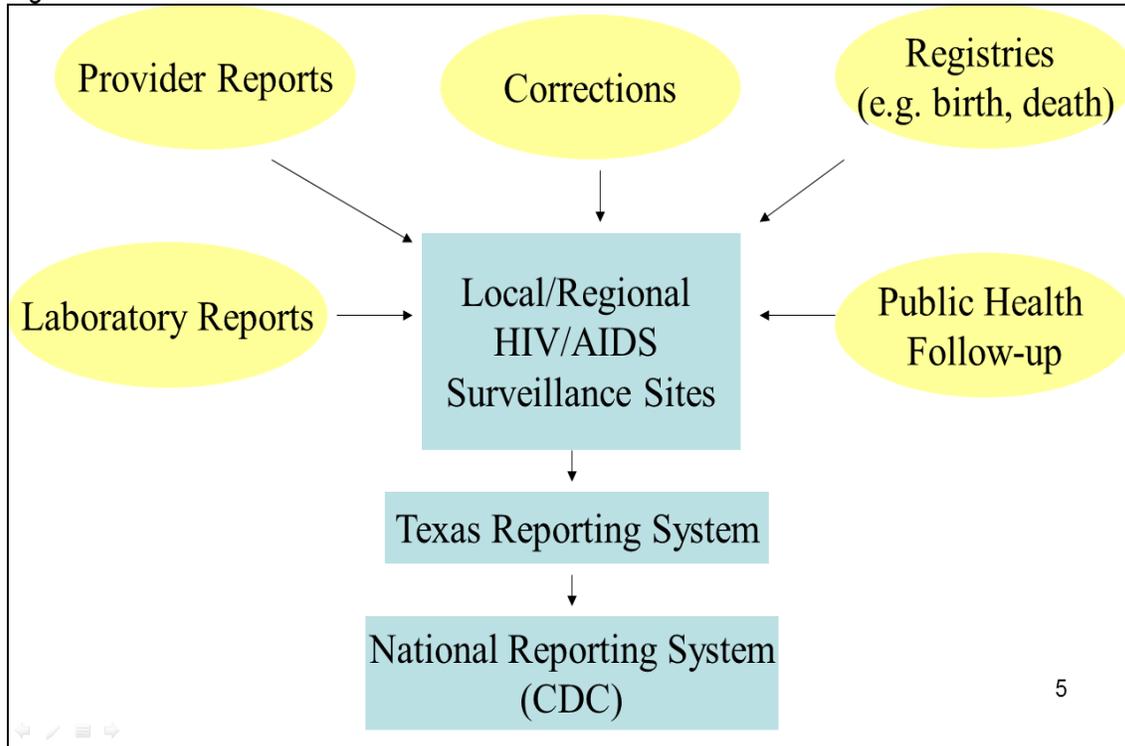


Flow of HIV Surveillance Information

Figure 1 provides a visual diagram showing the flow of HIV surveillance information, from the point of case identification to the point when the case is reported to the CDC. This chapter details each step in this information flow.

Figure 1



2-1 Case Ascertainment

HIV cases can be initially identified from a number of sources, including but are not limited to hospitals, physicians in non-hospital based practices, public and private clinics, counseling and testing sites, laboratories, insurance companies, and case registries (e.g. TB registry, death certificates). Laboratories are the most common method of initially identifying new cases. It is important and necessary to develop relationships with all potential case ascertainment sources to ensure complete case reporting.

This section summarizes the different mechanisms that surveillance sites should use to identify unreported HIV/AIDS cases or receive additional information on reported cases. Subsequent sections address how to follow-up on these reports.

A. Lab Reports from Central Office

Local/regional health departments often cannot accept electronic messaging from laboratories and hospitals. In addition, some laboratories process labs for many providers and do not have the capacity to distribute these to the appropriate jurisdictions in Texas. For this reason, DSHS receives electronic and paper lab reports for the entire state. DSHS processes the reports and distributes the laboratory information to the appropriate jurisdiction. Central Office receives daily

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lab reports from many laboratories, including several large reference laboratories. These lab reports are received in either electronic or paper format. The paper lab reports are entered into a database in Central Office and then combined with the lab reports received electronically, so all lab reports processed by Central Office are distributed in electronic format, commonly referred to as Electronic Lab Reports (ELR). Processing ELR's involves many steps to ensure the final daily ELR file contains a standardized, interpretable message in a consistent format. In addition, labs are electronically matched to records in enhanced HIV AIDS Surveillance data system (eHARS). Any lab reports for individuals who have existing records in eHARS will have their unique identification number, the State Number (Stateno), added to the lab report. *Appendix A* provides a visual diagram of the steps in ELR processing at Central Office. See *Appendix B* for more information on the matching algorithm used to electronically match incoming lab reports to eHARS. See *Appendix C: Decision Tree for Lab Reports Received via ELR*, for an outline of the process that surveillance sites should follow when receiving these reports from Central Office. Note that sites will see increased efficiency and improvement in their ability to manage ELR if an automated processing system is developed. For assistance with developing an automated processing system, contact your Central Office Technical Consultant or the Data Reporting Manager.

Central Office distributes ELRs daily over the TxPHIN to surveillance sites based on patient address or provider address if the patient address is not available. Labs can be easily viewed and printed using VueTil. Labs can also be opened in Excel to more easily sort and manage daily ELR files. For information on how to receive, view, and manage ELRs, see *Appendix D: Electronic Laboratory Report (ELR) Management*.

B. Paper Lab Reports Received Locally

In addition to the laboratory reports received electronically from Central Office, surveillance sites may receive paper lab reports directly from laboratories in their area. Some hospital-based laboratories report directly to their local surveillance sites. Since Central Office does not directly receive a copy of these lab reports, surveillance sites are required to send all lab reports received locally to Central Office. See *Appendix E: Paper Lab Submission to Central Office*, for guidance on how to submit paper labs to Central Office. Surveillance sites must also manually record search these cases to determine if the case has been reported to eHARS and initiate the appropriate follow-up needed for the case.

Chapter 7 contains information on different types of lab tests and how these labs can be interpreted for surveillance purposes.

C. Passive and Active Surveillance notifications from Providers

- Passive surveillance is the process by which providers report cases to local/regional health departments without the health department requesting information on a case.
- Active surveillance is the process by which surveillance staff contacts providers to identify any new or unreported cases.

Surveillance sites should develop a relationship with major HIV testing and treatment providers to establish active or passive reporting of HIV cases. This means that surveillance sites may receive two reports on the same individual, one from the provider and one from the lab. Dual reporting of cases ensures completeness of reporting and helps DSHS and surveillance sites to identify any reporting gaps. Some providers notify surveillance sites directly by contacting the surveillance site

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when a new case is identified or submitting line lists of identified HIV/AIDS cases. Alternatively, a surveillance site may request a line list of cases diagnosed at the facility with HIV. Chapter 4 provides more detail on conducting this type of active surveillance. If a new case is identified through active or passive surveillance, the surveillance site must record search the case in eHARS to verify that it has not been previously reported

In addition, some providers and local health departments may complete case report forms themselves. The surveillance site is responsible for record searching the case, identifying whether the case has been reported, assigning the appropriate Stateno, and ensuring that the form is completed correctly and thoroughly. The surveillance site may also need to collect additional information from other data sources on the case to complete reporting.

D. STD*MIS\DIS

In most circumstances, surveillance sites will receive laboratory reports for new HIV cases tested by the DIS. However, to ensure that all cases are ascertained, surveillance sites must establish and maintain regular dialogue with DIS on newly identified cases. In addition, at least weekly, surveillance sites must run reports in STD*MIS to identify any unreported cases.

E. Case Information from Registry Matches at Central Office

Central Office staff routinely matches the eHARS database to other disease registries to identify potential cases and obtain additional case information on existing cases in eHARS. Any potential cases identified through these registry matches will be distributed to the surveillance sites for appropriate follow-up. The following registry matches are performed on a routine basis.

Annually:

- STD*MIS
- Texas Vital Statistics birth and death records
- Social Security Death Index (SSDI)
- National Death Index (NDI)
- Accurint
- TDCJ inmate list

Quarterly:

- Tuberculosis registry

Monthly

- Texas HIV Medications program
- ARIES

Central Office may also match eHARS records to registries other than those listed above such as the Birth Defects and Cancer registries. Surveillance sites will be notified of any additional registry matches.

F. Potentially Unreported Cases Requiring Investigation

In an effort to improve case ascertainment and ensure complete HIV case reporting, Central Office has developed a process for adding potentially unreported cases to eHARS that should be investigated by the surveillance sites. The largest volume of these types of cases comes from laboratory reports indicative of HIV, such as positive western blots and detectable viral loads. Cases are also identified through registry/alternative database matches. Monthly, surveillance sites receive line lists of these cases to conduct further investigation. *Appendix F* details the

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process and how to resolve these cases, including how to request deletions, merges and transfers to another jurisdiction.

2-2 Case Investigation

Surveillance sites are responsible for investigating potential HIV cases, using multiple information sources to obtain required case information, completing one or several case report forms and ensuring that complete and accurate case information is reported into eHARS within 45 days of initial identification. All surveillance sites must report cases using the most recent version of the Texas Adult or Pediatric Case Report Forms (ACRF/PCRF).

Surveillance staff must also follow-up on all reported cases progressing from HIV to AIDS within 6 months of receipt of a lab result by completing a CRF. See Chapter 7 for more information on the HIV case definition and laboratory tests.

A. Medical Record Abstractions

At a minimum, a medical chart abstraction must be conducted at the time the case is initially identified and when the case transitions to AIDS. The medical record abstraction is used to gather the information required to complete the case report forms (CRF) and the TTH data elements. Medical record abstractions may provide information on previous diagnoses and treatment history, other medical conditions, including opportunistic infections, demographics, and risk factors. Medical record abstractions should be done through a field visit to the provider's facility to ensure that all case information is captured. Telephone abstractions should only be done in extenuating circumstances that would prevent surveillance staff from reporting cases within 45 days or when in-person medical record abstraction visits cannot be performed (for example, when a provider is located at a great distance and there are no other cases in that area or patient is tested by insurance agency). Medical records can be accessed electronically, either remotely or in the provider's office, as long as the electronic records contain all data elements available in the paper records. Surveillance staff must assess electronic medical records for completeness prior to routine use. See *Appendix G: Medical Record Abstraction Instructions*, for guidance on conducting medical chart abstractions. There are circumstances that prevent a medical record abstraction from being conducted for a case. For instance, cases identified by an insurance company or internet testing facility often do not have medical records available. In these cases, all other data sources should be evaluated and used to complete case report forms. If all other options have been exhausted and no case information can be collected from other data sources, surveillance staff should complete a case report form with the information on the lab report. Note that this is the only circumstance when staff should complete CRF directly from a lab report with no other sources of data. Surveillance staff should continue to attempt to collect information on the patient after the report is submitted. See *Appendix H: Special Instructions for Circumstances Where Medical Record Not Able to Be Completed* for more information on how to complete the case report form when copying data from a lab report.

B. Other Data Sources

In addition to conducting a medical record abstraction, surveillance staff are encouraged to explore other data sources available to gather information required to report new cases.

If there are elements on the CRF that cannot be completed based on the medical record abstraction (e.g. risk) surveillance staff must attempt to obtain the information from additional data sources such as STD*MIS or Disease Intervention Specialist (DIS) notes. Note that information

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obtained from another data source should be entered onto a new CRF; the information should never be entered onto the CRF used for the medical record abstraction.

If surveillance staff receives non-detectable viral loads accompanied by a CD4 test for persons who have not been reported, follow-up should be conducted by calling the patient's provider to determine if any additional tests have been performed to ascertain the patient's diagnostic status. However, these potential cases should be assigned a lower priority than potential new cases that are immediately reportable.

Surveillance staff should follow locally established protocol for notifying DIS officers of cases when appropriate. See *Appendix I: Disposition Codes*, for information on Disease Disposition, Field Record, and Interview Record Codes that are commonly used by DIS.

2-3 Reporting

A. Completing Reporting Forms

Adult/Pediatric Case Report Forms

Case report forms must be completed for all reportable HIV/AIDS cases within 45 days of learning of the case. Use the Adult HIV/AIDS Confidential Case Report Form (ACRF) (*Appendix J: Adult Case Report Form and Instructions*) to report all adults ≥ 13 years of age with an HIV infection or an AIDS diagnosis and the Pediatric HIV/AIDS Confidential Case Report Form (PCRf) (*Appendix K: Pediatric Case Report Form and Instructions*) for children < 13 years of age with an HIV infection, AIDS diagnosis or who were perinatal exposures to HIV (i.e., a child born to an HIV infected mother). The TTH portion of the ACRF must be completed for all newly reported adult (≥ 13 years of age) HIV cases.

Surveillance staffs are required to use available data sources to complete CRFs for newly diagnosed cases, cases transitioning from HIV to AIDS, and cases that have additional information from what's available in eHARS. All cases that are diagnosed or receiving care at a facility within a site's jurisdictional boundaries should be investigated and case report forms should be completed. This includes cases that reside in another jurisdiction in Texas and cases residing out of state. For more guidance on out jurisdiction cases and jurisdictional case ownership, see *Chapter 8*.

When completing Case Report Forms, surveillance staff must adhere to the document based principles of eHARS. Separate Case Report Forms must be completed for each source where relevant information was gathered. For example, information collected from a medical record should be completed on a separate form from information collected from STD*MIS. Information collected on different dates should also be completed on separate forms.

PLEASE DO NOT complete case report forms using only the information from a laboratory report unless the extenuating circumstances outlined in section 2-2 A of this chapter prevent data collection.

Specific fields on the case report form must be completed for entry into eHARS. Surveillance staff and supervisors should review each Case Report Form to ensure that all required fields are

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complete prior data entry. If any required field listed below is incomplete, the Case Report Form will be returned to the person who completed the form. All case report forms must have the following fields completed:

- Stateno;
- Report Status;
- Document source;
- Report Medium;
- Surveillance Method;
- Date Form Completed;
- Person Completing Form;
- Facility where information was obtained (all fields);
- Patient Legal Name; and
- Patient DOB.

In addition, for a case to be reportable and considered complete, the following information must be obtained for all new cases and case updates from HIV to AIDS-

- Patient Sex;
- Patient Race;
- Patient Residence at Diagnosis (including zip code);
- Facility of Diagnosis Fields;
- Lab information/Physician Diagnosis that made person a case; and
- Vital Status, including date of death if vital status is deceased.

Please note, surveillance sites should strive to provide the most complete and up to date information as possible for all reportable HIV/AIDS cases. Surveillance sites should enter CRFs into eHARS immediately after completion. If the surveillance site is not contractually obligated to enter information into eHARS, the surveillance site should submit CRF's to Central Office immediately after completion.

Abbreviated STD*MIS form

An abbreviated version of the Adult Case Report Form has been developed for reporting information from STD*MIS on an existing case in eHARS. This abbreviated form has been developed to facilitate the reporting of information from STD*MIS. It has a reduced selection of fields, some of which have been pre-completed to meet the specifications set for reporting information from STD*MIS. However, there are several limitations that must be recognized when using this form. If a case has never been reported to eHARS, the abbreviated ACRF for STD*MIS cannot be used; instead a full ACRF must be completed on the case. Review of STD*MIS does not meet the requirement for a medical record abstraction. Therefore, if a full ACRF is completed from STD*MIS, a medical record review must also be conducted at the facility of diagnosis or care. No laboratory information can be reported on the Abbreviated ACRF for STD*MIS. If there are earlier lab reports in STD*MIS than those received by HIV Surveillance, a medical record abstraction should be conducted at the facility from which those lab reports originated. This form should also not be used to report clinical information that was collected on patients who were diagnosed in the health department. Instead surveillance staff should review the patient's medical records at the health department and complete a full ACRF based on the medical record review.

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Please see *Appendix L: Abbreviated ACRF for STD*MIS Form and Instructions*, for detailed instructions on completing the Abbreviated Adult Case Report Form for STD*MIS.

Completing the TTH data elements on the Adult Case Report Form

Surveillance sites are required to complete the TTH portion of the ACRF for all newly-reported Texas HIV cases (including persons with HIV who are diagnosed with AIDS concurrently). This information should be reported to Central Office as part of the ACRF. The TTH data elements have been incorporated into eHARS and should follow the same document based principles that are used for reporting information on the ACRF; namely, only information from a single source is reported on an ACRF. For example, when conducting a medical record abstraction at Facility A, only information (including the TTH data elements) found during the medical record abstraction at Facility A is reported on the ACRF. Additional TTH information should be gathered from other sources, and in this case surveillance staff must complete a separate case report form for each source from which the information was gathered.

If there is documentation at the time of diagnosis that the case was previously diagnosed and reported in another state then an Out of State record search request HIV/AIDS Request Form should be completed (See Chapter 8, Appendix A, Procedures for OOS Request). If it is determined that the case has not been reported in another state, then an ACRF, including the TTH data elements, should be complete following the same procedures as you would use for any new case.

All ACRF forms received at Central Office will be reviewed for accuracy and completeness. Central Office will review TTH data elements to verify that all questions were answered and that the information on the form did not come only from a laboratory report. Sites will be notified of any missing or incomplete information for correction.

Completing the Death Report Form

The death report form has been created so that surveillance sites can provide updated death information on existing cases found in one of the following four sources: a coroner's database, an individual death certificate, Social Security Death Index (SSDI), or from your local Vital Statistics office. If death information is discovered during a medical records abstraction, that information should be included on the CRF and not reported separately on a Death Report Form. It is important to note that cases cannot be reported for the first time using the Death Report Form. There must be some type of clinical indication of HIV/AIDS diagnosis for a case to meet HIV case definition. See Appendix M for the Death Report Form and Instructions.

B. Data entry into eHARS

eHARS is the official HIV data collection system that is used to record HIV surveillance information and report to the CDC. eHARS was developed by the CDC and is provided to all states and territories participating in HIV surveillance. Texas has one eHARS database that is available to all contracted HIV surveillance sites in the state. Surveillance sites are expected to enter information into eHARS based on what's captured on the CRF. The eHARS Technical Reference Guide (assessable via the TxPHIN) and the Texas Data Entry instructions (Appendix N) provide guidance

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on entering information into eHARS. See Appendix O for information for surveillance sites to request eHARS access.

C. Data Submission

In addition to entering information into eHARS, surveillance staff must submit Case Report Forms and other necessary documentation to Central Office at least once a week. These submissions are used to review the quality and completeness of HIV surveillance case information. Submissions are due to Central Office by Friday each week. It is recommended that a supervisor review all CRFs prior to submission to Central Office. Surveillance sites should retain copies of all forms submitted to Central Office. All documents must be encrypted before submission to central office. The TxPHIN is the best mechanism for submission of CRFs. *Appendix P: Electronic Data Transfer Instructions* outlines how to encrypt, zip, and upload data for electronic submission. If a site is temporarily not able to transmit data electronically, documents must be sent using the mail service using the following procedures:

- Double envelope all mail with each envelope marked “CONFIDENTIAL” and “TO BE OPENED BY ADDRESSEE ONLY”.
- Do not include the words HIV/AIDS/STD in the body of the address or return address. This applies to any address stamps and pre-addressed envelopes.
- Address the package as follows:

- For ANY packages that are going through USPS, including USPS priority mail, USPS express mail, and USPS first class mail, use the below address:

STANLEY SEE
EPIDEMIOLOGY AND SURVEILLANCE BRANCH
TEXAS DEPARTMENT OF STATE HEALTH SERVICES
PO BOX 149347
AUSTIN, TX 78714-9347

- For mail sent using UPS, FEDEX, another overnight method, or mail delivered by courier use the address :

SURVEILLANCE: STANLEY SEE
DEPARTMENT OF STATE HEALTH SERVICES (DSHS)
4110 GUADALUPE STREET
BLDG. #636
AUSTIN, TX 78751

Confidential information should never be sent using facsimile transmission.

D. CDC Reporting

Monthly, DSHS transmits an eHARS generated file to the CDC. This file does not contain identifying information on cases; rather, it uses a coding system to establish unique individuals. The CDC uses the information transmitted monthly, and specifically the last data transmission of the year, to analyze national HIV surveillance data, identify trends and changes in the epidemic, conduct special projects, provide HIV surveillance reports, and generate reports of potential duplicate cases between states (RIDR). National HIV Surveillance Reports can be found at: <http://www.cdc.gov/hiv/library/reports/surveillance/>

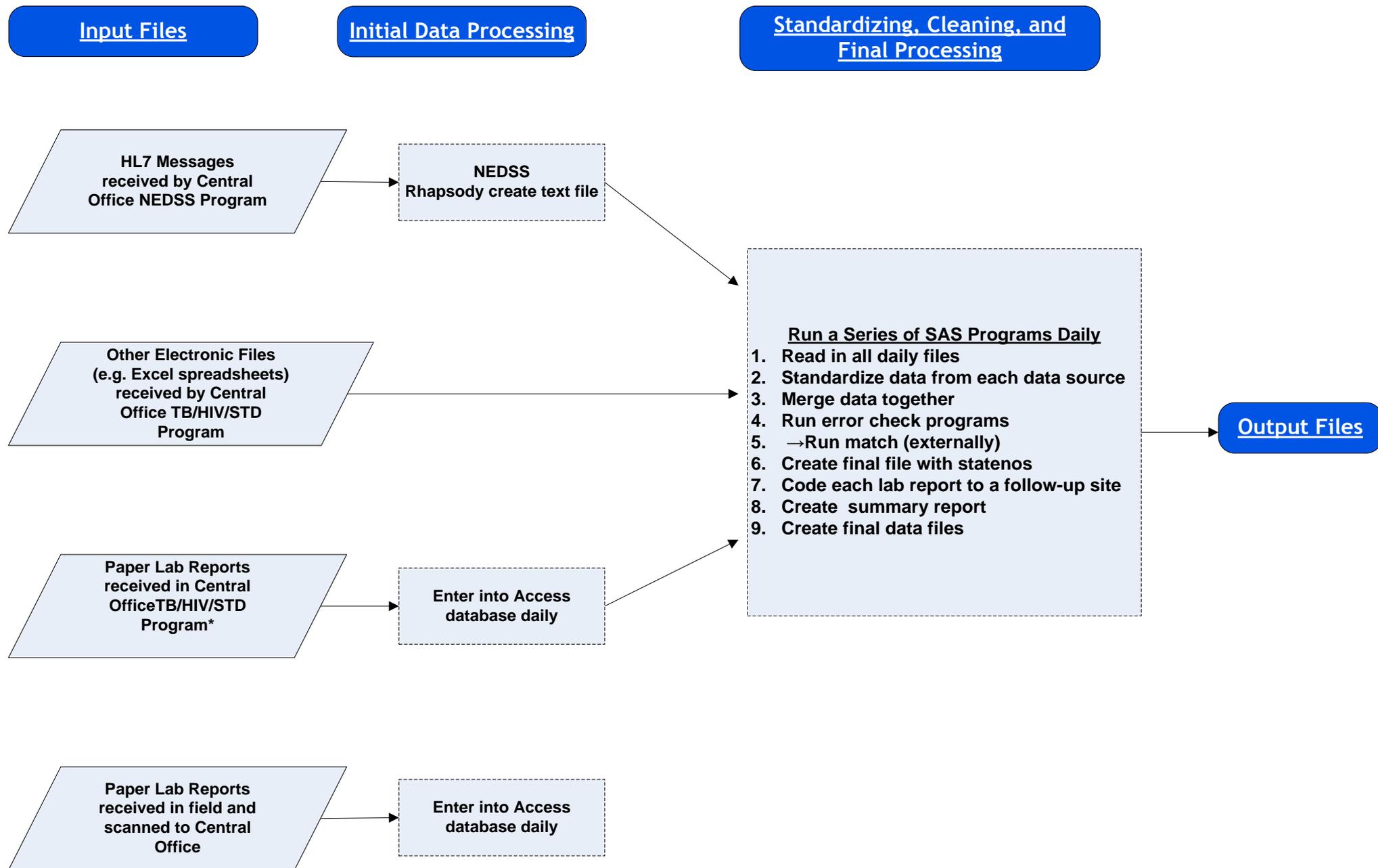
E. Texas HIV Surveillance Reports

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In June of each year, DSHS creates a frozen file from eHARS that is used to produce all Texas HIV surveillance data released to the public. The file contains prevalent cases diagnosed through December 31st of the previous year. An extensive cleaning and review process happens with the creation of this file. Usually efforts to minimize errors and resolve unreported cases begin in the spring of the year in anticipation of the file.

A group within the TB/HIV/STD Epidemiology and Surveillance Branch is responsible for producing epidemiological reports, responding to data requests, and providing information for analysis. Each year, in addition to routine HIV surveillance reports and HIV Epidemiological profile, they also create supplemental reports looking at specific topics in HIV and trends in Texas.

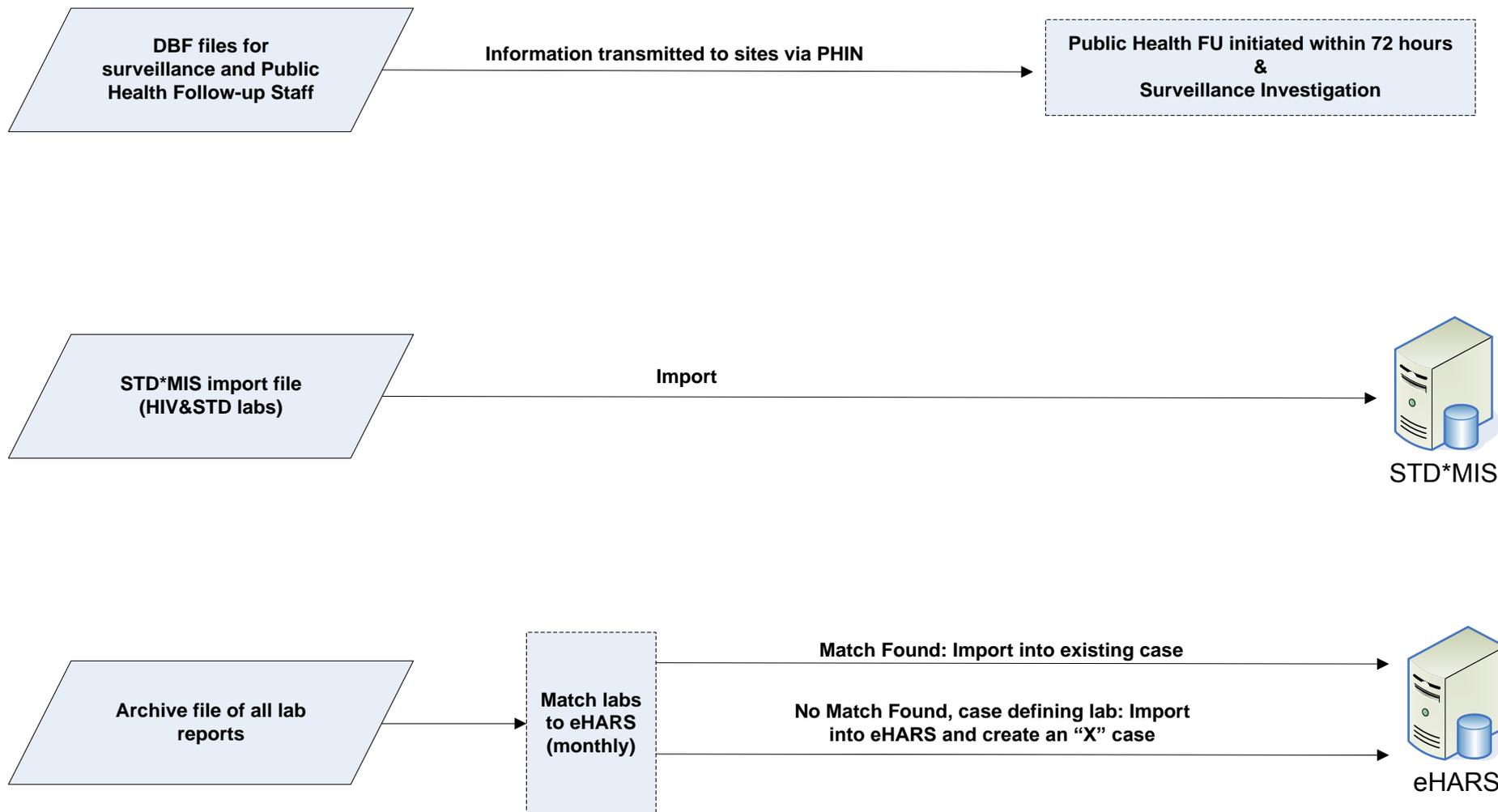
Texas HIV Surveillance Reports, including supplemental reports and analysis can be found at: <http://www.dshs.state.tx.us/hivstd/reports/default.shtm>. DSHS also provides custom data reports and responds to data requests for aggregate or summarized HIV surveillance information. To request data, contact: TBHIVSTDdata@dshs.state.tx.us



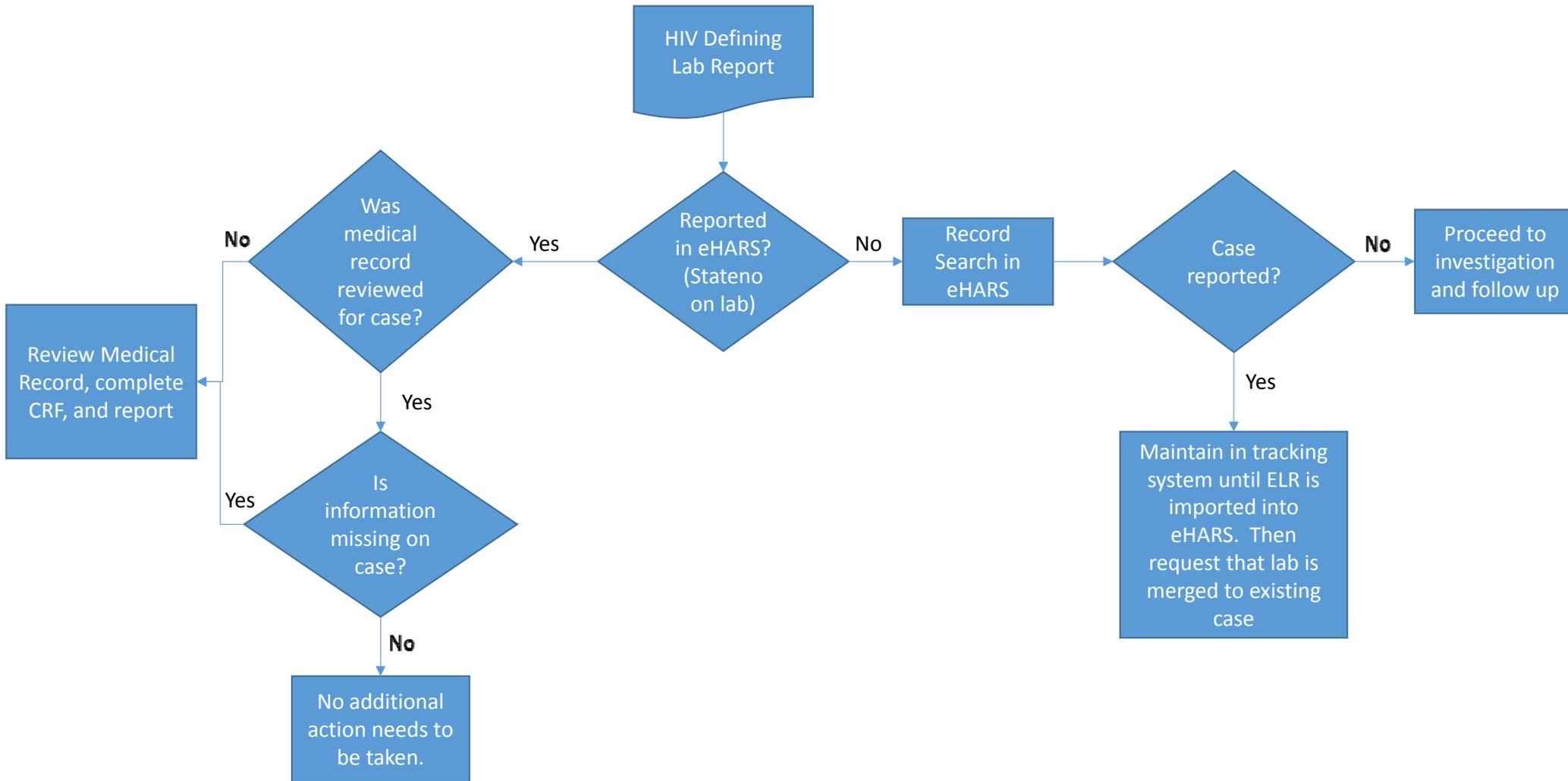
* Parkland Hospital labs are also included in this process, although they are first received by the local health department

Output Files

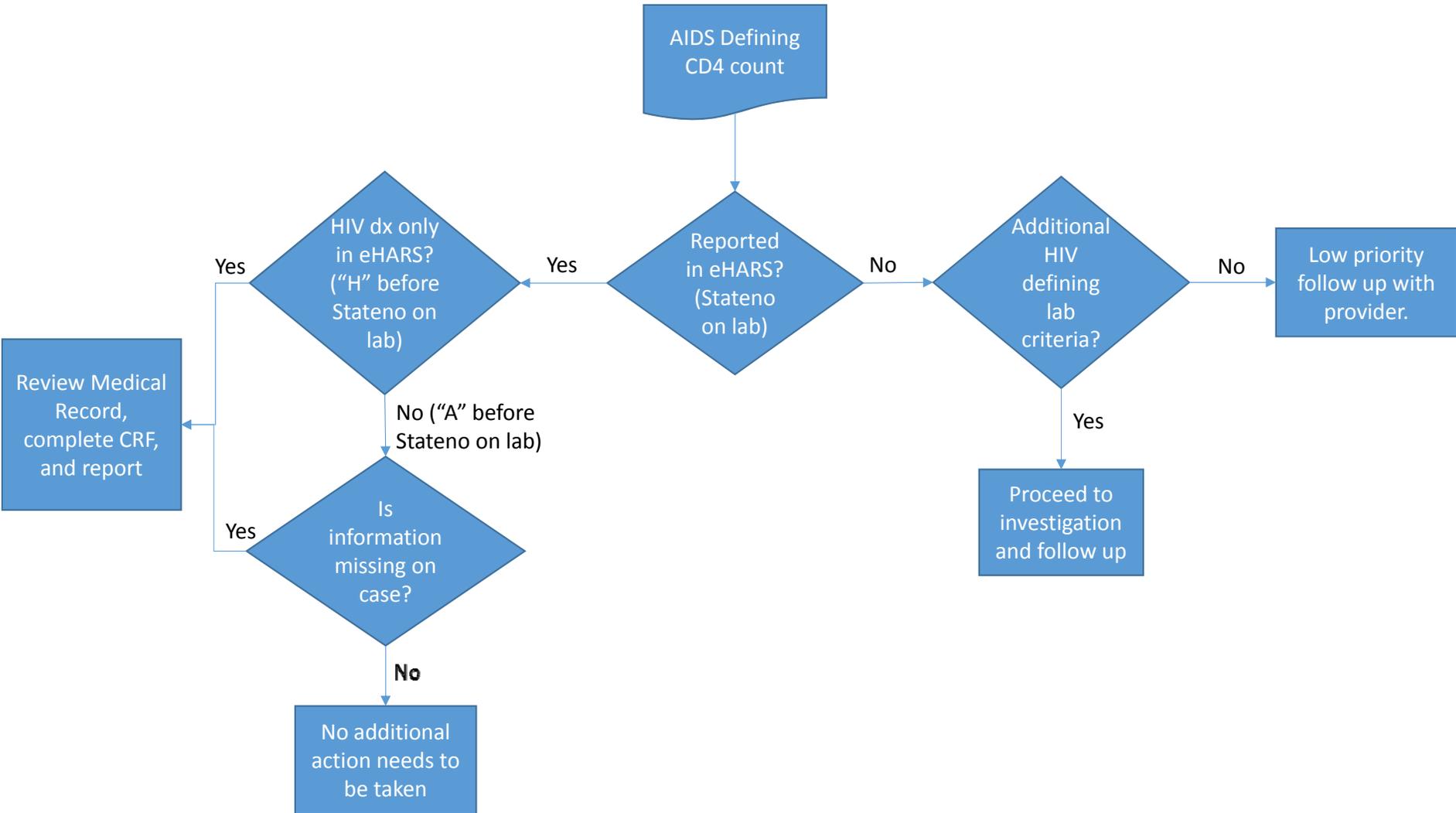
Follow-up and Import



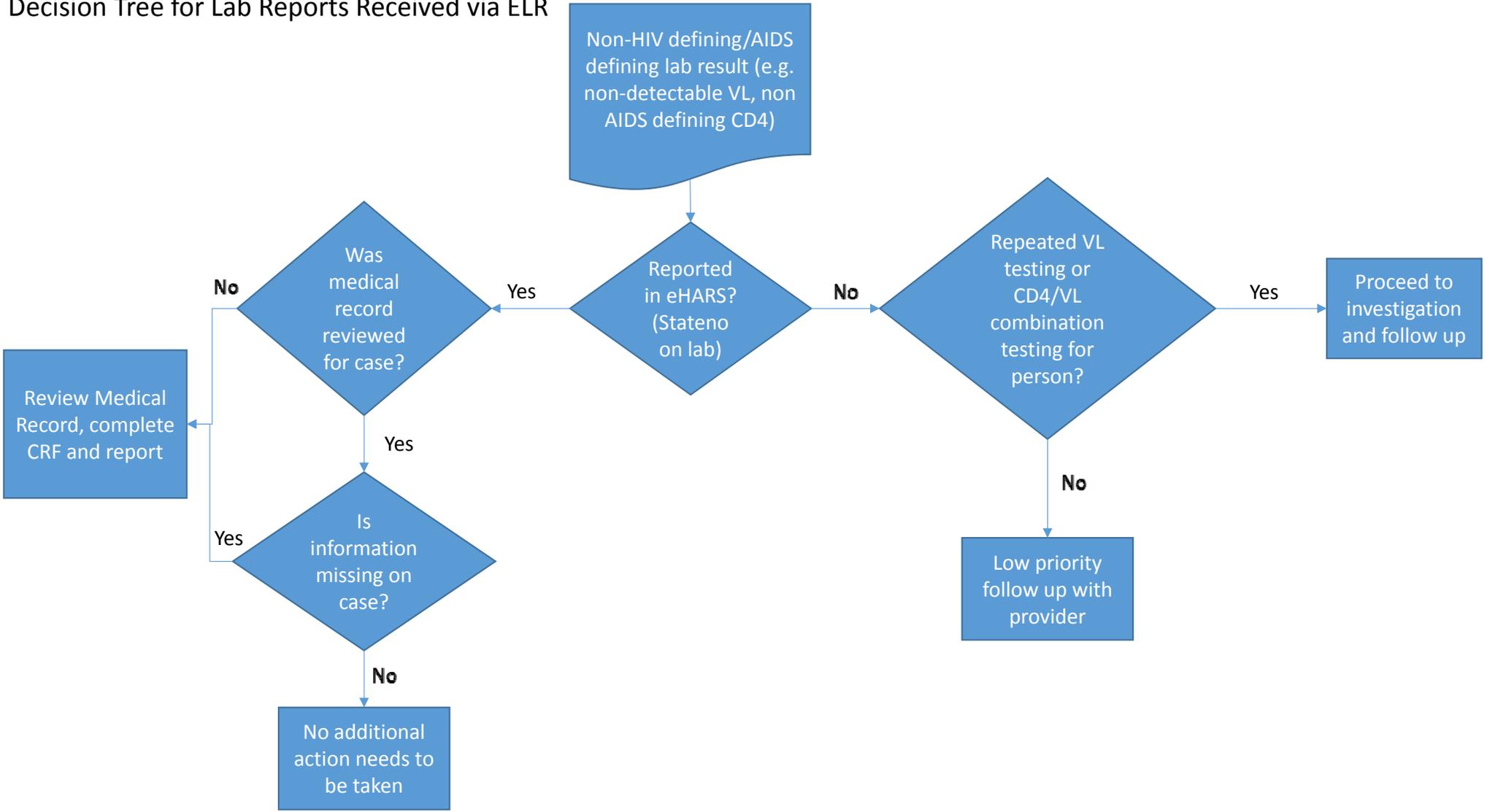
Decision Tree for Lab Reports Received via ELR



Decision Tree for Lab Reports Received via ELR



Decision Tree for Lab Reports Received via ELR



Electronic Laboratory Report (ELR) Management

On a daily basis, ELRs from across the state are processed and uploaded to the PHIN by Central Office to respective Local Surveillance Site folders in the PHIN. Instructions for accessing local surveillance site ELRs through the PHIN are listed below.

I. Accessing Your ELRs through the PHIN

- a. The PHIN can be accessed through the following website: https://www.txphin.org/sign_in .
- b. Enter email address and password info, then select Sign In.
 - i. If you do not have access to the PHIN and need access to ELR HIV/STD folders, please contact the Daily ELR coordinator for more info.

- c. At the bottom left hand corner of the following screen, Documents.

select the link



- d. Next, expand the folder ELR HIV/STD by double clicking on the plus sign to the left. Once expanded, the folder for your local surveillance site should be visible. Your folder may contain the following three subfolders (unless your site has pre-arranged with Central Office to not receive a specified file format):
 - i. ELR Scan- This is a scanned copy of any paper lab forms received by Central Office that belong to your jurisdiction (.PDF format).
 - ii. Import- This folder contains lab files for import (.TXT format) into STD*MIS. For more information on importing labs into STD*MIS, please refer to the STD POPS.
 - iii. VueTil- This folder holds .DBF formatted files of HIV and/or STD data.
- e. It is important to note that each surveillance site is responsible for the confidential transfer of their ELRs to a safe and secure site for proper ELR management. Please refer to the DSHS HIV-STD Security Policies and Procedures to ensure confidential transfer of information.

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- f. Once you have downloaded your ELR files from the PHIN, be sure to send an email to the Daily ELR coordinator to notify Central Office your file has been retrieved and can now be removed from the PHIN.

II. Managing Incoming ELRs

- a. Daily HIV ELR files will be sent from Central Office to local surveillance sites in .DBF format. Local surveillance sites have the option of managing incoming ELRs in a manner that is conducive to their local work flow systems.
 - i. **Electronic Management-** The best option for managing incoming ELRs is to utilize applications such as Microsoft Excel or Access. Fields can be created for tracking of labs. It is much easier to provide feedback to Central Office on cases in question when properly utilizing such applications to manage incoming ELRs.
 - ii. **Paper Management (VueTil)-** VueTil provides a mechanism to easily view and print individual ELRs. While VueTil allows for ease in terms of viewing and printing labs, it also allows for the easy misplacement of records (e.g. accidentally shredding of case stuck to another case, or misplacement of stack of labs). Refer to additional information at the end of this section for more information on VueTil.
- b. Part of the processing of ELRs at Central Office involves matching the incoming ELR to eHARS to look for possible matches. This is done using a number of algorithms that evaluate patient identifiers, including but not limited to first name, last name, date of birth (DOB) and SSN. If an ELR matches to a patient record in eHARS, the stateno is added to the ELR prior to distribution. It is important to note that although Central Office attempts to match ELRs to existing patients, there may be records that do not meet the matching algorithms, and thus, are not successfully matched. Patients may currently exist in eHARS under a married or an alias name, or the patient's DOB may have been incorrectly entered by the data entry staff of the laboratory report. With this notion in mind, it is very important that surveillance sites conduct record searches on each incoming ELR without a Stateno to ensure that the record is not a known case.

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III. Prioritizing your incoming ELRs

- a. It is important to note which lab markers are considered high-priority, medium-priority and low priority. Regardless of priority level, all incoming ELRs without Stateno's should have a final disposition assigned by the respective expected completion date. Please refer to the table below to view priority levels of ELRs and expected turnaround times.
- b. Thorough record searches (include search criteria's) should first be conducted in eHARS to be sure that the ELR does not belong to a previously established case in eHARS.
- c. Once it has been determined that the ELR in question is indeed a newly identified case, proceed with follow-up measures. See table below for guidance.
 - i. High priority ELRs should be investigated immediately, especially if your role requires referring the lab for Public Health Follow-up, as this activity is required to occur within 3 days of initial receipt. After the completion of 45 days, each high priority ELR should have the following completed:
 1. Lab is referred for public health follow-up.
 2. Medical chart abstraction is completed.
 3. A case report form submitted to Central Office or entered into eHARS.
 - ii. Medium priority ELRs should be completed within 6 months of receipt by local surveillance sites. After 6 months, all medium priority ELR that yielded a reported case should have the following completed:
 1. Medical chart abstraction is completed.
 2. A case report form submitted to Central Office or entered into eHARS.
 - iii. Low priority ELRs should be evaluated as time allows. The surveillance site should identify criteria to follow-up on low priority lab reports, such as the testing facility, and use this criterion to conduct follow up.
 1. For example, a CD4 only result coming from a facility known to routinely test or treat HIV patients should be elevated for follow-up whereas a CD4 only result from a facility not known to routinely test/treat HIV patients should be followed-up as time permits.

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Table 1: Expected Follow-up on Unreported (not in eHARS) Suspect HIV Labs				
PRIORITY LEVEL	LAB TEST	LAB RESULTS	EXPECTED TURNAROUND	REQUIRED ACTION
HIGH	<i>Adults</i>		45 days from first day of receipt by local surveillance site	<ol style="list-style-type: none"> 1. Ensure lab is referred for Public Health case investigation follow-up 2. Conduct medical record abstraction 3. Complete Case Report Form (CRF) 4. Enter case into eHARS and/or submit to Central Office for data entry
	Western Blot (WB)	Reactive		
	Indirect Immunofluorescence Assay (IFA)	Reactive		
	HIV Antibody Test	Reactive		
	HIV Nucleic Antigen (NAT)	Reactive		
	HIV Viral Load	Detectable		
	<i>Infants <18 months</i>			
	HIV Virologic Test (DNA or RNA)	Positive		
MEDIUM-Suspected Perinatal Exposures	<i>Children <3 years</i>		Infants born to HIV positive mother must have an HIV status determined within 18 months after birth	<ol style="list-style-type: none"> 1. Follow-up should be conducted every 6 months until infant's status is determined 2. Conduct medical record abstraction 3. Complete Perinatal Case Report Form (PCRf) 4. Enter case into eHARS and/or submit to Central Office for data entry
	HIV PCR	Negative		
	HIV Viral Load	Non-detectable		
	<i>Children <18 months</i>			
	HIV antibody test	Any positive confirmatory		
MEDIUM	<i>Adults</i>		6 months from first day of receipt by local surveillance site	<ol style="list-style-type: none"> 1. Conduct medical record abstraction 2. Complete Case Report Form (CRF) 3. Enter case into eHARS and/or submit to Central Office for data entry
	CD4 Count/%	<200 or <14%		
	Drug resistance testing (Genotype, Phenotype)			
	Enzyme immunoassay (EIA)	Reactive without confirmatory WB or IFA		
	HIV Viral Load	Non-detectable		
LOW	CD4 Count/%	>200 or >14%	As time allows	<ol style="list-style-type: none"> 1. Conduct follow-up to determine if case is HIV-infected
No follow-up Needed	Confirmatory tests	Non-reactive	--	--

Appendix D

Table 2: Expected Follow-up on Labs for Known HIV Cases Currently in eHARS				
PRIORITY LEVEL	LAB TEST	LAB RESULTS	EXPECTED TURNAROUND	REQUIRED ACTION
MEDIUM	CD4 Count/%	<200 or <14%	6 months from first day of receipt by local surveillance site	<ol style="list-style-type: none"> 1. Conduct medical record abstraction 2. Complete new Case Report Form with updated info 3. Enter case into eHARS and or/submit updated CRF to Central Office

Paper Lab Submission to Central Office

Some providers, such as major hospitals with in house lab testing facilities, report lab results directly to local/regional health departments. All paper lab reports received at local surveillance sites are required to be submitted to Central Office. This includes all reportable HIV-indicating lab results regardless of whether lab is confirmatory.

The submission of paper lab reports to Central Office is important because it provides updated lab information on known cases in eHARS which aids in monitoring the care patterns of known cases. The collection of timely and accurate patient lab info allows for better monitoring of how well patient medication regimens are faring and for identification of patients who may potentially have fallen out of care. It is also the responsibility of the surveillance site to identify gaps in reporting. For example, if a local hospital that has routinely submitted paper lab results to your surveillance site is no longer submitting results and you are not getting these results through ELR, you should contact the hospital to resolve the problem. Similarly, if you are not receiving all expected types of laboratory tests from a facility, even though you see the specific test within patients' medical records, you should alert the facility to the problem. Central office can aid you in discussions with facilities, on request.

Instructions for Submitting Paper Labs to Central Office

- 1) Scan all HIV-indicating paper lab reports received at local surveillance site. Ensure that the scan documents are in order and that all pages have been included. Note: Do not write on the lab reports prior to scanning.
- 2) Using WinZip, encrypt the scanned lab file. See *Appendix P* for more information on encrypting documents with WinZip.
- 3) Upload the encrypted scanned lab file to the PHIN. See *Appendix P: Electronic Data Transfer Instructions* for guidance on uploading files to the PHIN. Unless otherwise instructed by Central Office, all surveillance sites are required to scan and upload paper labs at least once per month (Dallas is required to submit weekly).
- 4) Once the scanned lab file has been uploaded to the PHIN, send an email to the lab coordinator indicating that a paper lab file was uploaded along with the following info:
 - a. File name
 - b. Password to access file
 - c. Number of pages
 - d. Name of submitting laboratory

Appendix E

- 5) All local surveillance sites are required to submit notification of the prior month's paper lab receipt to Central Office by the 5th of the following month (e.g. due date for notifying Central Office for the month of September is due by October 5th).
- 6) It is important to note that even if a surveillance site has *not* received any paper laboratories for the month, an email notification must still be sent on a monthly basis to lab coordinator indicating such.

❖ Note that submission of paper lab reports is evaluated during Site Reviews.

Appendix F Instructions for Managing Imported Laboratory Reports

In addition to receiving the daily electronic lab report files, we also import all confirmatory tests into eHARS regardless of whether the case has already been reported. This includes Western Blots, IFA's , NAATs, Viral Loads and any other test that meets HIV case definition. If the test matches to an existing case in eHARS, the lab will be attached to the case's record. If the test does not match to eHARS, the case will be imported and assigned Stateno, starting with "X". Sites will be responsible for performing routine investigations on these cases at the time the Electronic Lab Report is received. In addition, a list of cases missing a case report form will be generated monthly and sent to the jurisdiction where the case was diagnosed (based on facility of diagnosis). This list will be titled "Unreported Cases" and will include a status based on the length of time the case has been unreported to facilitate prioritization. As a reminder, sites have 45 days from initial receipt of a lab result to report a case. Most circumstances will require a new case investigation to occur and a new case report form to be completed. Case report forms should be added as new documents to the existing lab report. The assigned Stateno should be retained for the case.

Please note: If your monthly reports includes cases that begins with "X" this does not indicate any penalizations to sites, and treat it as you will treat your other cases.

There are circumstances when a new investigation may not be appropriate. These include when: 1) The lab document/s should be merged with an existing case; 2) The lab document/s should be deleted; 3) The lab document/s should be transferred to another jurisdiction. Below, you will find instructions on how to handle these specific situations:

- 1) If the case has been reported but the lab document/s did not attach to the correct case, you must do the following:
 - a. Record Search the case using the provided Stateno;
 - b. Open a lab document;
 - c. Go to the local fields on the lab document ; and
 - d. In the Lab Status drop down, select "Merge with Existing Case".

The screenshot shows the 'HIV/AIDS REPORTING SYSTEM v4.0 (MJ-Open)' interface. The user is logged in as 'miranda.lanning'. The main content area displays a 'Laboratory Report' document. The 'Local Fields' section is visible, with a table of fields and their corresponding answers. The 'LAB STATUS' field has a dropdown menu open, showing several options. A red arrow points to the 'MERGE WITH EXISTING CASE' option.

Field/Question	Answer
ENTERED BY	<SELECT>
LAB STATUS	<SELECT>
MERGE WITH	<SELECT>
DELETION REASON	MERGE WITH EXISTING CASE
LAB JURISDICTION	DELETE LAB DOCUMENT
	SEND TO JURISDICTION
	<SELECT>

- e. In the "Merge with" field, enter the Stateno. Note that the Stateno must already be entered in eHARS to select this option.

Appendix F Instructions for Managing Imported Laboratory Reports

The screenshot shows the 'Laboratory Report' form in the HIV/AIDS Reporting System v4.0 (MJ-Open). The 'Local Fields' section is expanded, showing a table with the following fields and options:

Field/Question	Answer
ENTERED BY	<SELECT>
LAB STATUS	<SELECT>
MERGE WITH	<SELECT>
DELETION REASON	<SELECT>
LAB JURISDICTION	<SELECT>

A red arrow points to the 'LAB STATUS' dropdown menu.

If you do not proceed through the above steps and ensure that drop down and Merge with Stateno fields accurately reflect that the lab/s need to be moved to another case, the lab will remain on your jurisdiction's monthly "Unreported Cases" list. If multiple labs are associated with the same case, only one lab document needs to be updated.

- 2) If the lab document/s should be deleted for the following reasons:
 - a. The lab is a false positive
 - b. The lab is a control test
 - c. The person tested anonymously and after contacting the facility, you were not able to get the person's correct information
 - d. The case is baby whose mother was not positive
 - e. The case does not reside or receive care in Texas

You must do the following:

- A. Go to the local fields on the lab document
- B. In the Lab Status drop down, select "Delete Lab Document"

The screenshot shows the 'Laboratory Report' form in the HIV/AIDS Reporting System v4.0 (MJ-Open). The 'Local Fields' section is expanded, and the 'LAB STATUS' dropdown menu is open, showing the following options:

- DELETE LAB DOCUMENT
- MERGE WITH EXISTING CASE
- DELETE LAB DOCUMENT
- SEND TO JURISDICTION

A red arrow points to the 'DELETE LAB DOCUMENT' option.

- C. In the Reason field, select the reason that the labs should be deleted. If there is a not an available reason for deletion, contact central office for advice.

Appendix F Instructions for Managing Imported Laboratory Reports

The screenshot shows the 'HIV/AIDS REPORTING SYSTEM v4.0 (MJ-Open)' interface. The user is logged in as 'miranda fanning'. The document is titled 'Laboratory Report'. The 'Local Fields' section is active, and the 'DELETION REASON' dropdown menu is open, showing the following options: '<SELECT>', 'FALSE POSITIVE', 'ANONYMOUS (UNABLE TO GET NAME)', and 'PEDIATRIC CASE, MOTHER NOT POSITIVE'. A red arrow points to the 'PEDIATRIC CASE, MOTHER NOT POSITIVE' option.

If you do not proceed through the above steps and ensure that drop down and reason fields accurately reflect that the lab/s need to be deleted, the lab will remain on your jurisdiction's monthly "Unreported Cases" list. If you do not thoroughly describe the reason the lab should be deleted, a central office staff member will contact you for additional information. If multiple labs are associated with the same case, only one lab document needs to be updated.

- 3) If the case lives in another jurisdiction but is receiving care in your jurisdiction, you are still responsible for reviewing the medical record and reporting the medical record information for the case. In the unusual circumstance that a laboratory report is assigned to your jurisdiction but the provider is not in your jurisdiction, you must indicate the correct jurisdiction by doing the following:
 - A. Go to the local fields on the lab document
 - B. In the Lab Status drop down, select "Send to Jurisdiction"

The screenshot shows the 'HIV/AIDS REPORTING SYSTEM v4.0 (MJ-Open)' interface. The user is logged in as 'miranda fanning'. The document is titled 'Laboratory Report'. The 'Local Fields' section is active, and the 'LAB STATUS' dropdown menu is open, showing the following options: '<SELECT>', 'MERGE WITH EXISTING CASE', 'DELETE LAB DOCUMENT', and 'SEND TO JURISDICTION'. A red arrow points to the 'SEND TO JURISDICTION' option.

- C. In the Lab Jurisdiction drop down, select the appropriate jurisdiction

Appendix F Instructions for Managing Imported Laboratory Reports

The screenshot shows the HIV/AIDS Reporting System v4.0 (MJ-Open) interface. The user is logged in as 'miranda fanning'. The system title is 'HIV/AIDS REPORTING SYSTEM v4.0 (MJ-Open)'. The user is currently viewing a 'Laboratory Report' document. The interface includes a search bar, a 'Submit' button, and a 'Local Field Information' table. The table has columns for 'Field/Question' and 'Answer'. The 'LAB JURISDICTION' field is currently set to '<SELECT>' and a dropdown menu is open, showing a list of jurisdictions: AMARILLO, AUSTIN, CORPUS CHRISTI, DALLAS, EL PASO, FORT WORTH, GALVESTON, HOUSTON, REGION 23, REGION45, REGION 65, REGION 7, REGION 8, REGION 910, REGION 11, SAN ANTONIO, TDCJ, and OOS. A red arrow points to the 'OOS' option in the dropdown menu.

Field/Question	Answer
ENTERED BY	<SELECT>
LAB STATUS	<SELECT>
MERGE WITH	
DELETION REASON	<SELECT>
LAB JURISDICTION	<SELECT>

If you do not proceed through the above steps and ensure that both drop down menus accurately reflect that the lab needs to transfer to another site, the lab will remain on your jurisdiction's monthly "Unreported Cases" list. If multiple labs are associated with the same case, only one lab document needs to be updated.

Other Circumstances:

- VA/Military/Federal Detention Centers/ Federal Prisons;
- Cases from facilities that do not have medical records (e.g. Insurance Companies, Online testing sites); and
- Cases from facilities that no longer have the medical records available (e.g. the medical records have been archived and you cannot gain access, the facility has closed).

These cases must be reported. Refer to Chapter 2 *Appendix H* of the procedure manual for instructions on how to report the cases.

How to Initiate an Abstraction Visit

If surveillance staff have never visited a facility, they should initially contact the facility by sending a letter to the facility's Health Information Management Director 2-3 weeks prior to the visit. The letter should include a request for a list of patients with HIV/AIDS ICD-9/10 codes in the primary and secondary diagnoses for persons who received services at the facility during a specified time frame. See Figure 1 for a phone script for initiating contact to hospitals and Figure 2 for an example letter requesting medical chart access. For perinatal exposures, surveillance staff must request prenatal, labor and delivery and pediatric birth records to ensure that all necessary records are obtained.

Reviewing Records

Staff should become familiar with the facility where medical records are being viewed, as some facilities may have multiple satellite offices and records may not be stored at the main facility. Medical records from the following types of facilities typically have the information necessary to complete case report forms:

- Inpatient Facility
- Emergency Room
- Outpatient Facility
- HIV Counseling and Testing site
- Infectious Disease Clinic
- Prenatal Clinic
- Adult HIV Clinic
- Pediatric HIV Clinic
- Private Physician's office

The following items are collected on the case report forms. The information should be obtained whenever possible when abstracting:

- Demographics
 - Race
 - Sex
 - Origin of birth
 - Date of birth
 - Vital Status
 - Social Security Number (SSN). We cannot ask the provider to supply us with the SSN, but it can be noted during a medical record review.
- Risk
- Testing history
 - HIV-1 IA (EIA or other)
 - HIV-2 IA (EIA or other)
 - HIV-1/2 IA (EIA or other)
 - HIV 1/2 Ag/Ab
 - HIV 1/2 Type Differentiating Immunoassay (Multispot)
 - Western blot
 - Indirect Fluorescent Antibody (IFA)
 - CD4 T-lymphocytes. Ensure that you document the first AIDS defining CD4 count.
 - AIDS defining CD4: CD4 count below 200 or 14%
 - Viral loads
 - Qualitative: negative or positive (e.g. HIV DNA PCR)

- Quantitative: has a numerical value ; (including results with a "<" or ">" result). (e.g. HIV-1 Qnt RT-PCR)
- Any opportunistic infections
- Pregnancy
 - Note if pregnancy is indicated in the medical records.. Each site is responsible for tracking pregnant HIV+ women until the birth of the child. The estimated date of delivery, prenatal care facility, and expected delivery hospital for the woman are collected. (*See Chapter 3: Perinatal Surveillance for more information*).
 - Documentation of negative tests during pregnancy or at labor and delivery should be recorded for women who seroconvert after their initial negative test.
 - Documentation of CD4 counts and Viral Loads during pregnancy/labor and delivery/ and 6 months postpartum should be recorded.
- Treatment History
 - Antiretroviral therapy
 - Referral to HIV care
 - Patient notified of infection
 - Partner notification
- Names of sex partners
 - All named sex partners should be record searched in eHARS and STD*MIS
 - Any partners found in eHARS will be cross referenced in comments so risk may be updated or validated.

The following portions of a medical record are useful in obtaining information to complete fields on the CRF. To be considered a complete abstraction, surveillance staff must be review the following: (when available):

- Intake forms or demographic face sheet
 - Race
 - Sex
 - Country of origin
 - Date of birth
 - SSN
 - Address
 - Insurance information
- History and physical
 - Demographics (Race, Sex etc.)
 - Risk
 - AIDS related complexes
 - Indication of out of state diagnosis/treatment
- Discharge summaries
 - Risk
 - AIDS related complexes
 - Referral for treatment
 - Medications
 - Diagnosing Information
- Laboratory reports/Test results
 - Antibody Tests
 - Viral loads

- CD4's
- AIDS related viral infections
- AIDS related bacterial infections
- AIDS related parasitic infections
- Pathological reports
 - AIDS related cancers
 - AIDS related brain lesions
 - AIDS related bacterial infections
- CT/MRI/X-ray reports
 - AIDS related cancers
 - AIDS related brain lesions
 - AIDS related bacterial infections
- Social histories
 - Risk
 - Transgender reassignment
 - Indication of out of state diagnosis/treatment
 - Substance Use
- Social worker notes
 - Risk
 - Transgender reassignment
- Case manager notes
 - Risk
 - Transgender reassignment
 - Treatment
 - Indication of out of state diagnosis/treatment
- Nursing Notes
 - Risk
 - Additional information from patient discussions with the nurse
- Medical Administration records
 - Includes medications patient received
 - Antiretroviral therapy
 - PCP prophylaxis
- Physician Progress Notes
 - Risk
 - Diagnosing information
- Consultation Notes
 - Indication of out of state diagnosis/treatment
 - Diagnosis of Opportunistic Infections
 - Medications
 - Risk
 - Social history
 - Substance Use
- Prenatal records
 - Reproductive history
 - Antiretroviral therapy during pregnancy
 - Substance Use during pregnancy

- Diagnosing information
- Testing history
- Labor and Delivery Records
 - Birth history for the infant (Birth type, Birth weight, Gestational age, delivery method)
 - Antiretroviral therapy during labor and delivery
 - Time and date of delivery

Pediatric birth records

- Birth history for the infant (Birth type, Birth weight, Gestational age, delivery method)
- Antiretroviral therapy for the infant
- Maternal HIV history

Figure 1

HIV Surveillance-Phone Script
Guide for Making Contact with Hospital Staff

(Make contact with the hospital at least 10 days in advance to assure charts are pulled.)

Good morning/afternoon. My name is _____ and I am calling from the Texas Department of State Health Services in Austin.

May I please speak with _____? *(Health Information Management/Infection Control Nurse)*

When connected with correct person:

Hello. My name is _____ and I am calling from the Texas Department of State Health Services in Austin.

Your reason for the request:

In accordance with the Texas Health and Safety Code §81.061, I am calling to arrange a visit to your facility to review medical records for required epidemiological data collection on a reportable communicable disease.

What you will be reviewing:

There **is/are ## patient(s)** at this hospital whose information we will review. We are requesting the medical records for patients diagnosed with the following ICD 9 codes: 042 and V08. We would also like to review medical records for children born to women with the previously mentioned ICD 9 codes. In order to properly and completely fill out the data collection forms, we will review the following sections of the medical record (as available): demographic face sheet, physician progress notes, history and physical notes, physician consultation notes, social work notes, discharge summary, death summary, medication administration records and laboratory reports including pathology, radiology and reference laboratory reports. For mothers and their respective infants, we will review the prenatal record, obstetric admissions record, newborn record, birth certificate and labor and delivery summary in addition to those records aforementioned. All information obtained is kept strictly confidential.

When they ask you for the list of patients you would like to review, please provide them with the following information. (Please note: date of service is usually the date of collection for the diagnosing lab)

The patient's name, date of birth, and date of service are _____.

I would like to visit your facility to conduct the medical chart abstraction on **[Date]**. For future abstractions, how far in advance would you like for me to call and request charts for abstraction?

I will be calling next week to confirm our visit on **[Agreed Date]**. Thank you for your time and assistance.

Only use if they question your authority to receive these records. For questions related to your request/authority mention the following:

The Texas Health and Safety Code 81.061 authorizes DSHS to investigate the existence of communicable disease in the state to determine the nature and extent of the disease and to formulate and evaluate the control measures used to protect the public health. *Hospital and other entities* shall provide records and other information to the department on request according to the department's written instructions.

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES**

KIRK S. COLE
INTERIM COMMISSIONER

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx.us

April 17, 2015

BSA Health System
1600 Wallace Blvd
Amarillo, TX 79106

ATTN: Sherri Richardson

An authorized representative of the Texas Department of State Health Services in accordance with the Texas Health and Safety Code §81.061 will visit your facility on the dates listed below to review medical records for required epidemiological data collection on a reportable communicable disease.

We are requesting the medical records for patients diagnosed with the following ICD 9 codes: 042 and V08. We would also like to review medical records for children born to women with the previously mentioned ICD 9 codes. In order to properly and completely fill out the data collection forms, we will review the following sections of the medical record (as available): demographic face sheet, physician progress notes, history and physical notes, physician consultation notes, social work notes, discharge summary, death summary, medication administration records and laboratory reports including pathology, radiology and reference laboratory reports. For mothers and their respective infants, we will review the prenatal record, obstetric admissions record, newborn record, birth certificate and labor and delivery summary in addition to those records aforementioned. All information obtained is kept strictly confidential.

Kacey Russell will visit your facility on Wednesday, May 13, 2015. You may contact Kacey Russell at 512-533-3040 or via e-mail at kacey.russell@dshs.state.tx.us

Please confirm that the address listed below is the appropriate location to perform medical chart reviews. In addition, please confirm that charts will be available for review on Wednesday, May 13, 2015.

BSA Health System
1600 Wallace Blvd
Amarillo, TX 79106

If there are any instructions that should be provided before arrival, please notify Kacey Russell of these instructions as soon as possible. Upon arrival, if a person should be contacted to begin record abstractions, please provide Kacey with the respective point of contact information. Thank you for your time and cooperation, your assistance is truly appreciated.

Miranda Fanning, MPH
Texas Department of State Health Services
Phone: (512) 533 3054
miranda.fanning@dshs.state.tx.us

An Equal Opportunity Employer and Provider

Appendix H Special Instructions for Circumstances Where Medical Record Abstraction Not Able to Be Completed

There are circumstances when a medical record abstraction cannot be completed because the testing/treatment facility does not allow access to surveillance staff or does not retain patient information. In these circumstances, all other available data sources must be evaluated. In the event that no other data is available for the patient, surveillance staff should proceed as follows:

- 1) Contact Central Office staff to provide information on the facility that will not allow access to medical records or does not retain patient records.
- 2) Complete a case report form from the lab information as follows:
 - a. Document Source: A05 (Laboratory)
 - b. Report Medium: Electronic
 - c. Surveillance Method: Follow up
 - d. Facility where information was obtained: Name of the testing/treatment facility
 - e. Complete all available information from laboratory report
 - f. Select "No" to Clinical Record Reviewed
 - g. In the comments section, clearly describe why a medical record could not be obtained

Note: This is the only circumstance when a lab report should be used to complete a case report form.

- 3) Retain case in a pending queue for additional follow up. Surveillance staff will need to routinely investigate data sources to identify and report any new information available for the case. In addition, surveillance staff will receive routine notification of missing case information from central office until all necessary information can be collected.

Disease Disposition 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 Venerium
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
901	HIV Previously Reported
950	AIDS

STD Disposition Codes

A	Preventive Treatment
B	Refused Preventive Treatment
C	Infected, Brought For Treatment
D	Infected, Not Treated
E	Previously Treated for This Infection
P	Not Infected
G	Insufficient Info to Begin Investigation
H	Unable to Locate
J	Located - Refused Examination/Treatment
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 Retested
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 /Testing
K	Out of Jurisdiction
L	Other

Partner Codes

P1	Sex Partner
P2	Needle Sharing Partner
P3	Both

Cluster Codes

S1	Suspect 1	A1	Associate 1
S2	Suspect 2	A2	Associate 2
S3	Suspect 3	A3	Associate 3

OOJ/ICCR

01	Partner
02	Cluster
03	Reactor

Type Interview

O	Original
R	Re-interview
C	Cluster
P	Post-test counseling
U	Unable to Ix (but partners initiated)

Appendix O Procedures for requesting eHARS new users and terminations

New user accounts

When a supervisor wants to add a new eHARS user, he/she should complete a Request for eHARS Access form.

Instructions for completing the form:

Complete all fields as applicable

1. Date of Request;
2. Name of person requiring access;
3. Date of Security training (contact DSHS security officer to obtain security training);
4. Name of supervisor approving access;
5. Site location;
6. Type of access (view only, data entry, or administrator);
7. Duration of access (indefinite or limited); and
8. Access Termination date (*only if known).

Once all necessary fields on the form have been completed, select the submit button to transmit the request for approval. Selecting submit will attach the form to an email addressed to me that can be immediately sent. The supervisor and user will be notified once the account has been added.

Glossary:

- “View only” access will allow users to record search cases and see the entire cases’ record, but not enter data.
- “Data entry” will allow the user to record search cases and enter data.
- “Administrative” should only be used in special circumstance and requires specific approval from central office.
- “Indefinite access” the access is granted until the staff leaves his/her position
- “Limited access” the staff is contracted and there is an actual termination date they will be able to function with their tasks as assigned but access will be terminated based on the termination date listed on the ehars request form.

Account Terminations

All account terminations must be requested at least **24 hours** after determining that a staff member should no longer have account access. To request an account termination, the supervisor should send an email with the below information:

- User name
- Date of account termination
- Reason for account termination

Appendix O Procedures for requesting eHARS new users and terminations

This email should be sent to the following email accounts the Data Reporting Manager and the eHARS Database Manager.

Please see below of a sample completed eHARS request form.

Request for eHARS Access

Date:	<input type="text" value="03/24/2015"/>	Date of Security Training:	<input type="text" value="03/20/2015"/>
Name of Person Needing Access:	<input type="text" value="Adam Smith"/>	Site:	<input type="text" value="Central Office"/>
Supervisor Approving Access:	<input type="text" value="Lili Blue"/>		
Type of Access:	<input type="text" value="Data Entry"/>		
Duration of Access:	<input type="text" value="Indefinite"/>	Access Termination Date:	<input type="text"/>

Request for eHARS Access

Date:

Date of Security
Training:

Name of Person Needing Access:

Supervisor Approving Access:

Site:

Type of Access:

Duration of Access:

Access Termination Date:

For Central Office Use Only

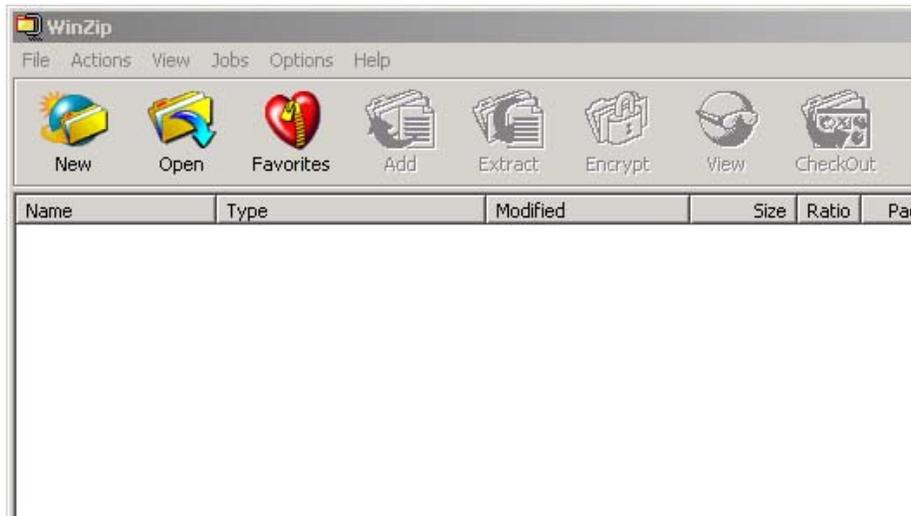
Approved by: _____

It is exceedingly important to ensure that all data is encrypted and sent to Central Office through secure mediums (See Chapter 7 for more information on security requirements). The following sections describe how to zip, encrypt, unzip and decrypt files using WinZip and how to use the TxPHIN web portal to safely transfer data to Central Office.

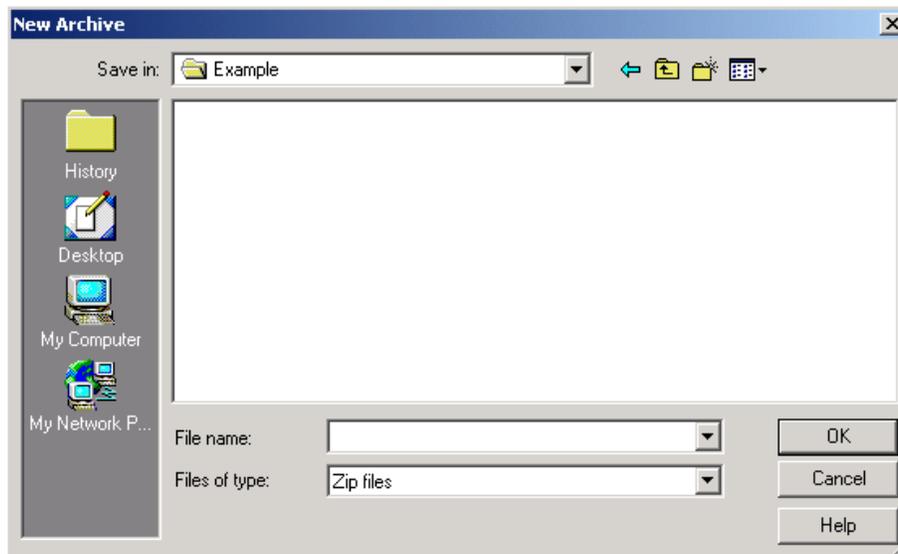
Using WinZip to compress files

Winzip is a tool to make working with Zip files and other types of archive files easier. Archives are files that contain other files, and Zip files are the most common format. The files in an archive are compressed. Winzip uses the term “Add” to mean “compress files and add them to an archive”.

- 1) Click on Winzip Icon to Open

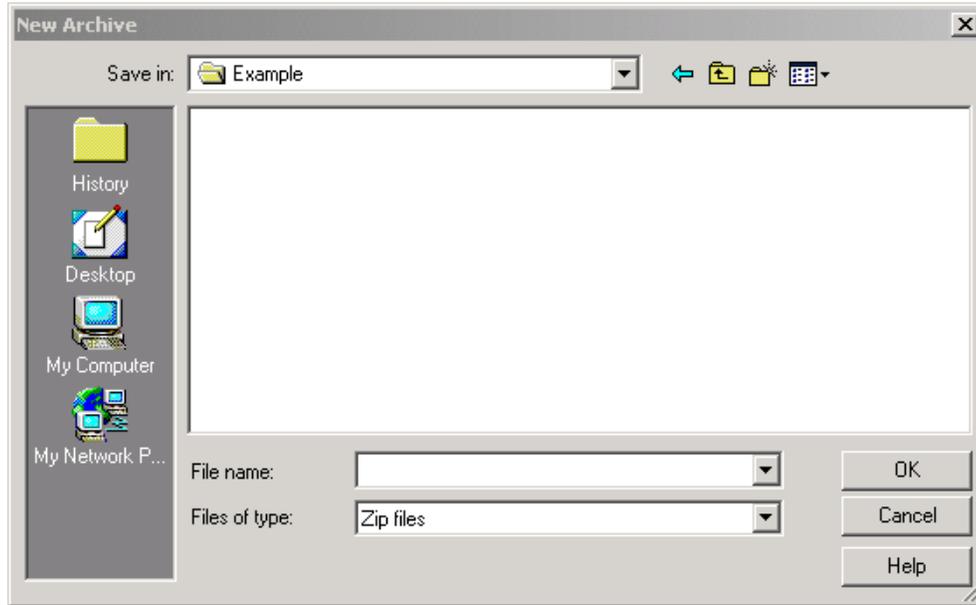


- 2) Go to Menu Bar and *select File*
- 3) In the pull-down menu, *select New Archive* (see screen below)

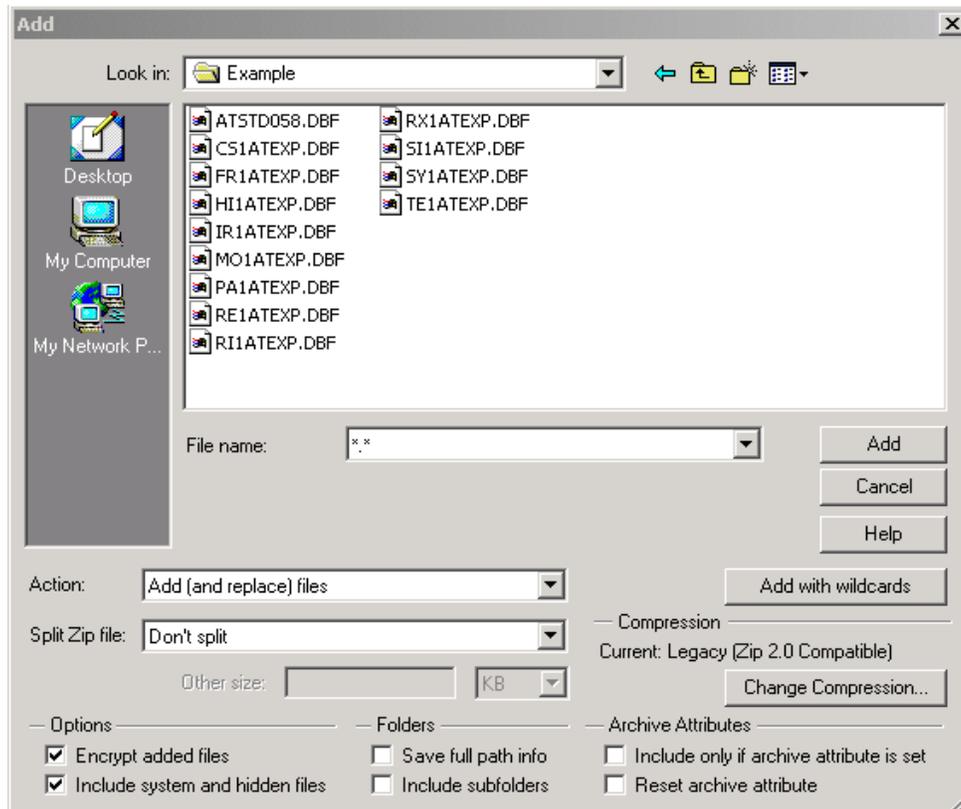


- 4) In the File name: box, type the name of the archive/zip file you want to create. *Do not enter the names of the files you want to compress/zip.*

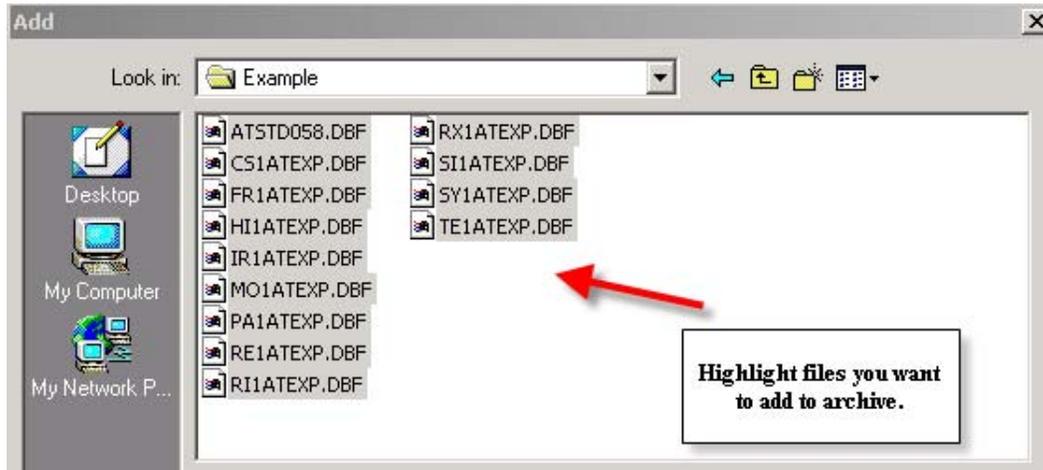
- 5) In the Save in: box, choose the drive and folder where the archive/zip file will be created.
(see screen below)



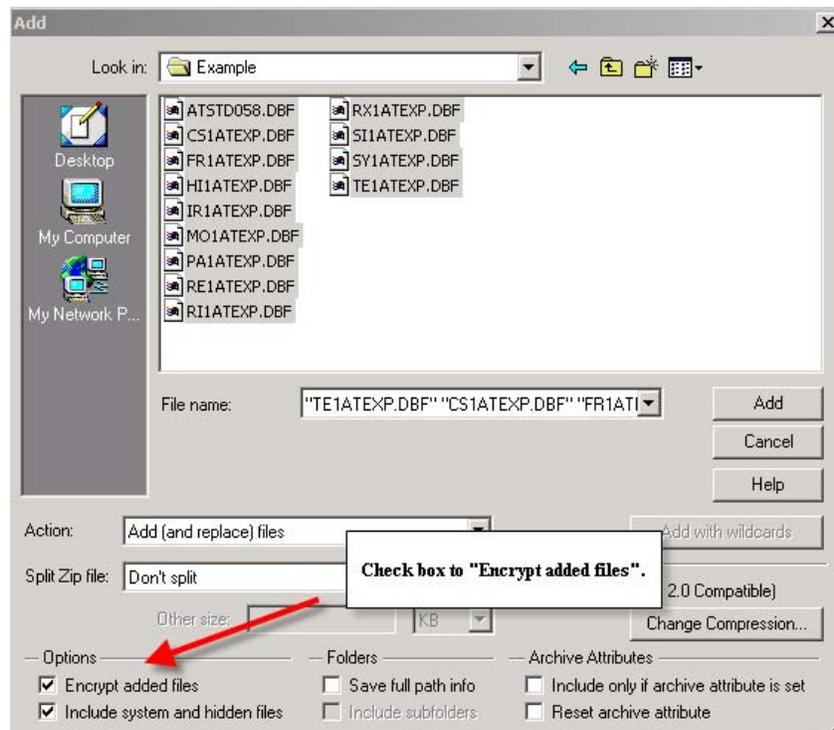
- 6) In the Files of type: box, *select* Zip files
 7) Next, *click* the OK box to go to the *Add window*
 8) You should now see the **Add window** (see screen below)



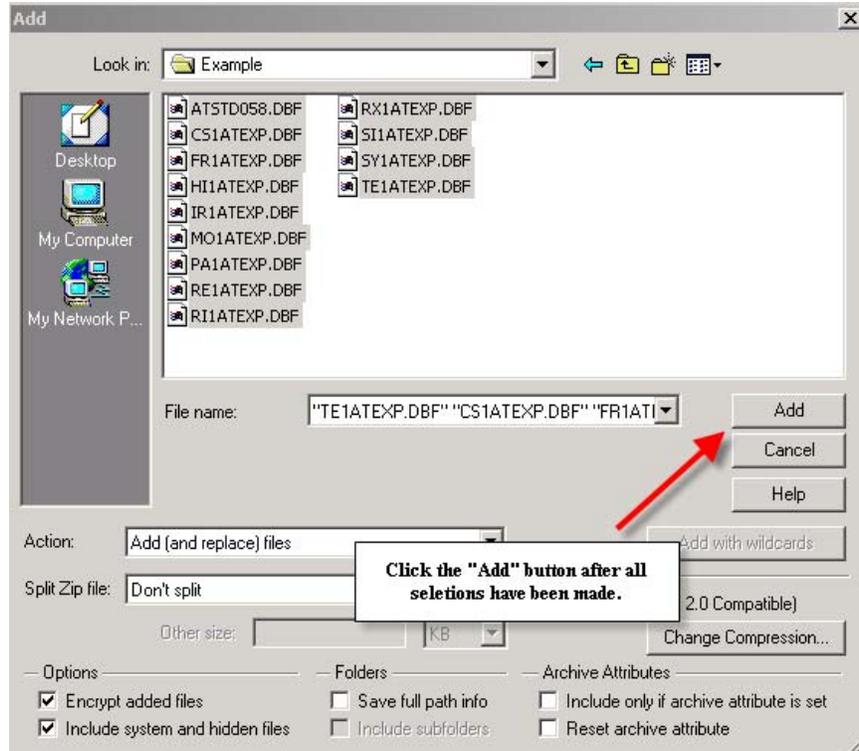
- 9) In Look in: box, select drive and folder where the files are located you want to add to the zip file.
- 10) In the Add window, *select* the files by highlighting the ones you would like to add to the archive file. (see screen below)



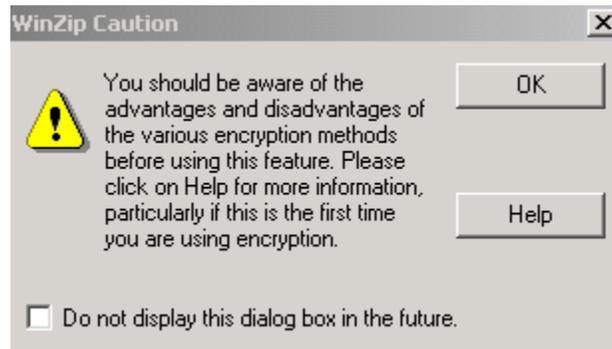
- 11) In Options, located in the bottom left corner of Add window, check Encrypt added files box.



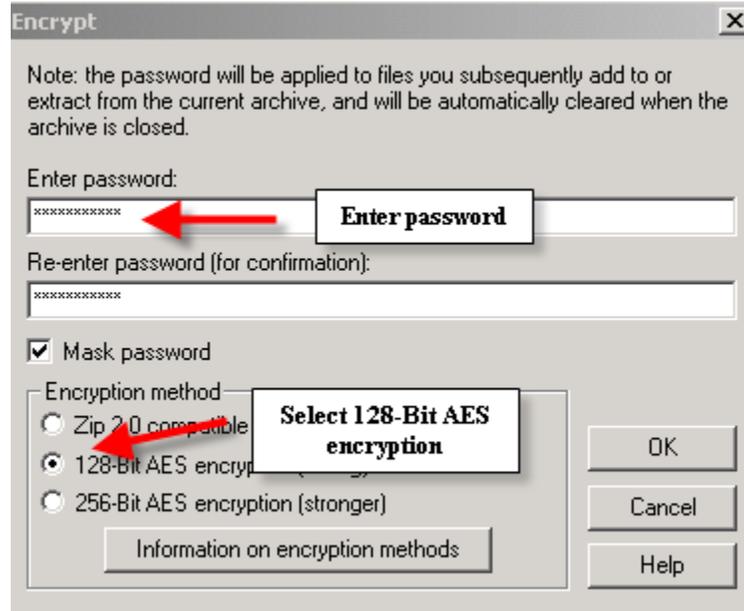
12) *Click* the Add button after all selections have been made.



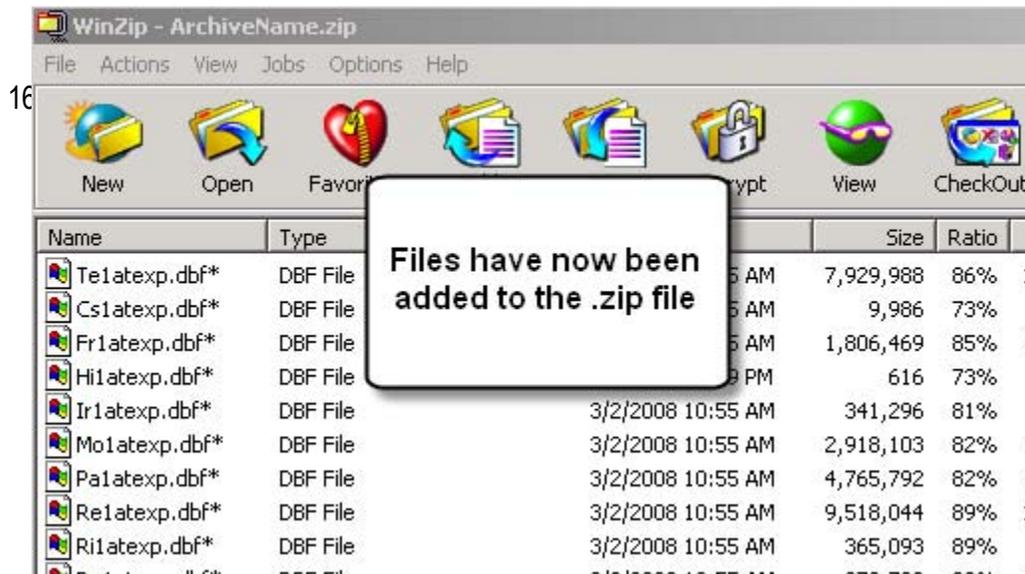
13) You will now see the screen below, *click* OK.



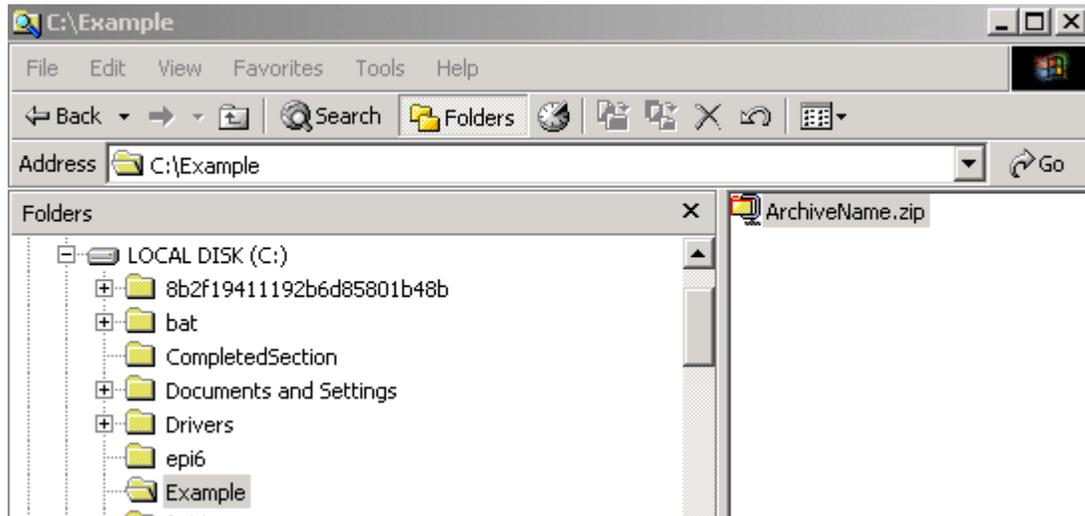
14) Enter password for the ****.zip file, see screen below.



15) Click OK button



- 16) Go to where you specified the new archive/zip file to be created. You should now see the .zip file listed. *See example screen below.*



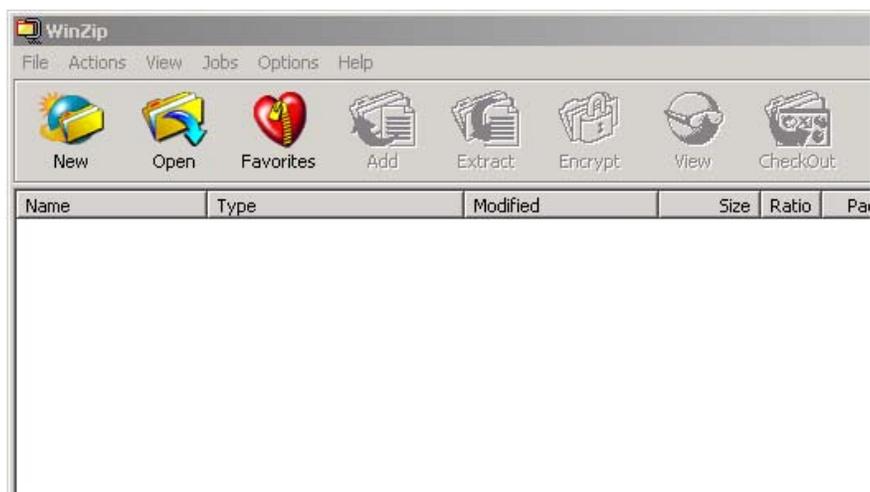
- 17) You are now ready to upload the .zip file via TxPHIN.

You have now compressed files into a new archive using Winzip. There are other ways to compress files into a new archive. For introductory information, please see the section [Brief Tutorial – Creating New Archives](#) in Winzip “Help”.

Using WinZip to extract files

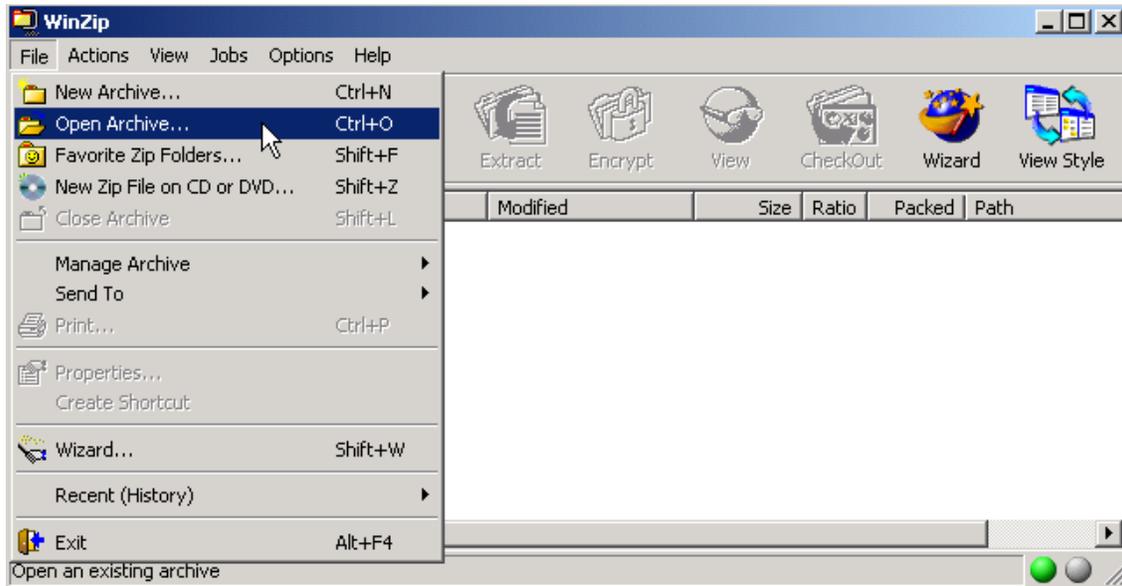
Winzip is a tool to make working with Zip files and other types of archive files easier. Archives are files that contain other files, and Zip files are the most common format. The files in an archive are compressed. Winzip uses the term “Extract” means “decompress files in an archive, creating separate files on a disk or folder”.

- 18) Click on Winzip Icon to Open



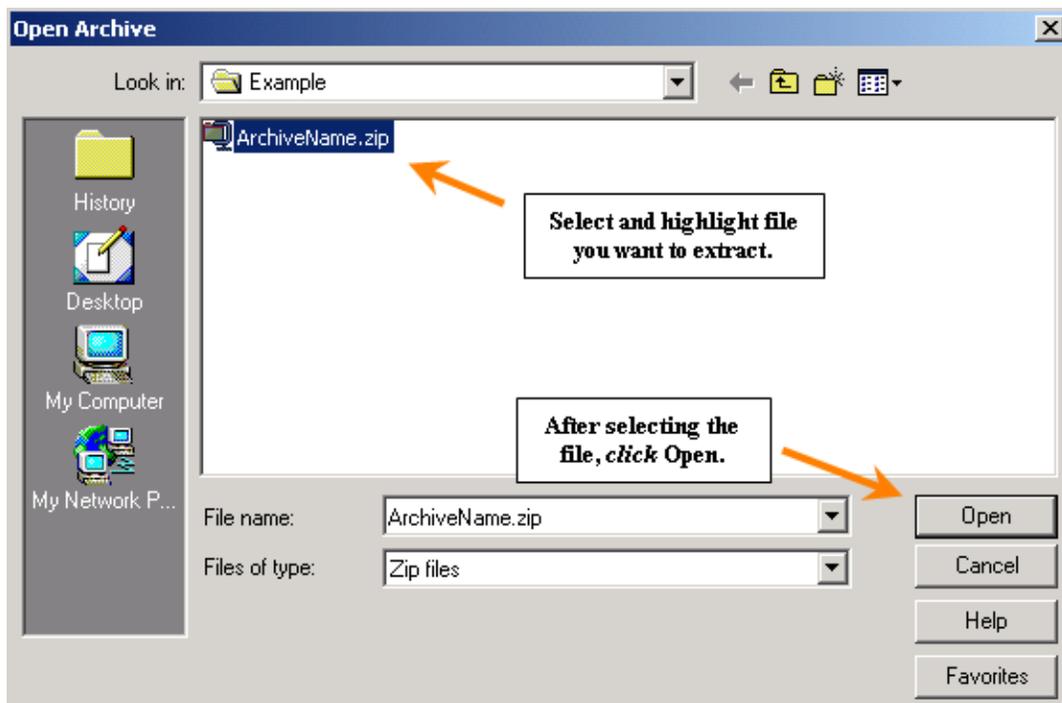
19) Go to Menu Bar and *select* File

20) In the pull-down menu, *select* Open Archive (see screen below)

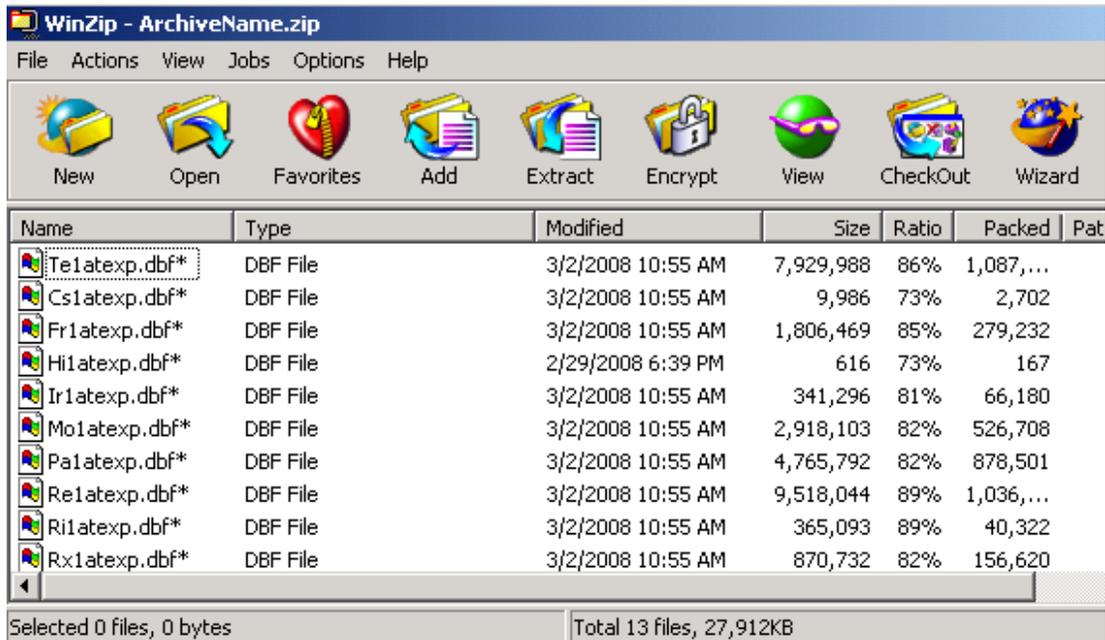


21) In the Look in: box, browse to find the compressed file (.zip) you wish to extract. Select and highlight the #####.zip file. (See screen below)

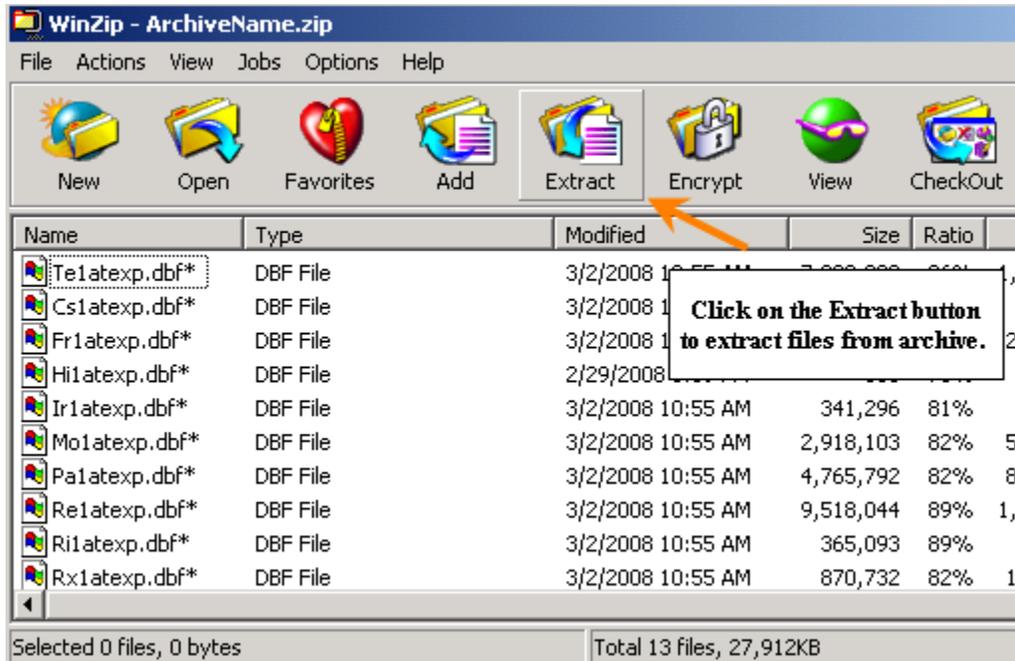
22) *Click* Open. (See screen below)



23) After you open the ****.zip file. Winzip will list the compressed files in the ****.zip file. (see screen below)

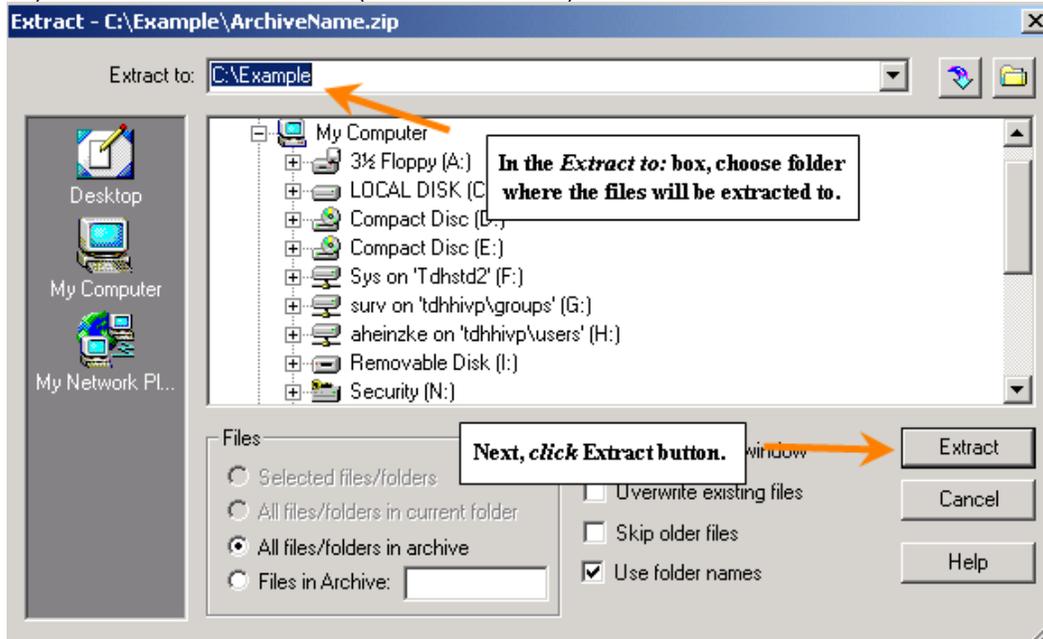


24) Next, click the “Extract” button to extract the files from the archive (see screen below)

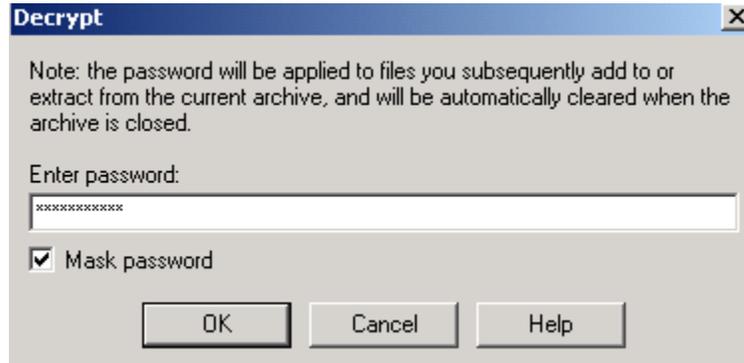


25) In the Extract to: box, choose folder or location to extract the files too.

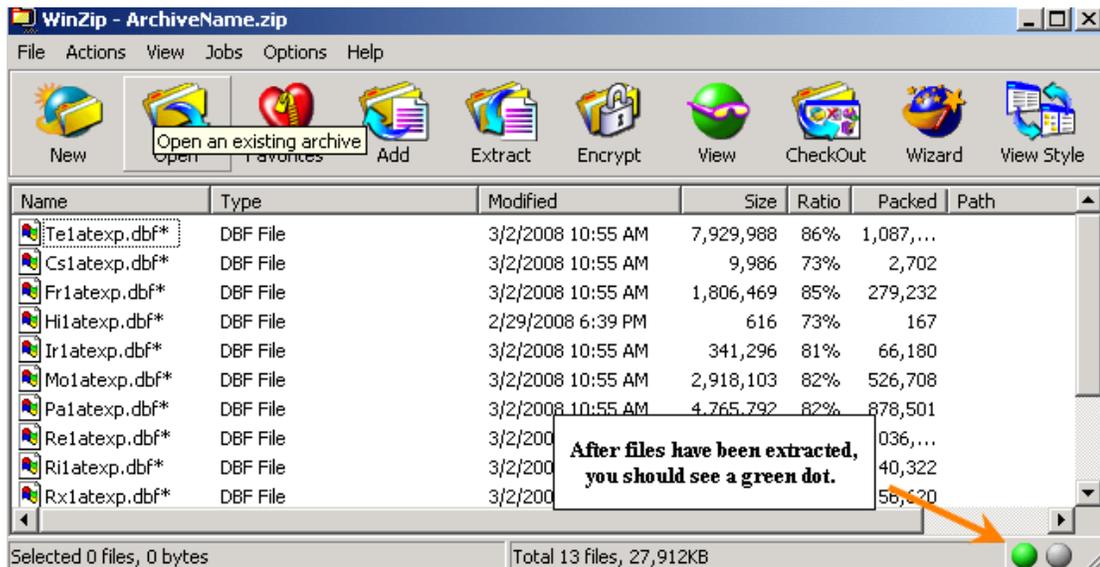
26) Next, *click* Extract button. (see screen below)



- 27) Enter password, if archive file is encrypted.
 28) Next, *click* OK. (see screen below)

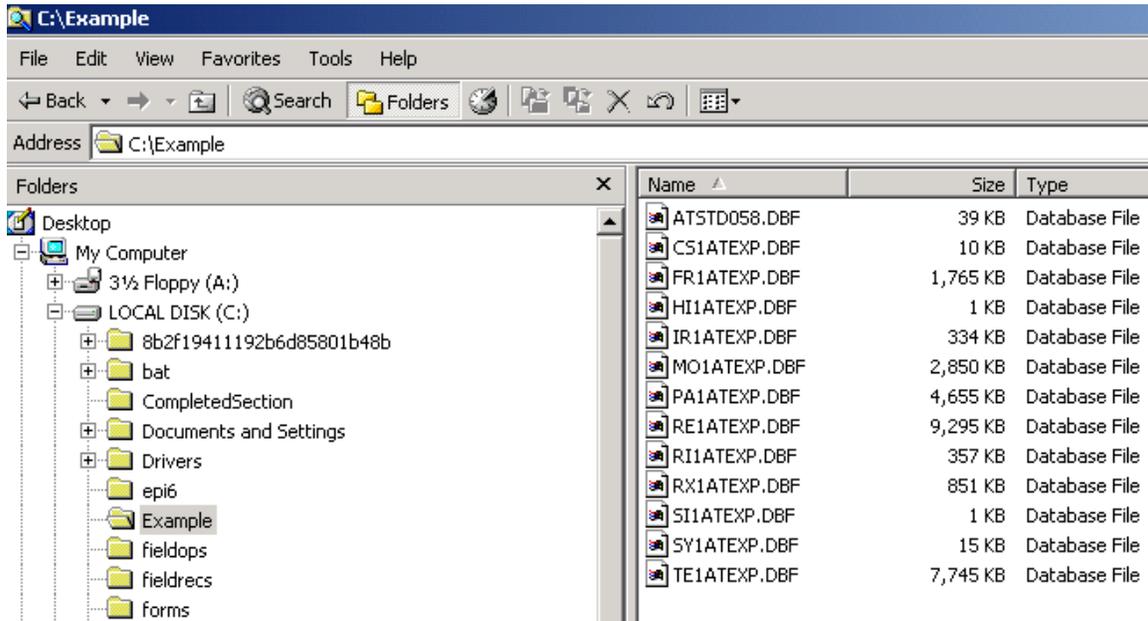


- 29) After files have been extracted, you should see a green dot at the bottom of the Winzip window. This indicates that the extraction process is complete. (See screen below)



- 30) All files should now be extracted to the location you specified.

- 31) Goto Windows Explorer and choose the specified folder. You should see the extracted files listed. (See screen below)



You have now extracted data from a compressed file using Winzip. There are other ways to extract files from an archive. For introductory information, please see the section [Brief Tutorial – Extracting Files](#) in Winzip “Help