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CDC-RFA-PS-24-0003 Support and Scale-Up of HIV Prevention Services in Sexual Health Clinics (SHIPS) Data Entry Guide

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Purpose of Guidance Document

This document provides data entry/reporting guidance to sexual health clinics (SHCs) participating in the Division of Sexually Transmitted Disease Prevention's (DSTDP) CDC-RFA-PS-24-0003 Support and Scale-Up of HIV Prevention Services in Sexual Health Clinics (or SHIPS).

CDC-RFA-PS-24-0003, or SHIPS, has two required strategies. Recipients must address both Strategies A and B.

- Strategy A: Strengthen clinic infrastructure and improve service delivery to address the syndemic of HIV and other STIs. There are four required activities associated with Strategy A.
- Strategy B: Foster strategic partnerships in support of the EHE initiative. There are three required activities associated with Strategy B.

Recipients should familiarize themselves with these required strategies and activities by referring to the CDC-RFA-PS-24-0003 Notice of Funding Opportunity. Recipients will enter planned strategy and activity implementation information into their work plans. Performance measure monitoring will help the CDC and recipients understand where reality deviated from plans and the proximal benefit of implemented work.

This document will provide clarification on SHIPS data collection which feeds directly into SHIPS performance monitoring (for additional information on SHIPS performance measures, see the **Performance Measure Guidance** document). The **Data Entry Guidance** document (this document) reviews how to report base data used to calculate performance measures, covers key definitions to aid in data entry, and covers concepts related to reporting such as best practices for data abstraction processes. **The Data Entry Guidance document should be thoroughly reviewed before reporting and submitting these data through REDCap**.

Overarching Responsibilities/Activities of SHIPS Collaborators

As part of SHIP's monitoring and evaluation efforts, collaborating partners will maintain compliance with agreed-upon data reporting and data management standards, agree to consensus schedules for reporting, and commit to ongoing data quality assurance.

Fidelity to Data Collection

Adherence to reporting guidance, data definitions and recommendations for reporting is important for assuring fidelity of data while maintaining comparability across all participating clinics. To ensure the accuracy of data and efficiency of extraction after data submission, recipients will use the applicable REDCap instruments. REDCap will be open for data submission at least once month prior to the submission due date.

Further, recipients are expected to maintain SAMS and REDCap access for any persons responsible for submitting data to the CDC. Should there be changes to staffing, recipients must notify their assigned Project Officer and Evaluation Officer so that appropriate access levels may be maintained within reporting systems.

Continuous quality improvement is of utmost importance in a clinic setting as it ensures that patient care remains at the highest standard. CDC will not require electronic medical record (EMR) systems to be altered (recipients will have the option to indicate whether data is or is not available), however, by regularly updating the EMR system, healthcare providers can enhance accuracy, efficiency, and overall patient outcomes. Updating the clinic EMR allows for the incorporation of new medical knowledge and best practices, ensuring that healthcare professionals have access to the most up-to-date information when making critical decisions about patient care.

Adherence to Data Security & Confidentiality Requirements

SHIPS reporting will be completed in the aggregate; **no individual, patient-level records will be made available to CDC**. Collaborating clinics may or may not be affiliated with public health departments, and from this perspective are considered covered entities under HIPAA regulation. However:

> *"Without individual authorization, a covered entity may disclose protected health information to a public health authority that is legally authorized to collect or receive the information for the purposes of preventing or controlling disease, injury, disability including, but not limited to reporting of disease...and conducting public health surveillance…" (MMWR, 2003).*

DSTDP programs value the principles embodied in these protections and strive to establish and maintain the highest level of performance in protecting the confidentiality and security of all information. Aggregate data reported to CDC must not contain personal identifiers such as name, social security number, date of birth, street address, or medical record number.

Unique, personally identified clinic visit, patient and laboratory information are critical for the success of these reporting activities at the clinic level and should be extracted into clinic-maintained databases or a set of related tables from which aggregate reporting is exported. To do this reliably, *the unique identifiers associated with individual patients and related health events must be maintained over the full SHIPS project period.*

CDC Roles/Responsibilities

Upon receipt of recipient data submissions, CDC will individually check for completeness and obvious errors or omissions, with rapid follow-up to the sender if needed. Files received from clinics will be stored in a secure shared drive at CDC with limited access only for staff working on this initiative. Using standard data management techniques, the clinic-level information will be merged into a single data file, resulting in a dataset including all clinics' data for a particular reporting period. This dataset will be further checked and reviewed prior to analysis, to identify any issues that require follow-up with recipients.

Substantial involvement by CDC collaborators include:

- Facilitation of routine communications
- Provision of infrastructure for secure transport and storage of aggregate reports to CDC
- Provision of technical assistance and training (limited, targeted)
- Summary and aggregate reporting to CDC leadership, clinic collaborators and external stakeholders

Clinic-Based Data Aggregation Activities

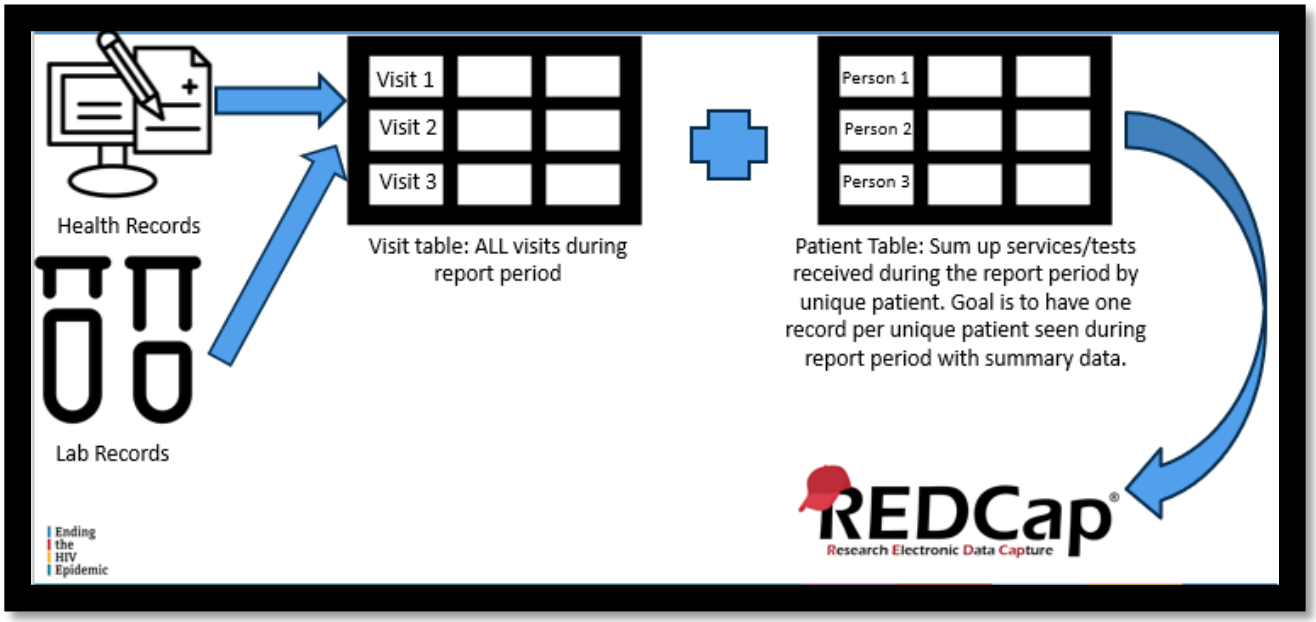
Collaborating sexual health clinics are expected to have (or to develop) the capacity to extract record-level data from existing clinic health record systems for aggregating patient visit and laboratory data. Clinics are expected to develop their own local processes to manipulate, map and re-code data from their EHR/EMR into new variables for aggregate reporting at specified frequencies. Clinics will be responsible for creating tables, maintaining an archive of required datasets for reporting using locally available resources (Excel, SAS, Access, SPSS, SQL, etc.), and running simple pivots/frequencies needed to produce data for aggregate reporting back to the CDC.

Sexual Health Clinic Data Management

Each sexual health clinic will likely have different electronic health records and have data systems that have been developed and modified over time to fit their particular clinical practice environment. No single solution will fit the data management requirements across all reporting sexual health clinics. However, to successfully complete reporting for SHIPS, recipients will likely need to maintain at minimum two master datasets at the local level.

1) **Visit table**: Visit-level records in the clinic's EHR will populate this table. This table will include all visits that occurred within the reporting period. A departure from EHE Component C, this table will be used to collect information on patient visit volume, STI test volume, and HIV test volume.
2) **Patient table**: The primary source for reporting is a list of the *unique* persons who visited the clinic at least once during the reporting period. Some patients will have multiple visits and you will need to use the patient ID (medical record number, client ID, patient ID, etc.) to develop a list/panel with a single row for each patient.

Some data (e.g., PrEP referral/utilization) may come from separate record-keeping systems and clinics would use the patient ID or name to merge into a single record for each patient. This high-level scheme is diagrammed below.



Reporting Schedule

Here below recipients will find the SHIPS reporting frequency and data submission schedule, by REDCap instrument.

Reporting Frequency & Data Submission Schedule

Recipients should carefully review the table below and set a reminder for the reporting periods referenced. CDC will send specific guidance to recipients ahead of each major reporting deadline.

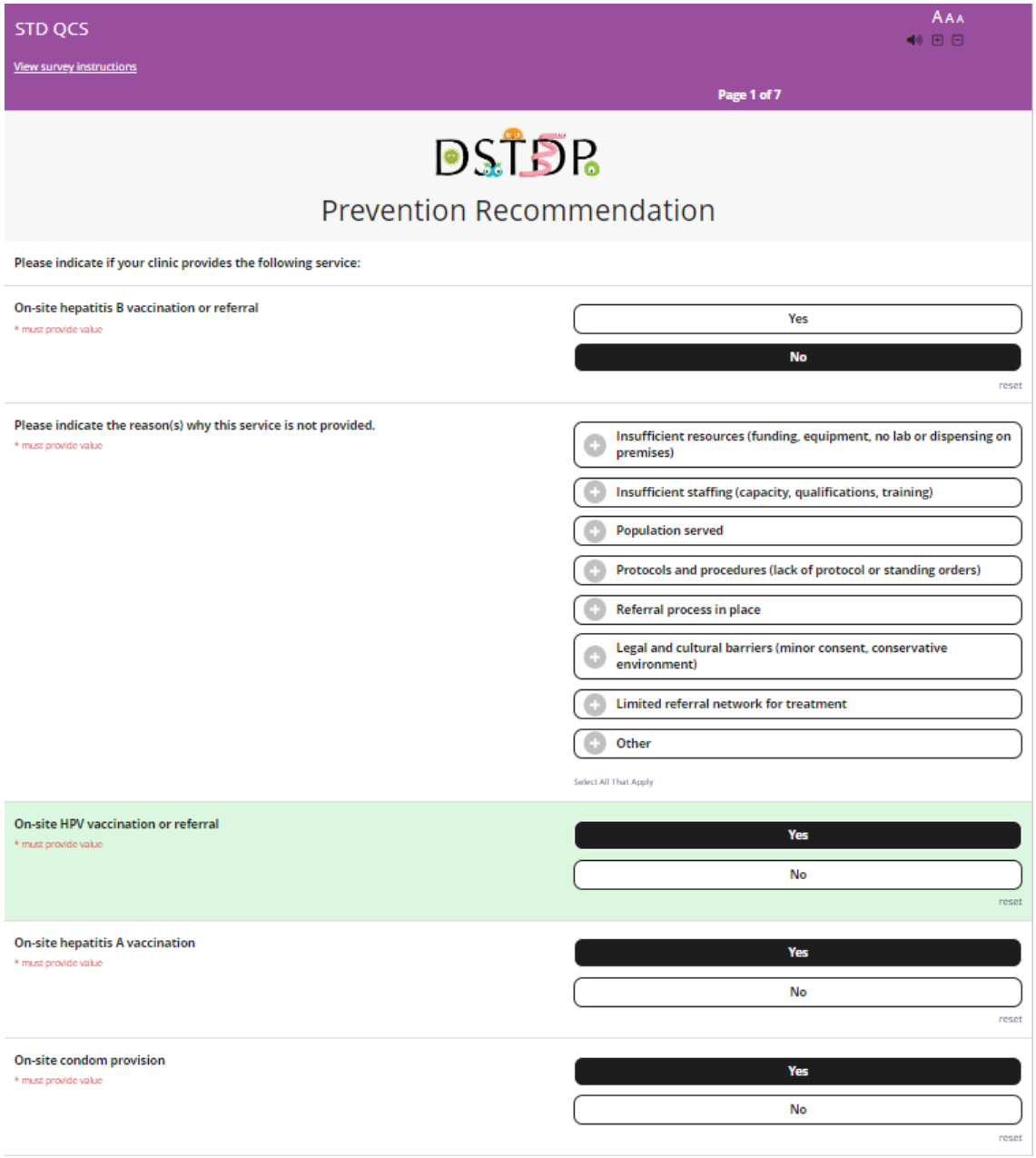
PS24-0003 (SHIPS) Instrument Reporting Schedule Note: If the reporting deadline falls on a weekend, slight adjustments may be made and communicated to recipients as needed.				
Instrument	**Frequency of Reporting to the CDC**	**Platform to be Used to Report to CDC**	**When Report Due to CDC**	**Reporting Note**
STD-QCS Assessment	Collected annually with the first submission being the most extensive to complete.	REDCap	Due at application submission and 9/1 annually beginning 9/1/25.	Recipients will receive a copy of their previous year's submission to aid in data entry for the current year.
Annual Performance Measures	Collected annually.	REDCap	Due annually beginning 9/1/25.	Look-back period of one year.
Biannual Performance Measures	Collected biannually.	REDCap	First biannual collection to occur 3/1/25 with subsequent submissions due 9/1 and 3/1 of each year.	9/1 submissions will use a look-back period of January 1 to June 30. 3/1 submissions will use a look-back period of July 1 to December 31 (with the exception of the first submission occurring on 3/15/25).
Annual Partnerships	Collected annually, as needed.	REDCap	9/1 annually if changes are present beginning 9/1/25.	Collection only triggered if recipients indicate a change in partnerships.

STD-QCS:

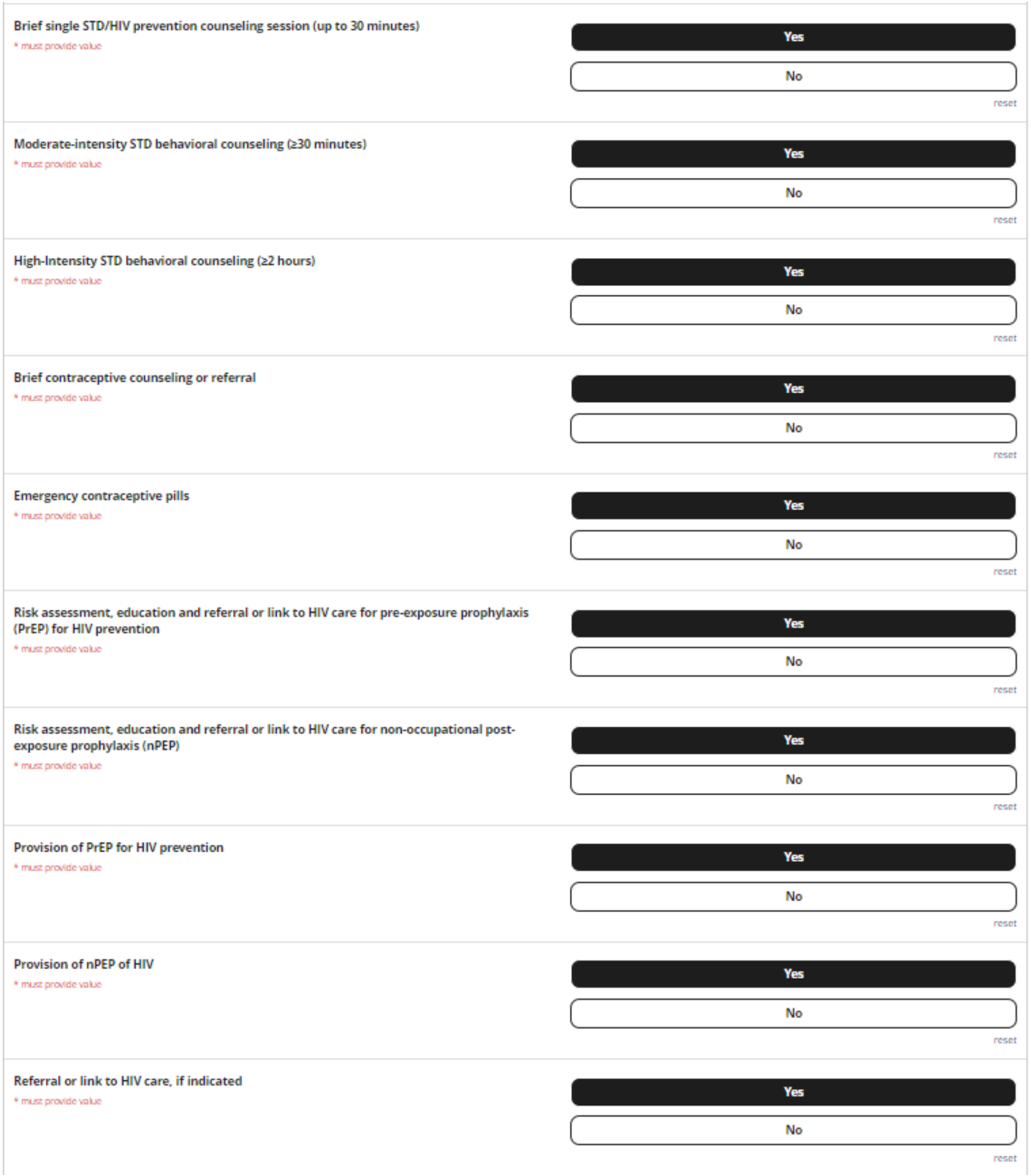
The Recommendations for Providing Quality Sexual health clinical Services (or STD QCS) is the roadmap that bolsters SHIPS. The STD-QCS highlights the services healthcare settings can offer to provide the highest-quality STD care to their patients. The recommendations are **designed to go hand-in-hand with the STI Treatment Guidelines** – STD QCS can help guide clinical operations, while the Treatment Guidelines focus on the clinical management of patients. Healthcare professionals can use the recommendations to identify opportunities to build, maintain, or enhance the delivery of their services.

The National Association of County and City Health Officials, or NACCHO, in partnership with the CDC, created the Planning Toolkit for Using CDC's Recommendations for Providing Quality Sexually Transmitted Diseases Clinical Services, which operationalizes CDC's STD-QCS by guiding clinical settings through assessing their currently offered STD services. It provides tools and resources for supporting decision-making regarding additional service provision for addressing identified service gaps.

The STD QCS comprises recommendations that are separated into eight service categories. Clinics will use the assessment tool and assessment summary to review and document in REDCap which of the services outlined in the STD QCS are or are not provided in clinic. Recipients should note that a screenshot of the STD-QCS instrument is provided on the left-hand side of the pages that follow while key definitions are to the right. STD-QCS definitions are associated with MMWR guidance and as such are set until or if guidance is updated.



If 'No' is selected for any service, a select all that applies picklist will appear. Recipients may then select reasons the service is not provided in clinic.



Brief single STD/HIV prevention counseling session (up to 30 minutes): Brief prevention counseling is conducted in a single session using strategies, such as motivational interviewing and building rapport, and includes patient circumstances and needs in the counseling plan. Moderate-intensity and high-intensity behavioral counseling is contact time of 30–120 minutes and ≥2 hours, respectively.

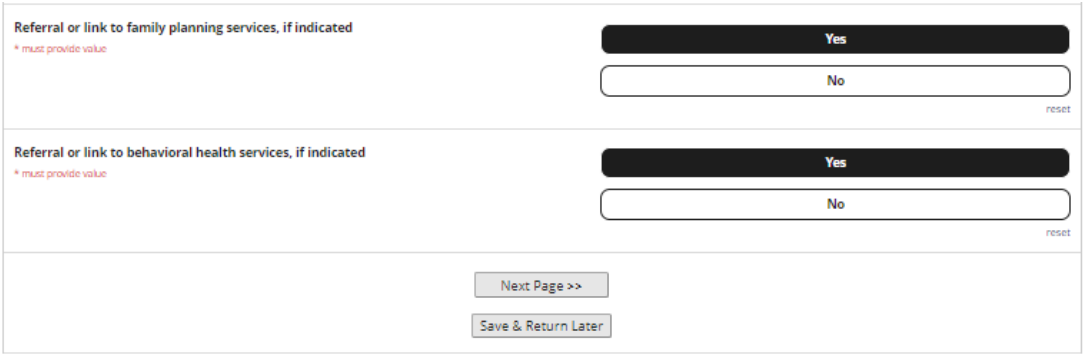
Moderate-intensity STD behavioral counseling (≥30 minutes): Brief prevention counseling is conducted in a single session using strategies, such as motivational interviewing and building rapport, and includes patient circumstances and needs in the counseling plan. Moderate-intensity and high-intensity behavioral counseling is contact time of 30–120 minutes and ≥2 hours, respectively.

High-intensity STD behavioral counseling (≥2 hours): Brief prevention counseling is conducted in a single session using strategies, such as motivational interviewing and building rapport, and includes patient circumstances and needs in the counseling plan. Moderate-intensity and high-intensity behavioral counseling is contact time of 30–120 minutes and ≥2 hours, respectively.

Risk assessment, education and referral or link to HIV care for pre-exposure prophylaxis (PrEP) for HIV prevention: Provided by a clinician or other appropriately trained staff.

Risk assessment, education and referral or link to HIV care for non-occupational post-exposure prophylaxis (nPEP): Provided by a clinician or other appropriately trained staff.

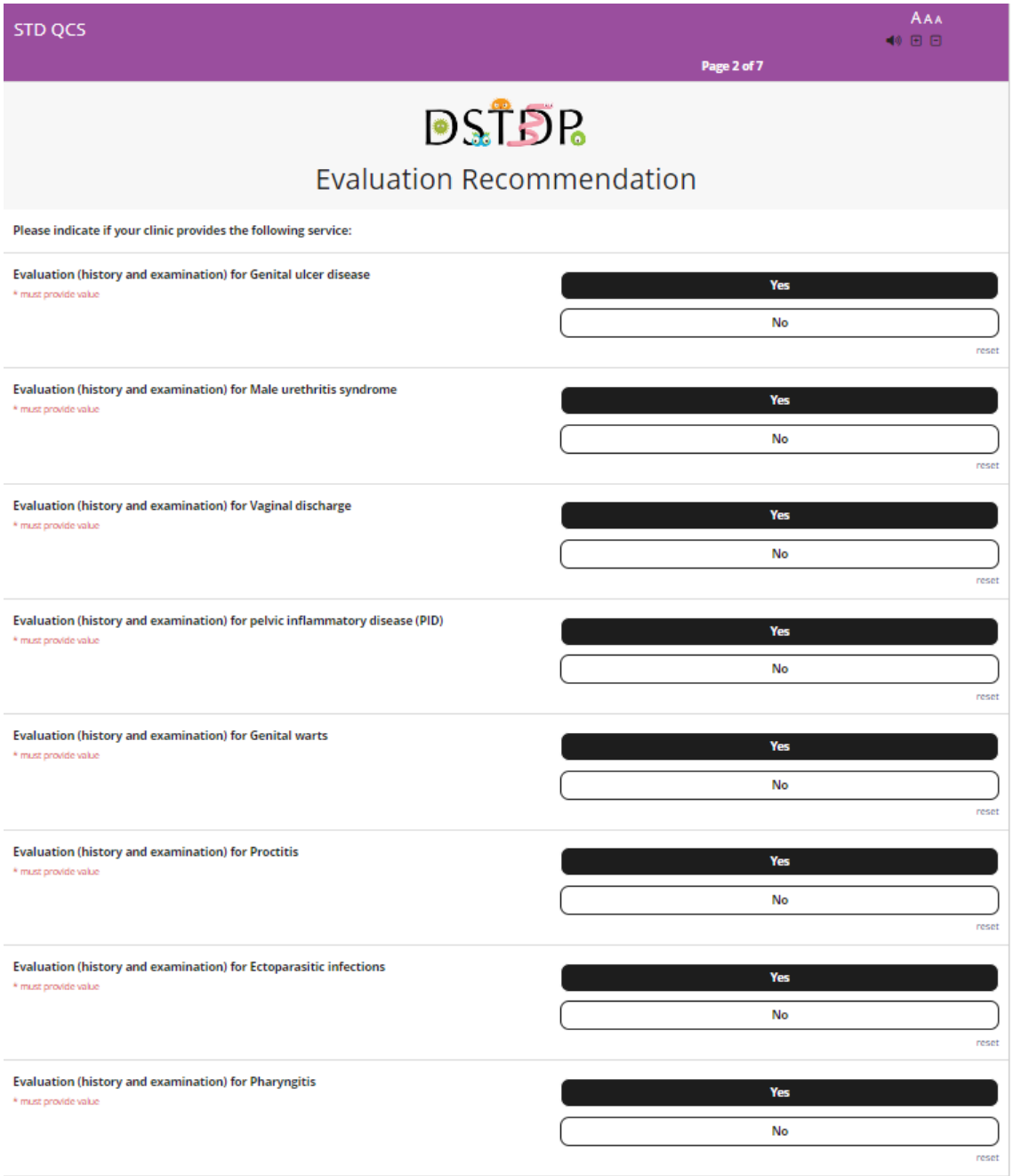
Emergency contraceptive pills: If emergency contraceptive pills are not available on site or by prescription, patients can be advised that levonorgestrel emergency contraceptive pills are available over the counter and ulipristal acetate emergency contraceptive pills are only available by prescription. Emergency contraceptive pills should be taken as soon as possible within 5 days of unprotected sex.



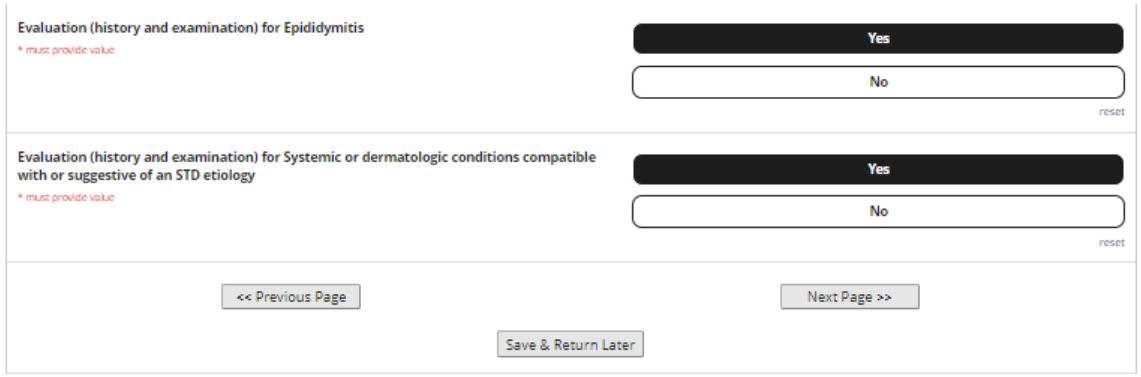
On-site condom provision: Providers can partner with local organizations, such as the local health department and community-based organizations, to procure condoms. In some states, prescriptions can be written for condoms. For certain settings, such as family planning clinics, condoms should be available on-site.

Provision of PrEP for HIV prevention: Specialized STD Care: PrEP should be available in starter packs or by prescription with on-site follow-up care for specialized STD care. If PrEP is not provided, navigator-assisted referral for PrEP should be provided with first appointment made while the patient is on site.

Provision of nPEP of HIV: Specialized STD Care: nPEP starter pack (3–7 days of medication) should be available on site, with either on-site follow-up care or referral to specialized STD care. nPEP complete 28-day course should be available by prescription, with either on-site follow-up care or referral, with first appointment made while the patient is on site. Provision of the complete 28-day nPEP medication supply at the initial visit rather than a starter pack of 3–7 days has been reported to increase likelihood of adherence, especially when patients find returning for multiple follow-up visits difficult.



Proctitis: Evaluation for proctitis might include visual examination of the anus, anorectal examination with a rectal swab, digital anorectal exam, or anoscopy. For specialized STD care, high-resolution anoscopy might be included.


Evaluation (history and examination) for Epididymitis
* must provide value
Yes
No
reset
Evaluation (history and examination) for Systemic or dermatologic conditions compatible with or suggestive of an STD etiology
* must provide value
Yes
No
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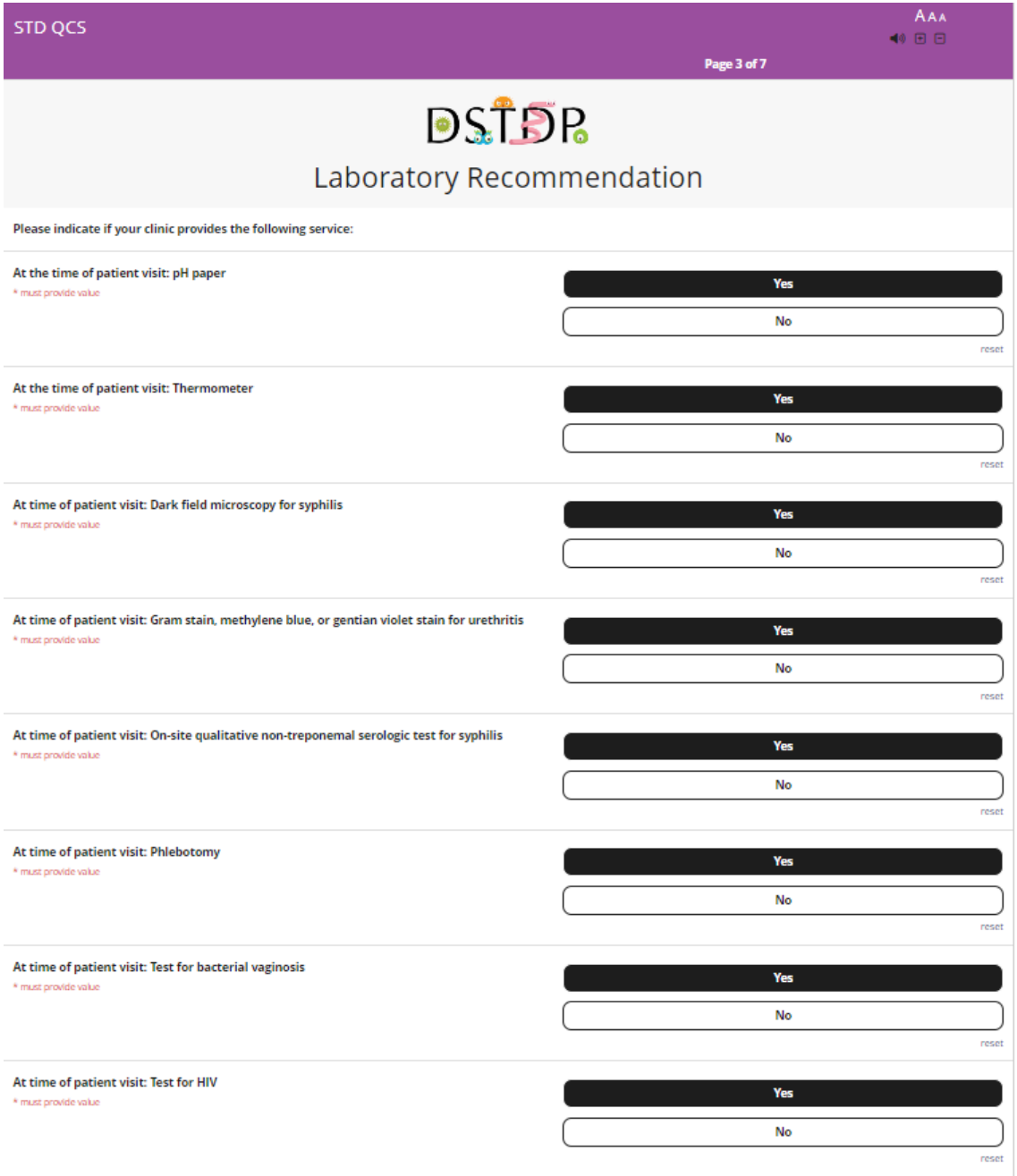
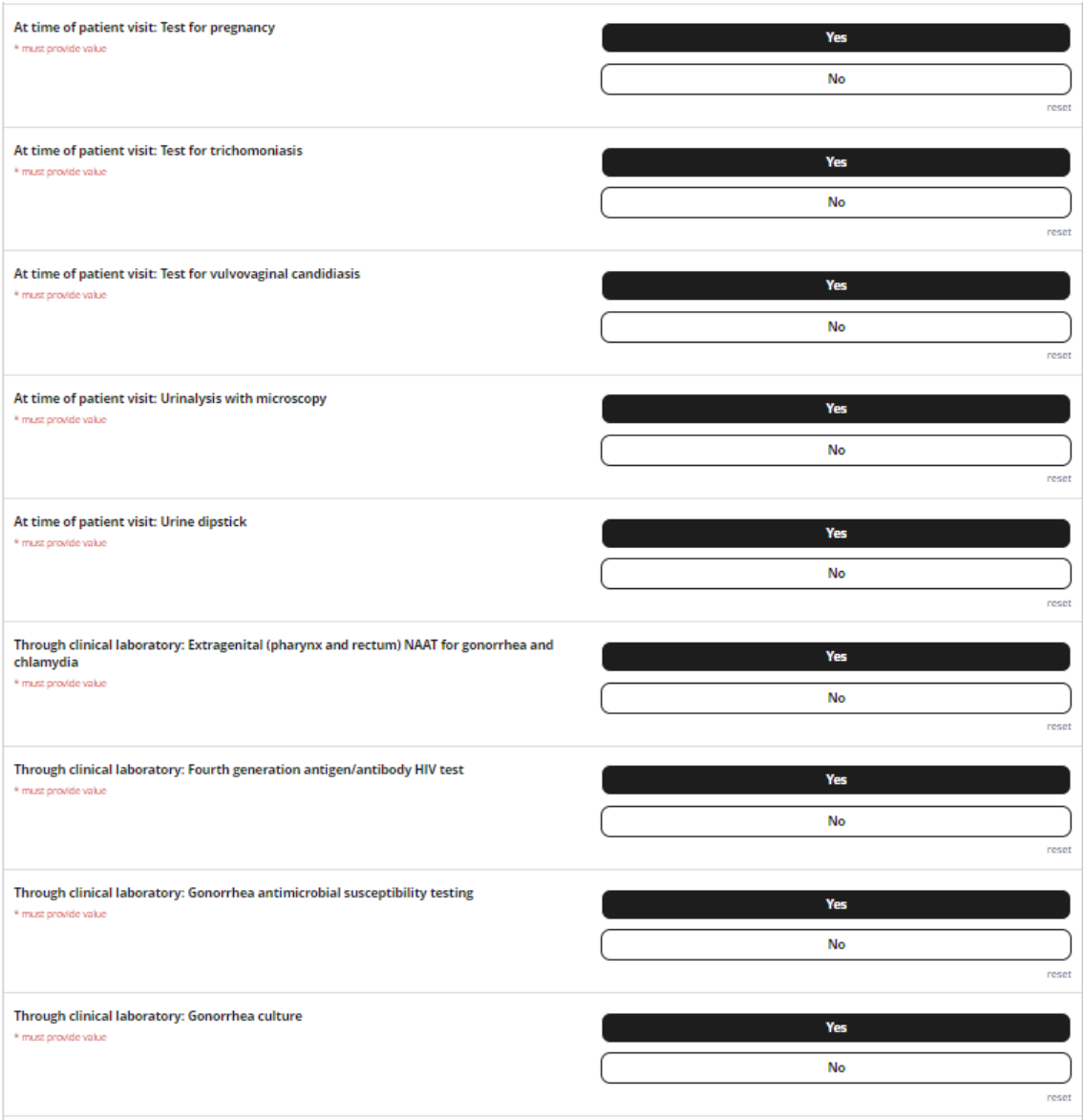


At the time of patient visit: "At the time of patient visit" refers to providing a service the same day of the patient encounter. The intent is for a patient to receive test results prior to the conclusion of a clinic visit to ensure same day diagnosis and initiation of treatment as needed.

Test for trichomoniasis: On-site test for trichomoniasis can include wet mount microscopy and OSOM® Trichomonas.

Test for bacterial vaginosis: On-site test for bacterial vaginosis can include wet mount microscopy, OSOM® BVBlue®, and Affirm™.



Test for vulvovaginal candidiasis: On-site test for vulvovaginal candidiasis can include wet mount microscopy.

Gonorrhea antimicrobial susceptibility testing: Access needs to be established for transport medium that adequately maintains the viability of Neisseria gonorrhoeae until the specimen reaches a laboratory (e.g., transport medium in transport container, transport system, or transport swab). Providers should contact their state or local health department if they have concerns about resistant N. gonorrhoeae infection or if assistance is required for culture and antimicrobial susceptibility testing.

Through clinical laboratory: Gram stain, methylene blue, or gentian violet stain for urethritis
* must provide value

Yes
No
reset

Through clinical laboratory: HSV serology
* must provide value

Yes
No
reset

Through clinical laboratory: HSV viral culture or PCR
* must provide value

Yes
No
reset

Through clinical laboratory: NAAT for trichomoniasis
* must provide value

Yes
No
reset

Through clinical laboratory: Laboratory tests needed for providing nPEP and PrEP, as per clinical protocol
* must provide value

Yes
No
reset

Through clinical laboratory: Oncogenic HPV NAATs with Pap smear
* must provide value

Yes
No
reset

Through clinical laboratory: Quantitative nontreponemal serologic test for syphilis
* must provide value

Yes
No
reset

Through clinical laboratory: Serologic tests for hepatitis A
* must provide value

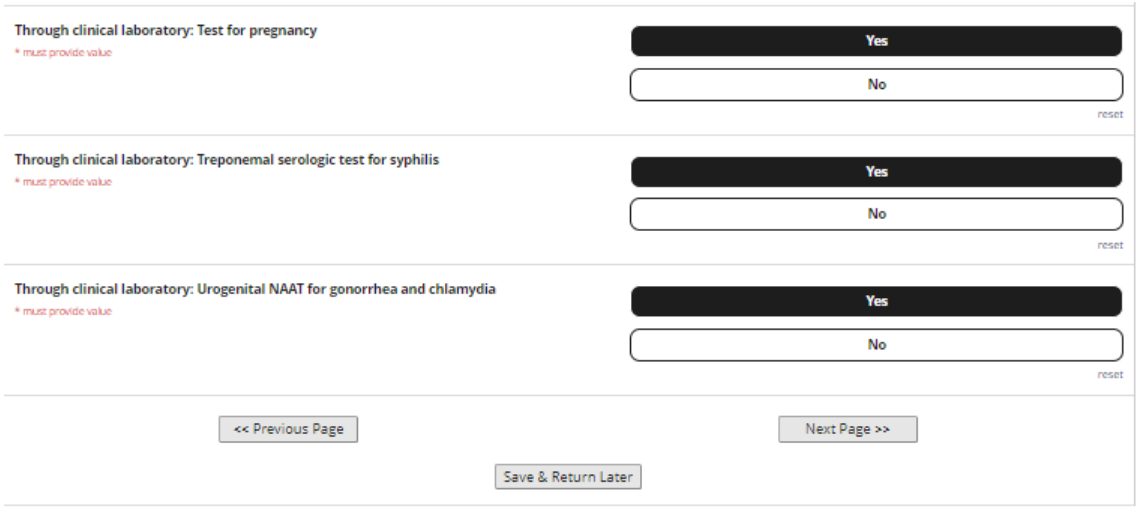
Yes
No
reset

Through clinical laboratory: Serologic tests for hepatitis B
* must provide value

Yes
No
reset

Through clinical laboratory: Serologic tests for hepatitis C
* must provide value

Yes
No
reset


Through clinical laboratory: Test for pregnancy
* must provide value
Yes
No
reset
Through clinical laboratory: Treponemal serologic test for syphilis
* must provide value
Yes
No
reset
Through clinical laboratory: Urogenital NAAT for gonorrhea and chlamydia
* must provide value
Yes
No
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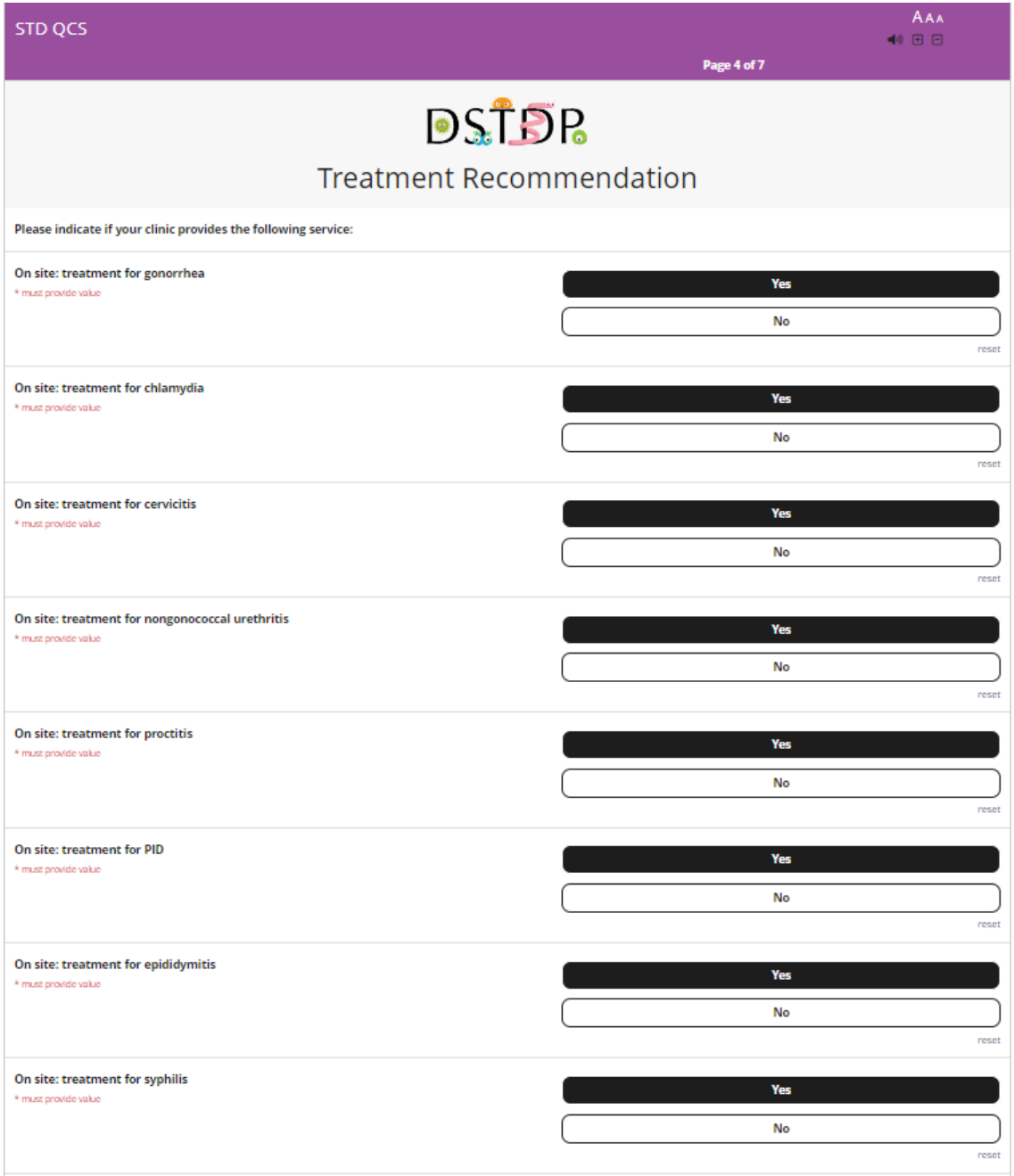
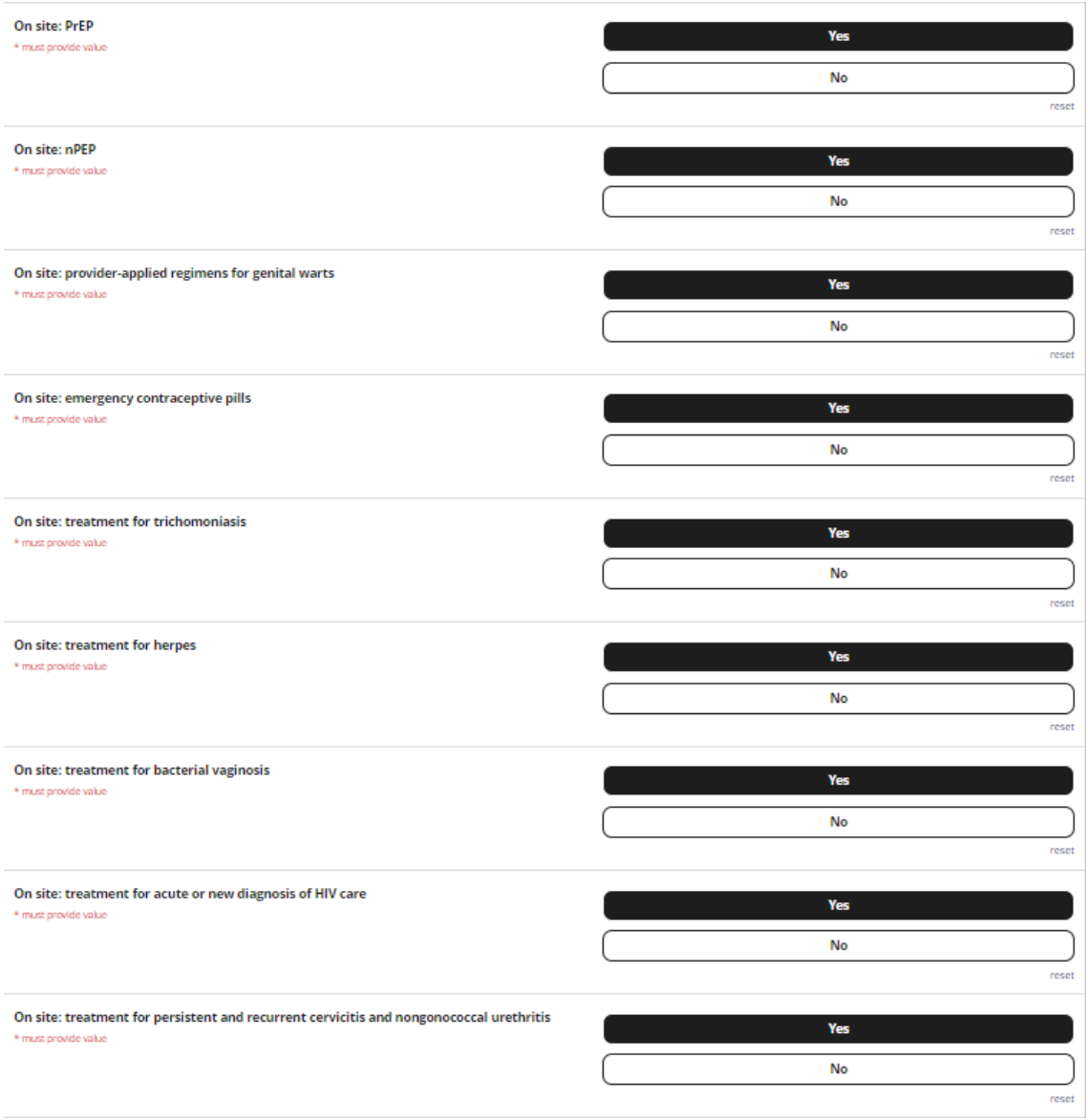


Gonorrhea: Providers might not receive reimbursement for oral medications without an on-site pharmacy. Providers can partner with local organizations, such as the local health department and community-based organizations, to procure oral medications or refer patients to local organizations.

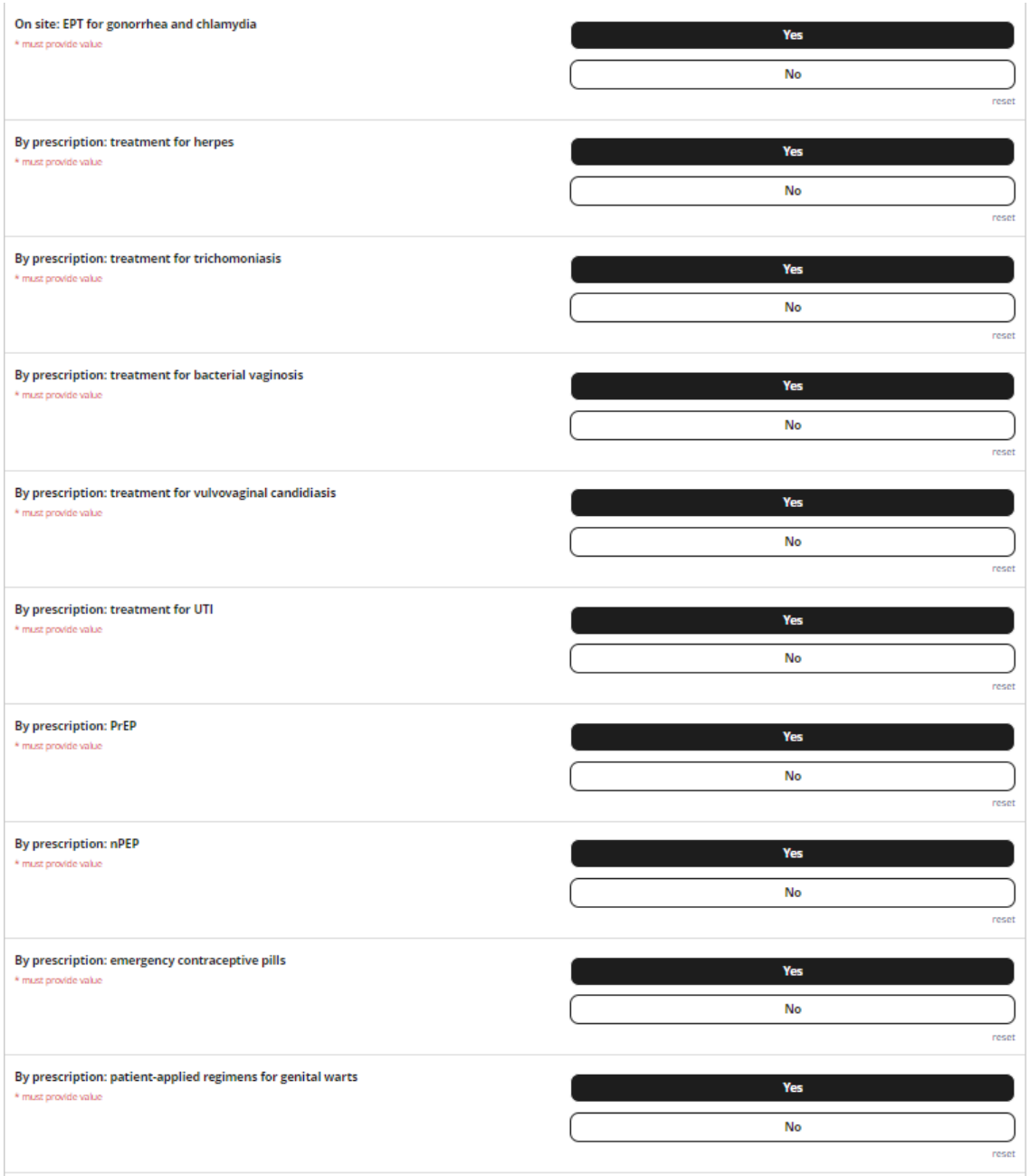
Chlamydia: Providers might not receive reimbursement for oral medications without an on-site pharmacy. Providers can partner with local organizations, such as the local health department and community-based organizations, to procure oral medications or refer patients to local organizations.

Nongonococcal urethritis: Providers might not receive reimbursement for oral medications without an on-site pharmacy. Providers can partner with local organizations, such as the local health department and community-based organizations, to procure oral medications or refer patients to local organizations.

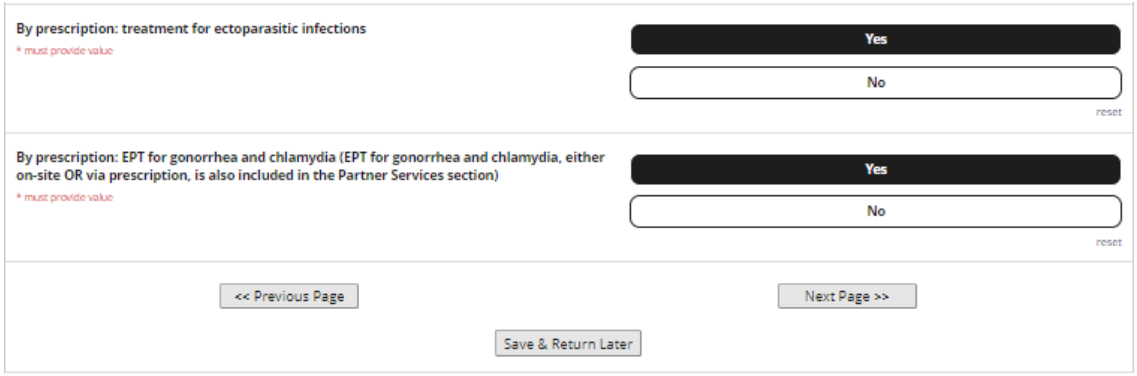
Syphilis: Providers can partner with local health departments to procure injectable benzathine penicillin G or refer patients to local health department and verify treatment.



Emergency contraceptive pills: If emergency contraceptive pills are not available on-site or by prescription, patients can be advised that levonorgestrel emergency contraceptive pills are available over the counter and ulipristal acetate emergency contraceptive pills are only available by prescription. Emergency contraceptive pills should be taken as soon as possible within 5 days of unprotected sex.



EPT for gonorrhea and chlamydia: Information on the legal status of EPT for each state is available at https://www.cdc.gov/std/ept/legal/default.htm.



EPT for gonorrhea and chlamydia: Information on the legal status of EPT for each state is available at https://www.cdc.gov/std/ept/legal/default.htm.

DSTDP

Sexual History and Physical Exam Recommendation

Please indicate if your clinic provides the following service:

A sexual history and risk assessment as part of initial comprehensive or annual visit
* must provide value

Yes
No
reset

A sexual history and risk assessment at each visit concerning reproductive, genital, or urological issues
* must provide value

Yes
No
reset

A sexual history and risk assessment at each visit unrelated to reproductive, genital, or urologic concerns
* must provide value

Yes
No
reset

A sexual history and risk assessment at every visit for patients with STD-related symptoms, STD-related concerns, or concerns about preventing or achieving pregnancy
* must provide value

Yes
No
reset

A physical examination for male and female patients with STD-related symptoms, STD-related concerns, or those at high behavioral risk for incident STDs
* must provide value

Yes
No
reset

A pelvic examination
* must provide value

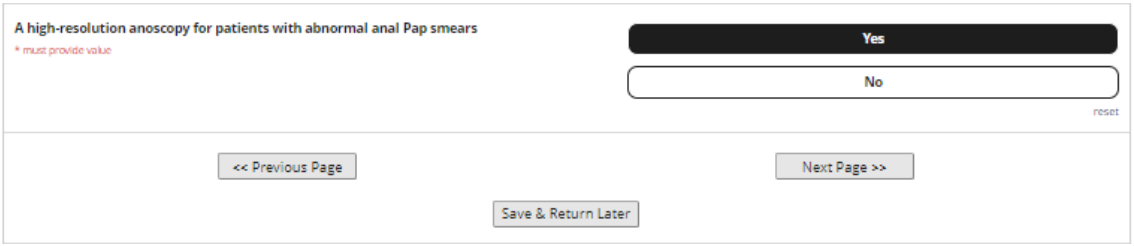
Yes
No
reset

Colposcopy for female patients with abnormal Pap smears
* must provide value

Yes
No
reset

Anoscopy
* must provide value

Yes
No
reset


A high-resolution anoscopy for patients with abnormal anal Pap smears
* must provide value
Yes
No
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STD QCS

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DSTDP

Screening Recommendation

Please indicate if your clinic provides the following service:

Gonorrhea screening
* must provide value

Yes
No
reset

Chlamydia screening
* must provide value

Yes
No
reset

Syphilis screening
* must provide value

Yes
No
reset

Hepatitis B screening
* must provide value

Yes
No
reset

Hepatitis C screening
* must provide value

Yes
No
reset

HIV screening
* must provide value

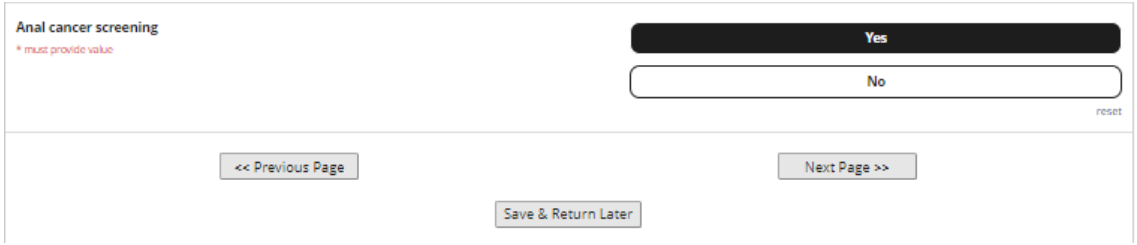
Yes
No
reset

Cervical cancer screening
* must provide value

Yes
No
reset

Trichomoniasis screening
* must provide value

Yes
No
reset


Anal cancer screening
* must provide value
Yes
No
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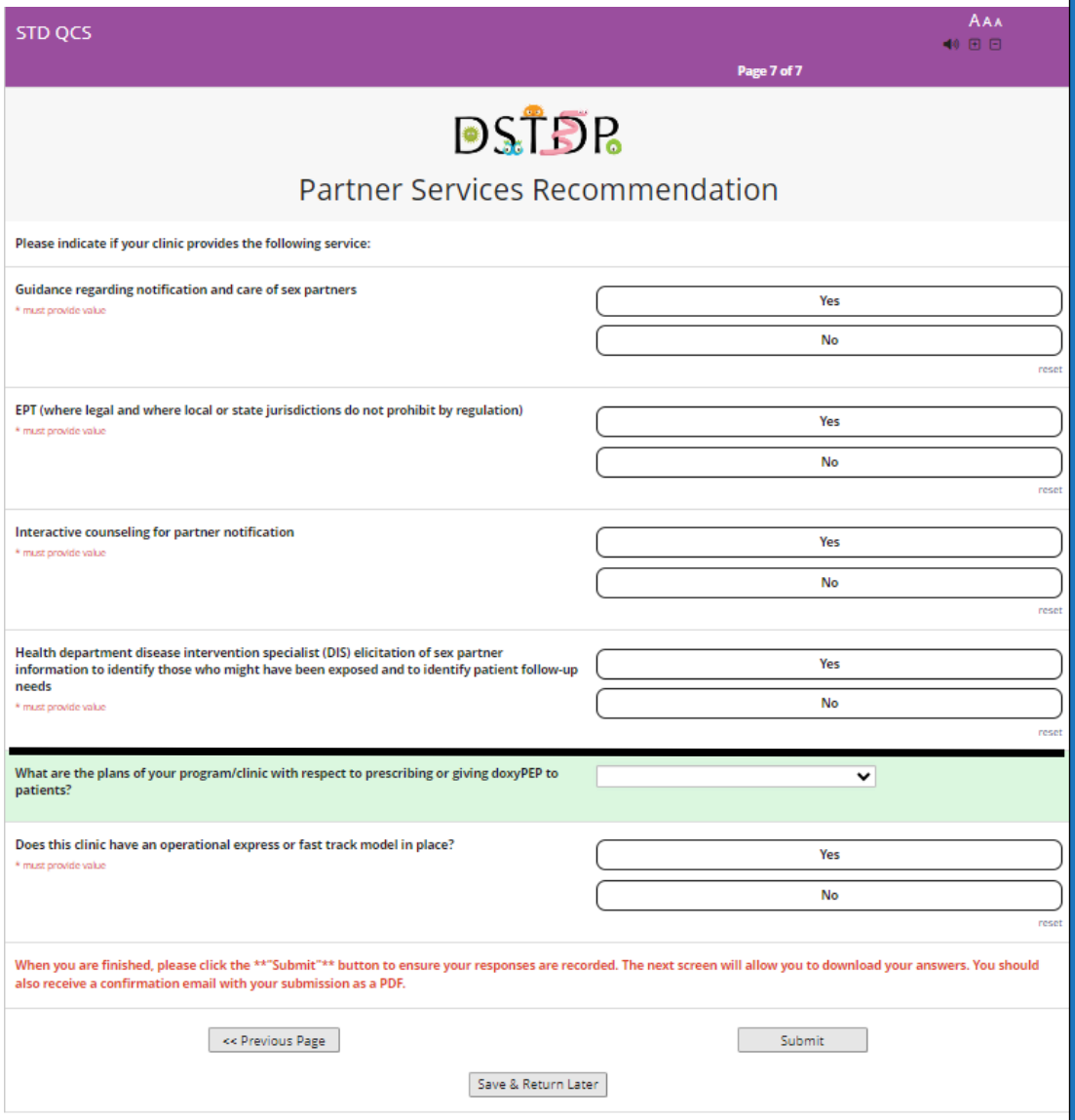


Express/Fast Track Model: Express/Fast Track Visits Conducted: In express services, asymptomatic patients are routed to a less intensive testing-only experience through standing orders and no physical examination. Please see the PS-24-0003 NOFO for core elements of express/fast track models.

Partner services: Partner services consist of various strategies with differing levels of time and effort to enable persons who are exposed to an STD to be identified, tested, and treated. (Refer to the 'Partner Services' section of the Recommendations for additional information.)

Guidance regarding notification and care of sex partners: Guidance regarding notification and care of sex partners is described as providers giving how-to information to their patients about the need to notify their sex partner(s) of the exposure, the need for sex partner(s) to seek care and treatment even if they do not have symptoms, and where partner(s) could go for STD care. (Refer to the 'Partner Services' section of the Recommendations for additional information.)

EPT (where legal and where local or state jurisdictions do not prohibit by regulation): Expedited Partner Therapy (EPT), also termed patient-delivered partner therapy (PDPT), is the clinical practice of treating the sex partner(s) of persons who receive chlamydia or gonorrhea diagnoses by providing medications or prescriptions to the patient. Patients then provide partner(s) with these therapies without the health care provider having examined the partner(s) (see www.cdc.gov/std/ept).Information on legal status of EPT for each state is available at http://www.cdc.gov/std/ept/legal/default.htm.

Interactive counseling for partner notification: In interactive counseling, the provider and patient both actively participate in an individualized plan to notify the patient's sex partner(s). Interactive counseling typically is conducted by staff with specific training or skills in communication, interviewing, or counseling. The patient provides information about their sex partner(s) and develops a plan with the counselor to notify partner(s).

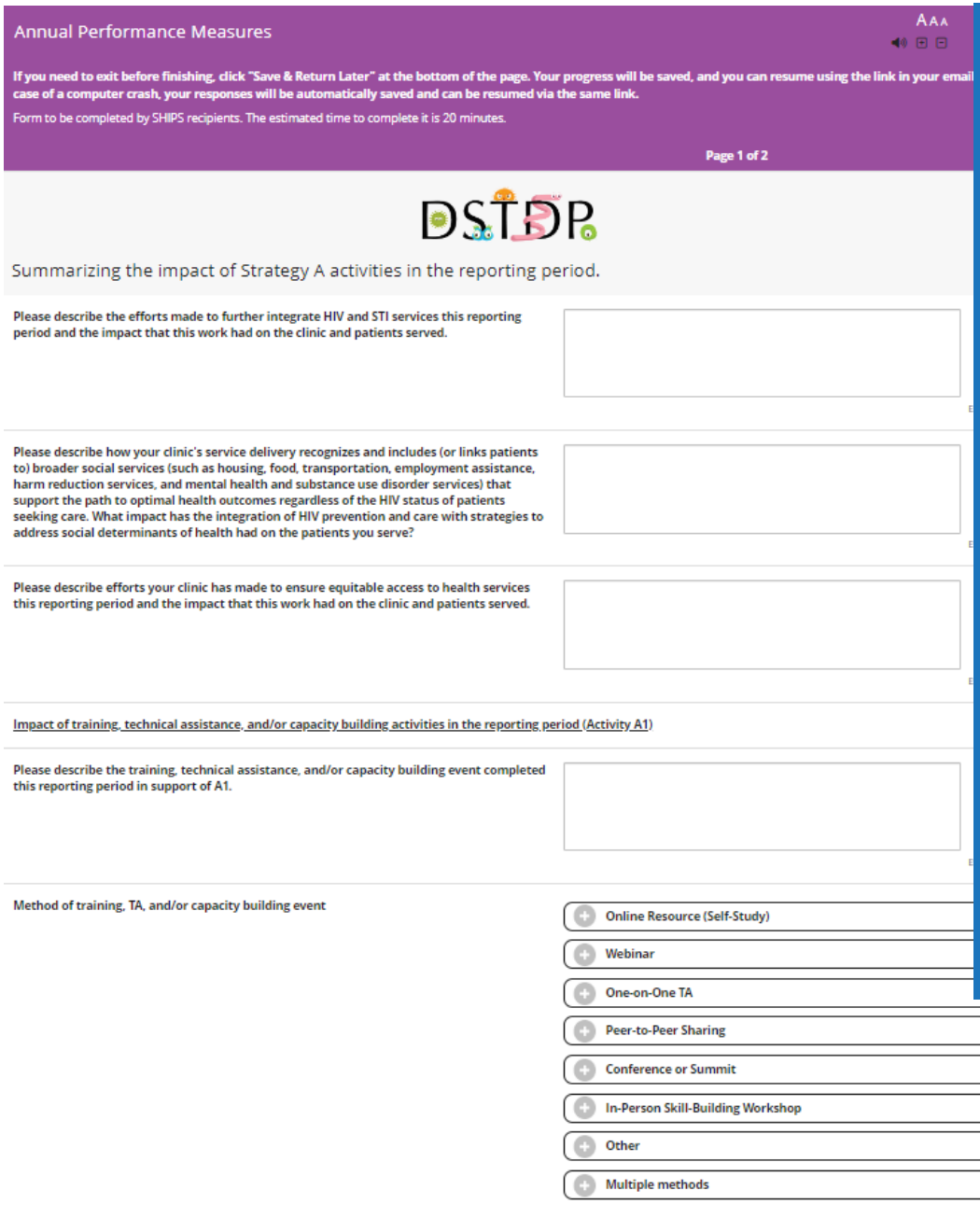
DIS: A disease intervention specialist (DIS) is a public health professional with applied expertise in client-centered interviews; partner services that include contact tracing, directly observed therapy, field specimen collection, and field investigation in outbreaks; and navigation of health care systems to ensure patient evaluation and treatment, among other areas. (Refer to the 'Partner Services' section of the Recommendations for additional information.)

Health department DIS elicitation of sex partner information to identify those who might have been exposed and to identify patient follow-up needs: Partner services can be provided on site or by referral.

Annual Performance Measures

The Annual Performance Measure instrument is meant to collect primarily qualitative information about recipient activities conducted under SHIPS. The information gathered in this instrument links to the recipient work plan. The work plan thoughtfully describes what activities you are planning, how you will accomplish those activities, and how these activities will contribute to your success. The work plan can be used as a planning tool for you and as a resource as you continue to implement project activities. This will also be used by your Project Officer to help monitor progress towards the planned activities/sub-activities and provide technical assistance for any anticipated challenges. The Annual Performance Measures instrument is a continuation of the work plan and is where you will report on the "impact" of implemented work under SHIPS. For the purposes of this cooperative agreement, we will define "impact" broadly (see below).

"Impact": Impact refers to the tangible or intangible change or effect that results from an action, decision, or program. It could be positive or negative, direct or indirect, and can be observed in various areas such as behavior, knowledge, conditions, or systems. In an informal context, impact is about understanding the difference a specific action or effort makes in the real world, even if it's not measured through rigorous evaluation methods.



Annual Performance Measures

If you need to exit before finishing, click "Save & Return Later" at the bottom of the page. Your progress will be saved, and you can resume using the link in your email case of a computer crash, your responses will be automatically saved and can be resumed via the same link.

Form to be completed by SHIPS recipients. The estimated time to complete it is 20 minutes.

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DSTDP

Summarizing the impact of Strategy A activities in the reporting period.

Please describe the efforts made to further integrate HIV and STI services this reporting period and the impact that this work had on the clinic and patients served.

Please describe how your clinic's service delivery recognizes and includes (or links patients to) broader social services (such as housing, food, transportation, employment assistance, harm reduction services, and mental health and substance use disorder services) that support the path to optimal health outcomes regardless of the HIV status of patients seeking care. What impact has the integration of HIV prevention and care with strategies to address social determinants of health had on the patients you serve?

Please describe efforts your clinic has made to ensure equitable access to health services this reporting period and the impact that this work had on the clinic and patients served.

Impact of training, technical assistance, and/or capacity building activities in the reporting period (Activity A1)

Please describe the training, technical assistance, and/or capacity building event completed this reporting period in support of A1.

Method of training, TA, and/or capacity building event

- Online Resource (Self-Study)
- Webinar
- One-on-One TA
- Peer-to-Peer Sharing
- Conference or Summit
- In-Person Skill-Building Workshop
- Other
- Multiple methods

HIV and STI service integration strengthens clinic infrastructure and enhances the provision of comprehensive sexual health services in an existing clinic to address the syndemic of HIV and other STIs. Syndemics are epidemics that interact with each other and by that interaction increase their adverse effects on the health of communities that face systemic, structural, and other inequities. Holistic, coordinated care is a hallmark of the syndemic approach. Activities under this NOFO will support a syndemic approach that is essential to providing patients comprehensive sexual health care in clinic settings where they routinely receive care.

Broadly defined, social determinants of health are non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces (e.g., racism, climate) and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.

Recipients should collaborate with the National Network of STD Clinical Prevention Training Centers (NNPTC) to identify training, technical assistance, and capacity-building opportunities to implement quality sexual health services at the participating clinic in accordance with the STD QCS. Emphasis should be placed on the identification of training needs to support the provision of culturally sensitive, trauma-informed, patient-centered care. Recipients will enter information about each training, technical assistance, and/or capacity-building event completed in the reporting period.

Additional information and context can be found in the SHIPS (PS-24-0003) NOFO.

Audience for the event

- Administration/leadership
- Clinic staff
- Patients
- Community members external to clinic
- Other

Was your assigned PTC involved in this training, TA, or capacity building event?

- Yes
- No

reset

If applicable, how was your assigned PTC involved in this training, TA, or capacity building event?

- Determine and understand audience needs
- Source or provide content or background for the development of the event (e.g., sharing of protocols)
- Adapt event content to the audience
- Publicize/promote the event
- Conduct event
- Provide continuing education units for event
- Other

Expand

How many sessions of the training were held?

How, if at all, did this training, technical assistance, and/or capacity building event impact your clinic and/or patients served?

Expand

Do you have a second training, technical assistance, and/or capacity building event completed this reporting period in support of A1?

- Yes
- No

reset

Recipients should establish strong working relationships with the National Network of STD Clinical Prevention Training Centers (NNPTC) for training and capacity-building support. Recipients should collaborate with a regional Prevention Training Center (PTC) to implement and promote quality sexual health services in their clinics in accordance with the STD QCS.

Additional information and context can be found in the SHIPS (PS-24-0003) NOFO and at the following website: https://www.cdc.gov/sti/php/projects/nnptc.html

Impact of evidence-based or evidence-informed approaches in the reporting period (Activity A2)

Please describe the evidence-based or evidence-informed project you completed this reporting period in support of A2.

Was your assigned PTC involved in this training, TA, or capacity building event?

Yes

No

How, if at all, did this evidence-based or evidence-informed project impact your clinic and/or patients served?

Impact of assessing patient satisfaction and needs in the reporting period (Activity A3)

Please describe the method used to assess patient satisfaction and needs as completed this reporting period in support of A3.

Method type:

Which of the following areas were identified for improvement based on this data collection method?

Service offerings

Service delivery/clinic flow

Clinic's physical environment

Staff experience/engagement

Other

How did or will you use this data to make improvements to patients' experiences in clinic?

Recipients will identify and propose evidence-based or evidence-informed approaches or emerging strategies to implement at the participating clinic that will improve patient flow, increase patient volume, and allow clinic staff to serve patients more efficiently, including the provision of timely testing and treatment.

Evidence-based interventions: Demonstrated effectiveness at improving the care and treatment of people with HIV, or at-risk of HIV. Published research evidence supporting these interventions meets CDC criteria for being evidence-based. (Adapted from Psihopaidas et al., 2020).

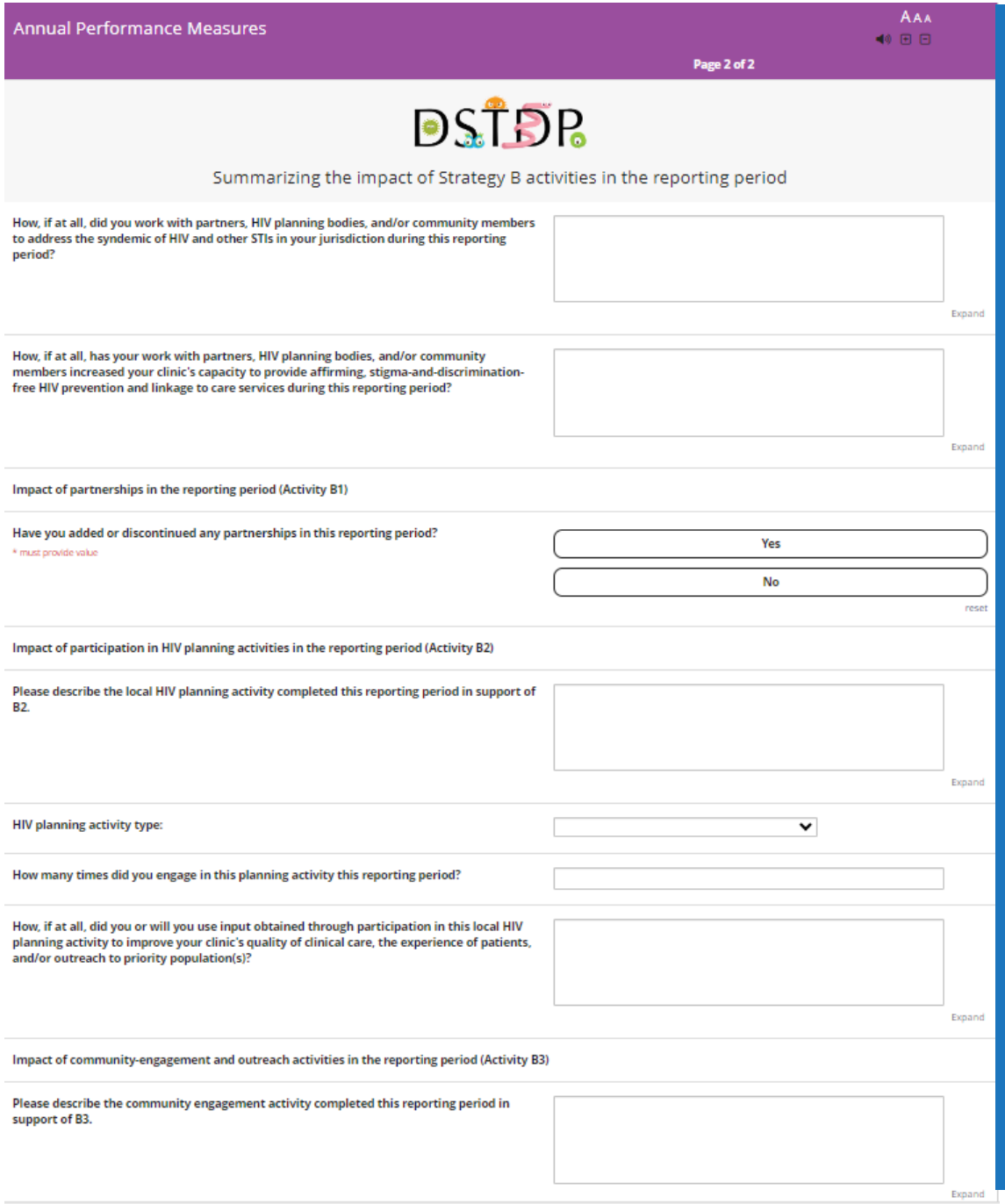
Evidence-informed interventions: Demonstrated effectiveness at improving the care and treatment of people with HIV, or at-risk of HIV. Published research evidence meets HRSA (and potentially CDC) evidence-informed criteria but does not meet CDC criteria for evidence-based interventions. (Adapted from Psihopaidas et al., 2020).

Emerging strategies: Demonstrated effectiveness at improving the care and treatment of people with HIV, or at-risk of HIV. Innovative strategies that address emerging priorities for improving the care and treatment of people with HIV or those at risk for HIV. Real world validity and effectiveness have been demonstrated, but emerging strategies do not yet have sufficient published research evidence. (Adapted from Psihopaidas et al., 2020).

Under A2, clinics are expected to implement or expand an express service model. In express services, asymptomatic patients are routed to a less intensive testing- only experience through standing orders and no physical examination. While express service models vary, there are several core elements seen across models:

- Triage to route patients to either an express visit or a traditional provider visit
- No physical examination during an express visit
- Patient self-collects specimens, including swabs and urine, while a nurse, DIS or phlebotomist collects blood
- Aided by technology/automation for triaging, faster lab turnaround times, and notification of results
- Reliance on diverse staffing to allow healthcare professionals to work at the top of their licenses (i.e., task-shifting)

Additional information and context can be found in the SHIPS (PS-24-0003) NOFO.

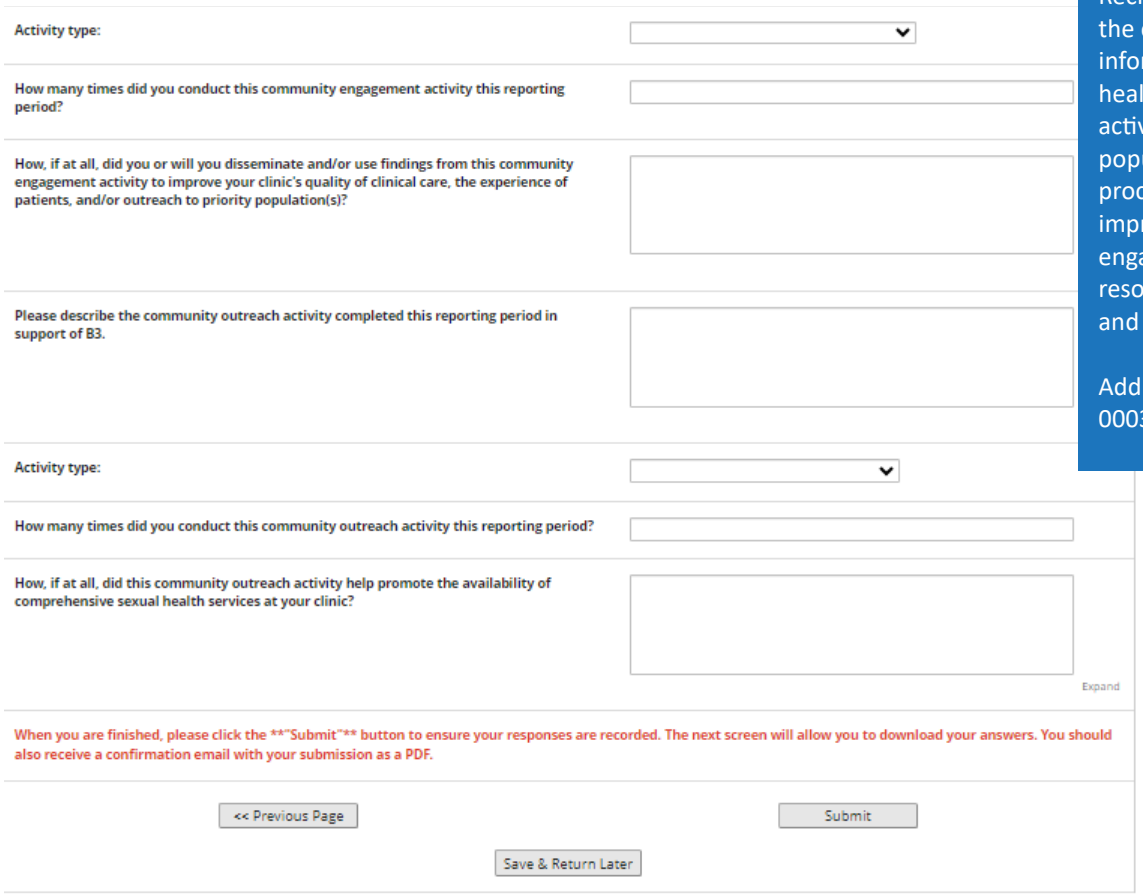


Recipients are expected to actively participate in existing local HIV planning activities including but not limited to engagement with existing EHE advisory groups or committees, HIV care continuum consortiums or Ryan White **HIV/**AIDS program planning councils/bodies, PrEP coalitions, and rapid start collaboratives (for PrEP and/or HIV care) in their jurisdiction. Recipients are expected to use input obtained through participation in local HIV planning activities to improve the quality of clinical care and clinic experience in their participating clinic, and to focus on their priority population(s).

What is the difference between activity B1 and B2? The distinction between B1 and B2 lies in the fact that B1 primarily emphasizes the recipient's responsibility to delineate the necessary steps for establishing partnerships with specific organizations for well-defined projects, while B2 is oriented towards more broader-based coalition-building efforts. HIV planning entities might have looser charges and might be more focused on ensuring a referral network is in place. Further, participation in HIV planning efforts will help ensure that individual member organizations are not providing redundant services but that rather member organizations leverage one another's niches and specialties.

What is the difference between activity B3 and A3? A3 is primarily centered around the collection of information from patients who are currently receiving medical care at the clinic. On the other hand, B3 is specifically dedicated to obtaining input from priority populations that may not be adequately reached or engaged within the clinic setting. The objective is to identify strategies for bridging this gap by directly engaging with priority populations to understand what might motivate them to seek care at the clinic, to better understand messaging that may resonate and other relevant factors.

Additional information and context can be found in the SHIPS (PS-24-0003) NOFO.



Recipients are expected to build active and meaningful engagements with the communities of priority populations affected by HIV and other STIs to inform clinic sexual health service delivery improvements and advance health equity. Clinics should tailor their community engagement (CE) activities to available resources, training, expertise, and the priority populations identified in their application. Community engagement: The process of working collaboratively with and through groups of people to improve the health of the community and its members. Community engagement often involves partnerships and coalitions that help mobilize resources and influence systems, improve relationships among partners, and serve as catalysts for changing policies, programs, and practices.

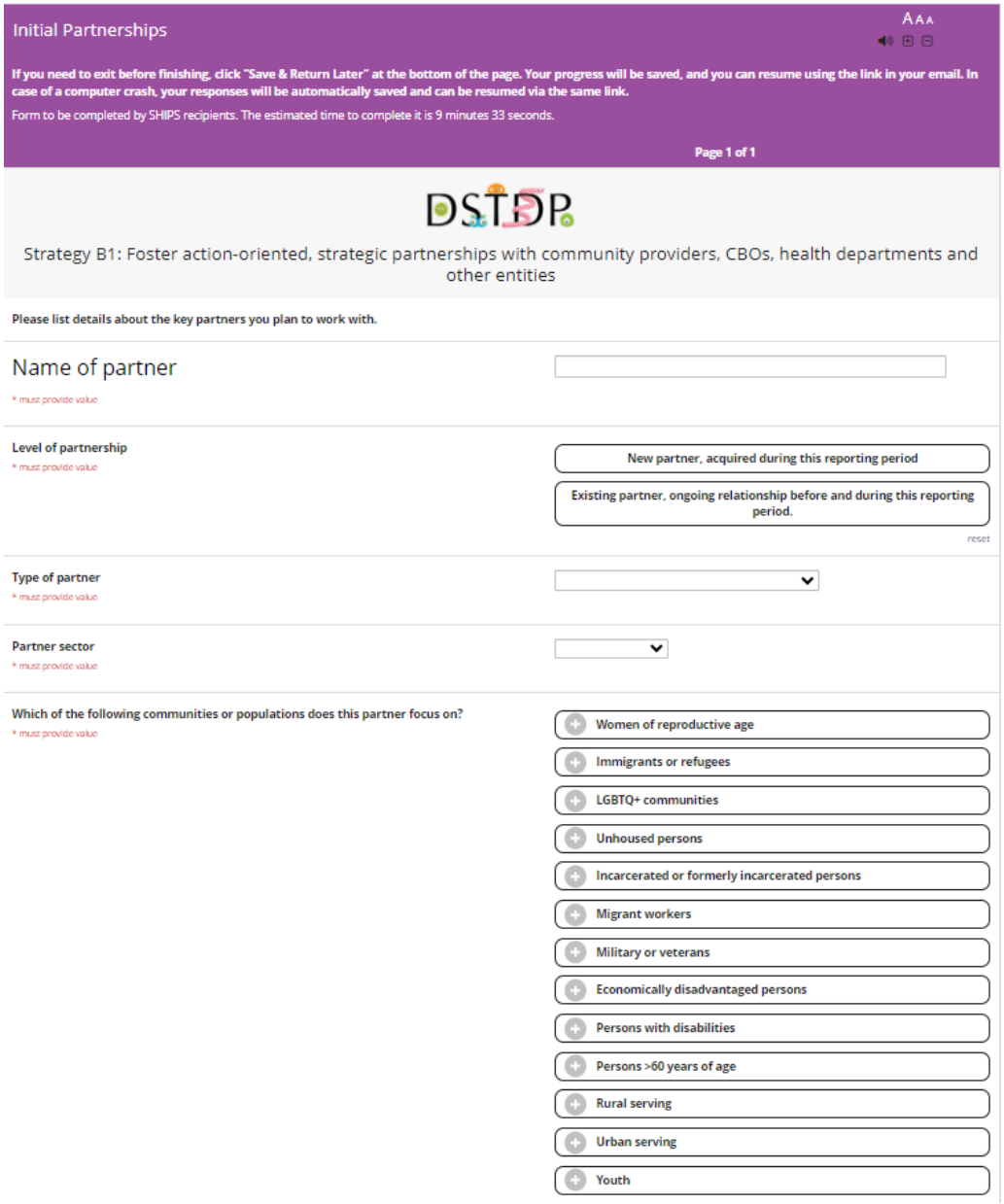
Additional information and context can be found in the SHIPS (PS-24-0003) NOFO.

Partnerships (Initial & Annual)

CDC expects recipients to foster strategic community partnerships with providers, community- based organizations, and health departments to maximize the impact of EHE implementation and improve equitable access to HIV and sexual health services. Using Partnership instruments, recipients can describe how their community partners serve their priority population(s).

Recipients will complete an initial Partnership Instrument which will be updated annually if changes occur.

Initial Partnerships



Initial Partnerships

AAA

If you need to exit before finishing, click "Save & Return Later" at the bottom of the page. Your progress will be saved, and you can resume using the link in your email. In case of a computer crash, your responses will be automatically saved and can be resumed via the same link.

Form to be completed by SHIPS recipients. The estimated time to complete it is 9 minutes 33 seconds.

Page 1 of 1

DSTDP

Strategy B1: Foster action-oriented, strategic partnerships with community providers, CBOs, health departments and other entities

Please list details about the key partners you plan to work with.

Name of partner

* must provide value

Level of partnership

* must provide value

- New partner, acquired during this reporting period
- Existing partner, ongoing relationship before and during this reporting period.

reset

Type of partner

* must provide value

Partner sector

* must provide value

Which of the following communities or populations does this partner focus on?

* must provide value

- Women of reproductive age
- Immigrants or refugees
- LGBTQ+ communities
- Unhoused persons
- Incarcerated or formerly incarcerated persons
- Migrant workers
- Military or veterans
- Economically disadvantaged persons
- Persons with disabilities
- Persons >60 years of age
- Rural serving
- Urban serving
- Youth

Recipients should identify the highest priority collaborations to focus on in Year 1. For each existing and new collaboration, recipients must describe 1) the extent of the current collaboration with the entity, 2) the specific objectives of the partnership for the purposes of implementing strategies and activities in this NOFO, 3) plans for strengthening or maintaining that collaboration in Year 1, and 4) any funding or sharing of resources that the clinic proposes to give the partner organization.

Additional information and context can be found in the SHIPS (PS-24-0003) NOFO.

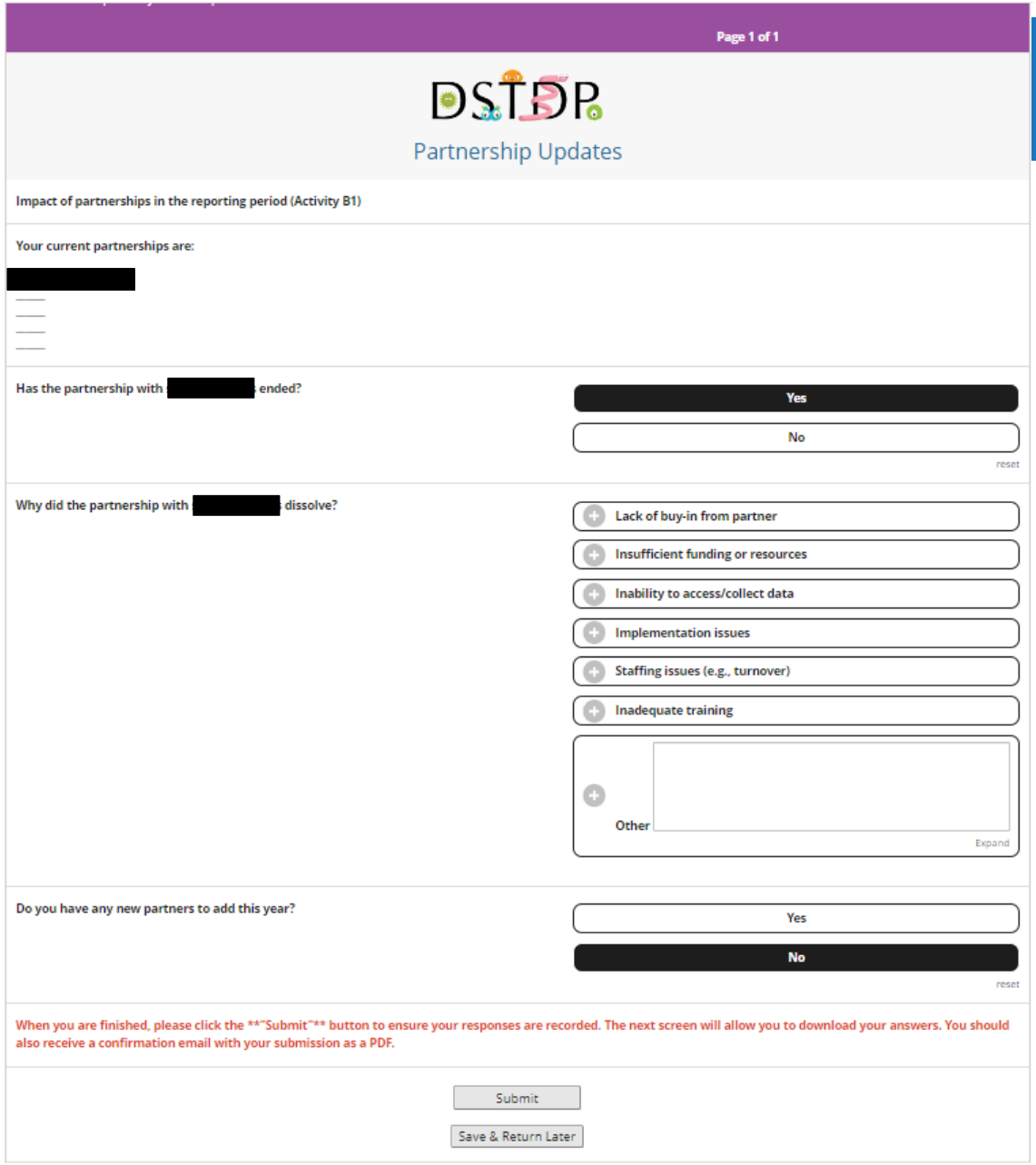
- Hispanic or Latino persons
- Black or African American persons
- Asian persons
- American Indian/Alaskan Native persons
- Native Hawaiian/Pacific Islander persons
- Middle Eastern or North African persons
- Other

What role does this partner play? How did you collaborate with this partner?

* must provide value

- Plan or organize community engagement and/or outreach activities
- Mobilize the community to access clinic services
- Collect and organize data
- Conduct needs assessments
- Train community members
- Leverage funds from sources other than SHIPS
- Leverage resources other than funding (e.g., personnel, space, supplies)
- Plan or implement prevention interventions
- Ensure that SHIP-funded prevention interventions address issues related to health equity
- Plan or implement process or outcome evaluations of prevention interventions
- Educate others about needed changes in policy at the organizational, local, or state/tribal/jurisdiction level
- Other

Annual Partnerships (Updates Y2-5)



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DSTDP

Partnership Updates

Impact of partnerships in the reporting period (Activity B1)

Your current partnerships are:

[redacted]

Has the partnership with [redacted] ended?

Yes

No

reset

Why did the partnership with [redacted] dissolve?

Lack of buy-in from partner

Insufficient funding or resources

Inability to access/collect data

Implementation issues

Staffing issues (e.g., turnover)

Inadequate training

Other

Expand

Do you have any new partners to add this year?

Yes

No

reset

When you are finished, please click the **"Submit"** button to ensure your responses are recorded. The next screen will allow you to download your answers. You should also receive a confirmation email with your submission as a PDF.

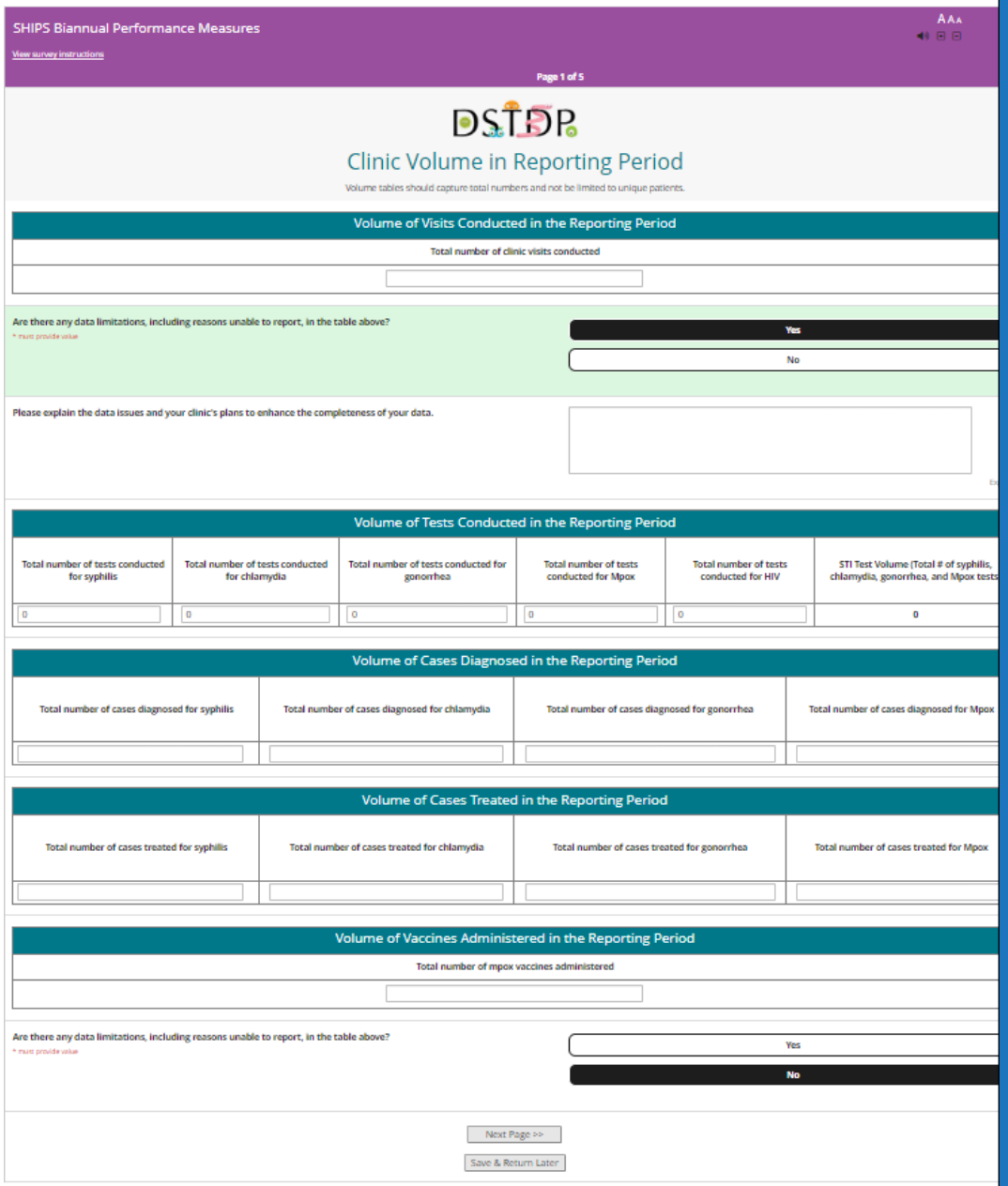
Submit

Save & Return Later

This form will only be triggered if recipients indicate a change in partnerships. If a change is indicated, this form will appear wherein recipients may update their partnership list accordingly.

Biannual Performance Measures

Unless stated otherwise, all reporting categories should be reported using the qualifier “as of the end of the reporting period.” In other words, if CDC requests the total number of unique persons testing positive for HIV, this is to mean that CDC is interested in the total number of unique persons testing positive for HIV as of the end of the specified reporting period. If a unique individual tests negative at the start of the reporting period and seroconverts during the reporting period, use the most up-to-date categorization as of the end of the reporting period.



Volume of Visits Conducted in the Reporting Period-Total Number of Visits: Visits documented here need not be per unique patients. Rather, we are looking for total visit numbers. Do not include encounters with persons outside of the clinic (e.g., community-based services) that are not documented on an individual basis in your clinic's medical records system (information about community activities will be collected elsewhere).

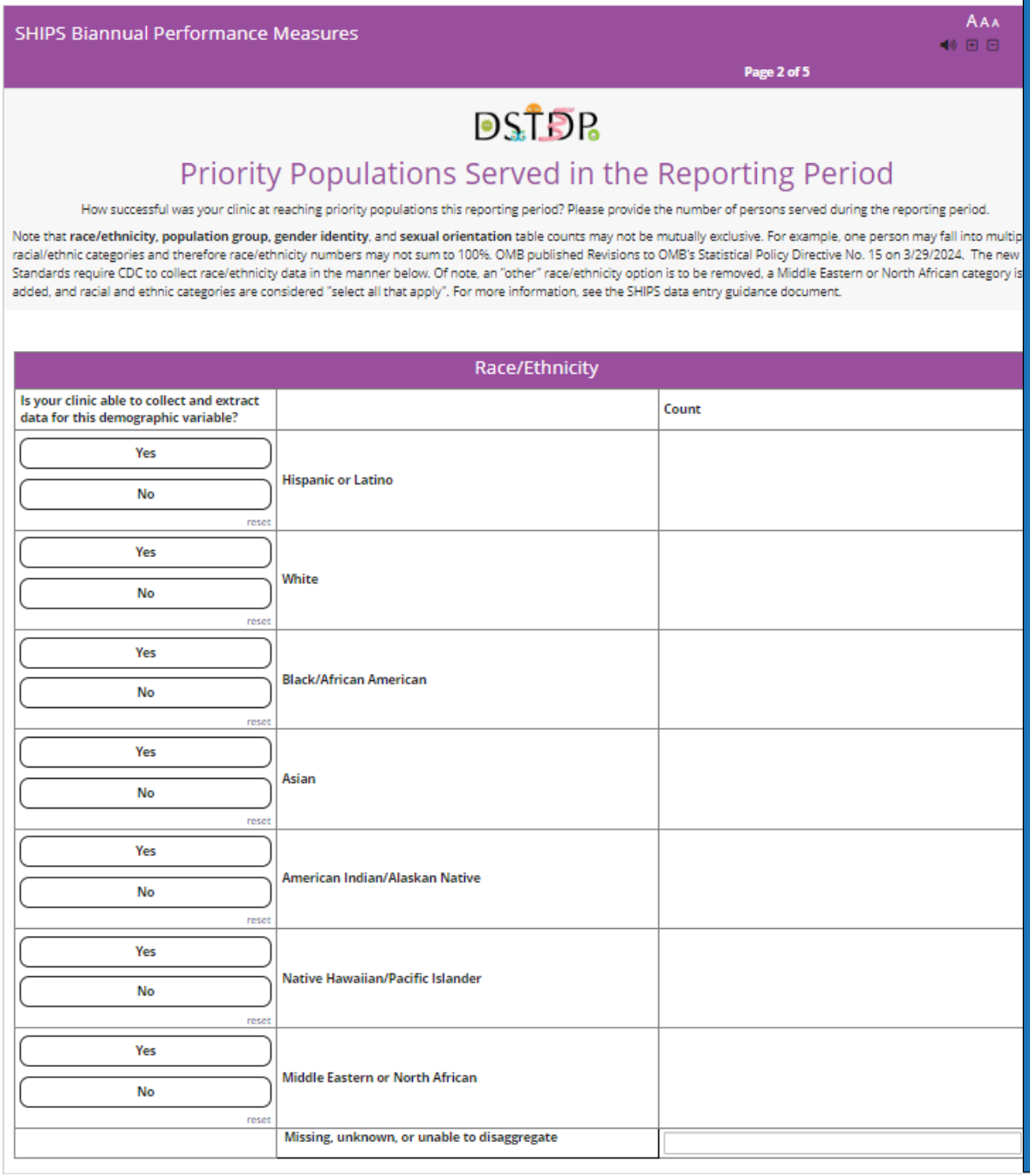
Volume of Tests Conducted in the Reporting Period-Total Number of Tests Conducted: Includes all STI (syphilis, chlamydia, gonorrhea, mpox) tests that are supported in any way by EHE (e.g., funding, test kits, personnel, training and technical assistance, laboratory support) or other resources available to the clinic so long as results are obtained in or reported to the clinic. Report all tests here, not the number of persons tested. Includes all negative and positive test results in the budget period. Walk-in testing at a partner lab would be counted here if a medical record is generated at the clinic during the report period AND the results (both negative or positive) are reported by the laboratory to the clinic to drive routine care.

Total Number of Tests Conducted for HIV: Includes all HIV tests (antibody, antigen/antibody, NAT) that are supported in any way by EHE (e.g., funding, test kits, personnel, training and technical assistance, laboratory support) or other resources available to the clinic so long as results are obtained in or reported to the clinic.

Volume of Cases Diagnosed in the Reporting Period-Total Number of Cases Diagnosed: Please enter the total number of new STI cases identified (syphilis, gonorrhea, chlamydia, and mpox), in the specified reporting period. This may include cases diagnosed in any previous reporting period and reinfected, then diagnosed in this reporting period. Please count only cases with a positive test AND confirmed clinical diagnosis.

Volume of Cases Treated in the Reporting Period-Total Number of Cases Treated: Please enter the values of the total number of STI cases identified receiving CDC-recommended treatment for syphilis, gonorrhea, chlamydia, and mpox in the specified reporting period. This may include cases treated in any previous reporting period and reinfected, then diagnosed and treated in this reporting period. CDC's recommendations for treating STIs are outlined in the 2021 STI Treatment Guidelines.

Volume of Vaccines Administer in the Reporting Period-Total Number of mpox vaccines administered: Please enter the total number of mpox vaccines (either Jynneos, ACAM2000, or a commercial alternative) administered in the reporting period.



SHIPS Biannual Performance Measures

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DSTDP

Priority Populations Served in the Reporting Period

How successful was your clinic at reaching priority populations this reporting period? Please provide the number of persons served during the reporting period.

Note that **race/ethnicity**, **population group**, **gender identity**, and **sexual orientation** table counts may not be mutually exclusive. For example, one person may fall into multip racial/ethnic categories and therefore race/ethnicity numbers may not sum to 100%. OMB published Revisions to OMB's Statistical Policy Directive No. 15 on 3/29/2024. The new Standards require CDC to collect race/ethnicity data in the manner below. Of note, an "other" race/ethnicity option is to be removed, a Middle Eastern or North African category is added, and racial and ethnic categories are considered "select all that apply". For more information, see the SHIPS data entry guidance document.

Race/Ethnicity		
Is your clinic able to collect and extract data for this demographic variable?		**Count**
Yes / No (reset)	**Hispanic or Latino**	
Yes / No (reset)	**White**	
Yes / No (reset)	**Black/African American**	
Yes / No (reset)	**Asian**	
Yes / No (reset)	**American Indian/Alaskan Native**	
Yes / No (reset)	**Native Hawaiian/Pacific Islander**	
Yes / No (reset)	**Middle Eastern or North African**	
	Missing, unknown, or unable to disaggregate	

Race/Ethnicity: Race and ethnicity are to be collected at the local level in accordance with OMB standards and reported to the CDC in the aggregate using these standards. The Office of Management and Budget (OMB) announced revisions effective as of March 28, 2024, to Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (SPD 15). The revised SPD 15 replaces and supersedes OMB's 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity.* SHIPS will comply with this directive by utilizing the below minimum categories for data on race and ethnicity. Respondents shall be offered a single combined race and ethnicity question that allows them to select one category or multiple categories. A single selection will be considered a complete response (e.g., Hispanic or Latino respondents are not required to select an additional category).

American Indian or Alaska Native. Individuals with origins in any of the original peoples of North, Central, and South America, including, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, and Maya.

Asian. Individuals with origins in any of the original peoples of Central or East Asia, Southeast Asia, or South Asia, including, for example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, and Japanese.

Black or African American. Individuals with origins in any of the Black racial groups of Africa, including, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali.

Hispanic or Latino. Includes individuals of Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, and other Central or South American or Spanish culture or origin.

Middle Eastern or North African. Individuals with origins in any of the original peoples of the Middle East or North Africa, including, for example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, and Israeli.

Native Hawaiian or Pacific Islander. Individuals with origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands, including, for example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, and Marshallese.

White. Individuals with origins in any of the original peoples of Europe, including, for example, English, German, Irish, Italian, Polish, and Scottish.

For additional information about SPD 15, please visit spd15revision.gov

Population group: As applicable to the recipient's priority population and/or available data, please enter numbers of persons who fall into population group categories.

Age Group: Age reporting is fairly straightforward, though "edge" issues for age reporting come up (when people have a birthday during the report period that puts them in a different age category by the end of the reporting period). For activities funded through SHIPS (e.g., PrEP referrals, HIV testing), use "as of the end of the report period" to guide reporting. In other words, take the fictional character Sheldon Plankton as an example. Sheldon was 29 years of age when he first tested positive for HIV, but by the end of the same reporting period, he would be 30. As such, Sheldon should be reported in the 30-65 age group for this reporting period.

Population Group		
Is your clinic able to collect and extract data for this demographic variable?		Count
Yes / No / reset	Persons who are unhoused/persons experiencing homelessness	
Yes / No / reset	Women of reproductive age (includes anyone of reproductive capacity based on assigned sex at birth)	
Yes / No / reset	Pregnant persons	
Yes / No / reset	Persons who inject drugs	

Age Group		
Is your clinic able to collect and extract data for this demographic variable?		Count
Yes / No / reset	Under 15 years	
Yes / No / reset	15-19 years	
Yes / No / reset	20-29 years	
Yes / No / reset	30-64 years	
Yes / No / reset	65 years and older	
	Missing, Unknown, or Unable to Disaggregate Variable	

Sex at Birth		
Is your clinic able to collect and extract data for this variable?		Count
Yes / No (reset)	Male	
Yes / No (reset)	Female	
Yes / No (reset)	Intersex	
	Missing, Unknown, or Unable to Disaggregate Variable	

Gender Identity		
Is your clinic able to collect and extract data for this variable?		Count
Yes / No (reset)	Male	
Yes / No (reset)	Female	
Yes / No (reset)	Transgender, non-binary, or another gender	
	Missing, Unknown, or Unable to Disaggregate Variable	

Sex at birth: Sex is a multidimensional construct based on a cluster of anatomical and physiological traits (sex traits). Sex at birth definitions can be found here below.

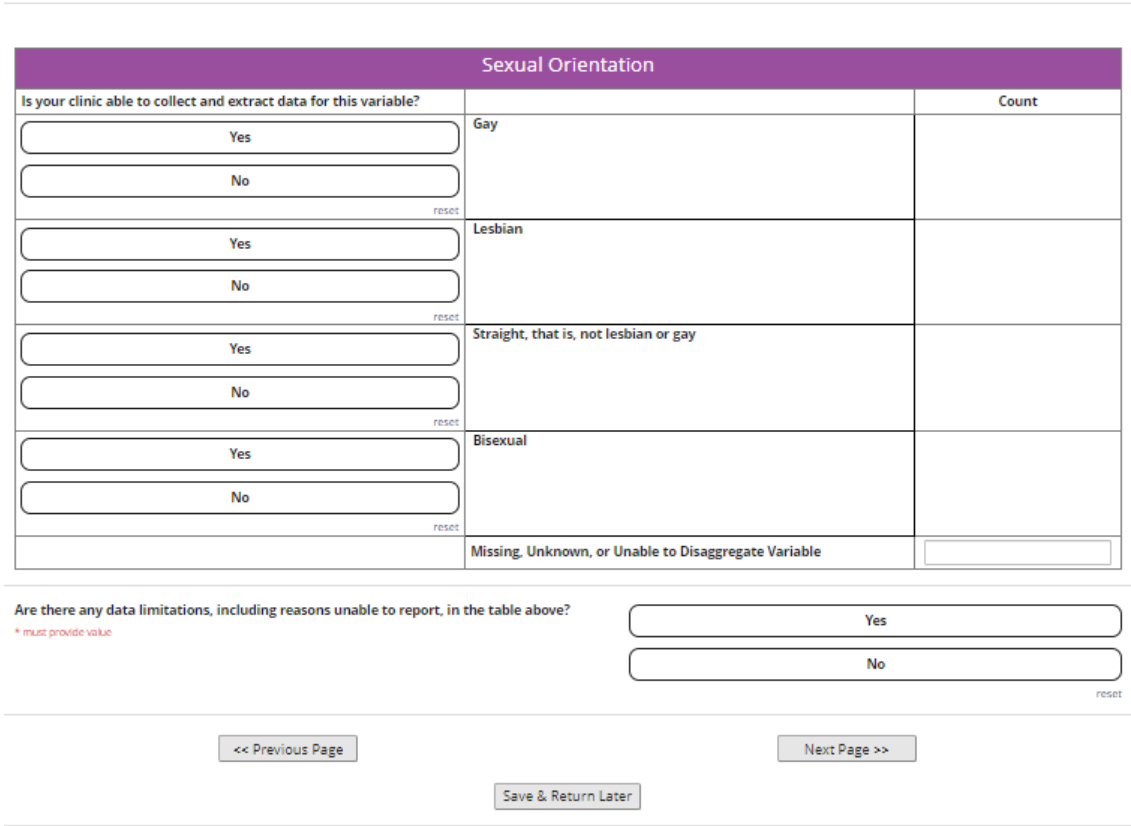
Male: Male sex assigned at birth on an individual's birth certificate.

Female: Female sex assigned at birth on an individual's birth certificate.

Intersex. Individuals born with sexual anatomy, reproductive organs, and/or chromosome patterns that do not fit the definition of male or female.

Gender: Gender is a multidimensional construct that links gender identity, gender expression, and social and cultural expectations about status, characteristics, and behavior that are associated with sex traits.

Please refer to the Recommendations on the Best Practices for the Collection of Sexual Orientation and Gender Identity Data on Federal Statistical Surveys located here: https://www.whitehouse.gov/wp-content/uploads/2023/01/SOGI-Best-Practices.pdf



Sexual Orientation

Is your clinic able to collect and extract data for this variable?		Count
Yes / No / reset	Gay	
Yes / No / reset	Lesbian	
Yes / No / reset	Straight, that is, not lesbian or gay	
Yes / No / reset	Bisexual	
	Missing, Unknown, or Unable to Disaggregate Variable	

Are there any data limitations, including reasons unable to report, in the table above?

* must provide value

Yes

No

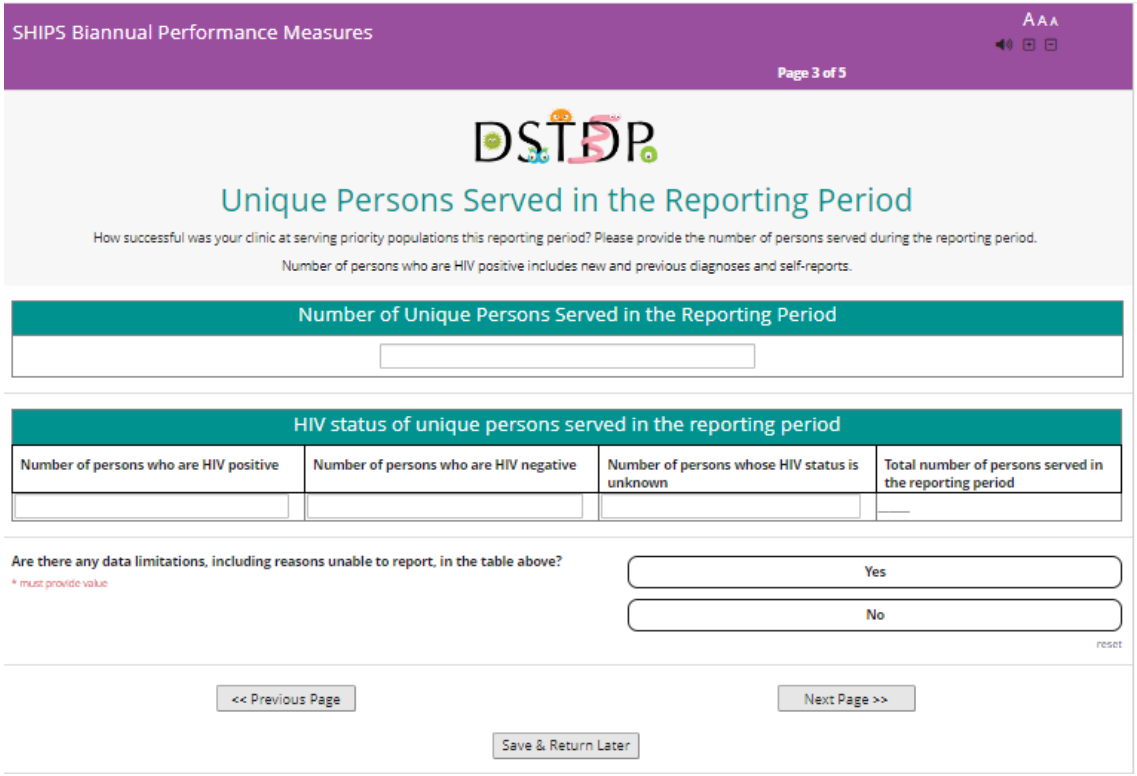
reset

<< Previous Page

Next Page >>

Save & Return Later

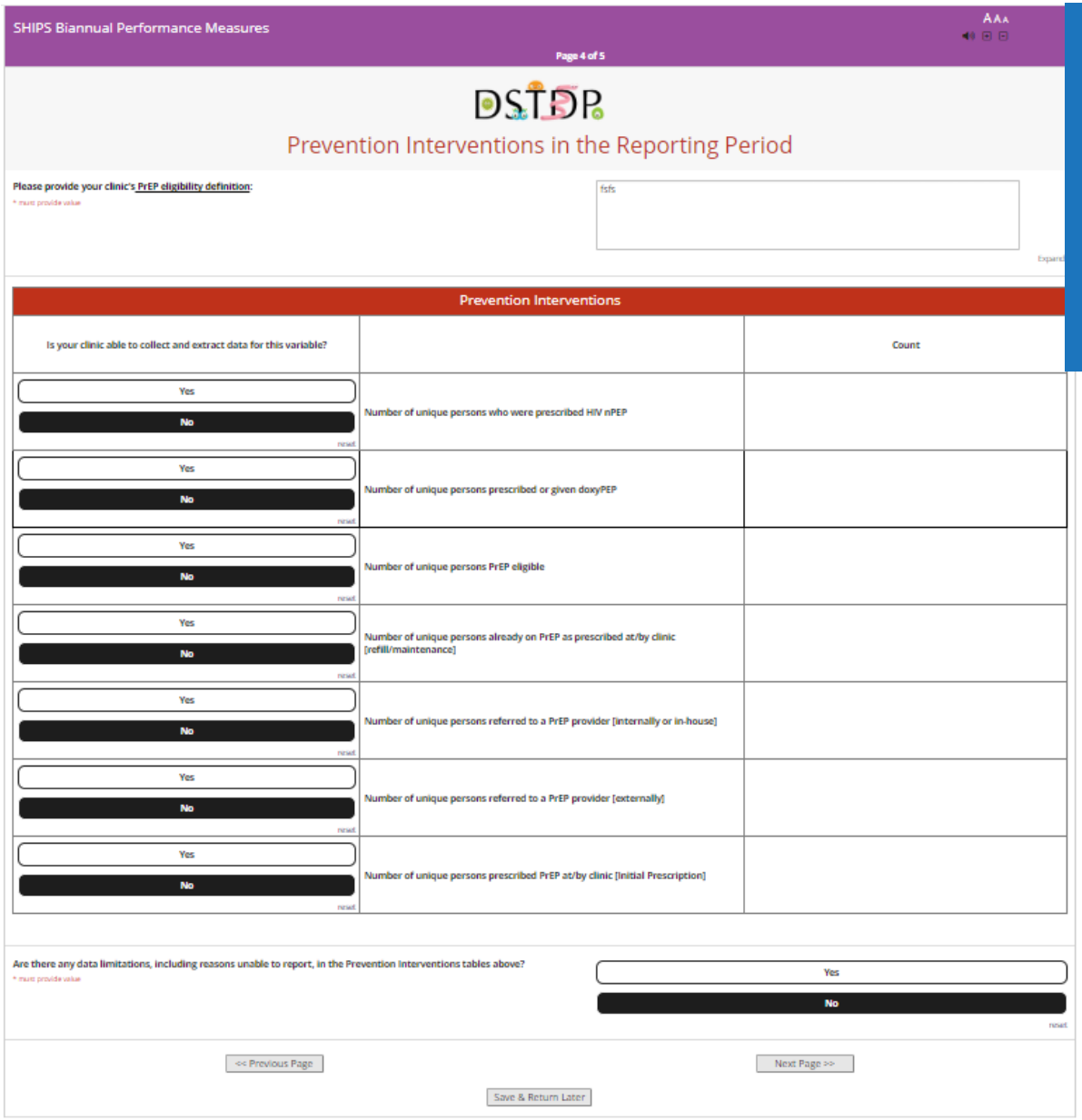
Please refer to the Recommendations on the Best Practices for the Collection of Sexual Orientation and Gender Identity Data on Federal Statistical Surveys located here: https://www.whitehouse.gov/wp-content/uploads/2023/01/SOGI-Best-Practices.pdf



Number of unique persons who are HIV positive: Includes all persons known to be HIV-positive either by self-report (with or without prior test history at the Sexual health clinic), prior confirmed positive HIV test or those who received a positive test at the SHC during the reporting period.

Number of unique persons who are HIV-negative: Includes all persons known to be HIV-negative either by self-report (with or without prior test history at the Sexual health clinic), a prior negative HIV test, or those who received a negative test at the SHC during the reporting period.

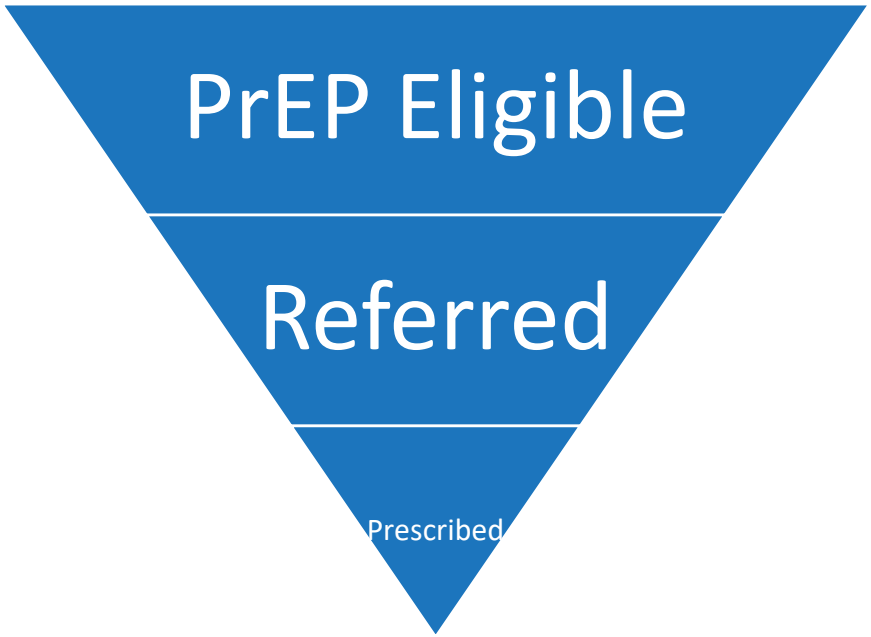
Number of unique persons whose HIV status is unknown: Includes all persons with an unknown HIV status. For the most part, this field will capture persons who decline an HIV test in the reporting period.



Number of unique persons prescribed HIV nPEP: This is the number of people who started nPEP for HIV at least once, in the specified reporting period. Count all persons who received one or more prescriptions for nPEP. The number of people who received preventive services should be a subset and cannot be greater than the number of people served.

Number of unique persons prescribed or given doxyPEP: This is the number of people who were prescribed or given DoxyPEP for bacterial STIs, in the reporting period. Count all unique persons who received one or more prescriptions for DoxyPEP.

SHIPS PrEP Cascade



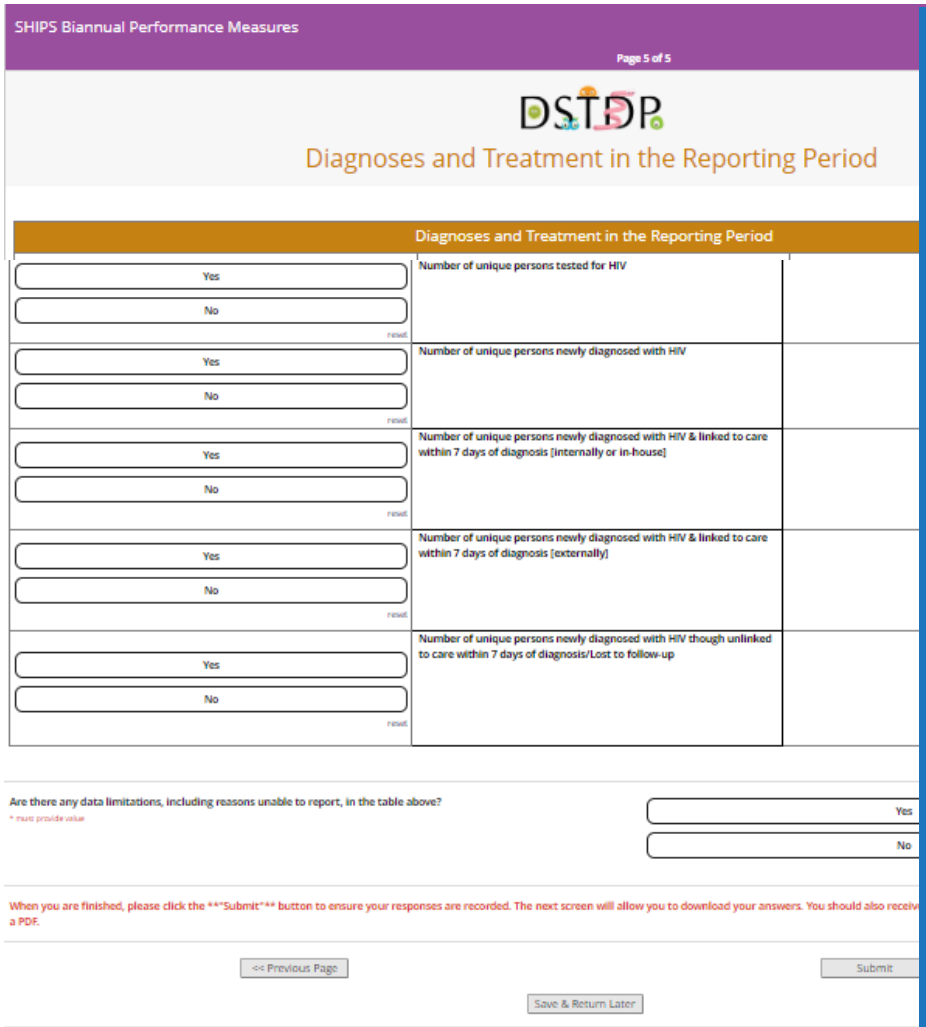
PrEP eligibility definition: Those eligible for PrEP are HIV-negative and at substantial risk for HIV, as defined locally or by CDC guidelines for PrEP (https://www.cdc.gov/hiv/effective-interventions/prevent/prep/index.html). CDC is interested in capturing the operationalized clinic definition for PrEP eligibility.

Number of unique persons already on PrEP as prescribed at/by clinic [refill/maintenance]: Includes persons with no prior HIV-positive test history, conferment HIV-negative test or self-report of HIV-negative status in the clinic, who are documented in their medical record as currently prescribed PrEP at/by the clinic and on appropriate monitoring in the current reporting period. For people with PrEP refills (distinct from new in that these imply current, ongoing PrEP use), they should not get counted multiple times in this column but should be reflected once.

Number of unique persons referred to a PrEP provider [internally or in-house]: Persons referred to an internal PrEP provider are HIV-negative and at risk for HIV, as defined locally or by CDC guidelines for PrEP, or are HIV-negative and requesting PrEP. If the clinic has a co-located PrEP provider (i.e., a CBO doing PrEP, Ryan White HIV Clinic or other agency not fiscally related to the clinic) referral to that specific practitioner could count as an external PrEP referral and should be recorded as an external referral.

Number of unique persons referred to a PrEP provider [externally]: Referral to a PrEP provider external to the clinic 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. If the clinic has a co-located PrEP provider (i.e., a CBO doing PrEP, Ryan White HIV Clinic or other agency not fiscally related to the clinic) referral to that specific practitioner could count as an external PrEP referral and would be recorded here.

Number of unique persons prescribed PrEP at/by clinic [Initial Prescription]: Prescribed PrEP refers to a person who has been adequately evaluated and received an initial prescription for PrEP at the clinic. If an initial prescription and subsequent refill prescriptions are provided to a patient during the same reporting period, only record the patient in this column and not in Column D. Information may come from EHR or pharmacy records.



Number of unique persons tested for HIV: This is the number of people who were tested for HIV at least once in the specified reporting period. Do not include persons who are known to be HIV positive and receiving confirmatory testing here. For unavailable or missing values, please enter the applicable numbers in the 'unknown' fields.

Number of unique persons newly diagnosed with HIV: This is the number of persons that are newly diagnosed and were not tested and diagnosed in a previous reporting period. New HIV cases are the numbers of people who, at minimum, test positive after being tested in the specified reporting period, and should not be greater than the number of people tested. For unavailable or missing values, please enter the applicable numbers in the 'unknown' fields.

Number of unique persons newly diagnosed with HIV & linked to care within 7 days of diagnosis [internally or in-house]: CDC will be defining rapid linkage to care as meeting at least one of the following markers within 7 days of HIV diagnosis: patient entry into specialist HIV care measured by confirmed attendance at the first appointment, the first CD4+ cell count or viral load date, or HIV treatment start date, depending on data availability. Only document those rapidly linked to care internal to the clinic here.

Number of unique persons newly diagnosed with HIV & linked to care within 7 days of diagnosis [externally]: CDC will be defining rapid linkage to care as meeting at least one of the following markers within 7 days of HIV diagnosis: patient entry into specialist HIV care measured by confirmed attendance at the first appointment, the first CD4+ cell count or viral load date, or HIV treatment start date, depending on data availability. Only document those who received a warm handoff to an external provider here.

Number of unique persons newly diagnosed with HIV though unlinked to care within 7 days of diagnosis/Lost to follow-up: CDC will be defining rapid linkage to care as meeting at least one of the following markers within 7 days of HIV diagnosis: patient entry into specialist HIV care measured by confirmed attendance at the first appointment, the first CD4+ cell count or viral load date, or HIV treatment start date, depending on data availability. Document any persons newly diagnosed with HIV who do not meet the criteria for being rapidly linked to care (internally or externally) here.