THE FLORIDA DEPARTMENT OF HEALTH

DIVISION OF DISEASE CONTROL AND HEALTH PROTECTION

BUREAU OF COMMUNICABLE DISEASES

STD AND VIRAL HEPATITIS SECTION

THE QUALITY MANAGEMENT PLAN FOR

STD FIELD OPERATIONS

Version *1.2*

11/08/2018

Version #	Developed By	Completion of Draft Date	Approved By	Approval Date	Reason
1.0	Dan George	*10/31/2015*	*<name>*	*<mm/dd/yy>*	*To provide Area STD Programs with the necessary tools to conduct self-administered QA reviews of STD field operations activities.*
1.1	Dan George *(Revision)*	*12/31/2015*	Ian Henning	*1/12/16*	
1.2	Janet Compton Tom Burns Isa Chinea Alessandria Killingsworth Gayreon Cowan George Gibbs	*10/26/2018*	Dan George Craig Wilson	*11/08/2018*	*Update performance measures, management materials, QA Checklists, procedures and appendix.*

Salute to Florida's STD Field Operation Team

When our clients are vulnerable and coping with the range of emotions that accompany news of their infection, DIS offer confidence, understanding, trust, and assurance. They are the humanity of STD awareness.

Stacey Shiver

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PURPOSE OF THE STD FIELD OPERATIONS QUALITY MANAGEMENT PLAN

Implementing the data management program, Patient Reporting Investigation Surveillance Manager (PRISM), made it possible to conduct statewide assessments of Sexually Transmitted Disease (STD) field operations case management activities. Program evaluations and assessments are necessary to determine: Quality Assurance (QA), Policy Development, and Disease Prevention. Area STD Programs are monitored remotely by the Bureau of Communicable Diseases, STD and Viral Hepatitis (STDVH) Section. The QA review method and processes are cost-effective, efficient, and can be used as a tool for on-site program reviews.

The Quality Management Plan (QMP) was developed as a guide for Area STD Programs to self-assess, monitor, evaluate, and improve the overall performance of the field operations. The STDHV is transitioning a significant proportion of quality assessment to the Area STD Programs. The STDVH staff are available to provide support and technical assistance as needed.

The QMP contains materials to assist with program improvement and established STD performance and outcome measures. It defines policies, procedures, criteria for application, roles, responsibilities, and authorities. The intended audience includes: STD Program Managers, STD Field Operations Team, Disease Intervention Specialist (DIS), and County Health Department (CHD) leaders.

STD FIELD OPERATIONS OVERVIEW: ORGANIZATION, RESPONSIBILITIES

The STD Program Manager (PM): Implementing quality assurance and improvement begins with leaders who believe in, embrace, and fully engage their supervisors and frontline staff in developing an organizational culture whose vision is to maximize desired program outcomes. The STD Program Manager should serve as the pivotal force to motivate supervisors and DIS to adopt realistic and measurable quality management goals and objectives.

The STD Frontline Supervisor (FLS)/ Field Operations Manager (FOM)*:* It is often said, the key to a successful STD prevention program begins with the STD supervisor. They serve as teacher, coach, and mentor for DIS under their direction. The STD supervisor's role, is to provide quality instruction on field visit procedures, interview techniques, and PRISIM data entries. It is the supervisor's responsibility to monitor and review DIS work to provide meaningful and timely constructive feedback.

The Disease Intervention Specialist (DIS): DIS are the frontline defense in the prevention and control of STDs. They link thousands of people to medical assessments and treatments for bacterial STDs and HIV. Their work is critical to the collective public health mission. Their investigative skills are key components of emergency and outbreak response, STD/HIV exposure notification, and other infectious disease control efforts when called upon.

Regional Consultant (RC): Public health advisors are assigned to three or four STD Program Areas. They monitor task lists, support DIS training activities, and report issues and best practices to STDVH. They are positioned to maximize area operations through technical assistance and routine troubleshooting.

The STD Surveillance Supervisor (SSS): It is well known, that surveillance is the backbone of communicable disease control, including STD, and that the surveillance supervisor has a key role in STD prevention programs. The SSS serve as teacher, coach, and mentor, for STD surveillance clerks under their direction. The STD surveillance supervisor role is to provide clear, timely, and constructive feedback to clerks on data collection, report processing, case reporting, field records assignments.

The STD Surveillance Clerk (SSC): The surveillance clerks have an important role often beings the first ones in an STD prevention program to review a positive, reactive result, or new case. They establish close working relationship with health care providers and other institutions that identify new STD or HIV cases. Surveillance clerks also provide support to the work done by the DIS.

STDVH Section: The primary role of the STDVHS is to provide technical support in terms of coordinating STD field operations training, development of QA tools, and monitoring program outcome measures.

Name	Role	Responsibility
STD PM	Planning Manager, Implement QM Plan	Quality reviews, mentoring, and coaching
SSS	Team Lead	Quality audits, surveillance clerk guidance, coaching, and mentoring
SSC	Data collection, report processing, case reporting, assign records to field	Adhere to established guidelines for processing reports
STD FLS/FOM	Team Lead	Assessment, DIS instruction, coaching, mentoring, apply QA checklists and conduct Chalk Talks
DIS	Partner Services	Adhere to established guidelines for Partner Services, follow QA checklists and participate in Chalk Talks
RC	Technical support to the area STD programs for all aspects of STD program operations	Monitor, support training, promote Partner Services, and report best practices and issues
STDVH Section	Technical support, facilitate staff training, consulting	Develop and maintain QA tools, schedule trainings, and monitor progress

PROGRAM QUALITY MANAGEMENT

Quality management involves planning, implementing, reviewing, and improving project quality standards. The following sections define how this plan will apply each of these practice groups to define, monitor, and control quality standards for STD Field Operations.

Planning*:* It is essential to define the desired outcomes relevant to the overall success of STD field operations. Leadership must clearly identify measures to be used and document standardized expectations for staff. Expected measures include PRISM reports and supervisor assessment. Area STD Programs may include additional measures as needed. For example, an area experiencing increases in congenital syphilis should include measurements and appropriate tools that focus on reducing congenital syphilis cases.

Measuring: PRISM is an ideal resource to assess and evaluate STD Program outcomes. Detailed reports are available to assist with analysis. In addition to PRISM, the Division of Public Health Statistics and Performance Management provides county level status of indicators, goals, and objectives (e.g. CHD Snapshot, County Summary Report). To maximize the benefits of performance measure reports, develop a plan to share data with staff that will be meaningful for their individual expectations. There are important process measures that are essential to achieve desired outcome measures. Specifically, STD managers and supervisors need to use the DIS interview, field investigation, and field record assessments to maximize the performance of the DIS workforce. Review performance assessment schedules and tools, page 14.

Assess and Evaluate

Schedule a formal quarterly meeting to review quality assessment measures with the STD field operations team.

Management tools: The following will serve as tools to measure STD field operations quality and level of conformance to defined quality standards/metrics. (See Appendix A STD Performance Measures).

Tool	Description
PRISM Reports	Disease Intervention Index Favorable Dispositions Report Interviews Closed Without Partners Partner - Cluster Indexes Timeliness of Disposition Timeliness of Treatment Unfavorable Disposition Report National Measures End of Year Review
Supervisor Assessments	Electronic Field Record Assessment (EFRA) (formally known as the Pouch Review) Interview Record Assessment (IRA) Field Investigation Assessment (FIA)

This section provides detailed instructions for STD managers and supervisors to use for field staff development. The instruction and associated tools include:
a) Guidance for newly-hired DIS
b) Tools for DIS training, development, performance improvement, and evaluation
c) References for customized training needs and supervisory coaching
d) Safety in the field is of upmost importance. (See Appendix H for the Field Safety Checklist.)

Successful field operations are measured by the overall program performance, DIS performance, and outcome measures. The FLS and FOM are responsible for STD established measures, including measures pertaining to the DIS, and to be cognizant of the DIS as they perform their daily duties. It is essential that **ALL** STD staff are familiar with the STD Florida Statutes and Administrative Rules (see Appendix A). Internal Operating Procedures (IOPs) and Technical Assistance Guidelines (TAGs) are available at DOH SharePoint, Central Library, Policy and Procedures, search STD.

SUPERVISORS QA CHECKLISTS

The following STD supervisor checklists (daily, weekly, monthly, quarterly) serve as a guide to ensure a constant focus on improved outcome measures. It is the responsibility of the STD Program Manager to make certain FLS are adhering to the checklist expectations. Sustained focus on sound processes will directly influence desired performance and outcome measures. Adhering to the checklists will instill confidence that program quality is being met and achieved. Not all counties have a PM, FLS, and FOM. In those instances, the responsibilities fall on the Manager and/or Supervisor to carry out the required assessment and evaluations.

Daily Checklist

- ❑ Debrief with DIS staff each morning (15–20 minutes) regarding challenges, emphasize high priority FRs, team work, and swapping FRs when needed. Give daily direction on high-priority field records and cases.
- ❑ Ensure that instructions are carried out same day/next day.
- ❑ Review FRs with adverse dispositions (CN, D, H, J, L) ensure proper follow-up and record search is complete and documented. Ensure all efforts for a favorable disposition have been exhausted.
- ❑ Check PRISM task list for record reviews, such as, lab, field, interview, maternal, and congenital.
- ❑ ABC-*Always Be Checking.* Check items submitted for review or closure so they are taken care of promptly and returned to DIS with specific direction, deadlines for update, and include proper use of QA Checklists to close records. FLS should actively seek out DIS to ensure that field records and cases are dispositioned correctly and promptly. (See Appendix E for FR/IR Record Timeframes.)

Weekly Checklist

- ❑ Review PRISM task list for open or delayed labs, field interviews, maternal, and congenital records.
- ❑ Review and give written instructions on any Field Record or Interview Record open 7 days, 14 days, 21 days.
- ❑ Review and give written instructions on any Maternal or Congenital Records open 14 days, 21 days.
- ❑ Review and give direction on cases open 28 days or longer. Inquire why the case is opened and discuss a plan to close it promptly. Consult FOM, PM or RC if needed.
- ❑ Review FRs for appropriate and accurate electronic documentation, dispositions, and diagnoses; provide feedback.
- ❑ Monitor all incoming/outgoing OOJs for your team to ensure timely transfer to the receiving agency and to ensure dispositions are received or sent within two weeks.
- ❑ Spot-check high-priority field records and cases for QA purposes.

Monthly and Quarterly Checklist

- ❑ Submit a schedule of performance reviews—monthly for new DIS and quarterly for experienced staff.
- ❑ Conduct field, interview and field records (pouch or task) assessments, case management, pre/posttest counseling; each type of review may be conducted during any month within each calendar quarter.
- ❑ Submit to FOM/PM monthly performance statistics for new DIS and quarterly statistics for experienced staff. Provide oral and written feedback to the DIS on their performance.
- ❑ Coordinate Chalk Talks or case discussions at a minimum quarterly.
- ❑ Provide feedback to management and assist with quarterly progress reports, list objectives achieved, action plans implemented, outstanding contributions, and performance achievements. The progress report is in response to the performance indicator report.
- ❑ Quarterly meeting with each DIS to review performance measures are on track.

FIELD OPERATIONS/PROGRAM MANAGERS QA CHECKLISTS

The following STD Field Operations Manager (FOM) or Program Manager (PM) checklists (daily, weekly, monthly, quarterly) serve as a guide to instill focus on improved outcome measures. It is the responsibility of the STD Program Manager to make certain FOM and FLS are adhering to the checklist expectations. Adhering to the checklists will instill confidence that program quality is being met and achieved.

Daily Checklist

- ❑ Shield FLS from administrative activities as much as possible.
  ABC-*Always Be Checking*. FOM or PM should check to ensure that the FLS and Surveillance Supervisors are closing records in a timely manner. See Appendix E for FR/IR Record Timeframes.
- ❑ Monitor all incoming/outgoing OOJ/ICCR records to ensure timely transfer to the receiving agency and to ensure dispositions are received or sent within two weeks.
- ❑ ABC-*Always Be Closing*. FOM or PM should review their PRISM task daily to ensure that field records and cases are dispositioned promptly and correctly. See Appendix O for FR Disposition Codes.

Weekly Checklist

- ❑ Review Monday mornings' PRISM Critical Task List for overdue high priority records or records missing key information. Ensure guidance is provided for timely and favorable outcome.
- ❑ Spot-check high-priority field records and cases for QA purposes.
- ❑ Debrief with FLS or Surveillance Supervisors after team meetings.

Monthly and Quarterly Checklist

- ❑ Ensure FLS follow the schedule of performance assessments—monthly for new DIS and quarterly for experienced staff.
- ❑ Check FLS's review schedule. Give FLS a due date for quarterly reviews to be submitted. Support and assist FLS with field staff development to ensure progress.
- ❑ Review monthly statistics for DIS and field teams and provide feedback to FLS including action plans to develop staff where needed; meet with FLS and DIS as needed.
- ❑ Run reports to check field operations performance. Assist FLS in guiding DIS to achieve individual and program performance measures. Provide an immediate action plan when goals are 15% below required performance measures. Monitor monthly during the next quarter.
- ❑ Participate in Chalk Talks or case discussions. Ensure they are scheduled and take place.
- ❑ Conduct field, task (pouch) and interview assessments at random when possible to evaluate staff strengths and weaknesses. Provide oral and written feedback to the DIS on their performance.
- ❑ Provide quarterly updates to staff on how the program is performing on key indicators, morbidity trends, highlight strengths, discuss weaknesses and encourage discussion of possible action plans to improve outcomes. Address expectations.

QA CHECKLISTS FOR CLOSING FIELD, INTERVIEW, MATERNAL, AND CONGENITAL RECORDS

Checklists have been developed to ensure consistency of field record reviews, interview record reviews, maternal and congenital records review making certain records have been accurately completed, and ready to close. The next eight pages contain a series of checklists for: 200/300, 710/720, 730, 745, 910, 900, Maternal and Congenital records.

- Routinely use the respective QA Checklist to ensure all actions have been taken, required fields have been completed accurately, and the record is ready for supervisor review to close.

- Routinely use the respective QA Checklist to make certain DIS have exercised due diligence and conducted a thorough investigation with appropriate documentation that justifies closure of the record.

- Periodically select a random sampling of records to apply the QA Checklist to ensure quality standards are being upheld.

QA Check List for Closing 200/300 Positive Field Record

Check Your Field Record	A ✓ next to the number indicates a completed record element!
1	All Investigative activities have time/date/person reporting documented in PRISM, to include record searches/phone calls/field visits (Must document date and time when the activity took place.)
2	HARS record search has been completed and documented.
3	If field record is closed with disposition "C" with morbidity, appropriate treatment has been documented.
4	If client was not located for treatment, the notes must include documentation of a reasonable effort in the follow-up. It should include record search for updated or additional locating information (see Appendix J, Unable to Locate Checklist). Field Records for clients with positive or reactive tests that meet an STD Case Definition, should be closed with disposition "D-Infected Not Treated" and morbidity reported. All Syphilis morbidity require an attached Interview Record. Sex partners or individuals-at-risk that are not located for testing are closed with disposition "H-Unable to Locate."
5	If co-infected with 900, chronic box on profile has been checked.
6	If co-infected with 700/900, interview has been created and Partner Services initiated for all diseases.
7	Interview has been initiated if pregnant or age 15 or under.
8	All locatable partners identified in notes have been initiated (60-day interview period).
9	All appropriate labs within a 30-day window have been attached to the same Field Record (following CDC's De-Duplication Guidance for Gonorrhea and Chlamydia Laboratory Reports- June 2016 available in www.cdc.gov/std.)
10	Ensure appropriate disposition has been used when multiple 300 lab results are attached to the same Field Record for urethral, rectum and throat samples. Client may be positive for one of the sample sites and negative for the others. Morbidity should be reported for positive lab reports from any of the sample sites.
11	Pregnancy status has been identified YES or NO for all females in child bearing age (14 to 44 years of age). "Unknown" status must have a documented reason (i.e., "Provider did not know.")
12	If client with positive 200 or 300 is deceased, FR will be closed with appropriate disposition of "C, CN, D or DM" and morbidity "Yes." Information about death must be documented in the notes and in the "Date of Death" field in the Profile section.

QA Check List for Closing Field Record 710/720 Diagnosis

Check Your Field Record	A ✓ next to the number indicates a completed record element!
1	All Investigative activities have time/date/person reporting documented in PRISM, to include record searches/phone calls/field visits (Must document date and time when the activity took place.)
2	HARS record search has been completed. If co-infected with 900, chronic box on profile has been checked.
3	If the 900 history is previous, a previous 900 field record has been initiated and linked to syphilis case.
4	Signs and symptoms have been entered in appropriate box on field record.
5	Appropriate symptoms type/onset date/duration has been entered in Symptoms box on field record.
6	If provider and client claimed no signs or symptoms, a Symptoms box with “None Reported” selection has been added.
7	Appropriate treatment has been entered on field record.
8	If client was not located for treatment, the notes must include documentation of a reasonable effort in the follow-up. It should include record search for updated or additional locating information (see Appendix J, Unable to Locate Checklist). Field Records for clients with positive or reactive tests that meet an STD Case Definition, should be closed with disposition “D-Infected Not Treated” and morbidity reported. All Syphilis morbidity require an attached Interview Record. Sex partners or individuals-at-risk that are not located for testing are closed with disposition H- Unable to Locate.
9	Interview record has been initiated for cases meeting 710 or 720 diagnoses.
10	If client is co-infected with 900/200/300, field records have been linked, interview has been opened and Partner Services initiated for all related diseases.
11	All locatable P1's/AR's identified in the notes have been initiated.
12	All appropriate labs have been attached.
13	Pregnancy status has been identified YES or NO. "Unknown" status must have a documented reason (i.e., "Provider did not know.")
14	If 710 AND 720 symptoms are both present, the diagnosis is 720.
15	If original interview results in No Contacts Elicited (NCE), DIS has referenced in narrative why P1's/AR’s were not elicited.
16	As priority cases, there was an effort to complete Re-Interview and Re-Interview Date has been added to field record. If no Re-interview pursued, it is justified in the Notes.

QA Check List for Closing 730 Field Record	
Check Your Field Record	**A ✓ next to the number indicates a completed record element!**
1	All investigative activities have time/date/person reporting documented in PRISM, to include record searches/Phone calls/Field visits (Must document date and time when the activity took place.)
2	If field record is disposition "C" with morbidity, appropriate treatment has been documented.
3	If client was not located for treatment, the notes must include documentation of a reasonable effort in the follow-up. It should include record search for updated or additional locating information (see Appendix J, Unable to Locate Checklist). Field Records for clients with positive or reactive tests that meet an STD Case Definition, should be closed with disposition “D-Infected Not Treated” and morbidity reported. All Syphilis morbidity require an attached Interview Record. Sex partners or individuals-at-risk that are not located for testing are closed with disposition “H-Unable to Locate.”
4	One of the five 730 criteria have been met/identified and documented. (See Appendix M)
5	Any signs/symptoms noted at the time of the initial exam would cause the diagnosis/syphilis stage of disease to default to the appropriate diagnosis for that sign/symptom stage of syphilis.
6	All available previous history of syphilis (including diagnosis, labs, treatments, and dates) has been documented.
7	HARS record search has been completed.
8	If co-infected with 900, chronic box on profile has been checked.
9	Interview record has been opened.
10	If client co-infected with 900/200/300, interview has been created and Partner Services initiated for all diseases.
11	All locatable P1's/AR's identified in notes have been initiated.
12	All appropriate labs have been attached.
13	Pregnancy status has been identified YES or NO. "Unknown" status must have a documented reason (i.e., "Provider did not know").
14	Any history of symptoms has been documented in PRISM with type/onset/duration.

QA Checklist for Closing 745 Field Record	
Check Your Field Record	**A ✓ next to the number indicates a completed record element!**
1	All Investigative activities have time/date/person reporting documented in PRISM, to include record searches/phone calls/field visits (Must document date and time when activity took place.)
2	If field record is disposition "C" with morbidity - appropriate treatment has been documented.
3	If client was not located for treatment, the notes must include documentation of a reasonable effort in the follow-up. It should include record search for updated or additional locating information (see Appendix J, “Unable to Locate Checklist”). Field Records for clients with positive or reactive tests that meet an STD Case Definition, should be closed with disposition “D-Infected Not Treated” and morbidity reported. All Syphilis morbidity require an attached Interview Record. Sex partners or individuals-at-risk that are not located for testing are closed with disposition “H- Unable to Locate.”
4	Interview initiated to rule out 730
5	None of the five 730 criteria has been met/identified and this is documented. (See Appendix M)
6	Any signs/symptoms noted at the time of the initial exam would cause the diagnosis/syphilis stage of disease to default to the appropriate diagnosis for that stage of syphilis.
7	All available previous history of syphilis (including diagnosis, labs, treatments, and dates) has been documented.
8	HARS record search has been completed.
9	If co-infected with 900, chronic box on profile has been checked.
10	If client co-infected with 900, interview has been created and Partner Services initiated for both diseases.
11	All locatable P1's/AR's identified in notes have been initiated to rule out epi relationship to positive 700.
12	Effort made to repeat titer prior to treatment and outcome documented in notes.
13	All appropriate labs have been attached.
14	Pregnancy status has been identified YES or NO. "Unknown" status must have a documented reason (i.e., "Provider did not know.")
15	Any history of symptoms has been documented in PRISM with type/onset/duration.

QA Check List for Closing 910 Positive Field Record	
Check Your Field Record	**A ✓ next to the number indicates a completed record element!**
1	Ensure that all steps required in the “HIV/AIDS, STD and Bureau of Public Health Laboratories (BPHL) Manual for Nucleic Acid Amplification Test (NAAT) Follow Up” have been completed before closure. (See Appendix G, NAAT Follow-up Alert Process).
2	All investigative activities have time/date/person reporting documented in PRISM, to include record searches/phone calls/field visits (Must document date and time when the activity took place.)
3	HARS record search has been completed.
4	Chronic box on profile has been checked.
5	If client was not located for Partner Services and referrals, the notes must include documentation of a reasonable effort in the follow-up. It should include record search for updated or additional locating information with HIV/AIDS Surveillance and other sources (see Appendix J). If after all efforts the client is “Unable to Locate”, close FR with disposition “H”. There is no need to attach “Unable to Interview” Interview Record or report morbidity. A Linkage to Care record must be initiated, even if not found for Partner Services. Client should be re-initiated for Partner Services and referral when another HIV test is reported to the STD Program.
6	If a Partner Services Interview has been completed an Interview Record has been initiated with an interview period of three months.
7	All locatable P1s/AR's identified in notes have been initiated.
8	All appropriate labs have been attached as well as repeat blood test.
9	Pregnancy status has been identified YES or NO. "Unknown" status must have a documented reason (i.e., "Provider did not know").
10	Re-interview has been done within 24 hours of the original interview on client and added to interview record.
11	Initiate a Linkage to Care record in PRISM and forward to HIV Linkage to Care coordinator.

QA Check List for Closing 900 Positive Field Record	
Check Your Field Record	**A ✓ next to the number indicates a completed record element!**
1	All investigative activities have time/date/person reporting documented in PRISM, to include record searches/phone calls/field visits (Must document date and time when the activity took place.)
2	HARS record search has been completed.
3	Chronic box on profile has been checked.
4	If client was not located for Partner Services and referrals, the notes must include documentation of a reasonable effort in the follow-up. It should include record search for updated or additional locating information with HIV/AIDS Surveillance and other sources (see Appendix J). If after all efforts the client is “Unable to Locate”, close FR with disposition “H”. There is no need to attach “Unable to Interview” Interview Record or report morbidity. A Linkage to Care record must be initiated, even if not found for Partner Services. Client should be re-initiated for Partner Services and referral when another HIV test is reported to the STD Program.
5	If a Partner Services interview has been completed, an Interview Record has been initiated.
6	All locatable P1/'s AR's identified in notes have been initiated.
7	All appropriate labs have been attached.
8	Pregnancy status has been identified YES or NO for all females in child bearing age (14 to 44 years of age). "Unknown" status must have a documented reason (i.e., "Provider did not test and did not know").
9	For a 900- field record to be closed as a previous 900, notes must document why a retest was done, and that the client does not meet one of the following five conditions: 1) New STD diagnosis, 2) known exposure to STD infection, 3) pregnant or P1 to pregnant female, 4) volunteer for STD exam, 5) court ordered. Also, Viral Load (VL) record search must be completed for previous 900 to prioritize who needs Partner Services. Needs Partner Services: Pregnant females, regardless of VL status, Individuals diagnosed with syphilis (all stages), Not virally suppressed, Patient Care or VL status unknown and No VL test within past 7 months. Doesn’t Need Partner Services: VL <200 in past 7 months and VL of <1,000 in past 7 months and lower than previous VL tests.
10	Did the DIS complete the HIV Medical Care section on the interview record if the client is positive?
11	Initiate a Linkage to Care record in PRISM and forward to HIV Linkage to Care Coordinator.

QA Check List for Closing Interview Record	
Check Your Interview Record	**A ✓ next to the number indicates a completed record element!**
1	Disease Code matches client's diagnosis. All related Disease Codes within the longest interview period have been linked to the Interview Record (IR). If previous 900, a FR with disposition "1" was created and linked.
2	Interview Type is correct: Original Interview, Re-Interview, Cluster Interview or Unable to Interview.
3	"First Interviewed By" and "First Date Interviewed" have been entered. If applicable, "Re-Interview By" and "Date Re-Interviewed" have been added.
4	Correct "Where Interviewed" has been selected: Clinic, Field, Phone, Other, Located but refused or Unable to Locate.
5	"Where Interviewed Additional Info" is useful to specify location (e.g.: Client's home, Jail, Hospital, MD office, College campus…).
6	Correct "Detection Method" has been selected: Screening, Self-Referred, Client Referred Partner, Health Department Referred Partner, Cluster Related or Other.
7	Interview Period has been added with correct selection of: Year(s), Month(s), Week(s) or Day(s). If client has dual infections, the interview period for the disease that has the most months has been entered. Correct Interview Period has been entered: 60 Days or 2 Months for 200 or 300; 90 Days or 3 Months for 710 or 910; 197 Days or 27 Weeks or 6 or 7 months for 720 (6 ½ Months not available in PRISM) and 12 Months or 1 Year for 730, 745 and 900.
8	Correct "Referral Service" has been selected. It refers to the type of clinic, provider or other entity that gave the STD Program the initial information that ultimately lead to the identification of the case (usually where the first specimen was taken). The choices include: 01-HIV Counseling and Testing site; 02-STD Clinic; 03-Drug treatment; 04-Family Planning; 06-TB Clinic; 07-Other Health Department Clinic; 08-Private MD/HMO; 10-Hospital (Emergency Room/ER); 11-Correctional Facility; 12-Laboratory; 13-Blood Bank; 14-Labor and Delivery; 14-Labor and Delivery; 15-Prenatal; 16-Job Corps; 17-School-based Clinic; 18-Mental Health Services; 29-Hospital (Other); 66-Indian Health Services; 77-Military; 88-Other; 99-Unknown.
9	The total "# of Sex Partners" claimed by the index client during the interview period has been entered.
10	Partner Meeting Locations has been specified (e.g.: Facebook, Grindr, Tinder, Jack'd, Scruff, Tumblr, adam4adam, manhunt, (specific name) Bar/Club…).
11	HIV Self-Reported Status has been selected: HIV Positive, HIV Negative, Equivocal HIV test result, Unknown, Refused to Answer or Did not ask.
12	HIV Section has been completed considering if an HIV test was done at the time of the initial or follow-up screening that led to the reporting of the STD case. Fields completed are: HIV Test-Yes, No, Refused or Unknown and HIV Confirmed Status- Positive/Reactive, NAAT-Positive, Negative, Indeterminate, Invalid or No Result.
13	For a 910 or new 900 case the following sections have been completed: HIV Post Test Counseling Information, HIV Medical Care Information, and HIV Confidential Case Report.
14	A Linkage to Care (LTC) record has been initiated for 910, new 900 or pregnant 900 Interview Record.
15	DIS narrative and supervisor review notes included.

QA Check List for Closing Maternal and Congenital Records	
Check Your Record	**A ✓ next to the number indicates a completed record element!**
1	Review the mother's profile "Episodes": tests, diagnosis, treatment, field records (FR) and interview records (IR). Ensure all related FRs with tests during the pregnancy and for the delivery are linked to the Maternal Record. If client delivered at another county, refer to that county for delivery tests, baby's history.
2	Complete the "Link Vital Stat Child" record search to link vital stats children to the mother. Link PRISM Children to the Mother. Create profile for "Children" (baby) if one has not been created and add Field Record.
3	If "Link Vital Stat Child" record search (R/S) comes out negative, try R/S with * (asterisk) and first two letters of mother's first and last name. You may also try by mother's date of birth with * (asterisk) for name. Sometimes the proper name has an apostrophe (') that we may not know and R/S comes out negative.
4	If "Link Vital Stat Child" record search (R/S) comes out negative repeatedly and it is verified the Mother had baby in another State, please document so and how the information was obtained in the FR, IR and Profile notes. Ask your Program Manager to place a PRISM Help Desk request to delete the Maternal Record. Do not document in the Maternal Record, because it will be deleted.
5	Check field, interview and Vital Stat record information to answer Maternal questions, including those that need click to populate. Ensure all relevant information pertaining to the disease that is being investigated has been added in the notes or proper section.
6	Refer to the Congenital Syphilis section of the CDC STD Treatment Guidelines to verify which scenario the Mother and Baby's history fits to determine if it is a Congenital Syphilis case or not.
7	If Mother is considered a case, check the field record with the QA Check List for Closing criteria set for the related diagnosis (see QMP QA Check list).
8	Review the neonate/infant's profile "Episodes": tests (labs), diagnosis, treatment and field records (FR). Ensure related tests at birth and medical record notes are added to the baby's field record. If baby was born in another county, refer to that county for tests at birth, treatment, description of his condition and any other relevant information. Complete the Congenital Record.
9	Ensure that Maternal and infant profiles are linked Make Maternal case determination bases on flow of congenital algorithm (see appendix for algorithm).
10	If baby is stillborn, make determination bases of flow of congenital algorithm for syphilitic stillbirth (see appendix for algorithm).
11	If fetus is miscarried, make sure to obtain weight and gestational age (weeks) of the fetus. A fetal death that occurs after 20-week gestation or if the fetus weighs greater than 500 g and the mother had untreated or inadequately treated syphilis at delivery, is considered a syphilitic stillbirth.

PROGRAM QUALITY ANALYSIS

Before implementing Quality Improvement (QI) measures for field operation, first conduct an in-depth analysis of outcomes and indicators for the program. (See Appendix A STD Performance Indicators.) Outcomes should be compared to statewide goals and objectives. Once the analysis is complete, use QI tools to implement strategies to improve outcomes. Examples of QI tools include DIS field investigation, interview and field record assessments. Another useful strategy is to closely observe the top performing DIS to determine their means for successful outcomes as compared to the DIS who need to improve. The goal of your quality analysis is to define deficiencies and develop opportunities for improvement. Applying what was learned from the quality analysis enables a program to eliminate gaps between current and desired levels of performance.

Improving a STD Program: Trying to identify ways of doing things better, cheaper, and faster is quite a challenge. It is important to solicit feedback and suggestions from the FLS since they see inefficiencies first-hand. They can provide suggestions to improve efficiency and effectiveness. In addition, peers around the state have tested and incorporated many innovative activities with positive impact and improved performance.

***Quality Performance*:**
To ensure DIS are performing to the best of their ability, it is imperative that STD supervisors closely monitor, critique, and provide timely constructive feedback to the DIS. The DIS skills assessment tools should be used by program managers and supervisors. A routine schedule should be set by the STD program manager.

GREAT DIS IDEA

A major STD Program noted that many syphilis and HIV cases were reported from a single private provider. Unfortunately, the provider's clients were not interested in receiving Partner Services, due to mistrust, and other reasons. A DIS suggested to management to reach out to the provider to see if a DIS could be stationed at the provider's office. The provider agreed to the partner indices and disease intervention. Partner Services improved.

DIS PERFORMANCE ASSESSMENT SCHEDULES AND TOOLS

The **Managers/Supervisors** are required to conduct routine assessments on all field staff employees using the Assessment Schedules, Field Record, Interview, and Field Investigation Assessment tools.

- New DIS (less than one year experience) must have field assessments conducted once a month to assist in identifying training needs and offering coaching/instructing insight into alternative measures. Frequency can be increased or reduced based on performance.

- Experienced DIS (greater than one year) should have assessments done at least once a quarter to assist in moving stalled investigations and offer coaching/instructing insight into alternative measures. Frequency can be increased or reduced based on performance.

Rating Criteria:
- ***Excellent,*** performance is above the expectations for satisfactory performance.
- ***Satisfactory***, adequately performs appropriately and at average skill level.
- ***Needs Improvement***: an unacceptable level of sufficient actions, requiring immediate improvement.
- ***Not Observed*:** A skill element was not observed. Role playing may be conducted to determine skill capability. It is best to see skills performed with an actual client during assessment.

DIS FIELD INVESTIGATION ASSESSMENT

Name of DIS: _____ Review Date: _____

Reviewing Supervisor: _____ Date Completed: _____

Check the appropriate box for performance. (E = Exceeds, S = Satisfactory, NI = Needs Improvement, NO = Not Observed)	E	S	NI	NO
1. Assumes responsibility for success of investigations				
2. Uses resources effectively				
3. Recognizes investigative priorities				
4. Selects appropriate referral methods				
5. Takes prompt action on initial and follow-up investigations				
6. Demonstrates timely, persistent, and imaginative action to move a stalled investigation				
7. Demonstrates discretion using a telephone as an investigative tool				
8. Confidentially and professionally manages obstacles				
9. Motivates people to come in promptly				
10. Documents investigative activities completely				

Comments:_____
_____
_____
_____
_____

DIS Signature _____ Date _____
Signature means only DIS has reviewed comments. This signature does not constitute agreement with evaluation above.

Supervisor's
Signature_____Date_____

DEFINITIONS OF ELEMENTS IN DIS FIELD INVESTIGATION ASSESSMENT

1. **Assumes responsibility for success of investigations**: Displayed a sense of obligation for the successful resolution of any investigation in which the DIS plays a role. Assumed responsibility for initiating the investigation (gathers identifying/locating information and updates the field record completely, and if a printout, legibly) and following through with prompt, persistent, imaginative, assertive, and sensitive application of techniques and the complete, timely documentation of all activities.

2. **Utilizes resources effectively**: Used standard locating resources before and during investigations (e.g. phone books, (411.com, www.pipi.com.)cross directory (Accurint),, closed field records, HMS (clinic medical records), utility companies, voter's registration, public assistance files, driver's license bureau (DAVID), corrections or jail records, neighbors, apartment managers, children in vicinity, neighborhood business, zip code directory, approved internet websites, and computer resources).

3. **Recognizes investigative priorities**: Observed program guidelines routinely and appropriately to determine high and low priority investigations and organized field activity accordingly, while managing field activities in an efficient manner.

4. **Selects appropriate referral methods**: Selected methods that ensured the earliest examination while preserving confidentiality. Mailed letters only in accordance with local protocols, in conjunction with field or telephone referrals, or after such referrals had failed. Left referral cards/envelopes only after a reasonably exhaustive investigation failed to bring about personal or telephone contact.

5. **Takes prompt action on initial and follow-up investigations**: Verified the locating information for priority investigations within 24 hours of assignment. Consulted private physicians within 24 hours after receiving follow-ups from them. Intervals between actions on priority investigations did not exceed more than one working day except under circumstances deemed justifiable to the supervisor.

6. **Demonstrates timely, persistent, and imaginative action to move a stalled investigation**: With investigative workload and other professional obligations considered, took all reasonable steps to ensure that assigned investigations were resolved promptly.

7. **Demonstrates discretion in use of the telephone as an investigative tool**: When using the telephone to expedite an investigation, tried to motivate subject to come in or to meet face-to-face in a confidential setting. Revealed as little sensitive information as possible, including exposure to an STD. Before discussing any sensitive information, took all reasonable steps to verify that the person on the line was the subject of the investigation.

8. **Confidentially and professionally manages obstacles**: Demonstrated ability to think on his/her feet when confronted with investigative obstacles such as, parents, siblings, spouses, roommates, school officials, bartenders, coworkers, and employers who have blocked notification efforts or whose curiosity could threaten confidentiality unless handled effectively.

9. **Motivates people to come in promptly**: Created a sense of urgency about examinations or need of treatment through information about the infection, its possible complications and persistence. During field visits, updated locating information such as telephone numbers, work, address, and other methods of getting back in touch. To allay fears (about embarrassment, parking, delays), explained how the appointment is likely to go.

10. **Documents investigative activities**: Documents each investigative step immediately after the activity occurred and accurately records the date, time, and nature of the activity per protocols. Documentation was sufficiently legible, coherent, and accurate to permit the reconstruction of all activities so that a coworker could complete any investigation without duplicating steps. **ALL** information from the field investigation was entered into the record notes on the PRISM field record.

DIS INTERVIEW ASSESSMENT

Name of DIS: _____ Review Date: _____

Reviewing Supervisor: _____ Date Completed: _____

Type of Interview(s): ____ 710/720 ____ 730 ____ 900 ____Other (Specify)

Check the appropriate box for performance. (E = Exceeds, S = Satisfactory, NI = Needs Improvement, NO = Not Observed)	E	S	NI	NO
1. Demonstrates professionalism				
2. Establishes rapport				
3. Listens effectively				
4. Uses open-ended questions				
5. Communicates at the client's level of understanding				
6. Gives accurate information				
7. Solicits client feedback				
8. Uses appropriate nonverbal communication				
9. Recognizes verbal and nonverbal problem indicators				
10. Confronts problems communicated by the client				
11. Uses STD motivators, motivates clearly, and convincingly				
12. Emphasizes confidentiality				
13. Emphasizes sex and/or needle sharing partner referral				
14. Details locating/identifying on all sex and/or needle partners				
15. Emphasizes prevention counseling				
16. Conveys a sense of urgency, ask about pregnancy, partners, clusters				
17. Establishes specific contracts and coach's client				

Comments:_____
_____
_____
_____
_____

DIS Signature _____ Date _____
Signature means only DIS has reviewed comments. This signature does not constitute agreement with evaluation above.

Supervisor's
Signature_____Date_____

DEFINITIONS OF ELEMENTS IN DIS INTERVIEW ASSESSMENT

1. **Demonstrates professionalism**: Displayed self-confidence, dependability, preparation, integrity, appropriate seriousness. Was nonjudgmental and objective about client behavior/lifestyle.

2. **Establishes rapport**: Displayed respect, empathy, and sincerity to clients, e.g. introduced self, was polite, used plausible and factual motivations, sought out and dealt with client concerns.

3. **Listens effectively**: Did not interrupt, responded to client's questions appropriately, and noted important information such as following up with additional questions or mentioning specifics in the post counseling critiques.

4. **Uses open-ended questions**: Phrased questions (who, what, when, where, why, how, tell me) to stimulate responses, particularly in sensitive areas of the session.

5. **Communicates at the client's level of understanding:** Avoided words beyond the comprehension of clients.

6. **Gives accurate information**: Demonstrated an accurate knowledge of STDs, corrected client misconceptions, and provided comprehensive disease information.

7. **Solicits client feedback**: Asked appropriate questions to determine whether client understood. Used content (re-phrasing what the client said) and feelings (interpreting how the client felt) to verify client's meanings.

8. **Uses appropriate nonverbal communication**: Conveyed interest by maintaining eye contact, minimizing physical barriers, and leaning toward the client. Avoided negative nonverbal signals (anger, distaste, or fear).

9. **Recognizes verbal and nonverbal problem indicators**: Responded to client's direct questions and body language.

10. **Confronts problems communicated by the client**: Demonstrated self-confidence and communicated his/her position while maintaining rapport. Solved typical STD client problems: marital situation, guilt, embarrassment, fatalism, sexual orientation, hostility at sex partners or clinic personnel, and apathy about infections.

11. **Uses STD motivators, motivates clearly and convincingly**: Demonstrated STD motivations, discussed reinfection, responsibility to others, and disease complications. Using visual aids created a sense of urgency and motivations.

12. **Emphasizes confidentiality**: Explained program with emphasizes on discretion. Reassure client of partner(s) or at-risk individual(s) confidentiality.

13. **Emphasizes sex and/or needle sharing partner referral**: Ensured that appropriate time, attention, and importance was given to partner referral. Maintained rapport and probed for additional partners.

14. **Locating/identifying information on all sex and/or needle sharing partners**: Detail locating information home address/phone number/job. Obtained identifying information (age, race, sex, marital status, height, weight, and complexion) and characteristics (hair color/style, facial hair, glasses, scars, physical impairments, tattoos, clothing). Asked who they live with, what car they drive, what do they do for a living and other useful information to identify or locate. Ask for user ID (e.g., chat name and/or email).

15. **Emphasizes prevention counseling**: Discuss additional individualized intervention behaviors with client.

16. **Conveys a sense of urgency**: Communicated the spread of infection. development of symptoms, and complications can be averted by immediately notifying and referring others who are at risk.

17. **Establishes specific contracts and coach's clients:** Explained the time frame a client could refer partner(s) before the DIS would contact partner(s). Assist client with what to say when confronting partner(s).

DIS FIELD RECORD OR TASK ASSESSMENT

Name of DIS: _____ Review Date: _____

Reviewing Supervisor: _____ Date Completed: _____

Check the appropriate box for performance. (E = Exceeds, S = Satisfactory, NI = Needs Improvement, NO = Not Observed)	E	S	NI	NO
1 Prioritization of field records				
2. Utilization and timeliness of record search methods				
3. Speed of initial investigation				
4. Speed of follow-up investigations				
5. Activities are completely and accurately documented				
6. Resourcefulness in overcoming obstacles or stalled investigations				

Comments:_____
_____
_____
_____
_____

DIS Signature _____ Date _____
Signature means only DIS has reviewed comments. This signature does not constitute agreement with evaluation above.

Supervisor's
Signature_____Date_____

DEFINITIONS OF ELEMENTS FOR FIELD RECORD or TASK ASSESSMENT

1. **Organization Electronic Field Records**: The DIS has created a list of PRISM profile numbers of the field records to be field visited during the day which reflects program guidelines in determining high and low priority investigations, and organized field activities in an efficient manner.

2. **Utilization and timeliness of record search methods:** Used standard locating resources before and during investigations (e.g. phone books, (411.com, www.pipl.com.),cross directory (Accurint), closed field records, clinic medical records HMS, utility companies, corrections or jail records, public assistance files, voter's registration, driver's license bureau (DAVID), neighbor's, apartment managers, children in vicinity, neighborhood business, zip code directory, approved internet websites and computer resources.

3. **Speed of initial investigation:** Documentation indicated initial investigative activities occurred within 24 hours of assignment, including such activities as verification of locating information, appropriate record searches, communication with providers to gather additional information, phone call to client where appropriate, and/or field visits.

4. **Speed of follow-up investigations**: Documentation indicated that follow-up activities were within 24-48 hours following initial investigation, except under circumstances deemed justifiable to the supervisor.

5. **Activities are completely and accurately documented**: Documentation indicated that DIS documents each investigative step immediately after the activity occurred, reflecting the date, time and nature of the activity per protocols. Documentation was sufficient legible, coherent, and accurate to permit the reconstruction of all activities so that a coworker could complete any investigation without duplicating steps. ALL information from the field investigation was entered in PRISM.

6. **Resourcefulness used in overcoming obstacles or stalled investigations**: With investigative workload and other professional obligations considered, took all reasonable steps to ensure that assigned investigations were resolved promptly and that they were not unnecessarily delayed or resolved inappropriately because of procrastination, timidity, the premature concession of defeat, or the inappropriate use of resources or investigative techniques. Discussed stalled investigations with supervisor after 4-5 days of failed efforts.

7. **Follow-up of supervisory instruction**: Documentation indicated DIS has taken prompt action after directives from supervisor on stalled investigations, and has documented answers to all questions from Supervisor.

COLLABORATIVE CASE CONFERENCES (Chalk Talks)

A Collaborative Case Conference, often referred to as a “Chalk Talk” is an open, objective analysis, and interactive discussion among DIS and their supervisor. The purpose of a chalk talk is to analyze facts concerning an issue, problem, intervention activity, case or lot, and develop a plan of action. These brainstorming sessions almost always lead to improved outcomes on stalled investigations and/or difficult cases.

Participants in Chalk Talks may include DIS, FLS, and PMs, as well as team members with expertise in surveillance, clinical services, laboratory science, administrative support, counseling, health education, and/or outreach. In Chalk Talks, staff may assist with case reviews, share information (e.g., hot spots, meeting places, Internet chat rooms), discover commonalities leading to the linking of cases, or develop ideas for future action steps and suggestions for intensified field efforts such as serologic screenings.

The Chalk Talks differs from a debriefing, as it includes team members and adds group participatory analysis, brainstorming and the creation of an action plan. Chalk Talks can be formal or spontaneous. For example, an FLS or team leader may quickly convene those present to discuss cases deemed particularly interesting or having programmatic implications. Cases might be selected because they afford specific learning opportunities, they represent an opportunity to tie cases (lots) together, or they represent possible emerging problems.

Chalk Talks provide a forum to build a sense of team, develop confidence in one another, share information (e.g., locating resources, location of crack houses or newly identified sex worker “stroll areas”, community resources), and identify training needs. Chalk Talks may also promote a greater understanding of programmatic objectives and activities and achieve consensus and “buy-in” by inviting other health department staff to participate. Chalk Talks are helpful to both new and experienced staff since they develop and refine disease intervention skills. They can also prepare DIS to become facilitators or supervisors by developing preparation, group meetings, and evaluation skills. The STD Chalk Talk should not be a used to put a DIS on “trial” by subjectively critiquing their casework in front of peers. The success of the unit or a team requires the collective contributions of each player. Everyone’s contribution to the team process is valued. There are no individual winners in the business of STD.

Suggested Chalk Talk Ground Rules (ideally on display during the Chalk Talk)

- Chalk Talks are not critiques; everyone’s contributions are valued
- Participation is encouraged and accepted
- One person speaks at a time
- Listen and respect input without interruption
- Build or “piggyback” on others’ ideas
- Introduce creative strategies (“Think outside of the box”)
- Be specific with your thoughts
- Provide constructive information, not a critique
- Consider all suggestions and feasibility without the need to defend
- Make this a safe environment and enjoyable process

Chalk Talk Steps

1. Chalk Talk Administration: PM and FOM/FLS establish Chalk Talks as a routine activity with defined purpose and goals, established ground rules (refer to suggested ground rules in following section); b) FLS build chalk talks into their monthly calendar; c) Frequency of chalk talks conducted occur at minimum monthly, more often in high morbidity areas, and weekly during outbreaks.

2. Pre-Chalk Talk Preparation; FLS identifies case(s) or issues to be presented and informs the responsible DIS; b) Staff are informed of chalk talk time and location; c) Staff are notified to bring relevant materials and are reminded of the ground rules for participation/discussion; d) FLS and DIS prepare the facility and set-up the equipment and visual aids; e) FLS acts as the recorder or identifies an employee so that information and ideas are displayed and easily viewed by all participants.

3. Presentation of Facts: FLS reminds participants of the ground rules; b) Each DIS presents the original/index client (OP) overview: name, age/gender, reason for exam, diagnosis, symptoms, medical history, social-sexual history and health behaviors, partner and cluster information obtained/pursued/dispositioned, linkages to other cases and lot, visual case analysis (VCA), problems encountered, next plan of action.

4. Group Discussion: FLS discusses commonalities with other cases, successful or challenging interventions and other background information that may be useful to the group discussion process; b) FLS assists the DIS and group through case analysis and any gaps/inconsistencies identified; c) FLS and DIS elicit questions and suggestions from participants; d) FLS ensures that elicited responses are recorded and easily viewed/referenced.

5. Intervention Strategy / Plan of Action: FLS reviews the groups' recorded suggestions, opportunities missed or revisited, and activities or screenings needed; b) FLS helps prioritize the next intervention steps or realistic plan of action with consideration to staffing and workloads when assistance other than DIS is needed.

6. Post Chalk Talk: FLS debriefs (recaps) with the DIS and documents the intervention strategies to be followed; b) FLS sets follow-up debriefings with DIS to occur at minimum weekly to bring cases to closure.

NOTES:

STD PROGRAM QUALITY MANAGEMENT PLAN ACKNOWLEDGEMENT

The undersigned acknowledge they have reviewed the STD Program Quality Management Plan and agree with the approach it presents. Changes to this Program Quality Management Plan will be coordinated with and approved by the undersigned or their designated representatives.

Signature: **Date:**

Print Name:

Title: Area STD Program Manager

Role:

Signature: **Date:**

Print Name:

Title: STD Program Field Operations Manager

Role:

Signature: **Date:**

Print Name:

Title: STD Program Frontline Supervisor

Role:

Signature: **Date:**

Print Name:

Title: Disease Intervention Specialist

Role:

APPENDIX A: STD PERFORMANCE MEASURES

TIMELINESS OF TREATMENT	TARGET
% Of Cases Treated Within 14 Days	**90%**
% Of Female Syphilis Cases Ages 15–44 Years Treated Within 14 Days	**90%**
% Of Pregnant Females Treated Within 14 Days	**90%**
TIMELINESS OF DISPOSITION	
% Of Pregnant Females HIV Records Dispositioned Within 14 Days	**90%**
DISEASE INTERVENTION INDEX	
Total Early Syphilis Intervention Index	**0.50**
HIV Intervention Index	**0.50**
PARTNER/CLUSTER INDEX	
Partner Index	**1.00**
Cluster Index	**0.50**
HIV Partner Index	**1.00**
Cluster Index	**0.50**
OVERDUE RECORDS	
% Of Overdue Field Records	**< 20%**
% Of Overdue Interview Records	**< 20%**

APPENDIX B: QUALITY MANAGEMENT DASHBOARD

	Activity	Responsible	Action Required	Time Frame/ Frequency	QA/QI Processes	Measure of Improvement
1.	Convene debriefings (Chalk Talks) with FLS, DIS, and Program Manager to develop strategies for improved outcomes of recent STD cases.	STD Program Manager, and FLS	Daily reviews of current active open cases with the DIS. Develop strategies to overcome obstacles.	Once weekly at a minimum. Update boards should be in common area for all to see progress.	Monitor success through increased partner and disease intervention indices.	Increased partner/cluster index. Increased disease intervention and reduced time frames.
2.	Interview Assessment-Interview critiques (audits) of all DIS by the immediate supervisor.	STD DIS Supervisor	Observe interviews once monthly for DIS < 1 year, quarterly for DIS > 1 year experience or as necessary based on performance.	Every month for new DIS, quarterly for veteran DIS.	Documentation provided to DIS on strengths and areas in need of improvement that will increase partner index.	The expectation is to increase the partner and disease intervention index by the DIS via supervisory mentoring.
3.	Field Investigation Assessment - Field investigation critiques of all DIS by the immediate supervisor.	STD DIS Supervisor	Observe field investigations once monthly for DIS < 1 year experience, quarterly for DIS > 1 year experience or as necessary based on performance	Once monthly for new DIS, quarterly for veteran DIS.	Documentation provided to DIS on strengths and areas in need of improvement that will increase field investigation effectiveness.	The expectation is to increase DIS productivity in conducting field investigations via supervisory mentoring.
4.	Field Record Assessment - Field Record critiques for all DIS by the immediate supervisor.	STD DIS Supervisor	Review Field Records once weekly for DIS < 1 year experience, monthly for DIS > 1 year experience or as necessary based on performance and caseload.	Weekly for new DIS, monthly for veteran DIS.	Documentation provided to DIS with advice on means to advance stalled investigations.	The expectation is to provide DIS with alternative strategies to favorably disposition Field Records in a more efficient manner.
5.	Quality Assurance (QA) Checklist reviews for positive Field Records 200, 300, 710, 720, 730, 745, 900, and 910.	STD DIS Supervisor	Compare Field Records submitted for closure to the QA checklists.	Daily for all Field Records submitted for closure.	Return Field Records not meeting QA checklists to DIS for correction and/or completion.	The expectation is to increase the accuracy and completeness of closed Field Records.

APPENDIX C: FLORIDA STATUTES AND RULES

Statutes
Florida Statute, Section 384 – Sexually Transmissible Disease

- 384.21 Short title
- 384.22 Findings; intent
- 384.23 Definitions
- 384.24 Unlawful acts
- 384.25 Reporting required
- 384.26 Contact investigation
- 384.27 Physical examination and treatment
- 384.287 Screening for sexually transmissible disease
- 384.29 Confidentiality
- 384.30 Minors' consent to treatment
- 384.31 Testing of pregnant women; duty of the attendant
- 384.34 Penalties

Rules
The Florida Administrative Code for STD is 64-D3

- 64D-3.028 Definitions
- 64D-3.029 Diseases or Conditions to be Reported
- 64D-3.030 Notification by Practitioners
- 64D-3.031 Notification by Laboratories
- 64D-3.032 Notification by Medical Facilities
- 64D-3.033 Notification by Others
- 64D-3.035 Congenital Anomaly Reporting
- 64D-3.036 Notifiable Disease Case Report Content is Confidential

APPENDIX D: STD LINKS TO RESOURCES

CDC Program Operations Guidelines for STD Prevention (POGS) - www.cdc.gov/std/program/gl-2001.htm

County Performance Improvement Process – Timeliness of Treatment Measurement for STDs that appears on the DOHA County Snap Shot report
hpe00ws.doh.state.fl.us/snapshot/CountyPerformanceSnapshot.aspx

Florida Charts - www.flhealthcharts.com/charts/default.aspx

Linkage to Care Quick Guide - "Linkage to Care- A DIS Perspective".

Partner Services Quick Guide - www.cdc.gov/std/Program/PartSerQuickGuideJan-2012.pdf

STD Awareness Month - April is STD Awareness Month, an opportunity to address ways to prevent STDs.

STD TAGS - floridahealth.sharepoint.com/search/Pages/CL-Policies.aspx

STD Tools and Materials - www.cdc.gov/std/products/default.htm

STD Treatment Guidelines - *Sexually Transmitted Diseases Treatment Guidelines, 2015*

IOP 360-28-15 – Field Delivered Therapy –
floridahealth.sharepoint.com/sites/DISEASECONTROL/Policies/IOP_360-28_FieldDeliverTherapy.pdf

IOP 360-40-17- "Expedited Partner Therapy (EPT)":

floridahealth.sharepoint.com/sites/DISEASECONTROL/Policies/IOP_360-40_ExPartnerTherapy.pdf

APPENDIX E: FIELD AND INTERVIEW RECORD OWNER AND TIMEFRAMES

Field Record: Field Records should be closed within 14 days of the field record Add Date. Period can be extended by supervisor, if justified.

Owner	Document Initial Investigative Activity	Document Follow Up Activity	Document Response to Supervisory Instruction(s)
DIS	Within one business day of assignment	Within two business days after initial investigation	Within two business days after initial instruction(s)
Owner	**Document Initial Supervisory Review**	**Document Follow Up Review**	**Document Response to PM and/or STDHQ Instruction(s)**
Supervisor	Within three business days of assignment to DIS	Within three business days after initial review	Within two business days of instruction(s) entry

Interview Record: Interview Records should be closed within 45 business days of the Original Interview Add Date. Period can be extended by supervisor, if justified.

Owner	Add Interview Record and Original Narrative	Pursue Re-interview and document re/IX Narrative	Document Response to Supervisory Instruction(s)
DIS	Within two business days from interview	Within seven business days from original interview	Within two business days from instruction(s) entry
Owner	**Document Initial Review**	**Document Follow Up Review**	**Document Response to PM and/or STDHQ Instruction(s)**
Supervisor	Within three business days from DIS adding Interview Record	Within seven business days from first review	Within two business days from instruction(s) entry

APPENDIX F: MATERNAL AND CONGENITAL RECORD OWNER AND TIMEFRAMES

Maternal and Congenital Records should be closed within 45 business days of Estimated Delivery Date (EDD), actual delivery date, date of stillbirth or miscarriage. Period can be extended by supervisor, if justified.

Owner	Follow-up Maternal Record, R/S Vital Stats, R/S provider or hospital	Complete Maternal and Congenital Questions	Document Response to Supervisory or STDHQ Instruction(s)
Designated Staff (Surveillance, DIS or FLS)	Within seven business days from EDD, actual delivery date, date of stillbirth or miscarriage	Within 21 business days from EDD, actual delivery date, date of stillbirth or miscarriage	Within two business days from instruction(s) entry
Owner	**Assign Maternal Record to designated Congenital investigation staff**	**Document Follow Up Review**	**Document Response to STDHQ Instruction(s)**
Supervisor or Program Manager	Within 30 business days before EDD	Within 14 business days from EDD, actual delivery date, date of stillbirth or miscarriage	Within two business days from instruction(s) entry

APPENDIX G: HIV/AIDS, STD, AND BUREAU OF PUBLIC HEALTH LABORATORIES (BPHL) MANUAL FOR NUCLEIC ACID AMPLIFICATION TEST (NAAT) FOLLOW-UP ALERT PROCESS

HIV-1 RNA Supplemental NAAT testing is available through the BPHL, Jacksonville and Miami-Dade Retrovirology Units. Because the most cost-effective manner to detect HIV is with concordant reactive immunoassays (Combo screening and differentiation), HIV-1 NAAT is reserved to resolve discordant immunoassays and is essential in determining **algorithm-defined acute HIV-1 infections** (Combo r/r, differentiation IA nonreactive, HIV-1 NAAT reactive).

The purpose of the manual is to add a layer of alerts to key Department of Health personnel to the existing same day reporting of these pedigree cases. Through same-day reporting, STD Program field staff can significantly reduce timeframes to provide counseling, Partner Services (PS) and linkage to care by alerting key STD and HIV program personnel once an acute HIV case is identified.

To access the current up to date HIV Acute Notification Call List, go to the Florida SharePoint and search "HIV/AIDS, STD and Bureau of Public Health Laboratories (BPHL) Manual for Nucleic Acid Amplification Test (NAAT) Follow Up" and find the up-to-date list of designated staff by name and phone number. The steps outlined below offer staff the most efficient way to address an acute HIV infection report.

Reporting Instructions for BPHA Retrovirology Unit Personnel

The "same day" procedure used by the Jacksonville Lab and Miami-Dade Retrovirology Labs is as follows:
Step 1: Call the care provider first (most often this is the coordinator or counselor of record for the submitting site number) to inform of the test result. This step is critical to determine the reason for client visit, to obtain locating information to contact the patient regarding HIV test results and to offer PS and linkage to care.
Step 2: Call the respective Area STD Program Manager in charge for the county in which the case is located.
Step 3: Notify staff in the STD and Viral Hepatitis Section (STDVHS).
Step 4: Notify office of HIV/AIDS. A message may be left; HIV staff will call back to obtain the pertinent patient information.) Note: For each contact listed, BPHL staff will provide the client name, date of birth, collection date, test date, lab accession number, provider site number and any other information available on the lab requisition (DOH 1628) via phone.
Step 5: Perform a baseline viral load and CD4 tests on the initial client blood specimen to expedite linkage to care once the individual is located and Partner Services (PS) is offered.

NAAT Follow up for Area STD Programs

Designated Area STD Program field staff (STD Program manager, STD Supervisor, STD Disease Intervention Specialists (DIS) will apply the following procedure upon receipt of an acute HIV infection report:
Step 1: Once the Area STD Program Manager or STD program back-up receives a report of an acute HIV infection report from the Bureau of Laboratories, they will immediately create a PRISM Field Record.
Step 2: The Area STD Manager or DIS Supervisor will immediately assign the Field Record for follow up by a DIS and email the Profile ID to STDVHS and the STD Regional Program Consultant.
Step 3: The DIS will immediately work to locate, post-test counsel, and provide PS within 24 hours of assignment. The DIS will immediately alert their immediate supervisor/program manager of any difficulties/obstacles (For example, "unable to locate") throughout the continuum of case follow up.
Step 4: Establish Interview period of three months prior to the client's test date. Once the DIS conducts/completes the PS session, the DIS and Linkage to Care Specialist (dependent on local organizational structure) should link the patient into care within 24 hours.
Step 5: All PS information including linkage to care should be documented in PRISM immediately following the PS session and linkage to care.

Step 6: Obtain a second blood specimen during the original interview. Collect two pearl top tubes (if available); if not then, two purple top tubes. Spin down the blood for viral load only (**do not spin blood for CD4)** and ship overnight to the respective lab who performed the original test, either to the BPHL Jacksonville or Miami-Dade.

- **Note: The lab will conduct a baseline CD4 and viral load at no charge to the county health department (CHD). Baseline genotyping will be conducted only at the request of the CHD and a charge will apply if the client is not on Ryan White.**

Step 7: The Area STD Program will make courtesy call to BPHL Jacksonville to inform them that the specimens are being sent. Contact the office of HIV/AIDS and let them know that you are shipping viral load and CD4 directly to BPHL Jacksonville. Provide the scan number from the DOH 1628 that was attached to the specimen. Make a note on the specimen lab requisition "follow up blood for acute infection. Attention: Designated person at BPHL, "Document the scan number in the note section of the patient's field record."

For county health departments who send specimens to BPHL Miami-Dade for NAAT testing and if the specimen tests positive, either a) ship the 2 blood tubes for viral load and CD4 testing directly to Jacksonville (following the instructions in the previous paragraph) or b) drop the two blood tubes at the BPHL Miami-Dade (contact designated person at BPHL to let them know that the specimens were sent for that purpose). Miami Lab staff will ship the specimens to the Jacksonville Lab and contact designated person to inform.

Step 8: An interview record should be created for the client and interview notes added into PRISM immediately after the interview has taken place.
Step 9: Immediately assign all sex and needle-sharing partners and other at-risk persons for follow up to locate, counsel and test within 24 hours.
Step 10: Click the "Add Linkage to Care" tab on the patient's PRISM Interview Record.
The DIS will enter all relevant information in the client's PRISM record to be available to a Linkage to Care Specialist.

- **Note: If you close the linkage to care record using "Reason Not Referred to Care" this will not make for a successful linkage to care record as part of the performance metric. That reason should only be used when there is no way to link the patient to care, for example, unable to locate, patient refused care, to spare the Linkage to Care Specialist time spent attempting to locate the client.**

Step 11: Make a courtesy phone call to the Linkage to Care (LTC) Specialist who was assigned the record to alert them that a linkage to care record was created for the client with an acute HIV infection. Provide the LTC Specialist with the clients PRISM profile number. Complete HIV medical and risk sections of the PRISM Interview Record.

- **Note: As this is going to the LTC Specialist, it should be considered a best practice to advise the client that a LTC specialist will be following up to assist them with their needs.**

Step 12: The DIS should re-interview the client within 24 hours of the original interview. If linkage LTC information not available from the first interview, the DIS should update and record their re-interview findings in PRISM.

APPENDIX H: FIELD SAFETY CHECKLIST

BEFORE LEAVING FOR THE FIELD

☐ Map out field visit stops before you go. Make visits in the morning or during daylight hours.

☐ Do not change your attire to try to blend into a high crime neighborhood. Wear comfortable, professional attire, including low-heal footwear.

☐ Prepare referral letters for scheduled field visits.

☐ Secure purse and other valuables in the vehicle trunk or other locked location.

☐ Let supervisors and co-workers know your planned route.

☐ Go to high risk areas in pairs and during the time of day there is less activity. Know the neighborhood. Know drug and gang hangouts.

☐ Make sure your vehicle is in good working order with plenty of gas.

☐ Carry health department identification, state issued driver's license, charged cell phone and vehicle charger.

☐ Know location of neighborhood and community police precincts and fire departments.

WHILE IN THE FIELD

☐ Avoid wearing or carrying articles that look valuable.

☐ Do not leave articles visible inside your vehicle that may look valuable (GPS, phone charger, cell phone, backpack, sunglasses, money, etc.).

☐ Avoid tampering with mailboxes. This is a federal offense.

☐ Roll your vehicle window down only a few inches when asking directions from strangers.

☐ Be aware of dogs in the neighborhood. Whistle or rattle fence to check for animals. Check for signs nearby (food bowl, toys, chain, path, etc.).

☐ Park your vehicle facing the direction needed to leave so that you can do so quickly.

☐ Avoid looking at maps or documenting visits in your vehicle at the same place you parked when you made your field visit. Drive to a secure location nearby to document your field visit.

☐ Report any incidents to your supervisor.

☐ Let supervisors and co-workers know changes in your planned route before leaving for location.

☐ Never leave keys in your vehicle and always lock your vehicle door.

☐ Secure confidential information such as a pouch in a locked trunk or under the seat out of view.

☐ Be aware of large numbers of people congregating in an area where you are accustomed to seeing few people. Come back another time.

☐ Always check out the house or building before you enter. Plan an escape route.

☐ LOOK, LISTEN, and LEAVE, if necessary.

AFTER RETURNING FROM THE FIELD

☐ Report or follow up on any incidents reported to your supervisor.

☐ eek supervisory guidance in documenting encounters in the field involving safety concerns.

☐ Shred referral letters and envelopes addressed with client's name or identifiers.

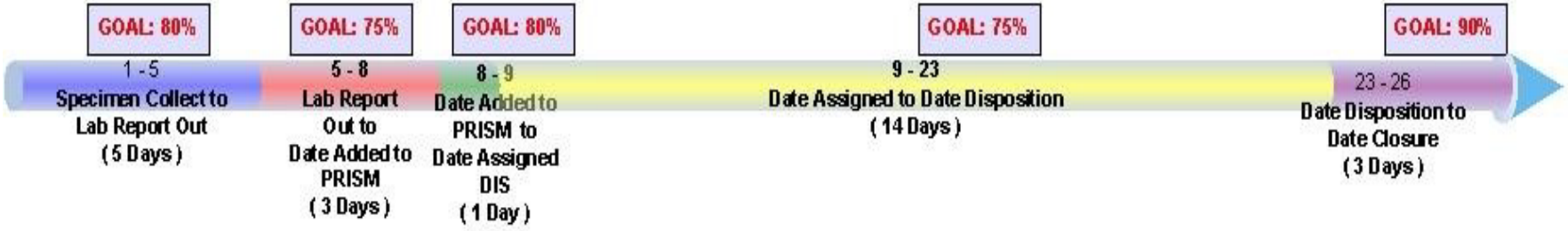
APPENDIX I: FIELD RECORD LIFE CYCLE

Timeliness Measure Tier 1 A and B: Timeliness for Prenatal and Neonatal Infections

This measure is a comparison of the average number of days involved in the process from specimen collection to the closure of disease investigation divided into distinct increments, specific to prenatal and neonatal infection. The following timeline is provided as the *ideal* performance expectation for this measure.

Timeliness Measure Tier 1 C: < = 15 Year Olds

This measure is a comparison of the average number of days involved in the process from specimen collection to the closure of disease investigation divided into distinct increments, specific to investigations for infected clients that are between the ages of 13 to 15 years of age. The following timeline is provided as the *ideal* performance expectation for this measure.



Measure Tier 2A: Timeliness for Primary and Secondary Syphilis Cases (Infectious Syphilis)

This measure is a comparison of the average number of days involved in the process from specimen collection to the closure of disease investigation divided into distinct increments, specific to Infectious Syphilis cases. The following timeline is provided as the *ideal* performance expectation for this measure.

Measure Tier 2B: Timeliness for New HIV or Exposed to HIV infection

This measure is a comparison of the average number of days involved in the process from specimen collection to the closure of disease investigation divided into distinct increments, specific to New HIV infections and exposure to HIV infections. The following timeline is provided as the *ideal* performance expectation for this measure.

APPENDIX J: UNABLE TO LOCATE CHECKLIST AND H VERSUS D CHECKLIST

Use the Unable to Locate Checklist as a guide and document investigative attempts in the notes before using disposition H or D.

	Unable to Locate Checklist Recommended Activities
Record Search Resources	☐ PRISM (profile, phone #, lab result and HARS search)
	☐ HMS/Medicaid/FLIMMIS
	☐ Vital Statistics/HIV data systems
	☐ Healthy Start/WIC
	☐ Employment verification
	☐ Utility Companies: Electric, Gas, Water
	☐ DMV/DAVID/Accurint
	☐ Local 'walk-in' clinics
	☐ Major local hospitals
Public Info/ Internet Search	☐ Google, switchboard.com, cross reference directory, zabasearch.com, brbpublications.com/free resources/pubrecsites.aspx
	☐ Phone book/411.com/whitepages.com/pipl.com
Dept. of Corrections	☐ Booking/Police/Sheriff
	☐ Juvenile Detention Center/Jail/Prison Search
	☐ Probation/Parole Officer
Field Visits	☐ Post Office/Carrier: forwarding address
	☐ Homeless Shelter/Food Pantry
	☐ Local Drug/Alcohol Rehab Centers
	☐ Past Residence
	☐ Talk with Neighbors or Relatives
	☐ Schools/Employer
Medical Record/ Provider	☐ Emergency contact, locating and work information

Revised from Area 8_DP: 9/2018/IMC_ADK

H Versus D Disposition

For a T-4 (P1 or AR1-3) that was not located after a thorough DIS investigation (use H Checklist), then use disposition “H-Unable to Locate”. This disposition should always be discussed with supervisor.

For a T-1 Positive Test Result or a T-4 that was tested and resulted infected, if the client was not located for treatment and/or interview after thorough DIS investigation (use H Checklist), select the “Disease” for the STD Case Definition that the medical history meets. Then use disposition “D-Infected Not Treated”. For syphilis 710, 720, 730 and 745, you must attach “Unable to Interview” Interview Record (IR) and report morbidity.

APPENDIX K: SYPHILIS AND HIV INTERVIEW NARRATIVE

Original Patient (OP) Information to go in the Interview Record Notes:
Use checklist questions to ensure appropriate information has been included in the Original Interview (OI) narrative. Avoid including demographic or Test information that is already in the profile (OP is a 28-year-old Hispanic male with RPR 1:128/FTA R that was treated with Bicillin 2.4mu IM X 1…). Demographic and descriptive information should be updated in the Profile.

GENERAL INFO

- ☐ Who does the client live with? What does he/she do for a living?
- ☐ Why did the client initially seek care?
- ☐ When/where did the client have any blood tests within the last year? Any blood donation, emergency room/hospital visits, PCP…? (looking for previous RPRs)
- ☐ What antibiotic use occurred during the interview period?
- ☐ What signs/symptoms has client ever noticed on himself or any of his partners?
- ☐ Any probable neurologic, auditory or ocular manifestations?
- ☐ What was the client's attitude/feeling toward the diagnosis? What was your impression of the client's feelings? (Describe: scared, lying, withholding info, helpful, etc.)
- ☐ What problems or inconsistencies did the client present? How did you address them?
- ☐ What did you have to challenge the client about?
- ☐ If the client was not tested for HIV, why?
- ☐ If the client is a new HIV positive client, have they been linked to care? If so, who is the provider?
- ☐ Other information as appropriate.

PARTNER INFO

- ☐ If OP is pregnant, is she in prenatal care? Where? When was she last seen there? Who is the father of baby?
- ☐ Does client hook up online or with smartphone Apps? Sites used, names used?
- ☐ What is the client's lifestyle like? How and where does the client spend his/her free time? What is the client's travel history within the interview period?
- ☐ If involved in drug use, who does the client use them with? Where does the client use them? How does the client get the money to buy drugs? Is the client exchanging sex for drugs? Who does the client share needles/works with?
- ☐ What is the nature of the client's relationship with the named partners and clusters? How did the client feel about having you notify his/her partners? If unwilling, what did you do to convince him/her of the urgency and importance to notify? How will the partners be referred? If no partners are linked, why?
- ☐ Where does client have sex with his partners, and type sex?
- ☐ What pregnant females does he/she know that could benefit of a free check-up?

Next Steps/Plan of Action (POA)

- ☐ What information did you forget to ask?
- ☐ What problems do you foresee in managing this case? What are your instincts on where this case is headed?
- ☐ What is your POA, next steps, questions for re-OI, etc.)?
- ☐ When did you agree to talk again to make sure he/she is okay? (re-OI)

APPENDIX L: INTRASTATE/INTERSTATE COMMUNICATION CONTROL RECORDS (ICCR) QUICK REFERENCE GUIDE

Scope/Purpose: There is a National Interstate Communication Control Record (ICCR) network in place whose membership includes all STD prevention programs in all 50 states and U.S. Territories. The networks purpose is to enable efficient cross-jurisdictional communication to ensure follow-up for positive STD laboratory reports, sex and needle-sharing partners, and persons with a suspected exposure to an STD, including HIV.

Procedure: For all incoming STD investigation requests from out-of-state jurisdictions (OOJ) and conversely, those submitted by Florida STD programs for out-of-state STD jurisdictions, shall be communicated through the ICCR/OOJ staff in the STD and Viral Hepatitis Section in Tallahassee, as a single point of contact for this process.

- For all outgoing interstate/intrastate communication requests created by the DIS or surveillance staff, all persons initiated must first have a complete Profile ID created in PRISM.

- Once a PRISM Profile ID is created, a field record and any other related intervention records (interview, maternal, or congenital) is auto created for submission to the local ICCR/OOJ designee, usually the STD Program Manager.

- Once the local ICCR/OOJ designee receives the Field Record, they should review to make certain there is enough locating information to begin an investigation by the receiving jurisdiction.

- Once approved (meets minimum criteria required to begin investigation), the local ICCR/OOJ designee submits the Field Record to the STD and Viral Hepatitis Section ICCR/OOJ staff in Tallahassee.

Requirements for Submission of an ICCR: Information requirements for the submission of an OOJ Field Record should include the following information, as available.

- Individual's name, including nicknames and aliases, Jr. Sr. etc.
- Age, date of birth, race, sex, ethnicity.
- Physical description to include height, weight, color and length of hair, complexion, etc.
- Home address, color of house, telephone, place of employment, hangouts, name of school, type car, directions to house, or other means to locate an individual.
- Pertinent epidemiologic information to include exposure dates, frequency and type of exposure.
- For all outgoing contacts to syphilis, please make certain to indicate stage of disease (710, 720, 730) of the original index patient.

Minimum Locating Information: If insufficient information is available to locate or begin the investigation, local ICCR/OOJ staff will use public sources or commercially available tools (Accurint) to obtain locating information.

"Rule of Thumb": If you were the recipient of the Field Record you plan on sending to another jurisdiction, do you feel there is adequate locating information to begin the investigation? If the answer is no, then don't send until additional locating information is obtained.

The ICCR/OOJ staff at headquarters will monitor all Field Records sent out of state and to other Florida jurisdictions to ensure compliance with the expected timeframes associated with the communication of closure of the investigative records as stated in TAG 355-33-15.

APPENDIX M: SYPHILIS—EARLY LATENT (730) VERSUS LATE LATENT (745)

How can you tell?

Determine the stage of syphilis latency based on criteria outlined in the three tables below.

Proceed through each step and table as sequentially presented to best determine the appropriate latency stage.

Remember to always reference the Syphilis Reactor Grid to assist in your determination.

Check for 730 Criteria

CRITERIA MET **(Within Past Year)** **If any of the five criteria are met diagnosis = 730**	**CRITERIA NOT MET** **If none of the five criteria have been met proceed to 745 Criteria**
1) Negative RPR in past 12 months **2)** Rising titer (2 dl. Or more) **3)** Signs/symptoms recalled with past 12 months **4)** Epidemiologic link to recent syphilis case **5)** Adolescent first time sexual exposure < 1 year	**1)** No negative RPR history **2)** No rising titer **3)** No sign/symptoms in past 12 months **4)** No link to a known syphilis case **5)** Adolescent sexually active > 1 year

When any of the above 730 criteria are NOT met, consider the diagnosis to be a 745

Check for 745 Criteria

ALL OTHER CRITERIA NOT MET **If 730 criteria are not met, diagnosis = 745**	**You have reached your final choice of diagnosis** **745**
730 Checklist (criteria) ***Are not met***	None of the five criteria were met for 730

APPENDIX N: STD/HIV FIELD RECORD DISPOSITION CODES

Disposition Code	Definition	Applicable Disease	Treatment Required?	Morbidity Required?
A	The partner/cluster was examined and preventatively treated but the infection was not found by lab tests/clinical evidence.	Any Bacterial STD	Yes	No
B	The partner/cluster was examined and infection was not found; however, the partner/cluster refused preventive therapy.	Any Bacterial STD	No	No
C	The patient was examined or treated for the suspected infection as a direct result of this field investigation.	Any Bacterial STD	Yes	Yes
CN	The patient was examined or treated for the suspected infection as a direct result of this field investigation however, the patient was not treated with the recommended standard treatment.	Any Bacterial STD	Yes	Yes
D	Lab from a health care provider indicates the presence of an STD infection but ***adequate*** treatment was not administered.	Any Bacterial STD	No	Yes
DM	Lab from a health care provider indicates the presence of an STD infection. No follow- up was taken but morbidity was reported.	CT/GC	No	Yes
E	The patient was adequately treated for the disease since the last exposure but prior to the initiation of a field record.	Any Bacterial STD	No	No
F	The tests/exam for the suspected disease is negative and preventive therapy was not required for this individual.	Any Bacterial STD	No	No
H	The patient was not found after a thorough DIS investigation. This disposition should always be reviewed with a supervisor. To ensure quality control. ***If the infection status of the patient is known, use disposition "D".***	Any Disease	No	No

Disposition Code	Definition	Applicable Disease	Treatment Required	Morbidity Required
I	A field record was initiated through the course of the investigation. It was determined that the field record should be closed administratively. This disposition should be discussed with the supervisor prior to use.	Any Bacterial STD	No	No
IO	The patient resides or has moved outside of the local jurisdiction and locating information is available to forward the record for continued investigation.	Any Disease	No	No
IR	The field record was administratively closed based on the Syphilis Reactor Grid. This disposition code is used by surveillance staff.	Syphilis	No	No
J	The partner/AR3 was found but refused examination and/or an Interview. This disposition should always be reviewed by a supervisor before being given as final.	Any Disease	No	No
JP	The patient was found but refused partner services. This disposition should be used for 900 reactors only. This disposition must be reviewed by a supervisor prior to closure.	HIV Reactors	No	No
L	This disposition is to be used when none of the other dispositions apply. Document the reason why this disposition was selected and discuss with a supervisor prior to using this disposition.	Any Bacterial STD	No	No
LV	No follow-up completed due to provider (private or public) assessed that contacting the partner or cluster could pose the risk of domestic violence to the index patient, partner, or cluster.	Any Disease	No	No

Disposition Code	Definition	Applicable Disease	Treatment Required	Morbidity Required
LX	Through the course of the investigation the patient was determined to be deceased.	Any Disease	No	No
1	The patient had a previous positive HIV test.	HIV Only	No	No
2	The patient has a prior documented negative HIV test and has seroconverted to positive.	HIV Only	No	Yes
3	The patient has a previous negative result and has a negative test result from this investigation.	HIV Only	No	No
4	The patient has a negative result, but is not retested at this time due to a recent test or other circumstances.	HIV Only	No	No
5	The patient has no documented previous test and is a new HIV - positive.	HIV Only	No	Yes
6	The patient has not been previously tested (or is unable to document previous test) and has tested negative for this investigation.	HIV Only	No	No
7	The patient has not been previously tested in the past and has not been currently tested.	HIV Only	No	No

APPENDIX O: 2018 CODES/ACRONYMS/ABBREVIATIONS

Disease Codes	CDC Disease Codes in PRISM
10	Hepatitis A Acute
30	Hepatitis B Acute
32	Hepatitis B Chronic
42	Hepatitis D
51	Hepatitis C Acute
53	Hepatitis E Acute
54	Hepatitis C Chronic
70	Hepatitis unknown
100	Chancroid
200	Chlamydia
220	Chlamydial Opthalmia Neonatorum
300	Gonorrhea
320	Gonorrheal Opthalmia Neonatorum
350	Gonorrhea - Resistant
400	Non-gonnoccal Urethritis (NGU)
410	Pediculosis - Pubic Lice
420	Scabies
450	Mucopurulent Cervicitis (MPC)
490	Pelvic Inflammatory Disease (PID)
500	Granuloma Inguinale (GI)
600	Lymphogranuloma Venereum (LGV)
700	Syphilis
710	Syphilis - Primary
720	Syphilis - Secondary
730	Syphilis - Early Non-Primary, Non Secondary (< one year duration)
745	Syphilis - Unknown Duration or Late (> one year duration)
750	Syphilis - Late with Clinical Manifestations
760	Syphilis - Neurosyphilis
790	Syphilis - Congenital - Early Unspecified
800	Human Papillomavirus (HPV)
850	Herpes Simplex (HSV)
900	HIV
910	HIV - Acute
950	Acquired Immunodeficiency Syndrome

TB	Tuberculosis
TBC	Tuberculosis Consult
Referrals	PRISM Case Management/Referral Codes
P1	Sex Partner
P2	Needle Sharing Partner
P3	Sex and Needle Sharing Partner
AR1	Person with Symptoms (Case related)
AR2	Undisclosed partner by the Original Patient but known to us
AR-3	At-risk individual (Case related)
T-1	Positive test Result
T-2	Case Report (Provider referred)
T-3	Clinic Walk-in
T-4	Profile Referred (When linking clients)
T-5	Court Ordered
T-6	Negative Lab Result
Acronyms	Commonly Used Acronyms in PRISM
AAP	Area Action Plan
ACA	Affordable Care Act
ADA	Americans With Disabilities Act
ADAP	AIDS Drug Assistance Program
AHF	AIDS Healthcare Foundation
AIDS	Acquired Immunodeficiency Syndrome
AKA	Also Known As
APHL	Association of Public Health Laboratories
APS	Adult Protective Services
ARVDRT	Antiretroviral Drug Resistance Testing
ASHA	American Social Health Association
ASO	Aids Service Organization
ASTHO	Association of State and Territorial Health Officers
ASTPHLD	Association of State and Territorial Public Health Laboratory Directors
AR3	At-risk Individual
ART	Antiretroviral Treatment
ATR	Adult Transmission Risk
AXIOM PRO	HIV Viral load and CD4 database
AZT	Azidothymidine
Bic.	Bicillin
BID	Twice a day

BED testing	B,E and D refer to the strains of HIV tested by this methodology
B/M	Black Male
C/B	Call back/Called back
BRFSS	Behavioral Risk Factor Surveillance System
CBO	Community Based Organization
CD4	Lymphocytes

CD4+	Helper T lymphocyte white blood cell
CHD	County Health Department
CDC	Centers for Disease Control and Prevention
CI	Cluster Interview
CLI	Community-level Interaction
CLIA	Clinical Laboratory Improvement Amendments
COB	Close of business
COPHI	Cases of Public Health Importance
CPS	Child Protective Services
CSF	Cerebrospinal fluid
CSW	Commercial Sex Worker
CSTE	Council of State and Territorial Epidemiologists
C/E	Counseling and education
C/T	Counseling and testing
CT	Chlamydia
CTR	Counseling, Testing and Referral
CTRPN	Counseling, Testing, Referral and Partner Notification
DAVID	Driver and Vehicle Information Database
DC	Disconnected Phone
DHAP	CDC’s Divisions of HIV/AIDS prevention
DHHS	Department of Health and Human Services
DIS	Disease Intervention Specialist
DMV	Department of Motor Vehicles
DNS	Did not show
DSTDP	Division of STD Prevention (CDC)
DOC	Department of Corrections
DOB	Date of birth
DOH	Department of Health
DOT	Directly observed therapy
DTC	Drug treatment center
Dx	Diagnosis

EAC	Epidemiologic analysis chart
EBI	Evidence Based Intervention (Prevention)
HARS	evaluation HIV/AIDS Reporting System
EI	Early intervention
EIA	Enzyme immunoassay (same test as an ELISA)
EL	Early latent syphilis
ELISA	Enzyme-linked Immunosorbent Assay (same test as an ELISA)
ELR	Electronic Laboratory Reporting
FB	Field blood
F/MS	Female with male sexual activity (heterosexual contact transmission of HIV)
F/V	Field visit
FIBs	Factors which influence behavior
FR	Field Record
FOB	Father of Baby
FOPS	Field Operations (or FO)
FTA-ABS	Fluorescent Treponemal Antibody Absorption Test (Confirmatory test for syphilis)

F/up	Follow-up
FQHC	Federally Qualified Health Center
GC	Gonorrhea
GISP	Gonococcal Isolate Surveillance Project
GLI	Group-level interaction
HAART	Highly Active Antiretroviral Treatment
HAN	Health Alert Network
HARS	HIV/AIDS Reporting System
HBV	Hepatitis B virus
HCPI or HC/PI	Health communications and public information
HCV	Hepatitis C Virus
HE/RR or HERR	HIV Prevention Health Education/Risk Reduction
HFS	HIV family of surveys (a study during the 90's)
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HIV+	HIV infected status for an individual or body fluid specimen
HMAZ	High Morbidity Analysis Zone
HMS	Health Management System
HOPWA	Housing Opportunities for Persons with AIDS
HPV	Human Papilloma Virus (Genital Warts)

Hx.	History
HRSA	Health Resources and Services Administration
HSV	Herpes simplex virus
IDK	I don't know
ICCR	Inter/Intra State Communicator Control Record
IDU	Injecting drug use (also IVDU, injecting drug user)
IFA	Immunofluorescence Assay
IgG	Immunoglobulin G
ILI	Individual-level interaction
IM	Intramuscular
IRB	Interview Record
IPP	Infertility Prevention Project
IRB	Institutional Review Board (Committee for the Protection of Human Subjects in research studies)
IT	Information Technology
LHD	Local Health Department
LM	Left message
LMP	Last Menstrual Period
LR	Left referral
LSE	Last Sexual Exposure
LS EIA (HIV)	Less sensitive HIV enzyme immunoassay
LSP	Last Sexual Partner
LTC	Linkage to Care
LTCS	Linkage to Care Specialist
LVM	Left voice vail message
LX	Lesion
LM	Left message

M/MS	Male with male sexual activity, includes bisexual men
M/MS/IDU or MSM- IDU	Male with male sexual activity and injecting drug use, includes bisexual men who inject drugs
MH	Mental Health
MHA-TP	Micro hemagglutination assay for Treponema Pallidum
MMWR	CDC’s weekly publication, Morbidity and Mortality Weekly Report
MOB	Mother of Baby
MOU/A	Memorandum of understanding/agreement
MR	Medical Record

MSA	Metropolitan Statistical Area
MSM	Men who have sex with men
MSM-IDU	Male with male sexual activity and injecting drug use, includes bisexual men who inject drugs
NASTAD	National Association of State and Territorial AIDS Directors
NAAT	Nucleic Acid Amplification Test
NCSD	National Coalition of STD Directors
NEDSS	National Electronic Data Surveillance System
NETSS	National Elective Telecommunications Systems of Surveillance
NGU	Non-gonococcal Urethritis
NIAID	National Institute of Allergy and Infectious Disease
NICU	Neonatal Intensive Care Unit
NIH	National Institutes of Health
NIR	No identified risk (HIV or AIDS case reported without a behavioral risk) information
NKA	No known allergies
NKDA	No known drug allergies
NMAC	National Minority AIDS Council
NNPTC	National Network Prevention Training Center
NON-IDU	Non-injecting drug user (Substance abuse other than through injection)
NPEP	Non-occupational Exposure Prophylaxis
OB	Obstetrician
OI	Original Interview
OIG	Office of Inspector General
OOJ	Out of jurisdiction
OP	Original Patient
OOS	Out of state
OOT	Out of town
P&S	Primary and secondary (syphilis)
PC	Phone Call
PCM	Prevention case management
PCN	Penicillin
PCPE	Prevention Counseling and Partner Elicitation
PCR	Polymerase chain reaction
PEP	Post-exposure prophylaxis for HIV
PID	Pelvic Inflammatory Disease
PG	Pregnant

PHIN	Public Health Information Network
PrEP	Pre-exposure Prophylaxis for HIV

PO	By mouth
POA	Plan of Action
POC	Point of Care
PMD	Private Medical Doctor
PRISM	Patient Reporting Investigating Surveillance Manager
PRN	As needed
PS	Partner services
PT	Patient
PTC	Post-test counseling
PWAs	Persons with AIDS
QA	Quality assurance
QID	Four times a day
QRNG	Fluoroquinolone-resistant Neisseria gonorrhoeae
RA	Rapid assessment
RI	Re-interview
RIBA	Recombinant Immunoblot Assay (Confirmatory test for hepatitis C)
RS	Record search
RPR	Rapid Plasma Reagent (test for syphilis)
RTC	Return to Care
RW	Ryan White
Rx	Treatment
SDN	Secure data network
S.O.B.	Shortness of Breath
SP	Sexual Partner
S/S	Signs and Symptoms
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSN	Social Security Number
STARHS	Serologic Testing Algorithm for Recent HIV Seroconversions
STD	Sexually Transmitted Disease
STD-MIS	STD Management Information System Database
STI	Sexually-Transmitted Infection
STS	Serologic tests for syphilis
S/W	Spoke with
Sx	Symptoms

T and T	Test and Treat
TA	Technical assistance
TOPWA	Targeted Outreach for Persons With AIDS
TB	Tuberculosis
TPPA	Treponema Pallidum Particulate Agglutination
Tx	Treatment
UI	Unique Identifier (in lieu of names on morbidity reports)
Unk	Unknown
VARHS	Variant, Atypical and Resistant HIV Surveillance
VDRL	Venereal Disease Research Laboratory (slide test for syphilis)
VL	Viral Load
VM	Voice Mail
VR	Vital Records
WB	Western Blot Confirmatory Antibody Test for HIV
WBI	Will be in
WBC	White blood count
W/	With
W/O	Without
W/M	White Male
WIC	Women, Infant, Children
WNL	Within normal limits
WSW	Women who have sex with women
Wt.	Weight
y/o	Years old
YRBS	Youth Risk Behavior Survey
ZDV	Zidovudine (same as AZT)