



2006 CSTE ANNUAL CONFERENCE

INTEGRATING DATA TO MEET NEW CHALLENGES

HIV INCIDENCE AND CASE SURVEILLANCE BRANCH

PRECONFERENCE WORKSHOP



JUNE 4, 2006
HYATT REGENCY ORANGE COUNTY
ANAHEIM, CALIFORNIA



Table of Contents

CSTE Pre-Conference Schedule	i
HIV Surveillance Support: The Funding Process	1
Setting Standards: A CDC/CSTE Collaboration	5
Michigan Quality Assurance Procedures	11
Risk Factor Ascertainment	17
Record Linkages and Death Ascertainment in Massachusetts	25
Electronic Lab Reporting in Seattle	31
Integrating HIV Incidence Surveillance with Core Surveillance Systems	37
Integration of Core and Incidence Surveillance: San Francisco's Experience	39
Integrating Incidence and Core Surveillance: Texas	45
Integration of Core & Incidence Surveillance in King County, Washington	49
Florida's HIV/AIDS Data Monitoring and Quality Process	55
Kansas Data Quality	59
Demonstration of eHARS	63
The 411: on HIV/AIDS Core Surveillance Site Visits	71
The Importance of the Site Visit Letter to the Grantee	77
Integrate and Conquer: Incorporating HIV surveillance into broader public health assessment activities	81
Integration of Surveillance with Other Programs	87

CSTE Pre-Conference Workshop

Integrating Data to Meet New Challenges

8:00 a.m. Registration

Morning Session

Moderator: Anthony Merriweather

8:30-8:45 Welcome (Matthew T. McKenna, CDC)
 8:45-9:00 HIV Surveillance Support: The Funding Process (Ronald Sanders, CDC)
 9:00 – 10:30 State and Local Implementation of Technical Guidance for HIV/AIDS Surveillance
 Setting Standards: A CDC/CSTE Collaboration (Martha Miller, CDC)
 (Re-abstraction in Georgia, Luke Shouse, Georgia Department of Public Health)
 (Michigan Quality Assurance Procedures, Nilsa Mack, Michigan Department of Community Health)
 (Risk Factor Ascertainment, Sharon Carter, Virginia Department of Health)
 (Record Linkages and Death Ascertainment in Massachusetts, James Murphy, Massachusetts Department of Public Health)
 (Electronic Lab Reporting in Seattle, Jim Kent, Seattle & King County Public Health)

10:30-10:45 Break

10:45 – 11:45 Integration of Core and Incidence Surveillance
 (Joseph Prejean, CDC)
 (Susan Scheer, San Francisco Department of Public Health)
 (Cheryl Jablonski, Texas Department of Health)
 (Christina Lynch, Washington State Department of Health, Seattle & King County Public Health)

11:45-12:00 Break – get boxed lunch Moderator: Doug Frye

12:00-1:15 Roundtable Discussions – Security & Confidentiality Case Studies
 (Kathleen S. Brousseau, New York State Department of Health)
 (Maree Kay Parisi, San Francisco Department of Public Health)
 (Pam Lowell, Florida Department of Health)
 (Gail Maureen Hansen, Washington D.C. Department of Health)

1:15-1:30 Break

Afternoon Session

Moderator: David Fields

1:30-1:50 Ryan White CARE Act Update
 (Pat Sweeney, CDC)
 1:50-2:30 The Joy of Quality Data
 (Maria Rangel, CDC)
 (Becky Grigg, Florida Department of Health)
 (Jeni Mulqueen, Kansas Department of Health and Environment)
 2:30-2:50 Demonstration of eHARS
 (Sam Costa, CDC)
 2:50-3:10 The 411 on Site Visits
 (Loren Cadena, CDC)
 (Maree Kay Parisi, San Francisco Department of Public Health)
 3:10-3:45 Integration of Surveillance with Other Programs
 (Marie Courogen, Washington State Department of Health)
 (Bill Jones, North Carolina Division of Public Health)
 3:45-4:15 Presentation from Dr. Kevin Fenton – New NCHHSTP Director
 4:15-4:30 Break to convene for Business Meeting
 4:30-5:30 CSTE Business Meeting

**HIV Surveillance Support:
The Funding Process**

Ron Sanders, MPA
Program Consultant
HIV Incidence and Case Surveillance
Branch

 The findings and conclusions in this presentation are those of the author and do not necessarily represent the views of the Centers for Disease Control and Prevention. 

Topics Covered Today

- 2006 Surveillance Funding Process
- Financial Status Reports
- Carryover requests
- 2007 application timeline
- Answer your questions

2006 Surveillance Funding Process

- Congress appropriated \$8.4 billion in 2006 for CDC – the first overall cut in 25 years
- Congressional rescission of 1.0% (\$60 million) compared with 0.8% cut in 2005 – applied across the board at CDC
- HICSB absorbed part of the cut
- All surveillance grantees were cut 1%
- Initial \$300,000 award exempted from further cuts
- Awards above \$300,000 were further reduced by 1.98%

Funding Rescission Example

Total recommended	\$450,000
Exempt	- <u>300,000</u>
Subject to cut	\$150,000
Sliding scale cut	\$2,970 (1.98% X \$150,000)
1% rescission	+ <u>4,500</u> (1.0% X \$4,500)
Total cut	\$7,470



4

Financial Status Reports

- Due 90 days after the end of the previous funding period
- Documents unobligated funds, not necessarily spent
- Must accompany request for use of carryover funds



5

Carryover Funds

- Only unobligated funds from the immediate prior budget period can be carried over
- Requests must be signed by grantee's business office as well as the project director.
- Recommendation for approval is required from the program office – copy your Program Consultant
- Response is usually issued within 30 days of receipt



6

The Small Print

- Proposed activities and budget must be within the scope of the cooperative agreement
- Carryover funds should be used to support one-time activities
- Cannot support education, seroprevalence, or prevention activities
- Cost of information technology to implement eHARS will be supported through Direct Assistance supplements



CDC

7

FY 2007 Funding Timeline

- New appropriation period: FY 2007-2009
- Funding period: Jan. 1 – Dec. 31, 2007
- Funding Guidance Available: July 1, 2006
- Competitive applications due to CDC: Sept. 1, 2006
- Award notices sent by: Nov. 2006



CDC

8

WHY DON'T YOU KEEP
TELLING ME PREPOSTER-
OUS STORIES WHILE I
STARE AT YOU WITH A
MIXTURE OF HOSTILITY
AND CURIOSITY?



© 2004 Scott Adams, Inc./Dist. by UFS, Inc.

Questions?



CDC

State and Local Implementation of Technical Guidance for HIV/AIDS Surveillance

Presented by
Martha Miller, MPH

CSTE Pre-Conference Workshop
June 2006

The findings and conclusions in this presentation are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.



Setting Standards A CDC/CSTE Collaboration



Uses of HIV/AIDS Surveillance Data

- to monitor the spread of HIV infection at the state and local levels
- to link persons to prevention and treatment services
- to target prevention programs and health care services
- to allocate funding for HIV prevention and care



Evaluation

Purpose:

- to monitor progress toward achieving program goals (outcome standards)
- to ensure accurate, complete, and timely data
- to find opportunities for continuous quality improvement



CDC

Technical Guidance for HIV/AIDS Surveillance Programs

Volume I: Policies and Procedures

Volume II: Data Collection Resources and Reporting

Volume III: Security and Confidentiality Guidelines



CDC

Standards for Collection of HIV/AIDS Surveillance Data

- Structural requirements
- Process standards
- Outcome standards (measurable objectives)



CDC

The Essence

- Or—measuring what matters for data quality...



CDC

Process Standards

- Intrastate duplicate review: monthly
- Interstate duplicate review: monthly
- Death ascertainment: annually



CDC

Outcome Standards (I)

Completeness and Timeliness

- minimum: $\geq 85\%$ of expected cases reported by 12 months after diagnosis year
- target: $\geq 95\%$ of expected cases reported by 12 months after diagnosis year



CDC

Outcome Standards (II)

Edits

- minimum: $\geq 97\%$ of case records pass all standard data edits, assessed at 12 months after the diagnosis year
- target: 100% of case records pass all standard edits



CDC

Outcome Standards (III)

Risk factor ascertainment

- $\geq 85\%$ of reported cases (or representative sample) for a diagnosis year with identified HIV risk factor within 12 months of date of initial case report, measured at 12 months after close of diagnosis year



CDC

Outcome Standards (IV)

Duplicate reports

- Intrastate
 - $< 5\%$ duplicates, assessed at 12 months after diagnosis year
- Interstate
 - $< 5\%$ duplicates in national database, assess for each diagnosis year 12 months after diagnosis year



CDC

Outcome Standards (V)

Proportion of Death-Certificate-Only (DCO) cases

- < 5% with only a death certificate
- assessed at 24 months after death/diagnosis year

Data reporting and dissemination

annual HIV/AIDS surveillance reports



CDC

Outcome Standards (VI)

CD4 reporting*

≥ 50% initial CD4 counts for newly diagnosed adults
(≥ 13 years) reported to national HIV/AIDS
surveillance system within 12 months of diagnosis

* developmental standard



CDC

**“Knowing is not enough; we must apply.
Willing is not enough; we must do.”**

-- Goethe



CDC

State Implementation of Technical Guidance

- Luke Shouse: Re-abstraction in Georgia
- Nilsa Mack: Michigan Quality Assurance Procedures
- Jim Murphy: Record Linkage and Death Ascertainment Activities in Massachusetts
- Sharon Carter: Risk Factor Ascertainment in Virginia
- Jim Kent: Electronic Lab Reporting in Seattle & King County



CDC



HIV/AIDS Surveillance Program
MI Department of Community Health
Bureau of Epidemiology

Michigan Quality Assurance Procedures

Nilsa Mack, MPH
CSTE Annual Conference-Anaheim, CA
June 5, 2006

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



Topics

- Quality Control Activities:
 - *Documentation of Procedures- HIV/AIDS Surveillance Procedures Manual and other manuals (HARS)
 - *Quarterly data cleaning procedures
 - *CRF comparison
 - *Re-abstractions
- Training of Staff and Report Sources
- Feedback

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



MI- Background Information

- Two offices- Detroit and Lansing
- Detroit office- handles 2/3 of cases (SE MI), dedicated data entry person, data manager (QA), 4 surveillance staff (1 QA staff), special projects
- Lansing office- handles 1/3 of cases (outstate), 3 surveillance staff (1 QA), staff do their own data entry, lab coordinator and lab data entry person. More providers, rural counties, traveling

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



MI- Background Information

- HARS centralized system (both offices connect to same server via a Wide Area Network), ~25,000 HARS records
- There were 1,324 cases reported in 2005 and about 240 deaths in 2004
- Medium morbidity state

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



Documentation of Procedures HIV/AIDS Procedures Manual

- Data Collection and Data Entry (standardized)
- Processing of confidential and anonymous reports
- Processing of lab reports, death certificates and other documents
- NRRS/NIRs
- Linkage of electronic records
- Data quality, analysis and dissemination

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



Routine Quarterly Data Cleaning

- Consists of 3 components:
 - 1) investigation of possible duplicate cases
 - 2) investigation of data entry errors
 - 3) cleaning of site fields (legal list of providers)

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



Quarterly Data Cleaning Investigation of Duplicate Cases

- HARS duplicate verification utility (intra)-compares cases by soundex and dob
- CRFs are pulled and compared, duplicates are reconciled (Reconciliation Form)
- Some cases have to be followed up with provider
- Alias field (helpful especially for prisoners and women)
- Findings- 5-10 potential duplicates

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



Quarterly Data Cleaning Investigation of Data Entry Errors

- Errors checking SAS program- a list of cases with suspect status, errors and missing diagnostic, demographic and death information (E and R records)
- CRFs are pulled, investigated and updated (document on same CRF or do an update, staff initials and date)

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



Quarterly Data Cleaning Cleaning of Legal List

- SAS program that compares all facilities of diagnoses and sites of care to the legal list of facilities
- Facilities not in the legal list are investigated and corrected (standard codes/format to enter facilities)
- New facilities are added to legal list

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



Common Data Quality Issues

- **HARS-** Cases entered as AIDS without AIDS-defining condition(s)
- Residence of HIV or AIDS diagnosis missing
- Demographic information missing
- DOD and/or source of death information missing
- Legal list- typo errors, staff not using standard codes when entering new facilities, etc.

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



Case Report Form Comparison

- 200 CRFs (100 in Detroit and 100 in Lansing)- ~20% of cases are selected and are compared to what is entered in HARS
- Discrepancies are corrected
- Findings- spelling discrepancies, info recorded on CRF but not entered into HARS, facilities not entered per legal list, typos, etc.
- Once a year

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



Re-abstraction Studies

- All surveillance staff participate
- Once a year
- Re-abstract: demographic, laboratory, risk factor information
- Discrepancies between "initial" and "reabstraction" CRFs are documented, recommendations are presented to staff
- Findings- middle name discrepancies, race indicated v. blank, address discrepancies, diff facility names, diagnostic tests indicated v. blank, OI's pres v. def, etc.
- Planning to revise current protocol

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



New Staff Training

- Orientation list
- One-on-one training
- Reference procedures manual
- Site visits with a senior staff for chart abstractions (data collection)
- Visual editing (proofreading of CRF before data entry into HARS) and verify keyed data
- Feedback- provided one-on-one and at surveillance meetings

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



Existing Staff Training

- SAS and Epi classes at a local university
- CDC workshops and trainings
- Feedback- provided one-on-one and at surveillance meetings. New or updated protocols are presented and discussed. Summary report of data errors (aggregated) is shared with staff

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



Report Sources Training- LHDs and Private Providers

- Site visits- train one person at the site; consider staff turnover
- Provider packet- includes reportable events, instructions on how to complete CRFs, HIPPA letter, HIV/AIDS reporting law, quarterly stats, etc.
- Mechanisms of reporting- phone, site visits or mail

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



Report Sources Training- LHDs and Private Providers

- Lab F/U protocol and letter to private providers
- Feedback- quarterly stats newsletter; considering the possibility of using report cards, on line training, timeliness and completeness by report source

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



Thank You!!!

www.michigan.gov/mdch
Statistics and Reports
Communicable Diseases
HIV/AIDS

Mackn@michigan.gov

MDCH/Bureau of Epidemiology/HIV/AIDS Surveillance Section



Virginia Dept of Health
Division of Disease Prevention
 hiv, std, hepatitis, tb, RX



Sharon Carter Hall
 Core Surveillance Supervisor




Virginia HIV/AIDS
Core Surveillance Staff

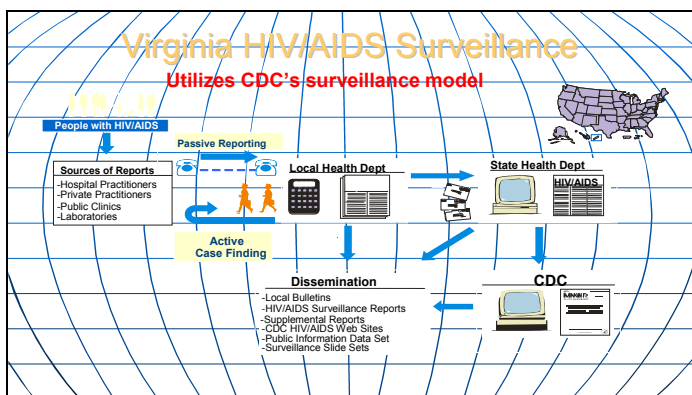
- 1 Surveillance Director
- 1 Core "Working" Supervisor + 3 Core Epi Consultants
 based in Central Office
 5 Regions
- 1 HARS Data Manager
- 1 HARS Data Entry Statistician
- 2 Data Entry Staff

Central Registry Unit (CRU) Staff

- 1 Medical Records Technician
 Provides assistance to Disease Intervention Specialists (DIS) & Virginia Emergency Response Team (VERT) for record searches & initiating Field Records (FRs) to Out of Jurisdiction Areas for STD's only
- 1 Office Service Specialists
 Provides assistance to the five regional Disease Intervention Specialists (DIS) and the Epi Consultants for record searches & initiating Field Records to Out of Jurisdiction Areas for HIV & AIDS

Virginia Surveillance Program

- Name-based HIV reporting since July 1989
- Integrated HIV/STD Program
 - Access daily to STD database
 - Communicate daily with local health department Disease Intervention Specialists (DIS)

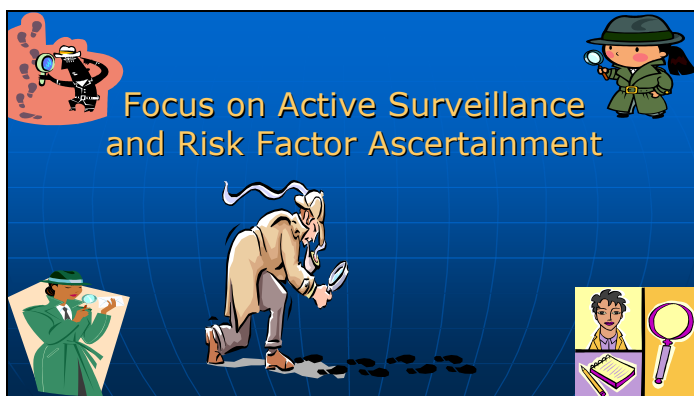


Division Databases

- HARS = HIV/AIDS Reporting System
- STD*MIS = Sexually Transmitted Disease Management Information System
- Code 1 Excel File – Used by Epi Consultant to track patients and potential cases that cannot be entered into HARS or STD*MIS

*Core Surveillance Staff receive and initiate CDC forms, Field Record and/or Interview Record and forwards to Disease Intervention Specialists

*Patient information that is missing pertinent data and cannot be entered into HARS and/or STD*MIS



What are HIV Risk factors?

V. PATIENT HISTORY

AFTER 1977 AND PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST
OR AIDS DIAGNOSIS, THIS PATIENT HAD (Respond to ALL Categories)

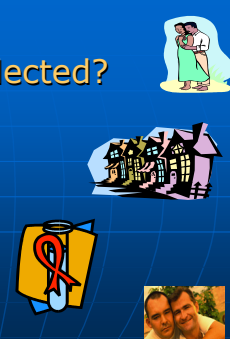
	Yes	No	Unit
• Sex with male	1	0	9
• Sex with female	1	0	9
• Injected nonnarcotic drugs	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9
Specific: Factor VIII (Hemophilia A) Factor IX (Hemophilia B) Other (specify):	1	0	9
• HETEROSEXUAL relations with any of the following:	1	0	9
• • • • •	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9
First [] [] [] Last [] [] []			
• Received transplant of tissue/organs or artificial insemination	1	0	9
• Worked in a health-care or clinical laboratory setting (specify occupation):	1	0	9

Why are Risk Factors Important

- Identify new or unusual cases
- Monitor trends in the transmission of HIV
- Allocate resources
- Plan prevention programs
- Target risk reduction interventions
- Evaluate HIV/AIDS programs

What Data are Collected?

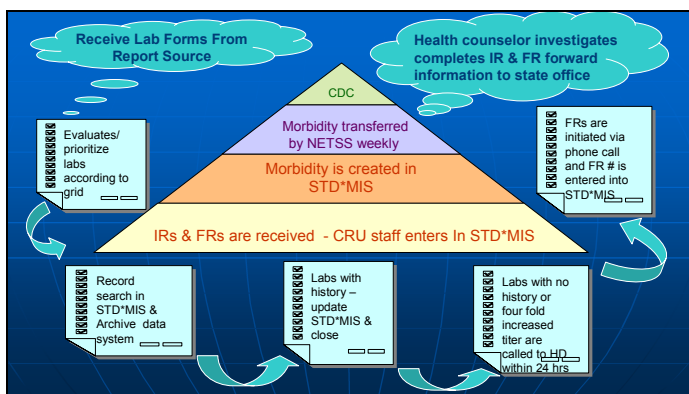
- CDC50 Case Report Form
 - Demographic characteristics
 - Sex, race/ethnicity, age, residence
 - Risk information
 - Potential modes of exposure to HIV
 - Laboratory and clinical information
 - Virologic and immunologic status
 - Opportunistic illnesses diagnosed



HIV/AIDS Surveillance

How Data are Collected

- **Active reporting**
 - Health department surveillance staff find cases by contacting health care practitioners and reviewing medical records in hospitals and clinics
- **Passive reporting**
 - Health care practitioners, hospitals, clinics, and laboratories report cases of HIV/AIDS to state and local health departments
- **Primary case reporting**
 - Providers and facilities
- **Secondary case reporting**
 - Death records, hospital discharge summaries, TB, ADAP, etc.



Risk Factor Ascertainment Procedures

- 4 Epi Consultants work in conjunction with DIS and Central Registry unit
- One Medical Records Technician staff member provides record searches & sends Field Records (FRs) to out of jurisdiction/area (OOJ) for STD patients/cases
- One Office Service Specialist staff member dedicated to provide record searches & sending FR's to OOJ for HIV/AIDS patients/cases
- Epi Consultants & Central Registry Unit (CRU) staff provide Record Searches for 5 regions statewide for STDs and HIV & AIDS cases

Risk Factor Ascertainment Procedures Continued

- STD*MIS record searches for risk factors on new & existing HARS cases via STD records
- Risk updated in HARS & STD*MIS Databases
- New STD, pregnancy or Contact is a marker for high risk sexual activity in existing cases:
 - Indicator to re-interview patient for Partner Counseling, & Referral Services (PCRS)
 - FR initiated by Epi Consultant
 - Forwarded to local DIS
 - Patient located for re-interview by DIS

Risk Factor Ascertainment Procedures Continued

- Dedicated Central Registry Units staff members allow Epi Consultants to focus on Active Surveillance
- Reviews: No Reported Risk (NRR), No Identified Risk (NIR), Pediatric Cases and Cases of Public Health Interest (COPHI)
- Educate & Develop with providers
- Actively provide feedback to providers

PROCESS STANDARDS

- Standard Non-Reported Risks (NRR) are changed to Non-Identified Risks (NIR) in 12 months based on Interview Records (IR)
 - Closed – **NO** → further investigation needed
 - Closed – **YES** → no additional investigation needed
- Plan to add eHARS local use fields to specify
 - Outcome of risk investigation
 - If case is still NIR, Epi Consultant and/or Disease Intervention Specialists still needs to review records
 - Review Expanded Risk variables such as:
 - Sex for drugs and/or money
 - Foreign born

PROCESS STANDARDS *Continued*

- Sampling
 - Focus on large facilities
 - Regions (areas) with large number of NIR cases
 - Have Core Surveillance Staff work with the Statistical Staff on samples and get their involvement

How to Meet Process Standards

- Utilize non-Core Surveillance staff during down time
- Offer Internships for Grad Students Practicum
- Wage staff

Questions?



Record Linkage and Death Ascertainment Activities in Massachusetts

James Murphy, MPH
Director HIV/AIDS Surveillance
Massachusetts Department of Public Health

HIV/AIDS Surveillance and Incidence Coordinator's Meeting
2006 CSTE Annual Conference
June 4, 2006

Overview

- Record Linkage Activities in Massachusetts
- Death Ascertainment as a Record Linkage Activity in Massachusetts
- Questions

Data Files Used for Record Linkage in Massachusetts

- Death Registries
 - MA Vital Records (annually)
 - NDI (1996 and 2005)
 - Social Security Administration Death Master File (planned 2006)
- TB Registry (annually)
- STD Registry (2001)
- Hepatitis C Registry (planned 2006)
- Laboratory Test Data Files (ongoing)
- HDAP Registry (annually)
- ACT Now Registry (annually)
- National AIDS/Cancer Match Registry or NACMR (1997 and 2004)
- Administrative or Clinical Data Files with ICD-9 Codes
 - Hospital Discharge Data (planned when data available)
 - Medicaid/Medicare Data (data availability under negotiation)
 - Large HMO (data availability under negotiation)

Death Ascertainment Record Linkage in Massachusetts

- State Vital Records Match
 - Annually
- National Death Index
 - 1996 and 2005
- Social Security Administration's Death Master File
 - Planned 2006

Record Linkage to Massachusetts Vital Records Data Collected

- Full Name
- Date of Birth
- Gender
- Social Security number
- Date of Death
- State of Death
- Underlying cause of death
- Death certificate number

Record Linkage to Massachusetts Vital Records Procedure

- Standardize the characteristics of the two datasets:
 - File type (Access 97)
 - Create soundex
 - Variable attributes
 - Name
 - Type (character or numeric)
 - Length
 - Component sequence or format

**Record Linkage to Massachusetts Vital Records
Procedure - AIDS**

- One-to-one match with sex and soundex of last name and:
 1. Date of birth and soundex of first name or
 2. Year of birth, month of birth, and last 4 of ss# or
 3. Year of birth, day of birth, and last 4 or
 4. Year of birth, month of birth, and day of birth

**Record Linkage to Massachusetts Vital Records
Procedure - HIV**

- One-to-one match with sex and first two letters of the first name and:
 1. # of letters in last name, last 4, month of birth, and year of birth or
 2. # of letters in last name, last 4, year of birth, and day of birth or
 3. # of letters in last name, 9999 for last 4 (in either dataset), month of birth, year of birth, and day of birth or
 4. Last 4, month of birth, year of birth, and day of birth

**Record Linkage to Massachusetts Vital Records
Results**

- Visual analysis of output
 - Match
 - Not a match
 - Indeterminate and requires further work
- Update HARS and HIV database

Record Linkage to Massachusetts Vital Records Results 2005

- AIDS – 8,657 records examined
 - 265 new deaths identified
- HIV – 7,007 records submitted
 - 61 new deaths identified

Record Linkage with National Death Index

- Part of survival analysis project
- Match to our AIDS and HIV databases
- NDI records 1983-2003 (1999-2003 HIV)

Record Linkage with National Death Index

- Process
 - Application submission
 - NDI approved format
 - Delimited text file
 - Appropriate secure exchange of data
 - PGP encrypted

Record Linkage with National Death Index

- Variables
 - First name
 - Last name
 - Social security number
 - Date of birth
 - Father's surname
 - Sex
 - Race
 - Marital status
 - State of residence
 - State of birth
 - Control (stateno)
 - Optional user data

Record Linkage with National Death Index

- Matching Criteria:
 - ss#, first name
 - ss#, last name
 - month & exact year of birth, first & last name
 - month & exact year of birth, first & middle initials, last name
 - month, & $\pm$ year of birth, first & middle initials, last name
 - month, & $\pm$ year of birth, first, last name
 - month & day of birth, first & last name
 - month & day of birth, first & middle initials, last name

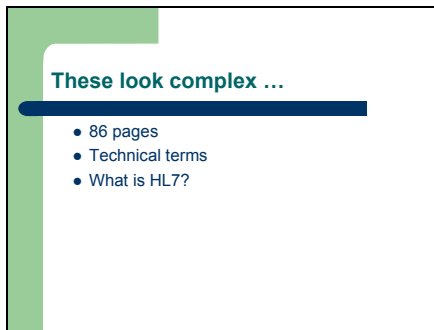
Record Linkage with National Death Index Results

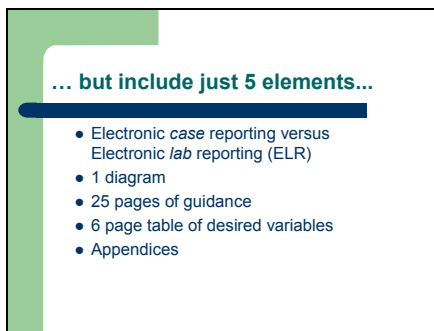
- Records had numerous potential matches
 - One to as many as 50 possible matches per record
- Visual analysis of the results from NDI

**Record Linkage with National Death Index
Results 2005**

- AIDS - 7841 records submitted
– 307 new deaths identified
- HIV - 6404 records submitted
– 30 new deaths identified







... and 8 simple steps

- Do your homework
- Set up your database
- Negotiate
- Implement
- Receive data
- Translate data
- Assess and Streamline
- Success!

Do your homework

- What is Public Health already doing?
 - Talk to non-HIV surveillance programs
 - Talk with NEDSS staff
 - Check with Computer / Network support
- What are labs already sending?
- What do the rules already say?
- Have I got all the labs covered?

Set up your database

- Tracking database to store all the incoming records
- Include all the variables you want
- Include stateno for linked records
- Include an outcome indicator

Negotiate

- Talk with each lab
- Talk with network support staff
- Integrate with other programs if you can
- Request HL7
- Request automated delivery
- Request daily / weekly delivery
- Ensure security at every step

Implement

- Labs that already report results
 - create electronic files
 - encrypt them (with PGP)
 - route them electronically
 - automate the reports
- MIS secure file transfer protocol (sftp)
- Automated delivery notification
- Download to secure location

Receive data

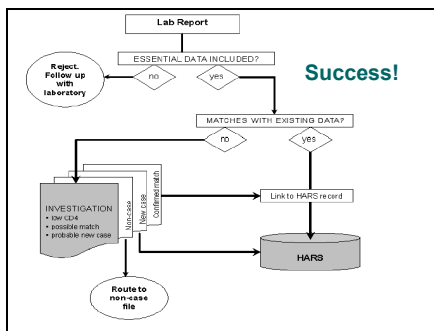
- SKC went live mid-2004
- Public Health lab was not the first in line
- Each lab has accomplished different steps
 - Automated HL7 daily transfers
 - Automated HL7 monthly transfers
 - Electronic monthly transfers
 - Files on floppy disk
 - Paper reports

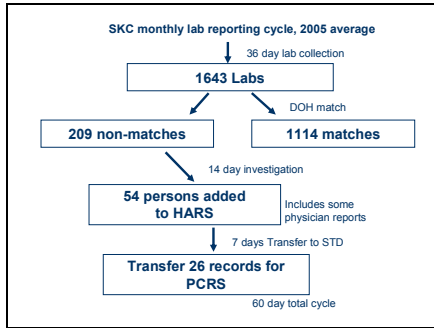
Translate data

- Handle each lab individually
- SAS program to read incoming data and output to your tracking database

Re-assess and Streamline

- Are the contents interpretable?
- Are there missing values?
- Do you know if a lab misses a report?
- Does SAS translator work?
- Are all the results linked to HARS?





Next steps!

- Route data to various projects
 - State and local
 - HIV Incidence Surveillance
 - Antiretroviral Resistance Testing
 - Never-In-Care project
- We are ready to implement expanded laboratory reporting
 - (all CD4s and all viral load results)

Contact Info

Jim.Kent@metrokc.gov
206-205-6121

**So Happy Together:
Integrating HIV Incidence
Surveillance with Core
Surveillance Systems**

Joseph Prejean, Ph.D.
National Center for HIV, STD, and TB Prevention
HIV Incidence and Case Surveillance Branch
June 4, 2006

 The findings and conclusions in this presentation are those of the author and do not necessarily represent the views of the Centers for Disease Control and Prevention. 

Using our Assets

- The ability to conduct HIV Incidence Surveillance is dependent on a fully functioning Core Surveillance System
 - People
 - Data
 - Tools

People

- Co-location of staff
- Data Collection
- Quality Assurance
- Reporters
 - Established Relationships
 - New Opportunities

Data

- Targeting/Prioritizing
- Lab Reporting
- Timeliness
- Transition to Name-based Reporting



CDC

Tools

- Changing the Case Report Form
- Creating additional reporting Tools
- Databases
- eHARS



CDC

Thank You!

Christina Lynch, M.P.H.
Public Health - Seattle & King County
Cheryl Jablonski, M.A.
Texas Department of Health
Susan Scheer, Ph.D., M.P.H.
San Francisco Department of Health

David Fields, B.S.P.H.
Indiana State Department of Health



CDC

Integration of Core and Incidence Surveillance: San Francisco's Experience

Susan Scheer, PhD, MPH
San Francisco Department of Public Health

June 2006

Overview of Presentation

- Overview of Core & Incidence Surveillance in San Francisco: structure, activities, status
- How SF has integrated Core & Incidence Surveillance
 - Space
 - Staffing & Staff Responsibilities
 - Other Coordination
- Challenges
- Successes

Overview of Core Surveillance

- Majority of the AIDS cases (79%) are reported actively by Core surveillance field staff
- Can do this because SF is relatively small; have to do this because history of 'spoiling' PMDs
- Laboratory reports processed each month (CD4 and viral load)
- Data from chart review at diagnosis and every 1.5 – 2 years thereafter
- System evaluated every year (>95% complete)

AIDS Cases: Source of Report

- N= 30,105 cumulative AIDS cases
- 79% Active surveillance
 - includes HIV/VL and CD4 lab generated investigations, and validation studies
- 14% Passive surveillance
 - Includes Counseling & Testing sites and a few private medical providers (<15)
- 7% Other
 - Includes research studies, other Counties, etc.

Electronic Tracking Database Pending List (PLIST)

- Repository for all electronic labs received (170,800 test reports including AB, CD4, VL)
- Labs are assigned a disposition when it is processed
 - Match HARS
 - Match other jurisdiction's case
 - Possible matches
 - Matches another lab already received
 - Pending (no match to registries/databases)

Overview of Incidence Surveillance

- Implemented Standard protocol in April 2005
- Coordinating Incidence surveillance efforts with the State of CA and Los Angeles
- Testing history questionnaire (THQ) being collected by Core field staff at active surveillance sites
- CTR sites began collecting THQ February 2006 when Prevention branch decided not to implement PEMS
- Passive case report forms changed to include THQ when SF changed from code-based to name-based reporting in April 2006
- The SFDPH laboratory is currently the only lab participating; SF General Hospital has agreed to ship specimens pending letter from Director of Health

Status of HIV Incidence Surveillance

New HIV cases reported since implementation (04/05)	1220	
Total Cases Eligible for Incidence Surveillance	526	43%
Ineligible for Incidence** (**prevalent HIV cases before 4/05)	694	57%
Source of Report	526	100%
Public Facilities	230	44%
Private Facilities	215	41%
CTR Sites	72	14%
Research	8	1%
Other jurisdictions	1	<1%

Labs Reporting New HIV Cases (Since Implementation 04/2005)

Labs reporting new HIV cases (n=23)	% of specimens
SFGH	19%
DPH Lab	15%
Quest	15%
Kaiser	15%
CPMC	14%
UCSF	5%
UNILAB	4%
Lab Corp	3%
SF VA	2%
Subtotal (n=9)	92%

Overview of Core and Incidence Surveillance Integration

- Physical space is shared
- Staff responsibilities overlap and/or are shared as needed by Core and Incidence surveillance
- Leadership of Surveillance Branch is shared by Co-Directors representing Core and Incidence surveillance
- Coordination & collaboration with other Branches/Departments in the SFDPH such as the Prevention Branch, the SFDPH laboratory, and the Director of Public Health

Physical Space is Shared

- All Surveillance staff is housed on the 5th and 6th floor in the AIDS Office
- Provides easy access to information
- Provides easy access to personnel
- Provides for easy communication and the possibility for 'eavesdropping' on each other
- Provides a sense of common goals and collaboration; equal partners

Staff Responsibilities Overlap and/or are Shared by Core and Incidence Surveillance

- Most Surveillance staff have funding from other surveillance activities: Core, Incidence, MMP
- Dual responsibilities enhance understanding & integration of Core and Incidence surveillance
- If either Core or Incidence has staff shortages or shifting priorities, staff is temporarily shifted to areas of greatest need as needed
- Surveillance staff meetings cover both Core and Incidence activities & are attended by full staff
- Guiding philosophy is that Core surveillance needs to be complete and timely to make Incidence surveillance successful

How Dual Responsibilities Enhance Understanding and Integration of Core & Incidence Surveillance

Project Coordinator:

- Hired before implementation.
- Extensive prior experience as a HIV counselor.
- Worked as Core field staff to understand field activities and case reporting before Incidence implementation.
- Drawing on experience in the field, has been able to train Core field staff to collect THQ and make suggestions on how this is best done without burden to field site. Able to pilot forms and procedures at his assigned field sites.
- Drawing on experience as HIV counselor, was able to train counselors at CTR sites on THQ and was able to design forms in format favorable to counselors.

How Dual Responsibilities Enhance Understanding and Integration of Core & Incidence Surveillance

Data Manager:

- Also works as Core Surveillance lab database manager
- Extensive knowledge of HARS, lab databases and local variables
- This knowledge allows her to modify CDC SAS programs to use local variables that best identify needed Incidence cases, labs or fields
- Has been able to quickly identify Incidence data that is incomplete or missing in HARS and suggest changes; e.g. missing lab accession numbers and laboratory names
- Examples: 1) Initiated entering hard copy of lab reports into lab database, encourages labs to report electronically with complete data (accession numbers & collection dates); 2) helped coordinate data management during transition to name-based HIV reporting so that Incidence cases could be easily identified and accessed after the transition 3) set-up programs to rematch Incidence database with lab database to identify other eligible remnant specimens

Leadership of the Surveillance Branch shared by Co-Directors

- Last year the Director of the Surveillance Branch stepped down
- Co-Directors took over; one Co-Director was previously the PI of Incidence Surveillance and the other was the Director of Core Surveillance
- Joint decisions for the Branch ∴ more likely to consider the competing & corresponding needs of both Core & Incidence surveillance
- As Co-Directors, can weigh the needs of Incidence surveillance in Branch level decisions including staffing, budgetary & policy priorities
- Examples: Integrated QA procedures for Incidence data into existed procedures for Core surveillance & during transition to name-based reported, made sure incident HIV cases continued to be a reporting priority

Surveillance Branch Collaboration with other SFDPH Departments

- Incidence draws on past collaborations between Core Surveillance and other SFDPH agencies
- The Surveillance branch has a long relationship of collaboration with the SFDPH Prevention Branch with good communication & working knowledge of each others' work
- Relationship w/Prevention was key to access to CTR sites for implementing the THQ. Incidence staff provided training for CTR counselors
- Relationship with SFDPH Lab is ongoing & positive. SFDPH lab has participated in past Surveillance Branch research studies including STARHS testing
- Director of Public Health supportive and willing to assist with approaching labs & providers

Challenges with Integration

- With the good, comes the bad; there are trade-offs
- Budget is tight, each staff member usually has funding from multiple projects: Core, Incidence, MMP
- Sometimes conflicting goals -- e.g. Incidence staff not working 100% time on Incidence
- As deadlines, priority changes occur, etc., staff is shifted to meet those needs. Examples names-based HIV reporting, implementation of MMP
- Only 14% of AIDS cases reported passively; ∴ no history of PMDs doing the work themselves
- Reliance of Core surveillance on active surveillance has made it difficult for Incidence surveillance to get PMDs to add the THQ to their patient routine

Successes with Integration

- Has been structured as a highly integrated system since the beginning
- Integration has increased over time; examples: 1) as Core staff asked to assist with Incidence they become aware of goals of Incidence and become more pro-active "Incidence thinkers" 2) Co-Directors working together to make joint decisions
- Relatively small geographic area and limited number of providers and labs make integration easier
- Incidence surveillance has been able to exploit relationship that Core surveillance has with providers, labs & other DPH branches
- With name-based HIV reporting, we can perform chart review and follow-up Incidence cases using systems set up for Core surveillance
- Incidence is able to use Core databases to set priorities; e.g. identify high volume labs & providers for inclusion

Contact:

Susan Scheer, PhD, MPH
Co-Director
HIV/AIDS Statistics & Epidemiology Section
San Francisco, CA
415-554-9076
susan.scheer@sfdph.org

Integrating Incidence and Core Surveillance: Texas

June 4, 2006

CSTE Pre-Conference – Anaheim, CA

Cheryl Jablonski, MA
Texas Department of State Health Services
HIV/STD Surveillance Group

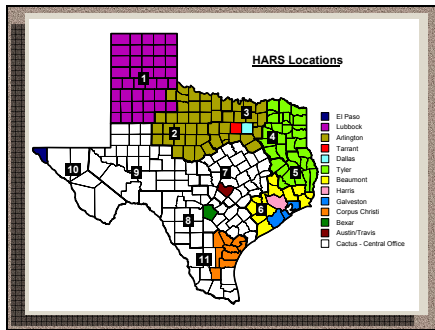


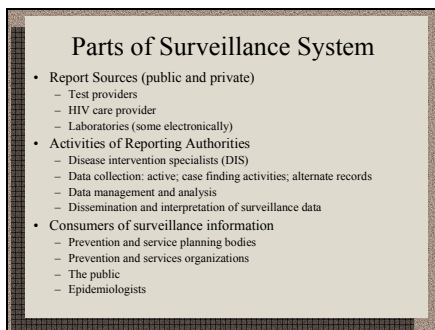
First Thoughts

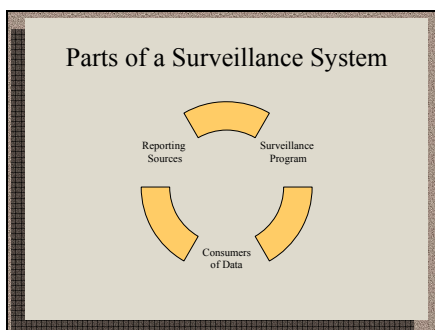
- Core and Incidence are funding streams
- Speak the language of the audience
 - Providers: expanding HIV disease surveillance
 - Surveillance: expanding case surveillance; it's all Surveillance
 - Labs: improving HIV surveillance to use new testing technology
- Build on current structure and processes

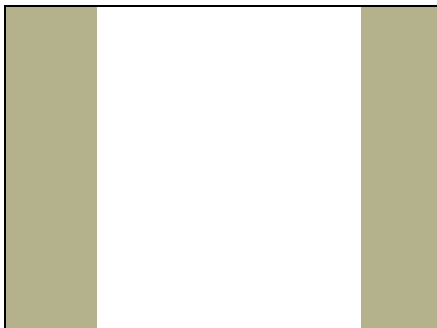
Know Your Surveillance Structure and Processes: Texas

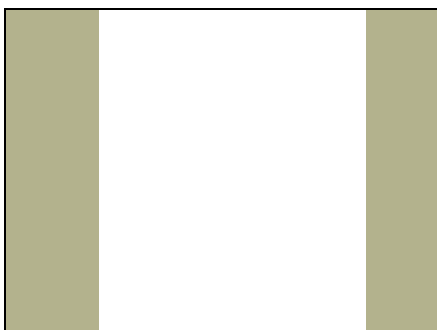
- State separately funded from Houston
- Contracts with 11 local surveillance sites
 - Each has HARS
 - Upload through Texas Health Alert Network (TxHAN)
- UT Southwestern Medical Center (UTSW)-technical assistance provider











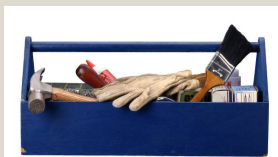
Integration at Grantee Level
• Team meetings • Incorporate into written surveillance procedures • Accompany surveillance staff on site visits • Support from someone over all surveillance staff • Share incidence info from CDC with surveillance partners • eHARS • Share resources: funding, people, support • Combine forms, if appropriate • Track completion rates to provide feedback

Integration at the System Level

- Develop relationships with providers through their current surveillance contacts
- Provide technical assistance and training
- Seek stakeholder input
- Assess current legislation
- Understand and use current mechanisms of communication
- “Talk up” your surveillance activity
- Carry each other’s messages

Surveillance of any reportable condition is a challenge!

Incidence surveillance is another tool in the HIV surveillance tool box.



Contact Information:

Cheryl L. E. Jablonski, MA
Incidence and Resistance Surveillance Coordinator
HIV/STD Surveillance Group (for confidential, substitute Box 406)
Department of State Health Services
1100 West 49th Street
Austin, TX 78756
(512) 533-3041
cheryl.jablonski@dshs.state.tx.us

Acknowledgements:

Centers for Disease Control and Prevention

Council of State and Territorial Epidemiologists

Texas Department of State Health Services:

Sharon K. Melville, MD, MPH
HIV/STD Epidemiology & Surveillance Branch Manager

Integration of
Core & Incidence Surveillance
in King County, Washington

HIV/AIDS Surveillance & Incidence
Coordinators Meeting
June 4, 2006

Christina Lynch, MPH
Public Health – Seattle & King County




Overview

- Surveillance in King County
- Core/Incidence points of intersection:
 - Pursuing the THQ
 - Identifying STARHS specimens
 - Other

King County HIV Core & Incidence
Surveillance Background

- Core and incidence staff housed in separate secure rooms on same floor
- 350-400 new HIV diagnoses annually (~25% w/concurrent AIDS diagnosis)
- Standard BED incidence protocol implemented April 2005
 - As of April 2006, 5/7 of labs that conduct WBs are submitting specimens for STARHS
 - Since Jan 2006, 69% of new cases had sera available and/or THQ collected

THQ: On Case Report Form

- Testing history questions added to adult HIV/AIDS case report form – September 2005
- Announced in our HIV provider newsletter

4

THQ: On Case Report Form

5

THQ: On Case Report Form

- Issues
 - >50% of new case reports are completed by PH surveillance staff via medical record chart review
 - THQ section incomplete on forms from providers
- Plan
 - Revision of CRF anticipated this summer due to changes in reporting laws, actively promote new form at that time with focus on THQ section, personalized approaches
 - Evaluate which data elements are being collected
 - Focus provider follow-up on four key data elements

6

THQ: During PCRS

- Core surveillance prepares list of new cases weekly
- Incidence surveillance reviews list, denotes if THQ is needed
- List of cases submitted to PCRS staff who administer THQ following routine activities (unless inappropriate)
- Approximately 1/3 of THQs currently collected this way

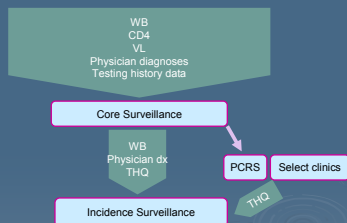
7

Specimens: Identifying for test/toss lists

- Core surveillance maintains "lab tracking" database with all reported lab results
- SAS dataset with WB results provided to incidence surveillance, weekly or monthly
 - Lab name, accession #, Stateno, first HIV+ date
- Incidence surveillance determines eligibility of each WB for test/toss list, uploads eligibles to local tracking database

8

Sources of incidence data



9

Other: Integrate communications to private labs

- When incidence approaches private lab re: submitting specimens for STARHS, good opportunity for core surveillance to address any issues
 - promote electronic reporting
 - promote timely reporting
 - re-establish contact with private labs, put a face on surveillance
- Present unified front, shows incidence as extension of core surveillance

10

Other: Deidentified data

- Core surveillance de-identified datasets available to incidence staff on secure network drive:
 - HARS
 - Lab reports
- Used by incidence staff for analysis, updating incidence database demographic variables, etc

11

Lessons learned

- Minimize duplicate data entry
- Automate as much as possible (i.e. with SAS programs)
- Keep things simple

Questions?

12

Contact Info

Christina Lynch, MPH
HIV Incidence Coordinator
Public Health – Seattle & King Co
christina.lynch@metrokc.gov
(206) 205-0997

13

***FLORIDA'S
HIV/AIDS DATA
MONITORING AND QUALITY
PROCESS***

Becky Grigg, Ph.D.
HIV/AIDS Surveillance Coordinator
Florida Department of Health

HARS Transfers

Transfers from local field offices usually contain six components:

- ✂ New cases
- ✂ Updates
- ✂ Out of Jurisdiction (OJJ) cases
- ✂ Labs
- ✂ Correction Sheets
- ✂ Transfer file

Monitoring Data Quality

Monitoring data quality occurs at three levels in Florida:

- ✂ At the local level
- ✂ At the case manager level
- ✂ At the program reporting manager level

Local Level Procedures to Improve Data Quality

- ✗ All new data entry operators (DEOS) receive one-on-one HARS data entry training, as well as a HARS data processing manual
- ✗ The data processing manual is a user friendly document developed to provide a reference tailored specifically to the individual responsible for data entry into the HARS software
- ✗ This manual provides clear and concise answers to situations and questions that may arise during data entry
- ✗ The manual goes into detail on each screen in HARS and each variable on that screen, e.g. what should and should not be entered, correct codes, etc.

Local Level Procedures to Improve Data Quality

- ✗ All incoming documents are record searched in the local database to determine status, i.e., new case or previously reported
- ✗ If a match is not found in either of these searches, the local DEO calls their case manager at the state health office to do a record search against the statewide database
- ✗ Field staff are trained to look for any indication a case may have prior diagnosis/residence in another state and to document this on the completed case report form

Local Level Procedures to Improve Data Quality

- ✗ The DEO will search STDMIS and HMS (the health department clinical system) for additional information, if necessary
- ✗ Cases are then sorted into new cases and updates
- ✗ All new cases are entered prior to entering updates

Case Manager Level Procedures to Improve Data Quality

- ✘ Each local field office has a dedicated case manager at the state health office to provide TA and to audit their transfers
- ✘ Transfers are audited after the electronic transfer file has been uploaded in HARS
- ✘ Every variable on the hard copy case report form is checked against the electronic copy in HARS
- ✘ Any data entry errors or fields with incorrect codes are noted on a correction sheet
- ✘ The correction sheet contains instructions on the cases that need some form of correction

Case Manager Level Procedures to Improve Data Quality

- ✘ The correction sheets are returned to the local DEOs once a month for them to make the necessary updates in HARS
- ✘ These audits provide information about each DEOs error rate to better facilitate data entry standards, evaluate data entry practices, and quality control in completing data entry
- ✘ They also allow us to monitor the progress of new DEOs or identify the need for “refresher training” for existing staff

Case Manager Level Procedures to Improve Data Quality

- ✘ They provide direction for standardization, duplicate resolution, and other data validation procedures
- ✘ The correction sheets are returned in the next transfer with an indication of the status of all requested actions
- ✘ The case managers periodically audit each other’s audits to provide quality assurance on their own work

*Program Reporting Manager Level Procedures to
Improve Data Quality*

- ✂ Once the case managers have completed their updates and edits in HARS, the Program Reporting Manager runs the standard HARS validation programs
- ✂ These validation programs are run several times a month but specifically prior to freezing the database and prior to sending transfers to CDC
- ✂ Any errors found as a result of running the validation programs are returned to the case managers for correction
- ✂ The case managers make the necessary corrections and instruct the DEOs at the local level to make the same corrections in their stand-alone HARS

The Future State

- ✂ Data entry for all sites will be centralized at the state health office
- ✂ Sites will scan all of their case reports and back-up documentation to their secure folders and the case managers will enter the cases in HARS
- ✂ Weekly or twice weekly (depending on the sites' morbidity) a backward transfer will be sent to the local offices so they can run reports and respond to data requests

KANSAS DATA QUALITY

Jeni Mulqueen
HIV/STD Surveillance Director
Kansas Department of Health & Environment

How Good Is Our Data?

From the minute I started working at KDHE I was told.....



Garbage In

=



Garbage Out!!!

Source of Data (Garbage In?)

- Doctors
- Ryan White Case Managers (Medical Eligibility)
- Laboratories
- Disease Intervention Specialists
- Counseling and Testing Contractors
- Other States
- Death Certificates
- Chart Reviews

*With all those reports, the fun
begins*

- Data Manager Sorts and Reviews Each Report
- Desk Reference Manual (Protocols)



Database Access

Direct Access

- STD MIS
- Ryan White Title II



Indirect Access

- TB Registry
- SRS
- Immunization Registry



Routine Data Quality Control

- In-State Duplicate Check In HARS
- ALL New Cases Are Checked With CDC
- Other Databases Checked As Necessary
- Daily Change Reports From Ryan White
- Weekly List From Care
- Weekly List From Counseling and Testing
- Monthly Patient List From Major Provider
- Review Of Closed Interview Records

Other Data Quality Control

- SAS Program (Quarterly)
- NIR Letter (Annually)
- Database Match With KCMO (At least Annually)
- Hospital Reviews (Annually)
- Chart Reviews (As Needed)
- Ancestry SSDI Check (Annually)

Activities To Come (Hopefully)

- Complete Access to Death Records
- Hospital Discharge Summary Information
- SRS Database Matches



THE END

Jeni Mulqueen
 Kansas Department of Health & Environment
jmulqueen@kdhe.state.ks.us
 785-368-8218



Demonstration of eHARS



The findings and conclusions in this presentation are those of the author and do not necessarily represent the views of the Centers for Disease Control and Prevention.

Demonstration of eHARS

Topics for this session are:

- QSIB Organization
- eHARS Overview
- HARS to eHARS Differences
- HARS to eHARS Conversion
- The Person View document
- eHARS Demonstration
- eHARS Reports

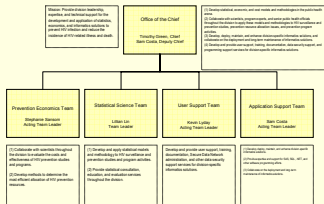


QSIB Organization

(Formerly Statistics and Data Management Branch)

Quantitative Sciences and Informatics Branch (Proposed)

Mission and Functions



HARS-to-eHARS Differences	
HARS	eHARS
- One record per case (regardless of source) - Flat file PRODAS database - Local installation - DOS-based - Limited amount of data fields/local fields - A lot of field level edits and skip patterns	- Document-based - Relational SQL database - Server-based - Browser-based - Unlimited local fields, IDs, names, addresses, and labs - Document-based edit checks

HARS to eHARS Conversion

- Existing HARS records will be converted to eHARS as read only legacy documents
- After conversion, eHARS will generate a synthesized HARS-like document called the Person View for each HARS document converted

ID	Description	Tolerance	Signature Required	Unit	Risk	Frequency	Due	Assigned
ADD DOCUMENT	NOD-00000000 - Person View	00000	0000	None	High	As required or 365/000000 00000000 0 - EAR		DELETE
	NOD-00000000 - Person Adult System	00000	0000	None	High	As required or 365/000000 00000000 000000 000000		
	NOD-00000000 - NARRS (Legacy)	00000	0000	None	High	As required or 365/000000		
ADD DOCUMENT	NOD-00000000 - Person View	00000	0000	None	High	As required or 365/000000 00000000 0 - EAR		DELETE
	NOD-00000000 - Person Adult System	00000	0000	None	High	As required or 365/000000 00000000 000000 000000		
	NOD-00000000 - NARRS (Legacy)	00000	0000	None	High	As required or 365/000000		

The
eHARS demonstration
begins now!

Reports Person View Status Report

This report returns a count of Person View documents by status and lists the documents for statuses selected.

Reports Person View Status Report

This report can help a site determine which cases are considered eligible for transfer to CDC

Person View Status			
Status	Frequency	%	
Active	50367	78	
Inactive	8	0	
Other	13488	21	
Deceased	0	0	
Not a Case	0	0	
Unreported	4	0	
Unreported (not missing)	1411	2	
Missing	1742	3	
Total number of documents: 65275			

Status-Error			
SI	Document	SI	Count
000001	NL00-000000000-0	0000-0000000000	0000-0000000000
000002	NL00-000000000-0	0000-0000000000	0000-0000000000

Status-Warning			
SI	Document	SI	Count
000001	NL00-000000000-0	0000-0000000000	0000-0000000000
000002	NL00-000000000-0	0000-0000000000	0000-0000000000

Person View Override Report

This report lists all overrides by field applied to Person View documents

[New Country](#)
[New Project](#)
[New User](#)
[New Country](#)
[New Project](#)
[New User](#)
[New Country](#)
[New Project](#)
[New User](#)

HIV/AIDS REPORTING SYSTEM

HOME [HELP](#) [CONTACT US](#) [ABOUT](#) [CONTACT](#)

Person View Overview

[Home](#)

No report will be run until the START and END dates are entered

Title 1	Person View Overview
Title 2	
Title 3	

Date Variable: Date 1: 00000000000000000000 Date 2: 00000000000000000000	Person View Overview Date ? Report Date: 00000000000000000000 End Date: 00000000000000000000 Date 1: ?
--	---

Facility 1: Facility 2: Facility 3: Facility 4: Facility 5: Facility 6: Facility 7: Facility 8: Facility 9: Facility 10: Facility 11: Facility 12: Facility 13: Facility 14: Facility 15: Facility 16: Facility 17: Facility 18: Facility 19: Facility 20: Facility 21: Facility 22: Facility 23: Facility 24: Facility 25: Facility 26: Facility 27: Facility 28: Facility 29: Facility 30: Facility 31: Facility 32: Facility 33: Facility 34: Facility 35: Facility 36: Facility 37: Facility 38: Facility 39: Facility 40: Facility 41: Facility 42: Facility 43: Facility 44: Facility 45: Facility 46: Facility 47: Facility 48: Facility 49: Facility 50: Facility 51: Facility 52: Facility 53: Facility 54: Facility 55: Facility 56: Facility 57: Facility 58: Facility 59: Facility 60: Facility 61: Facility 62: Facility 63: Facility 64: Facility 65: Facility 66: Facility 67: Facility 68: Facility 69: Facility 70: Facility 71: Facility 72: Facility 73: Facility 74: Facility 75: Facility 76: Facility 77: Facility 78: Facility 79: Facility 80: Facility 81: Facility 82: Facility 83: Facility 84: Facility 85: Facility 86: Facility 87: Facility 88: Facility 89: Facility 90: Facility 91: Facility 92: Facility 93: Facility 94: Facility 95: Facility 96: Facility 97: Facility 98: Facility 99: Facility 100: Facility 101: Facility 102: Facility 103: Facility 104: Facility 105: Facility 106: Facility 107: Facility 108: Facility 109: Facility 110: Facility 111: Facility 112: Facility 113: Facility 114: Facility 115: Facility 116: Facility 117: Facility 118: Facility 119: Facility 120: Facility 121: Facility 122: Facility 123: Facility 124: Facility 125: Facility 126: Facility 127: Facility 128: Facility 129: Facility 130: Facility 131: Facility 132: Facility 133: Facility 134: Facility 135: Facility 136: Facility 137: Facility 138: Facility 139: Facility 140: Facility 141: Facility 142: Facility 143: Facility 144: Facility 145: Facility 146: Facility 147: Facility 148: Facility 149: Facility 150: Facility 151: Facility 152: Facility 153: Facility 154: Facility 155: Facility 156: Facility 157: Facility 158: Facility 159: Facility 160: Facility 161: Facility 162: Facility 163: Facility 164: Facility 165: Facility 166: Facility 167: Facility 168: Facility 169: Facility 170: Facility 171: Facility 172: Facility 173: Facility 174: Facility 175: Facility 176: Facility 177: Facility 178: Facility 179: Facility 180: Facility 181: Facility 182: Facility 183: Facility 184: Facility 185: Facility 186: Facility 187: Facility 188: Facility 189: Facility 190: Facility 191: Facility 192: Facility 193: Facility 194: Facility 195: Facility 196: Facility 197: Facility 198: Facility 199: Facility 200: Facility 201: Facility 202: Facility 203: Facility 204: Facility 205: Facility 206: Facility 207: Facility 208: Facility 209: Facility 210: Facility 211: Facility 212: Facility 213: Facility 214: Facility 215: Facility 216: Facility 217: Facility 218: Facility 219: Facility 220: Facility 221: Facility 222: Facility 223: Facility 224: Facility 225: Facility 226: Facility 227: Facility 228: Facility 229: Facility 230: Facility 231: Facility 232: Facility 233: Facility 234: Facility 235: Facility 236: Facility 237: Facility 238: Facility 239: Facility 240: Facility 241: Facility 242: Facility 243: Facility 244: Facility 245: Facility 246: Facility 247: Facility 248: Facility 249: Facility 250: Facility 251: Facility 252: Facility 253: Facility 254: Facility 255: Facility 256: Facility 257: Facility 258: Facility 259: Facility 260: Facility 261: Facility 262: Facility 263: Facility 264: Facility 265: Facility 266: Facility 267: Facility 268: Facility 269: Facility 270: Facility 271: Facility 272: Facility 273: Facility 274: Facility 275: Facility 276: Facility 277: Facility 278: Facility 279: Facility 280: Facility 281: Facility 282: Facility 283: Facility 284: Facility 285: Facility 286: Facility 287: Facility 288: Facility 289: Facility 290: Facility 291: Facility 292: Facility 293: Facility 294: Facility 295: Facility 296: Facility 297: Facility 298: Facility 299: Facility 300: Facility 301: Facility 302: Facility 303: Facility 304: Facility 305: Facility 306: Facility 307: Facility 308: Facility 309: Facility 310: Facility 311: Facility 312: Facility 313: Facility 314: Facility 315: Facility 316: Facility 317: Facility 318: Facility 319: Facility 320: Facility 321: Facility 322: Facility 323: Facility 324: Facility 325: Facility 326: Facility 327: Facility 328: Facility 329: Facility 330: Facility 331: Facility 332: Facility 333: Facility 334: Facility 335: Facility 336: Facility 337: Facility 338: Facility 339: Facility 340: Facility 341: Facility 342: Facility 343: Facility 344: Facility 345: Facility 346: Facility 347: Facility 348: Facility 349: Facility 350: Facility 351: Facility 352: Facility 353: Facility 354: Facility 355: Facility 356: Facility 357: Facility 358: Facility 359: Facility 360: Facility 361: Facility 362: Facility 363:

Reports

Person View Override Report

This report is shows the field value selected before and after the override.

[illegible]

Reports

Auto Match Report

This report provides a list of imported records added to existing cases or used to create new cases. The report also provides a list of records that failed import standardizations

HIV/AIDS REPORTING SYSTEM
HARS v1.0.0

HOME CONTACT US HELP LOGOUT

ADMIN

Auto Match

This report will not export the HARS real time database

Title 1:

Title 2:

Title 3:

Input Source File:

Start Date:

Postdate 1:

Postdate 2:

End Date:

Output File:

Reports

Auto Match Report

This report can be used for quality assurance, to determine if records have been correctly added to cases or correctly used to create a new case

[illegible]

Reports

Indeterminate Match Report

This report supplies information to allow an indeterminate record to be matched to an existing case

HIV/AIDS REPORTING SYSTEM NEXT: BACK TO REPORT LAYOUT

Indeterminate Matches

This report will run against the HARS real time database

Table 1	Table 2	Table 3
Indeterminate Match		

Report Format List:

☐ Formative 1
☐ Formative 2
☐ Formative 3
☐ Survey Types

Print: HIV, 10/04/2010 10:04 AM
 Cancel

Reports

Indeterminate Match Report

The goal of this report is to provide enough demographic information to match an indeterminate record with an existing case or rule out a match

Indeterminate Matches												
Filename: labg_sus_030808_RJ1.d												
Contaminant ID	STAD/MSD	File Name	Match Score	Library Name	Library Size	Library Utility	Score of Match	Date of Match	Reference Size	Reference Score	Reference Date	Reference File
NUS-00021144-5	NUS045	0055	99.99	PGDIT	W	RA	E2	1214/1073				TRICENTON NJ
NUS-00021144-4		0055	99.99	PGDIT	W	RA	E2	1214/1073				
POTENTIAL MATCHES 2												
NUS-00021144-5	NUS045	0055	99.99	PGDIT	W	RA	E2	1214/1073				TRICENTON NJ
NUS-00021144-4		0055	99.99	PGDIT	W	RA	E2	1214/1073				
NUS-00021144-3		0055	99.99	PGDIT	W	RA	E2	1214/1073				
POTENTIAL MATCHES 2												
NUS-00021144-3	4500001	PROG1	F	W	W	W	E2	1021/1060				TRICENTON NJ
NUS-00021144-2	4500001	PROG1	F	E2	E2	E2	1021/1060					TRICENTON NJ
NUS-00021144-1	4500001	PROG1	F	E2	E2	E2	1021/1060					
POTENTIAL MATCHES 2												

Reports

Surveillance Summary Report

This report lists the numbers of cases and deaths for a chosen diagnostic status. Comparable to HARS Report A

The screenshot shows the 'HIV/AIDS REPORTING SYSTEM' interface. The 'Surveillance Summary' section is active. It includes a message: 'This report will be run against the HARS data for the period of 1/1/2005 to 12/31/2005'. Below this, there are input fields for 'Site ID', 'Site Name', and 'Date Range'. A 'Run Report' button is visible. The bottom of the screen shows a table with columns for 'Site ID', 'Site Name', and 'Date Range'.

Reports

Surveillance Summary Report

This report can help a site conduct analysis on the cases reported in eHARS

The screenshot shows a detailed table of data from the 'HIV/AIDS REPORTING SYSTEM'. The table is titled 'Table 1. Number of cases and deaths by diagnostic status and age category'. It has columns for 'Diagnostic Status', 'Age Category', 'Cases', and 'Deaths'. The data is presented in a grid format with multiple rows and columns.

Demonstration of eHARS

Questions?



**The 411:
on HIV/AIDS Core
Surveillance
Site Visits**

HIV Incidence and Case
Surveillance Branch
June 4, 2006



Why CDC conducts site visits?

- Outlined in cooperative agreement
- Provide technical assistance to State/local grantees
- Learn how State/local HIV/AIDS surveillance programs operate
- Understand where national HIV/AIDS surveillance data comes from



**Surveillance site visits:
Role of all HICSB staff**

- Support HICSB funded activities
- Good understanding of case reporting activities
- Principles of data security and confidentiality
- Issues of integrating/prioritizing surveillance activities in the field
- Evaluation issues – minimum performance standards
- TA to states on synthesizing and using data for prevention and treatment program planning



What Determines the Need for a Site Visit

- State/local area identified as a priority for a site visit based on Branch criteria
 - Change in HIV/AIDS infection reporting
 - Identified problems with core surveillance
 - Evaluation activities
 - Have not been visited in a while
 - Morbidity
 - Beginning new HICSB activities
- Grantee requests a site visit



The Process of Site visits

- Pre-site visit preparation
- Conducting the site visit
- Site visit follow-up



Pre-site visit preparation

- Collaboration between Epi(s) and Consultant
 - Determine purpose(s) for visit
 - Agree on visit length and possible dates
 - Agenda guidance – list of discussion topics
 - Materials to review



Collaboration

- Epis and Consultants work together with Grantee to:
 - Goals of visit
 - Proposed agenda
 - Identify problems
 - Consult with other HICSB/SDMB staff as appropriate
- Consultant coordinates visit plans with Grantee and HICSB staff participating in visit
- Select appropriate local reporting sites to visit
- Avoid the "dog and pony show" sessions



Materials to review

- PA 04017 cooperative agreement guidance
- Current year cooperative agreement application
- Previous site visit letters and recommendations
- Local HIV/AIDS Surveillance Report
- Local security and confidentiality guidelines
- Data runs



Materials to review

Cooperative agreement for current year

- Technical review of recent application
- Core surveillance activities proposed
- Staffing and funding issues
- Other funded HICSB activities
- Current progress reports
- Current local HIV/AIDS surveillance report
- Reporting requirements
- Local protocols/procedures for case reporting and follow-up



Materials to review
Previous Site Visit Letters and Recommendations

- Review the major problems identified in letter
 - Were problems resolved?
 - Do they still exist/relevant?
- Review the recommendations made
 - Was action taken?



Materials to review
Local HIV/AIDS surveillance report

- How are they presenting surveillance data?
- Other data dissemination issues/opportunities



Materials to review
Local security and confidentiality guidelines

- Staff training and retraining
- NEDSS/Centralization of activities?
 - Electronic reporting
 - Data storage
- Prior security and confidentiality issues discussed in last site visit



Materials to review Data runs

- Work with HICSB lead programmer
- Standard data request format
- Site specific data analysis needs
 - Changes/unusual patterns in reporting
 - Primary reporting sources (>2%)
 - Timeliness
 - Risk factor ascertainment
 - HIV reporting
 - Reporting scheme
 - Time since implementation



Conducting a Site Visit

- The agenda should guide the site visit
- The agenda should balance the needs HICSB and the Site
 - Ample opportunity for the site report to successes and problems
 - Time for HICSB to ask questions and provide positive feedback



Summary of Findings and Recommendations

- Findings should be discussed at the end of the visit
- Recommendations should be made to the site before HICSB departs the visit
- Successes and issues should have been clearly defined. HICSB and grantee should be clear on what the site visit letter will entail before the site visit is completed



Follow up activities

- Follow up on information requested by or promised to grantee during the visit
- Site visit letter – the final letter should be sent to the grantee within one month of visit



Site Visit Letter

- Contents of the letter should have been discussed with the site and reviewed and Ok'd by the site prior to sending final.
- Serves as record of visit for later planning of next visit



Site Visit Letter cont'd

- Specific problems and recommendations
 - Clearly state deficiencies and recommended correction
 - Each recommendation should include rationale and expected benefits.
 - Identify areas needing improvement, and suggested ways to improve



Site Visit Letter

- Planned Next Steps
 - Note any requests by the site for follow up information or technical assistance
 - Note planned activities and timelines for things listed in the "Problems and Recommendations" section
 - Note any specific need for another site visit



The Importance of the Site Visit Letter to the Grantee

San Francisco Department of Health
will present how they use the site visit
letter to plan their activities



Receiving and Responding to Site Visit Letter

Maree Kay Parisi
San Francisco Department of
Public Health

Influencing letter

- No surprises
 - Overview at site visit of recommendations
 - Dialogue, comments

Receiving Letter

- Draft letter
 - Input
 - Correct, clarify, make requests to add specific needs
- Final version from CDC
 - Overview
 - Specific recommendations

Addressing Letter

- Approach letter as an aide to accomplish tasks
 - Example from SF
- Response to CDC
 - Letter on how things are accomplished
 - Issues may have been addressed
 - Prioritize
 - Action plan and timeline
 - Request assistance

Accomplishing Tasks

- Delegate work
 - Revisit letter, stay on track
- Keep CDC in the loop
 - Notify CDC of progress

Integrate and Conquer

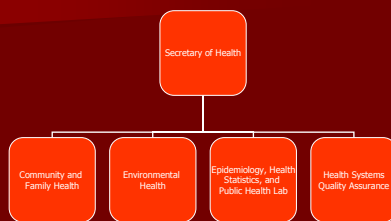
Incorporating HIV surveillance into broader
public health assessment activities

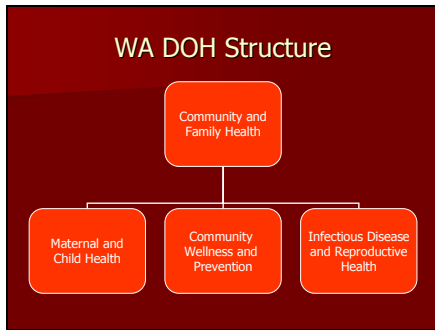
Maria Courrogen, MPH
WA State Department of Health
CSTE Annual Meeting, June 4, 2005

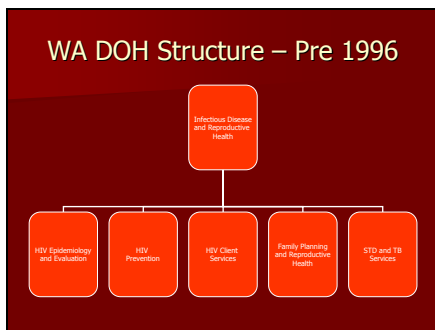
To cover:

- Structure of Washington State Department of Health
- Reasons for reorganization
- Staffing of the Infectious Disease and Reproductive Health Assessment Unit
- Annual work plans
- Benefits and challenges

WA DOH Structure









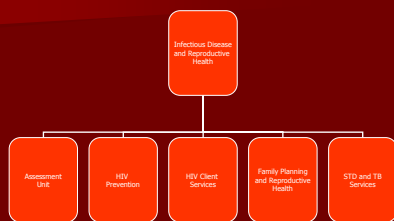
Reasons for reorganization

- HIV Prevention Program – HIV community planning
- HIV Client Services Program – Ryan White Care Act Title II prioritization processes
- *Assessment* identified as the core function that could be consolidated across IDRH programs

Assessment

- Collection, analysis, and dissemination of information on health status, personal health problems, population groups at greatest risk, availability and quality of services, resource availability, and concerns of individuals
- Broader than surveillance

WA DOH Structure – As of 1996



Evolution

- Started with staff working on and funded by HIV surveillance activities (core, SHAS, serosurveys)
- Other IDRH programs contributed resources for additional Assessment Unit staff
- Hired AU staff to meet needs of programs

Assessment Unit staffing

- Four epidemiologists (soon to be five), funded with STD, TB, HIV client services, HIV prevention, HIV surveillance, and HCV dollars
- Research investigator funded with HIV and FPRH dollars
- HIV surveillance coordinator
- Data manager and data compiler funded with HIV surveillance, HIV client services, and TB dollars
- Interviewers and evaluators funded with HIV surveillance, HIV prevention, and HIV client services dollars
- HCV program coordinator funded with HCV and HIV client services dollars
- Fiscal and administrative staff funded across programs

Annual work plans

- Describe agreements with each program about scope of work for the year
- Scope of work to align with %FTE funded
- Document to refer to when scope of work for program changes to avoid overwhelming AU staff
- Reinforcement that AU oversees work methods and staff for project
- Example

Benefits of AU structure

- Multiple funding sources
- Staff become cross-trained across disease areas and types of analyses
- Access to data (STD, TB, HIV client services)
- Analyses are conducted consistently across disease areas
- HIV expertise has been shared
- The bar on security and confidentiality has been raised for non-HIV programs

Examples

- HIV-STD match, HIV-HCV match
- Never In Care
- Participation on planning groups
- Hepatitis program support
- Reascertaining names for HIV reporting
- More data get shared with more stakeholders

Challenges

- As all CDC-funded programs get cut, program managers prioritize funding their own staff
- Need to remain vigilant about work loads
- Continue to deal with different data systems across disease areas
- Programs need to maintain some in-house assessment capacity

Questions?

Maria Courogen, MPH
Washington State Department of Health
(360) 236-3458
Maria.Courogen@doh.wa.gov

Integration of Surveillance
with Other Programs

Bill Jones, MPH
Epidemiologist
NC Division of Public Health

June 2006



Integration of Surveillance
with Other Programs

- NC HIV/AIDS Surveillance
- NC PCRS

June 2006



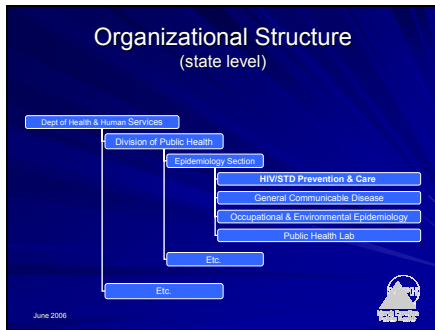
Public Health in North Carolina

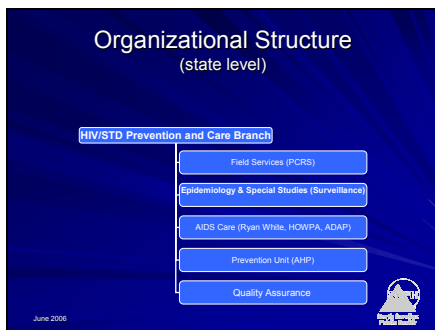


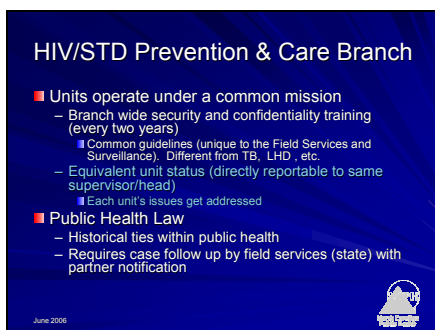
- 100 individual counties comprising 87 health departments
- Each county has responsibility for public health in its jurisdiction

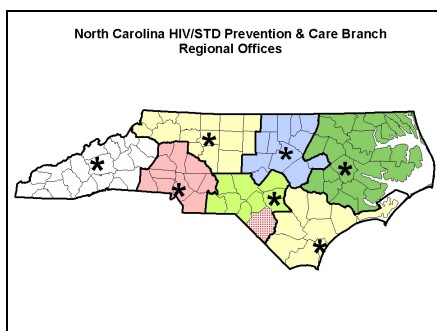
June 2006

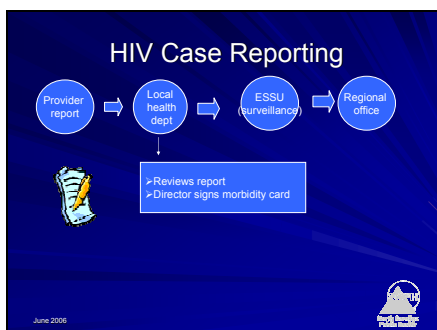


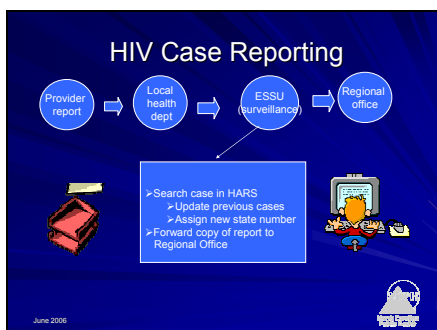


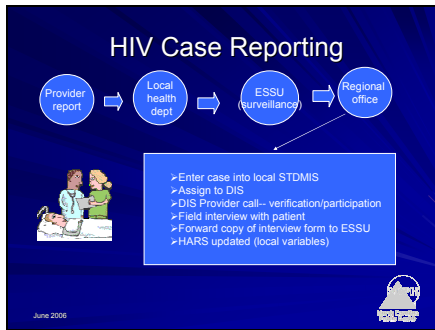


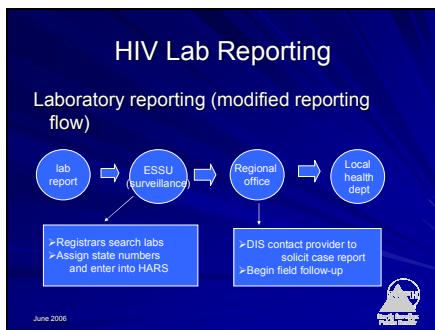


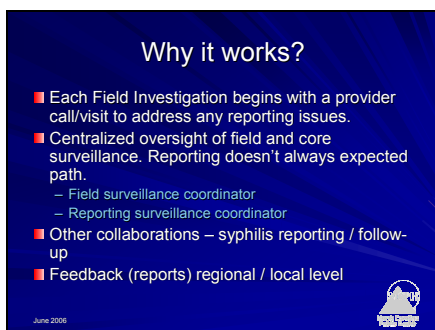












Benefits

■ For Field Services

- ESSU maintains a centralized registry for limited PCRS information (acts as a bridge between the regional STDMS systems)
- ESSU conducts interstate contact notifications
- Notification about new providers. Useful for Field Services to develop relationship with providers

June 2006



Benefits

■ For ESSU

- Field interview records have much more risk information
 - DIS are trained to collect good risk information
 - Capture four additional risk categories in HARS
 - Used to define "presumed heterosexual" risk
 - Can periodically link to regional STDMS for additional risk information

June 2006



Benefits

■ For ESSU

- Expands available resources locally
 - 2000 individual reporters
 - Physical distance to some providers
- Documentation of case information with provider and patient

June 2006



Challenges

- Paper based
- Different program focus for surveillance and PCRS
 - Provider interaction/education can be time consuming and challenging for DIS
 - Surveillance must process the reports quickly to determine new cases and assign state numbers. Data entry is often segmented.

June 2006



Questions?

June 2006



Anthony Merriweather, MSPH
Alabama Department of Public Health
HIV/AIDS Surveillance Director
The RSA Tower
201 Monroe Street/ Suite 1400
Montgomery, AL 36104
Phone: (334) 206-2621
Fax: (334) 206-2092
E-Mail:
amerriweather@adph.state.al.us

Mersija Hadzihasanovic, MD
Arizona Department of Health Services
Epidemiologist
150 N. 18th Ave
Phoenix, AZ 85007
Phone: (602) 364-3613
Fax: (602) 364-3268
E-Mail: hadzihm@azdhs.gov

Laura Lund, MA
California Department of Health
Services
Chief, HIV-AIDS Case Registry
1616 Capitol Avenue, Suite 74-616
MS 7700
Sacramento, CA 95814
Phone: (916) 449-5866
Fax:
E-Mail: LLund@dhs.ca.gov

Allison Crutchfield, BS
Colorado Department of Public Health
and Environment Surveillance
Coordinator
STD/AIDS Section
4300 Cherry Creek Drive South
DENVER, CO 80246
Phone: (303) 692-2691
Fax: (303) 782-0904
E-Mail: allison.crutchfield@state.co.us

Becky Grigg, PhD
Florida Department of Health
Surveillance Program Administrator
Bureau of HIV/AIDS
4052 Bald Cypress Way
Tallahassee, FL 32399
Phone: (850) 245-4430
Fax: (850) 922-4263
E-Mail: Becky_Grigg@doh.state.fl.us

Wendy Craytor, MBA, MPH
State of Alaska
HIV/STD Program Coordinator
Section of Epidemiology, Suite 540
PO Box 240249
Anchorage, AK 99524-0249
Phone: (907) 269-8058
Fax: (907) 561-0453
E-Mail: wendy_craytor@health.state.ak.us

Sharon Donovan, MHSA
Arkansas Department of Health and Human Services
Section Chief/Senior Epidemiologist
P.O. Box 1437, Slot H33
Little Rock, AR 72203
Phone: (501) 661-2971
Fax: (501) 661-2035
E-Mail: sjudah@healthyarkansas.com

Nanette Benbow, MAS
Chicago Department of Public Health
Director of the Office of HIV/AIDS Surveillance
333. South State St. 2150
Chicago, IL 60604
Phone: (312) 747-9620
Fax: (312) 747-9663
E-Mail: Benbow_nanette@cdph.org

Aaron Roome, PhD MPH
Connecticut Department of Public Health
HIV/AIDS Surveillance Program Coordinator
410 Capital Avenue MS - 11ASV
Hartford, CT 06134
Phone: (860) 509-7900
Fax: (860) 509-8237
E-Mail: aaron.roome@po.state.ct.us

R. Luke Shouse, MD, MPH
Georgia Department of Public Health
Chief HIV/STD Epidemiologist
2 Peachtree Street#14-450
Atlanta, GA 30303
Phone: (404) 657-2601
Fax: (404) 657-4141
E-Mail: rlshouse@dhr.state.ga.us

Glenn Wasserman, MD, MPH
State of Hawaii Department of Health
Chief, Communicable Disease Division
P.O. Box 3378
Honolulu, HI 96801-3378
Phone: (808) 586-4583
Fax:
E-Mail: glenn.wasserman@doh.hawaii.gov

Christine Miller, BA, BS, RT
Illinois Department of Public Health
HIV/AIDS Surveillance Coordinator
HIV/AIDS Section
525 W. Jefferson Street, 1st Floor
Springfield, IL 62761
Phone: (217) 524-5983
Fax: (217) 524-4766
E-Mail: cleflier@idph.state.il.us

Randy Mayer, MS, MPH
Iowa Department of Public Health
Surveillance Program Manager
Bureau of Disease Prevention and
Immunization
321 E. 12th Street
Des Moines, IA 50319-0075
Phone: (515) 242-5150
Fax: (515) 281-4570
E-Mail: rmayer@idph.state.ia.us

Mollie Adkins
Department for Public Health
HIV/AIDS Surveillance Coordinator
275 E Main St/ MS HS2E-C
HIV/AIDS Branch
Frankfort, KY 40621
Phone: (502) 564-6539
Fax: (502) 564-9865
E-Mail: Mollie.Adkins@ky.gov

Amy Zapata, MPH
Louisiana Office of Public Health, HIV/AIDS
Program
HIV/AIDS Surveillance Program Manager
234 Loyola Avenue, 5th Floor
New Orleans, LA 70112
Phone: (504) 568-7523
Fax: (504) 599-1307
E-Mail: azapata@dhh.la.gov

Marcia Wolverton, MPH, BS
Houston Department of Health and Human
Services
Epidemiologist Manager
8000 N. Stadium Drive
Houston, TX 77054
Phone: (713) 794-9441
Fax: (713) 794-9182
E-Mail: marcia.wolverton@cityofhouston.net

Jerry V Burkman, BSN, MPH
Indiana State Department of Health
HIV Disease Surveillance Program Manager
HIV/STD Division
2 North Meridian Mailstop 6C
Indianapolis, IN 46204
Phone: (317) 233-7506
Fax: (317) 233-7663
E-Mail: jburkman@isdh.in.gov

Jennifer Mulqueen, BSW
Kansas Department of Health & Environment
HIV/STD Surveillance Director
Bureau of Epidemiology and Disease Prevention
1000 SW Jackson, Suite 210
Topeka, KS 66612-1274
Phone: (785) 368-8218
Fax: (785) 296-0792
E-Mail: JMulqueen@kdhe.state.ks.us

Douglas Frye, MD, MPH
Los Angeles County HIV Epidemiology Program
Medical Director
600 S Commonwealth Ave
Suite 1920
Los Angeles, CA 90005
Phone: (213) 351-8149
Fax: (213) 427-8840
E-Mail: dfrye@ladhs.org

Mark Griswold, MSc
Maine Bureau of Health
HIV/AIDS Epidemiologist
State House Station 11
286 Water Street, 9th Floor
Augusta, ME 04333
Phone: (207) 287-5193
Fax: (207) 287-3498
E-Mail: mark.griswold@maine.gov

Angelique Griffin, MS

Maryland AIDS Administration
Acting Deputy Chief, Center for Surveillance &
Epidemiology
500 N. Calvert St
5th Floor
Baltimore, MD 21202
Phone: (410) 767-5645
Fax: (410) 333-3974
E-Mail: griffina@dnhm.state.md.us

Nilsa E. Mack, MPH

Michigan Department of Community Health
Epidemiologist
201 Townsend/ Capitol View Bldg.- 5th Floor
Lansing, MI 48909
Phone: (517) 335-8165
Fax: (517) 335-8121
E-Mail: mackn@michigan.gov

David Peyton, MPH

Mississippi Department of Health
STD/HIV Surveillance Coordinator
570 E Woodrow Wilson Blvd, Suite 350
Jackson, MS 39215
Phone: (601) 576-7723
Fax: (601) 576-7909
E-Mail: dpeyton@msdh.state.ms.us

Jim Murphy

Montana Department of Public Health and Human
Services
Surveillance Coordinator
AIDS/STD Program
Health Policy and Health Services Division
Helena, MT 59620
Phone: (406) 444-0274
Fax: (406) 444-0308
E-Mail: jmurphy@mt.gov

Dave Crockett

Nevada State Health Department
HIV Surveillance Coordinator
Bureau of Community Health
Room 103
Carson City, NV 89701
Phone: (775) 684-4056
Fax:
E-Mail: dcrockett@nvhd.state.nv.us

James Murphy, BA, MPH

Massachusetts Department of Public Health
Director HIV/AIDS Surveillance
Bureau of Communicable Disease Control
305 South Street
Boston, MA 02130
Phone: (617) 983-6577
Fax: (617) 983-6580
E-Mail: james.murphy2@dph.state.ma.us

Peter Carr, MPH

Minnesota Department of Health
Epidemiologist Supervisor
Freeman Building
625 Robert Street North
Saint Paul, MN 55164
Phone: (651) 201-4007
Fax: (651) 201-4000
E-Mail: peter.carr@health.state.mn.us

Yelena Friedberg, MD

Missouri Department of Health
Epidemiology Specialist
930 Wildwood Dr
Jefferson City, MO 65102
Phone: (573) 526-7304
Fax: (537) 751-6417
E-Mail: friedy@dhss.mo.gov

Tina Brubaker, MPH

Nebraska Department of Health and Human Services
HIV Surveillance Coordinator
R & L Communicable Diseases
P.O. Box 95007
Lincoln, NE 68509-5007
Phone: (402) 471-0360
Fax: (402) 471-3601
E-Mail: tina.brubaker@hhss.ne.gov

Helene Cross, PhD

New Jersey Department of Health & Senior Services
Director HIV Epidemiologic Services
P.O. Box 363
Trenton, NJ 08625-0363
Phone: (609) 984-5940
Fax: (609) 633-2791
E-Mail: helene.cross@doh.state.nj.us

Monica Olkowski, MS

New Mexico Department of Health
HIV/AIDS Surveillance Coordinator
1190 St. Francis Dr. N1350
Santa Fe, NM 87502

Phone: (505) 827-0074

Fax: (505) 476-3544

E-Mail: monica.olkowski@state.nm.us

Alexa Bontempo

New York State Department of Health
Surveillance Coordinator
Bureau of HIV/AIDS Epidemiology
Corning Tower 717
Albany, NY 12237

Phone: (518) 474-4284

Fax: (518) 474-5121

E-Mail: anb01@health.state.ny.us

Judith Sackoff, PhD

New York City Department of Health
HIV/AIDS Case Surveillance Unit
346 Broadway, RM 703
Box 44

New York, NY 10013

Phone: (212) 442-3443

Fax: (212) 349-5170

E-Mail: jsackoff@health.nyc.gov

Bill Jones, BS, MPH

North Carolina Department of Health and Human
Services

Epidemiologist

1902 Mail Service Center

HIV/STD Prevention & Care Branch

Raleigh, NC 27699-1902

Phone: (919) 733-9603

Fax: (919) 715-7540

E-Mail: bill.jones@ncmail.net

Denise Steinbach, BSc

North Dakota Department of Health
Surveillance Coordinator
600 East Blvd. Ave
Bismarck, ND 58505

Phone: (701) 328-2378

Fax: (701) 328-2499

E-Mail: dsteinb@state.nd.us

Carol Bohumolski, MS

Ohio Department of Health
Chief, HIV/AIDS Surveillance
246 N. High St.

Columbus, OH 43215

Phone: (614) 387-7483

Fax: (614) 644-1909

E-Mail: carol.bohumolski@odh.ohio.gov

Mark Turner, MPH

Oklahoma State Department of Health
Epidemiology Division Director
1000 NE 10th Street
Oklahoma City, OK 73119-1299

Phone: (405) 271-4636

Fax: (405) 271-1187

E-Mail: markt@health.state.ok.us

Sean Schafer, MD

Oregon Department of Human Services
Medical Epidemiologist
800 NE Oregon St., Suite 1105
Portland, OR 97232

Phone: (971) 673-0153

Fax: (971) 673-0178

E-Mail: Sean.Schafer@state.or.us

Bonnie Krampe, MPH

Pennsylvania Department of Health
HIV/AIDS Field Surveillance
Coordinator
Bureau of Epidemiology
PO Box 90

Harrisburg, PA 17108

Phone: (717) 783-0481

Fax: (717) 772-6975

E-Mail: bkrampe@state.pa.us

James McAnaney

Philadelphia Department of Public Health
Surveillance Coordinator
AACO, Epidemiology Unit
1101 Market Street, 9th Floor
Philadelphia, PA 19107

Phone: (215) 685-4777

Fax: (215) 685-4774

E-Mail: james.mcananey@phila.gov

Sandra Miranda

Puerto Rico Health Department
AIDS Surveillance
AIDS Surveillance Program
San Juan, PR 00921

Phone: (787) 763-0240

Fax:

E-Mail: smiranda@salud.gov.pr

Maree Kay Parisi, BA

San Francisco Department of Public Health
HIV/AIDS Statistics and Epidemiology Section
HIV/AIDS Surveillance Coordinator
AIDS Office

25 Van Ness Avenue, Suite 500

San Francisco, CA 94102

Phone: (415) 554-9095

Fax: (415) 431-0353

E-Mail: maree.kay.paris@sfdph.org

Christine Olson

South Dakota Department of Health
HIV Surveillance Coordinator

615 E. 4th Street

Pierre, SD 57501

Phone: (605) 773-3737

Fax:

E-Mail: christine.olson@state.sd.us

Sharon Melville, MD, MPH

Texas Department of State Health Services
Director, HIV/STD Epidemiology and
Surveillance Branch

HIV/STD Epidemiology and Surv Branch

1100 West 49th Street H33000, HSES,

Mailcode 1873 SKM

Austin, TX 78756

Phone: (512) 533-3100

Fax: (512) 371-4672

E-Mail: sharon.melville@dshs.state.tx.us

Matthew Pettengill

Vermont Department of Health

HIV/AIDS Surveillance

P.O. Box 70

Burlington, VT 05401

Phone: (802) 863-7572

Fax: (802) 863-7314

E-Mail: mpetten@vdh.state.vt.us

Paul Loberti, MPH

Rhode Island Department of Manager

HIV/AIDS Program Manager

3 Capitol Hill, Cannon Building Room 106

Providence, RI 02908

Phone: (401) 222-6001

Fax: (401) 222-6001

E-Mail: paulL@doh.state.ri.us

Dana-Mihaela Giurgiutiu, PhD

South Carolina Department of Health and
Environmental Control

HIV/STD Surveillance Coordinator

1751 Calhoun St

Columbia, SC 29201

Phone: (803) 898-0933

Fax: (803) 898-0573

E-Mail: giurgid@dhec.sc.gov

Thomas Shavor, MBA

Tennessee Department of Health

Director, HIV/AIDS/STD Surveillance

Cordell Hull Bldg.

425 5th Ave. North 4th floor

Nashville, Tennessee 37247-4911

Phone: (615) 532-8506

Fax: (615) 741-3857

E-Mail: thomas.shavor@state.tn.us

George A. Usher, MPA

Utah Department of Health

HIV/AIDS Surveillance Manager

Box 142105

Salt Lake City, Utah, UT 84114-2105

Phone: (801) 538-6096

Fax: (801) 538-6096

E-Mail: gausher@utah.gov

Dena Ellison, MPH

Virginia Department of Health

Director, HIV/AIDS Surveillance

Division of Disease Prevention

109 Governor St Room 326

Richmond, VA 23218

Phone: (804) 864-7959

Fax: (804) 864-7983

E-Mail: Dena.Ellison@vdh.virginia.gov

Mark Charonis, BBA

Washington-Department of Health
HIV/AIDS Surveillance Coordinator
Infectious Disease and Reproductive Health
Assessment
PO Box 47388
Olympia, WA 98504
Phone: (253) 395-6731
Fax: (253) 395-7729
E-Mail: mark.charonis@doh.wa.gov

Wendy Schell, MS

Wisconsin Division of Public Health
AIDS/HIV Surveillance Coordinator
AIDS/HIV Program
PO Box 2659
Madison, WI 53701-2659
Phone: (608) 266-2664
Fax: (608) 266-1288
E-Mail: schelwl@dhfs.state.wi.us

Kennar Briand

Ministry of Health
Public Health Medical Director
P.O. Box 16
Majuro, MH 96960
Phone: (692) 625-3355
Fax: (692) 625-4372
E-Mail: kbriand@moh.com

Johanan Ngiruchelbad

Ministry of Health
Administrator, Prevention Services
Bureau of Public Health
PO Box 716
Koror, Palau 96940
Phone: (680) 488-8517
Fax: (680) 488-3115
E-Mail: hana@palau-health.net

Taetia Phillips-Dorsett, BS, MS

St. Thomas Department of Health
Surveillance Coordinator
STD/HV/TB Program
Old Municipal Complex
St Thomas, US VI 00801
Phone: (340) 774-9000
Fax: (340) 715-1589
E-Mail: phillipsdorsett@yahoo.com

Kaluwa Schoen, RN, BA

West Virginia Bureau for Public Health
Nurse Epidemiologist
Room 125 350 Capiol Street
Charleston, WV 25301
Phone: (304) 558-6460
Fax: (304) 558-6478
E-Mail: kaluwaschoen@wvdhhr.org

Cheryl Corbin

Wyoming Department of Health
HIV Surveillance Coordinator
6101 Yellowstone Rd #510
Cheyenne, WY 82002
Phone: (307) 777-7719
Fax: (307) 777-6144
E-Mail: ccorbi@state.wy.us

Edward Diaz

Department of Health
CNMI Epidemiologist
PO Box 500409
Saipan, MP 96950
Phone: (670) 236-8820
Fax: (670) 233-0214
E-Mail: dabit@vzpacificia.net

Faraitoafa Utu

Department of Health
HIV/AIDS Program Coordinator
Public Health Division
Department of Health
Pago Pago, AS 96799
Phone: (684) 633-2437
Fax: (684) 633-7561
E-Mail: farautu@yahoo.com

Jared Bartschi, MA, BS

Idaho Department of Health & Welfare, Office of
Epidemiology & Food Protection
Disease Intervention Surveillance Specialist
450 W State Street 4th floor
4th Floor
Boise, ID 83720
Phone: (208) 334-5944
Fax: (208) 332-7307
E-Mail: bartschj@idhw.state.id.us

Christina Melvin

Delaware Department of Health and Social Services
HIV/AIDS Surveillance Officer
655 South Bay Rd., Suite 218
Dover, DE 19901
Phone: (302) 741-2928
Fax: (302) 741-2955
E-Mail: christina.melvin@state.de.us

Johnny Hebel, AS

Department of Health Education and Social Affairs
FSM HIV/AIDS
P. O. Box PS70
Palikir, FSM 96941
Phone: (691) 320-2619
Fax: (691) 320-5263
E-Mail: fsmhivaids@mail.fm

Kris Hartmann, MS

Arizona Department of Health Services
Epidemiology Specialist II/ HIV Incidence
Surveillance Coordinator
150 N 18th Ave, Suite 110
Phoenix, AZ 85007
Phone: (602) 364-3605
Fax: (602) 364-3268
E-Mail: hartmak@azdhs.gov

Gail Maureen Hansen, BS

Government of the District of Columbia, Department
of Health
Interim Director, HIV/AIDS Surveillance and
Epidemiology
64 New York Ave., N.E. - 5th floor
Washington, DC 20002
Phone: (202) 671-4922
Fax: (202) 673-4367
E-Mail: gail.hansen@dc.gov

Leo Rennie

HIV/AIDS Surveillance and Epidemiology
64 New York Avenue, NE Suite 5001
Washington, DC 20002
Phone: (202) 671-5052
Fax: (202) 671-4860
E-Mail: leo.ennie@dc.gov

Mathewa Mathi

Guam Department of Public Health
Surveillance Coordinator
P.O. Box 2816
Hagatna, Guam 96932
Phone: (671) 735-7137
Fax: (671) 734-2105
E-Mail: mathewsmathi@yahoo.com

Jennifer Donnelly

Colorado Department of Public Health
& Environment
Project Coordinator/HIV/STD
Surveillance Program
4300 Cherry Creek Drive South
DCEED-A3
Denver, CO 80246
Phone: (303) 692-2711
Fax: (303) 782-0904
E-Mail: jennifer.donnelly@state.co.us

Kim Lucas, MPH

Office of AIDS, California Department of Health
Services
Research Scientist II
MS 7700, P.O. Box 997426
Sacramento, CA 95899
Phone: (916) 650-6902
Fax: (916) 449-5858
E-Mail: klucas@dhs.ca.gov

Joanna Bentley-Haller

Florida Department of Health
Incidence Surveillance Coordinator
4052 Bald Cypress Way, Bin A#09
Tallahassee, FL 32399
Phone: (850) 245-4444
Fax: (850) 922-4202
E-Mail: joanna_bentley@doh.state.fl.us

Deborah Crippen, BA

Georgia Department of Public Health
Incidence Surveillance Coordinator
2 Peachtree St. Suite 14-462
Atlanta, GA 30303
Phone: (404) 657-4046
Fax: (404) 657-4141
E-Mail: djcrippen@dhr.state.ga.us

Marti Merritt

Illinois Department of Public Health
Special Studies Coordinator HIV/AIDS Section
160 N. LaSalle Street, 7 South
Chicago, IL 60601

Phone: (312) 814-2023

Fax: (312) 814-4844

E-Mail: mmerritt@idph.state.il.us

Melissa VanDyne, B.S.

Missouri Department of Health
HIV Incidence Surveillance Coordinator
P.O. Box 570

Jefferson City, MO 65102

Phone: (573) 751-6129

Fax: (573) 526-0235

E-Mail: melissa.VanDyne@dhss.mo.gov

Charlotte Sadashige

New Jersey Department of Health and Senior Services
Coordinator/ Epidemiologic Services Unit

P.O. Box 363

Trenton, NJ 08625

Phone: (609) 984-5940

Fax: (609) 633-2791

E-Mail: charlotte.sadashige@doh.state.nj.us

Joanna Eavey

Louisiana Office of Public Health
Incidence Program Coordinator-HIV AIDS Program
234 Loyola Avenue 5th Floor

New Orleans, LA 70112

Phone: (504) 894-7525

Fax: (504) 269-9933

E-Mail: jeavy@dhh.la.gov

Colin Flynn, ScM

Maryland Department of Health and Mental Hygiene
Chief Center for Surveillance and Epidemiology
500 N. Calvert Street

5th Floor

Baltimore, MD 21202

Phone: (410) 767-5050

Fax: (410) 333-6333

E-Mail: flynnc@dhmh.state.md.us

Sonita Singh, MPH

Mississippi Department of Health
HIV Incidence and Resistance Coordinator
P.O. Box 1700

Jackson, MS 39215

Phone: (601) 576-7723

Fax: (601) 576-7909

E-Mail: sonita.singh@msdh.state.ms.us

Penny Padgett

North Carolina Department of Health and Human
Service

Public Health Epidemiologist II

1902 Mail Services Center

HIV/STD Prevention & Care

Raleigh, NC 27699-1902

Phone: (917) 715-1739

Fax: (917) 715-7560

E-Mail: penny.padgett@ncmail.net

Yussef Bennani, MPH

New York City Department of Health and Mental
Hygiene

HIV Incidence Surveillance Coordinator

346 Broadway, Room 706 CN 44

New York, NYC 10013

Phone: (212) 442-3518

Fax: (212) 788-2520

E-Mail: ybennani@health.nyc.gov

Shannon Page

Ohio Department of Health

HIV Incidence Coordinator

246 North High Street

Columbus, OH 43215

Phone: (614) 728-0877

Fax: (614) 644-1909

E-Mail: shannon.page@odh.ohio.gov

Martin Ngokion, MD, MPH

Pennsylvania Department of Health

ISP Epidemiologist/ HIV/AIDS Epidemiology Section

Room 933, Heath & Welfare Building

7th & Forster Streets

Harrisburg, PA 17120

Phone: (717) 783-0481

Fax: (717) 783-6975

E-Mail: mngokion@state.pa.us

Kelly McCormick

South Carolina Department of Health and
Environmental Control
HIV Incidence Program Coordinator
1751 Calhoun St.
Columbia, SC 29201

Phone: (803) 898-0794

Fax: (803) 898-0573

E-Mail: mccormkd@dhec.sc.gov

Cheryl Jablonski

Texas Department of State Health Services
Incidence Surveillance Coordinator
1100 W. 49th Street
Austin, TX 78756

Phone: (512) 533-3041

Fax: (512) 371-4674

E-Mail: cheryl.jablonski@tdh.state.tx.us

Alexia Exarchos, MPH

Washington State Department of Health
Epidemiologist
20435 72nd Ave. S, Suite 200
Kent, WA 98032

Phone: (253) 395-6730

Fax: (206) 205-5281

E-Mail: alexia.exarchos@doh.wa.gov

Christie McDonald

Oklahoma State Department of Health
Incidence Surveillance Coordinator
1000 NE 10th Street (Mailstop 0308)
Oklahoma City, OK 73117

Phone: (405) 271-4636

Fax: (405) 271-1187

E-Mail: christiem@health.state.ok.us

Ruth Trino, MD, MPH

Philadelphia Department of Health - AACO
HIV Incidence and Laboratory Coordinator
1101 Market Street, 9th Floor
Philadelphia, PA 19107

Phone: (215) 685-4786

Fax: (215) 685-4774

E-Mail: ruth.trino@phila.gov

Bernardita Lopez, MS

Puerto Rico Department of Health
HIV Incidence Coordinator
AIDS Surveillance Program
Reperto Metropolitano Shopping Center
San Juan, PR 00921

Phone: (787) 763-0240

Fax: (787) 763-0399

E-Mail: b15lopez@hotmail.com

Nene Diallo, MPH

Virginia Department of Health
HIV Incidence & Resistance Coordinator
109 Governor Street Room 326
Richmond, VA 23219

Phone: (804) 864-8003

Fax: (804) 864-8052

E-Mail: nene.diallo@vdh.virginia.gov

Divina Vargas

Chicago Department of Health
Epidemiologist
333 South State Street, Room 2151
Chicago, IL 60604

Phone: (312) 747-9609

Fax: (312) 747-9663

E-Mail: vargas_divina@cdph.org

Ling Wang, PhD

New York State Department of Health
Research Scientist (Epidemiology)
P.O. Box 2073 Cornifng Tower
Empire State Plaza Tower Bldg.
Albany, NY 12220

Phone: (518) 474-4284

Fax: (518) 473-4169

E-Mail: lxw03@health.state.ny.us

Sharon Carter

Virginia Department of Health Division of Disease
Prevention
HIV/AIDS Core Surveillance Supervisor
109 Governor St. Roome 326
P.O. Box 2448

Richmond, VA 23218

Phone: (804) 864-8032

Fax: (804) 864-8052

E-Mail: sharon.carter@vdh.virginia.gov

Nicola Bulled

Massachusetts State Lab Institute
HIV Incidence Coordinator
305 South Street, Room 706
Jamaica Plain, MA 02130
Phone: (617) 983-6318
Fax: (617) 983-6227
E-Mail: nicola.bulled@gmail.com

Kathy Brousseau

New York Department of Health
Surveillance IT Coordinator/Database Programmer
ESP, Corning Tower Room 729
Albany, NY 12237
Phone: (518) 474-4284
Fax:
E-Mail: ksb01@health.state.ny.us

Marianne O'Connor, MPH, MT(ASCP)

Michigan Department of Community Health
HIV Incidence Surveillance Coordinator
1151 Taylor
Room 210B
Detroit, MI 48202-1734
Phone: (313) 876-0854
Fax: (313) 876-0888
E-Mail: oconnormf@michigan.gov

Susan Scheer, PhD, MPH

San Francisco Department of Public Health
Director, HIV Incidence Surveillance
25 Van Ness Avenue, Suite 500
San Francisco, CA 94102
Phone: (415) 554-9076
Fax: (415) 431-0353
E-Mail: susan.scheer@sfdph.org

Donna Cecere, BA

Alaska Department of Health and Social Services
STD Program Manager
3601 C Street, Suite 540
Anchorage, AK 99503
Phone: (907) 269-8056
Fax: (907) 561-4239
E-Mail: donna_cecere@health.state.ak.us

Jerald Harms, MPH

Houston Department of Health and Human Services
HIV Surveillance Supervisor
8000 N. Stadium Drive, 4th Floor
Houston, TX 77054
Phone: (713) 794-9190
Fax: (713) 794-9391
E-Mail: gerald.harms2@cityofhouston.net

Ishan Azzam, MD, MPH

Nevada State Health Division
State Epidemiologist
505 E. King Street, Room 203
Carson City, NV 89701
Phone: (775) 684-5946
Fax: (775) 684-5998
E-Mail: iazzam@nvhd.state.nv.us

Eve Mokotoff, MPH

Michigan Department of Community Health
HIV/AIDS Epidemiology Manager
Herman Kiefer Health Complex
1151 Taylor, Rm 210 B
Detroit, MI 48202
Phone: (313) 876-4769
Fax: (313) 876-0888
E-Mail: mokotoffe@michigan.gov

Luisa Pessoa-Brandao, MS

Minnesota Department of Health
HIV/AIDS Surveillance Coordinator
625 Robert Street N
Saint Paul, MN 55164
Phone: (651) 201-4032
Fax: (651) 201-4000
E-Mail: luisa.pessoa-brandao@health.state.mn.us

David Fields, BS

Indiana State Department of Health
HIV Incidence Surveillance Coordinator
2 N. Meridian St.
MailStop 6C -95
Indianapolis, IN 46204
Phone: (317) 234-3122
Fax: (317) 233-7663
E-Mail: dfields@isdh.in.gov

Mike Herbert, BS

Missouri Department of Health and Senior Services
Chief, Bureau of HIV, STD, and Hepatitis
930 Wildwood
Jefferson City, MO 65109

Phone: (573) 751-6475

Fax: (573) 526-0235

E-Mail: mike.herbert@dhss.mo.gov

Karen Wallace, MPH

Massachusetts Department of Public Health
Epidemiologist 1 MDPH, HIV/AIDS Surveillance
305 South Street, Room 241
Jamaica Plain, MA 02130

Phone: (617) 983-6561

Fax: (617) 983-6580

E-Mail: karen.wallace@state.ma.us

