HIV/STD THISIS End User Guide

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A note to users

In this manual, **bold** is used to signify vocabulary terms or field and features in the system. *Italics* is used to emphasize important points of instruction.

Chapter 1 Electronic Laboratory Reporting (ELR)

Learning Objectives:

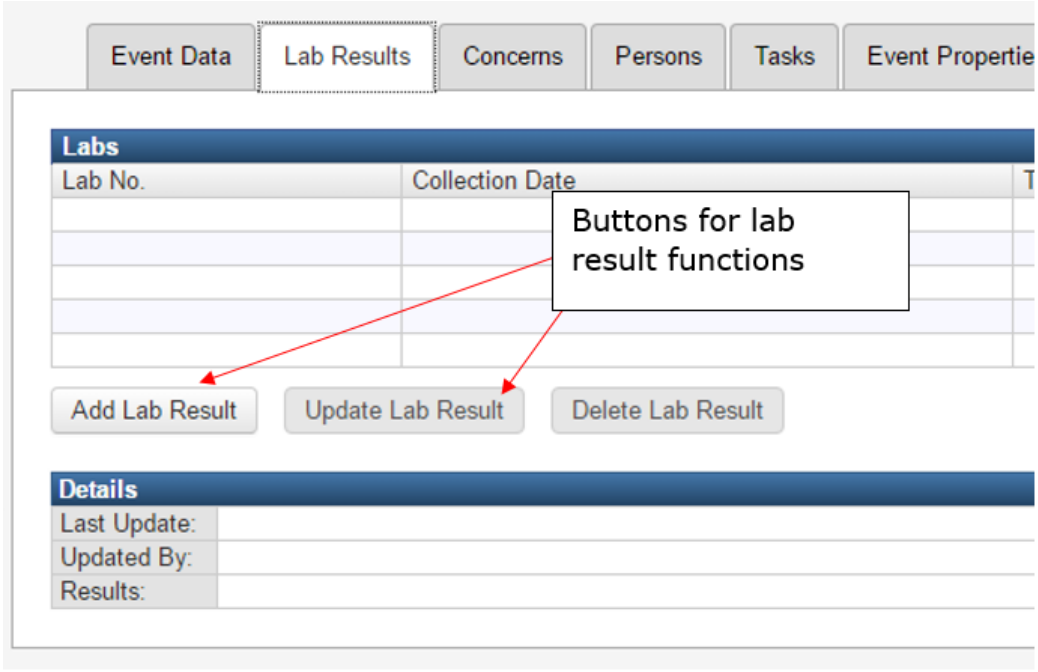
- Be able to identify the laboratory fields.
- Be able to create a laboratory report.
- Be able to update a laboratory report.

1.1 Overview of Laboratory Management

The Lab Results tab allows you to view, add, update, and delete lab reports. Some of these options may not be available depending on your **rights** or **permissions**. The Labs section on the Lab Result tab displays all lab reports for an event, and can be sorted by collection date, test, result, and ordering facility. If you highlight on an individual lab report, all the information entered on the report is displayed in the Details section.

1.2 Updating and Creating a Lab Report

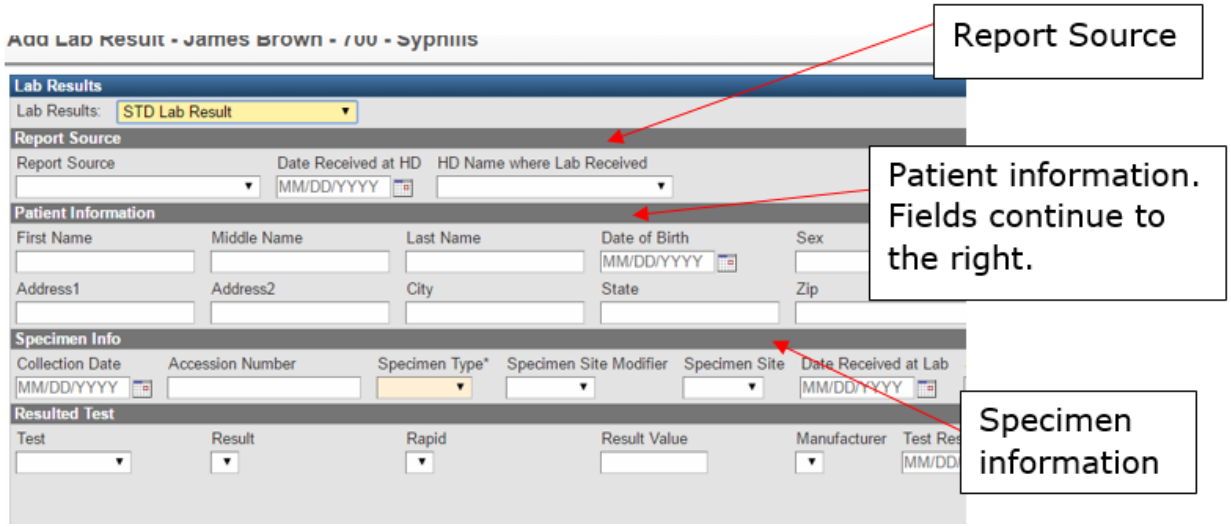
To update a lab report, highlight the correct lab report in the Lab Summary Screen, and select Update Lab Result. Update the information in the lab report following the data entry instruction below and select Save.
To add a new lab report, navigate to the Lab Results tab in the correct event and select Add Lab Result. Select HIV Lab Result for a HIV event, STD Lab Result for a Chlamydia, Gonorrhea, or Syphilis event, and TB Lab Result for a TB event. Note that the options offered for an entry are specific to the type of event. For example, HIV labs will only be the only options available if you are in an HIV event. The same person could have a syphilis event and HIV lab results would not appear as an option to the Add Lab Result function in the syphilis event.



1.2.1 This section provides information on how and when the laboratory report was received at the local, regional, or state public health department (HD). The entry method of the lab report automatically populates as either Manual or Electronic based on how the lab report was created.

1. **Report Source** – The type of report, laboratory or medical record, the laboratory test result has reported. Select laboratory report if the test result was received directly from a laboratory. Select medical record/provider report if the lab test result was abstracted from a medical record or the provider reported the laboratory test result to the health department.

2. **HD Name** – The name of the local, regional, or state health department that first received the laboratory report.
3. **Date Received at HD** – The date the laboratory report was first received at the health department.



1.2.2 Patient Information

The patient information section is used to enter patient's demographic information as well as locating information. For HIV events, all information should be entered as it appears on a lab report. This is not necessary for other STD lab reports.

1.2.3 Specimen Information

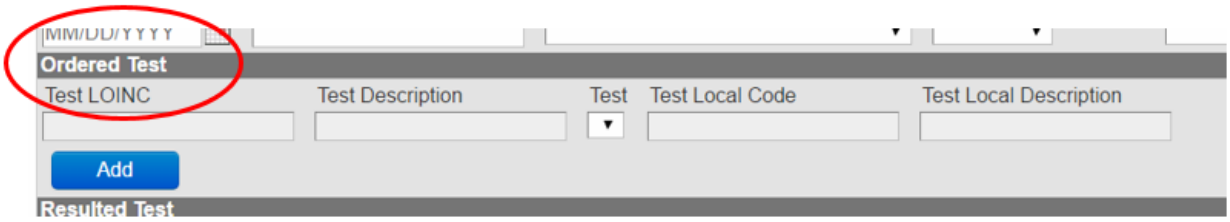
The Specimen Information section displays information regarding the collection date, accession number, specimen type, specimen site modifier (if applicable), specimen site, date received at lab, specimen type (raw), and specimen site (raw).

1. Collection date – The month, day, and year that the medical specimen was obtained from the patient.
2. Accession number – The unique identifier assigned to a medical specimen. The Accession Number may not always be available.
3. Specimen type – The type of specimen obtained from the patient's body (i.e., saliva, blood, urine).
4. Specimen site modifier – The modifier associated with the specimen (i.e., right, left).
5. Specimen site – The physical anatomic site on the patient's body where the specimen was obtained (i.e., throat, rectum, vagina).

The collection date, accession number, specimen site, and date received at the lab are entered the same way for each disease, from the picklist or entered (dates), from information located on the lab. Specimen type picklist options differ for each disease. The specimen type (raw) and specimen site (raw) fields will be populated through ELR.

1.2.4 Ordered Test

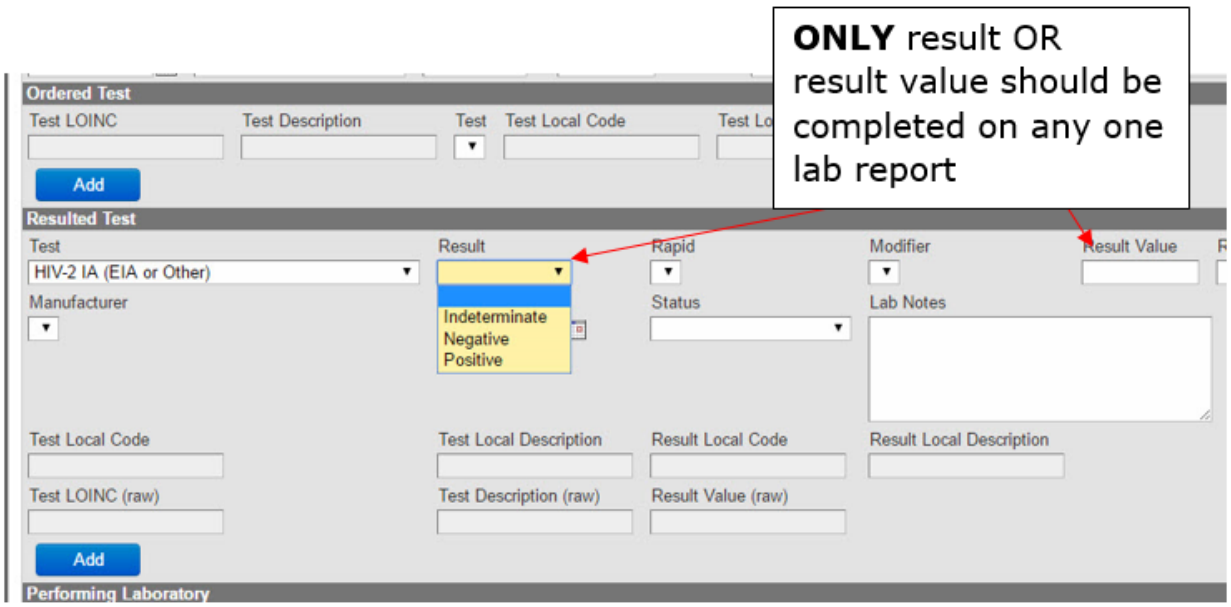
The Ordered Test section of the Lab Report is only visible on a HIV event. The ordered test information comes in via ELR (electronic lab reporting), and does not need to be manually entered.



1.2.5 Resulted Test

The test name should be selected from the pick list in the Test field. If the test is not available in the pick list, contact the ELR team at Central Office.
There are two result fields available in THISIS, Result and Result Value, and *only one of the two fields should be completed on a single laboratory report.*

1. Result – The result (positive, negative, etc.) for qualitative tests should be selected from the picklist. The valid result options will display for qualitative tests based on the name of the resulted test.
    a. Rapid – The picklist is only available for tests that can be performed outside of a laboratory setting (point of care tests). Select yes only if the test was performed in the provider's office or another setting outside of the laboratory.
2. Result Value – The result for quantitative tests (i.e., CD4 tests, VL tests, RPR titers). There are two additional fields that should be completed when applicable for quantitative tests.
    a. Modifier – The modifier or interpretation (i.e., =, <, >) must be selected from the pick list for HIV Viral Load tests.
    b. Result Units – The units (i.e., %, CNT) units of the result.

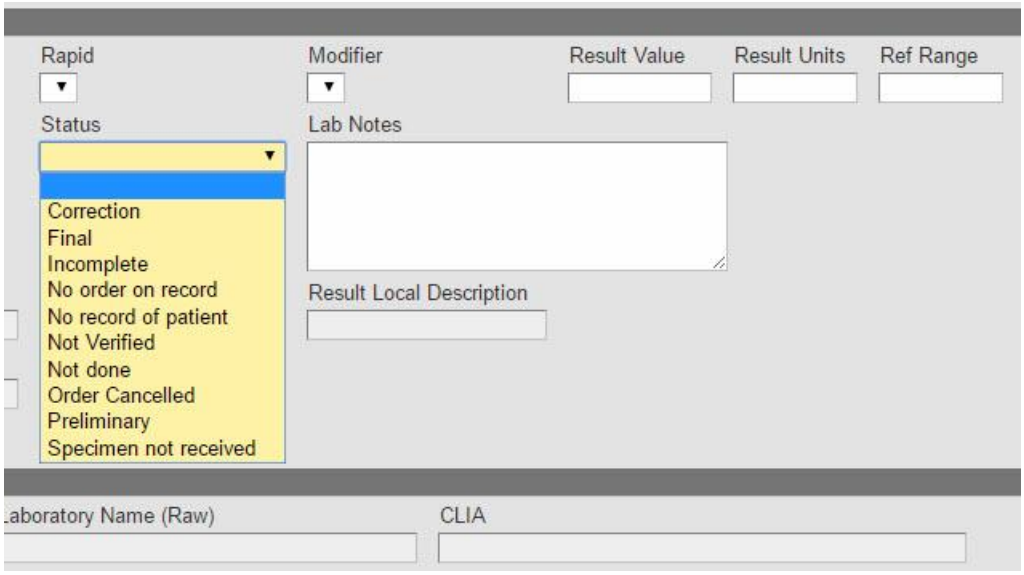


The rest of the fields in the resulted test section should be entered for all tests if the information is included on the laboratory report.

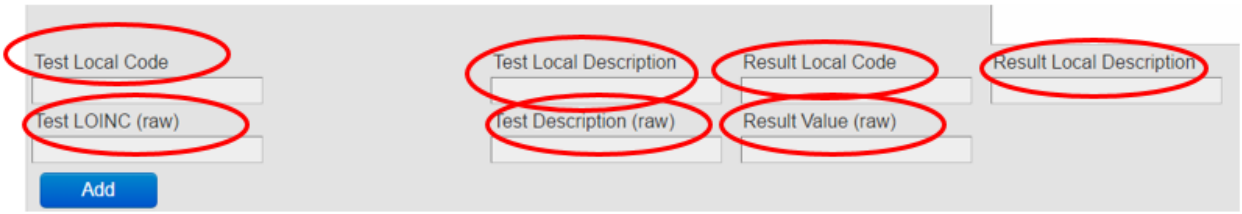
1. Ref Range – The reference range of the test should be entered for both qualitative and quantitative tests if it is known. For a qualitative test, it is generally negative. A laboratory report for a quantitative test, such as the HIV-1 Viral Load test, often specifies the range that the test can accurately measure (20-10,000,000 copies/ml). Complete the Test Result Date (the date the test resulted in the laboratory) if it is available.

2. Status – The status field is used by laboratories to signify the status of the lab report. You will most often see final (F), but will occasionally see corrected (C), or other status options. The lab report may contain only the single code. *This field is often not filled on manually entered lab reports.*

   C – Correction
   F – Final
   I – Incomplete
   Y – No order on record
   Z – No record on patient
   R – Not verified
   S – Not done
   X – Order canceled
   P – Preliminary
   O – Specimen not received



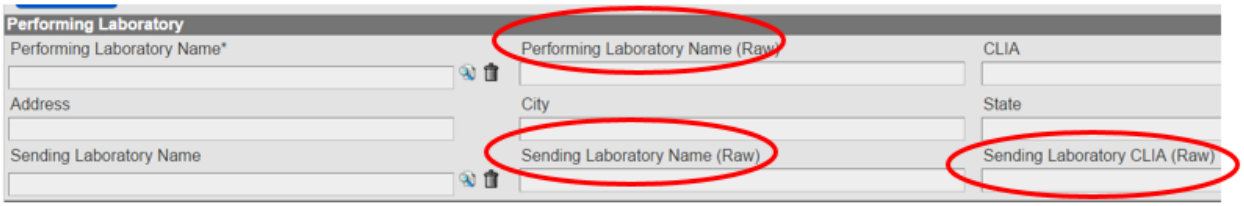
The fields Test Local Code, Test Local Description, Result Local Code, Result Local Description, Test LOINC (raw), Test Description (raw), and Result Value (raw) cannot be entered manually. These are raw fields imported via ELR and may be useful as a reference when updating a lab report.



You have the ability to add multiple resulted tests on the same lab report. Multiple resulted tests should only be entered on the same lab report if all tests are for the same event and collection date, specimen type, ordering facility, performing laboratory, and sending laboratory are the same. Select Add under the Resulted Test section and complete the test information to add multiple tests. Performing and Sending Laboratory

1.2.6 Performing and Sending Laboratory

The Performing and Sending Laboratory section displays information regarding the lab where the specimen was evaluated and the laboratory reporting the test result(s). The Performing Laboratory Name and Sending Laboratory fields are entered by clicking the magnifying glass and searching for the Lab. The address fields are populated after the lab name is found and selected.
Sending Laboratory – The laboratory that reported the test result to the health department.
Performing Laboratory – The laboratory where the specimen was received and evaluated.
Additionally, there are three raw fields that cannot be entered manually, which are populated through ELR, Performing Laboratory Name (Raw), Sending Laboratory Name (Raw), and Sending Laboratory CLIA (Raw).

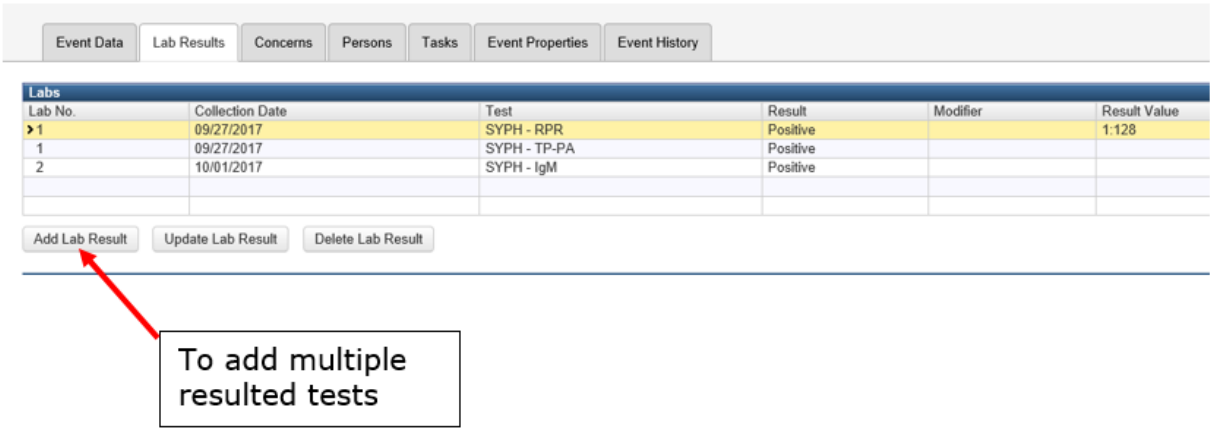


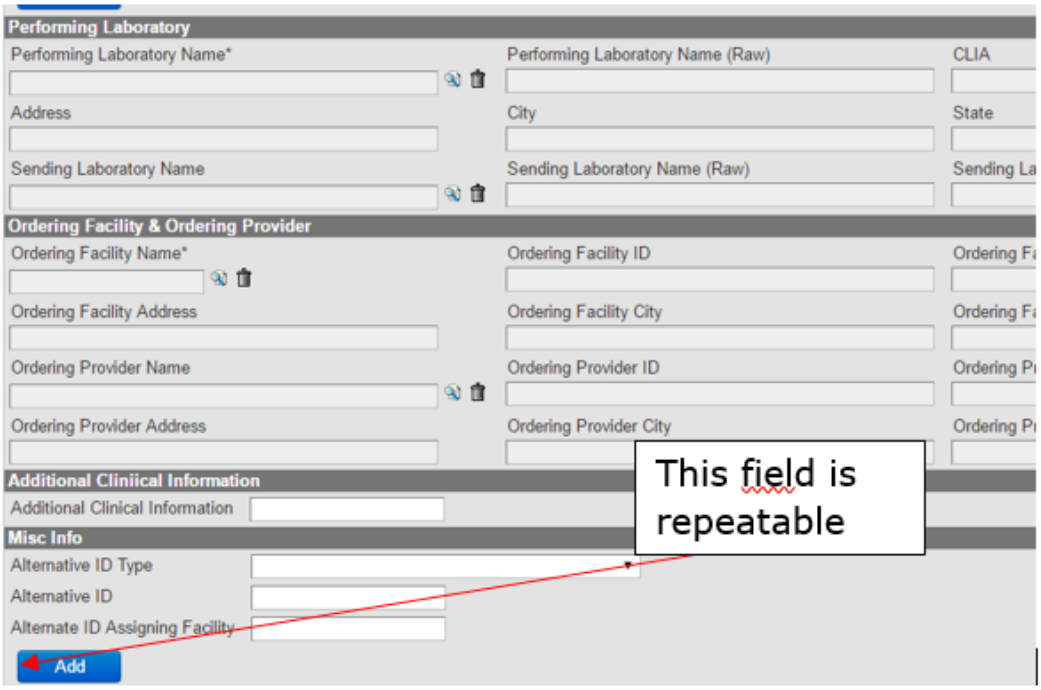
1.2.7 Ordering Facility and Provider

This section is used to enter information for the ordering facility and provider (Search option is used to select both the facility and the provider). See Appendix A in the core manual for more information on advanced searches.

1.2.8 Additional Identifiers, Next of Kin and Comments

The Alternate ID fields are repeatable, so all identifiers on the lab report should be entered. The Alternate ID Assigning Facility is the healthcare facility that assigned the medical record number or other facility identifier. This field should be left blank if the identifier is not assigned by the healthcare facility.
Additional Clinical Information includes pregnancy status or any other clinical information included on the lab report.
Next of Kin should only be completed if next of kin information is found on the lab report. Enter all information on the next of kin found on the lab report, including name, address, phone, and other contact information.
The comments section is an open field where the user may enter any information related to understanding that laboratory report.

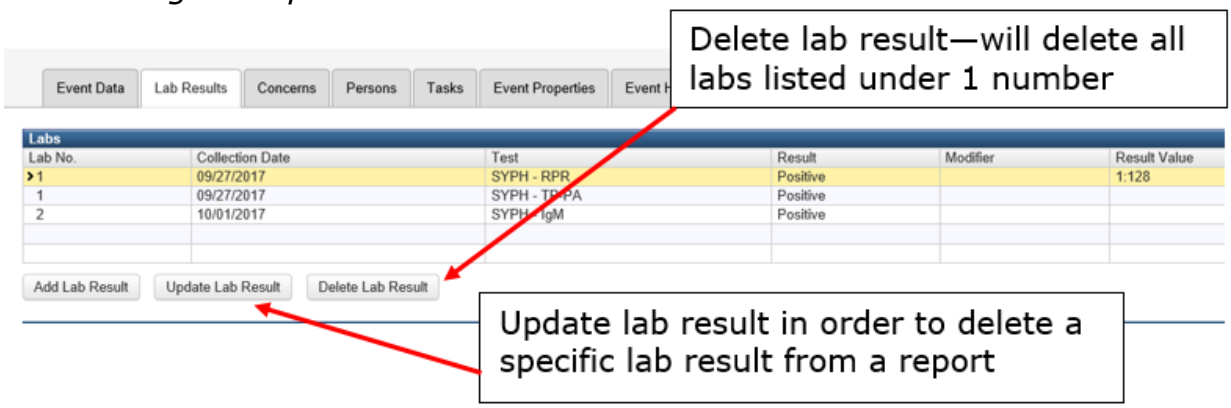




1.3 Deleting a Lab Report

To delete a lab report, open the Lab Results tab within the event summary screen. Locate the "Labs" section; highlight the lab report that you wish to delete. Once you have verified that the correct lab report is highlighted, click the "Delete Lab Result" button located at the bottom of the "Labs" section. You will receive a pop-up warning that states, *"This action will delete ALL results for the selected specimen. Do you want to proceed?"* Once you are certain that it is safe to delete all results from the selected specimen, select the "OK" button to delete all results from the selected specimen.

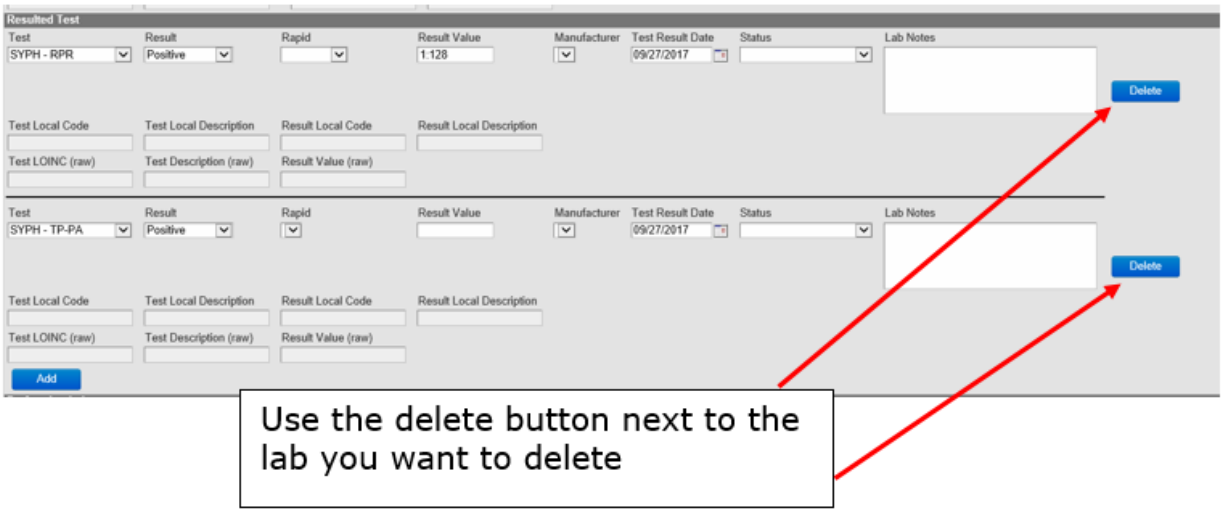
NOTE – Deleting a lab result from the Lab Results tab is permanent, and cannot be reversed. Please verify that it is absolutely necessary to delete this lab prior to selecting this option.



1.3.1 Deleting an Individual Lab Result

The instructions above will delete all lab results for a single laboratory report. If you need to delete just one lab result from a lab report, you will need to go into the laboratory report. Open the Lab Results tab within the event summary screen. Locate the "Labs" section; highlight the lab report that you wish to alter. Select "Update Lab result". Once you are in the lab report, you may delete an

individual result.



Chapter 2 Question Packages

Learning Objectives

- Identify basic steps in Case Assignment for STD/HIV activities
- Enter Surveillance activities
- Identify basic steps in Public Health Follow-up

2.1 Question Packages Overview

Question packages are sets of information entered into THISIS. The Question Packages are organized around tasks related to disease diagnosis, treatment and public health management. For various diseases, this might include laboratory reports and follow-up testing, medication administration, patient follow-up, and investigation of potential contacts.

2.2 Reporting/Morbidity

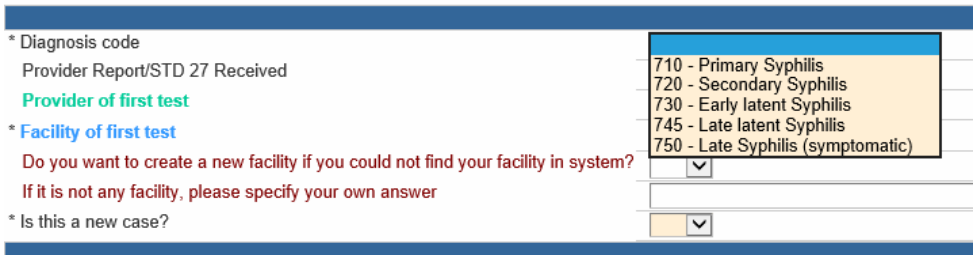
The reporting/morbidity question package is event-specific and serves as the mechanism for recording morbidity for all STDs, like Chancroid, Chlamydia, Gonorrhea, and Syphilis.

This question package is not available for HIV reporting, as it will be in the AIDS Case Report Form (ACRF) event, only available to HIV Surveillance staff. From this question package, diseases will be reported to the Centers for Disease

Control and Prevention (CDC). All Chlamydia and Gonorrhea morbidities will be auto-generated for both electronic lab imports and manually entered labs and provider reports. Required fields within this question package must be filled out prior to the report being submitted to CDC. Workflows identifying missing values have been developed to assist the user in completing this information.

2.2.1 Reporting Information

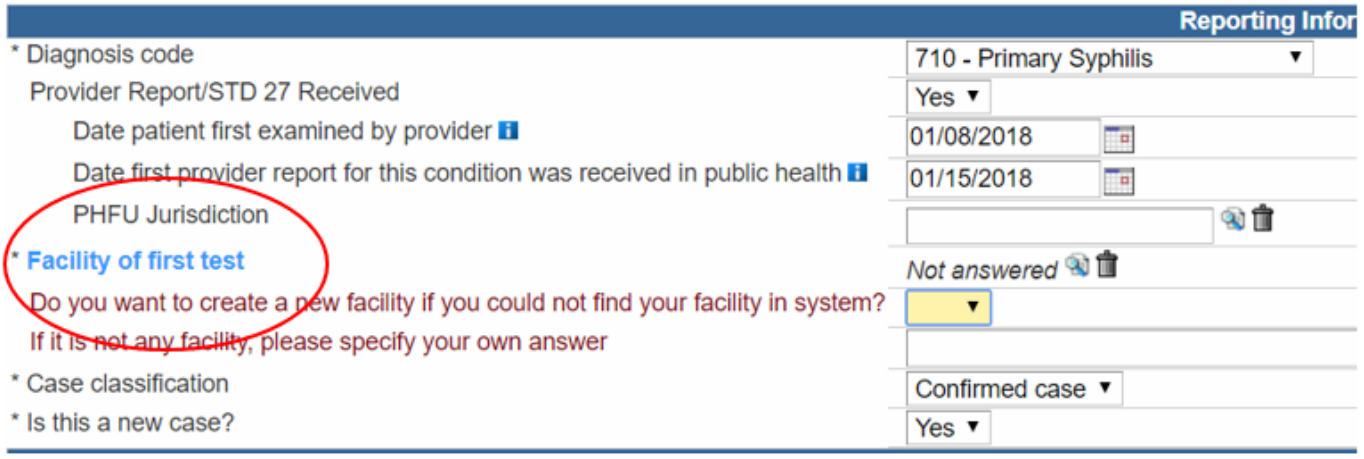
a. **Diagnosis code**: the user will enter the diagnosis code appropriate for the stage of disease, specifically for syphilis.



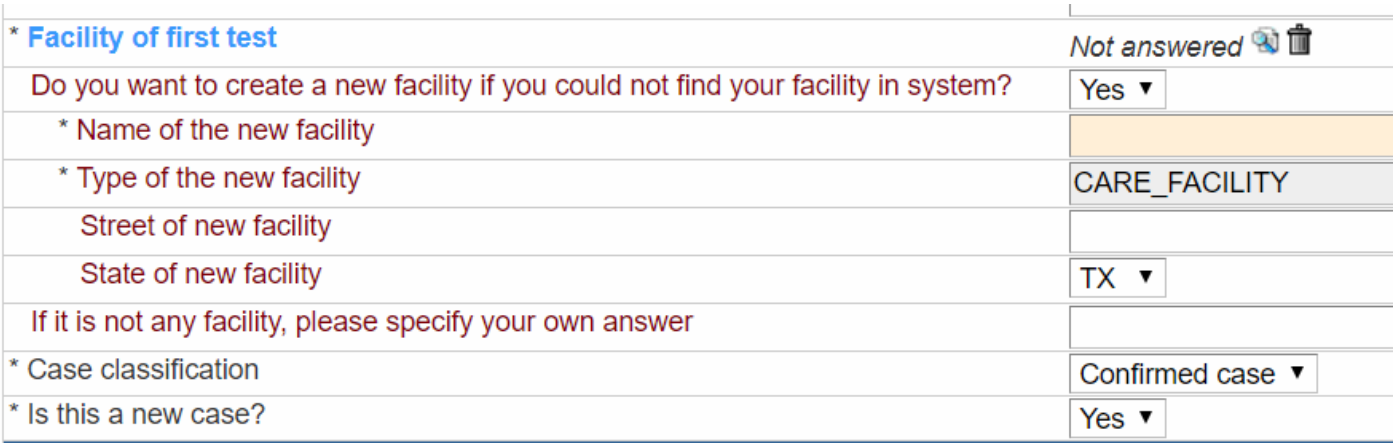
If the user selects a diagnosis code, but the event does not meet the diagnosis code requirements (e.g. – symptoms for a primary syphilis case), concerns in the event notification section will be generated.

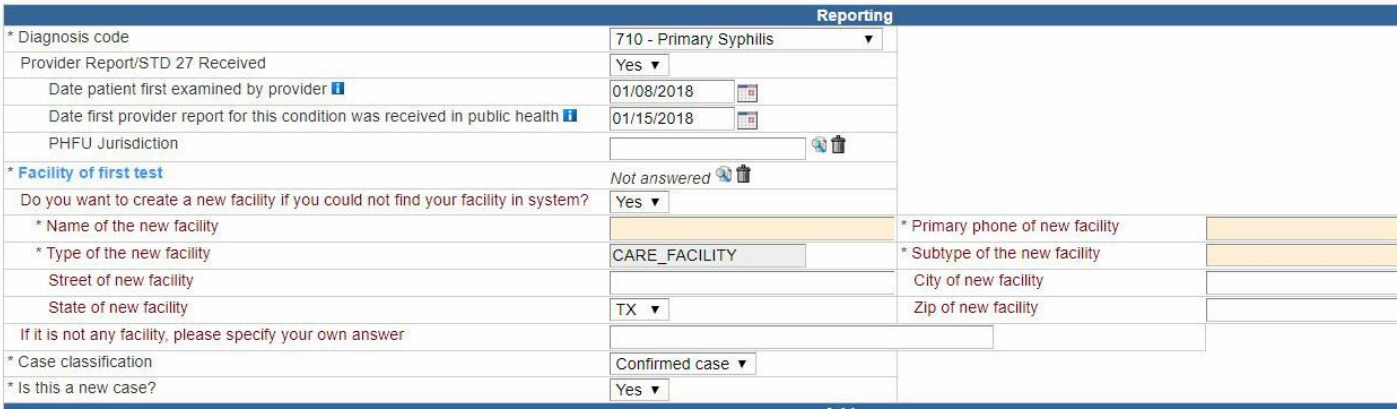
b. **STD-27 Received**: User will enter whether or not the STD surveillance site received a report from the provider. If the user selects yes, the user will be asked to fill out the date the patient was first examined by the provider and when it was first reported to the health department. Date of first report is autopopulated.

c. **Facility of first test****: User will have to select the facility at first test.

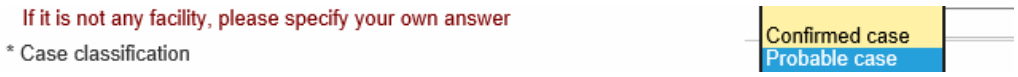


**If the user does not find the facility that they need to enter, there is an opportunity to add a facility for review. Adding a facility here will *not* make the added facility available in the search page.





d. **Case classification**: Case classification options are



a. **Confirmed**: presence of disease which meets clinical description and is verified with laboratory results. For example, with syphilis, a positive direct identification test results (e.g. – darkfield, PCR, IHC, etc.).

b. **Probable**: presence of disease that meets clinical description and diagnosis is supported by non-direct identification test results.

For more information on case classifications, please visit: https://www.cdc.gov/std/stats15/appendixc.htm

e. **Is this a new case?** User will select whether or not this is a new case. Selecting "Yes" will trigger additional reporting and morbidity questions.

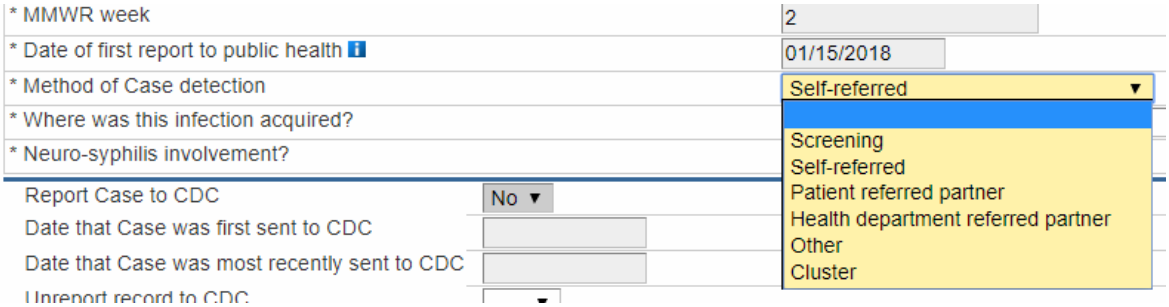
I. Address at Infection

a. **Case address source**: Case address source is the address which is affiliated with this morbidity. This field will auto-populate for Chlamydia and Gonorrhea events. If the patient has a known address, the patient address will be entered. If there is no known patient address, the system will default to the provider/facility or laboratory address.

b. Select Address at the Time of Report: The user will click in "Select Address at the Time of Report" which will generate a list of all of the known addresses affiliated with the person. Once the user selects an address to use, all of the address fields will populate in the Reporting/Morbidity question package. If there are changes that need to be made to the address, the user will have to go to the party to make the needed changes.

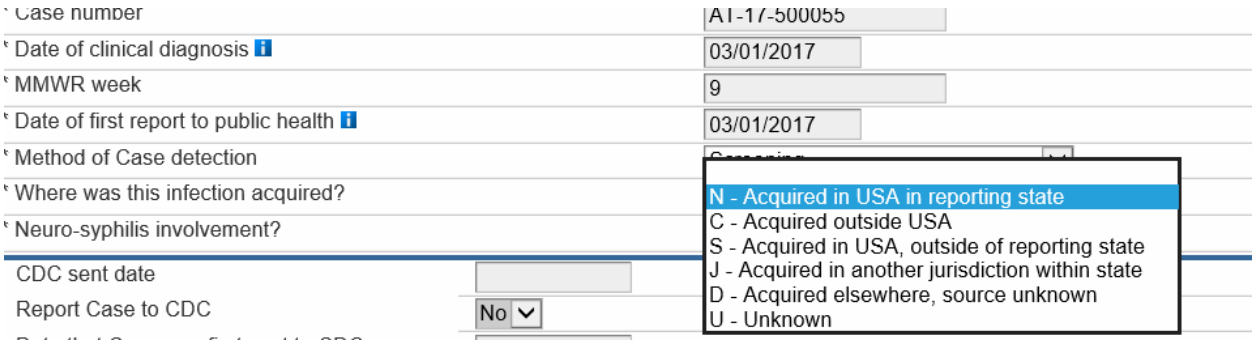
II. Morbidity Information

a. **Reporting jurisdiction:** If there is a city associated with the patient's address above, the jurisdiction will be automatically selected. This remains an editable field.
b. **Case number:** This is a system generated field that is created by the first two letters of the reporting jurisdiction, year of diagnosis, and case number. This will be generated upon save or save and stay, as long as a jurisdiction is populated. (non-editable)
c. **Date of Clinical Diagnosis:** This field will auto-populate with either the first date of specimen collection or first exam date, whichever is earliest. (non-editable)
d. **MMWR week/MMWR year:** This field is auto-populated once the date of clinical diagnosis is identified. (non-editable)
e. **Date of first report to public health:** This field will auto-populate with the either the date of laboratory report or the date of provider report, whichever is earliest. (non-editable)
f. **Method of Case detection:** User will select which process identified this case of infection.



a. Screening – most often used which refers to a test which was part of a screening
b. Self-referred – patient is self-referred to clinical services and testing due to presentation of symptoms or other reasons.
c. Patient referred partner – patient is referred in by an infected partner
d. Health department referred partner – patient is referred in as a result of partner services and notification
e. Other – Other will also include all additional options within this list as they are not reported to CDC
f. Cluster related – patient is identified as a Social Contact (Suspect) or Associate of the original patient. Cluster was brought to the attention of the program as a result of a DIS interview.

g. Where was this infection acquired? This field is a required field for reporting. This field will be auto-populated for all Chlamydia and Gonorrhea cases. This question is trying to identify where the person acquired their infection.



III. Disease-Specific Morbidity/Reporting Questions

The questions within this section are special questions that will be available for specific events.

a. Chlamydia

i. Pelvic inflammatory disease (PID) present? (available only for persons who are indicated as female at birth) Usually received through provider report, user will document if PID is indicated. This field will default to unknown.
ii. Conjunctivitis: Usually received through a provider report, the user will document whether or not conjunctivitis is indicated. This field will default to unknown.

b. Gonorrhea
iii. Pelvic inflammatory disease present? (available only for persons who are indicated as female at birth) Usually received through provider report, user will document if PID is indicated. This field will default to unknown.
i. Disseminated: Usually received through provider report, user will document if disseminated gonorrhea is indicated. If disseminated gonorrhea is documented, treatment adequacy (in the clinical question package) will require more intensive treatment.
ii. Conjunctivitis: Usually received through a provider report, the user will document if conjunctivitis is indicated. This field will default to unknown.
iii. GC drug resistance: The user will document which drug regimen this infection is resistant to. The choices for this section are: Azithromycin (Azithromax, Zithromax), Betalactamase, Cefixime, Ceftriaxone (Rocephin), Ciprofloxacin, Penicillin, Spectinomycin (Trobicin), or Tetracycline

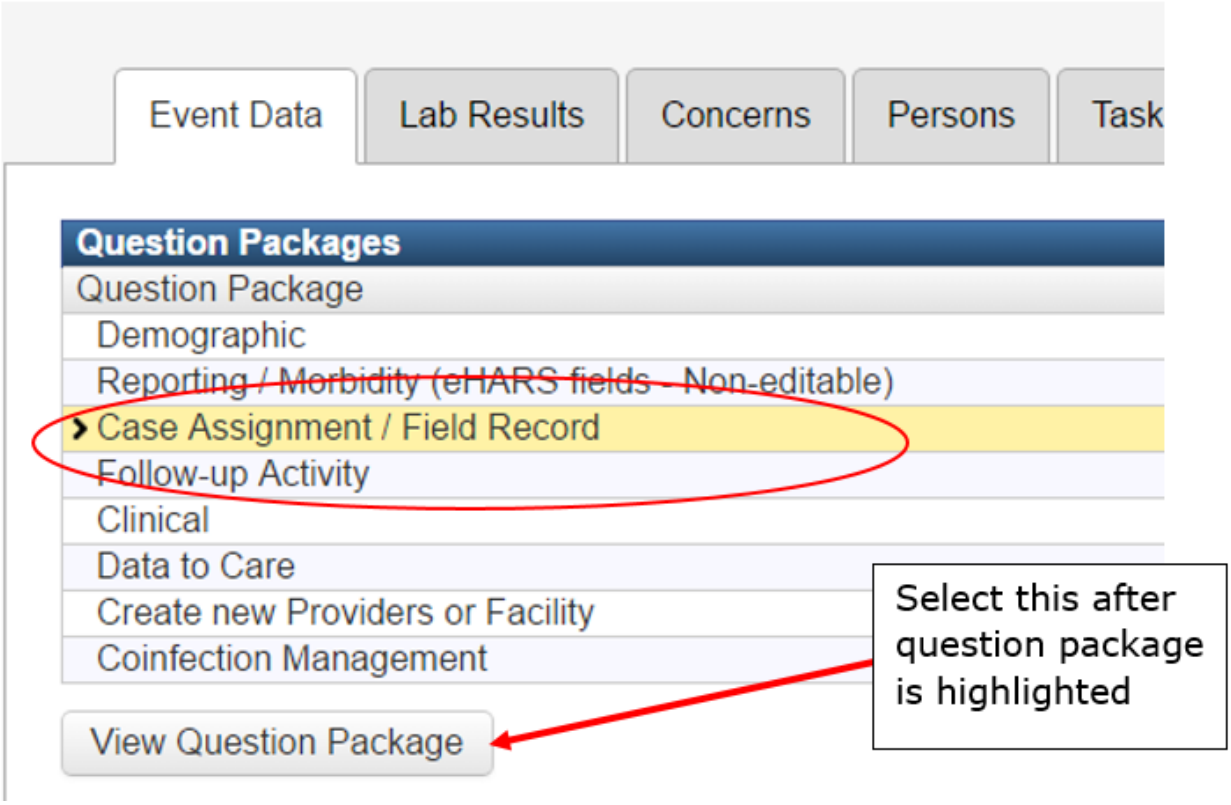
c. Syphilis
i. Neuro-syphilis involvement: If there is indication of neuro-syphilis involvement, the user will document if this is a confirmed case (reactive CSF-VDRL, with or without symptoms documented) or a suspected case (documented neurological manifestations with a required clinical question package)

Once the required fields for reporting are completed, the last section of this question package will auto-populate once the case has been successfully reported to the CDC. Users will be able to update the values in this question package and updates will be sent to the CDC. Only specific Central Office staff will have the rights to “unreport” a case.

2.3 Case Assignment/Field Record

The case assignment question package (QP) captures information about case-specific follow-up work assigned to THISIS users. The assignment of all case activities, including field records and interview records, will be done in the Case Assignment\Field Record QP. In this QP, users will have the ability to make different types of assignments, assign a jurisdiction and\or specific user to the task, and close the task with the appropriate outcome when the work is complete. The case assignment QP is divided into two sections: Initial Assignment and Case Assignment/Field Record Information.

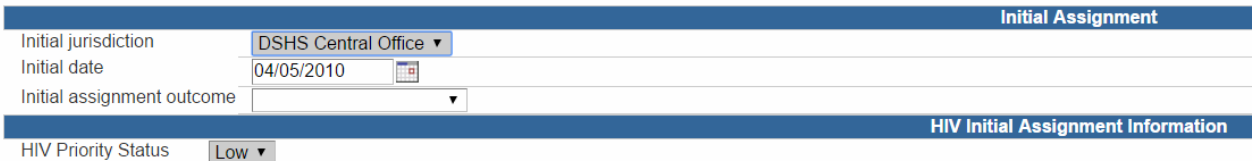
2.3.1 Completing the Initial Assignment Section



Initial Jurisdiction and Initial Date

When an event record is created for a new report of a disease (e.g., a new Syphilis test result) this section should auto-populate with the initial assigned jurisdiction and the initial assignment date. This assignment will go to the role responsible for evaluating event information and following up with the provider to determine what type of additional follow-up activities are needed for this case (e.g., Field Investigation).

1. Electronic lab reports for syphilis and HIV will automatically be assigned to a jurisdiction based on the patient's address on the first positive laboratory report. If the patient's address is not complete, the jurisdiction will assign based on the ordering facility/provider address. The initial date assigned for ELRs will be the date the laboratory result is entered into THISIS. Gonorrhea and Chlamydia labs will not be assigned for follow-up unless it is a priority case (e.g., a pregnant woman, patient under the age of 10, rectal or pharyngeal gonorrhea in a male, or co-infection with HIV). Local priorities may also identify others for follow-up (e.g., females of child bearing age, adolescent females, persons diagnosed with pelvic inflammatory disease, etc.)

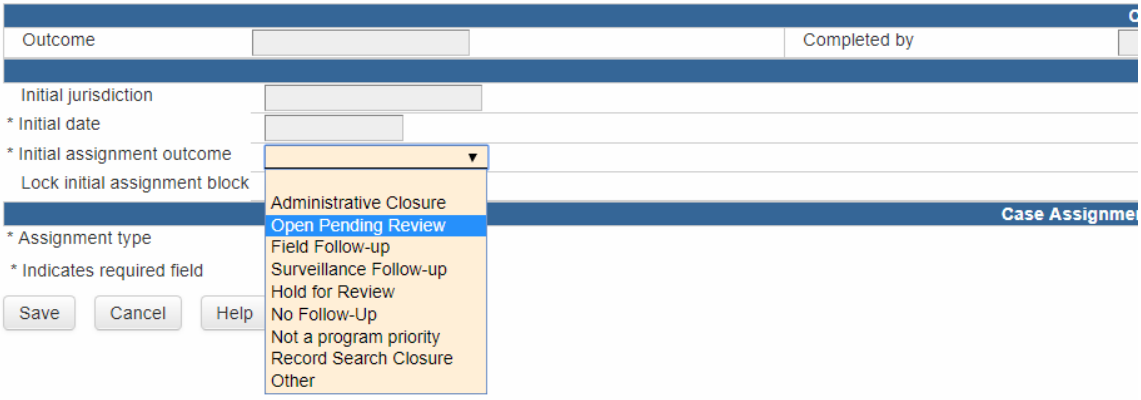


Initial Assignment Outcome

Once the case has been initially reviewed and/or the provider has been contacted to determine what type of follow-up (if any) is needed, the user responsible for reviewing the initial assignments will close out the section by completing the Initial Assignment Outcome and any associated follow-up questions. The Initial Assignment section will become read-only once it has been saved.

2.3.2 STD (non-HIV) Initial Assignment Outcomes

When closing an STD (non-HIV) assignment the user should select the most appropriate initial assignment outcome. Selecting this outcome will close the initial assignment.



Administrative closure – Select this option to immediately close the current investigation due to local policies and/or procedures that indicate follow-up is not needed for this particular situation. If this option is selected, the user will be required to select a justification.

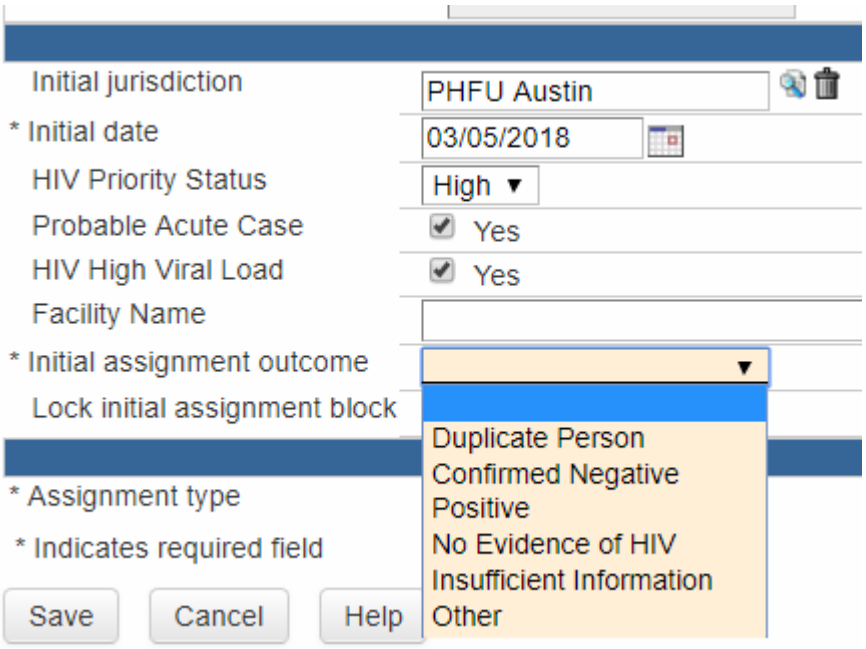
Options for justification for administrative closure include:

- Does not meet reactor grid
- Not a program priority
- Other

1. **BFP No Follow-Up -** Biological False Positive Select this option to close the current investigation due to test results indicating that this patient had a false positive result.
2. **Field Follow-up** – Select this option to initiate follow-up through field services activities.
3. **Insufficient Information** – Select this option to immediately close the current investigation due to a lack of adequate demographic information to conduct a follow-up investigation. For example, a result from a clinical trial with all information deidentified.
4. **Not a Program Priority** – Select this option for Gonorrhea and Chlamydia events which are identified as lower priority due to program workload or capacity.
5. **Record search closure**– Select this option to immediately close the current investigation due to a previous history of this disease, indicating the current report is not considered a new infection and does not need treatment/counseling or additional follow-up.
6. **Surveillance Follow-up** – Select this option to initiate follow-up through contacting the provider. Depending on local policies and procedures this type of follow-up may be conducted by surveillance office staff or disease intervention field staff.
7. **Other**– Select this option if none of the above selections are outcomes for this assignment. Selecting other will require the user to complete a justification for selecting this option.

2.3.3 HIV Initial Assignment Outcomes

When closing an HIV initial assignment, the user should select the most appropriate initial assignment outcome.



When closing an initial outcome for an HIV case, the user must select from the following options:

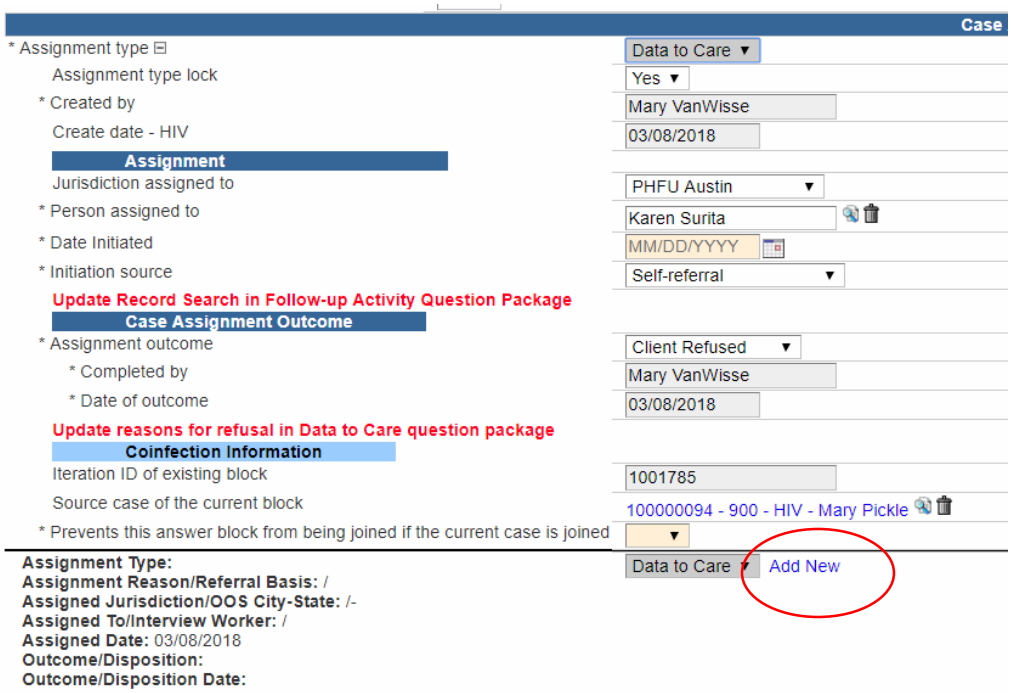
1. **Duplicate Person**– Select this option if this event was created for a case that already exists in THISIS.
2. **Confirmed Negative**_– Select this option if you have a lab report or a physician report that confirms that the person is negative. If this option is selected, you must enter the negative laboratory information in the Lab section of the event.
3. **Positive**– Select this option when a person is considered to be positive and follow-up activities should be initiated for the person. Selecting this option will trigger a number of questions that must be completed:
    a. Was diagnosed within the last year?
    b. Did the patient receive public health follow-up?
    c. Is this person currently in case for this infection?
    d. Note: Once these questions have been completed, red text will appear if a follow-up assignment is needed based on the user's responses to the questions.
4. **No Evidence of HIV**– Select this option when the health care provider confirms the person has no evidence of HIV.
5. **Insufficient Information** – Select this option to immediately close the current investigation due to a lack of adequate demographic information to conduct a follow-up investigation.

6. **Other**– Select this option if none of the above selections are outcomes for this assignment. Selecting other will require the user to complete a justification for selecting this option.

2.3.4 Completing the Case Assignment/Field Record

The Case Assignment/Field Record question package is repeatable (see Core Manual), so more than one case assignment can be made on a single event. To assign any work to the field, the user must first select the type(s) of assignment:

1. Congenital Investigation (Syphilis Only)
2. Data to Care (HIV Only)
3. Field Record/Interview
4. Medical Record Abstraction (HIV Only)
5. Out of State (OOS)
6. Re-Interview
7. STD Surveillance (STD Only)
8. Update Initial Assignment Outcome



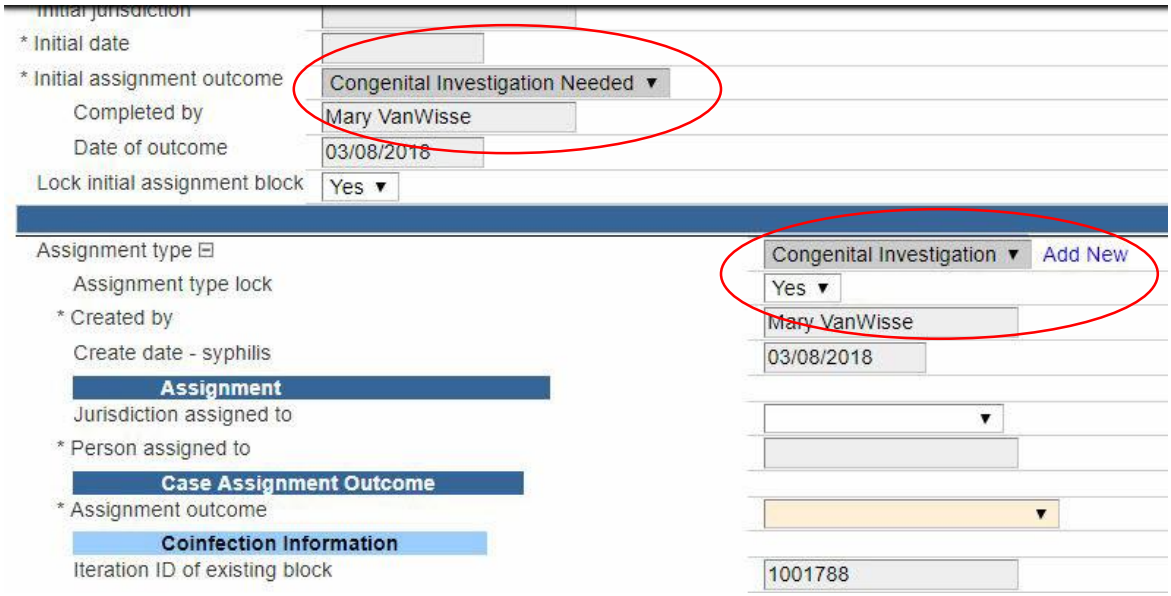
All assignment types have several fields that must completed to assign the work to a user in the system and a number of fields that must be completed in order to close the work assignment. For all case assignments the following fields must

be completed: Jurisdiction Assigned To, Person Assigned To, Date Assigned, and Assignment Outcome.

2.3.5 Congenital Investigation (Syphilis Only)

Making the assignment

Once it has been determined that a congenital syphilis investigation needs to occur, the user will assign jurisdiction and a specific staff (THISIS user) to the investigation. User will enter any notes regarding the investigation in the notes section. The designation of Congenital Syphilis is reserved for patients 10 years old and younger.



Next Steps

Once the assignment is created, the person conducting the congenital investigation will need to report details in THISIS. Information on this process is explained in chapter 3.1: Congenital Syphilis.

Closing the assignment

Upon completion of the congenital investigation and event, the user will close out the assignment as "Investigation Complete." If it is determined that a congenital investigation is not necessary, the user will select "Investigation Not Completed." The user will be prompted to enter in a justification as to why the

investigation was not warranted. This action will flag the record for central office review.

2.3.6 Data to Care (HIV Only)

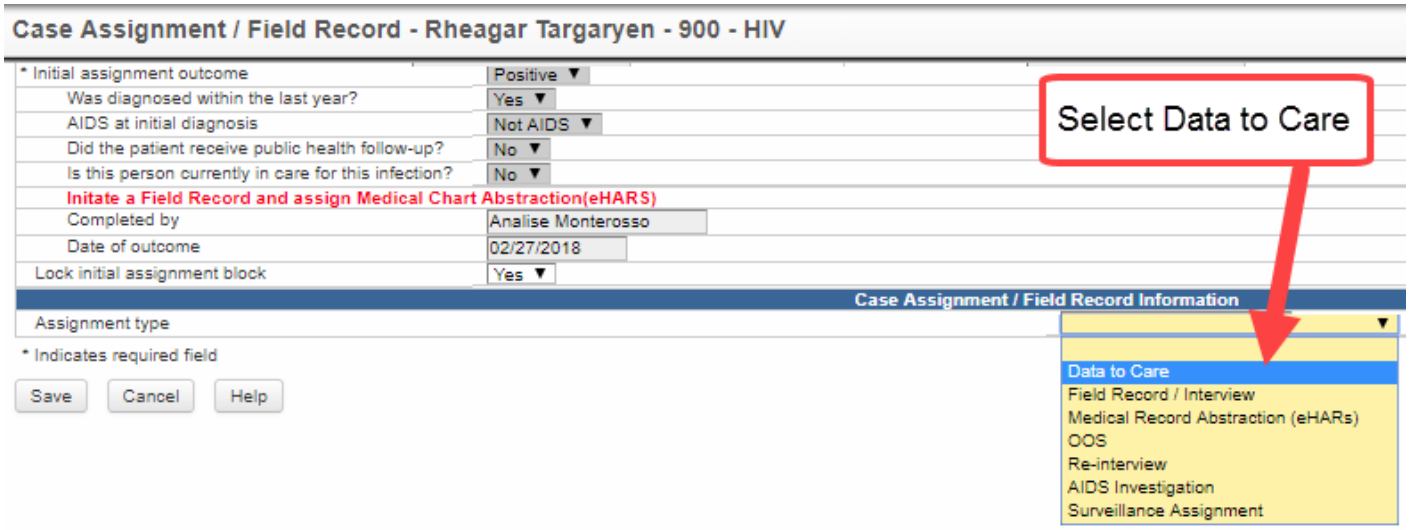
Making the assignment

Data to Care aims to connect or reconnect people living with HIV into receiving medical care. The Data to Care assignment type should be selected for persons living with HIV who have received medical care in the past but have no evidence of receiving care within the past 12 months. It should also be selected for people newly diagnosed with HIV who have no evidence starting medical care within 6 months of their initial diagnosis.

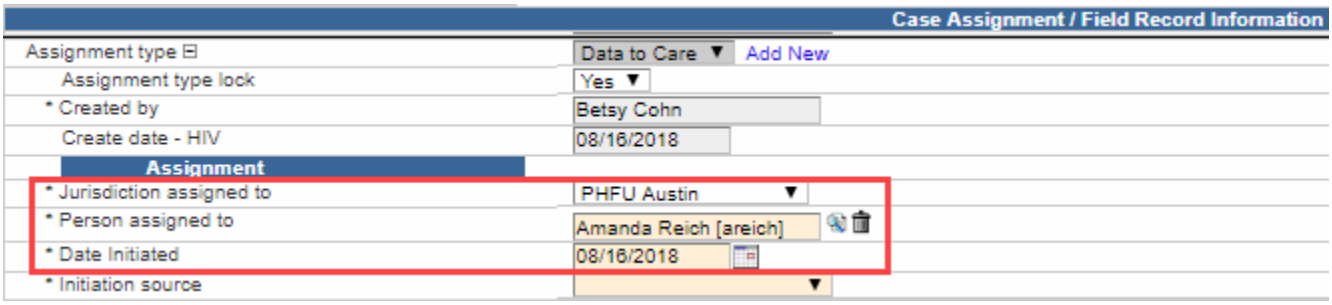
When the user selects Data to Care, the assigned jurisdiction will be selected based on the last known locating information for the patient. A user should then be assigned to perform Data to Care activities and the user assigning the work will be auto-populated.

To assign a case for Data to Care, the user should complete the following fields:

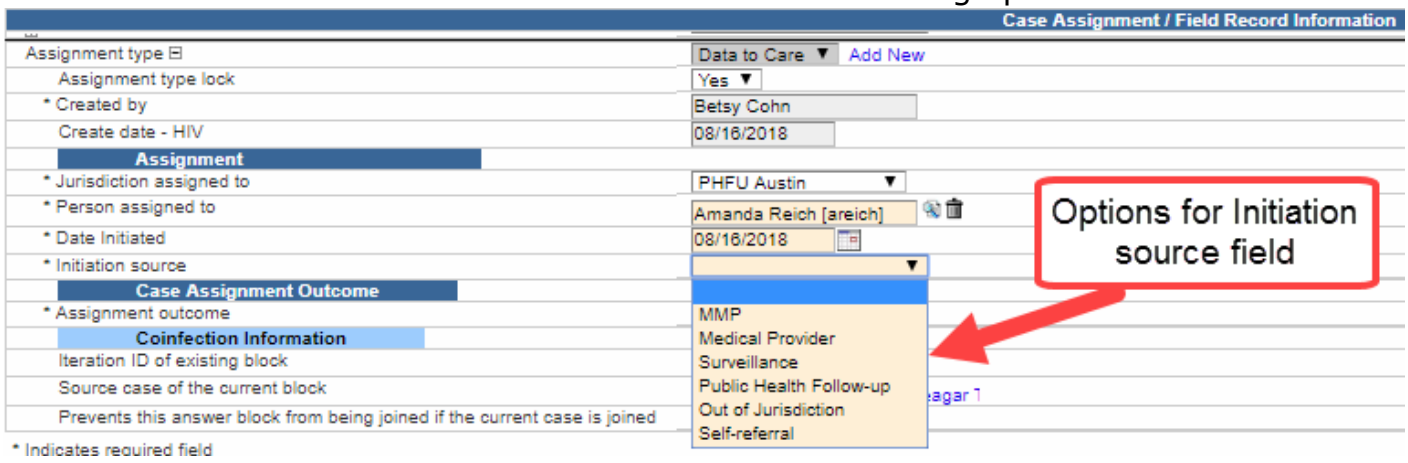
Assignment type – Select Data to Care from the dropdown menu



Jurisdiction assigned to – The PHFU jurisdiction (HDR or LHD) that will be responsible for performing Data to Care activities.
Person assigned to – The public health follow-up staff person in the jurisdiction that will be responsible for performing Data to Care activities.
Date initiated – The date the Data to Care assignment is created and assigned to the PHFU staff person.



Initiation Source- The user must select from the following options:

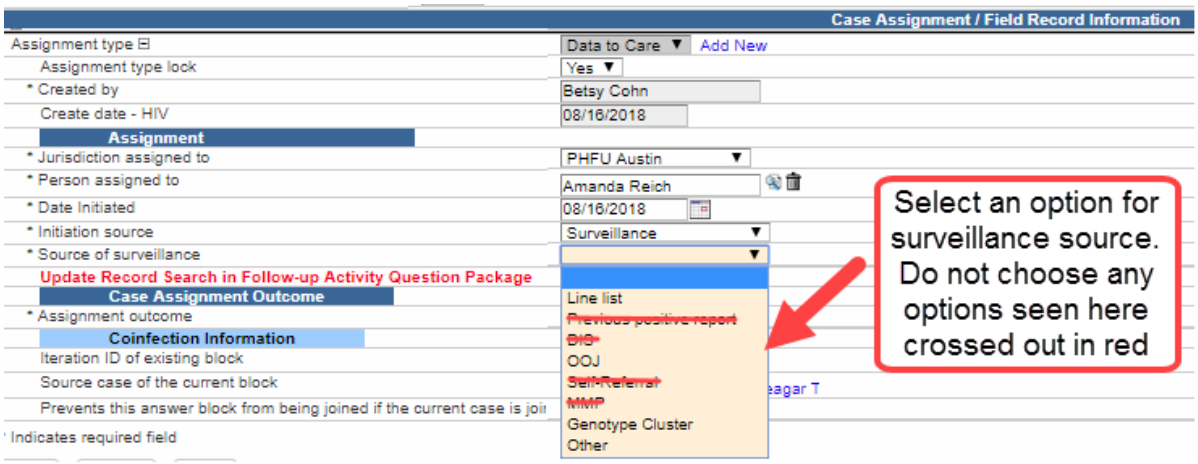


1. ***MMP***- Select this option if the person was selected for follow-up as a result of being selected for the Medical Monitoring Project (MMP) sample.
2. ***Medical Provider***- Select this option if the person was selected for follow-up from a medical provider who was caring for the individual. The user must then select the name of the facility associated with the provider who initiated the Data to Care investigation.
3. ***Surveillance***- Select this option if the person was selected for follow-up from surveillance efforts. The user must then select the source of surveillance
    a. **Source of surveillance-** The user must select the specific category of surveillance activity that led to a Data to Care investigation for the person.

    ***The current dropdown menu includes a few options that are not applicable for this field. Please *ONLY* select one of the four options listed below:

        i. **Line list**-Person is determined to be out of care using surveillance data.
        ii. **Out of Jurisdiction (OOJ)**- Program received an assignment from another state who identified the person from surveillance data.
        iii. **Genotype Cluster**- Person was identified as a result of molecular HIV cluster analysis.

iv. **Other**- This is a placeholder in case other surveillance mechanisms are identified.



4. ***Public Health Follow-up*** - Select this option if the person was selected for follow-up based on a Disease Intervention Specialist (DIS) investigation.
5. ***Self-Referral*** - Select this option if the person was selected for follow-up as a result of seeking medical care, without referral from the health department or partner. In many cases a person may present to the local or regional program for other services and not have a new reportable STI, but as a result of that visit, it is determined s/he is not in medical care.

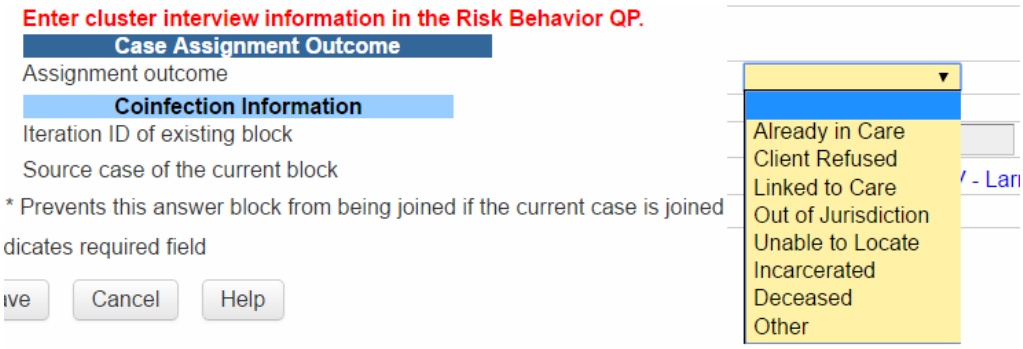
Next Steps

Once the information in the Case Assignment/Field Record question package is saved, it will trigger an assignment in the Data to Care Require workflow queue. The assignment will appear in the Data to Care workflow queue for all STD staff in that assigned jurisdiction. If the workflow appears in your workflow queue, you will have to go into the Case Assignment/Field Record question package for that event and see if it was assigned to you (in the 'Person assigned to' field). If there is not a user specified in that field, it is then up to the individuals in that jurisdiction to decide which staff person will become responsible for handling the Data to Care reporting for the assignment.

Details on reporting Data to Care assignments in THISIS after its initial creation are described in Chapter 3.2: Data to Care.

Closing the assignment

The Data to Care assignment will remain open until the person who was assigned to do the reengagement work completes the assignment outcome field in the Case Assignment/Field Record question package.



The user will indicate that they have completed the assignment with one of the following options:

1. **Already in Care**- Select this option if the person was determined to be in medical care after a field investigation was conducted.
2. **Client Refused** - Select this option if the person did not want to participate in reengagement activities.
3. **Linked to Care** - Select this option if the person attended a medical appointment as a result of reengagement activities.
4. **Out of Jurisdiction** - Select this option if the person lives in another jurisdiction or outside the state of Texas.
5. **Unable to Locate** - Select this option if the person was unable to be located during field investigation activities.
6. **Incarcerated** – Select this option if the person is currently in prison or jail.
7. **Deceased** – Select this option if the person has passed away.
8. **Other** - Select this option if none of the above selections are outcomes for this assignment. Selecting other will require the user to complete a justification for selecting this option.

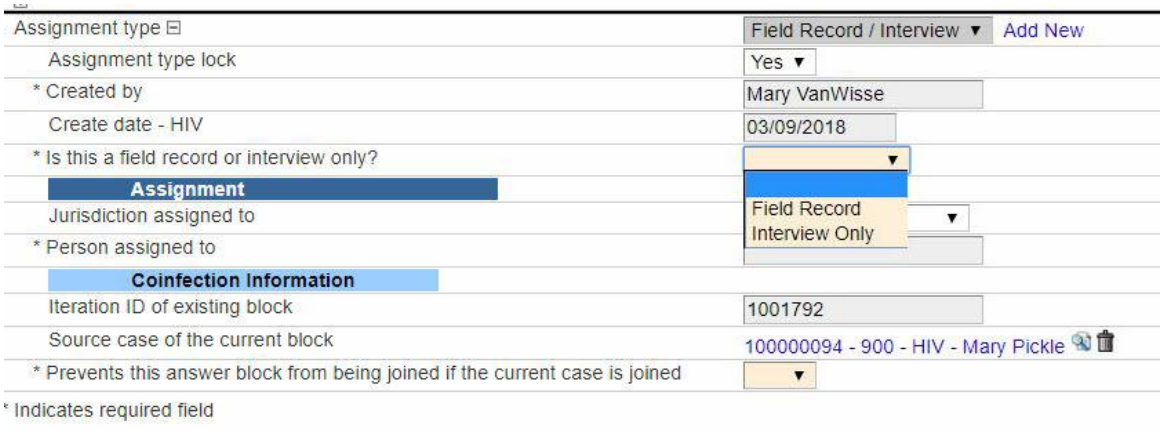
2.3.7 Field Record/Interview

Making the assignment

To assign a case for field record or interview, the user should complete the following fields:

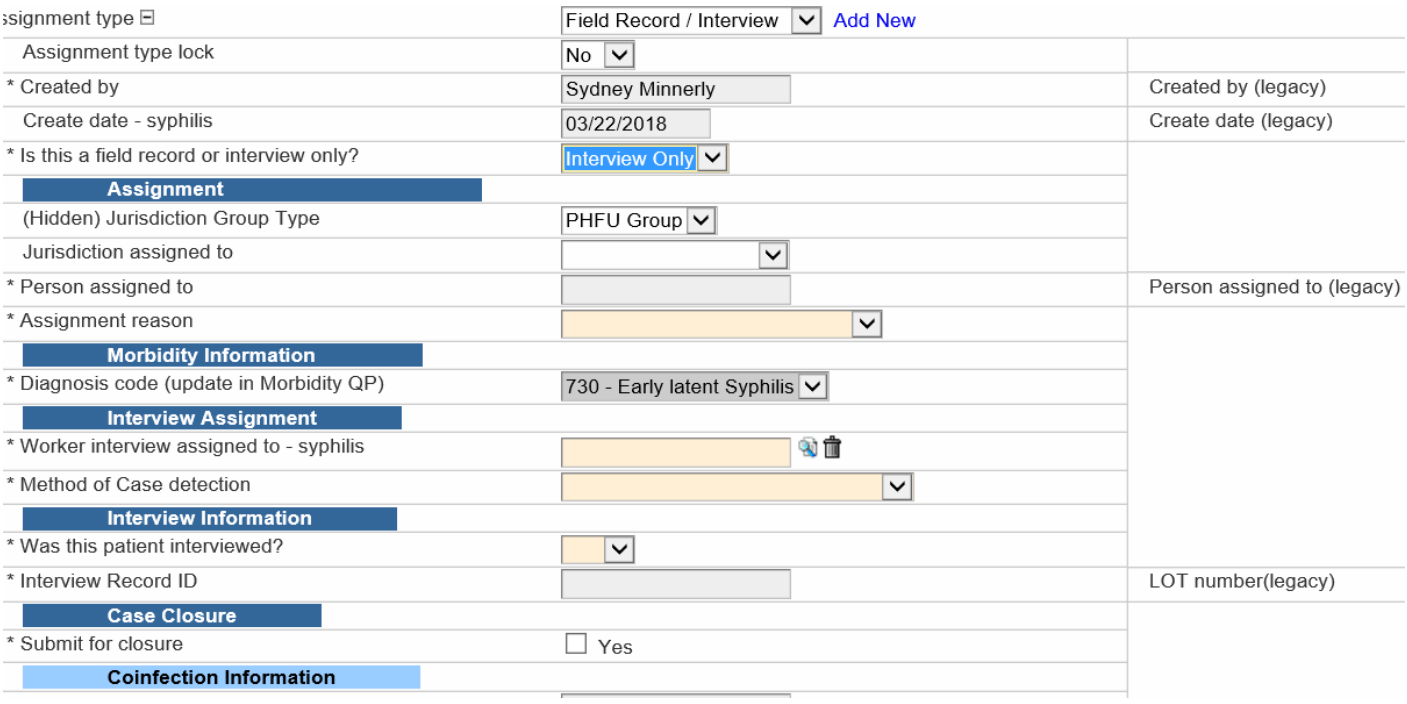
Jurisdiction assigned to – The public health follow-up jurisdiction that will be responsible for performing field follow-up or an interview.

Person assigned to – The public health follow-up staff person in the jurisdiction that will be responsible for field follow-up or an interview.



The user will select one of two options: field record for DIS field activities or interview only. Field record should be selected for requiring field activities and investigation (e.g. – field visits, phone calls, internet contact, provider visits etc.) and Interview only should be selected when *only* an interview is needed with no field activity needed (e.g. – a clinic walk-in who was self-referred in for services). Based on the user's selection, associated questions will need to be completed.

Interview Only – Select this option to open an interview not associated with a field record (e.g. – clinic walk-ins not referred in by a partner). Selecting this option will trigger the following questions that must be completed:



Field Record- Select this option to initiate a field record for follow-up. Selecting this option will trigger the following questions that must be completed:

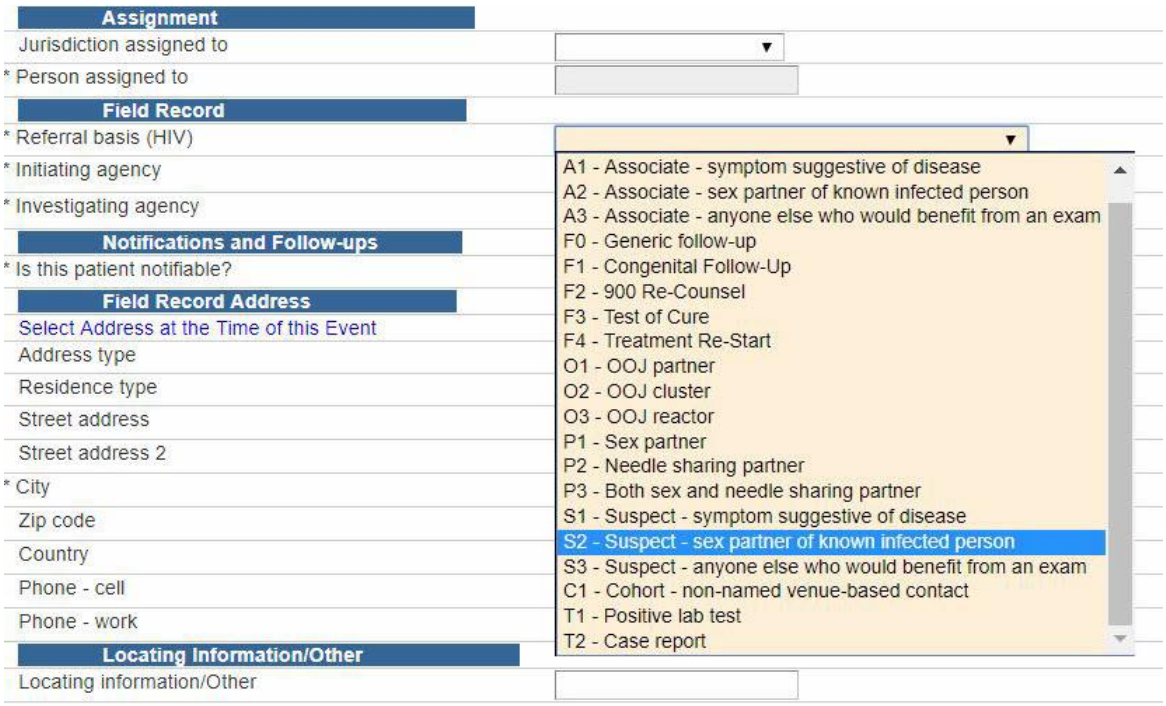
- Referral Basis: Select type of referral which brought the patient to the attention of the investigating jurisdiction.

    - **ASSOCIATE** - Persons named by an uninfected partner, social contact, or associate
        - **A1** - Person who has or had symptoms suggestive of the condition documented
        - **A2** -Person who is named as a sex partner of a known infected person
        - **A3** - Anyone else who would benefit from an exam (i.e., someone who has engaged in a behavior that might put them at risk)
        - **F0**- Generic Follow-up
        - **F1** - Congenital Follow-Up – Follow-up initiated on a mother and/or child due to positive lab result or provider case report. These could also take the place of baby FRs initiated for congenital investigation – positive or negative labs.
        - **F2** - 900 Re-Counsel – Follow-up initiated on a patient with a previous history of living with HIV or AIDS diagnosis for additional HIV counseling, partner services, and other HIV related intervention activities
        - **F3** - Test of Cure – Follow-up initiated on a patient for repeat testing to ensure adequate treatment of a given condition
        - **F4** - Treatment Re-Start – Follow-up initiated on a patient that has a lapsed treatment history to ensure adequate treatment of a given condition
    - **OOJ/ICCR** (Out of State/Interstate Communication Control Records) – This record is initiated due to information obtained from an out of state jurisdiction
        - **O1** – OOS Partner
        - **O2** - Social Contact or Associate (Cluster)
        - **O3** – Positive Lab Test
    - **PARTNER** - Persons having sexual activities (of any type) or sharing needles with the original patient
        - **P1** - Sex Partner
        - **P2** - Needle sharing Partner
        - **P3** - Both Sex and Needle sharing Partner
    - **SUSPECT** - Persons named by an infected person (e.g., the Original patient or an infected partner, social contact, or associate)
        - **S1** - Person who has or had symptoms suggestive of the condition(s) documented
        - **S2** - Person who is identified as a sex partner of a known infected person

- **S3** – Other persons within the socio-sexual network who would benefit from an exam (i.e., someone who has engaged in a behavior that might put them at risk or an out of period partner).

- **COHORT** - **C1** - A person identified through outreach screening efforts as a result of case investigation (i.e., common geographical area of residence or hangout). The person was **not individually named** by anyone interviewed during case investigation. This may also be a venue or location identified as a place for partner selection.
  POSITIVE LAB TEST - This record is initiated for follow-up on a positive laboratory test result obtained through screening, private physicians, or other sources.
  - **T1** - Positive Test Result
  - **T2** - Case Report

- Date Initiated
- Initiating agency
- Investigating agency
- **Field Record Address-** The user will select the address at the time of the event.
- Locating Information
- Employment Information
- Physical Attributes
- Marital Status/Exposure
- Notifications and Follow- Ups



Closing the assignment - Field record

The field record assignment will remain open until the person assigned to the field record completes the field investigation outcome section. The user will enter the date the field record was dispositioned and select the appropriate disposition. Additional questions may appear based on the selected the disposition.

The following lists provide descriptions for each disposition option. Note that there are separate lists for STD and HIV.

STD Dispositions

A - Preventative Treatment - The partner/cluster was examined and preventatively treated but the infection was not found by lab tests/clinical evidence.

B - Refused Preventative Treatment - The partner/cluster was examined and infection was not found; however, the partner/cluster refused preventive therapy.

C - Infected, Brought to Treatment - The patient was examined or treated (for the suspected infection) as, direct result of this field investigation. If the individual was treated prior to the initiation of this Field Record, the dispositions will be "E."

D - Infected, Not Treated - Information from a health care provider indicates the presence of an STD infection but adequate treatment was not administered.

E - Previously Treated for This Infection - The patient was adequately treated for the disease since the last exposure but prior to the initiation of a Field Record.

F - Not Infected - The tests/exam for the suspected disease is negative and preventive therapy was not required for this individual.

G - Insufficient Information to Begin Investigation - There is not sufficient information to begin an investigation. In most instances you would create a Marginal Field Record and during the course of an investigation you can promote this if you receive additional locating information. This disposition should always be discussed with a supervisor.

H - Unable to Locate - The patient was not found after a thorough DIS investigation. This disposition should always be reviewed with a supervisor. To ensure quality control, it is recommended that all resources be exhausted before this disposition is used.

I – Previous Positive Successful Interview/Recounsel – This disposition should be used in the situation where the only field activity

required on a patient is to conduct an interview and the interview was conducted on the patient. This disposition should rarely be used with new reactors.

J - Located, Not Examined and/or Interviewed - The patient was found but refused examination and/or an Interview. This disposition should always be reviewed and initialed by a supervisor before being given as final.

K - Out Of Jurisdiction - The patient resides or has moved outside of the state and locating information is available to forward it for continued investigation. After selecting this disposition, **you need to create an OOS assignment**.

L - Other - is disposition is to be used when none of the other dispositions apply. Document the reason why this disposition was selected and discuss with a supervisor prior to using this disposition.

N- Reactive Not a Current Infection- This dispo is to be used when patient is serofast and previously treated for the infection. This implies the patient still has reactive labs but is no longer infected. Can be used for reactors and partners/clusters

Q - Administrative Closure -Though a field record was initiated through the course of the investigation it was determined that the field record should be closed administratively. This disposition should be discussed with the supervisor prior to use.

V – Domestic Violence Risk – No follow-up completed due to provider (private or public) assessed that contacting the partner or cluster could pose the risk of domestic violence to the index patient, partner, or cluster.

W- **Out of country-** NO PHFU- The patient resides or has moved outside of the country.

X - Patient Deceased - through the course of the investigation the patient was determined to be deceased.

Z - Previous Preventative Treatment – The patient has received prophylactic treatment relevant to the current investigation prior to the involvement of the DIS who is working the current field record. A patient can only receive preventative treatment once per incident unless the patient is re-exposed to a condition

HIV Dispositions

1- Previous Positive -The patient had a previous positive HIV test.

2-Previous Negative, New Positive -The patient has seroconverted.

3- Previous Negative, Still Negative -The patient still has a negative test result.

4- Previous Negative, Not Re- Tested -The patient has a negative result but is not retested at this time due to a recent test or other circumstances.

5- Not Previously Tested, New Positive -The patient has no documented previous test and has seroconverted.

6- Not Previously Tested, New Negative -The patient has not been previously tested (or is unable to document previous test) and has tested negative for this investigation.

7- Notified, Not Tested Now -The patient has not been previously tested and is still not tested after investigation.

G - Insufficient Information to Begin Investigation - There is not sufficient information to begin an investigation. In most instances you would create a Marginal Field Record and during the course of an investigation you can promote this if you receive additional locating information. This disposition should always be discussed with a supervisor.

H - Unable to Locate - The patient was not found after a thorough DIS investigation. This disposition should always be reviewed with a supervisor. The DIS should attempt to obtain information about previous testing history and use the appropriate dispositions.

I - Successful Interview/Recounsel – This disposition should be used in the situation where the only field activity required on a patient is to conduct an interview and the interview was conducted on the patient. This disposition is appropriate for F0- Generic Follow Up and F2- 900 Re Counsel.

J - Located, Not Examined and/or Interviewed – Do not use for HIV. The DIS should attempt to obtain information about previous testing history and use the appropriate dispositions.

K - Sent Out Of Jurisdiction - The patient resides or has moved outside of the state and locating information is available to forward it for continued investigation. After selecting this disposition, **you need to create an OOS assignment.**

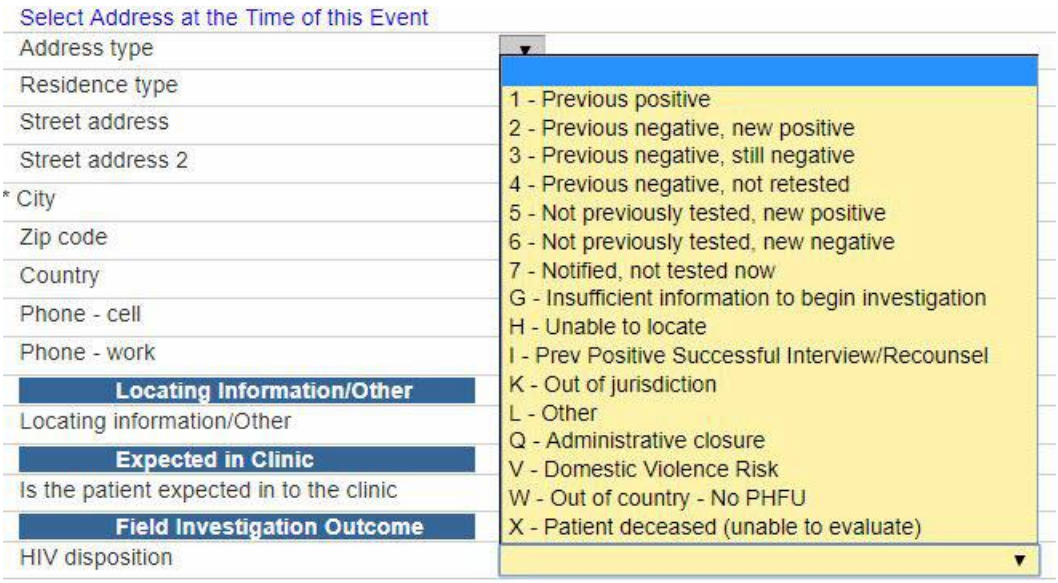
L - Other - is disposition is to be used when none of the other dispositions apply. Document the reason why this disposition was selected and discuss with a supervisor prior to using this disposition.

Q - Administrative Closure -Though a field record was initiated through the course of the investigation it was determined that the field record should be closed administratively. This disposition should be discussed with the supervisor prior to use.

V – Domestic Violence Risk – No follow-up completed due to provider (private or public) assessed that contacting the partner or cluster could pose the risk of domestic violence to the index patient, partner, or cluster.

W- Out of country- NO PHFU- The patient resides or has move outside of the country.

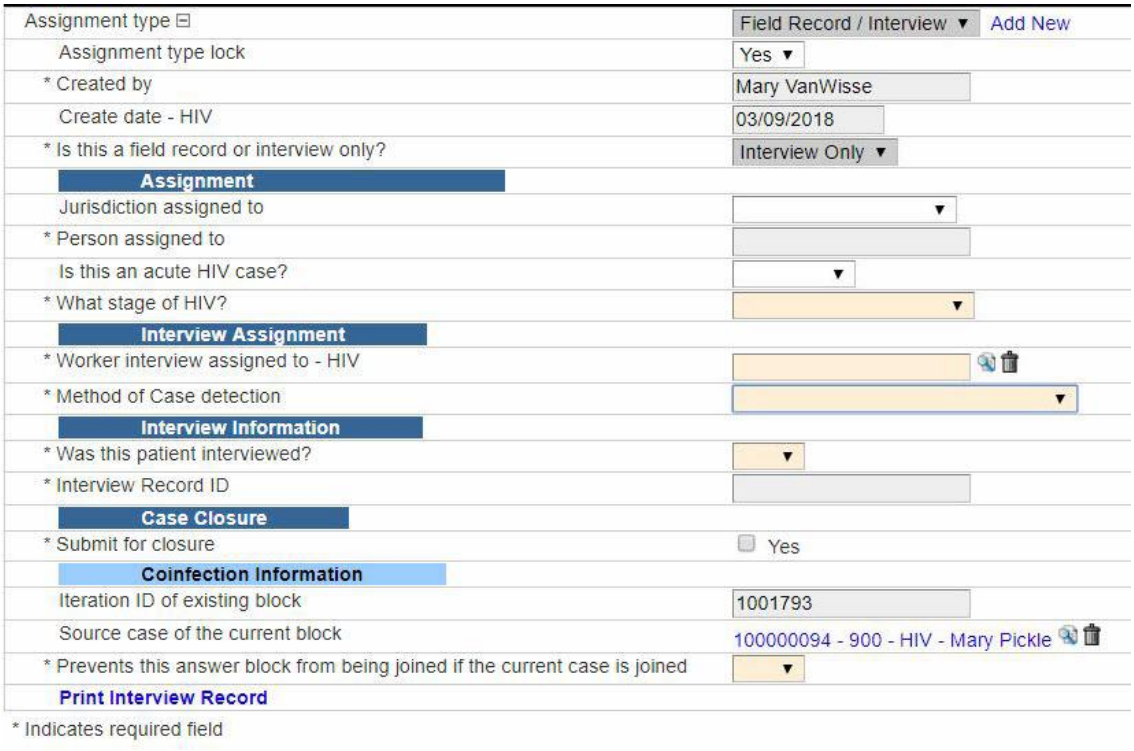
X - Patient Deceased - through the course of the investigation the patient was determined to be deceased.



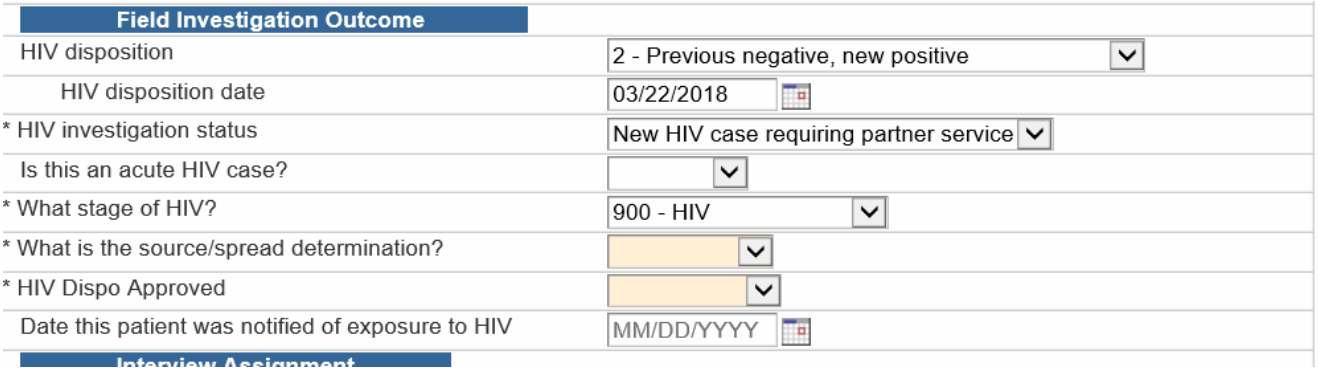
Closing the assignment - Interview only

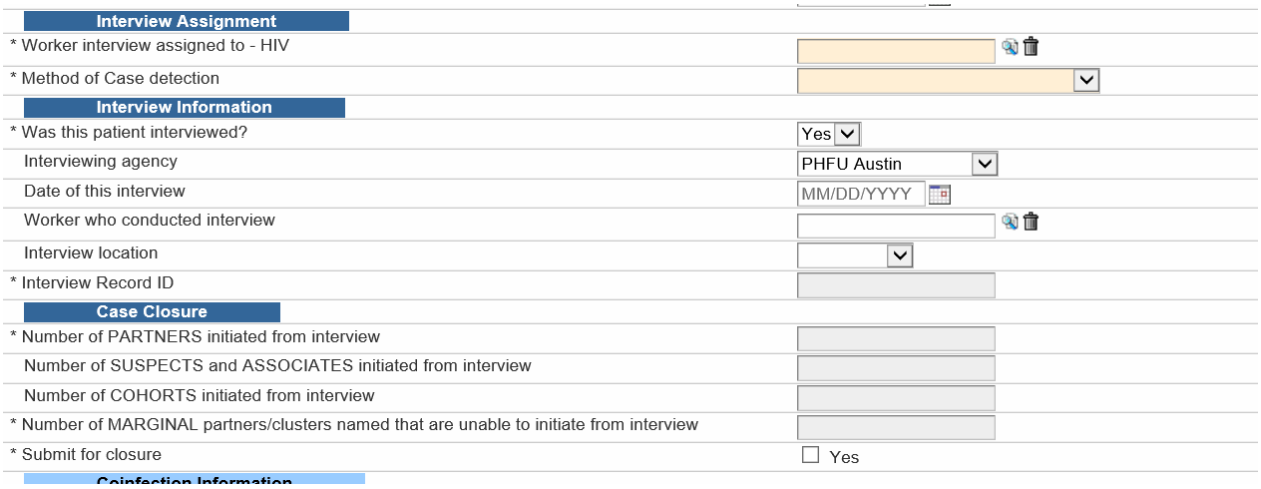
If an interview only is required for the investigation, then the user will select: Interview Only- The user will select this option when a patient has been treated at the time the condition is reported, the patient may only need an interview (i.e., risk reduction, partner services, person diagnosed at the clinic, etc.). Selecting this option will trigger the following questions that must be completed:

- Date first assigned for interview
- Worker interview assigned to
- Method of Case Detection
- Was this patient interviewed?
    - If yes, Interviewing agency
    - Date of interview
    - Interview Location



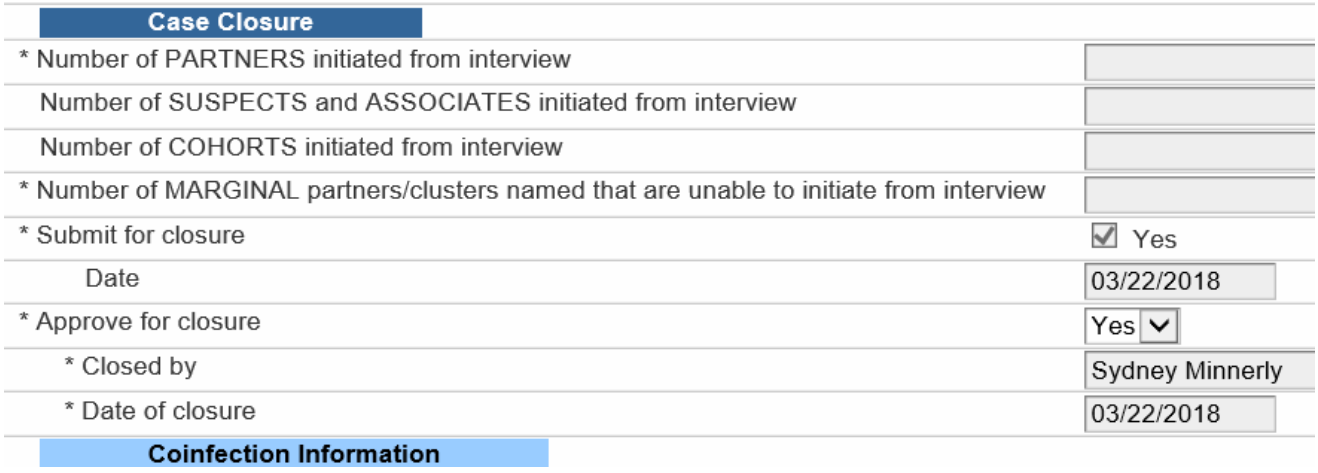
The following questions are triggered for HIV only events:





The interview only assignment will remain open until the person assigned to the interview only completes the case closure field. Case closure is complete when both the DIS has completed the assignment and the FLS has approved the case for closure. The user will need to indicate that they have completed the assignment by answering the following:

- FLS initial review
- Submit for closure
- Approve for closure



2.3.8 Re-Interview

Making the assignment

To assign a case for re-interview the user will complete the following fields:

- Jurisdiction assigned to – The public health follow-up jurisdiction that will be responsible for performing the re-interview.
- Person assigned to – The public health follow-up staff person in the jurisdiction who will be responsible for the re-interview.

The Re-Interview Plan- The user will select Re-interview assignment type to document when an additional interview is planned. The following questions will need to be answered by the user prior to conducting the re-interview:

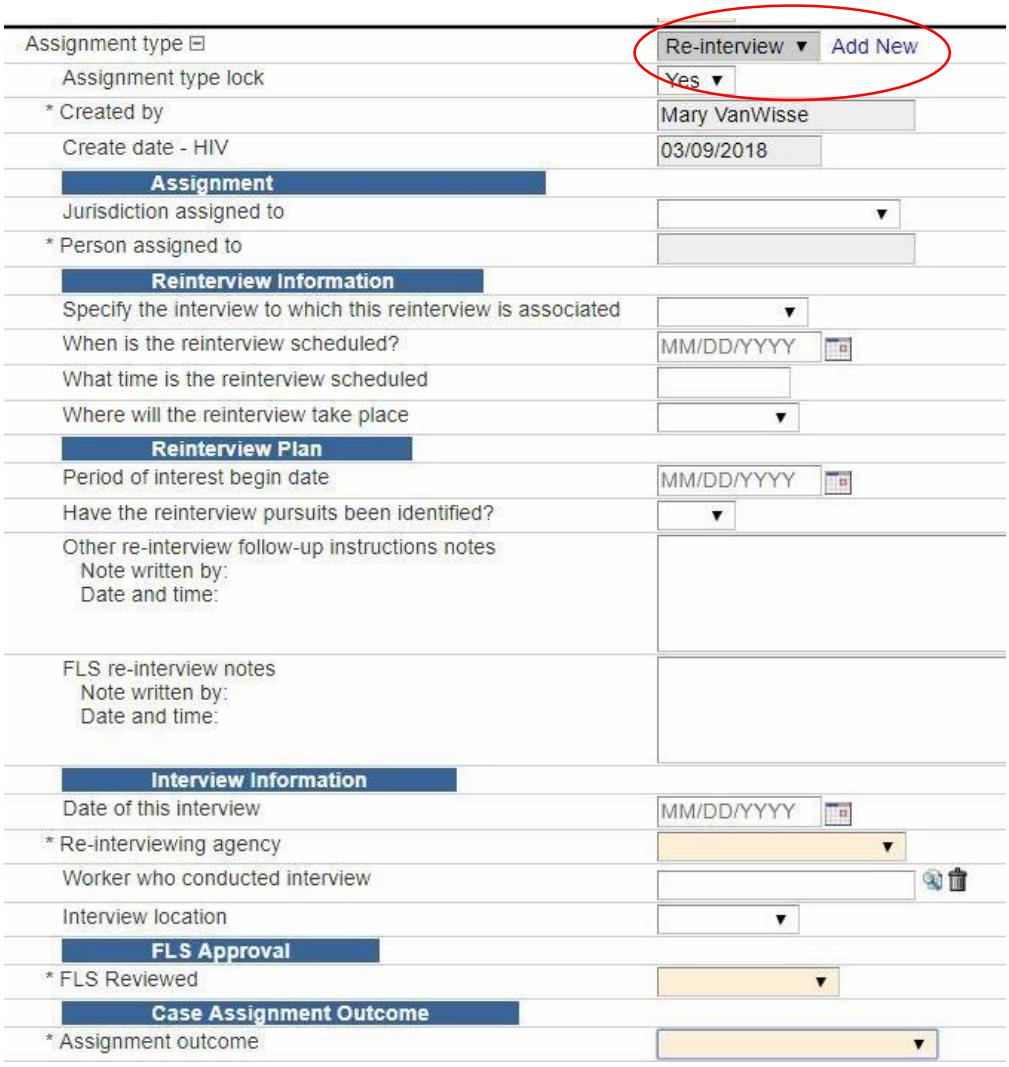
- Specify the original interview to which this re-interview is associated
- Date the re-interview is scheduled to occur (captured at the closing of the original interview)
- Time the re-interview is scheduled to occur?
- Where the interview is scheduled to take place?
- Period of interest begin and end date
- Have the re-interview pursuits been identified? (If yes, check the What Topics were Pursed and Covered) – these should be submitted at the time of case review within 24 hours of the original interview
- DIS may enter additional notes in the free text field for additional items to pursue. This field will be locked once the record is saved.

Once the re-interview is conducted:

- Was the patient re-interviewed? (If yes, then select the re-interviewing agency)
- Enter the date the re-interview was conducted
- Re-interview agency
- Enter the worker who conducted the re-interview – it does not have to be the same person who conducted the original interview.
- Where did the interview take place?
- FLS Reviewed – FLS must approve
- Case assignment Outcome-select if the patient was or was not re-interviewed.

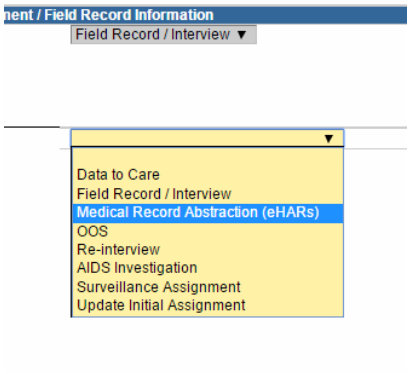
Closing the assignment

Once the re-interview assignment is made, the assignment will be placed in an FLS workflow for the FLS to review. The FLS will indicate whether or not they reviewed the plan and the FLS Reviewed field will trigger a date and timestamp. The assignment will remain open until the user indicates whether or not the re-interview was conducted. Once this field is entered, the assignment will be closed.



2.3.9 Medical Record Abstraction (HIV Only)

Newly identified HIV cases in Texas, determined through initial assessment (e.g., following up on electronically reported labs) or through other mechanisms (e.g., a call from another state) should be assigned to HIV Surveillance staff for a medical record abstraction. A medical record abstraction must occur in order to report an HIV case. A medical record abstraction may also be assigned to update an existing HIV case to AIDS.
Under the case assignment, choose medical record abstraction:



Making the assignment

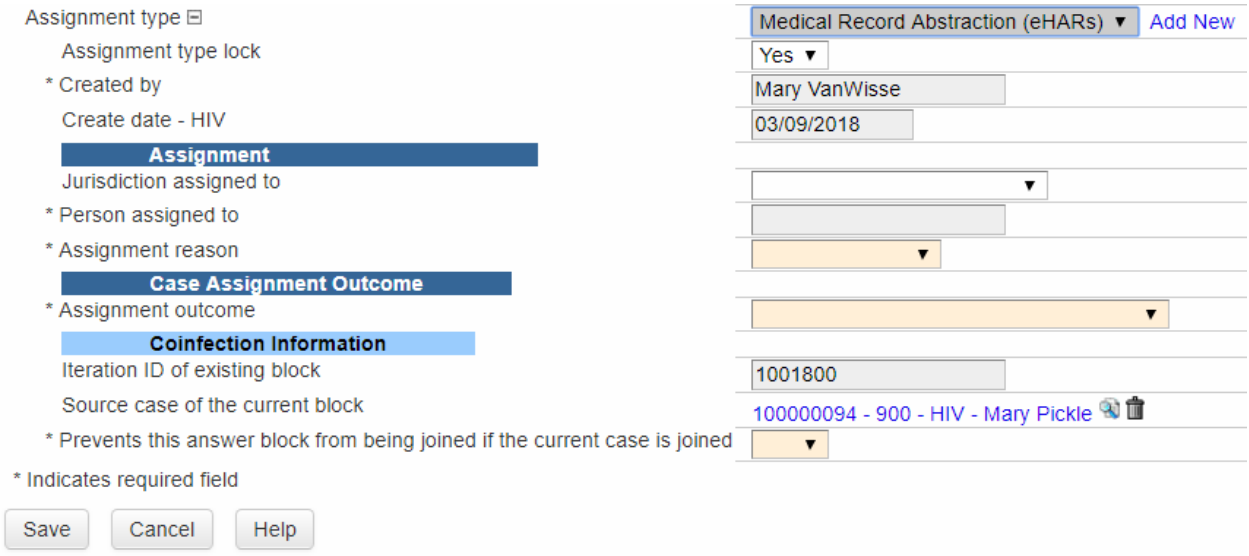
To assign a case for medical record abstraction, the user should complete the following fields:

Jurisdiction assigned to – The HIV Surveillance jurisdiction that will be responsible for performing the medical record abstraction.

Person assigned to – The HIV Surveillance staff person in the jurisdiction who will be responsible for doing the abstraction.

Assignment reason – The reason why the case is being assigned for a medical record abstraction. The user should select: New HIV, Update an existing HIV case to AIDS, or Other. If "Other" is selected, the user should also complete 'Specify Other' with the reason for selecting other.

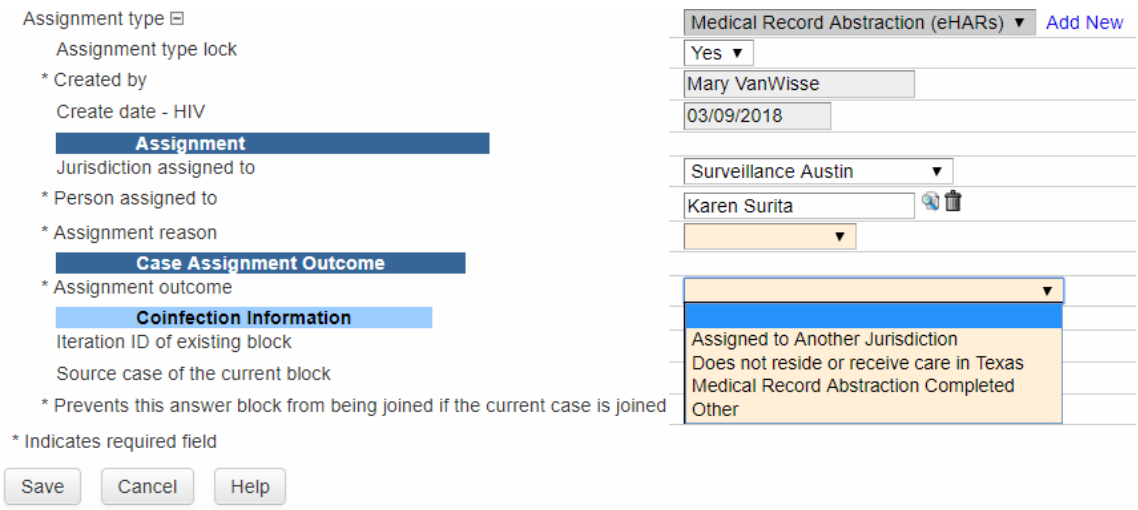
Assignment Notes – This field is used to capture any notes that the User would like to convey to the person being assigned the medical record abstraction. Completing this field is optional.



Closing the assignment

The medical record abstraction assignment will remain open until the person who was assigned to do the abstraction completes the case assignment outcome field to indicate that they have completed the assignment with one of the following options:

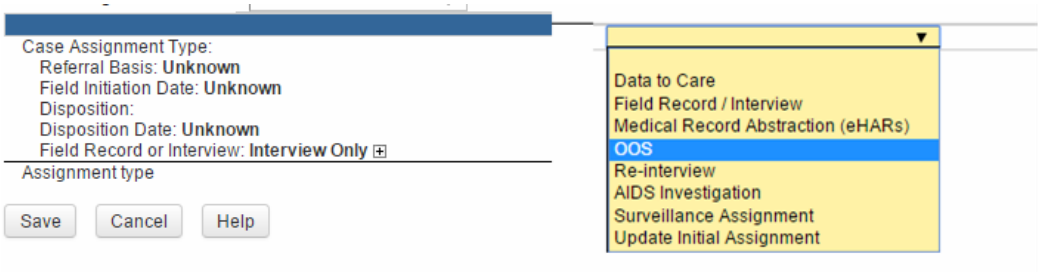
1. **Assigned to another jurisdiction** – Select this option if the medical record abstraction needs to be assigned to another jurisdiction. If this option is selected, the user must create a new medical record abstraction case assignment block to assign the abstraction to another jurisdiction.
2. **Does not reside or receive care in Texas** – Select this option if it is determined that the case does not reside in Texas and has not received any care in Texas.
3. **Duplicate** (see HIV Initial Assignment Outcomes)
4. **Confirmed Negative** (see HIV Initial Assignment Outcomes)
5. **Lab Error** (see HIV Initial Assignment Outcomes)
6. **Medical Record Abstraction Completed** – Select this option if the medical record abstraction is completed. If the medical record abstraction is completed, the user should also enter the CRF for this case and link the CRF to the main HIV event.
7. **No evidence of HIV** (see HIV Initial Assignment Outcomes)
8. **Other** (see HIV Initial Assignment Outcomes)



In the case above, Surveillance Austin was selected as the Jurisdiction and Karen Surita was assigned to the case. The drop-down menu displays the options for Assignment outcome.

2.3.10 Out of State

Cases that need out of state follow-up should be given an Out-of-State (OOS) assignment. OOS assignment can be used for requesting an out of state record search to gather information about a case or for sending a field record to another state for public health follow-up investigation. All OOS assignments will be followed-up by staff in Central Office.

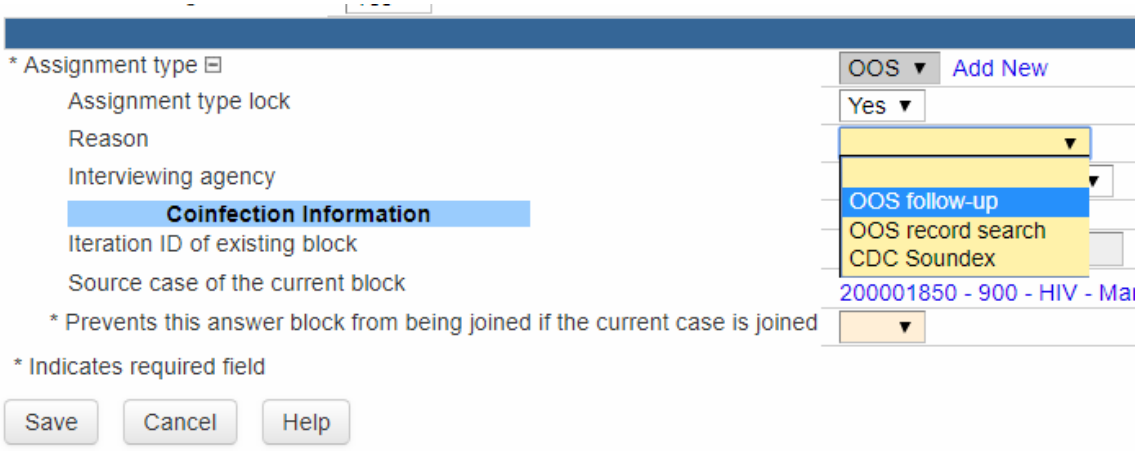


Making the Assignment

To assign a case for out of state follow-up you must first select the OOS reason:
OOS Follow-Up: The case needs to have a field record sent to another state for follow-up

OOS Record Search: The case needs to be record searched for previous history in another state.

CDC Soundex (Available for HIV events only): is a National HIV Record Search



OOS Follow-up

If OOS Follow-up is selected, you must complete the OOS location section. At a minimum the state field must be completed with the state where the field record is to be sent. The city field only needs to be completed if the field record needs

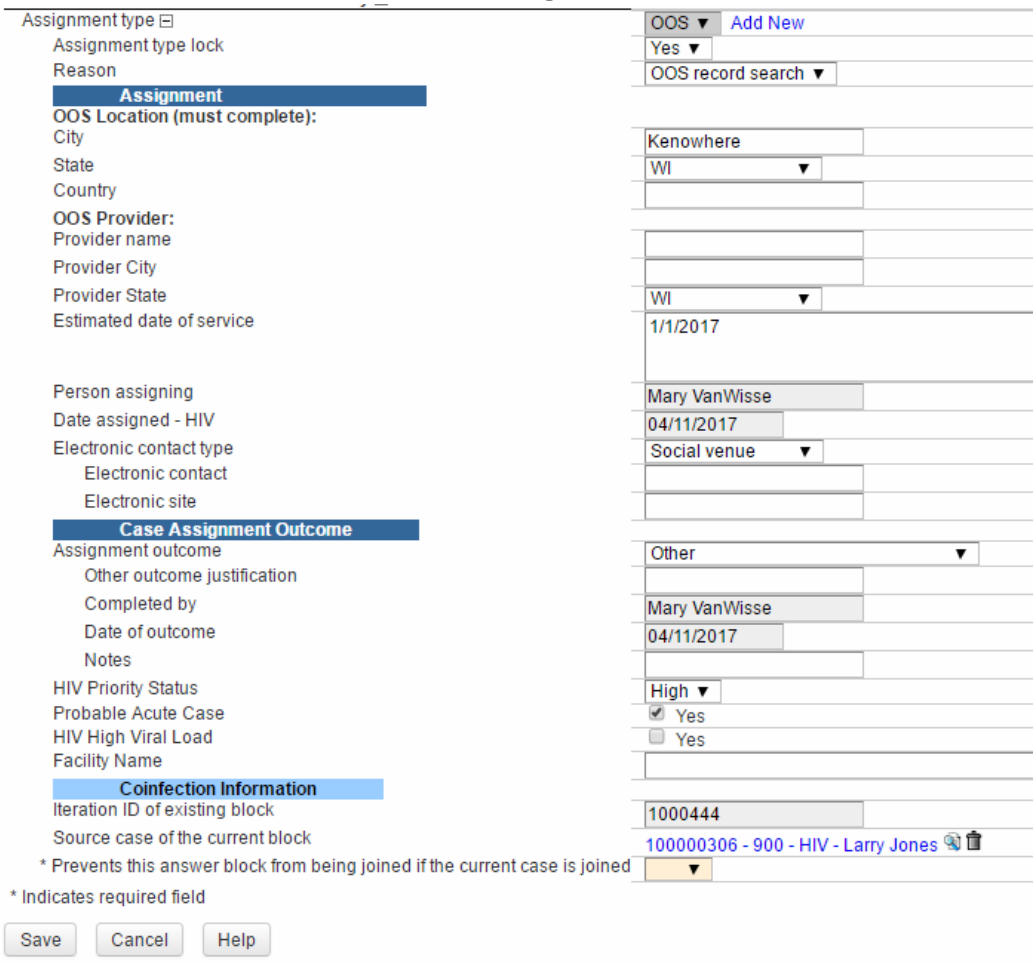
to be sent to specific city in the state and the Country field only needs to be completed if the field record is being sent to another Country.

OOS Record Search

If OOS Record Search is selected, you must complete the OOS location section. At a minimum the state field must be completed in this section. The city field only needs to be completed if the field record needs to be sent to specific city in the state and the Country field only needs to be completed if the field record is being sent to another Country.

- You should also complete the OOS Provider ('Provider name,' 'Provider City,' and 'Provider State') information section, if you know this information.
- Enter treatment history date(s) or estimated timeframes in the 'Estimated Date of Service' (if available).

Use the estimated date of service to enter any relevant progress notes or treatment history details that would be helpful to the other state or Central Office consultant staff in the 'Assignment notes' field.



If you need to enter notes about this case these notes can be entered in the event notes section of the case.

Closing the assignment

The central office consultants will be responsible following up with out of state record assignments and appropriately closing these assignments.

2.3.11 STD Surveillance (STD Only)

Making the assignment

To assign a lab for surveillance follow-up, complete the following fields:

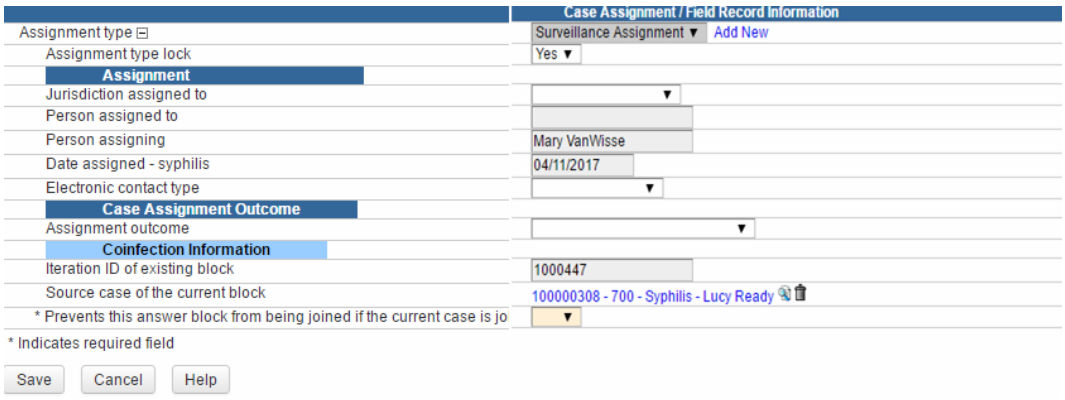
- Jurisdiction assigned to
- Person assigned to
- Assignment notes

Closing the assignment

To close the assignment, the user will select from the following:

- Administrative Closure
- BFP – No Follow-Up
- Field Follow-Up
- Insufficient Information
- Record Search Closure
- Not a program priority
- Surveillance Follow-up
- Congenital Follow-up
- Other

*Refer to STD (non-HIV) Initial Assignment Outcomes for details
Once an outcome is assigned, the system will identify the user and the date the outcome assignment occurred. The options for completing these fields are the same options as those found in the Initial Assignment Outcomes section.



2.3.12 Update Initial Assignment Outcome

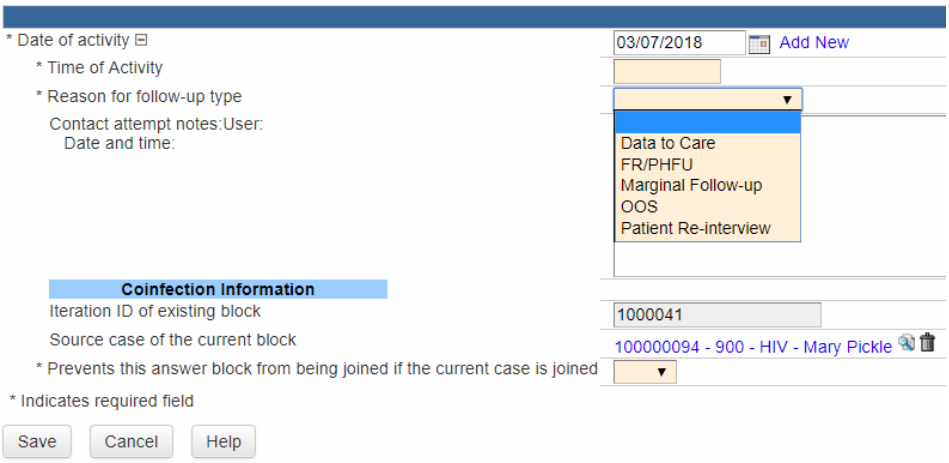
Once the initial assignment fields have been completed and saved, this section will become read only. If the user wants to change the initial assignment outcome, select the 'Update Initial Assignment Outcome' and complete the Update Initial Assignment Outcome fields. The options for completing these fields are the same options as those found in the Initial Assignment Outcomes section. A FLS must approve any changes to the initial assignment outcome; it is important that the user enter notes related to this change in the Justification for Updating an Initial Assignment Outcome.

2.4 Follow-up Activity

The follow-up activity question package is used for documenting activities related to locating a person once an assignment has been given to a user. This section is for documenting activities related to assignments such as record searches, provider or patient phone calls, field visits and the outcomes of these activities. This is a tool which will assist the field staff with complete documentation of their investigation activities.

2.4.1 Documenting an activity

Select the date the activity occurred using the format MM/DD/YYYY or the user can select a recent date by clicking on the calendar.



2.4.2 Time of Activity

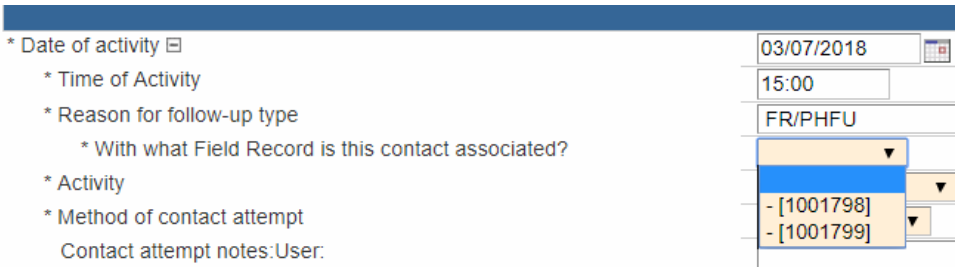
Enter the time the activity occurred using military time. The activity below occurred at 3:00 pm, or 15:00 in military time. Military time is based on a 24 hour clock. For more information, visit Military Time Clock.

2.4.3 Reason for Follow-Up Type

Enter the reason for the follow-up activity

- Data to Care- select if the user is attempting to locate a person who requires re linkage to medical services for their HIV care
- FR/PHFU- select if the user is attempting to locate reactors, partners, suspects, and associates
- Marginal Follow-up- select if the user is attempting to locate an individual whose referral basis was Marginal
- OOS- Select if the person lives out of state
- Patient Re-interview- select if the user is attempting to re-interview the patient.

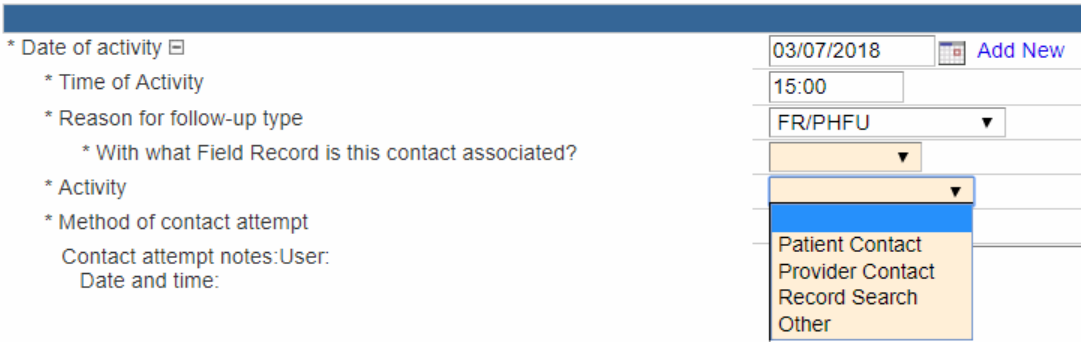
Additional questions will appear depending on the reason the user selects. The user will need to select which event the reason for follow-up is associated with.



2.4.4 Activity

Activity: The user will select what type of activity was conducted from a pull-down menu

- Patient Contact- Select if the user is contacting patient
- Provider Contact- Select if the user is contacting the provider who may have additional testing or treatment information
- Record Search- Select when conducting searches in local databases or online
- Other- Select if the activity does not exist in the drop-down menu.



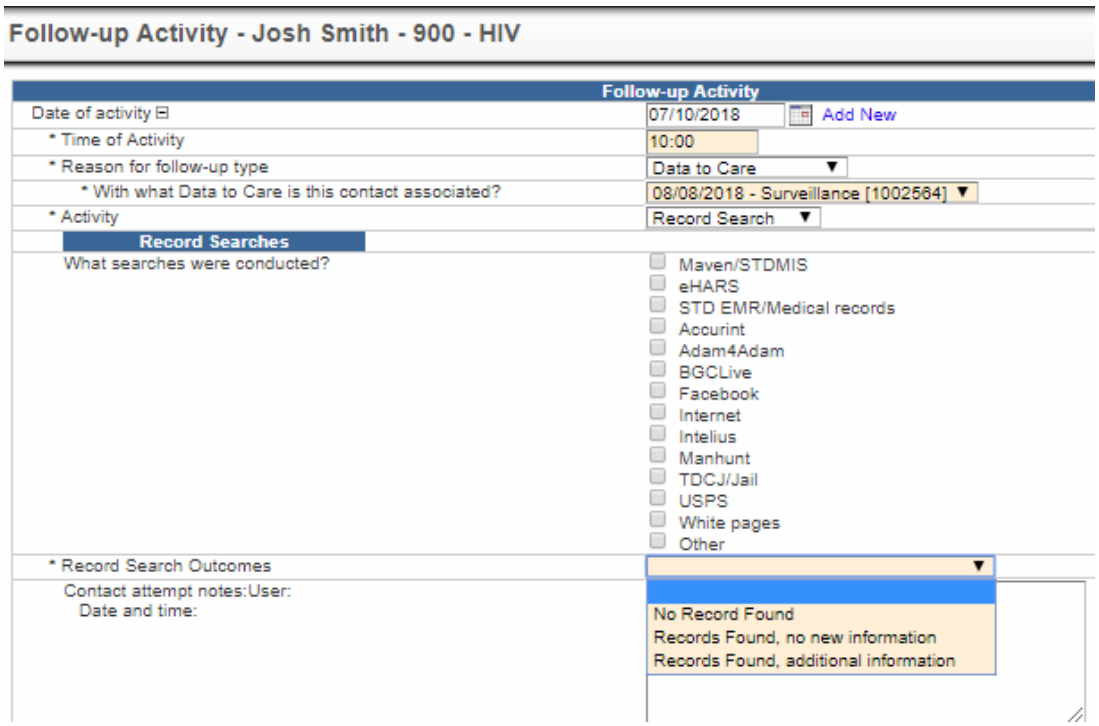
2.4.5 Record Searches

Record Searches: Additional fields will appear if this activity is selected. The user can select multiple searches conducted. Additional questions will appear and the user can update the outcomes of the searches.

What searches were conducted?- The user will select what method(s) of contact was used to contact the person. Some examples of record search databases could include:

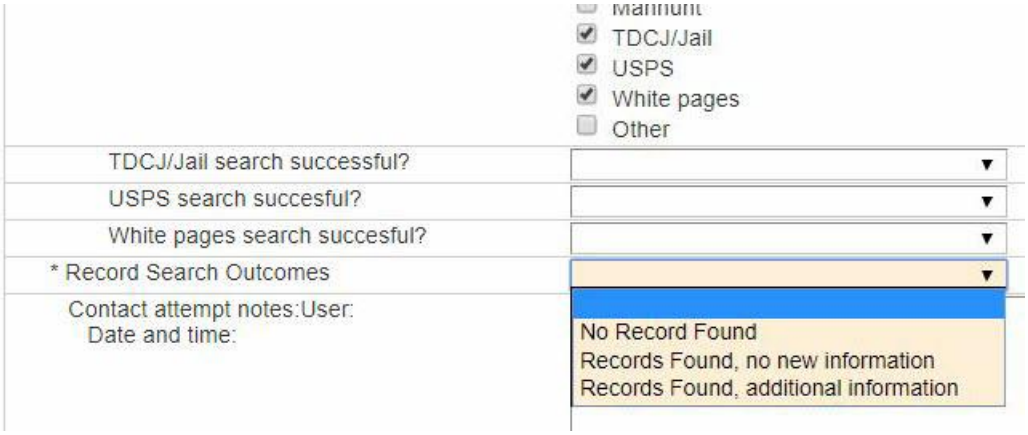
- THISIS/STDMIS
- EHARS
- STD EMR/Medical Records
- Accurint
- Adam4Adam
- BGCLive
- Facebook
- Internet
- Intelius
- Manhunt
- Jail/TDCJ
- USPS
- White Pages
- Other

Record search outcomes-Record the finding from the record search



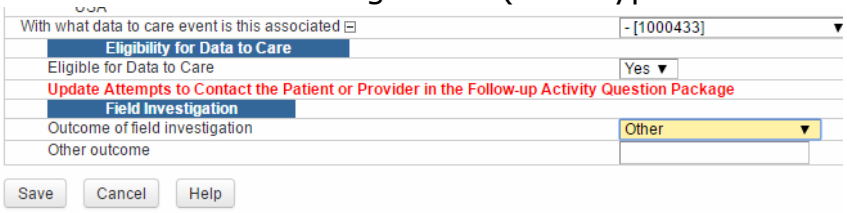
2.4.6 Activity Outcome

The user can document the outcomes of attempts made to contact the patient by selecting an option from the drop-down menu. The options available to the user are dependent on the method selected for each activity. The user may also add additional notes about the attempt to locate the patient in the free text.



2.4.6 Other

Select this option if none of the above selections are outcomes for this assignment. The user will then return to the Case Assignment/Field record QP and close the case assignment (Add Hyperlink to closing case assignment)



2.5 Risk Factors

This section focuses on the documentation of the patient's risk factors at the time of the event. This information can be obtained during either a case investigation or cluster interview. In other words, this section can apply to any patient with an event (Original Interview (Case) for the OP or Cluster interview for a related contact). The user will enter what type of interview the information was elicited from, and a series of questions will appear for the purposes of documenting risk behaviors.

- Original interview- There can only be one original interview per STD event for a person. There can be multiple interviews for HIV cases over the course of the person's lifetime event. It is critical the user select the correct Original Interview so risk factors and personal history are associated with the correct interview.
- Cluster Interview- An interview with a non-infected contact, suspect, or associate designed to elicit information about the related original patient or non-infected contact to the original patient. Cluster interviews are entered on the contacts event, not the original patient's event.

2.5.1 Original Interview

From which interview was this information elicited – user will select the original interview (case) from which this information was collected. Interview period – this interview period will be set to a default number but can be updated by the user.
Default Values:

- 200 or 300 Gonorrhea or Chlamydia– 2 months
- 710 Primary Syphilis – 4 months
- 720 Secondary Syphilis– 8 months
- 730 Early Syphilis – 12 months
- 755 Late Latent Syphilis – 12 months
- All 900 HIV – 12 months

If an alternate interview period is selected, the user will have to enter the new interview period and a justification for altering the interview period. Some possible justifications could include – testing history, symptom history, etc.

The following questions need to be answered by the user under each heading:

2.5.2 Living Situation & Education

- User will select the address to associate with the case. These fields will auto-populate from the party section.
- If the original patient is living with another person, the user will select "Yes" and then **Enter** the person's name. The user may also select "No" or "Did not ask".
- If the OP is living with another person, the user will be asked the relationship between the OP and the other person.
- Length of residence (at current address) – this is the amount of time, *in months*, the original patient has lived at their current address.

- Education – user will select from a drop-down menu the original patient's level of education.

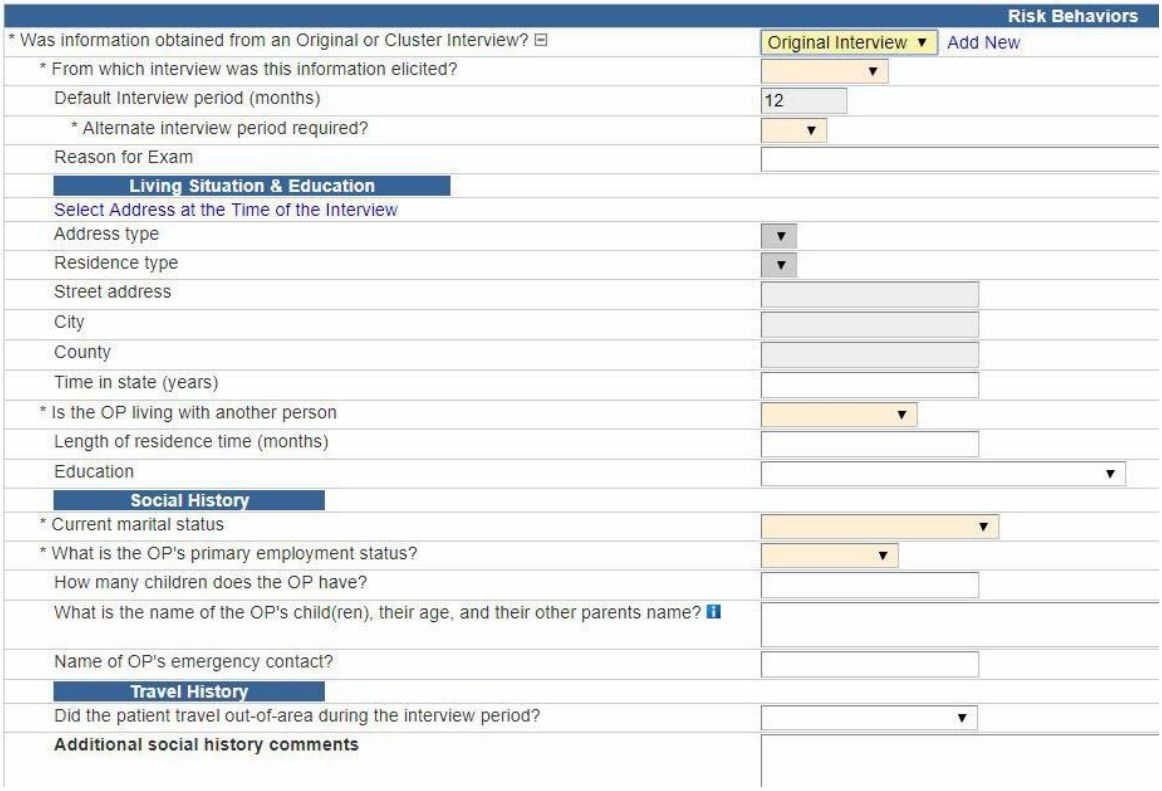
2.5.3 Social History

- Current Marital Status- the user will select from a drop-down menu.
- What is the original patient's primary employment status? - The user will select from a drop-down menu the type of employment and the following questions will appear:
  - Where does the OP work?
  - What hours does the OP work?
  - The user may enter additional information regarding employment in the notes section.
- Children – the user will enter the number of children the original patient reports to have and will be able to enter the names, ages, and other parent's information in a text box.
- Emergency Contact – User has a free text box to enter the emergency contact information. The user will be prompted to enter the relationship to the emergency contact.

2.5.4 Travel History

The user will enter in the information regarding the OP's travel history during the interview period. If the user selects that the original patient reported travel history within the interview period, the user will be prompted to fill out the following information (for up to ten trips):

- Where traveled (free text)
- Purpose of the travel – business or personal
- Arrival and Departure dates
- Travel Companions (free text)
- Local Sex Partners

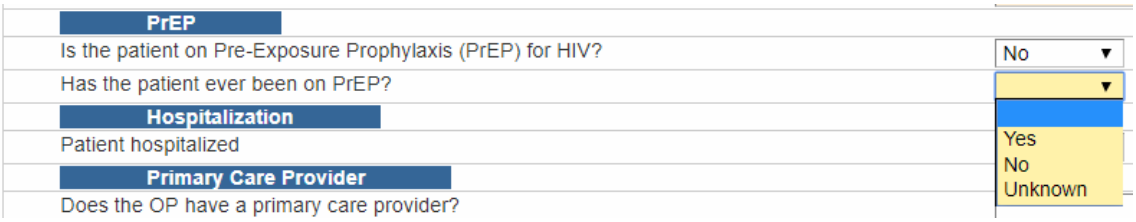


2.5.5 STD History

STD History is based on patient self-report and can be, but does not have to be, verified with the provider and record search. If the STD history is verified, the user should enter the information into the THISIS system if it does not already exist.

2.5.6 PrEP

The user will enter in any information related to Pre-Exposure Prophylaxis (PrEP) for HIV, as reported by the original patient. The user may enter if the patient is currently on PrEP. Note that the user may enter No for currently on PrEP, and will still have the option to indicate if the patient has ever been on PrEP



2.5.7 HIV Information

The user will enter the patient's HIV testing history. There are 3 mandatory fields for this set of questions:

Previously tested for HIV-User may enter:

- Yes
- No
- Refused
- Did not ask
- Unknown

HIV pre-test counseled at this event-User may enter:

- Yes
- No
- Unknown

Tested for HIV at this event-User may enter:

- Yes
- No
- No Known positive
- Refused
- Unknown

Ever taken any antiretroviral medications (ARV)?-User may enter:

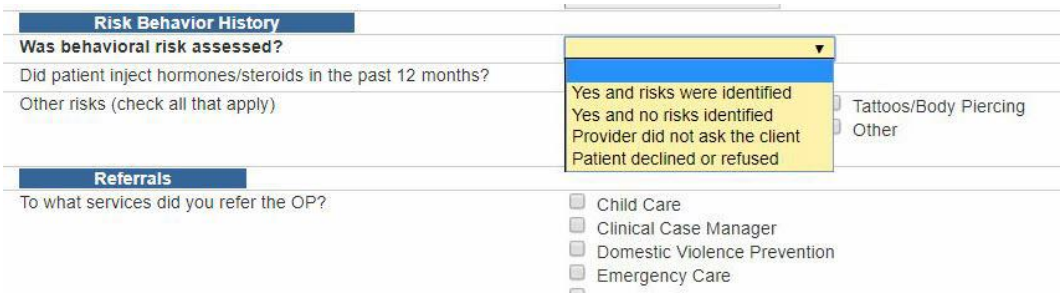
- Yes
- No
- Refused
- Don't know

The user may enter additional medical history comments in the free text box.

2.5.8 Risk Behavior

There are four possible responses to "Was behavioral risk assessed? The user may enter:

- Yes and risks were identified
- Yes and no risks identified
- Provider did not ask the client
- Patient declined or refused



"Yes and risk were identified is selected" then the following questions:

Sexual Behaviors for the past 12 months

The user will select sexual risk factors. The risk factors have follow-up questions for many of the options.

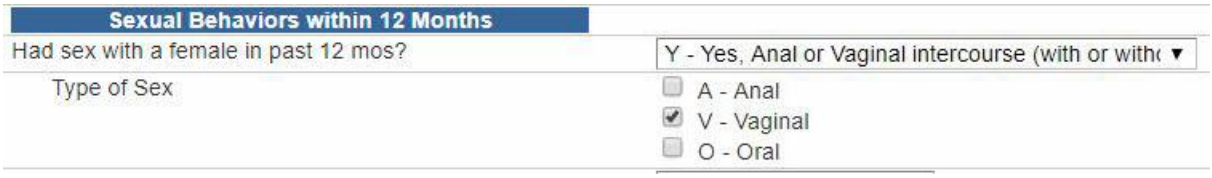
For example, for "Sex with a female partner in the past 12 months" the user may enter:

Y- Yes, Anal or Vaginal intercourse (with or without oral sex)
O- Oral Sex only
U-Unspecified type of sex
N-No
R-Refused to answer
D-Did not ask.

If the user enters "Y" the following fields appear:

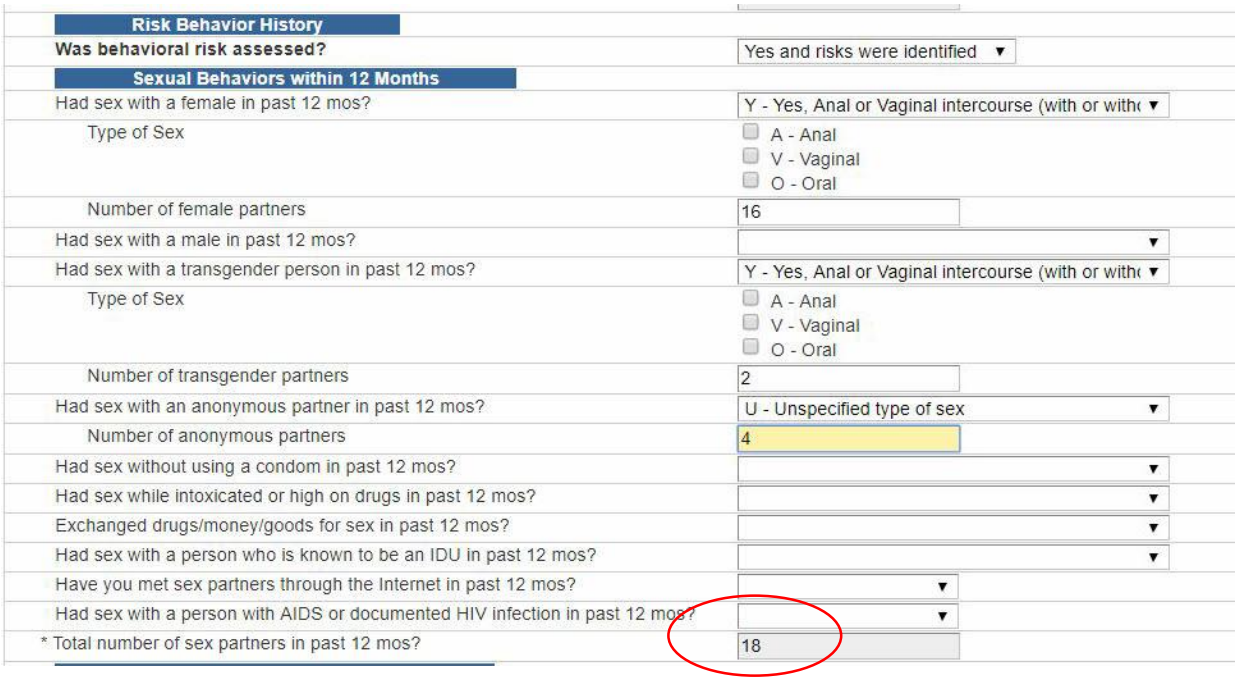
Oral
Anal
Vaginal

User would place a checkmark (√) in the corresponding box. For example:



Possible risk factors listed:

Had sex with a female in past 12 mos?
Had sex with a male in past 12 mos?
Had sex with a transgender person in 12 mos?
Had sex with an anonymous partner in past 12 mos?
Had sex without using a condom in past 12 mos?
Had sex while intoxicated or high on drugs in past 12 mos?
Exchanged drugs/money/goods for sex in past 12 mos?
Had sex with a person who is known to an IUD in the past 12 mos?
Have you met sex partners through the internet in the past 12 mos?
Had sex with a person with AIDS or documented HIV infection in the past 12 mos?



Note that the system will add the total number of sex partners for the first two questions.

Substance Use within 12 Months

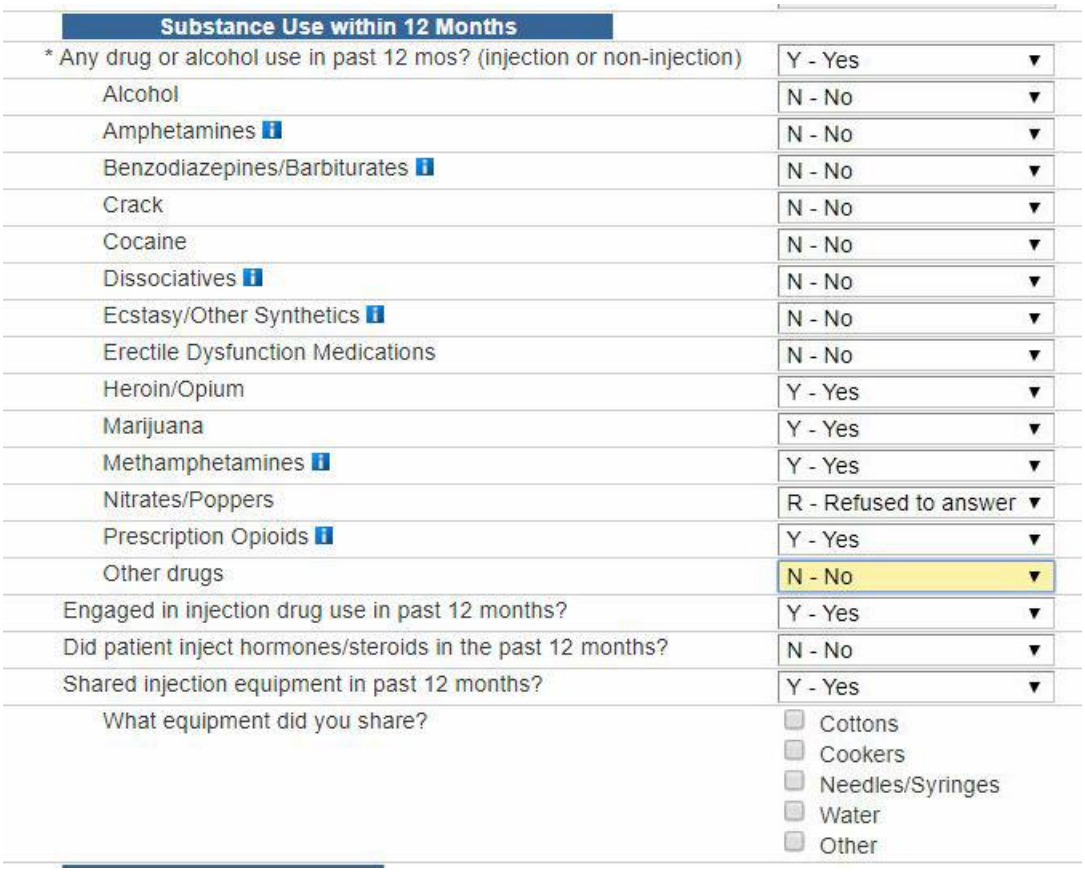
If "Yes" is selected for any drug use in the past 12 months then a set of child questions will appear. The user may select: Yes, No, Refused to Answer, or Did Not Ask.

- Engaged in injection drug use in past 12 months? - If "Yes" is selected a set of follow-up questions will appear, prompting the user to indicate

the type of drug that was used. If the user selects "Refused to answer" the system will not prompt for type of drug

The user will also be prompted to complete:

- Did patient inject hormones/steroids during the interview period?
- Shared injection equipment in the past 12 months?
    - What equipment did you share? - select equipment the original patient reports.



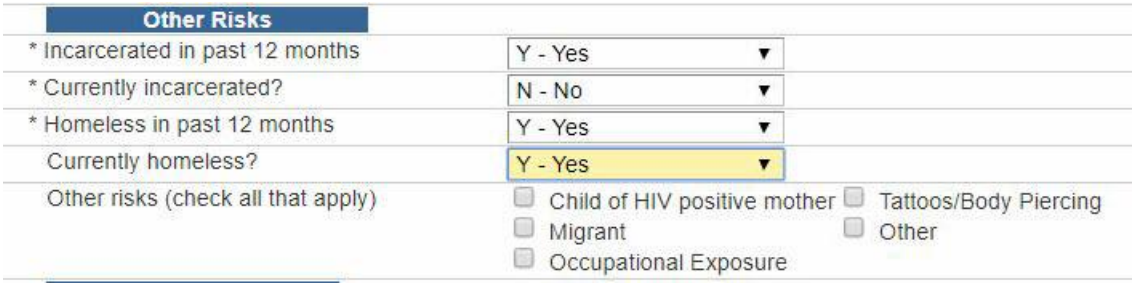
2.5.9 Other Risks

The user will enter information about other risks:

- Incarcerated – the user will enter "Yes, No, Refused to answer, or Did Not Ask" to indicate if the original patient has been incarcerated within the past 12 months.
- Homeless – the user will enter "Yes, No, Refused to answer, or Did Not Ask" to indicate original patient has been homeless within the past 12 months.

For each of the above questions, a Yes response will trigger a follow-up question to determine if the person is still incarcerated or homeless.

- Other risks – a multi-select list that allows to user to select other risk factors that are less common in the transmission of HIV/STD.

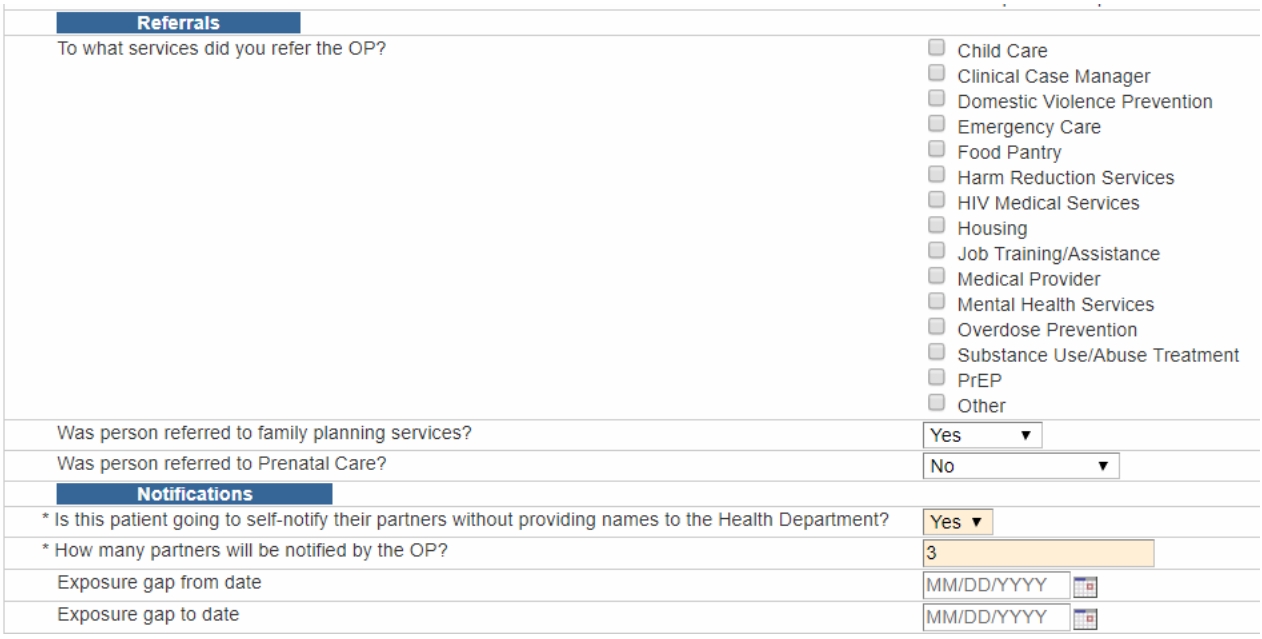


2.5.10 Referrals

The user will document any referrals made during the case management process. If the user selects **HIV Medical Services, PrEP or Family Planning/Prenatal Care**, the user will be asked to complete the provider, intake, and medical appointment information below the referral section.

Notifications

1. Is this patient going to self-notify their partners without providing names to the Health Department? – the user selects "Yes or No"
2. How many partners will be notified by the original patient? - The user will enter the number of partners reported.
3. Exposure gap – date field that the user can enter an identified exposure gap. If there are multiple gaps, enter the one of most concern.



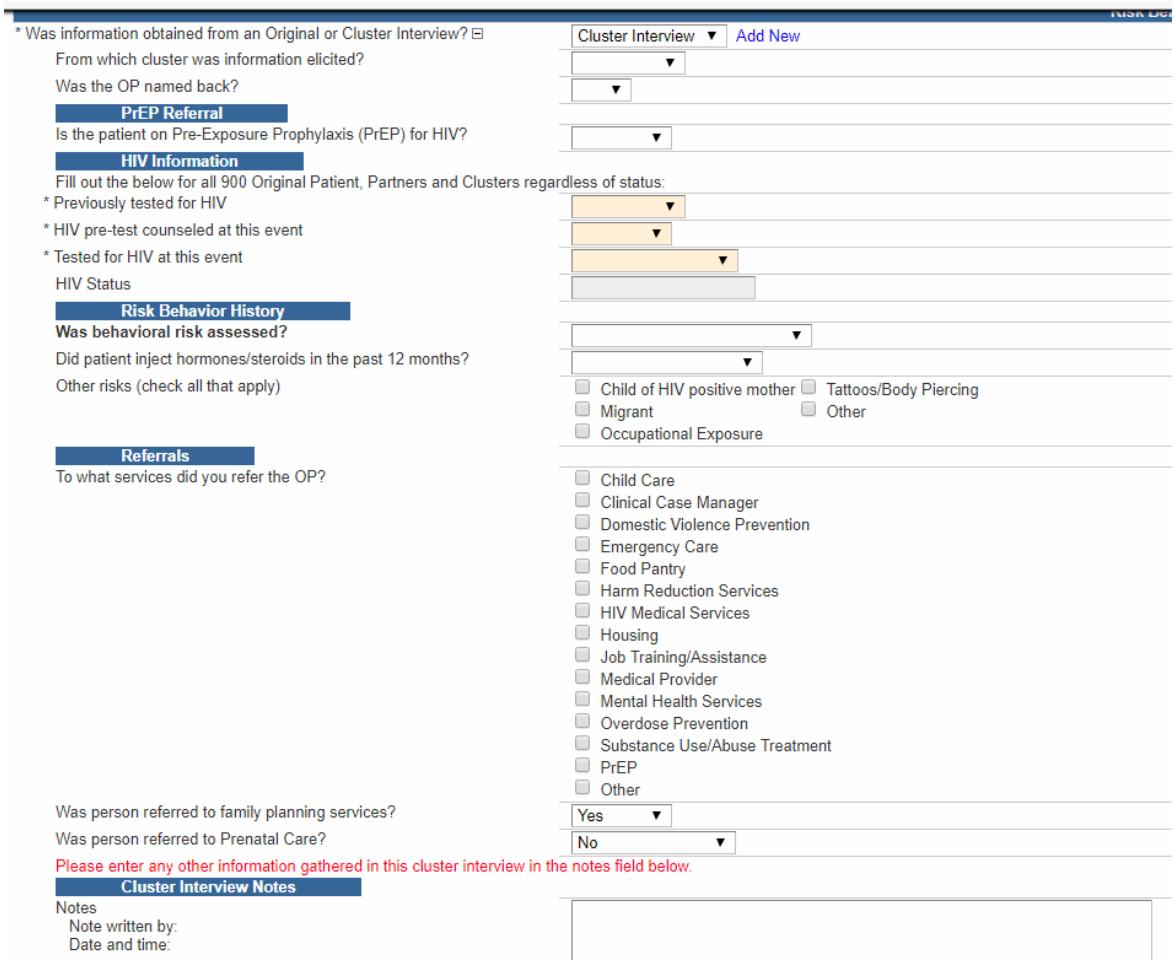
2.5.11 Cluster Interviews

This section of the system records cluster interview sessions. A cluster interview is conducted on a named partner, suspect, or associate who is **uninfected**. A cluster interview will be associated with the closed field record, so the user must be sure to disposition the field record and then indicate that a cluster interview occurred. This is where the date of interview will appear (Case Assignment/Field Record QP). The user will indicate the field record to which this interview is associated.
The user will then indicate whether or not the OP was named back. If the OP was named, the user will enter the reported exposure dates, as reported by the partner.

- Yes- Select if the original patient was named back; enter exposure dates (first, last, frequency) provided by the cluster.
- No- Select if the original patient was not named back by the cluster.

The rest of the cluster interview mimics the original interview risk behavior QP (see above). The user will enter in all information as reported by person on whom the interview is conducted.

Note that the user may enter additional notes from the interview after the referrals section.



2.6 Clusters and Partners

The Partner/Cluster QP captures information about partners and clusters identified during the course of the investigation.

2.6.1 Creating a new partner/cluster

The user will select from the pull-down menu where the contact information came from:

- Interview/Re-Interview- Select if the contact information was elicited from the infected index patient during an original or re-interview. When this option is selected the user will have the option to specify the interview from which the information was elicited.
- Cluster Interview- Select if the contact information was elicited from an interview with a non-infected sex partner or a non-infected social contact

of the index patient. It is designed to elicit information about the related index patient or other sex partners. Cluster interviews also elicit information about persons within the social network who might benefit from counseling, examination, or testing for HIV or other STDs when person who is not diagnosed with an infection names others who are connected to the original patient or the original patient's partners. If the user selects this option, they need to select the person who was clustered interviewed.

- Other- Select if the other two options are not appropriate
- The user must select the referral basis (the relationship of the named person to the original index patient).

- **ASSOCIATE** - Persons named by an uninfected partner, social contact, or associate
    - **A1** - Person who has or had symptoms suggestive of the condition documented
    - **A2** -Person who is named as a sex partner of a known infected person
    - **A3** - Any other person who is within the socio-sexual network and would benefit from an exam (i.e., someone who has engaged in a behavior that might put them at risk)

- **PARTNER** - Persons having sexual activities (of any type) or sharing needles with the original patient
    - **P1** - Sex Partner
    - **P2** - Needle sharing Partner
    - **P3** - Both Sex and Needle sharing Partner

- **SUSPECT** - Persons named by an infected person (e.g., the Original patient or an infected partner, social contact, or associate)
    - **S1** - Person who has or had symptoms suggestive of the condition(s) documented
    - **S2** - Person who is named as a sex partner of a known infected person
    - **S3** - Any other person within the socio-sexual network who would benefit from an exam (i.e., someone who has engaged in a behavior that might put them at risk or an out of period partner).

- **COHORT** - **C1** - A person identified through outreach screening efforts as a result of case investigation (i.e., common geographical area of residence or hangout). These individuals should be associated with the interview from which the "hangout" information was collected. The person was **not individually named** by anyone interviewed during case investigation. This may also be a venue or location identified as a place for partner selection.

- **MARGINAL- M-** , a contact without enough information to perform public health follow-up (PHFU) activities. (The referral basis for the marginal contact can be promoted to another level once enough information is obtained to initiate public health activities).

The user will assign the jurisdiction and user who will follow-up with the named person. The system will auto generate the Partner/Contact ID and the following questions will require an answer:

- **Search to see if contact exists with a related event** – the user will search for the person related to the original patient's event. If the individual is found, select him/her and select one of the following:

  - Use existing person, but create new event – Select if the person exists, but this is not a related event
  - Select an existing event for the person – Select if the person and related event exists in the system
  - Not enough info to link a person- select if there is not enough information to begin an investigation, this person will be entered as a Marginal contact.

If the person is not found in the system, the user will create a new disease event for the person and create a new event.

If the user selects "Marginal" as the referral basis, the only option will be to select "Not enough info to link a person." This will allow the user to enter in as much information as possible on the marginal contact without creating an actual person within the system. If the DIS receives additional information, this person can be promoted to a different referral basis and a field record may be initiated, creating a new event for that person.

2.6.2 Create a new event for the person

If the person does not currently exist in the system: the user will enter Last Name, First Name, Date of Birth, and Gender

Who will notify this Contact?

- Provider- Select if the health department will notify the named person
- Client- Select if the original patient will notify the named person
- Dual- Select if the original patient and an employee of the health department will notify the named person together
- Contract-Select if the DIS develops a contract with the original patient to notify their partners. If contract terms are not met, DIS will conduct notification.
- Third Party-Select if another provider notifies the named partner. For example, if a private medical provider (non-health department notification) is going to contact the named partner for testing or treatment, the user will select this method of contact.

Please note: The user will select Yes for "Create Contact Field Record". This will lock the Partner/Cluster created and the user will make updates in the partner/cluster event. Should the user need to make changes to the Partner/Cluster question package, the user will "null" (erase) out the "Yes" response to creating a contact field record and the fields should be unlocked and editable. The user will then have to "re-lock" the partner/cluster in order for the field record to be available for editing.

Is this person the spouse of the original patient?

The following questions need to be answered by the user under each heading:

Contact's Address-

- The user will enter information obtained to identify the best physical address to contact the patient and additional contact information such as email or phone number.

Locating Information-

- The user will enter additional locating information on the patient obtained from the original patient.

Exposure and Follow-Up

- Current Marital Status?
- Spousal Notification required (HIV cases only)
- Exposure Dates First and Last: Enter the corresponding dates reported by the original patient for exposure

- Frequency: -Select from drop-down list the frequency at with the exposure is reported by the original patient.
- Additional questions will appear depending on the referral basis and product code selected.
- If an associate was selected as the referral basis, then the following question will appear:
- Was this person ever a sexual/needle sharing partner of the OP (Original Patient) (This field is only available for referral bases of Suspects and Associates)?
    - If yes, is selected then **ENTER** the First and Last Date of exposure as well as the frequency.

If 900 HIV product code is selected, the following questions will appear:

- Is this an acute case of HIV?
- OP stage of HIV?

Locating Information/Other

- Locating Information/ Other – The user will enter information gathered from the original patient regarding any locating information.
- Employment information –The user will enter any information pertaining to employment.

Physical Attributes/Description

The user will enter Height, Weight/Build, select visible physical identifiers, hair color, eye color, and complexion. Additional notes about the contact may be entered in the **Text Box**.

Once the partner or cluster is created , the information will be locked. To edit the partner/contact information, GREEN text instructs the user to select "**To edit fields, clear the create question above. When ready to commit changes, set create question above to Yes and Save."**

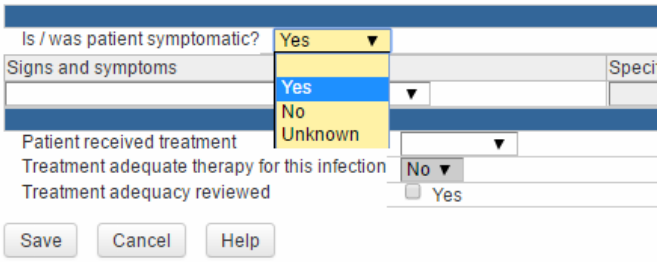
The user can add new partners and cluster by selecting Add New. The number of Partners, Suspects/Associates, Cohorts, and Marginals entered in the Partners/Clusters question package will auto calculate and appear in the Case Assignment/ Field Record QP under the interview information.

2.7 Clinical

The clinical question package is disease specific. It is predominately used for documenting the symptom a patient has and treatments the patient receives for the infection. The user should only enter disease specific information. This section is for documenting the symptoms, treatment, and pregnancy status of the patient.

2.7.1 Documenting Symptoms

Select from the drop menu (YES, NO, UNKNOWN)



Signs and Symptoms

If the user wishes to document the signs and symptoms, select from the drop-down menu. Note: Symptoms known to be related to primary, secondary and neuro syphilis are "flagged" to assist the system with determining proper case classification and neuro involvement. This means that a concern will be generated if the symptoms entered are inconsistent with the selected diagnosis. If the user selects other symptoms, the user will be prompted to document the symptoms. Most of the treatment lists are limited to the disease, so there are not a lot of options for the users to enter non-disease specific information.

- **Earliest observation date** – the user will enter the date the symptom was noticed, by either the patient or the clinician (the earliest occurrence).
- **Anatomic site** – the user can select all of the anatomic sites affected by this symptom.
- **Clinician Observed** – whether or not the clinician saw or identified the symptom.
- **Patient Described** – this is when the patient is able to describe the symptom, which was either observed or not observed by the clinician.
- **Duration** – the estimated number of days the symptom existed. This can be entered as '9999' for unknown duration.
- **Interview Elicited From** (select from drop-down list) – if this patient has an active interview associated with this event and symptom information was

obtained from the interview with the Disease Intervention Specialist or supervisor, an interview can be selected.

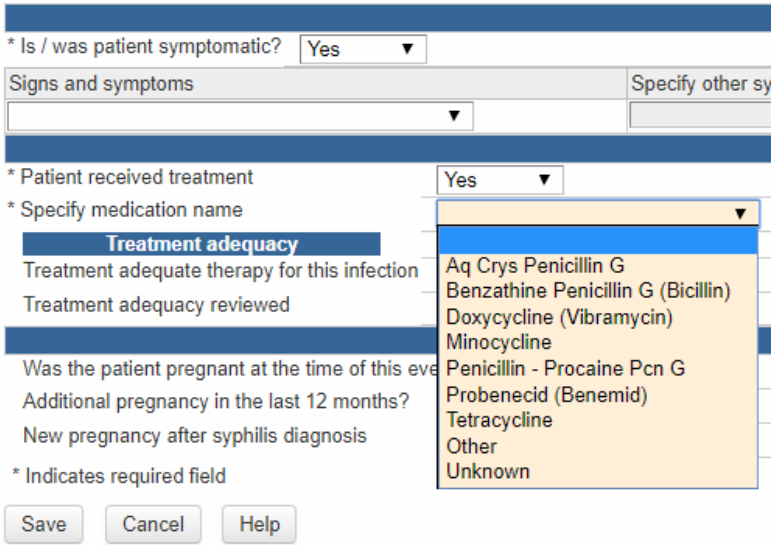
Treatment

The user will be able to enter treatment specifically associated with the disease event. Treatment information for HIV is not available from this screen. HIV medications will be tracked in the AIDS Case Report Form (ACRF) question package). Medication options will be limited to treatments deemed appropriate according to the CDC Treatment Guidelines. If another drug is used to treat the patient that is not on the list, the user will select Other and then enter the drug name/dosage/frequency/duration.

- **Medication Name** – name of the drug used to treat the patient
- **Dose** – pre-selected dose amounts
- **Frequency** – pre-selected frequency amounts (e.g. – BID, x3)
- **Duration** – how many days or weeks the treatment will be administered
- **Start Date Unknown**– select only if the start date is unknown
- **Date Treated** – treatment start date

Treatment Adequate for this infection – Will be determined by the treatment information entered above and selected diagnosis in the morbidity question package.

- **Override Treatment Adequacy** – reserved for Central Office staff to override treatment adequacy when treatment is reviewed and deemed adequate treatment, even although the treatment is not recommended by CDC.



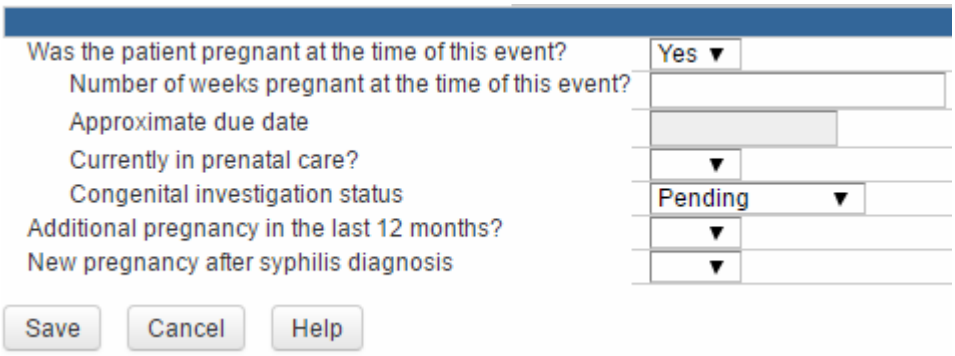
Pregnancy Information

If the patient is pregnant at any time during the investigation related to this event, or 12 months prior to the event, the user will document pregnancy information in this section. The user now has the option to enter additional pregnancies when a person was previously diagnosed and appropriately treated for syphilis, but a congenital report needs to be filed.

- **Was the patient pregnant at the time of this event?** – This field will be automatically populated if a lab is imported with pregnancy information documented. The user will be allowed to update this field as more information is obtained.
- **Number of weeks pregnant at time of this event?** – User will enter up to 44 weeks gestation. If pregnancy gestation is unknown, the user can enter 999.
    - **Approximate Due Date**? – This is a calculated field and is non-editable and will be calculated off of the event create date and the estimated weeks of gestation.
    - **Currently in prenatal care?** – The user will answer whether or not the client is currently receiving prenatal care.
- **Additional pregnancy in last 12 months**? – the user will enter any additional pregnancies during the past 12 months.
        - **Pregnancy outcome?** – if the patient was pregnant during the past 12 months, even if pregnant at the time of exam, the user will enter in the outcome of the additional pregnancy.
        - **Date of outcome?** – the user will enter in the outcome of the additional pregnancy.

New pregnancy after diagnosis?- If user selects Yes, the following fields are populated:

- Date of pregnancy reporting
- Number of weeks pregnant at time of lab report
- approximate due date (auto-populated)
- Currently in prenatal care
- Congenital investigation status
- Weeks remaining in pregnancy (auto-populated)



Congenital investigation status? – this will be automatically populated as "pending" for syphilis events with morbidity involving pregnancy. The user will update the status once the case report (Congenital Question Package in the Congenital Event) is completed. If a congenital investigation is updated as "Not Completed," the user will be prompted to justify why and the event will be sent to Central Office for review.

2.8 Venues

The Venue Question Package offers opportunities for the user to identify partner selection venues based on venue type and venue name. The user will enter venues where the original patient selects sex and/or needle sharing partners. The user will have the opportunity to enter in new venues as they are identified. Quarterly, central office staff will update the reference table so the reported venues not previously available will be included in the drop-down.
Venues will be able to be added to the case relationship analysis which will be available in a later version of THISIS.

2.8.1 Venue Type

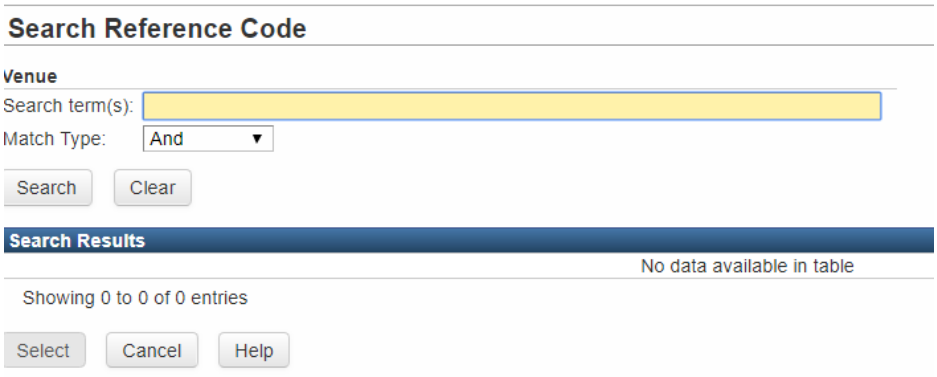
User will select a venue type from the drop-down list. Venue types include: bars, internet, phone apps, adult bookstores, parks, streets, etc.

2.8.2 Venue Name

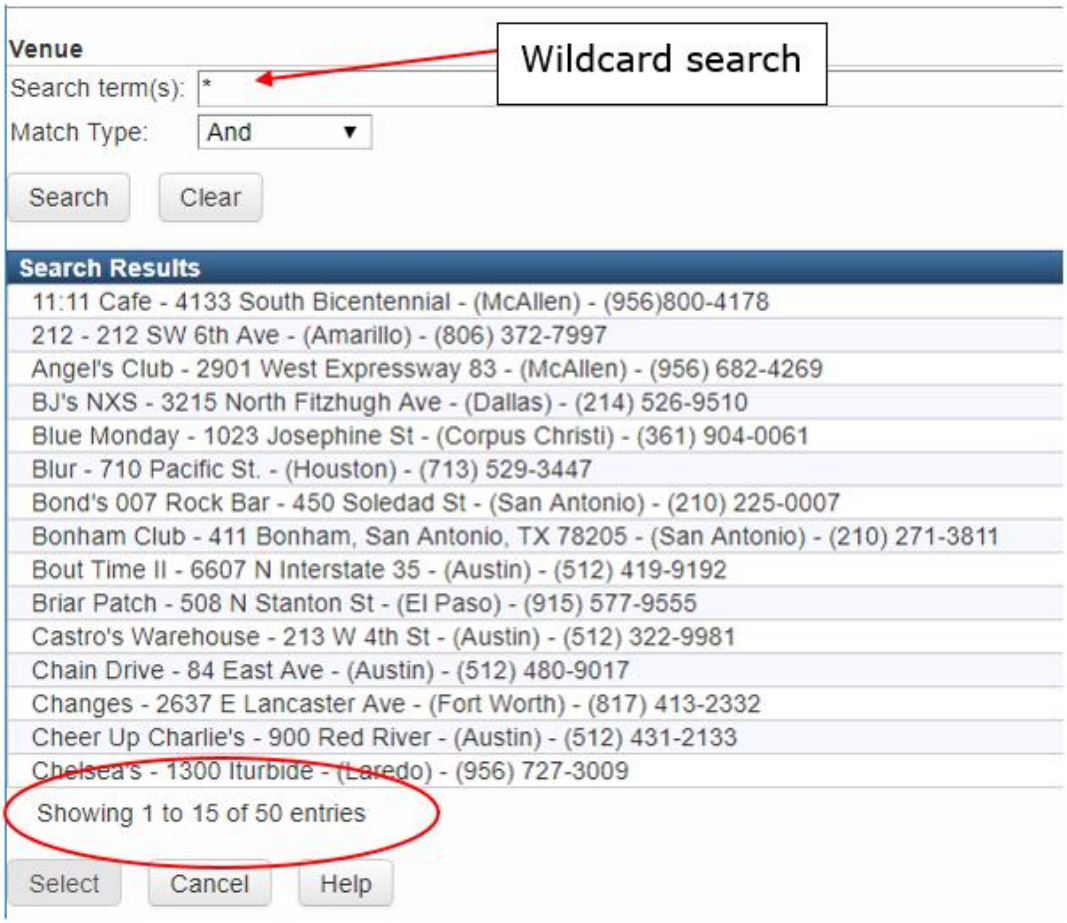
Once a type is selected, enter the name of the venue. If the venue is not listed, click on the magnifying glass to search. Once on the search screen, the user can

see all venues listed in that type by typing in "*". Once the user has identified the venue name in the search screen, the user can select from the search screen and they will be taken back to the venue question package.

Selecting the magnifying glass icon, next to the trash container will bring up the following screen:



The user may search for a venue by name, or enter the wildcard (*).



Note there are several more pages of results.

2.8.3 Activity

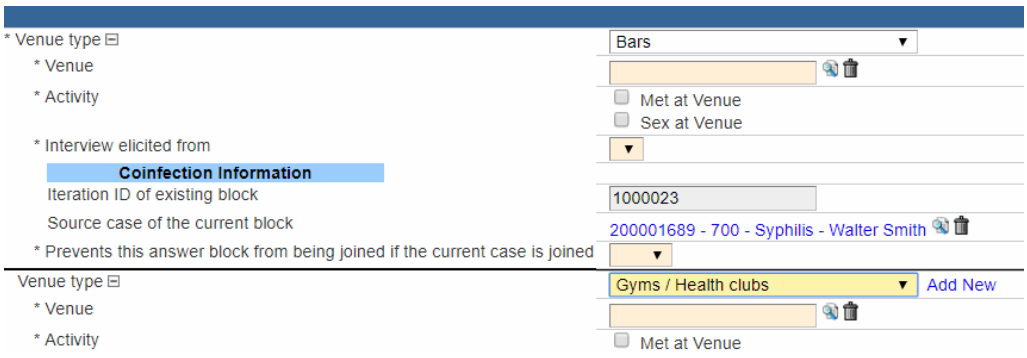
The user will be able to select whether this venue was used by the OP solely as a partner selection venue, or if sexual activities occurred at that venue.

2.8.4 Interview Elicited From

The user will have the opportunity to select which interview identified this venue. It will be possible that the OP will have multiple 900 Original interviews, and venues will change over time.

2.8.5 Multiple Venues

The user may add multiple venues. After one venue is entered, select "Add New" for additional venues.



Chapter 3 Enhanced Activities

Learning Objectives:

- Identify Enhanced Activities.
- Enter Enhanced Activities in THISIS.

Overview of Enhanced Activities

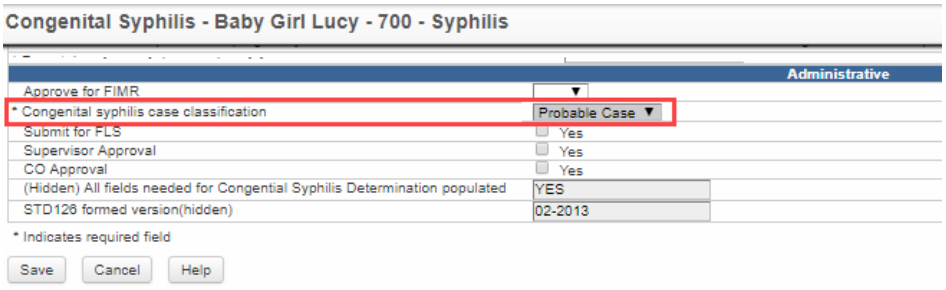
Enhanced activities occur for situations that fall outside the routine of public health care follow-up. Examples include congenital syphilis cases and connecting people who are out of care back into the HIV care system.

3.1 Congenital Syphilis

Details on the initial creation of a congenital syphilis event are described in Chapter 2.3.5: Congenital Investigation.

This section is for the reporting of all congenital cases (non-cases, probable, stillborn and confirmed). Recall that the congenital syphilis designation is reserved for patients 10 years old and younger. The congenital syphilis question package should be completed by the person completing the congenital investigation.

In the Congenital Syphilis question package, ***required fields*** *(marked with an * and response fields are filled in a light-yellow color)* ***will be mandatory prior to saving the event.*** Once the form is completed and the user has confirmed all required fields are answered, the user must select *Save* or *Save & Stay*, then the system will automatically generate a case classification based on the information entered.



Once the case classification is determined, a congenital case ID will be generated. Once the case classification and the congenital case ID are completed, the system will generate a congenital morbidity for reporting purposes if the case is classified as a probable, stillbirth or confirmed case. Once completed, the case will be ready to submit to the CDC for reporting purposes.

3.1.1 Prior to entering a congenital event:

For all congenital syphilis investigations, regardless of whether or not the baby is infected or the baby's vital status at time of birth, the user must create a THISIS event for the baby (the congenital QP is only available in a child's event); however, it should not be created until an investigation occurs (e.g. when a baby is born or pronounced as deceased/stillborn). There should also be a syphilis event for the mother (this event can be created prior to the congenital investigation), which will be linked to the baby's congenital event. For example, if Jane Doe had a stillborn, the user will create an event for Jane Doe **and** an event for Baby Girl Doe, then link Baby Girl Doe's congenital investigation question package to Jane Doe's syphilis event.

The steps to complete this process in THISIS are as follows:

1. Search the system for the mother's event or record. If you have never entered data in THISIS for the mother before, use the Create Event button in the toolbar to conduct this search. See Chapter 3 of the Core Manual for more information about searching and creating events.
2. If the mother's event or record is not located in the search but information about her is available to enter into the database, the user will create a new event for her in THISIS (following instructions on creating events in Chapter 3 of the Core Manual). Be sure to enter the mother's demographic information all other event details – including labs, morbidity and clinical data – as all of these are used to make the case determination for the baby.
3. Search for the baby's event or record. If the baby's event is not located, the user will create a congenital event for the baby, making sure to enter the baby's demographics. Remember, the baby's date of birth must be within the last 10 years in order for the congenital question package to show up.
4. Once the event is created, the user will fill out the congenital question package.

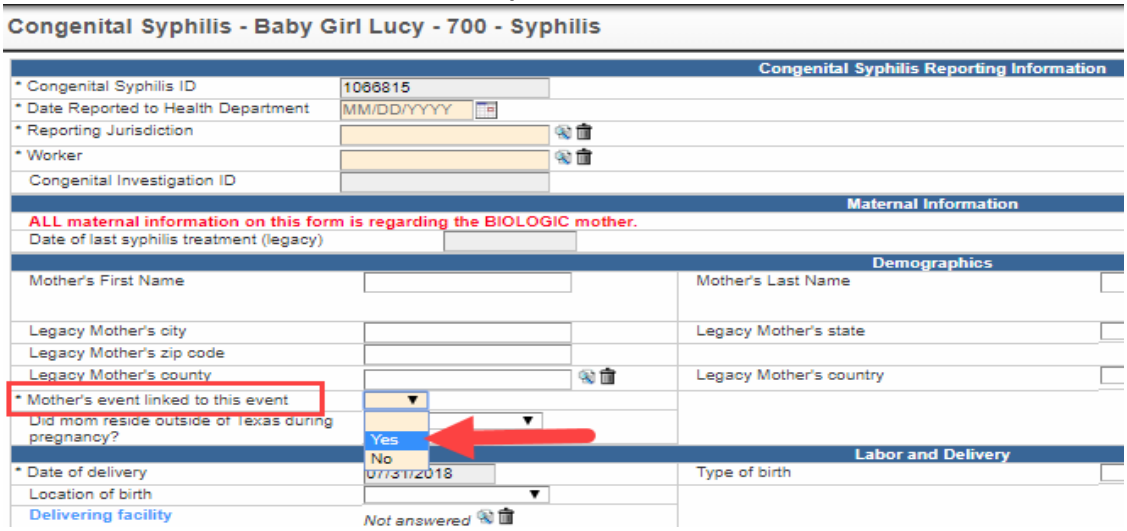
3.1.2 Entering Maternal Information in Child's Congenital Syphilis Question Package

All information entered in this section is for the biological mother

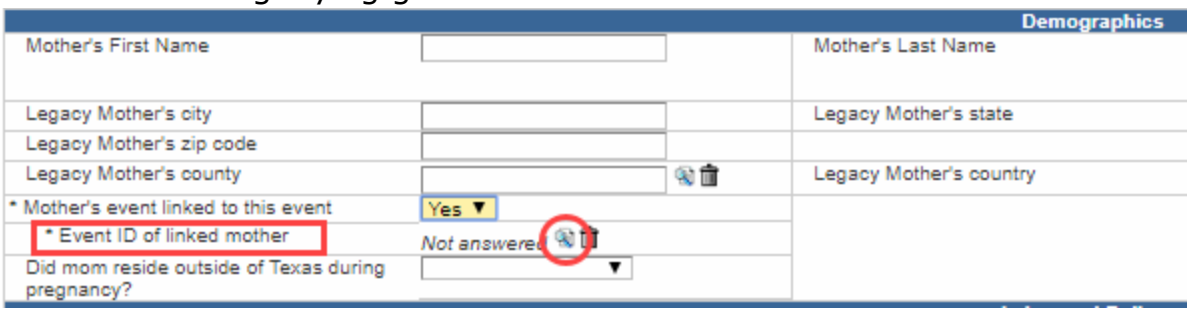
1. Demographics: User will select the maternal syphilis event linked to this congenital event, if known. Once the event is selected, the demographic fields will be populated.

   To link congenital event to mother's event, follow the steps below:

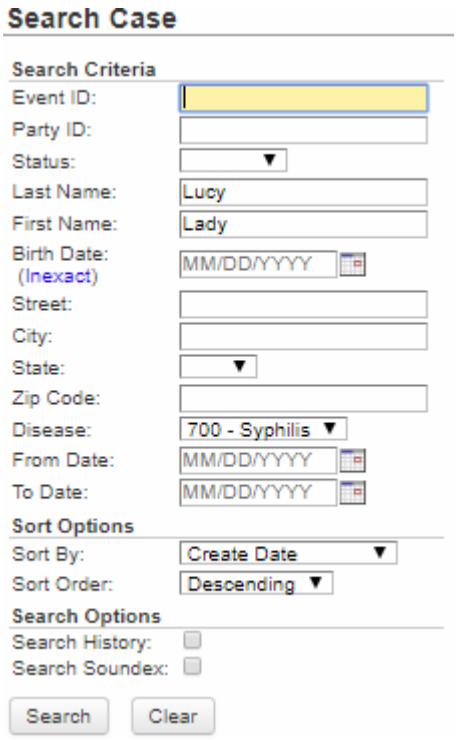
   1. Select 'Yes' for the field that says, 'Mother's event linked to this event.'



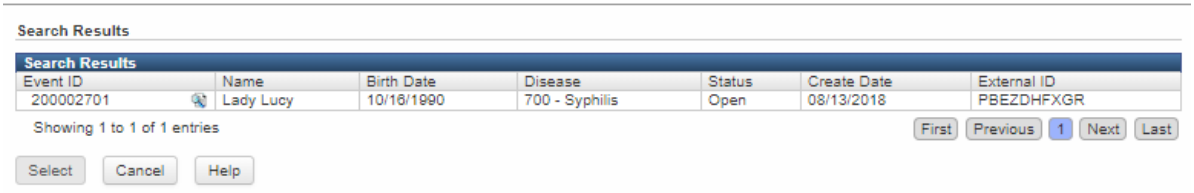
   2. After selecting Yes, a new field will appear: 'Event ID of linked mother.' Click on the magnifying glass next to it.



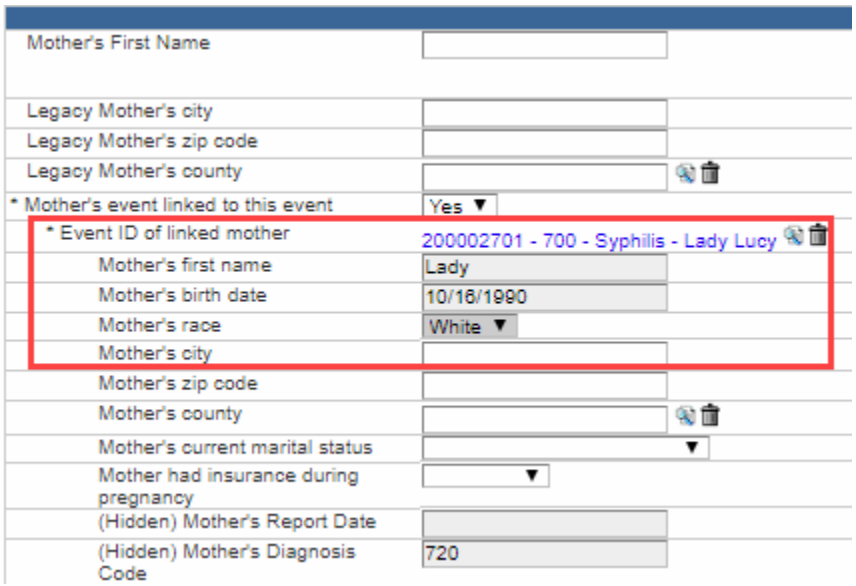
   3. Enter the mother's information into the Search Case window



4. Find the correct result and double click.

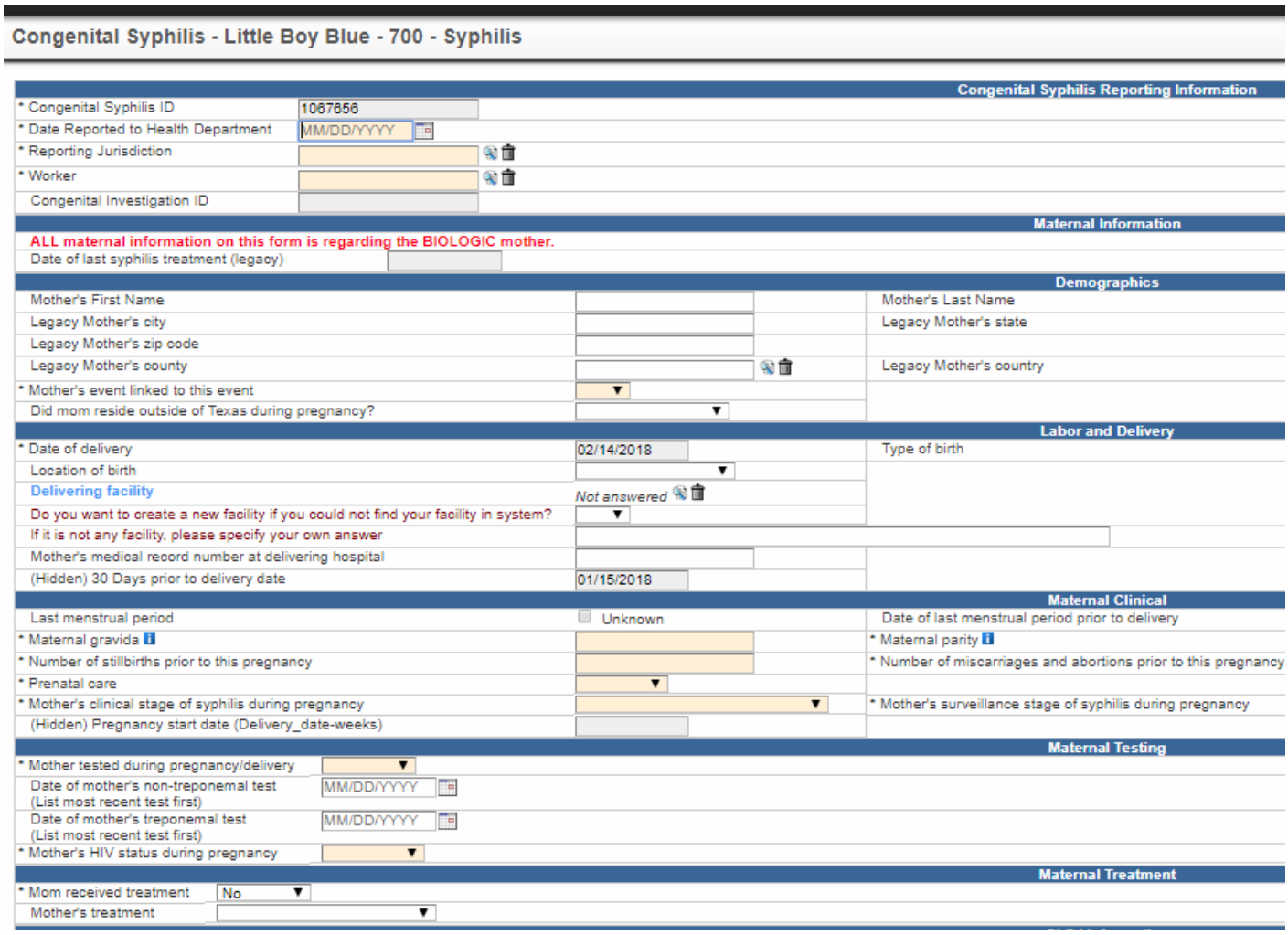


5. The mother's syphilis event will now be linked to the baby's congenital event



2. Labor and Delivery: this will include information specific to this delivery event.

3. Maternal Clinical:
    a. *Gravida:* number of times a mother has been pregnant
    b. *Para:* number of deliveries >20 weeks, including stillbirths. Multiple births such as triplets, counts only once
    c. *Stillbirths:* (if known) the number of known stillbirths prior to this pregnancy. This is a subset of Para.
    d. *Abortus:* number pregnancies lost, including induced. Stillbirths (> than 20weeks) do not count in this category
4. Clinical stage vs. Surveillance Stage – these can vary. The surveillance stage is used to determine whether or not the mother received adequate treatment for her stage of infection.
5. Maternal Testing
    a. Testing during pregnancy – user must identify when the mother received testing during pregnancy (first prenatal, third trimester, and during delivery)
    b. Labs – user must enter in the maternal syphilis labs related to this syphilis event. The user will enter the most recent first. There is the opportunity to add the treponemal and non-treponemal labs in this section.
6. Maternal Treatment – Mother's treatment adequacy will be pulled from the mother's clinical question package

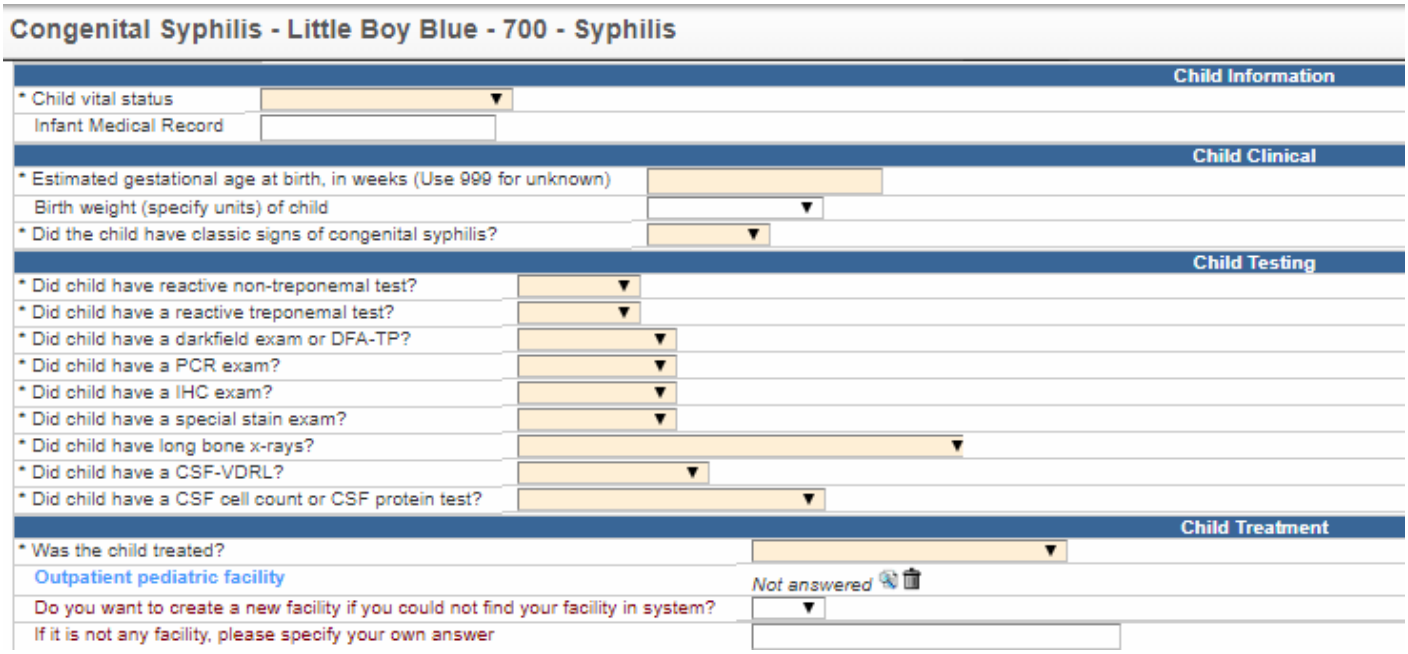


3.1.3 Entering Child's Information in Congenital Syphilis Question Package

1. Date of Birth – the date of birth of the child (if known) will be auto-populated from the child's party information.
2. Child Vital Status
    a. Born Alive and Still Alive.
    b. Born Alive and then died – fill out death information Update DOD in the person tab.
    c. Stillborn – fill out death information. Update DOD in the person tab, if available.
3. Child Clinical
    a. Birth weight can be entered as grams or pounds and will be converted automatically for user's reference. The grams will be used for reporting purposes.

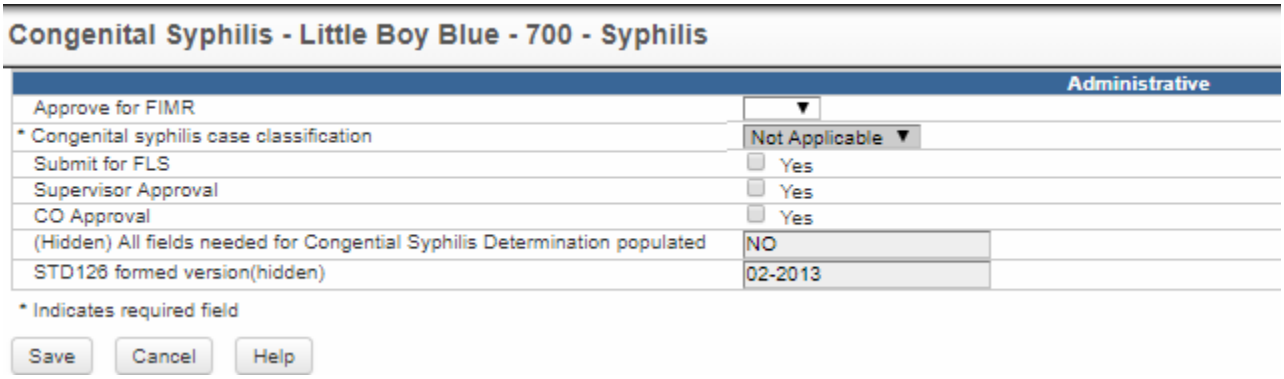
b. Classical signs of congenital syphilis – if the user enters that the child displayed classic signs of congenital, a multi-select list will appear. If the symptoms are late congenital syphilis, the user will select "Stigmata" and then select from an additional multi-select list.

4. Child Testing – the user will enter all tests performed on the infant related to congenital syphilis event.
5. Child Treatment – the user will enter all treatment information related to the congenital syphilis event.



3.1.4 Reporting Information (Administrative Section of Congenital Syphilis Question Package)

1. FIMR Eligible – this will be populated for all confirmed, stillbirths, and probable cases from identified jurisdictions.
2. Approve for FIMR – central office staff will review the case eligibility for FIMR
3. Case Classification – this will be auto-generated based on the CDCs case definition. The field will not be populated until all required fields in the congenital syphilis question package have been answered *and saved*.
4. Submit for FLS – once the DIS has completed the congenital form, they will submit to the FLS for review and approval.
5. Supervisor Approval – the FLS will approve the congenital report once the form is submitted and all requirements are met.
6. CO Approval – the central office staff will review and approve the case report.



3.2 Data to Care

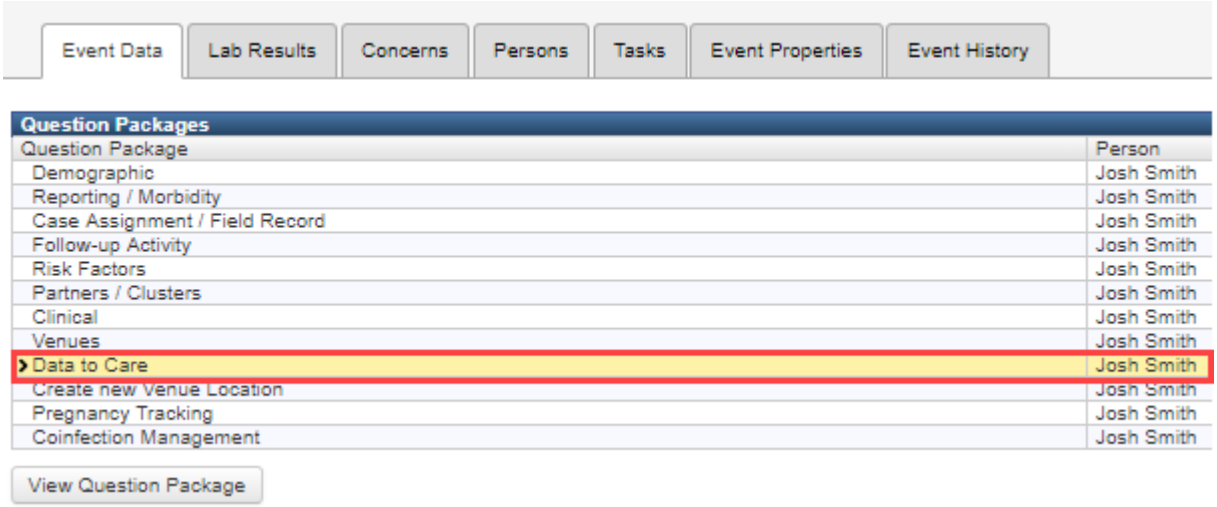
The Data to Care (DTC) question package captures information about Data to Care specific follow-up work assigned to THISIS users. In this QP, users will have the ability to select eligibility for Data to Care activities as well as provide information about the outcomes of an investigation when work is complete. The Data to Care QP is to be completed when users are tasked with re-engaging persons living with HIV who have no recent evidence of receiving medical care.

3.2.1 Overview

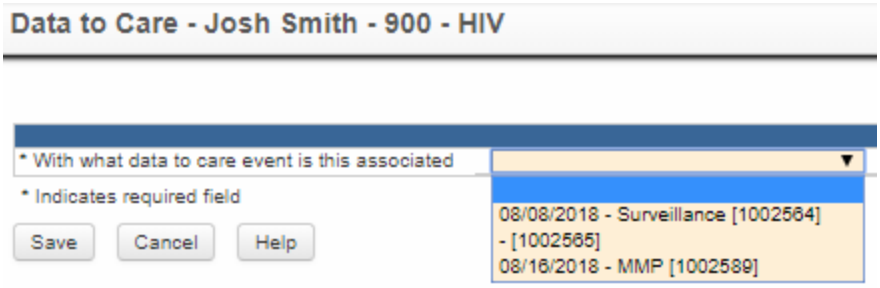
Details on creating a Data to Care assignment are described in Chapter 2.3.6: Data to Care. The process of creating the assignment is completed in the Case Assignment/Field Record question package.

After the Data to Care assignment has been created, it will appear in the 'Data to Care Require Follow Up' workflow queue for all STD users in the assigned jurisdiction. A specific user should be assigned to the case, and it is then that user's responsibility to handle the DTC activities and get the assignment out of the workflow queue. In some instances, however, a specific user may not be assigned so the STD staff in that jurisdiction will need to choose someone from their staff to work on the assignment.

Once the user is assigned or selected, s/he will open the Data to Care question package in the HIV event for the person needing to be re-linked to medical care, then follow the steps listed below.

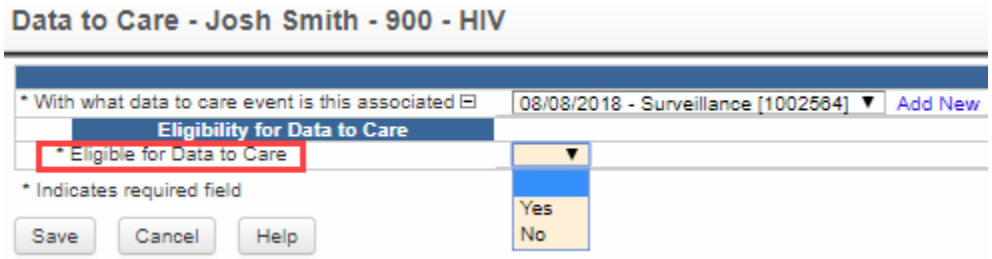


1. Select a response for the question that appears in the Data to Care question package, 'With what Data to Care event is this associated?'. This question is referring to the initiation source—the response should indicate which initiation source (specified in the Case Assignment/Field Record question package during the creation of the DTC assignment) led to the initiation of a Data to Care investigation. If more than one source exists, choose the most recent one.



2. Conduct a record search to see if the person is eligible for Data to Care.
3. Once the record search is complete and eligibility status is determined, open the Follow-up Activity question package to record details about the search. Instructions on entering this information are described in Chapter 2.4: Follow-Up Activity.
4. Return to the Data to Care question package and select appropriate response for the 'Eligible for Data to Care' field.

   A person is considered to be eligible for Data to Care if record searching efforts result in no evidence of medical care or if the person still lives in Texas, but in a jurisdiction other than the one to which it was originally assigned (the jurisdiction where the staff member conducting the investigation is located).



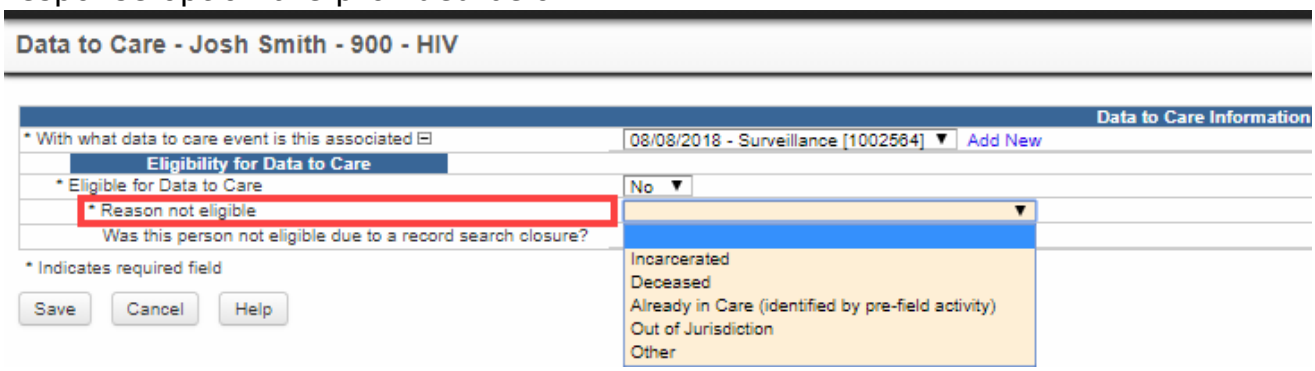
5. If the person is determined to *not* be eligible for Data to Care, continue to the next section, 3.2.2: Not Eligible for Data to Care.

   If the person is determined to be eligible for Data to Care, continue to section 3.2.3: Eligible for Data to Care.

3.2.2 Not Eligible for Data to Care

After completing the record search, proceed with the following steps if the user determines the person is *not* eligible for Data to Care:

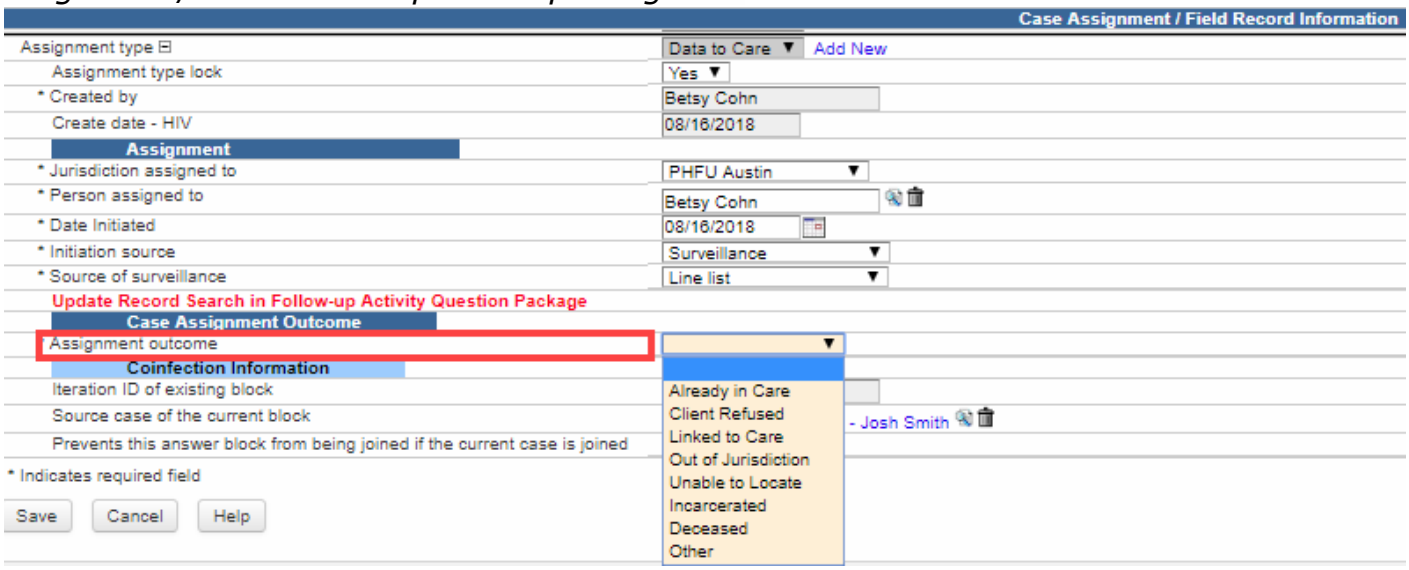
6. In the Data to Care question package, select 'No' from the drop-down menu as the response to the field, 'Eligible for Data to Care'.
7. A new field will appear asking for a reason not eligible. From the drop-down menu, select the reason why the person is not eligible for Data to Care. Depending on the reason, the user may need to provide additional information. Descriptions of each response option are provided below.



- **Incarcerated-** Enter the facility where the individual is located.
- **Deceased** – Enter death information.
- **Already in Care (Identified by pre-field activity)**- Enter the date of the last medical visit or CD4/VL and facility where the person currently gets care.
- **Out of Jurisdiction**- Enter city, state, and country where the person resides. *This is reserved for persons who now live out of state.*
- **Other-** Document in the free text box.

- **Was this person not eligible due to a record search closure?** - The user will select Yes, if record searching was the only activity conducted to determine if the person was not eligible.

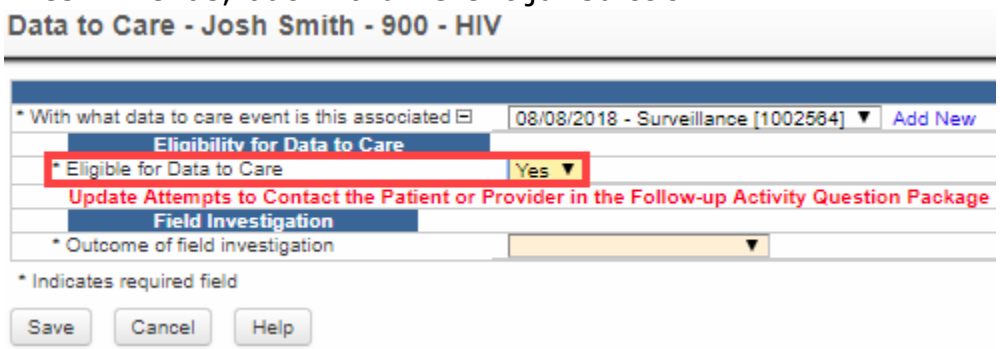
8. For *all* Data to Care assignments (regardless of whether the person is eligible or ineligible for DTC), return to the Case Assignment/Field Record question package. In the Case Assignment Outcome section, select response for 'Assignment outcome' field. This step closes the assignment and completing this task will get the assignment out of the workflow queue. ****User must provide the outcome of the investigation in BOTH the Data to Care question package and the Case Assignment/Field Record question package****



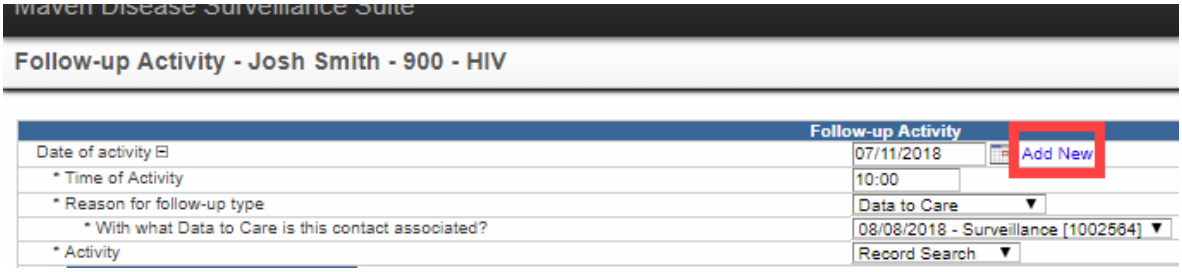
3.2.3 Eligible for Data to Care

After completing the record search, proceed with the following steps if the user determines the person is eligible for Data to Care:

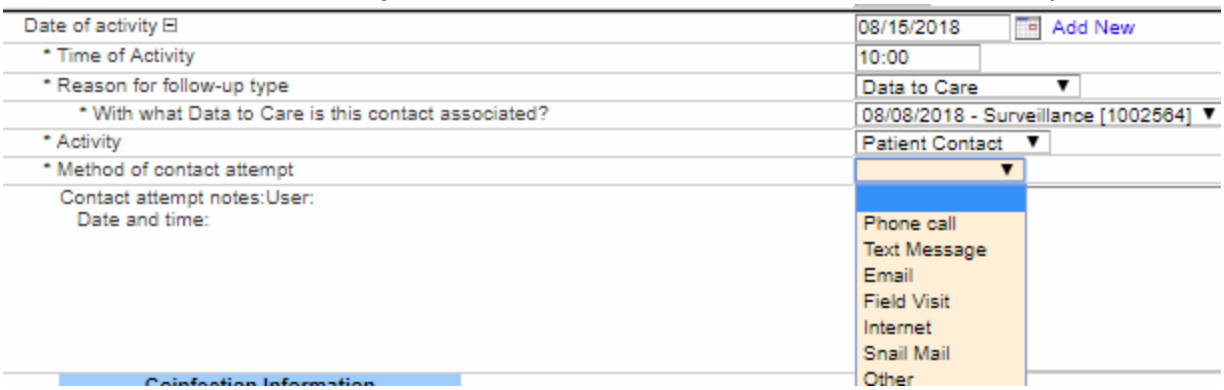
6. In the Data to Care question package, select 'Yes' from the drop-down menu as the response to the field, 'Eligible for Data to Care'. As a reminder, 'Yes' should be selected if there is no evidence of a person being in medical care or the person still lives in Texas, but in a different jurisdiction.



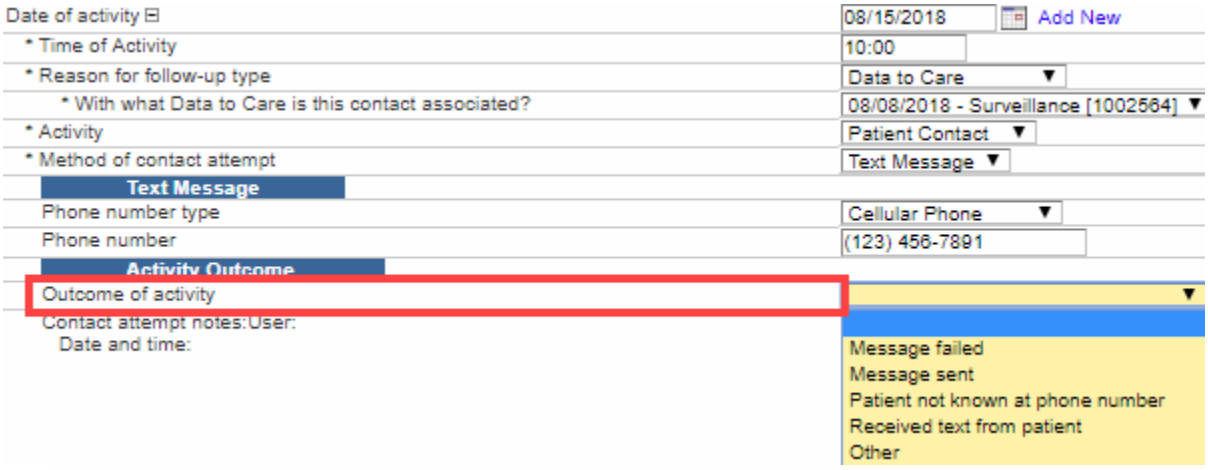
7. Red text will appear instructing the user to "Update Attempts to Contact the Patient or Provider in the Follow-up Activity Question Package." This is where the user will document all activities associated with contacting the patient and/or provider in an effort to re-establish medical care for the patient.
    a. Open the Follow-up Activity question package.
    b. The record search should already be documented in this question package as an activity, so user will click the 'Add New' link located next to the date associated with the record search.



    c. A new set of fields will appear to enter information for the additional follow-up activity. Enter date of activity, time of activity, reason for follow-up type (select Data to Care), the Data to Care source associated with the contact, the type of activity (in this case it will often be 'Patient Contact' or 'Provider Contact'), as well as the method of contact attempt.



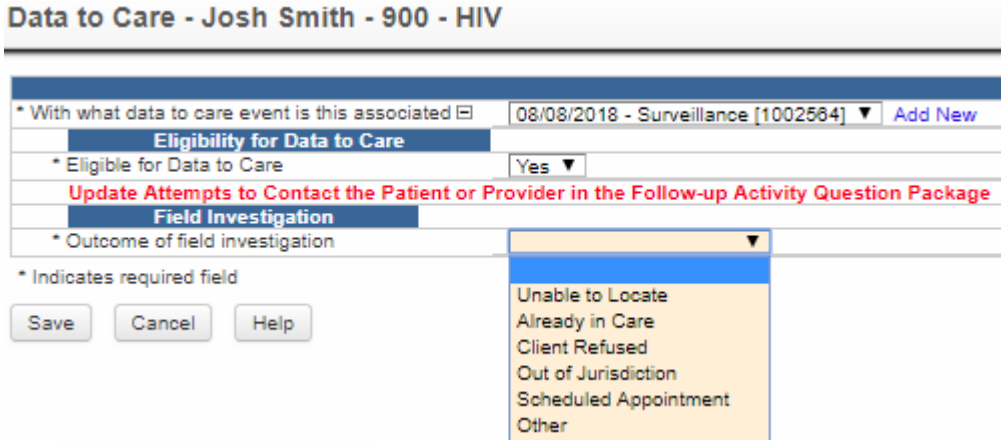
    d. Additional questions will appear when a method of contact attempt is selected. Provide responses to the follow-up questions.
    e. Select a response for the 'Outcome of activity' to report the outcome of attempting to contact the patient or provider.



f. If the user has any notes about the contact attempts, this should be noted in this section.

g. Repeat steps b-f for any additional attempts to contact the patient and/or provider as part of the Data to Care activities.

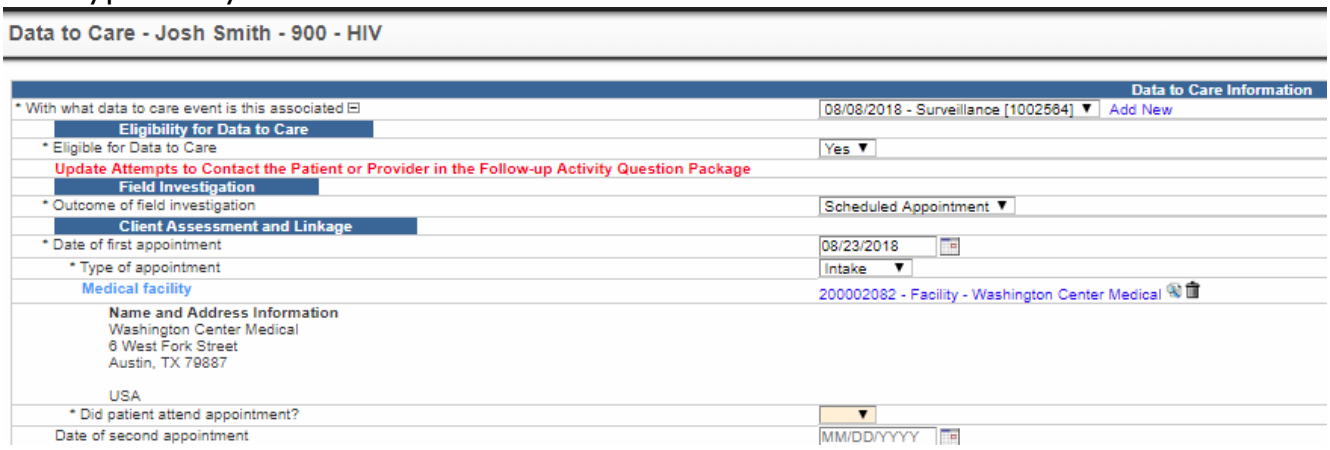
8. Once the DTC investigation is completed, open the Data to Care question package and provide a response to 'Outcome of field investigation' and answer all follow-up questions associated with the selected outcome. Descriptions of each outcome are described below.



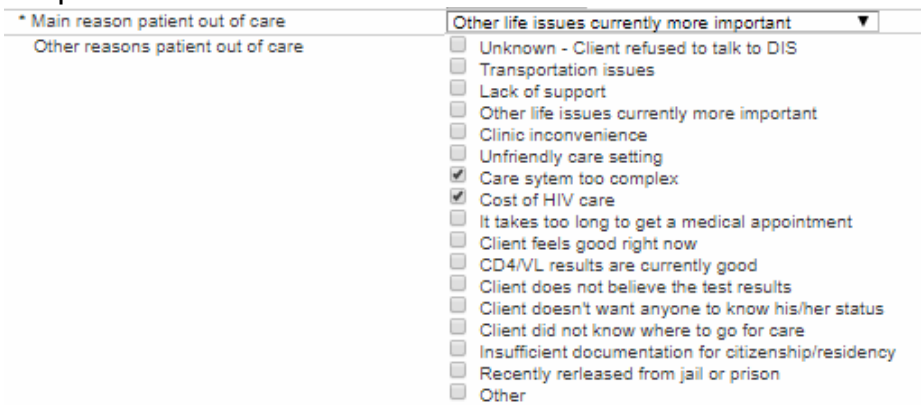
- **Unable to Locate:** If the user is unable to get in touch or locate the person, select Unable to Locate
- **Already in Care:** If it is determined that the person is already in care after attempts to contact the patient through phone or field activities were conducted, select Already in Care then select the In-care facility (facility where the patient is currently receiving HIV care).
- **Client Refused:** If the person refuses services into medical care after field activity has been conducted, select Client Refused, then select the main reason the patient refused case from the drop-down list. The user may select up to two additional reasons a patient refuses services by checking the appropriate boxes in the options below.
- **Out of Jurisdiction:** If further record search investigation leads to the determination that an individual resides in a state other than Texas, select

'Out of Jurisdiction' then enter the country, state, and city where the person resides. If it is determined that an individual still resides in Texas but in a jurisdiction other than where the DTC investigation is taking place. In this situation, the user can then go into the Case Assignment/Field Record question package and update the 'Jurisdiction assigned to' and 'Person assigned to' (if known) fields to reflect the appropriate jurisdiction in which the assignment should be handled.

- **Scheduled Appointment:** If an appointment is scheduled for the person after field activity has been conducted, select Scheduled Appointment. The user will enter the date of the first appointment and select intake, medical, or lab only from the 'Type of Appointment' drop-down list. Enter the medical facility where the first appointment is scheduled to take place. The user will confirm attendance to the appointment, and additional appointment dates and types may be entered.



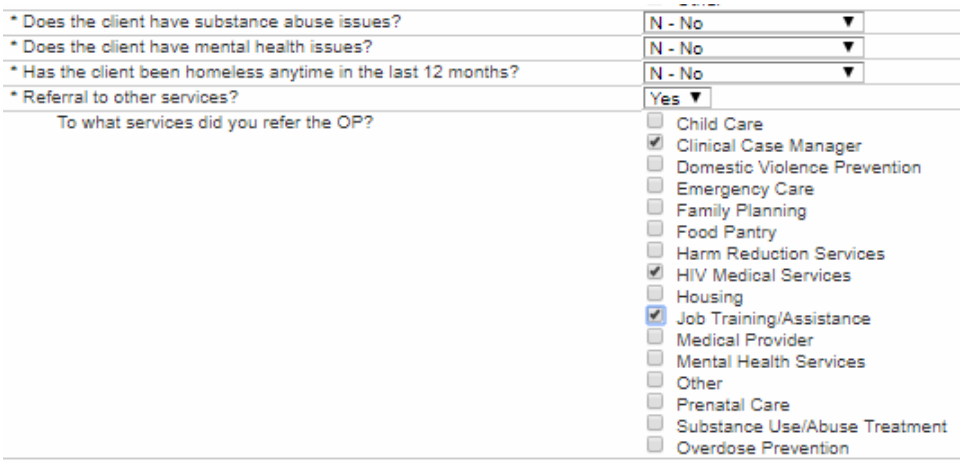
From the drop-down list, select the main reason the patient reported being out of care. Additional reasons may be selected by checking the reported responses.



Select the patient's response from a drop-down list for the following questions:

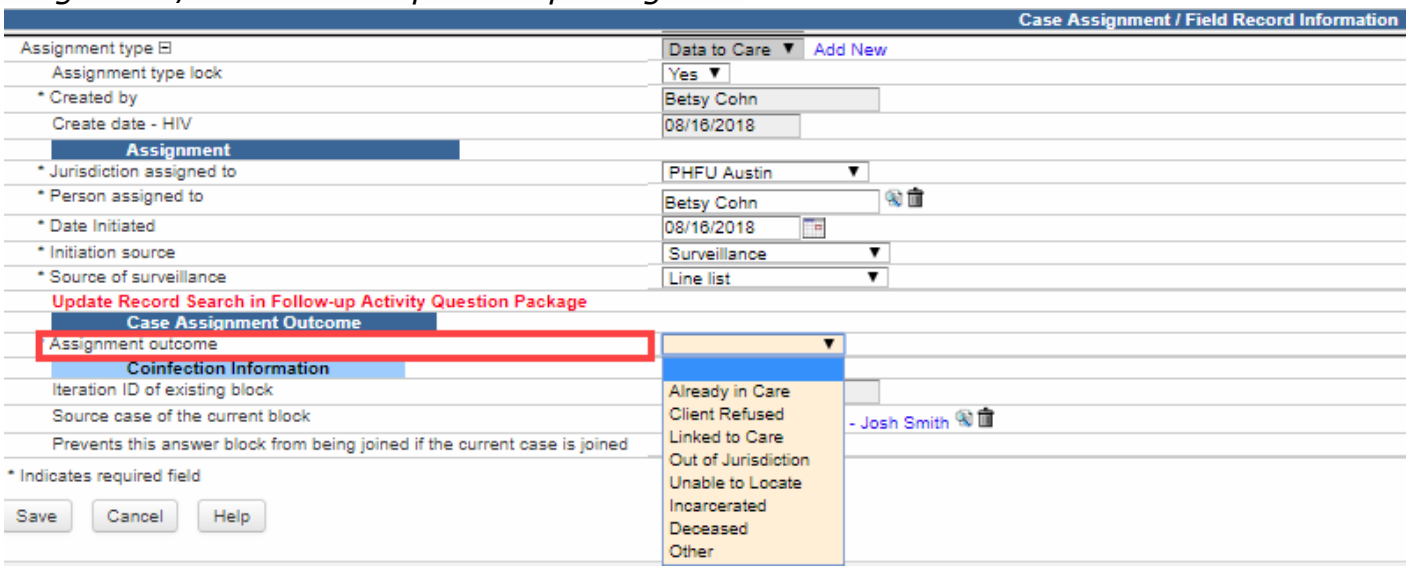
- Does the client have substance abuse issues?
- Does the client have mental health issues?
- Has the client been homeless anytime in the last 12 months?

If referral to services were made, select **Yes** and then check the type of referrals made.



- **Other:** If Other is selected, a text box is displayed and the user will need to specify the type of outcome that occurred.

9. For *all* Data to Care assignments (regardless of whether the person is eligible or ineligible for DTC), return to the Case Assignment/Field Record question package. In the Case Assignment Outcome section, select response for 'Assignment outcome' field. This step closes the assignment and completing this task will get the assignment out of your workflow queue. ****User must provide the outcome of the investigation in BOTH the Data to Care question package and the Case Assignment/Field Record question package****



Chapter 4 Partners/Clusters

Learning Objectives:

- Be able to enter Partners and Clusters.
- Be able to enter a Venue.
- Be able to update a laboratory report.

Overview

The Partner/Cluster QP captures information about partners and clusters identified during the course of the investigation.

4.1 Creating a new partner/cluster

4.1.1 Information Source

The user will select from the drop-down menu where the contact information came from:

- Interview/Re-Interview- Select if the contact information was elicited from the infected index patient during an original or re-interview. When this option is selected the user will have the option to specify the interview from which the information was elicited.
- Cluster Interview- Select if the contact information was elicited from an interview with a non-infected sex partner or a non-infected social contact of the index patient. It is designed to elicit information about the related index patient or other sex partners. Cluster interviews also elicit information about persons within the social network who might benefit from counseling, examination, or testing for HIV or other STDs when a non-infected individual names others who are connected to the original patient or the original patient's partners. If the user selects this option, they need to select the person who was clustered interviewed.
- Other- Select if the other two options are not appropriate

4.1.2 Referral Basis

The user must select the referral basis (the relationship of the named person to the original index patient). This is done the same was as in section 2.3.7.

4.1.3 Jurisdiction

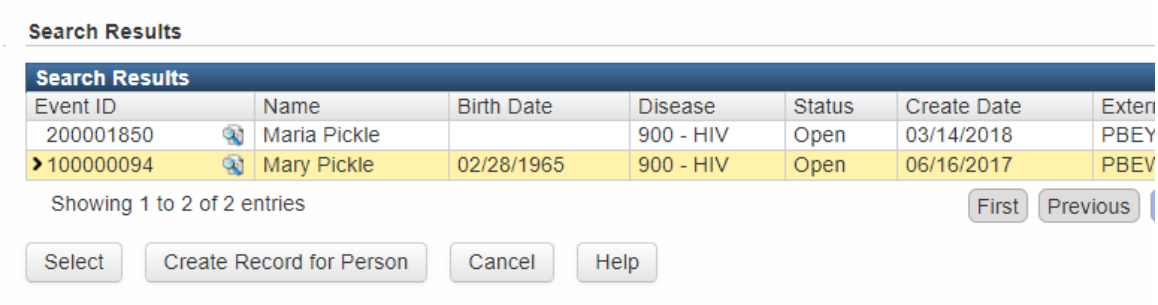
The user will assign the jurisdiction and user who will follow-up with the named person. The system will auto generate the Partner/Contact ID and the following questions will require an answer:

- **Search to see if contact exists with a related event** – the user will search for the person related to the original patient's event. If the individual is found, select him/her and select one of the following:

  - Use existing person, but create new event – Select if the person exists, but this is not a related event
  - Select an existing event for the person – Select if the person and related event exists in the system
  - Not enough info to link a person- select if there is not enough information to begin an investigation, this person will be entered as a Marginal contact.

4.2 Create a new event for the person

If the person is not found in the system, the user will create a new disease event for them and select: Create a new event for the person?



4.2.1 Person does not exist in system

If the person does not currently exist in the system: the user will enter Last Name, First Name, Date of Birth, and Gender

4.2.2 Who will notify this Contact?

This section is completed as in section 2.6.2.

4.2.3 Contact party information

The following questions need to be answered by the user under each heading:

- Contact's Address: The user will enter information obtained to identify the best physical address to contact the patient and additional contact information
- Locating Information: The user will enter additional locating information on the patient obtained from the original patient.
- Exposure and Follow-Up: The user will enter the patient's Current Marital Status.
- Exposure Dates First and Last: Enter the corresponding dates reported by the original patient for exposure
- Frequency: -Select from drop-down list the frequency at with the exposure is reported by the original patient.
- Additional questions will appear depending on the referral basis and product code selected.
- If an associate was selected as the referral basis, then the following question will appear:
- Was this person ever a sexual/needle sharing partner of the OP (Original Patient)?

If yes, is selected then **ENTER** the First and Last Date of exposure as well as the frequency.

If 900 HIV product code is selected, the following questions will appear:

- Is this an acute case of HIV?
- OP stage of HIV?

4.2.4 Locating Information/Other

Locating Information/ Other – The user will enter information gathered from the original patient regarding any locating information.
Employment information –The user will enter any information pertaining to employment.

4.2.5 Physical Attributes/Description

The user will enter Height, Weight/Build, select visible physical identifiers, hair color, eye color, and complexion. Additional notes about the contact may be entered in the **Text Box**.

Once the partner or cluster is created , the information will be locked. To edit the partner/contact information, GREEN text instructs the user to select "**To edit fields, clear the create question above. When ready to commit changes, set create question above to Yes and Save.**"
The user can add new partners and cluster by selecting Add New. The number of Partners, Suspects/Associates, Cohorts and Marginals entered in the Partners/Clusters question package will auto calculate and appear in the Case Assignment/ Field Record QP under the interview information.

h. Where was this infection acquired? This field is a required field for reporting. This field will be auto-populated for all Chlamydia and Gonorrhea cases. This question is trying to identify where the person acquired their infection.