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NEW JERSEY (STATE) DEPARTMENT OF HEALTH .

MANUAL OF PROCEDURES : *public health, disease control and constructive health* ,

GROUP I

Alcoholism Control

Cancer Control

Cardiovascular Disease Control

Chronic Disease Control

Communicable Disease

Convulsive Disorders

Crippled Children

Dental Health

Diabetes Control

Migrant Health

Tuberculosis Control

Venereal Disease Control

GROUP II

Nutrition

Public Health Nursing

Public Health Social Work

GROUP III

Maternal & Child Health

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NEW JERSEY STATE DEPARTMENT OF HEALTH

ALCOHOLISM CONTROL

Alcoholism Control Services in New Jersey Hospitals

The treatment of alcoholics in the out-patient department of selected hospitals is an activity established as part of the Alcoholism Control Program in collaboration with hospitals.

The activity is regarded and conducted as an integrated part of the out-patient department of the hospital. The Department supports in part the costs of the project through a grant-in-aid to the hospital and acts as a consultant and advisor to the project in cooperation with the administration and medical department of the hospital. Here ambulatory patients receive social casework, medical treatment and psychiatric help. The above arrangement remains in effect until abrogated by mutual consent, or the responsibility for the maintenance and continuance of the clinic is assumed by the hospital.

To the incipient alcoholic to whom alcoholism suggests a disagreeable connotation, the clinic may provide the open door through which such persons may seek guidance, treatment and advice before alcoholism to them becomes a primary affliction. Treating the incipient alcoholic must be considered in the field of preventive medicine, and if we are to combat the disease of alcoholism successfully, it is to this type patient, our greatest efforts must be directed.

In going to the clinic, the problem drinker is treated in an integrated service of the hospital which implies the acceptance of alcoholism as a disease. For study, the clinic will provide an excellent source of material for research, investigation, and the treatment of physical, emotional disorders generally associated with the prolonged excessive use of alcohol.

The inability of some patients to use other forms of therapy calls for the development of a clinic discussion group. The candidates for this discussion group will be selected by the clinic personnel.

After a reasonable period of time, the clinic approach to the problem of alcoholism should be evaluated by a study of the case records. A determination of the results should establish whether or not such a treatment facility warrants continuation as a service to the problem drinker and the community. If the findings are favorable, the facility should be accepted by the hospital as a part of its regular services to the community, assuming at the same time, financial responsibility for its continued support.

As a sick person, the alcoholic patient should be treated with the same consideration and respect as other sick persons who go to the out-patient department to be treated for their afflictions. They should not be subjected to situations that tend to isolate or magnify their problem, but

should be treated with complete objectivity, yet with singular understanding and perception of their problem.

The same policy, rules and regulations governing admissions to the out-patient department should be made applicable to patients seeking treatment in the Alcoholism Clinic.

The same policy with regard to the payment of fees by patients for medical and other services provided in the various clinics should be observed and applied to patients receiving medical attention in the alcoholism clinic.

As a matter of good public health practice, it is recommended that all patients who are accepted for treatment receive a blood serology and chest x-ray.

The payment of a fee by the Alcoholism Clinic patient establishes within him a responsibility for his own illness and the need for contributing toward his recovery. Such payments should be encouraged, for it is most important to the successful treatment of alcoholics that they be made aware of their personal responsibilities. It is one way of helping them achieve lasting sobriety.

All referrals to the alcoholism clinic should be by appointment. The only requirement for admission to the clinic should be an honest desire on the part of the patient to be helped.

Even though the needs for the more seriously deteriorated alcoholic are recognized, it is suggested that the facilities of the alcoholism clinic be geared primarily to the incipient alcoholic. Efforts should be directed through education and by personal contacts to alert industry to the facilities available in the clinic for assisting employees with a drinking problem who are willing to be treated.

Group Education Meetings

Conducting group meetings for alcoholics who are confined in hospitals for care and treatment of long term illnesses is an activity of the Alcoholism Control Program.

Once a week a representative of the program meets with individuals who have been selected by the physicians of the hospital staff as those with a drinking problem. Attendance at these meetings is considered to be a part of the treatment program while the patients are in the hospital or until such time the staff feels the meetings are no longer necessary.

There are five tuberculosis hospitals participating in this activity at the present time, namely: Roosevelt Hospital, Metuchen; Bonnie Burn Sanatorium, Scotch Plains; Allenwood Sanatorium, Allenwood; Camden County Hospital for Chest Diseases, Lakeland; and Donnelly Memorial Hospital, Trenton.

The field representative of this Program also conducts group meetings weekly at the Middlesex County Workhouse.

Intra-departmental Activities

Departmental personnel should be properly informed on the many problems that are created by the excessive use of alcohol. This is necessary because the use of beverage alcohol is a very controversial subject and many individual attitudes, emotionally rooted, result in bias and prejudice.

Working jointly with the PC, the Districts will:

1. Interpret the objectives of the Alcoholism Program when the opportunity arises.
2. Assess the potential for the development of out-patient clinics or group education meetings.
3. Participate in development of projects.
4. Assist in recruiting personnel for alcoholism treatment facilities.
5. Act as a resource to the alcoholism clinics.
6. Act as an information and referral center for alcoholism treatment facilities.
7. Stimulate the dissemination of information and use of educational material such as pamphlets, films, exhibits; and promote the use of the speakers bureau for meetings of community organizations.
8. Stimulate and participate in the planning and development of meetings and institutes and workshops.
9. Recommend suitable persons in the community to attend the Yale Summer School of Alcohol Studies.
10. Will promote a free flow of pertinent information between the District office and the PC.
11. Prevent the duplication of efforts and costs, and foster better community understanding and support of the Program.

NEW JERSEY STATE DEPARTMENT OF HEALTH

CANCER CONTROL

The program is carried out by the following procedures.

- A. Selection of Hospital or Hospitals for Programs
 1. Criteria for selection of a hospital
 - a. Patient cancer load
 - b. Existing facilities for cancer work
 - c. Tumor board activities
 - d. Calibre of staff -- professional and non-professional
 2. Criteria for evaluation of geographical needs in the State
 - a. Concentration of population
 - b. Facilities in the area already existing for cancer work
 - c. Availability of space for special projects in the hospital of the area under consideration
 3. Criteria for evaluation of the overall cancer problem in the State
 - a. Mortality rates for the State as compared with other states
 - b. Mortality rates of each year as compared with other years
 - c. Morbidity rates for the State as compared with other states
 - d. Morbidity rates for the State as compared with other years
 - e. Facilities for cancer diagnosis and treatment in various parts of the State compared with mortality and morbidity rates
- B. Training Programs
 1. In hospitals
 - a. Professional
 - (1) placed in selected hospital
 - (2) possibility of clinical demonstrations
 - (3) one day hospital cancer seminars
 - b. Paramedical
 - (1) selection of individual to participate
 - (2) evaluation of training so given by:
 - (a) written examinations
 - (b) practical examinations
 - c. Nurses Training
 - (1) full day in-service training

2. Outside hospitals

- a. Oncology courses
- b. Fellowships for doctors and nurses
- c. Cooperation with the New Jersey Division of the American Cancer Society to supply one or more speakers at the Annual Cancer Symposium given by the New Jersey Division.

3. Public education

- a. Lectures with physician speakers in department stores, churches and schools on cancer
- b. Articles in the press
- c. Film programs
- d. Radio and television programs

C. Procedures for Setting these Activities in Motion are the following:

- 1. Selection of a hospital is made using the criteria set down on Page 1.
- 2. Geographical need is also determined.
- 3. A long period of preliminary study is made of the hospital, of the facilities available, for a particular project.
- 4. During the preliminary study of the hospital and staff, some measure of the administration of the hospital is gained, as well as some of the problems that confront the hospital. It is in the light of this that the project planned for the hospital is either negotiated or set aside until conditions in the hospital seem more favorable to conducting such a project.

This preliminary period of study can take anywhere from 6 months to a year, before a definite project is started in a selected hospital.

The project is written up for approval of the Commissioner and the Divisional Director and often an accompanying letter for approval of expenditures of Federal funds from the United States Public Health Service, Region II.

Negotiations start at the hospital with the administrator and the doctors to be incorporated into the project.

When agreement is reached, the following methods are used: a grant-in-aid of monies is made to the hospital for use on the project.
(see grant-in-aid program details)

Example I. Pollak Hospital Contract

This program is primarily a pulmonary exfoliative cytological diagnostic program with screening services to be rendered when necessary, and in-

cluded as part of this study a palliative chemotherapeutic study for clinical investigation for terminal cases of lung cancer.

- a. A medical coordinator with definite experience in cytology and cancer is required who will coordinate and supervise all the details of such a faceted program.
- b. A training program in the special techniques used in this project is also to be started here and supervised by the medical coordinator.
- c. The requirement for technicians to participate in this program are specified as are the physicians'.

Example II. Presbyterian Hospital Contract

This particular hospital program so far is concerned with two specific facets of cancer: 1, cytology - including training; and 2, the development of a biophysics department, which works closely with the isotope laboratory, radiology department, and deep x-ray therapy department.

The contract contains all the necessary and specific requirements for establishing an approved cytology service, which includes the training of technicians, and physicians in all the techniques now used in this field, and in the more varied new applications of cytology as these are made available for scientific purposes.

The personnel requirements of the coordinator are specified in the contract as well as those of the other technicians.

Special medical technologist services are outlined in detail in the contract. This requires a hospital physicist, who has been especially trained in the application of physics to clinical cancer problems, in isotopes, diagnostic, x-rays and deep x-ray therapy; also included in the services of this technologist in the hospital is the supervision of the Radiological Health and Monitoring Programs outlined in the contract and the training of isotope and deep x-ray therapy technicians, as the direction and development of the biophysics department. The personnel requirements are specified in the contract.

- D. The State Health Districts are in a Position to Augment the Activities of the Cancer Program
 1. The District office cooperates in the dissemination of educational material, stimulates the use of films, speakers, exhibits for organized meetings, and acts as an information center in the area of its jurisdiction.
 2. The District office working closely with the PC of the Cancer Program in any mass screening project, when such a program is undertaken, performs the following services:
 - a. Organizes the local community plan of action for a mass screening program.

- b. Keeps records of the data and forwards this to the Cancer Program office for study and analysis by the cancer statistician in the Statistics Program.
 - c. Organizes with the PC of the Cancer Program and other voluntary organizations cooperating with the State in carrying out the follow-up devised and necessary to collect this statistical data from such a survey.
3. There will be a reciprocal exchange of information between the districts and the PC of the Cancer Program of a general nature and for specific activities in the district on the subject of cancer.
 4. Promote further development and integration of community supported essential comprehensive services.
 - a. Public Health Nursing for the cancer patient is based on the total needs of the patient and family and is directed toward case findings, prevention and rehabilitation.
 - b. Medical Social Services
Effective medical social service begins at the point of diagnosis. Its aim is to help individuals with cancer to understand the disease and to motivate them to make maximum use of medical care so as to realize fuller possible physical and social recovery.

E. Promotion of Cancer Research

1. Specific problems that have Public Health significance are discussed with the doctors who might be interested in such a research project.
2. The project is usually set up so that services to patients as well as research are the consequences of such an arrangement.
3. Protocol is written in conjunction with the doctor in charge of the project.
4. A grant-in-aid of monies is then made to the hospital for personnel required to carry out the project.
5. Loan agreements for equipment needed by the hospital for carrying out this project.
6. Program Coordinator attends staff meetings reviewing data correlated on a periodic basis, monthly or quarterly.
7. The data correlated is analysed by the department cancer statistician.
8. Publicity will be by Department of Health in a Medical Journal with proper credits for those who participated.

NEW JERSEY STATE DEPARTMENT OF HEALTH

CARDIOVASCULAR DISEASE CONTROL

A. PROMOTE DEVELOPMENT AND EXPANSION OF COMMUNITY RESOURCES FOR
CARDIOVASCULAR DISEASE

1. Assist in Development of Diagnostic Facilities in Community Hospitals

"The Recommended Standards and Minimum Requirements for a Cardiovascular Clinic" prepared by the Committee on Cardiovascular Clinics of the American Heart Association, and approved by the Board of Directors of the American Heart Association in December, 1949, is the reference used for guiding the development of community cardiovascular clinics. Community facilities are stimulated to reach these standards through loan of equipment and grant-in-aid for specialized personnel. The recipient facilities are selected for support by:

- a. Willingness to cooperate in development of a cardiovascular clinic.
- b. Necessity for development of such a facility on basis of regional need.

2. Expand Case-Finding Facilities

a. Mass Chest X-Ray Screening

- (1) Routine 70 mm. chest-screening film is reported for suspected cardiovascular pathology.
- (2) Findings are then forwarded to the patient's physician and, simultaneously, notice is sent to the patient suggesting that he report to his physician for a medical check-up.
- (3) The physician reports back via provided form indicating:
 - (a) If patient reported;
 - (b) If further examinations were accomplished;
 - (c) What diagnosis was made;
 - (d) If diagnosis was previously unknown.
- (4) Statistical and epidemiological data are then compiled in this office.

b. Multiphasic Screening in Hospital Centers

Routine 70 mm. chest-screening film is reported for suspected cardiovascular pathology.

34 Cooperate in Development of State-Wide Rheumatic Fever Prophylaxis Program

The plan is to stimulate the use of prophylactic medication in accordance with the recommendations of the American Heart Association by all the afflicted persons in the State of New Jersey; and to make medication available at reduced rates to those whose limited financial capacity would be further impaired by the cost of the drugs.

To achieve this goal, it is recommended that a central rheumatic fever file be established where all responsible authorities may enroll rheumatic fever patients. "Responsible authority" refers to physician, heart clinic, or hospital medical clinic. This, in effect, would place the management of the majority of patients in the hands of the family physician without the mandatory need for referral to a cardiac clinic, and would consequently reach a far greater number of patients than possible under existing conditions. The registration of the patient would entitle him to purchase prophylactic medication at suitable intervals for administration and follow-up. Such an overall plan would require the sponsorship, endorsement, and participation of the Medical Society of New Jersey, the New Jersey Heart Association, State Department of Health, State Pharmaceutical Society, County Medical Societies, County Heart Associations, County Pharmaceutical Societies, local boards of health, and individual physicians and pharmacists.

The purpose of a centralized file operated by the New Jersey Heart Association would be:

- a. To arrange for delivery of prophylactic medication to the patient via the pharmacies throughout the State.
- b. To compile a regional listing of all paramedical services available to the responsible authority for help in management of the patient. This list includes social work agencies, work-classification units, public health nurse services, homemaker services, convalescent homes, visiting teachers, camps, cardiac diagnostic centers, cardiac surgery centers.
- c. To offer these services to the responsible authority in the form of a (✓) check follow-up card at periodic intervals and then to channel the requests to the proper agency who will report directly to the responsible authority.
- d. To stimulate the formation of the necessary services in the areas where they are lacking by bringing the need for these services to the attention of the existing agencies. And to partition the services needed between the existing agencies to prevent duplication of work and effort.

The organization most suited for the development of this plan is the N. J. Heart Association, since it is already purchasing prophylactic medication. Moreover, the secondary operational units (County Heart Associations) form the basis for a distribution and information-gathering system. The procedure of drug distribution might be patterned after that employed by the Connecticut Heart Association. In addition, the existing cardiac clinics may continue to distribute free prophylactic penicillin to indigent persons under framework of this new system.

The role of the State Department of Health would be:

- a. To cooperate in every way possible with the services offered by our existing agencies.
 - b. To serve on an advisory council with other interested parties concerned with the development of a rheumatic fever prophylaxis program.
 - c. To offer consultation services towards expanding and modifying the scope of the Heart Association program, when these services are requested.
4. Promote Continuity of Care Services (See General Section)
 5. Develop a Diet Service for Physicians
 - a. Diet lists will be prepared with the cooperation of available nutritionists, and approved by the Medical Society of the State of New Jersey.
 - b. Physicians will be canvassed for requests for diet list pads.
 - c. Diet list pads will be distributed to physicians upon their request.
 - d. At suitable intervals reaction of physicians will be sought by form letter.

B. PROVIDE SERVICES FOR SPECIAL NEEDS

Due to the inherent nature of this objective there are many ways of proceeding, since most activities, though encouraged and stimulated by the Program, are planned and carried through by community facilities. Criteria for selection of a hospital include patient caseload, existing facilities and availability of space, calibre of staff -- medical and paramedical. Criteria in evaluation of geographical needs in State include concentration of population, existing facilities in area, availability of space for special projects in the hospital under consideration.

Procedures for setting these activities in motion are the following:

1. Selection of a hospital is made using the above criteria.
2. Geographical need is also determined.
3. A long period of preliminary study is made of the hospital, of the facilities available, for a particular project.
4. During the preliminary study of the hospital and staff, some measure of the administration of the hospital is gained, as well as some of the problems that confront the hospital. It is in the light of this that the project planned for the hospital is either negotiated or set aside until conditions in the hospital seem more favorable to conducting such a project.

This preliminary period of study can take anywhere from 6 months to a year, before a definite project is started in a selected hospital.

The project is written up for approval of the Commissioner and the Divisional Director and often an accompanying letter for approval of expenditures of Federal funds from the United States Public Health Service, Region II.

Negotiations start at the hospital with the administrator and the doctors to be incorporated into the project.

5. When agreement is reached, the following methods are used: A grant-in-aid of monies is made to the hospital for use on the project.

If equipment is to be part of the Department of Health contribution to the project then an equipment loan agreement is written for the named equipment.

Grant-in-aid of monies are only given for a limited time, usually about five years, with plans that each year the hospital can amortize a certain amount of the monies. However, this has to be flexible as it is not always possible to obtain 100% return on a project within 5 years.

C. STIMULATE RESEARCH ACTIVITIES

1. Requests are submitted including protocol of proposed research activity.
2. Evaluation of project is performed by P.C.
3. Help is provided in the form of equipment and grant-in-aid for personnel based upon merit of project, the ability of the facility to carry out the project, and the availability of funds.

NEW JERSEY STATE DEPARTMENT OF HEALTH

CHRONIC DISEASE CONTROL

The family physician and the community hospital or health institution, serve as the main avenues from which evidence of need may be obtained, and through whom assistance of many types may be given. The Chronic Disease Control Program collaborates at every level -- from exploration of a need, through formulation of an idea into a plan and procedure, and actual application to the individual -- and assists communities in better utilization and expansion of their health and general welfare resources.

A. GUIDE FOR SPECIFIC APPLICATION OF DETECTION AND DIAGNOSTIC SERVICES

1. Selective Screening

To promote the earlier detection of incipient chronic illness, multiphasic screening programs in selected hospitals are developed or expanded and made available for in-patient, out-patient and hospital personnel. Chest x-ray apparatus and other diagnostic equipment and supplies needed for screening procedures are jointly purchased by participating programs and loaned to these hospitals on a contract basis. Grants-in-aid of monies are given to the hospitals to assist them in providing training as indicated for personnel, and in payment of salaries of essential technical and clerical personnel to carry out the screening procedures. Assumption of financial responsibility within a specified time interval is implied.

Tests applicable on a mass screening basis are utilized to detect both clinical and preclinical cases of chronic diseases. Evaluation of the screening procedures as to administration, methodology, use of various types of equipment, accuracy and costs is made. Pilot studies are made so that low-cost, accurate screening tests are available to patients referred by hospital medical staff in demonstration hospital centers. After screening tests, the findings are referred to the patient's physician for his complete diagnostic evaluation and follow-up.

2. Diagnostic and Consultation Services in Community Hospitals

These may be accomplished by providing equipment and monies for personnel needed for establishing and maintaining consultation and diagnostic facilities after surveys and conferences with lay and professional personnel have determined suitable hospitals for this purpose. Projects included under these services are:

a. Arthritis

Plans are being explored to establish cooperatively evaluation centers for arthritis in selected hospitals in order to make accessible to all individuals in need of them, the latest

advances in the diagnosis and treatment of this category of diseases. This will be accomplished by grants-in-aid of monies to hospitals for necessary technical personnel or equipment to implement the program.

b. Hearing and Speech Disorders

Testing units to detect hearing loss and speech defects in pre-school and school children are functioning in four hospitals of the State. This is a cooperative effort of the medical societies, Department of Education and the State Department of Health under the direction of the staff of the Newark Eye and Ear Infirmary and other cooperating agencies.

c. Visual Disorders

Plans are being formulated to promote the early detection of incipient glaucoma through screening programs, by cooperation with all interested agencies such as the New Jersey State Commission for the Blind.

*d. Endocrine and Metabolic Dysfunctions

*e. Nutritional Dysfunctions

*f. Neuromuscular Disorders

*g. Problems of Aging

A plan for work in this service includes cooperative preparation and application of an attitude survey of a broad section of New Jersey citizens; utilization of an existing facility for research projects such as evaluation of drug effects and performance of and correlation of basic testing or screening devices; assistance in establishment of geriatrics clinics, for direct and educational services; and furtherance of application to the aged and pre-aged of social and restorative techniques and services, in their development.

*h. Gastrointestinal Disorders

*i. Collagen and Sensitivity Disorders

*j. Hematologic Disorders

*These categories of chronic diseases and related problems properly are within the province of study of this Division and plans are being formulated for projects to extend services in each of those areas contingent upon availability of personnel and funds.

B. RESEARCH SERVICES

The information received from the quarterly reports of the program activities is proper material for statistical and epidemiological study. In addition, specific projects and activities furnish their own research material and are so scrutinized and analyzed. Basic research studies, including attitude surveys, in the various categories of planned activities will be a directed endeavor wherever feasible and practical.

C. GUIDE FOR PROMOTION OF CONTINUITY OF CARE SERVICES

1. These services incorporate social worker, nursing, homemaker and other home care practices as integrated in the Chronic Disease Control Program and include home aspects of prevention, case-finding and treatment, and especially follow-up, so as to assure maximum patient use of available diagnostic and therapeutic facilities and physical restoration.
2. There are presently community homemaker services in operation and others are being developed. These services may enable certain patients to remain in their home environment under the care of a family physician, and also may serve to release hospital beds for the acutely ill.

D. GUIDE FOR INTERPRETIVE SERVICES

In this area a wide range of activities is explored and applied. Specific guides for these activities are discussed in Division conferences and assignments made.

E. GUIDE FOR PROMOTION OF RESTORATIVE SERVICES

1. In Community Hospitals

Restorative services are made available to both in and out-patients, starting with the premise that the rehabilitation process begins at the point of diagnosis. Full evaluation of the patient's potentials for physical and vocational restoration and a plan of treatment that will enable him to attain his optimal functional capacity is required. Both evaluation and planning are determined jointly by a group of specialists working together in a team relationship. This involves as a minimum, physician, nurse, medical-social worker, and vocational counsellor, but may also include physio-therapist, occupational therapist, speech therapist, psychologist, psychiatrist and others, depending on the patient's condition. Depending on facilities in the surrounding community, some of these services, notably the vocational counsellor, psychiatric, psychological and psychiatric services may be brought in from other agencies. Affiliations with other institutions and close working relationship with community agencies should be developed to assure the patient the wide variety of services he may require.

Rehabilitation services within the medical care program of the general hospital are an important aspect of secondary prevention. Residual disabilities following long-term illnesses are held in check and feelings of lethargy are avoided as the patient moves toward recovery and the full use of his capacities.

To help initiate such services in hospitals, grants-in-aid may be required for personnel for a demonstration period.

Placement of medical social workers and others in general hospitals with chronic illness diagnostic programs is a means of initiating rehabilitation services. A demonstration of such services is in operation at Somerset Hospital, Somerville.

2. In Chronic Disease Hospitals, Nursing and Custodial Homes

The objectives of restorative services in these institutions are somewhat modified in that the patients or residents have already experienced long-time disability, incapacity and dependency. Many of these may with skillful care be returned to remunerative employment; for many, the objective is to develop to the maximum their capacity for self-help and self-direction. Socio-psychological factors will play a dominant role in the team evaluation. Occupational therapy and activities programs are a major aspect of treatment. The integration of community services is an essential part of the program.

Through the rebuilding of abilities, many disabled persons may be enabled to return home and live in a normal environment. Others remaining in the institution will require less nursing and attendant care or may be able to adjust comfortably in a less protective and less expensive environment, such as foster homes.

Funds will be necessary to assist in providing personnel to initiate such programs on a demonstration basis.

A demonstration project is established at the Essex County Hospital in Belleville (Soho) and another in the Camden County General Hospital in Blackwood where aged and severely disabled Public Assistance clients are now being hospitalized.

3. In the ~~Home~~ COMMUNITY

As the numbers of chronically ill and disabled individuals increase with the lengthening of the life span, the home becomes more important as the basic health care unit. Many homebound people can be helped to assume responsibility for many of their own health needs, under medical supervision. In addition, the services of professional personnel such as physical therapists, public health nurses and social workers are necessary. Consultation services of nutritionists, occupational and recreational therapists, and others are also essential if the total needs of the homebound, chronically ill are to be met.

NEW JERSEY STATE DEPARTMENT OF HEALTH

COMMUNICABLE DISEASE CONTROL

Determine When, Where, And Under What Conditions Communicable Diseases Are Occurring

1. study current incidence of communicable diseases

Physicians and other responsible persons listed in Chapter II of the State Sanitary Code are required to report all notifiable diseases. Physicians are also required to report unusual manifestations or outbreaks of disease.

Local boards of health are required by law to receive and record reports of communicable diseases (except venereal diseases).

Local boards of health are required by law to send copies of communicable disease reports to the State Department of Health, to the local health district where the disease was believed to have been contracted, and to the local health district in New Jersey wherein the home address of the ill or infected person is situated.

It is the responsibility of the Public Health Statistics Program, the State Health District, and the Communicable Disease Control Program to stimulate reporting of communicable diseases.

It is the responsibility of the Program Coordinator of the Communicable Disease Control Program to study case reports, weekly, monthly, and annual tabulations provided by the Public Health Statistics Program. These data are used to determine the nature and extent of the communicable disease problem, to guide intelligent planning of the control program, and to initiate epidemiologic investigations.

Titles and contents of IBM listings and statistical tables provided by Public Health Statistics Program to Communicable Disease Control Program (excluding tuberculosis and venereal diseases):

Weekly

1. Table I which includes a count by disease, by county of residence of all reportable diseases except measles, pertussis, streptococcal sore throat and scarlet fever, influenza, and pneumonia.
2. Table II which includes a count by disease, by county of residence of measles, pertussis, streptococcal sore throat and scarlet fever, influenza, and pneumonia.

Monthly

1. IBM tabulation of data shown in Table I above.

Annually

1. IBM tabulations. (NOTE: IBM tabulations "a" through "e" which follow are for reportable diseases other than measles, pertussis, streptococcal sore throat and scarlet fever, influenza, and pneumonia.
 - a. Same as shown under monthly.
 - b. Tabulation of reportable diseases by cause for each municipality by county.
 - c. Tabulation for the State of reportable diseases by cause, by sex, and age groups.
 - d. Tabulation for the State of reportable diseases by cause, by race, and age groups.
 - e. Tabulation for the State of reportable diseases by month of report to the State Health Department.
 - f. Tabulation of resident poliomyelitis cases by county, by month of report.
 - g. Tabulation for the State of resident poliomyelitis cases by paralytic status and by month of report.
2. Statistical tables.
 - a. Reported cases of notifiable diseases by county of residence.
 - b. Selected morbidity by State Health District, numbers and rates.
 - c. Selected morbidity by State Health Districts, numbers and percentages.
 - d. Poliomyelitis cases by month with medians for 5 year periods.
 - e. Cases and deaths by age groups and by sex for poliomyelitis.
 - f. Cases and deaths with rates and per cent fatality for selected reportable diseases.
 - g. Recorded deaths from reportable diseases by counties.
 - h. Deaths from reportable diseases by age, race, and sex.

The Division of Laboratories transmits two copies of positive culture reports on communicable diseases for which the Communicable Disease Control Program has responsibility

1. One copy is sent to the Communicable Disease Control Program which notes pertinent data and then transmits the laboratory report to the appropriate State Health District for epidemiologic study.
2. One copy is sent to the Public Health Statistics Program for check against case reports.
 - a. If case is reported, this information is indicated on the laboratory report and promptly forwarded to the Communicable Disease Control Program.
 - b. If case is not reported, the Public Health Statistics Program holds the laboratory report for a three week period, during which time a case report may be received. If one is received, the laboratory report is processed as in item "a".
 - c. If no report is received during the three week period, the Public Health Statistics Program sends the laboratory report with appropriate notation to the Communicable Disease Control Program.
 - d. Upon receipt of the laboratory report, the Communicable Disease Control Program asks the physician who requested the laboratory test to report the case to the local board of health of the jurisdiction wherein the diagnosis was made. A copy of this letter is sent to the Public Health Statistics Program.
 - e. When the Public Health Statistics Program receives the case report, it marks the letter accordingly and returns it to the Communicable Disease Control Program.
 - f. If a case report is not received within ten days as a result of action in item "d", the Public Health Statistics Program indicates this on the copy of the letter and sends it to the Communicable Disease Control Program.
 - g. The Communicable Disease Control Program transmits the file to the appropriate District for action.
 - h. The Public Health Statistics Program notifies the Communicable Disease Control Program when a case report is received.
2. promote use of advisory medical and laboratory diagnostic services
Local boards of health may provide or utilize the facilities of laboratories complying with the provisions for certification and standards of laboratories contained in Chapter IV of the State Sanitary Code. Development and use of local laboratory services are encouraged but

it is the responsibility of the Bacteriology, Serology, and Virology Programs to provide such laboratory tests as may be required by law and to make available other selected diagnostic tests as necessary. Advisory medical diagnostic services are provided to local boards of health to assist in the determination and control of diseases of public health importance.

3. coordinate epidemiologic services

The central responsibility for coordinating epidemiologic investigations of communicable diseases rests with the Program Coordinator of the Communicable Disease Control Program.

The Public Health Statistics Program transmits to the Program Coordinator of the Communicable Disease Control Program morbidity or mortality information for the following reportable diseases, except for those cases occurring in State institutions and military encampments:

Amebiasis	Plague
Anthrax	Poliomyelitis
Botulism	Psittacosis
Brucellosis	Q fever
Cholera	Rabies in man
Dengue	Rocky Mountain spotted fever
Diarrhea of newborn	Salmonellosis (other than typhoid fever)
Diphtheria	Shigellosis
Encephalitis	Smallpox
Food poisonings	Tetanus
Glanders	Trachoma
Infectious hepatitis	Trichinosis
including serum hepatitis	Tularemia
Influenza	Typhoid fever
Leprosy	Typhus fever
Leptospirosis	Yellow fever
Malaria	
Meningococcal meningitis	
Ophthalmia neonatorum	

The Communicable Disease Control Program records pertinent data from the morbidity or mortality information provided by the Public Health Statistics Program and then transmits the information, except that relating to poliomyelitis, to the State Health Districts. In the case of poliomyelitis, a letter requesting the completion of a standard poliomyelitis surveillance form is sent directly to the municipality where the case resides. The surveillance form is then returned to the Communicable Disease Control Program for tabulation and evaluation. It is the responsibility of the Program Coordinator to alert all participating personnel about communicable disease information received from sources other than through the official reporting procedure.

Local boards of health are required to make investigations, when necessary, of illnesses listed in Chapter II, Regulation 1 of the State Sanitary Code and of unusual manifestations of disease or outbreaks of diseases not listed as reportable, in order to protect the public health.

The State Health Districts assist local boards of health, when necessary.

The Program Coordinator of the Communicable Disease Control Program provides advisory epidemiologic services to the State Health Districts.

The State Health Districts have the responsibility for submitting epidemiologic reports for the following diseases or unusual occurrences of diseases to the Program Coordinator of the Communicable Disease Control Program. Reports should be submitted within two weeks of the District's first knowledge of the occurrence of illness. If it has not been possible to complete the investigation within this period, a preliminary report should be submitted.

Anthrax

Botulism

Brucellosis

Cholera

Dengue

All outbreaks of diarrhea of the newborn occurring in hospitals or institutions

Encephalitis

All outbreaks in which either water or food (including milk, milk products, and shellfish) is found to be or suspected of being the vehicle of infection, regardless of their etiology.

Glanders

Leprosy

Leptospirosis

Malaria

Plague

Psittacosis

Q fever

Rabies in man

Smallpox

Trachoma

Trichinosis

Tularemia

Typhoid fever

Typhus fever

Yellow fever

All outbreaks occurring in hospitals, schools, orphanages, neighborhoods, summer camps, etc., regardless of their etiology.

All outbreaks of diseases not listed in Chapter II, Regulation 1 of the State Sanitary Code.

Unusual manifestations of disease.

High incidence of respiratory diseases, particularly during periods when influenza is likely to occur.

Unusual occurrence of anthrax, psittacosis, plague, Q fever, equine and St. Louis types of encephalomyelitis, and leptospirosis in animals, since these diseases may spread to man.

Multiple or groups of cases of a disease occurring under unusual circumstances such as an uncommon mode of spread, a relatively high case-fatality rate, and a high incidence of disease "out of season."

Summaries of epidemiologic reports submitted by State Health Districts and approved by the Program Coordinator of the Communicable Disease Control Program will be submitted for publication in "Morbidity and Mortality Weekly Reports" issued by the Public Health Service. A guide to the preparation of these reports appears in the booklet, "National Morbidity Reporting: Manual of Procedures", National Office of Vital Statistics: U.S. Department of Health, Education, and Welfare, Public Health Service; Jan. 1, 1956.

Control Spread Of Infection From Cases, Contacts, And Carriers

It is the responsibility of the State Health Districts to interpret the regulations established to control the spread of communicable diseases and to assist local health officers in the performance of their duties during unusual prevalence of communicable diseases.

Promote Immunization Against Certain Diseases

It is the responsibility of all participating personnel to stimulate the immunization of susceptible individuals against the communicable diseases such as diphtheria, pertussis, tetanus, smallpox, and poliomyelitis, for which prophylactic biologicals are available and to stimulate the administration of booster doses at appropriate intervals.

It is the responsibility of all participating personnel to stimulate the immunization against typhoid fever of persons subject to unusual exposure by reason of occupation, travel, or presence in disaster or epidemic areas.

It is the responsibility of the Program Coordinator of the Communicable Disease Control Program to specify the biologicals to be made available for active immunization and to assist in the preparation of specifications for their purchase.

It is the responsibility of the Administrative Services Program to maintain a supply of biologicals in distributing stations in various parts of the State, from which physicians may obtain them without cost for patients who need to be spared the cost of the biologicals.

Rabies vaccine (human) is available in small quantities from seventeen distributing stations.

It is the responsibility of the Program Coordinator of the Communicable Disease Control Program to establish criteria for an equitable and effective use of gamma globulin for poliomyelitis, measles, German measles, infectious hepatitis, and agammaglobulinemia.

It is the responsibility of the Administrative Services Program to maintain a supply of gamma globulin in Distributing Stations for the prevention and modification of measles, and for the prevention of German measles in pregnant women.

From the supply of gamma globulin stored by Administrative Services shipments are made by mail on order of Program Coordinator of the Communicable Disease Control Program to physicians for household contacts of poliomyelitis and infectious hepatitis, and for cases of agammaglobulinemia.

From the supply of poliomyelitis vaccine stores by Administrative Services shipments are made by mail on order of the Program Coordinator of the Communicable Disease Control Program to municipalities conducting public vaccination programs.

NEW JERSEY STATE DEPARTMENT OF HEALTH

CONVULSIVE DISORDERS

I. APPRAISE NEEDS AND RESOURCES

Through active participation in the planning of a State-wide program of education and service for epileptics and those with other convulsive disorders, proposed by the Medical Society of New Jersey in the spring of 1950, the State Department of Health cooperated in a project which came to be known as the New Jersey Consultation Service for Convulsive Disorders. An Advisory Council including members from:

Medical Society of New Jersey
New Jersey State Department of Institutions & Agencies
New Jersey State Department of Health
 Director of Division of Constructive Health
 Director of Division of Chronic Illness Control
New Jersey State Department of Labor and Industry
New Jersey State Department of Education
New Jersey State Department of Law and Public Safety
New Jersey Society for Welfare and Epileptics
New Jersey Hospital Association
New Jersey Chamber of Commerce

devises policies and defines the function of the Consultation Service. A Coordinator of the Project is supplied by the Department of Institutions and Agencies, which also supplies the services of a medical-social worker, secretarial help, and a consultant in neurology, who was approved by the Medical Advisory Committee as Medical Director of the Service. The office of the Consultation Service is located at the Neuro-psychiatric Institute in Princeton.

Through participation in the Advisory Council and its Interim Committee meetings, the Health Department and this Division (Chronic Illness) have received valuable assistance in clarifying the needs and defining the resources for control of convulsive disorders in this State, and have been able to outline a program which avoids duplication of effort, and whose main function has been to make available throughout the State the services of electroencephalographic machines operated by qualified technicians. Continuity of participation in Council meetings is a prerequisite to further planning and action in all areas of convulsive disorder control.

II. SELECT AREAS OF ACTIVITY WITH SPECIAL REFERENCE TO:**A. Present Programs and Facilities**

The aims and objectives of the Consultation Service coincide at every point with those of the Division of Chronic Illness Control as they apply to those convulsives whom it serves.

A broader participation in other State programs relative to convulsives, however, is inherent in this Program, and it is envisioned that personnel and funds will permit such activities as:

1. Enhancement of convulsive disorders control training programs for all physicians, both in the State Medical School and in local institutions;
2. Support and furtherance of existing research projects into the prevention and control of convulsive disorders;
3. Furtherance of legislation and lay education projects aimed at promoting the general welfare of those with convulsive disorders.

Specific application of the ConvD Program to the Consultation Service follows. (See #1.)

The New Jersey Consultation Service for Convulsive Disorders is a demonstration clinic held once monthly in each of four geographic areas in the State; i.e., Metropolitan, Northern, Central and Southern. EEG machines were placed by the ConvD Program in the four hospitals attended by the physicians selected by the Medical Advisory Committee to act as contact physicians for the opening Consultation Services. Subsequently, their placement has been in hospitals selected by the ConvD Program because they were, in reality, community hospital centers, where auxiliary services were available, such as multi-phasic screening, medical-social services, and others, and also where this type of facility (i.e., EEG) is not otherwise readily accessible. Further placement of this and other equipment is contingent upon these qualifications. As the Consultation Service has expanded, the clinics have rotated among the hospitals where the EEG machines were available and where both the community interest and patient load made the holding of the clinics feasible.

B. Community Interest and Readiness to Assume Responsibility for Ultimate Financial Support:

Assessment of these qualities is essential to the success of a Program involving loan of expensive equipment. It is arrived at through consultation with hospital administrators, staff, and with members of District and local health and welfare agencies. An evaluation of past performances is often most helpful.

C. Professional Strength:

It is the aim of this Program to enhance and reinforce the quality of the professional services rendered to those with convulsive disorders. For this it is necessary to select institutions and areas which do not already extend services in this field, but who have available the facilities and personnel for proper utilization and application of the EEG and Consultation Clinic services which may be furnished them.

It has become necessary to standardize the requirements for quality in interpretation of the electroencephalograms. Hereafter contracts for services related to the EEG machines will be issued or renewed contingent upon proper preparation of the contact physician (or individual designated by the institution in which the EEG is placed to act as official reader of the EEG's) by a course of instruction presently being standardized.

D. Integration of other Programs in the Community:

(See II A.) Wherever possible the services of the EEG machines are made available to other organizations and programs in the community which deal with chronic illness, and to whom this facility would be advantageous. Examples of this include:

Cerebral Palsy Clinics and Projects
Programs dealing with Aging
" " Mental Illness
" " Neurologic Research

E. Extent of Program Funds and Participation in Initiation of Activity:

Current needs and Program allotments determine the extent of Program funds and participation in initiation of activity.

III. ARRANGE FOR:

A. Equipment

The ConvD Program has arranged for procurement of EEG machines to be placed in community hospital centers, under the terms of the "Equipment Lease" form of the State Department of Health.

The placement of these machines in community hospital centers provides not only expanded hospital services for promoting the earlier detection and control of convulsive disorders, but allows for similar services for those with other neurological conditions; i.e., cerebral trauma, cerebrovascular disorders, cerebral palsy, and tumors; and, in addition, furnishes a research tool for investigation in related fields, notably mental health and aging.

Under the terms of the grant-in-aid contract entered into by the Department of Health and the institution receiving the machine, the apparatus is to be available for diagnostic purposes according to the general operating policies of the institutions in which they are located. The institution is to employ an EEG technician, who has received at least four weeks' training in skilled use of the machine at the Neurological Institute in New York, or its equivalent.

The interpretation of the EEG's is to be performed by physicians designated by the hospital in which the machines are located. Their qualifications are indicated in II. C.

B. Personnel

Funds are allocated for grant-in-aid contracts to the hospitals with EEG machines to supply for limited periods of time the services of trained technicians for the operation of these machines, until the cost of technician services can be absorbed by the hospitals. The monies allocated for this service are on a decreasing scale extending over a period of not more than four years.

C. Forms and Contracts

Forms are furnished to the hospitals in which the EEG machines are located, for the quarterly reporting to the Department of Health of the services performed.

D. Education Media

The ConvD Program has available an assortment of information documents and pamphlets on convulsive disorders, which have been secured or prepared through this Program. Periodically these are distributed and reviewed, augmented, and promoted.

Participation by Division personnel in programs relating to convulsive disorders, such as Governor's conferences, is sponsored or facilitated.

E. Community Supportive Services

(See Section V.)

IV. PROVIDE SUPERVISION AND CONSULTATION

So that adequate insight into the current status of convulsive disorders is maintained and foresight directed toward the future, it is essential that those coordinating and administering this Program be familiar both with its mechanisms on all levels, and with all relative resources and material available elsewhere. At every turn the Division should stand ready to provide supervision and consultation, from answering and directing queries for information, to actual participation in the structure of the clinics, and should, further, seek out areas wherein such services might be utilized and by means at its command encourage their utilization. Where services are requested beyond the scope of this Program, knowledge of their availability should be considered essential (i.e., cerebral palsy clinic referrals, etc.).

V. PROMOTE CONTINUITY OF CARE SERVICES IN HOSPITAL AND COMMUNITY

Continuity of care in the ConvD Program has best been facilitated to date by the application of nursing, social and vocational services to the patients seen by the Consultation Service.

In the clinic, the consultant examines the patient, reviews his record of seizures, etc., and prepares recommendations for the referring physician relative to medications, further examinations, and follow-up evaluation. The other members of the team undertake to plan indicated non-medical services, social assistance, job placement, vocational counselings. With the assistance of the referring physician, the patient is followed and reviewed by the Consultation Service at intervals.

In certain instances nursing follow-up service is indicated. The Coordinator of the Consultation Service has a list of public health and other nursing agencies serving 567 municipalities in this State. Referrals for nursing follow-up service for patients served by State-supervised nurses will be sent to the patient's District State Health Officer, who will in turn refer it to a nurse. Other referrals will be sent to the nursing agency named for each municipality; payment of fees for this latter service cannot be assumed by the State Department of Health or the Consultation Service.

Availability of other services, such as homemaker, institution, and rehabilitation may be desirable, and adequate provision for an interplay of these must be maintained by Division personnel, and by an alert social service program.

VI. ARRANGE FOR COLLECTION OF INTERPRETATIVE DATA

(See III. C.) Periodic reporting of data from the Consultation Service is facilitated by joint planning of reporting forms, now under way between the coordinators of the two programs (Consultation Service, ConvD Program).

VII. EVALUATE MATERIALS, TECHNIQUES, SERVICES

In addition to Program Evaluation, the quality of equipment and services receive individual evaluation. This is done by:

- A. Periodic inspection of equipment and clinics by Division personnel.
- B. Careful scrutiny and comparison of reports from hospitals and clinics.
- C. Comparative study of other similar programs and services elsewhere.

VIII. PUBLISH FINDINGS

The findings of the Program are reported periodically in the Division reports. They include data received in the reporting forms, and also that submitted by the Consultation Service through its Coordinator.

Minutes of the Advisory Council and Interim Committee meetings are recorded and filed in the Division office.

NEW JERSEY STATE DEPARTMENT OF HEALTH
CRIPPLED CHILDREN PROGRAM

MANUAL OF PROCEDURES

Index

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SECTION I.

Definition of a "Crippled Child" with Types of Crippling Conditions Acceptable for Services.

1. The definition of a "Crippled Child" adopted and approved by the Crippled Children Commission is as follows:

"Any child between birth and twenty-one years of age suffering from rheumatic heart disease or with a deformity which, because of loss, defect, or deformity of bones, muscles or other soft tissue, reduces, or due to a progressive condition, may reduce normal capacity for education or self-support."

2. Types of Crippling Conditions that have been approved by the State Crippled Children Commission as acceptable for care in the Crippled Children Program of the State Department of Health:

(For complete list see CC-D5)

Congenital heart disease
 Rheumatic Fever - Rheumatic heart disease
 Tuberculosis of bone
 Poliomyelitis, residual or late effects
 Cleft palate - cleft lip
 Other deformities of bones, nerves, muscles or soft tissues-
 congenital or acquired
 Cerebral palsy, all categories
 Post-traumatic deformities except new fractures
 Scoliosis
 Osteomyelitis, acute or chronic
 Rheumatoid arthritis, acute or chronic
 Muscular dystrophy - cases requiring corrective surgery or bracing

3. Types of Handicapping Conditions by Code that are not presently approved by the State Crippled Children Commission as acceptable for care in the Crippled Children Program:

Children's			
Bureau	IEM		
<u>Code #</u>	<u>Code #</u>		<u>Description of Conditions</u>
2600	06		Diabetes mellitus
2830	07		Rickets, active
3530	16		Epilepsy
3809	18		Refractive errors
3849	19		Strabismus
3899	20		Other diseases of the eye

SECTION II.Administrative Services for CC Program Operation1. Case Registera. State Register

- (1) Names for Register are obtained from the following sources:
- (a) Birth reports (Visible Congenital Deformities), Form CC-8. Used by physicians along with birth certificate. Required by law (Title 9 Chapt. 13-5).
 - (b) School Reports of Handicapped Children. Sent to Pg. office by Dept. of Education.
 - (c) Cerebral Palsy Reporting Form CC-82. Used by physicians. Required by law (Chapt. 28 P.L. 1950).
 - (d) Poliomyelitis Reporting. From "flimsy" copy of CC-0 made out by Stat from Form P.D. 197.
 - (e) Cooperating Agencies by letter or by CC-0 Registration Form.
 - (f) Interested individuals direct or through Districts.
 - (g) New cases from approved Medical Clinics and Hospitals on Form CC-0 and Hospitalization Services Form CC-1 or Appliance Services Form CC-2.
 - (h) Physicians, direct by letter or through Districts on Form CC-0.
- (2) Form CC-0 to be eligible for registration must include the following minimum information:
- (a) Name of child.
 - (b) Municipality by county (address is necessary for Bur. records but not included in registration).
 - (c) Date of birth (month and year).
 - (d) Sex
 - (e) Race (white or non-white)
 - (f) Diagnoses as given by physician with primary diagnosis listed first.
 - (g) Date reported (date referred, month and year).

NOTE: Names of parents are desirable for case reference purposes in the District but not included in registration.

(3) Processing of Form CC-0.

(a) New cases originating from Pg office:

- (i) "Completed cases" (all information necessary for registration).
 - (A) Eligibility of diagnosis for registration determined by PC
 - (B) Registration No., diagnostic code, or codes, agency code affixed.
 - (C) Case record opened. Two copies sent to SHD, one to be referred to agency and the other for SHD use.
 - (D) CC-0s are sent to Stat monthly.
- (ii) "Incompleted cases". (Further information for registration necessary)

Follow above procedure, but send three copies to SHD which forwards two copies to agency. The agency retains one copy after completion, and returns one copy to SHD, which takes off necessary information and forwards same copy to PG office. When forwarding the three copies to the SHD, the original will be retained in the Pg pending file.

In summary:

- 1 original for CC Pg "tickler" file
- 1 copy for SHD
- 2 copies to agency

(b) New cases originating from field (clinics, hospitals, nursing agencies, etc.) Case finding.

- (i) Private clinic and hospital originates and sends three copies to Pg office, keeping a copy for its records. A nursing agency follows the same procedure but sends three copies to SHD, which retains one copy and forwards two copies to Pg office.
- (ii) Pg office will process as (3) (a) (i) above, returning one copy to SHD, which takes off necessary information and forwards same copy to nursing agency.
- (iii) If presumed "new" case has been previously registered, originating agency is so notified, with old registration number affixed to copies of CC-0 returned.

(c) Registration:

After IBM punching, CC-0 is returned to Pg office for filing in case folder, and placed in active file.

(4) Use of Registration Correction Form CC-10

(a) Mechanics

- (i) Three copies CC-10 to be made but by agency and forwarded to SHD.
- (ii) One copy of CC-10 is used in SHD for correction of files and records. Two copies go to Pg office. Pg will code information received, change its case record, file a copy on case record, and send a copy to Stat for necessary register changes. At the end of the calendar year, Stat will return CC-10 to Pg.

(b) Correction of Registration

Form CC-10 is used for revision of registration in the following categories:

- 1. Additional diagnosis
- 2. Change of diagnosis, name, county, municipality, date of birth, sex, color, and other (specify).
- 3. Suspension of active nursing service due to lack of cooperation.*

(c) Dismissal from Registration (by IBM punch code)

Form CC-10 is used for dismissal from registration in the following categories:

- 1. Over age
- 2. Deceased
- 3. Cured,- when attested by a physician.
Physician or hospital reporting polio case will be contacted one year after such report to consider advisability of revisiting case to determine possible residual involvement.
- 4. Moved out of state.
- 5. Not eligible for C.C. services.
- 6. Registered in error.
- 7. Unable to locate.
- 8. Maximum recovery.**
- 9. Other (Specify)

* Suspension of Active Nursing Services due to Lack of Cooperation.

Experience has indicated that there may be parents who indicate to nursing agencies that they no longer desire medical care or supervision of child, or children, in their family. These cases may be associated with many varied circumstances as follows:

- 1. The case was originally entered in the program, received medical care, treatment, supervision and nursing follow-up.

2. The case subsequently lapsed from medical care, treatment or supervision, even though nursing follow-up may have continued for several years thereafter.
3. A record of improvement of the handicapping condition while under care may exist, the degree of improvement may practically include "maximum recovery", but the case was not discharged.
4. A nursing record of improvement may exist, or hearsay evidence may be recorded.
5. The family has refused to accept or follow guidance. It has disregarded requests for medical examination presented by the follow-up agency.

The following procedure is suggested:

1. When a nursing agency is confronted with a family who refuses consistently to accept or follow guidance and disregards requests for medical or nursing follow-up, such a case may be suspended from active nursing services and SHD office notified on Form CC-10 giving pertinent reasons why such action was necessary. It may then be possible for the District staff to assist in obtaining necessary cooperation, before mailing Form CC-10 to the CC Pg, where registration category will be changed to indicate "suspension of active nursing services due to lack of cooperation", receiving the symbol "O" on the IBM tabulation lists and cards.
2. It is also recommended that the child's physician or family be contacted once a year to determine whether further necessary services are indicated or possible. In this way, it is felt that each child's interests may be protected and its needs better met.

** Maximum Recovery.

The Pg has agreed upon a policy of removing patients from the registry who have obtained improvement in their condition to the point where medical care or further treatment does not appear to be indicated. The policy is stated below in the definition of a term, "maximum recovery." This category applied to those cases in which written testimony of a physician or hospital indicates that:

- a. Optimum recovery from the former handicapping condition has been attained.

- b. Residual abnormality or abnormalities are no longer considered handicapping, either physically, emotionally, socially or economically.
- c. Further treatment is not indicated.

This statement is to be obtained from the physician or hospital treating patients concerned and should contain a statement relative to the three parts of the definition. When such a statement has been obtained the case is reported as having achieved "maximum recovery" indicating the source of the statement, e.g., "maximum recovery" signed by Dr. _____ or _____ Hospital, and dated _____.

(5) Removal of IBM Register Cards.

Upon receipt of properly coded Registration Correction Form CC-10 from Pg office, Stat will dispose of the following IBM cards in register: (by punch code)

1. Over-age (21 years)
2. Deceased
3. Cured
4. Moved out of State
5. Ineligible for Service (changed diagnosis, etc.)
6. Error (registered in error)
7. Cannot locate (so coded after 5 years by Pg)
8. Maximum Recovery
9. Other

(6) Final Disposition of Case Records.

- (a) The following categories of case records (by IBM punch code) are eligible for final disposition by destruction (provided no reimbursable services were given.)

Ineligible for services.
Registered in error.

- (b) All categories of case records (by IBM punch code) are eligible for final disposition by destruction after federal auditing clearance:

1. Over-age (22 years or beyond)
2. Deceased
3. Cured, except for those diagnosed as polio. These cases will not be finally considered as "cured" until one (1) year after initial diagnosis has been made, or until follow-up visit or investigation has been completed.
4. Moved out of State
5. Ineligible for services
6. Registered in error, if reimbursable services have been rendered
7. Cannot locate for a period of five (5) years
8. Maximum recovery

(d) CC-Pg office

- (i) Case records in categories under (a) may be destroyed without auditing clearance, if no expenditures have occurred.
- (ii) Case records in categories under (b) will be kept until a final audit will have been completed. Request for destruction of case records in the District and Pg office will be made routinely by PC to the Public Records Supervisor of the Bur. of Archives, Dept. of Education, and upon approval, these records may then be destroyed. PC will notify the District when audit is complete, the years covered, and the records to be destroyed.

(7) Disposition of Program Activity Cards (Form CC-74)

In order to conform with demands for case information under new Social Security regulations, program activity cards (Form CC-74) representing case records eligible for destruction after federal auditing, will be withdrawn from Pg files and transferred to the Bur. of Archives for storage. Categories involved will include over-age, moved out of state, cannot locate and maximum recovery.

(8) Distribution of Register Lists.

- (a) A monthly alphabetic cumulative index of cases registered in the current year on 5-part paper with one copy to Pg office, one copy to each SHD.
- (b) A yearly alphabetic cumulative index of all cases on the register at the close of the year on 5-part paper with one copy to Pg office and one copy to each SHD.
- (c) Individual duplicated IBM cards for newly registered cases broken down by contract nursing agency codes and county code balance with essential register list information interpreted along top edge to file in either SHD or contract nursing agencies and used as case reference cards, and as a basis for local case register. SSSH receives an additional set to be used as date tickler file.
- (d) List of names by county of children on the register who will reach the age of 16 years during the ensuing calendar year. This list includes municipality, agency and diagnostic code numbers. Space is provided between names to permit insertion of street addresses. The procurement of such addresses will be the responsibility of the Pg office. Completed lists will then be transmitted by Pg to the Rehabilitation Commission, to each SHD and to each nursing agency via SHD. 5-part paper will be used as follows:

- One copy - Pg office
- Two copies - Rehabilitation Commission
 1. One for their files
 2. One for their district office
- Two copies - to SHD
 1. SHD file
 2. Nurse agency file

- (e) A yearly alphabetic list of names by county of children on register who reached their 21st birthday during the preceding calendar year. This list includes municipality, agency and diagnostic code numbers. Space is provided between names to permit insertion of street addresses. Responsibilities and procedures are identical to (d) above. These lists will permit all concerned to remove case records of "over-age" individuals from case files. These records may be destroyed only after notification by PC.
- (f) Alphabetic list of individuals removed from the register during the calendar year, exclusive of those removed because of "over-age". One copy for Pg office.

b. Local Case Registers

Detailed procedures for this activity have not been completed pending approvals for use of funds etc. Nursing agencies, county boards of Freeholders, or official local health agencies will use and retain registration duplicated IBM cards provided by Stat (see 7 (c) above) as basis of formal case register.

2. Requests for Individual Case Services

This involves analysis of all reports, diagnoses, requests for registration, case correspondence, medical-social petitions, and physician's recommendations to determine eligibility for program services; initiating arrangements for services with Districts, hospitals, convalescent homes, clinics, and obtaining necessary underwriting participation from parents, voluntary agencies and Boards of Freeholders. These administrative services take place in Pg office under direct supervision and participation of PC. The use of specific forms and form letters are described under Section III.

3. Program Accounting and Fiscal Control

These procedures are the responsibility of the Pg office. Specially designed commitment and authorization records are in use which indicate expenditures, commitments, and balances of the several budget accounts

at all times. The SHD and the Div. LHS are responsible for book-keeping and for invoicing for reimbursable home nursing services of contract nursing agencies according to allotments pro-rated by Pg office on a quarterly basis. Payments of physician fees for State cerebral palsy clinics are the responsibility of Pg office.

4. Program Statistics

a. Preparation and Distribution of Tabulations

These tabulations are provided by Stat through the following IBM card counts:

- (1) Annual tabulation by municipality and county of the number of cards (not individuals) in each diagnostic code.
Copies 3: 1-Stat
1-SHD via Pg office
1-Pg office
- (2) Annual tabulation for State as a whole as in (1) above, with details as to sex, color, and age groups for each diagnostic code.
Copies to: 1-Stat
1-Pg office
- (3) An annual tabulation for each municipality by county of the number of individuals on the register as of December 31 of each year. Tabulation will include number of individuals by sex, color, and age groups for each municipality.
Copies 3: 1-Stat
1-Pg office
1-SHD via Pg office
- (4) Card counts of individual registrations to determine:
 - (a) New cases placed on State register during the calendar year.
 - (b) Total cases on State register.
 - (c) Cases removed from State register during calendar year.
 - i. Over-age (21 years)
 - ii. Deceased
 - iii. Cured
 - iv. Maximum recovery
 - v. Moved out of State
 - vi. Ineligible for service (changed diagnosis, etc.)
 - vii. Registered in error
 - viii. Cannot locate
 - (d) Cases on State register as of December 31.
Copies 2: 1-Stat
1-Pg office
 - (e) Counts of register revisions, determined by Pg office from Stat accumulated Form CC-10's to show case services complexities.

- (5) Monthly tabulation of newly registered cases for State as a whole by diagnostic code.

Copies 2: 1-Stat
1-Pg office

b. Program Service Statistics

- (1) Annual report prepared by Stat (on Children's Bureau Form CB-253) from Form CC-74 cards supplied by Pg of physician and hospital services given to registered children throughout the calendar year. Pg provides data from cerebral palsy diagnostic clinic attendance (State only) and State cerebral palsy consultation clinics, and bed day purchases for hospitalization and convalescent care, with the number of children receiving same.
- (2) Additional program statistics compiled by Pg office on Activity Form CC-74 includes data in (1) above, plus the following:
- (a) Number of appliances underwritten and number of children for whom appliances were provided.
 - (b) Number of allotted reimbursable nursing visits by contract nursing agencies, and the number of children so served.
 - (c) Number of treatments given by Department employed physical therapists at State demonstration cerebral palsy treatment centers, and the number of children so served.
 - (d) Number of physical therapy treatments purchased under contract act with Monmouth County United Cerebral Palsy, and number of children so served.
 - (e) Number of evaluations at the Cleft Palate Center.
 - (f) Number of preoperative evaluation or postoperative special nursing fees for children with congenital heart disease at approved cardiac centers.
 - (g) Number of preoperative evaluation fees for children with neurological disorders at the Pediatric Neuro-surgical Center.
 - (h) Number of drug purchases and number of children receiving same.
 - (i) Number of psychological examinations rendered by Pg psychologists and the number of children examined.
- (3) Special Cystic Fibrosis Statistics including number of children served, hospital days, drugs provided, home nursing follow-up services.
- (4) Pg Annual Fiscal Year Report

Prepared by Stat from Activity Form CC-74 cards supplied by Pg on all services to registered children throughout the fiscal year. This report will be posted on a revised Children's Bureau four-page form (Form CC-33) using same format but with additional county breakdown of numbers of children served.

SECTION IIIServices for Children with Physically Handicapping Conditions1. Case Referral to Physicians on Panelsa. Pg Office:

- (1) Upon receipt of Visible Congenital Deformity Report (CC-8) on a category acceptable for Pg registration, a follow-up letter (CC-L1) together with a Department Referral Form (Adm.-25) and guide (CC-D25) is sent to reporting physician. Physician is advised of CC Pg services if required, and is referred to local nursing agency covering the community of child's residence, for further Pg information.
- (2) Copy of CC-L1 is sent to nursing agency via SHD together with appropriate number of CC-O's. Processing of CC-O described in Section II - 1,a (3).
- (3) Similar procedures as (1) and (2) above are followed upon receipt of other reports of new cases. (Cerebral Palsy report CC-82, if not diagnosed by a recognized C.P. physician or clinic; school reports; personal letters of inquiry.) Form letter is not used, but format for personal acknowledgment is employed. Nursing agency receives copies of all correspondence to physician.
- (4) Physician reporting poliomyelitis case is sent personal letter following an accepted format, indicating availability of program services, and referring him to local nursing agency for further Pg referral information and services.

Processing procedure is identical to newly reported congenital deformity cases. Physician or hospitals reporting polio cases will be contacted one year after initial report to consider advisability of revisiting case to determine possible residual involvement previously unrecognized.

b. SHD or Local Nursing Agency

- (1) Upon receipt of CC-O and copies of correspondence from Pg office via SHD, nurse agency completes CC-O if indicated, by means of telephone call, if possible to home or physician, and inquires from physician whether home nursing services are indicated. Physician and family are also advised of specific CC services available and assist in the referral of child to panel specialist. Every contract and cooperating county or local nursing agency possess Crippled Children Program Reference Lists, as guides for referral.

- (2) Where case records are in SHD Office, Public Health Nurse Supervisors and nursing staff of SHD have responsibility of assisting in referral of reported cases to specialists.
- (3) Nursing agencies under contract with the CC Pg render case-finding services. The nursing agency initiates three copies of CC-0 on cases discovered and forwards them to Pg office via SHD for coding and registration.

c. Hospitals and Clinics

These have case finding and referral responsibilities for those children in need of hospitalization, and appliances under Pg auspices. Children with rheumatic fever, congenital heart disease, and neurological disorders are referred to panel physicians for admission to hospitals, cardiac centers, and pediatric neuro-surgical center. Children attending approved orthopedic clinics are referred to Pg for underwriting of braces prescribed by panel physician. Those attending private cerebral palsy centers may be referred to state clinics furnishing diagnostic or consultation services or to the Pg for appliance underwriting. All of these private agencies may initiate CC-0 (3 copies) and send same to Pg office, referring cases to panel physicians, if Pg underwriting for hospitalization and appliances are required.

2. Hospitalization and Convalescent Care as Requested by Panel Physicians.

a. Request for Hospital Services form CC-1 set

This form is a complete unit involving requests and underwriting of hospital, convalescent home or rehabilitation centers for bed day purchases. It includes necessary medical information, commitment requests, socio-medial petition, authorizations, fiscal statement and cancellations. It replaces eleven (11) forms and thirty-nine (39) previous copies.

A summary of the use and routing of this form will be supplied when final draft is completed. Detailed instructions will be given in CC-D22.

b. Operational Policies concerning Hospital Services

- (1) When hospitals choose to arrange for additional underwriting contributions from a voluntary agency such as a local infantile paralysis chapter in behalf of a child receiving underwriting assistance from the Pg, such contributions toward bed day care may be added to the ceiling rate paid by the Pg, provided amount agreed is posted in Hospital Services Form CC-1. In such instances, the Pg will assure itself that the total amounts from underwriters and parents will not exceed the reimbursable per diem cost of the hospital as filed under the Federal formula. Any amount in excess of the reimbursable cost will be deducted from the "State and County balance" underwriting at the time of issuance.

- (2) Under program policy, the Pg reserves the right to deduct contributions from parents, and from voluntary agencies, where the latter have been initiated by the Pg, from the ceiling rate paid by the Pg to the hospital.
- (3) Under program policy, should a Board of Freeholders refuse to share in the underwriting cost upon request, for whatever reason, (lack of funds, residency restrictions, social-economic status of parents etc.), the PC has the responsibility to determine whether the Pg shall participate.
- (4) The Pg does not underwrite bed day care for acute poliomyelitis cases in hospitals during the acute contagious period (7 days), and only thereafter for those cases where there is evidence of residual effects.
- (5) Ceiling rates paid by Pg include all charges except in those hospital centers where there are contracts for special evaluation or post-operative nursing fees, and except for special drugs approved by PC and emergency nursing services approved by PC in very special instances.
- (6) Hospital Case Summaries or Records
Local nursing agencies are responsible for obtaining case summaries or records from hospitals and clinics within the State. If a hospital is unable to honor the request, SHD will assume responsibility for obtaining necessary record. PC will obtain out-of-state summaries or records.

3. Braces, Prosthetic Devices and Appliances as Prescribed by Approved Physicians and Clinics.

a. Request for Appliance Services, Form CC-2 set

This form is a complete unit involving requests and underwriting for braces, orthopedic shoes, appliances, prosthetic devices, hearing devices, and orthodontic appliances. It includes necessary medical information, socio-medical petition, authorizations, fiscal statement and approvals. It is basically similar in design, purpose and use to Form CC-1 set.

A summary of the use and routing of this form will be supplied when final draft is completed. Detailed instructions will be given in CC-D23.

b. Medical Clinic Reports (exclusive of State C.P. Clinics)

(1) Orthopedic Clinic Reports

When a case which has been assisted in an approved hospital with Pg funds is followed up at an orthopedic clinic, such clinics are requested to forward three copies of the clinic report to the Pg office for forwarding of two copies to SHD.

One copy should be retained by the SHD, if case file is in its office (or in its field offices), and a copy forwarded to appropriate nursing agency. Pg copy is used for program evaluation, statistics, and background for PC's approval of hospital or appliance underwriting.

(2) Private Approved Cerebral Palsy Clinic Reports

These clinics, staffed by approved cerebral palsy panel physicians, and eligible to receive underwriting assistance for appliances for non-fee paying cases, or obtaining psychological, or nursing services through contract nursing agencies, are requested to send three copies of their medical clinic reports on Pg assisted cases to the Pg office. For forwarding procedure and use of reports see (1) above.

(3) Private Approved Speech and Hearing Centers

These clinics, staffed by approved panel personnel, and eligible to receive underwriting assistance for hearing aids for non-fee payment cases, are requested to send three copies of clinic reports of those cases where Pg assistance is requested to Pg office. For forwarding procedure and use of reports see (1) above.

(4) Private Approved Orthodontic Clinics

It is anticipated that reports of these clinics will operate in the same way as those from speech and hearing centers in (3) above.

(5) Special Case Evaluation Reports from Rehabilitation Centers

See 8.

4. Special Services for Children with Cerebral Palsy

a. State Medical Diagnostic and Follow-up Clinics

(1) Cerebral Palsy Information Blank (CC-16)

Upon receipt of Registration Form CC-0 indicating diagnosis of cerebral palsy, physician should be contacted by local nursing agency or public health nurse and, in the event that State services are requested, Form CC-16 shall be used for purpose of obtaining history and case information at the initial home visit. The form is then returned to the SHD for the purpose of filing in the case folder if same is in the District or field office, or it is filed in the agency file. When case comes to a state C.P. clinic, this CC-16 form will be reviewed by the examining physician, and it will be filed in a C.P. case folder either on the clinic premises or at the SHD office.

(2) State Cerebral Palsy Clinic and Follow-up Medical Reports
(CC-76 and 77)

When transcription records of state diagnostic and follow-up clinics are received by the SHD, clinic information as dictated by C.P. Physician is transcribed by District staff upon CC-76 and 77 in seven (7) copies and one copy forwarded to Pg office for necessary reference of psychologist, registration of C.P. category and program statistics. Other copies are distributed to C.P. Clinic folder-(casefolder), either at SHD or respective treatment center, local family physician or clinic, school report if indicated, and to local nursing agency, Copies should not be shown or given to parents.

(3) Cerebral Palsy Report Form CC-82

If case is presumed to be newly diagnosed as cerebral palsy, a cerebral palsy report or registration form CC-82 should be signed by the diagnosing physician, and sent to the Pg office to conform to the reporting law 26:5A-1.

(4) Requests for Bracing or Appliances are made on Form CC-2 as described in 3 a. Appliance maker often attends clinic sessions in order to receive and discuss prescription for bracing directly with the C.P. physician.

(5) Requests for Psychological Services

These are described under 11.

(6) Requests for Follow-up Nursing Services

These are described under 10.

(7) State Medical Follow-up Cerebral Palsy Services

Any child with cerebral palsy who has been seen and diagnosed as having cerebral palsy at a state medical diagnostic clinic, may continue to receive the follow-up services of these clinics upon recommendation of the C.P. panel physician, and with the approval of the child's referring physician, and provided further, that such a child is receiving therapy (physical, occupational, speech, etc.) at a state cerebral palsy treatment center or at an approved private cerebral palsy treatment center; or that, in any event, the type of such treatments will not conflict or differ from those prescribed by the panel physician.

(8) Responsibilities of SHD

Each SHD is responsible for the supervision of the State medical diagnostic and follow-up C.P. clinics held within the District,

and to ascertain that the District or its delegated contract nursing agency arrange case lists and attendance, obtain cerebral palsy information blank (CC-16), clinic reports (Forms CC-76 and 77), initiate appliance request Form CC-2 and arrange for follow-up nursing services, psychological examinations, and nutrition services (See 13). Pg and SHD are responsible for assuring proper preparation and submission of clinic reports. Arrangements for hospitalization, nursing consultation, and other special services should also be made through SHD.

b. State Medical Consultation Clinics

These clinics are handled in a manner similar to the medical diagnostic clinics except that:

- (1) Clinic lists must be submitted to the Pg office in the event that children from other SHD may need to be seen by the Consultant, number permitting;
- (2) Pg office supplies stenographer for these clinics, and reports are prepared in the Pg office and distributed.

c. State Demonstration Treatment Services for Cerebral Palsy

The state employed physical therapists in these treatment centers are directly responsible to the DSHO, who advises with PC in regard to standards of work, reports and activities. Even though private agencies may provide additional therapeutic services, no clinic fees may be charged to those children served by state employed physical therapists. Essential operating supplies are supplied by CC Pg.

d. Approved Private Centers for Cerebral Palsy

- (1) Requests for underwriting of hospitalization or bracing services are made on Forms CC-1 and CC-2 (see 2 and 3). Psychological services are requested either on clinic reports utilized by approved agencies or by direct communication, to the Pg psychologist. Psychological report (Form CC-49) is made out in CC Pg office in sufficient copies so that both private agency, local nursing agency, DSHO, private physician and schools involved may have the benefit of pertinent information. Requests for services of the public health nurse consultants for CC are made through the SHD.
- (2) Physical Therapy Treatment Fees

Details of this contract for the payment of physical therapy clinic fees may be found in CC-D12.

e. Note on the Definitive Diagnosis and Coding of Cerebral Palsy

Whenever the Crippled Children Program receives a report of "cerebral palsy", such a diagnosis is given code number 15 and the case is correspondingly registered. Because of the complexity and variety of conditions labeled as cerebral palsy, it is highly desirable to obtain a more definitive diagnostic breakdown in order to furnish the Program and all interested parties with a more accurate picture of cerebral palsy.

One of the responsibilities of a State or approved private cerebral palsy clinic or treatment center is to furnish this more definitive diagnosis involving one of the several categories of cerebral palsy. These classifications of cerebral palsy receive the following coding:

<u>IBM Code #</u>	<u>Description</u>
09	C.P. Spastic
10	C.P. Athetosis
11	C.P. Rigidity
12	C.P. Tremor
13	C.P. Ataxia
14	C.P. Others (incl. flaccidity)
15	C.P. Unknown

If Case Registration Form CC-0 does not already include these diagnostic categories of cerebral palsy, three (3) copies of Registration Correction Form (CC-10) will be filled out, and two (2) copies forwarded to SHD for further forwarding to Pg office.

5. Special Services for Children With Congenital Heart Disease

Presently the following hospitals are approved for congenital heart disease surgery under program auspices. Arrangements for hospitalization and convalescent care are made and approved in exactly the same manner as with orthopedic cases by use of Hospital Service Form CC-1. Admission is based upon recommendation of an approved panel cardiologist.

St. Michaels Hospital, Newark
 Passaic General Hospital, Passaic
 West Jersey Hospital, Camden

Details of these contracts may be found in CC-D12. Special fees applicable under each contract will appear in appropriate space in CC-1. Prescribed follow-up nursing services on post-hospital or convalescent home cases are provided by public health nurses and nursing agencies holding contracts with the Pg and are reimbursable under regular nursing visit allotments in the usual way.

6. Special Services for Children with Neurological Defects or Disorders

Details of this contract may be found in CC-D12. Arrangements for hospitalization and convalescent care are made and approved in exactly the same manner as with orthopedic cases by the use of Hospital Services Form CC-1. Additional orientation courses for physicians and pediatricians will be arranged under same auspices and outline as previously given in 1956, for the purpose of familiarizing physicians with the potential definitive surgery possible upon early referral and adequate evaluation.

7. Special Services for Children with Cystic Fibrosis

Detailed procedures will be described upon final approval of this activity.

8. Special Evaluation Services for Rehabilitation Centers

a. Plastic Surgery Rehabilitation Center, St. Barnabas Hospital

The evaluation services which are paid for by Pg pertain only to those Pg registered post-operative cleft lip and palate patients referred to the Center from panel plastic surgeons.

Upon receipt by Pg of a case request either by letter or Hospital Services Request Form CC-1, such request will be checked by Pg for previous Pg participation and registration, and whether case is not less than 3 years of age or over 21 years. Requests will be routed to Center for arrangements with referring plastic surgeon.

Following evaluation at the Center, case will be referred back to the referring panel surgeon, unless that surgeon wishes his patient to receive follow-up treatment at the Center. Pg, however, does not pay for such treatment services.

Cases after evaluation at the Center will be followed up by Pg through the cooperation of hospital social service department and by local nursing agencies through and with the assistance as necessary of the SHD to assure that each child is receiving the recommended treatment.

The Center makes an individual case evaluation report for PC, which must have been received prior to bill for special evaluation fee. An official State bill (Form 100) is sent to Center for signature and return monthly.

b. Kessler Institute for Rehabilitation

Detailed procedures will be outlined upon completion of activity plan and approval.

9. Special Materials

a. Special Drugs

Requests for such special medicines and drugs will be included in Form CC-1 in order to receive approval of PC.

b. Hearing Aids

Form CC-2 will be used for hearing aids in same manner as for braces or appliances. A list of approved manufacturers of hearing devices has been furnished PC, together with price lists.

c. Orthodontic Devices

Form CC-2 will be used for requesting these devices in the same manner as for braces or appliances. Lists of such devices and prices will be furnished and approved by PC.

10. Nursing Services

a. Direct Home-Nursing and Follow-up Services

(1) Nursing Agencies holding contracts with the Dept for CC services:

Lists of such agencies, their geographic coverage and code numbers are found in CC-D7. Details of standard grant-in-aid contract are given in Form CC-3. The Contracts Manual and Schedule A are labeled as CC-D15.

A standard type of contract has been drawn up for all agencies. Each agency will be evaluated periodically by PC of CC in cooperation with the PHN Pg and SHD, to determine the extent of supervision given. Evaluation criteria have been developed by an advisory committee consisting of representatives of the Department and nursing agencies.

Where contracts with a nursing agency are to be renewed or initiated, it shall be the responsibility of the District to make recommendations to the PC of the CC Pg, (copy to PC of PHN) after discussion by District staff with representatives of the nursing agency.

i. "Consultation type" Agencies

Such agencies upon receipt of a CC-0 or other correspondence from the Pg through the SHD may initiate home visits with the prior approval of the physician except for a case-finding visit, and continue to render follow-up home nursing services depending upon need and upon physician's request, being reimbursed by the Pg for same upon submission of Professional Services Form CC-11 quarterly within allocated amounts. Case finding

services may be similarly initiated and rendered. Irrespective of Pg case allotment, the agency is responsible to render proper and necessary nursing services for crippled children, and to keep adequate case records which are subject to State and Federal audit. Supervision of the agency is a responsibility of the District Chief Public Health Nurse with the assistance of the Public Health Nurse Consultant for CC, who is expected to visit these agencies every six months.

ii. "Supervised Type" Agencies

These agencies render services on the same basis as described for "consultation" type. They are, however, dependent upon the supervisory services of the District Chief Public Health Nurse. Instructions relative to individual case visits are provided by SHD. An adequate report of each visit shall be maintained in the case record of each agency, and if necessary in the SHD.

(2) Nursing Agencies Cooperating with CC Pg.

Although not reimbursed by the Pg for crippled children services rendered, these agencies cooperate with the Pg in the same manner as do the "consultation type" of agencies, using all standard Pg forms and procedures, receiving the general guidance of the District Chief Public Health Nurse of the SHD and the consulting services of the public health nurse consultants for crippled children. Where such agencies are small and consist essentially of an individual field nurse (viz. Elks), arrangements have been made for these nurses either to accept supervision of a contract nursing agency, or the direct supervision of the District Chief Public Health Nurse in the SHD.

(3) Direct Services by Local Public Health Nurses

Such nurses are under the direction and supervision of the District Chief Public Health Nurse. Standard Pg forms and procedures are used.

(4) Contracts with County Boards of Freeholders

State supervision for CC nursing services will be identical to those rendered to nursing agencies holding contracts directly with the Department. Boards of Freeholders serve as fiscal agents only.

(5) Contracts with Local, Regional or County Health Departments

Where such contain qualified physician health officers, the Pg contracts for CC nursing services as described in the standard Contracts Manual and Schedule A. (CC-3 and CC-D15)

b. Responsibilities of SHD relative to Pg Nursing Services

All communications and Pg forms involving Pg nursing services are channeled through SHD to and from cooperating nursing agencies. When required, SHD will assist in obtaining information from local nursing agencies on Hospital Services Form CC-1 and Appliance Services Form CC-2. Nurse Case Service Reports CC-40 are not required to be sent to Pg office, but remain in agency or SHD case file. Dept. Referral Form (Adm.25) are not required to be sent to Pg office, but are to be filed with case records in SHD or nursing agency for use of State and Federal auditing. Nurse Activity Reports rendered by public health nurse supervisors in SHD remain in SHD offices.

The use of Professional Services Form CC-11 is detailed in Crippled Children's Nursing Service Contract Manual (CC-D15). Upon receipt of Form CC-11 reports from a contract nursing agency, each SHD is responsible for checking the correctness of these reports. Where case record is in the SHDO or delegated field office, the public health nurse supervisor supervising the agencies within her geographic jurisdiction should check Form CC-11 with the case records and register lists as may be necessary to assure herself of correctness or the need for correction. Upon completion of Form CC-11 checking, the public health nurse supervisor will give her approval or make the necessary corrections thereon. SHD will then complete State Invoice Form 100 and send same with the approved or corrected copy of Form CC-11 to the agency for their signature and to enable them to make corrections, if any, on their own copy of Form CC-11. The agency will then return to the District the signed Form 100 with the District copy of CC-11. The District will forward the corrected copy of CC-11, together with the signed Form 100, to LHS, who will in turn process same to Fisc, and send Form CC-11 copy to CC Pg office for program activity statistics.

11. Psychological Services

a. Use of Form CC-49 Psychological Report

Six copies, as necessary, are sent from Pg office to SHD for the following distribution of copies:-

- 1-to C.P. Clinic Folder
- 1-to contract nursing agency or local nursing agency or nurse
- 1-to Treatment Center unit
- 1-through SHD to agency to school that child attends
- 1-through SHD to agency to family physician
- 1-speech or hearing therapist where indicated

- b. Requests for direct Psychological Services are obtained by Pg psychologist from copies of CC-77, usually forwarded through SHD. Requests for other types of services are received through written communications. SHD assist with arrangement of services either directly or through contract or local nursing agencies.

12. Medical Social Services

Direct medical social services are provided by medical social departments of hospitals, and by community agencies. The consultative services of medical social rehabilitation consultants are available to hospitals, individual cases and, on occasion, direct services may be provided on a demonstration basis. Social economic investigations in connection with required form CC-1 are a primary responsibility of hospital or clinic, with the assistance as required of local nursing agencies through the SHD. Further investigations and checking are privileges of Board of Freeholders or their designated agents.

13. Nutrition Services

Limited direct nutrition services are available at State operated medical cerebral palsy clinics through the services of the District Nutritionists. They also render consultant services to these clinics, to State cerebral palsy consultant clinics and upon request to other approved private cerebral palsy treatment centers, orthopedic clinics, with hospitals, and convalescent homes receiving program registered cases, and with nursing agencies. Supervision for these activities is a responsibility of DSHO and PC of N with advice and consent of PC CC.

NEW JERSEY STATE DEPARTMENT OF HEALTH

DENTAL HEALTH

PROMOTE TOTAL COMMUNITY DENTAL HEALTH

1. Develop Understanding of Community Dental Health Problems

Local dental programs are essentially the responsibility of the community. The Dental Health Program serves only in an assisting role. The Program not only concerns itself with dental treatment for children of low income families, but is primarily interested in prevention - not only of dental caries, but also other disorders such as, orthodontia and periodontia.

The Program personnel attempts to promote community dental health by four basic approaches: 1. Education; 2. Prevention; 3. Research and Evaluation; 4. Dental Treatment. The Program collaborates with communities in the formulation of plans and procedures for the better utilization and expansion of their dental health resources.

Most communities are aware of their dental health needs and are seeking the solution to their dental problems. The Program assists a community as follows:

- 1- Loan of dental equipment to promote the establishment of demonstration treatment programs.
- 2- The provision of Grant-In-Aid Contracts which permit local dental personnel to supply the actual dental care.
- 3- Establishment of a dental health education program by providing speakers, films, exhibits and the distribution of dental health educational materials.

A community group requesting assistance for a dental health program should:

- 1- Forward a written application to the Department requesting a Grant-In-Aid, giving full information as to items such as, type of program desired, facilities on hand, facilities and personnel needed, approximate number and age group of children to be treated, and a complete statement of the funds available from local sources.
- 2- Plan a long range program, one that can be expanded in time, and definitely not of the type which results in examination and extraction only. This latter type of program with no thought of prevention, or control, is not acceptable.

- 3- Be prepared to assume increasing financial responsibility for the services so that the grant can be terminated within five years.
- 4- Accept program supervision and consultation services as required.

The Dental Health Program personnel are responsible for the following procedures:

- 1- The dental operators are to make every effort to acquaint local officials and community groups with the dental health problems and needs of the communities in which they work.
- 2- The Districts will assist local officials and community groups in developing an understanding of local dental health problems, and will refer matters requiring technical advice and assistance to the dental supervisors or the program coordinator as indicated.
- 3- The dental supervisors will assure that operating dentists adequately inform local officials and groups of community dental health problems and needs.
- 4- The dental supervisors will provide information and assistance for District personnel and for local officials and groups as indicated.
- 5- The program coordinator will give overall supervision of the work of the operating dentists and the dental supervisors, and will provide additional technical information and assistance as indicated.

2. Promote Dental Caries Prevention

At the present time there is no way to prevent all tooth decay, however, the wisest use of all control measures available can prevent much dental caries. The primary preventive measures are:

- 1- Reduction of the daily consumption of refined carbohydrates and carbonated beverages.
- 2- Fluoridation of public water supplies.
- 3- Topical application of fluoride to the teeth.

Reduction of Consumption of Refined Carbohydrates

The Program makes vigorous efforts to educate parents, children and school personnel on the cariogenic properties of refined carbohydrates and the desirability of reducing the dietary intake of such items. This is accomplished by arranging for speakers, films, exhibits and distributing dental educational materials. This activity has the approval of the N. J. State Dental and Medical Societies. In-Service Training on the role of carbohydrate restriction, and the prevention of dental caries is provided for public health nurses by the Maternal Child Health and Nutrition Programs. The Program includes carbohydrate restriction as the general educational activity for the dental trailers, clinics and all dental offices.

Fluoridation of Public Water Supplies

This has been a foremost Dental Health Program activity. The Program works closely with professional and lay organizations in the education of their members on fluoridation, the answering of technical questions, and the promotion of its use as a preventive measure.

The Program has two (2) films and eight (8) pamphlets on the subject of fluoridation which are available to interested groups, cost free. In addition, the Program has two table top exhibits available for local use, and can schedule larger exhibits for conventions, fairs and exhibitions. To obtain the loan of these materials the only requisite is that the interested person(s) communicate with the program coordinator of the Dental Health Program. It is the responsibility of the program coordinator to develop and supply all visual aids and educational materials.

The District Public Health Engineering personnel assists local officials and community groups on technical engineering questions relating to fluoridation, and handle requests from local water works officials for assistance with operational problems. They also perform a critical review of each monthly operating statement with particular attention directed to the study of the data relating to fluoridation. Monthly reports from water works operators showing the daily test of fluoride concentrations are forwarded to the State Health Districts. In addition, arrangements have been made to provide for the quarterly sampling of each fluoridated water supply as outlined in the Manual of Procedures of the Potable Water Program. Field supervision of the fluoridated water supplies is the responsibility of the District offices.

The promotion of fluoridation of public water supplies is the responsibility of the program coordinator and the Program personnel. Environmental Sanitation is responsible for the engineering phases of fluoridation, including the approval of fluoridation installations.

Topical Application of Fluorides to the Teeth

The term "topical application of sodium fluoride," refers to the use of a 2% solution of sodium fluoride on the surface of the teeth. In making the applications the dentist cleans the teeth, dries them thoroughly and then applies the solution. The Dental Health Program recommends this preventive measure for children at the ages of 3-7-10 and 13. Four separate applications are given at each period. This is an absolute requisite for all Program dentists.

The Program promotes the use of topical sodium fluoride for all children who have not been born or raised on water supplies containing the proper amount of fluorides. This activity is promoted by means of talks to PTA organizations, and other community groups, conferences with local school and health officials, and contacts with practicing dentists and dental societies. This procedure is described in the booklet entitled "Instructions - Dental Treatment Program" (D-D1).

3. Promote Dental Caries Control and Correction

This activity refers to "Dental Care" or "Dental Treatment." All dental decay cannot be prevented, and there is no substitute for regular and frequent visits to the dentist. The child should first visit his dentist between 2½ and 3 years of age, shortly after the primary teeth have erupted.

"Instructions - Dental Treatment Program" (D-D1) states specifically how the community dental care program is to be conducted. The type of program and standards of eligibility are determined by the local dental health committee and the component dental society, with the overall approval of the N. J. State Dental Society. The treatment program now operating in 19 counties within the State of New Jersey must be considered the main activity of the Dental Health Program. This activity, it is expected, will be expanded during the course of the next biennium.

Treatment programs are in operation in approximately 203 of the 574 municipalities (19 of the 21 counties) of the State. (See map - p. 8). Approximately 100 dentists work a total of approximately 12,740 hours a year on these programs. Treatment

is provided in approximately 70 private dental offices, 13 fixed dental clinics, 3 dental trailers, and 4 mobile dental clinics. The fixed clinics are located in public schools, municipal buildings, or hospitals. One of the trailers and all of the mobile clinics are owned by the Department of Health. The two other trailers are owned jointly by the Department of Health, Ocean and Somerset Counties.

Under these programs, all necessary dental care except prosthetic restorations and appliances is provided without charge for pre-school and school children eligible under a financial need formula which has been approved by the State and local dental societies and by county dental health committees. Eligibility under this formula is determined locally by social workers, school nurses, or other designated officials, in accordance with procedures approved by the local dental society and county dental health committee having jurisdiction.

Where budget restrictions limit the number of children who can be admitted to service, children in the lowest age group are admitted first, before children in the next higher age group are considered, and admissions are carried through as many ages in this fashion as funds will permit. Once a child is admitted to service, he continues to receive care until he enters high school, unless changing family finances make him ineligible under the formula. Only emergency services are provided for high school students. On the average, approximately 59 percent of the children examined annually under these programs receive complete treatment before the end of the fiscal year. Approximately 7,144 children are treated annually.

The costs of the treatment programs are shared with county boards of freeholders, local boards of health, and other community agencies. The total cost of the treatment programs is approximately \$190,000 a year, of which approximately 49 percent is from State funds, 46 percent from local funds and less than 5 percent from Federal funds.

Dentists employed under the treatment programs must be recommended by the local dental society having jurisdiction, and are supervised by the Program dental supervisor in each State Health District.

Local dental agencies are responsible for arranging the necessary funds to initiate or promote their dental programs. The Program assists this effort by providing additional funds through Grant-In-Aid Contracts.

The aforementioned activities will be continued in the coming biennium. In addition, the Dental Health Program plans to:

1. Start treatment programs in at least 8 new communities.
2. Make a determined effort to increase the proportion of local funds in existing treatment programs by means of amortizing Grant-In-Aid Contracts.
3. Have all dentists working on dental trailer and mobile dental clinic programs devote at least an hour of their time at each school where they work on general dental health education of the entire school population.
4. The dental trailer now in use in Ocean County is being replaced by a new trailer, fully equipped; the cost of which is being entirely assumed by the county.

4. Conduct Special Studies in Periodontal Disease

a. Courses for Dentists

The program coordinator is planning to arrange for special courses on the subject of "Periodontal Disease." At the present time the program coordinator is working in cooperation with the Deans of two dental schools in New Jersey, and with several interested prominent dentists in developing plans for providing these studies and courses. The etiology, prevalence, as well as early detection and treatment will be emphasized.

These special courses are primarily for the interested dental membership of the N. J. State Dental Society. As soon as plans are completed, requests will be made to all the component dental societies comprising the N. J. State Dental Society, requesting the names of those men interested. This activity is primarily the responsibility of the program coordinator of the Dental Health Program.

b. Research Studies in Epidemiology of Periodontal Disease

The program coordinator of the Program is studying the possibility of establishing public health research in this previous unexplored field.

5. Provide Professional Dental Health Education

This activity relates to the promotion of dental health education by means of postgraduate training for the dental operators of the N. J. State Department of Health Dental Program on the subjects of "Oral Cancer," "Dentistry For Handicapped Children," and "Pedodontia." The program coordinator of the Dental Health Program is primarily responsible for providing this education by:

- (a) Developing study plans
- (b) Securing authorization
- (c) Securing funds
- (d) Enlisting cooperation of membership of N. J. State Dental Society
- (e) Coordinating dental activities with other programs in the Department

As these postgraduate courses are entirely for the dental profession, the method of determining the participants for these courses is restricted to those interested dentists who present a written request for attendance to the program coordinator of the Dental Health Program, and have obtained the approval of their component dental society.

The program coordinator works in close conjunction with the Cancer, Crippled Children, and the Maternal and Child Health Programs, which provide funds for these courses.

6. Develop Orthodontic Services

This activity to date has not been initiated because funds have not been available. Initial plans for establishing such a project, even though on a small scale, have been developed by the program coordinator of the Dental Health Program and the program coordinator of the Crippled Children Program. Local resources have been investigated, and orthodontists are being asked to cooperate to the extent of reducing their fees to a minimum.

The program coordinator has prime responsibility for establishing an Orthodontic Service project in conjunction with the Crippled Children Program. This activity is to be given a high priority.

NEW JERSEY STATE DEPARTMENT OF HEALTH
DENTAL HEALTH

DENTAL TREATMENT PROGRAMS
FOR CHILDREN IN NEW JERSEY

Map indicates number of communities and types of dental treatment programs as conducted by the N. J. State Dept. of Health for children of low-income groups.

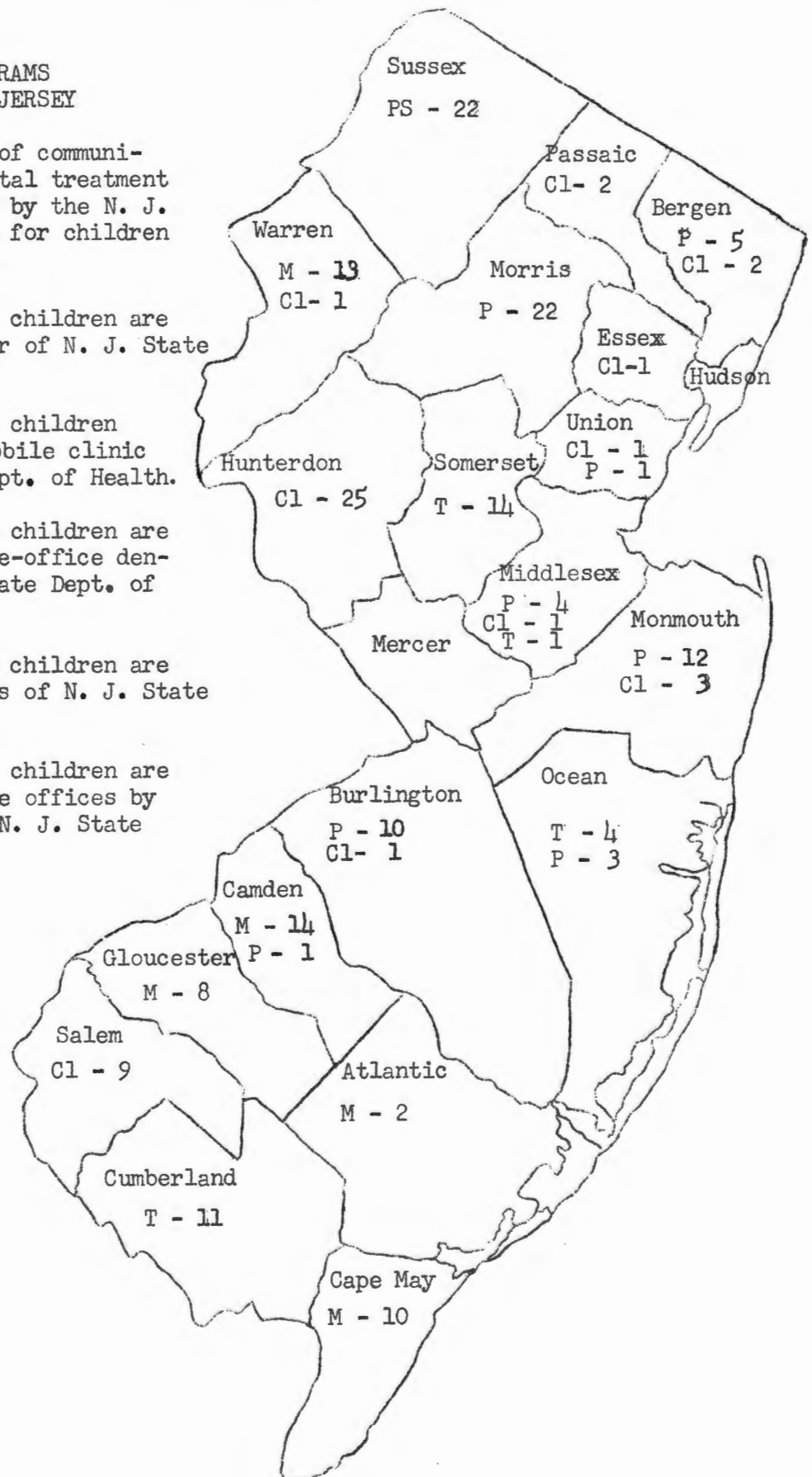
T - Communities where children are treated in trailer of N. J. State Dept. of Health.

M - Communities where children are treated in mobile clinic of N. J. State Dept. of Health.

P - Communities where children are treated by private-office dentists in N. J. State Dept. of Health.

C - Communities where children are treated in clinics of N. J. State Dept. of Health.

PS - Communities where children are brought to private offices by station wagon of N. J. State Dept. of Health.



NEW JERSEY STATE DEPARTMENT OF HEALTH

DIABETES CONTROL PROGRAM

PART I

DIABETES CASE-FINDING ACTIVITIES

A. Organization and Procedures

1. State-wide Diabetes Detection Drive

The policy for the broad case-finding drive during Diabetes Week is established by the major sponsors, i.e., the Medical Society of New Jersey, the New Jersey Diabetes Association and the New Jersey State Department of Health, through their representatives. A multitude of professional, voluntary and community organizations have taken active roles in all stages of the program, from the earliest pre-planning to final evaluation. These include the following:

- New Jersey Society of Clinical Pathologists
- New Jersey Hospital Association
- New Jersey State Nurses' Association
- New Jersey State League for Nursing
- New Jersey Health Officer's Association
- New Jersey Pharmaceutical Association
- New Jersey Congress of Parents and Teachers
- New Jersey Chiropractors Society
- New Jersey State Dental Society
- The Women's Auxiliary to the Medical Society
of New Jersey
- Local Boards of Health
- Voluntary Health Agencies

A diabetes committee has been organized in each of the twenty-one counties, with a chairman and associate members appointed by the president of the County Component Medical Society. The basic plan for the county is devised by this committee, which works with Parent-Teacher Association members, local and district health officials and personnel, members of the Women's Auxiliary, etc. The primary functions of these committees are to organize a plan of distribution of test materials and educational materials among industrial groups and the general public, and to arrange for local publicity, meetings and radio programs.

Health Department personnel, including those from the Diabetes Program, State Health Districts, and local offices have actively participated in conjunction with the county committees. It has been desirable to establish permanent or semi-permanent diabetes committees on a county basis, but this has not been accomplished as yet.

Dissemination of educational information has been general and professional in nature. National radio and television releases have emanated from the American Diabetes Association in New York City. State-wide newspaper and organizational magazine releases are prepared by the Health Department Public Relations Director to supplement local efforts by health officials and committee members. Educational pamphlets, posters and information documents are utilized, and public forums, conferences and meetings are held.

A Symposium on Diabetes Mellitus has been held annually for physicians. It has been scientific in nature, consisting primarily of medical data of a clinical, investigative or public health nature, which deals with diabetes and related metabolic disorders. The subjects are timely, being based on recent trends and developments as well as the current interests and activities of the speakers. In-service training, institutes, exhibits, and conferences for health officers and para-medical personnel are arranged.

Dreypaks are purchased from the American Diabetes Association with Diabetes Control Program funds, and, in some instances, by County Component Medical Societies. Distribution from the central supply has been made to county committees, large industrial groups, including employees of the State Government, municipal and district health officials, and to special groups such as the chiropodists, selected physicians and others. Some general public distribution is arranged by local committees, via drug stores, hospital clinics, Parent-Teacher Association members, etc. Dreypaks are generally returned by mail to collecting centers at each of the four State Health District Offices and the office of the Division of Chronic Illness Control. The kits are counted and forwarded to laboratories of volunteer member hospitals of the New Jersey Hospital Association, and to state laboratory facilities, for testing in accordance with specified techniques. More than 70 hospitals have participated in this phase of the program each year. The Chemistry Program has performed a considerable share of the tests each year.

Participants who submit specimens are promptly notified of the results. Those screened positive are advised to see a physician, who is also notified of the test result. A summary of suggested confirmatory procedures is forwarded to each physician to assist him with the establishment of a final diagnosis. In general, re-tests by combined postprandial urine and blood sugar determinations or glucose tolerance tests are the preferred methods for the final evaluation of a diabetes suspect.

Follow-up is initially instituted by a letter and questionnaire to physicians of participants who screened positive. If the follow-up is not completed, a second questionnaire and, later, a telephone call to the physician is utilized to gain the information. In some instances, where a suspect fails to report to a physician or clinic, a public health nurse visits the individual to interpret the need for further study.

The final phase includes a summary and statistical analysis of results. This data is communicated to all interested, participating groups.

2. Local Urine Screening

Diabetes case-finding should be a year-round endeavor, so short or long-term programs are organized, assisted or encouraged in various communities throughout the State. They are generally offered to specific groups of people, such as municipal employees, industrial personnel, members of service clubs, school teachers, etc. Such detection programs are usually arranged by local health officials, school physicians or nurses, industrial physicians or nurses, TB and Health Associations, etc. The general organization of such is similar to that described previously.

3. Blood Screening for Diabetes: Clinitron Method

Blood sugar testing is superior to urine examination for the detection of diabetes, but it is somewhat more complicated and more expensive. Blood is obtained from a vein, finger-tip or ear-lobe and tested within a short period of time. This type of study is more specific and more sensitive than urine analysis.

The Hewson Clinitron is an automatic device for performing blood sugar screening tests. The process of a single test takes 5 minutes, and, when working at full capacity, under ideal circumstances, a result can be obtained every 30 seconds, i.e., 120 tests per hour. It is quite practical to screen large numbers of persons rather easily and quickly by this device.

The chemical technique is based on the method of Hagedorn, Halstrom and Jensen as modified by Wilkerson and Heftmann. A true glucose screening level is obtained by this method, allowing for comparison with quantitative true-glucose techniques such as that of Somogyi and Nelson.

Blood screening for diabetes with the clinitron is performed throughout the year in New Jersey in two community hospitals, the Newark Bureau of Health and as part of the New Jersey State Employees Health Program:

a) Hunterdon Medical Center, Flemington, N. J.

The Wilkerson-Heftmann blood test is performed with the clinitron as part of a multiphasic screening program. The tests are offered to members of the community who report to the out-patient department for a complete battery of studies. A postprandial sample of venous blood is obtained and analyzed. The positive specimens are re-tested by the hospital laboratory utilizing a standard blood sugar determination. Those which are positive after re-testing are referred to a private physician for further evaluation.

b) Middlesex General Hospital, New Brunswick, N. J.

A clinitron is utilized for screening attendants of all out-patient clinics and in-patients as well. In addition, a program of testing employees of industries in the New Brunswick area has been inaugurated. In this instance, capillary blood is utilized and re-testing is performed on venous blood. Positive reactors are referred to the hospital diabetes clinic or to private physicians for confirmatory studies and diagnosis.

c) State Employees Health Program

There are 23,000 employees of the New Jersey State Government, and a large proportion of them are located in Trenton. A year-round program of blood screening has been inaugurated utilizing capillary blood samples. Re-testing is done on venous blood and positive reactors are referred to their private physicians for confirmatory studies and final diagnosis.

d) Newark Bureau of Health

A clinitron is utilized in this local health department for screening the general public. It has been used throughout the year and during Diabetes Detection Week.

e) Paterson Health Department

A clinitron is utilized in this health department for screening the general public.

f) General Public

Diabetes detection by blood tests will be combined with other public surveys, including chest x-rays for tuberculosis and serological tests for syphilis. Screening will preferably be applied to selected population groups.

PART II

SERVICES AND FACILITIES FOR LONG-TERM CONTROL OF DIABETES

A. Background Information

"See General Section I"

B. Activities Related to the Patient and Family

1. Establish the Diagnosis and Provide Effective Medical Therapy.

Diabetes screening is an attempt to identify persons most likely to have the disorder by testing large numbers of people at random or after a specific carbohydrate meal. Screening tests do not establish a final diagnosis, but simply pinpoint the suspects. On the other hand, the establishment or elimination of the diagnosis of diabetes mellitus in such a suspect entails the acumen necessary to digest pertinent facts from the participants personal and family history, physical examination and specific laboratory tests. The personal physician is the logical person to evaluate such a situation.

The diagnosis of diabetes is easily established in many persons, who have unquestioned hyperglycemia, glycosuria and symptoms of uncontrolled diabetes. In many instances, the diagnosis can easily be eliminated after carefully study. There is a group of persons in every study, however, who are difficult to categorize. They are often labeled as "potential diabetics", "borderline diabetics" or "latent diabetics". These persons have laboratory studies which are suggestively positive or "borderline". Inasmuch as the diagnosis of such a complex metabolic disorder as diabetes ultimately hinges on laboratory examinations, one must realize that fortuitous physiologic changes may interfere with or delay a definitive diagnosis. It is here that the judgement of the physician plays such an important role, since it has been shown that many of these "borderline diabetics" will subsequently prove to have frank diabetes.

Establishment of the diagnosis of diabetes is the responsibility of the physician in his private office, hospital or clinic. The provision of effective medical therapy and supervision rests in the same domain. Aside from education of the patient, the physician determines the specific diet, the need for, amount and type of insulin and other medications. The physician sets the standard of control for himself and the patient. Objectives are freedom from symptoms, maintenance of adequate growth and nutrition, protection of the insulin-producing capacity of the pancreas, continuation of the diabetic as a useful, functioning member of society, maintenance of the female capability for procreation of living and healthy offspring, and the prevention of complications. The latter includes

the prevention of short-term problems such as acidosis and hypoglycemia, as well as long-term and secondary disabilities such as the "diabetic triopathy" (retinopathy, neuropathy and nephropathy), accelerated vascular sclerosis and gangrene.

Periodic revisits and examinations by the physician should include an evaluation of diet, urine tests, insulin reactions and interim interpretation and instructions. A blood sugar determination, complete urinalysis, record of the weight and examination of the feet are a part of such check-ups. The diabetic should have an annual chest x-ray and complete physical examination, including a thorough eye examination.

2. Patient and Family Education; Para-Medical Guidance and Assistance.

Diabetes is a unique disorder which requires the patient to shoulder a great deal of the responsibility for his daily care, including dietary management, insulin administration, regulation of exercise, and good general body hygiene, especially the care of the feet. Thorough indoctrination and continued guidance by a team of individuals including the physician, nurse, nutritionist, medical social worker, chiroprapist and other medical and para-medical specialists, is the keystone to the best regulation of the disease.

This type of patient and family orientation is most effectively presented by group and individual instruction, audio-visual aids (films, film-strips and slides), educational pamphlets, booklets and reprints and demonstrations. The physician teaches the nature of diabetes, the signs and symptoms of pending acidosis or hypoglycemia, the principles of general body hygiene, the need to maintain normal weight and the balance between insulin, diet and exercise. The nurse supplements this by presenting the technical material concerning insulin administration, syringe and needle care, urine testing, body hygiene and foot care. The public health nurse is invaluable in transferring and strengthening the transition of care from the hospital ward, clinic, or private office to the home. Both the nurse and the medical social worker help by recognizing and assisting with socio-economic and emotional problems. The nutritionist translates the physician's prescription into a diet and gives specific dietary instruction to the patient and family. This necessitates individual counseling, but is more effective when group instruction is also utilized. The chiroprapist assists by teaching the patient good techniques of foot care, while giving podiatric treatments.

Activities related to the patient and family are generally the responsibility of the physician and his associated para-medical personnel. The Diabetes Control Program interest and responsibility is related to consultation and assistance in the organization of local facilities in the community. This includes educational materials, certain equipment and supplies, and, in some instances,

assistance in obtaining personnel. The overall plan is to strengthen New Jersey diabetes clinic facilities, and to cooperate with, and assist, private physicians as well as interested voluntary, community health organizations.

C. Activities Involving the Community

1. Definition

"See General Section I"

2. Activities

a. Dissemination of Information

The program will provide information of an educational nature through its own resources, in cooperation with local organizations.

"See General Section I"

b. Organizational and Consultative Activities

(1) The Health Department "Diabetes Team", consisting of physician, community health educator, nurse, social worker and nutritionist, shall be available for consultation to the community. Such personnel should include individuals in the Diabetes Control Program, State Health District personnel and, where available, those qualified individuals associated with local boards of health. Assistance and advice relative to the development of a local program, which includes all phases of diabetes control, shall be offered. It is especially desirable to work with hospital personnel, professional organizations and voluntary health agencies. It is not within the province of the program to give direct services, but to strengthen local activities and programs.

(2) Patient Education Programs

See Part II, B, 2.

The logical place for patient education programs is in the community hospital, under the jurisdiction of the medical staff and their associates. Many New Jersey hospitals have an organized diabetes clinic, or a medical clinic which cares for diabetic patients. The necessary teaching personnel are generally present on the hospital staff, or available to it. The number of diabetics on the clinic records makes group therapy and individual teaching possible and necessary.

It shall be a function of the Diabetes Control Program to assist in the organization, development, and implementation of such patient education programs in community hospitals. In some instances, facilities other than the hospital may prove more practical or desirable.

D. Activities Involving Professional Organizations and Personnel

1. Educational Activities

a. General

Medical Societies, as well as professional organizations representing nursing, medical social service, dentistry, chioprody, dietetics, pharmacy, hospitals and public health, have an important responsibility to provide educational data to the general public.

Program personnel shall encourage, assist and cooperate with such recognized groups, who have an interest in diabetes control. In fact, they should be brought into program activities whenever possible and practical. Examples of this type of cooperation would include the following:

(1) Annual Symposium on Diabetes Mellitus

This is a one-day scientific meeting jointly sponsored by the New Jersey Diabetes Association and the New Jersey State Department of Health. It has been presented annually since 1953 and has attracted a large audience each year because of the high level of interest of the program and the presentation by competent authorities in the field. Proceedings of the Symposium will be published and made available to interested persons.

(2) Short Courses

A short course in endocrinology and metabolism has been jointly sponsored by the St. Michael's Hospital and the New Jersey State Department of Health. This course is given at the hospital for interested physicians. The lecturers have included prominent physicians of high academic rank, who have discussed various metabolic disorders including diabetes.

b. In-Service Training

(1) Purpose

- a. To provide information to the Diabetes Program Personnel, departmental personnel of the same or other divisions, as well as district and local health department staffs, who have an interest or responsibility in the program.
- b. To orient all interested individuals, including physicians, nurses, nutritionists, medical social service workers, and other allied disciplines, to newer knowledge in the field of diabetes and related metabolic conditions.
- c. To strengthen the Diabetes Program, and its personnel, in relation to OBJ. A., i.e., PROMOTE EARLY DETECTION AND CONTROL OF DIABETES.

(2) Methods

- a. In-service training in the Diabetes Program includes all non-accredited courses or institutes, concerning diabetes, with which the Department is associated. The curricula of such courses or institutes may be more or less fixed, depending on the formality of the endeavor.
- b. Certain formal meetings may be considered in-service training since their educational value to all participants may be considerable.

(3) Content of In-Service Training Courses and Institutes in Diabetes.

a. General Content

1. Diabetes is a chronic disorder, whose fulcrum of control rests firmly on a base of education. Education at all levels will ultimately help to reduce the morbidity and mortality from diabetes.
2. It is now apparent that indoctrination of the diabetic to all aspects of his disease is a most essential objective of therapy. Education at the physician level is more likely to emphasize the clinical, chemical, physiological and pathological elements of the disease. The practitioner may also benefit by orientation as to patient education, public health nursing and medical social service problems as they concern the diabetic.

3. The general content of in-service training for nurses, nutritionists and medical social-service workers will overlap to a certain extent, yet will retain some uniqueness by virtue of the major interests and responsibilities of the individual specialty represented.

b. Content of Specific Courses and Institutes.

1. Diabetes Symposium (See Part II, D-1-a-(1)).

2. U.S. Public Health Service Diabetes Courses

(a) The Diabetes Field Research and Training Unit the U.S. Public Health Service offers training in diabetes control through courses. The faculty includes a medical officer, internist, nutritionist, public health nurse, statistician, biochemist, health educator, and medical technician. Courses are offered to physicians, public health administrators, nurses, dieticians, nutritionists, health educators, medical technologists, and medical social workers.

(b) In general, the courses consist of discussions, demonstrations and field trips relative to the problems involved in the care of the diabetic in the hospital and in the community.

(c) Specific Courses and Their Content

In the past, a number of courses have been offered including:

- (1) A Diabetes Program in Public Health
- (2) Patient Education in Diabetes
- (3) Nursing Aspects of a Diabetes Program
- (4) Nutritional Aspects of a Diabetes Program
- (5) Laboratory Aspects of a Diabetes Program
- (6) Organization & Management of a Diabetes Clinic

The specific content of each course can be found in the descriptive brochure provided by the Diabetes Field Research and Training Unit. Courses are offered at various times during the year; they last one week and usually the enrollment is limited to ten persons per course. A number of State Department of Health personnel, in various divisions, have attended these courses.

3. Institutes on Diabetes

- (a) Plans are being considered for the future development of diabetes institutes for nurses, medical social service workers, nutritionists, and other public health personnel. Such plans are contingent upon the interim training of diabetes program personnel and related staffs of the Department of Health, so they are in a better position to offer valuable material for teaching purposes.

2. Research

"See General Section I"

E. Continuity of Care

"See General Section I"

NEW JERSEY STATE DEPARTMENT OF HEALTH

MIGRANT HEALTH

Since the enactment of the migrant labor law in 1945, the Migrant Health Program has been primarily one of venereal disease control although some attention has been given to other health problems.

The content of each specific health program among migrants is the responsibility of the coordinator for the appropriate departmental program. For example, coordinators of the MCH, TB, VD and CDC programs are responsible for their respective program activities among migrants. Recruiting and supervision of personnel, the execution of program activities in the field and record keeping are the responsibilities of the State Health Districts. The coordination of these activities is the responsibility of the Migrant Health Program as is the maintenance of liaison with the Migrant Labor Board.

Interpretation of the health needs of migrants to local official and voluntary agencies, and the stimulation of cooperative efforts towards meeting these needs are responsibilities of District State Health Officers, of those coordinators carrying out specific health programs among migrants, and of the coordinator of the Migrant Health Program.

Periodic and annual reports are to be submitted by coordinators carrying out specific health programs among migrants to the coordinator of the Migrant Health Program.

VENEREAL DISEASE CONTROL

The VD Control Program encompasses venereal disease control among migrants. Consequently, the manual of procedures of the VD Control Program is generally applicable.

The Migrant Labor Act requires that any migrant laborer who cannot show satisfactory evidence of examination for venereal disease having been performed within 90 days prior to entering New Jersey must submit to such examination 30 days after entry.

Within the limitations of the budget, emphasis is placed upon the examination of southern Negroes. Several hundred Jamaicans (B.W.I.) and several thousand Puerto Ricans annually are not required to be examined, since, as a rule, an examination before entry into the United States screens out venereally infected individuals.

Clinics for Agricultural Migrants

Clinics are conducted each season at stationary sites and in a mobile unit. While the schedule of clinic sessions depends upon the number of migrants during a given season and the areas of their concentration, ordinarily the mobile unit and the stationary clinics provide about four evening clinic sessions each per week during the peak of the harvest season. An effort is

made to contact personally each farmer employing migrants and the contractors concerned. They are advised of the exact time and place that a given crew is expected to attend a clinic. The mobile unit is scheduled to cover the largest concentrations of migrant population. A centrally located farm or other place is selected as the site for the unit so that few individuals are required to travel more than 3 or 4 miles to obtain an examination.

The clinics are staffed with physicians, nurses, technicians for drawing blood, venereal disease interviewer-investigators, program aides, and clerks, the numbers of each being dictated by their availability and the anticipated needs of a given clinic session. The key persons in the conduct of the program are the specialized venereal disease personnel on the staffs of the VD Control Program and the District State Health Offices. They perform duties of program coordination, scheduling and advance work, blood letting, interviewing and investigating, and actual camp-to-camp canvassing just before and during clinic sessions to assure attendance at clinics.

Long and irregular work hours are required for successful operation of the program. Since migrant laborers work until nightfall, clinic sessions do not begin until 7:30 or 8:00 o'clock in the evening and often continue until midnight or later.

Clinics for Migrants Other than Agricultural Workers

In addition to those employed in agriculture, migrant race track workers are examined each year in an intermittent season running from May to October. Individuals examined at the tracks include grooms, stable boys, exercise boys, jockeys, and concession employees. Track facilities are used. While the services of track physicians are available for diagnosis and treatment, other necessary services are provided by personnel on the staff performing similar duties for the agricultural migrants.

Seasonal employees of seafood industries are tested annually, for which activity the mobile unit, appropriately staffed, is used.

Diagnosis and Treatment Policies

Patients are examined and treated according to the following policies established by the VD Control Program. The extent and thoroughness of physical examinations depend largely upon the number of migrants to be examined during a given clinic session and on physical facilities.

I Serologic tests for syphilis (STS) shall be provided for:

- A All persons over 12 years of age
- B All children, regardless of age, of mothers with reactive results on STS

II Physical Examinations

A Physical examinations shall be provided for:

- 1 All males over 12 years of age undergoing serologic screening
- 2 All individuals with reactive STS
- 3 All contacts, male or female, to cases of venereal disease
- 4 All individuals complaining of or manifesting obvious signs or symptoms of disease

B Physical examination shall consist of:

- 1 For category II A1, inspection of mouth and genitalia
- 2 For categories II A2,3 and 4, a general physical examination with special attention to:
 - a Examination of eyes and mouth and skin of face, trunk and hands
 - b Examination of heart
 - c Examination of external genitalia, cervix (females), and anal region
 - d Examination for cervical, epitrochlear, and inguinal lymphadenopathy

III Diagnosis

Accurate diagnosis and management of venereal disease depends on correlating history, physical examination, laboratory findings, and clinical judgment. Because of the peculiar problems of transiency associated with migrants, certain compromises with regard to diagnosis and management must be made. Following are acceptable diagnostic criteria.

- A Presumptive diagnosis of venereal disease may be made on initial inspection in the presence of objective clinical findings.
- B Presumptive diagnosis of syphilis may be made with one reactive result on STS when confirmatory blood tests are not feasible.
- C Diagnosis of early latent syphilis should be made when the duration of the latent infection is under four years, and diagnosis of late latent syphilis when the duration is over four years.
- D When a diagnosis of latent syphilis is made and the history does not establish the duration of the infection, a diagnosis of early latent syphilis should be made when the patient is under 26 years of age and late latent syphilis when the patient is 26 years of age or over.

IV Treatment

Because of the follow-up problem which transiency introduces, treatment schedules involving only one clinic visit are preferred.

A Prophylactic treatment

- 1 All contacts of primary and secondary syphilis shall be treated with 2.4 million units of benzathine penicillin G (bicillin)
- 2 All contacts of diagnosed gonorrhea shall be treated with 1.2 million units of bicillin

B Recommended treatment schedules for diagnosed cases of venereal disease (including presumptive diagnoses).

Disease	Drug	Administration and Dosage
Syphilis (all stages except congenital)	Benzathine Penicillin G (Bicillin)	2.4 million units intramuscularly in a single administration of 1.2 million units in each buttock
Congenital Syphilis	Bicillin	$\frac{1}{2}$ adult dosage under 2 yrs. of age; full dosage over 2 yrs. of age
Gonorrhea	Bicillin	1.2 million units in a single administration in the buttocks
Lymphogranuloma Venereum	Terramycin	500 mg. dose orally every 6 hours for 12.5 days to a total of 25 gms.
Chancroid	Sulfathiazole	One gram (15 grains) orally 4 times a day for 7 days to a total dosage of 28 grams
Granuloma Inguinale	Terramycin	500 mg dose orally every 6 hours for 12.5 days to a total of 25 gms

C Retreatment

- 1 Individuals with high titer bloods (reactive in a dilution of 1:8 or higher) who have received one previous course of penicillin or bicillin, may be retreated once. If two courses of penicillin or bicillin have already been given, no further treatment need be administered.

V Drug Supplies

- A A supply of bicillin shall be provided to clinics at the beginning of the season by the VD Control Program
- B Other drugs shall be provided as need arises

VI Reporting

- A All cases of venereal disease, including those treated on presumptive diagnosis, shall be reported on the morbidity report form. These forms shall bear the stamp "MIGRANT".

Epidemiologic Study

Under existing conditions, no easy solution is apparent to the problem of thorough contact interviewing and investigation. Epidemiologic study is difficult for several reasons:

- I Space is inadequate for proper contact interviewing
- II Lack of privacy reduces the effectiveness of interviewing
- III In crowded clinic situations, physicians often fail to refer patients for interview
- IV Interviewers are often pressed into service as clerks or technicians in order to process large numbers of patients during short clinic sessions

To the extent permitted within these limitations, patients with infectious venereal disease are interviewed and their contacts investigated. The following policies established by the VD Control Program are applicable:

- I Who shall be interviewed?
 - A All individuals with primary or secondary syphilis
 - B All individuals with early latent syphilis
 - C All women with late syphilis for children, husband, and long standing sexual partners
 - D All males with gonorrhoea
 - E All individuals with chancroid
 - F All individuals with granuloma inguinale
 - G All individuals with lymphogranuloma venereum
- II When shall these individuals be interviewed?
 - A Immediately after diagnosis
- III Who shall interview?
 - A An interviewer shall attend each clinic session

IV Where shall interviews be performed?

A Within the limitations imposed by clinic facilities, in as private a place as possible

V For whom shall epidemiologic report forms (VD-1) be prepared?

A Interviewer shall prepare epidemiologic report forms on all contacts elicited during interviews

B VD Control Program personnel shall prepare epidemiologic report forms on all individuals with reactive STS

VI Who shall investigate?

A Investigations shall be performed by special VD personnel assigned to the State Health Districts

AMBULATORY MEDICAL AND SURGICAL SERVICES

Many migrant laborers come to clinics in need of medical and surgical care for conditions such as upper respiratory infections, gastro intestinal disorders, infections, lacerations, burns, removal of foreign bodies, etc. Minor conditions are cared for within the limits of time, personnel, and physical facilities. Patients requiring more extensive care than can be provided in migrant clinics are referred to private physicians, clinics, or hospitals, as appropriate.

TUBERCULOSIS CONTROL

The TB Control Program embraces case-finding and control of tuberculosis among migrants. The manual of procedure of that program is therefore generally applicable.

Previous pilot studies have revealed that seasonal resort workers are of a relatively high socio-economic strata including college students and do not present an important tuberculosis problem. Agricultural workers procured by agreement with Puerto Rican and Jamaican authorities through State and federal agencies are usually screened by pre-entry Xray and also contribute little to the State's tuberculosis problem. These groups are therefore not routinely screened by the TB Control Program.

However, studies have shown a relatively high tuberculosis incidence among race track employees and emphasis is placed upon their examination. Chest Xray surveys are scheduled annually by the appropriate District State Health Officer at each of three race tracks within the State.

Thousands of other agricultural workers migrating into the State annually present a potentially high risk element which has not yet been measured. Ways and means of screening this group will be explored and appropriate screening schedules arranged.

Rapid movement of workers requires that suspects from screening surveys be promptly brought for further examination, diagnosis and appropriate disposition. It is essential that, in active cases, proper control for prevention of spread of infection be instituted and adequate comprehensive care be arranged before the individual has opportunity to migrate to some other and unknown area.

Suspects from migrant surveys are referred to nearby existing local clinics for follow-up and diagnosis. Active cases are referred by the TB Control Program to the State Department of Health of the state of patient's residence for assumption of responsibility. The local board of health is responsible for surveillance and control of cases pending disposition. The District State Health Officer and the coordinator of the TB Control Program provide consultation where needed.

MCH SERVICES

Admission of migrant children to child health conferences shall be encouraged. It shall be the responsibility of the State Health Districts to stimulate public health nurse supervision of migrant children and their attendance at child health conferences.

Funds for additional personnel and travel to meet increased case loads shall be made available on a grant-in-aid basis to community health agencies offering their existing MCH services, such as prenatal clinics, child health conferences, and public health nursing services to migrant families. Contracts are negotiated by the State Health Districts with approval by MCH.

It is proposed that pediatric clinics providing health supervision, including immunizations and treatment of minor conditions such as impetigo, colds and scabies, be established in conjunction with the schools for migrant children. Clinic personnel required for each session are part-time physician, nurse and clerical worker. Necessary medication and equipment shall be provided. Patients with major medical problems shall be referred for appropriate medical care (hospitals, physicians). Public health nursing follow-up shall be arranged where feasible.

INSTRUCTIONS FOR COMPLETING AND PROCESSING FORMS

Forms used specifically in the Migrant Health Program are described below. Since the VD, TB, CDC and MCH Programs include services to migrants, the forms, form letters, and information documents described in those programs are generally applicable.

Form Mig-1, Clinic Record

I Instructions for completing and processing this form in a migrant clinic

- A When a report of a reactive blood test is received by the VD Control Program, a check of previous clinic records is made. If a past record is found, the blood test result is entered on this record. When no past record is found, a new clinic record is in-

initiated and completed, to the extent possible, from the Registration form. The record is then forwarded, with the Epidemiologic Report form, through the District State Health Office to the appropriate migrant clinic.

- B Clinic records are initiated and completed in a migrant clinic when individuals are clinically diagnosed as having venereal disease; when they are examined as contacts of infectious venereal disease; and when they are examined for other reasons, such as for pregnancy, lacerations, colds, etc.
- C Upon completion of diagnosis, treatment and/or referral, clinic records are forwarded to the VD Control Program.

II Instructions for processing this form in the VD Control Program

- A Clinic records are filed alphabetically by last name in an active file, which contains records for individuals examined, diagnosed and/or treated during the current season.
- B Clinic records are transferred from the active file to an inactive file at the end of the current season.

Form Mig-2, Health Examination Card

- I Complete and present to each individual at the time of initial examination for venereal disease.
- II Instruct individuals to carry this card at all times.

Form Mig-3, Treatment Card

- I Complete and present to each individual treated for syphilis.
- II Indicate the date and amount of treatment.
- III Instruct individuals to carry this card at all times.

Form Mig-4, Migrant Labor Referral Form

- I Complete face of referral form in quadruplicate for each individual referred to a physician, hospital, clinic or other agency.
- II Distribute copies as follows:
 - A Original copy to physician, hospital, clinic, or other agency to which individual is referred.
 - B One copy to individual being referred.
 - C One copy to appropriate State Health District.
 - D One copy to VD Control Program.

- III If patient is referred by some one other than a physician, so indicate by crossing through the word physician and write in the title of person making referral.
- IV It is the responsibility of the appropriate State Health District to carry out follow-up procedures.

Form Mig-5, Daily Migrant Clinic Report

- I Complete clinic report in duplicate at close of each clinic session. This is the responsibility of the clinic coordinator.
- II Forward one copy to the appropriate State Health District and one to the VD Control Program.

Form Mig-6, Time and Attendance Report

- I Enter hours worked by each employee at the close of each clinic session. This is the responsibility of the clinic coordinator.
- II Forward completed forms to the VD Control Program the 1st and 16th of each month.

Form VD-1, Venereal Disease Epidemiologic Report

- I All epidemiologic reports for individuals with reactive or weakly reactive blood test results shall be initiated by the VD Control Program.
- II All epidemiologic reports for contacts and for suspects other than those noted above shall be initiated by the migrant clinics.
- III All epidemiologic reports shall be processed and routed according to instructions in the Manual of Procedures of the VD Control Program.

Form VD-2, VD Morbidity Report (Clinics)

- I Complete this form on all patients diagnosed as having venereal disease. If treatment is administered on epidemiologic evidence, complete this form and indicate disease for which treatment is given.
- II Complete one morbidity report for each venereal disease diagnosed. If an individual has two or more venereal infections, complete a morbidity report form for each one.
- III Complete morbidity report during the same clinic session that patient is diagnosed or treated.
- IV Forward morbidity reports to VD Control Program at close of each clinic session.

Form VD-3, Interview Record

- I Prepare an Interview Record for each patient interviewed whether or not contacts are obtained.
- II Interview patients diagnosed as having any of the following venereal diseases:
 - A Primary or secondary syphilis
 - B Early latent syphilis
 - C Gonorrhea (males only)
 - D Chancroid
 - E Lymphogranuloma venereum
 - F Granuloma inguinale
- III Interview women with late syphilis for husband, long standing sexual partners, and children.
- IV Forward Interview Records to the VD Control Program at the close of each clinic session.

Form VD-9, Registration Form

- I Instructions for completing and processing this form in a migrant clinic
 - A Information required
 - 1 Full name of patient
 - 2 Name and address of farm on which patient is living
 - 3 Name of patient's crew boss (indicate this information in the space assigned for husband, parent or guardian)
 - 4 Name of examining clinic (indicate this information in the space assigned for station location 4-9)
 - 5 Date, serial #, age, race and sex (indicate this information in the assigned spaces)
 - B Complete this form each time a blood specimen is taken for STS
 - C If a blood test is being repeated to confirm a diagnosis of syphilis, indicate this by writing "repeat blood test of serial number ___" on Registration Form. (Indicate this information in space just below perforated line)
 - D At the close of each clinic session forward all completed Registration forms, in numerical order, to the VD Control Program.

II Instructions for processing this form in the VD Control Program

- A As soon as laboratory results are available, transcribe all reactive and weakly reactive test results, by serial number, from the Selective Blood Testing Survey Laboratory form to the Registration form.
- B Prepare an Epidemiologic Report form #1 for each Registration form indicating a reactive or weakly reactive blood test result.
- C Separate and tabulate all Registration forms by clinic, result of blood test, age group, race, and sex for PHS Form #1892-2.
- D Forward all Registration forms to the appropriate State Health District for use in future migrant programs.

Form VD-11, Selective Blood Testing Survey Laboratory Form

- I Complete this form in duplicate indicating numbers that correspond to serial numbers on blood test tubes.
- II Forward both copies of form to the Serology Laboratory with blood specimens.
- III The laboratory then forwards one copy of the form to VD Control Program with results of tests indicated thereon.

Form PHS 1892-2 Summary of Blood Testing Activities by Race, Age and Sex

- I This form is completed and processed by the VD Control Program. Instructions appear in the Manual of Procedures of that program.

NEW JERSEY STATE DEPARTMENT OF HEALTH

TUBERCULOSIS CONTROL

MANUAL OF PROCEDURES

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NEW JERSEY STATE DEPARTMENT OF HEALTH

TUBERCULOSIS CONTROL

The Program and State Health Districts are committed to promote improvement in the control of tuberculosis to the highest degree of effectiveness possible. Municipal boards of health are encouraged to assume full responsibility for direct services to individuals in keeping with authority vested in them. These services should be available either through locally provided facilities and adequately trained personnel, or by contractual arrangement with qualified local agencies. District staff will offer guidance, stimulate interest and action where indicated, and provide available manuals and information documents. The Program will give support to the Districts as requested or indicated.

CASE FINDING

Contact Investigation

Public health nurses, employed by the board of health or by the health agency designated, are usually best qualified and it is their recognized responsibility to assure examination of contacts. "Guide for the Medical and Public Health Nursing Supervision of Tuberculosis Cases and Contacts" (APHA), available to local health agencies from State Health District offices, contains recommended procedures.

Chest X-Ray Screening in Hospitals and Institutions

Division, Program and District staff, when opportune, will direct attention of hospital management and medical staff to x-ray screening as a valuable method for early detection of chest pathology for which diagnosis and early treatment might otherwise be delayed. Department staff will encourage initiation of this service by the hospital. Priority of effort should be directed to institutions having large patient turnover, serving populations of high tuberculosis incidence or receptive to multiphasic screening. "Guide for a Tuberculosis Control Program for General Hospitals" (PHS-516), is available from the Program.

Mass Chest X-Ray Screening

Allocation of Survey Time

Community Surveys: Survey time is prorated to counties and selected cities in each of the State Health Districts at the beginning of the calendar year on the basis of demonstrated existence of tuberculosis in the previous calendar year. Local schedules are prepared by the respective District State Health Officers after agreement with local health officers and other sponsoring agencies and submitted to the Program for approval. Individual community schedules shall be submitted by the District State Health Officers at least 45 days prior to the first day of scheduled operation to permit

time for approval and compliance with contract. Schedules shall include proposed dates of operation, specific locations, intended time period of operation and types of equipment (bus or portable) desired. Where use of portable equipment is requested, sites will receive advance inspection by Program personnel to insure that technical requirements have been met. When indicated, aid of Radiological Health Program will be solicited to insure radiological safety.

Industrial Surveys: A portion of allotted community survey time may be applied to industry. In addition, time may be otherwise allotted to industry dependent upon justification and availability of equipment. State sponsored industrial surveys, as a general rule, are conducted on a one time basis to demonstrate their value. Request for re-survey shall be submitted by District State Health Officers with supporting justification. Consultation with Occupational Health Program will be sought when indicated.

Special Surveys: Annual survey of State employees is arranged early in the year by the Program in cooperation with representatives of State government and coordinators of other programs participating in multiphasic screening. "State Employees Chest X-Ray Survey Schedule" (TB-31) and accompanying work sheet (TB-32) are used to facilitate planning. Request for race tracks, migrant labor, fairs and other special surveys are submitted with supporting justification by District State Health Officers prior to March 15 of each year. Such projects will be considered according to individual merit and time allocated will not be charged against allocation for community surveys.

State Health District, local health officer, other local sponsors and x-ray contractor are notified of each approved schedule by transmittal of form "Guide for X-Ray Survey" (TB-5).

Organization

Successful organization requires mobilization of all appropriate community resources including the local health officers, public health nurses, private physicians, medical societies, clinic personnel, sanatoria, social and health agencies, church and civic groups and other interested citizens. Volunteers, with proper orientation, lend valuable assistance in promotion of interest, recruitment, and preparation of "Survey Data Card" (TB-6, TB-D11). State Health Districts provide consultation, guidance and printed flyers to local sponsors (TB-D13).

Interpretation of Film

Films are read by chest physicians within the Program or by pre-arrangement with local agencies in selected counties. Interpretation is coded on "Survey Data Card" (TB-6) in accordance with "Survey Film Impression Code" (TB-D6).

Follow-up

Postal card "Negative Report of X-Ray Examination" (attachment to TB-6), and "Unsatisfactory Report" (TB-7) are promptly forwarded to all participants with negative or unsatisfactory readings. Attending physicians, participants, local health officers and authorized follow-up agencies are notified of all pulmonary referrals, using form "Findings of Chest X-Ray Examination" (TB-8,

A,B,C,D). Transmittal of individual 70mm x-ray film or interpretation thereof is accomplished by "Transmittal for Survey Film and Findings" (TB-L9). Diagnosis not otherwise received is requested by use of "Follow-up of Survey Referral - Private Physician" (TB-L12). EXCEPTION - Referrals among Essex County residents, excluding Newark, will be followed in accordance with procedure established by agreement with the Essex County Health Officers Association (TB-D12).

Cardiac referrals are transferred to the Heart Program for appropriate follow-up and disposition. Cancer referrals are included with other pulmonary referrals.

"Survey Statistics Summary" (TB-10) for each local survey is forwarded to appropriate State Health District, local health officer, and local sponsor by use of "Transmittal Letter" (TB-L11). Local health officials will assure that suspects are brought to diagnosis, adequately followed up, and cases reported.

Record Keeping

"Technician's Daily Report of Survey" (TB-12) submitted by the contractor through the District office, provides current information as to number of participants and is essential for fiscal purposes.

As rapidly as work load permits, "Survey Index Card" (TB-16) is prepared from information obtained from "Survey Statistics Summary" (TB-10) and alphabetically filed for ready reference. At the same time, entries are made on "Survey Record Sheet" (TB-30) for numeric reference and statistical summation.

"Survey Data Card" (TB-6) with negative readings, are temporarily filed and discarded after one year. Those with other than negative readings are permanently filed. All survey film is discarded after one year.

Analysis

Case finding values and efficiency of follow-up are determined six months following completion of each survey by cooperative endeavor of the Program, the District and local officials and agencies. State Health Districts are requested by "Survey Field Study Memo" (TB-L7) to arrange for evaluation of each survey effort. Individual field study evaluations are consolidated into District and State-wide reports, using form "Result of Mass Chest X-Ray Survey" (TB-18, A-P).

Tuberculin Testing

The Program in cooperation with the State Department of Education will develop and evaluate procedures to be recommended for tuberculosis detection in schools with emphasis upon the ultimate institution of tuberculin testing as the basic case-finding procedure. In support of this, a demonstration intradermal tuberculin testing (PPD) project has been planned for the schools (public and parochial) of Mercer and Somerset Counties. A protocol for this project is being prepared by the Program (TB-D16).

State Health Districts will:

1. Cooperate in the demonstration as indicated in the protocol
2. Stimulate cooperative action between boards of health and education to assure epidemiological investigation of positive reactors found in school detection activities
3. Promote tuberculin testing as a basic case-finding procedure among selected population groups
4. Stimulate routine tuberculin testing as a part of well child supervision

ACCOUNTING

Case Reporting

By New Jersey Physicians and Institutions: Case report forms (TB-22, TB-23) flow through local reporting officer with exception of certain State institutions, in accordance with printed instructions on forms and in manner prescribed in Flow Chart (TB-D1). Case reports are received and processed by Public Health Statistics Program.

From Out-of-State Sources: Appropriate board of health, case register and Stat Pg are provided information through use of "Notification of Reportable Disease" (TB-L1), after check for previous report and verification of residence.

Follow-up of Positive Laboratory Reports: Departmental laboratory provides a copy of each positive report to Stat Pg which, after check against roster of reported cases, notifies TB Pg of patients not reported as active cases (30 day waiting period allowed following date of laboratory report). Report of case is stimulated by initiation of "Request to Physicians for Report of Positive Sputum Case" (TB-L16) with copy to appropriate board of health. Subsequent action to assure report, when required, includes assistance from State Health Districts.

TB Pg will cooperate with other programs concerned in effective compliance by private laboratories in reporting positive findings as required by Chapter IV, Regulation 9, State Sanitary Code. Reports received are processed in the same manner as Departmental laboratory reports.

TB and Stat Pgs are jointly conducting a pilot study to determine the health status of those cases of tuberculosis appearing on the State roster for more than 10 years for which no information has been received over a 10 year period. Results of this study will provide justification for the removal of certain of these cases from the roster (TB-35, TB-L15).

Referrals

Monthly and annual listings of newly reported tuberculosis cases are prepared by Stat Pg and forwarded to TB Pg for transmittal to boards of health or follow-up agencies designated thereby and to case registers (TB-D8, TB-D9).

Information received by TB Pg concerning status, hospitalization, change of residence or other reference to cases requires notification to specific agencies concerned. The table on following page indicates nature of the report, reason therefore, form letters employed and program responsibility.

Referrals of suspects discovered in screening programs of other agencies, alien suspects entering the State, and contacts of cases and deaths coming to attention are referred to health agencies designated to render follow-up services (TB-L1, TB-L2, TB-L3, TB-L4).

In the course of mass chest x-ray surveys, individuals may be discovered to have tuberculosis and yet not be reported. When indicated TB Pg shall request from the attending physician confirmation of the diagnosis of tuberculosis and submission of the appropriate report of case to board of health (TB-L10). Upon receipt of confirmation of this diagnosis, TB Pg notifies Stat Pg that an official report of the case is to be expected. In the event that request yields no information from physician, TB Pg notifies board of health having jurisdiction, advising necessary action to assure examination and final diagnosis.

Stat Pg shall check rotary file monthly for cases of tuberculosis remaining in file for a period of three months, with clinical status undetermined and complete TB-L14 for each case. Forms are returned to TB Pg for mailing. TB Pg will inform Stat Pg of information received in reply and will advise board of health having jurisdiction of individuals not returning for, or refusing, diagnostic examination.

Case Register

A system of records for maintaining a current summary of medical and public health data on proven and suspected cases of tuberculosis requiring supervision is an effective administrative tool in tuberculosis control because it provides:

1. A continuous case history in abstract form (TB-20)
2. A mechanism for follow-up (TB-15, TB-24)
3. An accurate current evaluation of problem in area covered (TB-14)

TB Pg has undertaken to promote establishment of registers, usually on a county level and preferably under official agency auspices, on a gradually expanding scale so as to eventually attain State-wide coverage. Priority is given to areas of highest population density and greatest tuberculosis risk. Successful register operation and effective tuberculosis control are dependent upon understanding, cooperation and integration of effort by boards of health, local health officials, follow-up agencies, diagnostic clinics, sanatoria, community hospitals, medical societies and physicians.

Tuberculosis Control Program Provides:

1. Administrative forms
2. Equipment to extent possible through existing policies re equipment leases

REFERRAL OF CASE INFORMATION

Resident of N.J. Yes No		Living in N.J. Yes No		Reason for Report	Action Required	Form Used	Pg Action
X	X	X		Moving within State and Change of Status	Check for previous report Notify BdH of intended, present or past residence and register	TB-L1	Stat TB
X	X	X		Moving out-of State	Check for previous report *Notify other State Health Department, PHS and register	Stat L6	Stat Stat
X			X	Diagnosed, Hospitalized OR returning to New Jersey	Check for previous report Verify residence Determine and order charge Charge case Notify BdH and register of charge	TB-L1 TB-L1	Stat TB TB Stat TB
	X	X		Diagnosed or Hospitalized	Check for previous report *Notify other State Health Department and PHS Notify register	Stat-L6 TB-L1	Stat Stat TB
	X		X	Moving in	Check for previous report Notify BdH of intended residence Verify arrival Verify case and care Recommend posting Post if not previously reported Notify register Notify BdH of charge (if necessary)	TB-L1 TB-L1 TB-L1	Stat TB TB TB Stat TB TB

*State of residence or intended residence. Exception: direct communication is maintained with Philadelphia and New York City.

3. Basic technical guides (TB-D17 and PHS Manual)
4. Recommendations for qualification of personnel
5. Training and supervision
6. Consultation
7. Periodic evaluation
8. Out-of-State case reports of local residents
9. Pertinent case information available
10. Positive laboratory reports

Public Health Statistics Program Provides:

1. Technical advice and assistance to TB Pg in implementation of methods for statistical analysis and evaluation
2. State institution case reports for area residents
3. Monthly and annual lists of newly reported cases
4. Compilation of case status statics from registers

State Health Districts Provide:

1. Promotion for establishment
2. Education of local agencies
3. Stimulation of local personnel in contributing to, and utilizing register information

Case Register:

1. Exchanges case information with follow-up agencies
2. Prepares statistical reports of case status
3. Submits semi-annual report to TB Pg (TB-14)
4. Advises Stat Pg of discrepancies between RO cards and morbidity listings received

DIAGNOSTIC SERVICES AND CONTINUITY OF CARE

Physicians

The medical profession is kept informed as to current methods and techniques for early detection and medical management as well as to available community resources of value in the comprehensive rehabilitation of tuberculosis patients. Acceptable media include informational documents, exhibits, scientific programs, study courses and on occasion personal contact. Personnel in all health agencies should be alert to the variety of opportunities to promote this activity (TB-D4, TB-D5, TB-D7, TB-D14, TB-D15).

Clinics

Various official voluntary, county, local and state agencies maintain and operate clinics rendering screening and diagnostic services. The basic standard manuals recommended for operation of the clinics are: "Chest Clinic Manual" NTA; "Diagnostic Standards" NTA. Pg shall provide these manuals to functioning clinics.

PC, with the cooperation of District State Health Officers, is responsible for evaluating practices of clinics and for adherence by clinics to recommended standards and procedures. Public health physicians assigned to the Division will assist in this evaluation. When indicated, PC recommends to appropriate authorities the expansion of existing facilities and development of new facilities. Where possible, clinic facilities should be incorporated into the general clinical facilities of community hospitals.

Equipment and services to increase and improve screening and diagnostic services and continuity of care may be provided under existing lease agreements and grant-in-aid arrangements. Division and District personnel will consults and advise local agencies in developing these forms of assistance.

Uniform clinic records are provided for integration with registry system now developing throughout the State (TB-1, TB-3, TB-4, TB-15, TB-D5).

Laboratory Services

Boards of health are required by law to provide for microscopic examinations of sputum of any persons within their jurisdiction having symptoms of tuberculosis upon request of any physician, hospital or dispensary. Establishment of local facilities for making routine laboratory examinations is encouraged.

PREVENTION OF SPREAD OF INFECTION

Control of Active Cases

Boards of health or their agent, the executive officer, will carry out provisions of law necessary to prevent spread of tuberculosis. In the event of non-compliance with medical and legal supervision, action may be initiated by BdH to commit patient as set forth in RS 30:9-57, 30:9-58. The DSHO will lend assistance to local officials when required or indicated and may in selected instances initiate action as representative of the State Commissioner of Health.

Superintendents of hospitals shall inform boards of health concerned and the State Commissioner of Health of all individuals afflicted with tuberculosis in a communicable form who leave against medical advice (RS 26:4-71.3). Pg will follow up (TB-L5).

TB Pg proposes to develop a system of periodic reports providing current measurements essential to adequate control:

- (1) Sanatorium admissions, bed occupancy and discharges (by type of discharge)
- (2) Inventory of medical and para-medical out-patient and in-patient services to the tuberculous (annually).

Hospitalization of Active Cases

Voluntary acceptance of hospitalization by the active tuberculosis patient is basic and is advocated by the American Trudeau Society (TB-D15). Orienta-

tion of patient to this concept by medical, para-medical and public health personnel is vital.

Care of Non-hospitalized Cases

Boards of health and follow-up agencies are encouraged to provide adequate facilities to render continuing comprehensive care to non-hospitalized patients as recommended by the American Trudeau Society (TB-D15). This group of cases includes the vast majority of actual and potential spreaders of infection and may require stringent control measures.

Post-hospital Drug Therapy

The introduction of the chemotherapeutic and antibiotic agents has modified the concepts of prolonged hospitalization, has resulted in earlier discharge of patients from sanatoria and has placed responsibilities upon communities to assure that recommended therapy is continuously maintained. Early discharge of patients under such therapy has resulted in savings that can be realized only if complete recovery is assured and relapse and spread of infection prevented.

TB Pg proposes to develop, in conjunction with sanatoria throughout the State, standard procedures for discharge of cases of tuberculosis under medication; to determine needs in local provision of drugs to needy patients; and to develop ways and means by which these drugs will be made available in every area of the State.

SUPPORTIVE COMMUNITY SERVICES

Public Health Nursing

Generalized public health nursing, an integral part of a community health program, encompasses supervision of tuberculosis cases, contacts and suspects. Nursing services include assistance to these individuals in attaining maximum benefit from diagnostic and treatment facilities, and other available community resources. Education efforts are directed toward assisting the physician in interpretation of:

1. The disease - a long term illness
2. The importance of carrying out medical recommendations and continuing supervision
3. The necessity for precautionary measures

"Guide for the Medical and Public Health Nursing Supervision of Tuberculosis Cases and Contacts" (APHA) and "Tuberculosis Handbook for Public Health Nurses" (NTA) are recommended as basic guides in tuberculosis nursing.

State Health Districts:

1. Adhere to above principles and guides in provision of consultation and nursing supervision
2. Make guides available to local agencies
3. Utilize consultation from the program when indicated

Medical Social Services

Effective medical social service begins at the point of diagnosis. It includes social case work service to individual patients, a teamwork relationship with physicians and others and the selective use of community resources. Its aim is to help individuals with tuberculosis understand their disease and to motivate them to make maximum use of medical care so as to realize the fullest possible physical and social recovery. Not only should there be consideration of rehabilitation for the employable, but also adjustment for the patient who may never be employable after maximum benefit has been achieved.

Tuberculosis Control Program and State Health Districts:

1. Stimulate development of these services in tuberculosis hospitals and clinics
2. Promote extension and maximum use of existing services
3. Encourage employment of qualified medical social workers

"A Handbook on Social Services for the Tuberculosis Patient" (NTA) and "Medical Social Service in a Tuberculosis Sanatorium" (PHS) are recommended as basic guides and are available from the State Health Districts,

Vocational Training

TB Program maintains liaison with State Departments of Education, Labor and Industry with intent to foster greater opportunities for training of tuberculosis patients.

State Health Districts:

1. Encourage earlier and more extensive utilization of existing resources for vocational restoration
2. Stimulate development of feasible training projects in communities or counties accessible to tuberculosis patients

Occupational Therapy

TB Program and State Health Districts, when opportune, advise provision of adequate services in sanatoria.

NEW JERSEY STATE DEPARTMENT OF HEALTH
VENEREAL DISEASE CONTROL

Section 1

INSTRUCTIONS FOR COMPLETING AND PROCESSING FORMS AND FORM LETTERS

Form PHS-1632, Monthly Activity Report - VD Case-Finding Workers

This report gives a quantitative and qualitative measure of all case-finding activities performed by specialized venereal disease personnel in strategic areas of the State. It provides, on a cumulative basis, a means of evaluating individuals and the areas where they work, justifying continuing assignments. This form is prepared in quintuplicate by VD personnel assigned to the districts. Of these copies, one is retained by the individual, one is for the district file, and three copies are forwarded to the VD Control Program, two of which are forwarded to the Regional Office PHS and one is retained for the VD files. Field personnel who interview private physician cases and who investigate their contacts prepare, in quintuplicate, a second set of these forms. The designation "Private Physician" replaces "Contacts - Clinic or P&C Center Cases" above line 21 and lines 21 through 25 are completed.

"INSTRUCTIONS FOR PREPARING REVISED 'MONTHLY ACTIVITY REPORT
FOR VENEREAL DISEASE CASE-FINDING WORKERS 'PHS-1632 REVISED'

The above named report carrying the revision date of July 1, 1953, is effective that date and replaces all earlier forms of the same number. This report is to be submitted monthly by each interviewer-investigator assigned to a case-finding project regardless of the source of funds from which employed.

The report is divided into four parts; (1) interviewing (2) investigation (3) disposition of persons examined and (4) other activity.

These (except other activity) are each subdivided into two main categories--Armed Forces and Civilian. Activity should be reported in the category responsible for originating the interview or investigation. For example, the assignment and results of investigation of civilian contacts of Armed Forces personnel should be reported in Columns D through T of the Armed Forces section since the epidemiologic report was originated as a result of interviewing personnel of the Armed Forces. Conversely, investigation of Armed Forces contacts to civilian patients will be reported in the civilian section.

These two main categories are divided into type of informant or types of suspects as listed in the left hand column of the report.

Contacts (Note definition under interviewing) are divided according to the diagnosis of the patient at the time of interview. This classification is made without regard to the previous treatment status of the patient. An infectious relapse will be included with primary and secondary syphilis, a serologic relapse will be included with early

latent syphilis. Other VD includes Chancroid, Lymphogranuloma Venereum and Granuloma Inguinale. Note that private physician cases are entered on line 27 without regard to diagnosis.

Other types of Suspects include the Armed Forces, 'Selectees and Separatees' and for Civilians, 'Positive STS and Other Suspects' and 'Other Follow-up Cases'. Positive STS and Other Suspects include investigation of all survey or other positive diagnostics such as premarital, prenatal, or employment. Positive diagnostics for gonorrhea or the other venereal diseases are also to be included. Other Follow-up Cases include field investigation to return lapsed cases to treatment or to obtain post-treatment observation of study cases and other field follow-up of venereal disease cases not appropriate to other lines to this report. Disposition of post-treatment observations, if examined, will be entered in Column G for each such observation requiring field follow-up, and also in Column Q unless cases are retreated or diagnosed with a new disease.

1. Interviewing

For the purpose of this report a contact is defined to include:

- A. All persons who had sexual contact with the patient and who could have infected or have been infected by the patient.
- B. Infants and small children of parents with lesion syphilis and very rarely other persons frequently in close contact with infectious patients in crowded living conditions.
- C. Children of mothers with syphilis, who might have contracted congenital syphilis from the mother's infection.

For diseases other than syphilis, the contacts will be almost exclusively sex partners.

Column A. Enter the number of patients interviewed for contacts according to diagnosis of the patient at the time of interview without regard to treatment to status. If the patient has more than one disease count the patient for each disease. Include patients from whom no contacts are obtained. Do not count patients who are re-interviewed, regardless of who conducted the original interview.

Column B. Enter the number of contacts obtained from each patient interviewed. If the patient has more than one disease count the contact named as a contact to each disease to which exposed or possible source. New contacts obtained by reinterview are to be included regardless of date of initial interview.

Column C. Derive the contact index for each disease by dividing Column B by Column A. Carry result to two decimal places.

2. Investigation

Note: There have been some major changes in procedure in this Section.

Column D. Enter the number of investigative assignments on hand at the beginning of the month. This figure must be identical with the number remaining on hand at the end of the previous month.

Column E. Enter the number of cases assigned during the month of report regardless of source. That is, include assignments taken over from some other worker. This column is meant to show only investigations assigned to the worker that require some investigative activity on his part. An epidemiologic report form that is closed out by simply checking a file should not be counted as an investigation assigned for this report. In cases where it is known to the investigator that two or more epidemiologic report forms represent the same individual under field investigation, the contact may be counted each time. Of course a person may be brought or returned to treatment only once in the same investigation.

Column G. The number of persons examined this period includes the number of persons actually examined (either as a result of this investigation or already under treatment) and on whom final disposition has been made. These examinations may be performed either in clinics or by private physicians.

Column H. Enter the number of report forms closed out because the person was not brought to examination. Do not count those persons who moved, for whom a new address is secured. These 'moves' are to be counted as reassignments in Column I.

Column I. Enter the number of cases reassigned to another worker in this month. See special note below.

Column J. Enter the number of open cases remaining on hand at the end of the month. This must equal Column F minus the sum of G, H and I. This figure becomes the entry for Column D next month.

Column K. This total is included in Column J. 'Overdue' cases are those which according to State Health Department policy should have received final closing action by the end of month for which report is prepared. For most areas, this period of time is generally 60 days after the last day of the month in which they were assigned. In this instance, for example, those epidemiologic forms assigned during January for which no final closing action has been made by the last day of March, are shown in this column of the March report. A case may be reported in this column more than one time until a disposition is made in either Column G or Column H, or reassigned in Column I.

SPECIAL NOTE ON REASSIGNMENTS

This is a new column to provide for the interchange of assignments. Previous to July 1, 1953, such transfers were entered in Column H, which in many instances worked a hardship on some workers. It is a major problem when a worker is given a new area. Some examples of how this now operates are given below.

1. Resignation. John Doe leaves the project with 50 open cases. His report is completed for the cases closed and the 50 cases are entered in Column I with nothing remaining on hand. The 50 cases are picked up in Column E of one or more other workers either in the same month or in the next.

2. Transfer within active areas. John Doe in area 1 is transferred to help Richard Roe in area 2. John enters in his Column I all those open cases he leaves to be picked up in Column E of other workers in area 1. Richard enters in Column I of his report those cases he gives to John. John counts them in Column E. When John leaves area 2, the process is reversed.

3. Transfers or assignments to inactive areas. John Doe goes into country 3 which has no investigator and has accumulated a back-log of epi-forms. He accepts these in Column E, plus any he receives while working there. When he leaves country 3, which will be inactive again, he will show the open cases in Column I as transferred, not as remaining on hand.

4. Cases which move out of your area, for which a new address in your State is secured are to be entered as reassignments.

The net base for a worker or project for any period is derived as follows:

1. Number on hand Column D (July only, if period is cumulative)
2. Plus assignments Column E
3. Minus reassignments Column I
4. Minus remainder on hand Column J
5. Plus overdue cases Column K

This is the figure which will be used to determine the percent examined. Note that no new worker can have any 'on hand' Column D, for his first report. Any worker on the project who has a carry-over must report those cases in Columns D and J of the reporting month even if he spent all that month on 'other activity' or on leave.

SPECIAL NOTE ON 'BALANCING'

The items of this investigation section are defined so that the section must balance.

1. Columns D plus E equals F
2. Columns G plus H plus I plus J equals F, or
3. Columns F minus G minus H minus I equals J
4. Column J for any month equals Column D for the following month.

3. Disposition of Persons Examined

Entries in this section relate to the persons shown as examined in Column G. The total of Columns L through T may exceed Column G if there are dual infections or dual dispositions, but the total can never be less than Column G. In the event that a person investigated is found to have more than one infection, each infection will be reported in its respective column. If the person is infected with some other disease than the one suspected, the disease found will be reported in the proper column and also the person will be counted in Column T, not infected with disease suspected.

Columns L through P. Enter the infections which are identified and are either brought or returned to treatment. In Column P include only Chancroid, Lymphogranuloma Venereum and Granuloma Inguinale.

Column Q. Enter cases of syphilis which are identified but which do not require treatment because they are either already under treatment or have had adequate treatment.

Column R. Enter those infections which are identified but which are not applicable to Column L through Q, such as treatment contra-indicated, treatment refused, died before treatment, etc.

Column S. 'Prophylactic or epidemiologic treatment' refers to persons given preventive or precautionary therapy without establishing a diagnosis. Include such cases only if so treated for the disease suspected.

Column T. Enter those persons who are not infected with the disease suspected, even though some of these persons may have other infections identified and shown in any of Columns L through Q.

4. Other Activity

This is a place for indicating certain activities other than interviewing and investigating done or caused to be done by the casefinding worker. Civilian STS performed refers to any special selective blood testing done by the worker in areas of high prevalence. Under 'other' include lectures, special distribution of literature, exhibits, and other educational technics used in the area as a result of the worker's work. A separate line is provided for reporting hours spent in giving formal instruction in interviewing or investigation technics. Where one or more workers may be a member of a group performing a given activity (e.g. mass blood testing survey) the activity for the total group should be reported for each worker. The worker should indicate his contribution to the activity. If space is not suitable to report other activities, use back of form.

Each man should specify clearly his location -- particularly in the case of military installation. It would be most helpful if he would specify a change of area.

Project Number: Inasmuch as many states have more than one case-finding project, each worker must be identified with the project to which he is assigned. The appropriate project number is to be written after the worker's name at the lower corner of the form.

When completed, the form should be forwarded through channels so that errors may be caught early. This will save time in the long-run by reducing correspondence."

Form PHS-688 Morbidity Report

This report gives a quantitative measure of the VD problem by source of report, color, sex, disease, and stage of syphilis. Non-resident morbidity is excluded. All syphilis morbidity is unduplicated. The report is pre-

pared in quadruplicate, quarterly, by the Public Health Statistics Program. It is prepared for reported cases among civilians for Newark, Jersey City, Trenton and for the State as a whole, and for reported cases among military personnel as a group. One copy of the report is retained by the Public Health Statistics Program and three copies are forwarded to the VD Control Program. Of these, two copies are forwarded to the Regional Office PHS and one is for the VD files.

Form PHS-2127, Quarterly Epidemiologic Activity Report for Venereal Diseases

This report guides administrative action relative to the various aspects of case-finding since it indicates the quantity and, cumulatively, the quality of epidemiologic activity. In a program which places major emphasis on case-finding, it is important to relate the number of cases of infectious VD that are reported (Form PHS-688, Morbidity Report) to the number of such cases that are interviewed for contacts and to the number of contacts obtained for each venereal disease and for each stage of syphilis. The columns divide the disposition of persons examined and provide a measure of the proportion of reported cases which are found as a result of epidemiologic activity. This form is prepared in triplicate by the VD Control Program. Of these copies, two are forwarded to the Regional Office PHS and one is for the VD files.

"INSTRUCTIONS AND DEFINITIONS PHS-2127 - Quarterly Epidemiologic Activity Report for Venereal Diseases

This report is requested for the quarters ending September 30, December 31, March 31, and June 30. This report is a consolidation (with modifications) of the information formerly obtained on the Evaluation of Contacts of Armed Forces PHS-1673, the Special Semi-Annual Contact Investigation Report PHS-1565, Sections C and D of the Quarterly Venereal Disease Control Activity Report PHS-724-1, and Section D of the Monthly Report of Outpatient Prevention and Control Centers. The latter reports or sections of reports are now obsolete. This report is similar in content and format to the Monthly Activity Report for Venereal Disease Case-Finding Workers, PHS-1632. States familiar with the monthly report will note that the quarterly all-State report is a recapitulation of the monthly activity reports of individual workers plus a summation of all activity by workers not submitting monthly activity reports including epidemiologic investigations closed by checking against files in State or local health departments.

This report is an activity report in that the results tabulated include activity actually completed in the quarter. A modification has been introduced in that a trend comparison of the number of investigations assigned (Col. E) compared to the total number of investigations closed (sum of Columns G and H) provides an evaluation of the volume of investigations accomplished.

The source of data for this report are (1) an interview card on each patient interviewed with number of contacts named; (2) all epidemiologic report forms (ER forms) assigned for investigation

during the period; (3) all ER forms for investigations closed during the period. (It is suggested that forms be automatically closed if no disposition is received after 60 days from the date reported.) ER forms for which a duplicate has been prepared because a contact has moved out of area will be excluded.

The report is divided into three main parts: (1) interviewing, (2) investigation, and (3) disposition of persons examined.

These activities are each sub-divided into two main categories - Armed Forces and Civilians. Activity should be reported in the category responsible for originating the interview or investigation. For example, the assignment and results of investigation of civilian Contacts of Armed Forces personnel should be reported in Columns E through T of the Armed Forces section since the epidemiologic report was originated as a result of interviewing personnel of the Armed Forces. Conversely, investigation of Armed Forces contacts to civilian patients will be reported in the civilian section.

These two main categories are divided into the type of informant or suspect as listed in the left hand column of the report.

Contacts (note definition under interviewing) are to be divided according to the diagnosis of the patient at the time of interview. This classification is made without regard to the previous treatment status of the patient. An infectious relapse will be included with primary and secondary syphilis; a serologic relapse will be included in the early latent syphilis. 'Other VD' includes chancroid, lymphogranuloma venereum, and granuloma inguinale. Note that contacts of private physician cases are entered on line 27 without regard to diagnosis.

Other types of suspects include for the Armed Forces, 'Selectees and Separates', and for civilian, 'Positive STS and Other Suspects' and 'Other Follow-up' cases. Positive STS and other suspects include investigation of all survey or other positive diagnostics such as premarital, prenatal, or employment. Positive diagnostics for gonorrhea or the other venereal diseases are also to be included. Other follow-up includes field investigation to return lapsed cases to treatment or to obtain posttreatment observation of study cases and other field follow-up of venereal disease cases not appropriate to other lines of this report. Disposition of posttreatment observations, if examined, will be entered in Column G for each such observation requiring field follow-up and also in Column Q unless the case is retreated or diagnosed with a new disease.

1. Interviewing

For the purposes of this report a contact is defined to include (a) all persons who had sexual contact with the patient and who could have infected or have been infected by the patient; (b) infants and small children of parents with lesion syphilis and very rarely other persons frequently in close contact with the infectious patient in crowded living conditions; (c) children of mothers with

syphilis who might have contracted congenital syphilis from the mother's infection. For diseases other than syphilis, the contacts will be almost exclusively sex partners.

Column A - Enter the number of patients interviewed for contacts according to the diagnosis of the patient at the time of interview without regard to treatment status. If the patient has more than one disease, count the patient for each disease. Include patients from whom no contacts were obtained. Do not count patients a second time if they were reinterviewed regardless of who conducted the original interview.

Column B - Enter the number of contacts obtained from each patient interviewed. If the patient has more than one disease, count the contact named as a contact to each disease to which exposed or possible source. New contacts obtained by reinterview are to be included regardless of date of initial interview.

Column C - Derive contact index for each line by dividing column B by column A. Carry result to two decimal places.

2. Investigation

Column E - The 'Number of Investigations Assigned This Period' includes all ER forms (excluding those for which a duplicate has been prepared because a contact has 'moved out of area') reported for investigation and assigned to field investigators or clerks for closure during the reporting period. Reassignments of ER forms are not to be counted, and for this reason if this report is obtained by a summation of individual-worker PHS-1632 forms plus a tabulation of other workers and clerical closures, the sum of column I by line, on PHS-1632 (Cases reassigned to other investigators) for all workers submitting the form must be subtracted from the sum of Column E on the individual worker PHS-1632's. Since some time is required for investigation, the results of investigation recorded in Columns G and H (and in L through T) may not be for exactly the same group of persons assigned for investigation in that period.

Column G - 'Number of Persons Examined This Period' includes the number of persons actually examined (either as a result of this investigation or already under treatment) and on whom final disposition has been made. These examinations may be performed either in clinics or by private physicians.

Column H - The 'Number of Persons Not Examined This Period' refers to the number of cases closed as not examined and includes those who could not be located, those who moved out of State, those who refused to be examined, and those for whom too little information was available to begin investigation, and those automatically closed as 'no disposition received'. (Exclude duplicates because contacts 'moved out of area'.)

3. Disposition of Persons Examined

Entries in this section relate to the persons shown as examined, in Column G. The total of Columns L through T may exceed Column G if there are dual infections or dual dispositions, but the total can never be less than Column G. In the event that a person investigated is found to have more than one infection, each infection will be reported in its respective column. If the person is infected with some other disease than the one suspected, the disease found will be reported in the proper column and also the person will be counted in Column T, 'Not infected with the disease suspected'.

Columns L through P - Enter the infections which are identified and either brought or returned to treatment. 'Other VD' in Column P refers only to chancroid, lymphogranuloma venereum, and granuloma inguinale.

Column Q - Enter cases of syphilis which are identified but which do not require treatment because they are either already under treatment or have had adequate treatment.

Column R - Enter those infections which are identified but which are not applicable to Columns L through Q such as treatment contra-indicated, treatment refused, died before treatment was given, etc.

Column S - 'Prophylactic or Epidemiologic Treatment' refers to persons given preventive or precautionary therapy without establishing a diagnosis. Include such cases only if so treated for the disease suspected.

Column T - Enter those persons who are not infected with the disease suspected even though some of these persons may have other infections identified and shown in any of Cols. L through Q."

Form PHS 724-1 Quarterly Report of Diagnostic Observations for Venereal Diseases in Public Clinics

This report provides a measure of diagnostic observations in VD clinics throughout the State. From this report the VD Control Program judges volume of clinic activity in any given area, thus defining areas requiring special attention. Each clinic prepares the report in duplicate, one copy for local office filing and one copy for the VD Control Program. A statewide summary of these reports is prepared in triplicate by the VD Control Program. Of these copies, two are forwarded to the Regional Office PHS and one is for VD files.

"INSTRUCTIONS AND DEFINITIONS PHS-724-1 - Quarterly Report of Diagnostic Observations for Venereal Diseases in Public Clinics.

This form is for the use of all health units performing diagnostic observations and is to be prepared for the quarters ending September 30, December 31, March 31, June 30. If desired, the State health department may submit a one-page total to the Public Health Service instead of individual unit reports. The one-page summary should include

diagnostic observations in Outpatient Prevention and Control Centers summarized from Section A of the Monthly Report of Outpatient Prevention and Control Centers, PHS-724-3.

A diagnostic observation is defined as an examination of a person to determine the presence or absence of venereal disease other than observations to determine response to therapy. A diagnostic observation is completed (1) when the doctor has decided on all venereal diseases for which he is observing the person, (2) when the observation is terminated as either 'dropped or transferred', or (3) when the doctor gives 'prophylactic or epidemiologic treatment'.

(1) When the doctor has decided on all venereal diseases for which he is observing the person - The person should be counted as infected when the decision is made that any venereal disease is present, but cannot be counted as not infected until a decision is made on all venereal diseases for which the person is being observed. The number of persons diagnosed as not infected should be entered on line A1 and those diagnosed as infected should be entered on line A2.

(2) When the observation is terminated as 'dropped or transferred' - Enter on line B1 the total number observations terminated because the person transferred to another clinic before diagnosis was completed or because the person was dropped from observation for non-attendance. Do not include persons still under observation at the end of the quarter and whose observation is not completed; enter these in the next report.

(3) When the doctor gives prophylactic or epidemiologic treatment - Enter the total number of such observations on line B2. 'Prophylactic or epidemiologic treatment' includes preventive or precautionary therapy such as that given to contacts of early syphilis or gonorrhoea on whom a diagnosis is not established or precautionary therapy given previously treated women currently pregnant."

Form PHS-1320 (VD) Results of Epidemiologic Investigations

This report provides information relative to the final disposition of all civilian and military contacts and suspects that are followed epidemiologically. The information is used in quantitative and qualitative evaluation of epidemiologic investigations by each district and the State as a whole. The form is prepared 60 days after the close of each quarter and data obtained are made available to each district.

Form PHS-2126, Quarterly Report of Unproductive Contact Investigation of Primary and Secondary Syphilis

This form provides a system for pinpointing failure in referring cases of primary and secondary syphilis for interview, in interviewing of those patients, and in investigation of their contacts. This form is prepared quarterly, in quadruplicate by the VD Control Program. Of these copies one

is for the State Health District Office, two are forwarded to the Regional Office PHS and one is for VD files.

"INSTRUCTIONS FOR PREPARING QUARTERLY REPORT OF UNPRODUCTIVE CONTACT INVESTIGATION PHS-2126

This report is to be prepared quarterly. The definitions apply 30 days after the close of the month in which the interview took place. The report is due 45 days after the close of the quarter.

1. 'The number of patients with primary or secondary syphilis available for interview' is the number of such cases treated in clinics, hospitals and other institutions in this period (as shown on PHS-688).
2. 'Number of these patients interviewed' is the number of patients with primary and secondary syphilis who are interviewed including those who named no contacts. Count a patient only once even if re-interviewed.
3. 'Number of patients naming no contacts'. This is the number of patients interviewed for primary and secondary syphilis who named no contacts. If the patient is re-interviewed and then produces contacts, this would take him out of this category which represents interviewing failure.
4. 'Number of patients for whom no contacts were located'. This includes only those patients, naming one or more contacts for whom none of the contacts named was located within thirty days. Contacts of primary and secondary syphilis who have not been located and had at least a preliminary examination within this time are field investigation failures.
5. 'Number of patients, none of whose examined contacts were found to be infected with syphilis'. This includes only those patients for whom one or more contacts were examined but none found to be infected. An infected contact found may be either source or spread contact, but if no infected contacts are found in this period, this represents a failure to locate the source of infection for the patient interviewed."

Form PHS 1072, Semi-Annual Venereal Disease Laboratory Report

This report indicates the type and volume of venereal disease laboratory services rendered by our State laboratories and by approved private laboratories throughout the State. This form is prepared by each laboratory in duplicate, one copy for local office filing and one copy for VD Control Program. A statewide summary of these reports is prepared in triplicate by the VD Control Program. Of these copies, two are forwarded to the Regional Office PHS and one is for VD files.

Form PHS 1892-2, Summary of Blood Testing Activities by Race, Age and Sex

This report provides information relative to the number of individuals blood tested during a survey by race, age and sex. It indicates the number of reactors found and their final disposition. Information from this report is used in quantitative and qualitative evaluations of serologic surveys. This form is prepared in quintuplicate. Of these copies, one is for the local board of health, one for the appropriate State Health District, two are forwarded to the Regional Office, PHS and one is for the VD Control Program files.

VD 539a, Morbidity Report

This form is basic for the administration of the VD Control Program since each report represents a unit of the problem. Periodic analyses of summarized morbidity data (PHS-688) provide information for budgeting, casefinding, and applying specific control measures for certain population groups and geographic areas. Morbidity data indicate the long-term trends in venereal disease incidence. The form is prepared by the physician who establishes a diagnosis of venereal disease in a patient. The white morbidity form is for reporting private or institutional patients. The yellow form is for clinic patients. Yellow morbidity forms are stamped 'Migrant' or 'Military' before issuance to migrant clinics and military installations. Morbidity reports are forwarded directly to the Public Health Statistics Program by reporting agencies.

VD 539 b-53, Interview Record

This is one of the basic forms used in interviewing venereal disease patients. All district and local personnel who interview infected patients for contacts should complete this form in duplicate following each interview. One copy should be retained by initiating agency and one copy forwarded immediately to the VD Control Program. Interview subjects may be patients of private physicians, clinics, hospitals, institutions or military installations. Data obtained from this form are used in determining contact indices and in determining interview and investigation failures.

"INSTRUCTIONS FOR THE COMPLETION OF INTERVIEW RECORD (Form VD 539b-53)

This form is to be prepared for each patient interviewed whether contacts are obtained or not. Interview subjects may be patients of private physicians, clinics, hospitals, institutions, or military installations.

- Item 1. Date - Enter the month, day, and year of the interview
- Item 2. Treating Agency - Enter the name of the private physician, clinic, hospital, institution, or military installation treating the patient
- Item 3. Patient's Name - Enter the name of the patient, last name first
- Item 4. Sex - Self explanatory

- Item 5. Race - Self explanatory
- Item 6. Diagnosis - Enter the disease(s) for which the patient is being treated
- Item 7. Previous Rx for This Infection - Check proper block. Note: A patient might have had treatment at some previous time for the same disease but not for this particular infection. In this event, the 'NO' block is checked
- Item 8. Re-Interview - If more than one interview is held with a patient concerning an infection, the 'YES' block should be checked. This will prevent duplication in tabulating interviews in the Bureau of Venereal Disease Control
- Item 9. Remarks - Enter any pertinent information concerning the patient, the interview, or contacts
- Item 10. Names of Contacts -- List all contacts, last name first, who have been reported on ER Form VD 452-51. If only a first name is elicited, list as '? , Mary'. If no contacts are named, so indicate
- Item 11. E.R. No. - Enter the number of the E.R. Form on which each contact was reported
- Item 12. Investigated By - If the interviewer is to investigate any or all of the named contacts, he should enter his name or Code number in this space. If another person is to investigate, leave blank
- Item 13. Disposition - To be completed by Bureau of V.D. Control
- Item 14. Diagnosis - To be completed by Bureau of V.D. Control
- Item 15. Date of Disposition - To be completed by Bureau of V.D. Control
- Item 16. Interviewer - This space is provided for the name or Code number of the interviewer. Each completed card should specify the person who actually conducts the interview"

VD 153, Central File Card

This form is used only by the VD Control Program. It is prepared for each suspect reported on an ER Form and provides an index of all suspects reported for investigation during the current and the last calendar year. As a central index, it prevents duplication of investigations recently completed. The name of the suspect, the type of suspect, and date of the report are entered on each card.

Form VD 375

This form is used for referring infectious patients who were diagnosed and reported by private physicians to District State Health Offices to arrange for

interview. Form VD 375 is prepared weekly by the Public Health Statistics Program from morbidity report cards. Cases of gonorrhoea and early infectious syphilis are entered on duplicate copies of Form VD 375 according to State Health District, and county or municipality. Both copies of the form are forwarded to the District State Health Officer or a person designated by him to receive them. The cases listed are then assigned to field personnel who request permission of the reporting physicians to interview the patients.

Form VD-1 (452-51) Venereal Disease Epidemiologic Report

This is one of the basic forms used in VD interviewing and investigating. It is used both for contact and suspect investigation. Space is provided for complete information relevant to the investigation. Data obtained from these forms are used in evaluation of the VD Control Program, in pinpointing areas of high incidence and in stimulating VD morbidity reporting by private physicians and other health agencies.

"INSTRUCTIONS FOR THE COMPLETION OF THE VENEREAL DISEASE EPIDEMIOLOGIC REPORT VD-1 (452-51)

A separate quadruplicate set of forms is made for each contact or suspect.

1. Items 1 and 2. Self explanatory
2. Item 3. 'Date Reported' refers to the time information becomes known to the investigator or referring authority. This does not mean the time this form is prepared except when it corresponds to the date the information becomes known.
3. Items 4,5,6,7,8,9 and 10. 'Age, Color, Sex, Marital Status, Height, and Weight'. Self explanatory.
4. Item 11. 'Date Last Exposure' refers to the most recent sexual relation the informant had with the contact. Month and year should always be indicated for purposes of follow-up. It is imperative that all early syphilis contacts receive a 90-day period of follow-up after exposure. This covers the usual incubation period limits. It is advisable that the follow-up be based on the date reported in order to give each contact an opportunity to develop his symptoms.
5. Item 12. 'Type of Suspect' Check only one block. Persons suspected of having venereal disease are referred to as either contacts or suspects. A contact is an individual who has been allegedly exposed sexually to a diagnosed case of venereal disease. There are two types of contacts -- familial and non-familial. The former may be sex contacts of the wife or husband and children within the family exposed to an infection. However, suspects are individuals possessing a positive or doubtful serology such as premarital, prenatal, employment, selectees, etc. This is a much broader category than contacts.

The designation 'Other' is used for a suspect which cannot be classified by the checking of one of the other blocks given. Example: A person who is investigated because of suspicious lesions. This in-

formation should be entered in the 'Remarks' section, Item 21.

6. Item 13. 'Relation to Informant'. Under 'Other' include parents of diagnosed congenitals and other relationships not provided for.
7. Item 14. 'Place of employment and Occupation'. This information about the contact should be obtained routinely. Actually determine the job he performs at his place of employment.
8. Item 15. 'Other Contact Report Numbers'. This space will be utilized for the numerical recording of all additional epidemiologic report forms made up on contacts of an informant named in the interview.
9. Item 16. 'Interviewer'. This space is to be utilized for the recording of the interviewer's code number or the area in which the interviewer is located. The interviewer's initials or name should be included if only the area is given.
10. Item 17. 'Reporting Agency'. Until such time as clinics or areas are assigned code numbers, the area, clinic or health jurisdiction in which or by which the patient is interviewed should be written in this space.
11. Item 18. 'Informant Number'. In this space should be written the number or any designation which will enable the local worker to identify the informant. This may be necessary if the Bureau requests that a patient, who is unknown to the Bureau, be re-interviewed for additional contact information.

A remarkably simple way of keeping this information is by the calendar year and the numerical order of the patient. Thus, the first infectious syphilis patient to be interviewed in 1951 would be assigned the number '51-1', the second '51-2'. These numbers could be entered in the space 'Informant No.' on the E.R. Form. Any practical way of identifying the informant is acceptable. UNDER NO CIRCUMSTANCES will the Informant's name be entered in any place on the E.R. Form.

If the patient is that of a private physician enter the physician's name and initials, or code number if known.

12. Item 19. 'Disease of Informant'. Indicate the disease with a check in the appropriate box. If it is syphilis, record the stage of the disease. 'Other' refers to the remaining types of venereal disease -- chancroid, granuloma inguinale, lymphogranuloma venereum. Please write in the disease by using these abbreviations:

Key to Syphilis	Key to Other Diseases
Pri. - Primary	G.C. - Gonorrhoea
Sec. - Secondary	Chan. - Chancroid
E.L. - Early Latent	G.I. - Granuloma Inguinale
L.L. - Late Latent	L.G.V. - Lymphogranuloma Venereum
C.V. - Cardiovascular	
C.N.S. - Neurosyphilis	
Cong. - Congenital	

13. Item 20. 'Was the Informant Previously Treated for this Infection?' Indicate whether the informant has or has not received treatment for the current infection for which he has been diagnosed. This item is of the utmost importance in epidemiologic and interviewer evaluations."

Form VD-9 Registration Form

This form provides identifying information regarding each individual who is tested during a serologic survey. The upper portion of the form is mailed to all individuals whose serologic test is non-reactive. Information from the lower portion of the form is utilized in compiling survey evaluation reports.

VD-11, Selective Blood Testing Survey Laboratory Form

This form indicates the serial numbers on survey blood tubes and accompanies the tubes to the serology laboratory. The laboratory indicates the result of each specimen tested by corresponding serial number and returns the form to the VD Control Program.

Stat-L7, Form Letter

This letter is used by the Public Health Statistics Program to request a venereal disease morbidity report when the disposition on Epidemiologic Report Form VD 1 (452-51) indicates that a case has been diagnosed. The VD Control Program forwards the pink copy of all pertinent Epidemiologic Report Forms to the Public Health Statistics Program. A check against the morbidity files is made and, if no morbidity report has been received, this form letter is sent to the physician who established the diagnosis.

VDL-2, Check Sheet

This letter is used to instruct local personnel in the procedure for handling patients referred on the Form VD 375. It is also used to instruct District and local personnel in correcting or clarifying dispositions reported on the Epidemiologic Report Form VD 1 (452-51). The check sheet is prepared by the State Health Districts or by the VD Control Program for returning incorrect dispositions to the State Health Districts, depending upon where errors are detected.

Section 2

CONTACT AND SUSPECT INVESTIGATION

Case-finding continues to be the most urgent current problem in the VD Control Program. Case interviewing and contact and suspect investigation constitute the most effective case-finding method and are to receive greatest emphasis. Personnel specially trained in these activities are assigned by the VD Control Program to problem areas in New Jersey. These individuals account for approximately 3/4 of the total VD epidemiologic activity in the State. They interview virtually all infected military personnel. In addition, they promote the use of proper techniques by others.

- I Factors requiring attention to strengthen case-interviewing and contact and suspect investigation are:
- A Obtaining complete and accurate contact information immediately after diagnosis. Personnel engaged in contact investigation must be thoroughly indoctrinated by continuing in-service training programs in the techniques involved, in the use of records and forms, and in the use of indices for measuring performance and progress.
 - B Permitting no delays in the routing of morbidity and epidemiologic data. Investigations are to be performed immediately upon the elicitation of contacts. Epidemiologic Report Forms VD-1 (452-51) received by the VD Control Program and by the District State Health offices will be forwarded immediately to investigating agencies. Telephoning of information about contacts of primary and secondary syphilis will be routine procedure.
 - C Increasing the awareness of physicians of the fact that the solution of the problem of epidemiology is directly dependent upon them and of the importance of reporting venereal disease cases and arranging for interview of those patients requiring it. This is to be accomplished by the VD Control Program through the use of informational media and through liaison with the State Medical Society; by District personnel through their liaison with the county medical societies and individual physicians; and by local health department personnel through their liaison with individual physicians.
 - D Stressing the epidemiologic controls of gonorrhea, the disease that constitutes more than 77% of the acute venereal disease problem. This is to be accomplished by continuing in-service training programs directed towards departmental and local personnel, and by liaison with the medical profession, and by liaison with the military.
 - E Broadening the epidemiologic approach to case-finding among migrant workers, a proved high prevalence group. This is to be accomplished by interviewing each infectious patient diagnosed in migrant clinics and referring named contacts for investigation and by preparing an Epidemiologic Report Form VD-1 (452-51) on each migrant who manifests a reactive serologic test for syphilis. This is to be performed by personnel employed by or loaned to the Migrant Health Program for these purposes.

II Use of Venereal Disease Epidemiologic Report Form

- A The Epidemiologic Report Form is prepared for all suspects requiring any type of investigation.

Examples of instances in which the form is ALWAYS prepared:

- 1 All sex contacts including spouses.
- 2 Persons with reactive results to the serologic test for syphilis who need investigative activity to bring them to further diagnostic observation.
- 3 Persons who lapse from diagnostic observation.
- 4 Children of syphilitic parents when the children have not already been treated for syphilis.
- 5 Mothers of congenitally syphilitic children where it is not known that the mother has been treated for syphilis.

Examples of instances in which form is SOMETIMES prepared:

- 1 Persons with reactive results to a diagnostic serologic test for syphilis regardless of the necessity for follow-up activity. This happens sometimes in serologic surveys when a form is prepared on each person with a reactive result to the serologic test.
- 2 Persons being treated who lapse without completion of treatment and further treatment is considered necessary.

Example of an instance in which form is NEVER prepared:

- 1 Persons who report to a clinic voluntarily for diagnosis either because of symptoms or to "know for sure", and on whom no follow-up is necessary.

- B The present procedure for routing of the Epidemiologic Report Form is indicated on the flow charts VD-D2, VD-D3, VD-D4, VD-D5, VD-D6. When contact and suspect information is received on forms other than VD-1 (452-51), as in the case of reports from other states, from the Armed Forces and other agencies, the information is transcribed to Form VD-1 (452-51) by the VD Control Program. Routing and follow-up procedures then are the same as for any other type of referral. As the completed pink action copy of Form VD-1 (452-51) passes from the Board of Health to the District State Health office to the VD Control Program the disposition is transcribed on the blue form in the Board of Health, on the yellow form in the District State Health office, and the white form in the VD Control Program.

III Who Interviews

- A Interviewing patients and investigating contacts and suspects is to be performed by qualified District or by qualified local personnel. District personnel are to function only until qualified local personnel are available.
- B Specialized VD personnel, in areas where assigned by the VD Control Program, shall interview all infected military personnel and shall interview all cases of primary and secondary syphilis, as well as other venereal disease patients who are assigned to them by Boards of Health or District State Health offices.

IV Who Shall Be Interviewed

- A All individuals with primary and secondary syphilis
- B All individuals with early latent syphilis
- C All mothers with any stage of syphilis
- D All males with gonorrhea
- E All individuals with chancroid
- F All individuals with granuloma inguinale
- G All individuals with lymphogranuloma venereum

V Interview Procedure

- A The characteristics of a good interviewer are patience, poise, understanding, and a sincere desire to help the infected individual and his contacts. The interviewer must be able to elicit, by persuasion rather than force, the names of the patient's sexual partners. He cannot allow the patient to digress too far from the line of conversation and thought which lead to this objective. Most patients have multiple contacts. No estimate of the patient's sexual activity is possible from his speech, appearance, or environmental conditions.
- B Preparation for the Interview
 - 1 Almost any location will suffice if it meets certain requirements.
 - a It must be private enough to insure no interruptions, such as phone calls or visitors.
 - b There shall be no obstruction between the interviewer and the patient, not even a desk. If a desk is used, the patient's chair shall be placed beside the desk, facing the interviewer.

- c The chosen place shall be as quiet as possible, removed from casual passersby, other conversations, and distracting noises.
- 2 The ideal time for a contact interview is immediately after diagnosis. This enables the interviewer to serve as a source of information in interpreting the diagnosis for the patient. Regardless of the patient's mental or social level, a diagnosis of venereal disease carries a definite emotional impact.
 - 3 When time has elapsed since diagnosis, the interviewer shall try to refresh the patient's interest in his diagnosis. The reason for the delay, as in the instance of a doctor's delayed report of the case to the health authority, shall be explained to him.
 - 4 Nothing shall be left on the top of the desk to distract the patient. Pencil and paper shall be kept out of patient's sight until ready for use. Actual contact report forms shall probably be made later, but may be completed during the interview, with discretion.
 - 5 Neither the patient's nor the interviewer's chair shall be so comfortable as to permit complete relaxation. Otherwise, it is difficult to prevent lapses of attention.
- C The Interview. The interview is a controlled conversation. As such, the Interviewer shall ask pointed questions to arrive at the objective, which is the identification of contacts.
- 1 Establish rapport. A cheerful greeting pays dividends. Seat the patient comfortably and offer him a cigarette. Introduce yourself and indicate that you are there to help him to understand the disease which he has contracted. Assure him that this conversation and his treatment record are absolutely confidential.
 - 2 Determine the extent of his knowledge of venereal disease. Re-educate the patient. Do you know what is wrong with you? Do you know how this disease can affect you now? In later years? Can you know whether or not a person has syphilis by looking at him? How do people get syphilis? Try to help the patient adjust to the fact of having a venereal disease. Correct his misconceptions without offending him. How did you get your infection? Help him overcome his reluctance to discuss his infection. Explain the difference between syphilis and gonorrhoea; many patients believe them to be the same disease. Would you like your friends to have this disease? Do you think they could have it and not know it? Would you like to help those people to get examinations and treatment? Explain that only by examining all of his contacts can the health department wipe out syphilis.

- 3 Emphasize the confidentiality of contact information and encourage cooperation. No person ever knows who gives this information except the interviewer and the patient. Is he happy to have a chance to get well? Only he can give this information. He will not be forced to say anything. He must believe that it is the proper thing to do. There will be no penalty if he does not wish to answer a question or talk to you about his contacts. Does he want to talk to you?
- 4 Establish social and sexual patterns. Where does he live? What sort of work is he doing? Does he like his work? How long on this job? What was last grade completed in school? Like school? Does he go to church? What preference? Is he married? First time? Living with wife? With someone else? If single, does he have plans for marriage? How often does he go out with girls (approximate times per week, month)? What do they do for entertainment? With about how many of these people does he have sexual intercourse (per week, month)? General estimate of the number of different sexual partners during last six months?
- 5 Obtain names of contacts. Who was the last person with whom he had intercourse? When? Where does person live? Do not try, at this point, to get all of the necessary information. The interviewer shall get as many names as possible before requesting qualifying data on each contact. Never ask, "Is there someone else?" Rather ask him, "Who is next?" Indicate that you realize how difficult it is to recall such information readily. Give the patient ample time. Read the names back to him. If you suspect false information, ask the patient to give them to you again "in order to help you remember the others".
- 6 Take suspect information, if desirable. The interviewer should be thoroughly experienced before attempting this activity. The investigation of such suspects can be a very delicate operation. Ask the patient, "Do you know anyone else, whether or not you have been exposed to him, who has what you have?" "What makes you think that this person is infected?" The experienced interviewer can very often elicit an actual contact by this procedure who was concealed because of fear of reprisal, family relationship or for other reasons.
- 7 See information document VD-D7 for critical periods for contact interviewing.

D Termination of the Interview

- 1 Ask the patient whether or not he has questions about his treatment; about the investigation of his contacts.

- 2 Give the patient assurance and confidence. Assure him that he will get adequate treatment. Promise any possible assistance in the arrangement of his affairs. Assure him of your sincere desire to help him.
- 3 Re-emphasize confidential aspects of contact information.
- 4 Ask for contacts possibly overlooked in the interview.

VI Who Investigates

- A All suspects and contacts to primary and secondary syphilis, all military contacts, all selectees, all inadequately described civilian contacts, all contacts alleged to be prostitutes and pickups are to be referred to specialized VD personnel in areas where they are assigned.
- B Specialized VD personnel are to perform other investigations as assigned by Boards of Health or District State Health offices.
- C Adequately described civilian contacts, marital and familial contacts, other suspects, may be assigned to local health officers and public health nurses for investigation.

VII Contact and Suspect Investigation Procedure

- A Check with private physician on those individuals suspected of having syphilis because of a reactive blood test.
- B Check all available records
 - 1 To determine whether or not the contact or suspect has previously been a clinic patient.
 - 2 To determine the necessity for a field visit. The contact might have received treatment subsequent to the exposure date given. He might have moved to another jurisdiction.
 - 3 To determine previous treatment. This information will be valuable to the examining physician.
 - 4 To determine any other pertinent information, such as nicknames and aliases, remarks relative to cooperativeness, other suggestions with regard to the location of the contact.
- C Locate the contact or suspect
 - 1 Cultivate local people who readily give reliable information.
 - 2 Determine by inquiry or reflection the approximate location of the contact or suspect.

- 3 Identify yourself. "I am Nurse Smith of the Health Department", will usually suffice.
 - 4 Ask leading questions which will result in positive answers. Approach is of the utmost importance.
 - a Examples of questions which are never asked: "Do you know Mary Doe? Does Mary Doe live on this street (in this neighborhood, in this block, in this house)?"
 - b Examples of an approach which results in positive answers: "In which one of these houses does Mary Doe live"? After locating the house and after identifying yourself, "I would like to talk with Mary for a minute".
 - c If, in response to your knock or the doorbell, a person appears who is similar to the person for whom you are looking, address him by the name which is given on the VD-1 (452-51). In the event that he is not the contact or suspect, he is usually very quick to indicate the proper person.
- D Inform the contact or suspect. Explain the purpose of your visit. Absolute privacy is necessary.
- 1 Indicate that a patient is, or was, under treatment for a very dangerous and contagious disease.
 - 2 Indicate that the patient was interviewed, feared infecting him, and requested that he be informed of this possibility. Never divulge the informant's name. Never indicate to the contact that he might have infected the informant.
 - 3 Ascertain contact's knowledge of the venereal diseases and give brief additional information on the disease to which he was allegedly exposed.
 - 4 In some instances, it is advisable to ask the suspect whether or not he has symptoms.
 - 5 When an individual is suspected by reason of a reactive test, he should be informed that the report of his test, taken for employment or other reason, was reactive. Indicate that while this does not mean that he is infected necessarily, it is important that he obtain further tests and examination.
- E Arrange for examination
- 1 Indicate that an examination by his private physician or in a clinic is not only desirable but absolutely necessary
 - 2 Suspects of primary and secondary syphilis should be persuaded to accompany the investigator immediately to a physician or clinic.

- 3 A definite time for examination of all suspects should be established. Have the patient make a definite commitment, which will interfere as little as possible with his work.
- 4 If the contact or suspect requests examination by a private physician, rather than a clinic, indicate that you will notify the physician relative to the visit and that the physician will again be contacted for diagnostic information following examination. It is well to remember that a good working relationship with the private physician is absolutely necessary.
- 5 If it is obvious that the suspect is medically indigent arrangements should be made immediately for him to attend a clinic or other facility.

F Terminate the Investigation

- 1 Ask confirmatory questions with regard to time, date, and place of the examination, emphasizing the necessity for promptness of action.
- 2 Assure him of your desire to help in any way possible.
- 3 Assure him that the contact information is confidential.

G Return the completed Form VD-1 (452-51)

- 1 The maximum time allowed for the return of disposition copies of form VD-1 (452-51) is 60 days. However, investigations shall be completed as quickly as possible and dispositions recorded and returned on the earliest date that the information is available. If no disposition is known at the end of 60 days after the "Date Reported", an entry of "No Disposition" shall be written in Item 22-1 and the form returned to the VD Control Program. In order that quarterly evaluations may be completed a list of pending epidemiologic reports will be prepared by the VD Control Program and forwarded to the State Health Districts 30 days following the close of each quarter.

Section 3

SEROLOGIC TESTING OF SELECTED GROUPS

I Factors requiring attention to strengthen selective screening as an effective case-finding device are:

- A Extending measures for the enforcement of the law providing for examination of migrant workers. This is to be accomplished by the Commissioner's office in liaison with the Department of Labor and Industry and by the VD Control Program and the District State Health offices by contacting farmers, crew leaders, and groups of migrant laborers, and by providing appropriate informational material to be directed at the migrant population. The mobile unit will continue to visit areas where there are concentrations of workers for the purpose of screening, diagnosis and treatment for venereal disease. Policies governing VD activities among migrant workers follow:

Serologic tests for syphilis (STS) shall be provided for:

- All persons over 12 years of age
- All children, regardless of age, of mothers with reactive results on STS

Physical examinations shall be provided for:

- 1 All males over 12 years of age undergoing serologic screening
- 2 All individuals with reactive STS
- 3 All contacts, male or female, to cases of venereal disease
- 4 All individuals complaining of or manifesting obvious signs or symptoms of disease

Physical examination shall consist of:

For category 1, inspection of mouth and genitalia
 For categories, 2,3 and 4, a general physical examination with special attention to:

- a Examination of eyes and mouth and skin of face, trunk and hands
- b Examination of heart
- c Examination of external genitalia, cervix (females) and anal region
- d Examination for cervical, epitrochlear, and inguinal lymphadenopathy

Diagnosis

Accurate diagnosis and management of venereal disease depends on correlating history, physical examination, laboratory findings, and clinical judgment. Because of the peculiar problems of mobility associated with migrants, certain compromises with regard to diagnosis and management must be made. Following are acceptable diagnostic criteria:

Presumptive diagnosis of venereal disease may be made on initial inspection in the presence of objective clinical findings.

Presumptive diagnosis of syphilis may be made with one reactive result on STS when confirmatory blood tests are not feasible.

Diagnosis of early latent syphilis should be made when the duration of the latent infection is under four years, and diagnosis of late latent syphilis when the duration is over four years.

When a diagnosis of latent syphilis is made and the history does not establish the duration of the infection, a diagnosis of early latent syphilis should be made when the patient is under 26 years of age and late latent syphilis when the patient is 26 years of age or over.

Treatment

Because of the unique follow-up problem which the transiency of migratory labor introduces, treatment schedules involving only one clinic visit are preferred:

Prophylactic treatment

All contacts of primary and secondary syphilis shall be treated with 2.4 million units of benzathine penicillin G (bicillin).

All contacts of diagnosed gonorrhea shall be treated with 1.2 million units of bicillin.

Recommended treatment schedules for diagnosed cases of venereal disease (including presumptive diagnoses)

Disease	Drug	Administration and Dosage
Syphilis (all stages except congenital)	Benzathine penicillin G (Bicillin)	2.4 million units intramuscularly in a single administration of 1.2 million units in each buttock
Congenital	Bicillin	$\frac{1}{2}$ adult dosage under 2 yrs. of age; full adult dosage over 2 yrs. of age
Gonorrhea	Bicillin	1.2 million units in a single administration in the buttocks
Lymphogranuloma Venereum	Terramycin	500 mg. dose orally every 6 hours for 12.5 days to a total of 25 gms.
Chancroid	Sulfathiazole	One gram (15 grains) orally 4 times a day for 7 days to a total dosage of 28 grams
Granuloma Inguinale	Terramycin	500 mg dose orally every 6 hours for 12.5 days to a total of 25 gms

Retreatment

Individuals with high titer bloods (reactive in a dilution of 1:8 or higher) who have received one previous course of penicillin or bicillin, may be retreated once. If two courses of penicillin or bicillin have already been given, no further treatment need be administered.

Drug Supplies

A supply of bicillin shall be provided to clinics at the beginning of the season by the VD Control Program.

Other drugs shall be provided as need arises.

Reporting

All cases of venereal disease, including those treated on presumptive diagnosis, shall be reported on the morbidity report form. These forms shall bear the stamp "MIGRANT".

Interviewing and Investigating

Who shall be interviewed?

All individuals with primary or secondary syphilis
 All individuals with early latent syphilis
 All women with late syphilis for husband, long standing sexual partners and children
 All males with gonorrhoea
 All individuals with chancroid
 All individuals with granuloma inguinale
 All individuals with lymphogranuloma venereum

When shall these individuals be interviewed?

Immediately after diagnosis

Who shall interview?

An interviewer shall attend each clinic session

Where shall interviews be performed?

Within the limitations imposed by clinic facilities, in as private a place as possible

For whom shall epidemiologic report forms VD-1 (452-51) be prepared?

Interviewer shall prepare Epidemiologic Report Forms on all contacts elicited during interviews

VD Control Program personnel shall prepare Epidemiologic Report Forms on all individuals with reactive STS.

Who shall investigate?

Investigations shall be performed by special VD personnel assigned to the State Health Districts.

- B Extending measures for blood testing of jail and other institutional populations. This would include demonstrations. Stimuli are to be provided by the VD Control Program, State Health Districts and by local boards of health.
 - C Stimulating routine serologic testing of patients admitted to hospitals and out-patient clinics, and in routine medical practice. Stimulating serologic testing for industrial workers. Promoting "cluster testing", which is the concept of blood testing associates of cases or of contacts of venereal disease. Stimuli are to be provided by the VD Control Program, Occupational Health Program, Division of Chronic Illness, District personnel and local health personnel.
 - D Extending measures for enforcement of the premarital and prenatal laws. To be accomplished by the VD Control and Maternal and Child Health Programs through the use of informational media directed toward the public and special groups and through liaison with the State Medical Society; by District personnel through their liaison with County Medical Societies and individual physicians; by local health department personnel through their liaison with individual physicians and through their personal contacts with families and pregnant women in particular.
 - E Following all suspects of venereal disease discovered by screening procedures until a diagnosis is established or ruled out. Actual follow-up procedures are to be carried out by qualified District and local personnel. When the Serology Program reports a reactive test result on Form Ser-3, Report of Quantitative Test for Syphilis, the result is forwarded to the Public Health Statistics Program for check against morbidity files. If no morbidity report is received within three weeks of the date of test, Form Ser-3 is forwarded by the Public Health Statistics Program to the VD Control Program, where a form VD-1 (452-51) is issued to initiate investigation.
- II Selective screening is an effective case-finding measure only when limited to high prevalence groups and therefore should be applied only to such groups.
- III Since selective screening is the least effective of the major case-finding devices for controlling the spread of syphilis, the routine blood testing often recommended for certain employment (food handlers, domestics, barbers) should be discontinued.

Section 4

DIAGNOSIS OF VENEREAL DISEASES

I Factors requiring attention to strengthen this activity are:

- A Evaluating medical resources and diagnostic and treatment facilities, including jail, institution and migrant clinics, with regard to adequacy (qualitative and quantitative) of physical facilities, availability of facilities as relates to distance and time, adequacy (qualitative and quantitative) of personnel, adherence to Department recommendations for diagnosis, treatment and supervision following treatment. This is to be accomplished by the VD Control Program, District State Health offices, and boards of health.
- B In areas where the indigent patient-load warrants, local health departments should operate clinics, to the extent needed to supplement hospital and other facilities. Where the patient-load does not justify this, an alternative system for the diagnosis and treatment of indigent venereal disease patients should be developed. This is to be accomplished by the VD Control Program, District State Health offices, and boards of health.
- C In areas where there are several small and relatively ineffectual clinics, thought should be given to the feasibility of consolidation into a single Prevention and Control Center. The more the work can be concentrated the more effective and less costly it will be.
- D Urging prompt reporting of diagnosed civilian and military cases in order that prompt interviewing and investigation may be started. This is to be accomplished by the VD Control Program through the use of informational media and through liaison with the State Medical Society and the Armed Services; by District personnel through their liaison with the county medical societies; individual physicians and the Armed Services; and by local health department personnel through their liaison with individual physicians.

II The Public Health Statistics Program will provide the VD Control Program with the following:

- A Monthly cumulative alphabetic lists of VD cases reported for the first time. Lists to be prepared on two part stock paper for the first eleven months of the year. One copy is retained by the Public Health Statistics Program and one copy is forwarded to the VD Control Program.
- B An annual alphabetic index of syphilis cases on two part stock paper. One copy is retained by the Public Health Statistics Program and one copy is forwarded to the VD Control Program.

- C An annual alphabetic index of venereal disease cases other than syphilis on two part stock paper. One copy is retained by the Public Health Statistics Program and one copy is forwarded to the VD Control Program.
 - D A quarterly count of syphilis by stage by municipality by county by sex by race by reporter (private physician, other than private physician) on two part stock paper. Both copies are forwarded to the VD Control Program. One copy for the VD Control Program, one for Regional Office of Public Health Service.
 - E A quarterly count of venereal diseases (other than syphilis) by specific disease by municipality by county by sex by race by reporter (private physician, other than private physician) on two part stock paper. Both copies are forwarded to the VD Control Program. One copy for the VD Control Program, one for Regional Office of Public Health Service.
 - F Two copies of a stock paper annual tabulation of syphilis by stage by municipality by county. Both copies are forwarded to the VD Control Program. One copy for the VD Control Program. One copy separated by the VD Control Program according to county and distributed to the State Health Districts.
 - G Two copies of a stock paper tabulation of all venereal diseases by specific disease group (syphilis, gonorrhea, all other venereal disease as a group) by reporter (private physician, other than private physician) by municipality by county. Both copies are forwarded to the VD Control Program. One copy for the VD Control Program. One copy separated by the VD Control Program according to county and distributed to the State Health Districts.
 - H Two copies of stock paper listing of all heading cards for municipality by county which failed to report any case of any venereal disease during the year. Both copies are forwarded to the VD Control Program. One copy for the VD Control Program. One copy separated by the VD Control Program according to county and distributed to the State Health Districts.
 - I Form PHS-688 (VD), in quadruplicate, quarterly for the State as a whole, and military posts as a group. This form will be furnished by the VD Control Program. One copy to be retained by the Public Health Statistics Program. Three copies forwarded to the VD Control Program. One copy for the VD Control Program, two copies for the Regional Office of Public Health Service.
- III The Public Health Statistics Program will furnish the following data on forms to be provided in duplicate by the VD Control Program. One copy to be retained by the Public Health Statistics Program. One copy for the VD Control Program.

- A Reported cases of all venereal diseases* by disease by stage (for syphilis only) and reporting agency.
 - B Syphilis and gonorrhoea cases and rates** by District and county of residence.
 - C Syphilis and gonorrhoea cases and rates** by District and selected city of residence.
 - D Reported gonorrhoea cases of civilians by age, race and sex.
- IV Specialized personnel assigned to the Migrant Health Program will assist physicians with blood letting, will deliver blood specimens to the State Department of Health Laboratory, will pick up blood reports within 24 hours, will arrange to have epidemiologic report forms prepared on all reactive blood reports, and will notify suspects to report for examination at the next clinic session.

* Includes all cases reported in New Jersey, plus New Jersey residents reported in other states and referred to the Division of Vital Statistics and Administration.

** Rates expressed per 100,000 estimated population. Includes residents of New Jersey only.

Section 5

TREATMENT AND POST-TREATMENT OBSERVATION OF VENEREAL DISEASES

I Factors requiring attention to strengthen this activity are:

- A Urging treatment of gonorrhea on clinical and epidemiologic evidence without waiting for laboratory confirmation of diagnosis. The deficiencies inherent in both spread and culture diagnostic methods, even in the hands of qualified technicians, suggest that clinical and epidemiologic evidence are still the principal diagnostic tools from the public health viewpoint. This is to be accomplished by the VD Control Program through the use of informational media and through liaison with the State Medical Society; by District personnel through their liaison with the county medical societies and individual physicians; and by local health department personnel through their liaison with individual physicians.
- B Urging morbidity reporting of gonorrhea which has been treated on clinical evidence. This is to be accomplished by the VD Control Program through the use of informational media and through liaison with the State Medical Society; by District personnel through their liaison with the county medical societies and individual physicians; and by local health department personnel through their liaison with individual physicians.

II Drugs for the treatment of venereal diseases will be provided without charge to private physicians, clinics, and hospitals in accordance with the treatment schedules shown on page 34. The procedure for requesting and distributing drugs is:

A Private physicians and hospitals

- 1 Physicians will request drugs on the reverse side of the Morbidity Report Form (VD-2).
- 2 The Public Health Statistics Program will prepare a drug order, will send it to the Administrative Services Program which will ship drugs and will forward remaining portion of drug order form to the VD Control Program.

B Clinics

- 1 The State Health Districts will provide VD clinics with forms (VD-8) upon which bicillin needs for a 6 month period will be indicated. These bicillin requests will not attempt to separate the needs for syphilis and gonorrhea but will show the total estimated needs. Bicillin will be forwarded twice each year. If special needs arise, requests should be made by letter or telephone to the appropriate State Health District.

- C The Administrative Services Program will keep an inventory and will forward balances of drugs on hand monthly to the VD Control Program.
- D The VD Control Program will not routinely provide drugs for the treatment of venereal diseases to State and county institutions. When emergency situations arise requiring more drugs than an institution is able to provide, the VD Control Program will render assistance.

III Post-Treatment Observation

- A Because modern antibiotic therapy accomplishes a great deal in a few days the case-holding problem during the treatment period has decreased, but the importance of post-treatment observation has increased. The ultimate effectiveness of penicillin and bicillin are not yet known and patients must be urged to remain under observation. This is to be accomplished by the VD Control Program through the use of informational media and through liaison with the State Medical Society; by District personnel through their liaison with the county medical societies, and individual physicians and patients; and by local health personnel through their liaison with individual physicians and patients.
- B When a patient lapses from diagnostic observation or treatment, an Epidemiologic Report Form VD-1 (452-51) shall be prepared. Item 12 of the form shall indicate that the patient is an "Other" type of suspect, specifically a lapsed case. The procedure for returning him to medical observation is essentially the same as for the investigation of any other suspect.

TREATMENT FOR THE VENEREAL DISEASES
 EXAMPLES OF ACCEPTABLE TREATMENT SCHEDULES
 Venereal Disease Control Program
 New Jersey State Department of Health

Disease	Drug	Administration and Dosage
<u>Syphilis</u> (All stages except congenital syphilis)	Benzathine Penicillin G (Bicillin)	2.4 million units intramuscularly in a single administration of 1.2 million units in each buttock
<u>Congenital Syphilis</u>	Bicillin	One-half adult dosage under two years of age; full dosage over two years of age
<u>Gonorrhea</u>	Bicillin	1.2 million units in a single administration in the buttocks
<u>Lymphogranuloma Venereum</u>	Terramycin	500 mg. dose orally every 6 hours for 12.5 days to a total of 25 gms.
<u>Chancroid</u>	Sulfathiazole	One gram (15 grain) orally 4 times a day for 7 days to a total dosage of 28 grams
<u>Granuloma Inguinale</u>	Terramycin	500 mg. dose orally every 6 hours for 12.5 days to a total of 25 gms.