National Assessment of HIV/AIDS Surveillance Capacity
Appendix 2: Summary statistics

	Question	Number of responses	percent responding	Mean	Median	Minimum	Maximum
2	What was the reported HIV/AIDS prevalence in your area as of 12/06?	57	100%	15350.39	9871.00	25.00	98338.00
3	How many people were newly diagnosed with HIV (including AIDS) in:	57	100%				
	2004	57	100%	1121.81	642.00	15.00	7270.00
	2005	57	100%	1098.40	629.00	6.00	7117.00
	2006	57	100%	1027.65	657.00	11.00	6159.00
4	According to www.census.gov data, what is the July 2004 population of your area?	57	100%	5043225.37	3724347.00	112128.00	22517901.00
5-6	What percentage of your HIV Core Surveillance activities are funded from the following sources? (summary statistics include only those who indicated they received each type of funding).	55	96%				
	% federal funds HRSA	10*	18%	1.40	0.00	0.00	16.00
	% federal funds CDC Prevention	10*	18%	2.47	0.00	0.00	26.00
	% federal funds CDC Surveillance	55*	100%	91.65	100.00	48.00	100.00
	% state funds	12*	22%	2.86	46.50	0.00	34.00
	% Other (*including resistance surveillance, net county cost, state AIDS, local heath department generated funds*)	4*	7%	1.62	0.00	0.00	33.00
7	Please provide the total amount your surveillance area received from Program Announcement 04017/Part I-Core Surveillance in 2005. Do not include incidence, MP, Epi Capacity, Resistance, Enhanced Perinatal, Behavioral Surveillance or any other surveillance program's funding.	57	100%	608591.02	447800.00	61619.00	2959773.00
8	Does your program rely on assistance from local health department personnel which are not funded by surveillance money to conduct field investigations?	57	100%				
	no	32	56%				
	yes	25	44%				
9	How much does your program rely on this assistance, if received?	24	96%				
	very little	2	8%				
	a great deal	22	92%				
10	For which of the following surveillance activities has your state/city received CDC funding since 2007 (check all that apply):						
	HIV/AIDS Core Surveillance	57	100%				
	HIV Incidence Surveillance	33	58%				
	HIV Resistance Surveillance (VARHS)	13	23%				

	Capacity Building for Epidemiologic and Program Evaluation Activities	20	35%				
	Enhanced Surveillance for Perinatal Prevention	14	25%				
	National HIV Behavioral Surveillance (NHBS)	23	40%				
	Medical Monitoring Project (MMP)	25	44%				
	Never in Care Project (NIC)	5	9%				
	Evaluating Integration of HIV/AIDS Surveillance Data with Geographic Information System (GIS)	3	5%				
11	Did your health department or a community-based organization in your state participate in a rapid assessment activity with the assistance from CDC's Behavioral and Clinical Surveillance Branch since 2004? (These events would include assessments at Gay Pride, Minority Gay Pride, or other rapid assessment activities).	55	96%				
	no	33	60%				
	yes	22	40%				
12-13	Please indicate the number of FTEs conducting surveillance activities in your program. Only consider employees funded by CDC Program Announcement 04017- Part 1- Core Surveillance. (summary statistics include only those who employ each of the following)	56	98%				
	Field Investigation	42	75%	3.15	2.00	0.00	17.00
	RIDR/Out of State Record Searches	36	64%	0.45	0.50	0.00	1.00
	Data Entry	43	77%	1.45	1.00	0.00	7.00
	Data Management	40	71%	0.88	1.00	0.00	4.00
	Data Analysis	39	70%	0.76	0.50	0.00	4.00
	Surveillance Coordinator	52	93%	0.80	1.00	0.00	3.00
	Administrative Support	41	73%	0.81	0.50	0.00	4.00
	IT	28	50%	0.38	0.00	0.00	2.00
	Epidemiologists	39	70%	0.91	0.50	0.00	4.00
	Other (*including director of disease control, program manager, support staff, laboratory, surveillance specialists, fiscal management, specialists, contract work*)	20	36%	0.48	0.18	0.00	2.00
14-15	Please indicate the number of current FTEs using funding from other surveillance projects (MMP, Incidence, etc.) to assist with Core Surveillance. (summary statistics include only those who fund FTEs from other surveillance projects)	47	82%				
	Field Investigation	38	81%	2.13	0.15	0.00	20
	RIDR/Out of State Record Searches	27	57%	0.09	0.00	0.00	1
	Data Entry	35	74%	0.45	0.00	0.00	4
	Data Management	36	77%	0.51	0.28	0.00	3
	Data Analysis	33	70%	0.39	0.25	0.00	2

	Surveillance Coordinator	30	64%	0.26	0.00	0.00	1.00
	Administrative Support	31	66%	0.24	0.00	0.00	1.50
	IT	25	53%	0.19	0.00	0.00	1.00
	Epidemiologists	33	70%	0.69	0.25	0.00	3.00
	Other (*including prevention coordinators, ERTS manager, health educator, lab staff, lab coordinator*)	15	32%	1.07	0.00	0.00	13.00
16-17	Please indicate the number of additional FTEs needed.	52	91%				
	Field Investigation	39	75%	2.47	1.00	0.00	22.00
	RIDR/Out of State Record Searches	25	48%	0.37	0.00	0.00	2.00
	Data Entry	37	71%	1.02	1.00	0.00	4.00
	Data Management	37	71%	0.72	1.00	0.00	3.00
	Data Analysis	25	48%	0.57	0.50	0.00	3.00
	Surveillance Coordinator	22	42%	0.32	0.00	0.00	1.00
	Administrative Support	27	52%	0.56	0.25	0.00	4.00
	IT	29	56%	0.58	0.50	0.00	2.00
	Epidemiologists	27	52%	0.89	1.00	0.00	4.00
	Other (*including SAS and SQL programmers, IT development, field follow-up, data-linkage, active core surveillance, ELR/record linkage coordinator*)	10	19%	0.35	0.00	0.00	2.00
18-19	How many HIV surveillance staff, regardless of funding source, use SAS for the following:	54	95%				
	Data analysis	53	98%	2.76	2.00	0.00	11.00
	Data management (including data matching)	49	91%	2.18	1.00	0.00	9.00
	Other (including pre-conversion edits, ERTS program, database conversion, report writing, data research)	15	28%	1.87	1.00	0.00	10.00
20	The following is a list of possible areas of training for surveillance staff. Please choose the top areas you feel are most needed by your staff?	57	100%				
	eHARS/HARS	38	67%				
	Database Management/Manipulation	30	53%				
	SAS	44	77%				
	GIS	15	26%				
	Linking/Database matching	27	47%				
	Statistics	4	7%				
	MS Excel	1	2%				
	MS Access	8	14%				
	Medical Record Abstraction	4	7%				
21	Providing continuing education for surveillance staff is a problem in our organization.	57	100%				
	No problem	8	14%				
	Somewhat problematic	20	35%				
	Moderately problematic	16	28%				

	Mostly problematic	4	7%				
	A major problem	9	16%				
22-23	In the past twelve months, have you been able to acquire the resources necessary to enhance essential staff training?	57	100%				
	no	26	46%				
	yes (*funding sources include CDC, NASTAD, Union/one-time opportunities, PA 04017, CSTE, State health department, MATEC, University, Cooperative agreement, federal, state, or local funds*)	31	54%				
24	Please select the average salary in your program for 1 FTE in each of the major job classes in HIV Surveillance programs.	57	100%				
	Data Entry	47	82%				
	$20,000 to $29,000	21	45%				
	$30,000 to $39,000	16	34%				
	$40,000 to $49,000	2	4%				
	$50,000 to $59,000	1	2%				
	$60,000 to $69,000	1	2%				
	> $70,000	0	0%				
	N/A	6	13%				
	Field Staff	45	79%				
	$20,000 to $29,000	4	9%				
	$30,000 to $39,000	15	33%				
	$40,000 to $49,000	13	29%				
	$50,000 to $59,000	6	13%				
	$60,000 to $69,000	2	4%				
	> $70,000	0	0%				
	N/A	5	11%				
	Entry Level Epidemiologist	46	81%				
	$20,000 to $29,000	0	0%				
	$30,000 to $39,000	15	33%				
	$40,000 to $49,000	15	33%				
	$50,000 to $59,000	7	15%				
	$60,000 to $69,000	2	4%				
	> $70,000	0	0%				
	N/A	7	15%				
	Senior Level Epidemiologist	44	77%				
	$20,000 to $29,000	0	0%				
	$30,000 to $39,000	1	2%				
	$40,000 to $49,000	9	20%				
	$50,000 to $59,000	8	18%				
	$60,000 to $69,000	8	18%				
	> $70,000	11	25%				

	N/A	7	16%				
	Surveillance Coordinator	54	95%				
	$20,000 to $29,000	0	0%				
	$30,000 to $39,000	7	13%				
	$40,000 to $49,000	11	20%				
	$50,000 to $59,000	8	15%				
	$60,000 to $69,000	12	22%				
	> $70,000	15	28%				
	N/A	1	2%				
	IT	41	72%				
	$20,000 to $29,000	0	0%				
	$30,000 to $39,000	3	7%				
	$40,000 to $49,000	8	20%				
	$50,000 to $59,000	3	7%				
	$60,000 to $69,000	7	17%				
	> $70,000	6	15%				
	N/A	14	34%				
	Other (*including administrative support, information analyst, data manager, program manager, division director, statistician, medical epidemiologist, surveillance specialists, laboratory surveillance*)	25	44%				
	$20,000 to $29,000	2	8%				
	$30,000 to $39,000	3	12%				
	$40,000 to $49,000	2	8%				
	$50,000 to $59,000	2	8%				
	$60,000 to $69,000	3	12%				
	> $70,000	3	12%				
	N/A	10	40%				
25	To what extent is each of these factors a problem in recruiting and/or retaining epidemiologists	54	95%				
	Salary scale	54	100%				
	no problem	8	15%				
	Somewhat problematic	8	15%				
	Moderately problematic	17	31%				
	Mostly problematic	7	13%				
	A major problem	14	26%				
	Enough qualified applicants	53	98%				
	no problem	7	13%				
	Somewhat problematic	8	15%				
	Moderately problematic	19	36%				
	Mostly problematic	8	15%				
	A major problem	11	21%				

Personnel policies and procedures	53	98%				
no problem	16	30%				
Somewhat problematic	13	25%				
Moderately problematic	9	17%				
Mostly problematic	6	11%				
A major problem	9	17%				
Job benefits	53	98%				
no problem	40	75%				
Somewhat problematic	6	11%				
Moderately problematic	7	13%				
Mostly problematic	0	0%				
A major problem	0	0%				
Job security	53	98%				
no problem	40	75%				
Somewhat problematic	8	15%				
Moderately problematic	4	8%				
Mostly problematic	0	0%				
A major problem	1	2%				
Job location	53	98%				
no problem	36	68%				
Somewhat problematic	10	19%				
Moderately problematic	4	8%				
Mostly problematic	2	4%				
A major problem	1	2%				
Opportunity for promotion	54	10000%				
no problem	11	20%				
Somewhat problematic	13	24%				
Moderately problematic	14	26%				
Mostly problematic	8	15%				
A major problem	8	15%				
Travel required	53	98%				
no problem	44	83%				
Somewhat problematic	7	13%				
Moderately problematic	2	4%				
Mostly problematic	0	0%				
A major problem	0	0%				
Travel permitted	53	98%				
no problem	32	60%				
Somewhat problematic	6	11%				
Moderately problematic	11	21%				
Mostly problematic	3	6%				
A major problem	1	2%				

Job interests/fulfillment	53	98%				
no problem	19	36%				
Somewhat problematic	19	36%				
Moderately problematic	11	21%				
Mostly problematic	4	8%				
A major problem	0	0%				
Opportunities for training	53	98%				
no problem	24	45%				
Somewhat problematic	13	25%				
Moderately problematic	13	25%				
Mostly problematic	2	4%				
A major problem	1	2%				
Limitations recruiting outside your organization	53	98%				
no problem	30	57%				
Somewhat problematic	10	19%				
Moderately problematic	6	11%				
Mostly problematic	3	6%				
A major problem	4	8%				
Restrictions on choosing the best candidate	53	98%				
no problem	19	36%				
Somewhat problematic	17	32%				
Moderately problematic	5	9%				
Mostly problematic	9	17%				
A major problem	3	6%				
Restrictions on hiring quickly enough	53	98%				
no problem	12	23%				
Somewhat problematic	12	23%				
Moderately problematic	6	11%				
Mostly problematic	5	9%				
A major problem	18	34%				
Restrictions on offering competitive pay	54	100%				
no problem	8	15%				
Somewhat problematic	10	19%				
Moderately problematic	11	20%				
Mostly problematic	10	19%				
A major problem	15	28%				
Hiring freeze	53	98%				
no problem	28	53%				
Somewhat problematic	7	13%				
Moderately problematic	5	9%				
Mostly problematic	5	9%				
A major problem	8	15%				

	Loss to private or government sector	53	98%				
	no problem	18	34%				
	Somewhat problematic	17	32%				
	Moderately problematic	9	17%				
	Mostly problematic	5	9%				
	A major problem	4	8%				
	Restrictions on merit raises	53	98%				
	no problem	13	25%				
	Somewhat problematic	8	15%				
	Moderately problematic	12	23%				
	Mostly problematic	9	17%				
	A major problem	11	21%				
	Restrictions on travel outside jurisdiction	53	98%				
	no problem	28	53%				
	Somewhat problematic	10	19%				
	Moderately problematic	6	11%				
	Mostly problematic	4	8%				
	A major problem	5	9%				
26	To what extent is each of these factors a problem in recruiting and/or retaining IT personnel.	53	93%				
	Salary scale	52	98%				
	no problem	6	12%				
	Somewhat problematic	8	15%				
	Moderately problematic	5	10%				
	Mostly problematic	3	6%				
	A major problem	11	21%				
	N/A	19	37%				
	Enough qualified applicants	52	98%				
	no problem	4	8%				
	Somewhat problematic	8	15%				
	Moderately problematic	8	15%				
	Mostly problematic	5	10%				
	A major problem	6	12%				
	N/A	21	40%				
	Personnel policies and procedures	52	98%				
	no problem	14	27%				
	Somewhat problematic	5	10%				
	Moderately problematic	2	4%				
	Mostly problematic	4	8%				
	A major problem	6	12%				
	N/A	21	40%				
	Job benefits	52	98%				

no problem	23	44%				
Somewhat problematic	5	10%				
Moderately problematic	1	2%				
Mostly problematic	1	2%				
A major problem	1	2%				
N/A	21	40%				
Job security	52	98%				
no problem	25	48%				
Somewhat problematic	4	8%				
Moderately problematic	2	4%				
Mostly problematic	0	0%				
A major problem	0	0%				
N/A	21	40%				
Job location	52	98%				
no problem	22	42%				
Somewhat problematic	5	10%				
Moderately problematic	3	6%				
Mostly problematic	1	2%				
A major problem	0	0%				
N/A	21	40%				
Opportunity for promotion	52	98%				
no problem	10	19%				
Somewhat problematic	6	12%				
Moderately problematic	5	10%				
Mostly problematic	2	4%				
A major problem	8	15%				
N/A	21	40%				
Travel required	52	98%				
no problem	25	48%				
Somewhat problematic	2	4%				
Moderately problematic	2	4%				
Mostly problematic	1	2%				
A major problem	0	0%				
N/A	22	42%				
Travel permitted	52	98%				
no problem	23	44%				
Somewhat problematic	3	6%				
Moderately problematic	4	8%				
Mostly problematic	0	0%				
A major problem	0	0%				
N/A	22	42%				
Job interests/fulfillment	52	98%				

no problem	18	35%				
Somewhat problematic	5	10%				
Moderately problematic	7	13%				
Mostly problematic	1	2%				
A major problem	0	0%				
N/A	21	40%				
Opportunities for training	52	98%				
no problem	16	31%				
Somewhat problematic	5	10%				
Moderately problematic	7	13%				
Mostly problematic	3	6%				
A major problem	0	0%				
N/A	21	40%				
Limitations recruiting outside your organization	52	98%				
no problem	18	35%				
Somewhat problematic	4	8%				
Moderately problematic	5	10%				
Mostly problematic	2	4%				
A major problem	2	4%				
N/A	21	40%				
Restrictions on choosing the best candidate	52	98%				
no problem	12	23%				
Somewhat problematic	8	15%				
Moderately problematic	6	12%				
Mostly problematic	3	6%				
A major problem	3	6%				
N/A	20	38%				
Restrictions on hiring quickly enough	52	98%				
no problem	8	15%				
Somewhat problematic	9	17%				
Moderately problematic	4	8%				
Mostly problematic	2	4%				
A major problem	7	13%				
N/A	22	42%				
Restrictions on offering competitive pay	52	98%				
no problem	5	10%				
Somewhat problematic	7	13%				
Moderately problematic	6	12%				
Mostly problematic	3	6%				
A major problem	9	17%				
N/A	22	42%				
Hiring freeze	52	98%				

	no problem	17	33%				
	Somewhat problematic	4	8%				
	Moderately problematic	2	4%				
	Mostly problematic	2	4%				
	A major problem	5	10%				
	N/A	22	42%				
	Loss to private or government sector	52	98%				
	no problem	11	21%				
	Somewhat problematic	3	6%				
	Moderately problematic	7	13%				
	Mostly problematic	4	8%				
	A major problem	7	13%				
	N/A	20	38%				
	Restrictions on merit raises	52	98%				
	no problem	10	19%				
	Somewhat problematic	5	10%				
	Moderately problematic	8	15%				
	Mostly problematic	2	4%				
	A major problem	6	12%				
	N/A	21	40%				
	Restrictions on travel outside jurisdiction	52	9800%				
	no problem	21	40%				
	Somewhat problematic	5	10%				
	Moderately problematic	3	6%				
	Mostly problematic	2	4%				
	A major problem	0	0%				
	N/A	21	40%				
27	Does your health department use a NEDSS or NEDSS-like electronic reporting system for reporting of some notifiable diseases?	57	100%				
	no	11	19%				
	yes	46	81%				
28	Can providers use it (i.e., providers electronically report cases to the system)?	45	98%				
	no	29	64%				
	yes	16	36%				
29	Are all conditions reported this way (including HIV)?	19	41%				
	no	17	89%				
	yes	2	11%				
30	Do you use digital certificates or some other method of authentication besides user id and password?	2	4%				
	no	0	0%				

	yes	1	50%				
	other (*including SSL side servers*)	1	50%				
31	Are you planning on messaging or communicating information between eHARS and any other system (such as a local NEDSS) in your health department?	56	98%				
	no	28	50%				
	yes	28	50%				
32	In which direction are you planning on messaging or communicating information?	28	100%				
	Both directions (e.g. import/export between eHARS/HARS and other system)	11	39%				
	One direction (e.g. export or import eHARS/HARS data to or from other systems)	17	61%				
33	Do you maintain a database separate from eHARS/HARS to collect any surveillance data?	57	100%				
	no	15	26%				
	yes	42	74%				
34	What surveillance data do you collect using a separate database?(Check all that apply)	47	82%				
	Laboratory test results	35	74%				
	HIV (not AIDS)	9	19%				
	Co-infections (i.e., Hepatitis, TB, STDs)	13	28%				
	Residential street address	6	13%				
	Perinatal exposure	15	32%				
	Anonymous cases	4	9%				
	Other (*including Ryan White titles for cross-match, resistance data, CDC lab results, NIR investigations, non-resident reports, risk factor and drug use, incidence, all counseling and testing results, co-infections, screening, tracking of incoming paper mail, under investigations, contact tracing, PCRS, risk assessment, treatment regimens, passive case reports, pregnancy*)	16	34%				
35	Have you ever cleaned your provider and facility lists?	57	100%				
	no	11	19%				
	yes	46	81%				
36	Do you routinely clean them in order to maintain standardized lists?	46	10000%				
	no	15	33%				
	yes	31	67%				
37	Do you have internal IT support within the HIV/AIDS surveillance unit?	57	100%				
	no	36	63%				

	yes	21	37%				
38	Is it supported:	30	53%				
	Internal to Health Department	28	93%				
	External to Health Department (Contractor)	2	7%				
39	Does your health department have a multi-departmental GIS system which provides access to geospatial data, common databases, and services?	56	98%				
	no	23	41%				
	yes	33	59%				
40	Does your program map its HIV/AIDS surveillance data?	57	100%				
	no	24	42%				
	yes	33	58%				
41	Do you think GIS should play a larger role in routine HIV surveillance in your state?	56	98%				
	no	16	29%				
	yes	40	71%				
42	If GIS technology and training were available, would your surveillance program use it?	57	100%				
	no	11	19%				
	yes	46	81%				
43	Does your program geocode HIV/AIDS Surveillance data?	57	100%				
	no	33	58%				
	yes	24	42%				
44	Is the geocoding performed on a secure computer or network in your HIV/AIDS Surveillance Program?	24	100%				
	no	1	4%				
	yes	23	96%				
45	What software is used to perform geocoding? (Check all that apply)	23	96%				
	StreetMap (ArcView)	15	65%				
	Mapmarker	0	0%				
	Centrus	4	17%				
	MapInfo	0	0%				
	External Vendor (e.g. contractor, Map Quest, Geocode.com)	0	0%				
	Matchmaker	0	0%				
	Geostan	1	4%				
	Other (*arcGIS, blue fusion*)	6	26%				
46	Who is geocoding the data?	18	75%				
	Surveillance Staff	12	67%				
	Another program in the health department (i.e., centralized multidepartmental GIS program, cancer registry)	5	28%				

	Private vendor/contractor	0	0%				
	Other (*epi profile coordinator*)	1	6%				
47	How does the other program/contractor ensure the confidentiality of address-level records during geocoding? (Check all that apply)	6	100%				
	Program/Contractor signs a data confidentiality agreement	4	67%				
	Program/Contractor does not retain a copy of the addresses after geocoding	2	33%				
	Personal identifiers are removed	2	33%				
	Other (*geocoding by surveillance staff or no contractor used*)	2	33%				
48	Have you evaluated the accuracy of your geocoded data?	23	96%				
	no	15	65%				
	yes	8	35%				
49	Describe how your program uses geocoded HIV/AIDS Surveillance data?						
	Behavioral surveillance						
	Map County						
	Used in Epi Profiles, powerpoint presentations, articles, CHARTS, fact sheets, unmet need reports, monthly surveillance report,						
	mapping, analysis						
	For QA of ZIP and County fields, some Census tract mapping for internal customers						
	to create maps of morbidity and to map where PLWH live in relationship to HIV clinics around the state.						
	Generation of maps (aggregated data).						
	Assign census tracts to calculate rates, created maps of HIV and AIDS data by important demographic and risk variables for prevention and care planning. Used geocoded data for NHBS.						
	maps to present data. used in local planning process; presented to legislature.						

	We use geocoded data to assign census tract locations to a selected subset of surveillance data. this provided a basis for choosing census tracts to a sample for conducting behavioral surveillance. *We are exploring the possibility of geocoding residential locations of new HIV infections during a year and of all living HIV/AIDS causes; and then apply geostatistical procedures that would mask the specific location of patients but would produce hot spot maps showing concentrated areas of HIV/AIDS cases, as a guide for prevention and treatment programs.*						
	We have used geocoded data to examine census tract-based prevalence and prevalence rates. We also participated in the HET cycle of NHBS, which required geocoding of heterosexual HIV data to combine with poverty data in order to obtain an index of risk by census tract.						
	In process. It is our hope to use these data to evaluate incident infections and inform preventions programs. We also intend to better evaluate unmet need in collaboration with the RWCA program.						
	Mapping incidence and prevalence rates. Identifying neighborhoods for prevention activities, testing campaigns, NHBS.						
	AIDS Dot Maps, County Prevalence Maps,						
	Quality Assurance *-Mapping*						
	DC geocodes information by Ward to assess where incident and prevalent cases reside at the time of diagnosis; Use of geocoding for NHBS to examine high risk areas; Uses for city council members to allocate capacity building and other resources for their ward						
	Presentation of county level incidence data. Presentation of comorbid HIV/syphilis cases. Geographic trends for HIV and syphilis cases over time.						
	We have not had the resources to work with the data yet.						
	Identify clusters of disease patterns and geographic correlates; provide support to state and local prevention planning; conduct NHBS protocols to identify high-risk areas for hetero transmission						
	Haven't used it yet						
	Planning HIV Services						

50	Indicate the main reason why your HIV/AIDS surveillance program has not geocoded. (Check all that apply)	33	100%				
	Budget constraints	12	36%				
	Lack of trained staff	24	73%				
	Time constraints	14	42%				
	Not a priority	13	39%				
	Unsure of maintaining confidentiality	13	39%				
	Other (*including small population size, low morbidity status, lack of staff, uncertain utility, low incidence, small area, no address record in HARS*)	8	24%				
51	How confident are you in the quality of street addresses collected through routine HIV/AIDS surveillance?	54	95%				
	Not at all confident	2	4%				
	Somewhat confident	11	20%				
	Moderately confident	15	28%				
	Confident	23	43%				
	Extremely confident	3	6%				
52	Do you or does anyone above you, in your agency's organizational structure, report directly to the State AIDS Director (NASTAD member)? (NA for cities)	54	95%				
	no	19	35%				
	yes	35	65%				
53	Is it you or someone else?	35	100%				
	You, the Surveillance Coordinator	22	63%				
	Someone Else	13	37%				
54	Do you or does anyone above you, in your agency's organizational structure, report directly to the State Epidemiologist?	56	98%				
	no	29	52%				
	yes	27	48%				
55	Is it you or someone else?	27	100%				
	You, the Surveillance Coordinator	10	37%				
	Someone Else	17	63%				
56	Do you utilize local health departments (i.e. county, city, regional) to complete case report forms?	56	98%				
	no	30	54%				
	yes	26	46%				
57	To what extent do you oversee or determine HIV Surveillance procedures at the local levels?	27	47%				
	Do not oversee	0	0%				
	Somewhat oversee	4	15%				
	Moderately oversee	9	33%				

	Mostly oversee	5	19%				
	Completely oversee	9	33%				
58	Does your state have satellite HARS installation?	57	100%				
	Do not have HARS	4	7%				
	No	43	75%				
	Yes	10	18%				
59	Which of the following do you envision for eHARS installation:	11	19%				
	Satellite	3	27%				
	Remote	2	18%				
	Central eHARS	6	55%				
60	Please describe the relationship between your program and the programs listed in the first column.	57	100%				
	HIV Prevention*	56	98%				
	Not at all integrated	8	14%				
	Somewhat integrated	11	20%				
	Moderately integrated	7	13%				
	Mostly integrated	10	18%				
	Completely Integrated	20	36%				
	N/A**	0	0%				
	HIV Care (Ryan White)	57	100%				
	Not at all integrated	10	18%				
	Somewhat integrated	10	18%				
	Moderately integrated	8	14%				
	Mostly integrated	8	14%				
	Completely Integrated	21	37%				
	N/A**	0	0%				
	STD Program (excludes PCRS)	57	100%				
	Not at all integrated	16	28%				
	Somewhat integrated	16	28%				
	Moderately integrated	3	5%				
	Mostly integrated	7	12%				
	Completely Integrated	14	25%				
	N/A**	1	2%				
	Partner Counseling Referral Services	56	98%				
	Not at all integrated	9	16%				
	Somewhat integrated	12	21%				
	Moderately integrated	9	16%				
	Mostly integrated	8	14%				
	Completely Integrated	17	30%				
	N/A**	1	2%				
	STD Surveillance	57	100%				
	Not at all integrated	13	23%				

Somewhat integrated	17	30%				
Moderately integrated	4	7%				
Mostly integrated	7	12%				
Completely Integrated	16	28%				
N/A**	0	0%				
TB	57	100%				
Not at all integrated	26	46%				
Somewhat integrated	16	28%				
Moderately integrated	6	11%				
Mostly integrated	6	11%				
Completely Integrated	3	5%				
N/A**	0	0%				
Hepatitis	57	100%				
Not at all integrated	18	32%				
Somewhat integrated	18	32%				
Moderately integrated	5	9%				
Mostly integrated	3	5%				
Completely Integrated	10	18%				
N/A**	3	5%				
Medical Monitoring Project (MMP)	57	100%				
Not at all integrated	3	5%				
Somewhat integrated	1	2%				
Moderately integrated	2	4%				
Mostly integrated	4	7%				
Completely Integrated	18	32%				
N/A**	29	51%				
National HIV Behavioral Surveillance	57	100%				
Not at all integrated	2	4%				
Somewhat integrated	1	2%				
Moderately integrated	6	11%				
Mostly integrated	3	5%				
Completely Integrated	12	21%				
N/A**	33	58%				
Incidence	57	100%				
Not at all integrated	1	2%				
Somewhat integrated	0	0%				
Moderately integrated	1	2%				
Mostly integrated	3	5%				
Completely Integrated	29	51%				
N/A**	23	40%				
Resistance	56	98%				
Not at all integrated	2	4%				

	Somewhat integrated	0	0%				
	Moderately integrated	0	0%				
	Mostly integrated	2	4%				
	Completely Integrated	20	36%				
	N/A**	32	57%				
	GIS	57	100%				
	Not at all integrated	7	12%				
	Somewhat integrated	0	0%				
	Moderately integrated	2	4%				
	Mostly integrated	4	7%				
	Completely Integrated	6	11%				
	N/A**	38	67%				
	Epi Capacity Building and Technical Assistance Grant	56	98%				
	Not at all integrated	2	4%				
	Somewhat integrated	0	0%				
	Moderately integrated	0	0%				
	Mostly integrated	2	4%				
	Completely Integrated	18	32%				
	N/A**	34	61%				
	Enhanced Perinatal Surveillance	56	98%				
	Not at all integrated	2	4%				
	Somewhat integrated	0	0%				
	Moderately integrated	0	0%				
	Mostly integrated	1	2%				
	Completely Integrated	16	29%				
	N/A**	37	66%				
61	Please describe the level of collaboration between your program and the programs listed in the first column.	57	100%				
	HIV Prevention*	56	98%				
	Collaborate Very Poorly	0	0%				
	Collaborate Somewhat	3	5%				
	Moderate Collaboration	3	5%				
	Collaborate Well	18	32%				
	Collaborate Very Well	32	57%				
	N/A**	0	0%				
	HIV Care (Ryan White)	57	100%				
	Collaborate Very Poorly	0	0%				
	Collaborate Somewhat	4	7%				
	Moderate Collaboration	5	9%				
	Collaborate Well	18	32%				
	Collaborate Very Well	30	53%				
	N/A**	0	0%				

STD Program (excludes PCRS)	57	100%				
Collaborate Very Poorly	1	2%				
Collaborate Somewhat	9	16%				
Moderate Collaboration	8	14%				
Collaborate Well	19	33%				
Collaborate Very Well	20	35%				
N/A**	0	0%				
Partner Counseling Referral Services	56	98%				
Collaborate Very Poorly	2	4%				
Collaborate Somewhat	8	14%				
Moderate Collaboration	5	9%				
Collaborate Well	11	20%				
Collaborate Very Well	27	48%				
N/A**	3	5%				
STD Surveillance	57	100%				
Collaborate Very Poorly	1	2%				
Collaborate Somewhat	10	18%				
Moderate Collaboration	10	18%				
Collaborate Well	15	26%				
Collaborate Very Well	21	37%				
N/A**	0	0%				
TB	56	98%				
Collaborate Very Poorly	3	5%				
Collaborate Somewhat	10	18%				
Moderate Collaboration	10	18%				
Collaborate Well	16	29%				
Collaborate Very Well	17	30%				
N/A**	0	0%				
Hepatitis	56	98%				
Collaborate Very Poorly	4	7%				
Collaborate Somewhat	12	21%				
Moderate Collaboration	9	16%				
Collaborate Well	8	14%				
Collaborate Very Well	13	23%				
N/A**	10	18%				
Medical Monitoring Project (MMP)	56	98%				
Collaborate Very Poorly	1	2%				
Collaborate Somewhat	1	2%				
Moderate Collaboration	1	2%				
Collaborate Well	2	4%				
Collaborate Very Well	21	38%				
N/A**	30	54%				

	National HIV Behavioral Surveillance	56	98%				
	Collaborate Very Poorly	0	0%				
	Collaborate Somewhat	1	2%				
	Moderate Collaboration	3	5%				
	Collaborate Well	4	7%				
	Collaborate Very Well	16	29%				
	N/A**	32	57%				
	Incidence	56	98%				
	Collaborate Very Poorly	1	2%				
	Collaborate Somewhat	0	0%				
	Moderate Collaboration	0	0%				
	Collaborate Well	1	2%				
	Collaborate Very Well	30	54%				
	N/A**	24	43%				
	Resistance	55	96%				
	Collaborate Very Poorly	1	2%				
	Collaborate Somewhat	0	0%				
	Moderate Collaboration	0	0%				
	Collaborate Well	0	0%				
	Collaborate Very Well	21	38%				
	N/A**	33	60%				
	GIS	56	98%				
	Collaborate Very Poorly	1	2%				
	Collaborate Somewhat	2	4%				
	Moderate Collaboration	3	5%				
	Collaborate Well	2	4%				
	Collaborate Very Well	10	18%				
	N/A**	38	68%				
	Epi Capacity Building and Technical Assistance Grant	56	98%				
	Collaborate Very Poorly	0	0%				
	Collaborate Somewhat	0	0%				
	Moderate Collaboration	0	0%				
	Collaborate Well	2	4%				
	Collaborate Very Well	17	30%				
	N/A**	37	66%				
	Enhanced Perinatal Surveillance	54	95%				
	Collaborate Very Poorly	1	2%				
	Collaborate Somewhat	0	0%				
	Moderate Collaboration	0	0%				
	Collaborate Well	0	0%				
	Collaborate Very Well	16	30%				
	N/A**	37	69%				

62	Are your HIV/AIDS prevention and care community planning groups integrated?	57	100%				
	no	27	47%				
	yes	30	53%				
63	Do you have surveillance staff that work directly with Prevention community planning groups (CPGs) on an on-going basis?	56	98%				
	no	7	13%				
	yes	49	88%				
64	Do you have surveillance staff that work directly with Care community planning groups (CPGs) on an on-going basis?	56	98%				
	no	11	20%				
	yes	45	80%				
65	To what extent are surveillance data utilized in the prioritization process of Prevention community planning groups (CPGs)?	55	96%				
	Not at all	1	2%				
	Somewhat	1	2%				
	Moderately	4	7%				
	Mostly	25	45%				
	Completely	24	44%				
66	To what extent are surveillance data utilized in the prioritization process of Care community planning groups (CPGs)?	55	96%				
	Not at all	2	4%				
	Somewhat	2	4%				
	Moderately	11	20%				
	Mostly	23	42%				
	Completely	17	31%				
67	Do you use the CDC/HRSA Integrated Guidelines for Developing Epi-Profiles?	54	95%				
	Not at all	5	9%				
	Somewhat	7	13%				
	Moderately	4	7%				
	Mostly	19	35%				
	Completely	19	35%				
68	How can CDC provide further guidance or technical assistance to improve the usefulness and production of Epi-Profiles by CPGs? Check all that apply.	56	98%				
	Funding for a dedicated position	34	61%				
	Usable SAS programs to adjust for reporting delay to produce trends over time	37	66%				
	Examples of best practices in the use of surveillance data in prevention/care planning	41	73%				
	Opportunities for peer-to-peer sharing of effective processes	30	54%				

	Examples and models of CPG/Surveillance relationships	26	46%				
	Further guidance for surveillance sections in the Epi-Profile Guidelines	18	32%				
	Expertise for linkages to various datasets	23	41%				
	SAS programs for estimation of unmet needs	40	71%				
	Expanded national surveillance reports	18	32%				
	Respond to specific data requests	16	29%				
	Other (*including wasted effort, not applicable to rural/low morbidity states, more national data on perinatal surveillance/trends, advice/assistance with desktop publishing, funding for IT support*)	6	11%				
69	Does your surveillance program receive direct reports of HIV Viral Loads?	57	100%				
	no	2	4%				
	yes	55	96%				
70-71	By what method does your program receive direct reports of HIV Viral Loads?	55	100%				
	% Mail	49	89%	60.63	75.00	4.00	100.00
	% Electronic Transmission	34	62%	57.94	60.00	1.00	100.00
	% Other (*including direct physician contact, site visit, fax, CD, phone, CARE, web FTP, or does not track reports*)	14	25%	34.93	22.50	5.00	100.00
72	Does your surveillance program receive direct reports of CD4 Counts?	57	100%				
	no	3	5%				
	yes	54	95%				
73-74	By what method does your program receive direct reports of CD4 counts?	54	100%				
	% Mail	48	89%	62.85	77.50	5.00	100.00
	% Electronic Transmission	34	63%	53.21	59.50	1.00	100.00
	% Other (*including direct physician contact, site visit, fax, phone calls, CARE, web FTP, or does not track reports*)	14	26%	32.43	17.50	5.00	100.00
75	Does your surveillance program receive direct reports of confirmed Positive Antibody Tests?	55	96%				
	no	1	2%				
	yes	54	98%				
76-77	By what method does your program receive direct reports of confirmed Positive Antibody Tests?	54	100%				
	% Mail	47	87%	62.21	70.00	5.00	100.00
	% Electronic Transmission	36	67%	54.36	60.00	1.00	100.00
	% Other (*including direct physician contact, site visit, drop-off, fax, phone calls, web FTP, DHL, or does not track reports*)	12	22%	26.92	15.50	0.00	100.00

78	Does your surveillance program receive direct reports of electronic sequence data from HIV genotyping results?	57	100%				
	no	39	68%				
	yes	18	32%				
79-80	By what method does your program receive direct reports of electronic sequence data from HIV genotyping results?	18	100%				
	% Mail	13	72%	65.38	100.00	0.00	100.00
	% Electronic Transmission	9	50%	77.78	100.00	0.00	100.00
	% Other (*including fax or does not track reports*)	2	11%	75.00	75.00	50.00	100.00
81	Do you use an electronic database separate from HARS/eHARS to store laboratory test results?	57	100%				
	no	24	42%				
	yes	33	58%				
82	Do you use laboratory records for the following purposes? (Check all that apply)	57	100%				
	Case ascertainment	54	95%				
	Monitor morbidity	37	65%				
	Monitor proportion in-care	46	81%				
	Update HARS	52	91%				
83-84	What percent of your HIV cases are initially identified through:	54	95%				
	% Direct Provider Reporting	54	100%	24.41	15.00	1.00	90.00
	% Lab Reporting	54	100%	66.65	75.00	1.00	98.00
	% PCRS	33	61%	5.88	2.00	1.00	33.00
	% Other (*including ICD-9, CTS, corrections, Medicaid billing, data matches, blood bank, out of state, correctional facilities, drug treatment, STD/HIV prevention, CARE database, TB database, death certificates, state/local in-state/out-state health department, medical record search, counseling and testing sites, active surveillance*)	19	35%	15.21	12.00	1.00	40.00
85	Viral loads? (check all that apply)	57	100%				
	All	40	70%				
	Some	13	23%				
	None	4	7%				
	Under consideration	4	7%				
86	CD4 Counts? (check all that apply)	57	100%				
	All	28	49%				
	Some	26	46%				
	None	5	9%				
	Under consideration	2	4%				
87	Antibody tests? (check all that apply)	57	100%				
	All	35	61%				
	Some	21	37%				

	None	1	2%				
	Under consideration	1	2%				
88	Electronic sequence data from HIV genotyping results? (check all that apply)	57	100%				
	All	10	18%				
	Some	5	9%				
	None	36	63%				
	Under consideration	6	11%				
89	Pregnancy in known HIV+ women? (check all that apply)	57	100%				
	All	17	30%				
	Some	8	14%				
	None	28	49%				
	Under consideration	5	9%				
90	Perinatal HIV exposure?	54	95%				
	Explicitly stated in state rules or regulations	16	30%				
	State rules or regulations interpreted to include HIV exposure reporting	18	33%				
	Exposure reporting is not included in state rules or regulations	12	22%				
	State rules or regulations interpreted as not including exposure reporting	4	7%				
	Exposure reporting under consideration	4	7%				
91-92	Does your surveillance program have a method for systematically identifying and tracking Antiretroviral HIV drug resistance?	55	96%				
	no	39	71%				
	yes	16	29%				
	VARHS	11	31%				
	Other (*DFS project including submission of specimen in labs for all new diagnosis for resistance, atypical strains project, previously ARDVRR, customized database*)	5	69%				
93	Does your surveillance program have a method for systematically identifying and tracking incident cases of HIV infection as determined by the serologic testing algorithm for recent HIV seroconversion (STARHS)?	57	100%				
	no	24	42%				
	yes	33	58%				
94	Does your surveillance program have a method for systematically identifying and tracking incident opportunistic infections in persons with previously reported cases of HIV infection?	57	100%				

	no	31	54%				
	yes	26	46%				
95	Does your surveillance program have a method for systematically identifying and tracking multiple CD4 counts over time in persons with previously reported cases of HIV infection?	57	100%				
	no	16	28%				
	yes	41	72%				
96	Does your surveillance program have a method for systematically identifying and tracking cases of HIV/AIDS diagnosed outside of your jurisdiction but living in/receiving care in yours?	57	100%				
	no	8	14%				
	yes	49	86%				
97	Does your state (city) have a legal requirement to offer anonymous HIV testing?	56	98%				
	no	25	45%				
	yes	31	55%				
98	Is it permissible in your state (city) for a provider or laboratory to report a new HIV/AIDS case without the name or other personal identifiers (i.e. anonymously)?	56	98%				
	no	45	80%				
	yes	11	20%				
99-100	Since 2004, how many times has your surveillance program formally evaluated HARS? (Indicate for all categories)	52	91%				
	Completeness of case reporting	51	98%	3.92	2.00	0.00	43.00
	Timeliness of case reporting	51	98%	3.55	3.00	0.00	24.00
	Intrastate case count accuracy	46	88%	6.70	2.00	0.00	50.00
	Completeness of risk factor ascertainment	49	94%	4.02	3.00	0.00	24.00
	Validity of data elements	48	92%	5.63	1.00	0.00	100.00
	Other (*including perinatal exposures, no formal review policy, or monthly review policy*)	6	12%	0.17	0.00	0.00	1.00
101	Do you have written protocols to evaluate HARS? (Check all that apply)	53	93%				
	Completeness of case reporting	53	100%				
	No	0	0%				
	Yes-CDC	37	70%				
	Yes-Local	14	26%				
	Timeliness of case reporting	53	100%				
	No	6	11%				
	Yes-CDC	39	74%				
	Yes-Local	12	23%				

	Intrastate case count accuracy	53	100%				
	No	15	28%				
	Yes-CDC	27	51%				
	Yes-Local	10	19%				
	Completeness of risk factor ascertainment	53	100%				
	No	7	13%				
	Yes-CDC	36	68%				
	Yes-Local	16	30%				
	Validity of data elements	53	100%				
	No	13	25%				
	Yes-CDC	28	53%				
	Yes-Local	13	25%				
	Other	53	100%				
	No	3	6%				
	Yes-CDC	5	9%				
	Yes-Local	0	0%				
102	If a formal evaluation has not been done, why not? (Check all that apply)	23	40%				
	Completeness of case reporting	23	100%				
	Funding	4	17%				
	Time	14	61%				
	Skill	8	35%				
	Other	1	4%				
	Timeliness of case reporting	23	100%				
	Funding	4	17%				
	Time	9	39%				
	Skill	7	30%				
	Other	0	0%				
	Intrastate case count accuracy	23	100%				
	Funding	3	13%				
	Time	9	39%				
	Skill	5	22%				
	Other	2	9%				
	Completeness of risk factor ascertainment	23	100%				
	Funding	4	17%				
	Time	10	43%				
	Skill	5	22%				
	Other	0	0%				
	Validity of data elements	23	100%				
	Funding	7	30%				
	Time	10	43%				
	Skill	6	26%				

	Other	3	13%				
	Other (staff)	23	100%				
	Funding	1	4%				
	Time	0	0%				
	Skill	0	0%				
	Other	0	0%				
103	Are you reporting to CDC a version of Soundex code different from the one automatically generated in HARS or eHARS when the name is entered?	57	100%				
	no	55	96%				
	yes	2	4%				
104	What is the other version you are reporting?	2	4%				
	Sybase soundex						
	SAS soundex						
105	What priority does your health department place on actively looking for AIDS-defining opportunistic illnesses in an HIV-infected patient?	56	98%				
	Lowest priority	11	20%				
	Somewhat of a priority	14	25%				
	Moderate priority	16	29%				
	High priority	11	20%				
	Highest priority	4	7%				
106	For comparison with the above, what priority does your health department place on collecting data on CD4 counts in an HIV-infected patient?	57	100%				
	Lowest priority	2	4%				
	Somewhat of a priority	2	4%				
	Moderate priority	8	14%				
	High priority	31	54%				
	Highest priority	14	25%				
107	How much time does your surveillance staff spend collecting data on AIDS-defining opportunistic illnesses?	57	100%				
	Little or none	26	46%				
	A moderate amount	28	49%				
	A large amount	3	5%				
108	Do you link to the following databases?	57	100%				
	STD	57	100%				
	no	14	25%				
	yes	43	75%				
	ADAP	57	100%				
	no	15	26%				
	yes	42	74%				

	TB	56	98%				
	no	5	9%				
	yes	51	91%				
	Hepatitis B	55	96%				
	no	41	75%				
	yes	14	25%				
	Hepatitis C	55	96%				
	no	35	64%				
	yes	20	36%				
	State/Local Birth Records	54	95%				
	no	28	52%				
	yes	26	48%				
	Birth Defects	54	95%				
	no	50	93%				
	yes	4	7%				
	Cancer	54	95%				
	no	32	59%				
	yes	22	41%				
	Medicaid	54	95%				
	no	34	63%				
	yes	20	37%				
	Hospital Discharge	54	95%				
	no	37	69%				
	yes	17	31%				
	Counseling and Testing	55	96%				
	no	23	42%				
	yes	32	58%				
	Client Services (Careware, ARIES, etc.)	56	98%				
	no	28	50%				
	yes	28	50%				
	EPS (for areas with EPS)	48	84%				
	no	34	71%				
	yes	14	29%				
	TIS Testing History Forms	51	89%				
	no	42	82%				
	yes	9	18%				
	Electronic Lab Reports	55	96%				
	no	19	35%				
	yes	36	65%				
	State/Local Death Certificate Records	57	100%				
	no	2	4%				
	yes	55	96%				

109	Do you currently link Manually or Electronically?	57	100%				
	STD	54	95%				
	Manually	22	41%				
	Electronically (not eHARS)	19	35%				
	Electronically (eHARS)	2	4%				
	N/A	11	20%				
	ADAP	54	95%				
	Manually	21	39%				
	Electronically (not eHARS)	19	35%				
	Electronically (eHARS)	2	4%				
	N/A	12	22%				
	TB	54	95%				
	Manually	32	59%				
	Electronically (not eHARS)	14	26%				
	Electronically (eHARS)	2	4%				
	N/A	6	11%				
	Hepatitis B	50	88%				
	Manually	5	10%				
	Electronically (not eHARS)	9	18%				
	Electronically (eHARS)	0	0%				
	N/A	36	72%				
	Hepatitis C	50	88%				
	Manually	8	16%				
	Electronically (not eHARS)	10	20%				
	Electronically (eHARS)	1	2%				
	N/A	31	62%				
	State/Local Birth Records	51	89%				
	Manually	6	12%				
	Electronically (not eHARS)	17	33%				
	Electronically (eHARS)	3	6%				
	N/A	25	49%				
	Birth Defects	48	84%				
	Manually	1	2%				
	Electronically (not eHARS)	2	4%				
	Electronically (eHARS)	2	4%				
	N/A	43	90%				
	Cancer	51	89%				
	Manually	6	12%				
	Electronically (not eHARS)	11	22%				
	Electronically (eHARS)	2	4%				
	N/A	32	63%				
	Medicaid	52	91%				

	Manually	7	13%				
	Electronically (not eHARS)	12	23%				
	Electronically (eHARS)	2	4%				
	N/A	31	60%				
	Hospital Discharge	52	91%				
	Manually	8	15%				
	Electronically (not eHARS)	8	15%				
	Electronically (eHARS)	1	2%				
	N/A	35	67%				
	Counseling and Testing	54	95%				
	Manually	16	30%				
	Electronically (not eHARS)	11	20%				
	Electronically (eHARS)	3	6%				
	N/A	24	44%				
	Client Services (Careware, ARIES, etc.)	53	93%				
	Manually	9	17%				
	Electronically (not eHARS)	16	30%				
	Electronically (eHARS)	2	4%				
	N/A	26	49%				
	EPS (for areas with EPS)	50	88%				
	Manually	7	14%				
	Electronically (not eHARS)	6	12%				
	Electronically (eHARS)	1	2%				
	N/A	36	72%				
	TIS Testing History Forms	49	86%				
	Manually	6	12%				
	Electronically (not eHARS)	3	6%				
	Electronically (eHARS)	1	2%				
	N/A	39	80%				
	Electronic Lab Reports	54	95%				
	Manually	15	28%				
	Electronically (not eHARS)	17	31%				
	Electronically (eHARS)	6	11%				
	N/A	16	30%				
	Statel/Local Death Certificates	57	100%				
	Manually	27	47%				
	Electronically (not eHARS)	26	46%				
	Electronically (eHARS)	4	7%				
	N/A	0	0%				
110-111	How frequently do you link?	57	100%				
	STD	54	95%				
	Monthly	8	15%				

Quarterly	2	4%
Semi-Annually	5	9%
Annually	15	28%
Did it once	6	11%
Other (*when needed, time permitting, every few years, weekly, daily*)	8	15%
N/A	10	19%
ADAP	54	95%
Monthly	10	19%
Quarterly	7	13%
Semi-Annually	6	11%
Annually	11	20%
Did it once	4	7%
Other*	6	11%
N/A	10	19%
TB	56	98%
Monthly	9	16%
Quarterly	6	11%
Semi-Annually	5	9%
Annually	26	46%
Did it once	0	0%
Other*	6	11%
N/A	4	7%
Hepatitis B	48	84%
Monthly	2	4%
Quarterly	1	2%
Semi-Annually	0	0%
Annually	7	15%
Did it once	1	2%
Other*	3	6%
N/A	34	71%
Hepatitis C	50	88%
Monthly	4	8%
Quarterly	1	2%
Semi-Annually	1	2%
Annually	11	22%
Did it once	0	0%
Other*	3	6%
N/A	30	60%
State/Local Birth Records	50	88%
Monthly	5	10%
Quarterly	2	4%

Semi-Annually	2	4%				
Annually	13	26%				
Did it once	1	2%				
Other*	3	6%				
N/A	24	48%				
Birth Defects	45	79%				
Monthly	0	0%				
Quarterly	0	0%				
Semi-Annually	0	0%				
Annually	0	0%				
Did it once	2	4%				
Other*	2	4%				
N/A	41	91%				
Cancer	49	86%				
Monthly	0	0%				
Quarterly	1	2%				
Semi-Annually	0	0%				
Annually	3	6%				
Did it once	13	27%				
Other*	5	10%				
N/A	27	55%				
Medicaid	49	86%				
Monthly	2	4%				
Quarterly	1	2%				
Semi-Annually	2	4%				
Annually	10	20%				
Did it once	6	12%				
Other*	1	2%				
N/A	27	55%				
Hospital Discharge	50	88%				
Monthly	2	4%				
Quarterly	3	6%				
Semi-Annually	2	4%				
Annually	7	14%				
Did it once	0	0%				
Other*	3	6%				
N/A	33	66%				
Counseling and Testing	51	89%				
Monthly	13	25%				
Quarterly	5	10%				
Semi-Annually	6	12%				
Annually	0	0%				

Did it once	0	0%				
Other*	6	12%				
N/A	21	41%				
Client Services (Careware, ARIES, etc.)	49	86%				
Monthly	6	12%				
Quarterly	3	6%				
Semi-Annually	6	12%				
Annually	6	12%				
Did it once	3	6%				
Other*	0	0%				
N/A	25	51%				
EPS (for areas with EPS)	49	86%				
Monthly	7	14%				
Quarterly	0	0%				
Semi-Annually	1	2%				
Annually	2	4%				
Did it once	0	0%				
Other*	2	4%				
N/A	37	76%				
TIS Testing History Forms	45	79%				
Monthly	9	20%				
Quarterly	0	0%				
Semi-Annually	0	0%				
Annually	0	0%				
Did it once	0	0%				
Other*	0	0%				
N/A	36	80%				
Electronic Lab Reports	51	89%				
Monthly	18	35%				
Quarterly	1	2%				
Semi-Annually	0	0%				
Annually	1	2%				
Did it once	0	0%				
Other*	14	27%				
N/A	17	33%				
Statel/Local Death Certificates	57	100%				
Monthly	14	25%				
Quarterly	7	12%				
Semi-Annually	6	11%				
Annually	21	37%				
Did it once	2	4%				
Other*	6	11%				

	N/A	1	2%				
112	Do you have a MOU or a data sharing agreement?	57	100%				
	STD	56	98%				
	No	36	64%				
	Yes	14	25%				
	N/A	6	11%				
	ADAP	55	96%				
	No	39	71%				
	Yes	10	18%				
	N/A	6	11%				
	TB	55	96%				
	No	35	64%				
	Yes	17	31%				
	N/A	3	5%				
	Hepatitis B	51	89%				
	No	24	47%				
	Yes	3	6%				
	N/A	24	47%				
	Hepatitis C	51	89%				
	No	27	53%				
	Yes	4	8%				
	N/A	20	39%				
	State/Local Birth Records	52	91%				
	No	17	33%				
	Yes	20	38%				
	N/A	15	29%				
	Birth Defects	48	84%				
	No	13	27%				
	Yes	2	4%				
	N/A	33	69%				
	Cancer	51	89%				
	No	13	25%				
	Yes	18	35%				
	N/A	20	39%				
	Medicaid	51	89%				
	No	17	33%				
	Yes	12	24%				
	N/A	22	43%				
	Hospital Discharge	51	89%				
	No	18	35%				
	Yes	8	16%				
	N/A	25	49%				

	Counseling and Testing	53	93%				
	No	25	47%				
	Yes	8	15%				
	N/A	20	38%				
	Client Services (Careware, ARIES, etc.)	50	88%				
	No	28	56%				
	Yes	1	2%				
	N/A	21	42%				
	EPS (for areas with EPS)	48	84%				
	No	16	33%				
	Yes	3	6%				
	N/A	29	60%				
	TIS Testing History Forms	47	82%				
	No	16	34%				
	Yes	2	4%				
	N/A	29	62%				
	Electronic Lab Reports	54	95%				
	No	29	54%				
	Yes	9	17%				
	N/A	16	30%				
	Statel/Local Death Certificates	57	100%				
	No	20	35%				
	Yes	35	61%				
	N/A	2	4%				
113	Do you link to the databases for any of the following purposes? (Check all that apply)	57	100%				
	STD	53	93%				
	Case ascertainment	28	53%				
	Co-morbidity	34	64%				
	Updating HARS	29	55%				
	N/A	9	17%				
	ADAP	53	93%				
	Case ascertainment	41	77%				
	Co-morbidity	6	11%				
	Updating HARS	29	55%				
	N/A	10	19%				
	TB	55	96%				
	Case ascertainment	33	60%				
	Co-morbidity	42	76%				
	Updating HARS	5	9%				
	N/A	5	9%				
	Hepatitis B	48	84%				

Case ascertainment	3	6%				
Co-morbidity	15	31%				
Updating HARS	7	15%				
N/A	33	69%				
Hepatitis C	50	88%				
Case ascertainment	4	8%				
Co-morbidity	20	40%				
Updating HARS	6	12%				
N/A	28	56%				
State/Local Birth Records	51	89%				
Case ascertainment	18	35%				
Co-morbidity	2	4%				
Updating HARS	21	41%				
N/A	23	45%				
Birth Defects	46	81%				
Case ascertainment	1	2%				
Co-morbidity	2	4%				
Updating HARS	3	7%				
N/A	42	91%				
Cancer	48	84%				
Case ascertainment	15	31%				
Co-morbidity	15	31%				
Updating HARS	15	31%				
N/A	27	56%				
Medicaid	49	86%				
Case ascertainment	18	37%				
Co-morbidity	3	6%				
Updating HARS	14	29%				
N/A	28	57%				
Hospital Discharge	48	84%				
Case ascertainment	15	31%				
Co-morbidity	2	4%				
Updating HARS	8	17%				
N/A	32	67%				
Counseling and Testing	51	89%				
Case ascertainment	25	49%				
Co-morbidity	6	12%				
Updating HARS	18	35%				
N/A	22	43%				
Client Services (Careware, ARIES, etc.)	51	89%				
Case ascertainment	18	35%				
Co-morbidity	6	12%				

	Updating HARS	19	37%				
	N/A	26	51%				
	EPS (for areas with EPS)	47	82%				
	Case ascertainment	11	23%				
	Co-morbidity	2	4%				
	Updating HARS	9	19%				
	N/A	36	77%				
	TIS Testing History Forms	42	74%				
	Case ascertainment	2	5%				
	Co-morbidity	1	2%				
	Updating HARS	7	17%				
	N/A	35	83%				
	Electronic Lab Reports	53	93%				
	Case ascertainment	36	68%				
	Co-morbidity	7	13%				
	Updating HARS	30	57%				
	N/A	15	28%				
	Statel/Local Death Certificates	57	100%				
	Case ascertainment	46	81%				
	Co-morbidity	17	30%				
	Updating HARS	50	88%				
	N/A	1	2%				
114	What barriers have you experienced with linking records? (Check all that apply)	57	100%				
	STD	46	81%				
	Lack of time	23	50%				
	Lack of staff with technical skills	18	39%				
	Lack of software	11	24%				
	Lack of funds	11	24%				
	Data sharing problems	6	13%				
	Other	2	4%				
	N/A	14	30%				
	ADAP	47	82%				
	Lack of time	17	36%				
	Lack of staff with technical skills	16	34%				
	Lack of software	7	15%				
	Lack of funds	8	17%				
	Data sharing problems	8	17%				
	Other	2	4%				
	N/A	18	38%				
	TB	45	79%				
	Lack of time	19	42%				

Lack of staff with technical skills	14	31%				
Lack of software	6	13%				
Lack of funds	7	16%				
Data sharing problems	2	4%				
Other	16	36%				
N/A	14	31%				
Hepatitis B	43	75%				
Lack of time	5	12%				
Lack of staff with technical skills	5	12%				
Lack of software	6	14%				
Lack of funds	4	9%				
Data sharing problems	3	7%				
Other	23	53%				
N/A	0	0%				
Hepatitis C	45	79%				
Lack of time	17	38%				
Lack of staff with technical skills	7	16%				
Lack of software	8	18%				
Lack of funds	8	18%				
Data sharing problems	4	9%				
Other	4	9%				
N/A	19	42%				
State/Local Birth Records	47	82%				
Lack of time	17	36%				
Lack of staff with technical skills	12	26%				
Lack of software	8	17%				
Lack of funds	9	19%				
Data sharing problems	8	17%				
Other	2	4%				
N/A	18	38%				
Birth Defects	44	77%				
Lack of time	11	25%				
Lack of staff with technical skills	5	11%				
Lack of software	4	9%				
Lack of funds	5	11%				
Data sharing problems	3	7%				
Other	3	7%				
N/A	27	61%				
Cancer	48	84%				
Lack of time	24	50%				
Lack of staff with technical skills	13	27%				
Lack of software	9	19%				

Lack of funds	12	25%				
Data sharing problems	6	13%				
Other	2	4%				
N/A	19	40%				
Medicaid	49	86%				
Lack of time	16	33%				
Lack of staff with technical skills	15	31%				
Lack of software	8	16%				
Lack of funds	11	22%				
Data sharing problems	15	31%				
Other	4	8%				
N/A	15	31%				
Hospital Discharge	46	81%				
Lack of time	14	30%				
Lack of staff with technical skills	7	15%				
Lack of software	3	7%				
Lack of funds	8	17%				
Data sharing problems	13	28%				
Other	2	4%				
N/A	18	39%				
Counseling and Testing	43	75%				
Lack of time	13	30%				
Lack of staff with technical skills	11	26%				
Lack of software	6	14%				
Lack of funds	7	16%				
Data sharing problems	7	16%				
Other	1	2%				
N/A	22	51%				
Client Services (Careware, ARIES, etc.)	46	81%				
Lack of time	14	30%				
Lack of staff with technical skills	13	28%				
Lack of software	7	15%				
Lack of funds	8	17%				
Data sharing problems	8	17%				
Other	2	4%				
N/A	25	54%				
EPS (for areas with EPS)	45	79%				
Lack of time	7	16%				
Lack of staff with technical skills	7	16%				
Lack of software	4	9%				
Lack of funds	5	11%				
Data sharing problems	3	7%				

	Other	0	0%				
	N/A	37	82%				
	TIS Testing History Forms	42	74%				
	Lack of time	5	12%				
	Lack of staff with technical skills	5	12%				
	Lack of software	2	5%				
	Lack of funds	3	7%				
	Data sharing problems	2	5%				
	Other	0	0%				
	N/A	37	88%				
	Electronic Lab Reports	44	77%				
	Lack of time	14	32%				
	Lack of staff with technical skills	13	30%				
	Lack of software	12	27%				
	Lack of funds	13	30%				
	Data sharing problems	3	7%				
	Other	2	5%				
	N/A	21	48%				
	Statel/Local Death Certificates	49	86%				
	Lack of time	19	39%				
	Lack of staff with technical skills	12	24%				
	Lack of software	9	18%				
	Lack of funds	11	22%				
	Data sharing problems	5	10%				
	Other	3	6%				
	N/A	19	39%				
115	Have you ever used any of the following software:	57	100%				
	Link Plus	56	98%				
	no	36	64%				
	yes	20	36%				
	Link King	52	91%				
	no	50	96%				
	yes	2	4%				
	AutoMatch (Matchware)	53	93%				
	no	46	87%				
	yes	7	13%				
	Integrity (Validity)	52	91%				
	no	49	94%				
	yes	3	6%				
	Quality Stage (IBM)	52	91%				
	no	50	96%				
	yes	2	4%				

	Custom Program developed by Surveillance or IT Staff (e.g. SAS, MS Access, etc.)	57	100%				
	no	14	25%				
	yes	43	75%				
	Other (*SAS enterprise guide, Prodas, HARS matching tools, SPSS*)	30	53%				
	no	26	87%				
	yes	4	13%				
116	How would you describe the ease of use of this software?	55	96%				
	Link Plus	52	95%				
	Not applicable, don't use	32	62%				
	Difficult to use	0	0%				
	Somewhat difficult to use	11	21%				
	Easy to use	7	13%				
	Very easy to use	2	4%				
	Link King	49	89%				
	Not applicable, don't use	47	96%				
	Difficult to use	0	0%				
	Somewhat difficult to use	2	4%				
	Easy to use	0	0%				
	Very easy to use	0	0%				
	AutoMatch (Matchware)	52	95%				
	Not applicable, don't use	46	88%				
	Difficult to use	3	6%				
	Somewhat difficult to use	2	4%				
	Easy to use	0	0%				
	Very easy to use	1	2%				
	Integrity (Validity)	49	89%				
	Not applicable, don't use	46	94%				
	Difficult to use	0	0%				
	Somewhat difficult to use	1	2%				
	Easy to use	0	0%				
	Very easy to use	2	4%				
	Quality Stage (IBM)	51	93%				
	Not applicable, don't use	48	94%				
	Difficult to use	0	0%				
	Somewhat difficult to use	2	4%				
	Easy to use	1	2%				
	Very easy to use	0	0%				
	Custom Program developed by Surveillance or IT Staff (e.g. SAS, MS Access, etc.)	55	100%				
	Not applicable, don't use	13	24%				

	Difficult to use	5	9%				
	Somewhat difficult to use	15	27%				
	Easy to use	17	31%				
	Very easy to use	5	9%				
	Other (*SAS enterprise guide, Prodas, HARS matching tools, SPSS*)	31	56%				
	Not applicable, don't use	27	87%				
	Difficult to use	0	0%				
	Somewhat difficult to use	1	3%				
	Easy to use	2	6%				
	Very easy to use	1	3%				
117	How would you describe the specificity of linkage for case ascertainment, updating HARS records, or co-morbidity findings?	54	95%				
	Link Plus	50	93%				
	Not applicable, don't use	31	62%				
	Low (too many matches are actually different persons or too many non-matches are actually the same persons for this method to be worthwhile)	1	2%				
	Intermediate	15	30%				
	High (almost all matches are true [same persons] and almost all non-matches are truly different persons)	3	6%				
	Link King	48	89%				
	Not applicable, don't use	46	96%				
	Low (too many matches are actually different persons or too many non-matches are actually the same persons for this method to be worthwhile)	0	0%				
	Intermediate	1	2%				
	High (almost all matches are true [same persons] and almost all non-matches are truly different persons)	1	2%				
	AutoMatch (Matchware)	49	91%				
	Not applicable, don't use	44	90%				
	Low (too many matches are actually different persons or too many non-matches are actually the same persons for this method to be worthwhile)	0	0%				
	Intermediate	2	4%				
	High (almost all matches are true [same persons] and almost all non-matches are truly different persons)	3	6%				
	Integrity (Validity)	48	89%				
	Not applicable, don't use	45	94%				

	Low (too many matches are actually different persons or too many non-matches are actually the same persons for this method to be worthwhile)	0	0%				
	Intermediate	1	2%				
	High (almost all matches are true [same persons] and almost all non-matches are truly different persons)	2	4%				
	Quality Stage (IBM)	47	87%				
	Not applicable, don't use	44	94%				
	Low (too many matches are actually different persons or too many non-matches are actually the same persons for this method to be worthwhile)	0	0%				
	Intermediate	1	2%				
	High (almost all matches are true [same persons] and almost all non-matches are truly different persons)	2	4%				
	Custom Program developed by Surveillance or IT Staff (e.g. SAS, MS Access, etc.)	54	100%				
	Not applicable, don't use	15	28%				
	Low (too many matches are actually different persons or too many non-matches are actually the same persons for this method to be worthwhile)	2	4%				
	Intermediate	22	41%				
	High (almost all matches are true [same persons] and almost all non-matches are truly different persons)	15	28%				
	Other	27	50%				
	Not applicable, don't use	24	89%				
	Low (too many matches are actually different persons or too many non-matches are actually the same persons for this method to be worthwhile)	0	0%				
	Intermediate	3	11%				
	High (almost all matches are true [same persons] and almost all non-matches are truly different persons)	0	0%				
118	How would you describe the sensitivity of linkage for case ascertainment, updating HARS records, or co-morbidity findings?	56	98%				
	Link Plus	52	93%				
	Not applicable, don't use	32	62%				
	Low (too many true matches are missed for this method to be worthwhile)	0	0%				
	Intermediate	12	23%				
	High (few true matches are missed)	8	15%				
	Link King	50	89%				
	Not applicable, don't use	48	96%				

	Low (too many true matches are missed for this method to be worthwhile)	0	0%				
	Intermediate	1	2%				
	High (few true matches are missed)	1	2%				
	AutoMatch (Matchware)	51	91%				
	Not applicable, don't use	46	90%				
	Low (too many true matches are missed for this method to be worthwhile)	0	0%				
	Intermediate	3	6%				
	High (few true matches are missed)	2	4%				
	Integrity (Validity)	50	89%				
	Not applicable, don't use	47	94%				
	Low (too many true matches are missed for this method to be worthwhile)	0	0%				
	Intermediate	1	2%				
	High (few true matches are missed)	2	4%				
	Quality Stage (IBM)	46	82%				
	Not applicable, don't use	43	93%				
	Low (too many true matches are missed for this method to be worthwhile)	0	0%				
	Intermediate	1	2%				
	High (few true matches are missed)	2	4%				
	Custom Program developed by Surveillance or IT Staff (e.g. SAS, MS Access, etc.)	56	100%				
	Not applicable, don't use	17	30%				
	Low (too many true matches are missed for this method to be worthwhile)	1	2%				
	Intermediate	23	41%				
	High (few true matches are missed)	15	27%				
	Other	30	54%				
	Not applicable, don't use	27	90%				
	Low (too many true matches are missed for this method to be worthwhile)	0	0%				
	Intermediate	2	7%				
	High (few true matches are missed)	3	10%				
119	Would you recommend this software to another surveillance program?	56	98%				
	Link Plus	51	91%				
	No	8	16%				
	Yes	16	31%				
	N/A	27	53%				
	Link King	50	89%				

	No	8	16%				
	Yes	2	4%				
	N/A	40	80%				
	AutoMatch (Matchware)	51	91%				
	No	11	22%				
	Yes	3	6%				
	N/A	37	73%				
	Integrity (Validity)	50	89%				
	No	8	16%				
	Yes	2	4%				
	N/A	40	80%				
	Quality Stage (IBM)	48	86%				
	No	6	13%				
	Yes	2	4%				
	N/A	40	83%				
	Custom Program developed by Surveillance or IT Staff (e.g. SAS, MS Access, etc.)	56	100%				
	No	8	14%				
	Yes	32	57%				
	N/A	16	29%				
	Other	29	52%				
	No	5	17%				
	Yes	2	7%				
	N/A	22	76%				
120	Does your surveillance program receive:	56	98%				
	State/Local Level Hardcopy Death Certificates	56	100%				
	No	11	20%				
	Yes	45	80%				
	State/Local Level Electronic Death Records	56	100%				
	No	18	32%				
	Yes	38	68%				
121	What type of death data does your surveillance program receive?	57	100%				
	Records with HIV/AIDS as the underlying cause of death	57	100%				
	State/Local Level Hardcopy Death Certificates	34	60%				
	State/Local Level Electronic Death Records	22	39%				
	Records with any mention of HIV/AIDS, regardless of whether it was the underlying cause or one of the multiple causes (e.g., a contributing cause) of death	57	100%				
	State/Local Level Hardcopy Death Certificates	36	63%				
	State/Local Level Electronic Death Records	22	39%				
	Records with ICD codes for opportunistic disease	57	100%				

	State/Local Level Hardcopy Death Certificates	17	30%				
	State/Local Level Electronic Death Records	13	23%				
	Both records with any mention of HIV/AIDS, regardless of whether it was the underlying cause or one of the multiple causes and records with ICD codes for opportunistic disease	57	100%				
	State/Local Level Hardcopy Death Certificates	26	46%				
	State/Local Level Electronic Death Records	19	33%				
	All death records, regardless of causes of death	57	100%				
	State/Local Level Hardcopy Death Certificates	5	9%				
	State/Local Level Electronic Death Records	30	53%				
	Other (*upon request, as needed, newspaper obituaries*)	57	100%				
	State/Local Level Hardcopy Death Certificates	5	9%				
	State/Local Level Electronic Death Records	2	4%				
122	Who provides the death data to your surveillance program?	57	100%				
	State/Local Level Hardcopy Death Certificates	47	82%				
	City or county registrars	6	13%				
	State vital statistics office	39	83%				
	Other	2	4%				
	State/Local Level Electronic Death Records	40	70%				
	City or county registrars	2	5%				
	State vital statistics office	37	93%				
	Other	1	3%				
123	How frequently do you receive death data?	57	100%				
	State/Local Level Hardcopy Death Certificates	49	86%				
	Monthly	31	63%				
	Quarterly	7	14%				
	Semi-Annually	2	4%				
	Annually	5	10%				
	Every 2 years	0	0%				
	Every 3 years	0	0%				
	Less frequently, but more than once	1	2%				
	Only once	0	0%				
	Never	3	6%				
	State/Local Level Electronic Death Records	41	72%				
	Monthly	7	17%				
	Quarterly	4	10%				
	Semi-Annually	1	2%				
	Annually	24	59%				
	Every 2 years	3	7%				
	Every 3 years	0	0%				
	Less frequently, but more than once	2	5%				

	Only once	0	0%				
	Never	0	0%				
124	For electronic linkage to state death records, which procedure do you follow?						
	Linkage to all death records, including those with no mention of HIV/AIDS, to find all deaths.	30					
	State/Local Level Hardcopy Death Certificates	6	20%				
	State/Local Level Electronic Death Records	24	80%				
	Linkage only to death records that mentioned HIV/AIDS to find potential new cases from non-matching death records.	21					
	State/Local Level Hardcopy Death Certificates	12	57%				
	State/Local Level Electronic Death Records	9	43%				
	Both, with two linkages: option 1 followed by option 2	8					
	State/Local Level Hardcopy Death Certificates	0	0%				
	State/Local Level Electronic Death Records	8	100%				
	Both, with two linkages: option 2 followed by option 1	7					
	State/Local Level Hardcopy Death Certificates	2	29%				
	State/Local Level Electronic Death Records	5	71%				
	Only 1 as a single linkage combining features of both 1 and 2 (after the linkage, but ICD codes for HIV in non-matching death records were then used to identify potential new cases)	8					
	State/Local Level Hardcopy Death Certificates	3	38%				
	State/Local Level Electronic Death Records	5	63%				
	N/A	9					
	State/Local Level Hardcopy Death Certificates	7	78%				
	State/Local Level Electronic Death Records	2	22%				
125	How much does your surveillance program pay for the data?	47	82%				
	State/Local Level Hardcopy Death Certificates	47	100%				
	No cost	44	94%				
	Less than $1000	0	0%				
	Greater than $1000 and less than $5000	0	0%				
	Greater than $5000	0	0%				
	Not applicable	3	6%				
	State/Local Level Electronic Death Records	46	98%				
	No cost	39	85%				
	Less than $1000	2	4%				
	Greater than $1000 and less than $5000	0	0%				
	Greater than $5000	0	0%				
	Not applicable	5	11%				
126	Has your surveillance program used any of the national death data sources?	57	100%				

	Social Security Administration's Death Master File (DMF)also referred to as SSDI	57	100%				
	Yes	35	61%				
	No, because we do not collect Social Security Numbers	6	11%				
	No, because although we collect Social Security Numbers, the percentage of missing SSN is greater than 30%	2	4%				
	No, because it hasn't been a high priority	7	12%				
	No, because we don't have the funds	7	12%				
	National Death Index (NDI)	57	100%				
	Yes	13	23%				
	No, because we do not collect Social Security Numbers	2	4%				
	No, because although we collect Social Security Numbers, the percentage of missing SSN is greater than 30%	3	5%				
	No, because it hasn't been a high priority	14	25%				
	No, because we don't have the funds	22	39%				
	National Death Index Plus (NDI-Plus)	57	100%				
	Yes	5	9%				
	No, because we do not collect Social Security Numbers	2	4%				
	No, because although we collect Social Security Numbers, the percentage of missing SSN is greater than 30%	3	5%				
	No, because it hasn't been a high priority	16	28%				
	No, because we don't have the funds	24	42%				
127	Please indicate the year or range of years you have used each source (e.g. 1999 or 1999-2003). If you do not know the earliest year, at least state the most recent year. If you didn't use the source, then code as "N/A"	42	74%				
	Social Security Administration's Death Master File (DMF) also referred to as SSDI	42	100%				
	information available on request	33	79%				
	N/A	9	21%				
	National Death Index (NDI)	29	69%				
	information available on request	10	34%				
	N/A	19	66%				
	National Death Index Plus (NDI-Plus)	26	62%				
	information available on request	6	23%				
	N/A	20	77%				

128	Please indicate the usefulness of the source in identifying deaths among HARS cases:	51	89%				
	Social Security Administration's Death Master File (DMF) also referred to as SSDI	51	100%				
	Not useful at all	3	6%				
	Somewhat useful	9	18%				
	Moderately useful	4	8%				
	Very useful	14	27%				
	Extremely useful	6	12%				
	N/A	15	29%				
	National Death Index (NDI)	49	96%				
	Not useful at all	1	2%				
	Somewhat useful	3	6%				
	Moderately useful	4	8%				
	Very useful	3	6%				
	Extremely useful	2	4%				
	N/A	36	73%				
	National Death Index Plus (NDI-Plus)	46	90%				
	Not useful at all	0	0%				
	Somewhat useful	1	2%				
	Moderately useful	1	2%				
	Very useful	2	4%				
	Extremely useful	2	4%				
	N/A	40	87%				
129	For linkage to the National Death Index (NDI) or to the NDI-Plus, what methods did you use to determine a true match? (check all that apply)	49	86%				
	N/A	5	10%				
	Probabilistic Score	0	0%				
	Class Code	1	2%				
	Status Code	3	6%				
	We assumed it was a true match if it was the only potential match listed for a case	39	80%				
	Other (*predetermined match*)	1	2%				
130	Please provide the range of probabilistic scores for a true match:						
	85-100						
	information unavailable						
	11 of class 1; Class 2 = 44.7; Class 3 =37.5						
	0.34						
131	Please provide the class values for a true match:						
	1,2,3						

132	Please provide the status code for a true match:						
	predetermined match results only						
	1						
133	Does your program have written guidelines for security and confidentiality?	57	100%				
	No	1	2%				
	Yes	56	98%				
134	Are they the CDC Confidentiality and Security Guidelines exactly as written?	55	96%				
	No	42	76%				
	Yes	13	24%				
135	Are they a local adaptation of the CDC Guidelines?	43	75%				
	No	3	7%				
	Yes	40	93%				
136	Do you have local guidelines that do not incorporate the CDC Confidentiality and Security Guidelines?	56	98%				
	No	52	93%				
	Yes	4	7%				
137	How often does staff receive training in security/confidentiality? (Check all that apply)	57	100%				
	Annually	40	70%				
	Less than annually	4	7%				
	More than annually	1	2%				
	When new staff comes on board	38	67%				
138	What is required for non-surveillance staff who have access to potentially identifiable surveillance data? (Check all that apply)	57	100%				
	Security training	46	81%				
	Signed confidentiality agreement	56	98%				
	Background check	8	14%				
	Direct oversight by surveillance unit staff	34	60%				
	Restrictions on physical work location	40	70%				
139	What additional steps do you take when HIV surveillance data are linked to other databases (e.g., hospital discharge data)? (Check all that apply)	57	100%				
	Conduct linkages in our office	46	81%				
	Encrypt HIV data when in transport to and from offsite location	24	42%				
	Sign memorandum of understanding with other unit of how HIV data will be protected and used	24	42%				
	Obtain IRB approval	2	4%				

	Other (*N/A, confidentiality training/agreement, committee of public health program managers, manual match by HIV staff only*)	5	9%				
140	Do you have adequate IT support to meet your security and confidentiality requirements (e.g. transmission of data, laptops, encryption software, etc.)	57	100%				
	No	15	26%				
	Yes	42	74%				
141	In what organizational unit of your health department is your HIV ORP located? Is it over:	57	100%				
	All HIV programs	15	26%				
	HIV surveillance only	7	12%				
	HIV Prevention and Surveillance	3	5%				
	All Infectious diseases	20	35%				
	Other (Epidemiology and Response; Bureau of City; Department Head - Commissioner; Administration; Health Department Administration; Public Health Administration; Chronic/Infectious Disease Surveillance; HIV/STD/TB/Family Planning/Chronic Hepatitis; Department Administration; Office of Public Health; HIV Surveillance and Care; Acute Disease Prevention; Emergency Response)	12	21%				
142	Is your ORP? (Check one)	54	95%				
	State Epidemiologist	14	26%				
	State Health Officer	1	2%				
	State AIDS Director	13	24%				
	HIV Surveillance Manager	4	7%				
	Other (*Health Surveillance Division Director; HIV EPI Program Director; Assistant State Health Officer; Division Director - Epidemiology and Laboratory Services; Division Director - Health and Medical Services; Bureau Chief; STD Director; Chief Administrator; Commissioner; Local AIDS Director; Deputy Director of Health Department; Bureau Director; Deputy Director; IT Manager; Director of the Division of Disease Control; Secretary - DHHS; Office of Public Health; Director of Surveillance and Care; Assistant Director of Health Department*)	22	41%				
143	Does the ORP have the authority to make changes regarding security and confidentiality policies?	56	98%				
	No	2	4%				
	Yes	54	96%				

144	How are changes made?						
	Surveillance Coordinator updates annually						
	Submission to HIV Section Chief and Division Director						
145	What encryption software do you use?	57	100%				
	None	1	2%				
	PGP	29	51%				
	Seal	45	79%				
	Point Sec	5	9%				
	Other (*Password-protected Zip file; Cryptainer LE; WinZip 9.0; WNTSTP*)	0	0%				
146	Is it 128 byte encryption?	48	84%				
	No (higher than 128 byte)	14	29%				
	No (lower than 128 byte)	0	0%				
	Yes (128 byte)	34	71%				
147	Are personally identifiable information in ancillary datasets (e.g. lab databases) encrypted when not in use?	55	96%				
	No, we do not encrypt databases	35	64%				
	Yes, all ancillary databases are encrypted	11	20%				
	Yes, some databases are encrypted	9	16%				
148	Is HARS/eHARS accessible on a:	57	100%				
	Stand-alone machine (HARS)	21	37%				
	Server, dedicated/isolated	28	49%				
	Server, part of regular LAN	8	14%				
149	Do you routinely share <u>individual-level data</u> with other programs, agencies, or local health departments (excluding routine communication with other HIV/AIDS surveillance programs)?	57	100%				
	No	39	68%				
	Yes	18	32%				
150	When individual-level data are shared do you require or usually have the provisions outlined in a specific data sharing agreements (e.g. memoranda of understanding or memoranda of agreement)?	18	32%				
	No	10	56%				
	Yes	8	44%				
151	Is sharing of individual-level data addressed in your program's data release policy?	18	32%				
	No	4	22%				
	Yes	14	78%				
152	Do you share individual-level information with personal identifiers?	57	100%				
	No	19	33%				

	Yes	38	67%				
153	If yes, with whom? (Check all that apply)	57	100%				
	N/A	0	0%				
	Local health department	17	30%				
	Partner notification	24	42%				
	HIV/AIDS Surveillance Program of another State	31	54%				
	Other health department programs external to the surveillance program (*no specifications; TB/Hepatitis programs; STD programs; Vital Statistics; STD surveillance/PCRS; IRB approved projects*)	16	28%				
154	If yes, for what purpose? (Check all that apply)	57	100%				
	N/A	0	0%				
	Court order	6	11%				
	Research purposes	6	11%				
	Deduplication of cases	32	56%				
	Other (*partner notification; case ascertainment and management; death certificate ascertainment; monitoring of co-morbidities; verification of HIV status for participation in HIV-specific state Medicaid program; public health purposes including disease control and compliance with disease reporting; epidemiologist investigation; disease intervention*)	23	40%				
155	Please indicate for which of the options below there are laws, rules, and/or regulations that address the release of personal identifiers.	57	100%				
	Local health department	20	35%				
	Other health department programs	13	23%				
	HIV/AIDS Surveillance Program of another state	12	21%				
	Partner notification	19	33%				
	Court order	21	37%				
	Deduplication of cases	9	16%				
	Research	14	25%				
	Other (*State Health Department, routine circumstances*)	1	2%				
156	Please indicate which one of the following best describes how HIV cases are reported to the health department in your jurisdiction:	57	100%				
	Cases are reported directly to the HIV surveillance program or	40	70%				
	Cases are reported to a central point in the health department, then forwarded to the HIV surveillance program or unit, but not to the HIV PCRS program	2	4%				
	Cases are reported directly to both the HIV surveillance program or unit and the HIV PCRS program	11	19%				

	Cases are reported to a central point in the health department, then forwarded to both the HIV surveillance program or unit and the HIV PCRS program	4	7%				
157	Does your HIV Surveillance program or unit provide any HIV case information to the health department program or unit that conducts HIV Partner Counseling and Referral Services (HIV PCRS program)?	42	74%				
	No	12	29%				
	Yes	30	71%				
158-160	How is HIV case information provided to the HIV PCRS program? (Check all that apply)						
	The HIV surveillance program provides names and locating information to the HIV PCRS program for all reported cases to initiate follow-up for PCRS.	17					
	The HIV surveillance program provides names and locating information to the HIV PCRS program only for some subset of cases to initiate follow-up for PCRS (e.g., from some specific providers, those who request assistance, from public only).*	7					
	Currently only public sector clients are forwarded to STD for PCRS and private sector clients whose provider has given permission for PCRS. This will be changing in the near future and all new cases will be sent for PCRS;						
	Sometimes a DIS will call will a contact who says they were diagnosed in another state, or who have indicated they already know they are HIV+, so the DIS will ask to determine if the info is true. They the month/yr of dx will be provided and any risks, and the last known lab date						
	HIV surveillance provides the name and contact information of patient to disease prevention specialist only with permission from the patient first, via the healthcare provider						
	PCRS is initiated by the state health department and completed by the local health department in the patient's county of residence.						
	Cases diagnosed within 12 months of case report with provider permission to follow.						
	Newly diagnosed and Partner Notification requests						

	The HIV surveillance program provides names and locating information to the HIV PCRS program to initiate follow-up for PCRS only when specifically requested by the provider reporting the case.	6					
	The HIV surveillance program notifies the HIV PCRS program of providers that may be requesting assistance with PCRS or have newly diagnosed patients that may need PCRS.	6					
	The HIV surveillance program provides aggregate data only to the HIV PCRS program for evaluation purposes or to guide outreach or screening activities (no individual level data shared).	0					
	HIV PCRS staff request additional information from the HIV surveillance program on individual cases as needed, and the surveillance program provides this information on a case-by-case basis.**	7					
	Generally locating information						
	Alternate address information; information that may help PCRS staff w/the case or alert them to potential hazards (safety, mental health, potential legal issues)						
	HIV PCRS staff are granted access to search in HARS directly as needed.	1					
	The HIV surveillance program obtains information from PCRS program staff regarding certain variables (e.g. risk factors) for select cases (e.g. cases that have been followed up and still have unreported risk factors).	16					
	Other (*counseling and testing sites request direct assistance from the DIS in their region for partner notification; the PCRS program is part of the surveillance unit; lab test results and identifying information for individuals not previously reported with positive western blots and positive HIV viral loads; providers may also report directly to the PCRS program, though most are reported to surveillance first; HIV surveillance program initiates PCRS directly*)	5					
161	How do you handle the requirements for security/confidentiality of data when individual level HIV surveillance data are provided to the HIV PCRS program?	32	56%				
	The HIV PCRS program follows HIV/AIDS surveillance security and confidentiality guidelines	21	66%				

	The HIV PCRS program has written security and confidentiality guidelines and/or policies that are equivalent to or more rigorous than those for HIV/AIDS surveillance	4	13%				
	The HIV PCRS program has written security and confidentiality guidelines and/or policies, but they are less rigorous than those for HIV/AIDS surveillance	4	13%				
	Unknown	3	9%				
162	Does your jurisdiction have legislation or regulations in place that prohibit the use of surveillance data for purposes (including PCRS) other than statistical analysis?	39	68%				
	No	31	79%				
	Yes	8	21%				
163	Does your jurisdiction have legislation or regulations in place that mandate/allow the use of surveillance data for PCRS or other public health purposes?	38	67%				
	No	13	34%				
	Yes	25	66%				
164	From the list below select the SINGLE response that best describes your HIV/AIDS data release policy:	57	100%				
	We have a written data release policy specific to HIV/AIDS surveillance data.	37	65%				
	We use a data release policy that covers infectious disease (STD, TB, etc.).	7	12%				
	We use the general health department data release policy.	6	11%				
	We do not have a written data release policy that applies to HIV/AIDS surveillance data.	5	9%				
	Other (*follow CDC guidelines of data release policy and do not release less than four cases for county, race, risk, age, and gender; currently updating data release policy*)	2	4%				
165	Are you willing to share your data release policy?	46	81%				
	No	4	9%				
	Yes	42	91%				
166	Is there a specific STATE/TERRITORY law or regulation that defines your data release policy?	55	96%				
	No	38	69%				
	Yes	17	31%				
167	Is there a process for responding to non-routine or external data requests?	56	98%				
	No	4	7%				
	Yes	52	93%				

168	Is this process included in any written policy or standard operating procedures?	50	88%				
	No	14	28%				
	Yes	36	72%				
169	Who decides how to respond to non-routine data requests?(Check all that apply)	57	100%				
	Surveillance Coordinator	43	75%				
	Data manager	10	18%				
	Assigned staff in surveillance unit	9	16%				
	Ad hoc depending on subject matter	9	16%				
	As specified in security or data release policy	5	9%				
	Senior staff (above surveillance coordinator)	21	37%				
	ORP	25	44%				
	Committee	2	4%				
	Other (*epidemiologist; bureau chief; program manager; data analysis unit manager*)	4	7%				
170	How often are you asked for data (inclusive of maps, tables, reports) but are not able to provide it because of uncertainty of confidentiality?	56	98%				
	Never	0	0%				
	Rarely	3	5%				
	Occasionally	21	38%				
	Frequently	26	46%				
	Very Frequently	5	9%				
171	What is the most detailed level of maps provided in any of your publicly disseminated HIV/AIDS materials? (Check one)	57	100%				
	No maps are provided in surveillance reports	6	11%				
	Public Health Jurisdictions/Regions (e.g. Ryan White Title areas)	6	11%				
	County	26	46%				
	Metropolitan statistical area	0	0%				
	City	3	5%				
	Zip code	8	14%				
	Census Tract (1,000-8,000 people)	3	5%				
	Census Block Group (300-3,000 people)	0	0%				
	Census Block	0	0%				
	Case level	0	0%				
	Other (*area development district; service planning area; health district; neighborhoods/districts*)	5	9%				
172	What is the most detailed level of tabular data provided in any publicly disseminated HIV/AIDS materials? (Check one)	57	100%				
	State	3	5%				

	Public Health Jurisdictions/Regions (e.g. Ryan White Title areas)	7	12%				
	County	30	53%				
	Metropolitan statistical area	6	11%				
	City	0	0%				
	Zip code	7	12%				
	Census Tract (1,000-8,000 people)	1	2%				
	Census Block Group (300-3,000 people)	0	0%				
	Census Block	0	0%				
	Case level	0	0%				
	Other (*SAS produced Epi-profile tables - race, gender, age, risk; Ward*)	3	5%				
173	Does your surveillance unit have a statistical disclosure policy?	56	98%				
	No	4	7%				
	Yes	52	93%				
174	Does your program or health department provide training on statistical disclosure limitation for staff that responds to data requests?	56	98%				
	Unknown	15	27%				
	No	36	64%				
	Yes	5	9%				
175-176	Do you have a need for training or additional training on statistical disclosure limitation? Which topics?	5	9%				
	No	4	80%				
	Yes	1	20%				
	Protecting tabular data (e.g., removing small values)	1					
	Removing personal identifiers	1					
	Construction and release of maps	1					
177-178	Do you have a need for training or additional training on statistical disclosure limitation? Which topics?	16	28%				
	No	5	31%				
	Yes	11	69%				
	Protecting tabular data (e.g., removing small values)	8	73%				
	Removing personal identifiers	6	55%				
	Construction and release of maps	8	73%				
179	How is this training provided?	57	100%				
	Training manual (formal)	9	16%				
	Short course/presentation (formal)	3	5%				
	No manual but staff learn from each other/supervisor (informal)	24	42%				
	Other mechanism (*Review of policy and protocols in place. All requests reviewed before release*)	1	2%				

180	Which of the following topics does your training cover? (Check all that apply)	57	100%
	Protecting tabular data (e.g., removing small values)	31	54%
	Removing personal identifiers	27	47%
	Construction and release of maps	16	28%
	Other (*small cell size; consistent with data release policy*)	2	4%
181-182	Which of the following types of aggregated data do you routinely release in standard dissemination products? (Check all that apply)	57	100%
	HIV (not including AIDS)	40	70%
	AIDS only	47	82%
	HIV and AIDS	53	93%
	Incidence estimates	22	39%
	Persons living with HIV/AIDS (PLWHA)	51	89%
	Persons in care	24	42%
	Co-morbid conditions	24	42%
	Mortality	50	88%
	Other (*persons living with AIDS; HIV+ by women; HIV by code from 2002-2006; percent of late testers; number of exposed infants/perinatal transmission; HIV regardless of AIDS; HIV reported in last 5 years as a surrogate for recent incidence*)	7	12%
183	How often do you disseminate aggregate HIV/AIDS data through the following formats/products?	57	100%
	Integrated Epi-Profiles	57	100%
	Monthly	0	0%
	Quarterly	2	4%
	Twice a year	0	0%
	Annually	24	42%
	Every other year	8	14%
	Every funding cycle	10	18%
	Sporadically	9	16%
	When requested	3	5%
	Never	0	0%
	Standard statistical reports	57	100%
	Monthly	11	19%
	Quarterly	18	32%
	Twice a year	15	26%
	Annually	12	21%
	Every other year	0	0%
	Every funding cycle	0	0%
	Sporadically	1	2%

When requested	2	4%				
Never	0	0%				
Fact sheets	57	100%				
Monthly	2	4%				
Quarterly	3	5%				
Twice a year	3	5%				
Annually	13	23%				
Every other year	2	4%				
Every funding cycle	0	0%				
Sporadically	11	19%				
When requested	17	30%				
Never	7	12%				
Slide sets	57	100%				
Monthly	1	2%				
Quarterly	3	5%				
Twice a year	2	4%				
Annually	13	23%				
Every other year	2	4%				
Every funding cycle	0	0%				
Sporadically	6	11%				
When requested	28	49%				
Never	3	5%				
Presentations	57	100%				
Monthly	4	7%				
Quarterly	5	9%				
Twice a year	1	2%				
Annually	1	2%				
Every other year	0	0%				
Every funding cycle	0	0%				
Sporadically	9	16%				
When requested	37	65%				
Never	1	2%				
On website	57	100%				
Monthly	7	12%				
Quarterly	17	30%				
Twice a year	12	21%				
Annually	17	30%				
Every other year	3	5%				
Every funding cycle	1	2%				
Sporadically	4	7%				
When requested	3	5%				
Never	1	2%				

	Peer-reviewed journal articles	57	100%				
	Monthly	0	0%				
	Quarterly	1	2%				
	Twice a year	0	0%				
	Annually	1	2%				
	Every other year	1	2%				
	Every funding cycle	1	2%				
	Sporadically	27	47%				
	When requested	8	14%				
	Never	17	30%				
	Tables for data requests	57	100%				
	Monthly	14	25%				
	Quarterly	4	7%				
	Twice a year	2	4%				
	Annually	1	2%				
	Every other year	0	0%				
	Every funding cycle	0	0%				
	Sporadically	2	4%				
	When requested	37	65%				
	Never	0	0%				
184	Where do you obtain your staff expertise for developing these dissemination products? (Check all that apply)	57	100%				
	HIV/AIDS surveillance unit (in-house)	54	95%				
	Other units in the health department	15	26%				
	Contract mechanism	1	2%				
	University partner	8	14%				
	Other (*state epi; CDC; internet resources*)	3	5%				
185	Which groups utilize these dissemination products? (Check all that apply)	57	100%				
	Other HIV/AIDS surveillance staff	48	84%				
	Health department prevention programs	55	96%				
	Health care programs	50	88%				
	Community-based organizations	56	98%				
	HIV/AIDS Prevention CPGs	56	98%				
	HIV/AIDS Care CPGs	53	93%				
	Legislature	42	74%				
	Funding sources	41	72%				
	Anyone who accesses the web	50	88%				

	Other (*Organizations/hospitals applying for grants; requests from media; congressman, senator, medical students, HIV/AIDS related programs; grant seekers; students, ASOs; Universities; HIV Care regional groups, not CPGs*)	8	14%				
186	Do you utilize data sources other than HARS/eHARS during the development of HIV/AIDS dissemination products?	56	98%				
	No	7	12%				
	Yes	49	86%				
187	Check all data sources utilized:	57	100%				
	STD	47	82%				
	ADAP	30	53%				
	TB	28	49%				
	Hepatitis B	14	25%				
	Hepatitis C	21	37%				
	Cancer	6	11%				
	Medicaid	9	16%				
	Hospital Discharge	4	7%				
	Counseling and Testing	35	61%				
	Client Services (Careware, Aries, CADR, etc.)	30	53%				
	Perinatal surveillance	24	42%				
	Behavioral surveillance	19	33%				
	Special project surveys	18	32%				
	Other (*Dept of Corrections HIV data; Census, economic development data; AIDS services organization, syringe exchange program, HSPAMM; harm reduction data; prison data; census, addictions data; youth risk behavior survey - YRBS, behavioral risk factor surveillance system - BRFSS, US census bureau; census; unique ID HIV system; military recruiting, blood bank, HIV prevention research special studies; lab database, BRFSS; PCRS data, reports from HIV care providers; census; death files*)	14	25%				
188	Which of the following CDC-developed SAS programs do you use/have you used? (Check all that apply)	57	100%				
	None	9	16%				
	Canned tables/reports for Integrated Epi-Profiles	16	28%				
	Adjustments for reporting delays	13	23%				
	Redistribution of HIV/AIDS risk factors (NIR)	10	18%				
	In care/Not in care estimations	7	12%				
	Estimates for HRSA/Ryan White Care Act	13	23%				
	Data cleaning for preconversion to eHARS	42	74%				

189	Which dissemination products are developed with these CDC-provided SAS programs? (Check all that apply)	57	100%				
	None	23	40%				
	Epi-Profiles/Annual reports	14	25%				
	Integrated Epi-Profiles	20	35%				
	Fact Sheets	9	16%				
	Slide sets	12	21%				
	Presentations	15	26%				
	Grant proposals	16	28%				
	Data requests	15	26%				
	Evaluation purposes	7	12%				
	Reports to legislature	8	14%				
	Annual trend reports	12	21%				
	Other (*data cleaning*)	2	4%				
190	Which of the following are barriers to developing dissemination products? (Check all that apply)	57	100%				
	No barriers/not applicable	9	16%				
	Lack of technical expertise to analyze HARS data	8	14%				
	Lack of technical expertise to program SAS	21	37%				
	Lack of modifiable SAS programs provided by CDC	20	35%				
	Lack of expertise for data management	10	18%				
	Lack of funding	25	44%				
	Insufficient staff	36	63%				
	Lack of time	37	65%				
	Other	0	0%				
191	Do you use the national annual HIV/AIDS surveillance report information in your data dissemination products?	57	100%				
	No	12	21%				
	Yes	45	79%				
192	If you could have additional information in the national annual HIV/AIDS surveillance report, what would you add?						
	different age groupings						
	A correlation between HARS data and PEMS data collected by the HIV Prevention Branch.						
	HIV/AIDS case counts by county for every state in U.S. When attempting to calculate MSA prevalence rates for HRSA grants, it is very difficult to obtain standardized data from every state. Additionally, as each state has different reporting policies, obtaining small cell counts for inclusion in these grants is near impossible.						
	results by year of diagnosis in addition to year of report						
	City level data.						

	N/A						
	None at this time.						
	it would be useful to have case reporting rank by state.						
	Move to people newly diagnosed with HIV, regardless of diagnosis state. Late diagnoses.						
	City specific data.						
	Trend data on AIDS by Race/ethnicity, age and mode. Mortality data based on vital records.						
	Break out race/ethnic, sex, risk, age group, and trends for low-morbidity areas.						
	I would have data on at the state, MSA, and major metropolitan area broken out by demographics and risk behaviors.						
	Data based on date of diagnosis instead of report date.						
	Make them mirror as much as possible the types of state level reports that HIV programs create						
	HIV and AIDS prevalence rates by age of diagnosis by year						
	Info on perinatal transmission/exposed infants; more regional breakdowns						
	Include estimates of HIV cases gathered under coded surveillance. Include more behavioral, incidence, resistance, perinatal data.						
193	What are your surveillance program's experiences with the Technical Guidance for HIV/AIDS Surveillance Programs?						
	Use as a reference. still getting familiarized						
	The technical Guidance has been beneficial in providing clarification in general surveillance matters.						
	Disseminated to all HIV Surveillance Managers last year, reviewed for input on evaluation and grant objectives.						
	All staff have access to copies of the guidelines and we are beginning to phase in implementation.						
	core surveillance unit supervisors have read and try to incorporate as much of it as we can, security first!						
	We having been implementing elements not presently part of our SOPs on a rolling basis.						
	Used it as a training resource for the surveillance coordinator (Montana's only FTE for this program)						
	Used it for policy and procedure development.						
	Overall very helpful. Some does not apply because only have one staff that complete specific surveillance functions.						
	Very useful.						

Attended regional training. *Use the guidance to direct program.*						
We use it regularly especially during grant period						
We reference as needed						
Periodic use for suspected HIV-2 cases, educational materials for risk assessment, and data evaluation techniques.						
At the May 2006 Midwest Technical guidance Training, I gave a presentation on Case Residence. *I am using the guidance to write the grant, to find info on evaluation procedures, to provide info to the 2 county health departments who conduct surveillance, to obtain risk assessment instruments to disseminate to providers, to use as a guide in developing the security and confidentiality policies, and in writing the policy and procedures manual.*						
We apply the technical guidance to most areas of our surveillance program. We reference the technical guidance in preparation of the CDC Cooperative Agreements for each funding cycle.						
All Core and Incidence staff attended the May 2006 training in Chicago on the Guidance. The Guidance is being utilized and is referenced frequently. Still need to update some of our written Standard Operating Procedures to fit the guidance's.						
We consistently and routinely refer back to the Technical Guidance for direction and clarification.						
Use it for reference, clarification						
Help train new staff; consulting resource for technical questions.						
We are using this for training personnel. Using guidelines to develop our next evaluation plan.						
Just starting to use them						
Using them to develop internal policies.						
Staff members participated in their development and training.						
A staff that sits in the Advisory Group that conducts final review of all Guidance protocols. Staff that helped write some of the chapters in the Guidance and a staff that presented at one of the Regional Workshops.						
We use it as a guide for our program but find its complete implementation daunting.						

	Relatively positive, however it is difficult to implement each requirement with level funding for years on end...						
	Could you be more vague on the 193rd question. Multiple readings/reviews and a regional conference.						
	The Technical Guidance is referred to routinely for program operations.						
	We have used them for grant objectives, for our procedures, and for data management.						
	Two staff members attended 2006 Technical Guidance Training; action section of the TG Manual reviewed with surveillance staff in weekly training sessions.						
	The technical guidance has been extensively used by staff and contractors to re-engineer bureau operations, including setting standards, writing manuals and developing trainings						
	Use as reference and training guidance						
	Assisted in writing some of them. Still in the process of implementing some of them.						
	some guidances are fully integrated into day to day practices; some are being used to develop or supplement local protocols. Sec/conf fully integrated into local manual.						
	We are familiar with almost all of them. We find them helpful and easy to use.						
	good basic resource, fairly easy to use, comprehensive						
	Have used as a reference, and for developing objectives for application (and as a doorstop!)						
	We review the guidelines for many HIV surveillance activities including security and confidentiality, data matching guidelines, and program policies and procedures.						
	It is very helpful.						
	We Read them for Application						
194	Does each of the staff involved in HARS data collection have access to a copy of the Technical Guidance?	56	98%				
	No	2	4%				
	Yes	54	96%				
195	Does your surveillance program have a policy and procedure manual?	57	100%				
	No	8	14%				
	Under development; partially completed	49	86%				
	Yes, fully completed and operational.	0	0%				
196	How would you rate the usefulness of the table of contents in terms of your ability to readily find specific information?	55	96%				
	Don't use	2	4%				

	Somewhat useful	10	18%				
	Moderately useful	23	42%				
	Easy to use	17	31%				
	Very easy to use	3	5%				
197	Are you using the Technical Guidance at this time?	57	100%				
	No	4	7%				
	Yes	53	93%				
198	What are the barriers to using it?						
	Used as the need arises...						
	None						
	A lot to look through to find the topic you are looking for						
	None.						
199	How are you using it and what are you using it for?						
	To answer various questions regarding protocols						
	How to carry-out evaluation assessment, data quality, and using guidelines for completeness and timeliness of reports						
	It is being used as an orientation manual as well as a resource for surveillance tasks.						
	It is used in the training of new staff. We are also beginning to implement the TG into our local policy and procedures manual.						
	Just the security and confidentiality.						
	Using the document to research methods of operating HIV surveillance programs, create objectives for grant purposes, evaluation.						
	We are using the timeliness and completeness measures to evaluate our program. We are in compliance with the security and confidentiality policies.						
	to guide us on reporting HIV and writing our Sample guidelines and other procedures/protocols.						
	We having been implementing elements not presently part of our SOPs on a rolling basis.						
	Evaluations						
	Writing the grant and conducting surveillance activities.						
	N/A						
	Risk ascertainment for more complete data, residency assignment, and development of protocols.						
	For security and confidentiality.						
	to guide our program. especially when beginning new activities such as managing electronic laboratory reporting. to standardize other activities, i.e. RIDR.						
	Grant Application						

Use it to understand surveillance						
we are using it for reference as needed						
Periodic use for suspected HIV-2 cases, educational materials for risk assessment, and data evaluation techniques.						
see answer to Question 193						
As needed						
On the web. Security and confidentiality guidelines.						
We use it to evaluate surveillance program functions and to set program objectives for each funding cycle.						
For writing the Cooperative Agreement. Updated our Security and Confidentiality Manual in April of 2006. Have incorporated some of the tools in the Risk Ascertainment Section to revise our methods of handling NRR/NIRs. Have been using it to update our policies and procedures.						
Grant preparation and program development.						
for reference as needed - just getting started using it so limited use so far - want to sit down and go through entirely						
Help train new staff; consulting resource for technical questions.						
As time permits, to update specific policies and procedures.						
Preparing our competitive surveillance applications.						
Reference, evaluation						
To develop internal policy specific to the HIV surveillance program.						
It is the basis for our local procedures.						
Currently being used to update local protocols and generate new protocols according to Guidance.						
We use TG for completeness and timeliness of reporting, and NIR monitoring. Security/confidentiality guidelines are incorporated into our manual.						
Staff time and availability						
Guidance on the technical aspects of surveillance.At this point in this survey, particularly with questions like this, you should be worried about the quality of your data responses.						
In general, since we have been following the guidelines routinely we are just trying to bring these processes a close to the guidelines as possible.						
I am not using the Guidance at this time.						

	For measures for our objectives, data for site reviews, monitoring data quality						
	RIRD; Grant Writing; Case Ascertainment; Policies. Lack of time is a barrier for accessing manual.						
	Developing manuals-Completing a comprehensive program evaluation-data benchmarking-implementation of programs-staff training-provider training tandards						
	Reference material. Electronic and paper copies used.						
	Most useful as a stand alone reference for sec/confidentiality, case residency, COPHI. *Barriers to full use/integration (question 198) include time to document/disseminate local policies and procedures. Also, some guidances not possible to fully implement with current resources (risk ascertainment, reabstractions)*						
	Pre eHARS cleaning, data security, death match and linking methods, risk redistribution, pediatric AIDS definitions, surveillance case report procedures						
	grant writing, program evaluation, developing outcome and process objectives, guide to filling out case report forms, training						
	As a reference to familiarize new staff with CDC guidances around elements of surveillance activities.						
	For data matching.						
	To develop Grant objectives and policies .						
200	Has your surveillance program used the TG to train staff?	57	100%				
	Policies and Procedures	54	95%				
	No	14	25%				
	Yes	40	70%				
	Access to Source Data and Completeness of Reporting	53	93%				
	No	12	21%				
	Yes	41	72%				
	Risk Factor Ascertainment	54	95%				
	No	11	19%				
	Yes	43	75%				
	Death Ascertainment	53	93%				
	No	15	26%				
	Yes	38	67%				
	Electronic Reporting	51	89%				
	No	28	49%				
	Yes	23	40%				
	Case Residency	54	95%				
	No	13	23%				

	Yes	41	72%				
	Duplicate Review	52	91%				
	No	15	26%				
	Yes	37	65%				
	Data Management	53	93%				
	No	18	32%				
	Yes	35	61%				
	Record Linkage	51	89%				
	No	21	37%				
	Yes	30	53%				
	Data Quality	51	89%				
	No	12	21%				
	Yes	39	68%				
201	Are you incorporating any of the following procedures into a state or local policy procedure manual?	57	100%				
	Policies and Procedures	51	89%				
	We have not incorporated it and are not planning to incorporate it into our manual.	2	4%				
	We have incorporated it into our manual (final version).	10	18%				
	We are currently working on incorporating it into our local manual (still drafting)	21	37%				
	We're planning to incorporate it into the manual, but we have not started working on it yet.	18	32%				
	Access to Source Data and Completeness of Reporting	47	82%				
	We have not incorporated it and are not planning to incorporate it into our manual.	2	4%				
	We have incorporated it into our manual (final version).	4	7%				
	We are currently working on incorporating it into our local manual (still drafting)	22	39%				
	We're planning to incorporate it into the manual, but we have not started working on it yet.	19	33%				
	Risk Factor Ascertainment	49	86%				
	We have not incorporated it and are not planning to incorporate it into our manual.	1	2%				
	We have incorporated it into our manual (final version).	6	11%				
	We are currently working on incorporating it into our local manual (still drafting)	23	40%				
	We're planning to incorporate it into the manual, but we have not started working on it yet.	19	33%				
	Death Ascertainment	48	84%				
	We have not incorporated it and are not planning to incorporate it into our manual.	1	2%				

We have incorporated it into our manual (final version).	5	9%				
We are currently working on incorporating it into our local manual (still drafting)	21	37%				
We're planning to incorporate it into the manual, but we have not started working on it yet.	21	37%				
Electronic Reporting	48	84%				
We have not incorporated it and are not planning to incorporate it into our manual.	7	12%				
We have incorporated it into our manual (final version).	3	5%				
We are currently working on incorporating it into our local manual (still drafting)	17	30%				
We're planning to incorporate it into the manual, but we have not started working on it yet.	21	37%				
Case Residency	49	86%				
We have not incorporated it and are not planning to incorporate it into our manual.	1	2%				
We have incorporated it into our manual (final version).	5	9%				
We are currently working on incorporating it into our local manual (still drafting)	20	35%				
We're planning to incorporate it into the manual, but we have not started working on it yet.	23	40%				
Duplicate Review	49	86%				
We have not incorporated it and are not planning to incorporate it into our manual.	2	4%				
We have incorporated it into our manual (final version).	5	9%				
We are currently working on incorporating it into our local manual (still drafting)	23	40%				
We're planning to incorporate it into the manual, but we have not started working on it yet.	19	33%				
Data Management	49	86%				
We have not incorporated it and are not planning to incorporate it into our manual.	3	5%				
We have incorporated it into our manual (final version).	3	5%				
We are currently working on incorporating it into our local manual (still drafting)	24	42%				
We're planning to incorporate it into the manual, but we have not started working on it yet.	19	33%				
Record Linkage	48	84%				
We have not incorporated it and are not planning to incorporate it into our manual.	3	5%				
We have incorporated it into our manual (final version).	3	5%				

	We are currently working on incorporating it into our local manual (still drafting)	21	37%				
	We're planning to incorporate it into the manual, but we have not started working on it yet.	21	37%				
	Data Quality	48	84%				
	We have not incorporated it and are not planning to incorporate it into our manual.	2	4%				
	We have incorporated it into our manual (final version).	4	7%				
	We are currently working on incorporating it into our local manual (still drafting)	24	42%				
	We're planning to incorporate it into the manual, but we have not started working on it yet.	18	32%				
202	How would you rate the usefulness of the contents in terms of your ability to understand how to implement them within your surveillance program?	57	100%				
	Policies and Procedures	48	84%				
	Not applicable, don't use	3	5%				
	Difficult to understand how to implement	1	2%				
	Somewhat difficult to understand how to implement	11	19%				
	Easy to understand how to implement	25	44%				
	Very easy to understand how to implement	8	14%				
	Access to Source Data and Completeness of Reporting	45	79%				
	Not applicable, don't use	2	4%				
	Difficult to understand how to implement	3	5%				
	Somewhat difficult to understand how to implement	14	25%				
	Easy to understand how to implement	21	37%				
	Very easy to understand how to implement	5	9%				
	Risk Factor Ascertainment	45	79%				
	Not applicable, don't use	2	4%				
	Difficult to understand how to implement	4	7%				
	Somewhat difficult to understand how to implement	14	25%				
	Easy to understand how to implement	18	32%				
	Very easy to understand how to implement	7	12%				
	Death Ascertainment	43	75%				
	Not applicable, don't use	2	4%				
	Difficult to understand how to implement	1	2%				
	Somewhat difficult to understand how to implement	10	18%				
	Easy to understand how to implement	23	40%				
	Very easy to understand how to implement	7	12%				
	Electronic Reporting	46	81%				
	Not applicable, don't use	12	21%				
	Difficult to understand how to implement	2	4%				

	Somewhat difficult to understand how to implement	13	23%				
	Easy to understand how to implement	14	25%				
	Very easy to understand how to implement	5	9%				
	Case Residency	45	79%				
	Not applicable, don't use	1	2%				
	Difficult to understand how to implement	0	0%				
	Somewhat difficult to understand how to implement	10	18%				
	Easy to understand how to implement	24	42%				
	Very easy to understand how to implement	10	18%				
	Duplicate Review	45	79%				
	Not applicable, don't use	3	5%				
	Difficult to understand how to implement	0	0%				
	Somewhat difficult to understand how to implement	10	18%				
	Easy to understand how to implement	24	42%				
	Very easy to understand how to implement	8	14%				
	Data Management	46	81%				
	Not applicable, don't use	4	7%				
	Difficult to understand how to implement	0	0%				
	Somewhat difficult to understand how to implement	17	30%				
	Easy to understand how to implement	19	33%				
	Very easy to understand how to implement	6	11%				
	Record Linkage	45	79%				
	Not applicable, don't use	4	7%				
	Difficult to understand how to implement	4	7%				
	Somewhat difficult to understand how to implement	17	30%				
	Easy to understand how to implement	17	30%				
	Very easy to understand how to implement	3	5%				
	Data Quality	44	77%				
	Not applicable, don't use	3	5%				
	Difficult to understand how to implement	5	9%				
	Somewhat difficult to understand how to implement	13	23%				
	Easy to understand how to implement	17	30%				
	Very easy to understand how to implement	6	11%				
203	In your opinion, what would you need to be changed about the Technical Guidance--in terms of either form or content --that would make it more accessible, easier to use, or otherwise useful?						
	I have no complaints about the guidance. It just takes so much time to digest. It is very massive.						

The overall purpose and function of Surveillance should be added to the TG. Guidance in completing the case reports and the significance of each question should be explained in the TG.						
Including a prioritization tool for implementing the TG would make it easier to use and less overwhelming. It would be nice to know what pieces are considered most important to implement everything.						
CDC program expectations should be put in BOLD font within each section of the document. Additionally, they could be placed in another section completely.						
They should be much shorter and more realistic.						
It is a good document; it pretty much outlines what we already do; indeed, our staff have contributed more than one section of the guidance. Hopefully, once name reporting is in place, we will have time to take a breath and review the guidance in depth.						
None						
Less detail for some areas that are smaller so we can prioritize.						
N/A						
prioritization of the different parts of the guidance in order of importance to surveillance.						
Maybe make the content a little less but easier to understand						
seems good to me						
Size of document is intimidating. Electronic access to improve subject searches.						
Uses eHARS, features not known to all sites.						
I haven't been in the position of HIV Surv Director long enough to give a definite answer to this question.						
Provide examples of typical situations and those that generate the most questions. For example, unusual residency situations.						
Concrete examples, SAS programs if data needs to be abstracted						
Seems very geared toward high-morbidity, highly funded areas with many staff.						
Reabstraction (Data Quality chapter)protocol is somewhat difficult to understand and apply to surveillance practice. Risk Ascertainment chapter was not well organized(COPHI vs NIR/NRR).						

	Keep it simple!						
	shorter and more concise						
	It is somewhat difficult to find specific material in the Guidance. Many hours can be spent reading through sections to locate information.						
	point out different ways of doing things if you have hars or if you have ehars or if you are high morbidity or low						
	Provide SAS code written by sites for data cleaning, management, and analysis as a resource to all programs						
	There is conflicting information between some of the sections.						
	Protocols for reabstraction are ideal, but do not necessarily give me the information I'd be most interested in knowing--are my field staff completing the case report forms in manner consistent w/one another. We tend to opt for much simpler reabstraction.						
	Why is access restricted to those with privileges to log on, etc? The document is way too big to use conveniently.						
	smaller binders for hard copy						
	I would suggest a CD rom format with a sensitive search tool to use from the desktop with greater ease and convenience.						
	Completeness of reporting is difficult to accomplish without eHARS						
204	Is there anything else, no matter how distantly related, that you would like to communicate to CDC about the Technical Guidance?						
	No						
	There should be a hands-on training for new Surveillance Coordinators that orients them to all aspects of the surveillance unit. Trainings on different segments of the TG should also be offered annually.						
	Since much of the TG is based on what eHARS can do, some of the guidance does not make as much sense for states still using HARS. It would be nice if the procedures relating directly to eHARS were highlighted in some way to let HARS users know this is not applicable to them. It's probably a little late for this now, but in the future, if a procedure won't apply for certain groups it would be nice if it was denoted in some way.						
	N/A						

	Program consultants and Epi TAs could work with each site to develop individualized plans of implementing the guidance in their jurisdiction.						
	Needed more training with more time devoted to detail and the opportunity to train more staff.						
	I have found the Technical Guidance a very valuable document/tool.						
	A summary of what is different since the last set of guidelines was printed. A prioritized listing of expected products that we should have at the state level as a result of implementing the guidance. A definition of what 'implementing the guidance means'.						
	It sometimes sets unrealistic expectations and can only be fully implemented if funding is increased.						
	It is actually fairly weak in stating the importance/value of HIV surveillance, and of the need to adhere to the standards in the Guidance.						
	more formulas and programs to do the data analysis						
	Including various information by virtue of a hyperlink runs the risk of omission. Just because something is "posted"; somewhere, doesn't mean that anyone has seen it.						
	would like to see the unfinished parts finished						
205	The CSTE HIV/AIDS Surveillance Coordinators Workgroup conducts monthly conference calls the second Wednesday of each month from 2-3 pm eastern time. How often do you participate?						
	Every month						
	Most months						
	About half the time						
	Less than half the time						
	I have never participated						
206	Why?						
	The call day doesn't work for me						
	The call time doesn't work for me						
	I didn't know that there were monthly calls						
	Call agendas do not seem relevant to my work						
	Just not a priority						
	I don't understand the purpose of the calls						
	Other (*limited surveillance staff and time of call; non-comprehension due to limited experience; work load*)						

* number of responses indicating funds received from source (excludes count of responses where funding = 0)