

QUICK GUIDE

RECOMMENDATIONS FOR PARTNER SERVICES PROGRAMS FOR HIV INFECTION, SYPHILIS, GONORRHEA, AND CHLAMYDIAL INFECTION



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION



— QUICK GUIDE — RECOMMENDATIONS FOR PARTNER SERVICES PROGRAMS FOR HIV INFECTION, SYPHILIS, GONORRHEA, AND CHLAMYDIAL INFECTION

Introduction

In 2008, the Centers for Disease Control and Prevention (CDC) released new recommendations for HIV/STD partner services in the United States. Published as an *MMWR* Recommendations & Reports entitled *Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection*, the complete document provides not only programmatic and policy guidance, but also critical contextual information. This *Guide* is only intended to serve as a quick reference resource and as such, lists only the recommendations and data security guidelines included in the *MMWR*. The document is available in its entirety at www.cdc.gov/nchhstp/partners.

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Summary of Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection

Legal and Ethical Concerns

Public health agencies responsible for partner services should conduct a thorough review of all laws relevant to their provision of these services. This review should serve as a basis for developing policies and procedures for partner services programs. Program managers should also ensure that program staff members understand the implications these laws have for conducting partner services. Laws relevant to provision of these services include the following:

- the legal authority for the public health agencies for partner services;
- provisions related to privacy and confidentiality (e.g., requirements of the Health Insurance Portability and Accountability Act [HIPAA]);
- provisions related to duty or privilege to warn and criminal transmission and exposure;
- the ability of the public health agencies to coordinate with other agencies (e.g., law enforcement).

Program managers should ensure that their staff members understand the legal basis for their work, legal restrictions on their practice (e.g., duty or privilege to warn), the extent to which they are protected from civil litigation, and how to coordinate with law enforcement officials in ways that protect the civil and procedural rights of the persons involved.

To ensure that program staff members invoke their duty or privilege to warn appropriately, partner services programs should have written policies and procedures to guide staff members in handling complex cases. Guidelines and protocols should be based on the jurisdiction's statutory and case law and developed in consultation with legal counsel. Legal counsel should also be consulted regarding specific cases in which duty to warn or privilege to warn might apply.

Program managers should be aware of the applicable laws regarding criminal transmission and exposure in their jurisdictions and should coordinate with legal counsel regarding specific cases in which allegations of criminal transmission or exposure are made.

Identifying Index Patients

General

All persons with newly diagnosed or reported early syphilis infection should be offered partner services. All persons with newly diagnosed or reported HIV infection should be

offered HIV partner services at least once, typically at diagnosis or as soon as possible after diagnosis. Partner services program managers should develop strategies with written policies, procedures, and protocols for identifying as many persons as possible with newly diagnosed or reported infection and ensuring that they are offered services.

Resources permitting, all persons with newly diagnosed or reported gonorrhea should be offered partner services. Programs should consider which resources and services they can devote to partner services for chlamydial infection. Persons with newly diagnosed or reported chlamydial infection should either be offered partner services (e.g., as are those with gonorrhea), or programs should plan alternative strategies to enable partners to be notified.

Partner services programs should use surveillance and disease reporting systems to assist with identifying persons with newly diagnosed or reported HIV infection, syphilis, gonorrhea, or chlamydia infection, who are potential candidates for partner services. To maximize the number of persons offered partner services, health departments should strongly consider using individual-level data, but only if appropriate security and confidentiality procedures are in place. At a minimum, health departments should use provider- and aggregate-level data from their surveillance systems to help guide partner services.

Strategies for identifying potential index patients for partner services should be carefully monitored and evaluated for completeness, timeliness, effectiveness, and cost-effectiveness.

Partner services programs should establish and adhere to strict, jurisdiction-specific guidelines, policies, and procedures for information security and confidentiality. These should incorporate the guiding principles and program standards and should adhere to all applicable laws. They should be applied to all individual-level information used by partner services programs, including hard-copy case records and electronic-record systems or data-collection systems.

All partner services and surveillance programs that share information should meet the minimum security and confidentiality standards.

Penalties for unauthorized disclosure of information should exist for both surveillance and program staff members. All staff members should be informed of these penalties to ensure that data remain secure and confidential.

For successful sharing of individual-level information, open communication channels between surveillance and partner services programs, adequate resources, clear quality-assurance standards, community inclusion and awareness of the processes, recognition of the rights of infected persons, and sensitivity to health-care providers' relationships with their patients are all needed.

Jurisdictions that plan to initiate use of disease reporting data to prompt partner services should consider information flow, develop written protocols, and pilot test the proposed

system. Protocols should cover practical considerations, such as which types of information will be shared and who will have access, staffing, security measures, and methods for evaluating the system.

To ensure that appropriate policies and procedures are developed and followed, partner services programs should designate an overall responsible party (ORP) who has responsibility for the security of the program's information collection and management systems, including processes, data, information, software, and hardware. Preferably, a single person should serve as the ORP of both the surveillance and partner services programs.

Partner services programs that involve community-based organizations (CBOs) in partner services (e.g., for interviewing index patients receiving diagnoses in their counseling and testing programs) should assess the CBOs' ability to meet the minimum standards for data security. CBOs that cannot meet these minimum standards should have limited access to data, although they can still participate in partner services.

HIV Infection

HIV partner services programs should collaborate with health-care providers who provide HIV screening or testing, other HIV counseling and testing providers, HIV care providers, and HIV case managers to ensure that their clients and patients are offered HIV partner services as soon as possible after diagnosis and on an ongoing basis, as needed.

HIV partner services programs should work with providers of anonymous HIV testing services to develop strategies for providing partner services to persons who test positive, even if the person decides not to enter a confidential system. These providers should be trained on how to offer partner services and elicit partner information from persons with newly diagnosed HIV infection.

Prioritizing Index Patients

General

Program managers should establish criteria for prioritizing index patients to determine which patients will be interviewed first. In general, these criteria should include behavioral and clinical factors that affect the likelihood of additional transmission. Pregnant women should always be considered a high priority, regardless of behavioral or other clinical factors.

Persons with evidence of ongoing risk behaviors for transmission (e.g., recurrent STDs, being repeatedly named as a partner of other infected persons) might be playing an important role in transmission in the overall community and should be prioritized for partner services.

Syphilis

Many program areas use a reactor grid to assist with determining investigative priorities for syphilis reactors. The reactor grid is based on age and syphilis serology laboratory results (titers). Programs that use a reactor grid are strongly encouraged to validate its performance annually and during suspected outbreaks.

Interviewing Index Patients

General

In general, partner names should be elicited (partner elicitation) during the original interview. If this is not possible, a reinterview should be scheduled.

Programs should establish clear policies and procedures for the timing of interviews relative to date of diagnosis or report.

Index patients should be provided information about the following:

- the purpose of partner services;
- what partner services entail;
- benefits and potential risks of partner services for index patients and their partners, and steps taken to minimize any risks;
- how and to what extent privacy and confidentiality can be protected;
- the right to decline participation in partner services without being denied other services; and
- options available for notifying partners.

Program managers should ensure that policies and protocols are in place to safeguard the confidentiality of information shared with health department staff members during the partner notification process. Specifically, staff members must be trained to maintain confidentiality in both their professional and private lives. Confidentiality is particularly salient in rural areas, where a disease intervention specialist (DIS) might have substantial contact with clients outside of the professional environment (e.g., because they are neighbors, parents of children's classmates, or members of the same church).

To ensure confidentiality, interviews should not be conducted with other persons present, except for quality assurance or for interpreting.

In general, partner-elicitation interviews should be conducted by trained health department specialists. However, to expand partner services coverage, health departments should consider enlisting other types of providers to conduct interviews on their behalf. Successfully eliciting information about partners requires skilled counseling and interviewing; therefore, all providers conducting interviews on behalf of the health department should receive appropriate training. The yield of interviews conducted by other providers should be carefully monitored.

In general, interviews should be conducted in person. Telephone interviews might be conducted if no reasonable alternative exists, with strict safeguards in place to verify the identity of the person being spoken with and ensure that privacy and confidentiality are protected.

Programs should use interview techniques that maximize the amount of information gathered in the original interview about the index patient's partners. Policies, procedures, and protocols should establish criteria for instances in which reinterviews should be done, how soon they should be done, and when they are unnecessary. The yield of original interviews and reinterviews should be monitored closely and policies, procedures, and protocols adjusted accordingly.

In addition to information about partners, interviewers also can elicit information about the index patient's social network, including venues frequented, for use in planning additional prevention activities.

Policies, procedures, and protocols should address circumstances that might require specific consideration in interviews with index patients (e.g., age and developmental level, literacy, language barriers, hearing or visual impairment, alcoholism or abuse of other substances, mental health concerns, or potential violence).

Syphilis, Gonorrhea, and Chlamydial Infection

For early stages of syphilis, policies, procedures, and protocols should specify that all index patients receive an original interview as close to the time of diagnosis and treatment as possible. Every reasonable effort should be made to ensure the partner notification process begins on the date of the original interview.

For cases of gonorrhea and chlamydial infections that partner services staff members will follow up, policies, procedures, and protocols should specify that all index patients receive an original interview as close as possible to the time of diagnosis and treatment. Unless the index patient has evidence of recent infection, notification primarily serves case-finding goals and might be briefly delayed, if necessary.

For cases of gonorrhea and chlamydial infection that partner services staff members will not follow up, patient referral instructions should be provided as close as possible to the time of diagnosis and treatment.

For STDs other than HIV, partner services programs should follow established recommendations for interview periods.

HIV Infection

Policies, procedures, and protocols should specify that all index patients receive an original interview as soon as possible after diagnosis, ideally within a few days. For index patients who are not willing or able to provide partner information during the original interview, a reinterview should be scheduled, preferably no later than 2 weeks after contact was first made (and sooner, if possible, for index patients with acute infections).

Programs should develop criteria for establishing the interview period for index patients with HIV. Criteria for prioritizing partners should be developed in consultation with persons who have expertise in clinical and laboratory aspects of HIV (e.g., viral and serologic markers of HIV infection).

Program managers should ensure that policies and procedures regarding notification of spouses adhere to requirements of the Ryan White CARE Act Amendments of 1996 and any other applicable laws.

Policies, procedures, and protocols should address interviews for persons with reactive rapid HIV tests, including when partner names should be elicited, when partners should be notified, and policies about notifying partners when a confirmatory test is not available.

Risk-Reduction Interventions for Index Patients

Program managers should develop protocols that establish the minimum amount of information and prevention messages that should be provided to all index patients. For patients with HIV, the information should include the index patients' responsibility for disclosing their HIV serostatus to current and future partners.

Program managers should develop protocols for screening HIV index patients for current or recent behavioral risks and other factors that facilitate transmission. Screening should include asking all index patients about possible signs or symptoms of STDs, which enhance risk for HIV transmission and indicate current or recent risky sex behaviors.

Protocols should address management of index patients with risky sex or drug-injection behaviors or who have signs or symptoms of STDs. All index patients with ongoing risk behaviors or recurrent STDs should be provided prevention counseling or referred for counseling or other prevention interventions.

Program managers should assess the program's capacity for providing prevention counseling to all index patients without interfering with partner elicitation. For partner services programs that do not have the internal capacity to regularly provide prevention counseling to all index patients or are limited by resource or logistical factors, program managers should establish formal relationships with other agencies that can provide prevention counseling and more intensive behavioral intervention services and develop clear policies and procedures for making and following up on referrals.

Program managers should develop protocols to ensure that DISs conducting prevention counseling receive adequate training and supervision and should ensure that quality assurance plans are in place.

Treatment for Index Patients

Syphilis, Gonorrhea, and Chlamydial Infection

Program managers should ensure that patients are treated according to CDC treatment guidelines for timely and efficacious treatment with appropriate instructions and attention to recommendations regarding the importance of follow-up testing.

HIV Infection

Program managers should create strong referral linkages with HIV care providers and case managers to help ensure that the medical needs of index patients are addressed.

HIV-infected index patients who are not receiving medical care should be referred or directly linked to medical care or to case managers who can then link them to care services.

Referring Index Patients to Other Services

Because of the diverse needs of many index patients with HIV and other STDs, program managers should identify resources for psychosocial and other support services. DISs routinely should be provided updated information about referral resources.

Many referral needs can be addressed through linkage to medical care and HIV case management; however, DISs should screen for immediate needs and make appropriate referrals.

Notifying Partners of Exposure

Partners

All identified partners should be notified of their possible exposure as soon as possible, typically within 2–3 working days of identification, unless a potential for partner violence exists.

Program managers should ensure that protocols include screening for potential violence with each partner named before notification. If the provider considers a violent situation possible, the provider should seek expert advice before proceeding with notification. DISs should follow up on referrals for partner violence services to verify that referred persons are safe and have accessed these services.

Programs should establish criteria for prioritizing the order in which partners are notified. Criteria should be based on behavioral and clinical factors that confer a higher likelihood of the partner having been infected as a result of exposure or, if already infected, of transmitting infection to others. In addition, the Ryan White CARE Act Amendments of 1996 require that states receiving funds under part B of title XXVI of the Public Health Service Act should ensure that a good-faith effort is made to identify spouses of HIV-infected patients. Criteria should be reviewed at regular intervals (at least annually).

Programs should accommodate various notification strategies that allow the DIS and index patient to collaborate on the best approach for notifying each partner of exposure and ensure that the partner receives appropriate counseling and testing. Regardless of which strategy is used, the DIS and index patient should plan for potential unanticipated outcomes.

For partners for whom the index patient has provided a name (or other identifying information, such as an alias) and locating information, programs should strongly encourage provider referral but be supportive of index patients who choose contract referral for selected partners.

When contract referral is chosen, the DIS should establish an agreement with the index patient specifying when partners should be notified (typically within 24–48 hours), how the provider will confirm that partners were notified, and which follow-up services will be required for situations in which the index patient does not notify the partner within the allotted time frame.

Programs should allow for self-referral as permitted by state and local laws and regulations. Index patients who choose self-referral for certain or all partners should be informed of its disadvantages and informed about methods for accomplishing the notification safely and successfully. Self-referral should be discouraged if screening indicates a potentially violent situation.

Protocols for self-referral should, when possible, incorporate interventions that enhance its effectiveness and include instructing the index patient about the following:

- when to notify the partner (e.g., within 24–48 hours);
- where to notify the partner (e.g., private and safe setting);
- how to tell the partner;
- how to anticipate potential problems and respond to the partner's reactions;
- how and where the partner can access counseling and testing for HIV and other STDs;
- for persons with HIV, how to address the psychological and social impact of disclosing infection status to others; and
- how to contact the DIS with any questions or concerns that might arise.

To the extent possible, programs should develop methods of monitoring whether partners who are to be notified by the index patient (i.e., via contract or self-referral) are actually notified and receive appropriate counseling and testing.

Dual referral should be an option for index patients who prefer to be directly involved in the notification but express a need for assistance and support from the DIS. When dual referral is chosen, the DIS and index patient should plan in advance how the session will be conducted.

Program managers should ensure that policies and procedures, consistent with applicable laws, are in place to protect the identities of index patients when informing partners of

their exposure and to ensure that information about partners is not reported back to index patients.

Local reporting laws relating to domestic violence, including child abuse and abuse of older adults, must be followed when clients report risk or history of abuse.

Program managers should ensure that DISs are the following:

- knowledgeable about HIV and STD infection, transmission, and prevention;
- well informed about relevant laws and regulations;
- familiar with HIV and STD program standards, objectives, and performance guidelines;
- culturally competent in providing partner services;
- skilled at problem solving and dealing with situations that might be encountered in the field (e.g., personal safety, intimate partner violence, violence to others); and
- trained how to screen for and address partner violence concerns.

Social Contacts

General

In general, notification of partners should have a higher priority than notification of individual social contacts identified through clustering. Routine follow-up of social contacts should be carried out only after the program is successfully interviewing most new patients with cases and locating and notifying most partners and only after carefully considering the potential case-finding yield and resource implications. If this strategy is used, the number of cases identified should be carefully monitored, and the approach should be continued only if its effectiveness and cost-effectiveness equal or exceed those of other case-finding strategies. Notification of social contacts might be given higher priority during an outbreak.

HIV Infection

For persons with HIV, information about social contacts should be used as an aid to understanding transmission dynamics in the community and to help guide additional prevention interventions at the community level (e.g., screening and social marketing). In general, if individual social contacts are to be recruited for HIV testing, a self-referral approach rather than provider referral should be used. A provider referral approach should be used only after careful consideration of potential individual and community concerns about privacy and confidentiality. Provider referral might be appropriate during an outbreak.

Risk-Reduction Interventions for Partners

Program managers should develop protocols that describe the minimum amount of general and prevention information that should be provided to all partners at the time of notification.

All partners of STD/HIV-infected index patients should receive prevention counseling.

Because a substantial proportion of partners decline to or do not keep appointments for counseling and testing, prevention counseling should be provided by the DIS at the time of notification.

Prevention counseling should be based on counseling models that have demonstrated efficacy (e.g., the Project RESPECT model).

Program managers should develop protocols for screening partners to determine whether they need additional risk-reduction interventions and refer them for such interventions.

Program managers should develop protocols to ensure that DISs conducting prevention counseling receive adequate training and supervision and ensure that quality improvement plans are in place.

Cluster Interviewing Partners

General

When notifying partners of their possible exposure, DISs might also elicit information about the partners' social networks, including venues frequented, for use in planning additional prevention activities.

In general, notification of partners should be prioritized over follow-up of individual associates identified through cluster interviews. Routine follow-up of associates should be done only after the program is successfully interviewing most new patients with cases and locating and notifying most partners, and only after carefully considering the potential case-finding yield and resource implications. If this strategy is used, its case-finding yield should be carefully monitored, and the strategy should be continued only if its effectiveness and cost-effectiveness equal or exceed those of other case-finding strategies. Follow-up of associates might be given higher priority during an outbreak.

HIV Infection

For persons with HIV, information about associates should be used as an aid to understanding transmission dynamics in the community and to help guide additional prevention interventions at the community level (e.g., screening and social marketing). In general, if individual associates are to be recruited for HIV testing, a self-referral approach rather than provider referral should be used. A provider referral approach should be used only after careful consideration of potential individual and community concerns about privacy and confidentiality. A provider referral approach might be appropriate during an outbreak.

Testing Partners

General

To the extent possible, testing for STDs/HIV should be done at the time of notification. Partners who are not tested at the time of notification should be escorted or referred to the health department for testing or linked to other health-care providers who can provide these services.

DISs should follow up on partners not tested at the time of notification to verify that testing has occurred, test results were received and understood, and other referral services were accessed. If another health jurisdiction has been asked to contact a partner, follow up should be conducted by the initiating health department to determine whether services have been received.

Program managers should explore ways in which screening for HIV, screening and treatment for other STDs, screening for hepatitis B and hepatitis C viruses and vaccination for hepatitis A and hepatitis B viruses might be integrated in partner services programs.

Syphilis

Blood should be drawn in the field when DISs are trained to do so and when specimen maintenance conditions can be met. Partners should be referred for evaluation regardless of whether a specimen has been collected.

Gonorrhea and Chlamydial Infection

If provider referral is used, programs should consider protocols for collecting specimens in the field.

HIV

Partner services programs should consider using rapid HIV tests to maximize the number of partners who are tested and receive test results.

When notification is done in the field, rapid tests should be used or a blood or oral fluid specimen should be collected for conventional testing. If neither of these is possible, the partner should be escorted or referred to the clinic for testing.

Partners who test negative for HIV antibody should be advised to be retested in 3 months.

Treatment for Partners

Syphilis, Gonorrhea, and Chlamydial Infection

Program managers should ensure that partners are treated according to CDC treatment guidelines as soon as possible after notification.

Programs should consider field-delivered therapy for gonorrhea and chlamydial infection when partners are notified via provider referral.

For STDs in which single-dose oral therapy is feasible (i.e., gonorrhea and chlamydial infection), programs should consider patient-delivered partner therapy for partners who will not be notified via provider referral.

Programs should be sure that all appropriate parties are consulted to ensure that any EPT strategy in the jurisdiction is medically and legally sound. Appropriate parties vary by jurisdiction but might include state health commissioners or legislative bodies.

HIV Infection

Program managers should create strong referral linkages with HIV care providers and case managers to help ensure that the medical needs of HIV-infected partners are addressed.

Partners who test positive for HIV should be linked as soon as possible to early intervention services, medical care, and HIV case management, through which they can receive complete medical evaluations and treatment, assessment, and referral for psychosocial needs, and additional prevention counseling.

Follow-up should be conducted to verify that HIV-infected partners have accessed medical care or HIV case management at least once.

Partner services programs implementing postexposure prophylaxis (PEP) should develop protocols to ensure that persons exposed to HIV within the previous 72 hours are informed of the option of PEP, including risks and benefits as they relate to the exposure risk. Staff members conducting partner services should be aware of the options for persons to access PEP, whether through existing programs, urgent care facilities, emergency departments, or private physicians.

Referring Partners to Other Services

Because of the diverse needs of partners, program managers should identify referral resources for psychosocial and other support services. DISs routinely should be provided updated information about referral resources.

Many referral needs of partners testing positive for HIV will be addressed through linkage to early intervention, medical care, and HIV case management; however, DISs should screen for immediate needs and make appropriate referrals.

Partners testing negative for HIV should be screened and referred for other medical and psychosocial needs and prevention services.

Specific Populations

Youths

Programs should have specific protocols in place to guide partner services for youths. Protocols should address assessment of maturity and extent of social support, use of age-appropriate counseling and communication models, provision of services in youth-friendly environments, and assessment for physical and sexual abuse. These protocols should be developed in collaboration with legal counsel to ensure that they are consistent with all applicable laws and regulations.

Program managers should ensure that all staff members are aware of state and local requirements related to reporting of suspected sexual activity involving an adult and a minor child, child abuse, and sexual crimes. DISs providing services to youths should be sure to discuss the possibility of sexual abuse with their clients and, if sexual abuse is suspected, should notify the appropriate authorities (e.g., child protective services agency), in accordance with applicable laws and regulations.

Program managers should ensure that partner services staff members remain knowledgeable and updated on state and local laws and regulations related to parental consent, diagnosis and treatment of STDs, and HIV counseling and testing. If doubt or confusion arises regarding a specific case, legal counsel should be sought.

Program managers should ensure that any staff person who conducts elicitation of partner names and notification of partners for youths has received training on conducting services in a way that is appropriate for each child's age and developmental level. Training should include ways to recognize and address child abuse or sexual abuse situations.

Immigrants and Migrants

Program managers should review epidemiologic and other data to identify potential immigrant and migrant populations at high risk for infection in their jurisdictions and be prepared to provide partner services that are linguistically and culturally appropriate.

Based on the immigrant and migrant needs identified in the community, program managers should develop partnerships with community-based organizations and health-care providers that can deliver linguistically and culturally appropriate care, treatment, prevention, and support services.

Program managers should consider the diversity training needs of DISs who are working with the immigrant and migrant populations. In particular, staff members conducting interviews should be sensitive to cultural norms governing the discussion of sex and sexual behaviors. To the extent possible, clients who have limited ability to speak English should be interviewed in their native language.

Programs should consider the literacy level of their clients as well as the primary (or only) language of the clients. Programs should ensure that HIV and STD prevention educa-

tional materials are available in appropriate languages that reflect the cultural norms of the population.

Because of the geographic mobility of immigrants and migrants, program managers should consider use of rapid HIV tests and active outreach strategies for migrant and seasonal workers in nontraditional settings.

Health jurisdictions should consider developing collaborative agreements with bordering countries (i.e., Canada and Mexico) to assist with notification and follow-up of partners.

Program managers should be aware of federal, state, and local laws and regulations that might affect partner services for undocumented immigrants.

Incarcerated Populations

Program managers should become familiar with the federal, state, or county jail and correctional facilities in their jurisdictions. They should meet with key personnel in correctional facilities to discuss the services offered and goals of partner services as a public health intervention, the need for public health staff members to have access to facilities and adequate private space to meet with clients, and ways that partner services activities can be integrated into the facility response plans that are required by the Prison Rape Elimination Act (PREA). Follow-up meetings to facilitate communications and coordination should be held periodically.

Program managers and key correctional facility personnel should establish a formal written agreement to clearly outline roles and responsibilities for both public health and correctional facility staff members.

Program managers should collaborate with correctional facility staff members to develop protocols for partner services staff members to follow while in the facility, especially during emergencies. Ensuring that partner services staff members know and adhere to facility rules and regulations also is essential. Not adhering to the rules and regulations of a correctional facility will jeopardize implementation and continuation of the partner services program.

Program managers should collaborate with correctional facility staff members to develop protocols regarding administration of partner services for named partners within a correctional facility.

Strategies to Enhance Case Finding and Partner Notification

Core Areas

Health departments should assess the geographic concentration of gonorrhea and consider focusing provider-referral partner notification in core areas.

Social Networks

Programs should assess the social networks that influence disease transmission in the area as a strategy for finding persons who are at risk for disease but have not been identified by an index patient or partner.

This strategy should be used to enhance case finding, considering relevant epidemiological and behavioral information.

The Internet

When an index patient indicates having Internet partners, the DIS should attempt to obtain identifying and locating information about the partners (e.g., e-mail addresses, chat room handles, and names of chat rooms or websites where the partner might be located).

Internet partner notification is recommended for partners who cannot be contacted by other means or can be more efficiently contacted and notified through the Internet. This type of notification includes ensuring policies and protocols are in place to 1) ensure that confidentiality or anonymity of the index patient and partners are maintained on the Internet and 2) eliminate structural and bureaucratic barriers to staff member use of the Internet for partner notification.

Partner services programs should collaborate with community partners to develop strategies for addressing structural challenges to health department–mediated Internet partner notification.

Program Collaboration and Service Integration

To the extent possible, partner services program managers should ensure that persons receive coordinated HIV and STD prevention and related social services, particularly when the persons are affected by more than one disease.

Partner services program managers should assess and eliminate barriers to programmatic collaboration and service integration within the jurisdiction, so that, at a minimum, services are well integrated at the client (i.e., service delivery) level.

Partner services program managers should ensure that shared protocols and policies are developed to help coordinate partner services for persons identified through HIV or STD clinics or other health department clinics.

Partner services program managers should encourage private medical care providers to support partner services through active communication mechanisms (e.g., by visiting key medical providers, making presentations about partner services at local and state meetings of providers of HIV care, mailing educational brochures, or providing a summary of these recommendations).

Partner services program managers should establish systems of communication and information to ensure widespread distribution of these recommendations to health department partners, medical providers, and CBOs.

HIV program managers should ensure that communication and information about the partner services recommendations are shared with HIV prevention community planning groups.

Partner services programs should ensure that clearly defined, written protocols and procedures that address confidentiality and data security are in place to address incoming and outgoing requests for intrastate and interstate transmission of information.

Program Monitoring, Evaluation, and Quality Improvement

Partner services programs should be monitored closely to assess program performance and identify areas that need improvement.

Monitoring should be designed to answer specific questions about program performance; all data collected should be clearly related to answering these questions.

Data should be analyzed and reviewed regularly and used to improve program effectiveness and efficiency.

At a minimum, the following questions should be addressed through monitoring:

- How completely is the program identifying newly reported cases and interviewing patients for partner services?
- How effectively is the program identifying partners, notifying them of their risk, and examining or testing them for infection?
- How effectively is the program identifying new cases of syphilis, gonorrhea, and chlamydial infection and treating patients or identifying new HIV-positive patients and linking them to care services (HIV), through partner services?
- Are there any differences in the assessed measures according to index patient age, race/ethnicity, sex, or risk behavior?

Programs should establish specific objectives for essential steps in the partner services process and continuously track progress toward achieving these objectives.

All partner services programs should develop and implement quality improvement procedures and ensure that program staff members receive orientation and training on quality improvement.

Responsibility for conducting quality improvement procedures should be clearly assigned to a specific person or persons.

Quality improvement activities should be conducted at regular, scheduled intervals (e.g., quarterly or more often if needed).

Program staffing infrastructure should include enough staff members who have specific training and expertise in technical supervision of partner services activities to supervise

DISs. Quality improvement and review of performance of staff members should be made clear priorities for supervisors.

Support of Staff Members

Programs should develop and implement comprehensive training plans for partner services staff members at all levels, including program managers and supervisors. All staff members should receive initial training at the time of employment and updates at least annually. Initial training for DISs should include the CDC training course Introduction to STD Intervention or equivalent, and training for managers should include the CDC training course Fundamentals of STD Intervention or equivalent (course information available at www.cdc.gov/std/training/courses.htm). Staff members also should receive training in public health laws and regulations relevant to partner services.

Programs should use a balance of quantitative and qualitative methods for assessing the performance of individual staff members at all levels (including program managers and supervisors) and developing strategies for improvement.

Programs should develop and maintain written policies and procedures for maximizing safety of staff members, including policies and procedures that help staff members avoid occupational exposure to infections and procedures for addressing any exposure that occurs. Policies and procedures should be reviewed and updated at least annually.

DISs should receive initial and periodic (at least annually) training and orientation on policies and procedures related to workplace safety and should be required to follow them.

At a minimum, local policies and procedures should encompass applicable policies of the Occupational Safety and Health Administration (available at www.osha.gov).

Guiding Principles and Standards for Record Keeping and Data Collection, Management, and Security

Sharing data regarding human immunodeficiency virus (HIV) or sexually transmitted disease (STD) cases between surveillance and prevention programs can help maximize the number of persons who are offered partner services. The five guiding principles and 32 program standards outlined in this appendix are essential to ensuring the confidentiality and security of shared data. These standards were adapted from CDC and Council of State and Territorial Epidemiologists Technical Guidance for HIV/AIDS Surveillance Programs, Volume III: Security and Confidentiality Guidelines.* Most of the standards in this appendix directly reflect the requirements in the technical guidelines. However, to better adapt the guidelines to partner services programs, certain standards have been modified or not included based on input from the Partner Services Surveillance and Program Connections Workgroup and other committee members.

All program standards and security considerations should be based on the following five guiding principles:

Guiding Principle 1. STD/HIV partner services information and data should be maintained in a physically secure environment.

Guiding Principle 2. Electronic STD/HIV partner services data should be held in a technically secure environment, with the number of data repositories and persons permitted access kept to a minimum. Operational security procedures should be implemented and documented to minimize the number of staff members that have access to personal identifiers and to minimize the number of locations where personal identifiers are stored.

Guiding Principle 3. Individual program staff members and persons authorized to access case-specific information will be responsible for protecting confidential STD/HIV partner services case information and data; these persons will face legal action for confidentiality violations.

Guiding Principle 4. Security breaches of STD/HIV partner services information or data will be investigated thoroughly and sanctions imposed as appropriate.

Guiding Principle 5. Security practices and written policies will be reviewed and assessed continuously and, as necessary, changed to improve the protection of confidential STD/HIV partner services case information and data.

The following program standards should be adhered to by STD/HIV partner services programs in developing area-specific guidelines, policies, and procedures for individual-level record keeping and data collection, management, and security:

Standard 1. All policies and procedures must be written and reviewed at least annually and revised as needed.

Standard 2. A policy must name the persons who act as the overall responsible party (ORP) for the security of the data that might be stored in various data systems.

Standard 3. A policy must describe the methods for review of security practices for data. Included in the policy should be a requirement for an ongoing review of evolving technology to ensure that information and data remain secure.

Standard 4. The ORP must certify annually that these standards are met.

Standard 5. Access to and use of individual-level information must be defined in a data-release policy.

Standard 6. Policies must be readily accessible to any staff members having access to confidential, individual-level data.

Standard 7. A policy must define the roles and access level for all persons with authorized access and describe which standard procedures or methods will be used when accessed.

Standard 8. All authorized staff members must sign a confidentiality statement annually. Newly hired staff members must sign a confidentiality statement before access to individual-level information and data are authorized.

Standard 9. A policy must outline procedures for handling incoming mail and faxes to the programs and outgoing mail and faxes from the programs. The amount and sensitivity of information contained in any piece of correspondence must remain minimal.

Standard 10. All persons who are authorized to access individual-level information must be knowledgeable about the organization's information security policies and procedures.

Standard 11. All staff members authorized to access individual-level information must be responsible for questioning persons who attempt to access this information but who are not authorized to do so.

Standard 12. All staff members that are authorized to access individual-level information are responsible for protecting their own computer workstation, laptop computer, or other devices with confidential, individual-level information or data. This responsibility includes protecting keys, passwords, and codes that would allow access to confidential information or data. Staff members must be careful not to infect program software with computer viruses and not to damage hardware through exposure to extreme heat or cold.

Standard 13. Every person with access to individual-level information or data must attend security training annually or pass an annual proficiency test. The date of the training or test must be documented in the employee's personnel file. Information technology (IT) staff members and contractors who require access to information and data must undergo the same training as STD/HIV partner services program staff members and sign the same agreements. This requirement applies to any staff members with access to servers, workstations, backup devices, etc.

Standard 14. To the extent possible, workspace for persons working with individual-level information must be within a secure, locked area.

Standard 15. Paper records and copies of individual-level information and data must be stored inside locked file cabinets that are inside a locked room with limited access.

Standard 16. Program staff members must shred documents containing confidential information before disposing of them. Shredders should be of commercial quality, preferably with a crosscutting feature.

Standard 17. STD/HIV partner services analysis data sets must be stored securely with protective software (i.e., software that controls the storage, removal, and use of the data), and personal identifiers should be removed when possible.

Standard 18. STD/HIV partner services information and data transfers and methods for data collection must be approved by the ORP and incorporate the use of access controls. Individual-level information and data must be encrypted before electronic transfer. When possible, databases and files with individual-level data must be encrypted when not in use.

Standard 19. When individual-level STD/HIV partner services information and data are electronically transmitted, any transmission that does not incorporate the use of an encryption package meeting the encryption standards of the National Institute of Standards and Technology[†] and approved by the ORP must not contain identifying information or use terms easily associated with HIV, AIDS, or other STDs. The terms "HIV" and "AIDS," terms that specifically identify other STDs, or specific behavioral information must not appear anywhere in the context of the transmission, including the sender and recipient address and label.

Standard 20. When STD/HIV partner services information with personal identifiers or data are taken from secured areas and included in line lists or supporting notes, in either electronic or paper format, the documents must contain the least amount of information needed for completing a given task and, if possible, coded to disguise any information that could easily be associated with HIV, AIDS, or other STDs.

Standard 21. Individual-level information or data with personal identifiers must not be taken to private staff members' residences unless specific, documented permission is granted or the transfer is permitted according to a written policy established by the program manager or ORP.

Standard 22. Prior approval must be obtained from the program manager or approved procedures must be followed when planned business travel precludes the return of information with personal identifiers to the secured area by the close of business on the same day.

Standard 23. Access to any STD/HIV partner services program information or data containing names for research purposes (i.e., for other than routine program purposes) must be contingent on a demonstrated need for the names, institutional review board (IRB) approval, and the signing of a confidentiality statement regarding rules of access and final disposition of the information. Access to STD/HIV partner services program information or data without names for research purposes beyond routine program activities might still require IRB approval, depending on the numbers and types of variables requested in accordance with local data release policies.

Standard 24. Access to any secured areas where individual-level STD/HIV partner services information are stored must be limited to authorized persons as documented within policies and procedures (e.g., cleaning or maintenance staff members).

Standard 25. Access to confidential STD/HIV partner services information and data by personnel outside the STD/HIV partner services program must be limited to those authorized based on an expressed and justifiable public health need, must not compromise or impede program activities, must not affect the public perception of confidentiality of the data system, and should be approved by the ORP.

Standard 26. Access to STD/HIV partner services information and data with identifiers by those who maintain other disease data stores should be limited to those for whom the ORP has weighed the benefits and risks of allowing access and can certify that the level of security established is equivalent to these standards.

Standard 27. Access to STD/HIV partner services information or data for purposes unrelated to public health (e.g., litigation, discovery, or court order) can only be granted to the extent required by law.

Standard 28. All staff members who are authorized to access STD/HIV partner services information and data must be responsible for reporting suspected security breaches. Non-program staff members also must be informed of this directive.

Standard 29. Any breach of protocol or procedures, regardless of whether personal information was released, must be investigated immediately to assess causes and implement remedies.

Standard 30. A breach of confidentiality (i.e., a security infraction that results in the release of private information with or without harm to one or more persons) must be reported immediately to the ORP. In consultation with appropriate legal counsel, STD/HIV partner services staff members should determine whether a breach warrants reporting to law enforcement agencies.

Standard 31. Laptop computers and other portable devices (e.g., personal digital assistants [PDAs], other handheld devices, and tablet personal computers [tablet PCs]) that receive or store STD/HIV partner services program information or data with personal identifiers must have encryption software. Program information with identifiers must be encrypted and stored on an external storage device or on the laptop removable hard drive. The external storage device or hard drive containing the information must be separated from the laptop and held securely when not in use. The decryption key cannot be on the laptop. Other portable devices without removable or external storage components must use encryption software that meets federal standards.

Standard 32. All removable or external storage devices containing STD/HIV partner services information or data that contains personal identifiers must 1) include only the minimum amount of information necessary to accomplish assigned tasks as determined by the program manager; 2) be encrypted or stored under lock and key when not in use; and 3) be sanitized immediately after a given task (excludes devices used for backups). Before any device containing sensitive data is taken out of a secured area, the information or data must be encrypted. Methods for sanitizing a storage device must ensure that the information cannot be retrievable using “undelete” or other data-retrieval software. Hard drives that contain identifying information must be sanitized or destroyed before computers are labeled as excess or surplus, reassigned to non-program staff members, or sent off site for repair.

For the complete *Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection* visit www.cdc.gov/nchstp/partners