

2024 Standards Evaluation Report (SER)

Surveillance Program Performance

Jurisdiction's name: _____

Provide the following:	Name	email
1. Primary Surveillance Contact:		
2. Secondary Surveillance Contact:		
3. S&C Overall Responsible Party:		

A. Death Ascertainment

- ☐ We are a separately funded city AND all death ascertainment is done at the state level. (*Skip to section B: Laboratory*).
- ☐ We are a state, territory, or separately funded city and perform our own death ascertainment. (*Respond to the questions below and complete the table*).

Ascertain dates of deaths		Linked with deaths occurring through	
1	Vital statistics file loaded for deaths		
	OR	☐ Prohibited	
2	NDI-Plus early release file loaded for deaths		
2	SSDMF loaded for deaths		
Ascertain causes of deaths		Linked with deaths occurring through	
3	NDI Plus final file with cause-of-death information loaded for deaths	☐ Prohibited	
4	Vital statistics final file with cause-of-death information loaded for deaths		
Search for potentially unreported HIV cases		Linked with deaths occurring through	
5	Searched all vital records deaths mentioning HIV infection and loaded previously unreported cases		

If you did not load all the required files in 1-5 above in accordance with the process standards outlined in the Death Ascertainment Technical Guidance for HIV Surveillance Programs file, please discuss:

- Why you did not load each file in accordance with the process standards.
- Your plan to ensure your program loads each file in the next evaluation period in accordance with the process standards.

Public reporting burden of this collection of information is estimated to average 8 hours per response, including the time for reviewing instructions, searching existing data sources, gathering, and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0573).

B. Laboratory

- 1. In 2023, did your surveillance program develop and/or update the list of all laboratories (in jurisdiction and out of jurisdiction) that conducted HIV-related testing for persons who reside in your jurisdiction using a method such as Centers for Medicare and Medicaid Services (CMS) search, or evaluation of your electronic laboratory report (ELR) program baseline spreadsheet?**

☐ Yes

- Did you identify new laboratories that conduct HIV testing for persons who reside in your jurisdiction?
☐ Yes
☐ No
- What is the total number of laboratories that report HIV-related test results for persons who reside in your jurisdiction? [Click here to enter text.](#)
 - o Please describe how your program obtained this number. [Click here to enter text.](#)

☐ No

- 2. In 2023 did your surveillance program conduct an assessment of laboratories that conduct HIV-related testing for persons who reside in your jurisdiction? This assessment is to maintain documentation, such as types of tests performed and LOINC usage, by all laboratories that report to your jurisdiction.**

☐ Yes

☐ No

- 3. Are you aware of any laboratory reporting lapses of HIV-related test results for persons who reside within your jurisdiction that resulted in missing laboratory data in your December 2023 data transfer? Please include lapses in laboratory reporting to CDC, including those attributed to the laboratory not reporting test results or because the HL7 reader/transmitter in the health department did not send the results to HIV surveillance.**

☐ Yes

Year of specimen collection	Approximately what percentage of your total jurisdiction's laboratory volume is missing for the calendar year indicated?	Approximately what percentage of your total jurisdiction's CD4 results (< 200 and ≥ 200) and viral load results (detectable and undetectable) are missing for the calendar year indicated?
2023*		
2022		

*At a minimum, lab results through September 2023

☐ No

- In 2023, did your program monitor the quality of incoming reports of laboratory test results (including test result volumes) on a quarterly basis or more frequently? ☐ Yes ☐ No

C. Pediatric/Perinatal

Birth Ascertainment	1A. In 2023, did you link women with diagnosed HIV infection reported to the surveillance system to state/local/territory birth certificate data for all 2022 births to identify all perinatally exposed infants with a residence of birth in your jurisdiction? ☐ Yes ☐ No 1B. If no to 1A, please describe why you did not link with all state/local/territory birth certificate data. [Free text] 1C. If yes to 1A, did you enter all information identified from the linkage to state/local/territory birth certificate data into eHARS before your final December 2023 data transfer to CDC? ☐ Yes ☐ No ID. If no to 1C, please describe why you did not enter all information identified from the link to state/local/territory birth certificate data into eHARS. [Free text]
Number of perinatally HIV exposed infants for birth year 2022	Provide the number of perinatally HIV exposed infants born in 2022 that were identified through the match to birth certificates. *This should include exposed infants previously known to the HIV surveillance program. Does this match with the number of perinatally exposed infants reported to CDC through your final December 2023 data transfer? ☐ Yes ☐ No If this does not match, please describe the reasons the numbers do not match (e.g., X perinatally exposed infants reported to health department that were not in the state/local birth certificate data because the infant was a resident of another jurisdiction).
Perinatal HIV Exposure Reporting	Provide percentage of perinatally HIV exposed infants born in 2021 who have HIV infection status determined by 18 months of age (Standard: 85%):

D. Geocoding and Data Linkage

Submission of Geocoded Data	In 2023, did you submit your geocoded data to CDC, per the Geocoding and Data Linkage Technical Guidance for HIV Surveillance Programs file and the joint MOU?	☐ Yes	☐ No
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E. Cluster Detection

	Yes	No
1. In 2023, did your program analyze molecular data using CDC-recommended approaches at least monthly to identify HIV transmission clusters and outbreaks?	☐	☐
2. In 2023, did your program conduct time-space analysis using CDC-recommended approaches at least monthly to identify HIV transmission clusters and outbreaks?	☐	☐

F. Submission of Required Outcome Standards with SAS Tables

NOTE: All areas **MUST** run the CDC-supplied SAS programs against the December 2023 frozen eHARS SAS datasets to evaluate and report on your program's outcome standards. **In addition, all SAS table output MUST be included with your SER submission.**

SAS outcome table	Included indicators
Completeness and timeliness tables	- Of the expected number of persons whose HIV infection was diagnosed during 2022, at least ($\geq$) 95% are reported in the local HIV surveillance system, assessed December 2023 - Of the expected number of persons whose HIV infection was diagnosed during 2022, at least ($\geq$) 90% are reported in the local HIV surveillance system within six months of the diagnosis, assessed December 2023
Intra-jurisdiction case duplication rate table	- Of all persons with diagnosed HIV infection who were reported to the local surveillance program through the end of 2022 (cumulative), less than or equal to ($\leq$) 1% have duplicate case reports, assessed December 2023
RIDR progress summary tables	- Of all pairs on the Routine Interstate Duplicate Review (RIDR) list received January 2023, at least ($\geq$) 98% were resolved by June 30, 2023 - Of all pairs on the Routine Interstate Duplicate Review (RIDR) list received July 2023, at least ($\geq$) 98% were resolved by December 31, 2023
CIDR progress summary table	- Of all pairs on the Cumulative Interstate Duplicate Review (CIDR) list received January 2018, 100% are resolved by December 31, 2023 - o Only needs to be submitted by jurisdictions that did not report 100% completion in December 2022: Alabama, Alaska, Arkansas, California, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Los Angeles, Louisiana, Maine, Massachusetts, Michigan,

	Minnesota, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York City, Ohio, Pennsylvania, Philadelphia, South Carolina, Texas, Utah, Vermont, Virgin Islands, Wisconsin.
Risk factor ascertainment tables	- Of all persons with diagnosed HIV infection who were first entered in the local HIV surveillance system during 2022, at least ($\geq$) 80% have sufficient risk factor information to be classified into a known transmission category, assessed December 2023
Lab reporting tables	- Of all persons aged 13 years or older with HIV infection diagnosed during 2022, at least ($\geq$) 85% have a CD4 count or percent based on a specimen collected within one month following HIV diagnosis, assessed December 2023 - Of all persons aged 13 years or older with HIV infection diagnosed during 2022, at least ($\geq$) 85% have a viral load based on a specimen collected within one month following HIV diagnosis, assessed December 2023 - Of all laboratory test results entered into eHARS in 2022 for persons with HIV infection diagnosed during 2022, at least 85% were entered into eHARS within 60 days of the specimen collection date, assessed December 2023 - Of all persons with HIV infection diagnosed during 2022, at least ($\geq$) 60% have an analyzable nucleotide sequence, assessed December 2023 - Of all persons with HIV infection diagnosed during 2022, at least ($\geq$) 70% have a known value for previous negative HIV test result, assessed December 2023 - Of all persons with HIV infection diagnosed during 2022 who have a previous negative test result, at least ($\geq$) 50% have a valid date of documented negative test result, assessed December 2023 -
Data quality tables	- Of all persons with HIV infection diagnosed during 2022, at least ($\geq$) 97% have no required fields missing and pass all standard data edit checks, assessed December 2023 - Of all persons with HIV infection diagnosed during 2022, at least ($\geq$) 70% have prior antiretroviral use history, assessed December 2023
Death ascertainment tables	- Of all deaths that occurred during 2021, at least ($\geq$) 85% have an underlying cause of death, assessed December 2023
GDL eval outcome tables	- Of all persons with HIV infection diagnosed during 2022, at least ($\geq$) 90% have their residence at diagnosis geocoded to the census tract level, assessed December 2023
Outcome indicator summary	- Summarizes all indicators above (excluding RIDR, CIDR, and GDL)
Required only for Ending the HIV Epidemic in the US (EHE) priority jurisdictions: (EHE jurisdictions and jurisdictions with EHE counties: Alabama, Arizona, Arkansas, California, Chicago, District of Columbia, Florida, Georgia, Houston, Indiana, Kentucky, Los Angeles, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nevada, New	

Jersey, New York City, North Carolina, Ohio, Oklahoma, Philadelphia, Puerto Rico, San Francisco, South Carolina, Tennessee, Texas, Washington)	
PS20_2010 HIV case report timeliness tables	- Of all persons with diagnosed HIV infection whose diagnoses were first entered into the local HIV surveillance system during 2023, at least ($\geq$) 75% were first entered within ($\leq$) 30 days after the date of diagnosis. ⁺
PS20_2010 Laboratory results report timeliness tables	- Of all laboratory test results that were entered into the HIV surveillance system during 2023, at least ($\geq$) 75% were entered within ($\leq$) 14 days after the date of specimen collection. ⁺

⁺Among cases with person view status = 'A' or 'W'.

G. Data Reporting and Dissemination

In 2023 did you develop and disseminate:	Yes	No
A comprehensive revision of your integrated HIV Epidemiologic Profile?	☐	☐
Updates to the HIV Epidemiologic Profile in the form of updates to core epidemiologic tables and figures, fact sheets, supplemental reports, slide sets, or other publications (but not a comprehensive revision)?	☐	☐
An annual HIV surveillance report?	☐	☐

H. Security and Confidentiality

In 2023:	Yes	No
1. Did your program provide a statement signed by the Overall Responsible Party (ORP) certifying that your program was in <u>full compliance</u> with the <i>Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action (2011)</i> ; hereafter referred to as the NCHHSTP guidelines? Submit your current ORP statement with the SER.	☐	☐
2. Did your program ensure <u>all</u> persons with access to HIV data (including IT personnel) complete an annual security and confidentiality training that is consistent with the NCHHSTP guidelines, sign a confidentiality statement, and store it in the personnel file?	☐	☐
3. Did your program conduct the required annual review of your <u>written</u> security and confidentiality policies and procedures to assess whether changes in legislation or regulations, technology, priorities, personnel, or other situations require updates in policies and procedures?	☐	☐
4. Did your program apply the NCHHSTP guidelines to all sub-contractors and sub-recipients funded through PS18-1802 that have access to or maintain confidential HIV data?	☐	☐
5. Did your program implement secure procedures for data sharing, including Data to Care (D2C) activities, within the context of existing laws, including within your public health program and with external partners (such as sub-recipients)?	☐	☐
6. Did your program implement practices that support secure sharing and use of HIV data across necessary programs within the health department for collaboration with the Medical Monitoring Project (MMP) (if applicable)? ☐ Not applicable	☐	☐
7. Did any data security breach occur, whether it was of personally identifiable information (PII) or a policy breach? (If yes, please answer a and b below)	☐	☐

a. Did your program ensure documentation and reporting of the data security breach with immediate investigation (regardless of whether there was the release of personal information)?	☐	☐
b. Did your program implement corrective actions to avoid breaches of data security protocol?	☐	☐
8. Did any breach occur that resulted in the release of PII to unauthorized persons? (If yes, please answer a and b below)	☐	☐
a. Did your program ensure that the breach that resulted in the release of PII to unauthorized persons was reported to the ORP, to CDC, and, if warranted to law enforcement agencies?	☐	☐
b. Did your program implement corrective actions to avoid breaches that result in the release of PII to unauthorized persons?	☐	☐

I. Cluster Response Performance Measures

Measure	Standard	Result		
		%	Numerator	Denominator
Testing/re-testing of HIV-negatives and persons with unknown HIV status	For partners of transmission cluster members who were not known to be HIV positive at the time of cluster identification, what percentage were tested or re-tested within 6 months of identification as part of the risk network (for persons identified as part of a risk network in 2022)? Persons with unknown HIV status: Persons with negative HIV status: Total:			
		%	n	n
		%	n	n
		%	n	n
PrEP Referral	For HIV-negative partners of transmission clusters not on PrEP, what percentage were referred for PrEP within 6 months of identification as part of the risk network (for persons identified as part of a risk network in 2022)?	%	n	n
Viral Suppression	Of persons with diagnosed HIV infection who were identified as part of a cluster during 2022 and were not virally suppressed at the time of identification, at least ($\geq$) 60% achieved viral suppression within 6 months of cluster identification, assessed December 2023	Results included in Lab reporting tables generated by the CDC-supplied SAS programs		

For the two Testing/re-testing and PrEP Referral standards above, please briefly discuss what you plan to do in the coming year to improve testing/re-testing and PrEP referral outcomes for persons in clusters and risk networks.