

CENTERS FOR DISEASE CONTROL AND PREVENTION
National Center for HIV/AIDS, Viral Hepatitis, STD, & TB Prevention
Division of HIV/AIDS Prevention

Expanded HIV Testing for Disproportionately Affected Populations Monitoring & Evaluation Plan

PS 10-10138

December 2010

Centers for Disease Control and Prevention
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*Expanded Human Immunodeficiency Virus (HIV) Testing for
Disproportionately Affected Populations*

PS 10-10138

Monitoring & Evaluation Plan
December 2010

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Purpose

The purpose of this document is to detail the methods and strategies that the Centers for Disease Control and Prevention (CDC) will use in conducting a comprehensive and systematic evaluation of *Expanded Human Immunodeficiency Virus (HIV) Testing for Disproportionately Affected Populations*, PS 10-10138. This document delineates the monitoring and evaluation (M&E) questions associated with the program announcement along with the identified data sources and report(ing) timelines. This document also describes the strategies for dissemination of M&E findings and how we anticipate those data will be used to inform CDC HIV prevention planning.

While grantees may find the national PS 10-10138 M&E plan helpful as they consider and develop local M&E plans, this document is not meant to serve as a guide that outlines how to develop those local M&E plans. That guidance and technical assistance will be provided through other mechanisms, such as webinars and the grantee orientation meeting.

Goals of the PS 10-10138 Evaluation

In this era of heightened accountability, reduced fiscal resources, and the need to identify evidence-based strategies that most effectively impact the epidemic, monitoring and evaluation have become even more critical for qualitatively and quantitatively assessing the extent to which we are meeting national and local objectives. CDC hopes to achieve several overarching goals through the PS 10-10138 evaluation:

1. Characterize CDC-funded HIV testing activities occurring in the United States, by conducting routine documentation and review of program activities, populations served, and resources used in order to improve HIV prevention programs.
2. Conduct an assessment of planned versus actual program performance over a period of time for the purpose of program improvement and future planning.
3. Routinely document and review program outcomes in order to determine the extent to which program goals and objectives are being met.
4. Provide a context for understanding the successes of and challenges associated with expanding HIV testing and the changes required at the program level to improve the reach and effectiveness of testing.
5. Provide a more accurate assessment to account for public health expenditures and resources.

Target Audience

This M&E plan should be referenced by anyone involved with or interested in the monitoring and evaluation of PS 10-10138 activities including CDC grantees, national partners, and CDC. Within the Division of HIV/AIDS Prevention (DHAP), this includes the Prevention Program Branch (PPB), the Program Evaluation Branch (PEB), and the Office of the Director (OD). Since this announcement has a service integration component, this document is also meant to provide the Divisions of Viral Hepatitis (DVH), Tuberculosis Elimination (DTBE), and Sexually Transmitted Diseases Prevention (DSTDP) information about M&E efforts related to screening through PS 10-10138 for Chlamydia, gonorrhea, syphilis, TB, and Hepatitis B and C in HIV test settings.

Described in more detail later, the target audience for PS 10-10138 evaluation data reports and lessons learned includes: CDC; federal agencies other than CDC; external partners and national organizations; CDC grantees; and the general public.

Background

More than 25 years into the epidemic, HIV continues to exact a tremendous toll in the United States. CDC estimates that, in this country, over 50,000 new HIV infections occur each year and 1.1 million Americans are living with HIV. The epidemic continues to have a disproportionate impact on racial and ethnic minority populations – particularly African Americans and Hispanics – and on men who have sex with men (MSM) and injection drug users (IDUs) regardless of race or ethnicity.

In 2007, CDC implemented a new HIV testing program – PS 07-768: *Expanded and Integrated Human Immunodeficiency Virus (HIV) Testing for Populations Disproportionately Affected by HIV, Primarily African Americans* – aimed at (1) significantly increasing the number of persons tested each year in jurisdictions with a high incidence of HIV among disproportionately affected populations and (2) supporting dissemination and implementation of its *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*. Through PS 07-768, grantees achieved several notable successes:

1. In the first two years, conducted over 1.4 million HIV tests.
2. Identified over 10,000 persons with newly diagnosed HIV infection.
3. Linked to care and treatment approximately 75% of newly diagnosed HIV-infected persons.
4. Successfully targeted African Americans: In the first two years, approximately 62% of tests were among African Americans, and approximately 70% of new HIV positives were identified among African Americans.
5. Established new relationships with and initiated routine HIV screening programs in a variety of healthcare settings, including emergency departments, sexually transmitted disease (STD) clinics, tuberculosis (TB) clinics, state and local jails, urgent care clinics, and community health centers.
6. Achieved high success rates in linking persons with newly diagnosed HIV infection to medical care, partner services, and other support services.
7. Strengthened public health and preventive care infrastructure, particularly in venues and communities serving disproportionately affected populations.

PS 10-10138: Expanded Testing Program

The Expanded Human Immunodeficiency Virus (HIV) Testing for Disproportionately Affected Populations announcement is intended to sustain progress made under announcement PS 07-768 and expand routine testing services to new healthcare and non-healthcare settings to reach a broader array of at-risk populations. PS 10-10138 aims to:

1. Increase HIV testing opportunities for populations disproportionately affected by HIV – primarily (1) African American and Hispanic men and women, and (2) men who have sex with men (MSM) and injection drug users (IDUs), regardless of race or ethnicity.

2. Increase the proportion of HIV-infected persons in these populations who are aware of their infection and are linked to appropriate services.
3. Identify strategies for leveraging resources to maximize the yield and sustainability of routine HIV screening programs in healthcare settings.

Further, in order to maximize the health benefits that persons receive from prevention services, this program encourages and supports integration of diagnostic and prevention services for HIV, hepatitis C virus (HCV), hepatitis B virus (HBV), sexually transmitted diseases (STD), and tuberculosis (TB).

Operational Context

PS 10-10138 funding is limited to health departments in jurisdictions with at least 175 estimated combined AIDS diagnoses among Blacks/African Americans and Hispanics/Latinos in 2007. The following 30 jurisdictions were eligible to participate: Alabama, Arizona, California, Chicago, Connecticut, District of Columbia, Florida, Georgia, Houston, Illinois, Los Angeles, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, New Jersey, New York City, New York State, North Carolina, Ohio, Pennsylvania, Philadelphia, Puerto Rico, San Francisco, South Carolina, Tennessee, Texas, and Virginia.

PS10-10138 includes two components: Part A – HIV Screening and HIV Counseling, Testing, and Referral; and Part B – Enhanced Linkage to Medical Care and Partner Services. For Part A, CDC awarded 30 cooperative agreements. For Part B, CDC funded 18 jurisdictions. The project period for PS 10-10138 is up to three years.

Program Goals and Objectives

Measurable outcomes of the program align with one or more of the following performance goal(s) for the National HIV/AIDS Strategy for the United States, the National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), and the Division of HIV/AIDS Prevention Strategic Plans:

1. Decrease the annual HIV incidence rate.
2. Increase the proportion of HIV-infected people in the United States who know they are infected.
3. Increase the proportion of HIV-infected persons who are linked to prevention and care services.

The following are specific, national-level goals and objectives for PS 10-10138:

Table 1. PS 10-10138 program goals and objectives

Goals	Objectives
<p>1. Among populations disproportionately affected by HIV – primarily (1) African American and Hispanic men and women, and (2) MSM and IDUs, regardless of race or ethnicity – increase the number of persons who receive HIV testing, and the number and proportion of HIV-infected persons who are aware of their infection, through the following strategies:</p> <p>A. Routine HIV screening in healthcare settings serving these populations.</p> <p>B. Expanded, targeted HIV counseling, testing, and referral (CTR) in non-clinical settings or venues where high-risk members of these populations can be accessed.</p>	<p>1. In the first year, conduct approximately 1.1 million HIV tests and identify approximately 5,500 HIV-infected persons who were previously not aware of their infection. When the program is fully implemented, annually conduct approximately 1.3 million HIV tests and identify approximately 6,500 HIV-infected persons who were previously not aware of their infection.</p> <p>2. Ensure that at least 85% of persons who test positive for HIV receive their test results.</p> <p>3. For targeted CTR in non-clinical settings or venues, achieve at least a 1.0% rate of newly identified HIV-positive tests annually.</p>
<p>2. Ensure that persons testing positive for HIV infection (new positives and previously diagnosed positives not in care) receive prevention counseling and are linked to medical care, partner services, and HIV prevention services.</p>	<p>1. Ensure that at least 80% of persons who receive their HIV positive test results are referred to medical care and attend their first appointment.</p> <p>2. Ensure that at least 75% of persons who receive their HIV positive test results are referred to partner services.</p> <p>3. Ensure that at least 75% of persons who receive their HIV positive test results receive prevention counseling or are referred to prevention services.</p>
<p>3. Promote adoption of sustainable, routine HIV screening programs in healthcare facilities, consistent with CDC’s 2006 Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings</p>	<p>1. Over the course of the project, in the funded jurisdictions, increase the number of healthcare facilities that have implemented sustainable, routine HIV screening programs consistent with CDC’s 2006 guidelines.</p>
<p>4. Support integration of HIV testing with testing and prevention services for other infections, such as hepatitis C virus (HCV), hepatitis B virus (HBV), other sexually transmitted diseases (STDs), and tuberculosis (TB).</p>	<p>1. Over the course of the project, in the funded jurisdictions, increase the number of venues offering integrated testing programs for HIV, HCV, HBV, other STDs, and TB.</p>

Table 2. PS 10-10138 program activity requirements

PS 10-10138 ACTIVITY REQUIREMENTS	
Activity	Requirement
<i>Part A: HIV Screening and HIV Counseling, Testing, and Referral</i>	Required
1. Program Services	Required
Category 1 – HIV Screening in Healthcare Settings	Required
A. HIV Screening	Required
B. Service Integration	Optional
Category 2 – HIV Counseling, Testing, and Referral in Non-healthcare Settings	Optional
A. HIV Counseling, Testing, And Referral	Required if Category 2 funded
B. Service Integration	Optional
2. Program Support	Required
<i>Part B – Enhanced Linkage to Medical Care and Partner Services</i>	Optional
1. Program Services	Required if Part B funded
2. Program Support	Required if Part B funded

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Figure 1. PS10-10138 program logic model

Inputs	Activities	Outputs	Short-term Outcomes	Long-term Outcomes
<ul style="list-style-type: none"> • Funding • CDC staff • Health department, venue staff • Training, technical assistance • Program monitoring • Partners and stakeholders 	<p><u>HIV Testing</u></p> <ul style="list-style-type: none"> • Provide routine HIV screening in healthcare, targeted CTR non healthcare settings <p><u>Activities for HIV positive clients</u></p> <ul style="list-style-type: none"> • Deliver test results to clients • Link clients to medical care • Interview clients for partner services • Provide prevention counseling and/or referral to prevention services to clients <p><u>Activities for HIV negative clients</u></p> <ul style="list-style-type: none"> • Ensure that high-risk HIV negative clients in non health care settings are referred to prevention services <p><u>Service Integration</u></p> <ul style="list-style-type: none"> • Provide testing for HCV, HBV, STDs and TB in conjunction with routine HIV testing <p><u>Sustainability</u></p> <ul style="list-style-type: none"> • Promote the adoption of sustainable HIV screening programs in healthcare settings <p><u>Part B: Enhanced Linkage to Medical Care and Partner Services activities</u></p> <ul style="list-style-type: none"> • Link HIV positive clients to medical care within 90 days of HIV test • Interview HIV positive clients for partner services within 30 days of HIV test • Provide prevention counseling and/or referral to prevention services to HIV positive clients • Screen HIV positive clients upon their first medical visit • Retain in medical care 3 months and 6 months after receiving HIV test result. • Locate and re-engage HIV positive clients lost to follow-up 	<ul style="list-style-type: none"> • # of HIV test events • # of newly identified positives • # of HIV positive clients receiving test results • # of HIV positive clients linked to medical care • # of HIV positive clients interviewed for partner services • # of HIV positive clients counseled or referred to prevention services • # of high risk negative clients are referred to prevention services • # of healthcare facilities with sustainable routine HIV screening programs • # of tests for HCV, HBV, STDs and TB conducted in conjunction with HIV testing. <p><u>Part B: Enhanced Linkage to Medical Care and Partner Services</u></p> <ul style="list-style-type: none"> • # of HIV positive clients linked to medical care with 90 days of HIV test • # of HIV positive clients interviewed for partner services within 30 days of HIV test • # of HIV positive clients receiving prevention counseling and/or referred to prevention services • # of HIV positive clients screened upon 1st medical visit • # of HIV positive clients in medical care after 3 months of HIV test and after 6 months of HIV test? • # of HIV positive clients lost to follow-up who are located and re-engaged in care 	<ul style="list-style-type: none"> • Expanded routine HIV screening in healthcare settings • Increased HIV testing among target populations • Increased number of HIV infected persons who are aware of their HIV status • Increased number of HIV positive clients linked to care • Increased number of HIV positive clients linked to partner services • Increased number of HIV positive clients counseled or referred to prevention services • Increased awareness and knowledge of HIV • Increased number of sustainable routine HIV screening programs in healthcare settings • Increased testing for HCV, HBV, STDs and TB conducted in conjunction with HIV testing 	<ul style="list-style-type: none"> • Reduction in risk behavior • Improved health outcomes for HIV positives • Decreased HIV incidence • Decreased HIV transmission rate • Decrease in HIV morbidity and mortality

PS 10-10138 M&E Plan Development Process

Framework

The *Framework for Program Evaluation in Public Health* (CDC, 1999) guided the development of the PS 10-10138 M&E plan. The six steps of the framework are:

1. Engage the stakeholders
2. Describe the program
3. Focus the evaluation design
4. Gather credible evidence
5. Justify conclusions
6. Ensure use and share lessons learned.

In addition, the Framework outlines four standards—utility, feasibility, propriety, and accuracy—that were used to determine the most important questions that need to be answered and the appropriate methods for collecting, submitting, and reporting PS 10-10138 program data.

Stakeholder Engagement

In keeping with the evaluation framework and established practices within the Division, CDC engaged stakeholders early in the M&E planning process. Within the National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), DHAP, the Program Evaluation Branch (PEB) served as the lead in the development of the PS 10-10138 M&E plan. However, strong collaboration within DHAP and NCHHSTP was vital to ensure that M&E of program services activities were addressed effectively and efficiently. Therefore, CDC convened a workgroup comprised of key internal stakeholders, including representatives from each division within NCHHSTP—DHAP, DTBE, DSTDP, and DVH. Collaboration within the Center was important for ensuring that M&E of services integration activities were sufficiently addressed.

External stakeholders—DHAP funded grantees and national partners from each of the NCHHSTP divisions—were also invited to participate and provide input into the M&E plan for PS 10-10138. Note that grantee participants could not be engaged in the development of the plan until cooperative agreement awards had been made.

Core M&E Team

The Core M&E Team included an M&E lead from DHAP PEB, other key DHAP PEB staff, a member of DHAP Office of the Director (OD), a Manila contractor, and an ORISE fellow. This core team was ultimately responsible for the development of this M&E plan, e.g., engaging internal and external stakeholders to participate on the CDC M&E workgroup; coordinating and facilitating the CDC M&E workgroup meetings; eliciting, compiling, and incorporating stakeholder comments; and drafting of this plan. The core team was also responsible for identifying and addressing key considerations. The M&E lead was responsible for the overall coordination of all of these activities, as well as close collaborations with the DHAP PS 10-10138 Lead Team, the DHAP PS 10-10138 Implementation Team and DHAP OD.

Evaluation Methodology

CDC will use a multi-pronged M&E approach, to include the review, dissemination and use of process monitoring, process evaluation, and outcome monitoring data. The final set of M&E questions reflects the need to use multiple data sources for a more comprehensive evaluation approach. These data sources include the NHM&E data, grantees' interim and annual progress reports (IPR/APR), and Financial Status Reports (FSR) for cost-related questions.

Process Monitoring and Process Evaluation

The quarterly reported NHM&E data will be used as the main source for documenting the implementation and progress toward grantees' proposed PS 10-10138 activities and for monitoring progress in achieving desired goals. Variables that will be assessed include those that document characteristics of clients, settings for HIV testing events, and overall numbers of HIV tests conducted. Grantees should also anticipate on-going communication with their project officers between data submissions and IPR/APR reporting. CDC may collect additional information through telephone or e-mail communications or by conducting site visit assessments.

Outcome Monitoring

Outcome monitoring will continue with a mixed methods approach, assessing the achievement of program milestones and the levels of achievement of goals and objectives by analyzing quantitative data received through NHM&E and through grantees' IPR/APRs.

- Intermediate outcomes will primarily focus on annual numbers of HIV testing events in target populations and the levels and types of program expansions reported by grantees.
- Longer term outcomes will focus largely on the sustainability of activities initiated or expanded upon with PS 10-10138.

Key Considerations

While this plan specifically addresses activities, outputs and outcomes associated with PS10-10138, this announcement is one part of DHAP's overall HIV prevention efforts. Similar to what occurs at the local level, PS 10-10138 there are many competing, and often complex factors that inform what data are collected, how, when, and by whom. Numerous factors were considered and addressed as part of the M&E plan development process.

- Consistency with collection and reporting of the Prevention Program Performance Indicators for HIV testing (CTR1, CTR2, and CTR3);
- Revision of HIV testing data variables;
- On-going work related to the critical review and revision of HIV Testing recommended definitions;
- Identification of available data sources and feasible processes to capture quantitative and qualitative data, in order to address key M&E questions;
- National strategic planning and anticipated questions and requirements as part of comprehensive prevention effort;
- Ensuring a balance between the need to streamline reporting requirements and reduce data burden and the need for new HIV testing reporting requirements

Testing Strategy

In keeping with the 2006 HIV testing recommendations, through PS 10-10138 CDC continues its emphasis on screening in healthcare settings and targeted testing in non-healthcare settings. Targeted testing involves testing persons based on characteristics that increase their likelihood of being infected with HIV. These characteristics can include the presence of sexually transmitted diseases, behavioral risks, or attendance at venues frequented by high-risk persons. Screening involves testing persons regardless of whether they have a recognized behavioral risk or presence of signs or symptoms of HIV infection. This might be accomplished by testing all persons in a defined population or by selecting persons with specific population-level characteristics (e.g., demographic, geographic area).

While testing strategy will no longer be required at the national level as a mechanism for distinguishing between targeted testing and screening, CDC still encourages the use of this variable at the jurisdictional level to help inform program planning.

Key Terms and Definitions

Throughout this document and the PS 10-10138 FOA a number of terms are used that relate to how the M&E questions and their related data collection measures are operationalized. Following is a selection of key terms that are useful when reviewing the national M&E plan. The definitions for these terms are taken from the CDC document “*Recommended HIV Testing Definitions and Examples*.” This document is in clearance and so therefore, definitions included here are still considered draft.

Confirmed HIV-positive test result: An HIV-positive test result that is confirmed using a highly specific test. Both preliminary HIV-positive rapid test results and positive conventional EIA test results must be confirmed by supplemental testing to provide an HIV diagnosis. The person is considered HIV-positive only if the confirmatory test result is positive.

Healthcare setting: A setting in which both medical diagnostic and treatment services are provided.

Integrated service: A situation in which a person is offered and can receive two or more CDC-recommended prevention, treatment, or care services across sexually transmitted diseases (STDs), viral hepatitis, or tuberculosis (TB) in the course of a single HIV testing event within one facility.

Interviewed for Partner Services (PS): Indicates whether or not the client was interviewed for the purpose of HIV PS by health department staff and/or providers on behalf of the health department. It may include interviews conducted by providers other than health department staff (e.g., CBO staff; physicians; other persons authorized by law, regulation, or policy), but only if these interviews can be verified. “Verified interviews” are interviews whose outcomes are routinely reported to the health department and may come from outside sources.

Linkage to HIV medical care: Indicates whether or not the client attended his or her first HIV medical care appointment within 90 days of receiving the HIV test.

Newly diagnosed HIV infection: HIV infection in a person who meets both of the following criteria: (1) does not self-report having previously tested positive and (2) has not been previously reported to the health department's surveillance registry as being infected with HIV. Newly diagnosed HIV infection is also referred as to a newly diagnosed HIV case.

Newly identified HIV-positive test result: A confirmed HIV-positive test result associated with a person who does not self-report having previously tested positive. This term is mainly used for data analysis purposes. The history of a previous HIV-positive test result should be determined at a minimum from the person's perspective. It is possible that some persons who do not self-report as having a previous HIV-positive test result, may in fact be found to be HIV infected via agency record review or a health department's surveillance registry check.

Non-healthcare setting: A setting in which neither medical diagnostic nor treatment services are provided, but health screening may be provided.

Previously diagnosed HIV infection: HIV infection in a person who meets either of the following criteria: (1) self-reports having previously tested positive or (2) has been previously reported to the health department's surveillance registry as being infected with HIV. Previously diagnosed HIV infection is also referred as a previously diagnosed HIV case.

Provision of test result: Process by which the person is provided with his or her HIV test result.

Referral to prevention services: The process by which persons' needs for prevention services are assessed and persons are provided with assistance, including necessary follow-up efforts to facilitate initial contact with appropriate service providers. Comprehensive risk counseling services and health education and risk reduction (HE/RR) are some examples of the other prevention services available for HIV-infected persons.

Testing Event: The sequence of one or more tests conducted with a person to determine his or her HIV status. During one testing event, a person may be tested once (e.g., one rapid test or one conventional test) or multiple times (e.g., one rapid test followed by one conventional test to confirm the preliminary HIV-positive test result). A single testing event may involve more than one face-to-face interaction over more than 1 day.

Data Collection and Submission

Tables 3 and 4 list the specific M&E questions for Parts A and B of PS 10-10138, the data source and the period of analysis for each question (e.g., annually, quarterly). Client-level data are captured at the time of the testing event and include client demographic and risk characteristics; HIV testing outcomes; and documentation of referrals for HIV-positive clients. Client-level HIV testing data are reported quarterly to the CDC, generally no later than 45 days after the end of the quarter or as specified in the cooperative agreement.

Other data that are important for cooperative agreement program monitoring and accountability will be submitted qualitatively and quantitatively in aggregate via grantees' interim and annual progress reports. These data are used to complement the HIV testing reports and summaries from test level quantitative data analyzed by PEB (see Table 3).

CDC is leasing [EvaluationWeb®](#) (Luther Consulting, LLC), for all HIV testing data submitted to CDC by ETP grantees. HIV testing data will be key entered or uploaded by ETP grantees to Evaluation Web and then submitted to CDC after undergoing initial data quality checks in Evaluation Web.

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Table 3. PS 10-10138 monitoring and evaluation questions, Part A

	M&E Question	Measures & Stratifications	Data Source	Required Variables or Data Source Reference	M&E Domain	Analytic Reference Period
<i>Was the program successful in achieving its national objective of conducting ≥ 1.1 million tests in the first year and ≥ 1.3 million tests in years one and two?</i>						
1.	How many HIV tests were conducted? <ul style="list-style-type: none"> How many and what percentage were conducted in healthcare facilities? How many and what percentage were conducted in non-healthcare settings? 	Number of HIV tests conducted stratified by: <ul style="list-style-type: none"> Client demographic characteristics Client risk factors 	NHM&E	Sample Date Test Technology Site Type Year of Birth Ethnicity Race Current Gender Identity Client Risk Factors Additional Client Risk Factors	HIV tests	By fiscal year: 09/30/2010 – 09/29/2011 09/30/2011 – 09/29/2012 09/30/2012 – 09/29/2013
2.	What barriers and challenges were encountered with respect to reaching objectives for the numbers of tests conducted?	N/A	IPR/APR	Corresponding APR question	HIV tests	By fiscal year
3.	What strategies were successful in addressing these barriers and challenges?	N/A	IPR/APR	Corresponding APR question	HIV tests	By fiscal year
<i>Was the program successful in achieving its national objective of identifying $\geq 6,500$ persons with newly diagnosed HIV infection annually?</i>						
4.	How many and what percentage of HIV tests were positive? <ul style="list-style-type: none"> How many and what percentage were previous positive? How many and what percentage were newly positive? 	Number of HIV-positive tests stratified by: <ul style="list-style-type: none"> Type of setting Client demographic characteristics 	NHME	Sample Date Test Technology Test Result Site Type Year of Birth Ethnicity Race Current Gender Identity	HIV positivity	By fiscal year

	M&E Question	Measures & Stratifications	Data Source	Required Variables or Data Source Reference	M&E Domain	Analytic Reference Period
		<ul style="list-style-type: none"> Client risk factors 		Client Risk Factors Additional Client Risk Factors Self reported HIV status		
5.	What barriers and challenges were encountered with respect to reaching objectives for number and percent of tests that were newly diagnosed HIV infections?	N/A	IPR/APR	Corresponding APR question	HIV positivity	By fiscal year
6.	What strategies were successful in addressing these barriers and challenges?	N/A	IPR/APR	Corresponding APR question	HIV positivity	By fiscal year
<i>Was the program successful in reaching its intended target populations?</i>						
7.	How many and what percentage of HIV tests were among African Americans or Hispanics?	Number of tests overall and number of tests among African Americans and Hispanics	NHME	Sample Date Test Technology Test Result Site Type Year of Birth Ethnicity Race Current Gender Identity	Testing target populations, HIV testing	By fiscal year
8.	In non-healthcare settings, how many and what percentage of HIV tests were among MSM or IDUs?	Number of tests stratified by clients' self-reported risk	NHME	Sample Date Test Technology Test Result Site Type Year of Birth Ethnicity Race Current Gender Identity Client Risk Factors	Testing target populations, HIV testing	By fiscal year
9.	How many and what percentage of newly positive tests were among African		NHME		Testing target populations,	By fiscal year

	M&E Question	Measures & Stratifications	Data Source	Required Variables or Data Source Reference	M&E Domain	Analytic Reference Period
	Americans, Hispanics, MSM, and IDUs?				HIV testing	
10.	What barriers and challenges were encountered with respect to reaching the intended target populations?	N/A	IPR/APR	Corresponding APR question	Testing target populations, HIV testing	By fiscal year
11.	What strategies were successful in addressing these barriers and challenges?	N/A	IPR/APR	Corresponding APR question	Testing target populations, HIV testing	By fiscal year
<i>Was the program successful in achieving its national objectives for percentage of persons with newly positive tests who 1) receive their test results, 2) are linked to medical care, 3) are interviewed for partner services, and 4) receive or are referred for prevention counseling?</i>						
12.	<p>Among clients with newly positive HIV tests:</p> <ul style="list-style-type: none"> • How many and what percentage received their positive test results? • How many and what percentage were linked to medical care? • How many and what percentage were interviewed for partner services? • How many and what percentage received prevention counseling or were referred for prevention services? 	<ul style="list-style-type: none"> • Numbers of clients who received their test results • Number who were linked to: HIV medical care, partner services, prevention services 	NHME	Sample Date Test Technology Test Result Result Provided Site Type Year of Birth Ethnicity Race Current Gender Identity Client Risk Factors Attended first medical care appointment Interviewed for Partner Services Linked to prevention services	Receipt of HIV test results, linkages to care, PS, prevention services	By fiscal year
13.	<p>What barriers and challenges were encountered with respect to the following:</p> <ul style="list-style-type: none"> • Returning positive test results to clients? • Linking newly diagnosed positive 	N/A	IPR/APR	Corresponding APR question	Receipt of HIV test results, linkages to care, PS, prevention	By fiscal year

	M&E Question	Measures & Stratifications	Data Source	Required Variables or Data Source Reference	M&E Domain	Analytic Reference Period
	clients to medical care? • Interviewing newly diagnosed positive clients for partner services? • Providing prevention counseling to newly diagnosed positive clients, or referring them for prevention services?				services	
14.	What strategies were successful in addressing these barriers and challenges to returning results and linking clients to HIV medical care, Partner Services, and prevention services?	N/A	IPR/APR	Corresponding APR question	Receipt of HIV test results, linkages to care, PS, prevention services	By fiscal year
<i>Was the program successful in achieving its national objective of increasing the number of healthcare facilities that have implemented sustainable HIV screening programs consistent with the 2006 recommendations?</i>						
15.	What barriers were encountered in obtaining reimbursement for testing from 3 rd party payers?	N/A	IPR/APR	Corresponding APR question	Reimbursement	By fiscal year
16.	What strategies were successful in addressing barriers and challenges to obtaining reimbursement?	N/A	IPR/APR	Corresponding APR question	Reimbursement	By fiscal year
17.	How many screening programs implemented under PS10-10138 were able to continue after the project period ended?	Reported numbers of screening programs that continue to adhere to the 2006 recommendation	TBD	Special survey	Sustainability	One year after PS 10-10138 concludes

	M&E Question	Measures & Stratifications	Data Source	Required Variables or Data Source Reference	M&E Domain	Analytic Reference Period
		s one year after PS 10-10138 concludes				
<i>Was the program successful in achieving its national objective of increasing the number of venues offering integrated testing programs for HIV, other STDs, HCV, HBV, and TB?</i>						
18.	How many venues were funded to conduct service integration activities (i.e., to conduct testing for other STDs, viral hepatitis, and TB in conjunction with HIV testing)? Need to define service integration	Number of venues conducting service integration as defined by CDC	IPR/APR	Corresponding APR question	Service integration	By fiscal year
19.	How many tests for each of the following were conducted in conjunction with HIV testing in venues funded to conduct service integration activities? <ul style="list-style-type: none"> • Syphilis • Gonorrhea • Chlamydial infection • Hepatitis B • Hepatitis C • TB 	Aggregate numbers of tests for each activity	IPR/APR	Corresponding APR question	Service integration	By fiscal year
20.	What barriers and challenges were encountered in implementing and conducting service integration activities?	N/A	IPR/APR	Corresponding APR question	Service integration	By fiscal year
21.	What strategies were successful in addressing barriers to service integration?	N/A	IPR/APR	Corresponding APR question	Service integration	By fiscal year

Table 4. PS 10-10138 monitoring and evaluation questions, Part B

NOTE: This table will be populated once the Part B evaluation is completely drafted through a separate process. However, these are the M&E questions that will serve as the basis for Part B evaluation planning.

	M&E Question	Measure(s) & Stratifications	Data Source	Required Variables or Data Source Reference	M&E Domain	Analytic Reference Period
<i>Was the program successful in achieving its national objectives for percentage of persons with newly diagnosed positive HIV tests who 1) receive their test results, 2) are linked to medical care, 3) are interviewed for partner services, and 4) receive prevention counseling or are referred for prevention services?</i>						
1.	<p>Among clients with newly diagnosed positive HIV tests:</p> <ul style="list-style-type: none"> • How many and what percentage received their positive test results? • How many and what percentage were linked to medical care within 90 days of their positive test? • How many and what percentage were interviewed for partner services within 30 days of their positive test? • How many and what percentage received prevention counseling or were referred for prevention services? 					
<i>Was the program successful in achieving its national objectives for percentage of persons with newly diagnosed positive HIV tests who are linked to medical care who 1) receive appropriate screening for other STDs, viral hepatitis, and TB at their initial medical visit; 2) are still in care three months after their initial medical visit; and 3) are still in care six months after their initial medical visit?</i>						
2.	<p>Among clients with newly diagnosed positive HIV tests who are linked to medical care:</p> <ul style="list-style-type: none"> • How many and what percentage received appropriate screening for 					

	M&E Question	Measure(s) & Stratifications	Data Source	Required Variables or Data Source Reference	M&E Domain	Analytic Reference Period
	<p>other STDs, viral hepatitis, and TB at their initial medical visit?</p> <ul style="list-style-type: none"> • How many and what percentage were still in care three months after their initial medical visit? • How many and what percentage were still in care six months after their initial medical visit? 					
<p><i>For newly diagnosed HIV positive clients who are linked to medical care, but are subsequently lost to follow-up, was the program successful in locating them and re-engaging them in care?</i></p>						
3.	<p>Among clients with newly diagnosed positive HIV tests who are linked to medical care, but are subsequently lost to follow-up, how many and what percentage were located and re-engaged in care?</p>					

***Note: Jurisdictions funded to conduct Part B activities will be evaluated on the questions in both Tables 3 and 4.**

Data Quality Assurance and Analysis

PEB will continue to utilize existing data management and data quality (DM/DQ) processes to provide quarterly feedback and guidance to grantees regarding their submitted HIV testing data. Through this process, PEB aims to provide support that will result in timely feedback to grantees regarding the quality and validity of their data and improved quality of the data collected and reported to CDC by grantees. This is accomplished by:

- Providing grantees with comprehensive and user-friendly DM/DQ reports on a quarterly basis after data submission.
- Discussing with and providing feedback to grantees at least quarterly regarding the data included in DM/DQ reports.
- As necessary, providing reports to PPB project officers and PEB leadership to help facilitate programmatic discussions related to data quality and data completeness.

Analysis

CDC will largely use descriptive statistics to assess how well PS 10-10138 is meeting objectives (i.e., numbers of HIV testing events, numbers of African American, Hispanic, MSM, and IDU tested, proportion of HIV-positive clients receiving results, proportion of HIV-positive clients attending the first HIV medical care appointment, proportion of HIV-positive clients interviewed for Partner Services).

Feedback Loop

A collaborative approach is intended for all levels of M&E. While CDC is accountable to its stakeholders and must respond to national-level questions, the aim is to also consider the unique insight that grantees provide to the M&E process, including the interpretation of data observations. Much of this will be accomplished through the DM/DQ process, but a substantial part of this will also be a result of communications between grantees and their project officers.

PS 10-10138 Data Dissemination and Use

Data Utilization

“Primary users of the evaluation are the specific persons who are in a position to do or decide something regarding the program. In practice, primary users will be a subset of all stakeholders identified. A successful evaluation will designate primary users early in its development and maintain frequent interaction with them so that the evaluation addresses their values and satisfies their unique information needs.” – (CDC, 1999)

PS 10-10138 M&E findings should be used internally and externally by program staff, researchers, policymakers, health departments and others to inform national- and local-level HIV prevention program decision-making. The ultimate goal of providing meaningful and user-friendly deliverables from this evaluation is to facilitate the sharing and use of information that can contribute to the best services and care for clients and to decrease HIV transmission, HIV incidence, progression from HIV to AIDS, and HIV-related morbidity and mortality rates. Key stakeholders and their anticipated uses of evaluation findings are summarized in Table 4.

Table 5. Summary: Key Stakeholders and Anticipated Uses of Evaluation Findings

	Program Monitoring	Program Improvement	Program Planning	Reporting to Funders and Stakeholders	Advocacy
CDC	X	X	X	X	
Congress and Non-CDC Federal Agencies	X	X	X	X	
CDC grantees	X	X	X	X	X
External partners / National organizations		X	X	X	X
General public				X	X

At the national level, it is anticipated that Congress will use information for accountability and to assess the effective and efficient use of PS 10-10138 funds to inform decisions about future funding appropriations. CDC will aggregate local data across jurisdictions and create a national picture, which Congress, non-CDC federal agencies, and CDC can use to identify future program areas and influence national health policies (CDC, April 9, 2010).

CDC itself, including NCHHSTP-OD, DHAP-OD, PPB, CBB, PEB, DSTDP, DTBE and DVH will use the findings from this evaluation: (1) to monitor performance of the PS 10-10138 grantees and program, so CDC and grantees can identify service providers who need to make changes early on; (2) to determine if CDC needs to (a) change the PS 10-10138 program to better meet its goals or to better fit the local situations – perhaps by identifying changes in client characteristics or shifts in client demographics, or (b) help grantees and service providers make positive changes by providing focused TA – including showing stakeholders how to use program data to make program improvements; (3) to make appropriate changes in the program early on if not reaching the outcomes expected; identify intended and unintended effects; and make recommendations for the next FOA; (4) to investigate if outcomes can be attributed to implementation and to celebrate successes, share information with stakeholders, make recommendations for program development and structural interventions; (5) to investigate the costs in 10138 dollars of new positive HIV tests; and (6) to fulfill reporting requirements to stakeholders.

It is also anticipated that information from this evaluation will be helpful to NCHHSTP-OD, DHAP-OD, DSTDP, DTBE, and DVH in investigating to what extent PS 10-10138 funding has resulted in the development of new and established linkages among HIV, STD, TB and VH programs and facilitated delivery of services. Finally, individually, STD, VH, and TB may benefit from evaluation findings related to STD, TB, and VH tests and services for program monitoring, program planning, and program improvement purposes.

External partners, including NASTAD and UCHAPS, can use PS 10-10138 M&E findings to supplement their current knowledge for enhanced planning, guidance and technical assistance; and to advocate for HIV programs and people living with HIV.

Deliverables and Dissemination

In consultation with partners internal and external to PEB, including but not limited to PPB, OD, and grantees, reports and other deliverables will be produced. CDC has engaged stakeholders in the process of developing this evaluation (as previously indicated) and has identified and used stakeholder information needs as the basis for planning deliverables and dissemination methods. Planning effective communication requires consideration of the timing, style, tone, message source, vehicle, and format of information products (CDC, 1999). CDC is responsive to the needs of different stakeholders.

The proposed deliverables and delivery schedules for this evaluation are presented in Table 5. Additional information in the table includes the deliverable purpose, contents, periodicity, target audience(s), and format. Proposed deliverables in this table include: a Programmatic Activities Report, Special Purpose or Audience Specific Reports, a Quarterly Grantee Report Card, an Interim Progress Report (IPR), an Annual Progress Report (APR), and Jurisdiction Reports. Specific information related to these deliverables is indicated in the table. Second is a proposed reporting schedule for the proposed quarterly reports.

Table 6: Summary of PS 10-10138 M&E dissemination strategies

Deliverable	Purpose	Content Summary	Periodicity	Primary Target Audience(s)	Format and Dissemination	Potential Uses
Programmatic Activities Report	<p>To describe the planned and implemented program activities for each funding year</p> <p>To provide recommendations for changes in the next FOA</p>	<p>Executive summary, introduction, process and outcome objectives, key variables and questions, description of data sources, data collection methods, data analysis methods and quality assurance processes, limitations, findings. May include recommendations for program monitoring and evaluation, program improvement, and program planning</p> <p>Will include quantitative and qualitative data</p>	Annual	DHAP OD PPB CBB	<p>Written with text and tables distributed electronically</p> <p>PowerPoint presentations</p> <p>PS 10-10138 community forums and website</p>	<p>Determine if and what changes are needed to improve the program</p> <p>Determine whether program components are working well and which factors need to be improved</p> <p>Determine if training or technical assistance is needed</p>
Quarterly Grantee Report	To describe progress of jurisdictions in reaching program objectives.	Summary of PS 10-10138 priority questions and CT performance indicators	Quarterly	PPB PEB	Written, electronic	Program monitoring. Determine what factors contribute to program success. Program planning Program improvement

Deliverable	Purpose	Content Summary	Periodicity	Primary Target Audience(s)	Format and Dissemination	Potential Uses
Jurisdiction Reports	To give back to grantees information about their own jurisdictions.	Will need to work with grantees to determine what data are most useful		Grantees	Must work with grantees to determine the best formats—conference calls, reports, etc.	Program monitoring Program planning Program improvement

Table 7. PS 10-10138 dissemination reporting schedule

	Q1/ Y1	Q2/ Y1	Q3/ Y1	Q4/ Y1	Y1, Annual	Q1/ Y2	Q2/ Y2	Q3/ Y2	Q4/ Y2	Y2, Annual	Q1/ Y3	Q2/ Y3	Q3/ Y3	Q4/ Y3	Y3, Annual
Programmatic Activities Report					X					X					X
Cost Assessment or Cost Analysis Report															X
Quarterly Grantee Report	X	X	X	X		X	X	X	X		X	X	X	X	
Jurisdiction Reports				X					X					X	

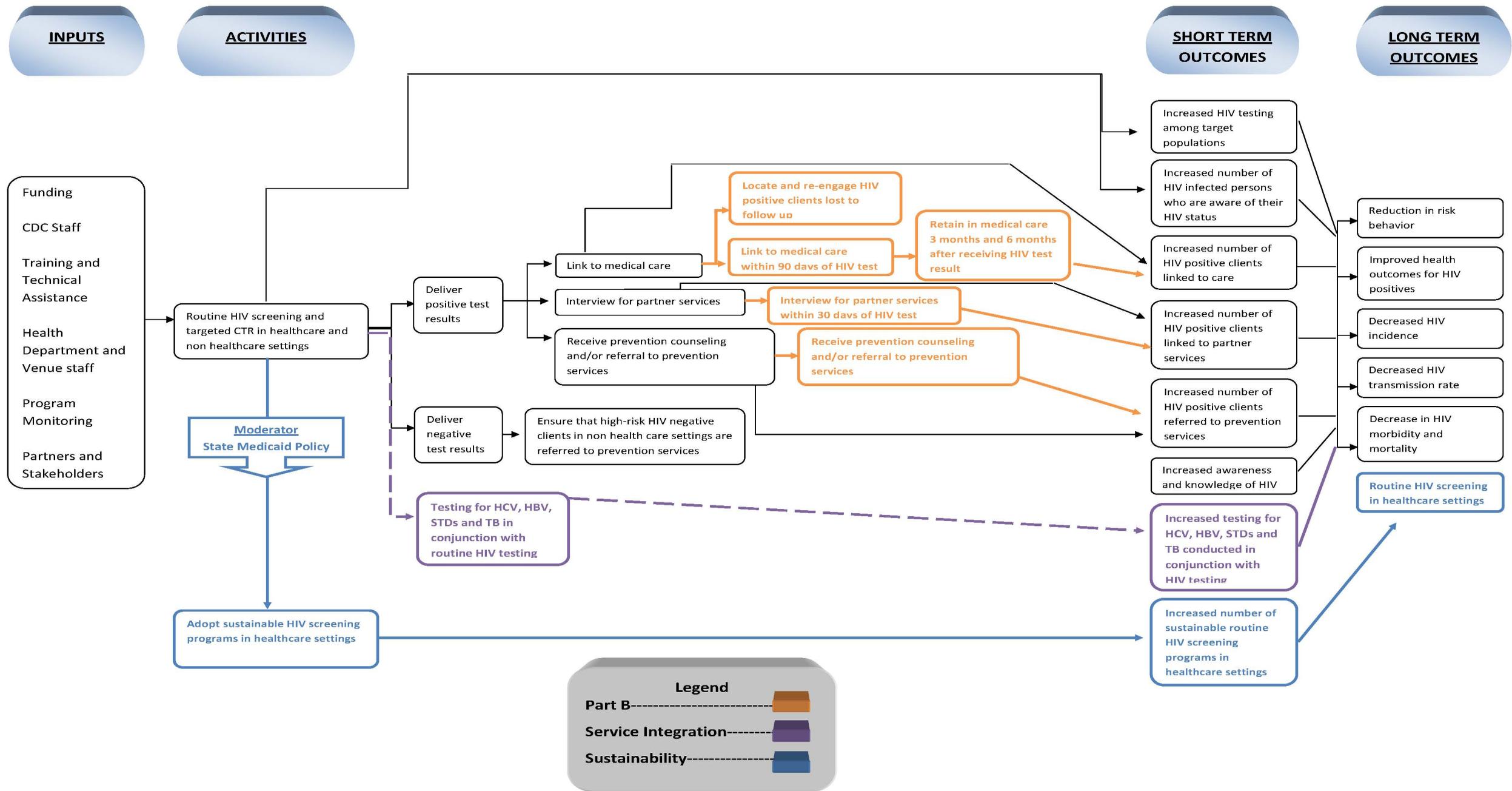
References

Centers for Disease Control and Prevention. Framework for program evaluation in public health. MMWR 1999;48 (No. RR-11):1-41.

Centers for Disease Control and Prevention. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. MMWR 2006;55 (No. RR-14):1-17.

CDC (April 9, 2010). Partner Services Evaluation Field Guide.

**Appendix A
Causal Logic Model**



Appendix B
NHME Data Reporting Requirements for PS 10-10138

Agency Level Variables

Community plan jurisdiction
Agency ID
Form ID
Intervention ID
Site ID
Site type
Site zip code
Client ID
Session date

Client Variables

Year of birth
Current gender identity
Race
Ethnicity
State of residence
Previous HIV test
Self-reported HIV test result
Behavioral Risk Category

HIV Test Variables

Sample date
Test election
Test technology type
Test result
Result provided
Date result provided

Referral Variables (HIV positive clients only)

Client referred to HIV Medical Care
Client attended first appointment within 90 days of test date
Client referred to Partner Services
Client referred to HIV prevention services
Is female client pregnant
Is female client in prenatal care
If no was client referred to prenatal care
Did client attend first prenatal appointment

Other

CDC02 – Tag using “10138”