PCSI
Program Collaboration and Service Integration

Evaluation Plan for Program Collaboration and Service Integration

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

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Executive Summary
Evaluation Plan for Program Collaboration and Service Integration (PSCI)
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Introduction

The Centers for Disease Control and Prevention defines Program Collaboration and Service Integration (PCSI) as a mechanism of organizing and blending inter-related health issues, separate activities, and services in order to maximize public health impact through new and established linkages between programs to facilitate delivery of services. CDC has two goals related to PCSI evaluation: 1) obtain a picture of the amount and types of PCSI activities currently occurring among funded entities in the United States, and 2) monitor internal CDC progress on commitments and activities, and the effect of these activities in the field. This evaluation plan presents a PCSI logic model, evaluation questions, data collection methods, and implementation tasks and timeline.

Plan Development

This plan was developed iteratively with thoughtful feedback provided by NCHHSTP leadership, PCSI office staff, members of the Program Integration Excellence (PIE) Group, and Division Directors, Program Officers, Project Consultants, and Evaluation Branch staff representing the four Divisions. Valuable input was also received during a meeting with CDC's national partner organizations, including NASTAD, NCSD, NTCA, UCHAPS, ASTHO, NACCHO, NACH, APHL, NNPTC, and RMTCC.

Logic Model

The logic model depicts the inputs, activities, and intended outcomes of CDC's PCSI initiative, as well as the pathways through which these activities are to produce the specified outcomes. Shorter-term and longer-term outcomes are identified at the jurisdiction-level and within NCHHSTP. Achieving outcomes at the NCHHSTP-level is essential to realizing jurisdiction-level outcomes and client-level public health impact.

Evaluation Questions

Evaluation questions are derived directly from the logic model and are designed to monitor availability of PCSI inputs, track progress on PCSI activities, assess accomplishment of shorter-term and longer-term outcomes, and identify any unintended effects of PCSI on service delivery. Although the evaluation questions map to a discrete components of the logic model, they are best viewed as a comprehensive suite of questions to guide the overall evaluation.

Implementation Plan

Four data collection strategies are recommended to evaluate PCSI: 1) input and activity monitoring to track availability of inputs and progress of PCSI activities conducted by CDC and the national partner agencies to help highlight accomplishments and identify actions steps that need greater attention, 2) web survey sponsored by the national partner agencies to collect data from health department grantees for a national-level understanding of program collaboration and service integration trends, 3) case studies to gather detailed qualitative and quantitative data about program collaboration and service integration from a subset of jurisdictions and service delivery sites that would otherwise not be available from national-level evaluation, and 4) analysis of health services delivery data available to CDC to better understand the extent of service integration and trends at the national-level. Action steps and timelines for implementing each evaluation strategy have been identified

Annual and Interim Progress Reports

Annual Progress Report (APR) and Interim Progress Report (IPR) guidance for each Division were reviewed to assess information in those reports for use in evaluating PCSI. Based on this review, APR and IPR are not recommend as a source of data for PCSI evaluation due to concerns about the availability, quality, uniformity, and completeness of these data, and the level of effort required to abstract this information.

Indicators and Data Sources

Indicators and data sources for PCSI evaluation are described for each of the following areas: PCSI input monitoring, PCSI activity monitoring, shorter-term jurisdiction-level outcomes, longer-term jurisdiction-level outcomes, shorter-term NCHHSTP outcomes, and longer-term NCHHSTP outcomes.

Introduction

The Centers for Disease Control and Prevention defines Program Collaboration and Service Integration (PCSI) as a mechanism of organizing and blending inter-related health issues, separate activities, and services in order to maximize public health impact through new and established linkages between programs to facilitate delivery of services. CDC has two goals related to PCSI evaluation: 1) obtain a picture of the amount and types of PCSI activities currently occurring among funded entities in the United States, and 2) monitor internal CDC progress on commitments and activities, and the effect of these activities in the field (Internal Review of NCHHSTP Cooperative Agreements and Reports for PCSI Analysis, Sept. 3, 2008). This evaluation plan presents a PCSI logic model, evaluation questions, data collection methods, and implementation tasks and timeline.

Plan Development

This plan was developed iteratively with thoughtful feedback provided during conference calls and face-to-face meetings with NCHHSTP leadership, PCSI office staff, members of the Program Integration Excellence (PIE) Group, and Division Directors, Program Officers, Project Consultants, and Evaluation Branch staff representing the four Divisions.

Valuable input on the evaluation plan was also received during a meeting with CDC's national partner organizations in Washington, DC, in April 2009. Participating organizations included: National Alliance of State and Territorial AIDS Directors (NASTAD), National Coalition of STD Directors (NCSD), National Tuberculosis Controllers Association (NTCA), Urban Coalition of HIV/AIDS Prevention Services (UCHAPS), Association of State and Territorial Health Officials (ASTHO), National Association of City and County Health Officials (NACCHO), National Association of Community Health Centers (NACH), Association of Public Health Laboratories (APHL), National Network of Prevention Training Centers (NNPTCs), and TB Regional Training and Medical Consultation Centers (RMTCCs).

A wide variety of documents were reviewed in developing the evaluation plan, including CDC's PCSI Green paper; External Consultation Meeting Report Summary, April 21 -22, 2007; CDC Sponsored Training Courses Meeting Report, June 24, 2008; PCSI 2008 Action Plan; Evaluating the Impact of Viral Hepatitis Integration on HIV and STD Prevention Services, July 2005; Public Health Reports on Integrating Viral Hepatitis Prevention in Public Health Settings, 2007; and surveillance reports, and Annual and Interim Progress Report Guidance from all four Divisions.

Logic Model

The logic model (see attachment) depicts the inputs, activities, and intended outcomes of the PCSI initiative, as well as the pathways through which these activities are to produce the specified outcomes. Shorter-term and longer-term outcomes are identified at the jurisdiction-level and within NCHHSTP.

CDC inputs to support PCSI include leadership, governance, policy and guidance, financial and human resources, and collaborative relationships with national partner organizations. CDC PCSI activities are planned or underway in the areas of funding and program announcements, program guidelines and recommendations, integrated surveillance, CDC-sponsored training courses, integrated work-structures within the Center, and nation communications about PCSI. In addition, national organizations are collaborating with CDC to conduct PCSI activities in the areas of communications, training, partnerships, policy, and evaluation.

CDC and national organization activities are intended to produce shorter-term outcomes at the jurisdiction-level, including increased flexibility to use funds for PCSI within jurisdictions, adoption of integrated partner services guidelines, greater sharing and use of data across disease areas within jurisdictions, acquisition of PCSI-related knowledge and skills through participation in CDC-sponsored training programs, coordinated communication between grantees and POs across disease areas within jurisdictions, and broad understanding of and support for PCSI[1]. These shorter-term outcomes, however, are not assumed to occur simultaneously or at a fixed point in time, nor are they expected to occur to the same degree among all jurisdictions.

Shorter-term jurisdiction-level outcomes specified in the logic model are intended to yield longer-term improvements in program collaboration across disease areas within jurisdictions and enhanced service integration across disease areas at the point of service delivery. These outcomes, in turn, should yield the following public health impacts: improved behavioral and health outcomes for clients; accessible, holistic, high-quality client services, and greater opportunities to manage multiple epidemics.

CDC PCSI activities described above also intend to influence the internal operations of NCHHSTP. Shorter-term internal effects include routine integration of PCSI language in FOAs, sharing and using data across disease areas and Divisions, and regular cross-Division collaboration on PCSI initiatives. Longer-term outcomes include institutionalization of PCSI in the day-to-day operations within NCHHSTP. The logic model portrays outcomes at the NCHHSTP-level as essential to achieving jurisdiction-level outcomes and client-level public health impact.

Evaluation Questions

The following evaluation questions are derived directly from the logic model and are designed to monitor availability of PCSI inputs, track progress on PCSI activities, assess accomplishment of shorter-term and longer-term outcomes, and identify any unintended effects of PCSI on service delivery. Although the evaluation questions map to a discrete components of the logic model, they are best viewed as a comprehensive suite of questions to guide the overall evaluation.

I. PCSI Input Monitoring

1. What inputs have been available to support PCSI activities? How have inputs changed over time?
2. What is the relationship between the level of inputs and accomplish of PCSI activities?

II. PCSI Activity Monitoring

NCHHSTP Activities

1. What has CDC done to integrate the following areas?
    a. Funding and program announcements
    b. Partner services guidelines and other program recommendations
    c. Surveillance
    d. Training courses
    e. Work-structure within NCHHSTP
2. What has CDC done to communicate PCSI nationally?

National Organization Activities

3. What have national organizations done to support PCSI in the areas of communications, training, partnerships, policy, and evaluation?

III. Shorter-Term Jurisdiction-Level Outcomes

1. To what extent have CDC's efforts to integrate funding and program announcements increased grantee flexibility to use funds for PCSI? How are grantees using those funds for PCSI? What barriers remain?
2. To what extent have CDC's integrated partner services guidelines led to the adoption of integrated partner services guidelines within jurisdictions? How are grantees establishing these guidelines? What barriers to integrated partner services remain?
3. To what extent have CDC's efforts to integrate surveillance made it easier for grantees to share and use data across disease areas within their jurisdiction? How are grantees using those data for PCSI? What barriers remain?
4. To what extent have participants in NCHHSTP-sponsored training programs gained PCSI-related knowledge and skills? How have these training programs adapted to PCSI?
5. To what extent has communication improved between grantees and POs across disease areas within jurisdictions? Are grantees accessing the extranet resource listing of PO assignments and do they find this useful? What communication barriers remain?
6. To what extent have CDC's efforts to communicate PCSI nationally fostered understanding of and support for PCSI? What questions and concerns remain?
7. How have national organizations' PCSI activities in the areas of communications, training, partnerships, policy, and evaluation affected jurisdiction efforts to improve collaboration and service integration?

IV. Longer-Term Jurisdiction-Level Outcomes

1. To what extent has program collaboration increased across disease areas within jurisdictions? What collaborative barriers remain?
2. What is the level of service integration across disease areas at the point of service delivery? How has service integration changed over time? What barriers to service integration remain?
3. What unintended effects has PCSI had on the delivery of HIV, STD, TB, and viral hepatitis services?

V. Shorter-Term NCHHSTP Outcomes

1. To what extent is PCSI language integrated in all relevant FOAs? Are the Standards of Practice followed? Is the FOA builder being used? What barriers remain?
2. To what extent do project officers collaborate across divisions to monitor overlapping grantee activities? What barriers remain?
3. To what extent do Divisions share and use data across disease areas? What barriers remain?
4. To what extent do Divisions communicate and collaborate on PCSI? What barriers remain?

VI. Longer-Term NCHHSTP Outcomes

1. To what extent has PCSI been institutionalized into the day-to-day operations of NCHHSTP?

Annual and Interim Progress Reports

In preparing this evaluation plan, Annual Progress Report (APR) and Interim Progress Report (IPR) guidance for each Division was reviewed to assess the availability of information in those reports for use in evaluating PCSI as well as the feasibility of abstracting those data for evaluation purposes. This review pertains only to the use of these data for evaluating program collaboration and service integration and is not a critique of the reports' utility for other Division-specific purposes. The following documents were reviewed:

- DHAP PA 04012 APR Guidance FY 2006 and FY 2008
- DHAP PA 07768 APR Guidance, Sept 30, 2007 – Sept 29, 2008
- DSTDP FOA CSPS 05004 APR and FPR Guidance
- DTBE FOA 05003CONT IPR Guidance FY 2008
- DVH FOA PS08-801CONT APR Guidance FY 2008

The format and content of APR and IPR vary across Divisions including dichotomous yes / no questions about program elements, counts of services provided, and descriptions of program accomplishments. Report content sometimes changes over time; for example, the DHAP FY 2006 and 2008 report guidance differed somewhat in the types of information requested and the location within the report that information was to be provided. While variation in report content and format is not surprising given that reports are tailored to information needs of project and program officers within Divisions, this variation makes it difficult to combine information across reports for evaluating program collaboration and service integration at the jurisdiction-level.

While information about program collaboration and service integration is explicitly requested in the DHAP APR and IPR guidance reviewed, this information does not appear to be directly asked for in the report guidance from other Divisions. For example, the DHAP PA 04012 APR Guidance for FY 2006 and FY 2008 requests information about HIV testing in STD clinics and in TB clinics, and includes dichotomous yes / no questions about collaboration and coordination between HIV and STD, TB, and Hepatitis programs. However, key constructs in the guidance such as "meaningful coordination and collaboration" are vulnerable to different interpretations across grantees, compromising the quality of these data for PCSI evaluation purposes. While it is possible that information about program collaboration and service integration may be contained in the narrative sections of APR and IPR for any of the Division reports, the specificity and completeness of this information likely varies across jurisdictions and disease areas.

Consideration must also be given to possible bias in self-report data from jurisdictions. Given that PCSI is widely recognized as a strategic imperative for NCHHSTP, some grantees may over report the extent of program collaboration and service integration occurring in their jurisdiction. Alternative methods of collecting de-identified data from jurisdictions should be considered; for example, the recent National HIV Prevention Program Inventory, a joint project of NASTAD and the Henry J. Kaiser Family Foundation, included measures of program collaboration and service integration between health department HIV prevention programs and other disease areas.

In addition to issues of data quality, it is worthwhile to consider the level of effort needed to abstract information from APR and IPR. Data abstraction would likely be very time-intensive and would involve clearly defining constructs such as program collaboration and service integration, hiring and training staff to conduct data abstraction, developing and piloting a data abstraction protocol to ensure inter-coder reliability, reviewing APR and IPR reports, abstracting data, entering information into a database, and analyzing and interpreting the information gleaned from the reports. Based on estimates of similar tasks conducted for DHAP by MACRO International, APR and IPR abstraction for PCSI evaluation for 65 jurisdictions across four Divisions could require approximately 12 FTE for six weeks.

Based on this review, APR and IPR in their current form are not recommend as a source of data for PCSI evaluation. It may be possible to modify the report guidance from the four Divisions to enhance the availability, quality, uniformity, and completeness of these data, and to decrease the level of effort required to abstract this information. Although concerns about possible self-report bias remain, the recommendations listed below may improve APR and IPR as a future source of PCSI evaluation data. Implementing these recommendations, however, could take considerable

time and should be balanced against other opportunities outlined in this report to more efficiently collect PCSI evaluation data.

- Clearly operationalize the terms "program collaboration" and "service integration", and incorporate these definitions in all APR and IPR guidance across Divisions.

- Develop a core set of questions about the extent and nature of program collaboration and service integration to be included in all APR and IPR guidance across Divisions; these questions should be clustered together to facilitate easy access to the information once the completed reports are sent to CDC.

- Request both quantitative and qualitative PCSI data in APR and IPR; for example, the number and type of venues within which HIV, STD, and Viral Hepatitis services are integrated as well as narrative description of program collaboration and service integration challenges.

- Establish a mechanism, including a staffing plan, for the routine, systematic abstraction, analysis, and use of these data to evaluate PCSI.

Implementation Plan

Four data collection strategies are recommended to answer the PCSI evaluation questions listed earlier in this report:

1. Input and activity monitoring to track availability of inputs and progress of PCSI activities conducted by CDC and the national partner agencies to help highlight accomplishments and identify actions steps that need greater attention.

2. Web survey sponsored by the national partner agencies to collect data from health department grantees for a national-level understanding of program collaboration and service integration trends.

3. Case studies to gather detailed qualitative and quantitative data about program collaboration and service integration from a subset of jurisdictions and service delivery sites that would otherwise not be available from national-level evaluation.

4. Analysis of health services delivery data available to CDC to better understand the extent of service integration and trends at the national-level.

Use of the term "health services delivery" data in this evaluation plan refers broadly to secondary data available to CDC describing the extent to which screening, testing, vaccine, and other prevention services are integrated across disease areas. These data are distinct from morbidity and mortality surveillance data that have less utility in measuring integration as a PCSI outcome. The following tables present action steps and timelines for each data collection strategy. The implementation plans assume that financial resources have been secured for conducting the

evaluation activities described herein, the PCSI office has identified staff to coordinate these evaluation activities, and that implementation will be phased such that the level of effort to execute this plan does not exceed financial and staffing resources.

1. Input and Activity Monitoring

Purpose: Track availability and inputs and progress of PCSI activities conducted by CDC and the national partner agencies to help highlight accomplishments and identify actions steps that need greater attention.

Action Steps	Year 1				Year 2			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Finalize project concept, budget, and staffing for activity monitoring.	x							
2. Develop input and progress tracking sheets, check-lists, and other tools to document availability of inputs and completion of PCSI activities carried out by CDC.	x	x						
3. Review CDC work products (e.g., integrated surveillance report) and conduct interviews with CDC staff to assess availability of inputs and completion of PCSI activities.		x	x			x	x	
4. Develop interview guide and conduct interviews with national organization staff to identify their inputs and inventory PCSI-related activities.			x				x	
5. Produce twice annual status report on input levels and implementation of PCSI activities at CDC and national organizations.				x				x

2. Web Survey

Purpose: Develop and deploy a web survey sponsored by the national partner agencies to collect data from health department grantees to track national-level changes in program collaboration and service integration over time.

Action Steps	Year 1				Year 2			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Finalize project concept, budget, and staffing to conduct web survey.	x							
2. Develop a web survey working group including representatives across Divisions and external stakeholders representing the four disease areas.	x							
3. Develop draft survey and implementation plan, including procedures for hosting the survey and ensuring data confidentiality.		x	x					
4. Pilot test survey with a subset of respondents and revise as needed.				x				

2. Web Survey (continued)

Action Steps	Year 1				Year 2			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
5. Conduct full implementation of web survey.					x			
6. Analyze survey data and produce written report of findings.						x	x	
7. Disseminate findings and identify ways in which they can be used to further support program collaboration and service integration.								x

3. Case Studies

Purpose: Gather detailed qualitative and quantitative data about program collaboration and service integration from a subset of jurisdictions and service delivery sites that would otherwise not be available from national-level evaluation.

Action Steps	Year 1				Year 2			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Finalize project concept, budget, and staffing for case studies.	x							
2. Develop a case study working group including representatives across Divisions and external stakeholders representing the four disease areas.	x							
3. Develop criteria for selection of jurisdictions and service delivery sites within those jurisdictions to participate in case studies.		x						
4. Identify jurisdictions and service delivery sites that meet case selection criteria.		x						
5. Develop draft data collection tools and protocols including confidentiality guidelines, site-visit plans, local data inventory, interview guides, etc.			x	x				
6. Pilot test data collection tools and protocols with one site and revise as needed.				x	x			
7. Conduct case studies with remaining sites including site visits, phone and in-person interviews, and analysis of data on health service delivery and disease indicators.					x	x		
8. Analyze case study data and produce written report of findings.							x	x
9. Disseminate findings and identify ways in which they can be used to further support program collaboration and service integration.								x

4. Health Services Delivery Data								
Purpose: Use health services delivery data available to CDC to better understand the extent of service integration and changes over time at the national-level.								
Action Steps	Year 1				Year 2			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Finalize project concept, budget, and staffing for use of health services data.	x							
2. Develop a health services delivery data working group including representatives across Divisions and external stakeholders representing the four disease areas.	x							
3. Establish a mechanism for the PCSI office to access health service data from Divisions and / or collaborate with data analysts within Divisions.		x	x					
4. Create a schedule for routine analysis of health service data (e.g., analysis of specified variables conducted every two years).		x	x					
5. Analyze data to develop baseline measures of service integration and produce written report of findings.			x	x	x			
6. Disseminate findings and identify ways in which they can be used to further support program collaboration and service integration.						x	x	
7. Identify opportunities to include PCSI related variables on future special studies and/or health services delivery data routinely reported to CDC by grantees to address data gaps identified during analysis.							x	x

Indicators and Data Sources

Indicators and data sources for PCSI evaluation are presented in the following tables and are organized by the by six categories of evaluation questions described earlier in this report.

1. PCSI Input Monitoring
2. PCSI Activity Monitoring
3. Shorter-Term Jurisdiction-Level Outcomes
4. Longer-Term Jurisdiction-Level Outcomes
5. Shorter-Term NCHHSTP Outcomes
6. Longer-Term NCHHSTP Outcomes

I. PCSI Input Monitoring		
Evaluation Questions	**Indicators**	**Methods / Sources**
1. What inputs have been available to support PCSI activities? How have inputs changed over time?	▪ Leadership ▪ Governance ▪ Policy and guidance ▪ Financial and human resources ▪ Collaboration with national partner organizations	▪ Interview CDC staff and national organization staff to assess availability of inputs to support PCSI activities
2. What is the relationship between the level of inputs and accomplish of PCSI activities?	▪ Sufficient inputs to accomplish activities	▪ Interview CDC staff and national organization staff to assess relationship between the level of inputs and accomplish of PCSI activities

II. PCSI Activity Monitoring		
Evaluation Questions	**Indicators**	**Methods / Sources**
1. What has CDC done to integrate funding and program announcements?	▪ PCSI language appears in all relevant FOAs ▪ Program guidance allows greater flexibility in use of funds across disease areas ▪ Standard of Practice is followed for Divisions to consulate with PCSI office in developing FOAs ▪ Inventory of FOAs is completed ▪ FOA builder incorporates PCSI language	▪ Review FOAs for PCSI language and flexibility in use of funds for PCSI ▪ Review Standard of Practice regarding collaboration with PCSI office ▪ Review FOA inventory ▪ Review FOA builder
2. What has CDC done to integrate partner services guidelines and other program recommendations?	▪ Integrated partners services guidelines issued ▪ Recommendations published in MMWR for integrated services for substance users	▪ Review integrated partners services guidelines and recommendations for substance users
3. What has CDC done to integrate surveillance?	▪ Integrated surveillance report completed ▪ Confidentiality standards for data-sharing established and disseminated	▪ Review integrated surveillance report and confidentiality standards for data-sharing as well as dissemination plans

II. PCSI Activity Monitoring (continued)		
Evaluation Questions	**Indicators**	**Methods / Sources**
4. What has CDC done to integrate CDC-sponsored training courses?	▪ Curricula review completed with report of findings ▪ Core competencies for trainers and trainees identified ▪ PCSI slide set is developed and in use by trainers ▪ Integrated training programs are delivered	▪ Review training materials, curricula, and slides; and core competencies ▪ Count number of integrated trainings delivered, and training participants
5. What has CDC done to integrate work-structure within NCHHSTP?	▪ PIE meetings and GRIP meetings occur regularly and participants find the meetings to be beneficial ▪ A master list of PO assignments has been disseminated via intranet and extranet, and this resource is being used by its intended audience	▪ Review purpose, schedule, participants, and minutes for PIE and GRIP ▪ Key informant interviews within NCHHSTP about usefulness of PIE and GRIP meetings, and intranet features ▪ Review intra and extranet resource
6. What has CDC done to communicate PCSI nationally?	▪ White Paper issued ▪ PCSI sessions conducted at national conferences	▪ Review WP and dissemination plan ▪ Count number of PCSI sessions conducted and participants
7. What have national organizations done to support PCSI in the areas of communications, training, partnerships, policy, and evaluation?	▪ Documented activities in communications, training, partnerships, policy, and evaluation	▪ Interview key informants at each national organization and review related work products and documents

III. Shorter-Term Jurisdiction-Level Outcomes		
Evaluation Questions	**Indicators**	**Methods / Sources**
1. To what extent have CDC's efforts to integrate funding and program announcements increased grantee flexibility to use funds for PCSI? How are grantees using those funds for PCSI? What barriers remain?	▪ Percent of grantees reporting greater flexibility in use of funds for PCSI ▪ Examples of how funds are used for PCSI	▪ Web survey of grantees administered by national organizations representing disease areas ▪ Case Study and key informant interviews with jurisdictions and with national organizations representing disease areas

III. Shorter-Term Jurisdiction-Level Outcomes (continued)		
Evaluation Questions	**Indicators**	**Methods / Sources**
2. To what extent have CDC's integrated partner services guidelines led to the adoption of integrated partner services guidelines within jurisdictions? How are grantees establishing these guidelines? What barriers to integrated partner services remain?	▪ Percent of grantees reporting adoption of integrated partner services guidelines. ▪ Examples of how integrated partner services guidelines have been established.	▪ Web survey of grantees administered by national organizations representing disease areas ▪ Key informant interviews with jurisdictions and with national organizations representing disease areas
3. To what extent have CDC's efforts to integrate surveillance made it easier for grantees to share and use data across disease areas within their jurisdiction? How are grantees using those data for PCSI? What barriers remain?	▪ Percent of grantees reporting increased sharing and use data across disease areas within their jurisdiction ▪ Examples of how data are used for PCSI	▪ Web survey of grantees administered by national organizations representing disease areas ▪ Key informant interviews with jurisdictions and with national organizations representing disease areas
4. To what extent have participants in NCHHSTP-sponsored training programs gained PCSI-related knowledge and skills? How have these training programs adapted to PCSI?	▪ Percent of participants in NCHHSTP-sponsored training programs with increased pre/post test PCSI knowledge and skills	▪ Core set of PCSI measures used in pre / post evaluation across all NCHHSTP-sponsored training programs ▪ Key informant interviews with trainers for NCHHSTP-sponsored training program
5. To what extent has communication improved between grantees and POs across disease areas within jurisdictions? Are grantees accessing the extranet resource listing of PO assignments and do they find this useful? What communication barriers remain?	▪ Percent of grantees reporting improved communication with POs across disease areas within jurisdictions ▪ Extranet resources used by grantees	▪ Web survey of grantees administered by national organizations representing disease areas ▪ Key informant interviews with jurisdictions and with national organizations representing disease areas ▪ Monitor usage / hits of intra and extranet

III. Shorter-Term Jurisdiction-Level Outcomes (continued)		
Evaluation Questions	**Indicators**	**Methods / Sources**
6. To what extent have CDC's efforts to communicate PCSI nationally fostered understanding of and support for PCSI? What questions and concerns remain?	▪ Percent of grantees who report having read the White Paper and / or attended a PCSI session at a national conference ▪ Percent of grantees reporting understanding of and support for PCSI	▪ Web survey of grantees administered by national organizations representing disease areas ▪ Key informant interviews with jurisdictions and with national organizations representing disease areas ▪ Post-session evaluation of PCSI sessions at a national conferences
7. How have national organizations' PCSI activities in the areas of communications, training, partnerships, policy, and evaluation affected jurisdiction efforts to improve collaboration and service integration?	▪ Communications and training has supported understanding of PCSI ▪ Partnerships and policy efforts have supported PCSI goals ▪ National organizations have assisted in PCSI evaluation efforts	▪ Interview key informants at each national organization and review related work products and documents ▪ Web survey of grantees administered by national organizations representing disease areas

IV. Longer-Term Jurisdiction-Level Outcomes		
Evaluation Questions	**Indicators**	**Methods / Sources**
1. To what extent has program collaboration increased across disease areas within jurisdictions? What collaborative barriers remain?	▪ Percent of grantees reporting increased collaboration across disease areas within jurisdictions ▪ Examples of collaboration across disease areas	▪ Web survey of grantees administered by national organizations representing disease areas ▪ Key informant interviews with jurisdictions and with national organizations representing disease areas ▪ Key informant interviews with project officers within NCHHSTP to assess extent of program collaboration within jurisdictions

IV. Longer-Term Jurisdiction-Level Outcomes (continued)		
Evaluation Questions	**Indicators by Disease**	**Methods / Sources**
2. What is the level of service integration across disease areas at the point of service delivery? How has service integration changed over time? What barriers to service integration remain?	**a. STD**	
	1. Percent of all persons attending an STD clinic receiving an HIV test	▪ DSTDP MSM Prevalence Monitoring Project (this study is completed but may be added to SUN protocol allowing future measures) ▪ SUN Project (originally was just six sites but has recently been expanded to 12) ▪ May be able to use STD MIS "optional" health services variables from some jurisdictions but would need to request from jurisdiction since not collected by CDC ▪ DHAP NHM&E data available on proportion of DHAP funded HIV tests occurring in STD venues
	2. Percent of all persons diagnosed with an STD receiving an HIV test.	▪ DHAP NHM&E data on proportion of persons with self-reported or laboratory confirmed STD in the past 12 months who have received an HIV test ▪ May be able to use STD MIS "optional" health services variables from some jurisdictions but would need to request from jurisdictions since not collected by CDC
	b. HIV/AIDS	
	1. Percent of persons within funded HIV prevention facilities / venues receiving TB screening per recommendations	▪ DHAP NHM&E data about "other testing – TB" offered as a component of an HIV prevention intervention
	2. Percent of persons within funded HIV prevention facilities / venues receiving STD screening (or tracked referral for screening) per recommendations	▪ DHAP NHM&E data about "other testing – STD" offered as a component of an HIV prevention intervention

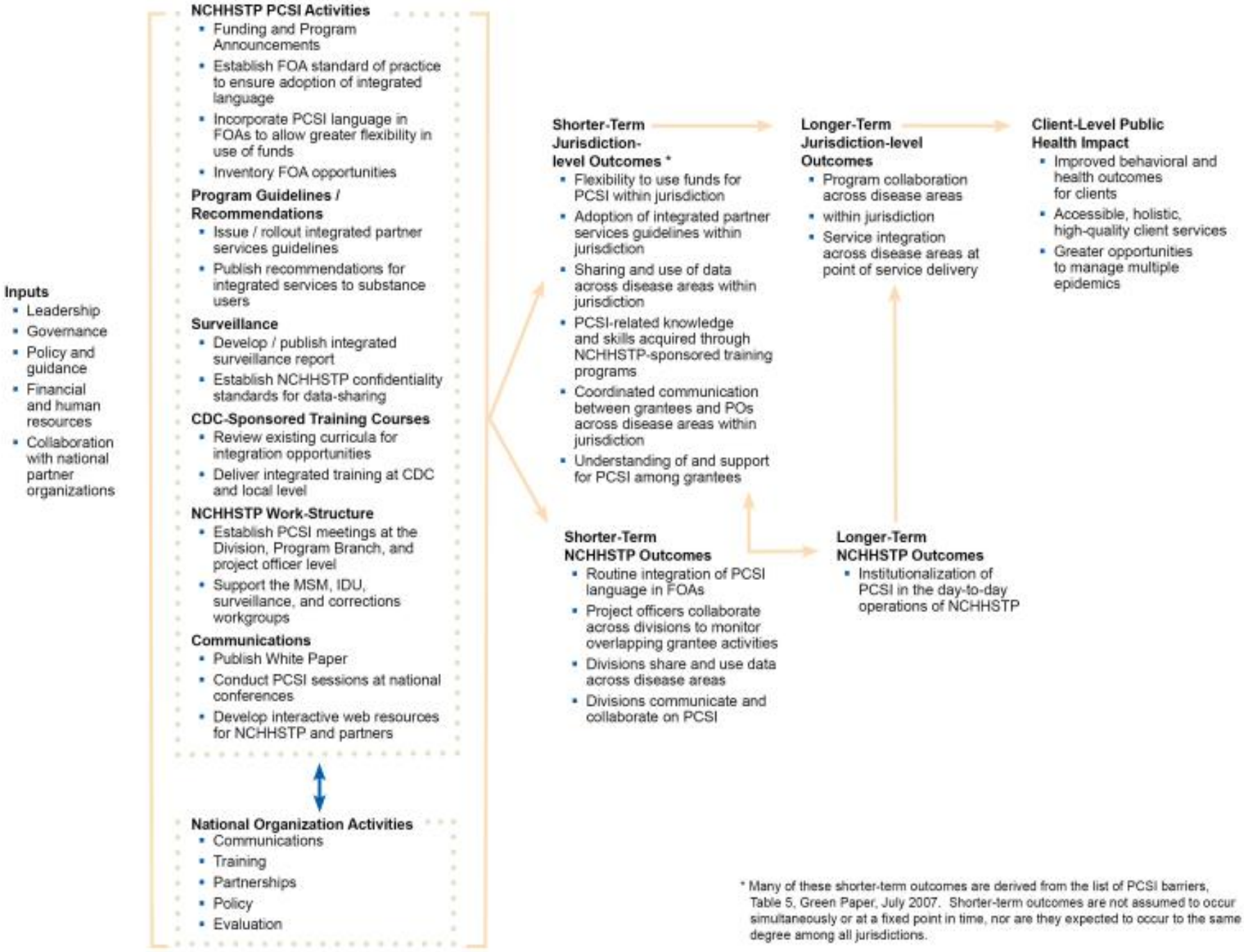
IV. Longer-Term Jurisdiction-Level Outcomes (continued)		
Evaluation Questions	**Indicators by Disease**	**Methods / Sources**
2. What is the level of service integration across disease areas at the point of service delivery? How has service integration changed over time? What barriers to service integration remain? (Continued from above)	**b. HIV/AIDS (continued)**	
	3. Percent of persons within funded HIV prevention facilities / venues receiving HBV/HAV vaccine per recommendations	▪ DVH data on number of vaccines by venue
	4. Percent of persons within funded HIV prevention facilities / venues receiving HCV testing if indicated	▪ DHAP NHM&E data about "other testing – Viral Hepatitis" offered as a component of an HIV prevention intervention
	5. Percent of persons diagnosed with HIV receiving tracked referral to HIV medical care	▪ DHAP C&T (Legacy) Data and NHM&E data
	6. Percent of persons diagnosed with HIV receiving partner services	▪ DHAP NHM&E data on number of persons enrolled in partners services as numerator and case reports as denominator (must account for reporting lag)
	7. Percent of persons diagnosed with HIV receiving TB screening per recommendations	▪ DHAP NHM&E data about "other testing – TB" offered as a component of partners services
	8. Percent of persons diagnosed with HIV receiving STD screening (or tracked referral) per recommendations	▪ DHAP NHM&E data about "other testing – STD" offered as a component of partners services
	9. Percent of persons diagnosed with HIV receiving HBV/HAV vaccine per recommendations	▪ DVH data on number of vaccines by venue
	10. Percent of persons diagnosed with HIV receiving HCV testing if indicated	▪ DHAP NHM&E data about "other testing – Viral Hepatitis" offered as a component of partners services
	c. Tuberculosis	
	1. Percent of identified TB cases enrolled in treatment receiving an HIV test (or documented HIV status)	▪ DTBE performance measure data

IV. Longer-Term Jurisdiction-Level Outcomes (continued)		
Evaluation Questions	**Indicators by Disease**	**Methods / Sources**
2. What is the level of service integration across disease areas at the point of service delivery? How has service integration changed over time? What barriers to service integration remain? (Continued from above)	**d. Hepatitis**	
	1. Percent of all persons attending an STD clinic receiving HBV/HAV vaccine per recommendations	▪ DVH data on number of vaccines by venue ▪ SUN Project may be able to add HBV/HAV vaccine variable ▪ May be able to use STD MIS "optional" health services variables from some jurisdictions but would need to request from jurisdiction since not collected by CDC
	2. Percent of all persons attending an STD clinic receiving HCV testing if indicated	▪ SUN Project may be able to add HCV testing variable ▪ May be able to use STD MIS "optional" health services variables from some jurisdictions but would need to request from jurisdiction since not collected by CDC
	3. Percent of all persons enrolled in an HIV prevention facility / venue receiving HBV/HAV vaccine per recommendations	▪ DVH data on number of vaccines by venue
	4. Percent of all persons enrolled in an HIV prevention facility / venue receiving HCV testing if indicated	▪ DHAP NHM&E data about "other testing – Viral Hepatitis" offered as a component of an HIV prevention intervention
3. What unintended effects has PCSI had on the delivery of HIV, STD, TB, and viral hepatitis services?	**e. All Disease Areas**	
	There are no predefined indicators for this evaluation question as it is exploratory in nature.	▪ Web survey of grantees administered by national organizations representing disease areas ▪ Key informant interviews with jurisdictions and with national organizations representing disease areas ▪ Key informant interviews with project officers within NCHHSTP

V. Shorter-Term NCHHSTP Outcomes		
Evaluation Questions	**Indicators**	**Methods / Sources**
1. To what extent is PCSI language integrated in all relevant FOAs? Are the Standards of Practice followed? Is the FOA builder being used? What barriers remain?	▪ PCSI language in FOAs ▪ Standards of Practice followed ▪ FOA builder used for PCSI	▪ Review FOAs for PCSI language ▪ Conduct key informant interviews within NCHHSTP assessing compliance with Standards of Practice and use of FOA builder
2. To what extent do project officers collaborate across divisions to monitor overlapping grantee activities? What barriers remain?	▪ Coordinated site visits ▪ Project officers collaborate across divisions ▪ Examples of project officer collaboration	▪ Conduct key informant interviews with project officers within NCHHSTP to assess extent of collaboration ▪ Web survey of grantees administered by national organizations representing disease areas ▪ Key informant interviews with jurisdictions and with national organizations representing disease areas
3. To what extent do Divisions share and use data across disease areas? What barriers remain?	▪ Data shared and used across disease areas ▪ Examples of data sharing and use	▪ Conduct key informant interviews within NCHHSTP to assess extent of data sharing and use ▪ Review documents, reports, and other products from data sharing and use
4. To what extent do Divisions communicate and collaborate on PCSI? What barriers remain?	▪ Cross Division PCSI communication and collaboration occurs ▪ Examples of cross Division communication and collaboration	▪ Conduct key informant interviews within NCHHSTP to assess extent of cross-division communication on PCSI

VI. Longer-Term NCHHSTP Outcomes		
Evaluation Questions	**Indicators**	**Methods / Sources**
1. To what extent has PCSI been institutionalized into the day-to-day operations of NCHHSTP?	▪ New PCSI activities identified and implemented ▪ PCSI activities occur without intervention from PCSI office ▪ PCSI used as paradigm for NCHHSTP planning and action	▪ Conduct key informant interviews within NCHHSTP

PCSI Logic Model



* Many of these shorter-term outcomes are derived from the list of PCSI barriers, Table 5, Green Paper, July 2007. Shorter-term outcomes are not assumed to occur simultaneously or at a fixed point in time, nor are they expected to occur to the same degree among all jurisdictions.