

Component 2: Core Viral Hepatitis Prevention Activities

The Annual Performance Report (APR) is required.

Recipients must submit the APR via www.Grantsolutions.gov no later than 120 days prior to the end of the budget period. Please visit the Notice of Funding Opportunity (CDC-RFA-PS21-2103) starting on page 68 for additional information.

Evaluation and Performance Measures are listed in the Notice of Funding Opportunity (CDC-RFA-PS21-2103) starting on page 29. Please review this section, along with Strategies and Activities starting on page 11, before completing your APR.

Complete this form with information from the Reporting Period selected.

Note: Timelines are provided for each measure, however in general:

- Short-term outcomes should be reached by the end of year 3. Measures associated with these outcomes should be reported each year. Recipient can define year 1 goal, and year 2 goal should be determined based on interim activities.
- Intermediate outcomes should be reached by the end of year 5. Measures associated with these outcomes should be reported each year.
- Outcomes for measures that are “contingent on funding” are not required to be reached unless funded during the course of the award. Reporting of these measures is recommended but not required.

2.1—Support viral hepatitis elimination planning and surveillance, and maximize access to testing, treatment, and prevention

Measure 2.1.1.a

Have you established a viral hepatitis elimination technical advisory committee (or coalition) to support viral hepatitis elimination planning?

Identify the stakeholder groups represented on this committee (or coalition). *(select all that apply)*

Does the committee (or coalition) plan to support elimination for hepatitis C and/or hepatitis B? *(select all that apply)*

- The purpose of this section is to facilitate the development and implementation of viral hepatitis elimination plans. This is a short-term outcome (years 1–3). Jurisdictions will vary when they are able to establish a viral hepatitis elimination technical advisory committee (or coalition) within years 1–3. After the committee (or coalition) is established, jurisdictions should continue to report on progress of the committee (or coalition) proceedings throughout the five-year funded reporting period.
- **Committee (or coalition) status** — Report the committee (or coalition) status as of the close of the reporting period.
- **Groups represented (select all that apply)** — Once the committee (or coalition) is established, report the stakeholder groups represented on the committee (or coalition) as of the close of the reporting period.
- **Committee (or coalition) plans (select all that apply)** — Does the committee (or coalition) plan to support elimination planning for hepatitis C and/or hepatitis B? Jurisdictions may choose to prioritize hepatitis C elimination initially, depending upon available resources.
- See page 14 in the Notice of Funding Opportunity (CDC-RFA-PS21-2103) for more information.

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Measure 2.1.1.b

During this reporting period, when did the committee (or coalition) meet? (MM/DD/YYYY)

If the committee (or coalition) met during this reporting period, please submit a copy of meeting agenda(s) with the APR.

- The purpose of this section is to provide detailed information about committee (or coalition) meetings. This is a short-term outcome (years 1–3). Committee (or coalition) meetings should begin once the committee (or coalition) is established. Each jurisdiction should conduct at least two meetings per year once the committee (or coalition) has been established.
- **Committee (or coalition) meeting dates** — Report the dates of the committee (or coalition) meetings that occurred during this reporting period.
- **Meeting agenda(s)** — For informational purposes, please submit meeting agendas for the committee (or coalition) meetings that occurred during this reporting period to your Regional Team with the APR.

Measure 2.1.1.c

Have you developed a viral hepatitis elimination plan as part of this cooperative agreement?

Does the viral hepatitis elimination plan address hepatitis C and/or hepatitis B?

If the viral hepatitis elimination plan is completed or in progress, please submit a copy with the APR.

- The purpose of this section is to provide detailed information about the viral hepatitis elimination plan, which should be developed with support from the technical advisory committee (or coalition). This is a short-term outcome (years 1–3). Jurisdictions will vary when they are able to complete viral hepatitis elimination plan within years 1–3. After the elimination plan is completed, jurisdictions should continue to report on elimination plan updates throughout the five-year funded reporting period.
- **Plan status** — Report the status of plan development as of the close of the reporting period.
- **Content (*select all that apply*)** — Does it contain plans for elimination of hepatitis C and/or hepatitis B? Jurisdictions may choose to prioritize hepatitis C elimination initially, depending upon available resources.
- **Completed elimination plans** — For informational purposes, please submit a copy of your elimination plan to your Regional Team with the APR.
- Additional guidance on developing a viral hepatitis elimination plan will be shared by CDC.
- See page 14 in the Notice of Funding Opportunity (CDC-RFA-PS21-2103) for more information.

Measures 2.1.2.c and 2.1.4.a

Does your viral hepatitis elimination plan address recommendations for increasing HCV RNA reflex testing?

Does your viral hepatitis elimination plan address provider training in prescribing hepatitis C treatment?

Does your viral hepatitis elimination plan address provider training in prescribing hepatitis B treatment?

- The purpose of this section is for jurisdictions to demonstrate coordination and collaboration with key partners to improve viral hepatitis testing and provider capacity and training. These are short-term outcomes (years 1–3). Jurisdictions will vary when they are able to complete viral hepatitis elimination plan within years 1–3. Jurisdictions may choose to prioritize hepatitis C elimination initially, depending upon available resources. After the elimination plan is completed, jurisdictions should continue to report on elimination plan updates throughout the five-year funded reporting period.
- **HCV RNA reflex testing, prescribing hepatitis C and hepatitis B treatment** — Report if the viral hepatitis elimination plan, once developed, addresses HCV RNA reflex testing, prescribing hepatitis C treatment, and prescribing hepatitis B treatment.
- See pages 15–18 in the Notice of Funding Opportunity (CDC-RFA-PS21-2103) for more information.

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Measures 2.1.2.a and 2.1.2.b

Have you worked with your surveillance and/or epidemiology teams to identify the total number of CLIA-certified laboratories in your jurisdiction that report hepatitis C antibody testing results?

Of those, have you selected the subset that reports at least 80% of the hepatitis C antibody testing results in your jurisdiction?

Have you performed a needs assessment to identify key barriers and challenges to increasing HCV RNA reflex testing?

What proportion of that subset is conducting HCV RNA reflex testing?

Have you provided recommendations to increase HCV RNA reflex testing?

- The purpose of this section is to ensure that jurisdictions have identified CLIA-certified laboratories in their jurisdiction that perform hepatitis C antibody testing, have performed a needs assessment regarding the performance of HCV RNA reflex testing, and have provided feedback to these laboratories with recommendations. These are short-term outcomes (years 1–3).
- **Clinical Laboratory Improvement Amendments (CLIA) of 1988** — regulations that include federal standards applicable to all U.S. facilities or sites that test human specimens for health assessment or to diagnose, prevent, or treat disease. For more information, please refer to CLIA at 42 CFR 493.3. Demographic information about CLIA-certified laboratories is available here: <https://www.cdc.gov/clia/LabSearch.html>
- **Laboratory identification** — In year 1, each jurisdiction should work with their surveillance and/or epidemiology teams to identify the total number of CLIA-certified laboratories in their jurisdiction that report hepatitis C antibody testing results. Labs included could be CLIA-certified labs conducting hepatitis tests or labs conducting hepatitis tests under CLIA. Among these, they should select the subset of laboratories that report 80% or more of the hepatitis C antibody testing results.
- **Needs assessment** — By the end of year 1, each jurisdiction should, in consultation with the technical advisory committee (or coalition), conduct a needs assessment that describes the current hepatitis C antibody and HCV RNA reflex testing practices among this subset of laboratories and identifies key barriers and challenges to HCV RNA reflex testing. Laboratories that routinely perform RNA reflex testing on all HCV antibody positive test (e.g., QUEST Diagnostics, etc.) should be included in the numerator, but jurisdictions do not need to conduct a detailed needs assessment.
- **HCV RNA reflex testing** — By the end of year 1, for the subset that reports 80% or more of the hepatitis C antibody testing results, each jurisdiction should determine the proportion that is conducting HCV RNA reflex testing.
- **Providing feedback** — In year 2, each jurisdiction should, in consultation with the technical advisory committee (or coalition), summarize this needs assessment, develop recommendations to improve HCV RNA reflex testing, and share these recommendations with this subset of laboratories.
- In years 3–5, each jurisdiction should, in consultation with the technical advisory committee (or coalition), work with the laboratories to improve HCV RNA reflex testing.
- See page 15 in the Notice of Funding Opportunity (CDC-RFA-PS21-2103) for more information.

Measures 2.1.3.a and 2.1.3.b

What are the top 5 highest volume health systems in your jurisdiction?

Have you assessed how many of these health systems are promoting routine HCV testing?

If so, what percent of health systems are promoting routine HCV testing?

Have you assessed how many of these health systems are promoting routine HBV testing?

If so, what percent of health systems are promoting routine HBV testing?

Have you provided feedback to the top 5 highest volume health systems with recommendations on promoting routine HBV and HCV testing?

- These are short-term outcome (years 1–3).

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- **Top 5 highest volume health systems** — In year 1, each jurisdiction should work with their surveillance and/or epidemiology teams to identify the top five highest volume health systems, either by volume of patients or by volume of HCV and/or HBV testing.
- Health systems are defined as organizations of people, institutions, and resources that deliver health care services to meet the health needs of the target population. Examples of health systems could include a group of Federally Qualified Health Systems that share the same Electronic Medical Records system or a group of affiliated hospitals and clinics.
- **Needs assessment** — By the end of year 1, each jurisdiction should, in consultation with the technical advisory committee (or coalition), conduct a needs assessment for these high-volume health systems to describe their current HCV and/or HBV testing practices, disease prevalence, and key barriers and challenges to routine HCV and/or HBV testing.
- **Providing feedback** — In year 2, each jurisdiction should, in consultation with the technical advisory committee (or coalition), summarize this needs assessment, develop recommendations to improve routine HCV and/or HBV testing, and share these recommendations with these high-volume health systems.
- In years 3–5, each jurisdiction should, in consultation with the technical advisory committee (or coalition), work with these high-volume health systems to improve routine HCV and/or HBV testing.
- See page 15 in the Notice of Funding Opportunity (CDC-RFA-PS21-2103) for more information.

2.2—Increase access to hepatitis C and/or hepatitis B testing and referral to care in high-impact settings

Was Section 2.2 funded?

- If your jurisdiction was not funded for activities described under 2.2, check No and stop here. Do not complete measures beginning 2.2.
- If your jurisdiction was funded for activities described under 2.2, check Yes and complete the rest of this form.

Measures 2.2.2.a and 2.2.2.b

Relationship established to expand HCV testing, by setting

Relationship established to expand HBV testing, by setting

Number of clients seen during this reporting period, by setting, during this reporting period

- The purpose of this section is to ensure that jurisdictions collaborate with key stakeholders and partners to establish relationships with one or more high-impact settings and develop plans to expand HCV and/or HBV testing. These are short-term outcomes (years 1–3).
- **High-impact settings** — In year 1, for each collaborating high-impact setting (one or more), report if relationship has been established to expand HCV and/or HBV testing. Stratify by setting (one row per setting). Choose the appropriate setting from the drop-down list (Syringe services programs, Substance use disorder treatment programs, Correctional facilities, Emergency departments, Hospital-based programs, Sexually transmitted disease clinics, Homeless services, Health Centers, Other).
- **Number of clients** — Report the unduplicated count of clients seen at least once in each collaborating high-impact setting during the reporting period.
- **Needs assessment** — By the end of year 1, each jurisdiction should, in consultation with the technical advisory committee (or coalition), conduct a needs assessment for each collaborating high-impact setting regarding HCV and/or HBV testing practices.
- **Providing feedback** — In year 2, each jurisdiction should, in consultation with the technical advisory committee (or coalition), summarize this needs assessment, develop recommendations to improve HCV and/or HBV testing, and share these recommendations with each collaborating high-impact setting.
- In years 3–5, each jurisdiction should, in consultation with the technical advisory committee (or coalition), work with each collaborating high-impact setting to improve routine HCV and/or HBV testing.
- Include total number of settings and total number of clients across all settings in last row of table.
- See pages 18–20 in the Notice of Funding Opportunity (CDC-RFA-PS21-2103) for more information.

Measures 2.2.2.c – f and 2.2.3.a

Number of clients screened for hepatitis C (anti-HCV), by setting, during this reporting period

Number of clients positive for anti-HCV, by setting, during this reporting period

Number of clients tested for HCV RNA, by setting, during this reporting period

Number of clients positive for HCV RNA, by setting, during this reporting period

Number of clients positive for HCV RNA linked to treatment, by setting, during this reporting period

- The purpose of this section is to assess hepatitis C testing in high-impact settings. These are short-term outcomes (years 1–3).
- Stratify by setting (one row per setting). Choose the appropriate setting from the drop-down list. Report data for all collaborating settings.

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- **Clients screened for anti-HCV** — Report the total number of clients (from 2.2.2.b) who were screened for anti-HCV antibody. Anti-HCV tests may include rapid point-of-care tests.
- **Clients positive for anti-HCV** — Of clients who tested for anti-HCV antibody (from 2.2.2.c), report the number of clients who were positive for anti-HCV antibody.
- **Clients tested for HCV RNA** — Of clients who tested positive for anti-HCV antibody (from 2.2.2.d), report the number of clients who were tested for HCV RNA.
- **Clients positive for HCV RNA** — Of clients who were tested for HCV RNA (from 2.2.2.e), report the number of clients who had a positive result for HCV RNA. This includes test results that are detectable but not quantifiable.
- **Clients positive for HCV RNA linked to hepatitis C treatment** — Of clients who had a positive HCV RNA result (Measure 2.2.2.f), report the number who were linked to hepatitis C treatment. **Linkage** is defined as provision of medical care at the facility or attendance at the initial visit to evaluate for medical treatment of hepatitis C. “Referral” could have a variety of meanings and does not count as “linkage.” Successful linkage can be documented by review of records or direct report by a peer navigator or other reliable means.
- Include total number of settings and total for each column across all settings in last row of table.
- See pages 20 in the Notice of Funding Opportunity (CDC-RFA-PS21-2103) for more information.

Measures 2.2.2.g - h and 2.2.3.b

Number of clients screened for hepatitis B, by setting, during this reporting period

Number of clients positive for HBsAg, by setting, during this reporting period

Number of clients positive for HBsAg linked to care, by setting, during this reporting period

- The purpose of this section is to assess hepatitis B testing in high-impact settings. These are short-term outcomes (years 1–3).
- Stratify by setting (one row per setting). Choose the appropriate setting from the drop-down list. Report data for all collaborating settings.
- **Clients screened for hepatitis B** — Report the total number of clients (from 2.2.2.b) who were screened for hepatitis B, defined as receipt of testing for all of the following:
 - Total anti-hepatitis B core antibody (total anti-HBc)
 - Hepatitis B surface antigen (HBsAg); and
 - Hepatitis B surface antibody (anti-HBs).
- **Clients positive for HBsAg** — Of clients who were screened for hepatitis B (from 2.2.2.g), report the number who had a positive test result for hepatitis B surface antigen (HBsAg).
- **Clients positive for HBsAg linked to hepatitis B care** — Of clients who had a positive HBsAg result (Measure 2.2.2.h), report the number who were linked to hepatitis B care. **Linkage** is defined as provision of medical care at the facility or attendance at the initial visit to evaluate for medical treatment for hepatitis B. “Referral” could have a variety of meanings and does not count as “linkage.” Successful linkage can be documented by review of records or direct report by a peer navigator or other reliable means.
- Include total number of settings and total for each column across all settings in last row of table.
- See pages 20 in the Notice of Funding Opportunity (CDC-RFA-PS21-2103) for more information.

2.3—Improve access to services preventing viral hepatitis and other bloodborne infections among people who inject drugs (PWID)

Was Section 2.3 funded?

- If your jurisdiction was not funded for activities described under 2.3, check No and stop here. Do not complete measures beginning 2.3.
- If your jurisdiction was funded for activities described under 2.3, check Yes and complete the rest of this form.

Measures 2.3.3.a - 2.3.3.d

Number of hepatitis A vaccination doses administered, by setting, during this reporting period

Number of clients who completed hepatitis A vaccination series, by setting, during this reporting period

Number of hepatitis B vaccination doses administered, by setting, during this reporting period

Number of clients who completed hepatitis B vaccination series, by setting, during this reporting period

- These are short-term outcomes (years 1–3).
- Stratify by setting (one row per setting). Choose the appropriate setting from the drop-down list. Report data for all collaborating settings.
- **Hepatitis A vaccination doses administered** — Report total doses of any hepatitis A vaccine (single antigen or combination) administered.
- **Clients who completed hepatitis A vaccination series** — Report the number of clients (from 2.2.2.b) who received the final dose of a complete hepatitis A vaccine series.
- **Hepatitis B vaccination doses administered** — Report total doses of any hepatitis B vaccine (single antigen or combination) administered.
- **Clients who completed hepatitis B vaccination series** — Report the number of clients (from 3.1.1.a) who received the final dose of a complete hepatitis B vaccine series.
- Include total number of settings and total for each column across all settings in last row of table.
- See page 22 in the Notice of Funding Opportunity (CDC-RFA-PS21-2103) for more information.

Measure 2.3.1.a

List syringe services programs (SSPs) in the jurisdiction

- This is a short-term outcome (years 1–3).
- **Syringe services programs (SSPs)** — List the collaborating SSPs in your jurisdiction by name. The total number of rows equals the number of jurisdictions. Stratify by SSP (one row per SSP).
- Include total number of SSPs in last row of table.
- See pages 20–21 in the Notice of Funding Opportunity (CDC-RFA-PS21-2103) for more information.

Measure 2.3.1.b and 2.3.1.c

Number of client visits, by SSP, during this reporting period

Number of unduplicated SSP clients, by SSP, during this reporting period

- This is a short-term outcome (years 1–3).
- Stratify by SSP (one row per SSP). Report data for all collaborating SSPs.
- **Number of client visits** — Report the number of client visits to each collaborating SSP during the reporting period.

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- **Number of unduplicated SSP clients** — Report the unduplicated count of clients seen at least once in each collaborating SSP during the reporting period.
- Include total for each column across all SSPs in last row of table.
- See pages 20–21 in the Notice of Funding Opportunity (CDC-RFA-PS21-2103) for more information.

Measure 2.3.1.d

During this reporting period, number of clients linked to substance use disorder treatment, by SSP

- This is a short-term outcome (years 1–3).
- Stratify by SSP (one row per SSP). Report data for all collaborating SSPs.
- **Clients linked to substance use disorder treatment** — Report the total number of SSP clients (from 2.1.3.c) who were linked to substance use disorder treatment. **Linkage** is defined as attendance at an initial visit to evaluate for medical treatment for substance use disorder. “Referral” could have a variety of meanings and does not count as “linkage.” Successful linkage can be documented by review of records or direct report by a peer navigator or other reliable means.
- **Treatment** is defined as any treatment, behavioral or medical or a combination, for substance use disorder under the care of a licensed provider.
- **Substance use disorder** is defined as a pathologic pattern of behaviors in which patients continue to use a substance despite experiencing significant problems related to its use. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM 5) gives 11 criteria divided into 4 categories.
 - **Impaired control over use**
 - The person takes the substance in larger amounts or for a longer time than originally planned
 - The person desires to stop or cut down use of the substance
 - The person spends substantial time obtaining, using, or recovering from the effects of the substance
 - The person has an intense desire (craving) to use the substance
 - **Social impairment**
 - The person fails to fulfill major role obligations at work, school, or home
 - The person continues to use the substance even though it causes (or worsens) social or interpersonal problems
 - The person gives up or reduces important social, occupational, or recreational activity because of substance use
 - **Risky use**
 - The person uses the substance in physically hazardous situations (eg, when driving or in dangerous social circumstances)
 - The person continues to use the substance despite knowing it is worsening a medical or psychologic problem
 - **Pharmacologic symptoms***
 - **Tolerance:** The person needs to progressively increase the drug dose to produce intoxication or the desired effect, or the effect of a given dose decreases over time
 - **Withdrawal:** Untoward physical effects occur when the drug is stopped or when it is counteracted by a specific antagonist

* Note that some drugs, particularly opioids, sedative/hypnotics, and stimulants, can result in tolerance and/or withdrawal symptoms even when taken as prescribed for legitimate medical reasons. Withdrawal symptoms that develop following appropriate medical use do not count as criteria for diagnosis of a substance use disorder.

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People with two or more of the 11 criteria within a 12-month period are considered to have a substance use disorder. **Mild substance use disorder** is defined as meeting 2 to 3 criteria. **Moderate substance use disorder** is defined as meeting 4 to 5 criteria. **Severe substance use disorder** is defined as ≥ 6 criteria

Source: <https://www.merckmanuals.com/professional/psychiatric-disorders/substance-related-disorders/substance-use-disorders>

- Include total number of clients linked to substance use disorder treatment across all SSPs in last row of table.
- See pages 20–21 in the Notice of Funding Opportunity (CDC-RFA-PS21-2103) for more information.

Measure 2.3.2.a

During this reporting period, mean (median) syringe coverage rates during this reporting period, by SSP

- This is a short-term outcome (years 1–3).
- Stratify by SSP (one row per SSP). Report data for all collaborating SSPs.
- **Mean (median) syringe coverage rates** — Report the percentage of injecting episodes covered by the acquisition of a sterile syringe for SSP clients (from 2.1.3.c) from collaborating SSPs. Coverage of needle and syringe distribution is an important dimension in measuring the effectiveness of programs.
- An individual-level measure of coverage calculates the percentage of injecting episodes covered by the acquisition of a sterile syringe for each person who injects drugs. Formalized methods of calculating individual-level coverage are relatively recent. For more information, see:
 - [Measures of harm reduction service provision for people who inject drugs](#) (World Health Association)
 - [Needle and syringe programme: coverage calculator](#) (Harm Reduction Works)
- Include overall mean (median) syringe coverage rate across all SSPs in last row of table.
- See pages 20–21 in the Notice of Funding Opportunity (CDC-RFA-PS21-2103) for more information.