

# STD Program Operations Manual



January 2007

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## Introduction

### ***STD Partner and Field Services Program Guidelines***

The Georgia Division of Public Health STD Section constructed guidelines based on the “Program Operations Guidelines for STD Prevention” developed by the Center’s for Disease Control and Prevention. The purpose of developing guidelines is to serve as a resource to local health districts, health departments, and providers delivering STD services to effectively conduct disease intervention and treatment efforts.

In Georgia there are obvious differences in availability and accessibility to STD services, particularly between the rural and metropolitan regions. Some differences that impact STD service delivery are: Morbidity, socioeconomic status, access to quality health care, health care resources, clinics, and knowledge of STDs. Therefore, the guidelines in this manual are designed to assist all areas with varying resources to at least meet the minimum standards in providing an effective STD Program while allowing flexibility to meet the unique needs of the districts.

Many public health professionals that deliver STD services are familiar with and work closely with staff such as Communicable Disease Specialist (CDS), Front-line Supervisors (FLS), the Field Operations Manager (FOM), and the STD Program Coordinator. To simplify terms used in the manual the use of CDS, FLS, and FOM will be used to identify staff and roles.

As the need arrives to revise, add, or omit specific policies and guidelines, the STD Section will give proper notice to districts. Prior to adjusting the policies and guidelines of the manual a formal notice stating the changes and dates of implementation will be sent to all districts. If major modifications are warranted due to funding, morbidity, or staffing, a meeting will be called to discuss the proposed changes.

### ***Disease Case Management***

Disease case management is a systematic pursuit, documentation and analysis of medical and epidemiological case information that focuses on opportunity to develop and implement timely disease intervention plans. Effective case management must include pre-interview analysis, interview, (e.g., original, re-interview, clustering, and cluster interviewing), post-interview analysis, partner referral, and case closure.

CDS must have thorough knowledge of STDs, interviewing, and analyzing cases. This can be achieved through studying and taking exams in the *STD Employee Development Guide (CDC 2005)* and attending a two-week Introduction to Sexually Transmitted Disease Intervention course. After completing these courses, CDS skills will be refined through shadowing experienced CDS staff and working cases with Front-line Supervisor.

This section provides an overview of the key elements, basic tools, and recommendations to be used in STD case management. The information in this section follows *CDC program*

*Operations Guidelines for STD Prevention (POGS)* and shall be a reference for obtaining disease intervention, developing performance management evaluations, and continuous quality improvement tools. Many references are specific to syphilis case management, and most are applicable for all STDs.

### ***Partner & Field Services STD Supervisory Guidelines***

Involved program managers and front-line supervisors are critical to the success of STD Programs. Active involvement of supervisors is necessary to maximize CDS disease intervention activities. Supervisors must regularly observe individual CDS in the performance of their day-to-day activities.

Audit forms must be in place to fully document these activities and demonstrations (pouch, interview, and field audits). Supervisors must share the assessment with the CDS following the audit.

Supervisors should conduct weekly “chalk talks” to facilitate CDS discussion of case management efforts and provide opportunity for input from others.

### ***Partner & Field Services Confidentiality & HIPAA***

HIPAA (Health Insurance Portability and Accountability Act of 1996) was adopted to ensure health insurance coverage after leaving an employer and to provide standards for facilitating health care related electronic transactions.

The new regulations provide protection for the privacy of certain individually identifiable health data, referred to as Protected Health Information (PHI). Protecting the health information of an individual with the need to protect the health of the public, **HIPAA expressly permits disclosure without individual authorization to Public Health Authorities (PHA)** authorized by Law to collect or receive the information for the purpose of *preventing or controlling disease, injury, or disability*, including but not limited to *public health surveillance, investigation, and intervention*.

STD Disease Investigation Programs can obtain PHI without the authorization of the client only if the information is being used for preventing, controlling disease, injury, and/or disability. Programs are strongly recommended to conduct required HIPAA training to all staff with access to medical information. Programs should also compose memorandums, letters, and brochures, clearly providing HIPAA information and the obligation of providers to disclose medical information to public health authorities for disease prevention, intervention, public health surveillance, etc.

### ***Surveillance***

Surveillance is the ongoing and systematic collection, analysis, interpretation and dissemination of data in the process of describing and monitoring disease trends. This information can assist state and local district health units to plan, implement and evaluate efforts to monitor and control STDs.

Georgia STD Prevention Section uses the STD Management Information System (STD\*MIS) version 4.0b software from the Centers for Disease Control and Prevention (CDC) as a state patient registry and management information system. Sources of data include laboratory reports, morbidity reports, patient interviews and other information provided and obtained from patients and health care providers. Data captured in STD\*MIS is used to estimate the burden of disease, trends for local and statewide reports, acquire and allocate resources for STD prevention and control, and evaluate the effectiveness of intervention activities.

When using these recommendations, consideration must be given to the following: prevalence of disease within the state and local districts health units, characteristics of existing network of providers and laboratories, and the level of resources available to support STD prevention activities. These recommendations are a source of guidance to the state, local district health units and their partners in STD prevention.

### ***Legal Authority***

Georgia Law Code 1933, Section 31-17-2 requires any physician or other person who makes a diagnosis of or treats a case of venereal disease and any superintendent or manager of a hospital, dispensary, or charitable or penal institution in which there is discovered a case of venereal disease shall make report of such case to the health authorities in such form and manner as the Department of Human Resources shall direct.

## **Vision**

We envision healthy Georgia communities free of Sexually Transmitted Disease (STDs).

## **Philosophy**

We believe in:

- Open, honest and respectful communication among the Georgia Department of Human Resources Divisions, health districts, community partners and our diverse clients.
- Accountability for maximizing job performance according to Process Performance Standards, to best serve our internal and external constituents.
- Shared responsibility and active participation in maximizing disease intervention opportunities.
- A mutual commitment to increase awareness, enhance services and significantly reduce STDs in the State of Georgia.

## **Mission**

To provide technical assistance to the Public Health Districts to prevent STD infection, ensuring the availability of quality prevention and treatment by improving quality assurance guidelines and methods by appropriate training.

The STD Section works to reduce morbidity associated with sexually transmitted disease in Georgia by preventing STDs and their complications in both the public and private sectors through:

- Coordinated, comprehensive statewide STD prevention
- Statewide STD screening
- Effective surveillance of sexually transmitted diseases through:
  - Planning
  - Training
  - Monitoring and evaluation services



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# Clinical Services

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## **Section I**

### **STD Clinical Services**

#### ***Standard for STD Clinical Services***

*(Adapted from CDC Program Operation Guidelines for STD Prevention)*

Note: The following standards apply to all public health sites providing STD clinical services. However, it is understood that some variations in management details may be expected between categorical STD Clinics and clinics that see clients for many different services.

#### **I. STRUCTURE AND MANAGEMENT**

##### **A. ACCESSIBILITY**

1. Clinic Schedule
  - a. Clinic hours should meet the needs of the community.
  - b. Clinic hours and staffing should be sufficient to accommodate clients and avoid prolonged waiting time or clients being turned away.
2. Physical Location
  - a. Clinics, particularly new ones, should be located near residential areas of high STD prevalence and be readily accessible to public and private transportation.
3. Cost to Client
  - a. Fees, if charged, should be minimal or on a sliding scale. Services and/or medications must never be withheld because clients cannot pay a fee.
  - b. Fees should not be assessed for examining persons referred to the clinic by a Communicable Disease Specialist (CDS) or by another health professional.

##### **B. CLINIC ENVIRONMENT**

1. Clinic Directions
  - a. The building that houses an STD clinic should have easily readable signs that clearly direct clients.
2. Waiting Areas
  - a. Waiting areas should be clean, maintained at a comfortable temperature and large enough to accommodate all clients.
  - b. Waiting areas should contain appropriate client educational materials.

- c. Except in facilities where the STD clients wait in a common area with clients attending other clinics, confidentiality should be promoted by calling clients by number, not by name.
3. Examination Rooms
  - a. Exam rooms should be clean and private, so it is not possible to overhear clients who are being examined.
  - b. The number of exam rooms should be adequate to have at least one room per clinician.
  - c. Rooms should have adequate equipment and supplies for physical exams and specimen collection for both male and female clients.
4. Client Consideration
  - a. All interaction with clients and other staff should be courteous and respectful.
  - b. Cross-cultural awareness and bilingual fluency (where appropriate) should be promoted as crucial elements in establishing a positive clinic-client relationship.

### **C. REGISTRATION PROCESS**

1. Clerks need to obtain complete and accurate identifying and locating information. Positive identification (e.g., drivers license, state issued identification) may be requested at registration. However, services must not be denied because a client does not show identification, and a waiver of identification for those seeking only anonymous HIV antibody counseling/testing should be advertised.
2. Registration interviewing should not be overheard by other clients.
3. Where privacy is a problem, the clinic should consider a self-registration process where little information is exchanged verbally.
4. Sufficient clerical staff should be available to register clients expeditiously and continuously.
5. Walk-in clinics should have special, rapid registration procedures for follow-up visits, sex partners, and other high-priority referrals.
6. An “expected-in” file for referrals by a CDS should be maintained at the registration desk, and checked for every client seeking STD services.

### **D. CLINICAL RECORDS**

1. STD clinical records should have a mostly “check-off” design with sufficiently complete sets of symptoms, history, examination and lab test categories to cover most STDs. Additional space should be adequate for necessary narrative description of findings.
2. Clinical records should contain sufficient information in all clinical evaluation categories so that any clinician, or other authorized person, who

looks at a record will understand the examining clinician's findings and assessment.

3. The clinical evaluation and laboratory items should be designed so that clinicians must mark each as to whether it is: positive or negative, done or not done, normal or abnormal, etc., so that a quality assurance (QA) audit of records can determine if clinician performance is consistent with STD Program standards and protocols.
4. Clinical records should be stored in locked files where they can be easily located by authorized medical and clerical personnel but are inaccessible to unauthorized persons.
5. Clinical records stored on computer need to have rigorous access protection procedures to prevent unauthorized entry into the file, as well as back-up filing process to prevent any loss of information.

## **E. CLINIC FLOW**

1. Clients are required to make a maximum of four stops (e.g., registration, clinical care, phlebotomy, and interviewing/counseling).
2. The next available clinician should see the next client in order, regardless of gender or complaint.
3. Initial client visits should take no more than an hour from registration to treatment.
4. Walk-in clients with genital ulcers, genital discharges, and females with abdominal pain or who are pregnant, should be examined that day.
5. Clients referred by a CDS should be seen on a priority basis on the same day.
6. Walk-in clients who are not examined within the day should be given a list of alternative STD clinical resources and encouraged to call for a next-session appointment.
7. Any clinic with an average STD client volume exceeding three (3) clients per clinician per operating hour should adopt a combined appointment and walk-in system to smooth out client flow.

## **F. CLINIC MANAGEMENT**

### **Manager Responsibilities**

1. Management responsibilities should include:
  - a. Maintain an accessible clinic manual in a visible and strategic area of the clinic that contains up-to-date clinic protocols, policies, procedures and performance standards.
  - b. Ensure that the facility, equipment and supplies are adequate.
  - c. Ensure that medication available from the State Pharmacy is obtained administered or dispensed to clients for the appropriate conditions.

- Through other sources, obtain medication to treat other STDs of significant morbidity.
- d. Ensure that STD morbidity reporting is accurate and timely.
  - e. Oversee QA procedures.
2. Personnel responsibilities should ensure that:
- a. Adequate staff are assigned to STD clinical services.
  - b. All staff have appropriate job descriptions and know what is expected.
  - c. All staff are adequately trained and regularly updated.
  - d. All staff follow performance standards and protocols.
  - e. Input for staff is encouraged and frequent staff meetings are held.
  - f. Universal blood and body fluid precautions are observed by all staff.
  - g. All staff have annual performance reviews.

## **G. CLINICIAN ROLES AND TRAINING**

1. Nurse clinicians are responsible for the clinic visit, with physician back-up available onsite or on call.
2. Nurses are to receive STD clinical training and preceptorship (per requirements found in the Georgia Public Health Nursing Quality Assurance Manual) to diagnose and treat all STDs for which model protocols are available from the Division of Public Health.
3. Clinicians are to be trained as HIV pre- and post-test counselors and have additional training, as appropriate, about signs/symptoms of HIV related illness and case management.

## **H. STANDARDS AND PROTOCOLS FOR CLIENT MANAGEMENT**

1. The STD clinic manual should contain written standards to be used by all clinicians, which comply with the CDC Program Operations Guidelines Manual. The Georgia STD Nurse Protocol is written according to the CDC STD Treatment Guidelines.

## **I. CLINIC STAT LABORATORY**

1. Each clinic should have an on-site stat laboratory to perform, at a minimum, the following tests: Gram stain of male urethral discharge, saline and KOH wet mounts of vaginal discharge, and urine pregnancy tests.
2. Each laboratory must have a current CLIA certificate and be in compliance with CLIA-88, including requirements for staff training, proficiency testing and procedure manuals.
3. The lab should, at minimum, have the following properly-maintained equipment, along with the appropriate controls and supplies:
  - Brightfield microscope for Gram stains and wet mounts.
  - GenProbe or other approved kits for gonorrhea and Chlamydia testing for both male and female clients.

- Transport media for oral and rectal gonorrhea specimens.
- 4. Labs performing RPRs need a card test rotator, centrifuge, antigen kits and control kits.
- 5. Labs performing darkfield exams need either darkfield microscope or a convertible brightfield microscope.
- 6. The stat lab should have the accessible back-up or a reference lab for performance of other procedures necessary for STD diagnosis.
- 7. The stat lab should maintain complete and current logs/records of stat tests and results, and results of tests on specimens sent off-site.
- 8. All staff performing lab tests must be trained in, and follow universal precautions and biosafety standards.

#### **J. DISEASE INTERVENTION OUTREACH STAFF**

1. Communicable Disease Specialist (CDS) are available on-site or on-call to provide disease intervention services during hours of clinic operation.
2. CDS staff is provided with an adequate number of private rooms to ensure confidential STD interviewing and counseling.
3. Procedures are established so all relevant disease intervention information is smoothly exchanged between CDS and other clinic staff (e.g., the “expected-in” file mentioned previously).
4. CDS/clinician communication is maintained to ensure consistency between messages given to the client.

#### **K. FORMAL QUALITY ASSURANCE PROCEDURES**

##### **Quality assurance procedures for STD clinical services are in place for:**

1. The periodic auditing of clinical records to determine the appropriateness of diagnosis and treatment, and the completeness of documentation.
2. Regular direct observation of clinic staff (clerks, clinicians and CDS) performance during interactions with clients.
3. Regular monitoring of the quality of specimen collection and stat lab procedures (e.g., correlation between male urethral Gram stain and gonorrhea Gen-Probe or amplification test results, stat RPR and back-up lab results).
4. Monitoring customer satisfaction and receiving/management of significant complaints of clients about STD clinical services.
5. Dispensing medication and monitoring its usage.

## **II. STANDARDS FOR CLIENT EVALUATION, DIAGNOSIS AND MANAGEMENT**

- Clinical records should be complete and legible.
- Clinicians should respond sensitively to client concerns.
- Client history and physical exam should be thorough and adequate, according to the standards.

- Appropriate specimens for laboratory testing are collected according to standards.
- Clinicians should be skilled in specimen collection and the performance of standard laboratory procedures.
- Diagnoses should be accurate and based on diagnostic criteria found in the latest nurse protocols.
- Treatment should be appropriate according to nurse protocols and the latest CDC STD Treatment Guidelines.
- Medical consultation and referral to other health services, or to a CDS, should be accomplished according to nurse protocols for individual conditions, and standards.
- Counseling and client education should be thorough and appropriate to diagnosis, treatment and necessary follow-up.
- Appropriate handouts should be given to clients to reinforce educational messages.
- STD risk reduction and prevention counseling should be appropriate to the client situation, and an individualized risk reduction plan should be discussed and recorded in the clinical record.
- If the client is to refer his/her own sex partner(s) for examination and treatment, the clinician should give him/her adequate information, reinforced by written notes to give to the partner(s), to accomplish this in a timely manner.

**Policy:** The STD clinical record should be designed in a clear and logical manner.

**Standard of Expectations:**

- A “check-off” design is suggested to provide a fairly complete set of symptoms, history, physical exams, and lab test categories to cover the common STDs. Use of “Other” spaces and areas for detailed descriptions of symptoms, and abnormal physical findings should augment the check-off format.
- The clinical evaluation and laboratory items should be designed so each must be marked whether it is done or not done; positive or negative; normal or abnormal, etc., (A quality assurance record audit can determine whether clinicians meet performance standards.) Enough information should be included in all categories so that others using the record will understand the examining clinician’s assessment.

**A. DOCUMENTATION**

As for all clinical records for Georgia Public Health programs, documentation on STD clinical records should be according to appropriate standards such as those found in Chapter 8 of the Division of Public Health Manual entitled “Quality Assurance/Quality Improvement for Public Health Nursing Practice.”

Identifying/Locating Information. *Ask about any changes at each visit.*

Although the client's name must be written on every page of a clinical record, the following, additional, information should be in an easily accessible place in a client's chart:

1. Complete Name: Include maiden name or aliases, if applicable.
2. Address: Include apartment number and zip code.
3. Phone Number: Note where and when client prefers to be called, and if a private message may be left on an answering machine.
4. Date of Birth.
5. Sex, Marital Status, Race/Ethnic Origin.
6. Employer/School, if applicable.
7. Emergency Contact Person: Name, address, and phone number.

### **Basic Medical History and STD Risk Assessment**

Information collected should accurately define the problem(s) and lead to successful client management. Assure clients that all information is confidential.

1. Reason for Visit: Note if client is a volunteer, a contact to a specific disease, has a positive lab test, or needs follow-up for a specific problem.
2. Symptom History: Duration, location, character. Note if a recurring problem.
3. Past History of STDs: Especially Gonorrhea, Chlamydia, Syphilis and HIV infection. Also, history of Hepatitis B infection or immunizations.
4. Medication History: Recent use of antibiotics; other current prescription and nonprescription medications; use of herbal remedies.
5. History of Drug Use and Needle Sharing Practices: In self and sex partners. Includes oral, inhaled or injected "street" drugs and alcohol.
6. Sexual History: Last exposure; sex of partners (male/female/both); exposure sites (oral/genital/anal; number of partners in past 1-2 months; recent new partner; frequency of condom use, if use with all partners, and if partner has signs/symptoms.
7. Females - Contraception, Menses, Last Pap Smear, Last douche: Note any abnormalities of last menses and likelihood of pregnancy.
8. Other History: Allergies and current significant health problems. As indicated, note recent pulmonary infection or breathing problems; frequency and type of bacterial infections in the past year; unexplained weight loss, night sweats, fatigue, loss of appetite, and unexplained diarrhea.

### **Physical Examination**

Note all areas examined and clearly describe abnormal findings.

### **Laboratory**



Note all tests done onsite and those sent to an outside lab, including tests for HIV. Document all test results on the visit record, even if a printed copy is placed elsewhere in the chart.

*Note: Documentation of Gram stain findings must include the presence or absence of both White Blood Cells (WBCs/PMNs) and Gram-negative intracellular diplococci (GNID).*

### **Assessment/Diagnosis**

Base the assessment on history, exam and laboratory findings, and diagnostic criteria found in nurse protocols. Using the title of the applicable nurse protocol is suggested, to clarify the bases of the diagnosis. For syphilis, the clinician must designate the stage of the infection.

### **Treatment**

Record all medications ordered/administered/dispensed. Also note any suggested nonprescription medications (e.g., analgesics, antipruritics).

### **Counseling/Education and Referrals**

Document counseling and education about diagnosis, medication, partner referral, HIV testing and follow-up appointments. Record the client's risk-reduction plan, using the Progress Notes page, if there is not enough space on the visit flow sheet. Note referrals to a Communicable Disease Specialist (CDS), physician or other provider.

### **Clinician Signature**

Clinician should record complete name and initials of title.

## **B. RECORD STORAGE**

Clinician records should be stored in a secured area where they can be easily located by clinic personnel, but not accessible to unauthorized persons. Records stored on computer need to have rigorous protection procedures to prevent unauthorized entry into the file, as well as a back-up filing process to prevent any loss of information.

## **C. RECORD REVIEW/AUDIT**

Reviewing records to assure proper completion is often done at the end of each day; more formal reviews/audits should also be done periodically to assess the quality of client care and determine if program standards are being met. Principles for clinical record review may be found in Chapter 9 of the "Quality Assurance/Quality Improvement . . ." manual noted above.

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# Examples of Questions Used to Obtain an STD- Related Client History

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## Section II

### Examples of Questions Used to Obtain an STD-Related Client History

1. What brings you to the clinic today?
2. (If applicable) What is your main symptom? How long has it been present?
3. Do you have a discharge from your penis/vagina? How would you describe it?
4. Do you have any burning when you pass urine? For how long?
5. Have you noticed any sores on you genitals? How long have you had them?
6. Do you have any rash or itching in your genital area? For how long?
7. Have you noticed any rash or sores on other parts of your body? Where, and for how long?
8. Have you noticed any swollen glands/knots in your groin? In your neck?
9. Do you have any pain in your abdomen/belly/scrotum or rectal area?
10. Have you ever had any of these symptoms before? When?
11. Have you ever been told you had a sexually transmitted disease (STD)? (Name specific diseases to prompt the client.)
12. Have you ever had hepatitis B disease, or the immunizations for hepatitis B?
13. When was the last time you had a test for HIV? What were the results?
14. What antibiotics have you taken in the past 2 weeks? What other prescription medications are you taking? Are you allergic to any medication/drugs? If so, what happened when you took it?
15. What non-prescription drugs are you taking (e.g., for colds, pain, headaches)?
16. When was the last time you used any kind of street drug (e.g., marijuana, cocaine, speed)? If you use injection/IV drugs, do you ever share needles? Do any of your sex partners use street drugs or share needles?
17. How often do you drink alcohol? How much do you usually drink?
18. When was the last time you had sex? How many sexual partners have you had in the past month? Any new partners in the past 2 months? Do any partners have signs of infection (specify which signs)?
19. Do you have sex with males, females, transgender or all?
20. When you have sex, do you:
  - a. Put your penis in your partner's vagina? Rectum? Mouth?
  - b. Put your mouth on your partner's vagina/penis? Rectum?
  - c. Let your partner put his penis in your vagina? Rectum? Mouth?
  - d. Let your partner put his/her mouth on your vagina/penis? Rectum?

21. What do you do to prevent pregnancy? To prevent catching/spreading infection?
22. Do you use latex condoms sometimes, always or never? With all partners, or just some partners? How often do you/your partner forget to use them? During sex, do you use condoms when under the influence of drugs or drink alcohol?
23. Specific to females:
  - a. When was your last menstrual period? Was it normal?
  - b. When did you have your last Pap smear? What were the results?
  - c. When was the last time you douched?

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# Basic STD

## Physical Examinations

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## Section III

### Basic STD Physical Examinations

#### **Policy:**

All clients are to receive an STD examination. Document all areas examined and clearly describe abnormal findings.

#### **Standard Expectations for Males and Females**

1. Inspect skin of face, chest, back forearms and palms for lesions, rashes, nodules or discoloration. Also inspect legs and soles of feet if syphilis is suspected.
2. Inspect oral cavity and mucosal surfaces for lesions, blisters, and discoloration. Palpate cervical nodes for swelling and/or tenderness.
3. Palpate inguinal and femoral nodes for swelling and/or tenderness. Also palpate the supraclavicular, epitrochlear and axillary areas for lymphadenopathy if systemic disease is suspected.
4. Inspect pubic hair for lice and nits.
5. Examine genital and anal areas:

#### **Females**

- a. Inspect perineum/external genitalia for discharge, redness, masses, and lesions.
- b. Palpate Bartholin's and Skene's glands, mildly express any fluid.
- c. Inspect cervix, with attention to the amount, color and character of any discharge. Note presence of ectopy, edema, friability or lesions.
- d. Inspect vaginal mucosa. Note any lesions and the amount, character and color of any discharge. Obtain discharge from the vaginal wall. To diagnose bacterial vaginosis at least three of the following four clinical criteria are present:
  1. Homogeneous, white, noninflammatory discharge that smoothly coats the vaginal walls.
  2. The PH of vaginal secretions is higher than 4.5.
  3. A "fishy" odor of vaginal discharge, before or after mixing it with 10% KOH (positive "whiff" test).
  4. "Clue cells" (epithelial cells with granular appearance caused by adherent bacteria) on microscopic wet mount of vaginal discharge.
- e. Palpate lower abdomen for tenderness/pain. Examine for tenderness/pain on cervical motion.
- f. Perform bimanual examination. Note any enlargement, adnexal tenderness/masses or other pelvic masses.
- g. Rectovaginal exam to palpate uterus, adnexa and rectum, if indicated.

**Males**

- a. Inspect penis, with attention to the meatus, retraction of the foreskin and discharge from the urethra. Note color, amount and character of discharge.
  - b. Inspect scrotum and palpate contents. Note any testicular masses or tenderness. Review testicular self-exam with client.
  - c. Inspect anorectal area if symptoms or history of sexual exposure.
6. Document and clearly describe all examination findings.

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# Routine STD Laboratory Tests

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## Section IV

### Routine STD Laboratory Tests

**Policy:**

All STD clients must be tested for Gonorrhea, Chlamydia, and Syphilis.

**Standard Expectations:**

**Gonorrhea**

1. Urethral Gram-stained smear (for Gonorrhea or Non-Gonococcal Urethritis [NGU]) on males.
2. Culture Method: Culture can be used for adult endocervical or urethral infections. Culture is less sensitive than DNA probe and NAAT and requires additional testing by non-culture nucleic acid test (Accuprobe) for confirmation. However, culture is the recommended method for detecting GC genital infection in children and rectal/pharyngeal infections in adults, as these anatomical sites are not currently approved for NAAT.
3. Non-Culture Methods: Nucleic Acid Amplification Test (NAAT) can be performed on both urine and swabs. For females collect endocervical swabs or urine (if cervix is absent do not collect urethral swabs, collect urine, instead) and for males collect either urethral swabs or urine. DNA hybridization (probe) can also be performed on swabs (in proper collection outfits) however, this test is no longer offered at the Georgia Public Health Laboratory, effective December 2006.
4. For men who have sex with men (MSMs):
  - NAAT test from urethral specimen,
  - Culture of pharynx if oropharyngeal exposure,
  - Culture of rectum if history of receptive anal intercourse.

**Chlamydia**

1. Culture is not commonly available, but it is the method recommended for legal cases involving underage females and for rectum and pharynx (see MSM, below).
2. Non-Culture Method: Nucleic Acid Amplification Test (NAAT) can be performed on both urine and swabs: for females collect endocervical swabs or urine (if cervix is absent do not collect urethral swabs, just collect urine) and for males collect either urethral swabs or urine. DNA probe can also be performed, using proper collection outfits, however, this test is no longer offered at the Georgia Public Health Laboratory, effective December 2006.
3. For MSM:
  - Test urine by NAAT
  - Culture either rectum or pharynx, depending on the mode of sexual behavior.

4. For male and/or female clients having pharyngeal (throat) and/or rectal exposure a culture should be done.

### **Syphilis**

1. Perform serologic test for syphilis unless history of negative test within the past 30 days.
2. The following tests should be available in at least one county in every district:
  - a. Rapid Plasma Reagin (RPR).
  - b. Enzyme ImmunoAssay (EIA)
  - c. Fluorescent Treponemal Antibody (FTA)
  - d. Darkfield microscopic examination.

### **HIV Infection**

1. HIV antibody testing should be routinely performed, unless the client was recently tested and has not participated in high-risk behaviors since the previous test.
2. Repeat testing may also be indicated if there has been possible exposure within a significantly short time period before the previous test was done.
3. A separate consent form is required for HIV antibody testing.

### **Herpes**

1. A herpes culture should be done on all suspicious genital ulcerative lesions.

NOTE: A herpes culture should be done to confirm an initial diagnosis of typical lesions. If the client has a history of recurring atypical lesions and obtaining an adequate specimen for a culture is not possible, order type specific serologic antibody test for HSV 1 and 2.

2. Herpes serologies should NOT be ordered for general screening or for diagnosis of current ulcerative lesions.

### **Hepatitis Vaccines**

1. Vaccines are available for prevention of Hepatitis A and B viruses.
2. Clients seeking treatment for an STD should be evaluated for history of Hepatitis A and B diseases or a history of vaccination. See the current Immunization Program Manual for specific guidelines.

### **Other Test for Females**

1. Vaginal discharge:
  - a. “Whiff test” with KOH, or vaginal pH as part of the physical examination of all females.
  - b. Saline wet mount to detect trichomonads, “clue cells” and yeast, and KOH wet mount to detect yeast, if signs/symptoms of possible vaginal infection.

2. Pregnancy test, if indicated by history or exam findings.
3. Pap smear, if indicated by history.

**Test for MSMs**

1. Men who have sex with men are advised to be screened for STDs at least once a year, even if condoms are consistently used for insertive or receptive anal intercourse.
2. More frequent STD screening (e.g., 3-6 months intervals) is indicated for MSM who acknowledge having multiple anonymous partners or have sex in conjunction with illicit drug use, and clients whose sex partners participate in these activities.
3. See the information about Gonorrhea and Chlamydia tests on the previous two pages to determine the best choice(s) for testing each exposure site in MSMs.

**ROUTINE STD TESTING SUMMARY CHART**

<b>GONORRHEA</b>			
	<b>FEMALE</b>	<b>HETEROSEXUAL MALE</b>	<b>MSM</b>
Cervical	DNA probe, NAAT or culture	N/A	N/A
Urethral	Culture, if no cervix or NAAT (urine test)	Gram-stain and culture or NAAT	Gram stain and culture or NAAT
Anal/rectal	Culture, if exposed	Culture, if exposed	Culture, if exposed
Pharyngeal	Culture, if exposed	Culture, if exposed	Culture, if exposed
<b>CHLAMYDIA</b>			
	<b>FEMALE</b>	<b>HETEROSEXUAL MALE</b>	<b>MSM</b>
Cervical	DNA probe, NAAT or culture	N/A	N/A
Urethral	N/A	NAAT	NAAT
Anal/rectal	Not tested	Not tested	Culture, if exposed
Pharyngeal	Culture, if exposed	Culture, if exposed	Culture, if exposed
<b>SYPHILIS</b>			
	<b>FEMALE</b>	<b>HETEROSEXUAL MALE</b>	<b>MSM</b>
RPR	Yes, unless have had a negative in the past 30 days.		
Darkfield	On serous fluid from genital ulcers, or moist lesions of possible secondary syphilis.		
STAT RPR (*If possible)	Contacts to syphilis or presence of suspicious lesions.		
<b>HIV INFECTION</b>			
	<b>FEMALE</b>	<b>HETEROSEXUAL MALE</b>	<b>MSM</b>
Routine	Yes, unless has had a previous positive test, or a recent negative test with no high-risk behaviors since then.		
Repeat	Possible exposure within a short time period before previous negative test.		
<b>HERPES SIMPLEX</b>			
	<b>FEMALE</b>	<b>HETEROSEXUAL MALE</b>	<b>MSM</b>
Culture	Suspicious ulcerative lesions on or near the genitals		
Serology	Negative culture form ulcerative lesion or History of suspicious recurrent lesions, but unable to obtain a specimen to culture or Sex partner of a person with genital herpes (to compare antibody profiles).		
<b>HEPATITIS B ANTIBODY (at time of the first immunization)</b>			
	<b>FEMALE</b>	<b>HETEROSEXUAL MALE</b>	<b>MSM</b>
	Only if has a history of high-risk behavior (e.g., needle sharing)		Yes

\*Currently, Stat RPR test can only be done at Fulton and DeKalb Counties.

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# Medical Consultation and Referral

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## **Section V**

### **Medical Consultation and Referral**

**Policy:**

The following conditions may warrant referral to another healthcare provider. An explanation of each referral must be documented in the medical record.

**Standard Expectations:**

1. A pelvic examination could not be done satisfactorily or abnormalities such as unexplained uterine enlargement and adnexal masses are found.
2. Tender or enlarged Bartholin glands are present in a female client, or a male client has abnormal scrotal findings.
3. Diagnostic criteria for a suspected STD cannot be met.
4. Appropriate treatment is not covered by a nurse protocol; is not available; or when nurse protocol dictates consultation/referral.
5. There are signs of adverse reaction to treatment (e.g., anaphylaxis, skin rash or severe anxiety).
6. The client develops undesirable side effects to treatment, or the condition does not adequately respond to treatment.
7. Local regulations dictate (e.g., young age of client).
8. A pregnant client is not receiving prenatal care.
9. The client needs contraceptive-related services (e.g., is at risk of unwanted pregnancy or shows undesirable side effects of her current contraceptive).
10. Exam reveals an inguinal hernia or extensive hemorrhoids needing treatment.
11. An HIV-infected client is not being followed clinically.

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# STD Client Education and Counseling

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## Section VI

### STD Client Education and Counseling

**Policy:**

When conducting an STD education and counseling session with a client, discussion of laboratory results, partner evaluation, examination follow-up, recognition of STD symptoms and risk reductions must occur with all clients at their level of understanding.

**Standard Expectations:**

**A. Laboratory results, diagnosis and treatment information**

1. Result of all tests.
2. The name of the diagnosed or suspected disease (or the disease to which the client has been exposed) and its importance.
3. Treatment information to include:
  - The name(s) of all medications and expected outcome of treatment.
  - When/how much dispensed medication to take and what to do if doses are missed.
  - Potential side effects and what to do about them.
  - Any special instructions to maximize efficacy or minimize side effects.

**B. The importance of evaluating sexual partners, as applicable (see current STD nurse protocols)**

1. How the disease is transmitted, its incubation period and infectiousness.
2. The likelihood of asymptomatic infection and health consequences to the client and partners if partners not evaluated/treated.
3. Information that sexual partners need to obtain appropriate medical evaluation and treatment, and partner notification assistance available through the health department, as applicable.

**C. When applicable, necessary follow-up examinations/lab tests (see current STD nurse protocols)**

1. Specific appointment date and time to return.
2. The purpose of the return visit and potential consequences of not returning.

**D. How to recognize major STD symptoms and to respond if symptoms occur**

## **E. STD risk reduction**

1. A personalized STD risk-reduction plan that addresses needle-sharing behavior, in addition to sexual behavior, for prevention of HIV, HBV, and HCV should be developed. The clinician should use the principles taught in the HIV Counseling and Testing course to assist the client to develop his/her own plan. The client's plan should be documented in the clinical record.
2. The proper use of male and/or female condoms should be a part of a client's personal risk-reduction plan.
3. Syphilis testing and HIV antibody testing should be part of the risk reduction plan for pregnant women.
4. Annual STD testing is a part of the risk reduction plan for men who have sex with men (MSM).



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Referral for STD Client  
for Follow-up by a  
Communicable Disease  
Specialist

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**Section VII**  
**Referral of STD Clients for**  
**Follow-up by a Communicable Disease Specialist**

**Policy:**

Clinicians must refer all clients with positive STD Laboratory Reports to a Communicable Disease Specialist (CDS):

**Standard Expectations:**

1. Pregnant females with Chlamydia and/or Gonorrhea, for interviewing and sex partner follow-up.
2. All cases of syphilis, for interviewing and sex partner follow-up.
3. Contacts to cases of primary, secondary and early latent syphilis, and contacts to cases of latent syphilis of unknown duration, for cluster interviewing.
4. HIV-infected clients, for interviewing and partner follow-up.
5. Clients with positive Chlamydia and/or Gonorrhea tests who do not respond to initial attempts to notify them of their test results or who fail to keep appointments for treatment.
6. Clients with Chlamydia, Gonorrhea and PID, who need assistance with partner notification, may be referred to the CDS. If a CDS is not immediately available, the clinician should obtain and record the identifying and locating information the CDS will need for field follow-up of the partner(s).

**Identifying information includes:** full name and nicknames, age, race, sex, height, size/build, hair color/length/style, complexion, and other identifying marks such as birthmarks, tattoos or body piercing.

**Locating information includes:** home address, telephone/pager number(s), other place he/she frequents, and place of employment or school.

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# Management of Sex Partners

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## **Section VIII**

### **Management of Sex Partners**

**Policy:**

When eliciting partners and contacts, adequate information to assist disease investigation and disease control must be obtained.

**Standard Expectations:**

Clients who state they are a contact to a specific STD (e.g., Gonorrhea, Chlamydia, Syphilis) should receive complete STD-related examinations including laboratory tests, and be given appropriate treatment for the named STD. The clinician should record in the chart “client states (he/she) is a contact to the (named STD).”

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# STD Client Clinical Follow-up

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## Section IX

### STD Client Clinical Follow-up

#### **Policy:**

Clients diagnosed with Pelvic Inflammatory Disease, Epididymitis, Human Papillomavirus (that need possible re-treatment), who had an HIV test (not yet post-test counseled), and have begun Hepatitis B immunizations must have follow-up appointments according to the current STD Treatment Guidelines.

#### **Standard Expectations:**

- A. Specific follow-up appointments should be made with clients who:
1. Have been diagnosed with syphilis, for follow-up serologies.
  2. Have been diagnosed with pelvic inflammatory disease (PID) or epididymitis, for follow-up examinations.
  3. Have genital warts that need possible re-treatment.
  4. Had HIV antibody test, to discuss test results and receive post-test counseling.
  5. Have begun the series of Hepatitis B immunizations, for the second dose.
  6. In the clinician's judgment would benefit from follow-up.
  7. Had an OraQuick test and must return for confirmatory test result.
- B. A typical re-visit should include at least some, or all, of the following:
1. Client History
    - a. Changes in previous symptoms, or presence of new symptoms.
    - b. Reaction to treatment.
    - c. Compliance with previous instructions.
    - d. Sexual activity since therapy.
    - e. Treatment status of sex partner(s), if applicable and known.
  2. Physical Examination

Reassess the abnormal physical findings of the previous examination and evaluate new complaints.
  3. Laboratory Tests

Order tests according to previous findings and any new complaints.
  4. Counseling

Review client's STD/HIV risk-reduction plan.

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# Side Effects/Reactions to STD Medication

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## Section X

### Side Effects/Reactions to STD Medication

**Policy:**

Clinicians should maintain current knowledge about possible side effects of all medications administered, dispensed or prescribed for STD treatment, in order to provide appropriate counseling of the client.

**Standard Expectations:**

The Division of Public Health Office of Pharmacy recommends that each clinic site have a copy of a drug reference book for the current year.

#### Examples of Side Effects/Reactions to STD Medications

**Vasovagal Syncope (Fainting) and Hyperventilation**

- Either of the above may occur when the client is anxious about having blood drawn or receiving an injection. The client should be observed until recovered, and ideally should be accompanied when leaving the clinic.

**Jarisch-Herxheimer Reaction**

- This may occur within 12 hours after treatment of early syphilis. Local reaction may consist of intensification of lesions (e.g., a chancre may become edematous or a faint secondary rash may become prominent). Systemic reaction may consist of a rise in temperature of 101-102 degrees Fahrenheit. The self-limiting reaction usually only last a few hours, but may be up to 24 hours. Antipyretic may be taken as needed. Pregnant women may have more severe reactions and should contact their prenatal care provider at the first sign of premature labor or possible fetal distress.

**Anaphylactic (allergic) Reactions**

A. Assessment:

1. When they occur, anaphylactic reactions after injection of medication usually are immediate or within a few minutes, but occasionally may be delayed for several hours. Patients should be told to stay in the clinic for a designated length of time (usually up to 30 minutes) after receiving an injection. The speed of onset of the reaction means increasing severity and prompt treatment is imperative.
2. Any, or all, of the following symptoms may be present: swelling, shortness of breath, wheezing, generalized itching, itching of eyes, nausea, vomiting, diarrhea, rash, weakness, tingling of the extremities, flushing or pallor, tightness in chest, choking sensation, fall in blood pressure, weak pulse and loss of consciousness.

B. Treatment:

Refer to the Georgia Nurse Protocol Manual, Emergency Protocols and Procedures.



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# Nursing Guidelines

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## Section XI Nursing Guidelines

### Laboratory Tests for STDs

**This section provides the following:**

1. Information on supplies and techniques for collecting specimens for available laboratory tests for STDs.
2. Forms completion and shipping information for specimens routinely sent to the Georgia Public Health Laboratories.
3. Performance instructions, quality control and quality assurance activities for routine onsite tests (male urethral Gram stains and vaginal wet mounts).
4. Interpretation of test results.

When appropriate, the clinician is also referred to the current edition of the Georgia Public Health Laboratory (GPHL) Service Manual.

**Note:** If a client is suspected of having chancroid, the client must be referred to a physician, as there is no nurse protocol available for the diagnosis and treatment of this disease through Georgia's Division of Public Health. The Georgia Public Health Laboratory provides presumptive identification by gram stain for chancroid. However, testing is available through the CDC.

1. If a case of chancroid were suspected/reported, arrangements must be made with the CDC to obtain the appropriate culture media. The CDC does not recommend use of the gram-stain slide test described in the GPHL Service Manual for the diagnosis of chancroid.

**Note:** The Georgia Division of Public Health has developed an STD Nurse Protocol for the diagnosis and treatment of clients suspected of having Lymphogranuloma Venereum (LGV).

1. If a clinician strongly suspects LGV in a patient with a consistent sexual history and symptoms (i.e., mucopurulent anal discharge, rectal bleeding, inguinal/femoral lymphadenopathy, and/or genital/rectal ulcer or papule), a rectal swab and serologic specimen must be obtained from the client and submitted to the GPHL. The Georgia Public Health Laboratory will forward the specimens to the CDC.

## A. Chlamydia and Gonorrhea Laboratory Tests

**Note:** The Georgia Public Health Laboratory currently accepts female endocervical and male urethral swab specimens for screening Chlamydia (CT) and Gonorrhea (GC). Urine and swabs are accepted specimens. The GPLH performs Nucleic Acid Amplifications Tests (NAAT) for the detection of CT and GC and can culture rectal and oropharyngeal swabs for GC only.

### 1. Specimen Collection for Aptima Combo 2

#### 1. Endocervical Swab Specimens

- a. Remove excess mucus from the cervical os and surrounding mucosa using the cleaning swab (white shaft swab in the package with red printing). Discard this swab. Note: To remove excess mucus from the cervical os, a large-tipped cleaning swab (not provided) may be used. Discard the swab after use.
- b. Insert the specimen collection swab (blue shaft swab in the package with green printing) into the endocervical canal.
- c. Gently rotate the swab clockwise for 10 to 30 seconds in the endocervical canal to ensure adequate sampling.
- d. Withdraw the swab carefully; avoid any contact with the vaginal mucosa.
- e. Remove the cap from the swab specimen transport tube and immediately place the specimen collection swab into the transport tube tightly.
- f. Carefully break the swab shaft at the score line; avoid splashing the contents.
- g. Recap the swab specimen transport tube tightly.

#### 2. Male Urethra Swab Specimens

- a. The patient should not have urinated for at least one hour prior to specimen collection.
- b. Insert the specimen collection swab (blue shaft swab in the package with green printing) 2 to 4 cm into the urethra.
- c. Gently rotate the swab clockwise for 2 to 3 seconds in the urethra to ensure adequate sampling.
- d. Withdraw the swab carefully.
- e. Remove the cap from the swab specimen transport tube and immediately place the specimen collection swab into the transport tube tightly.
- f. Recap the swab specimen transport tube tightly.

#### 3. Urine Specimens

- a. The patient should not have urinated for at least one hour prior to specimen collection.
- b. Direct the patient to provide a first-catch urine (approximate 20 to 30 ml of the initial urine stream) into the collection cup which is free of any preservatives. Collection of larger volumes of urine may result in specimen

dilution that may reduce test sensitivity. Female patients should not cleanse the labial area prior to providing the specimen.

- c. Remove the cap and transfer 2 ml urine into the urine specimen transport tube using the disposable pipette provided. The correct volume of urine has been added when the fluid level is between the black fill lines on the urine transport tube label.
- d. Recap the urine specimen transport tube tightly. This specimen is not referred to as the processed urine specimen.

Wrap specimen(s) vials in kyfax paper and place them in a Specimen Transport Bag (plastic bag), available from the appropriate laboratory services and supply representative (Decatur, Albany or Waycross). Place the submission form for each specimen in the pouch of the plastic bag.

Send the specimens via First Class, 2-Day Priority mail or transportation/courier services to the designated laboratory for processing.

## 2. Interpretation of Results

- **Positive** = rRNA detected for *C. trachomatis* and/or *N. gonorrhoeae* by Amplified Aptima Combo 2 Test.
- **Negative** = No rRNA detected for *C. trachomatis* and/or *N. gonorrhoeae* by Amplified Aptima Combo 2 Test.
- **Indeterminate** = A new specimen should be recollected.
- **Unsatisfactory** = Unsatisfactory for *C. trachomatis* and/or *N. gonorrhoeae* by Amplified Aptima Combo 2 Test. Reason for unsatisfactory specimens:

<ul style="list-style-type: none"> <li>• Urine collected in outfit other than APTIMA Urine Specimen Collection Kit for Male and Female.</li> </ul>	<ul style="list-style-type: none"> <li>• Any specimen other than urine, endocervical swab, or urethral swab (e.g., vaginal, throat or rectal swabs are unacceptable)</li> </ul>
<ul style="list-style-type: none"> <li>• Swab other than Aptima Unisex Swab Specimen Collection Kit</li> </ul>	<ul style="list-style-type: none"> <li>• No patient identifier on specimen</li> </ul>
<ul style="list-style-type: none"> <li>• Two swabs in Collection Outfit</li> </ul>	<ul style="list-style-type: none"> <li>• Name (identifier) on specimen does not match name (identifier) on request form</li> </ul>
<ul style="list-style-type: none"> <li>• No swab in the Collection Outfit</li> </ul>	<ul style="list-style-type: none"> <li>• Expired Collection Outfit</li> </ul>
<ul style="list-style-type: none"> <li>• No solution in Collection Outfit</li> </ul>	<ul style="list-style-type: none"> <li>• QNS (Quality Not Sufficient)</li> </ul>
<ul style="list-style-type: none"> <li>• Swab &gt;60 days old, when received in the Lab</li> </ul>	<ul style="list-style-type: none"> <li>• Medical Legal Case</li> </ul>
<ul style="list-style-type: none"> <li>• Urine &gt;30 days old, when received in the Lab</li> </ul>	<ul style="list-style-type: none"> <li>• Overfilled. Liquid level in the urine transport tube must fall between the two black indicator lines.</li> </ul>

## Instructions for Completing Georgia Department of Human Resources Public Health Laboratory Chlamydia and Gonorrhea (GC) Submission Form 3568

Georgia Department of Human Resources  
Public Health Laboratory  
**CHLAMYDIA AND GONORRHEA (GC) SUBMISSION FORM**

SUBMITTER INFORMATION	CLIENT INFORMATION
<b>1</b> CODE: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>4</b> PATIENT ID: _____ <b>5</b> DOB: ____ / ____ / ____
CLINIC NAME: _____	<b>6</b> NAME: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Last</span> <span>First</span> <span>Middle</span> </div>
<b>2</b> STREET: _____	<b>7</b> RESIDENCE: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Street</span> <span>City</span> <span>State</span> <span>Zip</span> </div>
CITY: _____	PHONE: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>County</span> <span>Home</span> <span>Work</span> <span>Cell/other</span> </div>
STATE & ZIP CODE: _____	<b>8</b> RACE: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> White
<b>3</b> PHONE NO: _____	<b>9</b> ETHNICITY: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino
FAX NO: _____	<b>10</b> GENDER: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown
SPECIMEN INFORMATION	
<b>11</b> TEST REQUESTED: <input type="checkbox"/> Nucleic Amplified Test (GC/CT) <input type="checkbox"/> Culture (GC only throat/rectal) <input type="checkbox"/> Other (Specify): _____	
<b>12</b> DATE COLLECTED: ____ / ____ / ____	<b>13</b> SPECIMEN SOURCE: <input type="checkbox"/> Urethra <input type="checkbox"/> Urine <input type="checkbox"/> Pharynx <input type="checkbox"/> Endocervical <input type="checkbox"/> Rectum <input type="checkbox"/> Other (Specify): _____
<b>14</b> REASON FOR TEST: <input type="checkbox"/> Screening <input type="checkbox"/> Urogenital Symptoms/Diagnostic <input type="checkbox"/> Contact to Chlamydia <input type="checkbox"/> Contact to Gonorrhea <input type="checkbox"/> Medical Legal	
CLINICAL INFORMATION	
<b>15</b> REASON FOR VISIT: <input type="checkbox"/> Volunteer/Medical Problem <input type="checkbox"/> Sex Partner Referral <input type="checkbox"/> Other: _____ <input type="checkbox"/> Initial Visit (FP) <input type="checkbox"/> Prenatal <input type="checkbox"/> Unknown <input type="checkbox"/> Annual (FP)	
<b>16</b> UROGENITAL SYMPTOMS: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <small>(Symptoms Include: Vaginal/Urethral Discharge, Dysuria, Abdominal Pain, Abnormal vaginal bleeding, Dyspareunia)</small>	
<b>17</b> CLINICIAN ID: _____	<b>18</b> PREGNANCY STATUS: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>19</b> IN LAST 60 DAYS HAS PATIENT HAD?: NEW PARTNER: <input type="checkbox"/> Yes <input type="checkbox"/> No MULTIPLE PARTNERS: <input type="checkbox"/> Yes <input type="checkbox"/> No	
TREATMENT INFORMATION	
<b>20</b> TEST RESULTS: CHLAMYDIA: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not Done GONORRHEA: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not Done	
<b>21</b> TREATMENT OF CHLAMYDIA: <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, DATE: ____ / ____ / ____	MEDICATION: <input type="checkbox"/> Azithromycin <input type="checkbox"/> Ofloxacin <input type="checkbox"/> Doxycycline <input type="checkbox"/> Amoxicillin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____
TREATMENT OF GONORRHEA: <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, DATE: ____ / ____ / ____	MEDICATION: <input type="checkbox"/> Cefixime <input type="checkbox"/> Ofloxacin <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____

LABORATORY COPY

Form 3568 (Rev. 8-06)

**Note:** Directions for completing each field on the form (duplicated above) are given in the table on the next page.

## Line by Line Instructions (Laboratory Copy) Chlamydia and Gonorrhea (GC) Submission Form

**Instructions:**

1. Check to ensure that you are using the proper form.
2. Fill out the form completely by printing or typing legibly. Only legible information can be entered correctly into the laboratory database. Incomplete or illegible information may delay your result or the laboratory may report the test as unsatisfactory. If available, use computer generated labels for the client information.
3. If you have any questions, please contact the appropriate Georgia Public Health Laboratory for assistance.

Section	Line Number	Line Name	Instructions
<b>Submitter Information</b>	<b>1</b>	CODE	Place your submitter code here. The code must include a letter of the alphabet for the specific type of clinic service. If you do not know your code, or do not have a code, call (404) 321-2241.
	<b>2</b>	NAME & ADDRESS	Enter the clinic's name and return address here.
	<b>3</b>	PHONE NO.	Put the area code, number, and extension where you can be reached in this space so the laboratory staff can call if there is a problem or question.
<b>Client Information</b>	<b>4</b>	CLIENT ID #	Place your client's identification number here. This is a unique number of your choice that will help identify your client when you receive the report.
	<b>5</b>	DATE OF BIRTH (DOB)	The date of birth (mm/dd/ccyy) is used for additional client identification.
	<b>6</b>	NAME	Type or Print patient's name on form (LN/fn/m). Patient's name should also be placed on the specimens going to the lab and should be typed or written exactly as listed on submission form.
	<b>7</b>	RESIDENCE (Street, Phone, County, City, State, Zip)	Enter the client's home street, phone number, county, zip code, and state. This is to help identify and locate your client and is also used by the STD Surveillance Unit. In addition, it answers the questions 'who are my clients' and 'where are they?'
	<b>8</b>	RACE	Check the appropriate box(es).
	<b>9</b>	ETHNICITY (Hispanic or Latino)	Check the appropriate box.
	<b>10</b>	GENDER	Check the appropriate box.
<b>Specimen Information</b>	<b>11</b>	TEST REQUESTED	Check the appropriate box.
	<b>12</b>	DATE COLLECTED	Enter the date (mm/dd/ccyy) the specimen is collected.
	<b>13</b>	SPECIMEN SOURCE	Check the appropriate box.
	<b>14</b>	REASON FOR TEST	Check the box for: <ol style="list-style-type: none"> <li>1. Screening – If the client is being tested as part of a routine physical examination.</li> <li>2. Urogenital Symptoms/Diagnostic – If the client is presenting with signs/symptoms consistent with those for Chlamydia and/or gonorrhea.</li> <li>3. Contact to Chlamydia – If the client is a sex partner of a person with Chlamydia.</li> <li>4. Contact to Gonorrhea – If the client is a sex partner of a person with gonorrhea.</li> <li>5. Medical Legal – If the test have been ordered as part of a legal action.</li> </ol>

Section	Line Number	Line Name	Instructions
	15	REASON FOR VISIT	<p><u>Family Planning Clinics:</u> Initial, annual, or comprehensive medical exams only.</p> <p><u>STD/Primary Care/General Clinics:</u> STD visit/medical problem, sex partner referral.</p> <ol style="list-style-type: none"> <li>1. Volunteer/Medical Problem (includes FP comprehensive medical visit).</li> <li>2. Initial visit (FP)</li> <li>3. Annual visit (FP)</li> <li>4. Sex Partner Referral</li> <li>5. Prenatal visit</li> <li>6. Other</li> <li>7. Unknown</li> </ol>
<b>Clinical Information</b>	16	UROGENITAL SYMPTOMS	This information is obtained from the client. Symptoms include vaginal or urethral discharge, dysuria, abdominal pain, abnormal vaginal bleeding, and/or dyspareunia.
	17	CLINICIAN ID.	Enter the identifying information for the person collecting the specimen.
	18	IS THE CLIENT PREGNANT?	Check the appropriate box if the client is female.
	19	IN LAST 60 DAYS HAS PATIENT HAD?	Check the appropriate box if the patient has had a new sex partner or more than one sex partner in the last 60 days (2 months).
<b>Treatment Information</b> (Clinic Use)	20	TEST RESULTS	Check the appropriate box.
	21	HAVE ANTIBIOTICS BEEN GIVEN? For Clients Testing Positive for Chlamydia and/or Gonorrhea Only	Indicate the date (mm/yy/ccyy) and specify the name of the antibiotics used to treat the client for Chlamydia and/or gonorrhea.
<b>General Instructions</b>	LABORATORY COPY		The form is comprised of three sheets. Only the top (white copy) should be submitted to the laboratory with the specimen.
	REPORTING COPY (POSITIVES ONLY)		The second sheet (yellow copy) should be used to send to the State Office to confirm treatment only for those testing positive for Chlamydia and/or gonorrhea.
	SUBMITTER COPY		<p>The third sheet (pink copy) should be retained by the provider. Retain this copy until the hard copy of the test result is received from the laboratory. For negative test results, discard at this time.</p> <p><b>POSITIVE RESULTS:</b> Provider can discard this sheet (pink copy) once the CDS staff has confirmed receipt of the second sheet (yellow copy).</p>
<b>REMINDER:</b> Please print legibly. It is critical that data entry staff is able to properly identify you client. If they are unable to read the name and other information on the form, it may be entered incorrectly in the computer and make it difficult to match the data with the correct client.			

## B. Other Gonorrhea Laboratory Tests

### Male Urethral Gram Stains

Gram stains of male urethral discharge are classified as moderate complexity tests by CLIA. Perform proficiency testing three times a year. Performing quality control (QC) slides is required weekly and when a new bottle of reagent is opened, with results recorded on a QC log.

### Gram Stain Procedure

1. Label the frosted end of a microscope slide with the client's name.
2. Wearing gloves, and using a sterile cotton swab, calcium alginate swab or the swab from a Gen-Probe or amplification test kit, obtain discharge from the urethra.
3. Roll the swab on the slide. Take care not to push or smear the swab on the slide; this could disrupt the white blood cells and distort the morphology of bacteria.
4. Allow the slide to air dry for 2-3 minutes; heat-fix the smear by passing the flame of a disposable lighter under the slide 2-3 times. The slide should not become "hot" to the touch.
5. Stain the slide, not allowing it to dry between any of the steps:
  - a. Cover the slide with Crystal Violet for 30-60 seconds.
  - b. Gently wash off the stains with flowing tap water; drain off the excess water.
  - c. Cover the slide with Grams Iodine for 30-60 seconds
  - d. Gently wash off the stain with flowing tap water; drain off the excess water.
  - e. Carefully pour the Decolorizer reagent over the smear while the slide is held at an angle. Stop the flow when the runoff becomes clear and no more purple stain washes off; this may take up to 60 seconds if the smear is thick.
  - f. Gently wash off the Decolorizer with flowing tap water and drain off excess water.
  - g. Cover the slide with the Safranin counterstain for 30-60 seconds.
  - h. Gently wash off the stain with flowing tap water and drain off the excess water.
6. Allow the slide to air dry, or may blot with bibulous paper or a paper towel.

**Note:** To prevent cross-contamination, do not blot more than one slide with the same paper.
7. Examine the stained slide:
  - a. Begin on low (10x) power to locate thin areas of the smear where staining is correct and PMNs (polymorphonuclear white blood cells) are present.
    - 1) The PMNs appear light pink, with a darker, pink-lobed nucleus.
    - 2) Background material should appear pink.



- b. Rotate the 10x object, add a drop of immersion oil to the slide, and use the oil immersion objective (100x) to examine the smear for GNID (Gram-negative intracellular diplococci) characteristic of *Neisseria gonorrhoeae*.
8. Record the results on the laboratory log.

**Note:** Wipe the oil immersion objective with lens paper between slides to avoid possible carry-over of organisms from one slide to another.

**Results and Interpretation of Gram Stains**

1. If Gram-negative intracellular diplococci (GNID) are seen, a presumptive diagnosis of *Neisseria gonorrhoeae* (GC) can be made.
2. If no Gram-negative intracellular diplococci are seen, but if  $\geq 5$  PMNs per OIF (oil immersion field) are reported, a diagnosis of NGU (non-gonococcal urethritis) can be made.

**Note:** If only Gram-negative extra-cellular diplococci are seen, wait to see if NAAT or the GC culture test results are positive to make a diagnosis of gonorrhea.

**URETHRAL GRAM STAIN LOG**

Date	Patient ID	GNID seen		#PMNs per OIF
		Yes	No	

## Gram Stain Weekly Quality Control

CLIA Regulations for moderate complexity tests require that quality control slides for gram stains be performed weekly.

Test/expected results:

Blue/Purple Positive (Pos) Control = Satisfactory (S)                      Otherwise, Not Satisfactory (NS)

Pink/Red Negative (Neg) Control) = Satisfactory (S)                      Otherwise, Not Satisfactory (NS)

Control slide expiration date: \_\_\_\_\_

Reagent	Test Date	Lot #	Date Received	Date Opened	Expiration Date	Pos Control Results (S/NS)	Neg Control Results (S/NS)	Tech Initials
Crystal Violet Iodine Decolorizer Safranin								
Crystal Violet Iodine Decolorizer Safranin								
Crystal Violet Iodine Decolorizer Safranin								
Crystal Violet Iodine Decolorizer Safranin								
Crystal Violet Iodine Decolorizer Safranin								
Crystal Violet Iodine Decolorizer Safranin								
Crystal Violet Iodine Decolorizer Safranin								
Crystal Violet Iodine Decolorizer Safranin								

## C. Gonorrhea Cultures

### Specimens:

- Use a sterile swab to obtain a sample of a discharge from the exposed site, then either inoculate onto Martin-Lewis or Thayer-Martin culture medium.
- Cultures are necessary for specimens from the female/male oropharyngeal, rectum, and other extra genital sites. Cultures must also be done on specimens from any site in a child and for other medical legal situations.

### Collection Techniques:

- Rectal specimens are obtained by inserting a sterile cotton-tipped swab 2-3 cm into the anal canal. If the tip is inadvertently pushed into feces, use another swab to obtain the specimen. Move the swab from side to side, and allow several seconds for secretions to be absorbed.
- Specimens collected from prepubertal females should be obtained from the vaginal vault by separating the labia manually, exposing the introitus, and gently inserting and rotating a sterile cotton-tipped swab.
- Oropharyngeal specimens are obtained on a sterile cotton-tipped swab from the posterior pharynx and tonsillar crypts.

### **Transport medium sent to private laboratories**

Follow instructions appropriate to the type of medium used and the laboratory receiving the specimens in regard to shipping and accompanying paperwork.

### **Standards for use of Martin-Lewis culture medium**

1. Store fresh culture plates in a refrigerator at 2-8 degrees C, agar side up, away from the freezer.
2. Bring culture plates to room temperature before inoculating.
3. Do not use plate if medium appears dry, cracked or pulled away from the edges, if it appears to have been frozen, or if it is past the expiration date on the label.
4. Fill in the client's name and date of inoculation on the label.
5. Complete a separate information form for each plate.
6. Roll specimen swab in a "Z" pattern on the surface of the medium. Cross-streak with the same swab, sterile stick end of another swab, sterile wire, or plastic loop.
7. Place inoculated plate in carbon dioxide (CO<sup>2</sup>) atmosphere within 15 minutes.
  - a. When using a candle jar, relight the candle each time the lid is opened. Place candle in the bottom of the jar and do not stack more than 12 plates to the side.

- b. With the bag/pill CO<sup>2</sup> system, tear foil pack to expose pill and place pack in bag. **Do not** moisten the pill.
  - c. When using an onsite CO<sup>2</sup> incubator, no other container is needed.
8. Place plates in an incubator at 35-36 degrees C, within 2 hours of inoculating, and overnight before sending by courier or mail to an off-site lab.

**Note:** Check refrigerator and incubator temperatures each work day, and record on a log.

9. For off-site shipping:
- a. Mark the number of hours of pre-incubation on the lab form before shipping. If it is not appropriately marked, or if the specimen has not been pre-incubated a minimum of 18 hours, a report of “unsatisfactory” could result.
  - b. Pack plates and forms in a sturdy box, with sufficient padding. Padded bags are usually safe; manila envelopes are unacceptable.
  - c. First class, special handling, is the most economical and fastest method for mailing specimens (up to 2 pounds weight) to the lab.
  - d. Specimens collected on Friday or the day before a holiday should be incubated over the weekend or holiday and mailed on the next appropriate mail service date.

**Note:** The Georgia Public Health Laboratory (GPHL) **does not** perform testing for Chlamydia cultures of any source. The submitting facility **must** secure a contract with an independent laboratory service for testing of Chlamydia cultures. Gonorrhea cultures are accepted by GPHL for genital or extra genital sites, by prior arrangement.

## D. Herpes Laboratory Test

### Herpes Simplex Virus (HSV) Types 1 and 2

#### HSV Isolation and Identification, from Cell Culture

(Refer to the latest edition of the Georgia Public Health Laboratory Service Manual for full instructions)

Indication: Any suspicious genital lesion(s).

Specimen: Vesicle Fluids/Skin Scrapings.

1. Use water, NOT disinfectants to clean the site of any topically applied agents.
2. The longer the duration and/or dryness of the lesions, the less chance of obtaining a viable specimen. For primary infections, the virus may be recovered up to 7-10 days after onset.
3. Collect the specimen from the base of the lesion(s).
  - a. Vesicles: Aspirate fluid with 26/27 gauge needle attached to a tuberculin syringe, or with a capillary pipette. Promptly rinse collected fluids into the Viral Swab Outfit transport medium to prevent clotting.
  - b. Open lesions: Obtain fluid and cells on a dry, sterile cotton swab. Place the swab in the tube of transport medium. Break off the stem of the swab where handled before capping the tube.
4. Complete Form #3595R (Virology Request Form) and ship the specimen, with ice, according to the instructions in the Laboratory Service Manual.

#### Reporting and Interpreting of Results:

GPHL uses an Enzyme Linked Virus Inducible System (ELVIS) for the rapid culture identification of herpes simplex virus type I and 3, and can report the results in 2-3 days.

1. Positive cultures are reported as soon as herpes virus is isolated and detected. Isolation of the virus, with type confirmation by fluorescent antibody (FA) testing, means a definitive diagnosis of HSV-1 or HSV-2.
2. Negative cultures will be reported after allowing 2-3 days for herpes virus to be isolated. Inability to isolate the virus does not rule out herpes. Obtain a specimen for type-specific serologic antibody testing as described below.

### **Type-Specific Serologic Testing for Antibodies to HSV-1 and HSV-2**

#### **Indications:**

1. To confirm a clinical diagnosis of genital herpes in:
  - a. A symptomatic client whose herpes culture was negative, or
  - b. A client with a history of recurring atypical lesions when obtaining an adequate specimen if a culture is not possible.
2. To determine the antibody status of asymptomatic sex partners of persons with genital herpes.

**Note:** This test is **not** to be used for general screening.

**Specimen:** Approximately 6 ml whole blood (for serum)

Follow the instructions in the latest edition of the Laboratory Services Manual for collection and shipment to the Microbial Immunology Unit. Use same Immunology Form as for Syphilis serologies.

#### **Reporting and Interpretation of Results**

The presence/absence of HSV-1 and HSV-2 serologic antibodies is reported.

1. In a person with a history of suspicious genital lesions:
  - a. If only one type of herpes antibodies is detected, that type is presumed to be the cause.
  - b. If both HSV-1 and HSV-2 antibodies are detected, either type could be the cause.
2. For asymptomatic sex partners of persons with genital herpes, risk-reduction counseling of the couple depends on comparing the HSV serologic antibody profile of the partner to the culture or serologic antibody profile of the person with known genital herpes.

**Note:** Since the State Lab began using the HerpeSelect™ serologic test in January 2003, diagnosis of HSV-1 and/or HSV-2 no longer requires paired sera as described in the Laboratory Services Manual.

#### **Rapid Serologic Test for Antibodies to HSV-2 only**

Clinicians interested in offering clients an FDA-approved rapid test for serologic antibodies to HSV-2 only, can find information at [www.diagnology.com](http://www.diagnology.com).

## E. Human Immunodeficiency Virus (HIV) Antibody Testing

Refer to the Georgia Division of Public Health HIV/HBV Policy Manual for additional requirements and information regarding HIV testing and counseling.

Types of tests: Qualitative Enzyme-Linked Immunosorbant Assay (EIA or ELISA) and Qualitative Western Blot.

Specimen: 5-10 Milliliters of blood in a red-top tube, without additive.

Form: Virology Request Form #3605.

Submission: Use red address label.

Send to: Virology Unit of GPHL in Decatur, Georgia.

### Interpretation of results:

1. EIA Negative/Repeat Negative, Western Blot not performed, means no HIV antibodies were detected.
2. EIA Repeat Reactive, Western Blot Negative, means no HIV antibodies were detected.
3. EIA Repeat Reactive, Western Blot Positive, means HIV antibodies were detected.
4. EIA Repeat Reactive, Western Blot Indeterminate, means no HIV antibodies were confirmed.

**Note:** When no antibodies are detected, or confirmed, either no infection has occurred or there were not sufficient HIV antibodies to be detected. Another test is suggested if risk of exposure to infection occurred in the previous six months.

**Note:** Consider primary HIV infection if signs and symptoms of acute retroviral syndrome are, or have recently been present. HIV viral load testing may be indicated.

## F. Lymphogranuloma Venereum (LGV) Laboratory Test

Lymphogranuloma Venereum (LGV) is a systemic, sexually transmitted disease (STD) caused by a subtype of Chlamydia Trachomatis (serovars L1, L2 or L3). There are three clinical stages:

- **Primary Stage:** A papule at the site of infection, which ulcerates and then heals rapidly. Mild urethritis may also occur.
- **Secondary Stage:** Usually occurring 10-30 days after primary stage, it is characterized by increasing inguinal lymphadenopathy or, in persons exposed by receptive anal intercourse, acute hemorrhagic proctitis. The lymphadenopathy is usually unilateral; less than 20% have the “groove sign” showing involvement of the femoral nodes also.
- **Third Stage:** Denoted by chronic inflammation of the lymph nodes, ulceration and fistula formation. Clients, especially those who have engaged in unprotected anal sex may present with an atypical presentation. Symptoms could include proctitis or proctocolitis with rectal discharge, bleeding, pain on defecation or tenesmus.

The Georgia Division of Public Health has developed an STD Nurse Protocol for the diagnosis and treatment of clients suspected of having LGV.

**Note:** Diagnosis of LGV can be complicated. Diagnosis should be made considering a thorough sexual history, travel history, clinical findings and several laboratory tests including Chlamydia serology and Chlamydia genotyping.

LGV genotype testing technology is not commercially available. However, the CDC has the capacity to perform LGV diagnostic testing in its Chlamydia Laboratory. The CDC will assist state and local health departments in identifying patients with LGV in cities across United States.

**Note:** If a clinician strongly suspects LGV in a patient with a consistent sexual history and symptoms, a rectal swab and serologic specimen **must** be obtained from the client and submitted to the Georgia Public Health Laboratory. The GPHL will forward the specimens to the CDC for LGV-specific antibody testing.

### **Specimen Collection Procedures**

#### **1. Rectal Specimen Collection**

##### Equipment:

- Use the small swab and specimen tube included in Aptima Combo 2 (Gen-Probe) test kits.  
**Note:** Do not use the large tipped cleaning swab.
- If these kits are unavailable, use a sterile, dry swab and a specimen collection tube that contains no fluid or jellied medium.



Collection Technique:

**Note:** Specimens obtained under direct visualization during anoscopy or sigmoidoscopy are preferred.

- If direct visualization is performed, collect specimen from visible mucosal ulceration, if present.
- For blind specimen collection, insert swab 3-5 cm into the rectum.
- Rotate the swab against the rectal wall several times.

**Note:** Discard swabs grossly contaminated with feces and repeat collection.

- Insert the swab into the specimen collection tube, break the swab stick off at the score mark, and secure cap.

**Note:** For all patients with a rectal, genital, or ulcer specimen, you must also collect a serum specimen.

**Note:** For asymptomatic sex partners of a suspected or confirmed LGV case, urethral/urine testing through the GPHL should be conducted for *C. trachomatis*. If positive for *C. Trachomatis*, specimens may be submitted to the CDC for LGV testing along with a serum specimen.

**2. Serum Specimen Collection**

Equipment:

- Red top vacutainer tube

Collection Technique:

- Collect approximately 5 ml of blood in the red top vacutainer tube.
- Allow specimen to incubate at 37° C for 30 minutes, for clot formation.
- Store specimen overnight at 4° C to allow clot to contract.
- Separate serum by centrifugation at 10,000g for 10 minutes at 4° C.

**Note:** Serum specimens submitted alone without accompanying specimens will not be tested.

**3. Specimen Packaging, Storage, and Shipping Procedure**

- Specimens should be placed in biohazard bags and packaged according to the GPHL protocol.
- All specimens should be packed with insulated cold packs or freezer packs for shipping.
- Complete a separate specimen information sheet for each specimen. Forms may be obtained from the GPHL or downloaded from the CDC's website.
- Attach labeling to the specimens that clearly indicate that specimens are for LGV testing at the CDC.
- Contact the GPHL to confirm plans for shipping specimens.

4. If you have a patient that you suspect may have LGV or you have questions regarding these procedures, please call, (404) 657-2601 or (404) 463-0781.

Georgia Department of Human Resources  
Public Health Laboratory  
LGV Submission Form

SUBMITTER INFORMATION	PATIENT INFORMATION
SUBMITTER CODE: <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> NAME _____ STREET _____ CITY _____ ZIP CODE _____ COUNTY _____ PHONE NUMBER: (     ) _____ CONTACT PERSON: _____	<p style="text-align: center;"><b>PLEASE PRINT ALL INFORMATION LEGIBLY</b></p> NAME: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Last</span> <span>First</span> <span>Middle Initial</span> </div> STREET: _____ ZIP Code: _____ + _____ COUNTY: _____ STATE _____ CITY: _____ DATE OF BIRTH: ____/____/____ OCCUPATION: _____ <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <b>RACE:</b>  <input type="checkbox"/> Black  <input type="checkbox"/> White  <input type="checkbox"/> Am. Indian/Alaska Native  <input type="checkbox"/> Asian/Pacific Islander  <input type="checkbox"/> Multi-racial  <input type="checkbox"/> Unknown             </div> <div style="width: 30%;"> <b>ETHNICITY:</b>  <input type="checkbox"/> Hispanic  <input type="checkbox"/> Non-Hispanic  <input type="checkbox"/> Unknown             </div> <div style="width: 30%;"> <b>SEX:</b>  <input type="checkbox"/> Male  <input type="checkbox"/> Female  <input type="checkbox"/> Unknown             </div> </div>
SPECIMEN INFORMATION	
<p><b>Please use one form for each specimen submitted</b></p>	
DATE COLLECTED: ____/____/____  TIME COLLECTED: _____  DATE OF ONSET OF FEVER: ____/____/____	SOURCE: <input type="checkbox"/> Serum <input type="checkbox"/> Rectum <input type="checkbox"/> Other (Specify) _____

## **G. Microscopy for Crab Lice and Scabies**

### **Crab Lice (*Phthirus pubis*)**

Although diagnosis can be made through gross visualization of louse/lice, and/or nits at the base of the pubic hair shaft, microscopic examination of hair shaft can also reveal nits, and adult lice can also be examined microscopically.

### **Scabies (*Sarcoptes scabiei*)**

A clinical diagnosis of scabies can be confirmed by microscopically demonstrating the mite, its egg, and fecal pellets.

1. Locate recently developed, unexcoriated papules or burrows.
2. Place a small drop of mineral oil (or immersion oil) on the chosen site.
3. Immobilize the site between the forefinger and the thumb.
4. Using a sterile scalpel (e.g., #15), held parallel to the skin, scrape the lesion(s) 6-7 times to remove the tops of the papules and burrows. No anesthesia is required.
5. Transfer oil and scalpel material to microscope slide and cover with a cover slip.
6. Examine under low (10X) power. The adult female mite is 400 microns long. Eggs are large and oval in shape. Fecal pellets may be more numerous than mites or eggs.

## H. Syphilis Laboratory Tests

### Darkfield Microscopic Identification of *Treponema Pallidum*

Specimen: Abrade lesion to remove exudates, epithelium and crust. Collect serum on slide. Use cover slip. Examine immediately.

Interpretation of results: Observing motile spirochetes means a definitive diagnosis of Primary or Secondary Syphilis, depending on the type lesion(s).

### Serologic Test, Nontreponemal (not specific for Syphilis)

1. **STAT RPR (rapid plasma reagin) card test, qualitative (undiluted serum)**

Specimen: Serum from 5-10 ml whole blood. Perform test per kit instructions, including use of control cards to test antigen daily.

Interpretation of results: A positive test may support a diagnosis of Syphilis when the other criteria are met for the stage suspected.

(Send the remainder of the specimens to the Georgia Public Health Laboratory Microbial Immunology Lab or a local lab for quantitative RPR.)

2. **Quantitative RPR (serially diluted to an endpoint)**

Specimen: Serum from 5-10 ml whole blood (or serum, as above) in serologic outfit, with properly completed Microbial Immunology Submission Form 3432.

Send to: The Georgia Public Health Laboratory, Microbial Immunology Lab or a local lab.

Interpretation of results:

- a. More than a reactive test is needed to justify a diagnosis of Syphilis.
- b. A negative test does not rule out Syphilis.
  - 1) The RPR may not be reactive in Primary Syphilis until at least one week after appearance of the chancre.
  - 2) In 1-2% of cases of Secondary Syphilis an initially negative test may be due to the "Prozone Phenomenon." In these cases, an initially non-reactive but "rough" pattern will become reactive upon further dilution. When lesions suggestive of Secondary Syphilis are present, check the "Quantitative (Titer) and Confirmatory test" boxes on the lab form.
  - 3) The nontreponemal test may also be negative in Congenital or Late Symptomatic Syphilis.

- c. A reactive nontreponemal test (titer usually 1:8 or less) may be a false positive. Though most remain unexplained, some causes are:

Acute False Positives

(up to 6 month duration)

Various viral and bacterial infections

Immunizations

Drug use

Pregnancy

Chronic False Positives

Various autoimmune diseases:

- Rheumatoid arthritis
- Lupus erythematosus

Cancer chemotherapy

Chronic infections

Narcotic addiction

Genetic factors

Aging

A negative treponemal test will rule out a diagnosis of Syphilis in a person with a false-positive non-treponemal test.

- d. Depending on the stage when treatment is given, the RPR may remain positive in low titer, or even in relatively high pre-treatment titer, for life even after adequate treatment.
- e. A sustained 4-fold (two-dilution) rise in titer (e.g., 1:2 to 1:8) performed by the same lab indicates probably need for re-treatment. The only exception is adequately treated congenital syphilis where the titer may fluctuate without particular significance.
- f. On occasion, such things as drug use, immunosuppressive conditions and pregnancy may produce unusual titer patterns.

### **Serologic Test, Treponemal (specific for syphilis)**

#### **1. Enzyme immunoassay (EIA) for antitreponemal IgG antibody**

Specimen: Same as for RPR. The EIA will automatically be performed on all reactive RPRs sent to the Georgia Public Health Laboratory, Microbial Immunology Lab, unless there is a notation on the lab form that it is not needed. To avoid unnecessary EIA testing, check the “No confirmatory test needed” box on the lab form if the client has a:

- a. History of a previous reactive treponemal test.
- b. History of previous diagnosis of syphilis.
- c. Darkfield-positive lesion of primary or secondary syphilis.

**Note:** At times, confirmatory/treponemal test results are needed on clients with negative RPR results (i.e., when a very early ulcer typical of Primary Syphilis is present, or

for newborn reactor follow-up). To request that the state lab perform an EIA even when RPR results are negative, check the box on the lab form by “Quantitative (Titer) and Confirmatory even if screening test (RPR) negative.”

Interpretation of Syphilis EIA results:

- **Reactive** means a diagnosis of Syphilis is confirmed.
- **Reactive, equivocal** means the test could not be called either reactive or non-reactive. The specimen was tested two more times and repeat test results were still equivocal. In these cases, the lab will also do an FTA-Abs on the specimen before reporting the results.
- **Non-reactive** means a diagnosis of syphilis is not confirmed.

2. **FTA-Abs (fluorescent treponemal antibody-absorbtion double staining test)**

Specimen:

1. The FTA will be performed on equivocal EIAs after the test has been repeated in duplicates and two out of three readings are equivocal.
2. The FTA will be performed if the RPR card test is 1:16 or greater and the EIA is negative.
3. FTA will be performed if “FTA needed” is written under “special test request” on form 3432. Do not request confirmatory test if:
  - a. History of a previous reactive treponemal test.
  - b. History of previous diagnosis of syphilis.
  - c. Darkfield-positive lesion of primary or secondary syphilis.

**Note:** At times, confirmatory/treponemal test results are needed on clients with negative RPR results (i.e., when a very early ulcer typical of primary syphilis is present, or for newborn reactor follow-up). To request that the state/regional lab perform an FTA even when RPR results are negative, write in under Special Test Requested, FTA needed.

Interpretation of Syphilis FTA results:

**Reactive** means a diagnosis of syphilis is confirmed.

**Minimal Reactive** means the test could not be called either reactive or non-reactive. The specimen was tested two more times and repeat test results were still minimal reactive. The Lab will request a second specimen to be submitted.

**Non-reactive** means a diagnosis of syphilis is not confirmed.

## I. Wet Preps of Vaginal Discharge

### Saline and 10% KOH

Vaginal wet preps are classified as moderate complexity tests by CLIA. There is not commercial quality control (QC) available, but routine quality assurance (QA) measures should be used (e.g., a weekly practice comparing the readings of two persons separately examining a saline and a KOH slide and recording their findings on a QA log). If the results are not comparable, the discrepancy is recorded and appropriate follow-up action is taken. (Refer to the example of a QA log in this manual).

#### **Saline Tube Procedure (recommended)**

1. Obtain discharge from high on the vaginal wall on a cotton swab; place swab in a tube containing 0.5-1.0 ml of room temperature unsterile saline. Note: to test the pH of the discharge, place small amount on pH paper before placing the swab in the saline.
2. Wearing gloves, mix the saline suspension and place one (1) drop on a microscope slide (with the client's name written on the frosted end) using a plastic, disposable Pasteur pipette w/bulb, or the saturated swab.
3. Apply a cover slip. Be careful not to produce air bubbles.
4. Prepare another slide, as above, and add one (1) drop of 10% KOH before placing the cover slip. Record if the addition of KOH produces a "fishy" or amine odor (positive whiff/sniff test) or not.
5. As soon as possible (within an hour), spend at least three minutes methodically examining each slide:
  - a. Examine the saline slide first. Use the 10x objective to find and focus on the specimen before switching to the 40x objective to examine the slide for motile trichomonads, white blood cells (WBCs/PMNs), normal squamous epithelial cells (SECs), and "clue cells" (SECs with the cell walls obscured by adherent bacteria).
  - b. Examine the KOH slide last, to allow time for the KOH to dissolve (lyse) the cellular debris. Use 10x and 40x objectives as above to examine the slide for budding yeast and pseudohyphae/mycelia.
6. Record the results on a laboratory log (see the following for an example of a log) and on the client's clinical record.

#### **Direct Slide Procedure (alternative)**

1. Prepare two microscope slides (with the client's name written on the frosted ends), one with 2 drops of saline and one with 2 drops of 10% KOH.

2. Wearing gloves, collect vaginal wall discharge on two swabs. (To determine the pH place a small amount on pH paper before preparing the saline slide.)
3. Immediately make 2-3 rotations of one swab in the saline and apply a cover slip. The resulting suspension should be fairly light.
4. With the other swab, make 10-15 rotations in the 10% KOH for a fairly heavy suspension and apply a cover slip. Record if the addition of the discharge produces a “fishy” or amine odor (positive whiff/sniff test) or not.
5. As soon as possible (within an hour), spend at least three minutes methodically examining each slide as above.
6. Record the results on the laboratory log and the client’s clinical record.

**Results and Interpretation of Wet Preps**

**Note:** The client may have more than one vaginal infection diagnosed.

1. Observation of motile trichomonads = diagnosis of trichomoniasis.
2. Observation of budding yeast with pseudo-hyphae/mycelia = diagnosis of vulvovaginal candidiasis (VVC).
3. If >1 “clue cell” per high power field (hpf) are observed, one of three required criteria for diagnosing bacterial vaginosis (BV) has been met (See BV diagnostic criteria in vaginal infections section).
4. Observation of many WBCs is expected for trichomoniasis, but not for candidiasis or BV.

SALINE/KOH WET PREPS WEEKLY QUALITY ASSURANCE								
Date	Patient ID	SECs	WBCs	Clue Cells	Motile Trich.	Yeast/Hyphae		Initials
						Saline	KOH	
								1.
								2.
								1.
								2.
								1.
								2.
								1.
								2.



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# STD Signs, Symptoms, and Diagnostic Criteria

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## Section XII

### STD Signs, Symptoms and Diagnostic Criteria

### Syphilis

<b>PRIMARY SYPHILIS</b>	
<b>Signs and Symptoms</b>	<b>Diagnostic Criteria</b>
<ul style="list-style-type: none"> <li>• Painless ulcer (chancre) with indurated border and smooth base found at the site of sexual exposure, usually on genitals, anus or mouth.</li> <li>• Usually a single ulcer, but may be more than one.</li> <li>• Localized firm, non-tender, enlarged lymph nodes.</li> </ul>	<ol style="list-style-type: none"> <li>1. Identification of <i>T. pallidum</i> on dark field microscopic exam of serum from a lesion <b>OR</b></li> <li>2. Typical ulcer (chancre) <b>AND</b> <ol style="list-style-type: none"> <li>a. A newly reactive RPR/VDRL, confirmed by a reactive treponemal EIA, FTA-ABS or TPPA, <b>OR</b></li> <li>b. A four-fold or greater increase over the last known titer in a person with a history of previous syphilis.</li> </ol> </li> </ol> <p>Typical ulcer(s) and exposure to a known case of early syphilis in the previous 10-90 days is <u>suggestive</u> of primary syphilis.</p>

<b>SECONDARY SYPHILIS</b>	
<b>Signs and Symptoms</b>	<b>Diagnostic Criteria</b>
<p>Has one or more of the following:</p> <ul style="list-style-type: none"> <li>• Bilaterally symmetrical macular or papular, non-pruritic rash on body and/or extremities. May be on the palms and soles of the feet (palmar/plantar).</li> <li>• Condyloma lata – moist growths in the anogenital region.</li> <li>• Patchy hair loss.</li> <li>• Generalized enlarged lymph nodes.</li> <li>• Mucous patches in mouth or on cervix.</li> <li>• May have fever and malaise.</li> </ul>	<ol style="list-style-type: none"> <li>1. Identification of <i>T. pallidum</i> on dark field microscopic or DFA (direct fluorescent antibody) exam of serum from a lesion <b>OR</b></li> <li>2. Typical signs <b>AND</b> <ol style="list-style-type: none"> <li>a. A newly reactive RPR/VDRL, titer <math>\geq 1:8</math>, <b>OR</b></li> <li>b. Four-fold or greater increase over the last known titer in a person with a history of previous syphilis.</li> </ol> </li> </ol>

			Typical dermatologic signs and exposure to a known case of early syphilis in the previous six months is <u>suggestive</u> of secondary syphilis.
<b>LATENT SYPHILIS</b>			
<b>Diagnostic Criteria</b>			
No clinical symptoms or signs <b>AND</b> A reactive RPR <b>AND</b> A reactive EIA, FTA-ABS, or TPPA <b>AND</b>			
<b>Early Latent</b>	<b>Latent Unknown Duration</b>	<b>Late Latent</b>	
<p>Has had, <u>within the past year</u>:</p> <p>a. A non-reactive serologic test, or a 4-fold titer increase on serial RPRs,</p> <p style="text-align: center;"><b>OR</b></p> <p>b. Symptoms highly suggestive of primary or secondary syphilis,</p> <p style="text-align: center;"><b>OR</b></p> <p>c. Sexual exposure to a known case of primary, secondary or early latent syphilis.</p>	<p>a. The criteria for early latent syphilis in the previous column are not met,</p> <p style="text-align: center;"><b>AND</b></p> <p>b. The client is between 13-35 and has an RPR titer of <math>\geq 1:32</math>.</p>	<p>a. The criteria for having acquired the infection within the preceding year (see early latent column are not met),</p> <p style="text-align: center;"><b>AND</b></p> <p>b. The client's age and titer do not meet the criteria for latent syphilis of unknown duration (see previous column).</p>	

## Herpes

<b>GENITAL HERPES</b>	
<b>Signs and Symptoms</b>	<b>Diagnostic Criteria</b>
<ul style="list-style-type: none"> <li>• Single or multiple vesicular lesions (blisters) and/or shallow ulcers, usually painful, anywhere on the genitals.</li> <li>• May have atypical papular lesions and no ulcers.</li> <li>• May have a history of previous similar outbreaks.</li> <li>• Tender inguinal lymphadenopathy may be present during first outbreak.</li> <li>• The first occurrence may last 2-3 weeks; recurrent episodes may last 1-2 weeks.</li> <li>• Prodromal symptoms of itching/tingling at the site may be noticeable a day or more before recurrent episodes.</li> </ul>	<ol style="list-style-type: none"> <li>1. Identification of herpes simplex virus (HSV) type 1 and/or type 2 in lesion scraping, identified cell culture.</li> </ol> <p style="text-align: center;"><b>OR</b></p> <ol style="list-style-type: none"> <li>2. A clinical diagnosis may be made based on the presence of characteristic single or multiple blisters and/or shallow painful ulcers that are typical for herpes, but not for syphilis or chancroid.</li> <li>3. Suspicious genital papules, vesicles or ulcers, with a history of episode(s) of similar symptoms or sexual exposure to a person with HSV, is <u>suggestive</u>.</li> </ol> <p>Note: A herpes culture should be done to confirm an initial diagnosis of typical lesions. If client has a history of recurring atypical lesions and obtaining an adequate specimen for a culture is not possible, order type-specific serologic antibody test HSV 1 and 2</p>

## Chancroid

<b>CHANCROID</b>	
<b>Signs and Symptoms</b>	<b>Diagnostic Criteria</b>
<ul style="list-style-type: none"> <li>• One or more painful genital ulcers with a purulent base and a non-indurated soft, undermined edge.</li> <li>• 50% have a fluctuant “bubo,” a painful, greatly-enlarged inguinal lymph node with redness of overlying skin. It may need aspiration or incision to prevent rupture.</li> </ul>	<p>A positive culture for <i>Hemophilus ducreyii</i>, on specialized medium available from the CDC.</p> <p>Rule out primary syphilis and genital herpes.</p>

## Gonorrhea

<b>GONORRHEA</b>	
<i>Urethral, Endocervical or Rectal Infection</i>	
<b>Signs and Symptoms</b>	<b>Diagnostic Criteria</b>
<ul style="list-style-type: none"> <li>• May have history of sexual contact to an individual with gonorrhea.</li> <li>• May have no clinical signs or symptoms, especially females.</li> <li>• Males frequently have purulent urethral discharge and burning on urination (dysuria)</li> <li>• Mucoid, mucopurulent, or purulent discharge from infected site.</li> <li>• Rectal inflammation, discharge or pain, with history of rectal sex.</li> <li>• Sore throat and/or pharyngeal inflammation, with history of oral sex.</li> </ul>	<p><b>A. Adult Urethral or Endocervical</b></p> <ol style="list-style-type: none"> <li>1. Positive culture for <i>Neisseria gonorrhoeae</i>, with or without confirmatory tests.</li> <li>2. Gram-negative intracellular diplococci seen on smear of male urethral discharge.</li> <li>3. Nonculture identification of <i>N. gonorrhoeae</i> (e.g., DNA probe, amplification test).</li> </ol> <p><b>B. Genital Infection in a Child</b></p> <p>Positive culture for <i>N. gonorrhoeae</i>, confirmed by two different acceptable methods.</p> <p><b>C. Rectal or Pharyngeal Infection</b></p> <p>Positive culture for <i>N. gonorrhoeae</i>, confirmed by an acceptable method.</p>

## Chlamydial Infections

CHLAMYDIA URETHRITIS OR CERVICITIS	
Signs and Symptoms	Diagnostic Criteria
<ul style="list-style-type: none"> <li>• Females usually have no signs or symptoms. OR <u>May have:</u> <ul style="list-style-type: none"> <li>▪ Mucoid to mucopurulent cervical discharge and/or cervical friability.</li> <li>▪ Dysuria.</li> <li>▪ Pain with intercourse, or bleeding after intercourse.</li> </ul> </li> <li>• Males may have no signs or symptoms. OR <u>May have:</u> <ul style="list-style-type: none"> <li>▪ Mucoid to mucopurulent urethral discharge.</li> <li>▪ Itching/inflammation of the urethral meatus or burning on urination.</li> </ul> </li> </ul>	<ol style="list-style-type: none"> <li>1. Positive culture for Chlamydia Trachomatis.  <b>OR</b></li> <li>2. Positive non-culture test (e.g., DNA probe or amplification test).</li> </ol>

## Lymphogranuloma Venereum (LGV)

LYMPHOGRANULOMA VENEREUM (LGV)	
Signs and Symptoms	Diagnostic Criteria
<ul style="list-style-type: none"> <li>• Primary stage: a single small, painless genital ulcer; may not be noticed.</li> <li>• Secondary stage (10-30 days after primary): <ul style="list-style-type: none"> <li>▪ Painful femoral/inguinal lymphadenopathy, increasingly enlarging over two weeks.</li> <li>▪ It is usually unilateral, with “groove” sign present in at least 20% of cases.</li> </ul> </li> </ul>	<p>A positive serologic test for LGV-specific chlamydial antigen. The State Lab will forward the specimens to the CDC for testing.</p>

## Female Syndromes

<b>MUCOPURULENT CERVICITIS (MPC)</b>	
<b>Signs and Symptoms</b>	<b>Diagnostic Criteria</b>
<ul style="list-style-type: none"> <li>• Frequently asymptomatic.</li> <li>• May report abnormal vaginal bleeding (e.g., after intercourse).</li> <li>• Yellow or green exudates observed in endocervical canal or in an endocervical swab specimen.</li> <li>• Easily-induced cervical bleeding.</li> </ul>	<ol style="list-style-type: none"> <li>1. Presence of a purulent or mucopurulent yellow exudates visible in the endocervical canal or in an endocervical swab specimen (possible swab test).</li> </ol> <p style="text-align: center;"><b>AND/OR</b></p> <ol style="list-style-type: none"> <li>2. Easily-induced bleeding occurs with insertion of the first endocervical swab (cervical friability).</li> </ol> <p>Note: Do tests for Gonorrhea and Chlamydia to determine if appropriate treatment is indicated.</p>

<b>PELVIC INFLAMMATORY DISEASE (PID)</b>	
<b>Symptoms/History</b>	<b>Signs/Diagnostic Criteria</b>
<ul style="list-style-type: none"> <li>• Mild to moderate lower abdominal pain or tenderness.</li> <li>• Vaginal discharge.</li> <li>• Fever and chills.</li> <li>• Anorexia and/or nausea.</li> <li>• May have a history of exposure to gonorrhea or Chlamydia.</li> <li>• May have a history of previous PID, recent insertion of an IUD, or onset of symptoms during the first 5-10 days of menstrual cycle.</li> </ul>	<ol style="list-style-type: none"> <li>1. <u>Minimum criteria to institute treatment in sexually active young females and other females at risk for STDs:</u> <ol style="list-style-type: none"> <li>a. Cervical motion tenderness,</li> </ol> <p style="text-align: center;"><b>AND</b></p> <ol style="list-style-type: none"> <li>b. Uterine/adnexal tenderness.</li> </ol> </li> <li>2. Additional criteria that support a diagnosis of PID include:           <ol style="list-style-type: none"> <li>a. Abnormal cervical or vaginal mucopurulent discharge.</li> <li>b. Presence of white blood cells (WBCs) on saline microscopy of vaginal secretions.</li> <li>c. Laboratory documentation of cervical infection with <i>Neisseria Gonorrhoeae</i> or <i>Chlamydia Trachomatis</i>.</li> </ol> </li> </ol>

## Male Syndromes

NONGONOCOCCAL URETHRITIS (NGU)	
Signs and Symptoms	Diagnostic Criteria
<ul style="list-style-type: none"> <li>• Mucoïd to mucopurulent urethral discharge (common in the morning before voiding).</li> <li>• Itching or burning of the urethra.</li> </ul>	<p>1. Documentation of urethritis by:</p> <ol style="list-style-type: none"> <li>a. Presence of mucopurulent or purulent discharge,</li> </ol> <p style="text-align: center;"><b>OR</b></p> <ol style="list-style-type: none"> <li>b. Gram stain or urethral secretions demonstrating <math>\geq 5</math> WBCs per oil immersion field.</li> </ol> <p>2. Gram stain is negative for Gram-negative diplococci.</p> <p><b>Note:</b> If the criteria for urethritis are not present, treatment should be deferred until GC and CT results are obtained.</p>

EPIDIDYMITIS	
Signs and Symptoms	Diagnostic Criteria
<ul style="list-style-type: none"> <li>• Scrotal pain and swelling, usually unilateral.</li> <li>• May have dysuria and/or urethral discharge.</li> <li>• No history of trauma to the area.</li> <li>• Epididymitis not distinguishable from the testicles on palpation.</li> </ul>	<p>1. Tender scrotal swelling and on palpation cannot distinguish epididymis from testicles.</p> <p>2. Gram-stained smear is positive for urethritis (i.e., contains <math>&gt;5</math> WBCs per oil immersion field). The smear may or may not be positive for Neisseria Gonorrhoeae.</p> <p><b>Note:</b> Do test for Gonorrhea and Chlamydia, and also order a urine culture and Gram stain.</p>

GENITAL/PERIANAL WARTS Human Papillomavirus (HPV) Infection	
Symptoms/History	Signs/Diagnostic Criteria
<ul style="list-style-type: none"> <li>• May have no noticeable symptoms.</li> <li>• May have a history of similar growths in the past, or having sex partner with genital warts.</li> <li>• Bumps/growths in the genital or anal areas.</li> </ul> <p><b>Note:</b> Perianal warts can occur in both males and females without a history of anal sex.</p>	<p>Single or multiple typical soft, fleshy growths on the skin mucous membranes around the vulvovaginal area, anal area, penis, urethra or perineum. They may be shaped like cauliflower, with a stalk-like base, or be flatter and have a broad base.</p>



<b>MOLLUSCUM CONTAGIOSUM</b>	
<b>Signs and Symptoms</b>	<b>Diagnostic Criteria</b>
<ul style="list-style-type: none"><li>• Smooth, firm, shiny, single or multiple papules with umbilicated centers.</li><li>• When sexually transmitted, commonly found on the genitals and/or adjacent skin.</li><li>• May spread through nonsexual contact and appear on the face, extremities and trunk, especially in children. This pattern often recurs in HIV-infected persons.</li></ul>	Typical umbilicated 3-5 mm. Papules, usually flesh-colored but may also be yellow, pink or white.

## Vaginal Infections

<b>TRICHOMONIASIS</b>	
<b>Signs and Symptoms</b>	<b>Diagnostic Criteria</b>
<ul style="list-style-type: none"> <li>• May be asymptomatic.</li> <li>• Profuse, vaginal discharge with an offensive odor.</li> <li>• External genitalia may be edematous, reddened and/or excoriated.</li> <li>• Cervix may appear granular with punctate hemorrhages (“strawberry cervix”).</li> </ul>	<ol style="list-style-type: none"> <li>1. Identification of typical motile trichomonads on a saline wet mount.</li> </ol> <p style="text-align: center;"><b>OR</b></p> <ol style="list-style-type: none"> <li>2. Identification of <i>T. vaginalis</i> on culture.</li> </ol>

<b>VULVOVAGINAL CANDIDIASIS (VVC)</b>	
<b>Signs and Symptoms</b>	<b>Diagnostic Criteria</b>
<ul style="list-style-type: none"> <li>• Vulvovaginal itching.</li> <li>• Thick, white vaginal discharge that may resemble cottage cheese.</li> <li>• May report vaginal soreness, pain with intercourse, vulvar burning and external dysuria.</li> </ul>	<ol style="list-style-type: none"> <li>1. Pruritis and erythema in the vulvo-vaginal area. A thick white vaginal discharge may be present. Vaginal pH is &lt;4.5.</li> </ol> <p style="text-align: center;"><b>AND</b></p> <ol style="list-style-type: none"> <li>2. Identification of typical budding yeast forms or pseudohyphae on microscopic exam of vaginal discharge, by saline or KOH wet mount.</li> </ol>

<b>BACTERIAL VAGINOSIS (BV)</b>	
<b>Symptoms</b>	<b>Sign/Diagnostic Criteria</b>
<p>May report vaginal discharge with an offensive odor that is often more noticeable after intercourse.</p>	<p><u>At least</u> 3 of the following are present:</p> <ol style="list-style-type: none"> <li>a. Homogeneous, white, non-inflammatory discharge that coats the vaginal walls.</li> <li>b. Vaginal pH &gt;4.5.</li> <li>c. “Fishy” odor of vaginal discharge, before or after mixing it with 10% KOH (positive “whiff” test).</li> <li>d. “Clue cells” (epithelial cells with a granular appearance caused by adherent bacteria on a microscopic wet mount of vaginal discharge).</li> </ol>

<b>SCABIES</b>	
<b>Signs and Symptoms</b>	<b>Diagnostic Criteria</b>
<ul style="list-style-type: none"> <li>• Severe itching, usually worse at night.</li> <li>• Reddened papules, vesicles and finely raised burrows, from a few millimeters to a centimeter long.</li> <li>• May have excoriations and possible signs of secondary infection from scratching.</li> <li>• In adults, lesions are commonly found on the genitals, inner upper thighs, flexor surface of the wrists, fingerwebs, and anterior axillary folds.</li> </ul>	<ol style="list-style-type: none"> <li>1. Gross or microscopic identification of mite, larva or eggs on scraping from papules or burrows.</li> </ol> <p style="text-align: center;"><b>OR</b></p> <ol style="list-style-type: none"> <li>2. Burrows in the skin or characteristic pruritic, erythematous, papular eruptions and other causes of dermatitis are excluded.</li> <li>3. Compatible skin lesions and sexual or other close physical contact to a person infested with scabies is suggestive.</li> </ol>

<b>PEDICULOSIS PUBIS</b> <b>“Crabs” / Pubic Lice</b>	
<b>Signs and Symptoms</b>	<b>Diagnostic Criteria</b>
<ol style="list-style-type: none"> <li>1. Itching in the pubic area.</li> <li>2. “Bugs” or “crabs.”</li> <li>3. May have excoriations and possible signs of secondary infection due to scratching.</li> </ol>	<ol style="list-style-type: none"> <li>1. Identification of lice, larvae or nits attached to genital hairs.</li> </ol> <p style="text-align: center;"><b>OR</b></p> <ol style="list-style-type: none"> <li>2. History of recent exposure to pubic lice and pruritic, reddened macules or papules or secondary excoriations is observed in the genital area.</li> </ol>

## Human Immunodeficiency Virus (HIV)

<b>HIV INFECTION</b>	
<i>See the HIV/HSV Policy Manual, HIV Prevention Counseling training material, and other appropriate guidelines for information on pre- and post-test counseling and referral of clients who test positive for HIV antibody.</i>	
<b>Signs and Symptoms</b>	<b>Diagnostic Criteria</b>
<ul style="list-style-type: none"> <li>• May have no signs or symptoms.</li> <li>• May give a history of suspected exposure.</li> <li>• May have current/recent signs or symptoms of acute retroviral syndrome ranging from mild fever, myalgia, and arthralgia to severe syndromes that may include lymphadenopathy, anorexia, pharyngitis, weight loss, rash and meningitis.</li> </ul> <p>Note: Confidential HIV antibody testing is the standard of care for all clients seen for STD-related services in public health clinics. Informed consent must be obtained. Anonymous testing can be done if the client refuses confidential testing.</p>	<ol style="list-style-type: none"> <li>1. Repeatedly reactive EIA/ELISA (enzyme-linked immunosorbant assay) for HIV antibody.</li> </ol> <p style="text-align: center;"><b>AND</b></p> <ol style="list-style-type: none"> <li>2. Positive Western Blot confirmatory test.</li> <li>3. Viral load testing is indicated when signs or symptoms of primary infection are, or have recently been present.</li> </ol>

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# Disease Intervention Guidelines for STD Clients

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## Section XIII

### Disease Intervention Guidelines for STD Clients

#### I. Completion of the Interview Record (CDC 73.54) and Field Record (CDC 73.2936S)

Interview Records (CDC 73.54) and Field Records (CDC 73.2936S) may be used for monitoring and case management of any STD or HIV disease intervention and prevention activity. For detailed information on the correct way to complete the 73.54, refer to the CDC Interview Record Instructions. For the correct way to complete the 73.2936S, see CDC Field Record Instructions.

The notes below serve as additional explanation and clarification on some of the most frequent concerns in completing the Interview Record and Field Record, and apply to any disease for which these records are used. For specific instructions on how to submit Syphilis interview records and field records to the State STD Surveillance Unit, see the Syphilis section in this manual.

#### INTERVIEW RECORD

##### 1. Informant identity

Remember to complete “Informant Identity” when the case has been brought to treatment through disease intervention.

##### 2. Dual Dispositions on 73.54

- a. Dual dispositions should appear on the 73.54 when “ping-pong” infection are involved. For example, when an individual is both the source and spread, enter the name of the contact on two lines, as though he were two different contacts. The first line should show the appropriate disposition for the first infection (when he/she was the source or spread, whichever is the case). The other lines should show the current disposition and whether he/she is the source or a spread.
- b. For a previously diagnosed and treated partner who is related to the case (either source or spread), and has been located, examined again and receives epidemiologic treatment, show this partner as the source or spread with the appropriate dates, disposition and diagnosis applicable to the previous infection. Show this partner as a current record closure. Put an asterisk by the partner’s name, and indicate on the bottom of the 73.54 that this partner was treated prophylactically and the date of treatment.

In contrast, if a previously treated partner is untreated (not a source or spread), but is re-examined and receives epidemiological treatment, show the current examination and treatment (disposition “A”) information, put an asterisk by the partner’s name and indicate on the bottom of the 73.54 that this partner was

previously treated, showing the stage and date of diagnosis. (An “F” disposition would be handled the same as an “A”).

3. Patient Address

List complete address, including house or apartment number, street, city, and zip code.

4. Supervisor/Investigative Agency Code

Enter codes in the 3-digit code blocks for each district/unit as listed below. DO NOT use county code for Investigative Agency Code.

<u>DISTRICT/UNIT</u>	<u>CODE</u>	<u>DISTRICT/UNIT</u>	<u>CODE</u>
1-1 Rome	110	5-1 Dublin	510
1-2 Dalton	120	5-2 Macon	520
2 Gainesville	200	6 Augusta	600
3-1 Marietta	310	7 Columbus	700
3-2 Fulton County	320	8-1 Valdosta	810
3-3 Clayton County	330	8-2 Albany	820
3-4 Lawrenceville	340	9-1 Savannah	910
3-5 DeKalb County	350	9-2 Waycross	920
4 LaGrange	400	10 Athens	100

5. Dates of Events

Assure that all dates entered on the 73.54 are accurate and logical. For instance, “date interviewed” cannot be prior to “date assigned.”

6. Date Assigned

The date assigned is the date the Communicable Disease Specialist (CDS) becomes aware that the person is diagnosed as a case. It is always good to stamp the date received on all field records.

7. Intrastate Morbidity Assignment

When morbidity is assigned from one district to another district within the state, photocopies of Interview Records and relevant Field Records will be sent to the other involved district. Confidentiality of information must be assured.

8. Notation of Out-of-State Morbidity Assignment

If morbidity is being assigned to another state, please specify by writing at the very top of the 73.54 “**MORBIDITY TO \_\_\_\_\_.**” List client’s complete address. Remember, MORBIDITY IS BASED ON CLIENT’S USUAL STATE OF RESIDENCE AT TIME OF TREATMENT AND DIAGNOSIS.

## **FIELD RECORD**

### 1. Original Patient ID Number

Assure that the local patient ID/case number is written in the relevant box on the Field Record, especially if it is being sent to another district.

### 2. Brought to Treatment/Previous Treatment Dispositions

An “infected, brought to treatment” disposition (disposition “C”) is used when the partner, cluster or reactor was examined and treated (for the suspected infection) as a direct result of this field investigation. If the individual was treated prior to the initiation of this field investigation, the disposition should be “previously treated for this infection: (disposition “E”).

### 3. Disposition Date

Date of disposition in the partner/cluster section of the Interview Record (and in the “disposition date” box of the Field Record) should be the date the investigation or record search was completed. This should be immediately after the completion of the activity. **DISREGARD ITEM 31-F (“DISPO DATE”) IN THE CDC FIELD RECORD INSTRUCTION AND ITEM 46 (“DISP. DATE”) OF THE CDC INTERVIEW RECORD INSTRUCTIONS.**

## **II. Routing of Field Record (Form 73.2936S)**

Below is the policy for interstate and intrastate routing of Field Records (Form 73.2936S) for investigation of the following sexually transmitted diseases, partners and clusters:

- Syphilis reactors
- Partner and clusters to primary, secondary, and early latent Syphilis
- Gonorrhea cases and partners
- Chlamydia cases and partners
- PID partners
- HIV positives and partners

### **A. Out of Jurisdiction Investigations Within Georgia**

The initiating district should thoroughly complete a four-part 73.2936S and mail three copies (including the free copy) to the investigating district, retaining one copy for control purposes. The initiating district may call the investigating district prior to mailing the 73.2936S. The investigating district should provide a preliminary disposition to the initiating district within 5 workdays after receipt. This preliminary disposition should, at a minimum, verify the address, name, locating information, etc. in the event that additional information is needed, the original patient can then be re-interviewed.



Within 14 calendar days of receiving the 73.2936S, the investigating district should send a dispositional copy back to the initiating district so that case analysis may be completed. The investigating district also should forward the **white** copy to the STD Section for data entry. Note: The 73.54 should not be closed until final dispositions are recorded.

## **B. Out-of-State Investigations**

### 1. Epidemiologic information originating in Georgia:

Information on contacts/clusters to early Syphilis or HIV infection and persons who have reactive Syphilis test with titer  $\geq 1:8$  will be phoned. Information on HIV positives, Syphilis reactors with titers  $\geq 1:8$ , Chlamydia/Gonorrhea cases/contacts and PID contacts, will be mailed, with one exception. If a person is pregnant, the information will be phoned.

- a. Phone information on Syphilis/HIV contacts, priority Syphilis reactors and other contacts/reactors known to be pregnant to the Georgia STD Section on the date initiated. Buff copies of the 73.2936S should be used for Syphilis and HIV contacts as a control measure, with no paperwork being sent to the STD Section.
- b. Mail four-part Field Record (73.2936S) to the STD Section for low priority Syphilis reactors, contacts to Gonorrhea/Chlamydia and HIV positives on the date initiated. For HIV positives, (See the HIV manual).
- c. Upon receiving the information, the STD Section Interstate Communication Clinical Record (ICCR) Clerk will appropriately either telephone the state in which the investigation is to be performed or forward the four-part Field Record to the other state.
- d. A disposition must be provided within 14 days for early Syphilis contacts (30 days for HIV contacts). The ICCR Clerk will request the disposition. When a disposition is received from the investigating state, results will be called to the initiating district.

### 2. Epidemiologic Information Originating in Another State:

- a. All epidemiologic information received from other states relative to Georgia residents will be called to the investigating district by the Georgia STD Section ICCR Clerk.
- b. The investigating district will initiate a four part Field Record 73.2936S. The investigating district should provide a preliminary disposition to the STD ICCR clerk within 5 working days after receipt. A final disposition should be called to the Georgia STD Section ICCR Clerk by the investigating district as soon as possible, but no later than 14 days from the initiation date, if a final disposition has not been reported within 14 calendar days (on the “Disposition Due Date”), the responsible district

CDS must report the status of the investigation to the Georgia STD Section.

- c. The white copy of the closed Field Record should be forwarded to the Georgia STD Section for inclusion in data processing reports.

3. Military

Any domestic military installation that initiates STD intervention information for investigation anywhere within the United States or its territories should forward forms through the local district health office. The district offices must screen these forms for accuracy and transmit to the appropriate district if the investigation is within Georgia, or to the Georgia STD Section ICCR Clerk if the investigation is to be performed in another state.

### III. Use of the Notifiable Disease Report Form (Form 3095)

All licensed physicians, laboratories, hospitals, military installations and other health care providers should report on the Notifiable Disease Report Form (3095). Only one disease per card should be reported on the Notifiable Disease Report Form with the exception of Gonorrhea and Chlamydia, which are frequently tested for and reported together.

The Notifiable Disease Report Form is used to report **“positive results”** or diagnosed disease. This form should not be used to report **“pending,” “non-reactive,” “ruled-out” or “possible”** results.

All healthcare providers using the Notifiable Disease Report Form are required to report the minimum information: the disease or condition, client’s name, address, telephone number, date of birth, pregnancy status and treatment status. Treatment should be indicated in the “comment” section of the original version of the form (10/96) or in the specifically designated section on the revised form.

Note: It is important that the name, facility and telephone number of the reporting physician be included on the form.

1. District receiving Gonorrhea, Chlamydia, chancroid or LGV morbidity information on a Notifiable Disease Report Form directly from county/private laboratories, hospitals, military installations, physicians, and other reporting agencies will forward the form to the State STD Surveillance Unit.
2. The State STD Surveillance Unit will process Form 3095 morbidity information into the STD/MIS system. Districts may request that the data from the State STD Surveillance Unit be downloaded monthly.
3. Local, District and State Surveillance units should access and review SENDSS for STD Morbidity that may have been entered by non-public health providers.

#### IV. Early Syphilis, Primary and Secondary (P & S) and Early Latent (EL)

##### A. Screening

The State STD Surveillance Unit is responsible for processing, maintaining, and forwarding reports of positive Syphilis serologies to the public health districts for follow-up. This ensures the State STD Surveillance Unit maintains a quality assurance system to monitor all open reactors.

1. Positive laboratory serologies that are not closed by the State STD Surveillance Unit as administrative closure (A/C) or out-of-jurisdiction (OOJ) will be record searched. If a reactive serology cannot be record-searched closed (R/C) by the STD Surveillance Unit, surveillance follow-up log sheet will be generated and, along with the laboratory report forwarded to the appropriate district for follow-up according to the standards for investigation. The receiving district **will return disposition** information to the STD Surveillance Unit **within 30 days**.

**Note:** Record search closures and administrative closures will be forwarded to the districts only at a district's request.

2. When follow-up has been completed on positive laboratory serologies, districts will mail a copy of the completed records, along with the surveillance sheet to the STD Surveillance Unit.

Note: If a reactor Field Record is dispositioned “**K**” (out-of-jurisdiction), the district will initiate a new Field Record to the appropriate district. The surveillance follow-up reactor number must be placed on the new Field Record. A copy of the completed “**K**” Field Record and a copy of the positive reactor laboratory serology will be mailed back to the State STD surveillance unit to update the surveillance follow-up reactor log file. The receiving district will report the final results of the investigation back to the initiating district and to the State STD Surveillance Unit.

##### B. Reactive Serology Resolutions

Reactive serologies should be evaluated according to the reactor grid. (See appendix)

It is the responsibility of the communicable disease specialist supervisor in each district to initiate a Field Record on any reactor needing further investigation to rule out a new infection.

##### 1. Syphilis Reactor Grid - Interviewing/Counseling

###### Submission of Syphilis Cases to the State STD Surveillance Unit:

- a. For all diagnosed early Syphilis cases, districts should mail an initial yellow copy of the Interview Record (CDC 73.54) to the State STD Section STD Surveillance Unit within 72 hours of the interview.
- b. After the case is closed, a photocopy (from the white copy) of the closed Interview Record should be forwarded to the State STD

Surveillance Unit at the end of the month after the month the interview was done, (e.g., cases interviewed in January are due before March 1.) All patient information, laboratory work and the disposition of contacts/clusters must be complete at that time. The white copy of closed partner/cluster Field Records should also be included.

- c. The State STD Surveillance Unit will enter all Syphilis Interview Records into STD Management Information System (MIS). Districts may request the data from the STD Surveillance Unit on a monthly basis.

*Minimum process performance standards:*

- a. Interview at least 85% of all early Syphilis cases within 3 workdays of becoming aware of a case.
- b. Re-interview 85% of selected clients within 5 work days of original interview.
- c. During the interview, obtain a complete description and two items of locating information at least 75% of the time on each partner that a Field Record is initiated.

Investigation

*Minimum process performance standards:*

- a. Initiate all public and non-public high priority reactive serologies immediately. Begin investigation within 24 hours of initiation and accomplish proper follow-up (e.g., examination of patient, closure information obtained from the physician) on at least 80% within 3 working days. Lower priority reactors may demand the same standards based on epidemiological information.
- b. Examine at least 75% of partners of primary and secondary Syphilis cases within 3 workdays.
- c. Examine at least 70% of partners of early latent Syphilis cases within 3 workdays.
- d. Document all investigative activities (dates and times of phone calls, field visits, failed appointments, etc.) on the back of the cardboard copy of all Field Records.

*Additional program expectations:*

- a. Interview 100% of locatable early Syphilis cases for partners and cluster suspects, and select partners for associates, with emphasis on S-1's, S-2's, A-1's and A-2's. (See CDC Interview Record Instructions for definitions of S-1, S-2, etc., in appendix).

- b. Begin all partner/cluster field investigations within 24 hours of completion of the interview; all available pre-investigative materials such as telephone directories, city directories and closed Field Records should be utilized prior to initiating follow-up.
- c. Epidemiologically treat examined seronegative partners to early (P & S and EL) Syphilis who were exposed within the previous 90 days (3 months).
- d. Perform ongoing source/spread analysis during the entire course of Syphilis case management.
- e. Assure that any public laboratories not reporting directly to the State Office report Syphilis reactors to the district program daily.
- f. Assure that private laboratories report Syphilis reactors to the district program or to the Epidemiology and Prevention Branch daily on the Notifiable Disease Report Form (3095).
- g. Visit private laboratories within the district at least annually. Visit should be made more frequently if problems arise.
- h. Supervisors should maintain quality assurance by performing routine reviews of employee work, depending on employee experience and identified problems. This may start with at least one review of open field work (pouch review), case review, interview audit and field audit per month for new employees or after problems have been identified, and progress to quarterly reviews for veteran employees for whom no recent problems have been identified.

#### Criteria for Requesting State Office Record Searches

- 1. Attempt to talk with the patient to obtain specifics before calling for a record search. To assist the STD Section in performing a more accurate record search, try to have as much of the following information as possible:
  - a. Client's full name: This might include middle name or initials used, nickname, a.k.a., female maiden name, names by former marriages or husband's first name.
  - b. Client's age/date of birth, sex, and race.
  - c. Year and age when treated.
  - d. Where treated (name of clinic, doctor or correctional facility) and/or who performed the serology.
- 2. When calling the State Office for a record search, have recent information (such as current titer) available so if a record is found, it can be updated.

## **V. Late Latent and Late Syphilis**

Marital or steady sex partner of all clients diagnosed with late latent or late Syphilis should be referred for a serologic test for Syphilis. Infant of women diagnosed with late latent Syphilis must also be evaluated.

## **VI. Congenital Syphilis**

Measures, which have successfully led to control of congenital Syphilis, have been well studied and extensively practiced. Contributing to control is a range of public health activities, which integrate service delivery with community outreach: comprehensive prenatal care, strategically targeted STD educational programs and responsive, high-quality diagnostic and treatment services. Equally crucial is well-managed Syphilis prevention/intervention component.

The Georgia law requires a blood specimen to be taken at the initial visit for prenatal care and during the third trimester. Postnatal women, for whom a STS during pregnancy cannot be confirmed, must have a blood specimen drawn within six hours of delivery.

Penicillin is the preferred treatment because it crosses the placenta in adequate amounts to treat the fetus. Tetracycline and doxycycline are contraindicated in pregnancy. Erythromycin may be used to treat when there is a delay in receiving services for desensitization.

Women who have allergy to penicillin should receive a skin test. Those who skin test is negative should be treated with penicillin immediately. Women who are truly allergic should be desensitized and then treated with penicillin. When desensitization services cannot be provided, the mother must receive close clinical follow-up for the duration of pregnancy. The mother must receive a monthly qualitative nontreponemal serologic test for the remainder of the pregnancy. The neonate must receive penicillin treatment at birth even if the infant is asymptomatic.

Mothers treated during pregnancy should have treatment follow-up. Women who show a fourfold (two dilution) increase should be retreated. Women whose titer does not drop fourfold within a three-month period (primary & secondary) or six months (early latent) should be retreated.

In addition to the performance of traditional epidemiology of early adult Syphilis, the communicable disease specialist must also serve as the focal point for newborn reactor epidemiology. The CDS is responsible for initiating the follow-up of congenital Syphilis suspects and for subsequent data collection from physicians and hospitals, field investigations, clinical referral and reporting.

### **Questions to Ask During Evaluation of Mother and Infant** *(also in appendices)*

1. Was the mother untreated at delivery?
2. Did the mother show signs of reinfection?

3. Was the mother treated less than 30 days prior to delivery?
4. Was the mother treated with a non-penicillin regimen during pregnancy?
5. Did the mother have appropriate serologic follow-up to syphilis treatment during gestation?
6. Was mother exposed to syphilis but did not receive preventive treatment?
7. Was penicillin treatment given (if treated during pregnancy)?
8. Did a two-dilution (fourfold) titer decrease occur within three months (primary & secondary) or six months (early latent)?
9. Does the mother appear to be reinfected showing a fourfold (two-dilution) rise in titer since treatment?
10. Are there signs or symptoms of reinfection (lesions, palmer/plantar rash, condyloma lata, etc.)?
11. Does the infant have signs of congenital syphilis?
12. Does the infant have a reactive serologic test?
13. Does the long bone x-ray suggest congenital syphilis?
14. Are the CSF findings reactive or elevated?
15. Was infant IgM reactive?

#### Case Classification: Confirmed

Regardless of mother's treatment history

Infant has identification of *T. Pallidum* by darkfield microscopy or other stain.

#### Classification: Presumptive

Regardless of infant's findings

Mother infected during pregnancy:

Not treated or inadequately treated

OR

Regardless of mothers findings

Infant has reactive treponemal test and one of the following:

Signs of CS

Evidence of CS in long bone x-ray

Reactive VDRL-CSF

Elevated CSF Cell Count or Protein  
Reactive FTA-ABS-19s-IGM



**LOCAL USE ONLY**

Mother's Name: \_\_\_\_\_ Chart No.: \_\_\_\_\_  
 Address: \_\_\_\_\_ (Number, Street, City, State) \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_  
 Infant's Name: \_\_\_\_\_ Chart No.: \_\_\_\_\_ Delivering Physician: \_\_\_\_\_ (Zip Code) \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_  
 Pediatrician: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_ - Patient identifier information is **not** transmitted to CDC -



**PART I. MATERNAL INFORMATION**

1. Report date to health dept. \_\_\_\_\_ (Mo. / Day / Yr. (8-15))  Unk

2. Reporting state FIPS code: \_\_\_\_\_ (16-17) Reporting State Name \_\_\_\_\_  Unk

3. Reporting county FIPS code: \_\_\_\_\_ (18-20) Reporting County Name \_\_\_\_\_  Unk

4. Reporting city FIPS code: \_\_\_\_\_ (21-24) Reporting City Name \_\_\_\_\_  Unk

5. Other geographic unit (optional): \_\_\_\_\_ (25-27)

6. Country of residence: (leave blank if USA) \_\_\_\_\_ (28-30) Country of Residence \_\_\_\_\_  Unk

7. State FIPS code: \_\_\_\_\_ (31-32) Residence State Name \_\_\_\_\_  Unk

8. Residence county FIPS code: \_\_\_\_\_ (33-35) Residence County Name \_\_\_\_\_  Unk

9. Residence city FIPS code: \_\_\_\_\_ (36-39) Residence City Name \_\_\_\_\_  Unk

10. Residence zip code: \_\_\_\_\_ (40-44)  Unk

11. Mother's date of birth: \_\_\_\_\_ (Mo. / Day / Yr. (45-52))  Unk

12. Mother's ethnicity: (53)  
 1  Hispanic/Latino 9  Unk  
 2  Non-Hispanic/Latino

13. Mother's race: (Code 1 for all that apply)  
 (54)  American Indian/Alaskan Native (55)  Asian (56)  Black or African American  
 (57)  Native Hawaiian or Other Pacific Islander (58)  White (59)  Unk

14. Mother's marital status: (60)  
 1  Single, never married 3  Separated/Divorced 8  Other  
 2  Married 4  Widow 9  Unk

15. Last menstrual period (LMP) (before delivery) \_\_\_\_\_ (Mo. / Day / Yr. (61-68))  Unk

16. Did mother have prenatal care? (69)  
 1  Yes 9  Unk (Go to Q19)  
 2  No (Go to Q19)

17. Indicate date of first prenatal visit: \_\_\_\_\_ (Mo. / Day / Yr. (70-77))  Unk

18. Indicate number of prenatal visits: \_\_\_\_\_ (78-79)  Unk

19. Did mother have a nontreponemal test (e.g., RPR or VDRL) in pregnancy, at delivery, or soon after delivery within 3 days? (80)  
 1  Yes 2  No (Go to Q21) 9  Unk (Go to Q21)

20. Indicate dates and results of nontreponemal tests: (list the most recent first)

Date	Results	Titer
a. _____ (81-88) <input type="checkbox"/> Unk	1 <input type="checkbox"/> Reactive 2 <input type="checkbox"/> Nonreactive 9 <input type="checkbox"/> Unk (89)	1: _____ (90-93)
b. _____ (94-101) <input type="checkbox"/> Unk	1 <input type="checkbox"/> Reactive 2 <input type="checkbox"/> Nonreactive 9 <input type="checkbox"/> Unk (102)	1: _____ (103-106)
c. _____ (107-114) <input type="checkbox"/> Unk	1 <input type="checkbox"/> Reactive 2 <input type="checkbox"/> Nonreactive 9 <input type="checkbox"/> Unk (115)	1: _____ (116-119)
d. _____ (120-127) <input type="checkbox"/> Unk	1 <input type="checkbox"/> Reactive 2 <input type="checkbox"/> Nonreactive 9 <input type="checkbox"/> Unk (128)	1: _____ (129-132)

21. Did mother have confirmatory treponemal test result (e.g., FTA-ABS or TP-PA)? (133)  
 1  Yes, reactive 3  No test  
 2  Yes, nonreactive 9  Unk (Footnote a)

22. Did mother have darkfield or direct fluorescent antibody (DFA) exam of lesions at delivery? (134)  
 1  Yes, positive 3  No test of lesions 9  Unk  
 2  Yes, negative 4  No lesions present (Footnote a)

23. Before this delivery, when was mother last treated for syphilis? (135)  
 1  Before pregnancy (Go to Q24) \_\_\_\_\_ (Mo. / Day / Yr. (136-143))  
 2  During pregnancy (Go to Q25) 3  No Treatment (Go to Q27) 9  Unk (Go to Q27)

24. Before pregnancy, was mother's treatment adequate? (144) (Footnote b)  
 1  Yes, adequate (Go to Q26) 9  Unk (Go to Q27)  
 2  No, inadequate (Go to Q27)

25. During pregnancy, was mother's treatment adequate? (145) (Footnote b)  
 1  Yes, adequate 3  No, inadequate: penicillin therapy begun < 30 days before delivery (Go to Q27)  
 2  No, inadequate: non-penicillin therapy (Go to Q27) 4  Unknown (Go to Q27)

26. An appropriate serologic response? (146) (Footnote c)  
 1  Yes, appropriate response with adequate serologic follow-up during pregnancy 3  No, inappropriate response: evidence of treatment failure or reinfection  
 2  Yes, appropriate response but no follow-up serologic titers during pregnancy 4  No, response was equivocal or could not be determined from available nontreponemal titer information

**PART II. INFANT INFORMATION**

27. Date of Delivery: \_\_\_\_\_ (Mo. / Day / Yr. (147-154))  Unk

28. Vital status: (155)  
 1  Alive (Go to Q30) 3  Stillborn (Go to Q31) (Footnote d)  
 2  Born alive, then died 9  Unk (Go to Q30)

29. Indicate date of death: \_\_\_\_\_ (Mo. / Day / Yr. (156-163))  Unk

30. Gender: (164)  
 1  Male 2  Female 9  Unk

31. Birthweight (in grams) \_\_\_\_\_ (165-168)  Unk

32. Estimated gestational age (in weeks) \_\_\_\_\_ (169-170) (if infant was stillborn go to Q42)  Unk

33. a) Did infant/child have a reactive non-treponemal test for syphilis (e.g., VDRL, RPR)? (171)  
 1  Yes 2  No 9  Unk

b) When was the infant/child's first reactive non-treponemal test for syphilis? \_\_\_\_\_ (Mo. / Day / Yr. (172-179)) (172-179)

c) Indicate titer of infant/child's first reactive non-treponemal test for syphilis? \_\_\_\_\_ (180-183) 1: \_\_\_\_\_

34. a) Did infant/child have a reactive treponemal test for syphilis (e.g., FTA-ABS, TP-PA)? (184)  
 1  Yes 2  No 9  Unk

b) When was the infant/child's first reactive treponemal test for syphilis? \_\_\_\_\_ (Mo. / Day / Yr. (185-192)) (185-192)

35. Did the infant/child have any classic signs of CS? (193) (Footnote e)  
 1  Yes 2  No, asymptomatic infant/child 9  Unk.

**Laboratory Confirmation**

36. Did the infant/child have a darkfield exam or DFA-TP? (194)  
 1  Yes, positive 3  No test  
 2  Yes, negative 9  Unk.

37. Did the infant/child have an IgM-specific treponemal test? (195) (Footnote f)  
 1  Yes, reactive 3  No test  
 2  Yes, nonreactive 9  Unk.

**Infant/Child Evaluation**

38. Did the infant/child have long bone X-rays? (196)  
 1  Yes, changes consistent with CS 3  No xrays  
 2  Yes, no signs of CS 9  Unk.

39. Did the infant/child have a CSF-VDRL? (197)  
 1  Yes, reactive 3  No test  
 2  Yes, nonreactive 9  Unk.

40. Did the infant/child have a CSF cell count or CSF protein test? (198) (Footnote g)  
 1  Yes, one or both elevated 3  No test  
 2  Yes, both not elevated 9  Unk.

41. Was the infant/child treated? (199)  
 1  Yes, with Aqueous or Procaine Penicillin for ≥ 10 days 3  Yes, with Benzathine penicillin x 1  
 2  Yes, with Ampicillin followed by Aqueous or Procaine Penicillin for a total > 10 days 5  No treatment  
 9  Unk.

**PART III. Congenital Syphilis Case Classification**

42. Classification (200)  
 1  Not a case 2  Confirmed case (Laboratory confirmed identification of *T. pallidum*, e.g., darkfield or direct fluorescent antibody positive lesions) 3  Syphilitic stillbirth (Footnote d) 4  Presumptive case (A case identified by the above algorithm, which is not a confirmed case or syphilitic stillbirth).

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0128). Do not send the completed form to this address.

**Footnotes: a)** For the case definition of congenital syphilis (CS), the mother must have evidence of syphilis by one of the following tests: 1) a syphilitic lesion at the time of delivery proven by positive darkfield or direct fluorescent antibody (DFA) examination; or 2) a reactive treponemal test (e.g., FTA-ABS, MHA-TP). A treponemal test on the mother may not be available for an infant evaluated outside the newborn period or a child with late CS. In these instances, the investigation may proceed on the basis of infant/child treponemal and nontreponemal tests. An attempt to obtain a maternal treponemal test should be made.

**b)** Adequate therapy in a non-pregnant woman should be one of the standard treatment regimens recommended for her particular stage of infection (See 1989 STD Treatment Guidelines).

Adequate therapy in a pregnant woman is treatment with a penicillin regimen, appropriate for the mother's stage of syphilis, started at least 30 days before delivery (see 1989 STD Treatment Guidelines). Any non-penicillin treatment or penicillin treatment in the last 30 days of pregnancy is inadequate for the unborn child.

**c)** Appropriate response to therapy is a fourfold decline in non-treponemal titer by three months with primary or secondary syphilis, or a fourfold decline in non-treponemal titer by six months with early latent syphilis.

An inappropriate response is less than a fourfold drop over the expected time period unless the patient is known to be serofast (see below). An equivocal response includes instances where it was difficult to assess adequate response because either no interim titers from treatment to delivery were available or insufficient time had passed between treatment and delivery. An unknown response includes those instances where titers before treatment and/or at delivery are not available. The infant/child of a mother with an equivocal or unknown response should be evaluated for CS.

Special consideration is required in the case of a serofast patient. If a mother's titer was 1:1 or 1:2 before pregnancy, there is evidence of adequate treatment, and at delivery her titer is still the same low level, she should be regarded as serofast. Stop the case investigation; this is not a case.

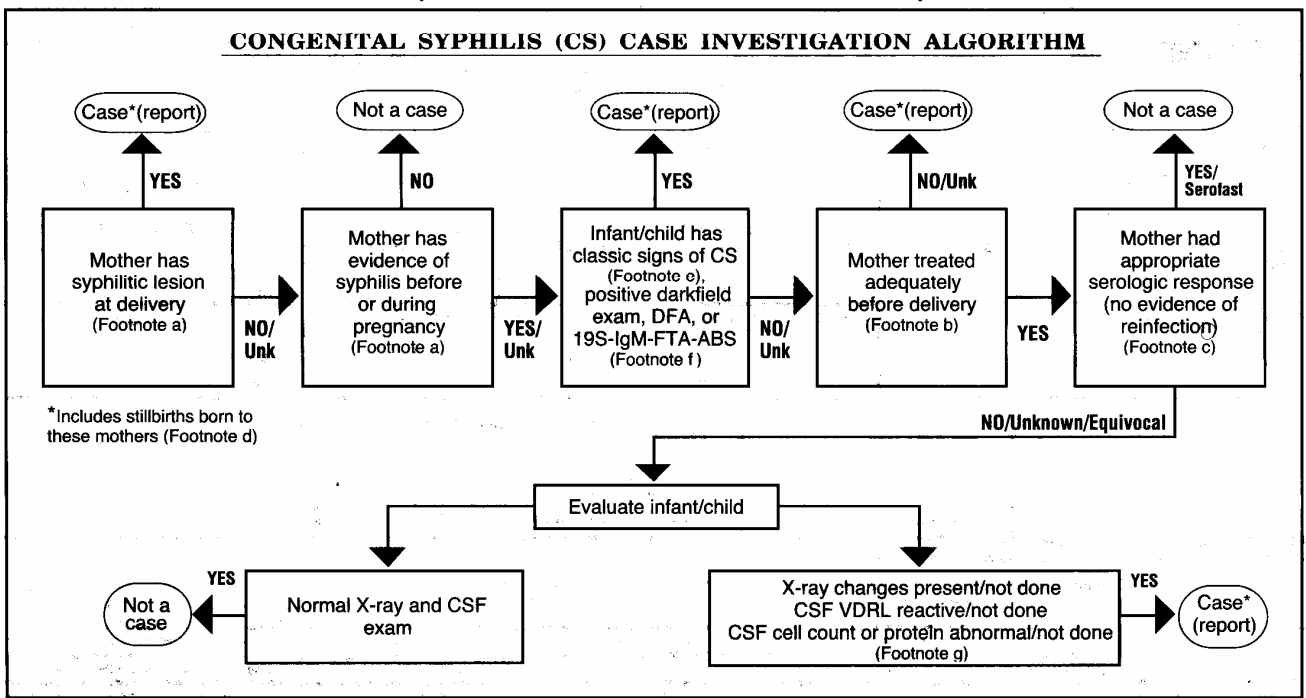
**d)** A syphilitic stillbirth is defined as a fetal death in which the mother had untreated or inadequately treated syphilis at delivery of a fetus after a 20-week gestation or weighing >500 grams.

**e)** Signs of CS (usually in an infant or child <2 years old) include: condyloma lata, snuffles, syphilitic skin rash, hepatosplenomegaly, jaundice due to syphilitic hepatitis, pseudoparalysis, or edema (nephrotic syndrome and/or malnutrition). Stigmata in an older child may include: interstitial keratitis, nerve deafness, anterior bowing of shins, frontal bossing, mulberry molars, Hutchinson's teeth, saddle nose, rhagades, or Clutton's joints.

**f)** The 19S-IgM-FTA-ABS is highly sensitive and specific in untreated neonatal syphilis. Other IgM-based treponemal tests are in use or in development. These are not yet considered standard tests of syphilis and should not be relied upon to define a case of CS. For specific questions regarding IgM-based treponemal test(s) being used in your area, contact the Division of STD Laboratory Research (404) 639-3224.

**g)** In the immediate newborn period, interpretation of these tests may be difficult; normal values vary with gestational age and are higher in preterm infants. CSF cell count and protein in a term or preterm infant should be interpreted by the clinician. Beyond the neonatal period, a CSF cell count >5 wbc/mm<sup>3</sup> or a CSF protein >40 mg/dl is abnormal, regardless of CSF serology.

(See instruction booklet for more details)



## **Interviewing/Counseling**

Successful interviewing of early Syphilis cases should impart accurate information about the medical and social aspects of congenital Syphilis to the patient. The communicable disease specialist should attempt to convince the patient of the importance of congenital Syphilis control and of the key role the patient can play. When interviewing men or women diagnosed with Syphilis, the CDS should attempt to elicit names of acquaintances (i.e., clusters) that may be pregnant.

## **Program Expectations**

### 1. Female Cases:

- a. All females should be asked if they have delivered an infant during the preceding year. If so, serologies should be obtained on any infant born during the time the mother was likely to have been infected. If delivery has been during the past three months, treatment of the infant would also be indicated.
- b. If the female is currently pregnant, the prenatal care provider should be contacted to assure follow-up of the mother and infant according to established guidelines.

### 2. Male Cases:

All males should be asked if any of their female contacts are pregnant or delivered an infant during the past year. If so, these contacts should be considered of the highest priority so as to be examined as soon as possible.

### 3. Clustering:

Cluster interviewing should stress the identification of women who are pregnant or who have recently delivered, to assure their examination.

## **Investigation**

### ***Minimum process performance standard:***

All newborn reactive serologies should be investigated. A Congenital Syphilis follow-up worksheet should be completed on all newborn reactors who meet the surveillance case definition for reporting Congenital Syphilis. This should be forwarded to the STD Section within 30 days of becoming aware of the reactor.

Note: See previous pages for additional interviewing and investigation standards for early Syphilis.

## **VII. Gonorrhea**

### **Screening**

An estimated one million new infections with *N. Gonorrhoeae* occur in the United States each year. Many infections among women do not produce recognizable symptoms until

complications such as PID have occurred. Because gonococcal infections among women are often asymptomatic, a primary measure for controlling Gonorrhea has been the screening of high-risk women. Through selective screening at public and private clinics, each district has the ability to identify and bring to treatment individuals who have gonococcal infection or its complications. All screening sites, which send specimens to the State Lab, a Regional Lab or a local Public Health lab, should be routinely visited in order to assess quality control standards. Written records of these visits should be kept.

#### Procedures for follow-up of Positive Gonorrhea Tests

1. Positive Gonorrhea test results received at the STD Surveillance Unit, that need follow-up outside Georgia, will be mailed to the appropriate state.
2. For in-state positive Gonorrhea test results reported to the STD Surveillance Unit, for both private and public laboratories, morbidity information will be processed into the STD/MIS system.
3. Field Records will be initiated on untreated positives reported to the districts from the State/Regional/Local Public Health Laboratories.
4. When follow-up, including verification of treatment, has been completed on positive Gonorrhea test reported to the districts, the white copy of the dispositional Field Record will be mailed to the State STD Surveillance Unit. Treatment information will be added to the morbidity record already in the STD/MIS system.

#### **Interviewing/Counseling**

All Public Health clinic clients diagnosed with Gonorrhea should receive counseling about their infection and partner notification by the clinician, including discussion of consequences to partners if not treated, and consequences to themselves from reinfection if partners are not treated before further sexual contact. They should emphasize that clients must have their sex partners evaluated and treated as soon as possible. Based on local priorities and availability of CDS staff, certain Gonorrhea clients may be referred to a communicable disease specialist for an interview. These may include STD repeaters and women with pelvic inflammatory disease. All clients should be offered partner notification assistance according to their specific needs.

Sex partners of all clients with Gonorrhea should be evaluated and appropriately treated if their last sexual contact with the client was within 60 days prior to the client's symptoms or positive test. Women diagnosed with pelvic inflammatory disease, with Gonorrhea test results pending, should also be interviewed for sex partners from a period of 60 days prior to treatment. The most recent sex partner should be treated if the last exposure was prior to 60 days.

#### ***Minimum process performance standards for CDS:***

## **VIII. Chlamydia**

Infections caused by *Chlamydia trachomatis* are recognized as the most prevalent and among the most damaging of all STDs. More than 4 million Chlamydial infections occur annually. Adolescent and young adults are at substantial risk of becoming infected with Chlamydia, and symptoms are often absent or minor among most infected women and many men. This large group of asymptomatic and infectious persons sustains transmission within a community.

Every effort should be made to ensure that infected persons are adequately treated and that the sex partners of women, especially those diagnosed with Pelvic Inflammatory Disease (PID), are followed and treated. Field follow-up may be needed to motivate asymptomatic women and their partners to be treated.

### ***Screening***

Various tests are available for Chlamydial infection. However, many tests are not available in all public health clinics. Since many cases of the syndromes of Non-Gonococcal Urethritis (NGU), Pelvic Inflammatory Disease (PID) and Epididymitis are probably caused by *Chlamydia Trachomatis*, those syndromes may be diagnosed on clinical grounds and treatment to cover *C. Trachomatis* given accordingly.

### **Procedures for Follow-up of Positive Chlamydia Tests**

1. Positive Chlamydia test results received at the STD Surveillance Unit that need to be followed outside of the state will be mailed to the appropriate other state immediately.
2. For in-state positive Chlamydia test results from private laboratories, the STD Surveillance Unit will process morbidity information into the STD/MIS system.

### **Interviewing/Counseling**

Besides giving infected clients information about Chlamydia and its treatment (see Clinical Section), clinicians should discuss the management of their sex partners, including consequences to partners if not treated, and consequences to themselves from reinfection if partners are not treated before further sexual contact. They should emphasize that clients must have their sex partners evaluated and treated as soon as possible. Based upon availability of CDS staff and the need for assistance with partner referral, clients may be referred to a CDS for an interview.

For all clients with diagnosed genitourinary Chlamydia infections the referral period for partners is 60 days before the date of the client's examination/test. For those women diagnosed with PID, the interview period is 60 days prior to the date of treatment. If no exposure has occurred within these specified periods, the most recent sex partner should be evaluated and treated.

### ***Minimum process performance standards:***

1. Interview at least 70% of all Chlamydia cases referred for interview, within 3 workdays of receiving the referral, with notification of sex partners from the above time period.
2. During the interview, obtain a complete description and two items of locating information at least 75% of the time on each partner Field Record initiated.

## **Investigation**

### **A. Follow-up of positive test results:**

Chlamydia Program Protocols state that screening sites must have a written plan for follow-up of positive Chlamydia test results. Plans will include a provision for a minimum of two documented attempts to be made to contact the client, by telephone or mail, for all positive test results. The first attempt must be initiated within one working day of receipt of test results. If attempts to reach the client by telephone and mail are unsuccessful in bringing her in to treatment, and communicable disease specialists are available, it is strongly urged that clients be notified in person.

#### ***Minimum process performance standards:***

1. Initiate a Field Record on all reported public untreated positives and non-public positives when the provider has requested assistance immediately. Begin investigation within 24 hours of receiving test results.
2. Bring to treatment at least 70% of untreated public positives and 65% of referred non-public positives within 3 workdays of receiving test results.
3. Thoroughly document all investigative activities (dates and times of phone calls, field visits, failed appointments, etc.) on the back of the cardboard copy.

### **B. Follow-up of partners:**

#### ***Minimum process performance standards:***

1. Examine and treat at least 65% of initiated partners within 3 workdays of the interview.
2. Thoroughly document all investigative activities (dates and times of phone calls, field visits, failed appointments, etc.) on the back of the cardboard copy of all Field Records.

#### ***Additional program expectations:***

1. Ensure adequate treatment of at least 90% of public and referred non-public cases of Chlamydia.
2. For clients interviewed, begin all partner/cluster field investigations immediately upon completion of the interview; all available pre-investigative materials such as telephone directories, city directories and closed Field Records should be utilized prior to initiating follow-up.

3. Assure the private laboratories report Chlamydia-screening positives to the district program or to the Epidemiology and Prevention Branch daily on the Notifiable Disease Report Form (form 3095).
4. Visit private laboratories within the district. Visits should be made more frequently if problems arise.
5. Supervisors should maintain quality assurance by performing routine reviews of employee work, depending on employee experience and identified problems.

This may start with at least one review of open field work (pouch review), case review, interview audit and field audit per month for new employees or after problems have been identified, and progress to quarterly reviews for veteran employees for whom no recent problems have been identified.

## **IX. Other STDs**

Preventing the spread of STDs requires that persons at risk for transmitting or acquiring infections change their behaviors. The health care provider has an opportunity to assist the client in identifying risks and in making a realistic plan, with incremental steps if necessary, to avoid acquiring or transmitting STDs.

The disease intervention methodologies and standards for screening, interview/counseling and epidemiologic field investigation described for Syphilis, Gonorrhea, and Chlamydia may be utilized for outbreaks of any of the other sexually transmitted diseases. It is the prerogative and responsibility of the State STD Section and each district to devise and implement surveillance and control procedures for any STD when it is deemed appropriate.

The guidelines for identification, treatment and counseling of clients with other STDs are found in the preceding Clinical Section of this manual.

## **X. HIV Infection**

This section contains standards for HIV Prevention Counseling and investigation activities as they relate to HIV partner notification services. For additional information and discussion, see the Division's Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV) Policy manual.

Partner notification and provider referral of partners will be offered to both anonymous and confidentially tested HIV positive clients. However, the Division of Public Health will not initiate follow-up or make contact with an HIV positive person reported by a private physician or laboratory without first obtaining the physician's permission.

### **A. HIV Prevention Counseling and Partner Elicitation**

1. Interview at least 70% of all public uncomplicated Gonorrhea cases referred for interview, within 3 workdays of receiving the referral, with notification of sex partners from the above time periods.
2. During the interview, obtain a complete description and two items of locating information at least 75% of the time on each Field Record initiated through interviewing.

### **Investigation**

Partner notification by the health department staff should be performed if requested by the patient or if patient referral is inappropriate.

#### ***Minimum process performance standards:***

1. Initiate a Field Record on all reported public untreated positives, and non-public positives when the provider has requested assistance, immediately. Begin investigation within 24 hours of receiving test results.
2. Bring to treatment at least 70% of public and 65% of referred non-public untreated positives within 3 workdays of initiation.
3. Examine and treat at least 65% of initiated partners within 3 workdays of interview.
4. Thoroughly document all investigative activities (phone calls, field visits, failed appointments, etc.) on the back of the cardboard copy of all Field Records.

#### ***Additional program expectations:***

1. Ensure adequate treatment of at least 90% of all public cases and referred non-public cases of Gonorrhea.
2. For clients interviewed, begin all partner/cluster field investigations within 24 hours of completion of the interview; all available pre-investigative materials such as telephone directories, city directories and closed Field Records should be utilized prior to initiating follow-up.
3. Assure that public state/regional/county laboratories appropriately report positive Gonorrhea results.
4. Ensure that private laboratories report Gonorrhea screening positives to the district program or to the Epidemiology and Prevention Branch daily on the Notifiable Disease Report Form (Form 3095).
5. Visit private laboratories within the district at least annually. Visits should be made more frequently if problems arise.
6. Supervisors should maintain quality assurance by performing routine reviews of employee's work, depending on employee experience and identified problems. This may start with at least one review of open field work (pouch review), case review, interview audit and field audit per month.



1. Partner notification services will be offered to every client on the initial and subsequent post-test positive counseling sessions or clinic visits. During each session, all feasible options should be explored with the client to ensure that all at-risk and/or needle-sharing partners are identified, located and offered an HIV test.

While timing of an initial partner elicitation interview should allow the client sufficient time to deal with his/her positive status, receive a clinical evaluation/referral and a psychosocial needs assessment, the welfare of partners needing notification must also be considered. Because the emotional status of clients will vary, a specific time frame is impossible to define. However, the interview should occur as soon as reasonably possible.

**Note:** If the client claims to be positive from a previous test that cannot be documented, he/she should be retested before being interviewed and receiving partner notification assistance.

**Note:** When a minor, or an adult in the care of a guardian of the state, tests positive, the counselor will discuss with the client the desirability of informing his/her parent or guardian.

2. In order to maintain consistency of counseling messages, the post-test positive counseling session must be conducted by staff trained to perform HIV prevention counseling. In order to be trained in HIV prevention counseling, staff must attend and satisfactorily complete DHR approved training courses. All district CDS staff (HIV, STD, and TB) should be cross-trained in HIV prevention counseling.
3. During the post-test prevention counseling session, the counselor should provide the HIV seropositive client with a copy of his/her positive laboratory report if it is available. If the client has been tested in another district or state (intrastate or interstate out-of-jurisdiction) and if a copy of the positive laboratory report is sent to the area providing the client's prevention counseling, the outer envelope should be marked "CONFIDENTIAL-OPEN BY COMMUNICABLE DISEASE SPECIALIST SUPERVISOR OR ADDRESSEE ONLY."
4. Because of the seriousness of the disease and the fact that it is not clear when someone might have become infected with the virus, communicable disease specialists must attempt to elicit all sex and needle-sharing partners for whom locating information is available. Regardless of the client's current marital status, state law mandates that all exposed spouses from within seven years be notified. Per Ryan White funding requirements, all spouses from within ten years of the diagnosis of HIV infection must be notified.
5. An Interview Record (CDC 73.54) will be completed for all HIV positive clients who receive prevention counseling and partner notification

services. The interview record will serve as an evaluation tool for prevention, early intervention and partner notification actions per program standards.

Note: A 73.54 that omits demographic information such as name, address, telephone number, etc., should be completed on anonymously tested clients receiving prevention and partner notification services.

Field Records will be initiated for all partners and clusters needing investigation.

6. During the interviewing and investigation phases, individuals who are not partners, but may be at high risk, should be identified through the clustering process. Priority should be given those individuals who have symptoms associated with HIV disease (S1 or A1) and those individuals who have been or may have been exposed to HIV positive persons (S2 or A2). Additional individuals who may be at risk for exposure to HIV positive persons (S3 or A3), especially pregnant women or women who have given birth within the past two years should be considered for investigation and referral.

## **B. Seropositive clients not returning for test results**

1. If the seropositive client does not return for his/her test result within 3 workdays of his/her scheduled appointment, an investigation is necessary for post-test HIV prevention counseling. A Field Record (CDC 73.2936S) will be initiated by the testing site and assigned for follow-up. If the HIV positive client lives in, or has relocated to another district and post-test counseling is needed, a copy of the positive laboratory report will be forwarded to the district responsible for providing the HIV counseling and follow-up prior to that district performing the counseling.
2. In order to schedule a new appointment for test results, the client may be contracted by field visit, telephone or mail. Since the investigator has the least amount of control over confidentiality when using the mail, field visits and telephone calls should be performed whenever possible.
  - a. When a field visit is conducted, every effort should be made to establish face-to-face contact with the client to give him/her the appointment to return for “test results.” If an appointment notice is left in the field for the client (residence, workplace, etc), a generic referral slip which does not make any reference to HIV should be left in a plain, sealed envelope marked “confidential.” The referral slip should list the investigator’s name and phone number.
  - b. When the client is contacted by telephone, he/she should be requested to return to the clinic for his/her “test result.” No reference to HIV or

AIDS will be made over the telephone. Test results will not be given over the telephone.

- c. When an appointment notification is mailed to the client, the generic referral slip that does not make any reference to HIV or AIDS should be sent in a plain, sealed envelope marked “confidential.” The referral slip should list the investigator’s name and phone number.
3. It is highly recommended that all post-test positive prevention counseling be conducted in the clinic. This allows the counselor ready access to support resources should the client have difficulty coping with his/her positivity status. However, the CDS must be prepared to provide post-test positive prevention counseling in the field as necessary. HIV seropositive prevention counseling and partner notification performed in the field must occur in a private and confidential setting.

### **C. Partner notification activities**

1. Priority should be given to the following sex and/or needle-sharing partners when conducting notification activities:
  - a. Pregnant females and women of child-bearing age
  - b. Spouses of HIV seropositives (legally mandated)
  - c. Victims of AIDS-transmitting crimes (legally mandated)
2. Field Records will be initiated for all partners and clusters needing Notification and sufficient locating or identifying information is available. The original seropositive client’s name will not be documented on the Field Record of any partner/cluster.
3. The client who wishes to notify his/her on own partners should be encouraged to do so. The HIV counselor should provide referral cards/notes and negotiate a contract with the client that defines the following:
  - a. When and how the client will notify each partner/cluster
  - b. What the client will say to each partner/cluster
  - c. When and where each partner/cluster will be referred
  - d. That a field worker will contact a partner/cluster who does not respond to an agreed upon referral to the public health clinic within three workdays.
4. If the client-referred partner/cluster fails to keep an agreed upon appointment within three workdays of the interview, then the communicable disease specialist (or other field worker) will attempt to contact the partner/cluster by field visit, telephone or mail. Since the investigator has the least amount of control over confidentiality when

using the mail, field visits and telephone calls should be performed whenever possible.

- a. When a field visit is conducted, every effort should be made to establish face-to-face contact with the partner/cluster. If an appointment notice is left in the field for the partner/cluster (residence, workplace, etc.) a generic referral slip which does not make any reference to HIV should be left in a plain, sealed envelope marked “confidential.” The referral slip should list the investigator’s name and phone number only.
  - b. When the partner or cluster is contacted by telephone, arrangement should be made for the investigator and the partner/cluster to meet to discuss “an important health matter” or that the partner/cluster has been exposed to an infectious disease. No reference to HIV or AIDS will be made over the telephone. Face-to-face notification is required to acknowledge specific exposure of HIV.
  - c. When an appointment notice is mailed to the partner or cluster, the generic referral slip which does not make any reference to HIV or AIDS should be sent in a plain, sealed envelope marked “confidential.” The referral slip should be sent in a plain, sealed envelope marked “confidential.” The referral slip should list the investigators’ name and phone number only.
5. Once located, the partner or cluster will be counseled about his/her exposure to HIV and encouraged to be tested. A specific appointment should be given for testing. If this individual fails to keep the appointment, a second visit should be made to reinforce the importance of being tested. If the partner/cluster fails to keep two appointments, it will be the responsibility of the communicable disease specialist supervisor (or other designated person) to determine if further follow-up should be attempted. Frontline supervisor must conduct investigations on all field records dispositioned as “J.”
  6. The investigator may provide confidential pre-test counseling and draw the blood specimen in the field as an alternative to a clinic appointment for HIV testing. However, a clinic appointment for post-test counseling should be given to the partner/cluster whenever possible.
  7. When talking with the partner/cluster, the identity of the infected original client, the date of exposure to that client, the location of the exposure cannot be revealed or acknowledged by the investigator. The following specific messages would be delivered to the partner/cluster:
    - a. His/Her possible exposure to an HIV infection and the meaning of the exposure.

- b. Actions that can be taken to reduce the risk of exposure or infecting others in the future.
- c. Motivations to seek further counseling and HIV antibody testing.
- d. If he/she refuses testing, it is in his/her best interest, as well as the community's best interest, to practice safe behavior as though seropositive.

Appropriate written information should be given to the partner/cluster reinforcing the above messages.

- 8. A partner or cluster that cannot be located after every reasonable attempt, including field investigation, may be dispositioned as "H" (unable to locate) following consultation with the communicable specialist supervisor or other designated person.
- 9. All investigative activities (dates and times of phone calls, field visits, failed appointments, client's refusal of testing, etc.) must be documented on the back of the green cardboard copy of field record. The documentation should clearly and accurately reflect what has occurred.
- 10. Out-of-jurisdiction (intrastate or interstate) HIV partner notification will be handled in the same manner as out-of-jurisdiction Syphilis investigations.

#### **D. Syphilis/HIV co-infected clients**

Persons diagnosed with early Syphilis should be informed of their increased risk of HIV infection and strongly encouraged to be tested. Individuals diagnosed with Syphilis who choose HIV testing should be informed that if the HIV test result is positive, then partners named during the original Syphilis interview may be notified of their exposure to HIV. Every attempt will be made to notify the original patient of his/her positive HIV results prior to notifying the partners. However, if the seropositive client cannot be located, HIV partner notification will take place without further delay.

Consideration might be given to using a one-year interview period for individuals diagnosed with primary or secondary Syphilis who choose HIV testing. If the original Syphilis client's HIV test results are positive, the one-year interview period may identify additional partners of the seropositive patient who would need notification of exposure to HIV.

#### **Interviewing/Counseling**

##### ***Minimum process performance standards:***

- 1. Counsel at least 70% of public HIV seropositives within 3 working days of Field Record initiation (3 working days after failure to keep appointment for test results). Counsel at least 65% of non-public positives within 3 working days of the provider's request.

2. For program expectations regarding original interviewing HIV seropositives for partner notification, see Item #1 under “Additional program expectations” below.
3. Reinterview selected seropositive clients relative to epidemiologic intelligence obtained through field investigations. If it is determined that a patient needs to be reinterviewed, the initial reinterview should occur within 5 workdays of the original interview at least 75% of the time on each partner Field Record initiated.
4. During the interview, obtain a complete description and two items of locating information at least 75% of the time on each partner Field Record initiated.

### **Investigation**

#### ***Minimum process performance standards:***

1. Initiate Field Records on public seropositive clients who do not return for test results within 3 workdays after their appointments. Begin investigation within 24 hours of initiation.
2. Bring to counseling at least 70% of public and 65% of referred non-public HIV seropositive clients within 3 workdays of Field Record initiation.
3. Provide counseling/testing to at least 60% of partners within 3 workdays of the interview (provider-referred partners) or failure to keep the appointment (client-referred partners).
4. Documented all investigative activities (dates and times of phone calls, field visits, failed appointments, etc.) on the back of the cardboard copy of all Field Records.

#### **Additional program expectations:**

1. Interview all locatable public and referred non-public HIV seropositives for partners and cluster suspects, and selected partners for associates, with emphasis on S-1's, S-2's, A-1's and A-2's. The original interview should take place only after the client has had sufficient time to deal with his or her positive status, but as soon as he/she is able to participate in a productive interview.
2. Begin all provider-referral partner/cluster field investigations immediately upon completion of the interview; begin client-referral field investigations after the partner/cluster has failed to appear at the clinic within 3 workdays of the original interview. All available pre-investigative materials such as telephone directories, city directories and closed Field Records should be utilized prior to initiating follow-up.
3. Supervisors should maintain quality assurance by performing routine reviews of employee work, depending on employee experience and identified problems. This may start at least one review of open field work (pouch review), case review, interview audit and field audit per month for new employees or after problems have been identified, and progress to quarterly reviews for veteran employee for whom no recent problems have been identified.

4. Complete and submit monthly (by the 15<sup>th</sup> of the following month) to the STD Section the Results of HIV Prevention Counseling and Partner Notification Form.

## **XI. Process Evaluation of Disease Intervention Activities**

The following pages contain an audit format to allow for in-depth analysis of individual or programmatic disease intervention activity for priority STDs. The audit format is divided into components of the program with each component listing process performance standards. Interview Records (73.54) and Field Records (73.2936S) should be utilized on all interviewed cases of Syphilis, HIV infection, Gonorrhea and Chlamydia. These records should be retained for a minimum of one year, to allow for evaluation and quality control.

It is recommended that the communicable disease specialist supervisor do periodic appraisals of various program components and individual communicable disease specialists utilizing the format and methods contained herein. This will allow for frequent and timely program evaluation and planning.

For additional program expectations see each specific disease section on previous pages.

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# STD Field Services Division Program Guidelines

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## **Section XIV**

### **STD Field Services Division Program Guidelines**

#### ***Follow-Up with Infected Clients and Contacts***

##### **Policy**

Partner services shall be offered to individuals who are infected with STD, to their partners, and to other persons who are at increased risk for infection in an effort to prevent transmission of these diseases and to reduce suffering from their complications.

##### **Standard Expectations**

1. Provide information regarding current infection(s) and other STDs;
2. Ensure confidential notification, appropriate medical attention, and appropriate social referrals for partners and other high-risk individuals;
3. Using client-centered counseling to develop risk reduction plans to reduce the likelihood of acquiring future STDs;
4. Provide needed referrals to additional medical or social services; and
5. Define and better target the at-risk community while assuring complete confidentiality for the patient.

##### **Procedures & Implementation**

1. When a client is diagnosed with an STD the Communicable Disease Specialist (CDS) must introduce themselves, their role in providing additional STD services, and stress confidentiality. CDS shall educate client on the infection they have, how to manage the infection, taking medication, risk reduction, and partner referral.
2. Conduct an original Interview on the client.

CDS Staff should cover the following during an Original Interview:

- a. Reason for exam
- b. Signs/symptoms, previous STD history/treatment
- c. Medical history
- d. Use of Viagra, Cialis, Levitra, or other sexual/erectile dysfunction drugs
- e. Alcohol and/or drug history
- f. Referral of Sexual partners, suspects, and high-risk individuals
- g. Risk Reduction Plan (Client-centered)
- h. High Risk Areas, venues (e.g., areas with prostitution, drugs, bath houses, bookstores, clubs, etc.)

- i. Patient feedback, interaction, behavior or attitude
- j. Referral for services (e.g., substance abuse, mental health, HIV, Gyn, etc.)

## ***Partner Elicitation***

### **Policy**

Programs shall provide CDS and managers with the tools, training, and resources necessary to conduct partner services successfully.

### **Standard Expectations**

1. Interview rooms that are quiet and contain at least a desk or table, chairs, a telephone, and appropriate support materials should be readily accessible to the CDS.
2. CDS should have access to appropriate STD clinic patient records, program interview and investigative files, relevant maps, telephone books, and cross directories.
3. Investigative resources should be carefully developed and maintained.
4. At minimum, efforts should be made to develop access to department of motor vehicles (DMV), welfare, utilities, post office, local schools, and health department records.

### **Procedures & Implementation**

1. Designate an office complete with necessary tools for CDS staff to conduct interviews
2. Establish a procedure for CDS staff to access client health records to aid in investigative activities.
3. Update and distribute to CDS staff telephone books, cross-directories, maps, and investigative forms.
4. All STD investigation forms such as lab reports, field records, case files, and computerized client health information must be locked and/or secured on computers at all times when not in use.
5. Only managers, supervisors, and a designated CDS staff should have keys to the aforementioned information and specific passwords, and administrative rights to computerized and electronically stored client health information.

## ***Partner Elicitation & Referral***

### **Policy**

Partners referred to the STD clinic as a result of being exposed to a disease shall be tested, examined, and possibly treated.

### **Standard Expectations for Syphilis Investigations**

1. Clients referred to the STD clinic who are exposed to an STD within the preceding 90 days, even if the Syphilis test is negative, the client may be incubating Syphilis and shall be examined, tested, and presumptively treated for Syphilis according to the latest CDC STD Treatment Guidelines.
2. Clients referred to the STD clinic and last sexual exposure to the original patient is greater than 90 days, and the Syphilis test is negative, presumptive treatment is not needed. However, presumptive treatment should be considered in the event of a Syphilis outbreak in the community.
3. Partners exposed to Syphilis that present to the clinic as a result of having sex with an infected person shall be treated for Syphilis always if the Syphilis lab result is positive. Positive contacts must be given an original interview and pursuit of partners must take place.

Recommendation: Clients that present to the clinic as a result of an exposure to an infected person should be treated for Syphilis.

### **Procedures & Implementation**

1. CDS Staff must explain clinic services, fees (if applicable) hours of operation, and what the referred contacts should say upon arrival to the clinic.
2. If clients have barriers such as transportation, CDS should arrange transportation for clients to receive care.
3. CDS staff should discuss the case(s) the contacts are linked to, CDC recommendations for exam, labs, and treatment options with health care providers delivering services to the client.

## ***Partner Elicitation & Cluster Interviewing***

### **Policy**

Partners that test negative for Syphilis shall be cluster interviewed for additional contacts, areas, and venues where high-risk people can be offered STD services. Emphasis should be placed on gathering more information around the Original Patient without breaking confidentiality to gain increased knowledge of the Original Patient's activities, lifestyle, and additional contacts, if named during the Cluster Interview.

Cluster Interviews are essential to identifying infected persons and the Original Patient's source. Care must be taken never to indicate that any specific person is infected with any disease, has been exposed to disease, or has been examined for disease.

### **Standard Expectations**

1. CDS shall explain to uninfected clients why it is in his or her personal interest to discuss partners and other high-risk persons and that behavior of others to reduce the risk of disease in his or her social network; and
2. Give easily understood information about the disease to which he or she has been exposed, and ways to avoid similar risk in the future.
3. Clustering Interviewing shall be conducted and are particularly helpful in outbreak situations.
4. Contacts named by the original patient that are not sex partners shall be elicited by CDS through "**clustering.**" These contacts are called "**suspects.**" Contacts named by others named on a case are called "**associates**" because the original patient did not name them.

#### Three Types of Suspects & Associates

1. Person with signs and symptoms suggestive of infection
2. Persons who had sex or shared needles with a known case;
3. and, friends, acquaintances, persons within the same social group, roommates, sex partners outside the interview period, infants and small children of clients, pregnant women not seeking prenatal care, and anyone else deemed at risk (e.g., those who trade sex for drugs or money).

### **Procedures & Implementation**

1. All contacts with negative Syphilis serologies and no signs and symptoms should be Cluster Interviewed after CDS receives the results.
2. Cluster Interviewing shall be conducted and is particularly helpful in outbreak situations.
3. When notifying suspects and associates that fall in categories 1, and 2 it is encouraged that CDS follow this format:

**(S-1) (A-1)** “Hello my name is \_\_\_\_\_ and I work for the \_\_\_\_\_ health department. We are noticing an increase in infectious Syphilis in this area and I’ve noticed that you have signs and symptoms suggestive of Syphilis [**Show Pictures**]. When is a good time for you to come in for a Syphilis screening, the sooner the better because Syphilis is a serious infection and if left untreated can cause serious health problems?” [**This is a good time to offer a field blood**]

**(S-2) (A-1)** “Hello my name is \_\_\_\_\_ and I work for the \_\_\_\_\_ health department. According to information gathered from a person infected with Syphilis that gave your name, I have reason to believe you may have been exposed to Syphilis and I want to arrange for you to come in for a test, exam, and treatment, if needed. Have you ever seen anything like this on someone or on yourself [**Show pictures**]? [**This is a good time to offer a field blood**]

**(S-3) (A-3)** “Hello my name is \_\_\_\_\_ and I work for the \_\_\_\_\_ health department. I am so glad I got in touch with you. Someone was recently treated for Syphilis and when asked who else would benefit from a test they cared enough to suggest you.

## ***Prioritizing Partners & Contacts for Disease Intervention***

### **Policy**

Once field records have been completed for notification of partners, suspects, and associates, they should be prioritized to ensure that those at highest risk are contacted and interviewed first.

### **Standard Expectations**

1. Once field records are initiated for field follow-up CDS shall prioritize them to reach contacts at highest risk.

### **Hierarchy of Prioritizing Field Records**

#### **➤ Pregnant females who have:**

- a. Reactive STD or HIV
- b. Contact to Syphilis and/or HIV
- c. Women of childbearing age and all adolescents 16 and under with positive HIV and/or Syphilis
- d. Females of childbearing age, believed or known to be pregnant suspects and associates named in early Syphilis cases identified as having symptoms or who are associated with known highly infectious cases.

#### **➤ All Clients who are:**

- a. Persons with STDs and infectious symptoms with no treatment
- b. Persons with positive HIV tests who have been post-test counseled
- c. Contacts exposed to HIV, and/or infectious Syphilis
- d. Priority requests for assistance from local health districts and/or local providers
- e. Suspects and associates named in early Syphilis cases identified as having symptoms or who are associated with known highly infectious cases.

#### **➤ Second Priority:**

- a. Contacts to Syphilis of unknown duration
- b. Clients that have been treated for STD and need interviews only
- c. HIV positive clients that have been post-test counseled needing interview only
- d. Re-interviews of pregnant women treated for Syphilis, persons treated for early Syphilis
- e. Cluster Interviews of uninfected clients

#### **➤ Third Priority:**

- a. All other suspects and associates to Syphilis cases of unknown duration
- b. Re-interview of persons treated for other stages of Syphilis and/or HIV positives

➤ **Considerations:**

- a. Reactor Grid should be used for initiation and follow-up of Syphilis reports
- b. Supervisor must consider their county needs
- c. Travel concerns and field efficiency must be considered

**Procedures & Implementation**

1. CDS will prioritize field records based on the criteria listed above in the Standard Expectations.

## ***Case Management Tools***

### **Policy**

Programs must ensure that CDS and managers possess the tools, training, and resources necessary to conduct program business.

### **Standard Expectations**

1. Programs shall ensure CDS have appropriate tools to collect behavioral risk data (e.g., Original Patient Information Sheet)
2. Programs shall ideally store and retrieve information electronically
3. Programs shall make maximum possible use of current technology to facilitate CDS record keeping and case management, including computer storage and case analysis software when available.
4. Programs shall provide for the security and confidentiality of all client information on cases, in Lot files, field records, notebooks, etc.

### **Procedures & Implementation**

2. Maintain a contact at the CDC to assure the above supplies are available and delivered to the program.
3. Designate a secure area with locked file cabinets, locked room doors, with access limited to STD Program Managers and CDS staff where cases, field records, computers, and any identifying patient information will be secure and confidential.
4. Programs shall prepare for the possibility of new data collecting systems to be implemented and used in the program in addition to STD\*MIS (e.g., SENDSS, PAM).



## ***Case Management Pre-Interview Analysis***

### **Policy**

CDS shall identify, research, and analyze information that may facilitate an effective and positive interaction with the client during the original interview.

### **Standard Expectations**

1. CDS or designated staff shall conduct provider calls and/or interview medical records to gather information pertaining to the client (e.g., reason for exam, signs & symptoms, history, socio-sexual information, etc.).
2. CDS or designated staff shall conduct record searches on all STD clients initiated to the field.
3. CDS must use maps and/or access website driving directories.
4. CDS shall assemble necessary materials and supplies such as visual aids (SD pictures), writing material (notepad), business cards, disease-specific brochures, referral forms and envelope.

## ***Case Management Original Interview Session***

### **Policy**

CDS shall conduct original interviews on clients infected with Syphilis and/or HIV. The objective for the original interview is to prevent further transmission of disease through the prompt identification and examination of all elicited partners, suspects, and associates.

### **Standard Expectations**

1. Conduct the original interview within 72 hours of assignment.
2. CDS shall provide face-to-face original interviews in the clinic, at the client's place of residence, or some suitable private place.
3. CDS must elicit or confirm all information necessary and provide appropriate case management to complete the interview record.
4. CDS shall obtain a commitment from the client to pursue identified information needs, establish appointment for a re-interview, and determine the best time(s) and alternate methods for reaching patient.
5. Arrange for a field tour with the client to identify home addresses, locations where partners and contacts hang out, where the client met the partner, etc., when necessary
6. CDS shall address any questions and/or concerns clients have, provide assurance on any problem areas, restate commitments, provide information, and plan for the re-interview.

### **Procedures & Implementation**

1. CDS will use information to contact clients via telephone, field visits, and leaving referrals to arrange face-to-face interviews in a safe and comfortable environment to the client and CDS.
2. CDS must use open-ended questions to gather as much information as possible from a client. Try to limit closed-end questions to avoid many yes and no answers.
3. During original interviews with clients, address the client's reason for exam, medical history, other medical problems, provider, locating information, demographics, lifestyle/behavior, partners, clusters, and develop risk reduction plan. CDS shall establish commitments and timelines for client to be involved in their personal health and the health of their partners, suspects, and associates. CDS shall explain their commitments to the client as well, such as, arranging re-interviews, partner notification, field tours, etc.
4. CDS shall address client questions and concerns about their infection, partner elicitation, risk-reduction, etc.

## ***Case Management When Clients Refuse Original Interview***

### **Policy**

When the client is resistant to the interview process, the CDS should attempt to determine the reason(s) behind the willingness to cooperate and address each issue and use motivational techniques to encourage the client to actively participate in the interview process.

### **Standard Expectations**

1. CDS shall address modes of transmission, confidentiality, asymptomatic nature of disease, re-infection, complications, consequences, Social responsibility, and risks of HIV.
2. Instruct the front-line Supervisor (FLS) to consider a change of interviewers to a CDS who may have success with encouraging the client to participate in the interview process.
3. Submit field record to the FLS for approval to close as a refused interview if no success in getting client to cooperate and agree to be interviewed by the CDS.

## ***Case Management and Re-Interviews***

### **Policy**

While the original interview is intended to elicit all interview period partners and suspects, the re-interview of persons with high-priority infections (HIV, early Syphilis, or other high-priority infections, based on local criteria) is warranted. Re-interviews are any interview sessions following the initial interview with an STD client.

Re-interviews are required on all clients that have clearly evaded discussing or referring all partners or suspects during the original interview.

### **Standard Expectations**

CDS shall conduct re-interviews to:

1. Gather additional information that may help prove or disprove a hypothesis about case relationships.
2. Address points not covered during the original interview.
3. Gather information to identify additional partners or suspects (clustering) to the original patient.
4. Support client risk-reduction attempts.
5. Support and reinforce a client's successful use of referred services.
6. Confront points that are illogical or that are disputed by other information.
7. Solicit assistance in locating previously named contacts who have not been located or are being uncooperative.
8. Document the results of re-interviews on a STD Re-interview Record within time lines established by the local program.
9. Assure that case write-ups (particularly priority Syphilis and HIV) are submitted by CDS within 24 hours.
10. Documentation of case submission by CDS and receipt of by supervisor must be written in the case file where dialogue between the supervisors and CDS are written.

### **Procedures & Implementation**

1. Arrange re-interviews with clients during original interview.
2. Re-emphasize confidentiality.
3. Stress importance of keeping previously made commitments.
4. Discuss problems with commitments made in the original interview.
5. Discuss new information learned about client's infection.

6. Stress risk-reduction plan previously developed in the original interview.

## ***Case Management and Risk Reduction***

### **Policy**

STD and HIV prevention counseling interviews shall be conducted according to CDC standards for prevention counseling, including a discussion of risk reduction strategies tailored to fit the client's specific needs.

### **Standard Expectations**

1. CDS shall assist clients with establishing reasonable risk-reduction skills to reduce their risks of STD.

## ***Case Management and Making Referrals***

### **Policy**

CDS should facilitate appropriate referrals to other available services in a tactful manner that does not interfere with disease intervention priorities.

Local programs should develop a community referral guide or directory, update the referral guide to keep current resources listed, including such services as:

- HIV Intervention
- Prenatal Care
- Family Planning
- Drug and Alcohol Counseling
- Tuberculosis
- Maternal and Child Health
- Mental Health
- Immunizations
- Intimate or Domestic Violence
- Sex Addiction Groups
- Crisis Intervention
- Rape Crisis
- Language Assistance
- Temporary Housing
- Family Counseling
- Legal Services
- Child Protective Services

### **Standard Expectations**

1. CDS shall make referrals to other medical and social services, although the focus of interactions is disease intervention.
2. CDS should remain sensitive to health or social needs of individuals served in the STD clinic or through the disease intervention process.

### **Procedures & Implementation**

1. When interviewing address socio-economic issues (e.g., homelessness, unemployment, need for prenatal care, etc.) and related concerns (domestic violence, gangs).
2. Provide appropriate referral information for social services that assist clients in navigating public service.

## ***Case Management Post Interview Activities (Documentation)***

### **Policy**

Concisely and legibly document the results of interviews, including case analysis, on the interview record and related program forms at the first reasonable opportunity not to exceed one workday

The interview record and related forms are never to be completed in the presence of the client. Interview and field records, whether on paper or in electronic format, must be viewed as legal and confidential documents. As such, every effort must be made to ensure that each record is complete, accurate, fully legible, and able to stand the test of careful scrutiny.

### **Standard Expectations**

1. In order to assure timely follow-up and achieve maximum disease intervention, review, update, and appropriately manage their open cases at least twice weekly to determine status and evaluate needs.
2. Document each time a case is reviewed and all activities leading to case closure.

#### ***Example of documenting case updates:***

“02/09/04 @ 2pm case reviewed, awaiting partner labs, OOJ dispositions, etc.”

3. Direct supervisors to review cases and clearly date, record, and initial all comments and directives.



## **Case Management: Visual Case Analysis (VCA)**

### **Policy**

CDS shall systematically document medical and epidemiologic facts related to early Syphilis cases. Visual Case Analysis (VCA) is an essential tool in Syphilis case management for analyzing data from multiple sources and shall be complete, accurate, and submitted with all early Syphilis cases.

### **Standard Expectations**

1. Complete VCAs for all early Syphilis cases accurately and completely.
2. Submit VCAs with all early Syphilis cases.
3. Use the VCA to determine the most likely hypothesis of disease spread, identify where disease intervention could occur, and develop a plan of action.
4. Re-interview clients about information gaps discovered through VCA that are conflicting with the course of disease, absent, but pertinent (for example number of partners, last exposure, symptom history, etc.)

### **Procedures & Implementation**

1. The original patient and all infected partners, suspects, and associates named in the case will be accurately plotted and complete on the VCA sheet. Information that must be on the VCA are:
  - Original Patient Name
  - Stage of Disease
  - Reason for Exam
  - Signs & Symptoms
  - Lab Date
  - Treatment & Date of Treatment
  - Infected Partners and all of the Information Previously Stated
  - Titer & Confirmatory
  - Interview Period
  - Inoculation Period
  - Ghosting (if needed)
  - Sexual Frequency
  - Source/Spread Analysis
2. Submit the VCA with all early Syphilis cases and update the VCA with new information while managing the case until closure.

## ***Case Management: Developing Plan of Actions (POAS)***

### **Policy**

Develop a client-centered plan of action for all cases. A plan of action is a road map describing the next steps the CDS will conduct after the interviews are completed. The plan of action may change as a result of new investigative findings and additional information is gathered around the original patient.

### **Standard Expectations**

1. Conduct a post-interview analysis and make decisions in efforts to intervene in disease spread.

### **Procedures & Implementation**

1. Review interview notes
2. Complete the VCA (Syphilis only)
3. Record search for information on partners to determine any prior medical or disease intervention history on the partners.
4. Utilize standard investigative resources to confirm locating information on all sex partners and accurately determine probable relationships, possible factual omissions, set priorities for field follow-up, and potential avenues to pursue future disease intervention strategies.

## **Case Management: Lot System & Lot System Forms**

### **Policy**

All Districts should use a Lot System. A Lot System ensures that all obtainable information regarding the continued management of cases contained in a Lot is readily available to all responsible workers.

CDS shall have access to information regarding other infections so they can have a comprehensive picture of the situation before further follow-up is conducted such as re-interviews and/or cluster interviews preference.

### **Lot System Forms**

All Lot files must have all required forms used in completing case information. The forms may vary in design. The following are recommended and/or required:

1. Major Analytical Points (MAP) sheet
2. Original Patient Interview Form
3. Cluster Sheet
4. Plan of Action
5. Case write-up
6. Visual Case Analysis (VCA) Syphilis only
7. Copy of medical record
8. Copy of closed field record

## ***Case Management: Case Closure***

### **Policy**

Submit all cases for closure when all possible disease intervention effort are made and the Supervisor agrees to close case in final review.

### **Standard Expectations**

1. By completing all re-interviews, cluster interviews, source spread analysis, and proper closure of field records, CDS can prepare case for closure.
2. Supervisors will make the final decision as to whether the case may be closed, document comments, and return to CDS agreeing to close.

### **Procedures & Implementation**

1. Assure all forms in each open case is completed according to stated guidelines
2. Follow-up on all lab reports and partner/cluster dispositions
3. Determine Source and Spread on cases
4. Document efforts made to address plan of action (e.g., notification of partners/clusters, and interviewing all infected partners) in order to close case.

## ***Field Services: Field Records***

### **Policy**

Initiate Field Records (form CDC 73.2936S) for all partners, suspects, and associates and document as a part of case investigation. Marginal contacts will be placed on “buffs” with the expectation that CDS will place importance on pursuing marginals and follow-up with the original patient to gather additional information to locate marginals, field tour, or establish a contract with the original patient to notify marginal partners. CDS will document all field investigations and activities on back of the field records.

### **Standard Expectations**

1. Document date, time, place, activity for all field visits, telephone calls, provider calls, and record searches pertaining to the client being followed.
2. At the end of each entry CDS will write their worker number to identify who wrote the entry.
3. Field records are legal documents so all written documentation must be in blue or black ink.
4. CDS will prioritize all assigned field records.
5. CDS will initiate investigative activities on all initiated field records within 24 hours of receiving the field record (e.g., record search, provider call, contact client, arrange appointment)
6. CDS will follow supervisor directives.
7. For stalled field investigations CDS will seek supervisory guidance within 24 hours and no more than 48 hours on how to best move the investigation along.
8. All activities and directives will be documented by the CDS and supervisor.
9. At a minimum 3 field visits three separate times of day and 3 telephone calls three times during different hours must be conducted and documented prior to field record closure as “H” or “J” and/or supervisor agrees to close as a result of non-compliance, issues of CDS safety, etc.

## ***Field Services: Field Records Dispositions***

### **Policy**

Field Records must be accurately dispositioned by CDS and according to CDC disposition definitions. (See Surveillance Section “*Type of Closure*” for detailed information on codes for closing field records.)

### **Standard Expectations**

1. Dispositions located on the back of field records and in STD\*MIS must be used to close field records.

## ***Field Services: Field Records Dispositions Special Uses***

### **Policy**

Dispositions “**H**”, “**J**”, “**D**”, “**K**”, “**B**”, and “**L**”, must be approved by the supervisor.

### **Standard Expectations**

1. Exhaust all possibilities within the guidelines to locate a client, get client to agree to exam, and treatment, if needed.
2. Review field activities conducted by CDS for thorough follow-up and to assess if other creative techniques within the guidelines can be done to achieve disease intervention prior to signing and agreeing to close field records.
3. Provide sufficient information for CDS in other districts and states to follow-up before supervisor can approve to “**K**” call out. (See OOJ policy in Surveillance)

### **Procedures & Implementation**

1. Conduct thorough field investigations and if no success in gaining disease intervention, seek supervisors’ guidance
2. Document, review and have supervisory approval to close field records where the disposition is supported by information recorded on the field record.
3. Gather identifying and two pieces of locating information on contacts being OOJ’d to other districts and states.
4. The “**L**” disposition should be rarely used, except in the following instances:
  - a. Client is deceased,
  - b. Client claims treatment in another country,
  - c. Client can describe treatment, disease, and prefers not to be retreated.

## ***Field Services: CDS Pouches***

### **Policy**

Maintain all open field records in a secure pouch.

Supervisors and FLS must at minimum conduct monthly team meetings, including a review of Syphilis cases to be used as a training tool **“chalk talks.”**

### **Standard Expectations**

1. Pouches must provide security for medical information identifying clients, such as a zipper or lock.
2. Pouches can be divided according to activities to be completed (e.g., field visit, phone call, record search, pending sections, Syphilis reactors, HIV reactors, Gonorrhea (GC) and Chlamydia (CT) reactors, partners, suspects and associates to Syphilis, HIV, GC, and Chlamydia, re-interviews, cluster interviews, record searches, and marginals).
3. Pouches must be prioritized daily to achieve maximum disease intervention opportunities.



## ***Partner & Field Services STD Supervisory Guidelines***

### **Policy**

Assure that the disease intervention processes are in accordance with the CDC, Georgia Division of Public Health, and local policies and procedures.

### **Standard Expectations**

1. Provide a framework for a corrective action work plan when CDS is unable to perform at an acceptable level after a reasonable amount of remedial training or supervisory coaching.

### **Procedures & Implementation**

1. Evaluate CDS field and case management statistics, run open field record reports, open case reports and other applicable STD management information systems. Discuss and document findings for work opened past deadline.
2. Use audit tools to evaluate CDS interviewing, partner notification, and field investigation skills.
3. Keep individual files on CDS documenting significant events such as performance audits, employee counseling sessions, time and attendance, and personnel actions, both positive and negative.

## ***Services STD Supervisory Guidelines for CDS Performance Standards***

### **Policy**

Supervisors will provide CDS with a job description, performance standards and assure the CDS understands what is expected of them and obtain a signed statement that the CDS has read and understands what is expected.

### **Standard Expectations**

1. Conduct performance evaluations in accordance with the appropriate agency's guidelines (federal, state, and local).
2. Prepare a performance improvement plan (according to federal, state, or local personnel policies).

### **Procedures & Implementation**

1. Conduct day-to-day review, observation, and feedback related to team member activities.
2. Maintain quality documentation reviews to identify performance discrepancies.

## ***STD Supervisory Guidelines for Training and Maintaining Skills of CDS***

### **Policy**

Prepare CDS for the two-week “Introduction to Sexually Transmitted Disease Intervention” (ISTDI) training course. CDS success in (ISTDI) training depends on supervisory involvement beginning with the evaluation and documentation of the CDS initial work performance.

### **Standard Expectations**

*At a minimum, a Supervisor/FLS must:*

1. Complete the New Employee Orientation/Training Guidelines for each newly hired CDS
2. Facilitate successful completion of STD EMPLOYEE DEVELOPMENT GUIDE (CDC, 1992) modules by planning activities to correspond with the applicable module (e.g., case management, field investigations).
3. Assure CDS successfully completes each module by scoring 80% or above.
4. Ensure CDS receive ISTDI training within the first year of employment.
5. Assure CDS maintains a calendar to document daily training activities during the pre- and post-ISTDI assessment period. The post-ISTDI assessment period is typically six months and may be extended if satisfactory performance is not achieved.
6. Maintain records documenting trainings, CDS audits, including performance. STD Program Managers must have access and/or receive updates on CDS performance at the end of each month during the employee’s probationary period.
7. Demonstrate record searching process, field investigations, interviews, case management, and other activities prior to ISTDI. Supervisors and FLS may delegate portions of early development of the CDS to experience CDS, or Lead CDS. However, the Supervisor/FLS are ultimately responsible for new employees training.

## **Services Post ISTD I Assessment Period (Six Months)**

### **Policy**

Complete the following post-ISTDI Assessment Schedule before the CDS is able to operate independently during the six-month period after ISTD I.

### **Standard Expectations**

<b>First Month</b>	<b>Second Month – Sixth Month</b>
Supervisor/FLS demonstrates/models a minimum of 2 original interviews and 5 field investigations.	FLS assess CDS skills monthly
FLS & CDS conducts a minimum of 2 dual interviews	FLS conducts pouch audits twice a month
FLS observes CDS conducting a minimum of 2 original interviews and 5 field investigations.	FLS completes the Case Management Audit twice a month.
FLS observes or models a minimum of 2 re-interviews with CDS.	FLS completes the Interview audit original, cluster, re-interview monthly.
FLS observes or models a minimum of 2 cluster interviews with CDS.	FLS completes the Field Audit monthly.

### **Procedures & Implementation**

1. Complete a written skills inventory assessment summary of the CDS six-months post-ISTDI. The summary must include interviewing, field investigations, and case management skills.
2. Documentation of progress and potential made by the CDS staff, also discuss with the CDS staff along with the STD Program Manager, where applicable, within 30 days of the end of the post-ISTDI assessment period.
3. Give the original form to the CDS employee, forward a copy to the next level of supervision, where applicable, and the FLS must keep a copy for evaluations.
4. When performance weaknesses are identified the Supervisor/FLS must create a written performance improvement plan inclusive of a more in-depth assessment and coaching directives by the supervisor.

## **CDS Quality Assurance**

### **Policy**

Supervisors/FLS must conduct performance audits. Supervisors/FLS must also conduct periodic performance audits of each experienced CDS to assess their current skill sets and abilities.

Supervisors/FLS must also provide positive reinforcement and acknowledge CDS that consistently produce high quality work.

### **Standard Expectations**

<b>QUALITY ASSURANCE SCHEDULE</b>		
<b>TYPE OF AUDIT</b>	<b>7-12 MONTHS EMPLOYEMENT</b>	<b>&gt;1 YEAR EMPLOYMENT FOR SUCCESSFUL CDS</b>
Pouch Audit	Twice a month	Twice a month
Case Management Audit	Twice a month	Twice a month
Interview Observation Audit	Monthly	Quarterly
Field Audit	Monthly	Quarterly

### **Procedures & Implementation**

1. Use appropriate audit tools to thoroughly capture all elements essential to conducting good quality CDS work (e.g., pouch audit form, interview audit form, field investigation audit form).

## ***Partner & Field Services Case Review Requirements***

### **Policy**

Maintain a system to ensure that all appropriate case management forms are complete, legible, accurate, and in accordance with the case management guidelines.

### **Standard Expectations**

1. Conduct thorough technical reviews.
2. Review the case diagnosis for accuracy according to information gathered by the CDS (information must support diagnosis, symptoms history, Syphilis history, lab reports, and partner information).
3. Have all updated lab results, treatment, method of case detection, and partner information.
4. Review the plan-of-action developed by CDS to assure appropriate disease case management follow-up is appropriate to achieve maximum disease intervention.
5. Check for all required forms to be in case when submitted.
6. Return cases within 48 hours with all comments, directives, and recommendations. However, the maximum timeframe to return cases to CDS should be no more than 72 hours. Documentation of reason for delay in review and return to CDS must be documented in supervisor comments.
7. Document their technical assessment, case management recommendations, directives, and next course of action for the CDS.
8. Review must always be dated, initialed, and returned to the CDS.

### **Procedures & Implementation**

1. Supervisors must make general comment about overall case that is encouraging (i.e., good case write up, good pursuit, improved case write-up, etc.).
2. Supervisor/FLS must provide technical guidance such as correct case diagnosis the CDS may have gotten wrong explaining why, method of case detection, appropriate lab work to support diagnosis.
3. Supervisors must give specific dates when certain CDS activities must be completed and when case must be re-submitted for further reviews and with updates.

## ***Partner & Field Services Re-Opening Cases***

### **Policy**

Supervisor/FLS must assess that all cases that are re-opened will provide additional intervention.

### **Standard Expectations**

1. The information obtained will change diagnosis.
2. New information will provide a source and/or spread.
3. Disease intervention will occur.
4. New positives will be found that are linked to the case.

### **Procedures & Implementation**

1. If the case closed prior to the discovery of new information the case should be re-opened.

## ***Supervisor's Follow-up on Unproductive and/or "Bust" Cases***

### **Policy**

Supervisors must review "bust" cases and discuss with CDS prior to client leaving the clinic. Supervisor/FLS must also follow-up on "bust" cases (i.e., no sex partners, no needle sharing partners, clusters)

### **Standard Expectations**

1. Supervisor/FLS must review all cases followed by new CDS for gaps and follow-up with the client.
2. Supervisor/FLS must cover all areas of the original interview focusing on missing information.

### **Procedures & Implementation**

(See Standard Expectations)



## ***Records/Reports (Statistics)***

### **Policy**

Supervisor/FLS must prepare individual and team statistics, quarterly, and annually on CDS performance relating to the state and local objectives.

### **Standard Expectations**

1. Supervisor/FLS must produce individual and team reports according to local program standards.

### **Procedures & Implementation**

1. Use current technology to generate reports or calculate statistics by calculator.
2. Run reports for the entire team and individuals.
3. Discuss the team statistics with the team during staff meetings and/or chalk talks.
4. Discuss individual statistics with each CDS separately to reward strengths and provide coaching in area of weakness to encourage the CDS to raise their statistics to standard expectations.

### **Records/Reports Procedures & Implementation**

<b>Reports to be Generated</b> Formula (N = X÷Y)	
<b>Syphilis Contact Index</b> $\frac{\text{Total \# of Contacts Initiated}}{\text{Total \# of Cases Interviewed}}$	<b>Syphilis Cluster Index</b> $\frac{\text{Total Syphilis Cluster Contacts Initiated}}{\text{Total Syphilis Cases Interviewed}}$
<b>Disease Intervention Index</b> $\frac{\text{Total \# Cases with an "A" or "C"}}{\text{Total \# of Cases Interviewed}}$	<b>Female Reactor Index Females</b> $\frac{\text{OI'd within 7 days}}{\text{Females OI'd}}$
<b>% HIV &amp; Syphilis Cases Interviewed</b> $\frac{\text{Total \# of HIV \& Syphilis Cases OI'd}}{\text{Total \# of HIV \& Syphilis Cases Assigned}}$	<b>Notify &amp; Counsel HIV Partners</b> $\frac{\text{Total Contacts New N \& C}}{\text{Total Contacts-Contacts with "1"}}$
<b>Treatment Index</b> $\frac{\text{Total \# of "As" and "Cs" \& Total Cluster "As" and "Cs"}}{\text{Total \# of Cases Interviewed}}$	<b>HIV Contact Index</b> $\frac{\text{Total \# of HIV Contacts Initiated}}{\text{Total \# of Cases Interviewed}}$
<b>P &amp; S Syphilis Sources Identified</b> $\frac{\text{Total \# of P\&S Sources Identified}}{\text{Total \# of Cases Interviewed}}$	<b>Syphilis Re-Interview Index (FYI)</b> $\frac{\text{Total \# of Syphilis Cases Re-Interviewed}}{\text{Total \# of Syphilis Cases Interviewed}}$
<b>Syphilis Partners Brought to Exam</b> $\frac{\text{Total \# of Contacts Newly Examined}}{\text{Total \# Contacts Initiated-Contacts with and "E"}}$	<b>HIV Partner Notification Index</b> $\frac{\text{Total \# of Partners N\&C}}{\text{Total \# of Cases Interviewed}}$
<b>Syphilis Partners Examined within 7 days</b> $\frac{\text{Partners Examined within 7 days}}{\text{Total Contacts Newly Examined}}$	

## ***Partner & Field Services Records/Reports & Providing Feedback to CDS***

### **Policy**

Supervisor/FLS must provide individual feedback to CDS on outcome & process performance indicators (i.e., contact, and cluster indices).

### **Standard Expectations**

1. Supervisor/FLS must provide individual feedback to CDS on outcome & process performance (individually) monthly, quarterly, and annually.

### **Procedures & Implementation**

1. Run Statistical Report for case management & field investigations on each CDS.
2. Compare CDS statistics with the minimum Process Performance & Outcome Standards required of CDS (i.e., Work plan).
3. Meet with CDS individually to discuss expectations, individual statistics, and performance improvement recommendations.
4. Keep statistics of individual CDS in a file to monitor progress.

## ***Partner & Field Services Outreach, Education, & Screenings***

### **Policy**

Supervisor/FLS must coordinate, oversee STD presentations, community outreach screenings and document all activities conducted by CDS.

Supervisors/FLS must also establish and maintain collaborative relationships with community-based organizations to identify target groups and to assist with outreach activities.

### **Standard Expectations**

1. All collaborative efforts, outreach screenings, STD presentations must be requested through and implemented by the supervisors and FLS.
2. Meet frequently with local health departments, CBOs, and providers to discuss current morbidity and where to best focus intervention efforts by providing statistical information on STDs and geographic locations of the highest morbidity areas.

### **Procedures & Implementation**

1. Supervisors must maintain a listing of key stakeholders of local health departments and CBOs to collaborate on community outreach efforts.
2. Arrange periodic meetings with community partners in health care delivery to share STD statistical information and recommended areas to target.

## ***Partner & Field Services Safety***

### **Policy**

Programs must have written safety guidelines and procedures in place and follow these policies to ensure safety in the performance of their responsibilities.

### **Standard Expectations**

1. Supervisors/FLS must address appropriate attire for working in the field such as, avoiding wearing expensive looking jewelry, purses, and other valuables should be kept out of site.
2. CDS must be given appropriate directives to leave car door locked and windows rolled up.
3. Maintain awareness of their surroundings at all times.
4. Rely on instincts.

### **Procedures & Implementation**

1. Provide safety in-services during staff meetings.
2. Alert CDS or have CDS alert all staff of high crime areas and recent activities.
3. Invite Police that specialize in Gang Prevention, Domestic Violence, and Drug Investigations, to discuss the latest updates of what's going on in the community, how to protect themselves, recognize gangs, colors, graffiti, and symbols.

## ***Partner & Field Services Safety (I.D. Badges)***

### **Policy**

Programs must provide CDS with picture I.D. and must require that it be worn when in the field at all times.

### **Standard Expectations**

1. Wear I.D. Badge when in the field as a way to assure the visit is legitimate.
2. Use I.D. Badge while introducing themselves to clients always.
3. Keep I.D. Badge visible to avoid mistaken identity by community members and authorities.
4. Always display I.D. Badge when meeting with providers, in health departments, schools, and hospitals.

### **Procedures & Implementation**

1. Assure personnel is notified when new CDS comes on board to schedule I.D. picture and badge pick up.
2. If CDS misplaces their I.D. badge, arrange for personnel to replace the I.D. as soon as possible.
3. Assure CDS understands that conducting field work without their I.D. is considered lack of preparation to begin field investigations and can reflect negatively on their performance evaluations.

## ***Partner & Field Services Safety (Employee Information File)***

### **Policy**

Supervisor/FLS must maintain an employee file on each CDS, which can be shared with authorities in case of emergency.

### **Standard Expectations**

1. The employee file must include name, address, physical description, emergency locating information, a recent employee picture, description of employee's vehicle, and vehicle license number.

### **Procedures & Implementation**

1. Collect information on all employees and keep in Supervisor/FLS office.
2. Supervisor/FLS must update employee information, to assure the most current information is in the employee file.

## ***Partner & Field Services Occupational Safety***

### **Policy**

Each program area must have a local policy for avoiding occupational exposures and how to handle occupational exposures.

### **Standard Expectations**

3. Each CDS must be required to practice local policies and procedures for avoiding infection(s) that could be acquired in the performance of their responsibilities.
4. Supervisor/FLS must update policies and procedures regularly and formally review with staff annually.

### **Procedures & Implementation**

1. Post Universal Precautions in the office (refer to [www.osha.gov](http://www.osha.gov)) to obtain current policies regarding occupational exposure to infectious diseases.
2. Create a packet of instructions for CDS injured in the field (i.e., needle-sticks, car accidents on the job) to keep in their car at all times.
3. Provide Phlebotomy Training for all CDS.
4. Offer Hepatitis B vaccination to all CDS free of charge, and document all employees that had the HBV vaccination as well as the employees that declined to take the HBV series.
5. Follow-up on all CDS that take the HBV vaccination to assure they've completed the series.



## ***Partner & Field Services Confidentiality & HIPAA***

### **Policy**

All public health staff involved in partner notification activities with access to confidential health information must sign a “confidentiality statement” provided by the supervisors acknowledging the legal requirements not to disclose STD information.

All confidentiality forms must reference HIPAA, local, state, and federal requirements of adhering to confidentiality of public health information.

### **Standard Expectations**

1. All public health staff with access to client health information must be provided with HIPAA training.
2. HIPAA training should be considered a mandatory training for public health staff.
3. Specific documents/forms must be created stating the program confidentiality requirements and laws regarding confidentiality with a signature line for all staff to sign that have medical information access with client identifying information.
4. Penalties with high regards to breaching client confidentiality must be clearly written and discussed with public health staff as well.

### **Procedures & Implementation**

1. Plan and coordinate required HIPAA training for all staff in the public health system annually, and as needed for new employees.
2. Develop a document that clearly details policy regarding confidentiality, laws, and a signature line for public health employees to review, adhere to, and sign. The document shall be kept in the staff personnel files.

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# Surveillance

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## **Section XV Surveillance**

### ***Reporting Source***

#### **Policy**

Reporting Requirements for Physicians and Laboratories.

In the state of Georgia all physicians, laboratories and other health care providers are required by law to notify County Health Department or District Health Office of a reportable communicable disease (e.g., Gonorrhea, Chlamydia, and Syphilis). Reports can also be made to the Notifiable Disease Section of the Epidemiology Branch. All lab-confirmed and clinical diagnoses are reportable. These reports are to be submitted within seven (7) working days on the Georgia Notifiable Disease Report Form (3095), except for Syphilis, which should be reported immediately. Reporting communicable disease allows for identification and monitoring of disease trends and outbreaks, and enables public programs to provide appropriate follow-up of health services.

#### **Standard Expectations**

Identifying information required on the report form is as follows:

1. Client's name.
2. Client's address and phone number.
3. Age, date of birth, race, sex and ethnicity.
4. Disease or condition.
5. Treatment including date, drug and dosage.
6. Laboratory test type, collection date, specimen site and results.
7. Name, address and phone number of provider submitting the report.
8. Name, address and phone number of laboratory processing specimen.

All reports are to be submitted in a sealed envelope marked "Confidential."

## ***Georgia Patient Registry***

### **Policy**

Georgia Surveillance and local district health units shall have a computerized patient registry and case management system.

### **Standard Expectations**

*All surveillance systems must have the following information:*

1. Patient name including nicknames, alias and maiden names.
2. Current and previous addresses including zip codes.
3. Age, race, sex, ethnicity and date of birth.
4. Diagnosis, date diagnosed, date received at county or district and date reported to state STD Surveillance Unit.
5. Date of collection, test type, specimen site, provider and laboratory.
6. Date of treatment, drug and dosage.
7. Clinic visit information including risks, signs, symptoms.
8. Field investigation, prevention activities and case management.

## ***Reactor Grid***

### **Policy**

A Reactor Grid categorizes Syphilis laboratory tests by titer and age. The Grid is flexible and is based on an assessment of three factors: 1) distribution of infectious early latent, late latent and latent Syphilis cases, 2) previously treated and biological false positives and 3) current level of Syphilis morbidity. Due to potential of a woman transmitting Syphilis in utero, there may be separate reactor grids for females and males.

### **Standard Expectations**

The Reactor Grid should be evaluated periodically, especially during times of real or apparent change in Syphilis morbidity in conjunction with demands of communicable disease priorities other than Syphilis on disease intervention. As an example, if Syphilis morbidity is or appears to be decreasing, it is important to review the Grid. An age/titer evaluation should be done to determine if the Grid should be expanded to include more categories for field follow-up of reactors. The general rule is - as reported morbidity declines, the range of the Reactor Grid should be expanded.

The exact content and range of the Reactor Grid may differ by health district. However, these general principles for women of childbearing age should be followed: Unless there is well documented previous adequate treatment history, assign all pregnant females and females of child bearing age reactors for CDS follow-up regardless of titer or the age. Pregnant women with reactive non-treponemal tests and non-reactive treponemal tests should be followed. While these women might be biological false positives (BFP's) due to their pregnancy, treponemal tests are often negative in early Syphilis. Therefore, pregnant women should be retested one month after the initial false positive serology to see if the non-treponemal and treponemal test is still reactive or has become reactive.

All reactive serologies known or believed to be associated with lesions should be followed. This is especially true for cases involving low titers that are known to be associated with genital ulcers, even if the patient in question has a documented history of previously adequate treatment.

Reactive serologies among persons whose sexual partners have not been preventively treated and who are not clearly serofast should be followed by CDS even if they are low titers.

All clinic patients who have genital ulcers with reactive non-treponemal tests and non-reactive treponemal tests should be followed, as treponemal tests are often negative in early Syphilis. Repeat serologic testing if a Treponemal examination was not a part of the patients STD clinical and laboratory evaluation.

### ***Syphilis Initiation Reactor Grid***

Record searches will be performed on all positive Syphilis reactors (RPR) received by the Surveillance Unit. Syphilis reactors will be initiated according to the following criteria.

AGE	EIA/FTA/MHA/TREP ONLY	1:1	1:2	1:4	1:8	1:16	1:32	> 1:64
0-19	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>
20-29	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>
30-39	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>
40-49	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>
50-59	<b>AC</b>	<b>AC</b>	<b>AC</b>	<b>AC</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>
60-69	<b>AC</b>	<b>AC</b>	<b>AC</b>	<b>AC</b>	<b>AC</b>	<b>AC</b>	<b>I</b>	<b>I</b>
70+	<b>AC</b>	<b>AC</b>	<b>AC</b>	<b>AC</b>	<b>AC</b>	<b>AC</b>	<b>AC</b>	<b>AC</b>
Unknown Age	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>	<b>I</b>

I = Initiate Surveillance Follow-Up

AC = Administrative Closures

A four-fold rise in titer will be initiated unless increase in titer occurs within 30 days of last recorded RPR.

Record search and administrative closures will be forwarded to local districts for processing in accordance to their individuals grids.

In high morbidity areas the Syphilis Initiation Reactor Grid should be adjusted according to behavior and surveillance data.

Females of child bearing age and adolescent reactors should be treated with the highest priority.

## ***Types of Closures***

### **Policy**

The Syphilis Laboratory Reactor Program receives reports of positive tests from laboratories, physicians, and other health care providers. These reports shall be entered into state registry and local district health unit's registries.

### **Standard Expectations**

The following data must be entered into the registries: patient name, age, and other demographic information. Each report, regardless of reporting source (e.g., laboratory) is reviewed and evaluated to determine if follow-up is needed. Aside from follow-up being required for a report, a report could be placed in one of the following categories:

**Administrative Closure** – The report will not be investigated or otherwise processed because of the provisions of the Reactor Grid. The most common criteria for this closure are age and titer.

**Record Search Closure** – This report can be closed due to information found in the patient registry or other health records that document a history of adequate treatment for Syphilis. Further, the patient's current titer is lower than at the time of treatment and the patient's current titer has not risen four-fold above the last known positive report. A patient's entire history must be taken into consideration when determining if a positive test is serofast or if the patient needs follow-up. Among the considerations involved are:

- a. Infectious Syphilis (P & S) clients should demonstrate a four-fold decrease in titer within three (3) months after treatment Early Latent patients should demonstrate a four-fold decrease within six (6) months after treatment.
- b. Late or late latent patients may or may not demonstrate decreasing titers within a year especially if the titer is equal to or less than 8 dilutions.

For instance, if a patient was adequately treated for secondary Syphilis a year ago with a titer of 1:64 (at the time of treatment) and no follow-up serological test results are available and today the patient has a 1:32, a field record should be initiated for follow-up. The reasons for follow-up are: 1) that there is no evidence demonstrating a decline in titer and the patient maybe re-infected 2) the patient may have experience treatment failure 3) the patient has HIV 4) patient may be using drugs and 5) the current test was processed by a different lab than the previous test, (e.g., State lab versus Quest). Patients with this type of history should not be closed as a record search closure without appropriate follow-up.

**Physician Closure** - *Only when follow-up can be ended medically* i.e. ensuring adequate treatment and diagnosis. Physician closure also means contact with any health care provider including hospitals, walk-in clinics, etc.

**Surveillance Follow-up** - Assign follow-up to communicable disease specialist (CDS) staff and allow for the tracking of the report through the surveillance log.

**Field Follow-up** - Reactors that were not eliminated or otherwise ruled out by any of the categories describe above.

Any reactors sent for field follow-up should receive one of the following dispositions:

**STD Dispositions:**

1. Preventive treatment
2. Refused Preventive Treatment
3. Infected, brought to treat
4. Infected, not treated
5. Previously treated for this infection
6. Not infected
7. Insufficient Information to begin investigation
8. Unable to locate
9. Refused preventive treatment
10. Out of jurisdiction
11. Other

**Documentation for disposition:**

**“D” disposition- infected not treated**

CDS must have documentation to support why this disposition is used, (i.e. client lost to follow-up, but was located and notified of infection, client moved out of the area with no new locating information before treatment) before Supervisor/FLS can approve.

**“J” disposition- located refused exam**

CDS must have documentation (detailed) of what strategies were used to encourage exam, testing, and possible treatment. Did client threaten the CDS? Are there legitimate religious reasons, or did client just simply refuse to cooperate. Several attempts by CDS, FLS, local health departments, and/or provider must be made and documented.

**“G” disposition- insufficient information to begin investigation**

CDS should rarely use this disposition. When there is insufficient information to follow clients, if it is a reactor, provider call must be made to gather locating information. If it is a partner, suspect, or associate the CDS should re-interview the original patient for additional information, place the contacts on buffs as marginals, record search, or attempt to locate them in the field. If no success, the client should not be placed on the case.

**“H” disposition- unable to locate**



CDS has adequate locating information but are unable to locate the client. There should be an established “H” criteria on the local level that the CDS must exhaust all possibilities such as check with neighbors, mail man, post-office, correctional facilities, etc, prior to submitting for closure as “H”.

**“B” disposition- refused preventive treatment**

CDS must provide thorough documentation of attempts to strongly encourage the client to get treated. If there are public health laws in place to support CDS efforts the CDS must inform the client. CDS must work with FLS, provider, and original patient to convince client to get treated before FLS can approve this disposition.

**“L” disposition- other**

“L” dispositions can only be approved if upon receiving the field record the CDS subsequently finds out the client is deceased. Another use for disposition “L” is if a patient has a positive Syphilis test and claims a Syphilis history and treatment out of the country that cannot be otherwise validated, the client’s partner is negative with no signs and symptoms, the client has a relatively low titer, no signs and symptoms and low risks. Also, if a Doctor documents in the medical records that this is not a new case and patient claims previous treatment and refuse additional follow-up on the positive blood, close as “L.”

**Syphilis E and F Dispositions:** If a client is infected with Syphilis and initiated after they’ve been treated then the “E” disposition is appropriate, previously treated for this infection.

If a client is initiated for Syphilis, and after CDS investigation it’s discovered that the client has a previous history and their titer does not indicate re-infection (No 4-fold increase), there is a not linked to a current early Syphilis case, have no signs and symptoms, and no infected sex partners the appropriate disposition will be “F” not infected.

**BFP No Follow-up:** This option is chosen when the lab result is a biological false positive, i.e. patient has a 1:2 reactive RPR with a non-reactive treponemal test (FTA-ABS).

## ***Lab Visitation***

### **Policy**

Lab visitation means ensuring laboratories and other health care providers submit communicable disease report as required by law. The visitation by local district health unit should determine if positive tests are recorded, evaluated, reviewed, followed, tabulated and reported to the state surveillance unit.

### **Standard Expectations**

***State and local surveillance units must consider the following:***

Maintain up-to-date laboratory and provider lists that include address, telephone number, and contact person.

Review reports outlining reporting time frames from laboratories and health care providers. Identify laboratories or providers who have slowed down, stopped reporting and those who are not reporting according to the law. Contact these providers immediately to arrange a meeting to discuss reporting problems.

Periodically (at least once a year) visit all laboratories to strengthen the collaboration between the laboratory and the STD Program.

## **Active Surveillance**

### **Policy**

Active surveillance is important in finding new morbidity. Active surveillance shall be limited to brief periods of time and have a specific purpose, i.e., to document a suspected outbreak, or to enhance timely disease intervention and/or epidemiologic investigation.

### **Standard Expectations**

State and local STD Programs will perform active surveillance.

- a. Laboratory visitation is one of the most effective and least labor-intensive forms of active surveillance. The evaluation of laboratory reporting practices is effective in ensuring timely and complete reporting of laboratory findings to the program. Each program area should maintain and update yearly a list of laboratories that perform tests for health care providers in the area and conduct site visits to these laboratories.
- b. Non-County Health Departments are excellent places to perform active surveillance (i.e. emergency rooms, walk-in-clinics, HMO's, etc.). Visit these sites to determine if the facility is providing adequate treatment, applying appropriate diagnostic methodology and reporting as required by law.

## ***Data Management***

### **Policy**

Georgia's STD Surveillance Unit and local health district units will utilize a patient registry for all case reports and/or positive laboratory test results received from health care providers and laboratories regardless of patient residency at the time of report. Data entry into these systems may differ in procedures due to staffing, and volume of reports.

### **Standard Expectations**

***The following procedures will apply to all program areas:***

1. All reports will be date stamped upon receipt.
2. All positive results, for new cases, based on criteria will be entered in Patient Registry.
3. All reports will be sorted by disease and reviewed.
4. Field investigation will be initiated for follow-up of positive results that meet the following criteria:
  - a. Reactive non-treponemal test
  - b. Reactive serologic test for Syphilis on a neonate regardless of titer or
  - c. Reactive serologic test for Syphilis on a prenatal client regardless of titer or
  - d. Positive Chlamydia and/or Gonorrhea test on an untreated prenatal client.

## **Quality Assurance**

### **Policy**

Each surveillance program will have a Quality Assurance Plan. Quality assurance in a surveillance program is essential and is both external and internal. External quality assurance means making sure that laboratories and health care providers report to the program as required by statutes, rules and regulations. Internal quality assurance means making sure that the reports of positive tests are recorded, evaluated, reviewed, followed, counted and reported to the state health office according to program guidelines.

### **Standard Expectations**

*To accomplish quality assurance audits, each program area will:*

1. Maintain an up-to-date laboratory and provider list. Each laboratory that performs tests for STD's along with hospitals, Community Health Department (CHD) clinics, migrant clinics, walk-in clinics, physicians and/or large group practices that see a large volume of patients with STD infections will be characterized as an individual laboratory or provider. In addition, program areas should maintain the address, telephone number and contact person for each laboratory and provider.
2. Periodically review reports to measure reporting time frames from laboratories and health care providers to ensure that the program areas are receiving reports as required by statutes, rules and regulations. Laboratories and/or providers, who have slowed down, stopped reporting or not reporting according the statutes, rules and/or regulations will be contacted immediately to arrange a meeting to discuss reporting requirements.
3. Periodically (at least once a year) visit all laboratories in assigned area of responsibility to encourage reporting, to strengthen the working relationships between the laboratory and the STD Program and to reinforce how important laboratories are in the prevention of STD's in the community.
4. To ensure that all STD infections have been recorded, reviewed, evaluated, followed and reported to the State STD Program. The STD Program will review and reconcile quarterly the following quality assurance reports generated from STD\*MIS:
  - a. Infected Field Records (FR's without morbidity)
  - b. Interview Records without Morbidity
  - c. Morbidity Listing
  - d. Morbidity Missing Lab or Treatment
  - e. Multiple Morbidity by Index of Diagnosis
  - f. Patients with Multiple Interviews
  - g. Positive Lab Tests without Morbidity for Chlamydia and Gonorrhea.

## ***Case Reporting***

### **Policy**

Syphilis infections should be staged according to CDC guidelines at the time of specimen collection. Diagnosed cases of Syphilis should be reported regardless of whether they have been treated or interviewed. All programs should use the Centers for Disease Control and Prevention (CDC) case definitions.

### **Standard Expectations**

***Syphilis morbidity should be reported in accordance with the following guidelines:***

- a. For all diagnosed early Syphilis cases (i.e., primary -710, secondary-720 or early latent of less than one year duration-730) districts should mail an initial yellow copy of the Interview Record (CDC 73.54) to the State STD Surveillance Unit within 72 hours of the interview.
- b. When reporting latent Syphilis of unknown duration-740, an interview record **MUST** be submitted for reporting morbidity.
- c. When reporting late latent Syphilis-745, and any Syphilis case not interviewed or treated, a field record **MUST** be submitted for reporting morbidity.

Note: Because HIV-positive patients who have early syphilis may be at increased risk for neurologic complications of syphilis, the incidence of neurosyphilis may increase as the number of syphilis cases among HIV-infected persons increases. However, neurosyphilis may be underreported based on the past classification of neurosyphilis as a unique stage of syphilis. While neurosyphilis can occur at almost any stage of syphilis, in the past, it has been classified and coded as one of several mutually exclusive stages. To improve and clarify reporting of neurosyphilis as a clinical manifestation of any stage of syphilis, the separate EVENT code (760) for neurosyphilis was retired and should no longer be used.

- d. After case is closed, a photocopy (from the white copy) of the closed Interview Record should be forwarded to the Surveillance Unit 45 days from date of interview. All patient information, laboratory work and dispositions of contacts/clusters must be complete at that time. The white copy of the closed partner/cluster Field Records should also be attached.

## Surveillance Case Definitions

### (A) SYPHILIS, PRIMARY

#### *Clinical description*

A subcategory of latent Syphilis. When initial infection has occurred > 1 year previously, latent Syphilis is classified as late latent. In the absence of symptom or serology history, sex partners for the last year must be evaluated to determine if the case is classified as early or late latent.

#### *Laboratory criteria for diagnosis*

Demonstration of *T pallidum* in clinical specimens by darkfield microscopy, direct fluorescent antibody (DFA-TP), or equivalent methods.

#### *Case classification*

*Probable:* a clinically compatible case with one or more ulcers (chancres) consistent with primary Syphilis and a reactive serologic test:

*Nontreponemal:* Venereal Disease Research Laboratory (VDRL) or rapid plasma reagin (RPR);

*Treponemal:* fluorescent treponemal antibody absorbed [FTA-ABS), Treponema Pallidum Particle Agglutination (TPPA), IgG-EIA. Although not yet endorsed as part of the case definition by CSTE, treponemal tests such as the TPPA and IgG-EIA (that are generally considered to be equivalent confirmatory tests) may be used.

#### *Confirmed*

A clinically compatible case that is laboratory confirmed.

### (B) SYPHILIS, SECONDARY

#### *Clinical description*

A stage of infection caused by *T. pallidum* and characterized by localized or diffuse mucocutaneous lesions, often with generalized lymphadenopathy. The primary chancre may still be present.

#### *Laboratory criteria for diagnosis*

Demonstration of *T. pallidum* in clinical specimens by darkfield microscopy, DFA-TP, or equivalent methods.

#### *Case classification*

*Probable:* a clinically compatible case with a nontreponemal (VORL or RPR) titer  $\geq 4$

#### *Confirmed*

A clinically compatible case that is laboratory confirmed

### (C) SYPHILIS, LATENT

#### *Clinical description*

A stage of infection caused by *T pallidum* in which organisms persist in the body of the infected person without causing symptoms or signs. Latent Syphilis is subdivided into early, late, and unknown categories based on the duration of infection.

#### *Case classification*

*Probable:* no clinical signs or symptoms of Syphilis and the presence of one of the following:

- No past diagnosis of Syphilis, a reactive nontreponemal test (i.e., VORL or RPR), and a reactive treponemal test (i.e., FTA-ABS or TPPA), or
- A history of Syphilis therapy and a current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer.

### (D) SYPHILIS, EARLY LATENT

#### *Clinical description*

A subcategory of latent Syphilis. When initial infection has occurred within the previous 12 months, latent Syphilis is classified as early latent.

#### *Case classification*

*Probable:* latent Syphilis (see Syphilis, latent) in a person who has evidence of having acquired the infection within the previous 12 months based on one or more of the following criteria:

- Documented negative test in the last 12 months or fourfold or greater increase in titer of a nontreponemal test during the previous 12 months, or
- A history of symptoms consistent with primary or secondary Syphilis during the previous 12 months, or
- A history of sexual exposure to a partner who had confirmed or probable primary or

secondary Syphilis or probable early latent Syphilis, or reactive nontreponemal and treponema test from a person whose only possible exposure occurred within the preceding 12 months.

**(E) SYPHILIS, LATE LATENT**

***Clinical description***

A subcategory of latent Syphilis. When initial infection has occurred > 1 year previously, latent Syphilis is classified as late latent. In the absence of symptom or serology history, sex partners for the last year must be evaluated to determine if the case is classified as early or late latent.

***Case classification***

*Probable:* latent Syphilis (see Syphilis, latent) in a patient who has no evidence of having acquired the disease within the preceding 12 months (see Syphilis, early latent) and whose age and titer do not meet the criteria specified for latent Syphilis of unknown duration.

**(F) SYPHILIS, LATENT, OF UNKNOWN DURATION**

***Clinical description***

A subcategory of latent Syphilis. When the date of initial infection cannot be established as having occurred within the previous year and the patient's age and titer meet criteria described below, latent Syphilis is classified as latent Syphilis of unknown duration. In the absence of symptom or serology history, sex partners for the last year must be evaluated to determine if the case is classified as early or late latent.

***Case classification***

*Probable:* latent Syphilis (see Syphilis, latent) that does not meet the criteria for early latent Syphilis when the patient is aged (13-35) years and has a nontreponemal titer <:32

**(G) NEUROSYPHILIS**

***Clinical description***

Evidence of central nervous system infection with *T Pa Jj dum*

***Laboratory criteria for diagnosis***

A reactive serologic test for Syphilis and reactive VDRL in cerebrospinal fluids (CSF)

***Case Classification***

*Probable:* Syphilis of any stage, a negative VDRL in CSF, and both the following:

- Elevated CSF protein or leukocyte count in the absence of other known causes of these abnormalities, and
- Clinical symptoms or signs consistent with neuroSyphilis in the absence of other unknown causes for these clinical abnormalities.

***Confirmed***

Syphilis of any stage that meets the laboratory criteria for neuroSyphilis

**(H) SYPHILIS, LATE, WITH CLINICAL MANIFESTATIONS OTHER THAN NEUROSYPHILIS (LATE BENIGN SYPHILIS AND CARDIOVASCULAR SYPHILIS)**

***Clinical description***

Clinical manifestations of late Syphilis other than neuroSyphilis may include inflammatory lesions of the cardiovascular system, skin, or bone. Rarely, other structures (e.g., the upper and lower respiratory tract, mouth, eye, abdominal organs, reproductive organs, lymph nodes, and skeletal muscle) may be involved. Late Syphilis usually becomes clinically manifest only after a period of 15-30 years of untreated infection.

***Laboratory criteria for diagnosis***

Demonstration of *T palJidum* in late lesions by fluorescent antibody or special stains (although organisms are rarely seen in late lesion)

***Case classifications***

*Probable:* characteristic abnormalities or lesions of the cardiovascular system, skin, bone, or other structures with a reactive treponemal test, in the absence of other known causes of these abnormalities, and without CSF abnormalities and clinical symptoms or signs consistent with neuroSyphilis.

***Confirmed***

A clinically compatible case that is laboratory confirmed.



## ***Chlamydia and Gonorrhea***

### **Policy**

All cases of Chlamydia and Gonorrhea shall be reported regardless of treatment status.

### **Standard Expectations**

***STD State Program and local program areas will:***

1. Perform record searches on all positive Chlamydia and Gonorrhea.
2. Update demographic information, enter laboratory information and create morbidity if client is in the central registry.
3. Enter provider and treatment information if the client is adequately treated for the infection reported.
4. Contact the local health district to initiate a CDS field follow-up if client is pregnant and not treated.

Health districts will initiate Field Records on untreated positives from the State Public Health laboratories.

Chlamydia and Gonorrhea may be reported to the Surveillance Unit on the Georgia Notifiable Disease Reporting Form (3095), Field Record (73.29) or Chlamydia (CT) and Gonorrhea (GC) submission form (yellow copy).

## ***Interstate Communication Control Record (ICCR) Out of Jurisdiction (OOJ)***

### **Policy Within Georgia**

#### ***STD program areas will transmit the following:***

A completed four-part (including the green copy) Field Record (73.2936S) to the investigating district, retaining one copy for control purposes.

#### **Standard Expectations**

The initiating district may call the investigating district prior to mailing the Field Record 73.2936S. The investigating district should provide a preliminary disposition to the initiating district within 5 workdays after receipt. This preliminary disposition should, at a minimum, verify the address, name locating information, etc. In the event that additional information is needed, the original patient can then be re-interviewed.

Within 14 calendar days of receiving the 73.2936S, the investigating district should send a dispositioned copy back to the initiating district so that case analysis may be completed. The investigating district also should forward the white copy to the STD Surveillance Unit for entry into the STD database, STD\*MIS.

**NOTE:** The 73.54 should not be closed until final dispositions are recorded

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### **Policy Outside Georgia**

The Georgia STD Program, ICCR Clerk must handle all out-of-state transmissions. No one is to communicate directly with another state without clearance from the STD Epidemiology Section. If paperwork or phone calls are received in a local clinic directly from another state, please contact the STD Epidemiology Section.

#### **Standard Expectations**

Epidemiologic information originating in Georgia:

Information for contacts/clusters to early Syphilis or HIV infection and person who have reactive Syphilis tests with titers > 1:8 will be telephoned to the state ICCR clerk. HIV positives, Syphilis reactors with titers <1:8, Chlamydia/Gonorrhea cases/contacts and PID contacts, will be mailed, with one exception. If a person is pregnant, the information will be phoned to the state ICCR clerk.

The investigating state should provide a disposition to the initiating state within 14 workdays for Syphilis and 30 workdays for HIV from the date of receipt. This disposition should, at a minimum, verify the address, examination date, test results, date of treatment, and dosage of drug.

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# Appendix

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# Evaluation Tools

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## Evaluation Tools

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### ***Process of Evaluation of Disease Intervention Activity***

This section contains an audit format to allow for in-depth analysis of individual and programmatic disease intervention activities for priority STDs. The audit format is divided into components of the program with each component listing process performance standards. Interview Records (73.54) and Field Records (73.2936S) should be utilized on all interview cases of Syphilis, HIV infection, Gonorrhea, and Chlamydia. These records should be retained for a minimum of one year, to allow for evaluation and quality control.

It is recommended that the communicable disease specialist supervisor do periodic appraisals of various program components and individual communicable disease specialists utilizing the format and methods contained herein. This will allow for frequent and timely program evaluation and planning. A clinical review, interview, field, and pouch audit document, as well as individual vital component documents of such forms can be found in the pages that follow.

Additionally, clinical standards for STD client evaluation and management establish the minimum standards of care and documentation for STD clients in Georgia Public Health clinics. They are based on CDC and other best-practice guidelines and assure an adequate level of care for clients.

Based on the degree that standards of care are met, the following guidelines are suggested for CPT Evaluation and Management coding for STD clinics:

<b><u>New Client</u></b>	<b><u>CPT Codes</u></b>
• Complete STD work-up (Meet standards for client history, physical exam and lab tests.)	99203
• Incomplete STD work-up (e.g., omit some history elements and do no oral or skin exam.)	99202
• Major element(s) omitted (e.g., no physical exam and/or lab tests.)	99201
<b><u>Established Client</u></b>	<b><u>CPT Codes</u></b>
• Complete STD work-up for a new problem (e.g., has urethritis symptoms 6 months after being treated for Syphilis.)	99214
• Return visit for related problem. (e.g., vaginitis symptoms after treatment for Chlamydia; problem-focused history and physical exam are done.)	99213
• Brief return visit for same problem (e.g., seen weekly for re-treatment of genital warts)	66212

Reviewing records for proper completion is often done at the end of each day, but more formal review/audit should also be done periodically to assess the quality of client care and if program standards are being met. Principles for clinical record review may be found in the “Quality Assurance/Quality Improvement . . .” Manual noted above. An STD-specific clinical record review tool can be found in the pages that follow.

*Note: For additional program expectations, see each specific disease section on the previous pages.*

## INTERVIEW AUDIT

Employee Name: \_\_\_\_\_ Worker: \_\_\_\_\_

Reviewer: \_\_\_\_\_ Date of Review: \_\_\_\_\_

### 1. COMMUNICATION

	Excellent	Needs Improvement	Acceptable
A. Establishes rapport			
B. Effectively elicits socio-sexual information			
C. Uses open-ended questions			
D. Gives factual information			
E. Interview progresses in a logical manner			
F. Communicates at clients level of understanding			
G. Emphasizes confidentiality			

### 2. PROBLEM SOLVING

	Excellent	Needs Improvement	Acceptable
A. Recognizes problems communicated by client			
B. Resolves client concerns			
C. Clearly and convincingly uses STD motivations			

### 3. ANALYTICAL CAPABILITIES

	Excellent	Needs Improvement	Acceptable
A. Computes and uses interview periods			
B. Recognizes exposure gaps			
C. Recognizes discrepancies in previous responses			
D. Gives factual information			



**4. DISEASE INTERVENTION BEHAVIOR**

	Excellent	Needs Improvement	Acceptable
A. Persists to identify all at risk sex partners			
B. Pursues detailed locating/identifying			
C. Ask questions using information obtained in the interview			
D. Clusters around named sex partners			
E. Establishes specific contacts and coaches clients			
F. Assesses risk behavior and discuss relevant risk reduction messages			

COMMENTS:

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Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## FIELD AUDIT

Employee Name: \_\_\_\_\_ Worker: \_\_\_\_\_

Reviewer: \_\_\_\_\_ Date of Review: \_\_\_\_\_

Number of Field Visits Made: \_\_\_\_\_

	Excellent	Needs Improvement	Acceptable
A. Establish priorities before leaving office			
B. Uses resources effectively in planning field activities			
C. Prioritized field visits geographically			
D. Professionally manages circumstances which are obstacles			
E. Maintained client's confidentiality			
F. Motivates people to respond promptly			
G. Utilizes field resources in executing referrals			
H. Documents investigative activities clearly and accurately			
I. Observes field safety			

COMMENTS:

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Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## POUCH AUDIT

Employee Name: \_\_\_\_\_ Worker: \_\_\_\_\_

Reviewer: \_\_\_\_\_ Date of Review: \_\_\_\_\_

Number of open field records: \_\_\_\_\_

Number of field records closed: \_\_\_\_\_

Number of missing field records: \_\_\_\_\_

	Excellent	Needs Improvement	Acceptable
A. Organization-arrangement/orderliness of pouch			
B. Consistent and proper use of verification resources			
C. Timeliness of investigative efforts, within 24 hours			
D. Manage of investigations on a daily basis			
E. Documentation is legible, thorough, and appropriate			
F. Stalled investigations (Reviewed with FLS)			

COMMENTS:

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Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## STD CLINICAL RECORD REVIEW

Clinic: \_\_\_\_\_ Date: \_\_\_\_\_ Reviewer: \_\_\_\_\_

Client Identification: \_\_\_\_\_

Date/Reason for visit: \_\_\_\_\_

	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
<b>STD-RELATED HISTORY IS COMPLETE</b>												
<b><u>Symptoms</u></b>												
Description												
Duration												
Location												
<b><u>STD History</u></b>												
Previous STDs												
Hepatitis A												
Hepatitis B												
HIV tests												
<b><u>Sexual History</u></b>												
Last exposure												
Partners (#/new/sex)												
Exposure sites												
Condom use												

	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
<b><u>Recent Travel</u></b>												
Out of State												
Out of Country												
<b><u>Medication</u></b>												
Recent antibiotics												
Other Rx/OTC												
<b><u>Drugs</u></b>												
Street drugs												
Alcohol												
Herbal remedies												
<b><u>Other Significant Health History</u></b>												
Allergies												
Health problems												
<b><u>Gynecologic History</u></b>												
Last menses												
Contraception												
Last Pap smear												
Last douche												
<b>COMMENTS:</b>												

	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
<b>STD CLIENT ID</b>												
<b><u>Physical examination is complete</u></b>												
Mouth, skin, lymph nodes												
External genitals (M/F)												
Anus												
Vagina/cervix												
Bimanual/cervical motion												
<b><u>Abnormal findings</u></b> clearly described?												
<b><u>Laboratory tests done as indicated</u></b>												
STAT:												
Urethral Gram stain												
Vaginal wet mount/KOH												
RPR/Dark Field exam												
ORDERED:												
Gonorrhea probe/culture(s)												
Chlamydia probe/culture(s)												
RPR												
HIV												
Herpes culture												
Hepatitis B antibody												
<b><u>Assessment/Diagnosis/Impression(s)</u></b>												
Correlate with history, exam and												

	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
laboratory findings												
<b><u>Treatment</u></b>												
Medication choice/dosage correlates with the assessment/diagnosis and the nurse protocol												
<b><u>Education/Referral/Counseling</u></b> <b><u>Diagnosis/Treatment Information</u></b>												
Call/Return Instructions												
Appropriate referrals												
Risk reduction: Partner referral												
Condom use												
Personal plan												
<p>Clinician signature: _____ Date: _____</p> <p><b>COMMENTS:</b></p>												

**PROCESS EVALUATION**

**COMPONENT 1**

TIME FRAME TO INTERVIEWING OR COUNSELING	PROCESS PERFORMANCE STANDARDS (All within 5 workdays)	ACHIEVEMENT
Syphilis (interview)	≥85%: Exceeds Expectations 75-84%: Meets Expectations <70%: Does Not Meet Expectations	Syphilis interviewed: _____% within 5 workdays
Gonorrhea and Chlamydia (interview of referred cases)	≥85%: Exceeds Expectations 70-84%: Meets Expectations <70%: Does Not Meet Expectations	Gonorrhea interviewed: _____% within 5 workdays Chlamydia interviewed: _____% within 5 workdays

Disease intervention begins with the interview. Unless there are unusual circumstances, all diagnosed cases of public and non-public Syphilis should be interviewed for partners and clusters. Based upon local priorities and availability of CDS staff, certain Gonorrhea and Chlamydia clients may be referred for an interview by a CDS.

Speed of investigation, which must begin with the interview, is crucial to effective case prevention. The sooner partners and clusters are identified and examined/counseled, the more likely that the chain of infection will be interrupted. Every effort should be made to interview diagnosed Syphilis cases as soon as possible. Completed copies of Interview Records and field Records should be provided to the district STD program supervisor within 24 hours. This component is measured from the date assigned to the date interviewed or counseled.

SOURCE DOCUMENTS: Syphilis and HIV . . . Interview Record (73.54); Gonorrhea and Chlamydia . . . STD clinic record, Interview Record, or case log.



**PROCESS EVALUATION****COMPONENT 2**

<b>PERCENT OF INITIAL RE-INTERVIEWS (within 5 workdays)</b>	<b>PROCESS PERFORMANCE STANDARDS</b>	<b>ACHIEVEMENT</b>
Syphilis	>90%: Exceeds Expectations 75-89%: Meets Expectations <75: Does Not Meet Expectations	Syphilis: _____% within 5 workdays

Re-interviews are additional exchanges of information with selected clients occurring after the original interview. They are conducted for the purpose of eliciting additional information, confronting conflicting information and confirming new information. These should be based on an analysis of epidemiologic intelligence obtained through filed investigations. There is a direct correlation between the time lapses from original interview to re-interview. The sooner the re-interview, the more productive it is likely to be.

**PROCESS EVALUATION**

**COMPONENT 3**

<p><b>QUALITY OF IDENTIFYING AND LOCATING INFORMATION</b>                      (Percent of partner Field Records including: A complete description and at least two items of locating information.)</p>	<p><b>PROCESS PERFORMANCE STANDARDS</b></p>	<p><b>ACHIEVEMENT</b></p>
<p>Syphilis, Gonorrhea, and Chlamydia</p>	<p>≥85%: Exceeds Expectations                      75-84%: Meets Expectations                      &lt;75%: Does Not Meet Expectations</p>	<p>Syphilis: _____%                      Gonorrhea: _____%                      Chlamydia: _____%</p>

During the interview, it is important to gather as much information as possible to facilitate rapid investigation and examination. Field Records should be documented with a complete description (physical appearance items, such as height, weight, hair style and complexion) and at least two items of locating information.

SOURCE DOCUMENT: Field Record (73.2936S)

**PROCESS EVALUATION**

**COMPONENT 4**

<p><b>ADEQUACY OF DOCUMENTATION OF INVESTIGATIONS</b> (Work copies of all Field Records should be documented to indicate all investigative activities)</p>	<p><b>PROCESS PERFORMANCE STANDARDS</b></p>	<p><b>ACHIEVEMENT</b></p>
<p>Syphilis, Gonorrhea, and Chlamydia</p>	<p>100%: Meets Expectations &lt;100%: Does Not Meet Expectations</p>	<p>Syphilis: _____% Gonorrhea: _____% Chlamydia: _____%</p>

Documentation of Field Records should be written in such a way that if the Field Record is reassigned or reinitiated the new CDS can proceed with minimal difficulty. In addition, the Field Record serves as a quasi-medical record, a worker activity/quality assurance document, a potential legal document and a historic locator.

SOURCE DOCUMENT: Interview Record (73.54)

**PROCESS EVALUATION**

**COMPONENT 5**

PERCENT PARTNER EXAMINATIONS (New investigations) (Within 5 workdays)	PROCESS PERFORMANCE STANDARDS	ACHIEVEMENT
Syphilis Gonorrhea Chlamydia Early Latent Syphilis Latent Syphilis (unknown duration)	<b>Partners to P &amp; S, Gonorrhea/Chlamydia</b> >80%: Exceeds Expectations 65-79%: Meets Expectations <65%: Does Not Meet Expectations	<b>Partners to P &amp; S Syphilis (710 &amp; 720)</b> _____% within 5 workdays  <b>Partners to Gonorrhea/Chlamydia</b> _____% within 5 workdays
	<b>Partners to Early Latent Syphilis</b> >70%: Exceeds Expectations 65-69%: Meets Expectations <60%: Does Not Meet Expectations	<b>Partners to Early Latent Syphilis (730)</b> _____% within 5 workdays
	<b>Partners to Latent Syphilis</b>	<b>Partners to Latent Syphilis (740)</b> _____% within 5 workdays

Speed of investigations is imperative in a disease control program. CDS should evaluate and prioritize investigations where infections most probably will occur. Partners to infectious Syphilis (primary and secondary) should command a higher priority than partners to early latent. Contacts of clients who are diagnosed latent Syphilis (740) should be screened and evaluated.

SOURCE DOCUMENT: Interview Record (73.54)

**PROCESS EVALUATION**

**COMPONENT 6**

<p><b>TIME FROM INITIATION TO DOCUMENTATION OF 1<sup>ST</sup> INVESTIGATION (POSITIVE TEST)</b>                      (Field investigations of positive test for priority STD's should commence within 48 hours of Field Record initiation or receipt date if initiated out of jurisdiction.)</p>	<p><b>PROCESS PERFORMANCE STANDARDS</b></p>	<p><b>ACHIEVEMENT</b></p>
<p>Syphilis, Gonorrhea, Chlamydia.</p>	<p>Investigation begun in                      &lt;48 hours: Meet Expectations                      &gt;48 hours: Does Not Meet Expectations</p>	<p>Syphilis: _____% &lt;48 hrs.                      Gonorrhea: _____% &lt;48 hrs.                      Chlamydia: _____% &lt;48 hrs.</p>

See discussions of Components 4 and 5.

SOURCE DOCUMENT: Field Record (73.29365)

**PROCESS EVALUATION**

**High Priority**

**COMPONENT 7A  
(Public Health Clinic Clients)**

<b>PERCENT POSITIVE TESTS WITH PROPER FOLLOW-UP (Within 3 Workdays of Initiation)</b>	<b>PROCESS PERFORMANCE STANDARDS</b>	<b>ACHIEVEMENT</b>
Syphilis (subsequent exam, contact with physician, etc.)	>90%: Exceeds Expectations 80-89%: Meets Expectations <80%: Does Not Meet Expectations	Syphilis: _____% within 5 workdays
Gonorrhea and Chlamydia (treatment)	>85%: Exceeds Expectations 70-84%: Meets Expectations <70%: Does Not Meet Expectations	Gonorrhea: _____% within 5 workdays Chlamydia: _____% within 5 workdays

Proper follow-up for public Syphilis reactors would include subsequent exam, and for counseling and referral to a medical provider. Follow-up of women and neonatals who have tested positive for either Gonorrhea or Chlamydia, and are untreated, should be a high priority because of the likelihood of PID.

SOURCE DOCUMENTS: Field Record (73.2936S)

Follow-up of prenatals and neonatals who have tested positive for Syphilis should also be high priority because of the likelihood of congenital Syphilis.

SOURCE DOCUMENT: Field Record (73.2936S), Congenital Syphilis Case Report Form (73.126)

**PROCESS EVALUATION**

**High Priority**

**COMPONENT 7B**

**(Non-Public Health Clinic Clients)**

<b>PERCENT POSITIVE TESTS WITH PROPER FOLLOW-UP (Within 3 Workdays of Initiation)</b>	<b>PROCESS PERFORMANCE STANDARDS</b>	<b>ACHIEVEMENT</b>
Syphilis (contact with physician, subsequent exam, etc.)	>90%: Exceeds Expectations 80-89%: Meets Expectations <80%: Does Not Meet Expectations	Syphilis: _____% within 5 workdays
Gonorrhea and Chlamydia, if assistance requested by private provider (treatment)	>85%: Exceeds Expectations 65-84%: Meets Expectations <65%: Does Not Meet Expectations	Gonorrhea: _____% within 5 workdays Chlamydia: _____% within 5 workdays

Proper follow-up for non-public Syphilis reactors would include subsequent exam, contact with physician, etc. Follow-up of women who have tested positive for either Gonorrhea or Chlamydia, and are untreated, should be a high priority because of the likelihood of PID.

SOURCE DOCUMENT: Field Record (73.2936S)

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# Syphilis Initiation Reactor Grid

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## Syphilis Initiation Reactor Grid

Record searches will be performed on all positive Syphilis reactors (RPR) received by the Surveillance Unit. Syphilis reactors will be initiated according to the following criteria.

AGE	EIA/FTA/MHA/TREP ONLY	1:1	1:2	1:4	1:8	1:16	1:32	> 1:64
0-19	I	I	I	I	I	I	I	I
20-29	I	I	I	I	I	I	I	I
30-39	I	I	I	I	I	I	I	I
40-49	I	I	I	I	I	I	I	I
50-59	AC	AC	AC	AC	I	I	I	I
60-69	AC	AC	AC	AC	AC	AC	I	I
70+	AC	AC	AC	AC	AC	AC	AC	AC
Unknown Age	I	I	I	I	I	I	I	I

Grid Revised 4/2006

I = Initiate Surveillance Follow-Up

AC = Administrative Closures

A four-fold rise in titer will be initiated unless increase in titer occurs within 30 days of last recorded RPR.

Record search and administrative closures will be forwarded to local districts for processing in accordance to their individuals grids.

In high morbidity areas the Syphilis Initiation Reactor Grid should be adjusted according to behavior and surveillance data.

Females of child bearing age and adolescent reactors should be treated with the highest priority.

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Questions to Ask  
During Evaluation of  
Mother and Infant

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## **Syphilis: Questions to Ask During Evaluation of Mother and Infant**

1. Was the mother untreated at delivery?
2. Did the mother show signs of reinfection?
3. Was the mother treated less than 30 days prior to delivery?
4. Was the mother treated with a non-penicillin regimen during pregnancy?
5. Did the mother have appropriate serologic follow-up to syphilis treatment during gestation?
6. Was mother exposed to syphilis but did not receive preventive treatment?
7. Was penicillin treatment given (if treated during pregnancy)?
8. Did a two-dilution (fourfold) titer decrease occur within three months (primary & secondary) or six months (early latent)?
9. Does the mother appear to be reinfected showing a fourfold (two-dilution) rise in titer since treatment?
10. Are there signs or symptoms of reinfection (lesions, palmer/plantar rash, condyloma lata, etc.)?
11. Does the infant have signs of congenital syphilis?
12. Does the infant have a reactive serologic test?
13. Does the long bone x-ray suggest congenital syphilis?
14. Are the CSF findings reactive or elevated?
15. Was infant IgM reactive?

### **Case Classification: Confirmed**

Regardless of mother's treatment history

Infant has identification of T.Pallidum by darkfield microscopy or other stain.

### **Classification: Presumptive**

Regardless of infant's findings

Mother infected during pregnancy:

Not treated or inadequately treated

OR

Regardless of mothers findings

Infant has reactive treponemal test and one of the following:

Signs of CS

Evidence of CS in long bone x-ray  
Reactive VDRL-CSF  
Elevated CSF Cell Count or Protein  
Reactive FTA-ABS-19s-IGM

**Forms Used for Reporting Congenital to State Office**

Congenital Syphilis Follow-up Form 3467  
Congenital Syphilis Case Investigation and Report Form 73.126  
Field Record Form 73.29365

**LOCAL USE ONLY**

Mother's Name: \_\_\_\_\_ Chart No.: \_\_\_\_\_  
 Address: (Number, Street, City, State) \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_  
 Infant's Name: \_\_\_\_\_ Chart No.: \_\_\_\_\_ Delivering Physician: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_  
 Pediatrician: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_

- Patient identifier information is not transmitted to CDC -


**DEPARTMENT OF HEALTH & HUMAN SERVICES**  
**CENTERS FOR DISEASE CONTROL AND PREVENTION**  
 ATLANTA, GA 30333

**CONGENITAL SYPHILIS (CS) CASE INVESTIGATION AND REPORT**  
 Form Approved OMB No. 0920-0128 Exp. Date: 09/30/2006

CASE ID No.: **0203667**  
 (1-7)  
 Local Use ID No.: \_\_\_\_\_

**PART I. MATERNAL INFORMATION**

1. Report date to health dept. \_\_\_\_\_  Unk  
 (Mo. / Day / Yr. (8-15))

2. Reporting state FIPS code: \_\_\_\_\_  Unk  
 (16-17) Reporting State Name \_\_\_\_\_

3. Reporting county FIPS code: \_\_\_\_\_  Unk  
 (18-20) Reporting County Name \_\_\_\_\_

4. Reporting city FIPS code: \_\_\_\_\_  Unk  
 (21-24) Reporting City Name \_\_\_\_\_

5. Other geographic unit (optional): \_\_\_\_\_ (25-27)

6. Country of residence: (leave blank if USA) \_\_\_\_\_ (28-30) Country of Residence \_\_\_\_\_

7. State FIPS code: \_\_\_\_\_  Unk  
 (31-32) Residence State Name \_\_\_\_\_

8. Residence county FIPS code: \_\_\_\_\_  Unk  
 (33-35) Residence County Name \_\_\_\_\_

9. Residence city FIPS code: \_\_\_\_\_  Unk  
 (36-39) Residence City Name \_\_\_\_\_

10. Residence zip code: \_\_\_\_\_  Unk  
 (40-44)

11. Mother's date of birth: \_\_\_\_\_  Unk  
 (Mo. / Day / Yr. (45-52))

12. Mother's ethnicity: (53)  
 1  Hispanic/Latino 9  Unk  
 2  Non-Hispanic/Latino

13. Mother's race: (Code 1 for all that apply)  
 (54)  American Indian/Alaskan Native (55)  Asian (56)  Black or African American  
 (57)  Native Hawaiian or Other Pacific Islander (58)  White (59)  Unk

14. Mother's marital status: (60)  
 1  Single, never married 3  Separated/Divorced 8  Other  
 2  Married 4  Widow 9  Unk

15. Last menstrual period (LMP) (before delivery) \_\_\_\_\_  Unk  
 (Mo. / Day / Yr. (61-68))

16. Did mother have prenatal care? (69)  
 1  Yes 9  Unk (Go to Q19)  
 2  No (Go to Q19)

17. Indicate date of first prenatal visit: \_\_\_\_\_  Unk  
 (Mo. / Day / Yr. (70-77))

18. Indicate number of prenatal visits: \_\_\_\_\_  Unk  
 (78-79)

19. Did mother have a nontreponemal test (e.g., RPR or VDRL) in pregnancy, at delivery, or soon after delivery within 3 days? (80)  
 1  Yes 2  No (Go to Q21) 9  Unk (Go to Q21)

20. Indicate dates and results of nontreponemal tests: (list the most recent first)

Date	Results	Titer
Mo. Day Yr.		
a. ____ / ____ / ____ (81-88) <input type="checkbox"/> Unk	1 <input type="checkbox"/> Reactive 2 <input type="checkbox"/> Nonreactive 9 <input type="checkbox"/> Unk (89)	1: _____ (90-93)
b. ____ / ____ / ____ (94-101) <input type="checkbox"/> Unk	1 <input type="checkbox"/> Reactive 2 <input type="checkbox"/> Nonreactive 9 <input type="checkbox"/> Unk (102)	1: _____ (103-106)
c. ____ / ____ / ____ (107-114) <input type="checkbox"/> Unk	1 <input type="checkbox"/> Reactive 2 <input type="checkbox"/> Nonreactive 9 <input type="checkbox"/> Unk (115)	1: _____ (116-119)
d. ____ / ____ / ____ (120-127) <input type="checkbox"/> Unk	1 <input type="checkbox"/> Reactive 2 <input type="checkbox"/> Nonreactive 9 <input type="checkbox"/> Unk (128)	1: _____ (129-132)

21. Did mother have confirmatory treponemal test result (e.g., FTA-ABS or TP-PA)? (133)  
 1  Yes, reactive 3  No test  
 2  Yes, nonreactive 9  Unk (Footnote a)

22. Did mother have darkfield or direct fluorescent antibody (DFA) exam of lesions at delivery? (134)  
 1  Yes, positive 3  No test of lesions 9  Unk  
 2  Yes, negative 4  No lesions present (Footnote a)

23. Before this delivery, when was mother last treated for syphilis? (135)  
 1  Before pregnancy (Go to Q24)  
 2  During pregnancy (Go to Q25) 3  No Treatment (Go to Q27) 9  Unk (Go to Q27)

24. Before pregnancy, was mother's treatment adequate? (144) (Footnote b)  
 1  Yes, adequate (Go to Q26) 9  Unk (Go to Q27)  
 2  No, inadequate (Go to Q27)

25. During pregnancy, was mother's treatment adequate? (145) (Footnote b)  
 1  Yes, adequate 3  No, inadequate: penicillin therapy begun < 30 days before delivery (Go to Q27)  
 2  No, inadequate: non-penicillin therapy (Go to Q27) 4  Unknown (Go to Q27)

26. An appropriate serologic response? (146) (Footnote c)  
 1  Yes, appropriate response with adequate serologic follow-up during pregnancy 3  No, inappropriate response: evidence of treatment failure or reinfection  
 2  Yes, appropriate response but no follow-up serologic titers during pregnancy 4  No, response was equivocal or could not be determined from available nontreponemal titer information

**PART II. INFANT INFORMATION**

27. Date of Delivery: \_\_\_\_\_  Unk  
 (Mo. / Day / Yr. (147-154))

28. Vital status: (155)  
 1  Alive (Go to Q30) 3  Stillborn (Go to Q31) (Footnote d)  
 2  Born alive, then died 9  Unk (Go to Q30)

29. Indicate date of death \_\_\_\_\_  Unk  
 (Mo. / Day / Yr. (156-163))

30. Gender: (164)  
 1  Male 2  Female 9  Unk

31. Birthweight (in grams) \_\_\_\_\_  Unk  
 (165-168)

32. Estimated gestational age (in weeks) \_\_\_\_\_  Unk  
 (169-170) (If infant was stillborn go to Q42)

33. a) Did infant/child have a reactive non-treponemal test for syphilis (e.g., VDRL, RPR)? (171)  
 1  Yes 2  No 9  Unk

b) When was the infant/child's first reactive non-treponemal test for syphilis? (172-179)  
 (Mo. / Day / Yr. (172-179))

c) Indicate titer of infant/child's first reactive non-treponemal test for syphilis? (180-183) 1: \_\_\_\_\_

34. a) Did infant/child have a reactive treponemal test for syphilis (e.g., FTA-ABS, TP-PA)? (184)  
 1  Yes 2  No 9  Unk

b) When was the infant/child's first reactive treponemal test for syphilis? (185-192)  
 (Mo. / Day / Yr. (185-192))

35. Did the infant/child have any classic signs of CS? (193) (Footnote e)  
 1  Yes 2  No, asymptomatic infant/child 9  Unk.

**Laboratory Confirmation**

36. Did the infant/child have a darkfield exam or DFA-TP? (194)  
 1  Yes, positive 3  No test  
 2  Yes, negative 9  Unk.

37. Did the infant/child have an IgM-specific treponemal test? (195) (Footnote f)  
 1  Yes, reactive 3  No test  
 2  Yes, nonreactive 9  Unk.

**Infant/Child Evaluation**

38. Did the infant/child have long bone X-rays? (196)  
 1  Yes, changes consistent with CS 3  No xrays  
 2  Yes, no signs of CS 9  Unk.

39. Did the infant/child have a CSF-VDRL? (197)  
 1  Yes, reactive 3  No test  
 2  Yes, nonreactive 9  Unk.

40. Did the infant/child have a CSF cell count or CSF protein test? (198) (Footnote g)  
 1  Yes, one or both elevated 3  No test  
 2  Yes, both not elevated 9  Unk.

41. Was the infant/child treated? (199)  
 1  Yes, with Aqueous or Procaine Penicillin for ≥ 10 days 3  Yes, with Benzathine penicillin x 1  
 2  Yes, with Ampicillin followed by Aqueous or Procaine Penicillin for a total ≥ 10 days 5  Yes, with other treatment  
 9  Unk. 6  No treatment

**PART III. Congenital Syphilis Case Classification**

42. Classification (200)  
 1  Not a case 2  Confirmed case (Laboratory confirmed identification of *T. pallidum*, e.g., darkfield or direct fluorescent antibody positive lesions) 3  Syphilitic stillbirth (Footnote d) 4  Presumptive case (A case identified by the above algorithm, which is not a confirmed case or syphilitic stillbirth).

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0128). Do not send the completed form to this address.

**Footnotes: a)** For the case definition of congenital syphilis (CS), the mother must have evidence of syphilis by one of the following tests: 1) a syphilitic lesion at the time of delivery proven by positive darkfield or direct fluorescent antibody (DFA) examination; or 2) a reactive treponemal test (e.g., FTA-ABS, MHA-TP). A treponemal test on the mother may not be available for an infant evaluated outside the newborn period or a child with late CS. In these instances, the investigation may proceed on the basis of infant/child treponemal and nontreponemal tests. An attempt to obtain a maternal treponemal test should be made.

**b)** Adequate therapy in a non-pregnant woman should be one of the standard treatment regimens recommended for her particular stage of infection (See 1989 STD Treatment Guidelines).

Adequate therapy in a pregnant woman is treatment with a penicillin regimen, appropriate for the mother's stage of syphilis, started at least 30 days before delivery (see 1989 STD Treatment Guidelines). Any non-penicillin treatment or penicillin treatment in the last 30 days of pregnancy is inadequate for the unborn child.

**c)** Appropriate response to therapy is a fourfold decline in non-treponemal titer by three months with primary or secondary syphilis, or a fourfold decline in non-treponemal titer by six months with early latent syphilis.

An inappropriate response is less than a fourfold drop over the expected time period unless the patient is known to be serofast (see below). An equivocal response includes instances where it was difficult to assess adequate response because either no interim titers from treatment to delivery were available or insufficient time had passed between treatment and delivery. An unknown response includes those instances where titers before treatment and/or at delivery are not available. The infant/child of a mother with an equivocal or unknown response should be evaluated for CS.

Special consideration is required in the case of a serofast patient. If a mother's titer was 1:1 or 1:2 before pregnancy, there is evidence of adequate treatment, and at delivery her titer is still the same low level, she should be regarded as serofast. Stop the case investigation; this is not a case.

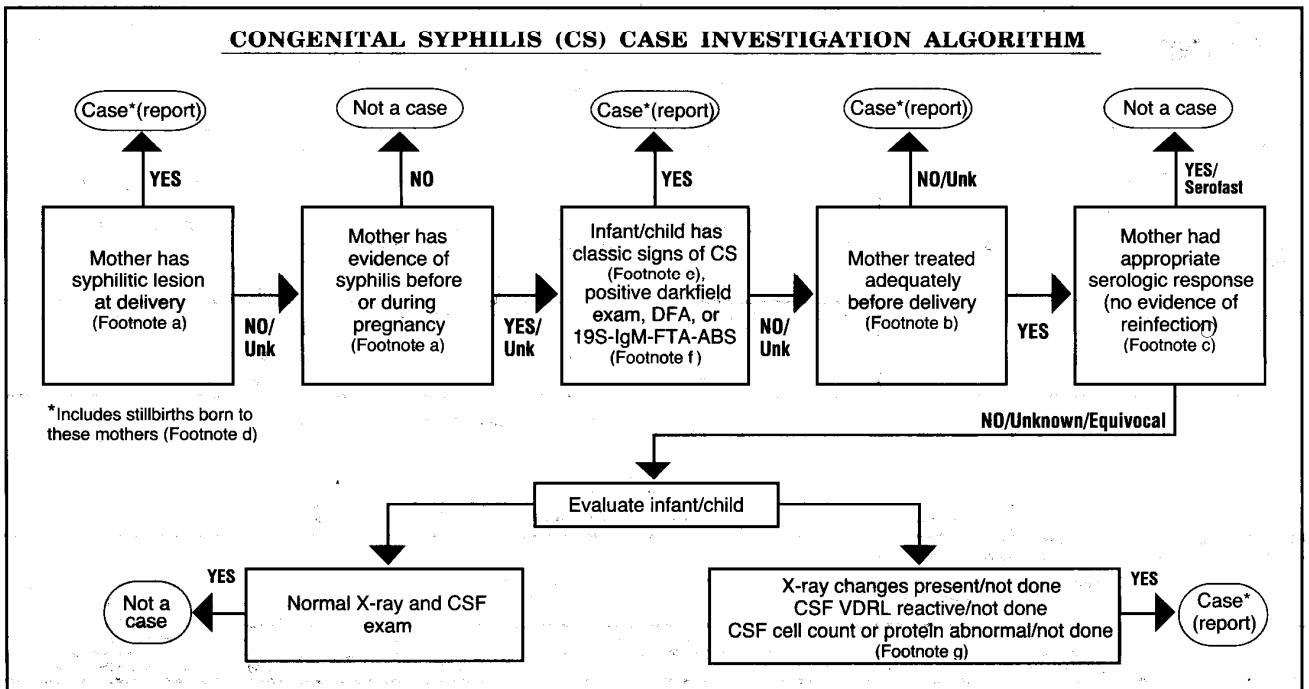
**d)** A syphilitic stillbirth is defined as a fetal death in which the mother had untreated or inadequately treated syphilis at delivery of a fetus after a 20-week gestation or weighing >500 grams.

**e)** Signs of CS (usually in an infant or child <2 years old) include: condyloma lata, snuffles, syphilitic skin rash, hepatosplenomegaly, jaundice due to syphilitic hepatitis, pseudoparalysis, or edema (nephrotic syndrome and/or malnutrition). Stigmata in an older child may include: interstitial keratitis, nerve deafness, anterior bowing of shins, frontal bossing, mulberry molars, Hutchinson's teeth, saddle nose, rhagades, or Clutton's joints.

**f)** The 19S-IgM-FTA-ABS is highly sensitive and specific in untreated neonatal syphilis. Other IgM-based treponemal tests are in use or in development. These are not yet considered standard tests of syphilis and should not be relied upon to define a case of CS. For specific questions regarding IgM-based treponemal test(s) being used in your area, contact the Division of STD Laboratory Research (404) 639-3224.

**g)** In the immediate newborn period, interpretation of these tests may be difficult; normal values vary with gestational age and are higher in preterm infants. CSF cell count and protein in a term or preterm infant should be interpreted by the clinician. Beyond the neonatal period, a CSF cell count >5 wbc/mm<sup>3</sup> or a CSF protein >40 mg/dl is abnormal, regardless of CSF serology.

(See instruction booklet for more details)



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# Routine STD Testing Summary Chart

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## ROUTINE STD TESTING SUMMARY CHART

<b>GONORRHEA</b>			
	<b>FEMALE</b>	<b>HETEROSEXUAL MALE</b>	<b>MSM</b>
Cervical	DNA probe, NAAT or culture	N/A	N/A
Urethral	Culture, if no cervix or NAAT (urine test)	Gram-stain and culture or NAAT	Gram stain and culture or NAAT
Anal/rectal	Culture, if exposed	Culture, if exposed	Culture, if exposed
Pharyngeal	Culture, if exposed	Culture, if exposed	Culture, if exposed
<b>CHLAMYDIA</b>			
	<b>FEMALE</b>	<b>HETEROSEXUAL MALE</b>	<b>MSM</b>
Cervical	DNA probe, NAAT or culture	N/A	N/A
Urethral	N/A	NAAT	NAAT
Anal/rectal	Not tested	Not tested	Culture, if exposed
Pharyngeal	Culture, if exposed	Culture, if exposed	Culture, if exposed
<b>SYPHILIS</b>			
	<b>FEMALE</b>	<b>HETEROSEXUAL MALE</b>	<b>MSM</b>
RPR	Yes, unless have had a negative in the past 30 days.		
Darkfield	On serous fluid from genital ulcers, or moist lesions of possible secondary syphilis.		
STAT RPR (*If possible)	Contacts to syphilis or presence of suspicious lesions.		
<b>HIV INFECTION</b>			
	<b>FEMALE</b>	<b>HETEROSEXUAL MALE</b>	<b>MSM</b>
Routine	Yes, unless has had a previous positive test, or a recent negative test with no high-risk behaviors since then.		
Repeat	Possible exposure within a short time period before previous negative test.		
<b>HERPES SIMPLEX</b>			
	<b>FEMALE</b>	<b>HETEROSEXUAL MALE</b>	<b>MSM</b>
Culture	Suspicious ulcerative lesions on or near the genitals		
Serology	Negative culture from ulcerative lesion or History of suspicious recurrent lesions, but unable to obtain a specimen to culture or Sex partner of a person with genital herpes (to compare antibody profiles).		
<b>HEPATITIS B ANTIBODY (at time of the first immunization)</b>			
	<b>FEMALE</b>	<b>HETEROSEXUAL MALE</b>	<b>MSM</b>
	Only if has a history of high-risk behavior (e.g., needle sharing)		Yes

\*Currently, Stat RPR test can only be done at Fulton and DeKalb Counties.



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Standards of Basic  
STD-Related Medical  
History and Risk  
Assessment

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## **STANDARDS FOR BASIC STD-RELATED MEDICAL HISTORY AND RISK ASSESSMENT**

Information obtained, and recorded, should accurately define the problem(s), determine risk for STD/HIV infection and lead to successful client management.

1. Reason for Visit – Note whether client is a volunteer, a contact to a specific disease, has a positive lab test, or needs follow-up.
2. Symptom History – Duration, location, character; note if a recurring problem.
3. Sexual History – Last exposure; sexual partners (male/female/both); exposure sites (oral/genital/anal); number of recent (1-2 months) partners; recent new partner; frequency of condom use/if use with all partners, and if a partner has signs/symptoms.
4. Medical History – Recent use of antibiotics; other current medications; known drug allergies, including name of drug and type of reaction.
5. History of Drug Use and Needle-Sharing Practices – In self and/or sex partners. Including oral, inhaled or injected “street” drugs and alcohol.
6. Past History of STDs – Especially gonorrhea, chlamydia, Syphilis and HIV infection. Also, history of Hepatitis A and B infection or immunizations.
7. Females: Contraception, Date of Last Menses, Last Pap Smear, Last Douche – Note any abnormalities of last menses and likelihood of pregnancy.
8. Other History – Allergies and current significant health problems. As indicated, note recent pulmonary infection or breathing problems; frequency and type of bacterial infections in the past year; unexplained weight loss, night sweats, fatigue, depressed appetite, unexplained diarrhea.
9. List any other Health Problems.

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# Field and Partner Services Continuous Quality Improvement Overview

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## **Field Investigation, Case Management & Partner Services Site Visit Guide**

### **Purpose**

To provide the 18 Health Districts with a working document of the STD Program Consultants purpose and intent to review the STD Field Service & Partner Notification Program. The Quality Assurance Team will listen to Lead and CDS concerns, randomly select field and interview records during District visits. It is also an opportunity to acknowledge and encourage continued success in most program areas. It will also allow us to assist Districts to implement systems that are in compliance with State/Federal Guidelines, and CDS Process Performance Expectations that will improve existing systems. Overall, the STD Program Consultants job is to provide technical support to STD Programs in Georgia that will maximize disease intervention opportunities.

### **Overview**

The STD Quality Assurance Team will review CDS statistics, field record documentation, case lots, and medical record documentation for completeness and accuracy such as number of telephone calls, number of field visit attempts, collaborative efforts between CDS Staff, local health departments, hospitals, and private providers.

The STD Quality Assurance Team will also evaluate the process of all out-of-state records searches that are completed via calling STD Section Case Reporting Unit Data Transcribers prior to client pursuit.

STD Quality Assurance Team will evaluate the request for record search process to ensure that designated personnel in the Districts exclusively call the STD Section Case Reporting Unit Data Transcribers for record searches to minimize the possibility of breeching client confidentiality.

## Standards for Reviewing Process of Initiating Syphilis Reactors

### Purpose

Observe efforts and evaluate process of all disease intervention opportunities to decrease the number of infectious Syphilis cases in Georgia in accordance with STD Program expectations.

The STD Quality Assurance Team will:

1. Review Reactor Grids appropriate for each District's morbidity.
2. Assess timeliness of reporting from the providers (i.e., health departments, hospitals, private providers, CBO's, and Non-traditional Test Sites).
3. Evaluate time between provider report, surveillance, initiation, and CDS follow-up to address delays and establish systems to improve timeliness of reporting.
4. Review thoroughness and accuracy of CDS Pre-interview Analysis (i.e., record searches, provider calls, confirmatory testing, and medical records).
5. Review ability of all Districts to **PRIORITIZE** Syphilis reactors based on infection stage, and other conditions such as pregnancy).
6. Review swiftness of follow-up on all Syphilis serologies that are primary, secondary, early latent, and unknown duration.
7. Discuss any needs to expand interview questions to address MSM that do not identify with being Gay and/or homosexual.

## **Congenital Syphilis Case Reviews**

### **Purpose**

Review cases and provide feedback on methods used to decrease the number of congenital Syphilis cases in Georgia based on STD Program expectations

### **The STD Quality Assurance Team will**

1. Observe timeliness in reporting of Congenital Reactors
2. Review Congenital Syphilis Surveillance
3. Review accuracy in how Districts' determine a case, a presumptive case, and those that are not cases
4. Ascertain methods used by the Districts to follow-up on Congenital Cases and report morbidity to the State
5. Assure prevention of congenital cases and/or assure treatment is given
6. Assure compliance with CDC recommendations
7. Review completeness and accuracy of CDC Congenital Forms

## **Review of Standards for Following Up on Positive Gonorrhea and Chlamydia Test Results**

### **Purpose**

To review and provide feedback on methods used to follow-up on positive Gonorrhea and Chlamydia cases according to the STD Program expectations

### **The STD Quality Assurance Team will review**

1. Timeliness of reporting
2. Process of initiating reactive Gonorrhea and Chlamydia field records
3. Gonorrhea & Chlamydia surveillance
4. Observe CDS knowledge-base on Gonorrhea and Chlamydia
5. Field records & cases for completeness, accuracy, and thoroughness
6. CDS ability to establish interview period

## **Partner Notification Services Review**

### **Purpose**

To evaluate how partner notification activities are prioritized, what to initiate, field pursuit, and exploration of socio-sexual networks

### **STD Quality Assurance Team will review**

1. Initiated partners and clusters
2. Descriptive information to locate partners/clusters
3. Pursuit convey a sense of urgency
4. Appropriate documentation of activities
5. Where notification of partners/clusters are done
6. Direct observation of a Syphilis, HIV, Gonorrhea, and Chlamydia partner notification
7. Frequency of CDS offering field bloods
8. How partners/clusters are referred
9. Dispositions



## **Review of Out of Jurisdiction (OOJ) Process**

### **Purpose**

To ensure OOJ's are followed up on and given the same level of priority as day-to-day assigned field records.

Standardize the OOJ system in all Districts while recognizing the unique systems already in place.

### **STD Quality Assurance Team will review**

1. Requirements for approving OOJ's (i.e., completeness of locating and descriptive information)
2. Step-by-step process for calling OOJ's
3. Timely follow-up and return of dispositions
4. Level of communication between Districts on OOJ's (i.e., meetings)
5. OOJ Log and follow-up on due dates

## CDS Pouch Reviews

### **Purpose**

To ensure organization, confidentiality and security of client information in pouches.

To observe if field records are in appropriate sections of pouch, documentation is urgent, and field records are prioritized.

To review frequency of pouch reviews by Supervisors and Leads

*STD Quality Assurance Team will*

1. Discuss frequency of pouch reviews with Supervisors and Leads.
2. Observe confidentiality of material in pouch and security of field records.
3. Review prioritization and organization of field records in pouch according to disease, stage of disease, cases, partners, and clusters.
4. Review documentation of field activities.

## **Review of Field Records**

### **Purpose**

To ensure that a criteria is established for dispositions: “H”, “J”, “D”, “G”, and “L” and that Supervisor approval is given prior to official closure.

### **STD Quality Assurance Team will**

1. Observe guidelines and/or protocols in place for the dispositions listed above.
2. Randomly select field records with dispositions: “**H**”, “**J**”, “**D**”, “**G**”, and, “**L**” for review of investigative activities conducted to support disposition given.

## **Examinations, Interview and Treatment**

### **Purpose**

To review the amount of time spent in locating, notifying, arranging for client exam, treatment, and interview of client to determine if the activities are completed according to Process Performance Standards

STD Quality Assurance Team will identify the strengths CDS have in the field as well as provide technical support needed in areas of improvement. STD Quality Assurance Team will learn a lot from CDS as well as provide expertise to enhance the CDS level of skills.

### **The STD Quality Assurance Team will observe**

1. Field Preparedness (i.e., I.D., educational tools, client location, blood kit)
2. Field Safety
3. CDS access to Accident/Injury reports, knowledge of what to do in the event of an injury while working in the field
4. Unique strategies used to find client, partner notify, arrange for treatment, exam, interview, and referral
5. Ability to establish rapport with clients and thorough client-centered interviews
6. Knowledge-base of disease (i.e., etiology, transmission, signs/symptoms, treatment, partner referral, establish accurate interview periods, and risk reduction)
7. Confidentiality
8. Knowledge of available resources in the community to meet client needs
9. Clustering techniques
10. Phlebotomy Skills (i.e., proper set up, universal precautions, completion of lab slips)
11. Familiarity with the morbidity in their area

## **Interview Process**

### **Purpose**

To directly observe CDS interviews with clients infected with Syphilis, Gonorrhea or Chlamydia.

The STD Quality Assurance Team will not get involved in the interview sessions unless CDS request assistance. The Consultant's primary focus is to observe, listen, and learn.

The STD Quality Assurance Team will:

1. Observe a Syphilis, and either a Gonorrhea, or Chlamydia interview.
2. Provide constructive feedback.
3. Commend CDS strengths and provide coaching in areas needing improvement.
4. Review interview records for completeness, and accuracy.
5. Review case notes, plan of action, and dialogue between Supervisor & CDS.
6. Will evaluate disease intervention opportunities and/or lack thereof.
7. Provide assistance in developing systems that will foster improved interviewing skills, and enhance disease intervention opportunities.

## Case Management

### Purpose

To evaluate the systematic approach, documentation, and analysis of medical and epidemiological case information to further disease intervention opportunities.

Once the CDS has interviewed client, completed post-interview analysis, and is prepared to write up the case, the key to maximizing good disease intervention is through good and timely case management of contacts. By prioritizing who needs to be followed first based on exposure and/or infectiousness, the goal of obtaining primary intervention should be top priority. Avoiding extreme time lapses between original interviews, and subsequent follow-up re-interviews will provide the opportunity for the CDS to further explore risk reduction techniques, gain clarity on original interview information, elicit more contacts, and discuss client's ability to change behaviors that put them at risk for STD.

**The STD Quality Assurance Team will observe all of the aforementioned and:**

1. Appropriate documentation on field records, interview records.
2. Ability to prioritize contacts.
3. Provide appropriate resources.
4. Timely contact follow-up.
5. Cluster Interviewing when warranted.
6. Good Visual Case Analysis (VCA).
7. Techniques used to identify Source & Spreads.
8. Define appropriate plan-of-action based on case and disease intervention needs.
9. Timely response to Supervisor Comments.
10. Timeliness on following Supervisor directives especially directives with timeframes.
11. Evaluate the Lot System and content to verify completion and accuracy in format.

## Review of Questionable Dispositions

### *Purpose*

To assure that dispositions “H”, “J”, “D”, “G”, and “L”, have supporting field activities justification and are approved by Supervisor or Lead prior to filed record closure.

### *STD Quality Assurance Team will review*

1. Criteria for giving “H” disposition and randomly select “H” dispositioned field records
2. Criteria for giving “J” dispositions and efforts of urgency used to convince client to accept treatment by randomly selecting field records with “J” disposition
3. Criteria & explanation of closing with disposition “D” and randomly select field records with “D” disposition
4. The use of the “G” disposition and random selection of field records with “G” disposition
5. The use of the “L” disposition and randomly select field records dispositioned “L”

### Review of Cases Submitted as Refused Interview

**Purpose:** To ensure that every possible technique is exhausted prior to making decision to close a case as refused interview without going outside of District parameters.

### STD Quality Assurance Team will review:

1. Randomly select cases submitted and/or closed as a refusal, to assure the client did not consider other alternatives (i.e., after 5pm interview, before 8am interview, telephone only, etc.)
2. Ensure Supervisor or Lead approved of the refused interview 73.54 prior to closure.

## Review of Lot System

### *Purpose*

To evaluate the arrangement of the Lot System

### *STD Quality Assurance Team will look for:*

1. Confidentiality and security of files
2. Lots are filed accurately (i.e., sequentially, by year, no duplication of Lot numbers)
3. All paperwork kept in Lots is present
4. Lot Book



## REVIEW OF ADDITIONAL ACTIVITIES/REQUIREMENTS OF CDS

### **Purpose**

CDS completes numerous tasks in addition to the aforementioned expectations. The STD Quality Assurance Team will review and take into consideration the impact of additional tasks CDS does as well as provide feedback on how to best maximize their time in terms of priority.

### **STD Quality Assurance Team will look for the:**

1. Number of outreach screenings CDS participate in.
2. Number of in-services CDS provides to various providers.
3. Collaborative efforts between CDS colleagues, CDS and hospitals, local health departments, community-based organizations, faith-based organizations, and private providers.
4. Frequency of CDS training, and Chalk talks.
5. Special Projects (i.e., STD studies).
6. Documentation of training and training needs.



# Georgia Department of Human Resources

**STD QUALITY ASSURANCE TEAM**

**CONTINUOUS QUALITY IMPROVEMENT (CQI) TOOL**

## **INTRODUCTION TO CONTINUOUS QUALITY IMPROVEMENT (CQI) FOR THE EIGHTEEN DISTRICTS**

### **SEXUALLY TRANSMITTED DISEASE (STD) PROGRAM**

#### **PURPOSE**

The purpose of this tool is to serve as a guide to enhance the STD Control Program and maximize disease intervention opportunities. A myriad of strategies will be implemented within the program to improve the quality of care to people infected with and/or exposed to Syphilis, Chlamydia, Gonorrhea.

#### **CONTINUOUS QUALITY IMPROVEMENT (CQI) BACKGROUND & PURPOSE**

CQI is a method of evaluation that is composed of structure, process, and outcome objectives that focuses on improvement efforts to identify performance gaps, resource needs, and to identify areas that need improvement. A plan of action has been established to conduct district visits, review and assess programmatic gaps, programmatic needs, develop systems to enhance disease intervention and improve existing systems to reach the same end.

#### **STRUCTURE**

The CQI monitoring team currently consists of staff from STD, and STD/EPI Surveillance.

#### **PROCESS**

The CQI Tool will be used as a standard which each district should work towards. The STD Quality Assurance Team will review systems used to intervene in the spread of STDs.

Prior to each site visit the districts will receive the CQI Tool and an overview of the systems being assessed. Following the district visits feedback will be given within 30-45 days providing recommendations for structure, function, resource needs, and process improvement.

# Continuous Quality Improvement

**Review:**                    \_\_\_\_/\_\_\_\_/\_\_\_\_

**Review Site(s):**        \_\_\_\_/\_\_\_\_/\_\_\_\_

## CQI Team Members

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

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Objective 14,15, 16

## **STD FIELD INVESTIGATION QUICK REFERENCES**

<b>R-1</b>	<b>STD Quality Assurance Team District Review Checklist</b>
<b>R-2</b>	<b>Disease Intervention Priority List</b>
<b>R-3</b>	<b>Components of A Field Investigation</b>
<b>R-4</b>	<b>Documenting Field Investigation Activities On Field Records</b>
<b>R-5</b>	<b>Recommended Checklist For Unable To Locate Clients (H) Disposition</b>
<b>R-6</b>	<b>Recommendations For Thorough Case Interview Write-ups</b>
<b>R-7</b>	<b>Definitions For Method Of Case Detection</b>
<b>R-8</b>	<b>Developing Plan Of Actions (POA's)</b>

Objectives and Action Steps (AS)	Yes	No	Incomplete	COMMENTS
<b><i>PARTNER AND FIELD SERVICES CONTINUOUS QUALITY IMPROVEMENT (CQI) TOOL</i></b>				
<b>OBJECTIVE 1:</b>				
<b>Conduct annual site visits to the local health districts to evaluate partner and field services activities to assist with improving existing systems and implement new systems to maximize disease intervention opportunities</b>				
<b>Action Steps:</b>				
A). Conduct Pre-site visit interviews with the STD Frontline Supervisors and CDS staff regarding concerns unique to each district; and,				
B). Audit randomly selected field records, interview records, documentation of field activities, and partner notification services for accuracy, timeliness, quality, and disease intervention				
<b>OBJECTIVE 2:</b>				
<b>Evaluate Record Search Techniques</b>				
<b>Action Steps:</b>				
A). Review step-by-step process of how records searches are conducted, who the designated person is, who the point of contacts are, and how information is conveyed to the CDS Staff				
<b>OBJECTIVE 3:</b>				
<b>Evaluate Process of Initiating Syphilis Reactors</b>				
<b>Action Steps:</b>				
A). Review Reactor Grid to ensure it correlates with the Districts current morbidity				
B). Review how Field Records are assigned to CDS				
C). Review CDS workload				

Objectives and Action Steps (AS)	Yes	No	Incomplete	COMMENTS
<b>OBJECTIVE 4:</b>				
<i>Review STD Reporting for Compliance with Georgia's Notifiable Disease Requirements</i>				
<b>Action Steps:</b>				
A). Evaluate time between provider report, surveillance, initiation, and CDS follow-up to address reporting delays and establish systems to improve timeliness of reporting				
<b>OBJECTIVE 5:</b>				
<i>Evaluate Congenital Syphilis Follow-up</i>				
<b>Action Steps:</b>				
A). Observe timeliness of reporting congenital Syphilis reactors				
B). Review Congenital Syphilis Surveillance				
C). Review accuracy on determining if a congenital reactor is a case, a presumptive case, or not a case				
D). Assure compliance with CDC Recommendations on Congenital Case follow-up and accuracy of completing congenital forms				
<b>OBJECTIVE 6:</b>				
<b>Review Positive Gonorrhea and Chlamydia Test Follow-up</b>				
<b>Action Steps:</b>				
A). Review timeliness of Gonorrhea and Chlamydia reporting and follow-up				
B). Observe process of initiating positive Gonorrhea and Chlamydia field records to CDS				
C). Evaluate CDS field follow-up on Gonorrhea and Chlamydia interview, notification process and disease case management				

Objectives and Action Steps (AS)	<i>Yes</i>	<i>No</i>	<i>Incomplete</i>	<i>COMMENTS</i>
<b>OBJECTIVE 7:</b>				
<b>Evaluate Field Preparedness</b>				
<b>Action Steps:</b>				
A). Review CDS organization of Priority field investigation activities				
B). Evaluate confidentiality of field records in pouch				
C). Observe CDS for proper identification and prepared referral letters				
D). Evaluate strategies used to locate clients that are difficult to find and ability to prioritize field records				
E). Review ability to use maps and web-based directions				
F). Review CDS ability to establish rapport with clients				
G). Evaluate STD knowledge and accuracy of delivery of STD information				
H). Review CDS knowledge of available resources in the community to meet client needs				
I). Observe CDS Phlebotomy Kit for proper equipment, protective gear, educational brochures, and condoms				
J). Assess CDS familiarity with the morbidity in the local districts they work				



Objectives and Action Steps (AS)	Yes	No	Incomplete	COMMENTS
<b>OBJECTIVE 8:</b>				
<b>Review Field Records</b>				
<b>Actions Steps:</b>				
A). Randomly select field records for review for completeness, accuracy, timeliness in beginning investigation, and documentation				
B). Review field records dispositioned, “H”, “L”, “J”, “D”, and “G” to ensure appropriate field investigation strategies support the dispositions listed above				
<b>OBJECTIVE 9:</b>				
<b>Evaluate Partner Notification Services</b>				
<b>Action Steps:</b>				
A). Review Prioritization of contacts				
B). Review locating information				
C). Evaluate CDS urgency in pursuing high priority partners				
D). Review confidentiality in delivery of partner notification information				
E). Review completeness and accuracy STD information given to partners, use of pictures, and distribution of risk reduction material				
F). Evaluate how partners and contacts are referred to providers for exam and treatment				
G). Review frequency CDS staff offer and/or perform field bloods				
<b>OBJECTIVE 10:</b>				
<b>Evaluate CDS Interview Skills</b>				
<b>Action Steps:</b>				
A). Directly observe CDS conduct a Syphilis, Gonorrhea, and Chlamydia interview using the evaluation tools located in the <u>“Program Operations Guidelines for STD Prevention Manual”</u>				

Objectives and Action Steps (AS)	<i>Yes</i>	<i>No</i>	<i>Incomplete</i>	<i>COMMENTS</i>
<b>OBJECTIVE 11: Review Lot System</b>				
<b>Action Steps:</b>				
A). Assess confidentiality and security of files in the districts (Lot Files and field records only)				
B). Review order of Lots filed for chronological order, year, etc.				
C). Review completeness of Lot Files (i.e., MAP sheet, Interview Record, Case Notes, Re-interview Forms, Cluster Interview Forms, and Plan of Action)				
D). Review the Lot Log Book				

Objectives and Action Steps (AS)	<i>Yes</i>	<i>No</i>	<i>Incomplete</i>	<i>COMMENTS</i>
<b>OBJECTIVE 12:</b>				
Evaluate Disease Case Management Strategies for Maximizing Disease Intervention.				
<b>Action Steps:</b>				
A). Review Post-Interview Case Analysis				
B). Review timeliness in case write up and submission and the thoroughness of the case notes (i.e., Reason for exam, Medical history, Demographics, lifestyle, behavior, risk reduction methods that are client-centered, and CDS general impression of client and interview				
C). Review CDS ability to develop a plan of action that will expand disease intervention opportunities				
D). Observe creative techniques used to get additional partner/cluster information				
E). Assess CDS ability to prioritize contacts gathered through Original Interview, Re-interview, and Cluster Interviews				
F). Evaluate communication between Front Line Supervisors and CDS on disease case management that will facilitate skills-building for the CDS in maximizing disease intervention opportunities				
G). Review accuracy of plotting Syphilis signs/symptoms, treatment, contacts, ghosting, and source spread analysis when using the Visual Case Analysis Tool				
H). Review determining factors in closing cases				
I). Review 73.54 (Interview Records) for completeness & accuracy				
J). Review accuracy & completeness of Field Records				

Objectives and Action Steps (AS)	<i>Yes</i>	<i>No</i>	<i>Incomplete</i>	<i>COMMENTS</i>
<b>OBJECTIVE 13:</b>				
<b>Review Cases Submitted as Refused Interview</b>				
<b>Action steps:</b>				
A). Randomly select cases submitted and/or closed as a refused interview				
B). Evaluate events that influenced client refusal				
<b>OBJECTIVE 14:</b>				
<b>Review and Discuss with the 19 local health districts additional activities and requirements of the CDS Staff that impact Partner and Field Services</b>				
<b>Action Steps:</b>				
A). Assess number of special studies that directly impact CDS activities				
B). Assess number of outreach efforts and screenings CDS are involved in and their role in the success of outreach activities				
<b>OBJECTIVE 15:</b>				
<b>Evaluate Supervisor and CDS Staff Training needs</b>				
<b>Action Steps:</b>				
A). Assess number of Supervisors needing Advanced) Introduction to Sexually Transmitted Disease Intervention (AISTDI)				
B). Review records of pouch, interview, and field audits conducted by Supervisors				
C). Increase one-on-one coaching between Supervisors and CDS				
D). Assess and implement STD MIS Training for CDS Staff				



## **STD Field Investigation Quick References**

<b>R-1</b>	<b><i>STD Quality Assurance Team District Review Checklist</i></b>
<b>R-2</b>	<b>Disease Intervention Priority List</b>
<b>R-3</b>	<b>Components of a Field Investigation</b>
<b>R-4</b>	<b>Documenting Field Investigation Activities on Field Records</b>
<b>R-5</b>	<b>Recommended Checklist for Unable To Locate Clients (H) Disposition</b>
<b>R-6</b>	<b>Recommendations for Thorough Case Write-ups</b>
<b>R-7</b>	<b><i>Definitions for Method of Case Detection</i></b>
<b>R-8</b>	<b>Developing Plan of Actions (POA's)</b>
<b>(Attachment)</b>	<b>Skills Inventory from <u><i>“Program Operations Guidelines for STD Prevention”</i></u> Manual</b>

## STD QUALITY ASSURANCE TEAM DISTRICT VISIT CHECKLIST

**R-1**

	Y	N	N/A	Comments
Pre-Assessment Meeting w/Supervisors & Leads & Training Needs Assessment				
Processing Reactors (Syphilis, Chlamydia, and Gonorrhea)				
Congenital Syphilis Case Review				
Follow-up on + Gonorrhea & Chlamydia Test Results				
Review of Partner Notification Services				
Review of OOJ Process/Follow-up				
Pouch Review (Frequency)				
Field Record Review (Random)				
Review of Examination, Interview, and Treatment Process				
Case Management Review				
Focus on Specific Dispositions (“H”, “J”, “D”, “G”, and “L”)				
Review of Cases That Refused Interview				

**Top Priority**

1. Pregnant Females who have
  - a. Reactive STS
  - b. Contact to Syphilis
  - c. Reactive Syphilis test on adolescents 16 and under
  - d. Persons with positive STS and infectious symptoms with no treatment
  - e. Contacts who have been exposed to infectious Syphilis
  - f. Priority requests for assistance from Local Health Districts and/or Local Providers

Section 1.01 Second Priority

- a. Contacts to other stages of Syphilis (unknown duration)
- b. Reactors that have been treated and need to be interviewed
- c. Re-Interviews of persons treated for infectious Syphilis and pregnant females treated for Syphilis
- d. Suspects and associates to Syphilis cases who are identified as having symptoms or who are associated with known highly infectious cases

Section 1.02 Third Priority

- a. All other suspects to Syphilis cases
- b. Re-Interview of persons treated for other stages of Syphilis

This prioritization list enables CDS to strive for optimal intervention in the spread of Syphilis and to also reduce incidents of congenital Syphilis

Prioritizing is just one of the methods used to achieve disease intervention. Once CDS arrange their paperwork according to the recommended priorities, it is essential that expeditious interviews and field investigations be completed.

This list can only work if case reviews and pouch audits occur within prescribed timeframes and according to protocols (i.e., cases are reviewed and returned to CDS within 48hours, weekly pouch audits, routine field audits, etc.)

**Considerations**

- ◆ Reactor Grid should be used for initiation and follow-up of Syphilis reports
- ◆ Supervisors must consider their counties needs

# COMPONENTS OF A FIELD INVESTIGATION

## Preparation

1. **Organize Workload**
2. *Set Priorities*
3. **Geographic Consideration**

### *Record Search*

1. Clinical Medical Records
2. Open & Closed Epidemiological Records
3. Telephone Directory/Directory Assistance
4. Cross References / Corrections System
5. DMV
6. Post Office
7. InfoSearch (Web)
8. Corrections System

### *Investigating*

1. Use Maps
2. Access Website Driving Directories
3. Use Common Sense
4. Select proper time of day for referral based on the particular circumstances
5. Ask Confidentially: Postman, Neighbors, Apartment managers, Children
6. Check mail boxes (don't open)
7. Transpose numbers within reason

### *Performing the Referral*

1. Be assertive and dress appropriately for the situation
2. Have accurate information
3. Be prepared for confrontation about who you are
4. Plan what you're going to say
5. Assess the situation: *What else can I learn about this person? Am I safe here? Should I go in? Who else is here? Who is watching or listening to me?*

### *Notification*

1. Advise client of what disease is involved
2. Outline the basis and validity of the information
3. Define the steps which must be taken and the urgency
4. Establish the follow-up plan



## DOCUMENTING FIELD INVESTIGATION ACTIVITIES ON FIELD RECORDS

R-4

1. Time and Date
2. Type of activity (field visit, telephone call, interview)
3. Who was seen
4. What was said
5. Changes in address/telephone numbers/other locating information
6. Referral plan
7. Problems encountered/cautions to be considered
8. New information about other clients obtained

**RECOMMENDED CHECKLIST FOR UNABLE TO LOCATE CLIENTS (H) DISPOSITIONED**

**R-5**

<b>ACTION STEPS</b>	<b>Yes/No</b>	<b>COMMENTS</b>
Record Search STDMIS and Closed Field Records		
Record Search Complete Medical Records		
Phone Book and Cross Directory Check		
Follow up w/Residence Manager or Landlord as needed		
Appropriate Field Visits to address (3) Field Visits/Telephone calls (3) different times of day, ask neighbors		
Follow-up with employer and/or supervisor as needed		
Record search local shelters		
Follow-up or Re-interview Original Client		
Second contact with physician to see if client has returned		
Record Search local jails/Prison Locator		
Contact neighbors to confirm address or to get additional locating		
Record Search Case Registry		
Follow-up with other Districts if any indication of OOJ activity, residence, employment, family		
Collaborate with appropriate Outreach Workers		

# RECOMMENDATIONS FOR THOROUGH CASE WRITE-UP

R-6a

## ORIGINAL INTERVIEW

What To Include	<ul style="list-style-type: none"> <li>❖ Reason for visit</li> <li>❖ Signs/Symptoms, previous STD history/treatment</li> <li>❖ Medical History</li> <li>❖ Alcohol or Drug History, If Any</li> <li>❖ Referral of Sex Partners and/or Suspects</li> <li>❖ Follow up Exams and Treatment</li> <li>❖ Risk Reduction Plan (Client-Centered)</li> <li>❖ Client Response, Interaction, Behavior or Attitude</li> </ul>
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## RE-INTERVIEW

What To Include	<ul style="list-style-type: none"> <li>❖ Introduce/Re-introduce self</li> <li>❖ Explain Role if different from original interviewer</li> <li>❖ Re-visit and ensure confidentiality</li> <li>❖ Define purpose of session:             <ol style="list-style-type: none"> <li>1. Discuss problems with commitments made in the original interview</li> <li>2. Discuss new information learned about client's infection                 <ol style="list-style-type: none"> <li>(i). <u>Client Assessment</u></li> </ol> </li> </ol> </li> <li>❖ Client concerns</li> <li>❖ Social-sexual Information</li> <li>❖ Medical History and Disease Comprehension</li> </ul>
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<p><i>What To Include</i></p>	<p><b>Disease Intervention Activities</b></p> <ul style="list-style-type: none"> <li>❖ Assure Examination of all Partners</li> <li>❖ Identification of potential Source Candidates</li> <li>❖ Identification of potential Spread Candidates</li> <li>❖ Dispositions of previously identified partners or suspects</li> <li>❖ Analysis of areas unexplored in the original interview</li> <li>❖ Locating Problems of Contacts</li> <li>❖ Results of Cluster Interview(s)</li> </ul> <p><b><u>Risk Reduction Plan</u></b></p> <ul style="list-style-type: none"> <li>❖ Review client’s plan for preventing future STD/HIV exposures as discussed in original interview</li> <li>❖ Support positive changes and explore barriers to making positive changes</li> <li>❖ Additional Contacts</li> </ul>
<p><b>Conclusion</b></p>	<ul style="list-style-type: none"> <li>❖ Evaluate client needs, compliance problems, inconsistencies in case, reinforce commitments made by client</li> </ul>

## *CLUSTER INTERVIEWS*

<b>What To Include</b>	<ul style="list-style-type: none"><li>❖ Introduce yourself/explain your role as a CDS</li><li>❖ Explain confidentiality</li><li>❖ Define purpose of session<ol style="list-style-type: none"><li>1. To provide information about the disease exposed to and the reason for treatment</li><li>2. To provide information to help prevent future exposures</li><li>3. To help the client know what to do if re-exposed</li></ol></li></ul> <p><b>Client Assessment</b></p> <ul style="list-style-type: none"><li>❖ <b>Client Concerns (why treatment is given when test is negative; why talk to CDS if test is negative; confidentiality, time, clinic experience)</b></li><li>❖ Client-centered discussion of disease intervention behaviors</li></ul> <p><b><u>Socio-sexual Information</u></b></p> <ul style="list-style-type: none"><li>❖ Importance of accurate locating information and medical information on client</li><li>❖ Pursue the following items of information by assessing client response and using two-way communication:<ol style="list-style-type: none"><li>A). Current address and telephone number (if needed)</li><li>B). Living with and marital status</li><li>C). Lifestyle (travel, recreational behaviors, social groups)</li></ol></li></ul> <p><b>Medical Information</b></p> <ul style="list-style-type: none"><li>❖ Assess what the client knows about the disease</li><li>❖ Reinforce what the client knows and correct misconceptions</li></ul>
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<p><b>What To Include</b></p>	<p><b>If Original Client is Named</b></p> <ul style="list-style-type: none"> <li>❖ Don't display special interest in the Original Client when mentioned to maintain confidentiality</li> <li>❖ Subtly inquire about Original Client's behavior, risks, partners, etc.</li> <li>❖ Pursue Associates with signs &amp; symptoms suggestive of disease (A-1s); pursue Associates who had sex with infected person (A-2s); may pursue Associates that will benefit from an exam (A-3s)</li> </ul> <p><b>Take Medication (when applicable) R-6b</b></p> <ul style="list-style-type: none"> <li>❖ Emphasize need to take all medicine</li> <li>❖ Establish a medication schedule</li> <li>❖ Discuss contraindications and possible side-effects</li> <li>❖ Identify and discuss any compliance problems</li> </ul>
<p><b>Conclusion</b></p>	<ul style="list-style-type: none"> <li>❖ Evaluate client needs or potential compliance problems</li> <li>❖ Reinforce any commitments made by client</li> <li>❖ Redefine respective roles and referral procedures</li> </ul>

**R-6c**

## DEFINITION FOR METHOD OF CASE DETECTION

**R-7**

<b>Provider Referral (01)</b>	Client diagnosed as a result of being informed by a Communicable Disease Specialist or other health care provider that they were exposed to an infection and needed an exam. Testing an individual with an occupational exposure is also a Provider Referral.
<b>Cluster (02)</b>	This case was brought to the attention of the program as a result of a DIS cluster interview. This case was originally designed as a <i>Suspect</i> or <i>Associate</i> .
<b>Client Referral (03)</b>	This case was referred to the program by another known case following an interview. This may be a named or unnamed partner. No provider involvement was necessary for this referral. Enter the disease code of the known case to which the provider referral, cluster referral, or client referral is reportedly related.
<b>Prenatal (04)</b>	This case was found as a result of prenatal screening
<b>Delivery (05)</b>	This case was found as a result of screening at the time of delivery. This only applies to the mother, the Method of Case Detection for the infant is a <b>Cluster (02)</b>
<b>Institutional Screening (06)</b>	A client is tested, at intake, because the facility where the test was performed has a policy to test everyone who makes use of their services. Prisons, jails, substance abuse treatment centers, Red Cross, plasma centers, insurance and Job Corps are examples of this type agency.
<b>Community Screenings (07)</b>	A targeted intervention in the community. Rapid Response, Non-traditional Test Sites, Outreach by the STD Branch or other agencies, or if CDS target an area for screening based on clustering are examples.
<b>Reactor (08)</b>	This case was found as a result of routine Syphilis reactor surveillance and follow-up by program staff.
<b>Provider Report (09)</b>	This case was identified by a written or telephoned report initiated by a private health care provider.
<b>Volunteer (10)</b>	The diagnosis was made because the client went to the provider to determine if they have infection (self-referral). This means exhibiting symptoms of the infection or specifically asking to be tested for the disease for which they are later diagnosed. The volunteer client does not have to recognize that the symptoms are for the diagnosed infection (a client going to the health department with a syphilitic lesion thinking it's Gonorrhea is still a volunteer).

## DEVELOPING PLAN OF ACTIONS (POA'S)

R-8

### **Purpose**

To identify opportunities and develop a plan for disease intervention at the earliest opportunity

### **What is a Plan of Action (POA)?**

*A Plan of Action is a road map describing the next steps after completing the original interview. POA's can change as a result of investigative findings and additional information is gathered around the original client.*

### **How To Develop a POA?**

- The first step is to conduct a thorough post-interview analysis and make decisions in efforts to intervene in disease spread.
- Record search for information of named sex partner(s) to determine any prior medical or disease intervention history on the partner(s)
- Utilize standard investigative resources to confirm locating information on all sex partners and clusters (phone books, cross-references, prior investigations, etc.)
- Analyze the disease intervention information on identified sex partners and accurately determine probable relationships; possible factual omissions; set priorities for field investigations; and potential avenues to pursue future disease intervention
- Complete the Visual Case Analysis (VCA), and analyze exposure information for any gaps in exposure, changes in sexual activity, possible source/spread candidates (or lack of source candidates), and set priorities



# **ATTACHMENT: FIELD INVESTIGATION SKILLS INVENTORY**

*“Program Operation Guidelines for STD Prevention (POGS Manual)”*

## INTERVIEWING SKILLS INDIVIDUAL FEEDBACK RECORD

A-1

**Interview Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

*How did the Disease Intervention Specialist perform in the following areas?*

Write N/O (not observed) in the satisfactory column if the interview did not present an opportunity to observe the skill

COMMUNICATION	NEEDS IMPROVEMENT	SATISFACTORY	EXCELLENT
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 factual information			
7. Solicits client feedback			
8. Uses reinforcement			
9. Uses appropriate nonverbal communication			

Observations:

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Recommendations:

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**Interview Skills Inventory, continued**

<b>PROBLEM SOLVING</b>	<b>NEEDS IMPROVEMENT</b>	<b>SATISFACTORY</b>	<b>EXCELLENT</b>
10. Recognizes verbal problem indicators			
11. Recognizes nonverbal problem indicators			
12. Verifies the meaning of recognized problem indicators			
13. Assertively confronts problems communicated by clients			
14. Resolves clients problems			
15. Uses STD motivations			
16. Motivates clearly and convincingly			
17. Emphasizes Confidentiality			

<b>ANALYTICAL CAPABILITIES</b>	<b>NEEDS IMPROVEMENT</b>	<b>SATISFACTORY</b>	<b>EXCELLENT</b>
18. Computes and uses interview periods			
19. Recognize exposure gaps			
20. Determines accurate source/spread relationships			
21. Determines investigative priorities			
22. Recognizes discrepancies in client responses			

Observations:

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Recommendations:

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**Interview Skills Inventory, continued**

DISEASE INTERVENTION BEHAVIORS	NEEDS IMPROVEMENT	SATISFACTORY	EXCELLENT
23. Emphasizes sex partner referral			
24. Tactfully persists to identify all at-risk sex partners			
25. Pursues detailed locating/identifying information on sex partners			
26. Emphasizes appropriate risk reduction behaviors			
27. Conveys a sense of urgency			
28. Establishes specific contracts and coaches clients			
29. Pursues timely re-interviews with a plan			

Observations:

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Recommendations:

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## SKILLS INVENTORY, CONTINUED

Field Activity One-Day Skills Feedback Record

A-2

Field Investigation Date:    \_\_\_/\_\_\_/\_\_\_

Number of Persons Investigated:    \_\_\_\_\_

*How well did the Disease Intervention Specialist perform in the following areas?*

Write N/O (not observed) in the satisfactory column if the investigation did not present an opportunity to observe the skill.

DISEASE INTERVENTION BEHAVIORS	NEEDS IMPROVEMENT	SATISFACTORY	EXCELLENT
1. Assume the responsibility for the ultimate success of assigned investigations, regardless of co-worker participation in the referral process			
2. Utilize resources effectively in planning and executing referrals			
3. Recognize investigative priorities			
4. Select appropriate referral methods			
5. Take prompt initial action on priority investigations and promptly follow up when a person defaults on a referral			
6. Demonstrates timely, persistent, and imaginative action required to move a stalled investigation			
7. Demonstrate discretion and judgment in the use of the telephone as an investigative tool			
8. Confidentially and professionally manage circumstances that are obstacles in any investigation			
9. Motivate people to come in promptly			
10. Document the investigative activities completely and accurately			

Observations:

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Recommendations:

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# Legal Section

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# GEORGIA PUBLIC HEALTH LAWS AND CODE REGULATIONS RELATED TO SEXUALLY TRANSMITTED DISEASES

## INTRODUCTION

The STD Section, in addition to all STD-related activities across Georgia, is governed by official rules and regulations. The legislative authority granted by the State of Georgia (Official Code of Georgia Annotated (O.C.G.A.) and Rules of the Department of Human Resources can be found on the pages that follow. In addition, these laws also govern the way STDs are reported throughout the state.

**State Law OCGA 31-12-2:** The department is empowered to declare certain diseases, injuries, and conditions to be diseases requiring notice and to require the reporting thereof to the county board of health and the department in a manner and at such times as may be prescribed. The department shall require that such data be supplied as are deemed necessary and appropriate for the prevention of certain diseases, injuries, and conditions as are determined by the department. All such reports and data shall be deemed confidential and shall not be open to inspection by the public; provided, however, the department may release such reports and data in statistical form or for valid research purposes.

**Rules of Department of Human Services, Chapter 290-53-.02:** It shall be the duty of every licensed physician to report all cases of notifiable diseases or conditions declared notifiable to the board of health in the county where the report originates or the Department. Such reports shall also be made by the chief administrative officer, or a designee thereof (hereinafter referred to as reporters), of each hospital, nursing home, clinic, health maintenance organization, university health service, primary health care center, or institution such as a school, day care center, mental health hospital, and detention facility. These reports may be made by telephone, by letter, or by completing and mailing forms provided by the Department.

*\*Clinical laboratories shall report to the Department evidence of notifiable disease on forms provided by the Department.*

*\*Outbreaks/clusters of disease (infectious and non-infectious) should be reported immediately by telephone to the county board of health or to the Epidemiology and Prevention Services Branch, Division of Public Health.*

Diseases to be reported to local health departments or to the Epidemiology and Prevention Services Branch, DHR, within the specified time period:

**DISEASE:**

AIDS  
Anthrax

**REPORT WITHIN:**

Within 7 days  
Immediately



Aseptic Meningitis	Within 7 days
Botulism	Immediately
Brucellosis	Immediately
Campylobacteriosis	Within 7 days
Chancroid	Within 7 days
Chlamydia trachomatis (genital infection)	Within 7 days
Cholera	Immediately
Cryptosporidiosis	Within 7 days
Diphtheria	Immediately
<i>E. coli</i> 0157:H7 (invasive)*	Immediately
Encephalitis (arboviral)	Immediately
Giardiasis	Within 7 days
Gonorrhea	Within 7 days
Haemophilus influenza disease (invasive)*	Immediately
Hantavirus pulmonary syndrome	Immediately
Hepatitis: A, B, C	Within 7 days
Lead blood Level. 10µg/dl	Within 7 days
Legionellosis	Within 7 days
Leptospirosis	Within 7 days
Listeriosis (invasive)***	Within 7 days
Lyme Disease	Within 7 days
Lymphogranuloma venereum	Within 7 days
Malaria	Within 7 days
Measles (Rubeola)	Immediately
Meningitis (specify agent)	Immediately
Meningococcal disease (invasive)*	Immediately
Mumps	Within 7 days
Pertussis	Within 7 days
Poliomyelitis	Immediately
Psittacosis	Within 7 days
Rabies (human and animal)	Immediately
Rocky Mountain spotted fever	Within 7 days
Rubella (including congenital)	Within 7 days
Salmonellosis	Within 7 days
Streptococcal disease, Group A or B (invasive)*	Within 7 days
Streptococcus pneumoniae (invasive)	Within 7 days
Syphilis (congenital, adult)	Immediately
Tetanus	Within 7 days
Toxic Shock syndrome (TSS)	Within 7 days
Tuberculosis	Immediately
Typhoid	Within 7 days

\* Invasive = isolated from blood, bone, CSF, joint, pericardial fluid, peritoneal fluid, or pleural fluid.

\*\*\* *L. monocytogenes* isolated from any site. Infant mortality is reportable to Vital Records.

**Rules of the Department of Human Resources  
Public Health**

**Chapter 290-5-3  
Notification of Disease**

**TABLE OF CONTENTS**

290-5-3-.01	Definitions.Amended
290-5-3-.02	Provisions.Amended
290-5-3-.03	Confidentiality.Amended
290-5-3-.04	Liability
290-5-3-.05	Enforcement

**290-5-3-.01 Definitions.Amended.**

Unless a different meaning is required by the context, the terms as used in these regulations shall have the following meanings:

- (a) "Notifiable Disease" means any illness, condition, or disability declared to be notifiable by the Department of Human Resources in a published "Official" list.
- (b) "Department" means the Department of Human Resources of the State of Georgia.
- (c) "Reporter" means a person specifically designated by law or these regulations to report notifiable diseases or conditions.
- (d) "Person" means any individual, firm, partnership, association, corporation, the State or any municipality or other subdivision thereof, or any other entity whether organized for profit or not.

Authority O.C.G.A. Secs. 31-2-4, 31-12-2, 31-17-2, 31-18-3 & 4 and 50-13-4. **Administrative History.** Original Rule entitled "Definitions" was filed on July 1, 1980; effective July 31, 1980, as specified by the Agency. **Amended:** Rule repealed and a new Rule of the same title adopted. Filed December 15, 1983; effective January 4, 1984.

**290-5-3-.02 Provisions.Amended**

(1) It shall be the duty of every licensed physician to report all cases of notifiable diseases or conditions declared notifiable to the board of health in the county where the report originates or to the Department. Such reports shall also be made by the chief administrative officer, or a designee thereof (hereinafter referred to as reporters), of each hospital, nursing home, clinic, health maintenance organization, university health service, primary health care center, or institution such as a school, day care center, mental health hospital, and detention facility. These reports may be made by telephone, by letter, or by completing and mailing forms provided by the Department.

(2) Outbreaks or unusual clusters of disease (infectious and noninfectious) must be reported promptly by telephone to the county board of health or to the Department, Division of Public Health.

(3) The Department shall determine which diseases and conditions are notifiable and shall provide an official list of said diseases and conditions to the county Boards of Health. Each county health department shall be responsible for supplying reporting forms, which contain the official list, to the designated reporters. The Board of Human Resources will review any changes of disease which are to be added or removed from the official list of reportable diseases.

(4) The Department may employ sampling techniques to contain by special request information regarding the occurrence of certain noninfectious diseases of public health significance, e.g. alcohol/drug abuse, birth defects, cancer, heart attack, stroke, injuries, poisonings and occupational diseases.

(5) Reporters are expected to provide additional information to the Department concerning cases for which they have submitted laboratory specimens and to provide additional specimens when so requested for the purpose of providing complete laboratory confirmation of cases having public health importance, if the condition and circumstances of the patient permit.

(6) Clinical laboratories shall report to the Department evidence of notifiable diseases on forms provided by the Department. Report forms shall be retained on file by clinical laboratories for two years from the date of the report. Clinical laboratories are required to retain each isolate of an agent of notifiable disease for at least one week from the date of the report and to send said isolate to the Department for further testing upon request.

(7) Information concerning the occurrence or probable occurrence of any notifiable disease and condition which comes to the attention of any county board of health shall be transmitted to the Department weekly on a routine basis or immediately if circumstances dictate.

Authority O.C.G.A. Secs. 31-2-4, 31-12-2, 31-17-2, 31-18-3 & 4, and 50-13-4. **Administrative History.** Original Rule entitled "Provisions" was filed on July 1, 1980; effective July 31, 1980, as specified by the Agency. **Amended:** Rule repealed and a new Rule of the same title adopted. Filed December 15, 1983, effective January 4, 1984.

### **290-5-3-.03 Confidentiality.Amended**

Case reports submitted to county boards of health or to the Department shall be deemed confidential and shall not be subject to public inspection.

Authority O.C.G.A. Secs. 31-2-4, 31-12-2, 31-17-2, 31-18-3 & 4, and 50-13-4. **Administrative History.** Original Rule entitled "Enforcement" was filed on July 1, 1980; effective July 31, 1980, as specified by the Agency. **Amended:** Rule repealed and a new Rule entitled "Confidentiality" adopted. Filed December 15, 1983; effective January 4, 1984.

#### **290-5-3-.04**    **Liability**

Any person, including but not limited to practitioners of the healing arts, submitting in good-faith reports or data to the Department or county boards of health in compliance with the provisions of this Rule shall not be liable for any civil damages therefore.

Authority O.C.G.A. Secs. 31-2-4, 31-12-2, 31-17-2, 31-18-3 & 4, and 50-13-4. **Administrative History.** Original Rule entitled "Liability" was filed on December 15, 1983; effective January 4, 1984.

#### **290-5-3-.05**    **Enforcement**

The administration and enforcement of these rules and regulations shall be as prescribed in Chapter 31-5 of the Official Code of Georgia Annotated.

Authority O.C.G.A. Secs. 31-2-4, 31-12-2, 31-17-2, 31-18-3 & 4, and 50-13-4. **Administrative History.** Original Rule entitled "Enforcement" was filed on December 15, 1983; effective January 4, 1984.

**Rules of the Department of Human Resources  
Public Health**

**Chapter 290-5-17  
Reporting of Venereal Disease**

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**290-5-17-.01 Definitions.Amended**

Unless a different meaning is required by the context, the following terms as used in these Rules shall have the meaning hereinafter respectively ascribed to same:

- (a) "Department" means the Department of Public Health of the State of Georgia.
- (b) "Venereal Disease" is any case of syphilis, gonorrhea or chancroid.
- (c) "Case of Venereal Disease" is any person diagnosed as having a venereal disease.
- (d) "Test" is any laboratory procedure conducted for the purpose of aiding in the discovery or diagnosis of a venereal disease.
- (e) "Reactive or Positive Test" means any laboratory result suggesting the presence of venereal disease.

Authority Ga. L. 1914, pp. 507, 579. **Administrative History.** Original Rule entitled "Venereal Diseases to be Reported" was filed and effective on July 19, 1965 as 270-5-11-.01. **Amended:** Rule repealed and a new Rule entitled "Definitions" adopted. Filed August 17, 1967; effective September 5, 1967. **Amended:** Rule renumbered as 290-5-17-.01. Filed June 10, 1980; effective June 30, 1980.

**290-5-17-.02 Provisions.Amended**

- (1) Any physician or other person who makes a diagnosis of or treats a case of venereal disease, any superintendent or manager of a hospital, dispensary, or charitable or penal institution in which there is discovered a case of venereal disease shall report it immediately to the Department. Each such venereal disease case shall be reported to the Department by giving name, address, color, age, sex, and a diagnosis on forms furnished by the Department.
- (2) All laboratories conducting tests for venereal disease shall report to the Department daily, as they occur, all reactive or positive tests for venereal disease by giving name, address, color, age and sex of patient on forms furnished by the Department.
- (3) Information reported on these forms shall be kept confidential by the Department.

Authority Ga. L. 1964, pp. 507, 579. **Administrative History.** Original Rule entitled "Patients to be Given Information" was filed and effective on July 19, 1965 as 270-5-11-.02. **Amended:** Rule repealed and a new Rule entitled "Provision" adopted. Filed August 17, 1967; effective September 5, 1967. **Amended:** Rule renumbered as 290-5-17-.02. Filed June 10, 1980; effective June 30, 1980.

### **290-5-17-.03 Enforcement.Amended**

The administration and enforcement of these rules and regulations shall be as prescribed in Chapter 88-3, Enforcement and Administrative Procedure, the Georgia Health Code, Acts 1964, pages 499, 518.

Authority Ga. L. 1964, pp. 507, 579. **Administrative History.** Original Rule entitled "Investigation of Cases" was filed and effective on July 19, 1965 as 270-5-11-.03. **Amended:** Rule repealed and a new Rule entitled "Enforcement" adopted. Filed August 17, 1967; effective September 5, 1967. **Amended:** Rule renumbered as 290-5-17-.03. Filed June 10, 1980; effective June 30, 1980.

**Rules of the Department of Human Resources  
Public Health**

**Chapter 290-5-20  
Prophylactic Treatment of the Eyes of the Newborn**

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**290-5-20-.01 Purpose.Amended**

To prescribe the prophylactic treatment of the eyes of the newborn; to require the person in attendance at childbirth to instill the prophylactic in the eyes of the live newborn immediately following birth; and to require the reporting of Ophthalmia Neonatorium.

Authority Ga. L. 1964, pp. 499, 507, 580. **Administrative History.** Original Rule entitled "Purpose" was filed on October 28, 1965 as 270-5-17-.01; effective November 16, 1965. **Amended:** Rule renumbered as 290-5-20-.01. Filed June 10, 1980; effective June 30, 1980. **Amended:** Rule repealed and a new Rule of the same title adopted. Filed April 22, 1982; effective May 12, 1982.

**290-5-20-.02 Definitions.Amended**

Unless a different meaning is required by the context, the following terms as used in these Rules shall have the meaning hereafter respectively ascribed to same:

(a) "Ophthalmia Neonatorium" means an infection by Neisseria Gonococcus of the eyes of an infant and occurring in the early neonatal period.

(b) "Prophylactic treatment" means the instillation of a one (1) percent aqueous silver nitrate solution in a single dose ampule, or an ophthalmic ointment or drops containing one (1) percent tetracycline or one-half (0.5) percent erythromycin in a single-use tube or ampule in the eyes of the live newborn immediately following birth. None of the agents used for prophylaxis should be flushed from the eyes following instillation.

Authority Ga. L. 1964, pp. 507, 580. **Administrative History.** Original Rule entitled "Definitions" was filed on October 28, 1965 as 270-5-17-02; effective November 16, 1965. **Amended:** Rule renumbered as 290-5-20-.02 Filed June 10, 1980; effective June 30, 1980. **Amended:** Rule repealed and a new Rule of the same title adopted. Filed April 22, 1982; effective May 12, 1982.

### **290-5-20-.03 Provisions.Amended**

(1) The person in attendance at any childbirth shall instill the prophylactic treatment in the eyes of the live newborn immediately following birth.

(2) On written application setting forth the objectives, the reasons requiring the use of a prophylactic treatment other than that defined in Section 290-5-20-.02(b) and the control methods to be followed, the Georgia Department of Human Resources may authorize the use of another agent or method of prophylactic treatment of the eyes of the newborn for research and other controlled use.

(3) Any physician licensed to practice in Georgia under the Medical Practice Act (Ga. L. 1913, pp. 101, 106; 1918, pp. 173, 192; 1931, pp. 7, 37; 1956, pp. 691, 692; 1966, pp. 232, 235; 1967, pp. 826, 829; 1970, pp. 301, 311; 1974, pp. 1156, 1161) shall report each case of Gonococcal Ophthalmia Neonatorium, diagnosed or treated by him.

(4) Each person who by Georgia law is permitted to attend the pregnant woman at childbirth but who is not permitted by Georgia law to prescribe medication or treat Ophthalmia Neonatorium shall immediately upon discovery report to the District Director of Public Health or the County Public Health Nurse, any newborn with signs of Ophthalmia Neonatorium such as swelling, redness of eyes or any discharge therefrom.

Authority Ga. L. 1964, pp. 499, 507, 580. **Administrative History.** Original Rule entitled "Provisions" was filed on October 28, 1965 as 270-5-17-.03; effective November 16, 1965. **Amended:** Rule renumbered as 290-5-20-.03. Filed June 10, 1980; effective June 30, 1990. **Amended:** Rule repealed and a new Rule of the same title adopted. Filed April 22, 1982; effective May 12, 1982.

### **290-5-20-.04 Repealed**

Authority Ga. L. 1964, pp. 507, 580. **Administrative History.** Original Rule entitled "Repeal" was filed on October 28, 1965 as 270-5-17-.04; effective November 16, 1965. **Amended:** Rule renumbered as 290-5-20-.04. Filed June 10, 1980; effective June 30, 1980. **Amended:** Rule repealed. Filed April 22, 1982; effective May 12, 1982.

### **290-5-20-.05 Repealed**

Authority Ga. L. 1964, pp. 507, 580. **Administrative History.** Original Rule entitled "Effective Date" was filed on October 28, 1965 as 270-5-17-.05; effective November 16, 1965. **Amended:** Rule renumbered as 290-5-20-.05. Filed June 10, 1980; effective June 30, 1980. **Amended:** Rule repealed. Filed April 22, 1982; effective May 12, 1982.



**Rules of the Department of Human Resources  
Public Health**

**Chapter 290-5-21  
Serologic Test For Syphilis For Pregnant Women**

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**290-5-21-.01 Purpose**

To detect the presence of syphilis in a pregnant or postpartum woman and provide appropriate treatment for the woman and baby.

Authority Ga. L. 1964, pp. 507, 580; O.C.G.A. Secs. 31-2-1, 31-2-4, 31-12-3, 31-17-4. **Administrative History.** Original Rule entitled "Purpose" was filed on October 28, 1965 as 270-5-18-.01; effective November 16, 1965. **Amended:** Rule renumbered as 290-5-21-.01. Filed June 10, 1980; effective June 30, 1980. **Amended:** F. Jul. 19, 1990; eff. Aug. 8, 1990.

**290-5-17-.02 Definitions.Amended**

Unless a different meaning is required by the context, the following terms as used in these Rules shall have the meaning hereinafter respectively ascribed to same:

(a) "Standard serologic test for syphilis" means a test designed to detect evidence of syphilis and approved by the Department. This definition includes, but is not limited to, the VDRL (Venereal Disease Research Laboratory) and the RPR (Rapid Plasma Reagin) tests.

(b) "Physician" means any person licensed to practice medicine in the State of Georgia under O.C.G.A. Chapter 43-34.

(c) "Clinical laboratory" means a laboratory licensed by the Department to perform a standard serologic test for syphilis. Provided however, a clinical laboratory exempted from the licensing requirement by other rules and regulations of the Department shall not be required to be licensed by these rules and regulations.

(d) "Department" means the Department of Human Resources of the State of Georgia.

Authority Ga. L. 1964, pp. 507, 580; O.C.G.A. Secs. 31-2-1, 31-2-4, 31-12-3, 31-17-4. **Administrative History.** Original Rule entitled "Definitions" was filed on October 28, 1965 as 270-5-18-.02; effective November 16, 1965. **Amended:** Rule renumbered as 290-5-21-.02. Filed June 10, 1980; effective June 30, 1980. **Amended:** F. Jul. 19, 1990; eff. Aug. 8, 1990.

### **290-5-17-.03 Provisions.Amended**

(1) Every pregnant woman shall have a blood specimen taken as prescribed herein for a standard serologic test for syphilis.

(2) Every pregnant woman who delivers a live born or stillborn baby and did not have the required blood specimens taken during gestation shall have a blood specimen taken as prescribed herein for a standard serologic test for syphilis.

(3) Every physician in this state providing prenatal care to a pregnant woman, or delivering or attending a woman just delivered, shall take or cause to be taken a venous blood specimen for submission to a clinical laboratory for a standard serologic test for syphilis as follows:

(a) A blood specimen shall be taken at the initial visit to the physician for prenatal care and a second blood specimen shall be taken during the third trimester of gestation. Provided however, if the initial visit is in the third trimester, a blood specimen is not required.

(b) Any physician who delivers a baby or who attends a woman who has just delivered a baby and cannot confirm that the woman had the test required in (a) above, shall within six (6) hours of such delivery take or cause to be taken a specimen of venous blood from the woman delivering a live born or stillborn baby.

(4) The attending physician shall report to the Department any positive standard serologic test for syphilis, within twenty-four (24) hours of receipt of the original laboratory report, unless the woman is proven not to be infected. The report shall be admitted in a manner prescribed by the Department.

Authority Ga. L. 1964, pp.507,580; O.C.G.A. Secs. 31-2-1, 31-2-4, 31-12-2, 31-12-3, 31-12-4, 31-17-1, 31-17-2, 31-17-3, 31-17-4, 31-22-7. **Administrative History.** Original Rule entitled "Provisions" was filed on October 28, 1965 as 270-5-18-.03; effective November 16, 1965. **Amended:** Rule renumbered as 290-5-21-.03. Filed June 10, 1980; effective June 30, 1980. **Amended:** F. Jul. 19, 1990; eff. Aug. 8, 1990.

### **290-5-17-.04 Enforcement.Amended**

The Department and its duly authorized agent or agents are hereby authorized to enforce compliance with the provisions of this Chapter as provided in O.C.G.A. Chapters 31-5, 31-17 or other statutes or regulations of the Department as applicable.

Authority Ga. L. 1964, pp. 507, 580; O.C.G.A. Secs. 31-5-9, 31-17-18. **Administrative History.** Original Rule entitled "Repeal" was filed on October 28, 1965 as 270-5-18-.04; effective November 16, 1965. **Amended:** Rule renumbered as 290-5-21-.04. Filed June 10, 1980; effective June 30, 1980. **Amended:** Rule entitled "Enforcement" adopted F. Jul. 19, 1990; eff. Aug. 8, 1990.

### **290-5-21-.05 Repealed**

Authority Ga. L. 1964, pp. 507, 580; O.C.G.A. Secs. 50-13-4, 50-13-9. **Administrative History.** Original Rule entitled "Effective Date" was filed on October 28, 1965 as 270-5-18-.05; effective November 16, 1965. **Amended:** Rule renumbered as 290-5-21-.05. Filed June 10, 1980; effective June 30, 1980.

**Repealed:** F. Jul. 19, 1990; eff. Aug. 8, 1990.

**Public Health Laws of Georgia  
Title 31, Chapter 17**

**Control of Venereal Disease**

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**31-17-1      Enumeration of diseases deemed dangerous to public health**

Syphilis, gonorrhea, and chancroid, hereinafter referred to as venereal diseases, are declared to be contagious, infectious, communicable, and dangerous to the public health.

**31-17-2      Reporting of diagnosis or treatment to health authorities**

Any physician or other person who makes a diagnosis of or treats a case of venereal disease and any superintendent or manager of a hospital, dispensary, or charitable or penal institution in which there is discovered a case of venereal disease shall make report of such case to the health authorities in such form and manner as the Department of Human Resources shall direct.

**31-17-3      Examination and treatment by health authorities**

The authorized agent or agents of the Department of Human Resources and county boards of health are directed and empowered, when in their judgment it is necessary to protect the public health, to make examination of persons infected or suspected of being infected with venereal disease; to require persons infected with venereal disease to report for treatment to a physician licensed to practice medicine under Chapter 34 of Title 43 and to continue treatment until cured, or to submit to treatment provided at public expense; and to isolate persons infected or reasonably suspected of being infected with venereal disease. Law enforcement authorities of the jurisdiction wherein any such person so infected or suspected of being infected is located shall offer such assistance, including restraint and arrest, as shall be necessary to assure examination and treatment in accordance with this chapter.

### **31-17-4      Serologic tests of pregnant women**

The department may require every pregnant woman to submit to a standard serologic test, as defined by the department, and may require any person attending or giving prenatal care to such woman to take or cause to be taken a blood specimen for use in such test. Such specimens shall be submitted for laboratory testing in the manner prescribed by the department; and all laboratories conducting such tests shall comply with the rules, regulations, and reporting requirements prescribed therefor by the department.

#### **31-17-4.1      Definitions**

(a) As used in this Code section, the term:

(1) 'Chlamydia screening test' means any laboratory test of the urogenital tract which specifically detects for infection by one or more agents of chlamydia trachomatis and which test is approved for such purposes by the federal Food and Drug Administration.

(2) 'Policy' means any benefit plan, contract, or policy except a disability income policy, specified disease policy, or hospital indemnity policy.

(b) (1) Every insurer authorized to issue an individual or group accident and sickness insurance policy in this state which includes coverage for any female shall include as part of or as a required endorsement to each such policy which is issued, delivered, issued for delivery, or renewed on or after July 1, 1998, coverage for one annual chlamydia screening test for those covered females who are not more than 29 years old.

(2) The coverage required under paragraph (1) of this subsection may be subject to such exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions as may be approved by the Commissioner of Insurance.

(3) Nothing in this subsection shall be construed to prohibit the issuance of accident and sickness insurance policies which provide benefits greater than or more favorable to the insured than those required by paragraph (1) of this subsection.

(4) The provisions of subsection (b) of this Code section shall apply to accident and sickness insurance policies issued by a fraternal benefit society, a nonprofit hospital service corporation, a nonprofit medical service corporation, a health care plan, a health maintenance organization, or any similar entity.

(5) Nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or having differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers as otherwise authorized under the provisions of Article 2 of Chapter 30 of Title 33, relating to preferred provider arrangements.

(c) (1) A contract executed or renewed on or after July 1, 1998, which provides for financing and delivery of health care services through a managed care plan, other than a dental plan,

shall provide coverage for one annual chlamydia screening test for each female who is covered under such contract and who is not more than 29 years of age. Such coverage may be subject to such exclusions, reductions, or other limitations as to coverages, deductibles, or copayment provisions as may be approved by the Commissioner of Insurance.

(2) Nothing in this subsection shall be construed to prohibit any managed care plan contract from providing benefits greater than or more favorable to the covered females than those required by paragraph (1) of this subsection.

(d) Code Section 31-17-8 shall not apply to this Code section.

(e) This Code section shall be subject to rules and regulations which shall be promulgated by the Commissioner of Insurance regarding notice and enforcement.

### **31-17-5      Prophylactic treatment at childbirth**

It shall be the duty of any person who shall be in attendance on any childbirth to apply to the child such prophylactic treatment as may be prescribed by the department to prevent blindness from gonococcus infection and otherwise to comply with such rules, regulations, and reporting requirements as shall be prescribed by the department.

### **31-17-6      Regulation of laboratories**

All laboratories conducting tests for venereal diseases shall comply with the rules, regulations, and reporting requirements prescribed therefor by the department.

### **31-17-7      Consent of minor to medical or surgical care or services; informing spouse, parent, custodian, or guardian**

(a) The consent to the provision of medical or surgical care or services by a hospital or public clinic or to the performance of medical or surgical care or services by a physician licensed to practice medicine and surgery, when such consent is given by a minor who is or professes to be afflicted with a venereal disease, shall be as valid and binding as if the minor had achieved his majority, provided that any such treatment shall involve procedures and therapy related to conditions or illnesses arising out of the venereal disease which gave rise to the consent authorized under this Code section. Any such consent shall not be subject to later disaffirmation by reason of minority. The consent of no other person or persons, including but not limited to a spouse, parent, custodian, or guardian, shall be necessary in order to authorize the provision to such minor of such medical or surgical care or services as are described in this subsection.

(b) Upon the advice and direction of a treating physician or, if more than one, of any one of them, a member of the medical staff of a hospital or public clinic or a physician licensed to practice medicine and surgery may, but shall not be obligated to, inform the spouse, parent, custodian, or guardian of any such minor as to the treatment given or needed. Such information may be given to or withheld from the spouse, parent, custodian, or guardian without the consent of the minor patient and even over the express refusal of the minor patient to the providing of such information.

**31-17-8**      **Penalty**

Any person who violates any provision of this chapter or any rule or regulation promulgated under this chapter shall be guilty of a misdemeanor.

**Public Health Laws of Georgia  
Title 19, Chapter 15**

**Reporting of Child Abuse or Neglect**

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**19-15-1      Definitions.**

As used in this chapter, the term:

(1) 'Abused' means subjected to child abuse.

(2) 'Child' means any person under 18 years of age.

(3) 'Child abuse' means:

(A) Physical injury or death inflicted upon a child by a parent or caretaker thereof by other than accidental means; provided, however, physical forms of discipline may be used as long as there is no physical injury to the child;

(B) Neglect or exploitation of a child by a parent or caretaker thereof;

(C) Sexual abuse of a child; or

(D) Sexual exploitation of a child.

(4) 'Child protection professional' means any person who is employed by the state or a political subdivision of the state as a law enforcement officer, school teacher, school administrator, or school counselor or who is employed to render services to children by the Department of Human Resources or any county board of health or county department of family and children services.

(5) 'Eligible deaths' means deaths meeting the criteria for review by a county child fatality review committee including deaths resulting from Sudden Infant Death Syndrome, unintentional injuries, intentional injuries, medical conditions when unexpected or when unattended by a physician, or any manner that is suspicious or unusual.

(6) 'Investigation' in the context of child death includes all of the following:

- (A) A post-mortem examination which may be limited to an external examination or may include an autopsy;
  - (B) An inquiry by law enforcement agencies having jurisdiction into the circumstances of the death, including a scene investigation and interview with the child's parents, guardian, or caretaker and the person who reported the child's death;
  - (C) A review of information regarding the child and family from relevant agencies, professionals, and providers of medical care.
- (7) 'Panel' means the Georgia Child Fatality Review Panel established pursuant to Code Section 19-15-4. The panel oversees the local child fatality review process and reports to the Governor on the incidence of child deaths with recommendations for prevention.
- (8) 'Protocol committee' means a multidisciplinary, multiagency child abuse protocol committee established for a county pursuant to Code Section 19-15-2. The protocol committee is charged with developing local protocols to investigate and prosecute alleged cases of child abuse.
- (9) 'Report' means a standardized form designated by the panel which is required for collecting data on child fatalities reviewed by local child fatality review committees.
- (10) 'Review committee' means a multidisciplinary, multiagency child fatality review committee established for a county or circuit pursuant to Code Section 19-15-3. The review committee is charged with reviewing all eligible child deaths to determine manner and cause of death and if the death was preventable.
- (11) 'Sexual abuse' means a person's employing, using, persuading, inducing, enticing, or coercing any minor who is not that person's spouse to engage in any act which involves:
- (A) Sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex;
  - (B) Bestiality;
  - (C) Masturbation;
  - (D) Lewd exhibition of the genitals or pubic area of any person;
  - (E) Flagellation or torture by or upon a person who is nude;
  - (F) Condition of being fettered, bound, or otherwise physically restrained on the part of a person who is nude;
  - (G) Physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area, or buttocks or with a female's clothed or unclothed breasts;



- (H) Defecation or urination for the purpose of sexual stimulation; or
- (I) Penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure.

'Sexual abuse' shall not include consensual sex acts involving persons of the opposite sex when the sex acts are between minors or between a minor and an adult who is not more than three years older than the minor. This provision shall not be deemed or construed to repeal any law concerning the age or capacity to consent.

(12) 'Sexual exploitation' means conduct by a child's parent or caretaker who allows, permits, encourages, or requires that child to engage in:

- (A) Prostitution, as defined in Code Section 16-6-9; or
- (B) Sexually explicit conduct for the purpose of producing any visual or print medium depicting such conduct, as defined in Code Section 16-12-100.

**19-15-2      Child Abuse Protocol Committee**

(a) Each county shall be required to establish a child abuse protocol as provided in this Code section.

(b) The chief superior court judge of the circuit in which the county is located shall establish a child abuse protocol committee as provided in subsection (c) of this Code section and shall appoint an interim chairperson who shall preside over the first meeting and the chief superior court judge shall appoint persons to fill any vacancies on the committee. Thus established, the committee shall thereafter elect a chairperson from its membership.

(c)(1) Each of the following agencies of the county shall designate a representative to serve on the committee:

- (A) The office of the sheriff;
- (B) The county department of family and children services;
- (C) The office of the district attorney;
- (D) The juvenile court;
- (E) The magistrate court;
- (F) The county board of education;
- (G) The county mental health organization;

(H) The office of the chief of police of a county in counties which have a county police department;

(I) The office of the chief of police of the largest municipality in the county;

(J) The county board of health, which shall designate a physician to serve on the committee; and

(K) The office of the coroner or county medical examiner.

(2) In addition to the representatives serving on the committee as provided for in paragraph (1) of this subsection, the chief superior court judge shall designate a representative from a local citizen or advocacy group which focuses on child abuse awareness and prevention.

(3) If any designated agency fails to carry out its duties relating to participation on the committee, the chief superior court judge of the circuit may issue an order requiring the participation of such agency. Failure to comply with such order shall be cause for punishment as for contempt of court.

(d) Each protocol committee shall elect or appoint a chairperson who shall be responsible for ensuring that written protocol procedures are followed by all agencies. That person can be independent of agencies listed in paragraph (1) of subsection (c) of this Code section. The child abuse protocol committee thus established may appoint such additional members as necessary and proper to accomplish the purposes of the protocol committee.

(e) The protocol committee shall adopt a written child abuse protocol which shall be filed with the Division of Family and Children Services of the Department of Human Resources and the Georgia Child Fatality Review Panel, a copy of which shall be furnished to each agency in the county handling the cases of abused children. The protocol shall be a written document outlining in detail the procedures to be used in investigating and prosecuting cases arising from alleged child abuse and the methods to be used in coordinating treatment programs for the perpetrator, the family, and the child. The protocol shall also outline procedures to be used when child abuse occurs in a household where there is violence between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household. The protocol adopted shall not be inconsistent with the policies and procedures of the Division of Family and Children Services of the Department of Human Resources.

(f) The purpose of the protocol shall be to ensure coordination and cooperation between all agencies involved in a child abuse case so as to increase the efficiency of all agencies handling such cases, to minimize the stress created for the allegedly abused child by the legal and investigatory process, and to ensure that more effective treatment is provided for the perpetrator, the family, and the child, including counseling.

(g) Upon completion of the writing of the child abuse protocol, the protocol committee shall

continue in existence and shall meet at least semiannually for the purpose of evaluating the effectiveness of the protocol and appropriately modifying and updating same.

(h) Each protocol committee shall adopt or amend its written child abuse protocol no later than July 1, 2001, to specify the circumstances under which law enforcement officers will and will not be required to accompany child abuse investigators from the county department of family and children services when these investigators investigate reports of child abuse. In determining when law enforcement officers shall and shall not accompany child abuse investigators, the protocol committee shall consider the need to protect the alleged victim and the need to preserve the confidentiality of the report. Each protocol committee shall establish joint work efforts between the law enforcement and child abuse investigative agencies in child abuse investigations. The adoption or amendment of the protocol shall also describe measures which can be taken within the county to prevent child abuse and shall be filed with and furnished to the same entities with or to which an original protocol is required to be filed or furnished. The protocol will be further amended to specify procedures to be adopted by the protocol committee to ensure that written protocol procedures are followed.

(i) The protocol committee shall issue a report no later than the first day of July in 2001 and no later than the first day of July each year thereafter. That report shall evaluate the extent to which child abuse investigations during the 12 months prior to the report have complied with the child abuse protocols of the protocol committee, recommend measures to improve compliance, and describe which measures taken within the county to prevent child abuse have been successful. The report shall be transmitted to the county governing authority, the fall term grand jury of the judicial circuit, the Georgia Child Fatality Review Panel, and the chief superior court judge.

(j) By July 1, 2001, members of each protocol committee shall receive appropriate training. As new members are appointed, they will also receive training within 12 months after their appointment. The Department of Human Resources shall provide such training.

(k) The protocol committee shall adopt a written sexual abuse and exploitation protocol which shall be filed with the Division of Family and Children Services of the Department of Human Resources and the Office of the Child Advocate for the Protection of Children, a copy of which shall be furnished to each agency in the county handling the cases of sexually abused or exploited children. The protocol shall be a written document outlining in detail the procedures to be used in investigating and prosecuting cases arising from alleged child sexual abuse and exploitation and the procedures to be followed concerning the obtainment of and payment for sexual assault examinations. Each protocol committee shall adopt or amend its written sexual abuse and exploitation protocol no later than December 31, 2004. The protocol may incorporate existing sexual abuse and exploitation protocols used within the county. The protocol adopted shall be consistent with the policies and procedures of the Division of Family and Children Services of the Department of Human Resources. A failure by an agency to follow the protocol shall not constitute an affirmative or other defense to prosecution of a sexual abuse or exploitation offense, nor shall a failure by an agency to follow the protocol give rise to a civil cause of action.

**19-15-3**

**Death of Child: Report: Investigation**

(a)(1) Each county shall establish a local multidisciplinary, multiagency child fatality review committee as provided in this Code section. The chief superior court judge of the circuit in which the county is located shall establish a child fatality review committee composed of, but not limited to, the following members:

- (A) The county medical examiner or coroner;
- (B) The district attorney or his or her designee;
- (C) A county department of family and children services representative;
- (D) A local law enforcement representative;
- (E) The sheriff or county police chief or his or her designee;
- (F) A juvenile court representative;
- (G) A county board of health representative; and
- (H) A county mental health representative.

(2) The district attorney or his or her designee shall serve as the chairperson to preside over all meetings.

(b) Review committee members shall recommend whether to establish a review committee for that county alone or establish a review committee with and for the counties within that judicial circuit.

(c) The chief superior court judge shall appoint persons to fill any vacancies on the review committee should the membership fail to do so.

(d) If any designated agency fails to carry out its duties relating to participation on the local review committee, the chief superior court judge of the circuit or any superior court judge who is a member of the Georgia Child Fatality Review Panel shall issue an order requiring the participation of such agency. Failure to comply with such order shall be cause for punishment as for contempt of court.

(e) Deaths eligible for review by local review committees are all deaths of children ages birth through 17 as a result of:

- (1) Sudden Infant Death Syndrome;
- (2) Any unexpected or unexplained conditions;
- (3) Unintentional injuries;

(4) Intentional injuries;

(5) Sudden death when the child is in apparent good health;

(6) Any manner that is suspicious or unusual;

(7) Medical conditions when unattended by a physician. For the purpose of this paragraph, no person shall be deemed to have died unattended when the death occurred while the person was a patient of a hospice licensed under Article 9 of Chapter 7 of Title 31; or

(8) Serving as an inmate of a state hospital or a state, county, or city penal institution.

(f) It shall be the duty of any law enforcement officer, medical personnel, or other person having knowledge of the death of a child to immediately notify the coroner or medical examiner of the county wherein the body is found or death occurs.

(g) If the death of a child occurs outside the child's county of residence, it shall be the duty of the medical examiner or coroner in the county where the child died to notify the medical examiner or coroner in the county of the child's residence.

(h) When a county medical examiner or coroner receives a report regarding the death of any child he or she shall within 48 hours of the death notify the chairperson of the child fatality review committee of the county or circuit in which such child resided at the time of death.

(i) The coroner or county medical examiner shall review the findings regarding the cause and manner of death for each child death report received and respond as follows:

(1) If the death does not meet the criteria for review pursuant to subsection (e) of this Code section, the coroner or county medical examiner shall sign the form designated by the panel stating that the death does not meet the criteria for review. He or she shall forward the form and findings, within seven days of the child's death, to the chairperson of the child fatality review committee in the county or circuit of the child's residence; or

(2) If the death meets the criteria for review pursuant to subsection (e) of this Code section, the coroner or county medical examiner shall complete and sign the form designated by the panel stating the death meets the criteria for review. He or she shall forward the form and findings, within seven days of the child's death, to the chairperson of the child fatality review committee in the county or circuit of the child's residence.

(j) When the chairperson of a local child fatality review committee receives a report from the coroner or medical examiner regarding the death of a child, that chairperson shall review the report and findings regarding the cause and manner of the child's death and respond as follows:

(1) If the report indicates the child's death does not meet the criteria for review and the chairperson agrees with this decision, the chairperson shall sign the form designated by

the panel stating that the death does not meet the criteria for review. He or she shall forward the form and findings to the panel within seven days of receipt;

(2) If the report indicates the child's death does not meet the criteria for review and the chairperson disagrees with this decision, the chairperson shall follow the procedures for deaths to be reviewed pursuant to subsection (k) of this Code section;

(3) If the report indicates the child's death meets the criteria for review and the chairperson disagrees with this decision, the chairperson shall sign the form designated by the panel stating that the death does not meet the criteria for review. The chairperson shall also attach an explanation for this decision; or

(4) If the report indicates the child's death meets the criteria for review and the chairperson agrees with this decision, the chairperson shall follow the procedures for deaths to be reviewed pursuant to subsection (k) of this Code section.

(k) When a child's death meets the criteria for review, the chairperson shall convene the review committee within 30 days after receipt of the report for a meeting to review and investigate the cause and circumstances of the death. Review committee members shall provide information as specified below, except where otherwise protected by statute:

(1) The providers of medical care and the medical examiner or coroner shall provide pertinent health and medical information regarding a child whose death is being reviewed by the local review committee;

(2) State, county, or local government agencies shall provide all of the following data on forms designated by the panel for reporting child fatalities:

(A) Birth information for children who died at less than one year of age including confidential information collected for medical and health use;

(B) Death information for children who have not reached their eighteenth birthday;

(C) Law enforcement investigative data, medical examiner or coroner investigative data, and parole and probation information and records;

(D) Medical care, including dental, mental, and prenatal health care; and

(E) Pertinent information from any social services agency that provided services to the child or family; and

(3) The review committee may obtain from any superior court judge of the county or circuit for which the review committee was created a subpoena to compel the production of documents or attendance of witnesses when that judge has made a finding that such documents or witnesses are necessary for the review committee's review. However, this

Code section shall not modify or impair the privileged communications as provided by law except as otherwise provided in Code Section 19-7-5.

(l) The review committee shall complete its review and prepare a report of the child's death within 20 days, weekends and holidays excluded, following the first meeting held after receipt of the county medical examiner or coroner's report. The review committee's report shall:

- (1) State the circumstances leading up to death and cause of death;
- (2) Detail any agency involvement prior to death, including the beginning and ending dates and kinds of services delivered, the reasons for initial agency activity, and the reasons for any termination of agency activities;
- (3) State whether any agency services had been delivered to the family or child prior to the circumstances leading to the child's death;
- (4) State whether court intervention had ever been sought;
- (5) State whether there have been any acts or reports of violence between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household;
- (6) Conclude whether services or agency activities delivered prior to death were appropriate and whether the child's death could have been prevented;
- (7) Make recommendations for possible prevention of future deaths of similar incidents for children who are at risk for such deaths; and
- (8) Include other findings as requested by the Georgia Child Fatality Review Panel.

(m) The review committee shall transmit a copy of its report within 15 days of completion to the panel.

(n) The review committee shall transmit a copy of its report within 15 days following its completion to the district attorney of the county or circuit for which the review committee was created if the report concluded that the child named therein died as a result of:

- (1) Sudden Infant Death Syndrome when no autopsy was performed to confirm the diagnosis;
- (2) Accidental death when it appears that the death could have been prevented through intervention or supervision;
- (3) Any sexually transmitted disease;
- (4) Medical causes which could have been prevented through intervention by an agency or by seeking medical treatment;

- (5) Suicide of a child in custody or known to the Department of Human Resources or when the finding of suicide is suspicious;
- (6) Suspected or confirmed child abuse;
- (7) Trauma to the head or body; or
- (8) Homicide.

(o) Each local review committee shall issue an annual report no later than the first day of July in 2001 and in each year thereafter. The report shall:

- (1) Specify the numbers of reports received by that review committee from a county medical examiner or coroner pursuant to subsection (h) of this Code section for the preceding calendar year;
- (2) Specify the number of reports of child fatality reviews prepared by the review committee during such period;
- (3) Be published at least once annually in the legal organ of the county or counties for which the review committee was established with the expense of such publication paid each by such county; and
- (4) Be transmitted, no later than the fifteenth day of July in 2001 and in each year thereafter, to the Georgia Child Fatality Review Panel and the Judiciary Committees of the House of Representatives and Senate.

**19-15-4      Child Fatality Review Panel**

(a)(1) Each county shall establish a local multidisciplinary, multiagency child fatality review committee as provided in this Code section. The chief superior court judge of the circuit in which the county is located shall establish a child fatality review committee composed of, but not limited to, the following members:

- (A) The county medical examiner or coroner;
- (B) The district attorney or his or her designee;
- (C) A county department of family and children services representative;
- (D) A local law enforcement representative;
- (E) The sheriff or county police chief or his or her designee;
- (F) A juvenile court representative;



(G) A county board of health representative; and

(H) A county mental health representative.

(2) The district attorney or his or her designee shall serve as the chairperson to preside over all meetings.

(b) Review committee members shall recommend whether to establish a review committee for that county alone or establish a review committee with and for the counties within that judicial circuit.

(c) The chief superior court judge shall appoint persons to fill any vacancies on the review committee should the membership fail to do so.

(d) If any designated agency fails to carry out its duties relating to participation on the local review committee, the chief superior court judge of the circuit or any superior court judge who is a member of the Georgia Child Fatality Review Panel shall issue an order requiring the participation of such agency. Failure to comply with such order shall be cause for punishment as for contempt of court.

(e) Deaths eligible for review by local review committees are all deaths of children ages birth through 17 as a result of:

(1) Sudden Infant Death Syndrome;

(2) Any unexpected or unexplained conditions;

(3) Unintentional injuries;

(4) Intentional injuries;

(5) Sudden death when the child is in apparent good health;

(6) Any manner that is suspicious or unusual;

(7) Medical conditions when unattended by a physician. For the purpose of this paragraph, no person shall be deemed to have died unattended when the death occurred while the person was a patient of a hospice licensed under Article 9 of Chapter 7 of Title 31; or

(8) Serving as an inmate of a state hospital or a state, county, or city penal institution.

(f) It shall be the duty of any law enforcement officer, medical personnel, or other person having knowledge of the death of a child to immediately notify the coroner or medical examiner of the county wherein the body is found or death occurs.

(g) If the death of a child occurs outside the child's county of residence, it shall be the duty of the medical examiner or coroner in the county where the child died to notify the medical examiner or coroner in the county of the child's residence.

(h) When a county medical examiner or coroner receives a report regarding the death of any child he or she shall within 48 hours of the death notify the chairperson of the child fatality review committee of the county or circuit in which such child resided at the time of death.

(i) The coroner or county medical examiner shall review the findings regarding the cause and manner of death for each child death report received and respond as follows:

(1) If the death does not meet the criteria for review pursuant to subsection (e) of this Code section, the coroner or county medical examiner shall sign the form designated by the panel stating that the death does not meet the criteria for review. He or she shall forward the form and findings, within seven days of the child's death, to the chairperson of the child fatality review committee in the county or circuit of the child's residence; or

(2) If the death meets the criteria for review pursuant to subsection (e) of this Code section, the coroner or county medical examiner shall complete and sign the form designated by the panel stating the death meets the criteria for review. He or she shall forward the form and findings, within seven days of the child's death, to the chairperson of the child fatality review committee in the county or circuit of the child's residence.

(j) When the chairperson of a local child fatality review committee receives a report from the coroner or medical examiner regarding the death of a child, that chairperson shall review the report and findings regarding the cause and manner of the child's death and respond as follows:

(1) If the report indicates the child's death does not meet the criteria for review and the chairperson agrees with this decision, the chairperson shall sign the form designated by the panel stating that the death does not meet the criteria for review. He or she shall forward the form and findings to the panel within seven days of receipt;

(2) If the report indicates the child's death does not meet the criteria for review and the chairperson disagrees with this decision, the chairperson shall follow the procedures for deaths to be reviewed pursuant to subsection (k) of this Code section;

(3) If the report indicates the child's death meets the criteria for review and the chairperson disagrees with this decision, the chairperson shall sign the form designated by the panel stating that the death does not meet the criteria for review. The chairperson shall also attach an explanation for this decision; or

(4) If the report indicates the child's death meets the criteria for review and the chairperson agrees with this decision, the chairperson shall follow the procedures for deaths to be reviewed pursuant to subsection (k) of this Code section.

(k) When a child's death meets the criteria for review, the chairperson shall convene the review

committee within 30 days after receipt of the report for a meeting to review and investigate the cause and circumstances of the death. Review committee members shall provide information as specified below, except where otherwise protected by statute:

(1) The providers of medical care and the medical examiner or coroner shall provide pertinent health and medical information regarding a child whose death is being reviewed by the local review committee;

(2) State, county, or local government agencies shall provide all of the following data on forms designated by the panel for reporting child fatalities:

(A) Birth information for children who died at less than one year of age including confidential information collected for medical and health use;

(B) Death information for children who have not reached their eighteenth birthday;

(C) Law enforcement investigative data, medical examiner or coroner investigative data, and parole and probation information and records;

(D) Medical care, including dental, mental, and prenatal health care; and

(E) Pertinent information from any social services agency that provided services to the child or family; and

(3) The review committee may obtain from any superior court judge of the county or circuit for which the review committee was created a subpoena to compel the production of documents or attendance of witnesses when that judge has made a finding that such documents or witnesses are necessary for the review committee's review. However, this Code section shall not modify or impair the privileged communications as provided by law except as otherwise provided in Code Section 19-7-5.

(1) The review committee shall complete its review and prepare a report of the child's death within 20 days, weekends and holidays excluded, following the first meeting held after receipt of the county medical examiner or coroner's report. The review committee's report shall:

(1) State the circumstances leading up to death and cause of death;

(2) Detail any agency involvement prior to death, including the beginning and ending dates and kinds of services delivered, the reasons for initial agency activity, and the reasons for any termination of agency activities;

(3) State whether any agency services had been delivered to the family or child prior to the circumstances leading to the child's death;

(4) State whether court intervention had ever been sought;

(5) State whether there have been any acts or reports of violence between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household;

(6) Conclude whether services or agency activities delivered prior to death were appropriate and whether the child's death could have been prevented;

(7) Make recommendations for possible prevention of future deaths of similar incidents for children who are at risk for such deaths; and

(8) Include other findings as requested by the Georgia Child Fatality Review Panel.

(m) The review committee shall transmit a copy of its report within 15 days of completion to the panel.

(n) The review committee shall transmit a copy of its report within 15 days following its completion to the district attorney of the county or circuit for which the review committee was created if the report concluded that the child named therein died as a result of:

(1) Sudden Infant Death Syndrome when no autopsy was performed to confirm the diagnosis;

(2) Accidental death when it appears that the death could have been prevented through intervention or supervision;

(3) Any sexually transmitted disease;

(4) Medical causes which could have been prevented through intervention by an agency or by seeking medical treatment;

(5) Suicide of a child in custody or known to the Department of Human Resources or when the finding of suicide is suspicious;

(6) Suspected or confirmed child abuse;

(7) Trauma to the head or body; or

(8) Homicide.

(o) Each local review committee shall issue an annual report no later than the first day of July in 2001 and in each year thereafter. The report shall:

(1) Specify the numbers of reports received by that review committee from a county medical examiner or coroner pursuant to subsection (h) of this Code section for the preceding calendar year;

- (2) Specify the number of reports of child fatality reviews prepared by the review committee during such period;
- (3) Be published at least once annually in the legal organ of the county or counties for which the review committee was established with the expense of such publication paid each by such county; and
- (4) Be transmitted, no later than the fifteenth day of July in 2001 and in each year thereafter, to the Georgia Child Fatality Review Panel and the Judiciary Committees of the House of Representatives and Senate.

**19-15-5                      Meeting and Proceeding of Committees and Panels**

- (a) Protocol committee or review committee in the exercise of its duties shall be closed to the public and shall not be subject to Chapter 14 of Title 50, relating to open meetings.
- (b) The panel shall be open to the public as long as information identifying a deceased or abused child, any family member of the child, or alleged or suspected perpetrator of abuse upon the child is not disclosed during such meetings or proceedings, but the panel is authorized to close such meeting to the public when such identifying information is required to be disclosed to members of the panel in order for the panel to carry out its duties.

**19-15-6                      Liability for Disclosing Information**

- (a) Records and other documents which are made public records pursuant to any other provisions of law shall remain public records notwithstanding their being obtained, considered, or both, by a protocol committee, a review committee, or the panel.
- (b) Notwithstanding any other provision of law to the contrary, reports of a review committee made pursuant to Code Section 19-15-3 and reports of the panel made pursuant to Code Section 19-15-4 shall be public records and shall be released to any person making a request therefor but the panel protocol committee or review committee having possession of such records or reports shall only release them after expunging therefrom all information contained therein which would permit identifying the deceased or abused child, any family member of the child, any alleged or suspected perpetrator of abuse upon the child, or any reporter of suspected child abuse.
- (c) Statistical compilations of data by a review committee or the panel based upon information received thereby and containing no information which would permit the identification of any person shall be public records.
- (d) Members of a protocol committee, a review committee, or of the panel shall not disclose what transpires at any meeting other than one made public by Code Section 19-15-5 nor disclose any information the disclosure of which is prohibited by this Code section, except to carry out the purposes of this chapter. Any person who knowingly violates this subsection shall be guilty of a misdemeanor.

(e) A person who presents information to a protocol committee, a review committee, or the panel or who is a member of any such body shall not be questioned in any civil or criminal proceeding regarding such presentation or regarding opinions formed by or confidential information obtained by such person as a result of serving as a member of any such body. This subsection shall not be construed to prohibit any person from testifying regarding information obtained independently of a protocol committee, a review committee, or the panel. In any proceeding in which testimony of such a member is offered the court shall first determine the source of such witness's knowledge.

(f) Except as otherwise provided in this Code section, information acquired by and records of a protocol committee, a review committee, or the panel shall be confidential, shall not be disclosed, and shall not be subject to Article 4 of Chapter 18 of Title 50, relating to open records, or subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding.

(g) A member of a protocol committee, a review committee, or the panel shall not be civilly or criminally liable for any disclosure of information made by such member as authorized by this Code section.

(h) Members of the review committee, persons attending a review committee meeting, and persons who present information to a review committee may release information to such government agencies as is necessary for the purpose of carrying out assigned review committee duties.

(i) Notwithstanding any other provisions of law, information acquired by and documents, records, and reports of the panel and child abuse protocol committees and review committees applicable to a child who at the time of his or her death was in the custody of a state department or agency or foster parent shall not be confidential and shall be subject to Article 4 of Chapter 18 of Title 50, relating to open records.

#### **19-15-7      Construction of Chapter**

Nothing in this chapter shall be construed to authorize or require the inspection of any records or the release of any information if that inspection or release would result in the loss of any federal funds to the state.

**Public Health Laws of Georgia  
Title 19, Chapter 7**

**Reporting of Child Abuse**

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**19-7-5(a)                    Purpose**

(a) The purpose of this Code section is to provide for the protection of children whose health and welfare are adversely affected and further threatened by the conduct of those responsible for their care and protection. It is intended that the mandatory reporting of such cases will cause the protective services of the state to be brought to bear on the situation in an effort to prevent further abuses, to protect and enhance the welfare of these children, and to preserve family life wherever possible. This Code section shall be liberally construed so as to carry out the purposes thereof.

**19-7-5(b)                    Definitions**

(b) As used in this Code section, the term:

(1) 'Abused' means subjected to child abuse.

(2) 'Child' means any person under 18 years of age.

(3) "Child abuse" means:

(A) Physical injury or death inflicted upon a child by a parent or caretaker thereof by other than accidental means; provided, however, physical forms of discipline may be used as long as there is no physical injury to the child;

(B) Neglect or exploitation of a child by a parent or caretaker thereof;

(C) Sexual abuse of a child; or

(D) Sexual exploitation of a child.

However, no child who in good faith is being treated solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall, for that reason alone, be considered to be an 'abused' child.

(3.1) 'Sexual abuse' means a person's employing, using, persuading, inducing, enticing, or coercing any minor who is not that person's spouse to engage in any act which involves:

(A) Sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex;

(B) Bestiality;

(C) Masturbation;

(D) Lewd exhibition of the genitals or pubic area of any person;

(E) Flagellation or torture by or upon a person who is nude;

(F) Condition of being fettered, bound, or otherwise physically restrained on the part of a person who is nude;

(G) Physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area, or buttocks or with a female's clothed or unclothed breasts;

(H) Defecation or urination for the purpose of sexual stimulation; or

(I) Penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure.

'Sexual abuse' shall not include consensual sex acts involving persons of the opposite sex when the sex acts are between minors or between a minor and an adult who is not more than five years older than the minor. This provision shall not be deemed or construed to repeal any law concerning the age or capacity to consent.

(4) 'Sexual exploitation' means conduct by a child's parent or caretaker who allows, permits, encourages, or requires that child to engage in:

(A) Prostitution, as defined in Code Section 16-6-9; or

(B) Sexually explicit conduct for the purpose of producing any visual or print medium depicting such conduct, as defined in Code Section 16-12-100.



**19-7-5(c)      Mandatory Reporting**

(c)(1) The following persons having reasonable cause to believe that a child has been abused shall report or cause reports of that abuse to be made as provided in this Code section:

- (A) Physicians licensed to practice medicine, interns, or residents;
- (B) Hospital or medical personnel;
- (C) Dentists;
- (D) Licensed psychologists and persons participating in internships to obtain licensing pursuant to Chapter 39 of Title 43;
- (E) Podiatrists;
- (F) Registered professional nurses or licensed practical nurses licensed pursuant to Chapter 24 of Title 43;
- (G) Professional counselors, social workers, or marriage and family therapists licensed pursuant to Chapter 10A of Title 43;
- (H) School teachers;
- (I) School administrators
- (J) School guidance counselors, visiting teachers, school social workers, or school psychologists certified pursuant to Chapter 2 of Title 20;
- (K) Child welfare agency personnel, as that agency is defined pursuant to Code Section 49-5-12;
- (L) Child-counseling personnel;
- (M) Child service organization personnel; or
- (N) Law enforcement personnel.

(2) If a person is required to report abuse pursuant to this subsection because that person attends to a child pursuant to such person's duties as a member of the staff of a hospital, school, social agency, or similar facility, that person shall notify the person in charge of the facility, or the designated delegate thereof, and the person so notified shall report or cause a report to be made in accordance with this Code section. A staff member who makes a report to the person designated pursuant to this paragraph shall be deemed to have fully complied with this subsection.

**19-7-5(d) Permissive Reporting**

(d) Any other person, other than one specified in subsection (c) of this Code section, who has reasonable cause to believe that a child is abused may report or cause reports to be made as provided in this Code section.

**19-7-5(e) Contents of Report**

(e) An oral report shall be made as soon as possible by telephone or otherwise and followed by a report in writing, if requested, to a child welfare agency providing protective services, as designated by the Department of Human Resources, or, in the absence of such agency, to an appropriate police authority or district attorney. If a report of child abuse is made to the child welfare agency or independently discovered by the agency, and the agency has reasonable cause to believe such report is true or the report contains any allegation or evidence of child abuse, then the agency shall immediately notify the appropriate police authority or district attorney. Such reports shall contain the names and addresses of the child and the child's parents or caretakers, if known, the child's age, the nature and extent of the child's injuries, including any evidence of previous injuries, and any other information that the reporting person believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator. Photographs of the child's injuries to be used as documentation in support of allegations by hospital staff, physicians, law enforcement personnel, school officials, or staff of legally mandated public or private child protective agencies may be taken without the permission of the child's parent or guardian; provided, however, that any photograph taken pursuant to this Code section shall, if reasonably possible, be taken in a manner which shall not reveal the identity of the subject. Such photograph shall be made available as soon as possible to the chief welfare agency providing protective services and to the appropriate police authority.

**19-7-5(f) Liability**

(f) Any person or persons, partnership, firm, corporation, association, hospital, or other entity participating in the making of a report or causing a report to be made to a child welfare agency providing protective services or to an appropriate police authority pursuant to this Code section or any other law or participating in any judicial proceeding or any other proceeding resulting therefrom shall in so doing be immune from any civil or criminal liability that might otherwise be incurred or imposed, provided such participation pursuant to this Code section or any other law is made in good faith. Any person making a report, whether required by this Code section or not, shall be immune from liability as provided in this subsection.

**19-7-5(g) Required Reporting based on Privileged or Confidential Communication**

(g) Suspected child abuse which is required to be reported by any person pursuant to this Code section shall be reported notwithstanding that the reasonable cause to believe such abuse has occurred or is occurring is based in whole or in part upon any communication to that person which is otherwise made privileged or confidential by law.

**19-7-5(h) Penalty for Failure to Make Mandatory Reports**

(h) Any person or official required by subsection (c) of this Code section to report a suspected case of child abuse who knowingly and willfully fails to do so shall be guilty of a misdemeanor.

**19-7-5(i) Reports Not Subject to Public Inspection**

(i) A report of child abuse or information relating thereto and contained in such report, when provided to a law enforcement agency or district attorney pursuant to subsection (e) of this Code section or pursuant to Code Section 49-5-41, shall not be subject to public inspection under Article 4 of Chapter 18 of Title 50 even though such report or information is contained in or part of closed records compiled for law enforcement or prosecution purposes unless:

(1) There is a criminal or civil court proceeding which has been initiated based in whole or in part upon the facts regarding abuse which are alleged in the child abuse reports and the person or entity seeking to inspect such records provides clear and convincing evidence of such proceeding; or

(2) The superior court in the county in which is located the office of the law enforcement agency or district attorney which compiled the records containing such reports, after application for inspection and a hearing on the issue, shall permit inspection of such records by or release of information from such records to individuals or entities who are engaged in legitimate research for educational, scientific, or public purposes and who comply with the provisions of this paragraph. When those records are located in more than one county, the application may be made to the superior court of any one of such counties. A copy of any application authorized by this paragraph shall be served on the office of the law enforcement agency or district attorney which compiled the records containing such reports. In cases where the location of the records is unknown to the applicant, the application may be made to the Superior Court of Fulton County. The superior court to which an application is made shall not grant the application unless:

(A) The application includes a description of the proposed research project, including a specific statement of the information required, the purpose for which the project requires that information, and a methodology to assure the information is not arbitrarily sought;

(B) The applicant carries the burden of showing the legitimacy of the research project; and

(C) Names and addresses of individuals, other than officials, employees, or agents of agencies receiving or investigating a report of abuse which is the subject of a report, shall be deleted from any information released pursuant to this subsection unless the court determines that having the names and addresses open for review is essential to the research and the child, through his or her representative, gives permission to release the information.

## **Health Insurance Portability and Accountability Act (HIPAA)**

The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) established a national floor of consumer privacy protection and marketplace reform. Some key provisions include: insurance reforms, privacy and security, administrative simplification, and cost savings. It required Congress to enact privacy legislation by August 1999 or the Secretary of DHHS was to develop regulations protecting privacy. The HIPAA Privacy Rule (Standards for Privacy of Individually Identifiable Health Information) sets national minimal standards for protected health information. The HIPAA Privacy Rule went into effect April 14, 2003.

While state specific preemptions exist, HIPAA is a set of *federal* rules and regulations that are meant to standardize the way that all healthcare covered entities protect the privacy and security of individually identifiable health care information (IIHI). HIPAA does not preempt more stringent state law that relates to the privacy of individually identifiable health information. See 45 CFR §160.203. In this situation, the state licensure laws governing clinical laboratories are more stringent than HIPAA, and therefore, you must comply with the state law. Georgia Rules and Regulations for the Licensure of Clinical Laboratories states that “the results of a test performed by a licensed clinical laboratory shall be reported only to (or as directed by) a licensed physician, dentist, or other authorized person requesting the test.” See Rules and Regulations, Chapter 290-9-8-.25. Accordingly, you must direct the VA Health Department to the patient’s health care provider instead of disclosing the PHI directly to them. (3)

### **Entities Covered Under HIPAA (3)**

A public health authority is defined in HIPAA as including state public health agencies and anyone performing public health functions under a grant of authority from or contract with a public health agency that is responsible for public health matters as part of its official mandate. Therefore, entities and/or individuals that perform a public health function for a public health agency pursuant to a contract are also considered public health authorities. See 45 CFR §164.501 (definition of "public health authority").

HIPAA states that a covered entity (i.e. physician office) can disclose PHI, without the individual's authorization, to a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability. Including but not limited to, the reporting of disease or injury and the conduct of public health surveillance, investigations and interventions. See 45 CFR §164.512 (b)(1)(i). The GDPH mandate related to NBS would fall under this provision.

### **Authorizations (3)**

1. Privacy Rule 45 CFR §164.512 (k)(5)(i) states that: a covered entity may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual protected health information about such inmate or individual, if the correctional institution or such law enforcement official represents that such protected health information is necessary for:

(A) The provision of health care to such individuals;

- (B) The health and safety of such individual or other inmates;
- (C) The health and safety of the officers or employees of or others at the correctional institution;
- (D) The health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility, or setting to another;
- (E) Law enforcement on the premises of the correctional institution; and
- (F) The administration and maintenance of the safety, security, and good order of the correctional institution.

The law enforcement official or correctional institution should represent to the Division in writing that PHI is needed for the reasons outlined in HIPAA as stated above. This can be done on an individual basis or as a blanket request, i.e. a letter to the Division stating that the correctional facility needs PHI regarding inmates that test positive for communicable diseases and that the PHI is necessary for the reasons outlined in HIPAA.

2. HIPAA specifically states that disclosures of PHI for law enforcement purposes to a law enforcement official are allowed in various circumstances without the individual's authorization. Among these circumstances, is that a disclosure can be made pursuant to process and in compliance with an authorized investigative demand, or similar process authorized under law, provided that: (1) the information sought is relevant and material to a legitimate law enforcement inquiry; (2) the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and (3) de-identified information could not reasonably be used. See 45 CFR §164.512 (f)(1).

**Protected health information (PHI) discloses by covered entities for public health activities requiring no authorization under the Privacy Rule (1)**

Without individual authorization, a covered entity may disclose PHI to a public health authority\* that is legally authorized to collect or receive the information for the purposes of preventing or controlling disease, injury, or disability including, but not limited to:

- (A) Reporting of disease, injury, and vital events (e.g., birth or death); and
- (B) Conducting public health surveillance, investigations, and interventions

PHI may also be disclosed without individual authorization to

- (A) Report child abuse or neglect to a public health or other government authority legally authorized to receive such;

- (B) A person subject to jurisdiction of the Food and Drug Administration (FDA) concerning the quality, safety, or effectiveness of an FDA- related product or activity for which that person has responsibility;
- (C) A person who may have been exposed to communicable disease or may be at risk for contracting or spreading a disease or may be at risk for contracting or spreading a disease or condition, when regally authorized to notify the person as necessary to conduct a public health intervention or investigation; and
- (D) An individual’s employer, under certain circumstances and conditions, as needed for the employer to meet the requirements of the Occupational Safety and Health Administration, Mine Safety and Health Administration, or similar state law.
- (E) Disclosure of patient health information without the authorization of the individual is permitted for purposes including but not limited to 1) disclosures required by law (45 CFR § 164.512(a)) or 2) for “public health activities and purposes.” This includes disclosure to “a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including but not limited to, the reporting of disease, injury, vital events. . . , and the conduct of public health surveillance,. . . investigations, and. . . interventions.”

Adapted from [45 CFR§164.512(b)].

\* Or to an entity working under a grant of authority from a public health authority, or when directed by a public health authority, to a foreign government agency that is acting in collaboration with a public health authority.

### **Individual Identifiers under the Privacy Rule (1)**

The following 18 identifiers of a person, or of relatives, employers, or household members of a person must be removed, and the covered entity must not have actual knowledge that the information could be used alone or in combination with other information to identify the individual, for the information to be considered de-identified and not protected health information (PHI):

- (A) Names;
- (B) All geographic subdivisions smaller than a state, including county, city, street address, precinct, zip code, \* and their equivalent geocodes;
- (C) All elements of dates (except year) directly related to an individual; all ages >89 and all elements of dates (including year) indicative of such age (except for an aggregate into a single category of age > 90);
- (D) Telephone numbers;
- (E) Fax numbers;
- (F) Electronic mail addresses;

- (G) Social Security numbers;
- (H) Medical record numbers;
- (I) Health-plan beneficiary numbers;
- (J) Account numbers;
- (K) Certificate and license numbers;
- (L) Vehicle identifiers and serial numbers, including license plate numbers;
- (M) Medical device identifiers and serial numbers;
- (N) Internet universal resource locators (URLs);
- (O) Internet protocol (IP) addresses;
- (P) Biometric identifiers including fingerprints and voice prints;
- (Q) Full-face photographic images and any comparable images; and
- (R) Any other unique identifying number, characteristic, or code, except that covered identities may, under certain circumstances, assign a code or other means of record identification that allows de-identified information to be re-identified.

Adapted from [45 CFR § 164.514 (b) (2) (i)].

\*The first three digits of a zip code are excluded from the PHI list if the geographic unit formed by combining all zip codes with the same first three digits contains >20,000 persons.

### **Use of Limited Data Sets Under the Privacy Rule (1)**

The following protected health information (PHI) can be included, without authorization, in a limited data set for public health, research, or health care operations:

- (A) Town or city, state, and zip code; and
- (B) Elements of dates related to a person (e.g., years, birth dates, admission dates, discharge dates, and dates of death).

To disclose a limited data set, a covered entity must enter into a data-use agreement with the recipient, which agrees to use or disclose the PHI for limited purposes. Disclosure of a limited data set is not subject to the accounting requirement, but must meet the minimum necessary standards of the Privacy Rule.

### **Disclosure of Information to a Public Health Authority (3)**

45 CFR §164.512(b)(1)(i), states that a covered entity can disclose PHI to a public health authority that is authorized to collect or receive such information for the purpose of preventing or us controlling disease. HIPAA also requires that you verify the status and identity of the public health authority before disclosing the requested PHI. If the request was sent on VA Dept. of Health letterhead, then this is enough verification.

### **Electronic Dissemination of Information (3)**

Any electronic data stored on a computer, backup tape, floppy disk, database, or CD must be protected – even during the physical transportation from one location to another. DHR systems that include protected health information include:

- (A) SUCCESS
- (B) AIMS
- (C) CHAT
- (D) MHMRIS
- (E) Membership Database
- (F) HOST
- (G) AEGIS
- (H) TB Information Management System
- (I) GroupWise

Emails being sent by members of the Division of Public Health should include a confidentiality disclaimer in the signature. This type of measure is a reasonable safeguard that should be taken pursuant to HIPAA. See 45 CFR §164.530(c). This signature should be used regardless of whether the email is being sent within or outside of DHR. Language for the email signature follows:

"This message and any included attachments are from the Division of Public Health and are intended only for the addressee(s). The information contained herein may include privileged or otherwise confidential information. Unauthorized review, forwarding, printing, copying, distributing, or using such information is strictly prohibited. If you receive this message in error or have reason to believe you are not authorized to receive it, please promptly delete this message and notify the sender by email."

It is the responsibility of DHR staff and their entities to ensure for privacy and confidentiality when health information is electronically stored, maintained, or transmitted.

### **Notice of Privacy Practices (NPP)(3)**

Under HIPAA, an individual has a right to adequate notice of the uses and disclosures of protected health information (PHI) that may be made by the covered entity, and of the



individual's rights and the covered entity's legal duties with respect to PHI. See 45 CFR §164.520. HIPAA requires DHR, as a covered entity, to post a Notice of Privacy Practices in accordance with these individual rights. DHR's Notice of Privacy Practice informs individuals of: 1) DHR's uses and disclosures of PHI; 2) the individual's rights; and 3) the HIPAA complaint process. DHR is required by HIPAA to make DHR's Notice of Privacy Practices available upon request to any person. In light of this requirement, please provide a copy of this Notice to any person that requests it. Please contact your HIPAA Coordinator to get a copy of the Notice.

### **Process for handling an incidental disclosure (3)**

Under HIPAA, incidental disclosures are okay and don't require action on the part of the covered entity when they occur if the particular incidental disclosure is a by-product of a permitted use or disclosure, reasonable safeguards have been applied and if the minimum necessary standard was implemented. See 45 CFR §164.502(a)(1)(iii).

The only time an incidental use or disclosure becomes problematic is if it was a by-product of an underlying use or disclosure that is not allowed by HIPAA to begin with.

In this case, you will have to document the unauthorized disclosure as well as efforts taken to mitigate the incidental disclosure, i.e. corrective action taken and steps taken to prevent such a disclosure from happening in the future. See 45 CFR §164.530(f).

### **Failure to Comply (2)**

District STD Programs and their entities will be held accountable for any errors in transmission of confidential information to the state STD Unit. Violations should be documented and reported to the STD Program Manager and Section Director. District STD staff and health care providers will be held accountable for any breaches of confidentiality. Any breaches of confidentiality will be followed with appropriate disciplinary actions.

### **References:**

1. HIPPA Privacy Rules and Public Health: Guidance from CDC and the U.S. Department of Health and Human Services. Available at:  
[www.cdc.gov/mmwr/preview/mmwrhtml/m2e411a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/m2e411a1.htm)
2. Introduction to Quality Assurance/Quality Improvement for STD services, Prepared by Georgia Department of Human Resources Staff/Division of Public Health. Available at  
[www.health.state.ga.us](http://www.health.state.ga.us)
3. FAQ's: Health Insurance Portability and Accountability Act (HIPPA), Prepared by Georgia Department of Human resources/Division of Public Health. Available at  
[www.health.state.ga.us](http://www.health.state.ga.us)

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# Miscellaneous Information

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## Child Abuse & Neglect

[How To Report Child Abuse](#)

### Mandated Reporters

[Special Investigations Unit](#)

[Fact Sheets](#)

[FAQ](#)

[Publications & Forms](#)

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## Mandated Reporters

While everyone is encouraged to report suspected child abuse or neglect, the law requires persons in some professions be required to report. They are called "mandated reporters" and they include the following professionals:

- Physicians licensed to practice medicine, interns or residents
- Hospital or medical personnel
- Dentists
- Licensed psychologists and persons participating in internships to obtain licensing pursuant to Chapter 39 of Title 43 (OCGA)
- Podiatrists
- Registered professional nurses or licensed practical nurses licensed pursuant to Chapter 24 of Title 43 (OCGA)
- Professional counselors, social workers or marriage and family therapists licensed pursuant to Chapter 10A of Title 43 (OCGA)
- School teachers
- School administrators
- School guidance counselors, visiting teachers, school social workers or school psychologists certified pursuant to Chapter 2 of Title 20 (OCGA)
- Child welfare agency personnel, as that agency is defined pursuant to OCGA 49-5-12. Child welfare agency means any child-caring institution, child-placing agency, maternity home, family boarding home, family day-care home and day care center
- Child counseling personnel
- Child service organization personnel

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# PROTECTING CHILDREN

## How to Report Abuse or Neglect

The job of protecting children starts in the community. While certain people are required by law to report child mistreatment, anyone can make a report of suspected abuse. The sooner the authorities know about a child, the faster they can move to help.

### Things to Look For

Children who are maltreated are

- often left home alone
- in the neighborhood for long periods without supervision
- frequently hungry
- dressed inadequately for the weather
- absent from school frequently
- bruised or have other marks of physical violence
- withdrawn or overly aggressive
- not receiving needed medical attention

If a relative, friend or neighbor sees one or more of these signs or suspects that the children are in danger, the situation should be reported to the county Department of Family and Children Services (DFCS).

### How to Report

If a child is in immediate danger (obviously being beaten or left alone overnight, for example), the police should be called immediately. In all other cases, reports should be made to the DFCS office in the county where the child lives.

People who call to report suspected abuse do not have to be sure maltreatment has occurred. They simply report what they have seen or heard. The authorities will investigate and confirm whether or not abuse has occurred. People who call are asked to give the name and location of the child and the name of the suspected perpetrator. Reports are confidential and those who call do

not have to give their name. However, it is most helpful to the child in the long run if the reporter is willing to give his or her name and address and, if necessary, testify in court.

### What Will Happen Next

If a child is under age 18 and appears to have been abused or neglected by a parent or caretaker, DFCS will begin investigating immediately.

If the child is not in imminent danger, a caseworker will visit the family within 5 days.

If the person who makes the original report wants to know what DFCS did, he or she can call the department and find out whether the maltreatment was confirmed.

### Who is Required to Report Suspected Abuse or Neglect?

Georgia law requires people in certain professions to report. Mandated reporters include

- physicians, nurses and hospital personnel
- school and day care personnel
- social workers and counselors
- dentists



*Division of Family and Children Services*

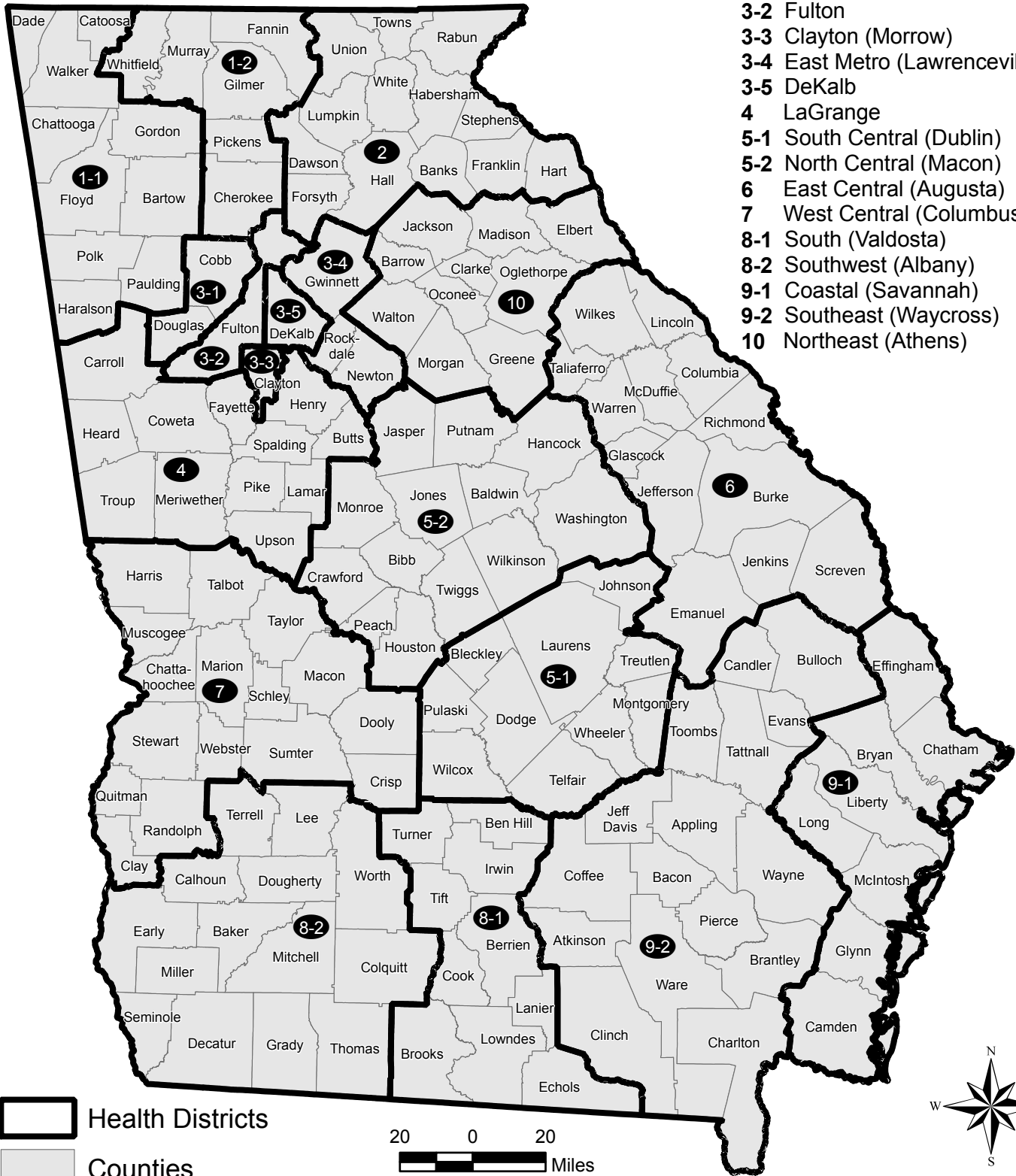
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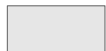
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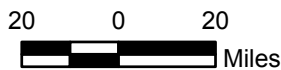
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# GEORGIA Public Health Districts

- 1-1 Northwest (Rome)
- 1-2 North Georgia (Dalton)
- 2 North (Gainesville)
- 3-1 Cobb-Douglas
- 3-2 Fulton
- 3-3 Clayton (Morrow)
- 3-4 East Metro (Lawrenceville)
- 3-5 DeKalb
- 4 LaGrange
- 5-1 South Central (Dublin)
- 5-2 North Central (Macon)
- 6 East Central (Augusta)
- 7 West Central (Columbus)
- 8-1 South (Valdosta)
- 8-2 Southwest (Albany)
- 9-1 Coastal (Savannah)
- 9-2 Southeast (Waycross)
- 10 Northeast (Athens)



 Health Districts  
 Counties



# GEORGIA DIVISION OF PUBLIC HEALTH HEALTH DISTRICT INFORMATION

JANUARY 2007

Health Director	Address	Program Manager	Administrator	Clinical Coordinator	Environmentalist	EMS Coordinator
<b>DISTRICT 1, UNIT 1 ♦ ROME ♦ Northwest Georgia Health District</b> Bartow, Catoosa, Chattooga, Dade, Floyd*, Gordon, Haralson, Paulding, Polk, Walker						
<b>District Health Director</b> C. Wade Sellers, M.D., M.P.H. <b>Contact Person</b> Kathy Kitchens 706-295-6704 <a href="mailto:kckitchens@dhr.state.ga.us">kckitchens@dhr.state.ga.us</a>	1305 Redmond Circle Building 614 Rome, Georgia 30165-1391 Phone No: 706-295-6704 Fax No: 706-802-5435 E-Mail: <a href="mailto:cwsellers@dhr.state.ga.us">cwsellers@dhr.state.ga.us</a>	Margaret Bean 706-295-6647 Fax: 706-802-5681	Chuck Wilson 706-802-5589 Fax: 706-295-6015	Gayle Brannon 706-802-5219 Fax: 706-802-5681	Tim Allee 706-295-6650 Fax: 706-802-5290	David Lofton 706-295-6154 Fax: 706-802-5292
<b>DISTRICT 1, UNIT 2 ♦ DALTON ♦ North Georgia Health District</b> Cherokee*, Fannin, Gilmer, Murray, Pickens, Whitfield						
<b>District Health Director</b> Harold Pitts, M.D., J.D. <b>Contact Person</b> Suzanne Jones 706-272-2342 <a href="mailto:shjones6@dhr.state.ga.us">shjones6@dhr.state.ga.us</a>	100 W. Walnut Ave. Suite 92 Dalton, Georgia 30720-8427 Phone No: 706-272-2342 Fax No: 706-272-2221 E-Mail: <a href="mailto:hwpitts@dhr.state.ga.us">hwpitts@dhr.state.ga.us</a>	Louise Hamrick 706-272-2342 Fax: 706-272-2221	Lamar Hamill 706-272-2342 Fax: 706-272-2221	Debbie Robbins 706-272-2342 Fax: 706-272-2221	Ray King 706-272-2342 Fax: 706-272-2221	David Lofton 706-295-6154 Fax: 706-802-5292
<b>DISTRICT 2 ♦ GAINESVILLE ♦ North Health District</b> Banks, Dawson, Forsyth, Franklin, Habersham, Hall*, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White						
<b>District Health Director</b> David N. Westfall, M.D., C.P.E. <b>Contact Person</b> Kathy Moreland 770-535-5866 <a href="mailto:kamoreland@dhr.state.ga.us">kamoreland@dhr.state.ga.us</a>	1280 Athens Street Gainesville, Georgia 30507-7000 Phone No: 770-535-5743 Fax No: 770-535-5958 E-Mail: <a href="mailto:dnwestfall@dhr.state.ga.us">dnwestfall@dhr.state.ga.us</a>	Edie Parsons, Ph.D 770-535-5743 <a href="mailto:eiparsons@dhr.state.ga.us">eiparsons@dhr.state.ga.us</a>	Gregg Sheffield 770-535-5743 <a href="mailto:gmsheffield@dhr.state.ga.us">gmsheffield@dhr.state.ga.us</a>	Angie Hanes 770-535-5876 Fax: 770-535-5958 <a href="mailto:ahhanes@dhr.state.ga.us">ahhanes@dhr.state.ga.us</a>	Larry Walker 770-535-5743	Earl McGrotha 770-535-5743

Health Director	Address	Program Manager	Administrator	Clinical Coordinator	Environmental	EMS Coordinator
<b>DISTRICT 3-1 ♦ MARIETTA ♦ Cobb/Douglas Health District</b> Cobb*, Douglas						
<b>District Health Director</b> Alpha Fowler Bryan, M.D. <b>Contact Person</b> Virginia Freeman or <a href="mailto:vfreeman@dhr.state.ga.us">vfreeman@dhr.state.ga.us</a> Pamela Mashburn 770-514-2330 <a href="mailto:pmashburn@dhr.state.ga.us">pmashburn@dhr.state.ga.us</a>	1650 County Services Parkway Marietta, Georgia 30008-4010 Phone No: 770-514-2330 Fax No: 770-514-2320 E-Mail: <a href="mailto:afbryan@dhr.state.ga.us">afbryan@dhr.state.ga.us</a>	Lisa Crossman 770-514-2323 Fax: 770-514-2320	Ty Carlson 770-514-2342 Fax: 770-514-2811	Patti Duckworth 770-514-2496 Fax: 770-514-2414	Murl McCall 3830 S. Cobb Dr. Suite 102 Smyrna, GA 30080 770-435-7815 Fax: 770-431-7410	Marty Billings 2600 Skyland Dr. Upper level Atlanta, GA 30319 404-248-8995 Fax: 404-248-8948
<b>DISTRICT 3, UNIT 2 ♦ ATLANTA ♦ Fulton Health District</b> Fulton*						
<b>District Health Director</b> Steven R. Katkowsky, M.D. <b>Contact Person</b> Dorothy Cassell 404-730-1242 <a href="mailto:djcassell@dhr.state.ga.us">djcassell@dhr.state.ga.us</a>	Fulton Co Dept of Health and Wellness 99 Jessie Hill Jr., Dr. Atlanta, Georgia 30303-3045 Phone No: 404-730-1202 Fax No: 404-730-1294 E-Mail: <a href="mailto:srkatkowsky@dhr.state.ga.us">srkatkowsky@dhr.state.ga.us</a>	VACANT	Christine Greene, Acting 404-730-1214 Fax: 404-730-1233	Dr. Kim Turner 404-730-1447 Fax: 404-730-1440	John Gormley 404-730-1305 Fax: 404-730-1462	Al Simmons 404 730-1409 Fax: 404-730-1283
<b>DISTRICT 3, UNIT 3 ♦ JONESBORO ♦ Clayton County Health District</b> Clayton*						
<b>District Health Director</b> Stephen Morgan, M.D. <b>Contact Person</b> Helen Garrett 678-610-7258 <a href="mailto:hgarrett@dhr.state.ga.us">hgarrett@dhr.state.ga.us</a>	1117 Battlecreek Road Jonesboro, GA 30236 Phone No: 678-610-7193 Fax No: 770-603-4872 E-Mail: <a href="mailto:stmorgan@dhr.state.ga.us">stmorgan@dhr.state.ga.us</a>	Jennifer Beane 678-610-7196 <a href="mailto:jbeane@dhr.state.ga.us">jbeane@dhr.state.ga.us</a>	Karen Babineau 678-610-7197 <a href="mailto:kibabineau@dhr.state.ga.us">kibabineau@dhr.state.ga.us</a>	Dianne Banister 678-610-7196, <a href="mailto:dbbanister@dhr.state.ga.us">dbbanister@dhr.state.ga.us</a>	Walter Howard 678-610-7430 Fax: 770-603-4874 <a href="mailto:wjhoward@dhr.state.ga.us">wjhoward@dhr.state.ga.us</a>	Marty Billings 2600 Skyland Dr. Upper level Atlanta, GA 30319 404-248-8995 Fax: 404-248-8948



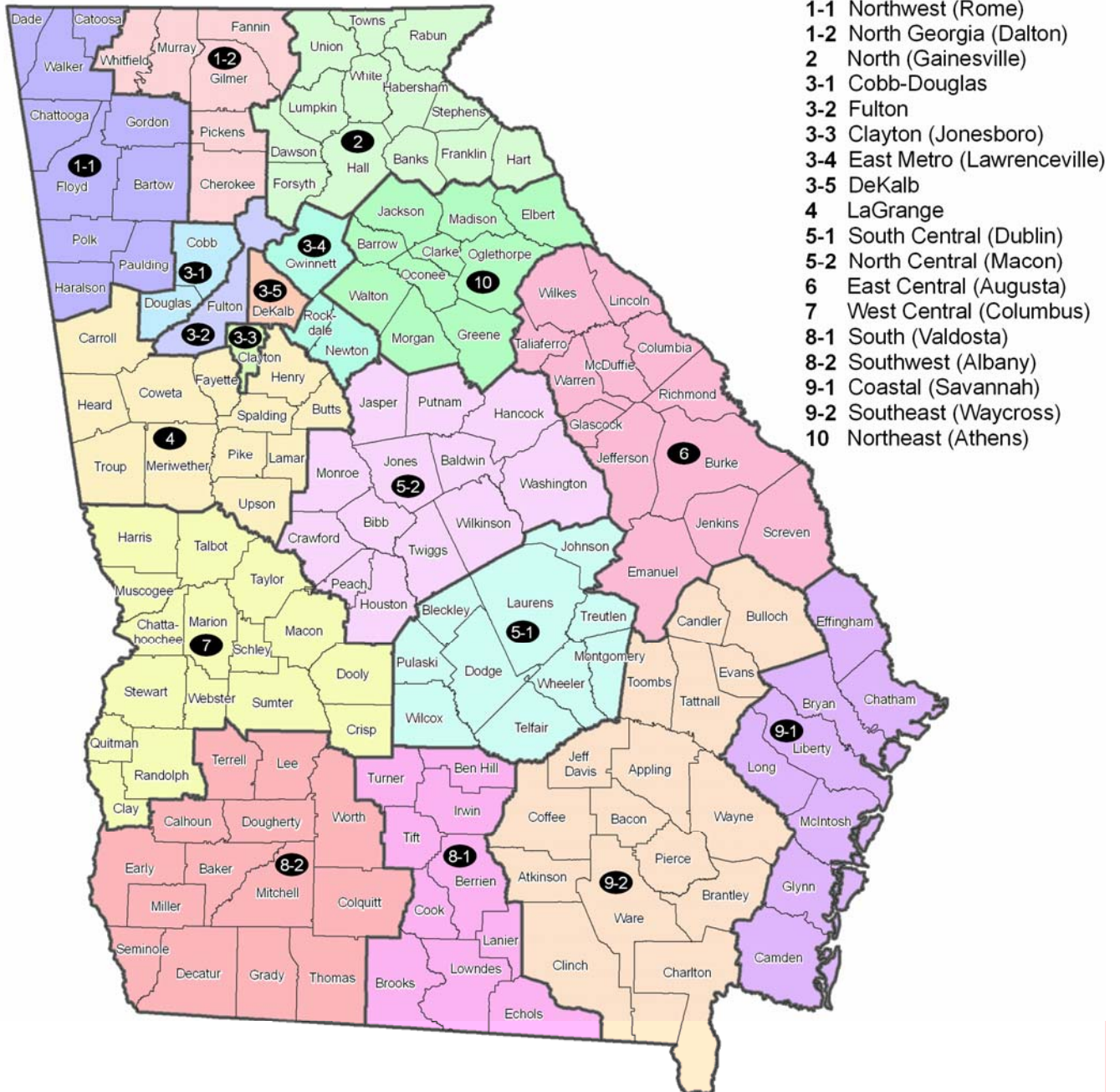
Health Director	Address	Program Manager	Administrator	Clinical Coordinator	Environmentalist	EMS Coordinator
<b>DISTRICT 3, UNIT 4 ♦ LAWRENCEVILLE ♦ East Metro Health District</b> Gwinnett*, Newton, Rockdale						
<b>District Health Director</b> Lloyd Hofer, M.D., M.P.H. <b>Contact Person</b> Sandra Warnock 678-442-6908 <a href="mailto:scwarnock@dhr.state.ga.us">scwarnock@dhr.state.ga.us</a>	324 West Pike Street P.O. Box 897 Lawrenceville, Georgia 30046-0897 Phone No: 770-339-4260 Fax No: 770-339-2334 E-Mail: <a href="mailto:lmhofer@dhr.state.ga.us">lmhofer@dhr.state.ga.us</a>	Stephanie Phillips 678-442-6900  Program Director Connie Russell 678-442-6865 Fax: 770-963-1418	Jim Griffin 770-339-4260 Fax: 770-237-5319	Debra C. Crowley, RNC 678-442-6868 Fax 770-339-2334	Joseph Sternberg 678-376-3217 Fax: 770-963-8420	Marty Billings 2600 Skyland Dr. Upper level Atlanta, GA 30319 404-248-8995 Fax: 404-248-8948
<b>DISTRICT 3, UNIT 5 ♦ DECATUR ♦ DeKalb Health District</b> DeKalb*						
<b>District Health Director</b> S. Elizabeth Bouchelion, M.D., M.B.A., F.A.A.P. 404-294-3789 <b>Contact Person</b> Sandra Pineyro 404-294-3787 <a href="mailto:scpineyro@dhr.state.ga.us">scpineyro@dhr.state.ga.us</a>	DeKalb County Board of Health 445 Winn Way, Suite 553 P.O. Box 987 Decatur, Georgia 30031-1701 Phone No: 404-294-3700 Fax No: 404-294-3715 E-Mail: <a href="mailto:sebouchelion@dhr.state.ga.us">sebouchelion@dhr.state.ga.us</a>	Les Richmond M.D. 404-294-3743 Fax: 404-508-7862	Dianne McWethy 404-508-7842 Fax: 404-297-7150	Gloria Chen RN, MBA, EdD 404-294-3798 Fax: 404-508-7862	Janice Buchanon Interim 404-508-7912 Fax: 404-508-7979	Billy Watson Interim 2600 Skyland Dr. Atlanta, GA 30319  404-248-8995 Fax: 404-248-8948
<b>DISTRICT 4 ♦ LAGRANGE ♦ LaGrange Health District</b> Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup*, Upson						
<b>District Health Director</b> Michael L. Brackett, M.D. <b>Contact Person</b> Debbi Heard 706-845-4035 <a href="mailto:daheard@dhr.state.ga.us">daheard@dhr.state.ga.us</a>	122-A Gordon Commercial Drive LaGrange, Georgia 30240-5740 Phone No: 706-845-4035 Fax No: 706-845-4350 Fax No. 706-845-4038 E-Mail: <a href="mailto:mlbrackett@dhr.state.ga.us">mlbrackett@dhr.state.ga.us</a>	John G. Darden 706-845-4035 Fax : 706-845-4038	Wyndia Wortham 706-845-4035 Fax : 706-845-4038	Susan Ayers 706-845-4035 Fax: 706-845-4350	Rodney Hilley 706-845-4035 Fax: 706-845-4038	Billy Watson 706-845-4035 Fax: 706-845-4309

Health Director	Address	Program Manager	Administrator	Clinical Coordinator	Environmentalist	EMS Coordinator
<b>DISTRICT 5, UNIT 1 ♦ DUBLIN ♦ South Central Health District</b> Bleckley, Dodge, Johnson, Laurens*, Montgomery, Pulaski, Telfair, Treutlen, Wheeler, Wilcox						
<b>District Health Director</b> Lawton C. Davis, M.D. <b>Contact Person</b> A. Kay Stevenson 478-275-6565 <a href="mailto:akstevenson@dhr.state.ga.us">akstevenson@dhr.state.ga.us</a>	2121-B Bellevue Road Dublin, Georgia 31021-2998 Phone No: 478-275-6545 Fax No: 478-275-6575 E-Mail: <a href="mailto:lcdavis@dhr.state.ga.us">lcdavis@dhr.state.ga.us</a>	Jannell Knight 478-275-6545 <a href="mailto:jrknight@dhr.state.ga.us">jrknight@dhr.state.ga.us</a>	Bruce Evans 478-275-6545 <a href="mailto:bwevens@dhr.state.ga.us">bwevens@dhr.state.ga.us</a>	Connie Copeland 478-275-6545	Mark Harden 478-275-6545	Chris Threlkeld 158 Sammons Industrial Pkwy, Suite 101 Eatonton, GA 31024 706-484-2991 Fax: 706-484-2994
<b>DISTRICT 5, UNIT 2 ♦ MACON ♦ North Central Health District</b> Baldwin, Bibb*, Crawford, Hancock, Houston, Jasper, Jones, Monroe, Peach, Putnam, Twiggs, Washington, Wilkinson						
<b>District Health Director</b> Joseph R. Swartwout, M.D. 478-751-6247 <b>Contact Person</b> Glenda Smith 478-751-6247 <a href="mailto:gmsmith3@dhr.state.ga.us">gmsmith3@dhr.state.ga.us</a>	811 Hemlock Street Macon, Georgia 31201-2198 Phone No: 478-751-6303 Fax No: 478-751-6099 E-Mail: <a href="mailto:jrswartwout@dhr.state.ga.us">jrswartwout@dhr.state.ga.us</a>	Roy M. Moore 478-751-3346 Fax: 478-751-6099	Nancy Mason 478-751-6049	Christy Sims 478-751-6119	David Blankenship 478-751-6114	Chris Threlkeld 158 Sammons Industrial Pkwy, Suite 101 Eatonton, GA 31024 706-484-2991 Fax: 706-484-2994
<b>DISTRICT 6 ♦ AUGUSTA ♦ East Central Health District</b> Burke, Columbia, Emanuel, Glascock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond*, Screven, Taliaferro, Warren, Wilkes						
<b>District Health Director</b> Cassandra D. Youmans, M.D., M.P.H., M.S.-H.C.M., F.A.A.P. <b>Contact Person</b> Helen Smith 706-667-4257 <a href="mailto:hsmith6@dhr.state.ga.us">hsmith6@dhr.state.ga.us</a>	1916 North Leg Road Augusta, Georgia 30909-4437 Phone No: 706-667-4250 Fax No: 706-667-4365 E-Mail: <a href="mailto:cduyomans@dhr.state.ga.us">cduyomans@dhr.state.ga.us</a>	John Nolan 706-667-4252	Barbara Spires 706-667-4330	Donna Scott 706-667-4296	John Tebeau 706-667-4346	Lawanna Mercer-Cobb 706-667-4338

Health Director	Address	Program Manager	Administrator	Clinical Coordinator	Environmentalist	EMS Coordinator
<b>DISTRICT 7 ♦ COLUMBUS ♦ West Central Health District</b> Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Muscogee*, Marion, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster						
<b>District Health Director</b> Zsolt Koppanyi, M.D., M.P.H. <b>Contact Person</b> Charlene Ellis 706-321-6108 <a href="mailto:ccellis@dhr.state.ga.us">ccellis@dhr.state.ga.us</a>	2100 Comer Avenue P.O. Box 2299 Columbus, Georgia 31902-2299 Phone No: 706-321-6300 Fax No: 706-321-6126 E-Mail: <a href="mailto:zhkoppanyi@dhr.state.ga.us">zhkoppanyi@dhr.state.ga.us</a>	Ed Saidla 706-321-6101	Margaret B. Gosden 706-321-6103	Eileen Albritton 706-321-6102	Jerome Deal 706-321-6185	Sam Cunningham 706-321-6151
<b>DISTRICT 8, UNIT 1 ♦ VALDOSTA ♦ South Health District</b> Ben Hill, Berrien, Brooks, Cook, Echols, Irwin, Lanier, Lowndes*, Tift, Turner						
<b>District Health Director</b> Lynne D. Feldman, M.D., M.P.H. <b>Contact Person</b> Theresa Clark 229-245-6431 <a href="mailto:ttclark@dhr.state.ga.us">ttclark@dhr.state.ga.us</a>	312 North Patterson Street (31601) P.O. Box 5147 Valdosta, Georgia 31603-5147 Phone: 229-333-5290 Fax No: 229-333-7822 E-Mail: <a href="mailto:ldfeldman@dhr.state.ga.us">ldfeldman@dhr.state.ga.us</a>	Elsie Napier 229-245-6415	Sherrie White 229-245-6439	Gene Godfrey 229-245-6433	Tad Williams 229-333-7827	Robert Vick 319 N. Main Street P.O. Box 3637 Moultrie, GA 31776 229-891-7034 Fax: 229-891-7031
<b>DISTRICT 8, UNIT 2 ♦ ALBANY ♦ Southwest Health District</b> Baker, Calhoun, Colquitt, Dougherty*, Decatur, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth						
<b>District Health Director</b> Jacqueline H Grant, M.D., M.P.H., M.P.A. <b>Contact Person</b> Nancy Rumph 229-430-4127 <a href="mailto:nhrumph1@dhr.state.ga.us">nhrumph1@dhr.state.ga.us</a>	1109 North Jackson Street Albany, Georgia 31701-2022 Phone: 229-430-4127 Fax No: 229-430-5143 E-Mail: <a href="mailto:jhgrant@dhr.state.ga.us">jhgrant@dhr.state.ga.us</a>	Ann Addison, PhD 229-430-4127	Carol Williams 229-430-4036	Brenda Greene 229-430-4599	Melvin Jones 229-430-4129	Robert Vick 319 N. Main Street P.O. Box 3637 Moultrie, GA 31776 229-891-7034 Fax: 229-891-7031
<b>DISTRICT 9, UNIT 1 ♦ SAVANNAH/BRUNSWICK ♦ Coastal Health District</b> Bryan, Camden, Chatham*, Effingham, Glynn, Liberty, Long, McIntosh						
<b>District Health Director</b> W. Douglas Skelton, M.D <b>Contact Person</b> Ruthie Smoak 912-644-5205 <a href="mailto:kschaffin@dhr.state.ga.us">kschaffin@dhr.state.ga.us</a>	P. O. Box 15879 (31416) 24 Oglethorpe Professional Boulevard Savannah, Georgia 31406 Phone: 912-644-5210 Fax: 912-644-5220 E-Mail: <a href="mailto:wdskelton@dhr.state.ga.us">wdskelton@dhr.state.ga.us</a>	Randy McCall 912-262-2342 Fax: 912-262-2339	Brent Jordan 912-356-2886 Fax: 912-356-2918	Betty Dixon 912-644-5201 Fax: 912-644-5220	Saroyi Morris 912-262-3032 Fax: 912-262-2339	Shirley Starling 912-264-3907 Fax: 912-264-2504

Health Director	Address	Program Manager	Administrator	Clinical Coordinator	Environmentalist	EMS Coordinator
<b>DISTRICT 9, UNIT 2 ♦ WAYCROSS ♦ Southeast Health District</b> Appling, Atkinson, Bacon, Brantley, Bulloch, Candler, Charlton, Clinch, Coffee, Evans, Jeff Davis, Pierce, Tattnall, Toombs, Ware*, Wayne						
<b>District Health Director</b> Rosemarie Parks, M. D., M.P.H. <b>Contact Person</b> Nancy Jackson (and) 912-285-6010 <a href="mailto:nfjackson@dhr.state.ga.us">nfjackson@dhr.state.ga.us</a> Melinda Monroe <a href="mailto:mtmonroe@dhr.state.ga.us">mtmonroe@dhr.state.ga.us</a>	1101 Church Street Waycross, Georgia 31501-3525 Phone No: 912-285-6010 Fax No: 912-284-2980 E-Mail: <a href="mailto:rdparks@dhr.state.ga.us">rdparks@dhr.state.ga.us</a>	Susan Horne 912-285-6020 Fax: 912-284-2980	Cindy Sowell 912-285-6037 Fax: 912-287-4033	Patricia Brannen 912-287-5897 Fax: 912-285-6004	Dwain Butler 912-284-2976 Fax: 912-284-2980	Shirley Starling 912-264-3907 Fax: 912-264-2504
<b>DISTRICT 10 ♦ ATHENS ♦ Northeast Health District</b> Barrow, Clarke*, Elbert, Greene, Jackson, Madison, Morgan, Oconee, Oglethorpe, Walton						
<b>District Health Director</b> Claude A. Burnett, M.D., M.P.H. <b>Contact Person</b> Linda McGinnis 706-583-2870 <a href="mailto:lwmcginnis@dhr.state.ga.us">lwmcginnis@dhr.state.ga.us</a>	220 Research Drive Athens, Georgia 30605-2738 Phone No: 706-583-2870 Fax No: 706-548-5181 E-Mail: <a href="mailto:cabmd@dhr.state.ga.us">cabmd@dhr.state.ga.us</a>	Ronald Barwick, PhD 706-583-2769	Joe Henneberger 706-583-2768	Carol Burnes 706-583-2777	Todd Jones 202 Ben Burton Circle, P. O. Box 190, Bogart, GA 30622 706-583-2854 Fax: 706-583-2665	Earl McGrotha 706-583-2862 Fax: 706-227-7960

# Georgia County Health Departments June 2006



**Appling County Health Department, District 9-2**

34 Walnut Street, P. O. Box 37  
Baxley GA 31515-0119  
912-367-4601, Fax: 367-1096

**Atkinson County Health Department, District 9-2**

818-A East Austin Street, P.O. Drawer 218  
Pearson GA 31642-9322  
912-422-3332, Fax: 422-7345

**Bacon County Health Department, District 9-2**

101 North Wayne Street, P.O. Box 116  
Alma GA 31510-2540  
912-632-4712, Fax: 632-7834

**Baker County Health Department, District 8-2**

100 Sunset Boulevard, P.O. Box 365  
Newton GA 39870-0365  
229-734-5226, Fax: 734-6023

**Baldwin County Health Department, District 5-2**

953 Barrows Ferry Road, P.O. Box 459 (31059)  
Milledgeville GA 31061-7937  
478-445-4264, Fax: 445-6525

**Banks County Health Department, District 2-0**

667 Thompson Street  
Homer GA 30547-3110  
706-677-2296, Fax: 677-4042

**Barrow County Health Department, District 10-0**

233 East Broad Street, Suite A, P. O. Drawer 1099  
Winder GA 30680-3773  
770-307-3011, Fax: 307-1039

**Bartow County Health Department, District 1-1**

100 Zena Drive SE, P.O. Box 665 (30120)  
Cartersville GA 30121-2482  
770-382-1920, Fax: 387-3999

**Ben Hill County Health Department, District 8-1**

251 Appomattox Road, P. O. Box 188  
Fitzgerald GA 31750-3757  
229-426-5288, Fax: 423-5291

**Berrien County Health Department, District 8-1**

600-A South Jefferson Street, P. O. Box 275  
Nashville GA 31639-2514  
229-686-5411, Fax: 686-9015

**Bibb County Health Department, District 5-2**

171 Emery Highway  
Macon GA 31201  
478-745-0411, Fax: 749-0101

**Bleckley County Health Department, District 5-1**

102 South East Eighth Street  
Cochran GA 31014-1053  
478-934-6590, Fax: 934-8729

**Brantley County Health Department, District 9-2**

115 Florida Avenue, P. O. Box 603  
Nahunta GA 31553  
912-462-6165, Fax: 462-7655

**Brooks County Health Department, District 8-1**

500 East Courtland Avenue, P. O. Box 447  
Quitman GA 31643-1165  
229-263-7585, Fax: 263-5332

**Bryan County Health Department, District 9-1**

430 Ledford Street, P. O. Box 9  
Pembroke GA 31321-0009  
912-653-4331, Fax 653-4328

**Bulloch County Health Department, District 9-2**

1 West Altman Street, P. O. Box 2009 (30459)  
Statesboro GA 30458-5212  
912-764-3800, Fax: 871-1901

**Burke County Health Department, District 6-0**

114 Dogwood Drive, P. O. Box 238  
Waynesboro GA 30830-0238  
706-554-3456, Fax: 554-2944

**Butts County Health Department, District 4-0**

463 Ernest Biles Drive, Suite A  
Jackson GA 30233-2229  
770-504-2231, Fax: 504-2229

**Calhoun County Health Department, District 8-2**

29040 North Bermuda, P. O. Box 57  
Morgan GA 39866-3516  
229-849-2515, Fax: 849-2701

**Camden County Health Department, District 9-1**

600 N. Charles Gillman Jr. Avenue  
Kingsland GA 31548-6290  
912-729-4554, Fax: 729-6056

**Candler County Health Department, District 9-2**

428 North Rountree Street, P. O. Box 205  
Metter GA 30439-0205  
912-685-5765, Fax: 685-7448

**Carroll County Health Department, District 4-0**

1004 Newnan Road  
Carrollton GA 30116-6428  
770-836-6667, Fax: 836-6722

**Catoosa County Health Department, District 1-1**

145 Catoosa Circle, P. O. Box 1427  
Ringgold GA 30736-8077  
706-935-2366, Fax: 965-2369

**Charlton County Health Department, District 9-2**

1209 North 3rd Street  
Folkston GA 31537-1303  
912-496-2561, Fax: 496-2623

**Chatham County Health Department, District 9-1**

1395 Eisenhower Drive, P. O. Box 14257 (31416)  
Savannah GA 31406-3905  
912-356-2441, Fax: 644-5220

**Chattahoochee County Health Department, District 7-0**

213 McNaughton Street  
Cusseta GA 31805-3013  
706-989-3663, Fax: 989-1243

**Chattooga County Health Department, District 1-1**

60 Farrar Drive, P. O. Box 203  
Summerville GA 30747-2013  
706-857-3471, Fax: 857-6941



**Cherokee County Health Department, District 1-2**

1219 Univeter Road  
Canton GA 30114-8261  
706-345-7371, Fax: 345-6978

**Clarke County Health Department, District 10-0**

345 North Harris Street  
Athens GA 30601-2411  
706-542-8600, Fax: 542-9754

**Clay County Health Department, District 7-0**

201 ½ Wilson Street  
Fort Gaines GA 39851-3611  
229-768-2355, Fax: 768-3356

**Clayton County Health Department, District 3-3**

1117 Battlecreek Road  
Jonesboro GA 30236  
678-610-7199, Fax: 770-603-4872

**Clinch County Health Department, District 9-2**

405 Sweat Street  
Homerville GA 31634-9745  
912-487-2199, Fax: 487-3407

**Cobb County Health Department, District 3-1**

1650 County Service Pkwy  
Marietta GA 30008-4010  
770-514-2300, Fax: 514-2320

**Coffee County Health Department, District 9-2**

1111 West Baker Highway  
Douglas GA 31533-2107  
912-389-4450, Fax: 389-4326

**Colquitt County Health Department, District 8-2**

214 West Central Street, P. O. Box 639 (31776)  
Moultrie GA 31768-3834  
229-891-7100, Fax: 891-7106

**Columbia County Health Department, District 6-0**

6420 Pollards Pond Road, P. O. Box 99  
Appling GA 30802-0099  
706-541-1318, Fax: 541-0753

**Cook County Health Department, District 8-1**

204 North Parrish Avenue, P. O. Box 463  
Adel GA 31620-2327  
229-896-3030, Fax: 896-4751

**Coweta County Health Department, District 4-0**

137 Jackson Street  
Newnan GA 30263-1572  
770-254-7400, Fax: 254-7411

**Crawford County Health Department, District 5-2**

141 McCrary Street, P. O. Box 305  
Roberta GA 31078-4915  
478-836-3167, Fax: 836-2629

**Crisp County Health Department, District 7-0**

111 24th Avenue East  
Cordele GA 31015-3834  
229-276-2680, Fax: 276-2683

**Dade County Health Department, District 1-1**

71 Case Avenue, Suite H-100, P. O. Box 446  
Trenton GA 30752-2408  
706-657-4213, Fax: 657-7813

**Dawson County Health Department, District 2-0**

54 Highway 53 East, P. O. Box 245  
Dawsonville GA 30534-0005  
706-265-2611, Fax: 265-1636

**Decatur County Health Department, District 8-2**

928 S. West Street, P. O. Box 417 (39818)  
Bainbridge GA 39819-4581  
229-248-3055, Fax: 248-2628

**DeKalb County Health Department, District 3-5**

445 Winn Way, P. O. Box 987 (30031)  
Decatur GA 30030-1707  
404-294-3700, Fax: 294-3715

**Dodge County Health Department, District 5-1**

1121 Plaza Avenue  
Eastman GA 31023-6761  
478-374-5576, Fax: 374-0234

**Dooly County Health Department, District 7-0**

209 West Union Street  
Vienna GA 31092-1094  
229-268-4725, Fax: 268-1567

**Dougherty County Health Department, District 8-2**

1710 South Slappey Boulevard, P.O. Box 3048  
Albany GA 31706-2634  
229-430-6200, Fax: 430-6256

**Douglas County Health Department, District 3-1**

6770 Selman Drive  
Douglasville GA 30134-1756  
770-949-1970, Fax: 942-9469

**Early County Health Department, District 8-2**

618 Flowers Drive  
Blakely GA 39823-2804  
229-723-3707, Fax: 723-8246

**Echols County Health Department, District 8-1**

149 Highway 94 East, P.O. Box 37  
Statenville GA 31648-2018  
229-559- 5103, Fax: 559-7256

**Effingham County Health Department, District 9-1**

802 Highway 119 South, P.O. Box 350  
Springfield GA 31329-3049  
912-754-6484, Fax: 754-7623

**Elbert County Health Department, District 10-0**

618 Jones Street  
Elberton GA 30635-1985  
706-283-3775, Fax: 283-7155

**Emanuel County Health Department, District 6-0**

50 Highway 56 North, P.O. Box 436  
Swainsboro GA 30401-0436  
478-237-7501, Fax: 289-2501

**Evans County Health Department, District 9-2**

4 North Newton Street, P.O. Box 366  
Claxton GA 30417-1756  
912-739-2088, Fax: 739-3975

**Fannin County Health Department, District 1-2**

95 Oudia Street, P.O. Box 387  
Blue Ridge GA 30513-4627  
706-632-3023, Fax: 632-5257

**Fayette County Health Department, District 4-0**

140 Stonewall Avenue West  
Fayetteville GA 30214-1520  
770-461-1178, Fax: 460-1520

**Floyd County Health Department, District 1-1**

315 West 10<sup>th</sup> Street  
Rome GA 30165-2638  
706-295-6123, Fax: 802-5444

**Forsyth County Health Department, District 2-0**

428 Canton Highway, P.O. Box 837  
Cumming GA 30028  
770-781-6900, Fax: 781-0629

**Franklin County Health Department, District 2-0**

6955 GA Highway 145 South, P.O. Box 546  
Carnesville GA 30521  
706-384-5575, Fax: 384-4217

**Fulton County Health Department, District 3-2**

99 Jessie Hill Jr. Dr. S.E.  
Atlanta GA 30303-3030  
404-730-1205, Fax: 730-1294

**Gilmer County Health Department, District 1-2**

28 Southside Church Street  
Ellijay GA 30540-5409  
706-635-4363, Fax: 276-4363

**Glascocock County Health Department, District 6-0**

658 West Main Street, P.O. Box 98  
Gibson GA 30810-0098  
706-598-2061, Fax: 598-2442

**Glynn County Health Department, District 9-1**

2747 Fourth Street  
Brunswick GA 31520-6730  
912-264-3961, Fax: 265-8837

**Gordon County Health Department, District 1-1**

310 North River Street  
Calhoun GA 30703-2157  
706-624-1444, Fax: 624-1450

**Grady County Health Department, District 8-2**

1030 Fourth Street, SE  
Cairo GA 39828-3000  
229-377-2992, Fax: 377-4544

**Greene County Health Department, District 10-0**

1031 Apalachee Road, P.O. Box 867  
Greensboro GA 30642-2710  
706-453-7561, Fax: 453-9120

**Gwinnett County Health Department, District 3-4**

15 South Clayton Street  
Lawrenceville GA 30045-5715  
770-339-4283, Fax: 339-2338

**Habersham County Health Department, District 2-0**

185 Scoggins Drive  
Demorest GA 30535-5355  
706-778-7156, Fax: 776-7694

**Hall County Health Department, District 2-0**

1290 Athens Street  
Gainesville GA 30507-7000  
770-531-5600, Fax: 531-6035

**Hancock County Health Department, District 5-2**

451-A Boland Street, P.O. Box 398  
Sparta GA 31087-1105  
706-444-6616, Fax: 444-5647

**Haralson County Health Department, District 1-1**

133 Buchanan By-Pass, P.O. Box 40  
Buchanan GA 30113-4928  
770-646-5541, Fax: 646-8193

**Harris County Health Department, District 7-0**

210 Foresthill Drive, P.O. Box 265  
Hamilton GA 31811  
706-628-5037, Fax: 628-7196

**Hart County Health Department, District 2-0**

64 Reynolds Street  
Hartwell GA 30643-1315  
706-376-5117, Fax: 376-5011

**Heard County Health Department, District 4-0**

7699 Highway 27, P.O. Box 189  
Franklin GA 30217-6551  
706-675-3456, Fax: 675-6795

**Henry County Health Department, District 4-0**

135 Henry Parkway  
McDonough GA 30253-6636  
770-954-2250, Fax: 954-2269

**Houston County Health Department, District 5-2**

98 Cohen Walker Drive  
Warner Robins GA 31088-2729  
478-218-2000, Fax: 218-2017

**Irwin County Health Department, District 8-1**

407 West Fourth Street, P.O. Box 2  
Ocilla GA 31774-1463  
229-468-5196, Fax: 468-5028

**Jackson County Health Department, District 10-0**

475 Darnell Road  
Jefferson GA 30549-2939  
706-367-5204, Fax: 367-9023

**Jasper County Health Department, District 5-2**

336 East Greene Street  
Monticello GA 31064-1012  
706-468-6850, Fax: 468-1422

**Jeff Davis County Health Department, District 9-2**

30 East Sycamore Street, P.O. Box 603  
Hazelhurst GA 31539-6162  
912-375-2425, Fax: 375-3845

**Jefferson County Health Department, District 6-0**

2501 U.S. Highway 1, P.O. Box 306  
Louisville GA 30434-0306  
478-625-3716, Fax: 625-8201

**Jenkins County Health Department, District 6-0**

709 Virginia Avenue, P.O. Box 627  
Millen GA 30442-0627  
478-982-2811, Fax: 982-1589

**Johnson County Health Department, District 5-1**

120 Hilton Holton Drive, P.O. Box 28  
Wrightsville GA 31096-1938  
478-864-3542, Fax: 864-1777

**Jones County Health Department, District 5-2**

114 Forest Avenue, P.O. Box 145  
Gray GA 31032-5860  
478-986-3164, Fax: 986-3339

**Lamar County Health Department, District 4-0**

118-B Academy Drive  
Barnesville GA 30204-3504  
770-358-1483, Fax: 358-1258

**Lanier County Health Department, District 8-1**

205 West Murrell Street  
Lakeland GA 31635-2103  
229-482-3294, Fax: 482-2006

**Laurens County Health Department, District 5-1**

2121 Bellevue Road  
Dublin GA 31021-2952  
478-272-2051, Fax: 275-6517

**Lee County Health Department, District 8-2**

112 Park Street, P.O. Box 303  
Leesburg GA 31763-0303  
229-759-3014, Fax: 759-3017

**Liberty County Health Department, District 9-1**

1113 East Oglethorpe Highway, P.O. Box 231 (31310)  
Hinesville GA 31313-1200  
912-876-2173, Fax: 368-8033

**Lincoln County Health Department, District 6-0**

176 North Peachtree Street, P.O. Box 65  
Lincolnton GA 30817-0065  
706-359-3154, Fax: 359-1939

**Long County Health Department, District 9-1**

57 North Macon Street, P.O. Box 279  
Ludowici GA 31316-9394  
912-545-2107, Fax: 545-2112

**Lowndes County Health Department, District 8-1**

206 South Patterson Street, P.O. Box 5619 (31603)  
Valdosta GA 31601-5668  
229-333-5255, Fax: 245-2341

**Lumpkin County Health Department, District 2-0**

56 Short Street A  
Dahlonega GA 30533-0543  
706-867-2727, Fax: 867-2739

**Macon County Health Department, District 7-0**

110 Chatham Street, P.O. Box 729  
Oglethorpe GA 31068-9100  
478-472-8121, Fax: 472-2500

**Madison County Health Department, District 10-0**

97 Sunset Drive, P.O. Box 26  
Danielsville GA 30633-5850  
706-795-2131, Fax: 795-2632

**Marion County Health Department, District 7-0**

111-A Baker Street, P.O. Box 404  
Buena Vista GA 31803-0404  
229-649-5664, Fax: 649-2025

**McDuffie County Health Department, District 6-0**

307 Greenway Street, P.O. Box 266  
Thomson GA 30824-0266  
706-595-1740, Fax: 595-8503

**McIntosh County Health Department, District 9-1**

311 Highway 251, P.O. Box 576  
Darien GA 31305-9459  
912-437-4561, Fax: 437-6996

**Meriwether County Health Department, District 4-0**

51 Gay Connector  
Greenville GA 30222-3339  
706-672-4974, Fax: 672-1065



**Miller County Health Department, District 8-2**

250 West Pine Street  
Colquitt GA 39837-3532  
229-758-3344, Fax: 758-3379

**Mitchell County Health Department, District 8-2**

88 West Oakland Avenue, P.O. Box 283  
Camilla GA 31730-1254  
229-336-2055, Fax: 336-1100

**Monroe County Health Department, District 5-2**

106 Culloden Road, P.O. Box 985  
Forsyth GA 31029-1649  
478-992-5083, Fax: 992-5085

**Montgomery County Health Department, District 5-1**

218 West Broad Street, P.O. Box 212  
Mt. Vernon GA 30445  
912-583-4602, Fax: 583-4085

**Morgan County Health Department, District 10-0**

2005 South Main Street, Suite 200  
Madison GA 30650-2055  
706-752-1266, Fax: 752-0286

**Murray County Health Department, District 1-2**

709 Old Dalton-Ellijay Road  
Chatsworth GA 30705-2019  
706-695-4585, Fax: 695-4587

**Muscogee County Health Department, District 7-0**

2100 Comer Avenue, P.O. Box 2299 (31902)  
Columbus GA 31904-8725  
706-321-6300, Fax: 321-6126

**Newton County Health Department, District 3-4**

8203 Hazelbrand Road  
Covington GA 30014-1519  
770-786-9086, Fax: 786-0715

**Oconee County Health Department, District 10-0**

1060 Experiment Station Road, P.O. Box 222  
Watkinsville GA 30677-5323  
706-769-3983, Fax: 769-3913

**Oglethorpe County Health Department, District 10-0**

109 South Boggs Street, P.O. Box 245  
Lexington GA 30648  
706-743-8181, Fax: 743-5811

**Paulding County Health Department, District 1-1**

451 Jimmy Campbell  
Dallas GA 30132-5500  
770-443-7881, Fax: 443-7885

**Peach County Health Department, District 5-2**

406 East Church Street, P.O. Box 1149  
Fort Valley GA 31030-3097  
478-825-6939, Fax: 825-6792

**Pickens County Health Department, District 1-2**

60 Health Way  
Jasper GA 30143-1912  
706-253-2821, Fax: 253-5863

**Pierce County Health Department, District 9-2**

715 Ware Street  
Blackshear GA 31516-1723  
912-449-2032, Fax: 449-0409

**Pike County Health Department, District 4-0**

541 Griffin Street, P.O. Box 342  
Zebulon GA 30295-0342  
770-567-8972, Fax: 567-3531

**Polk County Health Department, District 1-1**

125 East Ware Street  
Cedartown GA 30125-3051  
770-749-2270, Fax: 749-2298

**Pulaski County Health Department, District 5-1**

301 North Lumpkin Street, P.O. Box 480  
Hawkinsville GA 31036-1235  
478-783-1361, Fax: 892-8362

**Putnam County Health Department, District 5-2**

103 North Washington Street, P.O. Box 3776  
Eatonton GA 31024-1142  
706-485-8591, Fax: 485-2018

**Quitman County Health Department, District 7-0**

105 Main Street, P.O. Box 308  
Georgetown GA 39854-0308  
229-334-3697, Fax: 334-4389

**Rabun County Health Department, District 2-0**

19 Jo Dotson Circle  
Clayton GA 30525-5007  
706-212-0289, Fax: 212-0296

**Randolph County Health Department, District 7-0**

410 North Webster Street, Rt. 1 Box 7  
Cuthbert GA 39840-1245  
229-732-2414, Fax: 732-5007

**Richmond County Health Department, District 6-0**

950 Laney Walker Boulevard  
Augusta GA 30901-2960  
706-721-5800, Fax: 721-5903

**Rockdale County Health Department, District 3-4**

1329 Portman Road, Suite D  
Conyers GA 30094-6619  
770-785-5936, Fax: 785-6876

**Schley County Health Department, District 7-0**

45 West Oglethorpe Street, P.O. Box 346  
Ellaville GA 31806-0346  
229-937-2208, Fax: 937-5086

**Screven County Health Department, District 6-0**

416 Pine Street  
Sylvania GA 30467-2036  
912-564-2190, Fax: 564-7887

**Seminole County Health Department, District 8-2**

904 North Wiley Avenue  
Donalsonville GA 39845-1127  
229-524-2577, Fax: 524-8986

**Spalding County Health Department, District 4-0**

1007 Memorial Drive, P.O. Box 129  
Griffin GA 30224-4445  
770-467-4740, Fax: 229-3169

**Stephens County Health Department, District 2-0**

222 North Boulevard  
Toccoa GA 30577-1906  
706-282-4507, Fax: 282-4511

**Stewart County Health Department, District 7-0**

Highway 27 South, P.O. Box 307  
Lumpkin GA 31815-0307  
229-838-4859, Fax: 838-6053

**Sumter County Health Department, District 7-0**

208 Rucker Street, P.O. Box 806 (31709)  
Americus GA 31719-2216  
229-924-3637, Fax: 928-9863

**Talbot County Health Department, District 7-0**

1073 Woodland Highway, P.O. Box 247  
Talbotton GA 31827-0247  
706-665-8561, Fax: 665-3979

**Taliaferro County Health Department, District 6-0**

109 Commerce Street, P.O. Box 184  
Crawfordville GA 30631-0184  
706-456-2316, Fax: 456-2334

**Tattnall County Health Department, District 9-2**

200-B South Main Street, P.O. Box 426  
Reidsville GA 30453-4602  
912-557-7850, Fax: 557-7854

**Taylor County Health Department, District 7-0**

Highway 137 West, P.O. Box 459  
Butler GA 31006-0459  
478-862-5628, Fax: 862-3177

**Telfair County Health Department, District 5-1**

713 Telfair Avenue, P.O. Box 328  
McRae GA 31055-2163  
229-868-7404, Fax: 868-7245

**Terrell County Health Department, District 8-2**

969 Forester Drive, SE  
Dawson GA 39842-2106  
229-995-8435, Fax: 995-2074

**Thomas County Health Department, District 8-2**

440 Smith Avenue, P.O. Box 148 (31799)  
Thomasville GA 31792-5535  
229-226-4241, Fax: 226-5144

**Tift County Health Department, District 8-1**

305 East 12th Street, P.O. Box J (31793)  
Tifton GA 31794-4011  
229-386-8373, Fax: 386-5075

**Toombs County Health Department, District 9-2**

714 North West Broad Street, P.O. Box 308  
Lyons GA 30436-0308  
912-526-8108, Fax: 526-6504

**Towns County Health Department, District 2-0**

1104 Jack Dayton Circle  
Young Harris GA 30582-2334  
706-896-2265, Fax: 896-1816

**Treutlen County Health Department, District 5-1**

619 Third Street, P.O. Box 585  
Soperton GA 30457-1160  
912-529-4217, Fax: 529-4393

**Troup County Health Department, District 4-0**

107 Medical Drive  
LaGrange GA 30240-4137  
706-845-4085, Fax: 845-4089

**Turner County Health Department, District 8-1**

745 Hudson Avenue, P.O. Box 614  
Ashburn GA 31714-5312  
229-567-4357, Fax: 567-3947

**Twiggs County Health Department, District 5-2**

105 North Ash Street, P.O. Box 293  
Jefferson GA 31044-0293  
478-945-3351, Fax: 945-6693

**Union County Health Department, District 2-0**

55 Hughes Street, Suite A  
Blairsville GA 30512-3551  
706-745-6292, Fax: 745-6803

**Upson County Health Department, District 4-0**

314 East Lee Street  
Thomaston GA 30286-4122  
706-647-7149, Fax: 647-3372

**Walker County Health Department, District 1-1**

603 East Villanow Street, P.O. Box 609  
LaFayette GA 30728-2618  
706-638-5577, Fax: 638- 5543

**Walton County Health Department, District 10-0**

1404 South Madison Avenue  
Monroe GA 30655-2816  
770-207-4125, Fax: 207-4129

**Ware County Health Department, District 9-2**

604 Riverside Drive  
Waycross 31501-5323  
912-283-1875, Fax: 283-0894

**Warren County Health Department, District 6-0**

510 Legion Drive, P.O. Box 322  
Warrenton GA 30828-0322  
706-465-2252, Fax: 465-1410

**Washington County Health Department, District 5-2**

201 Morningside Drive  
Sandersville GA 31082-2426  
478-552-3210, Fax: 553-1832

**Wayne County Health Department, District 9-2**

240 Peachtree Street, P.O. Box 100 (31598)  
Jesup GA 31545-0212  
912-427-2042, Fax: 427-5880

**Webster County Health Department, District 7-0**

6814 Washington Street, P.O. Box 12  
Preston GA 31824-4032  
229-828-3225, Fax: 828-2208

**Wheeler County Health Department, District 5-1**

414 Kent Street, P.O. Box 669  
Alamo GA 30411-0669  
912-568-7161, Fax: 568-7770

**White County Health Department, District 2-0**

1241 Helen Highway, Unit 210  
Cleveland GA 30528-6938  
706-865-2191, Fax: 865-7745

**Whitfield County Health Department, District 1-2**

808 Professional Boulevard  
Dalton GA 30720-2536  
706-281-2320, Fax: 281-2325

**Wilcox County Health Department, District 5-1**

1001 Second Avenue, P.O. Box 235  
Rochelle GA 31079-2149  
229-365-2310, Fax: 365-7825

**Wilkes County Health Department, District 6-0**

204 Gordon Street  
Washington GA 30673-1602  
706-678-2622, Fax: 678-3115

**Wilkinson County Health Department, District 5-2**

123 High Hill Street  
Irwinton GA 31042-2611  
478-946-2226, Fax: 946-2180

**Worth County Health Department, District 8-2**

1012 West Franklin Street, P.O. Box 785  
Sylvester GA 31791-1900  
229-777-2150, Fax: 777-2170