



**NASTAD Recommendations**  
**CDC HIV Surveillance Cooperative Agreements with State and Local Health**  
**Departments 2013-2017**

**Respectfully submitted November 9, 2011**

The National Alliance of State and Territorial AIDS Directors (NASTAD) is the member organization representing the nation's chief state health agency staff with programmatic responsibility for administering HIV/AIDS and viral hepatitis programs.

Approximately 75 percent of AIDS directors oversee HIV surveillance activities<sup>1</sup>. HIV surveillance data are critical for measuring progress toward the goals of the President's National HIV/AIDS Strategy (NHAS) and for determining formula funding levels for the Ryan White Program and health department HIV prevention cooperative agreements funded by the Centers for Disease Control and Prevention (CDC).

NASTAD appreciates the opportunity to provide recommendations on the upcoming HIV surveillance funding opportunity announcement (FOA) and urges CDC to be as transparent as allowable as the development process continues.

NASTAD offers the following recommendations:

**Do not destabilize HIV surveillance systems at this time.** HIV surveillance has been chronically underfunded in most jurisdictions. As a result, many states and directly funded cities cobble together their HIV surveillance programs with resources leveraged from other programs including other HIV surveillance activities such as incidence funding as well as HIV prevention and care. With the significant reallocation of resources to state and local health departments through *FOA PS12-1201 Comprehensive HIV Prevention Programs for Health Departments* which will likely result in the dramatic loss of funding to many states, the ability of these health departments to continue supporting surveillance activities will be greatly diminished. A similar shift in HIV surveillance resources will exacerbate the already untenable situation faced by most state health departments facing major funding losses. Given the uncertainty of funding for HIV prevention and the instability this is causing across the country, we recommend that there be no reallocation of funding for core HIV surveillance at this time.

**Eligibility for federal HIV surveillance funding should not change.** As described above, HIV surveillance activities are already woefully underfunded. Eligibility of

---

<sup>1</sup> [http://nastad.org/Docs/102406\\_National%20HIV%20Prevention%20Inventory%20-%20July%202009%20-%20FINAL.pdf](http://nastad.org/Docs/102406_National%20HIV%20Prevention%20Inventory%20-%20July%202009%20-%20FINAL.pdf)

additional health departments would only spread precious resources more thinly and is not an efficient use of inadequate federal resources for surveillance.

**Do not solely use new HIV diagnoses as the basis for any future HIV surveillance funding formula.** HIV surveillance program responsibilities extend well beyond accounting for newly identified HIV cases. With the advent of eHARs, HIV surveillance is now a document-based system with multiple documents created per case over long periods of time. Increasingly HIV surveillance program staff are responsible for data management and analysis related to linkage and retention in care for the ever increasing number of persons living with HIV. Any funding formula must account for this.

**The application of a funding formula in the future must not diminish the capacity of low morbidity jurisdictions.** As previously noted, NASTAD opposes shifting resources for core HIV surveillance activities at this time. Furthermore, regardless of the morbidity level within a jurisdiction, all health department surveillance programs are required to perform the same activities. While they carry out the same essential functions, there is an “economy of scale” and HIV surveillance activities per case cost less in higher morbidity jurisdictions. A funding formula must account for this differential cost or it runs the risk of seriously compromising the existing population-based HIV surveillance system in the U.S.

**A formula must address the true costs associated with core surveillance.** Rather than trying to construct a “cost per case” formula, CDC should seek input from funded jurisdictions over the next project period on the true costs of conducting core HIV surveillance activities. HIV surveillance requires an ever-increasing advanced level of expertise. Surveillance programs require personnel with extensive knowledge of data systems, software programming, database development and electronic data sharing and processes – in particular with the advent of Electronic Laboratory Reporting (ELR) and Electronic Medical Records (EMR). Additionally, with the revisions to the security and confidentiality guidelines, HIV, hepatitis, STD and TB programs may be required to support the partial time of a privacy officer to manage and log suspected or confirmed breaches to the security and confidentiality standards. The costs associated with these levels of personnel are significant and as stated earlier are required by all jurisdictions regardless of morbidity levels.

**Both CDC and HRSA resources should be available to support HIV surveillance.** In order to evaluate and describe the status of HIV prevention and care programs, health departments increasingly rely on HIV surveillance programs to collect data, generate reports and perform analyses. It is likely that most if not all of the indicators developed to measure progress towards the NHAS will be based upon HIV surveillance data. Furthermore, expectations from HRSA related to Early Identification of Individuals with HIV/AIDS (EIIHA), linkage to care, viral suppression and treatment adherence require expertise of HIV surveillance staff. HRSA resources, however, have not been

explicitly directed to HIV surveillance. CDC should continue to work with HRSA to identify opportunities for HRSA to supplement resources to contribute to surveillance functions.

**Preserve Integrated Communicable Disease Surveillance.** In many jurisdictions, HIV surveillance resources have also provided support for other communicable diseases, notably hepatitis C. It improves the system to have HIV surveillance staff cross-trained to advance hepatitis C surveillance, data management and analysis. Coupled with the shifts of resources for HIV prevention, a decrease in surveillance capacity will have impacts beyond HIV surveillance and may reduce surveillance capacity for hepatitis and STD programs as well.

**Identify opportunities for meaningful engagement regarding the future of HIV surveillance activities.** The questions CDC has posed regarding the FOA are complex and multi-faceted, and the immediate timeline for feedback has been inadequate. Careful consideration must be given to the elements which would construct a viable funding formula from which to allocation HIV surveillance resources. Moreover, with health departments still unsure of their HIV prevention funding levels, some of the information which must factor into a formula is unknown. NASTAD recommends a process of meaningful engagement between CDC and HIV surveillance coordinators, AIDS directors, state epidemiologists and other key stakeholders including a series of calls and/or face to face meetings on these issues. Any formula developed in the future must be well vetted and its implications for programs well anticipated before implementation. NASTAD urges CDC to be as transparent as allowable through out the process to facilitate the necessary discussion to inform the best decisions for U.S. HIV surveillance programs.