PINAL COUNTY
WIDE OPEN OPPORTUNITY

NOTICE OF PUBLIC MEETING AND EXECUTIVE SESSION
PINAL COUNTY PUBLIC HEALTH SERVICES DISTRICT
BOARD OF DIRECTORS
AGENDA
Wednesday, May 15, 2024

9:30 AM - CALL TO ORDER

PINAL COUNTY ADMINISTRATIVE COMPLEX
BOARD OF SUPERVISORS HEARING ROOM
135 N. PINAL STREET
FLORENCE, AZ 85132

BUSINESS BEFORE THE BOARD
(Consideration/Approval/Disapproval of the following:)

(1) **CONSENT ITEMS:**

All items indicated by an asterisk (*) will be handled by a single vote as part of the consent agenda, unless a Board Member, County Manager, or member of the public objects at the time the agenda item is called.

* A. Discussion/approval/disapproval of Intergovernmental Agreement Contract No. CTR057224 Amendment No. 3, for the COVID-19 ELC Enhancing Detection Expansion project between the Arizona Department of Health Services and the Pinal County Public Health Services District through the Pinal County Board of Supervisors. This amendment extends the term of the agreement to end July 31, 2026. This agreement was originally approved December 15, 2021, all terms of the original agreement remain in effect with this extension. (Kore Redden/Merissa Mendoza)

* B. Discussion/approval/disapproval of a Contract award under the Family Planning Program between Affirm Sexual and Reproductive Health, and the Pinal County Public Health Services District, through the Pinal County Board of Supervisors, beginning April 1, 2024, ending March 31, 2025, for an amount not to exceed $350,000. This grant will be used by the Public Health Department for family planning services. Acceptance requires an amendment to the FY 23/24 budget to transfer appropriation between Fund 213 (Grants/Project Contingency) and Fund 82 (Health/Grants) to increase revenues and expenditures. The appropriation is a prorated amount for April 2024 through June 2024. The remaining amount will be budgeted in the following Fiscal Year. There is no impact on the General Fund. (Carey Lennon/Merissa Mendoza)

* C. Discussion/approval/disapproval of Award Agreement No. CTR055262 Amendment No. 4 (formerly IGA2020-043) for the Title V Maternal and Child Health, Healthy Arizona Families Program between the Arizona Department of Health Services and Pinal County, through the Pinal County Public Health Services District Board beginning July 1, 2023, ending June 30, 2024, for $226,379. The funding was included in the FY 23/24 budget for the Public Health Services District and has no impact on the General Fund. (Jan Vidimos/Merissa Mendoza)

* D. Discussion/approval/disapproval of Award Agreement No. CTR070160 under the Overdose

Data To Action grant between the Arizona Department of Health Services and the Pinal County Health Services District through the Pinal County Board of Supervisors beginning January 1, 2024, ending December 31, 2029, for $80,000 annually. This grant will be used by the department to enhance capacity to address the opioid epidemic through prevention-based strategies, develop and maintain public safety partnerships, increase linkages to care, and increase access to overdose prevention and reversal tools. This funding was included in the FY 24/25 budget development for the Public Health Services District and will have no impact on the General Fund. (Jan Vidimos/Merissa Mendoza)

* E. Discussion/approval/disapproval of Award Agreement No. CTR067691 with Arizona Department of Health Services for HIV Prevention Program. The term of this contract will be from January 1, 2024, to December 31, 2028. The total contract amount for the first year is not to exceed $23,714. The funding was adopted in the FY 23/24 budget. There is no impact on the General Fund. (Kore Redden/Merissa Mendoza)

ADJOURNMENT

(SUPPORTING DOCUMENTS ARE AVAILABLE AT THE CLERK OF THE BOARD OF SUPERVISORS' OFFICE AND AT https://pinal.novusagenda.com/AgendaPublic/)

NOTE: One or more members of the Board may participate in this meeting by telephonic conference call.

The Board may go into Executive Session for the purpose of obtaining legal advice from the County's Attorney(s) on any of the above agenda items pursuant to A.R.S. 38-431.03(A)(3).

In accordance with the requirement of Title II of the Americans with Disabilities Act (ADA), the Pinal County Board of Supervisors and Pinal County Board of Directors do not discriminate against qualified individuals with disabilities admission to public meetings. If you need accommodation for a meeting, please contact the Clerk of the Board Office at (520) 866-6068, at least (3) three business days prior to the meeting (not including weekends or holidays) so that your request may be accommodated.

Pursuant to A.R.S. 38-431.02, NOTICE IS HEREBY GIVEN, that the public will have physical access to the meeting room at 9:15 AM.

Meeting Notice of Posting

PINAL COUNTY
WIDE OPEN OPPORTUNITY

AGENDA ITEM

May 15, 2024 ADMINISTRATION BUILDING A
FLORENCE, ARIZONA

REQUESTED BY:

Funds #: 82

Dept. #: 359

Dept. Name: Public Health

Director: Merissa Mendoza

BRIEF DESCRIPTION OF AGENDA ITEM AND REQUESTED BOARD ACTION:

Discussion/approval/disapproval of Intergovernmental Agreement Contract No. CTR057224 Amendment No. 3, for the COVID-19 ELC Enhancing Detection Expansion project between the Arizona Department of Health Services and the Pinal County Public Health Services District through the Pinal County Board of Supervisors. This amendment extends the term of the agreement to end July 31, 2026. This agreement was originally approved December 15, 2021, all terms of the original agreement remain in effect with this extension. (Kore Redden/Merissa Mendoza)

BRIEF DESCRIPTION OF THE FISCAL CONSIDERATIONS AND/OR EXPECTED FISCAL IMPACT OF THIS AGENDA ITEM:

This program was included in the FY23/24 budget planning process and will have no impact to the General Fund.

BRIEF DESCRIPTION OF THE EXPECTED PERFORMANCE IMPACT OF THIS AGENDA ITEM:

These funds will allow Public Health to continue with established relationships with Community partners to enhance and expand response activities related to COVID-19 and other communicable infections.

MOTION:

Approve as presented.

History

Time	Who	Approval
5/3/2024 8:10 AM	County Attorney	Yes
5/6/2024 8:22 AM	Grants/Hearings	Yes
5/6/2024 10:26 AM	Budget Office	Yes
5/8/2024 11:51 AM	County Manager	Yes
5/8/2024 11:54 AM	Clerk of the Board	Yes

ATTACHMENTS:

Click to download
Grant Request
Contract Amendment 3

PINAL COUNTY
WIDE OPEN OPPORTUNITY

Board of Supervisors Grant Request

Board of Supervisors meeting date: _____

Department seeking grant: _____

Name of Granting Agency: _____

Name of Grant Program: _____

Project Name: _____

Amount requested: _____

Match amount, if applicable: _____

Application due date: _____

Anticipated award date/fiscal year: _____

What strategic priority/goal does this project address?: _____

Applicable Supervisor District: _____

Brief description of project:

Approval received per Policy 8.20: _____ OnBase Grant #: _____

Please select one:

- Discussion/Approve/Disapproval consent item _____
- New item requiring discussion/action _____
- Public Hearing required _____

Please select all that apply:

- Request to submit the application _____
- Retroactive approval to submit _____
- Resolution required _____
- Request to accept the award _____
- Request to approve/sign an agreement _____
- Budget Amendment required _____
- Program/Project update and information _____

	INTERGOVERNMENTAL AGREEMENT (IGA) **Amendment**	**ARIZONA DEPARTMENT OF HEALTH SERVICES** 150 18th Ave Suite 530 Phoenix, Arizona 85007
	AGREEMENT NO.: **CTR057224** / AMENDMENT NO: 3	PROCUREMENT OFFICER **DARRNELL WELCH**

COVID-19 ELC Enhancing Detection Expansion

It is mutually agreed that the Intergovernmental Agreement (IGA) referenced is amended as follows:

1. Pursuant to the Terms and Conditions, Provision Four (4) Contract Administration and Operation, Section 4.2. Contract Renewal: the IGA is hereby extended through July 31, 2026, Year 5 of the contract.

2. Pursuant to Terms and Conditions, Provision Six (6), Contract Changes, Section 6.1, Amendments, Purchases Orders, and Change Orders, the amendment is hereby revised with the following:

   2.1. The Price Sheet is revised and replaced.

ALL REVISIONS ARE INDICATED IN RED

All other provisions of this agreement remain unchanged.

Pinal County Public Health Services District

Contractor Name:

971 N. Jason Lopez Circle, Building D

Address:

Florence	**AZ**	**85132**
City	State	Zip

County Authorized Signature

Print Name

Title and Date

Pursuant to A.R.S. § 11-952, the undersigned public agency attorney has determined that this Intergovernmental Agreement is in proper form and is within the powers and authority granted under the laws of Arizona.	This Intergovernmental Agreement Amendment shall be effective the date indicated. The Public Agency is hereby cautioned not to commence any billable work or provide any material, service or construction under this IGA until the IGA has been executed by an authorized ADHS signatory. State of Arizona
Signature Date	Signed this _____ day of _____ 2024.
Print Name	Procurement Officer
Contract No.: **CTR057224**, which is an Agreement between public agencies, has been reviewed pursuant to A.R.S. § 11-952 by the undersigned Assistant Attorney, who has determined that it is in proper form and is within the powers and authority granted under the laws of the State of Arizona.	
Signature Date	
Assistant Attorney General	
Print Name	

	INTERGOVERNMENTAL AGREEMENT (IGA) **Amendment**		**ARIZONA DEPARTMENT OF HEALTH SERVICES** 150 18th Ave Suite 530 Phoenix, Arizona 85007
	AGREEMENT NO.: **CTR057224**	AMENDMENT NO: 3	PROCUREMENT OFFICER **DARRNELL WELCH**

Cost-Reimbursement Price Sheet
July 31, 2024 – July 31, 2026

ACCOUNT CLASSIFICATION	LINE-ITEM TOTALS
SALARIES AND WAGES	$273,750.00
FRINGE BENEFITS	$109,500.00
PROFESSIONAL AND OUTSIDE SERVICES	$5,557,500.00
EQUIPMENT	$199,203.00
ADDITIONAL PROJECT COSTS – building renovation and correctional health workshop	$58,300.00
INDIRECT COSTS	$38,325.00
	TOTAL $6,236,578.00

If applicable, the Contractor is authorized to transfer up to a maximum of ten percent (10%) of the total budget amount between line items.

Transfers exceeding ten percent (10%) or to a non-funded line item shall require an Agreement Amendment.

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AGENDA ITEM

May 15, 2024 ADMINISTRATION BUILDING A
FLORENCE, ARIZONA

REQUESTED BY:

Funds #: 82

Dept. #: 359

Dept. Name: Public Health

Director: Merissa Mendoza

BRIEF DESCRIPTION OF AGENDA ITEM AND REQUESTED BOARD ACTION:

Discussion/approval/disapproval of a Contract award under the Family Planning Program between Affirm Sexual and Reproductive Health, and the Pinal County Public Health Services District, through the Pinal County Board of Supervisors, beginning April 1, 2024, ending March 31, 2025, for an amount not to exceed $350,000. This grant will be used by the Public Health Department for family planning services. Acceptance requires an amendment to the FY 23/24 budget to transfer appropriation between Fund 213 (Grants/Project Contingency) and Fund 82 (Health/Grants) to increase revenues and expenditures. The appropriation is a prorated amount for April 2024 through June 2024. The remaining amount will be budgeted in the following Fiscal Year. There is no impact on the General Fund. (Carey Lennon/Merissa Mendoza)

BRIEF DESCRIPTION OF THE FISCAL CONSIDERATIONS AND/OR EXPECTED FISCAL IMPACT OF THIS AGENDA ITEM:

This contract offsets the Public Health Services Districts costs for providing family planning services. Majority of the award will offset personnel, equipment and supply costs for services provided in public health clinics. This award was included in the FY2024/25 budget planning and preparation. There is no impact to the general fund.

BRIEF DESCRIPTION OF THE EXPECTED PERFORMANCE IMPACT OF THIS AGENDA ITEM:

This program assists in offsetting the costs incurred by the Public Health Services District to provide Title X approved comprehensive family planning and related preventive health services to 2,800 unduplicated, program eligible clients (men/women) and to increase access to family planning for Pinal County residents at our public health clinics.

MOTION:

Approve as presented.

History

Time	Who	Approval
5/3/2024 4:15 PM	County Attorney	Yes
5/6/2024 8:16 AM	Grants/Hearings	Yes
5/6/2024 10:28 AM	Budget Office	Yes

5/8/2024 12:01 PM	County Manager	Yes
5/8/2024 12:02 PM	Clerk of the Board	Yes

ATTACHMENTS:

Click to download
Grant Request
Contract
COI
Budget Appropriation

PINAL COUNTY
WIDE OPEN OPPORTUNITY

Board of Supervisors Grant Request

Board of Supervisors meeting date: _____

Department seeking grant: _____

Name of Granting Agency: _____

Name of Grant Program: _____

Project Name: _____

Amount requested: _____

Match amount, if applicable: _____

Application due date: _____

Anticipated award date/fiscal year: _____

What strategic priority/goal does this project address?: _____

Applicable Supervisor District: _____

Brief description of project:

Approval received per Policy 8.20: _____ OnBase Grant #: _____

Please select one:

- Discussion/Approve/Disapproval consent item _____
- New item requiring discussion/action _____
- Public Hearing required _____

Please select all that apply:

- Request to submit the application _____
- Retroactive approval to submit _____
- Resolution required _____
- Request to accept the award _____
- Request to approve/sign an agreement _____
- Budget Amendment required _____
- Program/Project update and information _____

Affirm
3800 N. Central Ave Suite 820 Phoenix, AZ 85012
(602) 258-5777 | www.affirmaz.org

Merissa Mendoza, MPA, RDN, IBCLC
Public Health Director, Interim
Pinal County Public Health Services District
971 N. Jason Lopez Circle, Building D
Florence, AZ 85132

April 15, 2024

Dear Merissa:

Arizona Family Health Partnership is doing business as Affirm Sexual and Reproductive Health, hereby referred to as Affirm. Please see the attached electronic copy of the Affirm Family Planning Contract with Pinal County Public Health Services District for the term of April 1, 2024 through March 31, 2025. Please see below for substantial changes to the Contract:

- Attachment 5, includes additional Program Policy Notice (PPN) 2024-01: Clarification Regarding Confidential Services to Adolescents under the Title X Program
- Announced at the April 2024 Subrecipient Meeting, Office of Population Affairs granted 40% of Affirm's Title X award as of March 2024, with verbal notice that Affirm is likely to received level funding for 2024-2025 contract year. Affirm will send updates as we received confirmation on the remainder of the 2024 grant award, otherwise an amendment will be required to reduce award protected by section 6.1.3 of the attached contract.

Upon approval of attachments, you will receive a fully executed copy for your records. To complete the contract process, please sign and include all required attachments:

- If applicable, attach a list of any subcontractors and associated contracts for family planning services (Attachment 7)
- Ensure insurance policies name Arizona Family Health Partnership dba Affirm Sexual and Reproductive Health as an additional insured, they are in alignment with section 5.1 of the contract, and attach the Certificate of Insurance (COI) for Affirm's review.

Thank you for continuing to provide Title X family planning services. We truly value your partnership! If you have any questions, please contact me or Celeste Krell-Colum.

Sincerely,

Brenda "Bré" L. Thomas, MPA
Chief Executive Officer
Enclosures

AFFIRM SEXUAL AND REPRODUCTIVE HEALTH
FAMILY PLANNING PROGRAM CONTRACT

This AFFIRM SEXUAL AND REPRODUCTIVE HEALTH FAMILY PLANNING PROGRAM CONTRACT (the "***Contract***") is entered into by and between the Arizona Family Health Partnership dba Affirm Sexual and Reproductive Health, an Arizona not-for-profit corporation ("***Affirm***"), and **Pinal County Public Health Services District** (the "***Contractor***"). Affirm or the Contractor may be referred to individually as the "***Party***" or collectively the "***Parties***".

RECITALS

WHEREAS, Affirm has received a Title X Funding award under Federal Award Identification Number (FAIN): FPHPA006520 and Catalog of Federal Domestic Assistance (CFDA) number 93.217 (the "***Grant***") dated March 19th, 2024, from the Office of Population Affairs ("***OPA***") and the United States Department of Health and Human Services ("***DHHS***"), to provide family planning and related preventative health services to eligible clients in the State of Arizona;

WHEREAS, the Grant is made pursuant to Title X of the Public Health Service Act, 42 U.S.C. 300, et seq., as amended and program guidelines and requirements issued by DHHS and OPA ("***Title X***"). Title X authorizes federally funded grants "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents)."

WHEREAS, the Contractor provides services that qualify for reimbursement under Title X.

WHEREAS, the Parties desire to provide for a sub-award of the Grant to reimburse the Contractor's actual, allowable costs associated with providing the Family Planning Services, defined below.

AGREEMENT

NOW THEREFORE, in consideration of the mutual promises and covenants herein contained and intending to be legally bound thereby, Affirm and the Contractor agree as follows:

ARTICLE I
TERM AND STATEMENT OF WORK

1.1 Term. The Contract will begin on **April 1, 2024 and terminates March 31, 2025,** unless earlier terminated or amended pursuant to Article VI (the "***Term***").

1.2 Services and Standards. The Contractor will provide **2,800** unduplicated clients the comprehensive sexual and reproductive services identified in the Affirm Agency Health Center Report (the "***Family Planning Services***"), attached as Attachment 1. The Family Planning Services will be performed in strict compliance with Title X and:

1.2.1 The Contractor's Client Data Projections described in the Client Data Summary ("***Client Data Summary***"), attached as Attachment 2;

1.2.2 The Contractor's total 2024-2025 Family Planning Program Budget ("***Budget***"), which includes all revenues and expenses for the Contractor's Title X-funded site(s). The Budget is attached as Attachment 3.

1.2.3 Any Title X regulations, including 42 C.F.R. § 59 et seq. (the "***Title X Regulations***"). The current Title X Regulations are attached for reference as Attachment 4;

1.2.4 OPA Program Policy Notices ("***Program Notices***") attached as Attachment 5;

1.2.5 Affirm's Title X Program Standards and Policy Manual (the "***Manual***"), including the Legislative Mandates referenced therein, attached as Attachment 6; and

1.2.6 All other applicable federal and State laws and regulations.

1.3 Related Preventive Health Services. The Contractor will ensure clients have access to related and other preventive health services on-site or by referral ("***Related Preventive Health Services***"). Related Preventive Health Services are beneficial to reproductive health, are closely linked to family planning services, and are appropriate to deliver in the context of a family planning visit but do not contribute directly to achieving or preventing pregnancy: examples include breast and cervical cancer screening, screening for lipid disorders, skin cancer, colorectal cancer, or osteoporosis. The Contractor's employees and agents will be trained and equipped to offer these services onsite or by referral.

1.4 Subcontractors. The Contractor will submit a list of any subcontractors and/or independent consultants providing Family Planning Services within 30 days of the execution of this Contract or the subsequent engagement of any subcontractor(s) and/or independent consultant(s). Each will be attached as Attachment 7. All subcontractors and/or consultants must be insured, as required herein, and comply with Title X, the Title X Regulations, the Manual, Program Notices, and any other applicable laws and requirements.

ARTICLE II
REIMBURSEMENT

2.1 Reimbursement. Affirm will reimburse a portion of the Contractor's Budget for properly documented and allowable costs to provide the Family Planning Services ("***Reimbursement***"). The total Reimbursement payments by Affirm will not exceed **$350,000** ("***Reimbursement Award***"). Notwithstanding the foregoing, if Contractor has complied with all provisions of this Contract and Affirm receives additional discretionary funds though DHHS, Affirm may, in its sole discretion and upon written notice to Contractor, pay Contractor a one-time supplementary award in addition to the Reimbursement Award ("***Supplementary Award***"). The Contractor will not receive any Reimbursement until it identifies in writing and submits to Affirm the source and allocation of up to **$689,217 ("*Contractor Contribution*"**) to satisfy its Budget. At a minimum, the Contractor Contribution must constitute at least ten percent (10%) of the Budget. An amendment to the Contract is not required for Affirm to provide Contractor with the Supplementary Award, and the amount of the Supplementary Award may be provided to Contractor in the form of a reduction in Contractor Contribution without an amendment. The Contractor Contribution must: (i) be from non-Federal funds; (ii) be allowable by Federal regulations; (iii) cannot be used by more than one project; and (iv) must be auditable. The Contractor Contribution may include third party payments for Family Planning Services and patient collection fees, donations, local and State government contributions, agency in-kind and agency contributions. Reimbursement is contingent on: (i) the Contractor's satisfactory performance of the Family Planning Services and terms of this Contract, which determination will be in

Affirm's sole discretion; and (ii) Affirm's receipt of monies from DHHS in the amount specified in the Notice of Grant Award for the applicable funding period.

2.1.1 Reduction of Reimbursement Award. If Contractor provides Family Planning Services for less than 100%, but at least 97% of the unduplicated clients anticipated in the Affirm Agency Health Center Report, the Contractor will earn the full Reimbursement Award, provided that the Contractor Contribution are expended in full, and that the Contractor's total Title X family planning revenue equals the total cost of providing the Family Planning Services. If the Contractor serves less than 97% of the unduplicated clients anticipated in the Affirm Agency Health Center Report, the base Reimbursement will be reduced by **$125** for each client below the 97% threshold.

2.2 Reporting and Reimbursement Procedure. On a monthly or quarterly basis, the Contractor will submit the Arizona Family Health Affirm Request for Title X Contract Funds Form (the "***Reimbursement Request***") to Affirm, indicating the total funds used during that period. The Reimbursement Request is attached as Attachment 8. Within 30 days of receipt and approval of the Reimbursement Request and financial report as described in 2.2.2 by Affirm, Affirm will pay the Reimbursement. If the Contractor fails to deliver the Reimbursement Request or the following reports at the appropriate times, or otherwise comply with the terms of this Contract, Affirm may, upon reasonable notice, suspend Reimbursement until such reports are delivered to and approved by Affirm:

2.2.1 Encounter Data Report. The Contractor will submit encounter data through Affirm's Centralized Data System (CDS) on at least a monthly basis, no later than 15 days after the end of each month. Encounter data elements and format are described and defined in Affirm's Data Manual.

2.2.2 Financial Reports. The Contractor will submit monthly or quarterly financial reports through Affirm's Program Information Management System (PIMS). The Contractor will furnish Affirm with reports of its revenues and costs by the 25th of the month following the end of each calendar quarter. If the 25th falls on a weekend or holiday, the report will be due on the next business day.

2.2.3 Ad Hoc Reports. The Contractor will submit additional statistical or program information as requested or required by DHHS.

2.3 Limitations on use of Reimbursement. The Contractor will not use Reimbursement for any costs disallowed by Title X, Affirm, DHHS, or other appropriate federal officials ("***Disallowed Costs***"), which may include but are not limited to:

2.3.1 Costs to perform abortions or to supplant any funds used to perform abortion;

2.3.2 Costs to perform sterilization or to supplant any funds used to perform sterilization;

2.3.3 Indirect costs over 10% of the total program direct cost. (To charge indirect costs, the Contractor must submit a current Federally approved Indirect Rate letter or be limited to the de minimis indirect cost rate defined in 2 C.F.R. § 200.414);

2.3.4 Salaries over the current Executive Level II of the Federal Executive Pay Scale. For the purposes of the salary limitation, the direct salary is exclusive of fringe benefits and indirect costs. An individual's direct salary is not constrained by the legislative provision for a limitation

of salary. A Contractor may pay an individual's salary amount in excess of the salary cap with non-federal funds.

2.3.5 Those funds used for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the Congress, any state or local legislature or legislative body, or the executive branch of any State or local government itself;

2.3.6 Costs for salary or expenses of any Grant or Contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulations, administrative action, or Executive order proposed or pending before Congress or any State government, or a State or local legislature or legislative body, other than for normal and recognized executive–legislative relationships or participation by any agency or office of a State, local, or tribal government in policymaking and administrative processes within the executive branch of that government;

2.3.7 Advocating or promoting gun control; or

2.3.8 As described in 2 C.F.R. § 200.216, the Reimbursement may not be used to procure, obtain, or enter into a contract to procure or obtain equipment, services, or systems that use covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. As described in Public Law 115-232, section 889, covered telecommunications equipment is telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).

2.4 Return of Disallowed Costs and Appeal. If Affirm determines that the Contractor has spent Reimbursement funds on Disallowed Costs, the Contractor will remit to Affirm any such amounts. If the Contractor fails to remit such amounts within 30 days of notice of the Disallowed Costs from Affirm, Affirm may offset such amount against future funding obligations by Affirm or take other action available to it under law to reclaim such amount. If DHHS disallows any cost incurred by the Contractor under this Contract, at the Contractor's request, Affirm may pursue appropriate administrative appeals to DHHS. In the event Affirm elects to pursue such administrative appeals, the Contractor will pay into an escrow account such amount as Affirm deems appropriate to cover the Disallowed Costs and appeal costs, including attorney's fees and interest penalties. The Contractor agrees to cooperate fully with Affirm in providing documentation and other supporting material relevant to such a determination. If applicable, payment of questioned costs may be withheld from Reimbursement until the questions are resolved. Affirm will make Reimbursement of all otherwise properly documented and allowable costs not in question.

2.5 Reallocation. Should the Contractor fail to expend its Reimbursement Award, Affirm may reallocate the Reimbursement Award to ensure that funds are expended efficiently. Affirm will review the Contractor's Budget at the beginning of the last quarter of the Term, and upon determination that the Reimbursement Award is not being expended efficiently or will not be expended fully during the Term, Affirm may, in its sole discretion, reallocate all or a portion of the remaining Reimbursement Award to another organization. The Contractor may not carry over any non-obligated portions of its Reimbursement Award to the next grant or contract period.

ARTICLE III
THE CONTRACTOR'S REPRESENTATIONS AND WARRANTIES

The Contractor represents and warrants to Affirm the matters set forth in this Article III.

3.1 Title X System. The Contractor has had the opportunity to review the Title X Regulations and Manual, and fully understands Affirm's and Title X requirements for receiving Reimbursement. The Contractor has a system in place to meet these requirements, including a financial management system that is able to effectively segregate Reimbursement funds, revenue, and expenses.

3.2 Debarment and Suspension. The Contractor's employees and sub-contractors, its current and future subcontractors and their principals: (i) are not presently and will not be debarred, suspended, proposed for debarment or declared ineligible for the award of subcontracts, by any U.S. Government agency, any state department or agency, in accordance with federal regulations (53 Fed. Reg. 19161-19211) or has been so within the preceding three (3) year period; (ii) have not within a three (3) year period preceding this Contract had one or more public transactions (federal, state, or local) terminated for cause or default; and (iii) in the event any employee or sub-contractor of the Contractor's is debarred, suspended, or proposed for debarment, the Contractor must immediately notify Affirm in writing.

3.3 HIPAA Compliance. The Contractor is a Covered Entity as defined in 45 C.F.R. § 160.103 of the Health Insurance Portability and Accountability Act of 1996 ("***HIPAA***"), and is required to comply with the provisions of HIPAA with respect to safeguarding the privacy and confidentiality of protected health information. Affirm is neither a Covered Entity nor business associate under HIPAA; however, Affirm acknowledges that it is subject to the privacy and security requirements imposed on Grantees by DHHS under the Title X Program. In the event of a "breach" requiring notification under A.R.S. § 18-552, Affirm will notify Contractor of the breach of Contractor's data promptly, and in all cases, within 45 days of discovering the breach.

3.4 Conflict of Interest. This Contract does not create a conflict of interest, under any statute or rule of any governing jurisdiction, between the Contractor's officers, agents or employees and Affirm. The provisions of A.R.S. § 38-511 apply.

3.5 Equal Opportunity. The Contractor is an Equal Employment Opportunity employer in accordance with the requirements of 41 C.F.R. § 60-1.4(a), 60-250.5, 60-300.5(a), 60-741.5(a) and 29 C.F.R. § 471, Appendix A to Subpart A, if applicable, and the required equal opportunity clauses contained therein are hereby incorporated by reference.

ARTICLE IV
COVENANTS

4.1 Compliance with Laws, Regulations, and Manual. The Contractor will abide by the requirements of Title X, the Title X Regulations, the Manual, and Program Notices, which are incorporated as material terms of this Contract. As a recipient of federal funds, the Contractor is also required to comply with other laws and regulations. The following is a non-exclusive list of other laws and regulations by which the Contractor will abide:

4.1.1 The Contractor's purchase, use and disposition of property, equipment and supplies is governed by, 2 C.F.R. Part 200.310–316 and 45 C.F.R. Part 75.317-323, as applicable, and related DHHS policies;

4.1.2 The Transparency Act (2 C.F.R. Part 170);

4.1.3 2 C.F.R. Part 200 or 45 C.F.R. Part 75 (DHHS Grants Administration regulations), as applicable;

4.1.4 United States Generally Accepted Accounting Principles ("U.S. GAAP");

4.1.5 The Consolidated Appropriations Act, 2020 (Public Law 116-93), enacted December 20, 2019, and all subsequent Continuing Resolutions;

4.1.6 All applicable laws, ordinances, and codes of the state of Arizona and local governments in the performance of the Contract, including all licensing standards and all applicable professional standards; and

4.1.7 Requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. § 7104).

4.2 Licenses. The Contractor and each of its employees, agents and subcontractors will obtain and maintain during the Term of this Contract all appropriate licenses required by law for the operation of its facilities and for the provision of the Family Planning Services.

4.3 Status of the Contractor and Conflict of Interest. The Contractor, its agents and employees, including its professional and nonprofessional personnel, in the performance of this Contract, will act in an independent capacity and not as officers, employees or agents of Affirm. The Contractor will prevent its officers, agents or employees from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others with whom they may have business, family, or other connections. The Contractor will refrain from using any inside or proprietary information regarding the activities of Affirm and its affiliates for personal benefit, benefit to immediate family, or benefit to any entity in which he holds a significant financial or other interest. The Contractor's officers, agents, or employees will not deploy themselves so as to receive multiple payments from Affirm or otherwise manipulate the assignment of personnel or tasks so as to unnecessarily increase payments to the Contractor or its officers, agents or employees.

4.4 Retention of and Access to Records; Audit.

4.4.1 The Contractor will maintain financial records, supporting documents, statistical records, and all other books, documents, papers or other records pertinent to this Contract for a period of at least three (3) years from the date of Affirm submission of the annual financial report covering the Reimbursement awarded hereunder, or such other period as may be specifically required by 2 C.F.R. § 200.333 and 45 C.F.R. § 75.361, as applicable. If an audit, litigation, or other action involving the records is started before the end of the three (3) year period, the Contractor will maintain such records until the audit, litigation, or other action is completed, whichever is later. Client medical records must be retained in accordance with state and federal regulations.

4.4.2 The Contractor will make available to Affirm, DHHS, the Comptroller General, or any other of their duly authorized representatives, upon appropriate notice, such books, records, reports, documents, and papers that are pertinent to the award for audit, examination, excerpt, transcription, and copy purposes, for as long as such records, reports, books, documents, and papers are retained. This right also includes timely and reasonable access to the Contractor's facility and to the Contractor's personnel for interview and discussion related to such documents. The Contractor will, upon request, transfer certain records to the custody of Affirm or DHHS.

4.4.3 The Contractor agrees to permit Affirm and/or DHHS to evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services delivered under this Contract and to assess the Contractor's compliance with applicable legal and programmatic requirements. If Affirm identifies and notifies the Contractor of the Contractor's non-compliance with the terms of this Contract, or in providing the Family Planning Services, Affirm will notify the Contractor of such deficiencies. Affirm, in its sole discretion, may offer to provide technical assistance to the Contractor to correct or eliminate such deficiencies. Additionally, Affirm may grant the Contractor a reasonable time period to correct or eliminate such deficiencies; provided that in no case will the time allowed exceed twelve (12) months from the day of notice of the deficiency.

4.4.4 At the end of each of the Contractor's fiscal years, the Contractor will have an external audit performed, including of its Reimbursement, in accordance with the provisions of OMB Circular A-133 for a single audit, if applicable, and U.S. GAAP. For Contractors required to complete a Single Audit, expended Title X funds must be reported on the Schedule of Expenditures of Federal Awards (SEFA) under the Catalog of Federal Domestic Assistance (CFDA) number 93.217. Non-governmental contractors Audit will be conducted in accordance with 2 CFR Part 200 Subpart F. The Contractor will provide to Affirm the Contractor's financial statements and auditors' reports within 30 days of receipt of such reports, but in no case later than nine months following the Contractor's fiscal year-end. The audit package submitted to Affirm must contain all financial statements, footnotes, schedule of federal financial assistance, auditor's opinion on the financial statements and schedule, all reports on internal controls and compliance, a copy of the management letter from the Contractor's audit firm, and a copy of any responses to the management letter or findings. If a corrective action plan is required, Affirm reserves the right to request additional information regarding the corrective action plan, if any. The Contractor agrees to promptly implement such corrective action plan, including any recommendation made by Affirm.

4.5 Litigation. The Contractor will notify Affirm in writing within thirty (30) days of notice of any litigation, claim, negotiation, audit or other action, including violations of Federal criminal law involving fraud, bribery, or gratuity violations, involving the Family Planning Services or Reimbursement, occurring during the Term or within four (4) years after the expiration of the Term. The Contractor will retain any records until the completion of such action and the resolution of all issues arising from or relating to such action, or four (4) years after the end of the Term, whichever is later. Any notice regarding violations of Federal criminal law involving fraud, bribery, or gratuity must be sent in writing to Affirm at the address provided at Section 7.5, and to the DHHS OIG at the following addresses:

HHS OASH Grants and Acquisitions Management
1101 Wootton Parkway, Plaza Level
Rockville, MD 20852

AND

US Department of Health and Human Services Office of Inspector General

ATTN: OIG HOTLINE OPERATIONS—MANDATORY GRANT DISCLOSURES
PO Box 23489
Washington, DC 20026

4.6 Property Records. The Contractor will maintain adequate records of any property, inventory, and maintenance procedures for items purchased with Reimbursement funds. The Contractor will be responsible for replacing or repairing Equipment for which it is accountable under this Contract if lost, damaged or destroyed due to the negligence on the part of the Contractor, or failure to secure appropriate insurance, or noncompliance with property management regulations, or instructions of Affirm or DHHS. Affirm may require the transfer of property acquired with funds awarded under this Contract as provided for in 2 CFR Part 200.312 and 45 CFR 75.319. Records for real property and Equipment acquired with the Reimbursement will be retained for three (3) years after the final disposition. For the purpose of this Contract, "***Equipment***" is defined as any item purchased with Title X Award funds with a useful life of more than one (1) year with a per unit acquisition cost of $5,000 or more, unless the Contractor uses a lower limit. If required by Affirm, Contractor shall submit a list with the required elements from CFR Part 200.313 and 45 CFR part 75.320, as applicable, of all such Equipment to Affirm.

4.7 340B Drug Pricing Program. If the Contractor enrolls in the 340B Drug Pricing Program, the Contractor must comply with all 340B program requirements. The Contractor may be subject to audit at any time regarding 340B program compliance. 340B program requirements are available at https://www.hrsa.gov/opa/program-requirements and incorporated herein by this reference.

4.8 Required Meetings. The Contractor must participate in three (3) meetings with Affirm held during the Term of this Contract. The Contractor's staff attending such meetings must be persons with managerial responsibilities related to the Contract. Additionally, one family planning clinician must attend a clinician training that will coincide with one of the meetings.

ARTICLE V
INSURANCE AND INDEMNIFICATION

5.1 Insurance. The Contractor will procure, maintain, and provide proof of coverage of: (i) a Medical Malpractice Professional Liability Insurance Policy and such policy will be written on an occurence basis in the minimum amount of $1,000,000 for all medical provider employees and subcontractors and consultants, unless the Contractor qualifies for such insurance pursuant to Section 5.2; (ii) General Liability coverage of at least $1,000,000 per occurrence and $3,000,000 Annual aggregate against general liability endorsed for premises-operations, products/completed operations, contractual, property damage, and personal injury liability; (iii) Workers compensation in accordance with applicable law; and (iv) Fidelity coverage adequate to protect against loss due to employee dishonesty of at least$5,000. The Contractor will provide certificates indicating the proof of such insurance and incorporate them as Attachment 9. The insurance policies referred to above must name Affirm as an additional insured under each policy. The Contractor will promptly provide Affirm with written notice of any ineligibility determination, suspension, revocation or other action or change relevant to the insurance requirements set forth above. The Contractor may provide all or a portion of the required coverage through programs of self-insurance as allowed by law.

5.2 FTCA Status. If applicable as a Federally Qualified Health Center ("***FQHC***"), the Contractor has been deemed eligible and approved for medical malpractice liability protection through the Federal Tort Claims Act (FTCA), pursuant to the Federally Supported Centers Assistance Act of 1992 and 1995. The Contractor must remain in deemed status during the Term of this Contract. Should the Contractor

lose its designation as an FQHC or lose its deemed status during the Term, the Contractor must immediately secure Professional Liability Malpractice Insurance as required by Section 5.1 and must provide a copy of the insurance certificates confirming such insurance protection.

5.3 Indemnification. To the extent allowed under Arizona law, the Contractor will indemnify, defend, save, and hold harmless Affirm and its officers, officials, agents, and employees (hereinafter referred to as "***Indemnitee***") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "***Claims***") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of the Contractor or any of its owners, officers, directors, agents, employees, or subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of the Contractor to conform to any federal, state or local law, statute, ordinance, rule, regulation, or court decree. It is the specific intention of the Parties that the Indemnitee will, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the lndemnitee, be indemnified by the Contractor from and against any and all Claims. It is agreed that the Contractor will be responsible for primary loss investigation, defense, and judgment costs where this indemnification is applicable. To the extent permitted by law, the Contractor agrees to reimburse Affirm for any monies which Affirm is required to pay to the DHHS or other agencies of the United States Government or the State of Arizona for any Claims arising solely from the failure of the Contractor to perform in accordance with this Contract or, local, state, or federal laws and regulations. Affirm will appropriately invoice or file a Claim with the Contractor for any such reimbursement by the Contractor, and the Contractor will have opportunity to review, and protest when appropriate, the Claim prior to making any timely reimbursement to Affirm. The indemnification provided herein will survive the termination of this Contract.

ARTICLE VI
TERMINATION AND AMENDMENT

6.1 Termination of Contract. This Contract will terminate on the last date discussed in Section 1.1, unless earlier terminated pursuant to the terms of this Section. Upon termination: (i) the Contractor will return to Affirm any unencumbered balance of the Reimbursement disbursed under this Contract; and (ii) all nonexpendable personal property, finished or unfinished documents, data, studies, and reports purchased or prepared by the Contractor under this Contract will, at the option of Affirm, become Affirm’s property or be disposed of in accordance with Affirm's procedures or instructions. Final payment to the Contractor, if applicable, is contingent upon the Contractor completing closeout procedures as detailed in Affirm’s Delegate Closeout Checklist, as defined in the Manual.

6.1.1 Termination by the Contractor. If the Contractor is unable or unwilling to comply with additional conditions as may be lawfully imposed on the Contractor, the Contractor may terminate this Contract by giving written notice to Affirm signifying the effective date thereof. The Contractor may terminate this Contract for any other reason by providing Affirm with at least 90 days written notice. In the event the Contractor terminates this Contract, the Contractor will be entitled to compensation for any un-reimbursed expenses necessarily incurred in satisfactory performance of this Contract.

6.1.2 Termination by Affirm. Affirm may terminate this Contract or suspend Reimbursement, in whole or in part, in the event the Contractor: (i) fails to fulfill in a timely and proper manner its obligations under this Contract; or (ii) violates any of the covenants, agreements, or stipulations of this Contract, by providing the Contractor written notice of termination specifying

the date of termination. Affirm may give the Contractor an opportunity to cure deficiencies by providing a cure period, of at least 10 days, in any notice of termination. If Affirm does not provide a cure period or if Contractor does not cure all deficiencies within the time specified by Affirm, the Contract will be terminated. Despite any termination hereunder, the Contractor will not be relieved of liability to Affirm for damages sustained by Affirm by virtue of any material breach of this Contract by the Contractor. Affirm may withhold any reimbursement to the Contractor for the purpose of offset until such time as the exact amount of damages, if any, due Affirm from the Contractor is agreed upon or otherwise determined.

6.1.3 Termination or Reduction of DHHS Funding. Affirm has been informed by DHHS that the Grant provides funding for the Term. However, in the event any DHHS funding is reduced, terminated or otherwise negatively altered (including any change or limitation upon whom Affirm may pay or distribute monies to under this Contract), whether before or after this Contract is effective, Affirm may terminate this Contract in whole or in part by providing the Contractor a written notice of termination. The effective Contract termination date will be the date such DHHS funding is reduced, terminated or otherwise negatively altered ("***DHHS Funding Termination Date***"). Notwithstanding anything in this Contact to the contrary, if the Contract is terminated because of the foregoing, Affirm is relieved of all obligations under the Contract. Termination of this Contract hereunder will not be deemed a breach of this Contract by Affirm.

6.1.4 Termination due to Non-Appropriation. Notwithstanding any other provisions in this Contract, this Contract may be terminated by Affirm if the Contractor's governing body does not appropriate the Contractor Contribution or other sufficient monies to provide the Family Planning Services. In such an event, the Contractor will notify Affirm of its inability to appropriate the requisite funds and Affirm may, at its discretion, terminate this Contract.

6.2 Amendment. The Contract, together with Attachments referenced herein, fully expresses all understanding of the Parties concerning all matters covered and will constitute the total Contract. No amendment of, addition to, or alteration of the Terms of this Contract, whether by written or verbal understanding of the Parties, their officers, agents or employees, will be valid unless made in a writing that is formally approved and executed by the Parties or made pursuant to the following procedures:

6.2.1 If Affirm obtains additional Grant funding for periods after the expiration of the Term, the Contractor may request to extend the Term by updating the annual application forms and submit them through Affirm's Program Information Management System (PIMS). Any extension of the Term will be mutually agreed on by the Parties, in writing.

6.2.2 The Contractor may make changes to staff and location of its Family Planning services, provided that the Contractor will notify Affirm, in writing as soon as possible for staff changes and within 30 working days of any changes or closures of a Title X clinic site location.

6.2.3 The Contractor must submit written requests for any change in the Family Planning Services including, but not limited to, Affirm Agency Health Center Report, Client Data Summary, and Budget. Affirm will determine whether changes require Contract revision or amendment.

6.2.4 The Contractor must submit Budget modification requests within 30 days for prior approval by Affirm in the following instances: (i) The Contractor requires allocations of additional funds beyond the specified base amount; (ii) the Contractor wishes to reduce the Reimbursement Award; and (iii) the Contractor provides changes to the Budget representing a variance of 10% of any individual Budget category.

6.2.5 Changes in policies, procedures, and/or forms related to the Family Planning Services must be submitted in writing to Affirm for approval prior to implementation.

6.2.6 Within 15 days of change, the Contractor must notify Affirm of changes in key clinical or management personnel, including administrative officers and Family Planning Services program directors.

6.2.7 Affirm's exercise of Supplementary Award pursuant to Section 2.1 does not require an amendment to this Contract.

ARTICLE VII
MISCELLANEOUS PROVISIONS

7.1 Nonexclusivity. That this Contract is nonexclusive in nature and Affirm retains the authority to contract with other Parties for the delivery of Family Planning Services in the Contractor's geographic area.

7.2 Governing Law. Any action relating to this Contract will be brought in a court of the State of Arizona in the county in which the Family Planning Services are provided, unless otherwise prohibited by prevailing federal law. Any changes in the governing laws, rules and regulations that do not materially affect the Contractor's obligation under the Contract during the Term will apply but do not require an amendment.

7.3 Intangible Property and Copyright. The Contractor will ensure that publications developed while providing the Family Planning Services do not contain information that is contrary to Title X, the Manual, or to accepted clinical practice. Federal and Affirm grant support must be acknowledged in any publication. The Contractor will obtain pre-approval from Affirm for publications resulting from activities conducted under this Contract. The Contractor will also provide all publications referencing Affirm to Affirm for pre-approval prior to distribution. Restrictions on motion picture film production are outlined in the "Public Health Service Grants Policy Statement." The word "***publication***" is defined to include computer software. Any such copyrighted materials will be subject to a royalty-free, non-exclusive, and irrevocable right of the Government and Affirm to reproduce, publish, or otherwise use such materials for Federal or Affirm purposes and to authorize others to do so, as allowed by law.

7.4 Dispute Resolution. The Parties will first attempt to resolve any dispute arising under this Contract by informal discussion between the Parties, subject to good cause exceptions, including, but not limited to, disputes determined by either Party to require immediate relief (i.e., circumstances which may result in a misappropriation of the Reimbursement). Any dispute that has not been resolved by informal discussions between the Parties within a reasonable period of time after the commencement of such discussions (not to exceed 30 days), may be resolved by any means available.

7.5 Notice. All notices required or permitted to be given hereunder will be given in writing and will be deemed to have been given when sent by certified or registered mail, postage prepaid, return receipt requested.

Notices to Affirm will be addressed to:
Chief Executive Officer
Arizona Family Health Partnership

3800 N. Central Ave., Suite 820
Phoenix, Arizona 85012

Notices to the Contractor will be addressed to:
Merissa Mendoza, MPA, RDN, IBCLC
Public Health Director, Interim
Pinal County Public Health Services District
971 N. Jason Lopez Circle, Building D
Florence, AZ 85132

Either Party may change its address for notices by giving written notice of such change to the other Party.

7.6 Severability. If any provision of this Contract is declared void or unenforceable, such provision will be deemed severed from this Contract, which will otherwise remain in full force and effect. If any provision of this Contract is declared void or unenforceable, the Parties will engage in good faith efforts to renegotiate such provision in a matter that most closely matches the intent of the provision without making it unenforceable.

7.7 No Third-Party Beneficiary. This Contract was created by the Parties solely for their benefit and is not intended to confer upon any person or entity other than the Parties any rights or remedies hereunder.

7.8 Waiver. Performance of any obligation required of a Party hereunder may be waived only by a written waiver signed by the other Party, which waiver will be effective only with respect to the specific obligations described herein. The waiver of a breach of any provisions will not operate or be construed as a waiver of any subsequent breach.

7.9 Execution. This Contract will not be effective until it has been approved as required by the governing bodies of the Parties and signed by the persons having executory powers for the Parties. This Contract may be executed in two or more identical counterparts, by manual or electronic signature.

[Signatures to follow on next page]

[Remainder of page left intentionally blank]

IN WITNESS WHEREOF, the Parties have each caused an authorized representative to execute and deliver this Contract on the Date provided below.

CONTRACTOR:

_____
Signature

Mike Goodman

Chairman of the Board of Supervisors

Pinal County Public Health Services District

86-6000556
Contractor ID Number (EIN)

Nine Digit DUNS#: 074447095

DUNS Registered Name: County of Pinal

SAM #: GX4FM9VQD7W3

_____
Date

AFFIRM:

_____
Signature

Brenda L. Thomas, MPA

Chief Executive Officer

Affirm

_____
Date

AFFIRM AGENCY HEALTH CENTER REPORT

Agency Name : Pinal County Public Health Services District

Grant Name: ARIZONA GRANT

Revised Date : 11/30/2023

Date : 03/13/2024

Name	Address	Clinic Hours	Number of Clients
San Tan Valley	**Address:** 36235 North Gantzel Road, San Tan Valley, Arizona, 85142 **Phone Number:** 8669600633	**Tuesday - Wednesday:** 08:00 AM to 06:00 PM	513
Maricopa	**Address:** 41680 West Smith-Enke Road, Suite 110, Maricopa, Arizona, 85138 **Phone Number:** 8669600633	**Tuesday:** 08:00 AM to 06:00 PM	140
Coolidge	**Address:** 119 West Central, Coolidge, Arizona, 85128 **Phone Number:** 8669600633	**Thursday:** 08:00 AM to 06:00 PM	291
Casa Grande	**Address:** 1729 N Trekell Rd Suite 120, Casa Grande, Arizona, 85122 **Phone Number:** 8669600633	**Monday - Friday:** 08:00 AM to 06:00 PM	1211
Apache Junction	**Address:** 575 North Idaho Street, Suite 301, Apache Junction, Arizona, 85119 **Phone Number:** 8669600633	**Wednesday - Friday:** 08:00 AM to 06:00 PM	645

Agency Health Center Proposed Service Report

Level of service provided : 1=Service Provided, 2=Referral Provided, 3=Service Not Provided & Referral Not Provided.

Grant Name : ARIZONA GRANT

Proposed Year : April 2024-March 2025

Services	Apache Junction	Casa Grande	Coolidge	Maricopa	San Tan Valley
1) Family Planning Services					
1. Client Education and Counseling					
1.1. Pregnancy Prevention	1	1	1	1	1
1.2. Pregnancy Achievement	1	1	1	1	1
2. Family Planning Methods					
2.1. Male Condom	1	1	1	1	1
2.2. Oral Contraceptives	1	1	1	1	1
2.3. Injectables (Depo-Provera)	1	1	1	1	1
2.4. IUD without Hormones (ParaGard)	1	1	1	1	1
2.5. IUD with Hormones (Mirena, Skyla, Liletta, Kyleena)	1	1	1	1	1
2.6. Vaginal Ring (NuvaRing)	1	1	1	1	1
2.7. Emergency Contraception	1	1	1	1	1
2.8. Patch	2	2	2	2	2
2.9. Spermicide (Foams, Films, Suppositories)	1	1	1	1	1
2.10. Cervical Cap/Diaphragm	3	3	3	3	3
2.11. Sponge	2	2	2	2	2
2.12. Female Condom	2	2	2	2	2
2.13. Natural Family Planning (Fertility Awareness Based Methods)	1	1	1	1	1
2.14. Lactational Amenorrhea	1	1	1	1	1
2.15. Sexual Risk Avoidance (Abstinence Education)	1	1	1	1	1
2.16. Implant (Nexplanon)	1	1	1	1	1
2) Pregnancy Testing and Counseling as Indicated	1	1	1	1	1
3) Basic Infertility Services for Men					
1. Sexual History	1	1	1	1	1
2. Medical History/Family History	1	1	1	1	1
3. Reproductive History	1	1	1	1	1

Services	Apache Junction	Casa Grande	Coolidge	Maricopa	San Tan Valley
4. Physical Exam	1	1	1	1	1
5. Semen Analysis	3	3	3	3	3
6. Further Diagnosis	3	3	3	3	3
4) Basic Infertility Services for Women					
1. Sexual History	1	1	1	1	1
2. Medical History/Family History	1	1	1	1	1
3. Reproductive History	1	1	1	1	1
4. Physical Exam	1	1	1	1	1
5. Further Diagnosis	2	2	2	2	2
5) Preconception Health Screening, Counseling and Education					
1. Intimate Partner Violence	1	1	1	1	1
2. Alcohol And Other Drug Use	1	1	1	1	1
3. Tobacco Use	1	1	1	1	1
4. Immunization Status	1	1	1	1	1
5. BMI	1	1	1	1	1
6. Blood Pressure	1	1	1	1	1
7. Diabetes	2	2	2	2	2
8. Prenatal vitamins/Folic Acid supplements	1	1	1	1	1
6) Sexually Transmitted Infection Testing					
1. Chlamydia	1	1	1	1	1
2. Gonorrhea	1	1	1	1	1
3. Syphilis	1	1	1	1	1
4. Herpes	1	1	1	1	1
5. Hepatitis C	2	2	2	2	2
6. HIV	1	1	1	1	1
7. Hepatitis B	2	2	2	2	2

Services	Apache Junction	Casa Grande	Coolidge	Maricopa	San Tan Valley
7) Sexually Transmitted Infection Treatment					
1. Chlamydia	1	1	1	1	1
2. Gonorrhea	1	1	1	1	1
3. Syphilis	1	1	1	1	1
4. Herpes	1	1	1	1	1
5. HIV	1	1	1	1	1
8) Related Preventive Health Services					
1. Clinical Breast Exam as Indicated	1	1	1	1	1
2. Pelvic Exam as Indicated	1	1	1	1	1
3. Cervical Cytology with HPV Testing as Indicated	1	1	1	1	1
4. Genital Exam as Indicated	1	1	1	1	1
5. HPV Vaccine	1	1	1	1	1
6. Hepatitis B Vaccine	1	1	1	1	1
9) Other Preventive Health Services					
1. PrEP/PEP Services	2	2	2	2	2
2. Depression Screening	1	1	1	1	1

Attachment 2

AFFIRM AGENCY HEALTH CENTER CLIENT DATA SUMMARY REPORT

April 2024-March 2025 CLIENT DATA - SUMMARY

Agency Name:	Pinal County Public Health Services District - ARIZONA GRANT
Health Center Name:	Apache Junction
Name of Person filling out form:	Otilia Berrones
Date:	12/05/2023
Revision Date:	11/30/2023

Title X Family Planning Users:

Unduplicated Female Users	: 473
Unduplicated Male Users	: 172
**Total Unduplicated Females & Males	: 645

Adolescent Family Planning Users:
(included in Unduplicated Female and Male Users)

19 years and under	: 46
Total Unduplicated Teens	: 46

Income Status:
Poverty Level Income Percent

At or below 100% of FPL	: 388
Between 101 and 138%	: 83
Between 139 and 200%	: 81
Between 201 and 250%	: 34
At or above 251%	: 59
**Total Unduplicated clients by FPL %	: 645

	Females	Males	Total
Total Number of Client Visits*:	824	291	1115

* Duplicated clients numbers are okay
**Must be the same number between **Total Unduplicated Females & Males with **Total Unduplicated clients by FPL %
FPL = Federal Poverty Level

Attachment 2

AFFIRM AGENCY HEALTH CENTER CLIENT DATA SUMMARY REPORT

April 2024-March 2025 CLIENT DATA - SUMMARY

Agency Name:	Pinal County Public Health Services District - ARIZONA GRANT
Health Center Name:	Casa Grande
Name of Person filling out form:	Otilia Berrones
Date:	12/05/2023
Revision Date:	11/30/2023

Title X Family Planning Users:

Unduplicated Female Users	: 931
Unduplicated Male Users	: 280
**Total Unduplicated Females & Males	: 1211

Adolescent Family Planning Users:
(included in Unduplicated Female and Male Users)

19 years and under	: 160
Total Unduplicated Teens	: 160

Income Status:
Poverty Level Income Percent

At or below 100% of FPL	: 807
Between 101 and 138%	: 129
Between 139 and 200%	: 117
Between 201 and 250%	: 46
At or above 251%	: 112
**Total Unduplicated clients by FPL %	: 1211

	Females	Males	Total
Total Number of Client Visits*:	1698	436	2134

* Duplicated clients numbers are okay
**Must be the same number between **Total Unduplicated Females & Males with **Total Unduplicated clients by FPL %
FPL = Federal Poverty Level

Attachment 2

AFFIRM AGENCY HEALTH CENTER CLIENT DATA SUMMARY REPORT

April 2024-March 2025 CLIENT DATA - SUMMARY

Agency Name:	Pinal County Public Health Services District - ARIZONA GRANT
Health Center Name:	Coolidge
Name of Person filling out form:	Otilia Berrones
Date:	12/05/2023
Revision Date:	11/30/2023

Title X Family Planning Users:

Unduplicated Female Users	: 248
Unduplicated Male Users	: 43
**Total Unduplicated Females & Males	: 291

Adolescent Family Planning Users:
(included in Unduplicated Female and Male Users)

19 years and under	: 25
Total Unduplicated Teens	: 25

Income Status:
Poverty Level Income Percent

At or below 100% of FPL	: 202
Between 101 and 138%	: 40
Between 139 and 200%	: 19
Between 201 and 250%	: 8
At or above 251%	: 22
**Total Unduplicated clients by FPL %	: 291

	Females	Males	Total
Total Number of Client Visits*:	365	73	438

* Duplicated clients numbers are okay
**Must be the same number between **Total Unduplicated Females & Males with **Total Unduplicated clients by FPL %
FPL = Federal Poverty Level

Attachment 2

AFFIRM AGENCY HEALTH CENTER CLIENT DATA SUMMARY REPORT

April 2024-March 2025 CLIENT DATA - SUMMARY

Agency Name:	Pinal County Public Health Services District - ARIZONA GRANT
Health Center Name:	Maricopa
Name of Person filling out form:	Otilia Berrones
Date:	12/05/2023
Revision Date:	11/30/2023

Title X Family Planning Users:

Unduplicated Female Users	: 122
Unduplicated Male Users	: 18
**Total Unduplicated Females & Males	: 140

Adolescent Family Planning Users:
(included in Unduplicated Female and Male Users)

19 years and under	: 19
Total Unduplicated Teens	: 19

Income Status:
Poverty Level Income Percent

At or below 100% of FPL	: 102
Between 101 and 138%	: 14
Between 139 and 200%	: 13
Between 201 and 250%	: 5
At or above 251%	: 6
**Total Unduplicated clients by FPL %	: 140

	Females	Males	Total
Total Number of Client Visits*:	129	37	166

* Duplicated clients numbers are okay
**Must be the same number between **Total Unduplicated Females & Males with **Total Unduplicated clients by FPL %
FPL = Federal Poverty Level

Attachment 2

AFFIRM AGENCY HEALTH CENTER CLIENT DATA SUMMARY REPORT

April 2024-March 2025 CLIENT DATA - SUMMARY

Agency Name: Pinal County Public Health Services District - ARIZONA GRANT

Health Center Name: San Tan Valley

Name of Person filling out form: Otilia Berrones

Date: 12/05/2023

Revision Date: 11/30/2023

Title X Family Planning Users:

Unduplicated Female Users : 366

Unduplicated Male Users : 147

**Total Unduplicated Females & Males : 513

Adolescent Family Planning Users:
(included in Unduplicated Female and Male Users)

19 years and under : 58

Total Unduplicated Teens : 58

Income Status:
Poverty Level Income Percent

At or below 100% of FPL : 270

Between 101 and 138% : 58

Between 139 and 200% : 73

Between 201 and 250% : 45

At or above 251% : 67

**Total Unduplicated clients by FPL % : 513

	Females	Males	Total
Total Number of Client Visits*:	637	229	866

* Duplicated clients numbers are okay

**Must be the same number between **Total Unduplicated Females & Males with **Total Unduplicated clients by FPL %

FPL = Federal Poverty Level

Attachment 3

AFFIRM AGENCY ANNUAL EXPENSES BUDGET REPORT

Agency Name:	Pinal County Public Health Services District
Grant Name:	ARIZONA GRANT
Name of Person filling out form:	Otilia Berrones
Date:	11/16/2023
Revised Date:	11/16/2023
Reporting Period:	April 1, 2024 - March 31, 2025

Annual Budget Form April 2024-March 2025: Expenses Summary

EXPENSES	April 2023-March 2024 Budget	April 2024-March 2025 Total Program Budget
1. Personnel	$373429.52	$522705.31
2. Fringe Benefits	$130700.33	$182947.06
3. Travel	$2500.00	$4000.00
4. Equipment	$2500.00	$2500.00
5. Supplies	$125000.00	$137750.00
6. Contractual	$75000.00	$118750.00
7. Occupancy	$0.00	$0.00
8. Other	$0.00	$0.00
9. Indirect	$50413.00	$70565.00
TOTAL EXPENSES	**$759542.85**	**$1039217.37**

☒ I certify that information in this budget proposal is correct to the best of my knowledge.

Completed By : Otilia Berrones

Attachment 3

AFFIRM AGENCY ANNUAL REVENUE BUDGET REPORT

Agency Name:	Pinal County Public Health Services District
Grant Name:	ARIZONA GRANT
Name of Person filling out form:	Otilia Berrones
Date:	11/16/2023
Revised Date:	11/16/2023
Reporting Period:	April 1, 2024 - March 31, 2025

Annual Budget Form April 2024-March 2025 : Revenue Summary

REVENUE	April 2023-March 2024 Budget	April 2024-March 2025 Total Program Budget
1) Federal Grants		
1. Title X - Base	$350000.00	$350000.00
2. Bureau of Primary Health Care (BPHC)	$0.00	$0.00
3. Other Federal Grants (Specify)	$0.00	$0.00
4. Other Federal Grants (Specify)	$0.00	$0.00
5. Title X Additional Funds (Specify)	$0.00	$0.00
Sub Total of Federal Grants	$350000.00	$350000.00
2) Payment For Services		
1. Patient Collections/Fees	$2000.00	$8000.00
3) Third Party Payers		
1. Medicaid (Title XIX)	$25000.00	$40500.00
2. Medicare (Title XVIII)	$0.00	$0.00
3. Other public health insurance	$0.00	$0.00
4. Private health insurance	$7500.00	$28000.00
Sub Total of Third Party Payers	$32500.00	$68500.00
4) Other Sources		
1. Title V (MCH Block Grant)	$0.00	$0.00
2. Local Government	$375042.85	$612717.37
3. State Government	$0.00	$0.00
4. Client Donations	$0.00	$0.00
5. Agency In Kind	$0.00	$0.00
6. Agency Contribution (Non-County agencies only)	$0.00	$0.00
7. Other (Specify)	$0.00	$0.00
Sub Total of Other Sources	$375042.85	$612717.37

REVENUE	April 2023-March 2024 Budget	April 2024-March 2025 Total Program Budget
TOTAL REVENUE	**$759542.85**	**$1039217.37**

Title 42 —Public Health
Chapter I —Public Health Service, Department of Health and Human Services
Subchapter D —Grants

PART 59—GRANTS FOR FAMILY PLANNING SERVICES

Subpart A—Project Grants for Family Planning Services

Source: 86 FR 56177, Oct. 7, 2021, unless otherwise noted.

§ 59.1 To what programs do these regulations apply?

The regulations of this subpart are applicable to the award of grants under section 1001 of the Public Health Service Act (42 U.S.C. 300) to assist in the establishment and operation of voluntary family planning projects. These projects shall consist of the educational, comprehensive medical, and social services necessary to aid individuals to determine freely the number and spacing of their children.

§ 59.2 Definitions.

As used in this subpart:

Act means the Public Health Service Act, as amended.

Adolescent-friendly health services are services that are accessible, acceptable, equitable, appropriate and effective for adolescents.

Clinical services provider includes physicians, physician assistants, nurse practitioners, certified nurse midwives, and registered nurses with an expanded scope of practice who are trained and permitted by state-specific regulations to perform all aspects of the user (male and female) physical assessments recommended for contraceptive, related preventive health, and basic infertility care.

Client-centered care is respectful of, and responsive to, individual client preferences, needs, and values; client values guide all clinical decisions.

Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse patients.

Family means a social unit composed of one person, or two or more persons living together, as a household.

Family planning services include a broad range of medically approved services, which includes Food and Drug Administration (FDA)-approved contraceptive products and natural family planning methods, for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, sexually transmitted infection (STI) services, and other preconception health services.

Health equity is when all persons have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

Inclusive is when all people are fully included and can actively participate in and benefit from family planning, including, but not limited to, individuals who belong to underserved communities, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons

of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

Low-income family means a family whose total annual income does not exceed 100 percent of the most recent Poverty Guidelines issued pursuant to 42 U.S.C. 9902(2). "Low-income family" also includes members of families whose annual family income exceeds this amount, but who, as determined by the project director, are unable, for good reasons, to pay for family planning services. For example, unemancipated minors who wish to receive services on a confidential basis must be considered on the basis of their own resources.

Nonprofit, as applied to any private agency, institution, or organization, means that no part of the entity's net earnings benefit, or may lawfully benefit, any private shareholder or individual.

Quality healthcare is safe, effective, client-centered, timely, efficient, and equitable.

Secretary means the Secretary of Health and Human Services (HHS) and any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

Service site is a clinic or other location where Title X services are provided to clients. Title X recipients and/or their subrecipients may have service sites.

State includes, in addition to the several States, the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the U.S. Virgin Islands, American Samoa, the U.S. Outlaying Islands (Midway, Wake, et al.), the Marshall Islands, the Federated State of Micronesia, and the Republic of Palau.

Trauma-informed means a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.

§ 59.3 Who is eligible to apply for a family planning services grant?

Any public or nonprofit private entity in a State may apply for a grant under this subpart.

§ 59.4 How does one apply for a family planning services grant?

(a) Application for a grant under this subpart shall be made on an authorized form.

(b) An individual authorized to act for the applicant and to assume on behalf of the applicant the obligations imposed by the terms and conditions of the grant, including the regulations of this subpart, must sign the application.

(c) The application shall contain

(1) A description, satisfactory to the Secretary, of the project and how it will meet the requirements of this subpart;

(2) A budget and justification of the amount of grant funds requested;

(3) A description of the standards and qualifications which will be required for all personnel and for all facilities to be used by the project; and

(4) Such other pertinent information as the Secretary may require.

§ 59.5 What requirements must be met by a family planning project?

(a) Each project supported under this part must:

(1) Provide a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, STI services, preconception health services, and adolescent-friendly health services). If an organization offers only a single method of family planning, it may participate as part of a project as long as the entire project offers a broad range of acceptable and effective medically approved family planning methods and services. Title X service sites that are unable to provide clients with access to a broad range of acceptable and effective medically approved family planning methods and services, must be able to provide a prescription to the client for their method of choice or referrals to another provider, as requested.

(2) Provide services without subjecting individuals to any coercion to accept services or to employ or not to employ any particular methods of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services, assistance from or participation in any other program of the applicant.[1]

(3) Provide services in a manner that is client-centered, culturally and linguistically appropriate, inclusive, and trauma-informed; protects the dignity of the individual; and ensures equitable and quality service delivery consistent with nationally recognized standards of care.

(4) Provide services in a manner that does not discriminate against any client based on religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, or marital status.

(5) Not provide abortion as a method of family planning.[2] A project must:

(i) Offer pregnant clients the opportunity to be provided information and counseling regarding each of the following options:

(A) Prenatal care and delivery;

(B) Infant care, foster care, or adoption; and

(C) Pregnancy termination.

[1] 42 U.S.C. 300a-8 provides that any officer or employee of the United States, officer or employee of any State, political subdivision of a State, or any other entity, which administers or supervises the administration of any program receiving Federal financial assistance, or person who receives, under any program receiving Federal assistance, compensation for services, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening such person with the loss of, or disqualification for the receipt of, any benefit or service under a program receiving Federal financial assistance shall be fined not more than $1,000 or imprisoned for not more than one year, or both.

[2] Providers may separately be covered by federal statutes protecting conscience and/or civil rights.

(ii) If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and, referral upon request, except with respect to any option(s) about which the pregnant client indicates they do not wish to receive such information and counseling.

(6) Provide that priority in the provision of services will be given to clients from low-income families.

(7) Provide that no charge will be made for services provided to any clients from a low-income family except to the extent that payment will be made by a third party (including a government agency) which is authorized to or is under legal obligation to pay this charge.

(8) Provide that charges will be made for services to clients other than those from low-income families in accordance with a schedule of discounts based on ability to pay, except that charges to persons from families whose annual income exceeds 250 percent of the levels set forth in the most recent Poverty Guidelines issued pursuant to 42 U.S.C. 9902(2) will be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services.

(i) Family income should be assessed before determining whether copayments or additional fees are charged.

(ii) With regard to insured clients, clients whose family income is at or below 250 percent of the FPL should not pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied.

(9) Take reasonable measures to verify client income, without burdening clients from low-income families. Recipients that have lawful access to other valid means of income verification because of the client's participation in another program may use those data rather than re-verify income or rely solely on clients' self-report. If a client's income cannot be verified after reasonable attempts to do so, charges are to be based on the client's self-reported income.

(10) If a third party (including a Government agency) is authorized or legally obligated to pay for services, all reasonable efforts must be made to obtain the third-party payment without application of any discounts. Where the cost of services is to be reimbursed under title XIX, XX, or XXI of the Social Security Act, a written agreement with the title XIX, XX, or XXI agency is required.

(11)

(i) Provide that if an application relates to consolidation of service areas or health resources or would otherwise affect the operations of local or regional entities, the applicant must document that these entities have been given, to the maximum feasible extent, an opportunity to participate in the development of the application. Local and regional entities include existing or potential subrecipients which have previously provided or propose to provide family planning services to the area proposed to be served by the applicant.

(ii) Provide an opportunity for maximum participation by existing or potential subrecipients in the ongoing policy decision making of the project.

(b) In addition to the requirements of paragraph (a) of this section, each project must meet each of the following requirements unless the Secretary determines that the project has established good cause for its omission. Each project must:

(1) Provide for medical services related to family planning (including consultation by a clinical services provider, examination, prescription and continuing supervision, laboratory examination, contraceptive supplies), in person or via telehealth, and necessary referral to other medical facilities when medically indicated, and provide for the effective usage of contraceptive devices and practices.

(2) Provide for social services related to family planning, including counseling, referral to and from other social and medical service agencies, and any ancillary services which may be necessary to facilitate clinic attendance.

(3) Provide for opportunities for community education, participation, and engagement to:

(i) Achieve community understanding of the objectives of the program;

(ii) Inform the community of the availability of services; and

(iii) Promote continued participation in the project by diverse persons to whom family planning services may be beneficial to ensure access to equitable, affordable, client-centered, quality family planning services.

(4) Provide for orientation and in-service training for all project personnel.

(5) Provide services without the imposition of any durational residency requirement or requirement that the patient be referred by a physician.

(6) Provide that family planning medical services will be performed under the direction of a clinical services provider, with services offered within their scope of practice and allowable under state law, and with special training or experience in family planning.

(7) Provide that all services purchased for project participants will be authorized by the project director or their designee on the project staff.

(8) Provide for coordination and use of referrals and linkages with primary healthcare providers, other providers of healthcare services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs, who are in close physical proximity to the Title X site, when feasible, in order to promote access to services and provide a seamless continuum of care.

(9) Provide that if family planning services are provided by contract or other similar arrangements with actual providers of services, services will be provided in accordance with a plan which establishes rates and method of payment for medical care. These payments must be made under agreements with a schedule of rates and payment procedures maintained by the recipient. The recipient must be prepared to substantiate that these rates are reasonable and necessary.

(10) Provide, to the maximum feasible extent, an opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of all significant elements of the population to be served, and by others in the community knowledgeable about the community's needs for family planning services.

§ 59.6 What procedures apply to assure the suitability of informational and educational material (print and electronic)?

(a) A grant under this section may be made only upon assurance satisfactory to the Secretary that the project shall provide for the review and approval of informational and educational materials (print and electronic) developed or made available under the project by an Advisory Committee prior to their distribution, to

Title 42 —Public Health
Chapter I —Public Health Service, Department of Health and Human Services
Subchapter D —Grants

PART 59—GRANTS FOR FAMILY PLANNING SERVICES

Subpart A—Project Grants for Family Planning Services

Source: 86 FR 56177, Oct. 7, 2021, unless otherwise noted.

§ 59.1 To what programs do these regulations apply?

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Inclusive is when all people are fully included and can actively participate in and benefit from family planning, including, but not limited to, individuals who belong to underserved communities, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons

of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

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Secretary means the Secretary of Health and Human Services (HHS) and any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

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State includes, in addition to the several States, the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the U.S. Virgin Islands, American Samoa, the U.S. Outlaying Islands (Midway, Wake, et al.), the Marshall Islands, the Federated State of Micronesia, and the Republic of Palau.

Trauma-informed means a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.

§ 59.3 Who is eligible to apply for a family planning services grant?

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§ 59.4 How does one apply for a family planning services grant?

(a) Application for a grant under this subpart shall be made on an authorized form.

(b) An individual authorized to act for the applicant and to assume on behalf of the applicant the obligations imposed by the terms and conditions of the grant, including the regulations of this subpart, must sign the application.

(c) The application shall contain

(1) A description, satisfactory to the Secretary, of the project and how it will meet the requirements of this subpart;

(2) A budget and justification of the amount of grant funds requested;

(3) A description of the standards and qualifications which will be required for all personnel and for all facilities to be used by the project; and

(4) Such other pertinent information as the Secretary may require.

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(2) Provide services without subjecting individuals to any coercion to accept services or to employ or not to employ any particular methods of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services, assistance from or participation in any other program of the applicant.[1]

(3) Provide services in a manner that is client-centered, culturally and linguistically appropriate, inclusive, and trauma-informed; protects the dignity of the individual; and ensures equitable and quality service delivery consistent with nationally recognized standards of care.

(4) Provide services in a manner that does not discriminate against any client based on religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, or marital status.

(5) Not provide abortion as a method of family planning.[2] A project must:

(i) Offer pregnant clients the opportunity to be provided information and counseling regarding each of the following options:

(A) Prenatal care and delivery;

(B) Infant care, foster care, or adoption; and

(C) Pregnancy termination.

[1] 42 U.S.C. 300a-8 provides that any officer or employee of the United States, officer or employee of any State, political subdivision of a State, or any other entity, which administers or supervises the administration of any program receiving Federal financial assistance, or person who receives, under any program receiving Federal assistance, compensation for services, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening such person with the loss of, or disqualification for the receipt of, any benefit or service under a program receiving Federal financial assistance shall be fined not more than $1,000 or imprisoned for not more than one year, or both.

[2] Providers may separately be covered by federal statutes protecting conscience and/or civil rights.

(1) Provide for medical services related to family planning (including consultation by a clinical services provider, examination, prescription and continuing supervision, laboratory examination, contraceptive supplies), in person or via telehealth, and necessary referral to other medical facilities when medically indicated, and provide for the effective usage of contraceptive devices and practices.

(2) Provide for social services related to family planning, including counseling, referral to and from other social and medical service agencies, and any ancillary services which may be necessary to facilitate clinic attendance.

(3) Provide for opportunities for community education, participation, and engagement to:

(i) Achieve community understanding of the objectives of the program;

(ii) Inform the community of the availability of services; and

(iii) Promote continued participation in the project by diverse persons to whom family planning services may be beneficial to ensure access to equitable, affordable, client-centered, quality family planning services.

(4) Provide for orientation and in-service training for all project personnel.

(5) Provide services without the imposition of any durational residency requirement or requirement that the patient be referred by a physician.

(6) Provide that family planning medical services will be performed under the direction of a clinical services provider, with services offered within their scope of practice and allowable under state law, and with special training or experience in family planning.

(7) Provide that all services purchased for project participants will be authorized by the project director or their designee on the project staff.

(8) Provide for coordination and use of referrals and linkages with primary healthcare providers, other providers of healthcare services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs, who are in close physical proximity to the Title X site, when feasible, in order to promote access to services and provide a seamless continuum of care.

(9) Provide that if family planning services are provided by contract or other similar arrangements with actual providers of services, services will be provided in accordance with a plan which establishes rates and method of payment for medical care. These payments must be made under agreements with a schedule of rates and payment procedures maintained by the recipient. The recipient must be prepared to substantiate that these rates are reasonable and necessary.

(10) Provide, to the maximum feasible extent, an opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of all significant elements of the population to be served, and by others in the community knowledgeable about the community's needs for family planning services.

§ 59.6 What procedures apply to assure the suitability of informational and educational material (print and electronic)?

(a) A grant under this section may be made only upon assurance satisfactory to the Secretary that the project shall provide for the review and approval of informational and educational materials (print and electronic) developed or made available under the project by an Advisory Committee prior to their distribution, to

assure that the materials are suitable for the population or community to which they are to be made available and the purposes of Title X of the Act. The project shall not disseminate any such materials which are not approved by the Advisory Committee.

(b) The Advisory Committee referred to in paragraph (a) of this section shall be established as follows:

(1) ***Size.*** The committee shall consist of no fewer than five members and up to as many members the recipient determines, except that this provision may be waived by the Secretary for good cause shown.

(2) ***Composition.*** The committee shall include individuals broadly representative of the population or community for which the materials are intended (in terms of demographic factors such as race, ethnicity, color, national origin, disability, sex, sexual orientation, gender identity, sex characteristics, age, marital status, income, geography, and including but not limited to individuals who belong to underserved communities, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality).

(3) ***Function.*** In reviewing materials, the Advisory Committee shall:

(i) Consider the educational, cultural, and diverse backgrounds of individuals to whom the materials are addressed;

(ii) Consider the standards of the population or community to be served with respect to such materials;

(iii) Review the content of the material to assure that the information is factually correct, medically accurate, culturally and linguistically appropriate, inclusive, and trauma informed;

(iv) Determine whether the material is suitable for the population or community to which is to be made available; and

(v) Establish a written record of its determinations.

§ 59.7 What criteria will the Department of Health and Human Services use to decide which family planning services projects to fund and in what amount?

(a) Within the limits of funds available for these purposes, the Secretary may award grants for the establishment and operation of those projects which will in the Department's judgment best promote the purposes of section 1001 of the Act, taking into account:

(1) The number of clients, and, in particular, the number of low-income clients to be served;

(2) The extent to which family planning services are needed locally;

(3) The ability of the applicant to advance health equity;

(4) The relative need of the applicant;

(5) The capacity of the applicant to make rapid and effective use of the federal assistance;

(6) The adequacy of the applicant's facilities and staff;

(7) The relative availability of non-federal resources within the community to be served and the degree to which those resources are committed to the project; and

(8) The degree to which the project plan adequately provides for the requirements set forth in these regulations.

(b) The Secretary shall determine the amount of any award on the basis of an estimate of the sum necessary for the performance of the project. No grant may be made for less than 90 percent of the project's costs, as so estimated, unless the grant is to be made for a project which was supported, under section 1001, for less than 90 percent of its costs in fiscal year 1975. In that case, the grant shall not be for less than the percentage of costs covered by the grant in fiscal year 1975.

(c) No grant may be made for an amount equal to 100 percent for the project's estimated costs.

§ 59.8 How is a grant awarded?

(a) The notice of grant award specifies how long HHS intends to support the project without requiring the project to recompete for funds. This anticipated period will usually be for three to five years.

(b) Generally, the grant will initially be for one year and subsequent continuation awards will also be for one year at a time. A recipient must submit a separate application to have the support continued for each subsequent year. Decisions regarding continuation awards and the funding level of such awards will be made after consideration of such factors as the recipient's progress and management practices and the availability of funds. In all cases, continuation awards require a determination by HHS that continued funding is in the best interest of the government.

(c) Neither the approval of any application nor the award of any grant commits or obligates the United States in any way to make any additional, supplemental, continuation, or other award with respect to any approved application or portion of an approved application.

§ 59.9 For what purpose may grant funds be used?

Any funds granted under this subpart shall be expended solely for the purpose for which the funds were granted in accordance with the approved application and budget, the regulations of this subpart, the terms and conditions of the award, and the applicable cost principles prescribed in 45 CFR part 75.

§ 59.10 Confidentiality.

(a) All information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality. Otherwise, information may be disclosed only in summary, statistical, or other form which does not identify particular individuals. Reasonable efforts to collect charges without jeopardizing client confidentiality must be made. Recipient must inform the client of any potential for disclosure of their confidential health information to policyholders where the policyholder is someone other than the client.

(b) To the extent practical, Title X projects shall encourage family participation.[3] However, Title X projects may not require consent of parents or guardians for the provision of services to minors, nor can any Title X project staff notify a parent or guardian before or after a minor has requested and/or received Title X family planning services.

[3] 42 U.S.C. 300(a).

assure that the materials are suitable for the population or community to which they are to be made available and the purposes of Title X of the Act. The project shall not disseminate any such materials which are not approved by the Advisory Committee.

(b) The Advisory Committee referred to in paragraph (a) of this section shall be established as follows:

(1) ***Size.*** The committee shall consist of no fewer than five members and up to as many members the recipient determines, except that this provision may be waived by the Secretary for good cause shown.

(2) ***Composition.*** The committee shall include individuals broadly representative of the population or community for which the materials are intended (in terms of demographic factors such as race, ethnicity, color, national origin, disability, sex, sexual orientation, gender identity, sex characteristics, age, marital status, income, geography, and including but not limited to individuals who belong to underserved communities, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality).

(3) ***Function.*** In reviewing materials, the Advisory Committee shall:

(i) Consider the educational, cultural, and diverse backgrounds of individuals to whom the materials are addressed;

(ii) Consider the standards of the population or community to be served with respect to such materials;

(iii) Review the content of the material to assure that the information is factually correct, medically accurate, culturally and linguistically appropriate, inclusive, and trauma informed;

(iv) Determine whether the material is suitable for the population or community to which is to be made available; and

(v) Establish a written record of its determinations.

§ 59.7 What criteria will the Department of Health and Human Services use to decide which family planning services projects to fund and in what amount?

(a) Within the limits of funds available for these purposes, the Secretary may award grants for the establishment and operation of those projects which will in the Department's judgment best promote the purposes of section 1001 of the Act, taking into account:

(1) The number of clients, and, in particular, the number of low-income clients to be served;

(2) The extent to which family planning services are needed locally;

(3) The ability of the applicant to advance health equity;

(4) The relative need of the applicant;

(5) The capacity of the applicant to make rapid and effective use of the federal assistance;

(6) The adequacy of the applicant's facilities and staff;

(7) The relative availability of non-federal resources within the community to be served and the degree to which those resources are committed to the project; and

(8) The degree to which the project plan adequately provides for the requirements set forth in these regulations.

(b) The Secretary shall determine the amount of any award on the basis of an estimate of the sum necessary for the performance of the project. No grant may be made for less than 90 percent of the project's costs, as so estimated, unless the grant is to be made for a project which was supported, under section 1001, for less than 90 percent of its costs in fiscal year 1975. In that case, the grant shall not be for less than the percentage of costs covered by the grant in fiscal year 1975.

(c) No grant may be made for an amount equal to 100 percent for the project's estimated costs.

§ 59.8 How is a grant awarded?

(a) The notice of grant award specifies how long HHS intends to support the project without requiring the project to recompete for funds. This anticipated period will usually be for three to five years.

(b) Generally, the grant will initially be for one year and subsequent continuation awards will also be for one year at a time. A recipient must submit a separate application to have the support continued for each subsequent year. Decisions regarding continuation awards and the funding level of such awards will be made after consideration of such factors as the recipient's progress and management practices and the availability of funds. In all cases, continuation awards require a determination by HHS that continued funding is in the best interest of the government.

(c) Neither the approval of any application nor the award of any grant commits or obligates the United States in any way to make any additional, supplemental, continuation, or other award with respect to any approved application or portion of an approved application.

§ 59.9 For what purpose may grant funds be used?

Any funds granted under this subpart shall be expended solely for the purpose for which the funds were granted in accordance with the approved application and budget, the regulations of this subpart, the terms and conditions of the award, and the applicable cost principles prescribed in 45 CFR part 75.

§ 59.10 Confidentiality.

(a) All information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality. Otherwise, information may be disclosed only in summary, statistical, or other form which does not identify particular individuals. Reasonable efforts to collect charges without jeopardizing client confidentiality must be made. Recipient must inform the client of any potential for disclosure of their confidential health information to policyholders where the policyholder is someone other than the client.

(b) To the extent practical, Title X projects shall encourage family participation.[3] However, Title X projects may not require consent of parents or guardians for the provision of services to minors, nor can any Title X project staff notify a parent or guardian before or after a minor has requested and/or received Title X family planning services.

[3] 42 U.S.C. 300(a).

§ 59.11 Additional conditions.

The Secretary may, with respect to any grant, impose additional conditions prior to, at the time of, or during any award, when in the Department's judgment these conditions are necessary to assure or protect advancement of the approved program, the interests of public health, or the proper use of grant funds.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of the Secretary

Office of the Assistant Secretary for Health
Washington, D.C. 20201

DATE: March 22, 2024

TO: OPA Title X Grantees

FROM: Jessica Swafford Marcella, Deputy Assistant Secretary for Population Affairs

SUBJECT: Program Policy Notice (PPN) 2024-01: Clarification Regarding Confidential Services to Adolescents under the Title X Program

Purpose

The purpose of this PPN is to update Title X grantees regarding adolescent confidentiality requirements in response to the recent Fifth Circuit ruling in *Deanda v. Becerra*.

Background

On March 12, 2024, the U.S. Court of Appeals for the Fifth Circuit issued a decision in *Deanda v. Becerra*. On December 20, 2022, the U.S. District Court for the Northern District of Texas had ruled that HHS's administration of Title X to allow minors access to Title X services without parental consent violates Plaintiff Deanda's rights under Section 151.001(a)(6) of the Texas Family Code and under the Fourteenth Amendment. The district court also held unlawful and set aside the second sentence of 42 C.F.R. § 59.10(b). That sentence reads: "However, Title X projects may not require consent of parents or guardians for the provision of services to minors, nor can any Title X project staff notify a parent or guardian before or after a minor has requested and/or received Title X family planning services."

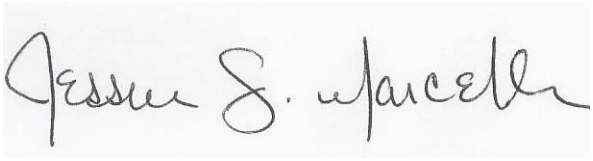
In its March 12 decision, the Fifth Circuit affirmed only part of the district court's ruling. The Fifth Circuit agreed with the district court that HHS's administration of Title X to allow minors access to Title X services without parental consent violates Deanda's rights under Section 151.001(a)(6) of the Texas Family Code. But it did not reach the constitutional question, and it reversed the part of the district court's judgment that held unlawful and set aside the parental consent language in HHS's regulation. Once the Fifth Circuit's mandate issues, the regulatory language will no longer be vacated, but the district court's grant of declaratory relief to Deanda will remain in effect.

Guidance

Pursuant to the court's declaratory judgment, Title X projects may not provide Mr. Deanda's minor daughter with Title X family planning services without parental consent. In addition, in light of the Fifth Circuit's decision, the Title X confidentiality regulation at 42 C.F.R. § 59.10(b) will remain in effect.

OPA will not be enforcing 42 C.F.R. § 59.10(b) in the State of Texas, nor will it enforce that regulation elsewhere in the fifth circuit to the extent it conflicts with state law. OPA will continue to enforce § 59.10(b) throughout the rest of the country.

Title X projects in states in the Fifth Circuit other than Texas may wish to consult with their own counsel regarding their states' requirements with respect to confidentiality.



3/22/2024

Jessica Swafford Marcella, MPA Date

OPA PPN *Program Policy Notice*

Clarification regarding *"Program Requirements for Title X Family Planning Projects"*

Confidential Services to Adolescents

OPA Program Policy Notice 2014 – 01

Release Date: June 5, 2014

I. Purpose

The purpose of this Program Policy Notice (PPN) is to provide Title X grantees with information to clarify some specific requirements included in the newly released *"Program Requirements for Title X-Funded Family Planning Projects Version 1.0 - April 2014."*

II. Background

On April 25, 2014, the Office of Population Affairs (OPA), which administers the Title X Family Planning Program, released new Title X Family Planning Guidelines consisting of two parts: 1) *Program Requirements for Title X Family Planning Projects* (hereafter referred to as *Title X Program Requirements*), and 2) *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs.*

The *Title X Program Requirements* document closely aligns with the various requirements applicable to the Title X Program as set out in the Title X statute and implementing regulations (42 CFR part 59, subpart A), and other applicable Federal statutes, regulations, and policies. The requirement that this Program Policy Notice addresses is confidential services to adolescents.

Requirements regarding **confidential services** for individuals regardless of age are stipulated in Title X regulations at 42 CFR § 59.5(a)(4) and § 59.11, and are repeated in the *Title X Program Requirements* in sections 9.3 and 10.

III. Clarification

It continues to be the case that Title X projects may not require written consent of parents or guardians for the provision of services to minors. Nor can any Title X project staff notify a parent or guardian before or after a minor has requested and/or received Title X family planning services.

OPA OFFICE OF POPULATION AFFAIRS

Title X projects, however, must comply with legislative mandates that require them to encourage family participation in the decision of minors to seek family planning services, and provide counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities. In addition, all Title X providers must comply with State laws requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.

Susan B. Moskosky, MS, WHNP-BC

Acting Director, Office of Population Affairs

Attachment 5

OFFICE OF POPULATION AFFAIRS

Title X Program Policy Notice

Integrating with Primary Care Providers

Release Date: November 22, 2016 **OPA Program Policy Notice: 2016 – 11**

I. Purpose

The purpose of this Program Policy Notice (PPN) is to clarify how Title X grantees may remain in compliance with *Program Requirements for Title X Funded Family Planning Projects* when integrating services with Health Resources & Services Administration (HRSA) Health Center Program grantees and look-alikes (i.e., health centers that receive funding under Section 330 of the Public Health Service Act, which authorizes the Health Center Program, as well as those that have been determined to meet Section 330 requirements but do not receive grant funding under that program). This PPN applies only to integrated settings, and not to settings in which only Health Center Program services are provided. We address three issues commonly faced by integrated Title X and HRSA-funded health center providers:

1) How to bill clients receiving Title X family planning services in compliance with Title X and Health Center Program Sliding Fee Discount Schedules and billing guidelines;

2) How to report data to the Family Planning Annual Reports (FPAR) and to the Uniform Data System (UDS) appropriately; and,

3) How to preserve Title X client confidentiality when billing for services provided.

II. Background

In 2014, the Office of Population Affairs (OPA) released new Title X program guidelines consisting of two parts:

1) *Program Requirements for Title X Funded Family Planning Projects* (Title X Program Requirements); and,

2) *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs* (QFP).

Title X Program Requirements align closely with the Title X statute and family planning services project implementing regulations (42 CFR part 59, subpart A), as well as other applicable federal statutes, regulations, and policies. This PPN is intended to help Title X grantees address integrated care settings with regard to Title X Program Requirements.

III. Clarification

This section provides clarification for some of the most common issues facing Title X Family Planning (FP) providers when integrating with primary care organizations, and suggests sample strategies to overcome these issues. Endnotes are provided for reference to the applicable section(s) of the Title X and HRSA Health Center Program Requirements aligned with each strategy.

Issue 1: Nominal Charge and Sliding Fee Discount Schedules (SFDS)

Strategy

The HRSA Health Center Program and the OPA Title X Program have unique Sliding Fee Discount Schedule (SFDS) program requirements, which include having differing upper limits. HRSA's policies, currently contained in Policy Information Notice (PIN) 2014-02, allow health centers to accommodate the further discounting of services as required by Title X regulations. Title X agencies (or providers) that are integrated with or receive funding from the HRSA Health Center Program may have dual fee discount schedules: one schedule that ranges from 101% to 200% of the Federal Poverty Level (FPL) for all health center services, and one schedule that ranges from 101% to 250% FPL for clients receiving **only** Title X family planning services directly related to preventing or achieving pregnancy, and as defined in their approved Title X project.

Title X agencies and providers may consult with the health center if they have additional questions regarding implementing discounting schedules that comply with Title X and Health Center Program requirements, which may result in the health center needing to consult their HRSA Health Center Program Project Officer.

To decide which SFDS to use, the health center should determine whether a client is receiving **only Title X family planning services** (Title X family planning services are defined by the service contract between the Title X grantee and health center) or **health center services in addition to Title X family planning services within the same visit.**

The following guidance applies specifically to clients who receive **only Title X family planning services** that are directly related to preventing or achieving pregnancy:

- Clients receiving only Title X family planning services with family incomes at or below 100% of the FPL must not be charged for services received. In order to comply with Title X regulations, any nominal fee typically collected by a HRSA health center program grantee or look-alike would **not be charged to the client receiving only Title X family planning services.**[i]

- Clients receiving only Title X family planning services with family incomes that are between 101% FPL and 250% FPL must be charged in accordance with a specific Title X SFDS based on the client's ability to pay. Any differences between charges based on applying the Title X SFDS and the health center's discounting schedule could be allocated to Title X grant funds. This allocation is aligned with the guidance provided in HRSA's PIN 2014-02, as discussed above. This PIN states that program grantees, "*may receive or have access to other funding sources (e.g.,*

Federal, State, local, or private funds) that contain terms and conditions for reducing patient costs for specific services. These terms and conditions may apply to patients over 200 percent of the FPG [Federal Poverty Guidelines]. *In such cases, it is permissible for a health center to allocate a portion (or all) of this patient's charge to this grant or subsidy funding source."*[ii]

- Note that unemancipated minors who receive confidential Title X family planning services must be billed according to the income of the minor.[iii]

The following guidance applies specifically to clients who receive **health center services in addition to Title X family planning services within the same visit:**

- For clients receiving health center services in addition to Title X family planning services, as defined above, within the same visit, the health center or look-alike may utilize its health center discounting schedule (which ranges from 101% to 200% FPL) including collecting one nominal fee for health center services provided to clients with family incomes at or below 100% FPL.

Issue 2: Fulfilling Data Reporting Requirements

Strategy

To comply with mandatory program reporting requirements for both the Title X and HRSA Health Center Program, health centers that are integrated with Title X funded agencies must provide data on services provided that are relevant to either or both through FPAR and UDS, as appropriate. In cases where a data element is applicable to both FPAR and UDS, reporting such data to each report does not result in "double" credit for services provided; rather, it ensures that both Title X and HRSA receive accurate information on services provided to clients during the given reporting period.

Further instructions on how a family planning "user" is defined can be found in the FPAR Forms & Instructions guidance document.

Issue 3: Sliding Fee Discount Schedule eligibility for individuals seeking confidential services

Strategy

For individuals requesting that Title X family planning services provided to them are confidential (i.e., they do not want their information disclosed in any way, including for third-party billing), the provider should ensure that appropriate measures are in place to protect the client's information, beyond HIPAA privacy assurances.[iv] Providers **may not bill third-party payers** for services in such cases where confidentiality cannot be assured (e.g., a payer does not suppress Explanation of Benefits documents and does not remove such information from claims history and other documents accessible to the policy holder). Providers may request payment from clients at the time of the visit for any confidential services provided that cannot be disclosed to third-party payers, as long as the provider uses the appropriate SFDS. Inability to pay, however, cannot be a barrier to services.[v] Providers may bill third-party payers for services that the client identifies as non-confidential.

Endnotes

[i] Section 8.4 of the Title X Program Requirements contains information related to charges, billing, and collections. The program requirements in section 8.4 most relevant to charging clients at or below 100% of the FPL, between 101% and 250% of the FPL, and above 250% of the FPL, are as follows:

Title X Program Requirement 8.4.1. *Clients whose documented income is at or below 100% of the Federal Poverty Level (FPL) must not be charged, although projects must bill all third parties authorized or legally obligated to pay for services (Section 1006(c)(2), PHS Act; 42 CFR 59.5(a)(7)).*

Within the parameters set out by the Title X statute and program requirements, Title X grantees have a large measure of discretion in determining the extent of income verification activity that they believe is appropriate for their client population. Although not required to do so, grantees that have lawful access to other valid means of income verification because of the client's participation in another program may use those data rather than re-verify income or rely solely on clients self-report.

Title X Program Requirement 8.4.2. *A schedule of discounts, based on ability to pay, is required for individuals with family incomes between 101% and 250% of the FPL (42 CFR 59.5(a)(8)).*

Title X Program Requirement 8.4.3. *Fees must be waived for individuals with family incomes above 100% of the FPL who, as determined by the service site project director, are unable, for good cause, to pay for family planning services (42 CFR 59.2).*

Title X Program Requirement 8.4.4. *For persons from families whose income exceeds 250% of the FPL, charges must be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services. (42 CFR 59.5(a)(8)).*

[ii] HRSA Policy Information Notice PIN 2014-02, "Sliding Fee Discount and Related Billing and Collections Program Requirements." *Individuals and families with annual incomes above 200 percent of the FPG are not eligible for sliding fee discounts. However, health centers may receive or have access to other funding sources (e.g., Federal, State, local, or private funds) that contain terms or conditions for reducing patient costs for specific services. These terms and conditions may apply to patients over 200 percent of the FPG. In such cases, it is permissible for a health center to allocate a portion (or all) of this patient's charge to this grant or subsidy funding source.*

[iii] Title X Program Requirement 8.4.5. *Eligibility for discounts for unemancipated minors who receive confidential services must be based on the income of the minor (42 CFR 59.2).*

[iv] Title X Program Requirement 8.4.8. *Reasonable efforts to collect charges without jeopardizing client confidentiality must be made.*

HRSA PIN 2014-02. *Patient privacy and confidentiality must be protected throughout the (SFDS eligibility determination) process. The act of billing and collecting from patients should be conducted in an efficient, respectful and culturally appropriate manner, assuring that procedures do not present a barrier to care and patient privacy and confidentiality are protected throughout the process.*

[v] Title X Program Requirement 8.4.3, repeated. *Fees must be waived for individuals with family incomes above 100% of the FPL who, as determined by the service site project director, are unable, for good cause, to pay for family planning services (42 CFR 59.2).*

Affirm™
Sexual and Reproductive Health for All

Affirm 2023 Program Standards and Policy Manual

(Revised April 2023)

Table of Contents

INTRODUCTION

TITLE X

To assist individuals in determining the number and spacing of their children through the provision of affordable, voluntary family planning services, Congress enacted the Family Planning Services and Population Research Act of 1970 (Public Law 91-572).
The law amended the Public Health Service (PHS) Act to add Title X, "Population Research and Voluntary Family Planning Programs." Section 1001 of the PHS Act (as amended) authorizes grants "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents)."

The Title X Family Planning Program is the only Federal program dedicated solely to the provision of family planning and related preventive health services. The program is designed to provide contraceptive supplies and information to all who want and need them, with priority given to persons from low-income families. All Title X-funded projects are required to offer a broad range of acceptable and effective medically (U.S. Food and Drug Administration (FDA)) approved contraceptive methods and related services on a voluntary and confidential basis. Title X services include the delivery of related preventive health services, including client education and counseling; cervical and breast cancer screening; sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) prevention education, testing, and referral; and pregnancy diagnosis and counseling. By law, Title X funds may not be used in programs where abortion is a method of family planning.

The Title X Family Planning Program is administered by the Office of Population Affairs (OPA), Office of the Assistant Secretary for Health (OASH), within the U.S. Department of Health and Human Services (DHHS). On October 4, 2021, the DHHS OPA amended the Title X Family Planning regulations to restore access to equitable, affordable, client-centered, quality family planning services.

The Title X program expectations come from the Title X statute, implementing regulations at 42 CFR Part 59, Subpart A, and applicable legislative mandates. Title X subrecipients are also expected to comply with additional program guidance (including Providing Quality Family Planning Services (QFP): Recommendations from Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs 2021 Final Rule FAQs, Program Policy Notices), OPA program priorities, and other expectations from the OASH Office of Grants and Acquisition Management (GAM) and the Notice of Award (NOA). All expectations have been compiled into this document, the Program Standards and Policy Manual.

In addition to the statute, regulations, legislative mandates, and additional program guidance that apply to Title X, OPA establishes program priorities that represent overarching goals for the Title X program. OPA expects recipients to develop and implement plans to address program priorities. The current priorities are:

1) Advance health equity through the delivery of Title X services;

2) Improve and expand access to Title X services; and

3) Deliver Title X services of the highest quality.

Affirm

Affirm Sexual and Reproductive Health for All is an Arizona non-profit 501(c)(3) agency, incorporated in 1974 (as the Arizona Family Planning Council). Since 1983, Affirm has been designated as a Title X ("ten") grantee and awarded federal family planning funds to provide services in Arizona.

As the grantee, Affirm performs a variety of roles in the oversight of the Title X Family Planning Program, including grant administrator, monitor, partner, facilitator, technical advisor, educator and payer. Affirm responds to requests from OPA and from other Federal DHHS Offices. As the grantee, the Affirm is responsible to the funding source for the following: quality, cost, accessibility, acceptability, and reporting for the Program and the performance of all subrecipient agencies.

Affirm's vision is universal access to quality reproductive healthcare services. In this role, the functions and responsibilities of Affirm include:

- Assessing compliance with Title X statute, regulations, and legislative mandates;
- Assessing community needs in the area of reproductive healthcare for individuals with low-incomes;
- Developing community programs to meet those needs;
- Identifying, funding, and contracting with service providers;

- Monitoring and evaluating the performance of subrecipient agencies;
- Collecting and disseminating data;
- Providing training and technical assistance;
- Providing information to the community;
- Coordinating services; and,
- Client advocacy.

Affirm provides a network of services through contracts with community-based, private non-profit, and public agencies for the provision of direct clinical and educational reproductive healthcare services to low-income adults and adolescents. Affirm is governed by a Board of Directors made up of volunteers representing diverse backgrounds and geographic areas of Arizona. Affirm is committed to providing quality reproductive healthcare services to as many people as possible with the resources available.

PROGRAM MONITORING AND EVALUATION

Affirm will conduct site reviews of each subrecipient agency to determine compliance with federal and local laws and requirements, program guidelines and other contractual agreements. These evaluations play a crucial role in ensuring that quality reproductive health care services are provided to women and men. The site reviews will be performed by Affirm periodically or on an as needed basis and will range from comprehensive to issue specific reviews, using a standardized monitoring tool. Monitoring and evaluation of the Title X Program and subrecipient agencies may include, but is not limited to: review and analysis of financial, statistical, and special project reports, discussions and meetings with subrecipient agency staff, site visits to health center location(s) and formal site reviews of subrecipient agencies.

Program Standards and Policy Manual (PSPM)

The purpose of this manual is to document the Affirm's Title X Family Planning Project's program standards for development, implementation, and management of the Title X Program, and other related projects funded by Affirm.

This manual establishes minimum standards and can be used as a reference and information resource for family planning programs. Subrecipients are required to adhere to the requirements and guidelines set forth in this manual, and are also responsible for incorporating any policy changes into their operation.

The PSPM has been developed to assist Title X subrecipient agencies in understanding and implementing the family planning services grants program. This manual mirrors the DHHS OPA's 2021 Title X Final Rule and contains just those sections that are relevant to sub-recipient or subrecipient agencies. Contents of the PSPM are subject to change to mirror the Program Review Tool to be published by OPA.

Grantee specific requirements are omitted.

Each Title X Requirement has at least two sections:

1) **Affirm Best Practice Suggestion** – Additional best practice suggestions and/or comments from Affirm to subrecipient agencies

2) **Evidence Requirement is Met** – evidence that the subrecipient agency must have to ensure that requirements are met

3) **Affirm Additional Standard** – Additional requirement from Affirm to subrecipient agencies

Helpful Links

Title X Statutes, Regulations, and Legislative Mandates: https://opa.hhs.gov/grant-programs/title-x-service-grants/title-x-statutes-regulations-and-legislative-mandates

Providing Quality Family Planning Services: https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/quality-family-planning

Sterilization of Persons in Federally Assisted Family Planning Projects Regulations: https://www.ecfr.gov/cgi-bin/text-idx?SID=f93c09d3dad79124016304b202ac9860&mc=true&node=pt42.1.50&rgn=div5#sp42.1.50.b

DEFINITIONS

Useful Title X Definitions	
Term	Definition
Adolescent-friendly health services	Services that are accessible, acceptable, equitable, appropriate and effective for adolescents. (42 CFR § 59.2)
Basic infertility services	Basic infertility services include services for both partners of an infertile couple. Basic infertility services include understanding the client's reproductive life plan and the client's and partner's difficulty in achieving pregnancy through a medical history, sexual health assessment and physical exam, in accordance with recommendations developed by professional medical associations. Basic infertility services also include infertility counseling. (QFP, p.15-16, https://opa.hhs.gov/sites/default/files/2020- 10/providing-quality-family-planning-services-2014_1.pdf).
Client-centered care	Client-centered care provided is respectful of, and responsive to, individual client preferences, needs, and values; client values guide all clinical decisions. (42 CFR § 59.2)
Culturally and linguistically appropriate services	Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse patients. (42 CFR § 59.2)

Family Planning Services	Family planning services delivered by Title X subrecipients include a broad range of medically approved services, which includes Food and Drug Administration (FDA)- approved contraceptive products and natural family planning methods for clients who want to prevent pregnancy and space births; pregnancy testing and counseling; assistance to achieve pregnancy; basic infertility services; sexually transmitted infection (STI) services; and other preconception health services. (42 CFR § 59.2). Family planning services include preconception health services, education, and general reproductive and fertility health care to improve maternal and infant outcomes, and the health of women, men, and adolescents who seek family planning services, and the prevention, diagnosis, and treatment of infections and diseases which may threaten childbearing capability or the health of the individual, sexual partners, and potential future children. (QFP, pp.1-5, https://opa.hhs.gov/sites/default/files/2020- 10/providing-quality-family-planning-services-2014_1.pdf). Family planning methods and services are never to be coercive and must always be strictly voluntary. (42 CFR § 59.5(a)(2)). These family planning services should be offered to both women and men in accordance with QFP, and Title X policies. Title X providers should be trained and equipped to offer these services.
FDA-approved contraceptive products	FDA-approved contraceptive products include Long-Acting Reversible Contraceptives (LARC), contraceptive injection, short-acting hormonal methods, barrier methods, emergency contraception, and permanent sterilization (https://www.fda.gov/consumers/free-publications-women/birth-control).
Health equity	Health equity is when all persons have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. (42 CFR § 59.2)
Inclusive	Inclusive is when all people are fully included and can actively participate in and benefit from family planning, including, but not limited to, individuals who belong to underserved communities, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. (42 CFR § 59.2)
Low-income family	Low-income family means a family whose total annual income does not exceed 100 percent of the most recent Poverty Guidelines issued pursuant to 42 U.S.C. 9902(2). "Low-income family" also includes members of families whose annual family income exceeds this amount, but who, as determined by the project director, are unable, for good reasons, to pay for family planning services. For example, unemancipated minors who wish to receive services on a confidential basis must be considered on the basis of their own resources. (42 CFR § 59.2)
Preconception health services	Preconception health services include counseling on folic acid; reproductive life planning; sexual health assessment; medical history intake; screening for intimate partner violence; alcohol and other drug use, and tobacco use; immunizations; depression; height, weight, and body mass index; blood pressure (QFP, p.16-17, https://opa.hhs.gov/sites/default/files/2020-10/providing-quality- family-planning-services-2014_1.pdf).
Quality healthcare	Quality healthcare is safe, effective, client-centered, timely, efficient, and equitable. (42 CFR § 59.2)
Service site	Service site is a clinic or other location where Title X services are provided to clients. Title X subrecipients may have service sites. (42 CFR § 59.2)
Sliding Fee Discount Schedule (SFDS)	The HRSA Health Center Program and the OPA Title X Program have unique Sliding Fee Discount Schedule (SFDS) program requirements, which include having differing upper limits. Title X agencies (or providers) that are integrated with or receive funding from the HRSA Health Center Program may have dual fee discount schedules: one schedule that ranges from 101% to 200% of the FPL for all health center services, and one schedule that ranges from 101% to 250% FPL for clients receiving only Title X family planning services directly related to preventing or achieving pregnancy, and as defined in their approved Title X project. (OPA Program Policy Notice: 2016-11—Integrating with Primary Care Providers)
STI services	STI services include services provided in accordance with CDC's STD treatment and HIV testing guidelines. STI services include assessing, screening, treating, and counseling. STI services should be provided for persons with or without signs or symptoms suggestive of an STD. (QFP, p. 17-18, https://opa.hhs.gov/sites/default/files/2020-10/providing-quality-family-planning-services- 2014_1.pdf).
Suggested Evidence to Submit for Program Review	The suggested evidence is a new addition to the Program Review Tool. The list includes the types of materials and documentation grant subrecipients should provide as evidence that the project is in compliance with Title X program expectations. The examples listed do not represent an exhaustive list, however are typical of what program review consultants review to assess grantee compliance for Title X. Evidence may include, but is not limited to, policies, procedures, protocols, documentation of training, medical record review, direct visual confirmation per consultants and/or OPA staff to ensure that what is contained in written policy or instructions is actually being carried out, or any other form of documentation that substantiates that the project is operating in accordance with the Title X program expectations and policies, including QFP.
Title X Program Expectations	The Title X program expectations come from the Title X statute, implementing regulations at 42 CFR Part 59, Subpart A, and applicable legislative mandates. Title X subrecipients are also expected to comply with additional program guidance (including QFP, 2021 Final Rule FAQs, Program Policy Notices) OPA program priorities, and other expectations from GAM and the Notice of Award (NOA). All subrecipients must comply with the expectations regarding the provision of family planning services that can be found in the statute (Title X of the Public Health Service Act, 42 U.S.C. § 300 et seq.) the implementing regulations (42 CFR Part 59, Subpart A), any applicable legislative mandates, and are expected to comply with additional program guidance. In addition, sterilization of clients as part of the Title X program must be consistent with 42 CFR Part 50, Subpart B ("Sterilization of Persons in Federally Assisted Family Planning Projects").
Trauma-informed	Trauma-informed means a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. (42 CFR § 59.2)

Terms used throughout this document include:

TERM	DEFINITION
The Act or Law	Title X of the Public Health Service Act, as amended.
Clinical services provider	Physicians, physician assistants, nurse practitioners, certified nurse midwives, and registered nurses with an expanded scope of practice who are trained and permitted by state-specific regulations to perform all aspects of the user (male and female) physical assessments recommended for contraceptive, related preventive health, and basic infertility care.
Family	A social unit composed of one person, or two or more persons living together, as a household.
Grantee	The entity that receives Federal financial assistance via a grant and assumes legal and financial responsibility and accountability for the awarded funds and for the performance of the activities approved for funding.
Nonprofit	Any private agency, institution, or organization for which no part of the entity's net earnings benefit, or may lawfully benefit, any private stakeholder or individual.
Project	Activities described in the grant application and any incorporated documents supported under the approved budget. The "scope of the project" as defined in the funded application consists of activities that the total approved grant-related project budget supports.
Secretary	The Secretary of Health and Human Services and any other officer or employee of the U.S. Department of Health and Human Services to whom the authority involved has been subrecipient.
Sub-recipients	Those entities that provide family planning services with Title X funds under a written agreement with a grantee. May also be referred to as subrecipients or contract agencies.
State	In addition to the several States, the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the U.S. Virgin Islands, American Samoa, the U.S. Outlaying Islands (Midway, Wake, et al.), the Marshall Islands, the Federated State of Micronesia, and the Republic of Palau.

ACRONYMS

The following is a list of acronyms and abbreviations used throughout this document.

ACRONYM/ ABBREVIATION	
CFR	Code of Federal Regulations
FDA	U.S. Food and Drug Administration
FPL	Federal Poverty Level
HHS	U.S. Department of Health and Human Services
HIV	Human Immunodeficiency Virus
I&E	Information and Education
OMB	Office of Management and Budget
OPA	Office of Population Affairs
OSHA	Occupational Safety and Health Administration
PHS	U.S. Public Health Service
STI	Sexually Transmitted Infection

COMMONLY USED REFERENCES

As a Federal grant program, requirements for the Title X Family Planning Program are established by Federal laws and regulations. For ease of reference, the laws and regulations most cited in this document are listed below. Other applicable laws and regulations are cited throughout the document.

Law	Title X Public Law ("Family Planning Services and Population Research Act of 1970")	Public Law 91-572
Law	Title X Statute ("Title X of the Public Health Service Act")	42 U.S.C.300, *et seq.*
Regulation	Sterilization Regulations ("Sterilization of persons in Federally Assisted Family Planning Projects")	42 CFR part 50, subpart B
Regulation	Title X Regulations ("Project Grants for Family Planning Services")	42 CFR part 59, subpart A
Regulation	HHS Grants Administration Regulations ("Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards")	45 CFR part 75

Regulation	Federal Award Administration Regulations ("Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards")	2 CFR part 200

1. Project Administration Expectation

Project Administration Expectation #1 : Non-Coercive Services

Provide services without subjecting individuals to any coercion to accept services or to employ or not to employ any particular methods of family planning. (42 CFR § 59.5(a)(2))

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Subrecipient written policies and procedures specify services are to be provided without subjecting individuals to any coercion
2. Contracts with clinical subcontractors/contractors specify that they are to provide services without subjecting individuals to any coercion
3. Staff acknowledgement statement is signed annually in inform Title X staff and clinical subcontractors that clients may not be coerced to use contraception, or to use any particular method of contraception or service
4. Record review at service sites demonstrates that each client has signed a general consent form or other documentation that demonstrates they have received an assurance that services are voluntary.
5. Observations and staff interviews display:
    - Establish and Maintain Rapport with the Client
    - Assess the Client's Needs and Personalize Discussions Accordingly
    - Work with the Client Interactively to Establish a Plan
    - Provide Information that Can Be Understood and Retained by the Client
    - Confirm Client Understanding

Project Administration Expectation #2: Voluntary and Acceptance of FP Services not a Prerequisite for Eligibility of Services

Ensure that acceptance of services is solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services, assistance from or participation in any other program of the recipient. (Sections 1001 and 1007, PHS Act; 42 CFR § 59.5(a)(2))

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Written policy and procedures that prohibits any subrecipient service sites from making the acceptance of family planning services a prerequisite to the receipt of any other services.
2. Documentation showing staff have been informed at least once during the current project period that a client's receipt of family planning services may not be used as a prerequisite to receipt of any other services offered.
3. General consent forms (signed by the client) or other documentation provided to clients states that receipt of family planning services is not a prerequisite to receipt of any other services offered
4. Medical record review demonstrates that each client has signed a general consent form.
5. Clinic signage

Project Administration Expectation #3: Subject to Prosecution

Ensure that staff are informed that any officer or employee of the United States, officer or employee of any State, political subdivision of a State, or any other entity, which administers or supervises the administration of any program receiving Federal financial assistance, or person who receives, under any program receiving Federal assistance, compensation for services, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening such person with the loss of, or disqualification for the receipt of, any benefit or service under a program receiving Federal financial assistance shall be fined not more than $1,000 or imprisoned for not more than one year, or both. (42 U.S.C. § 300a-8, as set out in 42 CFR § 59.5(a)(2) footnote 1)

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Written policies and procedures that require all subrecipient service sites be informed that they may be subject to prosecution if they coerce or try to coerce any person to undergo an abortion or sterilization procedure.
2. Documentation that subrecipient staff have been informed at least once during the current project period that they are subject to this expectation.

Project Administration Expectation #4: Non-Discriminatory Services

Provide services in a manner that does not discriminate against any client based on religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, or marital status. (42 CFR § 59.5(a)(4))

Affirm Best Practice Suggestion

Client experience of care surveys document that clients perceive providers and other clinic staff to be respectful during Family Planning Services, a consistent review is conducted, and plan is developed to address gaps the service provision, based survey feedback.

Observations during patient intake/registration, eligibility determination, history taking, examination, counseling, and fee collection

Evidence Requirement is Met

1. Service site has written policies and procedures that require services to be provided without regard to religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, or marital status, and to inform staff of this requirement on an annual basis.
2. Documentation showing Title X staff were informed of this expectation.

Project Administration Expectation #5: Durational Residency Requirements

Provide services without the imposition of any durational residence expectation or an expectation that the client be referred by a physician. (42 CFR § 59.5(b)(5))

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Subrecipient agencies have written policies and procedures requiring services to be provided without the imposition of any durational residency expectation or an expectation that the client be referred by a physician.

2. Reviewed through staff observations of the registration process and interviews (review of intake)

Project Administration Expectation #6 : Client Confidentiality

Ensure that all information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality. Information may otherwise be disclosed only in summary, statistical, or other form that does not identify the individual. Reasonable efforts to collect charges without jeopardizing client confidentiality must be made. Subrecipients must inform the client of any potential for disclosure of their confidential health information to policyholders where the policyholder is someone other than the client. (42 CFR § 59.10(a))

Affirm Best Practice Suggestion

Affirm, subrecipient agency and any health care providers that have access to identifying information are bound by Arizona Revised Statute (A.R.S.) §36-160, Confidentiality of Records

Evidence Requirement is Met

1. Subrecipient has a written policy requiring that all service sites safeguard client confidentiality, including release of records to clients or other providers, ensuring client information must only be transferred after the client has given written, signed consent.
2. Documentation demonstrates that staff have been informed about policies related to preserving client confidentiality and privacy.
3. The health records system(s) has safeguards in place to ensure adequate privacy, security, and appropriate access to personal health information.
4. There is evidence that HIPAA privacy forms are provided to clients and signed forms are collected as required.
5. General consent forms or other documentation at service sites state that services will be provided in a confidential manner and note any limitations that may apply.
6. Client education materials note that client's right to confidential services is available to clients.
7. The physical layout of the facility ensures that client services are provided in a manner that allows for confidentiality and privacy.
8. Observations during patient intake/registration, eligibility determination, history taking, examination, counseling, and fee collection
9. Third party billing is processed in a manner that does not breach client confidentiality.
10. Fiscal chart review

Project Administration Expectation #7 : Accessibility

Develop plans and strategies for implementing family planning services in ways that make services as accessible as possible for clients. (OPA Program Priority, as set out in PA-FPH-22-001 NOFO and the FY 2022 NOA Special Terms and Requirements)

Affirm Best Practice Suggestion

Strategies for making services more accessible include, but is not limited to: the location of services, hours of services, modality of service provision (e.g., in-person, telehealth, drive-thru, mobile clinics), availability of ancillary services and referral linkages, robust education and community outreach, ensuring access to a broad range of acceptable and effective family planning methods and services at service sites, and implementing billing and payment practices that expand access to services.

Evidence Requirement is Met

1. Workplan
2. Health Center hours inclusive of non-traditional hours
3. Relevant meeting minutes

Project Administration Expectation #8 :

Identify and execute strategies for delivering services that are responsive to the diverse needs of the clients and communities served. (OPA Program Priority, as set out in PA-FPH-22-001 NOFO and the FY 2022 NOA Special Terms and Requirements)

Affirm Best Practice Suggestion

Supply more than 1 month of contraception supplies, self-administered depo, offering self-swabbing specimen collection, telehealth services, ensuring members of care team are reflective of patients race or ethnicity when requested or when possible.

Evidence Requirement is Met

1. Workplan
2. Protocols & Procedures or Protocols – translation services, disability accommodations
3. Language Line
4. I&E

Project Administration Expectation #9: Notice of Changes

Provide notice in writing to Affirm of any deletions, additions, or changes to the name, location, street address and email, services provided on-site, and contact information for Title X service sites within 30 days.

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Interview with Affirm Program Manager and subrecipient.

Project Administration Expectation #10: 340B Program Requirements

If enrolled in the 340B Program, and comply with all 340B Program requirements, including annual recertification and avoiding diversion or duplicate discounts. 340B Program requirements are available at https://**www.hrsa.gov/opa/program-**requirements/index.html. (FY 2022 NOA Special Terms and expectations)

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Staff interviews (conducted by the fiscal consultant) and confirmed in inventory check, etc.
2. Documentation of 340B ID (entity registration)

Additional Special Terms and Requirements and Standard Terms of the FY 2022 Title X Notice of Award – Standard Terms Expectation #6:

***The following two expectations assessed under Project Administration derive from the Additional Expectations section in the Title X Program Handbook. These two expectations are part of the Title X Program Review.**
Intellectual Property and Data Rights: Recipients may copyright any work that is subject to copyright and was developed, or for which ownership was acquired, under a federal award. The federal government reserves a royalty-free, nonexclusive and irrevocable right to reproduce, publish, or otherwise use the work for Federal purposes, and to authorize others to do so. The awardee is subject to applicable regulations governing patents and inventions, including government- wide regulations issued by the Department of Commerce at 37 CFR part 401. The federal government has the right to:

obtain, reproduce, publish, or otherwise use the data produced under this award; and authorize others to receive, reproduce, publish, or otherwise use such data for federal purposes. (43 CFR § 75.322)

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Interviews with Project Director

Additional Special Terms and Requirements and Standard Terms of the FY 2022 Title X Notice of Award – Standard Terms Expectation #7:

Acknowledgement of Federal Grant Support: Recipients acknowledge Federal funding when issuing statements, press releases, publications, requests for proposal, bid solicitations and other documents --such as tool-kits, resource guides, websites, and presentations (hereafter "statements")-- describing the projects or programs funded in whole or in part with HHS federal funds, the recipient must clearly state the percentage and dollar amount of the total costs of the program or project funded with federal money and the percentage and dollar amount of the total costs of the project or program funded by non-governmental sources. When issuing statements resulting from activities supported by HHS financial assistance, the recipient entity must include an acknowledgement of federal assistance using one of the following or a similar statement:

i.If the HHS Grant or Cooperative Agreement is NOT funded with other non-governmental sources:
This [project/publication/program/website, etc.] [is/was] supported by the [full name of the PROGRAM OFFICE] of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $XX with 100 percent funded by [PROGRAM OFFICE]/OASH/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by [PROGRAM OFFICE]/OASH/HHS, or the U.S. Government. For more information, please visit [PROGRAM OFFICE website, if available].

ii.The HHS Grant or Cooperative Agreement IS partially funded with other nongovernmental sources:
This [project/publication/program/website, etc.] [is/was] supported by the [full name of the PROGRAM OFFICE] of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $XX with XX percentage funded by [PROGRAM OFFICE]/OASH/HHS and $XX amount and XX percentage funded by non-government source(s). The contents are those of the author (s) and do not necessarily represent the official views of, nor an endorsement, by [PROGRAM OFFICE]/OASH/HHS, or the U.S. Government. For more information, please visit [PROGRAM OFFICE website, if available].

The federal award total must reflect total costs (direct and indirect) for all authorized funds (including supplements and carryover) for the total competitive segment up to the time of the public statement.

Any amendments by the recipient to the acknowledgement statement must be coordinated with the OASH federal project officer and the OASH grants management officer.

If the recipient plans to issue a press release concerning the outcome of activities supported by this financial assistance, it should notify the OASH federal project officer and the OASH grants management officer in advance to allow for coordination.

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Subrecipient agencies have written policies and procedures requiring acknowledging federal funding when issuing statements, press releases, publications, requests for proposals, bid solicitations and other documents.
2. Copies of statements, press releases, publications, requests for proposals, bid solicitations, marketing and educational materials and other documents.
3. Subrecipient contracts

2. Provision of High-Quality Family Planning Services Expectation

Provision of High-Quality Family Planning Services Expectation #1: Range in Family Planning Methods

Provide a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, sexually transmitted infection (STI) services, preconception health services, and adolescent-friendly health services). If an organization offers only a single method of family planning, it may participate as part of a project as long as the entire project offers a broad range of acceptable and effective medically approved family planning methods and services. (Section 1001, PHS Act; 42 CFR § 59.5(a)(1))

Family planning services include a broad range of medically approved services, which includes Food and Drug Administration (FDA)-approved contraceptive products and natural family planning methods, for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, sexually transmitted infection (STI) services, and other preconception health services. (42 CFR § 59.2)

Title X service sites are expected to provide most, if not all, of acceptable and effective medically approved family planning methods and services on site and must detail the referral process for family planning methods and services that are unavailable on-site.

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Clinical Protocols with requirement to review and revise every 12 months (contraception, pregnancy testing and counseling; achieving pregnancy; basic infertility; STI services, preconception health services, and standing orders)
2. Client education/counseling protocol
3. Client education/counseling materials
4. Referral/Resource list
5. Medical records review

6. Documentation of staff training
7. Pharmacy/supply dispensing inventory records
8. Subrecipient must abide with local STI reporting requirements in accordance with state laws (see Arizona Administrative Code, Title 9, Chapter 6, for Utah see R386-702).
9. The reproductive life plan/pregnancy intention/attitude must be discussed at least once annually and documented with all family planning clients regardless of age, sex, and sexual orientation.
10. Subrecipients must follow state and federal laws and professional practice regulations related to security and record keeping for drugs and devices, labeling, client education, inventory, supply and provision of pharmaceuticals. All prescription drugs must be stored in a locked cabinet or room (see AZ Board of Nursing R4-19-513).
11. The subrecipient agency must have policies and procedures in effect for the prescribing, dispensing, and administering of medications .

Provision of High-Quality Family Planning Services Expectation #2: Family Planning Method of Choice Referral

Ensure that Title X service sites that are unable to provide clients with access to a broad range of acceptable and effective medically approved family planning methods and services, must be able to provide a prescription to the client for their method of choice or referrals to another provider, as requested. (42 CFR § 59.5(a)(1))

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Clinical Protocol
2. Referral list
3. Medical records review

Provision of High-Quality Family Planning Services Expectation #3: Cultural Competency

Provide services in a manner that is client-centered, culturally and linguistically appropriate, inclusive, and trauma-informed. (42 CFR § 59.5(a)(3))

Affirm Best Practice Suggestion

The education provided should be appropriate to the client's age and level of knowledge and presented in an unbiased manner. Client education must be noted in the client's clinical chart.

Refer to page 2, Useful Title X Definitions, for Client-centered, culturally, and linguistically, inclusive, and trauma-informed.

Evidence Requirement is Met

1. Subrecipient agencies have written policies and procedures addressing this expectation.
2. Copies of materials translated into other languages that are available to patients.
3. Signage within health center
4. Translation services policy
5. Client education/counseling materials, etc.
6. Medical record review
7. Staff trainings
8. Referrals
9. Policies, procedures, and protocols
10. Observation of the clinic environment demonstrates cleanliness of exam rooms, ease of access to service

Provision of High-Quality Family Planning Services Expectation #4: Client Dignity

Provide services in a manner that protects the dignity of the individual. (42 CFR § 59.5(a)(3))

Affirm Best Practice Suggestion

The agency must have a Client Grievances policy in place describing the process to address and resolve client problems regarding a variety of issues including but not limited to:

- a problem or conflict with their provider;
- questions about the availability or accessibility of certain types of services;
- disagreement with an administrative or medical staff member, process or policy; and,
- decisions made about eligibility for services or programs.

This policy must contain staff roles and responsibilities, description of a tracking system to document the process and communications regarding complaints, and timelines for resolution of issues and communication with the client.

A patient bill of rights or other documentation which outlines client's rights and responsibilities is available for review by the client.

Evidence Requirement is Met

1. Documentation of staff training
2. Client education/counseling protocols and materials
3. Observation of client education

4. Patient satisfaction surveys document that clients perceive providers and other clinic staff to be respectful.

Provision of High-Quality Family Planning Services Expectation #5: Standard of Care

Provide services in a manner that ensures equitable and quality service delivery consistent with nationally recognized standards of care. (42 CFR § 59.5(a)(3))

Affirm Best Practice Suggestion

- Sex-positive counseling and client education practices
- Clinical services provided in a gender-Affirming manner
- Clinical Protocols and Client-facing documents written with gender-expansive and inclusive language
- Clinical staff are broadly representative of the population demographics to be served by the project and should be sensitive to, and able to deal effectively with, the cultural and other characteristics of the client population, based on subrecipient records
- Chart records document client pronouns and it is seen that staff address their clients using the correct pronouns
- Documented annual clinical staff reviews (periodic peer-reviews, clinician observations, clinical privileges clearly documented, etc.)
- Onboarding new providers includes direct observation of family planning skills and procedures

Evidence Requirement is Met

1. Documentation of staff training on equitable and quality service delivery
2. Clinic protocols
3. Client education/counseling protocol
4. Observation of client education and clinical services delivery; medical record/chart review

Provision of High-Quality Family Planning Services Expectation #6: Nationally Recognized Standards of Care

Provide quality family planning services that are consistent with the *Providing Quality Family Planning Services: Recommendations from Centers for Disease Control and Prevention and the U.S. Office of Population Affairs (QFP)* and other relevant nationally recognized standards of care. (OPA Program Priority, as set out in PA-FPH-22-001 NOFO and the FY 2022 NOA Special Terms and Requirements)

Affirm Best Practice Suggestion

Service sites have current clinical protocols (i.e., updated within the past 12 months) that reflect the most current version of the federal and professional medical associations' recommendations for each type of service, as cited in QFP.

Written clinical protocols regarding pregnancy testing and counseling are in accordance with the recommendations presented in QFP, including reproductive life planning discussions and medical histories that include any coexisting conditions.

Staff training on Clinical Protocols

Evidence Requirement is Met

1. Documentation of staff training
2. Clinic protocol
3. Client education/counseling protocol
4. Observation of client education and clinical services; medical record review

Provision of High-Quality Family Planning Services Expectation #7: Health Equity

Advance health equity through the delivery of Title X services. Health equity is when all persons have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. (OPA Program Priority, as set out in PA-FPH-22-001 NOFO and the FY 2022 NOA Special Terms and Requirements; 42 CFR § 59.2)

Affirm Best Practice Suggestion

Strategic Plan based on community needs is current, includes documentation of progress and evaluation.

Seeks innovative ways to connect marginalized populations to Family Planning Services

Evidence Requirement is Met

1. Documentation of staff training
2. Referrals policy or system/process
3. Client education/counseling protocol
4. Observations of client education and clinical services and interviews

Provision of High-Quality Family Planning Services Expectation #8: Client-Centered Services

Improve and expand accessibility of services for all clients, especially low-income clients by providing client-centered services that are available when and where clients need them

and can most effectively access them. (OPA Program Priority, as set out in PA-FPH-22-001 NOFO and the FY 2022 NOA Special Terms and Requirements)

Affirm Best Practice Suggestion

- Strategic Plan, based on community needs, is current and includes documentation of progress.
- Title X service sites should be geographically accessible for the population being served.
- Subrecipients should consider clients' access to transportation, clinic locations, hours of operation, clinical equipment and supplies (procedure rooms/exam tables) for various body sizes, and other factors that influence clients' abilities to access services.
- Policies and procedures and staff training supports the use of adaptive equipment and supplies.
- Subrecipient utilizes language assistance through Affirm's Certified Languages International (CLI) for interpreting services. See Appendix 1 for specific instructions.

Evidence Requirement is Met

1. Client education/counseling materials
2. Client intake observations
3. Clinic hours
4. Transportation access (client mobility)
5. Clinic layout
6. Needs assessment
7. Patient observation
8. Interpretation services

Provision of High-Quality Family Planning Services Expectation #9:

Offer pregnant clients the opportunity to be provided information and counseling regarding each of the following options: prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination. If requested to provide such information and counseling, projects must provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant client indicates they do not wish to receive such information and counseling. (42 CFR § 59.5(a)(5), Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, 136 Stat. 49, 444 (2022))

Affirm Best Practice Suggestion

- Observation and/or medical record review demonstrates counseling recommendations in accordance with the principles presented in QFP including reproductive life planning discussions, for example:

- Chart review demonstrates that clients with a positive pregnancy test receive non-directive, client-centered counseling
- Chart review demonstrates that clients with a negative pregnancy test who do not want to become pregnant are offered same-day contraception, if appropriate, or preconception counseling if they desire pregnancy.
- Clients are assessed for their social support
- Clients who are aware that they are pregnant, seeking a written confirmation of the pregnancy, and refuse/are not provided counseling and education, must not be reported as a family planning client.
- Document the Pregnancy Options Resource list has been updated at least annually

Evidence Requirement is Met

1. Documentation of staff training
2. Pregnancy testing and counseling protocol
3. Referral list
4. Medical records review
5. Observation of pregnancy counseling visit and/or staff interview

Provision of High-Quality Family Planning Services Expectation #10:

> Provide that family planning medical services will be performed under the direction of a clinical services provider (CSP), with services offered within their scope of practice and allowable under state law, and with special training or experience in family planning. CSPs include physicians, physician assistants, nurse practitioners, certified nurse midwives, and registered nurses with an expanded scope of practice who are trained and permitted by state-specific regulations to perform all aspects of the user (male and female) physical assessments recommended for contraceptive, related preventive health, and basic infertility care. (42 CFR § 59.5(b)(6) and 42 CFR § 59.2)

Affirm Best Practice Suggestion

The clinical services provider:

- Supervises and evaluates medical services provided by other clinicians, including a review of the clinician's charts and observations of clinical performance (at a minimum annually); and,
- Supervises the medical quality assurance program.
- Documentation of chart audits and observations of clinical performance demonstrates clinical services provider's involvement.

Evidence Requirement is Met

1. CV of Clinical Service Provider
2. Interview

3. CSP Job Description
4. QA policy
5. QA or Other Meeting Minutes with CSP involvement

Provision of High-Quality Family Planning Services Expectation #11:

Ensure that non-clinical counseling services (such as contraceptive counseling, nondirective options counseling, reproductive life planning, etc.) is provided by any adequately trained staff member who is involved in providing family planning services to Title X clients; this may include CSPs and non-CSPs (e.g., health educators). (2021 Final Rule FAQs) An "adequately trained staff member" has attended and participated in required orientation, courses, curriculums, and/or teaching/mentoring experiences, maintains appropriate competencies, and is knowledgeable and proficient in providing non-clinical counseling services.

Affirm Best Practice Suggestion

Client education is provided in accordance with the 5 Principles of Quality Counseling from Appendix C (pages 45-46) and Strategies for Providing Information to Clients, Appendix E, of the QFP (pages 48-49).

Evidence Requirement is Met

1. Documentation of staff training/education
2. Observation of client education session and/or staff interview
3. Medical record review

3. Adolescent Services Expectation

Adolescent Services Expectation #1:

Apply all expectations listed under "Provision of Quality Family Planning Services" when providing services to adolescent clients.

Affirm Best Practice Suggestion

- Medical records confirm adolescent counseling on abstinence, the use of condoms and other contraceptive methods, including LARCs.
training on adolescent-specific content, especially confidentiality laws
-sexual health screening tool/assessment (RAAPS, etc)
-same-day contraception, including LARC, is available
-Confidentiality policies and procedures, specific for adolescents
-Promotion efforts targeting adolescents

Evidence Requirement is Met

1. Adolescent clinical protocols
2. Medical records review
3. Observation and/or staff interview

Adolescent Services Expectation #2:

Provide adolescent-friendly health services, which are services that are accessible, acceptable, equitable, appropriate and effective for adolescents. (42 CFR § 59.2)

Affirm Best Practice Suggestion

Staff Training on adolescent-friendly services

Adolescent Champion Model participation and certification

Evidence Requirement is Met

1. Medical records review
2. Client education/counseling materials
3. Observations and staff interviews
4. Title X subrecipient sites provide for an adolescent-friendly setting
5. Schedule of site hours
6. Information about public transportation

Adolescent Services Expectation #3 : Family Participation

To the extent practical, Title X projects shall encourage family participation. However, Title X projects may not require consent of parents or guardians for the provision of services to minors, nor can any Title X project staff notify a parent or guardian before or after a minor has requested and/or received Title X family planning services. (Section 1001, PHS Act; 42 CFR § 59.10(b))

Ensure that all applicants for Title X funds certify that they encourage family participation in the decision of minors to seek family planning services. (Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, 136 Stat. 49, 466 (2022))

Affirm Best Practice Suggestion

Provide documentation as to whom may have access to private information shared and staff are trained in how to check this before leaving messages/communicating about clients.

Evidence Requirement is Met

1. Documentation of staff training

2. Consent for services that includes information about confidentiality and limits of confidentiality
3. Adolescent counseling and education protocol
4. Medical records review
5. Observation and staff interviews
6. Subrecipient agencies have written policies and procedures and protocols requiring services be provided in a manner that encourage family participation
7. Monitoring/audit reports

Adolescent Services Expectation #4: Coercion

> Ensure that all applicants for Title X funds certify that they provide counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities. (Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, 136 Stat. 49, 466 (2022))

Affirm Best Practice Suggestion

Education on healthy relationships, consent, etc.

Evidence Requirement is Met

1. Documentation of staff training
2. Adolescent counseling and education protocol
3. Medical records review
4. Observations and staff interviews
5. Subrecipient policies and procedures state to provide counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities
6. Monitoring/audit reports

Adolescent Services Expectation #5: Mandatory Reporting

> No Title X services provider shall be exempt from any State law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest. (Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, 136 Stat. 49, 444, 466–67 (2022))

Affirm Best Practice Suggestion

-Subrecipients are advised to consult with legal counsel to ensure that their policies are in compliance with state law.
-Subrecipients are encouraged to inform minor clients about the reporting requirement and involve adolescent clients in the steps required to comply with the law.
-Subrecipients are encouraged to have a mechanism to track mandatory reports submitted to law enforcement agencies and easily accessible for review.

Evidence Requirement is Met

1. Documentation of staff training
2. Consent for services that includes information about confidentiality and limitation of confidentiality
3. Adolescent counseling and education protocol
4. Child Abuse Protocol
5. Sexual Abuse Protocol
6. Documentation of reporting
7. Medical records review
8. Policies and procedures and protocols comply with state laws requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest
9. Staff interviews

4. Referral for Social and Medical Services Expectation

Referral for Social and Medical Services Expectation #1:

Provide for medical services related to family planning (including consultation by a clinical services provider, examination, prescription and continuing supervision, laboratory examination, contraceptive supplies), in person or via telehealth, and necessary referral to other medical facilities when medically indicated, and provide for the effective usage of contraceptive devices and practices. (42 CFR § 59.5(b)(1))

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Clinical Protocol
2. Referral Protocol
3. Referral List
4. Medical records review

Referral for Social and Medical Services Expectation #2:

Provide for social services related to family planning, including counseling, referral to and from other social and medical service agencies, and any ancillary services which may be necessary to facilitate clinic attendance. (42 CFR § 59.5(b)(2))

Affirm Best Practice Suggestion

There is a process to refer clients to relevant social and medical services agencies for example: child care agencies, transport providers, WIC programs. (Optimally signed, written collaborative agreements). Evidence may include medical records that indicate that referrals were made based on documented specific conditions/issues.

Evidence Requirement is Met

1. Subrecipient needs assessment or other activities has documented the social service and medical needs of the community to be served and identified relevant social and medical services available to help meet those needs.
2. Subrecipient to develop and implement plans to address the related social service and medical needs of clients.
3. Service sites have policies and/or plans to address the related social service and medical needs of clients as well as ancillary services needed to facilitate clinic attendance.

Referral for Social and Medical Services Expectation #3:

Provide for coordination and use of referrals and linkages with primary healthcare providers, other providers of healthcare services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs, who are in close physical proximity to the Title X site, when feasible, in order to promote access to services and provide a seamless continuum of care. (42 CFR § 59.5(b)(8))

Additional Affirm Standard

Referrals for related and other services should be made to providers who offer services at a discount or sliding fee scale, where one exists.

Agencies must maintain a current list of health care providers, local health and human services departments, hospitals, voluntary agencies, and health services projects supported by other publicly funded programs to be used for referral purposes and to provide clients with a variety of providers to choose from.

Evidence Requirement is Met

1. Subrecipient referral policies/procedures/protocols
2. Referral list
3. MOUs (Optimally signed, written collaborative agreements)

Referral for Social and Medical Services Expectation #4

Ensure service sites have strong links to other community providers to ensure that clients have access to primary care. If a client does not have another source of primary care, priority should be given to providing related reproductive health services or providing referrals, as needed. Screening services such as, medical history; cervical cytology; clinical breast examination; mammography; and pelvic and genital examination should be provided for clients without a primary care provider, where applicable, and consistent with nationally recognized standards of care. In addition, appropriate follow-up, if needed, should be provided while linking the client to a primary care provider. (QFP, p.20, https://opa.hhs.gov/sites/default/files/2020-10/providing-quality-family-planning-services-2014_1.pdf).

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Clinic Protocol
2. Medical records review
3. Staff interviews
4. MOUs (Optimally signed, written collaborative agreements)

5. Financial Accountability Expectation

Financial Accountability Expectation #1:

Provide that no charge will be made for services provided to any clients from a low-income family except to the extent that payment will be made by a third party (including a government agency) which is authorized to or is under legal obligation to pay this charge. Low-income family means a family whose total annual income does not exceed 100 percent of the most recent Poverty Guidelines issued pursuant to 42 U.S.C. 9902(2). "Low-income family" also includes members of families whose annual family income exceeds this amount, but who, as determined by the project director, are unable, for good reasons, to pay for family planning services. (Section 1006(c)(1), PHS Act; 42 CFR § 59.5(a)(7) and 42 CFR § 59.2)

Affirm Additional Standard

None

Evidence Requirement is Met

1. Chart review of patient records
2. Schedule of discounts (SOD) and fee schedule by discount bracket review

3. Patient income declaration documentation review for placement onto the schedule of discounts
4. Review patient income, family size, placement in SOD into the EHR (how it's recorded)
5. Review the patient invoice for accuracy of billing and application of Title X discounts
6. Review application of payments, discounts, and insurance adjustments in the EHR
7. Patient chart review for 10-15 patients <100 percent of FPL to review patient income forms, invoices, fee schedule, schedule of discounts
8. Charges, billing, and collections policy review

Financial Accountability Expectation #2:

Unemancipated minors who wish to receive services on a confidential basis must be considered on the basis of their own resources. (42 CFR § 59.2)

Affirm Additional Standard

None

Evidence Requirement is Met

1. Chart review
2. Policy and procedure for determining whether a minor is seeking confidential services and stipulates that charges to minors seeking confidential services will be based solely on the minor's resources.
3. Documentation demonstrates the process outlined in the policy and procedure.

Financial Accountability Expectation #3:

Provide that charges will be made for services to clients other than those from low-income families in accordance with a schedule of discounts based on ability to pay, except that charges to persons from families whose annual income exceeds 250 percent of the levels set forth in the most recent Poverty Guidelines issued pursuant to 42 U.S.C. 9902(2) will be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services. (42 CFR § 59.5(a)(8)) The schedule of discounts should be updated annually in accordance with the FPL. The HRSA Health Center Program and the OPA Title X Program have unique Sliding Fee Discount Schedule (SFDS) program expectations, which include having differing upper limits. Title X agencies (or providers) that are integrated with or receive funding from the HRSA Health Center Program may have dual fee discount schedules: one schedule that ranges from 101% to 200% of the FPL for all health center services, and one schedule that ranges from 101% to 250% FPL for clients receiving only Title X family planning services directly related to preventing or achieving pregnancy, and as defined in their approved Title X project. (OPA Program Policy Notice: 2016-11 - Integrating with Primary Care Providers)

Affirm Additional Standard

None

Evidence Requirement is Met

1. Chart review of patient charts
2. Review of schedule of discounts and fee schedule by discount bracket
3. Patient income declaration documentation review for placement onto the schedule of discounts
4. Review how patient income, family size, placement in SOD in EHR
5. Cost analysis check to determine how fees are set (e.g. how does Title X work around free clinics)
6. Patient chart (e.g. to see patients >250 percent of FPL in chart)

Financial Accountability Expectation #4:

Ensure that family income is assessed before determining whether copayments or additional fees are charged. (42 CFR § 59.5(a)(8))

Affirm Additional Standard

Subrecipients must implement policies and procedures, approved by Affirm, for charging, billing, and collecting funds for the services provided by the program. Clients are informed of any charges for which they will be billed and payment options.

Eligibility for discount of client fees must be documented in the client's record.

Evidence Requirement is Met

1. Patient income documentation review
2. Charges, billing, and collections policy review
3. Patient chart review (E.g. patients with third-party insurance)

Financial Accountability Expectation #5:

Ensure that, with regard to insured clients, clients whose family income is at or below 250 percent of the FPL should not pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied. (42 CFR § 59.5(a)(8))

Affirm Additional Standard

None

Evidence Requirement is Met

1. Patient chart review
2. Charges, and billings and collections policies review (E.g. patients with income 101-250 percent of FPL)

Financial Accountability Expectation #6:

Take reasonable measures to verify client income, without burdening clients from low-income families. subrecipients that have lawful access to other valid means of income verification because of the client's participation in another program may use those data rather than re-verify income or rely solely on clients' self-report. If a client's income cannot be verified after reasonable attempts to do so, charges are to be based on the client's self-reported income. (42 CFR § 59.5(a)(9))

Affirm Additional Standard None

Evidence Requirement is Met

1. Patient chart review
2. Charges, and billings and collections policies review
3. All patient collection forms and income disclosure documents
4. Check to see how subrecipient verifies zero or no income (prove patient is <100 percent of FPL)

Financial Accountability Expectation #7:

Take all reasonable efforts to obtain the third-party payment without application of any discounts, if a third party (including a government agency) is authorized or legally obligated to pay for services. Where the cost of services is to be reimbursed under title XIX, XX, or XXI of the Social Security Act, a written agreement with the title XIX, XX, or XXI agency is required. (42 CFR § 59.5(a)(10))

Affirm Additional Standard Health insurance information, including AHCCCS eligibility, should be updated during each client visit.

Evidence Requirement is Met

1. Patient income documentations review
2. Patient chart review
3. Charges, billings, and collections policies review (E.g. Medicaid patient charts, and demonstration that subrecipient is billing Medicaid)

Financial Accountability Expectation #8:

Provide that all services purchased for project participants will be authorized by the project director or their designee on the project staff. (42 CFR § 59.5(b)(7))

Affirm Additional Standard
None

Evidence Requirement is Met

1. Fiscal policies review
2. Staff Interview
3. Purchase orders, packing slips, invoices, and payments review for proper documentation.

Financial Accountability Expectation #9:

Provide that if family planning services are provided by contract or other similar arrangements with actual providers of services, services will be provided in accordance with a plan which establishes rates and method of payment for medical care. These payments must be made under agreements with a schedule of rates and payment procedures maintained by the subrecipient. The subrecipient must be prepared to substantiate that these rates are reasonable and necessary. (42 CFR § 59.5(b)(9))

Affirm Additional Standard None

Evidence Requirement is Met

1. Fiscal policies review
2. Staff Interview
3. Contracts and payments review for accuracy and completion

Financial Accountability Expectation #10:

Comply with all terms and conditions outlined in the grant award, including grant policy terms and conditions contained in applicable Department of Health and Human Services (HHS) Grant Policy Statements (GPS), (note any references in the GPS to 45 CFR Part 74 or 92 are now replaced by 45 CFR Part 75, and the SF269 is now the SF-425), and requirements imposed by program statutes and regulations, Executive Orders, and HHS grant administration regulations, as applicable; as well as any requirements or limitations in any applicable appropriations acts. (FY 2022 NOA Special Terms and Requirements)

Affirm Additional Standard

Subrecipients must comply with the financial and other reporting requirements set out in the HHS grants administration regulations (2 CFR Part 200 and 45 CFR Part 75), as applicable.

Audits of subrecipients must be conducted in accordance with the HHS grants administration regulations, as applicable, by auditors meeting established criteria for qualifications and independence (OMB A-133).

Subrecipients must demonstrate continued institutional, managerial, and financial capacity (including funds sufficient to pay the non-Federal share of the project cost) to ensure proper planning, management, and completion of the project as described in the award (42 CFR 59.7(a)).

Subrecipients must maintain proper internal controls that address:

- Separation of duties: No one person has complete control over more than one key function or activity (i.e., authorizing, approving, certifying, disbursing, receiving, or reconciling).
- Authorization and approval: Transactions are properly authorized and consistent with Title X requirements.
- Responsibility for physical security/custody of assets is separated from record keeping/accounting for those assets.

Subrecipients must ensure that insurance coverage is adequate and in effect for: general liability; fidelity bonding; medical malpractice; materials or equipment purchased with federal funds; and officers and directors of the governing board.

A revenue/expense report for the total family planning program is prepared for Affirm as requested. The revenue/expense report details the subrecipient agency's cost share including client fees and donations, agency contribution, third party revenues and all other revenues contributing to the family planning program.

Subrecipients are required to submit to Affirm a copy of the annual fiscal year audit, including the management letter and any noted findings and responses to findings, within 30 days of Agency Board acceptance, but no later than nine (9) months after the end of the fiscal year.

Subrecipients must have a written methodology for the allocation of expenses and revenues for the family planning program. Expenses should include direct costs, administrative costs attributable to the program and, when applicable, indirect costs. Indirect cost will not exceed 10% of the total program costs. Revenues should include federal funds, client fees and donations, agency contribution, third party payer (AHCCCS, Medicaid, and Private Insurance), state and local government contributions.

The subrecipient must have written policies and procedures for procurement of supplies, equipment and other services, including a competitive process.
The subrecipient must maintain a property management system which includes the following:

- Asset description;
- ID number;
- Acquisition date; and,

- Current location and Federal (Title X) share of asset.

The subrecipient must perform a physical inventory of equipment at least once every two years. The subrecipient should periodically confirm perpetual inventory with actual inventory counts and provide credit/debit adjustment to Title X charges to reflect actual costs.

Evidence Requirement is Met

1. Financial policies and procedures review
2. Staff Interview

Financial Accountability Expectation #11:

Ensure that no mobile health unit(s) or other vehicle(s), even if proposed in the application for the Title X award, is purchased with award funds without prior written approval from the grants management officer. Requests for approval of such purchases must include a justification with a cost-benefit analysis comparing both purchase and lease options. Such requests must be submitted as a Budget Revision Amendment in Grant Solutions. (FY 2022 NOA Special Terms and Requirements)

Affirm Additional Standard

None

Evidence Requirement is Met

1. NOA review
2. Purchase orders
3. Depreciation schedule
4. Documentation of GMO authorization of an applicable purchase

Financial Accountability Expectation #12:

Include financial support from sources other than Title X as no grant may be made for an amount equal to 100 percent of the project's estimated costs. Although projects are expected to identify additional sources of funding and not solely rely on Title X funds, there is no specific amount of level of financial match expectation for this program. (42 CFR § 59.7(c))

Affirm Additional Standard Donations from clients do not waive the billing/charging requirements. Donations must be collected in a manner which respects the confidentiality of the client. No minimum or specific donation amount can be required or suggested.

The program must use client donations and fees to offset program expenses and must be tracked separately and reported in the Program Revenue line item of the Affirm revenue report.

Evidence Requirement is Met

1. NOA review
2. Budgets
3. Federal Financial Reports (FFRs)
4. Financial statements
5. Subrecipient reports

Financial Accountability Expectation #13:

> Ensure that Title X funds shall not be expended for any activity (including the publication or distribution of literature) that in any way tends to promote public support or opposition to any legislative proposal or candidate for public office. (Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, 136 Stat. 49, 444 (2022))

Affirm Additional Standard

None

Evidence Requirement is Met

1. Financial policies and procedures review

6. Community Education, Participation, and Engagement Expectation

Community Education, Participation, and Engagement Expectation #1

> Provide for opportunities for community education, participation, and engagement to: achieve community understanding of the objectives of the program; inform the community of the availability of services; and promote continued participation in the project by diverse persons to whom family planning services may be beneficial to ensure access to equitable, affordable, client-centered, quality family planning services. (42 CFR § 59.5(b)(3))

Affirm Best Practice Suggestion

Subrecipient agencies should promote the availability of Title X services in their brochures, newsletters, on websites and in the Health center waiting areas, noting that services are offered on a sliding fee schedule.

Evidence Requirement is Met

1. Subrecipient has written policies and procedures to guide community awareness and community education
2. Documentation demonstrates that the subrecipient conducts a periodic assessment of the needs of the community with regard to their awareness of and need for access to family planning services
3. Written community education and service promotion plan that has been implemented (e.g., media spots/materials developed, event photos, participant logs, and monitoring reports). The plan: (a) states that the purpose is to achieve community understanding of the objectives of the project, make known the availability of services to potential clients, and encourage continued participation by diverse persons to whom family planning may be beneficial, (b) promotes the use of family planning among those with unmet need, (c) utilizes an appropriate range of methods to reach the community, and (d) includes an evaluation strategy

Community Education, Participation, and Engagement Expectation #2

Provide, to the maximum feasible extent, an opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of all significant elements of the population to be served, and by others in the community knowledgeable about the community's needs for family planning services. (42 CFR § 59.5(b)(10))

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Subrecipient has written policies and
2. procedures in place for ensuring that there is an opportunity for community participation in developing, implementing, and evaluating the project plan
3. Community engagement plan: (a) engages diverse community members including adolescents and current clients, and (b) specifies ways that community members will be involved in efforts to develop, assess, and/or evaluate the program
4. Documentation of implementation of plan (meeting minutes, reports, events attended, etc.)

7. Information and Education (I&E) Expectation

Information and Education (I&E) Expectation #1:

Have an advisory committee (sometimes referred to as information and education committee) that reviews and approves print and electronic informational and educational materials

developed or made available under the project, prior to their distribution, to assure that the materials are suitable for the population or community to which they are to be made available and the purposes of Title X. The project shall not disseminate any materials which are not approved by the advisory committee. (Section 1006(d)(1) and (2), PHS Act; 42 CFR § 59.6(a))

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Subrecipient (The recipient and subrecipient(s) (if applicable Subrecipient(s) have policies and procedures that ensure materials are reviewed prior to being made available to clients
2. Committee meeting minutes
3. Demonstrate the process used to review and approve materials
4. Educational materials available at the service sites have been approved by the I&E advisory committee

Information and Education (I&E) Expectation #2:

Think specifically about the print and electronic materials made available to Title X clients under the Title X project when considering which materials require review and approval by the advisory committee. To help identify what materials require review and approval by the advisory committee, Title X projects should think specifically about the materials that they are making available to Title X clients under the Title X project. For Title X projects that provide non-Title X services (e.g., hospitals, FQHCs), this does not include all possible materials that a Title X client may find on the organization's website or as they walk through the building, but only those specific materials that are made available to the Title X client under the Title X project and those materials developed specifically for the Title X client. If the material is intended to be provided to the client as information and education, it should be reviewed by the advisory committee; this does not include tweets. (2021 Final Rule FAQs)

Affirm Best Practice Suggestion

Reference *How to I&E* guide

Evidence Requirement is Met

1. Applicable materials available at the service sites have been approved by the I&E advisory committee

Information and Education (I&E) Expectation #3:

Establish and maintain an advisory committee that:

i. consists of no fewer than five members and up to as many members the subrecipient determines; and

ii. includes individuals broadly representative of the population or community for which the materials are intended (in terms of demographic factors such as race, ethnicity, color, national origin, disability, sex, sexual orientation, gender identity, sex characteristics, age, marital status, income, geography, and including but not limited to individuals who belong to underserved communities, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality). (Section 1006(d)(2), PHS Act; 42 CFR § 59.6(b))

Affirm Best Practice Suggestion

Reference *How to I&E* guide

Evidence Requirement is Met

1. Subrecipient has policies and procedures in place to address the I&E advisory committee expectations
2. Rosters/member lists demonstrate committee membership is broadly representative of the population served
3. Summary of Reviews and Recommendations

Information and Education (I&E) Expectation #4:

Ensure that the advisory committee, in reviewing materials:

i. consider the educational, cultural, and diverse backgrounds of individuals to whom the materials are addressed;

ii. consider the standards of the population or community to be served with respect to such materials;

iii. review the content of the material to assure that the information is factually correct, medically accurate, culturally and linguistically appropriate, inclusive, and trauma informed;

iv. determine whether the material is suitable for the population or community to which is to be made available; and

v. establish and maintain a written record of its determinations. (Section 1006(d)(1), PHS Act; 42 CFR § 59.6(b))

Affirm Best Practice Suggestion

Reference *How to I&E* guide

Evidence Requirement is Met

1. The subrecipient policies and procedures document that the required elements of this section are addressed
2. Meeting minutes, review forms, review instructions document that all required components are addressed
3. Subrecipient policies and procedures specify how the factual, technical, and clinical accuracy components of the review are assured
4. If the review of factual, technical, and/or clinical content has been subrecipient, there is evidence of Advisory Committee oversight and final approval
5. Meeting minutes, review forms/tools and materials inventory log

8. Staff Training Expectation

Staff Training Expectation #1:

Provide orientation and in-service training for all project personnel. (42 CFR § 59.5(b)(4))

Affirm Best Practice Suggestion

-All program staff (Title X MDs, PAs, NPs, CNMs, RNs, LPNs, MAs, front desk, eligibility, call center, Title X program manager and supervisors, and practice managers) must complete the trainings in the Affirm required training document.

-Program staff must demonstrate competency in the topic areas listed above. Affirm staff will observe staff during formal and informal site visits to evaluate competency and technical assistance will be provided as needed.

-All program staff should participate in continuing education related to their activities. Programs should maintain documentation of continuing education to evaluate the scope and effectiveness of the staff training program.

Evidence Requirement is Met

1. The subrecipient records demonstrate the assessment(s) of staff training needs and a training plan that addresses key expectations of the Title X program and priority areas
2. The subrecipient agencies maintain written records of orientation, in-service and other training attendance by project personnel
3. Training logs

4. Title X expectations acknowledgment form, Statement of Understanding and/or Statement of Assurances

Staff Training Expectation #2:

Ensure routine training of staff on Federal/State requirements for reporting or notification of child abuse, child molestation, sexual abuse, rape or incest, as well as on human trafficking.

Affirm Best Practice Suggestion

Staff training should include agency reporting procedure.

Summarized reporting procedure is easily accessible to clinic staff.

Evidence Requirement is Met

1. The subrecipient(s) policies ensure that staff has received training within the current project period on state-specific reporting/notification expectations
2. Subrecipient(s) documentation includes evidence of staff training within the current project period specific to this area, which may include attendance records and certificates

Staff Training Expectation #3:

Ensure routine training on involving family members in the decision of minors to seek family planning services and on counseling minors on how to resist being coerced into engaging in sexual activities.

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. The subrecipient policies ensure staff have received training during the current project period on these expectations
2. Documentation includes training attendance records/certificate that indicate that training on family involvement counseling and sexual coercion counseling has been provided

Staff Training Expectation #4:

Subrecipients are expected to provide routine training as noted above on an annual basis. In addition, OPA recommends Title X subrecipients provide routine training in accordance with the RHNTC's Title X Training Requirements Summary Job Aid -

https://rhntc.org/sites/default/files/resources/rhntc_fed_title_x_training_requirements_12-17-2021.pdf.

Affirm Best Practice Suggestion

Subrecipients are expected to provide annual training in accordance with Affirm's Title X Annual Training Requirement list.

Evidence Requirement is Met

1. The subrecipient policies ensure staff have received training on an annual basis
2. Documentation includes training attendance records/certificate

9. Quality Improvement and Quality Assurance (QI & QA) Expectation

Quality Improvement and Quality Assurance (QI & QA) Expectation #1:

Develop and implement a quality improvement and quality assurance plan that involves collecting and using data to monitor the delivery of quality family planning services, inform modifications to the provision of services, inform oversight and decision-making regarding the provision of services, and assess patient satisfaction. (PA-FPH-22-001 NOFO)

Affirm Best Practice Suggestion

Family Planning data is reviewed with clinical and health center staff

Evidence Requirement is Met

1. Subrecipient policy and procedures regarding QI/QA, address oversight and service provision within their QI/QA plan
2. Subrecipient(s) QI/QA Work Plan; FPAR data informs this plan
3. Auditing tools, chart audits, and/or documented clinical observations
4. CDS/FPAR, Tableau and other data collection materials
5. Any relevant meeting notes and corrective action plans

Quality Improvement and Quality Assurance (QI & QA) Expectation #2:

Title X recipients must accurately collect and report family planning data in a timely manner.

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Submit encounter level data to Affirm's Centralized Data System (CDS) on the 15th of each month

10. Prohibition of Abortion Expectation

Prohibition of Abortion Expectation #1:

Subrecipient will not provide abortion as a method of family planning as part of their Title X project. (Section 1008, PHS Act; Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, 136 Stat. 49, 444 (2022); 42 CFR § 59.5(a)(5))

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Subrecipient policies and procedures
2. Subrecipient contracts/MOU/agreement
3. Staff assurances document
4. Clinical protocol

Prohibition of Abortion Expectation #2:

Prohibit providing services that directly facilitate the use of abortion as a method of family planning, such as providing transportation for an abortion, explaining and obtaining signed abortion consent forms from clients interested in abortions, negotiating a reduction in fees for an abortion, and scheduling or arranging for the performance of an abortion, promoting or advocating abortion within Title X program activities, or failing to preserve sufficient separation between Title X program activities and abortion-related activities. (65 Fed. Reg. 41281 (July 3, 2000))

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Subrecipient policies and procedures
2. Subrecipient contracts/MOU/agreement
3. Staff assurances document
4. Staff interviews and observations of clinic activities
5. I&E materials

Prohibition of Abortion Expectation #3:

Prohibit promoting or encouraging the use of abortion as a method of family planning through advocacy activities such as providing speakers to debate in opposition to anti-abortion speakers, bringing legal action to liberalize statutes relating to abortion, or producing and/or showing films that encourage or promote a favorable attitude toward abortion as a method of family planning. Films that present only neutral, factual information about abortion are permissible. A Title X project may be a dues paying participant in a national abortion advocacy organization, so long as there are other legitimate program-related reasons for the affiliation (such as access to certain information or data useful to the Title X project). A Title X project may also discuss abortion as an available alternative when a family planning method fails in a discussion of relative risks of various methods of contraception. (65 Fed. Reg. 41281, 41282 (July 3, 2000))

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Interviews with Project Director and other staff
2. I&E materials

Prohibition of Abortion Expectation #4:

Ensure that non-Title X abortion activities are separate and distinct from Title X project activities. Where subrecipients conduct abortion activities that are not part of the Title X project and would not be permissible if they were, the subrecipient must ensure that the Title X-supported project is separate and distinguishable from those other activities. What must be looked at is whether the abortion element in a program of family planning services is so large and so intimately related to all aspects of the program as to make it difficult or impossible to separate the eligible and non-eligible items of cost. The Title X project is the set of activities the subrecipient agreed to perform in the relevant grant documents as a condition of receiving Title X funds. A grant applicant may include both project and non-project activities in its grant application, and, so long as these are properly distinguished from each other and prohibited activities are not reflected in the amount of the total approved budget, no problem is created. Separation of Title X from abortion activities does not require separate subrecipients or even a separate health facility, but separate bookkeeping entries alone will not satisfy the spirit of the law. Mere technical allocation of funds, attributing federal dollars to non-abortion activities, is not a legally supportable avoidance of section 1008. Certain kinds of shared facilities are permissible, so long as it is possible to distinguish between the Title X supported activities and non-Title X abortion-related activities:

> i. a common waiting room is permissible, as long as the costs properly pro-rated,
> ii. common staff is permissible, so long as salaries are properly allocated, and all abortion related activities of the staff members are performed in a program which is entirely separate from the Title X project,
> iii. a hospital offering abortions for family planning purposes and also housing a Title X project is permissible, as long as the abortion activities are sufficiently separate from the Title X project, and maintenance of a single file system for abortion and family planning patients is permissible, so long as costs are properly allocated. (65 Fed. Reg. 41281, 41282 (July 3, 2000)

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Review of Title X policies
2. Review of clinic hours for each type of service
3. Review of location of where each type of service is being provided
4. Review of cost allocations, invoices, and accounting records for compliance
5. Review of clinic timesheets
6. Walkthrough of clinic
7. Staff interview

Prohibition of Abortion Expectation #5:

> A Title X project may not provide pregnancy options counseling which promotes abortion or encourages persons to obtain abortion, although the project may provide patients with complete factual information about all medical options and the accompanying risks and benefits. While a Title X project may provide a referral for abortion, which may include providing a patient with the name, address, telephone number, and other relevant factual information (such as whether the provider accepts Medicaid, charges, etc.) about an abortion provider, the project may not take further Affirmative action (such as negotiating a fee reduction, making an appointment, providing transportation) to secure abortion services for the patient. (65 Fed. Reg. 41281 (July 3, 2000))

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Chart/record review
2. Staff interview
3. Observations
4. Review of pregnancy testing and counseling protocol

5. Review of staff training records
6. Review of client education/counseling materials

Prohibition of Abortion Expectation #6:

Where a referral to another provider who might perform an abortion is medically indicated because of the patient's condition or the condition of the fetus (such as where the woman's life would be endangered), such a referral by a Title X project is not prohibited by section 1008 and is required by 42 CFR § 59.5(b)(1). The limitations on referrals do not apply in cases in which a referral is made for medical indications. (65 Fed. Reg. 41281 (July 3, 2000))

Affirm Best Practice Suggestion

None

Evidence Requirement is Met

1. Chart/record review
2. Staff interview
3. Observations
4. Review of pregnancy testing and counseling protocol
5. Review of staff training records
6. Review of client education/counseling materials

APPENDIX 1

Instructions for Certified Languages International (CLI)

1. Dial 1-800-225-5254
2. When the operator answers, tell them*:
    a. Your customer code is: ARIZFPC
    b. The language you need
    c. Your name, phone number, CDS health center ID, clinic name, and the client's ID
3. The operator will connect you with an interpreter promptly

*If the client is not at the health center, let the operator know you need a third-party dial out/outbound call.

APPENDIX 2

Affirm Subrecipient Close-Out Checklist

Task	Target Completion Date	Responsible Party	Actual Completion Date

Submit to Affirm: a) A written plan which addresses the provisions being made for notifying clients of termination of services OR b) Written confirmation that access to services and the scope of services will not change. c) If terminating a health center, provide a copy of the letter that will be sent to clients notifying them of the closure with a list of nearby Title X clinics or similar sliding fee providers.	30 days prior to the contract termination date		
Provide Affirm with confirmation that all subcontracts solely related to the Title X contract are terminated. a) Provide Affirm with a written plan for how subcontractors will be notified b) Provide Affirm with a list of all subcontracts related to the Title X contract c) Dates for subcontractor notification must be included	30 days prior to the contract termination date		
Provide Affirm with information accounting for any real and personal property acquired with federal funding	Prior to final payment		
Provide Affirm plans to return or purchase from Affirm capital equipment purchased with Title X funds that were greater than $5,000 and are not fully depreciated at the end of the contract period.	30 days prior to contract termination date		
Make arrangements with Affirm for the purchase of, transfer or delivery of any materials, equipment or documents related to the Title X program.	No later than 30 days after the end of the contract		
Provide Affirm with a written request for any requests for adjustments to the contract award amount.	30 days prior to contract termination date. Affirm reserves the right to disallow any costs resulting from obligations		

	incurred by the subrecipient agency during a termination unless these costs were approved or authorized by Affirm.		
Provide Affirm with a refund for any balances owed to Affirm for advances or other unauthorized costs incurred with contract funds.	Prior to final payment		
The Authorizing Official at the subrecipient agency must submit a 340B "Change Request Form" to end the 340B program for family planning services. The form can be found here: http://www.hrsa.gov/opa/programrequirements/forms/340bchangeform.pdf	Prior to the last day of clinic services		
Provide Affirm with a written description of how remaining 340B drugs will be used, returned, or destroyed. Note: 340B covered entities are prohibited from transferring 340B drugs to a different covered entity.	30 days prior to the health center closure		
Submit client data into Affirm's Central Data System (CDS).	The 15th of the month following the last day of clinic services		
Remove information regarding the Title X program from agency's website.	During the last week of clinic services		
Provide Affirm with all outstanding financial, performance and programmatic reports.	45 days after the contract termination date or on the date stipulated in the contract, whichever is sooner		
Ensure adherence to document and record retention per agency's policy	Ongoing, per agency's policy		

Final payment will be held until all Title X financial, performance, programmatic reports have been received, and arrangements have been made for all materials, equipment, and documents.

LIST OF SUBCONTRACTORS

&

SUBCONTRACTOR CONTRACTS

TO BE INSERTED HERE

Affirm

Request for Title X Contract Funds

Agency:

Reporting Period **From:** **To:**

This is a request for : **Advance Funds** **Reimbursement**

		Amount Awarded	Total Funds Earned this Reporting Period (i.e. **this request**)	Prior Report Period Year to Date Funds Earned	Total Year to Date Funds Earned	Available Balance	% Earned YTD
Title X Base Grant					$ -	$ -	#DIV/0!
Amendment 1					$ -	$ -	#DIV/0!
Amendment 2					$ -	$ -	#DIV/0!
					$ -	$ -	#DIV/0!
Total		$0.00	$ -	$ -	$ -	$ -	#DIV/0!

*To be determined by agency and verified by Affirm

Certification: By signing this request, I certify to the best of my knowledge and belief that the request is true, complete, and accurate, and the expenditures, disbursements and cash receipts are for the purposes and intent set forth in the award documents. I am aware that any false, fictitious, or fraudulent information may subject me to criminal, civil, or administrative penalties. (U.S. code, Title 18, Section 1001).

_____

Authorized Signature **Date of request**

Actual Signature required, stamped signature will not be accepted

_____

Name **Title**

Affirm Program Dept Use Only		**Affirm Accounting use only**	
Affirm Program Manager Certification			
	Performance satisfactory for payment		Date invoice recorded in QB
	Performance unsatisfactory withhold payment		Date of drawdown
	Incorrect invoice, returned for clarification		Affirm check #
	No payment due		Date of check
			Title X report updated
			Date of ACH deposit
Program Manager Signature **Date**		**Affirm Finance Manager Signature** **Date**	

CERTIFICATE OF INSURANCE

TO BE INSERTED HERE

RESERVED FOR

CONTRACT AMENDMENTS

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/30/2024

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Arthur J. Gallagher Risk Management Services, LLC
18201 Von Karman Ave
Suite 200
Irvine CA 92612

License#: 0D69293
ARIZCOU-01

CONTACT NAME: Nasreen Kopecky
PHONE (A/C, No, Ext): 949-349-9857 **FAX (A/C, No):** 949-349-9900
E-MAIL ADDRESS: nasreen_kopecky@ajg.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Arizona Counties Insurance Pool	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Pinal County
Attn: Risk Management Department
P O Box 2088
Florence AZ 85132.

COVERAGES **CERTIFICATE NUMBER:** 1963434786 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X **COMMERCIAL GENERAL LIABILITY**	Y		ACIP070123	7/1/2023	7/1/2024	EACH OCCURRENCE	$ 1,000,000
	[ ] CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ Included
	X Pub Offls' E&O						MED EXP (Any one person)	$ Not Covered
	X Misc Med Mal E&O						PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 4,000,000
	X POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$ 1,000,000
	[ ] OTHER:						Errors & Omissions	$ 1,000,000
A	**AUTOMOBILE LIABILITY**			ACIP070123	7/1/2023	7/1/2024	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	[ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS ONLY X NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
	X Comprehensiv X Collison						Comp/Coll Deductibles	$ $5,000/$5,000
	[ ] **UMBRELLA LIAB** [ ] OCCUR						EACH OCCURRENCE	$
	[ ] **EXCESS LIAB** [ ] CLAIMS-MADE						AGGREGATE	$
	[ ] DED [ ] RETENTION $							$
A	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N			ACIPWC070123	7/1/2023	7/1/2024	X PER STATUTE [ ] OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [N] **(Mandatory in NH)**	N / A					E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000
A	Medical Professional Liability			ACIP070123	7/1/2023	7/1/2024	Each Medical Incident Aggregate	$1,000,000 $3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Arizona Family Health Partnership dba Affirm Sexual and Reproductive Health are included as Additional Insured pursuant to and subject to the policy's terms, definitions, conditions and exclusions.
RE: Affirm Sexual and Reproductive Health Family Planning Program Contract 4/1/24-3/31/25.

CERTIFICATE HOLDER

AFFIRM - Arizona Family Health Partnership
Attn: Chief Executive Officer
3800 N. Central Avenue, Suite 820
Phoenix AZ 85012

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

ENDORSEMENT NO. 11 – Additional Insured – INSURED CONTRACT

THIS ENDORSEMENT MODIFIES INSURANCE PROVIDED UNDER SECTION I, COMPREHENSIVE GENERAL LIABILITY. PLEASE READ IT CAREFULLY.

1. The following is added to **SECTION I COMPREHENSIVE GENERAL LIABILITY**:

   Any person(s), entity(ies), or organization(s) to whom the **NAMED MEMBER** is obligated by virtue of an **INSURED CONTRACT** to provide coverage solely with respect to **BODILY INJURY** and **PROPERTY DAMAGE** and arising out of:

   a. **PREMISES** leased, rented, used or occupied by you;

   b. **AUTOMOBILES** leased or rented by you;

   c. Equipment owned, leased, rented, maintained or used by you; or

   d. Mortgagees of a **NAMED MEMBER.**

   However, this insurance under this endorsement does not apply to:

      1) Any **OCCURRENCE** which takes place prior to or after you cease to occupy the **PREMISES** as stated in the **INSURED CONTRACT**.

      2) Any structural alteration, new construction or demolition operations performed by or on behalf of the additional insured.

      3) Any **WRONGFUL ACT, EMPLOYMENT PRACTICES VIOLATION**, or **NEGLIGENT ACT, ERROR, OR OMISSION**.

The limits of Coverage afforded under this endorsement will be limited to the Limits of Insurance required within the terms of the **INSURED CONTRACT** or the Limits of Coverage of this **MOC**, whichever is less, and will apply in excess of any underlying insurance or your Member Deductible shown in the Declarations. We will not be obligated for Limits of Insurance shown in the **INSURED CONTRACT** that are greater than the Limits of Coverage of this **MOC**.

ENDORSEMENT NO. 11 – Additional Insured – INSURED CONTRACT (Continued)

DEFINITIONS

INSURED CONTRACT means:

1. A contract for **PREMISES** leased, rented or loaned to you. However, that portion of the contract for a lease of **PREMISES** that indemnifies any person or organization for damage by fire to **PREMISES** while rented to you or temporarily occupied by you with permission of the owner is not an **INSURED CONTRACT**;

2. A sidetrack agreement;

3. Any easement or license agreement, except in connection with construction or demolition operations on or within 50 feet of a railroad;

4. An obligation, as required by ordinance;

5. An elevator maintenance agreement;

6. That part of any other contract or agreement pertaining to your business under which you assume the tort liability to pay for **BODILY INJURY** or **PROPERTY DAMAGE** to a third person or organization. Tort liability means a liability that would be imposed by law in the absence of any contract or agreement.

INSURED CONTRACT does not include an agreement to indemnify the following:

1. A railroad for construction or demolition operations within 50 feet of railroad property and affecting any railroad bridge or trestle, tracks, roadbeds, tunnel, underpass, or crossing;

2. An architect, engineer, or surveyor for their professional services.

Except as amended in this Endorsement, this coverage is subject to all coverage terms, clauses, and conditions in the **MOC** to which this Endorsement is attached.

DEPARTMENT/FUND
APPROPRIATION ADJUSTMENT FORM

Fiscal Year	Agenda Item needed (yes/no)	Anticipated Meeting Date if applicable	Memo Attached if Board item
23/24	yes	5/15/2024	☐

Please use one form per agenda item.

Sources (Fund Balance, Revenues, Transfers In, etc...)								
Fund	**Input "yes" if change in Fund Balance (2511)**	**Cost Center**	**Sub Ledger**	**Object Code**	**Subsidiary**	**Current Budget**	**Adjustment Add/ (Subtract)**	**New Revised Budget**
82		TBD		421000		$0	$116,667	$116,667
213		3311003		457990		$9,064,070	($116,667)	$8,947,403
82		3590163	TBD	460002		$489,983	$5,000	$494,983
Insert rows above this line and copy New Revised Budget formula down								
Net Source Adjustment							$5,000	

Uses (Expenditures, Transfers Out, etc....)								
Fund		**Cost Center**	**Sub Ledger**	**Object Code**	**Subsidiary**	**Current Budget**	**Adjustment Add/ (Subtract)**	**New Revised Budget**
82		TBD		511010		0	$37,167	$37,167
82		TBD		512010		0	$2,933	$2,933
82		TBD		512020		0	$4,711	$4,711
82		TBD		512060		0	$5,267	$5,267
82		TBD		512070		0	$168	$168
82		TBD		512090		0	$13	$13
82		TBD		520011		0	$667	$667

DEPARTMENT/FUND
APPROPRIATION ADJUSTMENT FORM

82		TBD		521045		0	$15	$15
82		TBD		521990		0	$434	$434
82		TBD		522010		0	$1,334	$1,334
82		TBD		522030		0	$36,000	$36,000
82		TBD		522050		0	$11,200	$11,200
82		TBD		522070		0	$1,667	$1,667
82		TBD		524010		0	$333	$333
82		TBD		524020		0	$2,048	$2,048
82		TBD		524040		0	$1,469	$1,469
82		TBD		530615		0	$533	$533
82		TBD		533299		0	$540	$540
82		TBD		540025		0	$503	$503
82		TBD		530550		0	$3,333	$3,333
82		TBD		540130		0	$333	$333
82		TBD		540211		0	$333	$333
82		TBD		540212		0	$333	$333
82		TBD		540213		0	$333	$333
82		TBD	3590163	560002		0	$5,000	$5,000
213		3311003		599500		9,064,070	($116,667)	$8,947,403
82		3590163		599500		174,893	$5,000	$179,893
Insert rows above this line and copy New Revised Budget formula down								
Net Use Adjustment							$5,000	

Net Change	$0	

Prepared by:	Shanon Togneri	**Date:**	5/2/2024

Description:	New Cost Center set up for Grant as per Policy 8.20 new 1 year contract received and presented and approved by the Board of Supervisors on

TYPE OF REQUEST:

- ☐ **Transfer within same Cost Center**
- ☐ **Transfer between Cost Centers within same Fund**
- ☐ **Transfer between Funds or Transfer In/Out adjustments**
- ☑ **Transfer from/to of Reserve/Contingency (e.g., new grant, change in special revenue projection, new project…)**
- ☐ **Change in Fund Balance Appropriation**

PINAL COUNTY
WIDE OPEN OPPORTUNITY

AGENDA ITEM

May 15, 2024 ADMINISTRATION BUILDING A
FLORENCE, ARIZONA

REQUESTED BY:

Funds #: 82

Dept. #: 359

Dept. Name: Public Health

Director: Merissa Mendoza

BRIEF DESCRIPTION OF AGENDA ITEM AND REQUESTED BOARD ACTION:

Discussion/approval/disapproval of Award Agreement No. CTR055262 Amendment No. 4 (formerly IGA2020-043) for the Title V Maternal and Child Health, Healthy Arizona Families Program between the Arizona Department of Health Services and Pinal County, through the Pinal County Public Health Services District Board beginning July 1, 2023, ending June 30, 2024, for $226,379. The funding was included in the FY 23/24 budget for the Public Health Services District and has no impact on the General Fund. (Jan Vidimos/Merissa Mendoza)

BRIEF DESCRIPTION OF THE FISCAL CONSIDERATIONS AND/OR EXPECTED FISCAL IMPACT OF THIS AGENDA ITEM:

The total amount of this amendment will not exceed $226,379 for the amendment term and breaks down as follows; $152,111 Maternal Child Health Healthy AZ Families, $74,268 Public Health Improvement Plan. There is no match requirement for this program. This funding was included in the FY23/24 budget development for the Public Health Services District and will have no impact on the General Fund.

BRIEF DESCRIPTION OF THE EXPECTED PERFORMANCE IMPACT OF THIS AGENDA ITEM:

The overall goal of the Public Health Services District is to protect and improve the public's health through prevention and control of disease and disability. The purpose of the Maternal Child Health/Healthy Arizona Families is twofold. As outlined in section 3.2-3.1.4 and 3.2-3.22 on page 20 of the attached contract, Maternal Child Health will focus on implementing high impact childhood injury prevention strategies. Healthy Arizona Families Public Health Improvement utilizes county level data to develop a County Health Improvement Plan and implement strategies to address high priority health needs within the county. This goal is accomplished in collaboration with community partners.

MOTION:

Approve as presented.

History

Time	Who	Approval
5/3/2024 12:38 PM	County Attorney	Yes
5/6/2024 8:24 AM	Grants/Hearings	Yes

5/6/2024 9:56 AM	Budget Office	Yes
5/8/2024 9:51 AM	County Manager	Yes
5/8/2024 9:53 AM	Clerk of the Board	Yes

ATTACHMENTS:

Click to download
Contract
Contract Amendment 4

INTERGOVERNMENTAL AGREEMENT (IGA)

CONTRACT No.: IGA2020-043

ARIZONA DEPARTMENT OF HEALTH SERVICES
150 North 18th Avenue, Suite 530
Phoenix, Arizona 85007

Project Title: Title V Maternal and Child Health Healthy Arizona Families **Begin Date:** July 1, 2020

Geographic Service Area: Pinal County **Termination Date:** June 30, 2025

Arizona Department of Health Services has authority to contract for services specified herein in accordance with A.R.S. §§ 11-951, 11-952, 36-104 and 36-132. The Contractor represents that it has authority to contract for the performance of the services provided herein pursuant to:

- [X] **Counties: A.R.S. §§ 11-201, 11-951, 11-952 and 36-182.**
- [ ] **Indian Tribes: A.R.S. §§ 11-951, 11-952 and the rules and sovereign authority of the contracting Indian Nation.**
- [ ] **School Districts: A.R.S. §§ 11-951, 11-952, and 15-342.**
- [ ] **City of Phoenix: Chapter II, §§ 1 & 2, Charter, City of Phoenix.**
- [ ] **City of Tempe: Chapter 1, Article 1, §§ 1.01 & 1.03, Charter, City of Tempe.**

Amendments signed by each of the parties and attached hereto are hereby adopted by reference as a part of this Contract, from the effective date of the Amendment, as if fully set out herein.

Arizona Transaction (Sales) Privilege: _____

Federal Employer Identification No.: _____

Tax License No.: _____

Contractor Name: Pinal County Arizona
Address: PO BOX 1348
FLORENCE, Arizona 85132

FOR CLARIFICATION, CONTACT:

Name: Tim Ruiz

Phone: _____

FAX No: _____

E-mail: tim.ruiz@pinalcountyaz.gov

CONTRACTOR SIGNATURE:
The Contractor agrees to perform all the services set forth in the Agreement and Work Statement.

8/26/2020

Signature of Person Authorized to Sign **Date**

Pete Rios, Vice Chairman

This Contract shall henceforth be referred to as Contract No. IGA2020-043 The Contractor is hereby cautioned not to commence any billable work or provide any material, service or construction under this Contract until Contractor receives a fully executed copy of the Contract.

State of Arizona

Signed this _____ **day of** _____, 20____

Christine Ruth

Digitally signed by Christine Ruth
Date: 2020.10.07 16:35:02 -07'00'

Procurement Officer

CONTRACTOR ATTORNEY SIGNATURE:

Pursuant to A.R.S. § 11-952, the undersigned Contractor's Attorney has determined that this Intergovernmental Agreement is in proper form and is within the powers and authority granted under the laws of Arizona.

8/27/2020

Signature of Person Authorized to Sign **Date**

Chris Keller, Chief Civil Deputy County Attorney

Print Name and Title

Attorney General Contract, No. P0012014000078, which is an Agreement between public agencies, has been reviewed pursuant to A.R.S. § 11-952 by the undersigned Assistant Attorney General, who has determined that it is in the proper form and is within the powers granted under the laws of the State of Arizona to those parties to the Agreement represented by the Attorney General.

The Attorney General, BY:

Aubrey Joy Corcoran

Digitally signed by Aubrey Joy Corcoran
DN: cn=Aubrey Joy Corcoran, o=Arizona Attorney General's Office, ou, email=AubreyJoy.Corcoran@azag.gov, c=US
Date: 2020.10.06 13:10:32 -07'00'

Signature **Date**

Assistant Attorney General:

1. **Definition of Terms.** As used in this Contract, the terms listed below are defined as follows:

1.1 *"Attachment"* means any document attached to the Contract and incorporated into the Contract.

1.2 *"ADHS"* means Arizona Department of Health Services.

1.3 *"Budget Term"* means the period of time for which the contract budget has been created and during which funds should be expended.

1.4 *"Change Order"* means a written order that is signed by a Procurement Officer and that directs the Contractor to make changes authorized by the Uniform Terms and Conditions of the Contract.

1.5 *"Contract"* means the combination of the Uniform and Special Terms and Conditions, the Specifications and Statement or Scope of Work, Attachments, Referenced Documents, any Contract Amendments and any terms applied by law.

1.6 *"Contract Amendment"* means a written document signed by the Procurement Officer and the Contractor that is issued for the purpose of making changes in the Contract.

1.7 *"Contractor"* means any person who has a Contract with the Arizona Department of Health Services.

1.8 *"Cost Reimbursement"* means a contract under which a contractor is reimbursed for costs, which are reasonable, allowable and allocable in accordance with the contract terms and approved by ADHS.

1.9 *"Days"* means calendar days unless otherwise specified.

1.10 "*Emerging Issues*" are projects and/or strategies that become prominent and/or are unique to a particular County.

1.11 *"Evidence-Based Strategies"* are strategies that explicitly link public health or clinical practice recommendation to scientific evidence of the effectiveness and/or other characteristics of such practices. (Reference: Community Guide: http://www.thecommunityguide.org/) Evidence based public health practice is the careful, intentional and sensible use of current best scientific evidence in making decisions about the choice and application of public health interventions. (Reference: Community Commons http://www.communitycommons.org/)

1.12 *Evidence-informed* means interventions, strategies, approaches, and/or program models that bring together the best available research, professional expertise, and input from participants to identify and deliver services that have promise to achieve positive outcomes.

1.13 *"Gratuity"* means a payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, present or promised, unless

consideration of substantially equal or greater value is received.

1.14 *"Materials"* unless otherwise stated herein, means all property, including but not limited to equipment, supplies, printing, insurance and leases of property.

1.15 *"MCH HAF"* means the ADHS issued Title V Maternal and Child Health Healthy Arizona Families Intergovernmental Agreement. This IGA was developed to facilitate collaboration, coordination, and communication between the Contractors/Local Health Departments and ADHS to improve the health and well-being Arizona's women and children.

1.16 *"May"* means the Contractor is encouraged to utilize recommended policy in order to fulfill the intent of the contract

1.17 *"Must"* means a mandatory Program policy considered essential to the provision of high quality services. A Contractor who does not follow a required Program policy will be cited for this failure.

1.18 *"National Performance Measures Framework"* means a structure that enables states to demonstrate the impact of Title V on selected health outcomes within the state. The framework contains three levels of measure:
1) National Outcome Measures (NOMs) intended to represent the desired result of Title V program activities and interventions. These measures for improved health are longer-term than National Performance Measures.
2) National Performance Measures intended to drive improved outcomes relative to one or more indicators of health status (i.e., NOMs) for the MCH population.
3) Evidence based/informed strategy measures (ESMs) intended to hold states accountable for improving quality and performance related to the NPMs and related public health issues. ESMs will assist state efforts to more directly measure the impact of specific strategies on the NPMs.

1.19 *"Procurement Officer"* means the person duly authorized by the State to enter into, administer Contracts, and make written determinations with respect to the Contract.

1.20 *"Program Manager"* means the ADHS employee who is responsible for the implementation and oversight of the specific programs within the MCH HAF IGA. The Program Manager coordinates activities among Contractors and among ADHS staff, receives and reconciles invoices, handles budget issues, and provides technical support. The Program Manager is responsible for negotiating contracts, requesting contract amendments to be processed by the Procurement Office, conducting site visits, and monitoring Contractor compliance with the provisions of the contract.

1.21 *"Purchase Order"* means a written document that is signed by a Procurement Officer, that requests a vendor to deliver described goods or services at a specific price and that, on delivery and acceptance of the goods or services by ADHS, becomes an obligation of the State.

1.22 *"SOW"* means Scope of Work, which is the area in an agreement where

the work to be performed is described. The SOW should contain any milestones, reports, deliverables, and end products that are expected to be provided by the performing party

1.23 *"Services"* means the furnishing of labor, time or effort by a Contractor or Subcontractor.

1.24 *"Site Visit"* means any visit to the Contractor's or Sub-contractor's business location by ADHS MCH HAFIGA Program staff or a designee, once per year.

1.25 *"Subcontract"* means any contract, express or implied, between the Contractor and another party or between a subcontractor and another party delegating or assigning, in whole or in part, the making or furnishing of any material or any service required for the performance of this Contract.

1.26 *"State"* means the State of Arizona, or ADHS. For purposes of this Contract, the term "State" shall not include the Contractor.

2. CONTRACT TYPE:

This Contract shall be:

[X] **COST REIMBURSEMENT**

3. CONTRACT INTERPRETATION:

3.1. Arizona Law. The law of Arizona applies to this Contract including, where applicable, the Uniform Commercial Code as adopted by the State of Arizona.

3.2. Implied Contract Terms. Each provision of law and any terms required by law to be in this Contract are a part of this Contract as if fully stated in it.

3.3. Contract Order of Precedence. In the event of a conflict in the provisions of the Contract, as accepted by the State and as they may be amended, the following shall prevail in the order set forth below:

3.3.1. Terms and Conditions;

3.3.2. Statement or Scope of Work;

3.3.3. Attachments; and

3.3.4. Referenced Documents.

3.4. Relationship of Parties. The Contractor under this Contract is an independent Contractor. Neither party to this Contract shall be deemed to be the employee or agent of the other party to the Contract.

3.5. Severability. The provisions of this Contract are severable. Any term or condition deemed illegal or invalid shall not affect any other term or condition of the Contract.

3.6. No Parole Evidence. This Contract is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any terms used in this document.

3.7. No Waiver. Either party's failure to insist on strict performance of any term or condition of the Contract shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the nonconforming performance knows of the nature of the performance and fails to object to it.

3.8. Headings. Headings are for organizational purposes only and shall not be interpreted as having legal significance or meaning.

4. CONTRACT ADMINISTRATION AND OPERATION:

4.1. Term. As indicated on the signature page of the Contract, the Contract shall be effective as of the Begin Date and shall remain effective until the Termination Date.

4.2. Contract Renewal. This Contract shall not bind, nor purport to bind, the State for any contractual commitment in excess of the original Contract period. The term of the Contract shall not exceed five years. However, if the original Contract period is for less than five years, the State shall have the right, at its sole option, to renew the Contract, so long as the

original Contract period together with the renewal periods does not exceed five years. If the State exercises such rights, all terms, conditions and provisions of the original Contract shall remain the same and apply during the renewal period with the exception of price and Scope of Work, which may be renegotiated.

4.3. New Budget Term. If a budget term has been completed in a multi-term Contract, the parties may agree to change the amount and type of funding to accommodate new circumstances in the next budget term. Any increase or decrease in funding at the time of the new budget term shall coincide with a change in the Scope of Work or change in cost of services as approved by the Arizona Department of Health Services.

4.4. Non-Discrimination. The Contractor shall comply with State Executive Order No. 2009-09 and all other applicable Federal and State laws, rules and regulations, including the Americans with Disabilities Act.

4.5. Records and Audit. Under A.R.S. § 35-214 and A.R.S. § 35-215, the Contractor shall retain and shall contractually require each subcontractor to retain all data and other records ("records") relating to the acquisition and performance of the Contract for a period of five years after the completion of the Contract. All records shall be subject to inspection and audit by the State and where applicable the Federal Government at reasonable times. Upon request, the Contractor shall produce a legible copy of any or all such records.

4.6. Financial Management. For all contracts, the practices, procedures, and standards specified in and required by the Accounting and Auditing Procedures Manual for the ADHS funded programs shall be used by the Contractor in the management of Contract funds and by the State when performing a Contract audit. Funds collected by the Contractor in the form of fees, donations and/or charges for the delivery of these Contract services shall be accounted for in a separate fund.

4.6.1. *Federal Funding*. Contractors receiving federal funds under this Contract shall comply with the certified finance and compliance audit provision of the Office of Management and Budget (OMB) Circular A-133, if applicable. The federal financial assistance information shall be stated in a Change Order or Purchase Order.

4.6.2. *State Funding*. Contractors receiving state funds under this Contract shall comply with the certified compliance provisions of A.R.S. § 35-181.03.

4.7. Inspection and Testing. The Contractor agrees to permit access, at reasonable times, to its facilities.

4.8. Notices. Notices to the Contractor required by this Contract shall be made by the State to the person indicated on the signature page by the Contractor, unless otherwise stated in the Contract. Notices to the State required by the Contract shall be made by the Contractor to an ADHS Procurement Officer, unless otherwise stated in the Contract. An authorized ADHS Procurement Officer and an authorized Contractor representative may change their respective person to whom notice shall be given by written notice, and an amendment to the Contract shall not be necessary.

4.9. Advertising and Promotion of Contract. The Contractor shall not advertise or publish information for commercial benefit concerning this Contract without the prior written approval of an ADHS Procurement Officer.

4.10. Property of the State.

4.10.1. *Equipment.* Except as provided below or otherwise agreed to by the parties, the title to any and all equipment acquired through the expenditure of funds received from the State shall remain the property of the State by and through the ADHS and, as such, shall remain under the sole direction, management and control of the ADHS. When this Contract is terminated, the disposition of all such property shall be determined by the ADHS. For Fixed Price contracts, when the Contractor provides the services/materials required by the Contract, any and all equipment purchased by the Contractor remains the property of the Contractor. All purchases of equipment need to be reported to the ADHS Office of Inventory Control.

4.10.2. *Title and Rights to Materials.* As used in this section, the term "Materials" means all products created or produced by the Contractor under this Contract, including, but not limited to: written and electronic information, recordings, reports, research, research findings, conclusions, abstracts, results, software, data and any other intellectual property or deliverables created, prepared, or received by the Contractor in performance of this Contract. Contractor acknowledges that all Materials are the property of the State by and through the ADHS and, as such, shall remain under the sole direction, management and control of the ADHS. The Contractor is not entitled to a patent or copyright on these Materials and may not transfer a patent or copyright on them to any other person or entity. To the extent any copyright in any Materials may originally vest in the Contractor, the Contractor hereby irrevocably transfers to the ADHS, for and on behalf of the State, all copyright ownership. The ADHS shall have full, complete and exclusive rights to reproduce, duplicate, adapt, distribute, display, disclose, publish, release and otherwise use all Materials. The Contractor shall not use or release these Materials without the prior written consent of the ADHS. When this Contract is terminated, the disposition of all such Materials shall be determined by the ADHS. Further, the Contractor agrees to give recognition to the ADHS for its support of any program when releasing or publishing program Materials.

4.10.3. *Notwithstanding the above, if the Contractor is a State agency, the following shall apply instead:* It is the intention of ADHS and Contractor that all material and intellectual property developed under this Agreement be used and controlled in ways to produce the greatest benefit to the parties to this Contract and the citizens of the State of Arizona. As used in this paragraph, "Material" means all written and electronic information, recordings, reports, findings, research information, abstracts, results, software, data, discoveries, inventions, procedures and processes of services developed by the Contractor and any other materials created, prepared or received by the Contractor and subcontractors in performance of this Agreement. "Material" as used herein shall not include any pre-existing data, information, materials, discoveries, inventions or any form of intellectual property invented, created, developed or devised by Contractor (or its employees, subcontractors or agents) prior to the commencement of the services funded by this Agreement or that may result from Contractor's involvement in other service activities that are not funded by the Agreement.

4.10.4. Title and exclusive copyright to all Material shall vest in the State of Arizona, subject to any rights reserved on behalf of the federal government. As State agencies and instrumentalities, both ADHS and Contractor shall have full, complete, perpetual, irrevocable and non-transferable rights to reproduce, duplicate, adapt, make derivative works, distribute, display, disclose, publish and otherwise use any and all Material. The Contractor's right to use Material shall include the following rights: the right to use the Material in connection with its

internal, non-profit research and educational activities, the right to present at academic or professional meetings or symposia and the right to publish in journals, theses, dissertations or otherwise of Contractor's own choosing. Contractor agrees to provide ADHS with a right of review prior to any publication or public presentation of the Material, and ADHS shall be entitled to request the removal of its confidential information or any other content the disclosure of which would be contrary to the best interest of the State of Arizona. Neither party shall release confidential information to the public without the prior expressly written permission of the other, unless required by the State public records statutes or other law, including a court order. Each party agrees to give recognition to the other party in all public presentations or publications of any Material, when releasing or publishing them.

4.10.5. In addition, ADHS and Contractor agree that any and all Material shall be made freely available to the public to the extent it is in the best interest of the State. However, if either party wants to license or assign an intellectual property interest in the material to a third-party for monetary compensation, ADHS and Contractor agree to convene to determine the relevant issues of title, copyright, patent and distribution of revenue. In the event of a controversy as to whether the Material is being used for monetary compensation or in a way that interferes with the best interest of the state or ADHS, then the Arizona Department of Administration shall make the final decision. Notwithstanding the above, "monetary compensation' does not include compensation paid to an individual creator for traditional publications in academia (the copyrights to which are Employee-Excluded Works under ABOR Intellectual Property Policy Section 6-908C.4.), an honorarium or other reimbursement of expenses for an academic or professional presentation, or an unprofitable distribution of Material.

4.11. E-Verify Requirements In accordance with A.R.S. § 41-4401, Contractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. § 23-214, Subsection A.

4.12. Federal Immigration and Nationality Act The Contractor shall comply with all federal, state and local immigration laws and regulations relating to the immigration status of their employees during the term of the Contract. Further, the Contractor shall flow down this requirement to all subcontractors utilized during the term of the Contract. The State shall retain the right to perform random audits of Contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the Contract for default and suspension and/or debarment of the Contractor.

5. COSTS AND PAYMENTS:

5.1. Payments. Payments shall comply with the requirements of A.R.S. Titles 35 and 41, net 30 days. Upon receipt and acceptance of goods or services, the Contractor shall submit a complete and accurate Contractor's Expenditure Report for payment from the State within thirty (30) days, as provided in the Accounting and Auditing Procedures Manual for the ADHS.

5.2. Recoupment of Contract Payments.

5.2.1. *Unearned Advanced Funds.* Any unearned State funds that have been advanced to the Contractor and remain in its possession at the end of each budget term, or at the time of termination of the Contract, shall be refunded to the ADHS within forty-

five (45) days of the end of a budget term or of the time of termination.

5.2.2. *Contracted Services.* In a fixed price contract, if the number of services provided is less than the number of services for which the Contractor received compensation, funds to be returned to the ADHS shall be determined by the Contract price. Where the price is determined by cost per unit of service or material, the funds to be returned shall be determined by multiplying the unit of service cost by the number of services the Contractor did not provide during the Contract term. Where the price for a deliverable is fixed, but the deliverable has not been completed, the Contractor shall be paid a pro rata portion of the completed deliverable. In a cost reimbursement contract, the ADHS shall pay for any costs that the Contractor can document as having been paid by the Contractor and approved by ADHS. In addition, the Contractor will be paid its reasonable actual costs for work in progress as determined by Generally Accepted Accounting Procedures up to the date of contract termination.

5.2.3. *Refunds.* Within forty-five (45) days after the end of each budget term or of the time of termination of the Contract, the Contractor shall refund the greater of: i) the amount refundable in accordance with paragraph 4.2.1, Unearned Advanced Funds; or ii) the amount refundable in accordance with paragraph 5.2.2, Contracted Services.

5.2.4. *Unacceptable Expenditures.* The Contractor agrees to reimburse the ADHS for all Contract funds expended, which are determined by the ADHS not to have been disbursed by the Contractor in accordance with the terms of this Contract. The Contractor shall reimburse ADHS within 45 days of the determination of unacceptability.

5.3. Unit Costs/Rates or Fees. Unit costs/rates or fees shall be based on costs, which are determined by ADHS to be reasonable, allowable and allocable as outlined in the Accounting and Auditing Procedures Manual for the ADHS.

5.4. Applicable Taxes.

5.4.1. *State and Local Transaction Privilege Taxes.* The State of Arizona is subject to all applicable state and local transaction privilege taxes. Transaction privilege taxes apply to the sale and are the responsibility of the seller to remit. Failure to collect taxes from the buyer does not relieve the seller from its obligation to remit taxes.

5.4.2. *Tax Indemnification.* The Contractor and all subcontractors shall pay all federal, state and local taxes applicable to its operation and any persons employed by the Contractor. Contractor shall require all subcontractors to hold the State harmless from any responsibility for taxes, damages and interest, if applicable, contributions required under Federal, and/or state and local laws and regulations and any other costs, including transaction privilege taxes, unemployment compensation insurance, Social Security and Worker's Compensation.

5.4.3. *I.R.S. W9 Form.* In order to receive payment under any resulting Contract, the Contractor shall have a current I.R.S. W9 Form on file with the State of Arizona.

5.5. Availability of Funds for the Next Fiscal Year. Funds may not be presently available for performance under this Contract beyond the first year of the budget term or Contract term. The State may reduce payments or terminate this Contract without further recourse, obligation or penalty in the event that insufficient funds are appropriated in the subsequent budget term. The State shall not be liable for any purchases or Subcontracts entered into

by the Contractor in anticipation of such funding. The Procurement Officer shall have the discretion in determining the availability of funds.

5.6. Availability of Funds for the Current Contract Term. Should the State Legislature enter back into session and decrease the appropriations through line item or general fund reductions, or for any other reason these goods or services are not funded as determined by ADHS, the following actions may be taken by ADHS:

5.6.1. Accept a decrease in price offered by the Contractor;

5.6.2. Reduce the number of goods or units of service and reduce the payments accordingly;

5.6.3. Offer reductions in funding as an alternative to Contract termination; or

5.6.4. Cancel the Contract.

6. CONTRACT CHANGES:

6.1. Amendments, Purchase Orders and Change Orders. This Contract is issued under the authority of the Procurement Officer who signed this Contract. The Contract may be modified only through a Contract Amendment, Purchase Order and/or Change Order within the scope of the Contract, unless the change is administrative or otherwise permitted by the Special Terms and Conditions. Changes to the Contract, including the addition of work or materials, the revision of payment terms, or the substitution of work or materials, directed by an unauthorized State employee or made unilaterally by the Contractor are violations of the Contract and of applicable law. Such changes, including unauthorized Contract Amendments, Purchase Orders and/or Change Orders, shall be void and without effect, and the Contractor shall not be entitled to any claim under this Contract based on those changes.

6.2. Subcontracts. The Contractor shall not enter into any subcontract under this Contract without the advance written approval of the Procurement Officer. The subcontract shall incorporate by reference all material and applicable terms and conditions of this Contract.

6.3. Assignments and Delegation. The Contractor shall not assign any right nor delegate any duty under this Contract without the prior written approval of the Procurement Officer. The State shall not unreasonably withhold approval.

7. RISK AND LIABILITY:

7.1. Risk of Loss. The Contractor shall bear all loss of conforming material covered under this Contract until received and accepted by authorized personnel at the location designated in the Purchase Order, Change Order or Contract. Mere receipt does not constitute final acceptance. The risk of loss for nonconforming materials shall remain with the Contractor regardless of receipt.

7.2. Mutual Indemnification. Each party (as "indemnitor") agrees to indemnify, defend and hold harmless the other party (as "indemnitee") from and against any and all claims, losses, liability, costs or expenses (including reasonable attorney's fees) (hereinafter collectively referred to as "claims") arising out of bodily injury of any person (including death) or property damage, but only to the extent that such claims, which result in vicarious/derivative liability to the indemnitee, are caused by the act, omission, negligence, misconduct, or other fault of the indemnitor, its officers, officials, agents, employees or volunteers.

7.3. Force Majeure.

7.3.1. *Liability and Definition.* Except for payment of sums due, neither party shall be liable to the other nor deemed in default under this Contract if and to the extent that such party's performance of this Contract is prevented by reason of force majeure. The term "*force majeure*" means an occurrence that is beyond the control of the party affected and occurs without its fault or negligence. Without limiting the foregoing, force majeure includes acts of God; acts of the public enemy; acts of terrorism; war; riots; strikes; mobilization; labor disputes; civil disorders; fire; flood; lockouts; injunctions-interventions not caused by or resulting from the act or failure to act of the parties; failures or refusals to act by government authority not caused by or resulting from the act or failure to act of the parties; and other similar occurrences beyond the control of the party declaring force majeure, which such party is unable to prevent by exercising reasonable diligence.

7.3.2. *Exclusions.* Force Majeure shall not include the following occurrences:

7.3.2.1. Late delivery of Materials caused by congestion at a manufacturer's plant or elsewhere, or an oversold condition of the market;

7.3.2.2. Late performance by a subcontractor unless the delay arises out of a force majeure occurrence in accordance with this force majeure term and condition; or

7.3.2.3. Inability of either the Contractor or any subcontractor to acquire or maintain any required insurance, bonds, licenses or permits.

7.3.3. *Notice.* If either party is delayed at any time in the progress of the work by force majeure, the delayed party shall notify the other party in writing of such delay, as soon as is practicable and no later than the following working day of the commencement thereof, and shall specify the causes of such delay in such notice. Such notice shall be delivered or mailed certified-return receipt and shall make a specific reference to this article, thereby invoking its provisions. The delayed party shall cause such delay to cease as soon as practicable and shall notify the other party in writing when it has done so. The time of completion shall be extended by Contract Amendment for a period of time equal to the time that the results or effects of such delay prevent the delayed party from performing in accordance with this Contract.

7.3.4. *Default.* Any delay or failure in performance by either party hereto shall not constitute default hereunder or give rise to any claim for damages or loss of anticipated profits if, and to the extent that, such delay or failure is caused by force majeure.

7.4. Third Party Antitrust Violations. The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor for or toward the fulfillment of this Contract.

8. DESCRIPTION OF MATERIALS: The following provisions shall apply to Materials only:

8.1. Liens. The Contractor agrees that the Materials supplied under this Contract are free of liens. In the event the Materials are not free of liens, Contractor shall pay to remove the lien and any associated damages or replace the Materials with Materials free of liens.

8.2. Quality. Unless otherwise modified elsewhere in these terms and conditions, the Contractor agrees that, for one year after acceptance by the State of the Materials, they shall be:

8.2.1. Of a quality to pass without objection in the Contract description;

8.2.2. Fit for the intended purposes for which the Materials are used;

8.2.3. Within the variations permitted by the Contract and are of even kind, quantity, and quality within each unit and among all units;

8.2.4. Adequately contained, packaged and marked as the Contract may require; and

8.2.5. Conform to the written promises or affirmations of fact made by the Contractor.

8.3. Inspection/Testing. Subparagraphs 8.1 through 8.2 of this paragraph are not affected by inspection or testing of or payment for the Materials by the State.

8.4. Compliance With Applicable Laws. The Materials and services supplied under this Contract shall comply with all applicable federal, state and local laws, and the Contractor shall maintain all applicable license and permit requirements.

8.5. Survival of Rights and Obligations After Contract Expiration and Termination.

8.5.1. *Contractor's Representations.* All representations and warranties made by the Contractor under this Contract in paragraphs 7 and 8 shall survive the expiration or termination hereof. In addition, the parties hereto acknowledge that pursuant to A.R.S. § 12.510, except as provided in A.R.S. § 12-529, the State is not subject to or barred by any limitations of actions prescribed in A.R.S. Title 12, Chapter 5.

8.5.2. *Purchase Orders and Change Orders.* Unless otherwise directed in writing by the Procurement Officer, the Contractor shall fully perform and shall be obligated to comply with all Purchase Orders and Change Orders received by the Contractor prior to the expiration or termination hereof, including, without limitation, all Purchase Orders and Change Orders received prior to but not fully performed and satisfied at the expiration or termination of this Contract.

9. STATE'S CONTRACTUAL REMEDIES:

9.1. Right to Assurance. If the State, in good faith, has reason to believe that the Contractor does not intend to, or is unable to, perform or continue performing under this Contract, the Procurement Officer may demand in writing that the Contractor give a written assurance of intent to perform. Failure by the Contractor to provide written assurance within the number of Days specified in the demand may, at the State's option, be the basis for terminating the Contract.

9.2. Stop Work Order.

9.2.1. *Terms.* The State may, at any time, by written order to the Contractor, require the Contractor to stop all or any part of the work called for by this Contract for a period up to ninety (90) Days after the order is delivered to the Contractor, and for any further period to which the parties may agree. The order shall be specifically identified as a stop work order issued under this clause. Upon receipt of the order, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize the incurrence of costs allocable to the work covered by the

order during the period of work stoppage.

9.2.2. *Cancellation or Expiration.* If a stop work order issued under this clause is canceled or the period of the order or any extension expires, the Contractor shall resume work. The Procurement Officer shall make an equitable adjustment in the delivery schedule or Contract price, or both, and the Contract shall be amended in writing accordingly.

9.3. Non-exclusive Remedies. The rights and remedies of ADHS under this Contract are not exclusive, and ADHS is entitled to all rights and remedies available to it, including those under the Arizona Uniform Commercial Code and Arizona common law.

9.4. Right of Offset. The State shall be entitled to offset against any sums due the Contractor in any Contract with the State or damages assessed by the State because of the Contractor's non-conforming performance or failure to perform this Contract. The right to offset may include, but is not limited to, a deduction from an unpaid balance and a collection against the bid and/or performance bonds. Any offset taken for damages assessed by the State shall represent a fair and reasonable amount for the actual damages and shall not be a penalty for non-performance.

10. CONTRACT TERMINATION:

10.1. Cancellation for Conflict of Interest. Pursuant to A.R.S. § 38-511, the State may cancel this Contract within three (3) years after Contract execution without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the Contract on behalf of the State is, or becomes at any time while the Contract or an extension of the Contract is in effect, an employee of or a consultant to any other party to this Contract with respect to the subject matter of the Contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation, unless the notice specifies a later time. If the Contractor is a political subdivision of the State, it may also cancel this Contract as provided in A.R.S. § 38-511.

10.2. Gratuities. The State may, by written notice, terminate this Contract, in whole or in part, if the State determines that employment or a Gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State for the purpose of influencing the outcome of the procurement, securing the Contract or an Amendment to the Contract, or receiving favorable treatment concerning the Contract, including the making of any determination or decision about Contract performance. The State, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the Gratuity offered by the Contractor.

10.3. Suspension or Debarment. The State may, by written notice to the Contractor, immediately terminate this Contract if the State determines that the Contractor or its subcontractor has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity, including but not limited to, being disapproved as a subcontractor of any public procurement unit or other governmental body.

10.4. Termination Without Cause.

10.4.1. Both the State and the Contractor may terminate this Contract at any time with thirty (30) days' notice in writing specifying the termination date. Such notices shall be given by personal delivery or by certified mail, return receipt requested.

10.4.2. If the Contractor terminates this Contract, any monies prepaid by the State, for

which no service or benefit was received by the State, shall be refunded to the State within 5 days of the termination notice. In addition, if the Contractor terminates the Contract, the Contractor shall indemnify the State for any sanctions imposed by the funding source as a result of the Contractor's failure to complete the Contract.

10.4.3. If the State terminates this Contact pursuant to this Section, the State shall pay the Contractor the Contract price for all Services and Materials completed up to the date of termination. In a fixed price contract, the State shall pay the amount owed for the Services or Materials by multiplying the unit of service or item cost by the number of unpaid service units or items. In a cost reimbursement contract, the ADHS shall pay for any costs that the Contractor can document as having been paid by the Contractor and approved by ADHS. In addition, the Contractor will be paid its reasonable actual costs for work in progress as determined by GAAP up to the date of termination. Upon such termination, the Contractor shall deliver to the ADHS all deliverables completed. ADHS may require Contractor to negotiate the terms of any remaining deliverables still due.

10.5. Mutual Termination. This Contract may be terminated by mutual written agreement of the parties specifying the termination date and the terms for disposition of property and, as necessary, submission of required deliverables and payment therein.

10.6. Termination for Default. The State reserves the right to terminate the Contract in whole or in part due to the failure of the Contractor to comply with any material obligation, term or condition of the Contract, to acquire and maintain all required insurance policies, bonds, licenses and permits, or to make satisfactory progress in performing the Contract. In the event the ADHS terminates the Contract in whole or in part as provided in this paragraph, the ADHS may procure, upon such terms and in such manner as deemed appropriate, Services or Materials, similar to those terminated, and Contractor shall be liable to the ADHS for any excess costs incurred by the ADHS in obtaining such similar Services or Materials.

10.7. Continuation of Performance Through Termination. Upon receipt of the notice of termination and until the effective date of the notice of termination, the Contractor shall perform work consistent with the requirements of the Contract and, if applicable, in accordance with a written transition plan approved by the ADHS. If the Contract is terminated in part, the Contractor shall continue to perform the Contract to the extent not terminated. After receiving the notice of termination, the Contractor shall immediately notify all subcontractors, in writing, to stop work on the effective date of termination, and on the effective date of termination, the Contractor and subcontractors shall stop all work.

10.8. Disposition of Property. Upon termination of this Contract, all property of the State, as defined herein, shall be delivered to the ADHS upon demand.

11. ARBITRATION:

Pursuant to A.R.S. § 12-1518, disputes under this Contract shall be resolved through the use of arbitration when the case or lawsuit is subject to mandatory arbitration pursuant to rules adopted under A.R.S. § 12 -133.

12. COMMUNICATION:

12.1. Program Report. When reports are required by the Contract, the Contractor shall provide them in the format approved by ADHS.

12.2. Information and Coordination. The State will provide information to the Contractor pertaining to activities that affect the Contractor's delivery of services, and the Contractor shall be responsible for coordinating their activities with the State's in such a manner as not to conflict or unnecessarily duplicate the State's activities. As the work of the Contractor progresses, advice and information on matters covered by the Contract shall be made available by the Contractor to the State throughout the effective period of the Contract.

13. CLIENT GRIEVANCES:

If applicable, the Contractor and its subcontractors shall use a procedure through which clients may present grievances about the operation of the program that result in the denial, suspension or reduction of services provided pursuant to this Contract and which is acceptable to and approved by the State.

14. SOVEREIGN IMMUNITY:

Pursuant to A.R.S. § 41-621(O), the obtaining of insurance by the State shall not be a waiver of any sovereign immunity defense in the event of suit.

15. FINGERPRINT AND CERTIFICATION REQUIREMENTS/JUVENILE SERVICES:

15.1. Paid and Unpaid Personnel. Pursuant to A.R.S. § 36-425.03, the Contractor shall ensure that all paid and unpaid personnel who are required or are allowed to provide Services directly to juveniles have obtained fingerprint clearance cards in accordance with A.R.S. § 41-1758 et. seq.

15.2. Costs. The Contractor shall assume the costs of fingerprint certifications and may charge these costs to its fingerprinted personnel.

16. ADMINISTRATIVE CHANGES:

The Procurement Officer, or authorized designee, reserves the right to correct any obvious clerical, typographical or grammatical errors, as well as errors in party contact information (collectively, "Administrative Changes"), prior to or after the final execution of a Contract or Contract Amendment. Administrative Changes subject to permissible corrections include: misspellings, grammar errors, incorrect addresses, incorrect Contract Amendment numbers, pagination and citation errors, mistakes in the labeling of the rate as either extended or unit, and calendar date errors that are illogical due to typographical error. The Procurement Office shall subsequently send to the Contractor notice of corrections to administrative errors in a written confirmation letter with a copy of the corrected Administrative Change attached.

17. SURVIVAL OF TERMS AFTER TERMINATION OR CANCELLATION OF CONTRACT:

All applicable Contract terms shall survive and apply after Contract termination or cancellation to the extent necessary for Contractor to complete and for the ADHS to receive and accept any final deliverables that are due after the date of the termination or cancellation.

18. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA):

18.1. The Contractor warrants that it is familiar with the requirements of HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009, and accompanying regulations and will comply with all applicable HIPAA requirements in the course of this Contract. Contractor warrants that it will cooperate with the Arizona Department of Health Services (ADHS) in the course of performance of the

Contract so that both ADHS and Contractor will be in compliance with HIPAA, including cooperation and coordination with the Arizona Department of Administration-Arizona Strategic Enterprise Technology (ADOA-ASET) Office, the ADOA-ASET Arizona State Chief Information Security Officer and HIPAA Coordinator and other compliance officials required by HIPAA and its regulations. Contractor will sign any documents that are reasonably necessary to keep ADHS and Contractor in compliance with HIPAA, including, but not limited to, business associate agreements.

18.2. If requested by the ADHS Procurement Office, Contractor agrees to sign a "Pledge To Protect Confidential Information" and to abide by the statements addressing the creation, use and disclosure of confidential information, including information designated as protected health information and all other confidential or sensitive information as defined in policy. In addition, if requested, Contractor agrees to attend or participate in HIPAA training offered by ADHS or to provide written verification that the Contractor has attended or participated in job related HIPAA training that is: (1) intended to make the Contractor proficient in HIPAA for purposes of performing the services required and (2) presented by a HIPAA Privacy Officer or other person or program knowledgeable and experienced in HIPAA and who has been approved by the ADOA-ASET Arizona State Chief Information Security Officer and HIPAA Coordinator.

19. COMMENTS WELCOME:

The ADHS Procurement Office periodically reviews the Uniform Terms and Conditions and welcomes any comments you may have. Please submit your comments to: ADHS Procurement Administrator, Arizona Department of Health Services, 150 North 18th Avenue, Suite 260, Phoenix, Arizona 85007.

20. DATA UNIVERSAL NUMBERING SYSTEM (DUNS) REQUIREMENT:

For federal funding, pursuant to 2 CFR 25.100 et seq., no entity (defined as a Governmental organization, which is a State, local government, or Indian tribe; foreign public entity; domestic or foreign nonprofit organization; domestic or foreign for-profit organization; or Federal agency, but only as a sub recipient under an award or subaward to a non-Federal entity) may receive a subaward from ADHS unless the entity provides its Data Universal Numbering System (DUNS) Number to ADHS.

21. THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA OR TRANSPARENCY ACT - P.L.109-282, AS AMENDED BY SECTION 6202(A) OF P.L. 110-252), FOUND AT HTTPS://WWW.FSRS.GOV/ :

If applicable, the Contractor/Grantee shall submit to ADHS via email the Grant Reporting Certification Form. This form and the instructions can be downloaded from the ADHS Procurement website at http://www.azdhs.gov/operations/financial-services/procurement/index.php#ffata and must be returned to the ADHS by the 15th of the month following that in which the award was received. The form shall be completed electronically, and submitted using the steps outlined in the Grant Reporting Certification Form Instructions to the following email address: ADHS_Grant@azdhs.gov. All required fields must be filled including Top Employee Compensation, if applicable. Completing the Grant Reporting Certification Form is required for compliance with the Office of Management and Budget (OMB), found at http://www.whitehouse.gov/omb/open. Failure to timely submit the Grant Reporting Certification Form could result in the loss of funds. This requirement applies to all subcontractors/sub-awardees utilized by the Contractor/Grantee for amounts exceeding $30,000.00 during the term of the Award.

22. TECHNOLOGY REPLACEMENT:

In any event where product is discontinued, no longer available or technically inferior to newly developed product, the Contractor shall provide an equivalent replacement model at no additional cost and shall honor the original contract terms.

23. AUTHORIZATION FOR PROVISION OF SERVICES:

Authorization for purchase of services under this agreement shall be made only upon ADHS issuance of a Purchase Order that is signed by an authorized agent. The Purchase Order will indicate the agreement number and the dollar amount of funds authorized. The Contractor shall only be authorized to perform services up to the amount on the Purchase Order. ADHS shall not have any legal obligation to pay for services in excess of the amount indicated on the Purchase Order. No further obligation for payment shall exist on behalf of ADHS unless: a) The Purchase Order is changed or modified with an official ADHS Procurement Change Order, and/or b) An additional Purchase Order is issued for purchase of services under this agreement.

24. PUBLIC HEALTH EMERGENCIES:

24.1. In the event of a public health emergency, ADHS under the guidance of the federal funder may authorize a Contractor to temporarily reassign staff to address the emergency. Contractors shall adhere to the following reassignment conditions:

24.1.1. Approval from ADHS shall be requested prior to reassignment of staff.

24.1.2. Reassignment must be voluntary;

24.1.3. Locations for reassignment must be covered under the public health emergency; and

24.1.4. Any reassignment of staff shall be considered approved until further notice from the ADHS or until the Governor declares an end to the public health emergency.

24.2. ADHS shall continue to coordinate with program staff regarding the extent and duration of the planned assignment(s) and other potential impacts to the program.

1. BACKGROUND:

1.1. The vision of the Arizona Department of Health Services (ADHS) is "Health and Wellness for all Arizonans." The ADHS conducts a five (5) year statewide needs assessment to examine key health indicators and provide a comprehensive overview of the health of Arizonans. ADHS published the 2019 Arizona State Health Assessment which utilizes an evidence-based public health approach to improve the health and wellness of Arizona residents. This assessment informs other federally funded programs within ADHS that also require statewide needs assessments. One (1) of those programs is the Title V Maternal and Child Health (MCH) Block Grant located within the Bureau of Women's and Children's Health (BWCH);

1.2. The mission of the BWCH is to "strengthen the family and community by promoting and improving the health status of women, infants, and children." The BWCH administers the federal Title V MCH Block Grant, other federally funded programs, as well as private, and state supported programs;

1.3. BWCH is responsible for the implementation of the Health Resources and Services Administration (HRSA) funded Title V MCH Block Grant. Established in 1935, in Title V of the Social Security Act, the goal of the Title V MCH Block grant is to improve the health and well-being of America's mothers, children and families including children with special health care needs by supporting and promoting the development and coordination of systems of care for the MCH population, which are family-centered, community based and culturally appropriate. The Title V MCH Block Grant has five (5) population domains which include: Women/Maternal Health, Perinatal/Infant Health, Child Health, Children with Special Health Care Needs, Adolescent Health. The sixth (6^{th}) domain addresses Cross-Cutting and Systems Building;

1.4. The Title V MCH Block Grant also requires that a five (5) year statewide needs assessment be conducted and submitted as one (1) of the grant deliverables. The purpose of the Title V MCH statewide needs assessment is to identify the priority health needs and issues of Arizona's maternal and child health populations through a collaborative and systematic data collection and analytic process with stakeholder input. This needs assessment process is guided by eight (8) overarching principles and values that include:

1.4.1. **Listen** to those who are not traditionally involved,

1.4.2. **Learn** from community members as well as the MCH Community,

1.4.3. **Honor** and **respect** the work that others in the community and state have completed to assess the well-being of Arizona residents,

1.4.4. **Assess health disparities** across communities including racial, socioeconomic and access,

1.4.5. Use a **life course development approach and address social determinants of health** as a framework for planning,

1.4.6. **Recognize** that social, political and economic policies and conditions impact health outcomes,

1.4.7. **Value the community** as a core partner in public health and work to assure the equity in health, and

1.4.8. Plan, develop and **evaluate programs and systems of care** which are comprehensive, community-based, culturally competent, coordinated and effective.

1.5. The Title V MCH Block Grant uses a three-tiered National Performance Measurement Framework (Attachment A) which includes National Outcome Measures (NOMs), National Performance Measures (NPMs) and state-initiated Evidence-based or informed Strategy Measures (ESMs). The framework provides flexibility to a state in identifying the best combination of measures to address the MCH priority needs that were identified based on the findings of the Five-Year Needs Assessment (Attachment B).

2. PURPOSE:

The purpose of this IGA is to leverage partnerships between ADHS and Local County Health Departments by providing Title V MCH Block Grant funding to support the implementation of health priorities identified through the Arizona Statewide Needs Assessment and MCH statewide needs assessment. This IGA is intended to provide flexibility to the Local County Health Department to meet the needs of local communities through high impact strategies that align with the 2020-2025 MCH health priorities, the identified national performance measures and administrative functions.

3. OBJECTIVES:

3.1. Counties will implement evidence-based/evidence-informed strategies at the local community level that:

3.1.1. Promote and implement evidence-based or evidence-informed strategies that enhance preventive and primary care services for pregnant women, mothers and infants up to age one (1) for the Women/Maternal and Perinatal Infant population domains,

3.1.2. Promote and implement evidence-based or evidence-informed strategies that enhance preventive and primary care services for the Child Health, Adolescent Health and Children with Special Health Care Needs population domains,

3.1.3. Enhance family, youth, and community engagement for all five (5) population domains in the MCH Block Grant including children and families with special health care needs, and

3.1.4. Promote and implement evidence-based or evidence-informed strategies that enhance cross-cutting and system building infrastructure.

4. SCOPE OF WORK:

4.1. Counties can select to implement strategies within population domains and/or in National Performance Measures.

4.1.1. Population domains include:

4.1.1.1. Women/Maternal Health – women ages eighteen (18) to forty-four (44), before, during, and beyond pregnancy; and across the life course;

4.1.1.2. Perinatal/Infant Health – infants during the time surrounding childbirth, particularly three (3) months before and one (1) year after;

4.1.1.3. Child Health – children one (1) to ten (10) years of age;

4.1.1.4. Adolescent Health – young people ages ten (10) to nineteen (19) years of age;

4.1.1.5. Children/Youth with Special Health Care Needs – children/youth with a diverse range of needs ranging from behavioral and emotional conditions to chronic conditions, to more medically complex health issues;

4.1.1.6. Cross-cutting and Systems Building - priority need such as oral health, access to care, injury prevention, etc. that is related to program capacity and/or systems-building as it applies to all/any of the MCH population domains; or

4.1.1.7. Emerging Issues - projects and/or strategies that become prominent and are unique to a particular County, for example, reassignment of staff to address the COVID-19 pandemic or any other public health emergency, conducting focus groups to determine how to improve services for children/youth with special health care needs, etc.

4.1.2. NPMs selected by the State and identified through the findings of a five (5) year needs assessment include:

4.1.2.1. NPM #1 - Well-woman visits - Percent of women, ages eighteen (18) through forty-four (44), with a preventive medical visit in the past year, and family planning services;

4.1.2.2. NPM #4 Breastfeeding – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through six (6) months of age;

4.1.2.3. NPM #6 Developmental Screening - Percent of children, ages nine (9) through thirty-five (35) months, who received a developmental screening using a parent-completed screening tool in the past year;

4.1.2.4. NPM #9 Bullying - Percent of adolescents, ages twelve (12) through seventeen (17), who are bullied or who bully others;

4.1.2.5. NPM #10 Adolescent well visits - Percent of adolescents, ages twelve (12) through seventeen (17), with a preventive medical visit in the past year;

4.1.2.6. NPM #12 Transition - Percent of adolescents with and without special health care needs, ages twelve (12) through seventeen (17), who received services necessary to make transitions to adult health care; and

4.1.2.7. NPM #13 Preventive dental visits for pregnant women, children and adolescents - A) Percent of women who had a dental visit during pregnancy; and B) Percent of children, ages one (1) through seventeen (17), who had a preventive dental visit in the past year.

4.1.3. If strategies selected by the Counties do not align with the State selected NPMs listed above, BWCH in partnership with Counties will develop State Performance Measures (SPMs) as needed to measure priority needs that have not been addressed through the selected NPMs, and

4.1.4. Counties may elect to provide Family Planning Services which would qualify under NPM #1 and the Women/Maternal Health population domain:

4.1.4.1. Implement a clinic based reproductive health program which enhances maternal and child health;

4.1.4.2. Provide accessible, comprehensive education, screening and contraceptive services to underserved individuals of reproductive age; and

4.1.4.3. Adhere to the ADHS Family Planning Policy and Procedure Manual (Attachment H).

4.2. This IGA offers a variety of evidence-based and evidence-based informed strategies designed to

promote and positively impact the health status and outcomes of the MCH population in Arizona. Contingent upon available funding, Local County Health Departments are expected to implement at multiple levels, in accordance with local community needs infrastructure activities that integrate and build on each other to optimize the health improvements of the community. Counties have the option to select from a menu of evidence-based/evidence-informed strategies (Attachment B) or to propose their own evidence-based/evidence informed strategies that are identified as a need in their communities;

4.3. MCH has created Skill Sets in each of the NPMs to support implementation and further assist with thinking not only about evidence and strategies to make change but the capacity of the workforce to carry out activities (Attachment B); and

4.4. Where applicable, strategies shall be inclusive of children with special health care needs. Though counties are not required to implement strategies to specifically target this population, strategies designed for children, adolescents, and families assume an integrated approach that includes this population.

5. EVALUATION:

5.1. Performance measures and evaluations allow the counties and ADHS to collaboratively track progress, process indicators, outcomes measures, and impacts. As part of the local evaluation plan, the counties will be responsible for measuring the short term, and intermediate outcomes. Monitoring progress on short-term outcomes provides an opportunity for the counties to make adjustments to strategies to ensure increased long-term impact. ADHS in coordination with the counties will be responsible for measuring the long-term and impact outcomes. Process indicators, outcomes measures, and impacts must clearly relate to the selected strategies and activities identified within each County's Annual Action Plan; and

5.2. ADHS will provide technical support to counties on selecting the appropriate indicators to measure process and outcomes as they align with the new Title V MCH Priorities and Performance Metrics.

6. APPROVALS:

6.1. The quarterly reports, annual action plans, annual budget workbook, and monthly CERs with receipts supporting expenses billed for in-state and out-of-state travel and equipment purchases of $250 or more, as required and/or requested shall be approved by ADHS prior to payment reimbursement;

6.2. Upon approval of the Action Plan, any changes to the approved activities, or strategies must be resubmitted to ADHS for review and approval prior to implementation;

6.3. Any requests to provide additional information on quarterly reports will require resubmission of the report for ADHS review and approval prior to payment reimbursement;

6.4. Purchases of Capital Equipment (single item purchase of $5,000 or more) will require approval prior to purchasing;

6.5. All marketing materials (the use of ADHS logo, brochures, posters, public service announcements, paid media, videos, etc.) which have been developed, written, published, or recorded by the Counties and paid for with funds from this award must be first approved by ADHS prior to the dissemination of such materials or airing or use of such announcements;

6.6. All County local emerging issues and related supporting documentation must be approved by ADHS prior to implementation;

6.7. Any evaluation or study to be conducted that involves human subjects must be approved by ADHS prior to conducting; and

6.8. Request approval in writing to the MCH HAF IGA Program Manager for purchases of single items of capital equipment at or above the purchase price of five thousand dollars ($5,000.00);

6.8.1. Requests can be made via email and shall include the following information:

6.8.2. Type of equipment requesting to be purchased,

6.8.3. Cost of equipment, and

6.8.4. How the proposed purchase supports the current approved scope of work and annual action plan.

7. TASKS:

7.1. The Local County Health Department Contractor shall for the overall IGA:

7.1.1. Develop and submit an Annual Budget Workbook due January 15th of each year for the following year's budget period, including the federally approved indirect rate letter,

7.1.2. Develop and implement an Annual Action Plan within the first forty-five (45) days of each budget period,

7.1.3. Implement the selected approved evidence-based and/or evidence-informed strategies outlined in County Action Plans,

7.1.4. Participate in all calls (monthly, bi-monthly, quarterly), technical assistance calls, webinars, meetings, and training, and

7.1.5. Participate in the development of a shared comprehensive evaluation plan and report out on any performance measures related to the implementation of their activities (process and/or intermediate), or as defined by the funding sources.

7.2. Complete tagging and inventory of equipment in compliance with the policy in the State of Arizona Accounting Manual, https://gao.az.gov/sites/default/files/2535%20Stewardship%20190304.pdf;

7.2.1. Submit documents to the MCH HAF Program Manager pertaining to the asset, i.e., receiving papers, invoice, purchase order, receipt, etc., and

7.2.2. Documents shall include the make, model, serial number, and acquisition date of the asset.

7.3. All out-of-state travel shall follow the travel and per diem policies as outlined in the State of Arizona Accounting Manual;

9.5.1 https://gao.az.gov/sites/default/files/5009%20Traveler%20Responsibilities%20Draft%20200113.pdf, and

9.5.2 https://gao.az.gov/sites/default/files/5095%20Reimbursement%20Rates%20%20190102%20a.pdf.

7.4. Food purchases for events are an allowable cost under this grant. Food costs less than $500 per event and cumulative cost less than $5,000 annually do not require prior approval when spent within the State of Arizona Accounting Manual policies;

7.4.1. When food costs exceed the allowable thresholds set forth in the IGA, requests to purchase food shall be required by completing the *Request for Purchase of Food* form (Attachment F) and submitting to the MCH HAF Program Manager,

7.4.1.1. Requests shall be submitted ten (10) business days prior to needing to purchase food items;

7.4.1.2. Blanket food approval requests can be submitted for approval if multiple events, of the same nature, are reoccurring. The request shall indicate the number of events that will be held during the year and number of people attending; and

7.4.1.3. No food shall be purchased or reimbursed until the form has been approved and signed by the MCH HAF Program Manager.

7.4.2. Purchases shall follow the Food and Beverages policy outlined in the State of Arizona Accounting Manual, https://gao.az.gov/sites/default/files/8010%20Food%20and%20Beverages%20at%20State-sponsored%20Events%20181113.pdf, which includes but is not limited to:

7.4.2.1. Food provided must not exceed the allowable ADHS per person, per diem meal rates.

7.4.3. Justification for providing food at events requires but is not limited to:

7.4.3.1. how providing food serves a valid public purpose and does not violate the "gift clause",

7.4.3.2. is an integral part of the function, and

7.4.3.3. Benefits to the community.

7.4.4. A speaker/presentation during the time the meal is provided is required, and

7.4.5. Food provided should be healthy items. Please see the ADHS Healthy Meeting Policy for further guidance on nutritional guidelines for events/meetings: https://azdhs.gov/documents/prevention/nutrition-physical-activity/healthy-meeting policy.pdf.

7.5. Comply with all federal reporting requirements;

7.6. At least one (1) Program Manager or coordinator from each of the MCH HAF IGA programs must be in attendance at the Annual HPHC/MCH HAF IGA Summit;

7.7. Counties implementing Family Planning Programs with MCH HAF IGA funding shall abide by all standards and protocols outlined in the Family Planning Policies & Procedures manual (Attachment H); and

7.8. County program staff implementing strategies in this IGA will be required to participate in a one-time MCH HAF IGA orientation webinar, date to be determined.

7.9. ADHS will provide:

7.9.1. Review, feedback, and approval of the Annual Action Plan(s) within thirty (30) days of submitting,

7.9.2. Review, feedback, and approval of the annual Budgets Workbooks, CERs and Supporting Documentation within thirty (30) days of submission,

7.9.3. Feedback, technical assistance, and training to support the approved Annual Action Plan(s), Annual Budget, Quarterly Reporting, and Supporting Documentation,

7.9.4. Samples of evidence-based and/or evidence-informed strategies and supporting resources,

7.9.5. A Quarterly Reporting template upon execution of the IGA,

7.9.6. The Annual Action Plan template upon execution of the IGA,

7.9.7. Annual Budget Workbook and CER templates upon execution of the IGA,

7.9.8. Outcome Measures and examples of process, or intermediate performance measures, as needed,

7.9.9. Access to virtual technical assistance and guidance from ADHS staff, Local County Health Department peers/mentors, and subject matter experts related to the strategies for which the County has received funding, and

7.9.10. Coordinate and conduct annual Contractor site visits.

8. STATE PROVIDED ITEMS:

8.1. Attachment A – Maternal and Child Health National Performance Framework;

8.2. Attachment B – Evidence-based/Evidence-informed Strategies for MCH populations;

8.3. Attachment C – Contractor Expenditure Report (CER);

8.4. Attachment D – Financial Supporting Documentation Requirements;

8.5. Attachment E – Line Item Budget Move Tool;

8.6. Attachment F – Request for Food Form;

8.7. Attachment G – Emerging Issues Request Process and Form; and

8.8. Attachment H – Family Planning Policies and Procedures Manual

8.9. Upon execution of IGA:

8.9.1. Action Plan Template,

8.9.2. Quarterly Report Template, and

8.9.3. Budget Workbook Template.

9. Restrictions:

9.1. Funds cannot be used for any of the following:

9.1.1. Lobbying activities, including the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government,

9.1.2. Inpatient services, other than inpatient services provided to children with special health care needs or to high-risk pregnancy women and infants and such other inpatient services approved by the Secretary of the Department of Health and Human Services (DHHS),

9.1.3. Cash payments to intended service recipients of health services,

9.1.4. The purchase or improvements of land; the purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility; or the purchase of major medical equipment – unless the ADHS has obtained a waiver from the Secretary of DHHS,

9.1.5. Satisfying any requirements for the expenditure of non-federal funds as a condition for the receipt of federal funds,

9.1.6. Providing funds for research or training to any entity other than a public or non-profit private entity, and

9.1.7. Payment for any item of service (other than an emergency item or service) furnished by or at the medical direction or prescription of an ineligible or uncertified individual or entity.

10. Deliverables:

10.1. Annual Action Plan within the first forty-five (45) days of each budget period;

10.2. Contractor Expenditure Report (CER) to ADHS, due thirty (30) days following each month of services.

10.2.1. Receipts supporting expenses billed for any in-state/out-of-state travel and equipment purchases of $250 or more are to also be submitted, and

10.2.2. Upon request from ADHS, all receipts supporting expenses billed for a selected CER shall be submitted for review.

10.3. Written Quarterly Reports, due thirty (30) days after each quarter end (Q1: July – September; Q2: October – December; Q3: January – March; and Q4: April – June);

10.4. A final CER invoice no later than forty-five (45) days following the end of each contract year;

10.5. Annual Budget Workbook due by January 15th, for the next year's fiscal period;

10.6. Annual Report forty-five (45) days following the end of each Contract year; and

10.7. Family Planning Programs funded through this IGA will submit monthly data into the Family Planning Database as outlined in the policies and procedures manual.

10.7.1. Submit monthly CERs (Attachment C) and maintain sufficient documentation in the form of receipts in support of expenses incurred for any purchases that are being claimed for reimbursement or applied as match dollars to a budget (Attachment D),

10.7.1.1. Supporting documentation shall be kept by the Contractor and does NOT need to be submitted with quarterly CERs **with the exception of** travel documentation (in-state and out-of-state) and single purchases of equipment exceeding $250, and

10.7.1.2. Documentation supporting all expenses being billed shall be provided as requested by ADHS.

10.8. Provide the MCH HAF Program Manager with contact information of all program staff funded under this IGA within thirty (30) days of IGA execution to include:

10.8.1. Name, title, email address and phone numbers,

10.8.2. Staff Resumes, and

10.8.3. Program area assigned.

10.9. Submit the MCH HAF Program Manager of all staffing and programmatic changes within fifteen **(15) days** providing information outlined in 10.8;

10.10. Request to transfer budget amounts between line items, exceeding twenty-five percent (25%) of total annual budget or to a non-funded line item, will require a revised budget be submitted to the MCH HAF Program Manager and a IGA amendment issued by ADHS Procurement; and

10.11. Submit brochures, posters, public service announcements, paid media, videos, sponsorships, etc., to be paid for with funds from this IGA prior to development and use.

11. NOTICES, CORRESPONDENCE, REPORTS, AND INVOICES:

11.1. Notices, correspondence, reports, supporting documentation, and CERs from the County contractors to ADHS shall be sent to:

MCH HAF Program Manager
Arizona Department of Health Services
150 N. 18th Avenue
Phoenix, AZ 85007-3242
Email: TBD

11.2. Invoices shall be emailed to: invoices@azdhs.gov

11.3. Notices, Correspondence, Reports and Payments from ADHS to the Contractor shall be sent to:

Contractor _____

Attention _____

Address _____

City, State, ZIP _____

Phone _____

Fax _____

Email _____

CONTRACT NUMBER	INTERGOVERNMENTAL AGREEMENT (IGA)
IGA2020-043	PRICE SHEET

Pinal County Public Health Department
MCH Healthy Arizona Families IGA
Cost-Reimbursement Price Sheet
FY21

ACCOUNT CLASSIFICATION	LINE ITEM TOTALS
PERSONNEL EXPENSES	$78,437.00
EMPLOYEE RELATED EXPENSES	$31,375.00
PROFESSIONAL & OUTSIDE SERVICES EXPENSES	$10,000.00
TRAVEL EXPENSES	$3,499.00
OCCUPANCY EXPENSES	$0.00
OTHER OPERATING EXPENSES	$18,100.00
CAPITAL OUTLAY EXPENSES	$.00
INDIRECT COST EXPENSES (IF AUTHORIZED)	$10,700.00
	TOTAL $152,111.00

The Contractor is authorized to transfer up to a maximum of twenty-five percent (25%) of the total budget amount between line items.

Transfers exceeding twenty-five percent (25%) or to a non-funded line item shall require an amendment.

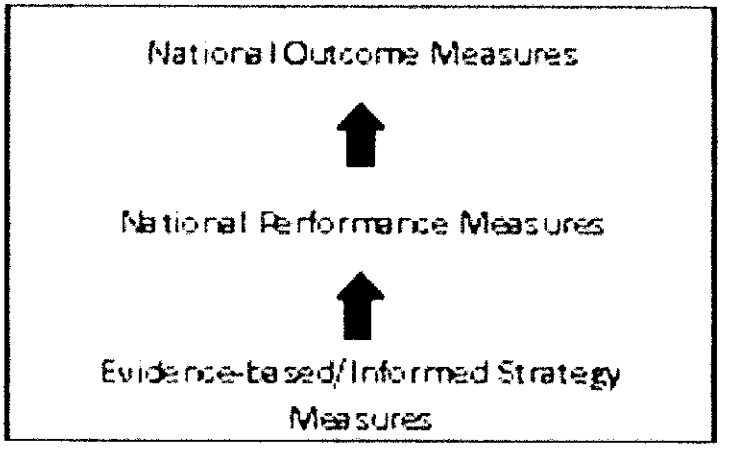
CONTRACT NUMBER	INTERGOVERNMENTAL AGREEMENT (IGA) ATTACHMENT A NATIONAL PERFORMANCE MEASURES FRAMEWORK
IGA2020-043	

The MCH Block Grant utilizes a three-tiered national performance measurement framework, which includes National Outcome Measures (NOMs), National Performance Measures (NPMs) and state-initiated Evidence-based or -informed Strategy Measures (ESMs). The framework provides flexibility to a state in identifying the best combination of measures to address the MCH priority needs that were identified based on the findings of the Five-Year Needs Assessment.

A state tracks the NOMs to monitor the impact of the NPMs.

The NPMs are a set of short-term and medium-term performance measures that utilize population-based, state-level data derived from national data sources and for which a state Title V program tracks prevalence rates and works towards demonstrated impact. They are intended to drive improved outcomes relative to one or more medium and long-term indicators of health status or access to quality health care (i.e., NOMs) for the MCH population.

ESMs are the final tier of the national performance measurement framework, and they are the structural or process measures through which a state can achieve intended impact on the NPMs. State-specific and actionable, the ESMs seek to track a state Title V program's strategies/activities and to measure evidence-based or –informed practices that will impact individual, population-based NPMs. The ESMs are developed by the state, and they provide accountability for improving quality and performance related to the NPMs and to the MCH public health issues that they are designed to address. While not part of the NPM framework, a state will also develop SPMs to address its identified priority needs to the extent that they have not been fully addressed through the selected NPMs and ESMs.



This overview of the NPMs, by MCH population health domains chart identifies which population domains are targeted in each of the NPMs. For example, the Women/Maternal Health population can be reached implementing strategies in NPM #1 Well-woman visit and NPM #2 Low-risk cesarean delivery.

		Women/ Maternal Health	Perinatal/ Infant Health	Child Health	Adolescent Health	Children with Special Health Care Needs	
1	Well-woman visit	✓					States have the option to develop a state performance measure (SPM) that is Cross-cutting/Systems Building. Examples of measure topic areas include but are not limited to: • Family partnership activities that cross all population health domains; • Social determinants of health; • Workforce development; and • Enhanced data infrastructure
2	Low-risk cesarean delivery	✓					
3	Risk-appropriate perinatal care		✓				
4	Breastfeeding++		✓				
5	Safe sleep		✓				
6	Developmental screening			✓			
7	Injury hospitalization*			✓	✓		
8	Physical activity*			✓	✓		
9	Bullying				✓		
10	Adolescent well-visit				✓		
11	Medical home*			✓	✓	✓	
12	Transition*				✓	✓	
13	Preventive dental visit*++	✓		✓	✓		
14	Smoking*++	✓		✓	✓		
15	Adequate insurance*			✓	✓	✓	

CONTRACT NUMBER	INTERGOVERNMENTAL AGREEMENT (IGA) ATTACHMENT B EVIDENCE-BASED AND EVIDENCE-INFORMED STRATEGIES FOR MCH DOMAINS
IGA2020-043	

Following are evidence-based and evidence-informed strategies that may be implemented in each selected population domain under each of the NPMs. Counties may elect to implement strategies other than these, as long as data supports that they are either evidence-based or evidence-informed. The NPM number identified in the strategy corresponds with the NPM number listed in the chart above.

Skill Sets have been identified in each of the NPMs to support implementation and further assist with thinking not only about evidence and strategies to make change but the capacity of the workforce to carry out activities. There are six (6) overarching skill set topics:

1. **Population Health** - Enables Title V professionals to analyze how program interventions and their related health outcomes are distributed among a state's MCH population. Population health skills complement all of Title V's work, including program design and implementation, strategic partnerships and communication.

2. **Strategic Planning & Program Design** - Effective strategic planning and program design requires the ability to base programs on defined goals and desired outcomes. Strategic planning should include a monitoring and evaluation system to track and monitor progress and inform program alterations as needed. Program design skills must ultimately be coupled with implementation, where program design is carried out.

3. **Strategic Alliance and Effective Partnership** - The wide array of stakeholders and partners in the field of MCH, from providers and insurers to women and children, require a set of skills in strategically aligning Title V goals with those of their partners. In the Title V world, there is an increasing interest in engaging unlikely or nontraditional partners to achieve the NPMs. The skills in this category take that into account and include unique partner groups linked to this measure.

4. **Consumer Engagement/Cultural & Linguistic Brokering** - Consumers are arguably the most important stakeholders in MCH work, thus skills in consumer engagement and cultural and linguistic brokering are essential to moving the needle for each NPM. In some cases, consumer engagement includes negotiating with other stakeholders on behalf of MCH populations. Closely linked with this skills category are skills in communication and strategic alliances.

5. **Policy & Program Implementation** - These skills ensure that MCH priorities are integrated into all aspects of policy and program implementation, as well as ensuring that policies and programs selected are well-aligned with NPMs and other MCH program goals. Implementing policies and programs with fidelity also requires skills in the implementation science drivers: technical and adaptive leadership; selection; training; coaching; systems intervention; facilitative administration; and decision support data systems.

6. **Communication** - Communication skills support the creation and delivery of effective messages between MCH professionals, professional and community partners, and populations served by Title V. Effective communication ensures the delivery of appropriate messages to audiences in the way that they were intended and is key to all aspects of MCH work. These skills are linked closely with skills in strategic partnerships and cultural and linguistic brokering.

Evidence-based Strategies	Evidence-informed Strategies	Skill Sets
		NPM #1 - Well Woman Visits
Community-Based Group Education: Utilize community-based education groups to promote annual preventative visits. Patient Reminders: Support providers in disseminating reminders (e.g., postcard, text, email, phone) to women about scheduling annual preventative visits. Designated Clinics/ Extended Hours: Increase access and visibility to clinics that offer extended hours of service within close proximity to MCH populations.	Nurse Family Partnership (National): Partnering nurses with low income mothers. Healthy Women, Health Futures (OK): Education, skills, and supports. Superior Babies Program (MN): Promotion of healthy prenatal & parenting behavior.	Population Health • Ability to conduct surveillance of well-woman visit utilization that allows public health practitioners to understand and respond to disparities in utilization of visits • Ability to use population health surveillance to inform proposed delivery system changes • Skills to analyze how health care delivery systems identify and refer women for appropriate treatment following a well-woman visit Strategic Planning & Program Design • Ability to employ qualitative methods in needs assessments with families, providers, and communities to identify attitudes about and root causes of low use in preventive services • Skills in quality improvement to support providers and health systems in making data-informed decisions Strategic Alliance & Effective Partnership • Skills to create and manage external alliances that engage public health, private health plans, federally qualified health centers, and Medicaid to increase awareness of well-woman visit coverage among providers and women • Skills to manage public health and inter-governmental partnerships that work to advance the receipt of preventive services and the health of women • Ability to foster collaboration between public and private health care providers to increase the utilization and quality of well-woman visits Consumer Engagement/Cultural & Linguistic Brokering • Ability to effectively engage consumers in policy and program efforts that provide education about and increase utilization of preventive health care services for women • Skills to educate and monitor providers about their responsibilities for accessible interactions with women related to translation services, linguistic access, and American Disability Act (ADA) compliance Policy & Program Implementation • Skills to support robust and effective referral systems to preventive services in

		community settings • Ability to analyze workforce shortage data that reflect the capacity of communities to provide well-woman visits • Ability to determine legal authority behind existing memoranda of understanding with governmental agencies in regard to well-woman care • Skills to develop memoranda of understanding with Medicaid and other payers to develop policies that ensure effective services and reimbursement for well-woman care Communication • Skills to effectively communicate the importance of preventive services with selected audiences of women • Ability to effectively market well-woman services offered by public health departments in states/territories where Title V provides or supports clinical services for women • Ability to communicate with consumers about their legal rights related to access and quality of preventive care • Skills to effectively integrate preventive service visit initiatives into existing health promotion campaigns for women, including preconception campaigns and healthy heart campaigns
Evidence-based Strategies	**Evidence-informed Strategies**	**Skill Sets**
NPM #2 – Low-risk Cesarean Delivery		
Childbirth Education Classes: Support the development of a community-based childbirth education class series. Supportive Care from Lay Doulas: Implement a statewide community-based doula program which contracts to local hospitals.	Healthy Babies are Worth the Wait (KY): Prevention of preterm births. Women's Health Education Navigation (WHEN) Program for justice-involved families (NY): Improvement of access to services through a strong referral network.	Population Health Ability to conduct surveillance of low-risk cesarean delivery first births that allows public health practitioners to understand and respond to disparities in trends regarding cesarean deliveries among low-risk first births. Strategic Planning & Program Design • Skills to implement evidence-based "train the trainer" models that use clinician champions to train other providers • Skills in quality improvement to support providers and health systems to make data-informed decisions • Skills to effectively align Title V initiatives related to low-risk cesarean deliveries and perinatal regionalization activities Strategic Alliances & Effective Partnerships • Ability to effectively collaborate with March of Dimes and state/territory perinatal quality collaboratives to decrease rates of low-risk cesarean deliveries

		• Ability to provide public health support for health systems to conduct quality improvement initiatives designed to decrease low-risk cesarean deliveries • Ability to align low-risk cesarean delivery activities with perinatal regionalization initiatives • Ability to foster collaboration between public and private health care providers in low-risk cesarean delivery <u>Consumer Engagement/Cultural & Linguistic Brokering</u> • Skills to identify and involve women of childbearing age in development of program and policy efforts • Ability to engage women and their families as advocates for policy change • Skills to empower women and those that influence them to make decisions about their deliveries <u>Policy & Program Implementation</u> • Skills to set up new agreements that include the minimum of what each agreement should include from a Title V perspective • Ability to determine legal authority behind existing memoranda of understanding with governmental agencies • Skills to develop memoranda of understanding with Medicaid and other payers to develop policies that address use of cesarean deliveries in low-risk first deliveries • Ability to understand options available to draw down Medicaid administrative match for Title V programs • Skills to negotiate health system and payer incentives to align with cesarean delivery goals • Skills to develop or edit delivery protocols for medical indications for hospital systems • Skills to ensure evidence-based regulations and guidelines are disseminated to health systems and physician practices <u>Communication</u> • Ability to effectively communicate the risks of cesarean delivery to pregnant women so they can make fully informed delivery decisions • Ability to communicate with professional associations to ensure best practices are communicated to physician groups
Also see: NPM # 13 – Preventive Dental Visits NPM #14 - Smoking		

Evidence-based Strategies	Evidence-informed Strategies	Skill Sets
NPM #3 – Risk-appropriate Perinatal Health		

Multicomponent: Continuing Education of Hospital Providers + State Policies/Guidelines: Support establishment of intra-hospital transportation system and develop educational CME module.
 	
Multicomponent: Access to Providers through Hotline + Continuing Education of Hospital Providers + State Policies/Guidelines: Support a 3-pronged approach.
	Prenatal Plus Program (CO): Care coordination, nutrition, & mental health counseling.
	
	The JJ Way Model of Maternity Care (FL): Improve birth outcomes.
		Population Health
		• Ability to calculate quality-adjusted life years (QUALYs) to quantify:
		  • Impact of appropriate level of care for very low birth weight infants
		  • Rates of morbidity/mortality by social, demographic and economic indicators
		• Ability to develop estimates of death rates and implications based on percent of very low birth weight infants born in a hospital with a Level III+ neonatal intensive care units (NICU)
		• Ability to conduct economic analyses for babies born in appropriate (or inappropriate) facilities, including transport costs and potential morbidities associated with inappropriate levels of care
		• Ability to collect and review perinatal regionalization policies from all hospitals in state/territory
		• Skills to obtain and establish coordinated data reports for key stakeholders
		
		Strategic Planning & Program Design
		• Skills to develop evaluation measures for targeted outreach and progress for the care of very low birth weight infants
		• Skills in quality improvement to provide public health support of providers and health systems to make data-informed decisions
		
		Strategic Alliances & Effective Partnerships
		• Ability to foster collaboration between public and private health care providers in perinatal regionalization efforts
		• Skills to engage with Level I and Level II hospitals to review very low birth weight data
		• Ability to align perinatal regionalization activities with low-risk cesarean delivery initiatives
		• Ability to convene a multi-stakeholder group to assess effectiveness of current perinatal regionalization plans with partners from:
		  • Public Health
		  • State legislature
		  • Family advocacy groups
		  • Medicaid and other payers
		  • Hospital associations

		• Managed care groups • State/territory hospital regulators • Health professional organizations • Health plans <u>Consumer Engagement/Cultural & Linguistic Brokering</u> • Ability to engage women at risk and mothers of very low birth weight infants as peer educators • Ability to navigate sensitivities around very low birth weight outcomes with women <u>Policy & Program Implementation</u> • Skills to analyze and align NICU levels of care and maternal levels of care • Skills to create or enhance voluntary reporting systems among Levels II and III care facilities • Ability to support implementation of CDC/CoIIN Level of Care Assessment Tool (LOCATe) • Ability to advocate for increasing numbers of Level III+ hospitals in rural areas to address disparities • Ability to support hospitals or hospital associations with implementation science tools to ensure effective level adjustment when necessary • Skills to analyze authorizing contexts related to levels of care in individual hospitals and determine with policy makers if there are opportunities for improvement • Ability to determine legal authority behind existing memoranda of understanding regarding NICU levels of care regarding relevant agencies • Skills to develop memoranda of understanding with Medicaid and other payers to develop policies that address appropriate Level III+ NICU care for very low birth weight infants • Ability to analyze transport policies and procedures of Level II care facilities to appropriate Level III care facilities • Ability to define policies, procedures, and incentives to women who deliver high-risk newborns in appropriate facilities (beyond transport of infants) <u>Communication</u> • Ability to effectively reach women of childbearing age with culturally appropriate and compelling level of care messages • Ability to create unified messages for parents and clinicians about delivery of risk-appropriate hospital levels and their impact on morbidity/mortality outcomes of very low birth weight infants

NPM #4 - Breastfeeding		

Home Visits: Provide training and coaching to MIECHV home visiting staff to promote breastfeeding best practices.
 	
Lactation Consultants: Maintain a 24-hour breastfeeding hotline staffed by a bilingual certified lactation consultant.
 	
Peer Counselors: Utilize breastfeeding peer counselors through WIC programs.
	Every Child Succeeds (OH): Building trusting relationships for those with children 0-3.
	
	First 5 California Kit for New Parents (CA): Parenting and community resources.
		Population Health
		• Ability to conduct surveillance of breastfeeding rates that allows public health practitioners to understand and respond to disparities in breastfeeding rates
		• Ability to develop estimates of death rates and implications based on breastfeeding rates
		• Ability to calculate quality-adjusted life years (QUALYs) to quantify impact of breastfeeding in local communities
		
		Strategic Planning & Program Design
		Ability to apply the socio-ecological framework to breastfeeding
		
		Strategic Alliances & Effective Partnerships
		• Ability to convene public health and primary care professionals to align their breastfeeding efforts
		• Ability to identify and collaborate with hospital and child care center partners, especially those that serve women least likely to initiate and continue breastfeeding
		• Ability to provide public health support for implementation of breastfeeding-friendly hospitals
		• Skills to collaborate with private sector partners to increase knowledge of benefits of workplace accommodations
		• Skills to encourage Medicaid and managed care organizations (MCOs) to:
		  • Collect data on breastfeeding
		  • Initiate a performance improvement project that seeks to increase breastfeeding rates among employees
		  • Reimburse for the provision of Medical Lactation Therapy services
		• Ability to align breastfeeding efforts with safe sleep initiatives
		
		Consumer Engagement/Cultural & Linguistic Brokering
		• Skills to promote meaningful participatory practice with families in the development and support of breastfeeding practices
		• Ability to effectively engage breastfeeding mothers as peer educators
		• Ability to leverage knowledge about cultural, racial, and socioeconomic differences regarding initiation and duration of breastfeeding
		• Ability to help consumers understand the rights they have under the Affordable Care Act (ACA) regarding breastfeeding
		
		Policy & Program Implementation
		• Ability to leverage opportunities through the ACA and other federal and state policies

		to support breastfeeding initiatives, particularly: • Reimbursement for International Board Certified Lactation Consultants • Greater access to pumps, • Leave time for pumping at work, • Ability to provide state public health recognition (e.g. certificates, awards, news releases) for employers, primary care clinics and birth facilities that promote breastfeeding according to the law and national recommendations • Ability to ensure that health care providers have access to tools and best practices regarding breastfeeding and are trained to use the tools in an evidence-based manner • Skills to ensure high-quality breastfeeding support is embedded in programs for which Title V has authority • Ability to support or provide incentives for hospitals to become Baby Friendly or take first steps in becoming Baby Friendly through a state recognition program. • Skills to partner with employers to implement workplace accommodations that they are required to provide by law • Skills to educate policymakers on the value of legislation that: • Gives women the right to breastfeed in any public or private place • Prohibits restricting or limiting the right of a mother to breastfeed • Ability to establish memoranda of understanding with Medicaid and other payers to promote coverage of breastfeeding services as separately reimbursable pregnancy-related services in hospitals, clinics, and other health care settings • Ability to determine legal authority behind existing memoranda of understanding with partners Communication • Ability to use traditional and social media to effectively reach women of childbearing age with culturally appropriate and compelling breastfeeding messages • Skills to train hospital staff as necessary to effectively support breastfeeding • Skills to effectively navigate around conflicting messages between safe sleep and breastfeeding • Skills to ensure that women of color are trained to become skilled lactation support providers
NPM #5 – Safe Sleep		
Multicomponent: Caregiver Education + Health Care Provider Education + Hospital	Nurse Family Partnership (National): Partnering nurses with low income mothers.	Population Health Ability to conduct surveillance of safe sleep that allows public health practitioners to understand and respond to disparities in safe sleep practices

Safe Sleep Policy: Implement a multicomponent strategy that targets caregivers, child care providers, health care providers, and hospital systems (not including quality improvement components). Mass Media: National Campaign: Promote the national Safe to Sleep Campaign locally by providing professionals (e.g., first responders) with safe sleep kits. Caregiver/Parent Education (e.g., mothers, family members): Partner with WIC, home visiting, and other programs to provide safe sleep education and counseling to new caregivers.	Welcome Family (MA): Nurse home visit and follow-up phone call to all mothers.	Strategic Planning & Program Design • Ability to apply the socio-ecological framework to safe sleep • Ability to ensure that evidence-based safe sleep promotion messages are included in home visiting and care coordination programs for which Title V provides oversight Strategic Alliances & Effective Partnerships • Ability to collaborate with federally qualified health centers and school-based health centers to promote policy solutions to unsafe sleep practices • Ability to partner with Medicaid and managed care organizations (MCOs) to collect and analyze data on sudden infant death syndrome/sudden unexplained infant death (SID/SUID) • Ability to align safe sleep efforts with breastfeeding initiatives Consumer Engagement/Cultural & Linguistic Brokering • Skills to effectively engage expectant families, new parents and intergenerational families in designing safe sleep interventions • Skills to engage families in needs assessment for safe sleep programs and policies • Ability to effectively engage new parents as peer educators for safe sleep initiatives • Skills to respectfully build relationships with families and communicate the importance of safe sleep practices using cultural understanding and humility • Ability to be sensitive to the cultural norms that impact newborn sleep practices Policy & Program Implementation • Skills to ensure high quality safe sleep counseling is embedded in programs for which Title V has authority • Ability to provide state public health recognition (e.g., certificates, awards, news releases) to health providers, birth facilities, and others who work to reduce SIDS/SUID or lessen its impact on families • Ability to leverage national safe sleep resources for a public education campaign, including distribution of materials to health providers, health department clinics, childcare centers and homes, and families in birth facilities • Ability to conduct a performance improvement project that attempts to increase rates of safe sleep among enrollees in partnership with Medicaid and/or MCOs • Ability to effectively communicate with policymakers about the value of laws requiring emergency medical technicians, firefighters, child care providers, and law enforcement officers to receive training on how to handle SID/SUID deaths • Ability to advocate for adoption of a law that requires post-mortem examinations or autopsies when SID/SUID death is suspected

		• Ability to create/maintain a child death/fatality review process that includes SID/SUID-specific protocols and SID/SUID experts Communication • Ability to effectively reach women of childbearing age with culturally appropriate and compelling safe sleep messages • Skills to train hospital staff as necessary to effectively support safe sleep practices • Skills to effectively navigate around potentially conflicting messages between safe sleep and breastfeeding

Evidence-based Strategies	Evidence-informed Strategies	Skill Sets
NPM #6 – Developmental Screening *(does NOT include Adolescent Health)*		

Home Visiting Programs: Utilize Home Visiting/MIECHV programs to provide the Ages and Stages Developmental Screening tool to clients.
 	
Implementation of Quality Standards: Support statewide learning collaborative for primary care practices + enhanced reimbursement + collaboration with local agencies.
 	
Provider Training: Train medical and childcare providers on developmental screening.
	Every Child Succeeds (OH): Building trusting relationships for those with children 0-3.
	
	Nurse Family Partnership (National): Partnering nurses with low income mothers.
		Population Health
		Ability to conduct surveillance of developmental screening that allows public health practitioners to understand and respond to disparities in screening rates
		
		Strategic Planning & Program Design
		• Skills to identify whether programs for which Title V provides oversight, such as home visiting and care coordination, are including evidence-based developmental screening tools
		• Ability to establish mechanisms that ensure that children with identified developmental risks and conditions are linked to a family-centered, community-based, and coordinated system of care
		
		Strategic Alliances & Effective Partnerships
		• Ability to convene multiple disciplines and systems (e.g., education, early childhood education, health, housing,) to assess, coordinate and increase rates of screening
		• Ability to build and/or sustain effective partnerships with primary care providers and early childhood systems, including:
		  ◦ Partnership with clinicians and child care health consultants
		  ◦ Training for clinicians and child care health consultants
		• Ability to build alliances with local chapters of the American Academy of Pediatrics (AAP), other child-serving organizations, and clinical provider organizations to:

		• Support developmental screening • Implement quality improvement projects • Establish learning collaboratives <u>Consumer Engagement/Cultural & Linguistic Brokering</u> • Ability to partner with parent support groups to promote developmental screening • Ability to assess cultural practices around developmental screening in partnership with parent groups • Ability to partner with consumers to test screening tools for cultural appropriateness • Ability to engage and empower families to be able to seek care and discuss their child's health and health care needs • Ability to ensure that evidence-based screening tool options are available in the most prevalent local languages <u>Policy & Program Implementation</u> • Skills to ensure high quality screening tools are embedded in programs for which Title V has authority • Ability to ensure that screening providers have access to tools and best practices and are trained to use the tools in an evidence-based manner • Ability to refer/connect (or support local public health to refer/connect) children identified through positive screenings to existing services in public health and health care systems • Ability to determine legal authority behind existing memoranda of understanding with governmental agencies • Ability to develop memoranda of understanding with Medicaid and other payers to develop policies that address use of developmental screenings, particularly coverage of standardized developmental screening tools for children at their 9-, 18-, and 30-month visits • Ability to effectively use electronic medical records to support screening as appropriate • Ability to support public and private practitioners in efforts to make accommodations for assessing children with special health care needs <u>Communication</u> • Ability to effectively communicate with families about the importance of developmental screening • Ability to effectively advocate and communicate with legislators and other policy makers about the importance of developmental screening

NPM #7 - Injury Hospitalization		

Education During Home Visiting Programs: Provide injury prevention education for families participating in home visiting programs.
 	
Oversight and Regulation of Innovative Programs: Provide oversight and regulation of innovative programs such as comprehensive home safety assessments.
 	
Person-to-Person Interventions Outside the Clinical Setting: Adopt person-to-person interventions such as the drug disposal program, Count it! Drop it! Lock it!
 	
School-Based Interventions: Conduct outreach, education campaigns, and trainings in school-based settings.
	Every Child Succeeds (OH): Building trusting relationships for those with children 0-3.
	
	Boys' Health Advocacy Program (SD): Increase access to health care services for boys.
	
	Teen Driving Safety Task Force (UT): Safe driving education campaign for teens.
		Population Health
		• Ability to conduct surveillance of child injury that allows public health practitioners to understand and respond to disparities in injury rates
		• Skills to model drug epidemics, motor vehicle accident patterns, mental health issues, homicides, and other systems-level patterns that influence injury and death rates
		• Ability to calculate quality-adjusted life years (QUALYs) to quantify impact of child injury in local communities
		
		Strategic Planning & Program Design
		• Skills to conduct needs assessment using consumer input, especially regarding effective messages about injury prevention
		• Ability to appreciate how child injury prevention efforts fit into the larger framework of youth development
		
		Strategic Alliances & Effective Partnerships
		• Ability to create injury topic-specific task forces that align multiple sectors in injury prevention efforts, including in the task force:
		  • Law enforcement
		  • Departments of Education and Transportation
		  • Child Protective Services
		  • Hospitals and community health centers
		  • Universities
		  • Community coalitions
		  • Organizations that serve families and youth
		  • Private sector partners
		
		Consumer Engagement/Cultural & Linguistic Brokering
		• Ability to understand and leverage cultural context when considering programmatic and policy changes related to childhood injury prevention
		• Ability to effectively engage youth as peer educators
		• Ability to develop and promote positive social norms for child safety that are culturally relevant
		
		Policy & Program Implementation
		• Ability to ensure health care providers have access to tools and best practices

		regarding injury prevention and are trained to use the tools in an evidence-based manner
		• Skills to ensure high quality injury prevention counseling is embedded in programs for which Title V has authority
		• Ability to support regulations that require:
		  • Smoke detectors, hot water heater temperature controls, and stair safety gates in all homes
		  • Protective restraints in cars
		  • Pool fencing, self-closing gates, and pool alarms
		  • Graduated driver licensing for teens
		  • Toy manufacturer safety standards
		  • Use of serialized, tamper-proof prescription forms by prescribing physicians
		  • Development and use of a prescription drug monitoring program for hospitals
		  • Prohibitions on cellphone use (including hands-free) by youth while driving
		
		Communication
		• Skills to effectively reach young adults, parents, and caretakers with injury prevention messages
		• Ability to work with media as part of injury prevention campaigns
		• Ability to alert the public about emerging injury-related trends
		• Ability to describe violence and injury as a health problem
		• Ability to communicate with policymakers and other opinion leaders about the health and financial impacts of injuries and proposed policies

NPM #8 – Physical Activity		
Individual Counseling by Health Professionals: Promote physical activity counseling during well-child visits. Infrastructure and Environmental Supports for Physical Activity: Promote the development and use of infrastructure that facilitates physical activity (e.g., walking trails, sidewalks, playgrounds, parks).	Empower Program (AZ): Promotion of physical activity standards in child care. La Vida Sana, La Vida Feliz (IL): Health, nutrition, and fitness promotion program. Trauma-Informed Yoga (NV): Specialized yoga for high-risk youth.	Population Health • Ability to conduct surveillance of physical activity during childhood and adolescence that allows public health practitioners to understand and respond to disparities in physical activity rates • Ability to analyze obesity trends and select leverage points for physical activity interventions • Ability to develop estimates of death rates related to physical activity rates • Ability to calculate quality-adjusted life years (QUALYs) to quantify impact of physical activity in local communities Strategic Planning & Program Design Ability to apply the socio-ecological framework to physical activity interventions

Policies Regarding the Use and Promotion of Local Locations and Resources: Develop policies for the use of local locations and resources (e.g., sporting clubs, community centers, shopping malls, schools) and promote physical activity events at these locations. Extracurricular Activities for Physical Activity: Provide chances for children and adolescents to be active via before- and after-school activities.		Strategic Alliances & Effective Partnerships Ability to collaborate effectively with broad public health campaigns and the private sector in efforts to increase physical activity Consumer Engagement/Cultural & Linguistic Brokering • Skills to include children, adolescents, and parents in physical activity intervention planning efforts • Ability to effectively engage youth as peer educators Policy & Program Implementation • Ability to ensure health care providers have access to tools and best practices regarding physical activity counseling and are trained to use the tools in an evidence-based manner • Skills to advocate for mandatory evidence-based physical activity interventions during school • Ability to effectively engage in park/land/school joint-use agreements in support of activities that promote physical activity for children and adolescents Communication • Ability to effectively communicate with the public about the importance of physical activity • Ability to navigate sensitivities about obesity and provide nuanced communication with children, adolescents and parents to ensure positive engagement • Ability to effectively communicate with policy makers and community leaders about the importance of investing in physical activity policies
NPM #9 – Bullying Prevention ***(does NOT include Child Health)***		

Adult-Led Counseling, Mentoring, and Support: Increase youth participation in evidence-based mentoring, counseling, or adult supervision programs.
 	
Suicide Prevention In-Class Training: Provide learning opportunities and support to youth in the classroom
	Social Support System (National): Intervention using a whole-school approach.
	
	Take the Lead (National): Curriculum-based bullying prevention program.
	
	Steps to Respect (National): Social-emotional learning resources.
		Population Health
		• Ability to conduct surveillance of bullying that allows public health practitioners to understand and repond to disparities in bulling rates
		• Skills to effectively analyze all relevant data sources, including school- and county-level data, to identify:
		  • Sub-groups of children affected by bullying
		  • Geographic areas with high prevalence of bullying
		• Ability to conduct community-wide bullying assessments where data are otherwise unavailable
		
		Strategic Planning & Program Design

regarding bullying and suicide prevention. Strengths-Based Classroom Training: Provide classroom training for students on positive youth development and non-violence intervention skills. Trauma Training: Provide education for school professionals and the community.		• Ability to apply the socio-ecological framework to bullying • Ability to appreciate how bullying prevention efforts fit into the larger framework of youth development Strategic Alliances & Effective Partnerships • Ability to identify and capitalize on mutually reinforcing anti-bullying activities with youth development organizations, safety committees, Girls on the Run and similar programs • Ability to partner with schools and afterschool programs to support evidence-based anti-bullying programs • Ability to partner with health care providers and provider organizations to ensure that health care providers screen for emotional distress in youth Consumer Engagement/Cultural & Linguistic Brokering • Ability to effectively work with youth to integrate evidence-based anti-bullying interventions in their contexts • Skills to engage youth to support anti-bullying efforts in younger children, including empowering youth to talk about bullying, aggregating stories, and communicating themes Policy & Program Implementation • Ability to support local health departments to participate in anti-bullying activities by sitting on local school and youth development committees to provide input on evidence-based interventions and public health resources • Skills to support local school efforts to build evidence-based anti-bullying initiatives into school curricula • Skills to support the development of early screening tools to detect bullying and follow-up tools to monitor youth who have bullied or been bullied to ensure they get to appropriate resources Communication • Ability to effectively communicate with youth about bullying-related concepts such as reading social cues, understanding differences, and reflecting on their actions • Ability to promote community-wide anti-bullying public health campaigns for general public/consumers in youth-friendly places like movie theaters • Ability to effectively work with media regarding bullying as a public health issue

Expanded Insurance Coverage: Ensure adolescents are enrolled in a health insurance program. Patient Reminders/Navigator Programs: Support a patient reminder/navigator program that includes telephone and mailed reminders with transportation services. Improving Young Adult Health: State and Local Strategies for Success. This guide outlines five real-life strategies that Title V programs can adopt to improve young adult (YA) health.	Hospital Transition Planning Tool (TX): EMR-based tool to improve readiness. Boys' Health Advocacy Program (SD): Increase access to health care services for boys. Youth Advisory Council (RI): Leadership development through council participation.	Population Health • Ability to conduct surveillance of adolescent well-visit utilization that allows public health practitioners to understand and respond to disparities in utilization of visits • Ability to use population health surveillance to inform proposed delivery system changes • Skills in analyzing how health care delivery systems identify and refer adolescents for appropriate treatment following a well-visit Strategic Planning & Program Design • Ability to employ qualitative methods in needs assessments with families and communities to identify attitudes about root causes of low use of preventive services • Skills in quality improvement to support providers and health systems in making data-informed decisions Strategic Alliances & Effective Partnerships • Skills to create and manage external alliances that engage public health, private health plans, federally qualified health centers, school-based health centers, and Medicaid/Children's Health Insurance (CHIP) to increase awareness of adolescent well visit coverage among providers and patients • Skills to manage public health and inter-governmental partnerships that work to advance the health, safety, and well-being of adolescents and the receipt of preventive services • Ability to foster collaboration between public and private health care providers to increase the utilization and quality of adolescent well-visits • Skills in working with other state agencies and relevant organizations from the private sector to improve access to high quality clinical preventive services by vulnerable groups of adolescents, including youth in foster care, homeless youth, and immigrant youth Consumer Engagement/Cultural & Linguistic Brokering • Ability to effectively engage adolescents and young adults in policy and program efforts that attempt to increase utilization and quality of preventive health care services for adolescents • Skills to educate and monitor providers about their responsibilities for accessible interactions with adolescents related to confidentiality of care, youth-centered care, translation services, linguistic access, and American Disabilities Act (ADA) compliance • Ability to assist public health and clinical health programs to provide evidence-

		based health education to youth and families on topics important to adolescent health including, for example, reproductive and sexual health, navigating the health care system, and inter-generational communications, to adolescents and their families in a variety of settings, including schools, and youth organizations Policy & Program Implementation • Ability to create evidence-based practices systems that support the planning and implementation of transition from adolescent to adult services by others e.g. providers, health care systems, local public health, schools • Skills to support robust and effective referral systems to preventive services in community settings • Skills to promote health care providers' effective use of youth-oriented community programs as resources to promote healthy development • Ability to include measurements of family perspectives in program evaluation plans • Ability to analyze workforce shortage data that impact capacity of communities to provide adolescent well visits • Ability to analyze and make recommendations to strengthen "adolescent-friendly" payment systems that protect patient confidentiality • Ability to determine legal authority behind existing memoranda of understanding with governmental agencies in regard to adolescent care • Skills to develop memoranda of understanding with Medicaid and other payers to develop policies that promote sharing of data and ensure effective services and reimbursement for adolescent care • Ability to analyze and refine state and health plan policies relevant to confidentiality, minor consent, and explanation of benefits statements Communication • Skills to effectively communicate the importance of preventive services with selected adolescent and family audiences • Skills to effectively communicate with health care providers regarding adolescent use of preventive service visits and enhancing the quality and comprehensiveness of the visit • Ability to effectively market adolescent health services offered by public health departments in states/territories where Title V provides or supports clinical services for adolescents • Ability to communicate with adolescents, families, and health care providers information about legal rights related to access and quality of preventive care, especially confidentiality issues related to adolescents

		• Ability to select and use traditional and/or social media to communicate the importance of adolescent visits and shift conversation to a culture of health
NPM #11 – Medical Home *(includes Children w/Special Health Care Needs)*		

Dedicated Care Coordinators: Use dedicated care coordinators to develop relationships with families to increase timely attendance of well-child visits and respond to the needs of families.
 	
Provider Alliance and Mid-Level Providers: Use a provider alliance and mid-level providers to create a "one-stop" medical home model to provide community outreach and coordination of services.
 	
Shared Care Coordination with Home Visiting: Develop early connections to a medical home through care coordination and collaboration with home visiting.
 	
Provider-School Partnerships: Develop partnerships between primary care providers (PCPs) and school-based health centers (SBHC) to create an expanded medical home model based on care coordination.
	Health-e-Access Telemedicine Program (NY): Diagnosis/treatment using technology.
	
	Hospital Transition Planning Tool (TX): EMR-based tool to improve readiness.
	
	Family Voices of California Project Leadership (CA): Advocacy training for families.
	
	Oregon Care Coordination Program (OR): Support and resources for CYSHCN.
		Population Health
		• Skills to effectively use data systems for service delivery improvements and reporting
		• Ability to assess and report the quality of medical homes within the state or territory
		
		Strategic Planning & Program Design
		• Ability to conduct strengths-opportunities-weaknesses-threat analyses to determine how best to support medical home efforts for children within the state or territory
		• Ability to assess where practices currently fall on the medical home implementation continuum
		
		Strategic Alliances & Effective Partnerships
		• Ability to convene stakeholders to:
		  • Ensure knowledge of, visualize and analyze current medical homes in local communities
		  • Advance medical home service utilization
		  • Identify, understand, and remove barriers to receiving care in medical homes
		  • Support the establishment of new medical homes as appropriate
		  • Build and Maintain a coordinated system from the state/territory level
		
		Consumer Engagement/Cultural & Linguistic Brokering
		• Skills to promote patient- and family-centered care that ensures shared decision making for families who use medical homes
		• Ability to assess cultural competence of services received by families who use medical homes
		• Skills to support an official role for underserved families in larger stakeholder medical home efforts
		
		Policy & Program Implementation
		• Skills in quality improvement to:
		  • Help guide medical home practices on workflow, ensuring quality health care delivery

		• Ensure high quality services in medical homes for which Title V has authority • Ability to assist in the development of comprehensive care plans/care planning in medical homes that are driven by families and shared across systems • Ability to adapt standards for pediatric practices, such as the National Committee for Quality Assurance, in medical homes • Ability to implement or support telemedicine clinics as part of medical home model • Ability to determine legal authority behind existing memoranda of understanding with governmental agencies about medical homes • Skills to develop memoranda of understanding with Medicaid and other payers that includes language providing for payment reforms that support medical homes and care integration models • Ability to ensure that Title V-sponsored care coordinators are trained to make and ensure completion of referrals to medical homes • Ability to include measurements of family perspectives in program evaluation plans • Ability to ensure that medical homes can meet the needs of both typically developing children and those with special health care needs Communication • Ability to communicate effectively with providers, families, and community stakeholders to align systems and ensure medical homes serve all children who need them • Ability to use traditional and/or social media marketing/outreach to communicate effectively with the public about the importance of medical homes for children and families
NPM #12 – Transition ***(includes Children w/Special Health Care Needs)***		
Six Core Elements Adaptation with Quality Improvement (QI): Incorporate the Six Core Elements in a learning collaborative or medical center/hospital system with built-in QI activities. Training/Educating Youth: Provide training including	Community Systems Building Grants for CYSHCN (NC): Capacity-building to launch innovative strategies and county-level and service delivery system change. PATCH Program (WI): Improve transition and overall health care experiences.	Population Health • Ability to conduct surveillance of adolescents who should be transitioning into adult care each year using state-specific transition tables from the 2009-10 National Survey of Children with Special Health Care Needs (NSCSHCN) or other state-specific data sources that allows public health practitioners to understand and respond to disparities in transition rates Strategic Planning & Program Design • Ability to employ qualitative methods in needs assessments with families,

communication and social media for adolescents with and without special health care needs who are ready for transition to adult health care.
 	
Peer Support and Mentorship: Create a peer support and mentorship program or adolescent advisory council to discuss issues around health care transition.
 	
Transition Care Coordination Services: Use care coordinators at clinics to help with appointments, scheduling, education, and other health care transition services.
	Care Connection for Children (VA): Care coordination for CYSHCN.	providers and communities to identify attitudes about and root causes of low use of transition services
		• Ability to align health care transition efforts with other life skills initiatives for young adults
		• Ability to perform a strengths-opportunities-weaknesses-threat analyses to consider ways to best support transition within the state/territory
		• Skills in quality improvement to support providers and health systems in making data-informed decisions
		
		Strategic Alliances & Effective Partnerships
		• Ability to effectively convene diverse partners in establishing a common goal around coordination of transition, including:
		  • Health care systems
		  • Insurers
		  • Health care providers
		  • Education systems
		  • Behavioral health
		  • Disability support and advocacy organizations
		• Organizations representing families, youth, and youth adults with special health care needs
		• Ability to build capacity at local level to facilitate coalitions of partners to mobilize around transition planning
		• Ability to work with state pediatric, family medicine, internal medicine, and nursing leadership to expand educational efforts about evidence-informed transition efforts
		
		Consumer Engagement/Cultural & Linguistic Brokering
		• Skills to effectively engage and partner with families/caregivers, youth and young adults in transition quality improvement efforts
		• Ability to connect with existing patient navigators and care coordination systems to align transition efforts
		• Skills to facilitate self-determination, leading to independence for youth, in systems where Title V programs are directly responsible for transition
		• Utilize the Got Transition assessment tools to do an initial assessment and document improvement of involvement of youth and families in their transition approach
		
		Policy & Program Implementation
		• Ability to critically review transition strategies and measures suggested by MCHB

		and Got Transition • Ability to analyze when efforts should move beyond programs and clinics toward supporting broader system changes that support funding of transition, especially for youth with special health care needs • Ability to leverage the Affordable Care Act (ACA) provisions that allow children to stay on parent insurance through the age of 26 • Ability to determine legal authority behind existing memoranda of understanding with governmental agencies in regard to transition services • Skills to develop memoranda of understanding with Medicaid and other payers to develop policies that ensure effective transition • Ability to work with state pediatric, family medicine, internal medicine, and nursing leadership to expand educational efforts of evidence-based transition efforts • Ability to include measurements of family perspectives in program evaluation plans Communication • Ability to effectively communicate with families, youth and adults about the importance of early and ongoing transition planning, especially for those with special health care needs • Ability to use life course language to communicate importance of transition services • Ability to adapt transition language to make it understandable for individuals outside MCH programs • Ability to effectively communicate positively with both pediatric and adult leaders, medical educators, and clinicians about evidence-based transition strategies
NPM #13 – Preventive Dental Visits		

Public Insurance Coverage (13.2): Collaborate with Medicaid to increase the number of children and youth who have had a preventive dental visit in the past year.
 	
School/Preschool Interventions (13.2): School-Based Dental Services/Head Start Participation: Increase oral
	Virtual Dental Home (HI): Community-based dental services.
	
	Children's Dental Services (MN): Safety net services for underserved populations.
	
	Home by One Program (CT): Trainings for parents, case managers, and providers.
		Population Health
		• Ability to conduct surveillance of oral health services during pregnancy, early childhood and adolescence that allows public health practitioners to respond to disparities in utilization of oral health services
		• Ability to identify workforce shortage areas related to:
		  • Dental provider adequacy
		  • Dental provider competencies
		  • Primary care provider competencies
		  • Excess utilization of emergency care for preventable dental problems
		
		Strategic Planning & Program Design

health referrals among children and youth through School Based Health Centers (SBHCs).
 	
Provider Education (13.1): Collaborate with Early Head Start programs, home visiting programs, and/or Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics to train staff to provide preventive oral health care to pregnant women and referrals to oral health professionals for dental visits.
 	
Caregiver Education/Counseling (13.2): Increase preventive dental visits by sharing postcards with information on dental enrollment and appointments.
		• Ability to support integration of medical and dental records for pregnant women, adolescents, and children
		• Skills to support robust and effective oral health referral systems in community settings for oral health
		• Ability to identify and implement evidence-based practices to address provider shortages and provider competencies
		
		Strategic Alliances & Effective Partnerships
		• Ability to convene and train medical and dental providers to:
		  • Include oral health promotion in primary care settings
		  • Include primary care health promotion in oral care settings
		  • Establish/improve bi-directional referral and follow-up systems
		• Ability to effectively partner with Medicaid, dental providers, and professional oral health organizations to assess and improve systems for pregnant women and youth, including those with special health care needs
		
		Consumer Engagement/Cultural & Linguistic Brokering
		Ability to consider local community culture to identify the most effective strategies and channels of communication for oral health messages
		
		Policy & Program Implementation
		• Skills to ensure that high quality oral health counseling is:
		• Embedded in programs for which Title V has authority (including medical home initiatives and EPSDT)
		• Offered by providers that serve pregnant women, adolescents, and children, including children and youth with special health care needs
		• Skills to support robust and effective referral systems for oral health services within all programs Title V delivers
		• Ability to determine legal authority behind existing memoranda of understanding with governmental agencies in regard to dental services
		• Skills to develop memoranda of understanding with Medicaid and other payers to develop policies that ensure effective services and reimbursement for oral health services
		
		Communication
		• Ability to communicate with policymakers about oral health and financial impacts of poor oral health
		• Ability to write and disseminate policy briefs and media messages that effectively increase awareness of the need for oral health care during pregnancy,

		capitalizing on pregnancy insurance coverage benefits • Ability to communicate, via traditional and social media, accurate, consistent and motivational oral health messages for pregnant women and children, including the benefits of sealants • Ability to effectively communicate with dentists and professional dental organizations to highlight the guidelines about dental care during pregnancy, infancy, and early childhood • Ability to communicate with medical homes about the importance of oral health • Ability to communicate with prenatal care providers about the importance of oral health • Skills to create effective public health messages about the negative impact poor oral health has on school readiness and academic achievement • Skills to create effective public health messaging about the relationship between poor oral health care and chronic health conditions such as gum disease, diabetes, heart disease, and stroke
NPM #14 - Smoking		
Telephone Counseling + Education Materials: Provide telephone counseling + educational materials to reduce children's exposure to secondhand smoke in the home. Incentives: Incentives to reduce smoking during pregnancy. Health Education: Provide health education to reduce smoking during pregnancy. Clinic-based Counseling + Education Materials: Provide in-person counseling + educational materials during visits with a health care provider to reduce child exposure to secondhand smoke	Baby and Me Tobacco Free (National): Tobacco cessation counseling & management. One Tiny Reason to Quit (VA): Social marketing directed to African-Americans. Internatal Care Program (AZ): Care coordination and health education.	Population Health • Ability to conduct surveillance of tobacco use during pregnancy and adolescence that allows public health practitioners to understand and respond to disparities in smoking rates • Ability to develop estimates of death rates and implications based on tobacco use rates • Ability to calculate quality-adjusted life years (QUALYs) to quantify impact of tobacco use in local communities Strategic Planning & Program Design • Ability to effectively leverage home visiting and other programs for which Title V has authority as a way to assess and address household tobacco use • Ability to apply the socio-ecological framework to smoking during pregnancy and household smoking Strategic Alliances & Effective Partnerships • Ability to collaborate to promote policy solutions with public housing officials, Medicaid and other payers for secondhand smoke interventions • Ability to address economic interests related to tobacco use among various stakeholders • Ability to effectively negotiate and utilize conflict resolution skills to support local partners in enforcement of smoke-free areas

in the home.		Consumer Engagement/Cultural & Linguistic Brokering • Skills to engage consumers in needs assessment regarding tobacco and alternative tobacco delivery use • Ability to effectively engage youth as peer educators for tobacco prevention efforts Policy & Program Implementation • Ability to ensure health care providers have access to tools and best practices regarding tobacco use/reduction/cessation and are trained to use the tools in an evidence-based manner • Skills to ensure high quality tobacco counseling is embedded in programs for which Title V has authority • Skills to support robust and effective referral systems for tobacco cessation, especially for pregnant women • Skills to effectively use electronic medical records for tobacco screening • Skills to develop memoranda of understanding with Medicaid and other payers to develop policies that reduce tobacco exposure • Ability to navigate political sensitivities around tobacco use and find common ground for action Communication • Skills to communicate effectively with tobacco users • Ability to build capacity at local level to facilitate coalitions of partners to mobilize tobacco prevention and control messages • Ability to communicate with policymakers about health and financial impacts of secondhand smoke exposure and pregnant women's tobacco use • Ability to work with young adults as part of preconception health campaigns • Ability to effectively reach young adults with tobacco messages specific to their local community and demographic profile
NPM #15 – Adequate Insurance *(includes Children w/Special Health Care Needs)*		
Insurance Utilization Support: Insurance enrollment helpline. Healthcare Delivery Quality Improvement (QI initiatives): On-site medical practice care coordination services.	Health-e-Access Telemedicine Program (NY): Diagnosis/treatment using technology. Parent Child Assistance Program (PCAP) (WA):	Population Health Skills to monitor trends of insurance adequacy for children Strategic Planning & Program Design • Skills to train local partners about insurance coverage options • Skills to map networks of adequate and inadequate coverage

Health Insurance Enrollment Outreach and Support: For un-/under-insured families.
 	
Patient Navigators: Provide care coordination to guide patients through supports.
 	
Strategies states are using to improve and finance care for CYSHCN
	Advocacy/case management for mothers.
	
	MN Care Coordination Systems Assessment and Action Planning (MN): Care Coordination assessment.
		Strategic Alliances & Effective Partnerships
		• Ability to collaborate with partners to promote insurance coverage, including:
		  • Accountable care organizations (ACOs) and managed care organizations (MCOs)
		  • Medicaid and Children's Health Program (CHIP)
		• Ability to align efforts to enroll children in health insurance with other initiatives related to insurance coverage for the population as a whole
		
		Consumer Engagement/Cultural & Linguistic Brokering
		• Skills to engage consumers, especially families of children and youth with special health care needs, to:
		  • Serve as peer educators
		  • Provide input into Title V outreach effort plans
		
		Policy & Program Implementation
		• Skills to identify, assess, and select appropriate outreach and enrollment activities for state and local jurisdictions
		• Skills to train local health agencies and health care providers to effectively inform families about insurance coverage options
		• Skills to support robust and effective referral systems for insurance enrollment
		• Skills to assist with enrollment in insurance for children
		
		Communication
		• Skills to effectively communicate with families about insurance coverage options
		• Ability to effectively use traditional and social media to conduct outreach for insurance enrollment
		• Ability to communicate effectively with decision makers/local legislators regarding:
		• The health impacts of insurance coverage
		• The economic benefits of insurance coverage
		• Ability to effectively communicate with decision makers/legislators regarding the importance of adequate coverage for children (CHIP reauthorization, Medicaid expansion, etc.)

See Child Health and Adolescent Health:
NPM #11 – Medical Home

CONTRACT NUMBER	INTERGOVERNMENTAL AGREEMENT (IGA) ATTACHMENT B EVIDENCE-BASED AND EVIDENCE-INFORMED STRATEGIES FOR MCH DOMAINS
IGA2020-043	

NPM #12 - Transition
NPM #15 – Adequate Insurance

Strategies include but are not limited to:

- Family partnership activities that cross all population health domains.
- Social determinants of health
- Workforce development
- Enhanced data infrastructure
- Capacity Building
- Oral Health
- Injury Prevention
- Access to care

Projects and/or strategies that become prominent and/or are unique to a particular County. These strategies will require pre-approval from ADHS (see Attachment G). Projects such as: reassignment of staff to address the COVID-19 pandemic or any other public health emergency, conducting focus groups to determine how to improve services for children/youth with special health care needs, etc.

CONTRACT NUMBER	INTERGOVERNMENTAL AGREEMENT (IGA)
IGA2020-043	ATTACHMENT C CONTRACTOR EXPENDITURE REPORT

Arizona Department of Health Services
Accounting/Contracts
150 N 18th Ave. Ste 280
Phoenix, Arizona 85007

Invoice #

CONTRACTOR'S EXPENDITURE REPORT ADHS

1. Contract Number ______
2. Contractor Name ______
3. Title of Program ______
4. Reporting Period: ______ To ______

Purchase Order No. PO-

☐ X Cost Reimbursement - Cumulative Actual Expenditures
☐ Fixed Price
☐ Periodic Report
☐ FINAL REPORT

Contractor's Detailed Statement of Expenditures and Fixed Price

5. COST REIMBURSEMENT (Actual Expenditures) **A. Account Classification:**	APPROVED Budget (Matches ORIGINAL Contract Price Sheet) (a)	REVISED Budget (with ADHS INTERNAL Adjustments)	Prior Report Period Year to Date Expenditures (b)	Current Reporting Period Expenditures (c)	Total Year to Date Expenditures (d)
Personnel Services					$ -
ERE					$ -
Professional and Outside Services					$ -
Travel					$ -
Occupancy					$ -
Other Operating					$ -
Capital Outlay					$ -
Indirect					$ -
Total	$ -	$ -	$ -	$ -	$ -

ADHS USE ONLY

ADHS PROGRAM
COORDINATOR CERTIFICATION:
☐ Performance satisfactory for payment
☐ Performance unsatisfactory, withhold payment
☐ No payment due

______
PROGRAM COORDINATOR SIGNATURE/DATE

THIS SECTION FOR ADHS ACCOUNTING USE ONLY

Total Expenditures or total Fixed Price	______
Adj (if required)	______
Less: Year to date payments	______
Adj (if required)	______
Net payment due.	

FUNCTION	PPC	BFY	AMOUNT

7. CONTRACTOR CERTIFICATION
I certify that this report has been examined by me, and to the best of my knowledge and belief, the reported expenditures and fixed price information is valid, based upon our official accounting records (book of account) and consistent with the terms of the contract. It is also understood that the contract payments are calculated by the Department of Health Services based upon information provided in this report.

______
AUTHORIZED CONTRACTOR'S SIGNATURE / TITLE / DATE

______
PLEASE PRINT - PREPARED BY / PHONE NUMBER

ADHS/BFS/F-110 (Rev. 7/7/2015)

CONTRACT NUMBER	INTERGOVERNMENTAL AGREEMENT (IGA) ATTACHMENT D FINANCIAL SUPPORTING DOCUMENTATION
IGA2020-043	

For Cost Reimbursement contracts, Counties are required to maintain sufficient documentation in the form of receipts in support of **expenses incurred for any purchases that are being claimed for reimbursement or applied as match dollars** to a budget. Supporting documentation is essential for successful auditing, monitoring and processing of Contractor Expenditure Reports (CERs). County contractors are to follow the guidelines below:

- Supporting documentation shall be kept by the Contractor and does NOT need to be submitted with CERs **with the exception of**:
    - Travel documentation (in-state and out-of-state), and
    - Single purchases of equipment/assets exceeding $250
- The ADHS Office of Auditing may conduct random audits each year. All supporting documentation, upon request by ADHS, must be provided for review.
    - It is strongly recommended that supporting documentation be maintained in an organized and readily available manner as delays in providing documentation for an Audit will delay reimbursement of a CER.

Acceptable support documentation of expenses by line item that should be retained and/or submitted includes:

Supporting Documentation of Expenses			
		Applicable Manual	
Line Item	**Supporting Documentation Needed**	**State of Arizona Accounting Manual (SAAM)**	**Office of Management & Budget *Code of Federal Regulation 2 (CFR) Part 200* (OMB)**
Personnel	• Staff time sheets /labor distribution, ***and*** • Staff pay stubs or electronic pay records *Please note that signatures must be in the form of an electronic signature with a time/date stamp (if converted to a PDF) or must be hand-written. Names that are typed out (regular font or cursive) are not allowable and can be considered a finding if ever audited. Signatures must indicate true authenticity of the signer.*	**Topic 55 Section 05 & 15**	**2 CFR 200.430**
Employee Related Expenses (ERE)	• Staff pay stubs ***or*** electronic pay records	**Topic 55 Section 05 & 15**	**C CFR 200.431**
Professional & Outside Services	• Paid invoice for service	**Topic 45 Section 20**	**2 CFR 200.302(3)**
Travel	Out-of-state and In-state (out of Contractor area)	**Topic 50 Section 05**	**2 CFR 200.474**

	Travel reimbursements claim form which includes traveling employee's name, date(s) of travel, time of departure and return, reason for travel, claim signed by traveler and their supervisor ***and*** • Itemized copies of all receipts - hotel, meals, transportation, etc. • Copy of the meeting/conference agendas Mileage claims that include start & end odometer readings, travel to/from, date of travel, signed by employee and supervisor *Please note that signatures must be in the form of an electronic signature with a time/date stamp (if converted to a PDF) or must be hand-written. Names that are typed out (regular font or cursive) are not allowable and can be considered a finding if ever audited. Signatures must indicate true authenticity of the signer.*	**Section 25** **Section 45** **Section 55** **Section 95**	
Occupancy	Bill, invoice, receipt or lease agreement and allocation breakdown	**Topic 45** **Section 20**	**2 CFR 200.302(3)**
Other Operating	• Itemized receipts and/or paid invoice to supplier • Percentage being billed, if expenses are divided amongst multiple programs	**Topic 45** **Section 20**	**2 CFR 200.302(3)**
Capital Outlay	• Paid invoice for service	**Topic 45** **Section 20**	**2 CFR 200.302(3)**
Indirect	• Contract Itemized Price Sheet • RFGA Budget Worksheet • Federally approved indirect cost letter	**Topic 70** **Section 40**	**2 CFR 200.414** **Appendix III Part 200** **Appendix IV Part 200**

CONTRACT NUMBER	INTERGOVERNMENTAL AGREEMENT (IGA) ATTACHMENT E LINE ITEM BUDGET MOVE REQUEST
IGA2020-043	

Note: This document is provided only for County use to assist with tracking budget line item moves to determine if/when a contract amendment needs to be requested.

BUDGET LINE ITEM MOVES

Revised Budget Per 25% Movement Between Line Items *(Budget moves exceeding 25% of total annual budget or to a non-funed line item will require a contract amendment.)*						
Account Classification	**Approved Contract Budget**	**Total Budget Change 00/00/00**	**Total Budget Change 00/00/00**	**Total Budget Change 00/00/00**	**Revised Budget ***	**% of Budget Change**
Personnel Services					$0.00	#DIV/0!
ERE					$0.00	#DIV/0!
Professional & Outside Services					$0.00	#DIV/0!
Travel Expenses					$0.00	#DIV/0!
Occupancy Expense					$0.00	#DIV/0!
Other Operating Expenses					$0.00	#DIV/0!
Indirect					$0.00	#DIV/0!
Total	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!
Total Amount & Percentage of Movement Request	$0.00	$0.00	$0.00	$0.00	$0.00	#DIV/0!

Request for Purchase of Food

When food costs exceed the allowable thresholds ($500 per event and cumulative cost less than $5,000 annually), requests to purchase food shall be required by completing the Request for Purchase of Food form and submitting to the MCH HAF Program Manager.

Agency Name:

MCH HAF IGA Contract Number:

A. A description of the event, including the public purpose of the meeting, the programmatic benefit of the meeting, how the benefit of the meals or refreshments exceeds the cost, and any alternatives that have been considered:

B. A description of the target audience:

C. An estimate of the number of participants and a breakout of the number of staff and the estimated number of participants:

D. A description of the meals or refreshments to be provided and the estimated cost:

E. The funding source(s) for the food:

F. A draft agenda or similar document with beginning and ending times of the meeting, and the activities planned to coincide with the meals/refreshments:

G. The name(s), title(s), contact number(s) and email address(s) of the contact for the event (if there are several individuals involved, please list all of them, along with the other information listed above):

H. This request form and the supporting documentation establish a clear purpose for the event. As the contractor, you certify that this event serves a valid public purpose and the meals, or refreshments do not violate **Article 9, Section 7**, "Gift or Loan of credit; subsides; stock
ownership; joint ownership" of the Arizona Constitution."

County Program Manager Signature_____Date_____

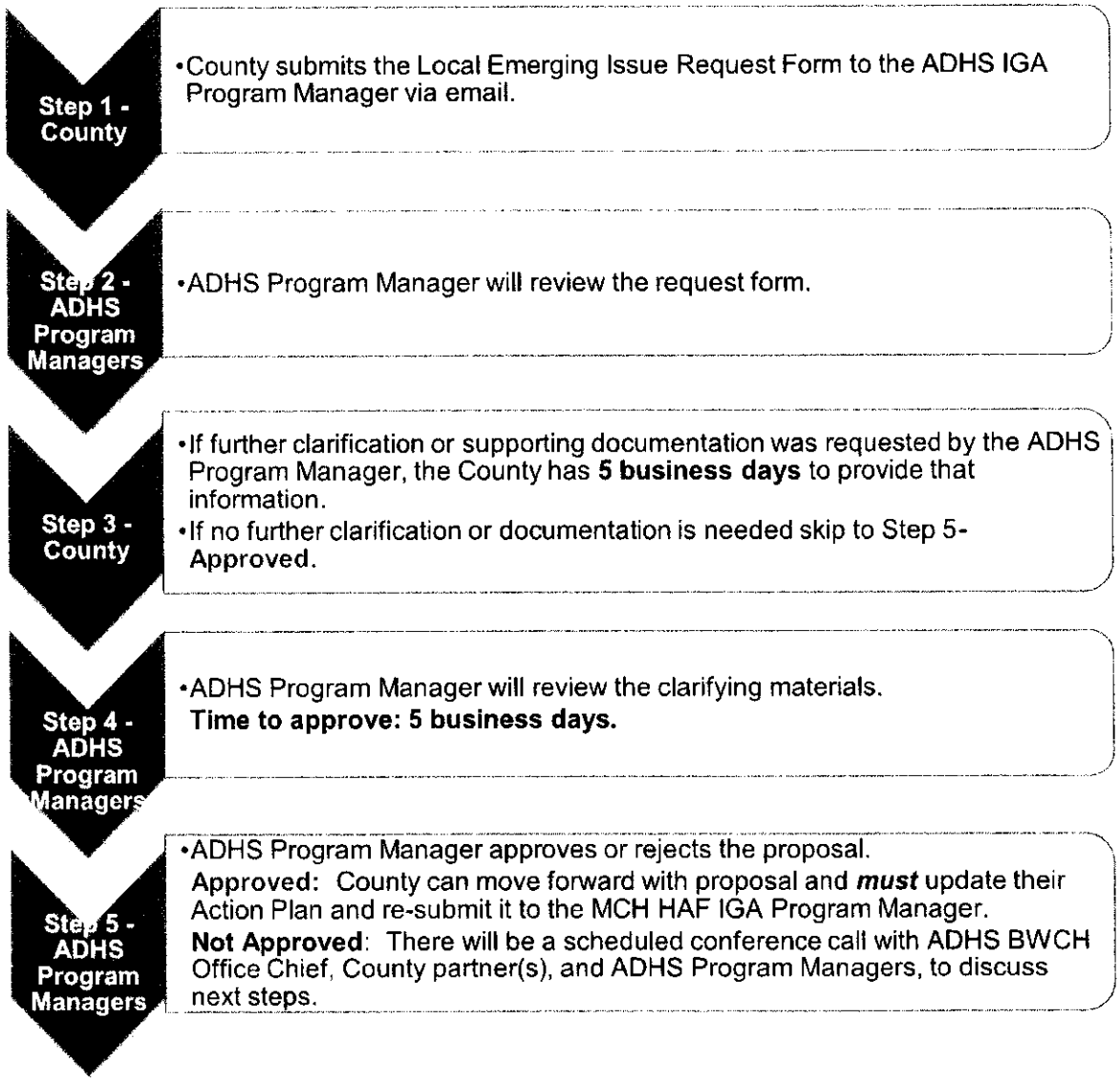
BWCH Financial Manager Signature_____Date_____

MCH HAF Signature_____Date_____

Approved_____Denied_____

CONTRACT NUMBER	INTERGOVERNMENTAL AGREEMENT (IGA) ATTACHMENT G EMERGING ISSUES APPROVAL PROCESS
IGA2020-043	

The local emerging issues approval process should be followed by the County partners when seeking to work on local emerging issues within the MCH HAF IGA. ADHS requires justification of the local emerging issue and the County staff can work with their designated program manager to identify potential documentation that will be acceptable.
This document was created in order to have a clear approval process in place. By following these steps, the local emerging issues' proposals will be approved in a timely manner, without delay.



Note: Time frame for ADHS approval may be outside of the 5 business days listed above based on the emerging issue, program, and funding guidelines.

CONTRACT NUMBER	INTERGOVERNMENTAL AGREEMENT (IGA) ATTACHMENT G EMERGING ISSUES APPROVAL PROCESS
IGA2020-043	

Please Fill in the Local Emerging Issue Request Form

Local Emerging Issue Request	**Responses**
Program Area	*Choose one:* **MCH HAF IGA:** ☐ Family Planning ☐ Maternal Child Health ☐ Children and Youth with Special Health Care Needs
Proposed Local Emerging Issue(s)/Project Title	
Staff Members Working on Project (List Names and Titles)	
Source (s) of the Projected Funds	
Time Period (Dates) That the Funds Will Be Utilized/Spent	
Proposed Funding Total	
Proposed Staff Time Spent	
Justification for Use of Funds (i.e. documentation from Health Officer on the emerging issue, County data, etc.)	
How Does This Project Connect with the MCH HAF IGAs?	
Population(s) or System(s) Impacted	
Describe How You Propose to Evaluate the Project to Show Impact/Success	
If Also Allocating Non-Personnel Resources (supplies, travel, etc.) Please Indicate That Here and Provide Funding Total and Justification for Use of Funds	
Line Item Budget is Attached (If cost sheet created please attach)	

ADHS Use Only:

Request is: ☐Approved ☐Rejected

--Insert e-Signature--

Staff Signature and Date

ARIZONA DEPARTMENT
OF HEALTH SERVICES

Bureau of Women's & Children's Health

Title V

Reproductive Health/Family Planning Program

Policies and Procedures Manual

Table of Contents

1.1 Program Background and Description

The mission of the Bureau of Women's and Children's Health (BWCH) is to "strengthen the family and community by promoting and improving the health status of women, infants, and children." This is accomplished through the provision of community-based services and the facilitation of systems development. The Bureau of Women's and Children's Health administers the federal Maternal Child Health Title V Block Grant and other federally funded programs, as well as private and state supported programs.

The Bureau of Women's and Children's Health, Reproductive Health/Family Planning Program is a statewide, clinic-based, program that provides comprehensive family planning and reproductive health services to promote optimal health to Arizona's men and women. Services include education, screening, counseling, and medical and referral services that enable people to make voluntary and informed decisions. Program services are preventive health services that enhance maternal and infant health, and the emotional and social health of the individual and the family.

Reproductive health and family planning is a cost effective intervention that plays a key role in health care delivery. Clinics are often the entry point into the health care system, and may be the only source of health care for the low income, for the young, and for the underinsured and the uninsured. Program services promote responsible and healthy lifestyles by providing accurate information, education, and counseling to people regarding their reproductive health and family planning options. Program services provide individuals with the information and means to exercise personal choice in determining the number and the spacing of their children.

Research indicates that women who can plan and space their pregnancies are likely to have healthier babies. The reduction of unplanned pregnancy increases the likelihood that women will receive early and continuous prenatal care. Improved birth outcomes include a reduction of birth defects, decreases in infant mortality, and decreases in the incidence of low birth weight babies. An important social statistic indicates that children born to individuals who are prepared for them are less likely to be abused and/or neglected.

Clients receive initial or annual exams which include a choice of a family planning method, cancer and Sexually Transmitted Infection (STI) screenings. Clients also receive treatment as indicated, pregnancy testing, counseling, education, and referrals to other medical services as needed. It is vital that reproductive health and family planning services be available, accessible, and linked to other types of necessary medical, social, educational, and financial resources in communities throughout Arizona.

1.2 **Authority for the Program**

Arizona Revised Statutes, ARS §36-104(1)(c)(i), authorizes the Director of the Arizona Department of Health Services (ADHS) to administer community health services which are to include medical service programs for family planning.

1.3 **Mission Statement**

The mission of the Reproductive Health/Family Planning Program is:

A. To provide preventive health services to enhance the emotional, physical, and social health and well-being of mother's, children, and the whole family unit.

B. To enable individuals to make and implement educated personal decisions regarding the quantity and spacing of their children

C. To make reproductive health and family services available and easily accessible to all who seek such assistance

1.4 **Reproductive Health/Family Planning, Maternal and Child Health Block Grant** To assure that mothers and children (in particular, those with low income or with limited access to health services) receive quality maternal and child health services, the United States Congress enacted Title V of the Social Security Act. Title V provides funds via the federal Maternal and Child Health Services Block Grant for the health promotion of mothers and children, particularly through preventive and primary care services for the low-income population. Title V also provides support for prenatal care, delivery assistance, and postpartum care for low-income mothers. Recognizing that reproductive health and family planning services are important components of maternal and child health care, the Bureau of Women's and Children's Health contributes a portion of this block grant to address various reproductive health and family planning needs.

The funding for reproductive health and family planning services administered by the Bureau of Women's and Children's Health is supported entirely by dollars received from the federal Maternal Child Health Title V Block Grant.

1.5 **Other Reproductive Health/Family Planning Programs**

A. Infertility Prevention Project (IPP) Referrals

Gonorrhea and chlamydia infections are considered major cause of pelvic inflammatory disease (PID), ectopic pregnancy and related infertility among women in Arizona and in the United States. ADHS Sexually Transmitted Disease Control Program (STDCP) manages the IPP component of the CDC Comprehensive STD Prevention Services (CSPS) Cooperative Agreement grant. The overall goal of the IPP is to assess and reduce the prevalence of chlamydial and gonococcal infection, and associated complications through increased education and training, targeted screening, timely, and effective treatment, effective partner referral and treatment, and dissemination of chlamydia-related information to providers and policy makers

in order to reduce infertility among women through the screening and treatment of chlamydia.

Should the contractor choose to participate in this program, the Contractor agrees to:

1. Provide universal chlamydia and gonorrhea screening for all women at Title V Health Clinics, during the first visit and annually thereafter. Prevalence requirements may change as funds for testing dictates.
2. Provide client level services including treatment, education and counseling, as well as partner elicitation and services.
3. Provide staff training in the process for collecting specimens, client education, referral, confidentiality, reporting, and requisition of laboratory supplies.
4. Provide comprehensive reports in a timely manner as dictated

Contingent upon the availability of IPP funds, ADHS' contracted laboratory will provide Contractor testing collection kits for the target population of women 25 years of age and younger at no cost. Failure to adhere to Region IX Infertility Prevention Chlamydia Clinical Guidelines may result in elimination of Chlamydia testing funds.

Contingent upon availability, IPP agrees to provide Contractor with dosages of azithromycin at no charge for treatment of Title V patients. If azithromycin is no longer available, Contractor will provide treatment at Contractor's expense or provide appropriate referrals for target population for treatment of a positive Chlamydia test result. Contractor agrees to submit the IPP Azithromycin Usage Report on a monthly basis to IPP.

B. Title X, Public Health Service Act

Congress enacted the Family Planning Service and Population Research Act, which added Title X, Population Research, and Voluntary Family Planning Programs, to the Public Health Service Act. Title X is administered by the Office of Population Affairs, a department within the U.S. Department of Health and Human Services. The regulations governing Title X are contained in the Code of Federal Regulations, (CFR), (42 CFR, Subsection A, Part 59). These regulations govern the provision of family planning services nationwide. In Arizona, The Arizona Family Health Partnership (AFHP) administers these funds and services. All clinics provide basic medical, educational, and counseling services related to contraception and pregnancy testing. These services are targeted for low-income women and men.

C. Title XIX

Title XIX of the Social Security Act funds federal Medicaid programs. Arizona's version of the Medicaid program is the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS acts as the health insurer for low income Arizonans who qualify for various state and federal programs. Enrollees are entitled to receive health care benefits, including family planning services through prepaid managed care health plans. Family planning services are covered services for Title XIX enrollees, but

AHCCCS health plans may elect at the time of contract negotiations not to provide family planning services directly. In those cases, services must be made available on a fee-for-service basis through referrals to AHCCCS registered providers.

1.6 Program Goals and Objectives

A. The overall goal of the Reproductive Health/Family Planning Program is to provide comprehensive health services to promote optimal health, outcomes, and wellness for all Arizonans.

1. Related goals include:
   a. Promoting safe sexual behaviors
   b. Improving access to quality health care
   c. Improving maternal and infant health
2. The related Bureau of Women's and Children's strategic plan priority is to improve the health of women prior to pregnancy.

B. The objectives of the Reproductive Health/Family Planning Program are to:

1. Decrease the teen pregnancy rate by providing reproductive health and family planning education, counseling, medical care, and referral services to adolescents statewide
2. Ensure access to health care by providing reproductive health and family planning education, counseling, medical care, and referral services to low- income individuals living in rural and other underserved areas

By meeting these objectives, Program services aim to improve birth outcomes by reducing birth defects, decreasing infant mortality, and decreasing the incidence of low birth weight babies. These services also aim to improve the emotional and social health of the individual and the family by decreasing the stress that can be caused by an unplanned pregnancy.

1.7 The Purpose of this Manual

The purpose of this manual is to document the Reproductive Health/Family Planning policy and procedures for the Maternal and Child Health Title V Block Grant Contractors to use in development, implementation, and management of the Program. The manual is to be used to supplement terms of the contracts as indicated in the Scope of Work (SOW). Program Contractors, Department Administration, and other interested parties are to use this manual for reference and to provide more detailed information than contained in the contract. Reproductive health and family planning Contractors are required to adhere to the requirements and guidelines set forth in this manual, and are also responsible for incorporating any policy changes into their operations.

Revisions to the manual will be distributed to all Contractors at least thirty days prior to the effective date of any change, when appropriate. Contractors may consider keeping relevant correspondence and program updates as an Appendix to this document. If this reference

does not answer a question or concern, or if Contractors have suggestions for additional information that might be included in the policy manual, please contact the Reproductive Health/Family Planning Program Manager via any of the information below:

Physical Address:

Attention: Family Planning Program Manager Arizona
Department of Health Services
Bureau of Women's and Children's Health 150 N. 18th
Avenue, Suite 320
Phoenix, Arizona 85007-3242
Office Number: 602-364-3124
Preferably e-mail:alison.lucas@azdhs.gov

1. "ACOG" means the American College of Obstetricians and Gynecologists. ACOG establishes and promotes standards for women's health care.

2. "ADHS" means the Arizona Department of Health Services. The Department is the Arizona state agency that is mandated to promote, protect and improve the health of the people of the state of Arizona. The Department is responsible for administering public health services and a variety of community health programs, including the Reproductive Health/Family Planning Program.

3. "AHCCCS" means the Arizona Health Care Cost Containment System. AHCCCS is the Arizona state agency that administers health care benefits and services for persons who are eligible for Title XIX services (Medicaid) or other low-income medical assistance programs.

4. "Annual Review" means compliance-based site visits that are conducted to ensure that services are delivered pursuant to the terms and conditions of the contract and in accordance with the Reproductive Health/Family Planning Program Policy and Procedure Manual. All Contractors will have at least one compliance-based site visit at least every two years, either virtually or in person, as circumstances dictate.

5. "Annual Visit" means an established client's yearly comprehensive well-woman preventive visit. Please click this link for updated guidelines for the annual visits: https://www.womenspreventivehealth.org/recommendations/well-woman-preventive-visits/. A client may only have one annual visit in a twelve month period.

6. "BWCH" means the Bureau of Women's and Children's Health at the Arizona Department of Health Services.

7. "CDC" means the Centers for Disease Control and Prevention, a federal public health agency. The CDC is recognized as the lead federal agency for protecting the health and safety of people in the United States and abroad, providing credible information to enhance health decisions, and promoting health through strong partnerships. The CDC serve as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.

8. "Client" means an individual who receives reproductive health/family planning services through the Program.

9. "Clinic Site" means an outpatient facility, or part of a facility, devoted to diagnosis and treatment of patients.

10. "Clinical Staff" means a designated physician or nurse practitioner who is licensed and board certified in the State of Arizona who administers clinical care for the Reproductive Health/Family Planning Program.

11. "Continuous Quality Improvement" (CQI) means the combination of activities traditionally referred to as quality assurance, quality management, utilization review, and risk management. CQI encompass any and all plans, actions, and evaluation practices used to monitor and improve services and service provision.

12. "Contractor" means the organization awarded by ADHS to provide services; also known as the Grantee.

13. "DES" means the Arizona Department of Economic Security. DES is the Arizona state agency that is responsible for determining eligibility for federal assistance programs for low income persons.

14. "Encounter" means an episode of contact or single unit of service provided to an eligible reproductive health/family planning client. An initial or annual visit is an example of a client encounter. A visit for contraceptive supplies is another example of a client encounter.

15. "Family Planning" means the process by which individuals and couples exercise their ability to make personal choices in the spacing and quantity of their children.

16. "FDA" means the Food and Drug Administration. The FDA is the federal agency that promotes and protects the public health by helping safe and effective products reach the market and by monitoring products for continued safety after they are in use. The FDA reviews clinical research and takes action on the marketing of foods, human and veterinary drugs, devices intended for human use, and cosmetics.

17. "HPHC IGA" means Healthy People Healthy Communities Intergovernmental Agreement, funding Arizona County Health Departments to provide family planning services.

18. "Informed and Written Consent" means that the client has provided written consent to participate in receiving Family Planning services after having been properly educated about the medical facts and risks involved.

19. "Initial Visit" means a client's first comprehensive visit. It will normally include a physical exam, a pap smear, if indicated, and issuing of a birth control method.

20. "Infertility Prevention Program (IPP)" is a program established by the CDC and the Office of Population Affairs to reduce the incidence of sexually transmitted diseases that can lead to infertility (primarily chlamydia and gonorrhea).

21. "Logic Model" is a diagram that shows the relationship between the program components and activities and desired process and outcome objectives. It is a visual way to present and share understanding of the relationships among the resources available to implement the proposed intervention, the strategies/activities planned for implementation, and the outputs and outcomes expected. Logic Models should typically be one (1) to three (3) pages in length.

22. "Low-Income/Low-Income Family" means an individual or family meeting the official poverty guideline, as revised annually by Health and Human Services.

25. "Network" means a collection of service resources or information pathways that have been developed to assist clients in accessing appropriate information, education, medical, social, and financial services.

26. "Nurse Practitioner" means a registered nurse with a graduate degree in advanced practice nursing. She/he must be certified by the Arizona State Board of Nursing to function as a nurse practitioner in the extended role under the provisions of ARS Title 32, Chapter 15, Nursing.

27. "Outpatient Treatment Center" means a class of health care institution without inpatient beds which provides medical services for the diagnosis and treatment of persons on an outpatient basis. See ARS §36-421.01.

28. "Outreach" means any method used to provide information and education to the community regarding Reproductive Health Family Planning Program, services, benefits, etc.

29. "Preconception Health" the physical, emotional, social well-being and economic stability of a man or woman during their reproductive years, before conception.

30. "Preconception Care" the provision of education and/or services to men or women related to the impact of their physical, emotional, social well-being and economic stability on their health status prior to conception.

31. "Primary Care Physician" means a main doctor who manages most of a patient's medical issues.

32. "Program" refers to the Title V Reproductive Health/Family Planning Program as outlined in the Policy and Procedure manual.

33. "Program Manager" means the Department employee who is responsible for the implementation and oversight of the Reproductive Health/Family Planning Program. The Program Manager coordinates activities among Contractors and among Reproductive Health Team members, receives and reconciles invoices, handles budget issues, and provides technical support. The Program Manager is responsible for negotiating contracts, requesting contract amendments to be processed by the Procurement Office, conducting site visits, and monitoring Contractor compliance with the provisions of the contract.

34. "Recommended Services" are those services that are not required by contract or Program policy, but may be provided by the Contractor in order to promote the general reproductive-related health care needs of the client.

35. "Related Services" are those services which are not authorized or paid for by the Department but may be provided by the Contractor in order to meet the general health care needs of the client.

36. "Reproductive Health/Family Planning Services" means the cost effective and preventative care provided to participants designed to help promote responsible and healthy lifestyles. Family planning services may include but are not limited to education, confidential counseling, comprehensive health history, physical exams, provision and maintenance of safe and effective contraceptive methods, health screenings and follow up for breast and cervical cancer, screening, testing, and treatment of sexually transmitted diseases, pre-pregnancy counseling, pregnancy testing and counseling, infertility screening, sterilization services for men and women, intimate partner violence and reproductive life planning screening and education, and referrals to other medical or social services. Abortion is not a family planning service.

37. "Required Services" means those services which are stipulated either by law, in rules, by contract, or by Program policy which are otherwise considered essential to the provision of high quality reproductive health services.

38. "SOW" means Scope of Work, which is the area in an agreement where the work to be performed is described. The SOW should contain any milestones, reports, deliverables, and end products that are expected to be provided by the performing party.

39. "Shall" means mandatory program policy.

40. "Site Visit" means any visit to the Contractor's or Sub-contractor's business location by ADHS Reproductive Health/Family Planning Program staff or a designee, at least every two years.

41. "Title V" means Title V of the Social Security Act. At the national level the Maternal and Child Health Bureau administers Title V. The bureau is a segment of the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. Title V funds programs that promote the health of women, infants, and children. Title V funding and services are administered in Arizona by the Arizona Department of Health Services, Bureau of Women's and Children's Health.

42. "Title X" means the National Family Planning Program created by the Public Health Service Act (P.L.910572). Title X is administered by the Office of Population Affairs, the U.S. Department of Health and Human Services. The regulations governing Title X are contained within the Code of Federal Regulations (CFR), (42 CFR, Subsection A, Part 59). In Arizona, Title X funding and services are administered by the Arizona Family Health Partnership.

43. "TITLE XIX" means Title XIX of the Social Security Act. Title XIX funds federal Medicaid programs. Arizona's version of the Medicaid program is the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS acts as the health insurer for low income Arizonans who qualify for various state and federal programs.

3.1 Role of the Bureau of Women's and Children's Health

A. The Bureau of Women's and Children's Health (BWCH) administers the federal Maternal Child Health Title V Block Grant. Recognizing that reproductive health and family planning services are important components of maternal and child health care, BWCH contributes a portion of this block grant specifically to address reproductive health and family planning needs. BWCH provides the criteria, policies, funding, and requirements for developing and implementing the Reproductive Health and Family Planning Program at the community level.

B. BWCH contracts with local public and private agencies. Contractors may use a variety of strategies and/or service delivery systems to achieve program standards and desired outcomes. Within the framework of the Reproductive Health and Family Planning Program is the flexibility for Contractors to implement clinical programs and provide reproductive health services in a manner that suits the needs of their community. BWCH provides technical assistance to the Contractor, monitors contract compliance, and authorizes payment of contracted deliverable services.

C. BWCH provides two annual summits each year for Contractors, the Family Planning Nurse Summit and the Healthy People Healthy Communities Intergovernmental Agreement (HPHC IGA) Annual Fall Summit. Each Annual Summit provides comprehensive training, education, and technical assistance support on reproductive health and family related topics. Continuing education credits may be available.

3.2 Role of the Contractor in Program Management

Contractors are required to achieve and maintain certain minimum standards. Contractors must provide services of high quality and must be efficiently administered. The Contractor must develop administrative, management, and organizational systems that meet all Reproductive Health/Family Planning Program requirements. The Contractor must also have adequate staff and support services to implement the program at each clinic site. The Contractor's personnel shall meet all certification and licensure requirements. At a minimum, the following personnel are required:

A. Administrator:

The Contractor is required to have a qualified Program Administrator who is responsible and accountable for overall Program planning, implementation, and evaluation at each contracted site. The Administrator's allocation of time to this position must be sufficient to ensure that program objectives are met.

B. Clinical Staff:

The clinical care component of the program must be under the supervision and responsibility of a designated physician or nurse practitioner who is licensed and board certified in the State of Arizona. If a nurse practitioner is overseeing the Program, she or he must work collaboratively with a physician for consultation or

referral on an as-needed basis. Training or experience in reproductive health services is preferred.

C. Nursing Coordinator:
The nursing care component of the Reproductive Health/Family Planning Program must be under the supervision and responsibility of a Nursing Coordinator who is a registered nurse licensed in the State of Arizona with special training or experience in reproductive health and family planning services. The Nursing Coordinator must maintain compliance with the Arizona State Board of Nursing regulations. The Nursing Coordinator must be committed to obtaining reproductive and family health training. Please see the Family Planning National Training Center www.fpntc.org for more information.

D. Other Support Staff:
Other support staff for the Contractor may include registered nurses, licensed practical nurses, nurse's aides, health educators, nutrition counselors, family planning counselors, and other administrative personnel required to support business and clinical operations.

3.3 Contractor Oversight of Medical Management Component

All medical functions for the Contractor's Reproductive Health/Family Planning Program are performed under protocols, or standing orders approved by the designated physician or nurse practitioner. The standing orders and protocols must be in compliance with state rules and laws.

3.4 Sub-contracts

A. The Contractor must not enter into any subcontract under this contract without the advance written approval of the Arizona Department of Health Services Procurement Officer.

B. In the event that family planning services are sub-contracted, the Contractor will remain responsible for ensuring that the subcontractor provides service in accordance with all specifications within the contract and the policy and procedure manual.

C. Contractors must have a written and signed agreement with the sub-contractor.

D. Contractor must monitor the sub-contractor's performance annually and provide a written evaluation for the Bureau of Women's and Children's Health Program Manager to review during the Contractor's annual site review.

3.5 Contractor's Personnel Policy Standards

Contractors must establish and maintain written personnel policies that comply with federal and state requirements and Title VI of the Civil Rights Act. These policies shall include, but need not be limited to: staff recruitment and selection, performance evaluation, promotion,

termination, compensation, benefits, orientation to the agency and the Program, in-service training, and grievance procedures. At a minimum, Contractors must require and ensure that:

A. Personnel records are kept confidential in a secured place.

B. An organizational chart and personnel policies are available to all personnel.

C. Job descriptions (specifying training, formal education, experience, and licensure) are available for all positions, and that these are reviewed annually and updated as necessary to reflect changes in duties.

D. A performance appraisal system is in place for all employees. An evaluation and review of the job performance of all program personnel must be conducted annually, at a minimum.

E. It is the responsibility of all sub-recipients and Contractors to be aware of, and monitor their staff and volunteers to be in compliance with protection of minors receiving Family Planning services.

3.6 Staff Training and Orientation

A. Contractors must provide an orientation to all Program personnel and must include the following:
   1. Orientation on the agency, or clinical site where the employee is employed.
   2. Orientation on reproductive and family health services, federal and state Program protocols, policies and procedures. Note* This Family Planning Policy and Procedure Manual must be reviewed by ALL staff and readily available for staff if applicable.
   3. Introductory call with the ADHS Family Planning Program Manager.
   4. Overview of the HPHC IGA and how the family planning program fits within the IGA.

B. Contractors must provide for the in-service training of all Program personnel. Contractors must also develop and implement plans for promoting and offering continuing education programs as needed. Contractors are required to attend the HPHC IGA Annual Fall Summit and Family Planning Nurse Summit. Furthermore, all program personnel must participate in continuing education related to their activities, including on-the-job training, workshops, institutes, and courses

C. Documentation of attendance at in-service trainings and of having received orientation must be kept in the Program's records or the staff's personnel record. Documentation of training and orientation will be used in evaluating the scope and effectiveness of the staff training program.

3.7 Continuous Quality Improvement (CQI)

A. Contractors must develop an ongoing, systematic process to monitor and evaluate the quality, efficiency, effectiveness, and appropriateness of client service and program operations. Required CQI:

1. Resolving Client Problems

   The Contractor and its subcontractors must develop and implement a process by which clients may present grievances about the operation and management of the program and services received. When developing grievance policy and procedure the following must be included:

   a. Contractors must inform the client of the right to grieve and must assist the client with the grievance process.
   b. Client grievances must be addressed in a timely manner.
   c. Client problems and issues must be tracked to identify potential trends.
   d. Contractors must incorporate findings and feedback into a plan to identify and correct future problems.
   e. The Contractor must include in the grievance process, contact information for the Bureau of Women's and Children's Health Program Manager and cooperate in the resolution of any client problems brought to the attention of the BWCH.

2. Client Satisfaction Surveys

   Contractors must develop a client satisfaction survey to facilitate client input into clinic operations and services. Survey results must be considered when identifying areas for improvement.

3. Medical Record Review

   Medical records should be reviewed periodically for accuracy, completeness, quality of care, and compliance with policy and contract obligations. Examples include but should not be limited to:

   a. Counseling and education provided to the client
   b. Client receives and is assisted as needed with referrals for services that are not provided by the clinic
   c. Notification and follow up of abnormal lab results
   d. Follow up by staff of client self-reported risk factors
   e. Informed consent
   f. Medical record documentation is signed and dated
   g. Staff certifications and licenses are current
   h. Staff has been fingerprinted as required by law

B. Recommended CQI

1. Monitoring Service Availability and Accessibility:
   a. Determine the time interval between the request for an appointment and the date the appointment is scheduled.
   b. Determine the time interval between the client's scheduled appointment and the time the client sees the care provider.
   c. Determine if there are any clients with unmet needs.

2. Timeliness of Deliverables
   Contractors should monitor the performance reports, CERs, and the annual reports for accuracy and for timely submission to the ADHS FP Program Manager.
3. Monitoring Referral Networks
   Contractors should periodically evaluate the accessibility, availability, and quality of service provided by the outside agencies, providers, and organizations to which they are referring clients.
4. CQI projects can be initiated by the County Contractors or started by ADHS.

3.8 Internal Policy and Procedure for Reproductive Health/Family Planning

A. Contractors must maintain an internal policy and procedure manual to be used to provide staff with guidelines for client care and Program management.

B. When developing policy, procedure, and protocols the Contractor must consider the contract requirements as further detailed in this manual. The internal manual should include but not limit policy to:

1. Management and administrative functions as detailed in Chapter 3 of this manual
2. All required services as detailed in Chapter 4 of this manual
3. Any recommended services detailed in Chapter 4 that are adopted by the Contractor
4. Monthly reporting
5. Monthly billing
6. Reporting physical, sexual, emotional abuse, and neglect to the protective agencies
7. Procedure for management of on-site medical emergencies

3.9 Clinic Facility Standards

A. Clinic sites and client care facilities for the Reproductive Health/Family Planning Program shall be licensed by the ADHS as Outpatient Treatment Centers.

B. Facilities must meet applicable federal, state, and local government standards, i.e.: fire codes, building codes, Occupational Safety and Health Administration (OSHA) requirements, Clinical Laboratory Improvement Amendments (CLIA) Licensure, etc.

C. Facilities must meet the accessibility standards as established by the American's with Disabilities Act (ADA). The current ADA recommendations can be found here: https://www.ada.gov/2010_regs.htm.

3.10 **Availability and Accessibility of Clinic Services**

A. Reproductive health and family planning facilities and services must be geographically accessible to the population served and should be available at times that are convenient to persons seeking services.

B. Facilities should be adequate to provide the required services and should be designed for the comfort and privacy for clients.

C. Facilities must have a written plan and procedure for management of emergencies.

3.11 **Program Eligibility**

A. Income Eligibility:

1. Reproductive health and family planning services are to be provided to persons from low income households as the highest priority.
2. Low income for the purpose of this Program is defined as at or below 150% of the Federal Poverty Level (FPL). The FPL is determined by the Office of Management and Budget and is revised annually. Contractors must maintain and use current information regarding the FPL. The current information for the FPL can be found here: https://aspe.hhs.gov/poverty-guidelines.
3. A client's self-declaration of income may be considered sufficient to receive services.
4. Eligibility for minors seeking services shall be based on the financial resources of the minor.
5. Client income must be reevaluated annually.
6. Clients at or below 150% FPL shall receive services free of charge. Voluntary donations from clients are permissible within the following guidelines:
   a. Clients must not be pressured to make donations
   b. The amount of the donation cannot be specified
   c. Those not donating cannot be refused service
   d. Those not donating must not be subjected to any variation in services
7. Clients who are above 150% of FPL can be provided services on a sliding fee scale within the following guidelines:
   a. The scale must be adjusted to reflect income and family size
   b. The scale must be posted in a visible public place
   c. Clients who do not pay the sliding scale rate must not be subjected to any variation in quality of services

B. Program services are to be provided to clients who are reproductive; i.e., not to clients who are post-menopausal, have had a hysterectomy, and/or who have been sterilized.

C. Program services are to be provided without the imposition of any duration residency requirement.

3.12 **Nondiscrimination**

Contractors must provide program services without regard to religion, race, color, national origin, creed, disability, gender, sexual orientation, and number of pregnancies, marital status, age, ability to pay, and contraceptive preference.

3.13 **Voluntary Participation**

A. Use of program services by any individual must be solely on a voluntary basis. Individuals must not be coerced to accept services or to use any particular method of family planning. Acceptance of reproductive health services must not be a prerequisite to eligibility for or receipt of any other service or assistance from or participation in any other programs.

B. Program personnel should be informed that it is an illegal action to coerce or attempt to coerce any person to undergo a sterilization procedure or an abortion procedure, (Arizona Revised Statutes, Section 36-2153).

3.14 **Confidentiality**

Every Contractor must assure client confidentiality and provide safeguards for individuals against the invasion of personal privacy as required by Arizona Revised Statute (ARS) and by Public Law 104-191, the Health Insurance Portability and Accountability Act (HIPAA).

A. All information obtained and records prepared in the course of providing service to clients shall be considered to be confidential information. No information obtained by the provider's staff about individuals receiving services may be disclosed without the client's written consent, except as required by law. The client's statement of written consent must be included in the client's medical record. Information may otherwise be disclosed only in summary, statistical, or other form that does not identify the individual.

B. Clients transferring care to other providers may be provided with a copy of their medical record to expedite continuity of care.

3.15 **Client Medical Records**

A. Contractors must establish a medical record for every client who obtains clinical services.

B. Clinic staff members are required to document all pertinent information about client interaction.

C. Entries in the medical record are to reflect professional, nonjudgmental statements of fact. Records must be legible, dated, and are to be signed in ink with the initial and last name of the clinician providing the service. Records must be complete, accurate, and follow standard practice for medical record documentation.

D. Medical records must contain the following information:
   1. Personal identifying information about the client
   2. Medical history, physical examination, laboratory tests, results, and follow-up, diagnosis, orders, allergies
   3. Treatment and instructions
   4. Informed and written consent
   5. Documentation of telephone contact of a clinical nature
   6. Documentation of attempts to contact client
   7. Refusal of service
   8. Documentation of counseling, referrals, and education; both written and verbal provided
   9. Financial information
   10. Procedures

E. Clients must be informed that a medical record will be maintained and that this information is confidential information to be divulged only upon their written permission, or as otherwise required by law.

F. Clients shall have access to their own medical record at all times, and shall have the right to correct any inaccurate information included in the records.

G. Clients will have signed an informed consent statement prior to receiving reproductive health services.

H. The Contractor is responsible for maintaining the client's case file record in a confidential manner, and ensuring that information contained in the records is released only to authorized parties.

I. The BWCH Program Manager may have access to client records without client consent in order to conduct necessary evaluations or programmatic review. The client's case file record is not available to other governmental agencies, except for the Auditor General, without specific prior written consent by the client for the release of information in the client record.

J. The Contractor shall store and maintain client records in a safe, secure location. Except for non-identifiable demographic characteristics, records shall be destroyed six (6) years after the client's last participation in the Reproductive Health/Family Planning Program. Minors' records must be maintained until the age of majority plus three (3) years.

To learn more about how to handle HIPAA Related client records, please review the Custom Records Retention Schedule Issued to: All State and Local Agencies Administrative and Management Records document, page 12, Record Series Number

10283 here: https://azlibrary.gov/sites/default/files/arm-all-general- schedules_2019-12-16.pdf.

For more information on Permanent and Historical records, please see here: https://azlibrary.gov/sites/default/files/arm_permanent_and_historical_records_20 19.pdf.

3.16 Informed Consent

A. A written, signed, informed consent statement must be received from the client prior to receiving family planning services or medical treatment. This statement documents the client's voluntary consent to receive program services.

B. The form must be written in the primary language of the client or witnessed by an interpreter the client knows and/or trusts. The form must cover all procedures and medications to be provided.

C. To give informed consent for contraception, the client must receive education about the benefits, risks and limitations of the various contraceptive alternatives, and details on the safety, effectiveness, potential side effects, complications, discontinuation issues, and danger signs of the contraceptive methods of choice.
The consent statement shall include at least the following:

1. A clear description of the services or procedures to be performed, including medical treatments and interventions, counseling, or other client contact
2. The right of the client to terminate treatment or refuse services at any time
3. Any responsibilities of the client
4. Any other information that is necessary to convey to the client a clear understanding of the Program
5. All consent forms must contain a statement that the client has been counseled, has read the appropriate informational material, and has understood the content of both. The signed informed consent must be a part of the client's record
6. The form must be renewed and updated when there is a major change in the client's health status or a change to a different prescriptive contraceptive method

3.17 Program Promotion

A. Contractors must establish and implement planned activities whereby family planning services are made known to the community.

B. In planning for Program promotion, providers should review and utilize a range of strategies to gain community acceptance. Program promotion activities should be updated periodically and be responsive to the needs of the community.

C. Contractors must develop written material for distribution to clients, the community, and to other agencies and organizations. When developing materials, the Contractor must follow the guidelines below:

1. Materials must be medically accurate and culturally suitable for the population and community to which they are being distributed.
2. Program materials must be printed in a size and type style that is easy to read.
3. The materials must be language and literacy level appropriate.
4. All marketing, or education materials shall bear the following "Funded in part by the Bureau of Women's and Children's Health, Arizona Department of Health Services as made available through the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau, Title V Maternal and Child Health Services Block Grant Program."
5. All written materials should be reviewed periodically to be certain that the information remains timely, correct, inclusive, and medically accurate.

3.18 Community Education

A. To enhance understanding of the objectives of the Program and to make known the availability of services to potential clients, Contractors must provide education to the community about the Reproductive Health/Family Planning Program services.

B. Community education should be directed toward identifying local agencies and organizations that are likely to serve significant numbers of individuals in need of family planning care. Programs should offer in-service training sessions for the staff of these agencies and organizations in order to help them provide better counsel and to offer reference options to potential clients.

C. Education directed toward the general community should employ a variety of approaches. Education must be designed to meet the educational, cultural, and language needs of the community to be served.

3.19 Establishing Referral and Communication Networks

A. Contractors must develop a comprehensive listing of available local resources to assist clients with obtaining services not provided by the Reproductive Health/Family Planning Program.

B. The resource information should be reviewed and updated periodically to ensure continued availability, accessibility, and quality of the services recommended to clients.

C. In circumstances where resources or necessary services do not exist within the local community, Contractors will provide the client with information to obtain access to equivalent services in another community.

D. The Contractor must network with those agencies and organizations most frequently used as referrals for clients. An established informal network helps to ensure acceptance of the client for services and can provide a smoother transition for the client. Networking also helps to ensure that the client did receive the services as referred or recommended.

E. The Contractor is encouraged to develop a community based Reproductive Health and Family Planning Advisory Committee to aid in the identification of communities' reproductive health needs and resources, and to help develop strategies to meet the needs.

F. The Contractor shall make uninsured clients aware of the possibility of coverage through the Arizona Health Care Cost Containment System (AHCCCS) and shall provide referrals to AHCCCS as appropriate.

3.20 Developing Partnerships and Establishing Collaborative Efforts

A. To avoid duplication of effort and to maximize resources, Contractors must develop partnerships, or collaborate with existing agencies providing family planning services in their local communities.

B. Contractors will be familiar with the AHCCCS eligibility criteria and refer clients who meet those criteria to an AHCCCS provider to receive services. If the Contractor identifies that a number of individuals seeking services at their clinic are eligible for AHCCCS, the Contractor will consider becoming an AHCCCS provider to maximize the state resources to serve all populations in need of services.

4.1 Required Services

A. Contractors must provide clinical, informational, educational, social, and referral services to Program clients who want such services.

B. Contractors must offer a broad range of acceptable and effective medically approved family planning methods and services either on site or by referral. Programs should make all methods of contraception approved by the Federal Food and Drug Administration (FDA) available to all clients.

C. Contractors must provide the following services as part of initial and annual exams, and at other times as deemed medically appropriate:

1. Client Education/Counseling
2. Physical Assessment
3. Laboratory Testing, as medically indicated
4. Fertility Regulation
5. Infertility Services Referral
6. Pregnancy Diagnosis and Counseling
7. Adolescent Services
8. Sexually Transmitted Infection Screening/Assessment, as medically indicated
9. Referral and Follow-up
10. Screening for intimate partner violence (IPV) and reproductive coercion
11. Education on Preconception Health and Reproductive Life Planning

4.2 History

A. A comprehensive personal, medical, and social history must be obtained on all clients at the initial medical visit and must be updated at subsequent visits.

B. The medical history must address but not be limited to the following areas:

1. Allergies
2. Immunizations, including rubella and TDAP
3. Current use of prescription and over-the-counter medications
4. Chronic and acute medical conditions
5. Significant hospitalization
6. Surgeries
7. Review of systems
8. Extent of use of tobacco, alcohol and other drugs
9. Genetic conditions or disorders that affect the client or her family
10. Pertinent medical history of immediate family members
11. Partner history, including:
    a. Injectable drug use

b. Multiple partners
c. Risk history for STI's and HIV
d. Biscxuality

C. History of reproductive function must include but not be limited to the following:
1. Menstrual history
2. Sexual history
3. Obstetrical history
4. Gynecological conditions
5. Sexually transmitted infections (Chlamydia, Gonorrhea, and Syphilis)
6. HIV
7. Pap smear history (date of last pap, any abnormal pap, treatment)
8. Contraceptive use, past and present, and any adverse reactions
9. Pregnancies
10. Genetic risk assessment

4.3 **Client Education/Counseling**

A. Contractors must provide clients with education needed to make informed decisions about family planning choices. Contractors must provide this information both orally and in writing. Furthermore, client education must be appropriate to the client's age, level of knowledge, language, and culture. Any instruction and other client education offered or provided must be documented in the client's medical record.

Contractors must also provide education to assist clients in reaching informed decisions regarding the choice and continued use of contraceptive methods. Education is designed to help clients resolve uncertainty, ambivalence, and anxiety in relation to their reproductive health. Education should be provided in a private environment in which the client feels comfortable and in a manner that protects the dignity of the individual. Documentation of all education provided, must be included in the client's medical record.

B. Client education must include but not be limited to the information needed to:
1. Make informed decisions about care
2. Choose specific methods of contraception
3. Perform breast self-exam
4. Reduce the risk of infection or transmission of STIs and HIV
5. Understand intimate partner violence and reproductive coercion
6. Understand the procedures involved in the clinic visit
7. Understand the services offered at the clinic

C. Clients must also be offered the following information/education, as appropriate:
1. Achieving optimal preconception/inter-conception health
2. Basic female and male reproductive anatomy
3. Benefits of Folic Acid

4. Fertility regulation referral
5. Developing an individualized reproductive life plan
6. Health promotion/disease prevention
7. MMR & TDAP information and/or referrals
8. Exercise
9. Nutrition
10. Smoking cessation
11. Alcohol and drug abuse
12. Sexual abuse

D. Persons who provide education must be knowledgeable, objective, non-judgmental, culturally aware, and sensitive to the rights and differences of clients as individuals. The counselor's knowledge must be sufficient to provide information regarding the risks, benefits, limitations, contraindications, and effective use of any method, procedure, treatment, or option being considered by the client.

E. Pre-examination counseling must be provided to clients to explain the Program, clinical procedures, eligibility requirements, and to allow the client the opportunity to ask questions, express concerns, etc.

F. Post-examination counseling should be provided to assure that the client:
1. Knows results of the physical examination and laboratory studies
2. Knows how to use and is comfortable with the contraceptive method selected and prescribed
3. Knows the common side effects and possible complications of the method selected and what to do if complications occur
4. Knows how to discontinue the contraceptive method and has information regarding a backup method
5. Receives appropriate referrals for additional services as needed
6. Knows an emergency 24-hour number and a location where emergency services can be obtained
7. Knows when to schedule a return visit

G. Sexually Transmitted Disease and HIV Counseling:
1. Contractors must provide clients with thorough and medically accurate counseling on STI's, HIV infection, and AIDS. Contractors must also offer information on risk and infection prevention, and referral services.

H. Other Counseling:
1. Clients should receive special counseling regarding future planned pregnancies, assistance with current pregnancy, and other individual concerns as indicated i.e. substance use and abuse, sexual abuse, sexual concerns, domestic violence, nutrition, etc. Preconception counseling and a reproductive life plan must also be provided.

2. Referral systems should be in place for those who require genetic counseling and evaluation.
3. Contractors should counsel clients about health promotion and disease prevention and make referrals as appropriate.

4.4 Physical Assessment

A. Clients must have a general physical examination at each initial and annual medical visit. The physical examination must include but not be limited to the following:
1. Height
2. Weight
3. Blood pressure
4. Thyroid
5. Heart
6. Lungs
7. Extremities
8. Breast
9. Abdomen
10. Pap smear as medically indicated

B. A client's refusal or deferral of a service, including the reason for refusal and/or deferral must be documented in the client's medical record.

C. Clients who decline or defer a service must be counseled regarding any possible health risks associated with declining and/or deferring the screening test or procedure. Counseling regarding any associated risk must be documented in the client's medical record.

D. Physical examinations and laboratory testing should not be deferred beyond 3 months after the client's visit unless in the clinician's judgment there is a compelling reason to extend the deferral. All deferrals and the reason for the deferral must be documented in the client's medical record.

E. Revisit schedules must be individualized, based upon the client's need for education, counseling, and medical care. Younger clients and clients initiating a new contraceptive method may need to be scheduled for a revisit to reinforce proper use, check for side effects, and to provide additional information or clarification.

4.5 Laboratory Testing

A. The following laboratory procedures must be provided as medically indicated for all clients at the initial and annual visit:
1. Hemoglobin (Hgb) or Hematocrit (Hct), as indicated
2. Pap smear/Guidelines:

First	Age 21, regardless of the age or onset of sexual activity

Pap Smear	Should be avoided before age 21
Until Age 30	Screen every 3 years instead of annually, using either the standard pap or liquid-based cytology
Ages 30 – 65	Contractors are required to follow the American College of Obstetricians and Gynecologists (ACOG) Clinical Guidance, found here:https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance?IsMobileSet=false
Note: Contractors are required to follow the ACOG Clinical Guidelines for women who have a history of cervical cancer, are infected with HIV, have a weakened immune system, or who were exposed to diethylstilbestrol (DES) before birth.	

3. Pregnancy testing
4. Wet mounts, as indicated
5. Urine Dip Stick/ Urinalysis
6. Syphilis serology, as indicated
7. Gonorrhea and Chlamydia tests
8. HIV testing, as medically indicated or upon client request
9. Other procedures and laboratory testing may be indicated for some clients and may be provided on-site or by referral

B. Laboratory procedures or services that cannot be performed on site must be made available through a referral when indicated.

C. Contractors must assure that laboratory tests performed by or for the clinic are of high quality. The Contractor must assess the credentials of the laboratories with which it contracts. Laboratories must be CLIA certified. If laboratory testing is performed on-site, written protocols for quality control and proficiency testing are necessary.

D. The Contractor must establish a procedure for timely client notification and adequate follow up of all abnormal laboratory results.
   1. The procedure must respect the client's request to maintain confidentiality
   2. When initial contact of the client is not successful, a reasonable further effort must be made to notify the client, this shall consist of at least three attempts, the means having been discussed during the visit.

E. A client who has had a negative Pap smear done at another facility within 6 months of the visit and has written test results, may have these procedures waived during the initial/annual visit.

F. Annual history updates, exams, and laboratory tests are required for all clients.

4.6 Fertility Regulation Referral

A. Contractors must make available through referral, all of the FDA approved methods of reversible contraception.
   1. Reversible Contraception:
      a. Non-hormonal Methods
      b. Hormonal Methods
      c. Long-Term Contraception
      d. Emergency Contraception
   2. Permanent Contraception Referral:
      a. Clients who request information regarding sterilization procedures must be counseled with regard to the permanence, risks, and benefits of this procedure.
      b. Contractors should be aware of federal sterilization regulations, (42 CFR Part 50, Subpart B). More information can be found here: https://www.hhs.gov/opa/sites/default/files/42-cfr-50-c_0.pdf.

B. More than one method of contraception can be used simultaneously by a client and may be indicated to minimize risk of STI, HIV, and pregnancy.

4.7 Infertility Services Referral

A. Providers are required to make basic (level 1) infertility services available to clients who request such service. Level I service includes initial infertility interview, education, physical examination, appropriate laboratory testing, counseling, and appropriate referral.

4.8 Pregnancy Screening, Counseling, and Referrals

A. Programs must provide pregnancy diagnosis and counseling to all clients in need or requesting this service. Pregnancy testing is one of the most frequent reasons for the initial visit to the family planning facility, particularly by adolescents. It is therefore important to use this occasion as an entry point for providing education and counseling about family planning.

B. Pregnancy screening consists of:
   1. Pregnancy History
   2. Pregnancy test
   3. Referrals to supportive programs

C. Programs providing pregnancy testing on-site should have available at least one test of high specificity. For those clients with positive pregnancy tests results who elect to

continue the pregnancy, the examination may be deferred, but should be performed within 30 days.

D. For clients with a negative pregnancy diagnosis and abnormal menstrual history, the cause of the abnormal menstruation should be investigated.

E. Pregnant women planning to carry their pregnancy to term must be offered information and education regarding their pregnancy. Clients must be given information about good health practices during early pregnancy, especially those practices that serve to protect the fetus during the first three months, and referral for prenatal care.

F. Women requesting information on options for the management of an unintended pregnancy must be given non-directive counseling on alternative courses of action and referral upon request.

H. Clients who are found to be not pregnant must be offered information about the availability of contraceptive, or infertility services, depending on the client's wishes. Anticipatory guidance regarding good health practices prior to pregnancy, including avoidance of teratogens should also be provided.

4.9 Adolescent Services

A. Contractors must offer age appropriate information and skilled services to adolescents.

B. Contractors must take steps to assure the adolescent that all information learned during any encounter is confidential information and that every effort will be made to ensure privacy in any encounter or any necessary follow-up contact. (See G. below regarding Duty to Report)

C. Adolescent clients require skilled counseling and detailed information. Program staff should have a comprehensive understanding of the following:
   a. Adolescent growth and development
   b. Psychosocial growth and development
   c. Nutritional needs
   d. Risk and resiliency factors
   e. Communication skills

D. When providing services to adolescents Contractors must:
   a. Inform the adolescent about all methods of contraception
   b. Make every attempt to schedule appointments for them on short notice
   c. Encourage the young person to participate in the full range of medical services
   d. Evaluate the adolescents understanding about the contraceptive method selected

e. Inquire about symptoms and exposure to STI's
f. Encourage examination and treatment either directly or by referral to those at risk for STI's

E. It should not be assumed that all adolescents are sexually active. Many teenagers are seeking assistance in reaching this decision. Abstinence as an option should be discussed.

F. Contractors do not need the consent of parent or guardian for provision of service to minors. Therefore, Contractors must not notify the parent or guardian before or after an adolescent has requested and/or received service. Staff should encourage young clients to involve a parent or guardian in their family planning decisions. Discussion of encouraging family involvement should be documented in the client's medical record.

G. Contractors must be knowledgeable regarding Department of Child Safety (DCS) reporting laws e.g. ARS § 13-3620, "Duty to report abuse, physical injury, neglect and denial or deprivation of medical or surgical care or nourishment of minors..." Contractors are advised to consult with their legal counsel regarding any clarification they may need regarding this and other related statutes. Adolescents seeking services who the staff member believes may meet DCS reporting requirements must be advised prior to any service provision that they will not be refused service but due to their particular circumstance, a report to DCS will need to be filed.

G. Fees for minors seeking services must be based on the income of the minor.

4.10 Sexually Transmitted Infection Screening

A. Contractors must have a process for identification of high-risk behavior for STIs and HIV/AIDS.

B. Appropriate education and preventive measures must be provided to discourage continuation of risk behaviors and to help prevent the client from contracting or spreading an infection.

C. The Contractor must offer Gonorrhea, Syphilis, Chlamydia, and HIV screening for clients and their partners with probable or definite exposure, signs, and symptoms suggesting an infection. The client may also request screening.

D. The Contractor must offer at risk clients either treatment or referral for treatment for clients and partners testing positive for an STI and/or HIV.

E. Contractors must establish a procedure for timely client notification and adequate follow up of all positive results:
a. The procedure must respect the client's request to maintain confidentiality.

b. When initial contact of the client is not successful, a reasonable further effort must be made to notify the client; this shall consist of at least three attempts, one of which is a certified letter.

F. The Contractor must comply with Arizona Administrative Code, Article 2, R9-6-202, Communicable Disease and Infestation Reporting, and any other local reporting requirements.

4.11 Referral and Follow-up

A. Contractors must assure that clients requiring services indicated to be medically necessary but beyond the scope of the Contractor, are referred to other providers for care.

B. Contractors must establish and maintain a comprehensive and current list of available quality health care providers and community resources.

C. The Contractor must assure that:
1. The client is able to follow through with contacting the referred provider; if the client is unable to follow through independently, the Contractor must offer assistance or find support for the client
2. Arrangements are made for the provision of pertinent information regarding client care and services to the referral provider with the prior written consent of the client
3. The client's confidentiality and privacy are always maintained
4. The client is advised of the importance of complying with the referral
5. The client is advised of their responsibility in complying with the referral

D. The Contractor must, whenever possible, give clients a choice of providers from whom to select.

E. The Contractor must have a procedure to prioritize referrals and follow-up. For example:
1. Referrals considered by the clinician to be emergencies should be made immediately
2. Referrals considered by the clinician to be urgent should be followed up with the client within two weeks
3. Referrals considered by the clinician to be important and necessary but not urgent, may be followed up at the discretion of the provider but prior to the next clinic visit
4. Referral requests made by the client and not considered to be urgent or of immediate need may be followed up with the client at the next clinic visit

4.12 Recommended Services

A. Minor Gynecologic Problems:

Contractors may provide for the diagnosis and treatment of minor gynecologic problems so as to avoid fragmentation of services or lack of medical care for clients with these conditions. Problems such as vaginitis or urinary tract infection may be amenable to on-the-spot diagnosis and treatment. More complex procedures may be offered providing the clinician has had the necessary training and has demonstrated proficiency.

B. Genetic Screening and Referral:

Contractors may provide basic counseling to clients who are at risk for transmission of genetic abnormalities. More complete genetic screening and counseling may be offered by referral to a comprehensive genetic service program. If feasible, training in genetics should be arranged to enable Program staff to provide simple genetic screening.

C. Health Promotion and Disease Prevention:

For many clients the family planning program services are their only continuing source of health information and medical care. The Contractor may whenever possible, provide health maintenance services such as screening, immunization, and general health education and counseling directed toward health promotion and disease prevention. These additional services enhance the client's general state of health, and in turn, the health of their families and children. Programs are therefore encouraged to assess the health problems prevalent among the populations they serve, and to develop services or referral mechanisms to address them.

D. Preconception Education and Reproductive Life Planning:

Couples and prospective mothers may receive preconception education from the Contractor to obtain an overview of the responsibilities of pregnancy and parenting. Preconception health helps women think about how their behaviors, lifestyles, and medical conditions affect their ability to live healthy lives and to have healthy children. It gives women the opportunity to be assessed for risks, to be counseled about healthy living and to be offered treatment if needed. The education may include but not be limited to:

1. Fertility awareness/menstrual cycle
2. A review of family genetic history
3. Immunizations (MMR & TDAP)
4. Spacing of children
5. Nutritional needs, including folic acid supplements
6. Effects of medications on maternal health and pregnancy
7. Current contraceptive method, when to stop using it, and the waiting to conceive timeframe
8. Substance use and abuse

E. Intimate Partner Violence and Reproductive Coercion:

Definitions:

a. Birth Control Sabotage: Active interference with contraceptive methods (flushing pills, poking holes in condoms, refusing to wear condoms).
b. Pregnancy Coercion: Threats or acts of violence if the partner does not comply with the perpetrator's wishes to continue or terminate a pregnancy.

Intimate partner violence and coercion have long been linked to negative health outcomes. In 2011, the National Academy of Medicine formerly named the Institute of Medicine, recommended screening patients for current and past domestic and sexual violence as part of basic preventative care.

The Bureau of Women's and Children's Health (BWCH) recognizes the negative impact of domestic and sexual abuse on reproductive health, and funded a program to assist communities in addressing it through Futures Without Violence (formerly the Family Violence Prevention Fund): https://www.futureswithoutviolence.org/. Future Without Violence, along with ACOG created a comprehensive document with guidelines on how to handle intimate partner violence.

In a nationally competitive application process, Arizona was selected to receive funding to implement a statewide public health initiative. Since the spring of 2010, Project Connect Arizona has trained over 300 health care providers on the links between abuse and reproductive health and has worked diligently to make positive changes in policies and procedures related to screening and response to abuse. Please see more on Project Connect Arizona here: https://vsuw.org/what-we- do/fight-for-families/project-connect. Health care providers are in a unique position to assist victims of domestic and sexual violence by providing validation, education, and resources. This simple process can be easily integrated into reproductive health appointments.

Domestic violence and reproductive coercion screening should include, at a minimum, three questions from the following sample screening questions:

1. Has your partner ever messed with your birth control or tried to get you pregnant when you didn't want to be?
2. Does your partner refuse to use condoms when you ask?
3. Has he/she ever tried to force or pressure you to become pregnant when you didn't want to be?
4. Are you afraid your partner will hurt you if you tell him/her you have an STI and he/she needs to be treated?
5. Do you feel controlled or isolated by your partner?
6. Do you feel safe in your current relationship?

4.13 Excluded Services

Programs funded by Title V may not provide abortion services to clients as a method of family planning.

CHAPTER 5: MONTHLY, QUARTERLY AND ANNUAL REPORTS

5.1 Monthly Reports

The contractor must submit a monthly Family Planning Database Report in a format approved by the Bureau of Women's and Children's Health (BWCH).

5.2 Monthly Report Requirements

A. Contractors must have procedures in place to review the completeness, accuracy, integrity, and timely submission of the information required on the Monthly Family Planning Database Report.

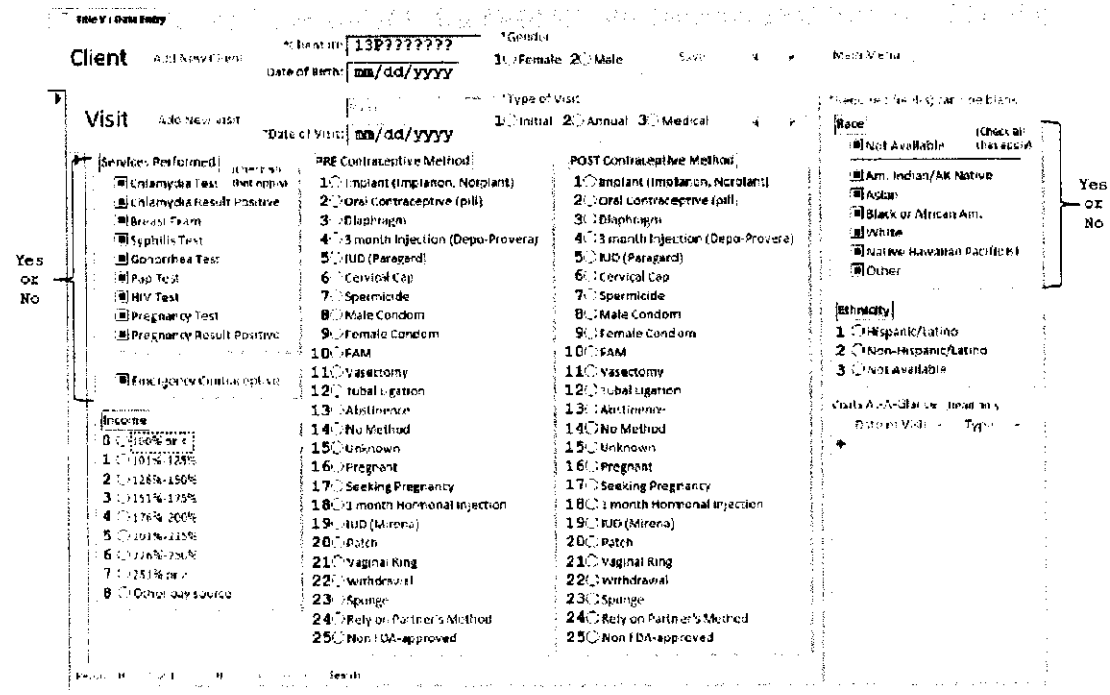
B. Under the HPHC IGA, the Family Planning Contractor's Expenditure Reports (CERs) are due quarterly to the ADHS Family Planning Program manager.

C. Beginning in March 2020, along with submitting the quarterly reports and CERS, Contractors are to also submit the following supporting documents: Certificates of Completion for training and conferences, and conference registration receipts. The ADHS Family Planning Program Manager will access the Family Planning database to verify the services provided are reflective of the narrative in the quarterly reports and document in the ADHS Program Procedure Tool

5.3 Monthly Performance Report Instructions

The Monthly Performance Report form is to be used to document encounters occurring during the calendar month. Documentation will be based on each individual client versus aggregate data. Here is what the Client and Visit key looks like:

Client and Visit - KEY



This document is provided to each Contractor, along with an Excel database document for the data to be listed.

A. Contractor will populate the 3 fields in the header with:
   1. Name of contractor
   2. Month reporting
   3. Date submitted to ADHS Family Planning Program Manager

B. Complete the form as follows for each qualifying Title V funded client:
Client ID number. (Column 1) This is an identification number assigned by the Contractor. No two clients may have the same client identification number. Client ID numbers must not exceed nine characters.

C. Date of visit. (Column 2) Must be recorded as mm/dd/yyyy.

D. Date of birth. (Column 3) Must be recorded as mm/dd/yyyy.

E. Age. (Column 4) This column will self-populate with correct date of visit and date of birth.

F. Type of visit. (Columns 5-7) Visit type #3 Medical captures all visits excluding initial follow-up, complaints, re-pap and/or follow ups, etc. Initial and annual visits will be unduplicated.

G. Gender. (Column 8) Determined by observation or medical records.

H. Race. (Columns 9-13) Based on Federal requirements; race is different than ethnicity.

I. Ethnicity. (Columns 14-15) Ethnicity should be provided through client self- declaration not through observation.

J. Income. (Columns 16-24) Record client's income, following the Federal Poverty Guidelines; update the income as necessary. Family size and monthly income are used to determine eligibility requirements for the Federal Poverty Level (FPL). The FPL is determined by the Federal Office of Management and Budget (OMB) and is revised annually. Contractors must stay current with OMB information regarding the FPL. The FPL was discussed earlier in this manual and the OMG website was provided.

When determining the client's income, the Contractor must:

a. Determine the family size, which is the number of people in the client's household, including spouse, and any other dependents. If the client is less than 18 years of age, do not include parents or siblings. Include only the teen and any children the teen reports
b. If the client is single use the total gross monthly household income (before taxes)
c. If the client is married, use the amount of gross income (before taxes), including any spousal income
d. If the client is a teen, include only the teen's income, not the parent's income
e. If income varies, or is seasonal, use an average of the annual income, i.e., annual income divided by 12 months

K. Services Provided. (Columns 25-33) Select all tests performed and record all positive results.

L. Emergency Contraception. (Column 34)

M. Pre Visit Contraceptive Method: (Columns 35-36) The method a client is using the majority of time prior to the visit. Post Visit Contraceptive Method: The method the client intends to use after the visit. Record both methods when possible using the contraceptive method coding numbers 1 – 26.

5.4 Quarterly Expenditure Report

Per the HPHC IGA, the Contractor shall submit a Quarterly Expenditure Report in a format approved by the Bureau of Women's and Children's Health (BWCH).

5.5 **Quarterly Expenditure Report Requirements**

A. The Quarterly Expenditure Report shall accurately reflect the Contractor's expenditures for each quarter (every three months). For the HPHC IGA, the quarters are: July-September, October-December, January-March, and April-June.

B. The Quarterly Expenditure Report must be submitted to the Program Manager by the 30th of October, January, April, and July.

5.6 **Contractor's Quarterly Expenditure Report Instructions**

A. The Quarterly Expenditure Report form is to be used to document expenditures for Title V Reproductive Health/Family Planning funds only.

B. Complete the form as follows:

1. Contract Number: Write in your contract number
2. Contractor's Name: Write in your agency name
3. Title of Program: Healthy People Healthy Communities IGA
4. Reporting Period Covered: Quarterly Expenditure Reports are submitted after each quarter (every three months) of the year and are to report expenditures occurring during that period. For example, a report submitted for the quarter of January 2010 thru March 2010 would read, Reporting Period From 1/1/10 to 3/31/10.
5. Contractor's Detailed Statement of Expenditures:
   a. Budget: Next to each line item, e.g. Personnel Salaries, Professional and Outside, Travel Expenses, etc. write the dollar amount that was budgeted or planned for in the quarter
   b. Prior Report Period Year to Date Expenditures: This amount is taken from the Total Year to Date Expenditures from the Contractor's Quarterly Expenditure Report from the previous quarter
   c. Current Reporting Period Expenditures: Write the actual expenditures for each line item for the quarter
   d. Total Year to Date Expenditures: Add the dollar amount in the Prior Report Period Year to Date Expenditures and the amount in the Current Reporting Period Expenditures. This amount is equal to the Total Year to Date Expenditures
6. Signature of Authorized Person: The authorized person that completed or reviewed the report must sign and date the report

5.7 **BWCH Program Manager's Role in Quarterly Expenditure Report Review**

A. The Program Manager in BWCH will review all Quarterly Expenditure Reports when received and will compare expenditures budgeted for the quarter, actual expenditures, and contracted amounts.

B. The Contractor will be contacted to discuss any discrepancies found or for any expenditure concerns.

C. If there are expenditure concerns, the Program Manager in BWCH and the Contractor will agree to a resolution.

5.8 **Annual Report**

The Contractor shall prepare an annual report that will summarize program activities.

5.9 **Annual Report Requirements**

A. The Annual Report must be submitted within 45 days of the end of the contract year..

B. A blank Annual Report template is provided to all County Contractors that are participating in the HPHC IGA.

CHAPTER 6: BILLING

6.1 Contractor Reimbursement and Contractor's Expenditure Report (CER)

Contractor reimbursement provisions and methods are specified in the Contractor's written contract agreement with the Arizona Department of Health Services. Reimbursement for services and any other program expenditures are made in accordance with these contract specifications, and upon approval of BWCH Program Manager.

The CER is a multi-purpose form for use by agencies that have a Negotiated Service Contract with the Arizona Department of Health Services. The CER must be completed, signed by an authorized person, and e-mailed to the Program Manager. It is the responsibility of the Chief Executive Officer/Health Officer/Authorized Signer of the reporting agency to insure valid representation of the agency's expenditures or units reported on Fixed Rate Contracts. Once satisfied, this person must sign and date the report.

6.2 Submission Requirements

Per the contractual language within the HPHC IGA, the contractor must submit a complete and accurate (CER) and narrative report (including all programs within the HPHC IGA), quarterly to the HPHC IGA Program Manager for payment for contracted services provided. For Family Planning specifically, the Contractor must submit the Family Planning Database Report for the ADHS Family Planning Program Manager by the 15th of each month. The CERs will be submitted with the other programs within the HPHC IGA quarterly. If there is an unavoidable delay in submission of any part of the report, the Contractor must notify the ADHS Family Planning Program Manager in a timely fashion.

6.3 Submission Location

Contractors are to submit the quarterly CER, supporting documentation, and the monthly Family Planning Database Reports to:

Physical Mail:

Attention: Family Planning Program Manager
Arizona Department of Health Services
Bureau of Women's and Children's Health
50 N. 18th Avenue, Suite 320
Phoenix, Arizona 85007-3242
Office Number: 602-364-3124
Preferably e-mail: alison.lucas@azdhs.gov

6.4 BWCH Program Manager's Role in CER Approval

A. The BWCH Program Manager will review the CER and supporting documents for errors, or omissions

B. The Contractor will be contacted to discuss any discrepancies found.

C. CER's not meeting specification may either be amended by the Contractor or by the BWCH Program Manager. If the CER is amended by the BWCH Program Manager, a copy of the amended document will be sent to the Contractor for their records.

D. Partial or no payment of CER's submitted may be authorized by the Program Manager when:
   1. Deliverables are billed but not submitted
   2. Insufficient funds exist to fully reimburse the Contractor for services provided
   3. Reports and FP databases are blank or if they are not properly filled out (i.e. missing information, data, etc.)

E. Once the BWCH Program Manager approves the CER, it will be forwarded for payment.

6.5 Supporting Documentation

The Contractor must maintain adequate supporting documentation to verify that units of service billed match units of service provided, and to verify that services were provided to eligible clients.

7.1 Annual Review

All Contractors shall have at least one compliance-based site visit at least every two years. This site visit is also referred to as the site review.

7.2 Multiple Sites

To the extent practical, annual reviews will include a visit to all Contractor site locations, if the Contractor is providing services at multiple sites.

7.3 Consultative Site Visit

In addition to the site review, additional consultative site visits will be conducted if Contractor performance or other circumstances deem it necessary.

7.4 Purpose of the Site Review:

A. Compliance-based site visits are provided to ensure that services were delivered pursuant to the terms and conditions of the contract and in accordance with the Reproductive Health/Family Planning Program Policy and Procedure Manual.

B. Other purposes for annual review include but are not limited to:
   1. Evaluation of State and Community Resource Utilization
   2. Investigation of areas in question
   3. Identification of strengths and accomplishments
   4. Identification of weaknesses or areas of needed focus
   5. Providing consultation and technical assistance
   6. Facilitation of communication between the Contractor and BWCH
   7. Follow-up on previous site visit findings

7.5 Review Guidelines

The review, which will take place at least every two years, will be conducted in accordance with the following guidelines:

A. Contractor Notification:
   1. The ADHS Family Planning Program Manager will notify the Contractor of the scheduling of annual review site visits.
   2. The ADHS Family Planning Program Manager will send an email to the Contractor which will:
      a. Confirm the date and the time of the visit
      b. Review the purpose of the visit
      c. Identify the reviewer
      d. Discuss activities to expect as part of the review process
      e. Provide the Contractor with a copy of the site review monitoring tool(s)
   3. The visit with the Contractor will be scheduled a minimum of 30 days in advance of the review. The reviewer will work with the Contractor as much as

possible to assist in minimizing interruptions to the staff's normal workload during the course of the review.

B. Review Process
   1. Contractors and Sub-contractors must cooperate fully with the reviewer during the review process by making records and information available, allowing interviews, and providing a tour of the facilities
   2. The reviewer will hold an entrance interview to obtain a current overview of clinic operations, clarify the review process, meet staff, answer any questions, and discuss completion of corrective action from any past review
   3. Examples of activities included in site visits may include, but are not limited to:
      a. Review of Contractor Documentation
         i. Any materials to be distributed to clients
         ii. Medical records
         iii. Management reports
         iv. Job descriptions, personnel files, etc.
      b. Meeting with or interviewing program personnel to discuss program successes and potential problems
      c. Work unit observation
   4. Exit Conference: The reviewer will provide feedback to the Contractor regarding preliminary findings, the Contractors will have the opportunity to clarify and provide any input they deem necessary

7.6 **Annual Review Draft Report**

A. The Program Manager will write findings in a draft report and e-mail the draft with a cover letter to the Contractor for review and comment. The cover letter will include instructions for review of the draft report. The Contractor must respond to the draft report within fourteen (14) days of receipt.

B. The ADHS Family Planning Program Manager will be available to provide technical assistance as needed.

7.7 **Annual Review Final Report and Corrective Action**

A. Within (5) five days of receipt and review of the Contractor's comments, the Program Manager will prepare a final report. The final report will identify areas of strength and a request for a written plan of corrective action, if required. The final report will be sent with a cover letter that will include instructions for completion of the written plan of correction.

B. The Contractor will prepare the plan of corrective action addressing each finding included in the current year's annual review. This plan must be returned within 14 days of receipt of the final report.

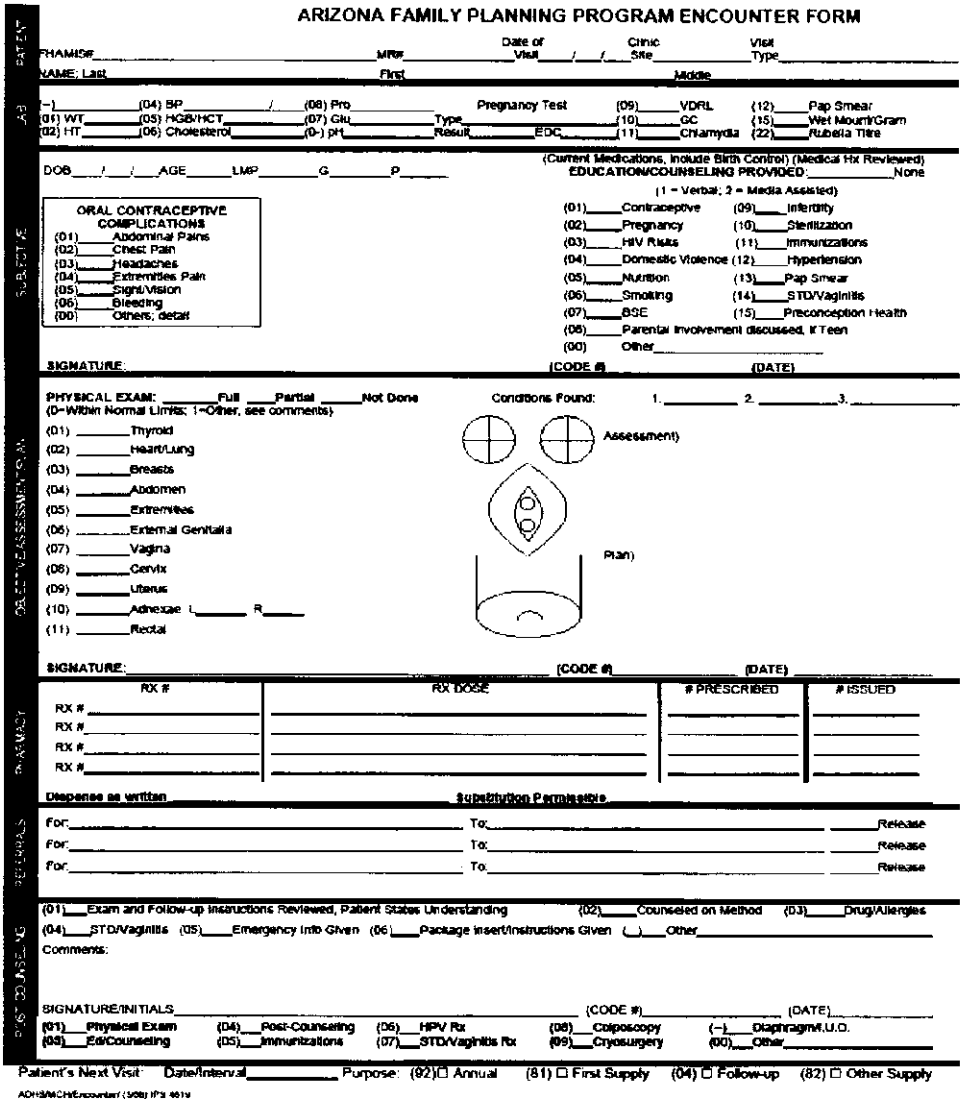
C. Once the written plan of corrective action has been reviewed and approved by the Program Manager, it will be included as part of the final report

D. The final report will be maintained in the Program files for future review.

7.8 **Failure to Comply**

Concerns of compliance failure or major contract performance issues will be reported to the Procurement Administrator. The Procurement Administrator will notify the Contractor within (7) seven days of receipt of the concern regarding further recourse.

CHAPTER 8: APPENDICES AND OPTIONAL DOCUMENTS



ARIZONA FAMILY PLANNING PROGRAM ENCOUNTER FORM

PATIENT

FNAME/SF _____ MR# _____ Date of Visit ___/___/___ Clinic Site _____ Visit Type _____

NAME: Last _____ First _____ Middle _____

LAB

(–) _____ (04) BP _____/_____ (08) Pro _____ Pregnancy Test (09) _____ VDRL (12) _____ Pap Smear
(01) WT _____ (05) HGB/HCT _____ (07) Glu _____ Type _____ (10) _____ GC (15) _____ Wet Mount/Gram
(02) HT _____ (06) Cholesterol _____ (0-) pH _____ Result _____ EDC _____ (11) _____ Chlamydia (22) _____ Rubella Titre

SUBJECTIVE

DOB ___/___/___ AGE _____ LMP _____ G _____ P _____

(Current Medications, Include Birth Control) (Medical Hx Reviewed)
EDUCATION/COUNSELING PROVIDED: _____ None
(1 = Verbal; 2 = Media Assisted)

ORAL CONTRACEPTIVE COMPLICATIONS
(01) _____ Abdominal Pains
(02) _____ Chest Pain
(03) _____ Headaches
(04) _____ Extremities Pain
(05) _____ Sight/Vision
(06) _____ Bleeding
(00) Others; detail

(01) _____ Contraceptive (09) _____ Infertility
(02) _____ Pregnancy (10) _____ Sterilization
(03) _____ HIV Risks (11) _____ Immunizations
(04) _____ Domestic Violence (12) _____ Hypertension
(05) _____ Nutrition (13) _____ Pap Smear
(06) _____ Smoking (14) _____ STD/Vaginitis
(07) _____ BSE (15) _____ Preconception Health
(08) _____ Parental Involvement discussed, if Teen
(00) Other _____

SIGNATURE: _____ (CODE #) _____ (DATE) _____

OBJECTIVE/ASSESSMENT/PLAN

PHYSICAL EXAM: _____ Full _____ Partial _____ Not Done
(0=Within Normal Limits; 1=Other, see comments)
(01) _____ Thyroid
(02) _____ Heart/Lung
(03) _____ Breasts
(04) _____ Abdomen
(05) _____ Extremities
(06) _____ External Genitalia
(07) _____ Vagina
(08) _____ Cervix
(09) _____ Uterus
(10) _____ Adnexae L _____ R _____
(11) _____ Rectal

Conditions Found: 1. _____ 2. _____ 3. _____

Assessment)

Plan)

SIGNATURE: _____ (CODE #) _____ (DATE) _____

PHARMACY

RX #	RX DOSE	# PRESCRIBED	# ISSUED
RX #			
RX #			
RX #			
RX #			

Dispense as written _____ Substitution Permissible

REFERRALS

For: _____ To: _____ _____ Release
For: _____ To: _____ _____ Release
For: _____ To: _____ _____ Release

PATIENT COUNSELING

(01) _____ Exam and Follow-up Instructions Reviewed, Patient States Understanding (02) _____ Counseled on Method (03) _____ Drug/Allergies
(04) _____ STD/Vaginitis (05) _____ Emergency Info Given (06) _____ Package Insert/Instructions Given (_) _____ Other _____
Comments:

SIGNATURE/INITIALS _____ (CODE #) _____ (DATE) _____

(01) _____ Physical Exam (04) _____ Post-Counseling (06) _____ HPV Rx (08) _____ Colposcopy (–) _____ Diaphragm/I.U.D.
(03) _____ Ed/Counseling (05) _____ Immunizations (07) _____ STD/Vaginitis Rx (09) _____ Cryosurgery (00) _____ Other _____

Patient's Next Visit: Date/Interval _____ Purpose: (92) ☐ Annual (81) ☐ First Supply (04) ☐ Follow-up (82) ☐ Other Supply

ADHS/MCH/Encounter/ (5/08) IPS 4619

Add in County Name

ARIZONA FAMILY PLANNING PROGRAM CLIENT MEDICAL HISTORY

NAME _____ DOB _____

Date of visit _____ (YR1) Date Updated (YR 2) _____ Date Updated (YR 3) _____

Allergies _____ Smoking _____ # of Cigs per day _____

Current Medications _____

Date and detail all positive comments 0 = within Normal Limits 1 = Other; See Detail

YR 1	YR 2	YR 3	
___	___	___	SKIN (Rashes, Lumps, Sores) _____
___	___	___	HEAD (HA's, Migraines, Seizures) _____
___	___	___	EYES (Glasses/Contacts, Visual Disturb) _____
___	___	___	EARS (Hearing Disturb, Pain, Infection) _____
___	___	___	NOSE, SINUS (Freq Colds, Hay Fever) _____
___	___	___	MOUTH/THROAT (Sores, Pain) _____
___	___	___	NECK (Lumps, Swollen Glands, Pain) _____
___	___	___	BREASTS (BSE, Pain, Lumps, Discharge) _____
___	___	___	RESPIRATION (Asthma, TB, Infection) _____
___	___	___	CARDIAC (Hypertension, Heart Disease, High Cholesterol) _____
___	___	___	GASTRO-INTESTINAL (Digestive upsets, bowel problems, Liver/ gallbladder disease) _____
___	___	___	URINARY (UTI's, Urinary Disorders) _____
___	___	___	REPRODUCTIVE (PID, STD, Vag. Inf., DES, Abn Pap) _____
___	___	___	MUSCULOSKELETAL (Pains, Cramps) _____
___	___	___	PERIPHERAL VASCULAR (Thrombophlebitis, Varicose veins) _____
___	___	___	NEUROLOGIC (Seizures, Fainting, Numbness, Tingling) _____
___	___	___	PSYCHIATRIC (Nervousness, depression) _____
___	___	___	ENDOCRINE (Diabetes, Thyroid disorders) _____
___	___	___	HEMATOLOGIC (Anemia, Bruising/Bleeding, Clotting disorders) _____
___	___	___	CANCER _____
___	___	___	OPERATIONS/HOSPITALIZATIONS/INJURIES _____
___	___	___	IMMUNIZATIONS _____
___	___	___	SEX HISTORY _____

FAMILY HISTORY

F = Father M = Mother PGM = Paternal Grandmother PGF = Paternal Grandfather MGM = Maternal Grandmother S = Sister B = Brother

___ Diabetes ___ Cholesterol ___ Heart Disease ___ Stroke ___ Hypertension

___ Cancer Type & REL _____

___ OTHER ___ SPECIFY _____

Signature (CODE) Date

Signature (CODE) Date

Signature (CODE) Date

El Cliente Del Programa De La Planificacion De La Familia De Arizona La Historia Medica

Nombre_____ La Fecha Del Nacimiento_____

Fecha (YR 1) _____ Fecha Actualizado (YR 2) _____ Fecha Actualizado (YR 3) _____

Alergias a Medicinas_____ Fumar_____ Mumere por Dia_____

Medicinas Actuales_____

Fecha y Detalla Todos Comentarios Positivos:	0=Dentro de Limites Normales	1=Otro, ve Detalle

YR 1	YR2	YR 3	
___	___	___	Pele (sarpullidos, amontonan, Lagas) _____
___	___	___	Dirija (dolores cabeza, migranas, ataquees) _____
___	___	___	Ojos (gafas, contactos, alborotos visuales) _____
___	___	___	Oreyas (oyendo alborotos, dolor, infecciones) _____
___	___	___	Nariz Seno (frecuenta los rnos, polinosis) _____
___	___	___	La Boca Garganta (llagas, el dolor) _____
___	___	___	El Cuello (amontona, glandulas hinchadas, paing) _____
___	___	___	Los Senos (auto examen mensual, dolor, amontona, descarga) _____
___	___	___	Respiratior (asma TB infecciones) _____
	___	___	Cardiaco (hipertension, enfermedad cardiaca, cholestarol alto) _____
___	___	___	Gastro-Intestinal (contratiempo digestivo, problemas intestineos, higado vesicula biliar_____
___	___	___	Urinario (las infecciones, desordenes) _____
___	___	___	Reproductor (enfermedad inciatante pelvica, ETS, infecciones vaginales, manchas anormales de papila _____
___	___	___	Musculoesqueletico (dolor, obstaculizando) _____
___	___	___	Periferico Vacular (thrombophlebitis, venas varicosis) _____
___	___	___	Neurologico (ataquees, desmayar, entumecimiento, sintiendo hormagueo) _____
___	___	___	Psiquiatrico (nerviosismo, depresion) _____
___	___	___	El Endocrino (diabetes, desordenes de tiroides) _____
___	___	___	Hemarologic (anemia, magullar, sangrar, coagulando _____
___	___	___	Cancer_____
___	___	___	Operaciones, Hospitalizaciones, Las Heridas_____
___	___	___	Inmunizaciones_____
___	___	___	Historia Del Sexo (a edad llego a ser activa/numero de socios) _____

Los Comentarios (fecha pr favor todo comenta)

HISTORIA DE LA FAMILIA

F = Padre M = Madre PGM = Abuela Paternal PGF = Abuelo Paternal
MGM = Abuela Materna MGF = Abuelo Paternal S = Hermana B = Hermano

_____ Diabetes _____ Cholesterol _____ Enfermedad Cardiaca _____ Stroke _____ Hipertension

_____ Cancer (maquina y el pariente) _____

_____ Otro (especifique)_____

Firma _____ Fecha _____

Firma _____ Fecha _____

Firma _____ Fecha _____

ARIZONA DEPARTMENT OF HEALTH SERVICES - FAMILY PLANNING PROGRAM CLIENT REGISTRATION FORM - **ALL INFORMATION IS CONFIDENTIAL**

Date of Visit:____/_____/_____Social Security Number_____/____/_____Clinic Site:

Personal Data: Please provide the following information.

Last Name:_____First_____Middle Initial_____Birth Date:__/__/__

Sex:	Marital Status:	Race:	Are you of Hispanic origin such as Mexican American, Latin American, Puerto Rican or Cuban?	Primary Language:	Years of Education Completed:
(___) Female (F) (___) Male (M)	(___) Never Married (N) (___) Married (M) (___) Divorced (D) (___) Living Together (L) (___) Separated (S) (___) Widowed (W)	(___) Asian (A) (___) Black (B) (___) White (W) (___) Other (O) (___) Native American (I) Tribe:_____	(___) Yes (H) (___) No	(___) English (01) (___) Spanish (02) (___) Other___	_____

Maiden Name:_____Mother's Maiden Name: ____

Residential Address:_____APT#___CITY_____ZIP_____

Mailing Address:_____APT#____CITY_____ZIP_____

Home #:(_____)_____Work #:(_____)_____Cell Phone #:(_)____

Check all the ways we may contact you for Follow-up:
___Mail only____Home Phone _____Work Phone____Cell Phone____Mail or Phone

Special Instructions/Other:_____

In case of EMERGENCY: Phone # (___)_____Relationship:_____NAME (Last, First)_____

What is your PRIMARY work status? (please check one)

_____Unemployed_____Working Full-Time__Working Part-Time_____Student Are you a:____

Seasonal Worker_____Migrant Worker ____Not Seasonal or Migrant Worker

Have you seen a doctor in the last 3 months?____Yes _____No If yes, why?_____

Who do you usually go to for health care? (_____) Doctor (_) Clinic (_____) Other (_) None Name:_____

If you are single, what is **your total monthly** income before taxes: OR
If you are married, what is **your total combined monthly income** before taxes: $___per month Number of people (including yourself) who are supported by this income: _____

How many children have you given birth to? (Parity)_____

FOR CLINIC USE ONLY		
FEDERAL GUIDELINE %_____	FEE SCALE: ___ No Fee__Partial Fee__Full	ASSIGNED SOURCE OF PAYMENT: ___ Title V ___Title XX ___Private Insurance ___ Title X ___AHCCCS ___Self ___ Other:_____ Authorization:_____

Are you enrolled in AHCCCS? Yes:___AHCCCS ID #: _____ No:_____

Do you ANY have Health Insurance? Yes___No_____
If Yes, does the insurance cover Family Planning services? Yes:__No:_____

How did you hear about this Clinic?____Friend ____Family Member _____Flyer/Pamphlet
_____ TV/Radio/Newspaper _____Referred by other agency
_____I am a regular patient

HIPPA / Patient Rights

ACKNOWLEDGEMENT

I acknowledge that I have been given the opportunity to view or receive a copy of the notice of Health Information Practices describing how medical information may be used and disclosed under the Health Insurance portability and Accountability Act (HIPAA), as well as a copy of Patient Rights.

_____ _____

Name **Date**

_____

Signature

ADVANCE DIRECTIVES
(LIVING WILL OR POWER OF ATTORNEY)

IF you have an advanced directive you may provide us with a copy.
If you do not, we can give you information on how you can obtain one.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

____ I have an **ADVANCE DIRECTIVE (Living Will or Power of Attorney)** for health care.

____ I do not have an **ADVANCE DIRECTIVE (Living will or Power of Attorney)** for health care.

____ I would like to have information on obtaining an Advanced Directive.

Witness/Staff Signature _____

HIPPA RECONOCIMIENTO

Yo reconozco que se me ha dado la oportunidad de ver o recibir una copia del aviso de Prácticas de Información de Salud que describe cómo su información médica puede ser utilizada y divulgada en virtud de la Ley de portabilidad y Responsabilidad de Seguros Médicos (HIPAA), igualmente copia de los derechos de paciente.

_____ _____

Nombre **Fecha**

_____ _____

Firma

LAS INSTRUCCIONES POR ADELANTADO (TESTAMENTO)

Si tiene una directiva avanzada puede proporcionarnos una copia.
Si no, podemos darle información sobre cómo puede obtener uno.

POR FAVOR MARQUE UNA DE LAS SIGUIENTES AFIRMACIONES:

_____ YO tener una directriz anticipada (Testamento) para el cuidado de la salud.

_____ No tengo una directriz anticipada (Testamento) para el cuidado de la salud.

_____ ME gustaría tener información sobre la obtención de una Directiva Avanzada.

DOMESTIC/SEXUAL VIOLENCE SCREENING FORM

Completing this form is voluntary. You do not have to fill out this form to receive services. Anything you disclose, including your relationship with the person, who has abused you, will be kept confidential, with the exception of child abuse and neglect.

You may complete this form and request counseling services regardless of your gender, sexual orientation, or marital status. You do not have to have children or have left the abusive situation. You are not required to provide any information or details about the abusive situation to anyone before you are referred to see a counselor.

Are you in danger of a family member, your partner, or ex-partner doing any of the following to you?:

- Hitting, slapping, kicking, choking, or in any way hurting you physically?
- Isolating you, making you feel like a prisoner, or controlling what you can do?
- Threatening to harm you, your children, or someone close to you?
- Stalking you, following you, or checking up on you?
- Shaming or belittling you, constantly putting you down, or telling you that you are worthless?
- Forcing you to have sex, or into sexual acts that you do not want to participate in?
- Making you feel afraid?

_____**YES**: I would like to meet with a domestic/sexual violence case worker to discuss my situation.

_____**YES**: But I do not want to meet with anyone at this time.

_____**NO:** None of the situations described above apply to me or I do not wish to answer these questions at this time.

In signing this form I affirm that the information above is correct.

Signature: _____

Revised 03/10/2020

VOLUNTARY CONSENT FORM

I voluntarily agree to receive Family Planning services from the Graham County Health Department, and further state that I have not been coerced, forced, threatened with physical violence, or otherwise received any undue influence to compel me to receive these services.

I understand that as a part of the overall services, I may be expected to have a physical exam, as well as a Pap smear if deemed necessary by the medical provider. These services will be conducted either by clinicians on contract with, or staff of, the Graham County Health Department. I also agree to participate in any administrative or consultation process that may be necessary to provide the identified services.

I understand that Graham County Health Department provides a teaching environment to students in the health care field. If I have any questions or concerns about this I will speak to a nurse.

I understand that family planning services are available to all females aged 14 years or older regardless of marital status, sexual orientation, religious affiliation, race, ethnicity, or national origin. If I feel I have been discriminated against by any contractor or staff member of the Graham County Health Department I will speak with the Health Director.

I have received and read my Patient Bill of Rights.

I have read the above information and hereby consent to and authorize the staff and contracted clinicians of the Graham County Health Department to conduct the identified Family Planning services.

_____ _____

Signature of Client Date

_____ _____

Signature of Witness Date

Please Note: This is an example of language that can be used.

FORMULARIO DE CONSENTIMIENTO VOLUNTARIO

Estoy de acuerdo voluntariamente recibir servicios de planificación familiar del Departamento de salud del Condado_____y más estado que yo he no sido coaccionado, obligado, amenazados con violencia física, o de lo contrario recibe cualquier influencia indebida para obligarme a recibir estos servicios.

Entiendo que como parte de los servicios generales se espera tener un examen físico, así como una prueba de Papanicolaou o sangre dibuja si se considera necesario por el médico. Estos servicios se llevará a cabo por los médicos por contrato con, o de personal, el Departamento de salud del Condado. También estoy de acuerdo en participar en alguna administrativo o proceso de consultas que sea necesaria para proveer los servicios identificados.

Entiendo que_____Graham Departamento de Salud proporciona un entorno de enseñanza a los estudiantes en el campo de la salud. Si tengo alguna pregunta o inquietud acerca de esto voy a hablar con una enfermera.

Entiendo que servicios de planificación familiar están disponibles para todas las mujeres de 14 años de edad o mayores independientemente del estado civil, orientación sexual, afiliación religiosa, raza, etnia o nacionalidad de origen. Si siento que he sido discriminado por cualquier contratista o miembro del personal del Departamento de salud del Condado voy a hablar con el Director de salud.

Haber leído la información anterior y por la presente consiente y autorizar al personal y los médicos contratados del Departamento de salud del Condado para llevar a cabo los servicios de planificación familiar identificados.

_____ _____

Firma del cliente fecha

_____ _____

Firma del testigo fecha

Optional Documents

Electronic copies of the following documents will be shared with each County: Consent for Birth

Control Patch
Consent for Birth Control Ring
Consent for Depo-Provera Consent for
NuvaRing
Consent for Oral Contraceptive ECP
Informed Consent

	INTERGOVERNMENTAL AGREEMENT (IGA) AMENDMENT	**ARIZONA DEPARTMENT OF HEALTH SERVICES** 150 18th Ave Suite 530 Phoenix, Arizona 85007
	CONTRACT NO.: CTR055262 / **IGA AMENDMENT NO: 4**	**PROCUREMENT OFFICER** **Ryan Garcia**

Title V Maternal and Child Health Healthy Arizona Families

It is mutually agreed that the Intergovernmental Agreement (IGA) referenced in this Amendment Four (4) is amended as follows:

1. Pursuant to the Terms and Conditions, Provision Six (6), Contract Changes, Section 6.1, Amendments, Purchase Orders and Change Orders, the Agreement is amended as follows:

   1.1. The Price Sheet is revised and replaced.

ALL CHANGES ARE IDENTIFIED BELOW IN RED

ALL OTHER PROVISIONS OF THIS AGREEMENT REMAIN UNCHANGED

Pinal County

Contractor Name:

PO Box 2945

Address:

Florence	**Arizona**	**85132**
City	State	Zip

Authorized Signature

Print Name

Title

Pursuant to A.R.S. § 11-952, the undersigned public agency attorney has determined that this Intergovernmental Agreement is in proper form and is within the powers and authority granted under the laws of Arizona

Signature Date

Print Name

This Intergovernmental Agreement Amendment shall be effective the date indicated. The Public Agency is hereby cautioned not to commence any billable work or provide any material, service or construction under this IGA until the IGA has been executed by an authorized ADHS signatory.

State of Arizona

Signed this . day of . 2024.

Procurement Officer

Contract No.: **CTR055262**, which is an Agreement between public agencies, has been reviewed pursuant to A.R.S. § 11-952 by the undersigned Assistant Attorney, who has determined that it is in proper form and is within the powers and authority granted under the laws of the State of Arizona.

Signature Date

Assistant Attorney General

Print Name

PRICE SHEET

Program: MCH Healthy Arizona Families
Federal Funding: Title V Maternal and Child Health Services Block Grant

ACCOUNT CLASSIFICATION	AMOUNT
Personnel	$82,764.00
ERE	$26,485.00
Professional & Outside Services	$15,000.00
Travel	$2,013.00
Occupancy	$0.00
Other Operating	$14,924.00
Capital Outlay	$0.00
Indirect (if authorized)	$10,925.00
TOTAL (annual amount not to exceed)	**$152,111.00**

Program: Public Health Improvement (PHI) Program
Federal Funding: Preventive Health and Health Services Block Grant

ACCOUNT CLASSIFICATION	AMOUNT
Personnel	$0.00
ERE	$0.00
Professional & Outside Services	$70,000.00
Travel	$0.00
Occupancy	$0.00
Other Operating	$4,268.00
Capital Outlay	$0.00
Indirect (if authorized)	$0.00
TOTAL (annual amount not to exceed)	**$74,268.00**

With prior written approval from the Program Manager, the Contractor is authorized to transfer up to a maximum of twenty-five percent (25%) of the total budget amount between funded line items. Transfers of funds are only allowed between funded line items. Transfers exceeding twenty-five percent (25%) or to a non-funded line item shall require an amendment.

PINAL COUNTY
WIDE OPEN OPPORTUNITY

AGENDA ITEM

May 15, 2024 ADMINISTRATION BUILDING A
FLORENCE, ARIZONA

REQUESTED BY:

Funds #: 82

Dept. #: 359

Dept. Name: Public Health

Director: Merissa Mendoza

BRIEF DESCRIPTION OF AGENDA ITEM AND REQUESTED BOARD ACTION:

Discussion/approval/disapproval of Award Agreement No. CTR070160 under the Overdose Data To Action grant between the Arizona Department of Health Services and the Pinal County Health Services District through the Pinal County Board of Supervisors beginning January 1, 2024, ending December 31, 2029, for $80,000 annually. This grant will be used by the department to enhance capacity to address the opioid epidemic through prevention-based strategies, develop and maintain public safety partnerships, increase linkages to care, and increase access to overdose prevention and reversal tools. This funding was included in the FY 24/25 budget development for the Public Health Services District and will have no impact on the General Fund. (Jan Vidimos/Merissa Mendoza)

BRIEF DESCRIPTION OF THE FISCAL CONSIDERATIONS AND/OR EXPECTED FISCAL IMPACT OF THIS AGENDA ITEM:

This funding was included in the FY24/25 budget development for the Public Health Services District and will have no impact on the General Fund.

BRIEF DESCRIPTION OF THE EXPECTED PERFORMANCE IMPACT OF THIS AGENDA ITEM:

This grant will be used by the department to enhance capacity to address the opioid epidemic through prevention-based strategies, develop and maintain public safety partnerships, increase linkages to care, and increase access to overdose prevention and reversal tools.

MOTION:

Approve as presented.

History

Time	Who	Approval
5/3/2024 1:00 PM	County Attorney	Yes
5/6/2024 8:19 AM	Grants/Hearings	Yes
5/6/2024 10:27 AM	Budget Office	Yes
5/8/2024 12:00 PM	County Manager	Yes

5/8/2024 12:01 PM	Clerk of the Board	Yes

ATTACHMENTS:
Click to download
Grant Request
Contract

PINAL COUNTY
WIDE OPEN OPPORTUNITY

Board of Supervisors Grant Request

Board of Supervisors meeting date: _____

Department seeking grant: _____

Name of Granting Agency: _____

Name of Grant Program: _____

Project Name: _____

Amount requested: _____

Match amount, if applicable: _____

Application due date: _____

Anticipated award date/fiscal year: _____

What strategic priority/goal does this project address?: _____

Applicable Supervisor District: _____

Brief description of project:

Approval received per Policy 8.20: _____ OnBase Grant #: _____

Please select one:

- Discussion/Approve/Disapproval consent item _____
- New item requiring discussion/action _____
- Public Hearing required _____

Please select all that apply:

- Request to submit the application _____
- Retroactive approval to submit _____
- Resolution required _____
- Request to accept the award _____
- Request to approve/sign an agreement _____
- Budget Amendment required _____
- Program/Project update and information _____

INTERGOVERNMENTAL AGREEMENT (IGA)

Contract No. CTR070160

ARIZONA DEPARTMENT OF HEALTH SERVICES
150 North 18th Avenue, Suite 530
Phoenix, Arizona 85007

Procurement Officer
Stacy Buske

Project Title: **CDC Overdose Data to Action - OD2A-S Pinal County**

Begin Date: **January 1st, 2024**

Geographic Service Area: **State of Arizona**

Termination Date: **December 31st, 2029**

Arizona Department of Health Services has authority to contract for services specified herein in accordance with A.R.S. §§ 11-951, 11-952, 36-104 and 36-132. The Contractor represents that it has authority to contract for the performance of the services provided herein pursuant to:

x	**Counties: A.R.S. §§ 11-201, 11-951, 11-952 and 36-182.**
	Indian Tribes: A.R.S. §§ 11-951, 11-952 and the rules and sovereign authority of the contracting Indian Nation.
	School Districts: A.R.S. §§ 11-951, 11-952, and 15-342.
	City of Phoenix: Chapter II, §§ 1 & 2, Charter, City of Phoenix.
	City of Tempe: Chapter 1, Article 1, §§ 1.01 & 1.03, Charter, City of Tempe.

Amendments signed by each of the parties and attached hereto are hereby adopted by reference as a part of this Contract, from the effective date of the Amendment, as if fully set out herein.

Arizona Transaction (Sales) Privilege: _____

Federal Employer Identification No.: _____

Tax License No.: _____

Contractor Name: **Pinal County Arizona Public Health Services District**
Address: **PO BOX 1348; Florence, AZ 85132**

FOR CLARIFICATION, CONTACT:

Name: _____

Phone: _____

FAX No: _____

E-mail: _____

CONTRACTOR SIGNATURE:
The Contractor agrees to perform all the services set forth in the Agreement and Work Statement.

Signature of Person Authorized to Sign Date

Print Name and Title

This Contract shall henceforth be referred to as Contract No. CTR070160
The Contractor is hereby cautioned not to commence any billable work or provide any material, service or construction under this Contract until Contractor receives a fully executed copy of the Contract.

State of Arizona

Signed this _____ day of _____, 202_

Procurement Officer

CONTRACTOR ATTORNEY SIGNATURE:
Pursuant to A.R.S. § 11-952, the undersigned Contractor's Attorney has determined that this Intergovernmental Agreement is in proper form and is within the powers and authority granted under the laws of Arizona.

Signature of Person Authorized to Sign Date

Print Name and Title

Contract, No. CTR070160, is an Agreement between public agencies, has been reviewed pursuant to A.R.S. § 11-952 by the undersigned Assistant Attorney General, who has determined that it is in the proper form and is within the powers granted under the laws of the State of Arizona to those parties to the Agreement represented by the Attorney General.
The Attorney General, BY:

Signature **Date**

Assistant Attorney General:

1. Definition of Terms

As used in this Contract, the terms listed below are defined as follows:

1.1. As used in this Contract, the terms listed below are defined as follows:

1.2. “Attachment” means any item in the Contract which requires the Contractor to submit as part of the Offer.

1.3. “Contract” means the combination of the Contract documents, including the Terms and Conditions, and the Specifications and Statement or Scope of Work; and any Contract Amendments.

1.4. "Contract Amendment" means a written document signed by the Procurement Officer that is issued for the purpose of making changes to the Contract.

1.5. “Contractor” means any person who has a Contract with the State.

1.6. “Data” means recorded information, regardless of form or the media on which it may be recorded. The term may include technical data and computer software. The term does not include information incidental to contract administration, such as financial, administrative, cost or pricing, or management information.

1.7. “Days” means calendar days unless otherwise specified.

1.8. “Exhibit” means any item labeled as an Exhibit in the Contract generally containing maps, schematics, examples of reports, or other documents that will be used to perform the requirements of the Scope of Work after contract award.

1.9. “Gratuity” means a payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value is received.

1.10. “Materials” means all property, including equipment, supplies, printing, insurance, and leases of property but does not include land, a permanent interest in land or real property or leasing space.

1.11. “Procurement Officer” means the person, or his or her designee, duly authorized by the State to enter into and administer Contracts and make written determinations with respect to the Contract.

1.12. “Services” means the furnishing of labor, time or effort by a Contractor or Subcontractor which does not involve the delivery of a specific end product other than required reports and performance but does not include employment agreements or collective bargaining agreements.

1.13. “State” means any department, commission, council, board, bureau, committee, institution, agency, government corporation or other establishment or official of the executive branch or corporation commission of the State of Arizona that executes the Contract.

1.14. “State Fiscal Year” means the period beginning with July 1st and ending June 30th.

1.15. “Subcontract” means any Contract, express or implied, between the Contractor and another party or between a Subcontractor and another party delegating or assigning, in whole or in part, the making or furnishing of any Materials or any Services required for the performance of the Contract.

1.16. “Subcontractor” means a person who contracts to perform work or render Services to a Contractor or to another Subcontractor as a part of a Contract with the State.

2. Contract Type

2.1. This Contract shall be:

[X] Cost Reimbursement

3. Contract Interpretation

3.1. Arizona Law. The Arizona law applies to this Contract including, where applicable, the Uniform Commercial Code as adopted by the State of Arizona and the Arizona Procurement Code, Arizona Revised Statutes (A.R.S.) Title 41, Chapter 23, and its implementing rules, Arizona Administrative Code (A.A.C.) Title 2, Chapter 7.

3.2. Implied Contract Terms. Each provision of law and any terms required by law to be in this Contract are a part of this Contract as if fully stated in it.

3.3. Contract Order of Precedence. In the event of a conflict in the provisions of the Contract, as accepted by the State and as they may be amended, the following shall prevail in the order set forth below:

3.3.1. Terms and Conditions.

3.3.2. Statement or Scope of Work.

3.3.3. Specifications.

3.3.4. Attachments.

3.3.5. Exhibits.

3.3.6. Any other documents referenced or included in the Contract including, but not limited to, any documents that do not fall into one (1) of the above categories.

3.4. Relationship of Parties. The Contractor under this Contract is an independent Contractor. Neither party to this Contract shall be deemed to be the employee or agent of the other party to the Contract.

3.5. Severability. The provisions of this Contract are severable. Any term or condition deemed illegal or invalid shall not affect any other term or condition of the Contract.

3.6. No Parol Evidence. This Contract is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any terms used in this document and no other understanding either oral or in writing shall be binding.

3.7. No Waiver. Either party's failure to insist on strict performance of any term or condition of the Contract shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the nonconforming performance knows of the nature of the performance and fails to object to it.

4. Contract Administration and Operation

4.1. Term. As indicated on the signature page of the Contract, the Contract shall be effective as of the Begin Date and shall remain effective until the Termination Date.

4.2. Contract Renewal. This Contract shall not bind, nor purport to bind, the State for any contractual commitment in excess of the original Contract period. The term of the Contract shall not exceed five (5) years. However, if the original Contract period is for less than five (5) years, the State shall have the right, at its sole option, to renew the Contract, so long as the original Contract period together with the renewal periods does not exceed five (5) years. If the State exercises such rights, all terms, conditions, and provisions of the original Contract shall remain the same and apply during the renewal period with the exception of price and Scope of Work, which may be renegotiated.

4.3. New Budget Term. If a budget term has been completed in a multi-term Contract, the parties may agree to change the amount and type of funding to accommodate new circumstances in the next budget term. Any increase or decrease in funding at the time of the new budget term shall coincide with a change in the Scope of Work or change in cost of services as approved by the Arizona Department of Health Services.

4.4. Records. Under A.R.S. § 35-214 and § 35-215, the Contractor shall retain and shall contractually require each Subcontractor to retain any and all Data and other "records" relating to the acquisition and performance of the Contract for a period of five (5) years after the completion of the Contract. All records shall be subject to inspection and audit by the State at reasonable times. Upon request, the Contractor shall produce a legible copy of any or all such records.

4.5. Non-Discrimination. The Contractor shall comply with State Executive Order Nos. 2023-09, 2023-01, 2009-09, and any and all other applicable Federal and State laws, rules, and regulations, including the Americans with Disabilities Act. Contractor shall include these provisions in contracts with Subcontractors when required by Federal or State law.

4.6. Audit. Pursuant to A.R.S. § 35-214, at any time during the term of this Contract and five (5) years thereafter, the Contractor's or any Subcontractor's books and records shall be subject to audit by the State and, where applicable, the Federal Government, to the extent that the books and records relate to the performance of the Contract or Subcontract.

4.7. Facilities Inspection and Materials Testing. The Contractor agrees to permit access to its facilities, Subcontractor facilities, and the Contractor's processes or services, at reasonable times for inspection of the facilities or Materials covered under this Contract as required under A.R.S. § 41-2547. The State shall also have the right to test, at its own cost, the Materials to be supplied under this Contract. Neither inspection of the Contractor's facilities nor Materials testing shall constitute final acceptance of the Materials or Services. If the State determines non-compliance of the Materials, the Contractor shall be responsible for the payment of all costs incurred by the State for testing and inspection.

4.8. Notices. Notices to the Contractor required by this Contract shall be made by the State to the person indicated on the Offer and Acceptance form submitted by the Contractor unless otherwise stated in the Contract. Notices to the State required by the Contract shall be made by the Contractor to the Solicitation Contact Person indicated on the Solicitation, stated in the Contract, or listed on the State's eProcurement system. An authorized Procurement Officer and an authorized Contractor representative may change their respective person to whom notice shall be given by written notice to the other and an amendment to the Contract shall not be necessary.

4.9. Advertising, Publishing and Promotion of Contract. The Contractor shall not use, advertise, or promote information for commercial benefit concerning this Contract without the prior written approval of the Procurement Officer.

4.10. Continuous Improvement. Contractor shall recommend continuous improvements on an on-going basis in relation to any Materials and Services offered under the Contract, with a view to reducing State costs and improving the quality and efficiency of the provision of Materials or Services. The State may require Contractor to engage in continuous improvements throughout the term of the Contract.

4.11. Other Contractors. State may undertake on its own or award other contracts to the same or other suppliers for additional or related work. In such cases, the Contractor shall cooperate fully with State employees and such other suppliers and carefully coordinate, fit, connect, accommodate, adjust, or sequence its work to the related work by others. Where the Contract requires handing-off Contractor's work to others, Contractor shall cooperate as State instructs regarding the necessary transfer of its work product, Materials, Services, or records to State or the other suppliers. Contractor shall not commit or permit any act that interferes with the State's or other suppliers' performance of their work, provided that, State shall enforce the foregoing section equitably among all its suppliers so as not impose an unreasonable burden on any of them.

4.12. Ownership of Intellectual Property:

4.12.1. Rights In Work Product. All intellectual property originated or prepared by Contractor pursuant to

the Contract, including but not limited to, inventions, discoveries, intellectual copyrights, trademarks, trade names, trade secrets, technical communications, records reports, computer programs and other documentation or improvements thereto, including Contractor's administrative communications and records relating to the Contract, are considered work product and Contractor's property, provided that, State has Government Purpose Rights to that work product as and when it was delivered to State.

4.12.2. "Government Purpose Rights" are:

4.12.2.1. The unlimited, perpetual, irrevocable, royalty free, non-exclusive, worldwide right to use, modify, reproduce, release, perform, display, sublicense, disclose and create derivatives from that work product without restriction for any activity in which State is a party.

4.12.2.2. The right to release or disclose that work product to third parties for any State government purpose.

4.12.2.3. The right to authorize those to whom it rightfully releases or discloses that work product to use, modify, release, create derivative works from the work product for any State government purpose; such recipients being understood to include the federal government, the governments of other states, and various local governments.

4.12.3. "Government Purpose Rights" do not include any right to use, modify, reproduce, perform, release, display, create derivative works from or disclose that work product for any commercial purpose, or to authorize others to do so.

4.12.4. Joint Developments. The Contractor and State may each use equally any ideas, concepts, know-how, or techniques developed jointly during the course of the Contract, and may do so at their respective discretion, without obligation of notice or accounting to the other party.

4.12.5. Pre-existing Material. All pre-existing software and other Materials developed or otherwise obtained by or for Contractor or its affiliates independently of the Contract or applicable Purchase Orders are not part of the work product to which rights are granted State under subparagraph 3.9.1 above, and will remain the exclusive property of Contractor, provided that:

4.12.5.1. Any derivative works of such pre-existing Materials or elements thereof that are created pursuant to the Contract are part of that work product.

4.12.5.2. Any elements of derivative work of such pre-existing Materials that was not created pursuant to the Contract are not part of that work product.

4.12.5.3. Except as expressly stated otherwise, nothing in the Contract is to be construed to interfere or diminish Contractor's or its affiliates' ownership of such pre-existing Materials.

4.12.5.4. Developments Outside of Contract. Unless expressly stated otherwise in the Contract, this Section does not preclude Contractor from developing competing Materials outside the Contract, irrespective of any similarity to Materials delivered or to be delivered to State hereunder.

4.13. Property of the State. If there are any materials that are not covered by Section 4.12 above created under this Contract, including but not limited to, reports and other deliverables, these materials are the sole property of the State. The Contractor is not entitled to a patent or copyright on those materials and may not transfer the patent or copyright to anyone else. The Contractor shall not use or release these materials without the prior written consent of the State.

4.14. Federal Immigration and Nationality Act. Contractor shall comply with all federal, state, and local immigration laws and regulations relating to the immigration status of their employees during the term of the Contract. Further, Contractor shall flow down this requirement to all Subcontractors utilized during the

term of the Contract. The State shall retain the right to perform random audits of Contractor and Subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Contractor or any Subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to: suspension of work, termination of the Contract for default and suspension or debarment of the Contractor.

4.15. E-Verify Requirements. In accordance with A.R.S. § 41-4401, Contractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. § 23- 214, Subsection A.

4.16. Offshore Performance of Work involving Data is Prohibited. Any Services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and involve access to Data shall be performed within the defined territories of the United States.

4.17. Certifications Required by State Law:

4.17.1. If Contractor is a Company as defined in A.R.S. § 35-393, Contractor certifies that it is not currently engaged in a boycott of Israel as described in A.R.S. §§ 35-393 *et seq*. and will refrain from any such boycott for the duration of this Contract.

4.17.2. Contractor further certifies that it shall comply with A.R.S. § 35-394, regarding use of the forced labor of ethnic Uyghurs, as applicable.

4.18. Protection of State Cybersecurity Interests. The Contractor shall comply with State Executive Order No. 2023-10, which includes, but is not limited to, a prohibition against (a) downloading and installing of TikTok on all State-owned and State-leased information technology; and (b) accessing TikTok through State information technology.

5. Costs and Payments

5.1. Payments. Payments shall comply with the requirements of A.R.S. Titles 35 and 41, Net 30 days. Upon receipt and acceptance of Materials or Services, the Contractor shall submit a complete and accurate invoice for payment from the State within thirty (30) days.

5.2. Delivery. Unless stated otherwise in the Contract, per A.R.S. § 47-2319, all prices shall be F.O.B. (“free on board”) Destination and shall include all freight delivery and unloading at the destination.

5.3. Firm, Fixed Price. Unless stated otherwise in the Special Terms and Conditions of the Contract, all prices shall be firm-fixed-prices.

5.4. Applicable Taxes:

5.4.1. Payment of Taxes. The Contractor shall be responsible for paying all applicable taxes.

5.4.2. State and Local Transaction Privilege Taxes. The State of Arizona is subject to all applicable state and local transaction privilege taxes. Transaction privilege taxes apply to the sale and are the responsibility of the seller to remit. Failure to collect such taxes from the buyer does not relieve the seller from its obligation to remit taxes.

5.4.3. Tax Indemnification. Contractor and all Subcontractors shall pay all Federal, state and local taxes applicable to its operation and any persons employed by the Contractor. Contractor shall and require all Subcontractors to hold the State harmless from any responsibility for taxes, damages, and interest, if applicable, contributions required under Federal, and/or state and local laws and regulations and any other costs including transaction privilege taxes, unemployment compensation insurance, Social Security and Worker’s Compensation.

5.4.4. IRS W9 Form. In order to receive payment, the Contractor shall have a current I.R.S. W9 Form on file with the State of Arizona, unless not required by law.

5.5. Availability of Funds for the Next State Fiscal Year. Funds may not presently be available for performance under this Contract beyond the current State Fiscal Year. No legal liability on the part of the State for any payment may arise under this Contract beyond the current State Fiscal Year until funds are made available for performance of this Contract.

5.6. Availability of Funds for the Current State Fiscal Year. Should the State Legislature enter back into session and reduce the appropriations or for any reason and these Materials or Services are not funded, the State may take any of the following actions:

5.6.1. Accept a decrease in price offered by the Contractor.

5.6.2. Cancel the Contract.

5.6.3. Cancel the Contract and re-solicit the requirements.

6. Contract Changes

6.1. Amendments. This Contract is issued under the authority of the Procurement Officer who signed this Contract. The Contract may be modified only through a Contract Amendment within the scope of the Contract. Changes to the Contract, including the addition of Services or Materials, the revision of payment terms, or the substitution of Services or Materials, directed by a person who is not specifically authorized by the Procurement Officer in writing or made unilaterally by the Contractor are violations of the Contract and of applicable law. Such changes, including unauthorized written Contract Amendments shall be void and without effect, and the Contractor shall not be entitled to any claim under this Contract based on those changes.

6.2. Subcontracts. The Contractor shall not enter into any Subcontract under this Contract for the performance of this Contract without the advance written approval of the Procurement Officer as described in Arizona State Procurement Office Standard Procedure 002. The Contractor shall clearly list any proposed Subcontractors and the Subcontractor's proposed responsibilities. The Subcontract shall incorporate by reference the terms and conditions of this Contract.

6.3. Assignment and Delegation. The Contractor shall not assign any right nor delegate any duty under this Contract without the prior written approval of the Procurement Officer. The State shall not unreasonably withhold approval.

7. Risk and Liability

7.1. Risk of Loss. The Contractor shall bear all loss of conforming Materials covered under this Contract until received by authorized personnel at the location designated in the purchase order or Contract. Mere receipt does not constitute final acceptance. The risk of loss for nonconforming Materials shall remain with the Contractor regardless of receipt.

7.2. Indemnification:

7.2.1. Contractor/Vendor Indemnification (Not Public Agency).To the fullest extent permitted by law, Contractor shall defend, indemnify, and hold harmless the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or Subcontractors. This indemnity includes any claim or amount arising out of, or recovered under, the Workers' Compensation Law or arising out of the failure of such Contractor to conform to any federal, state, or local law, statute, ordinance, rule, regulation, or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts

or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense, and judgment costs where this indemnification is applicable. In consideration of the award of this Contract, the Contractor agrees to waive all rights of subrogation Insurance and Indemnification Guidelines for State of Arizona Contracts Professional Service Contracts against the State of Arizona, its officers, officials, agents, and employees for losses arising from the work performed by the Contractor for the State of Arizona. This indemnity shall not apply if the Contractor or Subcontractor(s) is/are an agency, board, commission, or university of the State of Arizona.

7.2.2. Public Agency Language Only. Each party (as 'indemnitor') agrees to indemnify, defend, and hold harmless the other party (as 'indemnitee') from and against any and all claims, losses, liability, costs, or expenses (including reasonable attorney's fees) (hereinafter collectively referred to as 'claims') arising out of bodily injury of any person (including death) or property damage but only to the extent that such claims which result in vicarious/derivative liability to the indemnitee, are caused by the act, omission, negligence, misconduct, or other fault of the indemnitor, its officers, officials, agents, employees, or volunteers.

7.3. Indemnification - Patent and Copyright. The Contractor shall indemnify and hold harmless the State against any liability, including costs and expenses, for infringement of any patent, trademark or copyright arising out of Contract performance or use by the State of Materials furnished or work performed under this Contract. The State shall reasonably notify the Contractor of any claim for which it may be liable under this paragraph. If the Contractor is insured pursuant to A.R.S. § 41-621 and § 35-154, this paragraph shall not apply.

7.4. Force Majeure:

7.4.1. Except for payment of sums due, neither the Contractor nor State shall be liable to the other nor deemed in default under this Contract if and to the extent that such party's performance of this Contract is prevented by reason of force majeure. The term "force majeure" means an occurrence that is beyond the control of the party affected and occurs without its fault or negligence. Without limiting the foregoing, force majeure includes: acts of God, acts of the public enemy, war, riots, strikes, mobilization, labor disputes, civil disorders, fire, flood, lockouts, injunctions-intervention-acts, failures or refusals to act by government authority, and other similar occurrences beyond the control of the party declaring force majeure which such party is unable to prevent by exercising reasonable diligence.

7.4.2. Force Majeure shall not include the following occurrences:

7.4.2.1. Late delivery of equipment, Materials, or Services caused by congestion at a manufacturer's plant or elsewhere, or an oversold condition of the market.

7.4.2.2. Late performance by a Subcontractor unless the delay arises out of a force majeure occurrence in accordance with this force majeure term and condition.

7.4.2.3. Inability of either the Contractor or any Subcontractor to acquire or maintain any required insurance, bonds, licenses or permits.

7.4.3. If either the Contractor or State is delayed at any time in the progress of the work by force majeure, the delayed party shall notify the other party in writing of such delay, as soon as is practicable and no later than the following working day, of the commencement thereof and shall specify the causes of such delay in such notice. Such notice shall be delivered or mailed certified-return receipt and shall make a specific reference to this article, thereby invoking its provisions. The delayed party shall cause such delay to cease as soon as practicable and shall notify the other party in writing when it has done so. The time of completion shall be extended by Contract Amendment for a period of time equal to the time that results or effects of such delay prevent the delayed party from performing in accordance with this Contract.

7.4.4. Any delay or failure in performance by either party hereto shall not constitute default hereunder or give rise to any claim for damages or loss of anticipated profits if, and to the extent that such

delay or failure is caused by force majeure.

7.5. Third Party Antitrust Violations. The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern Materials or Services supplied by third parties to the Contractor, toward fulfillment of this Contract.

8. Warranties

8.1. Liens. The Contractor warrants that the Materials supplied under this Contract are free of liens and shall remain free of liens.

8.2. Quality. Unless otherwise modified elsewhere in the Terms and Conditions, the Contractor warrants that, for one (1) year after acceptance by the State of the Materials, they shall be:

8.2.1. Of a quality to pass without objection in the trade under the Contract description.

8.2.2. Fit for the intended purposes for which the Materials are used.

8.2.3. Within the variations permitted by the Contract and are of even kind, quantity, and quality within each unit and among all units.

8.2.4. Adequately contained, packaged, and marked as the Contract may require.

8.2.5. Conform to the written promises or affirmations of fact made by the Contractor.

8.3. Conformity to Requirements:

8.3.1. Contractor warrants that, unless expressly provided otherwise elsewhere in the Contract, the Materials and Services will for one (1) year after acceptance and in each instance:

8.3.1.1. Conform to the requirements of the Contract, which by way of reminder include without limitation all descriptions, specifications, and drawings identified in the Scope of Work and any and all Contractor affirmations included as part of the Contract.

8.3.1.2. Be free from defects of material and workmanship.

8.3.1.3. Conform to or perform in a manner consistent with current industry standards.

8.3.1.4. Be fit for the intended purpose or use described in the Contract.

8.3.2. Mere delivery or performance does not substitute for express acceptance by the State. Where inspection, testing, or other acceptance assessment of Materials or Services cannot be done until after installation or invoicing, the forgoing warranty will not begin until the State's explicit acceptance of the Materials or Services.

8.4. Inspection/Testing. The warranties set forth in this Section 8 [Warranties] are not affected by inspection or testing of or payment for the Materials or Services by the State.

8.5. Contractor Personnel. Contractor warrants that its personnel will perform their duties under the Contract in a professional manner, applying the requisite skills and knowledge, consistent with industry standards, and in accordance with the requirements of the Contract. Contractor further warrants that its key personnel will maintain any and all certifications relevant to their work, and Contractor shall provide individual evidence of certification to State's authorized representatives upon request.

8.6. Compliance With Applicable Laws. The Materials and Services supplied under this Contract shall comply with all applicable federal, state, and local laws and policies (including, but not limited to, information technology policies, standards, and procedures available on the State's website and/or the website of any department, commission, council, board, bureau, committee, institution, agency, government corporation or other establishment or official of the executive branch or corporation commission of the State of Arizona). Federal requirements may be incorporated into this Contract, if required, pursuant to A.R.S. §

41-2637. The Contractor shall maintain any and all applicable license and permit requirements. This requirement includes, but is not limited to, any and all Arizona state statutes that impact state contracts, regardless of whether those statutory references have been removed during the course of contract negotiations; this is notice to Contractors that the State does not have the authority to modify Arizona state law by Contract.

8.7. Intellectual Property. Contractor warrants that the Materials and Services do not and will not infringe or violate any patent, trademark, copyright, trade secret, or other intellectual property rights or laws, except only to the extent the Specifications do not permit use of any other product and Contractor is not and cannot reasonably be expected to be aware of the infringement or violation.

8.8. Licenses and Permits. Contractor warrants that it will maintain all licenses required to fully perform its duties under the Contract and all required permits valid and in force.

8.9. Operational Continuity. Contractor warrants that it will perform without relief notwithstanding being sold or acquired; no such event will operate to mitigate or alter any of Contractor's duties hereunder absent a consented delegation under paragraph 6.3. [Assignment and Delegation] that expressly recognizes the event.

8.10. Performance in Public Health Emergency. Contractor warrants that it will:

8.10.1. Have in effect, promptly after commencement, a plan for continuing performance in the event of a declared public health emergency that addresses, at a minimum:

8.10.1.1. Identification of response personnel by name.

8.10.1.2. Key succession and performance responses in the event of sudden and significant decrease in workforce.

8.10.1.3. Alternative avenues to keep sufficient product on hand or in the supply chain.

8.10.2. Provide a copy of its current plan to State within three (3) business days after State's written request. If Contractor claims relief under paragraph 7.4 [Force Majeure] for an occurrence of force majeure that is a declared public health emergency, then that relief will be conditioned on Contractor having first implemented its plan and exhausted all reasonable opportunity for that plan implementation to overcome the effects of that occurrence, or mitigate those effects to the extent that overcoming entirely is not practicable.

8.10.3. A request from the State related to this paragraph 8.10 does not necessarily indicate that there has been an occurrence of force majeure, and the Contractor will not be entitled to any additional compensation or extension of time by virtue of having to implement a plan.

8.10.4. Failure to have or implement an appropriate plan will be a material breach of contract.

8.11. Lobbying:

8.11.1. Prohibition. Contractor warrants that it will not engage in lobbying activities, as defined in 40 Code of Federal Regulations (CFR) part 34 and A.R.S. § 41-1231, *et seq*., using monies awarded under the Contract, provided that, the foregoing does not intend to constrain Contractor's use of its own monies or property, including without limitation any net proceeds duly realized under the Contract or any value thereafter derived from those proceeds; and upon award of the Contract, it will disclose all lobbying activities to State to the extent they are an actual or potential conflict of interest or where such activities could create an appearance of impropriety. Contractor shall implement and maintain adequate controls to assure compliance with above. Contractor shall obtain an equivalent warranty from all Subcontractors and shall include an equivalent no-lobbying provision in all Subcontracts.

8.11.2. Exception. This paragraph 8.11 does not apply to the extent that the Services are defined in the Contract as being lobbying for State's benefit or on State's behalf.

8.12. Covered Telecommunications or Services. Contractor warrants that the Materials and Services rendered under this Agreement will not require Contractor to use for the State, or provide to the State to use, "covered telecommunications equipment or Services" as a substantial or essential component of any system, or as critical technology as part of any system, within the meaning of Federal Acquisition Regulation ("FAR") Section 52.204-25.

8.13. Debarment, Suspension, U.S. Government Restricted Party Lists. Contractor warrants that it is not, and its Subcontractors are not, on the U.S. government's Denied Parties List, the Unverified List, the Entities List, the Specially Designated Nationals and Blocked Parties List, and neither the Contractor nor any Subcontractors are presently debarred, suspended, proposed for debarment or otherwise declared ineligible for award of federal contracts or participation in federal assistance programs or activities.

8.14. False Statements. Contractor represents and warrants that all statements and information Contractor prepared and submitted in response to the Solicitation or as part of the Contract documents are current, complete, true, and accurate. If the Procurement Officer determines that Contractor submitted an Offer or Bid with a false statement or makes material misrepresentations during the performance of the Contract, the Procurement Officer may determine that Contractor has materially breached the Contract and may void the submitted Offer or Bid and any resulting Contract.

8.15. Survival of Rights and Obligations after Contract Expiration or Termination:

8.15.1. Survival of Warranty. All representations and warranties made by Contractor under the Contract will survive the expiration or earlier termination of the Contract,

8.15.2. Contractor's Representations and Warranties. All representations and warranties made by the Contractor under this Contract shall survive the expiration or termination hereof. In addition, the parties hereto acknowledge that pursuant to A.R.S. § 12-510, except as provided in A.R.S. § 12-529, the State is not subject to or barred by any limitations of actions prescribed in A.R.S., Title 12, Chapter 5.

8.15.3. Purchase Orders. The Contractor shall, in accordance with all terms and conditions of the Contract, fully perform and shall be obligated to comply with all purchase orders received by the Contractor prior to the expiration or termination hereof, unless otherwise directed in writing by the Procurement Officer, including, without limitation, all purchase orders received prior to but not fully performed and satisfied at the expiration or termination of this Contract.

9. State's Contractual Remedies

9.1. Right to Assurance. If the State in good faith has reason to believe that the Contractor does not intend to, or is unable to perform or continue performing under this Contract, the Procurement Officer may demand in writing that the Contractor give a written assurance of intent to perform. Failure by the Contractor to provide written assurance within the number of Days specified in the demand may, at the State's option, be the basis for terminating the Contract under the Uniform Terms and Conditions or other rights and remedies available by law or provided by the Contract.

9.2. Stop Work Order:

9.2.1. The State may, at any time, by written order to the Contractor, require the Contractor to stop all or any part of the work called for by this Contract for period(s) of days indicated by the State after the order is delivered to the Contractor. The order shall be specifically identified as a stop work order issued under this clause. Upon receipt of the order, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize the incurrence of costs allocable to the work covered by the order during the period of work stoppage.

9.2.2. If a stop work order issued under this clause is canceled or the period of the order or any extension expires, the Contractor shall resume work. The Procurement Officer shall make an equitable adjustment in the delivery schedule or Contract price, or both, and the Contract shall be amended in writing accordingly.

9.3. Non-exclusive Remedies. The rights and the remedies of the State under this Contract are not exclusive;

9.4. Nonconforming Tender. Materials or Services supplied under this Contract shall fully comply with the Contract. The delivery of Materials or Services or a portion of the Materials or Services that do not fully comply constitutes a breach of contract. On delivery of nonconforming Materials or Services, the State may terminate the Contract for default under applicable termination clauses in the Contract, exercise any of its rights and remedies under the Uniform Commercial Code or pursue any other right or remedy available to it.

9.5. Right of Offset. The State shall be entitled to offset against any sums due the Contractor, any expenses or costs incurred by the State, or damages assessed by the State concerning the Contractor's non-conforming performance or failure to perform the Contract, including expenses, costs and damages described in the Uniform Terms and Conditions.

10. Contract Termination

10.1. Cancellation for Conflict of Interest. Pursuant to A.R.S. § 38-511, the State may cancel this Contract within three (3) years after Contract execution without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the Contract on behalf of the State is or becomes at any time while the Contract or an extension of the Contract is in effect an employee of or a consultant to any other party to this Contract with respect to the subject matter of the Contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time. If the Contractor is a political subdivision of the State, it may also cancel this Contract as provided in A.R.S. § 38-511.

10.2. Gratuities. The State may, by written notice, terminate this Contract, in whole or in part, if the State determines that employment or a Gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State with the purpose of influencing the outcome of the procurement or securing the Contract, an amendment to the Contract, or favorable treatment concerning the Contract, including the making of any determination or decision about contract performance. The State, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three (3) times the value of the Gratuity offered by the Contractor.

10.3. Suspension or Debarment. The State may, by written notice to the Contractor, immediately terminate this Contract if the State determines that the Contractor has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity, including but not limited to, being disapproved as a Subcontractor of any public procurement unit or other governmental body. Submittal of an offer or execution of a contract shall attest that the Contractor is not currently suspended or debarred. If the Contractor becomes suspended or debarred, the Contractor shall immediately notify the State.

10.4. Termination for Convenience. The State reserves the right to terminate the Contract, in whole or in part at any time when in the best interest of the State, without penalty or recourse. Upon receipt of the written notice, the Contractor shall stop all work, as directed in the notice, notify all Subcontractors of the effective date of the termination, and minimize all further costs to the State. In the event of termination under this paragraph, all documents, Data, and reports prepared by the Contractor under the Contract shall become the property of and be delivered to the State upon demand. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed, and Materials or Services accepted before the effective date of the termination. The cost principles and procedures provided in A.R.S. § 41-2543 and A.A.C. Title 2, Chapter 7, Article 7, shall apply.

10.5. Termination for Default:

10.5.1. In addition to the rights reserved in the Contract, the State may terminate the Contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the Contract, to acquire and maintain all required insurance policies, bonds, licenses and permits, or to make satisfactory progress in performing the Contract. The Procurement Officer shall provide written notice of the termination and the reasons for it to the Contractor.

10.5.2. Upon termination under this paragraph, all goods, Materials, documents, Data, and reports prepared by the Contractor under the Contract shall become the property of and be delivered to the State on demand.

10.5.3. The State may, upon termination of this Contract, procure, on terms and in the manner that it deems appropriate, Materials or Services to replace those under this Contract. The Contractor shall be liable to the State for any excess costs incurred by the State in procuring Materials or Services in substitution for those due from the Contractor.

10.5.4. Continuation of Performance Through Termination. The Contractor shall continue to perform, in accordance with the requirements of the Contract, up to the date of termination, as directed in the termination notice.

11. Contract Claims

All contract claims or controversies under this Contract shall be resolved according to A.R.S. Title 41, Chapter 23, Article 9, and rules adopted thereunder.

12. Arbitration

The parties to this Contract agree to resolve all disputes arising out of or relating to this Contract through arbitration, after exhausting applicable administrative review, to the extent required by A.R.S. § 12-1518, except as may be required by other applicable statutes (A.R.S. Title 41).

13. Communication

13.1. Program Report. When reports are required by the Contract, the Contractor shall provide them in the format approved by ADHS.

13.2. Information and Coordination. The State will provide information to the Contractor pertaining to activities that affect the Contractor's delivery of services, and the Contractor shall be responsible for coordinating their activities with the State's in such a manner as not to conflict or unnecessarily duplicate the State's activities. As the work of the Contractor progresses, advice and information on matters covered by the Contract shall be made available by the Contractor to the State throughout the effective period of the Contract.

14. Client Grievances

If applicable, the Contractor and its subcontractors shall use a procedure through which clients may present grievances about the operation of the program that result in the denial, suspension or reduction of services provided pursuant to this Contract and which is acceptable to and approved by the State.

15. Sovereign Immunity

Pursuant to A.R.S. § 41-621(O), the obtaining of insurance by the State shall not be a waiver of any sovereign immunity defense in the event of a suit.

16. Administrative Changes

The Procurement Officer, or authorized designee, reserves the right to correct any obvious clerical, typographical or grammatical errors, as well as errors in party contact information (collectively, "Administrative Changes"), prior to or after the final execution of a Contract or Contract Amendment. Administrative Changes subject to permissible corrections include: misspellings, grammar errors, incorrect addresses, incorrect Contract Amendment numbers, pagination and citation errors, mistakes in the labeling of the rate as either extended or unit, and calendar date errors that are illogical due to typographical error. The Procurement Office shall subsequently send to the Contractor notice of corrections to administrative errors in a written confirmation letter with a copy of the corrected Administrative Change attached.

17. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

17.1. The Contractor warrants that it is familiar with the requirements of HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009, and accompanying regulations and will comply with all applicable HIPAA requirements in the course of this Contract. Contractor warrants that it will cooperate with the Arizona Department of Health Services (ADHS) in the course of performance of the Contract so that both ADHS and Contractor will be in compliance with HIPAA, including cooperation and coordination with the Arizona Department of Administration-Arizona Strategic Enterprise Technology (ADOA-ASET) Office, the ADOA-ASET Arizona State Chief Information Security Officer and HIPAA Coordinator and other compliance officials required by HIPAA and its regulations. Contractor will sign any documents that are reasonably necessary to keep ADHS and Contractor in compliance with HIPAA, including, but not limited to, business associate agreements.

17.2. If requested by the ADHS Procurement Office, Contractor agrees to sign a "Pledge To Protect Confidential Information" and to abide by the statements addressing the creation, use and disclosure of confidential information, including information designated as protected health information and all other confidential or sensitive information as defined in policy. In addition, if requested, Contractor agrees to attend or participate in HIPAA training offered by ADHS or to provide written verification that the Contractor has attended or participated in job related HIPAA training that is: (1) intended to make the Contractor proficient in HIPAA for purposes of performing the services required and (2) presented by a HIPAA Privacy Officer or other person or program knowledgeable and experienced in HIPAA and who has been approved by the ADOA-ASET Arizona State Chief Information Security Officer and HIPAA Coordinator.

18. Fraud, Waste, or Abuse

18.1. ADHS requires all employees to abide by the State's Personnel System Rules, R2-5A-501; Standards of Conduct which includes maintaining high standards of honesty, integrity, and impartiality, free from personal considerations and/or favoritism, and Code of Conduct for individuals engaged in Accounting, Financial and Budgeting Activities which depicts the moral, ethical, legal and professional aspects of personal conduct. ADHS requires the same conduct of its consultants, vendors, contractors, subrecipients, or persons doing business with the agency.

18.2. Any State employee, consultant, vendor, contractor or subrecipient or person doing business with the Agency who receives a report of improper activity must report the information within one (1) business day. Note: Federal Award policy denotes awardees must disclose, in a timely manner, in writing to ADHS all violations of Federal Criminal Law, involving fraud, bribery, or gratuity violations potentially affecting Federal Awards.

18.3. Anyone suspecting Fraud, Waste, or Abuse related to ADHS activities are required to report Fraud, Waste, or abuse through any of the following reporting channels:

18.3.1. ADHS Ethics Action Hotline at (602) 542-2347.

18.3.2. ADHS Ethics Action Email at reportethics@azdhs.gov.

18.3.3. General Accounting Office (GAO) Fraud Reporting Email at reportfraud@azdoa.gov to report Fraud, Waste, or Abuse incidents.

19. Unique Entity Identifier (UEI) Requirement

Pursuant to 2 CFR 25.100 et seq., no entity (defined as a Governmental organization, which is a State, local government, or Indian tribe; foreign public entity; domestic or foreign nonprofit organization; domestic or foreign for-profit organization; or Federal agency, but only as a sub-recipient under an award or sub-award to a non-Federal entity) may receive a sub-award from ADHS unless the entity provides its Unique Entity Identifier Number to ADHS. The number can be created in SAM.gov. If already registered the UEI has been assigned and can be viewed in SAM.gov.

20. The Federal Funding Accountability and Transparency Act (FFATA or Transparency Act - P.L.109-282, as amended by section 6202(a) of P.L. 110-252), found at https://www.fsrs.gov/

If applicable, the subrecipient or sub-awardee is required to abide by the Federal Funding Accountability and Transparency Act (FFATA or Transparency Act – P.L. 109-282, as amended by section 6202(a) of P.L. 110-252), found at https://www.fsrs.gov/. The associated Grant Reporting Certification Form and completion instructions will be sent to the subrecipient from ADHS Program(s) responsible for the specific contract. The subrecipient or sub-awardee must return the completed form to ADHS Program(s) by the 15th of the month following that in which the award was received. Failure to complete a required Grant Reporting Certification Form may result in loss of funding.

21. Technology Replacement

In any event where product is discontinued, no longer available or technically inferior to newly developed product, the Contractor shall provide an equivalent replacement model at no additional cost and shall honor the original contract terms.

22. Authorization for Provision of Services

Authorization for purchase of services under this Agreement shall be made only upon ADHS issuance of a Purchase Order that is signed by an authorized agent. The Purchase Order will indicate the Agreement number and the dollar amount of the funds authorized. The Contractor shall only be authorized to perform services up to the amount of the Purchase Order. ADHS shall not have any legal obligation to pay for services in excess of the amount indicated on the Purchase Order. No further obligation for payment shall exist on behalf of ADHS unless 2) the Purchase Order is changed or modified with an official ADHS Procurement Change Order, and/or an additional Purchase Order is issued for purchase of services under this Agreement.

Additional Terms and Conditions for Title 2, Subtitle A, Chapter II, Part 200, Subpart C: §200.201 USE OF GRANT AGREEMENTS (INCLUDING FIXED AMOUNT AWARDS), COOPERATIVE AGREEMENTS AND CONTRACT

23. Civil Rights Assurance Statement.

The Contractor and Subcontractors are subject to Title VI of the Civil Rights Act of 1964, Section 504 of Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, Title IX of the Education Amendment of 1972, and offers all persons the opportunity to participate in programs or activities regardless or race, color, national origin, age, sex, or disability. Further, it is agreed that no individual will be turned away from or otherwise denied access to or benefit from any program or activity that is directly associated with a program of the RECIPIENT on the basis of race, color, national origin, age, sex (in educational activities) or disability.

24. Americans With Disabilities Act of 1990.

24.1. The Contractor shall comply with the Americans with Disabilities Act of 1990 (Public Law 101-336) and the Arizona Disability Act of 1992 (A.R.S § 41-1492 et. seq.), which prohibits discrimination of the basis of physical or mental disabilities in delivering contract services or in the employment, or advancement in employment of qualified individuals.

24.2. Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contracting the Contract Manager for the Contract. Request should be made as early as possible to allow time to arrange the accommodation.

25. Federal Funding.

Funding for these services is contingent upon the availability of federal government funding. No commitment of any kind is made by the State concerning this Grant unless there are monies provided by a federal grant. The Grantee should take this fact into consideration.

25.1. For the purposes of this Grant, a capital expenditure means expenditures to acquire capital assets, as

defined in 2 C.F.R. 200.12, or expenditures to make additions, improvements, modifications, replacements, rearrangements, reinstallations, renovations, or alterations to capital assets that materially increase their value or useful life, with a cost of $250 or greater.

25.2. Grantee agrees to maintain property records for equipment purchased with grant funds and perform a physical inventory and reconciliation with property records at least every year. Grantee agrees that funds will not be used for the construction of new facilities.

25.3. Grantee agrees to follow equipment disposition policies as determined by the Federal Awarding Agency at Award Completion or as depicted in the State of Arizona Accounting Manual. Grantee also agrees to follow the directives in ADHS Property and Procedure Policy FIN 111.

25.4. Charges to Federal awards for salaries and wages must be based on records that accurately reflect the work performed. These records must: Be supported by a system of internal control which provides reasonable assurance that the charges are accurate, allowable, and properly allocated; Be incorporated into the official records of the non-Federal entity; Reasonably reflect the total activity for which the employee is compensated by the non-Federal entity, not exceeding 100% of compensated activities (for IHE, this per the IHE's definition of IBS); Encompass both federally assisted and all other activities compensated by the non-Federal entity on an integrated basis, but may include the use of subsidiary records as defined in the non-Federal entity's written policy; Comply with the established accounting policies and practices of the non-Federal entity (See paragraph above for treatment of incidental work for IHEs.; and Support the distribution of the employee's salary or wages among specific activities or cost objectives if the employee works on more than one (1) Federal award; a Federal award and non-Federal award; an indirect cost activity and a direct cost activity; two (2) or more indirect activities which are allocated using different allocation bases; or an unallowable activity and a direct or indirect cost activity. Budget estimates (i.e., estimates determined before the services are performed) alone do not qualify as support for charges to Federal awards but may be used for interim accounting purposes only.

25.5. Grantee understands that financial reports are required as an accounting of expenditures for either reimbursement or ADHS-approved advance payments.

25.6. The final request for reimbursement of grant funds must be received by the ADHS no later than sixty (60) days after the last day of the award period.

25.7. All goods and services must be received or have reasonable expectations thereof and placed in service by Grantee by the expiration of this award.

25.8. Grantee agrees that all encumbered funds must be expended, and that goods and services must be paid by Grantee within sixty (60) days of the expiration of this award unless funding guidelines permit funds to be used at a future date.

25.9. Grantee agrees to remit all unexpended grant funds to the ADHS within thirty (30) days of written request from the ADHS.

25.10. Grantee agrees to account for interest earned on federal grant funds and shall manage interest income in accordance with the Cash Management Improvement Act of 1990 and as indicated in the State of Arizona Accounting Manual (SAAM) located at the following website https://gao.az.gov/publications/saam Interest earned in excess of allowable limits must be remitted to the ADHS within thirty (30) days after receipt of a written request from the ADHS.

25.11. Grantee agrees not to use grant funds for food and/or beverage unless explicitly approved in writing by the ADHS.

25.12. Grantee agrees to comply with all applicable laws, regulations, policies and guidance (including specific cost limits, prior approvals and reporting requirements, where applicable) governing the use of grant funds for expenses related to conferences, meetings, trainings, and other events, including the provision of food and/or beverages at such events, and costs of attendance at such events unless explicitly approved in writing by the ADHS.

25.13. No funds shall be used to supplant federal, state, county or local funds that would otherwise be made available for such purposes. Supplanting means the deliberate reduction of state or local funds because of the existence of any grant funds.

25.14. Grantee agrees that grant funds are not to be expended for any indirect costs that may be incurred by Grantee for administering these funds unless explicitly approved in writing by the ADHS. This may include, but is not limited to, costs for services such as accounting, payroll, data processing, purchasing, personnel, and building use which may have been incurred by the Grantee.

25.15. Grantee will comply with the audit requirements of *OMB* Office of Management and Budget's (OMB) Uniform Administrative Requirements, Cost Principles and Audit Requirement for Federal Awards and provide the ADHS with the Single Audit Report and any findings within ninety (90) days of receipt of such finding(s). If the report contains no findings, the Grantee must provide notification that the audit was completed. All completed Single Audits should be uploaded in the format specified to the Federal Audit Clearinghouse no later than nine (9) months after the entities fiscal year-end at the attached **Link**: https://harvester.census.gov/facweb/default.aspx/.

25.16. Grantee understands and agrees that misuse of award funds may result in a range of penalties, including suspension of current and future funds, suspension or debarment from federal grants, recoupment of monies provided under an award, and civil and/or criminal penalties.

25.17. Grantee agrees not to do business with any individual, agency, company or corporation listed in the Excluded Parties Listing Service.

25.17.1. **Link***: System for Award Management* https://www.sam.gov/portal/public/SAM/.

25.18. Grantee agrees to ensure that, no later than the due date of the Grantee's first financial report after the award is made, Grantee and any subgrantees have a valid UEI profile and active registration with the System for Award Management (SAM) database.

25.19. Grantee certifies that it presently has no financial interest and shall not acquire any financial interest, direct or indirect, which would conflict in any manner or degree with the performance of services required under this Agreement.

25.20. Compliance with 41 U.S.C. 4712 (including prohibitions on reprisal; notice to employees) Grantee must comply with, and is subject to, all applicable provisions of 41 U.S.C. 4712, including all applicable provisions that prohibit, under specified circumstances, discrimination against an employee as reprisal for the employee's disclosure of information related to gross mismanagement of a federal grant, a gross waste of federal funds, an abuse of authority relating to a federal grant, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation related to a federal grant.

25.21. Grantee certifies to comply with the Drug-Free Workplace Act of 1988, and implemented in 28 CFR Part 83, Subpart F, for grantees, as defined in 28 CFR, Part 83 Sections 83.620 and 83.650.

26. Comments Welcome

The ADHS Procurement Office periodically reviews the Uniform Terms and Conditions and welcomes any comments you may have. Please submit your comments to: ADHS Procurement Administrator, Arizona Department of Health Services, 150 North 18th Avenue, Suite 530, Phoenix, Arizona 85007.

1. DEFINITIONS:

1.1 "ADHS" for the purpose of this document refers to the Arizona Department of Health Services.

1.2 "OIVP" for the purpose of this document refers to the Office of Injury and Violence Prevention within the Arizona Department of Health Services.

1.2 "CDC" for the purpose of this document refers to the Centers for Disease Control and Prevention.

1.3 "CME" for the purpose of this document refers to Continuing Medical Education.

1.4 "CSPMP" for the purpose of this document refers to the Controlled Substances Prescription Monitoring Program.

1.5 "County or County Health Department" for the purpose of this document means the individual counties selected as high-burden areas in the state to implement the Prescription Drug Misuse and Abuse Toolkit.

1.6 "County Health Department Program Managers" for the purpose of this document, refers to the individual who works for the Contractor who has overall responsibility of the proposed project, including management of staff and Contractors to ensure that the State is in compliance with all grant requirements and communication with ADHS on progress made toward achieving the deliverables.

1.7 "DEA" for the purpose of this document refers to the United States Drug Enforcement Administration.

1.8 "High-burden areas" for the purpose of this document refers to communities which are identified by ADHS and Contractor as areas within the County with the highest rates of prescription drug mortality and morbidity.

1.9 "NAS" for the purpose of this document refers to Neonatal Abstinence Syndrome.

1.10 "Partners" for the purpose of this document refers to state agencies, providers, evidence-based practices (EBP's), communities and others.

1.11 "PSAs" for the purpose of this document refers to public service announcements.

1.12 "RHBAs" for the purpose of this document refers to Regional Behavioral Health Authorities.

1.13 "Rx" for the purpose of this document refers to prescription.

1.14 "ADHS Program Manager" means Arizona Department of Health Services employed staff managing the Project contract.

1.15 "ADHS Injury Epidemiologist" means Arizona Department of Health Services employed injury epidemiologist.

1.16 "Shall or Must" means a mandatory requirement. Failure to meet these mandatory requirements may deem Contractor out of compliance with the Contract.

2. BACKGROUND

2.1. ADHS OIVP administers funds provided by the CDC for operation of the Overdose Data to Action (OD2A) Intergovernmental Agreement.

2.2. The overarching goal of the Overdose Data to Action in States (OD2A-S) is to enhance ADHS' ability to track and prevent nonfatal and fatal overdoses while also identifying emerging drug threats. OD2A-S emphasizes surveillance strategies and the promotion of evidence-based and evidence-informed

interventions that have an immediate impact on reducing overdose morbidity and mortality, with a focus on opioids, stimulants, and polysubstance use (if addressed in combination with opioids and stimulants). OD2A-S is underpinned by a data to action framework that reinforces the use of surveillance and other data to inform and drive prevention efforts and policies, with an emphasis on addressing health equity and health disparities. ADHS is committed to supporting County health departments to implement data-driven prevention programs and to that end ADHS has included County support in its OD2A-S priorities. Participating counties will focus on activities related to one or more of the Prevention Strategies: Strategy 7--Public Safety Partnerships/Interventions, Strategy 8--Harm Reduction, and Strategy 9--Community-Based Linkages to Care.

2.3. Abuse and addiction to opioids is a serious and challenging national public health problem. Deaths from drug overdose have risen steadily over the past two (2) decades and have become the leading cause of injury death in the United States. The latest numbers from the CDC show a reported 92,452 overdose deaths for the year 2020, up thirty percent (30%) from the 71,130 deaths in 2019. Of those 2020 deaths, opioids were involved in 69,031, which accounts for seventy-five percent (75%) of all drug overdose deaths.

2.4. Previously, this opioid epidemic had been driven by prescription drug use. According to data from Arizona's CSPMP, there were 4.1 million Class II-IV prescriptions written and 240,511,812 pills dispensed in Arizona in 2019. This equates to thirty-four (34) Schedule II-IV controlled substance pills for every person, adults and children, living in Arizona. According to experts, recent prescribing practices in Arizona rank our state as twenty-eighth (28^{th}) for opioid prescribing with forty-four point one (44.1) prescriptions per one-hundred people; but this is no longer the root cause of overdose deaths.

2.5. Now, the main driver of the opioid crisis is fentanyl. In 2019, synthetic opioids were involved in more than 36,000 deaths in the U. S., which is about seventy-three percent (73%) of all opioid-involved deaths that year. Most of these fentanyl deaths were due to illicitly-made fentanyl, which is found in counterfeit pills and being mixed into other drugs such as heroin. Other street drugs (such as methamphetamines) may be laced with fentanyl without the user's knowledge, adding to risk of overdose. In Arizona, presence of fentanyl in overdoses significantly increased from nine percent (9%) in 2017 to fifty percent (50%) in 2021.

2.6. In addition to the human cost, the financial burden of opioid misuse is enormous. In 2019, there were 56,623 hospital visits related to opioids in Arizona, at an average cost of $11,942 per visit. This equals about $676 million dollars in health care costs due to opioids.

2.7. Prescription and illicit opioids, like fentanyl, are addictive and responsible for an increasing number of deaths in Arizona. This rise reflects a growing problem across the nation and overdose deaths are the leading cause of preventable injury death.

2.8. Pinal County has experienced a sharp increase in overdose deaths in recent years. From 2017 to 2022, overdose deaths increased by 54.2%. Pinal County sits firmly within the Drug Enforcement Administration's drug corridor. Further, due to the rural nature of the County, there are often long distances to travel for treatment and emergency medical support.

2.9. The Pinal County Public Health Services District is uniquely poised to provide prevention and harm reduction education. In partnership with the Pinal County Medical Examiner's Office and Substance Misuse Prevention Coalitions, Pinal County Public Health has demonstrated the ability to mobilize partners to raise awareness and educate. The goal of the Pinal County OD2A program is to address the opioid epidemic by implementing prevention-based strategies that will lessen the overall impact and burden of opioid misuse within Pinal County. Pinal County Public Health has been working to reduce stigma, improve access to harm-reduction methods, and increase prevention and education since 2019.

2.10. Pinal County Public Health will utilize the actionable prevention recommendations identified in the Overdose Fatality Review process to determine appropriate prevention strategies and target populations. Increase Naloxone education and distribution.

3. OBJECTIVE

With resources awarded through the CDC, Arizona will be well equipped to continue expanding prevention services and strategies to halt, reverse, and diminish the opioid crisis in our state. OD2A-S strategies and priorities include:

3.1. Enhancing the capacity of County health departments to address the opioid epidemic through implementation of prevention-based strategies that will lessen the overall impact and burden of opioid misuse across the community.

3.2. Developing and maintaining public health and public safety partnerships (Strategy 7).

3.3. Increasing access to overdose prevention and reversal tools, treatment options, and drug checking equipment through developing and sustaining partnerships and/or creating and disseminating education and communication materials (Strategy 8).

3.4. Expanding linkages to care and treatment for Opioid Use Disorder (OUD) that support retention in care (Strategy 9).

3.5. Activities using navigators are encouraged under Strategy 8 and Strategy 9. Navigators can include peer navigators, certified peer recovery specialists, peer support specialists, case managers, patient navigators, community health workers, persons with lived experience, Promotoras, Community Health Representatives (CHRs).

4. TASKS

The Contractor shall complete tasks to achieve the following goals under each prevention strategy:

4.1 Public Safety Partnerships: Developing or maintaining strong public health and public safety partnerships.

4.1.1 Ensure the Pinal County Overdose Fatality Review (OFR) team has a public safety representative on the team.

4.1.2 Strengthen partnerships with the medical examiner and EMS throughout Pinal County.

4.1.3 Collaborate with Emergency Medical Services (EMS)/First Responders to develop and implement a Pinal County community resource tool to provide to families and/or friends in the event of an overdose.

4.2 Harm Reduction: Dissemination of education and communication materials and media to community members.

4.2.1 Increase Naloxone training with local coalitions, worksites, and agencies serving high-risk populations.

4.2.2 Increase tracking of naloxone usage.

4.3 Community-Based Linkage to Care: Linkages to care that support retention in care.

4.3.1 Partner with Pinal County re-entry programs to ensure individuals newly released from incarceration have education on harm reduction tools access and a seamless transfer into treatment.

5. REQUIREMENTS

The County shall designate a point of contact that will be responsible for maintaining documentation of any PSAs created and placed in the County, regarding opioid misuse prevention.

6. DELIVERABLES

The Contractor shall:

6.1. Participate in surveys, interviews (remote or face-to-face), and questionnaires developed and disseminated by ADHS' Evaluation Team or Consultant to collect data and information necessary to assess the state and local progress with meeting grant related goals, objectives, evaluation, and outcomes.

6.2. Receive prior approval before developing or releasing any PSAs or new educational materials.

6.3. Prepare and submit annual budget(s) and work/action plan(s).

6.4. Prepare and submit quarterly Contractors Expenditures Reports (CERs) and documentation at the end of each quarter.

6.5. Submit quarterly reports to ADHS detailing quarterly progress on grant activities.

6.6. Plan, schedule and attend onsite/virtual site visit with ADHS staff, as necessary to meet grant requirements.

6.7. Attend and participate in quarterly Contractor meetings with ADHS.

6.8. Participate in statewide media/marketing efforts.

6.9. Attend and participate in ADHS' Linkages to Care workgroup.

6.10. Attend and participate in any training, statewide Contractor's meetings, or professional development provided by ADHS or its contracted vendors, as necessary.

CDC Overdose Data to Action (OD2A) Grant Deliverables Timeline (September 1st - August 31st)

DELIVERABLE TITLE	DUE DATE
1st Quarter Survey Completion and CER (September – November)	December 31st
2nd Quarter Survey Completion and CER (December – February)	March 31st
3rd Quarter Survey Completion and CER (March – May)	June 30th
4th Quarter Survey Completion and CER (June – August)	September 30th

7. STATE PROVIDED ITEMS

ADHS will:

7.1. Provide budget, work/action plan, CER, and quarterly report templates.

7.2. Coordinate quarterly Contractor calls with County staff to facilitate state and County updates, and progress on opioid prevention projects and activities.

7.3. Host an annual meeting for funded agencies and organization, either face-to-face or virtual.

7.4. Schedule meetings and professional development opportunities with Counties to provide additional support for the implementation of grant related activities.

8. REFERENCE DOCUMENTS

8.1. Arizona Opioid Epidemic webpage and Interactive Data Dashboard- https://azhealth.gov/opioid

8.2. Arizona Opioid Assistance and Referral (OAR) Line- https://phoenixmed.arizona.edu/oar

8.3. CDC Drug Overdose Website- https://www.cdc.gov/drugoverdose/

9. APPROVALS

9.1. Prior to publishing or recording any marketing materials including, but not limited to, brochures, posters, public service announcements, publications, videos, or journal articles which will be developed and paid using funds awarded under this Contract, a draft of the marketing material must first be approved by ADHS. The ADHS Communications Director must approve prior to the dissemination of such materials or airing of such announcements.

9.2. With prior written approval from the ADHS Program Manager, the Contractor is authorized to transfer up to a maximum of ten percent (10%) of the total budget amount between line items. Transfers of funds are only allowed between funded line items. Transfers exceeding ten percent (10%) or to a non-funded line item shall require an amendment. The Contractor should reach out to the ADHS Program Manager before the end of the 3rd quarter, so that a timely amendment can be processed by ADHS.

9.3. Requests for publication, student thesis or dissertations based on the work funded by this Intergovernmental Agreement must be approved in writing, in advance, by the ADHS Principal Investigator. The Contractor shall submit the request to the ADHS Principal Investigator at least forty-five (45) days in advance of proposed publication date. ADHS agrees to limit circulation and use of such materials to internal distributions with ADHS and agrees that such distribution will be solely for the purposes of review and comment. ADHS may require additional statements and will provide the statements when needed.

10. NOTICES, CORRESPONDENCE, REPORTS

10.1. Notices, Correspondence and Reports from the Contractor to ADHS shall be sent to:

Arizona Department of Health Services
Elizabeth Markona
Opioid Program Administrator
150 North 18th Avenue, Suite 310-B
Phoenix, AZ 85007
Email: elizabeth.markona@azdhs.gov

With an email cc: to maritza.valenzuela@azdhs.gov and invoices@azdhs.gov

10.2. Contractor Expenditure Reports (CERs) and documentation from the Contractor to ADHS shall be sent to:

Arizona Department of Health Services
Elizabeth Markona
Opioid Program Administrator
150 North 18th Avenue, Suite 310-B
Phoenix, AZ 85007
Email: elizabeth.markona@azdhs.gov

With an email cc: to maritza.valenzuela@azdhs.gov and invoices@azdhs.gov

10.3. Notices, Correspondence, and Reports from ADHS to the Contractor shall be sent to:

Pinal County Public Health Services District
Attention: Community Health Division Manager
PO Box 2945
Florence, AZ 85132
Phone: 820-866-7317
Email: Jan.Vidimos@pinal.gov

PRICE SHEET

COST REIMBURSEMENT

September 1st, 2023 - August 31st, 2024	
ACCOUNT CLASSIFICATION	**TOTAL BUDGET**
Personnel	$51,164.00
ERE	$19,163.00
Professional & Outside Services	$0.00
Travel	$0.00
Occupancy	$0.00
Other Operating	$2,641.00
Capital Outlay	$0.00
**Indirect (10%)	$7,032.00
TOTAL (ANNUAL NOT TO EXCEED)	**$80,000.00**

**With prior written approval from the Program Manager, the Contractor is authorized to transfer up to a maximum of ten percent (10%) of the total budget amount between line items. Transfers of funds are only allowed between funded line items. Transfers exceeding ten percent (10%) or to a non-funded line item shall require an amendment.

Exhibit One (1) - 2CFR 200.332

§ 200.332
Requirements for pass-through entities.
All pass-through entities must:

(a) Ensure that every subaward is clearly identified to the subrecipient as a subaward and includes the following information at the time of the subaward and if any of these data elements change, include the changes in subsequent subaward modification. When some of this information is not available, the pass-through entity must provide the best information available to describe the Federal award and subaward.

Prime Awardee:	**Arizona Department of Health Services**
DUNS #	**804745420**
Federal Award Identification (Grant Number):	NU17CE010227
Subrecipient name (which must match the name associated with its unique entity identifier):	Pinal County Public Health Services District
Subrecipient's unique entity identifier (DUNS #):	
Federal Award Identification Number (FAIN, sometimes it's the same as the Grant Number):	NU17CE010227
Federal Award Date (see the definition of Federal award date in § 200.1 of this part) of award to the recipient by the Federal agency;	08/23/2023
Subaward Period of Performance Start and End Date;	09/01/2023-08/31/2028
Subaward Budget Period Start and End Date:	09/01/2023-08/31/2024
Amount of Federal Funds Obligated by this action by the pass-through entity to the subrecipient (this is normally the contract amount):	$80,000.00

Total Amount of Federal Funds Obligated to the subrecipient by the pass-through entity including the current financial obligation (how much is available for contracts):	$2,897,299.00
Total Amount of the Federal Award committed to the subrecipient by the pass-through entity	$80,000.00
Federal award project description, as required to be responsive to the Federal Funding Accountability and Transparency Act (FFATA)	Overdose Data to Action in States
Name of Federal awarding agency, pass-through entity, and contact information for awarding official of the Pass-through entity	Department of Health and Human Services Center for Disease Control and Prevention
Assistance Listings number and Title; the pass-through entity must identify the dollar amount made available under each Federal award and the Assistance Listings Number at time of disbursement:	93.136
Identification of whether the award is R&D	No
Indirect cost rate for the Federal award (including if the de minimis rate is charged) per § 200.414	19.50%

Exhibit Two (2)

Required Disclosures for Federal Awardee Performance and Integrity Information System (FAPIIS): Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the CDC, with a copy to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Subrecipients must disclose, in a timely manner in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the CDC and to the HHS OIG at the following addresses:

CDC, Office of Grants Services
Keisha Thompson, Grants Management Specialist
Centers for Disease Control and Prevention
Branch 5 Supporting Chronic Diseases and Injury Prevention
2960 Brandywine Road
Atlanta, Georgia 30341
Email: dwt6@cdc.gov (Include “Mandatory Grant Disclosures” in subject line)

AND

U.S. Department of Health and Human Services
Office of the Inspector General
ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW
Cohen Building, Room 5527
Washington, DC 20201

Fax: (202)-205-0604 (Include “Mandatory Grant Disclosures” in subject line) or
Email: MandatoryGranteeDisclosures@oig.hhs.gov

—----------
Recipients must include this mandatory disclosure requirement in all subawards and contracts under this award.

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371. Remedies for noncompliance, including suspension or debarment (See 2 CFR parts 180 and 376, and 31 U.S.C. 3321).

CDC is required to report any termination of a federal award prior to the end of the period of performance due to material failure to comply with the terms and conditions of this award in the OMB-designated integrity and performance system accessible through SAM (currently FAPIIS). (45 CFR 75.372(b)) CDC must also notify the recipient if the federal award is terminated for failure to comply with the federal statutes, regulations, or terms and conditions of the federal award. (45 CFR 75.373(b))

PINAL COUNTY
WIDE OPEN OPPORTUNITY

AGENDA ITEM

May 15, 2024 ADMINISTRATION BUILDING A
FLORENCE, ARIZONA

REQUESTED BY:

Funds #: 82

Dept. #: 359

Dept. Name: Public Health

Director: Merissa Mendoza

BRIEF DESCRIPTION OF AGENDA ITEM AND REQUESTED BOARD ACTION:

Discussion/approval/disapproval of Award Agreement No. CTR067691 with Arizona Department of Health Services for HIV Prevention Program. The term of this contract will be from January 1, 2024, to December 31, 2028. The total contract amount for the first year is not to exceed $23,714. The funding was adopted in the FY 23/24 budget. There is no impact on the General Fund. (Kore Redden/Merissa Mendoza)

BRIEF DESCRIPTION OF THE FISCAL CONSIDERATIONS AND/OR EXPECTED FISCAL IMPACT OF THIS AGENDA ITEM:

The Public Health Department is statutorily required to provide these services; therefore, the revenue from this grant helps to offset the personnel costs associated with providing these services. This is a non-competitive intergovernmental agreement. There is no match requirement for this award, and there will be no impact to the general fund.

BRIEF DESCRIPTION OF THE EXPECTED PERFORMANCE IMPACT OF THIS AGENDA ITEM:

To implement a comprehensive, high-impact HIV Prevention Program in Pinal County that includes HIV testing and linkage to care.

MOTION:

Approve as presented.

History

Time	Who	Approval
5/3/2024 1:16 PM	County Attorney	Yes
5/6/2024 8:26 AM	Grants/Hearings	Yes
5/6/2024 4:09 PM	Budget Office	Yes
5/8/2024 10:48 AM	County Manager	Yes
5/8/2024 10:48 AM	Clerk of the Board	Yes

ATTACHMENTS:

Click to download
Grant Request
Contract

PINAL COUNTY
WIDE OPEN OPPORTUNITY

Board of Supervisors Grant Request

Board of Supervisors meeting date: _____

Department seeking grant: _____

Name of Granting Agency: _____

Name of Grant Program: _____

Project Name: _____

Amount requested: _____

Match amount, if applicable: _____

Application due date: _____

Anticipated award date/fiscal year: _____

What strategic priority/goal does this project address?: _____

Applicable Supervisor District: _____

Brief description of project:

Approval received per Policy 8.20: _____ OnBase Grant #: _____

Please select one:

- Discussion/Approve/Disapproval consent item _____
- New item requiring discussion/action _____
- Public Hearing required _____

Please select all that apply:

- Request to submit the application _____
- Retroactive approval to submit _____
- Resolution required _____
- Request to accept the award _____
- Request to approve/sign an agreement _____
- Budget Amendment required _____
- Program/Project update and information _____

INTERGOVERNMENTAL AGREEMENT (IGA)

Contract No. CTR067691

ARIZONA DEPARTMENT OF HEALTH SERVICES
150 North 18th Avenue, Suite 530
Phoenix, Arizona 85007

Procurement Officer
Karla Varela

Project Title: HIV Testing and Communicable Disease Investigation Services

Begin Date: 01/01/2024

Geographic Service Area: Pinal County

Termination Date: 12/31/2028

Arizona Department of Health Services has authority to contract for services specified herein in accordance with A.R.S. §§ 11-951, 11-952, 36-104 and 36-132. The Contractor represents that it has authority to contract for the performance of the services provided herein pursuant to:

- [X] **Counties: A.R.S. §§ 11-201, 11-951, 11-952 and 36-182.**
- [ ] **Indian Tribes: A.R.S. §§ 11-951, 11-952 and the rules and sovereign authority of the contracting Indian Nation.**
- [ ] **School Districts: A.R.S. §§ 11-951, 11-952, and 15-342.**
- [ ] **City of Phoenix: Chapter II, §§ 1 & 2, Charter, City of Phoenix.**
- [ ] **City of Tempe: Chapter 1, Article 1, §§ 1.01 & 1.03, Charter, City of Tempe.**

Amendments signed by each of the parties and attached hereto are hereby adopted by reference as a part of this Contract, from the effective date of the Amendment, as if fully set out herein.

Arizona Transaction (Sales) Privilege: _____

Federal Employer Identification No.: _____

Tax License No.: _____

Contractor Name: **Pinal County Public Health Services District**
Address: **PO BOX 1348, Florence, Arizona 85132**

FOR CLARIFICATION, CONTACT:

Name: Kore Redden

Phone: 520-866-7331

E-mail: Kore.Redden@Pinal.gov

CONTRACTOR SIGNATURE:
The Contractor agrees to perform all the services set forth in the Agreement and Work Statement.

Signature of Person Authorized to Sign Date

Print Name and Title

This Contract shall henceforth be referred to as **Contract No. CTR067691.** The Contractor is hereby cautioned not to commence any billable work or provide any material, service or construction under this Contract until Contractor receives a fully executed copy of the Contract.

State of Arizona

Signed this _____ day of _____, 202_

Procurement Officer

CONTRACTOR ATTORNEY SIGNATURE:
Pursuant to A.R.S. § 11-952, the undersigned Contractor's Attorney has determined that this Intergovernmental Agreement is in proper form and is within the powers and authority granted under the laws of Arizona.

Signature of Person Authorized to Sign Date

Print Name and Title

Contract, No. CTR067691, is an Agreement between public agencies, has been reviewed pursuant to A.R.S. § 11-952 by the undersigned Assistant Attorney General, who has determined that it is in the proper form and is within the powers granted under the laws of the State of Arizona to those parties to the Agreement represented by the Attorney General.
The Attorney General, BY:

Signature **Date**

Assistant Attorney General:

1. Definition of Terms As used in this Contract, the terms listed below are defined as follows:

As used in this Contract, the terms listed below are defined as follows:

1.1 “Attachment” means any item in the Contract which requires the Contractor to submit as part of the Offer.

1.2 “Contract” means the combination of the Contract documents, including the Terms and Conditions, and the Specifications and Statement or Scope of Work; and any Contract Amendments.

1.3 "Contract Amendment" means a written document signed by the Procurement Officer that is issued for the purpose of making changes in the Contract.

1.4 “Contractor” means any person who has a Contract with the State.

1.5 “Data” means recorded information, regardless of form or the media on which it may be recorded. The term may include technical data and computer software. The term does not include information incidental to contract administration, such as financial, administrative, cost or pricing, or management information.

1.6 “Days” means calendar days unless otherwise specified.

1.7 “Exhibit” means any item labeled as an Exhibit in the Contract generally containing maps, schematics, examples of reports, or other documents that will be used to perform the requirements of the Scope of Work after contract award.

1.8 “Gratuity” means a payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value is received.

1.9 “Materials” means all property, including equipment, supplies, printing, insurance and leases of property but does not include land, a permanent interest in land or real property or leasing space.

1.10 “Procurement Officer” means the person, or his or her designee, duly authorized by the State to enter into and administer Contracts and make written determinations with respect to the Contract.

1.11 “Services” means the furnishing of labor, time or effort by a Contractor or Subcontractor which does not involve the delivery of a specific end product other than required reports and performance, but does not include employment agreements or collective bargaining agreements.

1.12 “State” means any department, commission, council, board, bureau, committee, institution, agency, government corporation or other establishment or official of the executive branch or corporation commission of the State of Arizona that executes the Contract.

1.13 “State Fiscal Year” means the period beginning with July 1 and ending June 30.

1.14 “Subcontract” means any Contract, express or implied, between the Contractor and another party or between a Subcontractor and another party delegating or assigning, in whole or in part, the making or furnishing of any Materials or any Services required for the performance of the Contract.

1.15 “Subcontractor” means a person who contracts to perform work or render Services to a Contractor or to another Subcontractor as a part of a Contract with the State.

2. Contract Type

This Contract shall be:

☒ Cost Reimbursement

3. Contract Interpretation

3.1. Arizona Law. The Arizona law applies to this Contract including, where applicable, the Uniform Commercial Code as adopted by the State of Arizona and the Arizona Procurement Code, Arizona Revised Statutes (A.R.S.) Title 41, Chapter 23, and its implementing rules, Arizona Administrative Code (A.A.C.) Title 2, Chapter 7;

3.2. Implied Contract Terms. Each provision of law and any terms required by law to be in this Contract are a part of this Contract as if fully stated in it;

3.3. Contract Order of Precedence. In the event of a conflict in the provisions of the Contract, as accepted by the State and as they may be amended, the following shall prevail in the order set forth below:

3.3.1. Terms and Conditions,

3.3.2. Statement or Scope of Work,

3.3.3. Specifications,

3.3.4. Attachments,

3.3.5. Exhibits, then

3.3.6. Any other documents referenced or included in the Contract including, but not limited to, any documents that do not fall into one (1) of the above categories.

3.4. Relationship of Parties. The Contractor under this Contract is an independent Contractor. Neither party to this Contract shall be deemed to be the employee or agent of the other party to the Contract;

3.5. Severability. The provisions of this Contract are severable. Any term or condition deemed illegal or invalid shall not affect any other term or condition of the Contract;

3.6. No Parol Evidence. This Contract is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any terms used in this document and no other understanding either oral or in writing shall be binding; and

3.7. No Waiver. Either party's failure to insist on strict performance of any term or condition of the Contract shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the nonconforming performance knows of the nature of the performance and fails to object to it.

4. Contract Administration and Operation

4.1. Term. As indicated on the signature page of the Contract, the Contract shall be effective as of the Begin Date and shall remain effective until the Termination Date;

4.2. Contract Renewal. This Contract shall not bind, nor purport to bind, the State for any contractual commitment in excess of the original Contract period. The term of the Contract shall not exceed five (5) years. However, if the original Contract period is for less than five (5) years, the State shall have the

right, at its sole option, to renew the Contract, so long as the original Contract period together with the renewal periods does not exceed five (5) years. If the State exercises such rights, all terms, conditions and provisions of the original Contract shall remain the same and apply during the renewal period with the exception of price and Scope of Work, which may be renegotiated;

4.3. New Budget Term. If a budget term has been completed in a multi-term Contract, the parties may agree to change the amount and type of funding to accommodate new circumstances in the next budget term. Any increase or decrease in funding at the time of the new budget term shall coincide with a change in the Scope of Work or change in cost of services as approved by the Arizona Department of Health Services;

4.4. Records. Under A.R.S. § 35-214 and § 35-215, the Contractor shall retain and shall contractually require each Subcontractor to retain any and all Data and other "records" relating to the acquisition and performance of the Contract for a period of five (5) years after the completion of the Contract. All records shall be subject to inspection and audit by the State at reasonable times. Upon request, the Contractor shall produce a legible copy of any or all such records;

4.5. Non-Discrimination. The Contractor shall comply with State Executive Order Nos. 2023-09, 2023-01, 2009-09, and any and all other applicable Federal and State laws, rules and regulations, including the Americans with Disabilities Act. Contractor shall include these provisions in contracts with Subcontractors when required by Federal or State law;

4.6. Audit. Pursuant to A.R.S. § 35-214, at any time during the term of this Contract and five (5) years thereafter, the Contractor's or any Subcontractor's books and records shall be subject to audit by the State and, where applicable, the Federal Government, to the extent that the books and records relate to the performance of the Contract or Subcontract;

4.7. Facilities Inspection and Materials Testing. The Contractor agrees to permit access to its facilities, Subcontractor facilities, and the Contractor's processes or services, at reasonable times for inspection of the facilities or Materials covered under this Contract as required under A.R.S. § 41-2547. The State shall also have the right to test, at its own cost, the Materials to be supplied under this Contract. Neither inspection of the Contractor's facilities nor Materials testing shall constitute final acceptance of the Materials or Services. If the State determines non-compliance of the Materials, the Contractor shall be responsible for the payment of all costs incurred by the State for testing and inspection;

4.8. Notices. Notices to the Contractor required by this Contract shall be made by the State to the person indicated on the Offer and Acceptance form submitted by the Contractor unless otherwise stated in the Contract. Notices to the State required by the Contract shall be made by the Contractor to the Solicitation Contact Person indicated on the Solicitation, stated in the Contract, or listed on the State's eProcurement system. An authorized Procurement Officer and an authorized Contractor representative may change their respective person to whom notice shall be given by written notice to the other and an amendment to the Contract shall not be necessary;

4.9. Advertising, Publishing and Promotion of Contract. The Contractor shall not use, advertise or promote information for commercial benefit concerning this Contract without the prior written approval of the Procurement Officer;

4.10. Continuous Improvement. Contractor shall recommend continuous improvements on an on-going basis in relation to any Materials and Services offered under the Contract, with a view to reducing State costs and improving the quality and efficiency of the provision of Materials or Services. State may require Contractor to engage in continuous improvements throughout the term of the Contract;

4.11. Other Contractors. State may undertake on its own or award other contracts to the same or other suppliers for additional or related work. In such cases, the Contractor shall cooperate fully with State employees and such other suppliers and carefully coordinate, fit, connect, accommodate, adjust, or sequence its

work to the related work by others. Where the Contract requires handing-off Contractor's work to others, Contractor shall cooperate as State instructs regarding the necessary transfer of its work product, Materials, Services, or records to State or the other suppliers. Contractor shall not commit or permit any act that interferes with the State's or other suppliers' performance of their work, provided that, State shall enforce the foregoing section equitably among all its suppliers so as not impose an unreasonable burden on any of them;

4.12. Ownership of Intellectual Property:

4.12.1. Rights In Work Product. All intellectual property originated or prepared by Contractor pursuant to the Contract, including but not limited to, inventions, discoveries, intellectual copyrights, trademarks, trade names, trade secrets, technical communications, records reports, computer programs and other documentation or improvements thereto, including Contractor's administrative communications and records relating to the Contract, are considered work product and Contractor's property, provided that, State has Government Purpose Rights to that work product as and when it was delivered to State,

4.12.2. "Government Purpose Rights" are:

4.12.2.1. the unlimited, perpetual, irrevocable, royalty free, non-exclusive, worldwide right to use, modify, reproduce, release, perform, display, sublicense, disclose and create derivatives from that work product without restriction for any activity in which State is a party;

4.12.2.2. the right to release or disclose that work product to third parties for any State government purpose; and

4.12.2.3. the right to authorize those to whom it rightfully releases or discloses that work product to use, modify, release, create derivative works from the work product for any State government purpose; such recipients being understood to include the federal government, the governments of other states, and various local governments.

4.12.3. "Government Purpose Rights" do not include any right to use, modify, reproduce, perform, release, display, create derivative works from or disclose that work product for any commercial purpose, or to authorize others to do so,

4.12.4. Joint Developments. The Contractor and State may each use equally any ideas, concepts, know-how, or techniques developed jointly during the course of the Contract, and may do so at their respective discretion, without obligation of notice or accounting to the other party,

4.12.5. Pre-existing Material. All pre-existing software and other Materials developed or otherwise obtained by or for Contractor or its affiliates independently of the Contract or applicable Purchase Orders are not part of the work product to which rights are granted State under subparagraph 3.9.1 above, and will remain the exclusive property of Contractor, provided that:

4.12.5.1. any derivative works of such pre-existing Materials or elements thereof that are created pursuant to the Contract are part of that work product;

4.12.5.2. any elements of derivative work of such pre-existing Materials that was not created pursuant to the Contract are not part of that work product; and

4.12.5.3. except as expressly stated otherwise, nothing in the Contract is to be construed to interfere or diminish Contractor's or its affiliates' ownership of such pre-existing Materials.

4.12.6. Developments Outside of Contract. Unless expressly stated otherwise in the Contract, this Section does not preclude Contractor from developing competing Materials outside the Contract, irrespective of any similarity to Materials delivered or to be delivered to State hereunder.

4.13. Property of the State. If there are any materials that are not covered by Section 4.12 above created under this Contract, including but not limited to, reports and other deliverables, these materials are the sole property of the State. The Contractor is not entitled to a patent or copyright on those materials and may not transfer the patent or copyright to anyone else. The Contractor shall not use or release these materials without the prior written consent of the State;

4.14. Federal Immigration and Nationality Act. Contractor shall comply with all federal, state and local immigration laws and regulations relating to the immigration status of their employees during the term of the Contract. Further, Contractor shall flow down this requirement to all Subcontractors utilized during the term of the Contract. The State shall retain the right to perform random audits of Contractor and Subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Contractor or any Subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to: suspension of work, termination of the Contract for default and suspension or debarment of the Contractor;

4.15. E-Verify Requirements. In accordance with A.R.S. § 41-4401, Contractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. § 23- 214, Subsection A;

4.16. Offshore Performance of Work involving Data is Prohibited. Any Services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and involve access to Data shall be performed within the defined territories of the United States;

4.17. Certifications Required by State Law:

4.17.1. If Contractor is a Company as defined in A.R.S. § 35-393, Contractor certifies that it is not currently engaged in a boycott of Israel as described in A.R.S. §§ 35-393 *et seq*. and will refrain from any such boycott for the duration of this Contract, and

4.17.2. Contractor further certifies that it shall comply with A.R.S. § 35-394, regarding use of the forced labor of ethnic Uyghurs, as applicable.

4.18. Protection of State Cybersecurity Interests. The Contractor shall comply with State Executive Order No. 2023-10, which includes, but is not limited to, a prohibition against (a) downloading and installing of TikTok on all State-owned and State-leased information technology; and (b) accessing TikTok through State information technology.

5. Costs and Payments

5.1. Payments. Payments shall comply with the requirements of A.R.S. Titles 35 and 41, Net 30 days. Upon receipt and acceptance of Materials or Services, the Contractor shall submit a complete and accurate invoice for payment from the State within thirty (30) days;

5.2. Delivery. Unless stated otherwise in the Contract, per A.R.S. § 47-2319, all prices shall be F.O.B. (“free on board”) Destination and shall include all freight delivery and unloading at the destination;

5.3. Firm, Fixed Price. Unless stated otherwise in the Special Terms and Conditions of the Contract, all prices shall be firm-fixed-prices;

5.4. Applicable Taxes:

5.4.1. Payment of Taxes. The Contractor shall be responsible for paying all applicable taxes,

5.4.2. State and Local Transaction Privilege Taxes. The State of Arizona is subject to all applicable state and local transaction privilege taxes. Transaction privilege taxes apply to the sale and are the responsibility of the seller to remit. Failure to collect such taxes from the buyer does not relieve the seller from its obligation to remit taxes,

5.4.3. Tax Indemnification. Contractor and all Subcontractors shall pay all Federal, state and local taxes applicable to its operation and any persons employed by the Contractor. Contractor shall, and require all Subcontractors to hold the State harmless from any responsibility for taxes, damages and interest, if applicable, contributions required under Federal, and/or state and local laws and regulations and any other costs including transaction privilege taxes, unemployment compensation insurance, Social Security and Worker's Compensation, and

5.4.4. IRS W9 Form. In order to receive payment, the Contractor shall have a current I.R.S. W9 Form on file with the State of Arizona, unless not required by law.

5.5. Availability of Funds for the Next State Fiscal Year. Funds may not presently be available for performance under this Contract beyond the current State Fiscal Year. No legal liability on the part of the State for any payment may arise under this Contract beyond the current State Fiscal Year until funds are made available for performance of this Contract;

5.6. Availability of Funds for the Current State Fiscal Year. Should the State Legislature enter back into session and reduce the appropriations or for any reason and these Materials or Services are not funded, the State may take any of the following actions:

5.6.1. Accept a decrease in price offered by the Contractor,

5.6.2. Cancel the Contract, or

5.6.3. Cancel the Contract and re-solicit the requirements.

6. Contract Changes

6.1. Amendments. This Contract is issued under the authority of the Procurement Officer who signed this Contract. The Contract may be modified only through a Contract Amendment within the scope of the Contract. Changes to the Contract, including the addition of Services or Materials, the revision of payment terms, or the substitution of Services or Materials, directed by a person who is not specifically authorized by the Procurement Officer in writing or made unilaterally by the Contractor are violations of the Contract and of applicable law. Such changes, including unauthorized written Contract Amendments shall be void and without effect, and the Contractor shall not be entitled to any claim under this Contract based on those changes;

6.2. Subcontracts. The Contractor shall not enter into any Subcontract under this Contract for the performance of this Contract without the advance written approval of the Procurement Officer as described in Arizona State Procurement Office Standard Procedure 002. The Contractor shall clearly list any proposed Subcontractors and the Subcontractor's proposed responsibilities. The Subcontract shall incorporate by reference the terms and conditions of this Contract; and

6.3. Assignment and Delegation. The Contractor shall not assign any right nor delegate any duty under this Contract without the prior written approval of the Procurement Officer. The State shall not unreasonably withhold approval.

7. Risk and Liability

7.1. Risk of Loss. The Contractor shall bear all loss of conforming Materials covered under this Contract until received by authorized personnel at the location designated in the purchase order or Contract. Mere receipt does not constitute final acceptance. The risk of loss for nonconforming Materials shall remain with the Contractor regardless of receipt;

7.2. Indemnification:

7.2.1. Contractor/Vendor Indemnification (Not Public Agency).To the fullest extent permitted by law, Contractor shall defend, indemnify, and hold harmless the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees (hereinafter referred to as “Indemnitee”) from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys’ fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as “Claims”) for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or Subcontractors. This indemnity includes any claim or amount arising out of, or recovered under, the Workers’ Compensation Law or arising out of the failure of such Contractor to conform to any federal, state, or local law, statute, ordinance, rule, regulation, or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense, and judgment costs where this indemnification is applicable. In consideration of the award of this Contract, the Contractor agrees to waive all rights of subrogation Insurance and Indemnification Guidelines for State of Arizona Contracts Professional Service Contracts against the State of Arizona, its officers, officials, agents, and employees for losses arising from the work performed by the Contractor for the State of Arizona. This indemnity shall not apply if the Contractor or Subcontractor(s) is/are an agency, board, commission or university of the State of Arizona, and

7.2.2. Public Agency Language Only. Each party (as 'indemnitor') agrees to indemnify, defend, and hold harmless the other party (as 'indemnitee') from and against any and all claims, losses, liability, costs, or expenses (including reasonable attorney's fees) (hereinafter collectively referred to as 'claims') arising out of bodily injury of any person (including death) or property damage but only to the extent that such claims which result in vicarious/derivative liability to the indemnitee, are caused by the act, omission, negligence, misconduct, or other fault of the indemnitor, its officers, officials, agents, employees, or volunteers.

7.3. Indemnification - Patent and Copyright. The Contractor shall indemnify and hold harmless the State against any liability, including costs and expenses, for infringement of any patent, trademark or copyright arising out of Contract performance or use by the State of Materials furnished or work performed under this Contract. The State shall reasonably notify the Contractor of any claim for which it may be liable under this paragraph. If the Contractor is insured pursuant to A.R.S. § 41-621 and § 35-154, this paragraph shall not apply;

7.4. Force Majeure:

7.4.1. Except for payment of sums due, neither the Contractor nor State shall be liable to the other nor deemed in default under this Contract if and to the extent that such party’s performance of this Contract is prevented by reason of force majeure. The term “force majeure” means an occurrence that is beyond the control of the party affected and occurs without its fault or negligence. Without limiting the foregoing, force majeure includes: acts of God, acts of the public enemy, war, riots, strikes, mobilization, labor disputes, civil disorders, fire, flood, lockouts, injunctions-intervention-acts, failures or refusals to act by government authority, and other similar

occurrences beyond the control of the party declaring force majeure which such party is unable to prevent by exercising reasonable diligence,

7.4.2. Force Majeure shall not include the following occurrences:

7.4.2.1. Late delivery of equipment, Materials, or Services caused by congestion at a manufacturer's plant or elsewhere, or an oversold condition of the market;

7.4.2.2. Late performance by a Subcontractor unless the delay arises out of a force majeure occurrence in accordance with this force majeure term and condition; or

7.4.2.3. Inability of either the Contractor or any Subcontractor to acquire or maintain any required insurance, bonds, licenses or permits.

7.4.3. If either the Contractor or State is delayed at any time in the progress of the work by force majeure, the delayed party shall notify the other party in writing of such delay, as soon as is practicable and no later than the following working day, of the commencement thereof and shall specify the causes of such delay in such notice. Such notice shall be delivered or mailed certified-return receipt and shall make a specific reference to this article, thereby invoking its provisions. The delayed party shall cause such delay to cease as soon as practicable and shall notify the other party in writing when it has done so. The time of completion shall be extended by Contract Amendment for a period of time equal to the time that results or effects of such delay prevent the delayed party from performing in accordance with this Contract, and

7.4.4. Any delay or failure in performance by either party hereto shall not constitute default hereunder or give rise to any claim for damages or loss of anticipated profits if, and to the extent that such delay or failure is caused by force majeure.

7.5. Third Party Antitrust Violations. The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern Materials or Services supplied by third parties to the Contractor, toward fulfillment of this Contract.

8. Warranties

8.1. Liens. The Contractor warrants that the Materials supplied under this Contract are free of liens and shall remain free of liens;

8.2. Quality. Unless otherwise modified elsewhere in the Terms and Conditions, the Contractor warrants that, for one (1) year after acceptance by the State of the Materials, they shall be:

8.2.1. Of a quality to pass without objection in the trade under the Contract description,

8.2.2. Fit for the intended purposes for which the Materials are used,

8.2.3. Within the variations permitted by the Contract and are of even kind, quantity, and quality within each unit and among all units,

8.2.4. Adequately contained, packaged, and marked as the Contract may require, and

8.2.5. Conform to the written promises or affirmations of fact made by the Contractor.

8.3. Conformity to Requirements:

8.3.1. Contractor warrants that, unless expressly provided otherwise elsewhere in the Contract, the Materials and Services will for one (1) year after acceptance and in each instance:

8.3.1.1. Conform to the requirements of the Contract, which by way of reminder include without limitation all descriptions, specifications, and drawings identified in the Scope of Work and any and all Contractor affirmations included as part of the Contract;

8.3.1.2. Be free from defects of material and workmanship;

8.3.1.3. Conform to or perform in a manner consistent with current industry standards; and

8.3.1.4. Be fit for the intended purpose or use described in the Contract.

8.3.2. Mere delivery or performance does not substitute for express acceptance by the State. Where inspection, testing, or other acceptance assessment of Materials or Services cannot be done until after installation or invoicing, the forgoing warranty will not begin until State's explicit acceptance of the Materials or Services.

8.4. Inspection/Testing. The warranties set forth in this Section 8 [Warranties] are not affected by inspection or testing of or payment for the Materials or Services by the State;

8.5. Contractor Personnel. Contractor warrants that its personnel will perform their duties under the Contract in a professional manner, applying the requisite skills and knowledge, consistent with industry standards, and in accordance with the requirements of the Contract. Contractor further warrants that its key personnel will maintain any and all certifications relevant to their work, and Contractor shall provide individual evidence of certification to State's authorized representatives upon request;

8.6. Compliance With Applicable Laws. The Materials and Services supplied under this Contract shall comply with all applicable federal, state, and local laws and policies (including, but not limited to, information technology policies, standards, and procedures available on the State's website and/or the website of any department, commission, council, board, bureau, committee, institution, agency, government corporation or other establishment or official of the executive branch or corporation commission of the State of Arizona). Federal requirements may be incorporated into this Contract, if required, pursuant to A.R.S. § 41-2637. Contractor shall maintain any and all applicable license and permit requirements. This requirement includes, but is not limited to, any and all Arizona state statutes that impact state contracts, regardless of whether those statutory references have been removed during the course of contract negotiations; this is notice to Contractors that the State does not have the authority to modify Arizona state law by contract;

8.7. Intellectual Property. Contractor warrants that the Materials and Services do not and will not infringe or violate any patent, trademark, copyright, trade secret, or other intellectual property rights or laws, except only to the extent the Specifications do not permit use of any other product and Contractor is not and cannot reasonably be expected to be aware of the infringement or violation;

8.8. Licenses and Permits. Contractor warrants that it will maintain all licenses required to fully perform its duties under the Contract and all required permits valid and in force;

8.9. Operational Continuity. Contractor warrants that it will perform without relief notwithstanding being sold or acquired; no such event will operate to mitigate or alter any of Contractor's duties hereunder absent a consented delegation under paragraph 6.3. [Assignment and Delegation] that expressly recognizes the event;

8.10. Performance in Public Health Emergency. Contractor warrants that it will:

8.10.1. Have in effect, promptly after commencement, a plan for continuing performance in the event of a declared public health emergency that addresses, at a minimum:

8.10.1.1. Identification of response personnel by name;

8.10.1.2. Key succession and performance responses in the event of sudden and significant decrease in workforce; and

8.10.1.3. Alternative avenues to keep sufficient product on hand or in the supply chain.

8.10.2. Provide a copy of its current plan to State within three (3) business days after State's written request. If Contractor claims relief under paragraph 7.4 [Force Majeure] for an occurrence of force majeure that is a declared public health emergency, then that relief will be conditioned on Contractor having first implemented its plan and exhausted all reasonable opportunity for that plan implementation to overcome the effects of that occurrence, or mitigate those effects to the extent that overcoming entirely is not practicable,

8.10.3. A request from the State related to this paragraph 8.10 does not necessarily indicate that there has been an occurrence of force majeure, and the Contractor will not be entitled to any additional compensation or extension of time by virtue of having to implement a plan, and

8.10.4. Failure to have or implement an appropriate plan will be a material breach of contract.

8.11. Lobbying:

8.11.1. Prohibition. Contractor warrants that it will not engage in lobbying activities, as defined in 40 Code of Federal Regulations (CFR) part 34 and A.R.S. § 41-1231, *et seq*., using monies awarded under the Contract, provided that, the foregoing does not intend to constrain Contractor's use of its own monies or property, including without limitation any net proceeds duly realized under the Contract or any value thereafter derived from those proceeds; and upon award of the Contract, it will disclose all lobbying activities to State to the extent they are an actual or potential conflict of interest or where such activities could create an appearance of impropriety. Contractor shall implement and maintain adequate controls to assure compliance with above. Contractor shall obtain an equivalent warranty from all Subcontractors and shall include an equivalent no-lobbying provision in all Subcontracts, and

8.11.2. Exception. This paragraph 8.11 does not apply to the extent that the Services are defined in the Contract as being lobbying for State's benefit or on State's behalf.

8.12. Covered Telecommunications or Services. Contractor warrants that the Materials and Services rendered under this Agreement will not require Contractor to use for the State, or provide to the State to use, "covered telecommunications equipment or Services" as a substantial or essential component of any system, or as critical technology as part of any system, within the meaning of Federal Acquisition Regulation ("FAR") Section 52.204-25;

8.13. Debarment, Suspension, U.S. Government Restricted Party Lists. Contractor warrants that it is not, and its Subcontractors are not, on the U.S. government's Denied Parties List, the Unverified List, the Entities List, the Specially Designated Nationals and Blocked Parties List, and neither the Contractor nor any Subcontractors are presently debarred, suspended, proposed for debarment or otherwise declared ineligible for award of federal contracts or participation in federal assistance programs or activities;

8.14. False Statements. Contractor represents and warrants that all statements and information Contractor prepared and submitted in response to the Solicitation or as part of the Contract documents are current, complete, true, and accurate. If the Procurement Officer determines that Contractor submitted an Offer or Bid with a false statement, or makes material misrepresentations during the performance of the Contract, the Procurement Officer may determine that Contractor has materially breached the Contract and may void the submitted Offer or Bid and any resulting Contract; and

8.15. Survival of Rights and Obligations after Contract Expiration or Termination:

8.15.1. Survival of Warranty. All representations and warranties made by Contractor under the Contract will survive the expiration or earlier termination of the Contract,

8.15.2. Contractor's Representations and Warranties. All representations and warranties made by the Contractor under this Contract shall survive the expiration or termination hereof. In addition, the parties hereto acknowledge that pursuant to A.R.S. § 12-510, except as provided in A.R.S. § 12- 529, the State is not subject to or barred by any limitations of actions prescribed in A.R.S., Title 12, Chapter 5, and

8.15.3. Purchase Orders. The Contractor shall, in accordance with all terms and conditions of the Contract, fully perform and shall be obligated to comply with all purchase orders received by the Contractor prior to the expiration or termination hereof, unless otherwise directed in writing by the Procurement Officer, including, without limitation, all purchase orders received prior to but not fully performed and satisfied at the expiration or termination of this Contract.

9. State's Contractual Remedies

9.1. Right to Assurance. If the State in good faith has reason to believe that the Contractor does not intend to, or is unable to perform or continue performing under this Contract, the Procurement Officer may demand in writing that the Contractor give a written assurance of intent to perform. Failure by the Contractor to provide written assurance within the number of Days specified in the demand may, at the State's option, be the basis for terminating the Contract under the Uniform Terms and Conditions or other rights and remedies available by law or provided by the Contract;

9.2. Stop Work Order:

9.2.1. The State may, at any time, by written order to the Contractor, require the Contractor to stop all or any part of the work called for by this Contract for period(s) of days indicated by the State after the order is delivered to the Contractor. The order shall be specifically identified as a stop work order issued under this clause. Upon receipt of the order, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize the incurrence of costs allocable to the work covered by the order during the period of work stoppage, and

9.2.2. If a stop work order issued under this clause is canceled or the period of the order or any extension expires, the Contractor shall resume work. The Procurement Officer shall make an equitable adjustment in the delivery schedule or Contract price, or both, and the Contract shall be amended in writing accordingly.

9.3. Non-exclusive Remedies. The rights and the remedies of the State under this Contract are not exclusive;

9.4. Nonconforming Tender. Materials or Services supplied under this Contract shall fully comply with the Contract. The delivery of Materials or Services or a portion of the Materials or Services that do not fully comply constitutes a breach of contract. On delivery of nonconforming Materials or Services, the State may terminate the Contract for default under applicable termination clauses in the Contract, exercise any of its rights and remedies under the Uniform Commercial Code, or pursue any other right or remedy available to it; and

9.5. Right of Offset. The State shall be entitled to offset against any sums due the Contractor, any expenses or costs incurred by the State, or damages assessed by the State concerning the Contractor's non-conforming performance or failure to perform the Contract, including expenses, costs and damages described in the Uniform Terms and Conditions.

10. Contract Termination

10.1. Cancellation for Conflict of Interest. Pursuant to A.R.S. § 38-511, the State may cancel this Contract within three (3) years after Contract execution without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the Contract on behalf of the State is or becomes at any time while the Contract or an extension of the Contract is in effect an employee of or a consultant to any other party to this Contract with respect to the subject matter of the Contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time. If the Contractor is a political subdivision of the State, it may also cancel this Contract as provided in A.R.S. § 38-511;

10.2. Gratuities. The State may, by written notice, terminate this Contract, in whole or in part, if the State determines that employment or a Gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State with the purpose of influencing the outcome of the procurement or securing the Contract, an amendment to the Contract, or favorable treatment concerning the Contract, including the making of any determination or decision about contract performance. The State, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three (3) times the value of the Gratuity offered by the Contractor;

10.3. Suspension or Debarment. The State may, by written notice to the Contractor, immediately terminate this Contract if the State determines that the Contractor has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity, including but not limited to, being disapproved as a Subcontractor of any public procurement unit or other governmental body. Submittal of an offer or execution of a contract shall attest that the Contractor is not currently suspended or debarred. If the Contractor becomes suspended or debarred, the Contractor shall immediately notify the State; and

10.4. Termination for Convenience. The State reserves the right to terminate the Contract, in whole or in part at any time when in the best interest of the State, without penalty or recourse. Upon receipt of the written notice, the Contractor shall stop all work, as directed in the notice, notify all Subcontractors of the effective date of the termination and minimize all further costs to the State. In the event of termination under this paragraph, all documents, Data and reports prepared by the Contractor under the Contract shall become the property of and be delivered to the State upon demand. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed, and Materials or Services accepted before the effective date of the termination. The cost principles and procedures provided in A.R.S. § 41-2543 and A.A.C. Title 2, Chapter 7, Article 7, shall apply.

10.5. Termination for Default:

10.5.1. In addition to the rights reserved in the Contract, the State may terminate the Contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the Contract, to acquire and maintain all required insurance policies, bonds, licenses and permits, or to make satisfactory progress in performing the Contract. The Procurement Officer shall provide written notice of the termination and the reasons for it to the Contractor,

10.5.2. Upon termination under this paragraph, all goods, Materials, documents, Data, and reports prepared by the Contractor under the Contract shall become the property of and be delivered to the State on demand, and

10.5.3. The State may, upon termination of this Contract, procure, on terms and in the manner that it deems appropriate, Materials or Services to replace those under this Contract. The Contractor shall be liable to the State for any excess costs incurred by the State in procuring Materials or Services in substitution for those due from the Contractor.

10.6. Continuation of Performance Through Termination. The Contractor shall continue to perform, in accordance with the requirements of the Contract, up to the date of termination, as directed in the

termination notice.

11. Contract Claims

All contract claims or controversies under this Contract shall be resolved according to A.R.S. Title 41, Chapter 23, Article 9, and rules adopted thereunder.

12. Arbitration

The parties to this Contract agree to resolve all disputes arising out of or relating to this Contract through arbitration, after exhausting applicable administrative review, to the extent required by A.R.S. § 12-1518, except as may be required by other applicable statutes (A.R.S. Title 41).

13. Communication

13.1. Program Report. When reports are required by the Contract, the Contractor shall provide them in the format approved by ADHS; and

13.2. Information and Coordination. The State will provide information to the Contractor pertaining to activities that affect the Contractor's delivery of services, and the Contractor shall be responsible for coordinating their activities with the State's in such a manner as not to conflict or unnecessarily duplicate the State's activities. As the work of the Contractor progresses, advice and information on matters covered by the Contract shall be made available by the Contractor to the State throughout the effective period of the Contract.

14. Client Grievances

If applicable, the Contractor and its subcontractors shall use a procedure through which clients may present grievances about the operation of the program that result in the denial, suspension or reduction of services provided pursuant to this Contract and which is acceptable to and approved by the State.

15. Sovereign Immunity

Pursuant to A.R.S. § 41-621(O), the obtaining of insurance by the State shall not be a waiver of any sovereign immunity defense in the event of suit.

16. Administrative Changes

The Procurement Officer, or authorized designee, reserves the right to correct any obvious clerical, typographical or grammatical errors, as well as errors in party contact information (collectively, "Administrative Changes"), prior to or after the final execution of a Contract or Contract Amendment. Administrative Changes subject to permissible corrections include: misspellings, grammar errors, incorrect addresses, incorrect Contract Amendment numbers, pagination and citation errors, mistakes in the labeling of the rate as either extended or unit, and calendar date errors that are illogical due to typographical error. The Procurement Office shall subsequently send to the Contractor notice of corrections to administrative errors in a written confirmation letter with a copy of the corrected Administrative Change attached.

17. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

17.1. The Contractor warrants that it is familiar with the requirements of HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009, and accompanying regulations and will comply with all applicable HIPAA requirements in the course of this Contract. Contractor warrants that it will cooperate with the Arizona Department of Health Services (ADHS) in the course of performance of the Contract so that both ADHS and Contractor will be in compliance with HIPAA, including cooperation and coordination with the Arizona Department of Administration-Arizona Strategic Enterprise

Technology (ADOA-ASET) Office, the ADOA-ASET Arizona State Chief Information Security Officer and HIPAA Coordinator and other compliance officials required by HIPAA and its regulations. Contractor will sign any documents that are reasonably necessary to keep ADHS and Contractor in compliance with HIPAA, including, but not limited to, business associate agreements; and

17.2. If requested by the ADHS Procurement Office, Contractor agrees to sign a "Pledge To Protect Confidential Information" and to abide by the statements addressing the creation, use and disclosure of confidential information, including information designated as protected health information and all other confidential or sensitive information as defined in policy. In addition, if requested, Contractor agrees to attend or participate in HIPAA training offered by ADHS or to provide written verification that the Contractor has attended or participated in job related HIPAA training that is: (1) intended to make the Contractor proficient in HIPAA for purposes of performing the services required and (2) presented by a HIPAA Privacy Officer or other person or program knowledgeable and experienced in HIPAA and who has been approved by the ADOA-ASET Arizona State Chief Information Security Officer and HIPAA Coordinator.

18. Fraud, Waste, or Abuse

18.1. ADHS requires all employees to abide by the State's Personnel System Rules, R2-5A-501; Standards of Conduct which includes maintaining high standards of honesty, integrity, and impartiality, free from personal considerations and/or favoritism, and Code of Conduct for individuals engaged in Accounting, Financial and Budgeting Activities which depicts the moral, ethical, legal and professional aspects of personal conduct. ADHS requires the same conduct of its consultants, vendors, contractors, subrecipients, or persons doing business with the agency;

18.2. Any State employee, consultant, vendor, contractor or subrecipient or person doing business with the Agency who receives a report of improper activity must report the information within one (1) business day. Note: Federal Award policy denotes awardees must disclose, in a timely manner, in writing to ADHS all violations of Federal Criminal Law, involving fraud, bribery, or gratuity violations potentially affecting Federal Awards; and

18.3. Anyone suspecting Fraud, Waste, or Abuse related to ADHS activities are required to report Fraud, Waste, or abuse through any of the following reporting channels:

18.3.1. ADHS Ethics Action Hotline at (602) 542-2347,

18.3.2. ADHS Ethics Action Email at reportethics@azdhs.gov ,or

18.3.3. General Accounting Office (GAO) Fraud Reporting Email at reportfraud@azdoa.gov to report Fraud, Waste, or Abuse incidents.

19. Unique Entity Identifier (UEI) Requirement

Pursuant to 2 CFR 25.100 et seq., no entity (defined as a Governmental organization, which is a State, local government, or Indian tribe; foreign public entity; domestic or foreign nonprofit organization; domestic or foreign for-profit organization; or Federal agency, but only as a sub-recipient under an award or sub-award to a non-Federal entity) may receive a sub-award from ADHS unless the entity provides its Unique Entity Identifier Number to ADHS. The number can be created in SAM.gov. If already registered the UEI has been assigned and can be viewed in SAM.gov.

20. The Federal Funding Accountability and Transparency Act (FFATA or Transparency Act - P.L.109-282, as amended by section 6202(a) of P.L. 110-252), found at https://www.fsrs.gov/

If applicable, the subrecipient or sub-awardee is required to abide by the Federal Funding Accountability and Transparency Act (FFATA or Transparency Act – P.L. 109-282, as amended by section 6202(a) of P.L. 110-252), found at https://www.fsrs.gov/. The associated Grant Reporting Certification Form and completion instructions will

be sent to the subrecipient from ADHS Program(s) responsible for the specific contract. The subrecipient or sub-awardee must return the completed form to ADHS Program(s) by the 15th of the month following that in which the award was received. Failure to complete a required Grant Reporting Certification Form may result in loss of funding.

21. Technology Replacement

In any event where product is discontinued, no longer available or technically inferior to newly developed product, the Contractor shall provide an equivalent replacement model at no additional cost and shall honor the original contract terms

22. Authorization for Provision of Services

Authorization for purchase of services under this Agreement shall be made only upon ADHS issuance of a Purchase Order that is signed by an authorized agent. The Purchase Order will indicate the Agreement number and the dollar amount of the funds authorized. The Contractor shall only be authorized to perform services up to the amount of the Purchase Order. ADHS shall not have any legal obligation to pay for services in excess of the amount indicated on the Purchase Order. No further obligation for payment shall exist on behalf of ADHS unless 2) the Purchase Order is changed or modified with an official ADHS Procurement Change Order, and/or an additional Purchase Order is issued for purchase of services under this Agreement.

Additional Terms and Conditions for Title 2, Subtitle A, Chapter II, Part 200, Subpart C: §200.201 USE OF GRANT AGREEMENTS (INCLUDING FIXED AMOUNT AWARDS), COOPERATIVE AGREEMENTS AND CONTRACT

23. Civil Rights Assurance Statement.

The Contractor and Subcontractors are subject to Title VI of the Civil Rights Act of 1964, Section 504 of Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, Title IX of the Education Amendment of 1972, and offers all persons the opportunity to participate in programs or activities regardless or race, color, national origin, age, sex, or disability. Further, it is agreed that no individual will be turned away from or otherwise denied access to or benefit from any program or activity that is directly associated with a program of the RECIPIENT on the basis of race, color, national origin, age, sex (in educational activities) or disability.

24. Americans With Disabilities Act of 1990.

24.1. The Contractor shall comply with the Americans With Disabilities Act of 1990 (Public Law 101-336) and the Arizona Disability Act of 1992 (A.R.S § 41-1492 et. seq.), which prohibits discrimination of the basis of physical or mental disabilities in delivering contract services or in the employment, or advancement in employment of qualified individuals; and

24.2. Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contracting the Contract Manager for the Contract. Request should be made as early as possible to allow time to arrange the accommodation.

25. Federal Funding. Funding for these services is contingent upon the availability of federal government funding. No commitment of any kind is made by the State concerning this Grant unless there are monies provided by a federal grant. The Grantee should take this fact into consideration.

25.1. For the purposes of this Grant, a capital expenditure means expenditures to acquire capital assets, as defined in 2 C.F.R. 200.12, or expenditures to make additions, improvements, modifications, replacements, rearrangements, reinstallations, renovations, or– alterations to capital assets that materially increase their value or useful life, with a cost of $250 or greater;

25.2. Grantee agrees to maintain property records for equipment purchased with grant funds and perform a physical inventory and reconciliation with property records at least every year. Grantee agrees that funds

will not be used for the construction of new facilities;

25.3. Grantee agrees to follow equipment disposition policies as determined by the Federal Awarding Agency at Award Completion or as depicted in the State of Arizona Accounting Manual. Grantee also agrees to follow the directives in ADHS Property and Procedure Policy FIN 111;

25.4. Charges to Federal awards for salaries and wages must be based on records that accurately reflect the work performed. These records must: Be supported by a system of internal control which provides reasonable assurance that the charges are accurate, allowable, and properly allocated; Be incorporated into the official records of the non-Federal entity; Reasonably reflect the total activity for which the employee is compensated by the non-Federal entity, not exceeding 100% of compensated activities (for IHE, this per the IHE's definition of IBS); Encompass both federally assisted and all other activities compensated by the non-Federal entity on an integrated basis, but may include the use of subsidiary records as defined in the non-Federal entity's written policy; Comply with the established accounting policies and practices of the non-Federal entity (See paragraph above for treatment of incidental work for IHEs.; and Support the distribution of the employee's salary or wages among specific activities or cost objectives if the employee works on more than one (1) Federal award; a Federal award and non-Federal award; an indirect cost activity and a direct cost activity; two (2) or more indirect activities which are allocated using different allocation bases; or an unallowable activity and a direct or indirect cost activity. Budget estimates (i.e., estimates determined before the services are performed) alone do not qualify as support for charges to Federal awards, but may be used for interim accounting purposes only;

25.5. Grantee understands that financial reports are required as an accounting of expenditures for either reimbursement or ADHS-approved advance payments;

25.6. The final request for reimbursement of grant funds must be received by the ADHS no later than sixty (60) days after the last day of the award period;

25.7. All goods and services must be received or have reasonable expectations thereof and placed in service by Grantee by the expiration of this award;

25.8. Grantee agrees that all encumbered funds must be expended and that goods and services must be paid by GRANTEE within sixty (60) days of the expiration of this award unless funding guidelines permit funds to be used at a future date;

25.9. Grantee agrees to remit all unexpended grant funds to the ADHS within thirty (30) days of written request from the ADHS;

25.10. Grantee agrees to account for interest earned on federal grant funds and shall manage interest income in accordance with the Cash Management Improvement Act of 1990 and as indicated in the State of Arizona Accounting Manual (SAAM) located at the following website. https://gao.az.gov/publications/saam Interest earned in excess of allowable limits must be remitted to the ADHS within thirty (30) days after receipt of a written request from the ADHS;

25.11. Grantee agrees not to use grant funds for food and/or beverage unless explicitly approved in writing by the ADHS;

25.12. Grantee agrees to comply with all applicable laws, regulations, policies and guidance (including specific cost limits, prior approvals and reporting requirements, where applicable) governing the use of grant funds for expenses related to conferences, meetings, trainings, and other events, including the provision of food and/or beverages at such events, and costs of attendance at such events unless explicitly approved in writing by the ADHS;

25.13. No funds shall be used to supplant federal, state, county or local funds that would otherwise be made available for such purposes. Supplanting means the deliberate reduction of state or local funds because

of the existence of any grant funds;

25.14. Grantee agrees that grant funds are not to be expended for any indirect costs that may be incurred by Grantee for administering these funds unless explicitly approved in writing by the ADHS. This may include, but is not limited to, costs for services such as accounting, payroll, data processing, purchasing, personnel, and building use which may have been incurred by the Grantee;

25.15. Grantee will comply with the audit requirements of *OMB* Office of Management and Budget's (OMB) Uniform Administrative Requirements, Cost Principles and Audit Requirement for Federal Awards and provide the ADHS with the Single Audit Report and any findings within ninety (90) days of receipt of such finding(s). If the report contains no findings, the Grantee must provide notification that the audit was completed. All completed Single Audits should be uploaded in the format specified to the Federal Audit Clearinghouse no later than nine (9) months after the entity's fiscal year-end at the attached **Link**: https://harvester.census.gov/facweb/default.aspx/;

25.16. Grantee understands and agrees that misuse of award funds may result in a range of penalties, including suspension of current and future funds, suspension or debarment from federal grants, recoupment of monies provided under an award, and civil and/or criminal penalties;

25.17. Grantee agrees not to do business with any individual, agency, company or corporation listed in the Excluded Parties Listing Service.

Link: *System for Award Management* https://www.sam.gov/portal/public/SAM/;

25.18. Grantee agrees to ensure that, no later than the due date of the Grantee's first financial report after the award is made, Grantee and any subgrantees have a valid UEI profile and active registration with the System for Award Management (SAM) database;

25.19. GRANTEE certifies that it presently has no financial interest and shall not acquire any financial interest, direct or indirect, which would conflict in any manner or degree with the performance of services required under this Agreement;

25.20. Compliance with 41 U.S.C. 4712 (including prohibitions on reprisal; notice to employees) Grantee must comply with, and is subject to, all applicable provisions of 41 U.S.C. 4712, including all applicable provisions that prohibit, under specified circumstances, discrimination against an employee as reprisal for the employee's disclosure of information related to gross mismanagement of a federal grant, a gross waste of federal funds, an abuse of authority relating to a federal grant, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation related to a federal grant; and

25.21. GRANTEE certifies to comply with the Drug-Free Workplace Act of 1988, and implemented in 28 CFR Part 83, Subpart F, for grantees, as defined in 28 CFR, Part 83 Sections 83.620 and 83.650.

26. Comments Welcome

The ADHS Procurement Office periodically reviews the Uniform Terms and Conditions and welcomes any comments you may have. Please submit your comments to: ADHS Procurement Administrator, Arizona Department of Health Services, 150 North 18th Avenue, Suite 530, Phoenix, Arizona 85007.

1. Background

The Arizona Department of Health Services (ADHS) Office of HIV & Hepatitis C Services (OHHS), Human Immunodeficiency Virus (HIV) Prevention Program has the responsibility for administering HIV Prevention Program Cooperative Agreement funds provided by the U.S. Centers for Disease Control and Prevention (CDC). These funds are provided to state health departments to implement a comprehensive statewide HIV Prevention Program. Arizona's program is based upon CDC Cooperative Agreement guidelines.

Based on Arizona epidemiology, the overall recommendation for statewide prevention programming is to target HIV positive persons and their partners, men who have sex with men (MSM), and injection drug users (IDU). Men who have sex with men have a particular need for prevention services because this behavioral risk group represents the majority of emerging and existent HIV infections in Arizona. Additionally, County Health Departments should provide prevention services to other persons at risk of HIV infection or transmission in accordance with State statutes and rules. Arizona Revised Statutes: A.R.S. 36-661 (Definitions), A.R.S. 36-664 (Confidentiality; exceptions), A.R.S. 36-665 (Order for disclosure of communicable disease related information), A.R.S. 36- 666 (Violation; classification; immunity), and A.R.S. 36-667 (Civil penalty). Arizona Administrative Code R9- 6, Article 10 (HIV-related testing and notification) and Article 11 (Sexually Transmitted Diseases-related testing and notification), as appropriate to the services provided.

The mission of the ADHS and the OHHS, HIV Prevention Program is to meet the HIV prevention public health needs within the state of Arizona through collaboration with diverse community partners and individuals.

Funding to local health departments will ensure the successful implementation of HIV testing, HIV communicable disease investigation, and HIV partner services throughout Arizona. Federal funding is provided via a cooperative agreement that terminates on December 31, 2028 Each grant year begins January 1st and ends on December 31st.

2. Objective

2.1. The purpose of these funds is to assist the Contractor in implementing a comprehensive high impact HIV Prevention Program:

2.1.1. Initiate persons newly diagnosed with HIV to HIV medical care within five calendar days of their diagnosis.

2.1.2. Link persons out of HIV medical care to HIV medical care within five (5) calendar days of reestablishing contact with the HIV positive person.

2.1.3. Link ninety percent (90%) of newly diagnosed clients to HIV medical services in thirty (30) days or less.

2.1.4. Support retention of least ninety percent (90%) of all persons receiving partner services in HIV Medical Care.

2.1.5. Support viral load suppression among at least ninety percent (90%) of all persons receiving partner services within six (6) months.

2.1.6. To provide access to quality HIV Testing and Linkage (HTL) to care for persons residing in Pinal County.

2.1.7. To increase the number of persons in the jurisdiction who are aware of their status.

2.1.8. Contractor shall have the ability to perform routine HIV testing in clinical settings where there are other ancillary medical services available.

3. Scope of Service

The Contractor shall:

3.1. Provide low cost and free HIV Testing Services to individuals at-risk for acquiring HIV (priority populations).

3.1.1. Priority populations in Pinal County include White, Black and Latino Men who have Sex with Men (MSM), especially youth; Latinos of all genders; African Americans of all genders; Transgender and gender non-conforming individuals.

3.2. Develop and implement programming that fulfill the following objectives:

3.2.1. Availability: HIV testing is available to priority populations.

3.2.2. Accessibility: HIV testing is available to priority populations via multiple strategies that eliminate barriers to obtaining HIV testing (even if HIV testing is available, people may not get tested because of barriers).

3.2.3. Acceptability: Decrease fear and stigma of HIV testing by working to change norms of priority populations.

3.3. Provide HIV testing to any person seeking HIV testing under this agreement even if they are not part of a priority population.

3.4. Provide Partner Services in public and private sectors to all persons newly diagnosed with HIV or previously positive with a new Sexually Transmitted Diseases (STD) diagnosis, and to all HIV positive persons or their medical providers requesting continuing Partner Services.

4. Tasks

The Contractor shall:

4.1. Conduct HTL including but not limited to:

4.1.1. Providing access to quality HTL services in Pinal County.

4.1.2. Providing HTL services in accordance with the most recent version of the HIV Testing in Healthcare Settings issued by CDC.

4.1.3. Identifying a supervisor for the HIV program in order to facilitate accountability, communication, quality assurance, and the discussion of programmatic issues as appropriate. Training will be provided by ADHS, OHHS to all supervisors on an as-needed basis and during mandatory scheduled Contractor meeting.

4.1.4. Assure and document that ninety-five percent (95%) of the negative and 100% of the positive individuals tested in this program receive their test results.

4.1.5. Work with newly HIV-positive clients.

4.1.5.1. Seropositive clients shall receive medical and psychosocial referrals which shall be recorded in the ADHS OHHS web-based reporting systems, including but not limited to Prevention Impacts Simulation Model (PRISM), Enhanced HIV/AIDS Reporting System (eHARS), and Medical Electronic Disease Surveillance Intelligence System (MEDSIS).

4.1.5.2. HTL staff shall elicit clients' needles or “works” sharing contacts and sexual contacts for referral into the Partner Services System.

4.2. Collaborate with ADHS HIV Prevention funded programs or other federally funded programs [i.e. Substance Abuse and Mental Health Services Administration (SAMHSA) or CDC] to ensure the provision of HTL to program participants.

4.3. Ensure that HTL is:

4.3.1. Confidential in all aspects. It is critical that all HTL programs include strict procedures for ensuring privacy, confidentiality, and security of data, as well as screening for and addressing potential partner violence.

4.3.2. Screen for and address potential partner violence.

4.3.3. Culturally sensitive and acceptable to the populations being served by the program.

4.3.4. Appropriately documented data; shall be collected on all tests conducted in HTL programs in accordance with ADHS and CDC requirements, standards and guidance. This data shall be entered into the CDC OHHS mandated web-based reporting systems.

4.4. Work with the ADHS Arizona State Public Health Laboratory (ASPHL):

4.4.1. Appropriate laboratory submission forms shall be completed, and specimens shall be delivered to the ASPHL. All rapid test confirmations shall be tested using blood or serum.

4.4.2. Submitter shall submit, at minimum, a ten (10) ml tube of whole blood to ASPHL.

4.4.3. Programs within a county health department (STD, Family Planning, Prenatal, and Correctional) that use an HIV screening test [i.e. rapid test or enzyme immunoassay (EIA)] are eligible to utilize the ASPHL for confirmatory testing. These programs are subject to the same reporting requirements as the HIV HTL Program for any tests submitted to the ASPHL.

4.5. Develop and implement an ADHS approved plan to assure that all entities/departments providing HIV Tests under the auspices of the Contractor have written protocols which are reviewed quarterly to assure compliance with data entry requirements, CDC indicators and Contractor internal protocols. Any deviations shall be reported to ADHS along with a plan to remediate them.

4.6. Conduct Partner Services including partner/spousal elicitation and notification activities including but not limited to:

4.6.1. Partner Services activities including partner/spousal elicitation and notification and referral activities will be provided in accordance with the most recent version of the Partner Services Guidance issued by CDC.

4.6.2. Conduct a program to provide Partner Services in public and private sectors to all persons newly diagnosed with HIV in Pinal County. These programs shall address all steps of Partner Services, including:

4.6.2.1. Contacting individuals newly diagnosed with HIV to offer them Partner Services.

4.6.2.2. Interviewing individuals who accept Partner Services to elicit names of and locating information for sex and injection-drug-paraphernalia-sharing partners.

4.6.2.3. Locating, notifying, testing, and providing test results to partners.

4.6.2.4. Reporting preliminary positive and supplemental HIV positive test results to ADHS (Prevention and Surveillance) according to established guidelines.

4.6.2.5. Linking partners, especially those who test positive, to appropriate medical evaluation, treatment, prevention, and within five (5) calendar days.

4.7. Ensure that Partner Services are:

4.7.1. Confidential in all aspects. Concerns often voiced regarding HIV Partner Services include potential violations of confidentiality, the stigma associated with HIV, and the potential for partner violence associated with Partner Services. It is critical that all Partner Services programs include strict procedures for ensuring privacy, confidentiality, and security of data, as well as screening for and addressing potential partner violence.

4.7.2. Available to all cases, regardless of reporting source (i.e. self-report, testing service, surveillance, etc.). Cases shall be initiated within seven (7) days. Every client shall be investigated within twenty-one (21) days of identification to the County Health Department. Data shall be entered into the data system as received.

4.7.3. Culturally sensitive and acceptable to the populations being served by the program.

4.7.4. Locating and notifying activities are initiated and completed promptly within ADHS-established timelines. Managers may need to prioritize Partner Services activities, such as the order in which HIV-infected individuals are offered Partner Services or the order in which partners are located and offered Partner Services.

4.8. Work with community partners to promote the Integration of Partner Services into existing services:

4.8.1. Ensure that information about how to access Partner Services is easily accessible by health care providers in the public and private sectors, Community Based Organizations (CBOs), and other agencies diagnosing or providing services to HIV-infected individuals.

4.8.2. Encourage providers, CBOs, and other agencies providing services to HIV-infected individuals to routinely screen clients for ongoing sexual and injection-drug-use activities and to provide partner information to the County Health Department for provision of Partner Services.

4.8.3. Work with health care providers, CBOs, and other organizations serving or representing HIV-infected individuals to educate them about the potential benefits of Partner Services for HIV-infected individuals, their partners, and the community and to develop community support for these services.

4.9. Ensure that all cases of HIV and/or Acquired Immunodeficiency Syndrome (AIDS) are reported to the ADHS OHHS HIV Prevention Program and HIV.

4.10. Implement surveillance program in a timely manner utilizing ADHS OHHS required documentation.

4.11. Ensure that all staff providing HIV Testing, Linkage to Care, and/or Partner Services receive appropriate training.

4.11.1. All staff that provides HIV testing or Partner Services must successfully complete training activities. With guidance to be provided by ADHS OHHS, Contractor shall establish written protocols outlining internal county training activities and provide the protocol to ADHS OHHS within thirty (30) days of execution.

4.11.2. Supervisor shall review all staff performing activities under this contract to ensure adherence to Agreement elements, internal policies/procedures and CDC guidance for said activities. A brief summary of reviews performed shall be included as part of the monthly narrative report to ADHS OHHS.

4.12. Assure and document that timely client-centered prevention counseling, linkage to care and Partner Services are provided to each reported case of AIDS or HIV infection regardless of reporting source.

4.13. Monitor implementation of the HIV Prevention program. In accordance with CDC requirements, the Contractor must collaborate with ADHS OHHS Office of HIV Prevention in reaching performance levels set for HIV Prevention Program Indicators.

4.14. Record all HTL and Partner Services activities in ADHS, OHHS and CDC mandated databases- PRISM, MEDSIS, or eHARS:

4.14.1. All tests conducted in the HIV program shall have data entered into the web-based system within twenty-four (24) hours for positive tests and seven (7) days for negative tests.

4.14.2. Partner Services activities shall be entered into the web-based data system PRISM in accordance with ADHS OHHS HIV Prevention Program established timelines.

4.14.3. All staff utilizing the databases shall complete e-authentication procedures outlined by CDC within thirty (30) days of start of Agreement, or thirty (30) days of hire.

4.14.4. All programs shall sign the CDC established Memorandum of Understanding and Rules of Behavior documents with ADHS OHHS in accordance with CDC data-management requirements.

4.15. Additional HIV Prevention Program Elements:

4.15.1. Education to providers specifically related to increasing testing, reducing stigma and health disparities, improving HIV care and treatment, prevention with positive persons and linkage to Partner Services.

4.15.2. Contractor staff shall provide education to those in the community who provide services to clients with HIV/AIDS according to the ADHS OHHS approved work plan.

4.15.3. Partner with ADHS OHHS Academic Detailing Team for support with education activities.

4.15.4. Condom distribution to populations at risk for HIV infection or transmission per the ADHS OHHS approved work plan.

4.15.5. Outreach testing at sites identified within the county; sites and activities will be defined, and services provided according to the ADHS approved work plan.

4.16. Develop and Implement an annual strategy for low cost or free HIV Testing Services, including goals, objectives and activities. The strategy shall address individual, organizational, and community-level needs, and scale the nature and the volume of resources necessary to deliver HIV Testing Services to priority populations in the contractor's Planning Region.

4.17. Develop and implement strategies to inform recipients of HIV Testing Services of their test results in-person, or if necessary, post-test, such as text messaging, access to a secure online portal, phone calls, etc. Strategies for post-test results notification shall include mechanisms that document the time and date the client actually received the results.

4.18. For individuals whose test indicates a positive HIV status, provide confirmatory HIV testing or a referral for confirmatory testing, and referrals for STD testing, Partner Services, HIV prevention services, and other care and supportive services.

4.19. For individuals whose test indicates a positive HIV status, report the positive test result to the Arizona Department of Health Services HIV Surveillance Program, according to current Arizona Communicable Disease Rules.

4.20. For individuals whose test indicates a negative HIV status, provide referrals to STD testing and HIV prevention services such as Pre- and Post-Exposure Prophylaxis (PrEP/PEP) Navigation Services or providers that prescribe PrEP/PEP, risk-reduction behavioral interventions, condom distribution, and other care and support services.

4.21. Annually, the Contractor shall gather information from program participants, staff and partners to assess participant satisfaction, and the quality and effectiveness of its programming. The results of the assessment shall be used to inform quality improvement efforts, service delivery, service planning, and evaluation. Assessment activities will be developed and implemented in collaboration with the HIV Prevention Program.

4.22. Conduct ongoing program evaluation, and complete quantitative and qualitative programmatic reporting.

4.23. Reporting – HIV Testing.

4.23.1. Each month, the Contractor shall be required to collect and report quantitative and qualitative data related to program demographics, utilization and performance. A standard reporting form will be provided by the HIV Prevention Program.

4.23.2. All reporting requirements are provided in Attachment Five (5): National HIV Prevention Program Monitoring and Evaluation (NHM&E) NHM&E Data Variables & Values.

4.23.3. Contractor shall adhere to different requirements based on the testing site, test result, and other factors as outlined in the attachment.

4.23.4. Quantitative data reported by the Contractor will be reviewed by ADHS, and the Contractor shall respond to requests for corrections as needed.

4.23.5. Once quantitative data has been reviewed and any corrections have been made, ADHS will submit data to the required reporting system on Contractor's behalf.

4.23.6. Each report shall detail:

4.23.6.1. An overview of programmatic activity that occurred during the reporting period, including substantial work/staffing changes, successes, challenges, and anticipated changes for the next reporting period.

4.23.6.2. Along with any other reporting metrics as defined by programmatic necessity and/or CDC guidance.

4.23.6.3. ADHS shall contribute cumulative quantitative data to complement qualitative information provided by the Contractor.

4.24. Reporting Partner Services.

4.24.1. Support Partner Services and Data to Care Activities at the Contractor locations providing HIV Testing.

4.24.2. The Contractors with testing locations shall support current Partner Service or Data 2 Care activities for persons newly diagnosed with HIV across the County.

4.24.3. Staff conducting Partner Service or Data to Care activities shall participate in an ADHS approved training prior to start. Staff must comply with Partner Service delivery guidance and requirements from the ADHS Office of HIV & Hepatitis C Services. These are outlined in Attachments one through four (1-4).

4.24.4. Early Intervention Services or Partners Services activities shall be:

4.24.4.1. Confidential in all aspects. Programs shall include strict procedures for ensuring privacy, confidentiality, and security of data.

4.24.4.2. Timely (i.e. locating and notifying activities are initiated and completed promptly within ADHS-established timelines) and offered to every client identified by the HIV/STD testing program within twenty-one (21) days of learning their confirmatory HIV test result.

4.24.5. Appropriately documented in the reporting systems provided by the ADHS HIV/STD Prevention, Care and Epidemiology programs. All partner counseling sessions shall be in accordance with the most recent version of the Partner Services guidance issued by the CDC Prevention and Surveillance branches.

All HIV positive individuals contacted through Partner Services shall be entered into CAREWare and PRISM. All of these individuals must have a Release of Information completed.

4.24.6. Partner Services must be conducted following all of the requirements in Attachments one through four (1-4).

4.24.7. All Partner Services must be entered in PRISM according to requirements in Attachment Four (4) PRISM Manual.

4.24.8. The Contractor must complete all components of Partner Services.

4.25. Evaluation.

4.25.1. Performance measures reflect the National HIV Prevention Program Monitoring and Evaluation Number evaluation indicators, including:

4.25.1.1. Completeness of required data elements.

4.25.1.2. Number of valid HIV tests performed and the accompanying results.

4.25.1.3. Number of individuals who received their HIV test results.

4.25.1.4. Number of individuals who were asked about previous or current use of pre-exposure prophylaxis (PrEP).

4.25.1.5. Number of individuals whose test indicates a negative HIV status who were offered or referred to PrEP/PEP Navigation Services.

4.25.1.6. Number of individuals whose test indicated a positive HIV status that were reported to ADHS and verified in the surveillance data system.

4.25.1.7. Number of individuals whose test indicates a positive HIV status who were linked to a medical provider, Ryan White Early Intervention Specialist, or Ryan White Central Eligibility provider, and the timeframe in which they are linked within thirty calendar days.

4.25.1.8. Number of individuals whose test indicates a positive HIV status who were referred to the local health department for Partner Services.

4.25.1.9. Number of individuals whose test indicates a positive HIV status who were provided partner elicitation services.

4.25.1.10. Number of individuals whose test indicates a positive HIV status who were provided or referred to an essential support service.

4.25.1.11. Number of individuals whose test indicates a positive HIV status who were provided individualized behavioral risk reduction counseling.

5. Deliverables and Delivery Schedule

5.1. Quantitative reporting for HIV Testing shall occur on a monthly basis.

5.1.1. The Contractor shall send disaggregate testing data for the previous month no later than the fifteenth (15th) of the following month.

5.1.2. For activities conducted between January 1st to June 30th, quantitative data will be submitted no later than September 15th of the same year.

5.1.3. For activities conducted between July 1st and December 31st, quantitative data will be submitted no later than March 15th of the following year.

5.2. Qualitative reporting shall occur on a monthly basis, and a comprehensive report is required two (2) times each year.

5.2.1. August 15th for activities conducted between January 1st to June 30th.

5.2.2. February 15th of the following year, for activities conducted between January 1st to December 31st.

5.3. A Contractor's Expenditure Report (CER) shall be submitted monthly, due thirty (30) days from the end of the reporting period, and shall not exceed the total budget.

6. Notices, Correspondence, and Reports

6.1. Notices, correspondence, reports and invoices/CERs from the Contractor to ADHS shall be sent to:

Arizona Department of Health Services
Office of HIV & Hepatitis C Services
HIV Prevention Manager
Eduardo E. Moreira
150 North 18th Avenue, Suite 280,
Phoenix, AZ 85007
Email: eduardo.moreira-orantes@azdhs.gov
Phone: 480-698-5233

6.2. Notices, correspondence, and reports (and payments if sent to same address) from ADHS to the Contractor shall be sent to:

Pinal County Public Health Services District
Bio-Defense Preparedness and Response Administrator
Kore Redden
PO BOX 1348,
Florence, Arizona 85132
Email: Kore.Redden@Pinal.gov
Phone: 520-866-7331

CONTRACT NUMBER	INTERGOVERNMENTAL AGREEMENT PRICE SHEET
CTR067691	

Cost Reimbursement Contract Annual Price Sheet - 01/01/2024 – 12/31/2024	
ACCOUNT CLASSIFICATION	**LINE-ITEM TOTALS**
PERSONNEL*	$15,408.02
EMPLOYEE RELATED EXPENSES*	$3,852.01
TRAVEL	$942.97
PROFESSIONAL & OUTSIDE SERVICES	$0.00
CAPITAL EXPENSES	$0.00
OTHER OPERATING COSTS	$1,350.00
INDIRECT COSTS	$2,161.00
Total Annual not to exceed:	**$23,714.00**

If applicable, the Contractor is authorized to transfer up to a maximum of 25% of the total budget amount between line items with the written approval from the HIV Prevention Program Manager.

Transfers exceeding 25% or to a non-funded line item shall require an Agreement Amendment.

*Indicated indirect rate calculation

Exhibit - 2 CFR 200.332

§ 200.332
Requirements for pass-through entities.
All pass-through entities must:

(a) Ensure that every subaward is clearly identified to the subrecipient as a subaward and includes the following information at the time of the subaward and if any of these data elements change, include the changes in subsequent subaward modification. When some of this information is not available, the pass-through entity must provide the best information available to describe the Federal award and subaward.

Prime Awardee:	**Arizona Department of Health Services**
UEI #	**QMWUG1AMYF65**
Federal Award Identification (Grant Number):	NUE1EH001318
Subrecipient name (which must match the name associated with its unique entity identifier):	PINAL COUNTY
Subrecipient's unique entity identifier (UEI #):	GX4FM9VQD7W3
Federal Award Identification Number (FAIN, sometimes it's the same as the Grant Number):	NUE1EH001318
Federal Award Date (see the definition of Federal award date in § 200.1 of this part) of award to the recipient by the Federal agency;	05/27/2020
Subaward Period of Performance Start and End Date;	01/01/2024 - 12/31/2024
Subaward Budget Period Start and End Date:	01/01/2024 - 12/31/2024
Amount of Federal Funds Obligated by this action by the pass-through entity to the subrecipient (this is normally the contract amount):	$110,000.00
Total Amount of Federal Funds Obligated to the subrecipient by the pass-through entity including the current financial obligation (how much is available for contracts):	$110,000.00
Total Amount of the Federal Award committed to the subrecipient by the pass-through entity	$213,713.00
Federal award project description, as required to be responsive to the Federal Funding Accountability and Transparency Act (FFATA)	93.070 Environmental Public Health and Emergency Response

Name of Federal awarding agency, pass-through entity, and contact information for awarding official of the Pass-through entity	Centers for Disease Control and Prevention
Assistance Listings number and Title; the pass-through entity must identify the dollar amount made available under each Federal award and the Assistance Listings Number at time of disbursement:	
Identification of whether the award is R&D	
Indirect cost rate for the Federal award (including if the de minimis rate is charged) per § 200.414	

Program Operations
Guidelines for STD Prevention

Partner Services

CDC
Centers for Disease Control and Prevention

Table of Contents

Foreword

The development of the Comprehensive STD Prevention Systems (CSPS) program announcement marked a major milestone in the efforts of CDC to implement the recommendations of the Institute of Medicine report, *The Hidden Epidemic, Confronting Sexually Transmitted Diseases, 1997*. With the publication of these STD Program Operations Guidelines, CDC is providing STD programs with the guidance to further develop the essential functions of the CSPS. Each chapter of the guidelines corresponds to an essential function of the CSPS announcement. This chapter on partner services is one of nine.

With many STDs, such as syphilis, on a downward trend, now is the time to employ new strategies and new ways of looking at STD control. Included in these guidelines are chapters that cover areas new to many STD programs, such as community and individual behavior change, and new initiatives, such as syphilis elimination. Each STD program should use these Program Operations Guidelines when deciding where to place priorities and resources. It is our hope that these guidelines will be widely distributed and used by STD programs across the country in the future planning and management of their prevention efforts.

Judith N. Wasserheit
Director
Division of STD Prevention

Introduction

These guidelines for STD prevention program operations are based on the essential functions contained in the Comprehensive STD Prevention Systems (CSPS) program announcement. The guidelines are divided into chapters that follow the eight major CSPS sections: Leadership and Program Management, Evaluation, Training and Professional Development, Surveillance and Data Management, Partner Services, Medical and Laboratory Services, Community and Individual Behavior Change, Outbreak Response, and Areas of Special Emphasis. Areas of special emphasis include corrections, adolescents, managed care, STD/HIV interaction, syphilis elimination, and other high-risk populations.

The target audience for these guidelines is public health personnel and other persons involved in managing STD prevention programs. The purpose of these guidelines is to further STD prevention by providing a resource to assist in the design, implementation, and evaluation of STD prevention and control programs.

The guidelines were developed by a workgroup of 18 members from program operations, research, surveillance and data management, training, and evaluation. Members included CDC headquarters and field staff, as well as non-CDC employees in State STD Programs and university settings.

For each chapter, subgroups were formed and assigned the task of developing a chapter, using evidence-based information, when available. Each subgroup was comprised of members of the workgroup plus subject matter experts in a particular field. All subgroups used causal pathways to help determine key questions for literature searches. Literature searches were conducted on key questions for each chapter. Many of the searches found little evidence-based information on particular topics. The chapter containing the most evidence-based guidance is on partner services. In future versions of this guidance, evidence-based information will be expanded. Recommendations are included in each chapter. Because programs are unique, diverse, and locally driven, recommendations are guidelines for operation rather than standards or options.

In developing these guidelines the workgroup followed the CDC publication "CDC Guidelines—Improving the Quality", published in September, 1996. The intent in writing the guidelines was to address appropriate issues such as the relevance of the health problem, the magnitude of the problem, the nature of the intervention, the guideline development methods, the strength of the evidence, the cost effectiveness, implementation issues, evaluation issues, and recommendations.

STD prevention programs exist in highly diverse, complex, and dynamic social and health service settings. There are significant differences in availability of resources and range and extent of services among different project areas. These differences include the level of various STDs and health conditions in communities, the level of preventive health services available, and the amount of financial resources available to provide STD services. Therefore, these guidelines should be adapted to local area needs. We have given broad, general recommendations that can be used by all program areas. However, each must be used in conjunction with local area needs and expectations. All STD programs should establish priorities, examine options, calculate resources, evaluate the demographic distribution of the diseases to be prevented and controlled, and adopt appropriate strategies. The success of the program will depend directly upon how well

program personnel carry out specific day to day responsibilities in implementing these strategies to interrupt disease transmission and minimize long term adverse health effects of STDs.

In this document we use a variety of terms familiar to STD readers. For purposes of simplification, we will use the word patient when referring to either patients or clients. Because some STD programs are combined with HIV programs and others are separate, we will use the term STD prevention program when referring to either STD programs or combined STD/HIV programs.

These guidelines, based on the CSPS program announcement, cover many topics new to program operations. Please note, however, that these guidelines replace all or parts of the following documents:

- Guidelines for STD Control Program Operations, 1985.
- Quality Assurance Guidelines for Managing the Performance of DIS in STD Control, 1985.
- Guidelines for STD Education, 1985.
- STD Clinical Practice Guidelines, Part 1, 1991.

The following websites may be useful:

• CDC	www.cdc.gov
• NCHSTP	www.cdc.gov/nchstp/od/nchstp.html
• DSTD	www.cdc.gov/nchstp/dstd/dstdp.html
• OSHA	www.osha.gov
• Surveillance in a Suitcase	www.cdc.gov/epo/surveillancein/
• Test Complexity Database	www.phppo.cdc.gov/dls/clia/testcat.asp
• Sample Purchasing Specifications	www.gwu.edu/~chsrp/
• STD Memoranda of Understanding	www.gwumc.edu/chpr/mcph/moustd.pdf
• National Plan to Eliminate Syphilis	www.cdc.gov/Stopsyphilis/
• Network Mapping	www.heinz.cmu.edu/project/INSNA/soft_inf.html
• Domestic Violence	www.ojp.usdoj.gov/vawo/
• Prevention Training Centers	www.stdhivpreventiontraining.org
• Regional Title X Training Centers	www.famplan.org www.cicatelli.org www.jba-cht.com
• HEDIS	www.cdc.gov/nchstp/dstd/hedis.htm
• Put Prevention Into Practice	www.ahrq.gov/clinic/ppipix.htm

Program Operations Guidelines Workgroup Members

David Byrum	Program Development and Support Branch, DSTD
Janelle Dixon	Health Services Research and Evaluation Branch, DSTD
Bob Emerson	Training and Health Communications Branch, DSTD
Nick Farrell	Program Support Office, NCHSTP
Melinda Flock	Surveillance and Data Management Branch, DSTD
John Glover	Program Development and Support Branch, DSTD
Beth Macke	Behavioral Interventions and Research Branch, DSTD
Charlie Rabins	Illinois Department of Public Health
Anne Rompalo	Johns Hopkins School of Medicine
Steve Rubin	Program Development and Support Branch, DSTD, New York City
Lawrence Sanders	Southwest Hospital and Medical Center, Atlanta
Don Schwarz	Program Development and Support Branch, DSTD
Jane Schwebke	University of Alabama Birmingham
Kim Seechuk	Program Development and Support Branch, DSTD
Jerry Shirah	Training and Health Communications Branch, DSTD
Nancy Spencer	Colorado Department of Public Health
Kay Stone	Epidemiology and Surveillance Branch, DSTD
Roger Tulloch	Program Development and Support Branch, DSTD, Sacramento, California

Partner Services Subgroup Members

John Glover	Program Development and Support Branch, DSTD
Jim Lee	Program Development and Support Branch, DSTD, Austin, Texas
Lori Leonard	University of Texas
Beth Macke	Behavioral Interventions and Research Branch, DSTD
Nancy Spencer	Colorado Department of Public Health
Roger Tulloch	Program Development and Support Branch, DSTD, Sacramento, California

Partner Services Internal/External Reviewers

Mark Aubin	Washington Department of Health
Dennis Dorst	Program Development and Support Branch, DSTD, New Orleans, Louisiana
Dan George	Program Development and Support Branch, DSTD, Tallahassee, Florida
Matt Hogben	Behavioral Interventions and Research Branch, DSTD
Beverly Nolt	Texas Department of Health
Richard Rothenberg	Emory University School of Medicine

Partner Services

INTRODUCTION

Shared Principles

Both STD prevention programs and HIV programs provide guidance on services to partners. Although STD prevention programs call these services "Partner Services," and HIV programs call these services "Partner Counseling and Referral Services," the services offered share many principles. Those principles are listed below.

i. **Voluntary**—Partner services are voluntary on the part of the infected person and his or her partners.

ii. **Confidential**—Every part of the partner service process is confidential.

iii. **Science-Based**—Partner service activities are science-based and require knowledge, skill, and training.

iv. **Culturally Appropriate**—Partner services are to be delivered in a nonjudgmental, culturally appropriate, and sensitive manner.

v. **A Component of a Comprehensive Prevention System**—Partner services is one of a number of public health strategies to control and prevent the spread of STD and HIV. Other strategies include accessible clinics, outreach to, and targeted screening of at-risk populations, behavioral interventions, and educational programs.

vi. **Diverse Referral Approaches**—Partner services may be delivered through two basic approaches: provider referral, whereby the provider locates and informs partners of their exposure; and client referral, whereby the infected person takes responsibility for informing his or her partners. Sometimes a combination of these approaches is used.

vii. **Support Services and Referral**—Partner services are delivered in a continuum of care context that includes the capacity to refer partners to HIV counseling, testing, and treatment, as well as other services (e.g., family planning, violence prevention, drug treatment, social support, housing).

viii. **Analysis and Use of Partner Service Data**—Programs should collect confidential data on the counseling and referral services provided and use the data for evaluating and improving program efficiency, effectiveness, and quality.

ix. **Counseling and Support**—Counseling and support for those who choose to notify their own partners is essential. Assistance to patients in deciding if, how, to whom, where, and when to disclose their infection can help them avoid stigmatization, discrimination, and other potential negative effects.

x. **Client-Centered Counseling**—Providing client-centered counseling for STD-infected individuals and their partners can reduce behavioral risks for acquiring or transmitting STDs.

xi. **Increased Importance as New Technologies Emerge**—As new technologies emerge, such as more sophisticated testing procedures and behavioral interventions, partner services will become an increasingly important prevention tool.

Overview

Partner services have evolved from an exclusive focus on finding the sexual contacts of infected persons to a broad view of the clinical and epidemiologic activities needed to help persons infected with STDs. The basic process - interviewing infected persons and others potentially involved in transmission, identifying persons still at risk (whether through direct exposure or indirect involvement), and bringing the latter to diagnosis and treatment - has changed little, but the context for such activity has greatly changed. Partner services play several roles in this context. First, they are a clinical tool for identifying a patient's needs and requirements and connecting the patient to appropriate care. Second, partner services provide the basis for assessing local epidemiologic conditions, targeting resources, and evaluating program performance. Third, follow-up of partners who are at risk is a powerful tool for understanding the dynamics of disease transmission.

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

- providing information regarding current infection(s) and other STDs;
- ensuring confidential notification, appropriate medical attention, and appropriate social referrals for partners and other high-risk individuals;
- using client-centered counseling to develop risk reduction plans to reduce the likelihood of acquiring future STDs;
- providing needed referrals to additional medical or social services; and
- defining and better targeting the at-risk community while assuring complete cnfidentiality for the patient.

Provision of partner services involves discussion and documentation of highly sensitive personal information about patients and their partners. Therefore, programs must demonstrate the highest regard for individual privacy, confidentiality of medical records, disease histories, and related information. Programs must be perceived by at-risk populations in particular and by the community in general as being fully committed to this principle. STD program staff must understand and adhere to their responsibilities with regard to confidentiality and to the overall quality of partner services and must be held accountable by performance guidelines and by supervisor observation. For the purpose of these guidelines, the term Disease Intervention Specialist (DIS) will be used to describe those personnel who are charged with providing partner services once a person has been diagnosed with a STD.

Effective prevention of disease transmission begins with infections that are properly diagnosed, appropriately treated, and fully reported in accordance with established laws and regulations. Cases reported from non-STD clinic settings must be carefully reviewed and record searched before contact with the reporting provider is initiated to confirm diagnoses and treatment status and to obtain, if necessary, permission to contact patients regarding partner services. Oftentimes, prior agreement or a memorandum of understanding with a provider allows routine permission to follow up.

Each program must individually determine those STDs for which partner services will be made available and to what extent these services will be provided. Factors to be considered include staffing, specific morbidity, infectiousness of disease (and stage of infection for syphilis), public health costs of infections and their sequellae, cost benefit of services, and amenability of the disease to the intervention planned. The availability of resources and the ability to enlist the support and cooperation of the medical community—particularly those located in or serving high risk communities–also play a role in the decision-making process with respect to partner services. Measures should be implemented to identify such providers and to develop a wide range of strategies, including informing providers about the components and importance of partner services, to gain their support and cooperation. One example might be collaboration with high-volume providers such as family planning clinics, juvenile detention facilities, selected jails and correctional

facilities, delivery hospitals, drug rehab groups, or other high-volume providers to ensure more comprehensive testing, appropriate treatment, early reporting, and the availability of partner services.

Recommendations

- Programs should establish the mix of partner services that is appropriate to local epidemiology.
- Programs should prioritize patients for partner services in terms of specific diseases, local area data, the potential for productive intervention, case load, and available resources.

Legal authority

Legal authority for the notification and referral of partners to persons with known STD infections resides with the states. Program policies and procedures should be consistent with applicable state laws, statutes, and regulations.

Case Management

Case management is the systematic pursuit, documentation, and analysis of medical and epidemiologic case information that focuses on opportunities to develop and implement timely disease intervention plans. Effective case management normally progresses through a very specific process: pre-interview analysis, interview (original, reinterviews, and cluster interviews), post-interview analyses, referral of sex partners, and case closure. Although the concepts and techniques of case management are usually consistent in various program areas, specific policies may differ.

Effective case management is sustained by 1) identifying the information needs of individual and related cases; 2) developing agendas for prospective interviews; 3) assuming responsibility for critical communications with other members of the staff; and 4) remaining current on progress of case elements assigned to others. The DIS must promptly pursue case needs and activities resulting from personal analysis, supervisory input, or the contributions by other staff members—both within and outside of the immediate program area.

Resource Requirements

Programs should provide DIS and managers with the tools, training, and resources necessary to conduct partner services successfully. Interview rooms that are quiet and contain at least a desk or table, three chairs, a telephone, and appropriate support materials should be readily accessible to the DIS. Also, DIS should have access to appropriate STD clinic patient records, program interview and investigative files, relevant maps, telephone books, and cross directories. Investigative resources should be carefully developed and maintained. At a minimum, efforts should be made to develop access to department of motor vehicles (DMV), welfare, utilities, post office, local schools, and health department records.

DIS should be encouraged to identify, develop, and share information with each other on agencies that serve or that have information on at-risk populations. Such efforts would include identifying specific members of the at-risk community willing to advocate community support for program activities. Programs are further encouraged to develop and implement interview records and data collection instruments that reflect information needed by the program, that are easy to complete, that can be stored and retrieved electronically, and that will assist program efforts to better define and serve at-risk populations. Programs should make maximum possible use of current technology to facilitate DIS record keeping and case management, including computer storage and case analysis software when available. Case management tools can be stored and retrieved electronically, provided the security and confidentiality of those tools are maintained.

Recommendations

- Programs must ensure that DIS and managers possess the tools, training, and resources necessary to conduct program business successfully.
- Programs must have some form of case management process in place. Case management "tools" should reflect established information needs, should be easy to complete, and should provide information that can be used to define at-risk populations and to target them for intervention.
- Programs should provide interview space that is quiet and confidential, and contains at least a desk or table, three chairs, a telephone, and educational materials needed by the DIS.

Safety

Many field activities may pose potential unsafe situations for public health workers. Program managers should develop and maintain detailed guidelines for ensuring DIS safety in the performance of their responsibilities. Training should include a common-sense approach to field work (appropriate dress; expensive looking jewelry, purses, and other valuables kept out of sight; car doors locked and windows rolled up; constant awareness of surroundings; and the importance of relying on instincts). DIS should be provided picture identification (ID) and the ID should be required to be in an employee's possession when in the field. An employee file should be kept on each field worker which can be shared with authorities in case of emergency. This file should include name, address, physical description, emergency locating information, a recent picture of the employee, a description of the employee's vehicle, and the vehicle license number. Other steps that programs might take to promote safety include allowing DIS to work in pairs as situations warrant, making cellular phones and pagers available and requiring DIS to call in when changing plans or when an investigation becomes problematic. Some programs require DIS to have all field notes prepared ahead of time to ensure the DIS is efficient and alert to the surroundings. Others require that DIS submit a daily route sheet of intended stops to the supervisor so that a DIS route can be followed if an emergency arises. Although route sheets change as a DIS develops investigational leads, such sheets offer a place to start.

Before allowing new DIS to conduct field work alone, immediate supervisors or other, more experienced workers should be assigned to accompany them for purposes of identifying locations within the community where high-risk activities take place—drug houses, parks, bars, prostitution stroll areas, or those controlled by gangs—and to model desired behavior. When working in such areas, DIS must learn to be particularly alert. Safety issues and emerging problem areas should be routinely discussed in staff meetings and daily debriefings.

The primary protection from unsafe situations is the DIS's knowledge of the community and visibility in important locations. Programs should understand the need for DIS to spend time in areas to establish critical personal rapport with members of the community. This can be accomplished while performing outreach activities, organizing field screenings, and participating with CBOs in outreach activities.

Other safety issues involve "occupational infections in the workplace." At a minimum, local policies and procedures should encompass those in the Occupational Safety and Health Administration policy (more current information may be obtained from the OSHA website at www.osha.gov). Each program area must have a local policy for avoiding occupational exposure and for dealing with such exposures, should they occur. Each DIS should be required to practice local policies and procedures for avoiding infection(s) that could be acquired in the performance of their program responsibilities. These policies and procedures should be regularly updated and formally reviewed with staff members at least yearly. The section titled "Diagnostic assessment of partners in the field" also addresses this issue.

Confidentiality

Confidentiality policies of public health agencies are designed to prevent unauthorized persons from learning information shared in confidence. Confidential

information includes any material, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a person and is directly related to their health care.

Minimum professional standards for any agency handling confidential information should include providing employees with appropriate information regarding confidential guidelines and legal regulations. All public health staff involved in partner notification activities with access to such information should sign a confidentiality statement acknowledging the legal requirements not to disclose STD/HIV information.

Efforts to contact and communicate with infected patients, partners, and spouses must be carried out in a manner that preserves the confidentiality and privacy of all involved. This includes counseling partners in a private setting; trying to notify exposed partners face-to-face; never revealing the name of the original patient to the partner; not leaving verbal messages that include STD/HIV on answering machines; not leaving written messages that include any mention of STD/HIV; not giving confidential information to third parties (roommates, neighbors, parents, spouses, children).

Recommendations

- Programs must have written safety guidelines and procedures in place and follow these policies.
- Programs must ensure that DIS are aware of and comply with safety guidelines.

PARTNER SERVICES

Partner services are offered to all patients with STDs whether reported by public or private agencies. Some patients voluntarily seek medical attention, while others are examined as a direct result of outside intervention, such as insurance or job requirements, legal reasons (e.g., premarital, jail sentence), local health departments efforts, or partner request. Ideally, every patient would be offered partner services, but the specific population for partner services may vary by program, as determined by locally established priorities and by available resources.

Patients who are being treated for STDs are the best source of information regarding their infections. Every interview must be planned and approached as if it will be the only opportunity to provide and to secure information from the patient. Every effort must be made to interact face-to-face. Interviews should include an effort to identify others at risk within the community who would benefit from an examination. Necessary identifying, descriptive, locating, and exposure information for each partner within the interview period must be exhaustively pursued. Finally, interviews afford an opportunity to identify areas or specific locations within a community where at-risk populations reside or congregate. This information can be used to conduct carefully planned screening efforts for at-risk populations. Such an approach to targeted screening can be particularly effective and is critically important to the efficient use of limited resources.

While interviewing the patient, the DIS should make every attempt to enlist the patient as a resource, making it clear that the information the patient provides will be confidential and very helpful to the DIS, the patient, and the patient's partners. The DIS can incorporate elements of client-centered counseling by acknowledging treating the patient as a partner in reducing additional STD in their community. The partnership should be clear to the patient.

Recommendation

- Interviews with patients about partner services should be planned, client-centered, culturally appropriate, and voluntary.

Patient types

Volunteers and Index patients

The person who comes into a clinic for STD services without being referred is known as a volunteer. Generally, people who voluntarily come into the clinic for a STD exam have noticed symptoms of disease on themselves or their partners, have been told that they need an exam, or have been motivated by something they have read, seen, or heard. This reason may be an important clue which can be used later to elicit partners.

Index patient is a term often inter-changed with "original" patient and refers to patients newly diagnosed with a STD who are candidates for interview by trained DIS. Included among the services offered during the course of such interviews is assistance with the notification and timely referral of those partners determined to be at risk for infection. Effort also is expended to identify others within the patient's "community or social network" of friends or acquaintances (but not sexual partners) who might benefit from an examination. This is called "clustering".

In addition to partners, individuals who are identified as the result of an interview with an infected person but who are not partners of that person are called suspects and are divided into three (3) categories based on likelihood of infection:

S-1—People with symptoms suggestive of disease
S-2—Partners of other persons known to be infected
S-3—Others who might benefit from a STD examination (e.g., pregnant females, roommates)

All partners and suspects who are referred for examination as the result of an interview should, at a minimum, be informed as to the reason for the referral; should be provided information about the disease; should be informed of the reasons why they should have a sense of urgency in seeking a timely and appropriate medical evaluation; should be given the opportunity to be examined, should be given the opportunity to ask questions; and should receive client-centered counseling to develop a personalized risk reduction plan. In certain situations it may be appropriate also to interview partners and suspects.

Partners to the index patient

Another reason people come to the clinic is that they have been told by a partner or by a DIS that they may have been exposed to a disease. In such cases, the person may not have any signs or symptoms of the disease but still needs to be examined and treated. Anyone reasonably believed to have been exposed to a disease should be prophylatically treated at the time of exam based on CDC treatment guidelines. As an example, any partner thought to have been exposed to primary, secondary, or early latent syphilis within the preceding 90 days may test negative, yet still be infected since the incubation period for syphilis can be up to 90 days. Even though a partner tests negative, he or she should be treated. If test results are not available on a stat basis, the partner should still be treated during the initial visit and the infection status (infected-brought to treat or preventively treated) can be determined when test results return.

If the partner is not infected, he or she may be interviewed about recent partners and other persons within the community who might benefit from an examination. Interviews of this type are called cluster interviews and often provide important information. For example, if the individual being cluster interviewed is a partner who provides more recent date(s) of exposure than the date stated by the index patient, the result could be the prophylactic treatment that might otherwise not have been offered. These same individuals may be able to provide target locations for screening and outreach, additional information about partners, or locating information for other partners or cluster suspects already named but for whom there was insufficient information to initiate field investigation. To maintain confidentiality it is important to pursue such cluster information equally among all at-risk persons named by the partner during the interview. This approach provides valuable social network information. This type of interview requires special training, as the DIS employs specific motivational approaches and because special measures must be taken to preserve the confidentiality of the index patient.

Individuals initiated for field investigation from non-infected persons during cluster interviews are called "associates" and also fall into three categories:

A-1—People with symptoms suggestive of disease
A-2—Partners of other persons known to be infected
A-3—Others who might benefit from a STD examination

Information obtained from interviewing partners, suspects, and associates should be carefully reviewed in light of information provided by the index patient and through other investigative efforts and used as the basis for any subsequent reinterview of the index patient.

Index patients referred by other providers

New STD infections diagnosed by non-health department providers come to the attention of program surveillance units in a variety of ways. A health care provider may directly notify the program office of a newly diagnosed case; a provider may send a patient to the health department clinic for clinical management; or positive laboratory results may be reported which prompt follow-up by the surveillance unit. Providers reporting cases of STD to the health department should be contacted for permission before the DIS approaches the patient for partner services. Many providers prefer to treat their patients for STD and leave the responsibility of counseling them to the health department. In many instances, prior agreements or memoranda of agreement are in place, providing routine permission for follow up. In this case, the DIS would contact the patient and perform an original interview.

Another type of index patient is the patient who is identified via syphilis screening. In this case, the positive test result is reported to the health department by the laboratory while the result may not be known to the individual who was screened. The DIS in this situation must first perform a record search to determine whether the positive test is related to a previously known infection. If it is a new (and not previously adequately treated) infection, the DIS should notify the index patient of his or her infection and then refer the index patient for the full range of partner services.

Presumptive interviews

Patients are sometimes presumptively interviewed on the basis of presenting symptoms or laboratory findings that are suspicious or not yet available or confirmed. This also may be the only opportunity to speak to the patient. The purpose of this type of interview is to afford the staff additional information by assuring the rapid examination and medical evaluation of recent sex partners. This information can help medical practitioners make appropriate diagnostic and treatment decisions. These efforts have the secondary benefit of expediting the disease intervention process for those patients later determined to be infected.

Recommendation

- Anyone reasonably believed to have been exposed to a STD should be treated prophylatically at the time of exam based on CDC treatment guidelines.

Pre-interview activities

Case management efforts entail seven steps: pre- interview analysis, original interview, post-interview analysis, referral of at-risk individuals (sex or needle-sharing partners and clusters), cluster interview(s), reinterview(s), and case closure. Please refer to the STD Employee Development Guide (Centers for Disease Control and Prevention) for additional information. Because the interview process is complex, a recommended "interview format" has been developed and is discussed in the section on types of interviews. Formal training in the application of this format is available and programs are strongly encouraged to require formal training for all new staff performing DIS partner services before they interview patients.

Setting priorities

Ideally, every patient with a STD should be interviewed and counseled. However, the extent to which all such patients can be interviewed and counseled will be determined by the availability of qualified staff, by funding, and by morbidity levels. If it is not feasible to provide these services to every patient, programs should establish a priority basis for determining which patients with STD will be interviewed and counseled. The extent to which DIS assist patients in notifying their partners should also be determined by local program areas. The following factors should be considered for setting interview priorities: STD specific morbidity, infectiousness of disease (and stage of disease for syphilis), public health cost or burden of infections and their sequellae, amenability of the disease to the intervention, profile of partners (e.g., adolescent or female with a known or suspected pregnancy), and available program resources. Programs should re-evaluate priorities for partner notification in light of these factors at regular intervals.

Using these principles, some program areas have developed priorities similar to the following:

- Pregnant females testing positive for HIV, syphilis, gonorrhea, or chlamydia
- Persons testing positive for HIV
- Persons with early syphilis
- Persons with positive tests from a high risk geographic area

Interview periods

The interview period covers the time from the earliest date a patient could have been infected to the date of treatment. It is divided into two sections; the source period (which always includes the maximum incubation period) and the spread period. The incubation period begins with the date of infection and ends with the first appearance of signs or symptoms. The source period is the interval during which a patient most likely contracted the disease. The spread period is the time during which a patient is potentially infectious and could have passed the disease on to others. With syphilis, the source period and the incubation period never overlap with the spread period, since the exposure (source) and the development of disease (incubation) precede active infection (spread). It is important that the components of the interview period be thoroughly understood. See Appendix PS-A for disease specific information.

Although there are standard interview periods recommended in this guideline (Appendix PS-A), it is suggested that individual programs regularly review local data and social network analysis to determine appropriate interview periods for optimal resource allocation and case-finding. For example, recommendations based on localized data collection have ranged from 15 to 30 days for gonorrhea patients (Starcher, 1983; unpublished data, 1997), from 30 days to as long as six months for female chlamydia patients (Zimmerman-Rogers, 1997; unpublished data, 1997), and 90 to 180 days for early latent syphilis (Gunn, 1998; unpublished data, 1997).

The interview setting

Most often, the public health clinic provides a safe and convenient setting in which to interview and counsel patients compared to the field setting. The clinic allows for greater control over the interview process and permits access to additional personnel and materials, including medical records. However, interviews conducted outside the clinic setting afford the opportunity to observe patients in surroundings in which they are more comfortable and more in control. Interviews conducted in the home, for example, will afford the patient ready access to personal address books, pictures, etc., that can be helpful in locating partners, suspects, and associates. Interviews undertaken in other settings (e.g., crack houses, bars, housing projects, cars) also introduce the issue of personal safety for staff. Whatever the setting, DIS must foster a patient's trust and must assure confidentiality if an interview is to be successful, that is, create an opportunity for disease intervention.

Interviews should be conducted in person and confidentially. However, in certain situations, it may be necessary to interview and counsel the patient by telephone. When efforts to meet with a patient in person have been unsuccessful or when the patient is not in the same city as the DIS, a telephone interview may be considered, if consistent with local policy. Telephone interviews do not allow patient observation and should be used with discretion and in accordance with local program policy. When interviewing by phone, certain privacy issues must be taken into account (such as making sure that one is speaking to the patient, cellular phones are not being used, no one else is on the line, etc). Telephone interviews may be followed by a face-to-face reinterview. No studies have been published comparing the effectiveness of telephone interviewing vs. face-to-face interviewing, nor have any studies been published that discuss the ethical implications of telephone interviewing vs. face-to-face interviewing.

Pre-interview analysis (patient assessment)

DIS should thoroughly review all available materials related to a patient's case before each interview and counseling session. Such a review should include as many of the following as possible:

- reviewing available medical and case information, supervisor's notes/comments, and closed field records to:
  - establish the reason for the initial examination;
  - establish possible history of STDs;
  - establish a critical period and interview period;
  - establish pregnancy status for females;
  - establish information objectives (e.g. relationship to other cases); and
  - identify any unique problems and circumstances concerning the patient (confidentiality, embarrassment, sexual orientation, cooperativeness, apathy about infections, domestic violence history, etc.);
- reviewing available socio-sexual information and attempting to verify:
  - demographics (age, DOB, race and ethnicity, sex, marital status);
  - address and phone;
  - living situation;
  - employment; and
  - emergency locating information;
- assembling necessary materials and supplies, including:
  - visual aids;
  - writing materials (no official documents);
  - business cards;
  - disease-specific pamphlets;
  - referral forms and envelopes;
  - local map(s); and,
  - phone book and cross directory.

Verification is particularly important for those patients who "volunteer" at the STD clinic because any discrepancy provides cause for concern that must be addressed in the interview as this may be the only opportunity to speak with the patient.

Once pre-interview analysis is completed, the DIS should initiate the session. However, a willingness to speak with a DIS does not mean that the individual is willing to fully disclose everything that is needed to best manage the case, especially partner information. When the patient is resistant to the interview process, the DIS should attempt to determine the reason(s) behind this unwillingness to cooperate and then address each issue, using motivational techniques such as: mode of transmission, confidentiality, asymptomatic nature of disease, reinfection, complications, consequences, social responsibility, and risk of HIV. Sometimes, a change in interviewer will facilitate a more open discussion. An interview should not be conducted with a third party present, even at the patient's request, unless it is for reasons of auditing DIS performance or translation.

For those patients that still refuse to go forward with the interview, the DIS must carefully weigh any benefits to be gained by continuing to pursue the issue. Any decision not to interview a patient should be reviewed with the immediate supervisor. Whenever possible, this review should take place before the patient leaves the clinic. Programs are encouraged to require supervisory personnel to follow up with patients refusing an interview to assess whether there are DIS skill deficiencies that need to be addressed, patient dissatisfaction issues or a poor match of patient and interviewer.

Types of interviews and their objectives

The following section describes three types of interviews: the original interview, the reinterview, and the cluster interview. All interviews should employ the techniques in the section that follows, titled "Other important interviewing concepts." In any interview situation the interviewer should always pursue information on pregnant females who would benefit from STD screening and should ultimately ensure prenatal care. For example, the interviewer should always ask the interviewee (male or female) if they know anyone who is pregnant. If yes, the interviewer should then ask if they know if the pregnant person is receiving prenatal care. If the answer is no, the person should be initiated for follow-up and the interviewer should offer screening and have a specific prenatal service provider for referral.

Original Interview

The objective of the original interview (Appendix PS-B) is to prevent further transmission of disease through the prompt identification and examination of all elicited partners and suspects. The original interview is designed to ensure the patient understands the seriousness of the infection and the importance of their cooperation in STD/HIV prevention and control efforts. It is also designed to provide client-centered counseling to develop a personalized risk reduction plan and to increase the likelihood that all partners and suspects are disclosed so that they can receive an examination and treatment.

A fundamental part of the original interview (as well as reinterviews and cluster interviews) is partner elicitation. Elicitation is the process by which the interviewer assists the patient in identifying partners and other high-risk individuals (suspects) who might benefit from a medical examination. The goal of partner elicitation is to obtain sufficient information to confidentially locate, notify, and refer the partners or suspects for necessary examination, treatment (if appropriate), and risk reduction counseling.

Referrals to other medical and social services (such as HIV early intervention, prenatal care, or substance-abuse treatment) are an important aspect of original interviews. The interviewer should make every effort to create an accessible and appropriate referral and should also follow up to ensure that any referral appointment is kept. All information obtained in an original interview should be documented on a standardized form, an example of which is located in Appendix PS-E.

When a patient is diagnosed and treated in a non-public health clinic setting, or when a patient exits the clinic prior to the DIS conducting an interview, the original interview must be assigned for field follow-up at the earliest opportunity and with the expectation that the interview will:

- occur within 72 hours of assignment, or within established program time frames;
- be conducted face-to-face in the clinic, at the patient's place of residence, or in some other suitably private place; and
- elicit (or confirm) all information necessary and provide appropriate case management to complete the interview record.

In accordance with local practice, the DIS should confer with the supervisor (or designated co-worker) before completion of a patient interview if:

- an unexplained exposure gap exists;
- no source candidate has been elicited;
- inconsistencies in information persist; or
- the DIS feels dissatisfaction or uncertainty regarding the outcome.

The DIS should elicit a commitment from the patient to pursue identified information needs, establish an appointment for reinterview, and determine best time(s) and alternate methods for reaching the patient. When appropriate, the DIS arranges for a field tour with the patient to identify home addresses, to point out locations where partners hang out, where the patient met a partner, etc. The DIS concludes by addressing any questions, providing reassurance on any problem areas, restating commitments, providing handouts, and planing for the reinterview.

Reinterview

While the original interview is intended to elicit all interview period partners and suspects, the reinterview of persons with high-priority infections (HIV, early syphilis, or other high-priority infections, based on local criteria) is usually warranted. A reinterview may be required, for example, when a patient has clearly evaded discussing or referring all partners or suspects during the original interview.

A reinterview (Appendix PS-C) is any interviewing session following the initial interview with a STD patient. DIS conduct reinterviews when indicated, or when requested by the supervisor, and always with a plan to accomplish specific objectives that are the product of careful review and analysis. Reinterviews are conducted to:

- gather additional information that may help prove or disprove a hypothesis about case relationships;
- address points not covered during the original interview;

- identify additional partners or suspects ("clustering") to the original patient;
- support patient risk-reduction attempts;
- support and reinforce a patient's successful use of referred services;
- confront points that are illogical or that are disputed by other information; and
- solicit assistance in locating previously named persons who have not been located or are being uncooperative.

In most program areas, reinterviews are conducted with a plan to obtain information necessary to advance disease intervention. The benefits to be derived from reinterviews are further enhanced when conducted within reasonable time frames—normally within 72 hours of the last interview. The time and place of the reinterview should be set during the original interview process.

DIS should document the results of reinterviews on a STD Reinterview Record within time frames established by the local program. At a minimum, the documentation must address information needs previously established for the reinterview and must provide an updated analysis. The updated case is made available for supervisory review or is given to the appropriate case manager at the earliest reasonable time after the DIS completes the documentation.

The Cluster Interview

When interviewing patients regarding partners, adequate information for disease intervention is not always known or able to be obtained. Therefore, other intervention strategies, such as cluster interviewing, are initiated to expedite the intervention process. The cluster procedure has progressed through many stages since at least 1950 (Spencer, 2000) and currently consists of selective interviewing of partners, suspects, and associates who are not known to be infected at the time of the interview.

The purpose of the cluster interview (Appendix PS-D) is to gather information about previously unnamed or uninitiated partners, suspects, or associates of known cases. The cluster interview is designed to further expedite the disease intervention process by expanding the base of information about any high-risk groups associated with the infected person.

This information in turn may be used by the program to determine the appropriateness of screening activities, including risk or demographic profiles and the geographic location of target groups for screening. Cluster interviews should be planned, time permitting, and are particularly helpful in outbreak situations. They require skill and time commitment by the interviewer in exchange for returns that are often difficult to estimate in advance.

The DIS conducts cluster interviews, as indicated by case analysis or when requested by the supervisor, with a plan to accomplish specific objectives such as:

- identify high-risk associates such as individuals with symptoms of STD (A-1); individuals exposed to known cases of STD (A-2); and, others at increased risk for acquiring STD (A-3).
- meet informational needs revealed by case analysis; and,
- gain information about known cases of STD which can be used to better plan re-interviews through case management.

In conducting STD cluster interviews, care must be taken never to indicate that any specific person is infected with any disease, has been exposed to disease, or has been examined for disease. In the interview, the patient should be provided with:

- logical reasons as to why it is in his or her personal interest to discuss partners and other high-risk persons and the behavior of others to reduce the risk of disease in his or her social network; and
- easily understood information about the disease to which he or she has been exposed, and ways to avoid similar risk in the future.

Other important interview concepts

Motivational techniques to encourage voluntary disclosure

The ability to motivate patients to voluntarily disclose information about their partners and others is central to the success of disease control and prevention. An interviewer can use a number of techniques to motivate disclosure. Several approaches are described in the Employee Development Guide and the two week Introduction to STD Intervention course. One example,

the LOVER approach, is a very effective method of addressing patients' questions and encouraging disclosure of information. Using this approach, the interviewer will Listen, Observe, Verify, Evaluate, and Respond to the patient's issues. The interviewer must listen to what the patient is saying and observe any non-verbal cues that the patient is giving. The information must be verified and evaluated against other known information and the DIS must respond to the information given.

Another example is providing information about a potential issue such as same-sex transmission, complications, etc., followed by an open ended question. In addition, the interviewer can appeal to patient's sense of responsibility to other members of their community and to their responsibility to themselves with regard to re-infection. To increase the likelihood for success, motivational techniques should be tailored to the specific needs of the patient. Visual aids are also very helpful and can be used to depict the potential consequences of untreated infection. Suggestions for successful motivation of disclosure include:

- establishing and making the most of rapport with the patient;
- reassuring patient confidentiality by redefining confidentiality, role playing, or demonstrating confidentiality;
- remaining non-judgmental—exhibiting a strong sense of comfort in dealing with diverse sexual or social histories and being familiar with and using sexual vernacular;
- being direct and client-centered—asking the patient about his or her concerns;
- focusing on changing negative perceptions of disclosure;
- confronting and minimizing specific biases that may be apparent or relative to the case;
- addressing possibilities of and potential risks for reoccurrence of symptoms, re-infection, multiple infections, and complications for both the patient and others, including the possibility of fetal damage or death, when appropriate;
- using social or sexual network diagrams to illustrate the infection or re-infection picture;
- addressing and assisting with socio-economic issues (e.g., homelessness, unemployment, need for prenatal care, etc.), and related concerns (intimate violence, gangs);
- discussing partner location information and recent patient-partner or patient-network contacts in detail; and
- seeking assistance and advice about unknown information on clusters, screening sites, patient hangouts, and partner homes (e.g., field tours through area, etc.).

Client-centered approach to risk reduction

Counseling patients who are sexually active is likely to be more effective when counseling strategies are shaped to fit the individual patient's needs. To ensure patient-centered STD and HIV prevention counseling, interviews should be based on CDC's standards for prevention counseling, including a discussion of risk-reduction strategies the patient will be able to realistically attempt, as well as specific strategies to assist the patient with making these changes.

Referrals

Referrals to other medical and social services are an important aspect of all interviews. Although the focus of interactions is disease intervention, the interviewer should remain sensitive to other health or social needs of individuals served in the STD clinic or through the disease intervention process. Training will help DIS recognize and address problems that interfere with sexual health, such as intimate (or domestic) violence, substance abuse, and homelessness. When such needs are expressed by a patient or are otherwise perceived, the DIS should facilitate appropriate referrals to other available services in a tactful manner that does not interfere with disease intervention priorities. Local programs should develop a community referral guide or directory, including such services as:

- HIV intervention;
- Prenatal care;
- Family planning;
- Drug and alcohol counseling;
- Tuberculosis;
- Maternal and Child Health;
- Mental health;
- Immunization;
- Intimate or domestic violence;

- Sex addiction groups;
- Crisis intervention;
- Rape crisis;
- Language assistance;
- Temporary housing;
- Family counseling;
- Legal services;
- Child Protective Services;
- and other social or medical services.

When local policies allow, DIS should facilitate the referral by making a telephone call in the patient's presence and attempt to secure the first available appointment. All referrals should be documented in case management notes. The DIS should further assist patients by guiding them to a contiguous service area, providing directions to other locations, and offering transportation. Referrals should be documented and confirmed. Referrals made for the reasons listed below need to be followed up to ensure that they were successfully completed:

- HIV positive individuals referred for early intervention and case management;
- patients referred for penicillin desensitization;
- congenital syphilis treatment;
- pregnant females referred for prenatal care;
- and other locally defined priority referrals.

Unsuccessful referrals for these priority services require documentation and immediate action, including additional contact with the patient.

Post-interview activities

Documentation

Documentation is the careful and complete recording of facts surrounding a particular case or investigation and includes the essential events leading to its closure. DIS should concisely and legibly document the results of interviews, including case analysis, on the interview record and related program forms at the first reasonable opportunity (not to exceed one workday) consistent with established policy. Information to document includes unexplained exposure gaps, clustering needs or opportunities, and other information needs. The interview record and related forms are never completed in the presence of the patient. It may be helpful to review related cases and discuss the current interview with a supervisor or co-worker before completing the case write-up. Once all the paperwork necessary to fully document the initial interview has been completed, the entire case—including all field records and, where appropriate, a completed confidential morbidity report card—should immediately be directed to the attention of the supervisor for necessary review and comment. Proper documentation promotes effective disease intervention efforts through the efficient sharing of information with others—allowing co-workers to build on what has already occurred without having to needlessly repeat steps or actions already taken.

Interview and field records, whether on paper or in an electronic format, must be viewed as legal and confidential documents. As such, every effort must be made to ensure that each record is complete, accurate, fully legible, and able to stand the test of careful scrutiny. Interview records should be maintained in a secure location, accessible to the DIS and supervisors. DIS should review open cases at least twice weekly to determine status and evaluate needs. Such reviews enable reinterviews and cluster interviews to be easily and effectively planned. Supervisors should also regularly review cases and should clearly date, record, and initial all comments and directions. Whenever possible, supervisors should be encouraged to review cases in the presence of the responsible interviewers.

Information obtained from well documented interview and field records enables programs to make the most efficient use of resources by identifying and then targeting locations or specific populations within the community for screening activities. It also affords programs the opportunity to identify and draw upon additional resources and support by developing collaborations with carefully selected community-based and related organizations serving particular communities or at-risk populations.

Recommendation

- Documentation of partner services must be systematic, confidential, and regularly reviewed by the next level of supervision.

Analysis of case information and problem solving

Information obtained from medical records, interviews, reinterviews, and cluster interviews must be carefully analyzed for consistency. Visual case analysis (VCA) is an essential tool in syphilis case management for analyzing data from multiple sources. VCA allows the DIS to systematically document medical and epidemiologic facts related to early syphilis cases, analyze those facts, determine the most likely hypothesis of disease spread, identify where disease intervention could occur, and develop a plan for action. Information that is conflicting, unclear, or absent, but pertinent (for example, patient address(es), number of partners, descriptions of a partner, locating or exposure information) should be analyzed. In many instances, these issues can be quickly and easily clarified by speaking with the patient. There may be occasions, however, where the DIS chooses to explore other avenues before returning to the patient. Strategies for resolving inconsistencies in case management information include the following.

- Reinterviewing individuals who give sketchy information or whose partners give discrepant information.
- Offering field tours to patients in an effort to gain more complete locating information and to identify locations where the at-risk population gathers. These locations may become possible sites for targeted outreach activities.
- Performing an unannounced home visit for purposes of reinterview and to confirm the patients address and living situation.
- Clustering partners, suspects, and other individuals not named by the original patient (roommates, family members, neighbors, etc.) in an attempt to gain additional information about the original patient and the at-risk community. This is done with the understanding that some individuals can be expected to provide greater insights and information than others. For example, spouses and roommates should be considered for initiation and clustering even when exposure is denied by the index patient.

Prioritization of partners, suspects, and associates

Once field records have been completed for notification of partners, suspects, and associates, they should be carefully prioritized to ensure that those at highest risk—those who are pregnant, those exposed to lesions, or those indicated to have suspicious symptoms—are contacted or interviewed first. The prioritization of partners should be based on local program area policy and DIS workload using the same principles for priority setting discussed earlier.

Some program areas assign all field records (FRs) resulting from patient or cluster interviews to the interviewing DIS. However, if the number of priority partners or suspects is more than can reasonably be followed up in a 24-hour period, the immediate supervisor should assign some of the investigations to others. Priority suspects are individuals not named as sex partners, but who are identified as having suspicious symptoms (S-1) or as being an unnamed sex partner of another known case (S-2).

Quality analysis can only take place when interview records and supporting forms are properly completed and fully documented. A complete visual case analysis can be invaluable in documenting risk patterns in complex clusters of sex and STD transmission. Programs are encouraged to collect risk-behavior information on the interview record (i.e., with respect to drug use, the type of substances used and date of last use; whether the patient exchanged sex for drugs or money, or has had sex with someone or a partner of someone who exchanges sex for drugs or money). Important patient information should also identify the patient's usual health care provider and should provide sufficient space to fully document marginal partners. Collecting that information will assist program efforts to better understand the risk factors associated with various STDs.

Obtaining further information

DIS should tell all patients that it may become necessary to speak with them again and should attempt to determine the best way for doing so. Patients should be contacted the day following treatment to inquire about any reaction to medications, to answer any questions that may have come to mind, and to seek clarification concerning partner locating information as

needed. Follow-up after diagnosis underscores program concern for the patient as an individual. Rapid follow-up about partner locating information reinforces the urgent nature of partner notification. It provides an opportunity to follow up on how patients are doing with any commitments made; and affords an opportunity to review locating information already provided and to ask about additional partners that may have come to mind. If the original patient inquires about the status of partners that have been identified, the only information that may be relayed is whether the partners have or have not been notified.

Using Information Obtained From the Interview to Identify Possible Outbreak Situations

Programs should pursue information that will delineate at-risk populations so they might be more easily and effectively targeted for a wide range of interventions. This information can be obtained through community outreach activities, clustering, and increased testing by providers beyond the public STD clinic. Patients, their partners, and cluster suspects and associates can be particularly helpful in program efforts to identify specific at-risk populations in need of special initiatives. For example, a program may consider designing, evaluating, and implementing specific forms to identify and to assure the routine and continuing examination of sex workers within a particular community or program area.

Lot system: a case management tool

A lot system requires that case management records be maintained in a single folder. The goal of a lot system is to assure that all obtainable information regarding the continuing management of cases contained in a lot is readily available to all responsible workers. Workers should have access to information regarding other infections so that they have a comprehensive picture of the situation before conducting a reinterview or cluster interview. To further assure this process, information contained within each lot must be carefully maintained for each individual patient, and lots must be returned to a secure central location (file) when not being reviewed or updated. The lot system is a very useful tool in the management of syphilis, particularly in larger program areas or in areas with high syphilis morbidity. While it is most often used for syphilis, the lot system may be used for other diseases as well. Lot systems can facilitate identification of populations for which targeted screening is a suitable intervention.

The decision to file cases together can be for any "logical" reason, for example: 1) patients are related, i.e., they name one another as sex partners or are linked through clustering or 2) cases share something in common, such as working for the same company or living in the same apartment building.

The individual folders that constitute the lot system should be filed sequentially, by date reported. A "lot book", card file, or computerized system should be established, with information such as lot number, patient name, date of interview, diagnosis, etc. This system can be referred to when attempting to locate a particular interview record. When information allows cases in two or more lots to be "collapsed" into a single lot, the lot folder containing the most recently initiated case should normally be selected. The folders for those cases being moved should be retained in the file, with the lot number to which the case was moved written on the front.

With the increasing use of computers to store patient records, the use of an electronic lot system simplifies tasks. This may be accomplished by assigning a lot number in a local use field and then assigning the same number to all of the related records. When the records are sorted by the lot number, all of the records in that lot should be listed. A system should exist, either electronic or as hard copy, to cross-reference patient names, lot numbers, and case numbers.

Lot system forms

A major analytical points (MAP) sheet is used for gathering information about members of a lot as well as for analysis and communication. The MAP sheet is a preprinted list of items that are frequently needed in case management. Spaces are provided for other items unique to the lot. In addition, cluster and reinterview records may contain information that may generate agenda items during an interview of another patient in the same lot. These forms also may be used to document what occurred during the same interview. The original patient information sheet, along with the original interview record provides important disease intervention information. The lot folder status sheet is both

a reminder of cases in the lot and a summary of their relationships. Recent examples of these forms from the state of California, along with a field record form and a syphilis case management sheet, can be found in Appendix PS-E.

Partner Notification Strategies

Three primary strategies can be used to notify partners of possible exposure to STD or HIV infection: Provider, Self, or Contract referral. Often, more than one strategy may be used to notify different partners of the same infected patient. The strategy will depend on the particular patient, the particular STD, and on partner circumstances. For example, a patient with a STD may feel that he or she is in a better position to notify a main partner, but would prefer that the provider (DIS) notify other partners.

Programs must make the decision as to when a particular type of notification will work best in their area. This decision should be based on program priorities, disease morbidity, and program staffing levels. For example, a program may chose to utilize provider referral for patients with infectious syphilis yet utilize patient referral or contract referral for patients with gonorrhea and chlamydia. Others may chose to conduct provider referral for all patients, regardless of disease. In any case, DIS must work under the assumption they may have to locate a partner, even if the patient referral or contract referral option is used. DIS should obtain locating information on all partners and suspects, regardless of the option chosen, so they are prepared to follow up on partner notification activities.

Provider Referral

Provider referral is a notification strategy where, with the consent of the infected patient, the provider takes responsibility for confidentially notifying partners of the possibility of their exposure to a STD. The DIS will search health department open and closed records to determine whether the partner has ever been tested or treated for STD or HIV and to seek additional locating information. If the partner has been previously tested and/or treated, then the DIS determines whether notification is still warranted. Notification may not be needed if the partner has been recently tested, treated, or counseled and is aware that he or she has been exposed to an STD. If notification is needed, the DIS can use the information provided by the original patient or by record search to locate and refer the partner for prevention counseling, testing, and examination (see Appendix PS-F for details of provider notification process). Once the partner has been located, the DIS informs him or her confidentially and privately of the possibility of his or her exposure to STD. Information leading to the identity of the original patient is never revealed to the partner.

Research has shown that provider referral is the most effective method to notify partners (Macke, 1999). When discussing partners, the DIS should elicit names and exposure information with the assumption the health department will perform the notification. Advantages to this method are the ability to:

- verify that partners have been offered and have received evaluation and risk reduction counseling;
- ensure the patient's confidentiality since no information about the patient is disclosed to partners;
- help defuse any partner anger or blame reactions, and respond to the partner's questions or concerns;
- offer field specimen collection (blood, saliva, urine);
- provide on the spot counseling;
- identify opportunities to provide behavior change counseling; and
- provide immediate referrals and offer information.

Disadvantages to this method are:

- the difficulty in readily locating and identifying partners;
- less familiarity with the lifestyle and problems of the partner; and
- it uses more staff members and financial resources as compared with other methods.

Self (Patient) Referral

Self referral (sometimes called patient referral) is the notification strategy whereby the patient with a STD accepts full responsibility for informing partners of their exposure to a STD and for referring them to appropriate services. When self referral is chosen, the interviewer should coach and/or role play the following:

- WHEN to do the notification—encouraging the patient to notify partners promptly.
- WHERE to perform the notification—encouraging a private setting.
- HOW to tell the partner—coaching the patient to avoid blame by stating in simple terms someone has tested positive, and because this person cares about the partner, he/she is encouraging the partner to seek examination and treatment.
- REACTION—asking the patient how they think the partner will react, or has reacted to difficult news in the past. Help the patient anticipate potential problems, especially in regard to loss of anonymity. If a patient has difficulty at this point, the benefits of provider referral should be discussed and promoted.

Advantages to this method are:

- notification may result in a more prompt referral to appropriate services because the patient is usually more familiar with the identity and location of the partner; and
- fewer staff members and financial resources may be used.

The disadvantages of self referral include:

- forfeiting of anonymity, resulting in possible disclosure of the infection to third parties, subsequent discrimination, or a partner's reaction;
- the loss of confidentiality may increase the potential for violence;
- the patient may, intentionally or unintentionally, convey incorrect information, resulting in incomplete or ineffective referrals;
- the patient may not follow through on the notification of the partner, resulting in the increased probability of transmission to others and in additional time for the DIS, who will then have to contact the partner; and
- increased difficulty in evaluating outcomes.

Contract Referral

Contract referral is the notification strategy in which the provider negotiates a time frame (usually 24-48 hours) for the patient to inform his or her partners of their exposure and to refer them to appropriate services. The DIS collects all locating information for all partners, suspects, or associates discussed during the interview. If the patient is unable to inform partners within an agreed-upon time period, the DIS will notify and refer the partners. As in provider and self referral, the interviewer needs to obtain identifying and locating information on partners at the time of the interview. The DIS should also negotiate a confirmation of referral. Similar to provider referral, this option affords the DIS the ability to verify that partners have been notified and referred.

The advantages of this method are:

- it provides professionally trained support for the patient who chooses to notify his or her partners;
- it ensures that referral to appropriate services is provided and that prompt follow-up for the partner is available.

Disadvantages to this method are:

- it may result in lost time and the potential for further transmission of disease if the patient does not notify partners.

The following ideas and recommendations (West, 1997) may serve as guides for developing partner notification approaches:

- Provider referral is more effective than self referral in reaching partners, suspects, and associates.
- Most individuals will cooperate in notifying at least some partners, suspects, and associates.
- Partners are generally receptive to being notified and will seek testing once they have been notified.
- Partners often are unaware of their or their partners' STD risks.
- Partners frequently are found to have a STD.
- It is important for patients to recognize and understand the importance of partner notification.
- Reaching persons in early stages of their infection can enhance disease intervention and prevent disease complications.
- Many legal and ethical concepts pertain directly to partner notification and have important implications (duty to warn, right to know, duty to protect public health, right of confidentiality and privacy,

protection against discrimination, need to protect family and personal relationships).

DIS should be prepared to discuss the pros and cons of each notification strategy, including the likelihood of verbal or physical abuse. Programs should have in place a means of assessing the likelihood of violence as a result of partner notification and have a plan for addressing those situations.

Recommendation

- Partner services should be delivered in one of three ways: provider referral, patient referral, or contract referral.

Evidence supporting partner notification

While there are unanswered questions about partner notification, a review of the evidence supports several recommendations (Macke, 1999). There is good evidence to show 1) partner notification can be an effective means of finding at-risk and infected persons, 2) provider referral generally ensures that more partners are notified and medically evaluated; and 3) the reputation of partner notification service providers influences the success of partner notification as an intervention. More research is needed on tailoring elicitation and notification procedures to specific populations, the effect of new testing technologies on partner notification, and the consequences of partner notification for infected persons and their partners.

Other important concepts about partner notification

Encouraging the partner to seek medical treatment

The actions that a person takes (or does not take) to address health concerns include appraising the problem and the need for clinical care, reaching a decision to seek care, and acting on that decision. For example, a partner may have symptoms consistent with a STD but "appraise" the situation as a "normal" discharge and, as a result, not seek clinical care independently. People also sometimes treat themselves or consult with alternative practitioners. Partners tested in the field should be encouraged to obtain their test results and an appropriate medical evaluation (including treatment, if needed). Published literature identifies that the following factors contribute to delays in seeking appropriate treatment for an STD: a lack of symptoms (Niemiec, 1978) or the classification of STD symptoms as normal (Harrison, 1982; Fortenberry, 1997); being female (Leenaars, 1993); adolescents' sense of invulnerability and the stigma associated with acquiring a STD (Fortenberry, 1997). It is worth noting that persons with multiple partners and persons with a single partner are equally likely to delay care (Leenaars, 1993). Finally, partners may need other types of referrals as well (i.e., pregnancy, intimate violence) and DIS should be prepared to make these referrals and to support the patient in obtaining other services to the extent possible.

Follow-up to ensure notification is received and understood

When a partner who has been notified of his or her exposure does not seek medical evaluation, the DIS should follow up with that partner to ensure they understand the importance of timely and appropriate medical evaluation. Often, repeated conversations are needed. In these situations, DIS should be persistent and employ appropriate motivational techniques in a manner that conveys a sense of urgency and re-emphasizes the benefits and value of medical evaluation. Stalled investigations should be brought to the attention of a supervisor at the earliest opportunity for discussion and further action. Non-productive routine visits or dropping a referral letter is not an effective use of program resources.

Ensuring that the partner has access to health care

If a partner is evaluated by a provider outside the health department, the DIS should contact the provider to ensure that the partner receives appropriate and timely test(s) and treatment(s). Following the appointment time, the DIS should contact the provider to verify appropriate management of the partner. Self-reporting is not sufficient. The health care provider treating a partner should be personally contacted, or the medical record reviewed to verify that appropriate tests and treatments were administered. Conversely, if the partner was referred from another health care provider

and is treated in a health department clinic, the information regarding treatment of the partner should be communicated back to the referring health care provider.

Diagnostic assessment of partners in the field

Venipuncture is a skill required of public health nurses, and of many federal, state, and local DIS and is an especially valuable tool in the disease intervention process. Programs intending to use DIS in this manner need to review all relevant state health and safety codes and local public health protocols to determine required training and certification procedures before performing this activity. DIS must exercise the utmost care and professional judgement when performing field venipuncture procedures and must be certain to have the appropriate equipment and supplies available before undertaking field activities that may include drawing blood. For more detailed information regarding venipuncture, see the chapter titled "Medical and Laboratory Services." It is strongly recommended that part of the training afforded DIS include an orientation to the state or local "Occupational Infections in the Workplace" policy and the supporting procedural manual. This will expose the DIS to precautions and procedural recommendations set forth by NIOSH, CDC, and state OSHA programs. Programs also must have in place an "Occupational Infections in the Workplace" policy that is at least as restrictive as the Occupational Safety and Health Administration policy (see references for complete citation). More current information may be obtained from the OSHA website (www.osha.gov).

More and more disease control programs are exploring opportunities presented by emerging laboratory technology and the resulting testing procedures to identify and control communicable diseases. For example, tests that rely on urine or saliva to detect chlamydia, gonorrhea, or HIV infection have created opportunities for conducting screening activities that target specific high-risk populations at the community level. Some programs have expanded or are in the process of expanding the responsibilities of DIS to include administering these tests in the field and are using DIS to read skin tests for tuberculosis. Any decision to expand the responsibilities of the DIS in this area must be predicated on 1) the additional duties being consistent with DIS position descriptions; 2) DIS ability to legally provide the services outlined; and 3) DIS being afforded the necessary training to properly and safely deliver those services.

Case closure

For some cases of syphilis, diagnosis is not determined until case closure. This is particularly true for those persons with positive bloods, but without a symptom or blood test history. Only through interview and follow up of sex partners can it be determined if such a person should be classified as early latent, late latent, or syphilis of unknown duration.

A case is closed when the DIS and next level supervisor agree that all reasonable steps to intervene in the disease process have been completed. Before such a discussion, the DIS should carefully review the entire case record and those of related infections to ensure that all program required data needs have been met; that information is complete and consistent (e.g., test results documented, reinterview and cluster interview forms present, contacts and clusters dispositioned, and any necessary source/spread determinations made); and that all supervisory recommendations have been fully addressed. The entire lot or record should be submitted to the supervisor for final review. Interview records indicating that contact was not made or that partners were not medically evaluated must be discussed and signed off with the supervisor before closure. With the concurrence of the supervisor, the case is updated to reflect the closure date. Cases should be closed within locally established time frames.

Recommendations

- Partner services should be one of a number of public health strategies, including accessible clinics, outreach, and targeted screening of at risk populations.
- Programs should have the capacity to deliver services such as counseling, testing, and treatment, as well as referral for other services (e.g., family planning, drug treatment, social support, and housing).

SPECIAL CONSIDERATIONS

Collaborating with other service providers

Programs should implement protocols for the following circumstances:

- The diagnosis of the index patient is performed by non-health department agencies and the patient is referred to the health department for partner services;
- The elicitation of partners is performed by non-health department agencies and such information is provided to the health department for partner notification.

STD prevention programs should actively inform providers about partner services (for example, through DIS distributing pamphlets to key providers) and initiate collaborations with providers outside of the health department.

Interstate Transmission of STD Intervention Information

The Interstate Transmission of STD Intervention Information is the system that oversees the transmission of STD intervention information between STD prevention programs. Success depends upon the willingness of program managers to take the steps necessary to assure its provisions are observed and to hold one another accountable when deviations occur. STD prevention programs should review existing protocols and procedures to ensure they are specific on how to handle incoming and outgoing intervention requests. In reviewing or developing these protocols and procedures, programs should consider the principles outlined in Appendix PS-G to ensure consistency on a national level for interstate and intrastate transmission of information. Disease prevention will be facilitated by inter-jurisdictional sharing of information on patients, partners, suspects, and associates in a secure and confidential manner.

Suggested Strategies for Patients With Repeat Infections

Persons repeatedly infected and treated are often referred to as recalcitrant patients or "repeaters." Management of such patients should include HIV prevention counseling and testing (and possibly HIV prevention case management), since they are at high risk for acquiring HIV. Although such patients are a challenge for any STD prevention program, they are an important source of information regarding other at-risk individuals and locations within the community where they gather and interact. This information can be used to develop specific outreach screening activities targeting these areas that include carefully crafted and intensive behavioral interventions.

Recommendations

- Programs should implement a protocol for collaboration with non-health department care providers within their own area and with STD programs in other jurisdictions.
- Programs should implement a protocol for identifying and developing a case management plan for patients with repeat infections.

EVALUATION AND QUALITY ASSURANCE

Case Management

Supervisors and managers should regularly and carefully review information obtained through patient and cluster interviews to assure that cases are being vigorously pursued, properly documented, effectively analyzed, and that the findings are appropriately applied to continuing intervention activities. Managers should also assure that case information involving other program areas is being shared promptly and cooperatively.

Performance expectations of the program and personnel for all aspects of disease control should be established. Performance guidelines are relatively detailed instructions and standards about the process by which staff are expected to apply acquired knowledge and skills to critical elements of daily work in STD con-

trol. For supervisors, guidelines are an aid to evaluating the capabilities and deficiencies of workers. Beyond simply establishing program expectation, "guidelines" describe the process by which those expectations can be achieved. Programs should develop, disseminate, and maintain signed copies of local process performance standards, indicating that an employee has received, reviewed, understood, and agreed to these standards.

Components of case management quality assurance

Involved program managers and firstline supervisors are critical to successful case management. Active involvement of supervisors is necessary to maximize DIS intervention activities. There must be the expectation that DIS will obtain complete locating information on partners, negotiate a risk reduction plan, and cluster to determine who may benefit from examination or to identify locations where high risk activities occur.

Supervisors should regularly and directly observe individual DIS in the performance of their day-to-day activities and should be willing and able to demonstrate appropriate skills and behaviors. Forms should be in place to fully document these audits and demonstrations (pouch, interview, and field audits). Completed forms should be shared with the individual employee regularly and immediately following the audit. Such forms can be used when writing individual evaluations to call attention to areas of strength and to those requiring improvement. An example of tools that can be used to assess the quality of partner service work is the skills inventory assessment, included in Appendix PS-H.

Supervisors should conduct sessions (sometimes called "Chalk Talks") that facilitate DIS discussion of case management efforts and provide opportunity for input from others. Such discussions can be used to share information on marginal partners—those partners for whom insufficient information has been elicited to initiate. Such meetings should also be used to discuss other case management issues, safety concerns, social network analysis, and newly developed investigative resources. Chalk talks provide the opportunity for peer-to-peer sharing of interviewing and investigative techniques and approaches. They also provide opportunities for program management to encourage appropriate attitudes and philosophies.

Programs should establish the expectation that case management—and the interview and investigative activities that support it—will be rigorously approached, fully documented, and carefully analyzed. This will place the STD prevention program in position to obtain the information necessary to address STD morbidity within communities.

Recommendations

- Supervisors should regularly observe and document individual DIS in the performance of their day-to-day activities and should be willing and able to demonstrate appropriate skills and behaviors.
- Supervisors should conduct sessions that facilitate DIS discussion of case management efforts and provide opportunity for input from others.
- Programs should routinely monitor partner services to improve efficiency, effectiveness, and quality of services.

Using information gathered to describe and reach target populations

Much of the information gathered in the partner services process may be used to describe and reach target populations in the program's jurisdiction. Information that may be used includes, but is not limited to, disease outcomes, risk behaviors (i.e., drug use or commercial sex work), location of home and "hang-outs", as well as information about partners, suspects, and associates. At the most basic level, trends in disease found through evaluating partners should be used to monitor disease transmission and to increase program awareness regarding potential outbreaks. Once this system is in place, more advanced analyses of data should take place regularly. For example, tabulate monthly the number (and type, where applicable) of risk behaviors that the original patient discusses in the original interview (i.e., sex for drugs), partners testing positive, partners testing negative, and the number of partners tested.

Recommendations

- Trends in disease found through evaluating partners should be used to monitor disease transmission and to increase program awareness regarding potential outbreaks.
- At a minimum, programs should analyze partners who are positive by residence (zip code, address). If resources permit, programs should also analyze location, demographics, and risk behaviors of partners and should compare positive (including previously treated partners) with negative partners to see what, if any, factors predict positive partners.

Measures for evaluating program effectiveness

The list of measures that follow are aids to help evaluate the effectiveness of the partner services component and to help reallocate resources if necessary. These measures are not an end in themselves but a means to analyze and improve program effectiveness. They should be reviewed regularly (i.e., monthly or quarterly) and tailored to meet the program's identified needs. Many states have developed detailed monthly reports of DIS productivity. In addition, programs may wish to use the tables in Appendix PS-I as analysis tools. Tables may be completed for each disease for which patients are interviewed; separate tables for suspects and associates may be done as well. These measures can be calculated using STD*MIS.

Essential Measures (for each disease):

- Number of original patients interviewed
- Total number of partners elicited
- Number of partners initiated to field follow-up
- Number of partners out of jurisdiction
- Number of partners identified but not located
- Number of partners identified and located but not notified (i.e., located in records as previously treated)
- Number of partners located and notified by provider;
- Time frames for locating and notifying partners (i.e., How many were notified within seven days of the interview of the original patient);
- Number of partners notified of their exposure to an STD, including:
  - Number of STD negative and no subsequent STD infection
  - Number of STD negative who have at least one subsequent STD infection
  - Number of STD positive who have at least one subsequent STD infection
  - Number of STD positive with no subsequent STD infection

Programs should also be able to evaluate partner services by:

- Individual Program Area (e.g., county, district, region, etc.)
- Provider Type (STD Clinic, Family Planning, Correctional Facilities, PMD, HMO, etc.)
- Sex of the patient
- Referral strategy (patient, provider, or other)
- Any selected time frame

The ability to delineate partner services information in a variety of ways enables a program to more easily determine activities that appear to be effective from those that do not. Is one program area or type of activity more effective or worthwhile than another? What are the individual strengths and weaknesses of field staff? Individual employee reports may help a supervisor and the program identify interviewing deficiencies that can be remedied by training. For example, managers can generate reports for a particular area before a scheduled visit. They may identify possible areas of concern that can then be examined more closely during the visit.

Programs should also collect data on reinterviews (number reinterviewed and results), on new partners, suspects, and associates initiated, and on the numbers of partners, suspects, and associates afforded prophylaxis. Programs should also develop reports that routinely examine the speed and effectiveness by which services are delivered to partners, suspects, and associates. Finally, these reports should be available to and used by all levels of management.

Other types of analysis and measures:
The measures discussed above are the traditional "bottom line" measures of success of partner services, but they are not the only ones. Using the number of original patients interviewed as the denominator, one can calculate various indices for each time period such as:

- Number or percentage of patients being interviewed; percent in 24 hours.
- Number or percentage of patients coming from: clinic, corrections settings, substance-abuse programs. Knowing this can help target screening resources more effectively.
- Number of partners elicited compared to the number initiated.
- Number of out of jurisdiction partners initiated and the timeframe on receiving disposition on these out of jurisdiction partners.
- Number of incoming out-of-jurisdiction partners actively pursued. Number and timeframe of incoming out-of-jurisdiction partners where disposition was given to other jurisdictions.
- Number of partners closed as unable to locate. Additional locating resources or training in the use of those resources may be needed (e.g., Internet directories as well as updated cross-directories; closer relationship with the department of motor vehicles or other agencies).
- Number of partners refusing service.
- Number of partners treated prior to being notified by the DIS.
- Percentage of original patients, partners, suspects, and associates with more than one STD.
- Number of partners, suspects, and associates that were located, notified, examined, and treated.

These calculations may be done for each individual DIS as well as the entire program. Useful calculations include the percentage of partners located and tested in a timely manner, for example, in less than a week. The ultimate question that these data should answer is how the program is doing in terms of controlling disease.

Recommendations

- Programs must have a means of regularly evaluating the effectiveness of partner services by time period and disease.
- Programs should develop the capacity to evaluate the effectiveness of the partner services by other locally set criteria to improve services and target them better.

COMMUNITY-BASED OUTREACH

Public health and STD prevention programs, in particular, have a duty to warn individuals that they may have been exposed to a sexually transmitted disease. In response, most STD prevention programs provide for the notification and evaluation of exposed partners who have been identified by an infected index case or partner. Examples of such services include partner notification (PN), clinical evaluation and testing of partners, the concurrent provision of prophylaxis, and risk-reduction counseling. Some have stated that this duty to warn extends also to individuals who were exposed but who could not be located through PN (Peterman, 1997). However, not all STD prevention programs directly provide for the evaluation of persons who have not been located through PN or who have not been identified by an infected index case or partner. Examples of strategies that address this expanded charge include clinical evaluation and testing of patients who come to the clinic as volunteers, cluster interviewing with resultant disease screening and prophylaxis, review of epidemiologic data collected through ethnographic means, targeted outreach, screening, and public awareness campaigns. It is important for STD prevention programs to evaluate their local situations and to employ interventions which complement PN. Such interventions include social network analysis in conjunction with PN, targeted screening and field testing, and other forms of outreach.

Social Network Analysis

Network analysis is defined as the study of how people connect in social structures and of its implications (Potterat, 1998). A detailed discussion of social network analysis is available in Appendix PS-K. Several different social networking methods are commonly used. One method is to collect information about core environments in addition to partner names. Another is to make a programmatic commitment to investigate the networks where disease is located rather than investigating only individuals known to have a STD. Clustering, the technique by which infected and uninfected patients are interviewed about their associates (as well as their partners), may provide extra information about the identity and location of sought-after sex partners. Clustering also can be used to identify geographic areas or for narrowing criteria for targeted screening. Additional methods of social networking are spot-mapping home addresses and hangouts, studying partner mixing patterns, and performing old-fashioned shoe-leather epidemiology.

Research often centers around which behavioral and social features are necessary to continue disease transmission in epidemic numbers and around the exploration of which interventions could be implemented to halt transmission. Transmission dynamics are primarily dependent upon the effects of small populations with varying levels of sexual activity (i.e., frequency, number of different sex partners) (Oxman, 1996a). For example, in Oregon the number of syphilis infections was found to be affected by the number of clusters of women who have a large number of casual or anonymous partners. Oxman found that when the actual number of women in the group or the number of partners exchanged in any given time period, or both, was reduced, the rate of the group's infection decreased. When an epidemic begins, the number of infected people rises quickly to a peak that appears to be closely linked to the sexual behavior characteristics of the involved population.

There is support for the notion that syphilis outbreaks in heterosexuals, which are extremely difficult to control once underway, are a result of core transmission (a small number of interactive and networked individuals). STD control programs can incorporate social network methods, e.g., mapping, cluster interviewing, to identify the populations and conditions within its jurisdiction that facilitate disease transmission, especially by high-frequency (core) transmitters. In addition, programs may be able to prevent outbreaks by limiting disease occurrence in core transmitters. This should be done in partnership with communities that the program serves (Oxman, 1996a).

Woodhouse et al. researched how a group's social, sexual, and injection drug-sharing relationships might help or hinder the spread of various STD, including HIV (Woodhouse, 1994). What they found, surprisingly, was that the majority of the infected individuals were not part of the larger interconnected group engaging in high-risk activity, but in fact were connected to much smaller groups with no links to the larger group. In other words, it is not just the presence of infection that produces transmission, but other social factors such as group dynamics and behaviors, group size, and geographic area. Programs can take the information gathered from network analysis and review and can create and implement policy and operations that take into consideration the dynamics of day-to-day transmission within their jurisdictions (Woodhouse, 1994).

Rothenberg and Narramore outlined how social networking analysis was used by public health officials to address an increase in early syphilis cases in certain areas of Nashville, Tennessee (Rothenberg, 1996b). A map was created of all the addresses reported by individuals with early syphilis. As a result, staff were able to identify that 89.7% of all persons with early syphilis lived within nine well-defined geographic areas. This pattern had actually been occurring for several years. In addition, staff observed the use of crack cocaine in this network. In response, the Nashville STD control program implemented a network-informed approach to their syphilis prevention activities. Such efforts included the assignment of public health workers to specific geographic areas, staff having continuing contact with persons at risk and other community leaders, and mandatory reinterviewing of all infected persons to gather additional information on personal networks.

A recent report described the importance of social network and ethnographic tools in the investigation of a cluster of syphilis cases in Georgia (Rothenberg, 1998). Several complementary methods were used,

including the interviewing of as many people as possible who were believed to be involved in transmission (both infected and uninfected people); the detailed ethnographic exploration and documentation of sexual and social patterns; the collection of interview information on standard CDC interview forms; the conversion of interview data into databases to which network analysis software could be applied (including programs that allowed for graphic representations of patterns); and follow-up interviews several months to a year later to examine the social and sexual patterns that followed the outbreak. Ethnographic interviews revealed the existence of a complex sexual picture that predated the diagnosis of the first case by one year and that people without infection were often as central in the network and as important in transmission as infected people. In addition, uninfected people were as likely to identify partners with infection as people without infection. This approach underscores that if programs interview only people known to have infection, they will miss important people, including infected partners and individuals who do not have a STD, but who, by their connectedness within a network, sustain transmission. With appropriate training in ethnographic and social network methods and the use of databases such as STD*MIS, a network informed approach can be incorporated into STD prevention program activities.

An example of such incorporation has been attempted in an inner city area of Atlanta, Ga. with high syphilis rates. A DIS team, spending approximately 80% of its time in the field (compared to interviewing infected persons in the clinic and then seeking the partners), used network and ethnographic methods to identify an interconnected group of over 300 persons with a six month syphilis incidence of 12.6% (Rothenberg, in press). By identifying such groups at risk, the field team is in a position not only to interrupt disease transmission but to predict and respond to changing disease trends. These approaches provide direct observations of behavior change in a community (e.g., adoption of condom use, limiting numbers of anonymous partners, decreasing the frequency of sex and drug partner change) (Rothenberg, 1995), and provide a built-in mechanism for appropriate targeting.

Traditionally, public health has focused on specific behaviors or on some overall assessment of risk, which has often resulted in a broad characterization of various social groups, i.e., gay men and teenagers. Research has shown that specific behaviors determine the risk for infection and that social networks determine the extent of the disease within that given population. Over the years, partner notification has shown that social networks do play an important role in the public health approach to disease control. Initial work suggests that social structures can influence STD transmission. Social structures also can increase the effect of risky behaviors within each social setting. Epidemics do not result just from many risky acts, but are the result of complex interactions embedded in a social and geographic context (Rothenberg, 1996a). It is crucial that programs take into account both the risky behaviors of individuals and the risky behaviors ingrained within the culture of the social network when critiquing, revising, or developing disease control interventions.

History has shown that the act of segmenting social networks, such as closing bathhouses and shooting galleries, or housing disruption in economically impoverished areas, may result in higher rates and widespread disease for a period of time (Rothenberg, 1996a). Disease that was once self-contained in a small segregated community can expand beyond its previous boundaries and, as a result, create new possibilities for disease transmission. Instead of dividing social networks, programs can use social networking methods to identify those individuals who hold influence and who can potentially act in partnerships with health professionals in disease prevention.

A more formal approach to social network analysis has been shown to be very effective in reducing the incidence of disease transmission by targeting specific areas (Rothenberg, 1996b). However, it can be a very labor-intensive process and is recommended only if program staff are familiar with the techniques of data collection and evaluation and have the resources to process the information gathered. First, programs can expand the scope of partners to include close friends, acquaintances, persons within the same social group, roommates, former or occasional sex partners, and anyone else deemed at risk. Local protocol should dictate the exact criteria. Second, people identified would be (cluster) interviewed to determine the appropriateness of prophylaxis, to pursue further partners and associates, to identify what other social groups may

be involved, to determine the behaviors associated with the groups, and to gauge the strength of associations within the social network. Care must be taken to assure that there is no violation of confidentiality nor the perception of violation. Subsequently, programs can document what they have learned about individual communities, with a focus on the mixing patterns, frequency of partner change, and social hierarchy. Once these elements are understood and discussed by program staff, it will be easier to tailor and implement disease control methods toward the specific dynamics of disease transmission within the social network.

Social network analysis, in essence, means reducing the emphasis on individuals and looking at the commonalities among individuals with a STD and their associates. Experts believe that increased focus on STD transmission analysis or intervention should be placed on the social network rather than solely on the individual. It is widely thought that disease control methods targeted to the general population may be less valuable than approaches that focus resources on important group structures (Rothenberg, 1996a). Researchers add that since some social network analysis in the infectious diseases context may fall short in the area of sampling strategies and data collection, results should be used to stimulate further research in this area (Potterat, 1998). As a result, social network analysis can be seen as complementary to other models of infectious disease prevention.

Recommendations

- Programs should establish strategies for finding at-risk persons not identified by an infected index case or partner.
- Programs should evaluate or assess the social networks that influence disease transmission in their area.

Targeted Screening and Field Testing

Targeted screening can be defined as an activity to identify people with infection in a select group who are engaged in a behavior that puts them at greater risk for infection. Field testing is when public health workers offer testing at non-clinic locations associated with known cases and their partners.

As an example, the prevalence of Chlamydia trachomatis infection in inner-city youth was measured by collecting 486 urine specimens during a 20 month period (Rietmeijer, 1997). Specimens were collected both in the field and in clinic settings. The study found that positivity rates were higher in the field than in the clinic facilities (11.9% vs. 4.4%). Ninety-seven percent of all infected patients were treated within eight days of testing. Thus, screening can be done in non-traditional settings and still yield similar, if not better, results than screening done in standard clinic settings. Considering the substantial numbers of asymptomatic chlamydia infections in field-recruited male youths, the large number of recent sex partners, and a reluctance to seek clinic-based STD screening, it is doubtful whether, even with optimal access to STD treatment services, traditional clinic-based approaches will ever bring the chlamydia epidemic under control (Rietmeijer, 1997). In this context, the use of non-invasive screening methods embedded in targeted, community-level prevention programs has the potential to make significant contributions to STD control.

Disease control efforts also have used targeted screening to find otherwise unseen or undiagnosed disease. It continues to be a very effective way to locate a high percentage of new cases (Gerber, 1989). When traditional means of disease control fall short, clustering others within the same social network of the infected patient and offering them testing can be extremely effective. In this setting, screening close social associates of infected patients is almost as effective as screening actual partners.

During the first half of 1990, traditional approaches to the control of syphilis were found to be ineffective in slowing a syphilis epidemic (Mellinger, 1991). Persons who were involved in the exchange of drugs or money for sex often could not or would not provide sufficient information about their sex partners. That prevented public health personnel from locating exposed partners. As a result, alternative case-finding methods were needed. Disease transmission was reduced by using cluster interviewing to identify friends and associates at risk for syphilis and by setting up targeted serologic screening for those identified and for others engaging in high-risk sexual activity. This process documented a 27% reactivity rate, with 3%

of those newly infected diagnosed with either primary or secondary syphilis.

Similarly, staff involved in a different syphilis epidemic began to focus on identifying places associated with cases and partners, instead of just on partner names (Hutcheson, 1993). They discovered 21 places where affected people were most likely to meet sex partners. Subsequently, staff members familiar with the community visited the sites and took over 200 blood samples that were tested for syphilis. Thirty-one percent tested positive, and 17% were preventively treated. Of those testing positive, 78% received examination and treatment, and a majority were found to have additional STD. It is important to note that in this case a combination of innovative, conventional, and cluster interviewing and investigation methods were used to effectively identify previously undiagnosed syphilis cases.

Increased use of crack cocaine and the exchange of sex for money or drugs have been major contributors to the increased occurrence of syphilis in many areas throughout the country, affecting disproportionate numbers of people of color (Greenberg, 1992). Traditional syphilis control programs usually offer a combination of interventions, including serologic screening of asymptomatic individuals, diagnostic testing of individuals self-motivated by symptoms or by perceived risk, and DIS case management (Oxman, 1996b). To increase the effects on disease transmission, many programs have instituted targeted syphilis screening in areas connected with cases and their associates. In recent years, these targeted screenings have been provided for sex workers and their customers, and for the drug (crack cocaine) dealers and crack users. Since those groups tend not to use traditional health care, screening should be offered in non-clinic settings such as crack houses, bars, shelters, parks, jails, detention centers, back alleys, and other locations frequented by at-risk populations.

Traditional control of gonorrhea and chlamydia has often been clinic based and relied on the treatment of self-referred, mostly symptomatic patients in combination with the notification and treatment of their partners. However, delays between diagnosis and treatment are not uncommon and often result in recurrences of transmission and reinfection. To prevent the unintentional transmission of disease, suggestions have been made to expand targeted testing in non- clinic settings. Communities that have traditionally avoided clinical care will be more likely to seek care in non-traditional settings if given the opportunity. Field screening will become more practical with the increasing availability of convenient techniques for the detection of STD, such as urine testing.

While no one in the field of disease control is debating the usefulness of screening to identify undiagnosed disease, the common thought is that screening needs to target the highest prevalence areas to interrupt core transmission and, in turn, reduce disease rates. In general, STD prevention programs need to balance screening and DIS activity so that testing and field activity are complementary.

There is a strong movement to combine both field and clinic screening efforts. Each acts as a bridge to the other. Field screening results in patients accessing clinical care, and clinical care plays a very important part in disease control. Without traditional clinic screening, communities risk missing cases of other STDs, and reducing opportunities for such related prevention activities as pregnancy testing, Pap smear screening, risk-reduction counseling, HIV testing, hepatitis B vaccination, and the initiation of contraception.

Recommendations

- Programs should target screening based upon program morbidity data, including information on core transmission groups.
- Programs should use information from social network analysis, if available, to assist in targeting both field and clinic screening efforts.

Community Outreach

An effective strategy in reducing disease transmission is for DIS or other health professionals to develop relationships with the social and sexual leaders (core transmitters) within any given population. This requires that DIS build partnerships with people affected

by STD. However, first it is necessary to establish an effective line of communication between those who analyze data and the field staff, so that programs (and particularly DIS) can identify the core transmitters within their areas, i.e., develop a picture of the sociosexual networks and transmission dynamics (Potterat, 1992). Once trust is established between the community and DIS, it may be much easier to locate partners and associates, set up effective targeted screening, provide risk-reduction counseling, and perform cluster interviews.

STD Clinic Outreach

Some practical approaches that STD prevention programs can use to help control STD, especially in populations who trade sex for money or drugs include: locating clinics close to high-incidence areas, adding evening hours, reducing waiting time, encouraging community participation in targeting behaviors to be changed, and immediately following up with infected patients (Dunn, 1991) Presumptive treatment of close associates and cluster suspects can be more effective than partner notification in controlling transmission of syphilis, especially in crack users, and the cost of this treatment may be negated by the cost savings of the cases prevented. Others have suggested that clinics consider gang boundaries and their effects when planning and implementing services.

Recommendations

- Programs should build partnerships with people affected by sexually transmitted diseases to increase trust and to facilitate partner services and other interventions.
- Programs should assess which diseases are being transmitted within their jurisdiction and how, including partner selection patterns and other risk factors for infection.

Appendix PS–A

INTERVIEW PERIODS BY DISEASE

Disease Code	Disease Type	Interview Period
200/300	Chlamydia/Gonorrhea	Symptomatic—60 days prior to onset of symptoms through the date of treatment Asymptomatic cases—60 days prior to treatment
490	Pelvic Inflammatory Disease	60 days prior to onset of symptoms through the date of treatment
710	Primary Syphilis	90 days prior to date of onset of primary lesion through the date of treatment
720	Secondary Syphilis	6.5 months prior to date of onset of secondary symptoms through the date of treatment
730	Early Latent Syphilis*	1 year prior to start of treatment
900/950	HIV/AIDS	1 year prior to the date of positive test through the date of posttest counseling (extended interview period may be warranted by individual circumstances) 10-year interview period for current or any previous spouses

Note: Interview periods may be modified if a history of symptoms, a negative test result, or incidental treatment are documented. If symptom history is questionable, a maximum interview period should be used. If the patient claims no partners during the interview period, then the most recent partner before the interview period should be elicited and notified.

* Many syphilis cases cannot be staged until after the case is closed. When the stage of syphilis is undetermined at the time of interview, a one-year interview period should be used. That is, STD prevention programs should initially interview a patient as early latent syphilis (730) and then, if appropriate, reclassify at case closure as late latent syphilis (745), latent syphilis of unknown duration (740), or not syphilis (serofast). To reclassify an early latent case as late latent or unknown duration, the following criteria must be met: no history of exposure to a known case of syphilis (as determined by interviewing the case and following up on sex partners), no history of symptoms in the last year, no history of a negative blood test in the last year, and no rise in titer of two dilutions or more. A case should be reported even if treatment is not verified.

Introduction, Professional Role, and Purpose

The interviewer initiates the interview so as to foster productive dialogue by:

- introducing himself or herself and anyone else present, and explaining his or her professional role (avoiding titles such as DIS);
- explaining the purpose of the session; and
- emphasizing the confidential nature of the interview, defining confidentiality and its relevance to the patient's situation.

Patient Assessment

The interviewer maintains active, two-way client-centered communications throughout the interview by:

- communicating at the patient's level of understanding;
- using open-ended questions;
- using appropriate nonverbal communication;
- using positive reinforcement;
- soliciting feedback;
- listening effectively; and
- using plain paper to record interview notes (never take official forms into the interview).

Patient Concerns

The interviewer identifies and addresses the patient's concerns, determines reason for exam, and clarifies patient's concerns or misconceptions about the diagnosis.

Socio-sexual Information

The interviewer uses open-ended questions to gather information about where the patient lives; telephone, cell phone, beeper number; alternative locating information; who the patient is living with; employment; recent travel; recreation; and social groups. Explain reasons for questions if patient shows signs of concern.

Medical History and Disease Comprehension

The interviewer ensures that each patient is informed about the specific STD at issue (asymptomatic nature of disease, risk of re-infection, mode of transmission, course of disease, symptoms, sites of possible exposure, seriousness of disease, and risk reduction), uses visual aids to gather information on signs and symptoms of the original patient and ask about other persons with symptoms (S-1), and gathers information about STD history and previous testing and treatment.

Disease Intervention Behaviors

Assuring Examination of Partners and Suspects

After eliciting the names of partners and other high-risk persons (especially if pregnant), the interviewer pursues detailed identifying and descriptive information, making certain to get complete sexual exposure data and nature of symptoms when appropriate. Note: The same amount of locating and descriptive information should be pursued on all partners and suspects, even if the DIS is aware of the named individual.

"Clustering" is the process of identifying people who may be indirectly associated with the infected patient and who may benefit from an examination, even when they are not named as interview period partners. This is done by eliciting suspects during interviews with infected patients. While the number of actual partners exposed during the critical period is finite, the potential for clusters is almost limitless.

The following locating information should be pursued when a partner or suspect is elicited:

- name, nicknames, and other aliases;
- dates and frequency of exposure;
- address, phone and pager numbers;
- place and type of employment, trade, or school and phone number;
- personal appearance and description (including age or date of birth);
- co-residents and others residing at residence;
- other person(s) who can provide locating information or convey a message;

- hangouts, best places and times to encounter;
- previous place(s) of residence or employment;
- history of arrest or incarceration;
- other mailing address; and
- map and directions, especially when no address is known or there is patient uncertainty.

The DIS recognizes and addresses problem indicators through a process of:

- analysis;
- using the LOVER method (Listen, Observe, Verify, Evaluate, and Respond);
- assertive confrontation (without alienation);
- tactful persistence;
- timely uses of appropriate motivations, such as:
  - mode of transmission,
  - confidentiality,
  - asymptomatic nature of disease,
  - risk of re-infection,
  - complications and consequences,
  - social responsibility,
  - higher chance of getting or giving HIV, and
  - pregnancy and children.

Negotiating a risk reduction plan

STD prevention counseling should be incorporated into interviews. Prevention counseling with patients who are sexually active is likely to be more effective when the counseling skills and strategies are shaped to fit the individual's needs. To ensure that STD prevention counseling is client-centered, the interview should be based on appropriate CDC standards for prevention counseling, a discussion of risk-reduction or harm-reduction strategies that the patient will be able to attempt, and specific strategies to help the patient with making these changes.

Conclusion

Before concluding the original interview, the interviewer should:

- clear up any remaining questions;
- restate commitments (e.g., contract referral, risk reduction plan, referrals);
- plan for reinterview; and
- provide handouts (e.g., referrals, condoms, follow-up appointments, pamphlets)

In accordance with local practices, the DIS should confer with the supervisor (or designated co-worker) before completing a clinic interview if:

- an unexplained exposure gap exists;
- no source candidate has been elicited;
- information inconsistencies persist; or
- the DIS feels dissatisfaction or uncertainty regarding the results of the interview.

Appendix PS–C

REINTERVIEW FORMAT

Introduction, Professional Role, and Purpose

- Introduce (or reintroduce) yourself and anyone else present.
- Explain your role if different from the original interviewer.
- Review confidentiality (if different DIS, emphasize that confidentiality is maintained).
- Define the purpose of the session:
- to discuss problems with commitments made in the original interview,
- to discuss new information learned about the patient's infection.

Patient Assessment

Patient Concerns

- Inquire about and resolve any of the patient's concerns during the interim period (possible reactions to the medication, compliance issues, etc.)

Socio-sexual Information

- Describe the importance of having accurate personal and medical information in resolving the patient's disease problems.
- Address any conflicting locating or demographic information provided by the patient.

Medical History and Disease Comprehension

- Review what the patient knows about the disease.
- Emphasize the infectiousness of the disease, the asymptomatic nature of the disease, and the severity of the disease.
- Confirm that the patient kept referrals made in the original interview.
- Pursue S-1's based on the responsiveness of the patient.

Disease Intervention Behaviors

Assure the Examination of All Partners

- Stress the importance of all partners getting examined.
- Pursue a specific agenda based on the analysis of the original interview and the interim period.
- Analysis of the original interview:
  - Problem-solving analysis to motivate the patient effectively
  - Identification of potential source candidates
  - Identification of potential spread candidates
  - Dispositions of previously identified partners or suspects
- Analysis of areas unexplored in the original interview

- Analysis of the interim period:
  - Locating problems
  - Partner and locating information validity.
  - Results of cluster interview(s)
  - Other incidental intelligence
  - Pursue S-2's and S-3's

Risk-Reduction Plan

- Review the patient's plan for preventing future STD/HIV exposures, as discussed in the original interview.
- Engage the patient in a discussion on how their behavior change plan has worked to date.
- Support any positive changes that have occurred.
- Discuss any barriers to behavior change that occurred, and how to work around those barriers in the future.
- Review test results that have returned, and reinforce the necessity to return for future test results.

Conclusion

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

Appendix PS–D

CLUSTER INTERVIEW FORMAT

Introduction, Professional Role, and Purpose

- Introduce yourself and anyone else present.
- Explain your professional role (avoiding titles such as DIS).
- Explain confidentiality.
- Explain the purpose of the session:
  - to provide information about the disease to which exposed and the reason for treatment
  - to provide information to help prevent future exposures
  - to help the patient know what to do if reexposed

Patient Assessment

The interviewer maintains active, two-way client-centered communications throughout the interview by:

- communicating at the patient's level of understanding;
- using open-ended questions;
- using appropriate nonverbal communication;
- using positive reinforcement;
- soliciting feedback;
- listening effectively; and
- using plain paper to record interview notes (never take standard forms into the interview).

Patient Concerns

- Identify and resolve any of the patient's concerns (why given treatment with a negative test; why talk with DIS if test is negative; confidentiality; time; clinic experience; etc.).
- Determine the content and emphasis of disease intervention behaviors based on the patient's attitudes and needs.

Socio-sexual Information

- Describe the importance of having accurate personal and medical information in resolving the patient's disease problems.
- Question the patient conversationally about where he or she lives; telephone number; alternative locating information; living with whom: employment; travel; recreation; and social groups. Explain reasons for questions if patient shows signs of concern.

Medical History and Disease Comprehension

- Determine what the patient knows about the disease.
- Reinforce what the patient knows about the disease, and correct any misconceptions that arise.
- Present an individualized discussion, not a medical lecture.
- Discuss incubation and the natural course of the disease, mode of transmission, symptoms, possible sites of exposure, risk of re-infection, risk reduction, and patient's STD history.
- Pursue A-1's based on the responsiveness of the patient.

Disease Intervention Behaviors

Assuring Examination of Partners and Associates

- Review confidentiality and the professional role of the DIS.
- Briefly review the patient's comprehension of the disease and the modes of transmission.
- Define the significance of immediate partner referral, emphasizing that one or more may have an STD which would re-expose the patient.
- Establish that the referral will be done immediately and will be for everyone's benefit.
- Assess the patient's response to the session thus far and determine the patient's concerns regarding partners.
- Determine the patient's capability to participate in partner referral (if that option exists).
- Evaluate problems and select appropriate solutions. Some specific motivational approaches to problem solving are:

  - prevention of reexposure to disease
  - potential of having asymptomatic partners
  - risk of being asymptomatic if infected
  - risk of complications if infected
  - inconvenience
  - concern about partners or social group
  - rapid examination reduces potential for spread
  - reduce the chance of complications by helping now.

- Gather the following information about each partner:
  - Name (including nicknames), address (including apartment number), telephone number, living arrangements, work address and telephone number, age/race/sex/marital status, physical description, and other locating information
  - Exposure information
- Pursue A-2's and A-3's (A-2's will include the original patient's partners).

Risk-Reduction Plan

(This section shifts attention to the patient's behaviors that put him or her at risk for all sexually transmitted disease, and includes an HIV counseling session. These messages should be individualized and tailored to each patient.)

- Point out that the patient can expose themselves to HIV or other STDs in exactly the same manner as this exposure occurred.
- Determine what the patient knows about HIV and other STDs, and correct any misconceptions.
- Review the patient's sexual and drug-related behaviors and STD history from earlier in the interview, and engage the patient in a discussion regarding the patient's perceived risks for HIV and STDs.
- Reinforce and support patient's knowledge, actions, intentions, and communications about current or future safer sex and other risk-reduction behavior changes.
- Negotiate a realistic and incremental plan for reducing risks.
- Help the patient identify possible barriers to behavior change, particularly condom use.
- Document what the patient feels is a reasonable, attainable risk-reduction plan, and offer the patient a copy.
- Offer the patient the opportunity to test for HIV. If the patient refuses the test, offer the facility's HIV services in the future.
- Document the date and time for return appointments for STD and HIV test results.
- If tested, discuss the patient's plan to cope while waiting for the test results. If the patient appears not to have a support system, offer your office phone number and a hotline number as part of support available during the waiting period.

Conclusion

- Evaluate remaining patient needs or potential compliance problems.
- Reinforce any commitments made by the patient.
- Redefine respective roles and referral procedures.
- Reinforce confidentiality.

The lot system includes the major analytical points (MAP) sheet, the lot folder status sheet, an original interview record (73.54), the original patient information sheet, the reinterview record, the cluster interview record, the syphilis case analysis sheet, and copies of any field records (73.2936) associated with the case.

MAJOR ANALYTICAL POINTS SHEET

P = PURSUE / C = COVERED

Patient	Case Number	Control Number	Outbreak Number

GENERAL

P C
- ☐ ☐ Confirmation of Current Address
- ☐ ☐ Time: in Country, State, or Local Area; at Present Address; Reason for Moving
- ☐ ☐ Living With / Marital Status
- ☐ ☐ Occupation / Means of Support
- ☐ ☐

MEDICAL

- ☐ ☐ 710 / 720 Symptom History
- ☐ ☐ STS History
- ☐ ☐ Reason for Examination
- ☐ ☐ STD / Incidental Treatment History
- ☐ ☐ "Illogical" 710 / 720 Hx & STS Results
- ☐ ☐ Ghosted Primary Lesion from Approximately: _____ To _____
- ☐ ☐ Herxheimer Reaction
- ☐ ☐ Repeat STS _____
- ☐ ☐
- ☐ ☐ Pregnancy History

PARTNERS

- ☐ ☐ Revisit Exposure Information
- ☐ ☐ Exposure Gap(s) (_____ To _____) (_____ To _____)
- ☐ ☐ No Partners Named During Patient's Lesion Period
- ☐ ☐ Unexplained Change in Sexual Activity
- ☐ ☐ Steady Partner
- ☐ ☐ Challenge: Pick-ups Only; Pros Only; 1x Ct; 1x Cts Only, or Out-of-Area Cts Only
- ☐ ☐ NO Source / NO Source Candidate
- ☐ ☐ Locating / Identifying Information for **OPEN** Partners:
- ☐ ☐ Locating / Identifying Information for **MARGINAL** Partners / Suspects:
- ☐ ☐

CLUSTERS

P C
- ☐ ☐ OP is Not Being Named Back By Partners
- ☐ ☐ A2s / S2s Suggested as Partners to the OP:
- ☐ ☐ OP Has Not Named Partners Who Have Named Him/Her
- ☐ ☐ Other Patients Around Whom The OP Might Know S2s:

RISK ASSESSMENT

- ☐ ☐ Life Style (Social Habits & Pattern)
- ☐ ☐ Sexual Practices / Condom Use
- ☐ ☐ Jail / Prison History
- ☐ ☐ Drug Use
- ☐ ☐ Sex Worker (Sex for Drugs or Money)
- ☐ ☐ Gay / Bisexual
- ☐ ☐ HIV
- ☐ ☐

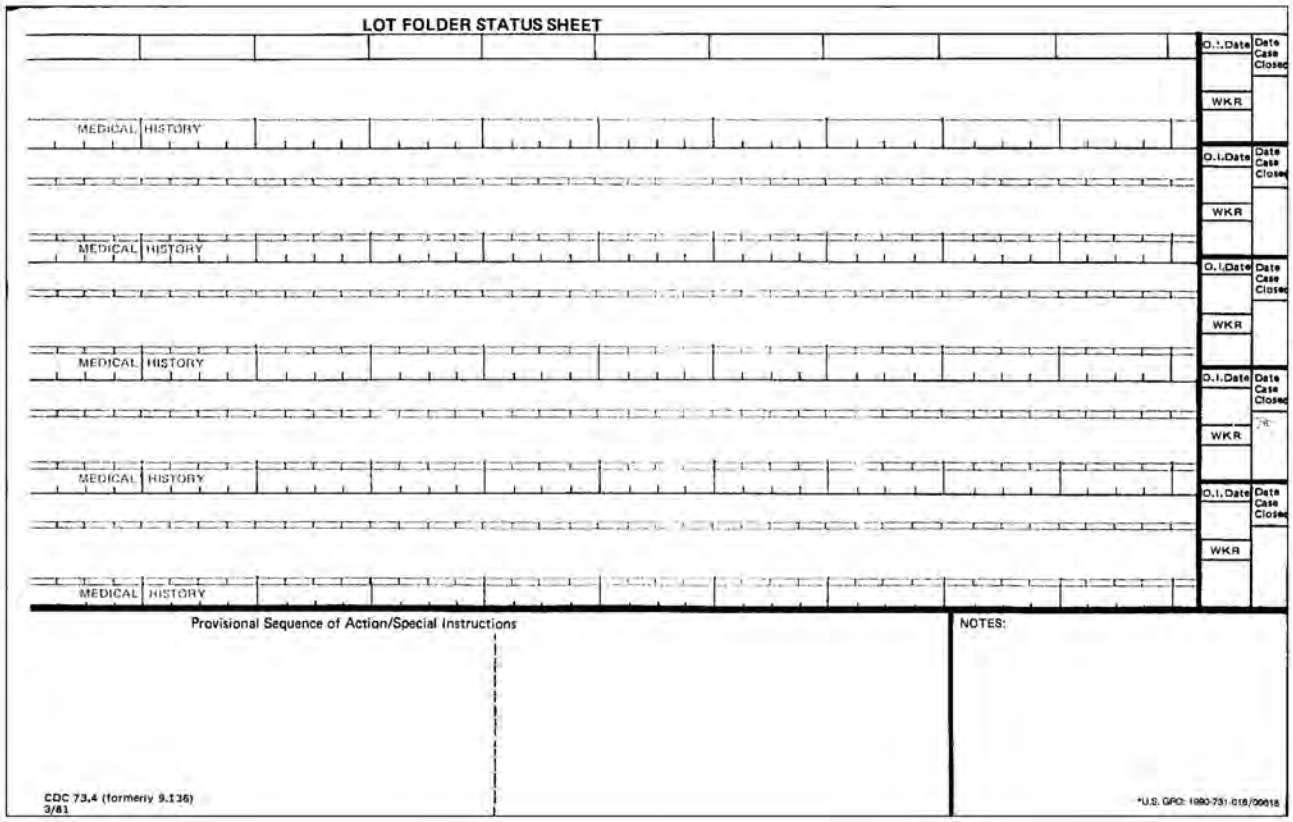
AT-RISK INDIVIDUALS / LOCATIONS

- ☐ ☐ OP's Roommate(s)
- ☐ ☐ Sex Workers / Others Who Exchange Sex for Drugs
- ☐ ☐ Individuals Involved With Drugs
- ☐ ☐ Pregnant Friends
- ☐ ☐ Gay / Bisexual / Transgendered Individuals
- ☐ ☐ Locations / Addresses Where High Risk Activities Occur
- ☐ ☐
- ☐ ☐ **Commitments Made To or By the OP:**

SPECIAL INSTRUCTIONS

- ☐ ☐ Change of Interviewer
- ☐ ☐ Chalk Talk
- ☐ ☐ Request Related Case(s) / Merge Lots
- ☐ ☐
- ☐ ☐

MAP.doc Rev 8/23/99



LOT FOLDER STATUS SHEET

O.I. Date | Date Case Closed

WKR

MEDICAL HISTORY

O.I. Date | Date Case Closed

WKR

MEDICAL HISTORY

O.I. Date | Date Case Closed

WKR

MEDICAL HISTORY

O.I. Date | Date Case Closed

WKR

MEDICAL HISTORY

O.I. Date | Date Case Closed

WKR

MEDICAL HISTORY

Provisional Sequence of Action/Special Instructions

NOTES:

CDC 73.4 (formerly 9.136)
3/81

*U.S. GPO: 1980-731-016/00618

Interview Record

Note: See the reverse side of page one of this record for the codes and the reverse side of pages two and three for an abbreviated set of instructions. See the full set of Interview Record instructions for further definition.

Disease: 1. [ ] 2. [ ]

Control Number A 0525162

Patient Name (Last) | (First & Nicknames) | Case # | Inform ID.

Home Address (Street) | City | Res. Co. | State | Zip Code | Home Phone

Date of Birth | Age | Race: W B A/PI AI/AN O/U | Ethnicity: H Non-His. | Sex: M F | Pregnant? Y ___ Wks. N U | Pregnancy in Last 12 Mos.? Y N U

Method of Case Detection:
- [ ] Provider Ref. To: ____
- [ ] Cluster To: ____
- [ ] Patient Ref. To: ____
- [ ] Prenatal
- [ ] Delivery
- [ ] Instit. Screening
- [ ] Community Screening
- [ ] Reactor
- [ ] Provider Report
- [ ] Volunteer

Information Source

Supv. No. | **Clinic Code** | **Medical Record No.**

	Date Assigned	Assigned to Wkr:	Date Treated	Case IX'D?	Interview Period	Period Partners Sex	N/S	Both
1.								
2.								

Since 1978: (Check All That Apply) — Initial / Final
1. Sex w/ Male? Y Y
2. Sex w/ Female? Y Y
3. Used IV drugs? Y Y
4. Hemophilia? Y Y

Known Heterosexual Relations w/:
5. IVDU? Y Y
6. Bisexual Male? Y Y
7. Person w/ Hemophilia? Y Y
8. HIV Positive Transfusion Recip.? Y Y
9. Person w/ AIDS or HIV Risk UNK.? Y Y
10. One Born in Pattern II? Y Y
11. Rec'd Blood Transfusion? Y Y
12. Worked in Health Care Setting? Y Y
13. Sex for Drugs/Money? Y Y

1. Pre-Test Counseled? Y N
2. Tested for HIV? Y N R
3. Post-Test Counseled? Y N

Previous HIV Test: No P N I U — Date: ____ Provider: [ ]

Current HIV Test: No P N I U — Date: ____ Provider: [ ]

Symptoms: Onset Date	Duration (Days)	Description	Lab Results: Date	Test	Result	Treatment	Other Infections
						1.	
						2.	

INT No.	Date of Interview	Type	P CL	Ref	Exposure Dates: First	Freq.	Last	FR Num	Name	Sex	Disease 1: Disp	Disp Date	Diag	Wkr. No.	Disease 2: Disp	Disp Date	Diag	Wkr. No.	Post Test CNSL	SO -- SP	Invst Agen
1																					
2																					
1																					
2																					
1																					
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Local Use: A B C D E F G | Date Closed (1): | Date Closed (2):

CDC 73.54 8-91

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control

Interview Record Codes

Disease/Diagnosis Codes

100 - Chancroid
200 - Chlamydia
300 - Gonorrhea
350 - Resistant Gonorrhea
400 - Non-Gonococcal Urethritis
450 - Mucopurulent Cervicitis
490 - Pelvic Inflammatory Disease (Syndrome)
500 - Granuloma Inguinale
600 - Lymphogranuloma Venereum
700 - Syphilis Reactor
710 - Primary Syphilis
720 - Secondary Syphilis
730 - Early Latent Syphilis
740 - Latent Syphilis, Unknown Duration
745 - Late Latent Syphilis
750 - Late Syphilis with Symptomatic Manifestations
760 - Neurosyphilis
790 - Congenital Syphilis
800 - Genital Warts
850 - Herpes
900 - HIV
950 - AIDS (Syndrome)

Information Source/Provider Codes

Clinics:
01 - HIV Counseling and Testing Site
02 - STD
03 - Drug Treatment
04 - Family Planning
05 - Prenatal/Obstetrics
06 - Tuberculosis
07 - Other Clinic (Specify)

Other:
08 - Private Physician/HMO
09 - Hospital (Inpatient)
10 - Emergency Room
11 - Correctional Facility
12 - Laboratory
13 - Blood Bank
88 - Other (Specify)

99 - Unknown

Case Interviewed

C - Clinic
F - Field
U - Unable to Locate
R - Refused Interview
O - Other

Type (of Interview)

O - Original
R - Reinterview
U - Unable to Interview (But Partners/Clusters are Initiated)
C - Cluster
P - Posttest

Type Ref. (Type Referral)

1 - Patient
2 - Provider

P/CL (Partner/Cluster)

P1 - Sex Partner
P2 - Needlesharing Partner
P3 - Both Sex and Needle
S1 - Suspect 1
S2 - Suspect 2
S3 - Suspect 3
A1 - Associate 1
A2 - Associate 2
A3 - Associate 3
N - No Partners/Clusters Initiated

Sex

M - Male
F - Female
P - Pregnant Female

Post-Test CNSL?

Y - Yes
N - No

SO/SP (Source/Spread)

1 - Source
2 - Spread

STD Dispositions

A - Preventive Treatment
B - Refused Preventive Treatment
C - Infected, Brought to Treatment
D - Infected, Not Treated
E - Previously Treated for This Infection
F - Not Infected
G - Insufficient Information to Begin Investigation
H - Unable To Locate
J - Located, Refused Examination
K - Out Of Jurisdiction
L - Other

HIV Dispositions

1 - Previous Positive
2 - Previous Negative, New Positive
3 - Previous Negative, Still Negative
4 - Previous Negative, Not Re-tested
5 - Not Previously Tested, New Positive
6 - Not Previously Tested, New Negative
7 - Not Previously Tested, Not Tested Now
G - Insufficient Information to Begin Investigation
H - Unable To Locate
J - Located, Refused Counseling and Testing
K - Out Of Jurisdiction
L - Other

ORIGINAL PATIENT INFORMATION SHEET

Patient Name	Epi Responsibility	Case Number	Control Number	Outbreak Number
	County:			

OP Description: Ht. _____ Wt. _____ Hair (style, color, length) _____ Other (scars, tattoos) _____

SOCIAL HISTORY:

Marital Status: *S M W D Sp Unk* Primary Language: ☐ English ☐ Spanish ☐ Other _____ SS# ___ - ___ - ____

Living Situation: ☐ House ☐ Apt ☐ Jail ☐ Homeless ☐ Transitional (*Shelter, Drug Rehab, Grp Home, Half Way*) ☐ Other _____

Country of Birth _____ Time: In U.S. _____ In State _____ At Current Address _____

Living With _____ Relationship _____

Other Interview Period Addresses (*Include City*):	Living With:	Dates:	Reason For Moving:
		to	
		to	

Education _____ Occupation/Means of Support: ☐☐ _____

Work Phone ___ - _____ Hours: ___ to ___ How Long? _____ Cell/Pager # ___ - _____ Code _____

Emergency Contact _____ Phone ___ - _____ Relationship _____

MEDICAL HISTORY:

Primary Care Provider: ☐☐ _____ Date Last Visited __/__/__ Purpose _____

Prenatal Care Provider: ☐☐ _____ Date Last Visited __/__/__

Previously Infected With Syphilis?: ☐ Y ☐ N ☐ U If Yes, Stage _____ Date Treated __/__/__ With _____

Date of Last Reactive STS __/__/__ Type _____ Titer _____ ☐ Unk Date of Last Negative STS __/__/__ ☐ Unk

HIV Infected?: ☐ Y ☐ N ☐ U If Yes, Date Diagnosed __/__/__ Receiving Antiretroviral Rx?: ☐ Y ☐ N ☐ U

Other STS or Rx Hx _____

Other STD Hx: ☐ CT ☐ GC ☐ HPV ☐ HSV ☐ Other _____ Past Year: ☐ CT ☐ GC ☐ HPV ☐ HSV ☐ Other _____ ☐ Unk

Self-Rx: ☐ Y ☐ N ☐ U If Yes, Indicate Source: ☐ Left Over (*own*) ☐ Other Person ☐ Out-of-Country ☐ Other _____

Pregnancy Hx: ☐ Denied _____

RISK ASSESSMENT:

Past 12 Months: Sex for $ / Drugs: ☐Y ☐N ☐U Exchanged $ / Drugs for Sex: ☐ Y ☐ N ☐ U Gender of Partners: ☐ M ☐ F ☐ B ☐ U

IDU Drug Use: ☐Y ☐N ☐U If Yes, indicate: ☐ Cocaine ☐ Heroin ☐ Methamphetamines ☐ Other _____

Non-IDU Drug Use: ☐Y ☐N ☐U If Yes, indicate: ☐ Cocaine ☐ Crack ☐ Heroin ☐ Methamphetamines ☐ Other _____

Currently Incarcerated: ☐Y ☐N ☐U In Past Year: ☐Y ☐N ☐U (*Facilities /Dates*) _____

Past 3 Months: Sexual Practices: ☐ Vaginal ☐ Anal, Insertive ☐ Anal, Receptive ☐ Oral Anonymous Sex Partners: ☐Y ☐N ☐U

Has Pregnant Partner(s): ☐Y ☐N ☐U Victim of: Sexual Assault: ☐Y ☐N ☐U Domestic Violence: ☐Y ☐N ☐U

Transgender: ☐ MTF ☐ FTM ☐N ☐U Gang Member: ☐Y ☐N ☐U If Yes, Indicate Gang _____

Condom Used At Last Vaginal/Anal Sex?: ☐Y ☐N ☐U Other Risk Behaviors _____

IIR Locales Frequented (*Possible Screening Sites*): ☐ Bars/Clubs _____

☐ Baths/Spas _____ ☐ Dance Halls _____

☐ Parks _____ ☐ Motels _____

☐ Streets _____ ☐ Internet _____

☐ Other _____

OTHER SERVICES ACCESSED (*Past Year*): ☐ ER ☐ DV ☐ HIV/ EIP ☐ Prenatal ☐ Sub Abuse ☐ WIC ☐ Other _____

REFERRALS MADE: ☐ DV ☐ FP ☐ HIV/EIP ☐ Prenatal ☐ Sub Abuse ☐ Other _____

OUT-OF-AREA TRAVEL (*Interview Period*): ☐ No ☐ Yes (*If Yes, document below*):

Place:	Reason:	Dates:	Companions:	Stayed With:	Local Sex Partners?:
		to			☐ Yes ☐ No ☐ Unk
		to			☐ Yes ☐ No ☐ Unk

Comments: _____

MARGINAL INFORMATION CONTACTS *(Account for all interview period sex partners not initiated)*

1	Name	Age	Sex	Race	Exposure Dates	Place of Encounter / Identifying-Locating / Other Risk Information
		Ht.	Wt.	Hair	Locations	
2	Name	Age	Sex	Race	Exposure Dates	Place of Encounter / Identifying-Locating / Other Risk Information
		Ht.	Wt.	Hair	Locations	
3	Name	Age	Sex	Race	Exposure Dates	Place of Encounter / Identifying-Locating / Other Risk Information
		Ht.	Wt.	Hair	Locations	
4	Name	Age	Sex	Race	Exposure Dates	Place of Encounter / Identifying-Locating / Other Risk Information
		Ht.	Wt.	Hair	Locations	
5	Name	Age	Sex	Race	Exposure Dates	Place of Encounter / Identifying-Locating / Other Risk Information
		Ht.	Wt.	Hair	Locations	

Every effort must be made to exhaustively pursue and develop information necessary to initiate marginal information contacts and high risk cluster suspects. Draw a single line through each MIC initiated.

Comments: _____

OPIS6.doc Rev 05/12/00

REINTERVIEW RECORD

PATIENT NAME	CASE NUMBER	CONTROL NUMBER	OUTBREAK NUMBER	DATE	WORKER
				/ /	

REINTERVIEW TYPE: ☐ Clinic ☐ Home ☐ Jail ☐ Telephone* ☐ Other _____
**Requires justification in Comments Section*

REINTERVIEW INSTRUCTIONS (P = Pursue / C = Covered)

C		C	
☐	S1s	☐	Income Source / Travel / Lifestyle
☐	S2s to: _____	☐	No Steady Partner
☐	S2 / A2s Named to the OP:	☐	No Source / No Candidate for Source
☐	710 / 720 Lesion History	☐	Time In Jail / Release Date
☐	Herxheimer Reaction	☐	Confront: Gay / 'Pro' / Drug Use
☐	Explore STS / Medical History	☐	Other 'Risk' Behaviors
☐	Incidental / Self Treatment	☐	High-Risk Individuals
☐	Exposure Gap(s) _____ to _____ _____ to _____	☐	Locations / Addresses Where High Risk Activities Occur (*Pos Screening Sites*)
☐	Unexplained Change in Sexual Pattern	☐	
☐	Locating / Identifying Information for OPEN Contacts / Suspec	☐	Review Commitments Made
☐	Locating / Identifying Information for MARGINAL Contacts /	☐	
☐	Living With:	☐	HIV
		☐	Obtain Follow-up Serology

COMMENTS (*Number Entries*): _____

SUSPECTS:

Name (Last, First)	S-	Ref	Relationship	FR Number	Sex	Disp	Date	DX	Worker Number	So Sp	Invest Agency
							/ /				
							/ /				
							/ /				
							/ /				
							/ /				

MARGINAL INFORMATION CONTACTS

	Name	Age	Sex	Race	Exposure Dates	Place of Encounter / Identifying-Locating / Other Risk Information
		Ht	Wt	Hair	Locations	
	Name	Age	Sex	Race	Exposure Dates	Place of Encounter / Identifying-Locating / Other Risk Information
		Ht	Wt	Hair	Locations	
	Name	Age	Sex	Race	Exposure Dates	Place of Encounter / Identifying-Locating / Other Risk Information
		Ht	Wt	Hair	Locations	

ENTS (*Continued*): _____

☐ New Partners / Suspects Named ☐ Recorded on Interview Record

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CLUSTER INTERVIEW RECORD

ORIGINAL PATIENT NAME	CASE NUMBER	CONTROL NUMBER	OUTBREAK NUMBER	DATE	WORKER
				/ /	

INDIVIDUAL INFORMATION (*Person Being Clustered*) **FR Number:** _____

Name: Type: ☐ Partner ☐ Suspect ☐ Associate ☐ Other _____

SOCIAL HISTORY:

Marital Status: *S M W D Sp Unk* Primary Language: ☐ English ☐ Spanish ☐ Other _____

Living Situation: ☐ House ☐ Apt ☐ Jail ☐ Homeless ☐ Transitional (*Shelter, Drug Rehab, Grp Home, Half Way*) ☐ Other _____

Country of Birth _____ Time: In U.S. _____ In State _____ At Current Address _____

Living With _____ Relationship _____

MEDICAL HISTORY:

Primary Care Provider: Date Last Visited / / Purpose

Previously Infected With Syphilis?: ☐ Y ☐ N ☐ U If Yes, Stage _____ Date Treated ___/___/___ With _____

Date of Last Reactive STS ___/___/___ Type _____ Titer _____ ☐ Unk Date of Last Negative STS ___/___/___ ☐ Unk

HIV Infected?: ☐ Y ☐ N ☐ U If Yes, Date Diagnosed ___/___/___ Receiving Antiretroviral Rx?: ☐ Y ☐ N ☐ U

Other STD Hx: ☐ CT ☐ GC ☐ HPV ☐ HSV ☐ Other _____ Past Year: ☐ CT ☐ GC ☐ HPV ☐ HSV ☐ Other _____ ☐ Unk

Self-Rx: ☐ Y ☐ N ☐ U If Yes, Indicate Source: ☐ Left Over (*own*) ☐ Other Person ☐ Out-of-Country ☐ Other _____

RISK ASSESSMENT:

Past 12 Months: Sex for $/Drugs: ☐Y ☐N ☐U Exchanged $/Drugs for Sex: ☐Y ☐N ☐U Gender of Partners: ☐M ☐F ☐B ☐ U

IDU Drug Use: ☐Y ☐N ☐U If Yes, indicate: ☐ Cocaine ☐ Heroin ☐ Methamphetamines ☐ Other _____

Non-IDU Drug Use: ☐Y ☐N ☐U If Yes, indicate: ☐ Cocaine ☐ Crack ☐ Heroin ☐ Methamphetamines ☐ Other _____

Currently Incarcerated: ☐Y ☐N ☐U In Past Year: ☐Y ☐N ☐U (*Facilities/Dates*) _____

Past 3 Months: Sexual Practices: ☐ Vaginal ☐ Anal, Insertive ☐ Anal, Receptive ☐ Oral Anonymous Sex: ☐Y ☐N ☐U

Has Pregnant Partner(s): ☐Y ☐N ☐U Victim of: Sexual Assault: ☐Y ☐N ☐U Domestic Violence: ☐Y ☐ N ☐ U

Transgender: ☐ MTF ☐ FTM ☐ N ☐ U Gang Member: ☐ Y ☐ N ☐ U If Yes, Indicate Gang _____

Condom Used At Last Vaginal/Anal Sex?: ☐ Y ☐ N ☐ U Other Risk Behaviors _____

HR Locales Frequented (*Possible Screening Sites*): ☐ Bars/Clubs _____

☐ Baths/Spas _____ ☐ Dance Halls _____

☐ Parks _____ ☐ Motels _____

☐ Streets _____ ☐ Internet _____

☐ Other _____

OUT-OF-AREA TRAVEL (*Interview Period*): ☐ No ☐ Yes _____

CLUSTER INTERVIEW INFORMATION

Original Patient Named Back? ☐ Yes ☐ No

	First	Freq	Last
Original Patient: Sex	___/___/___	_____	___/___/___
N/S	___/___/___	_____	___/___/___
Interviewee: Sex	___/___/___	_____	___/___/___
N/S	___/___/___	_____	___/___/___

Current Exam Information:

CLUSTER INSTRUCTIONS: P = PURSUE / C = COVERED

C	
☐	A-1s
☐	A-2s To: _____
☐	Lx Hx: _____
☐	OP's Living Situation
☐	OP's Source of Income
☐	Pregnant Friends
☐	OP's Risk Behaviors
☐	Possible Screening Sites
☐	
☐	
☐	

ASSOCIATES:

Name (Last, First)	A -	Ref	Relationship	FR Number	Sex	Disp	Date	DX	Worker Number	So Sp	Invest Agency

Name (Last, First)	A -	Ref	Relationship	FR Number	Sex	Disp	Date	DX	Worker Number	So Sp	Invest Agency
							/ /				
							/ /				
							/ /				
							/ /				

MARGINAL INFORMATION ASSOCIATES

	Name	Age	Sex	Race	Place of Encounter / Identifying-Locating / Other Risk Information
		Ht.	Wt.	Hair	
	Name	Age	Sex	Race	Place of Encounter / Identifying-Locating / Other Risk Information
		Ht.	Wt.	Hair	
	Name	Age	Sex	Race	Place of Encounter / Identifying-Locating / Other Risk Information
		Ht.	Wt.	Hair	

ENTS (*Continued*):

☐ New Associates Have Been Recorded on Interview Record (*Draw a single line through each MIA Initiated*)

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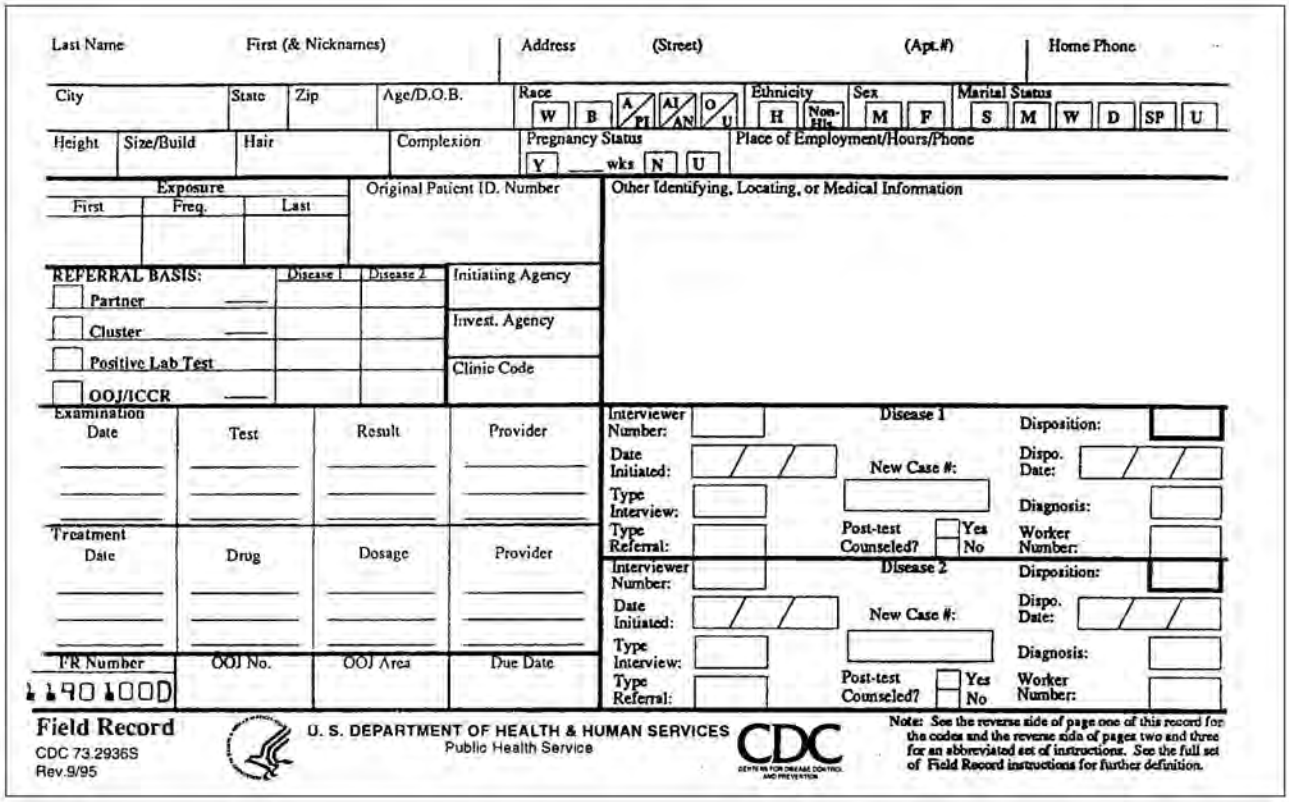

Last Name | First (& Nicknames) | Address (Street) (Apt.#) | Home Phone

City | State | Zip | Age/D.O.B. | Race: W B A/PI AI/AN O/U | Ethnicity: H Non-His | Sex: M F | Marital Status: S M W D SP U

Height | Size/Build | Hair | Complexion | Pregnancy Status: Y ___ wks N U | Place of Employment/Hours/Phone

Exposure: First | Freq. | Last

Original Patient ID. Number

Other Identifying, Locating, or Medical Information

REFERRAL BASIS: | Disease 1 | Disease 2 | Initiating Agency
- Partner ___
- Cluster ___
- Positive Lab Test
- OOJ/ICCR ___

Invest. Agency

Clinic Code

Examination Date	Test	Result	Provider

Treatment Date	Drug	Dosage	Provider

PR Number	OOJ No.	OOJ Area	Due Date
1190 1000			

Interviewer Number: | Disease 1 | Disposition:
Date Initiated: | New Case #: | Dispo. Date:
Type Interview: | Diagnosis:
Type Referral: | Post-test Counseled? Yes No | Worker Number:

Interviewer Number: | Disease 2 | Disposition:
Date Initiated: | New Case #: | Dispo. Date:
Type Interview: | Diagnosis:
Type Referral: | Post-test Counseled? Yes No | Worker Number:

Field Record
CDC 73.2936S
Rev.9/95

U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Note: See the reverse side of page one of this record for the codes and the reverse side of pages two and three for an abbreviated set of instructions. See the full set of Field Record instructions for further definition.

Field Record Codes

Disease/Diagnosis Codes

- 100 - Chancroid
- 200 - Chlamydia
- 300 - Gonorrhea (uncomplicated)
- 350 - Resistant Gonorrhea
- 400 - Non-Gonococcal Urethritis
- 450 - Mucopurulent Cervicitis
- 490 - Pelvic Inflammatory Disease (Syndrome)
- 500 - Granuloma Inguinale
- 600 - Lymphogranuloma Venereum
- 700 - Syphilis Reactor
- 710 - Primary Syphilis
- 720 - Secondary Syphilis
- 730 - Early Latent Syphilis
- 740 - Latent Syphilis, Unknown Duration
- 745 - Late Latent Syphilis
- 750 - Late Syphilis with Symptomatic Manifestations
- 760 - Neurosyphilis
- 790 - Congenital Syphilis
- 800 - Genital Warts
- 850 - Herpes
- 900 - HIV
- 950 - AIDS (Syndrome)

STD Disposition Codes

- A - Preventive Treatment
- B - Refused Preventive Treatment
- C - Infected, Brought to Treatment
- D - Infected, Not Treated
- E - Previously Treated for This Infection
- F - Not Infected
- G - Insufficient Information to Begin Investigation
- H - Unable To Locate
- J - Located, Refused Examination
- K - Out Of Jurisdiction
- L - Other

HIV Disposition Codes

- 1 - Previous Positive
- 2 - Previous Negative, New Positive
- 3 - Previous Negative, Still Negative
- 4 - Previous Negative, Not Re-tested
- 5 - Not Previously Tested, New Positive
- 6 - Not Previously Tested, New Negative
- 7 - Not Previously Tested, Not Tested Now
- G - Insufficient Information to Begin Investigation
- H - Unable To Locate
- J - Located, Refused Counseling and Testing
- K - Out Of Jurisdiction
- L - Other

Partner Codes

- P1 - Sex Partner
- P2 - Needlesharing Partner
- P3 - Both Sex and Needle

Cluster Codes

- S1 - Suspect 1
- S2 - Suspect 2
- S3 - Suspect 3
- A1 - Associate 1
- A2 - Associate 2
- A3 - Associate 3

Type Interview

- O - Original Interview
- R - Reinterview
- C - Cluster Interview
- P - Posttest Counseling
- U - Unable to Interview (But Partners/Clusters are Initiated)

OOJ/ICCR Codes

1 - Partner 2 - Cluster 3 - Positive Test

Type Referral

1 - Patient 2 - Provider

Appendix PS–F

FIELD INVESTIGATIONS

It is the responsibility of the DIS to ensure that persons who have or are at risk of acquiring a STD receive appropriate medical care at the earliest possible time. The use of the telephone for initial follow-up activities can be an efficient use of DIS time, especially when calls are made in the early morning or evening hours. Telephones, however, are not valuable for in-depth investigation and confronting highly sensitive issues. Also be aware of caller ID and like technologies, as they may compromise confidentiality.

While the field investigation may require a greater initial investment of DIS time, it is the most effective follow-up method and frequently the most efficient as well. All field investigations should be conducted in unmarked vehicles.

It is incumbent upon the DIS to make the most efficient use of field time and to conduct each field investigation thoroughly to make the most of this activity.

- To avoid duplication of effort and to expand locating information, the DIS should perform a record search immediately after initiating an investigation by reviewing available resources, including:
  a. open field investigation and case interview files;
  b. closed field investigation and case interview files;
  c. medical records;
  d. telephone white and yellow pages;
  e. directory assistance;
  f. cross directory; and
  g. computer locator resources.

The record(s) search and results should be completely documented on the back of the field record.

- The DIS should begin investigative action on priority follow-ups within one workday of assignment or of DIS initiation.

- When initial telephone attempts fail to reach the individual sought, or when the patient does not follow through with a commitment, the DIS should make a field visit within one working day or as directed by supervisor.

- The DIS should prepare for field investigations by:
  a. arranging investigations by investigative or intervention priority;
  b. planning a route that addresses the greatest number of investigative priorities in the most efficient sequence;
  c. including lower priority field activities that are near high-priority investigations;
  d. consulting the supervisor on the potential for pooling work when distant locations are involved;
  e. arranging work in the planned sequence at the front of the investigative pouch; and
  f. preparing all referral notes before leaving for the field to improve efficiency and alertness.

- Before leaving for the field, the DIS should assemble standard materials and supplies, including:
  a. investigative pouch;
  b. maps;
  c. venipuncture kit;
  d. writing materials (with spare pen);
  e. referral forms with envelopes;
  f. business cards;
  g. change for parking meter and public telephone (and telephone credit card, if available);
  h. identification card; and
  i. materials needed to perform field interviews, e.g., visual aids, consent forms.

- The DIS should record the beginning and ending odometer readings and the distances between stops, as needed for travel reimbursement.

- Before leaving the car for a field visit, the DIS should:
  a. review the field record and memorize all pertinent data to establish the precise objective(s) of the visit;
  b. observe the environment and anticipate obstacles to the investigation; and
  c. stow the pouch, confidential forms, and valuables in a secure place.

- When there is no response at the door of the individual sought, the DIS should check for occupants at the side and back of the building when the way is not barred and it appears safe to do so.
- When the individual sought is not found, the DIS should attempt to confirm the locating information in the initial visit by exploring all reasonable sources of information, such as:
  a. other persons encountered at the address;
  b. names on mailbox;
  c. neighbors, apartment managers, building superintendents;
  d. postal employees and other delivery personnel;
  e. local business people; and
  f. children in the area.

  - The DIS should gather patient locating information from sources in a manner which serves to improve upon the original data provided, including previously unknown information such as:

  a. full name and physical description;
  b. precise address, including apartment number;
  c. identity of co-residents;
  d. telephone number;
  e. type and place of employment;
  f. hours and habits;
  g. hangouts and associates;
  h. description of individual's car; and
  i. where the individual can be found now.
- When locating information appears invalid, the DIS should transpose house and street numbers, etc., and checks similar locations in the immediate vicinity.
- When the individual sought is encountered in the field, the DIS should convey a sense of urgency and motivate the patient to participate in the disease intervention process by:
  a. establishing the identity of the patient;
  b. engaging the patient in a private conversation;
  c. identifying self and conveying the reason for visit;
  d. establishing rapport and demonstrating concern;
  e. informing the patient of the STD at issue and of their risk status;
  f. clustering the patient for other high-risk persons; and
  g. referring the patient for the most immediate appropriate medical attention, which may include obtaining consent and collecting a specimen for testing.
- When the individual wants care from a non-health department provider, the DIS should arrange or confirm the appointment personally. The DIS should tell both the health provider and the individual of the need for recommended testing, counseling, and treatment, and determine when the test results will be available. The DIS should try to get a signed release of information form from the patient, so that test results and treatment can be confirmed.
- Even when the individual sought is not found, the field visit offers many advantages that can enhance disease intervention, such as:
  a. information about the individual's living situation, lifestyle, habits, or about the identity of cohabitants or co-residents, etc., may be gained, along with additional locating information;
  b. the DIS can leave a sealed referral notice that directs the individual to the first clinic session available;
  c. other high-risk persons may be identified; and,
  d. the validity of the provided locating information can be determined.
- When the individual sought is not encountered at a confirmed place of residence, the DIS may leave a referral notice in a sealed envelope marked "personal" or "confidential." The DIS may add a personal note of urgency to the form. Referral notices may be left by the DIS with co-residents, building managers, employers, or under the door or in any area where the referral is protected and not accessible to children or casual visitors. Referral notices

are not placed in or affixed to any mail box (U.S. Postal Service Code 1702, 1705, 1708, and 1725).

- The DIS should not leave a third referral notice at the same address except with supervisor's consent.
- When in a safe location, the DIS should document the results of the field investigation. The following information should be legibly, accurately, and concisely documented on the back of the investigative form with the use of accepted abbreviations and symbols:
  a. date and time of day;
  b. type activity (e.g. FV=field visit);
  c. persons encountered;
  d. results of investigation, which may include next planned action (date and type);
  e. referral specifics; and
  f. directions for difficult-to-find locations, when appropriate.
- If practical, before returning to the office from distant locations, the DIS should contact the supervisor (or other designated team member) by telephone to inquire about emergent needs to which she or he should attend before returning.
- The DIS should follow through on all commitments and pursue new information elicited during the course of investigations, as follows:
  a. confirms appointments made and kept (within one working day);
  b. re-initiates action within one working day when commitments fail; and,
  c. pursues new locating information within one working day.
- When the original information fails to locate the individual, the DIS should seek to contact the source of the information at the first reasonable opportunity in order to correct or to expand locating data. Sources to contact include:
  a. the patient or others involved in a case;
  b. other case managers;
  c. health care providers; and
  d. Interstate Transmission of STD Intervention Information desk (according to established local procedures)
- When there is no direct avenue to correct inadequate locating information, the DIS should discreetly accesses other agency resources, such as:
  a. Department of Motor Vehicles;
  b. Postal Service;
  c. utilities;
  d. Public Assistance;
  e. local schools;
  f. trade unions;
  g. law enforcement (jail rosters);
  h. voter registration;
  i. tax appraisal office;
  j. fire department (directory/department of streets);
  k. other health department programs (e.g. family planning, WIC, TB, etc.); and
  l. other community resources (e.g., hospitals, CBOs, etc.).
- When an investigation stalls, the DIS should notify the supervisor or appropriate case manager at the earliest reasonable opportunity (not to exceed 72 hours). Supervisor's approval is needed to close unsuccessful investigations.
- The DIS should complete and submit all assigned work to his or her supervisor before taking planned leave.

Appendix PS–G

INTERSTATE TRANSMISSION OF STD INTERVENTION INFORMATION

Basic Policy

The Interstate Transmission of STD Intervention Information is the system that oversees the transmission of STD intervention information among project areas. Success of the system depends on the willingness of each program manager to take the steps necessary to assure that its provisions are observed and to hold one another accountable when deviations occur. While these guidelines are designed to support and, where necessary, refine or clarify the process and procedures, project areas should review their protocols and procedures to ensure that they specify how to handle incoming and outgoing intervention requests. In reviewing or developing these protocols and procedures, programs are encouraged to consider these national guidelines in order to ensure consistency with respect to transmission of STD information between jurisdictions. Investigations should be conducted in accordance with local protocol, with respect to contacting partners outside your jurisdiction. There are situations where local protocol will specifically permit or prohibit cross-jurisdiction investigations. Disease prevention will be facilitated by the confidential sharing of information on STD cases, partners, suspects, and associates between jurisdictions.

All requests received by an area for conducting an interstate STD investigation, interview or counseling session, reinterview, etc., should be accorded at least the same priority as the same program activity initiated within the receiving area. It is suggested that the receiving area process cases from other areas, even if the program area does not process these same type of cases for patients in its own jurisdiction. To the extent possible, information on sex partners that is transmitted should focus on disease intervention priorities. Program areas should review the information carefully before transmitting information about partners or individuals with a last exposure date that represents a minimal likelihood of disease intervention and, if such a request is made, should explain the reason for the request. While each case is unique and rules must allow for flexibility, programs should assume that managers in other areas are exercising appropriate professional judgment when requests for follow-up are made. Therefore, the receiving area should accept these follow-up requests and act upon them without challenge. Questionable records should be brought to the attention of a supervisor. If it appears that areas are overloading the system with questionable requests, program managers are encouraged to discuss the issue with their counterparts in other program areas.

The following categories of partners and individuals are considered high priority:

- Women who are known to be pregnant and exposed to confirmed infectious syphilis, gonorrhea, chlamydia, or who have a reactive test for HIV.
- Women or infants with reactive prenatal or postpartum serologies and unknown treatment status.
- Persons with positive tests for or symptoms of gonorrhea, chlamydia, syphilis, and with unknown treatment status.
- Persons with positive tests for HIV (Not all areas will investigate HIV. If your area investigates HIV positives, then you should initiate an out-of-jurisdiction HIV positive. The receiving area will determine whether to investigate based on local policies and priorities).
- All partners who could be incubating disease because of a recent exposure to an infectious individual.

Areas with staff, workload capability, and desire to follow persons exposed to diseases beyond the normally prescribed periods should make this known in writing to other program areas. High-priority persons are those about whom the program has sufficient information to indicate that they may have been exposed to an infectious person, or those who the program has reason to believe may be infected and that locating them would prevent the further spread of disease.

Field Records

Field records (FR) that are initiated by a program area that are to be transmitted for investigations out of jurisdiction should be as accurate and complete as possible, and should at a minimum include the following information:

- For sex partners, suspects, or associates, a complete identification and physical description (name, sex, age, weight, height, complexion, ethnicity, etc.) as well as exposure dates, test results, and basis for the diagnosis of the original patient to whom the partner, suspect, or associate is linked, if applicable.
- At least two items of locating information (home address and telephone number are considered as one item). Other locating information could include place of work; work telephone number; beeper or cell phone numbers; friend or relative or other person known by the person; hangouts; make, model, color of car, etc.
- When a male partner is known to have the same name as his father or son, care should be taken to ensure that correct designations such as "Jr." or "Sr." are communicated to help avoid the potential for confidentiality problems.

When field records that are transmitted out of jurisdiction do not include any of these provisions, the initiating area should include the reason for the omission. An acceptable reason for omitting information should not include failure on the part of the initiating area to pursue the information. If the reason provided by the initiating agency is acceptable, receiving areas should accept and proceed with the individual requests. When an acceptable reason for omission of information is not given, receiving areas may demand one or suspend further action until an acceptable reason is given. Program areas should exercise sound judgment when making a decision to reject or suspend an investigation on technicalities since the primary concern for all areas should be the health of the individual and the prevention, or further spread, of disease in the community.

Military Patients

Program managers are encouraged to work closely with military installations in their jurisdictions to ensure that the military understands these guidelines for transmitting information on persons initiated during the course of their STD investigation, providing that no other system has been established. Any domestic military installation that initiates STD intervention information on civilians for investigation outside of its jurisdiction should forward the information through the appropriate state control point. The STD prevention program should review the information for appropriateness and comprehensiveness then transmit appropriately. Program managers should discourage military installations from sending investigative information directly to the Centers for Disease Control and Prevention (CDC).

Corrections

Program managers are encouraged to work closely with prisons, local jails, and juvenile detention centers. See the chapter on Special Emphasis for a detailed discussion of corrections issues.

Transmission and Disposition Procedures

When possible, program areas should telephone state control points in the receiving areas with all information on persons (see the following appendix for current list of interstate control points). When telephoning or transmitting STD intervention information, strict rules of confidentiality must be followed. The person responsible for transmitting that information between control points should observe confidentiality by affirming that the control point called is the correct one, and by receiving assurance that the person receiving the information is authorized to accept STD related intervention information. This assurance should come before the discussion of any STD intervention information. If either the initiating or receiving area is concerned about the confidential nature of the call,

communication should cease until such time as confidentiality can be assured by both parties. The initiating area should keep a record of the date, time of day, and name of the individual receiving the STD information. Confirmation of telephoned information can be mailed if requested by the receiving area.

Before telephoning or mailing STD investigation information, it would help the receiving area if the initiating area checked zip code directories and long distance telephone information to verify the spelling of the name and address and that the address and telephone number exist. Initiating areas should let receiving areas know if these verification activities were conducted and the results of those activities.

Priority STD intervention information, and information on individuals on which a "return disposition" is requested should be recorded on the Field Record, CDC 73.2936S, or a similar local form by the receiving area. Field record control numbers (preprinted number on a field record) and disposition due date should be exchanged between initiating and receiving areas. This information will be used by both areas to track the investigation request. The disposition due date is generally established as 14 calendar days from the date of receipt.

Low priority reactive serologic tests for syphilis (STS) are those tests that would not receive high priority attention within an area. Low priority requests should be written on Field Records and exchanged by mail. The information should be exchanged even if these low priority reactors would be administratively closed in the initiating area, or if they could be closed through a record search by the initiating area. A reason for exchanging the information is to give the receiving area test results that could be used for updating records. If a record exists on the reactor in the initiating area, and if local policy permits, that information should also be included on the field record when transmitted out of jurisdiction.

Initiating areas should not routinely expect or request a "return disposition" on low priority reactors unless there is a compelling reason to ask for the disposition. In those instances when a "return disposition" is desired, initiating areas should indicate "return disposition requested" on the field record. Requests for "return dispositions" on low priority reactors should be kept to a minimum. Sex partner information on uncomplicated gonorrhea and chlamydia should be written on a field record and exchanged by mail or phone. As with low priority reactors, "return dispositions" should not be routinely requested unless there is a compelling reason. Areas requesting "return dispositions" should follow procedures previously described in these guidelines.

Maps

A map showing where an individual may be found might prove critical to the success of an investigation. Since it could prove difficult to communicate the details of a map orally to the investigating area, the initiating area should prepare the field record with the map and mail it to the investigating area. If the request is a priority investigation, the investigating area should be telephoned and alerted to expect the mailed field record. Program areas should also consider faxing the information if it can be assured that the faxed information would be secure and confidential.

Record keeping

All areas should develop a record keeping system that will enable them to efficiently conduct the disease intervention outreach transmittal component of the interstate procedures. In most cases, the system will consist only of a file for field records or a log to record transmittal information. Simplicity is the key when record keeping systems are established by areas. For example, a system could be as simple as filing all incoming and outgoing forms together chronologically by "disposition due date." While the system should be specific to an area, each should have a method for keeping up with overdue follow-up requests. Overdue follow-up requests are those incoming and outgoing

requests that have been open for more than 14 days, or that are beyond the "disposition due date." Investigating areas have the responsibility to call initiating areas and inform them of the status of the investigations if they are still open beyond the "disposition due date." Whenever an initiating area obtains new or clarifying information on individuals being followed out of jurisdiction, every effort should be made to inform the area.

International Transmission of STD Information

The CDC policy and procedure for the international and military transmission of non-HIV/STD information is currently under review and is expected to be revised. While this policy is being reviewed, program areas should continue to use current polices that have been established in their areas for handling international and military transmission of non-HIV/STD information. The CDC involvement in the transmission of international STD information is minimal and will be done only on a case-by-case basis. Since CDC has limited involvement in the transmission of other international STD information, program areas are encouraged to counsel patients to self-refer or notify their partners who reside in foreign countries and who may have been exposed to a disease.

Appendix PS–H

SKILLS INVENTORY

Interviewing Skills Individual Feedback Record

Interview date_____

How did the Disease Intervention Specialist perform in the following areas?

Write N/O (not observed) in the satisfactory column if the interview did not present an opportunity to observe the skill.

COMMUNICATION	Needs Improvement	Satisfactory	Excellent
1. Demonstrates professionalism			
2. Establishes rapport			
3. Listens effectively			
4. Uses open-ended questions			
5. Communicates at the patient's level of understanding			
6. Gives factual information			
7. Solicits patient feedback			
8. Uses reinforcement			
9. Uses appropriate nonverbal communication			

Observations _____

_____

_____

Recommendations _____

_____

_____

PROBLEM SOLVING	Needs Improvement	Satisfactory	Excellent
10. Recognizes verbal problem indicators			
11. Recognizes nonverbal problem indicators			
12. Verifies the meaning of recognized problem indicators			
13. Assertively confronts problems communicated by patients			
14. Resolves patient problems			
15. Uses STD motivations			
16. Motivates clearly and convincingly			
17. Emphasizes confidentiality			

ANALYTICAL CAPABILITIES	Needs Improvement	Satisfactory	Excellent
18. Computes and uses interview periods			
19. Recognizes exposure gaps			
20. Determines accurate source/spread relationships			
21. Determines investigative priorities			
22. Recognizes discrepancies in patient responses			

Observations _____

_____

_____

Recommendations _____

_____

_____

DISEASE INTERVENTION BEHAVIORS	Needs Improvement	Satisfactory	Excellent
23. Emphasizes sex partner referral			
24. Tactfully persists to identify all at-risk sex partners			
25. Pursues detailed locating/identifying information on sex partners			
26. Emphasizes appropriate risk reduction behaviors			
27. Conveys a sense of urgency			
28. Establishes specific contracts and coaches patients			
29. Pursues timely reinterviews with a plan			

Observations _____

Recommendations _____

Field Activity One Day Skills Feedback Record

Field investigation date _____ Number of persons investigated _____

How well did the Disease Intervention Specialist perform in the following areas?

Write N/O (not observed) in the satisfactory column if the investigation did not present an opportunity to observe the skill.

DISEASE INTERVENTION BEHAVIORS	Needs Improvement	Satisfactory	Excellent
1. Assume the responsibility for the ultimate success of assigned investigations, regardless of co-worker participation in the referral process			
2. Utilize resources effectively in planning and executing referrals			
3. Recognize investigative priorities			
4. Select appropriate referral methods			
5. Take prompt initial action on priority investigations and promptly follow up when a person defaults on a referral			
6. Demonstrate timely, persistent, and imaginative action required to move a stalled investigation			
7. Demonstrate discretion and judgement in the use of the telephone as an investigative tool			
8. Confidentially and professionally manage circumstances that are obstacles in any investigation			
9. Motivate people to come in promptly			
10. Document the investigative activities completely and accurately			

Observations _____

_____

_____

Recommendations _____

_____

_____

Definitions of Elements in Interviewing and Field Activities Skills Inventories

Needs Improvement

Should be checked anytime the supervisor makes a constructive recommendation that the DIS is to follow.

Excellent

Should be checked anytime the supervisor compliments the DIS on a specific aspect that is clearly above the expectations for satisfactory performance. The supervisor should be able to articulate exactly what led to this rating.

Check marks should be placed in the center of the appropriate box so that the DIS does not interpret performance as almost satisfactory or excellent. If the supervisor is unable to observe a particular skill element for any reason, N/O should be placed in the Satisfactory box. An effort should be made to create an opportunity for observation before the completion of the next skills inventory. Supervisors may role-play to find out whether the DIS makes appropriate responses but should see how the DIS performs with an actual patient before making a determination on the skills inventory.

Interviewing

Satisfactory ratings indicate that the Disease Intervention Specialist consistently:

1. **Demonstrates professionalism**
   Displayed self-confidence, competence, dependability, preparation, integrity, and appropriate seriousness. Convincingly conveys the capability (expertise, training, knowledge, devotion) and commitment to maintaining a patient's confidentiality. Smoothly preempts a patient's likely concerns about confidentiality and effectively reinforces it when discussing sex partners and when resolving a patient's special problems. Was nonjudgmental and objective about patient's behavior and conveyed tolerance for patient's lifestyle.

2. **Establishes rapport**
   Displayed respect, empathy, and sincerity to patients, e.g., introduced self, was polite, used plausible and factual motivations and sought out and dealt with patient's concerns.

3. **Listens effectively**
   Did not interrupt patients unnecessarily. Responded to patients' questions appropriately and gave evidence that important information was noted, such as following up with additional questions or mentioning specifics in the post-counseling critiques.

4. **Uses open-ended questions**
   Phrased questions (beginning with who, what, when, where, why, how, tell me) to stimulate meaningful responses. Used open-ended questions, particularly where the patient might avoid giving candid answers by using negative or condescending responses.

5. **Communicates at the patient's level of understanding**
   Avoided technical terms, jargon, or words deemed beyond the comprehension of patients. Clearly explained necessary medical and technical terms and concepts.

6. **Gives factual information**
   Demonstrated an accurate knowledge of STDs. Corrected patient's misconceptions and provided comprehensive disease information. Avoided extraneous information.

7. **Solicits patient feedback**
   After delivering messages, asked appropriate questions to determine whether patients understood and how they intended to comply. Used content (rephrasing what the patient said) and feelings (interpreting how the patient felt) responses to verify patients' meanings.

8. **Uses reinforcement**
   Sincerely complimented or acknowledged patients after hearing intentions to use, or descriptions of, healthful behaviors. Used smiles and affirmative nods and words effectively.

9. **Uses appropriate nonverbal communication**
   Conveyed sincere interest by maintaining eye contact, minimizing physical barriers, and leaning toward the patient. Avoided negative nonverbal signals that communicate anger, surprise, distaste, or fear of contagion; avoided finger shaking, arm crossing, and expressions of disinterest. Nonverbal communication complemented the verbal communication.

10. **Recognizes verbal problem indicators**
    Recognized verbal indicators by responding when patients asked direct questions, made direct contradictions, expressed or reiterated concerns, hesitated, or expressed misunderstandings.

11. **Recognizes nonverbal problem indicators**
    Recognized problem indicators either by responding to patient's eye contact, body language, posture, or other nonverbal gestures and behaviors or by discussing observations after the interviews.

12. **Verifies the meaning of problem indicators**
Asked patients directly about problem indicators, using techniques such as soliciting feedback (described above).

13. **Assertively confronts problems**
    In confronting problems, demonstrated self-confidence, appropriate body language and eye contact, and communicated his or her position while still maintaining rapport.

14. **Resolves patient problems**
    Solved typical STD patient problems such as those concerning marital situation, confidentiality, guilt, embarrassment, fatalism, homosexuality, special sex partners, parents, employers, hostility toward sex partners or clinic personnel, and apathy about infections.

15. **Uses STD motivations**
    Demonstrated an understanding of STD motivations including confidentiality, reinfection, spread and reinfection, responsibility to others, self-survival, potential hassles, and disease complications.

16. **Motivates clearly and convincingly**
    Created a sense of urgency. Used visual aids to enhance motivations. Tailored motivations appropriately to patient and problem.

17. **Emphasizes confidentiality**
    Gave examples of how the system works and emphasized the discreet approaches used by the program. Demonstrated what would be said to the partner (suspect, associate) when confidentiality seems a particularly sensitive issue or when the partner seemed not to understand.

18. **Computes and uses interview periods**
    Used correct periods according to program criteria and communicated the time period to the patient, using an understandable beginning date.

19. **Recognizes exposure gaps**
    Identified gaps when they occurred during interviews and confronted patients about them appropriately.

20. **Determines accurate source/spread relationships**
    Used case management and analysis methods to accurately determine source/spread relationships. Accurately charted lesion histories, lesion locations, exposure data, and ghosted primary lesions on the infectious syphilis epidemiologic analysis chart.

21. **Determines investigative priorities**
    Given a set of field investigation forms, was able to set priorities according to the criteria set by the program or the course.

22. **Recognizes discrepancies in patient responses**
    Detected and appropriately challenged discrepancies such as history inconsistent with medical facts,

social and sexual history inconsistent with lifestyle described by patient, and contradictory exposure dates.

23. **Emphasizes sex partner referral**
Regardless of other issues, ensured that appropriate time, attention, and importance were given to sex partner referral.

24. **Tactfully persists in identifying sex partners**
Within reason, and in a manner that maintained rapport, continued to probe for additional sex partners (including same sex) after the patient indicated that all had been discussed.

25. **Pursues locating and identifying information**
Gathered detailed locating information, including at least two items (home address and telephone number count as one item). Obtained basic identifying information (i.e., age, race, sex, marital status, height, weight, and complexion) and pursued distinguishing characteristics (i.e., hair color and style, facial hair, glasses, scars, physical impairments, and distinctive clothing).

26. **Emphasizes risk reduction behaviors, as appropriate**
Time permitting, used an interactive approach to discuss (other than sex partner referral) additional individualized intervention behaviors with patient, including taking medication, returning for follow up tests, reducing risk, and responding to disease suspicion. Discussed a risk reduction plan with each patient to encourage behavioral change when applicable.

27. **Conveys a sense of urgency**
Communicated to patients by word and deed that the spread of infection and the development of symptoms and complications can be averted only by immediately notifying and referring others who are at risk.

28. **Establishes specific contracts and coaches patients**
Made it clear to patients the time period during which they could refer partners before the DIS would take on that responsibility. Pointed out the pros and cons of patient referral when the patient selects that option. Helps patients know what to say when confronting their partners and, when necessary, made suggestions as to how to direct the conversation.

29. **Pursues timely reinterviews with plan**
Scheduled and performed reinterviews on the basis of the knowledge gained from the analysis of interviews and investigations. Prepared written agendas specifying the points to be pursued in reinterviews. Performed reinterviews as quickly as possible when major problems arose (e.g., unlocatable partners, no eligible source candidates, or new information indicating unidentified partners).

Field Activities

1. **Assumes responsibility for success of investigations**
Displayed a sense of obligation for the successful resolution of any investigation in which the DIS played a role. Assumed responsibility for initiating the investigation (gathered identifying and locating information and prepared the 73.2936 completely and legibly) and followed through with prompt, persistent, imaginative, assertive, and sensitive application of techniques and the complete, legible documentation of all activities. Accorded the same importance and applied the same effort to investigations initiated by others as to those initiated by himself or herself.

2. **Utilizes resources effectively**
Used standard locating resources before and during investigations (e.g., telephone book, cross directory, closed 73.2936s, clinic medical records, utility companies, public assistance files, driver's

license bureau, telephone company security, neighbors, children in vicinity, neighborhood businesses, zip code directory, and long distance telephone information for investigations sent out-of-area).

3. **Recognizes investigative priorities**
   Observing program guidelines, routinely and appropriately determined high and low priority investigations and organized field activity accordingly. Explained logically to supervisor when lower priority work was done before higher priority work.

4. **Selects appropriate referral methods**
   Selected methods that ensured the earliest examination while preserving confidentiality. Mailed letters only with supervisor's approval in conjunction with field or telephone referrals or after such referrals had failed. Left referral cards only after a reasonably exhaustive investigation had failed to establish contact. Unless with supervisor's approval, referral methods that failed once were not repeated (e.g., calling the same number at the same approximate time of day, leaving referral cards at the same address).

5. **Takes prompt action on initial and follow-up investigations**
   Verified the locating information for priority investigations within 24 hours after assignment. Consulted private physicians within 24 hours after receiving follow-ups from them. Intervals between action on priority investigations did not exceed more than one working day except in circumstances deemed justifiable by the supervisor. Referrals were made for next working day. Followed up by the next day on anyone who failed to keep an appointment.

6. **Demonstrates timely, persistent, and imaginative action to move a stalled investigation**
   With investigative workload and other professional obligations considered, took all reasonable steps to ensure that assigned investigations were resolved promptly and that they were not unnecessarily delayed or resolved inappropriately because of procrastination, timidity, the premature concession of defeat, or the unimaginative use of resources or investigative techniques. Used alternative avenues for locating or notifying when primary approaches seemed unproductive or likely to violate confidentiality. The supervisor was involved only in legitimately difficult cases or when information was needed.

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

8. **Confidentially and professionally manages obstacles**
   Was able to think on his or her feet when confronted with obstacles to an investigation (i.e., parents, siblings, spouses, roommates, school officials, bartenders, coworkers, or employers who have blocked notification efforts or whose curiosity could threaten confidentiality unless handled effectively). Provided subjects of investigation with believable covers when a third party had to be circumvented to reach the intended person. Gave logical reasons for the need for face-to-face meetings in confidential settings. Gave no clues to people who have no need to know the identity of patients or the purpose of field investigations.

9. **Motivates people to come in promptly**
   Created a sense of urgency about examinations through factual information and persistence. Did not imply that persons who had been notified were infected. Verified whether people were likely to keep appointments by exploring transportation plans and other conflicts such as job and child care. During field visits, updated locating information such as

home and work telephone numbers and addresses, and other methods of getting back in touch. In order to allay patient's fears (about embarrassment, parking, delays, etc.), explained how the appointment is likely to go.

10. Documents investigative activities
Documented each investigative step immediately after the activity took place and reflected the date, time, and nature of the activity according to protocols. Documentation was sufficiently legible, coherent, and accurate to permit the reconstruction of all activities so that a co-worker could complete any investigation without duplicating steps.

Appendix PS–I

"EVALUATION TABLES"

Table 1. Comparison of risk factors among partners, by disease outcome.

Risk behavior discussed in original interview	# of partners testing positive for STD of index patient	# of partners testing negative for STD of index patient	# of partners initiated not tested	total # of partners initiated
Sex for drugs				
Yes				
No				
Multiple Partners				
Yes				
No				

Table 2. Partner Services Outcomes, by Disease and Time Period

For all original patients that are interviewed **Disease (Fill in):**								
Time Period	# of original patients interviewed	Number of sex partners (and needle-sharing, if applicable)						
		elicited	initiated	out of jurisdiction	located and not notified (Previously treated)	located and notified by provider but refused services	located and notified by provider; accepted services	not located
January								
February								

Appendix PS–J

GLOSSARY OF TERMS ASSOCIATED WITH PARTNER SERVICES

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

Case Closure—A case is closed when the responsible DIS and the next-level supervisor agree that all reasonable steps to intervene in the disease process have been completed and documented.

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

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

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

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

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

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

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

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

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

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

Interview Period—The interview period covers the time from the earliest date a patient could have been infected to the date of treatment; it always includes the maximum incubation period and the duration of symptoms. Thus, it includes the time during which a patient could become infected or spread the disease to others.

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

MAP Sheet—The major analytical points (MAP) sheet is used for gathering information about members of a lot as well as for analysis and communication.

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

Original Patient (OP)—See index patient.

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

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

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

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

Patient—An individual who is treated for a STD.

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

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

Pre-Interview Analysis—An analysis of the patient's situation done by the DIS before the original interview. The pre-interview analysis includes reviewing available medical information and case information, reviewing available socio-sexual information, and assembling necessary materials and supplies needed during the interview.

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

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

Re-Interview—Any interview following the original interview with a STD patient. Reinterviews are conducted to provide feedback, to gather additional information that may help prove or disprove a hypothesis about case relationships, to address points not covered during the original interview, to identify additional partners or suspects to the original patient, to confront points that are illogical or that are disputed by other information, to solicit assistance in locating

previously named persons who have not been located or are being uncooperative, to support patient risk-reduction attempts, and to support and reinforce a patient's successful use of referred services.

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

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

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

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

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

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

The lot system, developed in the 1960s to assist in the analysis of syphilis transmission, places person who are connected to each other in the same case folder (for example, if A and C are both interviewed, and both name B, they are thereby connected, and can be placed in the same lot). Thus, the notion of examining networks of persons involved in sexual transmission is a traditional part of syphilis epidemiology. In the past few years, a number of software tools have been developed to assist in network visualization and analysis. These tools, once implemented as part of a case management approach, can provide useful insights into the nature of the groups at risk for STD transmission, and may provide a program manager with guidance on how to proceed with the investigation of both endemic transmission and STD outbreaks.

The traditional syphilis and gonorrhea interviewing forms and the contact investigation form contain all of the information necessary to perform a network analysis. Program managers may choose as well to gather information not included in these forms (or the versions used in program areas) such as places of aggregation, household information, history of incarceration, etc.; such additional information can be systematically added to the record. Most managers will probably select a subset of the variables that are collected on the routine interview forms. For network analysis, the single critical variable is the unique identification number (ID). Together, the information on a patient and on one of his/her partners is the basic observational unit for network analysis. To create a file for network analysis, the manager will want a single observation for each patient-partner pair. Thus, if a man names four women, he will generate four observations in the data set. Each of the observations will contain all of his information and all the information on a contact. (The repetition of his information four times is simply a convenience; he will not be counted four times.)

The data set can be created directly from the STD*MIS, if it is used, or by entering the data from the interview record into a data base manager, such as Epi Info, or a spreadsheet. Once entered, the data are converted into an ASCII, or "flat" file. The total number of observations in the file will be equal to the total number of partners named by all of the persons interviewed. The preservation of a unique ID for each individual identified is crucial. For example, if a person is named as a partner, he or she will be assigned a unique ID. That unique ID should be carried with him if he is then interviewed. This procedure permits the network program to create the connections between people. If the STD*MIS currently in use in a program area uses multiple identifiers for the same person, this procedure will not work. Creating a unique ID for each individual, whether identified as a patient or a partner, may be the major source of extra work that has to be performed.

Once a flat file has been constructed, it is read by a program that converts it to a "DL" file that can be read by the network analysis program, UCINET V. The DL file is then used by the network analysis program to construct a file that can be used for network analysis. Program managers may or may not want to calculate the properties of the network they are examining. More likely, they will want to visualize the network. UCINET V contains a module that will create another file to be read by KRACKPLOT, a program that permits visualization of all the connections in the network, and permits the manager to move the nodes (patients and partners) on the screen to create a visually informative display. The combination of these two programs permits attributes to be assigned to nodes (such as infected or not infected, male or female, sex partner or nonsex partner, etc.). Specific attributes of nodes are represented by the types of boxes in which the node identifiers are placed, and specific types of connections can be identified by the color of connecting lines.

As an investigation unfolds, and cases with partners are added, the diagrams can be frequently redrawn to visualize the direction and intensity of the outbreak or of endemic spread. By manipulating the visualization, managers can develop a sense of the "loose ends" and the persons or groups that might be most important to revisit. Such visualization can also provide a graphic sense of the boundaries of the epidemic.

For additional information on programs for network mapping, consult: http://www.heinz.cmu.edu/project/INSNA/soft_inf.html

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Partner Services Providers Quick Guide

PCSP

Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

This pamphlet is meant for use by Disease Intervention Specialists and others conducting partner services activities.

High Priority Index Patients for Partner Services

- Pregnant women
- Male index patients known to have pregnant female partners
- Index patients suspected of (or known to be) engaging in behaviors that significantly increase the risk for transmission to multiple other persons
- Persons co-infected with HIV and one or more other STDs
- Persons with recurrent STDs
- Persons who present with clinical signs or symptoms suggestive of infection
- Cases from core areas – for gonorrhea, prioritizing cases from core areas may offer an opportunity to reduce transmission at the community level
- Persons with high HIV viral load (e.g., >50,000 copies RNA/mL) – high serum viral load is associated with increased risk for HIV transmission
- Persons with evidence of acute infection or recent infection

Effective Case Management Tips

- Conduct pre/post interview analysis
- Take notes and review them with the VCA
- Write up case quickly while information is still fresh
- Review VCA regularly
- Respond to supervisor comments
- Review case daily
- Maintain good organization
- Debrief case (peers, supervisor, etc.)
- Re-interview patient as soon as possible

DISEASE INTERVIEW PERIODS*

Chlamydial infection

Symptomatic . . . . 60 days before onset of symptoms through date of treatment

Asymptomatic . . . 60 days before date of specimen collection (through date of treatment if patient was not treated at time specimen was collected)

Gonorrhea

Symptomatic . . . . 60 days before onset of symptoms through date of treatment

Asymptomatic . . . 60 days before date of specimen collection (through date of treatment if patient was not treated at time specimen was collected)

** The time interval for which an index patient is asked to recall sex or drug-injection partners.*

Interview Periods* for Partner Services Programs for Chlamydial Infection, Gonorrhea, Human Immunodeficiency Virus (HIV) Infection or Acquired Immunodeficiency Syndrome (AIDS), and Syphilis

Interview Periods

Interview Periods* for Partner Services Programs for Chlamydial Infection, Gonorrhea, Human Immunodeficiency Virus (HIV) Infection or Acquired Immunodeficiency Syndrome (AIDS), and Syphilis

HIV infection, AIDS

1 or 2 years before date of first positive HIV test through date of interview; might be mitigated by evidence of recent infection or availability of verified previous negative test results.
All current or former spouses during 10 years before diagnosis.

Syphilis†

Primary Syphilis.	90 days prior to date of onset of primary lesion** through the date of treatment.
Secondary Syphilis	6.5 months prior to date of onset of secondary symptoms** through the date of treatment.
Early Latent Syphilis†	1 year prior to start of treatment.

** The time interval for which an index patient is asked to recall sex or drug-injection partners. Interview periods may be modified if a history of symptoms, a negative test result, or incidental treatment are documented. If symptom history is questionable, a maximum interview period should be used. If the patient claims no partners during the interview period, then the most recent partner before the interview period should be elicited and notified.*

† Many syphilis cases cannot be staged until after the case is closed. When the stage of syphilis is undetermined at the time of interview, a one-year interview period should be used.

*** If the onset of primary or secondary symptoms is unknown, or questionable, the maximum symptom duration (5 weeks for primary and 6 weeks for secondary) should be used to calculate.*

Interview Format

I. Introduction
State purpose/role
Assure confidentiality

II. Patient Assessment
Resolve patient concerns
Obtain social history
Obtain medical history
Ensure disease comprehension

III. Disease Intervention
Elicit partner information
(foundation, name, exposure, locating, clustering, description)
Develop risk reduction interventions

IV. Conclusion
Re-state commitments
Prepare for RI
Wrap up and summarize

Effective Interviewing Techniques

- Be professional
- State purpose of interview
- Explain and emphasize confidentiality
- Establish rapport
- Address concerns
- Observe verbal and non-verbal body language
- Display STD/HIV pictures to educate and motivate
- Identify persons with symptoms
- Identify persons exposed to known cases
- Identify screening opportunities
- Identify pregnant females
- Utilize effective listening skills

Example Questions to Ask When Contacting Health Providers

- What is the patient's current locating information? Emergency locating information?
- What *prompted* the visit?
- What is the result of pregnancy testing?
- What other STD/HIV/HEP/TB tests were conducted? (previous/current)
- What symptoms or history of symptoms were observed/noted?
- What medication(s) was prescribed?
- How many sexual and/or needle sharing partners have been identified? Treated?
- Has the patient been treated according to the most recent treatment guidelines? Date of guidelines?
- Has the patient been referred for follow-up care and to what facility?
- Ask if health provider has most recent treatment guidelines?
- Is the patient married? If so, has the spouse been notified and tested?

Sample Interview Questions

- What brought you into the clinic today?
- What did the doctor/nurse/clinician tell you?
- Where have you traveled in the last (interview period)?
- When was the last time you were treated for an STD?
- When was the last time you had a blood test?
- If female patient:

  *Have you been pregnant in the last year?

  *When was the last time you had a pelvic exam?

  *When was the last time you had a pap test?

  *What were the results?
- Some drugs like cocaine or heroin can affect test results. When was the last time you used drugs like these? What other drugs do you use? How often do you use?
- How many sex and/or needle-sharing partners have you had since (interview period)? How many were men… women…transgender?
- How many did you meet over the Internet?
- Who on your "buddy list" should be tested?
- Who do you know in the community…friends…at-risk populations…pregnant females that could benefit from a free test/exam?
- What have you heard you can do to lower your chances of contracting STD/HIV?
- What steps are you willing to try to further lower your chance of getting or transmitting HIV or STDs?
- What can interfere with you taking these steps?
- When are you to return for follow-up? Medication?
- I will be contacting you in a couple of days. When is the best time to reach you? Where is the best place to contact you?

Syphilis Ghosting Hierarchy

- An *Existing* Primary Lesion
- A *Historical* Primary Lesion
- A *Ghosted* Primary Lesion
- A *Secondary* Symptom

Ghosting a Source

Begin at the inoculation point of the patient suspected of being a spread. Make this point the center of the partner's ghosted lesion. The ghosted lesion should begin and end 1 ½ weeks on either side of the center point to give a total 3-week ghosted lesion.

Ghosting a Spread

Begin at the center of the lesion suspected to be the source of infection. Equate this to the inoculation point for the patient for whom the spread ghost is being developed. The onset of the ghosted lesion should be drawn 3-weeks after the ghosted inoculation point, and the ghosted lesion should have a 3-week duration.

Interview Periods: Syphilis

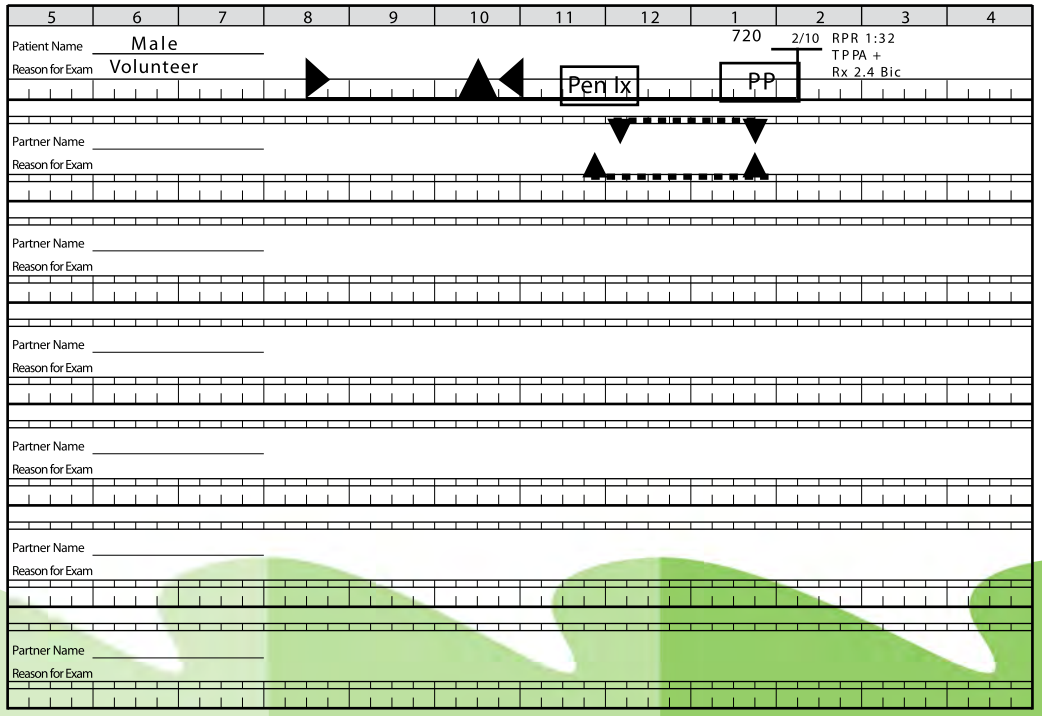
- Primary: 90 days before the onset of symptoms
- Secondary: 6 ½ months before onset of secondary symptoms
- Early Latent: 1 year prior to start of treatment

Visual Case Analysis Tips

Plot the Facts

1. Months of the year
2. Name of the patient
3. Reason for the exam
4. Medical history
5. Symptoms
6. Critical period
7. Exposure dates

VCA Chart



Hepatitis

Symptoms of Acute Infection: Symptoms of all types of viral hepatitis are similar, however not all newly infected persons show signs of illness. If symptoms do appear they can include one or more of the following: Fever; Fatigue; Loss of appetite; Nausea; Vomiting; Abdominal pain; Gray colored bowel movements; Joint pain; and Jaundice.

Hepatitis A Virus (HAV) Infection:

Routes of transmission: Ingestion of fecal matter, even in microscopic amounts, from: Close person-to-person contact with an infected person; Sexual contact with an infected person; and Ingestion of contaminated food or drinks.

Recommended treatment: No medication available. Best addressed through supportive treatment.

Persons at risk: Household members, sex contacts, or caregivers of infected persons; Men who have sex with men; Users of certain illegal drugs (injection and non-injection); Persons with clotting-factor disorders; and Travelers to regions where HAV is common.

Prevention: Vaccination for at-risk individuals including MSM and IDU.

hepatitis

Hepatitis

Hepatitis B Virus (HBV) Infection:

Routes of transmission: Contact with infectious blood, semen, and other body fluids, such as through: Birth from an infected mother; Sexual contact with an infected person; Sharing of contaminated needles, syringes or other injection drug equipment; and Needlesticks or other sharp instrument injuries.

Recommended treatment:

Acute: No medication available; best addressed through supportive treatment.

Chronic: Regular monitoring for signs of liver disease progression; some patients are treated with antiviral drugs.

Persons at risk: Sex partners of infected persons; Persons with multiple sex partners; Persons with a sexually transmitted disease; Men who have sex with men; Injection drug users; Household contacts of infected persons; Healthcare and public safety workers exposed to blood on the job; Hemodialysis patients; Residents and staff of facilities for developmentally disabled persons; and Travelers to regions with HBsAg prevalence of ≥2%; and Infants born to infected mothers.

Prevention: Vaccination for at-risk individuals including MSM, IDU, high-risk heterosexuals (HRHs), STD patients, incarcerated persons, and adults with diabetes aged 19 - 59; people aged > 60 years at the discretion of the treating clinician.

Hepatitis C Virus (HCV) Infection:

Routes of transmission: Contact with blood of an infected person, primarily through: Sharing of contaminated needles, syringes, or other injection drug equipment. Less commonly through: sexual contact; birth from an infected mother; and needlestick or other sharp instrument injuries.

Recommended treatment:
***Acute*:** Antivirals and supportive treatment.
***Chronic*:** Regular monitoring for signs of liver disease progression; some patients are treated with antiviral drugs. New treatments are now available.

Persons at risk: Current or former injection drug users; Recipients of clotting factor concentrates before 1987; Recipients of blood transfusions or donated organs before July 1992; Long-term hemodialysis patients; Persons with known exposures to HCV (e.g., healthcare workers after needlesticks, recipients of blood or organs from donor who later tested positive for HCV); HIV-infected persons; and children born to infected mothers (do not test before age 18 mos.); and adults born 1945-1965.

Prevention: Avoid risky behaviors. Screen IDU and others at risk for HCV infection.

hepatitis

Tuberculosis

Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. It usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine. Persons with TB can die if they do not get treatment. TB is spread when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings. These germs can stay in the air for several hours, depending on the environment.

Persons with active TB disease are considered infectious and may spread TB bacteria to others.

Active TB Disease:

- A skin test or blood test result indicating TB infection
- May have an abnormal chest x-ray, or positive sputum smear or culture
- Has active TB bacteria in his/her body
- Usually feels sick and may have symptoms such as coughing, fever, and weight loss
- May spread TB bacteria to others
- Needs treatment to cure active TB disease

Recommended treatment: Must be treated with several drugs for 6 to 12 months.

Tuberculosis

Latent TB Infection:

- Usually has a skin test or blood test result indicating TB infection
- Usually has a normal chest x-ray and a negative sputum test
- Has TB bacteria in his/her body that are alive, but inactive
- Does not feel sick
- Cannot spread TB bacteria to others
- Needs treatment for latent TB infection to prevent TB disease; however, if exposed and infected by a person with multidrug-resistant TB (MDR TB) or extensively drug-resistant TB (XDR TB), preventive treatment may not be an option

Recommended treatment: Several treatment options are now available to treat latent TB infection and prevent development of TB disease.

Chlamydia

Signs and Symptoms

Adolescent and Adult Women: **Most are asymptomatic,** may have abnormal vaginal discharge, pain or bleeding during intercourse, bleeding between menstrual periods, pain or burning sensation when urinating, urinary frequency, rectal pain or discharge, lower abdominal pain, lower back pain, nausea, or fever.

Adolescent and Adult Men: **Most are asymptomatic**, may have urethritis, urethral discharge, pain or burning sensation when urinating, or rectal pain or discharge.

Recommended Treatment Regimens

Adolescents and Adults: Azithromycin 1g orally in a single dose **OR** doxycycline 100 mg orally twice daily for 7 days.

Pregnancy: Azithromycin 1 g orally in a single dose **OR** amoxicillin 500 mg orally 3 times a day for 7 days.

HIV Infection: Patients who have chlamydial infection and also are infected with HIV should receive the same treatment as those who are HIV negative.

See STD Treatment Guidelines for Chlamydial Infections Among Infants and Children.

Gonorrhea

Signs and Symptoms

Adolescent and Adult Men: A burning sensation when urinating, or a white, yellow, or green discharge from the penis, or painful or swollen testicles. Rectal discharge, anal itching, soreness, bleeding, or painful bowel soreness and bleeding; most pharyngeal infections are asymptomatic.

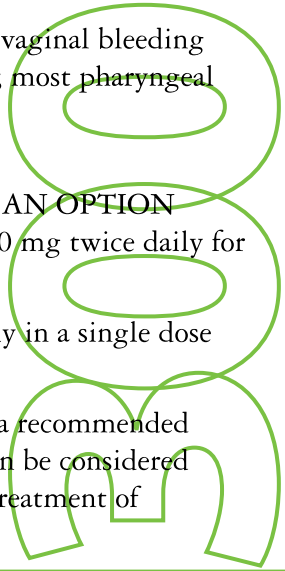
Adolescent and Adult Women: A painful or burning sensation when urinating, increased vaginal discharge, or vaginal bleeding between periods, rectal discharge, anal itching, soreness, bleeding, or painful bowel soreness and bleeding; most pharyngeal infections are asymptomatic.

Recommended Treatment Regimens:

Uncomplicated Infections of the Cervix, Urethra & Rectum: Ceftriaxone 250 mg IM in a single dose OR, IF NOT AN OPTION cefixime 400 mg orally in a single dose **PLUS** azithromycin 1 g orally in a single dose **OR** doxycycline 100 mg twice daily for 7 days.*

Uncomplicated Infections of the Pharynx: Ceftriaxone 250 mg IM in a single dose **PLUS** azithromycin 1 g orally in a single dose **OR** doxycycline 100 mg orally twice daily* for 7 days, PLUS Test-of-cure in 1 week.

Pregnancy: As with other patients, pregnant women who have gonococcal infection should be treated with a recommended or alternative cephalosporin. Because spectinomycin is not available in the US, azithromycin 2 g orally can be considered for women who cannot tolerate a cephalosporin. Either amoxicillin or azithromycin is recommended for treatment of presumptive or diagnosed chlamydia.



Because of the high prevalence of tetracycline resistance among Gonococcal Isolate Surveillance Project isolates, particularly those with elevated minimum inhibitory concentrations to cefixime, the use of azithromycin as the second antimicrobial is preferred.

Gonorrhea

Recommended Treatment Regimens *(continued)*

HIV Infection: Patients who have gonococcal infection and also are infected with HIV should receive the same treatment regimen as those who are HIV negative.

Dual Therapy for Gonococcal and Chlamydial Infections: Patients who have gonococcal infection frequently are coinfected with *C. trachomatis*; it is recommended that patients treated for gonococcal infection also be treated routinely with a regimen effective against uncomplicated genital chlamydial infection.

Disseminated Gonococcal Infection (DGI):
Signs and symptoms: Petechial or pustular acral skin lesions, asymmetrical arthralgia, tenosynovitis, or septic arthritis.

Recommended treatment: Ceftriaxone 1 g IM or IV every 24 hours.

See STD Treatment Guidelines for Gonococcal Infections Among Infants and Children.

Syphilis

Stage	Signs and Symptoms
Primary	A single sore (called a chancre) or multiple sores can appear. The chancre is usually a firm, round, small, and painless ulcer or chancre at the infection site.
Secondary	Rash on one or more areas of the body can appear. The rash may appear as rough, red, or reddish brown spots both on the palms of the hands and the bottoms of the feet. Fever, swollen lymph glands, sore throat, patchy hair loss, headaches, weight loss, muscle aches, and fatigue are other symptoms.
Latent	None. A positive serologic test for syphilis is the only evidence of infection during latent syphilis. Early latent is syphilis infection of less than one year. Late latent is syphilis infection of one year or longer.
Tertiary	Asymptomatic, cardiovascular manifestations, or gummatous lesions.
Neurosyphilis	Cognitive dysfunction, motor or sensory deficits, ophthalmic or auditory symptoms, cranial nerve palsies, and symptoms or signs of meningitis.

Syphilis (continued)

Recommended Treatment Regimens

Primary, Secondary, and Early Latent: Benzathine penicillin G 2.4 million units IM in a single dose.

Late Latent or Unknown Duration: Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals.

Tertiary: Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals.

Neurosyphilis: Aqueous crystalline penicillin G 18-24 million units per day, administered as 3-4 million units IV every 4 hours or continuous infusion, for 10-14 days.

Pregnancy: Pregnant women should be treated with the penicillin regimen appropriate for their stage of infection.

HIV Infection: HIV infected persons with syphilis should be treated according to the stage-specific recommendations for HIV-negative persons.

See STD Treatment Guidelines for Recommended Syphilis Regimens for Infants and Children.

Human Immunodeficiency Virus (HIV)

HIV is the human immunodeficiency virus. It is the virus that can lead to acquired immune deficiency syndrome, or AIDS.

HIV is transmitted from an infected person via unprotected sexual contact, the sharing of needles, syringes, or works; from mother to child during the birth process, or through breast feeding; transfusion of blood or blood products; and the transplantation of tissues and organs. Blood (or secretions and tissues contaminated by blood) is the major means of transmission.

Signs and Symptoms

Within a few weeks of being infected with HIV, some people develop fever, fatigue, and generalized body rash. Other signs and symptoms include headache, swollen lymph glands, sore throat, feeling achy, nausea, vomiting, diarrhea and night sweats.

Treatment

A variety of drug combinations may be used and will vary by medical care center.

Recommended screenings for HIV + Patients*

Screen for:

1. Hepatitis B, C
2. Tuberculosis
3. Chlamydia†, gonorrhea†, and syphilis
4. Screen for pregnancy, cervical cancer screening (Pap test) and trichomoniasis in females

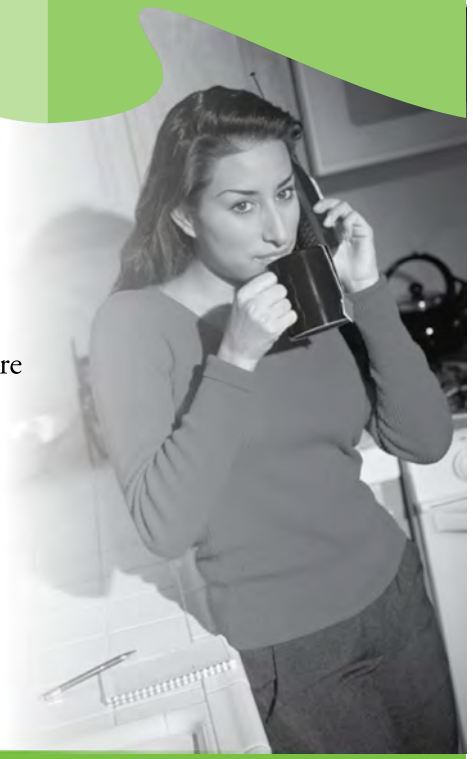
Vaccinate against:

1. HBV and HAV

**Please review IDSA HIV Primary Care Guidelines for additional information.*
† Including rectal and/or pharyngeal screening when appropriate

Conducting STD/HIV Partner Notification

1. Verify you have the right person and identify yourself
2. Ensure privacy
3. Provide notification
   - Ensure the patient knows the basics of the disease
   - Provide the patient with private/public options for receiving exam/treatment
   - Motivate him or her to act immediately
4. Draw blood to test for STDs and HIV. Depending on local protocols, a rapid antibody test might be used to test for HIV. Finger-stick whole blood specimens are preferred unless it is not feasible to obtain blood specimens.
5. Make/verify referrals



Ways to Confirm Locating Information

- Examine names on mailbox
- Speak with other people encountered at the address
- Inquire at local post office
- Inquire at local fire department

Safety Tips for the Field

- Plan stops before you go.
- Let supervisors and co-workers know your planned route.
- Know the neighborhood. Know drug and gang hangouts.
- Park your car so that you can leave quickly.
- Never leave keys in your car.
- When in your car and asking questions of strangers, roll your window down only a few inches.
- Don't wear expensive jewelry or carry expensive items.
- Don't try to blend in to a neighborhood. Promote the feeling that you are there to help someone.
- Be aware of large numbers of people congregating in an area.
- Avoid arguments.
- Report any incidents to your supervisor.
- Check for signs of animals nearby (food bowl, toys, chain, path, etc.).
- Whistle or rattle fence to check for animals.
- Always check out the house or building before you enter. Plan an escape route.
- Go to high risk areas in pairs and during the time of day there is less activity.

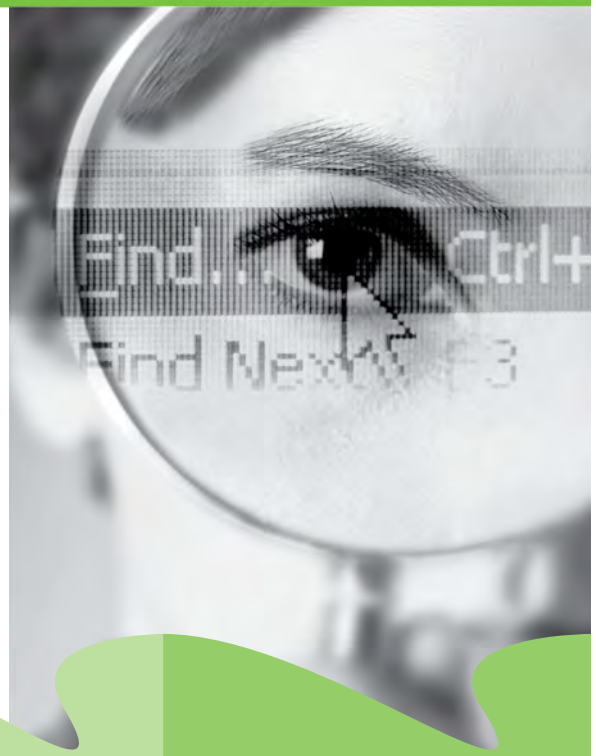
Investigative Resources to Check Before Closing "H" Dispos

- Public information sources
- National Electronic Disease Surveillance System (NEDSS) records
- Patient Tracking and Billing Management Information System (PTBMIS) records
- Department of Motor Vehicle (DMV) records
- White pages, Yellow pages
- Social networking websites (MySpace, Facebook, etc.)
- Sexually Transmitted Disease Management Information System (STDMIS) records
- State Immunization Registry
- Third Parties (housing authority, apartment manager, friends, etc.)
- High schools (if age appropriate)
- U.S. Postal Service
- Local police
- Old health department records
- College alumni directories
- "Usual hang out spots"
- Woman, Infants and Children (WIC)/other agencies
- Google maps
- GPS

Investigative Internet Sources

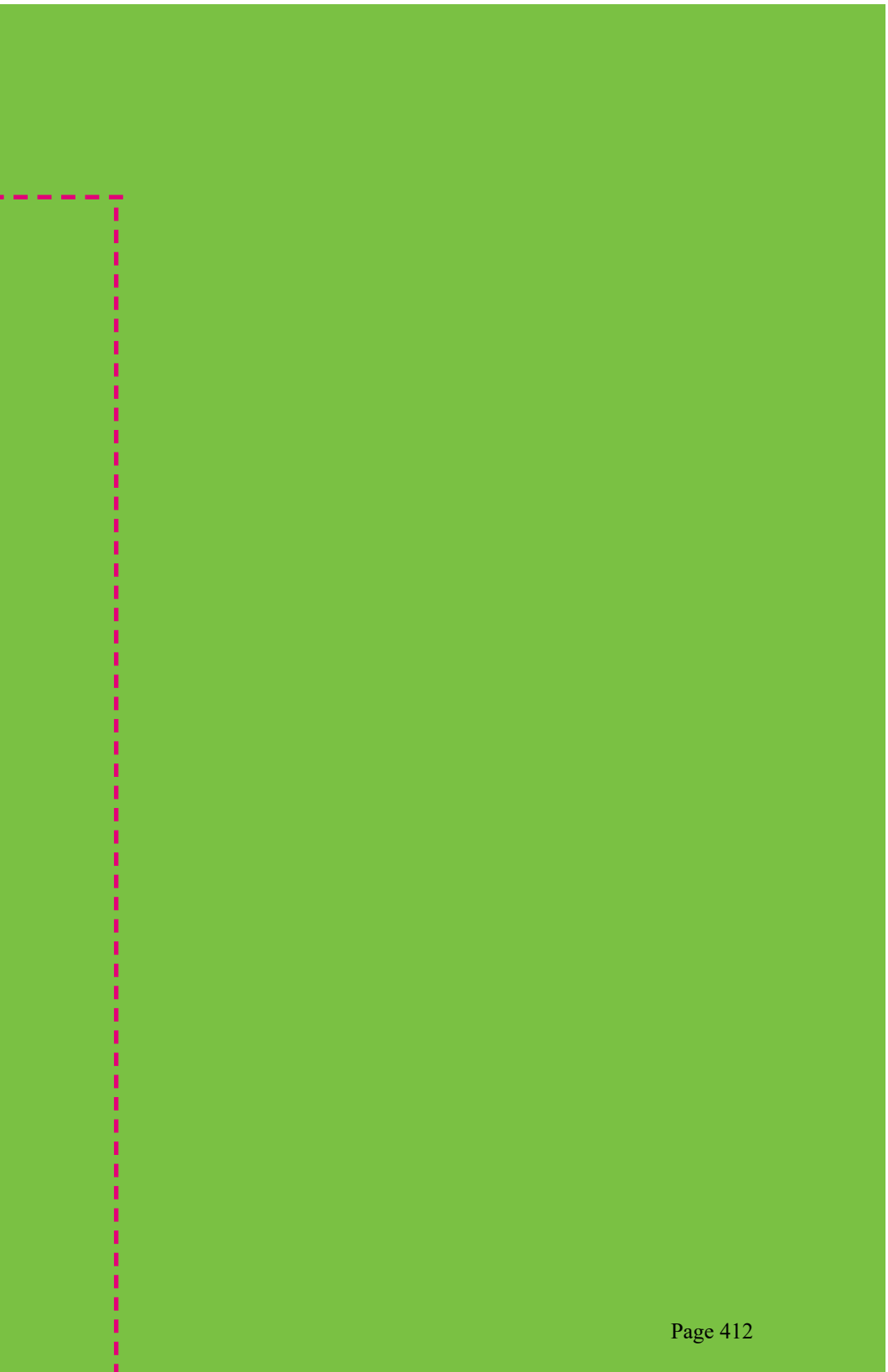
Below are some examples of currently used social networking sites, shopping sites, professional networking sites, microblogs, to use as a resource when conducting internet investigations. Social networking sites and names may change over time. Please note more than one site may be used to collect important information.

- www.anywho.com
- www.zabasearch.com
- www.theultimates.com
- www.google.com
- www.whitepages.com
- www.lexisnexis.com
- www.spokeo.com
- www.pipl.com
- www.people.Yahoo.com
- www.Snitch.name
- www.peekyou.com
- www.123People.com
- www.peopleSmart.com
- www.tnid.us (phone only)
- www.Linkedin.com
- www.twitter.com
- www.google.com/profiles
- www.Bing.com
- www.Yahoo.com
- www.Dogpile.com
- www.Ask.com
- www.Metacrawler.com



Referrals

	Name of Facility	Phone Number
Hepatitis	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Child Protective Services	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Domestic Violence	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Drug/Alcohol Treatment	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Family Counseling	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Family Planning Clinics	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
HIV Testing Sites	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Immunization	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Language Assistance	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Maternal and Child Health	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Mental Health	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Prenatal Clinics	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Rape Crisis Center	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
STD Clinics	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Temporary Housing	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Tuberculosis Clinics	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Community- Based Organizations	_____	___ ___ ___ ___ ___ ___ ___ ___ ___ ___



For additional information:

www.cdc.gov/nchhstp

www.stdhivpreventiontraining.org

www.cdc.gov/std/training

www.cdc.gov/std/treatment/2010/default.htm

www.cdc.gov/hepatitis

www.knowhepatitis.org

www.cid.oxfordjournals.org/content/49/5/651.full.pdf+html

For more information on the PSP Quick Guide:

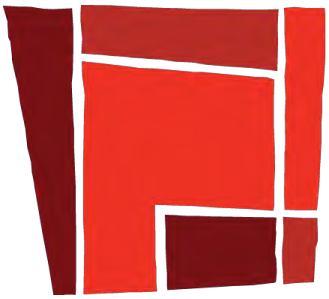
Division of STD Prevention

Program Development and Quality Improvement Branch

404-639-8360

STDTraining@cdc.gov

CS241981



ARIZONA DEPARTMENT
OF HEALTH SERVICES

Case Definitions for Communicable Morbidities

2021

(revised September 2021)

TABLE OF CONTENTS

Introduction

In the United States, requirements for reporting diseases are mandated by state or local laws or regulations, and the list of reportable diseases in each state differs. The reporting requirements for Arizona are part of the Arizona Administrative Code (A.A.C.), available at http://apps.azsos.gov/public_services/Title_09/9-06.pdf. The A.A.C. stipulates what communicable diseases healthcare providers, laboratories, and other entities need to report to public health officials, who will then review reports, conduct a public health investigation if appropriate, and classify cases according to the current case definitions.

Since 1990, in collaboration with the Council of State and Territorial Epidemiologists (CSTE), the Centers for Disease Control and Prevention (CDC) has published case definitions for public health surveillance to provide uniform criteria for case classification to increase the specificity of reporting and improve the comparability of diseases reported from different geographic areas.

The CDC/CSTE surveillance case definitions included in this report differ in their use of clinical, laboratory, and epidemiologic criteria to define cases. Some clinical syndromes do not have confirmatory laboratory tests; however, laboratory evidence may be one component of a clinical definition (e.g., toxic-shock syndrome). Most case definitions include a brief clinical description; however, unless this description is explicitly cited in the case classification section, it is included only as background information. Some diseases require laboratory confirmation for diagnosis regardless of clinical symptoms, whereas others are diagnosed based on epidemiologic data. Many case definitions for the childhood vaccine-preventable diseases and foodborne diseases include epidemiologic criteria (e.g., exposure to probable or confirmed cases of disease or to a point source of infection [i.e., a single source of infection, such as an event resulting in a foodborne-disease outbreak, to which all confirmed case-patients were exposed]). In some instances, the anatomic site of infection may be important; for example, whether the organism was isolated from a normally sterile site (e.g., blood).

Since each state has the authority to make additional morbidities reportable, there are some morbidities reportable in Arizona that are not nationally notifiable. Case definitions for those morbidities are also included in this report to standardize surveillance within Arizona. Case definitions in this document for nationally notifiable conditions match the CDC case definitions for most morbidities, unless noted.

For more information see:

- ADHS's Summary and Overview for Case Definitions for Public Health Surveillance at http://www.azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-case-definition;
- CDC's National Notifiable Diseases Surveillance System at http://wwwn.cdc.gov/nndss/; or
- the ADHS Infectious Disease Surveillance Overview posted at http://www.azdhs.gov/preparedness/epidemiology-disease-control/index.php#data-home

Definition of Terms Used in Case Classification

Confirmed case: A case that is classified as confirmed for reporting purposes.

Probable case: A case that is classified as probable for reporting purposes.

Suspected case: A case that is classified as suspected for reporting purposes.

Laboratory-confirmed case: A case that is confirmed by one or more of the laboratory methods listed in the case definition under Laboratory Criteria for Diagnosis. Although other laboratory methods may be used in clinical diagnosis, if specific test methods are listed in a case definition, only those listed are accepted as laboratory confirmation for case-defining purposes.

Epidemiologically-linked case: A case in which a) the patient has had contact with one or more persons who either have/had the disease or have been exposed to a point source of infection (e.g., a single source of infection, such as an event leading to a foodborne-disease outbreak, to which all confirmed case-patients were exposed) and b) transmission of the agent by the usual modes of transmission for that agent is plausible. A case may be considered epidemiologically linked to a laboratory-confirmed case if at least one case in the chain of transmission is laboratory-confirmed.

Supportive or presumptive laboratory results: Specified laboratory results that are consistent with the diagnosis, yet do not meet the criteria for laboratory confirmation.

Clinically compatible case: A clinical syndrome generally compatible with the disease, as described in the clinical description.

Normally sterile site: An anatomic location, or tissue or body fluid from an anatomic location, in which microorganisms are not found in the absence of disease. See Appendix 1: Specimen types and Guidelines for determining “sterile” and “non-sterile” sites for additional guidelines.

Definition of an Epidemiologic Investigation

Arizona Administrative Code R9-6-101.33 (http://apps.azsos.gov/public_services/Title_09/9-06.pdf)

Epidemiologic investigation: The application of scientific methods to ascertain a diagnosis; identify risk factors for a disease; determine the potential for spreading a disease; institute control measures; and complete forms and reports such as communicable disease, case investigation, and outbreak reports.

Definition of Binational Case

A binational case refers to an individual with a confirmed, probable or suspect case of a reportable communicable disease, AND meeting one or more of the following criteria:

- Potentially exposed while in Mexico or Canada (travel to Mexico or Canada during the appropriate period when patient may have been infected)
- Potentially exposed by resident of Mexico or Canada
- Resident of Canada or Mexico
- Has case contacts in or from Mexico or Canada (e.g., potentially exposed by person who recently traveled to Mexico or Canada, epi-linked contact of a binational case).
- Exposure to suspected product from Canada or Mexico
- Other situations that may require binational notification or coordination of response (e.g., a measles outbreak without known cross-border contacts in a border community or state; exposure to an exported product from the U.S. to Canada or Mexico; sought medical attention and/or treatment in Canada or Mexico)

Arizona and Sonora will utilize Arizona's Medical Electronic Disease Intelligence System (MEDSIS) and/or secure email accounts to share all confidential information.

Cross-border investigations of binational cases will be determined on a case-by-case basis. During cross-border disease investigations of binational interest:

- Arizona health authorities will use Arizona's Communicable Disease Case Definition guide for epidemiologic investigations.
- Sonora health authorities will use Communicable Disease Case Definitions based on the Guidelines established by the Mexican Official Norms for Epidemiologic Surveillance (http://www.cdc.gov/USMexicoHealth/pdf/us-mexico-guidelines.pdf).

Modified 2015

Case Definitions for Communicable Morbidities Reportable in Arizona

ACUTE FLACCID MYELITIS (AFM)	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS

Cases should be reported under the emerging or exotic disease requirement. Enter in MEDSIS as Acute Flaccid Myelitis.

CASE DEFINITION

Background

Acute flaccid myelitis (AFM) is characterized by rapid onset of flaccid weakness in one or more limbs and distinct abnormalities of the spinal cord gray matter on magnetic resonance imaging (MRI). AFM is a subtype of acute flaccid paralysis (AFP), defined as acute onset of flaccid weakness absent features suggesting an upper motor neuron disorder. The term 'AFP' is a generalized 'umbrella' term, and includes multiple clinical entities including paralytic poliomyelitis, AFM, Guillain-Barré syndrome (GBS), acute transverse myelitis, toxic neuropathy, and muscle disorders.

Clinical Description

- An illness with onset of acute flaccid* weakness of one or more limbs, AND
- Absence of a clear alternative diagnosis attributable to a nationally notifiable condition.

Laboratory Criteria for Diagnosis

Confirmatory laboratory/imaging evidence

- A magnetic resonance image (MRI) showing spinal cord lesion with predominant gray matter involvement† and spanning one or more vertebral segments, AND
- Excluding persons with gray matter lesions in the spinal cord resulting from physician diagnosed malignancy, vascular disease, or anatomic abnormalities.

Presumptive laboratory/imaging evidence

- MRI showing spinal cord lesion where gray matter involvement† is present but predominance cannot be determined, AND
- Excluding persons with gray matter lesions in the spinal cord resulting from physician diagnosed malignancy, vascular disease, or anatomic abnormalities.

Supportive laboratory/imaging evidence

- MRI showing a spinal cord lesion in at least some gray matter† and spanning one or more vertebral segments, AND
- Excluding persons with gray matter lesions in the spinal cord resulting from physician diagnosed malignancy, vascular disease, or anatomic abnormalitites.

Other Classification Criteria

Autopsy findings that include histopathologic evidence of inflammation largely involving the anterior horn of the spinal cord spanning one or more vertebral segments.

Case Classification

Confirmed

- Meets clinical criteria with confirmatory laboratory/imaging evidence, OR
- Meets other classification criteria.

Probable
Meets clinical criteria with presumptive laboratory/imaging evidence.

Suspect

- Meets clinical criteria with supportive laboratory/imaging evidence, AND
- Available information is insufficient to classify case as probable or confirmed.

* Low muscle tone, limp, hanging loosely, not spastic or contracted.
† Terms in the spinal cord MRI report such as “affecting gray matter,” “affecting the anterior horn or anterior horn cells,” “affecting the central cord,” “anterior myelitis,” or “poliomyelitis” would all be consistent with this terminology.

Comment
To provide consistency in case classification, review of case information and assignment of final case classification for all suspected AFM cases will be done by experts in national AFM surveillance. This is similar to the review required for final classification of paralytic polio cases.

CONTROL MEASURES
Arizona Administrative Code R9-6-333 Emerging or Exotic Disease

Case Control Measures
A local health agency shall:
1. Upon receiving a report under R9-6-202 of an emerging or exotic disease case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. In consultation with the Department, isolate an emerging or exotic disease case or suspect case as necessary to prevent transmission;
3. Conduct an epidemiologic investigation of each reported emerging or exotic disease case or suspect case; and
4. For each emerging or exotic disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures
A local health agency, in consultation with the Department,
1. Shall quarantine or exclude an emerging or exotic disease contact as necessary, according to R9-6-303, to prevent transmission.

INVESTIGATION FORMS
See the Acute Flaccid Myelitis: Patient Summary Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2021
Most Recent CDC/CSTE Revision Year	2021
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2021: Updated clinical description, confimatory and presumptive laboratory evidence, and confirmed, probable, and suspect case classifications. Added supportive laboratory evidence and other classification criteria. 2020: Updated presumptive laboratory evidence and added a suspect case classification. Changes based on modifications to CDC/CSTE definition. 2018: Updated clinical description. National experts in AFM surveillance will determine the final case classification. 2016: CSTE approved a case definition for AFM in 2015 in order to standardize surveillance, although AFM is not nationally notifiable and is not explicitly reportable in Arizona at this time.

AMEBIASIS	PROVIDERS REPORT WITHIN 24 HRS IF AN OUTBREAK IS DETECTED OR PERSON HAS A HIGH-RISK OCCUPATION PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 DAYS FOR ALL OTHER CASES

CASE DEFINITION

Clinical Description

Amebiasis is an infection caused by the protozoan parasite *Entamoeba histolytica* that may be either intestinal or extraintestinal.

Intestinal amebiasis may result in an illness of variable severity ranging from mild, chronic diarrhea and abdominal pain to fulminant dysentery.

Extraintestinal infection may occur with either abscess (e.g., hepatic abscess) or radiographic findings consistent with extraintestinal infection. Liver involvement is most common, but other sites include pleura, peritoneum, pericardium and brain.

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence

- Intestinal amebiasis:
  - Demonstration of cysts or trophozoites of *E. histolytica* in stool (e.g., light microscopy of stained specimen, or ova & parasite (O&P) exam), OR
  - Demonstration of trophozoites in tissue biopsy or ulcer scrapings by culture or histopathology.
- Extraintestinal amebiasis:
  - Demonstration of specific antibody against *E. histolytica* as measured by IHA (indirect hemagglutination), or other immunodiagnostic test (e.g., enzyme immunoassay (EIA)).

Supportive Laboratory Evidence

- Intestinal amebiasis:
  - Detection of *E. histolytica* using a culture-independent diagnostic test (CIDT) (e.g., polymerase chain reaction [PCR]).

Epidemiologic Linkage

A person who has had contact with a case that meets the confirmatory laboratory criteria.

Case Classification

Confirmed

A clinically compatible case that meets the confirmatory laboratory criteria.

Probable

A clinically compatible case that is epidemiologically linked to either a confirmed intestinal or extraintestinal amebiasis case.

Suspect
A clinically compatible case that meets the supportive laboratory criteria.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment
Asymptomatic intestinal carriage of *E. histolytica* should not be considered a clinically compatible case. Serology is used for the diagnosis of extraintestinal disease only, and should be disregarded when considering intestinal infection. However, a positive serologic test does not necessarily indicate extraintestinal amebiasis if other components of the extraintestinal amebiasis are not met.

CONTROL MEASURES
Arizona Administrative Code R9-6-306 Amebiasis

Case control measures
A local health agency shall:

1. Exclude an amebiasis case or suspect case with diarrhea from:
    a. Working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
        i. Either:
            (1) Treatment with an amebicide is initiated, and
            (2) A stool specimen negative for amoebae is obtained from the amebiasis case or suspect case; or
        ii. The local health agency has determined that the amebiasis case or suspect case is unlikely to infect other individuals; and
    b. Using an aquatic venue for two weeks after diarrhea has resolved;
2. Conduct an epidemiologic investigation of each reported amebiasis case or suspect case; and
3. For each amebiasis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS
See Amebiasis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2020
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A

Description of changes	2020: Revised the criteria for extraintestinal amebiasis (clinical description, laboratory evidence) and clarified that compatible symptoms must be present for all classifications (confirmed, probable, suspect). 2019: Added supportive laboratory criteria and suspect classification to allow for CIDT. Added probable classification for epi-linkage.

ANAPLASMOSIS	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description
A tick-borne illness characterized by acute onset of fever and one or more of the following signs or symptoms: headache, myalgia, malaise, anemia, leukopenia, thrombocytopenia, or elevated liver enzymes. Nausea, vomiting, or rash may be present in some cases.

Intracytoplasmic bacterial aggregates (morulae) may be visible in the leukocytes of some patients. There are at least three species of bacteria responsible for ehrlichiosis/anaplasmosis in the U.S.: *Ehrlichia chaffeensis*, found primarily in monocytes, and *Anaplasma phagocytophilum* and *Ehrlichia ewingii*, found primarily in granulocytes*. For cases with evidence of *Ehrlichia* spp. infection, see the Ehrlichiosis case definition.

Human anaplasmosis caused by *Anaplasma phagocytophilum* (formerly Human Granulocytic Ehrlichiosis or HGE) should be reported and entered as anaplasmosis. Human ehrlichiosis caused by *E. chaffeensis* (formerly Human Monocytic Ehrlichiosis or HME) or *E. ewingii* (formerly unspecified or other agent), or undetermined ehrlichiosis/anaplasmosis should be reported and entered as ehrlichiosis.

*Note: The clinical signs of disease from infection with these agents are similar, and the range distributions overlap, so testing for one or more species may be indicated. Serologic cross-reactions may occur among tests for these agents.

Clinical evidence
Any reported fever and one or more of the following: headache, myalgia, anemia, leukopenia, thrombocytopenia, or any hepatic transaminase elevation.

Exposure
History of having been in potential tick habitat in the 14 days prior to the onset of illness or history of tick bite.

Laboratory Criteria for Surveillance

Anaplasma phagocytophilum infection (formerly HGE):

Confirmatory Testing

- Serological evidence of a four-fold change in IgG-specific antibody titer to *A. phagocytophilum* antigen by IFA in paired serum samples, OR
- Detection of *A. phagocytophilum* DNA in a clinical specimen via PCR assay, OR
- Demonstration of anaplasma antigen in a biopsy or autopsy sample by IHC, OR
- Isolation of *A. phagocytophilum* from a clinical specimen in cell culture.

Presumptive Testing

- Serological evidence of elevated IgG or IgM antibody reactive with *A. phagocytophilum* antigen by IFA, ELISA, dot-ELISA, or assays in other acceptable formats, OR
- Identification of morulae in the cytoplasm of neutrophils or eosinophils by microscopic examination.

Human ehrlichiosis/anaplasmosis - undetermined:
See the Ehrlichiosis case definition.

Case Classification

Confirmed
A clinically compatible case that meets the criteria for clinical evidence criteria and for confirmatory laboratory testing.

Probable
A clinically compatible case that meets clinical evidence criteria and has presumptive laboratory results. For ehrlichiosis/anaplasmosis, an undetermined case can only be classified as probable. An undetermined case has compatible clinical criteria with lab evidence to support ehrlichia/anaplasma infection, but not with sufficient clarity to definitively place it in one of the categories described. This may include identification of morulae in white cells by microscopic examination in the absence of other presumptive lab results.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment
Problem cases for which sera demonstrate elevated antibody IFA responses to more than a single infectious agent are usually resolvable by comparing the levels of the antibody responses, the greater antibody response generally being that directed at the actual agent involved. Tests of additional sera and further evaluation using PCR, IHC, and isolation via cell culture may be needed for further clarification. Cases involving persons infected with more than a single agent, while possible, are extremely rare and every effort should be made to resolve cases that appear as such by other explanations.

Current commercially available ELISA tests are not quantitative, cannot be used to evaluate changes in antibody titer, and are not useful for serological confirmation. IgM tests are not always specific and the IgM response may be persistent. IgM tests are not strongly supported for use in serodiagnosis of acute disease.

CONTROL MEASURES
Arizona Administrative Code R9-6-307 Anaplasmosis

Case Control Measures
A local health agency shall:

1. Conduct an epidemiologic investigation of each reported anaplasmosis case or suspect case; and
2. For each anaplasmosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Tick-Borne Rickettsial Disease Case Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2012
Most Recent CDC/CSTE Revision Year	2008
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2018: Anaplasmosis split from ehrlichiosis, compatible with the listing in the reportable disease rules. ADHS case definitions revised in 2012 to match CDC/CSTE.

ANTHRAX (*Bacillus anthracis*)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

CASE DEFINITION

Clinical Description

- Cutaneous anthrax: It usually begins as a small, painless, pruritic papule on an exposed surface, which progresses through a vesicular stage into a depressed black eschar; the eschar is often surrounded by edema or erythema and may be accompanied by lymphadenopathy. Fever is also common.
- Ingestion anthrax: presents as two sub-types:
    - Oropharyngeal: When anthrax spores germinate in the oropharynx, a mucosal lesion may be observed in the oral cavity or oropharynx. Symptoms include sore throat, difficulty swallowing, and swelling of the neck. Less specific symptoms include fever, fatigue, shortness of breath, abdominal pain, and nausea/vomiting; the symptoms may resemble a viral respiratory illness. Cervical lymphadenopathy, ascites, and altered mental status may be observed.
    - Gastrointestinal: When anthrax spores germinate in the lower gastrointestinal tract, symptoms include abdominal pain, nausea, vomiting or diarrhea (either of which may contain blood), and abdominal swelling. Less specific symptoms such as fever, fatigue, and headache are also common. Altered mental status and ascites may be observed.
- Inhalation anthrax: Often described as a biphasic illness. Early nonspecific symptoms of inhalation anthrax include fever and fatigue. Localized thoracic symptoms such as cough, chest pain, and shortness of breath follow, as may non-thoracic symptoms such as nausea, vomiting, abdominal pain, headache, diaphoresis, and altered mental status. Lung sounds are often abnormal and imaging often shows pleural effusion or mediastinal widening.
- Injection anthrax: Usually presents as a severe soft tissue infection manifested as significant edema or bruising after an injection. No eschar is apparent, and pain is often not described. Nonspecific symptoms such as fever, shortness of breath, or nausea are sometimes the first indication of illness. Occasionally patients present with meningeal or abdominal involvement. A coagulopathy is not unusual.

Additional considerations:

1) Signs of systemic involvement from the dissemination of either the bacteria and/or its toxins can occur with all types of anthrax and include fever or hypothermia, tachycardia, tachypnea, hypotension, and leukocytosis. One or more of these signs are usually present in patients with ingestion anthrax, inhalation anthrax, and injection anthrax and may be present in up to a third of patients with cutaneous anthrax.

2) Anthrax meningitis: may complicate any form of anthrax, and may also be a primary manifestation. Primary symptoms include fever, headache (which is often described as severe), nausea, vomiting, and fatigue. Meningeal signs (e.g., meningismus), altered mental status, and other neurological signs such as seizures or focal signs are usually present. Most patients with anthrax meningitis have CSF abnormalities consistent with bacterial meningitis, and the CSF is often described as hemorrhagic.

Clinical Criteria for Diagnosis

- For surveillance purposes, an illness with at least one specific OR two non-specific symptoms and signs that are compatible with cutaneous, ingestion, inhalation, or injection anthrax; systemic involvement; or anthrax meningitis; OR
- A death of unknown cause AND organ involvement consistent with anthrax.

Laboratory Criteria for Diagnosis

Confirmatory laboratory criteria for* Bacillus anthracis *or* Bacillus cereus *expressing anthrax toxins:

- Culture and identification from clinical specimens by Laboratory Response Network (LRN);
- Demonstration of *B. anthracis* antigens in tissues by immunohistochemical staining using both *B. anthracis* cell wall and capsule monoclonal antibodies;
- Evidence of a four-fold rise in antibodies to protective antigen between acute and convalescent sera or a fourfold change in antibodies to protective antigen in paired convalescent sera using Centers for Disease Control and Prevention (CDC) quantitative anti-PA IgG ELISA testing in an unvaccinated person;
- Detection of *B. anthracis* or anthrax toxin genes by the LRN-validated polymerase chain reaction and/ or sequencing in clinical specimens collected from a normally sterile site (such as blood or CSF) or lesion of other affected tissue (skin, pulmonary, reticuloendothelial, or gastrointestinal);
- Detection of lethal factor (LF) in clinical serum specimens by LF mass spectrometry.

Presumptive laboratory criteria for* Bacillus anthracis *or* Bacillus cereus *expressing anthrax toxins:

- Gram stain demonstrating Gram-positive rods, square-ended, in pairs or short chains;
- Positive result on a test with established performance in a CLIA-accredited laboratory.

Epidemiologic Linkage

- Exposure to environment, food, animal, materials, or objects that is suspect or confirmed to be contaminated with *B. anthracis*;
- Exposure to the same environment, food, animal, materials, or objects as another person who has laboratory-confirmed anthrax;
- Consumption of the same food as another person who has laboratory-confirmed anthrax.

Case Classification

Confirmed
A case that meets the clinical criteria AND has confirmatory laboratory results.

Probable
A case that meets the clinical criteria AND has presumptive laboratory results, OR
A case that meets the clinical criteria AND has epidemiologic evidence relating it to anthrax.

Suspect
A case that meets the clinical criteria AND for whom an anthrax test was ordered, but with no epidemiologic evidence relating it to anthrax.

Criteria to Distinguish a New Case from an Existing Case
A case should never be counted as a new case if there was a previously reported infection in the same individual.

CONTROL MEASURES
Arizona Administrative Code R9-6-308 Anthrax

Case Control Measures
A local health agency shall:
1. Upon receiving a report under R9-6-202 of an anthrax case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported anthrax case or suspect case;
3. For each anthrax case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that an isolate or a specimen, as available, from each anthrax case or suspect case is submitted to the Arizona State Laboratory.

Environmental Control Measures:
A local health agency shall:
1. Provide or arrange for disinfection of areas or objects contaminated by *Bacillus anthracis* through sterilization by dry heating, incineration of objects, or other appropriate means.

INVESTIGATION FORMS
See Anthrax Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2018
Most Recent CDC/CSTE Revision Year	2018
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2018: Updated clinical description, removed meningeal anthrax, added injection anthrax. Added clinical criteria for diagnosis and criteria for epidemiologic linkage. Updated lab testing.

ARBOVIRAL INFECTION	PROVIDERS SUBMIT A REPORT WITHIN 5 WORKING DAYS LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Includes:

- California Serogroup Viruses (including California encephalitis, Jamestown Canyon, Keystone, La Crosse, Snowshoe hare, and Trivittatus viruses)
- Chikungunya (see Chikungunya page for Control Measures)
- Eastern Equine Encephalitis Virus
- Powassan Virus
- St. Louis Encephalitis Virus
- West Nile Virus (see West Nile Virus page for Control Measures)
- Western Equine Encephalitis Virus

For Dengue, Yellow Fever, or Zika Virus, please see the separately listed case definitions.

Background

Arthropod-borne viruses (arboviruses) are transmitted to humans primarily through the bites of infected mosquitoes, ticks, sand flies, or midges. Other modes of transmission for some arboviruses include blood transfusion, organ transplantation, perinatal transmission, consumption of unpasteurized dairy products, breast feeding, and laboratory exposures.

More than 130 arboviruses are known to cause human disease. Most arboviruses of public health importance belong to one of three virus genera: Flavivirus, Alphavirus, and Bunyavirus.

Clinical Description

Most arboviral infections are asymptomatic. Clinical disease ranges from mild febrile illness to severe encephalitis. For the purposes of surveillance and reporting, based on their clinical presentation, arboviral disease cases are often categorized into two primary groups: neuroinvasive disease and non-neuroinvasive disease.

Neuroinvasive disease: Many arboviruses cause neuroinvasive disease such as aseptic meningitis, encephalitis, or acute flaccid paralysis (AFP). These illnesses are usually characterized by the acute onset of fever with stiff neck, altered mental status, seizures, limb weakness, cerebrospinal fluid (CSF) pleocytosis, or abnormal neuroimaging. AFP may result from anterior ("polio") myelitis, peripheral neuritis, or post-infectious peripheral demyelinating neuropathy (i.e., Guillain-Barré syndrome). Less common neurological manifestations, such as cranial nerve palsies, also occur.

Non-neuroinvasive disease: Most arboviruses are capable of causing an acute systemic febrile illness (e.g., West Nile fever) that may include headache, myalgias, arthralgias, rash, or gastrointestinal symptoms. Some viruses also can cause more characteristic clinical manifestations, such as severe polyarthralgia or arthritis due to Chikungunya virus or other alphaviruses (e.g., Mayaro, Ross River, O'nyong-nyong).

Clinical Criteria for Diagnosis

A clinically compatible case of arboviral disease is defined as follows:

Neuroinvasive disease

- Meningitis, encephalitis, acute flaccid paralysis, or other acute signs of central or peripheral neurologic dysfunction, as documented by a physician, AND
- Absence of a more likely clinical explanation. Other clinically compatible symptoms of arbovirus disease include: headache, myalgia, rash, arthralgia, vertigo, vomiting, paresis and/ or nuchal rigidity.

Non-neuroinvasive disease

- Fever or chills as reported by the patient or a health-care provider, AND
- Absence of neuroinvasive disease, AND
- Absence of a more likely clinical explanation. Other clinically compatible symptoms of arbovirus disease include: headache, myalgia, rash, arthralgia, vertigo, vomiting, paresis and/ or nuchal rigidity.

Laboratory Criteria for Diagnosis

- Isolation of virus from, or demonstration of specific viral antigen or nucleic acid in, tissue, blood, CSF, or other body fluid, OR
- Four-fold or greater change in virus-specific quantitative antibody titers in paired sera, OR
- Virus-specific IgM antibodies in serum with confirmatory virus-specific neutralizing antibodies in the same or a later specimen, OR
- Virus-specific IgM antibodies in CSF or serum.

Case Classification

Confirmed

Neuroinvasive Disease

A case that meets the above clinical criteria for neuroinvasive disease and one or more the following laboratory criteria for a confirmed case:

- Isolation of virus from, or demonstration of specific viral antigen or nucleic acid in, tissue, blood, CSF, or other body fluid, OR
- Four-fold or greater change in virus-specific quantitative antibody titers in paired sera, OR
- Virus-specific IgM antibodies in serum with confirmatory virus-specific neutralizing antibodies in the same or a later specimen, OR
- Virus-specific IgM antibodies in CSF, with or without a reported pleocytosis, and a negative result for other IgM antibodies in CSF for arboviruses endemic to the region where exposure occurred.

Non-neuroinvasive Disease

A case that meets the above clinical criteria for non-neuroinvasive disease and one or more of the following laboratory criteria for a confirmed case:

- Isolation of virus from, or demonstration of specific viral antigen or nucleic acid in, tissue, blood,

CSF, or other body fluid, OR
- Four-fold or greater change in virus-specific quantitative antibody titers in paired sera, OR
- Virus-specific IgM antibodies in serum with confirmatory virus-specific neutralizing antibodies in the same or a later specimen.

Probable

Neuroinvasive Disease
A case that meets the above clinical criteria for neuroinvasive disease and the following laboratory criteria:
- Virus-specific IgM antibodies in CSF or serum but with no other testing.

Non-neuroinvasive Disease
A case that meets the above clinical criteria for non-neuroinvasive disease and the laboratory criteria for a probable case:
- Virus-specific IgM antibodies in serum but with no other testing.

Suspect
A case that meets the above clinical criteria for either neuroinvasive or non-neuroinvasive disease and the following laboratory criteria:
- Serologic (IgM) evidence of a flavivirus infection, but indistinguishable results by available testing.

Additional Guidance
Due to serologic cross-reactivity, differentiating between similar flaviviruses with positive results for virus-specific IgM antibodies can be challenging. In some instances, the ratio of serologic results can be used to assign a probable case classification. When testing cannot distinguish between specific viruses, the case should be classified as a probable case of unspecified flavivirus.

Refer to the Arizona Case Classification Algorithm for West Nile Virus & St. Louis Encephalitis Virus, or contact the vector-borne disease staff at 602-364-3676 for guidance on a case-specific basis.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within12 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment

Interpreting Arboviral Laboratory Results

- **Serologic cross-reactivity**. In some instances, arboviruses from the same genus produce cross-reactive antibodies. In geographic areas where two or more closely-related arboviruses occur, serologic testing for more than one virus may be needed and results compared to determine the specific causative virus. For example, such testing might be needed to distinguish antibodies resulting from infections within genera, e.g., flaviviruses such as West Nile, St. Louis encephalitis, Powassan, Dengue, or Japanese encephalitis viruses.

- **Rise and fall of IgM antibodies**. For most arboviral infections, IgM antibodies are generally first detectable at 3 to 8 days after onset of illness and persist for 30 to 90 days, but longer persistence has been documented (e.g., up to 500 days for West Nile virus). Serum collected within 8 days of illness onset may not have detectable IgM and testing should be repeated on a convalescent-phase sample to rule out arboviral infection in those with a compatible clinical syndrome.
- **Persistence of IgM antibodies**. Arboviral IgM antibodies may be detected in some patients months or years after their acute infection. Therefore, the presence of these virus-specific IgM antibodies may signify a past infection and be unrelated to the current acute illness. Finding virus-specific IgM antibodies in CSF or a fourfold or greater change in virus-specific antibody titers between acute- and convalescent-phase serum specimens provides additional laboratory evidence that the arbovirus was the likely cause of the patient's recent illness. Clinical and epidemiologic history also should be carefully considered.
- **Persistence of IgG and neutralizing antibodies**. Arboviral IgG and neutralizing antibodies can persist for many years following a symptomatic or asymptomatic infection. Therefore, the presence of these antibodies alone is only evidence of previous infection and clinically compatible cases with the presence of IgG, but not IgM, should be evaluated for other etiologic agents.
- **Arboviral serologic assays**. Assays for the detection of IgM and IgG antibodies commonly include enzyme-linked immunosorbent assay (ELISA), microsphere immunoassay (MIA), or immunofluorescence assay (IFA). These assays provide a presumptive diagnosis and should have confirmatory testing performed. Confirmatory testing involves the detection of arboviral-specific neutralizing antibodies utilizing assays such as plaque reduction neutralization test (PRNT).
- **Other information to consider**. Vaccination history, detailed travel history, date of onset of symptoms, and knowledge of potentially cross-reactive arboviruses known to circulate in the geographic area should be considered when interpreting results.

Imported Arboviral Diseases
Human disease cases due to Dengue, Yellow fever, or Zika viruses are nationally notifiable to CDC using specific case definitions; many other nationally notifiable arboviruses are covered by this case definition. Many other exotic arboviruses (e.g., Chikungunya, Japanese encephalitis, Tick-borne encephalitis, Venezuelan equine encephalitis, and Rift Valley fever viruses) are important public health risks for the United States as competent vectors exist that could allow for sustained transmission upon establishment of imported arboviral pathogens. Health-care providers and public health officials should maintain a high index of clinical suspicion for cases of potentially exotic or unusual arboviral etiology, particularly in international travelers. If a suspected case occurs, it should be reported to the appropriate local/state health agencies and CDC.

CONTROL MEASURES

Arizona Administrative Code R9-6-309 Arboviral Infection

Case Control Measures:
A local health agency shall:

1. Conduct an epidemiologic investigation of each reported arboviral infection case or suspect case;
2. For each arboviral infection case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and

3. Ensure that each arboviral infection case is provided with health education that includes measures to:
    a. Avoid mosquito bites, and
    b. Reduce mosquito breeding sites.

Environmental Control Measures:
A local health agency shall:

1. Conduct an assessment of the environment surrounding each arboviral infection case or suspect case and implement vector control measures as necessary.

INVESTIGATION FORMS

For Dengue, Chikungunya, and Zika see the Dengue Case Investigation Form, Chikungunya Case Investigation Form, and Zika Case Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

For other Arboviral diseases see the Arboviral Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017 (with 2020 addition of a hyperlink to the Case Classification Algorithm)
Most Recent CDC/CSTE Revision Year	2015
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2020: Added a hyperlink to the Case Classification Algorithm. 2017: Zika virus was removed from the list of arboviruses for this case definition, because a separate Zika virus case definition was created. A comment regarding unspecified flavivirus was added to the Additional Guidance. 2016: After the 2015 WNV/SLE outbreak in Arizona a suspect case definition and a note on additional guidance were added. These changes are not present in the CDC/CSTE case definitions. Zika virus was also added to the list of arboviruses. 2015: Chikungunya virus was added to the list of arboviruses included in the case definition. The list of clinically compatible symptoms was expanded. Both changes match CDC/CSTE changes.

	2014: Clinical criteria revised to accept subjective fever or chills in place of measured temperature; modification of laboratory criteria to exclude “Virus-specific IgM antibodies in CSF and a negative result for other IgM antibodies in CSF for arboviruses endemic to the region where exposure occurred” from the confirmed non-neuroinvasive definition and elimination of “IgM antibodies in CSF” from the probable non-neuroinvasive definition; changes were made to match the 2014 CDC/CSTE case definitions. 2013: Section moved from West Nile Virus to Arboviral Diseases. Material within the section is identical. .

BABESIOSIS	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

Babesiosis is a parasitic disease caused by intraerythrocytic protozoa of the *Babesia* genus (*Babesia microti* and other species). *Babesia* are transmitted in nature through the bites of infected ticks but can also be acquired through contaminated blood components from asymptomatic parasitemic donors or, more rarely, transplacentally. *Babesia* infection can range from subclinical to life-threatening. Clinical manifestations, if any, can include hemolytic anemia and nonspecific influenza-like signs and symptoms (e.g., fever, chills, sweats, headache, myalgia, arthralgia, malaise, fatigue, generalized weakness). Splenomegaly, hepatomegaly, or jaundice may be evident. In addition to signs of hemolytic anemia, laboratory findings may include thrombocytopenia, proteinuria, hemoglobinuria, and elevated levels of liver enzymes, blood urea nitrogen, and creatinine. Risk factors for severe babesiosis include asplenia, advanced age, and other causes of impaired immune function (e.g., HIV, malignancy, corticosteroid therapy). Some immunosuppressive therapies or conditions may mask or modulate the clinical manifestations (e.g., the patient may be afebrile). Severe cases can be associated with marked thrombocytopenia, disseminated intravascular coagulation, hemodynamic instability, acute respiratory distress, myocardial infarction, renal failure, hepatic compromise, altered mental status, and death.

Clinical Evidence

For the purposes of surveillance:

- Objective: one or more of the following: fever, anemia, or thrombocytopenia.
- Subjective: one or more of the following: chills, sweats, headache, myalgia, or arthralgia.

Laboratory Criteria for Diagnosis

For the purposes of surveillance:

Laboratory confirmatory

- Identification of intraerythrocytic *Babesia* organisms by light microscopy in a Giemsa, Wright, or Wright-Giemsa–stained blood smear; or
- Detection of *Babesia microti* DNA in a whole blood specimen by polymerase chain reaction (PCR); or
- Detection of *Babesia* spp. genomic sequences in a whole blood specimen by nucleic acid amplification; or
- Isolation of *Babesia* organisms from a whole blood specimen by animal inoculation.

Laboratory supportive

- Demonstration of a *Babesia microti* Indirect Fluorescent Antibody (IFA) total immunoglobulin (Ig) or IgG antibody titer of greater than or equal to (≥) 1:256 (or ≥1:64 in epidemiologically linked blood donors or recipients); or
- Demonstration of a *Babesia microti* Immunoblot IgG positive result; or
- Demonstration of a *Babesia divergens* IFA total Ig or IgG antibody titer of greater than or equal to (≥) 1:256; or

- Demonstration of a *Babesia duncani* IFA total Ig or IgG antibody titer of greater than or equal to (≥) 1:512.

Epidemiologic Evidence for Transfusion Transmission

For the purposes of surveillance, epidemiologic linkage between a transfusion recipient and a blood donor is demonstrated if all of the following criteria are met:

a. In the transfusion recipient:

   i. Received one or more red blood cell (RBC) or platelet transfusions within one year before the collection date of a specimen with laboratory evidence of *Babesia* infection; and
   ii. At least one of these transfused blood components was donated by the donor described below; and
   iii. Transfusion-associated infection is considered at least as plausible as tick-borne transmission; and

b. In the blood donor:

   i. Donated at least one of the RBC or platelet components that was transfused into the above recipient; and
   ii. The plausibility that this blood component was the source of infection in the recipient is considered equal to or greater than that of blood from other involved donors. (More than one plausible donor may be linked to the same recipient.)

Case Classification

Confirmed

A case that has confirmatory laboratory results and meets at least one of the objective or subjective clinical evidence criteria, regardless of the mode of transmission (can include clinically manifest cases in transfusion recipients or blood donors).

Probable

- A case that has supportive laboratory results and meets at least one of the objective clinical evidence criteria (subjective criteria alone are not sufficient); OR
- A case that is in a blood donor or recipient epidemiologically linked to a confirmed or probable babesiosis case (as defined above) and:
  - has confirmatory laboratory evidence but does not meet any objective or subjective clinical evidence criteria; or
  - has supportive laboratory evidence and may or may not meet any subjective clinical evidence criteria but does not meet any objective clinical evidence criteria.

Suspect

A case that has confirmatory or supportive laboratory results, but insufficient clinical or epidemiologic information is available for case classification (e.g., only a laboratory report was provided).

Comment

The validity of the diagnosis of babesiosis is highly dependent on the laboratory that performs the testing. For example, differentiation between Plasmodium and *Babesia* organisms on peripheral blood

smears can be difficult. Confirmation of the diagnosis of babesiosis by a reference laboratory is strongly encouraged, especially for patients without residence in or travel to areas known to be endemic for babesiosis.

A positive *Babesia* IFA result for immunoglobulin M (IgM) is insufficient for diagnosis and case classification of babesiosis in the absence of a positive IFA result for IgG (or total Ig). If the IgM result is positive but the IgG result is negative, a follow-up blood specimen drawn at least one week after the first should be tested. If the IgG result remains negative in the second specimen, the IgM result likely was a false positive.
When interpreting IFA IgG or total Ig results, it is helpful to consider factors that may influence the relative magnitude of *Babesia* titers (e.g., timing of specimen collection relative to exposure or illness onset, the patient's immune status, the presence of clinically manifest versus asymptomatic infection). In immunocompetent persons, active or recent *Babesia* infections that are symptomatic are generally associated with relatively high titers (although antibody levels may be below the detection threshold early in the course of infection); titers can then persist at lower levels for more than a year. In persons who are immunosuppressed or who have asymptomatic *Babesia* infections, active infections can be associated with lower titers.

Babesia microti is the most frequently identified agent of human babesiosis in the United States; most reported tick-borne cases have been acquired in parts of northeastern and north-central regions. Sporadic U.S. cases caused by other *Babesia* agents include *B. duncani* (formerly the WA1 parasite) and related organisms (CA1-type parasites) in several western states as well as parasites characterized as "*B. divergens* like" (MO1 and others) in various states. Serologic and molecular tests available for *B. microti* infection do not typically detect these other *Babesia* agents.

Blood-borne transmission of *Babesia* is not restricted by geographic region or season. The epidemiologic linkage criteria for transfusion transmission that are described here provide a low threshold for asymptomatic donor or recipient cases to be considered probable cases for surveillance purposes and are not intended to be regulatory criteria. Transfusion investigations entail laboratory testing for evidence of *Babesia* infection in recipients and donors as well as epidemiologic assessments of the plausibility of blood- and tick-borne transmission.

CONTROL MEASURES

Arizona Administrative Code R9-6-310 Babesiosis

Case Control Measures
A local health agency shall:

1. Conduct an epidemiologic investigation of each reported babesiosis case or suspect case; and
2. For each babesiosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Babesiosis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2011
Most Recent CDC/CSTE Revision Year	2011
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

BASIDIOBOLOMYCOSIS	PROVIDERS SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

A disease consistent with clinical presentation and/or:

- Subcutaneous nodules that are firm and painful;
- Nodules that involve the muscle;
- Nodules or inflammatory mass that involves the gastrointestinal tract or other organs

Laboratory Criteria for Diagnosis

- Biopsy with microscopic appearance consistent with *Basidiobolus ranarum* (septate hyphae with eosinophilic infiltration), OR
- Isolation of *B. ranarum* from culture of a mass, OR
- A positive serologic result for *Basidiobolus*

Case Classification

Confirmed

A clinically compatible illness that is laboratory confirmed.

CONTROL MEASURES

Arizona Administrative Code R9-6-311 Basidiobolomycosis

Case Control Measures

A local health agency shall:

1. Conduct an epidemiologic investigation of each reported basidiobolomycosis case or suspect case; and
2. For each basidiobolomycosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Basidiobolomycosis Questionnaire at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2006
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

BOTULISM	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

CASE DEFINITION

Subtypes

- Botulism, foodborne
- Botulism, wound
- Botulism, other

Botulism, Foodborne

Clinical Description
Ingestion of botulinal toxin results in an illness of variable severity. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

Laboratory Criteria for Diagnosis

- Detection of botulinum toxin in serum, stool, or patient's food, OR
- Isolation of *Clostridium botulinum* from stool

Case Classification

Confirmed
A clinically compatible case that is laboratory confirmed or that occurs among persons who ate the same food as persons with laboratory confirmed botulism.

Probable
A clinically compatible case with an epidemiologic link to a suspect food item (e.g. home-canned foods within the previous 48 hours)

Botulism, Wound

Clinical Description
An illness resulting from toxin produced *by Clostridium botulinum* that has infected a wound. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

Laboratory Criteria for Diagnosis

- Detection of botulinum toxin in serum, OR
- Isolation of *Clostridium botulinum* from wound

Case Classification

Confirmed
A clinically compatible illness that is laboratory confirmed in a patient who has no suspected exposure to contaminated food and who has either a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms, or a history of injection drug use within the 2 weeks before onset of symptoms.

Probable
A clinically compatible case in a patient who has no suspected exposure to contaminated food and who has either a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms, or a history of injection drug use within the 2 weeks before onset of symptoms.

Botulism, Other

Clinical Description
Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

Laboratory Criteria for Diagnosis:

- Detection of botulinum toxin in clinical specimen, or
- Isolation of *Clostridium botulinum* from clinical specimen

Case Classification

Confirmed
An illness clinically compatible with botulism that is laboratory confirmed among patients ≥1 year of age without histories of ingestion of suspect food and without wounds.

Comment
Botulism may be diagnosed without laboratory confirmation if the clinical and epidemiologic evidence is overwhelming.

CONTROL MEASURES
Arizona Administrative Code R9-6-312 Botulism, Foodborne, Wound, Other

Case Control Measures
A local health agency shall:

1. Upon receiving a report under R9-6-202 of a botulism case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported botulism case or suspect case; and
3. For each botulism case or suspect case:
    a. Submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
    b. Ensure that one or more specimens from each botulism case or suspect case are submitted to the Arizona State Laboratory.

Environmental Control Measures:
An individual in possession of:

1. Food known to be contaminated by Clostridium botulinum or Clostridium botulinum toxin shall boil the contaminated food for 10 minutes and then discard it, and
2. Utensils known to be contaminated by Clostridium botulinum or Clostridium botulinum toxin shall boil the contaminated utensils for 10 minutes before reuse or disposal.

INVESTIGATION FORMS

See the Botulism Adult Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2012
Most Recent CDC/CSTE Revision Year	2011
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	ADHS case definition was edited in 2012 to match CDC/CSTE

BOTULISM, INFANT	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

CASE DEFINITION

Clinical Description
An illness of infants, characterized by constipation, poor feeding, and "failure to thrive" that may be followed by progressive weakness, impaired respiration, and death.

Laboratory Criteria for Diagnosis

- Detection of botulinum toxin in stool or serum, OR
- Isolation of *Clostridium botulinum* from stool

Case Classification

Confirmed
A clinically compatible case that is laboratory-confirmed, occurring among children aged less than 1 year.

CONTROL MEASURES
Arizona Administrative Code R9-6-312 Botulism

Case Control Measures
A local health agency shall:
1. Upon receiving a report under R9-6-202 of a botulism case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported botulism case or suspect case; and
3. For each botulism case or suspect case:
    a. Submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
    b. Ensure that one or more specimens from each botulism case or suspect case are submitted to the Arizona State Laboratory.

Environmental Control Measures:
An individual in possession of:
1. Food known to be contaminated by Clostridium botulinum or Clostridium botulinum toxin shall boil the contaminated food for 10 minutes and then discard it, and
2. Utensils known to be contaminated by Clostridium botulinum or Clostridium botulinum toxin shall boil the contaminated utensils for 10 minutes before reuse or disposal.

INVESTIGATION FORMS
See the Botulism Infant Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2011
Most Recent CDC/CSTE Revision Year	2011
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

BRUCELLOSIS	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description

An illness characterized by acute or insidious onset of fever and one or more of the following: night sweats, arthralgia, headache, fatigue, anorexia, myalgia, weight loss, arthritis/spondylitis, meningitis, or focal organ involvement (endocarditis, orchitis/epididymitis, hepatomegaly, splenomegaly).

Laboratory Criteria for Diagnosis

Confirmatory Testing

- Culture and identification of *Brucella* spp. from clinical specimens
- Evidence of a fourfold or greater rise in *Brucella* antibody titer between acute- and convalescent-phase serum specimens obtained greater than or equal to 2 weeks apart.

Presumptive Testing

- *Brucella* total antibody titer of greater than or equal to 160 by standard tube agglutination test (SAT) or *Brucella* microagglutination test (BMAT) in one or more serum specimens obtained after onset of symptoms.
- Detection of *Brucella* DNA in a clinical specimen by PCR assay.

Case Classification

Confirmed

A clinically compatible illness with confirmatory laboratory evidence of *Brucella* infection

Probable

A clinically compatible illness with at least one of the following:

- Epidemiologically linked to a confirmed human or animal brucellosis case
- Presumptive laboratory evidence, but without definitive laboratory evidence, of *Brucella* infection

Criteria to Distinguish a New Case from an Existing Case*

A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

CONTROL MEASURES

Arizona Administrative Code R9-6-313 Brucellosis

Case Control Measures

A local health agency shall:

1. Conduct an epidemiologic investigation of each reported brucellosis case or suspect case;

2. For each brucellosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
3. Ensure that an isolate or a specimen, as available, from each brucellosis case is submitted to the Arizona State Laboratory.

INVESTIGATION FORMS

See the Brucellosis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2010
Most Recent CDC/CSTE Revision Year	2010
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

CAMPYLOBACTERIOSIS	PROVIDERS REPORT WITHIN 24 HOURS IF AN OUTBREAK IS DETECTED OR PERSON HAS A HIGH-RISK OCCUPATION PROVIDERES AND LABORATORIES SUBMIT A REPORT WITHIN 5 DAYS FOR ALL OTHER CASES

CASE DEFINITION

Clinical Description
An illness of variable severity commonly manifested by diarrhea, abdominal pain, nausea and sometimes vomiting. The organism may also rarely cause extra-intestinal infections such as bacteremia, meningitis or other focal infections.

Laboratory Criteria for Diagnosis

Confirmatory Testing
Isolation of *Campylobacter* spp. from a clinical specimen.

Presumptive Testing
Detection of *Campylobacter* spp. in a clinical specimen using culture-independent diagnostic tests (CIDTs).

Case Classification

Confirmed
A case that meets the confirmatory laboratory criteria.

Probable
A case that meets the presumptive laboratory criteria; or

A clinically compatible case that is epidemiologically linked to a case that meets the confirmatory or presumptive laboratory criteria for diagnosis.

Criteria to Distinguish a New Case from an Existing Case
A case should not be counted as a new case if laboratory results were reported within 30 days of a previously reported infection in the same individual.

Comment
The use of CIDTs as stand-alone tests for the direct detection of Campylobacter in stool is increasing. Data regarding their performance indicate variability in the sensitivity, specificity, and positive predictive value of these assays depending on the manufacturer (CDC unpublished data). Culture confirmation of CIDT-positive specimens is ideal, but not practical to achieve in most jurisdictions.

CONTROL MEASURES
Arizona Administrative Code R9-6-314 Campylobacteriosis

Case Control Measures
A local health agency shall:

1. Exclude a campylobacteriosis case or suspect case with diarrhea from:
    a. Working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
        i. Diarrhea has resolved,
        ii. A stool specimen negative for *Campylobacter* spp. is obtained from the campylobacteriosis case or suspect case, or
        iii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
    b. Using an aquatic venue until diarrhea has resolved;
2. Conduct an epidemiologic investigation of each reported campylobacteriosis case or suspect case; and
3. For each campylobacteriosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Campylobacteriosis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	2015
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2017: Added criteria to distinguish a new case from an existing case to match 2014 CDC/CSTE case definition. In 2015, CDC/CSTE modified the case definition for probable cases to include illnesses with positive culture-independent diagnostic tests (CIDTs). The previously suspect cases now count as probable and the suspect case classification has been eliminated. 2012: CDC/CSTE added suspect laboratory criteria for diagnosis and case classification, based on non-culture testing; ADHS edited the 2012 case definition to match CDC/CSTE.

CANDIDA AURIS	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

Cases should be reported under the emerging or exotic disease requirement. Enter in MEDSIS under the *Candida auris* morbidity.

CASE DEFINITION

Clinical Description

Clinical manifestation of *Candida auris* infection depends upon the site of infection. Patients with *C. auris* bloodstream infection typically have sepsis and severe illness. Other invasive infections, such as intraabdominal candidiasis and meningitis can also occur. *C. auris* has also been found to cause wound infections and otitis, and has been cultured from urine and respiratory specimens. *C. auris* has been found to colonize the skin of asymptomatic people.

Clinical Criteria

None

Laboratory Criteria

Confirmatory Laboratory Evidence

Detection of *C. auris* from any body site using either culture or culture-independent diagnostic test (CIDT) (e.g., polymerase chain reaction).

Presumptive Laboratory Evidence

Detection of *C. haemulonii* from any body site using a yeast identification method that is not able to detect *C. auris* AND either the isolate/specimen is not available for further testing, or the isolate/specimen has not yet undergone further testing.

Note: When additional test results are available, case re-classification may occur, including making this a non-case.

Epidemiologic Linkage

- Person resided within the same household with another person with confirmatory or presumptive laboratory evidence of *C. auris* infection or colonization; OR
- Person received care within the same healthcare facility as another person with confirmatory or presumptive laboratory evidence of *C. auris* infection or colonization*; OR
- Person received care in a healthcare facility that commonly shares patients with another facility that had a patient with confirmatory or presumptive laboratory evidence of *C. auris* infection or colonization*; OR
- Person had an overnight stay in a healthcare facility in the previous one year in a foreign country with documented *C. auris* transmission (https://www.cdc.gov/fungal/candida-auris/tracking-cauris.html).

*Note: the person with confirmatory or presumptive laboratory evidence of *C. auris* and potentially exposed individuals do not need to be present in a health care facility for any overlapping time period. Any case occurring in a facility with a confirmed or probable case identified in the prior 12 months would be considered epidemiologically linked.

Case Classification

***C. auris*, clinical**

Confirmed
Person with confirmatory laboratory evidence from a clinical specimen collected for the purpose of diagnosing or treating disease in the normal course of care. This includes specimens from sites reflecting invasive infection (e.g., blood, cerebrospinal fluid) and specimens from non-invasive sites such as wounds, urine, and the respiratory tract, where presence of *C. auris* may simply represent colonization and not true infection.

Probable
Person with presumptive laboratory evidence from a clinical specimen collected for the purpose of diagnosing or treating disease in the normal course of care and evidence of epidemiologic linkage.

Suspect
Person with presumptive laboratory evidence from a clinical specimen collected for the purpose of diagnosing or treating disease in the normal course of care and no evidence of epidemiologic linkage.

***C. auris*, screening/surveillance**

Confirmed
Person with confirmatory laboratory evidence from a swab collected for the purpose of screening or surveillance for *C. auris* colonization, regardless of site swabbed. Typical colonization/screening sites are skin (e.g., axilla, groin), nares, rectum, or other external body site. Swabs from wound or draining ear are considered clinical.

Probable
Person with presumptive laboratory evidence from a swab collected for the purpose of screening for *C. auris* colonization regardless of site swabbed. Typical colonization/screening specimen sites are skin (e.g., axilla, groin), nares, rectum, or other external body sites. Swabs from wound or draining ear are considered clinical.

Criteria to Distinguish a New Case from an Existing Case

- A person with a clinical case should not be counted as a colonization/screening case thereafter (e.g., patient with known infection who later has colonization of skin is not counted as more than one case).
- A person with a colonization/screening case can be later categorized as a clinical case (e.g., patient with positive screening swab who later develops bloodstream infection would be counted in both categories).

Comment

Some yeast identification methods are unable to differentiate *C. auris* from other yeast species. *C. auris* can be misidentified as a number of different organisms when using traditional biochemical methods for yeast identification such as VITEK 2 YST, API 20C, BD Phoenix yeast identification system, and MicroScan.

The most common misidentification of *C. auris* is *C. haemulonii. C. haemulonii* have been less commonly observed to cause invasive infections. Therefore, *C. auris* should be suspected when *C.*

haemulonii is identified on culture of blood or other normally sterile site unless the method used can reliably detect *C. auris. Candida* isolates from the urine and respiratory tract ultimately confirmed as *C. auris* have been initially identified as *C. haemulonii*; less data are available about the ability of *C. haemulonii* to grow in urine or the respiratory tract, although true *C. haemulonii* infections in general appear to be rare in the United States.

The table below summarizes common misidentifications based on the yeast identification method used. If any of the species listed below are identified using the specified identification method, or if species identity cannot be determined by any method, further characterization using appropriate methodology should be sought.

Common misidentifications for *C. auris* by yeast identification method

Identification Method	**Organism *C. auris* can be misidentified as**
Bruker MALDI Biotyper (FDA database)	No misidentifications of *C. auris*. Bruker MALDI-TOF is able to accurately identify *C. auris*
bioMérieux VITEK MS (IVD/RUO database)	*C. haemulonii*
VITEK 2 YST (Ver. 8.01 or older)	*C. haemulonii* *C. duobushaemulonii*
API 20C	*Rhodotorula glutinis* (characteristic red color not present) *C. sake*
BD Phoenix yeast identification system	*C. haemulonii* *C. catenulata*
MicroScan	*C. famata* *C. guilliermondii** *C. lusitaniae** *C. parapsilosis**
RapID YEAST PLUS	*C. parapsilosis**

**C. guilliermondii, C. lusitaniae, and C. parapsilosis* generally make hyphae or pseudohyphae on cornmeal agar. If hyphae or pseudohyphae are not present on cornmeal agar, this should raise suspicion for *C. auris* as *C. auris* typically does not make hyphae or pseudohyphae. However, some *C. auris* isolates have formed hyphae or pseudohyphae. Therefore, it would be prudent to consider any *C. guilliermondii, C. lusitaniae*, and *C. parapsilosis* isolates identified on MicroScan and any *C. parapsilosis* isolates identified on RapID YEAST PLUS as possible *C. auris* isolates and further identification should be sought.

CONTROL MEASURES

Arizona Administrative Code R9-6-333 Emerging or Exotic Disease

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of an emerging or exotic disease case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;

2. In consultation with the Department, isolate an emerging or exotic disease case or suspect case as necessary to prevent transmission;
3. Conduct an epidemiologic investigation of each reported emerging or exotic disease case or suspect case; and
4. For each emerging or exotic disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures

A local health agency, in consultation with the Department,

1. Shall quarantine or exclude an emerging or exotic disease contact as necessary, according to R9-6-303, to prevent transmission.

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2019
Most Recent CDC/CSTE Revision Year	2019
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2019: Case definition revised to match CDC/CSTE case definition. 2018: New CDC/CSTE case definition; added to Arizona case definition manual.

CARBAPENEM-RESISTANT ENTEROBACTERIACEAE (CRE)	LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description
Classification of CRE is based entirely on laboratory criteria; no clinical criteria are provided.

Laboratory Criteria for Diagnosis
Enterobacter spp., *E.coli, Klebsiella* spp., or any other Enterobacteriaceae (see Appendix 2) isolated from any clinical specimen:

- **Laboratory criterion A:** Resistant to any carbapenem (minimum inhibitory concentrations (MIC) of ≥4 mcg/ml for meropenem, imipenem*, and doripenem or ≥ 2 mcg/ml for ertapenem),
  * Note: Do not use imipenem for *Proteus* spp., *Providencia* spp. or *Morganella* spp., as these bacteria may be intrinsically nonsusceptible to imipenem.

OR

- **Laboratory criterion B:** Demonstrating laboratory evidence of carbapenemase production (for laboratories performing any of this testing):
  - Positive for known carbapenemase resistance mechanism (e.g., *Klebsiella pneumoniae* carbapenemase (KPC), New Delhi metallo-β-lactamase (NDM), Verona integron-encoded metallo-β-lactamase (VIM), imipenemase (IMP), oxacillinase-48-like carbapenemase (OXA-48)) demonstrated by a recognized test (e.g., polymerase chain reaction (PCR), Xpert Carba-R), OR
  - Positive on a phenotypic test for carbapenemase production (e.g., metallo-β-lactamase test, modified Hodge test, Carba NP, Carbapenem Inactivation Method (CIM), or modified CIM (mCIM)).

Enterobacteriaceae meeting either set of criteria (A or B) should be reported. Cultures collected for any reason (diagnosis as well as screening/surveillance) should be reported if they meet the above criteria. This document is not intended as guidance on whether or when surveillance cultures should be collected.

For Enterobacteriaceae resistant to any carbapenem (criterion A), include all drug susceptibility testing results when reporting the case.

Isolate submission
Enterobacteriaceae isolates meeting the above laboratory criteria (A and/or B) should be submitted to ASPHL for additional testing.

- Along with the isolate, include the results of the testing performed indicating that the isolate meets the above criteria (e.g., MIC = 8 for ertapenem, or positive CIM). Write this information on the laboratory submission form or attach printed results.
- See http://www.azdhs.gov/preparedness/state-laboratory/public-health-microbiology/index.php for additional information on submitting isolates.

Note: Changes have been made to the Clinical and Laboratory Standards Institute (CLSI) MIC breakpoints for carbapenems in the past decade (Clinical and Laboratory Standards Institute, "M100. Performance standards for antimicrobial susceptibility testing"). It is important to note that

clinical laboratory adoption of the most current breakpoints for these antibiotic classes may vary. Laboratories should report any results that meet the definition of resistance defined above that is, MIC of ≥4 mcg/ml for meropenem, imipenem, and doripenem or ≥ 2 mcg/ml for ertapenem, even if automated systems indicate these are susceptible or intermediate.

Note: Negative PCR for all known resistance mechanism (e.g., KPC, NDM, VIM, IMP, OXA-48) if accompanied by positive phenotypic test for carbapenemase production (e.g., mCIM, CIM, CarbaNP) should be reported urgently to public health (and isolate submitted to ASPHL) as it could signify a novel carbapenemase.

Case Classification

Confirmed
A case that meets:
- Laboratory criterion A, as confirmed by a public health laboratory; OR
- Laboratory criterion B (public health laboratory confirmation is not required).

Probable*
A case that:
- Meets laboratory criterion A, but not confirmed by a public health laboratory, AND
- Does not meet laboratory criterion B.

* The probable definition will generally apply only when testing at a public health laboratory cannot be performed. If a public health laboratory identifies that the specimen/isolate is not an Enterobacteriaceae or is not carbapenem-resistant, the case should be classified as "Not a case", even if the original testing met criterion A.

Note: This definition is broader than the national case definition, which defines only carbapenemase-producing (CP)-CRE in *Enterobacter* spp., *E.coli* or *Klebsiella* spp. The Arizona definition includes other mechanisms of resistance as well as other Enterobacteriaceae.

Sub-classifications of CRE
CRE cases should be further stratified according to:

a) the organism identified (*E.coli, Enterobacter* spp., *Klebsiella* spp., or other Enterobacteriaceae), and
b) the mechanism of resistance (carbapenemase-producing (CP)-CRE, CRE that is likely non-CP-CRE, or insufficient information to classify as CP-CRE or likely non-CP-CRE).

Additional notes on laboratory interpretation are included in the Comments.

1. CP-CRE:
    - Positive for known carbapenemase resistance mechanism (e.g., KPC, NDM, VIM, IMP, OXA-48) demonstrated by a recognized test (e.g., polymerase chain reaction (PCR), Xpert Carba-R), OR
    - Positive on a phenotypic test for carbapenemase production (e.g., metallo-β-lactamase test, modified Hodge test, Carba NP, Carbapenem Inactivation Method (CIM), or modified CIM (mCIM)).

Notes:
- Cases involving isolates that are phenotypically positive for carbapenemase production (e.g., mCIM), but negative for KPC, NDM, OXA-48, VIM, and IMP should be counted as confirmed CP-CRE.
- A positive Modified Hodge Test (MHT) can be used to confirm CP-CRE for *Klebsiella* spp., *E. coli,* and other Enterobacteriaceae, but not *Enterobacter* spp. An isolate that tests positive on MHT but negative PCR for KPC, NDM, OXA-48, VIM and IMP should have additional characterization performed with another phenotypic test for carbapenemase such as mCIM.
- If isolate is indeterminate on mCIM and negative by PCR for KPC, NDM, OXA-48, VIM and IMP, isolate should be tested using CarbaNP.

2. Likely non-CP-CRE (one or more of the following):
   - Negative mCIM;
   - Negative Carba NP and negative PCR for OXA-48;
   - Negative CIM and negative PCR for OXA-48;
   - Negative PCR for KPC, NDM, OXA-48, VIM, and IMP; OR
   - Negative Xpert Carba-R.

3. Insufficient information to classify as CP-CRE or likely non-CP-CRE:
   - No other recognized test performed and/or isolate no longer available
   - *Enterobacter* spp. and positive MHT and no other tests performed/isolate no longer available.
   - Combination of tests performed/results do not allow for classification as likely non-CP-CRE.

Criteria to Distinguish a New Case from an Exisitng Case

- Different organisms/species/carbapenemases are counted as separate events from other organisms/species/carbapenemases.
- There is at least a 365 day interval from previous notification event for clinical cases.
- A person with a clinical case should not be counted as a screening/surveillance case thereafter (e.g., patient with known infection who later has colonization of GI tract is not counted as more than one case).
- A person with a screening case can be later categorized as a clinical case (e.g., patient with positive peri-rectal screening swab who later develops blood stream infection would be counted in both categories).

Infection Control Implications

1. For all sub-classifications:
   Standard Precautions + Contact Precautions (+ additional transmission-based precautions per patient status (e.g. Droplet)). Interfacility communication.

2. Additionally:
   a. For confirmed CP-CRE: Perform more aggressive interventions (e.g. screening, cohorting of staff/patients).
   b. Insufficient information to classify: Strongly consider more aggressive interventions (e.g. screening, cohorting of staff/patients), based on the clinical circumstance, patient history of travel, and local CRE epidemiology.

For more infection control information, see the Facility Guidance for Control of CRE (CDC) and CRE Control and Prevention Toolkit (Agency for Healthcare Research and Quality) at https://www.cdc.gov/hai/organisms/cre/cre-toolkit/index.html.

Comment

Due to intrinsic production of AmpC beta-lactamase, non-CP *Enterobacter* spp. or *Citrobacter* spp. may produce a false positive Modified Hodge Test. False positive results may also be observed with organisms carrying extended-spectrum beta-lactamases of the CTX-M type. There is also a problem with false negative MHT results when testing New Delhi metallo-β-lactamase (NDM)-producing isolates. Therefore, caution is advised when interpreting results for these organisms. Other phenotypic tests for carbapenemase production, such as the mCIM should be used, if available.

Metallo-beta-lactamase carbapenemases require the presence of metal ions such as zinc to hydrolyze carbapenems. Lack of appropriate zinc ion supplementation in Mueller Hinton Agar media used in the Modified Hodge Test may lead to false negative results for NDM and other metallo-beta-lactamase enzymes. In addition, it has been observed that Modified Hodge Test results for NDM carbapenemases may vary depending on the carbapenem used for the test (i.e., ertapenem, meropenem, imipenem).

Due to the inherently weak carbapenem hydrolysis activity of OXA-48 and OXA-48-like enzymes, delayed, weak, indeterminate, or negative reactions may be observed with the Carba NP and the CIM test. Therefore, a Carba NP indeterminate or negative result or a negative CIM test should not be considered sufficient to rule out the presence of OXA-48 or OXA-48-like enzymes, particularly in patients with a history of previous medical care in endemic regions.

Gene Xpert Carba-R assay is FDA-approved for detection of carbapenemase genes from pure bacterial isolates and rectal surveillance swab specimens. Carbapenemase genes detected include those encoding KPC, NDM, VIM, OXA-48, and IMP (limited to the IMP-1 group) enzymes. The limitation of only detecting the IMP-1 group illustrates how variants of a gene could be missed; phenotypic tests (e.g. mCIM) for carbapenemase production are likely to detect these.

Serratia marcescens isolates carry the *sme* Class A carbapenemase gene. Also, some *Enterobacter cloacae* carry similar genes which are i*mi* and *nmc-A* which share 97% amino acid identity. All of these genes are chromosomally located but acquired. These carbapenemases also result in positive Carba NP and mCIM tests.

CONTROL MEASURES

Arizona Administrative Code R9-6-315 Carbapenem-resistant Enterobacteriaceae

Case Control Measures

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall:
    a. Institute isolation precautions as necessary for a carbapenem-resistant enterobacteriaceae case or carrier to prevent transmission; and
    b. If a carbapenem-resistant enterobacteriaceae case or carrier is being transferred to another health care provider or health care institution or to a correctional facility, comply with R9-6-305.
2. An administrator of a correctional facility, either personally or through a representative, shall:
    a. Institute isolation precautions as necessary for a carbapenem-resistant enterobacteriaceae case or carrier to prevent transmission; and

   b. If a carbapenem-resistant enterobacteriaceae case or carrier is being transferred to another correctional facility or to a health care institution, comply with R9-6-305.
3. A local health agency, in consultation with the Department, shall:
   a. Ensure that a case or carrier of carbapenem-resistant enterobacteriaceae is isolated as necessary to prevent transmission; and
   b. Upon request, ensure that an isolate or a specimen, as available, from each case or carrier of carbapenem-resistant enterobacteriaceae is submitted to the Arizona State Laboratory.

Outbreak Control Measures

A local health agency shall:

1. Conduct an epidemiologic investigation for each outbreak or suspected outbreak of carbapenem-resistant enterobacteriaceae; and
2. For each outbreak or suspected outbreak of carbapenem-resistant enterobacteriaceae, submit to the Department the information required under R9-6-206(E).

INVESTIGATION FORMS

None at this time

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2019
Most Recent CDC/CSTE Revision Year	2018
ADHS Case Definition Matches CDC/CSTE?	No
Description of changes	2019: Updated the criteria to distinguish a new case from an existing case to reflect what is in the 2018 CDC/CSTE case definition. 2018: CRE became reportable in Arizona and CP-CRE became nationally notifiable. Case definition updated to reflect decisions on reporting, isolate submission, classification, and stratification, as well as updating information from the national case definition. Arizona definition is broader than the national definition, which is for only three genera of Enterobacteriaceae (*E. coli*, *Enterobacter* spp., and *Klebsiella* spp.) and only one mechanism (carbapenemase producers). 2017: adopted 2015 CSTE case definition using modified expanded definition of CRE 2016: CSTE approved a case definition for CRE in 2015 in order to standardize surveillance,

	although CRE is not nationally notifiable and is not explicitly reportable in Arizona at this time.

CHAGAS DISEASE AND RELATED DISEASE (American trypanosomiasis)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Background

Chagas disease is a parasitic infection caused by *Trypanosoma cruzi*, which is spread to animals and people by means of vector-borne transmission. The disease is found only in the America's, commonly South America, Central America, and Mexico. In Chagas endemic countries, the principal method of transmission is through contact with fecal matter from an infected triatomine bug. The triatomine bug, also known as the kissing bug, bites a person or animal host, ingests a blood meal, and then defecates on the host. The host may accidentally scratch or rub the feces into the bite wound, eyes, or mouth, thereby allowing the *T. cruzi* parasite to enter the body through mucous membranes or bloodstream.

Infection with Chagas disease can also occur through congenital transmission, transfusion of blood or blood products, organ transplantation, consumption of uncooked food contaminated with feces from infected bugs, and accidental laboratory exposure. Chagas disease is not transmitted from person-to-person.

Clinical Description

There are two phases of Chagas disease: the acute and chronic phase. Both phases can be asymptomatic to life threatening. The majority of Chagas disease cases are asymptomatic.

The **acute phase** is characterized by the first 8 weeks of infection, detectable parasitemia, and asymptomatic or symptomatic manifestations of the disease. Symptoms can include:

- Fever
- Malaise
- Rash
- Body aches
- Headache
- Loss of appetite
- Vomiting
- Diarrhea
- Hepatomegaly
- Splenomegaly
- Lymphadenopathy
- Chagoma (nodular swelling at site where the parasite entered the body)
- Romaña's sign (swelling of the eyelid on the side of the face near the bite wound or where the bug feces were deposited or accidentally rubbed into the eye)
- Acute myocarditis (rare) and/or
- Meningoencephalitis (rare)

Even if symptoms develop during the acute phase, they usually fade away on their own, within a few weeks or months. However, the acute phase may be severe in people with weakened immune systems.

The **chronic intermediate phase** occurs after the acute phase when infected individuals enter into a

prolonged asymptomatic form of the disease. The infection remains silent during this phase and few or no parasites are found in the bloodstream. During this time, most people are unaware of their infection. Many people remain asymptomatic for their entire life and never develop chronic Chagas-related symptoms.

It is estimated that 20-30% of infected people will develop the **chronic symptomatic phase** of Chagas disease. This phase is characterized by undetectable parasitemia and severe life-threatening cardiac or intestinal medical complications. These include:

- Cardiomyopathy, heart failure, altered heart rate or rhythm, and cardiac arrest; and/or
- Intestinal complications, such as megaesophagus or megacolon, which can lead to difficulties with eating or with passing stool.

Laboratory Criteria for Diagnosis

Confirmatory Testing

- Isolation of *T. cruzi* by microscopy (microscopic examination, wet mount, thick and thin smears-Giemsa stain), OR
- Isolation of *T. cruzi* by culture, OR
- Detection of *T. cruzi* DNA by polymerase chain reaction (PCR), OR
- Detection of antibody specific to *T. cruzi* by two distinct diagnostic assays (can only be performed at CDC)

Presumptive Testing

- Evidence of *T. cruzi* antibodies on a single serologic diagnostic assay (IgG positive) (not blood screening); OR
- Reactive blood donor screen AND a secondary positive diagnostic assay (IgG positive). (Note that 'additional' or 'confirmatory' antibody tests performed by a blood screening agency do not count as diagnostic tests. See Comments.)

Case Classification

Confirmed
A case that meets the confirmatory laboratory criteria.

Probable
A case that meets the presumptive laboratory criteria.

Type Classification

Acute phase
Asymptomatic or symptomatic within 8 weeks of documented exposure* or symptom onset/diagnosis

Chronic, intermediate phase
Asymptomatic case >9 months of age and >8 weeks since documented exposure*

Chronic, symptomatic phase
Symptomatic case >9 months of age and >8 weeks since documented exposure*

Comments

*Documented exposure may include contact with triatomine bug, recipient of contaminated blood products, congenital exposure, or travel to an endemic country.

Note that the testing performed by a blood screening/blood donation agency (even those tests listed as "additional" or "confirmatory") should not be considered diagnostic. Blood donor testing is very sensitive by design, for the purposes for protecting the safety of the blood supply. Evidence of antibodies against *T. cruzi* on blood screening may prompt a patient to have further diagnostic testing performed, but only the results of the diagnostic testing should be considered in either the confirmatory or presumptive laboratory criteria.

Additionally, only the IgG results need to be considered when using presumptive testing criterion of a single serological diagnostic assay. Per communications with CDC (2019), the IgM assays are non-specific; in general, positive IgM tests have been confirmed as infections only when the patients also tested positive for IgG.

CONTROL MEASURES

Arizona Administrative Code R9-6-316 Chagas Infection and Related Disease (American Trypanosomiasis)

Case Control Measures

A local health agency shall:

1. Conduct an epidemiologic investigation of each reported Chagas infection or disease case or suspect case; and
2. For each Chagas infection or disease case:
    a. Submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
    b. Provide to the Chagas infection or disease case or ensure that another person provides to the Chagas infection or disease case health education that includes:
        i. The treatment options for Chagas infection or disease,
        ii. Where the Chagas infection or disease case may receive treatment for Chagas infection or disease, and
        iii. For women of childbearing age, the risks of transmission of Chagas infection or disease to a fetus.

INVESTIGATION FORMS

See Chagas Case Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2020
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	2020: Specified that single serological testing should rely on the IgG results.

	2019: Clarified that testing performed for blood donation screening should not be considered diagnostic and should not be used in the laboratory criteria. 2017: Case definition added to the surveillance manual.

CHANCROID (*Haemophilus ducreyi)*	PROVIDERS SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description
A sexually transmitted disease characterized by painful genital ulceration and inflammatory inguinal adenopathy. The disease is caused by infection with *Haemophilus ducreyi.*

Laboratory Criteria for Diagnosis
Isolation of *H. ducreyi* from a clinical specimen

Case Classification

Confirmed
A case that is laboratory confirmed.

Probable
A clinically compatible case with one or more painful genital ulcers in which:
- There is no evidence of *Treponema pallidum* infection by dark field examination of ulcer exudate or by a serologic test for syphilis performed at least 7 days after onset of ulcers, and
- The clinical presentation of the ulcer(s) is not typical of disease caused by HSV (herpes simplex virus) or HSV culture is negative.

CONTROL MEASURES
Arizona Administrative Code R9-6-317 Chancroid (*Haemophilus ducreyi*)

Case Control Measures
A local health agency shall:
1. Conduct an epidemiologic investigation of each reported chancroid case or suspect case;
2. For each chancroid case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
3. Comply with the requirements specified in R9-6-1103 concerning treatment and health education for a chancroid case.

Contact control measures:
1. When a chancroid case has named a contact, a local health agency shall comply with the requirements specified in R9-6-1103 concerning notification, testing, treatment, and health education for the contact.

INVESTIGATION FORMS
None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2010
Most Recent CDC/CSTE Revision Year	2010
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

CHIKUNGUNYA	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

For the case definition, see Arboviral infection in this document.

CONTROL MEASURES

Arizona Administrative Code R9-6-318 Chikungunya

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a chikungunya case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported chikungunya case or suspect case;
3. For each chikungunya case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that each chikungunya case is provided with health education that includes measures to:
    a. Avoid mosquito bites, and
    b. Reduce mosquito breeding sites.

Environmental control measures:

In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction

1. Shall conduct an assessment of the environment surrounding each chikungunya case or suspect case and implement vector control measures as necessary.

INVESTIGATION FORMS

See the Chikungunya Case Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

***CHLAMYDIA TRACHOMATIS* INFECTION**	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

Infection with *Chlamydia trachomatis* may result in urethritis, epididymitis, cervicitis, acute salpingitis, or other syndromes when sexually transmitted. Perinatal infections may result in conjunctivitis and pneumonia among newborns. Other syndromes caused by *C. trachomatis* include lymphogranuloma venereum (see separate case definition) and trachoma.

Laboratory Criteria for Diagnosis

- Isolation of *C. trachomatis* by culture, OR
- Demonstration of *C. trachomatis* in a clinical specimen
  - by antigen detection methods, OR
  - by detection of nucleic acid.

Case Classification

Confirmed

A case that is laboratory confirmed.

Criteria to Distinguish a New Case from an Existing Case

A case should not be counted as a new case if laboratory results were reported within 30 days of a previously reported infection in the same individual, unless there is evidence of reinfection. The 30 days should be counted from the date of initial screening unless treated. For cases with treatment, the 30 days should be counted from the initial treatment date. Additional details can be found at https://www.cdc.gov/std/laboratory/de-duplication-guidance-june2016.pdf.

CONTROL MEASURES

Arizona Administrative Code R9-6-319 *Chlamydia trachomatis* Infection

Case Control Measures:

A local health agency shall:

1. Comply with the requirements specified in R9-6-1103 concerning treatment and health education for a *Chlamydia trachomatis* infection case that seeks treatment from the local health agency.

Contact Control Measures:

If an individual who may have been exposed to chlamydia through sexual contact with a *Chlamydia trachomatis* infection case seeks treatment for symptoms of chlamydia infection from a local health agency, the local health agency shall comply with the requirements specified in R9-6-1103 concerning treatment and health education for the individual.

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2016
Most Recent CDC/CSTE Revision Year	2010
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2016: Nucleic acid detection added to the laboratory criteria for diagnosis.

CHOLERA	PROVIDERS REPORT WITHIN 24 HOURS IF CASE HAS A HIGH-RISK OCCUPATION PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY FOR ALL OTHER CASES

CASE DEFINITION

Clinical Description
An illness characterized by diarrhea and/or vomiting. Severity is variable.

Laboratory Criteria for Diagnosis

- Isolation of toxigenic (cholera toxin-producing) *Vibrio cholerae* O1 or O139 from stool or vomitus, OR
- Serologic evidence of recent infection

Case Classification

Confirmed
A clinically compatible illness that is laboratory confirmed.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

When two or more different serotypes are identified in one or more specimens from the same individual (as long as at least one week apart), each should be reported as a separate case.

*Based on ADHS guidelines

Comment
Only confirmed cases should be reported nationally. Illnesses due to strains of *V. cholerae* other than toxigenic *V. cholerae* O1 or O139 should be reported as Vibrio infection rather than cholera. The etiologic agent of a case of cholera should be reported as either *V. cholerae* O1 or *V. cholerae* O139.

CONTROL MEASURES
Arizona Administrative Code R9-6-320 Cholera

Case Control Measures
A local health agency shall:

1. Upon receiving a report under R9-6-202 of a cholera case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Exclude a cholera case or suspect case from:
    a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until a stool specimen

negative for toxigenic *Vibrio cholerae* is obtained from the cholera case or suspect case; and

b. Using an aquatic venue until diarrhea has resolved;

3. Conduct an epidemiologic investigation of each reported cholera case or suspect case; and
4. For each cholera case, submit to the Department, as specified in Article 2, Table 4 2.4, the information required under R9-6-206(D).

Contact Control Measures:

1. A local health agency shall provide follow-up for each cholera contact for five calendar days after exposure.

INVESTIGATION FORMS

See Cholera and other Vibrio Illness Surveillance Report at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2013
Most Recent CDC/CSTE Revision Year	2010
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2013 change to ADHS laboratory criteria to match CDC/CSTE case definition.

COCCIDIOIDOMYCOSIS (Valley fever)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

Infection may be asymptomatic or may produce an acute or chronic disease. Although the disease initially resembles an influenza-like illness or pneumonia-like febrile illness primarily involving the bronchopulmonary system, dissemination can occur to multiple organ systems. An illness is typically characterized by one or more of the following:

- Influenza-like signs and symptoms, including fever, chest pain, cough, myalgia, arthralgia, headache
- Pneumonia or other pulmonary lesion, diagnosed by chest X-ray
- Rashes, including erythema nodosum or erythema multiforme
- Involvement of bones, joints, or skin by dissemination
- Meningitis
- Involvement of viscera and lymph nodes

Laboratory Criteria for Diagnosis

Laboratory-confirmed coccidioidomycosis requires at least one of the following:

- Cultural OR histopathologic evidence of presence of *Coccidioides* species.
- Demonstration of *Coccidioides*-specific nucleic acid or proteins in a clinical specimen or isolate using a molecular assay (e.g., PCR, DNA Probe, MALDI-TOF).
- Detection of coccidioidal antibodies in serum, CSF, or other body fluids using:
    - Enzyme immunoassay (may be abbreviated as EIA or ELISA)
    - Immunodiffusion (may be abbreviated as ID, IMD, IMDF, IDTP, IDCF, etc.)
    - Complement fixation (CF)
    - Lateral flow assay (LFA)
    - Tube precipitin
    - Latex agglutination
- Detection of *Coccidioides* species antigen in serum, CSF, or other body fluids.
- Coccidioidal skin test conversion from negative to positive after the onset of clinical signs and symptoms.

Case Classification

Confirmed

A case that is laboratory confirmed.

Criteria to Distinguish a New Case from an Existing Case*

A case should never be counted as a new case if there was a previously reported infection in the same individual.

*Based on ADHS guidelines

CONTROL MEASURES

Arizona Administrative Code R9-6-322 Coccidioidomycosis (Valley Fever)

Outbreak Control Measures

A local health agency shall:

1. Conduct an epidemiologic investigation of each reported outbreak of coccidioidomycosis; and
2. For each outbreak of coccidioidomycosis, submit to the Department the information required under R9-6-206(E).

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2020
Most Recent CDC/CSTE Revision Year	2011
ADHS Case Definition Matches CDC/CSTE?	No
Description of changes	2020: Removed titer restrictions within the laboratory criteria to be consistent with laboratory reference ranges and the national case definition. Also, included additional laboratory tests (i.e., LFA and detection of *Coccidioides* species antigen). Coccidioidomycosis is endemic in Arizona, and previous study has shown that most reported cases that meet the laboratory criteria also meet the clinical case definition. Because of the high number of reported cases, lack of resources to investigate all reported cases, and very high rate of clinical symptoms among laboratory-reported cases, Arizona uses a laboratory-only case definition.

COLORADO TICK FEVER	PROVIDERS SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description
An acute viral disease characterized by fever, chills, lethargy, headache and myalgias with infrequent macular or maculopapular rash. After initial onset, a remission is usual, followed by a second bout of fever lasting 2-3 days.

Laboratory Criteria for Diagnosis

- Isolation of Colorado tick fever virus from blood or CSF, OR
- Fourfold or greater change in serum antibody

Case Classification

Confirmed
A case that is laboratory confirmed with symptoms and history as above.

Probable
A compatible history of tick or outdoor exposure, plus clinical symptoms with supportive laboratory results (demonstration of single serological test result suggestive of recent infection with no history of previous infection, by use of hemagglutination, IFA or ELISA).

CONTROL MEASURES
Arizona Administrative Code R9-6-323 Colorado Tick Fever

Case Control Measures
A local health agency shall:
1. Conduct an epidemiologic investigation of each reported Colorado tick fever case or suspect case; and
2. For each Colorado tick fever case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS
See http://www.cdc.gov/ticks/forms/2010_tbrd_crf.pdf.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2005 or before
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

CONJUNCTIVITIS, ACUTE	REPORT OUTBREAKS ONLY

CASE DEFINITION

Clinical Description
An acute inflammation of the conjunctiva involving redness and burning or itching of the eyes. Drainage from the eyes may be present as clear and watery fluid or white or yellowish pus.

Laboratory Criteria for Diagnosis
Cultures of purulent drainage or conjunctival swabs may be used to identify the specific infectious agent in cases of bacterial conjunctivitis.

Case Classification

Confirmed
A case that meets the clinical case description

Comment
Only outbreaks of acute conjunctivitis should be reported. An outbreak consists of:

- three or more cases,
- diagnosed or detected within a one-week period,
- all of whom have a common exposure AND
- not from the same household or family

CONTROL MEASURES
Arizona Administrative Code R9-6-324 Conjunctivitis

Case Control Measures
An administrator of a school or child care establishment, either personally or through a representative, shall exclude an acute conjunctivitis case from attending the school or child care establishment until the symptoms of acute conjunctivitis subside or treatment for acute conjunctivitis is initiated and maintained for 24 hours.

Outbreak control measures
A local health agency shall:
1. Conduct an epidemiologic investigation of each reported conjunctivitis outbreak; and
2. For each conjunctivitis outbreak, submit to the Department the information required under R9-6-206(E).

INVESTIGATION FORMS
Outbreak summary form only: http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2006
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

COVID-19 (2019 NOVEL CORONAVIRUS)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

Cases should be reported under the Novel Coronavirus (e.g., SARS or MERS) requirement. Enter in MEDSIS as Novel Coronavirus. Also see MULTISYSTEM INFLAMMATORY SYNDROME IN CHILDREN (MIS-C) for individuals aged <21 years.

CASE DEFINITION

Clinical Criteria

In the absence of a more likely diagnosis:

Acute onset or worsening of at least two of the following symptoms or signs:

- Fever (measured or subjective)
- Chills
- Rigors
- Myalgia
- Headache
- Sore throat
- Nausea or vomiting
- Diarrhea
- Fatigue
- Congestion or runny nose

OR

Acute onset or worsening of any one of the following symptoms or signs:

- Cough
- Shortness of breath
- Difficulty breathing
- Olfactory disorder
- Taste disorder
- Confusion or change in mental status
- Persistent pain or pressure in the chest
- Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone
- Inability to wake or stay awake

OR

Severe respiratory illness with at least one of the following:

- Clinical or radiographic evidence of pneumonia
- Acute respiratory distress syndrome (ARDS)

Laboratory Criteria for Diagnosis

Laboratory evidence should use a method approved or authorized by the FDA or designated authority:

Confirmatory[1] Laboratory Evidence

- Detection of SARS-CoV-2 RNA in a clinical or post-mortem respiratory specimen using a molecular amplification test; OR
- Detection of SARS-CoV-2 by genomic sequencing[2].

Presumptive[1] Laboratory Evidence

- Detection of SARS-CoV-2 by antigen test in a clinical or post-mortem respiratory specimen; OR
- Detection of SARS-CoV-2 RNA or specific antigen using a test performed without CLIA oversight, on a case-by-case basis[3].

[1]The terms confirmatory and presumptive are categorical labels used here to standardize case classifications for public health surveillance. The terms should not be used to interpret the utility or validity of any laboratory test methodology.

[2]Some genomic sequencing tests that have been authorized for emergency use by the FDA do not require an initial polymerase chain reaction (PCR) result to be generated. Genomic sequencing results may be all the public health agency receives.

[3]Public health departments may determine on a case-by-case basis if tests performed without CLIA oversight (i.e., over-the-counter non-proctored self/at-home tests) meet the presumptive laboratory evidence criteria.

Epidemiologic Linkage

- Close contact[4] with a confirmed or probable case of COVID-19 disease in the 14 days before onset of symptoms; OR
- Indicated as belonging to a known or suspected outbreak of COVID-19 disease.

[4]Close contact is generally defined as being within 6 feet for at least 15 minutes. However, it depends on the exposure level and setting; for example, in the setting of an aerosol-generating procedure in healthcare settings without proper PPE, this may be defined as any duration.

Vital Records Criteria

A death certificate that lists COVID-19 disease or SARS-CoV-2 or an equivalent term as an underlying cause of death or a significant condition contributing to death.

Case Classification

Confirmed

Meets confirmatory laboratory evidence.

Probable

To be used for reports received by public health on or after 4/13/2020

- Meets clinical criteria AND epidemiologic evidence with no confirmatory or presumptive laboratory evidence for SARS-CoV-2.
- Meets presumptive laboratory evidence[5].
- Meets vital records criteria[5].

[5]*Regardless of negative confirmatory laboratory testing.*

Additional Guidance
Refer to the Arizona Case Classification Algorithm for COVID-19, or contact the COVID-19 Response Team for guidance on a case-specific basis.

A person meeting the case definition for COVID-19 and for MIS-C should be entered in MEDSIS under both morbidities, and classified appropriately for each. For example, a confirmed MIS-C case will likely also count as a confirmed or probable COVID-19 case.

Supportive laboratory evidence (detection of specific antibody) and the suspect case classification were added in September 2020, moving serological evidence out of the "presumptive" category. Changes to supportive laboratory evidence applied to case classification for cases with positive serological results first reported on or after 9/16/2020; cases reported prior to that date with serological evidence of COVID-19, and who met the probable case definition in effect at the time, should continue to be classified as probable cases.

The suspect case classification and supportive laboratory evidence were subsequently *removed* in March 2021, as vaccination against COVID-19 and past exposures to or infection with SARS-CoV-2 complicates interpretation of these results. Cases with positive serological results first reported on or after 3/29/2021 should be classified as "not a case", unless they meet the criteria for confirmed or probable case classification. Positive serological results may inform investigations and continue to be used in the MIS-C case definition.

Criteria to Distinguish a New Case from an Existing Case (i.e., reinfections)

A new case should be created if a previously infected person meets the confirmed or probable case definition more than 3 months after the symptom onset date or first posive specimen collection date (whichever is earlier) from their previous infection. A new case should **not** be created or counted if within 3 months of a previously reported infection in the same individual except as outlined below.

Evidence of infection in the same person of SARS-CoV-2 from two distinct lineages or variants, based on whole genome sequencing, should be considered as separate cases even if within 3 months. ADHS will provide assistance, as needed, for identifying whether the sequencing results represent distinct lineages.

Per CDC, available evidence suggests that most recovered adults would have a degree of immunity for at least 90 days following initial diagnosis of laboratory-confirmed COVID-19 infection. The risk of reinfection may be increased in the future with exposure to SARS-CoV-2 variant virus strains that are not neutralized by immune antisera or possibly due to waning immunity. However, research is still ongoing and guidance will be updated as additional evidence emerges. Therefore, if a person who has recovered from COVID-19 has new symptoms of COVID-19, the person may need an evaluation for reinfection, especially if the person has had close contact with someone infected with COVID-19.

Some individuals (e.g., severely immunocompromised persons) can shed SAR-CoV-2 detected by molecular amplification tests >90 days after infection. For severely immunocompromised individuals, clinical judgement should be used to determine if a repeat posive test is likely to result from long-term shedding and, therefore, not be enumerated as a new case. CDC defines severe immunocompromised as certain conditions, such as being on chemotherapy for cancer, untreated human immunodeficiency

virus (HIV) infection with CD4 T lymphocyte count <200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days.

Contact ADHS if you believe there is a reinfection within 3 months or if a case with a positive test more than 3 months after the symptom onset date appears to be the same case upon investigation.

CONTROL MEASURES

Arizona Administrative Code R9-6-361 Novel Coronavirus (e.g., SARS or MERS)

Case Control Measures

A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute both airborne precautions and contact precautions for a novel coronavirus case or suspect case, including a case or suspect case of severe acute respiratory syndrome or Middle East respiratory syndrome, until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner.

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a novel coronavirus case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. In consultation with the Department, ensure that isolation and both airborne precautions and contact precautions have been instituted for a novel coronavirus case or suspect case to prevent transmission;
3. Conduct an epidemiologic investigation of each reported novel coronavirus case or suspect case; and
4. For each novel coronavirus case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures

A local health agency, in consultation with the Department, shall:

1. Determine which novel coronavirus contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission.

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	9/8/2021
Most Recent CDC/CSTE Revision Year	9/1/2021
ADHS Case Definition Matches CDC/CSTE?	No

Description of changes 4/5/2020	New CDC/CSTE case definition; added to Arizona case definition manual in April 2020. Compared to CDC/CSTE definition, ADHS has simplified the epidemiologic linkage by removing the travel-associated component, and more concisely defining “risk cohort” as well as what constitutes a close contact.
Description of changes 6/16/2020, based upon county health department input	Added language to the probable case classification using the vital record criterion, to clarify how to interpret confirmatory testing that has been conducted. When death certificate indicates COVID-19 was the cause of death or attributed to cause of death, if the test was within 3 days of death classify a case according to test results, if longer than 3 days prior to death then ignore test results, and classify according to death certificate.
Description of changes 9/16/2020	Removed serology as presumptive evidence, and moved serology into a suspect case classification. Removed negative test exclusion criterion (within 3 days of death) for classifying probable cases meeting vital records criteria. Include antigen-positive tests as probable cases regardless of meeting clinical criteria or epidemiologic linkage. Change new case creation to 3 months instead of 4 months based on revised CDC guidance.
Description of changes 3/29/2021	Removed supportive laboratory evidence and the suspect case classification. Added clarification that infections from two distinct lineages should be considered separate cases.
Description of changes 5/10/2021	Added clarification that reinfection after vaccination (i.e., vaccine breakthrough) in the same person should be considered a new case.
Description of changes 9/8/2021	Added genomic sequencing to confirmatory laboratory evidence. Added self tests/at-home tests to presumptive laboratory evidence. Added clarification on criteria to distinguish a new case from an existing case.

CREUTZFELDT-JAKOB DISEASE	PROVIDERS SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

Creutzfeldt-Jakob Disease (CJD) is a fatal disease characterized by progressive dementia and a variety of other neurological symptoms including:

- Myoclonus
- Visual or cerebellar signs
- Pyramidal/extrapyramidal signs
- Akinetic mutism

CJD is typified by development of spongy spaces in brain tissue where cells have died. Incubation periods range from 15 months to 30 years.

Laboratory Criteria for Diagnosis

Confirmatory Testing

- Detection of characteristic lesions by examination of frozen brain tissue. This diagnosis can be made in the U.S. only by the National Prion Disease Pathology Surveillance Center (NPDPSC) in Cleveland, Ohio.
- Detection of abnormal prion protein by Western blot testing performed on frozen brain tissue, or by immunohistochemistry (IHC)/histology performed on fixed tissue.

Presumptive Testing

- Detection of 14-3-3 protein in CSF.
- Genetic analysis suggestive of the presence of the mutation associated with CJD.
- Detection of characteristic patterns by EEG or MRI

Case Classification

When possible, each case of CJD should be classified into one of the types according to the mode of transmission.

Confirmed

A case that meets at least one of the confirmatory laboratory criteria and only when performed by the NPDPSC.

- Iatrogenic CJD meets the above criteria PLUS
  - Progressive cerebellar syndrome in a recipient of human cadaveric-derived hormone or
  - A CJD recognized exposure risk (i.e. antecedent neurosurgery with dura mater implantation, corneal transplants, brain surgery).
- Familial CJD meets the above criteria PLUS
  - Confirmed or Probable CJD in a first degree relative
- Sporadic CJD meets the above criteria PLUS
  - No evidence of iatrogenic and familial CJD

Probable
A case that meets one of the presumptive laboratory criteria and in which three of the five clinical findings described above are present. Findings must include progressive dementia with clinical duration lasting < 2 years. Routine investigations should not suggest an alternative diagnosis.

- Iatrogenic CJD meets the above criteria PLUS
  - Progressive cerebellar syndrome in a recipient of human cadaveric-derived hormone or
  - A recognized CJD exposure risk (i.e. antecedent neurosurgery with dura mater implantation, corneal transplants, brain surgery).
- Familial CJD meets the above criteria PLUS
  - Confirmed or Probable CJD in a first degree relative
- Sporadic CJD meets the above criteria PLUS
  - No evidence of iatrogenic and familial CJD

Suspect
A case that meets one of the presumptive laboratory criteria and in which no clinical information is known and routine investigations should not suggest an alternative diagnosis.

Criteria to Distinguish a New Case from an Existing Case*
A case should never be counted as a new case if there was a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment
Additional information and forms may be obtained by visiting the website for the National Prion Disease Pathology Surveillance Center at Case Western Reserve University in Cleveland, Ohio at www.cjdsurveillance.com or http://case.edu/med/pathology/centers/npdpsc/ CJD is reportable in Arizona but is not a nationally notifiable condition. ADHS should be notified of all pending case investigations involving possible CJD and may coordinate shipment of specimens to the NPDPSC.

Additional information regarding the different CJD classifications based on mode of transmission is included below:

- Classical (Sporadic or Spontaneous) CJD: CJD of unexplained origin and presumably autochthonous. The prevalence of classical CJD is about one case per 1,000,000 population/year. This type of CJD typically strikes older individuals with the vast majority of cases occurring in those over 65 years of age (median = 68 years). Median duration of illness is 4-5 months.
- Iatrogenic CJD: Occurs as a result of exposure to infectious prions during a medical procedure. Corneal transplants, dura mater grafts, brain surgery, and growth or gonadotropic hormones made from human pituitary glands have all been implicated in iatrogenic CJD cases.
- Familial (Genetic) CJD: Same general characteristics as classical CJD, but a case may be given this classification when the patient has a known family history of rapid-onset dementia.
- (New) Variant CJD: Associated with consumption of Bovine Spongiform Encephalopathy- (BSE, aka “Mad Cow Disease”) infected beef. Only three cases with this form of CJD have been found in the U.S. and all cases had acquisition of the disease almost certainly in countries with BSE-contaminated cattle products (United Kingdom and Saudi Arabia). The typical age of onset of

Variant CJD is much younger than Classical CJD (median = 28 years). Median duration of illness is 13-14 months.

- Human cases of CJD associated with consumption of venison contaminated with Chronic Wasting Disease (CWD) prions have not been documented. If such a situation were to occur, it would most likely be classified as a new type of CJD.

CONTROL MEASURES

Arizona Administrative Code R9-6-325 Creutzfeldt-Jakob Disease

Case Control Measures:
A local health agency shall:

1. Conduct an epidemiologic investigation of each reported Creutzfeldt-Jakob disease case or suspect case; and
2. For each Creutzfeldt-Jakob disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Creutzfeldt-Jakob Disease Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2006
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

CRYPTOSPORIDIOSIS (*Cryptosporidium parvum*)	PROVIDERS REPORT WITHIN 24 HOURS IF AN OUTBREAK IS DETECTED OR PERSON HAS A HIGH-RISK OCCUPATION PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 DAY FOR ALL OTHER CASES

CASE DEFINITION

Clinical Description
A gastrointestinal illness characterized by diarrhea with a duration of 72 hours or more, abdominal cramping, fever, nausea, vomiting or anorexia.

Laboratory Criteria for Diagnosis

Confirm*atory *Testing
The detection of *Cryptosporidium* organisms or DNA in stool, intestinal fluid, tissue samples, biopsy specimens, or other biological sample by certain laboratory methods with a high positive predictive value (PPV), e.g.,
- Direct fluorescent antibody [DFA] test,
- Polymerase chain reaction [PCR],
- Enzyme immunoassay [EIA], or
- Light microscopy of stained specimen.

Presumptive Testing
The detection of *Cryptosporidium* antigen by a screening method, such as immunochromatographic card/rapid card test; or laboratory test of unknown method.

Case Classification

Confirmed
A case that meets the clinical description and the respective criteria for laboratory-confirmation as described above.

Probable
A case that meets the clinical description and either meets the presumptive criteria for laboratory diagnosis or is epidemiologically linked to a confirmed case.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment
Test results known to be obtained with commercially-available immunochromatographic card tests are limited to meeting “probable” case criteria due to recent report of unacceptably high rates of false-positive results (Clin Infect Dis. 2010 Apr 15;50(8):e53-55)

CONTROL MEASURES

Arizona Administrative Code R9-6-326 Cryptosporidiosis

Case Control Measures

A local health agency shall:

1. Exclude a cryptosporidiosis case or suspect case with diarrhea from:
    a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until diarrhea has resolved; and
    b. Using an aquatic venue for two weeks after diarrhea has resolved;
2. Conduct an epidemiologic investigation of each reported cryptosporidiosis case or suspect case; and
3. For each cryptosporidiosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Environmental control measures

A local health agency shall:

1. Conduct a sanitary inspection or ensure that a sanitary inspection is conducted of each facility or location regulated under 9 A.A.C. 8 that is associated with an outbreak of cryptosporidiosis.

INVESTIGATION FORMS

See Cryptosporidiosis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2012
Most Recent CDC/CSTE Revision Year	2012
ADHS Case Definition Matches CDC/CSTE?	Yes (with additional comments)
Description of changes	ADHS edited the case definition in 2012 to match CDC/CSTE but kept additional comments about laboratory tests.

CYCLOSPORIASIS (*Cyclospora cayetanensis*)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description
An illness of variable severity caused by the protozoan parasite *Cyclospora cayetanensis* and commonly characterized by watery diarrhea. Other common symptoms include loss of appetite, weight loss, abdominal bloating and cramping, increased flatus, nausea, fatigue, and low-grade fever. Vomiting also may be noted. Relapses and asymptomatic infections can occur.

Laboratory Criteria for Diagnosis
Detection of *Cyclospora* organisms or DNA in stool, intestinal fluid/aspirate, or intestinal biopsy specimens.

Case Classification

Confirmed
A case that meets the clinical description and at least one of the criteria for laboratory confirmation as described above.

Probable
A case that meets the clinical description and that is epidemiologically linked to a confirmed case.

CONTROL MEASURES
Arizona Administrative Code R9-6-327 *Cyclospora* Infection

Case Control Measures
A local health agency shall:
1. Conduct an epidemiologic investigation of each reported Cyclospora infection case or suspect case; and
2. For each *Cyclospora* infection case submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS
See Cyclosporiasis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2010
Most Recent CDC/CSTE Revision Year	2010
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

CYSTICERCOSIS	PROVIDERS SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

Cysticercosis is a tissue infection with the larval stage of the pork tapeworm, *Taenia solium*. When tapeworm eggs or proglottids are swallowed, the hatching eggs release larvae which can migrate from the intestine into tissues (including muscle, organs or central nervous system (CNS)) where they form cysts or cysticerci. The occurrence of cysticerci in the CNS (neurocysticercosis) can present with headache, epileptiform seizures, signs of intracranial hypertension, or psychiatric disturbances.

Laboratory Criteria for Diagnosis

Diagnosis can be made from:

- Microscopic examination of excised cysticerci from tissues, OR
- Recognition of cysticerci by CAT scan, MRI, or, when calcified, X-ray, OR
- Specific serologic tests.

Case Classification

Confirmed

A case with cysticerci in tissues or CNS identified by microscopy

Probable

A clinically compatible case with suspected cysticerci visualized in CAT scan, MRI, or X-ray, OR positive serologic tests.

Criteria to Distinguish a New Case from an Existing Case*

A case should never be counted as a new case if there was a previously reported infection in the same individual.

*Based on ADHS guidelines

CONTROL MEASURES

Arizona Administrative Code R9-6-328 Cysticercosis

Case Control Measures

A local health agency shall:

1. Conduct an epidemiologic investigation of each reported cysticercosis case or suspect case; and
2. For each cysticercosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

Contact ADHS.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2006
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

DENGUE (Dengue, Severe dengue, Dengue-like illness)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description

Dengue-like illness is defined by fever as reported by the patient or healthcare provider.

Dengue is defined by fever as reported by the patient or healthcare provider and the presence of one or more of the following signs and symptoms:

- Nausea/vomiting,
- Rash,
- Aches and pains (e.g., headache, retro-orbital pain, joint pain, myalgia, arthralgia),
- Tourniquet test positive,
- Leukopenia (a total white blood cell count of <5,000/mm^3), **or**
- Any warning sign for severe dengue:
    - Abdominal pain or tenderness
    - Persistent vomiting
    - Extravascular fluid accumulation (e.g., pleural or pericardial effusion, ascites)
    - Mucosal bleeding at any site
    - Liver enlargement >2 centimeters
    - Increasing hematocrit concurrent with rapid decrease in platelet count

Severe dengue is defined as dengue with any one or more of the following scenarios:

- Severe bleeding from the gastrointestinal tract (e.g., hematemesis, melena) or vagina (menorrhagia) as defined by requirement for medical intervention including intravenous fluid resuscitation or blood transfusion.
- Severe plasma leakage evidenced by hypovolemic shock and/or extravascular fluid accumulation (e.g., pleural or pericardial effusion, ascites) with respiratory distress. A high hematocrit value for patient age and sex offers further evidence of plasma leakage.
- Severe organ involvement, including any of the following:
    - Elevated liver transaminases: aspartate aminotransferase (AST) or alanine aminotransferase (ALT) >1,000 units per liter (U/L)
    - Impaired level of consciousness and/or diagnosis of encephalitis, encephalopathy, or meningitis
    - Heart or other organ involvement including myocarditis, cholecystitis, and pancreatitis

Laboratory Criteria for Diagnosis

Diagnostic testing should be requested for patients in whom there is a high index of suspicion for dengue, based either on signs and symptoms, or epidemiological linkage to a confirmed or probable dengue case.

Confirmatory Testing

- Detection of DENV nucleic acid in serum, plasma, blood, cerebrospinal fluid (CSF), other body fluid or tissue by validated reverse transcriptase-polymerase chain reaction (PCR), or
- Detection of DENV antigens in tissue by a validated immunofluorescence or immunohistochemistry assay, or
- Detection in serum or plasma of DENV NS1 antigen by a validated immunoassay; or
- Cell culture isolation of DENV from a serum, plasma, or CSF specimen; or
- Detection of IgM anti-DENV by validated immunoassay in a serum specimen or CSF in a person living in a dengue endemic or non-endemic area of the United States without evidence of other flavivirus transmission (e.g., WNV, SLEV, or recent vaccination against a flavivirus (e.g., YFV, JEV)); or
- Detection of IgM anti-DENV in a serum specimen or CSF by validated immunoassay in a traveler returning from a dengue endemic area without ongoing transmission of another flavivirus (e.g., WNV, JEV, YFV), clinical evidence of co-infection with one of these flaviviruses, or recent vaccination against a flavivirus (e.g., YFV, JEV); or
- IgM anti-DENV seroconversion by validated immunoassay in acute (i.e., collected <5 days of illness onset) and convalescent (i.e., collected >5 days after illness onset) serum specimens; or
- IgG anti-DENV seroconversion or ≥4-fold rise in titer by a validated immunoassay in serum specimens collected >2 weeks apart, and confirmed by a neutralization test (e.g., plaque reduction neutralization test) with a >4-fold higher end point titer as compared to other flaviviruses tested.

Probable Testing

- Detection of IgM anti-DENV by validated immunoassay in a serum specimen or CSF in a person living in a dengue endemic or non-endemic area of the United States with evidence of other flavivirus transmission (e.g., WNV, SLEV), or recent vaccination against a flavivirus (e.g., YFV, JEV).
- Detection of IgM anti-DENV in a serum specimen or CSF by validated immunoassay in a traveler returning from a dengue endemic area with ongoing transmission of another flavivirus (e.g., WNV, JEV, YFV), clinical evidence of co-infection with one of these flaviviruses, or recent vaccination against a flavivirus (e.g., YFV, JEV).

Suspected Testing

- The absence of IgM anti-DENV by validated immunoassay in a serum or CSF specimen collected <5 days after illness onset and in which molecular diagnostic testing was not performed in a patient with an epidemiologic linkage.

Epidemiologic Linkage

- Travel to a dengue endemic country or presence at location with ongoing outbreak within previous two weeks of dengue-like illness, OR
- Association in time and place (e.g., household member, family member, classmate, or neighbor) with a confirmed or probable dengue case.

Case Classification

Confirmed
A clinically compatible case of dengue-like illness, dengue, or severe dengue with confirmatory laboratory results, as listed above.

Probable
A clinically compatible case of dengue-like illness, dengue, or severe dengue with laboratory results indicative of probable infection, as listed above.

Suspect
A clinically compatible case of dengue-like illness, dengue, or severe dengue with an epidemiologic linkage, as listed above.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment
Asymptomatic Blood or Tissue Donor: Dengue virus-specific viral antigen or genomic sequences demonstrated in donated blood or organs during screening and confirmatory testing in the absence of symptoms in the donor.

Dengue viruses are members of the Flaviviridae family and have sufficient antigenic similarity to Zika virus, yellow fever virus, Japanese encephalitis virus, and West Nile virus that previous infection or vaccination may raise cross-reactive serum antibodies. After a primary infection with a heterologous flavivirus, subsequent antibody testing by ELISA may produce false positive results for a different flavivirus. PRNT can often resolve cross-reactive serum antibodies in this situation and identify the infecting virus. However, high-titered cross-reactive antibody levels produced from multiple previous flavivirus infections cannot be resolved by PRNT. This demonstrates the complexity inherent in serological diagnosis and differentiation in populations living in regions where more than one flavivirus co-circulates. However, only a small proportion of the U.S. population has evidence of previous flavivirus infection (or vaccination) so that cross-reactive flavivirus antibodies should not be a significant limitation to dengue diagnosis among most US travelers. Among U.S. residents, most testing for dengue is done through private clinical laboratories using IgM or IgG detection techniques.

A person with two clinical episodes of dengue occurring at least two weeks apart and shown to be due to different infecting DENV-types confirmed by molecular diagnostic testing should be classified as two different cases. However, for two clinical episodes of dengue in the same person diagnosed only by IgM anti-DENV on the second episode; to be considered separate cases, the episodes would have to occur >90 days apart due to the persistence of detectable IgM anti-DENV for ~90 days.

Reference testing is available from CDC's Dengue Branch, Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases, 1324 Calle Cañada, San Juan, PR 00920-3860, telephone 787-706-2399, fax 787-706-2496

CONTROL MEASURES

Arizona Administrative Code R9-6-329 Dengue

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a dengue case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported dengue case or suspect case;
3. For each dengue case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that each dengue case is provided with health education that includes measures to:
    a. Avoid mosquito bites, and
    b. Reduce mosquito breeding sites.

Environmental Control Measures

1. In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each dengue case or suspect case and implement vector control measures as necessary.

INVESTIGATION FORMS

See Dengue Case Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2015
Most Recent CDC/CSTE Revision Year	2015
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2015: Overall name changed from Dengue Fever to Dengue Virus Infections. Classifications changed from dengue fever, dengue hemorrhagic fever and dengue shock syndrome to dengue-like illness, dengue, or severe dengue, to match the new classifications adopted by the WHO in 2008. Modification of the laboratory criteria for confirmatory, probable and suspect testing. Changes match those in the CDC/CSTE definition.

DIARRHEA, NAUSEA, OR VOMITING	REPORT OUTBREAKS ONLY

CASE DEFINITION

Clinical Description
Possible outbreaks of disease come to the attention of public health officials in various ways. Often, an astute clinician, infection control nurse, or clinical laboratory worker first notices an unusual disease or an unusual number of cases of a disease and alerts public health officials. Frequently, it is the patient (or someone close to the patient) who first suspects a problem, as is often the case in foodborne outbreaks after a shared meal.

Outbreak Definition for Diarrhea, Nausea, or Vomiting
An outbreak of D, N, V is defined as two or more people not from the same household or family diagnosed or detected within a one-week period with similar illness consisting of a new onset of diarrhea, nausea and/or vomiting all of whom have a common exposure (ingestion of common food, residence in common location, or other exposure or event common to those ill).

Case Definition of Gastroenteritis (D, N, V)
A case of gastroenteritis is defined as a person with new onset of nausea, diarrhea and/or vomiting. Diarrhea is defined as two or more loose stools per 24 hour period or an unexplained increase in the number of bowel movements.

CONTROL MEASURES
Arizona Administrative Code R9-6-330 Diarrhea, Nausea, or Vomiting

Outbreak Control Measures
A local health agency shall:

1. Conduct an epidemiologic investigation of each reported outbreak of diarrhea, nausea, or vomiting;
2. Submit to the Department the information required under R9-6-206(E); and
3. Exclude each case that is part of an outbreak of diarrhea, nausea, or vomiting from:
    a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
        i. Diarrhea and vomiting have resolved, or
        ii. The local health agency has determined that the case is unlikely to infect other individuals; and
    b. Using an aquatic venue for two weeks after diarrhea has resolved.

Environmental Control Measures
A local health agency shall:

1. Conduct a sanitary inspection or ensure that a sanitary inspection is conducted of each facility or location regulated under 9 A.A.C. 8 that is associated with an outbreak of diarrhea, nausea, or vomiting.

INVESTIGATION FORMS

See Outbreak Summary Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2006
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

DIPHTHERIA	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS

CASE DEFINITION

Clinical Description

Diphtheria is caused by toxin-producing *Corynebacterium diphtheriae (C. diphtheriae)*. This disease primarily manifests as respiratory infections that may result in death, but it may also present as mild infections in non-respiratory sites, such as the skin. While respiratory diphtheria is now extremely rare, non-respiratory infections caused by toxin-producing bacteria have recently been detected. Non-respiratory disease caused by toxin-producing *C. diphtheriae* may act as a source of transmission and can lead to new respiratory and non-respiratory diphtheria disease; both respiratory and non-respiratory disease caused by toxin-producing bacteria require public health follow-up. This diphtheria surveillance case definition better reflects the epidemiology of diphtheria in the U.S, in order to focus efforts on identifying disease caused by toxin-producing bacteria and appropriately guide public health interventions.

Clinical Criteria for Diagnosis

- Upper respiratory tract illness with an adherent membrane of the nose, pharynx, tonsils, or larynx OR
- Infection of a non-respiratory anatomical site (e.g., skin, wound, conjunctiva, ear, genital mucosa)

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence

- Isolation of *C. diphtheriae* from any site AND
- Confirmation of toxin-production by Elek test or by another validated test capable of confirming toxin-production

Supportive Laboratory Evidence

- Histopathologic diagnosis

Epidemiologic Linkage

Epidemiologic linkage requires direct contact with a laboratory-confirmed case of diphtheria.

Case Classification

Confirmed

- An upper respiratory tract illness with an adherent membrane of the nose, pharynx, tonsils, or larynx and any of the following:
    - isolation of toxin-producing *Corynebacterium diphtheriae* from the nose or throat OR
    - epidemiologic linkage to a laboratory-confirmed case of diphtheria.

OR

- An infection at a non-respiratory anatomical site (e.g., skin, wound, conjunctiva, ear, genital mucosa) and isolation of toxin-producing *Corynebacterium diphtheriae* from that site.

Suspect

- In the absence of a more likely diagnosis, an upper respiratory tract illness with each of the following:
    - an adherent membrane of the nose, pharynx, tonsils, or larynx AND
    - absence of laboratory confirmation AND
    - lack of epidemiologic linkage to a laboratory-confirmed case of diphtheria

OR

- Histopathologic diagnosis

Criteria to Distinguish a New Case from an Existing Case

Individuals without evidence of clinical criteria as described by the diphtheria surveillance case definition but for whom toxin-producing *Corynebacterium diphtheriae* is confirmed via laboratory testing (isolation and toxigenicity testing by modified Elek test or other validated test capable of confirming toxin-production) should not be classified as cases. These individuals are considered carriers of the bacteria and are not reportable.

Comment

- Cases of laboratory-confirmed, non-toxin-producing *C. diphtheriae* (respiratory or non-respiratory) should not be reported by state or local health departments to CDC as diphtheria cases.
- Negative laboratory results may be sufficient to rule-out a diagnosis of diphtheria; however, clinicians should carefully consider all lab results in the context of the patient's vaccination status, antimicrobial treatment, and other risk factors.
- PCR and MALDI-TOF diagnostics for *C. diphtheriae*, when used alone, do not confirm toxin production. These tests, when used, should always be combined with a test that confirms toxin production, such as the Elek test.

CONTROL MEASURES

Arizona Administrative Code R9-6-331 Diphtheria

Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall:
    a. Isolate and institute droplet precautions for a pharyngeal diphtheria case or suspect case until two successive sets of cultures negative for *Corynebacterium diphtheriae* are obtained from nose and throat specimens collected from the case or suspect case at least 24 hours apart and at least 24 hours after cessation of treatment; and
    b. Isolate and institute contact precautions for a cutaneous diphtheria case or suspect case until two successive sets of cultures negative for *Corynebacterium diphtheriae* are obtained from skin specimens collected from the case or suspect case at least 24 hours apart and at least 24 hours after cessation of treatment.
2. A local health agency shall:

a. Upon receiving a report under R9-6-202 of a diphtheria case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
b. Conduct an epidemiologic investigation of each reported diphtheria case or suspect case; and
c. For each diphtheria case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures:
A local health agency shall:

1. Exclude each diphtheria contact from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a school or child care establishment until a set of cultures negative for *Corynebacterium diphtheriae* is obtained from the contact's nose and throat specimens;
2. In consultation with the Department, quarantine a contact of a diphtheria case, if indicated, until two successive sets of cultures negative for *Corynebacterium diphtheriae* are obtained from nose and throat specimens collected from the contact at least 24 hours apart;
3. Offer each previously immunized diphtheria contact prophylaxis and a vaccine containing diphtheria toxoid; and
4. Offer each unimmunized diphtheria contact prophylaxis and the primary vaccine series.

INVESTIGATION FORMS

See Diphtheria Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2019
Most Recent CDC/CSTE Revision Year	2019
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2019: Updated to include non-respiratory disease and to require confirmation that the bacteria is toxin-producing. Probable classification removed and suspect added. Changes based on modifications to CDC/CSTE definition.

EHRLICHIOSIS	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

A tick-borne illness characterized by acute onset of fever and one or more of the following signs or symptoms: headache, myalgia, malaise, anemia, leukopenia, thrombocytopenia, or elevated liver enzymes. Nausea, vomiting, or rash may be present in some cases.

Intracytoplasmic bacterial aggregates (morulae) may be visible in the leukocytes of some patients. There are at least three species of bacteria responsible for ehrlichia/anaplasmosis in the U.S.: *Ehrlichia chaffeensis*, found primarily in monocytes, and *Anaplasma phagocytophilum* and *Ehrlichia ewingii*, found primarily in granulocytes*. For cases with evidence of *Anaplasma* spp. infection, see the Anaplasmosis case definition.

Three categories of confirmed or probable ehrlichiosis should be reported:

1. Human ehrlichiosis caused by *E. chaffeensis* (formerly Human Monocytic Ehrlichiosis or HME),
2. Human ehrlichiosis caused by *E. ewingii* (formerly unspecified or other agent), and
3. Human ehrlichiosis/anaplasmosis- undetermined. Cases in this category can only be reported as "probable" because the cases are only weakly supported by ambiguous lab test results.

Human anaplasmosis caused by *Anaplasma phagocytophilum* (formerly Human Granulocytic Ehrlichiosis or HGE) should instead be reported and entered as anaplasmosis.

*Note: The clinical signs of disease from infection with these agents are similar, and the range distributions overlap, so testing for one or more species may be indicated. Serologic cross-reactions may occur among tests for these agents.

Clinical evidence

Any reported fever and one or more of the following: headache, myalgia, anemia, leukopenia, thrombocytopenia, or any hepatic transaminase elevation.

Exposure

History of having been in potential tick habitat in the 14 days prior to the onset of illness or history of tick bite.

Laboratory Criteria for Surveillance

Ehrlichia chaffeensis infection (formerly HME):

Confirmatory Testing

- Serological evidence of a four-fold change in immunoglobulin G (IgG)-specific antibody titer to *E. chaffeensis* antigen by indirect immunofluorescence assay (IFA) in paired serum samples (one taken in first week of illness and a second 2-4 weeks later), OR
- Detection of *E. chaffeensis* DNA in a clinical specimen via PCR assay, OR
- Demonstration of ehrlichial antigen in a biopsy or autopsy sample by IHC, OR
- Isolation of *E. chaffeensis* from a clinical specimen in cell culture.

Presumptive Testing

- Serological evidence of elevated IgG or IgM antibody reactive with *E. chaffeensis* antigen by IFA, ELISA, dot-ELISA, or assays in other acceptable formats, OR
- Identification of morulae in the cytoplasm of monocytes or macrophages by microscopic examination.

Ehrlichia ewingii infection (formerly unspecified or other agent):

Confirmatory Testing
Detection of *E. ewingii* DNA in a clinical specimen via PCR assay. *E. ewingii* has never been cultured; therefore, antigens are not available and this infection may only be diagnosed by molecular detection methods.

Human ehrlichiosis/anaplasmosis - undetermined:
See case classification

Case Classification

Confirmed
A clinically compatible case that meets the criteria for clinical evidence criteria and for confirmatory laboratory testing.

Probable
A clinically compatible case that meets clinical evidence criteria and has presumptive laboratory results. For ehrlichiosis/anaplasmosis, an undetermined case can only be classified as probable. An undetermined case has compatible clinical criteria with lab evidence to support ehrlichia/anaplasma infection, but not with sufficient clarity to definitively place it in one of the categories described. This may include identification of morulae in white cells by microscopic examination in the absence of other presumptive lab results.

Suspect
A case with lab evidence of past or present infection but no clinical information available (e.g., a lab report).

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment
Problem cases for which sera demonstrate elevated antibody IFA responses to more than a single infectious agent are usually resolvable by comparing the levels of the antibody responses, the greater antibody response generally being that directed at the actual agent involved. Tests of additional sera and further evaluation using PCR, IHC, and isolation via cell culture may be needed for further clarification. Cases involving persons infected with more than a single agent, while possible, are

extremely rare and every effort should be made to resolve cases that appear as such by other explanations.

Current commercially available ELISA tests are not quantitative, cannot be used to evaluate changes in antibody titer, and are not useful for serological confirmation. IgM tests are not always specific and the IgM response may be persistent. IgM tests are not strongly supported for use in serodiagnosis of acute disease.

CONTROL MEASURES

Arizona Administrative Code R9-6-332 Ehrlichiosis

Case Control Measures

A local health agency shall:

1. Conduct an epidemiologic investigation of each reported ehrlichiosis case or suspect case; and
2. For each ehrlichiosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Tick-Borne Rickettsial Disease Case Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2012
Most Recent CDC/CSTE Revision Year	2008
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2018: Anaplasmosis split from ehrlichiosis, compatible with the listing in the reportable disease rules. ADHS case definitions revised in 2012 to match CDC/CSTE.

EMERGING OR EXOTIC DISEASE	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

The following conditions may be reported under Emerging and Exotic Disease; please see the separate sections in this manual for their case definitions. This is not an exhaustive list of possible emerging or exotic diseases, only ones for which a separate case definition exists.

- Acute Flaccid Myelitis (AFM)
- *Candida auris*
- Influenza A Novel Virus
- Vancomycin-resistant *Staphylococcus epidermidis* (VRSE)

CASE DEFINITION

Definition

Emerging or Exotic Diseases are defined as those meeting one of the following definitions:

- A disease which is newly appeared in the population, or
- A disease whose incidence in humans has increased in the past two decades or threatens to increase in the near future, or
- A disease with increasing incidence in a defined time period and location

Examples may include:

- New infections resulting from changes or evolution of existing organisms
- Known infections spreading to new geographic areas or populations
- Previously unrecognized infections appearing in areas undergoing ecologic transformation
- Old infections reemerging as a result of antimicrobial resistance in known agents or breakdown in public health measures

Case reports of emerging or exotic disease should specify the morbidity and etiological agent, if known, and may be subject to additional clinical or laboratory criteria for classification.

CONTROL MEASURES

Arizona Administrative Code R9-6-333 Emerging or Exotic Disease

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of an emerging or exotic disease case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. In consultation with the Department, isolate an emerging or exotic disease case or suspect case as necessary to prevent transmission;
3. Conduct an epidemiologic investigation of each reported emerging or exotic disease case or suspect case; and
4. For each emerging or exotic disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures

A local health agency, in consultation with the Department,

1. Shall quarantine or exclude an emerging or exotic disease contact as necessary, according to R9-6-303, to prevent transmission.

INVESTIGATION FORMS

None. Some pathogens reported under Emerging or Exotic Disease may have a specific investigation form; check with ADHS if uncertain.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	Before 2012
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

ENCEPHALITIS, PARASITIC	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS

CASE DEFINITION

Parasitic encephalitis may be caused by free-living amebae, including:

- Granulomatous Amebic Encephalitis (GAE), *Acanthamoeba* Disease, excluding keratitis
- Granulomatous Amebic Encephalitis (GAE), *Balamuthia mandrillaris* Disease
- Primary Amebic Meningoencephalitis (PAM), *Naegleria fowleri* Disease

Please see those individual case definitions for complete descriptions. Cases of parasitic encephalitis caused by other organisms not represented here may also occur and be counted as cases

Acanthamoeba keratitis is a form of *Acanthamoeba* disease that does not cause encephalitis. The case definition can be found in the non-reportable disease section.

CONTROL MEASURES

Arizona Administrative Code R9-6-334 Encephalitis, Viral or Parasitic

Case Control Measures

A local health agency shall:

1. Upon receiving a report of encephalitis under R9-6-202, notify the Department:
    a. For a case or suspect case of parasitic encephalitis, within 24 hours after receiving the report and provide to the Department the information contained in the report; and
    b. For a case or suspect case of viral encephalitis, within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported viral or parasitic encephalitis case or suspect case; and
3. For each encephalitis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

Contact ADHS. Depending on the etiology of the encephalitis, an investigation form may or may not be available.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	2017: Split into four separate case definitions: Granulomatous Amebic Encephalitis (GAE) *Acanthamoeba* Disease excluding keratitis,

	Granulomatous Amebic Encephalitis (GAE) *Balamuthia mandrillaris* Disease, Primary Amebic Meningoencephalitis (PAM) *Naegleria fowleri* Disease, and Acanthamoeba keratitis (moved to non-reportable diseases). Definitions for free-living amebic infections moved into Encephalitis, parasitic in 2013.

ENCEPHALITIS, VIRAL	PROVIDERS SUBMIT A REPORT WITHIN 1 WORKING DAY

Viral encephalitis is a general category meant to be used to report encephalitis of suspected viral origins until a specific etiology is identified, or to detect clusters of encephalitis cases of possible public health concern. Examples of viruses causing viral encephalitis are adenoviruses, enteroviruses, herpes simplex virus (HSV), varicella zoster virus (VZV) and some arboviruses (West Nile virus, St. Louis Encephalitis virus, etc.).

Since the viral encephalitis morbidity represents a collection of cases of different etiologies, and possibly with varying risk factors and public health implications, ADHS will no longer publish case counts for viral encephalitis, as those counts are difficult to interpret meaningfully. The viral encephalitis morbidity will instead be used solely for reporting and investigation purposes, to identify any need for further public health control measures or follow-up.

For cases reported or entered into MEDSIS under the "Encephalitis, viral" morbidity:

- Once a specific viral etiology has been identified, **please enter the case under that specific morbidity** in MEDSIS, if available, and classify using the corresponding case definitions:
    - For West Nile virus, St. Louis Encephalitis virus, California Serogroup viruses, Eastern Equine Encephalitis virus, Western Equine Encephalitis virus and other arboviruses, please refer to the Arboviral Infection case definition.
    - For varicella zoster virus (VZV) please refer to the Varicella case definition.
    - Please indicate in the MEDSIS viral encephalitis case that the case has been moved to the other morbidity. No further action is needed in the viral encephalitis case.
- For non-reportable etiologies (e.g., HSV, adenovirus, enterovirus) for which there is no case classification nor MEDSIS morbidity, the case should remain in the viral encephalitis morbidity.

Since ADHS will no longer report case counts for this morbidity, and since it represents a variety of etiologies, case classification (e.g., confirmed, probable) is not needed for these cases. Local case classifications can be used at the discretion of the local health agency.

Please note that reporting and investigation of viral encephalitis continues to be required by Arizona Administrative Code (see below). The investigation should identify whether any further public health action or follow-up is needed for the case.

CONTROL MEASURES

Arizona Administrative Code R9-6-334 Encephalitis, Viral or Parasitic

Case Control Measures

A local health agency shall:

1. Upon receiving a report of encephalitis under R9-6-202, notify the Department:
    a. For a case or suspect case of parasitic encephalitis, within 24 hours after receiving the report and provide to the Department the information contained in the report; and
    b. For a case or suspect case of viral encephalitis, within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported viral or parasitic encephalitis case or suspect case; and

3. For each encephalitis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2019
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	2019: Case definition modified to clarify its use. Case classifications have been removed.

***ESCHERICHIA COLI*, SHIGA TOXIN-PRODUCING**	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description

An infection of variable severity characterized by diarrhea (often bloody) and abdominal cramps. Illness may be complicated by hemolytic uremic syndrome (HUS). (Note that some clinicians still use the term thrombotic thrombocytopenic purpura [TTP] for adults with post-diarrheal HUS.)

Laboratory Criteria for Diagnosis

Confirmatory results

- Isolation of *E. coli* O157:H7 from a specimen, OR
- For all other *E. coli* isolates, identification of Shiga toxin or Shiga toxin genes

Supportive results

- Isolation of *E. coli* O157 from a clinical specimen, without confirmation of H antigen, detection of Shiga toxin, or detection of Shiga toxin genes, OR
- Identification of an elevated antibody titer against a known Shiga toxin-producing serogroup of *E. coli*, OR
- Detection of Shiga toxin or Shiga toxin genes in a clinical specimen using a culture-independent diagnostic test (CIDT) and no known isolation of *Shigella* from a clinical specimen, OR
- Detection of *E. coli* O157 or STEC/EHEC in a clinical specimen using a CIDT.

Epidemiologic Linkage

- A clinically compatible illness in a person that is epidemiologically linked to a confirmed or probable case with laboratory evidence, OR
- A clinically compatible illness in a person that is a member of a risk group as defined by public health authorities during an outbreak.

Case Classification

Confirmed

- A case that meets the confirmatory laboratory criteria for diagnosis

Probable

- A person with isolation of *E. coli* O157 from a clinical specimen, without confirmation of H antigen, detection of Shiga toxin, or detection of Shiga toxin genes, OR
- A clinically compatible illness in a person with identification of an elevated antibody titer against a known Shiga toxin-producing serogroup of *E. coli*, OR

- A clinically compatible illness in a person with detection of Shiga toxin or Shiga toxin genes in a clinical specimen using CIDT and no known isolation of *Shigella* from a clinical specimen, OR
- A clinically compatible illness in a person with detection of *E. coli* O157 or STEC/EHEC from a clinical specimen using a CIDT, OR
- A clinically compatible illness in a person with an epidemiological linkage, as defined above.

Suspect

- A person with no known clinical compatibility that meets one of the last three supportive laboratory criteria for diagnosis:
    - Identification of an elevated antibody titer against a known Shiga toxin-producing serogroup of *E. coli*, OR
    - Detection of Shiga toxin or Shiga toxin genes in a clinical specimen using a CIDT and no known isolation of *Shigella* from a clinical specimen, OR
    - Detection of *E. coli* O157 or STEC/EHEC in a clinical specimen using a CIDT; OR
- A person with a diagnosis of case of post-diarrheal HUS (see HUS case definition).

Criteria to Distinguish a New Case from an Existing Case

- A new case should be created when a positive laboratory result is received more than 180 days after the most recent positive laboratory result associated with a previously reported case in the same individual, OR
- When two or more different serogroups/serotypes are identified in one or more specimens from the same individual, each serogroup/serotype should be reported as a separate case.

Comment

Asymptomatic infections and infections at sites other than the gastrointestinal tract in people (1) meeting the confirmatory laboratory criteria for diagnosis or (2) with isolation of *E. coli* O157 from a clinical specimen without confirmation of H antigen, detection of Shiga toxin, or detection of Shiga toxin genes, are considered STEC cases and should be reported.

Although infections with Shiga toxin-producing organisms in the United States are primarily caused by STEC, in recent years an increasing number are due to infections by Shiga toxin-producing *Shigella*. Persons with (1) detection of Shiga toxin or Shiga toxin genes using a CIDT and (2) isolation of *Shigella* spp. from a clinical specimen should not be reported as an STEC case.

Due to the variable sensitivities and specificities of CIDT methods and the potential for degradation of Shiga toxin in a specimen during transit, discordant results may occur between clinical and public health laboratories. Persons with (1) detection of Shiga toxin or Shiga toxin genes using a CIDT and (2) the absence of isolation of *Shigella* from a clinical specimen, should be reported as a probable case, regardless of whether detection of Shiga toxin or Shiga toxin genes is confirmed by a public health laboratory.

CONTROL MEASURES

Arizona Administrative Code R9-6-335 *Escherichia coli*, Shiga Toxin-producing

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 or R9-6-203 of a Shiga toxin-producing *Escherichia coli* case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Exclude a Shiga toxin-producing *Escherichia coli* case or suspect case with diarrhea from:
    a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
        i. Two successive stool specimens, collected from the Shiga toxin-producing *Escherichia coli* case or suspect case at least 24 hours apart, are negative for Shiga toxin-producing *Escherichia coli*;
        ii. Diarrhea has resolved; or
        iii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
    b. Using an aquatic venue for two weeks after diarrhea has resolved;
3. Conduct an epidemiologic investigation of each reported Shiga toxin-producing *Escherichia coli* case or suspect case; and
4. For each Shiga toxin-producing *Escherichia coli* case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Environmental Control Measures

A local health agency shall

1. If an animal located in a private residence is suspected to be the source of infection for an a Shiga toxin-producing *Escherichia coli* case or outbreak, provide health education for the animal's owner about Shiga toxin-producing *Escherichia coli* and the risks of becoming infected with Shiga toxin-producing Escherichia coli; and
2. If an animal located in a setting other than a private residence is suspected to be the source of infection for a Shiga toxin-producing *Escherichia coli* case or outbreak:
    a. Provide health education for the animal's owner about Shiga toxin-producing *Escherichia coli* and the risks of becoming infected with Shiga toxin-producing *Escherichia coli*, and
    b. Require the animal's owner to provide information to individuals with whom the animal may come into contact about Shiga toxin-producing *Escherichia coli* and methods to reduce the risk of transmission.

INVESTIGATION FORMS

See Enterohemorrhagic *E. coli* (Shiga-toxin producing) Investigation Form at
http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2018
Most Recent CDC/CSTE Revision Year	2018
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2018: Included CIDT testing in supportive results, allowing for cases with this testing to be classified as probable. Added epidemiologic

	linkage and criteria to distinguish a new case from an existing case. 2016: Identification of Shiga toxin genes added to the supportive results. Addition of "Identification of Shiga toxin genes in a specimen from a clinically compatible case if no specimen is available to culture" to the suspect case definition. 2014: Modifications were made to the supportive laboratory results to match the 2014 CDC/CSTE case definitions. 2013: ADHS case definition was edited to match CDC/CSTE except for a difference in the suspect and probable case classifications for classifying cases when no specimen is available to culture.

FOODBORNE DISEASE OUTBREAK	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS

Outbreaks should be reported under the Diarrhea, Nausea, or Vomiting requirement.

CASE DEFINITION

Clinical Description
Symptoms of illness depend upon etiologic agent. Please see the "Guidelines for Confirmation of Foodborne-Disease Outbreaks" tables at http://www.cdc.gov/foodsafety/outbreaks/investigating-outbreaks/confirming_diagnosis.html.

Laboratory Criteria for Diagnosis
Dependent upon the etiologic agent.

Please see the "Guidelines for Confirmation of Foodborne-Disease Outbreaks" tables at http://www.cdc.gov/foodsafety/outbreaks/investigating-outbreaks/confirming_diagnosis.html.

Definition
An incident in which two or more persons experience a similar illness after ingestion of a common food, and epidemiologic analysis implicates the food as the source of the illness.

Comment
There are two exceptions: one case of botulism or chemical poisoning linked to a food item constitutes an outbreak.

CONTROL MEASURES
Arizona Administrative Code R9-6-330 Diarrhea, Nausea, or Vomiting

Outbreak Control Measures
A local health agency shall:

1. Conduct an epidemiologic investigation of each reported outbreak of diarrhea, nausea, or vomiting;
2. Submit to the Department the information required under R9-6-206(E); and
3. Exclude each case that is part of an outbreak of diarrhea, nausea, or vomiting from:
    a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
        i. Diarrhea and vomiting have resolved, or
        ii. The local health agency has determined that the case is unlikely to infect other individuals; and
    b. Using an aquatic venue for two weeks after diarrhea has resolved.

Environmental Control Measures
A local health agency shall:

1. Conduct a sanitary inspection or ensure that a sanitary inspection is conducted of each facility or location regulated under 9 A.A.C. 8 that is associated with an outbreak of diarrhea, nausea, or vomiting.

INVESTIGATION FORMS

See Outbreak Summary Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2011
Most Recent CDC/CSTE Revision Year	2011
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

GIARDIASIS	PROVIDERS REPORT WITHIN 24 HOURS IF AN OUTBREAK IS DETECTED OR PERSON HAS A HIGH-RISK OCCUPATION PROVIDERS SUBMIT A REPORT WITHIN 5 DAYS FOR ALL OTHER CASES

CASE DEFINITION

Clinical Description
An illness caused by the protozoan *Giardia lamblia* (aka *G. intestinalis* or *G. duodenalis*) and characterized by gastrointestinal symptoms such as diarrhea, abdominal cramps, bloating, weight loss, or malabsorption.

Laboratory Criteria for Diagnosis
Laboratory-confirmed giardiasis is defined as the detection of *Giardia* organisms, antigen, or DNA in stool, intestinal fluid, tissue samples, biopsy specimens or other biological samples.

Case Classification

Confirmed
A case that meets the clinical description and the criteria for laboratory confirmation as described above. When available, molecular characterization (e.g., assemblage designation) should be reported.

Probable
A case that meets the clinical description and that is epidemiologically linked to a confirmed case.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

CONTROL MEASURES
Arizona Administrative Code R9-6-336 Giardiasis

Case Control Measures
A local health agency shall

1. Exclude a giardiasis case or suspect case with diarrhea from:
    a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
        i. Treatment for giardiasis is initiated and diarrhea has resolved, or
        ii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
    b. Using an aquatic venue for two weeks after diarrhea has resolved;
2. Conduct an epidemiologic investigation of each reported giardiasis case or suspect case; and
3. For each giardiasis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Giardiasis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2011
Most Recent CDC/CSTE Revision Year	2011
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

GLANDERS (*Burkholderia mallei)*	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Please contact the Office of Infectious Disease Services at (602) 364-3676 to discuss the case definition if a suspected case of *Burkholderia mallei* is detected.

CONTROL MEASURES

Arizona Administrative Code R9-6-337 Glanders

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a glanders case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported glanders case or suspect case;
3. For each glanders case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that an isolate or a specimen, as available, from each glanders case or suspect case is submitted to the Arizona State Laboratory.

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2013
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	Separated from *Burkholderia pseudomallei* in 2013 to reflect distinct clinical presentation.

GONORRHEA	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description
A sexually transmitted infection commonly manifested by urethritis, cervicitis, or salpingitis. Infection may be asymptomatic.

Laboratory Criteria for Diagnosis

- Isolation of typical gram-negative, oxidase-positive diplococci by culture (presumptive *Neisseria gonorrhoeae*) from a clinical specimen, OR
- Demonstration of *N. gonorrhoeae* in a clinical specimen by detection of antigen or nucleic acid, OR
- Observation of gram-negative intracellular diplococci in a urethral smear obtained from a male or an endocervical smear obtained from a female

Case Classification

Confirmed
A person with laboratory isolation of typical gram-negative, oxidase-positive diplococcic by culture (presumptive *Neisseria gonorrhoeae*) from a clinical specimen, or demonstration of *N. gonorrhoeae* in a clinical specimen by detection of antigen or detection of nucleic acid via nucleic acid amplification (e.g., Polymerase Chain Reaction [PCR]) or hybridization with a nucleic acid probe.

Probable
Demonstration of gram-negative intracellular diplococci in a urethral smear obtained from a male or an endocervical smear obtained from a female.

Criteria to Distinguish a New Case from an Existing Case
A case should not be counted as a new case if laboratory results were reported within 30 days of a previously reported infection in the same individual, unless there is evidence of reinfection. The 30 days should be counted from the date of initial screening unless treated. For cases with treatment, the 30 days should be counted from the initial treatment date. Additional details can be found at https://www.cdc.gov/std/laboratory/de-duplication-guidance-june2016.pdf.

CONTROL MEASURES
Arizona Administrative Code R9-6-338, R9-6-1101 thru R9-6-1104 Gonorrhea

Case Control Measures:
1. For the prevention of gonorrheal ophthalmia, a physician, physician assistant, registered nurse practitioner, or midwife attending the birth of an infant in this state shall treat the eyes of the infant immediately after the birth with one of the following, unless treatment is refused by the parent or guardian:
    a. Erythromycin ophthalmic ointment 0.5%, or
    b. Tetracycline ophthalmic ointment 1%.

2. A local health agency shall comply with the requirements specified in R9-6-1103 concerning treatment and health education for a gonorrhea case that seeks treatment from the local health agency.

Contact Control Measures:
If an individual who may have been exposed to gonorrhea through sexual contact with a gonorrhea case seeks treatment for symptoms of gonorrhea from a local health agency, the local health agency shall comply with the requirements specified in R9-6-1103 concerning treatment and health education for the individual.

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2014
Most Recent CDC/CSTE Revision Year	2014
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2014: Laboratory criteria revised to include an endocervical smear obtained from a female; probable case definition modified to remove the criterion of a written morbidity report of gonorrhea submitted by a physician and urethral smear obtained from a male was added; modifications made to match the 2014 CDC/CSTE case definition.

GRANULOMATOUS AMEBIC ENCEPHALITIS (GAE), *Acanthamoeba* Disease excluding keratitis	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS

Cases should be reported under the Encephalitis, parasitic requirement. Enter in MEDSIS as Encephalitis, parasitic.

CASE DEFINITION

Clinical Description

The genus *Acanthamoeba* includes several species of opportunistic free-living amebae that might invade the brain through the blood, probably from a primary infection in the skin (from ulcers or dermatitis) or sinuses. Once in the brain, the amebae cause granulomatous amebic encephalitis (GAE). *Acanthamoeba* GAE has a slow and insidious onset and develops into a subacute or chronic disease lasting several weeks to months. *Acanthamoeba* GAE affects both immunocompetent persons and persons who are immunosuppressed from a variety of causes (e.g., HIV/AIDS, organ transplantation). Initial symptoms of *Acanthamoeba* GAE might include headache, photophobia, and stiff neck accompanied by positive Kernig's and Brudzinski's signs. Other symptoms might include nausea, vomiting, low-grade fever, muscle aches, weight loss, mental-state abnormalities, lethargy, dizziness, loss of balance, cranial nerve palsies, other visual disturbances, hemiparesis, seizures, and coma. Once the disease progresses to neurologic infection, it is generally fatal within weeks or months. However, a few patients have survived this infection.

Laboratory Criteria for Diagnosis

Confirmatory Testing

Detection of *Acanthamoeba* antigen or nucleic acid (e.g., immunohistochemistry or PCR) from a clinical specimen (e.g., tissue) or culture.

Case Classification

Confirmed

A case that meets the clinical criteria and confirmatory laboratory criteria for diagnosis

Criteria to Distinguish a New Case from an Existing Case*

A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment

Acanthamoeba and *B. mandrillaris* can cause clinically similar illnesses and might be difficult to differentiate using commonly available laboratory procedures. Definitive diagnosis by a reference laboratory might be required. Several species of *Acanthamoeba* are associated with infection (i.e., *A. castellanii*, *A. culbertsoni*, *A. hatchetti*, *A. healyi*, *A. polyphaga*, *A. rhysodes*, *A. astonyxis*, *A. lenticulata* and *A. divionensis*). A negative test on CSF does not rule out *Acanthamoeba* infection because the organism is not commonly present in the CSF. Although it is unknown if *Acanthamoeba* spp. can be

transmitted via organ transplantation, patients presenting with the above clinical criteria who have received a solid organ transplant should be further investigated to determine if the infection was transmitted through the transplanted organ. An investigation of the donor should be initiated through notification of the organ procurement organization (OPO) and transplant center.

CONTROL MEASURES

Arizona Administrative Code R9-6-334 Encephalitis, Viral or Parasitic

Case Control Measures

A local health agency shall:

1. Upon receiving a report of encephalitis under R9-6-202, notify the Department:
    a. For a case or suspect case of parasitic encephalitis, within 24 hours after receiving the report and provide to the Department the information contained in the report; and
    b. For a case or suspect case of viral encephalitis, within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported viral or parasitic encephalitis case or suspect case; and
3. For each encephalitis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

Contact ADHS. Depending on the etiology of the encephalitis, an investigation form may or may not be available.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	2017
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2017: Separated from encephalitis, parasitic and a separate case definition created. Laboratory criteria and confirmatory case classification updated. Comments expanded. All to match 2016 CSTE position statement.

GRANULOMATOUS AMEBIC ENCEPHALITIS (GAE), *Balamuthia mandrillaris* Disease	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS

Cases should be reported under the Encephalitis, parasitic requirement. Enter in MEDSIS as Encephalitis, parasitic.

CASE DEFINITION

Clinical Description

B. mandrillaris is an opportunistic free-living ameba that can invade the brain through the blood, probably from a primary infection in the skin (from ulcers or dermatitis), sinuses, or via organ transplantation. The incubation period is not well-characterized but has been observed to range from 2 weeks to months or possibly years. Once in the brain, the amebae can cause meningoencephalitis and/or granulomatous amebic encephalitis (GAE). *B. mandrillaris* GAE often has a slow, insidious onset and develops into a subacute or chronic disease lasting several weeks to months; however, *B. mandrillaris* infections associated with organ transplantation have an especially rapid clinical course. *B. mandrillaris* GAE affects both immunocompetent persons and persons who are immunosuppressed from a variety of causes (e.g., HIV/AIDS, organ transplantation). Initial symptoms of *B. mandrillaris* GAE might include headache, photophobia, and stiff neck accompanied by positive Kernig's and Brudzinski's signs. Other symptoms might include nausea, vomiting, low-grade fever, muscle aches, weight loss, mental-state abnormalities, lethargy, dizziness, loss of balance, cranial nerve palsies, other visual disturbances, hemiparesis, seizures, and coma. Painless skin lesions appearing as plaques a few millimeters thick and one to several centimeters wide have been observed in some patients, especially patients outside the U.S., preceding the onset of neurologic symptoms by 1 month to approximately 2 years. Once the disease progresses to neurologic infection, it is generally fatal within weeks or months; however, a few patients have survived this infection.

Laboratory Criteria for Diagnosis

Detection of *B. mandrillaris* antigen or nucleic acid (e.g., immunohistochemistry or PCR) from a clinical specimen (e.g., tissue) or culture.

Case Classification

Confirmed

A case that meets the clinical criteria and confirmatory laboratory criteria for diagnosis

Criteria to Distinguish a New Case from an Existing Case*

A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment

B. mandrillaris and *Acanthamoeba* spp. can cause clinically similar illnesses and might be difficult to differentiate using commonly available laboratory procedures. Definitive diagnosis by a reference laboratory might be required. A negative test on CSF does not rule out *B. mandrillaris* infection because

the organism is not commonly present in the CSF. Once the disease progresses to neurologic infection, it is generally fatal within weeks or months; however, a few patients have survived this infection. Patients presenting with the above clinical criteria who have received a solid organ transplant should be further investigated to determine if the infection was transmitted through the transplanted organ. An investigation of the donor should be initiated through notification of the organ procurement organization (OPO) and transplant center.

CONTROL MEASURES

Arizona Administrative Code R9-6-334 Encephalitis, Viral or Parasitic

Case Control Measures

A local health agency shall:

1. Upon receiving a report of encephalitis under R9-6-202, notify the Department:
    a. For a case or suspect case of parasitic encephalitis, within 24 hours after receiving the report and provide to the Department the information contained in the report; and
    b. For a case or suspect case of viral encephalitis, within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported viral or parasitic encephalitis case or suspect case; and
3. For each encephalitis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

Contact ADHS. Depending on the etiology of the encephalitis, an investigation form may or may not be available.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	2017
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2017: Separated from encephalitis, parasitic and a separate case definition created. Laboratory criteria and confirmatory case classification updated. Comments expanded. All to match 2016 CSTE position statement.

***HAEMOPHILUS INFLUENZAE*, INVASIVE DISEASE**	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description
Invasive disease due to *Haemophilus influenzae* may produce any of several clinical syndromes, including pneumonia, bacteremia, meningitis, epiglottitis, septic arthritis, cellulitis, or purulent pericarditis; less common infections include endocarditis and osteomyelitis.

Laboratory Criteria for Diagnosis

Confirmatory results

- Isolation of *H. influenzae* from a normally sterile body site (e.g., cerebrospinal fluid (CSF), blood, joint fluid, pleural fluid, pericardial fluid), or
- Detection of *Haemophilus influenzae*-specific nucleic acid in a specimen obtained from a normally sterile body site, using a validated polymerase chain reaction (PCR) assay

Presumptive results

- Detection of *Haemophilus influenzae* type b antigen in CSF

Case Classification

Confirmed
A case that meets either of the confirmatory laboratory criteria for diagnosis.

Probable
Meningitis with detection of *Haemophilus influenzae* type b antigen in CSF.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

When two or more different serotypes are identified in one or more specimens from the same individual, each should be reported as a separate case.

*Based on ADHS guidelines

Comment
Positive antigen test results in urine or serum are unreliable for diagnosis of *H. influenzae* disease and should not be used as a basis for case classification.

Isolates of *Haemophilus influenzae* are important for antimicrobial susceptibility testing.

See Appendix 1 for guidance on interpreting whether a specimen is from a “normally sterile body site”.

CONTROL MEASURES

Arizona Administrative Code R9-6-339 *Haemophilus influenzae*: Invasive Disease

Case Control Measures

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute droplet precautions for a *Haemophilus influenzae* meningitis or epiglottitis case or suspect case for 24 hours after the initiation of treatment.
2. A local health agency shall:
    a. Upon receiving a report under R9-6-202 or R9-6-203 of a *Haemophilus influenzae* invasive disease case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
    b. Conduct an epidemiologic investigation of each reported *Haemophilus influenzae* invasive disease case or suspect case; and
    c. For each *Haemophilus influenzae* invasive disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures

A local health agency shall

1. Evaluate the level of risk of transmission from each contact's exposure to a *Haemophilus influenzae* invasive disease case and, if indicated, shall provide or arrange for each contact to receive immunization or treatment.

INVESTIGATION FORMS

See *Haemophilus influenzae* Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2015
Most Recent CDC/CSTE Revision Year	2015
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2015: Added detection by PCR to confirmed case definition, and probable case definition modified to specify meningitis instead of clinically compatible. Both changes match CDC/CSTE revisions. 2013: Minor revisions to ADHS case definition to better match CDC/CSTE.

HANSEN'S DISEASE (Leprosy)	PROVIDERS SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

A chronic bacterial disease characterized by the involvement primarily of skin as well as peripheral nerves and the mucosa of the upper airway. Clinical forms of Hansen's disease represent a spectrum reflecting the cellular immune response to *Mycobacterium leprae* or *Mycobacterium lepromatosis*. The following characteristics are typical of the major forms of the disease, though these classifications are assigned after a case has been laboratory confirmed.

- *Tuberculoid*: One or a few well-demarcated, hypopigmented, and hypoesthetic or anesthetic skin lesions, frequently with active, spreading edges and a clearing center: peripheral nerve swelling or thickening may also occur.
- *Lepromatous*: A number of erythematous papules and nodules or an infiltration of the face, hands, and feet with lesions in a bilateral and symmetrical distribution that progress to thickening of the skin.
- *Borderline (dimorphous)*: Skin lesions characteristic of both the tuberculoid and lepromatous forms.
- *Indeterminate*: Early lesions, usually hypopigmented macules without developed tuberculoid or lepromatous features but with definite identification of acid-fast bacilli in Fite stained sections

Laboratory Criteria for Diagnosis

- Demonstration of acid-fast bacilli in skin or dermal nerve from a biopsy of skin lesion using Fite stain, without growth of mycobacteria on conventional media (if done), OR
- Identification of noncaseating granulomas with peripheral nerve involvement, without growth of mycobacteria on conventional media (if done).

Case Classification

Confirmed

A clinically compatible illness with confirmatory laboratory results.

Criteria to Distinguish a New Case from an Existing Case*

A case should never be counted as a new case if there was a previously reported infection in the same individual.

*Based on ADHS guidelines

CONTROL MEASURES

Arizona Administrative Code R9-6-340 Hansen's Disease (Leprosy)

Case Control Measures:

A local health agency shall:

1. Conduct an epidemiologic investigation of each reported Hansen's disease case or suspect case; and

2. For each Hansen's disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures:
In consultation with the Department, a local health agency shall

1. Examine contacts of a Hansen's disease case, if indicated, for signs and symptoms of leprosy at six-to-twelve month intervals for five years after the last exposure to an infectious case.

INVESTIGATION FORMS

See Hansen's Disease (Leprosy) Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2020
Most Recent CDC/CSTE Revision Year	2013
ADHS Case Definition Matches CDC/CSTE?	Yes (with exception of *Mycobacterium lepromatosis* in clinical description)
Description of changes	2020: Addition of *Mycobacterium lepromatosis* to the clinical description. 2013: ADHS case definition was updated to match the new 2013 CDC/CSTE case definition.

HANTAVIRUS INFECTION	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description

Hantavirus pulmonary syndrome (HPS), commonly referred to as hantavirus disease, is a febrile illness characterized by bilateral interstitial pulmonary infiltrates and respiratory compromise usually requiring supplemental oxygen and clinically resembling acute respiratory disease syndrome (ARDS). The typical prodrome consists of fever, chills, myalgia, headache, and gastrointestinal symptoms. Typical clinical laboratory findings include hemoconcentration, left shift in the white blood cell count, neutrophilic leukocytosis, thrombocytopenia, and circulating immunoblasts. While progression to cardiopulmonary symptoms consistent with HPS occurs in most patients, some patients with confirmed infection may show signs of only the prodrome (Hantavirus infection, non-Hantavirus pulmonary syndrome).

Clinical Case Definition

Hantavirus Pulmonary Syndrome (HPS)

Hantavirus Pulmonary Syndrome (HPS) is an acute febrile illness (i.e., temperature greater than 101.0 F [greater than 38.3 C]) with a prodrome consisting of fever, chills, myalgia, headache, and gastrointestinal symptoms, and one or more of the following clinical features:

- Bilateral diffuse interstitial edema, or
- Clinical diagnosis of acute respiratory distress syndrome (ARDS), or
- Radiographic evidence of noncardiogenic pulmonary edema, or
- An unexplained respiratory illness resulting in death, and includes an autopsy examination demonstrating noncardiogenic pulmonary edema without an identifiable cause, or
- Healthcare record with a diagnosis of hantavirus pulmonary syndrome, or
- Death certificate lists hantavirus pulmonary syndrome as a cause of death or a significant condition contributing to death

Hantavirus infection, non-Hantavirus pulmonary syndrome (non-HPS)

Non-HPS Hantavirus infection is a febrile illness with non-specific viral symptoms including fever, chills, myalgia, headache, and gastrointestinal symptoms, but no cardio-pulmonary symptoms. Typical clinical laboratory findings include hemoconcentration, left shift in the white blood cell count, neutrophilic leukocytosis, thrombocytopenia, and circulating immunoblasts.

Laboratory Criteria for Diagnosis

- Detection of hantavirus-specific immunoglobulin M or rising titers of hantavirus-specific immunoglobulin G, OR
- Detection of hantavirus-specific ribonucleic acid sequence by polymerase chain reaction in clinical specimens, OR
- Detection of hantavirus antigen by immunohistochemistry in lung biopsy or autopsy tissues

Case Classification

Confirmed
Hantavirus Pulmonary Syndrome: A clinically compatible case of HPS that is laboratory confirmed

Hantavirus infection, non-HPS: A clinically compatible case of Non-HPS Hantavirus infection that is laboratory confirmed.

Comment

Laboratory testing should be performed or confirmed at a reference laboratory such as the Arizona State Public Health Laboratory or Centers for Disease Control and Prevention. Because the clinical illness is nonspecific and ARDS is common, a screening case definition can be used to determine which patients to test. In general, a predisposing medical condition (e.g., chronic pulmonary disease, malignancy, trauma, burn, and surgery) is a more likely cause of ARDS than HPS, and patients who have these underlying conditions and ARDS need not be tested for hantavirus.

CONTROL MEASURES

Arizona Administrative Code R9-6-341 Hantavirus Infection

Case Control Measures
A local health agency shall:

1. Upon receiving a report under R9-6-202 of a hantavirus infection case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Ensure that a hantavirus infection case or, if the case is a child or incapacitated adult, the parent or guardian of the case receives health education about reducing the risks of becoming reinfected with or of having others become infected with hantavirus;
3. Conduct an epidemiologic investigation of each reported hantavirus infection case or suspect case; and
4. For each hantavirus infection case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Environmental Control Measures
A local health agency shall:

1. Conduct an environmental assessment for each hantavirus infection case or suspect case.

INVESTIGATION FORMS

See Hantavirus Case Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2015
Most Recent CDC/CSTE Revision Year	2015
ADHS Case Definition Matches CDC/CSTE?	Yes

Description of changes	2015: Non-HPS hantaviral infections have been added as a subcategory of hantavirus infections. The clinical case definition has been adjusted so that all febrile, laboratory-confirmed hantaviral infections are counted as cases, regardless of the presence or absence of pulmonary symptoms.

HEMOLYTIC UREMIC SYNDROME POST-DIARRHEAL (HUS, TTP)	PROVIDERS SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description

Hemolytic uremic syndrome (HUS) is characterized by the acute onset of microangiopathic hemolytic anemia, renal injury, and low platelet count. Thrombotic thrombocytopenic purpura (TTP) also is characterized by these features but can include central nervous system (CNS) involvement and fever and may have a more gradual onset. Most cases of HUS (but few cases of TTP) occur after an acute gastrointestinal illness (usually diarrheal).

Laboratory Criteria for Diagnosis

The following are both present at some time during the illness:

- Anemia (acute onset) with microangiopathic changes (i.e., schistocytes, burr cells, or helmet cells) on peripheral blood smear, and
- Renal injury (acute onset) evidenced by either hematuria, proteinuria, or elevated creatinine level (i.e., greater than or equal to 1.0 mg/dL in a child aged less than 13 years or greater than or equal to 1.5 mg/dL in a person aged greater than or equal to 13 years, or greater than or equal to 50% increase over baseline)

Note: A low platelet count can usually, but not always, be detected early in the illness, but it may then become normal or even high. If a platelet count obtained within 7 days after onset of the acute gastrointestinal illness is not less than 150,000/mm^3, other diagnoses should be considered.

Case Classification

Confirmed

An acute illness diagnosed as HUS or TTP that both meets the laboratory criteria and began within 3 weeks after onset of an episode of acute or bloody diarrhea

Probable

- An acute illness diagnosed as HUS or TTP that meets the laboratory criteria in a patient who does not have a clear history of acute or bloody diarrhea in preceding 3 weeks, OR
- An acute illness diagnosed as HUS or TTP, that has onset within 3 weeks after onset of an acute or bloody diarrhea AND meets the laboratory criteria except that microangiopathic changes are not confirmed

Comment

Some investigators consider HUS and TTP to be part of a continuum of disease. Therefore, criteria for diagnosing TTP on the basis of CNS involvement and fever are not provided because cases diagnosed clinically as post-diarrheal TTP also should meet the criteria for HUS. These cases are reported as post-diarrheal HUS. If a patient meets the case definition for both Shiga toxin-producing *E. coli* (STEC) and HUS, the case should be reported for each of the conditions.

CONTROL MEASURES

Arizona Administrative Code R9-6-342 Hemolytic Uremic Syndrome

Case Control Measures
A local health agency shall:

1. Upon receiving a report under R9-6-202 of a hemolytic uremic syndrome case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported hemolytic uremic syndrome case or suspect case; and
3. For each hemolytic uremic syndrome case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures
A local health agency shall

1. Exclude a hemolytic uremic syndrome contact with diarrhea of unknown cause from working as a food handler until diarrhea has resolved.

INVESTIGATION FORMS

See Enterohemorrhagic E.coli (Shiga-toxin producing) and/or HUS Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2013
Most Recent CDC/CSTE Revision Year	2010
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2013: Statement added about reporting a case as both STEC and HUS, when appropriate, in accordance with CDC/CSTE case definition.

HEPATITIS A	PROVIDERS REPORT WITHIN 24 HOURS IF AN OUTBREAK IS DETECTED OR PERSON HAS A HIGH-RISK OCCUPATION PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY FOR ALL OTHER CASES

CASE DEFINITION

Clinical Description

An acute illness with a discrete onset of any sign or symptom consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, abdominal pain, or dark urine),

AND

a) jaundice or elevated bilirubin levels (total bilirubin levels >3.0 mg/dL), OR
b) elevated serum alanine aminotransferase (ALT) levels (>200 IU/L)

AND

c) the absence of a more likely diagnosis

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence

- Immunoglobulin M (IgM) antibody to hepatitis A virus (anti-HAV) positive, OR
- Nucleic acid amplification test (NAAT; such as PCR or genotyping) for hepatitis A virus RNA positive

Epidemiologic Linkage

Contact (e.g., household or sexual) with a laboratory-confirmed hepatitis A case 15-50 days prior to onset of symptoms.

Case Classification

Confirmed

- A case that meets the clinical description and is IgM anti-HAV positive*, OR
- A case that has hepatitis A virus RNA detected by NAAT (such as PCR or genotyping), OR
- A case that meets the clinical description and occurs in a person with an epidemiologic linkage, as defined above.

Probable

A case that is IgM anti-HAV positive* but for which clinical illness information is unavailable. If an investigation indicates the absence of clinical illness, the case should be ruled out rather than classified as probable.

*And not otherwise ruled out by IgM anti-HAV or NAAT for hepatitis A virus testing performed in a public health laboratory.

Criteria to Distinguish a New Case from an Existing Case

A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual. Although hepatitis A is usually self-limiting and does not result in chronic infection, up to 10% of persons with hepatitis A may experience a relapse during the 6 months after acute illnesses.

CONTROL MEASURES

Arizona Administrative Code R9-6-343 Hepatitis A

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 or R9-6-203 of a hepatitis A case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Exclude a hepatitis A case or suspect case from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment during the first 14 calendar days of illness or for seven calendar days after onset of jaundice;
3. Conduct an epidemiologic investigation of each reported hepatitis A case or suspect case; and
4. For each hepatitis A case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures

A local health agency shall:

1. Exclude a hepatitis A contact with symptoms of hepatitis A from working as a food handler during the first 14 calendar days of illness or for seven calendar days after onset of jaundice;
2. For 45 calendar days after exposure, monitor a food handler who was a contact of a hepatitis A case during the infectious period for symptoms of hepatitis A; and
3. Evaluate the level of risk of transmission from each contact's exposure to a hepatitis A case and, if indicated, provide or arrange for each contact to receive prophylaxis and immunization.

INVESTIGATION FORMS

See Hepatitis A Case Report at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2019
Most Recent CDC/CSTE Revision Year	2019
ADHS Case Definition Matches CDC/CSTE?	No
Description of changes	2019: Nucleic acid amplification testing added to confirmatory laboratory criteria and classification. Clinical criteria modified to include bilirubin and remove AST liver function testing, and specify levels for "elevated". Changes based on modifications to CDC/CSTE

	definition. Confirmed case definition matches CDC/CSTE case definition. Probable case definition is not part of the CDC/CSTE case definition (see 2013 explanation below). 2013: A probable case classification was added to the ADHS case definition to be able to distinguish cases with confirmatory laboratory results but for which clinical information could not be obtained from those meeting both the clinical and laboratory criteria. The CDC/CSTE case definition also does not specify criteria for what constitutes "elevated" liver aminotransferase levels.

HEPATITIS B, ACUTE	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

An acute illness with a discrete onset of any sign or symptom* consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, and abdominal pain), and either

a) jaundice, or
b) elevated serum alanine aminotransferase (ALT) levels >100 IU/L.

*A documented negative hepatitis B surface antigen (HBsAg) laboratory test result within 6 months prior to a positive test (either HBsAg, hepatitis B "e" antigen (HBeAg), or hepatitis B virus nucleic acid testing (HBV NAT) including genotype) result does not require an acute clinical presentation to meet the surveillance case definition.

Laboratory Criteria for Diagnosis

- Hepatitis B surface antigen (HBsAg) positive, AND
- Immunoglobulin M (IgM) antibody to hepatitis B core antigen (HBcIgM) positive (if done)

Case Classification

Confirmed
A case that meets the clinical case definition, is laboratory confirmed (HBsAg positive and, if done, HBcIgM positive), and is not known to have chronic hepatitis B.

Probable
A case that meets the clinical case definition, is HBcIgM positive and either HBsAg negative or unknown

Suspect
A case that is IgM positive (HBsAg can be positive, negative, or unknown) but for which clinical illness information is unavailable. If an investigation indicates the absence of clinical illness, the case should be ruled out rather than classified as suspect.

Criteria to Distinguish a New Case from an Existing Case*

A case should never be counted as a new case if there was a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment

For positive hepatitis B surface antigen results that are accompanied by a negative hepatitis B surface antigen confirmation (both tests should have the same collection date), the negative confirmation result negates the original positive surface antigen result from the same date. The case should be classified using any other available test results.

CONTROL MEASURES

Arizona Administrative Code R9-6-344 Hepatitis B and Hepatitis D

Case Control Measures

A local health agency shall:

1. Evaluate a health care provider identified as the source of hepatitis B virus transmission in the work place and, if indicated, ensure reassignment of the health care provider to a position where the occupational risk of transmission is eliminated;
2. Conduct an epidemiologic investigation of each reported case or suspect case of hepatitis B or hepatitis B co-infected with hepatitis D; and
3. For each acute case of hepatitis B or hepatitis B co-infected with hepatitis D or case of perinatal hepatitis B, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of hepatitis B, as required under A.R.S. § 32-1483 and 21 CFR 630.6.

Contact Control Measures

A local health agency shall:

1. Refer each non-immune hepatitis B contact to a health care provider for prophylaxis and initiation of the hepatitis B vaccine series, and
2. Provide health education related to the progression of hepatitis B disease and the prevention of transmission of hepatitis B infection to each non-immune hepatitis B contact.

INVESTIGATION FORMS

See Hepatitis B and D Investigation Form http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2016
Most Recent CDC/CSTE Revision Year	2012
ADHS Case Definition Matches CDC/CSTE?	No
Description of changes	2016: Clarification added about confirmatory HBsAg test results from the same specimen. The CDC/CSTE case definition was changed in 2012, and the ADHS confirmed case definition was changed to match. CDC/CSTE does not have probable or suspect case definitions for acute hepatitis B, but we feel it is important to monitor symptomatic persons with HBcIgM positive results or for whom symptoms cannot be identified. The current suspect definition was considered probable before 2013.

HEPATITIS B, CHRONIC	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description
Persons with chronic HBV infection may have no evidence of liver disease or may have a spectrum of disease ranging from chronic hepatitis to cirrhosis or liver cancer. Persons with chronic infection may be asymptomatic.

Laboratory Criteria for Diagnosis

- IgM anti-HBc negative AND a positive result on one of the following tests: hepatitis B surface antigen (HBsAg), hepatitis B e antigen (HBeAg), or nucleic acid test for hepatitis B virus DNA (HBV DNA, including qualitative, quantitative and genotype testing), OR
- HBsAg positive or HBV DNA positive or HBeAg positive two times at least 6 months apart (any combination of these tests performed 6 months apart is acceptable.)

Case Classification

Confirmed
A case that meets either of the above laboratory criteria for diagnosis

Probable
A case with a single HBsAg positive or HBV DNA positive or HBeAg positive lab result that does not meet the case definition for acute hepatitis B (either does not have symptoms or symptoms are unknown)

Criteria to Distinguish a New Case from an Existing Case*
A case should never be counted as a new case if there was a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment
Multiple laboratory tests indicative of chronic HBV infection may be performed simultaneously on the same patient specimen as part of a “hepatitis panel”. Testing performed in this manner may lead to seemingly discordant results, e.g. HBsAg-negative AND HBV DNA-positive. For the purposes of this case definition, any positive result among the three laboratory tests mentioned above is acceptable, regardless of other testing results. Negative HBeAg results and HBV DNA levels below positive cutoff level cannot rule out HBV infection.

For positive hepatitis B surface antigen results that are accompanied by a negative hepatitis B surface antigen confirmation (both tests should have the same collection date), the negative confirmation result negates the original positive surface antigen result from the same date. The case should be classified using any other available test results.

In the United States, an estimated 1.25 million persons have chronic hepatitis B virus (HBV) infection. Fifteen to 25% of these persons will develop the complications of cirrhosis or hepatocellular carcinoma. In addition, chronically infected persons are a major reservoir of transmission to others. Persons who

test positive for the presence of hepatitis B surface antigen (HBsAg), HBeAg or HBV DNA are potentially infectious to contacts.

CONTROL MEASURES

Arizona Administrative Code R9-6-344 Hepatitis B and Hepatitis D

Case Control Measures

A local health agency shall:

1. Evaluate a health care provider identified as the source of hepatitis B virus transmission in the work place and, if indicated, ensure reassignment of the health care provider to a position where the occupational risk of transmission is eliminated;
2. Conduct an epidemiologic investigation of each reported case or suspect case of hepatitis B or hepatitis B co-infected with hepatitis D; and
3. For each acute case of hepatitis B or hepatitis B co-infected with hepatitis D or case of perinatal hepatitis B, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of hepatitis B, as required under A.R.S. § 32-1483 and 21 CFR 630.6.

Contact Control Measures

A local health agency shall:

1. Refer each non-immune hepatitis B contact to a health care provider for prophylaxis and initiation of the hepatitis B vaccine series, and
2. Provide health education related to the progression of hepatitis B disease and the prevention of transmission of hepatitis B infection to each non-immune hepatitis B contact.

INVESTIGATION FORMS

See Hepatitis B and D Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2016
Most Recent CDC/CSTE Revision Year	2012
ADHS Case Definition Matches CDC/CSTE?	Yes (except ADHS-added clarification about confirmatory HBsAg testing)
Description of changes	2016: Clarification added about confirmatory HBsAg test results from the same specimen.

HEPATITIS B, PERINATAL Acquired in the United States or U.S. Territories	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description
Perinatal hepatitis B in a child ≤24 months of age may range from asymptomatic to fulminant hepatitis.

Laboratory Criteria for Diagnosis
Laboratory evidence of HBV infection in a child consists of one or more of the following:

- positive HBsAg test (only if at least 4 weeks after last dose of hepatitis B vaccine)
- positive HBeAg test, OR
- detectable HBV DNA.

Case Classification

Confirmed
Child born in the U.S. to a HBV-infected mother and:

- positive for HBsAg at ≥ 1 month of age and ≤ 24 months of age, OR
- positive for HBeAg or HBV DNA ≥9 months of age and ≤ 24 months of age.

Probable
Child born in the U.S. whose mother's hepatitis B status is unknown, and with the following test results for the child:

- positive for HBsAg at ≥ 1 month of age and ≤ 24 months of age, OR
- positive for HBeAg or HBV DNA ≥9 months of age and ≤ 24 months of age.

Criteria to Distinguish a New Case from an Existing Case*
A case should never be counted as a new case if there was a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment
Infants born to HBsAg-positive mothers should receive hepatitis B immune globulin (HBIG) and the first dose of hepatitis B vaccine within 12 hours of birth, followed by the second and third doses of hepatitis B vaccine at 1 and 6 months of age, respectively. Post-vaccination testing for HBsAg and antibody to HBsAg is recommended 1 to 2 months following completion of the vaccine series, but not earlier than 9 months of age.

If mother known to *not* be infected with HBV, refer to the case definition for acute Hepatitis B.

CONTROL MEASURES

Arizona Administrative Code R9-6-344 Hepatitis B and Hepatitis D

Case Control Measures

A local health agency shall:

1. Evaluate a health care provider identified as the source of hepatitis B virus transmission in the work place and, if indicated, ensure reassignment of the health care provider to a position where the occupational risk of transmission is eliminated;
2. Conduct an epidemiologic investigation of each reported case or suspect case of hepatitis B or hepatitis B co-infected with hepatitis D; and
3. For each acute case of hepatitis B or hepatitis B co-infected with hepatitis D or case of perinatal hepatitis B, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of hepatitis B, as required under A.R.S. § 32-1483 and 21 CFR 630.6.

Contact Control Measures

A local health agency shall:

1. Refer each non-immune hepatitis B contact to a health care provider for prophylaxis and initiation of the hepatitis B vaccine series, and
2. Provide health education related to the progression of hepatitis B disease and the prevention of transmission of hepatitis B infection to each non-immune hepatitis B contact.

INVESTIGATION FORMS

None. Contact the perinatal hepatitis B coordinator for information to be collected.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	2017
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2017: Laboratory criteria updated to include HBeAg and HBV DNA. Probable definition added for classification of children for whom the mother's hepatitis B status is unknown. Changes were match to match changes to the CDC/CSTE case definition.

HEPATITIS C, ACUTE	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

All HCV cases in each classification category should be >36 months of age, unless known to have been exposed non-perinatally.

Clinical Criteria for Diagnosis

One or more of the following:

- Jaundice, OR
- Peak elevated total bilirubin levels ≥ 3.0 mg/dL, OR
- Peak elevated serum alanine aminotransferase (ALT) levels >200 IU/L,

AND

The absence of a more likely diagnosis (which may include evidence of acute liver disease due to other causes or advanced liver disease due to pre-existing chronic HCV infection or other causes, such as alcohol exposure, other viral hepatitis, hemochromatosis, etc.)

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence

- Positive hepatitis C virus detection test: Nucleic acid test (NAT) for HCV RNA positive (including qualitative, quantitative, or genotype testing), OR
- A positive test indicating presence of hepatitis C viral antigen(s) (HCV antigen)

Presumptive Laboratory Evidence

A positive test for antibodies to hepatitis C virus (anti-HCV).

Case Classification

Confirmed

- A case that meets clinical criteria and has confirmatory laboratory evidence,

OR

- A documented negative HCV antibody followed within 12 months by a positive HCV antibody test (anit-HCV test conversion) in the absence of a more likely diagnosis,

OR

- A documented negative HCV antibody **OR** negative hepatitis C virus detection test (in someone without a prior diagnosis of HCV infection) followed within 12 months by a positive hepatitis C virus detection test (HCV RNA test conversion) in the absence of a more likely diagnosis.

Probable

- A case that meets clinical criteria and has presumptive laboratory evidence,

AND

- Does not have a hepatitis C virus detection test reported,

AND

- Has no documentation of anti-HCV or HCV RNA test conversion within 12 months.

Criteria to Distinguish a New Case from an Existing Case*

A case should never be counted as a new case if there was a previously reported infection in the same individual, unless there is laboratory evidence of re-infection.

*Based on ADHS guidelines

Comment

A new acute case is an incident case that is over the age of 36 months and has not previously been reported meeting case criteria for chronic hepatitis C or for whom there is laboratory evidence of re-infection. Cases under the age of 36 months should be classified as Perinatal HCV unless the exposure mode is not perinatal (e.g., healthcare acquired).

CDC encourages all jurisdictions to track negative HCV viral detection tests to document both spontaneous clearance of infection or sustained viral response to HCV treatment. Cases that have evidence of having cleared the infection at time of initial report or are considered false positive should not be reported to CDC.

Acute cases determined via anti-HCV test conversion do not need to have a positive HCV viral detection test reported to be considered confirmed acute cases.

A new probable acute case may be reclassified as confirmed acute if a positive HCV viral detection test is reported in the same reporting year (e.g., prior to data closing for the calendar year).

Collection of risk history data is recommended for probable and confirmed acute HCV cases. Timing of risk history data to collect ranges from 2 weeks to 12 months prior to symptom onset or diagnosis. The time frame to employ depends on the method of classification (e.g. if a case meets clinical criteria and has a positive HCV detection test, a risk history time frame of 2 weeks to 6 months prior to onset should be used; for a case classified via anti-HCV test conversion or HCV RNA test conversion, 2 weeks to 12 months prior to onset should be considered).

If evidence indicating resolution of infection is received after a confirmed acute case has been reported to CDC, the case report does not need to be modified as it was a confirmed case at the time of initial report. However, negative HCV viral detection test results received on confirmed acute case, subsequent to an initial positive result, should be appended to case reports, as feasible, and considered for the purpose of data analysis by each jurisdiction.

For probable acute cases, the presence of a negative HCV viral detection test result, in the absence of criteria that would allow for confirmation, indicates that a case should not be classified as probable acute and should not be reported to CDC.

A confirmed acute case may be classified as a confirmed chronic case if a positive HCV viral detection test is reported one year or longer after acute case onset. A confirmed acute case may not be reported as a probable chronic case (i.e., HCV antibody positive, but with an unknown HCV viral detection test). For purposes of incidence and prevalence calculations, confirmed acute and chronic HCV cases should be counted.

CONTROL MEASURES

Arizona Administrative Code R9-6-345 Hepatitis C

Case Control Measures:
A local health agency shall:

1. Conduct an epidemiologic investigation of each reported hepatitis C outbreak;
2. For each hepatitis C outbreak, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(E);
3. Evaluate a health care provider identified as the source of hepatitis C virus transmission in the work place and, if indicated, ensure reassignment of the health care provider to a position where the occupational risk of transmission is eliminated; and
4. Ensure that health education related to the progression of hepatitis C disease and the prevention of transmission of hepatitis C infection is provided to each individual who may have been exposed to hepatitis C during the outbreak.

INVESTIGATION FORMS

See Acute Hepatitis C Case Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2020
Most Recent CDC/CSTE Revision Year	2020
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2020: Changes are based on modifications to CDC/CSTE definition and affect all sections (Clinical Criteria, Laboratory Criteria, Classification, Comments). 2016: ADHS case definition updated to match CDC/CSTE definition. Changes include: decreased ALT levels; updates to the laboratory criteria; confirmation based on known, recent seroconversion; and the addition of a probable case classification. 2013: ADHS case definition updated to match CDC/CSTE definition.

HEPATITIS C, CHRONIC	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

All HCV cases in each classification category should be >36 months of age, unless known to have been exposed non-perinatally.

Clinical Criteria for Diagnosis

One or more of the following:

- Jaundice, OR
- Peak elevated total bilirubin levels ≥ 3.0 mg/dL, OR
- Peak elevated serum alanine aminotransferase (ALT) levels >200 IU/L,

AND

The absence of a more likely diagnosis (which may include evidence of acute liver disease due to other causes or advanced liver disease due to pre-existing chronic HCV infection or other causes, such as alcohol exposure, other viral hepatitis, hemochromatosis, etc.)

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence

- Positive hepatitis C virus detection test: Nucleic acid test (NAT) for HCV RNA positive (including qualitative, quantitative, or genotype testing), OR
- A positive test indicating presence of hepatitis C viral antigen(s) (HCV antigen)

Presumptive Laboratory Evidence

A positive test for antibodies to hepatitis C virus (anti-HCV).

Case Classification

Confirmed

- A case that does not meet **OR** has no report of clinical criteria,
  AND
- Has confirmatory laboratory evidence,
  AND
- Has no documentation of anti-HCV or HCV RNA test conversion within 12 months.

Probable

- A case that does not meet **OR** has no report of clinical criteria,
  AND
- Has presumptive laboratory evidence,
  AND

- Has no documentation of anti-HCV or RNA test conversion within 12 months, AND
- Does not have an HCV RNA detection test reported.

Criteria to Distinguish a New Case from an Existing Case*

A case should never be counted as a new case if there was a previously reported infection in the same individual, unless there is evidence of re-infection.

*Based on ADHS guidelines

Comment

Only 20-30% of acutely infected persons are symptomatic. Regardless of whether symptoms are present, the majority of persons who are infected with HCV become chronically infected (75-85%), and 10-20% develop cirrhosis over the next 20-30 years. Among HCV-infected persons with cirrhosis, there is an annual risk of 1-5% for developing hepatocellular carcinoma. Acutely infected persons who clear the virus and persons who clear the virus due to treatment may show evidence of past infection by testing positive for antibodies to HCV (EIA or rapid test) even if they are not chronically infected.[1]

CDC encourages all jurisdictions are encouraged to track negative HCV viral detection tests to document both spontaneous clearance of infection or sustained viral response to HCV treatment. Cases that have evidence of having cleared the infection at time of initial report or are considered false positive should not be reported to CDC.

If evidence indicating resolution of infection is received after a confirmed chronic case has been reported to CDC, the case report does not need to be modified as it was a confirmed case at the time of initial report. However, negative HCV viral detection test results received on confirmed chronic cases, subsequent to an initial positive result, should be appended to case reports, as feasible, and considered for the purpose of data analysis by each jurisdiction.

Evidence for re-infection may include a case of confirmed chronic HCV infection that has at least two sequential negative HCV viral detection tests reported, indicative of treatment initiation and sustained virologic response, followed by a positive HCV viral detection test. Under current treatment recommendations, those two negative tests should be at least three months apart; however, the timing may change as standard of care for HCV treatment evolves. Other evidence of reinfection should be considered, including a report of a new genotype on a case that has previously cleared a different genotype. Jurisdictions are encouraged to ensure that cases of HCV treatment failure are not classified as new cases of HCV infection to the extent that it can be determined. Jurisdictions tracking re-infection should also consider collecting data on prior treatment completion (when relevant and possible to document), treatment failure, change in reported genotype if that applies, and the known time frame for reinfection.

For probable chronic cases, the presence of a negative HCV viral detection test result, in the absence of criteria that would allow for confirmation, indicates that a case should not be classified as probable chronic and should not be reported to CDC.

A new chronic case is a newly reported case that does not have evidence of being an acute case of HCV infection. A confirmed acute case may be classified as a confirmed chronic case if a positive HCV viral detection test is reported one year or longer after acute case onset. A confirmed acute case may not be reported as a probable chronic case (i.e., HCV antibody positive, but with an unknown HCV viral detection test). For purposes of incidence and prevalence calculations, confirmed chronic HCV cases should be counted.

Jurisdictions are also encouraged to track and classify possible re-infection cases that may have been previously submitted to CDC as a confirmed or probable chronic HCV infection case. Jurisdictions tracking re-infection should also consider collecting data on prior treatment completion (when relevant and possible to document), treatment failure, change in reported genotype if that applies, and the known time frame for reinfection.

[1]Statistics are from http://www.cdc.gov/hepatitis/hcv/hcvfaq.htm (accessed January 2016).

CONTROL MEASURES

Arizona Administrative Code R9-6-345 Hepatitis C

Case Control Measures:
A local health agency shall:

1. Conduct an epidemiologic investigation of each reported hepatitis C outbreak;
2. For each hepatitis C outbreak, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(E);
3. Evaluate a health care provider identified as the source of hepatitis C virus transmission in the work place and, if indicated, ensure reassignment of the health care provider to a position where the occupational risk of transmission is eliminated; and
4. Ensure that health education related to the progression of hepatitis C disease and the prevention of transmission of hepatitis C infection is provided to each individual who may have been exposed to hepatitis C during the outbreak.

INVESTIGATION FORMS

See Chronic Hepatitis C Case Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2020
Most Recent CDC/CSTE Revision Year	2020
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2020: Changes are based on modifications to CDC/CSTE definition and primarily affect the Comments. 2016: ADHS case definition updated to match CDC/CSTE definition. Renamed from "Hepatitis C, past or present". Changes include: updates to the laboratory criteria, and changes to both confirmed and probable classifications. 2013: ADHS definition was edited to match CDC/CSTE by removing an outdated laboratory criterion for diagnosis

HEPATITIS C, PERINATAL	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description
Test results prior to 2 months of age should not be used for classification. Cases in the specified age range (2 to 36 months of age) that are known to have been exposed to HCV via healthcare or another mechanism other than perinatally should be classified according to the acute or chronic hepatitis C infection case definitions. Test results after 36 months of age should also be classified as acute or chronic hepatitis C infection case definitions and not as perinatal hepatitis C infection.

Clinical Criteria
Perinatal hepatitis C in pediatric patients may range from asymptomatic to fulminant hepatitis.

Laboratory Criteria

- HCV RNA positive test results for infants between 2 to 36 months of age; OR
- HCV genotype test results for infants between 2 to 36 months of age or greater; OR
- HCV antigen test results for infants between 2 to 36 months of age or greater

Epidemiologic Linkage
Maternal infection with HCV of any duration, if known. Not known to have been exposed to HCV via a mechanism other than perinatal (e.g. not acquired via healthcare).

Case Classification

Confirmed
Infant who has a positive test for HCV RNA (NAAT), HCV antigen, or detectable HCV genotype at ≥2 months and ≤36 months of age and is not known to have been exposed to HCV via a mechanism other than perinatal.

Criteria to Distinguish a New Case from an Existing Case*
A case should never be counted as a new case if there was a previously reported infection in the same individual.

*Based on ADHS guidelines

CONTROL MEASURES
Arizona Administrative Code R9-6-345 Hepatitis C

Case Control Measures:
A local health agency shall:

1. Conduct an epidemiologic investigation of each reported hepatitis C outbreak;
2. For each hepatitis C outbreak, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(E);
3. Evaluate a health care provider identified as the source of hepatitis C virus transmission in the work place and, if indicated, ensure reassignment of the health care provider to a position where the occupational risk of transmission is eliminated; and

4. Ensure that health education related to the progression of hepatitis C disease and the prevention of transmission of hepatitis C infection is provided to each individual who may have been exposed to hepatitis C during the outbreak.

INVESTIGATION FORMS

See Chronic Hepatitis C Case Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2018
Most Recent CDC/CSTE Revision Year	2018
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2018: New CDC/CSTE case definition.

HEPATITIS D	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description
An acute illness with a discrete onset of symptoms and jaundice or elevated serum aminotransferase levels (alanine aminotransferase or aspartate aminotransferase) levels (greater than 2.5 times the upper limit of normal).

Laboratory Criteria for Diagnosis

- HBsAg-positive or IgM anti-HBc positive, and
- Positive for antibody to hepatitis delta virus

Case Classification

Confirmed
A case that meets the clinical case definition and is laboratory confirmed

Criteria to Distinguish a New Case from an Existing Case*
A case should never be counted as a new case if there was a previously reported infection in the same individual.

*Based on ADHS guidelines

CONTROL MEASURES
Arizona Administrative Code R9-6-344 Hepatitis B and Hepatitis D

Case Control Measures
A local health agency shall:

1. Evaluate a health care provider identified as the source of hepatitis B virus transmission in the work place and, if indicated, ensure reassignment of the health care provider to a position where the occupational risk of transmission is eliminated;
2. Conduct an epidemiologic investigation of each reported case or suspect case of hepatitis B or hepatitis B co-infected with hepatitis D; and
3. For each acute case of hepatitis B or hepatitis B co-infected with hepatitis D or case of perinatal hepatitis B, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of hepatitis B, as required under A.R.S. § 32-1483 and 21 CFR 630.6.

Contact Control Measures
A local health agency shall:

1. Refer each non-immune hepatitis B contact to a health care provider for prophylaxis and initiation of the hepatitis B vaccine series, and
2. Provide health education related to the progression of hepatitis B disease and the prevention of transmission of hepatitis B infection to each non-immune hepatitis B contact.

INVESTIGATION FORMS

See Hepatitis B and D Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2013
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

HEPATITIS E	PROVIDERS REPORT WITHIN 24 HOURS IF AN OUTBREAK IS DETECTED OR PERSON HAS A HIGH-RISK OCCUPATION PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 DAYS FOR ALL OTHER CASES

CASE DEFINITION

Clinical Description

An acute illness with a discrete onset of symptoms and jaundice or elevated serum aminotransferase levels (alanine aminotransferase or aspartate aminotransferase) levels (greater than 2.5 times the upper limit of normal).

Laboratory Criteria for Diagnosis

Confirmatory Testing

Presence of either of the following criteria in CDC-conducted testing:

- IgM or IgG to hepatitis E virus, OR
- Detection of hepatitis E virus by nucleic acid testing in a clinical specimen

Presumptive Testing

Presence of IgM to hepatitis E virus in non-CDC-conducted testing.

Case Classification

Confirmed

A case that meets the clinical case definition and is laboratory confirmed or, a case that meets the clinical case definition and occurs in a person who has an epidemiologic link with a person who has laboratory-confirmed hepatitis E (i.e., household or sexual contact with an infected person during the 15-50 days before the onset of symptoms).

Probable

A case that meets the clinical case definition and meets the presumptive laboratory criteria, with:

- History of international travel or residence during the incubation period prior to illness onset (15-50 days) OR another highly suspect risk factor for hepatitis E
- The absence of confirmatory diagnosis of any other acute viral hepatitis.

Criteria to Distinguish a New Case from an Existing Case*

A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

CONTROL MEASURES

Arizona Administrative Code R9-6-346 Hepatitis E

Case Control Measures

A local health agency shall:

1. Exclude a hepatitis E case or suspect case from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment during the first 14 calendar days of illness or for seven calendar days after onset of jaundice;
2. Conduct an epidemiologic investigation of each reported hepatitis E case or suspect case; and
3. For each hepatitis E case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Hepatitis E Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2014
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	2014: Confirmatory and supportive laboratory criteria were modified; Probable case definition was added; modifications were made to capture cases for which no clinical specimen is available for testing at CDC, but risk factors and clinical symptoms are compatible with acute HEV infection.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION AND RELATED DISEASE	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

2008 Surveillance Case Definition for HIV Infection Among Adults and Adolescents

The 2008 HIV infection case definition for adults and adolescents (aged >13 years) replaces the HIV infection and AIDS case definitions and the HIV infection classification system (1--3, 5). The case definition is intended for public health surveillance only and not as a guide for clinical diagnosis. The definition applies to all HIV variants (e.g., HIV-1 or HIV-2) and excludes confirmation of HIV infection through diagnosis of AIDS-defining conditions alone. For surveillance purposes, a reportable case of HIV infection among adults and adolescents aged >13 years is categorized by increasing severity as stage 0, stage 1, stage 2, or stage 3 (AIDS) or as stage unknown (Table).

Laboratory Criteria

- Positive result from an HIV antibody screening test (e.g., reactive enzyme immunoassay [EIA]*) confirmed by a positive result from a supplemental HIV antibody test (e.g., Western blot or indirect immunofluorescence assay test); OR
- Positive result or report of a detectable quantity (i.e., within the established limits of the laboratory test) from any of the following HIV virologic (i.e., non-antibody) tests†:
    - HIV nucleic acid (DNA or RNA) detection test (e.g., polymerase chain reaction [PCR])
    - HIV p24 antigen test, including neutralization assay
    - HIV isolation (viral culture)

Other Criterion (for Cases that Do Not Meet Laboratory Criteria)

HIV infection diagnosed by a physician or qualified medical-care provider§ based on the laboratory criteria and documented in a medical record. Oral reports of prior laboratory test results are not acceptable.

Case Classification

Confirmed

A confirmed case meets the laboratory criteria for diagnosis of HIV infection and one of the four HIV infection stages (stage 0, stage 1, stage 2, stage 3, or stage unknown) (Table). Although cases with no information on CD4+ T-lymphocyte count or percentage and no information on AIDS-defining conditions can be classified as stage unknown, every effort should be made to report CD4+ T-lymphocyte counts or percentages and the presence of AIDS-defining conditions at the time of diagnosis. Additional CD4+ T-lymphocyte counts or percentages and any identified AIDS-defining conditions can be reported as recommended (6).

HIV Infection, Stage 0

The criteria for stage 0 consist of a sequence of discordant test results indicative of early HIV infection in which a negative or indeterminate result was within 180 days of a positive result. The criteria for stage 0 supersede and are independent of the criteria used for other stages.

Stage 0 can be established either:

- Based on testing history (previous negative/indeterminate test results): a negative or indeterminate HIV test (antibody, combination antigen/antibody, or nucleic acid test) result within 180 days before the first confirmed positive HIV test result of any type. The first positive test result could be any time before the positive supplemental test result that confirms it; OR
- Based on a testing algorithm: a sequence of tests performed as part of a laboratory testing algorithm that demonstrate the presence of HIV-specific viral markers such as p24 antigen or nucleic acid (RNA or DNA) 0–180 days before or after an antibody test that had a negative or indeterminate result. Examples of algorithms that would fulfill this requirement include:
    - A positive initial HIV immunoassay result (e.g., antigen/antibody or antibody only) followed by a negative or indeterminate supplemental antibody test result (e.g., HIV-1/HIV-2 antibody differentiation assay or Western blot) and a positive NAT result. All three tests are usually performed as part of the same testing algorithm but time might elapse between tests if additional specimens must be obtained for definitive supplemental testing; AND
    - A negative initial HIV immunoassay result followed by a positive NAT result that might have been done to evaluate the presence of acute HIV infection (*19, 20*).

Exception
A confirmed case of HIV infection is not in stage 0 if the negative or indeterminate HIV test used as the criterion for it being a recent infection was preceded >60 days by evidence of HIV infection, such as a confirmed positive HIV test result, a clinical (physician-documented) diagnosis of HIV infection for which the surveillance staff have not found sufficient laboratory evidence, a CD4+ T-lymphocyte test result indicative of stage 3 (Table), or an opportunistic illness indicative of stage 3 (Appendix).
Classifying a case as stage 0 depends on documenting negative HIV antibody test results in the specific situations described above. Negative test results from testing algorithms that have concluded that the person is not infected need not be reported to HIV surveillance programs.

Progression of Stage After Initial Diagnosis in Stage 0
Although the stage at diagnosis does not change, if >180 days have elapsed after the stage was 0 at diagnosis, the stage at the later date is classified as 1, 2, 3, or unknown, depending on CD4+ T-lymphocyte test results (Table) or whether an opportunistic illness had been diagnosed >180 days after HIV infection diagnosis.

HIV Infection, Stage 1
No AIDS-defining condition and either CD4+ T-lymphocyte count of >500 cells/µL or CD4+ T-lymphocyte percentage of total lymphocytes of >29.

HIV Infection, Stage 2
No AIDS-defining condition and either CD4+ T-lymphocyte count of 200--499 cells/µL or CD4+ T-lymphocyte percentage of total lymphocytes of 14--28.

HIV Infection, Stage 3 (AIDS)
CD4+ T-lymphocyte count of <200 cells/µL or CD4+ T-lymphocyte percentage of total lymphocytes of <14 or documentation of an AIDS-defining condition (Appendix A). Documentation of an AIDS-defining condition supersedes a CD4+ T-lymphocyte count of >200 cells/µL and a CD4+ T-lymphocyte percentage of total lymphocytes of >14. Definitive diagnostic methods for these conditions are available in Appendix C of the 1993 revised HIV classification system and the expanded AIDS case definition (2) and from the National Notifiable Diseases Surveillance System (available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6303a1.htm?s_cid=rr6303a1_e).

HIV Infection, Stage Unknown
No information available on CD4+ T-lymphocyte count or percentage and no information available on AIDS-defining conditions. (Every effort should be made to report CD4+ T-lymphocyte counts or percentages and the presence of AIDS-defining conditions at the time of diagnosis.)

2008 Surveillance Case Definitions for HIV Infection and AIDS Among Children Aged 18 Months to <13 Years

These 2008 surveillance case definitions of HIV infection and AIDS supersede those published in 1987 (*1*) and 1999 (*3*) and apply to all variants of HIV (e.g., HIV-1 or HIV-2). They are intended for public health surveillance only and are not a guide for clinical diagnosis. The 2008 laboratory criteria for reportable HIV infection among persons aged 18 months to <13 years exclude confirmation of HIV infection through the diagnosis of AIDS-defining conditions alone. Laboratory-confirmed evidence of HIV infection is now required for all reported cases of HIV infection among children aged 18 months to <13 years (*20*).

Criteria for HIV Infection

Children aged 18 months to <13 years are categorized as HIV infected for surveillance purposes if at least one of laboratory criteria or the other criterion is met.

Laboratory Criteria for Diagnosis

- Positive result from a screening test for HIV antibody (e.g., reactive EIA), confirmed by a positive result from a supplemental test for HIV antibody (e.g., Western blot or indirect immunofluorescence assay); OR
- Positive result or a detectable quantity by any of the following HIV virologic (non-antibody) tests***:

    - HIV nucleic acid (DNA or RNA) detection (e.g., PCR)
    - HIV p24 antigen test, including neutralization assay
    - HIV isolation (viral culture)

Other Criterion (for Cases that Do Not Meet Laboratory Criteria)

HIV infection diagnosed by a physician or qualified medical-care provider based on the laboratory criteria and documented in a medical record. Oral reports of prior laboratory test results are not acceptable.

Criteria for AIDS

Children aged 18 months to <13 years are categorized for surveillance purposes as having AIDS if the criteria for HIV infection are met and at least one of the AIDS-defining conditions has been documented (Appendix A).

The 2008 surveillance case definition for AIDS retains the 24 clinical conditions in the AIDS surveillance case definition published in 1987 (*1*) and revised in 1994 (*4*) for children aged <13 years (Appendix A). Because the 2008 definition requires that all AIDS diagnoses have laboratory-confirmed evidence of HIV infection, the presence of any AIDS-defining condition listed in Appendix A indicates a surveillance diagnosis of AIDS. Guidance on the diagnosis of these diseases in the context of all nationally notifiable diseases is available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6303a1.htm?s_cid=rr6303a1_e.

2008 Surveillance Case Definition for HIV Infection Among Children Aged <18 Months

The 2008 case definition of HIV infection among children aged <18 months replaces the definition published in 1999 (*3*) and applies to all variants of HIV (e.g., HIV-1 or HIV-2). The 2008 definition is

intended for public health surveillance only and not as a guide for clinical diagnosis. The 2008 definition takes into account new available testing technologies. Laboratory criteria for children aged <18 months at the time of diagnosis include revisions to one category: presumptively uninfected with HIV. No substantial changes have been made to the remaining three categories (definitively HIV infected, presumptively HIV infected, and definitively uninfected with HIV), and no changes have been made to the conditions listed under the AIDS criteria in the 1987 pediatric surveillance case definition for AIDS for children aged <18 months (*1,3,13*). Because diagnostic laboratory testing for HIV infection among children aged <18 months might be unreliable, children in this age group with perinatal HIV exposure whose illness meets the AIDS case definition on the basis of clinical criteria are considered presumptively HIV infected when the mother has laboratory-confirmed HIV infection. The definitive or presumptive exclusion of HIV infection for surveillance purposes does not mean that clinical HIV infection can be ruled out. For the purposes of calculating the exact timing of tests (e.g., when a specimen was obtained for laboratory testing) based on the surveillance case definition, 1 month corresponds to 30 days.

Criteria for Definitive or Presumptive HIV Infection

A child aged <18 months is categorized for surveillance purposes as definitively or presumptively HIV infected if born to an HIV-infected mother and if the laboratory criterion or at least one of the other criteria is met.

Laboratory Criterion for Definitive HIV Infection

A child aged <18 months is categorized for surveillance purposes as definitively HIV infected if born to an HIV-infected mother and the following laboratory criterion is met.

- Positive results on two separate specimens (not including cord blood) from one or more of the following HIV virologic (non-antibody) tests:
    - HIV nucleic acid (DNA or RNA) detection**
    - HIV p24 antigen test, including neutralization assay, for a child aged >1 month
    - HIV isolation (viral culture)

Laboratory Criterion for Presumptive HIV Infection

A child aged <18 months is categorized for surveillance purposes as presumptively HIV infected if:

1. Born to an HIV-infected mother; AND
2. The criterion for definitively HIV infected is not met; AND
3. The following laboratory criterion is met:
    - Positive results on one specimen (not including cord blood) from the listed HIV virologic tests (HIV nucleic acid detection test; HIV p24 antigen test, including neutralization assay, for a child aged >1 month; or HIV isolation [viral culture] for definitively HIV infected) and no subsequent negative results from HIV virologic or HIV antibody tests.

Other Criteria (for Cases that Do Not Meet Laboratory Criteria for Definitive or Presumptive HIV Infection)

- HIV infection diagnosed by a physician or qualified medical-care provider based on the laboratory criteria and documented in a medical record. Oral reports of prior laboratory test results are not acceptable; OR
- When test results regarding HIV infection status are not available, documentation of a condition that meets the criteria in the 1987 pediatric surveillance case definition for AIDS (*1*) (Appendix A).

Criteria for Uninfected with HIV, Definitive or Presumptive

A child aged <18 months born to an HIV-infected mother is categorized for surveillance purposes as either definitively or presumptively uninfected with HIV if:

1. The criteria for definitive or presumptive HIV infection are not met; AND
2. At least one of the laboratory criteria or other criteria are met[††]:

    a. At least two negative HIV DNA or RNA virologic tests from separate specimens, both of which were obtained at age ≥1 month and one of which was obtained at age ≥4 months; OR
    b. At least two negative HIV antibody tests from separate specimens obtained at age ≥6 months; **AND**
    c. No other laboratory or clinical evidence of HIV infection (i.e., no positive results from virologic tests [if tests were performed] and no current or previous AIDS-defining condition) (Appendix A).

Laboratory Criteria for Uninfected with HIV, Presumptive

A child aged <18 months born to an HIV-infected mother is categorized for surveillance purposes as presumptively uninfected with HIV if:

1. The criteria for definitively uninfected with HIV are not met; AND
2. At least one of the laboratory criteria are met:

    a. Two negative RNA or DNA virologic tests, from separate specimens, both of which were obtained at age ≥2 weeks and one of which was obtained at age ≥4 weeks [§§]; OR
    b. One negative RNA or a DNA virologic test from a specimen obtained at age ≥8 weeks; OR
    c. One negative HIV antibody test from a specimen obtained at age ≥6 months; OR
    d. One positive HIV virologic test followed by at least two negative tests from separate specimens, one of which is a virologic test from a specimen obtained at age ≥8 weeks or an HIV antibody test from a specimen obtained at age ≥6 months; **AND**
    e. No other laboratory or clinical evidence of HIV infection (i.e., no subsequent positive results from virologic tests if tests were performed, and no AIDS-defining condition for which no other underlying condition indicative of immunosuppression exists) (Appendix A).

Other Criteria (for Cases that Do Not Meet Laboratory Criteria for Uninfected with HIV, Definitive or Presumptive)

- Determination of uninfected with HIV by a physician or qualified medical-care provider based on the laboratory criteria and who has noted the HIV diagnostic test results in the medical record. Oral reports of prior laboratory test results are not acceptable; AND
- No other laboratory or clinical evidence of HIV infection (i.e., no positive results from virologic tests [if tests were performed] and no AIDS-defining condition for which no other underlying condition indicative of immunosuppression exists) (Appendix A).

Criteria for Indeterminate HIV Infection

A child aged <18 months born to an HIV-infected mother is categorized as having perinatal exposure with an indeterminate HIV infection status if the criteria for infected with HIV and uninfected with HIV are not met.

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5710a1.htm

CONTROL MEASURES

Arizona Administrative Code R9-6-347 Human Immunodeficiency Virus (HIV) Infection and Related Disease

Case Control Measures

A local health agency shall:

1. Conduct an epidemiologic investigation, including a review of medical records, of each reported HIV-infected individual or suspect case; and
2. For each HIV-infected individual, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of HIV infection, as required under A.R.S. § 32-1483 and 21 CFR 630.6.

The Department and a local health agency shall offer anonymous HIV-testing to an individual as specified in R9-6-1005.

Contact Control Measures

The Department or the Department's designee shall confidentially notify an individual reported to be at risk for HIV infection under A.R.S. § 36-664(I) as specified in R9-6-1006(A).

Environmental Control Measures

An employer, as defined under A.R.S. § 23-401, or health care provider shall comply with the requirements specified in A.R.S. § 23-403 and A.A.C. R20-5-602.

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2014
Most Recent CDC/CSTE Revision Year	2014
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2014: Stage 0 added to the Case Definition for HIV Infection Among Adults and Adolescents as per CDC/CSTE revision (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6303a1.htm)

INFLUENZA	LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description
Influenza-like illness with a reported fever >100°F AND cough and/or sore throat, in the absence of a known cause other than influenza.

Laboratory Criteria for Diagnosis

- Isolation of influenza virus in tissue cell culture from respiratory specimens; OR
- Positive reverse-transcriptase polymerase chain reaction (RT-PCR) from respiratory specimens; OR
- Positive immunofluorescent antibody staining (direct or indirect) of respiratory specimens; OR
- Positive rapid influenza diagnostic test of respiratory specimens; OR
- Demonstration of immunohistochemical (IHC) staining for influenza viral antigens in respiratory tract tissue from autopsy specimens; OR
- Four-fold rise in influenza hemagglutination inhibition (HI) antibody titer in paired acute and convalescent sera*.

Case Classification

Confirmed
A case that meets the laboratory criteria for diagnosis.

Comment
Negative RT-PCR or culture results may be used to rule out cases identified by other testing methods (e.g., rapid diagnostic tests) at any time of year.

*Serologic testing for influenza is available in a limited number of laboratories, and should only be considered as evidence of recent infection if a four-fold rise in influenza (HI) antibody titer is demonstrated in paired sera. Single serum samples are not interpretable.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 4 months of a previously reported infection in the same individual.

If different flu seasons, count as separate cases.

When two or more different types (A, B) or subtypes (H3, H1) are identified from the same individual, these should be treated as separate cases, unless one or both results are from rapid diagnostic tests. For example, the following results should be treated as two separate cases:

- PCR type A and PCR type B
- PCR A(H3) and PCR A(H1N1)

While the following pairs would each be treated as a single case:

- rapid A+ and rapid B+ (categorized as type unknown)
- rapid A+ and PCR B+ (categorized as type B)

For questions, consult with the ADHS influenza team (flu@azdhs.gov) or refer to the current season's Influenza Case Classification Guide in MEDSIS > Resources > Surveillance and Investigation Resources > Influenza Resources.

*Based on ADHS guidelines

CONTROL MEASURES

None

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2019 (with 2020 removal of the Case Classification Guide Appendix)
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	2020: Removed appendix with Influenza Case Classification Guide, and listed the relevant components in the "Critieria to Distinguish a New Case". 2019: Removed comment about usage of rapid diagnostic tests to align with the changes starting in Summer 2018 regarding how rapid tests are counted.

INFLUENZA-ASSOCIATED MORTALITY IN A CHILD	PROVIDERS SUBMIT A REPORT WITHIN 1 WORKING DAY LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description
An influenza-associated death is defined for surveillance purposes as a death resulting from a clinically compatible illness that was confirmed to be influenza by an appropriate laboratory or rapid diagnostic test. There should be no period of complete recovery between the illness and death. Influenza-associated deaths in all persons aged <18 years should be reported.

A death should not be reported if:

- There is no laboratory confirmation of influenza virus infection.
- The influenza illness is followed by full recovery to baseline health status prior to death.
- The death occurs in a person 18 years or older.
- After review and consultation there is an alternative agreed upon cause of death.

Laboratory Criteria for Diagnosis
See laboratory criteria for influenza. Laboratory testing for influenza virus infection may be done on pre- or post-mortem clinical specimens.

Case Classification

Confirmed
A death meeting the clinical case definition that is laboratory confirmed. Laboratory or rapid diagnostic test confirmation is required as part of the case definition; therefore, all reported deaths will be classified as confirmed.

Criteria to Distinguish a New Case from an Existing Case*
A case should never be counted as a new case if there was a previously reported infection in the same individual.

*Based on ADHS guidelines

CONTROL MEASURES
Arizona Administrative Code R9-6-348 Influenza-Associated Mortality in a Child

Case Control Measures
A local health agency shall:
1. Upon receiving a report under R9-6-202 of a case or suspect case of an influenza-associated death of a child, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported case or suspect case of influenza-associated mortality in a child; and
3. For each case of influenza-associated mortality in a child, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Influenza-Associated Pediatric Deaths Case Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2006
Most Recent CDC/CSTE Revision Year	2004
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

INFLUENZA A NOVEL VIRUS	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

Cases should be reported under the emerging or exotic disease requirement.

CASE DEFINITION

Clinical Description
An illness compatible with influenza virus infection (fever >100 degrees Fahrenheit, with cough and/or sore throat).

Laboratory Criteria for Diagnosis
A human case of infection with an influenza A virus subtype that is different from currently circulating human influenza H1 and H3 viruses. Novel subtypes include, but are not limited to, H2, H5, H7, and H9 subtypes. Influenza H1 and H3 subtypes originating from a non-human species or from genetic reassortment between animal and human viruses are also novel subtypes. Novel subtypes will be detected with methods available for detection of currently circulating human influenza viruses at state public health laboratories (e.g., real-time reverse transcriptase polymerase chain reaction [RT-PCR]). Confirmation that an influenza A virus represents a novel virus will be performed by CDC's influenza laboratory. Once a novel virus has been identified by CDC, confirmation may be made by public health laboratories following CDC-approved protocols for that specific virus, or by laboratories using an FDA-authorized test specific for detection of that novel influenza virus.

Epidemiologic Linkage

- The patient has had contact with one or more persons who either have or had the disease; AND
- Transmission of the agent by the usual modes of transmission is plausible.

A case may be considered epidemiologically linked to a laboratory-confirmed case if at least one case in the chain of transmission is laboratory confirmed. Laboratory testing for the purposes of case classification should use methods mutually agreed upon by CDC and the Council of State and Territorial Epidemiologists (CSTE). Currently, only viral isolation, RT-PCR, gene sequencing, or a 4-fold rise in strain-specific serum antibody titers are considered confirmatory.

Case Classification

Confirmed
A case of human infection with a novel influenza A virus confirmed by CDC's influenza laboratory or using methods agreed upon by CDC and CSTE as noted in Laboratory Criteria, above.

Probable
A case meeting the clinical criteria and epidemiologically linked to a confirmed case, but for which no confirmatory laboratory testing for influenza virus infection has been performed or test results are inconclusive for a novel influenza A virus infection.

Suspect
A case meeting the clinical criteria, pending laboratory confirmation. Any case of human infection with an influenza A virus that is different from currently circulating human influenza H1 and H3 viruses is classified as a suspected case until the confirmation process is complete.

Comment

Once a novel virus is identified by CDC, it will be nationally notifiable until CSTE in consultation with CDC determines that it is no longer necessary to report each case.

On December 13, 2006, the United States formally accepted the revision of the International Health Regulations, referred to as IHR (2005) (http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf). The IHR (2005) are an international legal instrument that governs the roles of the World Health Organization (WHO) and its member countries in identifying and responding to and sharing information about public health emergencies of international concern (http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf). The updated rules are designed to prevent and protect against the international spread of diseases, while minimizing interference with world travel and trade. The revised regulations add human infections with new influenza strains to the list of conditions that Member States must immediately report to WHO. An outbreak of infections with a new influenza A virus that demonstrates human-to-human transmission could signal the beginning of the next pandemic. Robust epidemiologic and laboratory surveillance systems are required for a coordinated public health response to infections with a novel influenza virus subtype. Early detection of an influenza virus with pandemic potential will permit identification of viral characteristics (e.g., genetic sequence, antiviral susceptibility, and virulence) that will affect clinical management and public health response measures. It should also facilitate development of a virus-specific vaccine and testing strategies.

All state public health laboratories have the capacity to test respiratory specimens for influenza viruses with sensitive and specific assays that can detect human and non-human influenza A viruses. They also have the capacity to subtype currently circulating human influenza A H1, H3, and avian H5 (Asian lineage) viruses. The detection or confirmation by a state public health laboratory of an influenza A virus that is unsubtypable with standard methods (e.g., real-time RT-PCR assays for human influenza A(H3) or (H1) viruses), or a non-human influenza virus (e.g., H5) from a human specimen, could be the initial identification of a virus with pandemic potential. Prompt notification of CDC by a state epidemiologist in conjunction with the public health laboratory will permit rapid confirmation of results and reporting to WHO. In addition, it will aid prompt viral characterization, and the development of virus-specific diagnostic tests.

CONTROL MEASURES

Arizona Administrative Code R9-6-333 Emerging or Exotic Disease

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of an emerging or exotic disease case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. In consultation with the Department, isolate an emerging or exotic disease case or suspect case as necessary to prevent transmission;
3. Conduct an epidemiologic investigation of each reported emerging or exotic disease case or suspect case; and
4. For each emerging or exotic disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures

A local health agency, in consultation with the Department,

1. Shall quarantine or exclude an emerging or exotic disease contact as necessary, according to R9-6-303, to prevent transmission.

INVESTIGATION FORMS

See Novel Influenza A Case Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2013
Most Recent CDC/CSTE Revision Year	2013
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2013: New CDC/CSTE case definition.

LEGIONELLOSIS (Legionnaires' disease)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description

Legionellosis is associated with three clinically and epidemiologically distinct illnesses: Legionnaires' disease, Pontiac fever, or extrapulmonary legionellosis.

Clinical compatibility for surveillance purposes for each of these illnesses is defined below:

Clinical Compatibility	Legionnaires' disease	Pontiac fever	Extrapulmonary legionellosis
Pneumonia (clinical or radiographic)	Yes	No	No
Other clinical features	Fever, myalgia, and cough. These symptoms are typical but not required; additional symptoms (e.g., shortness of breath, headache, confusion, nausea, diarrhea) may be present.	A milder illness without pneumonia. A flu-like illness, often with fever, chills, headache, myalgia, fatigue, malaise; less often with symptoms such as cough or nausea.	Clinical evidence of disease at an extrapulmonary site. *Legionella* can cause disease at sites outside the lungs (for example, associated with endocarditis, wound infection, joint infection, graft infection).

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence

- Isolation of any *Legionella* organism from respiratory secretions, lung tissue, pleural fluid, or extrapulmonary site.
- Detection of any *Legionella* species from lower respiratory secretions, lung tissue, pleural fluid, or extrapulmonary site by a validated nucleic acid amplification test.
- Detection of *Legionella pneumophila* serogroup 1 antigen in urine using validated reagents.
- Seroconversion, a fourfold or greater rise in specific serum antibody titer to *Legionella pneumophila* serogroup 1, using validated reagents.

Supportive Laboratory Evidence

- Seroconversion, a fourfold or greater rise in antibody titer to specific species or serogroups of Legionella other than *L. pneumophila* serogroup 1 (e.g., *L. micdadei*, *L. pneumophila* serogroup 6).
- Seroconversion, a fourfold or greater rise in antibody titer, to multiple species of *Legionella* using pooled antigen.
- Detection of specific *Legionella* antigen or staining of the organism in lower respiratory secretions, lung tissue, pleural fluid, or extrapulmonary site associated with clinical disease by direct fluorescent antibody (DFA) staining, immunohistochemistry (IHC), or other similar method, using validated reagents.

Epidemiologic Linkage

Epidemiologic link to a setting with a positive environmental sampling result of *Legionella* (such as from a cruise ship, public accommodation, cooling tower, etc.).

Case Classification

Confirmed

A clinically compatible case that meets at least one of the confirmatory laboratory criteria[1].

Probable

- Legionnaires' Disease: A clinically compatible case with an epidemiologic link during the 10 days before onset of symptoms.
- Pontiac fever: A clinically compatible case with an epidemiologic link during the 3 days before onset of symptoms.

Suspect

A clinically compatible case that meets at least one of the supportive laboratory criteria[1].

[1]For extrapulmonary legionellosis there must be laboratory evidence of *Legionella* at an extrapulmonary site.

Epidemiologic Classification of Travel- and Healthcare-Associated Legionellosis

Legionellosis cases of either confirmed or suspect classifications may be further assessed for associations to travel or to healthcare facility exposures. Cases meeting the criteria below are considered to be definitely or possibly associated with travel and/or healthcare exposures. Legionellosis cases will be counted and reported based on the clinical and laboratory criteria above, regardless of the presence or absence of travel or healthcare exposures. (ADHS-added clarifications)

Travel-associated legionellosis:

- Definite: A case that has a history of spending the **entire** incubation period away from home, either in the same country of residence or abroad, in the incubation period prior to onset of illness.
    - for Legionnaires' disease of 2 to 10 days
    - for Pontiac fever of 0 to 3 days before the onset of symptoms
- Possible: A case that has a history of spending at least one night away from home, either in the same country of residence or abroad, in the incubation period prior to onset of illness.

Healthcare-associated legionellosis:

- Definite: A case with overnight (inpatient) stay at one or more healthcare facilities throughout the **entire** incubation period.
    - for Legionnaires' disease of 2 to 10 days
    - for Pontiac fever of 0 to 3 days before the onset of symptoms
- Possible: A case with overnight (inpatient) stay at one or more healthcare facilities during the incubation period but not during the entire incubation period, or that is epidemiologically linked to a healthcare facility during an outbreak investigation.

Criteria to Distinguish a New Case from an Existing Case

A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.*

On a case-by-case basis the following critieria can be used, regardless of the interval between laboratory results: An individual should be considered a new case if their previous illness was followed by a period of recovery prior to acute onset of clinically compatible symptoms and subsequent laboratory evidence of infection.

*Based on ADHS guidelines

CONTROL MEASURES

Arizona Administrative Code R9-6-349 Legionellosis (Legionnaires' Disease)

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a legionellosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported legionellosis case or suspect case; and
3. For each legionellosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Environmental control measures

The owner of a water, cooling, or ventilation system or equipment that is determined by the Department or a local health agency to be associated with a case of *Legionella* infection shall comply with the environmental control measures recommended by the Department or local health agency to prevent the exposure of other individuals.

INVESTIGATION FORMS

See Legionellosis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2020
Most Recent CDC/CSTE Revision Year	2020
ADHS Case Definition Matches CDC/CSTE?	No
Description of changes	2020: Moved nucleic acid amplification test (i.e., PCR) from supportive to confirmatory laboratory evidence, added extrapulmonary legionellosis as an illness, and added an epidemiological link which is used in a new probable case classification. These changes are based on modifications to CDC/CSTE definition. The ADHS epidemiological linkage requires more

	definitive confirmation of the source than the criteria in the CDC/CSTE definition. ADHS clinical criteria also differ slightly from the CDC/CSTE definition. The ADHS Epidemiological Classification section (travel and healthcare association) did not change in 2020 and is not defined in the CDC/CSTE case definition. 2019: Clinical compatibility language was clarified (pneumonia is sufficient for clinical compatibility for Legionnaire's disease) and the classification table removed. 2016: ADHS added the Epidemiological Classification section to better clarify and define healthcare- and travel-associated cases. These changes are based on a proposed 2015 CSTE position statement, which is also the source of the classification table. Although these sub-classifications differ from the CDC/CSTE definition, the overall confirmed and suspect case definitions match and are unchanged.

LEPTOSPIROSIS	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description

An illness characterized by fever, headache, chills, myalgia, conjunctival suffusion, and less frequently by meningitis, rash, jaundice, or renal insufficiency. Symptoms may be biphasic.

Clinical presentation includes history of fever within the past two weeks and at least two of the following clinical findings: myalgia, headache, jaundice, conjunctival suffusion without purulent discharge, or rash (i.e. maculopapular or petechial); OR at least one of the following clinical findings:

- Aseptic meningitis
- GI symptoms (e.g., abdominal pain, nausea, vomiting, diarrhea)
- Pulmonary complications (e.g., cough, breathlessness, hemoptysis)
- Cardiac arrhythmias, ECG abnormalities
- Renal insufficiency (e.g., anuria, oliguria)
- Hemorrhage (e.g., intestinal, pulmonary, hematuria, hematemesis)
- Jaundice with acute renal failure

Laboratory Criteria for Diagnosis

Diagnostic testing should be requested for patients in whom there is a high index of suspicion for leptospirosis, based either on signs and symptoms, or on occupational, recreational or vocational exposure to animals or environments contaminated with animal urine.

Confirmatory Testing

- Isolation of *Leptospira* from a clinical specimen; OR
- Fourfold or greater increase in *Leptospira* agglutination titer between acute and convalescent-phase serum specimens obtained >2 weeks apart and studied at the same laboratory; OR
- Demonstration of *Leptospira* in a clinical specimen by immunofluorescence; OR
- *Leptospira* agglutination titer of ≥800 by Microscopic Agglutination Test (MAT) in one or more serum specimens; OR
- Detection of pathogenic *Leptospira* DNA (e.g., by PCR) from a clinical specimen.

Presumptive Testing

- *Leptospira* agglutination titer of ≥200 but <800 by Microscopic Agglutination Test (MAT) in one or more serum specimens; OR
- Demonstration of anti-*Leptospira* antibodies in a clinical specimen by indirect immunofluorescence; OR
- Demonstration of *Leptospira* in a clinical specimen by dark field microscopy; OR
- Detection of IgM antibodies against *Leptospira* in an acute phase serum specimen

Case Classification

Confirmed

A clinically compatible case that meets the confirmatory laboratory criteria.

Probable
A clinically compatible case with at least one of the following:

- Involvement in an exposure event (e.g., adventure race, triathlon, flooding) with known associated cases, OR
- Presumptive laboratory findings, but without confirmatory laboratory evidence of *Leptospira* infection.

CONTROL MEASURES

Arizona Administrative Code R9-6-350 Leptospirosis

Case Control Measures
A local health agency shall:

1. Upon receiving a report under R9-6-202 of a leptospirosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported leptospirosis case or suspect case; and
3. For each leptospirosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Leptospirosis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2013
Most Recent CDC/CSTE Revision Year	2013
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2013: ADHS case definition was updated to match the new CDC/CSTE case definition.

LISTERIOSIS (*Listeria monocytogenes*)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description

Invasive Listeriosis

- Systemic illness caused by *L. monocytogenes* manifests most commonly as bacteremia or central nervous system infection. Other manifestations can include pneumonia, peritonitis, endocarditis, and focal infections of joints and bones.
- Pregnancy-associated listeriosis has generally been classified as illness occurring in a pregnant woman or in an infant aged < 28 days. Listeriosis may result in pregnancy loss (fetal loss before 20 weeks gestation), intrauterine fetal demise (>20 weeks gestation), pre-term labor, or neonatal infection, while causing minimal or no systemic symptoms in the mother. Pregnancy loss and intrauterine fetal demise are considered to be maternal outcomes.
- Neonatal listeriosis commonly manifests as bacteremia, central nervous system infection, and pneumonia, and is associated with high fatality rates. Transmission of *Listeria* from mother to baby transplacentally or during delivery is almost always the source of early-onset neonatal infections (diagnosed between birth and 6 days), and the most likely source of late-onset neonatal listeriosis (diagnosed between 7–28 days).

Non-invasive Listeria Infections

Listeria infection manifesting as an isolate from a non-sterile site suggestive of a noninvasive infection; includes febrile gastroenteritis, urinary tract infection, and wound infection.

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence

- Isolation of *L. monocytogenes* from a specimen collected from a normally sterile site reflective of an invasive infection (e.g., blood or cerebrospinal fluid [CSF] or, less commonly, pleural, peritoneal, pericardial, hepatobiliary, or vitreous fluid; orthopedic site such as bone, bone marrow, or joint; or other sterile sites including organs such as spleen, liver, and heart, but not sources such as urine, stool, or external wounds); OR
- For maternal isolates: In the setting of pregnancy, pregnancy loss, intrauterine fetal demise, or birth, isolation of *L. monocytogenes* from products of conception (e.g., chorionic villi, placenta, fetal tissue, umbilical cord blood, amniotic fluid) collected at the time of delivery; OR
- For neonatal isolates: In the setting of live birth, isolation of *L. monocytogenes* from a non-sterile neonatal specimen (e.g., meconium, tracheal aspirate, but not products of conception) collected within 48 hours of delivery.

Presumptive Laboratory Evidence

- Detection of *L. monocytogenes* by culture-independent diagnostic test (CIDT)* in a specimen collected from a normally sterile site (e.g., blood or cerebrospinal fluid or, less commonly: pleural, peritoneal, pericardial, hepatobiliary, or vitreous fluid; orthopedic site such as bone, bone marrow, or joint; or other sterile sites including organs such as spleen, liver, and heart, but not sources such as urine, stool, or external wounds); OR

- For maternal isolates: In the setting of pregnancy, pregnancy loss, intrauterine fetal demise, or birth, detection of *L. monocytogenes* by CIDT* from products of conception (e.g. chorionic villi, placenta, fetal tissue, umbilical cord blood, amniotic fluid) collected at the time of delivery; OR
- For neonatal isolates: In the setting of live birth, detection of *L. monocytogenes* by CIDT* from a non-sterile neonatal specimen (e.g., meconium, tracheal aspirate, but not products of conception) collected within 48 hours of delivery.

Supportive Laboratory Evidence
Isolation of *L. monocytogenes* from a clinical specimen collected from a non-invasive specimen source, e.g., stool, urine, wound, other than those specified under maternal and neonatal specimens in *Confirmatory laboratory evidence*, above.

*For listeriosis, a CIDT should only include PCR or other nucleic acid amplification test (NAAT) assays. Serological tests should not be considered evidence of infection.

Epidemiologic Linkage

For probable maternal cases:

- A mother who does not meet the confirmed case criteria, BUT
- Who gave birth to a neonate who meets confirmatory or presumptive laboratory evidence for diagnosis; AND
- Neonatal specimen was collected up to 28 days of birth.

For probable neonatal cases:

- Neonate(s) who do not meet the confirmed case criteria; AND
- Whose mother meets confirmatory or presumptive laboratory evidence for diagnosis from products of conception; OR
- A clinically compatible neonate whose mother meets confirmatory or presumptive laboratory evidence for diagnosis from a normally sterile site.

Case Classification

Confirmed
A person who meets confirmatory laboratory evidence.

Probable

- A person who meets the presumptive laboratory criteria for diagnosis; OR
- A mother or neonate who meets the epidemiologic linkage but who does not have confirmatory laboratory evidence.

Suspect
A person with supportive laboratory evidence.

Criteria to Distinguish a New Case from an Existing Case*
As a rule of thumb, a case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual. However, as noted in the 2018 CSTE position statement, there is currently insufficient data available to support a routine recommendation for criteria to distinguish a new case of listeriosis from prior reports or notifications.

Duplicate or recurring reports of listeriosis in an individual should be evaluated on a case-by-case basis.

*Based on ADHS guidelines

Comment

Pregnancy loss and intrauterine fetal demise are considered maternal outcomes and would be counted as a single case in the mother. Cases in neonates and mothers should be reported separately when each meets the case definition. A case in a neonate is counted if live-born.
See Appendix 1 for additional guidance on interpreting whether a specimen is from a “normally sterile body site”.

CONTROL MEASURES

Arizona Administrative Code R9-6-351 Listeriosis

Case Control Measures
A local health agency shall:

1. Upon receiving a report under R9-6-202 of a listeriosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported listeriosis case or suspect case;
3. For each listeriosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that an isolate or a specimen, as available, from each listeriosis case is submitted to the Arizona State Laboratory.

INVESTIGATION FORMS

See the Listeriosis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2019
Most Recent CDC/CSTE Revision Year	2019
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2019: Clarified classification of maternal and neonatal cases by adding epi linkages and accounting for isolation of *L. monocytogenes* from neonatal specimens or products of conception; included CIDT in the laboratory criteria (classified as probable); and accounted for *L. monocytogenes* isolated from non-sterile sites (classified as suspect). Changes based on modifications to CDC/CSTE definition.

	Mid-2019 revision: Clarified that serological testing should not be considered CIDT, per CDC.

LYME DISEASE	PROVIDERS SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Presentation

A systemic, tick-borne disease with protean manifestations, including dermatologic, rheumatologic, neurologic, and cardiac abnormalities. The best clinical marker for the disease is erythema migrans (EM), the initial skin legion that occurs in 60%-80% of patients.

Erythema migrans (EM)

For purposes of surveillance, EM is defined as a skin lesion that typically begins as a red macule or papule and expands over a period of days to weeks to form a large round lesion, often with partial central clearing. A single primary lesion must reach greater than or equal to 5 cm in size across its largest diameter. Secondary lesions also may occur. Annular erythematous lesions occurring within several hours of a tick bite represent hypersensitivity reactions and do not qualify as EM. For most patients, the expanding EM lesion is accompanied by other acute symptoms, particularly fatigue, fever, headache, mildly stiff neck, arthralgia, or myalgia. These symptoms are typically intermittent. The diagnosis of EM must be made by a physician. Laboratory confirmation is recommended for persons with no known exposure. Local reactions to insect bites and stings are often misidentified as EM. As a result, it is important to get additional information about the lesion, including (1) general description (shape and color), (2) was it itchy, painful, or warm to-the-touch, (3) when did the lesion first appear, (4) how many days did it persist, and (5) how much it expanded.

Late Manifestations

Late manifestations occur after the acute period of illness, usually after months or years of infection. For the purposes of surveillance, late manifestations include any of the following when an alternate explanation is not found:

- Musculoskeletal system
    - Recurrent, brief attacks (weeks or months) of objective joint swelling in one or a few joints, sometimes followed by chronic arthritis in one or a few joints.
    - Manifestation not considered as criteria for diagnosis include chronic progressive arthritis not preceded by brief attacks and chronic symmetrical polyarthritis.
    - Arthralgia, myalgia, or fibromyalgia syndromes alone are not criteria for musculoskeletal involvement.
- Nervous system
    - Any of the following signs that cannot be explained by any other etiology, alone or in combination: lymphocytic meningitis; cranial neuritis, particularly facial palsy (may be bilateral); radiculoneuropathy; or, rarely, encephalomyelitis.
    - Headaches, fatigue, paresthesia, or mild stiff necks alone are not criteria for neurologic involvement.
- Cardiovascular system
    - Acute onset of high-grade (2nd degree or 3rd degree) atrioventricular conduction defects that resolve in days to weeks and are sometimes associated with myocarditis.

- Palpitations, bradycardia, bundle branch block, or myocarditis alone are not criteria for cardiovascular involvement.

Laboratory Criteria for Diagnosis

For the purposes of surveillance, the laboratory evidence includes:

- A positive culture for *Borrelia burgdorferi*; OR
- A positive two-tier test, defined as a positive or equivocal enzyme immunoassay (EIA) or immunofluorescence assay (IFA) followed by a positive IgM or IgG western immunoblot (WB) for Lyme disease

  - IgM WB is considered positive when at least two of the following three bands are present: 24kDa (OspC)*, 39 kDa (BmpA), and 41 kDa (Fla).
  - Disregard IgM results for specimens collected >30 days after symptom onset.

- A positive single-tier IgG WB test for Lyme disease

  - IgG WB is considered positive when at least five of the following 10 bands are present: 18 kDa, 24 kDa (OspC)*, 28 kDa, 30 kDa, 39 kDa (BmpA), 41 kDa (Fla), 45 kDa, 58 kDa (not GroEL), 66 kDa, and 93 kDa.

*Depending upon the assay, OspC could be indicated by a band of 21, 22, 23, 24, or 25 kDa.

Exposure

Exposure is defined as having been (≤30 days before onset of EM) in wooded, brushy, or grassy areas (i.e., potential tick habitats) of Lyme disease vectors. Since infected ticks are not uniformly distributed, a detailed travel history to verify whether exposure occurred in a high or low incidence state is needed. An exposure in a high-incidence state is defined as exposure in a state with an average Lyme disease incidence of at least 10 confirmed cases / 100,000 for the previous three reporting years. A low-incidence state is defined as a state with a disease incidence of <10 confirmed cases / 100,000. A history of tick bite is not required.

Based on the data available at http://www.cdc.gov/lyme/stats/tables.html, the following states will be considered high-incidence states for 2019 (based on 2015—2017 data): Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia and Wisconsin. [NOTE: DC new for 2019.]

Case Classification

Confirmed

- A case of EM with exposure in a high-incidence state (as defined above); OR
- A case of EM with laboratory evidence of infection and a known exposure in a low-incidence state; OR
- A case with at least one late manifestation that has laboratory evidence of infection.

Probable

- Any other case of physician-diagnosed Lyme disease that has laboratory evidence of infection (as defined above).

Suspect

- A case of EM where there is no known exposure (as defined above) and no laboratory evidence of infection (as defined above); OR
- A case with laboratory evidence of infection but no clinical information available (e.g., a laboratory report).

Criteria to Distinguish a New Case from an Existing Case
If a case has been previously reported and counted, it should not be considered a new case.

Comment
This surveillance case definition was developed for national reporting of Lyme disease; it is NOT appropriate for clinical diagnosis.

Lyme disease reports will not be considered cases if the medical provider specifically states this is not a case of Lyme disease, or if the only symptom listed is “tick bite” or “insect bite”.

CONTROL MEASURES
Arizona Administrative Code R9-6-352 Lyme Disease

Case Control Measures
A local health agency shall:
1. Conduct an epidemiologic investigation of each reported Lyme disease case or suspect case; and
2. For each Lyme disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS
See the Lyme Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	2017
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2017: Exposure (epidemiological) criteria were revised to include a definition of a high-incidence state. Laboratory evidence now includes more information to help interpret results. Classification modified to use new epidemiological criteria. Changes were based on CDC/CSTE definition. 2013: ADHS definition changed to match CDC/CSTE.

LYMPHOCYTIC CHORIOMENINGITIS	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description

Lymphocytic choriomeningitis virus (LCMV) is a rodent-borne arenavirus which is endemic in house mice throughout the world. Infection has also been documented in pet rodents such as mice, guinea pigs, and hamsters. Transmission to humans can occur through direct contact with infected rodents or rodent-contaminated environments. LCMV infection in humans can range from asymptomatic to mild self-limited illness characterized by any or all of the following symptoms: fever, malaise, lack of appetite, muscle aches, headache, nausea, and vomiting. Aseptic meningitis can also occur in some patients. Orchitis, parotitis, arthritis, myocarditis, and rash occasionally occur. Lab findings can include leucopenia and thrombocytopenia.

Laboratory Diagnosis

Confirmatory Testing

- Isolation of the lymphocytic choriomeningitis virus
- Polymerase chain reaction (PCR) for LCMV

Presumptive Testing

- Serology indicating a positive IgM or a four-fold increase in IgG
- Complete blood count showing leukopenia and thrombocytopenia
- Cerebral spinal fluid analysis indicating increased protein or an increase in white blood cells with an increase in lymphocytes

Case Classification

Confirmed

A clinically-compatible illness that is laboratory confirmed by culture or PCR

Probable

A clinically-compatible illness that has at least one of the presumptive tests listed

CONTROL MEASURES

Arizona Administrative Code R9-6-353 Lymphocytic Choriomeningitis

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a lymphocytic choriomeningitis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported lymphocytic choriomeningitis case or suspect case; and
3. For each lymphocytic choriomeningitis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

Contact ADHS.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	Before 2013
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

LYMPHOGRANULOMA VENEREUM (LGV)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

Report under *Chlamydia trachomatis* infection

CASE DEFINITION

Clinical Description

Infection with L_1, L_2, or L_3 serovars of *Chlamydia trachomatis* may result in a disease characterized by genital lesions, suppurative regional lymphadenopathy, or hemorrhagic proctitis. The infection is usually sexually transmitted.

Laboratory Criteria for Diagnosis

- Isolation of *C. trachomatis*, serotype L1, L2, or L3, from clinical specimen; OR
- Demonstration of inclusion bodies by immunofluorescence in leukocytes of an inguinal lymph node (bubo) aspirate; OR
- Positive microimmunofluorescent serologic test for a lymphogranuloma venereum strain of *C. trachomatis* in a clinically compatible case.

Case Classification

Confirmed

A case that is laboratory confirmed.

Probable

A clinically compatible case with one or more tender fluctuant inguinal lymph nodes or characteristic proctogenital lesions with supportive laboratory findings of a single *C. trachomatis* complement fixation (CF) titer of greater than 64.

CONTROL MEASURES

Arizona Administrative Code R9-6-319 *Chlamydia trachomatis* Infection

Case Control Measures:

A local health agency shall:

1. Comply with the requirements specified in R9-6-1103 concerning treatment and health education for a Chlamydia trachomatis infection case that seeks treatment from the local health agency.

Contact Control Measures:

If an individual who may have been exposed to chlamydia through sexual contact with a Chlamydia trachomatis infection case seeks treatment for symptoms of chlamydia infection from a local health agency, the local health agency shall comply with the requirements specified in R9-6-1103 concerning treatment and health education for the individual.

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2013
Most Recent CDC/CSTE Revision Year	1997
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2013: Separated from ADHS Chlamydia case definition.

MALARIA	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

The first symptoms of malaria (most often fever, chills, sweats, headaches, muscle pains, nausea and vomiting) are often not specific and are also found in other diseases (such as influenza and other common viral infections). Likewise, the physical findings are often not specific (elevated temperature, perspiration, tiredness). In severe malaria (caused by *P. falciparum*), clinical findings (confusion, coma, neurologic focal signs, severe anemia, respiratory difficulties) are more striking and may increase the suspicion index for malaria.

Laboratory Criteria for Diagnosis

- Detection of circulating malaria-specific antigens using rapid diagnostic test (RDT); OR
- Detection of species specific parasite DNA in a sample of peripheral blood using a Polymerase Chain Reaction (PCR) test*; OR
- Detection of malaria parasites in thick or thin peripheral blood films, determining the species by morphologic criteria, and calculating the percentage of red blood cells infected by asexual malaria parasites (parasitemia).

Case Classification

Confirmed

- Detection and specific identification of malaria parasites by microscopy on blood films in a laboratory with appropriate expertise in any person (symptomatic or asymptomatic) diagnosed in the United States, regardless of whether the person experienced previous episodes of malaria while outside the country; OR
- Detection of *Plasmodium* species by nucleic acid test * in any person (symptomatic or asymptomatic) diagnosed in the United States, regardless of whether the person experienced previous episodes of malaria while outside the country; OR
- Detection of unspeciated malaria parasite by microscopy on blood films in a laboratory with appropriate expertise in any person (symptomatic or asymptomatic) diagnosed in the United States, regardless of whether the person experienced previous episodes of malaria while outside the country.

Suspect

Detection of *Plasmodium* species by rapid diagnostic antigen testing without confirmation by microscopy or nucleic acid testing in any person (symptomatic or asymptomatic) diagnosed in the United States, regardless of whether the person experienced previous episodes of malaria while outside the country.

Criteria to Distinguish a New Case from an Existing Case

A subsequent attack experienced by the same person but caused by a different *Plasmodium* species is counted as an additional case. A subsequent attack experienced by the same person and caused by the same species in the United States may indicate a relapsing infection or treatment failure caused by drug resistance or a separate attack.

Comment

* Laboratory-developed malaria PCR tests must fulfill CLIA requirements, including validation studies.

A subsequent attack experienced by the same person but caused by a different *Plasmodium* species is counted as an additional case. A subsequent attack experienced by the same person and caused by the same species in the United States may indicate a relapsing infection or treatment failure caused by drug resistance or a separate attack.

Blood smears from questionable cases should be referred to the CDC Division of Parasitic Diseases Diagnostic Laboratory for confirmation of the diagnosis.

Cases also are classified according to the following World Health Organization categories:

- Autochthonous:
    - Indigenous: malaria acquired by mosquito transmission in an area where malaria is a regular occurrence
    - Introduced: malaria acquired by mosquito transmission from an imported case in an area where malaria is not a regular occurrence
- Imported: malaria acquired outside a specific area (e.g., the United States and its territories)
- Induced: malaria acquired through artificial means (e.g., blood transfusion, common syringes, or malariotherapy)
- Relapsing: recurrence of disease after it has been apparently cured. In malaria, true relapses are caused by reactivation of dormant liver-stage parasites (hypnozoites) of *P. vivax* and *P. ovale*
- Cryptic: an isolated case of malaria that cannot be epidemiologically linked to additional cases

CONTROL MEASURES

Arizona Administrative Code R9-6-354 Malaria

Case Control Measures

A local health agency shall:

1. Conduct an epidemiologic investigation of each reported malaria case or suspect case; and
2. For each malaria case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Environmental Control Measures

In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction

1. Shall conduct an assessment of the environment surrounding each malaria case or suspect case and implement vector control measures as necessary.

INVESTIGATION FORMS

See the Malaria Case Surveillance Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	2014
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2017: Added criteria to distinguish a new case from an existing case to match 2013 CDC/CSTE case definition. 2014: Modifications were made to the laboratory criteria to include the determination of the parasite species and the quantification of the parasitemia; confirmed case definition was changed to include detection of unspeciated parasite; modifications were made to match the 2014 CDC/CSTE case definition.

MEASLES (Rubeola)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

CASE DEFINITION

Clinical Description

An acute illness characterized by:

- A generalized, maculopapular rash lasting ≥3 days; AND
- A temperature ≥101.0°F (≥38.3°C); AND
- Cough, coryza, or conjunctivitis.

Laboratory Criteria for Diagnosis

- Isolation of measles virus[†] from a clinical specimen; OR
- Detection of measles-virus specific nucleic acid[†] from a clinical specimen using polymerase chain reaction; OR
- IgG seroconversion[†] or a significant rise in measles immunoglobulin G antibody[†] using any evaluated and validated method; OR
- A positive serologic test for measles immunoglobulin M[†§] antibody.

[†]Not explained by MMR vaccination during the previous 6-45 days
[§]Not otherwise ruled out by other confirmatory testing or more specific measles testing in a public health laboratory.

Case Classification

Confirmed
An acute febrile rash illness[‡] with:

- Any of the laboratory criteria for diagnosis listed above; OR
- Direct epidemiologic linkage to a case confirmed by one of the laboratory criteria for diagnosis listed above.

Probable
In the absence of a more likely diagnosis, an illness that meets the clinical description with:

- No epidemiologic linkage to a laboratory-confirmed measles case; AND
- Noncontributory or no measles laboratory testing.

[‡]Temperature does not need to reach ≥101°F/38.3°C and rash does not need to last ≥3 days.

Epidemiologic Classification of Internationally-Imported and U.S-Acquired

Internationally imported case
An internationally imported case is defined as a case in which measles results from exposure to measles virus outside the United States as evidenced by at least some of the exposure period (7–21 days before rash onset) occurring outside the United States and rash onset occurring within 21 days of

entering the United States and there is no known exposure to measles in the U.S. during that time. All other cases are considered U.S.-acquired.

U.S.-acquired case

An U.S.-acquired case is defined as a case in which the patient had not been outside the United States during the 21 days before rash onset or was known to have been exposed to measles within the United States. U.S.-acquired cases are subclassified into four mutually exclusive groups:

- **Import-linked case**: Any case in a chain of transmission that is epidemiologically linked to an internationally imported case.
- **Imported-virus case**: a case for which an epidemiologic link to an internationally imported case was not identified, but for which viral genetic evidence indicates an imported measles genotype, i.e., a genotype that is not occurring within the United States in a pattern indicative of endemic transmission. An endemic genotype is the genotype of any measles virus that occurs in an endemic chain of transmission (i.e., lasting ≥12 months). Any genotype that is found repeatedly in U.S.-acquired cases should be thoroughly investigated as a potential endemic genotype, especially if the cases are closely related in time or location.
- **Endemic case**: a case for which epidemiological or virological evidence indicates an endemic chain of transmission. Endemic transmission is defined as a chain of measles virus transmission that is continuous for ≥12 months within the United States.
- **Unknown source case**: a case for which an epidemiological or virological link to importation or to endemic transmission within the U.S. cannot be established after a thorough investigation.

These cases must be carefully assessed epidemiologically to assure that they do not represent a sustained U.S.-acquired chain of transmission or an endemic chain of transmission within the U.S.

Note: Internationally imported, import-linked, and imported-virus cases are considered collectively to be import-associated cases. States may also choose to classify cases as “out-of-state-imported” when imported from another state in the United States. For national reporting, however, cases will be classified as either internationally imported or U.S.-acquired.

CONTROL MEASURES

Arizona Administrative Code R9-6-355 Measles (Rubeola)

Case Control Measures:

1. An administrator of a school or child care establishment, either personally or through a representative, shall:
    a. Exclude a measles case from the school or child care establishment and from school- or child-care-establishment-sponsored events from the onset of illness through the fourth calendar day after the rash appears; and
    b. Exclude a measles suspect case from the school or child care establishment and from school- or child-care-establishment-sponsored events until the local health agency has determined that the suspect case is unlikely to infect other individuals.
2. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute airborne precautions for a measles case from onset of illness through the fourth calendar day after the rash appears.
3. An administrator of a health care institution, either personally or through a representative, shall exclude a measles:
    a. Case from working at the health care institution from the onset of illness through the fourth calendar day after the rash appears; and

   b. Suspect case from working at the health care institution until the local health agency has determined that the suspect case may return to work.
4. A local health agency shall:
   a. Upon receiving a report under R9-6-202 or R9-6-203 of a measles case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
   b. Conduct an epidemiologic investigation of each reported measles case or suspect case;
   c. For each measles case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
   d. Ensure that one or more specimens from each measles case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.
5. An administrator of a correctional facility or shelter, either personally or through a representative, shall comply with the measles control measures recommended by a local health agency or the Department.

Contact Control Measures:

1. When a measles case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
   a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
   b. Comply with the local health agency's recommendations for exclusion.
2. A local health agency shall:
   a. Determine which measles contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission; and
   b. Provide or arrange for immunization of each non-immune measles contact within 72 hours after last exposure, if possible.
3. An administrator of a health care institution shall ensure that a paid or volunteer full-time or part-time worker at a health care institution does not participate in the direct care of a measles case or suspect case unless the worker is able to provide evidence of immunity to measles through one of the following:
   a. A record of immunization against measles with two doses of live virus vaccine given on or after the first birthday and at least one month apart;
   b. A statement signed by a physician, physician assistant, registered nurse practitioner, state health officer, or local health officer affirming serologic evidence of immunity to measles; or
   c. Documentary evidence of birth before January 1, 1957.

INVESTIGATION FORMS

See Measles Case Surveillance Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2013
Most Recent CDC/CSTE Revision Year	2013
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2013: ADHS definition was edited to match the new 2013 CDC/CSTE definition. Changes

	including adding PCR to the laboratory criteria and removing the Suspect case classification.

MELIOIDOSIS (*Burkholderia pseudomallei)*	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description

Clinical presentation of the disease varies on a case by case basis. The following characteristics are typical of melioidosis.

- An acute or chronic localized infection which may or may not include symptoms of fever and muscle aches. Such infection often results in ulcer, nodule, or skin abscess.
- An acute pulmonary infection with symptoms of fever, headache, chest pain, anorexia, and general muscle soreness.
- A bloodstream infection with symptoms of fever, headache, respiratory distress, abdominal discomfort, joint pain, muscle tenderness, and/or disorientation.
- A disseminated infection with symptoms of fever, weight loss, stomach or chest pain, muscle or joint pain, and/or headache or seizure. Abscesses in the liver, lung, spleen, and prostate are often observed in patients diagnosed with disseminated infections; less frequently, brain abscesses may be seen.

Laboratory Criteria for Diagnosis

Confirmatory Testing

- Isolation of *B. pseudomallei* from a clinical specimen of a case of severe febrile illness: Culture of the organism may be done by blood, sputum, urine, pus, throat swab, or swabs from organ abscesses or wounds.

Presumptive Testing

- Evidence of a fourfold or greater rise in *B. pseudomallei* antibody titer by IHA between acute- and convalescent-phase serum specimens obtained greater than or equal to 2 weeks apart.
- Evidence of *B. pseudomallei* DNA (for example, by LRN-validated polymerase chain reaction) in a clinical specimen collected from a normally sterile site (blood) or lesion of other affected tissue (abscesses, wound).

Case Classification

Confirmed

A case that meets the confirmatory laboratory criteria, with or without clinical evidence.

Probable

A case that meets the clinical case definition, one or more of the presumptive laboratory criteria, and one of the following epidemiologic findings:

- History of travel to melioidosis-endemic region; OR
- Known exposure to *B. pseudomallei* as a result of intentional release or occupational risk (lab exposure)

CONTROL MEASURES

Arizona Administrative Code R9-6-356 Melioidosis

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a melioidosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported melioidosis case or suspect case;
3. For each melioidosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that an isolate or a specimen, as available, from each melioidosis case or suspect case is submitted to the Arizona State Laboratory.

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2013
Most Recent CDC/CSTE Revision Year	2012
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2013: edited content to match CDC/CSTE. Moved *B. mallei* to a separate case definition.

MENINGOCOCCAL INVASIVE DISEASE	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

CASE DEFINITION

Clinical Description
Meningococcal disease presents most commonly as meningitis and/or meningococcemia that may progress rapidly to purpura fulminans, shock, and death. However, other manifestations may be observed.

Laboratory Criteria for Diagnosis

Confirmatory Testing

- Isolation of *Neisseria meningitidis* from a normally sterile site (e.g., blood or CSF or, less commonly, synovial, pleural, or pericardial fluid) or from purpuric lesions, OR
- Detection of *N. meningitidis*-specific nucleic acid in a specimen obtained from a normally sterile body site, using a validated polymerase chain reaction (PCR) assay.

Presumptive Testing

- Detection of *N. meningitidis* antigen in a formalin-fixed tissue by immunochemistry (IHC), or in CSF by latex agglutination.

Case Classification

Confirmed
A case that meets the confirmatory laboratory criteria for diagnosis.

Probable
A case that meets the presumptive laboratory criteria for diagnosis.

Suspect

- Clinical purpura fulminans in the absence of a positive blood culture, OR
- Gram-negative diplococci, not yet identified, isolated from a normally sterile site (e.g., blood or CSF)

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

When two or more different serogroups are identified in one or more specimens from the same individual, each should be reported as a separate case.

*Based on ADHS guidelines

Comment
See Appendix 1 for guidance on interpreting whether a specimen is from a “normally sterile body site”.

CONTROL MEASURES

Arizona Administrative Code R9-6-357 Meningococcal Invasive Disease

Case Control Measures:

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute droplet precautions for a meningococcal invasive disease case for 24 hours after the initiation of treatment.
2. A local health agency shall:
    a. Upon receiving a report under R9-6-202 or R9-6-203 of a meningococcal invasive disease case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
    b. Conduct an epidemiologic investigation of each reported meningococcal invasive disease case or suspect case;
    c. For each meningococcal invasive disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
    d. Ensure that an isolate or a specimen, as available, from each meningococcal invasive disease case is submitted to the Arizona State Laboratory.

Contact Control Measures:
A local health agency shall:

1. Evaluate the level of risk of transmission from each contact's exposure to a meningococcal invasive disease case and, if indicated, provide or arrange for each contact to receive prophylaxis.

INVESTIGATION FORMS

See Meningococcal Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2015
Most Recent CDC/CSTE Revision Year	2015
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2015: PCR of normally sterile sites specimen moved from a presumptive to confirmatory test, matching the CDC/CSTE change.

METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (INVASIVE)	LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

Staphylococcus aureus can produce a variety of presentations, ranging from skin or soft tissue infection to bacteremia or the involvement of various organs (e.g., endocarditis, pneumonia, osteomyelitis). Methicillin-resistant *Staphylococcus aureus* (MRSA) is resistant to beta-lactam antibiotics. Only MRSA from normally sterile sites (invasive disease) is reportable.

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence

- Isolation of *Staphylococcus aureus* by culture from a normally sterile site. Examples of sterile sites include but are not limited to: CSF, blood, peritoneal fluid, pericardial fluid, or pleural fluid; AND
- Resistance of *Staphylococcus aureus* isolate to oxacillin* or cefoxitin**, detected and defined according to the standards and guidelines approved by the National Committee for Clinical Laboratory Standards (NCCLS).

Interpretive Criteria (in µg/ml) for *S. aureus* MIC (Minimum Inhibitory Concentration) Tests			
	Susceptible	**Intermediate**	**Resistant**
Oxacillin	≤ 2 µg/ml	N/A	≥ 4 µg/ml
Cefoxitin	≤ 4 µg/ml	N/A	≥ 8 µg/ml

* Methicillin is no longer commercially available in the United States and oxacillin maintains its activity during storage better than methicillin and is more likely to detect heteroresistant strains. Oxacillin, which is in the same class of drugs as methicillin, was chosen as the agent of choice for testing staphylococci in the early 1990s. The acronym MRSA is still used by many to describe these isolates because of its historic role.

** Cefoxitin is used as a surrogate for oxacillin; report oxacillin susceptible or resistant based on the cefoxitin result. If both cefoxitin and oxacillin are tested against *S. aureus* and either result is resistant, the organism should be reported as oxacillin resistant.

Presumptive Laboratory Evidence

Identification of MRSA from a normally sterile body site by a culture-independent diagnostic test (CIDT) without isolation of the bacteria.

Case Classification

Confirmed

A case that meets the laboratory criteria for diagnosis.

Probable
A case that meets the presumptive laboratory evidence.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment
See Appendix 1 for guidance on interpreting whether a specimen is from a "normally sterile body site".

CONTROL MEASURES
Arizona Administrative Code R9-6-358 Methicillin-resistant *Staphylococcus aureus* (MRSA)

Case Control Measures:
1. A diagnosing health care provider or an administrator of a health care institution transferring a known methicillin-resistant *Staphylococcus aureus* case with active infection to another health care provider or health care institution or to a correctional facility shall, either personally or through a representative, ensure that the receiving health care provider, health care institution, or correctional facility is informed that the patient is a known methicillin-resistant *Staphylococcus aureus* case.
2. If a known methicillin-resistant *Staphylococcus aureus* case with active infection is being transferred from a correctional facility to another correctional facility or to a health care institution, an administrator of the correctional facility, either personally or through a representative, shall ensure that the receiving correctional facility or health care institution is informed that the individual is a known methicillin-resistant *Staphylococcus aureus* case.

Outbreak control measures:
A local health agency, in consultation with the Department, shall:
1. Conduct an epidemiologic investigation of each reported outbreak of methicillin-resistant *Staphylococcus aureus* in a health care institution or correctional facility; and
2. For each outbreak of methicillin-resistant Staphylococcus aureus in a health care institution or correctional facility, submit to the Department the information required under R9-6-206(E).

When an outbreak of methicillin-resistant *Staphylococcus aureus* occurs in a health care institution or correctional facility, the administrator of the health care institution or correctional facility, either personally or through a representative, shall comply with the control measures recommended by a local health agency or the Department.

INVESTIGATION FORMS
See Methicillin-resistant *Staphylococcus aureus* (MRSA) Surveillance Supplemental Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2020

Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	2020: Presumptive laboratory evidence added to allow for tests other than culture. Presumptive laboratory evidence used for a new probable definition. 2017: MIC values updated and table added.

MIDDLE EAST RESPIRATORY SYNDROME CORONAVIRUS (MERS)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

Cases should be reported under the Novel Coronavirus (e.g., SARS or MERS) requirement. Enter in MEDSIS as MERS.

CASE DEFINITION

Clinical and Epidemiological Criteria

These criteria serve as guidance for testing; however, patients should be evaluated and discussed with public health departments on a case-by-case basis if their clinical presentation or exposure history is equivocal (e.g., uncertain history of health care exposure).

Clinical Features		Epidemiologic Risk
Severe illness Fever[1] *and* pneumonia or acute respiratory distress syndrome (based on clinical or radiological evidence)	and	A history of travel from countries in or near the Arabian Peninsula[2] within 14 days before symptom onset, *or* close contact[3] with a symptomatic traveler who developed fever[1] and acute respiratory illness (not necessarily pneumonia) within 14 days after traveling from countries in or near the Arabian Peninsula[2]. *– or –* A member of a cluster of patients with severe acute respiratory illness (e.g., fever[1] and pneumonia requiring hospitalization) of unknown etiology in which MERS is being evaluated, in consultation with state and local health departments in the US.
Milder illness Fever[1] *and* symptoms of respiratory illness (not necessarily pneumonia; e.g., cough, shortness of breath)	and	A history of being in a healthcare facility (as a patient, worker, or visitor) within 14 days before symptom onset in a country or territory in or near the Arabian Peninsula[2] in which recent healthcare-associated cases of MERS have been identified.
Fever[1] *or* symptoms of respiratory illness (not necessarily pneumonia; e.g., cough, shortness of breath)	and	Close contact[3] with a confirmed MERS case while the case was ill.

Laboratory Criteria for Diagnosis

Confirmatory Testing

Confirmatory laboratory testing requires a positive PCR on at least two specific genomic targets or a single positive target with sequencing on a second.

Case Classification

Confirmed

A person with laboratory confirmation of MERS infection.

Probable

A person meeting the clinical and epidemiological criteria listed above, with absent or inconclusive laboratory results for MERS infection, who is a close contact[3] of a laboratory-confirmed MERS case. Examples of laboratory results that may be considered inconclusive include a positive test on a single

PCR target, a positive test with an assay that has limited performance data available, or a negative test on an inadequate specimen.

Comment

The MERS case definition may be subject to change as the situation evolves. Please refer to CDC website for the most up-to-date information.

Footnotes

1. Fever may not be present in some patients, such as those who are very young, elderly, immunosuppressed, or taking certain medications. Clinical judgment should be used to guide testing of patients in such situations.
2. Countries considered in the Arabian Peninsula and neighboring include: Bahrain; Iraq; Iran; Israel, the West Bank, and Gaza; Jordan; Kuwait; Lebanon; Oman; Qatar; Saudi Arabia; Syria; the United Arab Emirates (UAE); and Yemen, as of January 2016. Check http://www.cdc.gov/coronavirus/mers/case-def.html for the most up-to-date list of countries.
3. Close contact is defined as: a) being within approximately 6 feet (2 meters) or within the room or care area for a prolonged period of time (e.g., healthcare personnel, household members) while not wearing recommended personal protective equipment (i.e., gowns, gloves, respirator, eye protection– see https://www.cdc.gov/coronavirus/mers/infection-prevention-control.html); or b) having direct contact with infectious secretions (e.g., being coughed on) while not wearing recommended personal protective equipment (i.e., gowns, gloves, respirator, eye protection –see https://www.cdc.gov/coronavirus/mers/infection-prevention-control.html). Data to inform the definition of close contact are limited. At this time, brief interactions, such as walking by a person, are considered low risk and do not constitute close contact.

CONTROL MEASURES

Arizona Administrative Code R9-6-361 Novel Coronavirus (e.g., SARS or MERS)

Case Control Measures

A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute both airborne precautions and contact precautions for a novel coronavirus case or suspect case, including a case or suspect case of severe acute respiratory syndrome or Middle East respiratory syndrome, until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner.

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a novel coronavirus case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. In consultation with the Department, ensure that isolation and both airborne precautions and contact precautions have been instituted for a novel coronavirus case or suspect case to prevent transmission;
3. Conduct an epidemiologic investigation of each reported novel coronavirus case or suspect case; and
4. For each novel coronavirus case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures

A local health agency, in consultation with the Department, shall:

Determine which novel coronavirus contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission.

INVESTIGATION FORMS

See MERS Patient Under Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2016
Most Recent CDC/CSTE Revision Year	2015
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2016: Case definition was added to this manual.

MULTISYSTEM INFLAMMATORY SYNDROME IN CHILDREN (MIS-C)	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS

Cases should be reported under the Novel Coronavirus (e.g., SARS or MERS) requirement. See COVID-19 (2019 Novel Coronavirus) for the case definition specific to COVID-19.

Enter MIS-C in MEDSIS as Multisystem Inflammatory Syndrome in Children.

CASE DEFINITION

Clinical Criteria

An individual aged <21 years presenting with fever*, laboratory evidence of inflammation†, and evidence of clinically severe illness requiring hospitalization, with multisystem (>2) organ involvement (cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic or neurological).

AND

No alternative more likely diagnosis.

* Fever >38.0°C for ≥24 hours, or report of subjective fever lasting ≥24 hours.
† Including, but not limited to, one or more of the following: an elevated C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), fibrinogen, procalcitonin, d-dimer, ferritin, lactic acid dehydrogenase (LDH), or interleukin 6 (IL-6), elevated neutrophils, reduced lymphocytes and low albumin.

Laboratory Criteria for Diagnosis

Positive for current or recent SARS-CoV-2 infection by RT-PCR, serology, or antigen test.

Epidemiologic Linkage

Close contact with a confirmed or probable case of COVID-19 disease in the 4 weeks before onset of symptoms.

Case Classification

Confirmed

A clinically compatible case that meets either the laboratory OR epidemiologic linkage criteria for diagnosis.

Comments

- A person meeting the case definition for COVID-19 and for MIS-C should be entered in MEDSIS under both morbidities, and classified appropriately for each. For example, a confirmed MIS-C case will likely also count as a confirmed or probable COVID-19 case.
- Some individuals may fulfill full or partial criteria for Kawasaki Syndrome but should be reported if they meet the case definition for MIS-C.
- Consider MIS-C in any pediatric death with evidence of SARS-CoV-2 infection

CONTROL MEASURES

Arizona Administrative Code R9-6-361 Novel Coronavirus (e.g., SARS or MERS)

Case Control Measures

A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute both airborne precautions and contact precautions for a novel coronavirus case or suspect case, including a case or suspect case of severe acute respiratory syndrome or Middle East respiratory syndrome, until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner.

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a novel coronavirus case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. In consultation with the Department, ensure that isolation and both airborne precautions and contact precautions have been instituted for a novel coronavirus case or suspect case to prevent transmission;
3. Conduct an epidemiologic investigation of each reported novel coronavirus case or suspect case; and
4. For each novel coronavirus case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures

A local health agency, in consultation with the Department, shall:

1. Determine which novel coronavirus contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission.

INVESTIGATION FORMS

See the Multisystem Inflammatory Syndrome in Children Investigation Form at https://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2020
Most Recent CDC/CSTE Revision Year	2020
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	New CDC/CSTE case definition; added to Arizona case definition manual in June 2020.

MUMPS	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description

The clinical case definition requirements vary for each of the case classification categories. See the case classifications, below.

Laboratory Criteria for Diagnosis

Confirmatory Testing

- Isolation of mumps virus from clinical specimen; OR
- Detection of mumps nucleic acid via reverse transcriptase polymerase chain reaction (RT-PCR).

Presumptive Testing

Detection of serum mumps IgM antibody.

Case Classification

Confirmed

A case with confirmatory laboratory results and an acute illness characterized by any of the following:

- Acute parotitis or other salivary gland swelling, lasting at least 2 days
- Aseptic meningitis
- Encephalitis
- Hearing loss
- Orchitis
- Oophoritis
- Mastitis
- Pancreatitis

Probable

Acute parotitis or other salivary gland swelling lasting at least 2 days, or orchitis or oophoritis unexplained by another more likely diagnosis, in:

- A person with positive presumptive laboratory results; OR
- A person with epidemiologic linkage to another probable or confirmed case or linkage to a group/community defined by public health during an outbreak of mumps.

Suspect

- Parotitis, acute salivary gland swelling, orchitis, or oophoritis unexplained by another more likely diagnosis; OR
- A positive lab result with no mumps clinical symptoms (with or without epidemiological-linkage to a confirmed or probable case).

Classification of Import Status

Internationally imported case
An internationally imported case is defined as a case in which mumps results from exposure to mumps virus outside the United States as evidenced by at least some of the exposure period (12–25 days before onset of parotitis or other mumps-associated complications) occurring outside the United States and the onset of parotitis or other mumps-associated complications within 25 days of entering the United States and no known exposure to mumps in the U.S. during that time. All other cases are considered U.S.-acquired cases.

U.S.-acquired case
A U.S.-acquired case is defined as a case in which the patient had not been outside the United States during the 25 days before onset of parotitis or other mumps-associated complications or was known to have been exposed to mumps within the United States. U.S.-acquired cases are sub-classified into four mutually exclusive groups:

- **Import-linked case**: Any case in a chain of transmission that is epidemiologically linked to an internationally imported case.
- **Imported-virus case**: A case for which an epidemiologic link to an internationally imported case was not identified but for which viral genetic evidence indicates an imported mumps genotype, i.e., a genotype that is not occurring within the United States in a pattern indicative of endemic transmission. An endemic genotype is the genotype of any mumps virus that occurs in an endemic chain of transmission (i.e., lasting ≥12 months). Any genotype that is found repeatedly in U.S.-acquired cases should be thoroughly investigated as a potential endemic genotype, especially if the cases are closely related in time or location.
- **Endemic case**: A case for which epidemiological or virological evidence indicates an endemic chain of transmission. Endemic transmission is defined as a chain of mumps virus transmission continuous for ≥12 months within the United States.
- **Unknown source case**: A case for which an epidemiological or virological link to importation or to endemic transmission within the U.S. cannot be established after a thorough investigation. These cases must be carefully assessed epidemiologically to assure that they do not represent a sustained U.S.-acquired chain of transmission or an endemic chain of transmission within the U.S.

Note: Internationally imported, import-linked, and imported-virus cases are considered collectively to be import-associated cases.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment
With previous contact with mumps virus either through vaccination (particularly with 2 doses) or natural infection, serum mumps IgM test results may be negative; IgG test results may be positive at initial blood draw and viral detection in RT-PCR or culture may have low yield if the buccal swab is collected too long after parotitis onset. Therefore, mumps cases should not be ruled out by negative laboratory results. Serologic tests should be interpreted with caution, as false positive and false negative results are possible with IgM tests.

States may also choose to classify cases as “out-of-state-imported” when imported from another state in the United States. For national reporting, however, cases will be classified as either internationally imported or U.S.-acquired.

CONTROL MEASURES

Arizona Administrative Code R9-6-359 Mumps

Case Control Measures

1. An administrator of a school or child care establishment, either personally or through a representative, shall:
    a. Exclude a mumps case from the school or child care establishment for five calendar days after the onset of glandular swelling; and
    b. Exclude a mumps suspect case from the school or child care establishment and from school- or child-care-establishment-sponsored events until evaluated and determined to be noninfectious by a physician, physician assistant, registered nurse practitioner, or local health agency.
2. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute droplet precautions with a mumps case for five calendar days after the onset of glandular swelling.
3. An administrator of a health care institution, either personally or through a representative, shall exclude a mumps:
    a. Case from working at the health care institution for five calendar days after the onset of glandular swelling; and
    b. Suspect case from working at the health care institution until evaluated and determined to be noninfectious by a physician, physician assistant, registered nurse practitioner, or local health agency.
4. A local health agency shall:
    a. Upon receiving a report under R9-6-202 or R9-6-203 of a mumps case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
    b. Conduct an epidemiologic investigation of each reported mumps case or suspect case;
    c. For each mumps case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
    d. Ensure that one or more specimens from each mumps case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.
5. An administrator of a correctional facility or shelter, either personally or through a representative, shall comply with the mumps control measures recommended by a local health agency or the Department.

Contact Control Measures

1. When a mumps case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
    a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
    b. Comply with the local health agency’s recommendations for exclusion.
2. An administrator of a health care institution shall ensure that a paid or volunteer full-time or part-time worker at a health care institution does not participate in the direct care of a mumps case or suspect case unless the worker is able to provide evidence of immunity to mumps through one of the following:
    a. A record of immunization against mumps with two doses of live virus vaccine given on or after the first birthday and at least one month apart; or

   b. A statement signed by a physician, physician assistant, registered nurse practitioner, state health officer, or local health officer affirming serologic evidence of immunity to mumps.
3. A local health agency shall determine which mumps contacts will be:
   a. Quarantined or excluded, according to R9-6-303, to prevent transmission; and
   b. Advised to obtain an immunization against mumps.

INVESTIGATION FORMS

See Mumps Surveillance Worksheet Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2013
Most Recent CDC/CSTE Revision Year	2012
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2013: ADHS definition was updated to match the 2012 CDC/CSTE definition.

NOROVIRUS	LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

Outbreaks should be reported under the Diarrhea, Nausea, or Vomiting requirement.

CASE DEFINITION

Clinical Description
Norovirus usually causes a self-limited, mild-to-moderate disease that often occurs in outbreaks. Clinical symptoms include nausea, vomiting, diarrhea, abdominal pain, or other symptoms typical of gastrointestinal illnesses.

Laboratory Criteria for Diagnosis
Identification of norovirus through nucleic acid testing at the Arizona State Public Health Laboratory, CDC, or other approved laboratory.

Case Classification

Confirmed
A case that meets the laboratory criteria for diagnosis.

Suspect
A case with clinically compatible symptoms of norovirus and epi-linked to a confirmed norovirus case OR a confirmed norovirus outbreak.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

CONTROL MEASURES
Arizona Administrative Code R9-6-360 Norovirus

Outbreak Control Measures
A local health agency shall:
1. Conduct an epidemiologic investigation of each reported norovirus outbreak;
2. Submit to the Department the information required under R9-6-206(E); and
3. Exclude each case that is part of a norovirus outbreak from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
    a. Diarrhea has resolved, or
    b. The local health agency has determined that the case or suspect case is unlikely to infect other individuals.

Environmental Control Measures
A local health agency shall
1. Conduct a sanitary inspection or ensure that a sanitary inspection is conducted of each facility or location regulated under 9 A.A.C. 8 that is associated with a norovirus outbreak.

INVESTIGATION FORMS

See Outbreak Summary Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2015
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	2015: deleted “reference” from “approved reference laboratory” in the laboratory criteria. 2014: addition of suspect case definition to capture epi-linked/outbreak cases without laboratory testing available, that were not captured in the previous case definition. 2013: testing from other approved labs accepted

NOVEL CORONAVIRUS (e.g., SARS OR MERS)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

See COVID-19 (2019 Novel Coronavirus) or Severe Acute Respiratory Syndrome (SARS) or Middle Eastern Respiratory Syndrome (MERS) for separate case definitions.

CONTROL MEASURES

Arizona Administrative Code R9-6-361 Novel Coronavirus (e.g., SARS or MERS)

Case Control Measures

A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute both airborne precautions and contact precautions for a novel coronavirus case or suspect case, including a case or suspect case of severe acute respiratory syndrome or Middle East respiratory syndrome, until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner.

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a novel coronavirus case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. In consultation with the Department, ensure that isolation and both airborne precautions and contact precautions have been instituted for a novel coronavirus case or suspect case to prevent transmission;
3. Conduct an epidemiologic investigation of each reported novel coronavirus case or suspect case; and
4. For each novel coronavirus case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures

A local health agency, in consultation with the Department, shall:

1. Determine which novel coronavirus contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission.

PARATYPHOID FEVER	PROVIDERS REPORT WITHIN 24 HOURS IF AN OUTBREAK IS DETECTED OR PERSON HAS A HIGH-RISK OCCUPATION PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 DAY FOR ALL OTHER CASES

Cases should be reported under the Salmonellosis requirement. Enter in MEDSIS as Paratyphoid Fever.

CASE DEFINITION

Background

S. Paratyphi A, B (tartrate negative), and C are bacteria that often cause a potentially severe and occasionally life-threatening bacteremic illness. While fever and gastrointestinal symptoms are common, the clinical presentation varies, including mild and atypical infections. In the United States, approximately 80 cases of paratyphoid fever caused by *S.* Paratyphi A are reported each year, 90% of which are acquired during international travel. Cases of paratyphoid fever caused by serotypes *S.* Paratyphi B (tartrate negative) and C are reported much less frequently. Ongoing surveillance of *S.* Paratyphi infections is essential to detect and control outbreaks, determine public health priorities, monitor trends in illness, and assess effectiveness of public health interventions.

Of note, *S.* Paratyphi B (tartrate positive), previously known as *S.* Java, typically causes an uncomplicated gastroenteritis, with lower rates of hospitalization and recent international travel compared with *S.* Paratyphi A, B (tartrate negative), and C. For these reasons, Paratyphi B (tartrate positive) is categorized as salmonellosis instead of an *S.* Paratyphi Infection.

Clinical Description

An illness caused by *Salmonella enterica* serotypes Paratyphi A, Paratyphi B (tartrate negative), and Paratyphi C that is often characterized by insidious onset of sustained fever, headache, malaise, anorexia, relative bradycardia, constipation or diarrhea, and nonproductive cough. However, mild and atypical infections may occur. Carriage of paratyphoidal *Salmonella* may be prolonged.

Clinical Criteria

One or more of the following:

- Fever
- Diarrhea
- Abdominal cramps
- Constipation
- Anorexia
- Relative bradycardia

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence

Isolation of *Salmonella* Paratyphi A, Paratyphi B (tartrate negative) or Paratyphi C from a clinical specimen.

Presumptive Laboratory Evidence
Detection of *Salmonella* Paratyphi A, Paratyphi B (tartrate negative) or Paratyphi C in a clinical specimen using a culture-independent diagnostic test (CIDT).

*Serologic testing (i.e., detection of antibodies to S. Paratyphi A, B, or C) should not be utilized for case classification.

Epidemiologic Linkage

- Epidemiological linkage to a confirmed case of paratyphoid fever; OR
- Epidemiological linkage to a probable case of paratyphoid fever with laboratory evidence; OR
- Member of a risk group as defined by public health authorities during an outbreak.

Case Classification

Confirmed
A case that meets the confirmatory laboratory criteria.

Probable

- A clinically compatible illness in a person that meets the presumptive laboratory criteria.
- A clinically compatible illness in a person with an epidemiological linkage.

Criteria to Distinguish a New Case from an Existing Case
A case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual.

When two or more different serotypes are identified from one or more specimens from the same individual, each should be reported as a separate case.

Comment
Several serological tests have been developed to detect antibodies to S. Paratyphi A, B, and C. However, no current serological test is sufficiently sensitive or specific to replace culture-based tests for the identification of S. Paratyphi infections. Whether public health follow-up for positive serologic testing is conducted and how is at the discretion of the jurisdiction. The percentage of persons with S. Paratyphi A, B (tartrate negative), or C infections that become chronic carriers is not known.

Differentiating whether a person is a chronic carrier or is experiencing a new infection often relies on a variety of factors, including advanced laboratory testing (e.g., pulsed-field gel electrophoresis [PFGE], whole genome sequencing [WGS]) to compare the isolate from the previous infection to the new isolate. While these methodologies can provide detailed information about the genetic make-up of the organisms, there is still significant variability in how two organisms can be defined as different.

CONTROL MEASURES
Arizona Administrative Code R9-6-373 Salmonellosis

Case Control Measures:
A local health agency shall:

1. Upon receiving a report under R9-6-202 or R9-6-203 of a salmonellosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Exclude a salmonellosis case or suspect case with diarrhea from:
    a. Working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
        i. Diarrhea has resolved,
        ii. A stool specimen negative for *Salmonella* spp. is obtained from the salmonellosis case or suspect case, or
        iii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
    b. Using an aquatic venue until diarrhea has resolved;
3. Conduct an epidemiologic investigation of each reported salmonellosis case or suspect case; and
4. For each salmonellosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Typhoid and Paratyphoid Fever Surveillance Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2019
Most Recent CDC/CSTE Revision Year	2019
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2019: Clinical criteria added, presumptive lab testing (CIDT) added (counting as probable classification), and epidemiological linkage defined. Changes based on new CDC/CSTE definition for *S.* Paratyphi infections. 2018: Paratyphoid fever should be reported separately from salmonellosis, per CDC request, but no national case definition is available for paratyphoid fever with relevant clinical and laboratory criteria. An Arizona-specific case definition is created here, based on both salmonellosis and typhoid fever CDC/CSTE definitions.

PERTUSSIS (Whooping cough)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Background

Bordetella pertussis is among the most poorly controlled bacterial vaccine-preventable diseases in the U.S. Pertussis vaccine was introduced in the 1940s, and the routine childhood immunization program has resulted in substantial reductions of disease. However, the number of reported pertussis cases has increased steadily since the late 1980s, with a considerable resurgence observed over the last 10 years. The most notable peak was in 2012 when more than 48,000 cases and 18 deaths were reported, the largest number of cases in the U.S. since the mid-1950s. Significant numbers of cases were also reported in 2004, 2010 and 2014, ranging from 25,000–32,000 cases. Reasons for the increase in reported disease are likely multifactorial, with improved provider recognition and reporting of pertussis disease, changing diagnostic practices, molecular changes in the organism, and waning immunity from acellular pertussis vaccines potentially responsible.

Clinical Description

In the absence of a more likely diagnosis, a cough illness lasting ≥2 weeks, with at least one of the following symptoms:

- Paroxysms of coughing, OR
- Inspiratory whoop, OR
- Post-tussive vomiting, OR
- Apnea (with or without cyanosis).

Laboratory Criteria for Diagnosis

- Isolation of *Bordetella pertussis* from clinical specimen; OR
- Positive polymerase chain reaction (PCR) for *B. pertussis*.

Epidemiologic Linkage

Contact with a laboratory-confirmed case of pertussis.

Case Classification

Confirmed

Acute cough illness of any duration, in a case that meets the laboratory criteria for diagnosis:

- Isolation of *B. pertussis* from a clinical specimen, OR
- PCR positive for *B. pertussis*

Probable

- In the absence of a more likely diagnosis, illness meeting the criteria listed in the Clinical Description

OR

- Illness with cough of any duration, with
    - At least one of the following signs or symptoms:
        - Paroxysms of coughing; or
        - Inspiratory "whoop"; or

- Post-tussive vomiting; or
- Apnea (with or without cyanosis);

AND

- Contact with a laboratory-confirmed case (epidemiologic linkage).

OR

- A case with positive PCR results and unknown information on clinical symptoms.

Suspect

In the absence of a more likely diagnosis, a case that has positive serological tests against *B. pertussis* with unknown clinical symptoms. In the absence of other positive pertussis test results, cases with positive serology that are known to *not* meet the clinical case definition should be ruled out.

Criteria to Distinguish a New Case from an Existing Case*

A case should not be counted as a new case if laboratory results were reported within 2 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment

The clinical case definition above is appropriate for endemic or sporadic cases. In outbreak settings, a case may be defined as a cough illness lasting at least 2 weeks (as reported by a health professional). Because direct fluorescent antibody testing of nasopharyngeal secretions has been demonstrated in some studies to have low sensitivity and variable specificity, such testing should not be relied on as a criterion for laboratory confirmation. Serologic testing for pertussis is available in some areas but is not standardized and, therefore, should not be relied on as a criterion for laboratory confirmation.

CONTROL MEASURES

Arizona Administrative Code R9-6-363 Pertussis (Whooping Cough)

Case Control Measures:

1. An administrator of a school or child care establishment, either personally or through a representative, shall:
    a. Exclude a pertussis case from the school or child care establishment for 21 calendar days after the date of onset of cough or for five calendar days after the date of initiation of antibiotic treatment for pertussis; and
    b. Exclude a pertussis suspect case from the school or child care establishment until evaluated and determined to be noninfectious by a physician, physician assistant, registered nurse practitioner, or local health agency.
2. An administrator of a health care institution, either personally or through a representative, shall:
    a. Exclude a pertussis case from working at the health care institution for 21 calendar days after the date of onset of cough or for five calendar days after the date of initiation of antibiotic treatment for pertussis; and
    b. Exclude a pertussis suspect case from working at the health care institution until evaluated and determined to be noninfectious by a physician, physician assistant, registered nurse practitioner, or local health agency.
3. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and initiate droplet precautions for a pertussis case for five calendar days after the date of initiation of antibiotic treatment for pertussis.
4. A local health agency shall:

a. Upon receiving a report under R9-6-202 or R9-6-203 of a pertussis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
b. Conduct an epidemiologic investigation of each reported pertussis case or suspect case; and
c. For each pertussis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

5. An administrator of a correctional facility or shelter, either personally or through a representative, shall comply with the pertussis control measures recommended by a local health agency or the Department.

Contact Control Measures:

1. When a pertussis case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
   a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
   b. Comply with the local health agency's recommendations for exclusion.
2. A local health agency shall identify contacts of a pertussis case and shall:
   a. Determine which pertussis contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission; and
   b. If indicated, provide or arrange for a pertussis contact to receive antibiotic prophylaxis.

INVESTIGATION FORMS

See Pertussis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2020
Most Recent CDC/CSTE Revision Year	2020
ADHS Case Definition Matches CDC/CSTE?	No
Description of changes	2020: An acute cough of any duration is now sufficient clinical evidence for confirming PCR-positive cases. Clinical criteria for infants no longer differ from older persons. Epidemiologically-linked cases without PCR or culture confirmation are now classified as probable, not confirmed. These changes are based on modifications to the CDC/CSTE definition. ADHS also retains a separate Suspect case classification, and the last option for Probable classification (PCR-positive but no information on symptoms). 2018: Changes were made mid-year, to apply to all 2018 cases, removing the cough duration criterion for PCR-confirmed cases. Ensuring

	two weeks of cough is a burden on investigators and analysis of past years' data showed that criterion rarely changed the final classification. PCR-positive infants were moved from probable to confirmed classifications for consistency with this change. Both changes differ from the national case definition. 2014: changes were made to include apnea to the list of case-defining clinical signs and symptoms for infants; the probable classification was modified to PCR positive or epi-linked cases occurring among infants with cough of any duration and at least one other clinical symptom. Both changes follow the CDC/CSTE changes. 2013: ADHS case definition includes a Suspect classification for use in tracking serological results, including serologic cases that cannot be investigated. The probable case definition includes a classification for PCR positive individuals who are lost to follow up or are missing clinical information. The confirmed case classification matches the CDC/CSTE definitions.

PLAGUE	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

CASE DEFINITION

Background
The plague bacterium (*Yersinia pestis*) exists in enzootic cycles of rodents and their fleas in the western United States. People are infected with the plague bacterium through flea bites and direct contact with infected animal tissues or fluids. People are also infected by inhalation of droplets coughed by an infected human or animal.

Clinical Description
An illness characterized by acute onset of fever as reported by the patient or healthcare provider with or without one or more of the following specific clinical manifestations:

- Regional lymphadenitis (bubonic plague)
- Septicemia (septicemic plague)
- Pneumonia (pneumonic plague)
- Pharyngitis with cervical lymphadenitis (pharyngeal plague)

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence

- Isolation of *Yersinia pestis* from a clinical specimen with culture identification validated by a secondary assay (e.g., bacteriophage lysis assay, direct fluorescent antibody assay) as performed by a CDC or Laboratory Response Network (LRN) laboratory*; OR
- Fourfold or greater change in paired serum antibody titer to *Yersinia pestis* F1 antigen.

*CDC and ASPHL positive cultures are routinely confirmed with a secondary assay. Clinical laboratories using automated blood culture systems may not use secondary assays and so their results may not be confirmatory.

Presumptive Laboratory Evidence

- Elevated serum antibody titer(s) to *Yersinia pestis* fraction 1 (F1) antigen (without documented fourfold or greater change) in a patient with no history of plague vaccination; OR
- Detection of *Yersinia pestis* specific DNA or antigens, including F1 antigen, in a clinical specimen by direct fluorescent antibody assay (DFA), immunohistochemical assay (IHC), or PCR.

  Note: Other laboratory tests, including rapid bedside tests, are in use in some low resourced international settings but are not recommended as laboratory evidence of plague infection in the United States.

Epidemiologic Linkage
- Person that is epidemiologically linked to a person or animals with confirmatory laboratory evidence within the prior two weeks;

- Close contact with a confirmed pneumonic plague case, including but not limited to presence within two meters of a person with active cough due to pneumonic plague; OR
- A person that lives in, or has traveled within two weeks of illness onset to a geographically-localized area with confirmed plague epizootic activity in fleas or animals as determined by the relevant local authorities.

Case Classification

Confirmed
- A clinically-compatible case with confirmatory laboratory evidence; OR
- A clinically-compatible case with presumptive laboratory evidence AND epidemiologic linkage.

Probable
A clinically-compatible case with presumptive laboratory evidence without epidemiologic linkage in absence of an alternative diagnosis.

Suspect
- A clinically-compatible case with epidemiologic linkage without laboratory evidence; OR
- Confirmed or presumptive laboratory evidence without any associated clinical information.

Criteria to Distinguish a New Case from an Existing Case
Serial or subsequent plague infections in one individual should only be counted if there is a new epidemiologically-compatible exposure and new onset of symptoms.

For the purposes of entering new laboratory information for an existing case, the timeframe of 6 months can be used as a rule of thumb for creating a new case, until evidence is obtained to determine whether there is an epidemiologically-compatible exposure and new onset of symptoms.*

*Based on ADHS guidelines

CONTROL MEASURES
Arizona Administrative Code R9-6-364 Plague

Case Control Measures
1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute droplet precautions for a pneumonic plague case or suspect case until 72 hours of antibiotic therapy have been completed with favorable clinical response.
2. An individual handling the body of a deceased plague case shall use droplet precautions.
3. A local health agency shall:
    a. Upon receiving a report under R9-6-202 of a plague case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
    b. Conduct an epidemiologic investigation of each reported plague case or suspect case;
    c. For each plague case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
    d. Ensure that an isolate or a specimen, as available, from each plague case or suspect case is submitted to the Arizona State Laboratory.

Contact Control Measures

A local health agency shall:

1. Provide follow-up to pneumonic plague contacts for seven calendar days after last exposure to a pneumonic plague case.

INVESTIGATION FORMS

See Plague Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2020
Most Recent CDC/CSTE Revision Year	2020
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2020: Allows for febrile illness alone to be considered a clinically-compatible illness. Added newer diagnostic modalities as laboratory evidence of infection. Added Epidemiologic linkage criteria to be included in confirmed and suspect case classifications. Added criteria to distinguish a new case including a six month time frame. 2013: Suspect category added to ADHS definition to match CDC/CSTE definition. Slight rewording of laboratory criteria.

POLIOMYELITIS (PARALYTIC)	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS

CASE DEFINITION

Clinical Description
Acute onset of a flaccid paralysis of one or more limbs with decreased or absent tendon reflexes in the affected limbs, without other apparent cause, and without sensory or cognitive loss.

Laboratory Criteria for Diagnosis
None

Case Classification

Confirmed
A case that meets the clinical case definition and in which the patient has a neurologic deficit 60 days after onset of initial symptoms, has died, or has unknown follow-up status.

Probable
A case that meets the clinical case definition.

Comment
All suspected cases of paralytic poliomyelitis are reviewed by a panel of expert consultants before final classification occurs. Confirmed cases are then further classified based on epidemiologic and laboratory criteria (classification described in Sutter RW, et al. 1989. AJPH: 79(4):495-498).

I. SPORADIC: A case of paralytic poliomyelitis not linked epidemiologically to another case of paralytic poliomyelitis
   a. Wild virus poliomyelitis: Virus characterized as wild virus
   b. Vaccine-associated poliomyelitis
      i. Recipient—OPV was received 4 to 30 days before onset of illness
      ii. Contact—illness onset was 4 to 75 days after OPV was fed to a recipient in contact with patient and contact occurred within 30 days before onset of illness
      iii. Community—No history of receiving OPV or of contact with an OPV recipient, as defined in 1 and 2, and virus isolated and characterized as vaccine-related
   c. Poliomyelitis with no history of receiving OPV or of contact with an OPV recipient, as defined in BI and B2, and virus not isolated or not characterized

II. EPIDEMIC: A case of paralytic poliomyelitis linked epidemiologically to another case of paralytic poliomyelitis.
   a. Not a recipient of OPV
      i. Virus characterized as wild virus
      ii. Virus characterized as vaccine-related
      iii. Virus not isolated or not characterized
   b. OPV recipient—OPV received 4 to 30 days before onset of illness
      i. Virus characterized as wild virus
      ii. Virus characterized as vaccine-related
      iii. Virus not isolated or not characterized

III. IMMUNOLOGICALLY ABNORMAL: Proven or presumed
   a. Wild virus poliomyelitis—Virus characterized as wild virus
   b. Vaccine-associated poliomyelitis
      i. Recipient—OPV was received 4 to 30 days before onset of illness

ii. Contact—Illness onset was 4 to 75 days after OPV was fed to a recipient in contact with patient and contact occurred within 30 days before onset of illness
iii. Community—No history of receiving OPV or of contact with an OPV recipient, as defined in 1 and 2, and virus isolated and characterized as vaccine-related

c. Poliomyelitis with no history- of receiving OPV or of contact with an OPV recipient, as defined in BI and B2, and virus not isolated or not characterized.

IV. IMPORTED: Poliomyelitis in a person (US resident or other) who has entered the United States
a. Virus characterized as wild virus
b. Virus characterized as vaccine-related
c. Indeterminate—Virus not isolated or characterized

CONTROL MEASURES

Arizona Administrative Code R9-6-365 Poliomyelitis (Paralytic or Non-paralytic)

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a poliomyelitis case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported poliomyelitis case or suspect case;
3. For each poliomyelitis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that one or more specimens from each poliomyelitis case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.

INVESTIGATION FORMS

See Suspected Polio Case Worksheet Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2006
Most Recent CDC/CSTE Revision Year	2010 (identical to 1997 version)
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

POLIOVIRUS INFECTION (NON-PARALYTIC)	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS

CASE DEFINITION

Clinical Description

Most poliovirus infections are asymptomatic or cause mild febrile disease. Poliovirus infections occasionally cause aseptic meningitis and one out of 200 infections from poliovirus type 1 results in paralytic poliomyelitis, characterized by acute onset of flaccid paralysis that is typically asymmetric and associated with a prodromal fever. Poliovirus is spread through fecal material, oral secretions, some aerosols, and fomites.

*Note that this case definition applies only to poliovirus infections found in asymptomatic persons or those with mild, nonparalytic disease (e.g., those with a nonspecific febrile illness, diarrhea, or aseptic meningitis). Isolation of polioviruses from persons with acute paralytic poliomyelitis should continue to be reported as “paralytic poliomyelitis.”

Laboratory Criteria for Diagnosis

Poliovirus isolate identified in an appropriate clinical specimen (e.g., stool, cerebrospinal fluid, oropharyngeal secretions), with confirmatory typing and sequencing performed by the CDC Poliovirus Laboratory, as needed.

Case Classification

Confirmed

Any person without symptoms of paralytic poliomyelitis who meets the laboratory criteria for diagnosis.

Comment

In 2005, a vaccine-derived poliovirus (VDPV) type 1 was identified in a stool specimen obtained from an immunodeficient Amish infant and, subsequently, from 4 other children in 2 other families in the infant’s central Minnesota community[1]. Epidemiological and laboratory investigations determined that the VDPV had been introduced into the community about 3 months before the infant was identified and that there had been virus circulation in the community. Investigations in other communities in Minnesota and nearby states and Canada did not identify any additional infections or any cases of paralytic poliomyelitis.

Although oral poliovirus vaccine (OPV) is still widely used in most countries, inactivated poliovirus vaccine (IPV) replaced OPV in the United States in 2002. Therefore, the Minnesota poliovirus infections were the result of importation of a vaccine-derived poliovirus into the United States and the first time a VDPV has been shown to circulate in a community in a developed country[3]. Circulating VDPVs commonly revert to a wild poliovirus phenotype and have increased transmissibility & high risk for paralytic disease; they have recently caused polio infections and outbreaks of paralytic poliomyelitis in several countries[3]. Contacts between persons in communities with low polio vaccination coverage pose the potential for transmission of polioviruses and outbreaks of paralytic poliomyelitis.

Because of the success of the routine childhood immunization program in the U.S. and the Global Polio Eradication Initiative, polio has been eliminated in the Americas since 1991. Because the U.S. has used IPV exclusively since 2000, the occurrence of any poliovirus infections in the U.S. is a cause for concern. Reflecting the global concern for poliovirus importations into previously polio-free countries,

the World Health Assembly, W.H.O., has added circulating poliovirus to the notifiable events in the International Health Regulations (IHR)[4].

References

[1] CDC. Poliovirus infections in four unvaccinated children – Minnesota, August-October 2005. MMWR; 54(41); 1053–1055.
[2] CDC. Poliomyelitis prevention in the United States. Updated recommendations from the Advisory Committee on Immunization Practices (ACIP). MMWR 2000;49 (No. RR-5).
[3] Kew OM, Sutter RW, de Gourville EM, Dowdle WR, Pallansch MA. Vaccine-derived polioviruses and the endgame strategy for global polio eradication. Ann Rev Microbiol 2005;59;587-635.
[4] CDC. Brief report. Conclusions and recommendations of the Advisory Committee on Poliomyelitis Eradication — Geneva, Switzerland, October 2005. MMWR 2005;54;1186-8.

CONTROL MEASURES

Arizona Administrative Code R9-6-365 Poliomyelitis (Paralytic or Non-paralytic)

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a poliomyelitis case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported poliomyelitis case or suspect case;
3. For each poliomyelitis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that one or more specimens from each poliomyelitis case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.

INVESTIGATION FORMS

See Suspected Polio Case Worksheet Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2008
Most Recent CDC/CSTE Revision Year	2010 (identical to 2007)
ADHS Case Definition Matches CDC/CSTE?	Yes (with additional comments)
Description of changes	N/A

PRIMARY AMEBIC MENINGOENCEPHALITIS (PAM), *Naegleria fowleri* DISEASE PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS

Cases should be reported under the Encephalitis, parasitic requirement. Enter in MEDSIS as Encephalitis, parasitic.

CASE DEFINITION

N. fowleri is a free-living ameboflagellate that invades the brain and meninges via the nasal mucosa and olfactory nerve to cause acute, fulminant hemorrhagic meningoencephalitis (primary amebic meningoencephalitis – PAM), primarily in healthy children and young adults with a recent history of exposure to warm fresh water. Initial signs and symptoms of PAM begin 1 to 14 days after infection and include sudden onset of headache, fever, nausea, vomiting, and stiff neck accompanied by positive Kernig's and Brudzinski's signs. In some cases, abnormalities in taste or smell, nasal obstruction and nasal discharge might be seen. Other symptoms might include photophobia, mental-state abnormalities, lethargy, dizziness, loss of balance, other visual disturbances, hallucinations, delirium, seizures, and coma. After the onset of symptoms, the disease progresses rapidly and usually results in death within 3 to 7 days. Although a variety of treatments have been shown to be active against amebae in vitro and have been used to treat infected persons, most infections have still been fatal.

Laboratory Criteria for Diagnosis

Confirmatory Testing
Detection of *N. fowleri* antigen or nucleic acid from a clinical specimen (e.g., immunohistochemistry or PCR).

Presumptive Testing

- Visualization of motile amebae in a wet mount of CSF; OR
- Isolation of *N. fowleri* in culture from a clinical specimen.

Case Classification

Confirmed
A case that meets the clinical criteria and confirmatory laboratory criteria for diagnosis.

Probable
A case that meets the clinical criteria and the presumptive laboratory criteria for diagnosis.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment
N. fowleri might cause clinically similar illness to bacterial meningitis, particularly in its early stages. Definitive diagnosis by a reference laboratory might be required. Unlike *Balamuthia mandrillaris* and *Acanthamoeba* spp., *Naegleria fowleri* is commonly found in CSF of patients with PAM. After the onset

of symptoms, the disease progresses rapidly and usually results in death within 3 to 7 days. Patients presenting with the above clinical criteria and found to have a history of recreational freshwater exposure in the two weeks prior to presentation or are known to have performed nasal irrigation (e.g., use of a neti pot for treatment of sinus conditions or practice ritual ablution including nasal rinsing) in the absence of another explanation for their condition, should be investigated further. Urgent confirmatory testing and treatment should be initiated. Notify ADHS as soon as possible.

CONTROL MEASURES

Arizona Administrative Code R9-6-334 Encephalitis, Viral or Parasitic

Case Control Measures

A local health agency shall:

1. Upon receiving a report of encephalitis under R9-6-202, notify the Department:
    a. For a case or suspect case of parasitic encephalitis, within 24 hours after receiving the report and provide to the Department the information contained in the report; and
    b. For a case or suspect case of viral encephalitis, within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported viral or parasitic encephalitis case or suspect case; and
3. For each encephalitis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

Contact ADHS. Depending on the etiology of the encephalitis, an investigation form may or may not be available.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	2017
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2017: Separated from encephalitis, parasitic and a separate case definition created. Laboratory criteria and confirmatory case classification updated to include confirmatory and probable classifications. Comments expanded. All to match 2016 CSTE position statement.

PSITTACOSIS (*Chlamydia psittaci* /*Chlamydophila psittaci)* (Ornithosis)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical description

Psittacosis is an illness characterized by fever, chills, headache, myalgia, and a dry cough with pneumonia often evident on chest x-ray. Severe pneumonia requiring intensive-care support, endocarditis, hepatitis, and neurologic complications occasionally occur.

Laboratory Criteria for Diagnosis

- Isolation of *Chlamydophila psittaci* from respiratory specimens (e.g., sputum, pleural fluid, or tissue), or blood; OR
- Fourfold or greater increase in antibody (Immunoglobulin G [IgG]) against *C. psittaci* by complement fixation (CF) or microimmunofluorescence (MIF) between paired acute- and convalescent-phase serum specimens obtained at least 2-4 weeks apart; OR
- Supportive serology (e.g. *C. psittaci* antibody titer [Immunoglobulin M (IgM)] of greater than or equal to 32 in at least one serum specimen obtained after onset of symptoms); OR
- Detection of *C. psittaci* DNA in a respiratory specimen (e.g. sputum, pleural fluid or tissue) via amplification of a specific target by polymerase chain reaction (PCR) assay.

Case Classification

Confirmed

An illness characterized by fever, chills, headache, cough and myalgia, and laboratory confirmed by either:

- Isolation of *Chlamydophila psittaci* from respiratory specimens (e.g., sputum, pleural fluid, or tissue), or blood; OR
- Fourfold or greater increase in antibody (Immunoglobulin G [IgG]) against *C. psittaci* by complement fixation (CF) or microimmunofluorescence (MIF) between paired acute- and convalescent-phase serum specimens obtained at least 2-4 weeks apart.

Probable

An illness characterized by fever, chills, headache, cough and myalgia that has either:

- Supportive serology (e.g., *C. psittaci* antibody titer [Immunoglobulin M, IgM] of greater than or equal to 32 in at least one serum specimen obtained after onset of symptoms); OR
- Detection of *C. psittaci* DNA in a respiratory specimen (e.g. sputum, pleural fluid or tissue) via amplification of a specific target by polymerase chain reaction (PCR) assay.

Comment

Although MIF has shown greater specificity to *C. psittaci* than CF, positive serologic findings by both techniques may occur as a result of infection with other *Chlamydophila* species and should be interpreted with caution. To increase the reliability of test results, acute- and convalescent-phase serum specimens should be analyzed at the same time in the same laboratory. A real time polymerase chain reaction (rtPCR) has been developed and validated in avian specimens but has not yet been validated for use in humans (1).

References

1. Mitchell SL, BJ Wolff, WL Thacker, PG Ciembor, CR Gregory, KDE Everett, BW Ritchie, JM Winchell 2008 Genotyping of *Chlamydophila psittaci* by real-time PCR and high resolution melt analysis. J. Clin. Microbiol. 47:175-181

CONTROL MEASURES

Arizona Administrative Code R9-6-366 Psittacosis (Ornithosis)

Case Control Measures

A local health agency shall:

1. Conduct an epidemiologic investigation of each reported psittacosis case or suspect case; and
2. For each psittacosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Environmental Control Measures

A local health agency shall:

1. If a bird infected with *Chlamydia psittaci* or *Chlamydophila psittaci* is located in a private residence:
    a. Provide health education for the bird's owner about psittacosis and the risks of becoming infected with psittacosis, and
    b. Advise the bird's owner to obtain treatment for the bird; and
2. If a bird infected with *Chlamydia psittaci* or *Chlamydophila psittaci* is located in a setting other than a private residence:
    a. Provide health education for the bird's owner about psittacosis and the risks of becoming infected with psittacosis,
    b. Ensure that the bird is treated or destroyed and any contaminated structures are disinfected, and
    c. Require the bird's owner to isolate the bird from contact with members of the public and from other birds until treatment of the bird is completed or the bird is destroyed.

INVESTIGATION FORMS

See Psittacosis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2010
Most Recent CDC/CSTE Revision Year	2010
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

Q FEVER (*Coxiella burnetii*)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Exposure
Exposure is usually via aerosol, is broadly interpreted, and may be unknown (especially for chronic infection), but often includes the presence of goats, sheep, or other livestock, especially during periods of parturition. Direct contact with animals is not required, and variable incubation periods may be dose dependent.

Q Fever, Acute

Clinical Description
Acute fever usually accompanied by rigors, myalgia, malaise, and a severe retrobulbar headache. Fatigue, night-sweats, dyspnea, confusion, nausea, diarrhea, abdominal pain, vomiting, non-productive cough, and chest pain have also been reported. Severe disease can include acute hepatitis, atypical pneumonia with abnormal radiograph, and meningoencephalitis. Pregnant women are at risk for fetal death and abortion. Clinical laboratory findings may include elevated liver enzyme levels, leukocytosis, and thrombocytopenia. Asymptomatic infections may also occur.

Note: Serologic profiles of pregnant women infected with acute Q fever during gestation may progress frequently and rapidly to those characteristic of chronic infection.

Clinical Evidence
Acute fever and one or more of the following: rigors, severe retrobulbar headache, acute hepatitis, pneumonia, or elevated liver enzyme levels.

Laboratory Criteria for Diagnosis

Confirmatory Testing

- Serological evidence of a fourfold change in immunoglobulin G (IgG)-specific antibody titer to *C. burnetii* phase II antigen by indirect immunofluorescence assay (IFA) between paired serum samples, (CDC suggests one taken during the first week of illness and a second 3-6 weeks later, antibody titers to phase I antigen may be elevated or rise as well), OR
- Detection of *C. burnetii* DNA in a clinical specimen via amplification of a specific target by polymerase chain reaction (PCR) assay, OR
- Demonstration of *C. burnetii* in a clinical specimen by immunohistochemical methods (IHC), OR
- Isolation of *C. burnetii* from a clinical specimen by culture.

Presumptive Testing

- Has a single supportive IFA IgG titer of ≥1:128 to phase II antigen (phase I titers may be elevated as well).
- Has serologic evidence of elevated phase II IgG or IgM antibody reactive with *C. burnetii* antigen by enzyme-linked immunosorbent assay (ELISA), dot-ELISA, or latex agglutination.

Note: For acute testing, CDC uses in-house IFA IgG testing (cutoff of ≥1:128), preferring simultaneous testing of paired specimens, and does not use IgM results for routine diagnostic testing.

Case Classification

Confirmed acute Q fever
A laboratory confirmed case that either meets clinical case criteria or is epidemiologically linked to a lab confirmed case.

Probable acute Q fever
A clinically compatible case of acute illness (meets clinical evidence criteria for acute Q fever illness) that has laboratory presumptive results for past or present acute disease (antibody to Phase II antigen) but is not laboratory confirmed.

Q Fever, Chronic

Clinical Description
Infection that persists for more than 6 months. Potentially fatal endocarditis may evolve months to years after acute infection, particularly in persons with underlying valvular disease. Infections of aneurysms and vascular prostheses have been reported. Immunocompromised individuals are particularly susceptible. Rare cases of chronic hepatitis without endocarditis, osteomyelitis, osteoarthritis, and pneumonitis have been described.

Clinical Evidence
Newly recognized, culture-negative endocarditis, particularly in a patient with previous valvulopathy or compromised immune system, suspected infection of a vascular aneurysm or vascular prosthesis, or chronic hepatitis, osteomyelitis, osteoarthritis, or pneumonitis in the absence of other known etiology.

Laboratory Criteria for Diagnosis

Confirmatory Testing

- Serological evidence of IgG antibody to *C. burnetii* phase I antigen ≥ 1:800 by IFA (while phase II IgG titer will be elevated as well; phase I titer is higher than the phase II titer); OR
- Detection of *C. burnetii* DNA in a clinical specimen via amplification of a specific target by PCR assay; OR
- Demonstration of *C. burnetii* antigen in a clinical specimen by IHC; OR
- Isolation of *C. burnetii* from a clinical specimen by culture.

Presumptive Testing
Has an antibody titer to *C. burnetii* phase I IgG antigen ≥1:128 and < 1:800 by IFA.

Note: Samples from suspected chronic patients should be evaluated for IgG titers to both phase I and phase II antigens. Current commercially available ELISA tests (which test only for phase 2) are not quantitative, cannot be used to evaluate changes in antibody titer, and hence are not useful for serological confirmation. IgM tests are not strongly supported for use in serodiagnosis of acute disease, as the response may not be specific for the agent (resulting in false positives) and the IgM response may be persistent. Complement fixation (CF) tests and other older test methods are neither readily available nor commonly used.

Serologic test results must be interpreted with caution, because baseline antibodies acquired as a result of historical exposure to Q fever may exist, especially in rural and farming areas.

Case Classification

Confirmed chronic Q fever
A clinically compatible case of chronic illness (meets clinical evidence criteria for chronic Q fever) that meets the confirmatory laboratory criteria for chronic infection.

Probable chronic Q fever
A clinically compatible case of chronic illness (meets clinical evidence criteria for chronic Q fever) that has laboratory presumptive results for past or present chronic infection (antibody to Phase I antigen).

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 12 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

CONTROL MEASURES
Arizona Administrative Code R9-6-367 Q-Fever

Case Control Measures
A local health agency shall:
1. Upon receiving a report under R9-6-202 of a Q fever case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported Q fever case or suspect case; and
3. For each Q fever case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS
See Q Fever Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2010
Most Recent CDC/CSTE Revision Year	2009
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

RABIES, ANIMAL	LABORATORIES SUBMIT A REPORT WTIHIN 1 WORKING DAY

CASE DEFINITION

Laboratory Criteria for Diagnosis

- A positive direct fluorescent antibody test (preferably performed on central nervous system tissue)
- Isolation of rabies virus (in cell culture or in a laboratory animal)

Case Classification

Confirmed
A case that is laboratory confirmed

CONTROL MEASURES

Arizona Administrative Code R9-6 Articles 5 and 6 Rabies Control and Reporting Post-Exposure Rabies Prophylaxis

INVESTIGATION (REPORTING) FORMS

- Manual: http://www.azdhs.gov/preparedness/epidemiology-disease-control/rabies/index.php#manual
- Animal Bite or Exposure Form: http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2005 or before
Most Recent CDC/CSTE Revision Year	2010
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

RABIES, HUMAN	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS LABORATORIES SUBMIT A REPORT WTIHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description
Rabies is an acute encephalomyelitis that almost always progresses to coma or death within 10 days of the first symptom.

Laboratory Criteria for Diagnosis

- Detection by direct fluorescent antibody of Lyssavirus antigens in a clinical specimen (preferably the brain or the nerves surrounding hair follicles in the nape of the neck); OR
- Isolation (in cell culture or in a laboratory animal) of rabies virus from saliva, CSF (cerebrospinal fluid) or central nervous system tissue; OR
- Identification of Lyssavirus specific antibody (i.e. by indirect fluorescent antibody (IFA) test or complete rabies virus neutralization at 1:5 dilution) in the cerebrospinal fluid (CSF); OR
- Identification of Lyssavirus specific antibody (i.e. by indirect fluorescent antibody (IFA) test or complete rabies virus neutralization at 1:5 dilution) in the serum of an unvaccinated person; OR
- Detection of Lyssavirus viral RNA (using reverse transcriptase-polymerase chain reaction [RT-PCR]) in saliva, CSF, or tissue.

Case Classification

Confirmed
A clinically compatible illness that is laboratory confirmed.

Comment

- Laboratory confirmation by all of the above methods is strongly recommended.
- All confirmatory testing must be performed by the Centers for Disease Control and Prevention. Contact the Arizona Department of Health Services (602) 364-4562 to consult on suspected rabies cases.
- Serology performed by a commercial laboratory is not recognized for diagnosis of rabies.

CONTROL MEASURES
Arizona Administrative Code R9-6-368 Rabies in a Human

Case Control Measures
A local health agency shall:

1. Upon receiving a report under R9-6-202 of a human rabies case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported human rabies case or suspect case;
3. For each human rabies case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and

4. Ensure that a specimen from each human rabies case or suspect case, as required by the Department, is submitted to the Arizona State Laboratory.

Contact Control Measures:
A local health agency shall:

1. Evaluate the level of risk of transmission from each contact's exposure to a human rabies case and, if indicated, provide or arrange for each contact to receive prophylaxis.

INVESTIGATION FORMS

See Possible Human Rabies Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

ADHS Case Definition Matches CDC/CSTE?	Yes
Case Definition Matches 2018 ADHS Case Definition?	Yes
Most Recent CDC/CSTE Revision Year	2011
Description of changes	N/A

RELAPSING FEVER (Borreliosis)	PROVIDERS SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description
An acute febrile disease with headache, fever, shaking chills, and myalgia. Symptoms may relapse after a febrile periods of 2-4 days.

Laboratory Criteria for Diagnosis

- Demonstration of visible spirochetes in a peripheral blood smear; OR
- Demonstration of spirochetemia in inoculated Swiss mice; OR
- Serological evidence of non-treponemal spirochetes in persons not visiting endemic Lyme disease area.

Case Classification

Confirmed
A case that is laboratory confirmed with a consistent history of exposure or epidemiologically linked to confirmed case.

Probable
A compatible history of exposure to soft ticks in rustic cabins, caves, or firewood, and at least three of the major symptoms.

CONTROL MEASURES
Arizona Administrative Code R9-6-369 Relapsing Fever (Borreliosis)

Case Control Measures
A local health agency shall:

1. Upon receiving a report under R9-6-202 of a borreliosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported borreliosis case or suspect case; and
3. For each borreliosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS
None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2005 or before
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

RESPIRATORY DISEASE IN A HEALTH CARE INSTITUTION OR CORRECTIONAL FACILITY	PROVIDERS REPORT WITHIN 24 HOURS IF AN OUTBREAK IS DETECTED

CASE DEFINITION

Coming soon

CONTROL MEASURES

Arizona Administrative Code R9-6-370 Respiratory Disease in a Health Care Institution or Correctional Facility

Outbreak Control Measures

A local health agency shall:

1. Conduct an epidemiologic investigation of each reported outbreak of respiratory disease in a health care institution or correctional facility; and
2. For each outbreak of respiratory disease in a health care institution or correctional facility, submit to the Department the information required under R9-6-206(E).

When an outbreak of respiratory disease occurs in a health care institution or correctional facility, the administrator of the health care institution or correctional facility, either personally or through a representative, shall comply with the control measures recommended by a local health agency.

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2018
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	2018: Newly reportable in Arizona. New case definition (coming soon).

RESPIRATORY SYNCYTIAL VIRUS (RSV)	LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Laboratory Criteria for Diagnosis

- RSV isolation in tissue cell culture from nasopharyngeal secretions;
- Reverse-transcriptase polymerase chain reaction (RT-PCR) testing of respiratory specimens;
- Immunofluorescent antibody staining (direct or indirect) of respiratory specimens;
- Rapid RSV diagnostic testing of respiratory specimens; OR
- Four-fold rise in antibody titer in paired acute and convalescent sera.

Case Classification

Confirmed
A case that meets the laboratory criteria for diagnosis.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 4 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment
RSV is laboratory reportable, but RSV mortality is not routinely monitored. In situations where RSV-associated mortality needs to be defined, see the RSV-associated mortality section in this document under “Case Definitions for Communicable Morbidities of Public Health Significance which are not Reportable in Arizona”.

CONTROL MEASURES
None

INVESTIGATION FORMS
None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2006
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

ROCKY MOUNTAIN SPOTTED FEVER	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

See Spotted Fever Rickettsiosis in this document.

RUBELLA (German measles)	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS IF SUSPECT CASE HAS A HIGH-RISK OCCUPATION. PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY FOR ALL OTHER CASES

CASE DEFINITION

Clinical Description

An illness with all of the following characteristics:

- Acute onset of generalized maculopapular rash
- Temperature greater than 99.0°F or 37.2°C, if measured
- Arthralgia, arthritis, lymphadenopathy, or conjunctivitis

Laboratory Criteria for Diagnosis

- Isolation of rubella virus; OR
- Detection of rubella-virus specific nucleic acid by polymerase chain reaction; OR
- IgG seroconversion† or significant rise between acute- and convalescent-phase titers in serum rubella immunoglobulin G antibody level by any standard serologic assay; OR
- Positive serologic test for rubella immunoglobulin M (IgM) antibody†*.

†Not explained by MMR vaccination during the previous 6-45 days.
*Not otherwise ruled out by more specific testing in a public health laboratory.

Case Classification

Confirmed

- A case that is laboratory confirmed (with or without symptoms); OR
- A case that meets the clinical case definition, including a measured fever greater than 99.0°F or 37.2°C, and is epidemiologically linked to a laboratory-confirmed case.

Probable

A case that meets the clinical case definition, has no or noncontributory serologic or virologic testing, and is not epidemiologically linked to a laboratory-confirmed case, in the absence of a more likely diagnosis.

Suspect

Any generalized rash illness of acute onset that does not meet the criteria for probable or confirmed rubella or any other illness.

Epidemiologic Classification of Internationally-Imported and U.S.-Acquired

Internationally imported case: An internationally imported case is defined as a case in which rubella results from exposure to rubella virus outside the United States as evidenced by at least some of the exposure period (12–23 days before rash onset) occurring outside the United States and the onset of rash within 23 days of entering the United States and no known exposure to rubella in the U.S. during that time. All other cases are considered U.S.-acquired cases.

U.S.-acquired case: A U.S.-acquired case is defined as a case in which the patient had not been outside the United States during the 23 days before rash onset or was known to have been exposed to rubella within the United States. U.S.-acquired cases are subclassified into four mutually exclusive groups:

- **Import-linked case**: Any case in a chain of transmission that is epidemiologically linked to an internationally imported case.
- **Imported-virus case**: A case for which an epidemiologic link to an internationally imported case was not identified but for which viral genetic evidence indicates an imported rubella genotype, i.e., a genotype that is not occurring within the United States in a pattern indicative of endemic transmission. An endemic genotype is the genotype of any rubella virus that occurs in an endemic chain of transmission (i.e., lasting ≥12 months). Any genotype that is found repeatedly in U.S.-acquired cases should be thoroughly investigated as a potential endemic genotype, especially if the cases are closely related in time or location.
- **Endemic case**: A case for which epidemiological or virological evidence indicates an endemic chain of transmission. Endemic transmission is defined as a chain of rubella virus transmission continuous for ≥12 months within the United States.
- **Unknown source case**: A case for which an epidemiological or virological link to importation or to endemic transmission within the U.S. cannot be established after a thorough investigation. These cases must be carefully assessed epidemiologically to assure that they do not represent a sustained U.S.-acquired chain of transmission or an endemic chain of transmission within the U.S.

Note: Internationally imported, import-linked, and imported-virus cases are considered collectively to be import-associated cases.

Comment

Serum rubella IgM test results that are false positives have been reported in persons with other viral infections (e.g., acute infection with Epstein-Barr virus [infectious mononucleosis], recent cytomegalovirus infection, and parvovirus infection) or in the presence of rheumatoid factor. Patients who have laboratory evidence of recent measles infection are excluded.

CONTROL MEASURES

Arizona Administrative Code R9-6-371 Rubella (German Measles)

Case Control Measures

An administrator of a school or child care establishment, either personally or through a representative, shall:

1. Exclude a rubella case from the school or child care establishment and from school- or child-care-establishment-sponsored events from the onset of illness through the seventh calendar day after the rash appears; and
2. Exclude a rubella suspect case from the school or child care establishment and from school- or child-care-establishment-sponsored events until evaluated and determined to be noninfectious by a physician, physician assistant, registered nurse practitioner, or local health agency.

A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, and in consultation with the local health agency, shall isolate and institute droplet precautions for a rubella case through the seventh calendar day after the rash appears.

An administrator of a health care institution, either personally or through a representative, shall exclude a rubella:

1. Case from working at the health care institution from the onset of illness through the seventh calendar day after the rash appears; and
2. Suspect case from working at the health care institution until evaluated and determined to be noninfectious by a physician, physician assistant, registered nurse practitioner, or local health agency.

A local health agency shall:

1. Upon receiving a report under R9-6-202 or R9-6-203 of a rubella case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported rubella case or suspect case;
3. For each rubella case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that one or more specimens from each rubella case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.

An administrator of a correctional facility or shelter, either personally or through a representative, shall comply with the rubella control measures recommended by a local health agency or the Department.

Contact Control Measures:
An administrator of a health care institution shall ensure that a paid or volunteer full-time or part-time worker at a health care institution does not participate in the direct care of a rubella case or suspect case or of a patient who is or may be pregnant unless the worker first provides evidence of immunity to rubella consisting of:

1. A record of immunization against rubella given on or after the first birthday; or
2. A statement signed by a physician, physician assistant, registered nurse practitioner, state health officer, or local health officer affirming serologic evidence of immunity to rubella.

When a rubella case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:

1. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
2. Comply with the local health agency's recommendations for exclusion.

A local health agency shall:

1. Determine which rubella contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission; and
2. Provide or arrange for immunization of each non-immune rubella contact within 72 hours after last exposure, if possible.

INVESTIGATION FORMS

See Rubella Surveillance Worksheet Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2013

Most Recent CDC/CSTE Revision Year	2013
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2013: ADHS definition was edited to match CDC/CSTE, including addition of PCR testing.

RUBELLA SYNDROME, CONGENITAL	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description
Presence of any defect(s) or laboratory data consistent with congenital rubella infection. Infants with congenital rubella syndrome usually present with more than one sign or symptom consistent with congenital rubella infection. However, infants may present with a single defect. Hearing impairment is most common single defect.

Clinical Case Definition
An illness, usually manifesting in infancy, resulting from rubella infection in utero and characterized by signs or symptoms from the following categories:

a. Cataracts/congenital glaucoma, congenital heart disease (most commonly patent ductus arteriosus or peripheral pulmonary artery stenosis), hearing impairment, pigmentary retinopathy.
b. Purpura, hepatosplenomegaly, jaundice, microcephaly, developmental delay, meningoencephalitis, radiolucent bone disease.

Laboratory Criteria for Diagnosis

- Isolation of rubella virus; OR
- Demonstration of rubella-specific immunoglobulin M (IgM) antibody; OR
- Infant rubella antibody level that persists at a higher level and for a longer period than expected from passive transfer of maternal antibody (i.e., rubella titer that does not drop at the expected rate of a twofold dilution per month); OR
- A specimen that is PCR positive for rubella virus.

Case Classification

Confirmed
An infant with at least one of the symptoms listed in the clinical case definition and meets the laboratory criteria for diagnosis.

Probable*
A case that is not laboratory confirmed and that has any two complications listed in paragraph "a" of the clinical case definition or one complication from paragraph "a" and one from paragraph "b", and lacks evidence of any other etiology.

Suspect
A case with one or more compatible clinical findings but not meeting the criteria for a probable case.

Infection only*
A case that demonstrates laboratory evidence of infection, but without any clinical symptoms or signs.

Criteria to Distinguish a New Case from an Existing Case*
A case should never be counted as a new case if there was a previously reported infection in the same individual.
*Based on ADHS guidelines

Comment
*In probable cases, either or both of the eye-related findings (cataracts and congenital glaucoma) count as a single complication. In cases classified as infection only, if any compatible signs or symptoms (e.g., hearing loss) are identified later, the case is reclassified as confirmed.

Epidemiologic Classification of Internationally-Imported and U.S.-Acquired
Congenital rubella syndrome cases will be classified epidemiologically as internationally imported or U.S.-acquired, according to the source of infection in the mother, using the definitions below, which parallel the classifications for rubella cases.

Internationally imported case: To be classified as an internationally imported CRS case, the mother must have acquired rubella infection outside the U.S. or in the absence of documented rubella infection, the mother was outside the United States during the period when she may have had exposure to rubella that affected her pregnancy (from 21 days before conception and through the first 24 weeks of pregnancy).

U.S.-acquired case: A US-acquired case is one in which the mother acquired rubella from an exposure in the United States. U.S.-acquired cases are subclassified into four mutually exclusive groups:

- **Import-linked case**: Any case in a chain of transmission that is epidemiologically linked to an internationally imported case.
- **Imported-virus case**: A case for which an epidemiologic link to an internationally imported case was not identified but for which viral genetic evidence indicates an imported rubella genotype, i.e., a genotype that is not occurring within the United States in a pattern indicative of endemic transmission. An endemic genotype is the genotype of any rubella virus that occurs in an endemic chain of transmission (i.e., lasting ≥12 months). Any genotype that is found repeatedly in U.S.-acquired cases should be thoroughly investigated as a potential endemic genotype, especially if the cases are closely related in time or location.
- **Endemic case**: A case for which epidemiological or virological evidence indicates an endemic chain of transmission. Endemic transmission is defined as a chain of rubella virus transmission continuous for ≥12 months within the United States.
- **Unknown source case**: A case for which an epidemiological or virological link to importation or to endemic transmission within the U.S. cannot be established after a thorough investigation. These cases must be carefully assessed epidemiologically to assure that they do not represent a sustained U.S.-acquired chain of transmission or an endemic chain of transmission within the U.S.

Note: Internationally imported, import-linked, and imported-virus cases are considered collectively to be import-associated cases.

CONTROL MEASURES
Arizona Administrative Code R9-6-372 Rubella Syndrome, Congenital

Case Control Measures:
A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and implement contact precautions for an infant congenital rubella syndrome case until:

1. The infant congenital rubella syndrome case reaches one year of age; or

2. Two successive negative virus cultures, from specimens collected at least one month apart, are obtained from the infant congenital rubella syndrome case after the infant congenital rubella syndrome case reaches three months of age.

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a congenital rubella syndrome case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported congenital rubella syndrome case or suspect case;
3. For each congenital rubella syndrome case, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that one or more specimens from each congenital rubella syndrome case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.

Contact Control Measures

An administrator of a health care institution shall

1. Ensure that a paid or volunteer full-time or part-time worker at a health care institution who is known to be pregnant does not participate in the direct care of a congenital rubella syndrome case or suspect case unless the worker first provides evidence of immunity to rubella that complies with R9-6-371(B)(1).

INVESTIGATION FORMS

See Congenital Rubella Syndrome Case Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2008
Most Recent CDC/CSTE Revision Year	2007
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

SALMONELLOSIS	PROVIDERS REPORT WITHIN 24 HOURS IF AN OUTBREAK IS DETECTED OR PERSON HAS A HIGH-RISK OCCUPATION PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 DAY FOR ALL OTHER CASES

CASE DEFINITION

Note: For cases of infection with Salmonella *serotypes Paratyphi A, Paratyphi B [tartrate negative] and Paratyphi C, please see the Paratyphoid Fever case definition.* Salmonella enterica *serotype Typhi infections should be classified under Typhoid Fever.*

Clinical Description

An illness of variable severity commonly manifested by diarrhea, abdominal pain, nausea, and sometimes vomiting. Asymptomatic infections may occur and the organism may cause extraintestinal infections.

Laboratory Criteria for Diagnosis

Confirmatory Testing

Isolation of *Salmonella* from a clinical specimen.

Presumptive Testing

Detection of *Salmonella* from a clinical specimen using a culture-independent diagnostic test (CIDT).

Case Classification

Confirmed

A case that meets the confirmatory laboratory criteria

Probable

- A case that meets the presumptive laboratory criteria; OR
- A clinically compatible illness that is epidemiologically linked to a case that meets the presumptive or confirmatory laboratory criteria.

Criteria to Distinguish a New Case from an Existing Case

A case should not be counted as a new case if laboratory results were reported within 365 days of a previously reported infection in the same individual.

When two or more different serotypes are identified from one or more specimens from the same individual, each should be reported as a separate case.

Comment

Both asymptomatic infections and infections at sites other than the gastrointestinal tract, if laboratory confirmed, are considered confirmed cases that should be reported.

The use of CIDTs as stand-alone tests for the direct detection of *Salmonella* in stool is increasing. Specific performance characteristics such as sensitivity, specificity, and positive predictive value of these assays likely depend on the manufacturer and are currently unknown. It is therefore useful to collect information on the type(s) of testing performed for reported salmonellosis cases. When a

specimen is positive using a CIDT it is also helpful to collect information on all culture results for the specimen, even if those results are negative.

Culture confirmation of CIDT-positive specimens is ideal, although it might not be practical in all instances. State and local public health agencies should make efforts to encourage reflexive culturing by clinical laboratories that adopt culture-independent methods, should facilitate submission of isolates/clinical material to state public health laboratories, and should be prepared to perform reflexive culture when not performed at the clinical laboratory as isolates are currently necessary for molecular typing (PFGE and whole genome sequencing) that are essential for outbreak detection.

CONTROL MEASURES

Arizona Administrative Code R9-6-373 Salmonellosis

Case Control Measures:
A local health agency shall:

5. Upon receiving a report under R9-6-202 or R9-6-203 of a salmonellosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
6. Exclude a salmonellosis case or suspect case with diarrhea from:
    a. Working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
        i. Diarrhea has resolved,
        ii. A stool specimen negative for *Salmonella* spp. is obtained from the salmonellosis case or suspect case, or
        iii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
    b. Using an aquatic venue until diarrhea has resolved;
7. Conduct an epidemiologic investigation of each reported salmonellosis case or suspect case; and
8. For each salmonellosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Environmental Control Measures
A local health agency shall:

1. If an animal infected with *Salmonella* spp. is located in a private residence, provide health If an animal infected with Salmonella spp. is located in a private residence, provide health education for the animal's owner about salmonellosis and the risks of becoming infected with *Salmonella* spp.; and
2. If an animal infected with *Salmonella* spp. is located in a setting other than a private residence:
    a. Provide health education for the animal's owner about salmonellosis and the risks of becoming infected with *Salmonella* spp., and
    b. Require the animal's owner to provide information to individuals with whom the animal may come into contact about salmonellosis and methods to reduce the risk of transmission.

INVESTIGATION FORMS

See Salmonellosis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2018
Most Recent CDC/CSTE Revision Year	2017
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2018: Paratyphoid fever (specific serotypes of *Salmonella* enterica) was separated into its own morbidity for reporting nationally. All other salmonellosis remains unchanged. 2017: Supportive laboratory evidence modified to allow for tests other than culture. Supportive laboratory evidence used for a new probable definition. Added criteria to distinguish a new case from an existing case. Suspect definition removed. Changes based on CDC/CSTE definition. 2013: ADHS definition was changed to match CDC/CSTE, including the addition of non-culture based testing and a suspect case classification.

SCABIES	PROVIDERS REPORT WITHIN 24 HOURS IF AN OUTBREAK IS DETECTED

CASE DEFINITION

Clinical Description
A parasitic disease of the skin caused by a mite whose penetration is visible as papules, vesicles, or tiny linear burrows containing the mites and their eggs. Lesions are prominent around finger webs, anterior surfaces of wrists and elbows, anterior axillary folds, belt line, thighs, and external genitalia in men, nipples, buttocks, and abdomen in women.

Laboratory Criteria for Diagnosis
Recovery of *Sarcoptes scabiei* mite, parts of the mite, or eggs by scraping.

Case Classification

Confirmed
A laboratory confirmed case.

Probable
An infested individual with rash occurring as described above.

Comment
Only outbreaks of scabies are reportable.

CONTROL MEASURES
Arizona Administrative Code R9-6-374 Scabies

Case Control Measures
An administrator of a school or child care establishment, either personally or through a representative, shall exclude a scabies case from the school or child care establishment until treatment for scabies is completed.

An administrator of a health care institution or shelter, either personally or through a representative, shall exclude a scabies case from participating in the direct care of a patient or resident until treatment for scabies is completed.

An administrator of a shelter, either personally or through a representative, shall ensure that a scabies case receives treatment for scabies and that the case's clothing and personal articles are disinfested.

An administrator of a correctional facility, either personally or through a representative, shall ensure that a scabies case receives treatment for scabies and that the case's clothing and personal articles are disinfested.

Contact Control Measures
An administrator of a school, child care establishment, health care institution, or shelter, either personally or through a representative

1. Shall advise a scabies contact with symptoms of scabies to obtain examination and, if necessary, treatment.

Outbreak Control Measures
A local health agency shall:

1. Provide health education regarding prevention, control, and treatment of scabies to individuals affected by a scabies outbreak;
2. When a scabies outbreak occurs in a health care institution, notify the licensing agency of the outbreak; and
3. For each scabies outbreak, submit to the Department the information required under R9-6-202(D).

INVESTIGATION FORMS

See Outbreak Summary Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2005 or before
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

SEVERE ACUTE RESPIRATORY SYNDROME (SARS)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

Cases should be reported under the Novel Coronavirus (e.g., SARS or MERS) requirement. Enter in MEDSIS as SARS.

CASE DEFINITION

Clinical Description

Early illness
Presence of two or more of the following features: fever (might be subjective), chills, rigors, myalgia, headache, diarrhea, sore throat, or rhinorrhea.

Mild-to-moderate respiratory illness

- Temperature of >100.4° F (>38° C); AND
- One or more clinical findings of lower respiratory illness (e.g., cough, shortness of breath, or difficulty breathing).

Severe respiratory illness

- Meets clinical criteria of mild-to-moderate respiratory illness; AND
- One or more of the following findings:
    - Radiographic evidence of pneumonia; OR
    - Acute respiratory distress syndrome; OR
    - Autopsy findings consistent with pneumonia or acute respiratory distress syndrome without an identifiable cause.

Laboratory Criteria for Diagnosis*
Tests to detect SARS-CoV are being refined and their performance characteristics assessed; therefore, criteria for laboratory diagnosis of SARS-CoV are changing. The following are general criteria for laboratory confirmation of SARS-CoV:

- Detection of serum antibody to SARS-CoV by a test validated by CDC (e.g., enzyme immunoassay); OR
- Isolation in cell culture of SARS-CoV from a clinical specimen; OR
- Detection of SARS-CoV RNA by a reverse transcription polymerase chain reaction test validated by CDC and with subsequent confirmation in a reference laboratory (e.g., CDC).

*Information about the current criteria for laboratory diagnosis of SARS-CoV is available at https://www.cdc.gov/sars/lab/testing.html.

Exposure
One or more of the following exposures in the 10 days before onset of symptoms:

- Close contact with a person with confirmed SARS-CoV disease; OR

- Close contact with a person with mild-to-moderate or severe respiratory illness for whom a chain of transmission can be linked to a confirmed case of SARS-CoV disease in the 10 days before onset of symptoms.

Case Classification

SARS-CoV disease

Confirmed case of SARS-CoV disease
Clinically compatible illness (i.e., early, mild-to-moderate, or severe) that is laboratory confirmed.

Probable case of SARS-CoV disease
Meets the clinical criteria for severe respiratory illness and the epidemiologic criteria for likely exposure to SARS-CoV.

Other Criteria

SARS Report Under Investigation (RUI)
Reports in persons from areas where SARS is not known to be active

- SARS RUI-1: Cases compatible with SARS in groups likely to be first affected by SARS-CoV if SARS-CoV is introduced from a person without clear epidemiologic links to known cases of SARS-CoV disease or places with known ongoing transmission of SARS-CoV

Reports in persons from areas where SARS activity is occurring

- SARS RUI-2: Cases meeting the clinical criteria for mild-to-moderate illness and the epidemiologic criteria for possible exposure (spring 2003 CDC definition for suspect cases)
- SARS RUI-3: Cases meeting the clinical criteria for severe illness and the epidemiologic criteria for possible exposure (spring 2003 CDC definition for probable cases)
- SARS RUI-4: Cases meeting the clinical criteria for early or mild-to-moderate illness and the epidemiologic criteria for likely exposure to SARS-CoV

Exclusion Criteria
A case may be excluded as a SARS report under investigation (SARS RUI), including as a CDC-defined probable SARS-CoV case, if any of the following apply:

- An alternative diagnosis can explain the illness fully; OR
- Antibody to SARS-CoV is undetectable in a serum specimen obtained >28 days after onset of illness; OR
- The case was reported on the basis of contact with a person who was excluded subsequently as a case of SARS-CoV disease; then the reported case also is excluded, provided other epidemiologic or laboratory criteria are not present.

Comment
See the MMWR report from December 12, 2003 /52(49); 1202-1206 for more information and the full list of comments.

CONTROL MEASURES

Arizona Administrative Code R9-6-361 Novel Coronavirus (e.g., SARS or MERS)

Case Control Measures

A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute both airborne precautions and contact precautions for a novel coronavirus case or suspect case, including a case or suspect case of severe acute respiratory syndrome or Middle East respiratory syndrome, until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner.

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a novel coronavirus case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. In consultation with the Department, ensure that isolation and both airborne precautions and contact precautions have been instituted for a novel coronavirus case or suspect case to prevent transmission;
3. Conduct an epidemiologic investigation of each reported novel coronavirus case or suspect case; and
4. For each novel coronavirus case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures

A local health agency, in consultation with the Department, shall:

1. Determine which novel coronavirus contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission.

INVESTIGATION FORMS

Contact ADHS.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2013
Most Recent CDC/CSTE Revision Year	2003
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2013: ADHS definition was changed to match CDC/CSTE, including modifying the exposure criteria for the situation in which SARS is not currently known to be circulating in the world.

SHIGELLOSIS	REPORT WITHIN 24 HOURS IF AN OUTBREAK IS DETECTED OR PERSON HAS A HIGH-RISK OCCUPATION PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 DAY FOR ALL OTHER CASES

CASE DEFINITION

Clinical Description
An illness of variable severity characterized by diarrhea, fever, nausea, cramps, and tenesmus. Asymptomatic infections occur.

Laboratory Criteria for Diagnosis

Confirmatory Testing
Isolation of *Shigella* species from a clinical specimen.

Presumptive Testing
Detection of *Shigella* or *Shigella/*Enteroinvasive *Escherichia coli* (EIEC) from a clinical specimen using a culture-independent diagnostic test (CIDT).

Case Classification

Confirmed
A case that meets the confirmatory laboratory criteria.

Probable

- A case that meets the presumptive laboratory criteria for diagnosis; OR
- A clinically compatible illness that is epidemiologically linked to a case that meets the presumptive or confirmatory laboratory criteria.

Criteria to Distinguish a New Case from an Existing Case
A case should not be counted as a new case if laboratory results were reported within 90 days of a previously reported infection in the same individual.

When two or more different serotypes are identified in one or more specimens from the same individual, each should be reported as a separate case.

Comment
Both asymptomatic infections and infection at sites other than the gastrointestinal tract, if laboratory confirmed, are considered confirmed cases that should be reported.

The use of CIDTs as stand-alone tests for the direct detection of *Shigella/*EIEC in stool is increasing. EIEC is genetically very similar to *Shigella* and will be detected in CIDTs that detect *Shigella*. Specific performance characteristics such as sensitivity, specificity, and positive predictive value of these assays likely depend on the manufacturer and are currently unknown. It is therefore useful to collect information on the type(s) of testing performed for reported shigellosis cases. When a specimen is positive using a CIDT, it is also helpful to collect information on all culture results for the specimen, even if those results are negative.

CONTROL MEASURES

Arizona Administrative Code R9-6-375 Shigellosis

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 or R9-6-203 of a shigellosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Exclude a shigellosis case or suspect case with diarrhea from:
    a. Working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
        i. Diarrhea has resolved,
        ii. A stool specimen negative for *Shigella* spp. is obtained from the shigellosis case or suspect case, or
        iii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
    b. Using an aquatic venue for one week after diarrhea has resolved;
3. Conduct an epidemiologic investigation of each reported shigellosis case or suspect case; and
4. For each shigellosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Shigellosis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	2017
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2017: Supportive laboratory evidence modified to allow for tests other than culture. Supportive laboratory evidence used for a new probable definition. Suspect definition removed. Added criteria to distinguish a new case from an existing case. Changes based on CDC/CSTE definition. 2013: ADHS definition was edited to better match CDC/CSTE, including addition of non-culture based testing and the suspect case classification.

SMALLPOX	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

CASE DEFINITION

Clinical Description

An illness with acute onset of fever ≥101ºF or 38.3ºC followed by a rash characterized by firm, deep seated vesicles or pustules in the same stage of development without other apparent cause. Clinically consistent cases are those presentations of smallpox that do not meet this classical clinical case definition: a) hemorrhagic type, b) flat type, and c) *variola sine eruptione*. (Detailed clinical description is available on the CDC web site, see URL:https://www.cdc.gov/smallpox/index.html)

Laboratory Criteria for Diagnosis

- Polymerase chain reaction (PCR) identification of variola DNA in a clinical specimen; OR
- Isolation of smallpox (variola) virus from a clinical specimen (Level D laboratory only; confirmed by variola PCR).

Note: Laboratory testing of specimens from suspect smallpox vaccine adverse events or smallpox cases takes place in reference level Laboratory Response Network member laboratories and at CDC. Consultation with the state epidemiologist, state health laboratory, and CDC is necessary before sending specimens to CDC.

Generic orthopox PCR and negative strain electron microscopy (EM) identification of a pox virus in a clinical specimen are suggestive of an orthopox virus infection but not diagnostic for smallpox.

Case Classification*

Confirmed
Case of smallpox that is laboratory confirmed, or a case that meets the clinical case definition that is epidemiologically linked to a laboratory confirmed case.

Probable
A case that meets the clinical case definition, or a clinically consistent case that does not meet the clinical case definition and has an epidemiological link to a confirmed case of smallpox.

Suspect
A case with a generalized, acute vesicular or pustular rash illness with fever preceding development of rash by 1-4 days, without another apparent cause.

*Exclusion Criteria: A case may be excluded as a suspect or probable smallpox case if an alternative diagnosis fully explains the illness or appropriate clinical specimens are negative for laboratory criteria for smallpox.

Comment

The smallpox case definition is to be used only during post-event surveillance or once an outbreak has been confirmed. Different criteria may be used for evaluating a suspect case. See CDC guidance for Public Health Response Activities at https://www.cdc.gov/smallpox/bioterrorism-response-planning/public-health/index.html.

CONTROL MEASURES

Arizona Administrative Code R9-6-376 Smallpox

Case Control Measures

A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute both airborne precautions and contact precautions for a smallpox case or suspect case, until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner.

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a smallpox case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. In consultation with the Department:
    a. Ensure that isolation and both airborne precautions and contact precautions have been instituted for a smallpox case or suspect case to prevent transmission, and
    b. Conduct an epidemiologic investigation of each reported smallpox case or suspect case;
3. For each smallpox case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that a specimen from each smallpox case or suspect case, as required by the Department, is submitted to the Arizona State Laboratory.

Contact Control Measures

A local health agency, in consultation with the Department, shall:

1. Quarantine or exclude a smallpox contact as necessary, according to R9-6-303, to prevent transmission; and
2. Monitor the contact for smallpox symptoms, including fever, each day for 21 calendar days after last exposure.

INVESTIGATION FORMS

Contact ADHS in the event of a suspect case of smallpox.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017 (comment and note only)
Most Recent CDC/CSTE Revision Year	2010
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2017: Comment and Lab Note revised to remove references to the CDC Smallpox Response Plan, which is no longer available.

SPOTTED FEVER RICKETTSIOSIS (e.g., Rocky Mountain spotted fever)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

Enter Rocky Mountain Spotted Fever in MEDSIS under Rocky Mountain Spotted Fever. Other spotted fever rickettsioses (SFR), such as *Rickettsia parkeri* rickettsiosis and Pacific Coast tick fever (caused by infection with *Rickettsia* species 364D), should be entered under Spotted Fever Group Rickettsiosis.

CASE DEFINITION

Background

Spotted fever rickettsioses (SFR) are a group of tick-borne infections caused by some members of the genus Rickettsia.

Rocky Mountain spotted fever (RMSF) is an illness caused by *Rickettsia rickettsii*, a bacterial pathogen transmitted to humans through contact with ticks. In Arizona, the tick species primarily associated with the transmission of RMSF is the brown dog tick, *Rhipicephalus sanguineus.* In the rest of the United States, the American dog tick (*Dermacentor variabilis*) and the Rocky Mountain wood tick (*Dermacentor andersoni*) are associated with RMSF transmission.

In addition to RMSF, human illness associated with other spotted fever group *Rickettsia* species, including infection with *Rickettsia parkeri* (associated with *Amblyomma maculatum* ticks), has also been reported in Arizona and in the rest of the US. In these patients, clinical presentation appears similar to, but may be milder than RMSF.

Clinical Description

Fever as reported by the patient or a healthcare provider, AND one or more of the following:

- rash
- eschar
- headache
- myalgia
- anemia
- thrombocytopenia, or
- any hepatic transaminase elevation.

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence

- Detection of Spotted Fever Group *Rickettsiae* (SFGR) nucleic acid in a clinical specimen via amplification of a *Rickettsia* genus- or species-specific target by polymerase chain reaction (PCR) assay; OR
- Serological evidence of a fourfold increase in IgG-specific antibody titer reactive with SFGR antigen by immunofluorescence assay (IFA) between paired serum specimens (one taken in the first two weeks after illness onset and a second taken two to ten weeks after acute specimen collection)*; OR
- Demonstration of SFGR antigen in a biopsy or autopsy specimen by immunohistochemical methods (IHC); OR
- Isolation of SFGR from a clinical specimen in cell culture and molecular confirmation (e.g., PCR or sequence).

*A four-fold rise in titer should not be excluded (as confirmatory laboratory criteria) if the acute and convalescent specimens are collected within two weeks of one another.

Presumptive Laboratory Evidence

- Serologic evidence of elevated IgG antibody at a titer ≥1:128 reactive with SFGR antigen by IFA in a sample taken within 60 days of illness onset.**

**This includes paired serum specimens without evidence of fourfold rise in titer, but with at least one single titer ≥1:128 in IgG-specific antibody titers reactive with SFGR antigen by IFA. The 60-day cut-off is especially important for probable cases with a single IgG titer to better capture real acute infection.

Suspect Laboratory Evidence

- Serologic evidence of elevated IgG antibody at a titer <1:128 reactive with SFGR antigen by IFA in a sample taken within 60 days of illness onset.

Case Classification

Confirmed
A person who meets the clinical description and has confirmatory laboratory evidence.

Probable
A person who meets the clinical description and has presumptive laboratory evidence.

Suspect

- A case with confirmatory or presumptive laboratory evidence of infection with no clinical information available; OR
- A person who meets the clinical description and has supportive laboratory evidence.

Criteria to Distinguish a New Case from an Existing Case

A person previously reported as a probable or confirmed case-patient may be counted as a new case-patient when there is an episode of new clinically compatible illness with confirmatory laboratory evidence.

For the purposes of entering new laboratory information for an existing case, the timeframe of 6 months can be used as a rule of thumb for creating a new case, until evidence is obtained to determine whether there is a new episode of clinically compatible illness.*

*Based on ADHS guidelines

CONTROL MEASURES

Arizona Administrative Code R9-6-377 Spotted Fever Rickettsiosis (e.g., Rocky Mountain Spotted Fever)

Case Control Measures
A local health agency shall:

1. Upon receiving a report under R9-6-202 of a spotted fever rickettsiosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;

2. Ensure that a spotted fever rickettsiosis case or, if the case is a child or incapacitated adult, the parent or guardian of the case receives health education about reducing the risks of becoming reinfected with or of having others become infected with spotted fever rickettsiosis;
3. Conduct an epidemiologic investigation of each reported spotted fever rickettsiosis case or suspect case; and
4. For each spotted fever rickettsiosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Environmental Control Measures

In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall

1. Conduct an assessment of the environment surrounding each spotted fever rickettsiosis case or suspect case and implement vector control measures as necessary.

INVESTIGATION FORMS

See Tick-Borne Rickettsial Disease Case Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2020
Most Recent CDC/CSTE Revision Year	2020
ADHS Case Definition Matches CDC/CSTE?	Yes (with different background information)
Description of changes	2020: Updated clinical description to focus on the list of symptoms. Changed laboratory criteria for serological tests, including cut-off values and time frame of sample collection. Removed exposure section as it is not needed for classification. Updated criteria to distinguish a new case. 2013: ADHS has added additional criteria to the suspect case definition. Many cases do not go in for convalescent testing and most acute specimens are negative. For cases meeting clinical criteria with missing convalescent testing, ADHS is classifying these as suspect cases.

ST. LOUIS ENCEPHALITIS VIRUS DISEASE	PROVIDERS SUBMIT A REPORT WITHIN 5 WORKING DAYS LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

See Arboviral infection in this document.

STREPTOCOCCAL GROUP A INFECTION, INVASIVE DISEASE	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

Invasive group A streptococcal infections may present with any of several clinical syndromes including pneumonia, bacteremia in association with cutaneous infection (cellulitis, erysipelas, or infection of a surgical or nonsurgical wound), deep soft tissue infection (myositis or necrotizing fasciitis), meningitis, peritonitis, osteomyelitis, septic arthritis, postpartum sepsis (puerperal fever), neonatal sepsis, and non-focal bacteremia.

Streptococcal Toxic Shock Syndrome (STSS)

The streptococcal toxic shock syndrome is a severe illness associated with invasive or noninvasive group A streptococcal (*Streptococcus pyogenes*) infection. STSS may occur with infection at any site, but most often occurs in association with infection of a cutaneous lesion. Signs of toxicity and a rapidly progressive clinical course are characteristic, and the case fatality rate may exceed 50 percent. STSS cases should be reported and classified under Toxic Shock Syndrome - Streptococcal.

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence

Isolation of group A *Streptococcus* (*Streptococcus pyogenes*) by culture from a normally sterile site.

Presumptive Laboratory Evidence

Identification of group A *Streptococcus* (*Streptococcus pyogenes*) from a normally sterile body site by a culture-independent diagnostic test (CIDT) without isolation of the bacteria.

Case Classification

Confirmed

A case that meets the confirmatory laboratory evidence.

Probable

A case that meets the presumptive laboratory evidence.

Criteria to Distinguish a New Case from an Existing Case*

A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment

See Appendix 1 for guidance on interpreting whether a specimen is from a “normally sterile body site”.

CONTROL MEASURES

Arizona Administrative Code R9-6-378 Streptococcal Group A Infection

Non-invasive streptococcal group A infection:

Case Control Measures

An administrator of a school, child care establishment, or health care institution or a person in charge of a food establishment, either personally or through a representative

1. Shall exclude a streptococcal group A infection case with streptococcal lesions or streptococcal sore throat from working as a food handler, attending or working in a school, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution for 24 hours after the initiation of treatment for streptococcal group A infection.

Invasive streptococcal group A infection:

Outbreak Control Measures

A local health agency shall:

1. Conduct an epidemiologic investigation of each reported outbreak of streptococcal group A invasive infection;
2. For each streptococcal group A invasive infection case involved in an outbreak, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
3. For each outbreak of streptococcal group A invasive infection, submit to the Department the information required under R9-6-206(E).

INVESTIGATION FORMS

See Invasive Group A Streptococcus Surveillance Supplemental Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2019
Most Recent CDC/CSTE Revision Year	1995 (no longer nationally notifiable after 2009)
ADHS Case Definition Matches CDC/CSTE?	No
Description of changes	2019: Presumptive laboratory evidence added to allow for tests other than culture. Presumptive laboratory evidence used for a new probable definition, which was not part of the CDC/CSTE definition. 2014: Removed “clinically compatible” from confirmed definition. Matches the latest CDC/CSTE definition.

STREPTOCOCCAL GROUP B INFECTION IN AN INFANT YOUNGER THAN 90 DAYS OF AGE, INVASIVE DISEASE	PROVIDERS SUBMIT A REPORT WITHIN 5 WORKING DAYS LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description
Group B Streptococcus can produce a variety of syndromes in neonates. Clinical manifestations include pneumonia, bloodstream infection, and meningitis.

Laboratory Criteria for Diagnosis
Isolation of Group B Streptococcus (*Streptococcus agalactiae*) by culture from a normally sterile site

Case Classification

Confirmed
A clinically compatible case of invasive Group B Streptococcus that is laboratory-confirmed in a sterile site in children < 90 days of age.

Criteria to Distinguish a New Case from an Existing Case*
A case should never be counted as a new case if there was a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment
See Appendix 1 for guidance on interpreting whether a specimen is from a “normally sterile body site”.

CONTROL MEASURES
Arizona Administrative Code R9-6-379 Streptococcal Group B Infection in an Infant Younger Than 90 Days of Age

Case Control Measures
A local health agency shall:
1. Confirm the diagnosis of streptococcal group B invasive infection for each reported case or suspect case of streptococcal group B invasive infection in an infant younger than 90 days of age; and
2. For each case of streptococcal group B infection in an infant younger than 90 days of age, submit to the Department the information required under R9-6-202(C).

INVESTIGATION FORMS
None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2005 or before
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

***STREPTOCOCCUS PNEUMONIAE* INFECTION (Pneumococcal invasive disease)**	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

Streptococcus pneumoniae causes many clinical syndromes, depending on the site of infection (e.g., acute otitis media, pneumonia, bacteremia, or meningitis). Starting in 2000, a conjugate pneumococcal vaccine is recommended for prevention of pneumococcal disease in the pediatric population.

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence

Isolation of *S. pneumoniae* by culture from a normally sterile body site (e.g., blood, cerebrospinal fluid, or, less commonly, joint, pleural, or pericardial fluid).

Presumptive Laboratory Evidence

Identification of *S. pneumoniae* from a normally sterile body site by a culture-independent diagnostic test (CIDT) without isolation of the bacteria.

Case Classification

Confirmed

A case that meets the confirmatory laboratory evidence.

Probable

A case that meets the presumptive laboratory evidence.

Criteria to Distinguish a New Case from an Existing Case

A single case should be defined as a health event with a specimen collection date that occurs more than 30 days from the last known specimen with a positive lab finding.

Comment

See Appendix 1 for guidance on interpreting whether a specimen is from a “normally sterile body site”. In 2010 a new 13-valent pneumococcal conjugate vaccine (PCV 13) was licensed. Surveillance should be enhanced to provide baseline and ongoing data for the assessment of disease burden and immunization program effects.

In January 2008, the Clinical and Laboratory Standards Institute published new Minimum Inhibitory Concentration (MIC) breakpoints for defining susceptibility of *S. pneumoniae* isolates to penicillin (1). The new breakpoints are estimated to decrease the number of isolates classified as antibiotic-resistant by approximately 5% (2).The changes in breakpoints will likely result in a surveillance artifact in drug resistant *S. pneumoniae* reporting and further complicate interpretation of the reported data.

The use of CIDTs as stand-alone tests for the direct detection of *S. pneumoniae* from clinical specimens is increasing. Data regarding their performance indicate variability in the sensitivity, specificity, and positive predictive value of these assays depending on the manufacturer and validations methods used. It is therefore useful to collect information on the laboratory conducting the testing, and the type and manufacturer of the CIDT used to diagnose each invasive pneumococcal disease (IPD)

case. Culture confirmation of CIDT-positive specimens is still the ideal method of confirming a case of IPD.

References

1. Clinical and Laboratory Standards Institute. Performance Standards for Antimicrobial Susceptibility Testing; Eighteenth Informational Supplement. CLSI document M100-S18 (ISBN 1-56238-653-0). Clinical and Laboratory Standards Institute, 940 West Valley Road, Suite 1400, Wayne, Pennsylvania. 19087-1898 USA, 2008.
2. Centers for Disease Control and Prevention. Effect of New Penicillin Susceptibility Breakpoints for *Streptococcus pneumoniae*—United States, 2006-2007. MMWR 2008;57:1353-5.

CONTROL MEASURES

Arizona Administrative Code R9-6-380 *Streptococcus pneumoniae* Infection

Outbreak Control Measures

A local health agency shall:

1. Conduct an epidemiologic investigation of each reported outbreak of *Streptococcus pneumoniae* invasive infection; and
2. For each outbreak of *Streptococcus pneumoniae* invasive infection, submit to the Department the information required under R9-6-206(E).

INVESTIGATION FORMS

None.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	2017
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2017: Presumptive laboratory evidence added to allow for tests other than culture. Presumptive laboratory evidence used for a new probable definition. Suspect definition removed. Changes were based on CDC/CSTE definition. 2014: Suspect case definition added, and slight rewording of confirmed case definition, to match CDC/CSTE.

SYPHILIS	
Primary, Secondary, Early Non-Primary Non-Secondary, Unknown Duration or Late, Congenital, and Stillbirth	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Case Definition

Syphilis is a complex, sexually transmitted disease with a highly variable clinical course. Adherence to the following surveillance case definitions will facilitate understanding the epidemiology of this disease across the U.S. The following guidance is intended to be used for the purposes of syphilis surveillance, and is not intended to be used as a guide to the clinical management or public health management of syphilis cases.

In addition to describing the case definitions, the following also provides guidance for reporting neurologic, ocular, otic, and late clinical manifestations of syphilis. Cases should be reported according to **stage of infection**, as defined below (e.g., primary syphilis; secondary syphilis; early non-primary, non-secondary syphilis; unknown duration or late syphilis, as well as congenital syphilis and syphilitic stillbirth) and the **clinical manifestations** should be reported in the case report data, as defined below.

Criteria to Distinguish a New Case from an Existing Case

A case reported within the same calendar year as a previously reported syphilis case (in any stage of infection) in the same individual should not be counted as a new case unless there is a four-fold increase in titer or evidence of a new infection. If the test is from a new year but there is no evidence of reinfection, the new report will not be counted as a new case of syphilis. Consult with the ADHS STD Program for any questions about distinguishing new from existing cases, or how to appropriately mark cases in PRISM. Additional details can also be found at https://www.cdc.gov/std/tg2015/syphilis.htm.

STAGE OF INFECTION

PRIMARY SYPHILIS

Clinical Description

A stage of infection with *Treponema pallidum* characterized by one or more ulcerative lesions (e.g. chancre), which might differ considerably in clinical appearance.

Laboratory Criteria for Diagnosis

Confirmatory evidence

- Demonstration of *Treponema pallidum* by dark field microscopy in a clinical specimen that was not obtained from the oropharynx and is not potentially contaminated by stool; OR
- Demonstration of *T. pallidum* by polymerase chain reaction (PCR) or equivalent direct molecular methods in any clinical specimen.

Presumptive evidence

- A reactive nontreponemal serologic test (Venereal Disease Research Laboratory [VDRL], rapid plasma reagin [RPR], or equivalent serologic methods); OR
- A reactive treponemal serologic test (T. pallidum particle agglutination [TP-PA], enzyme immunoassay [EIA], chemiluminescence immunoassay [CIA], or equivalent serologic methods).*

* These treponemal tests supersede older testing technologies, including microhemagglutination assay for antibody to *T. pallidum* [MHA-TP].

Case Classification

Confirmed
A case that meets the clinical description of primary syphilis and the confirmatory laboratory criteria.

Probable
A case that meets the clinical description of primary syphilis and the presumptive laboratory criteria.

SECONDARY SYPHILIS

Clinical Description
A stage of infection due to *T. pallidum*, characterized by localized or diffuse mucocutaneous lesions (e.g., rash — such as non-pruritic macular, maculopapular, papular, or pustular lesions), often with generalized lymphadenopathy. Other signs can include mucous patches, condyloma lata, and alopecia. The primary ulcerative lesion may still be present*.

* Because of the wide array of symptoms and signs possibly indicating secondary syphilis, serologic tests for syphilis and a physical examination are crucial to determining if a case should be classified as secondary syphilis.

Laboratory Criteria for Diagnosis

Confirmatory evidence

- Demonstration of *T. pallidum* by dark field microscopy in a clinical specimen that was not obtained from the oropharynx and is not potentially contaminated by stool; OR
- Demonstration of *T. pallidum* by PCR or equivalent direct molecular methods in any clinical specimen.

Presumptive evidence

- A reactive nontreponemal serologic test (VDRL, RPR, or equivalent serologic methods); AND
- A reactive treponemal serologic test (TP-PA, EIA, CIA, or equivalent serologic methods).

Case Classification

Confirmed
A case that meets the clinical description of secondary syphilis and the confirmatory laboratory criteria.

Probable
A case that meets the clinical description of secondary syphilis and the presumptive laboratory criteria.

SYPHILIS, EARLY NON-PRIMARY NON-SECONDARY

Clinical Description
A stage of infection caused by *T. pallidum* in which initial infection has occurred within the previous 12 months, but there are no signs or symptoms of primary or secondary syphilis.

Laboratory Criteria for Diagnosis

Confirmatory Criteria
N/A

Presumptive Criteria
A current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer, unless there is evidence that this increase was not sustained for >2 weeks.

Epidemiologic Linkage
- A history of sexual exposure to a partner within the previous 12 months who had primary, secondary, or early non-primary non-secondary syphilis (documented independently as duration <12 months).
- Only sexual contact (sexual debut) was within the previous 12 months.

Case Classification

Confirmed
N/A

Probable
A person with no clinical signs or symptoms of primary or secondary syphilis who has one of the following:

- No prior history of syphilis, AND a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods), AND a reactive treponemal test (e.g., TP-PA, EIA, CIA, or equivalent serologic methods); OR
- A prior history of syphilis and meets the presumptive laboratory criteria.

AND

Evidence of having acquired the infection within the previous 12 months based on one or more of the following criteria:
- Documented seroconversion or fourfold or greater increase in titer of a nontreponemal test during the previous 12 months, unless there is evidence that this increase was not sustained for >2 weeks
- Documented seroconversion of a treponemal test during the previous 12 months
- A history of symptoms consistent with primary or secondary syphilis during the previous 12 months
- Meets epidemiologic criteria

SYPHILIS, UNKNOWN DURATION OR LATE

Clinical Description
A stage of infection caused by *T. pallidum* in which initial infection has occurred >12 months previously or in which there is insufficient evidence to conclude that infection was acquired during the previous 12 months.

Case Classification

Confirmed
N/A

Probable
A person with no clinical signs or symptoms of primary or secondary syphilis who meets one of the following sets of criteria:

- No prior history of syphilis, AND a current reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods), AND a current reactive treponemal test (e.g., TP-PA, EIA, CIA, or equivalent serologic methods); OR
- A prior history of syphilis therapy and a current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer, unless there is evidence that this increase was not sustained for >2 weeks; OR
- Clinical signs or symptoms and laboratory results that meet the likely or verified criteria for neurologic, ocular, otic, or late clinical manifestations syphilis.

AND

Who has no evidence of having acquired the disease within the preceding 12 months (see Syphilis, early non-primary non-secondary).

Comment
Although cases of syphilis of unknown duration are grouped together with late syphilis for the purposes of surveillance, the conservative clinical and public health responses to these cases will differ when there is uncertainty about the duration of infection. When faced with uncertainty, clinicians should act conservatively and treat unknown duration syphilis as if it were late infection, with three doses of benzathine penicillin. In contrast, the most conservative approach for STD control programs would be to manage cases of syphilis of unknown duration as early non-primary non-secondary infections and search for partners who may have been recently infected. Because this would not be feasible for most STD control programs, programs should consider prioritizing cases of syphilis of unknown duration with higher nontreponemal titers (e.g., 1:32 or higher) for investigation and partner services. Although nontreponemal titers cannot reliably distinguish between early infection (<12 months duration) and late infection (>12 months duration), nontreponemal titers usually are higher early in the course of syphilis infection.

The objective of treating persons in this stage of disease is to prevent long-term complications and transmission from a pregnant woman to her fetus. Persons diagnosed with late latent syphilis or syphilis of unknown duration should be treated with Benzathine penicillin G (Bicillin L-A) 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week (7-day) intervals. For surveillance purposes, persons who receive doses at 6-10 day intervals will be considered appropriately treated if they are not pregnant. Pregnant women who miss any dose of therapy OR are treated outside a 6-***8*** day interval MUST repeat the full course of treatment or they will be considered inappropriately treated. Infants of women that are considered inappropriately treated using the above treatment intervals will be

considered a congenital case for surveillance if appropriate treatment is not re-initiated 30 days prior to delivery. It is also recommended that non-pregnant persons with late latent syphilis who were treated at inappropriate intervals (i.e., outside the 6-10 day range) re-initiate treatment.

Pregnant women allergic to penicillin MUST be desensitized and treated with penicillin. Additionally, programs should prioritize cases of syphilis of unknown duration with higher nontreponemal titers (e.g., 1:32 or higher) for investigation and partner services. Although nontreponemal titers cannot reliably confirm a stage of syphilis, nontreponemal titers usually are higher early in the course of syphilis infection.

SYPHILIS, CONGENITAL

Clinical Description

A condition caused by infection in utero with *Treponema pallidum*. A wide spectrum of severity exists from inapparent infection to severe cases that are clinically apparent at birth. An infant or child (aged less than 2 years) may have signs such as hepatosplenomegaly, rash, condyloma lata, snuffles, jaundice (nonviral hepatitis), pseudoparalysis, anemia, or edema (nephrotic syndrome and/or malnutrition). An older child may have stigmata (e.g. interstitial keratitis, nerve deafness, anterior bowing of shins, frontal bossing, mulberry molars, Hutchinson teeth, saddle nose, rhagades, or Clutton joints).

Laboratory Criteria for Diagnosis

Demonstration of *Treponema pallidum* by:

- Dark field microscopy of lesions, body fluids, or neonatal nasal discharge; OR
- PCR or other equivalent direct molecular methods of lesions, neonatal nasal discharge, placenta, umbilical cord, or autopsy material; OR
- IHC or special stains (e.g., silver staining) of specimens from lesions, placenta, umbilical cord, or autopsy material.

Case Classification

Confirmed

A case that is laboratory confirmed.

Probable

- A condition affecting an infant whose mother had untreated or inadequately treated* syphilis at delivery, regardless of signs in the infant; OR
- an infant or child who has a reactive treponemal test for syphilis (VDRL RPR, or equivalent serologic methods)

AND

Any **one** of the following:

- Any evidence of congenital syphilis on physical examination (see Clinical Description)
- Any evidence of congenital syphilis on radiographs of long bones
- A reactive CSF VDRL test
- In a nontraumatic lumbar puncture, an elevated CSF leukocyte (white blood cell, WBC) count or

protein (without other cause):

Suggested parameters for abnormal CSF WBC and protein values:
1. During the first 30 days of life, a CSF WBC count of >15 WBC/mm^3 or a CSF protein >120 mg/dL.
2. After the first 30 days of life, a CSF WBC count of >5 WBC/mm^3 or a CSF protein >40 mg/dL, regardless of CSF serology.

The treating clinician should be consulted to interpret the CSF values for the specific patient.

*Adequate treatment is defined as completion of a penicillin-based regimen, in accordance with CDC treatment guidelines, appropriate for stage of infection, initiated 30 or more days before delivery.

Comment
Congenital and acquired syphilis may be difficult to distinguish when a child is seropositive after infancy. Signs of congenital syphilis may not be obvious, and stigmata may not yet have developed. Abnormal values for CSF VDRL, WBC count, and protein may be found in either congenital or acquired syphilis. Findings on radiographs of long bones may help because radiographic changes in the metaphysis and epiphysis are considered classic signs of congenitally acquired syphilis. While maternal antibodies can complicate interpretation of serologic tests in an infant, reactive tests past 18 months of age are considered to reflect the status of the child. The decision may ultimately be based on maternal history and clinical judgment. In a young child, the possibility of sexual abuse should be considered as a cause of acquired rather than congenital syphilis, depending on the clinical picture. For reporting purposes, congenital syphilis includes cases of congenitally acquired syphilis among infants and children as well as syphilitic stillbirths.

SYPHILIS, STILLBIRTH

Clinical Description
A fetal death that occurs after a 20-week gestation or in which the fetus weighs greater than 500 g and the mother had untreated or inadequately treated* syphilis at delivery.

*Adequate treatment is defined as completion of a penicillin-based regimen, in accordance with CDC treatment guidelines, appropriate for stage of infection, initiated 30 or more days before delivery.

Comment
For reporting purposes, syphilitic stillbirths should be reported as cases of congenital syphilis.

CLINICAL MANIFESTATIONS OF SYPHILIS

Syphilis is a systemic infection that, if untreated, can cause a variety of clinical manifestations, including:

- Signs and symptoms of primary and secondary syphilis (see above case definitions)
- Latent infections (i.e., those lacking any signs or symptoms)
- Neurologic, ocular, or otic manifestations (neurosyphilis, ocular syphilis, or otosyphilis), which can occur at any stage of syphilis
- Late clinical manifestations (tertiary syphilis), which generally occur after 15–30 years of untreated infection

The following provides guidance for reporting neurologic, ocular, otic, and late clinical manifestations of syphilis. Cases should be reported according to stage of infection, as defined above (e.g., primary syphilis; secondary syphilis; early non-primary, non-secondary syphilis; or unknown duration or late syphilis) and the clinical manifestations should be reported in the case report data, as defined below.

NEUROLOGIC MANIFESTATIONS

Neurologic manifestations (neurosyphilis) can occur at any stage of syphilis. If the patient has neurologic manifestations of syphilis, the case should be reported with the appropriate stage of infection (as if neurologic manifestations were not present) and neurologic manifestations should be noted in the case report data.

Clinical description

Infection of the central nervous system with *T. pallidum*, as evidenced by manifestations including syphilitic meningitis, meningovascular syphilis, general paresis, including dementia, and tabes dorsalis.

Classification of neurologic manifestations

Verified

A person with a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods) and a reactive treponemal test (e.g., TP-PA, EIA, CIA or equivalent serologic methods) with both of the following:

- Clinical symptoms or signs that are consistent with neurosyphilis without other known causes for these clinical abnormalities; AND
- A reactive VDRL in CSF in the absence of grossly bloody contamination of the CSF.

Likely

A person with a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods) and a reactive treponemal test (e.g., TP-PA, EIA, CIA or equivalent serologic methods) with both of the following:

- Clinical symptoms or signs that are consistent with neurosyphilis without other known causes for these clinical abnormalities; AND
- Elevated CSF protein (>50 mg/dL2) or leukocyte count (>5 white blood cells/cubic millimeter CSF) in the absence of other known causes of these abnormalities.

Possible

A person with a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods) and a reactive treponemal test (e.g., TP-PA, EIA, CIA or equivalent serologic methods) and clinical symptoms or signs that are consistent with neurosyphilis without other known causes for these clinical abnormalities.

OCULAR MANIFESTATIONS

Ocular manifestations (ocular syphilis) can occur at any stage of syphilis. If the patient has ocular manifestations of syphilis, the case should be reported with the appropriate stage of infection (as if ocular manifestations were not present) and ocular manifestations should be noted in the case report data.

Clinical description
Infection of any eye structure with *T. pallidum*, as evidenced by manifestations including posterior uveitis, panuveitis, anterior uveitis, optic neuropathy, and retinal vasculitis. Ocular syphilis may lead to decreased visual acuity including permanent blindness.

Classification of ocular manifestations

Verified
A person with a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods) and a reactive treponemal test (e.g., TP-PA, EIA, CIA or equivalent serologic methods) and both of the following:

- Clinical symptoms or signs consistent with ocular syphilis without other known causes for these clinical abnormalities; AND
- Demonstration of *T. pallidum* in aqueous or vitreous fluid by dark field microscopy, or by PCR or equivalent direct molecular methods.

Likely
A person with a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods) and a reactive treponemal test (e.g., TP-PA, EIA, CIA or equivalent serologic methods) and both of the following:

- Clinical symptoms or signs consistent with ocular syphilis without other known causes for these clinical abnormalities; AND
- Findings on exam by an ophthalmologist that are consistent with ocular syphilis in the absence of other known causes for these abnormalities.

Possible
A person with a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods) and a reactive treponemal test (e.g., TP-PA, EIA, CIA or equivalent serologic methods) and clinical symptoms or signs consistent with ocular syphilis without other known causes for these clinical abnormalities.

OTIC MANIFESTATIONS
Otic manifestations can occur at any stage of syphilis. If the patient has otic manifestations of syphilis, the case should be reported with the appropriate stage of infection (as if otic manifestations were not present) and otic manifestations should be noted in the case report data.

Clinical description
Infection of the cochleovestibular system with *T. pallidum*, as evidenced by manifestations including sensorineural hearing loss, tinnitus, and vertigo.

Classification of otic manifestations

Verified
A person with a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods) and a reactive treponemal test (e.g., TP-PA, EIA, CIA or equivalent serologic methods) and both of the following:

- Clinical symptoms or signs consistent with otosyphilis without other known causes for these clinical abnormalities; AND

- Demonstration of *T. pallidum* in inner ear fluid by dark field microscopy, or by PCR or equivalent direct molecular detection methods.

Likely
A person with a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods) and a reactive treponemal test (e.g., TP-PA, EIA, CIA or equivalent serologic methods) and both of the following:

- Clinical symptoms or signs consistent with otosyphilis without other known causes for these clinical abnormalities; AND
- Findings on exam by an otolaryngologist that are consistent with otosyphilis in the absence of other known causes for these abnormalities.

Possible
A person with a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods) and a reactive treponemal test (e.g., TP-PA, EIA, CIA or equivalent serologic methods) and clinical symptoms or signs consistent with otosyphilis without other known causes for these clinical abnormalities.

LATE CLINICAL MANIFESTATIONS

Late clinical manifestations of syphilis usually develop only after a period of 15–30 years of untreated infection. Therefore, if the patient has late clinical manifestations of syphilis, the case should be reported with the appropriate stage of infection (for the vast majority of cases, unknown duration or late syphilis) and late clinical manifestations should be noted in the case report data.

Clinical description

Late clinical manifestations of syphilis (tertiary syphilis) may include inflammatory lesions of the cardiovascular system (e.g., aortitis, coronary vessel disease), skin (e.g., gummatous lesions), bone (e.g., osteitis), or other tissue. Rarely, other structures (e.g., the upper and lower respiratory tracts, mouth, eye, abdominal organs, reproductive organs, lymph nodes, and skeletal muscle) may be involved. In addition, certain neurologic manifestations (e.g., general paresis and tabes dorsalis) are also late clinical manifestations of syphilis.

Classification of late clinical manifestations

Verified
A person with a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods) and a reactive treponemal test (e.g., TP-PA, EIA, CIA or equivalent serologic methods) and either of the following:

- Characteristic abnormalities or lesions of the cardiovascular system (e.g., aortitis, coronary vessel disease), skin (e.g., gummatous lesions), bone (e.g., osteitis), or other tissue in the absence of other known causes of these abnormalities, in combination with either demonstration of *T. pallidum* in late lesions by special stains or equivalent methods, or by PCR or equivalent direct molecular methods, or demonstration of pathologic changes that are consistent with *T. pallidum* infection on histologic examination of late lesions; OR
- Clinical signs and symptoms consistent with late neurologic manifestations of syphilis (e.g., general paresis, including dementia, or tabes dorsalis) in a case that meets the criteria for verified neurologic manifestations of syphilis (see above).

Likely
A person with a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods) and a reactive treponemal test (e.g., TP-PA, EIA, CIA or equivalent serologic methods) with either of the following:

- Characteristic abnormalities or lesions of the cardiovascular system (e.g., aortitis, coronary vessel disease), skin (e.g., gummatous lesions), bone (e.g., osteitis), or other tissue, in the absence of other known causes of these abnormalities; OR
- Clinical signs and symptoms consistent with late neurologic manifestations of syphilis (e.g., general paresis, including dementia, or tabes dorsalis) in a case that meets the criteria for likely neurologic manifestations of syphilis (see above).

CONTROL MEASURES

Arizona Administrative Code R9-6-381 Syphilis

Case Control Measures

1. A syphilis case shall obtain serologic testing for syphilis three months, six months, and one year after initiating treatment, unless more frequent or longer testing is recommended by a local health agency.
2. A health care provider for a pregnant syphilis case shall order serologic testing for syphilis at 28 to 32 weeks gestation and at delivery.
3. A local health agency shall:
    a. Conduct an epidemiologic investigation, including a review of medical records, of each reported syphilis case or suspect case, confirming the stage of the disease;
    b. For each syphilis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D);
    c. If the syphilis case is pregnant, ensure that the syphilis case obtains the serologic testing for syphilis required in subsection (A)(1) and (A)(2); and
    d. Comply with the requirements specified in R9-6-1103 concerning treatment and health education for a syphilis case.
4. The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of syphilis, as required under A.R.S. § 32-1483 and 21 CFR 630.6.

Contact Control Measures
When a syphilis case has named a contact, a local health agency shall:

1. Comply with the requirements specified in R9-6-1103 concerning notification, testing, treatment, and health education for the contact.

Outbreak Control Measures:
A local health agency shall:

1. Conduct an epidemiologic investigation of each reported syphilis outbreak; and
2. For each syphilis outbreak, submit to the Department the information required under R9-6-206(E).

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2020
Most Recent CDC/CSTE Revision Year	2018
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2020: Comment about treatment added to Syphilis, Unknown Duration or Late. 2018: Re-characterization of syphilis stages and clinical manifestations. Included congenital syphilis and syphilitic stillbirths in same definition. 2017: Added criteria to distinguish a new case from an existing case to match 2013 CDC/CSTE case definition. 2016: Late latent syphilis probable case definition updated to include no sexual exposure to a partner within the previous 12 months who had primary, secondary, or early latent syphilis. 2014: Laboratory criteria updated to reflect the addition of new diagnostic tests (PCR, TP-PA, EIA, CIA) and the removal of old ones (MHA-TP), according to the 2014 CDC/CSTE case definition; elimination of neurosyphilis as a separate category, syphilis, latent and syphilis latent of unknown; modification of clinical descriptions; addition of syphilis late, with clinical manifestations other than neurosyphilis; all modifications were made to match the 2014 CDC/CSTE case definition

TAENIASIS	PROVIDERS REPORT WITHIN 24 HOURS IF AN OUTBREAK IS DETECTED OR PERSON HAS A HIGH-RISK OCCUPATION PROVIDERS SUBMIT A REPORT WITHIN 5 DAYS FOR ALL OTHER CASES

CASE DEFINITION

Clinical Description
A parasitic disease characterized by an intestinal infection with the adult stage of large tapeworms. Clinical manifestations are variable and may include nervousness, insomnia, anorexia, weight loss abdominal pain and digestive disturbances. Many cases are asymptomatic.

Laboratory Criteria for Diagnosis
Recovery of *Taenia scolex*, proglottids or eggs from the stool.

Case Classification

Confirmed
A case that is laboratory confirmed.

CONTROL MEASURES
Arizona Administrative Code R9-6-382 Taeniasis

Case Control Measures
A local health agency shall:

1. Exclude a taeniasis case with Taenia spp. from working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until free of infestation;
2. Conduct an epidemiologic investigation of each reported taeniasis case; and
3. For each taeniasis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS
Contact ADHS.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2005 or before
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

TETANUS	PROVIDERS SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description
Acute onset of hypertonia and/or painful muscular contractions (usually of the muscles of the jaw and neck) and generalized muscle spasms without other apparent medical cause (as reported by a health professional)

Laboratory Criteria for Diagnosis
None

Case Classification

Probable

- In the absence of a more likely diagnosis, an acute illness with muscle spasms or hypertonia, AND diagnosis of tetanus by a health care provider; OR
- Death, with tetanus listed on the death certificate as the cause of death or a significant condition contributing to death.

Comment
There is no definition for “confirmed” tetanus.

CONTROL MEASURES
Arizona Administrative Code R9-6-383 Tetanus

Case Control Measures
A local health agency shall:

1. Conduct an epidemiologic investigation of each reported tetanus case or suspect case; and
2. For each tetanus case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS
See Tetanus Surveillance Worksheet Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2010
Most Recent CDC/CSTE Revision Year	2010
ADHS Case Definition Matches CDC/CSTE?	Yes (with additional comments)
Description of changes	N/A

TOXIC SHOCK SYNDROME: NON-STREPTOCOCCAL	PROVIDERS SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Note: For cases of Toxic Shock Syndrome with a confirmed etiology of group A streptococcus*, please follow the* Toxic Shock Syndrome – Streptococcal *case definition.*

Clinical Description

For Toxic Shock Syndrome (not Streptococcal)
An illness with the following clinical manifestations:

- Fever: Temperature >38.9°C (102°F)
- Rash: diffuse macular erythroderma
- Desquamation: 1-2 weeks after onset of illness
- Hypotension: systolic blood pressure ≤90 mm Hg for adults or <5th percentile by age for children <16 years of age;
- Multisystem involvement - three or more of the following organ systems:
    - Gastrointestinal (vomiting or diarrhea at onset of illness)
    - Muscular (severe myalgia or creatine phosphokinase level at least twice the upper limit of normal for laboratory):
    - Mucous membrane (vaginal, oropharyngeal, or conjunctival hyperemia);
    - Renal (blood urea nitrogen or creatinine at least twice the upper limit of normal for laboratory or urinary sediment with pyuria [greater than or equal to 5 leukocytes per high-power field] in the absence of urinary tract infection):
    - Hepatic (total bilirubin, AST/SGOT [aspartate aminotransferase enzyme/serum glutamic-oxaloacetic transaminase], or ALT/SGPT [alanine aminotransferase enzyme/serum glutamic - pyruvic transaminase] at least twice the upper limit of normal for laboratory):
    - Hematologic (platelets <100,000/mm^3)
    - Central nervous system (disorientation or alterations in consciousness without focal neurologic signs when fever and hypotension are absent)

Laboratory Criteria for Diagnosis

For Toxic Shock Syndrome (not Streptococcal)
Negative results on the following tests, if obtained:

- Blood or cerebrospinal fluid cultures (blood culture may be positive for *Staphylococcus aureus*);
- Negative serologies for Rocky Mountain spotted fever, leptospirosis, or measles

Case Classification

For Toxic Shock Syndrome (not Streptococcal)

Confirmed
A case which meets the laboratory criteria and in which all five of the clinical findings described above are present, including desquamation, unless the patient dies before desquamation occurs.

Probable
A case which meets the laboratory criteria and in which four of the five clinical findings described above are present.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

CONTROL MEASURES
Arizona Administrative Code R9-6-384 Toxic Shock Syndrome

Case Control Measures
A local health agency shall:
1. Conduct an epidemiologic investigation of each reported toxic shock syndrome case or suspect case; and
2. For each toxic shock syndrome case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS
See Toxic Shock Syndrome Case Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2015
Most Recent CDC/CSTE Revision Year	2011
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2015: Streptococcal and non-Streptococcal TSS split into separate definitions. 2013: ADHS case definition includes STSS under TSS. However, both STSS and TSS match the CDC/CSTE case definitions for those morbidities. Previous mistake in ADHS 2011 definition corrected.

TOXIC SHOCK SYNDROME: STREPTOCOCCAL	PROVIDERS SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Note: This case definition is for cases of Toxic Shock Syndrome with a confirmed etiology of group A streptococcus. *For other cases of Toxic Shock Syndrome, please follow the* Toxic Shock Syndrome – Non-Streptococcal *case definition.*

Clinical Description

For Streptococcal Toxic Shock Syndrome
An illness with the following clinical manifestations:

- Hypotension defined by a systolic blood pressure ≤90 mm Hg for adults or <5th percentile by age for children <16 years of age.
- Multi-organ involvement characterized by two or more of the following:
    - Renal impairment: Creatinine greater than or equal to 2 mg/dL (greater than or equal to 177 µmol/L) for adults or greater than or equal to twice the upper limit of normal for age. In patients with preexisting renal disease, a greater than twofold elevation over the baseline level.
    - Coagulopathy: Platelets less than or equal to 100,000/mm^3 (less than or equal to 100 x 106/L) or disseminated intravascular coagulation, defined by prolonged clotting times, low fibrinogen level, and the presence of fibrin degradation products.
    - Liver involvement: Alanine aminotransferase, aspartate aminotransferase, or total bilirubin levels greater than or equal to twice the upper limit of normal for the patient's age. In patients with preexisting liver disease, a greater than twofold increase over the baseline level.
    - Acute respiratory distress syndrome: defined by acute onset of diffuse pulmonary infiltrates and hypoxemia in the absence of cardiac failure or by evidence of diffuse capillary leak manifested by acute onset of generalized edema, or pleural or peritoneal effusions with hypoalbuminemia.
    - A generalized erythematous macular rash that may desquamate.
    - Soft-tissue necrosis, including necrotizing fasciitis or myositis, or gangrene.

Laboratory Criteria for Diagnosis

Isolation of group A *Streptococcus (Streptococcus pyogenes)*

Case Classification

Confirmed
A case that meets the clinical case definition and with isolation of group A *Streptococcus* from a normally sterile site (e.g., blood or cerebrospinal fluid or, less commonly, joint, pleural, or pericardial fluid).

Probable
A case that meets the clinical case definition in the absence of another identified etiology for the illness and with isolation of group A *Streptococcus* from a non-sterile site.

Criteria to Distinguish a New Case from an Existing Case*

A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment

Streptococcal toxic-shock syndrome (STSS) is a severe illness associated with invasive or noninvasive group A streptococcal (*Streptococcus pyogenes*) infection. STSS may occur with infection at any site but most often occurs in association with infection of a cutaneous lesion. Signs of toxicity and a rapidly progressive clinical course are characteristic, and the case fatality rate may exceed 50%.

CONTROL MEASURES

Arizona Administrative Code R9-6-384 Toxic Shock Syndrome

Case Control Measures

A local health agency shall:

1. Conduct an epidemiologic investigation of each reported toxic shock syndrome case or suspect case; and
2. For each toxic shock syndrome case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Toxic Shock Syndrome Case Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2015
Most Recent CDC/CSTE Revision Year	2010 (Streptococcal TSS)
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2015: Streptococcal and non-Streptococcal TSS split into separate definitions. 2013: ADHS case definition includes STSS under TSS. However, both STSS and TSS match the CDC/CSTE case definitions for those morbidities. Previous mistake in ADHS 2011 definition corrected.

TRICHINOSIS (Trichinellosis)	PROVIDERS SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description
A disease caused by ingestion of *Trichinella* larvae, usually through consumption of *Trichinella*-containing meat—or food contaminated with such meat—that has been inadequately cooked prior to consumption. The disease has variable clinical manifestations. Common signs and symptoms among symptomatic persons include eosinophilia, fever, myalgia, and periorbital edema.

Laboratory Criteria for Diagnosis

Human Specimens

- Demonstration of larvae of cysts of *T. spiralis* on biopsy; OR
- Positive serology for *T. spiralis*

Food Specimens

- Demonstration of *Trichinella* larvae in the food item (probable)

Case Classification

Confirmed
A clinically compatible illness that is laboratory confirmed in the patient.

Probable

- A clinically compatible illness in a person who shared an epidemiologically implicated meal or ate an epidemiologically implicated meat product; OR
- A clinically compatible illness in a person who consumed a meat product in which the parasite was demonstrated.

Suspected
Instances where there is no clinically compatible illness should be reported as suspect if the person shared an epidemiologically implicated meal, or ate an epidemiologically implicated meat product, and has a positive serologic test for trichinellosis (and no known prior history of *Trichinella* infection).

Criteria to Distinguish a New Case from an Existing Case
Serial or subsequent cases of trichinosis experienced by one individual should only be counted if there is an additional epidemiologically compatible exposure. Because the duration of antibodies to *Trichinella* spp. is not known, mere presence of antibodies without a clinically-compatible illness AND an epidemiologically compatible exposure may not indicate a new infection especially among persons with frequent consumption of wild game that is known to harbor the parasite.

Comment
Epidemiologically implicated meals or meat products are defined as a meal or meat product that was consumed by a person who subsequently developed a clinically compatible illness that was laboratory confirmed.

Negative serologic results may not accurately reflect disease status if blood was drawn less than 3-4 weeks from symptom onset.

CONTROL MEASURES

Arizona Administrative Code R9-6-385 Trichinosis

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a trichinosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported trichinosis case or suspect case; and
3. For each trichinosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Trichinosis Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	2014
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2017: Added criteria to distinguish a new case from an existing case to match 2013 CDC/CSTE case definition 2014: Laboratory criteria were modified to include the identification of the parasite in food as a laboratory criterion for diagnosis; suspected and probable case definitions were added; comments were modified to include definition of epidemiologically implicated meals and meat products and criteria to distinguish between new and existing cases; modifications were made to match the 2014 CDC/CSTE case definitions.

TUBERCULOSIS	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

For more information on control measures, see Arizona Administrative Code R9-6-381 and R9-6-601.

Complete the appropriate forms, located on the Tuberculosis Control Program Resources page (http://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/index.php#tb-control-programs):

- **Report of Verified Case of Tuberculosis Form** for confirmed *Mycobacterium tuberculosis* cases
- ADHS TB **Prevention Registry Form** for all contacts to confirmed *Mycobacterium tuberculosis* cases
- If Interjurisdictional: Complete **Interjurisdictional Tuberculosis Notification Form** and **Interjurisdictional Tuberculosis Notification Follow-up Form**

CASE DEFINITION

Clinical Description

A chronic bacterial infection due to *Mycobacterium tuberculosis* complex, characterized pathologically by the formation of granulomas. The most common site infection is the lung, but other organs may be involved.

Clinical Case Definition

A case must meet all the following criteria:

- Evidence of tuberculosis infection indicated by a positive tuberculin skin test or positive interferon gamma release assay for *M. tuberculosis*; AND
- Other signs and/or symptoms compatible with tuberculosis, such as an abnormal, unstable (i.e. worsening or improving) chest radiographs, or clinical evidence of current disease; AND
- Treatment with two or more antituberculosis medications; AND
- Completed diagnostic evaluation.

Laboratory Criteria for Diagnosis

- Isolation of *M. tuberculosis* complex from a clinical specimen; OR
- Demonstration of *M. tuberculosis* complex from a clinical specimen by nucleic acid amplification test; OR
- Demonstration of acid-fast bacilli and/or pathology consistent with *M. tuberculosis* in a clinical specimen when a culture has not been or cannot be obtained or is falsely negative or contaminated.

Case Classification

Confirmed

A case that meets the clinical case definition or is laboratory confirmed.

Comment

Only one case should be counted in a person within any consecutive 12-month period. However, a case in a patient who had previously had verified disease should be reported again if more than 12 months have elapsed since the patient was discharged from treatment. A case should also be reported again if the patient was lost to supervision for >12 months and disease can be verified again. Mycobacterial diseases other than those caused by *M. tuberculosis* complex should not be counted in tuberculosis morbidity statistics unless there is concurrent tuberculosis.

CONTROL MEASURES

Arizona Administrative Code R9-6-380 Tuberculosis

Case Control Measures:

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute airborne precautions for:
    a. An individual with infectious active tuberculosis until:
        i. At least three successive sputum smears collected at least eight hours apart, at least one of which is taken first thing in the morning as soon as possible after the individual awakens from sleep, are negative for acid-fast bacilli;
        ii. Anti-tuberculosis treatment is initiated with multiple antibiotics; and
        iii. Clinical signs and symptoms of active tuberculosis are improved;
    b. A suspect case of infectious active tuberculosis until:
        i. At least two successive tests for tuberculosis, using a product and methodology approved by the U.S. Food and Drug Administration for use when making decisions whether to discontinue isolation and airborne precautions, for the suspect case are negative; or
        ii. At least three successive sputum smears collected from the suspect case as specified in subsection (A)(1)(a)(i) are negative for acid-fast bacilli, anti-tuberculosis treatment of the suspect case is initiated with multiple antibiotics, and clinical signs and symptoms of active tuberculosis are improved; and
    c. A case or suspect case of multi-drug resistant active tuberculosis until a tuberculosis control officer has approved the release of the case or suspect case.
2. An administrator of a health care institution, either personally or through a representative, shall notify a local health agency at least one working day before discharging a tuberculosis case or suspect case.
3. A local health agency shall:
    a. Upon receiving a report under R9-6-202 of a tuberculosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
    b. Exclude an individual with infectious active tuberculosis or a suspect case from working, unless the individual's work setting has been approved by a tuberculosis control officer, until the individual with infectious active tuberculosis or suspect case is released from airborne precautions according to the applicable criteria in subsection (A)(1);
    c. Conduct an epidemiologic investigation of each reported tuberculosis case, or suspect case, or latent infection in a child five years of age or younger;
    d. For each tuberculosis case or suspect case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D);
    e. Ensure that an isolate or a specimen, as available, from each tuberculosis case is submitted to the Arizona State Laboratory; and
    f. Comply with the requirements specified in R9-6-1202.

Contact Control Measures

1. A contact of an individual with infectious active tuberculosis shall allow a local health agency to evaluate the contact's tuberculosis status.
2. A local health agency shall comply with the tuberculosis contact control measures specified in R9-6-1202.

An individual is not a tuberculosis case if the individual has a positive result from an approved test for tuberculosis but does not have clinical signs or symptoms of disease.

INVESTIGATION FORMS

Complete the appropriate forms, located on the Tuberculosis Control Program Resources page (http://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/index.php#tb-control-programs):

- **Report of Verified Case of Tuberculosis Form** for confirmed *Mycobacterium tuberculosis* cases
- ADHS TB **Prevention Registry Form** for all contacts to confirmed *Mycobacterium tuberculosis* cases
- If Interjurisdictional: Complete **Interjurisdictional Tuberculosis Notification Form** and **Interjurisdictional Tuberculosis Notification Follow-up Form**

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2019 (with 2020 addition of *M. tuberculosis* **complex** to the clinical description)
Most Recent CDC/CSTE Revision Year	2009
ADHS Case Definition Matches CDC/CSTE?	No
Description of changes	2020: Addition of *M. tuberculosis* **complex** to the clinical description. 2019: Laboratory criteria modified to include isolation of *M. tuberculosis* complex or pathology consistent with *M. tuberculosis*. These changes are not part of the current CSTE definition but are consistent with current practice and with RVCT reporting. 2016: Instructions and links for completion of forms updated. No changes to case definition itself. 2013: Updated the ADHS case definition to match CDC/CSTE, including addition of interferon gamma release assay criteria.

TULAREMIA	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description
An illness characterized by several distinct forms, including:

- Ulceroglandular (cutaneous ulcer with regional lymphadenopathy)
- Glandular (regional lymphadenopathy with no ulcer)
- Oculoglandular (conjunctivitis with preauricular lymphadenopathy)
- Oropharyngeal (stomatitis, pharyngitis, tonsillitis and cervical lymphadenopathy,)
- Pneumonic (primary pleuropulmonary disease)
- Typhoidal (febrile illness without early localizing signs and symptoms)

Clinical diagnosis is supported by evidence or history of a tick or deerfly bite, exposure to tissues of a mammalian host of *Francisella tularensis*, or exposure to potentially contaminated water.

Laboratory Criteria for Diagnosis

Confirmatory Testing

- Isolation of *F. tularensis* from a clinical specimen; OR
- Fourfold or greater rise in serum antibody titer to *F. tularensis* antigen between acute and convalescent specimens.

Presumptive Testing

- Detection of *F. tularensis* in a clinical or autopsy specimen by a polymerase chain reaction (PCR); OR
- Detection of *F. tularensis* in a clinical specimen by fluorescent assay; OR
- Elevated serum antibody titer(s) to *F. tularensis* antigen (without documented fourfold or greater change) in a patient with no history of tularemia vaccination.

Case Classification

Confirmed
A clinically compatible case that that meets the confirmatory laboratory criteria.

Probable
A clinically compatible case with presumptive laboratory evidence.

Criteria to Distinguish a New Case from an Existing Case
Serial or subsequent cases of tularemia experienced by one individual should only be counted if there is an additional epidemiologically compatible exposure and new onset of symptoms. Because the duration of antibodies to *F. tularensis* is not known, mere presence of antibodies without a clinically-compatible illness AND an epidemiologically compatible exposure within 12 months of onset may not indicate a new infection, especially among persons who live in endemic areas.

CONTROL MEASURES

Arizona Administrative Code R9-6-387 Tularemia

Case Control Measures

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate a pneumonic tularemia case until 72 hours of antibiotic therapy have been completed with favorable clinical response.
2. A local health agency shall:
    a. Upon receiving a report under R9-6-202 of a tularemia case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
    b. Conduct an epidemiologic investigation of each reported tularemia case or suspect case;
    c. For each tularemia case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
    d. Ensure that an isolate or a specimen, as available, from each tularemia case or suspect case is submitted to the Arizona State Laboratory.

INVESTIGATION FORMS

See Tularemia Case Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	2017
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2017: PCR included as supportive laboratory evidence. Changes to wording of oropharyngeal clinical form. Changes were based on CDC/CSTE definition. 2013: ADHS case definition updated to match CDC/CSTE.

TYPHOID FEVER (*Salmonella* Typhi)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description
An illness caused by *Salmonella* enterica serotype Typhi (*S.* Typhi) that is often characterized by insidious onset of sustained fever, headache, malaise, anorexia, relative bradycardia, constipation or diarrhea, and nonproductive cough. However, many mild and atypical infections occur. Carriage of *S.* Typhi may be prolonged.

Clinical Criteria
One or more of the following:

- Fever
- Diarrhea
- Abdominal cramps
- Constipation
- Anorexia
- Relative bradycardia

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence
Isolation of *S. typhi* from a clinical specimen.

Presumptive Laboratory Evidence*
Detection of *S.* Typhi in a clinical specimen using a culture-independent diagnostic test (CIDT).

*Serologic testing (i.e., detection of antibodies to *S.* Typhi) should not be utilized for case classification.

Epidemiologic Linkage

- Epidemiological linkage to a confirmed typhoid fever case; OR
- Epidemiological linkage to a probable typhoid fever case with laboratory evidence; OR
- Member of a risk group as defined by public health authorities during an outbreak.

Case Classification

Confirmed
A person with confirmatory laboratory criteria.

Probable

- A clinically compatible illness in a person with presumptive laboratory evidence.
- A clinically compatible illness in a person with an epidemiological linkage.

Criteria to Distinguish a New Case from an Existing Case

A new case should be created when a positive laboratory result is received more than 365 days after the most recent positive laboratory result associated with a previously reported case in the same person.

Comment

It is estimated that approximately 2-5% of persons infected with *S.* Typhi become chronic intestinal carriers who continue to shed *S.* Typhi for more than one year. These people are typically referred to as chronic carriers.

Differentiating whether a person became a chronic carrier or is experiencing a new infection often relies on a variety of factors, including advanced laboratory testing (e.g., pulsed-field gel electrophoresis [PFGE], whole genome sequencing [WGS]) to compare the isolate from the previous infection to the new isolate. While these methodologies can provide detailed information about the genetic make-up of the organisms, there is still significant variability in how two organisms can be defined as different. Given the potential for inconsistent application of the label “different” across jurisdictions, this case definition does not exclude persons with a previously reported *S.* Typhi Infection case from being counted as a new case if the subsequent positive laboratory result is more than 365 days from the most recent positive laboratory result associated with the existing case.

CONTROL MEASURES

Arizona Administrative Code R9-6-388 Typhoid Fever

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a typhoid fever case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported typhoid fever case or suspect case;
3. For each typhoid fever case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D);
4. Exclude a typhoid fever case or suspect case from working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
    a. At least one month after the date of onset of illness,; and
    b. After two successive stool specimens, collected from the typhoid fever case at least 24 hours apart and at least 48 hours after cessation of antibiotic therapy, are negative for Salmonella typhi;
5. If a stool specimen from a typhoid fever case who has received antibiotic therapy is positive for Salmonella typhi, enforce the exclusions specified in subsection (A)(4) until two successive stool specimens, collected from the typhoid fever case at least one month apart and 12 or fewer months after the date of onset of illness, are negative for Salmonella typhi;
6. If a positive stool specimen, collected at least 12 months after onset of illness, is obtained from a typhoid fever case who has received antibiotic therapy, redesignate the case as a carrier; and
7. Exclude a typhoid fever carrier from working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until three successive stool specimens, collected from the typhoid fever carrier at least one month apart, are negative for Salmonella typhi.

Contact Control Measures

A local health agency shall

1. Exclude a typhoid fever contact from working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until two successive stool specimens, collected from the typhoid fever contact at least 24 hours apart, are negative for *Salmonella typhi*.

INVESTIGATION FORMS

See Typhoid and Paratyphoid Fever Surveillance Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2019
Most Recent CDC/CSTE Revision Year	2019
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2019: Clinical criteria added. CIDT added as presumptive testing and probable case classification. Epidemiological linkage defined. Changes based on modifications to CDC/CSTE definition.

TYPHUS FEVER	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description
An acute febrile disease characterized by fever, headache, myalgia, and a maculopapular rash. The rash is distributed over the trunk, with minimal involvement of the extremities, palms, soles and face.

Laboratory Criteria for Diagnosis

- Single titer > 64 by Indirect Fluorescent Antibody (IFA) test using differentially absorbed sera with the respective rickettsial antigen prior to testing; OR
- Single titer > 16 by Complement-Fixation (CF) test with group-specific rickettsial antigen. Antibody tests usually become positive in the second week.

Case Classification

Confirmed
A case that is laboratory confirmed with symptoms and history as above.

Probable
A compatible history of exposure to domestic rats and their fleas, plus rash and symptoms of typhus.

Criteria to Distinguish a New Case from an Existing Case*
A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

CONTROL MEASURES
Arizona Administrative Code R9-6-389 Typhus Fever

Case Control Measures
A local health agency shall:

1. Upon receiving a report under R9-6-202 of a typhus fever case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported typhus fever case or suspect case; and
3. For each typhus fever case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).
4. Conduct an epidemiologic investigation of each reported typhus fever case or suspect case; and
5. For each typhus fever case, submit to the Department, as specified in Article 2, Table 4, the information required under R9-6-206(D).

INVESTIGATION FORMS
See Tick-Borne Rickettsial Disease Case Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2005 or before
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

VACCINIA-RELATED ADVERSE EVENT	PROVIDERS SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description

Adverse events may include one or more of the following:

- Common adverse reactions
  - Local skin reaction
  - Nonspecific rashes, e.g., reticular maculopapular, generalized urticarial rash
  - Erythema migrans
- Vaccinia-specific reactions
  - Inadvertent inoculation
  - Ocular vaccinia infection (keratitis)
  - Generalized vaccinia: disseminated, non-centrifugal maculopapular or vesicular rash
  - Progressive vaccinia/vaccinia necrosum: an initial lesion which continues to progress without healing for more than 15 days after the vaccination; painless progressive necrosis at the site with or without metastases to other distant sites
  - Eczema vaccinia: localized or generalized popular, vesicular or pustular rash anywhere on the body, especially at sites of previous atopic dermatitis lesions
  - Encephalopathy or encephalomyelitis: most common in infants; symptoms include fever, headache, change in mental status, lethargy, seizures, coma, and is diagnosed by exclusion of other causes
- Other adverse effects
  - Cardiac, e.g., myocarditis, pericarditis
  - Osteomyelitis
  - Transverse myelitis, seizures, paralysis and neuritis
  - Fetal vaccinia: transmission from mother to fetus resulting in skin diseases and other organ involvement leading to fetal or neonatal death
  - Wound complications

Exposure Criteria

- Vaccination with smallpox vaccine within the three months preceding symptom onset; OR
- Contact exposure to someone vaccinated with smallpox vaccine within the three months preceding symptom onset.

Case Classification

Confirmed

A person who has at least one of the clinical features and meets at least one of the exposure criteria.

Criteria to Distinguish a New Case from an Existing Case*

A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

CONTROL MEASURES

Arizona Administrative Code R9-6-390 Vaccinia-related Adverse Event

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a case or suspect case of a vaccinia-related adverse event, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported case or suspect case of a vaccinia-related adverse event; and
3. For each case of a vaccinia-related adverse event, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

There is no specific investigation form for vaccinia-related adverse events. Events following vaccination may be reported to the Vaccine Adverse Event Reporting System (VAERS).

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2006
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

VANCOMYCIN-INTERMEDIATE *STAPHYLOCOCCUS AUREUS* (VISA), or VANCOMYCIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (VRSA)	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Clinical Description

Staphylococcus aureus can produce a variety of syndromes with clinical manifestations including skin and soft tissue infections, empyema, bloodstream infection, pneumonia, osteomyelitis, septic arthritis, endocarditis, sepsis, and meningitis. *S. aureus* may also colonize individuals who remain asymptomatic. The most frequent site of *S. aureus* colonization is the nares.

Laboratory Criteria for Diagnosis

- Isolation of *Staphylococcus aureus* from any body site; AND
- Intermediate or resistance of the *S. aureus* isolate to vancomycin, detected and defined according to Clinical and Laboratory Standards Institute (CLSI, formerly NCCLS) approved standards and recommendations (Minimum Inhibitory Concentration [MIC]=4-8 µg/ml for VISA and MIC≥16 µg/ml for VRSA).

Case Classification

Confirmed

A case of vancomycin-intermediate or vancomycin-resistant *S. aureus* that is laboratory-confirmed (MIC=4-8 µg/ml for VISA and MIC≥16 µg/ml for VRSA) by a public health laboratory.

Suspect

A case of vancomycin-intermediate or vancomycin-resistant *S. aureus* that is laboratory confirmed (MIC=4-8 µg/ml for VISA and MIC≥16 µg/ml for VRSA), but not confirmed by a public health laboratory.

Note: The suspect definition will generally apply only when testing at a public health laboratory cannot be performed. If a public health laboratory identifies that the specimen/isolate is not vancomycin-intermediate/resistant, the case should be classified as “Not a case”.

References

Clinical and Laboratory Standards Institute/NCCLS. Performance Standards for Antimicrobial Susceptibility Testing. Sixteenth informational supplement. M100-S16. Wayne, PA: CLSI, 2006

CONTROL MEASURES

Arizona Administrative Code R9-6-391 Vancomycin-Resistant or Vancomycin-Intermediate *Staphylococcus aureus*

Case Control Measures

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and implement contact precautions for a case or suspect case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*.

2. A diagnosing health care provider or an administrator of a health care institution transferring a known case with active infection or a known carrier of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus* to another health care provider or health care institution shall, either personally or through a representative, comply with R9-6-305.
3. A local health agency, in consultation with the Department, shall:
    a. Upon receiving a report under R9-6-202 of a case or suspect case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
    b. Ensure that a case or suspect case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus* is isolated as necessary to prevent transmission;
    c. Conduct an epidemiologic investigation of each reported case or suspect case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*;
    d. For each case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
    e. Ensure that an isolate or a specimen, as available, from each case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus* is submitted to the Arizona State Laboratory.

INVESTIGATION FORMS

See Vancomycin-Resistant or Vancomycin-Intermediate *Staphylococcus aureus* Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2019
Most Recent CDC/CSTE Revision Year	2007
ADHS Case Definition Matches CDC/CSTE?	No
Description of changes	2019: Clarified that confirmation at a public health laboratory is required, to eliminate false positive results received from clinical laboratories. Added suspect case definition to capture cases not confirmed by a public health laboratory. CDC/CSTE case definition does not state that a public health laboratory must confirm the test, but the ADHS confirmed definition otherwise matches.

VANCOMYCIN-RESISTANT *STAPHYLOCOCCUS EPIDERMIDIS* (VRSE)	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

Cases should be reported under the emerging or exotic disease requirement.

CASE DEFINITION

Clinical Description

Vancomycin-resistant *Staphylococcus epidermidis* (VRSE) can cause a variety of infections ranging from skin infections to deeper tissue/organ involvement such as bacteremia, endocarditis, or urinary tract infections.

Laboratory Criteria for Diagnosis

- Isolation of *Staphylococcus epidermidis* from any body site; AND
- Resistance of *Staphylococcus epidermidis* isolate to vancomycin, detected and defined according to the standards and guidelines approved by the National Committee for Clinical Laboratory Standards (NCCLS) (MIC >32 mg/L (NCCLS 2006)).

Case Classification

Confirmed

A clinically-compatible case of vancomycin-resistant *Staphylococcus epidermidis* that is laboratory confirmed.

CONTROL MEASURES

Arizona Administrative Code R9-6-333 Emerging or Exotic Disease

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of an emerging or exotic disease case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. In consultation with the Department, isolate an emerging or exotic disease case or suspect case as necessary to prevent transmission;
3. Conduct an epidemiologic investigation of each reported emerging or exotic disease case or suspect case; and
4. For each emerging or exotic disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures

A local health agency, in consultation with the Department,

1. Shall quarantine or exclude an emerging or exotic disease contact as necessary, according to R9-6-303, to prevent transmission.

INVESTIGATION FORMS

See Vancomycin-resistant *Staphylococcus epidermidis* (VSRE) at
http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2006
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

VARICELLA (Chickenpox) AND VARICELLA DEATHS	PROVIDERS SUBMIT A REPORT WITHIN 5 WORKING DAYS

CASE DEFINITION

Clinical Description

An illness with acute onset of diffuse (generalized) maculopapular vesicular rash without other apparent cause.

Laboratory Criteria for Diagnosis

- Isolation of varicella virus from a clinical specimen; OR
- Varicella antigen by direct fluorescent antibody (DFA); OR
- Varicella-specific nucleic acid detected by polymerase chain reaction (PCR); OR
- Significant rise in serum varicella immunoglobulin G (lgG) antibody level by any standard serologic assay.

Case Classification (Varicella Case)

Confirmed

An acute illness with diffuse (generalized) maculopapular vesicular rash or a case of varicella reported by a provider or school, AND

- Laboratory confirmation by any of methods above; OR
- Epidemiologic linkage to a confirmed or probable case or known outbreak.

Probable

- A reported case of rash illness by a school or healthcare provider that does not meet the criteria for a confirmed case. Case may be negative on laboratory testing or have a single serology reported.

Suspect

- Laboratory evidence of infection, including single serologic assays, in someone who does not meet the confirmed or probable case definition.

Case Classification (Varicella Death)

Confirmed

A confirmed case of varicella that contributes directly or indirectly to acute medical complications that result in death.

Probable

A probable case of varicella that contributes directly or indirectly to acute medical complications that result in death.

Criteria to Distinguish a New Case from an Existing Case*

A case should not be counted as a new case if laboratory results were reported within 6 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment

Two probable cases that are epidemiologically linked would be considered confirmed, even in the absence of laboratory confirmation.

Laboratory confirmation of cases of varicella is not routinely recommended; laboratory confirmation is recommended for fatal cases and in other special circumstances, including outbreaks.

For reports meeting the laboratory criteria for diagnosis, and not reported by a school or a healthcare provider, attempts should be made to identify the presence of compatible symptoms. Laboratory reports without evidence of symptoms should be classified as suspect.

In vaccinated persons who develop varicella more than 42 days after vaccination (breakthrough disease), the disease is almost always mild with fewer than 50 skin lesions and shorter duration of illness. The rash may also be atypical in appearance (maculopapular with few vesicles).

CONTROL MEASURES

Arizona Administrative Code R9-6-392 Varicella (Chickenpox)

Case Control Measures:

1. An administrator of a school or child care establishment, either personally or through a representative, shall exclude a varicella case from the school or child care establishment and from school- or child-care-establishment-sponsored events until lesions are dry and crusted.
2. An administrator of a health care institution, either personally or through a representative, shall isolate and implement airborne precautions for a varicella case until the case is no longer infectious.
3. A local health agency shall:
    a. Conduct an epidemiologic investigation of each reported case of death due to primary varicella infection; and
    b. For each reported case of death due to varicella infection, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

Contact Control Measures

1. When a varicella case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
    a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
    b. Comply with the local health agency's recommendations for exclusion.
2. A local health agency shall determine which contacts of a varicella case will be:
    a. Excluded from a school or child care establishment, and
    b. Advised to obtain an immunization against varicella.

INVESTIGATION FORMS

If case expired, complete the Varicella Death Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2013
Most Recent CDC/CSTE Revision Year	2010 (Varicella); 1998 (Varicella death)
ADHS Case Definition Matches CDC/CSTE?	No
Description of changes	2013: ADHS removed one laboratory criterion for diagnosis in order to match that of CDC/CSTE. ADHS 2013 kept additional comments not present in CDC/CSTE. Additionally, ADHS case definition includes a Suspect category and criteria for classifying school or provider reports in the absence of information on specific symptoms.

VIBRIO INFECTION	PROVIDERS REPORT WITHIN 24 HOURS IF AN OUTBREAK IS DETECTED OR CASE HAS A HIGH-RISK OCCUPATION PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY FOR ALL OTHER CASES

CASE DEFINITION

Clinical Description
An infection of variable severity characterized by watery diarrhea, primary septicemia, or wound infections. Asymptomatic infections may occur, and the organism may cause extra-intestinal infections.

Laboratory Criteria for Diagnosis

Confirmatory Testing
Isolation of a species of the family *Vibrionaceae* (other than toxigenic *Vibrio cholerae* O1 or O139, which are reportable as cholera) from a clinical specimen.

Presumptive Testing
Detection of a species of the family *Vibrionaceae* (other than toxigenic *Vibrio cholerae* O1 or O139, which are reportable as cholera) from a clinical specimen using a culture-independent diagnostic test (CIDT).

Case Classification

Confirmed
A case that meets the laboratory criteria for diagnosis. Note that species identification and, if applicable, serotype designation (i.e., *Vibrio cholerae* non-O1/non-O139 or *Grimontia hollisae*) should be reported.

Probable
A case that meets the presumptive laboratory criteria for diagnosis; OR

A clinically-compatible case that is epidemiologically linked to a case that meets the presumptive or confirmatory laboratory criteria for diagnosis.

Criteria to Distinguish a New Case from an Existing Case
A case should not be counted as a new case if laboratory results were reported within 30 days of a previously reported infection in the same individual.

When two or more different species of the family *Vibrionaceae* are identified in one or more specimens from the same individual, each should be reported as a separate case.

Comment
The use of CIDTs as stand-alone tests for the direct detection of *Vibrio* in stool is increasing. Specific performance characteristics such as sensitivity, specificity, and positive predictive value of these assays likely depend on the manufacturer and are currently unknown. It is therefore useful to collect information on the type(s) of testing performed for reported vibriosis cases. When a specimen is positive using a CIDT it is also helpful to collect information on all culture results for the specimen, even if those results are negative.

Genera in the family *Vibrionaceae* (not all have been recognized to cause human illness) currently include:

- Aliivibrio
- Allomones
- Catenococcus
- Enterovibrio
- Grimontia
- Listonella
- Photobacterium
- Salinivibrio
- Vibrio

CONTROL MEASURES

Arizona Administrative Code R9-6-393 *Vibrio* Infection

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a Vibrio infection case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Exclude a *Vibrio* infection case or suspect case with diarrhea from:
    a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
        i. Diarrhea has resolved, or
        ii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
    b. Using an aquatic venue until diarrhea has resolved;
3. Conduct an epidemiologic investigation of each reported *Vibrio* infection case or suspect case; and
4. For each *Vibrio* infection case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

INVESTIGATION FORMS

See Cholera & Other Vibrio Illness Surveillance Report Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	2017
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2017: Supportive laboratory evidence modified to allow for tests other than culture. Supportive laboratory evidence used for a new probable definition. Added criteria to distinguish a new

	case from an existing case. Changes based on CDC/CSTE definition. 2013: ADHS case definition updated to match CDC/CSTE.

VIRAL HEMORRHAGIC FEVER	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

CASE DEFINITION

- Filoviruses (Ebola, Marburg)
- Lassa virus
- Lujo virus
- New World Arenaviruses (Guanarito, Machupo, Junin, Sabia)
- Crimean-Congo Hemorrhagic Fever (Nairovirus)

Clinical Description

A person with acute onset with ALL the following clinical findings:

- A fever > 40°C, AND
- One or more of the following clinical findings:
    - Severe headache
    - Muscle pain
    - Erythematous maculopapular rash on the trunk with fine desquamation 3–4 days after rash onset
    - Vomiting
    - Diarrhea
    - Pharyngitis (arenavirus only)
    - Abdominal pain
    - Bleeding not related to injury
    - Retrosternal chest pain (arenavirus only)
    - Proteinuria (arenavirus only)
    - Thrombocytopenia

Laboratory Criteria for Diagnosis

Laboratory criteria are virus-specific. Diagnostic tests should be performed in consultation with ADHS. Laboratory criteria include one or more of the following laboratory findings:

- Detection of VHF viral antigens in blood by enzyme-linked immunosorbent assay (ELISA) antigen detection
- VHF viral isolation in cell culture for blood or tissues
- Detection of VHF viral genes using reverse transcriptase with polymerase chain reaction amplification (RT-PCR) from blood or tissues
- Detection of VHF viral antigens in tissues by immunohistochemistry

Exposure/Epidemiological Criteria

One or more of the following exposures within the 3 weeks before onset of symptoms:

- Contact with blood or other body fluids of a patient with VHF
- Residence in, or travel to, a VHF endemic area
- Work in a laboratory that handles VHF specimens
- Work in a laboratory that handles bats, rodents, or primates from endemic areas

- Exposure to semen from a confirmed acute or convalescent case of VHF within the 10 weeks of that person's onset of symptoms

Case Classification

Confirmed
A case that meets the clinical and laboratory criteria.

Suspect
A case that meets the clinical and epidemiological linkage (exposure) criteria.

Comment

Viral hemorrhagic fever (VHF) may be due to a variety of etiologies which may have a wide spectrum of clinical presentations. The clinical presentations vary from constitutional symptoms of fever, myalgia, headache to bleeding/hemorrhaging from vascular abnormalities to shock and death. There are four RNA viral families that cause VHF:

- Arenaviridae family (Lassa fever, Argentina HF, Bolivian HF, Venezuelan HF, Brazilian HF);
- Bunyaviridae family (Rift Valley fever, Crimean-Congo HF, Hantavirus, Korean HF);
- Filoviridae (Marburg HF, Ebola HF);
- Flaviviridae (Yellow Fever, Dengue HF, Omsk HF, Kyasanur Forest Disease).

Hemorrhagic cases of dengue, hantavirus, or yellow fever should be reported and counted as those morbidities.

CONTROL MEASURES

Arizona Administrative Code R9-6-394 Viral Hemorrhagic Fever

Case Control Measures

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and implement both droplet precautions and contact precautions for a viral hemorrhagic fever case or suspect case for the duration of the illness.
2. A local health agency shall:
    a. Upon receiving a report under R9-6-202 of a viral hemorrhagic fever case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
    b. Conduct an epidemiologic investigation of each reported viral hemorrhagic fever case or suspect case;
    c. For each viral hemorrhagic fever case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
    d. Ensure that one or more specimens from each viral hemorrhagic fever case or suspect case are submitted to the Arizona State Laboratory.

Contact Control Measures

A local health agency, in consultation with the Department, shall:

1. Quarantine a viral hemorrhagic fever contact as necessary to prevent transmission.

INVESTIGATION FORMS

For Ebola Virus, see Ebola Case Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2011
Most Recent CDC/CSTE Revision Year	2011
ADHS Case Definition Matches CDC/CSTE?	Yes (with additional comments)
Description of changes	N/A

WATERBORNE DISEASE OUTBREAK	PROVIDERS SUBMIT A REPORT WITHIN 24 HOURS

Outbreaks should be reported under the Diarrhea, Nausea, or Vomiting requirement.

CASE DEFINITION

Definition
An incident in which two or more epidemiologically-linked persons experience a similar illness after exposure to the same water source and epidemiologic evidence implicates the water as the likely source of the illness.

Clinical Description
Symptoms of illness depend upon etiologic agent.

Laboratory Criteria for Diagnosis
Dependent upon etiologic agent.

Case classification

Confirmed
Any outbreak of an infectious disease, chemical poisoning or toxin-mediated illness where water is indicated as the source by an epidemiological investigation

Comment
The implicated water in these waterborne disease outbreaks may be drinking water, recreational water, water not intended for drinking (e.g., water used for agricultural purposes or in a cooling tower) or water of unknown intent. The route of exposure may be ingestion, inhalation, intranasal, or contact. The agent associated with the waterborne disease outbreak may be a microbe, chemical, or toxin. Water testing to demonstrate contamination or identify the etiologic agent is preferred, but not required for inclusion. Chemicals (including disinfection byproducts) in drinking water or in recreational water that cause health effects either through water exposure or by volatilization leading to poor air quality are included. Reports of waterborne disease outbreaks received through the National Outbreak Reporting System (NORS) are captured in the Waterborne Disease and Outbreak Surveillance System (WBDOSS).

Although not reported through NORS, the WBDOSS also accepts single cases of chemical exposure, wound infection and other illnesses, (e.g., *Naegleria* infections) that are epidemiologically linked to water exposure as well as aquatic facility-related health events (e.g., chemical mixing accidents or air quality problems). However, these single cases or aquatic facility-related health events are not reported or analyzed as waterborne disease outbreaks.

CONTROL MEASURES
Arizona Administrative Code R9-6-330 Diarrhea, Nausea, or Vomiting

Outbreak Control Measures
A local health agency shall:
1. Conduct an epidemiologic investigation of each reported outbreak of diarrhea, nausea, or vomiting;
2. Submit to the Department the information required under R9-6-206(E); and

3. Exclude each case that is part of an outbreak of diarrhea, nausea, or vomiting from:
    a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
        i. Diarrhea and vomiting have resolved, or
        ii. The local health agency has determined that the case is unlikely to infect other individuals; and
    b. Using an aquatic venue for two weeks after diarrhea has resolved.

Environmental Control Measures

A local health agency shall:

1. Conduct a sanitary inspection or ensure that a sanitary inspection is conducted of each facility or location regulated under 9 A.A.C. 8 that is associated with an outbreak of diarrhea, nausea, or vomiting.

INVESTIGATION FORMS

See Outbreak Summary Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2010
Most Recent CDC/CSTE Revision Year	2010
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

WEST NILE VIRUS	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 5 WORKING DAYS

For case definition, see Arboviral infection in this document.

CONTROL MEASURES

Arizona Administrative Code R9-6-395 West Nile Virus Infection

Case control measures:
A local health agency shall:

1. Conduct an epidemiologic investigation of each reported West Nile virus infection case or suspect case; and
2. For each case of West Nile virus infection, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
3. Ensure that each West Nile virus infection case is provided with health education that includes measures to:
    a. Avoid mosquito bites, and
    b. Reduce mosquito breeding sites.

Environmental control measures:
In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall:

1. conduct an assessment of the environment surrounding each West Nile virus infection case or suspect case and implement vector control measures as necessary.

INVESTIGATION FORMS

See the Arboviral Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

YELLOW FEVER	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 24 HOURS

CASE DEFINITION

Clinical Description

Most yellow fever virus infections are asymptomatic. Following an incubation period of 3–9 days, approximately one-third of infected people develop symptomatic illness characterized by fever and headache. Other clinical findings include chills, vomiting, myalgia, lumbosacral pain, and bradycardia relative to elevated body temperature. An estimated 5%–25% of patients progress to more severe disease, including jaundice, renal insufficiency, cardiovascular instability, or hemorrhage (e.g., epistaxis, hematemesis, melena, hematuria, petechiae, or ecchymoses). The case-fatality rate for severe yellow fever is 30%–60%.

A clinically compatible case of yellow fever is defined as:

- Acute illness with at least one of the following: fever, jaundice, or elevated total bilirubin ≥ 3 mg/dL, AND
- Absence of a more likely clinical explanation.

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence

- Isolation of yellow fever virus from, or demonstration of yellow fever viral antigen or nucleic acid in, tissue, blood, CSF, or other body fluid.
- Four-fold or greater rise or fall in yellow fever virus-specific neutralizing antibody titers in paired sera.
- Yellow fever virus-specific IgM antibodies in CSF or serum with confirmatory virus-specific neutralizing antibodies in the same or a later specimen.

Presumptive Laboratory Evidence

- Yellow fever virus-specific IgM antibodies in CSF or serum, and negative IgM results for other arboviruses endemic to the region where exposure occurred.

Epidemiologic Linkage

Epidemiologically linked to a confirmed yellow fever case, or visited or resided in an area with a risk of yellow fever in the 2 weeks before onset of illness.

Case Classification

Confirmed

A case that meets the above clinical criteria and meets one or more of the following:

- Isolation of yellow fever virus from, or demonstration of yellow fever viral antigen or nucleic acid in, tissue, blood, CSF, or other body fluid, AND no history of yellow fever vaccination within 30 days before onset of illness unless there is molecular evidence of infection with wild-type yellow fever virus.

- Four-fold or greater rise in yellow fever virus-specific neutralizing antibody titers in paired sera, AND no history of yellow fever vaccination within 30 days before onset of illness.
- Yellow fever virus-specific IgM antibodies in CSF or serum with confirmatory virus-specific neutralizing antibodies in the same or a later specimen, AND no history of yellow fever vaccination.

Probable
A case that meets the above clinical and epidemiologic linkage criteria, and meets the following:

- Presumptive laboratory evidence AND no history of yellow fever vaccination.

CONTROL MEASURES

Arizona Administrative Code R9-6-396 Yellow Fever

Case Control Measures
A local health agency shall:

1. Upon receiving a report under R9-6-202 of a yellow fever case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported yellow fever case or suspect case;
3. For each yellow fever case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D);
4. Ensure that each yellow fever case is provided with health education that includes measures to:
    a. Avoid mosquito bites, and
    b. Reduce mosquito breeding sites; and
5. Ensure that an isolate or a specimen, as available, from each yellow fever case or suspect case is submitted to the Arizona State Laboratory.

Environmental Control Measures
In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall

1. Conduct an assessment of the environment surrounding each yellow fever case or suspect case and implement vector control measures as necessary.

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2019
Most Recent CDC/CSTE Revision Year	2019
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2019: Laboratory criteria updated to include newer tests; classifications better reflect the role of vaccination in interpreting test results. Changes based on modifications to CDC/CSTE definition.

YERSINIOSIS (Enteropathogenic *Yersinia*)	PROVIDERS REPORT WITHIN 24 HOURS IF AN OUTBREAK IS DETECTED OR PERSON HAS A HIGH-RISK OCCUPATION PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY FOR ALL OTHER CASES

CASE DEFINITION

Clinical Description
An illness with either diarrhea that may or may not be bloody or abdominal pain that may be severe enough to mimic appendicitis.

Note: Extra-intestinal manifestations may also be present, such as abscess, which could be a source for testing, and reactive arthritis and erythema nodosum, which are often immunologic phenomena not directly caused by the infection. These manifestations are not required as part of the clinical criteria.

Laboratory Criteria for Diagnosis

Confirmatory Laboratory Evidence
Isolation of *Yersinia enterocolitica, Y. pseudotuberculosis, Y. intermedia, Y. fredericksenii, Y. kristensenii,* or *Y. ruckeri* by culture from a clinical specimen.

Presumptive Laboratory Evidence
Detection of any *Yersinia* non-*pestis* species using a PCR culture-independent diagnostic test (CIDT).

Epidemiologic Linkage
A person who has had contact with a case that meets the presumptive or confirmatory laboratory criteria.

Case Classification

Confirmed
A case that meets the confirmatory laboratory evidence.

Probable

- A case that meets presumptive laboratory evidence; OR
- A clinically compatible case that is epidemiologically linked to a case meeting confirmatory or presumptive laboratory evidence.

Criteria to Distinguish a New Case from an Existing Case
A case should not be counted as a new case if additional laboratory results are within 365 days of a previously reported infection in the same individual. When two or more different *Yersinia* non-pestis species are identified in one or more specimens from the same individual, each should be reported as a separate case.

CONTROL MEASURES
Arizona Administrative Code R9-6-397 Yersiniosis (Enteropathogenic *Yersinia*)

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a yersiniosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Exclude a yersiniosis case or suspect case with diarrhea from:
    a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
        i. Diarrhea has resolved,
        ii. A stool specimen negative for enteropathogenic Yersinia is obtained from the case or suspect case, or
        iii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
    b. Using an aquatic venue for two weeks after diarrhea has resolved;
3. Conduct an epidemiologic investigation of each reported yersiniosis case or suspect case;
4. For each yersiniosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
5. Ensure that an isolate or a specimen, as available, from each yersiniosis case is submitted to the Arizona State Laboratory.

INVESTIGATION FORMS

See Yersiniosis Infection Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2020
Most Recent CDC/CSTE Revision Year	2020
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2020: Added specific non-pestis Yersinia species for confirmatory laboratory evidence. 2019: CIDT changed from suspect to probable classification. Changes based on modifications to CDC/CSTE definition, although definition is intended to be used by FoodNet sites and is not posted with other CDC NNDSS case definitions. 2017: Added supportive laboratory criteria and suspect case definition.

ZIKA VIRUS INFECTION	PROVIDERS AND LABORATORIES SUBMIT A REPORT WITHIN 1 WORKING DAY

CASE DEFINITION

Background

Zika virus, a flavivirus in the family Flaviviridae, is an emerging disease primary transmitted through the bites of *Aedes aegypti and Aedes albopictus* mosquitoes. Zika has also been transmitted sexually and from mother-to-child. Transmission through contaminated blood products and organ donation is also possible.

Clinical Description

It is estimated that 80% of individuals infected with Zika virus are asymptomatic. In symptomatic cases, Zika virus can present with acute onset of fever, maculopapular rash, arthralgia, and/or conjunctivitis in addition to myalgia and headache. In congenital cases, Zika virus has been associated with microcephaly, intracranial calcifications, eye abnormalities, hearing loss, and other structural brain or central nervous system abnormalities. Zika virus has also been associated with Guillain-Barré syndrome. Severe illness, hospitalization, and/or death are rare in individuals infected with Zika virus; however, cases have occurred, particularly in immunocompromised patients.

Zika case definitions are categorized as non-congenital/ congenital and disease/infection.

Clinical Criteria for Zika Virus Disease

A clinically compatible case of Zika Virus Disease is defined as follows:

Non-Congenital Disease—A person with one or more of the following not explained by another etiology:

- Clinically compatible illness that includes:
  - Acute onset of fever (measured or reported) **OR**
  - Maculopapular rash **OR**
  - Arthralgia **OR**
  - Conjunctivitis
- Complication or pregnancy
  - Fetal loss **OR**
  - Fetus or neonate with
    - Congenital microcephaly **OR**
    - Congenital intracranial calcifications **OR**
    - Other structural brain or eye abnormalities **OR**
    - Other congenital central nervous system-related abnormalities including defects such as clubfoot or multiple joint contractures
- Guillain-Barré syndrome or other neurologic manifestations

Congenital Disease—Live born infant with one or more of the following not explained by another etiology:

- Congenital microcephaly **OR**
- Intracranial calcifications **OR**
- Structural brain or eye abnormalities **OR**

- Other congenital central nervous system-related

Note: testing for other congenital infections such as syphilis, toxoplasmosis, rubella, cytomegalovirus infection, lymphocytic choriomeningitis infection, and herpes simplex virus infectious should be considered in addition to an assessment of potential genetic and teratogenic causes of congenital anomalies.

Epidemiologic Linkage

- Resides in or recent travel to an area with known local Zika virus transmission **OR**
- Sexual contact with a confirmed or probable case within the infection transmission risk window of Zika virus infection or person with recent travel to an area with known Zika virus transmission **OR**
- Receipt of blood or blood products within 30 days of symptom onset **OR**
- Organ or tissue transplant recipient within 30 days of symptom onset **OR**
- Association in time and place with a confirmed or probable case **OR**
- Likely vector exposure in an area with suitable seasonal and ecological conditions for potential local vector borne transmission

Case Classification: Zika Virus Disease

Confirmed

Non-Congenital Disease
A case that meets the above clinical criteria for non-congenital disease and one or more the following laboratory criteria for a confirmed case:

- Detection of Zika virus by culture, viral antigen or viral RNA in serum, CSF, tissue, or other specimen (e.g. amniotic fluid, urine, semen, saliva) **OR**
- Positive Zika virus IgM antibody test of serum or CSF with positive Zika virus neutralizing antibody titers and negative neutralizing antibody titers against dengue or other flaviviruses endemic to the region where exposure occurred.

Congenital Disease
A case that meets the above clinical criteria for congenital disease and one or more of the following laboratory criteria for a confirmed case:

- Detection of Zika virus by culture, viral antigen or viral RNA in fetal tissue, umbilical cord blood, or amniotic fluid; or neonatal serum, CSF, or urine collected within 2 days of birth **OR**
- Positive Zika virus IgM antibody test of umbilical cord blood, neonatal serum or CSF collected within 2 days of birth **with** positive Zika virus neutralizing antibody titers and negative neutralizing antibody titers against dengue or other flaviviruses endemic to the region where exposure occurred.

Probable

Non-Congenital Disease
A case that meets the above clinical criteria for non-congenital disease **AND** has an epidemiologic linkage **AND** the following laboratory criteria for a probable case:

- Positive Zika virus IgM antibodies in serum or CSF **AND**

- Positive neutralizing antibody titers against Zika virus and dengue or other flaviviruses endemic to the region where exposure occurred **OR** negative dengue virus IgM antibody test and no neutralizing antibody testing performed

Congenital Disease
A case that meets the above clinical criteria for non-congenital disease **AND** the neonate's mother has an epidemiologic linkage **AND** the following laboratory criteria for a probable case:

- Positive Zika virus IgM antibodies in serum or CSF collected within 2 days of birth **AND**
- Positive neutralizing antibody titers against Zika virus and dengue or other flaviviruses endemic to the region where exposure occurred **OR** negative dengue virus IgM antibody test and no neutralizing antibody testing performed

Case Classification: Zika Virus Infection

Confirmed

Non-Congenital Infection
A case that does not meet the above clinical criteria for non-congenital disease **BUT** meets one or more the following laboratory criteria for a confirmed case:

- Detection of Zika virus by culture, viral antigen or viral RNA in serum, CSF, tissue, or other specimen (e.g. amniotic fluid, urine, semen, saliva) **OR**
- Positive Zika virus IgM antibody test of serum or CSF with positive Zika virus neutralizing antibody titers and negative neutralizing antibody titers against dengue or other flaviviruses endemic to the region where exposure occurred.

Congenital Infection
A case that does not meet the above clinical criteria for non-congenital disease **BUT** meets one or more of the following laboratory criteria for a confirmed case:

- Detection of Zika virus by culture, viral antigen or viral RNA in fetal tissue, umbilical cord blood, or amniotic fluid; or neonatal serum, CSF, or urine collected within 2 days of birth **OR**
- Positive Zika virus IgM antibody test of umbilical cord blood, neonatal serum or CSF collected within 2 days of birth **with** positive Zika virus neutralizing antibody titers and negative neutralizing antibody titers against dengue or other flaviviruses endemic to the region where exposure occurred.

Probable

Non-Congenital Infection
A case that does not meet the above clinical criteria for non-congenital disease **BUT** has an epidemiologic linkage **AND** the following laboratory criteria for a probable case:

- Positive Zika virus IgM antibodies in serum or CSF **AND**
- Positive neutralizing antibody titers against Zika virus and dengue or other flaviviruses endemic to the region where exposure occurred **OR** negative dengue virus IgM antibody test and no neutralizing antibody testing performed

Congenital Infection

A case that does not meet the above clinical criteria for non-congenital disease **BUT** the neonate's mother has an epidemiologic linkage **AND** the following laboratory criteria for a probable case:

- Positive Zika virus IgM antibodies in serum or CSF collected within 2 days of birth **AND**
- Positive neutralizing antibody titers against Zika virus and dengue or other flaviviruses endemic to the region where exposure occurred **OR** negative dengue virus IgM antibody test and no neutralizing antibody testing performed

Criteria to Distinguish a New Case from an Existing Case*

A case should not be counted as a new case if laboratory results were reported within 9 months of a previously reported infection in the same individual.

*Based on ADHS guidelines

Comment

Given the similarity of symptoms between Zika, chikungunya & dengue, in addition to the overlap in areas of endemicity between the viruses, simultaneous testing is recommended for all three arboviruses in symptomatic cases. Simultaneous testing can also assist in isolating the specific diagnosis as cross-reactivity of serum antibodies can occur.

Zika virus is a member of the Flaviviridae family and has sufficient antigenic similarity to have some degree of cross-reactivity with IgM antibody to other flaviviruses. Thus, final interpretation of a positive antibody test result must take into account the likelihood that the patient was recently infected with or vaccinated against another flavivirus (e.g., dengue, West Nile, Saint Louis encephalitis, yellow fever, Japanese encephalitis).

CONTROL MEASURES

Arizona Administrative Code R9-6-398 Zika Virus Infection

Case Control Measures

A local health agency shall:

1. Upon receiving a report under R9-6-202 of a Zika virus infection case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported Zika virus infection case or suspect case;
3. For each Zika virus infection case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D);
4. Ensure that one or more specimens from each Zika virus infection case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory; and
5. Provide to the Zika virus infection case or ensure that another person provides to the Zika virus infection case health education that includes measures to:
    a. Avoid mosquito bites,
    b. Reduce mosquito breeding sites, and
    c. Reduce the risk of sexual or congenital transmission of Zika virus.

Environmental Control Measures

In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall

1. Conduct an assessment of the environment surrounding each Zika virus infection case or

suspect case and implement vector control measures as necessary.

INVESTIGATION FORMS

See Zika Case Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	2017
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2017: Zika virus was removed from the list of arboviruses and a separate Zika virus case definition was created.

Case Definitions for Communicable Morbidities of Public Health Significance which are not Reportable in Arizona

ACANTHAMOEBA KERATITIS

CASE DEFINITION

Clinical Description

Acanthamoeba keratitis is a local infection of the cornea (outer layer of the visual pathway of the eye) caused by a microscopic, free-living ameba belonging to the genus *Acanthamoeba*. Symptoms include foreign body sensation, photophobia, decreased visual acuity, tearing, pain, and redness of the eye. It occurs most typically among healthy, contact lens users, but can occur in anyone. Although treatable with topical medications, affected individuals are at risk for permanent visual impairment or blindness. *Acanthamoeba* organisms are ubiquitous in nature and can be found in bodies of water (e.g., lakes and oceans), soil, and air.

Laboratory Criteria for Diagnosis

Laboratory-confirmed *Acanthamoeba* spp. keratitis infections are defined as the detection of *Acanthamoeba* spp.

- Organisms in corneal scraping, or biopsy specimens, OR
- Nucleic acid (e.g., polymerase chain reaction) in corneal scraping, or biopsy specimens, OR
- Antigen (e.g., direct fluorescent antibody) in corneal scraping, or biopsy specimens.

Case Classification

Confirmed

A clinically compatible illness that is laboratory confirmed. When available, species designation and molecular characterization (e.g., genotype) should be documented.

Probable

A clinically compatible illness with positive identification of *Acanthamoeba* trophozoites or cysts using confocal microscopy.

CONTROL MEASURES

A local health agency shall:

1. Conduct an epidemiologic investigation to determine potential sources of infection, in particular ophthalmic medications, solutions or devices.

INVESTIGATION FORMS

Contact ADHS. Depending on the etiology of the encephalitis, an investigation form may or may not be available.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2017
Most Recent CDC/CSTE Revision Year	2012
ADHS Case Definition Matches CDC/CSTE?	Yes

Description of changes	2017: Separated from the list of encephalitis, parasitic since not an encephalitic disease and a separate case definition created

AFRICAN TICK BITE FEVER

CASE DEFINITION

Clinical Description

A tick-borne illness caused by *Rickettsia africae*, a pathogen endemic to several countries in sub-Saharan Africa, and to Guadeloupe in the Caribbean. Clinic disease generally occurs within 1-15 days (median 4 days) following the bite of an infecting tick.

The illness is characterized by acute onset of fever, and is accompanied by single or multiple eschars. Regional lymphadenopathy and a maculopapular rash also occur in about half of all patients.

Laboratory Criteria for Diagnosis

Confirmed

- A four-fold or greater change in IgG antibody titer to spotted fever group rickettsia antigen in paired serum specimens; OR
- Demonstration of spotted fever group rickettsiae in a biopsy specimen by using an immunohistochemical stain; OR
- Detection of DNA of *R. africae* in a clinical specimen by using PCR; OR
- Isolation of *R. africae* from a clinical specimen cell culture

Probable

A single supportive IgG antibody titer to spotted fever group rickettsiae (cutoff titers are determined by individual laboratories)

Case Classification

A clinically compatible illness in a person with travel to an *R. africae*-endemic region within three weeks of illness onset

CONTROL MEASURES

None

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2005 or before
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

ASEPTIC MENINGITIS (VIRAL)

CASE DEFINITION

Clinical Description
A syndrome characterized by acute onset of meningeal symptoms, fever, and cerebrospinal fluid pleocytosis, with bacteriologically sterile cultures.

Laboratory Criteria for Diagnosis
No evidence of bacterial or fungal meningitis & evidence of pleocytosis.

Case Classification

Confirmed
A clinically compatible illness diagnosed by a physician as aseptic meningitis with no laboratory evidence of bacterial or fungal meningitis.

Comment
Aseptic meningitis is a syndrome of multiple etiologies, but many cases are caused by a viral agent.

CONTROL MEASURES
None

INVESTIGATION FORMS
None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2018 (moved to non-reportable)
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	Aseptic meningitis is no longer reportable, as of January 1, 2018.

ENTEROTOXIGENIC *ESCHERICHIA COLI* (ETEC)

CASE DEFINITION

Clinical Description
Diarrhea caused by enterotoxigenic *E. coli* or ETEC is a self-limited illness lasting 1 to 5 days of moderate severity with watery stools and abdominal cramps. Vomiting, dehydration, and low grade fever may also be present.

Laboratory Criteria for Diagnosis
Demonstration of production of enterotoxin in an *E. coli* isolate by a technique that is able to identify heat-labile toxin (LT) and heat-stable toxin (ST).

Case Classification

Confirmed
A clinically compatible case that is laboratory confirmed

Probable
A clinically compatible case that is epidemiologically linked to a probable or confirmed case

CONTROL MEASURES
None

INVESTIGATION FORMS
See Enterohemorrhagic *E. coli* (Shiga-toxin producing) and/or HUS Investigation Form at http://azdhs.gov/preparedness/epidemiology-disease-control/index.php#investigations-forms

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2018 (moved to non-reportable)
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	Enterotoxigenic *E. coli* is no longer reportable, as of January 1, 2018.

GENITAL WARTS

CASE DEFINITION

Clinical Description
An infection characterized by the presence of visible, exophytic (raised) growths on the internal or external genitalia, perineum, or perianal region

Laboratory Criteria for Diagnosis

- Histopathologic changes characteristic of human papillomavirus infection in specimens obtained by biopsy or exfoliative cytology OR
- Demonstration of virus by antigen or nucleic acid detection in a lesion biopsy

Case Classification

Confirmed
A clinically compatible case that is laboratory confirmed

Probable
A clinically compatible case without histopathologic diagnosis and without microscopic or serologic evidence that the growth is the result of secondary syphilis

CONTROL MEASURES
None

INVESTIGATION FORMS
None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2006
Most Recent CDC/CSTE Revision Year	1996
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

GRANULOMA INGUINALE (GI) (*Calymmatobacterium granulomatis*)

CASE DEFINITION

Clinical Description
A slowly progressive ulcerative disease of the skin and lymphatics of the genital and perianal area caused by infection with *Calymmatobacterium granulomatis*. A clinically compatible case would have one or more painless or minimally painful granulomatous lesions in the anogenital area.

Laboratory Criteria for Diagnosis
Demonstration of intracytoplasmic Donovan bodies in Wright or Giemsa-stained smears or biopsies of granulation tissue

Case Classification

Confirmed
A clinically compatible case that is laboratory confirmed.

CONTROL MEASURES
None

INVESTIGATION FORMS
None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2005 or before
Most Recent CDC/CSTE Revision Year	1997
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

HERPES GENITALIS

CASE DEFINITION

Clinical Description
An illness characterized by visible, painful genital or anogenital lesions

Laboratory Criteria for Diagnosis

- Isolation of herpes simplex virus from cervix, urethra, or anogenital lesion, OR
- Demonstration of virus by antigen detection technique in clinical specimens from cervix, urethra, or anogenital lesion, OR
- Demonstration of multinucleated giant cells on a Tzanck smear of scrapings from an anogenital lesions

Case Classification

Confirmed
A clinically compatible case that is laboratory confirmed

Probable
A clinically compatible case (in which primary and secondary syphilis have been ruled out by serology and dark field microscopy, when available) with either a diagnosis of genital herpes based on clinical presentation (without laboratory confirmation) or a history of one or more previous episodes of similar genital lesions.

Comment
Herpes should be reported only once per patient. The first diagnosis for a patient with no previous diagnosis should be reported.

CONTROL MEASURES
None

INVESTIGATION FORMS
None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2018 (moved to non-reportable)
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	Herpes genitalis is no longer reportable, as of January 1, 2018.

INFLUENZA-ASSOCIATED HOSPITALIZATIONS

CASE DEFINITION

Clinical Description
An influenza-associated hospitalization is defined for surveillance purposes as a hospital admission 14 days or less after influenza identification by an appropriate laboratory or rapid diagnostic test or a hospital admission 3 days or less before influenza identification by an appropriate laboratory or rapid diagnostic test.

Laboratory Criteria for Diagnosis
See laboratory criteria for Influenza.

Case Classification

Confirmed
A case that meets clinical case definition that is laboratory confirmed. Laboratory or rapid diagnostic test confirmation is required as part of the case definition; therefore, all reported hospitalizations will be classified as confirmed.

Comment
Influenza is not a required reportable condition by healthcare providers in Arizona, with the exception of influenza-associated pediatric deaths. However, influenza virus is a laboratory-reportable condition in the state. This definition should be used when designating any reported cases of influenza as "hospitalized".

CONTROL MEASURES
None

INVESTIGATION FORMS
None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2012
Most Recent CDC/CSTE Revision Year	2012
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2012: New CDC/CSTE case definition.

KAWASAKI SYNDROME

CASE DEFINITION

Clinical Description
A febrile illness of greater than or equal to 5 days' duration, with at least four of the five following physical findings and no other more reasonable explanation for the observed clinical findings:

- Bilateral conjunctival injection
- Oral changes (erythema of lips or oropharynx, strawberry tongue, or fissuring of the lips)
- Peripheral extremity changes (edema, erythema, or generalized or periungual desquamation)
- Rash
- Cervical lymphadenopathy (at least one lymph node greater than or equal to 1.5 cm in diameter)

Laboratory Criteria for Diagnosis
None

Case Classification

Confirmed
A case that meets the clinical case definition

Comment
If fever disappears after intravenous gamma globulin therapy is started, fever may be of less than 5 days' duration, and the clinical case definition may still be met.

CONTROL MEASURES
None

INVESTIGATION FORMS
None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2018 (moved to non-reportable)
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	Kawasaki disease is no longer reportable, as of January 1, 2018.

LATENT TUBERCULOSIS INFECTION	**IF THE CASE IS LESS THAN 6 YEARS OLD**: PROVIDERS SUBMIT A REPORT WITHIN 1 WORKING DAY. Not reportable in other age groups.

CASE DEFINITION

Clinical Criteria
Clinical criteria alone are not sufficient to classify a case of TB infection. Clinical criteria to confirm a suspected case of TB infection are as follows:

No clinical evidence compatible with TB disease including:

- No signs or symptoms consistent with TB disease AND
  - Chest imaging without abnormalities consistent with TB (chest radiograph or CT scan) OR
  - Abnormal chest imaging that could be consistent with TB disease with microbiologic testing that is negative for MTB complex AND where TB disease has been clinically ruled out

Laboratory Criteria
Laboratory/diagnostic criteria alone are not sufficient to confirm a case of TB infection. Laboratory criteria to identify suspected cases of TB infection are as follows:

- A positive tuberculin skin test (TST) OR
- A positive interferon gamma release assay (IGRA)

Case Classification

Confirmed
A case that meets one of the laboratory criteria for TB infection AND
M. tuberculosis complex was not isolated from a clinical specimen, if a specimen was collected AND
Meets the clinical criteria for TB Infection as listed above.

Suspect
A case that meets one or more of the laboratory criteria AND
M. tuberculosis complex was not isolated from a clinical specimen, if a specimen was collected.

Criteria to Distinguish a New Case from an Existing Case
A new case is an incident TB Infection case that meets the suspected or confirmed case criteria and has not previously been diagnosed or treated for TB infection OR previously treated for TB disease.

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2018
Most Recent CDC/CSTE Revision Year	2018
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	2018: New CDC/CSTE case definition.

MUCOPURULENT CERVICITIS (MPC)

CASE DEFINITION

Clinical Description
Cervical inflammation that is not the result of infection with *Neisseria gonorrhoeae* or *Trichomonas vaginalis*. Cervical inflammation is defined by the presence of one of the following criteria:

- Mucopurulent secretion (from the endocervix) that is yellow or green when viewed on a white, cotton-tipped swab (positive swab test)
- Induced endocervical bleeding (bleeding when the first swab is placed in the endocervix)

Laboratory Criteria for Diagnosis
No evidence of *N. gonorrhoeae* by culture, Gram stain, or antigen or nucleic acid detection, and no evidence of *T. vaginalis* on wet mount

Case Classification

Confirmed
A clinically compatible case in a female who does not have either gonorrhea or trichomoniasis

Comment
Mucopurulent cervicitis (MPC) is a clinical diagnosis of exclusion. The syndrome may result from infection with any of several agents. If gonorrhea, trichomoniasis, and chlamydia are excluded, a clinically compatible illness should be classified as MPC. An illness in a female that meets the case definition of MPC and *C. trachomatis* infection (see Chlamydia trachomatis Infection) should be classified as chlamydia.

CONTROL MEASURES
None

INVESTIGATION FORMS
None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2005 or before
Most Recent CDC/CSTE Revision Year	1996
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

NONGONOCOCCAL URETHRITIS (NGU)

CASE DEFINITION

Clinical Description
Urethral inflammation that is not the result of infection with *Neisseria gonorrhoeae*. Urethral inflammation may be diagnosed by the presence of one of the following criteria:

- A visible abnormal urethral discharge, OR
- A positive leukocyte esterase test from a male aged less than 60 years who does not have a history of kidney disease or bladder infection, prostate enlargement, urogenital anatomic anomaly, or recent urinary tract instrumentation, OR
- Microscopic evidence of urethritis (greater than or equal to 5 white blood cells per high-power field) on a Gram stain of a urethral smear

Laboratory Criteria for Diagnosis
No evidence of *N. gonorrhoeae* infection by culture, Gram stain, or antigen or nucleic acid detection

Case Classification

Confirmed
A clinically compatible case in a male in whom gonorrhea is not found, either by culture, Gram stain, or antigen or nucleic acid detection

Comment
Nongonococcal urethritis (NGU) is a clinical diagnosis of exclusion. The syndrome may result from infection with any of several agents. If gonorrhea and chlamydia are excluded, a clinically compatible illness should be classified as NGU. An illness in a male that meets the case definition of NGU and C. trachomatis infection (see Chlamydia trachomatis Infection) should be classified as chlamydia.

CONTROL MEASURES
None

INVESTIGATION FORMS
None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2005 or before
Most Recent CDC/CSTE Revision Year	1996
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

PEDICULOSIS

CASE DEFINITION

Clinical Description
Infestation of the hairy parts of the body with adult or larval lice or their eggs.

Criteria for Diagnosis
Recovery of crawling lice, or eggs (nits) on hair within 1/2 inch of scalp for head lice.

CONTROL MEASURES
Arizona Administrative Code R9-6-362 Pediculosis (Lice Infestation)

Case control measures:
1. An administrator of a school or child care establishment, either personally or through a representative, shall exclude a pediculosis case from the school or child care establishment until the case is treated with a pediculicide.
2. An administrator of a shelter shall ensure that a pediculosis case is treated with a pediculicide and that the case's clothing and personal articles are disinfested.

Contact control measures:
An administrator of a school or child care establishment that excludes a pediculosis case from the school or child care establishment, either personally or through a representative:
1. Shall ensure that a parent or guardian of a child who is a contact is notified that a pediculosis case was identified at the school or child care establishment.

INVESTIGATION FORMS
None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2005 or before
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	N/A

PELVIC INFLAMMATORY DISEASE (PID)

CASE DEFINITION

Clinical Description

A clinical syndrome resulting from the ascending spread of microorganisms from the vagina and endocervix to the endometrium, fallopian tubes, and/or contiguous structures. In a female who has lower abdominal pain and who has not been diagnosed as having an established cause other than pelvic inflammatory disease (PID) (e.g., ectopic pregnancy, acute appendicitis, and functional pain), all the following clinical criteria must be present:

- Lower abdominal tenderness, AND
- Tenderness with motion of the cervix, AND
- Adnexal tenderness

In addition to the preceding criteria, at least one of the following findings must also be present:

- Meets the surveillance case definition of C. trachomatis infection or gonorrhea
- Temperature greater than 100.4°F (greater than 38.0°C)
- Leukocytosis greater than 10,000 white blood cells/mm3
- Purulent material in the peritoneal cavity obtained by culdocentesis or laparoscopy
- Pelvic abscess or inflammatory complex detected by bimanual examination or by sonography
- Patient is a sexual contact of a person known to have gonorrhea, chlamydia, or nongonococcal urethritis

Case Classification

Confirmed

A case that meets the clinical case definition

Comment

For reporting purposes, a clinician's report of PID should be counted as a case.

CONTROL MEASURES

None

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2005 or before
Most Recent CDC/CSTE Revision Year	1996
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	N/A

RESPIRATORY SYNCYTIAL VIRUS (RSV)-ASSOCIATED MORTALITY

CASE DEFINITION

Clinical Description

A respiratory syncytial virus (RSV)-associated death is defined for surveillance purposes as a death resulting from a clinically compatible illness that was confirmed to be RSV by an appropriate laboratory or rapid diagnostic test. There should be no period of complete recovery between the illness and death.

A death should not be categorized as an RSV-associated death if:

1. There is no laboratory confirmation of RSV infection.
2. The RSV illness is followed by full recovery to baseline health status prior to death.
3. After review and consultation, it is determined that RSV infection did not contribute to death.

Laboratory Criteria for Diagnosis

Confirmatory laboratory evidence: Laboratory testing for RSV infection may be done on pre- or post-mortem clinical specimens, and include identification of RSV (A, B, or unspecified) infection by a positive result by at least one of the following:

a. Isolation of RSV by tissue cell culture
b. Detection of RSV nucleic acid by reverse-transcriptase polymerase chain reaction (RT-PCR) testing
c. Detection of RSV antigen by immunofluorescent antibody staining (direct or indirect)
d. Detection of RSV antigens by immunochromatographic or similar rapid diagnostic testing
e. Detection of RSV antigens from autopsy specimens by immunohistochemical (IHC) staining

Case Classifications

Confirmed: A death meeting the clinical and laboratory criteria.

CONTROL MEASURES

None

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2019
Most Recent CDC/CSTE Revision Year	2019
ADHS Case Definition Matches CDC/CSTE?	Yes
Description of changes	New for 2019. CSTE approved a new case definition, although the condition is not nationally notifiable.

REYE SYNDROME

CASE DEFINITION

Clinical Description
An illness that meets all of the following criteria:

- Acute, noninflammatory encephalopathy that is documented clinically by:
  - An alteration in consciousness and, if available, a record of the CSF containing ≤8 leukocytes/mm^3, or
  - A histologic specimen demonstrating cerebral edema without perivascular or meningeal inflammation, AND
- Hepatopathy documented by either:
  - A liver biopsy or an autopsy considered to be diagnostic of Reye syndrome or
  - A threefold or greater increase in the levels of the serum glutamic- oxaloacetic transaminase (SGOT), serum glutamic-pyruvic transaminase (SGPT), or serum ammonia, AND
- No more reasonable explanation for the cerebral and hepatic abnormalities.

Laboratory Criteria for Diagnosis
None

Case Classification

Confirmed
A case that meets the clinical case definition

CONTROL MEASURES
None

INVESTIGATION FORMS
None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2018 (moved to non-reportable)
Most Recent CDC/CSTE Revision Year	1990
ADHS Case Definition Matches CDC/CSTE?	No longer nationally notifiable, but matches CDC/CSTE 1990 case definition.
Description of changes	Reye syndrome is no longer reportable, as of January 1, 2018.

UNEXPLAINED DEATH WITH HISTORY OF FEVER

CASE DEFINITION

Deaths meeting any of the following criteria:

- Hospital or facility or patient-reported death with no known cause AND with a history of fever (>38.0°C) OR a temperature of <36°C within 48 hours of death.

CONTROL MEASURES

None

INVESTIGATION FORMS

None

CASE DEFINITION SUMMARY

Most Recent ADHS Revision Year	2018
Most Recent CDC/CSTE Revision Year	N/A
ADHS Case Definition Matches CDC/CSTE?	N/A
Description of changes	2018: Rules no longer include reporting or investigation of unexplained deaths with a history of fever. 2013: The case definition was changed to be more specific. Subjective criteria such as unmeasured fever or unattended deaths were removed. Clinical suspicion of an infectious disease was also removed as these cases should be reported under the suspected disease or should meet the criteria for unexplained deaths.

Appendix 1: Specimen types and guidelines for determining "sterile" and "non-sterile" sites

The following section is used by ADHS to determine if a site is considered sterile or non-sterile. This list is to be used as guidance and not set policy as it may not cover all situations. In some situations, it may be important to find out more information from the laboratory or provider when determining whether a site is considered sterile.

If you have questions about whether a specimen is considered sterile or not, please contact ADHS at 602-364-3676.

Specimen Type	Sterile	Non-Sterile	Comments/Notes
Abdominal fluid	✓		
Abscess, unspecified		✓	If collected in operating room still considered as non-sterile
Abscess - Closed *	✓		An abscess that does not communicate with the skin and collected from the operating room is considered as sterile
Amniotic fluid *	✓		
Anus		✓	
Eye aqueous fluid	✓		
Ascitic Fluid (=abdominal fluid)	✓		
Aspirate (needle)	✓		
Aspirate (lung or tracheal)		✓	
Aspirate (unspecified)			**If meningococcal, listeria, or *H. influenzae*, call to find out specific site**. If MRSA, *S. pneumo*, Group A or B Streptococcus, consider non-sterile.
Bile fluid	✓		
Biopsies from certain sites	✓		Example: Biopsies of the breast or internal organs. If uncertain see Epi Manager.
Blood (arterial, capillary, cord, venous, peripheral)*	✓		
Body Fluid	see note below		**If meningococcal, listeria, or *H. influenzae*, call to find out specific site.** If MRSA, *S. pneumo*, Group A or B Streptococcus, consider non-sterile.
Bone (including bone fragment)	✓		
Bone marrow*	✓		
Brain	✓		

Specimen Type	Sterile	Non-Sterile	Comments/Notes
Bronchial		✓	May be listed as "bronchial wash", "bronchialalveolar lavage", or "BAL"
Bursa	✓		
Cannula		✓	
Cardiac muscle	✓		
Catheter tip		✓	
Cerebral spinal fluid (CSF)*	✓		May be listed as “meninges”, “dura” or “dura mater”, “brain abscess”, “epidural abscess”
Cervical fluid		✓	
Cervix		✓	
Cysts from certain sites	✓		Example: Thyroid cysts, ovarian cysts, subcutaneous cysts, cysts of any internal organ. If uncertain see Epi Manager.
Colostrum		✓	
Conjunctiva		✓	
Cord blood	✓		
Cornea		✓	
Cyst, unspecified		✓	
Cystic fibrosis		✓	Cystic fibrosis is not a specimen site, but may reflect lung aspirate if listed.
Cystocentesis	✓		
Duodenal fluid	✓		
Ear		✓	
Endocardium	✓		
Endometrium		✓	
Endotracheal		✓	
Eye Swab		✓	
Fecal or feces		✓	
Fistula			**Need to find out location.** Call lab and/or provider if location is available. See HAI Program Manager once location is known.
Gastric fluid/contents		✓	
Genital (genital fluid, lochia, mucus, cervix, vaginal)		✓	
Hair		✓	
Intubation tube		✓	
Joint fluid (synovial fluid, arthrocentesis) *	✓		
Kidney tissue	✓		
Knee fluid	✓		

Specimen Type	Sterile	Non-Sterile	Comments/Notes
Liver	✓		
Lower respiratory tract *		✓	
Lymph *	✓		
Macrophages	✓		
Marrow (bone)	✓		
Meconium		✓	
Menstrual blood		✓	
Milk or Breast Milk		✓	
Nail		✓	
Nose / Nasopharynx		✓	
Ocular fluid	✓		
Operating Room (specimen collected in operating room)			If specimen from a non-sterile body site (e.g. nasopharynx, skin) then considered as non-sterile. If tissue collected in operating room, then as considered sterile.
Ovary	✓		
Pancreatic fluid	✓		
Paracentesis fluid	✓		
Pelvic fluid		✓	
Penis		✓	
Pericardial fluid *	✓		
Peritoneal dialysis fluid		✓	
Peritoneal fluid /ascites*	✓		
PICC line	✓		
Placenta		✓	
Plasma	✓		
Plasma bag	✓		
Platelets	✓		
Pluera	✓		
Pleural fluid (thoracentesis)*	✓		
Pus		✓	
Saliva		✓	
Seminal fluid		✓	
Serum	✓		
Skeletal muscle	✓		
Skin		✓	
Spleen tissue	✓		
Sputum		✓	
Stool		✓	

Specimen Type	Sterile	Non-Sterile	Comments/Notes
Surgical wound/ Surgical site culture		✓	Considered as non-sterile as it does not indicate if a specimen was collected in the operating room or after surgery
Swab (unspecified)			**If meningococcal, listeria, or *H. influenzae*, call to find out specific site.** If MRSA, *S. pneumo*, Group A or B Streptococcus, consider non-sterile.
Sweat		✓	
Synovial fluid (joint fluid, arthrocentesis)*	✓		
Tears		✓	
Throat		✓	
Thrombocytes (platelet)	✓		
Tissue gall bladder	✓		
Tissue, hallux		✓	
Tissue, large intestine	✓		
Tissue, lung	✓		
Tissue, placenta	✓		
Tissue, small intestine	✓		
Tissue, spinal	✓		
Tissue, ulcer	✓		
Tissue (if type of tissue is specified then refer to the specific site to determine if sterile or non-sterile)			**If meningococcal, listeria, or *H. influenzae*, call to find out specific site.** If MRSA, *S. pneumo*, Group A or B Streptococcus, consider non-sterile. Considered sterile if collected in operating room.
Trachea (such as biopsy, tissue specimen)	✓		
Tracheal aspirate		✓	
Urethra		✓	Cystocentesis is considered sterile
Urine (urine catheter, urine clean catch, urine sediment)		✓	
Vagina		✓	
Vitreous fluid	✓		
Vomitus		✓	
Whole Blood	✓		
Wound (wound abscess, wound drainage, wound exudate)		✓	

Notes (see next page):

1. *Defined as a "normally sterile site" in the Arizona Administrative Code, R9-06-201. (http://apps.azsos.gov/public_services/Title_09/9-06.pdf)
2. **"Body Fluid" or "Sterile Body Fluid"**
    a. Specimens reported as "sterile body fluid" may or may not be from normally sterile sites. "Sterile" may refer to the method of collection.
    b. If meningococcal, listeria, or H. influenzae, call to find out specific site. If MRSA, S. pneumo, Group A or B Streptococcus, consider non-sterile.
3. "Normally sterile site" means an anatomic location, or tissue or body fluid from an anatomic location, in which microorganisms are not found in the absence of disease.
4. This document is used by ADHS to determine if a site is sterile or non-sterile.This list is to be used as guidance and not set policy as it may not cover all situations.In some situations, it may be important to find out more information from the laboratory or provider.If you have questions about whether a specimen is considered sterile or not, please contact ADHS at 602-364-3676 or surveillance@azdhs.gov.

Appendix 2: Bacteria in the Enterobacteriaceae family

The most commonly encountered carbapenem-resistant Enterobacteriaceae are in the following genera:

Citrobacter spp.
Enterobacter spp.
Escherichia coli
Klebsiella spp.
Proteus spp.
Providencia spp.
Morganella spp.
Raoultella spp.
Serratia spp.

However, there are many genera in the Enterobacteriaceae family, including:

Alishewanella
Alterococcus
Aquamonas
Aranicola
Arsenophonus
Azotivirga
Blochmannia
Brenneria
Buchnera
Budvicia
Buttiauxella
Cedecea
Cosenzaea
Cronobacter
Dickeya
Edwardsiella
Enterobacillus
Erwinia
Ewingella
Franconibacter
Gibbsiella
Grimonetella
Hafnia
Izhakiella
Kosakonia
Kluyvera
Leclercia
Lelliottia
Leminorella
Levinea
Lonsdalea
Mangrovibacter
Moellerella
Obesumbacterium
Pantoea
Pectobacterium
Phlomobacter
Phaseolibacter
Photorhabdus
Phytobacter
Plesiomonas
Pluralibacter
Poodoomaamaana
Pragia
Pseudocitrobacter
Rahnella
Raoultella
Rosenbergiella
Rouxiella
Saccharobacter
Salmonella
Samsonia
Shigella
Shimwellia
Siccibacter
Sodalis
Tatumella
Thorsellia
Trabulsiella
Wigglesworthia
Xenorhabdus
Yersinia
Yokenella

Compiled from https://www.doh.wa.gov/Portals/1/Documents/5100/420-097-Guideline-CRE.pdf and https://en.wikipedia.org/wiki/Enterobacteriaceae

User's Manual

STD Control Program
Arizona Department of Health Services

GETTING STARTED

OVERVIEW

PRISM is a web-based, person-based, surveillance system capable of storing surveillance and investigation reports for sexually transmitted diseases. In 2006, the Patient Reporting Investigation Surveillance Manager (PRISM) application was developed in the state of Florida by the company Advanced Systems Design (ASD).

In 2013, PRISM replaced the STD*MIS system available from the Centers for Disease Control and Prevention (CDC) for the state of Arizona. PRISM is also used by several other states for STD surveillance and investigation.

PRISM can store basic surveillance information such as client demographics, labs, symptoms and treatment data as well as investigation data such as contact attempts, co-infections, risk information, partner linkages and other useful data that allows for contact tracing and outbreak detection. Each week the system generates a report of confirmed cases to send to the CDC.

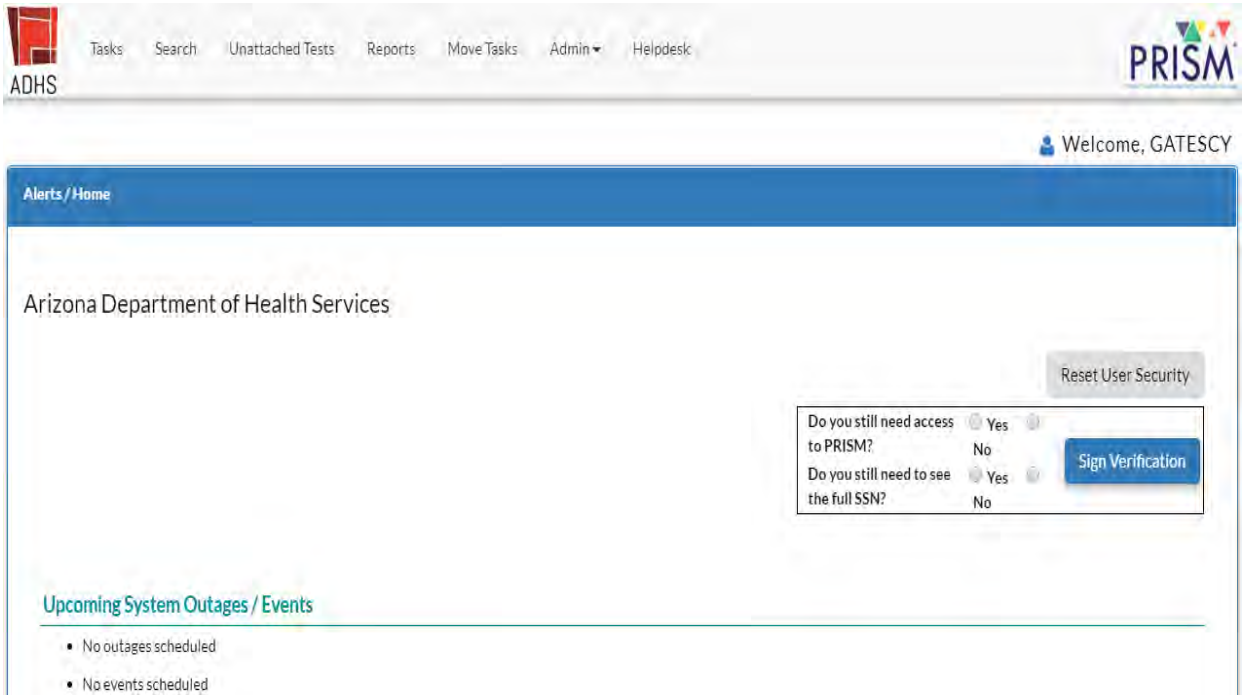
PRISM supports surveillance for multiple diseases. However, in Arizona, PRISM is only used for chlamydia, gonorrhea, syphilis, and some HIV Partner Services reporting.

Table of Contents

PRISM HOMEPAGE & ALERTS

PRISM can be navigated by using the tabs located at the top and bottom of your screen. Tabs appear based on the user's level of security. By default, when a user logs in to PRISM, the homepage is displayed. The homepage can be accessed from any page by clicking the ADHS logo on the top left or the PRISM logo on the top right. The PRISM homepage displays any upcoming system outages and/or events.

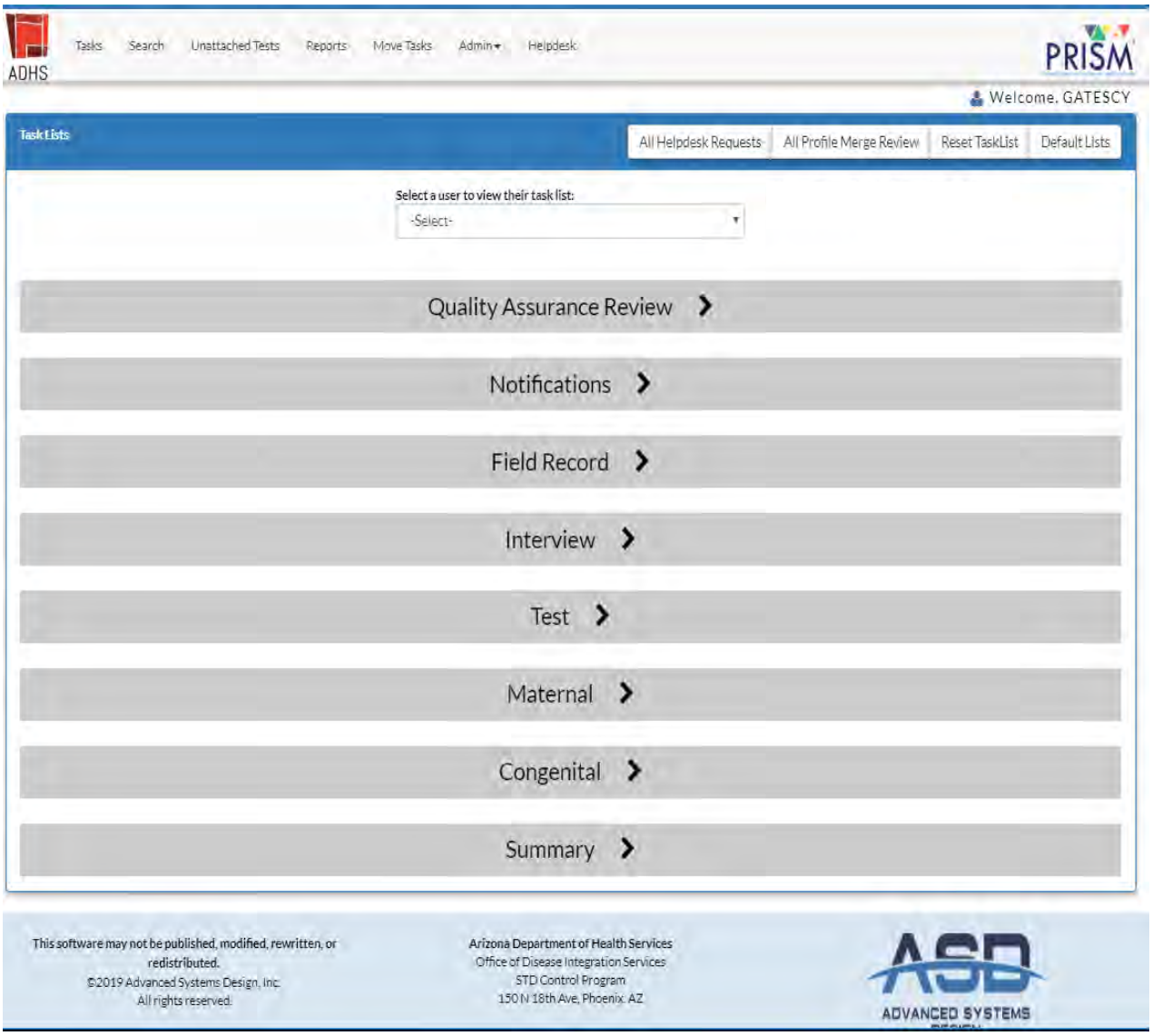
The questions asking "Do you still need access to PRISM?" and "Do you still need to see the full SSN?" can be ignored.



PRISM TASKLIST

A user's current list of tasks can be found by clicking on **Tasks** at the top of any page. The **Task List** displays all tasks that are assigned to a user as well as notifications created by a user.

The Task List is divided into the following sections: Quality Assurance Review, Notifications, Field Record, Interview, Test, Maternal, Congenital, Summary and Electronic Test. **The sections will only show if you have open records assigned to you of that type**. For example, if you do not have any open field records assigned to you, you will not see the Field Record section in your Task List. You must click the black arrow (>) in order to expand and view the records (see next page).



Newly Received in the last 2 days | Coming Due in 2 days | Due/Overdue - Total of 5 days

Quality Assurance Review

Area	Assigned	Reviewer	Type	Record Link	Name	Disease	Date Due	Date Closed	V
01	MHearn	MPearl	FieldRecord	91477	TESTPATIENT, MEGHAN	300	12/05/2015		

Due/Overdue

Notifications

Area	Requestor	Assigned	Requested Date	Record Link	Notification ID	Name	Type	Request	Date Due	Closed Assigned	Closed Requestor	Note
01	MPearl	MPearl	10/26/2015	648151	219839	TESTPATIENT, MARCIA	Linkage To Care Tracking	Linkage To Care Tracking	09/06/2015	10/27/2015		
01	MPearl	JMalasky	11/07/2015	648151	219844	TESTPATIENT, MARCIA	Linkage To Care Tracking	Linkage To Care Tracking	11/06/2015			

Newly Received in the last 2 days | Coming Due in 5 days | Due/Overdue - Total of 15 days

Field Record

Area	ST	Profile ID	Field Record ID	Name	Profile County	Profile Zip	Disease	Ordering Provider	Disposition	Status	PG	Age	Date Due	V
03	MD	648150	537638	TESTPATIENT, LAUREN	Baltimore	21204	900 (T2)	LHD - Baltimore - Drumcastle - STD				36 Year(s)	11/10/2015	X
01	MD	648151	537636	TESTPATIENT, MARCIA	Baltimore City	21202	054 (T2)	LHD - Baltimore City - Druid - STD				57 Year(s)	11/10/2015	X
01	MD	648151	537637	TESTPATIENT, MARCIA	Baltimore City	21202	900 (T1)	LHD - Baltimore City - Druid - STD			N	57 Year(s)	11/10/2015	X
01	MD	648149	537634	TESTPATIENT, SANDRA	Baltimore City	21202	900 (T1)	LHD - Baltimore City - Eastern - STD				31 Year(s)	11/10/2015	X

Newly Received in the last 2 days | Coming Due in 7 days | Due/Overdue - Total of 48 days

Interview

Area	Profile ID	Name	Interview Type	Date Initiated	Preg.	Age	Date Due	V
03	648150	TESTPATIENT, LAUREN	Original (700,900)	10/26/2015		36 Year(s)	12/13/2015	X
01	648151	TESTPATIENT, MARCIA	Original (054,900)	10/27/2015	N	57 Year(s)	12/14/2015	X
01	648149	TESTPATIENT, SANDRA	Original (900)	11/07/2015		31 Year(s)	12/25/2015	X

Newly Received in the last 2 days | Coming Due in 2 days | Due/Overdue - Total of 4 days

Test

Area	Date Initiated	Field Record ID	Accession ID	Name	Disease Category	Ordering Provider	Test	Quan.	Preg.	Age	V
01	12/28/2015	537637		TESTPATIENT, MARCIA	HIV	LHD - Baltimore City - Druid - STD	W/B			57 Year(s)	

Newly Received in the last 2 days | Coming Due in 21 days | Due/Overdue

Maternal

Area	ProfileID	Name	Age	Est. Delivery Date (Date Due)	V
01	648103	TESTPATIENT, MATERNAL	31 Year(s)	03/28/2015	

Newly Received in the last 2 days | Coming Due in 3 days | Due/Overdue - Total of 8 days

Congenital

Area	ProfileID	Date Initiated	Name	Age	Date Due	V
01	648114	04/10/2015	TESTPATIENT, CONGENITAL	8 Month(s)	04/18/2015	

Summary

Area / User	Notification	Notification Overdue	Field Record	Field Record Overdue	Interview	Interview Overdue	Test	Test Overdue	Maternal	Maternal Overdue	Congenital	Congenital Overdue	QA Review	QA Review Overdue
01	34	34	389	389	204	197	26	26	8	6	2	2	7	7
02	1	1	27	27	4	4	0	0	0	0	0	0	0	0
03	4	4	122	121	56	55	2	2	0	0	0	0	2	1

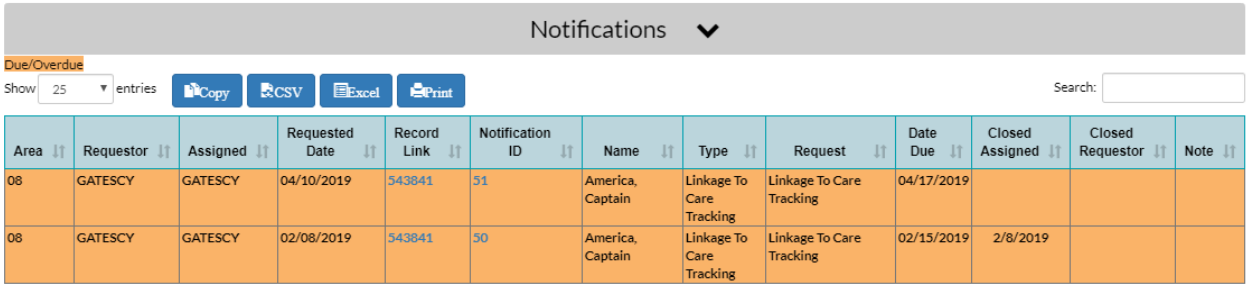
Quality Assurance Review	Field records that are sent for Quality Assurance review. These stay on the Reviewer's task list until closed. When they are re-opened, they will show on the Assignee's task list as well.


Newly Received in the last 2 days Coming Due in 2 days Due/Overdue - Total of 5 days

Quality Assurance Review

Area	Assigned	Reviewer	Type	Record Link	Name	Disease	Date Due	Date Closed
01	MHearn	MPearl	FieldRecord	91477	TESTPATIENT, MEGHAN	300	12/05/2015	

Notifications	Requests that are submitted to the Help Desk and remain there until both the requestor and assignee have closed the request. Help Desk requests include, but are not limited to, deleting records or notes, PRISM issues, out of state record search requests, merging profiles, re-opening records, reassigning records, and unlinking partners. Notifications are also created when a user creates a Linkage to Care record. When someone leaves a comment on a notification record, the Note column will update with a letter 'A'.

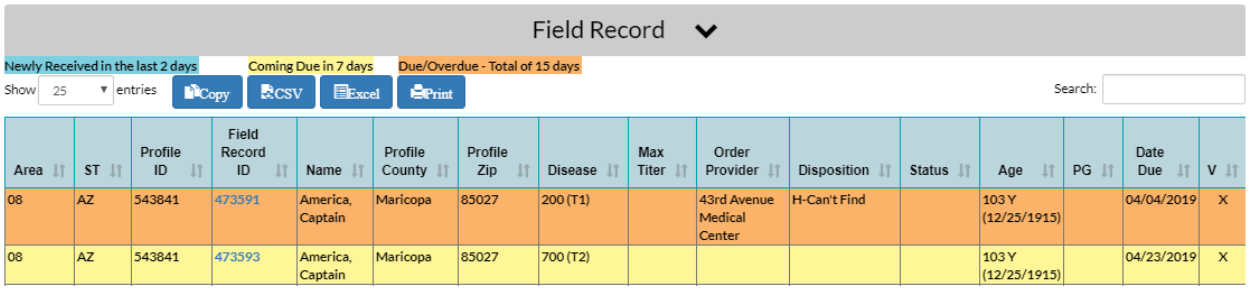

Notifications

Due/Overdue

Show 25 entries Copy CSV Excel Print Search:

Area	Requestor	Assigned	Requested Date	Record Link	Notification ID	Name	Type	Request	Date Due	Closed Assigned	Closed Requestor	Note
08	GATESCY	GATESCY	04/10/2019	543841	51	America, Captain	Linkage To Care Tracking	Linkage To Care Tracking	04/17/2019			
08	GATESCY	GATESCY	02/08/2019	543841	50	America, Captain	Linkage To Care Tracking	Linkage To Care Tracking	02/15/2019	2/8/2019		

Field Record	Field records that are assigned to a user. The Field Record section includes Area, State, Profile ID, Field Record ID, Name, Disease, Profile County, Ordering Provider, Disposition, Status, Pregnancy, Age, Date Due, and whether the record was viewed by the user.

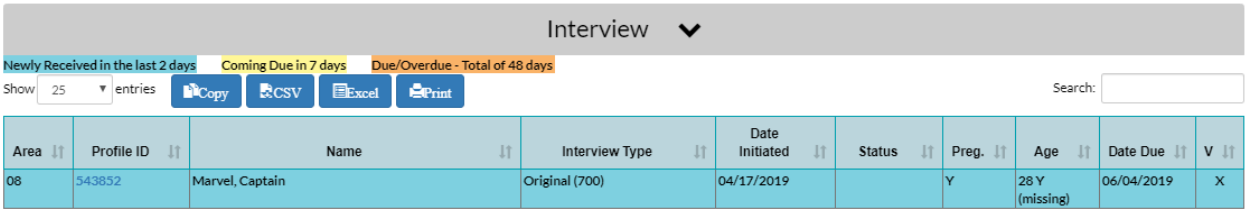

Field Record

Newly Received in the last 2 days Coming Due in 7 days Due/Overdue - Total of 15 days

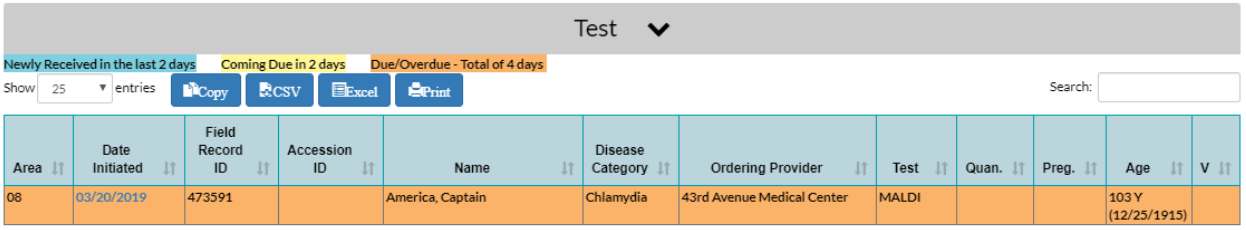
Show 25 entries Copy CSV Excel Print Search:

Area	ST	Profile ID	Field Record ID	Name	Profile County	Profile Zip	Disease	Max Titer	Order Provider	Disposition	Status	Age	PG	Date Due	V
08	AZ	543841	473591	America, Captain	Maricopa	85027	200 (T1)		43rd Avenue Medical Center	H-Can't Find		103 Y (12/25/1915)		04/04/2019	X
08	AZ	543841	473593	America, Captain	Maricopa	85027	700 (T2)					103 Y (12/25/1915)		04/23/2019	X

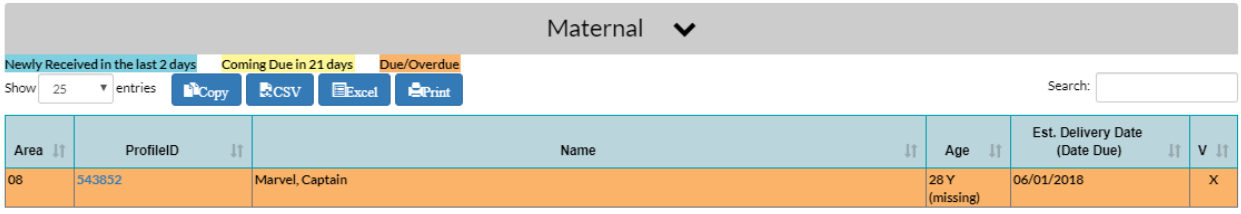
Interview	Interview records that are assigned to a user. The Interview section includes Area, Profile ID, Name, Interview Type, Date Initiated, Pregnancy Status, Age, Date Due, and whether the record was viewed by the user.



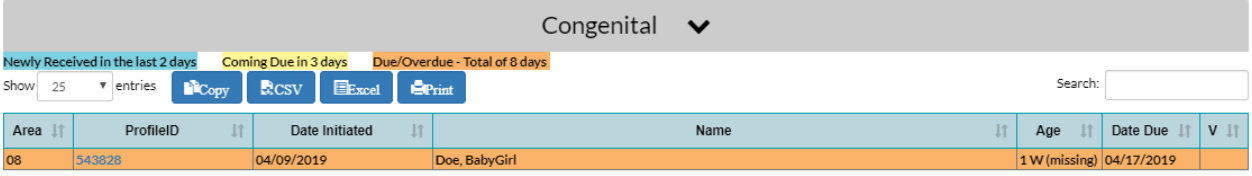
Test	Tests (electronic or manual) that are not marked as task completed by the user. The Test section includes Area, Date Initiated, Field Record ID, Accession ID, Name, Disease Category, Ordering Provider, Test, Quantitative Result, Pregnancy Status, Age, and whether the record was viewed by the user.



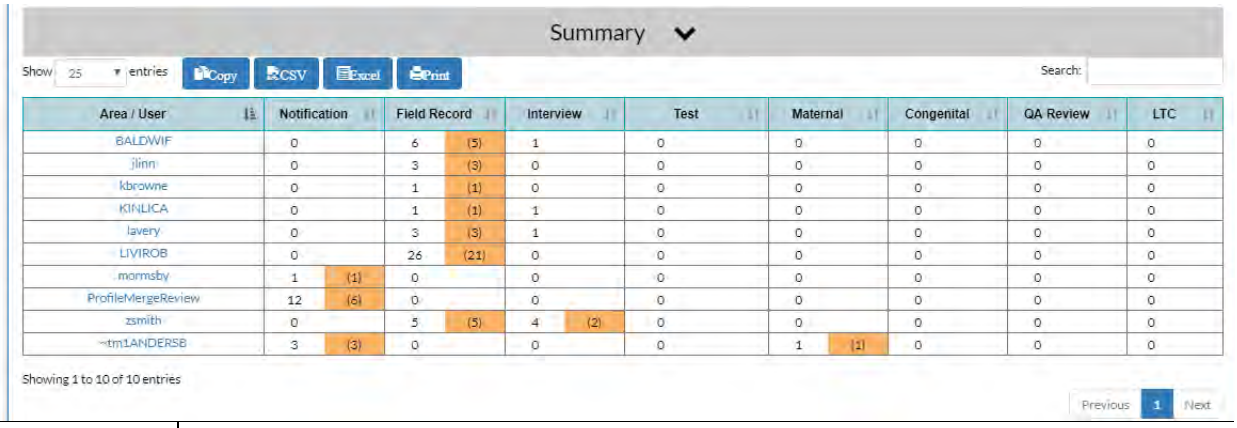
Maternal	Due or overdue maternal records that are assigned to a user. Each state specifies the number of days before the estimated due date that a maternal record begins showing up. The default is 31 days, but some states have changed this to be 90 days to reflect the last trimester of pregnancy. Therefore, there may be maternal records assigned to the user that are not displayed in this section. The maternal section includes Area, Profile ID, Name, Age, Estimated Delivery Date (Date Record Due), and whether the record was viewed by the user.



Congenital	All congenital records that are assigned to a user. The congenital record section includes Area, Profile ID, Date initiated, Name, Age, Date Due and whether the record was viewed by the user.



Summary	Summary is the total number of all records that are open for each Area and or user. The Area Manager is able to view each user he or she supervises and the number of records still open. The Summary also includes a column for records that are overdue.



Electronic Test	All unprocessed positive electronic lab tests that are marked for loading into the task list.

VISUALLY TRACKING AND SORTING TASKS ON THE TASKS LIST

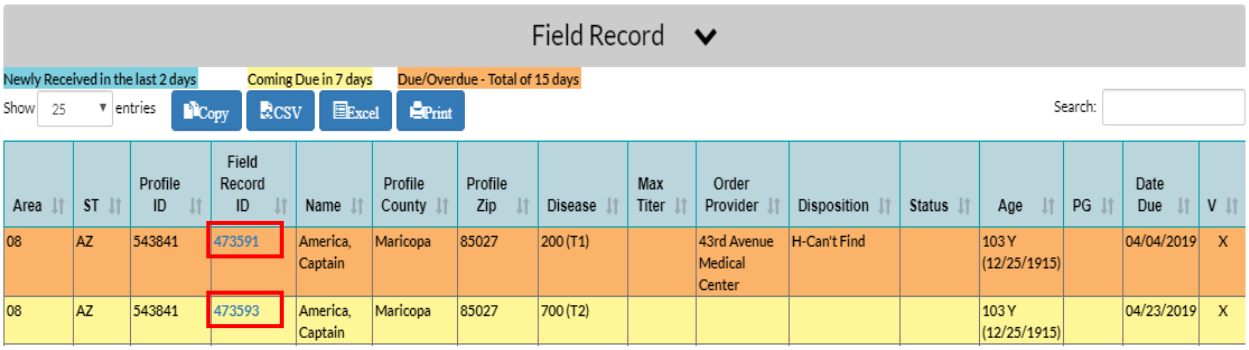
To aid in keeping track of tasks and their due dates, the task are highlighted in different colors depending on the record type and the time it should be completed. Color indicators notify the user when a task is

Newly Received in the last 2 days, **Coming Due**, or **Due/Overdue**.

Users can sort by clicking any heading within each section to help organize the task list based on the user's preference.

ACCESSING A RECORD FROM THE TASK LIST

Each task has a BLUE Record ID number hyperlink that opens that particular record for the user to view.



Area	ST	Profile ID	Field Record ID	Name	Profile County	Profile Zip	Disease	Max Titer	Order Provider	Disposition	Status	Age	PG	Date Due	V
08	AZ	543841	473591	America, Captain	Maricopa	85027	200 (T1)		43rd Avenue Medical Center	H-Can't Find		103 Y (12/25/1915)		04/04/2019	X
08	AZ	543841	473593	America, Captain	Maricopa	85027	700 (T2)					103 Y (12/25/1915)		04/23/2019	X

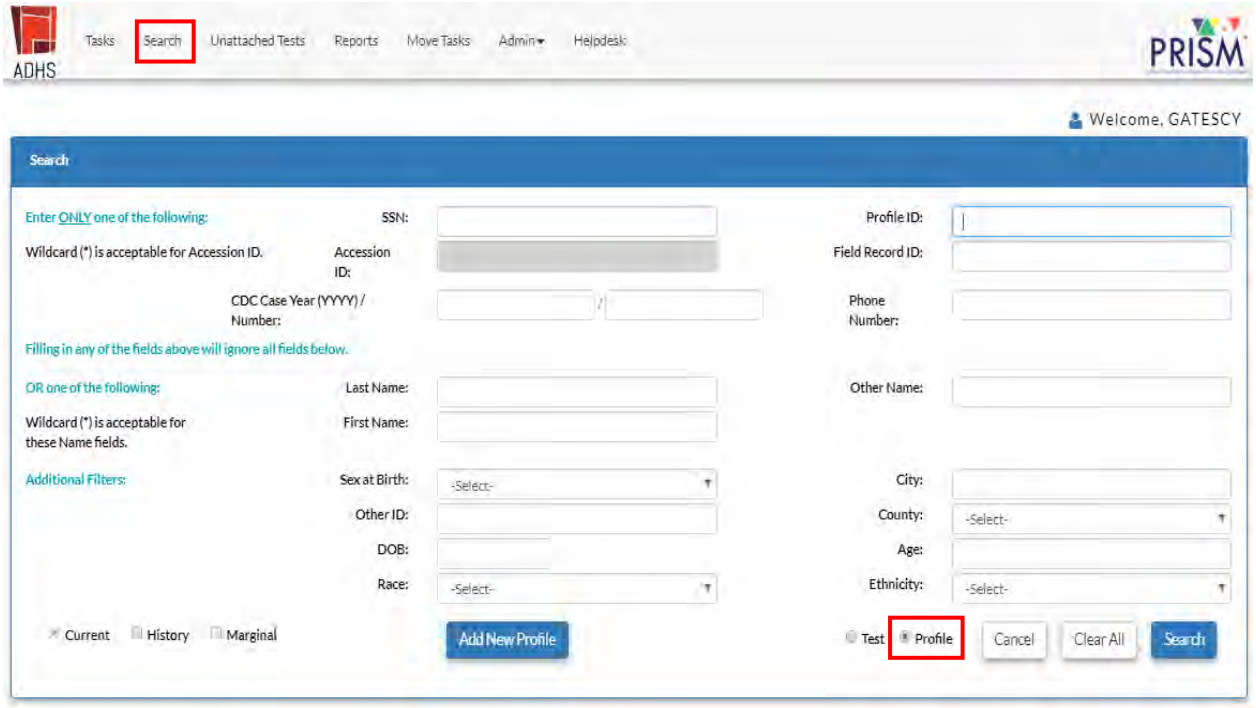
In addition to viewing records from the task list, users can also conduct a search for related profiles that may not be on the task list. Searching in PRISM is discussed in the next section.

SEARCHING IN PRISM

The search page is used to search for a patient, a patient's labs and for marginal/internet profiles which are created using limited information *(See* Marginal and Internet Profiles *section)*.

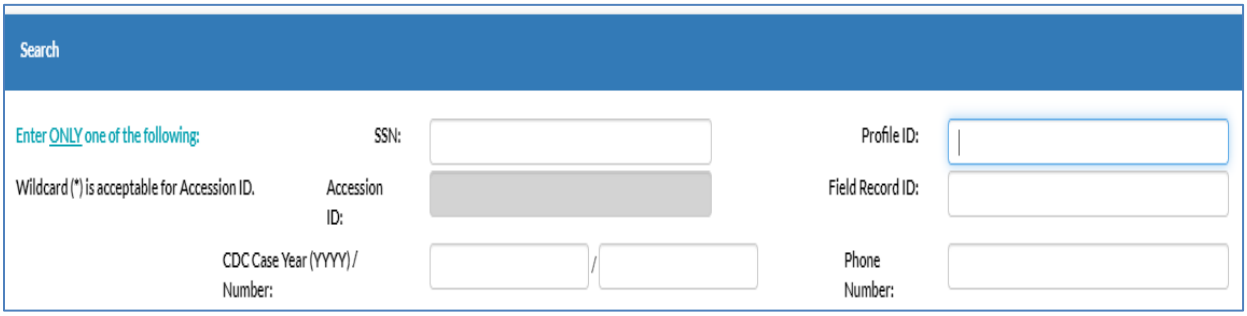
PROFILE SEARCH

The search page is viewed by clicking on the ***Search*** button at the top of the window.



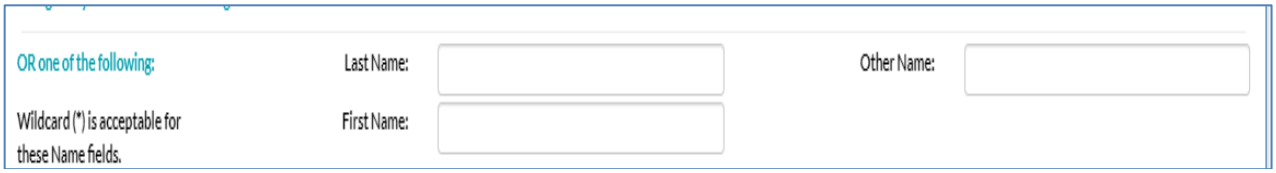
The search page is divided into three sections where data is entered to locate a profile in the system (***Profile*** radio button is selected).

- The first section requires one of the following fields, **SSN**, **Profile ID**, **Phone Number** or **CDC Case Year and Number**. This section is optional.



Any information entered in section one will override search criteria entered in the other sections. If no results are found when searching by a field in this section, these fields should be deleted or the *Clear All* button clicked before proceeding to search by fields in the sections below.

The second section requires one of the following fields: **First Name**, **Last Name**, or **Other Name**. The wildcard (*) can be used in this section to narrow the search results to the exact letters placed before or after the (*). The wildcard is especially helpful when a name has multiple spellings or special characters. Not using the wildcard (*) produces very broad results which include similar sounding names.

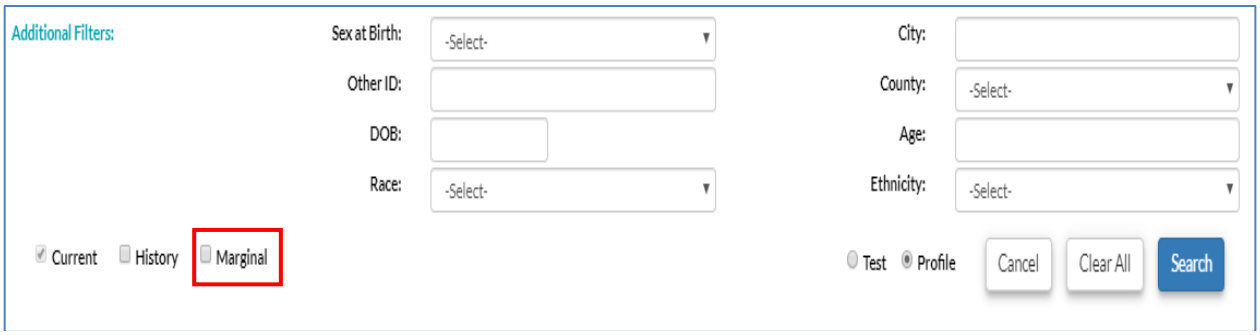


SEARCH	RESULTS	SEARCH	RESULTS
MEGHAN*	MEGHAN	M*EG*N	MAEGAN, MEGAN, MEGHAN
MEG*N	MEGAN, MEGHAN	M*G*N	MORGAN, MAEGAN, MEAGHAN, MEGAN, MEGHAN
MEGHAN	MASON, MAXINE, MEGAN, MESHAWN		

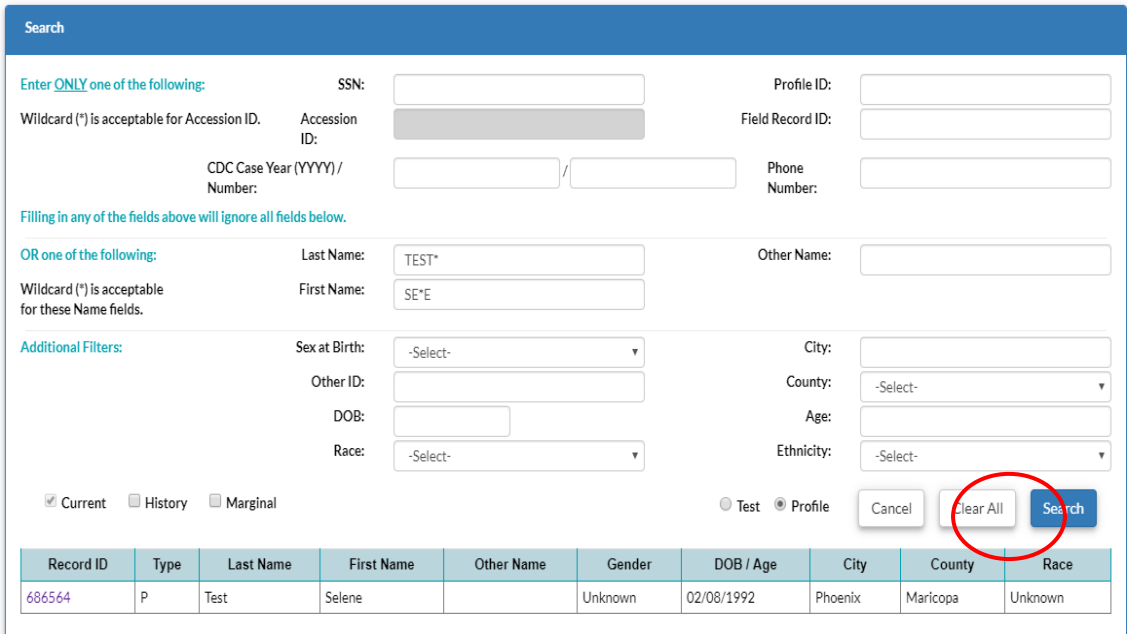
In the third section there are **Additional filters,** such as **Sex at Birth, Other ID, DOB, Race, City, County, Age** and **Ethnicity**, which are used in conjunction with the second section (first, last, or other name) to narrow search results.

If you want to include marginal profiles in your search, click the Marginal checkbox.

Once the information is entered, click the *Search* button at the bottom of the screen and results will appear at the bottom of the page.



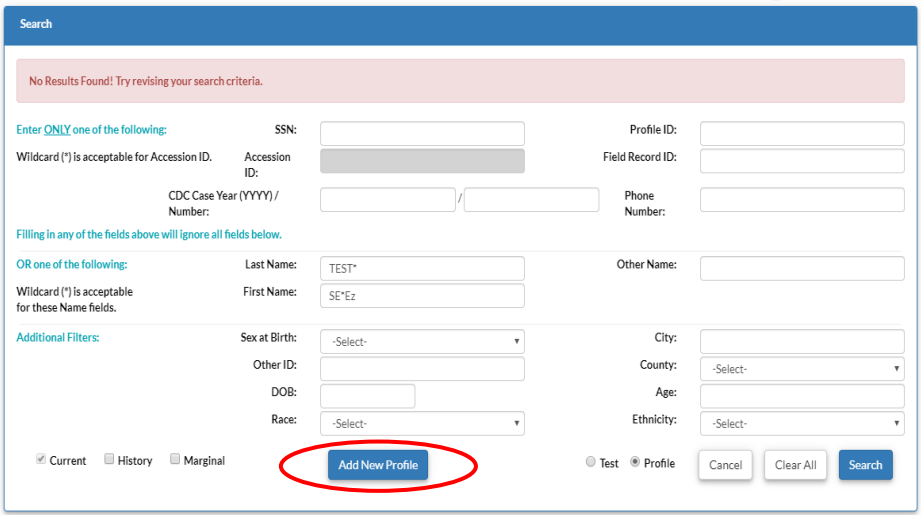
To view the profile, click on the Record ID highlighted in BLUE. If, after reviewing the profile, it is determined that the incorrect patient was selected, click the *Search* button at the top of the screen to return to the search page.



NO RESULTS FOUND IN SEARCH

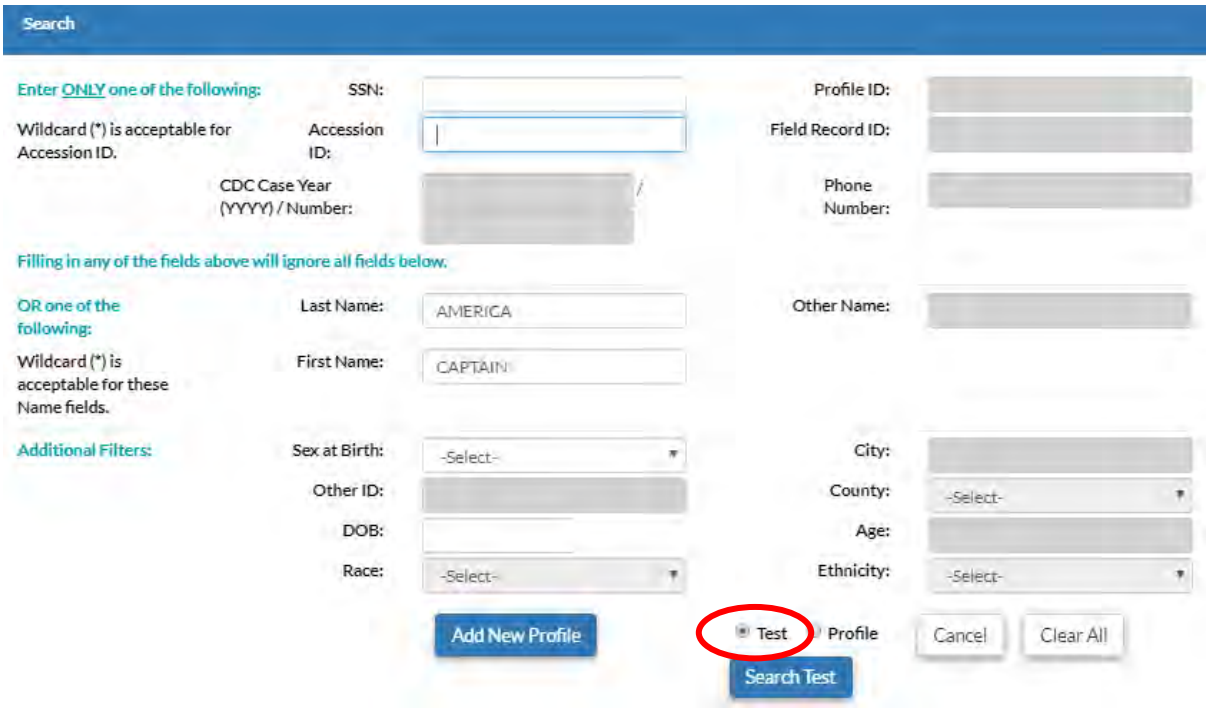
If a profile for the patient does not exist in the system, the following message will appear at the top of the screen - "No Results Found!!!!! Try revising your search criteria." If you receive this message, review your search criteria to ensure there are no errors. You may need to limit search criteria or use wildcards to perform a new search. If you are still unable to find a patient after several attempts, you will need to create a new profile. It is recommended that a search is attempted in various ways at least three times prior to creating a new profile in order to reduce duplicate profiles. The button to add a new profile only appears after a search attempt is made.

Click the *Add New Profile* button to enter a new patient profile. Adding a new profile is covered in the next section.



TEST SEARCH

Another way to search is PRISM is by **Test**, instead of Profile. At the bottom of the search screen there are two radio buttons. The default is always set to "Profile." If you want **to search for all tests in PRISM associated with a client**, change the radio button to "Test." Doing so will gray out many of the profile search fields and will leave you with Social Security Number (SSN), Accession ID, Last Name, First Name, Sex at Birth and Date of Birth (DOB). The wildcard (*) can still be used when searching to narrow the search results.



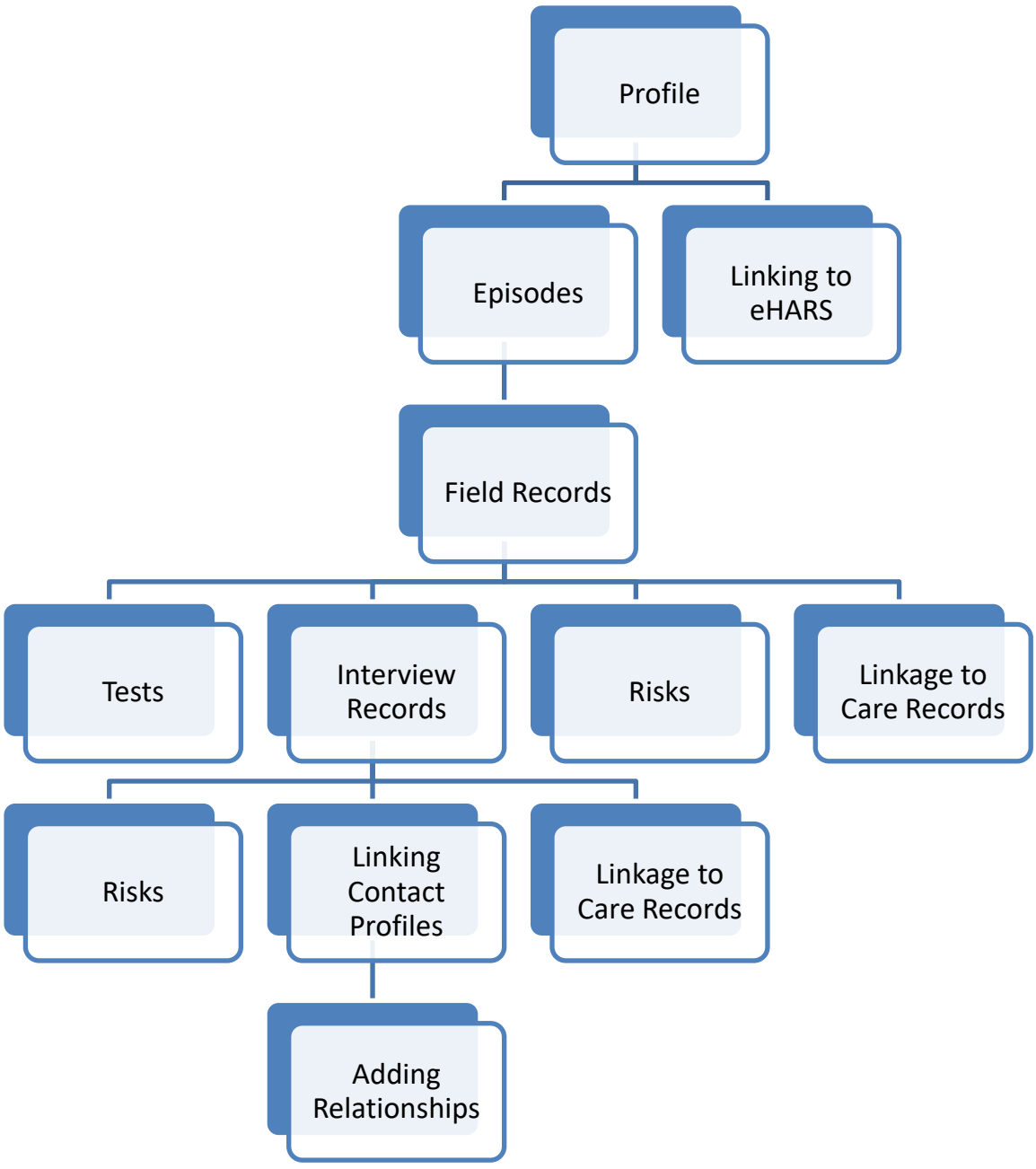
After searching by your desired fields, click "**Search Test**." The system will generate a list of all tests that match your search criteria for you to view. You can click on the Disease Category for each test to open the test in a new window.

Profile ID	FR ID	Disease Category	Accession ID	Last Name	First Name	Test	Qualitative Result	Quantitative Result	Ordering Provider Name	Specimen Date	Result Date	Added Date
543841	474621	Chlamydia		America	Captain	NAAT	Positive		IHS - Whiteriver Indian Hospital: PO Box 860, Whiteriver, AZ: 928-338-4911	10/05/2019	10/07/2019	10/07/2019
543841	473593	Syphilis		America	Captain	RPR	Reactive	1:64	IHS - Whiteriver Indian Hospital: PO Box 860, Whiteriver, AZ: 928-338-4911	10/03/2019	10/04/2019	10/07/2019
543841	473593	Syphilis		America	Captain	TP-PA	Reactive		21st Century Family Medicine: 202 E Earll Drive, Phoenix, AZ: 602-254-7554	09/16/2019	09/16/2019	09/18/2019
543841	473593	Syphilis		America	Captain	RPR	Reactive	1:128	IHS - Whiteriver Indian Hospital: PO Box 860, Whiteriver, AZ: 928-338-4911	09/15/2019	09/17/2019	09/18/2019
543841	473597	Gonorrhea		America	Captain	RNA	Positive		4c Medical Group, Plc: 16620 N 40th St Ste C1, Phoenix, AZ: 602-923-6666	04/10/2019	04/10/2019	04/17/2019
543841	473591	Chlamydia		America	Captain	MALDI	Positive		43rd Avenue Medical Center: 7725 N 43Rd Ave #111, Phoenix, AZ: 623-931-9201	03/12/2019	03/14/2019	03/20/2019
543841	473590	HIV		America	Captain	W/B	Positive		4C Medical Group: 9590 E Ironwood Sq Dr Ste 125, Scottsdale, AZ: 480-455-3000	09/05/2017	09/06/2017	02/08/2019

CREATING PATIENT DATA

Entering patient data begins with creating a profile. PRISM is designed to have a single profile for each patient and all data is added under that profile. Once a profile is created or accessed through a profile search, you are able to document data such as field records (disease episodes), interview records, tests, linkage to care records, and risks.

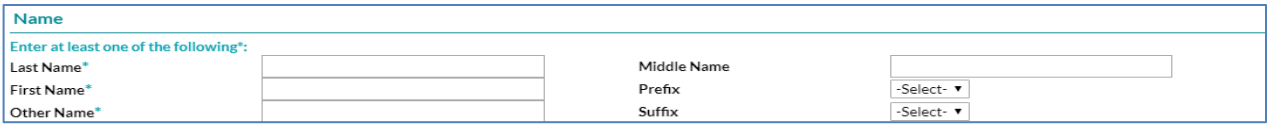
THE BIG PICTURE



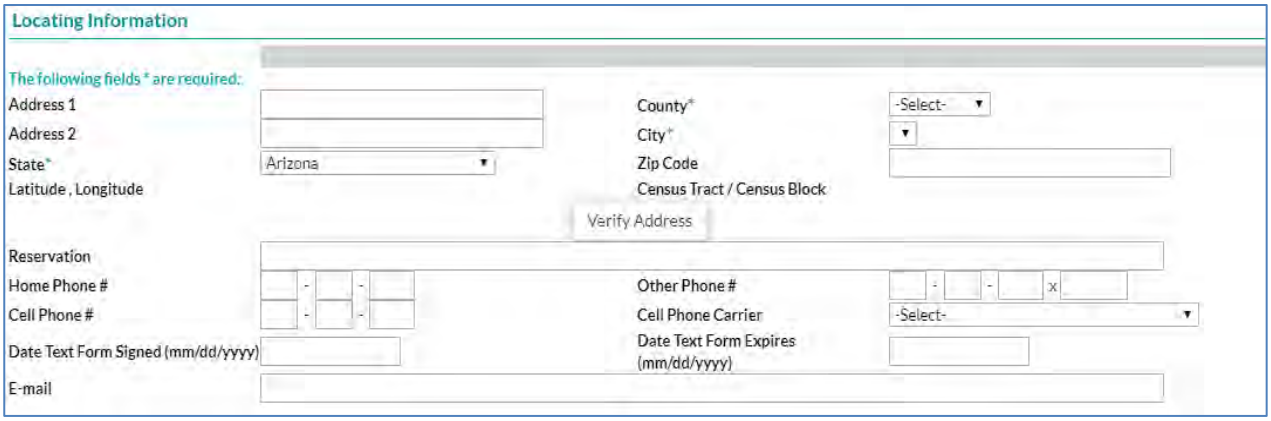
PROFILES

A new Profile is added from the **Search** page, once a search is completed, by clicking the ***Add New Profile*** button. The profile will display in edit mode for adding or updating a patient's demographic information. The profile is broken into six sections: **Name, Locating Information, Vital Statistics, Description, Notes,** and **Other**. Each section of the profile indicates if there are required fields that must be completed in order to save the profile.

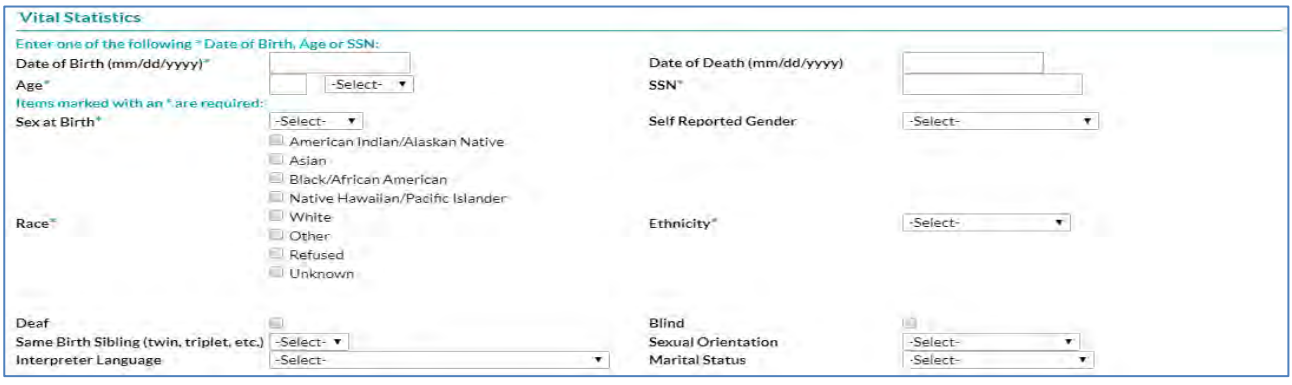
The **Name** section displays the first, middle, last name, prefix and suffix. Any alternate names should be entered in the Other Name such as a nickname or maiden name. A First Name, Last Name or Other Name is required in this section.



The **Locating Information** section displays the **Address**, **Phone Numbers**, and **Email Address**. The address entered is verified as a valid address by clicking the ***Verify Address*** button below. If an address is not valid, a message will appear in red asking you to confirm before saving the profile. This section requires entry of the County, City and State values.

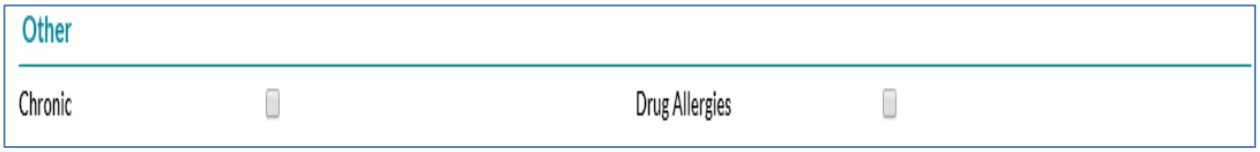


The **Vital Statistics** section displays the following fields: Date of Birth, Age, Date of Death, SSN, Sex at Birth, Self-Reported Gender, Race, Ethnicity, Deaf, Blind, Same Birth Sibling, Sexual Orientation, Interpreter Language, and Marital Status. This section requires the entry of a Date of Birth or Age. Sex at Birth, Race and Ethnicity are also required fields. "*Unknown*" is an option for these fields if the corresponding information is not available.

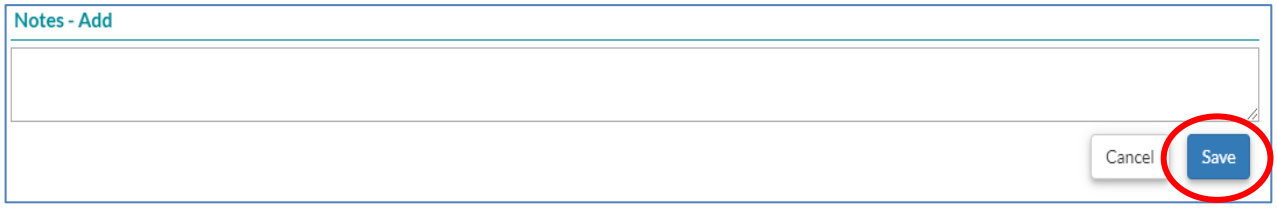


The **Description** section displays the fields for the Height, Weight, Size, Build, Complexion, Hair Length, Hair Color, Hair Style and a section to add Tattoos and/or Birth Marks.

The **Other** section contains Chronic and Drug Allergy information. **Chronic** refers to whether the client is HIV-positive. **Drug Allergies** refers to whether the client is allergic to any medications.

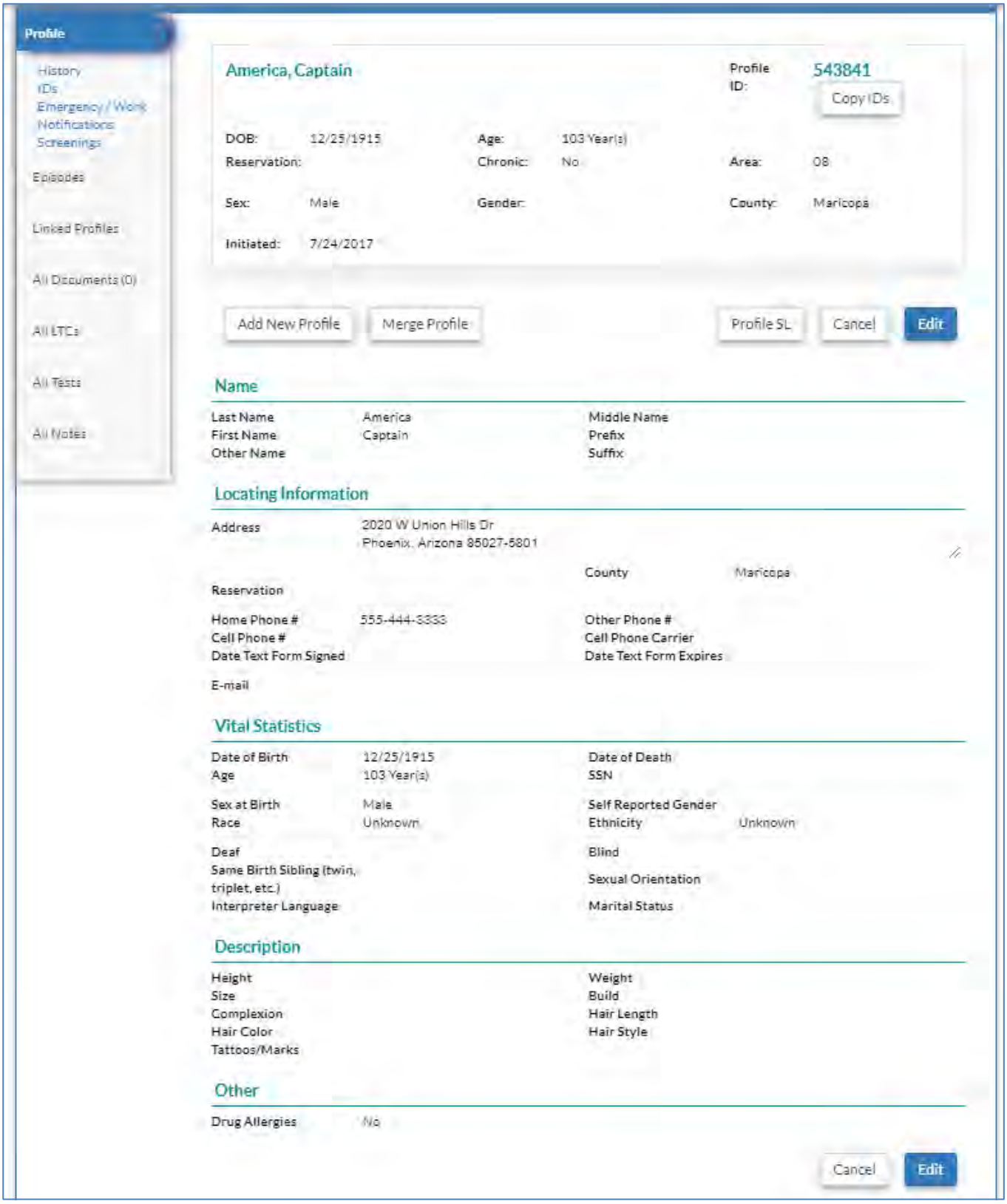


The **Notes** section allows you to add notes pertinent to the Patient's Profile. Notes entered here will display to all users accessing the profile in the future. Do not include information about a case in these notes. Only locating information or information pertaining to the profile fields should be placed in these notes. **A note may not contain a less than sign (<), a backward slash (\) or a pipe (|).**



Once all fields are completed, click on the ***Save*** button to save all changes. The ***Save*** button is found both at the top and the bottom of the page.

Example profile view



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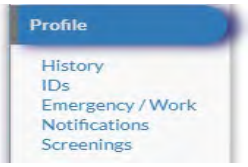
Reviewing and Entering Additional Profile Information

Once the profile is saved, it should be reviewed for accuracy. Updates are made to the profile at any time by clicking the ***Edit*** button at the top or bottom of the page.

There are also seven tabs on the left side of the page: **Profile, Episodes, Linked Profiles, All Documents, All LTCs, All Tests,** and **All Notes.** By clicking on the subtabs under the Profile tab, you can review or enter additional information related to the profile.



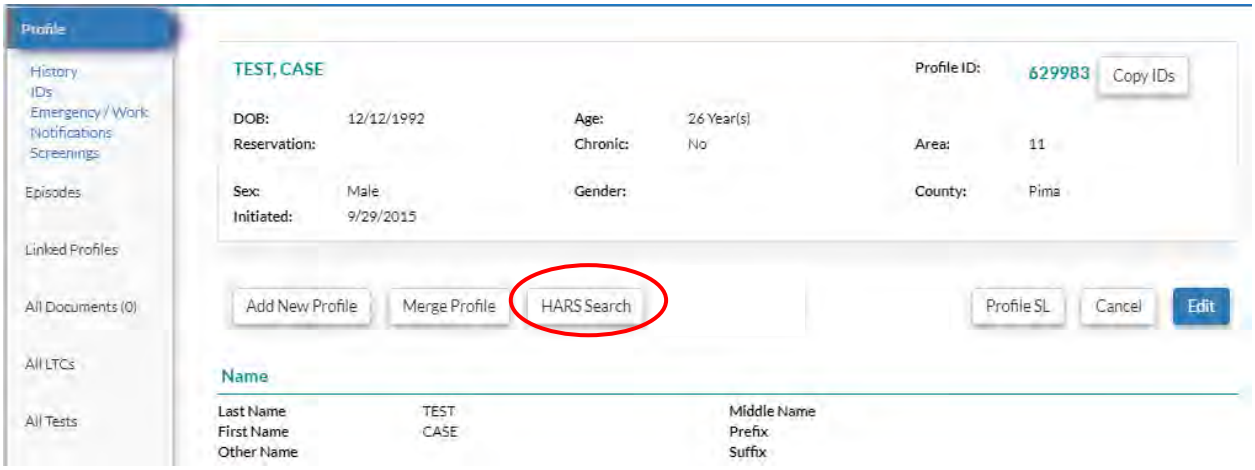
- **History** displays any changes made to the profile. The history includes the changes that were made, date, time, and user's name.
- **IDs** displays other identifiable information such as HARS ID, medical record #, inmate/prison #, Driver's license #, alternate SSN and alternate DOB, STDMIS Patient ID, etc.
- **Emergency/Work** displays an emergency contact as well as any work information.
- **Notifications** displays information that was requested on this profile, such as Accurint searches, profile merges, etc.
- **Screenings** displays all screening intake forms that are currently in the system for this particular profile. This feature is not currently used in Arizona.

eHARS SEARCH AND LINKING

The Enhanced HIV/AIDS Reporting System (eHARS) is a browser-based application provided by the Centers for Disease Control and Prevention (CDC) and is used by state and local health departments to collect, manage, and report HIV/AIDS case surveillance data to CDC.

Data from eHARS is automatically uploaded into PRISM and attached to a profile when the records match several criteria, such as name, date of birth, and address. Data is also manually linked by conducting an eHARS search and linking the appropriate record. This data is used to reference a patient's HIV/AIDS history.

eHARS Searches are completed by clicking on the *HARS Search* button from any profile page. Once you have clicked the *HARS Search* button, a search page is displayed.

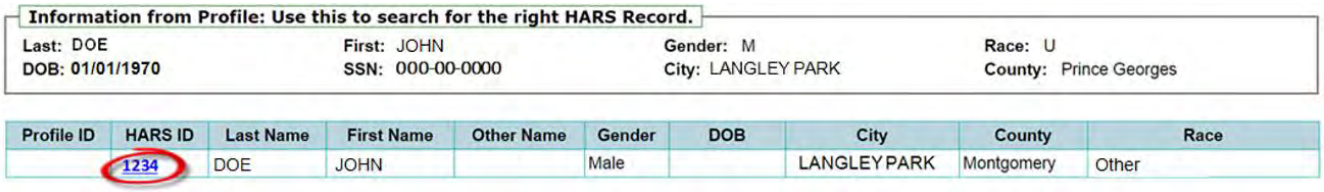


Only users with the privilege to conduct HARS searches and Link HARS Records will see the *HARS Search* button.

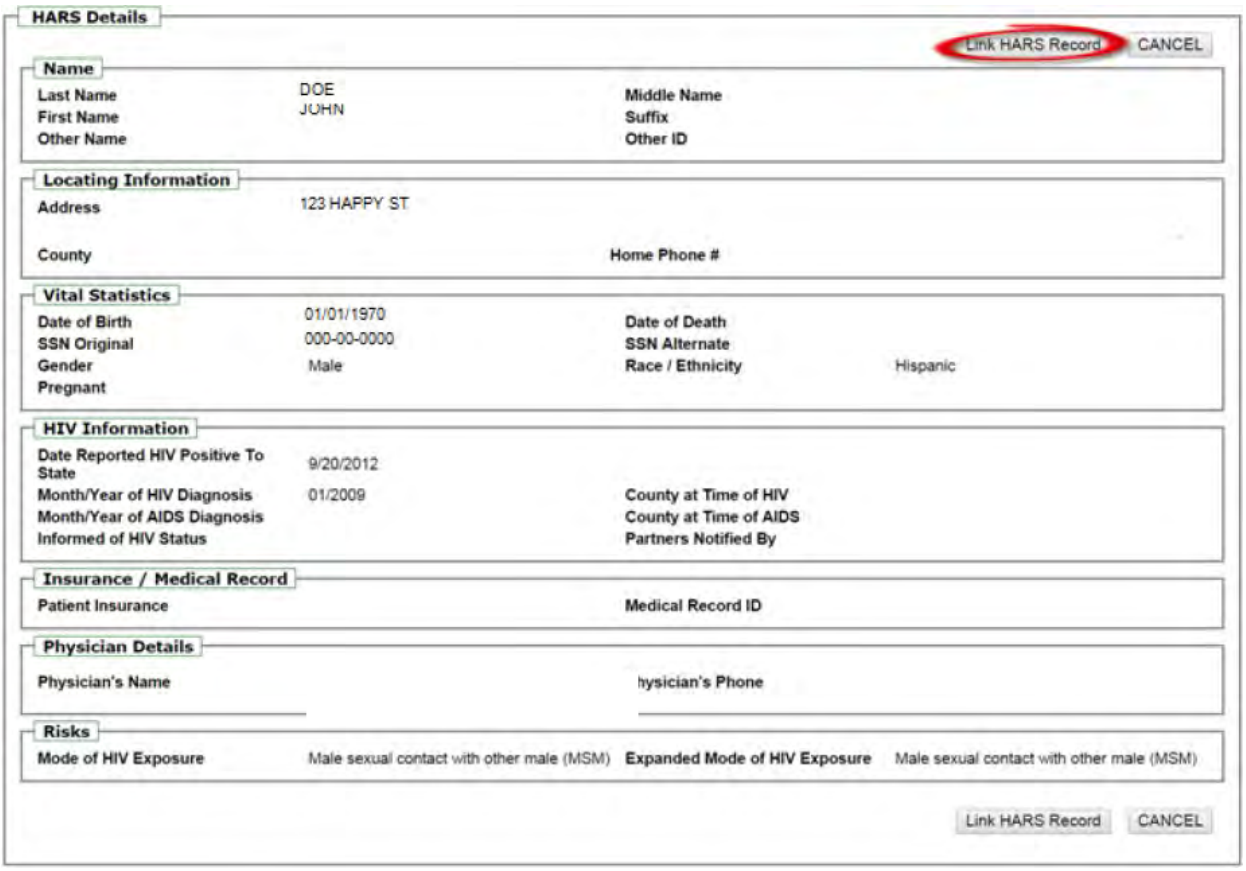
The current Profile name and sex at birth will automatically display in the fields on the search page. Information from the profile will display at the bottom of the search page, as a reference, to ensure that the correct profile is selected before conducting the HARS search. Click the *HARS Search* button or press enter to perform the search.

If there is no record of the selected profile found in the HARS search, the following message displays at the top of the search results page "No Results Found!!!!! Try revising your search criteria."

If a HARS record is found, the HARS ID will display at the bottom of the search page. Click the BLUE HARS ID number to display the HARS record.



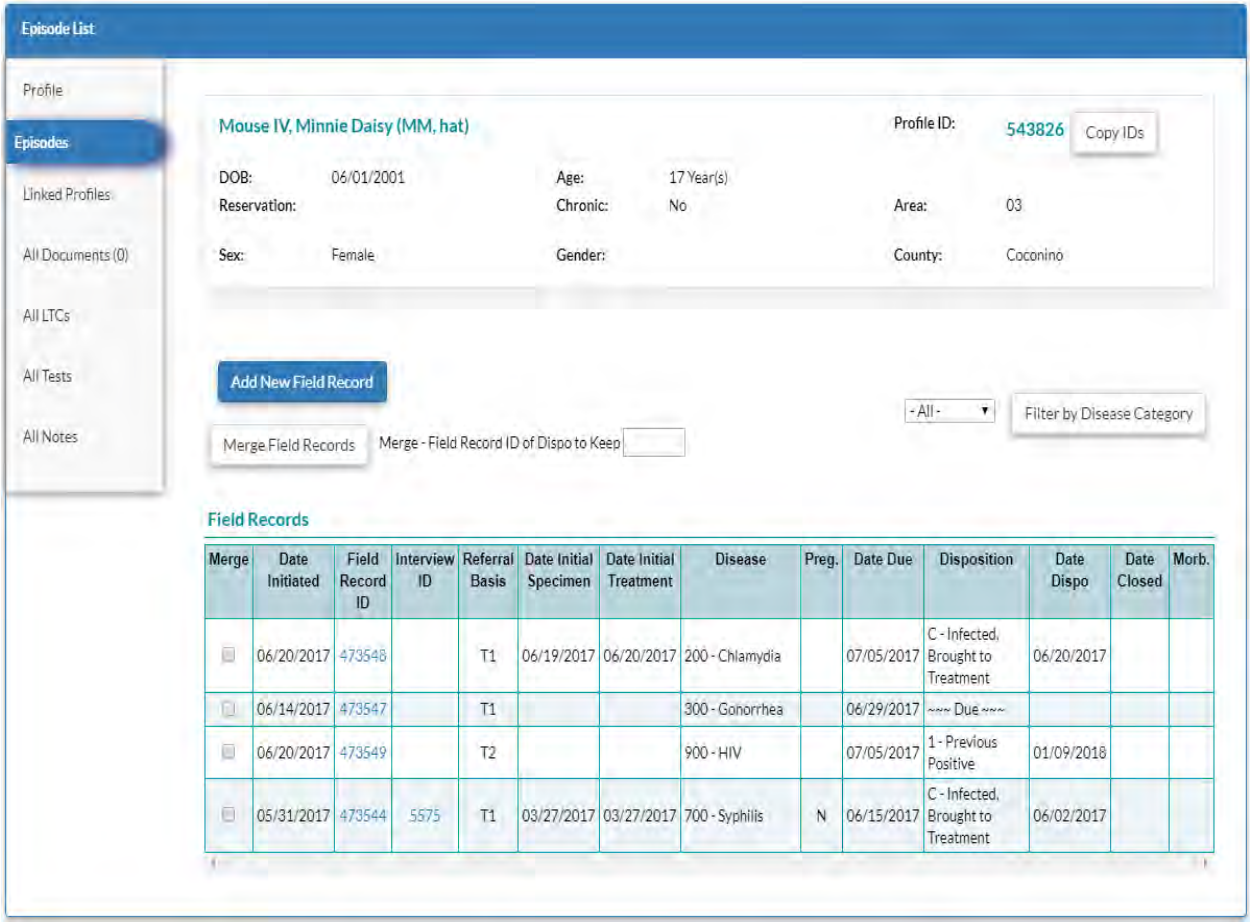
After reviewing the record, if the information matches (such as DOB, SSN, and date of diagnosis) click the *Link HARS Record* button to attach it to the profile. The *Link HARS Record* button is located at both the top and bottom of the screen. If this is not the HARS record that should be linked, click the *CANCEL* button to return to the Search for a HARS Record to Link page. If you cannot find a match, click the *CANCEL* button to return to the profile.



Clicking the **Link HARS Record** will create a **HARS** sub tab under the Profile tab, so the HARS record is viewable anytime the profile is displayed (for users who have the privilege to view HARS records).

EPISODES

The **Episodes** tab displays each STD disease event that caused a patient to come to the attention of the health department and resulted in the creation of a field record. The field record and corresponding interview can be viewed by clicking the BLUE Field Record ID number or the BLUE Interview ID.

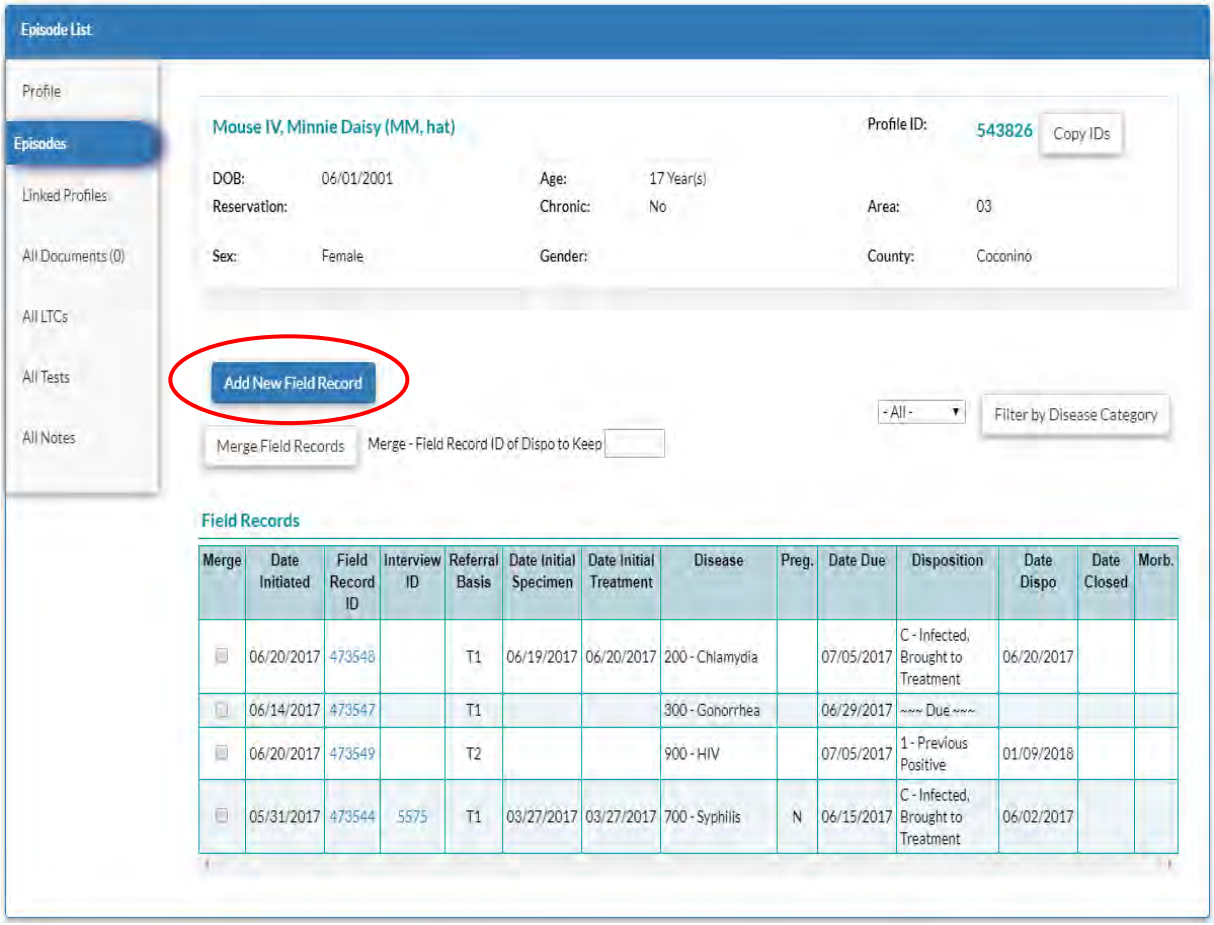


Merge	Date Initiated	Field Record ID	Interview ID	Referral Basis	Date Initial Specimen	Date Initial Treatment	Disease	Preg.	Date Due	Disposition	Date Dispo	Date Closed	Morb.
	06/20/2017	473548		T1	06/19/2017	06/20/2017	200 - Chlamydia		07/05/2017	C - Infected, Brought to Treatment	06/20/2017		
	06/14/2017	473547		T1			300 - Gonorrhea		06/29/2017	~~~ Due ~~~			
	06/20/2017	473549		T2			900 - HIV		07/05/2017	1 - Previous Positive	01/09/2018		
	05/31/2017	473544	5575	T1	03/27/2017	03/27/2017	700 - Syphilis	N	06/15/2017	C - Infected, Brought to Treatment	06/02/2017		

- **Date Report** is the date used to report to CDC, if reportable from PRISM. Every record will have this date even if they are not reportable from PRISM. In most cases, this is the Date Initiated. During duel year processing, usually January thru April, if a field record is created and it has a lab with a result date in the prior year, this date will be set to the result date of that laboratory test. In Arizona, this is not visible in the episodes view.
- **Date Initiated** is the date that the field record was added to the system.
- **Field Record ID** is the unique identifying number of the field record itself.
- **Interview ID** is the unique identifying number of the associated interview.
- **Referral Basis** is the code use to identify how public health receive notification of the case.
- **Date Initial Specimen** is the earliest specimen lab date on tests attached to the field record.
- **Date Initial Treatment** is the earliest treatment date on the field record.
- **Disease** is the disease of the field record.

- **Pregnancy** indicates whether the patient was pregnant at the date of lab specimen collection or initiation of the field record.
- **Date Due** is the date the field record is due to be closed.
- **Disposition** is the final disposition that was used to close the field record.
- **Date Dispo** is the date the field record was dispositioned.
- **Date Closed** is the date the field record was closed.
- **Morbidity** indicates whether morbidity was created for the field record.

New episodes are created by clicking ***Add New Field Record*** button.

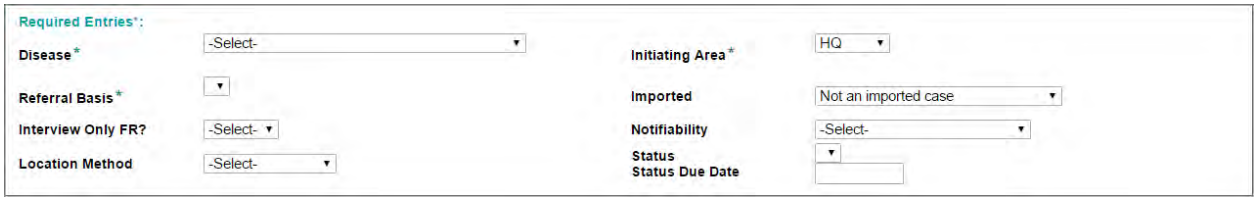


Merge	Date Initiated	Field Record ID	Interview ID	Referral Basis	Date Initial Specimen	Date Initial Treatment	Disease	Preg.	Date Due	Disposition	Date Dispo	Date Closed	Morb.
	06/20/2017	473548		T1	06/19/2017	06/20/2017	200 - Chlamydia		07/05/2017	C - Infected, Brought to Treatment	06/20/2017		
	06/14/2017	473547		T1			300 - Gonorrhea		06/29/2017	~~~ Due ~~~			
	06/20/2017	473549		T2			900 - HIV		07/05/2017	1 - Previous Positive	01/09/2018		
	05/31/2017	473544	5575	T1	03/27/2017	03/27/2017	700 - Syphilis	N	06/15/2017	C - Infected, Brought to Treatment	06/02/2017		

CREATING A FIELD RECORD

Field records are created when a patient has a positive test result, a case report is received from a provider or another state, a person is named as a contact in an interview, when linkage to care information is required, or when a jurisdiction wants to create a history of negative lab results. Clicking the ***Add New Field Record*** button displays a new field record, in edit mode, for information to be added. The sections of a new field record are **Required Entries**, **Contact Attempts**, **Female Specific**, **HIV**, **Symptoms**, **Screening/Exam/Treatment**, **Other**, **Notes,** and **Syphilis Manifestations** (syphilis records only).

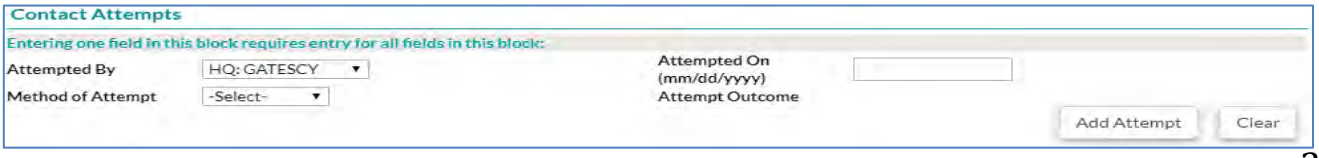
The **Required Entries** are marked with an (*) for all field records.



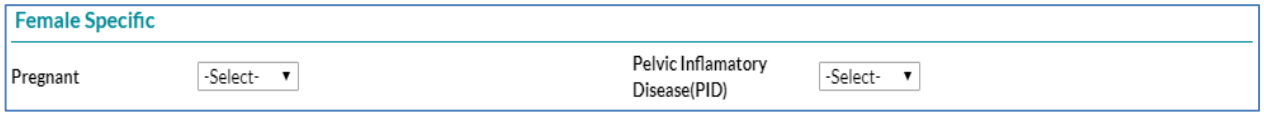
- **Disease** indicates the disease for the field record. Each disease requires a separate field record.
- **Initiating Area** is automatically populated with the area where the initiating user works.
- **Referral Basis** indicates in what way this patient came to the attention of the health department.
- **Imported** indicates whether the field record was imported from another county or state.
- **Interview Only FR** indicates whether this field record is only needed for an interview.
- **Notifiability** indicates whether patient can be notified.
- **Location Method** indicates how the patient was located for testing.
- **Status** allows the user to keep his or her supervisor up to date with pending information for the field record.
- **Status Due Date** is the date that the pending information from the status will be complete.

> The **Disease** can be changed to one in a different disease category as long as there are no symptoms, treatment, tests, linkage to care or interviews attached to the field record.

The **Contact Attempts** section documents all attempts to contact the patient and the outcome of each attempt. All four fields are required and the ***Add Attempt*** button must be clicked to save the contact attempt. All contact attempts should be documented in this manner and not placed in the notes.



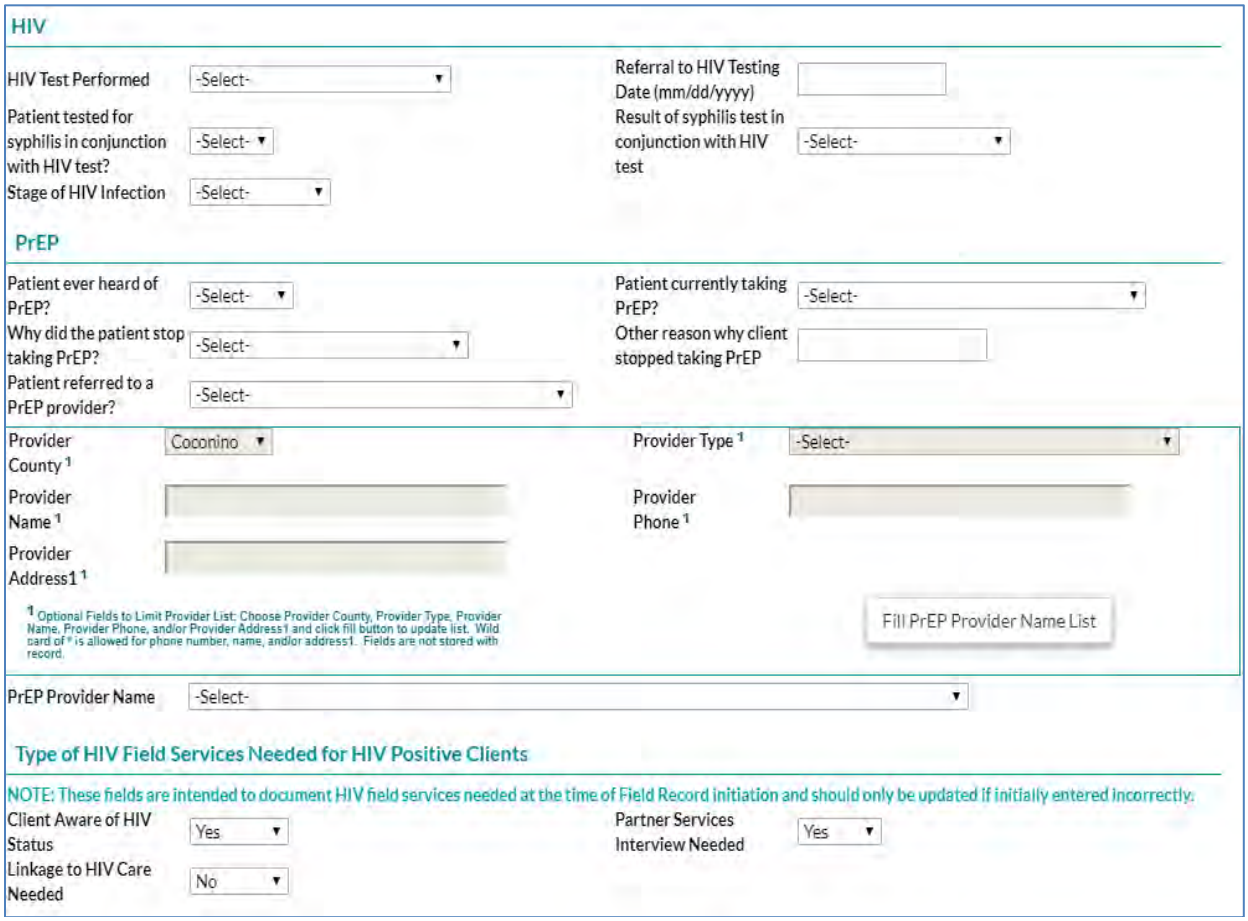
The **Female Specific** section appears when creating a field record on a female patient. Document whether the client is pregnant and/or has PID. If 'Yes' to pregnant is selected, an estimated delivery date box will appear. Entering an expected delivery date will create a maternal record *(See Maternal Record section)*. Maternal records will appear in the patient's episode tab.



HIV Section

Depending on whether the field record is for HIV, one of two sections will appear.

This **HIV** section only appears on HIV Field Records and includes additional questions to document the client's testing history, PrEP history, and the type of field services needed for HIV positive clients.



If **Partner Services Interview Needed** is marked "Yes," the field record cannot be closed without opening an Interview. If **Linkage to HIV Care Needed** is marked "Yes," the field record cannot be closed without opening an LTC Record.

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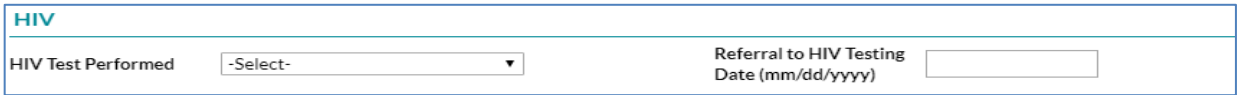
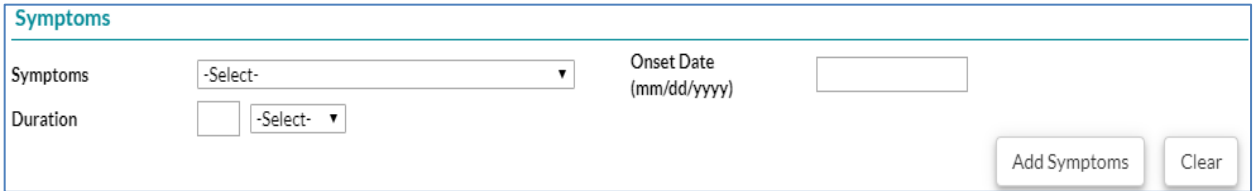
This **HIV** section will appear on a **Non-HIV Field Record**. Users should document whether the client was tested for HIV during this disease episode and/or the date the client was referred for testing.

> If the HIV Test Performed answer is **'Yes'** and there is not an HIV field record that was created in the last 30 days, a new HIV field record will be auto-generated to document the HIV test result. If it was negative, add a negative lab test and disposition as '3 – Negative'. If positive, add the positive lab test and conduct follow-up.

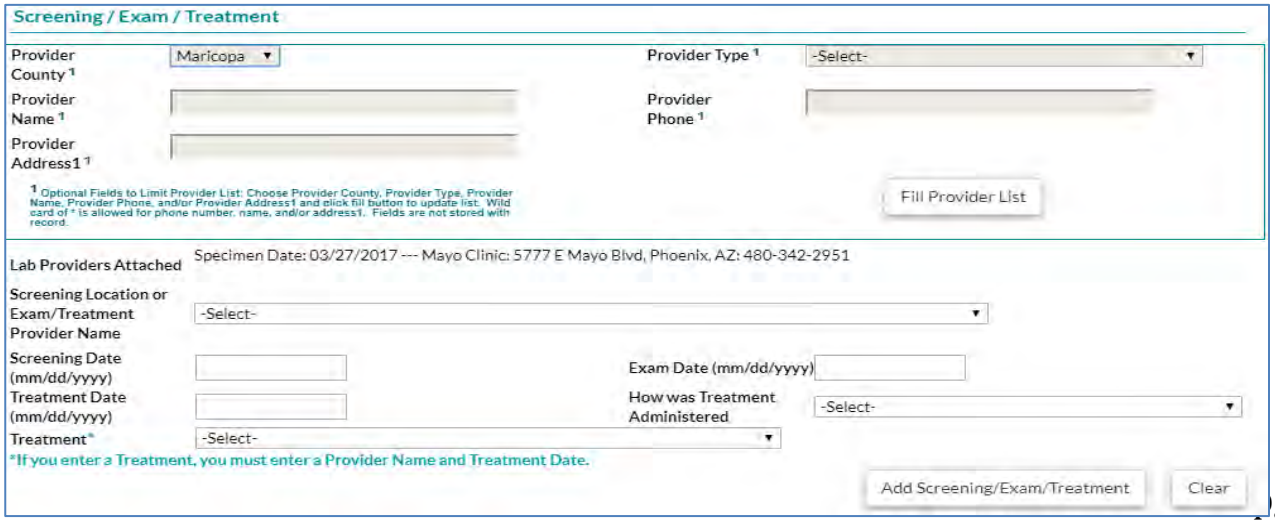


The **Symptoms** section documents all symptoms, based on disease, for proper diagnosis and disposition. Click ***Add Symptoms*** to save each symptom entered.



> Symptoms are required for all primary and secondary syphilis field records.

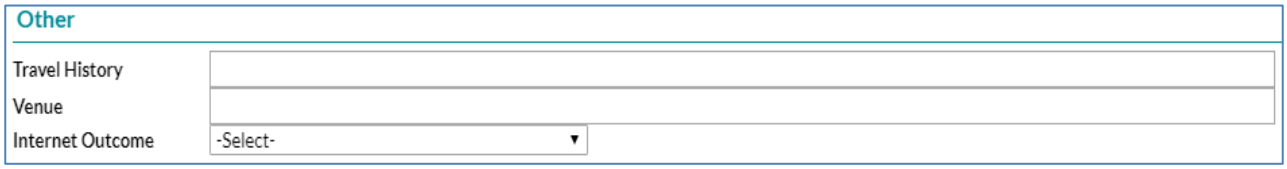
The **Screening/Exam/Treatment** section documents testing dates and entered treatment information. The **Treatment** list populates based on the disease associated with the field record. **Screening Date** documents when a client was tested through an outreach screening event and **Exam Date** documents when the patient was examined by a provider at a clinic or hospital.



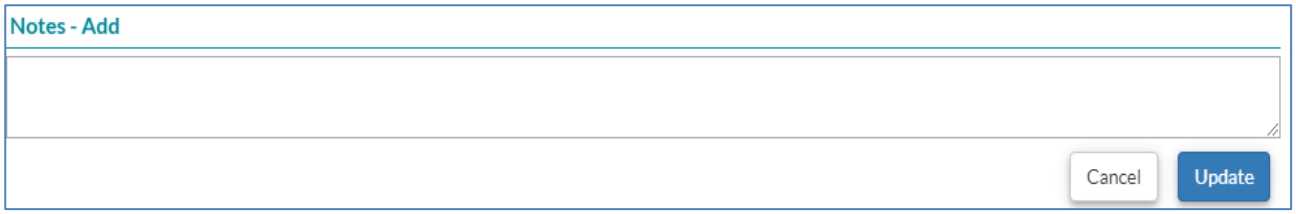
If documenting a screening, exam, or treatment, you must select the Provider from the drop-down list. There are filters that can be used to limit the providers in the provider drop-down. See the instructions in the APPENDEX called PROVIDER SEARCHING. Click the ***Fill Provider List*** button to update the selection list based on the selected filters.

You MUST click the ***Add Screening/Exam/Treatment*** button to save all entered information.

The **Other** section documents any recent travel the client has reported. **Internet Outcome** documents additional information pertaining to Internet Partner Services notifications.



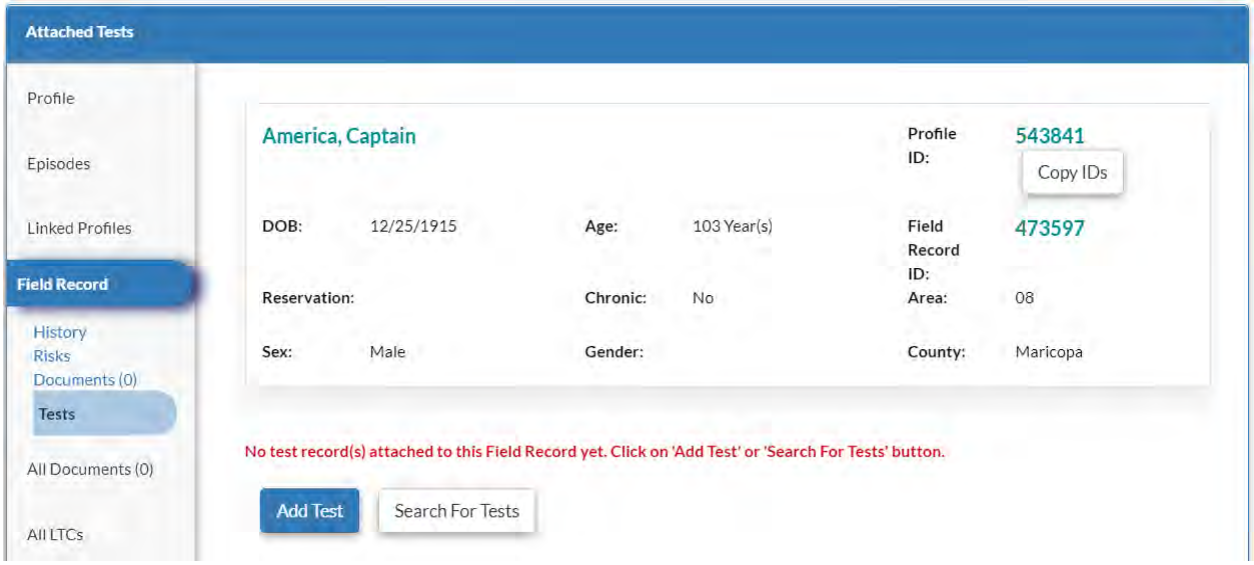
The **Notes** section documents any pertinent information about the client as well as communication between the DIS and his or her Supervisor regarding this specific field record investigation. Click ***Save*** to save all information entered on the field record.



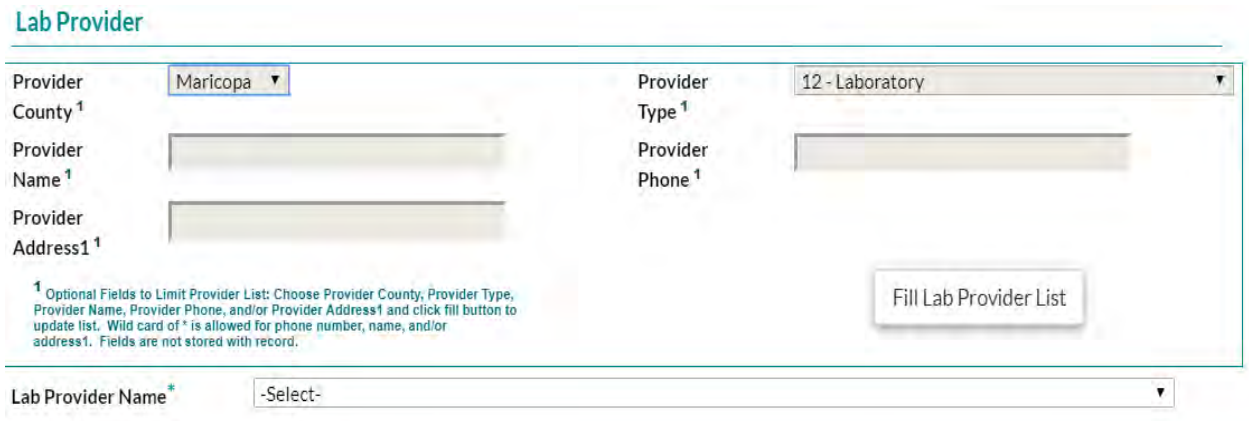
After the Field Record is created, a test can be attached.

Adding a Test

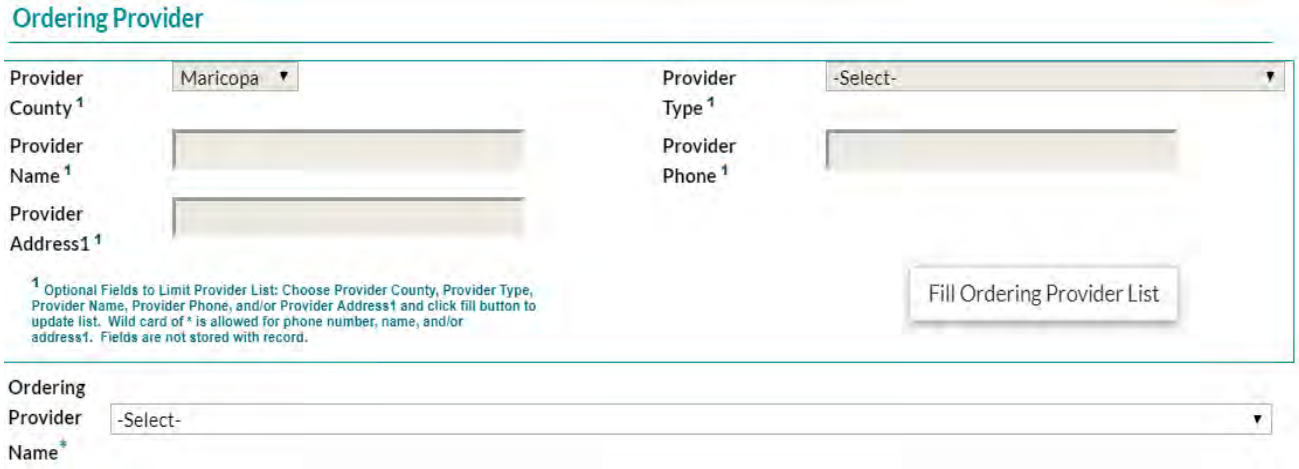
Manual/Paper Tests are only added through a field record by clicking on the Tests subtab under the **Field Record** tab. The tests must match the disease type of the field record. Multiple tests for the same disease can be added. Clicking the **Tests** subsection button under the field record, and then the ***Add Test*** button, displays a new test record in edit mode for adding information.



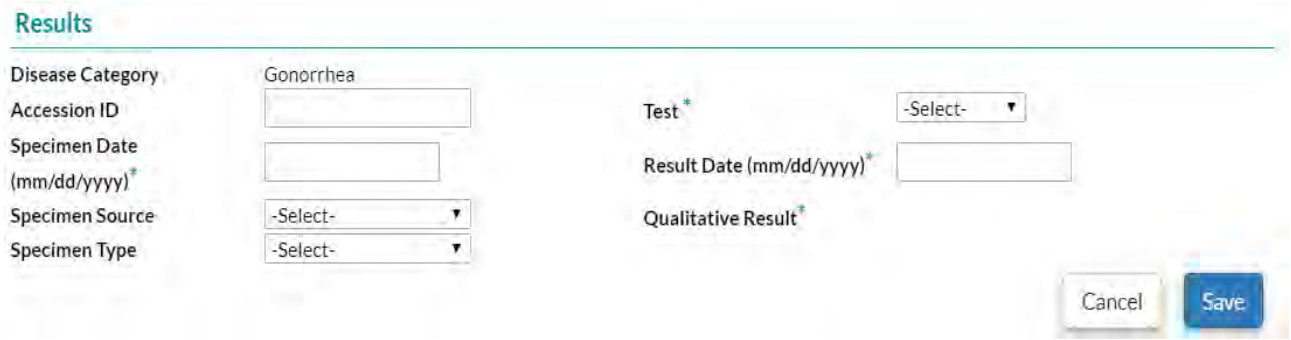
The **Lab Provider** section documents the laboratory that conducted the test on the specimen and provided the result. There are filters that can be used to limit the providers in the provider drop-down. See the instructions in the APPENDEX called PROVIDER SEARCHING. Click the ***Fill Lab Provider List*** button to update the selection list based on the selected filters.



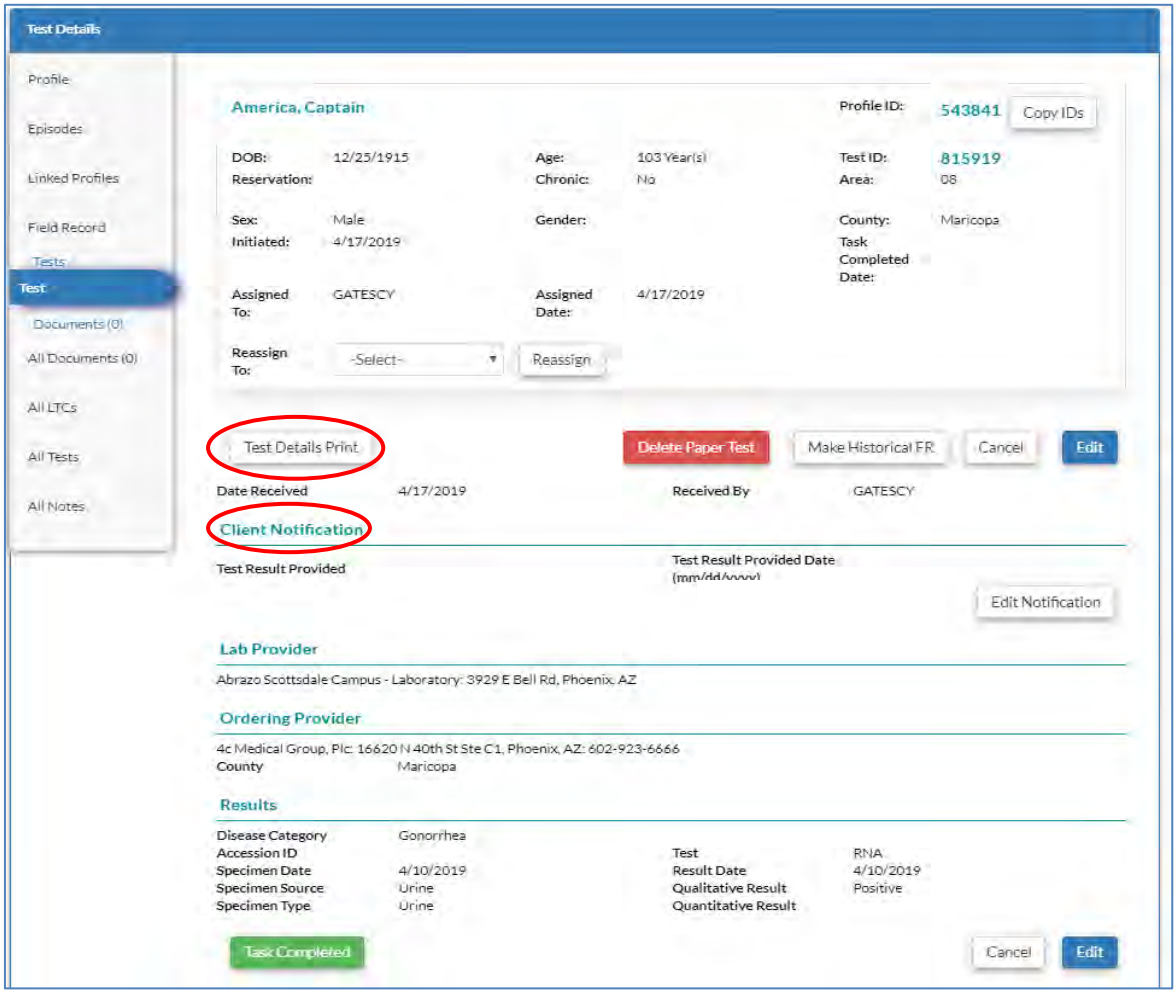
The **Ordering Provider** section documents the provider, doctor, or clinic that ordered the test. There are filters that can be used to limit the providers in the provider drop-down. Provider County will automatically default to the county where the patient resides but can be changed. See the instructions in the APPENDEX called PROVIDER SEARCHING. Click the ***Fill Ordering Provider List*** button to update the selection list based on the selected filters.



The **Results** section requires documenting the Specimen Date, Result Date, Specimen Source, Specimen Type, Test and Result. The type of test changes depending on the disease of the field record. Some tests only require a qualitative result. For those that require a quantitative result, a box or drop-down will appear for that information to be entered.



Click ***Save*** to review all information entered for this test. If a correction is required after clicking Save, then click ***Edit*** and make the changes.



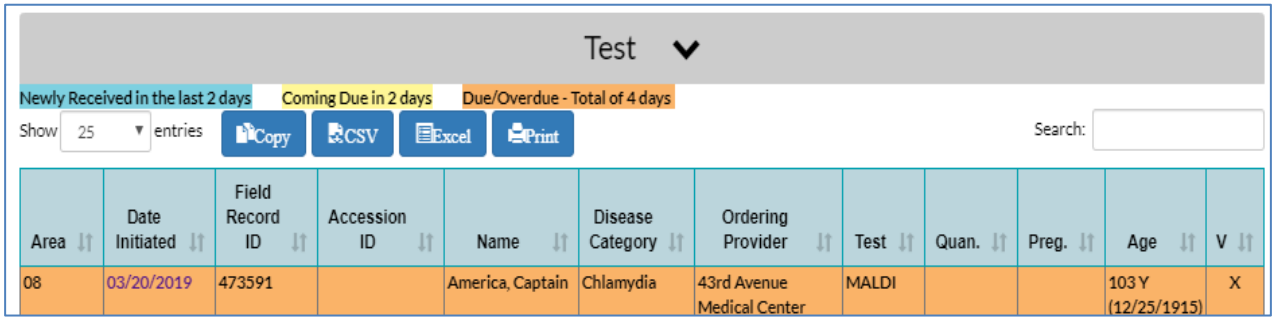
Client Notification documents whether the patient was given their results and the date they received them.

Test Details Print will bring up a report to print a paper copy of the test.

Make Historical FR documents previous tests the patient had that are not already in the system. When a test is added to a current field record that is not for that case, it should be moved to a historical field record and taken off the case. The earliest test date is used in many edits within the system and can invalidly calculate the report date. When the *Make Historical FR* button is clicked a field record will initiate on the date the test was performed and will automatically close. Field Records created from a positive test will be administratively closed. Field records created from a negative test will be closed as negative.

If all information entered is correct, and you do not have other tests to add to this field record, click the *Task Completed* button. Please note, all tests must be Task Completed prior to closing the field record.

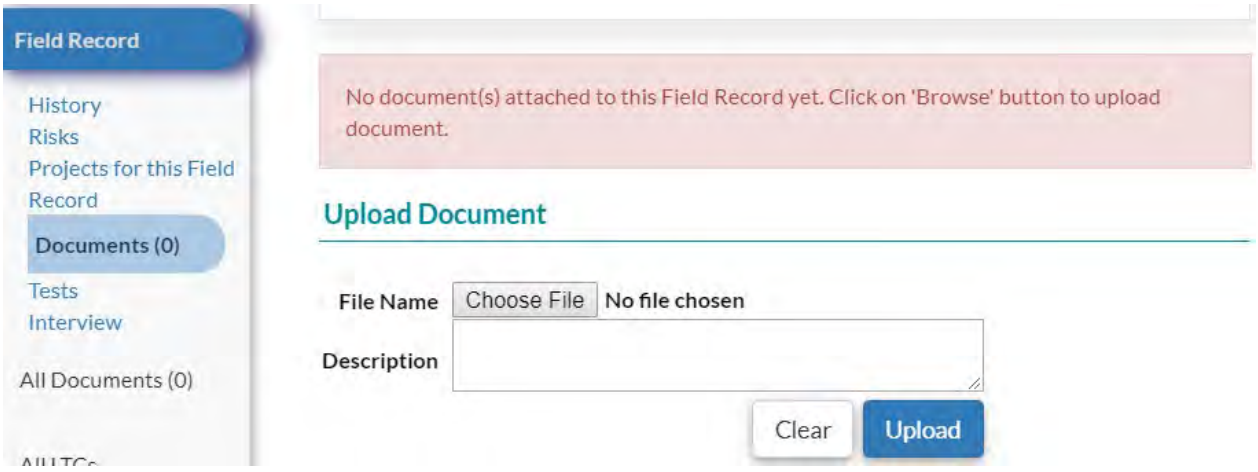
If there are other confirmatory or supplemental tests to be added to this field record, click the **Tests** subtab, and then click the ***Add Test*** button to enter additional tests. Once the test is entered, click the ***Task Completed*** button in the bottom left corner of the page. Previously entered tests that were not task completed will appear on your task list. Click on the BLUE date in the Date Initiated column to display the test and then click ***Task Completed***.



Once all tests are added and task completed, the field record is now ready for disposition and closure.

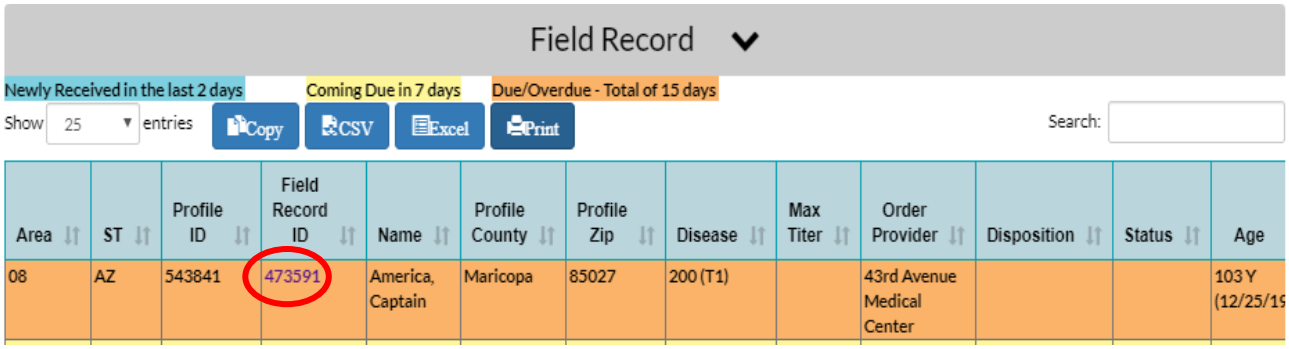
Uploading Documents

All PRISM users can upload documents directly to a client's field record when needed. Examples of documents that can be uploaded include, but are not limited to, laboratory reports, medical chart records, and out-of-state records request results. You MUST include a description for the document or PRISM will not let you upload it.

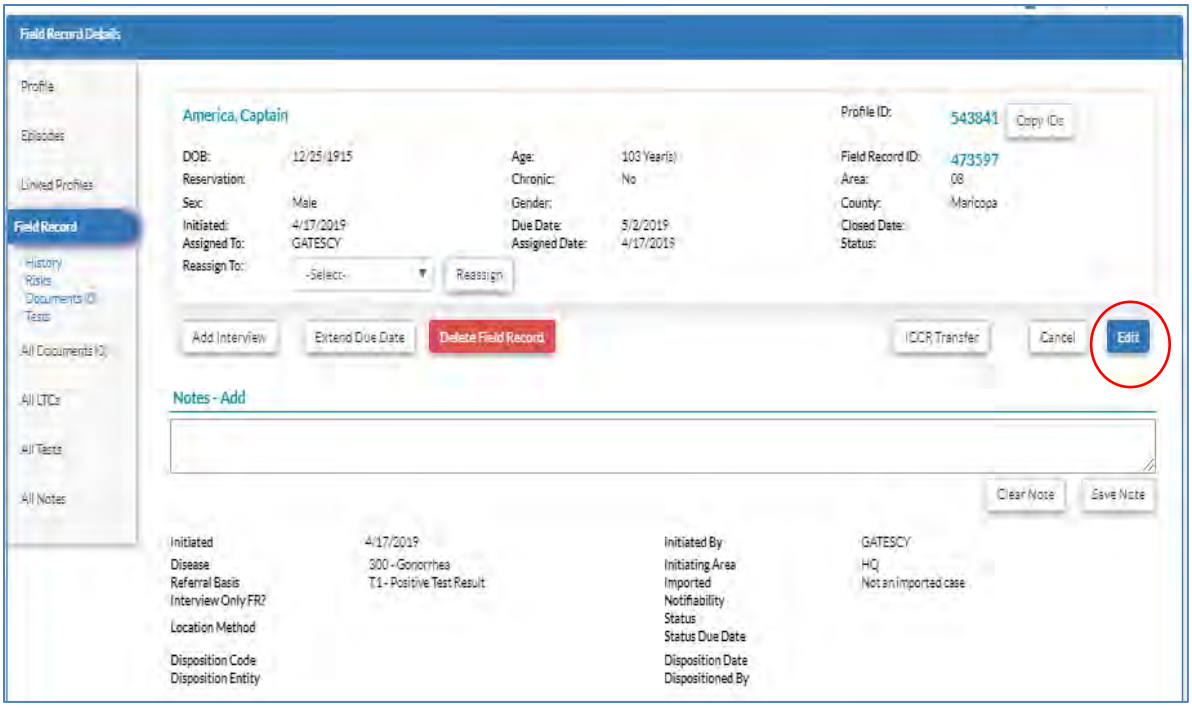


Adding Symptoms, Contact Attempts & Treatment

Once the tests are attached to the field record, you can now add symptoms, contact attempts, and/or treatment. You can either open the field record directly from your Task list or go back to the PRISM Search screen and find your client there. Click the ***BLUE*** Field Record ID to open the field record.



Click the ***EDIT*** button from the top of the field record page to add symptoms, contact attempts and/or treatment.



Contact Attempts

Once the field record is open for editing, scroll down to the **Contact Attempts** section. There will be 4 fields to enter: Attempted By, Attempted On, Method of Attempt and Attempt Outcome.

- **Attempted By**: This will auto-populate to your username, but you can change it to another PRISM user in your jurisdiction if you did not complete the attempt yourself.
- **Attempted On**: The date the contact attempt was made.
- **Method of Attempt**: Clinic, Email, Field Visit, Mail, Social Media, Telephone, and Text.
- **Attempt Outcome**: The outcome of your attempt.

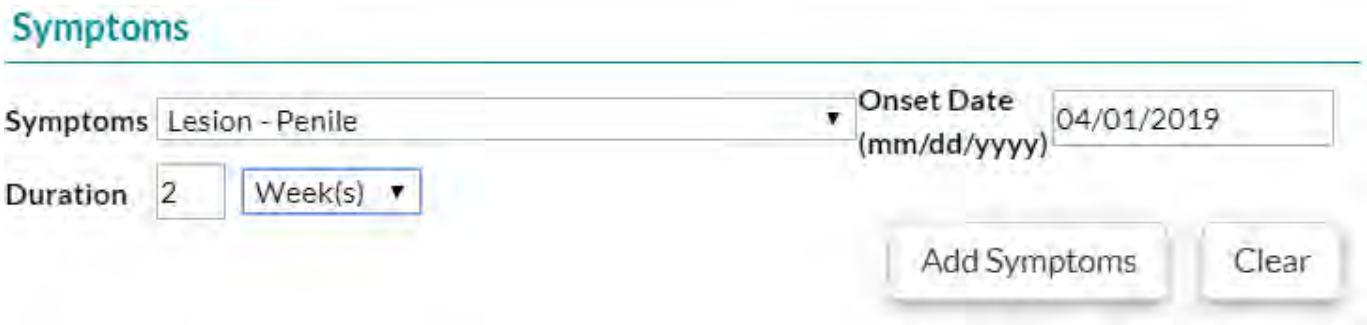
You MUST click "**Add Attempt**" in order for the contact attempt to save. You can repeat this process to add as many contact attempts as needed. If you have nothing else to enter on the field record, then click "Update" at the top of the Field Record to save your work.

Symptoms

To add symptoms, scroll down to the **Symptoms** section of the field record. There will be 3 fields to enter: Symptoms, Onset Date and Duration.

- **Symptoms**: The symptom you'd like to add to the field record.
- **Onset Date**: The date the symptom began either documented by the provider or reported by the client.
- **Duration**: The duration of the symptom. If the symptom was still present on date of diagnosis the Duration should be the difference between the Onset Date and the Date of Diagnosis.

You MUST click "**Add Symptoms**" in order for the symptom to save. You can repeat this process as many times as you need for additional symptoms. If you have nothing else to enter on the field record, then click "Update" at the top of the Field Record to save your work.



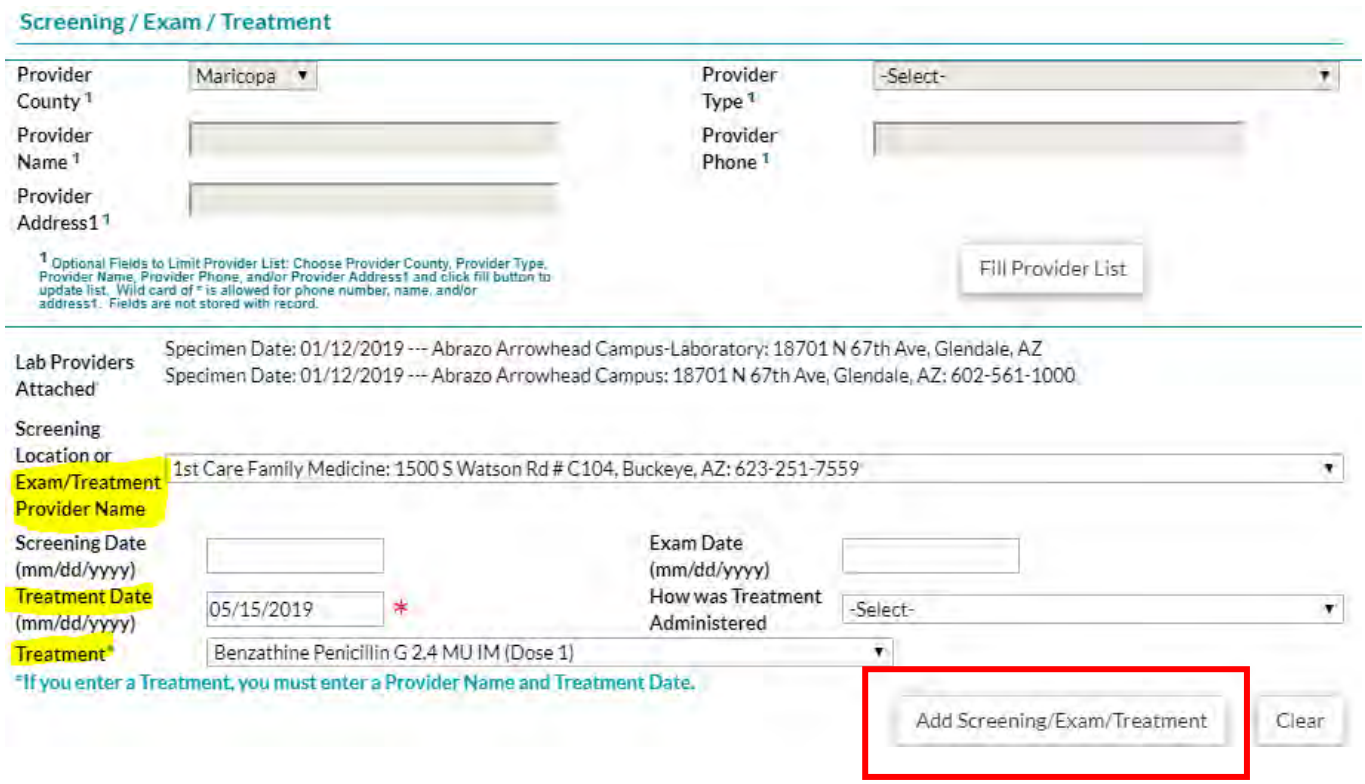
pg. 30

Treatment

To add treatment, scroll down to the **Screening/Exam/Treatment** section of the field record. There will be 6 fields in this section, however **only 3 are required**.

- **Screening Location or Exam/Treatment Provider Name:** Provider/Facility name. To add the provider or facility you will need to search for the provider in PRISM. See the instructions in the APPENDEX called PROVIDER SEARCHING.
- **Treatment Date:** The date the client was treated
- **Treatment:** The treatment that was prescribed or administered

You MUST click "**Add Screening/Exam/Treatment**" in order for the treatment to save. You can repeat this process as many times as you need for additional treatment given for the infection. If you have nothing else to enter on the field record, then click "Update" at the top of the Field Record to save your work.



Any tests added to the Field Record will appear in the Lab Providers attached section of the Screening/Exam/Treatment section of the Field Record.

Staging Syphilis Cases

Syphilis field records need to be staged before the field record can be closed as a case. If the individual turns out to not be infected or is serofasting, the disease code remains a 700.

In order to stage a syphilis field record, you must click "Edit" on the field record and then click the Disease field Dropdown to view the available options, which are:

- 700 – Syphilis
- 710 – Syphilis – Primary
- 720 – Syphilis – Secondary
- 730 – Syphilis – Early, Non-Primary, Non-Secondary
- 755 – Syphilis – Unknown Duration or Late
- 790 – Congenital – Early Unspecified

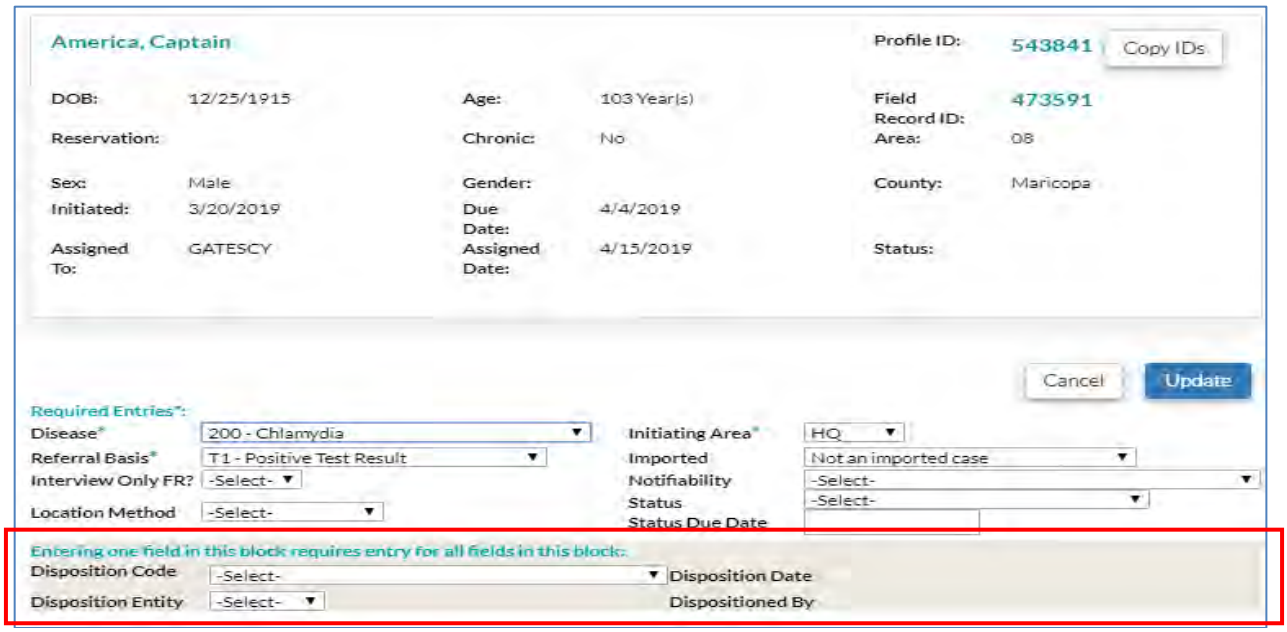
Certain field record options will change based on the stage you select, so it is recommended to stage the syphilis field record as early as possible.

Once staged, please note that primary and secondary syphilis cases will require symptoms to be added to the field record matching the stage you selected (e.g. lesion for primary syphilis, mucous patches or palmar/plantar rash for secondary syphilis, etc.).

Dispositioning Cases

To disposition a field record means to set the outcome of the case (e.g. if the patient was treated, refused treatment, unable to locate, etc.). As such, **it should be the last task performed before a case gets sent for closure.**

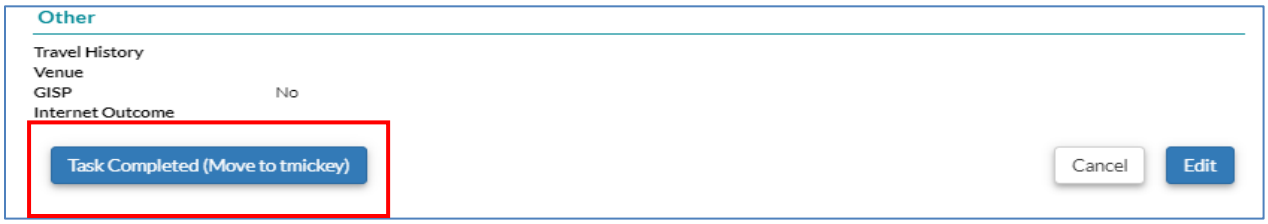
A list of all disposition codes can be found in the Appendix. Once a disposition is set, the Disposition Entity, Disposition Date and Dispositioned By field will all prepopulate. **Disposition Entity** is the county dispositioning the case. Dispositioned By will show the username of the PRISM user that set the disposition with the date.



Be aware that if you select a Disposition that states the patient was treated, you **MUST** already have added the treatment to the field record or else the system will give you the error message below.

- **The disposition selected requires a standard treatment. Either add the standard treatment, or change the disposition.**

If all required information is entered, click update to save changes made to the field record. If the field record is ready for review by the supervisor for closure, click the *Task Completed* button at the bottom of the field record to reassign the record to the supervisor.



Once the field record is **Task Completed**, it is reassigned to the Supervisor and move from the Investigator's Task List to the Supervisor's Task List.

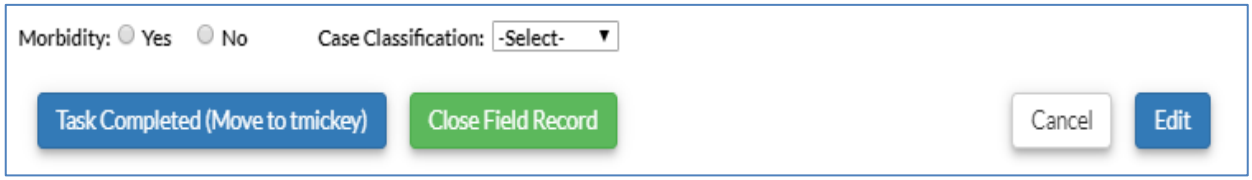
Setting Case Classifications and Closing Cases

Once the field record has been task completed, the **Morbidity** and **Case Classification*** fields will appear along with the *Close Field Record* button at the bottom of the screen.

*The **Case Classification** field should be completed as follows:

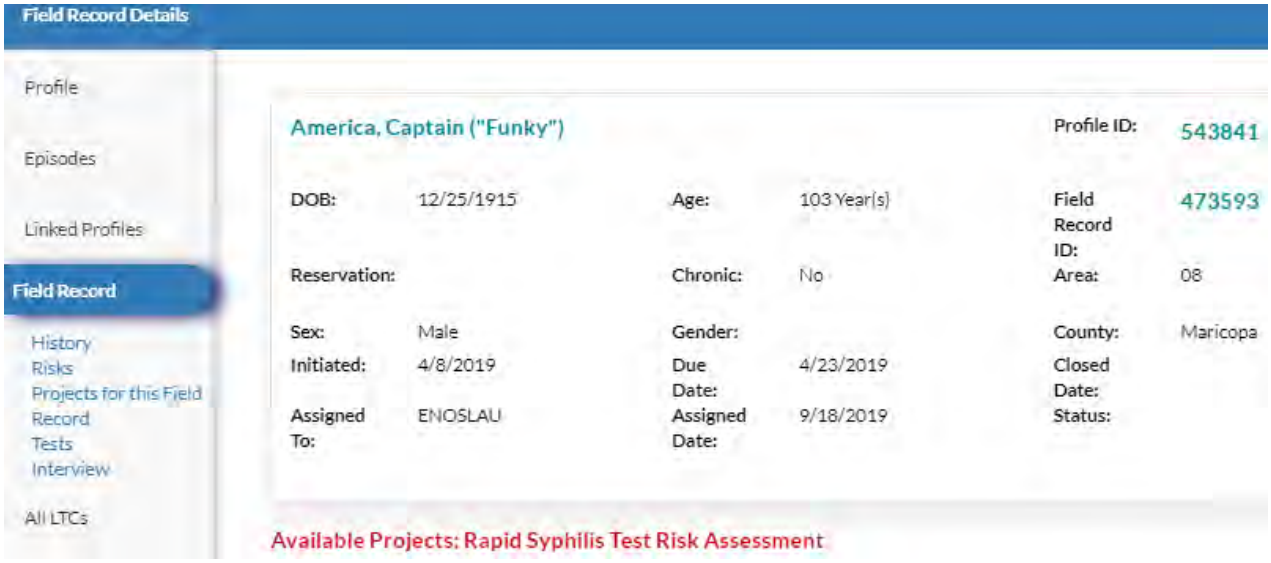
Disease Category	Case Classification
Chlamydia with any positive NAAT or culture test	Confirmed
Gonorrhea with any positive NAAT or culture test	Confirmed
Gonorrhea with a positive urethral smear test	Probable
Syphilis with positive Darkfield or PCR test	Confirmed
Syphilis without positive Darkfield or PCR test	Probable
Newly Diagnosed HIV	Confirmed

Morbidity should be set to 'Yes' if it is a case and 'No if it is not a case. Case classification is only needed for cases. If it is not a case, leave the Case Classification set to **–Select-.** Then *click Close Field Record* to close the record.

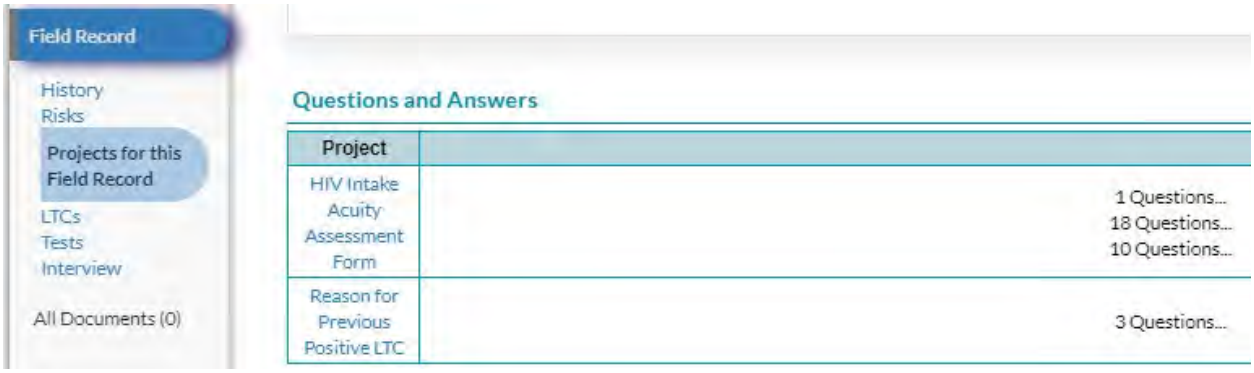


Answering Project Questions

If additional data collection needs are required, the ADHS STD Control Program has the ability to create special projects in PRISM with additional questions for PRISM users to answer, associated with a specific field record. If a special project is active and your field record meets the criteria for the project, an alert will show at the top of the field record as "Available Projects:"



In order to access the project, on the left-hand navigation under the Field Record tab, click the "**Projects for this Field Record"** subtab. It will show all available projects available for the field record. If there are no available projects, the subtab will not show at all. **There may be more than one project available for a field record**. ADHS will notify users if a new project has been created in PRISM that is required to be answered.

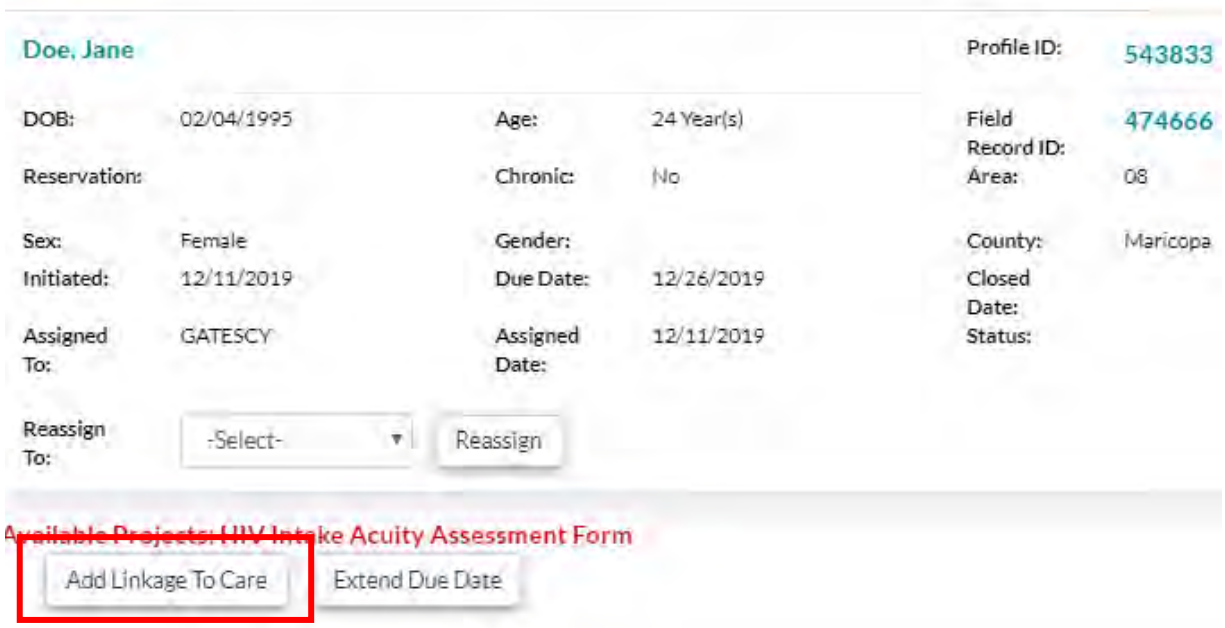


To answer project questions, simply click on the name of the project to open it and answer the questions. Remember to click **Save** at the bottom of the project to save your answers.

Project questions can be answered regardless of if the field record is open or closed.

LINKAGE TO CARE

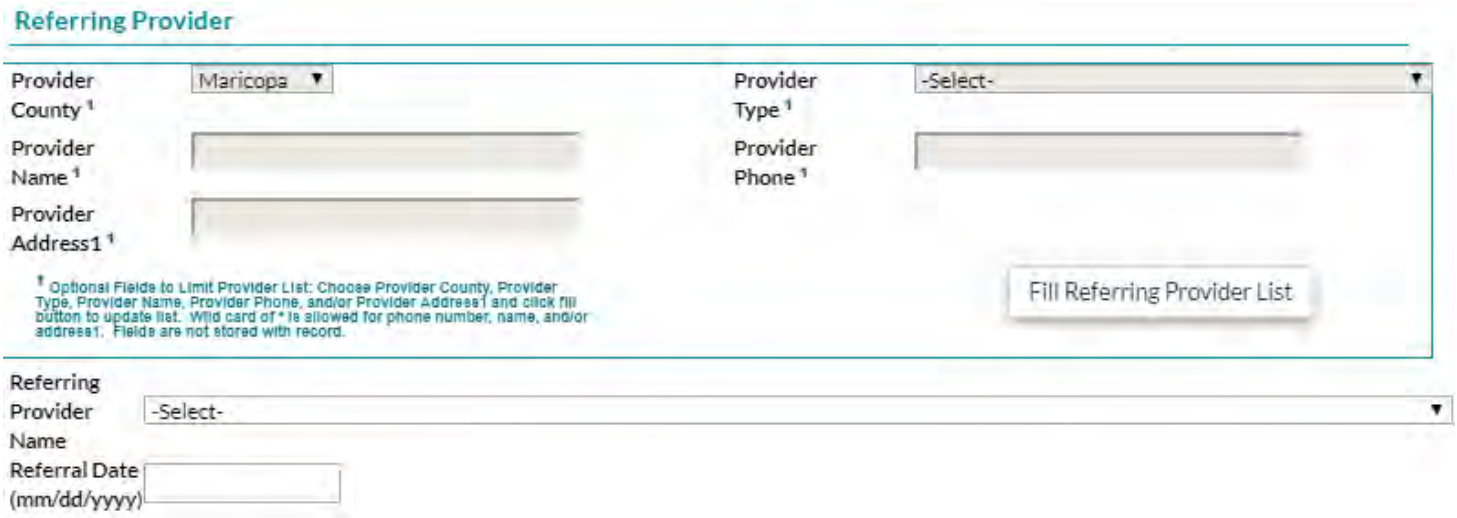
Linkage to Care is added from the field record or Interview tab to document linkage to HIV medical care.



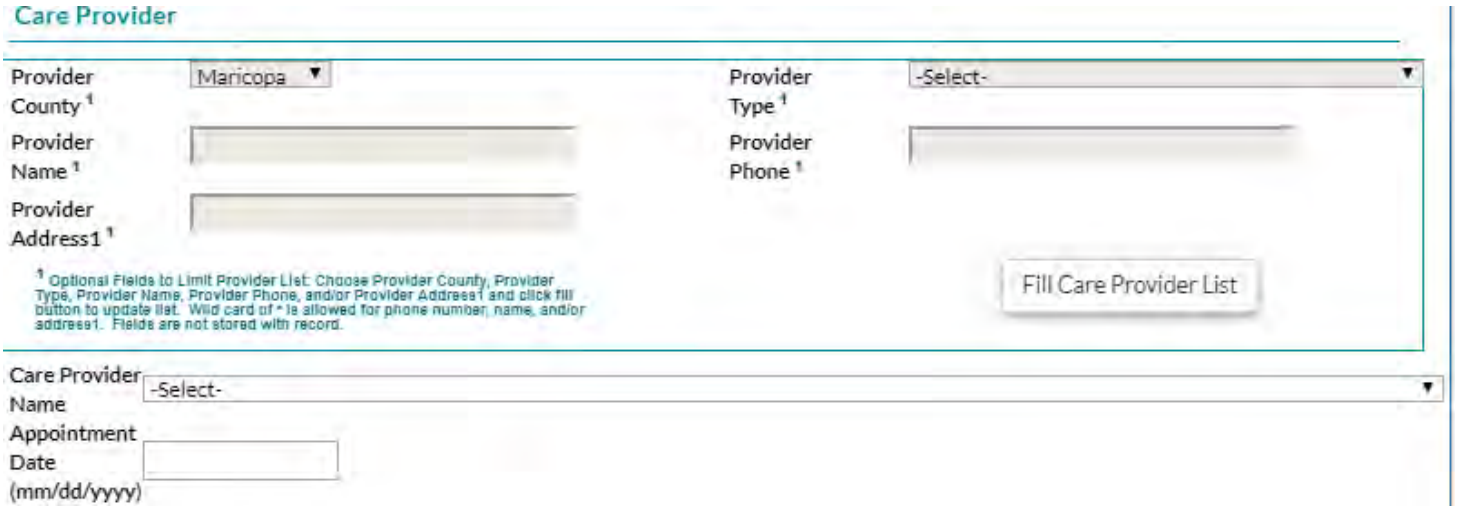
The first questions in the Linkage to Care Record are: Reason for Linkage Record, Status at Interview and Status at Case Close. The Reason for Linkage question refers to why an LTC record was created. The Status at Interview and Case Close questions refer to if the patient was in care or not at those time periods.

The **Contact Attempts** section documents all attempts to contact the patient to assist them with linkage to care and the outcome of each attempt. All four fields are required, and the ***Add Attempt*** button must be clicked to save the contact attempt. Contact attempts already entered on the field record do not need to be re-entered here. Click ***Add Attempt*** for each contact attempted to reach patient.

The **Referring Provider** section documents the name of the provider that referred the patient to care. This is often the DIS or LTC worker assigned to this LTC record, but if the patient was already referred to medical care, this field documents the name of the provider or agency who **initially** made the referral that the DIS or LTC worker is investigating. There are filters that can be used to limit the providers in the provider drop- down. See the instructions in the APPENDEX called PROVIDER SEARCHING. Click the ***Fill Referring Provider List*** button to update the selection list based on the selected filters



The **Care Provider** section documents the name of the provider from which the patient received HIV medical care. There are filters that can be used to limit the providers in the provider drop-down. See the instructions in the APPENDEX called PROVIDER SEARCHING. Click the ***Fill Care Provider List*** button to update the selection list based on the selected filters.



The **Results** section documents the final Referral Outcome of the linkage to care referral, the verification source of this referral, and the date the referral outcome was verified. If '**Attended Appointment**' is selected, the following fields are required: **Care Provider**, **Appointment Date**, **Verification Source** and **Verification Date**. There is also a section to document any pertinent **Notes** related to the linkage to care record at the bottom of the screen.

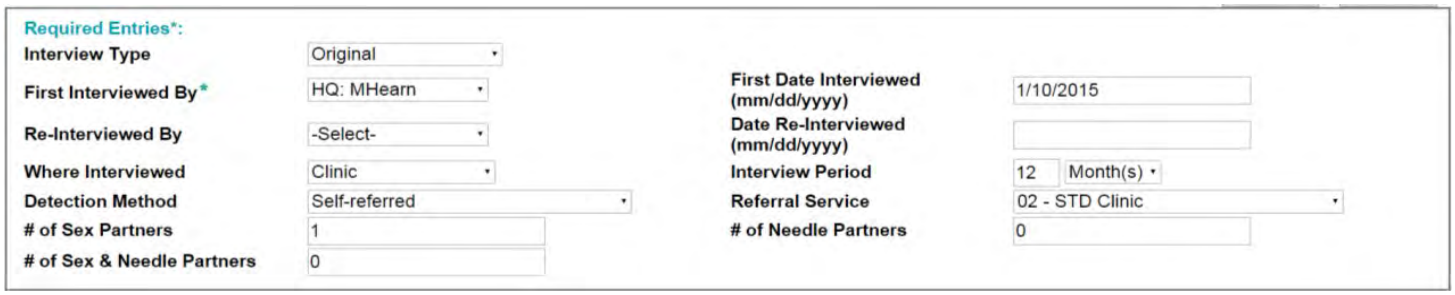
If all entered information is correct, click the ***Close LTC*** button to close the linkage to care record. The linkage to care record can remain open even if the field record or interview is closed Multiple linkage to care records can be added to a field record or interview, but only one can remain open at a time.

When the linkage to care record is created, a notification record will be placed on the task list of the person who the linkage to care record is assigned to as well as the task list of the person who created the linkage to care record. Once the linkage to care record has been closed by the assignee, the person who created the linkage to care record will need to close the notification by clicking the ***BLUE*** Notification ID link from the task list and then clicking the ***Close Requestor*** button from the Notification Details page.

CREATING AN INTERVIEW RECORD

Interviews are created on patients to elicit contacts that were exposed to a disease and need testing and treatment. Interview records are created from the Field Record. Click ***Add Interview*** to create an Interview for an existing field record. If an interview is already open for this profile, the button text reads ***Link Existing Interview***. All current positive field records requiring partner services should be linked to an Interview record to ensure partners are tested and treated for all diseases they were exposed to.

Required Entries are marked with an (*) for all interview records.



- **Interview Type** indicates the type of interview.
- **First Interviewed By** documents the worker that performed the first interview.
- **First Date Interviewed** documents the date of the first interview or the date it was determined that the client was unable to interview.
- **Re-Interviewed By** documents the worker that performed the re-interview.
- **Date Re-Interviewed** documents the date the re-interview was performed.
- **Where Interviewed** documents where the interview was performed.
- **Interview Period** is the timeframe that the interview questions pertain to.
- **Detection Method** documents how the patient came to the attention of the health department.
- **Referral Service** documents what type of provider referred the patient to the health department.
- **# of Sex Partners** documents the number of sex partners the patient claims to have

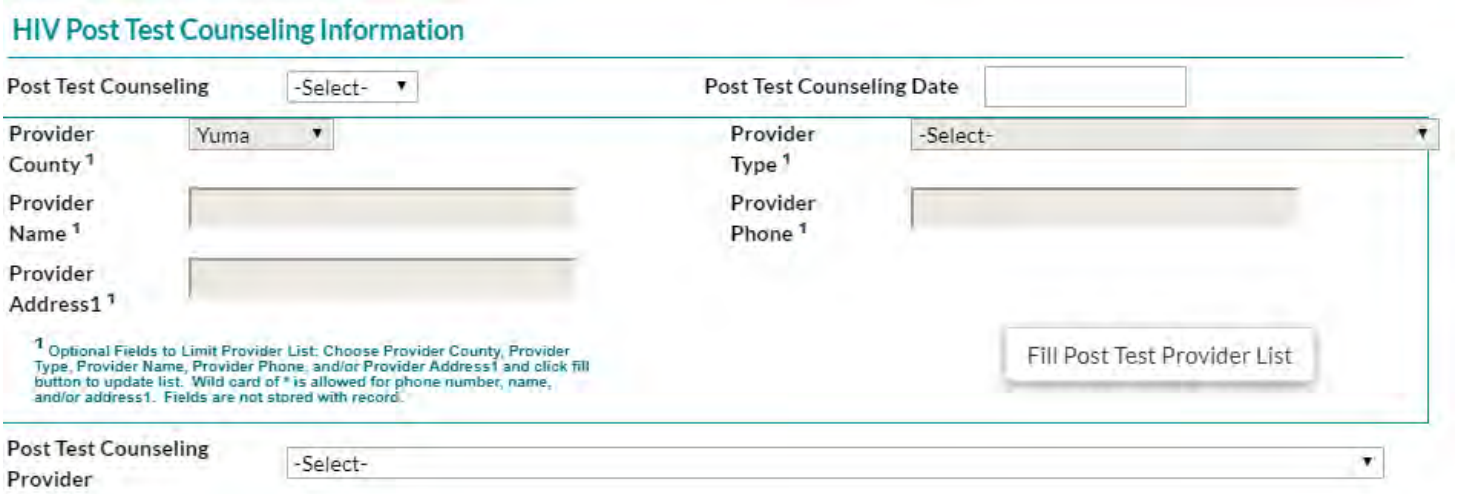
during the interview period.

- **# of Needle Partners** documents the number of needle partners the patient claims to have during the interview period.
- **# of Sex & Needle Partners** documents the number of sex and needle partners the patient claims to have during the interview period.

When entering the **# of Sex Partners**, **# of Needle Partners** and **# of Sex & Needle Partners**, do not include a partner in more than one category. Therefore, if the partner only has sex with the original patient, you would count that partner under **# of Sex Partners** and not under **# of Sex & Needle Partners**. When data is submitted to CDC, the three fields are added together.

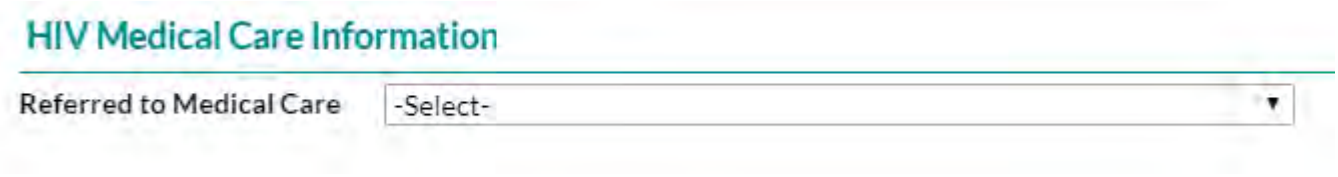
The **HIV Section** documents the patient's HIV testing history. **HIV Self-Reported Status** documents what the patient claims his or her status to be and is required for all interviews. **HIV Confirmed Status** documents the confirmed results of the patient's reported status.

The **HIV Post Test Counseling Information** section documents whether the patient has received their HIV test results, the date of post-test counseling, and the provider who delivered the result. There are filters that can be used to limit the providers in the provider drop-down. See the instructions in the APPENDEX called PROVIDER SEARCHING. Click the ***Fill Post Test Provider List*** button to update the selection list based on the selected filters.

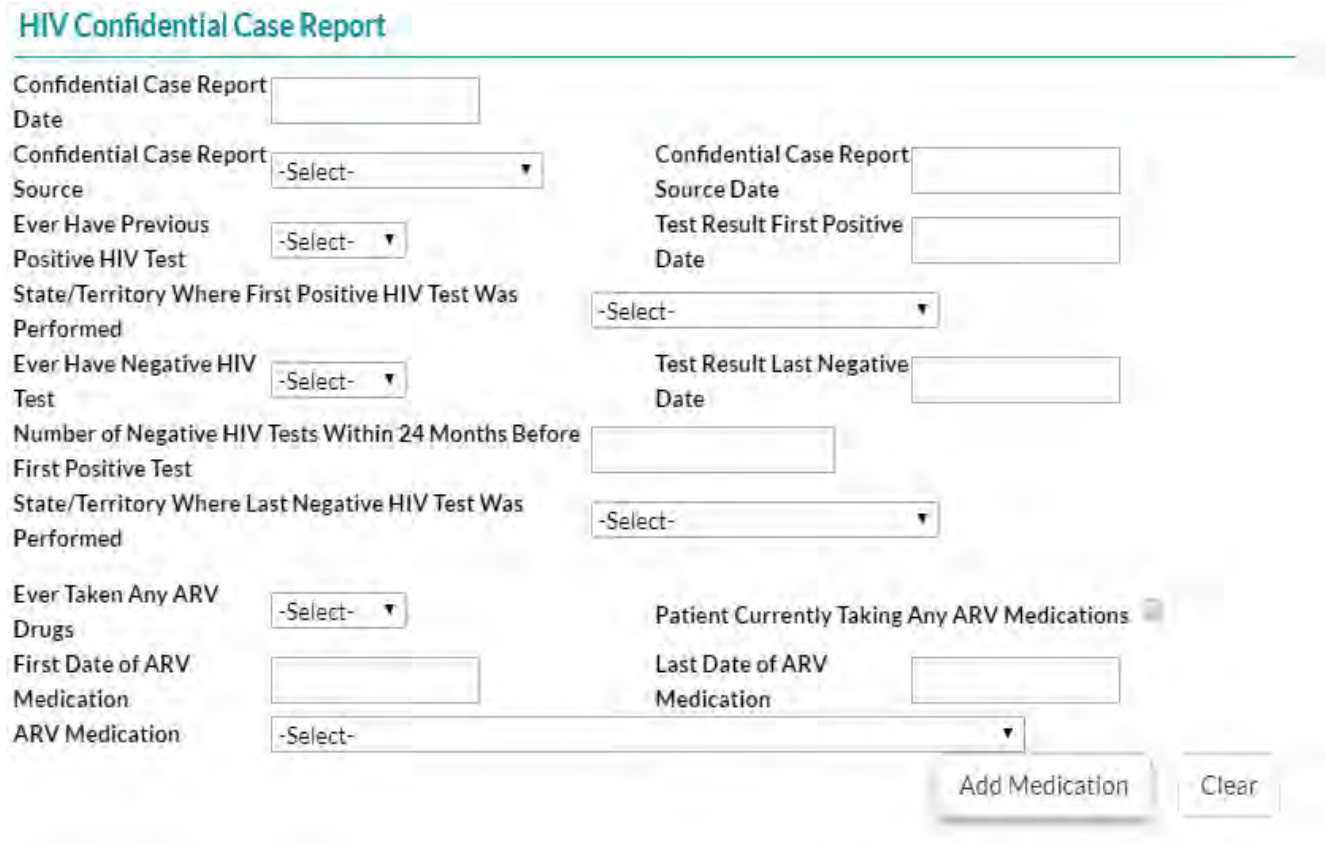


pg. 40

The **HIV Medical Care Information** section documents whether the patient was referred to HIV medical care. It is recommended to create Linkage to Care Record prior to interview closure regardless of the answer selected here.

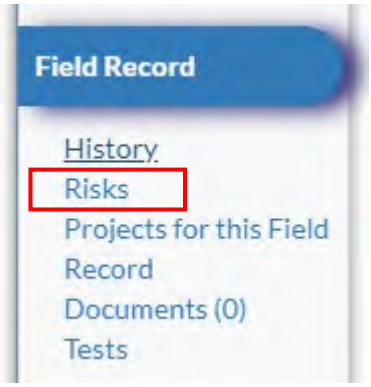


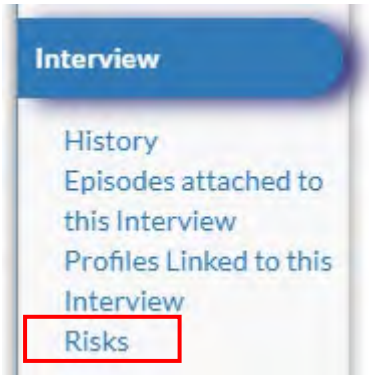
The **HIV Confidential Case Report** section documents whether the patient had a history of prior HIV testing and ARV drug use.

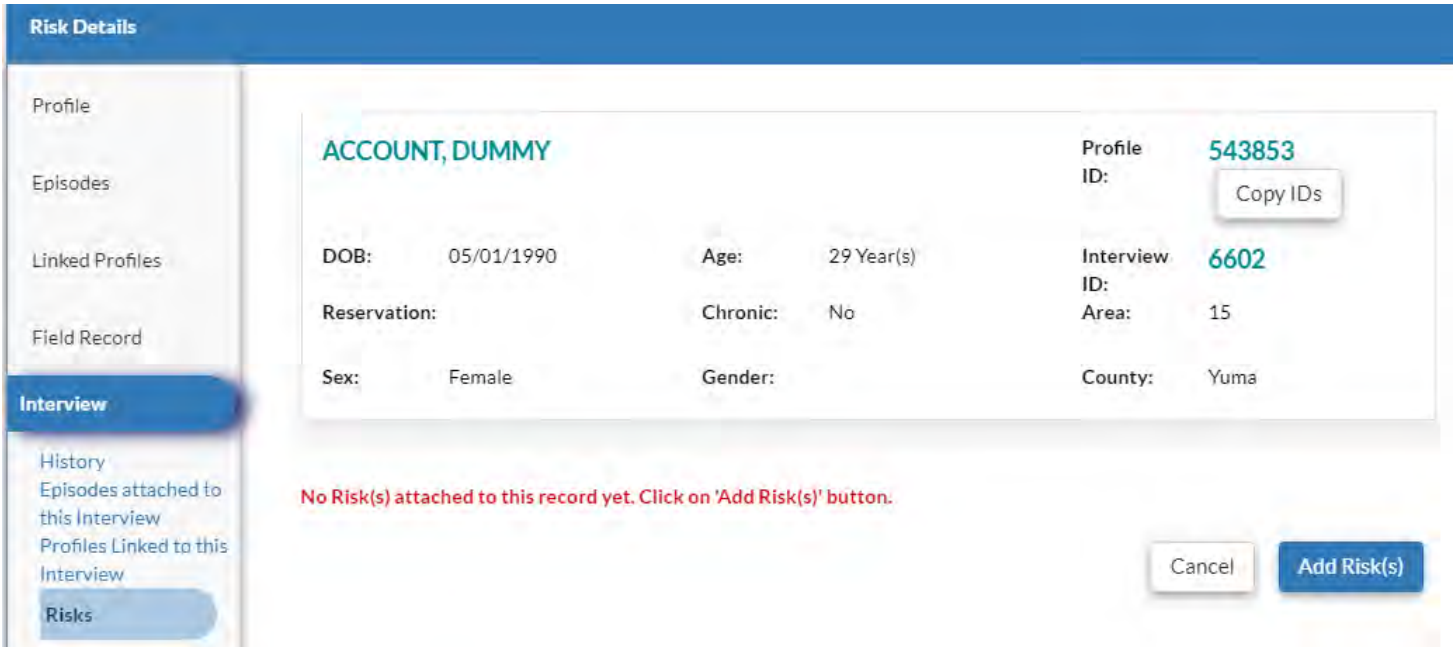


Adding Risks

Risks are added from a field record or Interview. If risks are added to a field record and then an interview is created, all risks on the field record will be copied over to the interview. Once an interview is linked, risks can only be added from the Interview. Click the Risks subtab from the field record or the interview record.







Click *Add Risks* to display a list of risks available to ask the patient. Risks marked with an asterisk (*) are required to be answered. Click the *SAVE* button once risks are entered. If the client declined to answer all or most of the questions or the questions were not asked, you can click the "Not Asked About Risk Factors" button or the "Declined to Answer" button, which will pre-populate all risk questions with those response. Once the risks are saved, they can be changed or deleted by clicking the *ADD/EDIT/CLEAR* button.

ACCOUNT, DUMMY

Profile ID: 543853 Copy IDs

DOB:	05/01/1990	Age:	29 Year(s)	Interview ID:	6602
Reservation:		Chronic:	No	Area:	15
Sex:	Female	Gender:		County:	Yuma

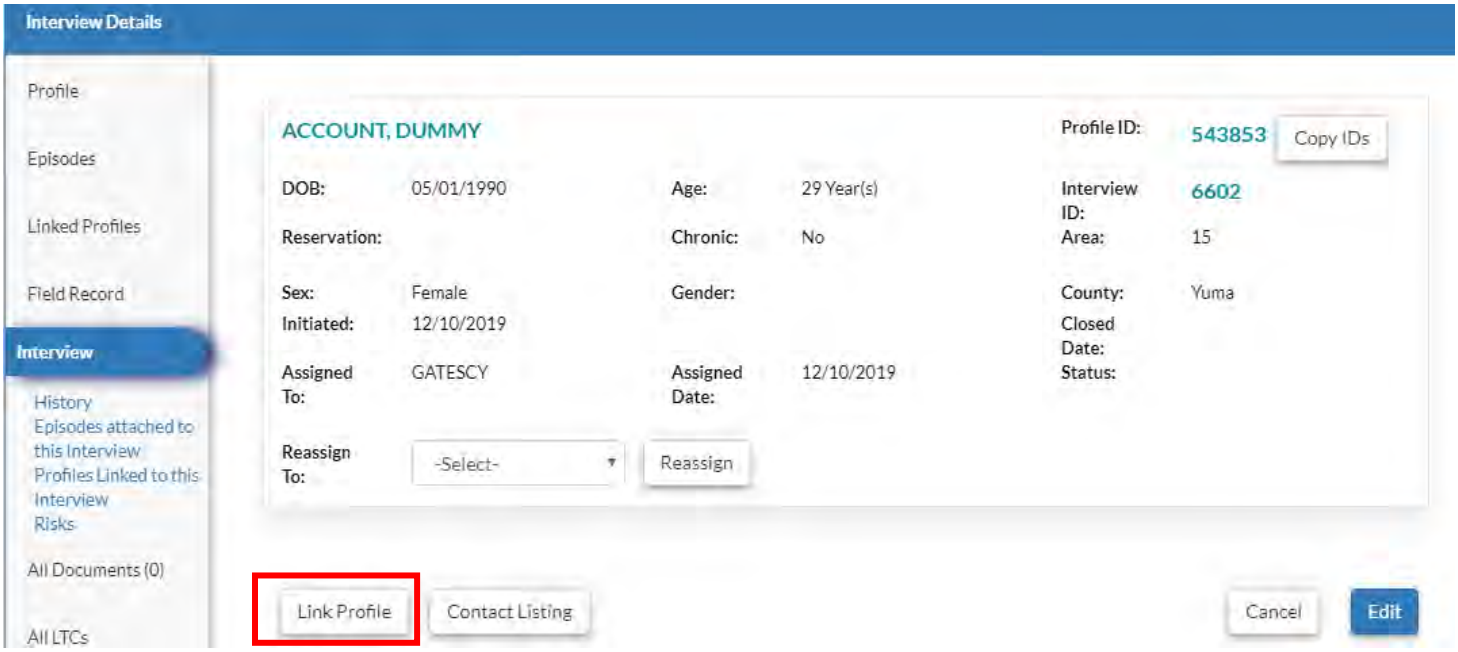
Not Asked About Risk Factors | Declined to Answer | The risks marked with an * are required since this interview is attached to a Syphilis field record. | Cancel | Save

Risks

	Req.	Risk Type	
		STD	Alcohol Use Yes No Refused to Answer Did not ask Clear
		STD	Citizen Yes No Refused to Answer Did not ask Clear
		STD	Client Behavioral Risk Profile Client completed a behavioral risk profile Client was asked but no behavioral risks were identified Client was not asked about behavioral risk factors Client declined to discuss behavioral risk factors Clear
	*	STD	Drug use - None Yes No Refused to Answer Did not ask Clear
	*	STD	History of prior STD Yes, patient has a history of STD No, patient has never had a prior STD Unknown if patient has had a prior STD Patient refused to answer any questions regarding prior STD history Clear
	*	STD	Incarcerated within last 12 months Yes No Refused to Answer Did not ask Clear
		STD	Sex - Anal - Insertive Yes No Refused to Answer Did not ask Clear
		STD	Sex - Anal - Receptive Yes No Refused to Answer Did not ask Clear
		STD	Sex - Anal - Versatile Yes No Refused to Answer Did not ask Clear
	*	STD	Sex exchanged - Client gave drugs/money/or something needed to someone else for sex Yes No Refused to Answer Did not ask Clear
	*	STD	Sex exchanged - Client received drugs/money/or something they needed for sex Yes No Refused to Answer Did not ask Clear

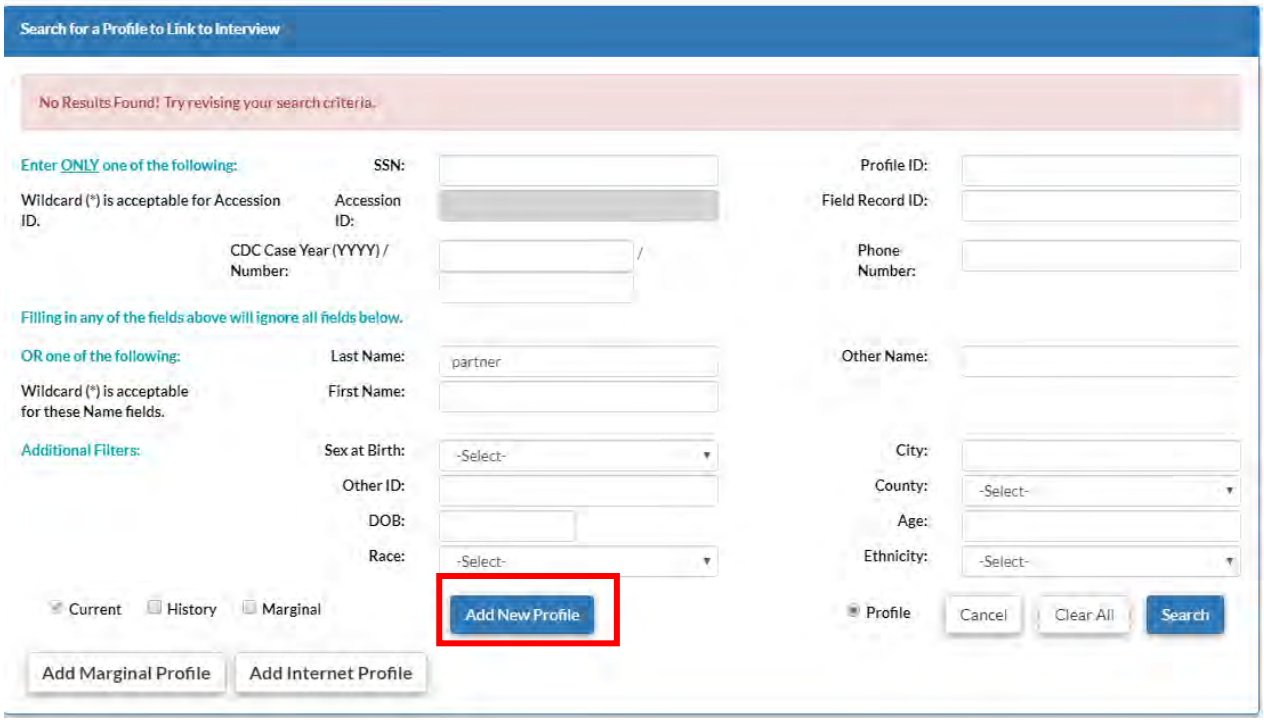
Linking Partners To An Interview

The **ONLY** way to link contacts to a patient is through the ***Link Profile*** button from the

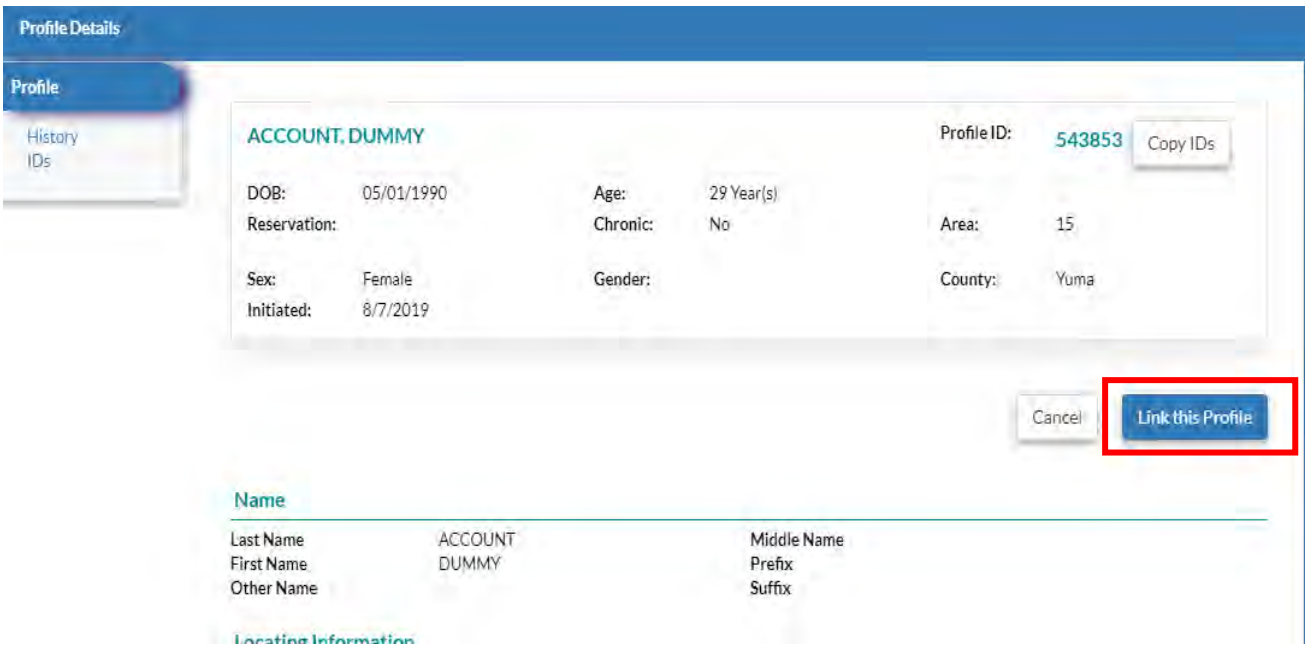


interview record.

Once the ***Link Profile*** button is clicked, the user is taken to the PRISM search page to search for the contact in the system. If the profile does not exist, a new profile can be added. There is also an option to ***Add Marginal Profile*** or ***Add Internet Profile*** *(See Marginal and Internet Profiles section).* Once the profile is found or created, click the ***Link this Profile*** button at the top right of the profile page.

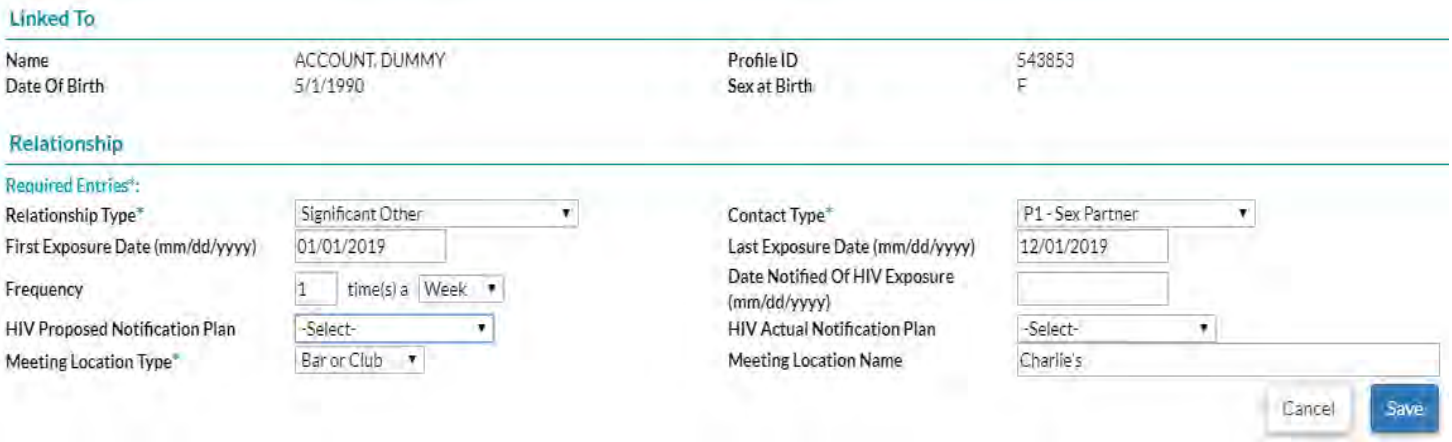


pg. 44

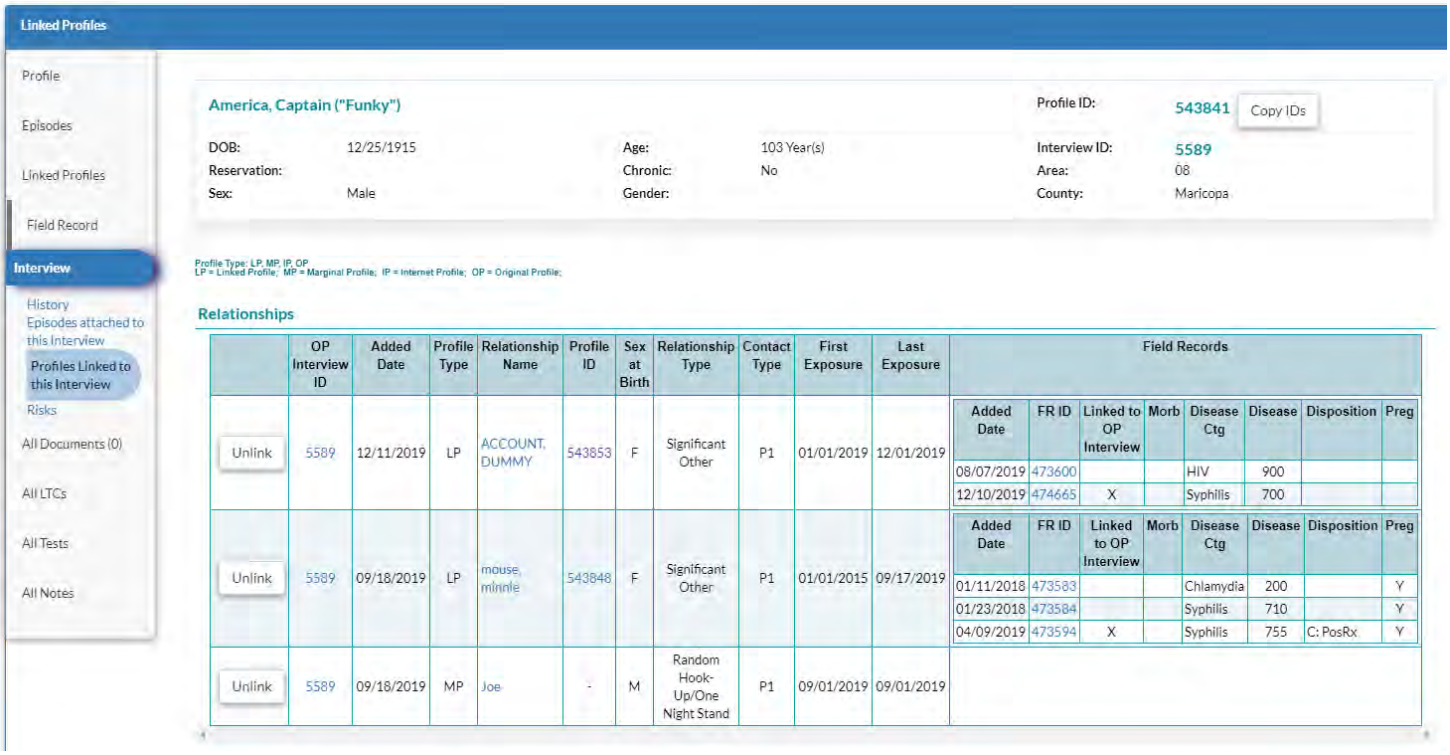


The Relationship page will now appear. The **Linked To** section displays the contact linked to this interview.

The **Relationship** section documents the type of relationship between the linked contact and the original patient as well as the specific exposure dates. For HIV cases, there is a section to document the proposed and actual notification plan for how this contact is notified of his or her HIV exposure. Click the ***Save*** button to save entered information.



The **Profiles Linked to this Interview** sub-tab displays the profiles that are linked to this particular interview. This page also displays a history of field records for each linked profile. If the original patient had multiple field records with different diseases linked to the interview, a field record for each disease is automatically initiated for each linked profile. If the linked profile has an existing field record for the same disease that was initiated within the last 30 days, the system will automatically attach that field record to the original patient's Interview.

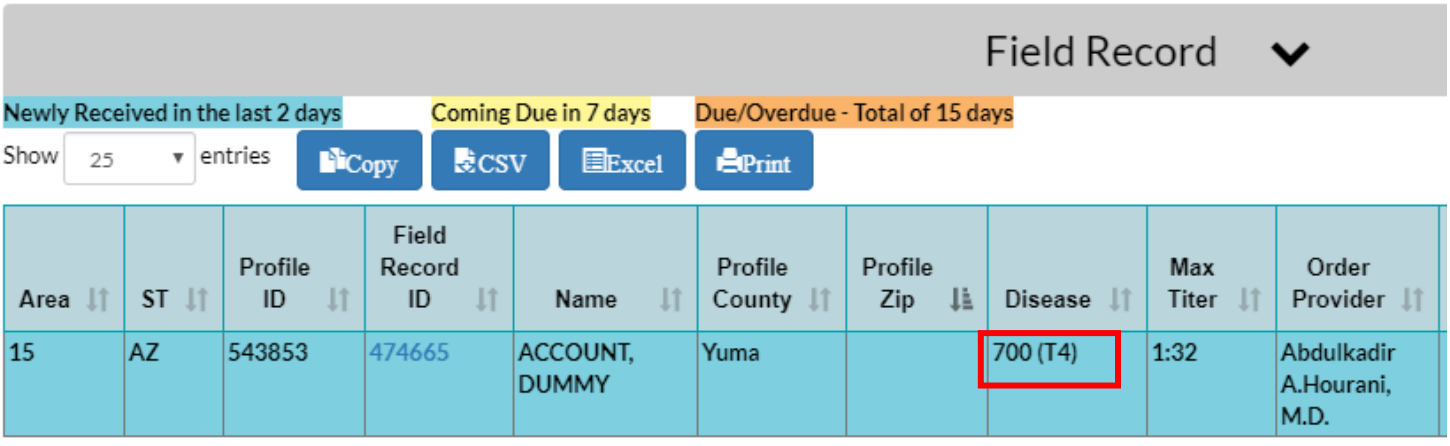


	OP Interview ID	Added Date	Profile Type	Relationship Name	Profile ID	Sex at Birth	Relationship Type	Contact Type	First Exposure	Last Exposure	Field Records
Unlink	5589	12/11/2019	LP	ACCOUNT, DUMMY	543853	F	Significant Other	P1	01/01/2019	12/01/2019	
Unlink	5589	09/18/2019	LP	mouse, minnie	543848	F	Significant Other	P1	01/01/2015	09/17/2019	
Unlink	5589	09/18/2019	MP	Joe	-	M	Random Hook-Up/One Night Stand	P1	09/01/2019	09/01/2019	

Added Date	FR ID	Linked to OP Interview	Morb	Disease Ctg	Disease	Disposition	Preg
08/07/2019	473600			HIV	900		
12/10/2019	474665	X		Syphilis	700		

Added Date	FR ID	Linked to OP Interview	Morb	Disease Ctg	Disease	Disposition	Preg
01/11/2018	473583			Chlamydia	200		Y
01/23/2018	473584			Syphilis	710		Y
04/09/2019	473594	X		Syphilis	755	C: PosRx	Y

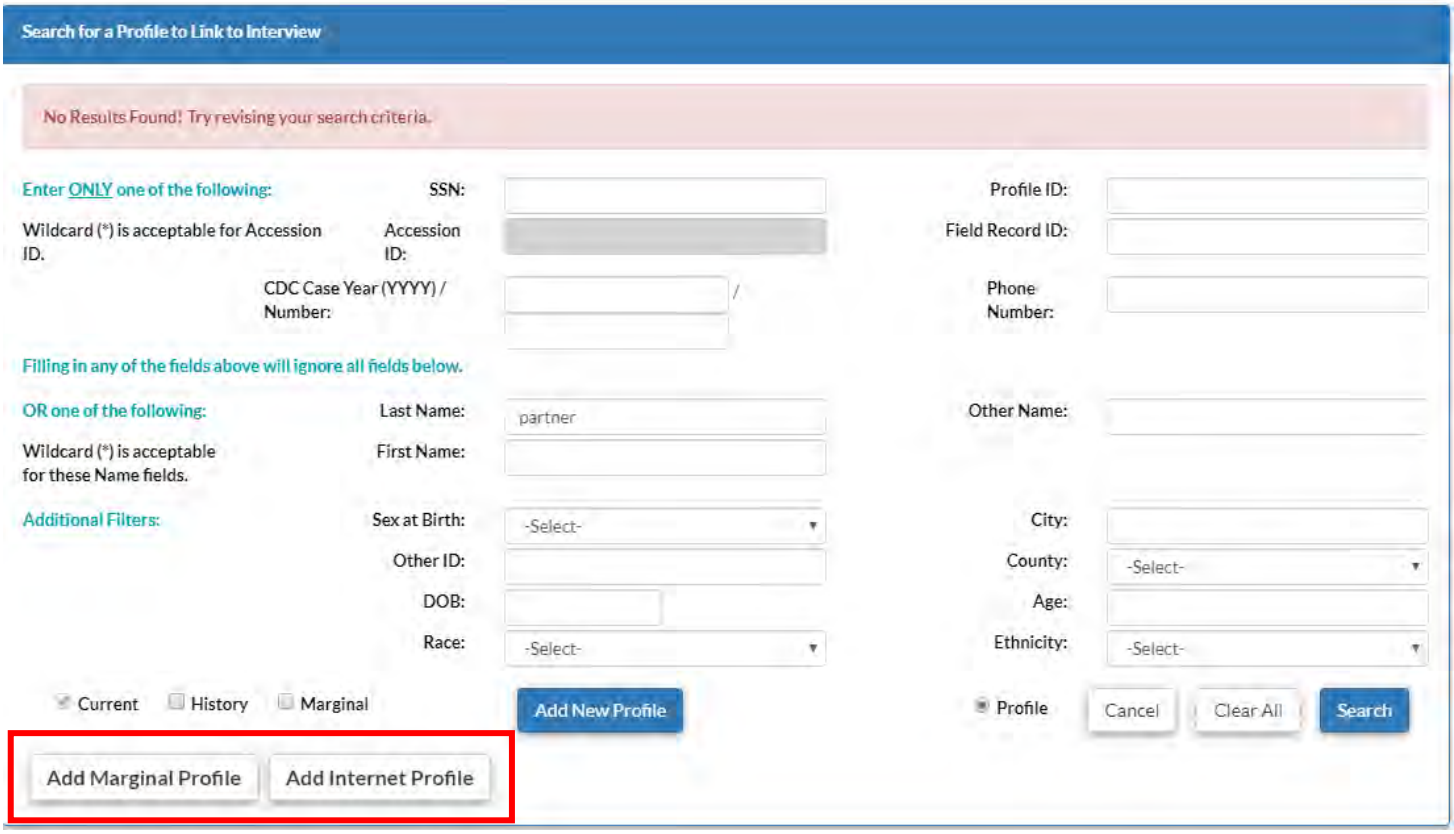
As contacts are linked to the interview, field records now appear on the users' Task List. Field records created from an interview will appear with a T4-Profile Referred referral basis in the disease column.



Area	ST	Profile ID	Field Record ID	Name	Profile County	Profile Zip	Disease	Max Titer	Order Provider
15	AZ	543853	474665	ACCOUNT, DUMMY	Yuma		700 (T4)	1:32	Abdulkadir A.Hourani, M.D.

Marginal and Internet Profiles

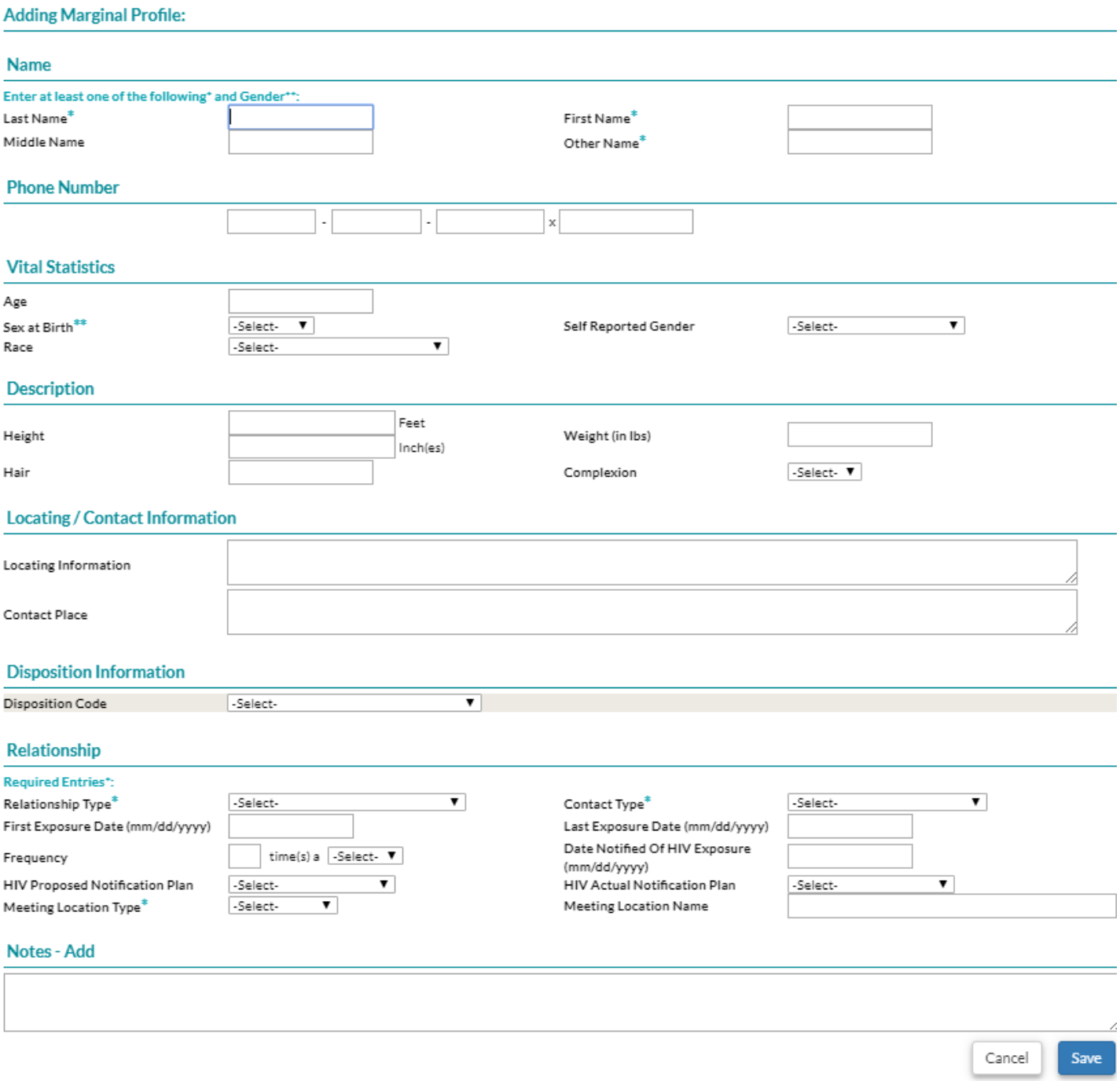
If no sufficient information is obtained, then a marginal or internet profile should be created. Marginal profiles are created from the Original Patient interview by clicking on the ***Link Profile*** button and choosing ***Add Marginal Profile*** or ***Add Internet Profile*** at the bottom of the



screen.

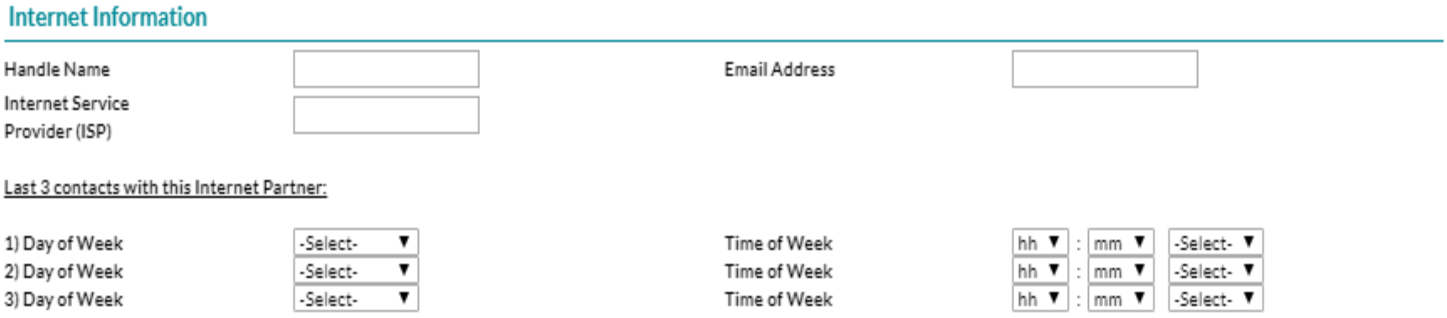
Marginal Profile

Adding a marginal contact includes the same relationship fields as a full profile link as well as demographic information.



INTERNET PROFILE

In addition to the information obtained in a marginal profile, the internet profile has a section to document specific internet information.



A field record for marginal and internet profiles will **not** appear on the task list. If enough additional information is obtained, a full profile is created and linked to the interview for a field record to be created for follow-up. If a full profile is created, the marginal or internet profile needs to be deleted.

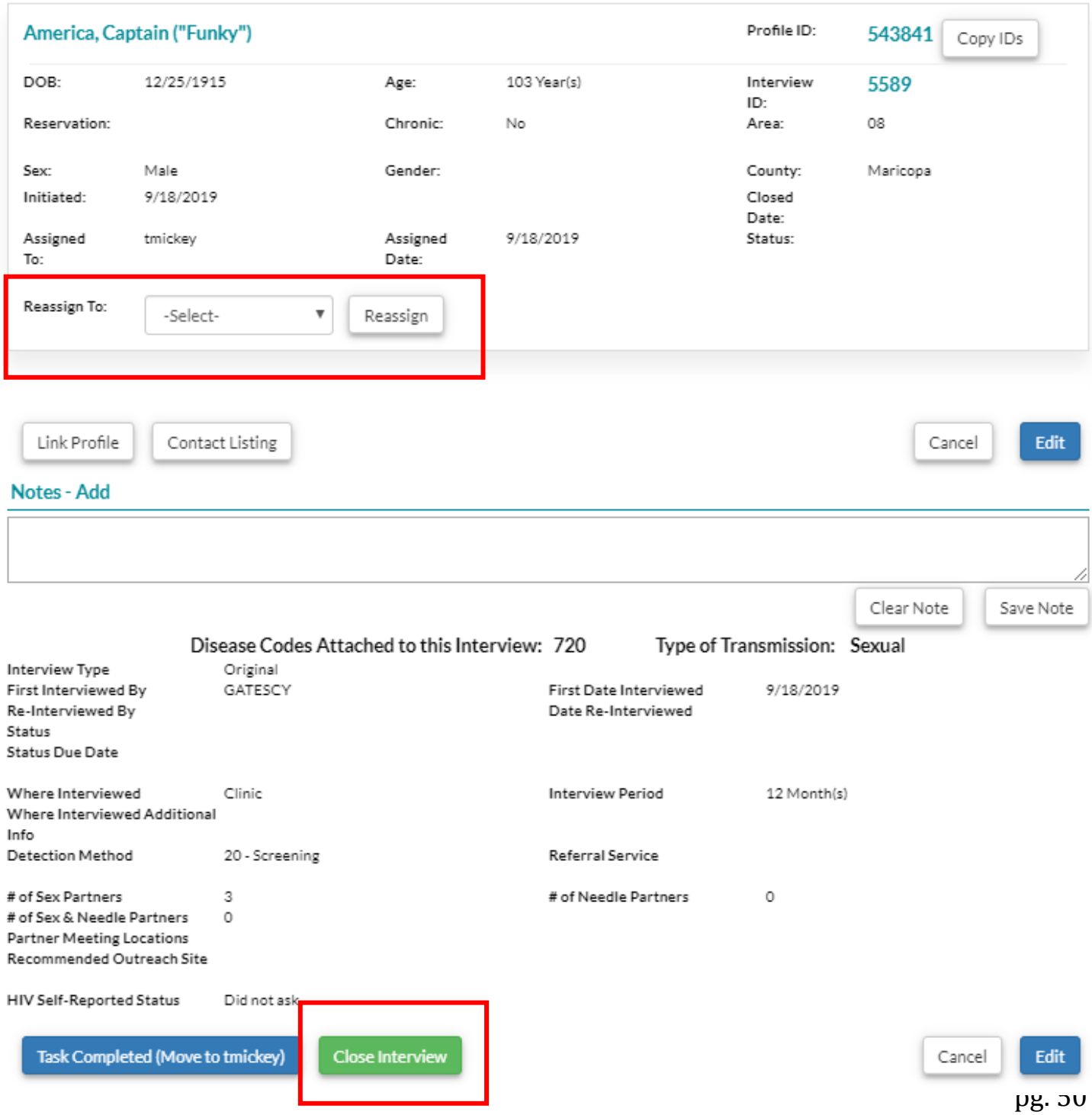
Closing Interviews

Once all required fields are entered, risks added, and linked profile field records are closed, the interview record is **task completed** to the manager for review and closure.

The interview record now appears on the manager's task list. Click the ***BLUE*** Profile ID to view the Interview Record from the task list.

The *Close Interview* button now appears at the bottom of the screen. To close the interview, click the *Close Interview* button at the bottom of the screen.

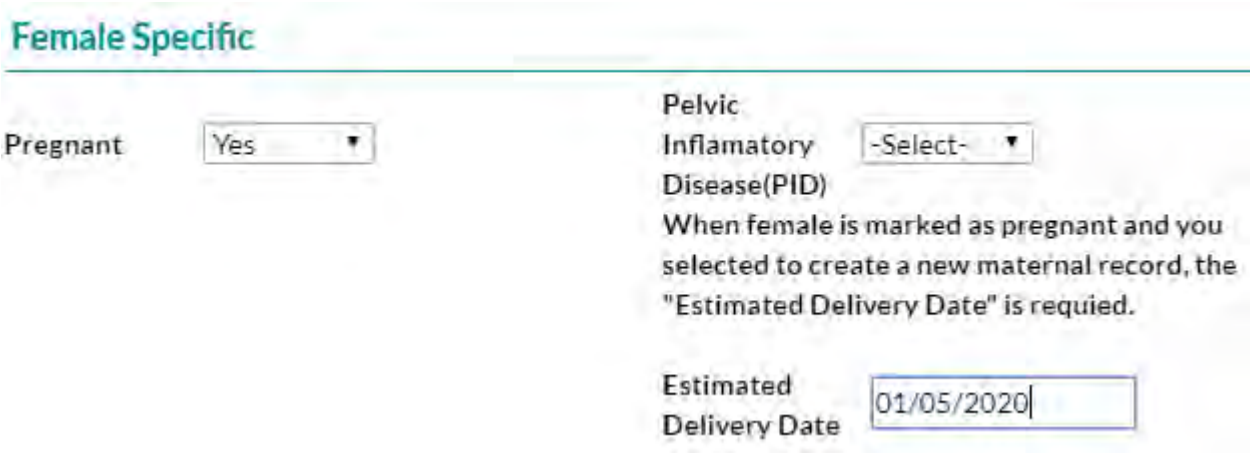
If the interview record requires additional or missing information, the supervisor can reassign the record to a user for completion. To reassign a record, choose the user from the dropdown list, and click the *Re-assign* button.



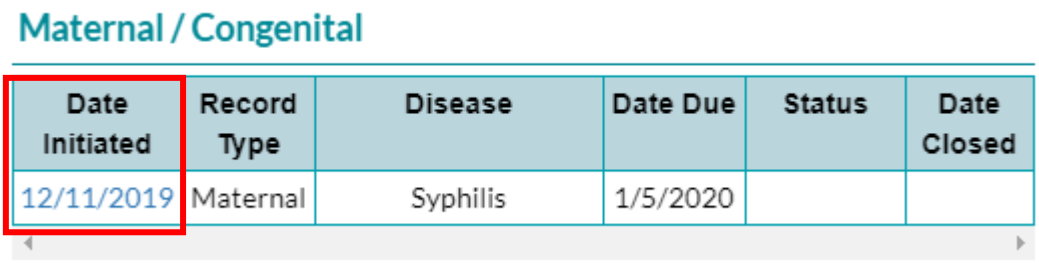
MATERNAL RECORDS

Maternal records are used to document maternal specific information **after** delivery. Maternal records are created from the **Female Specific** section of a field record and should be completed after the mother's field record has been completed.

The **Female Specific** section documents whether a patient is pregnant. When 'Yes' to pregnant is selected, an estimated delivery date box appears. Entering an **Estimated Delivery Date** automatically creates a maternal record for syphilis records once the field record is saved.

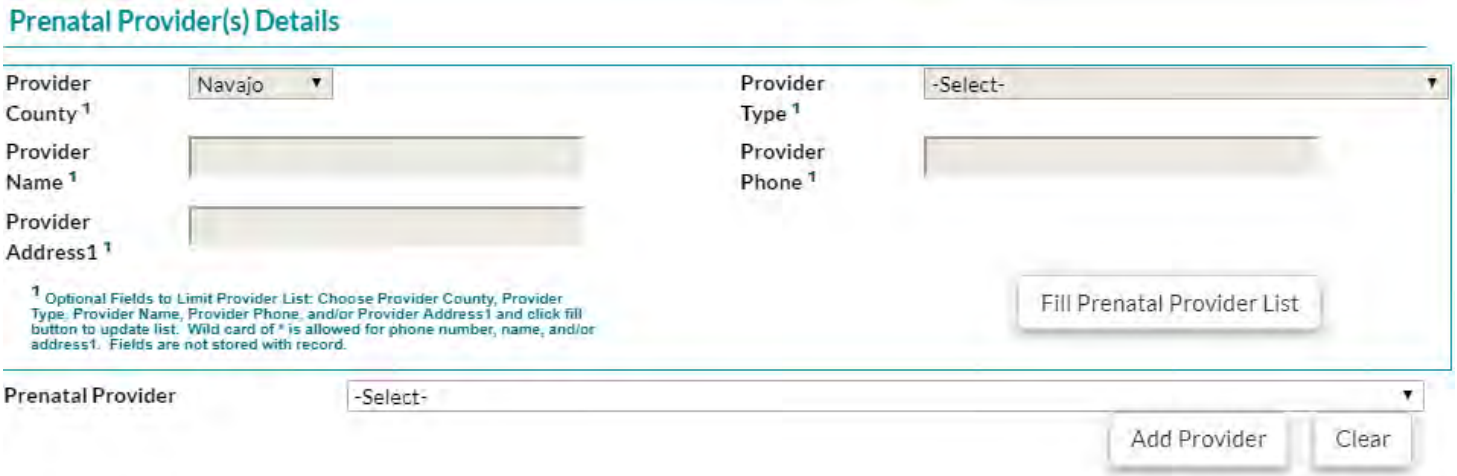


Maternal/Congenital records now appear in the patient's Episodes tab. Click the ***BLUE*** **Date Initiated** to view the maternal record.

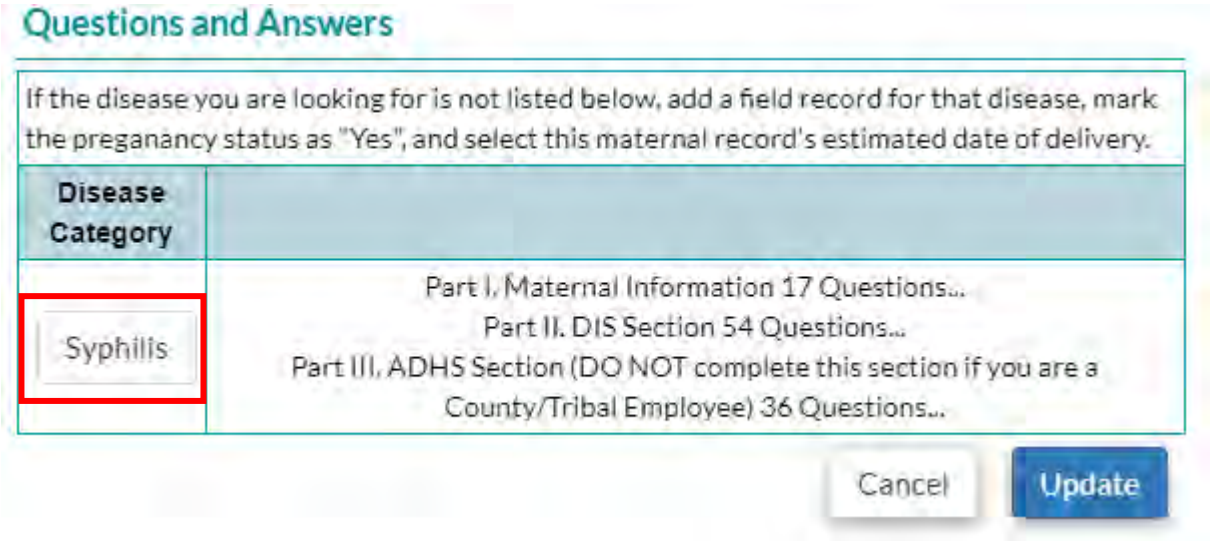


The maternal record consists of several questions concerning the patient's pregnancy. Click the ***EDIT*** button to open the maternal record.

Prenatal Provider Details section of the maternal record documents the prenatal provider details. There are filters that can be used to limit the providers in the provider drop-down. See the instructions in the APPENDEX called PROVIDER SEARCHING. Click the ***Fill Prenatal Provider List*** button to update the selection list based on the selected filters. Once the provider is chosen, click the ***Add Provider*** button.

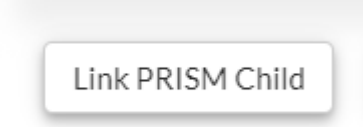


Questions and Answers section displays disease specific questions based on the field record disease. Click the button that says "**Syphilis**" and the questions will show. The questions in Part 1 follow the format of the CDC Congenital Syphilis Case Investigation Report (Form 73.126).



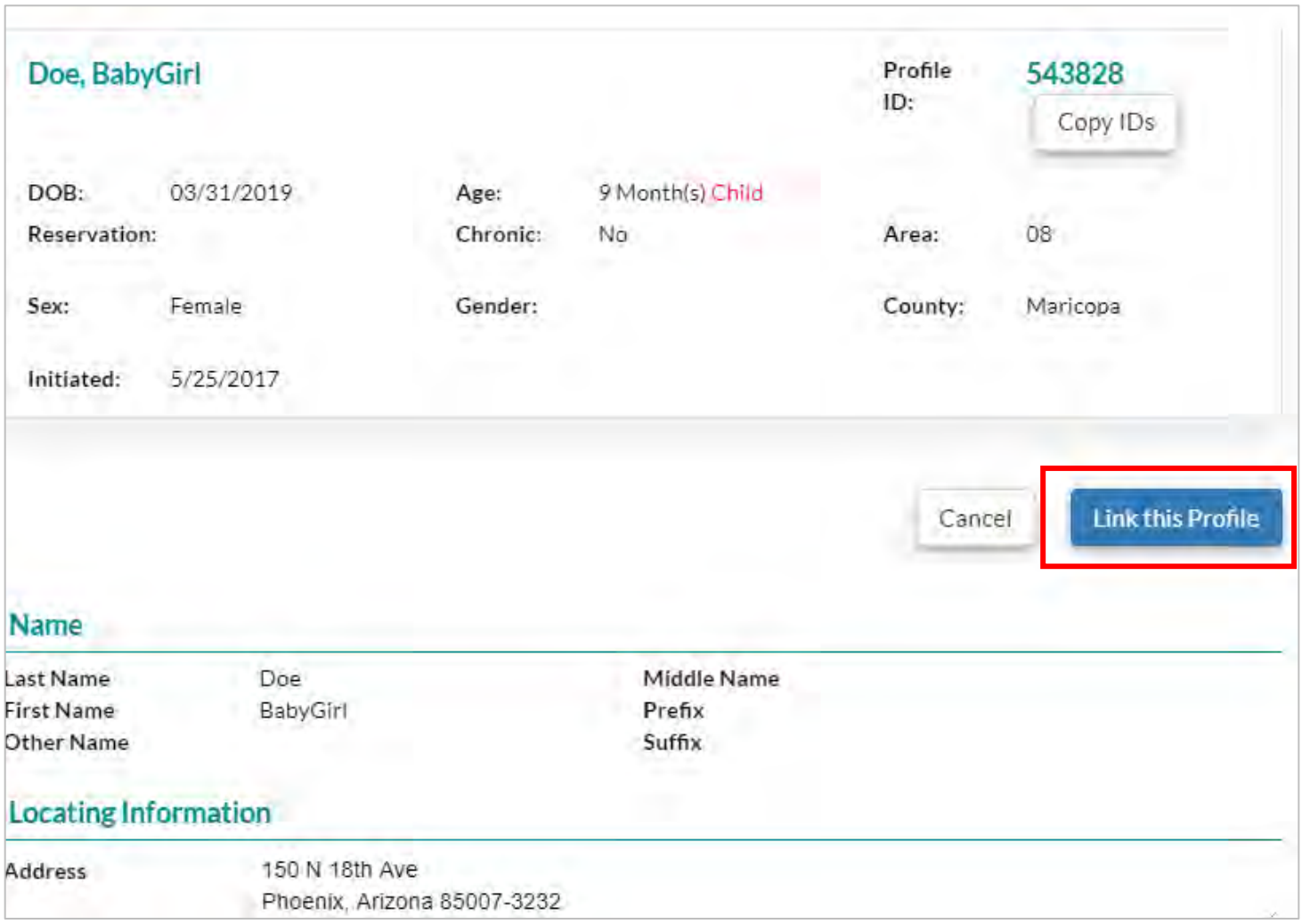
Once the questions have been answered, **FIRST** click the ***Save*** button, and **THEN** click the ***Update*** button on the maternal record.

Once the maternal record is updated, scroll up to the top of the maternal record and click the ***Link PRISM Child*** button to search for the baby in the system and link it to its mother's maternal record.



Similar to linking partners through the interview, once you click the ***Link PRISM Child*** button, the system will take you to the PRISM Search screen to search for an existing baby profile in the system. If the baby is not found, a new profile needs to be created by clicking the ***Add New Profile*** button. If the baby is found, click on the ***BLUE*** Record ID number and then ***Link this Profile*** button.

Record ID	Type	Last Name	First Name	Other Name	Gender	DOB / Age	City	County	Race
543828	P	Doe	BabyGirl		Female	03/31/2019	Phoenix	Maricopa	White
543846	P	Duck	Baby Girl	mom = 'Daisy'	Female	10/23/2017	Phoenix	Maricopa	White

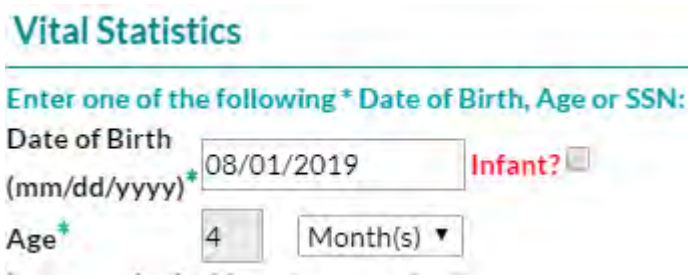


You will then be brought back to the maternal record and there will be a new section that says "PRISM Children Linked to this Mother.

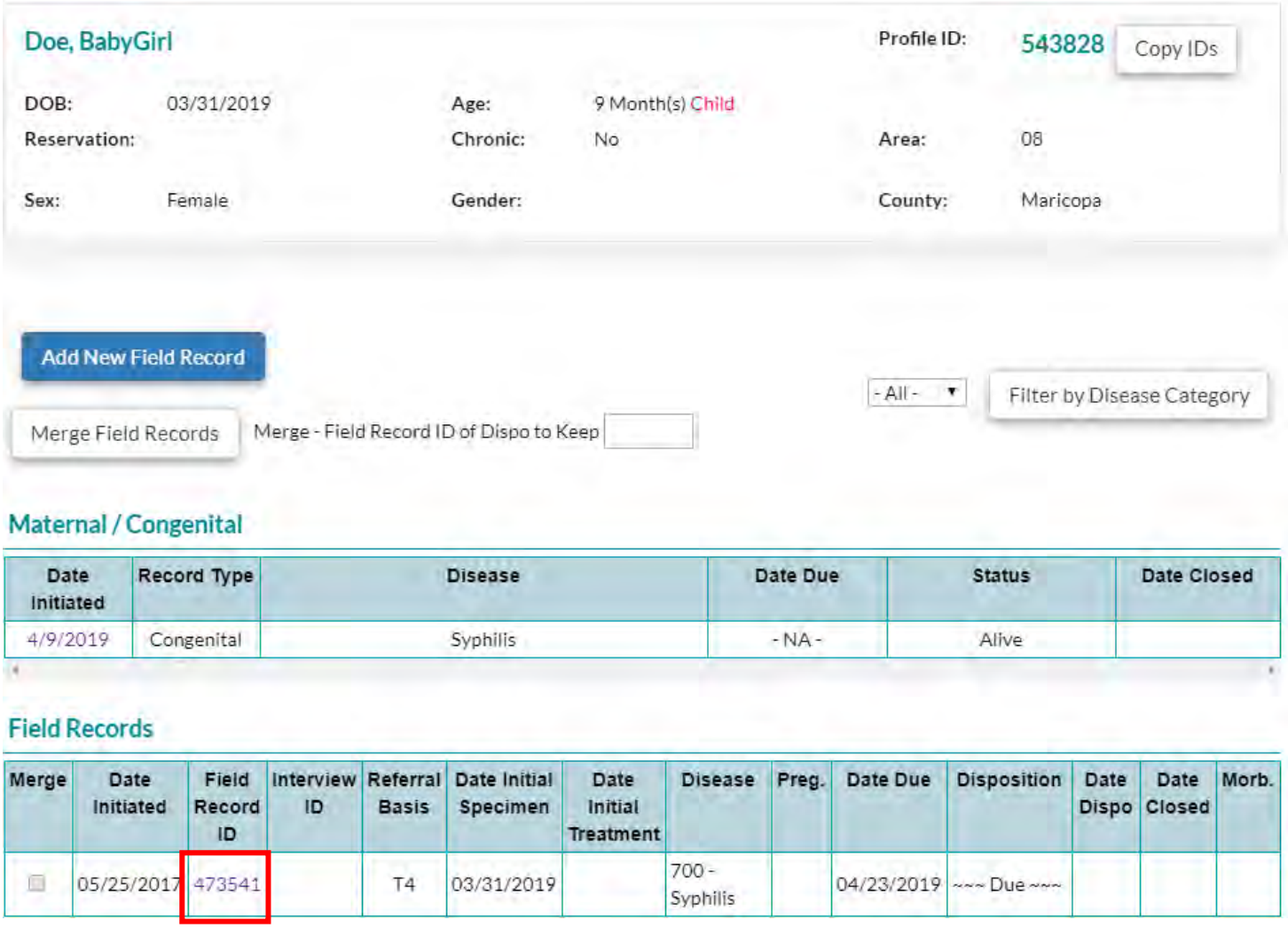
If the mother's maternal record has been completed, it can now be closed and the baby's congenital record can be worked on.

CONGENITAL RECORD

Congenital Records are generated when a profile is created, and the date of birth is within the last six months. Upon saving the profile, the system requires the user to verify the age by clicking in the box indicating the profile is for an infant.

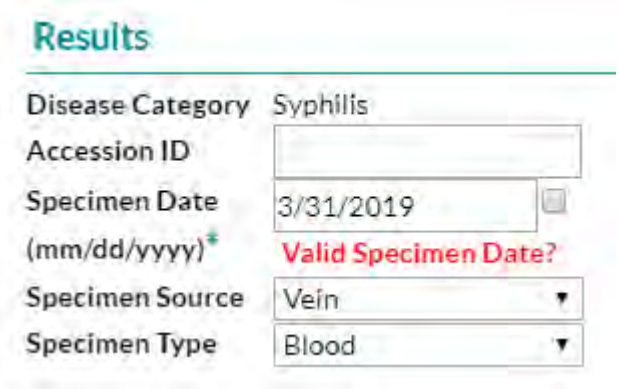


Once the profile is saved, a congenital record appears under the Episodes tab. A field record is automatically generated when the baby is linked to the mother's maternal record. Click the *BLUE* Field Record ID to view the field record.



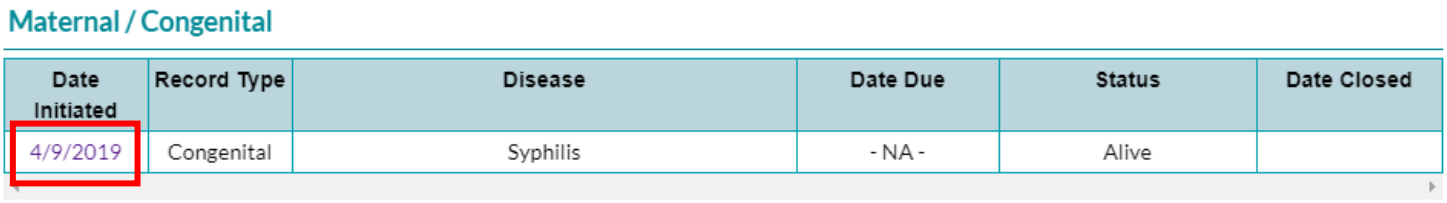
Tests for the baby need to be added to the field record. When adding a test, if the test was done the same day as birth, the system requires the user to verify the test date before saving the test. Remember to task complete all tests.

- **The specimen date entered is less than or equal to the date of birth, verify that this is correct. To save the test with this specimen date, check the box next to specimen date.**

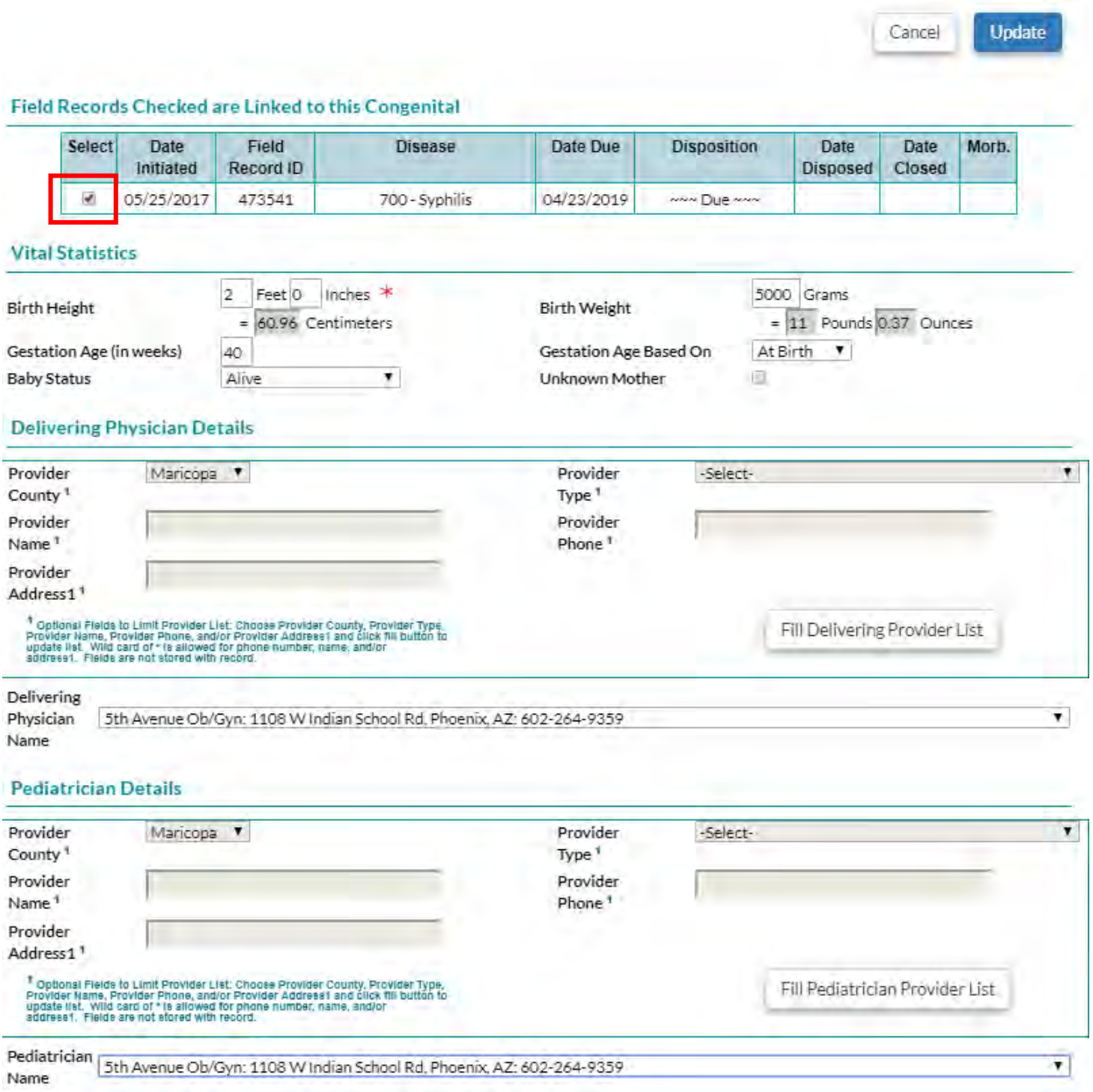


Additional information regarding the baby's disease follow-up such as treatment administered, diagnosis of congenital syphilis (or not), and relevant notes should be added to the infants field record.

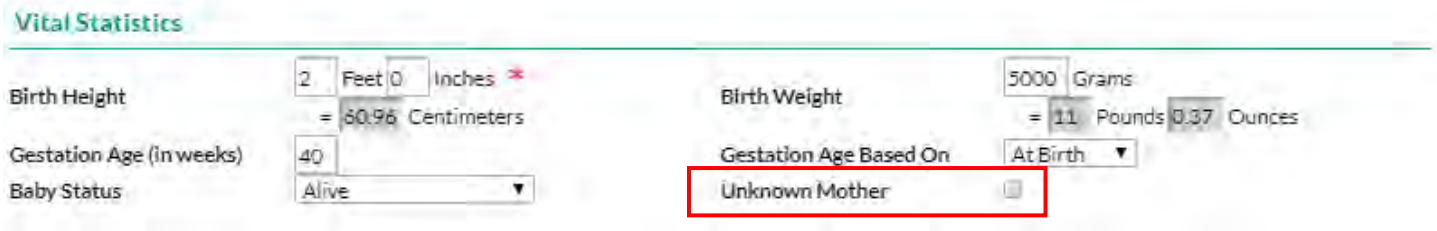
The congenital record can then be viewed from the Episodes tab to answer additional required questions. Click the ***BLUE*** Date Initiated to open the congenital record.



Once the congenital record is displayed, click the ***EDIT*** button. The first thing you should do here is click the "***Select***" button under the section titled "**Field Records Linked to This Congenital**." This tells PRISM what type of questions need to populate for the baby's congenital record. Then complete the **Vital Statistics**, **Delivering Physicians**, and **Pediatrician Details.** Click **Update**.



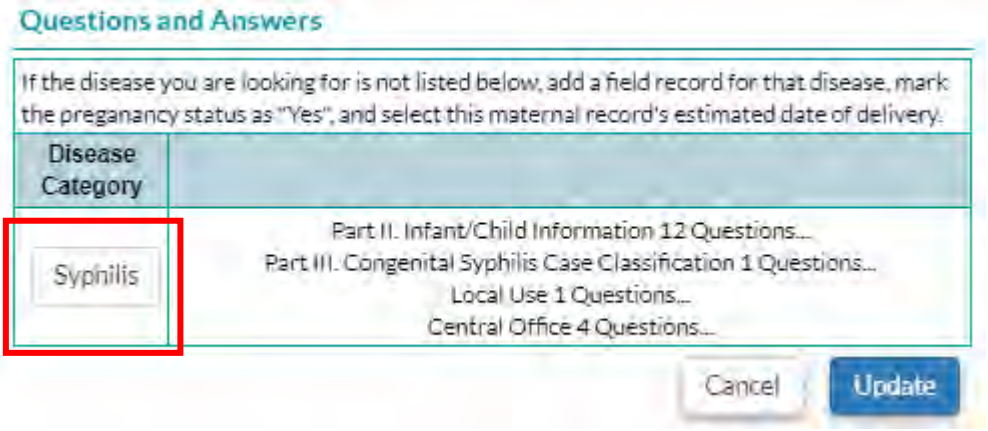
Congenital records must be linked to the appropriate Maternal record prior to closing. This step is completed in the Maternal record. If the mother is not known, the user must check the *Unknown Mother* box within the congenital record prior to closing.



Delivering Physician Details section of the congenital record will document the physician that delivered the child. There are filters that can be used to limit the providers in the provider drop-down. See the instructions in the APPENDEX called PROVIDER SEARCHING. Click the *Fill Delivering Provider List* button to update the selection list based on the selected filters. Once the provider is chosen, click the *Add Provider* button.

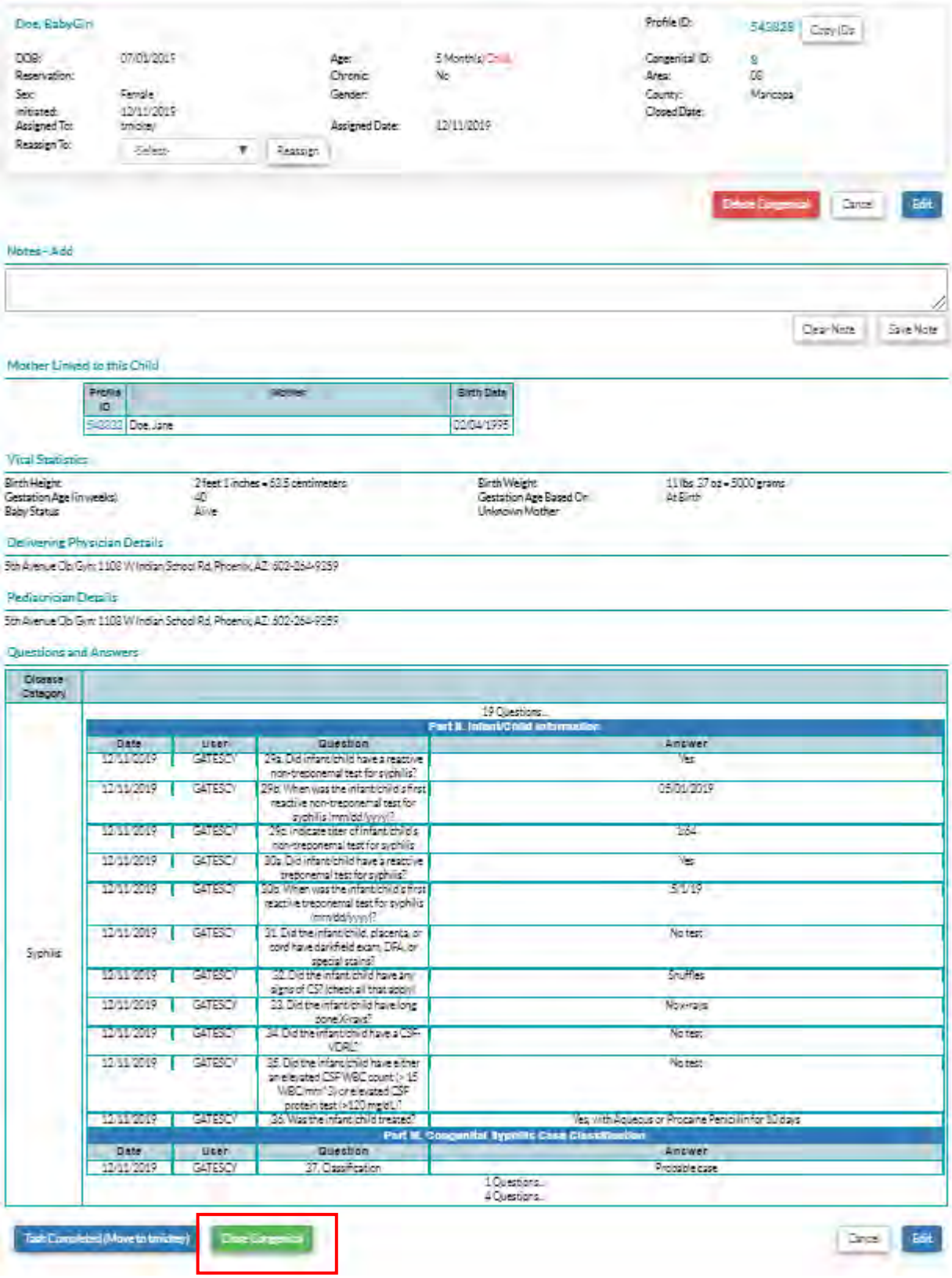
Pediatrician Details section of the congenital record will document the provider following up with the child after delivery. There are filters that can be used to limit the providers in the provider drop-down. See the instructions in the APPENDEX called PROVIDER SEARCHING. Click the *Fill Pediatrician Provider List* button to update the selection list based on the selected filters. Once the provider is chosen, click the *Add Provider* button.

The Questions and Answers section displays disease specific questions based on the field record disease. Click "**Syphilis**" button, and then the questions will show. The questions follow the format of the CDC Congenital Syphilis Case Investigation Report (Form 73.126).



Once the questions have been answered, **FIRST** click the ***Save*** button, and **THEN** click the ***Update*** button on the congenital record.

The congenital record and field record should now be ready for closure. Prior to closing the field record, the congenital record has to be closed first.



Doe, BabyGirl

Profile ID: 543833 Copy IDs

DOB: 07/01/2019 Age: 5 Months Child Congenital ID: 9
Reservation: Chronic: No Area: 00
Sex: Female Gender: County: Maricopa
Initiated: 12/11/2019 Closed Date:
Assigned To: tmickey Assigned Date: 12/11/2019
Reassign To: -Select- Reassign

Delete Congenital Cancel Edit

Notes - Add

Clear Note Save Note

Mother Linked to this Child

Profile ID	Mother	Birth Date
543833	Doe, Jane	02/04/1995

Vital Statistics

Birth Height:	2 feet 1 inches = 63.5 centimeters	Birth Weight:	11 lbs 12 oz = 5000 grams
Gestation Age (in weeks):	40	Gestation Age Based On:	At Birth
Baby Status:	Alive	Unknown Mother	

Delivering Physician Details

5th Avenue Ob Gyn: 1108 W Indian School Rd, Phoenix, AZ: 602-264-9359

Pediatrician Details

5th Avenue Ob Gyn: 1108 W Indian School Rd, Phoenix, AZ: 602-264-9359

Questions and Answers

Disease Category	
Syphilis	19 Questions...

Part II. Infant/Child Information

Date	User	Question	Answer
12/11/2019	GATESCV	29a. Did infant/child have a reactive non-treponemal test for syphilis?	Yes
12/11/2019	GATESCV	29b. When was the infant/child's first reactive non-treponemal test for syphilis (mm/dd/yyyy)?	05/01/2019
12/11/2019	GATESCV	29c. Indicate titer of infant/child's non-treponemal test for syphilis	1:64
12/11/2019	GATESCV	30a. Did infant/child have a reactive treponemal test for syphilis?	Yes
12/11/2019	GATESCV	30b. When was the infant/child's first reactive treponemal test for syphilis (mm/dd/yyyy)?	5/1/19
12/11/2019	GATESCV	31. Did the infant/child, placenta, or cord have darkfield exam, DFA, or special stains?	No test
12/11/2019	GATESCV	32. Did the infant/child have any signs of CS? (check all that apply)	Snuffles
12/11/2019	GATESCV	33. Did the infant/child have long bone X-rays?	No x-rays
12/11/2019	GATESCV	34. Did the infant/child have a CSF-VDRL?	No test
12/11/2019	GATESCV	35. Did the infant/child have either an elevated CSF WBC count (> 15 WBC/mm^3) or elevated CSF protein test (>120 mg/dL)?	No test
12/11/2019	GATESCV	36. Was the infant/child treated?	Yes, with Aqueous or Procaine Penicillin for 10 days

Part III. Congenital Syphilis Case Classification

Date	User	Question	Answer
12/11/2019	GATESCV	37. Classification	Probable case

1 Questions...
4 Questions...

Task Completed (Move to tmickey) Close Congenital Cancel Edit

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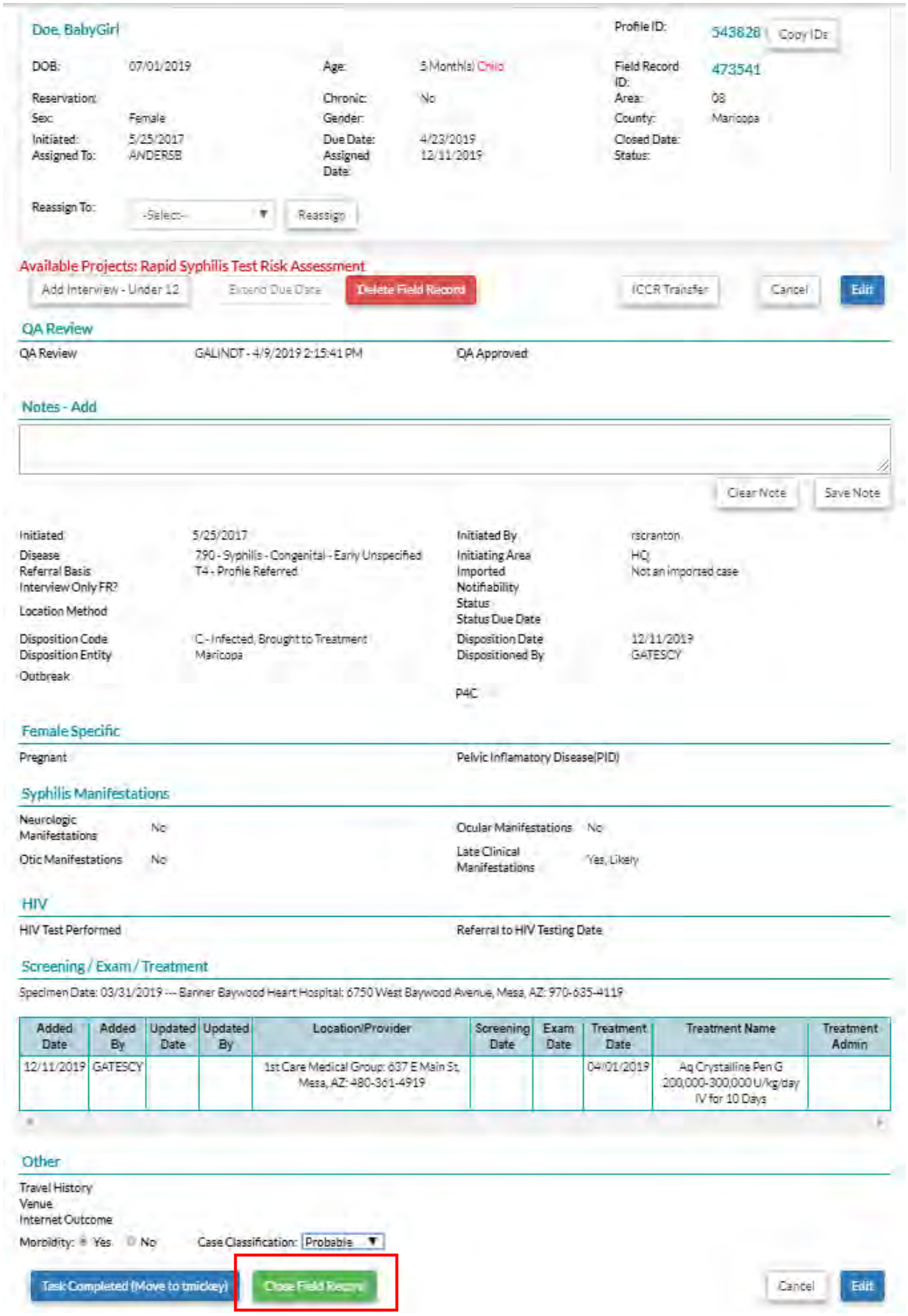
Doe, BabyGirl
Profile ID: 543828 Copy IDs
DOB: 07/01/2019
Age: 5 Month(s) Child
Field Record ID: 473541
Reservation:
Chronic: No
Area: 08
Sex: Female
Gender:
County: Maricopa
Initiated: 5/25/2017
Assigned To: ANDERSB
Due Date: 4/23/2019
Assigned Date: 12/11/2019
Closed Date:
Status:
Reassign To: -Select-
Reassign
Available Projects: Rapid Syphilis Test Risk Assessment
Add Interview - Under 12
Extend Due Date
Delete Field Record
ICCR Transfer
Cancel
Edit
QA Review
QA Review
GALINDT - 4/9/2019 2:15:41 PM
QA Approved
Notes - Add
Clear Note
Save Note
Initiated
5/25/2017
Initiated By
rscranton
Disease
790 - Syphilis - Congenital - Early Unspecified
Initiating Area
HQ
Referral Basis
T4 - Profile Referred
Imported
Not an imported case
Interview Only FR?
Notifiability
Location Method
Status
Status Due Date
Disposition Code
C - Infected, Brought to Treatment
Disposition Date
12/11/2019
Disposition Entity
Maricopa
Dispositioned By
GATESCY
Outbreak
P4C
Female Specific
Pregnant
Pelvic Inflamatory Disease(PID)
Syphilis Manifestations
Neurologic Manifestations
No
Ocular Manifestations
No
Otic Manifestations
No
Late Clinical Manifestations
Yes, Likely
HIV
HIV Test Performed
Referral to HIV Testing Date
Screening / Exam / Treatment
Specimen Date: 03/31/2019 --- Banner Baywood Heart Hospital: 6750 West Baywood Avenue, Mesa, AZ: 970-635-4119
Added Date
Added By
Updated Date
Updated By
Location/Provider
Screening Date
Exam Date
Treatment Date
Treatment Name
Treatment Admin
12/11/2019
GATESCY
1st Care Medical Group: 637 E Main St, Mesa, AZ: 480-361-4919
04/01/2019
Aq Crystalline Pen G 200,000-300,000 U/kg/day IV for 10 Days
Other
Travel History
Venue
Internet Outcome
Morbidity: Yes No
Case Classification: Probable
Task Completed (Move to tmickey)
Close Field Record
Cancel
Edit

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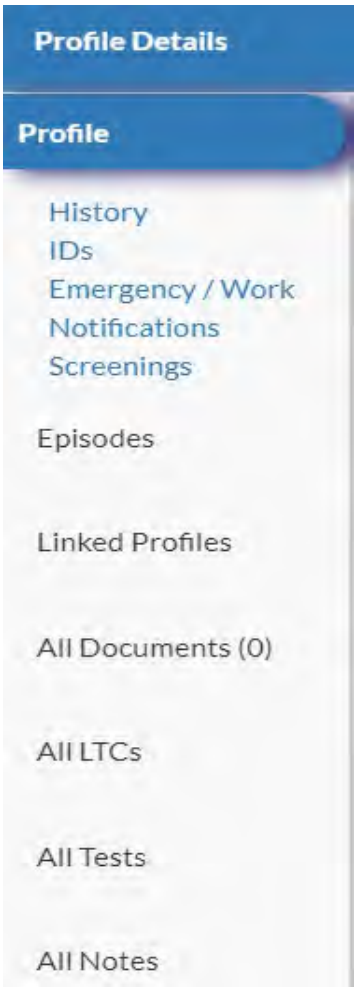
NAVIGATING PATIENT INFORMATION

PROFILE DETAILS

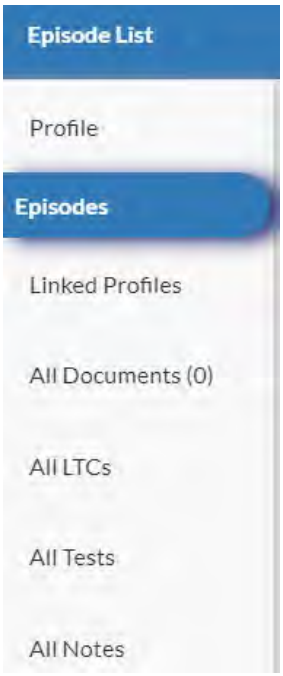
The Profile tab displays the person-specific (not disease specific) information for a client such as name, address, phone number, etc. Under the Profile tab there are 5 subtabs: History, IDs, Emergency/Work, Notifications and Screenings.

- History shows a history of every change made to the client's profile.
- IDs is where identification numbers can be stored such as medical record numbers, inmate numbers, driver's license numbers, etc.
- Emergency/Work is a place to store a client's emergency contact and information about their place of work.
- Notifications is where all Helpdesk tickets for a client are stored.
- Screenings is not utilized in Arizona, and can be ignored.



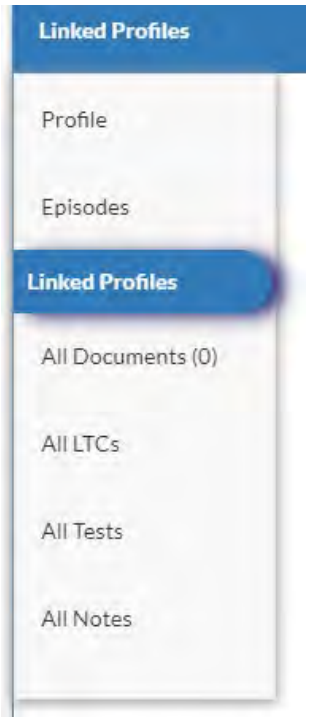
EPISODES

The Episodes tab displays all field records (disease events) that have been entered into PRISM.



LINKED PROFILES

The Linked Profiles tab shows EVERY person that has been linked to the patient for their entire STD history.



FIELDRECORD

After you click the Episodes tab, you will be able to select a specific Field Record to open. Under the Field Record tab there will always be 4 subtabs: History, Risks, Documents and Tests. If you create an interview for the Field Record then an Interview subtab will appear. If there are any projects available for the disease category, then the Projects for this Field Record subtab will appear.

- History shows a history of every change made to the client's field record.
- Risks is where client risks can be entered and viewed.
- Documents is where you can upload disease specific documents directly to the field record such as a lab report or medical record chart.
- Tests is where client tests can be entered and viewed. Screenings is not utilized in Arizona, and can be ignored.
- Interview is where you can view the client's interview record.
- Projects for this Field Record is where you can answer additional project-specific questions related to the client's disease.

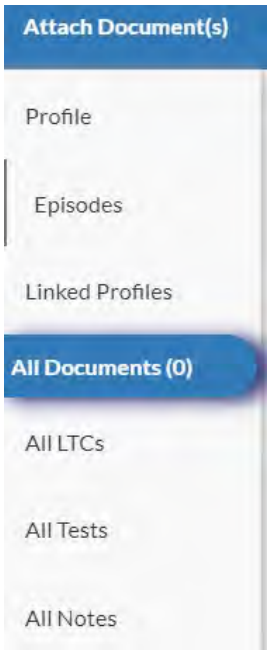
INTERVIEW

If you click the Interview subtab from the Field Record Details, you will open the interview and will see new subtabs. Under the Interview tab there will be 4 subtabs: History, Episodes attached to this interview, Profiles Linked to this Interview and Risks.

- History shows a history of every change made to the client's interview record.
- Episodes attached to this Interview shows all disease records attached to the interview. You can link multiple diseases to one interview.
- Profiles Linked to this Interview shows all contacts linked to the client for the specific interview period.
- Risks is where client risks can be entered and viewed.

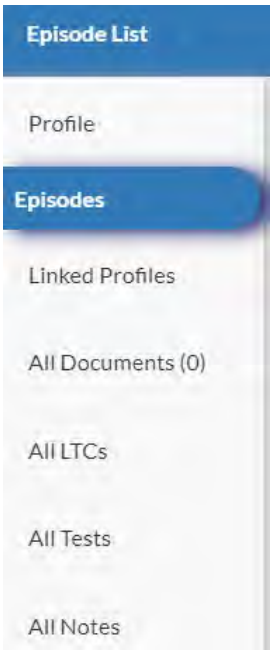
ALL DOCUMENTS

The All Documents tab displays all documents that have been uploaded to PRISM for the client.



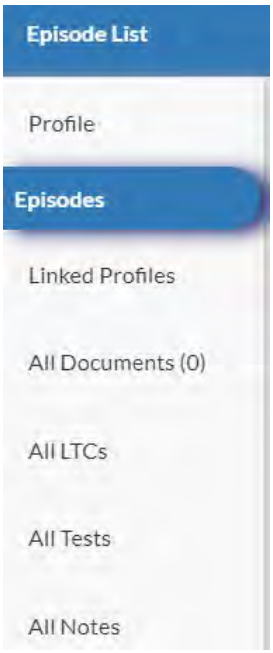
ALL LTCs

The All LTCs tab displays all Linkage to Care Records for the client.



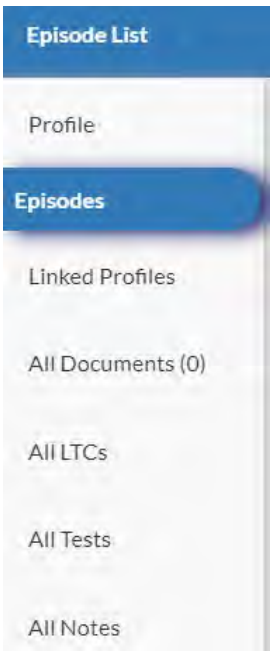
ALL TESTS

The All Tests tab shows the entire history of tests for the client across all diseases.



ALL NOTES

The All Notes tab displays all notes that have been written regarding the patient's disease records.



Electronic Laboratory Reports

Electronic Laboratory Reports (ELRs) are lab reports that are sent to PRISM directly from a hospital or reference laboratory. As long as the laboratory report has a client name, city, county and state the system will either auto-create a field record for the lab or will attach it to an existing field record.

All ELR-generated chlamydia field records are automatically dispositioned as "DM – Infected, Morbidity Only" and are closed. This is due to the high volume of chlamydia cases and the inability of most jurisdictions to follow-up on each chlamydia case. These records can always be re-opened to add treatment.

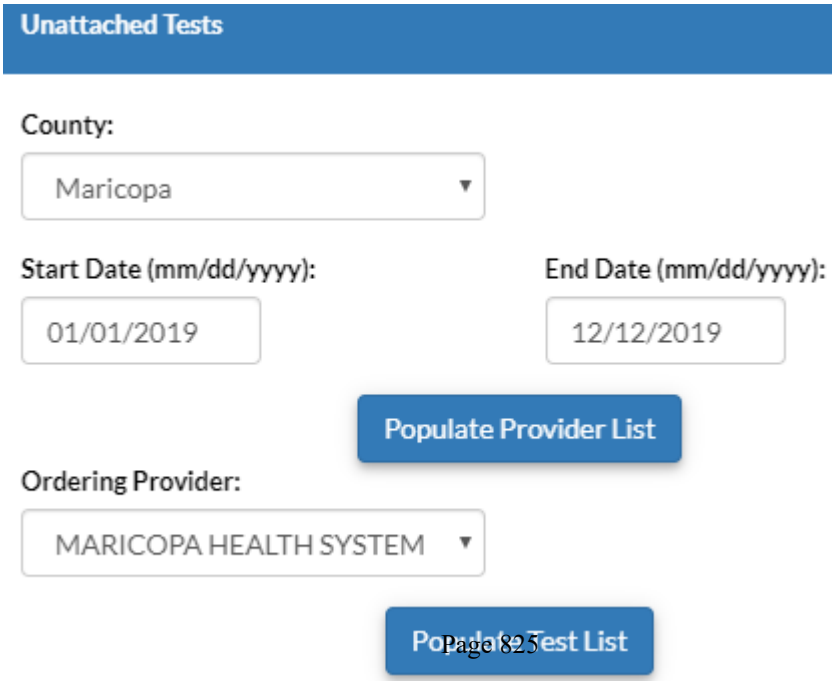
All ELR-generated gonorrhea and syphilis field records are automatically assigned to each county's ELR assignee. This is usually the Area Manager for the county. It is this person's responsibility to reassign the cases out to their staff appropriately.

UNATTACHED TESTS

All reactive/positive STD ELRs received into PRISM that have the minimum required information will get created into field records. Any non-reactive/negative STD ELRs and any reactive/positive STD ELRs that are missing name or address do not get auto-created into field records and instead go to Unattached Tests.

There are two ways to search for these types of tests. You can search for a particular client's tests using the Test Search. Or at the top of each user's PRISM window, there is a tab called "Unattached Tests." Here a user can search for all tests that are not attached (unattached) to an existing field record. The search will be specific to the Ordering Provider. The search fields include County, Start Date, End Date and Ordering Provider.

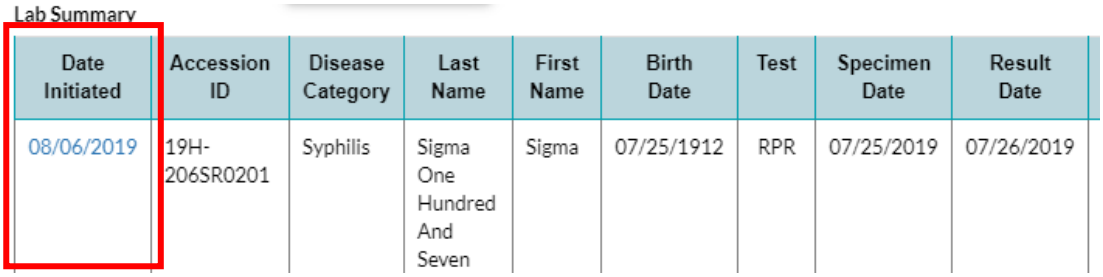
- County: County where the provider's office is.
- Start Date: The beginning of the date range you want to include in your search
- End Date: The end of the date range you want to include in your search
- Ordering Provider: The provider you want to see a list of unattached tests for



After selecting the County, Start Date and End Date you MUST click the "*Populate Provider List*" button to generate a list of providers who have unattached tests for that county and time frame. If any providers are found, you can then select the desired provider from the Ordering Provider dropdown and click "*Populate Test List*" to see a list of all unattached tests for the provider.

You can then click on the blue, hyperlinked *Date Initiated* field for each specific test to open the test and link it to an existing field record or create an existing field record for the test.

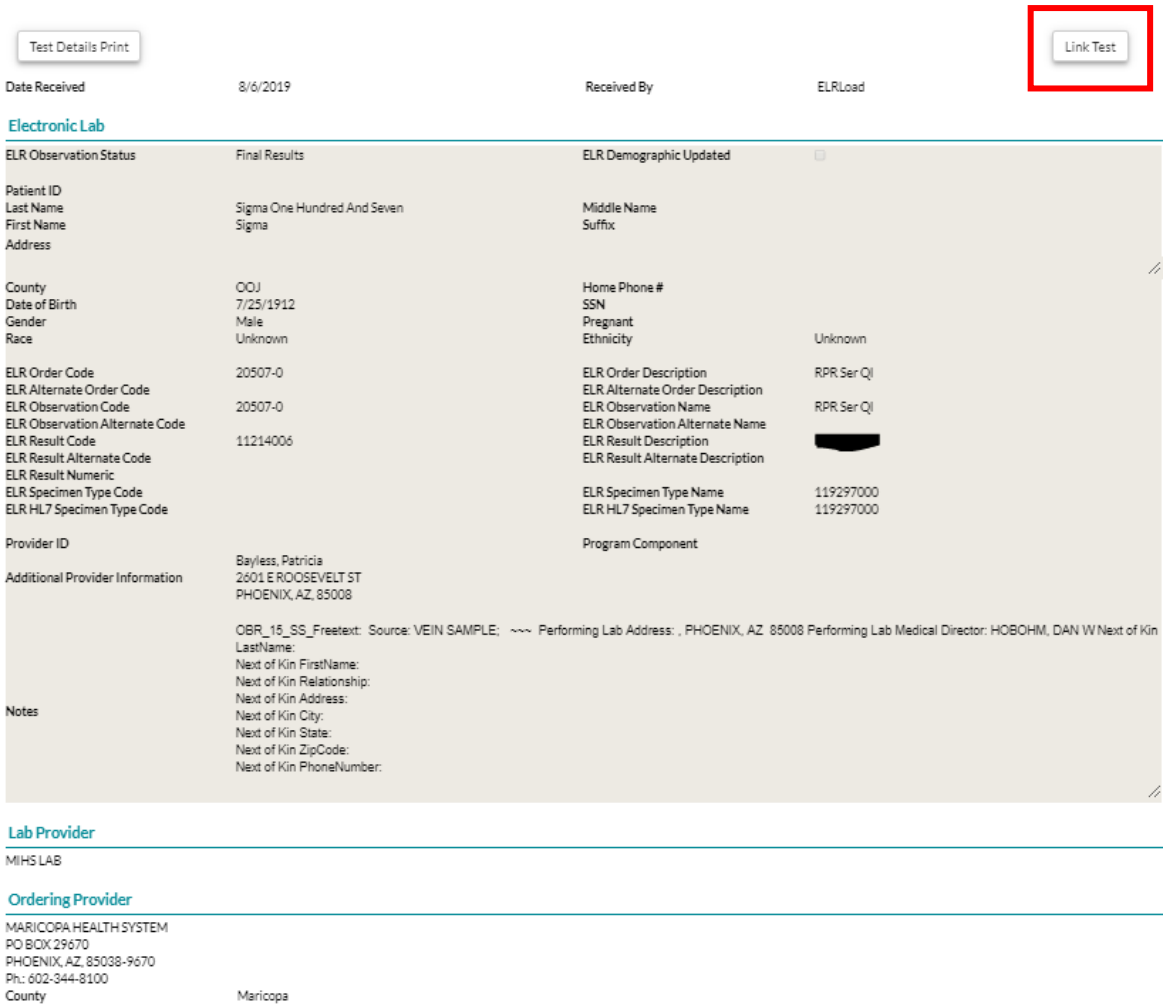
- Be careful here. Once you open an unattached ELR record it will automatically be assigned to you and will stay on your list until you do something with it (make it into its own record and close the record).



Lab Summary

Date Initiated	Accession ID	Disease Category	Last Name	First Name	Birth Date	Test	Specimen Date	Result Date
08/06/2019	19H-206SR0201	Syphilis	Sigma One Hundred And Seven	Sigma	07/25/1912	RPR	07/25/2019	07/26/2019

Once you click on the Date Initiated the ELR will appear in a new screen. In order to create a new field record for this ELR or link it to an existing field record, you must click the *Link Test* button at the top right of the screen.



Test Details Print | Link Test

Date Received 8/6/2019 | Received By ELRLoad

Electronic Lab

ELR Observation Status	Final Results	ELR Demographic Updated	
Patient ID			
Last Name	Sigma One Hundred And Seven	Middle Name	
First Name	Sigma	Suffix	
Address			
County	OOJ	Home Phone #	
Date of Birth	7/25/1912	SSN	
Gender	Male	Pregnant	
Race	Unknown	Ethnicity	Unknown
ELR Order Code	20507-0	ELR Order Description	RPR Ser Ql
ELR Alternate Order Code		ELR Alternate Order Description	
ELR Observation Code	20507-0	ELR Observation Name	RPR Ser Ql
ELR Observation Alternate Code		ELR Observation Alternate Name	
ELR Result Code	11214006	ELR Result Description	[redacted]
ELR Result Alternate Code		ELR Result Alternate Description	
ELR Result Numeric			
ELR Specimen Type Code		ELR Specimen Type Name	119297000
ELR HL7 Specimen Type Code		ELR HL7 Specimen Type Name	119297000
Provider ID		Program Component	
Additional Provider Information	Bayless, Patricia 2601 E ROOSEVELT ST PHOENIX, AZ, 85008		
Notes	OBR_15_SS_Freetext: Source: VEIN SAMPLE; ~~~ Performing Lab Address: , PHOENIX, AZ 85008 Performing Lab Medical Director: HOBOHM, DAN W Next of Kin LastName: Next of Kin FirstName: Next of Kin Relationship: Next of Kin Address: Next of Kin City: Next of Kin State: Next of Kin ZipCode: Next of Kin PhoneNumber:		

Lab Provider

MIHS LAB

Ordering Provider

MARICOPA HEALTH SYSTEM
PO BOX 29670
PHOENIX, AZ, 85038-9670
Ph.: 602-344-8100
County Maricopa

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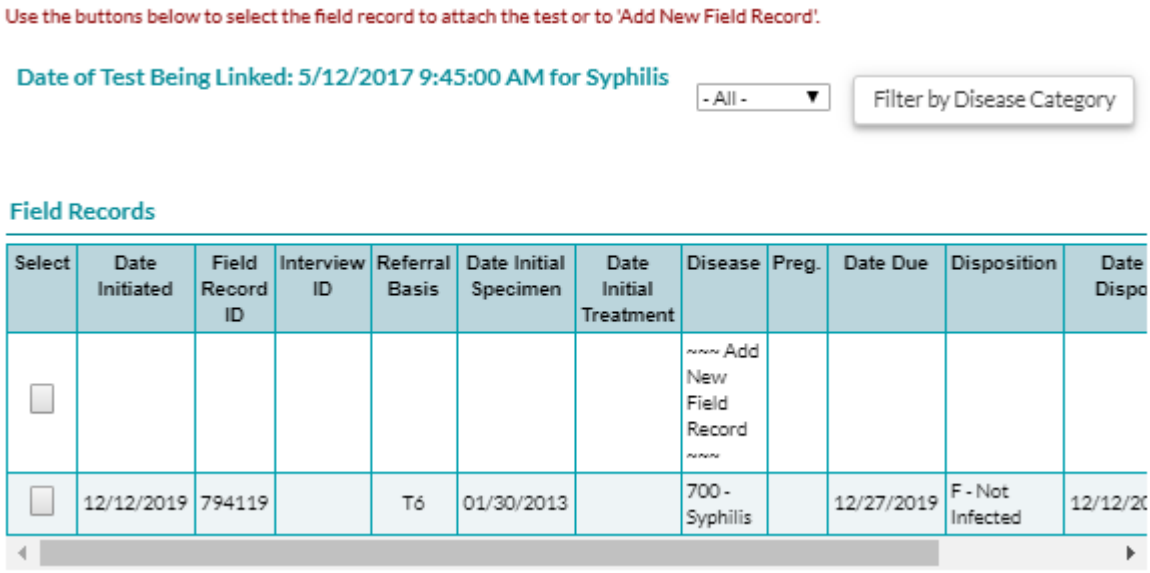
You will then be brought to the PRISM Search screen. The client's first and last name will be prepopulated from the ELR. You can add additional search criteria such as DOB or you can click the Search button to see if there is an existing PRISM Profile for this client.

If you see a match in the results, you can click the hyper linked *Record ID* to link the test to the existing Profile. Similar to linking partners, you will then be brought to a screen that asks you if you want to Link the Test to This Profile. If so, click the button.

You will then be brought to a screen comparing the demographic information found on the matching profile with the demographic information on the ELR. Based on what looks most accurate or is the most recent information you must use the radio buttons to decide which information to keep. Once that is done, click "Merge Test with Profile."

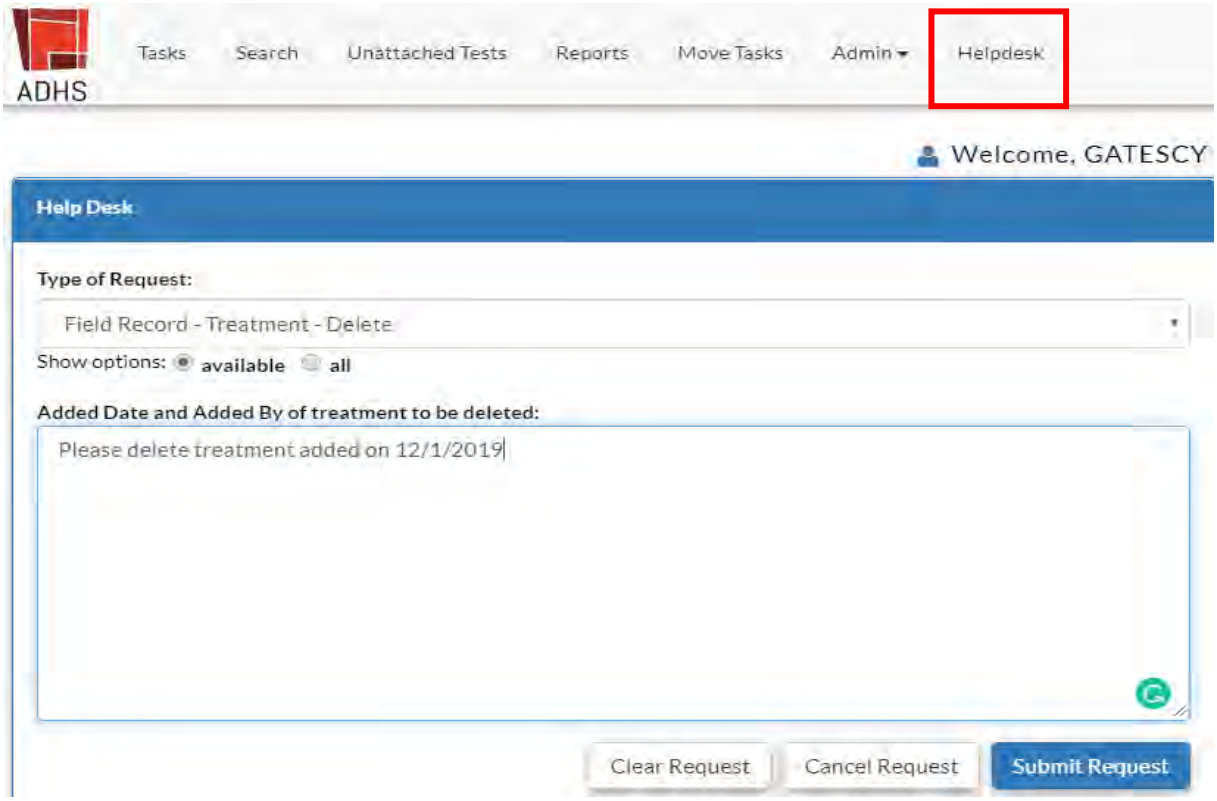
If there are no existing field records on the client's Profile for the disease category of the ELR, the system will automatically create a field record using the ELR and the record will be assigned to you.

If there's an existing record for the same disease category the system may ask you if you want to create a new record, or attach it to an existing field record. Select the most appropriate option based on the specimen date.

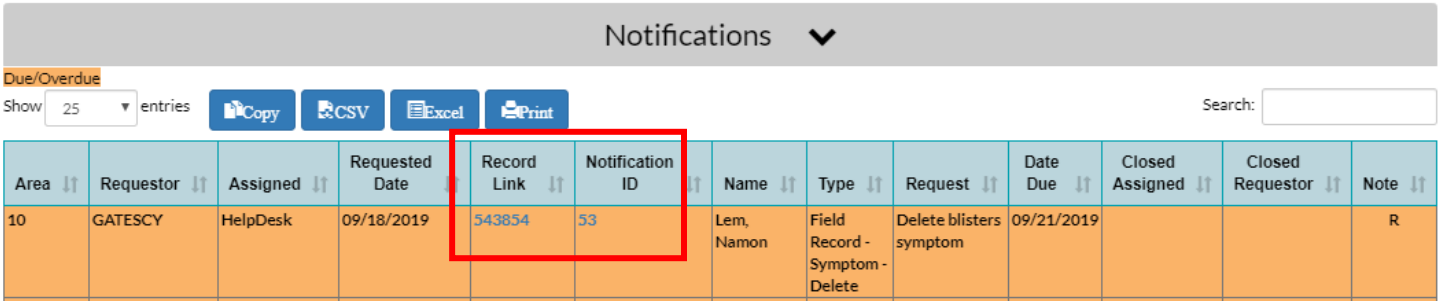


HELPDESK REQUESTS

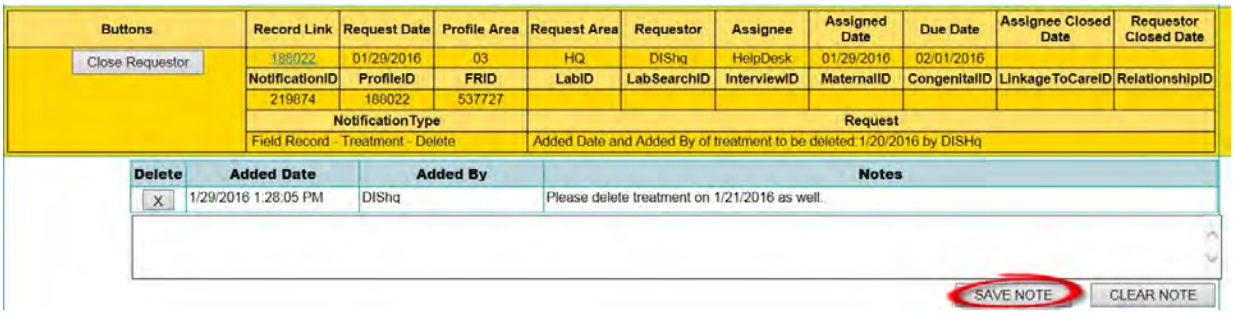
The helpdesk is used to request assistance or corrections for various types of records. The user must access the helpdesk from the record where assistance is needed. For example: if treatment needs to be deleted from a field record, the user should be on the field record and click the **Helpdesk** tab at the top of the screen to view the helpdesk page and choose **Field Record – Treatment Delete**. There is a note box to include the specific treatment that needs to be deleted. Click the ***Submit Request*** button to submit the request.



Helpdesk tickets appear on the Task list in the **Notifications** section of the user requesting assistance and on the Task list of the user assigned to complete the ticket. The ticket is viewed by clicking the ***BLUE*** Notification ID. Click the ***BLUE*** **Record Link** to access the record (profile, field record, interview, lab, etc.) that the ticket was created from. If the ticket is not associated with a specific record, the ***BLUE*** **Record Link** will take you to the ticket itself.

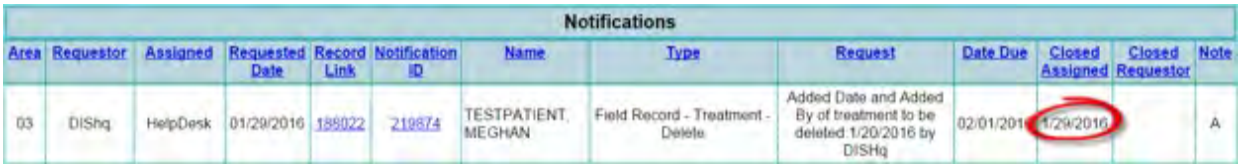


The user can add additional notes to the ticket by typing in the notes box and clicking ***Save Note***.

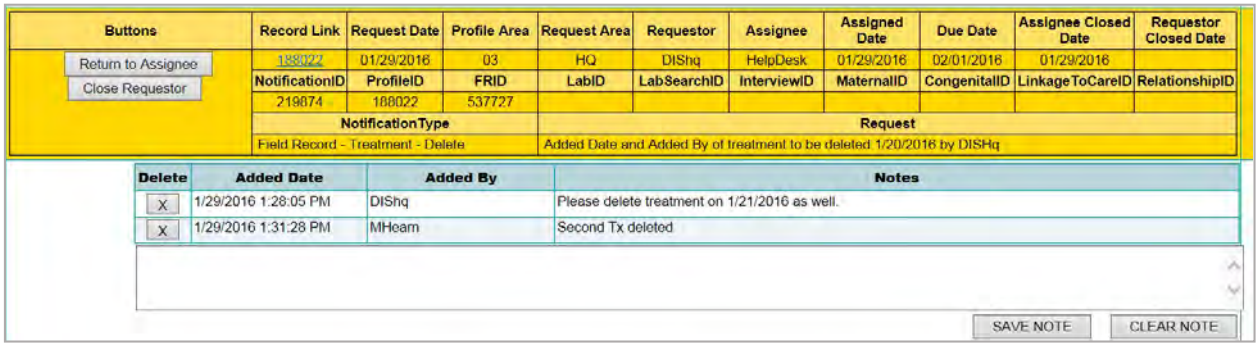


When the Requesting user adds a note to the ticket, the letter R will appear in the **Note** column. If the user Assigned to complete the ticket adds a note, the letter A will appear.

When the user assigned to complete the ticket closes it on their end, a date appears in the Closed Assigned column.



Once the ticket is worked, the requesting user can close the ticket by clicking the ***Close Requestor*** button. In the event the ticket was not resolved satisfactorily, the ticket can be reassigned to the assigned user by clicking the ***Return to Assignee*** button. If the ticket was created in error or is no longer needed, the Requestor can close the ticket at any time by clicking the ***Close Requestor*** button.

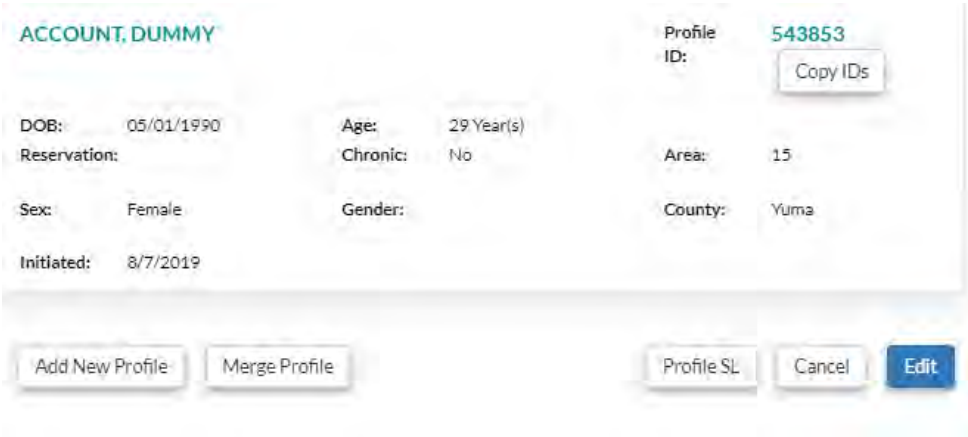


MERGING PROFILES & FIELD RECORDS

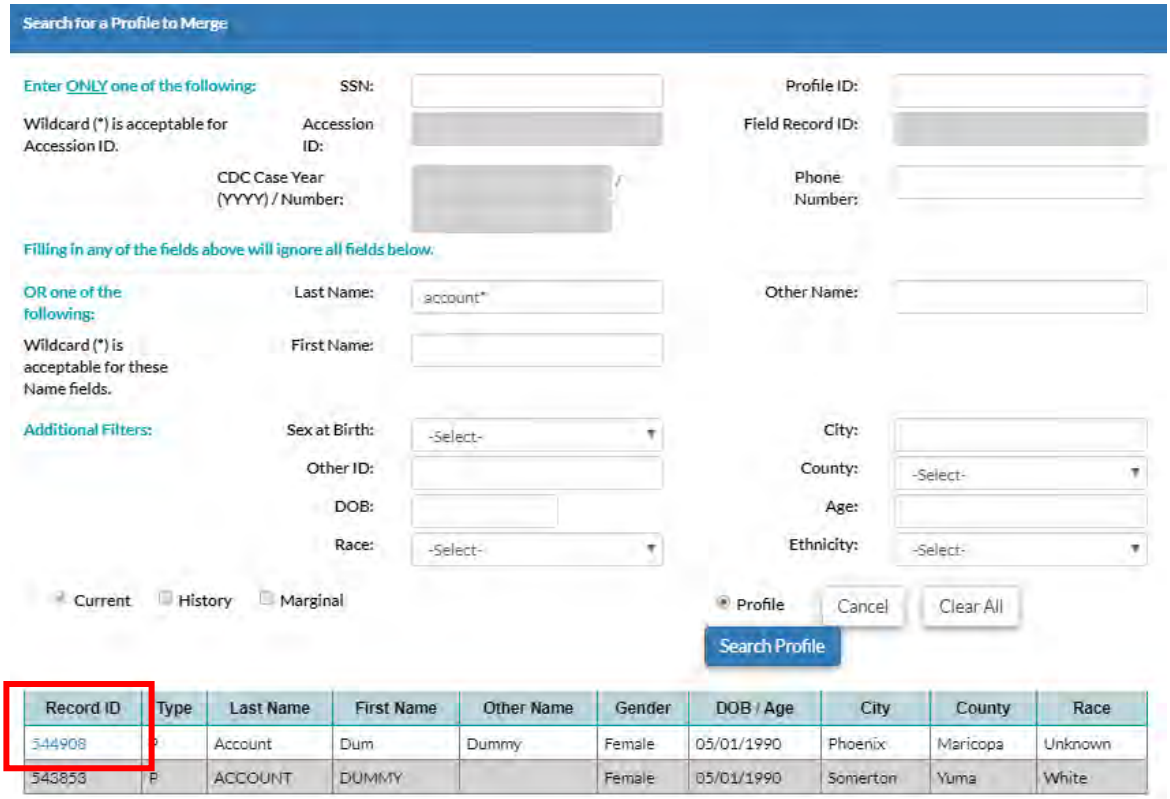
Only certain PRISM users have the ability to merge duplicate profiles and/or merge duplicate field records. If you do not have this privilege, simply submit a Helpdesk ticket for the necessary merge.

Merging Profile Records

To merge two duplicate profiles, first go to one of the Profile pages. Then click the "***Merge Profile***" button. Please note that the system will not let you merge two Profiles that have an open field record of the same disease category (e.g. an open syphilis field record on Profile A and an open field record on Profile B). You must close one before the merge.



The system will take you to the PRISM Search screen for you to search for the duplicate profile. The profile that you've started with will be grayed out, but any matching profiles that were generated from the search will show. Click the ***Record ID*** of the profile you'd like to merge with.



You will then be brought to the merge screen where you will see a comparison of the demographic information between the two profiles. For each demographic field, you must select with information you'd like to keep (Profile A vs Profile B). Once this is done, click the '**Merge Profiles**' button at the top or bottom of the page.

Once you merge the profiles, it will take you to the newly merged Profile. The new Profile ID will always be the lowest number between the two.

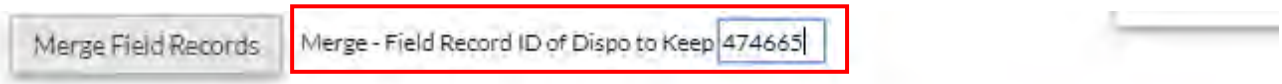
The last step is to go to the Episodes page of the newly merged Profile and check to see if there are any field records that now need to be merged.

Merging Field Records

To merge two duplicate field records found on one Profile, you must first go to the client's Episodes tab. If you have the privilege to merge field records, you will see a Merge column with checkboxes next to each field record on the episodes page. You can only merge two field records at once.

Click the merge checkboxes for the two field records you want to merge. Then, look for the text that says "**Merge – Field Record ID of Dispo to Keep**." There should be a text box next to it. In the text box, you must enter the field record ID of the field record that has the disposition you want to keep.

Once you merge the field records, you should see the resulting merged record. Please note that after merging syphilis field records, you should always to ensure the appropriate stage was saved. If not, you will have to re-open the record and change it.



Field Records

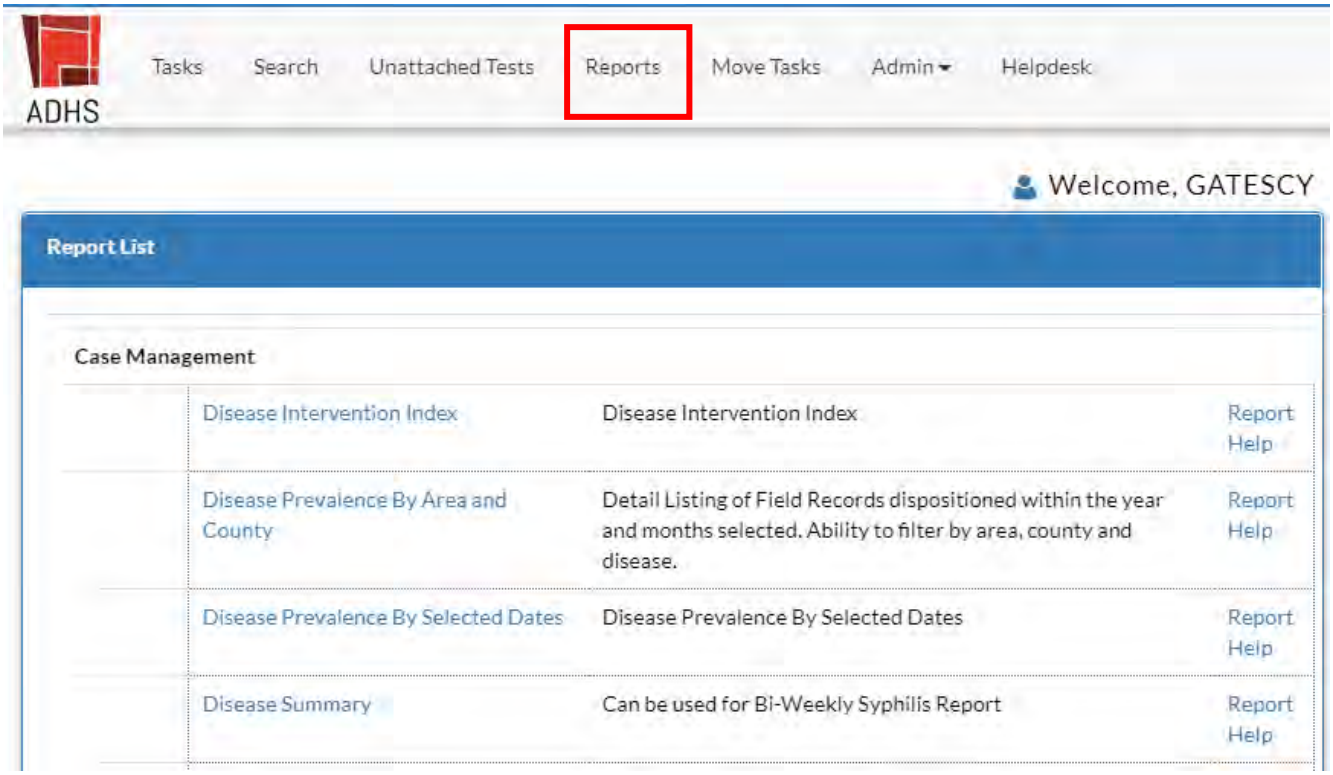
Merge	Date Initiated	Field Record ID	Interview ID	Referral Basis	Date Initial Specimen	Date Initial Treatment	Disease	Preg.	Date Due	Disposition
☑	12/12/2019	474669		T2			710 - Syphilis - Primary	N	12/27/2019	H - Unable to Locate
☑	12/10/2019	474665	6602	T4	12/10/2019		710 - Syphilis - Primary	N	12/25/2019	I - Administrative Closure

Field Records

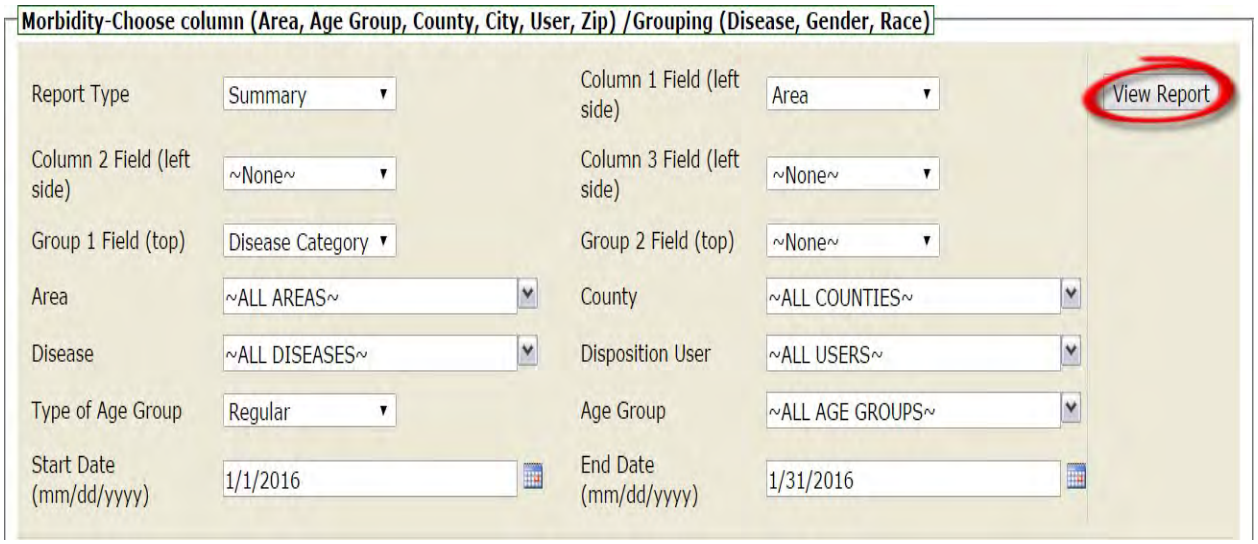
Merge	Date Initiated	Field Record ID	Interview ID	Referral Basis	Date Initial Specimen	Date Initial Treatment	Disease	Preg.	Date Due	Disposition
☐	12/10/2019	474665	6602	T4	12/10/2019		710 - Syphilis - Primary	N	12/25/2019	I - Administrative Closure

REPORTS

PRISM has several reports that give users an overall view of case management in their area. The reports available will depend on the type of access a user possesses. Click **Reports** to view the reports page.

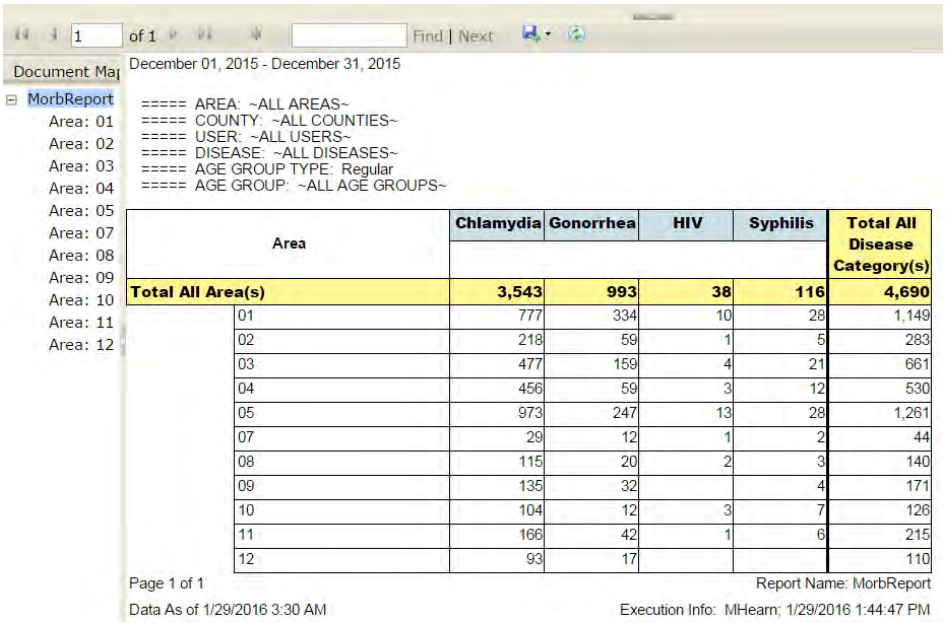


Depending on the information the user wants displayed, there are several criteria to select. Most reports have same fields.

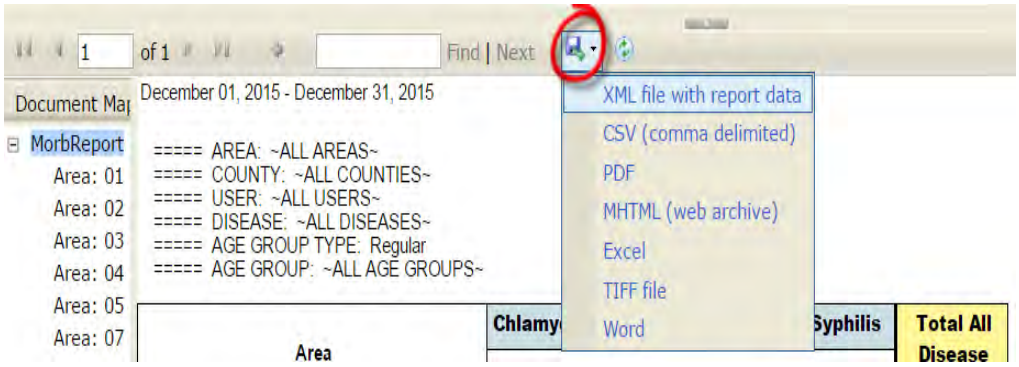


- Report Type indicates whether the user would like to view a summary report or a detailed report. A summary report will contain totals based off the criteria selected. A detailed report includes a detailed line listing and includes all options from each criteria field. Detailed reports are commonly used to export data for analysis.
- Column 1 Field (left side) indicates what criteria will display in the first column along the left side of the report (summary only).
- Column 2 Field (left side) indicates what criteria displays in the second column along the left side of the report and will further breakdown criteria in Column 1 (summary only).
- Column 3 Field (left side) indicates what criteria displays in the second column along the left side of the report and will further breakdown criteria in Column 2 (summary only).
- Group 1 Field (top) indicates what criteria displays at the top of the report first (summary only).
- Group 2 Field (top) indicates what criteria displays at the top of the report second and will further breakdown criteria in Group 1 (summary only).
- Area indicates the area the user works and includes all counties in that area.
- County indicates counties in the area the user works. The user can choose to include specific counties or all of them.
- Disease indicates what diseases are included in the report. Multiple diseases can be selected.
- Disposition User indicates what user added the disposition on the field record where morbidity was claimed.
- Type of Age Group indicates which age groups appear in the Age Group field. The user can choose between regular or state specific age groups.
- Age Group indicates which age groups appear on the report. The user can choose specific age groups or include all ages.
- Start Date indicates the first date the report uses to generate data.
- End Date indicates the last date the report uses to generate data.

Select all desired **criteria**. Click the *View Report* button to run the report. The user can change the column and group criteria to change how the data is displayed on the summary report.



Reports can be exported into **XML, CSV, PDF, MHTML, Excel, Tiff file,** or **Microsoft Word** formats. Click the disk and select the preferred format.



APPENDIX

DISPOSITION CODES

SYPHILIS, GONORRHEA AND CHLAMYDIA DISPOSITIONS			
DISPO	PRISM Dispositions	Requirements for Field Record Closure	MORB
A	Preventative Treatment	• Current negative test • Standard treatment information	N
B	Refused Preventative Treatment	• Current negative test • Documentation of attempts to motivate Patient to receive treatment	N
C	Infected, Brought to Treatment	• Current positive test • Standard treatment information • Diagnosis and case classification* upon closure	Y
	If Syphilis	• **MUST** have a confirmatory lab (previous or current) • An Interview record must be created prior to FR closure	
CN	Infected, Brought to Non-Standard Treatment	• Current positive test • Non-standard treatment information • Diagnosis and case classification* upon closure.	Y
	If Syphilis	• **MUST** have a confirmatory test (previous or current) • An interview **MUST** be created prior to FR closure.	
D	Infected, Not Treated	• Current positive test • Diagnosis and case classification* upon closure	Y
	If Syphilis	• **MUST** have a confirmatory test (previous or current) • An interview must be created prior to FR closure	
DM	Infected, Morbidity Only	• Current positive test • Diagnosis and case classification* upon closure	Y
	If Syphilis	• Should NOT be used for syphilis.	
	If GC / CT	• Use if no field follow-up and/or treatment • Case classification* upon closure	

E	Previously Treated for this Infection	• Current syphilis tests • Previous syphilis test and previous treatment	N
F	Not infected	• Current negative test • NOTE: If last exposure date is less than 90 days ago, FR cannot be closed with an F disposition.	N
H	Unable to Locate	• Patient was unable to locate for services	N
I	Administrative Closure	• Used to close historical field records to document previous tests	N
IO	Administrative Closure OOJ	• Requires Patient's address to be out of state	N
IR	Administrative Closure per Reactor Grid	• Patient meets specific criteria to close per syphilis reactor grid	N
J	Located, Refused Examination	• Patient refused to be examined • Used for T4 (Profile Referred) field records	N
JP	Located, Refused Partner Services	• Patient refused partner services	N
L	Other	• No other disposition is applicable	N
LV	Other Domestic Violence Risk	• Patient reports risk of domestic violence	N
LX	Other Patient Deceased	• Requires a date of death to be entered on the patient profile	N

HIV DISPOSITIONS			
DISPO	PRISM Dispositions	Requirements for Field Record Closure	MORB
1	Previous Positive	• Previous positive test* • Complete: 'Type of HIV Field Services Needed'	N

2	Previous Negative, New Positive	• Previous negative* test and current positive test • Complete: 'Type of HIV Field Services Needed' • An Interview MUST be created prior to field record closure • Case classification upon closure	Y
3	Previous Negative, Still Negative	• Previous negative* test in the patient test history • Current negative test attached to current field record	N
4	Previous Negative, Not Re-tested	• Previous negative* test in the patient test history	N
5	Not Previously Tested, New Positive	• Current positive test attached to current field record • Complete: ' Type of HIV Field Services Needed' • An interview MUST be created prior to field record closure • Case classification upon closure.	Y
6	Not Previously Tested, New Negative	• Current negative test attached to current field record	N
7	Not Tested	• Requires documentation of why patient was not tested	N
H	Unable to Locate	• Patient was unable to locate for services	N
I	Administrative Closure	• Used to close historical field records to document previous tests	N
IO	Administrative Closure OOJ	• Requires Patient's address to be out of state	N
J	Located, Refused Examination	• Patient refused to be examined • Used for T4 (Profile Referred) field records	N
JP	Located, Refused Partner Services	• Patient refused partner services	N
L	Other	• No other disposition is applicable	N
LV	Other Domestic Violence Risk	• Patient reports risk of domestic violence	N
LX	Other Patient Deceased	• Requires a date of death to be entered on the patient profile	N

REFERRAL BASIS

REFERRAL BASIS		
T1	Positive Test Result	• A positive test result is received • A positive ELR was received
T2	Case Report	• A case report was received from a clinic reporting a test result to the health department
T3	Clinic Walk-In	• Patient is self-referred for testing
T4	Profile Referred	• Patient is named as a contact on an interview • Patient is referred by someone to come to the health department to be tested
T5	Court Ordered	• Patient is ordered by court to be tested
T6	Negative Lab Test	• The health department has received a negative test result • A negative ELR was received
T7	Other Lab Result	• Other type of test result received
O1	OOJ Partner	• Patient was named as a partner by someone who resides out of jurisdiction (state)
O2	OOJ Social Contact or Associate	• Patient was named as a social contact or associate by someone who resides out of jurisdiction (state)
O3	OOJ Positive Lab Test	• A positive test result is received from an out of jurisdiction (state) provider

PROVIDER SEARCHING

To assist with choosing a provider, there are filters that are used to narrow the list. You can filter based on **Provider County**, **Provider Name**, **Provider Address**, **Provider Type**, and **Provider Phone.** Many of the places that have a provider section with have some defaults selected. When a filter is updated, click the ***Fill Provider*** button to update the selection list based on the selected filters.

Provider County	Click Provider County to find the provider by using the drop down to narrow results by county. Choosing a provider county will limit the provider list to all providers in that county.
Provider Type	Choosing a provider type will limit the provider list to all providers categorized as whatever type that is chosen. Ex. Hospital, Health Dept., Correctional Facility, etc.
Provider Name	Typing in the provider name will list providers with that name. It's recommended that the wildcard (*) is used in this field. A provider may not be listed in PRISM as it is on a lab report. When using this field to search for a name, it is advised to only put part of the name with an asterisk (*) before and after. As an example, when looking for Dr. John Smith, you would enter ***Smith*** in the Provider Name box.
Provider Phone	Typing in the provider phone will list any providers listed with that phone number.
Provider Address	Typing in the provider's address will list all providers with that address. It's highly recommended that the wildcard (*) is used in this field. The address may differ slightly than what you have on the report and you don't want to exclude appropriate results. For example, if a provider has an address of 1535 East Chimney Road, it would be best to enter 1535* in the Provider Address box to generate a list of all providers with addresses that start with 1535.

WHERE DATA ARE HOUSED

ALERTS/HOME
- UPCOMING SYSTEM OUTAGES/EVENTS

TASK LIST
- QUALITY ASSURANCE REVIEW
- NOTIFICATIONS
- FIELD RECORD
- INTERVIEW RECORD
- TEST
- MATERNAL
- CONGENITAL
- SUMMARY

SEARCHING IN PRISM
- PROFILE SEARCH
- TESTS SEARCH

CREATING PATIENT DATA
- PROFILE
  - NAME
  - LOCATING INFORMATION
  - VITAL STATISTICS
  - DESCRIPTION
- HISTORY
  - AUDIT TRAIL
- IDs
  - ADD IDENTIFIER
  - OTHER IDENTIFIERS
- EMERGENCY WORK
  - EMERGENCY CONTACT
  - EMPLOYER INFORMATION
- NOTIFICATIONS
  - HELP DESK TICKET REQUESTS
  - LTC REQUESTS
- ALL DOCUMENTS
  - DOCUMENT(S) LIST
- ALL LTCS
  - LINKAGE TO CARE SUMMARY
- ALL TESTS
  - TEST SUMMARY

EPISODES
- Field Record
- Interview Record
- Maternal
- Congenital

FIELD RECORD
- DISEASE
- REFERRAL BASIS
- INTERVIEW ONLY FR
- LOCATION METHOD
- INITIATING AREA
- IMPORTED
- NOTIFIABILITY
- STATUS
- STATUS DUE
- DISPOSITION INFORMATION
  - DISPOSITION CODE
  - DISPOSITION ENTITY
  - DISPOSITION DATE
  - DISPOSITIONED BY
- CONTACT ATTEMPTS
- OUTBREAK
- FEMALE SPECIFIC
- HIV
- SYMPTOMS
- SCREENING/ EXAM/ TREATMENT
- TRAVEL HISTORY
- VENUE
- INTERNET OUTCOME
- NOTES
- HISTORY
  - AUDIT TRAIL
- RISKS
- LINKAGE TO CARE (LTCs)
  - LINKAGE TO CARE DETAILS
    - DATE RECEIVED
    - RECEIVED BY
    - REASON NOT REFERRED TO CARE
    - REFERRING PROVIDER
    - CARE PROVIDER
    - RESULTS
- DOCUMENTS
  - DOCUMENTS SPECIFIC TO FIELD RECORD

TESTS
- TESTS DETAILS
  - CLIENT NOTIFICATION
  - LAB PROVIDER
  - ORDERING PROVIDER
  - RESULTS

INTERVIEW RECORD

- INTERVIEW TYPE
- FIRST INTERVIEWED BY
- FIRST INTERVIEWED DATE
- RE-INTERVIEWED BY
- DATE RE-INTERVIEWED
- INTERVIEW PERIOD
- WHERE INTERVIEWED
- WHERE INTERVIEWED ADDITIONAL INFO
- DETECTION METHOD
- REFERRAL SERVICE
- # OF SEX PARTNERS
- # OF NEEDLE PARTNERS
- # OF SEX AND NEEDLE PARTNERS
- PARTNER MEETING LOCATIONS
- RECOMMENDED OUTREACH SITE
- HIV SELF-REPRTED STATUS
- HIV SECTION
  - HIV POST TEST COUNSELING
  - HIV MEDICAL CARE INFORMATION
- NOTES
- HISTORY
  - AUDIT TRAIL
- EPISODES ATTACHED TO THIS INTERVIEW
  - POSITIVE FIELD RECORDS LINKED TO THIS SPECIFIC INTERVIEW
- PROFILES LINKED TO THIS INTERVIEW
  - CONTACTS LINKED TO THIS SPECIFIC INTERVIEW
- RISKS
- LINKING PROFILES
  - SEARCH AND LINK CONTACT PROFILE
    - RELATIONSHIP DETAILS
    - LINKED TO
    - RELATIONSHIP
  - ADD MARGINAL CONTACT PROFILE
    - NAME
    - PHONE NUMBER
    - VITAL STATISTICS
    - DESCRIPTION
    - LOCATING/CONTAC T INFORMATION
    - DISPOSITION INFORMATION
    - RELATIONSHIP
    - NOTES
  - ADD INTERNET CONTACT PROFILE
    - NAME
    - PHONE NUMBER
    - VITAL STATISTICS
    - DESCRIPTION
    - LOCATING/CONTAC T INFORMATION
    - DISPOSITION INFORMATION
    - INTERNET INFORMATION
    - RELATIONSHIP
    - NOTES

MATERNAL RECORD

- PRISM CHILD LINKED TO THIS MOTHER
- ESTIMATED DATE OF DELIVERY
- GAVE BIRTH IN THE LAST YEAR
- # OF WEEKS PREGNANT
- LAST MENSTRUAL DATE BEFORE DELIVERY
- PRENATAL CARE
- # OF PRENATAL VISITS
- FIRST PRENATAL VISITS
- LAST PRENATAL VISIT
- # OF PREGNANCIES
- # OF LIVE BIRTHS
- BABY STATUS
- STD TREATMENT DURING PRENATAL CARE
- PRENATAL PROVIDERS
- MATERNAL DISEASE QUESTIONS AND ANSWERS

CONGENITAL RECORD

- MOTHER LINKED TO THIS CHILD
- VITAL STATISTICS
  - DELIVERING PHYSICIAN INFORMATION
  - PEDIATRICIAN INFORMATION
  - NOTES
  - CONGENITAL QUESTIONS AND ANSWERS

NHM&E DATA VARIABLES & VALUES

National HIV Prevention Program Monitoring and Evaluation (NHM&E)

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

NHM&E Data Variables and Values

Table of Contents

Version Date: 1-Jul-22

NHME Variables and Values

Agency Level

Table: A General Agency Information

This table is required to be completed by all directly funded grantees. It is also required for all agencies that indirectly receive CDC funds for HIV prevention AND: 1) Provide HIV prevention services and/or 2) Provide contracts using CDC funds to support the provision of HIV prevention services.

Num	*Variable Name*	
A01	**Agency Name**	**XSD (Schema) Name: agencyName**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 100

Definition: The official legal name of the agency or organization.

Instructions: Enter the official legal name of the agency funded by CDC to provide HIV prevention programs.
Please note: for jurisdictions that upload HIV testing data, there is currently no way to enter the actual name of the agency. The system substitutes the Agency ID for the name. System administrators can log into EvaluationWeb® and update this field to the actual name of the agency.

Business rules HD HIV Testing: Required
Partner Services: Allowed, but not reported to CDC
CBO HIV Testing: Required

A01a	**Agency ID**	**XSD (Schema) Name: agencyId**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 32

Definition: An alpha-numeric identification used to uniquely identify an agency.

Instructions: Enter the unique agency ID generated by the CDC-funded agency. If using EvaluationWeb for direct key entry, this number may be automatically generated by that system.

Business rules HD HIV Testing: Mandatory
Partner Services: Mandatory
CBO HIV Testing: Not applicable

NHME Variables and Values

Num	Variable Name	
A02	**Jurisdiction**	**XSD (Schema) Name: populatedAreaValueCode**

Value Option: Choose only one **Format Type:** Number **Min Length:** 2 **Max Length:** 3

Definition: The CDC-directly funded state, territory, city area, or region where a state or city health department receives funding to monitor HIV prevention activities. Each jurisdiction has a corresponding Federal Information Processing Standards (FIPS) code.

Instructions: Select the code of state, city or territory in which your agency is located. If uploading data to EvaluationWeb, submit the two number FIPS code for your state or territory, not the value description or the name of the jurisdiction. FIPS codes contain leading zeros when applicable.

Business rules HD HIV Testing: Mandatory
Partner Services: Required
CBO HIV Testing: Mandatory

Code	Value Description	Value Definition
01	*AL*	*Alabama*
02	*AK*	*Alaska*
04	*AZ*	*Arizona*
05	*AR*	*Arkansas*
06	*CA*	*California*
08	*CO*	*Colorado*
09	*CT*	*Connecticut*
10	*DE*	*Delaware*
11	*DC*	*District of Columbia*
12	*FL*	*Florida*
13	*GA*	*Georgia*
15	*HI*	*Hawaii*
16	*ID*	*Idaho*
17	*IL*	*Illinois*
18	*IN*	*Indiana*
19	*IA*	*Iowa*
20	*KS*	*Kansas*
21	*KY*	*Kentucky*
22	*LA*	*Louisiana*
23	*ME*	*Maine*
24	*MD*	*Maryland*

Code	Value Description	Value Definition
25	MA	Massachusetts
26	MI	Michigan
27	MN	Minnesota
28	MS	Mississippi
29	MO	Missouri
30	MT	Montana
31	NE	Nebraska
32	NV	Nevada
33	NH	New Hampshire
34	NJ	New Jersey
35	NM	New Mexico
36	NY	New York
37	NC	North Carolina
38	ND	North Dakota
39	OH	Ohio
40	OK	Oklahoma
41	OR	Oregon
42	PA	Pennsylvania
44	RI	Rhode Island
45	SC	South Carolina
46	SD	South Dakota
47	TN	Tennessee
48	TX	Texas
49	UT	Utah
50	VT	Vermont
51	VA	Virginia
53	WA	Washington
54	WV	West Virginia
55	WI	Wisconsin
56	WY	Wyoming
60	AS	American Samoa
64	FM	Federated States of Micronesia
66	GU	Guam
68	MH	Marshall Islands
69	MP	Northern Mariana Islands
70	PW	Palau
72	PR	Puerto Rico
78	VI	Virgin Islands of the U.S.
80	San Francisco, CA	San Francisco Health Department

Code	Value Description	Value Definition
81	*Los Angeles, CA*	*Los Angeles Health Department*
82	*New York City, NY*	*New York City Health Department*
83	*Houston, TX*	*Houston Health Department*
84	*Chicago, IL*	*City of Chicago Health Department*
85	*Philadelphia, PA*	*City of Philadelphia Health Department*
87	*Baltimore, MD*	*Baltimore City Health Department*

NHME Variables and Values

Num	Variable Name	
A28	**CBO Agency ID**	**XSD (Schema) Name: CBOAgencyID**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 5 **Max Length:** 5

Definition: A unique alpha-numeric identifier assigned by CDC to CDC-funded community-based organizations. This requirement was implemented for CDC-funded CBOs January 1, 2012.

Instructions: Enter the CDC assigned CBO Agency ID.

Business rules HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Mandatory

Code	Value Description	Value Definition
AL001	*Aletheia House*	*CDC directly funded community-based organization, Birmingham, AL*
AL002	*AIDS Alabama, Inc.*	*CDC directly funded community-based organization, Birmingham, AL*
AL003	*AIDS Action Coalition*	*CDC directly funded community-based organization, Huntsville, AL*
AL004	*Birmingham AIDS Outreach, Inc.*	*CDC directly funded community-based organization, Birmingham, AL*
AL005	*Health Services Center, Inc.*	*CDC directly funded community-based organization, Anniston, AL*
AL006	*Knights & Orchids Society, Inc.*	*CDC directly funded community-based organization, Selma, AL*
AR001	*ARCARE*	*CDC directly funded community-based organization, Augusta, AR*
AZ001	*Southern Arizona AIDS Foundation*	*CDC directly funded community-based organization, Tucson, AZ*
AZ002	*Ebony House, Inc.*	*CDC directly funded community-based organization, Phoenix, AZ*
AZ003	*Native American Community Health Center, Inc.*	*CDC directly funded community-based organization, Phoenix, AZ*
AZ004	*Southwest Center for HIV/AIDS*	*CDC directly funded community-based organization, Phoenix, AZ*
CA001	*AmASSI Center of South Central Los Angeles*	*CDC directly funded community-based organization, Inglewood, CA*
CA002	*AIDS Healthcare Foundation*	*CDC directly funded community-based organization, Los Angeles, CA*
CA003	*APLA Health & Wellness*	*CDC directly funded community-based organization, Los Angeles, CA*
CA004	*AltaMed Health Services Corporation*	*CDC directly funded community-based organization, Los Angeles, CA*
CA005	*Bienestar Human Services*	*CDC directly funded community-based organization, Los Angeles, CA*
CA006	*Children's Hospital of Los Angeles*	*CDC directly funded community-based organization, Los Angeles, CA*
CA007	*Friends Research Institute, Inc./Friends Community Center*	*CDC directly funded community-based organization, Los Angeles, CA*
CA008	*JWCH Institute, Inc.*	*CDC directly funded community-based organization, Los Angeles, CA*
CA009	*Los Angeles LGBT Center*	*CDC directly funded community-based organization, Los Angeles, CA*
CA010	*Realistic Education in Action Coalition to Foster Health (REACH LA)*	*CDC directly funded community-based organization, Los Angeles, CA*
CA011	*Special Service for Groups*	*CDC directly funded community-based organization, Los Angeles, CA*

NHME Variables and Values

Code	Value Description	Value Definition
CA012	*AIDS Project of the East Bay*	*CDC directly funded community-based organization, Oakland, CA*
CA013	*CA Prostitutes Education Project*	*CDC directly funded community-based organization, Oakland, CA*
CA014	*HIV Prevention Project of Alameda County*	*CDC directly funded community-based organization, Oakland, CA*
CA015	*La Clinica De la Raza, Inc.*	*CDC directly funded community-based organization, Oakland, CA*
CA016	*Center for AIDS Research Education & Services*	*CDC directly funded community-based organization, Sacramento, CA*
CA017	*Family Health Centers of San Diego*	*CDC directly funded community-based organization, San Diego, CA*
CA018	*Asian and Pacific Islander Wellness Center*	*CDC directly funded community-based organization, San Francisco, CA*
CA019	*Larkin St. Youth Services*	*CDC directly funded community-based organization, San Francisco, CA*
CA020	*Stop AIDS Project*	*CDC directly funded community-based organization, San Francisco, CA*
CA021	*Centerforce*	*CDC directly funded community-based organization, San Rafael, CA*
CA022	*Tarzana Treatment Centers, Inc.*	*CDC directly funded community-based organization, Tarzana, CA*
CA023	*AIDS Services Foundation Orange County*	*CDC directly funded community-based organization, Irvine, CA*
CA024	*Centro De Salud La Comunidad De San Ysidro, Inc*	*CDC directly funded community-based organization, San Diego, CA*
CA025	*Black AIDS Institute/African-American AIDS Policy & Training Institute*	*CDC directly funded community-based organization, Los Angeles, CA*
CA026	*San Francisco AIDS Foundation*	*CDC directly funded community-based organization, San Francisco, CA*
CA027	*Bay Area Community Health dba Tri-City Health Center*	*CDC directly funded community-based organization, Fremont, CA*
CA028	*Sutter Bay Hospitals dba Alta Bates Medical Center – East Bay AIDS Center*	*CDC directly funded community-based organization, Oakland, CA*
CA029	*Via Care Community Health Center, Inc.*	*CDC directly funded community-based organization, Los Angeles, CA*
CO001	*Empowerment Program*	*CDC directly funded community-based organization, Denver, CO*
CO002	*Colorado Health Network*	*CDC directly funded community-based organization, Denver, CO*
CT001	*Latinos Conta Cida (Latino Community Services, Inc.)*	*CDC directly funded community-based organization, Hartford, CT*
CT002	*AIDS Project New Haven, Inc. dba APNH: A Place to Nourish Your Health*	*CDC directly funded community-based organization, New Haven, CT*
CT003	*Apex Community Care, Inc.*	*CDC directly funded community-based organization, Danbury, CT*
DC001	*Children's National Medical Center*	*CDC directly funded community-based organization, Washington, DC*
DC002	*Deaf-REACH*	*CDC directly funded community-based organization, Washington, DC*
DC003	*Sasha Bruce Youthwork, Inc.*	*CDC directly funded community-based organization, Washington, DC*
DC004	*The Women's Collective*	*CDC directly funded community-based organization, Washington, DC*
DC005	*Us Helping Us, People Into Living, Inc.*	*CDC directly funded community-based organization, Washington, DC*
DC006	*Washington Area Consortium on HIV Infection in Youth (dba Metro Teen AIDS)*	*CDC directly funded community-based organization, Washington, DC*
DC007	*La Clinica Del Pueblo, Inc.*	*CDC directly funded community-based organization, Washington, DC*
DC008	*Family and Medical Counseling Service, Inc.*	*CDC directly funded community-based organization, Washington, DC*
DC009	*Whitman-Walker Clinic, Inc dba Whitman-Walker Health*	*CDC directly funded community-based organization, Washington, DC*
FL001	*Broward House*	*CDC directly funded community-based organization, Fort Lauderdale, FL*
FL002	*River Region Human Services*	*CDC directly funded community-based organization, Jacksonville, FL*
FL003	*Jacksonville Area Sexual Minority Youth Network (JASMYN)*	*CDC directly funded community-based organization, Jacksonville, FL*
FL004	*EmpowerU*	*CDC directly funded community-based organization, Miami, FL*
FL005	*Care Resource Community Health Centers, Inc.*	*CDC directly funded community-based organization, Miami, FL*
FL006	*Miracle of Love*	*CDC directly funded community-based organization, Orlando, FL*

NHME Variables and Values

Code	Value Description	Value Definition
FL007	*Comprehensive AIDS Program of Palm Beach County, Inc.*	*CDC directly funded community-based organization, Palm Springs, FL*
FL008	*Gay Lesbian Community Center of Greater Fort Lauderdale*	*CDC directly funded community-based organization, Wilton Manors, FL*
FL009	*Latinos Salud*	*CDC directly funded community-based organization, Wilton Manors, FL*
FL010	*Hope and Help Center of Central FL, Inc.*	*CDC directly funded community-based organization, Winter Park, FL*
FL011	*Metropolitan Charities, Inc.*	*CDC directly funded community-based organization, St. Petersburg, FL*
FL012	*AIDS Service Association of Pinellas, Inc. dba EPIC (Empath Partners in Care)*	*CDC directly funded community-based organization, Clearwater, FL*
FL013	*BASIC NWFL, Inc.*	*CDC directly funded community-based organization, Panama City, FL*
FL014	*Borinquen Health Care Center, Inc.*	*CDC directly funded community-based organization, Miami, FL*
FL015	*FoundCare, Inc.*	*CDC directly funded community-based organization, West Palm Beach, FL*
FL016	*Health Care Center for the Homeless, Inc. dba Orange Blossom Family Health*	*CDC directly funded community-based organization, Orlando, FL*
FL017	*Treasure Coast Health Council, Inc. dba Health Council of Southeast Florida*	*CDC directly funded community-based organization, Palm Beach Gardens, FL*
FL018	*Village South, Inc.*	*CDC directly funded community-based organization, Pembroke Pines, FL*
GA001	*Saint Joseph's Mercy Care Services*	*CDC directly funded community-based organization, Atlanta, GA*
GA002	*AID Atlanta, Inc.*	*CDC directly funded community-based organization, Atlanta, GA*
GA003	*Positive Impact, Inc.*	*CDC directly funded community-based organization, Atlanta, GA*
GA004	*AID Gwinnett*	*CDC directly funded community-based organization, Duluth, GA*
GA005	*Empowerment Resource Center*	*CDC directly funded community-based organization, Atlanta, GA*
GA006	*Recovery Consultants of Atlanta, Inc.*	*CDC directly funded community-based organization, Decatur, GA*
GA007	*Positive Impact Health Centers, Inc.*	*CDC directly funded community-based organization, Atlanta, GA*
GA008	*Atlanta HARM Reduction Coalition*	*CDC directly funded community-based organization, Atlanta, GA*
GA009	*Someone Cares, Inc. of Atlanta*	*CDC directly funded community-based organization, Marietta, GA*
GA010	*National AIDS Education & Services for Minorities, Inc. (NASEM)*	*CDC directly funded community-based organization, Atlanta, GA*
HI001	*Life Foundation*	*CDC directly funded community-based organization, Honolulu, HI*
IA001	*Primary Health Care, Inc.*	*CDC directly funded community-based organization, Des Moines, IA*
IL001	*Access Community Health Network*	*CDC directly funded community-based organization, Chicago, IL*
IL002	*Center on Halsted*	*CDC directly funded community-based organization, Chicago, IL*
IL003	*Chicago House and Social Service Agency*	*CDC directly funded community-based organization, Chicago, IL*
IL004	*Christian Community Health Center*	*CDC directly funded community-based organization, Chicago, IL*
IL005	*Heartland Human Care Services*	*CDC directly funded community-based organization, Chicago, IL*
IL006	*Lester and Rosalie Anixter Center*	*CDC directly funded community-based organization, Chicago, IL*
IL007	*McDermott Center (dba Haymarket Center)*	*CDC directly funded community-based organization, Chicago, IL*
IL008	*Puerto Rican Cultural Center*	*CDC directly funded community-based organization, Chicago, IL*
IL009	*South Side Help Center*	*CDC directly funded community-based organization, Chicago, IL*
IL010	*Taskforce Prevention and Community Services*	*CDC directly funded community-based organization, Chicago, IL*
IL011	*Association House of Chicago*	*CDC directly funded community-based organization, Chicago, IL*
IL012	*Howard Brown Health Center*	*CDC directly funded community-based organization, Chicago, IL*
IL013	*Brothers Health Collective*	*CDC directly funded community-based organization, Chicago, IL*
IN001	*Brothers United, Inc. dba BU Wellness Network*	*CDC directly funded community-based organization, Indianapolis, IN*
IN002	*Damien Center, Inc.*	*CDC directly funded community-based organization, Indianapolis, IN*

NHME Variables and Values

Code	Value Description	Value Definition
KY001	Volunteers of America of Kentucky, Inc.	CDC directly funded community-based organization, Louisville, KY
KY002	Heartland CARES, Inc.	CDC directly funded community-based organization, Paducah, KY
LA001	HIV/AIDS Alliance for Region Two, Inc.	CDC directly funded community-based organization, Baton Rouge, LA
LA002	Brotherhood, Inc.	CDC directly funded community-based organization, New Orleans, LA
LA003	Institute of Women and Ethnic Studies	CDC directly funded community-based organization, New Orleans, LA
LA004	NO/AIDS Task Force	CDC directly funded community-based organization, New Orleans, LA
LA005	Priority Health Care	CDC directly funded community-based organization, Marrero, LA
MA001	Boston Medical Center	CDC directly funded community-based organization, Boston, MA
MA002	Fenway Community Health Center	CDC directly funded community-based organization, Boston, MA
MA003	Justice Resource Institute, Inc.	CDC directly funded community-based organization, Boston, MA
MA004	Massachusetts Alliance of Portuguese Speakers (MAPS)	CDC directly funded community-based organization, Cambridge, MA
MA005	Whittier Street Health Services	CDC directly funded community-based organization, Roxbury, MA
MA006	Multicultural AIDS Coalition	CDC directly funded community-based organization, Roxbury, MA
MD001	Women Accepting Responsibility	CDC directly funded community-based organization, Baltimore, MD
MD002	Identity, Inc.	CDC directly funded community-based organization, Gaithersburg, MD
MD003	Heart to Hand, Inc.	CDC directly funded community-based organization, Largo, MD
MD004	Pride Center of Maryland	CDC directly funded community-based organization, Baltimore, MD
ME001	Regional Medical Center at Lubec	CDC directly funded community-based organization, Lubec, ME
MI001	Teen Hype Youth Development Program	CDC directly funded community-based organization, Detroit, MI
MI002	Community Health Awareness Group	CDC directly funded community-based organization, Detroit, MI
MI003	Detroit Recovery Project	CDC directly funded community-based organization, Detroit, MI
MI004	Matrix Human Services	CDC directly funded community-based organization, Detroit, MI
MI005	Health Emergency Lifeline	CDC directly funded community-based organization, Detroit, MI
MN001	Indigenous People Task Force	CDC directly funded community-based organization, Minneapolis, MN
MN002	Minnesota AIDS Project	CDC directly funded community-based organization, Minneapolis, MN
MN003	Aliveness Project	CDC directly funded community-based organization, Minneapolis, MN
MO001	Kansas City CARE Clinic	CDC directly funded community-based organization, Kansas City, MO
MO002	The Community Wellness Project	CDC directly funded community-based organization, St. Louis, MO
MO003	AIDS Resource Center of Wisconsin, Inc. dba Vivent Health	CDC directly funded community-based organization, St. Louis, MO
MS001	Building Bridges, Inc.	CDC directly funded community-based organization, Jackson, MS
MS002	My Brother's Keeper, Inc.	CDC directly funded community-based organization, Ridgeland, MS
MS003	Institute for the Advancement of Minority Health	CDC directly funded community-based organization, Flowood, MS
NC001	Carolina Cares Partnership (formerly Regional HIV/AIDS Consortium)	CDC directly funded community-based organization, Charlotte, NC
NC002	Quality Home Care Services	CDC directly funded community-based organization, Charlotte, NC
NC003	Rain, Inc.	CDC directly funded community-based organization, Charlotte, NC
NJ001	PROCEED	CDC directly funded community-based organization, Elizabeth, NJ
NJ002	Hyacinth AIDS Foundation	CDC directly funded community-based organization, New Brunswick, NJ
NJ003	Newark Beth Israel Medical Center	CDC directly funded community-based organization, Newark, NJ
NJ004	Newark Community Health Centers	CDC directly funded community-based organization, Newark, NJ

NHME Variables and Values

Code	Value Description	Value Definition
NJ005	North Jersey AIDS Alliance (dba North Jersey Community Research Initiative)	CDC directly funded community-based organization, Newark, NJ
NV001	Gay & Lesbian Center of Southern Nevada, Inc.	CDC directly funded community-based organization, Las Vegas, NV
NV002	Impact Change	CDC directly funded community-based organization, Las Vegas, NV
NY001	AIDS Council of Northeastern New York	CDC directly funded community-based organization, Albany, NY
NY002	Whitney M Young Jr. Health Services	CDC directly funded community-based organization, Albany, NY
NY003	BOOM!Health	CDC directly funded community-based organization, Bronx, NY
NY004	CitiWide Harm Reduction Program	CDC directly funded community-based organization, Bronx, NY
NY005	Montefiore Medical Center/Women's Center	CDC directly funded community-based organization, Bronx, NY
NY006	Brookdale University Hospital and Medical Center	CDC directly funded community-based organization, Brooklyn, NY
NY007	Bridging Access to Care	CDC directly funded community-based organization, Brooklyn, NY
NY008	Sunset Park Health Council, Inc., (dba Family Health Centers at NYU Langone)	CDC directly funded community-based organization, Brooklyn, NY
NY009	Wyckoff Heights Medical Center	CDC directly funded community-based organization, Brooklyn, NY
NY010	Evergreen Health Services of Western New York	CDC directly funded community-based organization, Buffalo, NY
NY011	Long Island Association for AIDS Care, Inc.	CDC directly funded community-based organization, Hauppauge, NY
NY012	AIDS Service Center of Lower Manhattan, Inc.	CDC directly funded community-based organization, New York, NY
NY013	Asian and Pacific Islander Coalition on HIV/AIDS, Inc. (APICHA)	CDC directly funded community-based organization, New York, NY
NY014	Community Health Project	CDC directly funded community-based organization, New York, NY
NY015	Exponents	CDC directly funded community-based organization, New York, NY
NY016	Foundation for Research on Sexually Transmitted Diseases (FROSTD)	CDC directly funded community-based organization, New York, NY
NY017	Gay Men's Health Crisis	CDC directly funded community-based organization, New York, NY
NY018	Harlem United Community AIDS Center	CDC directly funded community-based organization, New York, NY
NY019	Hispanic AIDS Forum	CDC directly funded community-based organization, New York, NY
NY020	Iris House A Center for Women Living with HIV	CDC directly funded community-based organization, New York, NY
NY021	Latino Commission on AIDS	CDC directly funded community-based organization, New York, NY
NY022	Planned Parenthood of New York City, Inc.	CDC directly funded community-based organization, New York, NY
NY023	Safe Horizon	CDC directly funded community-based organization, New York, NY
NY024	The Door - A Center for Alternatives, Inc.	CDC directly funded community-based organization, New York, NY
NY025	The Hetrick-Martin Institute	CDC directly funded community-based organization, New York, NY
NY026	The Partnership for the Homeless	CDC directly funded community-based organization, New York, NY
NY027	Community Health Action of Staten Island	CDC directly funded community-based organization, Staten Island, NY
NY028	The Sharing Community	CDC directly funded community-based organization, Yonkers, NY
NY029	AIDS Center of Queens County, Inc.	CDC directly funded community-based organization, Jamaica, NY
NY030	Harlem Hospital Center/NYC Health & Hospitals Corporation	CDC directly funded community-based organization, New York, NY
NY031	North Shore University	CDC directly funded community-based organization, Manhasset, NY
NY032	William F. Ryan Community Health Center	CDC directly funded community-based organization, New York, NY
NY033	Women's Prison Association & Home	CDC directly funded community-based organization, New York, NY
NY034	African Services Committee, Inc.	CDC directly funded community-based organization, New York, NY
NY035	BronxCare Health System	CDC directly funded community-based organization, Bronx, NY
NY036	New York Presbyterian Hospital	CDC directly funded community-based organization, New York, NY

Code	Value Description	Value Definition
NY037	NYC Health + Hospitals: Jacobi Medical Center and North Central Bronx	CDC directly funded community-based organization, Bronx, NY
NY038	Long Island Crisis Center, Inc.	CDC directly funded community-based organization, Bellmore, NY
NY039	Long Island Gay and Lesbian Youth, Inc.	CDC directly funded community-based organization, Astoria, NY
OH001	AIDS Resource Center Ohio	CDC directly funded community-based organization, Columbus, OH
OH002	Recovery Resources	CDC directly funded community-based organization, Cleveland, OH
OK001	Guiding Right, Inc.	CDC directly funded community-based organization, Midwest City, OK
OR001	Cascade AIDS Project	CDC directly funded community-based organization, Portland, OR
OR002	HIV Alliance	CDC directly funded community-based organization, Eugene, OR
PA001	AIDS Care Group	CDC directly funded community-based organization, Chester, PA
PA002	Access Matters	CDC directly funded community-based organization, Philadelphia, PA
PA003	Mazzoni Center	CDC directly funded community-based organization, Philadelphia, PA
PA004	Philadelphia Fight	CDC directly funded community-based organization, Philadelphia, PA
PA005	Public Health Management Corp (dba Philadelphia Health Management)	CDC directly funded community-based organization, Philadelphia, PA
PA006	The Philadelphia AIDS Consortium	CDC directly funded community-based organization, Philadelphia, PA
PA007	Bebashi-Transition to Hope	CDC directly funded community-based organization, Philadelphia, PA
PA008	Congreso de Latinos Unidos, Inc.	CDC directly funded community-based organization, Philadelphia, PA
PA009	Children's Hospital of Philadelphia	CDC directly funded community-based organization, Philadelphia, PA
PR001	Corporacion de Salud Y Medicina Avanzada (COSSMA)	CDC directly funded community-based organization, Cidra, PR
PR002	Estancia Corazon (Program Fondita)	CDC directly funded community-based organization, Mayaguez, PR
PR003	Migrant Health Center, Western Region, Inc.	CDC directly funded community-based organization, Mayaguez, PR
PR004	ASPIRA of Puerto Rico	CDC directly funded community-based organization, San Juan, PR
PR005	COAI, Inc.	CDC directly funded community-based organization, San Juan, PR
PR006	Puerto Rico Community Network for Clinical Research on AIDS (PR CONCRA)	CDC directly funded community-based organization, San Juan, PR
SC001	Palmetto AIDS Life Support Services (PALSS)	CDC directly funded community-based organization, Columbia, SC
SC002	South Carolina HIV/AIDS Council	CDC directly funded community-based organization, Columbia, SC
TN001	Women on Maintaining Education and Nutrition	CDC directly funded community-based organization, Nashville, TN
TN002	Le Bonheur Community Health and Well-Being	CDC directly funded community-based organization, Memphis, TN
TN003	Nashville CARES	CDC directly funded community-based organization, Nashville, TN
TX001	AIDS Services of Austin, Inc.	CDC directly funded community-based organization, Austin, TX
TX002	The Wright House Wellness Center	CDC directly funded community-based organization, Austin, TX
TX003	Coastal Bend Wellness Foundation	CDC directly funded community-based organization, Corpus Christi, TX
TX004	Abounding Prosperity, Inc.	CDC directly funded community-based organization, Dallas, TX
TX005	AIDS Arms, Inc.	CDC directly funded community-based organization, Dallas, TX
TX006	Parkland Health and Hospital System	CDC directly funded community-based organization, Dallas, TX
TX007	Urban League of Greater Dallas, Inc.	CDC directly funded community-based organization, Dallas, TX
TX008	AIDS Foundation Houston, Inc.	CDC directly funded community-based organization, Houston, TX
TX009	Change Happens (formerly Families Under Urban and Social Attack, Inc.)	CDC directly funded community-based organization, Houston, TX
TX010	Houston Area Community Services (HACS) dba Avenue 360 Health & Wellness	CDC directly funded community-based organization, Houston, TX

NHME Variables and Values

Code	Value Description	Value Definition
TX011	*Legacy Community Health Services, Inc.*	*CDC directly funded community-based organization, Houston, TX*
TX012	*St. Hope Foundation*	*CDC directly funded community-based organization, Houston, TX*
TX013	*South Texas Council on Alcohol and Drug Abuse*	*CDC directly funded community-based organization, Laredo, TX*
TX014	*Beat AIDS Coalition Trust*	*CDC directly funded community-based organization, San Antonio, TX*
TX015	*Fundacion Latinoamerican de Accion Social, Inc.*	*CDC directly funded community-based organization, Houston, TX*
TX016	*Special Health Resources for Texas, Inc.*	*CDC directly funded community-based organization, Longview, TX*
TX017	*Valley AIDS Council*	*CDC directly funded community-based organization, Harlingen, TX*
TX018	*Montrose Center*	*CDC directly funded community-based organization, Houston, TX*
VA001	*LGBT Life Center*	*CDC directly funded community-based organization, Norfolk, VA*
VA002	*Inova Health Care Services*	*CDC directly funded community-based organization, Fairfax, VA*
VI001	*Virgin Islands Community AIDS Resource & Education (VICARE)*	*CDC directly funded community-based organization, Christiansted, VI*
VI002	*Helping Others in a Positive Environment, Inc. (HOPE)*	*CDC directly funded community-based organization, St. Thomas, VI*
VI003	*Frederiksted Health Care, Inc.*	*CDC directly funded community-based organization, St. Croix, VI*
WA001	*Neighborhood House*	*CDC directly funded community-based organization, Seattle, WA*
WA002	*People of Color Against AIDS Network*	*CDC directly funded community-based organization, Seattle, WA*
WI001	*Diverse and Resilient, Inc.*	*CDC directly funded community-based organization, Milwaukee, WI*

Table: S Site Information

A site is a facility or non-facility based setting (e.g. park, street corner), which serves as a point of service delivery. If an agency has multiple sites, this table is completed for each site. However, if an agency has multiple sites with the same zip code that are of the same site type, the agency may use a single site name and ID for the encompassing locations. For example, a mobile van that rotates to several sites within the same zip code.

Num	*Variable Name*	
S01	**Site ID**	**XSD (Schema) Name: siteId**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 32

Definition: A unique alpha-numeric identification code used to distinguish the locations where an agency delivers the HIV prevention service.

A site ID is unique to an agency.

For Partner services (PS), the Site ID distinguishes between the agency site locations and should identify the locality where the PS case is assigned (i.e., the county health department).

Instructions: Indicate the unique alpha-numeric ID that will be used to link prevention services delivered by a particular agency to a specific geographic area and type of setting. If using EvaluationWeb for direct key entry, this ID may be generated for you.

If a mobile van is used, an agency may assign the same ID to sites that are of the same type AND located within the same zip code (e.g., all churches in 39126).

Business rules HD HIV Testing: Mandatory
Partner Services: Mandatory
CBO HIV Testing: Mandatory

NHME Variables and Values

Num	*Variable Name*	
S03	**Service Delivery Site Name**	**XSD (Schema) Name: site/name**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 100

Definition: The official name of the agency's HIV prevention site of service delivery.

Instructions: Enter the official name of the site where your agency provides HIV prevention services. The Site Name must be unique for each site supported by your agency. If your agency's services are delivered at the same place your administrative office is located, then this site will automatically be entered in EvaluationWeb. Note: Please provide the official name for your agency's HIV prevention site, even though some staff and community residents may refer to it as something other than its official name.

Business rules HD HIV Testing: Required
Partner Services: Allowed, but not reported to CDC
CBO HIV Testing: Required

Num	Variable Name	
S04	**Site Type**	**XSD (Schema) Name: siteTypeValueCode**

Value Option: Choose only one **Format Type:** Alpha-Numeric **Min Length:** 3 **Max Length:** 6

Definition: The setting of the location in which HIV prevention services are provided. For PS, this is the type of local agency to which the PS case is assigned.

Instructions: Select the site type from the list provided that best represents the setting and/or primary type of services offered at this site of service delivery. You can only choose one site type.

Business rules HD HIV Testing: Required
Partner Services: Required
CBO HIV Testing: Required

Code	Value Description	Value Definition
F01.01	*Clinical - Inpatient hospital*	*A health facility that provides medical care to patients that reside within that facility while they are receiving those services.*
F02.12	*Clinical - TB clinic*	*A non-residential health care facility that specializes in the provision of tuberculosis treatment, care and prevention services.*
F02.19	*Clinical - Substance abuse treatment facility*	*A non-residential health care facility that provides alcohol and chemical dependency treatment services.*
F02.51	*Clinical - Community health center*	*A non-residential health care facility that provides primary and preventative health care services to the members of a community in which it is located.*
F03	*Clinical - Emergency department*	*A section of a hospital or clinic staffed and equipped to provide emergency care to persons requiring immediate medical treatment for sudden illness or trauma.*
F04.05	*Non-clinical - HIV testing site*	*A facility or non-facility based setting where HIV prevention counseling and testing services are provided.*
F06.02	*Non-clinical - Community setting - School/educational facility*	*A building or place where individuals receive knowledge through learning and instruction.*
F06.03	*Non-clinical - Community setting - Church/mosque/synagogue/temple*	*A building where a group of people who adhere to a common faith gather for prayer.*
F06.04	*Non-clinical - Community Setting - Shelter/transitional housing*	*A building or facility that provides supportive housing temporarily or may be used to facilitate the movement of homeless individuals and families to permanent housing.*
F06.05	*Non-clinical - Community setting - Commercial facility*	*A business or commercial facility (e.g., beauty salon, grocery store, shopping center) where HIV prevention services may also occur.*
F06.07	*Non-clinical - Community setting - Bar/club/adult entertainment*	*A place of entertainment, typically open at night, usually serves food and alcoholic beverages, and often provides music and space for dancing or having a floor show which may depict, describe, or relate to sexual conduct or sexual excitement.*

Num	Variable Name	
F06.08	Non-clinical - Community setting - Public area	An area, environment or context that is open to the community as a whole such as a park or city street.
F06.12	Non-clinical – Community setting – Individual residence	An individual's home or place of residence.
F06.88	Non-clinical - Community setting - Other	A defined area, environment or context (other than those already specified) in which a group of people live, work or congregate.
F07	Non-clinical - Correctional facility - Non-healthcare	A penal or correctional facility, prison, jail detention center, community-based rehabilitation center, or any similar institution designed for the confinement or rehabilitation of criminal offenders
F08	Clinical - Primary care clinic (other than CHC)	A health care facility in which medical care is provided by a clinician to a patient as part of regular, ambulatory care, and sometimes followed by referral to other medical providers.
F09	Clinical - Pharmacy or other retail-based clinic	A health care facility or business in which prescription and non-prescription drugs and/or medical equipment are dispensed. Primary care clinical services may be provided by a practicing nurse or pharmacist at the facility.
F10	Clinical - STD clinic	A health care facility in which sexual health is specialized in the prevention and treatment of sexually transmitted infections.
F11	Clinical - Dental clinic	A health care facility in which care is provided for dental patients. The facility may provide various treatments for the teeth, e.g. cleaning, X-rays, fillings, extractions, and root canal surgery.
F12	Clinical - Correctional facility clinic	An area within a penal or correctional facility, , including adult or juvenile detention facilities, that provides medical or health services.
F13	Clinical - Other	A health care facility where medical services are provided, other than those specified.
F14	Non-clinical - Health department - field visit	Services are provided in an unspecified location away from the clinician's usual place of business, except for Correctional Institution, Inpatient, or Residential Care for adults or children. An example may be the clients' home or place of employment.
F15	Non-clinical - Community Setting - Syringe exchange program	A facility or center where clients may exchange used hypodermic needles for sterile needles.
F40	Mobile Unit	A specialized vehicle used to provide HIV prevention services beyond the transport of agency staff to the field and/or for client recruitment.
F50	Self-Testing	Refers to HIV tests performed by the client at home or in a private location. Includes both rapid self-tests (e.g., oral fluid tests) and mail-in tests using a specimen collection kit.
F88	Non-clinical - Other	A site where prevention services are conducted other than those specified above.

Num	Variable Name	
S08	**Site - County**	**XSD (Schema) Name: site/county**

Value Option: Choose only one **Format Type:** Alpha-Numeric **Min Length:** 3 **Max Length:** 3

Definition: The county, parish, or municipality where the agency's site of service delivery is physically located.

Instructions: Indicate the FIPS code of the county where the site of service delivery is physically located. Note: Site County FIPS codes are unique within a jurisdiction.

Business rules
HD HIV Testing: Required
Partner Services: Allowed, but not reported to CDC
CBO HIV Testing: Required

NHME Variables and Values

Num	*Variable Name*	
S09	**Site - State**	**XSD (Schema) Name: site/State**

Value Option: Choose only one **Format Type:** Alpha-Numeric **Min Length:** 2 **Max Length:** 2

Definition: The numeric FIPS code for the state, territory or district in which the official mailing address for the site is physically located.

Instructions: Select the value code (numeric FIPS code, not state/territory abbreviation) for the name of the state, territory or district where the site you entered for variable S03: Site Name is located. This must represent one of the 50 states, the District of Columbia, the U.S. Virgin Islands, or Puerto Rico. The value codes are numeric FIPS codes and contain leading zeros. Do not submit your state or territory abbreviation.

Business rules HIV Testing: Required
Partner Services: Allowed, but not reported to CDC
CBO HIV Testing: Required

Code	Value Description	Value Definition
1	AL	Alabama
2	AK	Alaska
4	AZ	Arizona
5	AR	Arkansas
6	CA	California
8	CO	Colorado
9	CT	Connecticut
10	DE	Delaware
11	DC	District of Columbia
12	FL	Florida
13	GA	Georgia
15	HI	Hawaii
16	ID	Idaho
17	IL	Illinois
18	IN	Indiana
19	IA	Iowa
20	KS	Kansas
21	KY	Kentucky
22	LA	Louisiana
23	ME	Maine
24	MD	Maryland
25	MA	Massachusetts

Code	Value Description	Value Definition
26	MI	Michigan
27	MN	Minnesota
28	MS	Mississippi
29	MO	Missouri
30	MT	Montana
31	NE	Nebraska
32	NV	Nevada
33	NH	New Hampshire
34	NJ	New Jersey
35	NM	New Mexico
36	NY	New York
37	NC	North Carolina
38	ND	North Dakota
39	OH	Ohio
40	OK	Oklahoma
41	OR	Oregon
42	PA	Pennsylvania
44	RI	Rhode Island
45	SC	South Carolina
46	SD	South Dakota
47	TN	Tennessee
48	TX	Texas
49	UT	Utah
50	VT	Vermont
51	VA	Virginia
53	WA	Washington
54	WV	West Virginia
55	WI	Wisconsin
56	WY	Wyoming
60	AS	American Samoa
64	FM	Federated States of Micronesia
66	GU	Guam
68	MH	Marshall Islands
69	MP	Northern Mariana Islands
70	PW	Palau
72	PR	Puerto Rico
78	VI	Virgin Islands of the U.S.

Num	*Variable Name*	
S10	**Site - Zip Code**	**XSD (Schema) Name: site/zip**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 5 **Max Length:** 10

Definition: The postal zip code associated with the site where services are provided. The site's postal zip code is linked to the unique Site ID and Site Type.

Instructions: Enter the postal zip code for the site of service delivery.

Business rules HD HIV Testing: Required
Partner Services: Allowed, but not reported to CDC
CBO HIV Testing: Required

Code	Value Description	Value Definition
	~~##### ####~~	*Only the 5-digit zip code is required.*

Client Level

Table: G1 Client Characteristics-Demographic

This table is required to be completed by all agencies that provide HIV prevention interventions or services individually to clients (e.g., HIV testing).

Num *Variable Name*

G101 **Date Client Demographic Data Collected** **XSD (Schema) Name: collectedDateForClient**

Value Option: N/A **Format Type:** MM/DD/YYYY **Min Length:** 8 **Max Length:** 10

Definition: The date on which client demographic data or other information is collected. For reporting to CDC, this should be the intake date or the date of the first session before the intervention begins.

Instructions: Enter the date that client demographic data are collected.
This date cannot be greater than the current date at the time of data entry.

Business rules HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

G103 **Local Client ID** **XSD (Schema) Name: localClientId**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 32

Definition: A locally developed alpha-numeric unique client identification code used to distinguish an individual client receiving multiple services within an agency.

Instructions: This code can be shared and used by more than one agency throughout a city, territory or state. This code should not contain personal information that is organized in a way that can be easily deciphered (e.g., birth date, month and year).

Business rules HD HIV Testing: Allowed, but not reported to CDC
Partner Services: Mandatory
CBO HIV Testing: Allowed, but not reported to CDC

This ID must be unique for each client. At a minimum this ID needs to be unique within an agency.

G112 **Date of Birth - Year** **XSD (Schema) Name: birthYear**

Value Option: N/A **Format Type:** Number **Min Length:** 4 **Max Length:** 4

Definition: The calendar year in which the client was born.

Instructions: Enter the year in which the client was born. If birth year is unknown, enter 1800.

Business rules HD HIV Testing: Required
Partner Services: Required
CBO HIV Testing: Required

Value must be ≥ 1900 or = 1800 if birth year is unknown.

Num	*Variable Name*	
G114	**Ethnicity**	**XSD (Schema) Name: ethnicity**

Value Option: Choose only one **Format Type:** Alpha-Numeric **Min Length:** 2 **Max Length:** 2

Definition: The client's self-report of whether they are of Hispanic or Latino origin. Standard OMB ethnicity codes are applied.

Instructions: Indicate whether the client's self-reported ethnicity of Hispanic/Latino or not Hispanic/Latino.

Business rules HD HIV Testing: Required
Partner Services: Required
CBO HIV Testing: Required

Code	Value Description	Value Definition
E1	*Hispanic or Latino*	*A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.*
E2	*Not Hispanic or Latino*	*A person not identified by the definition of Hispanic or Latino.*
77	*Declined to answer*	*The client declines or is unwilling to report his or her ethnicity.*
99	*Don't know*	*The client reports that he or she is unaware of his or her ethnicity.*

Num	Variable Name	
G116	**Race**	**XSD (Schema) Name: raceValueCode**

Value Option: Choose all that apply **Format Type:** Alpha-Numeric **Min Length:** 2 **Max Length:** 2

Definition: A client's self-reported classification or classifications of the biological heritage with which they most closely identify. Standard OMB race codes are applied.

Instructions: Indicate the client's self-reported race(s) using standard OMB race codes. Record all race categories that the client reports.

Business rules HD HIV Testing: Required, see detailed business rule
Partner Services: Required, see detailed business rule
CBO HIV Testing: Required, see detailed business rule

Detailed business rule:
Multiple value codes may be selected if value code ≠ 55 or 77 or 99. Not specified should only be selected if ethnicity is Hispanic or Latino (G114 = E1) and no other race is indicated.

Code	Value Description	Value Definition
R1	*American Indian or Alaska Native*	*A person having origins in any of the original peoples of North or South America (including Central America), and who maintains tribal affiliation or community attachment.*
R2	*Asian*	*A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.*
R3	*Black or African American*	*A person having origins in any of the black racial groups of Africa.*
R4	*Native Hawaiian or Pacific Islander*	*A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.*
R5	*White*	*A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.*
55	*Not specified*	*The client reported that he or she is of Hispanic or Latino descent, but did not specify their race.*
77	*Declined to answer*	*The client declines or is unwilling to report his or her race.*
99	*Don't know*	*The client reports that he or she is unaware of their race.*

Num	Variable Name	
G120	**State/Territory of Residence**	**XSD (Schema) Name: stateOfResidence**

Value Option: Choose only one **Format Type:** Number **Min Length:** 2 **Max Length:** 2

Definition: The state, territory or district where the client was residing at the time of service delivery.

Instructions: Select the value code for the state, territory or district where the client lives at the time services are delivered. In some cases, where the client lives may not be the same as where the client is receiving HIV prevention services. For example, a person could reside in one state (or jurisdiction) but drive to another state to receive HIV testing out of fear of having their privacy or confidentiality exposed. Leading zeros are retained as the value codes are FIPS codes.

Business rules HD HIV Testing: Required
Partner Services: Allowed, but not reported to CDC
CBO HIV Testing: Required

Code	Value Description	Value Definition
1	AL	Alabama
2	AK	Alaska
4	AZ	Arizona
5	AR	Arkansas
6	CA	California
8	CO	Colorado
9	CT	Connecticut
10	DE	Delaware
11	DC	District of Columbia
12	FL	Florida
13	GA	Georgia
15	HI	Hawaii
16	ID	Idaho
17	IL	Illinois
18	IN	Indiana
19	IA	Iowa
20	KS	Kansas
21	KY	Kentucky
22	LA	Louisiana
23	ME	Maine
24	MD	Maryland
25	MA	Massachusetts

Code	Value Description	Value Definition
26	MI	Michigan
27	MN	Minnesota
28	MS	Mississippi
29	MO	Missouri
30	MT	Montana
31	NE	Nebraska
32	NV	Nevada
33	NH	New Hampshire
34	NJ	New Jersey
35	NM	New Mexico
36	NY	New York
37	NC	North Carolina
38	ND	North Dakota
39	OH	Ohio
40	OK	Oklahoma
41	OR	Oregon
42	PA	Pennsylvania
44	RI	Rhode Island
45	SC	South Carolina
46	SD	South Dakota
47	TN	Tennessee
48	TX	Texas
49	UT	Utah
50	VT	Vermont
51	VA	Virginia
53	WA	Washington
54	WV	West Virginia
55	WI	Wisconsin
56	WY	Wyoming
60	AS	American Samoa
64	FM	Federated States of Micronesia
66	GU	Guam
68	MH	Marshall Islands
69	MP	Northern Mariana Islands
70	PW	Palau
72	PR	Puerto Rico
78	VI	Virgin Islands of the U.S.
88	Other	Client does not currently reside in a US state, territory, or district.

NHME Variables and Values

Num	Variable Name	
G123	**Assigned Sex at Birth**	**XSD (Schema) Name: birthGenderValueCode**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The biological sex assigned to the client at birth, (i.e., the sex noted on the client's birth certificate).

Instructions: Indicate whether the client reports being born a male or female (i.e., born with male or female genitalia).

Business rules HD HIV Testing: Required
Partner Services: Required
CBO HIV Testing: Required

Code	Value Description	Value Definition
1	*Male*	*The sex that produces spermatozoa by which female ova are fertilized.*
2	*Female*	*The sex that produces ova, can conceive and bear offspring/children.*
77	*Declined to answer*	*The client declines or is unwilling to report his or her assigned sex at birth.*

Num	Variable Name	
G124	**Current Gender Identity**	**XSD (Schema) Name: currentGenderValueCode**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The client's current self-reported gender identity. This may include one's social status, self-identification, legal status, and biology.

Instructions: Select the value that most closely describes the client's current, self-reported gender identity.

Business rules HD HIV Testing: Required
Partner Services: Required
CBO HIV Testing: Required

Code	Value Description	Value Definition
1	*Male*	*A person who identifies as a male and whose behavioral, cultural, or psychological traits are typically associated with the male sex.*
2	*Female*	*A person who identifies as a female and whose behavioral, cultural, or psychological traits are typically associated with the female sex.*
3	*Transgender - Male to Female*	*Individuals whose physical or birth sex is male but whose gender expression and/or gender identity is female. MTF = male to female.*
4	*Transgender - Female to Male*	*Individuals whose physical or birth sex is female but whose gender expression and/or gender identity is male. FTM = female to male.*
5	*Transgender - Unspecified*	*Individuals whose physical or birth sex is male or female but whose gender expression and/or gender identity differs from that which was documented at birth.*
6	*Another Gender*	*Individuals whose physical or birth sex is male or female but whose gender expression or gender identity is other than male or female.*
77	*Declined to Answer*	*The individual declines to self-report his or her current gender identity.*

Num	Variable Name	
G132	**Client - County**	**XSD (Schema) Name: clientCounty**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 3 **Max Length:** 3

Definition: The county, parish, or municipality of the client's locating address.

Instructions: Enter the three-digit FIPS code of the county where the client's address is located.

Business rules HD HIV Testing: Required
Partner Services: Allowed, but not reported to CDC
CBO HIV Testing: Required

Num	Variable Name		
G134	**Client - Zip Code**	**XSD (Schema) Name:**	**clientZipCode**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 5 **Max Length:** 10

Definition: The postal zip code for the client's locating address.

Instructions: Enter the postal zip code of the client's locating address.

These data are collected from clients but not reported to CDC.

Business rules HD HIV Testing: Allowed, but not reported to CDC
Partner Services: Allowed, but not reported to CDC
CBO HIV Testing: Allowed, but not reported to CDC

Code	Value Description	Value Definition
	~~##### ####~~	*Only the 5-digit zip code is mandatory.*

Table: G2 Client Characteristics-Risk Profile

This table is required to be completed by all agencies when data are collected on individual clients. This could be part of interventions or services delivered individually (e.g., HIV testing).

Num	Variable Name		
G200	**Date Client Risk Collected**	**XSD (Schema) Name:**	**dateCollectedForRiskProfile**

Value Option: N/A **Format Type:** MM/DD/YYYY **Min Length:** 8 **Max Length:** 10

Definition: The date client risk profile data are collected. For reporting to CDC, this should be the intake date or the date of the first session before the intervention begins.

Instructions: Enter the date on which these risk profile data are collected.

Business rules HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

The client risk profile date collected must be equal or greater than case open date. Date collected cannot be greater than the date of file submission to CDC.

Num	Variable Name	
G204	**Previous HIV Test**	**XSD (Schema) Name: previousHivTestValueCode**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The client's self-report of having had at least one prior HIV test.

Instructions: Indicate if the client reports having at least one prior HIV test.

Business rules HD HIV Testing: Required
Partner Services: Required
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client reports that he or she has never had an HIV test.*
1	*Yes*	*The client reports that he or she has had at least one previous HIV test.*
99	*Don't know*	*The client reports that he or she is unaware if he or she has had a previous HIV test.*

Num	Variable Name	
G205a	**Previous HIV Test Result**	**XSD (Schema) Name: previousHIVTestResult**

Value Option: Choose only one **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 2

Definition: The client's result from his/her most recent HIV test confirmed through record review or surveillance.

Instructions: If the client reports having had a previous HIV test (i.e., G204: Previous HIV Test = "Yes"), then indicate the client's HIV test result as found using a record review or surveillance report. If no report found, may use self-report as alternative.

Business rules HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Required

Code	Value Description	Value Definition
1	*Record Found- Positive*	*Client's HIV status is positive as reported by a medical care provider, medical record review, other record review, other database (e.g., CareWare), or HIV-related laboratory report.*
2	*Record Found-Negative*	*Client's HIV status is negative as reported by a medical care provider, medical record review, other record review, other database (e.g., CareWare), or HIV-related laboratory report.*
3	*Record Found- Preliminary Positive*	*The client had a reactive HIV rapid test but has not received a conventional confirmatory test as reported by a medical care provider, medical record review, other record review, other database (e.g., CareWare), or HIV-related laboratory report.*
4	*Record Found-Indeterminate*	*The client's results did not conclusively indicate whether he or she is HIV-positive or HIV-negative as reported by a medical care provider, medical record review, other record review, other database (e.g., CareWare), or HIV-related laboratory report.*
5	*No Record Found-Self Report Negative*	*The client reports that his or her HIV status is negative.*
6	*No Record Found-Self Report Positive*	*The client reports that his or her HIV status is positive based on a confirmatory test result.*
7	*No Record Found- No Self Report*	*No HIV test result found from a medical care provider, medical record review, other record review, other database (e.g., CareWare), or HIV-related laboratory report and the client did not provide an HIV test result.*

Num	Variable Name	
G209	**Pregnant (Only If Female)**	**XSD (Schema) Name: pregnantStatusValueCode**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The self-reported pregnancy status of a client with a preliminary or confirmed positive HIV test.

Prior to 2012, these data were collected for only confirmed positive female clients. Currently, they are collected for both confirmed (conventional, RNA, NAAT or other test) or preliminary (rapid test) positive female clients.

Instructions: If the client is female and HIV-positive, indicate whether she is pregnant.

Business rules HD HIV Testing: Required, see detailed business rule
Partner Services: Not applicable
CBO HIV Testing: Required, see detailed business rule

Detailed business rule:
Required for birth gender females (birthGenderValueCode=2) with any positive HIV test (X125 = 1 or 2 or 6 or 7 or 8 or 9).

Code	Value Description	Value Definition
0	*No*	*The client reports she is not pregnant.*
1	*Yes*	*The client reports she is pregnant.*
77	*Declined to answer*	*The client declines or is unwilling to report if she is currently pregnant.*
99	*Don't know*	*The client reports that she is unaware if she is currently pregnant.*

Num	Variable Name	
G210	**In Prenatal Care (Only if Pregnant)**	**XSD (Schema) Name: prenatalCareStatusValueCode**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The self-reported status of the HIV-positive pregnant client's receipt of regular health care during pregnancy.

Prior to 2012, these data were collected for only confirmed positive pregnant female clients. Currently, they are collected for both confirmed or preliminary positive pregnant clients.

Instructions: If the client is HIV-positive and pregnant (G209: Pregnant = "Yes"), indicate whether she is receiving prenatal care.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Required for pregnant females (pregnantStatusValueCode=1).

Code	Value Description	Value Definition
0	*No*	*The client reports she is not currently receiving prenatal care.*
1	*Yes*	*The client reports she is currently receiving prenatal care.*
66	*Not asked*	*The provider did not ask the client if she was currently receiving prenatal care.*
77	*Declined to answer*	*The client declines or is unwilling to report if she is currently receiving prenatal care.*
99	*Don't know*	*The client reports that she is unaware if she is currently receiving prenatal care.*

Num	Variable Name	
G211_01	**Injection Drug Use**	**XSD (Schema) Name: injectionDrugUse**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The client self-reported use in the past 12 months of any injection drugs/substances (including narcotics, hormones, silicon, etc.).

Instructions: Indicate if the client reported having used injection drugs within the last 12 months.

Business rules HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

Code	Value Description	Value Definition
0	*No*	*Client indicates that he/she did not engage in injection drug use in the past 12 months.*
1	*Yes*	*Client indicates that he/she engaged in injection drug use in the past 12 months.*
66	*Not Asked*	*The provider did not ask the client that he/she engaged in injection drug use in the past 12 months.*
77	*Declined to Answer*	*The client declines or is unwilling to report if he/she engaged in injection drug use in the past 12 months.*

Num	Variable Name		
G216a	**Vaginal or Anal Sex with a Male**	**XSD (Schema) Name: withMale**	

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The client self-reported having vaginal or anal sex with a male in the past 12 months.

Instructions: Indicate if the client reported vaginal or anal sex in the past 12 months with a male.

Business rules HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

Code	Value Description	Value Definition
0	*No*	*Client indicates that he or she did not have vaginal or anal sex with a male in the past 12 months.*
1	*Yes*	*Client indicates that he or she had vaginal or anal sex with a male in the past 12 months.*
66	*Not Asked*	*The provider did not ask the client if he or she had vaginal or anal sex with a male in the past 12 months.*
77	*Declined to Answer*	*The client declines or is unwilling to report if he or she had vaginal or anal sex with a male in the past 12 months.*

Num	Variable Name		
G216b	**Vaginal or Anal Sex with a Female**	**XSD (Schema) Name: withFemale**	

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The client self-reported having vaginal or anal sex with a female in the past 12 months.

Instructions: Indicate if the client reported vaginal or anal sex in the past 12 months with a female.

Business rules HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

Code	Value Description	Value Definition
0	*No*	*Client indicates that he or she did not have vaginal or anal sex with a female in the past 12 months.*
1	*Yes*	*Client indicates that he or she had vaginal or anal sex with a female in the past 12 months.*
66	*Not Asked*	*The provider did not ask the client if he or she had vaginal or anal sex with a female in the past 12 months.*
77	*Declined to Answer*	*The client declines or is unwilling to report if he or she had vaginal or anal sex with a female in the past 12 months.*

Num	Variable Name		
G216c	**Vaginal or Anal Sex with a Transgender Person**	**XSD (Schema) Name:**	**withTransgender**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The client self-reported having vaginal or anal sex with a transgender person in the past 12 months.

Instructions: Indicate if the client reported vaginal or anal sex in the past 12 months with a transgender person.

Business rules HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

Code	Value Description	Value Definition
0	*No*	*Client indicates that he or she did not have vaginal or anal sex with a transgender person in the past 12 months.*
1	*Yes*	*Client indicates that he or she had vaginal or anal sex with a transgender person in the past 12 months.*
66	*Not Asked*	*The provider did not ask the client if he or she had vaginal or anal sex with a transgender person in the past 12 months.*
77	*Declined to Answer*	*The client declines or is unwilling to report if he or she had vaginal or anal sex with a transgender person in the past 12 months.*

Num	Variable Name		
G222	**Vaginal or Anal Sex without a Condom (PS only)**	**XSD (Schema) Name:**	**vaginalOrAnalSexWithoutCondomPS**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The client self-reported having unprotected vaginal or anal sex with a partner during the past 12 months.

Instructions: Indicate if the client reported unprotected (without a condom) vaginal or anal sex in the past 12 months.

Business rules HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

Code	Value Description	Value Definition
0	*No*	*The client indicates they have not had vaginal or anal sex without a condom in the past 12 months.*
1	*Yes*	*The client indicates they have had vaginal or anal sex without a condom in the past 12 months.*
66	*Not Asked*	*The provider did not ask the client that they have had vaginal or anal sex without a condom in the past 12 months.*
77	*Declined to Answer*	*The client declines or is unwilling to report if they have had vaginal or anal sex without a condom in the past 12 months.*

Num	Variable Name	
G224	**At risk for HIV infection**	**XSD (Schema) Name: atRiskForHIVInfection**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient is at risk for HIV infection based on an agency's local risk assessment.

Instructions: Indicate if the client/patient is at risk for HIV infection.

This variable is optional for HDs. Required for CDC-directly funded CBOs.

Business rules HD HIV Testing: Allowed, but not required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test negative for HIV.
Required if (X125 = 3 or 10 or 11 or 12)

Code	Value Description	Value Definition
0	*No*	*The client/patient is not at risk for HIV infection*
1	*Yes*	*The client/patient is at risk for HIV infection*
2	*Risk Not Known*	*It is not known if the client/patient is at risk for HIV infection*
3	*Not Assessed*	*No risk assessment was done*

Table: G4 Client Characteristics – Priority Populations

This table is required to be completed by all agencies when data are collected on individual clients as part of HIV testing service delivery.

Num *Variable Name*

G400 **Sex with a male** **XSD (Schema) Name: sexWithMale**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: The client/patient self-reported having sex with a male in the past 5 years.

Sex includes oral, anal, or vaginal sex.

Instructions: Indicate if the client/patient reported having sex in the past 5 years with a male.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient indicates he or she did not have sex with a male in the past 5 years.*
1	*Yes*	*The client/patient reported he or she had sex with a male in the past 5 years.*

Num *Variable Name*

G401 **Sex with a female** **XSD (Schema) Name: sexWithFemale**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: The client/patient self-reported having sex with a female in the past 5 years.

Sex includes oral, anal, or vaginal sex.

Instructions: Indicate if the client/patient reported having sex in the past 5 years with a female.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient reported he or she did not have sex with a female in the past 5 years.*
1	*Yes*	*The client/patient reported he or she had sex with a female in the past 5 years.*

Num	Variable Name	
G402	**Injection drug use**	**XSD (Schema) Name: injectionDrugUse**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: The client/patient reported having injected drugs/substances in the past 5 years.

Instructions: Indicate if the client/patient reported having injected drugs/substances in the past 5 years.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient reported he or she did not inject drugs in the past 5 years that were not prescribed to them by a medical care provider.*
1	*Yes*	*The client/patient reported he or she had injected drugs in the past 5 years that were not prescribed to them by a medical care provider.*

Num	Variable Name	
G403	**Sex with a transgender person**	**XSD (Schema) Name: sexWithTransgender**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: The client/patient self-reported having sex with a transgender person in the past 5 years.

Sex includes oral, anal, or vaginal sex.

Instructions: Indicate if the client/patient reported having sex in the past 5 years with a transgender person.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient reported he or she did not have sex with a transgender person in the past 5 years.*
1	*Yes*	*The client/patient indicates he or she had sex with a transgender person in the past 5 years*

Table: H Client Intervention Characteristics

This table is required to be completed for all interventions in which client level data are collected. This includes HIV prevention interventions delivered individually to clients (e.g. HIV testing or Partner Services). These data are captured for each provider/client interaction.

Num *Variable Name*

H04a **Form ID** **XSD (Schema) Name: formId**

Value Option: N/A **Format Type: Alpha-Numeric** **Min Length: 1** **Max Length: 32**

Definition: A unique alpha-numeric code or identification number used to identify and connect data collected on a standardized form for a given intervention.

Instructions: If you use a standardized form to collect data for HIV testing or other interventions enter the Form ID. The Form ID is used to uniquely identify data collected on the form. Form ID is unique at the agency level. This variable is most oftenused for data collected on the EvaluationWeb HIV Test Form template or locally developed HIV testing forms.

Business rules HD HIV Testing: Mandatory
Partner Services: Required
CBO HIV Testing: Mandatory

'FORM ID' must be unique within an agency and will be associated with only one client.

Num *Variable Name*

H04c **eHARS State Number** **XSD (Schema) Name: eHarsStateNumber**

Value Option: N/A **Format Type: Alpha-Numeric** **Min Length: 1** **Max Length: 32**

Definition: A unique state number assigned to each patient throughout the course of HIV infection assigned by the separately funded state/jurisdiction in which they are reported.

Instructions: Enter the assigned state number associated with this diagnosed HIV infection.

Business rules HD HIV Testing: Required
Partner Services: Allowed, but not required
CBO HIV Testing: Not applicable

Completed for persons who test positive for HIV.
HIV Testing: Required if (X104a is 1 or 2) and (X125 = 1 or 2 or 6 or 7 or 8 or 9)

PS: Allowed if (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Num	*Variable Name*	
H04d	**eHARS City/County Number**	**XSD (Schema) Name: eHarsCityCountyNumber**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 32

Definition: A unique city/county number assigned to each patient throughout the course of HIV infection assigned by the separately funded city in which they are reported.

Instructions: Enter the city/county number associated with diagnosed HIV infection.

Business rules HD HIV Testing: Required
Partner Services: Allowed, but not required
CBO HIV Testing: Not Applicable

Completed for persons who test positive for HIV.
HIV Testing: Required if (X104a is 1 or 2) and (X125 = 1 or 2 or 6 or 7 or 8 or 9)

PS: Allowed if (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Num	*Variable Name*	
H06	**Session Date**	**XSD (Schema) Name: sessionDate**

Value Option: N/A **Format Type:** MM/DD/YYYY **Min Length:** 8 **Max Length:** 10

Definition: The calendar date (month, day, and year) on which the session was delivered to the client.

Instructions: Enter the month, day, and year during which this session was delivered.

Business rules HD HIV Testing: Mandatory
Partner Services: Required, see detailed business rule
CBO HIV Testing: Mandatory

Detailed business rule:
Session date cannot be greater than the current date at the time of data entry.
For PS session data, the date falls within a valid case period.

NHME Variables and Values

Num	*Variable Name*	
H08	**Program ID**	**XSD (Schema) Name: program@id**

Value Option: N/A **Format Type: Alpha-Numeric** **Min Length: 1** **Max Length: 32**

Definition: A unique alpha-numeric identification number used to identify a program.

Instructions: Enter the ID used by your agency to identify this program. Program ID is unique for each agency. The Program ID can be associated with a group of one or more interventions. Agencies may choose to have EvaluationWeb generate this ID.

Business rules HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable

Num	Variable Name	
H800	**Ever heard of PrEP**	**XSD (Schema) Name: everHeardOfPrEP**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: The client/patient's awareness of HIV Pre-exposure prophylaxis (PrEP), the medication taken daily to reduce the risk for acquiring HIV infection.

Instructions: Indicate if the client/patient has ever heard of PrEP.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient reported he or she had never heard of Pre-exposure prophylaxis (PrEP)*
1	*Yes*	*The client/patient reported he or she had heard of Pre-exposure prophylaxis (PrEP)*

Num	Variable Name	
H802	**Used PrEP anytime in the last 12 months**	**XSD (Schema) Name: usedPrEPInLast12Months**

Value Option: TBD **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient has used PrEP anytime in the last 12 months.

Instructions: Indicate if the client/patient used PrEP in the last 12 months.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient reported he or she had not used PrEP anytime in the last 12 months*
1	*Yes*	*The client/patient reported he or she had used PrEP in the last 12 months*

Table: PCRS-1 Partner Services Case

This table provides details for a Partner Services (PS) case. A PS case will indirectly associate an HIV+ index case to his/her partners and the intervention through which services are provided.

Num *Variable Name*

PCR101 **Case Number** **XSD (Schema) Name: partnerServiceCaseNumber**

Value Option: N/A **Format Type: Alpha-Numeric** **Min Length: 1** **Max Length: 32**

Definition: A number to uniquely identify a PS case within an agency. This number is system-generated when establishing a PS case. It can also be an assigned number that is key-entered by the provider.
This number is associated with an index patient and links the index patient to his/her partner or partners. Only one PS case may have a status of open for any given index patient at any given time.

Instructions: Select the system-generated PS case number or enter the locally-defined case number.

Business rules HD HIV Testing: Required
Partner Services: Mandatory
CBO HIV Testing: Not applicable

A case number uniquely identifies a PS case within an agency.

PCR103 **Case Open Date** **XSD (Schema) Name: caseOpenDate**

Value Option: N/A **Format Type: MM/DD/YYYY** **Min Length: 8** **Max Length: 10**

Definition: The calendar date on which the PS case was opened at the agency.

Instructions: Enter the date on which the PS case was opened at the agency.

Business rules HD HIV Testing: Not applicable
Partner Services: Required, see detailed business rule
CBO HIV Testing: Not applicable

Detailed business rule:
The case open date must be less than the date of file submission to CDC.

PCR104 **Case Close Date** **XSD (Schema) Name: caseCloseDate**

Value Option: N/A **Format Type: MM/DD/YYYY** **Min Length: 8** **Max Length: 10**

Definition: The calendar date on which the PS case was closed at the agency.

Instructions: Enter the date on which the PS case was closed at the agency.

Business rules HD HIV Testing: Not applicable
Partner Services: Required, see detailed business rule
CBO HIV Testing: Not applicable

Detailed business rule:
The Case Closed Date must be between the caseOpenDate and the date of file submission to CDC. This date can be blank.

Num	Variable Name	
PCR104a	**Care Status at Case Close Date**	**XSD (Schema) Name: careStatusAtCaseClose**

Value Option: Choose only one **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 2

Definition: This is an indication of whether or not the client was in medical care at the time of the case close date.

Instructions: Indicate whether or not the client was in medical care at the time of the case close date.

Business rules HD HIV Testing: Not applicable
Partner Services: Required, see detailed business rule
CBO HIV Testing: Not applicable

Detailed business rule:
Required if Case Close Date is valid date.

Code	Value Description	Value Definition
1	*In Care*	*Client has seen a medical care provider at least once in the past 6 months for HIV treatment.*
2	*Not In Care*	*Includes HIV-positive persons who were never-in-care for their HIV diagnoses as well as those who were previously in HIV medical care, but are currently out-of-care.*
3	*Pending*	*There is an HIV medical appointment scheduled but the agency has not confirmed that the client attended.*
77	*Declined to Answer*	*The client declines or is unwilling to report his or her HIV care status.*
99	*Don't Know*	*The client reports that he or she is unaware of his or her HIV care status.*

Table: PCRS-2 Partner Services Partner

This table provides details about partners for a PS case and will include partner identifying and locating information as well as services received by the partner.

Num	*Variable Name*	
PCR207	**Partner Type**	**XSD (Schema) Name: partnerType**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The partner's sex and needle-sharing relationship with the index patient. This relationship could involve sexual relations between the client and the partner, needle-sharing between the client and partner or both sex and needle-sharing

Instructions: For each partner identified, indicate whether the partner and client are sex partners, needle-sharing partners or both sex and needle-sharing partners.

Business rules HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

Code	Value Description	Value Definition
1	*Sex partner*	*A person who engages in any type of sexual activity with the index patient.*
2	*Needle-sharing partner*	*A person who engages in any type of needle-sharing activity (e.g., shares needles to inject drug intravenously), with the index patient.*
3	*Both sex and needle sharing partner*	*A person who engages in any type of sexual activity and needle-sharing activity (e.g., shares needles to inject drug intravenously), with the index patient.*

Num *Variable Name*

Table: X-1 HIV Test

This table is completed for each HIV antibody test conducted for a client.

Num *Variable Name*

X104a **HIV Test Election** **XSD (Schema) Name:** **testElection**

Value Option: **Choose only one** **Format Type:** **Number** **Min Length:** **1** **Max Length:** **2**

Definition: An indication of whether the test is linked to a name or is anonymous.

Instructions: Indicate if the written test record is linked to the client's name.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Required when a testing event is reported.

Code	Value Description	Value Definition
1	*Anonymous*	*The HIV test was not linked to the client's name.*
2	*Confidential*	*The HIV test was confidential.*
3	*Test Not Done*	*An HIV test was not done.*

Num *Variable Name*

X105 **Specimen Collection Date** **XSD (Schema) Name:** **sampleDate**

Value Option: **N/A** **Format Type:** **MM/DD/YYYY** **Min Length:** **8** **Max Length:** **10**

Definition: The calendar date (month, day, year) that the specimen for the HIV test was collected.

Instructions: Indicate the month, day, and year that the specimen for the HIV test was collected.

Business rules HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

The specimen collection date cannot be greater than the file upload date or data entry date.

Num	Variable Name	
X111	**Result Provided**	**XSD (Schema) Name: provisionOfResultValueCode**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: The act of informing the client of the HIV test result.

Instructions: Indicate whether the result of this HIV test was provided.

Business rules HD HIV Testing: Required, see detailed business rule
Partner Services: Required, see detailed business rule
CBO HIV Testing: Required, see detailed business rule

Detailed business rule:
Required when at least one testing event occurred (X104a = 1 or 2) and test result final determination (X125) is not missing.

PS: Required when at least one testing event occurred (X712 = 1) and test result final determination (X125) is not missing.

Code	Value Description	Value Definition
0	*No*	*The result of this HIV test was not provided to the client.*
1	*Yes*	*The result of this HIV test was provided to the client.*
2	*Yes, client obtained the result from another agency*	*The result of this HIV test was provided to the client from a provider at another agency.*

Num	Variable Name	
X124	**Test Type**	**XSD (Schema) Name: testType**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: Refers to the type of test and technology used for determining the outcome of the current HIV test.

Instructions: Indicate the type of test used for determining the outcome of the current HIV test.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Required if at least one HIV test was conducted (X104a = 1 or 2)

Code	Value Description	Value Definition
1	*CLIA-waived point-of-care (POC) Rapid Test (s)*	*A diagnostic HIV test performed outside of a laboratory that produces a rapid and reliable result.*
2	*Laboratory-based Test (s)*	*Testing done by a laboratory for the diagnosis of HIV infection.*

Num	*Variable Name*	
X125	**HIV Test Result - Final Determination**	**XSD (Schema) Name: hivTestResult**

Value Option: Choose only one **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 2

Definition: The outcome of the current HIV test.

Instructions: Indicate the result of this HIV test.

Business rules HD HIV Testing: Required, see detailed business rule
Partner Services: Required, see detailed business rule
CBO HIV Testing: Required, see detailed business rule

Detailed Business rule:
Required when at least one HIV test event occurred (X104a = 1 or 2).

PS: Required when at least one testing event occurred (X712 = 1).

Code	Value Description	Value Definition
1	*Preliminary positive*	*One or more of the same point-of-care rapid tests were reactive and none are non-reactive and no supplemental testing was done at your agency*
2	*Positive*	*Two or more different (orthogonal) point-of-care rapid tests are reactive and none are non-reactive and no laboratory-based supplemental testing was done*
3	*Negative*	*One or more point-of-care rapid tests are non-reactive and none are reactive and no supplemental testing was done*
4	*Discordant*	*One or more point-of-care rapid tests are reactive and one or more are non-reactive and no laboratory-based supplemental testing was done*
5	*Invalid*	*A CLIA-waived POC rapid test result cannot be confirmed due to conditions related to errors in the testing technology, specimen collection, or transport.*
6	*HIV-1 Positive*	*Positive for HIV type 1 infection*
7	*HIV-1 Positive, possible acute*	*Positive for HIV type 1 infection and is a possible acute HIV infection*
8	*HIV-2 Positive*	*Positive for HIV type 2 infection*
9	*HIV Positive, undifferentiated*	*Positive for HIV infection. HIV antibodies could not be differentiated*
10	*HIV-1 Negative, HIV-2 inconclusive*	*Negative for HIV type 1 infection and HIV type 2 antibodies were not confirmed*
11	*HIV-1 Negative*	*Negative for HIV type 1 infection*
12	*HIV Negative*	*Negative for HIV infection*
13	*Inconclusive, further testing needed*	*HIV antibodies were not confirmed; further testing is needed*

Num	Variable Name	
X127	**Tests for co-infections**	**XSD (Schema) Name: otherTestingPerformed**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: The client/patient was tested for syphilis, gonorrhea, chlamydial infection, or Hepatitis C in conjunction with this HIV test.

Instructions: Indicate whether tests for syphilis, gonorrhea, chlamydial infection, or Hepatitis C were done in conjunction with this HIV test.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule: Required if an HIV test was conducted (X104a = 1 or 2).

Code	Value Description	Value Definition
0	*No*	*The client/patient was not tested for syphilis, gonorrhea, chlamydial infection, or Hepatitis C in conjunction with this HIV test.*
1	*Yes*	*The client/patient was tested for syphilis, gonorrhea, chlamydial infection, or Hepatitis C in conjunction with this HIV test.*

Num	Variable Name	
X127a	**Syphilis Test**	**XSD (Schema) Name: syphilis/testPerformed**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was tested for syphilis in conjunction with this HIV test.

Instructions: Indicate if the client/patient received a syphilis test in conjunction with this HIV test.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Required if X127 = 1

Code	Value Description	Value Definition
0	*No*	*The client/patient was not tested for syphilis in conjunction with this HIV test.*
1	*Yes*	*The client/patient was tested for syphilis in conjunction with this HIV test.*

Num	Variable Name	
X127b	**Gonorrhea**	**XSD (Schema) Name: gonorrhea/testPerformed**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was tested for gonorrhea in conjunction with this HIV test.

Instructions: Indicate if the client/patient received a test for Gonorrhea in conjunction with this HIV test.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Required if X127 = 1

Code	Value Description	Value Definition
0	*No*	*The client/patient was not tested for gonorrhea in conjunction with this HIV test.*
1	*Yes*	*The client/patient was tested for gonorrhea in conjunction with this HIV test.*

Num	Variable Name	
X127c	**Chlamydial infection**	**XSD (Schema) Name: chlamydia/testPerformed**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was tested for chlamydial infection in conjunction with this HIV test.

Instructions: Indicate if the client/patient was tested for Chlamydial infection in conjunction with this HIV test.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Required if X127 = 1

Code	Value Description	Value Definition
0	*No*	*The client/patient was not tested for chlamydial infection in conjunction with this HIV test.*
1	*Yes*	*The client/patient was tested for chlamydial infection in conjunction with this HIV test.*

Num	Variable Name	
X127d	**Hepatitis C**	**XSD (Schema) Name: hepC/testPerformed**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was tested for Hepatitis C in conjunction with this HIV test.

Instructions: Indicate if the client/patient received a Hepatitis C test in conjunction with this HIV test.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Required if X127 = 1

Code	Value Description	Value Definition
0	*No*	*The client/patient was not tested for hepatitis C in conjunction with this HIV test.*
1	*Yes*	*The client/patient was tested for hepatitis C in conjunction with this HIV test.*

Num	Variable Name	
X128a	**Result of Syphilis Test (Optional as of June 14, 2018)**	**XSD (Schema) Name: syphilis/testResult**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: The outcome of the current syphilis test done in conjunction with this HIV test.

Instructions: Indicate the result of the current syphilis test done in conjunction with this HIV test.

This variable is Optional for data collection and reporting as of June 14, 2018

Business rules HD HIV Testing: Allowed, but not required
Partner Services: Not applicable
CBO HIV Testing: Allowed, but not required

Code	Value Description	Value Definition
1	*Newly identified infection*	*The syphilis screening resulted in identifying a new infection.*
2	*Not infected*	*The client has either never been infected or was previously infected and successfully treated.*
3	*Not Known*	*The result of the current syphilis test is unknown.*

Num	Variable Name	
X128b	**Result of Gonorrhea Test (Optional as of June 14, 2018)**	**XSD (Schema) Name: gonorrhea/testResult**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: The outcome of the current gonorrhea test done in conjunction with this HIV test.

Instructions: Indicate the result of the current gonorrhea test done in conjunction with this HIV test.

This variable is Optional for data collection and reporting as of June 14, 2018

Business rules HD HIV Testing: Allowed, but not required
Partner Services: Not applicable
CBO HIV Testing: Allowed, but not required

Code	Value Description	Value Definition
1	*Positive*	*The client/patient tested positive for gonorrhea.*
2	*Negative*	*The client/patient tested positive for gonorrhea.*
3	*Not Known*	*The result of the current gonorrhea test is unknown.*

Num	Variable Name	
X128c	**Chlamydial infection test result (Optional as of June 14, 2018)**	**XSD (Schema) Name: chlamydia/testResult**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The outcome of the current test for chlamydial infection done in conjunction with this HIV test.

Instructions: Indicate the result of the current test for chlamydial infection done in conjunction with this HIV test.

This variable is Optional for data collection and reporting as of June 14, 2018

Business rules HD HIV Testing: Allowed, but not required
Partner Services: Not applicable
CBO HIV Testing: Allowed, but not required

Code	Value Description	Value Definition
1	*Positive*	*The client/patient tested positive for chlamydial infection.*
2	*Negative*	*The client/patient tested negative for chlamydial infection.*
3	*Not Known*	*The result of the current test for chlamydial infection is unknown.*

Num	Variable Name		
X128d	**Hepatitis C test result (Optional as of June 14, 2018)**	**XSD (Schema) Name:**	**hepC/testResult**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: The outcome of the current test for Hepatitis C done in conjunction with this HIV test.

Instructions: Indicate the result of the current test for Hepatitis C done in conjunction with this HIV test.

This variable is Optional for data collection and reporting as of June 14, 2018

Business rules HD HIV Testing: Allowed, but not required
Partner Services: Not applicable
CBO HIV Testing: Allowed, but not required

Code	Value Description	Value Definition
1	*Positive*	*The client/patient tested positive for hepatitis C.*
2	*Negative*	*The client/patient tested negative for hepatitis C.*
3	*Not Known*	*The result of the current hepatitis C test is unknown.*

Num	Variable Name		
X135	**Worker ID**	**XSD (Schema) Name:**	**workerId**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 32

Definition: A unique alpha-numeric identification code used to distinguish between persons who are delivering services to clients.

Instructions: Enter the unique ID of the worker delivering the HIV prevention service. Worker ID is unique at the jurisdiction level. If a state does not tie tests to a worker, no ID should be reported.

Business rules HD HIV Testing: Allowed, but not reported to CDC
Partner Services: Not applicable
CBO HIV Testing: Allowed, but not reported to CDC

Allowed when at least one testing event occurred. Can be missing if a state does not tie tests to a worker.

NHME Variables and Values

Num	Variable Name	
X137	**Program Announcement**	**XSD (Schema) Name: progAnnouncementProgStrategy**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The CDC program announcement and category, if applicable, from which the HIV prevention service was funded.

Instructions: Indicate the CDC funding source from which this HIV prevention service is funded.
Choose only one.

Business rules HD HIV Testing: Mandatory
Partner Services: Allowed, but not required
CBO HIV Testing: Mandatory

Code	Value Description	Value Definition
19	*PS 17-1711*	*Use of molecular HIV surveillance to identify active HIV transmission networks and implement HIV interventions for Hispanic/Latino men who have sex with men.*
20	*PS 18-1802*	*PS 18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments.*
21	*PS 18-1802 Demonstration Projects*	*PS 18-1802 Demonstration Projects: Funding to expand high-impact HIV prevention and surveillance interventions and strategies.*
22	*PS 19-1901 CDC STD*	*PS 19-1901: STD prevention funding for Health Departments.*
23	*PS 20-2010 - Component A*	*PS 20-2010: Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States.*
24	*PS 21-2102*	*PS 21-2102: Comprehensive High-Impact HIV Prevention Programs for Community-Based Organizations.*
25	*PS 22-2203 Category A*	*PS 22-2203: HIV prevention services for Young Men of Color Who Have Sex with Men (YMSM of color) and their partners regardless of age, gender, and race/ethnicity.*
26	*PS 22-2203 Category B*	*PS 22-2203: HIV prevention services for Young Transgender Persons of Color (YTG persons of color) and their partners regardless of age, gender, and race/ethnicity.*
89	*Other (specify)*	*A Program Announcement or Program Strategy other than those listed. This value option should also be used if the test being reported to CDC has been funded by another agency or organization.*
98	*Other CDC-funded*	*A program announcement other than those listed and an HIV test was conducted using a CDC-funded mechanism.*
99	*Other Non-CDC funded*	*A program announcement other than those listed and an HIV test was conducted using a non-CDC funded mechanism.*

Num	Variable Name		
X137-1	**Specify Program Announcement/Strategy**	**XSD (Schema) Name:**	**spfyProgAnnouncementProgStrategy**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 50

Definition: A specification of the funding source for the HIV prevention service if '98- Other, CDC-funded' or '99 - Other, non-CDC funded' was selected in X137 Program Announcement.

Instructions: For local use only. Collection and reporting of these data are not required by CDC.

Business rules HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable

Num	Variable Name		
X138	**New or Previous HIV-positive Diagnosis**	**XSD (Schema) Name:**	**clientHIVStatus**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The indication of if the client/patient's HIV infection is a new diagnosis or if their infection was previously diagnosed.

Instructions: Indicate whether the current positive HIV test is a new diagnosis for this client/patient or if their infection was previously diagnosed.

Business rules HD HIV Testing: Required, see detailed business rule
Partner Services: Required, see detailed business rule
CBO HIV Testing: Required, see detailed business rule

Detailed Business rule:
Completed for persons who test positive for HIV.
Required if (X104a is 1 or 2) and (X125 = 1 or 2 or 6 or 7 or 8 or 9)

PS: Completed when an index patient is identified for partner services.

Code	Value Description	Value Definition
1	*New diagnosis, verified*	*The HIV surveillance system was checked and no prior report was found and there is no indication of a previous diagnosis by either client self-report (if the client was asked) or review of other data sources (if other data sources were checked).*
2	*New diagnosis, not verified*	*The HIV surveillance system was not checked and the classification of new diagnosis is based only on no indication of a previous positive HIV test by client self-report or review of other data sources.*
3	*Previous diagnosis*	*Previously reported to the HIV surveillance system or the client reports a previous positive HIV test or evidence of a previous positive test is found on review of other data sources.*
4	*Unable to determine*	*The HIV surveillance system not checked and no other data sources were reviewed and there is no information from the client about previous HIV test results.*

Num	*Variable Name*	
X150	**Has the client/patient ever had a positive HIV test**	**XSD (Schema) Name: everHadPreviousPositiveTest**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The purpose of this variable is to ascertain whether a positive HIV test occurred earlier than the current HIV diagnosis date.

Instructions: Indicate if the client/patient has ever had a positive HIV test result

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Completed for all persons who test positive for HIV.
Required if (X125 = 1 or 2 or 6 or 7 or 8 or 9).

Code	Value Description	Value Definition
0	*No*	*The client/patient has never had a positive HIV test.*
1	*Yes*	*The client/patient had a positive HIV test prior to this positive test.*

Num	*Variable Name*	
X150a	**Date of first positive HIV test**	**XSD (Schema) Name: dateOfPreviousPositiveTest**

Value Option: N/A **Format Type:** Date **Min Length:** 8 **Max Length:** 10

Definition: The calendar date (month, day, year) of the earliest known positive HIV test.

Instructions: Record the date of the earliest known positive HIV test.

Enter 01/01/1800 if the complete date is not known.

If the month and year are known, but the day is not known, enter the 15th of the month as the day.

Business rules HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Required if X150 = 1

Table: X-2 HIV Test History

This table collects HIV test history.

Num *Variable Name*

X224 **HIV Stage** **XSD (Schema) Name:** **hivStage**

Value Option: **Choose only one** **Format Type:** **Number** **Min Length:** **2** **Max Length:** **2**

Definition: The stage of the HIV infection of the client. The stage for individuals 6years and older is based primarily on the CD4+ T-lymphocyte count; the CD4+ T-lymphocyte count takes precedence over the CD4 T-lymphocyte percentage, and the percentage is considered only if the count is missing.

If the client has ever been diagnosed with AIDS, they should be classified as Stage 3.

Instructions: Enter the HIV stage of the client. This should be noted at intake or before the intervention begins.

Business rules HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

Code	Value Description	Value Definition
10	*HIV Stage 0*	*If there was a negative HIV test within 6 months of the first HIV infection diagnosis, the stage is 0, and remains 0 until 6 months after diagnosis.*
11	*HIV Stage 1*	*≥500 Cells/µL or ≥26%*
12	*HIV Stage 2*	*200-499 Cells/µL or 14-25%*
13	*HIV Stage 3*	*<200 Cells/µL or <14%*
99	*HIV Unknown*	*If CD4 test result is missing, the stage is Unknown*

Table: X-3 Attempt to Locate

This table is to be completed for each index patient or partner to be located. While this table is intended to be for PS, it may be used optionally for any intervention.

Num	*Variable Name*	
X302	**Attempt to Locate Outcome**	**XSD (Schema) Name: attemptToLocateOutcome**

Value Option: **Choose only one** **Format Type:** **Number** **Min Length:** **1** **Max Length:** **1**

Definition: The result of a PS provider's attempt to locate the index patient or the index patient's partner(s).

Instructions: Indicate the result of the attempt to locate.

Business rules HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

Code	Value Description	Value Definition
1	*Unable to locate*	*The provider did not locate the index patient or partner during this attempt.*
2	*Located*	*The provider located the index patient or partner during this attempt.*

Num	Variable Name	
X303	**Reason for Unsuccessful Attempt**	**XSD (Schema) Name: reasonForUnsuccessfulAttempt**

Value Option: Choose only one **Format Type:** Number **Min Length:** 2 **Max Length:** 2

Definition: The explanation for why the location attempt was not achieved.

Instructions: If the attempt to locate the index patient or index patient's partner was unsuccessful (X302: Attempt to Locate Outcome = "Unable to locate"), indicate why the client was unable to be located.

Business rules HD HIV Testing: Not applicable
Partner Services: Required, see detailed business rule
CBO HIV Testing: Not applicable

Detailed business rule:
Required if client could not be located (attemptToLocateOutcome = 1).
Not expected if a client was located (attemptToLocateOutcome = 2).

Code	Value Description	Value Definition
1	*Deceased*	*The index patient or partner is no longer alive.*
2	*Out of Jurisdiction*	*The index patient or partner resides outside of the jurisdiction in which the provider is authorized to provide services.*
89	*Other*	*The index patient or partner was not located due to another reason not listed.*

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Num	Variable Name	
X306	**Enrollment Status**	**XSD (Schema) Name: enrollmentStatus**

Value Option: Choose only one **Format Type:** Number **Min Length:** 2 **Max Length:** 2

Definition: The decision made by the index patient or the index patient's partner to enroll in PS.

Instructions: Indicate if the index patient or index patient's partner accepted or declined enrollment into PS.

Business rules HD HIV Testing: Not applicable
Partner Services: Required, see detailed business rule
CBO HIV Testing: Not applicable

Detailed business rule:
Required if a client was located (attemptToLocateOutcome = 2).

Code	Value Description	Value Definition
1	*Accepted*	*The index patient or partner enrolled in PS.*
2	*Declined*	*The index patient or partner chose not to enroll in PS.*
3	*Client not located*	*The index patient or partner was not located.*

Table: X-5 Elicit partners

This table is to be completed for each enrolled PS index patient to capture partner information (e.g. number of partners).

Num *Variable Name*

X503 **Total Number of Partners Claimed** **XSD (Schema) Name:** **totalNumberOfPartnersClaimed**

Value Option: **N/A** **Format Type:** **Number** **Min Length:** **1** **Max Length:** **5**

Definition: The total number of sex or needle-sharing partners reported by the client over the last 12 months. This would include anonymous partners and partners for which there is not sufficient information to locate and notify.

Instructions: Enter the total number of partners identified by the index patient. This includes all anonymous, male, female, and transgender partners.

Business rules HD HIV Testing: Not applicable
Partner Services: Required, see detailed business rule
CBO HIV Testing: Not applicable

Detailed business rule:
"Total Number of Partners Claimed" must be greater than or equal to the number of named partners (totalNumberOfNamedPartners).

Num *Variable Name*

X511 **Total Number of Named Partners** **XSD (Schema) Name:** **totalNumberOfNamedPartners**

Value Option: **N/A** **Format Type:** **Number** **Min Length:** **1** **Max Length:** **3**

Definition: The total number of sex or needle-sharing partners reported by the client over the last 12 months for which there is sufficient identifying and locating information.

Instructions: Indicate the total number of sex or needle-sharing partners named for which there is sufficient information to identify and locate the partner.

Business rules HD HIV Testing: Not applicable
Partner Services: Required, see detailed business rule
CBO HIV Testing: Required

Detailed business rule:
"Total Number of Named Partners" must be less than or equal to the Total Number of Partners Claimed (totalNumberOfPartnersClaimed).

Table: X-6 Notification of Exposure

This table is completed for each partner located to determine their knowledge of HIV exposure and HIV status.

Num *Variable Name*

X600 **Partner Notifiability** **XSD (Schema) Name:** **partnerNotifiability**

Value Option: **Choose only one** **Format Type:** **Number** **Min Length:** **1** **Max Length:** **2**

Definition: An indication of whether or not a named partner is determined to be eligible for notification of exposure. Partners that are found to be deceased or for which there is a risk of domestic violence are not considered to be notifiable.

Instructions: For each partner named, indicate whether or not he or she is able to be notified of his or her exposure to HIV.

Business rules HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

Code	Value Description	Value Definition
1	*No - Partner is deceased*	*The partner is no longer alive.*
2	*No - Partner is out of jurisdiction*	*The partner resides outside of the jurisdiction in which the provider is authorized to provide services.*
3	*No - Partner has a risk of domestic violence*	*The provider has assessed that notifying the partner of his or her exposure to HIV could pose a risk of domestic violence to the partner.*
5	*No - Partner is known to be previously positive*	*The partner was not notified because he/she is known to be previously positive for HIV.*
6	*Yes - Partner is notifiable*	*The partner is able to be notified of his/her exposure to HIV.*
7	*Yes - Partner is notifiable and known to be previously positive*	*The partner was notified; he/she is known to be previously positive for HIV.*
88	*No - Other*	*The partner was not notified due to another reason not listed.*

Num	Variable Name	
X601	**Actual Notification Method**	**XSD (Schema) Name: actualNotificationMethod**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The actual method used to notify each identified partner that they may have been exposed to HIV.

Instructions: Indicate the method used to notify each notifiable partner that they may have been exposed to HIV.

Business rules HD HIV Testing: Not applicable
Partner Services: Required, see detailed business rule
CBO HIV Testing: Not applicable

Detailed business rule:
Required if the partner is able to be notified (partnerNotifiability =6 or 7).

Code	Value Description	Value Definition
1	*Client notification*	*The index patient informed his or her partner of their possible exposure to HIV and referred them to counseling, testing, and other support services.*
2	*Provider notification*	*The PS provider informed the partner of his or her possible exposure to HIV and referred them to counseling, testing, and other support services.*
3	*Dual notification*	*The index patient informed the partner of his or her serostatus in the presence of the PS provider.*
5	*Third-party notification*	*A notification strategy whereby the partner was notified by a professional other than the health department provider (e.g., a private physician) of his or her possible exposure to HIV.*
6	*Refused notification*	*The index patient's partner refused to be informed of his or her possible exposure to HIV.*
7	*Partner Not Notified*	*The index patient's partner was not informed of his or her possible exposure to HIV.*

Table: X-7 Referral

This table is completed for all clients receiving a referral.

Num	*Variable Name*	
X706c	**HIV Medical Care Linkage**	**XSD (Schema) Name: currentHIVMedicalCareStatus**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The current status of the client's HIV medical care after HIV diagnosis, current HIV test, or report to Partner Services.

Instructions: Select the value that reflects the current status of the client's HIV medical care after HIV diagnosis, current HIV test, or report to Partner Services.

Business rule HD HIV Testing: Not applicable
Partner Services: Required, see detailed business rule
CBO HIV Testing: Not applicable

Detailed business rule:
Required if HIV Test Results for CLIA-waived Point of Care Rapid Tests are Positive, or Laboratory-Based Tests HIV-1 Positive, HIV-1 Positive (Possible acute), or HIV-2 Positive (hivTestResult=2, 6, 7 or 8).

Code	Value Description	Value Definition
1	*Appointment Pending*	*There is an HIV medical appointment scheduled but the agency has not confirmed that the client attended.*
2	*Confirmed—Partner Accessed Service Within 14 Days of Positive Test*	*Client attended an HIV medical appointment within 14 days of their positive test as confirmed by a report from a medical care provider, medical record review, other record reviews, other databases (e.g., CareWare), HIV-related laboratory reports, or an ART prescription filled.*
3	*Confirmed—Partner Accessed Service Within 30 Days of Positive Test*	*Client attended an HIV medical appointment within 30 days of their positive test as confirmed by a report from a medical care provider, medical record review, other record reviews, other databases (e.g., CareWare), HIV-related laboratory reports, or an ART prescription filled.*
4	*Confirmed—Partner Accessed Service After 30 Days of Positive Test*	*Client attended an HIV medical appointment after 30 days of their positive test as confirmed by a report from a medical care provider, medical record review, other record reviews, other databases (e.g., CareWare), HIV-related laboratory reports, or an ART prescription filled.*
5	*Confirmed—Partner Did Not Access Service*	*Client did not attend an HIV medical appointment as confirmed by a report from a medical care provider, medical record review, other record reviews, other databases (e.g., CareWare), or HIV-related laboratory reports.*
6	*Partner Lost to Follow-Up*	*After 90 days of the positive test, the client's attendance at an HIV medical care appointment can't be confirmed.*
7	*No Appointment Necessary- Negative Test Result*	*Client was not referred to HIV medical care because he or she tested negative.*
8	*No Appointment Necessary-Partner Previous Positive and Engaged in Medical Care*	*Client was not referred to HIV medical care because he or she is known to be previous positive and already receiving care.*

Num	*Variable Name*	
X706d	**Date of 1st HIV Medical Appointment**	**XSD (Schema) Name: firstMedicalCareAppointmentDate**

Value Option: N/A **Format Type:** MM/DD/YYYY **Min Length:** 8 **Max Length:** 10

Definition: Date a client attended his/her HIV medical care appointment after HIV diagnosis, current HIV test, or report to Partner Services.

Instructions: Enter the date a client attended his/her HIV medical care appointment after HIV diagnosis, current HIV test, or report to Partner Services.

Business rule HD HIV Testing: Not applicable
Partner Services: Required, see detailed business rule
CBO HIV Testing: Not applicable

Detailed business rule:
Required if HIV Test Results for CLIA-waived Point of Care Rapid Tests are Positive, or Laboratory-Based Tests HIV-1 Positive, HIV-1 Positive (Possible acute), or HIV-2 Positive (hivTestResult=2, 6, 7 or 8).

Num	*Variable Name*	
X712	**HIV Test Performed**	**XSD (Schema) Name: HIVTestPerformed**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: A client received an HIV test while enrolled in partner services.

Instructions: Indicate if the client was tested for HIV while enrolled in partner services.

Business rule HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

Num	Variable Name	
X712a	**Coinfection Screen**	**XSD (Schema) Name: syphilisTest**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: A client received a syphilis test in conjunction with an HIV test during PS activities.

Instructions: Indicate if a client received a syphilis test in conjunction with an HIV test during PS activities.

Business rule HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

Code	Value Description	Value Definition
0	*No*	*The client did not receive a syphilis test in conjunction with the current HIV test.*
1	*Yes*	*The client received a syphilis test in conjunction with the current HIV test.*

Num	Variable Name	
X712b	**Coinfection Screen Result**	**XSD (Schema) Name: syphilisTestResult**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: The outcome of the current syphilis test in conjunction with an HIV test while enrolled in partner services.

Instructions: Indicate the outcome of the current syphilis test in conjunction with an HIV test while enrolled in partner services.

Business rule HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

Code	Value Description	Value Definition
1	*Newly Identified Infection*	*The syphilis screening resulted in identifying a new infection.*
2	*Not infected*	*Client has either never been infected or was previously infected and successfully treated.*
3	*Not Known*	*The results of the current syphilis test are unknown.*

Num	Variable Name	
X725b	**Care Status at Time of the PS Interview**	**XSD (Schema) Name: careStatusAtInterview**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: If a client was interviewed for Partner Services, this is an indication of whether or not he/she was in medical care at the time of the Partner Services interview.

Instructions: Indicate whether or not the client was in medical care at the time of the Partner Services interview.

Business rule HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

Detailed business rule:
Required if a client was enrolled (enrollmentStatus = 1).
Not expected if a client wasn't enrolled (enrollmentStatus = 2 or blank).

Code	Value Description	Value Definition
1	*In Care*	*Client has seen a medical care provider at least once in the past 6 months for HIV treatment*
2	*Not In Care*	*Includes HIV-positive persons who were never-in-care for their HIV diagnoses as well as those who were previously in HIV medical care, but are currently out-of-care.*
3	*Pending*	*There is an HIV medical appointment scheduled but the agency has not confirmed that the client attended.*
77	*Declined to Answer*	*The client declines or is unwilling to report his or her HIV care status.*
99	*Don't Know*	*The client reports that he or she is unaware of his or her HIV care status.*

Num	Variable Name	
X730a	**Housing status in past 12 months - revised**	**XSD (Schema) Name: housingStatusRevised**

Value Option: Enter one value only **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: The client's self-report of the most unstable housing status in the past 12 months.
Collection of these data began in 2013.

Instructions: For clients with a positive HIV test (confirmatory or preliminary), indicate the client's self-reported most unstable housing status in the past 12 months.

Business rule HD HIV Testing: Required
Partner Services: Allowed, but not required*
CBO HIV Testing: Required

*Not reported to CDC

Business rule:
Completed for persons who test positive for HIV.
Required if (X104a is 1 or 2) and (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Code	Value Description	Value Definition
1	*Literally Homeless*	*Client has lived in places not designed nor typically used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus/train station or camping ground; or in a shelter or emergency shelter that provides temporary living arrangements.*
3	*Unstably housed and/or at-risk of losing housing*	*Client has not been homeless, however, client has experienced housing instability as evidenced by frequent moves due to economic reasons, living with others due to economic hardship; eviction from a private dwelling unit (but having another place to go); living in overcrowded housing; or being at risk of having no housing options. This value code includes persons imminently losing housing.*
4	*Stably housed*	*Persons living in a consistent housing facility that is meant for human habitation and are not at risk of losing housing.*
66	*Not asked*	*Client was not asked about housing status in the past 12 months.*
77	*Declined to answer*	*Client declined to report housing status in the past 12 months.*
99	*Don't know*	*Only select 'don't know' if the client states that he or she doesn't know housing status in the past 12 months. Do not select 'don't know' if the client was not asked.*

Num	Variable Name	
X731	**Currently taking daily PrEP medicine**	**XSD (Schema) Name: currentlyOnPrEP**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication if the client is currently on Pre-exposure prophylaxis (PrEP) medicine.

Instructions: Indicate if the client is currently on Pre-exposure prophylaxis (PrEP) medicine.

Business rule HD HIV Testing: Required
Partner Services: Required
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient is not currently taking daily PrEP medicine.*
1	*Yes*	*The client/patient is currently taking daily PrEP medicine.*

Num	Variable Name	
X731a	**Referred to PrEP Provider**	**XSD (Schema) Name: referredToPrEP**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: An indication if the client was referred to a provider for Pre-exposure prophylaxis (PrEP).

Instructions: Indicate if the client was referred to a provider for Pre-exposure prophylaxis (PrEP).

Business rule HD HIV Testing: Not applicable
Partner Services: Required
CBO HIV Testing: Not applicable

Code	Value Description	Value Definition
0	*No*	*Client not offered referral for PrEP.*
1	*Yes*	*Client offered referral for PrEP.*
2	*Partner Declined*	*Client offered referral for PrEP but client declined.*
3	*Partner on PrEP*	*No referral necessary; Client currently on PrEP.*

Num	Variable Name	
X740	**Seen a Medical Care Provider in past 6 months for HIV treatment**	**XSD (Schema) Name: seenMedicalCareProvider**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: If the client/patient's HIV infection is a previous diagnosis or it is unknown if the diagnosis is a new or previous diagnosis, indicate if the client/patient has seen a medical care provider in the past six months for HIV treatment.

Instructions: Indicate whether the client/patient has seen a medical care provider at least once in the past six months for HIV treatment.

This question should be asked if the client/patient's HIV infection was previously diagnosed or if unable to determine if the client's infection was a new diagnosis or previous diagnosis.

Business rule HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed if the client's HIV infection is not a new diagnosis.
Required if (X138 = 3 or 4)

Code	Value Description	Value Definition
0	*No*	*The client/patient has not seen a medical care provider in the past 6 months for HIV treatment.*
1	*Yes*	*The client/patient has seen a medical care provider in the past 6 months for HIV treatment.*
77	*Declined*	*The client/patient declined to answer whether he or she had seen a medical care provider in the past 6 months for HIV treatment.*
99	*Don't Know*	*The client/patient does not know if he or she has seen a medical care provider in the past 6 months for HIV treatment.*

Num	Variable Name		
X741	**Attended HIV medical care appointment**	**XSD (Schema) Name:**	**attendHIVMedicalCare**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: Indicate if the client/patient attended a medical care appointment after this positive HIV test.

Instructions: Indicate whether the client/patient attended an appointment for HIV medical care after this positive test.

Business rule
HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test positive for HIV.
Required if (X104a is 1 or 2) and (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Code	Value Description	Value Definition
1	*Yes, confirmed*	*Confirmation that the client/patient did attend his or her HIV medical appointment after this positive test.*
2	*Yes, client/patient self-report*	*The client/patient's self-report of attending his or her HIV medical care appointment after this positive test.*
3	*No*	*The client/patient did not attend his or her HIV medical care appointment after this positive test.*
99	*Don't Know*	*The provider is unaware if the client/patient attended his/her HIV medical care appointment after this positive test.*

Num	Variable Name		
X741a	**Appointment Date**	**XSD (Schema) Name:**	**dateofMedicalCare**

Value Option: N/A **Format Type:** Date **Min Length:** 10 **Max Length:** 10

Definition: The calendar month, day, and year on which a client attended his/her HIV medical care appointment after this positive test.

Instructions: Indicate the date the client/patient attended his/her appointment for HIV medical care after this positive test.

Enter 01/01/1800 if date is unknown.

If the month and year are known, but the day is unknown, enter the 15th of the month as the day.

Business rule
HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed if HIV-positive client attended an HIV medical care appointment.
Required if (X741 = 1 or 2)

Num	Variable Name	
X742	**Individualized behavioral risk-reduction counseling**	**XSD (Schema) Name: behavioralRiskReductionCounseling**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: Refers to an HIV prevention service directly aimed at reducing risk for transmitting or acquiring HIV infection.

Instructions: Indicate whether individualized behavioral risk-reduction counseling was provided to the client/patient.

Business rule HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test positive for HIV.
Required if (X104a is 1 or 2) and (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Code	Value Description	Value Definition
0	*No*	*The client/patient was not provided individualized behavioral risk-reduction counseling.*
1	*Yes*	*The client/patient was provided individualized behavioral risk-reduction counseling.*

Num	Variable Name	
X743	**Contact information provided for partner services**	**XSD (Schema) Name: providedToHDForPS**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: This is an indication of if the client/patient's contact information was provided to the health department for partner services.

Instructions: Indicate whether the client/patient's name and contact information were provided to the health department for partner services.

Business rule HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test positive for HIV.
Required if (X104a is 1 or 2) and (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Code	Value Description	Value Definition
0	*No*	*The client/patient's information was not provided to the health department for partner services*
1	*Yes*	*The client/patient's information was provided to the health department for partner services.*

Num	Variable Name	
X744	**Interviewed for partner services**	**XSD (Schema) Name: interviewedForPS**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: This is an indication of if the client/patient was interviewed for partner services by health department staff or staff trained by the health department to conduct partner services interviews.

Instructions: Indicate if the client was interviewed for partner services.

This variable is only used for HIV testing and for reporting on HIV-positive clients.

Business rule HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Not applicable

Business rule:
Completed for persons who test positive for HIV.
Required if (X104a is 1 or 2) and (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Code	Value Description	Value Definition
1	*Yes, by health department staff*	*The client was interviewed for partner services by health department staff.*
2	*Yes, by a non-health department person trained by the health department to conduct partner services*	*The client was interviewed for partner services by a non-health department person who was trained by the health department to conduct partner services.*
3	*No*	*The client was not interviewed for partner services.*
99	*Don't Know*	*It is unknown if he client was interviewed for partner services.*

Num	Variable Name	
X744a	**Date of partner services interview**	**XSD (Schema) Name: dateOfPSInterview**

Value Option: N/A **Format Type:** MM/DD/YYYY **Min Length:** 8 **Max Length:** 10

Definition: The calendar month, day, and year on which the client/patient was interviewed for partner services.

Instructions: Enter the calendar month, day, and year the client/patient was interviewed for partner services.

Enter 01/01/1800 if date is unknown.

If the month and year are known, but the day is unknown, enter the 15th of the month as the day.

Business rule HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Not applicable

Business rule:
Completed if the client/patient was interviewed for partner services (X744=1 or 2).

Num	Variable Name	
X745	**Screened for perinatal HIV service coordination needs (Only if pregnant)**	**XSD (Schema) Name: screenedForPerinatalHIVCoordination**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: An indication of if the client/patient was screened for perinatal HIV service coordination needs.

This variable is used for reporting of perinatal HIV service coordination needs among women living with diagnosed HIV infection.

Instructions: If the client/patient is HIV-positive, indicate whether the client was screened for perinatal HIV service coordination needs.

Business rule HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for birth gender females who test positive for HIV.
Required if (birthGenderValueCode=2) and (X125 = 1 or 2 or 6 or 7 or 8 or 9) and (pregnantStatusValueCode=1)

Code	Value Description	Value Definition
0	*No*	*The client/patient was not screened for perinatal HIV service coordination needs*
1	*Yes*	*The client/patient was screened for perinatal HIV service coordination needs.*

Num	Variable Name		
X746	**Perinatal HIV service coordination needs identified**	**XSD (Schema) Name:**	**perinatalCoordinationNeedsIdentified**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of if perinatal HIV service coordination needs were identified for the client/patient.

Instructions: If the client/patient is HIV-positive and screened for perinatal HIV service coordination needs, indicate if perinatal HIV service coordination needs were identified.

Business rule
HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for birth gender females who test positive for HIV.
Required if (birthGenderValueCode=2) and (X125 = 1 or 2 or 6 or 7 or 8 or 9) and (pregnantStatusValueCode=1)

Code	Value Description	Value Definition
0	*No*	*The client/patient was screened, and no perinatal HIV service coordination needs were identified.*
1	*Yes*	*The client/patient was screened, and perinatal HIV service coordination needs were identified.*

Num	Variable Name		
X747	**Referred for HIV perinatal service coordination**	**XSD (Schema) Name:**	**referredForHIVPerinatalServiceCoordination**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: An indication of whether the client/patient was referred for HIV perinatal service coordination.

Instructions: If the client/patient is HIV-positive and HIV perinatal service coordination needs were identified, indicate if the client/patient was given a referral to HIV perinatal service coordination needs.

Business rule
HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for birth gender females who test positive for HIV.
Required if (birthGenderValueCode=2) and (X125 = 1 or 2 or 6 or 7 or 8 or 9) and (pregnantStatusValueCode=1)

Code	Value Description	Value Definition
0	*No*	*The client/patient was not referred to perinatal HIV service coordination.*
1	*Yes*	*The client/patient was referred to perinatal HIV service coordination.*

Num	Variable Name	
X748	**Screened for PrEP eligibility**	**XSD (Schema) Name: screenedForPrEPEligibility**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: Refers to whether an assessment was conducted to determine if the client/patient met the appropriate criteria for using pre-exposure prophylaxis (PrEP).

Instructions: Indicate whether the client/patient was screened for PrEP eligibility.

This variable is used for reporting on clients who test negative for HIV infection.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test negative for HIV.
Required if (X125 = 3 or 10 or 11 or 12)

Code	Value Description	Value Definition
0	*No*	*The client/patient was not screened for PrEP eligibility*
1	*Yes*	*The client/patient was screened for PrEP eligibility*

Num	Variable Name	
X749	**Eligible for PrEP referral**	**XSD (Schema) Name: eligibleForPrEPReferral**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient met the appropriate criteria for receiving a referral for using PrEP.

Instructions: Indicate whether the client/patient was eligible to receive a referral for PrEP.

This variable is used for reporting on clients who test negative for HIV infection.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test negative for HIV.
Required if (X125 = 3 or 10 or 11 or 12)

Code	Value Description	Value Definition
0	*No*	*The client/patient was not eligible for PrEP referral.*
1	*Yes, CDC criteria*	*The client/patient was eligible for PrEP referral based on CDC criteria.*
2	*Yes, local criteria or protocol*	*The client/patient was eligible for PrEP referral based on local criteria or protocol.*

Num	Variable Name	
X750	**Referred to a PrEP Provider**	**XSD (Schema) Name: referredToPrEPProvider**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was given a referral to a PrEP provider. PrEP providers are peers, volunteers, and staff members of clinics, health departments, and community-based organizations.

Instructions: Indicate whether the client/patient was given a referral to a PrEP provider.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test negative for HIV.
Required if (X125 = 3 or 10 or 11 or 12)

Code	Value Description	Value Definition
0	*No*	*The client/patient was not referred to a PrEP provider*
1	*Yes*	*The client/patient was referred to a PrEP provider*

Num	Variable Name	
X751	**Assistance with linkage to a PrEP provider**	**XSD (Schema) Name: providedAssistanceToPrEPProvider**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was provided navigation or linkage services to assist with linkage to a PrEP provider.

Instructions: Indicate whether the client/patient was provided navigation or linkage services to assist them with linkage to a PrEP provider.

Business rule
HD HIV Testing: Required
Partner Services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test negative for HIV.
Required if (X125 = 3 or 10 or 11 or 12)

Code	Value Description	Value Definition
0	*No*	*The client/patient was not provided navigation or linkage services to assist with linkage to a PrEP provider*
1	*Yes*	*The client/patient was provided navigation or linkage services to assist with linkage to a PrEP provider*

Num	Variable Name	
X752a	**Navigation services for linkage to HIV medical care - screened for need**	**XSD (Schema) Name: navOrLinkageHIVMedicalCare/screenedFor**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was screened for the need of navigation for linkage to HIV medical care.

Instructions: Indicate whether the client/patient was screened for the need of navigation services for linkage to HIV medical care.

Business rule
HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test positive for HIV.
Required if (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Code	Value Description	Value Definition
0	*No*	*The client/patient was not screened for navigation services needs for linkage to HIV medical care.*
1	*Yes*	*The client/patient was screened for navigation services needs for linkage to HIV medical care.*

Num	Variable Name		
X752b	**Navigation services for linkage to HIV medical care - need identified**	**XSD (Schema) Name:**	**navOrLinkageHIVMedicalCare/needIdentified**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was identified as needing navigation services for linkage to HIV medical care.

Instructions: Select 'Yes' if the client/patient needed navigation services for linkage to HIV medical care.

Business rule
HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test positive for HIV.
Required if (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Code	Value Description	Value Definition
0	*No*	*No service need was identified for navigation services for linkage to HIV medical care.*
1	*Yes*	*Need for navigation services for linkage to HIV medical care was identified.*

Num	Variable Name		
X752c	**Navigation services for linkage to HIV medical care - provided or referred for service**	**XSD (Schema) Name:**	**navOrLinkageHIVMedicalCare/providedOrReferred**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was provided or referred to navigation services for linkage to HIV medical care.

Instructions: Indicate if the client/patient was provided or referred to navigation services for linkage to HIV medical care.

Business rule
HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test positive for HIV.
Required if (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Code	Value Description	Value Definition
0	*No*	*The client/patient was not provided or referred to navigation services for linkage to HIV medical care.*
1	*Yes*	*The client/patient was provided or was given a referral to navigation services for linkage to HIV medical care.*

Num	Variable Name		
X752e	**Linkage services to HIV medical care – screened for need**	**XSD (Schema) Name:**	**linkageServicesHIVMedicalCare/screenedFor**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was screened for the need of linkage services to HIV medical care.

Instructions: Indicate if the client/patient was screened for the need of linkage services to HIV medical care.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test positive for HIV.
Required if (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Code	Value Description	Value Definition
0	*No*	*The client/patient was not screened for linkage to HIV medical care service needs.*
1	*Yes*	*The client/patient was screened for linkage to HIV medical care service needs.*

Num	Variable Name		
X752f	**Linkage services to HIV medical care – need identified**	**XSD (Schema) Name:**	**linkageServicesHIVMedicalCare/needIdentified**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was identified as needing linkage services to HIV medical care.

Instructions: Select 'Yes' if the client/patient needed linkage services for linkage to HIV medical care.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test positive for HIV.
Required if (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Code	Value Description	Value Definition
0	*No*	*No need for linkage to HIV medical care services was identified*
1	*Yes*	*A need was identified for linkage to HIV medical care services*

Num	Variable Name		
X752g	**Linkage services to HIV medical care – provided or referred for service**	**XSD (Schema) Name:**	**linkageServicesHIVMedicalCare/providedOrReferred**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was provided or referred for linkage services to HIV medical care.

Instructions: Indicate if the client/patient was provided or referred to linkage services for linkage to HIV medical care.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test positive for HIV.
Required if (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Code	Value Description	Value Definition
0	*No*	*The client/patient was not provided or referred to linkage to HIV medical care services.*
1	*Yes*	*The client/patient was provided or referred to linkage to HIV medical care services.*

X753a	**Health benefits navigation and enrollment - screened for need**	**XSD (Schema) Name:**	**healthBenefits/screenedFor**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether client/patients are screened for health benefits navigation and enrollment needs.

Instructions: Indicate whether the client/patient was screened for health benefits navigation and enrollment need.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient was not screened for health benefits navigation and enrollment service needs.*
1	*Yes*	*The client/patient was screened for health benefits navigation and enrollment service needs.*

Num	Variable Name	
X753b	**Health benefits navigation and enrollment - need identified**	**XSD (Schema) Name: healthBenefits/needIdentified**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was identified as needing health benefits navigation and enrollment services.

Instructions: Select 'Yes' if the client/patient needed health benefits navigation and enrollment services.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*No need was identified for health benefits navigation and enrollment services.*
1	*Yes*	*A need for health benefits navigation and enrollment services was identified.*

Num	Variable Name	
X753c	**Health benefits navigation and enrollment services - provided or referred for service**	**XSD (Schema) Name: healthBenefits/providedOrReferred**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was provided or referred to services for health benefits navigation and enrollment.

Instructions: Indicate if the client/patient was provided or referred to services for health benefits navigation and enrollment.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient was not provided or referred to health benefits navigation and enrollment services*
1	*Yes*	*The client/patient was provided or referred to health benefits navigation and enrollment services*

Num	Variable Name	
X754a	**Medication adherence support services - screened for need**	**XSD (Schema) Name: medicationAdherence/screenedFor**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether an assessment was done to determine if the client/patient needed medication adherence support services.

Instructions: Indicate whether the client/patient was screened for as needing medication adherence support service.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test positive for HIV.
Required if (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Code	Value Description	Value Definition
0	*No*	*The client/patient was not screened for medication adherence support service needs.*
1	*Yes*	*The client/patient was screened for medication adherence support service needs.*

Num	Variable Name	
X754b	**Medication adherence support - need identified**	**XSD (Schema) Name: medicationAdherence/needIdentified**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was identified as needing medication adherence support services.

Instructions: Select 'Yes' if the client/patient was identified as needing medication adherence support services.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Business rule:
Completed for persons who test positive for HIV.
Required if (X125 = 1 or 2 or 6 or 7 or 8 or 9)

Code	Value Description	Value Definition
0	*No*	*No need was identified for medication adherence support services*
1	*Yes*	*A need was identified for medication adherence support services*

Num	Variable Name		
X754c	**Medication adherence support - provided or referred to service**	**XSD (Schema) Name:**	**medicationAdherence/providedOrReferred**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was provided or referred to medication adherence support services.

Instructions: Indicate if the client/patient was provided or referred to services for medication adherence support.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient was not provided or referred to medication adherence support services.*
1	*Yes*	*The client/patient was provided or referred to medication adherence support services.*

Num	Variable Name		
X755a	**Evidence-based risk reduction intervention - screened for need**	**XSD (Schema) Name:**	**evidenceBaseRiskReduction/screenedFor**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was screened for evidence-based risk reduction intervention needs.

Instructions: Indicate whether the client/patient was screened for evidence-based risk reduction intervention need.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient was not screened for evidence-based risk reduction intervention needs.*
1	*Yes*	*The client/patient was screened for evidence-based risk reduction intervention needs.*

Num	Variable Name		
X755b	**Evidence-based risk reduction intervention - need identified**	**XSD (Schema) Name:**	**evidenceBaseRiskReduction/needIdentified**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was identified as needing evidence-based risk reduction intervention services.

Instructions: Select 'Yes' if the client/patient needed evidence-based risk reduction intervention services.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*No need was identified for evidence-based risk reduction intervention services.*
1	*Yes*	*A need for evidence-based risk reduction intervention services was identified.*

Num	Variable Name		
X755c	**Evidence-based risk reduction intervention - provided or referred to service**	**XSD (Schema) Name:**	**evidenceBaseRiskReduction/providedOrReferred**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was provided or referred to evidence-based risk reduction intervention services.

Instructions: Indicate if the client/patient was provided or referred to evidence-based risk reduction intervention services.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient was not provided or referred to evidence-based risk reduction intervention services.*
1	*Yes*	*The client/patient was provided or referred to evidence-based risk reduction intervention services.*

Num	Variable Name	
X756a	**Behavioral health services - screened for need**	**XSD (Schema) Name: behavioralHealthServices/screenedFor**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was screened for behavioral health services need.

Examples of behavioral health services include mental health treatment, and substance use treatment.

Instructions: Indicate whether the client/patient was screened for behavioral health services need.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient was not screened for behavioral health services need.*
1	*Yes*	*The client/patient was screened for behavioral health services need.*

Num	Variable Name	
X756b	**Behavioral health services - need identified**	**XSD (Schema) Name: behavioralHealthServices/needIdentified**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 2

Definition: An indication of whether the client/patient was identified as needing behavioral health services.

Examples of behavioral health services include mental health treatment, and substance use treatment.

Instructions: Select 'Yes' if the client/patient needed behavioral health services.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*No need was identified for behavioral health services.*
1	*Yes*	*A need for behavioral health services was identified.*

Num	Variable Name		
X756c	**Behavioral health services - provided or referred to service**	**XSD (Schema) Name:**	**behavioralHealthServices/providedOrReferred**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was provided or referred to behavioral health services.

Examples of behavioral health services include mental health treatment, and substance use treatment.

Instructions: Indicate if the client/patient was provided or referred to behavioral health services.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient was not provided or referred to behavioral health services.*
1	*Yes*	*The client/patient was provided or referred to behavioral health services.*

Num	Variable Name		
X758a	**Social services - screened for need**	**XSD (Schema) Name:**	**socialServices/screenedFor**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was screened for social services need.

Examples of social services include housing, transportation, domestic violence intervention, and employment.

Instructions: Indicate whether the client/patient was screened for social services need.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient was not screened for social services need.*
1	*Yes*	*The client/patient was screened for social services need.*

Num	Variable Name	
X758b	**Social services - need identified**	**XSD (Schema) Name: socialServices/needIdentified**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was identified as needing social services.

Examples of social services include housing, transportation, domestic violence intervention, and employment.

Instructions: Select 'Yes' if the client/patient needed social services.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*No need was identified for social services.*
1	*Yes*	*A need for social services was identified.*

Num	Variable Name	
X758c	**Social services - provided or referred to service**	**XSD (Schema) Name: socialServices/providedOrReferred**

Value Option: Choose only one **Format Type:** Number **Min Length:** 1 **Max Length:** 1

Definition: An indication of whether the client/patient was provided or referred to social services.

Examples of social services include housing, transportation, domestic violence intervention, and employment.

Instructions: Indicate if the client/patient was provided or referred to social services.

Business rule HD HIV Testing: Required
Partner services: Not applicable
CBO HIV Testing: Required

Code	Value Description	Value Definition
0	*No*	*The client/patient was not provided or referred to social services.*
1	*Yes*	*The client/patient was provided or referred to social services.*

Aggregate Level Requirements

Table: ME Aggregate level Variables

This table should be reported at the jurisdiction level and broken out by the program announcement.

Num *Variable Name*

ME201a **Total PS18-1802-funded aggregate test events** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Number **Min Length:** 1 **Max Length:** 8

Definition: PS18-1802-funded aggregate test events are test events supported in any way by PS18-1802-funded resources (e.g., funding, test kits, personnel, training and technical assistance, laboratory support), but for which test-level data are not obtainable.

Instructions: Enter the total number of PS18-1802-funded aggregate HIV test events conducted during the reporting period.

Business rules HD HIV Testing: Not applicable
Partner Services: Not applicable
HD Aggregate: Required
CBO HIV Testing: Not applicable

ME201b **Total reimbursed aggregate test events** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Number **Min Length:** 1 **Max Length:** 8

Definition: Reimbursed aggregate test events are done in PS18-1802-supported programs, but are actually paid for by a third-party payer (e.g., Medicaid, Medicare, private insurance). They are attributable to PS18-1802 because they would likely not be done in the absence of the PS18-1802-supported program, but they are not directly paid for by PS18-1802 funds.

Instructions: Enter the total number of reimbursed aggregate HIV testing events conducted during the reporting period.

Business rules HD HIV Testing: Not applicable
Partner Services: Not applicable
HD Aggregate: Required
CBO HIV Testing: Not applicable

ME202a **PS18-1802--funded aggregate newly diagnosed HIV-positive test events** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Number **Min Length:** 1 **Max Length:** 8

Definition: PS18-1802-1-funded aggregate test events are test events supported in any way by PS18-1802--funded resources (e.g., funding, test kits, personnel, training and technical assistance, laboratory support), but for which test-level data are not obtainable. Newly diagnosed HIV-positive test events include unconfirmed preliminary positive plus confirmed positive test events.

Instructions: Enter the total number of PS18-1802--funded aggregate newly diagnosed HIV-positive testing events conducted during the reporting period.

Business rules HD HIV Testing: Not applicable
Partner Services: Not applicable
HD Aggregate: Required
CBO HIV Testing: Not applicable

Num	*Variable Name*	
ME202b	**Reimbursed aggregate newly diagnosed HIV-positive testing events**	**XSD (Schema) Name:**

Value Option: N/A **Format Type:** Number **Min Length:** 1 **Max Length:** 8

Definition: Reimbursed aggregate test events are test events that are done in PS18-1802-supported programs, but are actually paid for by a third-party payer (e.g., Medicaid, Medicare, private insurance). They are attributable to PS18-1802 because they would likely not be done in the absence of the PS18-1802--supported program, but they are not directly paid for by PS18-1802- funds. Newly diagnosed HIV-positive test events include unconfirmed preliminary positive plus confirmed positive test events.

Instructions: Enter the total number of reimbursed aggregate newly diagnosed HIV-positive testing events conducted during the reporting period.

Business rules HD HIV Testing: Not applicable

Partner Services: Not applicable
HD Aggregate: Required
CBO HIV Testing: Not applicable

Budget Information

Table: BT Budget Allocation and Expenditure Variables (PS18-1802 Health Departments only)

This table is completed annually by health department recipients. It is used to provide their budget allocation and budget expenditure information for Prevention and Surveillance to the CDC. Budget information is required for health department recipients receiving PS18-1802 funds which support HIV prevention and surveillance strategies and activities.

Num *Variable Name*

BASTRAT1A1S **Percent Allocated - HIV Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 1: Percent of PS18-1802 funding allocated for HIV Surveillance data collection, analysis, and dissemination activities.

Instructions: Enter the percent of total funding that your agency allocated for HIV Surveillance data collection, analysis, and dissemination activities.

Business rules HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT1A1S **Percent Expended - HIV Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 1: Percent of PS18-1802 funding expended for HIV Surveillance data collection, analysis, and dissemination activities.

Instructions: Enter the percent of total funding that your agency expended for HIV Surveillance data collection, analysis, and dissemination activities.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BASTRAT1A2P **Percent Allocated - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 1: Percent of PS18-1802 funding allocated for HIV Prevention program monitoring and evaluation data collection, analysis, and dissemination activities.

Instructions: Enter the percent of total funding that your agency allocated for HIV Prevention program monitoring and evaluation data collection, analysis, and dissemination activities.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT1A2P **Percent Expended - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 1: Percent of PS18-1802 funding expended HIV prevention program monitoring and evaluation data collection, analysis, and dissemination activities.

Instructions: Enter the percent of total funding that your agency expended for HIV prevention program monitoring and evaluation data collection, analysis, and dissemination activities.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

CSTRATEGY1 **Comments - Strategy 1** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 100

Definition: Jurisdiction comments for Strategy 1, Data collection, analysis, and dissemination of HIV data.

Instructions: Please provide any additional information to explain limitations or caveats associated with funds allocated or expended for core activities related to Strategy 1, if applicable.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

NHME Variables and Values

Num *Variable Name*

BASTRAT2A1P **Percent Allocated - Routine HIV Testing, Healthcare - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 2: Percent of PS18-1802 funding allocated for HIV Prevention routine opt-out HIV testing in healthcare settings.

Instructions: Enter the percent of total funding that your agency allocated for HIV Prevention routine opt-out HIV testing in healthcare settings.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT2A1P **Percent Expended - Routine HIV Testing, Healthcare - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 2: Percent of PS18-1802 funding expended for HIV Prevention routine opt-out HIV testing in healthcare settings.

Instructions: Enter the percent of total funding that your agency expended for HIV Prevention routine opt-out HIV testing in healthcare settings.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT2A2P **Percent Allocated - Targeted HIV Testing, non-Healthcare - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 2: Percent of PS18-1802 funding allocated for HIV Prevention targeted HIV testing in non-healthcare settings.

Instructions: Enter the percent of total funding that your agency allocated for HIV Prevention targeted HIV testing in non-healthcare settings.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BESTRAT2A2P **Percent Expended - Targeted HIV Testing, non-Healthcare - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 2: Percent of PS18-1802 funding expended for HIV Prevention targeted HIV testing in non-healthcare settings.

Instructions: Enter the percent of total funding that your agency expended for HIV Prevention targeted HIV testing in non-healthcare settings.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT2A3P **Percent Allocated - HIV Partner Services - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 2: Percent of PS18-1802 HIV Prevention funding allocated for Partner Services.

Instructions: Enter the percent of total HIV Prevention funding that your agency allocated for Partner

Business rules HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT2A3P **Percent Expended - HIV Partner Services - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 2: Percent of PS18-1802 funding expended for HIV Prevention HIV Partner Services.

Instructions: Enter the percent of total funding that your agency expended for HIV Prevention HIV Partner Services.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BASTRAT2A4P **Percent Allocated - D2C-Prevention** **XSD (Schema) Name:**

Value Option: **N/A** **Format Type:** **Percent** **Min Length:** **1** **Max Length:** **4**

Definition: Strategy 2: Percent of PS18-1802 funding allocated for HIV Prevention Data-to-Care (D2C) Activities.

Instructions: Enter the percent of total funding that your agency allocated for HIV Prevention Data-to-Care (D2C) Activities.

Business rules HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT2A4P **Percent Expended - D2C- Prevention** **XSD (Schema) Name:**

Value Option: **N/A** **Format Type:** **Percent** **Min Length:** **1** **Max Length:** **4**

Definition: Strategy 2: Percent of PS18-1802 funding expended for HIV Prevention Data-to-Care (D2C) Activities.

Instructions: Enter the percent of total funding that your agency expended for HIV Prevention Data-to-Care (D2C) Activities.

Business rules HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BASTRAT2A4S **Percent Allocated - D2C - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 2: Percent of PS18-1802 funding allocated for HIV Surveillance Data-to-Care (D2C) Activities.

Instructions: Enter the percent of total funding that your agency allocated for HIV Surveillance Data-to-Care (D2C) Activities.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT2A4S **Percent Expended - D2C - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 2: Percent of PS18-1802 funding expended for HIV Surveillance Data-to-Care (D2C) Activities.

Instructions: Enter the percent of total funding that your agency expended for HIV Surveillance Data-to-Care (D2C) Activities.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

CSTRATEGY2 **Comments - Strategy 2** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 100

Definition: Jurisdiction comments for Strategy 2, Identify persons with HIV infection and uninfected persons at risk for HIV infection.

Instructions: Please provide any additional information to explain limitations or caveats associated with funds allocated or expended for core activities related to Strategy 2, if applicable.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT3A1P **Percent Allocated - HIV Transmission Clusters and Outbreaks - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 3: Percent of PS18-1802 HIV Prevention funding allocated to rapidly respond to and intervene in HIV transmission clusters and outbreaks.

Instructions: Enter the percent of total HIV Prevention funding that your agency allocated to rapidly respond to and intervene in HIV transmission clusters and outbreaks.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT3A1P **Percent Expended - HIV Transmission Clusters and Outbreaks - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 3: Percent of PS18-1802 funding expended for HIV Prevention to rapidly respond to and intervene in HIV transmission clusters and outbreaks.

Instructions: Enter the percent of total funding that your agency expended for HIV Prevention to rapidly respond to and intervene in HIV transmission clusters and outbreaks.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BASTRAT3A1S **Percent Allocated - HIV Transmission Clusters and Outbreaks - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 3: Percent of PS18-1802 HIV Surveillance funding allocated to rapidly respond to and intervene in HIV transmission clusters and outbreaks.

Instructions: Enter the percent of total HIV Surveillance funding that your agency allocated to rapidly respond to and intervene in HIV transmission clusters and outbreaks.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT3A1S **Percent Expended - HIV Transmission Clusters and Outbreaks - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 3: Percent of PS18-1802 HIV Surveillance funding expended to rapidly respond to and intervene in HIV transmission clusters and outbreaks.

Instructions: Enter the percent of total HIV Surveillance funding that your agency expended to rapidly respond to and intervene in HIV transmission clusters and outbreaks.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

CSTRATEGY3 **Comments - Strategy 3** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 100

Definition: Jurisdiction comments for Strategy 3, Develop, maintain, and implement plan to respond to HIV transmission clusters and outbreaks.

Instructions: Please provide any additional information to explain limitations or caveats associated with funds allocated or expended for core activities related to Strategy 3, if applicable.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

NHME Variables and Values

Num *Variable Name*

BASTRAT4A1P **Percent Allocated - CPP, Continuum of Care - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 4: Percent of PS18-1802 funding allocated for HIV Prevention Continuum of care activities - (linkage to HIV medical care, re-engagement, and retention in care).

Instructions: Enter the percent of total funding that your agency allocated for HIV Prevention Continuum of care activities - (linkage to HIV medical care, re-engagement, and retention in care).

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT4A1P **Percent Expended - CPP, Continuum of Care - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 4: Percent of PS18-1802 funding expended for HIV Prevention Continuum of care activities - (linkage to HIV medical care, re-engagement, and retention in care).

Instructions: Enter the percent of total funding that your agency expended for HIV Prevention Continuum of care activities - (linkage to HIV medical care, re-engagement, and retention in care).

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT4A2P **Percent Allocated - CPP, Risk-Reduction Interventions - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 4: Percent of PS18-1802 funding allocated for risk-reduction interventions for HIV-positive persons.

Instructions: Enter the percent of total funding that your agency allocated for risk-reduction interventions for HIV-positive persons.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BESTRAT4A2P **Percent Expended - CPP, Risk Reduction Interventions - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 4: Percent of PS18-1802 funding expended for risk-reduction interventions for HIV-positive persons.

Instructions: Enter the percent of total funding that your agency expended for risk-reduction interventions for HIV-positive persons.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT4A3P **Percent Allocated - Other CPP - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 4: Percent of PS18-1802 funding allocated for other CPP activities (e.g., health benefits navigation and enrollment, referrals to behavioral health services, and social services).

Instructions: Enter the percent of total funding that your agency allocated for other CPP activities (e.g., health benefits navigation and enrollment, referrals to behavioral health services, and social services).

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT4A3P **Percent Expended - Other CPP - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 4: Percent of PS18-1802 funding expended for other CPP activities (health benefits navigation and enrollment, referrals to behavioral health services, and social services).

Instructions: Enter the percent of total funding that your agency expended for other CPP activities (e.g., health benefits navigation and enrollment, referrals to behavioral health services, and social services).

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

CSTRATEGY4 **Comments - Strategy 4** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 100

Definition: Jurisdiction comments for Strategy 4, Comprehensive prevention with HIV-positive persons (CPP).

Instructions: Please provide any additional information to explain limitations or caveats associated with funds allocated or expended for core activities related to Strategy 4, if applicable.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT5A1P **Percent Allocated - Prevention with HIV-negative persons - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 5: Percent of PS18-1802 HIV Prevention funding allocated for HIV prevention activities with HIV-negative persons, including HIV testing and risk screenings, conducting risk- reduction interventions for HIV-negative persons, health benefits navigation and enrollment, referrals to behavioral health services, and social services.

Instructions: Enter the percent of total HIV Prevention funding that your agency allocated for HIV prevention activities with HIV-negative persons, including HIV testing and risk screenings, conducting risk-reduction interventions for HIV-negative persons, health benefits navigation and enrollment, referrals to behavioral health services, and social services.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT5A1P **Percent Expended - Prevention with HIV-negative persons - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 5: Percent of PS18-1802 HIV Prevention funding expended for HIV prevention activities with HIV-negative persons, including HIV testing and risk screenings, conducting risk reduction interventions for HIV-negative persons, health benefits navigation and enrollment, referrals to behavioral health services, and social services.

Instructions: Enter the percent of total HIV Prevention funding that your agency expended for HIV prevention activities with HIV-negative persons, including HIV testing and risk screenings, conducting risk reduction interventions for HIV-negative persons, health benefits navigation and enrollment, referrals to behavioral health services, and social services.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BASTRAT5A2P **Percent Allocated - PrEP Access and Support - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 5: Percent of PS18-1802 HIV Prevention funding allocated for PrEP access and support.

Instructions: Enter the percent of total HIV Prevention funding that your agency allocated for PrEP access and support.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT5A2P **Percent Expended - PrEP Access and Support - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 5: Percent of PS18-1802 funding expended for HIV Prevention PrEP access and support.

Instructions: Enter the percent of total funding that your agency expended for HIV Prevention PrEP access and support.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BASTRAT5A3P **Percent Allocated - PEP Access and Support - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 5: Percent of PS18-1802 HIV Prevention funding allocated for PEP access and support.

Instructions: Enter the percent of total HIV Prevention funding that your agency allocated for PEP access and support.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT5A3P **Percent Expended - PEP Access and Support - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 5: Percent of PS18-1802 HIV Prevention funding expended for PEP access and support.

Instructions: Enter the percent of total HIV Prevention funding that your agency expended for PEP access and support.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

CSTRATEGY5 **Comments - Strategy 5** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 100

Definition: Jurisdiction comments for Strategy 5, Comprehensive prevention with HIV-negative persons at risk for HIV infection.

Instructions: Please provide any additional information to explain limitations or caveats associated with funds allocated or expended for core activities related to Strategy 5, if applicable.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT6A1P **Percent Allocated - Perinatal HIV Exposure Reporting (PHER) - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 6: Percent of PS18-1802 funds allocated under HIV Prevention for developing and implementing standard operating procedures to identify and conduct follow-up of perinatally HIV-exposed infants.

Instructions: Enter the percent of total HIV Prevention funds allocated for developing and implementing standard operating procedures to identify and conduct follow-up of perinatally HIV-exposed infants (if conducted).

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT6A1P **Percent Expended - Perinatal HIV Exposure Reporting (PHER) - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 6: Percent of PS18-1802 funds expended under HIV Prevention for developing and implementing standard operating procedures to identify and conduct follow-up of perinatally HIV-exposed infants.

Instructions: Enter the percent of total HIV Prevention funds expended for developing and implementing standard operating procedures to identify and conduct follow-up of perinatally HIV-exposed infants (if conducted).

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BASTRAT6A1S **Percent Allocated - Perinatal HIV Exposure Reporting (PHER) - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 6: Percent of PS18-1802 funds allocated under HIV Surveillance for developing and implementing standard operating procedures to identify and conduct follow-up of perinatally HIV-exposed infants.

Instructions: Enter the percent of total HIV Surveillance funds allocated for developing and implementing standard operating procedures to identify and conduct follow-up of perinatally HIV-exposed infants (if conducted).

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT6A1S **Percent Expended - Perinatal HIV Exposure Reporting (PHER) - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 6: Percent of PS18-1802 funds expended under HIV Surveillance for developing and implementing standard operating procedures to identify and conduct follow-up of perinatally HIV-exposed infants.

Instructions: Enter the percent of total HIV Surveillance funds expended for developing and implementing standard operating procedures to identify and conduct follow-up of perinatally HIV-exposed infants (if conducted).

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT6A2P **Percent Allocated - Perinatal HIV Service Coordination - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 6: Percent of PS18-1802 HIV Prevention funds allocated for perinatal HIV service coordination (i.e., fetal and infant mortality review).

Instructions: Enter the percent of the total HIV Prevention funds that your agency allocated for perinatal HIV service coordination.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BESTRAT6A2P **Percent Expended - Perinatal HIV Service Coordination - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 6: Percent of PS18-1802 HIV Prevention funds expended for perinatal HIV service coordination (i.e., fetal and infant mortality review).

Instructions: Enter the percent of the total HIV Prevention funds that your agency expended for perinatal HIV service coordination.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT6A2S **Percent Allocated - Perinatal HIV Service Coordination - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 6: Percent of PS18-1802 funding allocated for HIV Surveillance perinatal HIV service coordination (i.e., fetal and infant mortality review).

Instructions: Enter the percent of the total HIV Surveillance funds that your agency allocated for perinatal HIV service coordination (i.e., fetal and infant mortality review).

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT6A2S **Percent Expended - Perinatal HIV Service Coordination - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 6: Percent of PS18-1802 funds expended for HIV Surveillance perinatal HIV service coordination (i.e., fetal and infant mortality review).

Instructions: Enter the percent of the total HIV Surveillance funds that your agency expended for perinatal HIV service coordination.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

CSTRATEGY6 **Comments - Strategy 6** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 100

Definition: Jurisdiction comments for Strategy 6, Perinatal HIV Prevention and Surveillance.

Instructions: Please provide any additional information to explain limitations or caveats associated with funds allocated or expended for core activities related to Strategy 6, if applicable.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT7A1P **Percent Allocated - Community-level Prevention Activities - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 7: Percent of PS18-1802 HIV Prevention funding allocated for community-level HIV prevention activities, including social marketing campaigns, social media strategies, and community mobilization.

Instructions: Enter the percent of total HIV Prevention funding that your agency allocated for community-level HIV prevention activities, including social marketing campaigns, social media strategies, and community mobilization (if conducted).

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT7A1P **Percent Expended - Community-level Prevention Activities - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 7: Percent of PS18-1802 HIV Prevention funding expended for community-level HIV prevention activities, including social marketing campaigns, social media strategies, and community mobilization.

Instructions: Enter the percent of total HIV prevention funding that your agency expended for community-level HIV prevention activities, including social marketing campaigns, social media strategies, and community mobilization (if conducted).

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BASTRAT7A2P **Percent Allocated - SSP - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 7: Percent of PS18-1802 HIV Prevention funding allocated for syringe services program.

Instructions: Enter the percent of total HIV Prevention funding that your agency allocated for syringe services program (if conducted).

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT7A2P **Percent Expended - SSP - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 7: Percent of PS18-1802 HIV Prevention funding expended for syringe services program.

Instructions: Enter the percent of total HIV Prevention funding that your agency expended for syringe services program (if conducted).

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BASTRAT7A3P **Percent Allocated - Condom Distribution - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 7: Percent of PS18-1802 HIV Prevention funding allocated for condom distribution.

Instructions: Enter the percent of total HIV Prevention funding that your agency allocated for condom distribution.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT7A3P **Percent Expended - Condom Distribution - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 7: Percent of PS18-1802 HIV Prevention funding expended for condom distribution.

Instructions: Enter the percent of total HIV Prevention funding your agency expended for condom distribution.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

CSTRATEGY7 **Comments - Strategy 7** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 100

Definition: Jurisdiction comments for Strategy 7, Community-level HIV prevention activities.

Instructions: Please provide any additional information to explain limitations or caveats associated with funds allocated or expended for core activities related to Strategy 7, if applicable.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT8A1P **Percent Allocated - HIV Planning - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 8: Percent of PS18-1802 funds allocated under HIV Prevention to develop partnerships to conduct integrated HIV prevention and care planning.

Instructions: Enter the percent of total HIV Prevention funds that your agency allocated to develop partnerships to conduct integrated HIV prevention and care planning.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT8A1P **Percent Expended - HIV Planning - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 8: Percent of PS18-1802 funds expended under HIV Prevention to develop partnerships to conduct integrated HIV prevention and care planning.

Instructions: Enter the percent of total HIV Prevention funds that your agency expended to develop partnerships to conduct integrated HIV prevention and care planning.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BASTRAT8A1S **Percent Allocated - HIV Planning - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 8: Percent of PS18-1802 funds allocated under HIV Surveillance to develop partnerships to conduct integrated HIV prevention and care planning.

Instructions: Enter the percent of total HIV Surveillance funds that your agency allocated to develop partnerships to conduct integrated HIV prevention and care planning.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT8A1S **Percent Expended - HIV Planning - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 8: Percent of PS18-1802 funds expended under HIV Surveillance to develop partnerships to conduct integrated HIV prevention and care planning.

Instructions: Enter the percent of total HIV Surveillance funds that your agency expended to develop partnerships to conduct integrated HIV prevention and care planning.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

CSTRATEGY8 **Comments - Strategy 8** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 100

Definition: Jurisdiction comments for Strategy 8, Integrated HIV Prevention and Care Planning.

Instructions: Please provide any additional information to explain limitations or caveats associated with funds allocated or expended for operational and foundational activities related to Strategy 8, if applicable.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BASTRAT9A1P **Percent Allocated - Health Information Infrastructure - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 9: Percent of PS18-1802 HIV Prevention funding allocated for health information infrastructure.

Instructions: Enter the percent of total HIV Prevention funding that your agency allocated for HIV Prevention health information infrastructure.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT9A1P **Percent Expended - Health Information Infrastructure - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 9: Percent of PS18-1802 HIV Prevention funding expended for health information infrastructure.

Instructions: Enter the percent of total HIV Prevention funding that your agency expended for health information infrastructure.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT9A1S **Percent Allocated - Health Information Infrastructure -Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 9: Percent of PS18-1802 HIV Surveillance funding allocated for health information infrastructure.

Instructions: Enter the percent of total HIV Surveillance funding that your agency allocated for health information infrastructure.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BESTRAT9A1S **Percent Expended - Health Information Infrastructure - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 9: Percent of PS18-1802 HIV Surveillance funding expended for health information infrastructure.

Instructions: Enter the percent of total HIV Surveillance funding that your agency expended for health information infrastructure.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT9A2P **Percent Allocated - Data Security and Confidentiality - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 9: Percent of PS18-1802 HIV Prevention funding allocated for data security and confidentiality.

Instructions: Enter the percent of total HIV Prevention funding that your agency allocated for data security and confidentiality.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT9A2P **Percent Expended - Data Security and Confidentiality - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 9: Percent of PS18-1802 HIV Prevention funding expended for data security and confidentiality.

Instructions: Enter the percent of total HIV Prevention funding that your agency expended for data security and confidentiality.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BASTRAT9A2S **Percent Allocated - Data Security and Confidentiality - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 9: Percent of PS18-1802 HIV Surveillance funding allocated for data security and confidentiality.

Instructions: Enter the percent of total HIV Surveillance funding that your agency allocated for data security and confidentiality.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT9A2S **Percent Expended - Data Security and Confidentiality - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 9: Percent of PS18-1802 HIV Surveillance funding expended for data security and confidentiality.

Instructions: Enter the percent of total HIV Surveillance funding that your agency expended for data security and confidentiality.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BASTRAT9A3P **Percent Allocated - Policies and Protocols - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 9: Percent of PS18-1802 HIV Surveillance funding allocated for strengthening policies and protocols to support HIV surveillance and prevention at the state and local level.

Instructions: Enter the percent of total HIV Prevention funding that your agency allocated for strengthening policies and protocols to support HIV surveillance and prevention at the state and local level.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT9A3P **Percent Expended - Policies and Protocols - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 9: Percent of PS18-1802 HIV Prevention funding expended for strengthening policies and protocols to support HIV surveillance and prevention at the state and local level.

Instructions: Enter the percent of total HIV Prevention funding that your agency expended for strengthening policies and protocols to support HIV surveillance and prevention at the state and local level.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT9A3S **Percent Allocated - Policies and Protocols - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 9: Percent of PS18-1802 HIV Surveillance funding allocated for strengthening policies and protocols to support HIV surveillance and prevention at the state and local level.

Instructions: Enter the percent of total HIV Surveillance funding that your agency allocated for strengthening policies and protocols to support HIV surveillance and prevention at the state and local level.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BESTRAT9A3S **Percent Expended - Policies and Protocols - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 9: Percent of PS18-1802 HIV Surveillance funding expended for strengthening policies and protocols to support HIV surveillance and prevention at the state and local level.

Instructions: Enter the percent of total HIV Surveillance funding that your agency expended for strengthening policies and protocols to support HIV surveillance and prevention at the state and local level.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

CSTRATEGY9 **Comments - Strategy 9** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 100

Definition: Jurisdiction comments for Strategy 9, Strengthen policies and protocols to support HIV surveillance and prevention at the state and local level.

Instructions: Please provide any additional information to explain limitations or caveats associated with funds allocated or expended for operational and foundational activities related to Strategy 9, if applicable.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT10A1P **Percent Allocated - Monitoring and Evaluation - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 10: Percent of PS18-1802 HIV Prevention funding allocated for developing work plans, ensuring data quality, monitoring Integrated HIV Prevention and Care Plan and Jurisdictional Epidemiological Profiles.

Instructions: Enter the percent of total HIV Prevention funding that your agency allocated for developing work plans, ensuring data quality, monitoring Integrated HIV Prevention and Care Plan and Jurisdictional Epidemiological Profiles.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BESTRAT10A1P **Percent Expended - Monitoring and Evaluation - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 10: Percent of PS18-1802 HIV Prevention funding expended for developing work plans, ensuring data quality, monitoring Integrated HIV Prevention and Care Plan and Jurisdictional Epidemiological Profiles.

Instructions: Enter the percent of total HIV Preventing funding that your agency expended for developing work plans, ensuring data quality, monitoring Integrated HIV Prevention and Care Plan and Jurisdictional Epidemiological Profiles.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT10A1S **Percent Allocated - Monitoring and Evaluation - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 10: Percent of PS18-1802 HIV Surveillance funding allocated for developing work plans, ensure data quality, monitor Integrated HIV Prevention and Care Plan and Jurisdictional Epidemiological Profiles.

Instructions: Enter the percent of total HIV Surveillance funding that your agency allocated for developing work plans, ensuring data quality, monitoring Integrated HIV Prevention and Care Plan and Jurisdictional Epidemiological Profiles.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT10A1S **Percent Expended - Monitoring and Evaluation - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 10: Percent of PS18-1802 HIV Surveillance funding expended for developing work plans, ensuring data quality, monitoring Integrated HIV Prevention and Care Plan and Jurisdictional Epidemiological Profiles.

Instructions: Enter the percent of total HIV Surveillance funding that your agency expended for developing work plans, ensuring data quality, monitoring Integrated HIV Prevention and Care Plan and Jurisdictional Epidemiological Profiles.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

CSTRATEGY10 **Comments - Strategy 10** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 100 **Max Length:** 1

Definition: Jurisdiction comments for Strategy 10, Monitoring and Evaluation to improve HIV surveillance, prevention, and care activities

Instructions: Please provide any additional information to explain limitations or caveats associated with funds allocated or expended for operational and foundational activities related to Strategy 10, if applicable.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT11A1P **Percent Allocated - Capacity Building and TA - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 11: Percent of PS18-1802 HIV Prevention funding allocated for supporting capacity building and TA, implementing capacity building assistance plans, building capacity of CBOs and community partners, and analytic capacity to support epidemiological science for HIV Prevention program activities.

Instructions: Enter the percent of total HIV Prevention funding allocated for supporting capacity building and TA, implementing capacity building assistance plans, building capacity of CBOs and community partners, and analytic capacity to support epidemiological science for HIV Prevention program activities.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT11A1P **Percent Expended - Capacity Building and TA - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 11: Percent of PS18-1802 HIV Prevention funding expended for supporting capacity building and TA, implementing capacity building assistance plans, building capacity of CBOs and community partners, and analytic capacity to support epidemiological science for HIV Prevention program activities.

Instructions: Enter the percent of total HIV Prevention funding expended for supporting capacity building and TA, implementing capacity building assistance plans, building capacity of CBOs and community partners, and analytic capacity to support epidemiological science for HIV Prevention program activities.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BASTRAT11A1S **Percent Allocated - Capacity Building and TA - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 11: Percent of PS18-1802 HIV Surveillance funding allocated for supporting capacity building and TA, implementing capacity building assistance plans, building capacity of CBOs and community partners, and analytic capacity to support epidemiological science for HIV Prevention program activities.

Instructions: Enter the percent of total HIV Surveillance funding allocated for supporting capacity building and TA, implementing capacity building assistance plans, building capacity of CBOs and community partners, and analytic capacity to support epidemiological science for HIV Prevention program activities.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT11A1S **Percent Expended - Capacity Building and TA - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 11: Percent of PS18-1802 HIV Surveillance funding expended for supporting capacity building and TA, implementing capacity building assistance plans, building capacity of CBOs and community partners, and analytic capacity to support epidemiological science for HIV Prevention program activities.

Instructions: Enter the percent of total HIV Surveillance funding expended for supporting capacity building and TA, implementing capacity building assistance plans, building capacity of CBOs and community partners, and analytic capacity to support epidemiological science for HIV Prevention program activities.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT11A2P **Percent Allocated - Geocoding - Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 11: Percent of PS18-1802 HIV Prevention funding allocated for Geocoding.

Instructions: Enter the percent of total HIV Prevention funding that your agency allocated for Geocoding.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

BESTRAT11A2P **Percent Expended – Geocoding -Prevention** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 11: Percent of PS18-1802 HIV Prevention funding expended for Geocoding.

Instructions: Enter the percent of total HIV Prevention funding that your agency expended for Geocoding.

Business rule
HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BASTRAT11A2S **Percent Allocated - Geocoding - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 11: Percent of PS18-1802 HIV Prevention funding allocated for Geocoding.

Instructions: Enter the percent of total HIV Prevention funding that your agency expended for Geocoding.

Business rule
HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BESTRAT11A2S **Percent Expended - Geocoding - Surveillance** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Percent **Min Length:** 1 **Max Length:** 4

Definition: Strategy 11: Percent of PS18-1802 HIV Surveillance funding expended for Geocoding.

Instructions: Enter the percent of total HIV Surveillance funding that your agency expended for Geocoding.

Business rule
HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

Num *Variable Name*

CSTRATEGY11 **Comments - Strategy 11** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 100

Definition: Jurisdiction comments for Strategy 11, Capacity Building and Technical Assistance.

Instructions: Please provide any additional information to explain limitations or caveats associated with funds allocated or expended for operational and foundational activities related to Strategy 11, if applicable.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BCAPPROACH **Approach** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 200

Definition: The approach used to calculate the distribution of estimated percentages within the strategy by each activity.

Instructions: Describe the approach used to calculate the distribution of estimated percentages within the strategy by each activity (e.g., estimated percentages of cost for continuum of care activities)

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

BYEAR **Budget Expenditure Reporting Year** **XSD (Schema) Name:**

Value Option: N/A **Format Type:** Number **Min Length:** 4 **Max Length:** 4

Definition: Budget expenditure reporting year refers to the 12-month calendar year (January-December) for which the budget expenditure is being reported.

Instructions: Indicate the year for which the budget expenditure data are being provided.

Business rule HD HIV Testing: Not applicable
Partner Services: Not applicable
CBO HIV Testing: Not applicable
Budget: Required

XML Specific Fields

Table: Z1 XML Specific Fields

This table contains the variables and the XML values to be used for records to identify updated and modified records. This table is only required for jurisdictions that upload XML files to EvaluationWeb. These fields apply to all XML formats, with the exception of the now obsolete CTv1 format. (Some variables may have had different XSD (Schema) Names in older formats. See the individual variables for details.

Num *Variable Name*

Z03c **Schema Version Number** **XSD (Schema) Name: SchemaVersionNumber**

Value Option: Enter one value only **Format Type:** Number **Min Length:** 1 **Max Length:** 10

Definition: Specifies the version of the XSD which has been used to validate the XML file.

Instructions: This value will be hard coded within the schema.
The number should exactly match the version number specified in the appropriate XSD.

Business rules Applicable only for XML uploads after January 2013.

Z06 **Data Type in File** **XSD (Schema) Name: dataType**

Value Option: Enter one value only **Format Type:** Alpha-Numeric **Min Length:** 1 **Max Length:** 5

Definition: Specifies the type of data being sent.

Instructions: Enter the date type of data sent.

Business rules Applicable only for XML uploads.

Code	Value Description	Value Definition
CBOAG	*CBO aggregate*	*Aggregate level directly funded CBO data*
CBOCL	*CBO client level*	*Client level directly funded CBO data*
CT	*Counseling and testing*	*Client level counseling and Testing Data*
HDAG	*Health department aggregate*	*Aggregate level health department data*
HDCL	*Health department client level*	*Client level health department non-CT non-PS data*
PS	*Partner services*	*Client level partner services data*

Appendix A

Table: Program Announcement

This table contains the complete listing of the value options for variable X137 Program Announcement.

Code	Value Description	Value Definition	Start - End Date
1	*PS 12-1201 – Category A*	*PS12-1201: The category within the health department flagship FOA that relates to overall HIV prevention program activities.*	*January 1, 2012 - December 31, 2016 extension: January 1, 2017 - December 31, 2017*
2	*PS 12-1201 – Category B*	*PS12-1201: The category within the health department flagship FOA that specifically addresses the Expanded HIV Testing Initiative.*	*January 1, 2012 - December 31, 2016 extension: January 1, 2017 - December 31, 2017*
3	*PS 12-1201 – Category C*	*PS12-1201: The category within the health department flagship FOA that funds demonstration projects.*	*January 1, 2012 - December 31, 2012 January 1, 2014 - December 31, 2015*
4	*PS 11-1113*	*PS11-1113: HIV Prevention Projects for Young Men of Color Who Have Sex with Men and Young Transgender Persons of Color for Community Based Organizations.*	*Value Option 4 - PS11-1113 available March 2012 - July 2013.*
5	*PS 10-1003*	*PS10-1003: HIV Prevention Projects for Community-Based Organizations.*	*July 1, 2010 - June 30, 2015*
6	*PS 08-803*	*PS08-803: HIV Prevention Projects in Puerto Rico and US Virgin Islands.*	*July 1, 2008 - June 30, 2013*
7	*MSM Testing Initiative*	*Scaling-up HIV Testing among African American & Hispanic MSM: The MSM Testing Initiative (MTI)*	*2012 through 2015*
8	*PS 11-1113 Category A - YMSM*	*PS11-1113: This category provides funding to Community-Based Organizations for HIV Prevention Programs for Young Men of Color Who Have Sex with Men and their partners.*	*September 30, 2011 - September 29, 2016 extension: September 30, 2016 - March 31, 2017*
9	*PS 11-1113 Category A - YTG*	*PS11-1113: This category provides funding to Community-Based Organizations for HIV Prevention Programs for Young Transgender Persons of Color and their partners.*	*September 30, 2011 - September 29, 2016 extension: September 30, 2016 - March 31, 2017*
10	*PS 12-1210 CAPUS*	*PS12-1210 CAPUS: This is the Secretary's Minority AIDS Initiative Fund for Care and Prevention in the United States (CAPUS) Demonstration Project. This program announcement is applicable only to eight funded health departments: Georgia, Illinois, Louisiana, Mississippi, Missouri, North Carolina, Tennessee, and Virginia.*	*September 30, 2012 - September 29, 2015 extension: September 30, 2015 – September 29, 2016*
11	*PS 13-1310*	*PS13-1310: HIV Prevention Projects for the Commonwealth of Puerto Rico and the United States Virgin Islands.*	*July 1, 2013 - June 30, 2015*
12	*PS 14-1410*	*PS14-1410: This is the Secretary's Minority AIDS Initiative Funding to Increase HIV Prevention and Care Services Delivery among Health Centers Serving High HIV Prevalence Jurisdictions (Partnerships for Care (P4C)) Demonstration Project. This program announcement is applicable only to four funded health departments: Florida, Maryland, Massachusetts, and New York.*	*June 3, 2014 - June 2, 2017*
13	*PS 15-1502 - Category A*	*PS15-1502: HIV prevention services for members of racial/ethnic minority communities.*	*July 1, 2015 - June 30, 2020 extension: July 1, 2020 - June 30, 2021*
14	*PS 15-1502 - Category B*	*PS15-1502: HIV prevention services for members of groups at greatest risk for acquiring and transmitting HIV infection, regardless of race/ethnicity.*	*July 1, 2015 - June 30, 2020 extension: July 1, 2020 - June 30, 2021*
15	*PS 15-1506 - PrIDE*	*PS15-1506: Health Department Demonstration Projects to Reduce HIV Infections and Improve Engagement in HIV Medical Care among Men Who Have Sex with Men (MSM) and Transgender Persons (PrIDE) Demonstration Project. This program announcement is applicable only to 12 funded jurisdictions: Baltimore, California, Chicago, Colorado, Houston, Los Angeles, Louisiana, Michigan, New York City, San Francisco, Tennessee, and Virginia.*	*August 1, 2015 - July 31, 2018 extension: August 1, 2018 – July 31, 2019*

Code	Value Description	Value Definition	Start - End Date
16	PS 15-1509 THRIVE	PS15-1509: Health Department Demonstration Projects for Comprehensive Prevention and Care for Men Who Have Sex with Men (MSM) of Color at Risk for and Living with HIV Infection. This program announcement is applicable only to seven funded jurisdictions: Alabama, Baltimore, District of Columbia, Louisiana, New York City, Philadelphia, and Virginia.	September 30, 2015 - September 29, 2019
17	PS 17-1704 Category A - YMSM	PS17-1704: This category provides funding to Community-Based Organizations for HIV Prevention Programs for Young Men of Color Who Have Sex with Men and their partners.	April 1, 2017 - March 31, 2022
18	PS 17-1704 Category B - YTG	PS17-1704: This category provides funding to Community-Based Organizations for HIV Prevention Programs for Young Transgender Persons of Color and their partners.	April 1, 2017 - March 31, 2022
19	PS 17-1711	Use of molecular HIV surveillance to identify active HIV transmission networks and implement HIV interventions for Hispanic/Latino men who have sex with men.	August 31, 2017 - August 30, 2020
20	PS 18-1802	PS 18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments.	January 1, 2018 - December 31, 2022
21	PS 18-1802 Demonstration Projects	PS 18-1802 Demonstration Projects: Funding to expand high-impact HIV prevention and surveillance interventions and strategies.	March 1, 2018 - February 28, 2022
22	PS 19-1901 CDC STD	PS 19-1901: STD prevention funding for Health Departments.	January 1, 2019 - December 31, 2023
23	PS 20-2010 - Component A	PS 20-2010: Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States.	August 1, 2020 - July 31, 2025
24	PS 21-2102	PS 21-2102: Comprehensive High-Impact HIV Prevention Programs for Community-Based Organizations.	July 1, 2021 - June 30, 2026
25	PS 22-2203 Category A	PS 22-2203: HIV prevention services for Young Men of Color Who Have Sex with Men (YMSM of color) and their partners regardless of age, gender, and race/ethnicity	April 1, 2022 - March 31, 2027
26	PS 22-2203 Category B	PS 22-2203: HIV prevention services for Young Transgender Persons of Color (YTG persons of color) and their partners regardless of age, gender, and race/ethnicity	April 1, 2022 - March 31, 2027
89	Other (specify)	A Program Announcement or Program Strategy other than those listed. This value option should also be used if the test being reported to CDC has been funded by another agency or organization.	Value option made optional in 2018
98	Other CDC-funded	A program announcement other than those listed and an HIV test was conducted using a CDC-funded mechanism.	Value option added in 2018
99	Other Non-CDC funded	A program announcement other than those listed and an HIV test was conducted using a non-CDC funded mechanism.	Value option added in 2018

PINAL COUNTY
WIDE OPEN OPPORTUNITY

AGENDA ITEM

May 15, 2024 ADMINISTRATION BUILDING A
FLORENCE, ARIZONA

REQUESTED BY:

Funds #:

Dept. #:

Dept. Name: Clerk of the Board

Director: Natasha Kennedy

BRIEF DESCRIPTION OF AGENDA ITEM AND REQUESTED BOARD ACTION:

Pursuant to A.R.S. 38-431.02, NOTICE IS HEREBY GIVEN, that the public will have physical access to the meeting room at 9:15 AM.

BRIEF DESCRIPTION OF THE FISCAL CONSIDERATIONS AND/OR EXPECTED FISCAL IMPACT OF THIS AGENDA ITEM:

BRIEF DESCRIPTION OF THE EXPECTED PERFORMANCE IMPACT OF THIS AGENDA ITEM:

MOTION:

History

Time	Who	Approval

ATTACHMENTS:

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No Attachments Available

PINAL COUNTY
WIDE OPEN OPPORTUNITY

AGENDA ITEM

May 15, 2024 ADMINISTRATION BUILDING A
FLORENCE, ARIZONA

REQUESTED BY:

Funds #:

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Dept. Name: Clerk of the Board

Director: Natasha Kennedy

BRIEF DESCRIPTION OF AGENDA ITEM AND REQUESTED BOARD ACTION:

Meeting Notice of Posting

BRIEF DESCRIPTION OF THE FISCAL CONSIDERATIONS AND/OR EXPECTED FISCAL IMPACT OF THIS AGENDA ITEM:

BRIEF DESCRIPTION OF THE EXPECTED PERFORMANCE IMPACT OF THIS AGENDA ITEM:

MOTION:

History

Time	Who	Approval

ATTACHMENTS:

Click to download
Notice of Posting

PINAL COUNTY
WIDE OPEN OPPORTUNITY

MEETING NOTICE OF POSTING

STATE OF ARIZONA

COUNTY OF PINAL

I, Natasha Kennedy, being duly sworn upon her oath, says as follows:

I am the appointed Clerk of the Pinal County Board of Supervisors.

In my position as Clerk of the Board of Supervisors and Board of Directors, I am responsible for posting all Agendas.

Pursuant to A.R.S. 38-431.02 notice is hereby given that the Pinal County Board of Supervisors and Pinal County Board of Directors will hold a Regular meeting on **Wednesday, May 15, 2024 at 9:30 AM** in the Board Hearing Room, 1891 Historic Courthouse, Administrative Complex, located at 135 N. Pinal Street, Florence, Arizona 85132. The public will have physical access to the meeting room at 9:15 AM.

Notice of Possible Recess: The Board may take a Recess around 12:30 PM and the meeting will reconvene around 1:00 PM.

Board Meetings are broadcasted live and the public may access the meeting on the County Website at Pinal.gov under "Meeting Videos."

Board Agendas are available on the County Website at Pinal.gov under "Agendas & Minutes."

At any time during business hours, citizens may reach the Clerk of the Board Office at (520) 866-6068 or via email at **ClerkoftheBoard@pinal.gov** for information about Board meeting participation.

Note: One or more members of the Board may participate in this meeting by telephonic conference call.

I hereby further certify that I caused to be posted this Friday, May 10, 2024, around 11:00 AM the Regular Agenda, Public Health Service District Agenda, and Executive Session as follows:

1. A kiosk located outside the front entrance to The Old Historical Courthouse, Administrative Complex Building, 135 North Pinal Street, Florence, Arizona 85132
2. County Website under Agendas & Meetings located at Pinal.gov
3. Emailed the NOVUS Agenda Distribution List and Clerk of the Board Notification Distribution List

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Official Pinal County, Arizona Seal this 10th day of May, 2024.

THE SEAL OF PINAL COUNTY ARIZONA 1875

Natasha Kennedy
Clerk of the Board of Supervisors
Pinal County, Arizona