

Partnerships for Care (P4C): Health Departments and Health Centers Collaborating to Improve HIV Health Outcomes

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Project Framework

- Multi-site demonstration project
 - CDC/DHAP: 4 State HDs (FL, MA, MD, NY)
 - HRSA/BPHC: 22 FQHCs (4-6 per state) Non-Ryan White Part C funded
- Overarching Goal
 - Enhance collaboration between HDs and FQHCs to improve HIV outcomes along continuum of care, especially among racial/ethnic minority persons
- Strategies
 - Integrate HIV services into primary care
 - Interventional surveillance (“D2C”)



DATA-TO-CARE



HIV-Positive Persons in the P4C Services Area and Health Center
Patients Lost to Follow-Up

Data to Care (D2C)



- A public health strategy using surveillance and other data to identify people with HIV that may be in need of HIV medical care and services and facilitating linkage to those services. Examples include:
 - Persons not in care
 - Persons in care but with sustained high viral load
 - Mothers and infants in need of perinatal HIV services coordination
- Uses surveillance data to determine care status
 - CD4 or viral load test result as proxy for care visit and dates
- Data are used and shared for public health follow up
 - Continuum of Care = aggregate data for monitoring
 - D2C = individual data for public health action

Health Departments



**HIV
Surveillance
System**



FQHCs



**Electronic
Health
Records**

Improved HIV Outcomes



D2C Not-in-Care Groups

Health Department-Initiated Not-In-Care (HIV Surveillance System)

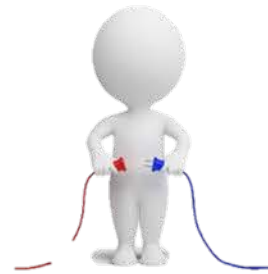


Persons in the P4C
Service Area



Never Linked

1



Previously Linked

2

FQHC-Initiated Not-In-Care (Electronic Health Records)



Former HC Patients Lost
to Follow-Up

3

P4C DATA-TO-CARE

- I. Have activities effectively identified people not in care and connected them to care?
- II. What are some strengths of the P4C collaborative D2C model?
- III. Can the process be improved?

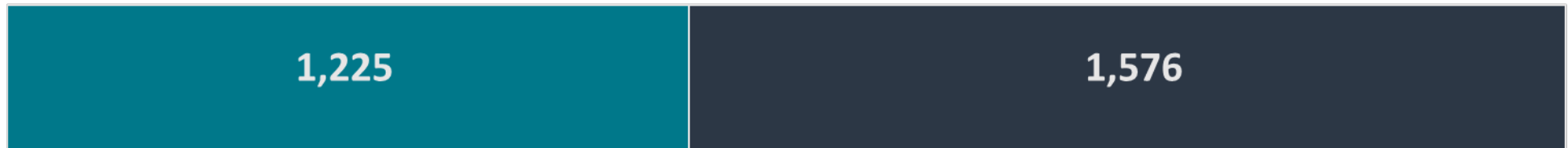
DATA-TO-CARE

- I. Have activities effectively identified people not in care and connected them to care?

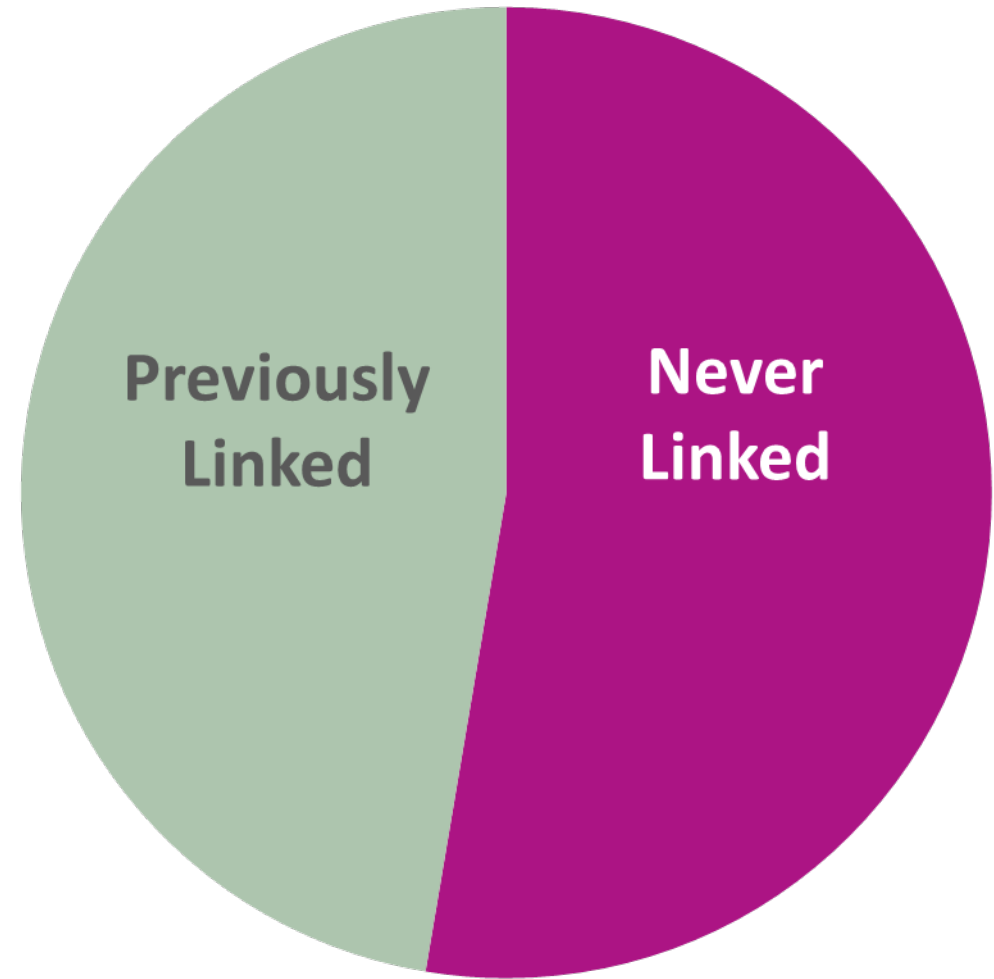
D2C Overall Outcomes



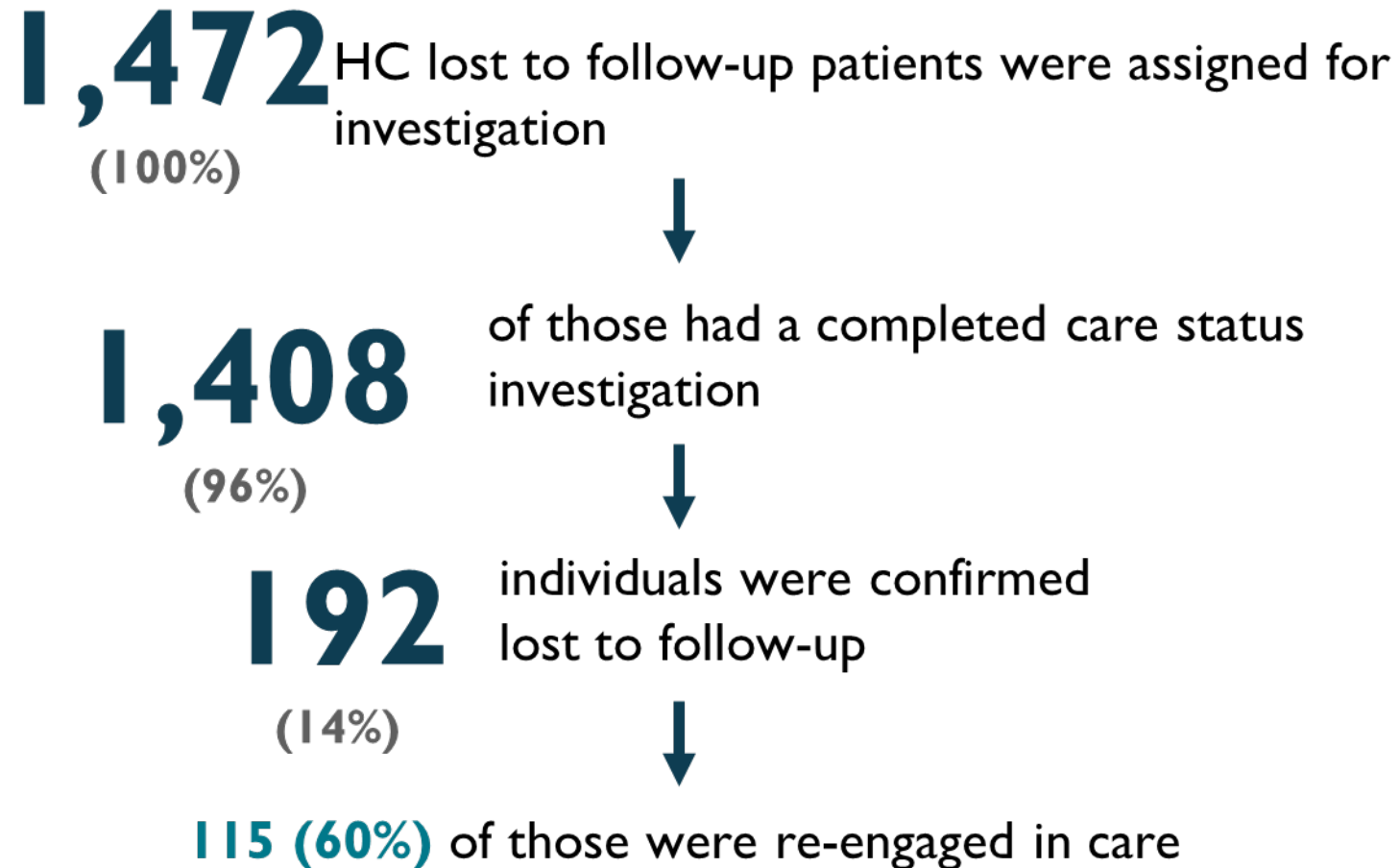
1,225 (44%) of confirmed NICs were **re-engaged in care**



53% of persons currently
'not-in-care' had previously
never been linked to care



Health Center Initiated: Lost to Follow-Up Patients



115
Re-engaged

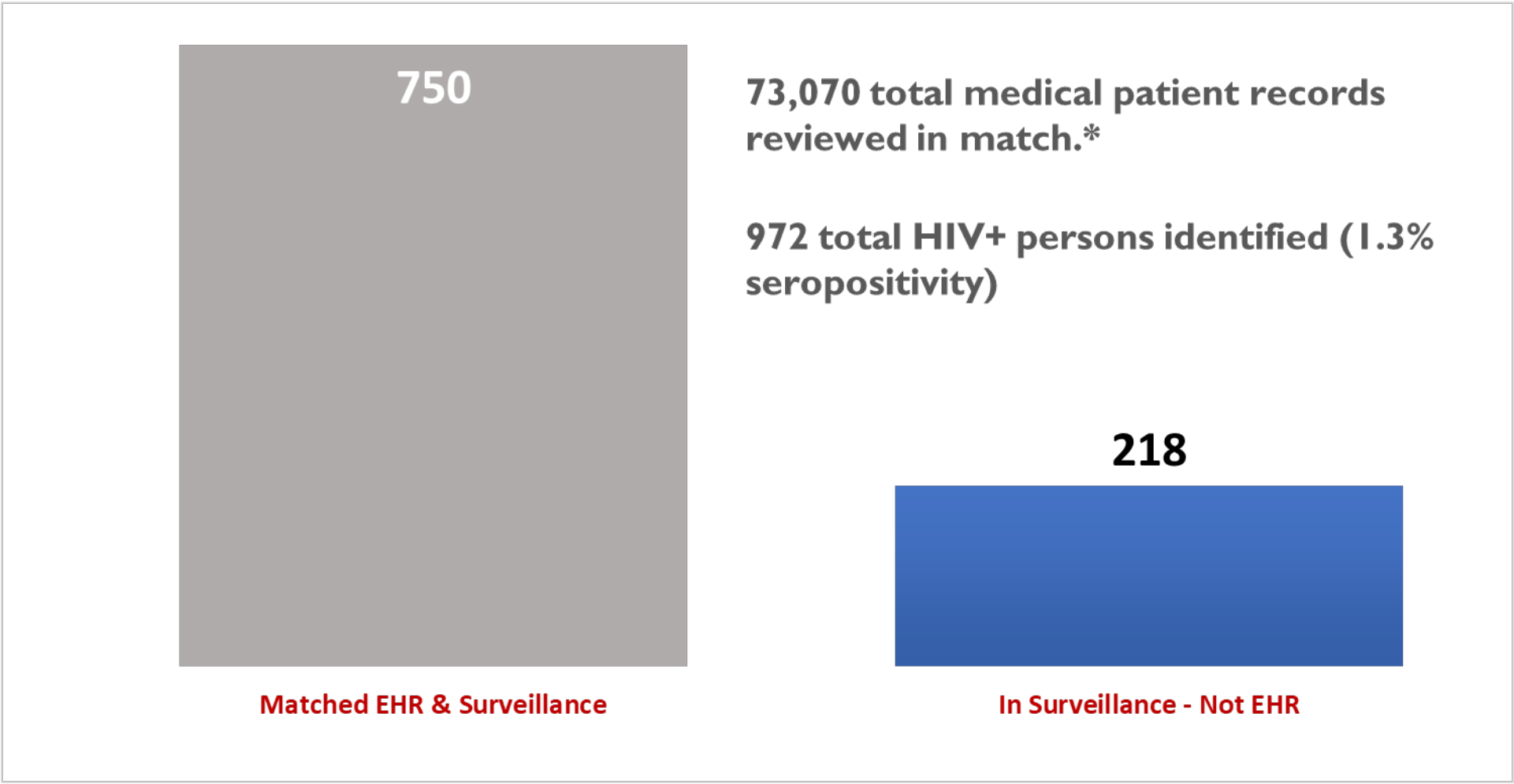
77
Not Re-engaged

DATA-TO-CARE

- II. What are some strengths of the P4C collaborative D2C model?

P4C Maryland Data Matching Results

FQHC Electronic Health Records & State Surveillance Registry



Hepatitis C Data to Care in Maryland

Program Approach



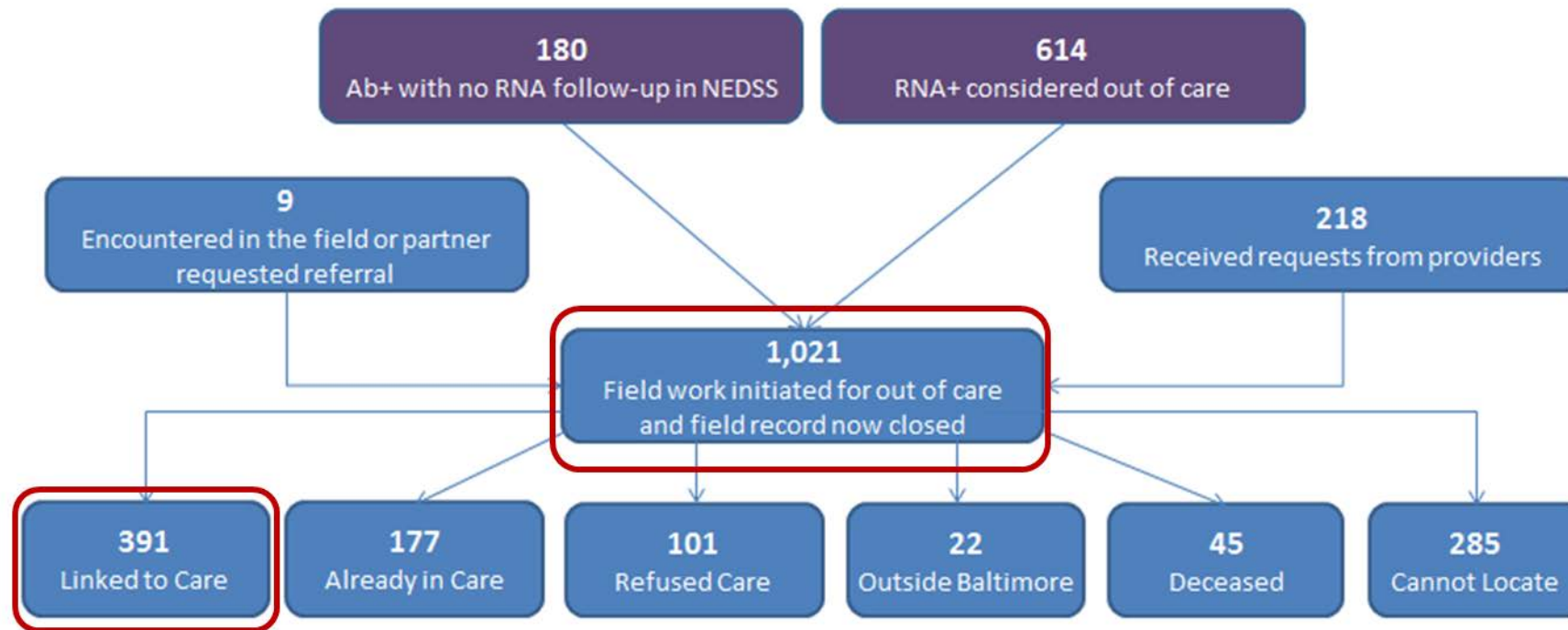
Surveillance Data

- Viral Hepatitis reportable in Maryland (COMAR 10.06.01.03)
- NEDSS HCV cases pulled from 7/1/12-11/30/15
- Share case information with participating Local Health Departments

Linkage to Care

- Outreach to providers
- Outreach to “out-of-care” patients
- Linkage-to-care work documented in PRISM

Informing HCV D2C Program



*Three individuals were encountered during outreach and requested a referral to HCV care. Two partners of the original client requested linkage to HCV testing. Both tested positive for active HCV infection and were linked to care.

P4C DATA-TO-CARE

III. Can the process be improved?

D2C CHALLENGES & OPPORTUNITIES

1. Establishing bi-directional data sharing agreements between DPH & providers can be complex and lengthy process
2. State statutes
3. Not-in-Care definitions, generating NIC lists, linkage outcomes
4. Electronic Health Records
5. Managing other external data sources for case investigations
6. Staffing (shift in skills)
7. Manual bi-directional data exchange & communication processes can be resource intensive and delay public health follow-up
8. Feedback to providers is an additional but important step

D2C CHALLENGES & OPPORTUNITIES

2. State statutes



"According to your HIPAA release form I can't share anything with you."

NY STATE PUBLIC HEALTH LAW

- ❖ 2010 - NYS Public Health Law broadened allowed use HIV surveillance data to locate out of care individuals and link them back to care. However, this information could not be shared with medical providers.
- ❖ 2015 - legislation passed expanding the permissible use of HIV surveillance data to allow NYSDOH to share patient specific HIV information with medical providers for the purposes of improving linkage to care (LTC)
- ❖ Formal guidance needed to be developed to operationalize what information could and could not be shared with individual providers
 - ❖ e.g., confirmed newly diagnosed status could not be shared
 - ❖ In the interim, data sharing protocols accommodated data sharing between HIV surveillance and the six partner FQHCs

Challenges in Florida

- Delays in development and implementation timelines
- Legal Issues
 - MOAs between health department and health centers
 - Client consent forms
- Data Sharing
 - Health centers and their EHR capabilities/costs associated with modifications
 - Format of shared data from multiple EHRs
 - Development time and processes
 - Consistent out-of-care definitions (linkage/retention)

D2C CHALLENGES & OPPORTUNITIES

3. Not-in-Care definitions, generating NIC lists, linkage outcomes

Not-In-Care Definitions

	Surveillance initiated definitions	Time Frame for Not-In-Care Status
FL	Never or previously linked	≥ 12 months without labs
MA	Previously linked	≥ 6 months without medical visit (after 12 months in care)
MA	Never linked	≥ 3 months post-diagnosis without medical visit
MD	Never or previously linked	≥ 13 months without labs (never linked diagnosed for 2-3 years currently prioritized)
NY	Previously linked – NYC	≥ 9 months without labs
NY	Previously linked – ROS	13-24 months without labs
NY	Never linked– NYC & ROS	≥ 3 months post-diagnosis without labs
	Health Center Initiated definitions	Time Frame for Not-In-Care Status
NY	Never linked - NYC & ROS	≥ 3 months post-diagnosis without medical visit
NY	Previously linked - NYC & ROS	≥ 9 months without medical visit

NY Defining “Not-in-Care”

Four definitions developed with input from our health centers

HICAPP/P4C Linkage to Care Cases

1. Health center patient 9 months

2. Health center October 2nd have NOT had HIV diagnosis

3. Presumed data for 9 months via HICAPP/P4C

4. Patients with HICAPP/P4C days of HIV

HICAPP/P4C Linkage to Care Cases

Health Center Initiated Case Assignments Submitted to HYSDOH

1. Health center patients who have NOT had an HIV-related medical visit with lab work (CD4/VL) in past 9 months.

Numerator: Number of health center patients who have NOT had an HIV-related medical visit with lab work (CD4/VL) in the past 9 months
Denominator: Number of HIV/AIDS patients at health center

2. Health center patients whose first ever HIV diagnosis was made by the health center between October 2nd of the previous reporting period and September 30th of the current reporting period who have NOT attended an HIV medical care visit within 90 days of HIV diagnosis.

Numerator: Number of health center patients whose first ever HIV diagnosis was made by the health center between October 2nd of the previous reporting period and September 30th of the current reporting period who have NOT attended an HIV medical care visit within 90 days of HIV diagnosis
Denominator: Number of HIV/AIDS patients at health center

Surveillance Initiated Case Assignments

3. PLWH Out-Of-Care: PLWH with no VL or CD4 labs within the HIV Tracking System in the past 13 to 24 months, whose last known address of residence was in the HICAPP/P4C service areas listed below [e.g., EDS generated assignments for the HICAPP/P4C service areas]

4. PLWH Diagnosed but Never Linked to Care: PLWH whose first ever HIV diagnosis was reported to NYSDOH or NYCDOHMH within the HICAPP/P4C service areas listed below who have no VL or CD4 reported within the past five years (January 1, 2010), excluding cases diagnosed within seven days of current date.

County	Jordan Health	Community Health Center of Buffalo	GHVHC	Danlan Family Care Centers	Betances Health Center	Bedford Stuyvesant Family Health Center
Wayne	Wayne	Niagara	Columbia	Queens	Queens	Queens
Monroe		Erie	Orange	Bronx	Bronx	Bronx
Ontario			Dutchess	New York	New York	New York
			Ulster	Kings	Kings	Kings
			Nassau			

HICAPP/P4C Cases

Newly Identified HIV+ Patient and/or Partner

- Health Center (HC) Previously Undiagnosed HIV+ Person: HIV Tracking/HIVS/HAS/CDEIS: 01 (all need to be PAC Evaluation Measure: HC2)
- Health Department Previously Undiagnosed HIV+ Partner: Partner of a newly diagnosed health center patient tested for HIV by the health center who had a new confirmed diagnosis of HIV identified through partner services. HIV Tracking/HIVS/HAS/CDEIS: 01 with health center code (will need to manually check partners of newly diagnosed) PAC Evaluation Measure: HD1

Previously Known Positive Health Center Patients

- Health Center Previously Known HIV+ Person: HIV+ patients currently in care at a partnering Health Center with identified risk. HIV Tracking/HIVS/HAS/CDEIS: 7 (PSU database) PAC Evaluation Measure: 0
- Health Department Previously Undiagnosed HIV+ Partner: Partner of a newly diagnosed health center patient tested for HIV by the health center who had a new confirmed diagnosis of HIV identified through partner services. HIV Tracking/HIVS/HAS/CDEIS: 01 with health center code (will need to manually check partners of newly diagnosed) PAC Evaluation Measure: HD1

Health Center Initiated Case Assignments Submitted to NYSDOH & NYCDOHMH¹

- Health Center PLWH Out-Of-Care: Health center PLWH patients who have NOT had an HIV-related medical visit in the past 9 months, excluding those who were diagnosed and never linked to care (case definition 5). HIV Tracking/HIVS/HAS/CDEIS: HC,00C (PSU database: HICAPP_P4C_00C) PAC Evaluation Measure: HC4
- Health Center PLWH Diagnosed but Never Linked to Care: Patients who received an HIV diagnosis at the health center at least 90 days prior to current date who have NOT attended an HIV medical care visit since. HIV Tracking/HIVS/HAS/CDEIS: HC,01C (PSU database: HICAPP_P4C_01C) PAC Evaluation Measure: HC3

Surveillance Initiated Case Assignments¹

- Surveillance PLWH Out-Of-Care: HIV Tracking/HIVS/HAS/CDEIS: EDS,00C (PSU database: HICAPP_P4C_00C) PAC Evaluation Measure: HC2

HICAPP/P4C Cases

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- Health Center PLWH Diagnosed but Never Linked to Care: Patients who received an HIV diagnosis at the health center at least 90 days prior to current date who have NOT attended an HIV medical care visit since. HIV Tracking/HIVS/HAS/CDEIS: HC,01C (PSU database: HICAPP_P4C_01C) PAC Evaluation Measure: HC3

Surveillance Initiated Case Assignments¹

- Surveillance PLWH Out-Of-Care: HIV Tracking/HIVS/HAS/CDEIS: EDS,00C (PSU database: HICAPP_P4C_00C) PAC Evaluation Measure: HC2

HICAPP/P4C Cases

Newly Identified HIV+ Patient and/or Partner¹

- Health Center (HC) Previously Undiagnosed HIV+ Person: Health center patient tested for HIV by the health center who had a new confirmed diagnosis of HIV identified through routine HIV testing. HIV Tracking/HIVS/HAS/CDEIS: 01 with health center code (will need to have provider report form indicate PAC HC) PAC Evaluation Measure: HC2
- Health Department Previously Undiagnosed HIV+ Partner: Partner of a newly diagnosed health center patient tested for HIV by the health center who had a new confirmed diagnosis of HIV identified through partner services. HIV Tracking/HIVS/HAS/CDEIS: 01 with health center code (will need to manually check partners of newly diagnosed) PAC Evaluation Measure: HD1

Previously Known Positive Health Center Patients

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Surveillance Initiated Case Assignments¹

- Surveillance PLWH Out-Of-Care: HIV Tracking/HIVS/HAS/CDEIS: EDS,00C (PSU database: HICAPP_P4C_00C) PAC Evaluation Measure: HC2

NYSDOH: PLWH with no VL or CD4 labs within the HIV Tracking System in the past 13 to 24 months, whose last known address of residence was in the HICAPP/P4C service areas listed below [e.g., EDS generated assignments for the HICAPP/P4C service areas]

NYCDOHMH: PLWH with no VL or CD4 labs within gSRAS in the past 9 months, whose last known address of residence/provider was in the HICAPP/P4C service areas listed below

HIV Tracking/HIVS/HAS/CDEIS: EDS,00C (PSU database: HICAPP_P4C_00C) PAC Evaluation Measure: HC2

HIV Tracking/HIVS/HAS/CDEIS: EDS,01C (PSU database: HICAPP_P4C_01C) PAC Evaluation Measure: HC3

County	Jordan Health	Community Health Center of Buffalo	GHVHC	Danlan Family Care Centers	Betances Health Center	Bedford Stuyvesant Family Health Center
Wayne	Wayne	Niagara	Columbia	Queens	Queens	Queens
Monroe		Erie	Orange	Bronx	Bronx	Bronx
Ontario			Dutchess	New York	New York	New York
			Ulster	Kings	Kings	Kings
			Nassau			

Key:
 HICAPP - High Impact Care and Prevention Project
 Da - Diagnosed
 HLTC - Never linked to care
 S - Surveillance
 PAC - Partnerships for Care
 EDS - Expanded Partner Services
 NYSDOH - New York State Electronic HIV Management System
 CDEIS - Communicable Disease Electronic Surveillance System
 PSU - Field Services Unit

¹ In NYC, these cases will be worked by Partner Services staff, not HICAPP linkage specialist. Data on these cases will be submitted with HICAPP cases during monthly data submissions.
² Submitted at least quarterly
³ Run monthly
⁴ Run monthly
 NYSDOH will base case assignment on address of last known residence. NYCDOHMH will base case assignment on address of last known provider.
 8/4/2016 version 10

D2C CHALLENGES & OPPORTUNITIES

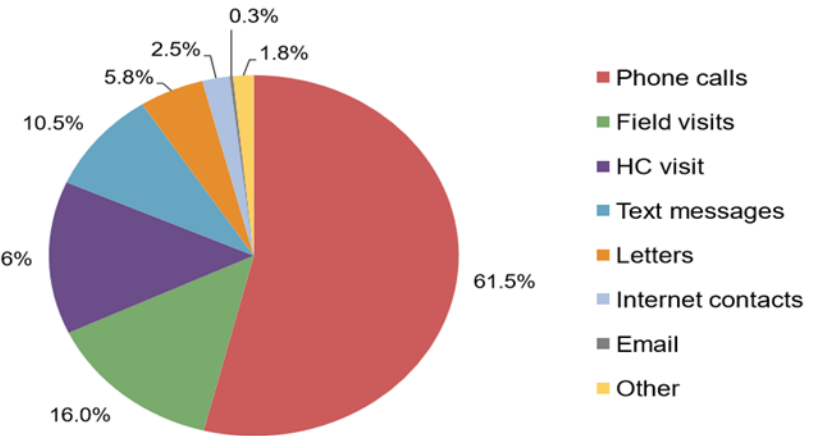
6. Staffing (shift in skills)

D2C STAFFING

- ❖ Traditional DIS/linkage coordinators
- ❖ Hiring epidemiologists as field staff
 - Data and technology background
 - Support provider education and coordination

- ❖ Emphasis on monitoring client engagement efforts for impact

Types of Field Epidemiologist Engagement



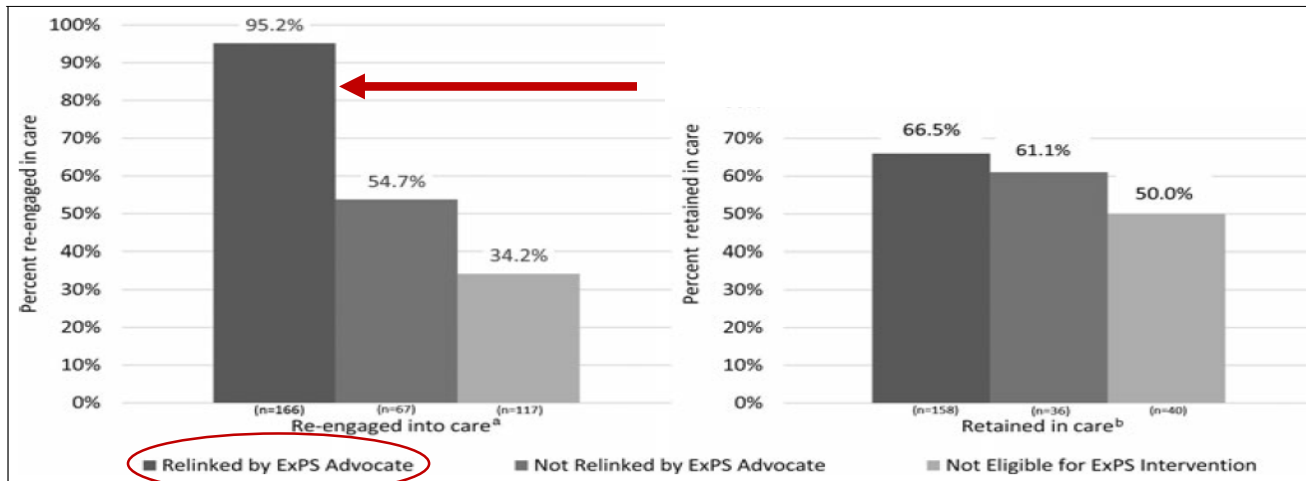
	Newly diagnosed cases (N=27)	Out of care cases (N=70)	All closed cases (N=97)
Average contacts per case	2.2	3.8	3.4
Median contacts per case	1.0	4.0	3.0
Range of contacts per case	0 – 9	0 – 13	0 – 13
Total contact attempts for all cases	58	267	325

Linkage to care	87%	50%
Linked by Field Epi	48%	69%

Improving Retention in HIV Care Through New York's Expanded Partner Services Data-to-Care Pilot

James M. Tesoriero, PhD; Britney L. Johnson, MPH; Rachel Hart-Malloy, PhD, MPH; Jennifer L. Cukrovany, BS; Brenda L. Moncur, MS, PMP; Kathleen M. Bogucki, MPH; Bridget J. Anderson, PhD; Megan C. Johnson, MPH

J Public Health Manag Pract 2017
May/Jun; 23(3):255-263



- **Objective:** Investigate feasibility of D2C approach applied to Partner Services program
- **Results:** Individuals relinked by ExPS DIS were more likely to reengage in care
- **Conclusions:** D2C can be effective when conducted outside a large MSA and/or closed health care systems. It can also be effectively incorporated into existing PS programs.

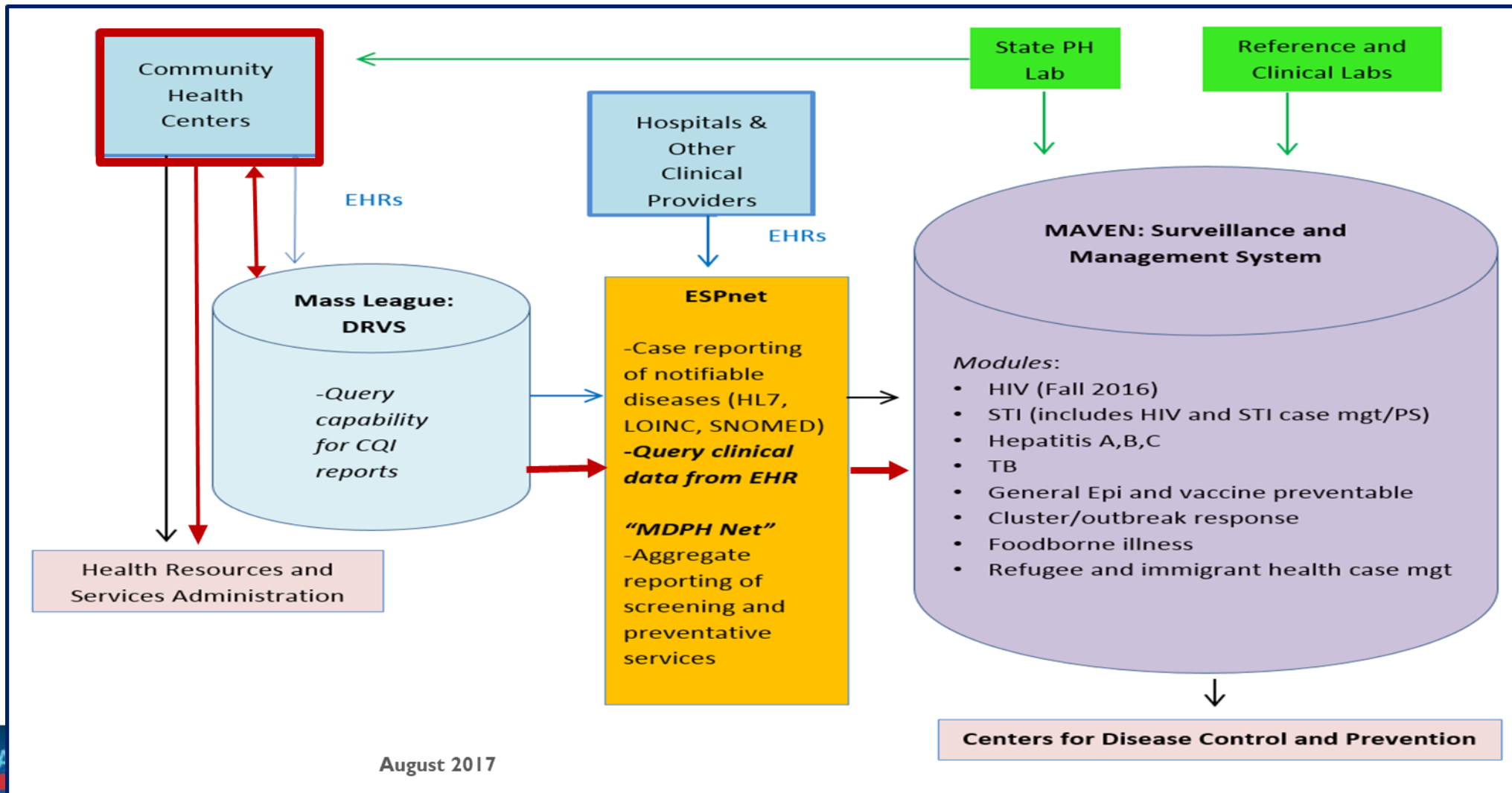
D2C CHALLENGES & OPPORTUNITIES



7. Manual bi-directional data exchange processes can be resource intensive and delay public health follow-up



Automated Notifiable Disease Surveillance & Case Management



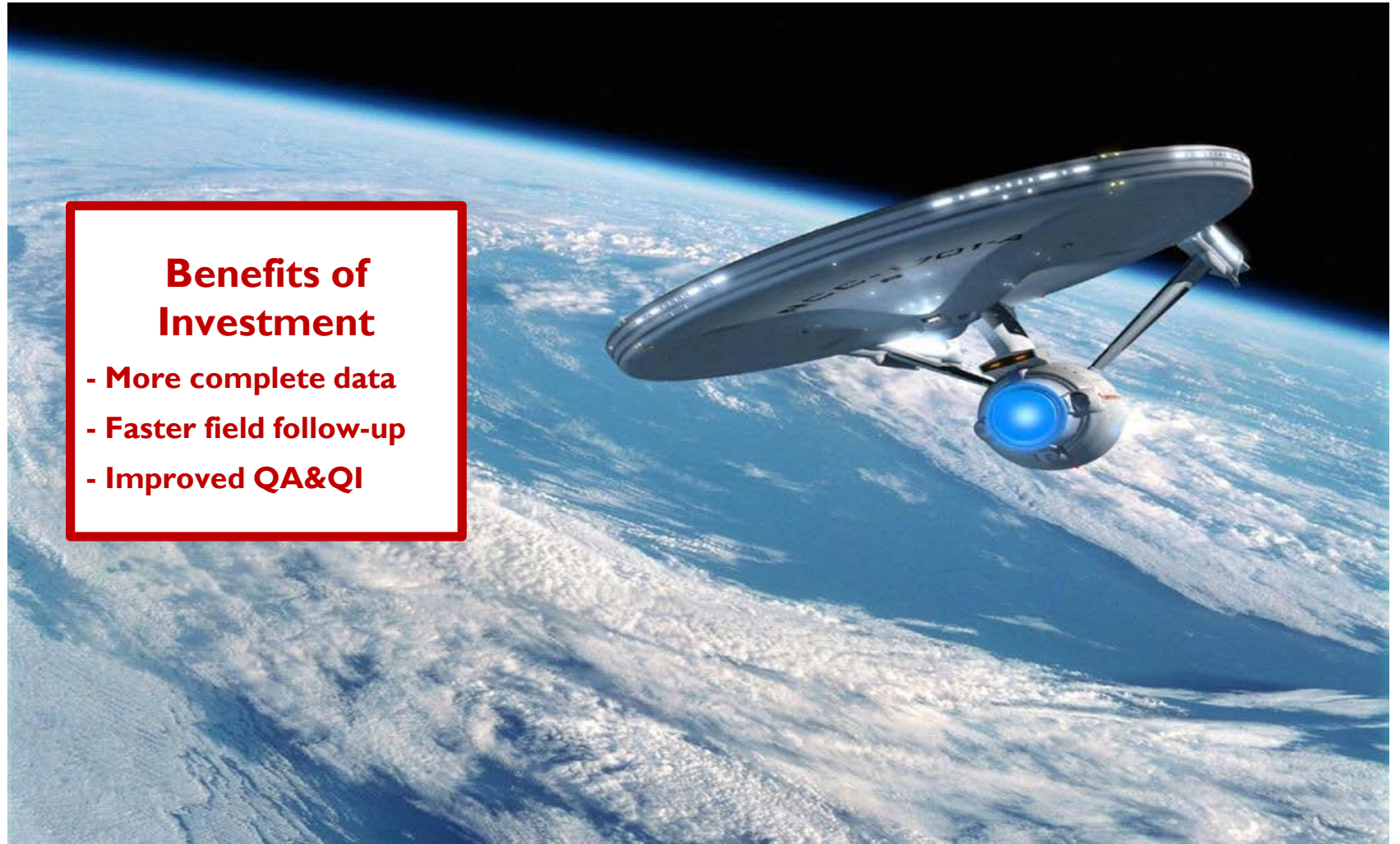
August 2017



“NEXT FRONTIER” OF D2C

Benefits of Investment

- More complete data
- Faster field follow-up
- Improved QA&QI



Disclaimer

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



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