2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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”)


Florida
HEALTH


MARYLAND
Department of Health
and Mental Hygiene


COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH


NEW YORK STATE
Department of Health
AIDS Institute


Broward Community & Family Health Centers, Inc.


CG
Community Clinic, Inc


Codman Square
Health Center


BEDFORD-STUYVESANT
FAMILY HEALTH CENTER


care resource


Family
Health Centers
of Baltimore


HealthFirst
Family Care Center


BETANCES
HEALTH CENTER


CHI
COMMUNITY HEALTH
of SOUTH FLORIDA, INC.
"Patient Care Comes First"


LOWELL
HEALTH
CENTER


Your Partner for Quality Care
CHCB
COMMUNITY
HEALTH CENTER OF BUFFALO


GENESIS
COMMUNITY HEALTH


HEALTH CARE
for the HOMELESS


Mattapan Community
Health Center


CORNERSTONE
FAMILY HEALTHCARE


ORANGE BLOSSOM
FAMILY HEALTH


Park West Health System
"Putting Patients First"


NSCH


D
F
C
C


Sulzbacher Center
The Way Home


WHITTIER STREET
HEALTH CENTER
Comprehensive. Compassionate. Community.

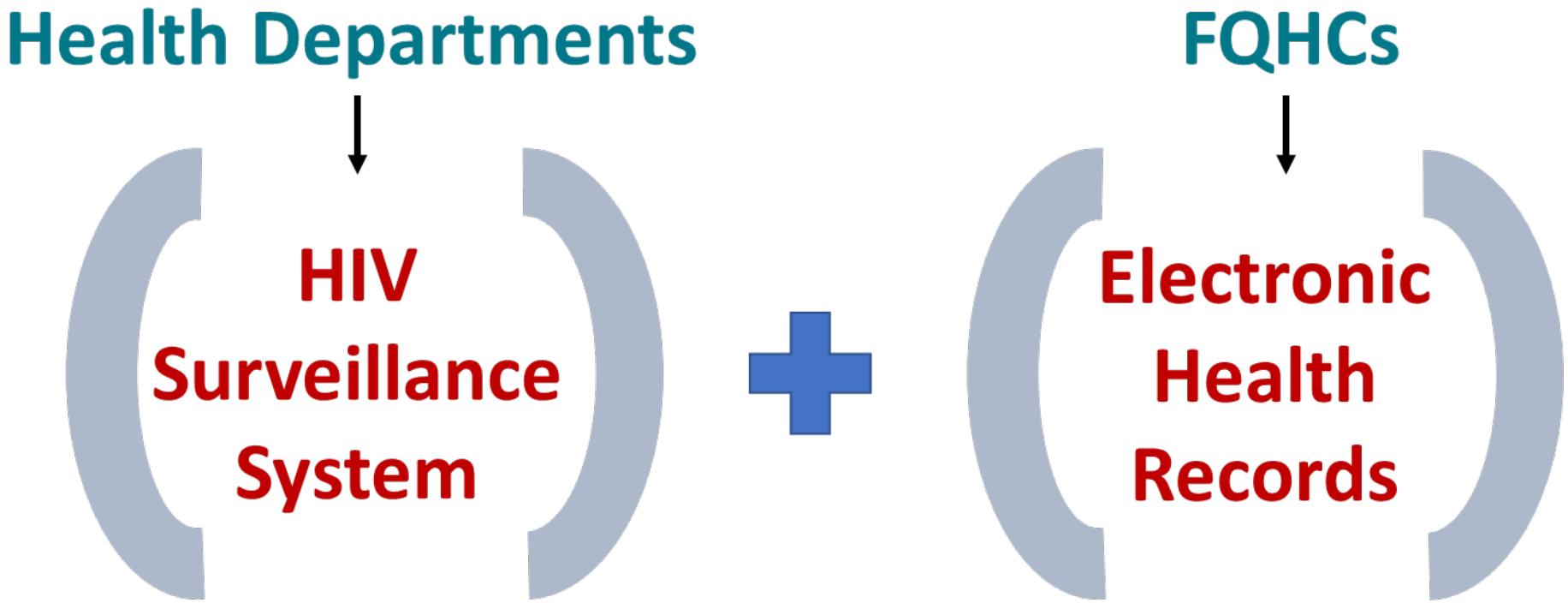

JH
Jordan Health

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



Improved HIV Outcomes

D2C Not-in-Care Groups

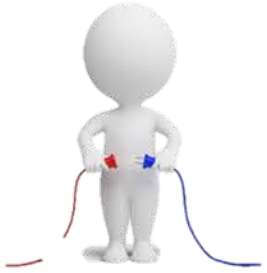
Health Department-Initiated
Not-In-Care
(HIV Surveillance System)

↓

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

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

D2C Overall Outcomes

8,527 presumed NIC assigned for investigations

→

4,971 (58%) presumed NIC with a known care status

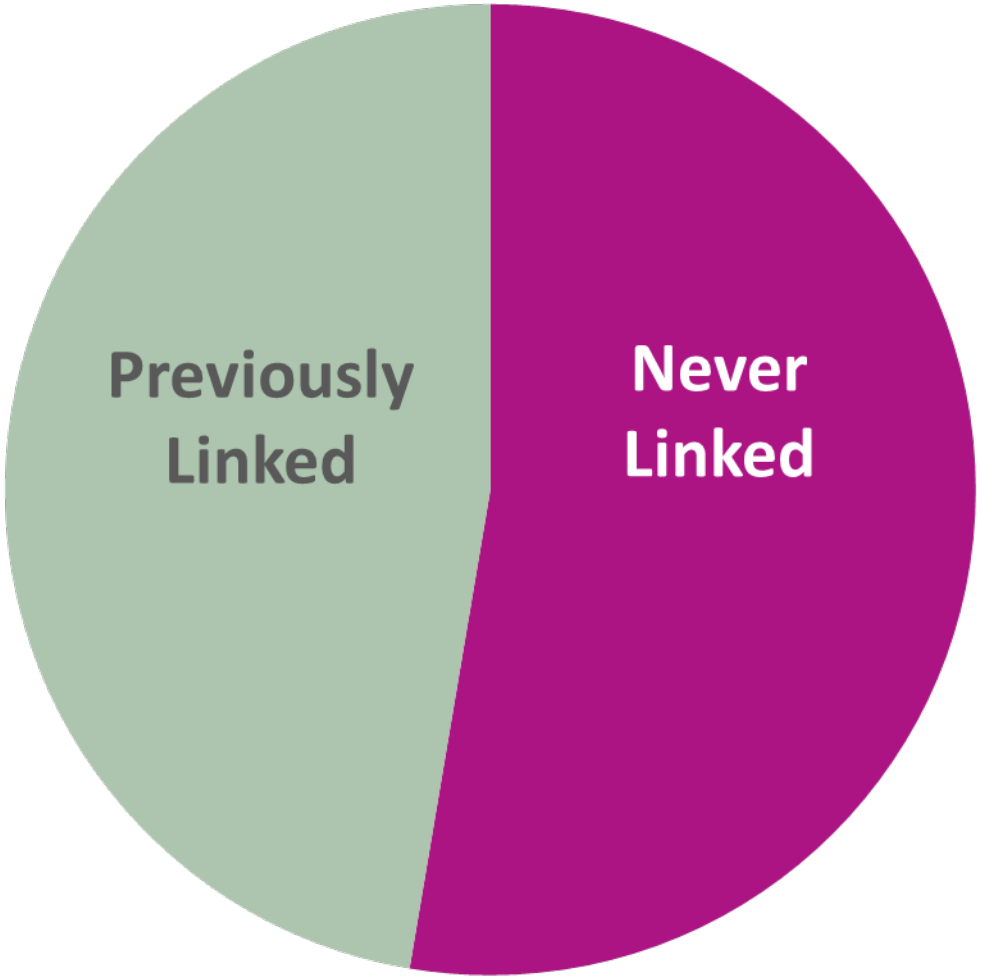
→

Of those,

2,801 (56%) are confirmed NICs

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

1,472 (100%) HC lost to follow-up patients were assigned for investigation

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1,408 (96%) of those had a completed care status investigation

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192 (14%) individuals were confirmed lost to follow-up

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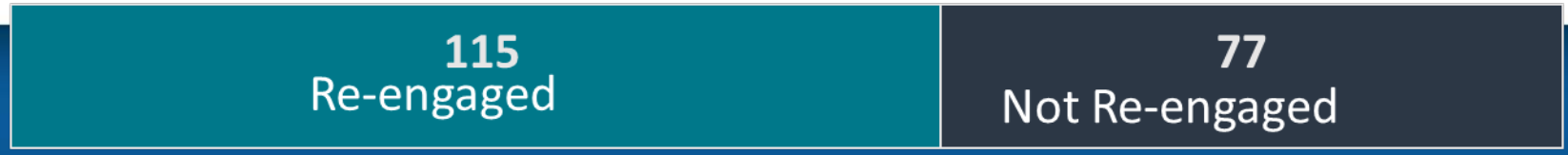
115 (60%) of those were re-engaged in care

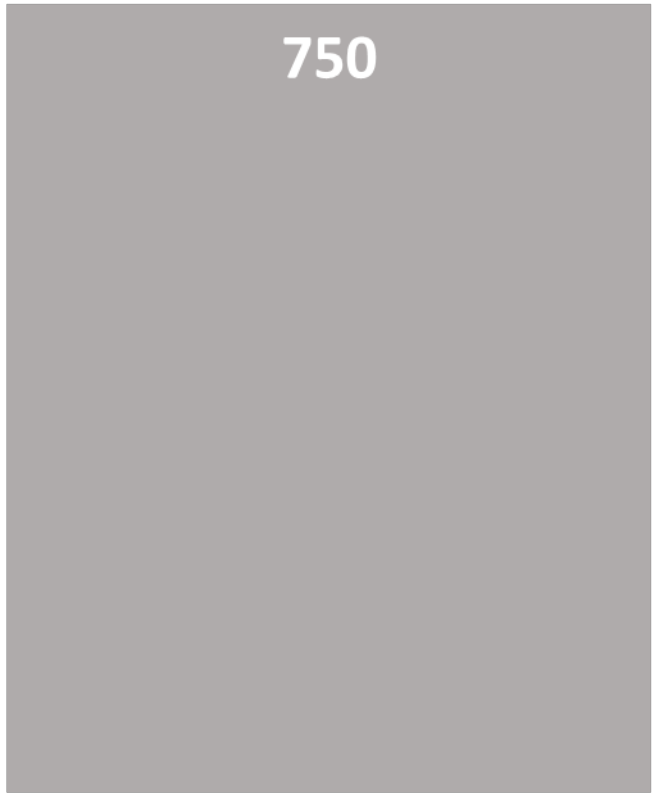


DATA-TO-CARE

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

P4C Maryland Data Matching Results

FQHC Electronic Health Records & State Surveillance Registry



Matched EHR & Surveillance

73,070 total medical patient records reviewed in match.*

972 total HIV+ persons identified (1.3% seropositivity)

In Surveillance - Not EHR

Hepatitis C
Data to Care in Maryland

Program Approach

BALTIMORE CITY HEALTH DEPARTMENT

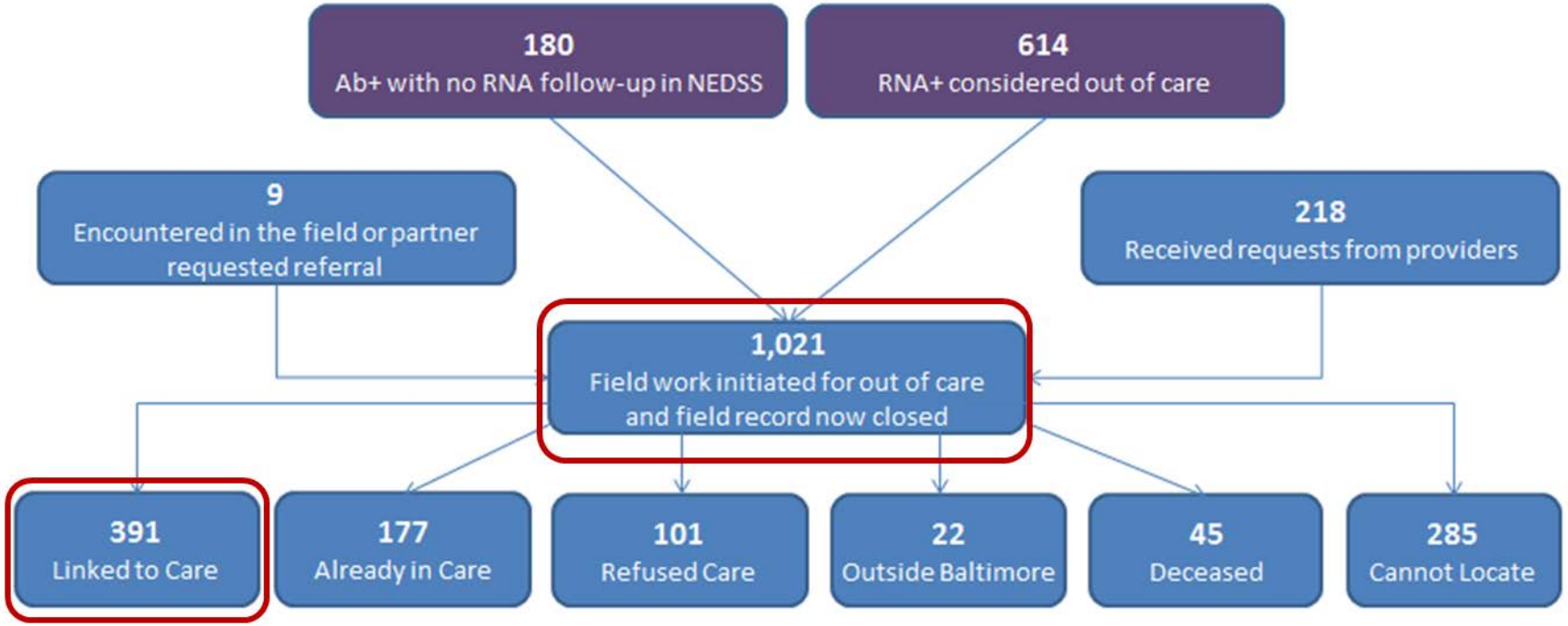
Surveillance Data

- 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

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

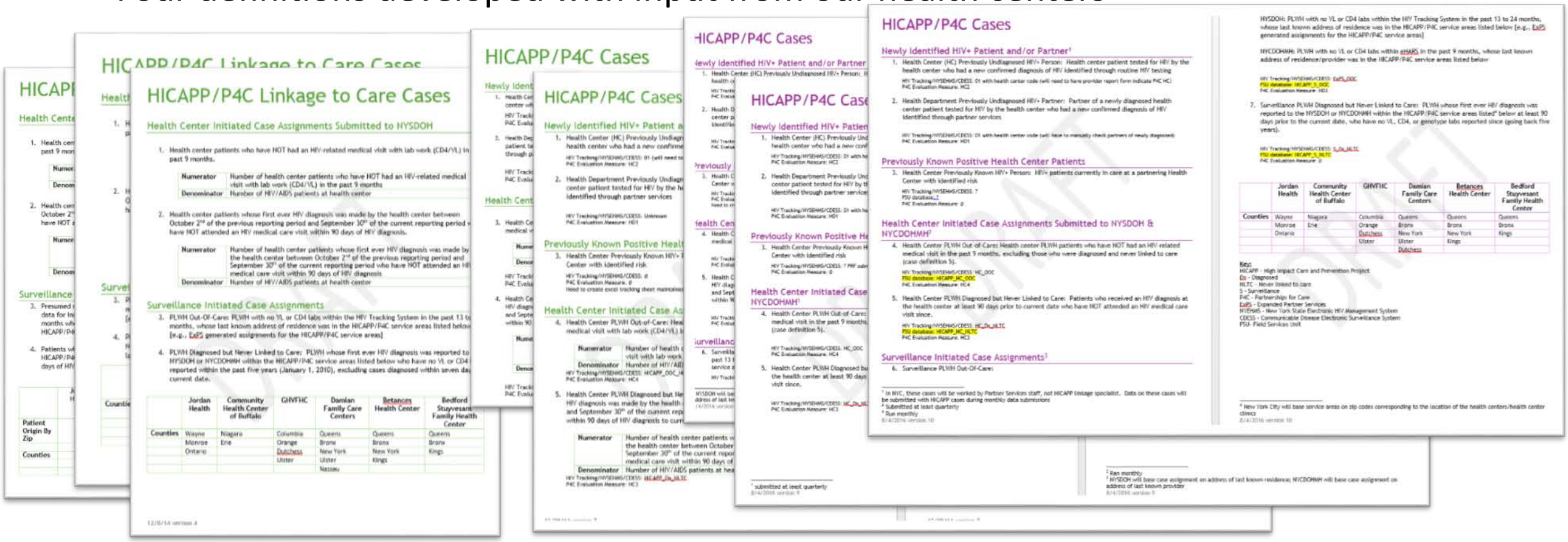
3. Not-in-Care definitions, generating NIC lists, linkage outcomes

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



D2C CHALLENGES & OPPORTUNITIES

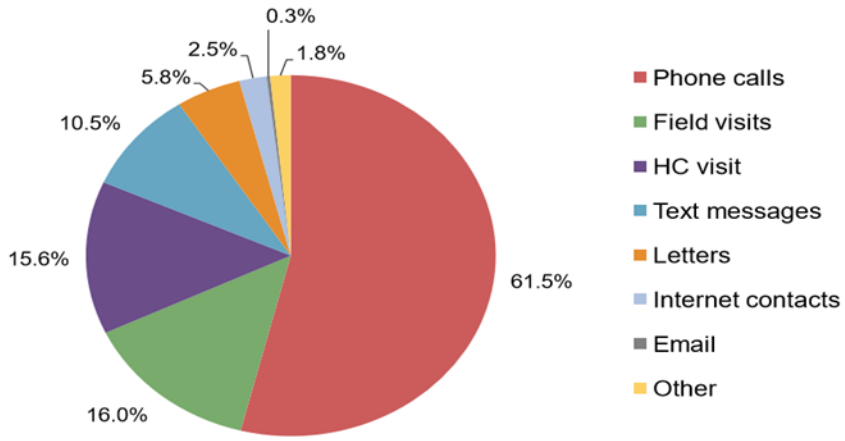
6. Staffing (shift in skills)

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

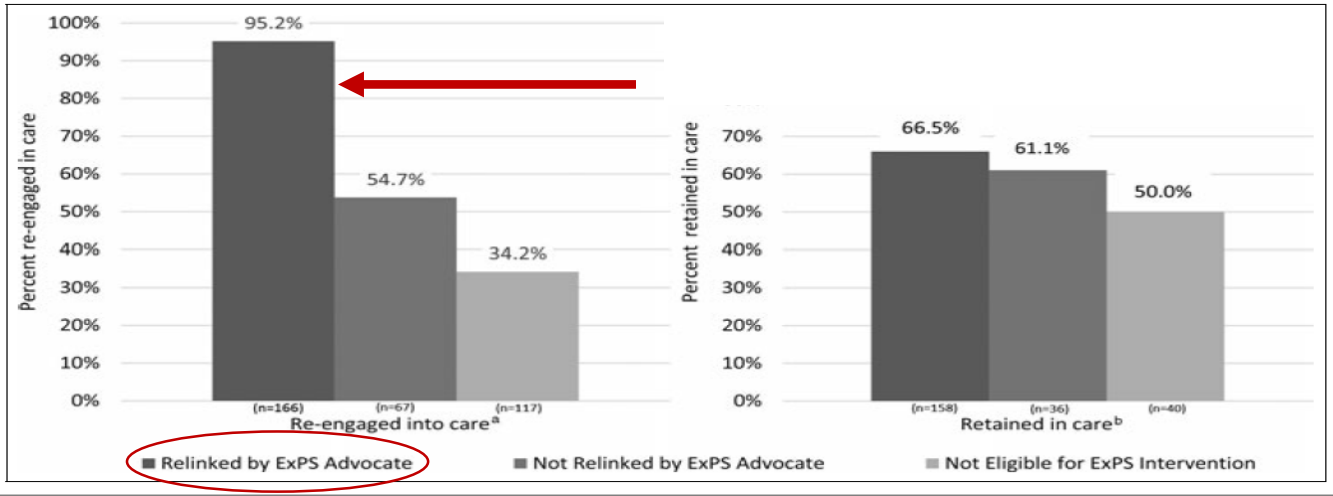
Linkage to care	87%	50%
Linked by Field Epi	48%	69%

Research Article

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

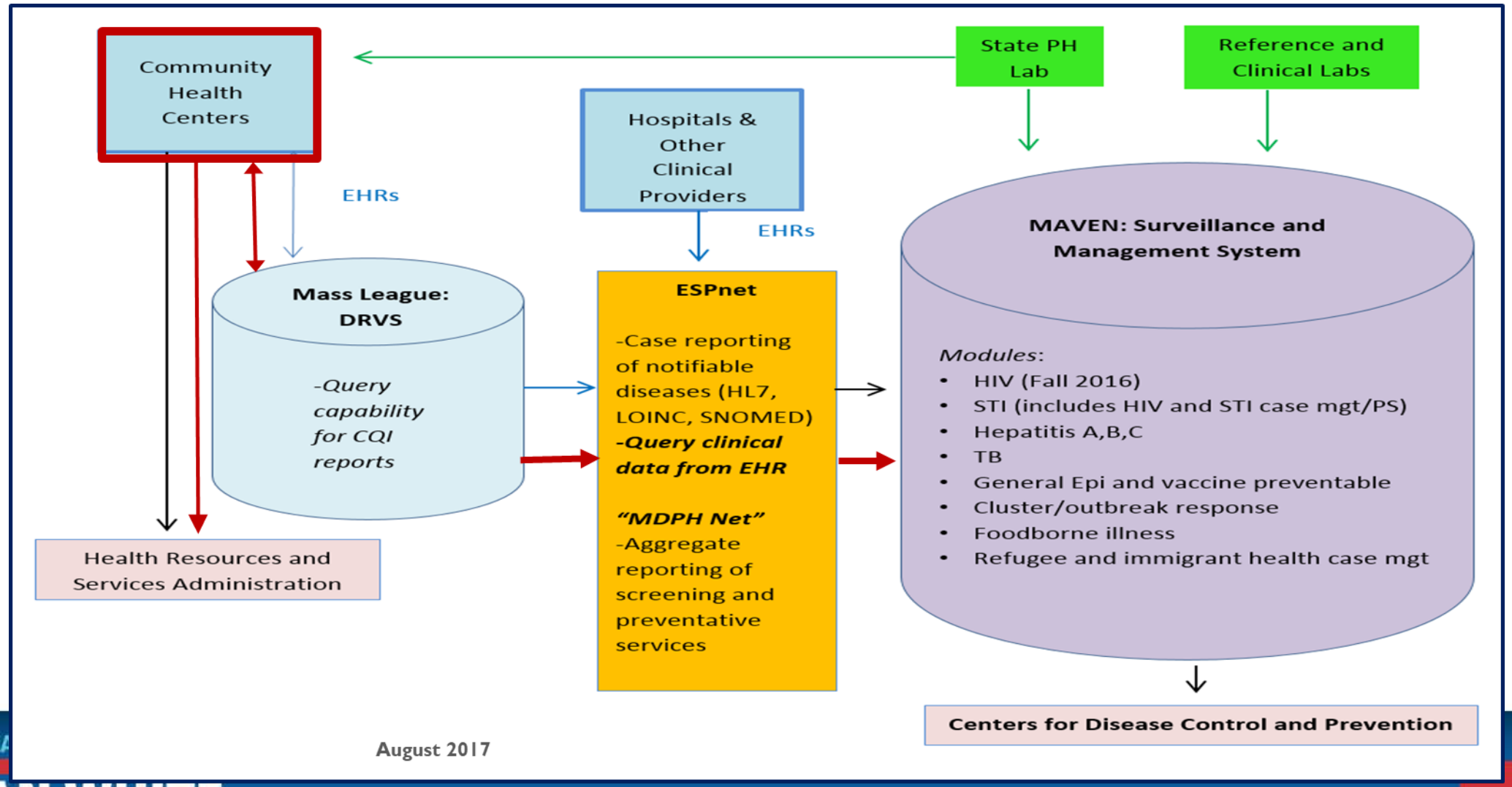


- **Objective:** Investigate feasibility of D2C approach applied to Partner Services program
- **Results:** Individuals relinked by ExPS DIS were more likely to reengage in care
- **Conclusions:** D2C can be effective when conducted outside a large MSA and/or closed health care systems. It can also be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

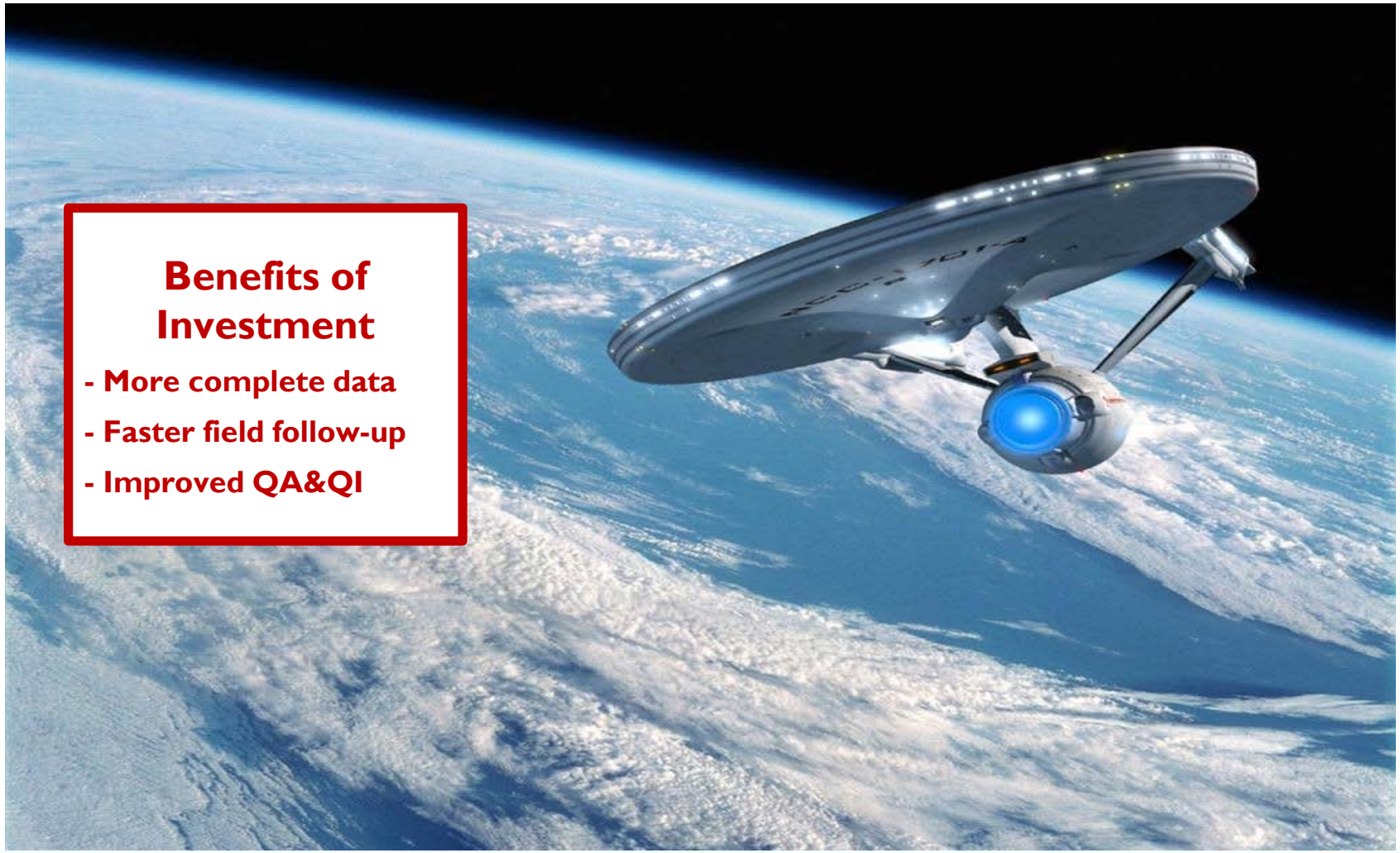
D2C CHALLENGES & OPPORTUNITIES

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

Automated Notifiable Disease Surveillance & Case Management



"NEXT FRONTIER" OF D2C



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