

novel methods of risk assessment such as computer-assisted interviews.

c. Evaluation of the performance of the surveillance system.

Recipients shall continue to evaluate the attributes of their HIV/AIDS surveillance system according to protocols provided by CDC that have been developed as part of focused pilot projects. Ongoing evaluation will continue regardless of the status of, or procedures used, to conduct HIV/AIDS surveillance (e.g. AIDS or HIV reporting, or name or code-based reporting).

All evaluation projects should include critical reviews of surveillance methods and redirection of resources to those case-finding methods that are the most accurate and productive. Using the recommendations published in "CDC Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome" (see Attachment A for summary) these evaluations should include routine analysis of surveillance data to discover possible sources of under reporting and delays in reporting, monitoring data quality, and assessing completeness of reporting by statistical methods developed by CDC (e.g. multiple source capture-recapture) or comparing surveillance registries with alternate databases that are not routinely used for case finding (e.g., Medicaid databases).

At least once a year, all recipients shall routinely re-abstract demographic, risk, laboratory, and clinical data from a representative sample of records to assess the quality and validity of information collected.

d. Interstate reciprocal notification of newly identified HIV/AIDS cases.

Recipients should routinely interact with other reporting areas using a list of potential inter-State duplicates supplied by CDC to ensure that reciprocal notification of newly identified HIV/AIDS cases, perinatal exposure cases, and deaths from HIV infection is executed. Routine engagement in this activity will minimize the number of duplicate case reports in the national data system. This communication is supported by the Council of State and Territorial Epidemiologists (Position statement 01-ID-04). It should be carried out by appropriately trained and authorized surveillance staff, in a confidential manner consistent with local security, confidentiality and reporting policies and procedures. Recipients will use the same system for reciprocal notification of HIV, AIDS, perinatal HIV exposure and deaths among persons with HIV infection,

including provision of appropriate identifying information (e.g., name or other identifier). Currently, because of the diversity and limitations of the coded identifiers used by reporting areas in States engaged in alternatives to confidential, name-based reporting for HIV cases, there is no scientifically validated, systematic way for CDC to identify potential duplicates for HIV cases in those areas. These areas are encouraged to communicate with nearby reporting areas to identify the most accurate and efficient methods for minimizing duplication across State reporting jurisdictions.

e. Analysis and dissemination of HIV/AIDS surveillance data and promoting their uses of prevention and health services planning and evaluation.

All recipients should routinely disseminate reports of aggregate surveillance data for epidemic monitoring and education of the public and reporting sources and should promote uses of HIV/AIDS surveillance data for prevention and health services planning and evaluation. These activities should include: Providing HIV/AIDS surveillance data and ongoing epidemiologic assistance to community planning groups; disseminating surveillance data through publications and presentations; participating in planning and implementation meetings; conducting analyses to monitor trends, assess need for health-care resources, and project the future impact of the disease; and providing feedback to reporting sources on ways in which the surveillance data have been used to promote public health.

f. Conduct activities to improve the quality, efficiency, and productivity of the core surveillance program.

As part of core surveillance (given availability of either increased core funding or a redirection of existing core surveillance funding) all recipients shall also conduct one or more surveillance activities to develop and test new approaches to conducting surveillance whose aim is to improve the quality of the data, develop more efficient methods of case ascertainment, ensure accurate and valid case report information, and maximize the performance of the system. In particular, areas should develop technical information systems that facilitate electronic reporting of HIV and AIDS surveillance data from health care providers and public and private laboratories to health departments. Examples of focused analyses and evaluations of surveillance data that applicants may conduct include:

(1) Assessing how priority populations access or receive referrals to prevention and treatment services in public and private settings (e.g., treatment for HIV infection and prevention of opportunistic infections).

(2) Assessing the association of stage of disease (i.e., HIV or AIDS) with interstate migration.

(3) Better defining trends (through analysis of HARS reports or chart reviews or interviews):

(a) In various populations (e.g., Native Americans, health-care workers, substance-abusing pregnant women).

(b) For various AIDS-defining conditions or opportunistic infections (e.g., Tuberculosis, Mycobacterium Avium Complex (MAC)).

(c) In conjunction with other Federal, State, local prevention and care programs (e.g., HRSA Ryan White CARE locations).

g. Reporting of data using CDC standards and software.

Recipients should ensure that data collection forms and electronic data formats used to submit case reports from laboratories, clinical records, and patient interviews contain CDC's recommended standard data elements/questions on HIV testing behaviors, risk/exposure behaviors, and treatment access/adherence behaviors. In addition, during this project period, recipients should report HIV/AIDS case surveillance data to CDC on at least a monthly basis using either standardized software or according to data submission standards established by CDC.

Data from reporting areas using coded identifiers for HIV surveillance will be eligible for inclusion in national surveillance reports after these systems are evaluated using published performance standards (see Attachment A) through the implementation of protocols established by CDC. Areas using coded identifier systems will need to use customized data transfer and storage systems (either electronic or hardcopy) in order to accommodate the diversity of codes, inconsistencies in codes between areas (e.g. inability to generate soundex in some areas), and inability of areas using coded reporting to reciprocally notify and de-duplicate cases with other areas using standardized lists generated by CDC. Specific data management systems will be developed by CDC in consultation with the local areas. These areas should continue to report AIDS cases and deaths to CDC using HARS or its identified equivalent, as is current practice.

h. Security.