investigation. Such activities may eventually involve numerous parties including local, regional, and state health department personnel, health care providers, and persons with an STD and their contacts.

A most basic and important principle of disease control is respect for the individuals reported with an STD and protection of their privacy. STDs involve the most personal and private of human behaviors. Some persons infected with HIV have faced extreme social prejudices. Obviously, the coordination of these activities and handling of this information requires the greatest sensitivity and care.

In protecting the confidentiality of individuals and security of information related to STD control efforts, some of the critical issues to be addressed include: 1) balancing respect for the individual's privacy with good public health efforts to control STDs; 2) determining who is authorized to receive personal identifying information and for what purposes; 3) handling the increasing requests for STD information and the new technology for handling STD data such as lap top computers; and 4) guarding against unintentional releases of information.

1. Personnel

- a. All employees must sign a Personnel Confidentiality Statement PH-3131 indicating their agreement not to release patient information to unauthorized persons. This form must be kept in the employee's personnel file.
- b. New employees must be trained regarding confidentiality and security guidelines during initial orientation and must sign form PH-3131 before having access to patient identifying information. Employees will be trained how to challenge unauthorized persons attempting to access confidential information and how to report security breaches for investigation.
- c. Any employee who causes the release of confidential patient information to unauthorized persons is subject to disciplinary action which may include termination of their employment.
- d. Handling Request for HIV/AIDS Disease Reporting Statistical Data

- e. HARS disease reporting statistical data will be made available for utilization by health care professionals, the public, the media, and other parties. However, data must be released in aggregate form in order to avoid the inadvertent identification of individuals with HIV/AIDS.
- f. All HARS data request will be directed to and handled by the Regional HIV/AIDS Surveillance Coordinators or to the Statewide Director of HIV/AIDS Surveillance in CO. A record of each data request must be made to include: the date, the name, title, and organization of person making the request, the specific data requested, and a description of how the data is to be used. Also, a copy of the data supplied in response to each request must be kept on file.
- g. Data will be released in aggregate form, e.g., frequency tables, to assure individuals with HIV/AIDS are not inadvertently identified. Geographically, information will not be released below the county level and will not be released for counties with less than five reports. Data analyses for counties with small populations and small cell size values may not be released if individuals with HIV/AIDS could be identified due to the linking of data. Data analysis below the county level, i.e., at the zip code and below level, must be reviewed and approved by the Statewide Director of HIV/AIDS Surveillance.
- h. When releasing data, the limitations of the data as to its interpretation or use must be clarified to the requesting party.

2. Storage and Disposal of Records

- a. Epidemiological (hard copy) records must be kept in locked file cabinets in secure, limited access areas behind two locked doors. The room where records are stored must have floor to ceiling walls, and it must be secured against unauthorized outside entry. When health department personnel responsible for security of the area where such records are kept are not present, the file cabinets and door to the room containing the records must be locked.
- b. One copy of the "HIV/AIDS Confidential Case Report" (forms PH 3273 and PH 3274) and associated epidemiological records for each case reported will be maintained in the offices of the Regional HIV/AIDS Surveillance Coordinator and one copy in the state offices of the STD/HIV Program, HIV/AIDS Surveillance Section. These records will not be maintained in any other locations or by any other personnel. These records will not be archived, they will not be filed in STD lot folders, and they will not be kept in local county health department offices.
- c. When records are no longer needed, they will be destroyed by shredding in a manner to assure they are no longer readable and then properly disposed.

IV. Roles and Responsibilities

A. Core Functions of the Central Office (CO)

The staff in the CO is federally funded under a combination of the grants previously mentioned.

1. **Policy Development and Implementation** -HIV/STD Program Policies and procedures are written and updated by the CO staff. The communication of changes to other programs is likewise their responsibility. CO staff works with other programs and divisions of the Department of Health to provide input in policies or procedures that impact the HIV/STD Program.
2. **Ensure Morbidity Reporting** -CO staff transmit weekly morbidity reports to the CDC as required. Other reports are likewise submitted as required. CO staff is responsible for ensuring that the data is complete and accurate.
3. **Technical Assistance**- CO staff is responsible for providing or arranging for help that regional programs need to achieve program goals and objectives.
4. **Training**-Staff training can be coordinated through the CO or local or regional office.
5. **Program Evaluation**-The CO staff is responsible for evaluation of all program activities. CO staff will provide staff with appropriate tools and technical assistance to evaluate their programs.
6. **Coordination of Activities**-The CO staff are responsible to plan meetings and conference calls to coordinate the activities of the program.
7. **Writing Funding Proposals** -CO staff are responsible for writing, submitting and reporting on all grants and cooperative agreements for which the program qualifies and the required budgets. They are also responsible for communicating grant progress, programmatic changes and gathering the data and other information required for submission.
8. **Assure Progress toward Goals and Objectives**-The CO is responsible to communicate the goals and objectives of each grant to the regional programs and assist each program in meeting the goals and objectives on a regional level.

B. Specific Roles and Responsibilities of the Central Office (CO)

1. **HIV/STD Program Director** - Manages all aspects of the HIV/STD program.
2. **HIV/STD Medical Director** - Provides medical oversight to the program, acts as a medical resource for consultation, and policy and procedure creation.
3. **STD Prevention Program Director** - Responsible for STD Prevention activities, Field/Partner Services activities, program planning, policy development and implementation, and grant and cooperative agreement writing and submission.

4. **STD Prevention Assistant Program Director** – Responsible for cooperative agreement monitoring and outcomes, Passport to Partner Services Coordination, supervision of the ICCR and CO CAPUS DIS
5. **HIV Prevention Program Director** - Responsible for HIV Prevention activities, for program planning, policy development and implementation, and grant and cooperative agreement writing and submission
6. **HIV Prevention Assistant Program Director** – Responsible for assisting the HIV Prevention Program Director with implementing HIV prevention strategies in county health departments and community based organizations, including partner services, community planning, effective behavioral interventions, and data management
7. **HIV/STD Surveillance Director** - Responsible for HIV and STD Surveillance across the state, ensuring that surveillance staff is trained and knowledgeable of surveillance, prevention, and Ryan White data needs. The director is responsible for eHARS administration and timely submission of morbidity information as required or requested.
8. **Grand Region Consultants** - Responsible for providing direct assistance, technical assistance, contract monitoring, data quality assurance in PRISM, and training within their assigned area, and for communicating needs and concerns between the CO and assigned area staff
9. **ICCR DIS** - Responsible for record searching morbidity in other states, forwarding field records and morbidity notification reports to other states when the client lives out of state, receiving field records and laboratory reports from other states on clients who reside in Tennessee, updating of records sent between states, requesting return dispositions, entering new information into PRISM, conducting Accurint record searches, conducting Internet Partner Services activities, and answering PRISM Help Desk inquiries

C. Roles and Responsibilities for Regional/Metropolitan HIV/STD Prevention Programs

1. **Program Manager/ Communicable Disease Control Director**- This individual is responsible for managing the regional HIV/STD Prevention Program. This includes setting regional goals, in consultation with their consultant and the State HIV/STD Prevention Director, that are in line with state goals and objectives. They are also responsible to assure that all members of their programs receive updates on policies and updates from the CO. They are responsible for communicating appropriate information to their local management and for communicating local issues and accomplishments to CO staff. Metropolitan regions are also responsible for submitting and operating within contract budgets.
2. **Front Line Supervisors/ STD Supervisors**-This individual directly supervises DIS and clerical staff that perform investigative and surveillance activities. They prepare schedules, assist in resolving clinic flow problems,

review cases, perform audits, monitor caseloads, assure timely and accurate data entry into surveillance databases, and train new DIS.

3. **Disease Intervention Specialists (DIS)**

- a. **Field Work:** The DIS is to ensure treatment of all reported chlamydia, gonorrhea, and syphilis infections and HIV test result notification, as well as offer partner services to named contacts. This is done by telephone, mail, internet, and visiting the person at home or work. (HIV results are given in-person only.)
 - b. **Interviewing:** Persons infected with an STD or HIV are interviewed to assure comprehension of the infection and to offer partner services.
 - c. **Educational Presentations:** The DIS is expected to be a resource for HIV and STD information for his clients and community. Regional DIS, assigned to one or more counties, are expected to perform Educational Presentations.
4. **Surveillance Staff-**Surveillance staff conduct laboratory and provider visits to educate providers on reporting requirements and enhance compliance, receive reports of STDs, and conduct follow-up with reporting laboratories or medical providers to collect any missing information. They also contact providers for treatment information. Not all regions have dedicated surveillance staff.
 5. **Administrative Staff-**Administrative staff performs clerical and data entry functions in the clinic including registering patients, maintaining storage of hard copy medical records and the entry of medical information into PTBMIS. Not all regions have administrative staff in the HIV/STD Program.
 6. **Epidemiologists-**Regional Epidemiologists review, analyze and monitor statistical data for their jurisdiction.

V. **HIV/STD Disease Reporting Requirements**

- a. Congenital syphilis (known or suspected) requires immediate telephonic reporting within 1 business day, followed by a written report within 1 week on form ph-1600 <http://health.state.tn.us/Downloads/ph-1600.pdf>
- b. Known or suspected cases of chancroid, chlamydia, gonorrhea and syphilis (other than congenital) require a written report on ph-1600 within 7 days.
- c. HIV/AIDS requires confidential reporting to designated personnel within 7 days.
 - 9) Adults - <http://health.state.tn.us/STD/PDFs/PH-3273.pdf>
 - 10) Pediatric - <http://health.state.tn.us/STD/PDFs/PH-3274.pdf>

Optimally, physicians will report primary and secondary (P&S) syphilis immediately. These reporting activities should be monitored at the regional/local level.

VI. Surveillance

Surveillance is the ongoing and systematic collection, analysis, interpretation, and dissemination of health data in the process of describing and monitoring disease trends. This information can assist programs to better plan, implement, and evaluate efforts to control STDs. For this reason, surveillance is a core public health function and must be considered one of the most essential and of the highest priority in any STD prevention program.

The reporting of HIV and STD follow the CDC's surveillance definitions. These are not and often vary from medical diagnoses. For CDC case definitions please see the [CDC's Case Definition Page](#).

A. STD Surveillance

1. Reportable sexually transmitted infections in Tennessee are: **gonorrhea, chlamydia, lymphogranuloma venereum, syphilis, chancroid, and HIV**. All initial infections are considered to be positive and require morbidity upon diagnosis. Morbidity does not depend on treatment. Morbidity is only declared for STDs on those cases that reside in Tennessee.
2. The STD surveillance and case management system is currently PRISM. All morbidity and case investigation information on all HIV and STD will be recorded in PRISM. This includes both private and health department patients. Regions will use the priority list to determine what is investigated.
3. If there are questions on the staging of syphilis refer to the current STD Nursing Protocols or to the *CDC Recommendations for the Surveillance of Syphilis, 2003* <http://www.cdc.gov/STD/SyphSurvReco.pdf>.

B. HIV Surveillance

1. All individuals who either tested positive in or currently live in Tennessee and are HIV positive must be reported to the state.
2. All reports of a confirmed HIV laboratory result on individuals, who live in, were tested in or are getting care in Tennessee, will be entered into eHARS. Even when it is known that the case is a previous positive,
3. At least one field record must be created in the PRISM database and dispositioned. This is a measure to ensure that all HIV positive individuals living in the state are entered in eHARS, the state HIV case registry.

C. Laboratory Visits

1. Non-health department laboratories comprise a crucial component in STD/HIV surveillance, both through their reporting practices and due to the level of testing that they perform.
2. DIS or other health department representatives should annually visit reference laboratories that perform STD testing in their area.

D. Provider Visits

1. DIS' or other health department representatives should visit hospitals and private medical doctors in the area at least yearly. A periodic meeting with the key staff in these sites builds rapport and facilitates cooperation.
2. These visits not only serve to expedite reporting and intervention efforts, but also allow representatives of public health to provide feedback on disease morbidity and reporting practices and to distribute treatment guidelines, reporting forms and other helpful information.

VII. Field Operations

A. HIV/STD Program Standards and Priorities

Recognizing differences between the rural and metropolitan regions in Tennessee regarding morbidity, staffing and clinic organizational structures, these guidelines are intended to provide a **fundamental framework** for the management of STD intervention and prevention. Many of the recommendations, schedules and forms found here may be modified to meet regional/metropolitan program operations. All programs in the state must adhere to these program standards and strive to meet the goals and objectives of the federal cooperative agreements which fund the HIV/STD Prevention Program.

1. **Program Priorities**-The following are the priorities set by The Tennessee HIV/STD Prevention Program:
 - a. Pregnant women and infants are a priority for all diseases
 - b. Children under age 13 including infants
 - c. Early (less than one year's duration) syphilis
 - d. Newly diagnosed HIV infection
 - e. Co-morbidity
 - f. Gonorrhea in females
 - g. Gonorrhea in males
 - h. Chlamydia in females
 - i. Chlamydia in males
 - j. HIV linkage to care
 - k. Old HIV case, new STD
 - l. Old HIV case, new to TN
2. **Program Objectives**-Program objectives are developed and reviewed annually and are submitted to the CDC in the annual cooperative agreement proposals. Unless otherwise stated in a contract with the State, the current objectives are:
 - a. Achieve a contact index of 1.5 for every case of early syphilis interviewed or newly diagnosed HIV interviewed
 - b. Treat 50% of cases for chlamydia, gonorrhea, or early syphilis within 30 days of specimen collection
 - c. Treat 90% of cases for chlamydia, gonorrhea, or early syphilis within 30 days of specimen collection
 - d. At least 80% of cases for chlamydia, gonorrhea, or new HIV will receive an interview
 - e. At least 90% of cases for early syphilis will receive an interview within 30

days of health department notification of specimen collection

- f. At least 75% of early syphilis cases interviewed will result in one partner who is interviewed and screened
- g. The percent of un-locatable partners for early syphilis is less than 25%

3. Field Investigation Priorities

- a. All positive HIV and syphilis lab tests (reactors) will have a field record initiated in PRISM within 1 business day of receipt; whether electronically or by paper lab receipt.
- b. All positive gonorrhea and chlamydia lab tests will have a field record initiated in PRISM within 5 business days of receipt; whether electronically or by paper lab receipt.
- c. All contacts to syphilis and HIV will be initiated to the field within 1 business day of the interview.
- d. Gonorrhea and chlamydia cases will be initiated to the field for interview based on the program priorities and program objectives as listed in paragraphs 1 and 2 of this section.
- e. All cases within a region's jurisdiction, regardless of where it originated (private providers, other regions), are to be investigated following the above criteria.
- f. All individuals with positive lab tests, who are untreated, will be treated when they report to a clinic regardless of where the test originated (private providers, other regions).
- g. All contacts to any STD infection, confirmed or suspected, will be tested and epidemiologically treated upon presentation to a clinic.

4. Field Standards

- a. All syphilis and HIV field records will have a documented attempt to contact the patient (phone, field visit, text message, etc.) or patient's provider within 1 business day of assignment. Documentation will include the date and time of the activity in the notes section of the field record.
- b. All syphilis and HIV field records will have documented follow-up activity at least every 2 business days.
- c. Gonorrhea and chlamydia field records will have a documented attempt to contact patient (phone, field visit, text message, etc.) within 3 business days of assignment. Documentation will include the date and time of the activity in the notes section of the field record.
- d. Gonorrhea and chlamydia field records will have documented follow-up activity at least every 3 business days.

- e. All field records with a B, D, H, I, J, LX, or LV closure must be reviewed by the supervisor and supervisor must note approval of disposition closure in the notes section of the PRISM field record.
 - f. Field records are to be dispositioned and closed as treatment notification is received. All remaining documentation will be noted in the interview record.
 - g. All reactive syphilis labs found not to be a new infection will have a field record dispositioned as "OLD" and previous positive HIV cases will have a field record dispositioned as 1, 8, 9 or 10.
 - h. Field records will not be open more than five business days without documentation of a supervisory review.
 - i. Field records not closed within 14 days will have documentation of supervisory review and extension.
 - j. Field records for females will have pregnancy status indicated.
5. Interview Standards
- a. All HIV and syphilis cases will be interviewed as soon as possible, with the goal of less than 5 business days from date of assignment.
 - b. All interviews are to be entered into PRISM within 3 business days of interview.
 - c. Supervisors will review all HIV and syphilis interviews and give comments (in the notes section of the interview record) to advance the case within 5 business days.
 - d. Re-interviews will be conducted for syphilis within 2 business days and HIV within 5 business days of original interview.
 - e. No interview is to be open longer than 30 days without written explanation and written plan for advancement of the case and concurrence by the supervisor.
 - f. A good interview should give a picture of the patient's life as outlined in the Client Assessment Section on page # and should be documented on the interview record in PRISM.

B. Regional Program Managers

1. The program managers, whether their title is Field Operations Manager or Regional Communicable Disease Director, are responsible for the overall management of the HIV/STD Program in their jurisdiction. While the supervisor deals with the everyday activities, the program manager monitors the performance of the program as a whole and the performance of the supervisor.

2. Managers must ensure that a system is in place for health department clinicians and DIS to communicate with each other about a client's relevant concerns or problems.
3. Managers must establish and maintain collaborative relationships with community-based organizations to identify target groups and to assist with outreach activities.
4. Managers must establish and maintain collaborations with external and internal programs/agencies as appropriate to enhance disease intervention activities.

C. Front Line Supervisors (FLS)/STD Supervisors

The quality of DIS performance is the highest priority for all STD program management and supervisory personnel. Each position within an STD program requires professional judgment and individual initiative. DIS must be certain that management will monitor and understand performance and assure compliance with standard. At a minimum, a front line supervisor (FLS) should:

1. Ensure that the DIS has received adequate and appropriate STD training.
2. Consistently plan assignments to maximize attainment of the program's objectives.
3. Monitor and evaluate all work of the DIS through the review of field record and interview record reports in PRISM.
4. Review DIS workloads to ensure even distribution of work among DIS, where applicable.
5. Maintain a file on each DIS containing documentation of significant events such as performance audits, employee counseling sessions, training, and time and attendance.
6. It is recommended that local/regional managers consider that this file also contain a recent photo of the DIS, the cell phone number, and the make, model, year and license plate number of the vehicle used in the field.
7. At a minimum, conduct monthly team meetings. These team meetings should include a review of interesting or difficult cases to be used as a training tool (chalk talks).
8. Provide the DIS with a job description, performance standards and ensure that s/he understands the Performance Guidelines for DIS (signed statement that the DIS has read and understood the guidelines should be maintained in the personnel file.)
9. Case Reviews
 - a. The FLS must review daily DIS PRISM task lists for overdue work, stalled investigations, and unlinked laboratory reports.
 - b. FLS must review and document the status of open PRISM syphilis and HIV

case management activities at least once a week, to monitor the progress of DIS follow-up in regards to re-interviews, cluster interviews, and field investigation dispositions. A change of interviewer, where possible, should occur on all unproductive high priority cases.

- c. The FLS must review, notate on the record in PRISM, and close completed cases submitted by the DIS.
- d. The FLS must ensure cases are closed in a timely manner and on an ongoing basis and inform the next level of supervision of cases delinquent for closure (open beyond 30 days from the date interviewed).

10. Field Record (FR)/ Interview Records (IR) Reviews

- a. The FLS must review all FRs/IRs to monitor the accuracy of information and quality of investigations as well as close the FR and declare morbidity as indicated.
- b. FLS must document supervisory instructions on the FR/IR in PRISM to assist with stalled investigations.
- c. Where applicable, FLS must inform the next level of supervision of FRs/IRs open over two weeks from the date assigned and take the necessary actions to bring it to closure.
- d. The FLS must note their approval to close on all adverse FRs/IRs reviewed before closure. The FLS must document specific instructions to be carried out by the DIS prior to closing all “B” (Refused Treatment), “D” (Infected Not Treated), “J” (Located, Refused Exam), “I” (Admin Closure), “H”(Unable to Locate), “L” (Other), “LX” (Dead), and “LV”(Domestic Violence Risk) dispositions.
- e. The FLS must personally contact the client to assure the DIS has explained the health consequences of refusing care on STD or HIV FRs dispositioned “J”, “B”, or “D” prior to final disposition.
- f. Where applicable, FLS must inform the next level of supervision of all closed “D”, “H” and “J” syphilis reactors, and HIV positives unable to locate for post test counseling.
- g. Conduct DIS performance evaluations in accordance with the appropriate agency’s guidelines (federal, state, or local).
- h. Prepare a performance improvement plan (according to federal, state or local personnel policies) for DIS with performance problems identified through regular audits and assessments. Performance improvement plans should be designed to enhance the DIS’ performance within specific time frames and should include supervisory involvement and modeling.

11. Performance Reviews

- a. Performance reviews are to be conducted according to the schedule in the appendix. The FLS must also conduct periodic performance audits of

each experienced DIS to determine their current level of skills and abilities.

- b. When the accumulated assessments of a DIS confirm consistently high quality performance, the FLS must provide positive reinforcement and work through management channels to provide appropriate official recognition.
- c. The Grand Regional Consultant must also be informed so that the CO management can provide appropriate recognition as well.

12. Clinic Responsibilities

- a. Where applicable, the FLS must prepare DIS schedules, in advance, and adjust appropriately for staffing shortages or changes to ensure disease intervention activities and program operations are carried out as effectively as possible.
- b. The FLS must ensure that the method for referring client(s) from a clinician to a DIS for interviewing or counseling is efficient and confidential.
- c. The FLS must ensure that a system is in place for health department clinicians and DIS to communicate with each other about a client's relevant concerns or problems.
- d. The FLS must work with the clinic management to ensure DIS referrals and priorities included in the statewide grant objectives receive priority in the clinic.
- e. The FLS must assure that an expected-in box or an equivalent system is set up and functioning.
- f. Where applicable, the FLS must review medical records to assure DIS interviewing and counseling activities are charted.
- g. All cases of HIV and early syphilis with no contacts elicited must be discussed with the supervisor before the patient leaves the clinic.

13. Records and Reports

- a. The FLS must prepare individual and team monthly, quarterly, semi-annual and annual statistics on the DIS performance relating to the state and local objectives. These statistics generally are available via reports in PRISM. Specific reports generated at the local or regional level can be incorporated as well.
- b. The FLS must submit individual and team statistics to the next level of supervision on a monthly basis.
- c. The FLS must provide individual feedback to DIS on outcome and process performance indicators on a monthly basis.
- d. The FLS must inform the next level of supervision of DIS performance

excellence and deficiencies as well as recommended actions.

14. Outreach, Educational Presentations and Screenings

- a. FLS must coordinate and oversee STD presentations and community outreach screenings.
- b. Each activity must be documented including date, time, place, type and size of audience, type of education/screening. If screening, how many tested, what tests done, and number of positives and new cases of STD or HIV.
- c. The FLS must monitor morbidity and disease intervention activities to identify and respond to changes.
- d. FLS must establish and maintain collaborative relationships with external and internal programs and agencies to identify target groups and to assist with outreach activities.
- e. FLS will initiate innovative screening and disease intervention methods including evaluating the performance and impact of these new activities.

D. Orientation and Training of New Disease Intervention Specialist (DIS)

1. Orientation is the foundation for all DIS development and is a critical responsibility of the FLS. Orientation helps DIS define their role, understand performance expectation, and see how they fit into the overall organization. Disease intervention skills acquired through the PPS training course must be refined and reinforced on the job. Success of this phase depends on supervisory involvement beginning with the evaluation and documentation of the DIS' initial work performance.
2. The FLS has a pivotal role in STD/HIV control. The FLS' main responsibility is to develop the performance potential of each DIS, allowing for career growth and assuring program objectives can be achieved. A detailed orientation schedule is included in this section. At a minimum, an FLS should:
3. Ensure each newly hired DIS complete the New Employee Orientation/Training Guidelines at the local level.
4. Facilitate successful DIS completion of **CDC's PPS** modules by scoring 80% or above. The supervisor section provides materials to assist in the orientation of the new employee and includes all information contained in the student section as well as a sample orientation plan for new DIS, suggested activities to accompany the PPS modules including post-PPS activities.
5. Assure DIS receives **PPS training** and **HIV Counseling and Testing** training within the first year of employment.
6. Assure that the DIS maintains a calendar to document daily training activities during the pre- and post-PPS assessment period. The post-PPS assessment period is six months and may be extended if satisfactory performance is not achieved.

7. Maintain a formal log of training demonstrations and audits of DIS. The log should be reviewed by the FLS at the end of each month of the employee's probationary period.
8. Augment the training modules by demonstrating/modeling record searches, field investigation, pre-interview analysis, interviewing, cases management and other activities prior to PPS. On occasion, the FLS may delegate portions of early development to an experienced DIS. However, the FLS must maintain the ultimate responsibility for training.
9. For new DIS with less than one year of experience, the FLS must discuss the pre-interview analysis and plan prior to original interviews, related re-interviews, and cluster interviews on syphilis and HIV cases.
10. Complete a post-ISTDI assessment schedule during the six month period after ISTDI.
 - a. Complete a written skills inventory assessment summary of the DIS after six months post-ISTDI. The summary must include interviewing, field investigations, and case management skills. The summary should include documentation reflecting the DIS' progress and potential and be presented and discussed with the DIS within 30 days of the end of the post-ISTDI assessment period. Program managers should also be present where applicable. The Grand Regional Consultants are available to attend these meetings upon request.
 - b. In rural regions where prolonged vacancies may exist, the FLS should provide accelerated mentoring, coaching, and skill demonstration to allow new DIS to perform at a basic level.
 - c. The Skills Inventory Assessment Summary should be submitted to the local STD/HIV program manager.

E. Duties of a Disease Intervention Specialist (DIS)

1. Disease Intervention Specialists (DIS) are trained health professionals who practice STD intervention.
2. The main objective of disease intervention is to prevent disease transmission by ensuring that all people who currently have or have been exposed to a treatable STD are promptly examined and adequately treated or to prevent transmission of those non-treatable STDs.
3. DIS therefore, have three major responsibilities:
 - a. Perform investigative activities to locate people who are suspected of having STDs and refer them for examination and treatment
 - b. Interview patients infected with STDs to ensure that persons who are infected with an STD or HIV, or who are at risk of acquiring such, receive appropriate medical care as soon as possible.
 - c. Partner Elicitation-State regulations require DIS to follow all clients

reported to the department of health with a known or suspected STD, including HIV, regardless of the permission of the health care provider.

4. It is the responsibility of a DIS to contact private providers
 - a. DIS' are encouraged to establish relationships with physicians in their area.
 - b. The DIS must secure a diagnosis, history and any treatment information from the health care provider as well as demographics and locating information before contacting the client.
 - c. The DIS must be able to help the health care provider to determine the appropriate stage of syphilis by tactfully sharing diagnostic criteria and other information (e.g., repeat quantitative STS, confirmatory tests).
 - d. Laboratory and provider visits must be conducted according to program guidelines.

F. Partner Services

1. Principles of Partner Services- The following principles serve as the foundation for providing partner services to persons with HIV infection or other STDs and their partners:
 - a. Client centered- All steps of the partner services process must be tailored to the behaviors, circumstances, and specific needs of each client.
 - b. Confidential- Confidentiality must be maintained and is essential to the success of partner services. Confidentiality also applies to data collected as part of the partner services process. When notifying partners of exposure, the identity of the index patient must never be revealed, and no information about partners should be conveyed back to the index patient.
 - c. Free- Partner services must be free of charge for infected persons and their partners.
 - d. Evidence based- Partner services must be based on demographic and morbidity data as much as possible.
 - e. Culturally, linguistically, and developmentally appropriate-Partner services must be provided in a nonjudgmental way and be appropriate for the cultural, linguistic, and developmental characteristics of each client.
 - f. Partner services must be accessible and available to all infected persons regardless of where they are tested or receive a diagnosis and whether they are tested confidentially or anonymously. Due to the chronic nature of HIV infection, HIV-infected persons should have the ability to access partner services whenever needed. They should be offered services when they learn their serostatus and partner services should be available throughout their counseling and care.

- 1) Referred partners who present at the health department seeking services must be seen the same day.
 - 2) Referred partners who contact the health department requesting to be seen must be seen within one business day of the request.
2. The goals of partner services for infected persons, their partners, and the community are as follows:
- a. Infected persons
 - 1) Maximize access to partner services to ensure that the partners are confidentially informed of their exposure.
 - 2) Maximize effective linkage to medical care, treatment, prevention interventions.
 - b. Partners of infected persons
 - 1) Maximize the proportion of partners who are notified of their exposure.
 - 2) Maximize early linkage of partners to testing, medical care, prevention interventions, and other services.
 - 3) Reduce future rates of transmission by aiding in early diagnosis and treatment or linkage to care and provision of prevention services to infected persons.

G. Case Management

1. Case management is the systematic pursuit, documentation, and analysis of medical and epidemiological case information that focuses on opportunities for disease intervention. The primary purpose of case management is to develop a timely plan for disease intervention from pre-interview analysis through case closure.
2. During the case management process, DIS will:
 - a. Initiate an FR for all interview period sex/needle partners and clusters that have adequate locating information. Internet and marginal partners must also be entered.
 - b. Begin the investigation within 1 business day.
 - c. Record search all partners and suspects immediately; including marginal partners.
 - d. For syphilis cases, complete a visual case analysis (VCA) and the IR at the same time.
 - e. Record new case information and review the progress of the case investigation daily.
 - f. The DIS should seek supervisory guidance as soon as case development appears to be stalled.

3. Maintain ongoing case management by:
 - a. Identifying the informational needs of the individual case and of related cases;
 - b. Developing agendas for prospective interviews, cluster interviews, and re-interviews;
 - c. Assuming responsibility for critical communications with other staff members; and,
 - d. Remaining abreast of the progress of case elements, which are assigned to other team members (when more than one DIS is working a case).
 - e. Promptly pursue case needs and activities resulting from personal analysis, supervisory input or contributions by other team members.
 - f. Maintain cases in such a manner that they are clearly documented with current data and developmental needs.
4. Client Assistance
 - a. Although the focus of most DIS interactions is disease intervention, DIS must be sensitive to other health or social needs of individuals involved in a case investigation.
 - b. A DIS must provide the client with information on other available services in a manner that does not interfere with disease intervention priorities.

H. Field Records

1. A field record in PRISM is to be initiated on all positive laboratory reports of STDs and all associated contacts to cases within 1 business day of receipt of lab or contact information.
2. A field record must be sent for field investigation following program priorities set forth in Section VII on page 16.
3. A DIS must begin investigative action on priority follow-ups within one workday of assignment or initiation.
4. To avoid duplication of effort and to expand locating information, a DIS must perform a record search immediately after initiating an investigation by reviewing available resources (i.e. past PRISM records, PTBMIS, TennCare data, USPS, jail records, online search engines, and social apps) and documenting the results in the notes section of the field record in PRISM.
5. All possible methods must be utilized to contact clients in the most efficient manner including internet search, text messaging, phone call, and field visit.
6. When the original information obtained in an interview does not lead to the person being sought, the DIS must contact the original patient at the first opportunity in order to correct or to expand locating data.

7. When an investigation stalls, the DIS must inform the supervisor at the earliest reasonable opportunity (not to exceed 72 hours). Supervisory approval is required to close unsuccessful investigations.
8. A DIS should complete and submit all work to the supervisor before taking planned leave. The supervisor must reassign the DIS' field records.

I. Interviews

1. For the purpose of disease intervention, the DIS conducts interviews of individuals based on program priorities.
2. It is preferred that the DIS conduct interviews in person and in a confidential setting. Telephone interviews are strongly discouraged for syphilis and HIV and must be conducted only when all other reasonable efforts to meet in person have been unsuccessful. Telephone interviews must be followed by a face-to-face re-interview. The interview format is found in the Appendix.
3. Before concluding the original interview (OI), a DIS should establish a tentative appointment for re-interview and elicit alternative methods to reach the client.
4. Interviews, re-interviews, and cluster interviews should be entered into PRISM within 24 hours.

J. Provider and Laboratory Visits

1. Laboratories and providers should report required STD results to the health department within seven (7) days of the test date, 24 hours for congenital syphilis.
2. Timely and accurate reporting by laboratories and providers is fundamental for effective STD control. Regional programs should regularly visit hospitals and private medical doctors in the area who perform STD tests. This section of the guidelines provides strategies for instituting an effective visitation program.
3. Health care providers view their time as very valuable and are not always receptive to meeting with health department representatives. Therefore, every visit must be well-organized. After all provider visits, documentation should be made as to what occurred and information given to the provider.
4. Non-health department laboratories comprise a crucial component in STD/HIV surveillance, both through their reporting practices and due to the level of testing that they perform.
5. Laboratory visits should only be done on laboratories that perform HIV and STD reference testing in their facility. This generally only includes some hospitals and private reference labs such as LabCorp, Quest, etc.
6. Categories of Provider/Laboratory Visits
 - a. **Annual Visits** -The obvious intent of these visits is to enhance relationships with the Providers and laboratories in the region.

- b. **New Provider/Laboratory Visits**-*These* must be conducted with recently opened or previously unidentified providers and laboratories.
 - 1) DIS must inform the provider or laboratory how to complete and submit PH1600 forms.
 - 2) DIS must provide the staff with a health department contact name, telephone phone number and email address.
- c. **Delinquent Reporter Visits**-*A Delinquent Reporter* is one not meeting reporting time frames required by law.
 - 1) Supervisors should assign DIS to visit these sites as soon as the problem is identified and determine if the laboratory must be contacted by telephone or through a site visit. If a site visit is warranted, the meeting must be scheduled versus conducting an unannounced visit.
 - 2) If a provider or laboratory continually appears on the delinquent reporter list, it is appropriate to escalate the level of the visit (i.e., from DIS to supervisor and/or from phone call to an onsite visit and perhaps after progressive attempts an onsite visit by the DIS and supervisor).
- d. **Problem Solving Visits**-*Problem Solving Visits* are designed to assist providers and laboratories that chronically make errors in completing the PH 1600 form.
- e. After all visits or contact, the DIS should complete a Provider or Laboratory Visitation form and provide it to the supervisor according to regional program standards.

VIII. Policies and Procedures

A. Policy for Declaring Morbidity

1. Chlamydia and Gonorrhea: CDC's STD Surveillance will accept only one case per disease in a 30 day time period. Morbidity should be declared on all positive laboratory reports separated by at least 30 days provided that the person was appropriately treated. Additional positive laboratory tests performed on a patient who has not been treated is a continuation of the same infection. However, if more than one year has passed, but no treatment has been documented, then morbidity should be declared a second time.
2. Syphilis: All newly infected or re-infected syphilis cases based on State Nursing Protocols or the *Recommendations for Public Health Surveillance of Syphilis in the United States, 2003*.
3. HIV: Morbidity should be declared on all newly diagnosed cases not found in the state or national database. HIV cases should only have morbidity declared once.

B. STD Testing Policy

1. STD testing is an integral part of the STD prevention program and conducted by all health department clinics in the state of Tennessee.
2. All patients entering a public health clinic, symptomatic or not, will be screened for chlamydia, gonorrhea, syphilis, and HIV unless they decline.
3. All persons exposed to an STD will be screened for HIV, chlamydia, gonorrhea, and syphilis and treated in accordance to the Public Health Nursing Protocol.
 - a. Patients presenting as a contact to gonorrhea or chlamydia should be treated for both.
 - b. Patients presenting as a contact to syphilis should be treated for syphilis.
4. STDs and HIV fall under the general medical consent to testing clients sign prior to examination in health department clinics.
5. Screening can be done as part of a more complete examination or in a “fast track” program where patients without symptoms, exposure to an STD, or significant risks have their blood drawn for syphilis and HIV as well as urine or self-administered vaginal swab collected for chlamydia and gonorrhea testing.
6. When conducting testing, it is recommended to make an appointment for the patient return to the clinic to receive their results. The HIV/STD program discourages the practice of providing negative syphilis results by telephone. We do, however, realize that this is not always practical. If negative syphilis results are to be given on the phone, the following must be followed:
 - 1) Consent to receive phone results must be obtained from the patient at the time of testing
 - 2) The patient must be counseled on:
 - (a) Basic understanding of the disease, how it is transmitted and how to prevent future exposure
 - (b) What the result means
 - (c) If or when re-testing is needed
 - (d) Referral to additional preventive services if applicable
 - (e) An entry in the patient’s chart must be made documenting;
 - i. The results and counseling were given
7. Documentation of any referrals made

C. HIV/STD Partner Notification

1. According to Tennessee Department of Health 1200-14-1-.15 (based on statutory authority), public health clearly has a responsibility in that we are required to, “make a complete epidemiological investigation to include (but

not limited to) review of appropriate medical and laboratory records, interviews of affected persons, etc.”

2. This responsibility is no less with patients reported by private providers. If a physician elects to assure that partner notification activities are performed, every effort should be made to assist them and to confirm that they have done so. Presently, high morbidity programs may not follow-up with private providers who performed partner services to obtain the contact information, test results or treatment information which must be on the case.
3. As part of the role of protecting the public's health, vigilance is required not only in conducting partner notification, but also in identifying new infections resulting from thorough case investigations.

D. Interstate Communication Control Record System Procedure

When it is determined that a Field Record (FR) must be sent to another state OR a record search is needed from another state, the following process should be followed:

OUTGOING

1. Positive lab tests on patients who reside outside of TN who received services in TN

- a. The jurisdiction in which the services were provided will:
 - i. Enter any information they have on the patient, specifically, test and treatment
 - ii. Task Complete all labs
 - iii. If patient was interviewed, make a note in the notes section of FR “Interview Done” along with any information the receiving state needs
 - iv. If an interview was not done, do not create an interview record, the interview record is not forwarded
 - v. Disposition the FR as “G” reassigned
 - vi. The Area Manager will reassign the FR to the ICCR clerk (when the FR is reassigned, an open Interview record and all open labs will be automatically transferred to the ICCR clerk)
- b. The ICCR clerk will:
 - i. Send the FR to the appropriate state
 - ii. Make an entry in the notes section “Faxed or Sent”
 - iii. Disposition the FR “K”
 - iv. Close the FR and mark “No” for morbidity
 - v. Transfer any open labs or Interview records back to the Area Manager of the originating jurisdiction to Task Complete
- c. No return disposition from the state is expected

2. Partner to syphilis or HIV

- a. The jurisdiction who initiated the FR will:
 - i. Enter any information they have on the patient, specifically, all possible locating information with a minimum of:
 1. First Name
 2. Working phone number with area code of the state receiving the FR
 3. State Name
 4. Date of last day of exposure to original patient
 5. Frequency of exposure
 - ii. Disposition the FR as “G” reassigned
 - iii. The Area Manager will reassign the FR to the ICCR clerk (be advised when the FR is reassigned to the ICCR clerk the patient’s open Interview record and all open labs will be automatically transferred to the ICCR clerk)
 - iv. When notified that a disposition has been returned, close the Interview record of the OP (if no other FRs are still open)
- b. The ICCR clerk will
 - i. Change the disposition on the FR to “I” Administrative Closure
 - ii. Send the FR to the appropriate state
 - iii. Make an entry in the notes section “Faxed or Sent”
 - iv. After the initial 2-week interval (4-week interval for HIV), call the receiving jurisdiction weekly until a disposition is returned
 - v. Make a note of any information received in the notes section in the FR
 - vi. Enter the appropriate disposition when received, adding any labs, treatment, notes and update the profile as appropriate
 - vii. Task Complete any labs entered
 - viii. Close the FR and mark “No” for morbidity
 - ix. Transfer any open labs or interview records back to the Area Manager of the originating jurisdiction to Task Complete
 - x. The Area Manager of originating jurisdiction will receive an automatic email response from PRISM to notify of closure

3. Partners to gonorrhea or chlamydia

- a. The jurisdiction in which the services were provided will:
 - i. Enter any information they have on the patient, specifically, all possible locating information with the minimum of:
 1. First Name
 2. Working phone number with area code of the state receiving the FR
 3. State Name

4. Date of last day of exposure to original patient
5. Frequency of exposure
- ii. Disposition the FR as "G" reassigned
- iii. The Area Manager will reassign the FR to the ICCR clerk (be advised when the FR is reassigned to the ICCR clerk, open Interview record and all open labs will be automatically transferred to the ICCR clerk)
- b. The ICCR clerk will:
 - i. If the partner has been exposed to syphilis or HIV as well as GC and/or CT, send all FRs at the same time
 - ii. Mail the appropriate information to the receiving state
 - iii. Disposition FR as "K" and close and mark "No" for morbidity
 - iv. Transfer any open labs or Interview records back to the Area Manager of the originating jurisdiction to Task Complete
- c. No return disposition is expected for the state

4. Record searches in other states

- a. The jurisdiction requesting the information will:
 - i. Request record searches for patients with a positive lab for syphilis, HIV, CT and/or GC OR for patients who are contacts to syphilis and/or HIV.
 - ii. Have appropriate contact person call ICCR Clerk or Public Health Representative 3 (PHR 3) to request search
 1. Contact the Central PHR 3 for record searches concerning HIV
 2. Contact the CO ICCR Clerk for record searches concerning all other diseases
 3. When requesting a record search give;
 - a. Name
 - b. Date of Birth
 - c. State of last known test and/or treatment
- b. If a patient is currently in clinic, inform ICCR clerk. If ICCR clerk is unavailable and immediate assistance is needed, follow local protocol for requesting health information from another health agency (and since patient is available to provide needed signature)
 - i. If information is returned, enter all information received in the PRISM FR
 - ii. The ICCR clerk or PHR 3 will:
 1. Call the appropriate state contact person to request information immediately (if a patient is in clinic)
 2. Call the requestor back with the information received (or lack of information)

INCOMING

5. When paperwork is received from another state (positive or contact)

- a. The ICCR clerk will:
 - i. Fax or mail the patient information and labs to the appropriate area contact person
 - ii. When notified of disposition, call originating state to report disposition and fax information
- b. The jurisdiction receiving the information will:
 - i. The Area Manager will have the FR and labs entered into PRISM
 1. Referral basis should be:
 - a. 01 – OOJ Profile Referred or
 - b. 02 – OOJ Cluster Referred or
 - c. 03 – OOJ Positive lab test
 - ii. Assign FR for follow-up
 - iii. Disposition the FR and close the record
 - iv. Have contact person call or email ICCR clerk, inform that the record is dispositioned and give the Profile and FR numbers
 - v. Enter in notes field that ICCR clerk was notified

E. STD Testing of Minors

1. *Tennessee Code Annotated 68-10-104, gives public health departments authority to offer testing and treatment for sexually transmitted diseases, without parental consent, to minors 14 years of age and older.*
2. Services to minors 13 years of age and younger require obtaining parental consent and are at the discretion of the Regional or Metro Health Officer.

F. HIV Testing Policy

1. **General Principle** - HIV testing is an integral part of the HIV Prevention Program and conducted at all public health clinics in the state of Tennessee at no charge to the patient. These tests are funded with a combination of local, state and federal funds. Anonymous testing is not permitted in the state. All HIV testing is confidential as is all personal health information.
2. **Prevention Counseling-**
 - a. All patients should be advised of all tests that are to be performed. If the patient does not want to be tested, he/she must verbally refuse the test, otherwise referred to as “opt-out.”
 - 3) **Level One Counseling** - Clients at Greatest Risk
 - (f) All clients should receive some form of prevention counseling. These guidelines provide two levels of counseling for clients based upon self identified risks. The risk factor categories identified in these guidelines are based upon HIV/AIDS prevalence data collected by our Surveillance and Data Management Program.
 - (g) The seven step HIV Prevention Counseling approach should be used for clients in this category. Counseling can be modified based on the client’s needs. Clients in this category are:
 - (1) MSM
 - (2) I.V. Drug users
 - (3) MSM and IDU
 - (4) Clients who are sex or needle-sharing partners of someone that is infected with HIV or AIDS
 - (5) Clients who are sex or needle-sharing partners of persons with risk factors 1 through 3 above
 - (6) Programs have the option to add risk categories to those listed above based on specific regional/ programmatic prevalence data.
3. **Level Two Counseling** – Clients at Lower Risk
 - a. Once it has been determined that clients do not meet any of the risks identified in Level One, a simple session informing the patient about the meaning of test results, the anticipated time for having results, and brief risk reduction messages should be provided.
4. **Clinical Settings**
 - a. In addition to using Level Two Counseling in clinical settings, this approach may also be used in outreach or correctional setting screenings regardless of the client’s self-identified risks.

- b. Elements to be included in Prevention counseling
 - 1) Introduction and assessment of the client’s understanding of the procedure. For rapid testing, ensure that the client understands the length of time needed to perform the test and the meaning of the preliminary result they will receive.
 - 2) Identify client’s personal risk behaviors and circumstances
 - 3) Identify a safer behavior goal (risk reductions goal)
 - 4) Develop a client action plan
 - 5) If the test is rapid, give results. If it is preliminary positive/reactive, obtain confirmatory specimen.
 - 6) Make appropriate referrals
 - 7) Summarize and close the session.
 - 8) If the test is conventional, make an appointment for Post Test Counseling to give results
- 5. Post Test (Results) Counseling
 - a. Post Test Counseling is counseling given to patients discussing the results of their test, the meaning of the result and guidance on future testing. Counseling also includes prevention counseling and referral to care or preventive services. The Tennessee HIV/STD Prevention Program requires that all patients who test positive be notified of their results, notified of their legal obligations and referred to HIV care. Documentation of this counseling must also be recorded on individuals who test at a private provider.
- 6. Required HIV Training and Certification
 - a. All HIV counseling and testing whether conducted in a health department or in an organization that receives funds from the Tennessee Department of Health, must meet CDC standards and meet the standards below:
 - b. Required trainings to conduct HIV testing, with exception to licensed medical providers: physicians, physician assistant, nurse practitioners and registered nurses
 - 1) Device training (Only if using rapid HIV tests)
 - 2) The Fundamentals of HIV Prevention Counseling (CDC Curriculum)
 - 3) Addressing Issues of Clients Who Test Positive (CDC Curriculum),
OR
 - 4) Tennessee Department of Health’s “I Know” curriculum.
 - c. Required training for anyone providing HIV Results, except physicians:
 - 1) The Fundamentals of HIV Prevention Counseling (CDC Curriculum)

- 2) Addressing Issues of Clients Who Test Positive (CDC Curriculum),
OR
 - 3) Tennessee Department of Health's "I Know" curriculum.
- d. When conducting conventional testing, it is recommended to make an appointment for the client return to the clinic to receive their results. Providing positive HIV results by phone is **never** permissible. The HIV/STD program discourages the practice of providing negative HIV results by telephone. We do, however, realize that this is not always practical. If negative HIV results are to be given on the phone, the following must be followed:
- 1) Consent to receive phone results must be obtained from the client at the time of testing
 - 2) A pre-arranged security code or question must be agreed upon at the time of testing.
 - 3) After the security code is given, results may be given
 - 4) The client must be counseled on:
 - (i) Basic understanding of the disease, how it is transmitted and how to prevent future exposure
 - (ii) What the result means
 - (iii) If or when re-testing is needed
 - (iv) Referral to additional preventive services if applicable
 - (v) An entry in the patient's chart must be made documenting;
 - ii. That the proper security code was given
 - iii. The results and counseling were given
 - iv. Documentation of any referrals made
 - (vi) Linkage to HIV care services (if the client is diagnosed as positive)

G. HIV Rapid Testing

1. Rapid HIV test technology increase access to HIV testing among at-risk populations by reducing barriers associated with traditional methods of testing. Additionally, almost all clients will receive their test results since they can be provided almost immediately. On the basis of data submitted by the manufacturer for test approval, the sensitivity of rapid tests in the clinical studies was 99.6%. While rapid tests are very reliable, confirmatory testing (Western Blot by serology or oral fluid) is required for all “preliminarily positive” rapid tests. Increasing testing and notification will facilitate provision of medical and supportive services to HIV infected individuals earlier in the course of their infection. Also, disease intervention activities such as partner notification can begin earlier. While rapid testing may be an appropriate test for many people, some may not be prepared to deal with the possibility of test results in 20 minutes. Provisions should be made to offer those individuals a blood test, when possible. Due to CDC positivity requirements, rapid tests are only used in high prevalence areas.
2. Required Documentation-All health departments or agencies using the rapid HIV testing, must comply with the following.
 - a. Each agency will be required to operate under a CLIA-waiver. Technical assistance on how to apply for a CLIA-waiver will be offered by the Testing and Training Coordinator. Additionally, the
 - b. Medical Lab Board requires that those who perform the test also have a color blind test administered via the internet at <http://www.toledobend.com/colorblind/Ishihara.html>. After completion of this test, a confirmation page should be printed and kept on file. All applicable documents should be maintained by the agency for annual site visits and audits.
 - c. Successful completion of each training component will be assessed by the Testing and Training Coordinator for the Tennessee Department of Health. Counselors may only provide services corresponding to the training component completed.
 - d. Please note that private medical providers are only accountable to their respective quality assurance policies.
 - e. Only qualified staff may train new staff on the OraQuick Advance Rapid HIV-1/2 Antibody Test device; specifically, a representative from OraSure Technologies, Inc. or CO staff. The Testing and Training coordinator will make every effort to ensure that device training is provided in a timely manner.
3. Quality Controls for OraQuick Advance Rapid HIV-1/2 Antibody Test*
 - a. OraQuick Advance Rapid HIV-1/2 Antibody Test Kit* Controls must follow the manufacturer’s recommendations, at a minimum. This policy

applies to all health departments, funded agencies and community-based organizations administering rapid HIV testing in the State of Tennessee.

- b. Proficiency testing for all qualified individuals performing testing and running quality controls will be conducted twice per year, or per site-specific policy, and documentation maintained. In addition, temperature logs should be maintained daily on both the storage area and the testing area.
- c. Successful completion of each training component will be assessed by the Testing and Training Coordinator for the Tennessee Department of Health.
- d. Counselors may only provide services corresponding to the training component completed.
- e. OraSure Technologies, Inc. recommends that a control should be run under the following circumstances:
 - 1) When opening a new test kit lot
 - 2) Whenever a new shipment of test kits is received
 - 3) If the temperature of the test kit storage area falls outside of the 2^o-27^oC (35^o-80^oF)
 - 4) If the temperature of the testing area falls outside of 15^o-37^oC (59^o-99^oF)
 - 5) At periodic intervals as dictated by the user facility
 - 6) Each new operator prior to performing testing on patient specimens
- f. What to do if controls are NOT as expected, per manufacturer's recommendations:
 - 1) If the test result for either the Negative Control or the HIV-1 Positive Control or the HIV-2 Positive control is not as expected, the test should be repeated using a new Test Device, Developer Solution Vial and control specimen.
 - 2) If the test result for any of the controls is not as expected upon repeat testing, discontinue testing and contact OraSure Technologies, Inc. Customer Service at 1-800-869-3538.

H. STD Formulary

The STD Program purchases drugs through the 340B Federal Program, which allows states to purchase drugs for STD treatment at significantly discounted prices. These drugs may **only** be used on STD Program patients. Patients who have a sexually transmitted disease are STD Program patients, regardless of the original reason for the visit. Therefore, the Program drugs may be used to treat them, but must be coded to Program **ST** in PTBMIS when they are issued. The use of drugs purchased through this program on patients who are not STD Program patients is considered an audit exception and may jeopardize the ability of the Department to continue receiving the discounted pricing in the future.

The formulary corresponds to the most recent CDC's STD Treatment Guidelines, and matches the PHN protocols for STD treatments. Drugs that do not appear on the list below are considered non-formulary. Requests for non-formulary medications are considered on a case-by-case basis by the HIV/STD Medical Director and the HIV/STD Prevention Director. To request a non-formulary medication, an email should be sent to the HIV/STD Medical Director, the HIV/STD Prevention Director, and the State Pharmacy Director with a justification of why the drug is needed. The formulary is listed below and replaces all previous STD formulary listings.

STD Formulary

Amoxicillin 500 mg #30

Azithromycin 500 mg #2

Bicillin 1.2 MU Pre-filled Syringe

Ceftriaxone 250 mg Single-dose Vial

Clotrimazole 3-Day 2% Cream 0.74 oz.

Doxycycline 100 mg #14

Metronidazole 500 mg #4, #14

Permethrin 1% Cream Rinse 60 ml

Permethrin 5% Cream 60 gm

Podofilox 0.5% Solution 3.5 ml, or Gel 3.5 gm

Terconazole 80 mg Vaginal Suppositories #3

Trichloroacetic Acid 80% Solution 15 ml

I. Records Retention Policy

1. The following are the HIV/STD Prevention Program's policies on record retention. They apply to all program documentation.
2. This policy clarifies only that which is not covered in department of health policies. The HIV/STD Program does not have jurisdiction over medical records.
 - a. Reports positive lab tests-
 - 1) Reports of positive laboratory tests from the State laboratory should be placed in the medical record according to bureau policy (RDA 2088 ALLOT 34349).
 - 2) Positive results that have not been electronically imported into the current reporting system (PRISM or eHARS) should be manually entered. Copies which are not part of the medical record may be destroyed after entering.
 - 3) Reports of positive laboratory tests from private providers should be entered into the appropriate reporting system: PRISM or eHARS.
 - b. STD Case reports (non-HIV)-2- years (RDA 2085 ALLOT 34349) –The PRISM record is a case report of record. There is no policy that *requires* local programs to keep paper reports.
 - c. Congenital Syphilis Case Records- 10 years (RDA 2086 ALLOT 34349) - Same as above, the PRISM record is the case report of record and no additional paper records are required.
 - d. HIV/AIDS Case Report files- microfilm- maintain in office 99 years or until obsolete (RDA 1897 ALLOT 34349). Both microfilm and paper copies are obsolete. The case report of record is the eHARS record. It is acceptable for jurisdictions to keep one paper copy of case reports with case notes not in the official record, provided these records are kept in a secure location as per HIV Surveillance policy.

As far as the HIV/STD Program is concerned, once a record is in electronic form, (in PRISM, eHARS, etc) the paper copy does not need to be retained.

IX. Legal

Tennessee State law requires reporting from physicians, laboratories, and all others knowing of or suspecting STD or HIV infection. Laws, also referred to as Tennessee Code Annotated (TCA), are generally short and do not give details. They generally give a department the authority to develop rules and regulations. Most of the laws that deal with HIV and STDs are governed by the Department of Health. Some however, are governed by the Department of Children's Services (DCS) and others by the Attorney General's Office. TCA can be accessed at [Michie's Legal Resources](#).

A. The following is a short synopsis of the state laws that govern HIV and STD Program Activity:

1. Confidentiality/Medical Records-

- a. **T.C.A. 68-10-104** –Allows any state, district, county or municipal health officer, or any physician to examine, diagnose and treat minors infected with an STD without the knowledge or consent of the parents. Releases the physician or health officer from any liability except for negligence.
- b. **T.C.A. 68-10-113** – Requires all records of information held by the Department of Health relating to known or suspected cases of STDs be confidential. Requires such information not be released or placed in court documents except under certain circumstances. Requires, under the Tennessee Child Abuse Law, reporting any STD case involving a minor less than 13 years old to the appropriate authorities.
- c. **T.C.A. 68-10-114** – Requires that no state or local health department officer be asked in civil, criminal or other proceeding about the existence or contents of pertinent records of a person examined or treated for an STD.

2. Reporting Statutory Rape

- a. **T.C.A. 39-13-506** - States the “rule of sevens” regarding Statutory rape.
 - 4) Mitigated Statutory rape- the victim is at least 15 but less than 18 and the defendant is at least 4 but not more than 5 years older.
 - 5) **Statutory rape**
 - (a) The victim is at least thirteen (13) but less than fifteen (15) years of age and the defendant is at least four (4) years but less than ten (10) years older than the victim; or
 - (b) The victim is at least fifteen (15) but less than eighteen (18) years of age and the defendant is more than five (5) but less than ten (10) years older than the victim.
 - 6) **Aggravated statutory rape** is the unlawful sexual penetration of a victim by the defendant, or of the defendant by the victim when the victim is at least thirteen (13) but less than eighteen (18) years of age

and the defendant is at least ten (10) years older than the victim

b. Criminal charges

- 1) Mitigated statutory rape is a Class E felony.
- 2) Statutory rape is a Class E felony
- 3) Aggravated statutory rape is a Class D felony

3. Reporting STDs

- a. **T.C.A. 68-5-102** – If a physician, surgeon, or medical practitioner knows or suspects a person is infected with AIDS, she/he must notify the local health authorities (municipal or county) where the person resides. In the event of a death of such person, the same notification must be given to the person to whom the body is delivered.
- b. **T.C.A. 68-5-103** – Upon receipt of such notice, the municipal or county health authorities must follow Department of Health rules for prevention and restriction of such diseases.
- c. **T.C.A. 68-10-101** – Requires physicians, health officers, clinics, hospitals, labs or penal institutions to report any STD cases. Outlines reporting procedures.
- d. **T.C.A. 68-10-103** – Requires a physician or other persons treating persons infected with an STD to provide printed information regarding STDs. Requires the information be furnished by the Department of Health.
- e. **T.C.A. 68-10-109** – Authorizes the department to make rules and bylaws for the control of STDs, including the reporting, isolation and quarantining of STD-related infected persons.

4. Exposure

- a. **T.C.A. 39-13-108** – Requires the department to establish rules and regulations regarding individuals who knowingly expose others to HIV. This includes the development of rules and regulations for quarantining such individuals.
- b. **T.C.A. 39-13-109** – It is a criminal offense for an individual with HIV to knowingly engage in intimate, sexual contact, to donate blood or tissue for use by another individual, or to exchange intravenous drug paraphernalia.
- c. **T.C.A. 68-10-102** – Requires physicians to notify a health officer and provide the name and address of an STD-infected person who is exposing others to infection.
- d. **T.C.A. 68-10-107** – Prohibits any person infected with an STD to expose another person to such infection.

- e. **T.C.A. 68-10-115** – A person who has a reasonable belief that a person has knowingly exposed another individual to HIV may inform the potential victim without incurring liability and is immune from liability for making disclosure to the potential victim.

5. Compulsory Testing and Treatment

- a. **T.C.A. 39-13-516** – Upon conviction of prostitution, the court shall order the person to be tested for HIV at a licensed laboratory at the convicted person's expense. The District Attorney can see the results of such tests in determining whether to prosecute for aggravated prosecution.
- b. **T.C.A. 39-13-521** – A person arrested and accused for aggravated rape, rape, statutory rape, or rape of a child shall immediately be tested for HIV at a licensed medical laboratory at the accused's expense. The lab tests are to be given to the victim. The test results are not a public record and shall be given only to the victim, to the parent or guardian of a victim who is a minor or incapacitated, to the accused's physician and the victim's physician, to the Department of Health, to the Department of Correction, to the accused, to the prosecuting District Attorney, and to the court in the event of conviction of the crime.
- c. **T.C.A. 68-10-104** – Authorizes state, district, county and municipal health officers to investigate and examine any person reasonably suspected of being infected with an STD and requires such person to report for treatment and quarantine. Allows any state, district, county or municipal health officer, or any physician to examine, diagnose and treat minors infected with an STD without the knowledge or consent of the parents. This releases the physician or health officer from any liability except for negligence.
- d. **T.C.A. 68-10-110** – Allows a health officer to appeal to the court for an arrest of a person infected with an STD who refuses treatment. Outlines court procedures for the arrest and temporary commitment for treatment. Requires the examination be made by a health officer or licensed and practicing physician. Allows the infected person to have his or her own physician present at the exam. Allows for an appeal by the infected person.
- e. **T.C.A. 68-10-116** - Allows an officer to request an arrested person's blood be tested for the presence of Hepatitis B or HIV if the officer is exposed during the arresting, transporting or processing of a person. Requires testing to occur at a licensed health care facility, with the cost to be paid by the division that employs the law enforcement officer. Requires the test to be confidential and allows the officer exposed to request test results.

6. Quarantine

- a. **T.C.A. 68-5-104** – After receipt of a notice called for by T.C.A. 68-5-102,

local health authorities must isolate and/or quarantine a person or premise determined to be the source of a communicable disease in accordance with the rules of the Department of Health.

- b. **T.C.A. 68-10-104** – Authorizes state, district, county and municipal health officers to investigate and examine any person reasonably suspected of being infected with an STD and requires such person to report for treatment and quarantine. Allows any state, district, county or municipal health officer, or any physician to examine, diagnose and treat minors infected with an STD without the knowledge or consent of the parents. Releases the physician or health officer from any liability except for negligence.
 - c. **T.C.A. 68-10-105** – Authorizes a health officer to designate and define limits within a specified area where the STD-infected person is to be isolated or quarantined. Authorizes only the physician or nurse working on the case to enter or leave the area of quarantine without the permission of the health officer.
 - d. **T.C.A. 68-10-106** – Requires that no one but a state, municipal, district or county health officer establish and terminate the quarantine of persons infected with STDs. Requires the commissioner to set up clinical laboratory criteria for the guidance of health officers in the performance of their duties regarding quarantining and infected person.
 - e. **T.C.A. 68-10-108** – Authorizes county legislative bodies, city officials and other boards to provide a place for the isolation and quarantine of an STD-infected person.
7. **Educational Materials- T.C.A. 49-6-1008** – Requires all educational materials directed toward school children that pertain to the prevention of AIDS and other STDs place primary emphasis on abstinence from premarital intimacy and avoidance of drug abuse in controlling the spread of AIDS. Requires AIDS education programs to be adopted by the local boards of education.
8. **Fines- T.C.A. 68-10-111** – Makes it a class C misdemeanor for any health officer or any person who fails to perform the duties required of them by STD rule or bylaw or who violates any STD rule or bylaw.
9. **Chlamydia-T.C.A. 56-7-2606** – Provides for insurance coverage on at least one chlamydia test annually in association with a pap smear when medically necessary for women less than 30 years of age.
10. **Definitions -T.C.A. 68-10-112** – Defines certain words used in regulating STDs. Defines an “STD” as any disease that is transmitted primarily through sexual practices and is identified in the rules and regulations of the department.
11. **HIV Pregnancy**
- a. **T.C.A. 68-5-701** – Establishes the Tennessee HIV Pregnancy Screening

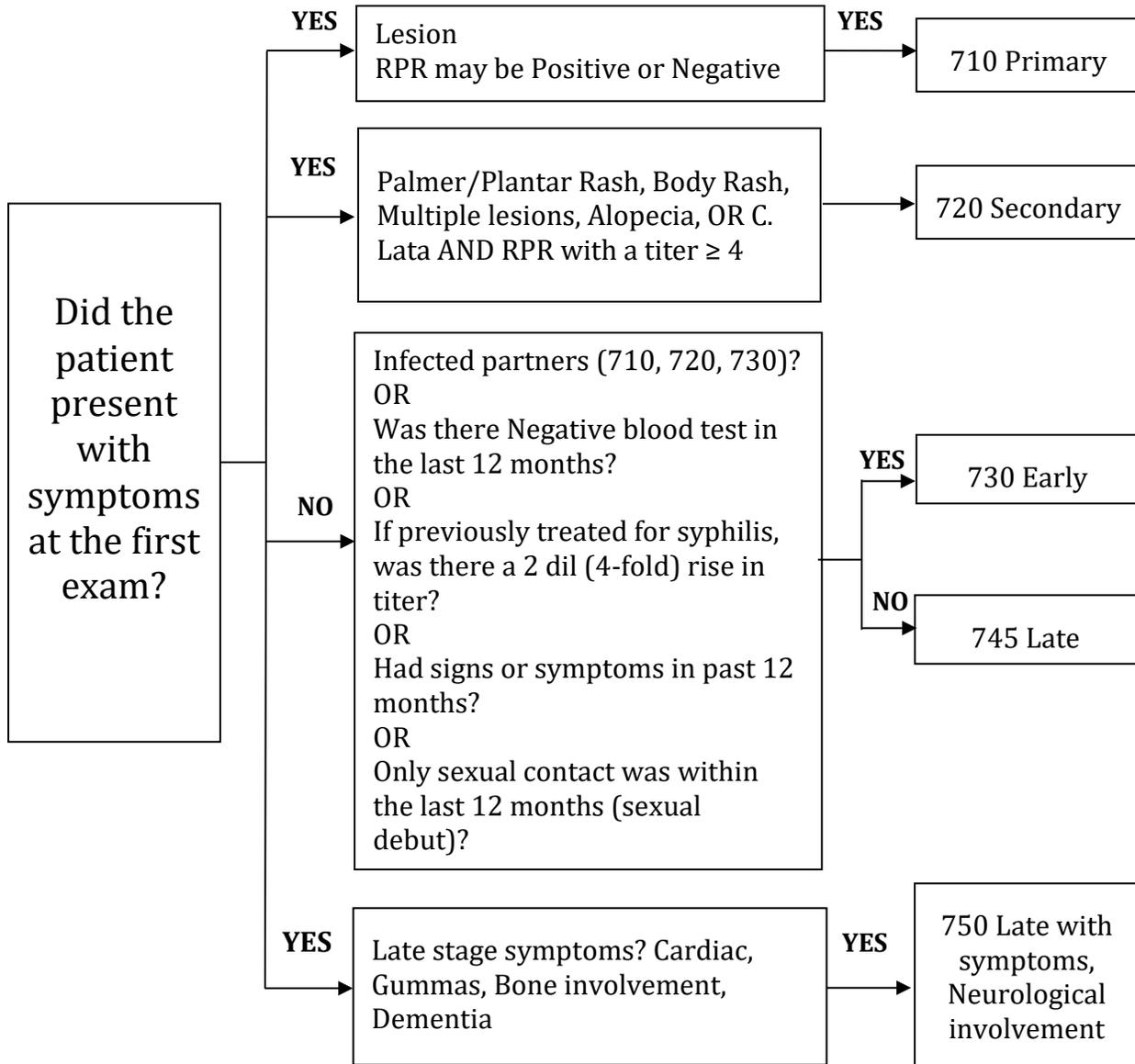
Act of 1997. Although this was updated in 2007, it retains the name.

- b. **T.C.A. 68-5-702** – Requires all health care providers that assume the responsibility of prenatal care for pregnant women to counsel them regarding HIV infections and to provide testing except when refused.
 - c. **T.C.A. 68-5-703** – Explains the content of HIV testing that prenatal care providers are to provide to patients.
 - 1) A health care provider shall arrange for each pregnant woman under the provider's care to be tested for HIV as early as possible in the course of the pregnancy, and again during the third trimester, unless the woman has refused testing in writing and this refusal has been placed in the medical chart.
 - 2) A pregnant woman who presents herself for delivery and who does not have a documented negative HIV test during the last trimester of the pregnancy, unless already known to be HIV positive, shall be tested for HIV using a rapid HIV test, unless she refuses in writing. If she refuses testing, and when the time and circumstances are medically appropriate, she should be counseled regarding the consequences of exposing her unborn child to HIV.
 - 3) All testing is confidential
 - 4) This provides language regarding those who test positive.
12. Department of Health Rules-Most rules that apply to the Department of Health are in the 1200 chapter. This can be found on the state web site at <http://www.tennesseeanytime.org/laws/laws.html>

X. Appendix

A. Syphilis Staging Chart

Staging Syphilis



* This staging chart should not be used for congenital case investigation.

B. GLOSSARY OF TERMS ASSOCIATED WITH PARTNER SERVICES

Associate— Individuals initiated for field follow-up from cluster interviews. Associates are named by persons not infected with the disease in question. Associates can fall into one of three categories: A-1 People with symptoms of the disease. A-2 Unnamed partners of an infected patient. A-3 Others who might benefit from an examination. See Cluster Interview, Social Network Analysis.

Case Management— The systematic pursuit, documentation, and analysis of medical and epidemiologic case information that focuses on opportunities to develop and implement timely disease intervention plans.

Client— An individual who seeks HIV prevention counseling and testing services.

Client-Centered Counseling— Counseling conducted in an interactive manner, responsive to the individual patient's needs and requiring an understanding of the unique circumstances of the patient including behaviors, culture, knowledge, and social and economic status.

Cluster Interview— An interview of an uninfected person conducted to gather information about previously unnamed or uninitiated partners of known cases and about individuals who may be in need of an STD examination. The cluster interview is conducted with partners, suspects, or associates of known cases.

Confidentiality— The concept that information will be released only to persons who need the information to help with the patient's medical care and to protect the public health.

Contract Referral— Notification strategy in which the provider elicits locating information, negotiates a time frame for the infected patient to notify his or her partners of the possibility of their exposure, and refer them to appropriate services. If the patient is unable to do so within an agreed-upon time period, the provider has permission to notify and refer the partner(s).

Disease Intervention— The process of stopping the spread of a disease and the complications of disease.

eHARS- Electronic HIV and AIDS Reporting System. The system used by the state of Tennessee as the HIV/AIDS registry.

Field Investigation— The process of informing infected persons and their partners of their status by going into the community to find them and to motivate them to accept medical attention and risk reduction counseling.

Incubation Period— The incubation period begins with the date of infection and ends with the appearance of signs or symptoms.

Index Patient— A patient newly diagnosed with a STD and who is a candidate for interview by trained DIS. The term index patient is often interchanged with original patient. Typically, the index patient is the first infected person identified in a lot involving multiple infections.

Interview Period— The interview period covers the time from the earliest date a patient could have been infected to the date of treatment; it always includes the maximum

incubation period and the duration of symptoms. Thus, it includes the time during which a patient could become infected or spread the disease to others.

Lot System— A system of organizing cases so that related cases are filed in the same “lot” or folder. The goal is to assure that all obtainable information regarding the continuing management of related cases contained in a lot is readily available to all responsible workers.

MAP Sheet— The **Major Analytical Points** (MAP) sheet is used for gathering information about members of a lot as well as for analysis and communication.

Original Interview—The first interview conducted with an infected patient. The interview is designed to ensure that the patient understands the seriousness of the disease, and motivates them to cooperate with STD/HIV control efforts. It is also designed to increase the likelihood that all at-risk partners and suspects are disclosed so they can be brought in for examination and treatment and to provide client-centered counseling to develop a personalized risk reduction plan.

Original Patient (OP)—See index patient.

Partner— A person who engages in any type of sexual activity or needle-sharing activity with the infected person.

Partner Elicitation— The process of obtaining names, descriptions, and locating information of persons who are either partners, suspects, or associates to the original patient.

Partner Notification— The process of locating and notifying partners that they have been exposed to a disease.

Partner Services— The wide range of services provided to partners of infected patients. Partner notification is but one aspect of these services. Other services include counseling, testing, and treatment, as well as referrals to appropriate services such as family planning, prenatal, drug treatment, social support, housing, etc.

Patient— An individual who is treated for a STD.

Patient (Self) Referral— A notification strategy whereby the infected patient accepts full responsibility for informing partners of the possibility of exposure to an STD and for referring them to appropriate services. With patient referral, the provider coaches the infected patient on when, where, and how to notify and what to expect with reactions.

Post-Interview Analysis— An analysis of the information obtained during the interview. The post- interview analysis should be done immediately after the interview when the information is still fresh on the mind of the DIS.

Post Test Counseling— Counseling given to patients discussing the results of their test, the meaning of the result and guidance on future testing. For HIV Testing, HIV Post Test Counseling also includes prevention counseling and referral to care or preventive services.

Pre-Interview Analysis— An analysis of the patient’s situation done by the DIS before the original interview. The pre-interview analysis includes reviewing available medical

information and case information, reviewing available socio-sexual information, and assembling necessary materials and supplies needed during the interview.

Pretest Counseling— Counseling prior to a test being performed.

Presumptive Interview— An interview conducted on the basis of a patient presenting with symptoms or laboratory findings that are suspicious or not yet available. The purpose of this type of interview is to afford the staff additional time and information by assuring the rapid examination and medical evaluation of recent sex partners.

PRISM— Patient Reporting, Investigating, and Surveillance Management. The system used by the State of Tennessee to record STD surveillance and Case Management information and HIV and STD field activities.

Provider Referral— A notification strategy where the provider takes responsibility for confidentially notifying partners of the possibilities of their exposure to a STD.

PTBMIS— Patient Tracking Billing Management Information System. The system used by local health departments to enter patient demographics, billing and encounter information.

Referral Basis— The reason a person was first tested, why they first sought medical care.

Re-Interview— Any interview following the original interview with a STD patient. Re-interviews are conducted to provide feedback, to gather additional information that may help prove or disprove a hypothesis about case relationships, to address points not covered during the original interview, to identify additional partners or suspects to the original patient, to confront points that are illogical or that are disputed by other information, to solicit assistance in locating previously named persons who have not been located or are being uncooperative, to support patient risk reduction attempts, and to support and reinforce a patient's successful use of referred services.

Screening— The testing of asymptomatic individuals routinely according to program criteria. For example: Performing GenProbe tests on all sexually active women under 25, seen in funded Family Planning Clinics.

Social Network Analysis— The study of how people connect in social structures and of its implications. See Cluster Interview.

Source Period— The interval during which a patient most likely contracted the disease.

Spread Period— The time during which a patient is potentially infectious and could have passed the disease on to others.

Suspect— Individuals identified as the result of an interview with an infected person but who are not partners of that person. Suspects are divided into three categories: S-1 People with symptoms of disease. S-2 An unnamed partner of an infected patient. S-3 Others who might benefit from a STD examination. See Cluster Interview, Social Network Analysis.

Targeted Screening— An activity to identify infected people in a select group who are engaged in behaviors that put them at greater risk for infection.

Volunteer— A person who comes into the clinic without being referred.

C. Common Abbreviations Used for Documentation on FRs and IRs

The following are standard abbreviations used in HIV/STD Programs throughout the country:

ACO	Administrative closure
AKA	Also know as/alias
Ct	Contact
Dx	Diagnosis
FB	FaceBook
FR	Field Record
FV	Field Visit
LR	Left Referral
LMTC	Left message to call
LMP	Date of last menstrual period
GC	Gonorrhea
Hx	History
IP	Index Patient (same as Original Patient/OP)
Ix	Interview
MR	Medical Record
NA	No answer
NOAH	No one at home
OI	Original Interview
OP	Original Patient (same as Index Patient/IP)
PC	Phone call
Pt	Patient
RS	Record Search
RI	Re-interview
Rx	Prescription or medication
S/S	Signs/symptoms
STS	Serologic test for syphilis
Tx	Treatment
UTL	Unable to locate
W/ or w/o	with or without

WCB will call back
XX Cross Directory

Disease Codes

200 Chlamydia
220 Chlamydia Ophthalmia Neonatorum
300 Gonorrhea
320 Gonorrheal Ophthalmia Neonatorum
350 Gonorrhea Resistant
710 Primary Syphilis
720 Secondary Syphilis
730 Early Latent Syphilis
745 Late, Latent Syphilis
790 Syphilis Congenital- Early Unspecified
900 HIV
910 Acute HIV Infection
950 AIDS

D. Field Record Dispositions

- A** Preventative Treatment- Not infected and received preventative treatment, exposure anytime in the interview period, may also use if provider treats but doesn't offer testing
- B** Refused Preventative Treatment- Tested, not infected, but not treated (can't find, Dr said didn't need treatment, etc)
- C** Infected, Brought to Treatment- Infected and treated after the initiation date of the field record
- D** Infected, not treated
- E** Previously Treated for This Infection- Treated any time prior to you initiating the field record
- EPT** Expedited Partner Therapy- A partner unable to attend a provider visit to obtain treatment receive EPT for chlamydia. Only to be used in PRISM on contacts.
- F** Not Infected- Tested and not infected
- G** Reassign- Out of jurisdiction (OOJ), either to another part of the state or to another state. Syphilis or HIV cases cannot be closed with this disposition. Need to get a "final" disposition to close.
- H** Unable to Locate (cannot be used for reactors)
- I** Administrative Closure- temporary closure for ICCR services to take place, only to be used by the ICCR Clerk
- IX** Interview or re-counsel only, patient already adequately treated
- J** Located, Refused Examination (cannot be used for reactors)
- K** Out of Jurisdiction- Only to be used by the ICCR clerk for record leaving the state for morbidity elsewhere
- L** Other- to be used with all other dispositions do not apply, must have detailed documentation in the notes section
- LPS** Located, traditional partner services
- LV** Domestic Violence Risk- Client at risk of domestic violence
- LX** Deceased
- OLD** Historical Syphilis- Record search closure syphilis
- PP** Previous Preventative Treatment- Previously epi treated for exposure in same time period
- 1** Previous Positive
- 2** Previous Negative, New Positive
- 3** Negative
- 4** Previous negative, not re-tested
- 5** No previous test, new positive
- 6** No previous test, new negative
- 7** Not tested
- 8** Previous 900+, needs partner services because not previously interviewed
- 9** Previous 900+, needs partner services because new STD diagnosis or pregnant
- 10** Previous 900+, needs partner services because contact to STD
- IND** Indeterminate- HIV Western Blot Indeterminate

E. FIELD VISIT STANDARDS

The following are standards that reflect satisfactory performance of areas found on the field audit. If any employee is performing at a level higher than these standards, they should be rated excellent. If the rating is below the standard level, the employee should be rated as needs improvement. In your comments on excellent or needs improvement, please provide the percentages that led to your rating.

If an employee achieves 80-90% in a category, they should be rated as satisfactory. Above 90% will be rated excellent, below 80% will be rated needs improvement.

1. Utilizes resources
 - a. Planned field visits will have referral cards made out prior to leaving the clinic and the planned route of field stops will be documented prior to leaving the clinic.
 - b. These field records will have documentation of record searches performed.
2. Investigative priorities
 - a. Field records should be in order of investigative priorities.
3. Referral Methods
 - a. Field records will be documented with appropriate referral methods (i.e., field record with phone number will have as first field activity a phone call).
4. Stalled Investigation
 - a. Stalled investigations will have documentation of efforts to overcome problems and obtain closure of the field record (variety of methods will be used).
5. Obstacles
 - a. Field visits that result in problems in the field are resolved in an appropriate manner.
6. Motivation
 - a. Appropriate STD motivations are used in field visits.
7. Documentation
 - a. Field visits are documented immediately (before next field stop).

F. INTERVIEW AUDIT STANDARDS

The following standards represent actions that indicate a satisfactory rating in the performance of various sections of the interview. If the employee went beyond these actions in the interaction with the patient, a rating of excellent should be given. If the employee did not perform these actions or performed them poorly, a rating of needs improvement should be given. For all excellent and needs improvement ratings, please indicate the reasons for the rating.

1. Demonstrates professionalism
 - a. Displays self-confidence, competence, dependability, preparation, and appropriate seriousness.
 - b. Nonjudgmental and objective about patient behavior and lifestyle.
2. Establishes rapport
 - a. Displays respect, empathy, and sincerity to patients.
3. Listens effectively
 - a. Does not interrupt patient unnecessarily.
 - b. Responds to patients questions appropriately.
4. Uses open-ended questions
 - a. Uses who, what, where, why, and how to stimulate responses
5. Communicates at patient's level of understanding-
 - a. Avoids technical terms, jargon, or words that patient may not understand.
 - b. Clearly explains necessary medical and technical terms and concepts.
6. Gives factual information-
 - a. Demonstrates an accurate knowledge of STDs.
 - b. Corrects patient's misconceptions and provides comprehensive disease information.
7. Solicits patient feedback
 - a. Asks appropriate questions to determine whether patients understand information and how they intend to comply.
8. Uses appropriate nonverbal communication
 - a. Maintains eye contact, minimizes physical barriers, and leans toward patient.
 - b. Avoids negative nonverbal signals such as finger shaking, arm crossing, or expressions of disinterest.
9. Recognizes verbal and nonverbal problem indicators
 - a. Responds when patients ask direct questions, make contraindications, express concerns, hesitate, or express misunderstandings.

- b. Responds to patient's eye contact, body language, or posture.
10. Confronts problems communicated by patient
- a. Demonstrates self-confidence, appropriate body language, and eye contact.
 - b. Communicates position while still maintaining rapport.
11. Uses STD motivations, motivates clearly and convincingly
- a. Demonstrates understanding of STD motivations including confidentiality, re-infection, spread and re-infection, responsibility to others, self-survival, potential problems, and disease complication.
12. Emphasizes confidentiality
- a. Emphasizes discreet approaches used by the program, gives examples of how it works.
 - b. Demonstrates what would be said to the partner if confidentiality seems a sensitive issue.
13. Emphasizes sex partner referral
- a. Ensures that appropriate time, attention, and importance are given to sex partner referral.
 - b. Tactfully persists in identifying sex partners.
14. Pursues detailed locating/identifying information
- a. Gathers detailed locating information on patient.
 - b. Obtains basic identifying information and pursues distinguishing characteristics.
15. Emphasizes prevention counseling
- a. Discusses risk factors with patient.
 - b. Discusses risk reduction messages as appropriate to patient including condom use.
16. Conveys a sense of urgency
- a. Communicates to patient the importance of immediately notifying and referring others who are at risk.
17. Establishes specific contracts and coaches patient
- a. Makes it clear to patients the time period during which they can refer partners before the DIS takes on that responsibility.
 - b. Points out pros and cons of patient referral if patient chooses to refer partners.
 - c. Helps patient to know what to say when confronting partners.

G. Disease Interview Format

Introduction and Professional Role

Purpose: to let client know what is going to take place is for his or her benefit; that he or she will be dealing with a professional; and they should not be afraid to discuss personal information.

- A. Introduce yourself and anyone else present to the client. Include your name, role, and purpose.
- B. Tell client you have been trained and have experience helping people who have STDs to understand and manage their disease and avoid getting another STD in the future.
- C. Discuss confidentiality by informing the client that part of your job is to ensure that no one else finds out about his or her infection so problems are minimized for all who may be involved.

Client Assessment

Purpose: to establish rapport, get client accustomed to talking, reduce the possibility of client concerns interfering with the rest of the process, gather information to be used in later sections, and give the client sufficient information to be able to understand and support disease intervention behaviors. By getting the client to talk during this section, issues may arise that can be used as motivators or as benchmarks against inconsistencies later in the interview.

- A. Client Concerns
 - a. Determine if the client has been told what the diagnosis was. Ask client about problems or if there are any questions regarding disease and how it has been handled thus far.
 - b. Address concerns even if they are involved in other elements of the format.
 - c. Determine who or what motivated the client to be examined.
- B. Socio-sexual Information
 - a. Question client conversationally about where they live or stay, others at same residence, phone numbers, email, alternate locating information, employment or school, travel, recreation, social groups, internet sites used. Basically, want an overview of their life.
 - b. Explain reasons for questions if client gives signs of concern.
- C. Medical History and Disease Comprehension
 - a. Ask what client knows about disease.
 - b. Compliment correct responses, tactfully correct any misconceptions, and add any information that supports disease intervention behaviors.
 - c. Ask about STD treatment, test, and symptom history.

- d. Show pictures appropriate to disease (if any) and ask if they client remembers any on self or anyone else.
- e. Impress upon the client that the disease is serious, people many times don't know they have it, that routine tests often do not look for STDs, and that it is passed unintentionally by sex.
- f. Define sex regarding STD transmission.

Disease Intervention Behaviors

- A. Assure Examination of All Sex/Needle Sharing Partners -This section begins by conveying to the client that the DIS understands how to get partners examined without causing problems and the DIS has to be involved to some degree no matter who notifies the partners or where they get examined. As many partners should be identified as possible before the more threatening and tedious process of gathering locating information begins.
 1. Re-emphasize the medical facts just discussed clearly show that both the client and the client's sex/needle sharing partners since a significant date are at risk until all sex/needle sharing partners have been examined and treated.
 2. Re-emphasize confidentiality.
 3. Explain that the sex partners need to be notified privately that they have been exposed to a serious disease.
 - a. This has to be done in a way that doesn't embarrass them or the client, but ensures that the examination takes place immediately.
 - b. The exam should cover any and all infections to which the partner could have been exposed and should be performed by a professional who knows enough about the infection to do the appropriate thing medically.
 4. Tell the client that you can work together to create the best plan for notifying all the partners and that you have to know about each of the partners within a certain time period in order to ensure all are examined and treated.
 5. If the client seems hesitant about discussing partners, problem solve and,
 - a. Explain the different plans and give examples of how you handle referrals.
 - b. If still hesitant, you may opt to ask for a decision about the method of referral. This may defuse the client's unarticulated concerns or prevent the client from making up a story.
 - c. Most importantly, this tactic can affirm that the partner really exists and the client knows how to reach the partner. Also, it can keep a dialogue going to assure partners get examined without the client having to back out of a story.
 6. Ask for the names of each partner during the interview period.

- a. Do not be concerned if the client does not supply the entire name, but emphasize you want to discuss EVERY partner during the period, regardless of how much they know about them.
 - b. Ask leading questions to help them remember. Continue to probe for additional partners even after the client has indicated there are no more.
 - c. Use some other identifier for partners if client cannot remember a name or nickname. Write down names leaving space for rest of the partner's information.
7. When further probing fails to produce other partners, ask and record exposure dates and frequency.
 8. Confront problems indicated by exposure gaps, lack of source candidates, and conflicts with previously gathered information.
 9. Gather locating information including name and nickname, address, phone numbers, email or screen names, others at residence, employment or school location and number, age, DOB, race, gender, marital status, physical description and defining characteristics, directions to and descriptions of place where they stay.
 10. Explain referral methods and determine methods of referral for each partner and agree on best approach.
 11. Coach client on any contract referrals, giving guidelines and deadlines.
 12. Pursue cluster suspects.
 13. If no partners are elicited, ideally the client should be interviewed by someone else.
- B. Reduce Risk- This section shifts attention from the client's current infection to the behaviors that put him or her at risk for all STDs and HIV. These messages should be individualized and tailored to each client.
1. Point out that all STDs and HIV are acquired the same way the client got this STD.
 2. Emphasize avoiding sex until all partners have been examined and while completing treatment regimen.
 3. Tell client to avoid sex when symptoms are present or when disease is suspected in a partner.
 4. Encourage use of condoms.
 - a) Work on other risk reduction behaviors including:
 - b) Limiting number of sex partners
 - c) Limiting anonymous sex
 - d) Not using equipment used for injecting drugs

- e) Having routine check-ups
- C. Respond to Disease Suspicion- In spite of risk reduction intentions, the client should understand how to react to logical suspicions about future infections of STDs.
 - 1. Discuss clinical symptoms of STDs and HIV.
 - 2. Tell client to avoid sex when disease is suspected.
 - 3. Tell client to return for medical care immediately when symptoms appear of if a partner may be infected.
 - 4. Bring sex partners in for medical care or give locating information to DIS if disease is suspected.
- D. Take Medication
 - 1. Emphasize need to take all the medication or to return for rest of medication.
 - 2. Establish specific schedule.
 - 3. Discuss contraindications and potential side effects.
 - 4. Identify and discuss potential compliance issues.
- E. Return for Follow-up Test (when applicable)
 - 1. Review medical purpose of retests.
 - 2. Negotiate appointment date and time. (CT 3 months, syphilis at 6 and 12 months)
 - 3. Identify and discuss potential compliance problems.
- F. Conclusion
 - 1. Ask what questions or problems remain.
 - 2. Review and reinforce all components of compliance plan.
 - 3. Reinforce commitments.
 - 4. Make arrangements for re-interview for syphilis or HIV.

H. Re-interview Format

Introduction, Professional Role and Purpose

- A. Re-Introduce yourself
- B. Review confidentiality
- C. Define purpose of re-interview:
 - a. Discuss commitments made in OI
 - b. Discuss new information learned about client's infection

Client Assessment

- A. Client Concerns
 - a. Inquire about and resolve any client concerns during the interim period (possible reactions to the medication, compliance issues, etc.)
- B. Socio-sexual Information
 - a. Describe the importance of having accurate personal and medical information in resolving the client's disease problems.
 - b. Address any conflicting locating or demographic information provided by the client.
- C. Medical History and Disease Comprehension
 - a. Review what the client knows about the disease
 - b. Emphasize the infectiousness, asymptomatic nature, and severity of the disease.
 - c. Pursue clusters with symptoms based on the responsiveness of the client.

Disease Intervention Behaviors

- A. Assure the Examination of All Partners
 - a. Review confidentiality and professional role of the DIS
 - b. Stress the importance of ALL partners being examined
 - c. Pursue a specific agenda based on the analysis of the original interview and the interim period
 - i. From analysis of the original interview:
 1. Problem solving analysis to effectively motivate the client
 2. Identification of potential source candidates
 3. Identification of potential spread candidates
 4. Analysis of areas unexplored in the OI.

- ii. From the analysis of the interim period:
 - 1. Locating problems
 - 2. Partners and locating information validity
 - 3. Questions from cluster interviews
 - 4. Other intelligence gathered
- d. Pursue S2s and S3s.
- B. Reduce Risk
 - a. Emphasize avoiding exposure until complete medication and all partners examined
- C. Respond to Disease Suspicion
 - a. Reinforce message to client to respond when symptoms are in self or partner by immediately seeking medical care, avoiding exposing others until checked, and getting partners into medical care.
- D. Take Medication
 - a. Identify and discuss any compliance problems
 - b. Emphasize the need to complete all the medication
- E. Return for Follow-up Tests
 - a. Review need and purpose of follow-up tests.
 - b. Identify and discuss potential compliance problems

Conclusion

- A. Evaluate remaining client needs or potential compliance problems.
- B. Analyze case information for any inconsistencies, gaps, or missing information.
- C. Confront any inconsistencies and apply problem solving approaches needed to resolve problems.
- D. Reinforce any commitments made by client.

I. Cluster Interview Format

Introduction, Professional Role, and Purpose

- A. Introduce yourself
- B. Explain your role as a trained and experienced DIS
- C. Explain Confidentiality
- D. Define purpose of the interview:
 - a. To provide information about the disease exposed to the reason for treatment
 - b. To provide information to help prevent future exposures
 - c. To help the client know what to do if re-exposed

Patient Assessment

- A. Client Concerns
 - a. Identify and resolve any client concerns (why treated if negative, why talk with DIS if negative, etc.)
 - b. Determine disease intervention behaviors needing emphasis based on client's attitudes and needs.
- B. Socio –sexual Information
 - a. Describe the importance of having accurate personal and medical information in resolving the client's disease problems
 - b. Pursue demographic information, including address and phone numbers, lifestyle
- C. Medical History and Disease Comprehension
 - a. Determine client knowledge of disease
 - b. Reinforce what the client knows about the infection and correct any misconceptions.
 - c. Discuss the course of disease, modes of transmission, and patient's STD history
 - d. Pursue A1s.

Disease Intervention Behaviors

- A. Assure Examination of All Partners
 - a. Review confidentiality
 - b. Define significance of immediate partner referral, emphasizing that one or more could have an STD and re-expose client.
 - c. Determine client's capability to participate in partner referral

- d. Emphasize that the referral will be done immediately and will occur for everyone's benefit.
 - e. Evaluate problems and use specific motivational approaches:
 - i. Prevention to re-exposure to disease
 - ii. Potential of having asymptomatic partners
 - iii. Risk of being asymptomatic if infected
 - iv. Risk of complications if infected
 - v. Inconvenience
 - vi. Concern about partners or social groups
 - vii. Rapid examination reduces spread potential
 - viii. Reduce the chance of complications by helping now
 - f. Gather information about each partner
 - g. Pursue A2s and A3s.
- B. Reduce Risk
- a. Discuss the client's sexual lifestyle
 - b. Present options tailored to the client's lifestyle
 - c. Emphasize avoiding exposure by use of condoms and when symptoms are present or disease suspected in self or partner.
- C. Respond to Disease Suspicion
- a. Assure the client is aware of STD symptoms.
 - b. Counsel client to immediately seek medical care, avoid sex, and get partner into medical care if an infection is suspected.
- D. Take Medication
- a. Emphasize importance of medication
 - b. Discuss contraindications and potential side effects.
 - c. Identify and discuss any compliance problems.

Conclusion

- A. Evaluate remaining client needs or potential complications.
- B. Reinforce any commitments made by the patient.

J. Internet-based Partner Services Interview

1. What sites are you a member of?
2. What is your screen name?
3. What is your email address?
4. When was the last time you had sex with someone you met online?
 - a. Which chat room or website did you meet him/her on? (using open-ended questions)
 - b. What website (chat room) did you meet him/her on?
 - c. Where did you physically meet? (What was the address?)
 - d. What was his/her name?
 - e. What is his/her email address?
 - f. What is his/her screen name?
 - g. When is a good time of day or a certain day that would be best to find this person?
 - h. What can you tell me a little about him/her? What does he/she look like? How is he/she built? What does his/her online profile look like?
 - i. What other websites have you seen him/her on? What were his/her screen names?
 - j. What is his/her phone number?
 - k. What other ways do you contact him/her?
 - l. What is your screen name on this website?
 - m. What time of day do you log on?
5. Before this person, when was the last time you met someone from online?
6. Tell me about your “Buddy List” (Manhunt) or a “Friends List” (Adam4Adam) or an iTrick list?

Notes:

- Try to get the patient to write down the contact information in order to ensure you have the exact spelling of the screen names.
- Some websites allow you to access profiles without being a member. For example, Manhunt will allow a personal URL to access a profile; the format is [http://my.Manhunt.net/\(screen name\)](http://my.Manhunt.net/(screen name)). The format for gay.com is the same ([http://my.gay.com/\(screen name\)](http://my.gay.com/(screen name)))
- Refer to the *Internet and Text Messaging Policies and Procedures* for more information on contacting patients online.

K. Forms

1. DIS Quality Assurance Schedule
2. Field Work Audit Form
3. Interview Observation Audit For
4. Quarterly Educational Activity Form
5. Educational Activity Form
6. Laboratory Visitation Form
7. Provider Visitation Form

DIS Quality Assurance Schedule

Type	7 – 12 months Employment or on performance improvement plan	>1 year Employment
Field Record Audit	Twice Monthly	Monthly
Case Management Audit	Monthly	Quarterly or during each interim evaluation period
Interview Observation Audit	Monthly	Quarterly or during each interim evaluation period
Field Work Audit	Monthly	Quarterly or during each interim evaluation period

Although the Interview Observation and Field Work Audits still need to be done in person and documented on the form, information for the Field Record and Case Management Audits can be produced from PRISM through reports and observation of the DIS task list.

FLS must document and present completed audits to DIS within 2 days of audit. Signed original forms are to be provided to the DIS and a copy maintained by supervisor.

- If a DIS scores below 80% overall on any audit, the supervisor must create a written performance improvement plan that includes the steps the supervisor will take to improve performance.
- FLS are to submit a monthly cumulative report of the number of reviews conducted to the next level of supervision, where applicable.

Supervisors must maintain a log of reviews completed with a copy of the review and, if applicable, the performance improvement plan.

FIELD WORK AUDIT

Field Investigation Date: _____ DIS Number: _____

Number of Field Investigations: _____ Supervisor Number: _____

	NO	NI	SAT	EX
Utilizes resources effectively in planning and executing referrals				
Recognizes investigative priorities				
Selects appropriate referral methods				
Demonstrates timely, persistent, and imaginative action required to move a stalled investigation				
Confidentially and professionally manages circumstances which are obstacles in any investigation				
Motivates people to come in promptly				
Documents investigative activities immediately				
Documents efforts to record search within 1 business day of date assigned				
Investigations documentation reflects program priority list				
Documentation reflects phone calls, letters sent, field visits as spelled out in program protocols				
Documentation reflects timely, persistent, and imaginative actions required to move a stalled investigation				
Documentation and supervision shows client confidentiality is maintained				
Documentation (time/date) of initial contact, result of contact, record searches, interaction with patient, plan for follow up, treatment information, partners elicited				
Attempted contact was made with patient within 1 business day for syphilis or HIV and 3 business days for gonorrhea or chlamydia after field record assigned				
Follow up on stalled investigations within 2 business days				
Record Search performed prior to the first field visit				
Responds to Supervisor instructions within 2 business days				
Documents all resources utilized during contact				

NO: Not observed NI: Needs Improvement SAT: Satisfactory EX: Excellent

Open Field Records from date assigned to DIS:

0-3 Days		12-14 Days	
4-7 Days		15> Days	
8-11 Days			

INTERVIEW OBSERVATION AUDIT

Interview Date: _____ DIS Number: _____ Supervisor Number: _____

	NO	NI	SAT	EX
Demonstrates professionalism				
Establishes rapport				
Listens effectively				
Use open-ended questions				
Communicates at the patient's level of understanding				
Gives factual information				
Solicits patient feedback				
Uses appropriate nonverbal communication				
Recognizes verbal and nonverbal problem indicators				
Confronts problems communicated by the patient				
Uses STD motivations, motivates clearly & convincingly				
Emphasizes confidentiality				
Emphasizes sex partner referral				
Pursues detailed locating/identifying information on all sex partners				
Emphasizes prevention counseling				
Conveys a sense of urgency				
Establishes specific contracts and coaches patients				
Acknowledges and responds to problems communicated by patient				
Emphasizes confidentiality at beginning of interview and throughout interview process				
Listens effectively, recognizes exposure gaps				

Open Interview Records from date assigned to DIS:

0-3 Days	
4-7 Days	
8-11 Days	
12-14 Days	
15> Days	

Quarterly Educational Activity Form

Quarter _____ Region _____

Reporting Person _____

Date	Location/ Presenter	Subject/ Was skill taught?	Number of Participants
10/10/2010	<i>Example:</i> Freedom High School Super DIS	STD Prevention yes	3 classes : 90 total

Educational Activity Form

Date of Activity _____ Name of Presenter (s) _____

Subject of Presentation _____

Location of the Activity _____

Approximate Number of Participants _____

Educational Goals/Objectives	Method of Presentation	Was a Skill Taught?	Presenter
<i>Example:</i> Instruct pregnant teens on STD & HIV Prevention	Power Point	Yes. Condom Negotiation	Super Dis

Laboratory Visitation Form

Laboratory Name:		Reason for Call / Visit:	
Contact Person:			
Address:		Type of Laboratory:	
Phone: Fax:		Reference Laboratory:	
County:		Lab Director:	
Comments:			
Type of visit :	Annual	New Lab	Delinquent Problem
Laboratory Tests Performed:			
Date Initiated:	Call/Visit:	Date of Call/Visit:	
DIS Name & #:		Supervisor:	

Completing the Laboratory Visitation Form

- The laboratory's name, address and identifying information should be entered in the first box.
- The reason for the call or visit box should be used as a quick reference for information pertaining to the problem the laboratory is having, a newly identified laboratory, or additional information.
- The Reference Laboratory box is any additional laboratory used for further testing. Type of Laboratory is, for example, a hospital laboratory or doctor's office laboratory, etc.
- Laboratory Testing Performed refers to the types of testing done by the laboratory.
- Copies of the Laboratory Visitation Form should be maintained by each region in order to reflect efforts.

Provider Visitation Form

Provider Name:		Reason for Call / Visit:	
Contact Person:			
Address:		Type of Provider:	
Phone:		County:	
Fax:			
Comments:			
Type of visit :	Annual	New Provider	Delinquent Problem
Date Initiated:	Call/Visit:	Date of Call/Visit:	
DIS Name & #:	Supervisor		

Completing the Provider Visitation Form

- The provider's name, address and identifying information should be entered in the first box.
- The reason for the call or visit box should be used as a quick reference for information pertaining to the problem the provider is having, a newly identified provider, or additional information.
- Comments should be as brief and concise as possible.
- The types of visit should be circled.
- Copies of the *Provider Visitation Form* should be maintained by each region in order to reflect efforts.