PS18-1802 Combined Jurisdictional Evaluatioin Performance Measurement Plan (EPMP) and Work Plan for Component A

(Updated May 1, 2018)

Name of Jurisdiction/Agency Submitting Plan:

Click to enter text.

Point of Contact for Correspondences: Click to enter text.

Mailing Address: Click to enter text.

Email: Click to enter text.

Phone: Click to enter text.

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Program Description

Section 1: Brief Description of the PS18-1802 Project Being Implemented (Abstract)

In approximately 800 words, please provide a brief, high-level narrative summary of your PS18-1802-funded program as it will be implemented over the course of the five-year project period.

Section 2: PS18-1802 Program Logic Model

* + 1. Below is the CDC logic model for PS18-1802, including all required HIV Prevention goals/priorities (e.g., increase individual knowledge of HIV status), strategies (e.g., identify persons with HIV infection and uninfected persons at risk for HIV infection), primary activities (e.g., conduct HIV testing), and outputs/outcomes (e.g., increased number of persons living with HIV infection who are aware of their HIV status). To meet the requirements of PS18-1802, unless otherwise exempted, your program must address all the goals/priorities, strategies, primary activities, outputs and outcomes noted in the logic model; however, you are only required to submit data to CDC for the outputs/outcomes bolded in blue. You may adopt this logic model for your local PS18-1802 program without modification; however, if you wish to include more detail in your logic model, you may add CDC-required sub-activities (e.g., implement and/or coordinate opt-out HIV testing of patients in healthcare settings; implement and/or coordinate targeted HIV testing in non-healthcare settings), locally defined sub-activities, or locally defined outputs/outcomes.

| **Logic Model – PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments**  **Part 1: Core Strategies & Activities** | | | |
| --- | --- | --- | --- |
| **Strategies & Activities** | | **Short-term Intended Outputs and Outcomes** | **Intermediate Intended Outcomes** |
| **HIV Prevention Goal/Priority 1: Cross-cutting surveillance core strategy** | | | |
| **Strategy 1** | **Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response** | | |
| Activity 1.A. HIV surveillance   * Collect HIV case data, including (but not limited to) data on CD4 cell count, HIV viral load, molecular laboratory test results, vital status, and geocoding   Click to enter additional activities. | | * **1.1. Improved completeness, timeliness, and quality of HIV surveillance data (Outcome)** | Click to enter outcomes. |
| * **1.2. Improved monitoring of trends in HIV infection (Outcome)** |
| * 1.3. Increased use of surveillance and epidemiological data to guide prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement services (Output)   Click to enter outputs/outcomes. |
| * 1.4. Increased use of geocoded data linked to census and social determinants of health datasets to guide prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement services (Output) |
| * **1.5. Increased ability to describe the geographic distribution of HIV and understand the social determinants of health in relation to HIV and HIV-related health disparities (Outcome)** |
| Activity 1.B. HIV prevention program monitoring & evaluation   * Collect data to monitor and evaluate HIV prevention programs | | * **1.6. Improved completeness, timeliness, and quality of HIV prevention program data (Outcome)** |  |
| **HIV Prevention Goal/Priority 2: Increase individual knowledge of HIV status** | | | |
| **Strategy 2** | **Identify persons with HIV infection and uninfected persons at risk for HIV infection** | | |
| Activity 2.A. Conduct HIV testing | | * **2.1. Increased HIV testing among persons at risk for HIV infection (Output)** |  |
| * **2.2. Increased number of persons living with HIV infection who are aware of their HIV status**   **(Outcome)** |
| * **2.3. Increased identification of HIV-negative persons at risk for HIV infection (Output)** |
| Activity 2.B. Conduct HIV partner services | | * **2.4. Increased participation in HIV partner services among persons with diagnosed HIV infection,**   **identified through PS18-1802-funded testing (Outcome)** |  |
| * **2.5. Increased participation in HIV partner services among persons with diagnosed HIV infection,**   **identified throughout the jurisdiction (Outcome)** |
| * **2.6. Increased partner elicitation through HIV partner services interviews of index patients with**   **newly diagnosed HIV infection (Outcome)** |
| * **2.7. Increased notification and HIV testing of partners identified through HIV partner services**   **(Output)** |
| * **2.8. Increased number of partners living with HIV infection who are aware of their HIV status**   **(Outcome)** |
| * **2.9. Improved laboratory reporting to HIV surveillance (Output)** |
| **HIV Prevention Goal/Priority 3: Rapidly detect and interrupt HIV transmission** | | | |
| **Strategy 3** | **Develop, maintain, and implement a plan to respond to HIV transmission clusters and outbreaks** | | |
| Activity 3.A. Identify and investigate HIV transmission clusters and outbreaks | | * **3.1. Improved early identification and investigation of HIV transmission clusters and**   **outbreaks (Outcome)** |  |
| Activity 3.B. Rapidly respond to and intervene in HIV transmission clusters and outbreaks | | * **3.2. Improved response to HIV transmission clusters and outbreaks (Outcome)** |  |
| Activity 3.C. Maintain outbreak identification and response plan | | * **3.3. Improved plan and policies to respond to and contain HIV outbreaks (Outcome)** |  |
| **HIV Prevention Goal/Priority 4: Reduce transmission from persons living with HIV infection** | | | |
| **Strategy 4** | **Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection (PLWH)** | | |
| Activity 4.A. Provide linkage to HIV medical care for persons with newly and previously diagnosed HIV infection identified through HIV testing and partner services | | * **4.1. Increased linkage to and retention in HIV medical care among PLWH (Outcome)** | * **4.5. Increased HIV viral load suppression**   **among PLWH (Outcome)** |
| Activity 4.B. Conduct data-to-care activities   * Identify persons with previously diagnosed HIV infection who are not in care through data-to-care activities * Provide linkage to, re-engagement in, and retention in HIV medical care services for persons with previously diagnosed HIV infection who are not in care identified through data-to-care activities | | * 4.2. Increased use of surveillance data to support PLWH throughout the HIV care continuum (Output) |  |
| Activity 4.C. Promote early ART initiation | | * 4.3. Increased early initiation of ART among PLWH (Outcome) |  |
| Activity 4.D. Support medication adherence | | * **4.4. Increased provision of ART medication adherence support for PLWH (Output)** |  |
| Activity 4.E. Promote and monitor HIV viral suppression | |  |  |
| Activity 4.F. Monitor HIV drug resistance | |  |  |
| Activity 4.G. Conduct risk-reduction interventions for PLWH | | * **4.6. Increased provision of risk reduction interventions for PLWH (Output)** | * 4.8. Decreased risk behaviors among PLWH   at risk of transmission (Outcome) |
| * **4.7. Increased active referral to HIV prevention services for PLWH (Output)** |
| Activity 4.H. Actively refer PLWH to essential support services, including screening and active referral for healthcare benefits, behavioral health services, and social services | | * **4.9. Increased screening and active referral of PLWH to essential support services, including**   **healthcare benefits, behavioral health services, and social services (Output)** |  |
| **HIV Prevention Goal/Priority 5: Prevent new infections among HIV-negative persons** | | | |
| **Strategy 5** | **Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection** | | |
| Activity 5.A. Provide periodic HIV testing and risk screening | | * 5.1. Increased periodic HIV testing and risk screening among persons at risk for HIV infection (Output) |  |
| Activity 5.B. Provide screening for PrEP eligibility | | * **5.2. Increased screening of HIV-negative persons for PrEP eligibility (Output)** |  |
| Activity 5.C. Provide linkage to and support for PrEP | | * **5.3. Increased active referral of persons eligible for PrEP to PrEP providers (Outcome)** | * 5.4. Increased linkage of persons eligible   for PrEP to PrEP providers (Outcome) |
| * 5.5. Increased prescription of PrEP to   persons for whom PrEP is indicated  (Outcome) |
| Activity 5.D. Provide risk reduction interventions for HIV-negative persons at risk for HIV infection | | * **5.6. Increased provision of risk reduction interventions for HIV-negative persons at risk for HIV**   **infection (Output)** | * 5.7. Decreased risk behaviors among HIV-   negative persons at risk for HIV and  other STDs (Outcome) |
| Activity 5.E. Actively refer HIV-negative persons at risk for HIV infection to essential support services, including screening and active referral for healthcare benefits, behavioral health services, and social services | | * **5.8. Increased screening and active referral of HIV-negative persons at risk for HIV infection to**   **essential support services, including healthcare benefits, behavioral health services,**  **and social services (Output)** |  |
| **Strategy 6** | **Conduct perinatal HIV prevention and surveillance activities** | | |
| Activity 6.A. Promote universal prenatal HIV testing | | * 6.1. Increased HIV screening among pregnant women (Output) | * **6.8. Reduced perinatally acquired HIV**   **infection (Outcome)** |
| * **6.2. Increased number of pregnant women who are aware of their HIV status (Outcome)** |
| Activity 6.B. Provide perinatal HIV service coordination | | * **6.3. Increased provision of perinatal HIV services or service coordination among pregnant women**   **living with diagnosed HIV and their infants (Output)** |
| * 6.4. Improved provision or coordination of perinatal HIV services (Outcome) |
| Activity 6.C. Conduct case surveillance for women with diagnosed HIV infection and their infants | | * **6.5. Increased completeness, timeliness, and quality of HIV surveillance data for pediatric cases and**   **HIV-exposed infant (Outcome)** |
| Activity 6.D. Conduct perinatal HIV exposure reporting | | * 6.6. Increased use of surveillance and epidemiological data to guide perinatal prevention and care   efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement  services (Output) |
| Activity 6.E. Conduct fetal and infant mortality reviews | | * **6.7. Increased review of cases demonstrating missed prevention opportunities (Output)** |
| **HIV Prevention Goal/Priority 6: Cross-cutting program core strategy** | | | |
| **Strategy 7** | **Conduct community-level HIV prevention activities** | | |
| Activity 7.A. Conduct condom distribution programs | | * **7.1. Increased availability of condoms among persons living with or at risk for HIV infection**   **(Outcome)** |  |
| Activity 7.B. Coordinate and collaborate with syringe services programs | |  | * **7.2. Increased access to syringe services**   **programs for persons who inject**  **drugs (Outcome)** |
| Activity 7.C. Conduct social marketing campaigns | |  | * 7.3. Increased awareness among members   of affected communities regarding  potential risk for transmitting or  acquiring HIV infection and knowledge  of strategies for reducing these risks  (Outcome) |
| Activity 7.D. Implement social media strategies | |  | * 7.4. Reduced stigma and discrimination for   persons diagnosed with HIV infection  (Outcome) |
| Activity 7.E. Support community mobilization | |  |
| **HIV Prevention Goal/Priority 7 (Cross-cutting): Reduce HIV-related health inequities** | | | |
|  | |  |  |

| **Logic Model – PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments**  **Part 2: Operational and Foundational Strategies & Activities** | | | |
| --- | --- | --- | --- |
| **Strategies & Activities** | | **Short-term Intended Outputs and Outcomes** | **Intermediate Intended Outcomes** |
| **HIV Prevention Goal/Priority 8: Cross-cutting operational and foundational strategies** | | | |
| **Strategy 8** | **Develop partnerships to conduct integrated HIV prevention and care planning** | | |
| Activity 8.A. Maintain HIV planning group | |  | * 8.1. Increased coordination of,   availability of, and access to  comprehensive HIV prevention,  treatment, and support services  (Outcome) |
| Activity 8.B. Develop HIV prevention and care networks | |  |
| **Strategy 9** | **Implement structural strategies to support and facilitate HIV surveillance and prevention** | | |
| Activity 9.A. Ensure data security, confidentiality, and sharing | | * **Outcome 9.1. Increased data security, confidentiality, and sharing** |  |
| Activity 9.B. Strengthen laws, regulations, and policies | |  | * 9.2. Reduced systemic, legal, regulatory,   organizational, operational, social,  or cultural barriers to HIV  surveillance, prevention, and care  (Outcome) |
| Activity 9.C. Strengthen health information systems infrastructure | |  |  |
| Activity 9.D. Promote expansion of technological advances | |  |  |
| **Strategy 10** | **Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities** | | |
| Activity 10.A. Conduct data-driven planning for HIV surveillance, prevention, and care activities | | * **10.1. Increased use of data to plan, monitor, evaluate, and improve HIV surveillance and prevention**   **programs and monitor the impact of local HIV prevention efforts (Output)** | * **10.2. Increased coordination and**   **integration of comprehensive HIV**  **prevention and care services**  **(Outcome)** |
| * **10.3. Improved targeting of HIV testing,**   **prevention, and care resources,**  **funding, and services (Outcome)** |
| Activity 10.B. Conduct data-driven monitoring and evaluation and use findings to continuously improve HIV surveillance and prevention activities | | * 10.4. Improved targeting, prioritization,   and effectiveness of funded HIV  prevention activities (Outcome) |
| * 10.5. Improved targeting of HIV   programs to address HIV-related  health disparities (Outcome) |
| **Strategy 11** | **Build capacity for conducting effective HIV program activities, epidemiologic science, and geocoding** | | |
| Activity 11.A. Assess capacity-building assistance needs | | * 11.1. Increased capacity-building support, including technical assistance, within the jurisdiction   (including CBOs and other partners) (Output)   * 11.2. Increased jurisdictional capacity to conduct HIV surveillance and prevention activities (including     data-to-care activities) (Output) |  |
| Activity 11.B. Develop and implement capacity-building assistance plans, including technical assistance | |  |
| Activity 11.C. Enhance epidemiologic and analytic capacity (e.g., data to care, cluster detection and investigation) and other prevention activities | |  | * 11.3. Strengthened interventional   surveillance and response capacity  (Outcome) |
| Activity 11.D. Enhance geocoding and data linkage capacity | | * 11.4. Enhanced capacity to geocode, manage, link, and integrate surveillance and other data for   surveillance, prevention, and care (Output) | * 11.5. Enhanced knowledge of the   influence of social determinants on  risk for disease and continuum of  care outcomes (Outcome) |

* + 1. In Table 1. below, please list any required primary activities or sub-activities from which your program has been exempted.

| **Table 1. Approved Surveillance and Prevention Activity Exemptions** | | | | |
| --- | --- | --- | --- | --- |
| **Activity or Sub-activity** | **Exemption Period** | **Based on** | **Project Officer Approved by** | **Date Approved** |
|  |  |  |  |  |
|  |  |  |  |  |

Section 3: Priority/Target Populations and Health Disparities

In Table 2 below, please describe, 1) 3-5 populations you will prioritize or target to receive HIV prevention services under your PS18-1802 program, 2) the needs identified for each population listed, and 3) the program strategies and activities planned to address the identified needs. The priority populations described in Table 2 should be congruent with those identified in your integrated care and prevention plan. If there are populations that you plan to prioritize or target for HIV prevention services, but will provide those services with funding other than that received under PS18-1802, please include them in the table and indicate “other” funding source.

| **Table 2. Priority/Target Populations** | | |  | |
| --- | --- | --- | --- | --- |
| **Priority/Target Populations** | **Identified Needs** | **Primary Strategies & Activities to Address Needs** | **Funding Source** | |
| **PS18-1802** | **Other** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |

Section 4: Detailed Program Description

In the tables below, please describe, concisely, what will be done in Year 1 and Years 2-5 under each CDC-required primary HIV prevention activity (e.g., conduct HIV testing), surveillance activity (e.g., collect HIV case data), CDC-required sub-activity (e.g., implement and/or coordinate opt-out HIV testing of patients in healthcare settings; CIDR, risk factor ascertainment, data quality), and locally defined that will be implemented to address the PS18-1802 goals/priorities and strategies. Add lines as needed.

**Note:** The primary activities and sub-activities should be the same as those identified in your PS18-1802 program logic model ([Section 2](#_Section_2:_PS18-1802)).

| **Goal/Priority 1:** | **Cross-cutting Core Surveillance and Program Monitoring & Evaluation Activities** | | |
| --- | --- | --- | --- |
| **Activities & Sub-activities** | | **What will be done** | |
| **Year 1** | **Years 2-5** |
| **Strategy 1:** Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response | | | |
| Activity 1.A: HIV surveillance: Collect HIV case data, including (but not limited to) data on CD4 cell count, HIV viral load, molecular laboratory test results, vital status, and geocoding | |  |  |
| Activity 1.B: HIV prevention program monitoring & evaluation: Collect data to monitor and evaluate HIV prevention programs | |  |  |

| **Goal/Priority 2:** | **Increase individual knowledge of HIV status** | | |
| --- | --- | --- | --- |
| **Activities & Sub-activities** | | **What will be done** | |
| **Year 1** | **Years 2-5** |
| **Strategy 2:** Identify persons with HIV infection and uninfected persons at risk for HIV infection | | | |
| Activity 2.A: Conduct HIV testing | |  |  |
| Activity 2.B: Conduct HIV partner services (for new and previously diagnosed persons) | |  |  |

| **Goal/Priority 3:** | **Rapidly detect and interrupt HIV transmission** | | |
| --- | --- | --- | --- |
| **Strategy 3:** Develop, maintain, and implement a plan to respond to HIV transmission clusters and outbreaks | | | |
| **Activities & Sub-activities** | | **What will be done** | |
| **Year 1** | **Years 2-5** |
| Activity 3.A: Identify and investigate HIV transmission clusters and outbreaks | |  |  |
| Activity 3.B: Rapidly respond to and intervene in HIV transmission clusters and outbreaks | |  |  |
| Activity 3.C: Maintain outbreak identification and response plan | |  |  |

| **Goal/Priority 4:** | **Reduce transmission from persons living with HIV infection** | | |
| --- | --- | --- | --- |
| **Strategy 4:** Provide comprehensive HIV-related prevention services for people living with diagnosed HIV infection | | | |
| **Activities & Sub-activities** | | **What will be done** | |
| **Year 1** | **Years 2-5** |
| Activity 4.A: Provide linkage to HIV medical care for persons with newly and previously diagnosed HIV infection identified through HIV testing and partner services | |  |  |
| Activity 4.B: Conduct data-to-care activities   * Identify persons with previously diagnosed HIV infection who are not in care through data-to-care activities * Provide linkage to, re-engagement in, and retention in HIV medical care services for persons with previously diagnosed HIV infection who are not in care identified through data-to-care activities | |  |  |
| Activity 4.C: Promote early ART initiation | |  |  |
| Activity 4.D: Support medication adherence | |  |  |
| Activity 4.E: Promote and monitor HIV viral suppression | |  |  |
| Activity 4.F: Monitor HIV drug resistance | |  |  |
| Activity 4.G: Conduct risk-reduction interventions for PLWH | |  |  |
| Activity 4.H: Actively refer PLWH to essential support services, including screening and active referral for healthcare benefits, behavioral health services, and social services | |  |  |

| **Goal/Priority 5:** | **Prevent new infections among HIV negative persons** | | |
| --- | --- | --- | --- |
| **Strategy 5:** Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection | | | |
| **Activities & Sub-activities** | | **What will be done** | |
| **Year 1** | **Years 2-5** |
| Activity 5.A: Provide periodic HIV testing and risk screening | |  |  |
| Activity 5.B: Provide screening for PrEP eligibility | |  |  |
| Activity 5.C: Provide linkage to and support for PrEP | |  |  |
| Activity 5.D: Provide risk reduction interventions for HIV-negative persons at risk for HIV infection | |  |  |
| Activity 5.E: Actively refer HIV-negative persons at risk for HIV infection to essential support services, including screening and active referral for healthcare benefits, behavioral health services, and social services | |  |  |
| **Strategy 6:** Conduct perinatal HIV prevention and surveillance activities (or indicate if opt-out has been approved by CDC) | | | |
| Activity 6.A: Promote universal prenatal HIV testing | |  |  |
| Activity 6.B: Provide perinatal HIV service coordination | |  |  |
| Activity 6.C: Conduct case surveillance for women with diagnosed HIV infection and their infants | |  |  |
| Activity 6.D: Conduct perinatal HIV exposure reporting | |  |  |
| Activity 6.E: Conduct fetal and infant mortality reviews | |  |  |

| **Goal/Priority 6:** | **Cross-cutting Program Core Strategy** | | |
| --- | --- | --- | --- |
| **Strategy 7:** Conduct community-level HIV prevention activities (or indicate if opt-out has been approved by CDC) | | | |
| **Activities & Sub-activities** | | **What will be done** | |
| **Year 1** | **Years 2-5** |
| Activity 7.A: Conduct condom distribution programs | |  |  |
| Activity 7.B: Coordinate and collaborate with syringe services programs | |  |  |
| Activity 7.C: Conduct social marketing campaigns | |  |  |
| Activity 7.D: Implement social media strategies | |  |  |
| Activity 7.E: Support community mobilization | |  |  |

| **Goal/Priority 7:** | **Reduce HIV-related Health Inequalities (cross-cutting)** | | |
| --- | --- | --- | --- |
| **Activities & Sub-activities** | | **What will be done** | |
| **Year 1** | **Years 2-5** |
|  | |  |  |

| **Goal/Priority 8:** | **Cross-cutting Operational and Foundational Strategies** | | |
| --- | --- | --- | --- |
| **Strategy 8:** Develop partnerships to conduct integrated HIV prevention and care planning | | | |
| **Activities & Sub-activities** | | **What will be done** | |
| **Year 1** | **Years 2-5** |
| Activity 8.A: Maintain HIV planning group | |  |  |
| Activity 8.B: Develop HIV prevention and care networks | |  |  |
| **Strategy 9:** Implement structural strategies to support and facilitate HIV surveillance and prevention | | | |
| Activity 9.A: Ensure data security, confidentiality, and sharing | |  |  |
| Activity 9.B: Strengthen laws, regulations, and policies | |  |  |
| Activity 9.C: Strengthen health information systems infrastructure | |  |  |
| Activity 9.D: Promote expansion of technological advances | |  |  |
| **Strategy 10:** Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities | | | |
| Activity 10.A: Conduct data-driven planning for HIV surveillance, prevention, and care activities | |  |  |
| Activity 10.B: Conduct data-driven monitoring and evaluation and use findings to continuously improve HIV surveillance and prevention activities | |  |  |
| **Strategy 11:** Build capacity for conducting effective HIV program activities, epidemiologic science, and geocoding | | | |
| Activity 11.A: Assess capacity-building assistance needs | |  |  |
| Activity 11.B: Develop and implement capacity-building assistance plans, including technical assistance | |  |  |
| Activity 11.C: Enhance epidemiologic and analytic capacity (e.g., data to care, cluster detection and investigation) and other prevention activities | |  |  |
| Activity 11.D: Enhance geocoding and data linkage capacity | |  |  |

1. Please briefly discuss potential barriers (e.g., environmental, political, social) you anticipate may be encountered when implementing or operating your program

Section 5: Timeline

Use the timeline below to list the project tasks and responsible parties associated with the planning, implementation, and evaluation of your program. Click on the appropriate date box to indicate task timeframes. Project tasks should support the activities described in [Section 4.](#_Section_3:_Detailed)

| **Project Task**  **(planning, implementation, or evaluation)** | | | **Responsible Party** | **Timeframe for Starting and Ending Activity related Tasks** | | | | | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **YEAR ONE**  **2018‐2019** | | | | **YEAR TWO**  **2019‐2020** | | | | **YEAR THREE**  **2020‐2021** | | | | **YEAR FOUR**  **2021‐2022** | | | | **YEAR FIVE**  **2022‐2023** | | | |
| Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| ***Strategy 1: Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response*** | | | | | | | | | | | | | | | | | | | | | | | |
| **Activity: 1.A** | **HIV surveillance: Collect HIV case data, including (but not limited to) data on CD4 cell count, HIV viral load, molecular laboratory test results, vital status, and geocoding** | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|  | | |  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Activity 1.B** | HIV prevention program monitoring & evaluation: Collect data to monitor and evaluate HIV prevention programs | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|  | | |  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ***Strategy 2: Identify persons with HIV infection and uninfected persons at risk for HIV infection*** | | | | | | | | | | | | | | | | | | | | | | | |
| **Activity 2.A** | Conduct HIV testing | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
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| **Activity 2.B** | Conduct HIV partner services (for new and previously diagnosed persons) | | | | | | | | | | | | | | | | | | | | | | |
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| ***Strategy 3: Develop, maintain, and implement a plan to respond to HIV transmission clusters and outbreaks*** | | | | | | | | | | | | | | | | | | | | | | | |
| **Activity 3.A** | Identify and investigate HIV transmission clusters and outbreaks | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 3.B** | Rapidly respond to and intervene in HIV transmission clusters and outbreaks | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 3.C** | Maintain outbreak identification and response plan | | | | | | | | | | | | | | | | | | | | | | |
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| ***Strategy 4: Provide comprehensive HIV-related prevention services for people living with diagnosed HIV infection*** | | | | | | | | | | | | | | | | | | | | | | | |
| **Activity 4.A** | Provide linkage to HIV medical care for persons with newly and previously diagnosed HIV infection identified through HIV testing and partner services | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 4.B:** | Conduct data-to-care activities | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 4.C:** | Promote early ART initiation | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 4.D** | Support medication adherence | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 4.E** | Promote and monitor HIV viral suppression | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 4.F** | Monitor HIV drug resistance | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 4.G** | Conduct risk-reduction interventions for PLWH | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 4.H** | Actively refer PLWH to essential support services, including screening and active referral for healthcare benefits, behavioral health services, and social services | | | | | | | | | | | | | | | | | | | | | | |
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| ***Strategy 5: Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection*** | | | | | | | | | | | | | | | | | | | | | | | |
| **Activity 5.A** | Provide periodic HIV testing and risk screening | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 5.B** | Provide screening for PrEP eligibility | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 5.C** | Provide linkage to and support for PrEP | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 5.D** | Provide risk reduction interventions for HIV-negative persons at risk for HIV infection | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 5.E** | Actively refer HIV-negative persons at risk for HIV infection to essential support services, including screening and active referral for healthcare benefits, behavioral health services, and social services | | | | | | | | | | | | | | | | | | | | | | |
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| ***Strategy 6: Conduct perinatal HIV prevention and surveillance activities (or indicate if opt-out has been approved by CDC)*** | | | | | | | | | | | | | | | | | | | | | | | |
| **Activity 6.A** | Promote universal prenatal HIV testing | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 6.B** | Provide perinatal HIV service coordination | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 6.C** | Conduct case surveillance for women with diagnosed HIV infection and their infants | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 6.D** | Conduct perinatal HIV exposure reporting | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 6.E** | Conduct fetal and infant mortality review | | | | | | | | | | | | | | | | | | | | | | |
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| ***Strategy 7: Conduct community-level HIV prevention activities (or indicate if opt-out has been approved by CDC)*** | | | | | | | | | | | | | | | | | | | | | | | |
| **Activity 7.A:** | Conduct condom distribution programs | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 7.B:** | Coordinate and collaborate with syringe services programs | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 7.C:** | Conduct social marketing campaigns | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 7.D:** | Implement social media strategies | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 7.E:** | Support community mobilization | | | | | | | | | | | | | | | | | | | | | | |
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| ***Strategy 8: Develop partnerships to conduct integrated HIV prevention and care planning*** | | | | | | | | | | | | | | | | | | | | | | | |
| **Activity 8.A** | Maintain HIV planning group | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 8.B** | Develop HIV prevention and care networks | | | | | | | | | | | | | | | | | | | | | | |
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| ***Strategy 9: Implement structural strategies to support and facilitate HIV surveillance and prevention*** | | | | | | | | | | | | | | | | | | | | | | | |
| **Activity 9.A** | Ensure data security, confidentiality, and sharing | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 9.B** | Strengthen laws, regulations, and policies | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 9.C** | Strengthen health information systems infrastructure | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 9.D** | Promote expansion of technological advances | | | | | | | | | | | | | | | | | | | | | | |
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| ***Strategy 10: Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities*** | | | | | | | | | | | | | | | | | | | | | | | |
| **Activity 10.A** | Conduct data-driven planning for HIV surveillance, prevention, and care activities | | | | | | | | | | | | | | | | | | | | | | |
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| **Activity 10.B** | Conduct data-driven monitoring and evaluation and use findings to continuously improve HIV surveillance and prevention activities | | | | | | | | | | | | | | | | | | | | | | |
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| ***Strategy 11: Build capacity for conducting effective HIV program activities, epidemiologic science, and geocoding*** | | | | | | | | | | | | | | | | | | | | | | | |
| **Activity 11.A** | Assess capacity-building assistance needs | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|  | | |  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Activity 11.B** | Develop and implement capacity-building assistance plans, including technical assistance | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|  | | |  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Activity 11.C** | Enhance epidemiologic and analytic capacity (e.g., data to care, cluster detection and investigation) and other prevention activities | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|  | | |  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Activity 11.D** | Enhance geocoding and data linkage capacity | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|  | | |  | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Evaluation Plan

Section 6: Evaluation Purpose and Users

* + 1. Please briefly describe the intended purpose(s) of the evaluation (e.g., identify areas of the program or approach that need improvement, assess program effectiveness or impacts, assess progress toward desired goals, demonstrate productive use of resources).
    2. In Table 3 below, please list the names of persons, organizations, or entities that have a stake in the PS18-1802 evaluation; what role, if any they will have in the evaluation; and when and how they will be engaged.

| **Table 3. Stakeholder Engagement** | | |
| --- | --- | --- |
| **Name of Person or Organization** | **Role in the Evaluation** | **When and How to Engage** |
|  |  |  |
|  |  |  |
|  |  |  |

* + 1. In Table 4 below, please list the names of persons, organizations, or entities that will be primary users of the evaluation and how they will use the evaluation findings.

| **Table 4. Primary Users of the Evaluation** | |
| --- | --- |
| **Name of Person or Organization** | **How Evaluation Findings Will Be Used by This Person or Organization** |
|  |  |
|  |  |

* + 1. In Table 5 below, please list the members of the evaluation team, their titles and organizational affiliations, and their responsibilities on the team, listing the team leader(s) first.

| **Table 5. Roles and Responsibilities of the Evaluation Team** | | |
| --- | --- | --- |
| **Name** | **Title and Organizational Affiliation** | **Responsibilities** |
|  |  |  |
|  |  |  |

**Section 7:** Local Evaluation Questions, Measures, **and Design**

* + 1. In Table 6 below, please list a) any local evaluation questions, in addition to the questions presented in the measure tables in [Appendix A](#_Appendix_B:_PS18-1802), you plan to address related to nationally monitored or locally monitored CDC PS18-1802 outputs and outcomes; and b) any evaluation questions you plan to address related to intended outcomes of locally defined sub-activities.

**Note:** If you do not have any additional questions or measures beyond those that are presented in CDC’s PS18-1802 measure tables, then you will not need to complete Table 6. Check this box if you have no additional questions or measures. ☐

| **Table 6. Local Monitoring and Evaluations Measures** | | | |
| --- | --- | --- | --- |
| **Outcome** | **Local M&E Question** | **Measures** | **Specifications** |
|  |  |  | **Numerator:** |
| **Denominator:** |
|  |  |  | **Numerator:** |
| **Denominator:** |

* + 1. Please describe the evaluation design(s) (e.g., survey, cross-sectional analysis, longitudinal analysis) you intend to use to address your local evaluation questions.

Section 8: Collection and Quality Assurance of CDC-Required Data

1. In Table 7 below, please describe how CDC-required surveillance and program data will be collected, what system will be used to enter and manage them at the local level, and how they will be transmitted to CDC (i.e., direct entry into CDC system, such as eHARS or EvaluationWeb; entry into local system and upload into CDC system).

| **Table 7. Data Collection and CDC Transmission** | | | |
| --- | --- | --- | --- |
| **Data Type** | **Data Collection Method and**  **Data Management System** | **Data Transmission Process** | **Transmission Frequency** |
| HIV case surveillance data |  |  | Monthly |
| HIV geo-coded data |  |  | Annually |
| HIV testing data |  |  | Bi-annually |
| HIV partner services data |  |  | Bi-annually |
| Budget expenditure tables |  |  | Annually |

1. Please describe any feasibility issues you anticipate may interfere with or prevent the collection of data included in the table above.
2. In table 8 below, please list any delays you anticipate in collecting the data included in Table 7, the reason for the anticipated delays, and any capacity-building assistance you will need to help resolve the delays.

| **Table 8. Data Collection Delays** | | |
| --- | --- | --- |
| **Delayed Activities** | **Reason for Data Collection Delay** | **TA and Capacity Building Needs** |
|  |  |  |
|  |  |  |

1. Please describe how data quality, accuracy, and completeness will be assured and how data quality, accuracy or completeness issues will be resolved prior to transmitting data to CDC.

**Section 9: Data Management Plan (DMP**)

Please describe how HIV prevention and surveillance data will be 1) appropriately managed, secured and remain confidential, 2) reviewed for data quality, and 3) made accessible for public use. Your response should address the following elements in the table below and reference existing standard operating procedures (SOPs) or polices where appropriate. Responses should be specific to data collections funded under PS18-1802 and may be organized and presented by data type or system (e.g., surveillance data (eHARS), prevention program evaluation data (EvaluationWeb direct entry or upload). Please use the table below **or** the narrative space provided to respond to the required DMP elements.

**Note**: The DMP must be updated annually and submitted with the Annual Progress Report (APR) or when any significant change is made to a data set or system to ensure that the DMP remains current throughout the lifecycle of the PS18-1802 NOFO. A final DMP must also be submitted at the closeout of PS18-1802.

| **Table 9. Data Management Plan Elements** | | |
| --- | --- | --- |
| **Elements** | **Surveillance Data** | **NHM&E Data** |
| Description of data collected and standards used. Include information on data sources or other databases if used (e.g., conforms to standards outlined in CDC technical guidance for HIV surveillance, etc.). |  |  |
| Data steward(s) |  |  |
| Mechanisms for within-agency limiting or sharing of data and justifications (e.g., data sharing agreements and process for using them) |  |  |
| Mechanisms for sharing data with partners (e.g., CPG, Ryan White) |  |  |
| Description of data release policies and procedures including precautions to protect confidentiality (e.g., data suppression criteria, other restrictions). |  |  |
| Mechanisms for making data available to the public (e.g., reports, epi profile, datasets, CDC Atlas plus). Include description of prerelease data quality reviews and validation, data suppression checks. Address access to identifiable and de-identified data. |  |  |
| Statement that procedures are in place to ensure all released data have appropriate documentation and any limitations described. |  |  |
| Description of steps taken to protect privacy and ensure confidentiality and security of data. Refer to applicable policies and statement signed by the overall responsible party (ORP) certifying program compliance with the NCHHSTP Guidelines |  |  |
| Description of data archiving policies or provide explanation for why long-term preservation and access are not required. |  |  |

**Or Narrative DMP Response:** If you choose to provide a narrative response to the DMP elements in the table above, please provide your response here.

## Section 10: Data Analysis and Reporting

1. Please briefly describe any local analyses you plan to conduct on your HIV surveillance and prevention program data.
2. Please use Table 10 below to list any reports you plan to produce from your HIV surveillance and prevention program data, beginning with all CDC-required reports.

| **Table 10. Evaluation Reports** | | | |
| --- | --- | --- | --- |
| **Report Title/Purpose** | **Primary Target Audience** | **Purpose of Report** | **Frequency and Timing of Report** |
|  |  |  |  |
|  |  |  |  |

## Section 11: Data Use

1. Please use Table 11 below to describe how HIV surveillance and prevention program data will be reviewed to monitor your surveillance and prevention activities and improve program performance.

| **Table 11. Data Monitoring Reviews and Use** | | | | |
| --- | --- | --- | --- | --- |
| **Activity Monitored** | **Data to be Reviewed** | **Reviewer (Name/Position)** | **Frequency of Review** | **Nature of Response** |
|  |  |  |  |  |
|  |  |  |  |  |

1. Please describe how lessons learned will be identified and summarized for sharing.
2. Please use Table 12 below to describe with whom and how evaluation findings and lessons learned will be shared within the health department, with health department contractors, with other primary users of the evaluation findings, with other health departments, and with other stakeholders and interested audiences.

| **Table 12. Sharing of Evaluation Findings and Lessons Learned** | | |
| --- | --- | --- |
| **Audience** | **Mechanism of Feedback** | **Frequency of Feedback** |
|  |  |  |
|  |  |  |

## Section 12: Human Subjects

If applicable, please describe all program and evaluation activities covered by a Human Subjects Protection/Institutional Review Board approval.

## Section 13: Memoranda and Contract Support

1. If contract support will be used to provide program services or monitoring and evaluation, please use Table 13 below to provide the names of each contractor and to provide a brief description of their required program and evaluation related duties, tasks, and primary deliverables.

| **Table 13. Contract Support for Program or Evaluation Related Activities** | | |
| --- | --- | --- |
| **Contract/Contractor for Program Activities** | **Description of Duties/Tasks Performed** | **Primary Deliverables** |
|  |  |  |
|  |  |  |
| **Contract/Contractor for Evaluation Activities** | **Description of Duties/Tasks Performed** | **Primary Deliverables** |
|  |  |  |
|  |  |  |

1. Use Table 14 to list Memoranda of Understanding (MOU), Agreements (MOA), or data sharing agreements that you have or will establish to support surveillance and prevention related activities.

| **Table 14. Memoranda of Understanding, Memoranda of Agreement, or Data Sharing Agreements** | |
| --- | --- |
| **Collaborator or Contributor** | **Services or Resources to be Provided** |
|  |  |
|  |  |

*Standards, Targets, and Local Objectives:*

## Section 14: National Targets and Related Local Objectives for Key CDC-required Indicators

Please insert your yearly objectives (local targets) for the key indicators in Table 15 below.

**Note:** Measures reflected in the Key CDC Indicators table below use data that CDC will use for reporting or responding to data requests. You will not be able to provide yearly objectives for measures with established standards. Standards must be met annually.

| **Table 15. Key CDC Indicators** | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Activity** | **Output/Outcome** | **Indicator (Measure)** | **Yearly CDC**  **Standard** | **Local Program Objectives** | | | | | | **Yearly CDC**  **Target** |
| **Baseline** | **Yr 1** | **Yr 2** | **Yr 3** | **Yr 4** | **Yr 5** |
| HIV Surveillance | **1.1:** Improved completeness, timeliness, and quality of HIV surveillance data(outcome) | **Measure 1.1.1. a.4** (Cause of Death):  ≥85% of the deaths that occurred in a year have an underlying cause of death, assessed 24 months after the death year | ≥85% |  |  |  |  |  |  |  |
|  |  | **Measure 1.1.2: Completeness of Case Ascertainment**  ≥95% of the expected number of cases for a diagnosis year are reported, assessed 12 months after the diagnosis year | ≥95% |  |  |  |  |  |  |  |
|  |  | **Measure 1.1.3: Timeliness of Case Ascertainment**  ≥90% of the expected number of cases for a diagnosis year are reported within six months following diagnosis, assessed 12 months after the diagnosis year | ≥90% |  |  |  |  |  |  |  |
|  |  | **Measure 1.1.4: Data Quality**  ≥97% of cases that meet the surveillance case definition for HIV infection for a diagnosis year will have no required fields missing and pass all standard data edit checks (i.e. Person View Status Flag is “A – Active” or “W – Warning”), assessed 12 months after a diagnosis year | ≥97% |  |  |  |  |  |  |  |
|  |  | **Measure 1.1.5: Risk Factor Ascertainment**  ≥80% of cases for a report year have sufficient HIV risk factor information to be classified into a known transmission category, assessed 12 months after the report year | ≥80% |  |  |  |  |  |  |  |
|  |  | **Measure 1.1.6: Intrastate duplicates**  ≤1% of cases for a report year have duplicate case reports, assessed 12 months after the report year | ≤1% |  |  |  |  |  |  |  |
|  |  | **Measure 1.1.7: Interstate duplicate**  ≤2% of Routine Interstate Duplicate Review (RIDR) pairs remain unresolved at the end of each six month RIDR cycle, assessed at the end of each cycle | ≤2% |  |  |  |  |  |  |  |
|  |  | **Measure 1.1.8: CD4 Reporting**  ≥85% of cases for a diagnosis year have a CD4 test result based on a specimen collected within one month following HIV diagnosis, assessed 12 months after the diagnosis year | ≥85% |  |  |  |  |  |  |  |
|  |  | **Measure 1.1.9: Viral Load Reporting**  ≥85% of cases for a diagnosis year have a viral load test result based on a specimen collected within one month following HIV diagnosis, assessed 12 months after the diagnosis year | ≥85% |  |  |  |  |  |  |  |
|  |  | **Measure 1.1.10: Timeliness of Laboratory Reporting**  ≥85% of all labs with a specimen collection date in the diagnosis year are loaded in the surveillance system within two months of the specimen collection date, assessed at 12 months after the diagnosis year | ≥85% |  |  |  |  |  |  |  |
|  |  | **Measure 1.1.11: Nucleotide Sequence**  ≥60% of cases for a diagnosis year have an analyzable nucleotide sequence, assessed at 12 months after the diagnosis year | ≥60% |  |  |  |  |  |  |  |
|  |  | **Measure 1.1.12: Antiretroviral History**  ≥70% of cases for a diagnosis year have prior antiretroviral use history, assessed at 12 months after the diagnosis year | ≥70% |  |  |  |  |  |  |  |
|  |  | **Measure 1.1.13.a:**  ≥70% of cases for a diagnosis year have a known value for previous negative HIV test, assessed at 12 months after the diagnosis year | ≥70% |  |  |  |  |  |  |  |
|  |  | **Measure 1.1.13.b:**  ≥50% of cases for a diagnosis year with a previous negative HIV test have a valid date of documented negative test result, assessed at 12 months after the diagnosis year. | ≥50% |  |  |  |  |  |  |  |
|  | **1.5:** Increased ability to describe the geographic distribution of HIV and understand the social determinants of health in relation to HIV and HIV-related health disparities (outcome) | **Measure 1.5.3:**  ≥90% of HIV cases are geocoded to the census tract level, assessed 12 months after the diagnosis year | ≥90% |  |  |  |  |  |  |  |
| HIV Prevention | **1.6 :** Improved completeness, timeliness, and quality of HIV prevention program data **(**outcome) | **Measure 1.6.1:** Percentage of PS18-1802-funded HIV-positive test records submitted to CDC that have all required fields related to linkage to HIV medical care completed and pass all standard data checks |  | Enter text. |  |  |  |  |  | ≥80% |
|  |  | **Measure 1.6.2:** Percentage of PS18-1802-funded HIV-positive test records submitted to CDC that have all required fields related to interview for partner services completed and pass all standard data checks |  |  |  |  |  |  |  | ≥80% |
|  |  | **Measure 1.6.3:** Percentage of PS18-1802-funded HIV-positive tests classified as new diagnoses that have been verified by checking the HIV surveillance system |  |  |  |  |  |  |  | ≥80% |
| HIV Testing | **2.1:** Increased HIV testing among persons at risk for HIV infection(output) | **Measure 2.1.1:** Number of PS18-1802-funded HIV tests conducted among persons at risk for acquiring or transmitting HIV infection |  |  |  |  |  |  |  | N/A |
|  | **2.2:** Increased number of persons living with HIV infection who are aware of their HIV status(outcome) | **Measure 2.2.2:** Number of persons with newly diagnosed HIV infection identified through PS18-1802-funded testing **(CDC calculated target)** |  |  |  |  |  |  |  | TBD |
|  | **Measure 2.2.3:** Of all PS18-1802-funded HIV tests conducted, the percentage of persons with newly diagnosed HIV infection |  |  |  |  |  |  |  | N/A |
|  | **Measure 2.2.4:** Of all persons with newly diagnosed HIV infection identified through PS18-1802-funded testing, the percentage provided an HIV test result |  |  |  |  |  |  |  | ≥90% |
| **Measure 2.2.5:** Of all persons living with HIV infection, the percentage who know their HIV-positive status |  |  |  |  |  |  |  | ≥90% |
| **2.3:** Increased identification of HIV-negative persons at risk for HIV infection(output) | **Measure 2.3.1:** Of all PS18-1802-funded HIV tests conducted that had HIV-negative results, the percentage of tests that are among persons at risk for HIV infection |  |  |  |  |  |  |  | N/A |
| Partner Services | **2.4:** Increased participation in HIV partner services among persons with diagnosed HIV infection, identified through PS18-1802-funded testing(outcome) | **Measure 2.4.1:** Of all persons with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage interviewed for partner services |  |  |  |  |  |  |  | ≥85% |
| **2.5:** Increased participation in HIV partner services among persons with diagnosed HIV infection, identified throughout the jurisdiction (outcome) | **Measure 2.5.1:** Of all persons with newly diagnosed HIV infection reported to surveillance, the percentage reported to the partner services program |  |  |  |  |  |  |  | N/A |
| **Measure 2.5.2:** Of all persons with newly diagnosed HIV infection reported to the partner services program, the percentage interviewed for partner services in ≤30 days after HIV diagnosis |  |  |  |  |  |  |  | N/A |
| **2.7:** Increased notification and HIV testing of partners identified through HIV partner services (output) | **Measure 2.7.2:** Of all named, notifiable partners identified through HIV partner services, the percentage tested for HIV infection |  |  |  |  |  |  |  | N/A |
| Identify, Investigate, and Rapidly Respond to Transmission Clusters | **3.2.** Improved response to HIV transmission clusters and outbreaks (outcome) | **Measure 3.2.1:**  Of all HIV-positive persons in transmission clusters who were not known to be virally suppressed at the time of identification as part of the cluster, percentage that achieved viral suppression within 6 months of identification as part of the cluster |  |  |  |  |  |  |  | ≥60% |
| **Measure 3.2.2:**  Of all partners of transmission cluster members who were not known to be HIV positive at the time of cluster identification, percentage tested or re-tested within 6 months of identification as part of the risk network |  |  |  |  |  |  |  | TBD |
| **Measure 3.2.3:**  Of all partners of transmission cluster members who were determined to be HIV-negative and not on PrEP, percentage referred for PrEP within 6 months of identification as part of the risk network |  |  |  |  |  |  |  | TBD |
| Linkage to and Retention in HIV Medical Care, and Viral Suppression | **4.1:** Increased linkage to and retention in HIV medical care among PLWH (outcome) | **Measure 4.1.5:**  Of all person with newly diagnosed HIV infection identified throughout the jurisdiction, the percentage linked to HIV medical care in ≤ 30 days of diagnosis |  |  |  |  |  |  |  | ≥85% |
| **Measure 4.1.6:**  Of all persons with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage linked to HIV medical care in ≤ 30 days after HIV diagnosis |  |  |  |  |  |  |  | ≥85% |
| **Measure 4.1.14:**  Of all persons living with diagnosed HIV infection, the percentage in HIV medical care |  |  |  |  |  |  |  | ≥90% |
|  | **Measure 4.1.15:**  Of all persons living with diagnosed HIV infection, the percentage retained in HIV medical care |  |  |  |  |  |  |  | ≥90% |
| **4.5:** Increased HIV viral load suppression among PLWH (outcome) | **Measure 4.5.1:**  Of all persons living with diagnosed HIV infection, the percentage virally suppressed |  |  |  |  |  |  |  | ≥80% |
| Risk Reduction and Support Services—HIV-Positive Persons | **4.6:** Increased provision of risk reduction interventions for PLWH(output) | **Measure 4.6.3:**  Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing a risk-reduction intervention, the percentage provided or actively referred for a risk-reduction intervention |  |  |  |  |  |  |  | ≥85% |
| **4.7:** Increased active referral to HIV prevention services for PLWH (output) | **Measure 4.7.1:**  Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing, percentage referred to any HIV prevention services |  |  |  |  |  |  |  | ≥80% |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Risk Reduction and Support Services—HIV Negative Persons | **5.6:** Increased provision of risk reduction interventions for HIV-negative persons at risk for HIV infection (output) | **Measure 5.6.3:**  Of all HIV-negative persons at risk for HIV infection identified through PS18-1802-funded testing who are identified as needing a risk-reduction intervention, the percentage provided a risk-reduction intervention |  |  |  |  |  |  |  | ≥85% |

## Section 15: Objectives for Locally Monitored CDC Outputs/Outcomes and Locally Defined Measures

Please use Table 16 below to establish and monitor local objectives for 1) CDC specified outputs/outcomes and measures not included in Table 15 above or 2) locally defined outputs/outcomes and measure.

**Note:** Table 16 is provided as a tool to assist in the monitoring and evaluation of your program; however, it is optional.

| **Table 16. Local Objectives** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Activity | Outputs/Outcomes | Measures | Baseline | Yr 1 | Yr 2 | Yr 3 | Yr 4 | Yr 5 |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

*Glossary of Locally Defined Terms*

Please use Table 17 to define all local terms used to describe your program

| **Table 17. Locally Defined Terms** | | |
| --- | --- | --- |
| **Term** | **Guidance** | **Definition** |
| At risk for HIV | Local definitions for “at risk” should identify persons at high or substantial risk for HIV infection |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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Appendix A: PS18-1802 Measure Tables

**PS18-1802 Monitoring and Evaluation Questions, Indicators, and Data Sources**

| **Strategy 1: Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response** | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Output or Outcome** | **M&E Question** | **Measures/Indicators** | **Specifications** | **Data Source** | **Data Type** |
| **HIV SURVEILLANCE** | | | | | |
| **1.1:** Improved completeness, timeliness, and quality of HIV surveillance data (outcome)  **1.1.a:** Meet standards detailed in the Technical Guidance for HIV Surveillance Programs for case ascertainment, death ascertainment, risk factor reporting, duplicate review,geocoding, laboratory reporting, timeliness, data quality, completeness, and dissemination, assessed as required by CDC standards (outcome) |  | **Measure 1.1.1: Death Ascertainment**  **Measure 1.1.1.a.1:**  Annually link case reports with state/local death certificate data file (or NDI, if state/local death certificate data file is not available) and SSDMF to ascertain dates of deaths that occurred in the previous year and enter or import results into eHARS  **Measure 1.1.1. a.2:**  Annually link case reports with NDI and state/local death certificate data file to ascertain causes of deaths that occurred 2 years prior to the current year and import results in eHARS  **Measure 1.1.1. a.3:**  Annually link case reports to state/local death certificate data file (from 2 years ago) to identify unreported cases of HIV infection and enter or import results into eHARS  **Measure 1.1.1. a.4** (Cause of Death):  ≥85% of the deaths that occurred in a year have an underlying cause of death, assessed 24 months after the death year | See the National HIV Surveillance System - Technical Guidance, May 2017 available at <https://partner.cdc.gov> | NHSS | Aggregate |
| **Measure 1.1.2: Completeness of Case Ascertainment**  ≥95% of the expected number of cases for a diagnosis year are reported, assessed 12 months after the diagnosis year | See the National HIV Surveillance System - Technical Guidance, May 2017 available at <https://partner.cdc.gov>  Must be met for the population of all cases and for the subset of pediatric cases age <13 years. | NHSS | Person-level |
| **Measure 1.1.3: Timeliness of Case Ascertainment**  ≥90% of the expected number of cases for a diagnosis year are reported within six months following diagnosis, assessed 12 months after the diagnosis year |
|  | **Measure 1.1.4: Data Quality**  ≥97% of cases that meet the surveillance case definition for HIV infection for a diagnosis year will have no required fields missing and pass all standard data edit checks (i.e. Person View Status Flag is “A – Active” or “W – Warning”), assessed 12 months after a diagnosis year | See the National HIV Surveillance System - Technical Guidance, May 2017 available at [https://partner.cdc.gov](https://partner.cdc.gov/).  Must be met for the population of all cases and for the subset of pediatric cases age <13 years. | NHSS | Person-level |
| **Measure 1.1.5: Risk Factor Ascertainment**  ≥80% of cases for a report year have sufficient HIV risk factor information to be classified into a known transmission category, assessed 12 months after the report year |
| **Measure 1.1.6: Intrastate duplicates**  ≤1% of cases for a report year have duplicate case reports, assessed 12 months after the report year | See the National HIV Surveillance System - Technical Guidance, May 2017 available at [https://partner.cdc.gov](https://partner.cdc.gov/). | NHSS | Person-level |
| **Measure 1.1.7: Interstate duplicate**  ≤2% of Routine Interstate Duplicate Review (RIDR) pairs remain unresolved at the end of each six month RIDR cycle, assessed at the end of each cycle |
| **Measure 1.1.8: CD4 Reporting**  ≥85% of cases for a diagnosis year have a CD4 test result based on a specimen collected within one month following HIV diagnosis, assessed 12 months after the diagnosis year | See the National HIV Surveillance System - Technical Guidance, May 2017 available at [https://partner.cdc.gov](https://partner.cdc.gov/).  Must be met for the population of all cases and for the subset of pediatric cases age <13 years. | NHSS | Person-level |
| **Measure 1.1.9: Viral Load Reporting**  ≥85% of cases for a diagnosis year have a viral load test result based on a specimen collected within one month following HIV diagnosis, assessed 12 months after the diagnosis year |
| **Measure 1.1.10: Timeliness of Laboratory Reporting**  ≥85% of all labs with a specimen collection date in the diagnosis year are loaded in the surveillance system within two months of the specimen collection date, assessed at 12 months after the diagnosis year |
| **Measure 1.1.11: Nucleotide Sequence**  ≥60% of cases for a diagnosis year have an analyzable nucleotide sequence, assessed at 12 months after the diagnosis year | See the National HIV Surveillance System - Technical Guidance, May 2017 available at [https://partner.cdc.gov](https://partner.cdc.gov/) | NHSS | Person-level |
| **Measure 1.1.12: Antiretroviral History**  ≥70% of cases for a diagnosis year have prior antiretroviral use history, assessed at 12 months after the diagnosis year |
|  | **Measure 1.1.13: Previous Negative HIV Test**  **Measure 1.1.13.a:**  ≥70% of cases for a diagnosis year have a known value for previous negative HIV test, assessed at 12 months after the diagnosis year  **Measure 1.1.13.b:**  ≥50% of cases for a diagnosis year with a previous negative HIV test have a valid date of documented negative test result, assessed at 12 months after the diagnosis year. |
| **1.2:** Improved monitoring of trends in HIV infection (outcome) |  | **Measure 1.2.1: Data Dissemination and Reporting**  **Measure 1.2.1.a:**  Publish and disseminate an HIV surveillance report annually, per CDC guidance  **Measure 1.2.1.b:**  Publish and disseminate at least one comprehensive Integrated HIV Epidemiologic Profile during the 5-year funding period, per CDC guidance | See the National HIV Surveillance System - Technical Guidance, May 2017 available at <https://partner.cdc.gov>  Must be met for the population of all cases and for the subset of pediatric cases age <13 years | NHSS | NA |
| **1.3:** Increased use of surveillance and epidemiological data to guide prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement services(output) | | | | **Monitored locally, data are not reported to CDC** | |
| **1.4:** Increased use of geocoded data linked to census and social determinants of health datasets to guide prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement services (output) | | | | **Monitored locally, data are not reported to CDC** | |
| **1.5:** Increased ability to describe the geographic distribution of HIV and understand the social determinants of health in relation to HIV and HIV-related health disparities (outcome) |  | **Measure 1.5.1:**  Establish a Memorandum of Agreement (MOA) to submit geocoded data to CDC for the 5-year funding period. | See the National HIV Surveillance System - Technical Guidance, May 2017 available at [https://partner.cdc.gov](https://partner.cdc.gov/). | APR, SER | NA |
| **Measure 1.5.2:**  On an annual basis, submit geocoded HIV data, for the HIV diagnosis year of interest, to CDC per CDC guidance |
| **Measure 1.5.3:**  ≥90% of HIV cases are geocoded to the census tract level, assessed 12 months after the diagnosis year | See the National HIV Surveillance System - Technical Guidance, May 2017 available at [https://partner.cdc.gov](https://partner.cdc.gov/). | NHSS | Person-level |
| **HIV PREVENTION PROGRAM** | | | | | |
| **1.6:** Improved completeness, timeliness, and quality of prevention program data (outcome) | **Question 1.6.1-1.6.3:**  To what extent did grantees improve their ability to provide quality, timely, and complete data for key performance variables | **Measure 1.6.1:**  Percentage of PS18-1802-funded HIV-positive test records submitted to CDC that have all required fields related to linkage to HIV medical care completed and pass all standard data checks  **(NOFO Target: ≥80%)** | **Numerator:**  Number of HIV-positive test records in the denominator that have all required fields related to linkage to HIV medical care completed and pass all standard data checks | NHM&E | Test-level |
| **Denominator:**  Number of PS18-1802-funded HIV-positive test records submitted to CDC |
| **Measure 1.6.2:**  Percentage of PS18-1802-funded HIV-positive test records submitted to CDC that have all required fields related to interview for partner services completed and pass all standard data checks  **(NOFO Target: ≥80%)** | **Numerator:**  Number of HIV-positive test records in the denominator that have all required fields related to interview for partner services completed and pass all standard data checks |
| **Denominator:**  Number of PS18-1802-funded HIV-positive test records submitted to CDC |
| **Measure 1.6.3:**  Percentage of PS18-1802-funded HIV-positive tests classified as new diagnoses that have been verified by checking the HIV surveillance system  **(NOFO Target: ≥80%)** | **Numerator:**  Number of HIV-positive test records in the denominator that have been verified as new diagnoses by checking the HIV surveillance system |
| **Denominator:**  Number of PS18-1802-funded positive HIV test records submitted to CDC that are classified as new diagnoses |

| **Strategy 2:**  **Identify persons with HIV infection and uninfected persons at risk for HIV infection** | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Output or Outcome** | **M&E Question** | **Measures/Indicators** | **Specifications** | **Data Source** | **Data Type** |
| **HIV TESTING** | | | | | |
| **2.1:** Increased HIV testing among persons at risk for HIV infection(output) | **Question 2.1.1:**  To what extent was there an increase in HIV testing among persons at risk for HIV? | **Measure 2.1.1:**  Number of PS18-1802-funded HIV tests conducted among persons at risk for HIV infection | **Count:**  Number of PS18-1802-funded HIV tests conducted in which a) the test result was positive or b) the test result was negative and the person tested was determined to be at risk for HIV infection | NHM&E | Test-level |
| **2.2:** Increased number of persons living with HIV infection who are aware of their HIV status(outcome) | **Question 2.2.1-2.2.4:**  To what extent was there an increase in the number of persons living with HIV infection who are aware of their HIV status? | **Measure 2.2.1:**  Number of PS18-1802-funded HIV tests conducted by grantee | **Count:**  Number of PS18-1802-funded HIV tests conducted | NHM&E | Test-level |
| **Measure 2.2.2 :**  Number of persons with newly diagnosed HIV infection identified through PS18-1802-funded testing  **(CDC calculated target)** | **Count: TBD** |
| **Measure 2.2.3:**  Of all PS18-1802-funded HIV tests conducted, the percentage of persons with newly diagnosed HIV infection | **Numerator:**  Number of HIV tests in the denominator in which the HIV infection was newly diagnosed | NHM&E | Test-level |
| **Denominator:**  Number of PS18-1802-funded HIV tests conducted |
| **Measure 2.2.4:**  Of all persons with newly diagnosed HIV infection, the percent provided an HIV test result **(NOFO target: ≥90%)** | **Numerator:**  Number of persons in the denominator who are provided their HIV test result | NHM&E | Client-level |
| **Denominator:**  Number of persons with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing |
| **Measure 2.2.5:**  Of all persons living with HIV infection, the percentage who know their HIV-positive status  **(NHAS and NOFO target: ≥90%)** | **Numerator:**  Number of persons in the denominator who are living with diagnosed with HIV infection | NHSS | Person-level |
| **Denominator:**  Number of persons in the jurisdiction who are estimated to be living with HIV infection |
| **2.3:** Increased identification of HIV-negative persons at risk for HIV infection (output) | **Question 2.3.1:**  To what extent was there an increase in the identification of HIV-negative persons at risk for HIV? | **Measure 2.3.1:**  Of all PS18-1802-funded HIV tests conducted that had HIV-negative results, the percentage of tests that are among persons at risk for HIV infection | **Numerator:**  Of negative HIV tests in the denominator, the number in which the person tested was at risk for HIV infection | NHM&E | Test-level |
| **Denominator:**  Number of PS18-1802-funded HIV tests with negative results |
| **PARTNER SERVICES—PS18-1802-Funded Testing** | | | | | |
| **2.4:** Increased participation in HIV partner services among persons with diagnosed HIV infection, identified through PS18-1802-funded testing (outcome) | **Question 2.4.1:**  To what extent was there an increase in participation in HIV partner services among persons with newly diagnosed HIV infection, identified through PS18-1802-funded testing? | **Measure 2.4.1:**  Of all persons with newly diagnosed HIV infection through PS18-1802-funded HIV testing, the percentage interviewed for partner services **(NOFO target: 85%)** | **Numerator:**  Number of persons in the denominator who are interviewed for partner services |  |  |
| **Denominator:**  Number of persons with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing |
| **Question 2.4.2:**  To what extent was there an increase in participation in HIV partner services among persons with previously diagnosed HIV infection identified through PS18-1802-funded HIV testing? | **Measure 2.4.2:**  Of all persons with previously diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage interviewed for partner services | **Numerator:**  Number of persons in the denominator who are interviewed for partner services |
| **Denominator:**  Number of persons with previously diagnosed HIV infection identified through PS18-1802-funded HIV testing |
| **PARTNER SERVICES—Jurisdiction Wide** | | | | | |
| **2.5:** Increased participation in HIV partner services among persons with diagnosed HIV infection, identified throughout the jurisdiction (outcome) | **Question 2.5.1:**  To what extent was there an increase in in participation in HIV partner services among all persons with newly diagnosed HIV infection? | **Measure 2.5.1:**  Of all persons with newly diagnosed HIV infection who are reported to surveillance, the percent who are reported to the partner services program | **Numerator:**  Number of persons in the denominator who are reported to the partner services program | NHM&E | Client-level |
| **Denominator:**  Number of persons with newly diagnosed HIV infection who are reported to surveillance in the 12-month observation period |
| **Question 2.5.2- 2.5.3:**  To what extent was there an increase in expedient HIV partner services interviews among persons with newly diagnosed HIV infection? | **Measure 2.5.2:**  Of all persons with newly diagnosed HIV infection who are reported to the partner services program, the percentage interviewed for partner services in ≤30 days after HIV diagnosis | **Numerator:**  Number of persons in the denominator who are interviewed for partner services in ≤30 days after HIV diagnosis |
| **Denominator:**  Number of persons with newly diagnosed HIV infection who are reported to the partner services program |
| **Measure 2.5.3:**  Of all persons with newly diagnosed acute or recent HIV infection, the percentage interviewed for partner services in ≤14 days after HIV diagnosis | **Numerator:**  Number of persons in the denominator who are interviewed for partner services in ≤14 days after HIV diagnosis |
| **Denominator:**  Number of persons with newly diagnosed acute or recent HIV infection who are reported to the partner services program |
| **Question 2.5.4:**  To what extent was there an increase in participation in HIV partner services among persons with previously diagnosed HIV infection? | **Measure 2.5.4:**  Of all persons with previously diagnosed HIV infection who are reported to the partner services program, the percentage interviewed for partner services | **Numerator:**  Number of persons in the denominator who are interviewed for partner services |
| **Denominator:**  Number of persons with previously diagnosed HIV infection who are reported to the partner services program |
| **2.6:** Increased partner elicitation through HIV partner services interviews of index patients with newly diagnosed HIV infection (outcome) | **Question 2.6.1-2.6.2:**  To what extent were notifiable partners elicited through HIV partner services interviews of index patients with newly diagnosed HIV infection | **Measure 2.6.1**  Average number of notifiable partners named per interviewed index patient with newly diagnosed HIV infection | **Numerator:**  Number of notifiable partners named by index patients with newly diagnosed HIV infection | NHM&E | Client-level |
| **Denominator:**  Number of index patients with newly diagnosed HIV infection who are interviewed for partner services |
| **Measure 2.6.2:**  Of all persons with newly diagnosed HIV infection interviewed for partner services, the percentage who named ≥1 notifiable partner | **Numerator:**  Number of persons in the denominator who named ≥1 notifiable partner |
| **Denominator:**  Number of index patients with newly diagnosed HIV infection who interviewed for partner services |
| **2.7:** Increased notification and HIV testing of partners identified through HIV partner services (output) | **Question 2.7.1-2.7.3:**  To what extent was there an increase in notification and HIV testing of partners identified through HIV partner services? | **Measure 2.7.1:**  Of all named, notifiable partners identified through HIV partner services, the percentage notified for HIV partner services | **Numerator:**  Number of partners in the denominator who are notified of their potential exposure to HIV |
| **Denominator:**  Number of named, notifiable partners identified through HIV partner services |
| **Measure 2.7.2:**  Of all named, notifiable partners identified through HIV partner services, the percentage tested for HIV infection | **Numerator:**  Number of partners in the denominator who are tested for HIV infection | NHM&E | Client-level |
| **Denominator:**  Number of named, notifiable partners identified through HIV partner services, who are not known to be HIV-positive |
| **Measure 2.7.3:**  Of all notified partners identified through HIV partner services, the percentage tested for HIV infection | **Numerator:**  Number of partners in the denominator who are tested for HIV infection |
| **Denominator:**  Number of notified partners identified through HIV partner services who are not known to be HIV-positive |
| **2.8:** Increased number of partners living with HIV infection who are aware of their HIV status (outcome) | **Question 2.8.1:**  To what extent was there an increase in the number of partners living with HIV infection who are aware of their HIV status? | **Measure 2.8.1:**  Of all partners identified through partner services with unknown HIV status who are tested, the percentage of partners with newly diagnosed HIV infection | **Numerator:**  Number of partners in the denominator who are newly diagnosed with HIV infection |
| **Denominator:**  Number of notified partners identified through HIV partner services, not known to be HIV-positive, who are tested for HIV infection |
| **DATA-TO-CARE** | | | | | |
| **2.9:** Improve laboratory reporting to HIV surveillance (output) | **Question 2.9:**  Did grantees meet the criteria for complete reporting of HIV-related test results? | **Measure 2.9.1:**  Meet criteria for complete reporting of all HIV-related test results | See the National HIV Surveillance System - Technical Guidance, May 2017 available at [https://partner.cdc.gov](https://partner.cdc.gov/).  See details in the Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2014. HIV Surveillance Supplemental Report 2016; 21(No. 4). <http://www.cdc.gov/hiv/library/reports/surveillance/> Published July 2016. | NHSS | NA |

| **Strategy 3: Develop, maintain, and implement plan to respond to HIV transmission clusters and outbreaks**  **Outcomes** | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Output or Outcome** | **M&E Question** | **Measures/Indicators** | **Specifications** | **Data Source** | **Data Type** |
| **3.1:** Improved early identification and investigation of HIV transmission clusters and outbreaks(outcome) |  | **Measure 3.1.1:**  Analyze surveillance and other data using CDC-recommended approaches at least monthly to identify HIV transmission clusters and outbreaks | See the National HIV Surveillance System - Technical Guidance, May 2017 available at [https://partner.cdc.gov](https://partner.cdc.gov/) | APR, SER | NA |
| **Measure 3.1.2:**  For each cluster of concern identified through analysis of surveillance and other data, submit analysis, investigation, and intervention results to CDC quarterly after identification of cluster until investigation and intervention activities are closed |
| **3.2:** Improved response to HIV transmission clusters and outbreaks (outcome) |  | **Measure 3.2.1:**  Of all HIV-positive persons in transmission clusters who were not known to be virally suppressed at the time of identification as part of the cluster, percentage that achieved viral suppression within 6 months of identification as part of the cluster  **(NOFO target ≥60%)** | See the National HIV Surveillance System - Technical Guidance, May 2017 available at [https://partner.cdc.gov](https://partner.cdc.gov/) | NHSS | Person-level |
| **Measure 3.2.2:**  Of all partners of transmission cluster members who were not known to be HIV positive at the time of cluster identification, percentage tested or re-tested within 6 months of identification as part of the risk network | See the National HIV Surveillance System - Technical Guidance, May 2017 available at [https://partner.cdc.gov](https://partner.cdc.gov/) | APR, SER | Aggregate |
| **Measure 3.2.3:**  Of all partners of transmission cluster members who were determined to be HIV-negative and not on PrEP, percentage referred for PrEP within 6 months of identification as part of the risk network |
| **3.3:** Improved plan and policies to respond to and contain HIV outbreaks (outcome) |  | **Measure 3.3.1:**  Develop and maintain a plan and capacity for cluster and outbreak detection and response | See the National HIV Surveillance System - Technical Guidance, May 2017 available at [https://partner.cdc.gov](https://partner.cdc.gov/) | APR, SER | NA |

| **Strategy 4: Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection (PLWH)** | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Output or Outcome** | **M&E Question** | **Measures/Indicators** | **Specifications** | **Data Source** | **Data Type** |
| **LINKAGE TO AND RETENTION IN HIV MEDICAL CARE** | | | | | |
| **Outcome 4.1:**  Increased linkage to and retention in HIV medical care among PLWH (outcome) |  | **Measure 4.1.1:**  Publish linkage to care, in HIV medical care, retention in care and viral suppression results using the CDC surveillance definitions in annual reports and epidemiologic profile | See the National HIV Surveillance System - Technical Guidance, May 2017 available at <https://partner.cdc.gov> | NHSS | Aggregate |
| **Question 4.1.2.-4.1.5**  To what extent was there an increase in screening and provision of linkage to HIV medical care navigation services for PLWH identified through PS18-1802-funded HIV testing? | **Measure 4.1.2:**  Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage screened for linkage to HIV medical care navigation services needs  (calculated by CDC) | **Numerator:**  Number of persons in the denominator who are screened for linkage to HIV medical care navigation services needs | NHM&E | Client-level |
| **Denominator:**  Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing |
| **Measure 4.1.3:**  Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for linkage to HIV medical care navigation services needs, the percentage identified as needing these services  (calculated by CDC) | **Numerator:**  Number of persons in the denominator who are identified as needing linkage to HIV medical care navigation services |
| **Denominator:**  Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for linkage to HIV medical care navigation services needs |
| **Measure 4.1.4:**  Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing linkage to HIV medical care navigation services, the percentage who are provided these services  (calculated by CDC) | **Numerator:**  Number of persons in the denominator who are provided or actively referred to linkage to HIV medical care navigation services |
| **Denominator:**  Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing linkage to HIV medical care navigation services |
| **Question 4.1.2.-4.1.5**  To what extent was there an increase in linkage of persons with newly diagnosed HIV infection to HIV medical care? | **Measure 4.1.5:**  Of all person with newly diagnosed HIV infection identified throughout the jurisdiction, the percentage linked to HIV medical care in ≤ 30 days of diagnosis **(NHAS and NOFO target: ≥85%)** | **Numerator:**  Number of persons in the denominator who are linked to HIV medical care in ≤ 30 days after HIV diagnosis | NHSS | Person-level |
| **Denominator:**  Number of newly diagnosed HIV infection cases reported to surveillance in a diagnosis year |
| **Measure 4.1.6:**  Of all persons with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage linked to HIV medical care in ≤ 30 days after HIV diagnosis **(NHAS and NOFO target: ≥85%)** | **Numerator:**  Number of persons in the denominator who are linked to HIV medical care in ≤ 30 days after HIV diagnosis | NHM&E | Client-level |
| **Denominator:**  Number of persons with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing |
| **Measure 4.1.7:**  Of all persons with newly diagnosed acute HIV infection identified through PS18-1802-funded HIV testing, the percentage linked to HIV medical care in ≤ 14 days after HIV diagnosis | **Numerator:**  Number of persons in the denominator who are linked to HIV medical care in ≤ 14 days after HIV diagnosis |
| **Denominator:**  Number of persons with newly diagnosed acute HIV infection identified through PS18-1802-funded HIV testing |
| **Measure 4.1.8:**  Of all partners with newly diagnosed HIV infection identified through partner services, the percentage linked to HIV medical care in ≤ 30 days after HIV diagnosis | **Numerator:**  Number of partners in the denominator who are linked to HIV medical care in ≤ 30 days after HIV diagnosis |
| **Denominator:**  Number of partners with newly diagnosed HIV infection identified through partner services |
| **Measure 4.1.9:**  Of all partners with newly diagnosed with acute or recent HIV infection identified through partner services, the percentage linked to HIV medical care in ≤14 days after HIV diagnosis | **Numerator:**  Number of partners in the denominator who are linked to HIV medical care in ≤ 14 days after HIV diagnosis |
| **Denominator:**  Number of partners with newly diagnosed acute or recent HIV infection identified through partner services |
| **Question 4.1.7.-4.1.8**  To what extent was there an increase in linkage of persons with previously diagnosed HIV infection to HIV medical care? | **Measure 4.1.10:**  Of all persons with previously diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage linked to HIV medical care in ≤ 30 days after last HIV test | **Numerator:**  Number of persons in the denominator who are linked to HIV medical care in ≤ 30 days after last HIV test | NHM&E | Client-level |
| **Denominator:**  Number of persons with previously diagnosed HIV infection identified through PS18-1802-funded HIV testing |
| **Measure 4.1.11:**  Of all persons with previously diagnosed HIV infection who are interviewed for partner services and determined to be not in care, the percent who are linked to HIV medical care in ≤ 30 days of report to partner services | **Numerator:**  Number of persons in the denominator who are linked to HIV medical care in ≤ 30 days of report to partner services |
| **Denominator:**  Number of persons with previously diagnosed HIV infection who are determined to be not in care at the time of partner services interview |
| **Question 4.1.9-4.1.10:**  Does the use of NHSS and other data sources increase linkage or re-engagement of not-in-care PLWH in HIV medical care? | **Measure 4.1.12:**  For PLWH identified through data-to-care activities, percentage of presumptively not-in-care PLWH with an investigation initiated during a specified time period, who were confirmed to be not in care within 60 days after the investigation was initiated | **Numerator:**  Number of PLWH in the denominator who were confirmed to be not in care within 60 days after the investigation was initiated | NHSS | Client-level |
| **Denominator:**  Number of PLWH identified through data-to-care activities as presumptively not in care who had an investigation initiated during a specified time period |
| **Measure 4.1.13:**  For PLWH identified through data-to-care activities, percentage of PLWH confirmed during a specified time period to be not in care, who were linked to HIV medical care within 30 days after being confirmed to be not in care | **Numerator:**  Number of PLWH in the denominator who were linked to HIV medical care within 30 days after being confirmed to be not in care |
| **Denominator:**  Number of presumptively not-in-care PLWH identified through data-to-care activities who were confirmed during a specified time period to be not in care |
| **Question 4.1.11-4.1.12**  To what extent was there an increase in PLWH in HIV medical care? | **Measure 4.1.14:**  Of all persons living with diagnosed HIV infection, the percentage in HIV medical care | **Numerator:**  Number of PLWH with evidence of an HIV medical care visit (e.g. ≥1 CD4 or VL test result) within a 12-month measurement period in the 12-month observation period |
| **Denominator:**  Number of persons living with HIV infection  (same as numerator 2.1.4) |
| **Measure 4.1.15:**  Of all persons living with diagnosed HIV infection, the percentage retained in HIV medical care **(NOFO target: ≥90%)** | **Numerator:**  Number of PLWH with ≥ 2 CD4 or VL (or genotype) test results based on specimens collected at least 3 months apart in the 12-month observation period |
| **Denominator:**  Number of PLWH who have lived with diagnosed HIV infection for at least 12 months by the end of the reporting period |
| **4.2** Increased use of surveillance data to support PLWH throughout the HIV care continuum (output) | | | | **Monitored locally, data are not reported to CDC** | |
| **TREATMENT AND ADHERENCE SUPPORT** | | | | | |
| **4.3:** Increased early initiation of ART among PLWH (outcome) | | | | **Monitored locally, data are not reported to CDC** | |
| **4.4:** Increased provision of ART medication adherence support for PLWH (output) | **Question 4.4.1-4.4.3:**  To what extent was there an increase in screening for and provision of ART medication adherence support services for PLWH who are in need of these services? | **Measure 4.4.1:**  Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage screened for ART medication adherence support service needs (calculated by CDC) | **Numerator:**  Number of persons in the denominator who are screened for ART medication adherence support service needs | NHM&E | Client-level |
| **Denominator:**  Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing |
| **Measure 4.4.2:**  Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for ART medication adherence support service needs, the percentage identified as needing these services (calculated by CDC) | **Numerator:**  Number of persons in the denominator who are identified as needing ART medication adherence support services |
| **Denominator:**  Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for ART medication adherence support service needs |
| **Measure 4.4.3:**  Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing ART medication adherence support services, the percentage who are provided these services | **Numerator:**  Number of persons in the denominator who are provided or actively referred to ART medication adherence support services |
| **Denominator:**  Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing ART medication adherence support services |
| **VIRAL SUPPRESSION** | | | | | |
| **Outcome 4.5:**  Increased HIV viral load suppression among PLWH (outcome) | **Question 4.5.1:**  To what extent was there an increase in HIV viral load suppression among persons living with diagnosed HIV infection? | **Measure 4.5.1:**  Of all persons living with diagnosed HIV infection, the percentage virally suppressed **(FOA target: ≥80%)** | **Numerator:**  Number of persons in the denominator who are virally suppressed | NHSS | Client-Level |
| **Denominator:**  Number of persons living with diagnosed HIV in the jurisdiction |
| **Question 4.5.2:**  Does using HIV surveillance data increase viral suppression among not-in-care PLWH who are linked to or re-engaged in HIV medical care? | **Measure 4.5.2:**  For PLWH identified through data-to-care activities, percentage of PLWH linked to HIV medical care during a specified time period, who achieved HIV viral suppression within six months (180 days) after being linked to care | **Numerator:**  Number of PLWH in the denominator who achieve HIV viral suppression within six months (180 days) after being linked to care |
| **Denominator:**  Number of confirmed not-in-care PLWH identified through data-to-care activities who were linked to HIV medical care during a specified time period |
| **Risk Reduction and Support Services—HIV-Positive Persons** | | | | | |
| **4.6:** Increased provision of risk reduction interventions for PLWH (output) | **Question 4.6.1-4.C.3:**  To what extent was there an increase in screening for and provision of risk reduction interventions for PLWH | **Measure 4.6.1:**  Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percentage screened for risk reduction intervention needs (calculated by CDC) | **Numerator:**  Number of persons in the denominator who are screened for risk reduction intervention needs | NHM&E | Client-level |
| **Denominator:**  Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing |
| **Measure 4.6.2:**  Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for risk reduction intervention, the percentage who are identified as needing an intervention (calculated by CDC) | **Numerator:**  Number of persons in the denominator who are identified as needing risk reduction intervention |
| **Denominator:**  Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for risk reduction intervention needs |
| **Measure 4.6.3:**  Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing risk reduction intervention, the percentage provided an intervention **(NOFO Target: 85%)** | **Numerator:**  Number of persons in the denominator who are provided or actively referred for risk reduction intervention |
| **Denominator:**  Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for and identified as needing risk reduction intervention |
| **4.7:** Increased referral to HIV prevention services for PLWH (output) | **Question 4.7.1:**  To what extent was there an increase in referral to any HIV prevention services for persons with diagnosed HIV infection? | **Measure 4.7.1:**  Of all persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing, percentage referred to any HIV prevention services  **(GPRA and NOFO target: ≥80%)** | **Numerator:**  Number of persons in the denominator who are provided or actively referred for any HIV prevention service | NHM&E | Client-level |
| **Denominator:**  Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing any HIV prevention service |
| **4.8:** Decreased risk behaviors among PLWH at risk of transmission(outcome) | | | | **Monitored locally, data are not reported to CDC** | |
| **4.9:** Increased screening and active referral of PLWH to essential support services, including healthcare benefits, behavioral health, and social services (output) | **Question 4.9.1-4.9.3:**  To what extent was there an increase in screenings and active referrals of PLWH to essential support services, including healthcare benefits, behavioral health, and social services? | **Measure 4.9.1:**  Of all persons living with diagnosed HIV infection, the percentage screened for essential support services, including healthcare benefits, behavioral health, and social services  (calculated by CDC) | **Numerator:**  Number of persons in the denominator who are screened for essential support services, including healthcare benefits, behavioral health, and social services | NHM&E | Client-level |
| **Denominator:**  Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing |
| **Measure 4.9.2:**  Of all persons living with diagnosed HIV infection who are screened for essential support services, including healthcare benefits, behavioral health, and social services, the percentage who are identified as needing one or more of these services  (calculated by CDC) | **Numerator:**  Number of persons in the denominator who are identified as needing essential support services, including healthcare benefits, and/or social services |
| **Denominator:**  Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened for essential support services, including healthcare benefits, behavioral health, and social services |
| **Measure 4.9.3:**  Of all persons living with diagnosed HIV infection who are screened and identified as needing essential support services, including healthcare benefits, behavioral health, and social services, the percentage who are actively referred for one or more of these services | **Numerator:**  Number of persons in the denominator who are provided or actively referred for essential support services, including healthcare benefits , and/or social services | NHM&E | Client-level |
| **Denominator:**  Number of persons living with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing essential support services, including healthcare benefits, behavioral health, and/or social services |

| **Strategy 5: Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infection** | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Output or Outcome** | **M&E Question** | **Measures/Indicators** | **Specifications** | **Data Source** | **Data Type** |
|  |  |  |  |  |  |
| **5.1:** Increased periodic HIV testing and risk screening among persons at risk for HIV infection (output) | | | | **Monitored locally, data are not reported to CDC** | |
| **PrEP** | | | | | |
| **5.2:** Increased screening of HIV-negative persons for PrEP eligibility (output) | **Question 5.2.1-5.2.4:**  To what extent was there an increase in screening of HIV-negative persons for PrEP eligibility? | **Measure 5.2.1:**  Of all at risk HIV-negative persons identified through PS18-1802-funded HIV testing and not already on PrEP at the time of testing, the percentage screened for PrEP eligibility | **Numerator:**  Number of persons in the denominator who are screened for PrEP eligibility | NHM&E | Client-level |
| **Denominator:**  Number of at risk HIV-negative persons not currently on PrEP at the time of PS18-1802-funded HIV testing |
| **Measure 5.2.2:**  Of all at risk HIV-negative persons, identified through PS18-1802-funded HIV testing, not already on PrEP at the time of HIV testing and screened for PrEP, the percentage identified as eligible for PrEP | **Numerator:**  Number of persons in the denominator who are eligible for PrEP |
| **Denominator:**  Number of at risk HIV-negative persons not currently on PrEP at the time of PS18-1802-funded HIV testing who are screened for PrEP eligibility |
| **Measure 5.2.3:**  Of all HIV-negative partners identified through partner services and not already on PrEP, the percentage screened for PrEP eligibility | **Numerator:**  Number of partners in the denominator who are screened for PrEP eligibility |
| **Denominator:**  Number of HIV-negative partners not currently on PrEP at the time of partner services contact |
| **Measure 5.2.4:**  Of all HIV-negative partners, identified through partner services, not already on PrEP at the time of partner services contact and screened for PrEP, the percentage identified as eligible for PrEP | **Numerator:**  Number of partners in the denominator who are eligible for PrEP |
| **Denominator:**  Number of HIV-negative partners not currently on PrEP at the time of partner services contactwho are screened for PrEP eligibility |
| **5.3:** Increased referral of persons eligible for PrEP to PrEP providers(outcome) | **Question 5.3.1:**  To what extent was there an increase in referrals of PrEP-eligible at risk HIV-negative persons for PrEP? | **Measure 5.3.1**  Of all at risk HIV-negative persons identified through PS18-1802-funded HIV testing, who are screened and identified as eligible for PrEP, the percentage referred for PrEP | **Numerator:**  Number of persons in the denominator who are referred for PrEP | NHM&E | Client-level |
| **Denominator:**  Number of at risk HIV-negative persons screened and identified as eligible for PrEP through PS18-1802-funded HIV testing |
| **Question 5.3.2:**  To what extent was there an increase in referrals of PrEP-eligible partners for PrEP? | **Measure 5.3.2**  Of all HIV-negative partners identified through partners, who are screened and identified as eligible for PrEP, the percentage referred for PrEP | **Numerator:**  Number of persons in the denominator who are referred for PrEP |
| **Denominator:**  Number of HIV-negative partners screened and identified as eligible for PrEP through partner services |
| **5.4:** Increased linkage of persons eligible for PrEP to PrEP providers (outcome) | | | | **Monitored locally, data are not reported to CDC** | |
| **5.5:** Increased prescription of PrEP to persons for whom PrEP is indicated (outcome) | | | |
| **Risk Reduction and Support Services—HIV Negative Persons** | | | | | |
| **5.6:** Increased provision of risk reduction interventions for HIV-negative persons at risk for HIV infection (output) | **Question 5.6.1-5.6.3:**  To what extent was there an increase in screening for and provision of risk reduction interventions for HIV-negative persons at risk for HIV infection and other STDs | **Measure 5.6.1:**  Of all HIV-negative persons at risk for HIV infection, the percentage screened for risk reduction intervention needs | **Numerator:**  Number of persons in the denominator who are screened for risk reduction intervention needs | NHM&E | Client-level |
| **Denominator:**  Number of HIV-negative persons identified through PS18-1802-funded HIV testing who are at risk for HIV infection |
| **Measure 5.6.2:**  Of all HIV-negative persons at risk for HIV infection who are screened for risk reduction intervention, the percentage identified as needing an intervention | **Numerator:**  Number of persons in the denominator identified as needing risk reduction intervention |
| **Denominator:**  Number of HIV-negative persons identified through PS18-1802-funded HIV testing who are screened for risk reduction interventionneeds |
| **Measure 5.6.3:**  Of all HIV-negative persons at risk for HIV infection who are screened and identified as needing risk reduction intervention, the percentage provided an intervention  **(NOFO Target: ≥85%)** | **Numerator:**  Number of persons in the denominator who are provided or actively referred for risk reduction intervention | NHM&E | Client-level |
| **Denominator:**  Number of HIV-negative persons identified through PS18-1802-funded HIV testing who are screened for and identified as needing risk reduction intervention |
| **5.7:** Decreased risk behaviors among HIV-negative persons at risk for HIV infection and other STDs (outcome) | | | | **Monitored locally, data are not reported to CDC** | |
| **5.8:** Increased screening and active referral of HIV-negative persons at risk for HIV infection to essential support services, including healthcare benefits, behavioral health, and social services (output) | **Question 5.8.1-5.8.3:**  To what extent was there an increase in screening and active referral of HIV-negative persons at risk for HIV infection to essential support services, including healthcare benefits, behavioral health, and social services? | **Measure 5.8.1:**  Of all HIV-negative persons at risk for HIV infection, the percentage screened for essential support services, including healthcare benefits, behavioral health, and social services | **Numerator:**  Number of persons in the denominator who are screened for essential support services, healthcare benefits, behavioral health, and social services | NHM&E | Client-level |
| **Denominator:**  Number of HIV-negative persons identified through PS18-1802-funded HIV testing who are at risk for HIV infection |
| **Measure 5.8.2:**  Of all HIV-negative persons at risk for HIV infection who are screened for essential support services, including healthcare benefits, behavioral health, and social services, the percentage identified as needing one or more of these services | **Numerator:**  Number of persons in the denominator who are identified as needing essential support services, healthcare benefits, behavioral health, and/or and social services |
| **Denominator:**  Number of HIV-negative persons identified through PS18-1802-funded HIV testing who are at risk for HIV infection and screened for essential support services, healthcare benefits, behavioral health, and social services |
| **Measure 5.8.3:**  Of all HIV-negative persons at risk for HIV infection who are screened and identified as needing essential support services, including healthcare benefits, behavioral health, and social services, the percentage who are actively referred to one or more of these services | **Numerator:**  Number of persons in the denominator who are provided or activity referred for essential support services, healthcare benefits, behavioral health, and/or social services |
| **Denominator:**  Number of HIV-negative persons identified through PS18-1802-funded HIV testing who are at risk for HIV infection and screened and identified as needing essential support services, healthcare benefits, behavioral health, and/or social services |

| **Strategy 6: Conduct perinatal HIV prevention and surveillance activities** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| **Output or Outcome** | | **M&E Question** | **Measures/Indicators** | **Specifications** | **Data Source** | **Data Type** |
|  | |  |  |  |  |  |
| **PRENATAL HIV SCREENING AND REFERRAL** | | | | | | |
| **6.1:** Increased HIV screening among pregnant women (output) | | | | | **Monitored locally, data are not reported to CDC** | |
| **6.2:** Increased number of pregnant women who are aware of their HIV status (outcome) | | **Question 6.2.1:**  To what extent was there an increase in the number of pregnant women living with HIV infection who are aware of their HIV status? | **Measure 6.2.1:**  Of all pregnant women with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing, the percent provided an HIV test result | **Numerator:**  Number of pregnant women in the denominator who are provided their HIV test result | NHM&E | Client-level |
| **Denominator:**  Number of pregnant women with newly diagnosed HIV infection identified through PS18-1802-funded HIV testing |
| **6.3:** Increased provision of perinatal HIV services or service coordination among pregnant women living with diagnosed HIV and their infants (output) | | **Question 6.3.1-6.3.2:**  To what extent was there an increase in screening and active referral to prenatal HIV care among pregnant women living with diagnosed HIV infection? | **Measure 6.3.1:**  Of all pregnant women identified through PS18-1802-funded HIV testing as newly diagnosed with HIV infection, the percentage screened for prenatal HIV care | **Numerator:**  Number of pregnant women in denominator who are screened for prenatal HIV care | NHM&E | Client-level |
| **Denominator:**  Number of pregnant women identified through PS18-1802-funded HIV testing with newly diagnosed with HIV infection |
| **Measure 6.3.2:**  Of all pregnant women with diagnosed HIV infection identified through PS18-1802-funded HIV testing who are screened and identified as needing prenatal HIV care, the percentage referred for prenatal HIV care | **Numerator:**  Number of pregnant women in denominator who are referred for prenatal HIV care | NHM&E | Client-level |
| **Denominator:**  Number of pregnant women identified through PS18-1802-funded HIV testing with newly diagnosed HIV infection screened for and identified as needing prenatal HIV care |
| **6.4.** Improved provision or coordination of perinatal HIV services (outcome) | | | | | **Monitored locally, data are not reported to CDC** | |
| **PERINATAL HIV CASES AND DATA** | | | | | | |
| **6.5:** Improved completeness, timeliness, and quality of HIV surveillance data for pediatric cases and HIV-exposed infants (outcome)  **6.5.a:** Meet standards detailed in the *Technical Guidance for HIV Surveillance Programs* for pediatric surveillance and Perinatal HIV Exposure Reporting(PHER), assessed as required by CDC standards (outcome) |  | | **Measure 6.5.1: Birth Ascertainment**  Annually link women with diagnosed HIV infection reported to surveillance to the state/local birth certificate data file to identify all perinatally exposed infants and infants with HIV infection not reported to surveillance, and enter results into eHARS | See the National HIV Surveillance System - Technical Guidance, May 2017 available at [https://partner.cdc.gov](https://partner.cdc.gov/) | NHSS | Person-level |
| **Measure 6.5.2: Perinatal HIV Exposure Reporting (PHER)**  ≥85% of HIV-exposed infants for a birth year have HIV infection status determined by 18 months of age | See the National HIV Surveillance System - Technical Guidance, May 2017 available at [https://partner.cdc.gov](https://partner.cdc.gov/)  This measure only applies to areas conducting Perinatal HIV Exposure Reporting (PHER) |
| **6.6**: Increased use of surveillance and epidemiological data to guide perinatal prevention and care efforts, monitor HIV health outcomes, develop policy, allocate resources, and plan and implement services (output) | | | | | **Monitored locally, data are not reported to CDC** | |
| **6.7:** Increased review of cases demonstrating missed prevention opportunities (output) | |  | **Measure 6.7.1:**  Number of cases reviewed to demonstrate missed prevention opportunities | **Count:**  Number of cases reviewed to demonstrate missed prevention opportunities | Fetal and Infant Mortality Review (FIMR) | NA |
| **6.8:** Reduced perinatally-acquired HIV infection (outcome) | | **Measure 6.8.1:**  Number of perinatally-acquired HIV infections among persons born in the jurisdiction, by year of birth | **Count:**  Number of perinatally-acquired HIV infections among persons born in the jurisdiction, by year of birth | NHSS | Person-level |

| **Strategy 7: Conduct community-level HIV prevention activities** | | | | | |
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| **Output or Outcome** | **M&E Question** | **Measures/Indicators** | **Specifications** | **Data Source** | **Data Type** |
| **7.1:** Increased availability of condoms among persons living with or at risk for HIV infection (outcome) | **Question 7.1.1:**  How many condoms were distributed to persons living with or at risk for HIV infection? | **Measure 7.1.1:**  Number of condoms distributed to persons living with or at risk for HIV infection | **Count:**  Number of condoms distributed to persons living with or at risk for HIV infection | NHM&E | Aggregate |
| **7.2:** Increased access to syringe service programs for persons who inject drugs (outcome) | **Question 7.2.1:**  How many syringe service programs are operating in the jurisdiction? | **Measure 7.2.1:**  Number of syringe service programs operating in the jurisdiction | **Count:**  Number of syringe service programs operating in the jurisdiction | APR, EOY | NA |
| **7.3:** Increased awareness among members of affected communities regarding potential risk for transmitting or acquiring HIV infection and strategies for reducing these risks (outcome) | | | | Qualitative | |
| **7.4:** Reduced stigma and discrimination for persons with diagnosed HIV infection (outcome) | | | |

| **Strategy 8: Develop partnerships to conduct integrated HIV prevention and care planning** | | |
| --- | --- | --- |
| **Output or Outcome** | **Data Source** | **Data Type** |
| **Outcome 8.1:** Increased coordination of, availability of, and access to comprehensive HIV prevention, treatment, and support services | Qualitative | |

| **Strategy 9: Implement structural strategies to support and facilitate HIV surveillance and prevention** | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Output or Outcome** | **M&E Question** | **Measures/Indicators1** | **Specifications** | **Data Source** | **Data Type** |
| **9.1:** Increased data security, confidentiality, and sharing (outcome) |  | **Measure 9.1.1:**  Full compliance with NCHHSTP Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs (2011):  <http://www.cdc.gov/nchhstp/programintegration/docs/PCSIDataSecurityGuidelines.pdf> | See requirements in the NCHHSTP Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs (2011):  <http://www.cdc.gov/nchhstp/programintegration/docs/PCSIDataSecurityGuidelines.pdf> | APR, EOY | NA |
| **9.2:** Reduced systemic, legal, regulatory, policy, organizational, operational, social, or cultural barriers to HIV surveillance, prevention, and care (outcome) | | | | Qualitative | |

| **Strategy 10: Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention, and care activities** | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Output or Outcome** | **M&E Question** | **Measures/Indicators** | **Specifications** | **Data Source** | **Data Type** |
| **10.1:** Increased use of data to plan, monitor, evaluate, and improve HIV surveillance and prevention programs and monitor the impact of local HIV prevention efforts (output) | **Question 10.1.1:**  To what extent did grantees use data to plan, monitor, evaluate, and improve HIV surveillance and prevention programs and monitor the impact of an integrated local HIV prevention efforts? | **Measure 10.1.1:**  Produce a continuum of care analysis using national standards and publish in annual reports and epidemiologic profile. | See guidance available in the National HIV Surveillance System - Technical Guidance, May 2017 available at [https://partner.cdc.gov](https://partner.cdc.gov/). | NHSS | NA |
| **10.2:** Increased coordination and integration of comprehensive HIV prevention and care services (outcome) | | | | Qualitative | |
| **10.3:** Improved targeting of HIV testing, prevention and care resources, funding, and services (outcome) | **Question 10.3.1:**  To what extent did the grantees improve targeting of HIV testing, prevention and care resources, funding, and services? | **Measure 10.3.1:**  Of all HIV PS18-1802-funded HIV tests conducted, the percentage of tests that were among persons at risk for HIV infection | **Numerator:**  Number of test in the denominator in which a) the test result was positive or b) the test result was negative and the person tested was determined to be at risk for HIV infection | NHM&E | Client-level |
| **Denominator:**  Number of PS18-1802 funded test conducted |
| **10.4:** Improved targeting, prioritization, and effectiveness of funded HIV prevention activities(outcome) | | | | Qualitative | |
| **10.5:** Improved targeting of HIV programs to address HIV-related health disparities (outcome) | | | | **Monitored locally, data are not reported to CDC** | |

| **Strategy 11: Build capacity for conducting effective HIV program activities, epidemiologic science, and geocoding** | | |
| --- | --- | --- |
| **Output or Outcome** | **Data Source** | **Data Type** |
| **Output 11.A:** Increased capacity building support and TA provided within the jurisdiction (including CBOs and other partners) | Qualitative | |
| **Output 11.B:** Increased jurisdictional capacity to conduct HIV surveillance activities (including D2C activities) and provide HIV prevention services |
| **Output 11.C:** Enhanced capacity to geocode, manage, link, and integrate surveillance and other data for surveillance, prevention, and care |
| **Outcome 11.1:** Strengthened interventional surveillance and response capacity | **Monitored locally, data are not reported to CDC** | |
| **Outcome 11.2:** Enhanced knowledge of the influence of social determinants on risk for disease and continuum of care outcomes |

Appendix B: CDC Defined Terms

| **Appendix B. CDC Defined Terms** | |
| --- | --- |
| **Term** | **Definition** |
| Active referral | This involves efforts beyond passive referral, in which the individual is only given contact information for the service(s) and is left to make their own contact. There are varying types of *active* referral. Active referral may include but is not limited to activities for the client such as: making appointments, providing transportation, using a case manager or peer navigator to help with access to services, providing the organization to which the client is referred with information collected about the client (including the professional assessment of the client’s needs), a “warm hand-off” – such as a ‘live’ three way conversation (individual/organization making the referral, individual/organization receiving the referral, and the client) – in person or by telephone – in which the client is introduced, and providing explanations about what has already been done to assist the client and reason for referral. |
| Acute HIV infection | This term refers to the interval between the appearance of detectable HIV RNA and the first detection of anti-HIV antibodies. It is identified when a screening test that detects HIV antigen or antibody is reactive/positive, a supplemental test that detects only IgG antibody is nonreactive/negative, and a NAAT test for HIV viral RNA is reactive/positive. Its duration is variable and depends on the characteristics of the test being used for screening and the supplemental test being used to document infection.  “Alternatively, acute HIV infection may be identified when a screening test is nonreactive/negative for HIV antibody, and a NAAT test for HIV RNA is reactive/positive (i.e., in the absence of a result from a supplemental test that detects only IgG antibody).”  For further discussion, see: *CDC (2104). Laboratory Testing for the Diagnosis of HIV Infection: Updated Recommendations.*  <http://www.cdc.gov/hiv/pdf/HIVtestingAlgorithmRecommendation-Final.pdf> |
| Analyzable nucleotide sequence | A nucleotide sequence (the genetic code for a person’s HIV strain) that includes valid information that can be analyzed and interpreted. |
| Anti-retroviral therapy (ART) medication adherence support services | Any intervention that is client‐centered and provides support and assistance to HIV‐diagnosed persons to improve medication adherence to ART. ART adherence interventions may involve any of the following elements: an educational/behavioral/motivational component, personal adherence counseling, skills‐building, tools for better medication management and ongoing support, and/or treatment delivery methods or monitoring devices to facilitate adherence. These programs may be implemented by HIV/AIDS service/health‐care providers or pharmacists.  A list of evidence based ART adherence interventions may be found at: <https://effectiveinterventions.cdc.gov> |
| Behavioral health | Behavioral health is a general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and the provision of treatments and services for substance misuse, addiction, substance use disorders, mental illness, and/or mental disorders. |
| Capacity Building | Activities that strengthen the core competencies of an organization and contribute to its ability to develop and implement an effective HIV prevention intervention and sustain the infrastructure and resource base necessary to support and maintain the intervention. |
| Condom distribution | The means by which condoms are transferred, disseminated, or delivered from a community resource (e.g., health department, community-based organization, or health care organization). |
| Data to Care (D2C) activities | Data to Care (D2C) is a public health strategy that uses HIV surveillance and other data to support the HIV Care Continuum by identifying persons living with HIV who are in need of HIV medical care and services and facilitating linkage to these services.  Example applications include (but may not be limited to) identifying persons living with HIV who are: 1) Not in HIV medical care, and providing linkage to care or re-engagement in care services, 2) In HIV medical care, but have sustained high HIV viral load, and provide needed care and social support services or 3) pregnant women or mothers and their exposed infants who may need coordinated services (perinatal HIV services coordination).  Additional information is available at<https://effectiveinterventions.cdc.gov> |
| Duplicate case reports | A person with more than one state-assigned case number in the surveillance database. This does not include cases where a person was exposed to HIV as an infant, but then became infected with HIV later in life. These people should have two state-assigned case numbers. |
| Employment assistance services | Programs that provide employment assistance, such as skills assessment, vocational training, employment referrals, job placement, and resume building support. Programs that provide employment assistance including vocational trainings, employment referrals, job placement, skills assessment, resume building support etc. |
| Essential support services | A service or intervention aimed at reducing risk for transmitting or acquiring HIV infection by modifying a factor (e.g., housing, transportation, employment assistance, and education) or combination of factors that can contribute to risk (e.g., healthcare benefits, behavioral health (see definition for behavioral health), and other medical and social services. |
| Geocoded data | Data that result from the computational process of transforming a description of a location (textual information on addresses) to a location on the Earth's surface (spatial representation in numerical coordinates). |
| Healthcare benefits services | Programs that help uninsured or under-insured clients enroll in public or private healthcare benefit programs. Services may include, but are not limited to outreach and education on available health benefit options (e.g., private insurance, health maintenance organizations, Medicaid, Medicare, medication assistance programs), eligibility assessment, and assistance with enrollment. Programs that help uninsured clients enroll in public or private healthcare benefits. Services may include outreach and education on available insurance options, eligibility assessment, enrollment etc. |
| HIV screening | A testing strategy that involves testing persons with no signs or symptoms of HIV infection, regardless of whether they have a recognized behavioral risk for HIV infection. A testing strategy that involves testing persons regardless of whether they have a recognized behavioral risk or symptoms of disease infection. This might be accomplished by testing all persons in a defined population or by selecting persons with specific population-level characteristics (e.g., demographic, geographic area). |
| HIV surveillance case definition | Public health surveillance requires specific case definitions. The definition of a diagnosis of HIV infection for surveillance purposes has changed over time. Reports of diagnoses of HIV infection must satisfy laboratory and clinical criteria included in the Revised Surveillance Case Definition for HIV Infection — United States, 2014, available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6303a1.htm>. The case definition will continue to be updated, as needed, to ensure the most accurate monitoring of HIV disease. |
| HIV test event | An HIV test event refers to a sequence of one or more individual tests conducted to determine a person’s HIV status. A test event may consist of a single individual test (e.g., one point-of-care rapid test or one laboratory-based test) or more than one individual tests (e.g., one point-of-care rapid test followed by a laboratory-based supplemental test to determine a final result). A test event may involve more than one face-to-face interaction over more than one day. In EvaluationWeb, a test event is associated with a single unique HIV test form identification number. |
| HIV transmission clusters | A group of HIV-infected persons (diagnosed and undiagnosed) who have a direct or indirect epidemiological connection related to HIV transmission. A transmission cluster can be detected through multiple mechanisms, including analysis of molecular HIV surveillance data or case surveillance data. |
| HIV-negative person | A person who has a negative test result based on the most recent HIV test conducted. |
| Housing services | Programs that help clients find adequate temporary or long-term housing (e.g., providing assistance with finding temporary shelter or housing, finding rental housing, home-buying, assessing eligibility for and making referrals to HUD/HOPWA programs). |
| In HIV medical care (prevention programs) | Evidence that a client/patient has seen a medical care provider at least once in the past 6 months for HIV treatment |
| In HIV medical care (surveillance) | Evidence of an HIV medical care visit (e.g. ≥1 CD4 or VL test result) within a 12-month measurement period. |
| Interviewed for partner services | Indicates whether or not a client was interviewed for the purpose of HIV partner services by health department specialists ornon-health departmentproviders trained and authorized to conduct partner services interviews on behalf of the health department. Non-health department providers include public health providers who are 1) collecting data on behalf of the health department and 2) provide information to the health department for partner servicesfollow-up. Interviews conducted by providers other than health department specialists are counted only if they can be verified (i.e., interview results are documented in writing and reported to the health department). |
| Linkage to care (surveillance) | A person is considered to be linked to HIV medical care if there is ≥1 CD4 or viral load test result based on a specimen collected ≤ 1 month following initial diagnosis.  See definition in the Continuum of HIV Case: Guidance for Local Analyses Updates, September 2016, available at https: partner.cdc.gov. |
| Linkage to HIV medical care within 30 days of diagnosis (prevention program) | This occurs when a patient is seen by a health care provider (e.g., physician, a physician’s assistant, or nurse practitioner) to receive medical care for his/her HIV infection, usually within a specified time. Linkage to medical care can include specific referral to care service immediately after diagnosis and follow-up until the person is linked to long-term case management. Linkage may be based on HIV-related laboratory tests or other methods of verification. Services may include evaluation of immune system function and screening, treatment, and prevention of opportunistic infections. |
| Linkage to PrEP provider | The process through which a person at risk for becoming infected with HIV is helped to access a healthcare provider who offers evaluation and management of pre-exposure prophylaxis (PrEP). This is often an active process (e.g., providing transportation, accompanying the person to the appointment, having multiple contacts with the person to support them in accessing the PrEP provider).  Linked to a PrEP provider refers to theoutcome of the referral or linkage of a PrEP eligible person to a PrEP provider, as indicated by the person’s attendance of the first appointment. |
| Linked to HIV medical care | This termrefers to the outcome resulting from referral or linkage of a person living with HIV (PLWH) to HIV medical care. A PLWH is considered to be linked to HIV medical care if they are seen by a healthcare provider (e.g., physician, physician assistant, nurse practitioner) after HIV diagnosis for evaluation and management of their HIV infection. Determination of linkage status may be based on report from a healthcare provider, medical record review, review of other records or databases, reported HIV-related laboratory tests, filling of a prescription for anti-retroviral medication, or client/patient self-report.  Linked to HIV medical carerefers to the outcome that results from referral or linkage of a patient to care, as indicated by the patient’s attendance at the first HIV care appointment. Services during the visit may include evaluation of immune system function and screening, treatment, and prevention of opportunistic infections.  For definitions of linkage and linked, consult:  https://effectiveinterventions.cdc.gov |
| Insurance navigation and enrollment services | Programs that help uninsured clients enroll in public or private healthcare insurance. Services may include outreach and education on available insurance options, eligibility assessment, enrollment etc. |
| Medication adherence support services | CDC-supported medication adherence interventions that improve medication adherence and/or viral load among HIV patients who have been prescribed (antiretroviral treatment). These include: HEART, Partnership for Health (Medication adherence), Peer Support, and SMART Couples. |
| Mental health services | Programs that are provided by a mental health professional. Services may include psychiatric assessment, consultation, treatment, psychotherapy, crisis intervention etc. See definition of behavioral health for more information |
| Newly diagnosed HIV infection | HIV infection in a person who: (1) does not self-report having previously tested positive for HIV; (2) has not been previously reported to the surveillance system as being infected with HIV; and 3) has no previous evidence of HIV infection in other records or databases. |
| Newly identified HIV-positive partner | A partner who a) has not previously been reported to the health department as being infected with HIV, b) has not been identified via record review as being previously positive, c) does not self-report having previously tested positive for HIV infection, and d) tested positive for HIV by the health departments or providers. |
| Notifiable partners | Notifiable partners are named partners that can be located and are determined to be eligible for notification of potential exposure. Partners out of jurisdiction, deceased, known to be previously diagnosed with HIV infection, or for which there is a risk of domestic violence are not considered notifiable. |
| Not-in-care (NIC) | Refers to a person living with HIV (PLWH) who has never been linked to HIV medical care (never in care) or was previously in HIV medical care but has not attended an HIV medical care appointment in a specified period of time (out of care). The length of time used to determine whether a PLWH is out of care may vary among jurisdictions. |
| Partner services | Partner services are a broad array of services that should be offered to persons with HIV infection, syphilis, gonorrhea, or chlamydial infection and their partners. A critical function of partner services is partner notification, a process through which infected persons are interviewed to elicit information about their partners, who can then be confidentially notified of their possible exposure or potential risk. Other functions of partner services include behavioral risk-reduction counseling; testing for HIV and other sexually transmitted infections (STIs); hepatitis testing and vaccination; treatment or linkage to medical care for HIV, STIs, and hepatitis; and linkage or referral to other services (e.g., pre-exposure prophylaxis [PrEP] and post-exposure prophylaxis [PEP]; risk-reduction interventions; case management; health benefits navigation; mental health and substance use treatment; transportation and housing services; other social and legal services). |
| Partners named | Partners named are sexual and injection drug using partners the index patient has had during the interview period, for which the index patient can provide identifying information (e.g., an actual name, an alias, or enough descriptive information that he/she can reasonably be considered identifiable) and sufficient information that he/she can reasonably be considered locatable. This is equivalent to the term “partners initiated” used in the STD Program Operations Guide. This does not include any associates that the partner may name. The amount of information that deems a partner locatable is defined by the jurisdiction (this may include a specific e-mail address or chat room communication). |
| Partners notified | Denotes sexual or drug using partners notified by health department staff through health department referral, referral after notification attempt by an index patient fails (i.e., contract referral), or referral by the index patient and health department staff together (i.e., dual referral).  A sex or drug-injection partner who has been notified of his or her possible exposure to HIV or other sexually transmitted infections (STIs). |
| Persons at risk for HIV infection | Groups or populations can be described as “vulnerable” or “key” or “groups [populations] at risk” if they are subject to societal pressures or social circumstances or engage in behaviors that make them vulnerable to HIV. |
| Pre-exposure prophylaxis (PrEP) | The use of antiretroviral medication by persons who are not infected with HIV, but are at substantial risk for infection, to reduce their risk for becoming infected. |
| PrEP eligibility | Refers to a person’s status with regard to whether or not he or she meets appropriate criteria for using pre-exposure prophylaxis (PrEP); specifically, whether or not he or she is HIV-negative and at substantial risk for HIV, as defined by CDC in its guidelines for PrEP (*U.S. Public Health Service (2014). Pre-exposure Prophylaxis for HIV Prevention in the United States - 2013: A Clinical Practice Guideline.* [*http://www.cdc.gov/hiv/pdf/PrEPguidelines2014.pdf*](http://www.cdc.gov/hiv/pdf/PrEPguidelines2014.pdf)) |
| PrEP provider | A healthcare professional (e.g., physician, advanced practice nurse, physician assistant) who conducts evaluations for pre-exposure prophylaxis (PrEP) eligibility and clinical appropriateness, prescribes PrEP, and provides comprehensive management of persons taking PrEP. PrEP providers are peers, volunteers, and staff members of clinics, health departments, and community-based organizations. Patient navigators may be lay persons, paraprofessionals, or medical professionals (e.g., RNs, LPNs). |
| PrEP screening | The process of conducting an initial assessment regarding a person’s eligibility for pre-exposure prophylaxis (PrEP) (i.e., HIV testing and behavioral risk screening) and determining whether or not a more thorough evaluation is warranted.  For further discussion on PrEP screening, see: *U.S. Public Health Service (2014). Pre-exposure Prophylaxis for HIV Prevention in the United States - 2013: A Clinical Practice Guideline.* [*http://www.cdc.gov/hiv/pdf/PrEPguidelines2014.pdf*](http://www.cdc.gov/hiv/pdf/PrEPguidelines2014.pdf) |
| Prescribed PrEP | Refers to a person who has been adequately evaluated and received a prescription for pre-exposure prophylaxis (PrEP).  <http://www.cdc.gov/hiv/pdf/guidelines/PrEPguidelines2014.pdf> |
| Prevalence | The total number of cases of a disease or behavior in a given population at a particular point in time. HIV prevalence refers to persons living with HIV, regardless of time of infection or diagnosis date. Prevalence does not give an indication of how long a person has had a disease. Another measure is an estimate of persons at risk for infection because of certain behaviors at a point in time. |
| Prevention services for HIV-negative persons | A broad array of services for HIV-negative persons living at risk for HIV infection to help them reduce their risk for acquiring HIV infection. These include services to help HIV-negative persons with the following: 1) periodic HIV testing and risk screening; 2) screening for PrEP eligibility; 3) linkage to and support for PrEP; 4) adopting and maintaining safer behaviors to reduce their risk for HIV transmission (e.g., risk reduction interventions); and 5) essential support services to address factors that affect their ability to access and remain in care and to achieve and maintain viral suppression (e.g., healthcare benefits, behavioral health, and social services).  See definitions for essential support services, healthcare benefits, behavioral health, and social services |
| Prevention services for HIV-positive persons | A broad array of services for persons living with HIV (PLWH) to help them reduce their risk for transmitting HIV. These include services to help PLWH with the following: 1) linkage to, re-engagement in, and retention in HIV medical care (e.g., linkage and navigation services); 2) achieving and maintaining viral suppression (e.g., early ART initiation, ART medication adherence support services, monitor HIV viral suppression, and monitor HIV drug resistance); 3) adopting and maintaining safer behaviors to reduce their risk for HIV transmission (e.g., HIV risk reduction interventions); and 4) essential support services to address factors that affect their ability to access and remain in care (e.g., healthcare benefits, behavioral health, and social services).  See definitions for essential support services, health care benefits, behavioral health, and social services |
| Previously diagnosed HIV infection | HIV infection in a person who 1) self-reports having previously tested positive for HIV or 2) has been previously reported to the health department surveillance system as being infected with HIV, or 3) has previous evidence of HIV infection in medical or other records or other databases. |
| Post-exposure prophylaxis (PEP) | Short-term antiretroviral prophylactic treatment provided to the client immediately (as soon as possible, but no more than 72 hours after exposure) to reduce the likelihood of HIV infection after potential exposure. |
| Re-engagement in HIV medical care | The process through which persons living with HIV (PLWH), who have previously received medical care for their HIV infection but are no longer receiving care, are helped to re-enter HIV medical care. This is often an active process (e.g., providing transportation, accompanying the PLWH to the appointment, having multiple contacts with the PLWH to support them in re-entering medical care).  Determination of re-engagement status may be based on report from a healthcare provider, medical record review, review of other records or databases, reported HIV-related laboratory tests, filling of a prescription for anti-retroviral medication, or client/patient self-report. |
| Referral | Directing clients to a service in person or through telephone, written, or other form of communication. Generally, a one-time event. Referral may be made formally from one clinical provider to another, within a case management system by professional case managers, informally through support staff, or as part of an outreach service program. |
| Referral to PrEP provider | Referral to PrEP providers is a process involving the provision of information on who the providers are, what documents referred person should take with them, how to get to the providers’ agency, and what to expect from the referral process. It is important that the agency that provides PrEP screening services tracks the referral and provides the necessary follow-up to verify the person attended the first appointment with the PrEP provider. A person can be referred to a PrEP provider internally (to another unit or person within the same agency) or externally (e.g. a CBO may screen and identify eligible persons, and then refer them to a healthcare provider that offers PrEP services). |
| Retention in care | A person is considered to have been retained in continuous HIV medical care during the specified 12-month period if he or she had ≥2 CD4 or VL test results based on specimens collected at least 3 months apart in that 12-month observation period. A nucleotide sequence test result may also be used to indicate a care event.  See definition in the Continuum of HIV Case: Guidance for Local Analyses Updates, September 2016, available at https: partner.cdc.gov. |
| Risk Behaviors | Behaviors that can directly expose persons to HIV or transmit HIV, if the virus is present (e.g., sex without a condom, sharing unclean needles). Risk behaviors are actual behaviors by which HIV can be transmitted, and a single instance of the behavior can result in transmission. |
| Risk reduction intervention | In the context of HIV prevention, a risk reduction intervention is a specific activity (or set of related activities) intended to reduce the risk for HIV transmission or acquisition. HIV risk reduction interventions may be structural, biomedical (e.g., treatment as prevention, pre-exposure prophylaxis [PrEP], post-exposure prophylaxis [PEP]) or behavioral (e.g., improve medication adherence for ART or PrEP, encourage linkage or re-engagement to HIV medical care, and promote HIV testing and PrEP screening and uptake), have protocols outlining steps for implementation, and have distinct process and outcome objectives.  Examples of risk reduction interventions may be found at https://effectiveinterventions.cdc.gov |
| Social Services | Social services includes housing, transportation, domestic violence intervention, and employment. |
| Substance misuse treatment and services | Drug and alcohol misuse treatment and support programs/services. See definition of behavioral health for more details. |
| Transportation services | The client received referral to agencies providing transportation assistance (e.g., through direct transportation services, vouchers or tokens) for transportation to and from HIV prevention and medical care appointments. |
| Viral suppression | A person is considered to have a suppressed viral load if the most recent test result during the specified 12-month observation period was <200 copies/mL.  See definition in the Continuum of HIV Case: Guidance for Local Analyses Updates, September 2016, available at https: partner.cdc.gov. |