USCA HRSA Track: Moving Forward on the HIV Continuum of Care

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HIV/AIDS Bureau
Health Resources and Services Administration

USCA 2015 - September 12, 2015

Outline

- About the Ryan White HIV/AIDS Program (RWHAP)
- Who we serve
- The RWHAP HIV continuum of care
- Next steps
- Today's seminar

Ryan White CARE Act 25th Anniversary

Ryan White CARE Act 25th Anniversary

"Moving Forward with CARE: Building on 25 Years of Passion, Purpose, and Excellence"

HRSA
Ryan White & Global HIV/AIDS Programs

Ryan White HIV/AIDS Program Overview

- **Part A (Cities)**
- **Part B (States and Territories)**
  - ADAP – AIDS Drug Assistance Program
- **Part C (Community-based Organizations)**
  - Early Intervention Services and Capacity Development
- **Part D (Women, Infants, Children and Youth)**
- **Part F (Other Programs)**
  - AIDS Education and Training Centers (AETCs)
  - Special Projects of National Significance (SPNS)
  - Dental Programs
  - Minority AIDS Initiative (MAI)

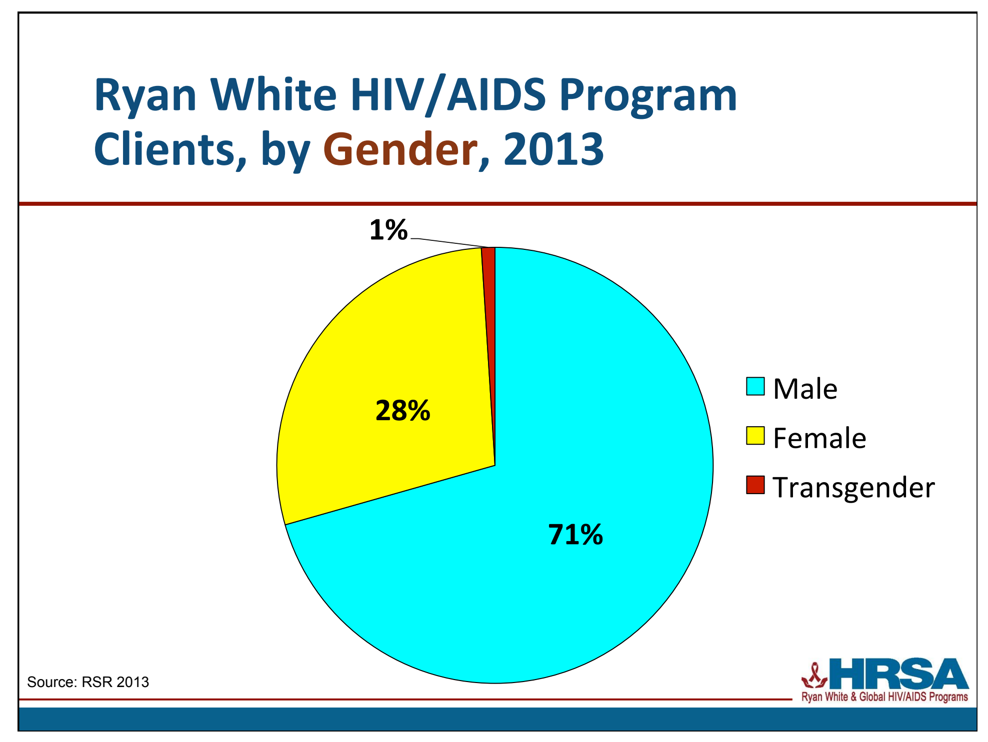
Ryan White HIV/AIDS Program and Healthcare

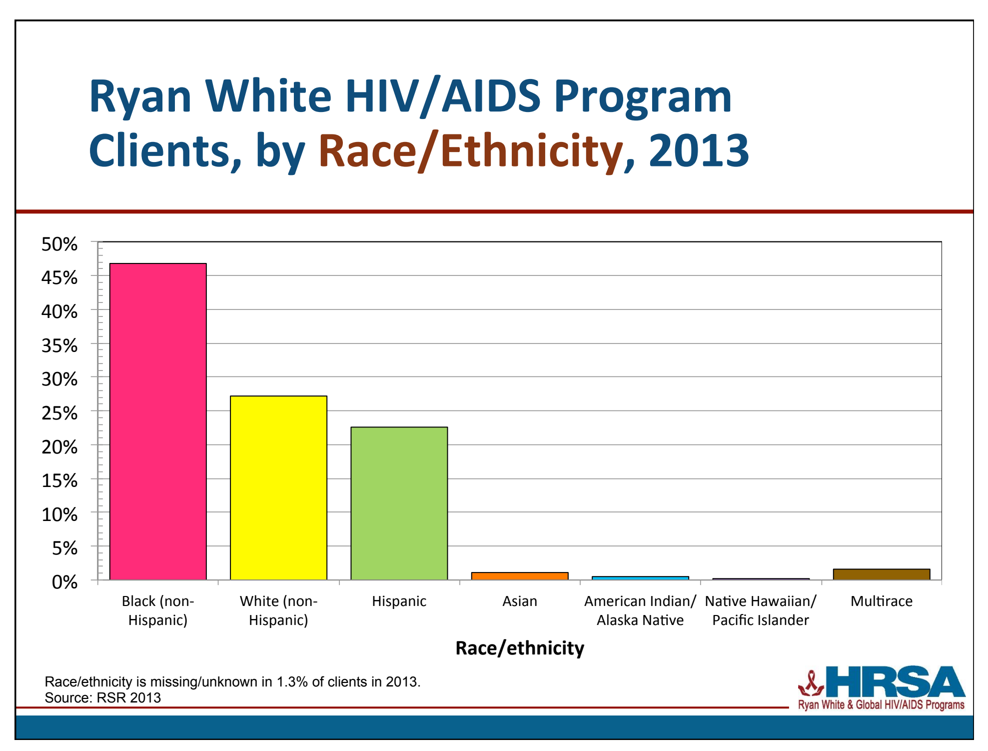
- The RWHAP supports a **dynamic and complex system of care**; it is not an insurance program for discrete services
- The **need for an HIV care system for low-income PLWH remains** until the outcomes on the HIV care continuum are addressed and there is a cure

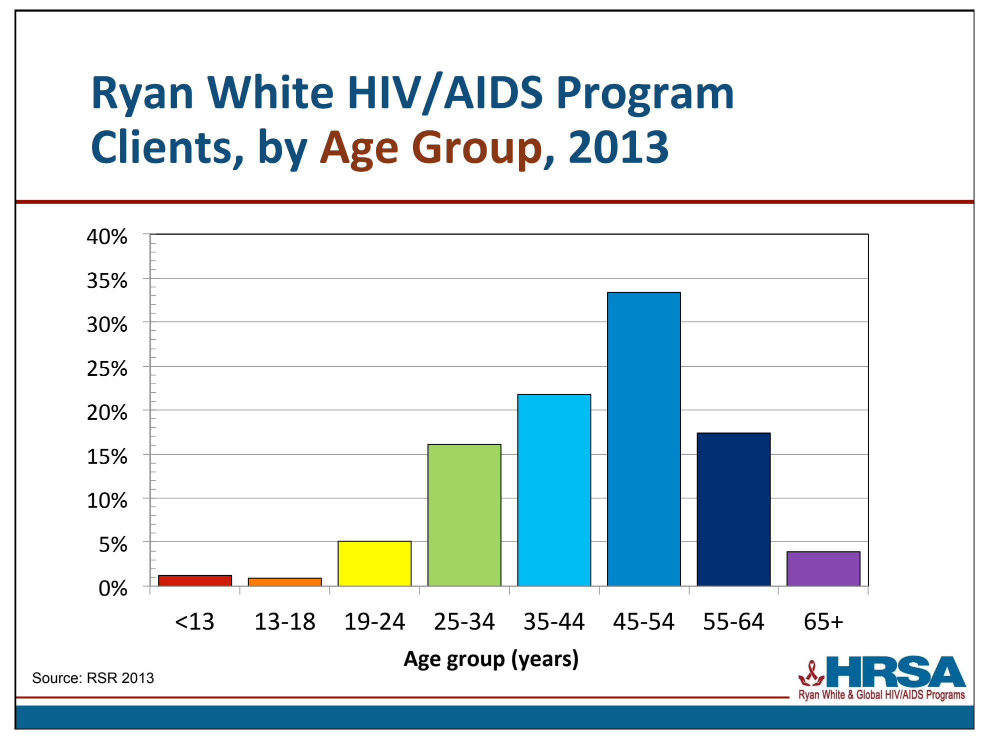
Who We Serve

Ryan White HIV/AIDS Program	**Served half a million (524,675) people** 2013
Care Engagement	~**2 out 3** PLWH engaged in medical care served by RWHAP
Demographics	47% Black/African American 23% Hispanic (2013) **~90%** living at/below 200% Federal Poverty Level (2013)

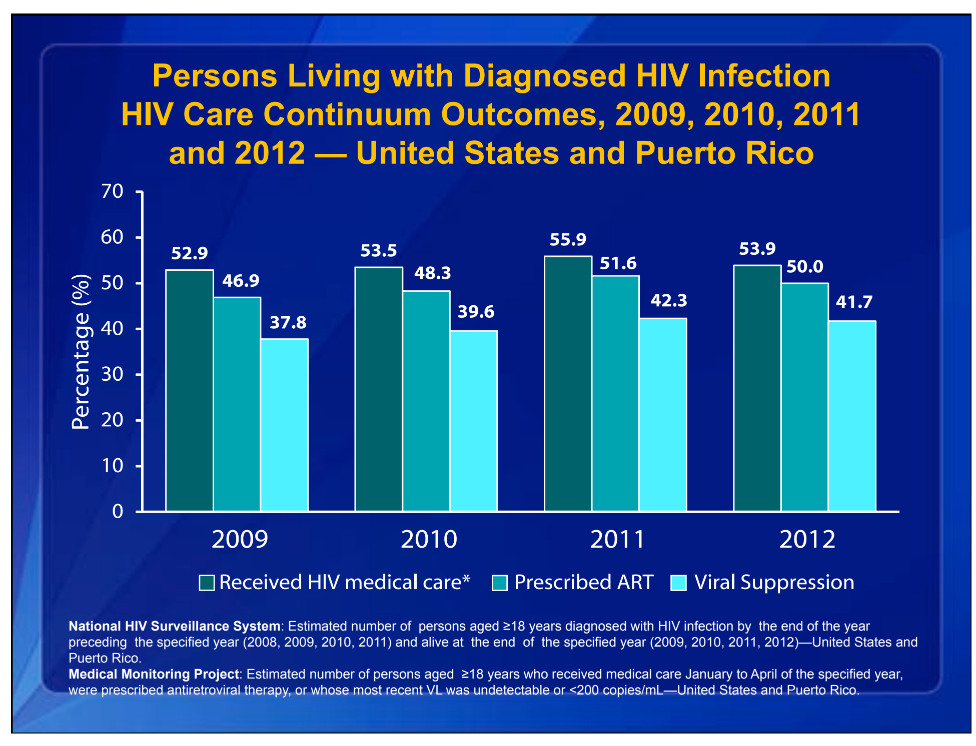
Source: RSR 2013

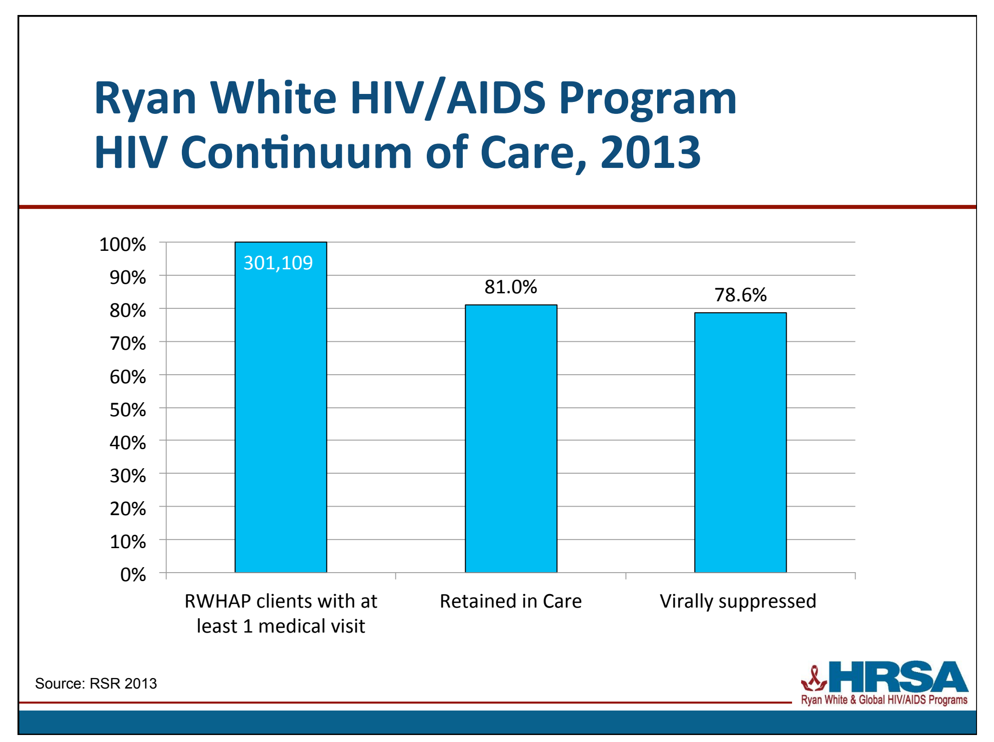

Ryan White HIV/AIDS Program
Clients, by Gender, 2013
1%
28%
71%
Male
Female
Transgender
Source: RSR 2013
HRSA
Ryan White & Global HIV/AIDS Programs

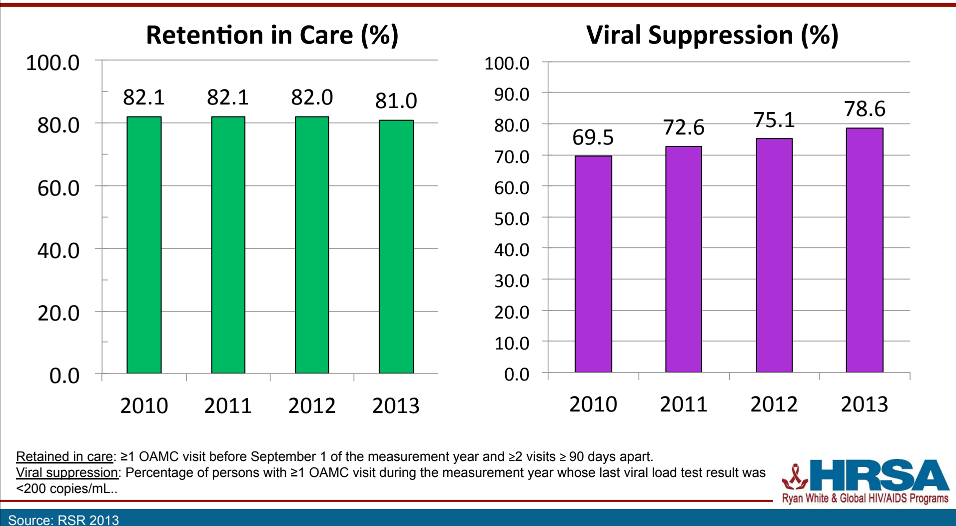

Ryan White HIV/AIDS Program
Clients, by Race/Ethnicity, 2013
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Black (non-Hispanic)
White (non-Hispanic)
Hispanic
Asian
American Indian/ Alaska Native
Native Hawaiian/ Pacific Islander
Multirace
Race/ethnicity
Race/ethnicity is missing/unknown in 1.3% of clients in 2013.
Source: RSR 2013
HRSA
Ryan White & Global HIV/AIDS Programs

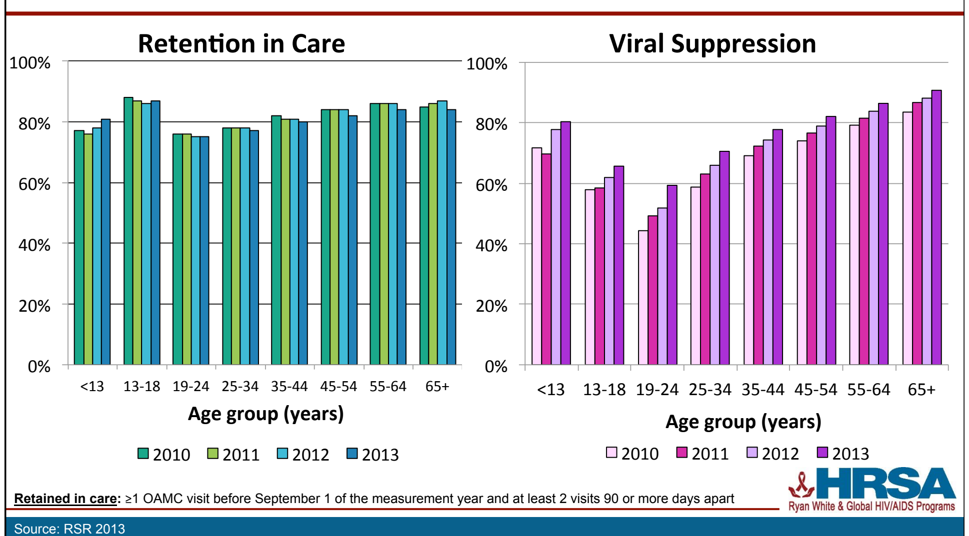

Ryan White HIV/AIDS Program
Clients, by Age Group, 2013
40%
35%
30%
25%
20%
15%
10%
5%
0%
<13
13-18
19-24
25-34
35-44
45-54
55-64
65+
Age group (years)
Source: RSR 2013
HRSA
Ryan White & Global HIV/AIDS Programs

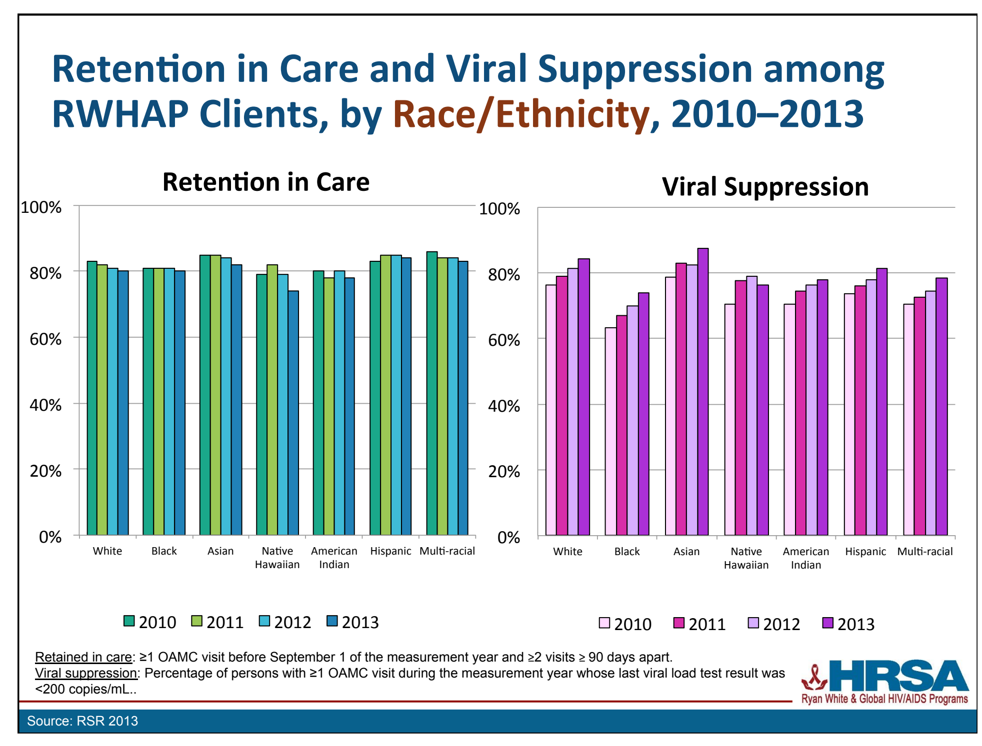
The RWHAP
HIV Continuum
of Care


Persons Living with Diagnosed HIV Infection
HIV Care Continuum Outcomes, 2009, 2010, 2011 and 2012 — United States and Puerto Rico
Percentage (%)
0
10
20
30
40
50
60
70
52.9
46.9
37.8
53.5
48.3
39.6
55.9
51.6
42.3
53.9
50.0
41.7
2009
2010
2011
2012
Received HIV medical care*
Prescribed ART
Viral Suppression
National HIV Surveillance System: Estimated number of persons aged ≥18 years diagnosed with HIV infection by the end of the year preceding the specified year (2008, 2009, 2010, 2011) and alive at the end of the specified year (2009, 2010, 2011, 2012)—United States and Puerto Rico.
Medical Monitoring Project: Estimated number of persons aged ≥18 years who received medical care January to April of the specified year, were prescribed antiretroviral therapy, or whose most recent VL was undetectable or <200 copies/mL—United States and Puerto Rico.


Ryan White HIV/AIDS Program
HIV Continuum of Care, 2013
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
301,109
81.0%
78.6%
RWHAP clients with at least 1 medical visit
Retained in Care
Virally suppressed
Source: RSR 2013
HRSA
Ryan White & Global HIV/AIDS Programs


Retention in Care & Viral Suppression among Ryan White HIV/AIDS Program Clients 2010 – 2013
Retention in Care (%)
100.0
80.0
60.0
40.0
20.0
0.0
82.1
82.1
82.0
81.0
2010
2011
2012
2013
Viral Suppression (%)
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
69.5
72.6
75.1
78.6
2010
2011
2012
2013
Retained in care: ≥1 OAMC visit before September 1 of the measurement year and ≥2 visits ≥ 90 days apart.
Viral suppression: Percentage of persons with ≥1 OAMC visit during the measurement year whose last viral load test result was <200 copies/mL..
HRSA
Ryan White & Global HIV/AIDS Programs
Source: RSR 2013

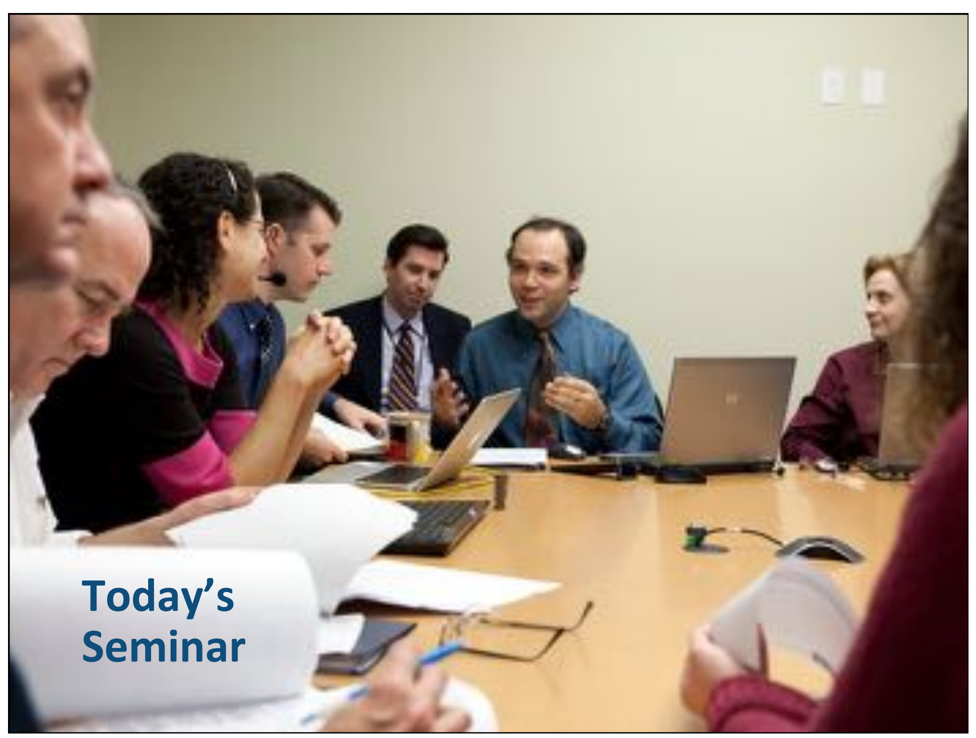

Retention in Care and Viral Suppression among Ryan White HIV/AIDS Program Clients, by Age Group 2010–2013
Retention in Care
100%
80%
60%
40%
20%
0%
<13
13-18
19-24
25-34
35-44
45-54
55-64
65+
Age group (years)
2010
2011
2012
2013
Viral Suppression
100%
80%
60%
40%
20%
0%
<13
13-18
19-24
25-34
35-44
45-54
55-64
65+
Age group (years)
2010
2011
2012
2013
Retained in care: ≥1 OAMC visit before September 1 of the measurement year and at least 2 visits 90 or more days apart
HRSA
Ryan White & Global HIV/AIDS Programs
Source: RSR 2013


Retention in Care and Viral Suppression among RWHAP Clients, by Race/Ethnicity, 2010–2013
Retention in Care
Viral Suppression
100%
80%
60%
40%
20%
0%
White
Black
Asian
Native Hawaiian
American Indian
Hispanic
Multi-racial
2010
2011
2012
2013
Retained in care: ≥1 OAMC visit before September 1 of the measurement year and ≥2 visits ≥ 90 days apart.
Viral suppression: Percentage of persons with ≥1 OAMC visit during the measurement year whose last viral load test result was <200 copies/mL..
HRSA
Ryan White & Global HIV/AIDS Programs
Source: RSR 2013

Next Steps…

Next Steps…

- Use data and information from key informants to bridge the gaps in care and treatment for those not achieving optimal health outcomes
- Evaluation and analysis projects to identify areas of strength and of need
- NHAS 2020 planning activities



Data and Interventions: Innovative Practices to Enhance Outcomes along the Care Continuum

Session	Presenter
Facilitating HIV Data Sharing Agreements Between States: A South Carolina/Georgia Collaboration	Eric Jalonen
Data and Care Improvements along the HIV Continuum of Care	Anne Rhodes
Data to Care: Improving Health Across the HIV Care Continuum in Colorado	Todd Grove
BREAK – 10 Minutes	
Better Planning and Care Using the HIV Care Continuum	Kate Burnett-Bruckman
NC-LINK: North Carolina Systems Linkage & Access To Care Initiative	Kristen Sullivan, Byrd Quinlivan
Innovative Practices to Enhance Outcomes along the Care Continuum	Ashley King
BREAK – 5 Minutes	
BREAKOUT SESSIONS – 45 Minutes (three 15-minute rounds)	

Resources

HRSA Ryan White HIV/AIDS Program:
http://hab.hrsa.gov/

- 25th Anniversary, Ryan White HIV/AIDS Program:
  http://hab.hrsa.gov/ryanwhite25/index.html
- Ryan White HIV/AIDS Program data resources:
  http://hab.hrsa.gov/data/index.html

TARGET Center: https://careacttarget.org/

CDC HIV reports, slide sets, fact sheets:
http://www.cdc.gov/hiv/library/index.html

Thank You

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South Carolina Department of Health and Environmental Control
Promoting and Protecting the Health of the Public and the Environment

Outline

- HIV epidemic in SC.
- Why was data sharing agreement needed?
- What is included in Memorandum of Agreement (MOA)?
- Results from data sharing initiative.
- Lessons learned.
- Resources to complete process.
- Continuing steps.

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HIV Epidemic in SC

- PLWHA (Persons Living with HIV/AIDS) in SC : 16,312 (as of Dec 31, 2014).
- New cases in 2014: 831.
- Per CDC: Ranked 13 in both Prevalence (2012) and Incidence rates (2013).
- Per CDC:3 Metropolitan areas rank in the top 50 for incidence and prevalence rates: Columbia (14th), Charleston (19th) and Greenville (45th).

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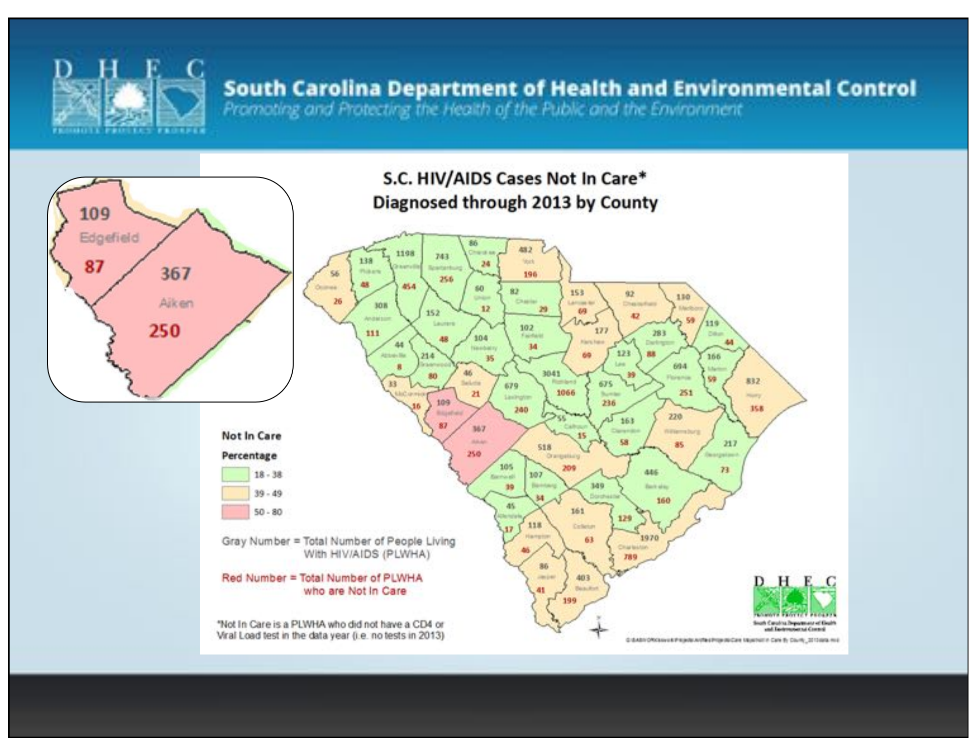
HIV Epidemic in SC

- African-Americans make up:
  - 73% of PLWHA.
  - 71% of new cases (2013).
- 49% of PLWHA in SC are over 49 years-old.
- 41% of new cases (2013) between 20-29 years old.
- MSM make up 40% of PLWHA in SC.



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Reasons for Data Sharing Agreement

Primary Reason for Data Sharing – to obtain accurate and timely linkage to care data.

Secondary Reason for Data Sharing – to facilitate data collection for HIV/AIDS status, living/deceased status, and mode of transmission.

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Timeline

- **June 2014 discussed using secure portals for transfer of data and MOA.**
- **September 2014 signed MOA sent to contracts department for final approval.**
- **November 2014 MOA approved by contracts department.**
- **March 5, 2015 first transfer of data between states.**

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MOA Components

Sections:

I. Purpose.

II. Legal Authority.

III. Data Exchange.

- Criteria for selection of cases and expectations for exchange of data.
- Data Source and variables.
- Method of Data Transfer.
- Frequency of Data Exchanges.

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MOA Components (2)

IV. Points of Contact.

V. Payment.

VI. Confidentiality and Security.

VII. Liability, No Agency Relationship.

VIII. Amendments to the Agreement.

IX. Penalties.

X. Disposition of Data.

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MOA Components (3)

XI. Terms of Agreement.
- Termination of Agreement.
- When reviewed.

Attachments:
- Fields for Data Transfer.
- Program Security and Confidentiality Manuals.
- CDC Data Security and Confidentiality Guidelines.

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Methodology

- The same SAS code was used in both states to generate Excel files. Files represented cases going back to 1981.
- Records Sent to South Carolina from Georgia N= 33,433, representing 1,820 unique cases.
- Records Sent to Georgia from South Carolina N=29,665, representing 1,608 unique cases.

Methodology (2)

- A secure portal was set up to transmit the encrypted files between the two states.
- The transmitted files were processed using SAS code. Lab records from cases already in SC eHARS were converted to a format that allowed for importation into eHARS.
- Records that represented information unknown to South Carolina (i.e. death information, risk information, cases not known to SC) were printed for further entry and/or processing.

Linkage Results

Approximately 30,000 lab records received from Georgia were imported into South Carolina eHARS.

Represents cases of HIV who live in South Carolina but who receive their care in Georgia.

Only includes cases that were previously known to both states.

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Linkage Results (2)

213 – Number of cases previously unknown to South Carolina who were identified in the Georgia database as having a South Carolina address at some point since their diagnosis. (Many of these cases have been deceased for years).

South Carolina HIV Surveillance staff are working with Partner Services to determine a plan for entering and initiating the cases.

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Linkage Results (3)

- 97 – Number of cases identified in South Carolina eHARS as an HIV case, but identified as an AIDS case according to Georgia records.
- 13 – Number of cases in South Carolina eHARS that were previously identified as living, but who were identified as deceased in Georgia.
- 71 – Number of cases in South Carolina eHARS with no previously identified risk, for which a risk was identified in the Georgia database

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Linkage Results (4)

Percent of HIV cases identified as Not in Care in 2013.

- **Prior to Importing Georgia Lab Data.**
  Aiken – 68%
  Edgefield – 80%

- **After Importing Georgia Lab Data.**
  Aiken – 41%
  Edgefield – 62%

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What Did We Learn?

Prep work:

- **Discuss MOA with legal and prevention staff prior to working with other state.**
- **Create plan for new cases.**
  - **Prioritization for DIS**
- **Determine best method of data transfer.**
- **Decide on information you want early.**

Diligence:

- **Ensure you have dedicated staff to serve as liaison.**

Resources Needed for Successful Data Sharing Between States

- **Patience – The project took 10 months from first contact to first data transfer.**
- **Need – The effort is more useful when states are neighboring and when many patients cross state boundaries for care.**
- **Means of Secure Transmission – Set up secure portal between the states. Good encryption software is a must.**

Staff Needed for Success

- **Experienced, highly motivated staff in both states are essential to the success of the project.**
- **HIV surveillance coordinators in both states to facilitate and coordinate data sharing processes.**
- **Agency Leadership – need to obtain their support.**
- **IT Staff to ensure security of data transmission.**
- **Experienced SAS programmers to set up code, process files, and prepare data for importing.**
- **Legal staff to review MOA.**

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Future Directions/Benefits

- Continue exchanging data with Georgia on a regular basis.
- Begin the process of setting up a data exchange with other states (i.e. North Carolina, Florida).

Benefits:

- Smaller RIDR and UNCL lists.
- More complete eHARS data.
- Prevention services offered to more cases.

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Thanks Are in Order!

The South Carolina HIV program wishes to thank the Georgia HIV program for their efforts to work with us in undertaking such a large-scale data sharing project.

Both states will agree that the time-intensive work necessary to accomplish the linkage is justified in order to ensure that states have the most accurate, complete, and timely HIV Surveillance data.

Contact Information
South Carolina HIV Surveillance Program

Eric Jalonen
HIV Surveillance Coordinator
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E-mail: jaloneef@dhec.sc.gov

Terri Stephens
Director of the Division of Surveillance and Technical Support
Phone: 803-898-0419
E-mail: stephetg@dhec.sc.gov

Data and Care Improvements along the HIV Continuum of Care

VIRGINIA DEPARTMENT OF HEALTH
Division of Disease Prevention

Anne Rhodes, PhD
Director, HIV Surveillance

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Overview

- Improving Care Continuum Data
- Data to Care Efforts/Pilot Results
- Evaluating Interventions with Care Continuum Data
- Lessons Learned
- Next Steps

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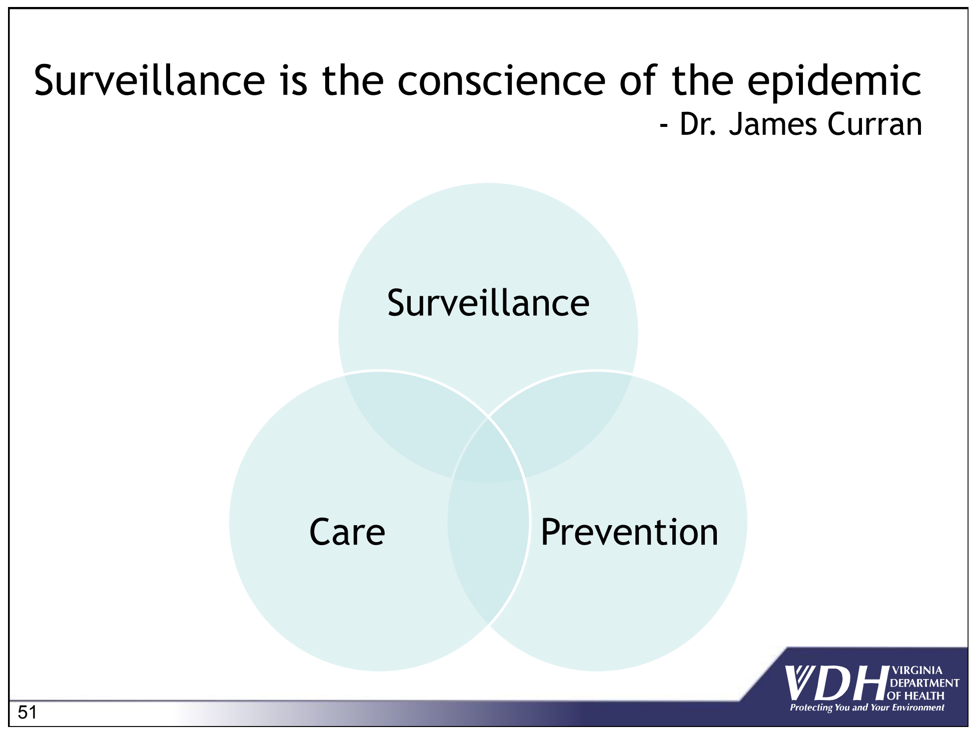
Surveillance is the conscience of the epidemic
- Dr. James Curran
Surveillance
Care
Prevention
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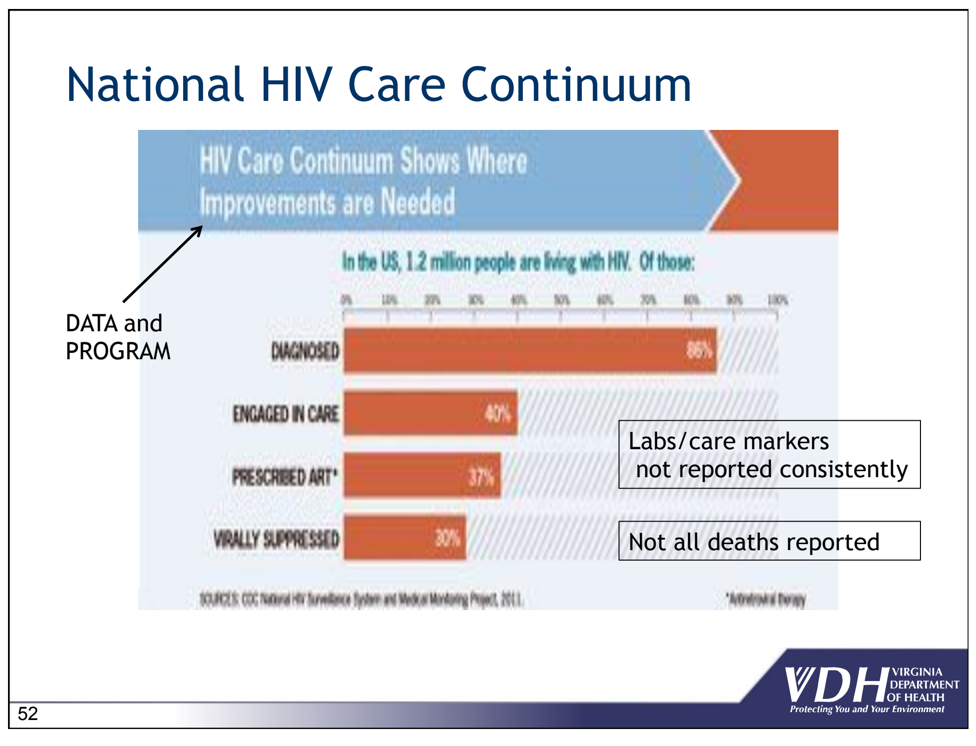
National HIV Care Continuum
HIV Care Continuum Shows Where Improvements are Needed
In the US, 1.2 million people are living with HIV. Of those:
DIAGNOSED 86%
ENGAGED IN CARE 40%
PRESCRIBED ART* 37%
VIRALLY SUPPRESSED 30%
SOURCES: CDC National HIV Surveillance System and Medical Monitoring Project, 2011.
DATA and PROGRAM
Labs/care markers not reported consistently
Not all deaths reported
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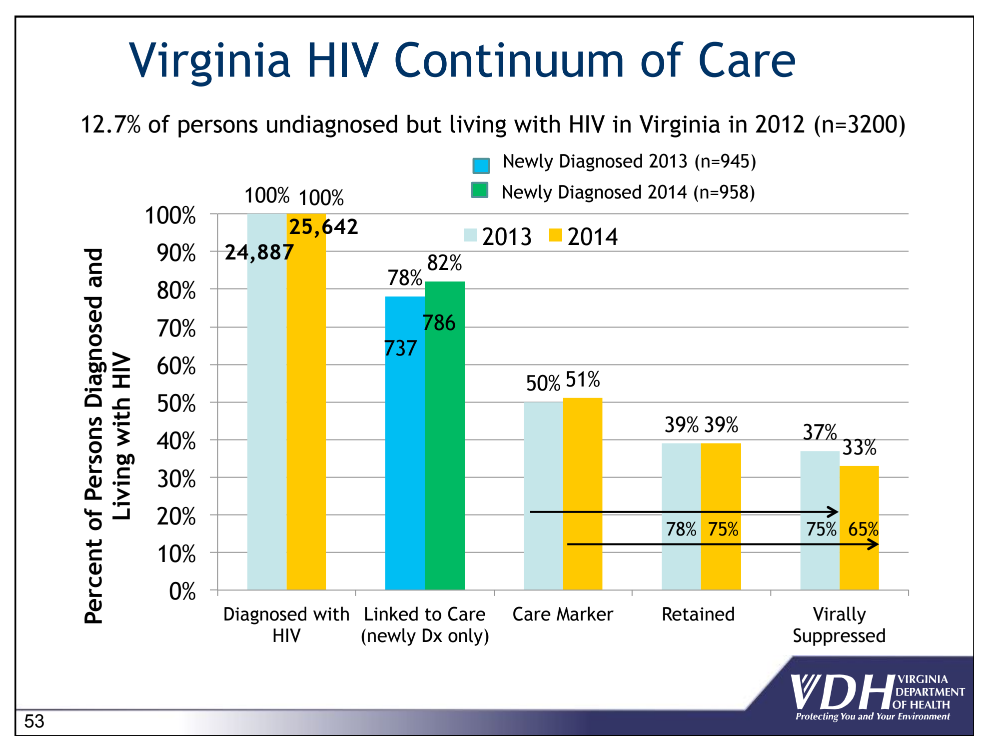
Virginia HIV Continuum of Care
12.7% of persons undiagnosed but living with HIV in Virginia in 2012 (n=3200)
Newly Diagnosed 2013 (n=945)
Newly Diagnosed 2014 (n=958)
2013
2014
Percent of Persons Diagnosed and Living with HIV
100% 100%
24,887
25,642
78%
82%
737
786
50% 51%
39% 39%
37%
33%
78% 75%
75% 65%
Diagnosed with HIV
Linked to Care (newly Dx only)
Care Marker
Retained
Virally Suppressed
53
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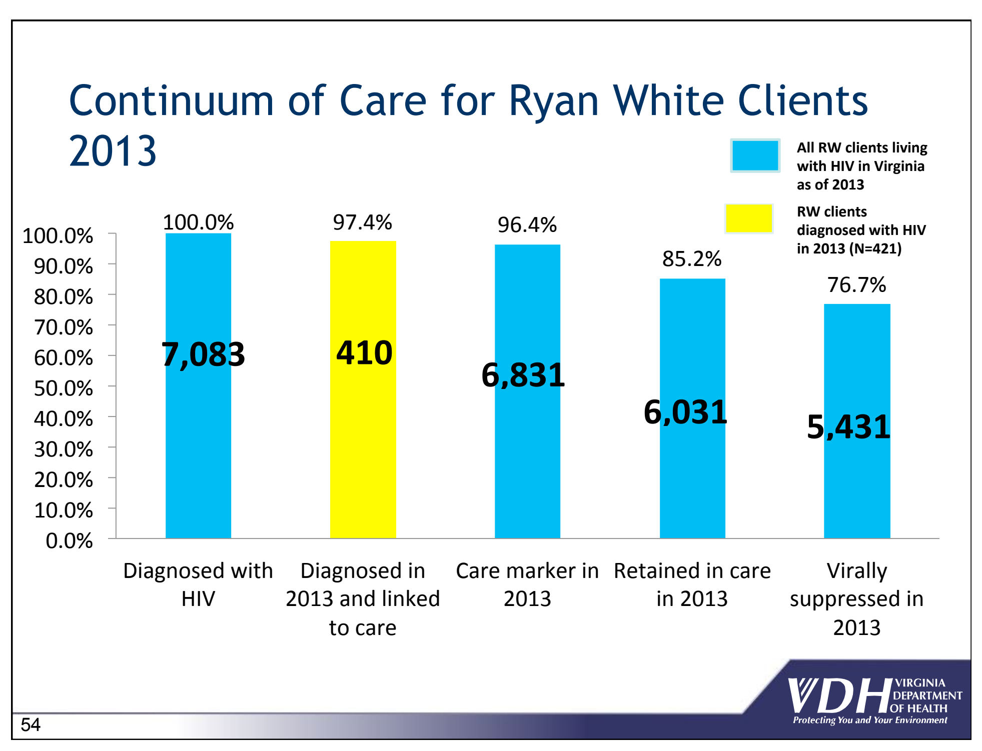
Continuum of Care for Ryan White Clients 2013
All RW clients living with HIV in Virginia as of 2013
RW clients diagnosed with HIV in 2013 (N=421)
100.0%
7,083
97.4%
410
96.4%
6,831
85.2%
6,031
76.7%
5,431
Diagnosed with HIV
Diagnosed in 2013 and linked to care
Care marker in 2013
Retained in care in 2013
Virally suppressed in 2013
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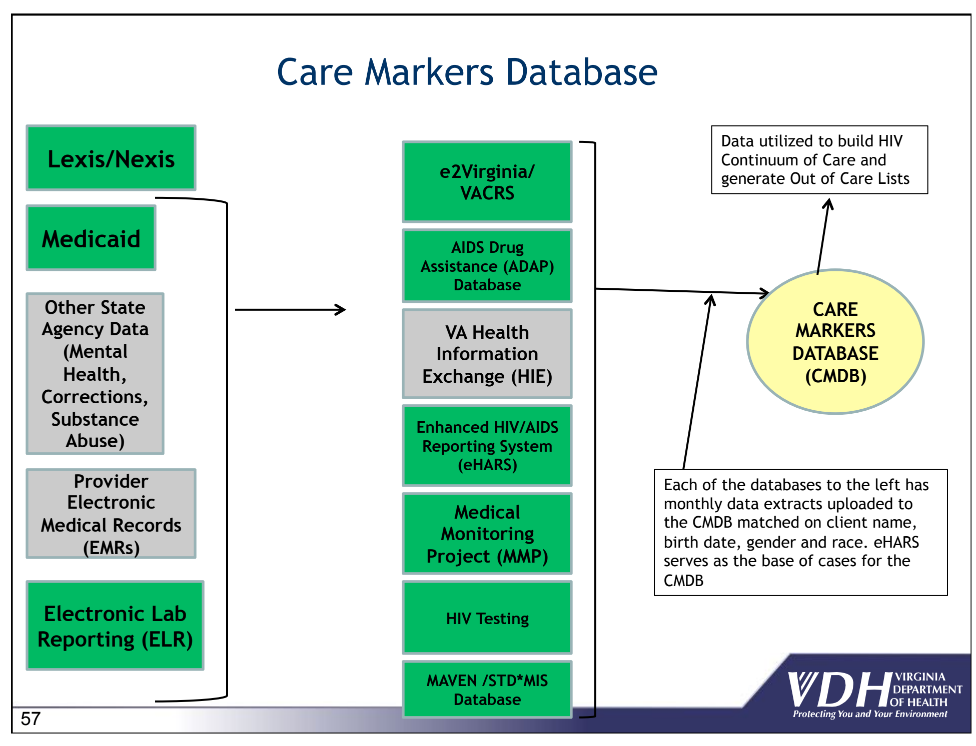
Black Box: Real Time HIV Care Continuum Data

- Pilot project from Georgetown, funded by NIH
- Involved DC, MD, and VA Departments of Health
- Utilized privacy technology for sharing surveillance data among jurisdictions where an algorithm for matching was set up in the "black box" and returned matches of varying strengths (Exact to Very Low) to each jurisdiction

Black Box Results

Numbers in the columns represent the number of persons who matched in each type of matching level.

Person matches across jurisdictions:	Exact	Very High	High	Medium High	Medium	Very Low	Total
DC-MD*	4,013	5,907	53	268	645	482	11,368
MD-VA*	856	2,343	11	117	377	865	4,569
VA-DC*	1,064	3,340	15	149	438	529	5,535
Total	5,933	11,590	79	534	1,460	1,876	21,472


Care Markers Database
Lexis/Nexis
Medicaid
Other State Agency Data (Mental Health, Corrections, Substance Abuse)
Provider Electronic Medical Records (EMRs)
Electronic Lab Reporting (ELR)
e2Virginia/ VACRS
AIDS Drug Assistance (ADAP) Database
VA Health Information Exchange (HIE)
Enhanced HIV/AIDS Reporting System (eHARS)
Medical Monitoring Project (MMP)
HIV Testing
MAVEN /STD*MIS Database
Data utilized to build HIV Continuum of Care and generate Out of Care Lists
CARE MARKERS DATABASE (CMDB)
Each of the databases to the left has monthly data extracts uploaded to the CMDB matched on client name, birth date, gender and race. eHARS serves as the base of cases for the CMDB
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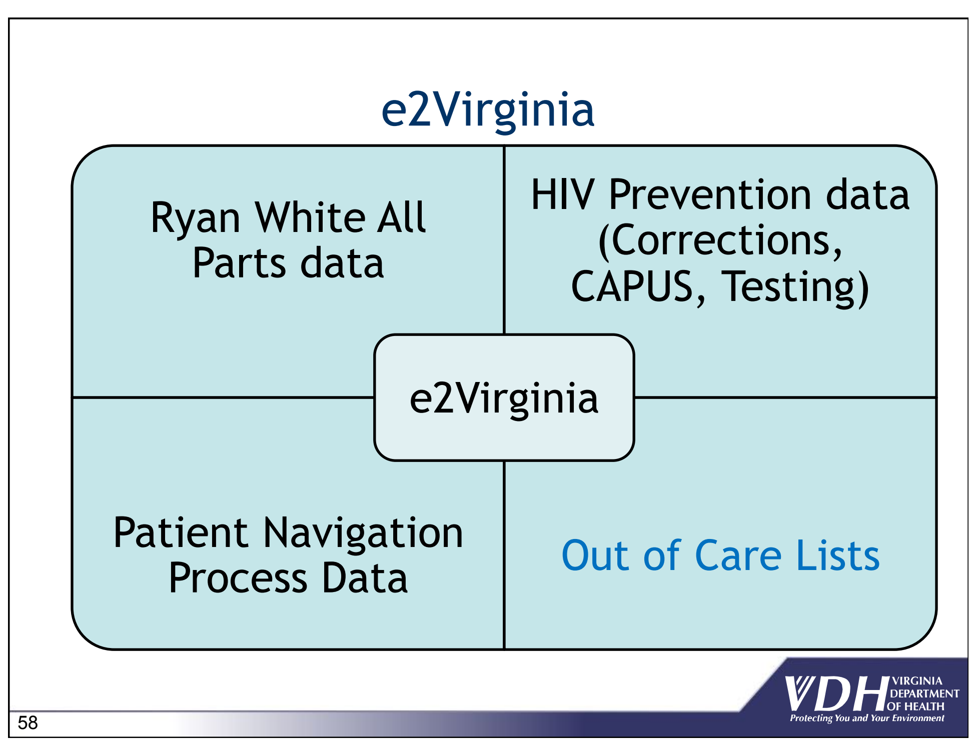
e2Virginia
Ryan White All Parts data
HIV Prevention data (Corrections, CAPUS, Testing)
e2Virginia
Patient Navigation Process Data
Out of Care Lists
58
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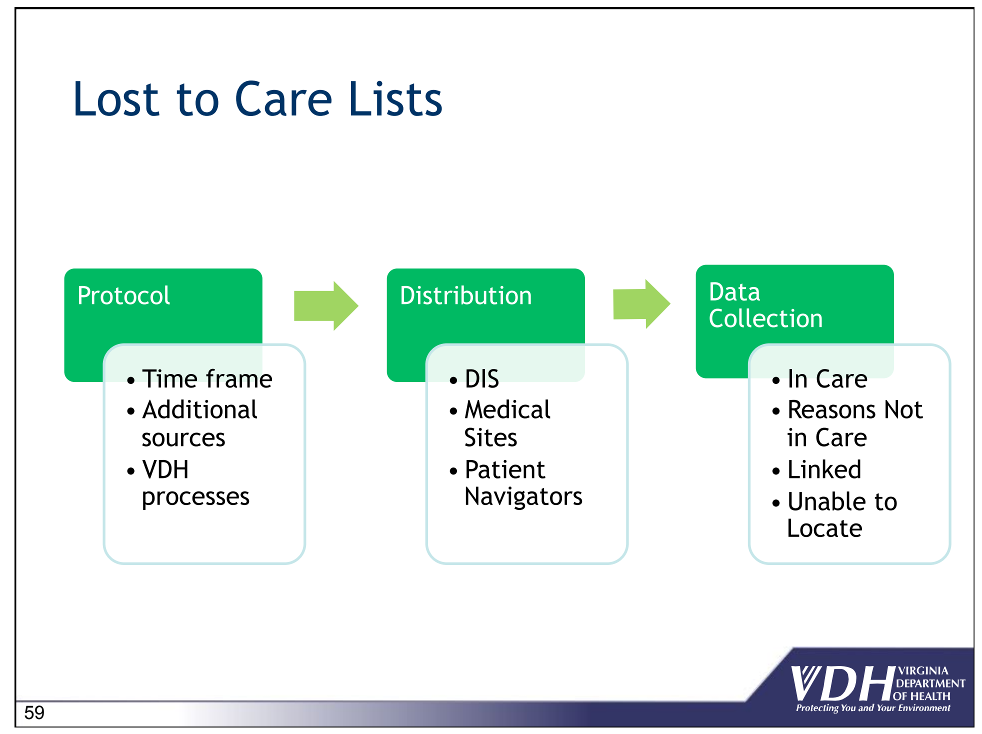
Lost to Care Lists
Protocol
• Time frame
• Additional sources
• VDH processes
Distribution
• DIS
• Medical Sites
• Patient Navigators
Data Collection
• In Care
• Reasons Not in Care
• Linked
• Unable to Locate
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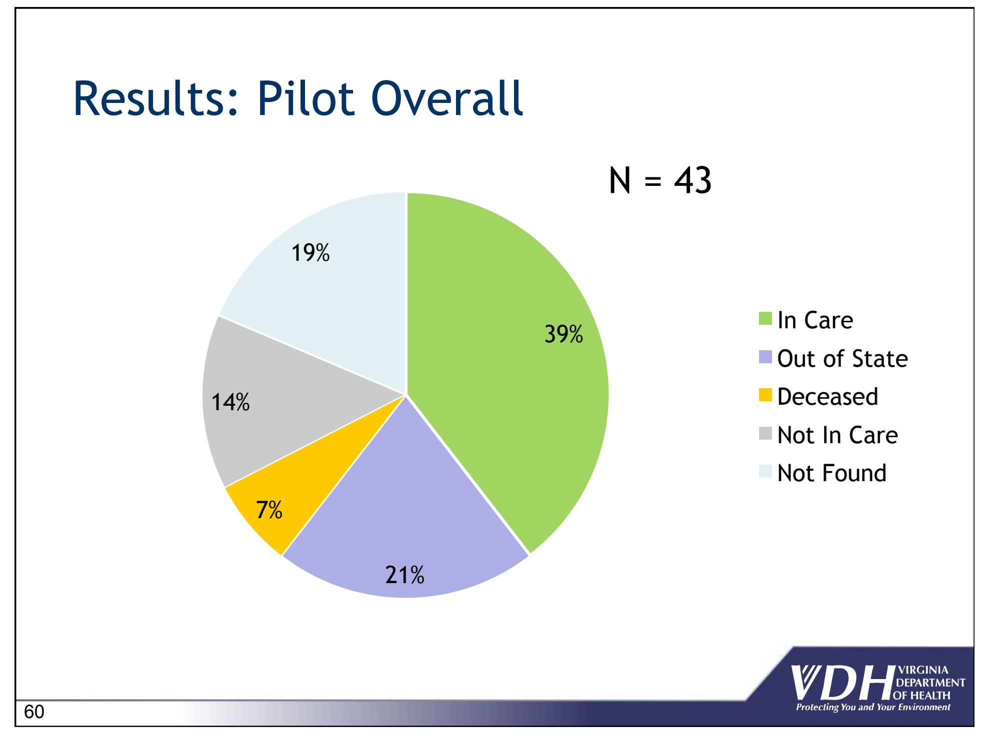
Results: Pilot Overall
N = 43
39%
21%
7%
14%
19%
In Care
Out of State
Deceased
Not In Care
Not Found
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Overview of Strategies/Interventions

- **Active Referral**:

  Referral process that requires Disease Intervention Specialists (DIS) to actively link patients directly to care via Patient Navigators (PNs) or medical providers.

Sites: Statewide coverage

Populations Targeted: Newly diagnosed

Outcomes: LINKAGE

- **Patient Navigation:**

  A client-centered PN model
  - 90 days of services focused on linking client to care and 12 month retention support
  - Use Fidelity Monitoring (FM) to evaluate Motivational Interviewing (MI) skills

Sites: VCU, Carilion, and Centra

Populations Targeted: Newly diagnosed and lost to care

Outcomes: LINKAGE, RETENTION, SUPPRESSION

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Overview of Strategies/Interventions

- **Mental Health:**

  Standardized screening and referral process to provide mental health (MH) services for clients with MH barriers for linking and retaining in care.

  Sites: Virginia Commonwealth University (VCU)

  Populations Targeted: HIV-positive persons with MH needs

  Outcomes: LINKAGE, RETENTION, SUPPRESSION

- **Care Coordination:**

  Coordinated access to medical care and medications for inmates released from Virginia Department of Corrections (VADOC) and Virginia Local/ Regional Jail (VLRJ) facilities.

  Sites: Statewide coverage

  Populations Targeted: Released from VDOCs and jails

  Outcomes: LINKAGE, RETENTION, SUPPRESSION

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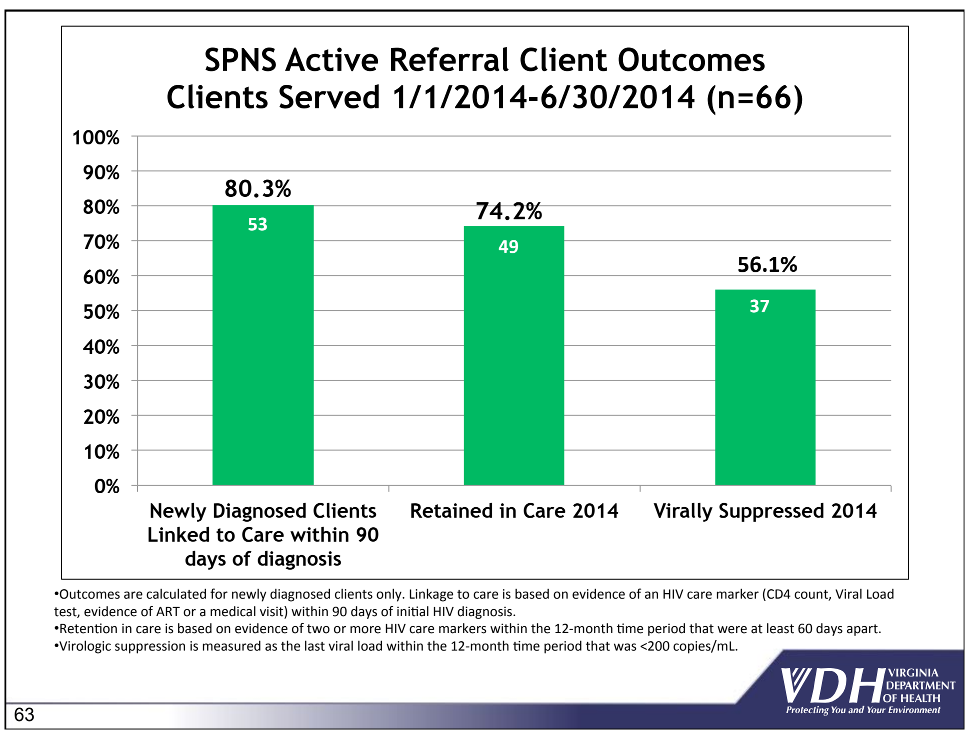
SPNS Active Referral Client Outcomes
Clients Served 1/1/2014-6/30/2014 (n=66)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
80.3%
53
74.2%
49
56.1%
37
Newly Diagnosed Clients Linked to Care within 90 days of diagnosis
Retained in Care 2014
Virally Suppressed 2014
•Outcomes are calculated for newly diagnosed clients only. Linkage to care is based on evidence of an HIV care marker (CD4 count, Viral Load test, evidence of ART or a medical visit) within 90 days of initial HIV diagnosis.
•Retention in care is based on evidence of two or more HIV care markers within the 12-month time period that were at least 60 days apart.
•Virologic suppression is measured as the last viral load within the 12-month time period that was <200 copies/mL.
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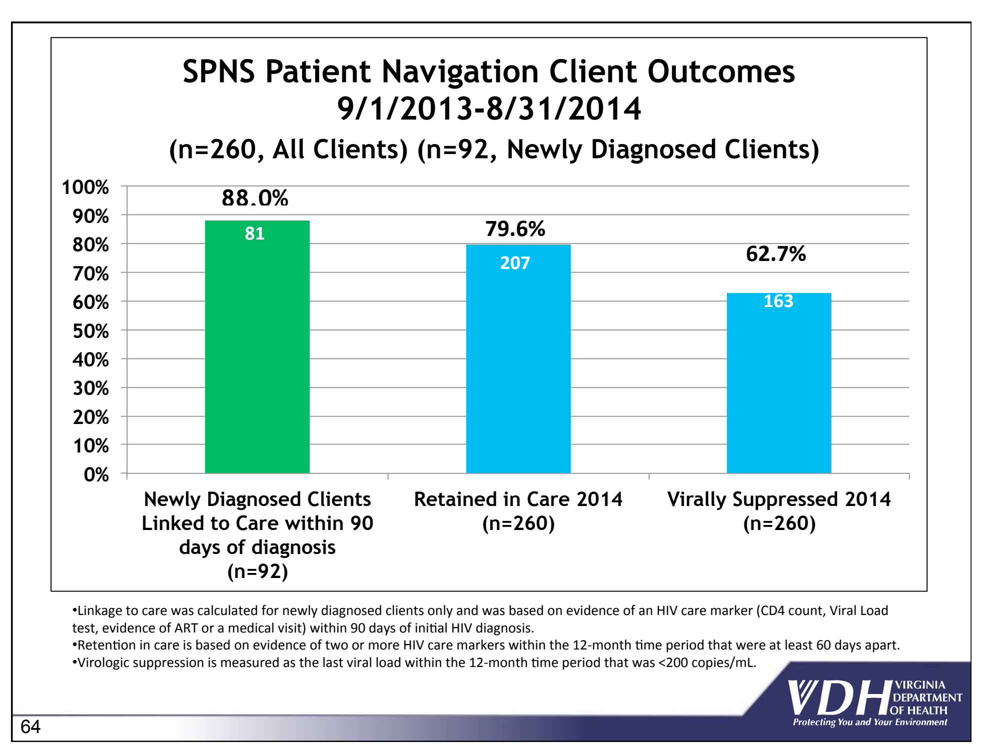
SPNS Patient Navigation Client Outcomes
9/1/2013-8/31/2014
(n=260, All Clients) (n=92, Newly Diagnosed Clients)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
88.0%
81
79.6%
207
62.7%
163
Newly Diagnosed Clients Linked to Care within 90 days of diagnosis (n=92)
Retained in Care 2014 (n=260)
Virally Suppressed 2014 (n=260)
•Linkage to care was calculated for newly diagnosed clients only and was based on evidence of an HIV care marker (CD4 count, Viral Load test, evidence of ART or a medical visit) within 90 days of initial HIV diagnosis.
•Retention in care is based on evidence of two or more HIV care markers within the 12-month time period that were at least 60 days apart.
•Virologic suppression is measured as the last viral load within the 12-month time period that was <200 copies/mL.
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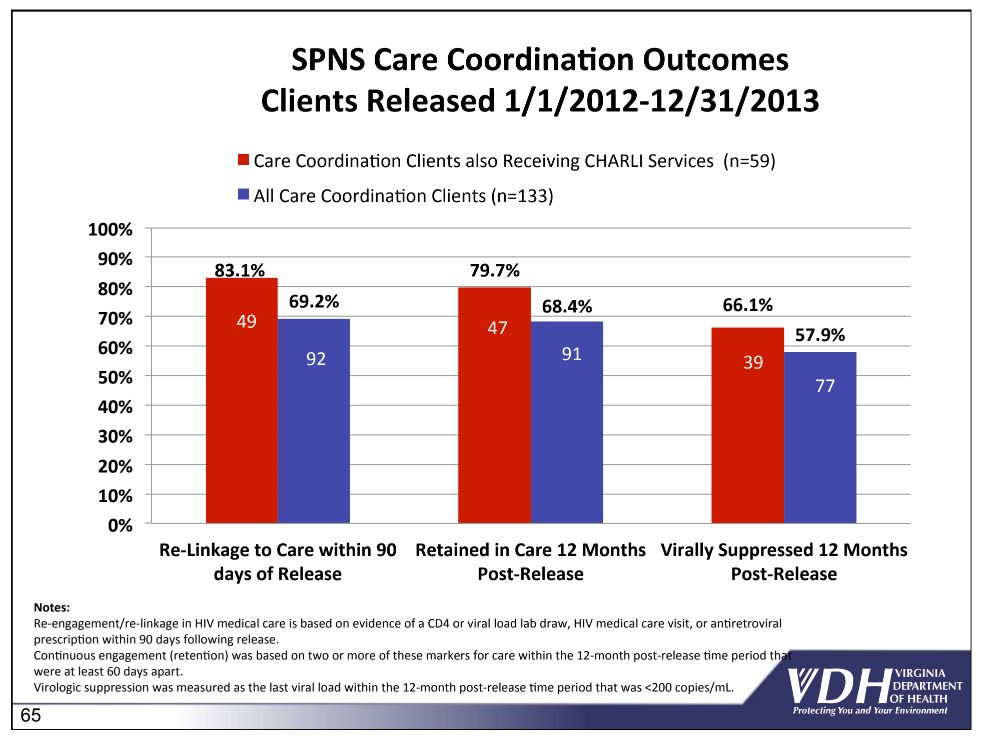

SPNS Care Coordination Outcomes
Clients Released 1/1/2012-12/31/2013
Care Coordination Clients also Receiving CHARLI Services (n=59)
All Care Coordination Clients (n=133)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
83.1%
49
69.2%
92
79.7%
47
68.4%
91
66.1%
39
57.9%
77
Re-Linkage to Care within 90 days of Release
Retained in Care 12 Months Post-Release
Virally Suppressed 12 Months Post-Release
Notes:
Re-engagement/re-linkage in HIV medical care is based on evidence of a CD4 or viral load lab draw, HIV medical care visit, or antiretroviral prescription within 90 days following release.
Continuous engagement (retention) was based on two or more of these markers for care within the 12-month post-release time period that were at least 60 days apart.
Virologic suppression was measured as the last viral load within the 12-month post-release time period that was <200 copies/mL.
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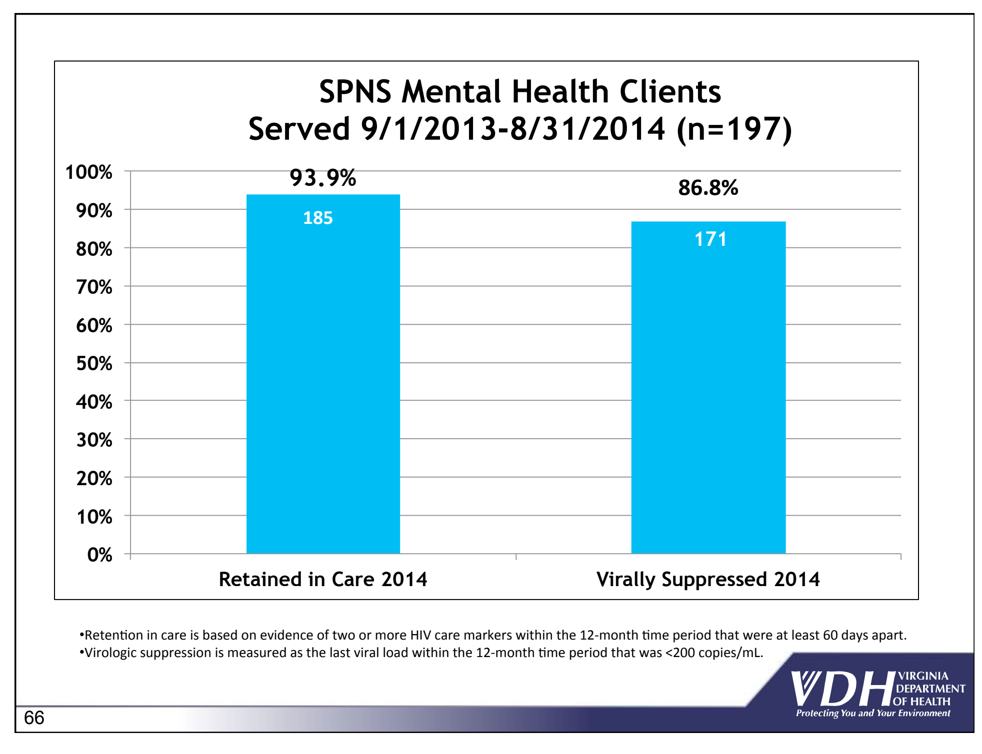

SPNS Mental Health Clients
Served 9/1/2013-8/31/2014 (n=197)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
93.9%
185
86.8%
171
Retained in Care 2014
Virally Suppressed 2014
•Retention in care is based on evidence of two or more HIV care markers within the 12-month time period that were at least 60 days apart.
•Virologic suppression is measured as the last viral load within the 12-month time period that was <200 copies/mL.
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Next Steps/Future Directions

- Data to Care Staff hired at VDH to review out of care lists internally (Lexis Nexis, other sources) and work with HIV prevention and HIV care contractors to determine missing/other potential data sources, including EMRs
- SPNS Linkages interventions all continuing after demonstration grant funding with ADAP/Ryan White/ ACA funds
- Black Box project expanding to include other jurisdictions and exchange data on care

Lessons Learned

- HIV Care Continuum is a tool for examining both data and care issues and requires investigation of how data are collected, reported and analyzed for persons living with HIV
- Utilizing data for public health action requires merging of multiple sources of information across systems and funding streams
- Interventions that leverage resources across different areas of HIV (prevention, care, surveillance, disease investigation) are effective

Acknowledgements

Virginia Department of Health Team: Lauren Yerkes, Kate Gilmore, Steve Bailey, Diana Jordan, Kimberly Scott, Misty Johnson, Sahithi Boggavarapu, and many more

External Partners: Jesse Thomas (e2Virginia), Lori DeLorenzo (Consultant), Jeff Collman (Georgetown), Colin Flynn (MD), Garrett Lum (DC)

HRSA Project Officers: Jessica Xavier, Kim Brown, John Hannay

Contact Information: Anne.Rhodes@vdh.virginia.gov
804-864-8013

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Data to Care: Improving Health Across the HIV Care Continuum in Colorado

US CONFERENCE ON AIDS

SEPTEMBER 2015

TODD GROVE
HEALTHCARE ACCESS UNIT SUPERVISOR – ADAP DIRECTOR

Background: Integrate Care & Prevention Programs

COLORADO'S CARE, PREVENTION, AND SURVEILLANCE UNITS HAVE ALWAYS BEEN WITHIN ONE BRANCH AT DOH

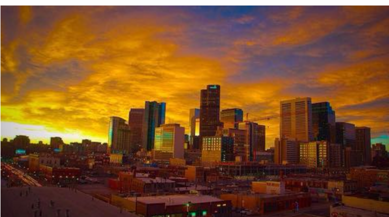
- Programs historically siloed due to concerns about HIV statute and community concerns
- HRSA / CDC guidance telescoped the need to integrate
- Prevention and Ryan White Services delivered mostly by the same CBOs
- Need for consolidated approach to evaluation, data, and capacity building
- Same State staff now provide both care and prevention contract monitoring

TREATMENT CASCADE: DATA WAS NOT FULLY TELLING THE PICTURE

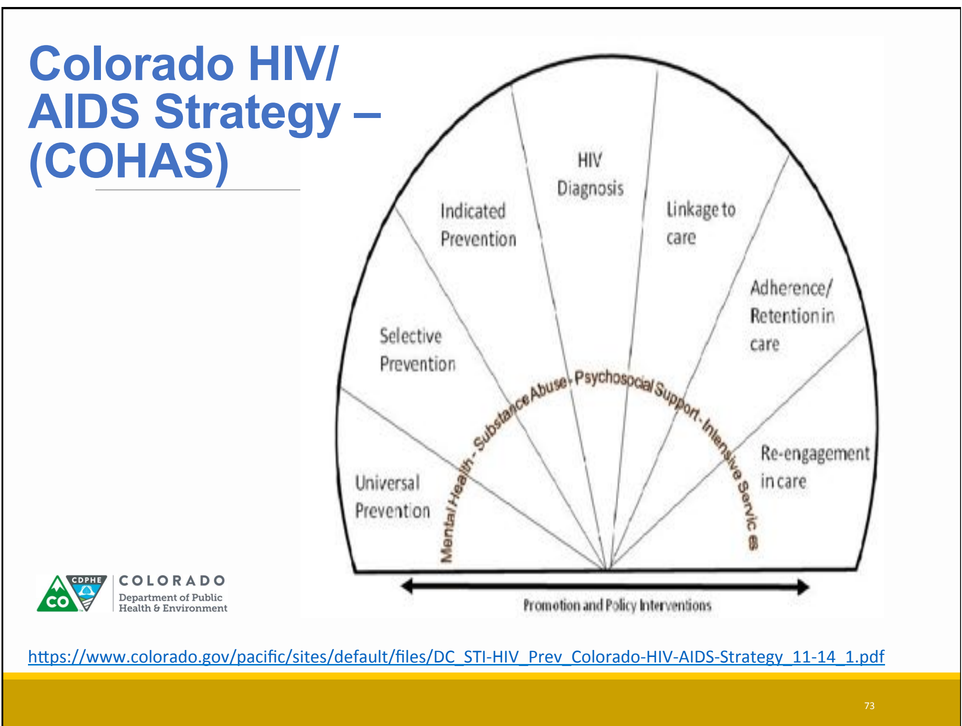
- Failure to capture all data required for reporting to surveillance
  - Particularly CD4 and Viral Load
- No report of CD4 over 500/ undetectable VL
- HIV statute and historical community concerns made information sharing with State by contractors controversial
- Board of Health approved changes to the regulation to address data sharing needs

Reorganization of the Colorado Planning Bodies

- Planning topics crossed boundaries between prevention and care
  - Overarching goal: Helping clients link promptly to care and achieve viral suppression
- HIV testing: entry point for HIV care and other services
- Basic life issues drive BOTH vulnerability to becoming HIV infected AND transmitting to others
  - e.g., substance use disorders
- Health care reform creates opportunities for prevention and care services, and requires careful planning
- Increased direction from HRSA and CDC to develop joint plans and planning processes



Colorado HIV/ AIDS Strategy – (COHAS)



https://www.colorado.gov/pacific/sites/default/files/DC_STI-HIV_Prev_Colorado-HIV-AIDS-Strategy_11-14_1.pdf

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CDPHE Highlighted Initiatives

DATA to CARE PROJECTS:

1) Data Sharing Projects

2) Adherence & Recertification

3) Linkage/Retention in Care

4) Critical Events

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Data to Care Initiative One: Data Sharing a) Medicaid

- Relationship with Medicaid has improved. Previous issues with data sharing a result of interpretation of HIPPA regulations and Business Associate Agreements
- Previously unable to have direct access to Medicaid eligibility database to check on enrollment and had to use an outside provider (Emdeon)
- Healthcare Policy and Finance Department (HCPF) has appointed a member to Part A planning council who has proven to be an ally
- ADAP enrollment specialists will have read-only access to Colorado Benefits Management System
- Data Sharing agreement is complete and CDPHE has received a tremendous amount of data which is beginning to be analyzed
- Will have far better data on medication compliance (as many who got Medicaid dropped out of ADAP, or pay their own small copays)
- Will help to confirm medical visit / lab work is being done and intervention is offered to those out of care

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b) Client buy-in of data sharing

Colorado was one of the first states to implement required name-based reporting (1985)

Disease Investigation and "Public Health Order" process led to substantial community activist concerns about the health department

In the meantime:

- Both HRSA and CDC have encouraged wider data sharing
- State initiatives continue to grow (CORHIO, APCD, etc.)
- Clients are experiencing more data expectations and burdens

The Task Force on Data Sharing and Client Privacy has met for over 3 years

- Consists of advocates, shareholders, and the Department

The Task Force principles strive to balance client privacy concerns, legal rights, and improving client experiences and outcomes.

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What are the pluses of providing more information from ADAP?

- If data sharing includes client contact information, all providers will be better able to reach clients and assure retention in care
- If data sharing does not include all information required for RSR, the contractor's reports will not be accurate
- Absolutely accepted that NO case notes or MH /substance abuse services would be shared
- If data sharing were to include CD4 or VL information, it could facilitate consumer access to critical events system, facilitate case manager understanding of client issues, and potential other benefits to clients.
  - Data sharing group determined that it was permissible for CDPHE to share these items with contractors, as well.
  - For enrollees of ADAP, there will be one source recertification available statewide.

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c) Data sharing with other Ryan White Parts:

Data sharing agreement is being developed between Part A (Denver), Part B (State) and Parts C/D clinics

What can/should be shared?

- The beginning and ending dates of the current ADAP certification period
- Client's most-recently reported place of residence
- Client's most-recently reported income level and household size
- Client insurance enrollment status ("vigorous pursuit")
- Other data needed for an accurate RSR report
- Client enrollment in the Critical Events Assistance Program
- CD4 VL values and dates
- Provided with encrypted URN, so entities would only have data on those clients which they match
- OPT OUT LANGUAGE IS INCLUDED IN APPLICATIONS

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Data to Care Initiative Two: Adherence and Viral Suppression

- Recertification frequently late (up to 41%)
- Endangers payment of insurance premiums and timely access to medications (as well as services)
- Consumers with Medicaid opting to drop ADAP due to reporting burden, complicating CHURN
- Over 85% of complaints to ADAP are regarding the burden of recertification

AJ Boggs – Colorado ADAP online recertification portal

https://co.goadap.com/adap_app_3_v2.html

CDPHE CO

COLORADO
AIDS Drug Assistance Program (ADAP) Self-Service Portal

Please login

Username

Password

Sign In

Forgot Username? Forgot Password?

If you do not have an account, please

Register for an Account

Registration Information

Español

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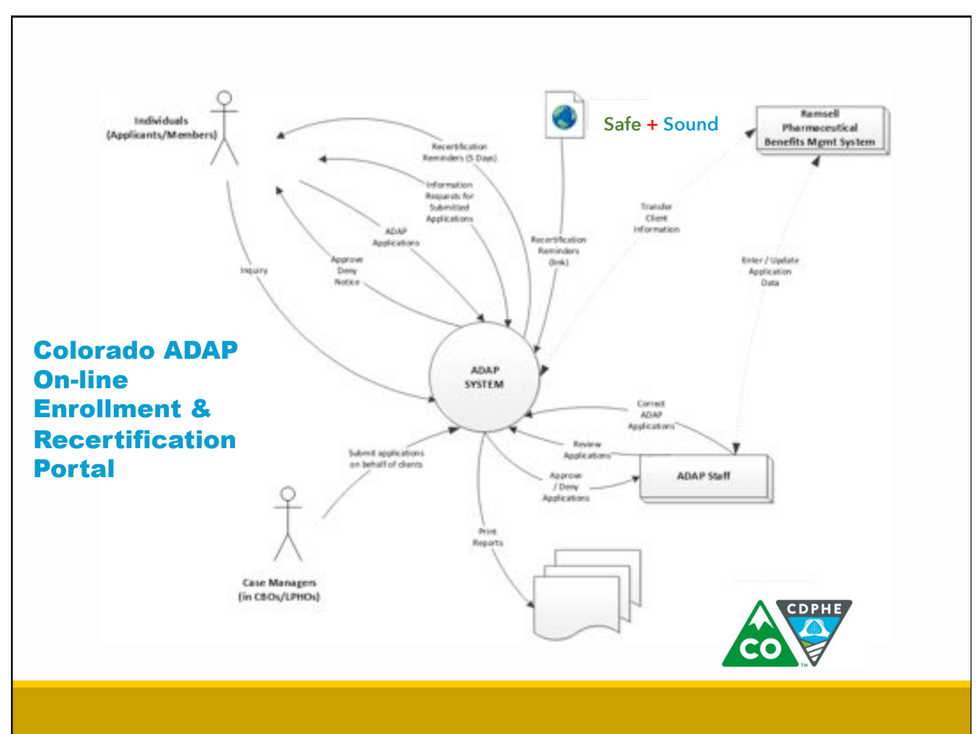
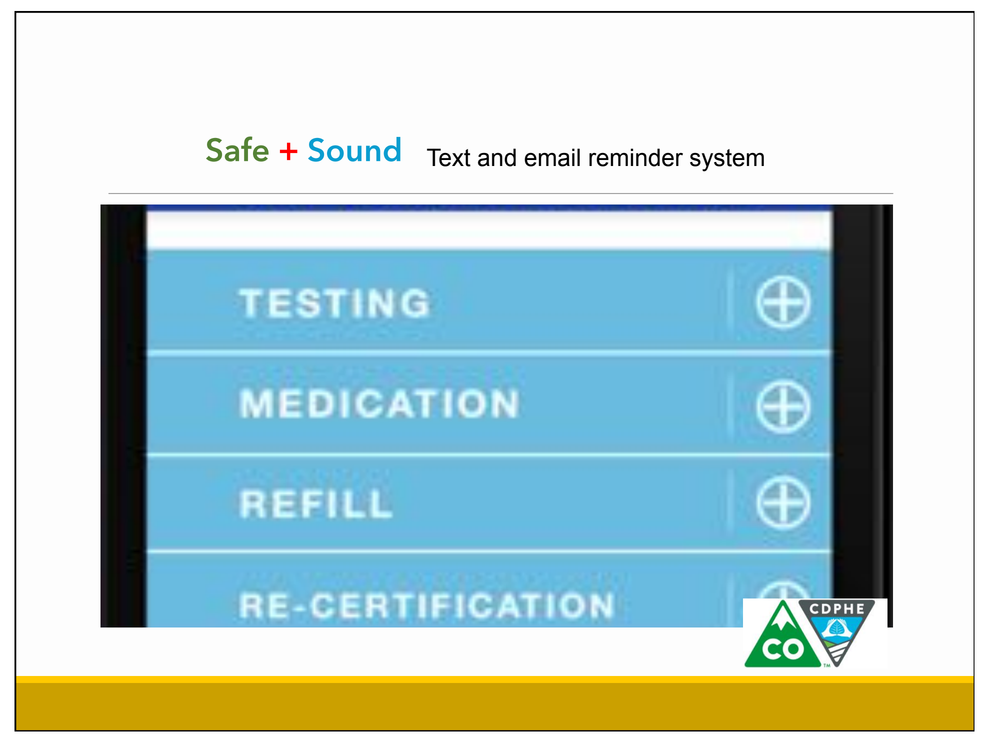
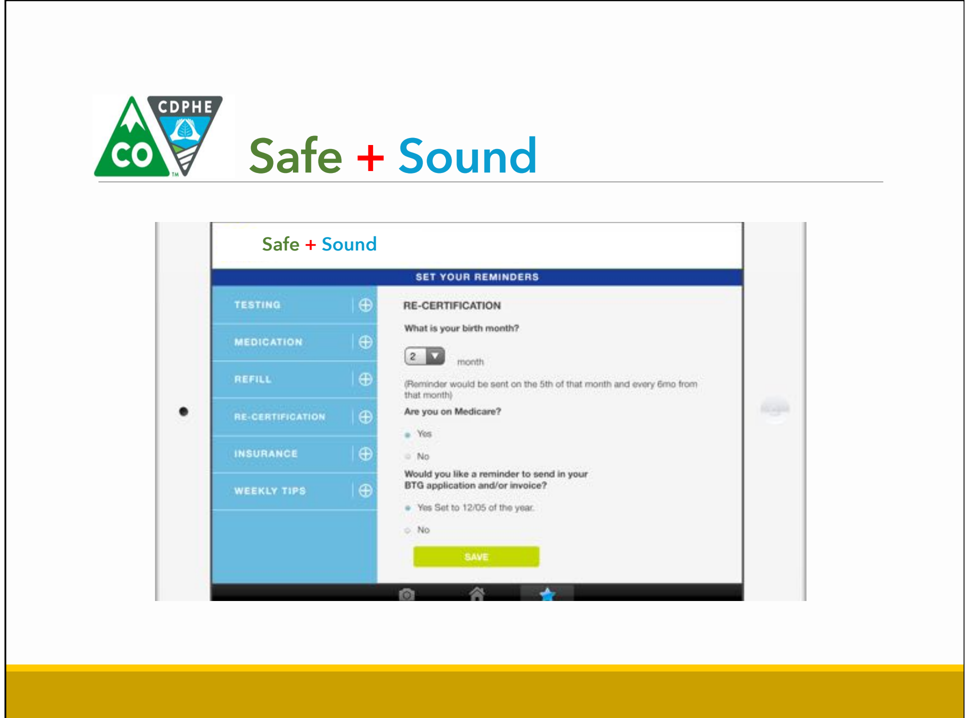

Colorado ADAP
On-line
Enrollment &
Recertification
Portal
Individuals
(Applicants/Members)
Safe + Sound
Ramsell
Pharmaceutical
Benefits Mgmt System
Recertification
Reminders (5 Days)
Information
Requests for
Submitted
Applications
ADAP
Applications
Approve
Deny
Notice
Inquiry
Recertification
Reminders
(link)
Transfer
Client
Information
Enter / Update
Application
Data
ADAP
SYSTEM
Correct
ADAP
Applications
Review
Applications
Approve
/ Deny
Applications
ADAP Staff
Submit applications
on behalf of clients
Print
Reports
Case Managers
(in CBOs/LPHOs)
CDPHE
CO


Safe + Sound
Text and email reminder system
TESTING
MEDICATION
REFILL
RE-CERTIFICATION
CDPHE
CO



Data Initiative Three: Linkage/ Retention in Care, and referral for interventions for high-risk negatives

Front-line health department staff and community HIV partners are in a unique position to identify seronegative individuals at a pivotal moment: when clients are most potentially at highest risk for HIV infection but have not yet acquired the virus, and HIV positive individuals are not reaching viral suppression

- Disease Intervention Specialists (DIS)
- Comprehensive Risk-Reduction & Care Services Providers (CRCS)
- Linkage to Care Staff (LTC)
- Biomedical Intervention Coordinator
- Integrated Care & Prevention Staff Members
- Community Based Organizations and Partners

- The majority of State HIV Care and Prevention staff are funded using both Ryan White and CDC funding so that they can work with high risk negative population.

Public Health interventions to find high-risk negative clients and those who are most infectious

- Identify through labs and CD4/VL who have dropped out of care (or uncontrolled virus) to offer support and make certain they are maintained in care.
- Use disease reporting and state statute to identify high-risk negatives
- Staff will address other medical or mental health /substance abuse concerns to support engagement and retention in care/prevention services.
- Address barriers to care and develop a care plan with the client.
- Work with Health Care unit staff to establish medical coverage if needed.
- Referrals to case management (CBOs/ASOs) to ensure client has adequate support moving forward
- Utilize Critical Event Program if necessary to address barriers

Data sources used to verify or update care status

Health Department Sources	External Data Sources
eHARS	TLO Lexis/Nexis
PRISM (DIS, STD database)	Social Media (e.g. facebook, white pages)
ADAP database	Post Office Searches
State Vital Record databases	Driver Motor Vehicle database
ARIES database	State Medicaid databases
	Hospital Electronic Medical Records
	Jail databases
	Shelter searches

Partner Services: Linking to Prevention and Care/ Support Services

After HIV serostatus has been determined and any newly identified STIs have been treated and addressed (partner services), staff offer a **variety of upstream prevention options:**

- Behavioral interventions
- Linkage to medical home (if indicated)
- Biomedical intervention referral

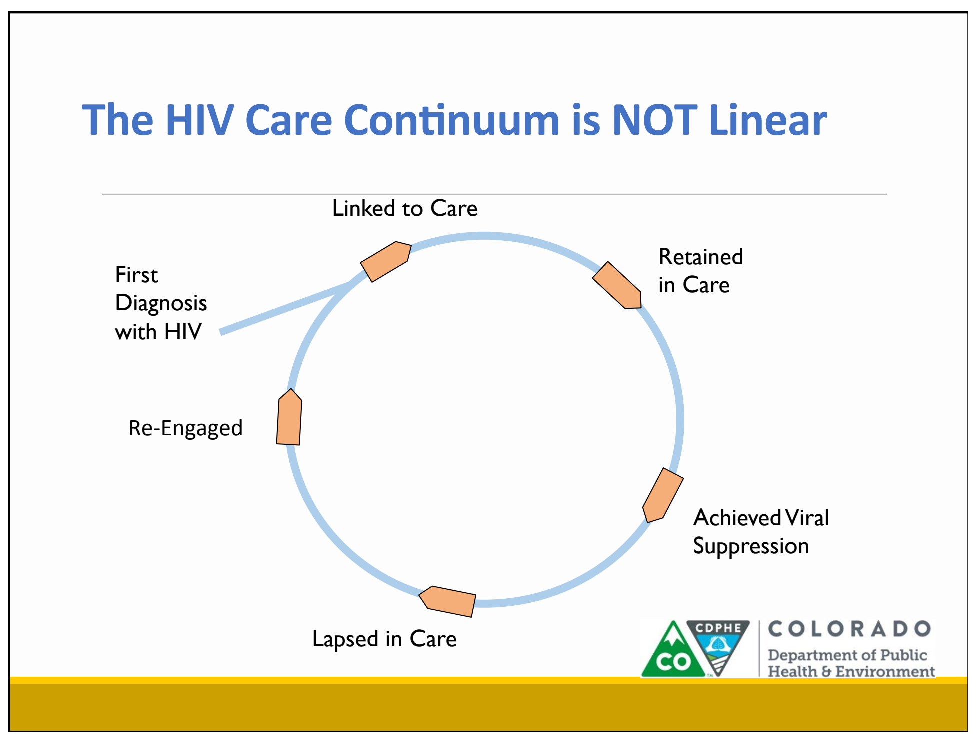
All seronegative clients are screened for PrEP eligibility and offered rapid response nPEP services if indicated.

Clients are also referred to needle-exchange and harm reduction resources as needed (IDU).

Linkage to Care Outcomes

January through December 2014

- Identified a total of 134 clients needing Linkage to Care of which 70% accepted services and were successfully linked
- 94% (345/367) of new HIV diagnoses in Colorado were linked to care within 90 days of diagnosis



Initiative Four: Critical Event Initiative

What is a "critical event"?

- An event that makes it much more likely a client will drop out of medical care or never seek medical care to begin with.
- A "marker" for a destabilizing crisis.
- A severe challenge to a client who wants to achieve and maintain viral suppression.

Current Targets: To be eligible, must be:

- Newly diagnosed with HIV (within the prior calendar year)

  OR

- Lapsed in care more than 365 days

  OR

- Over 100,000 viral load.

AND must have one of the following:

Critical Events

- Homeless
- Recently unemployed (within prior 90 days)
- Diagnosed with gonorrhea, syphilis, or chlamydia
- Worsening health status due to hepatitis C
- Named as a partner, to a person recently diagnosed with HIV
- Intimate partner violence or sexual assault
- Diagnosed with another acute illness requiring complex medical treatment or hospitalization, such as cancer
- Evidence based screening shows potentially severe addiction or drug dependence.
- Evidence based screening shows potentially severe mental illness
- Pregnancy

Lessons Learned

Legalities of sharing data.

Integration across the STI/HIV/VH Branch and community partners is essential.

Building relationships; clients and providers to show them the benefits of the program.

Building understanding of the LTC role both internally and externally.

Critical Events program to immediately address clients with highest need to retain or reengage them in care, offer prevention support.

Questions?

Todd Grove

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BREAK – 10 Minutes

CUYAHOGA COUNTY
BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

5550 Venture Drive Parma, Ohio 44130
216-201-2000 www.ccbh.net

Kate Burnett-Bruckman
Program Manager
Ryan White Part A
Cleveland TGA

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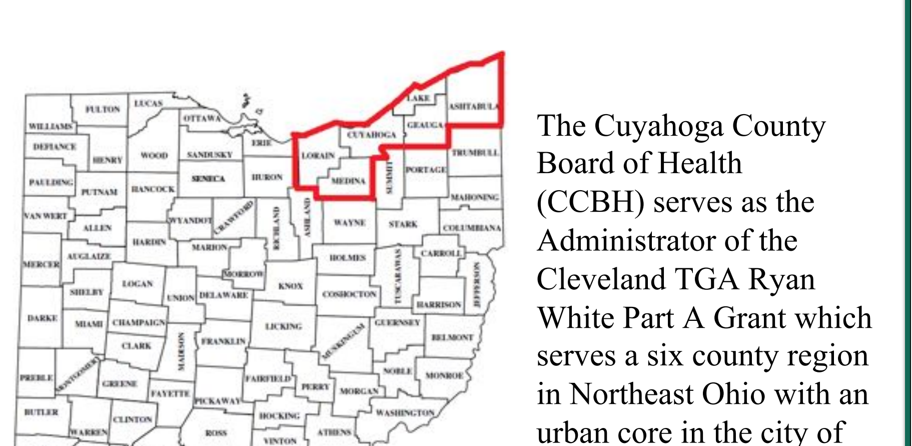
This morning we will review:

- An overview of The Ryan White Part A Cleveland TGA
- Analyzing data gaps and planning accordingly
- Adaptions used to create a local Part A Care Continuum
- Presenting care continuum information to planning bodies
- Presenting care continuum information to subgrantees
- Intersecting care continuums and quality improvement projects

Ryan White Part A Cleveland TGA



The Cuyahoga County Board of Health (CCBH) serves as the Administrator of the Cleveland TGA Ryan White Part A Grant which serves a six county region in Northeast Ohio with an urban core in the city of Cleveland.

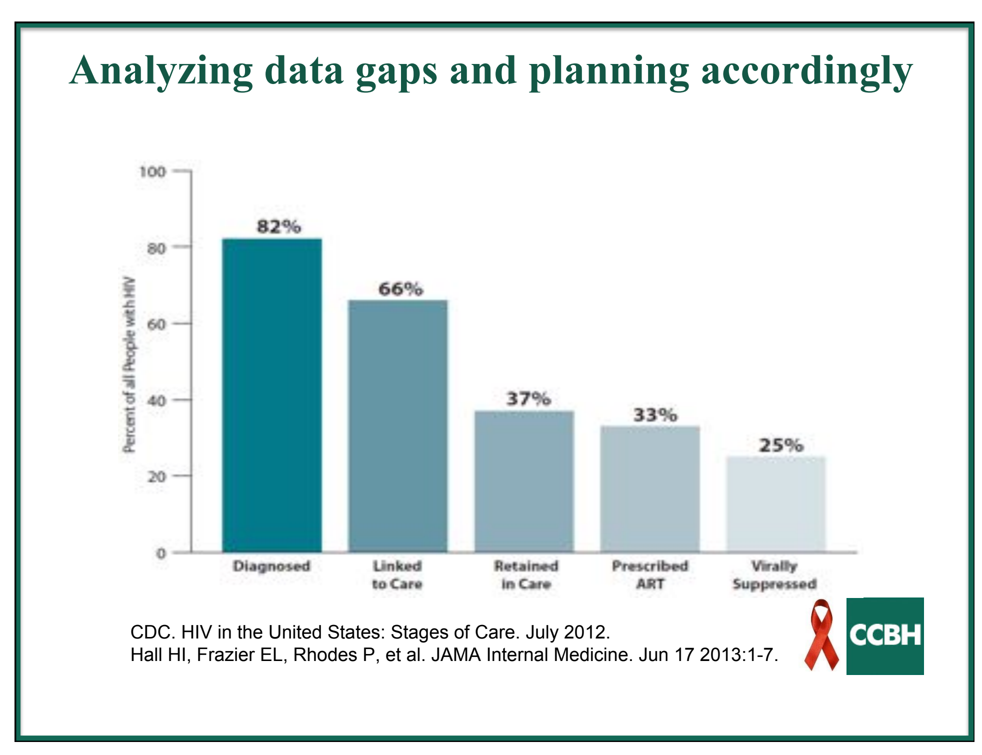
CCBH

Ryan White Part A Cleveland TGA

Ryan White Part A
Cleveland TGA
Service Summary By Provider - FY2014

	ADAMHS Board of Cuyahoga County	AIDS Taskforce of Greater Cleveland	Care Alliance	Cleveland Clinic Foundation	Dept. of Senior and Adult Services (DSAS)	The Free Medical Clinic of Greater Cleveland	Hospice of the Western Reserve	Lake County General Health District	Mercy Regional Medical	MetroHealth Medical Center	Nueva Luz URC	Orca House	Recovery Resources	University Hospitals of Cleveland
Core Services														
Early Intervention Services (EIS)			X	X				X		X			X	
Home and Community-Based Health Services					X									
Home Health Care					X									
Hospice Care							X							
Local AIDS Pharmaceutical Assistance (LPAP)				X						X				X
Medical Case Management				X		X		X	X	X	X			X
Medical Nutrition Therapy								X						X
Mental Health Services				X						X			X	X
Oral Health Services						X				X				X
Outpatient Ambulatory Medical Care (OAMC)				X		X			X	X				X
Substance Abuse - Outpatient	X											X	X	
Support Services														
Case Management (non-medical)		X								X	X			
Emergency/Financial Assistance				X		X			X	X				X
Food Bank / Home Delivered Meals		X									X			
Legal Services											X			
Medical Transportation Services		X	X	X		X		X	X	X	X		X	X
Outreach			X					X		X				X
Psychosocial Support Services				X				X		X				X
Substance Abuse - Residential	X											X		

Analyzing data gaps and planning accordingly



CDC. HIV in the United States: Stages of Care. July 2012.
Hall HI, Frazier EL, Rhodes P, et al. JAMA Internal Medicine. Jun 17 2013:1-7.

Analyzing data gaps and planning accordingly

Data gap summary:

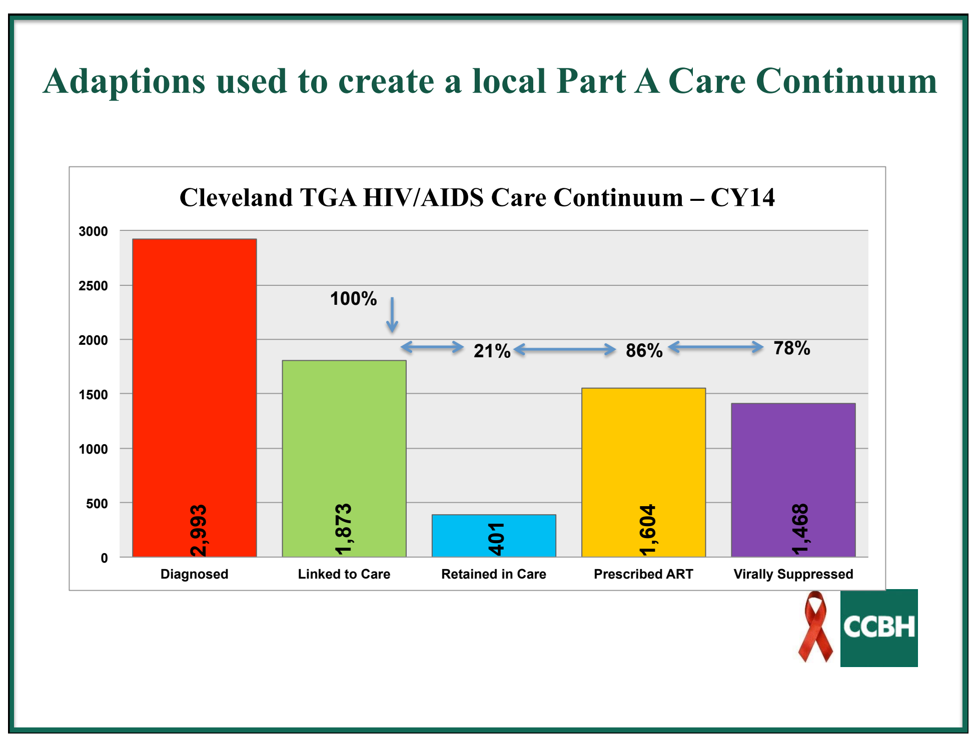
- Ohio historically did not mandate centralized reporting of CD4 or Viral load counts so we have no statewide data for how many individuals are currently in care.
- Because of the lack of state-wide data, we decided to only focus on clients who have received a Ryan White Part A funded service, however that still left us with a large gap because we have historically only collected clinical data for those that received OAMC services funded through Part A.

Adaptions used to create a local Part A Care Continuum

Cleveland TGA Care Continuum Definitions

- **Diagnosed:** Total number of HIV positive individuals receiving a RW Part A funded service.
- **Linked to Medical Care:** Number of HIV positive individuals who received at least one RW Part A funded Outpatient Ambulatory Medical Care (OAMC) visit.
- **Retained in Care:** Number of positive individuals who had a minimum of two RW Part A funded medical visits at least 90 days apart during the measurement year.
- **Prescribed ART**: Number of positive individuals prescribed HIV antiretroviral therapy in the measurement year.
- **Virally Suppressed:** Number of positive individuals with an HIV viral load less than 200 copies /mL at last HIV viral load test during the measurement year.

Adaptions used to create a local Part A Care Continuum



Presenting care continuum information to planning bodies

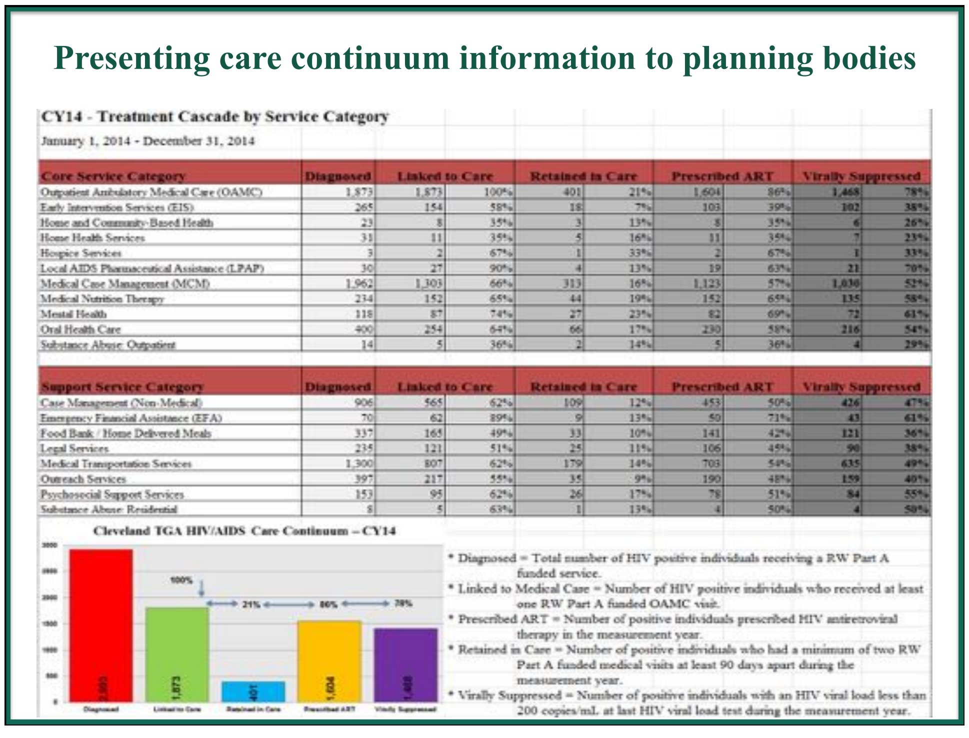
Working with our CAREWare / data consultant, a simple one page document was created to begin to familiarize planning council members with the continuum of care.

The document separates outcomes by funded service category and demographic profiles.

This form will be presented at both the Quality Improvement sub-committee meetings and the larger planning council group meetings on a quarterly basis.

CCBH

Presenting care continuum information to planning bodies



CY14 - Treatment Cascade by Service Category

January 1, 2014 - December 31, 2014

Core Service Category	Diagnosed	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
Outpatient Ambulatory Medical Care (OAMC)	1,873	1,873	100%	401	21%	1,604	86%	1,468	78%
Early Intervention Services (EIS)	265	154	58%	18	7%	103	39%	102	38%
Home and Community-Based Health	23	8	35%	3	13%	8	35%	6	26%
Home Health Services	31	11	35%	5	16%	11	35%	7	23%
Hospice Services	3	2	67%	1	33%	2	67%	1	33%
Local AIDS Pharmaceutical Assistance (LPAP)	30	27	90%	4	13%	19	63%	21	70%
Medical Case Management (MCM)	1,962	1,303	66%	313	16%	1,123	57%	1,030	52%
Medical Nutrition Therapy	234	152	65%	44	19%	152	65%	135	58%
Mental Health	118	87	74%	27	23%	82	69%	72	61%
Oral Health Care	400	254	64%	66	17%	230	58%	216	54%
Substance Abuse: Outpatient	14	5	36%	2	14%	5	36%	4	29%

Support Service Category	Diagnosed	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
Case Management (Non-Medical)	906	565	62%	109	12%	453	50%	426	47%
Emergency Financial Assistance (EFA)	70	62	89%	9	13%	50	71%	43	61%
Food Bank / Home Delivered Meals	337	165	49%	33	10%	141	42%	121	36%
Legal Services	235	121	51%	25	11%	106	45%	90	38%
Medical Transportation Services	1,300	807	62%	179	14%	703	54%	635	49%
Outreach Services	397	217	55%	35	9%	190	48%	159	40%
Psychosocial Support Services	153	95	62%	26	17%	78	51%	84	55%
Substance Abuse: Residential	8	5	63%	1	13%	4	50%	4	50%

* Diagnosed = Total number of HIV positive individuals receiving a RW Part A funded service.
* Linked to Medical Care = Number of HIV positive individuals who received at least one RW Part A funded OAMC visit.
* Prescribed ART = Number of positive individuals prescribed HIV antiretroviral therapy in the measurement year.
* Retained in Care = Number of positive individuals who had a minimum of two RW Part A funded medical visits at least 90 days apart during the measurement year.
* Virally Suppressed = Number of positive individuals with an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

Presenting care continuum information to planning bodies

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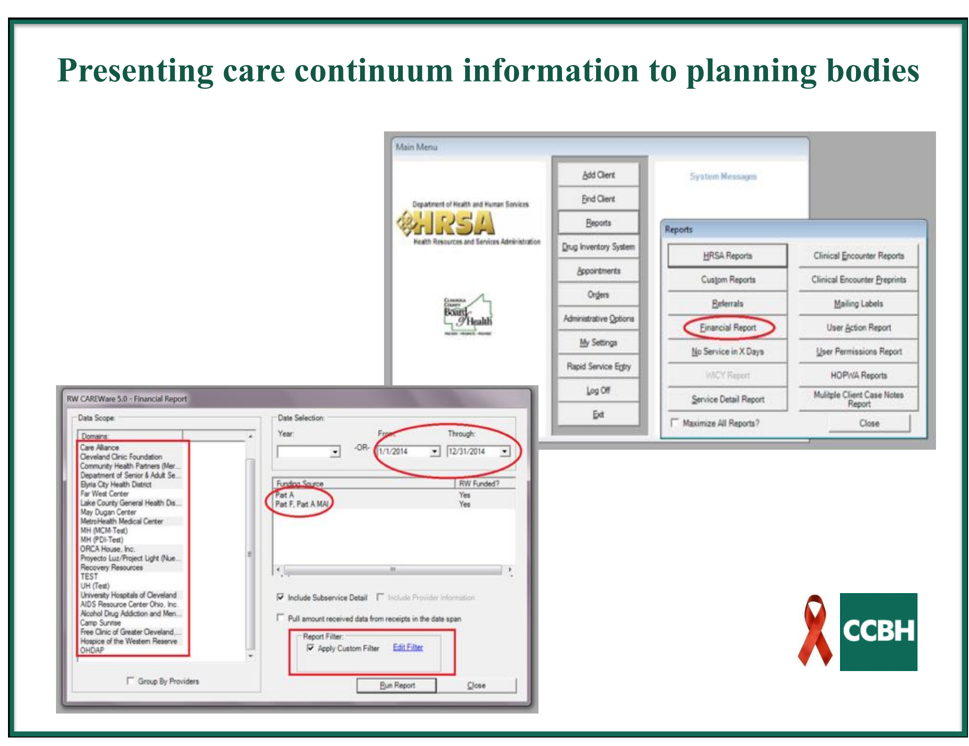
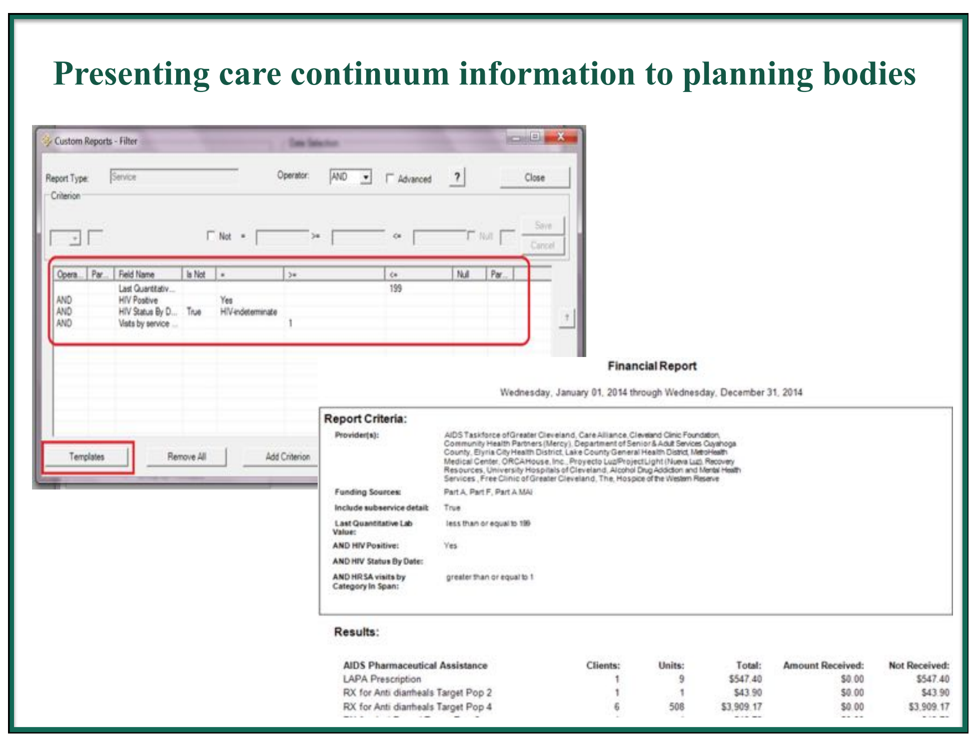
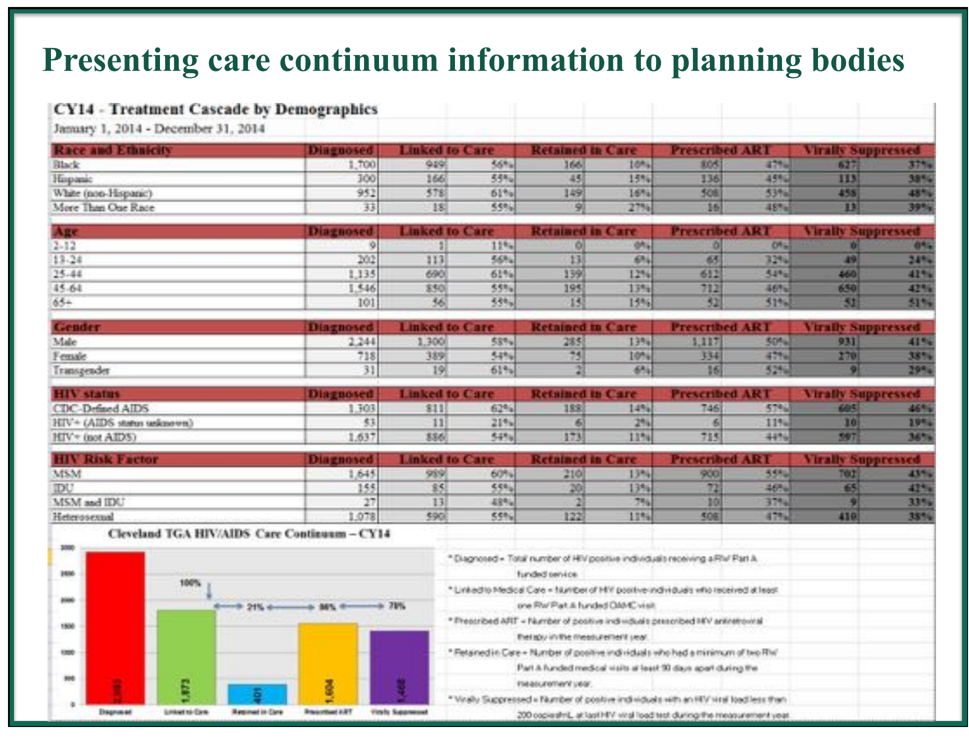
Food Bank / Home Delivered Meals	337	165	49%	33	10%	141	42%	121	36%
Legal Services	235	121	51%	25	11%	106	45%	90	38%
Medical Transportation Services	1,300	807	62%	179	14%	703	54%	635	49%
Outreach Services	397	217	55%	35	9%	190	48%	159	40%
Psychosocial Support Services	153	95	62%	26	17%	78	51%	84	55%
Substance Abuse: Residential	8	5	63%	1	13%	4	50%	4	50%

CCBH


Presenting care continuum information to planning bodies
Main Menu
Add Client
Find Client
Reports
Drug Inventory System
Appointments
Orders
Administrative Options
My Settings
Rapid Service Entry
Log Off
Exit
System Messages
Reports
HRSA Reports
Custom Reports
Referrals
Financial Report
No Service in X Days
Service Detail Report
Clinical Encounter Reports
Clinical Encounter Preprints
Mailing Labels
User Action Report
User Permissions Report
HOPWA Reports
Multiple Client Case Notes Report
Maximize All Reports?
Close
RW CAREWare 5.0 - Financial Report
Data Scope
Date Selection
Year:
-OR-
From:
Through:
1/1/2014
12/31/2014
Funding Source
RW Funded?
Part A
Part F, Part A MAI
Yes
Include Subservice Detail
Pull amount received data from receipts in the date span
Report Filter
Apply Custom Filter
Edit Filter
Group By Providers
Run Report
Close
CCBH


Presenting care continuum information to planning bodies
Custom Reports - Filter
Report Type:
Service
Operator:
AND
Advanced
Close
Criterion
Not
Null
Save
Cancel
Field Name
Is Not
Last Quantitativ...
HIV Positive
HIV Status By D...
Visits by service ...
199
Yes
True
HIV-indeterminate
1
Templates
Remove All
Add Criterion
Financial Report
Wednesday, January 01, 2014 through Wednesday, December 31, 2014
Report Criteria:
Funding Sources:
Part A, Part F, Part A MAI
Include subservice detail:
True
less than or equal to 199
AND HIV Positive:
Yes
AND HIV Status By Date:
greater than or equal to 1
Results:
AIDS Pharmaceutical Assistance
Clients:
Units:
Total:
Amount Received:
Not Received:
LAPA Prescription
RX for Anti diarrheals Target Pop 2
RX for Anti diarrheals Target Pop 4
$547.40
$43.90
$3,909.17
$0.00



Presenting care continuum information to planning bodies

CY14 - Treatment Cascade by Demographics

January 1, 2014 - December 31, 2014

Race and Ethnicity	Diagnosed	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
Black	1,700	949	56%	166	10%	805	47%	627	37%
Hispanic	300	166	55%	45	15%	136	45%	113	38%
White (non-Hispanic)	952	578	61%	149	16%	508	53%	458	48%
More Than One Race	33	18	55%	9	27%	16	48%	13	39%
Age	**Diagnosed**	**Linked to Care**		**Retained in Care**		**Prescribed ART**		**Virally Suppressed**	
2-12	9	1	11%	0	0%	0	0%	0	0%
13-24	202	113	56%	13	6%	65	32%	49	24%
25-44	1,135	690	61%	139	12%	612	54%	460	41%
45-64	1,546	850	55%	195	13%	712	46%	650	42%
65+	101	56	55%	15	15%	52	51%	52	51%
Gender	**Diagnosed**	**Linked to Care**		**Retained in Care**		**Prescribed ART**		**Virally Suppressed**	
Male	2,244	1,300	58%	285	13%	1,117	50%	931	41%
Female	718	389	54%	75	10%	334	47%	270	38%
Transgender	31	19	61%	2	6%	16	52%	9	29%
HIV status	**Diagnosed**	**Linked to Care**		**Retained in Care**		**Prescribed ART**		**Virally Suppressed**	
CDC-Defined AIDS	1,303	811	62%	188	14%	746	57%	605	46%
HIV+ (AIDS status unknown)	53	11	21%	6	2%	6	11%	10	19%
HIV+ (not AIDS)	1,637	886	54%	173	11%	715	44%	597	36%
HIV Risk Factor	**Diagnosed**	**Linked to Care**		**Retained in Care**		**Prescribed ART**		**Virally Suppressed**	
MSM	1,645	989	60%	210	13%	900	55%	702	43%
IDU	155	85	55%	20	13%	72	46%	65	42%
MSM and IDU	27	13	48%	2	7%	10	37%	9	33%
Heterosexual	1,078	590	55%	122	11%	508	47%	410	38%

* Diagnosed = Total number of HIV positive individuals receiving a RW Part A funded service
* Linked to Medical Care = Number of HIV positive individuals who received at least one RW Part A funded OAMC visit
* Prescribed ART = Number of positive individuals prescribed HIV antiretroviral therapy in the measurement year
* Retained in Care = Number of positive individuals who had a minimum of two RW Part A funded medical visits at least 90 days apart during the measurement year
* Virally Suppressed = Number of positive individuals with an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year

Presenting care continuum information to planning bodies

Race and Ethnicity	Diagnosed	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
Black	1,700	949	56%	166	10%	805	47%	627	37%
Hispanic	300	166	55%	45	15%	136	45%	113	38%
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Age	**Diagnosed**	**Linked to Care**		**Retained in Care**		**Prescribed ART**		**Virally Suppressed**	
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13-24	202	113	56%	13	6%	65	32%	49	24%
25-44	1,135	690	61%	139	12%	612	54%	460	41%
45-64	1,546	850	55%	195	13%	712	46%	650	42%
65+	101	56	55%	15	15%	52	51%	52	51%
Gender	**Diagnosed**	**Linked to Care**		**Retained in Care**		**Prescribed ART**		**Virally Suppressed**	
Male	2,244	1,300	58%	285	13%	1,117	50%	931	41%
Female	718	389	54%	75	10%	334	47%	270	38%
Transgender	31	19	61%	2	6%	16	52%	9	29%
HIV status	**Diagnosed**	**Linked to Care**		**Retained in Care**		**Prescribed ART**		**Virally Suppressed**	
CDC-Defined AIDS	1,303	811	62%	188	14%	746	57%	605	46%
HIV+ (AIDS status unknown)	53	11	21%	6	2%	6	11%	10	19%
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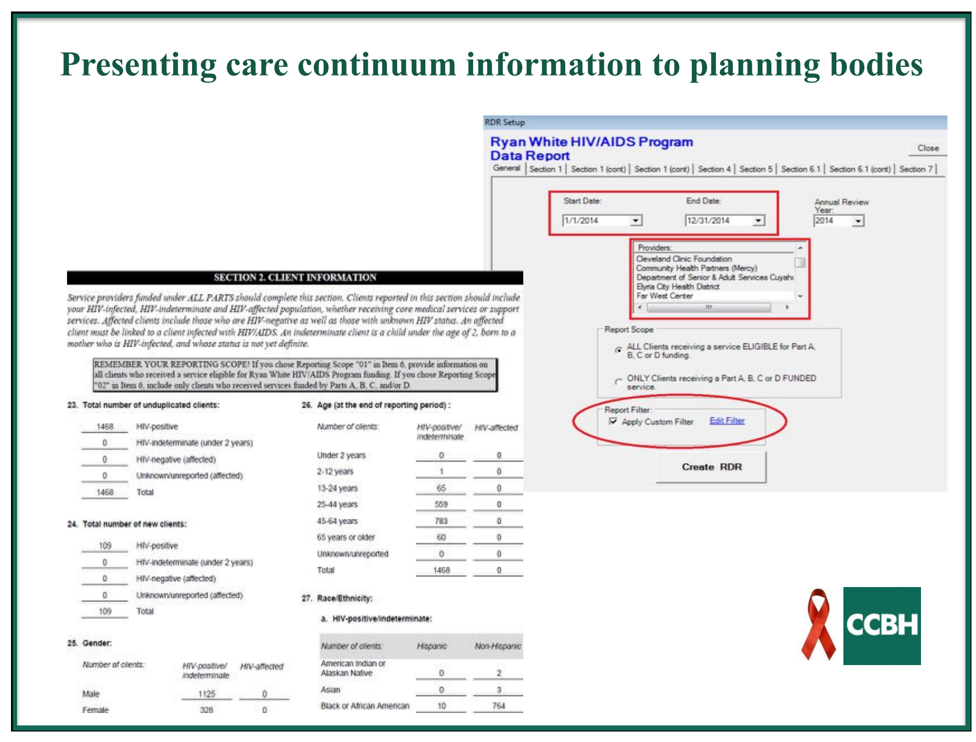
HIV Risk Factor	**Diagnosed**	**Linked to Care**		**Retained in Care**		**Prescribed ART**		**Virally Suppressed**	
MSM	1,645	989	60%	210	13%	900	55%	702	43%
IDU	155	85	55%	20	13%	72	46%	65	[illegible]
MSM and IDU	27	13	48%	2	7%	10	37%	9	33%
Heterosexual	1,078	590	55%	122	11%	508	47%	410	38%

CCBH



Presenting care continuum information to planning bodies

SECTION 2. CLIENT INFORMATION

Service providers funded under ALL PARTS should complete this section. Clients reported in this section should include your HIV-infected, HIV-indeterminate and HIV-affected population, whether receiving core medical services or support services. Affected clients include those who are HIV-negative as well as those with unknown HIV status. An affected client must be linked to a client infected with HIV/AIDS. An indeterminate client is a child under the age of 2, born to a mother who is HIV-infected, and whose status is not yet definite.

REMEMBER YOUR REPORTING SCOPE! If you chose Reporting Scope "01" in Item 6, provide information on all clients who received a service eligible for Ryan White HIV/AIDS Program funding. If you chose Reporting Scope "02" in Item 6, include only clients who received services funded by Parts A, B, C, and/or D.

23. Total number of unduplicated clients:

1468	HIV-positive
0	HIV-indeterminate (under 2 years)
0	HIV-negative (affected)
0	Unknown/unreported (affected)
1468	Total

24. Total number of new clients:

109	HIV-positive
0	HIV-indeterminate (under 2 years)
0	HIV-negative (affected)
0	Unknown/unreported (affected)
109	Total

25. Gender:

Number of clients:	*HIV-positive/ indeterminate*	*HIV-affected*
Male	1125	0
Female	328	0

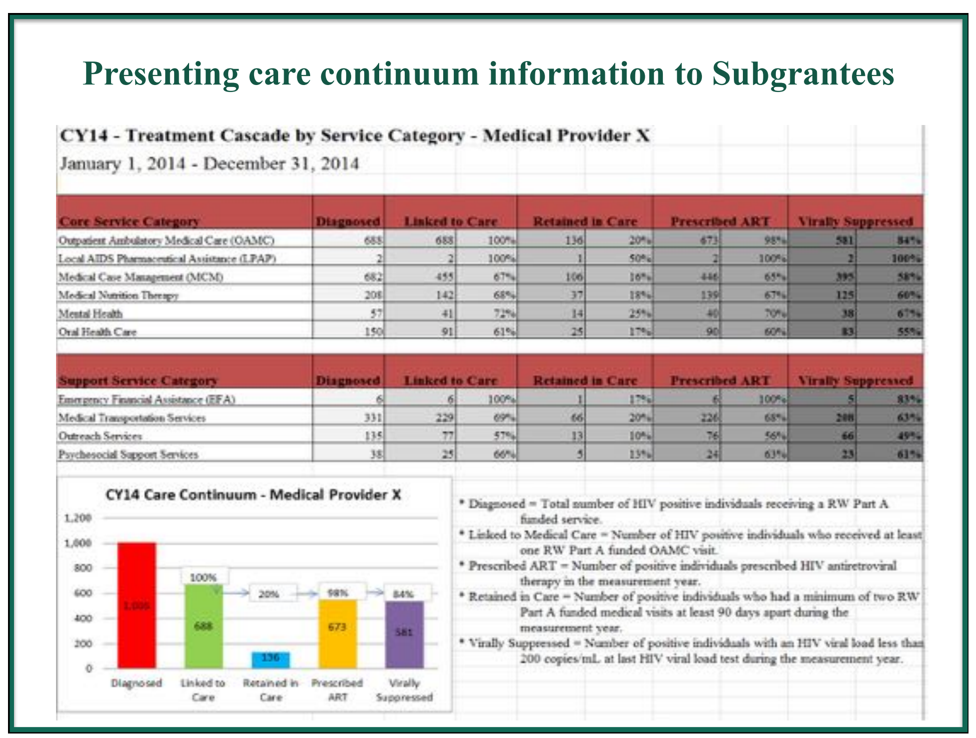
26. Age (at the end of reporting period):

Number of clients:	*HIV-positive/ indeterminate*	*HIV-affected*
Under 2 years	0	0
2-12 years	1	0
13-24 years	65	0
25-44 years	559	0
45-64 years	783	0
65 years or older	60	0
Unknown/unreported	0	0
Total	1468	0

27. Race/Ethnicity:

a. HIV-positive/indeterminate:

Number of clients:	*Hispanic*	*Non-Hispanic*
American Indian or Alaskan Native	0	2
Asian	0	3
Black or African American	10	764



Presenting care continuum information to Subgrantees

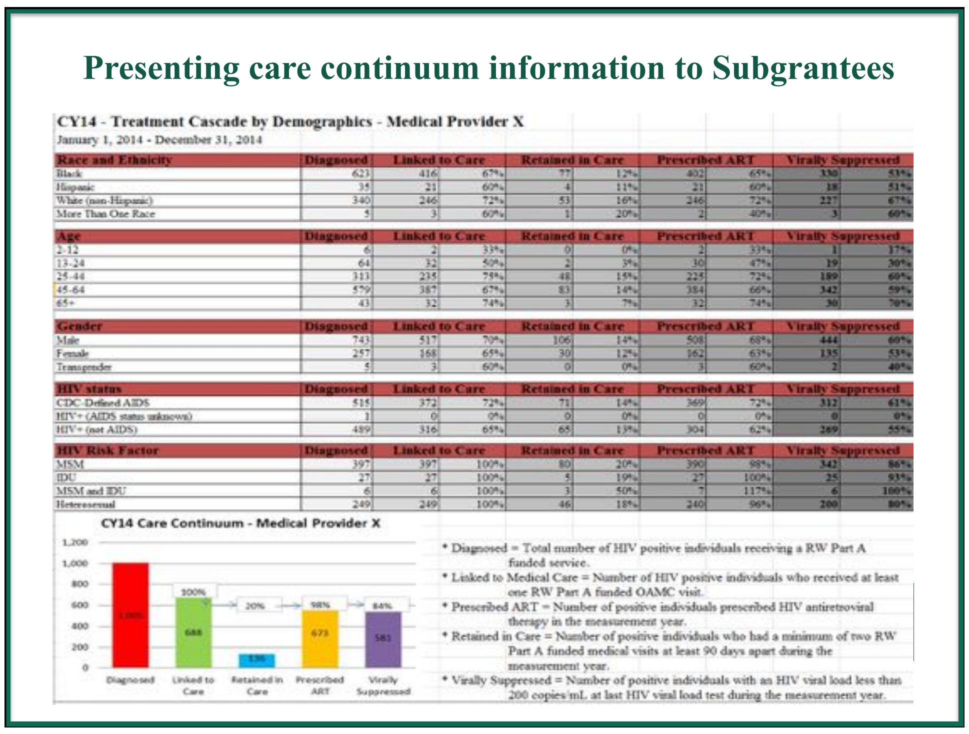
CY14 - Treatment Cascade by Service Category - Medical Provider X

January 1, 2014 - December 31, 2014

Core Service Category	Diagnosed	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
Outpatient Ambulatory Medical Care (OAMC)	688	688	100%	136	20%	673	98%	581	84%
Local AIDS Pharmaceutical Assistance (LPAP)	2	2	100%	1	50%	2	100%	2	100%
Medical Case Management (MCM)	682	455	67%	106	16%	446	65%	395	58%
Medical Nutrition Therapy	208	142	68%	37	18%	139	67%	125	60%
Mental Health	57	41	72%	14	25%	40	70%	38	67%
Oral Health Care	150	91	61%	25	17%	90	60%	83	55%

Support Service Category	Diagnosed	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
Emergency Financial Assistance (EFA)	6	6	100%	1	17%	6	100%	5	83%
Medical Transportation Services	331	229	69%	66	20%	226	68%	208	63%
Outreach Services	135	77	57%	13	10%	76	56%	66	49%
Psychosocial Support Services	38	25	66%	5	13%	24	63%	23	61%

* Diagnosed = Total number of HIV positive individuals receiving a RW Part A funded service.
* Linked to Medical Care = Number of HIV positive individuals who received at least one RW Part A funded OAMC visit.
* Prescribed ART = Number of positive individuals prescribed HIV antiretroviral therapy in the measurement year.
* Retained in Care = Number of positive individuals who had a minimum of two RW Part A funded medical visits at least 90 days apart during the measurement year.
* Virally Suppressed = Number of positive individuals with an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.



Presenting care continuum information to Subgrantees

CY14 - Treatment Cascade by Demographics - Medical Provider X
January 1, 2014 - December 31, 2014

Race and Ethnicity	Diagnosed	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
Black	623	416	67%	77	12%	402	65%	330	53%
Hispanic	35	21	60%	4	11%	21	60%	18	51%
White (non-Hispanic)	340	246	72%	53	16%	246	72%	227	67%
More Than One Race	5	3	60%	1	20%	2	40%	3	60%

Age	Diagnosed	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
2-12	6	2	33%	0	0%	2	33%	1	17%
13-24	64	32	50%	2	3%	30	47%	19	30%
25-44	313	235	75%	48	15%	225	72%	189	60%
45-64	579	387	67%	83	14%	384	66%	342	59%
65+	43	32	74%	3	7%	32	74%	30	70%

Gender	Diagnosed	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
Male	743	517	70%	106	14%	508	68%	444	60%
Female	257	168	65%	30	12%	162	63%	135	53%
Transgender	5	3	60%	0	0%	3	60%	2	40%

HIV status	Diagnosed	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
CDC-Defined AIDS	515	372	72%	71	14%	369	72%	312	61%
HIV+ (AIDS status unknown)	1	0	0%	0	0%	0	0%	0	0%
HIV+ (not AIDS)	489	316	65%	65	13%	304	62%	269	55%

HIV Risk Factor	Diagnosed	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
MSM	397	397	100%	80	20%	390	98%	342	86%
IDU	27	27	100%	5	19%	27	100%	25	93%
MSM and IDU	6	6	100%	3	50%	7	117%	6	100%
Heterosexual	249	249	100%	46	18%	240	96%	200	80%

* Diagnosed = Total number of HIV positive individuals receiving a RW Part A funded service.
* Linked to Medical Care = Number of HIV positive individuals who received at least one RW Part A funded OAMC visit.
* Prescribed ART = Number of positive individuals prescribed HIV antiretroviral therapy in the measurement year.
* Retained in Care = Number of positive individuals who had a minimum of two RW Part A funded medical visits at least 90 days apart during the measurement year.
* Virally Suppressed = Number of positive individuals with an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

Intersecting care continuums and quality improvement projects

- Agencies provided with exported client ID lists for those that are not virally suppressed on a quarterly basis.
- 20% improvement goal on viral load suppression rates throughout the TGA. (dif = 81)
- Ohio is also one of five states currently participating in the National Quality Center's H4C initiative.

2000 1800 1600 1400 1200 1000 800 600 400 200 0
Baseline | 20% improvement

CCBH

The Cleveland Ryan White Part A TGA
Thank you!
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BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION
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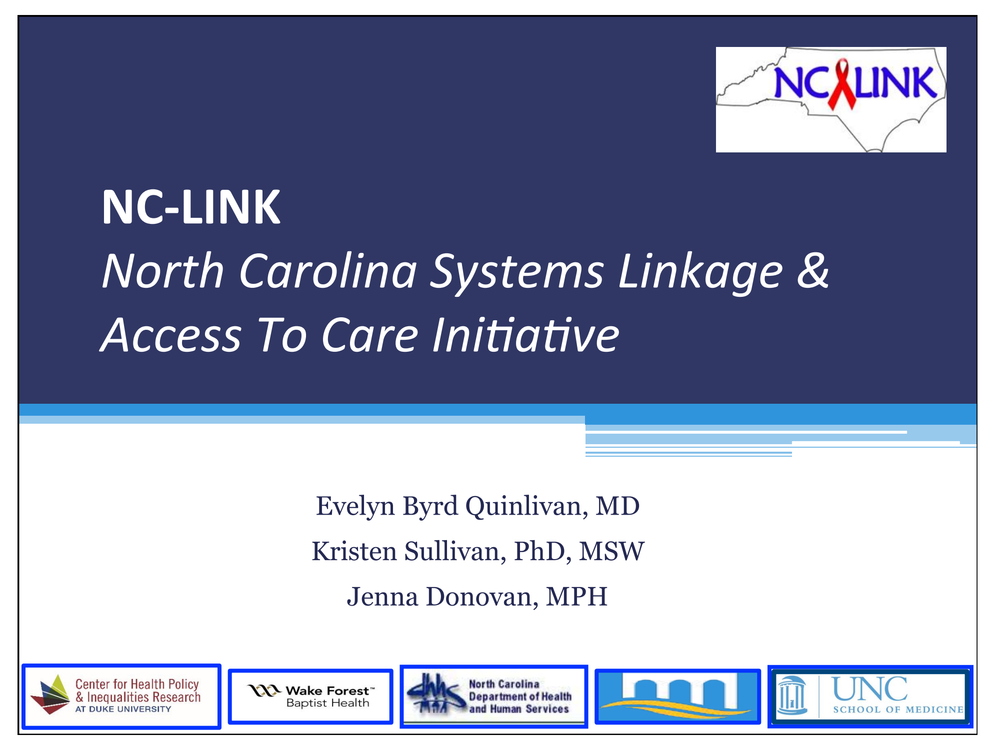
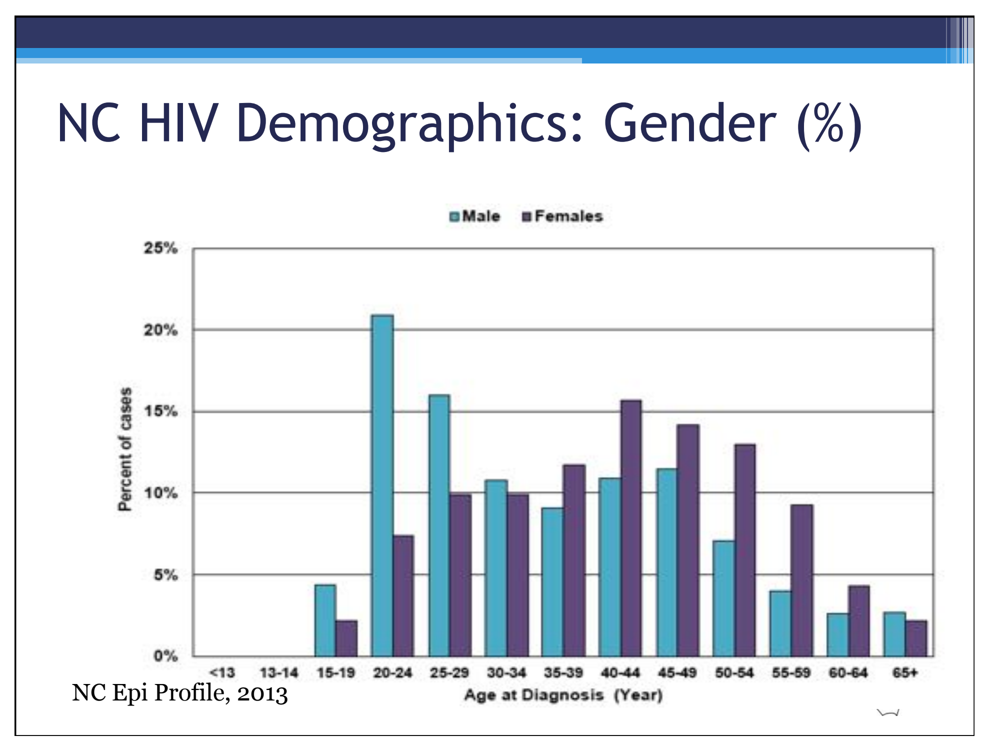
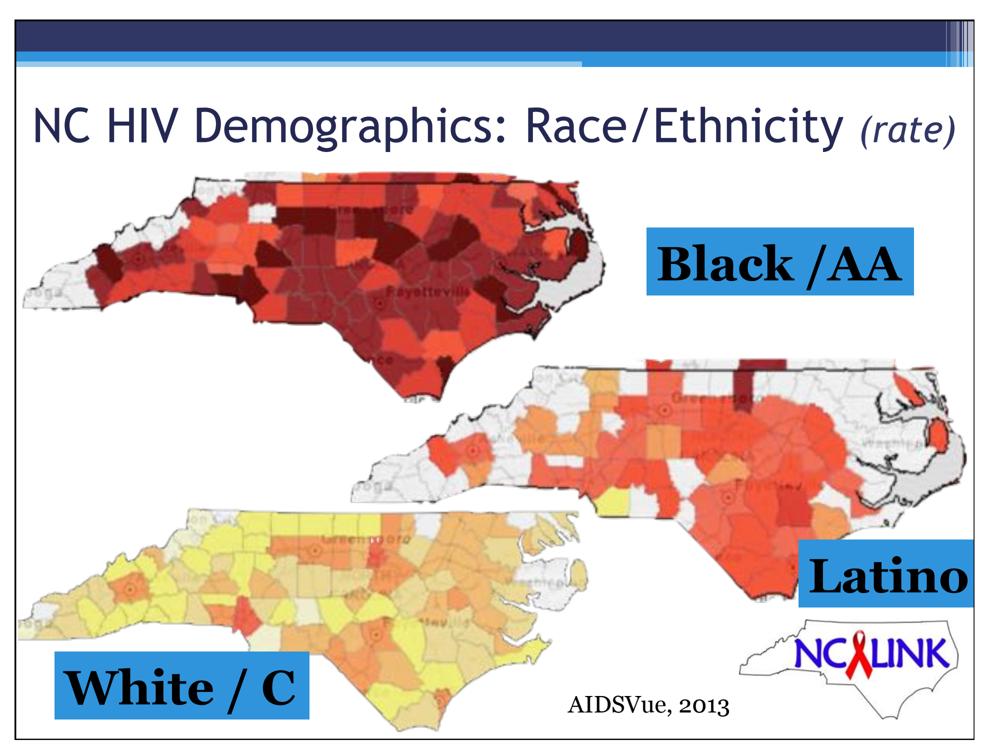

NC LINK
NC-LINK
North Carolina Systems Linkage & Access To Care Initiative
Evelyn Byrd Quinlivan, MD
Kristen Sullivan, PhD, MSW
Jenna Donovan, MPH
Center for Health Policy & Inequalities Research AT DUKE UNIVERSITY
Wake Forest Baptist Health
North Carolina Department of Health and Human Services
UNC SCHOOL OF MEDICINE


NC HIV Demographics: Gender (%)
Male
Females
25%
20%
15%
10%
5%
0%
Percent of cases
<13
13-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65+
Age at Diagnosis (Year)
NC Epi Profile, 2013


NC HIV Demographics: Race/Ethnicity (rate)
Black /AA
Latino
White / C
NCLINK
AIDSVue, 2013

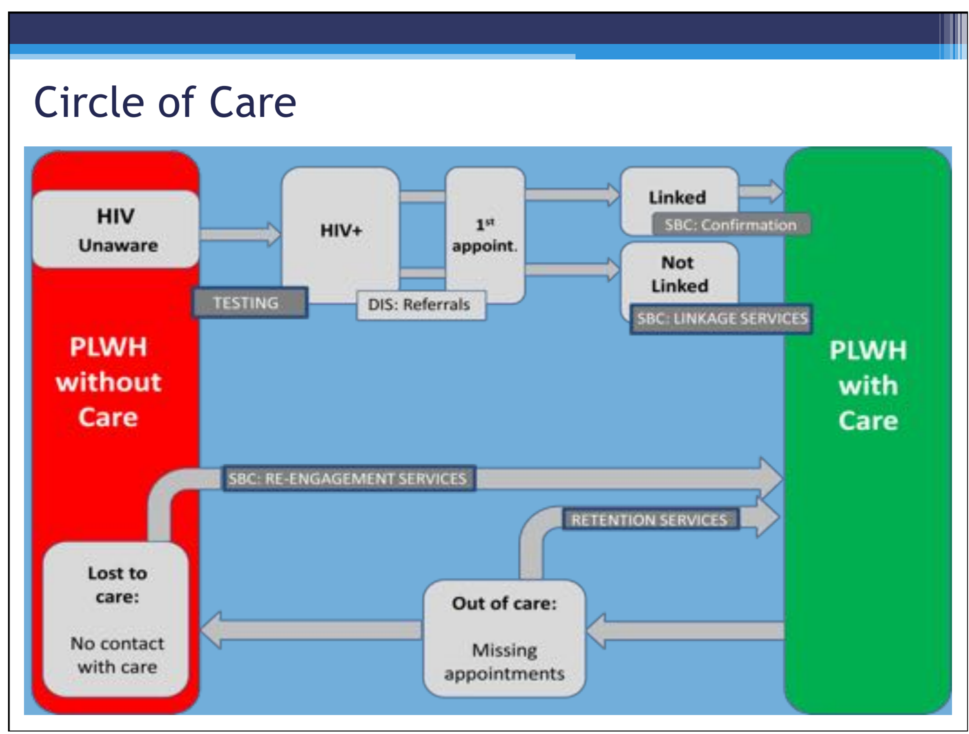
Challenges to Continuum of Care in NC

- Large geographic distances
- Limited fieldwork capacity of staff within regions/clinics
- Partner notification, control measures are the key responsibilities of Disease Intervention Specialists
- Processes for locating clients, varied, informal, absent

NC-LINK Pilot Phase (2012-2013)

- Learning Collaborative Model
- Formal Collaborative Structure
  - Conference calls monthly with pilot sites
  - Stakeholder meetings, at six months
  - Presentations by test site staff
  - PDSA cycles
  - Availability of team for technical assistance
- 4 clinic, 2 statewide interventions tested
- 4 interventions selected for expansion

Circle of Care



Retention Protocol Baseline

- 1 large academic clinic with 2,000 HIV patients
  - Existing procedure – irregular intervals (years)
- Large backlog
- Each list was generated independently
- Location and contact strategies - Best practices
- Lack of outreach /field skills
- No strategies to prevent gaps in care
- CAREWare Ryan White Data repository
- EMR

NC-LINK Retention Protocol

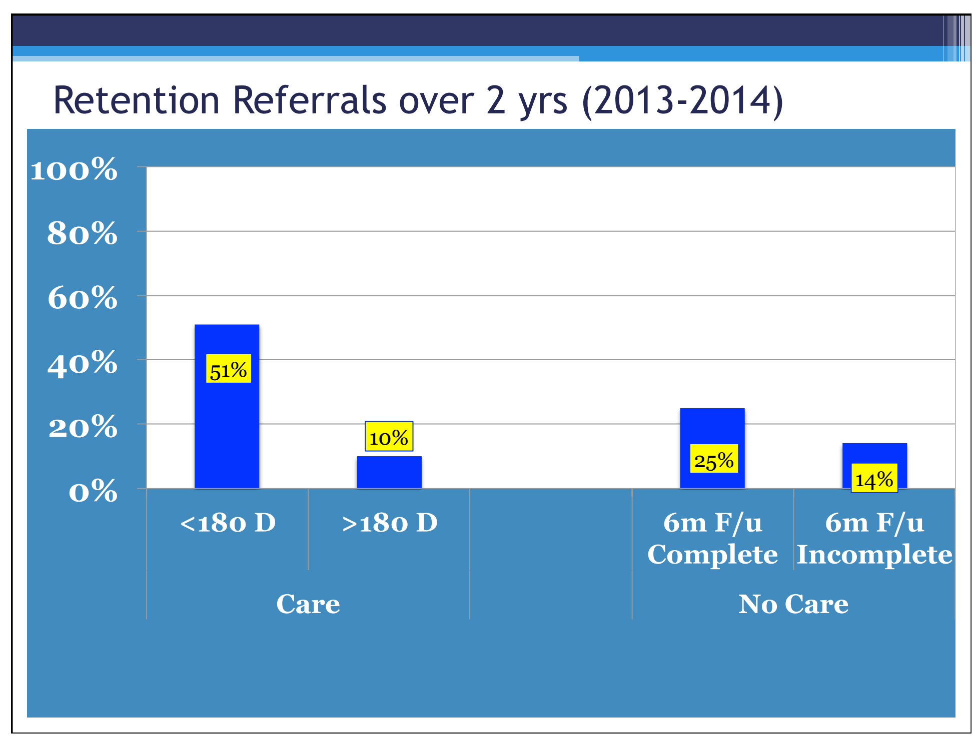
- Out-of-care list generated as a report
  - Data manager performs
  - PLWH who have not had a medical care visit in 6-9 m
  - Runs list through clinic EMR or CAREWare (CW)
- Data manager review
  - Remove clients who are not truly out-of-care
  - Have future appointment
  - Special circumstances
- Referral to retention staff
- Retention staff work on locating client for up to 30 days
  - Call all phone #s, contacts
  - Internet search- jails, prisons, death index, Google, Medicaid
  - Contact pharmacy to leave message
  - Letter

NC LINK

Retention Protocol (continued)

- 30-day search period of locating
  - Document efforts and provide outcomes via CAREWare
- Close out clients with definitive outcome
- *Lost to care referrals (Unknown/not located clients)*
  - Referred to State Bridge Counselor for re-engagement services including fieldwork
- Expanded to 4 Regional Networks of Care, 13 agencies

NC LINK



Challenges

- Staff resources can be limited
  - retention staff usually have many other job responsibilities
  - Turnover/training within retention positions
- Long initial lists (200-300 clients)
- Hand-off to external field workers required
- Client mobility

Successes

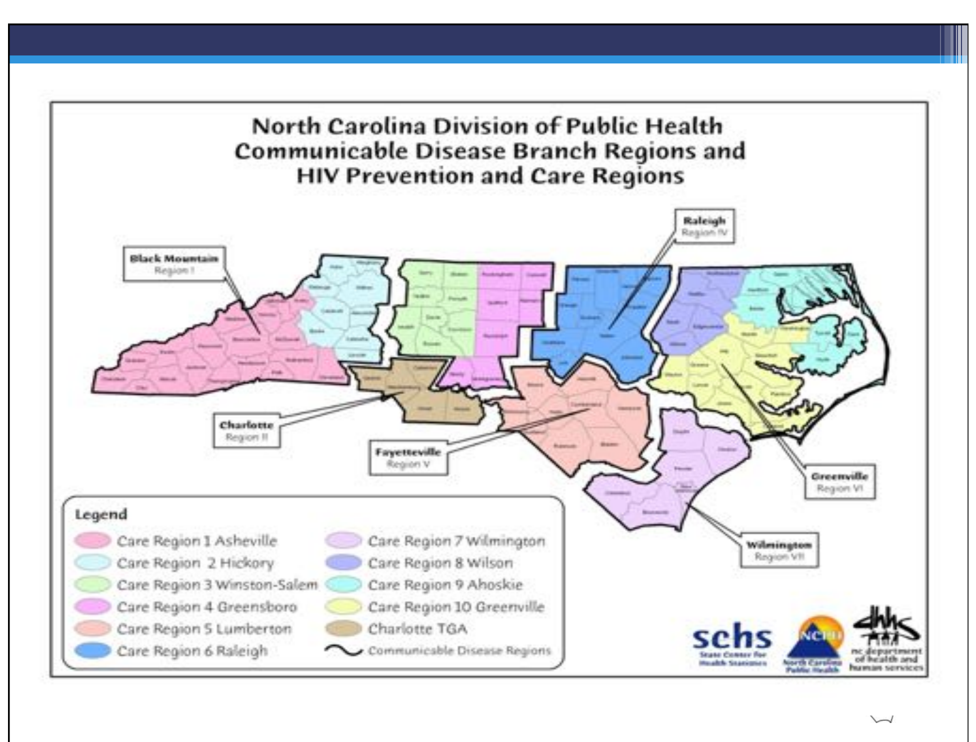
- > 60% are back in care
- Able to determine client status in the majority of cases.
- Processes are streamlined, transparent, documented
- Lists are shortened after backlog is addressed.
- Long lists can be worked using priorities
  - Patient Risk: low CD4, time out of care
  - Public Health Risk: high VL, target population

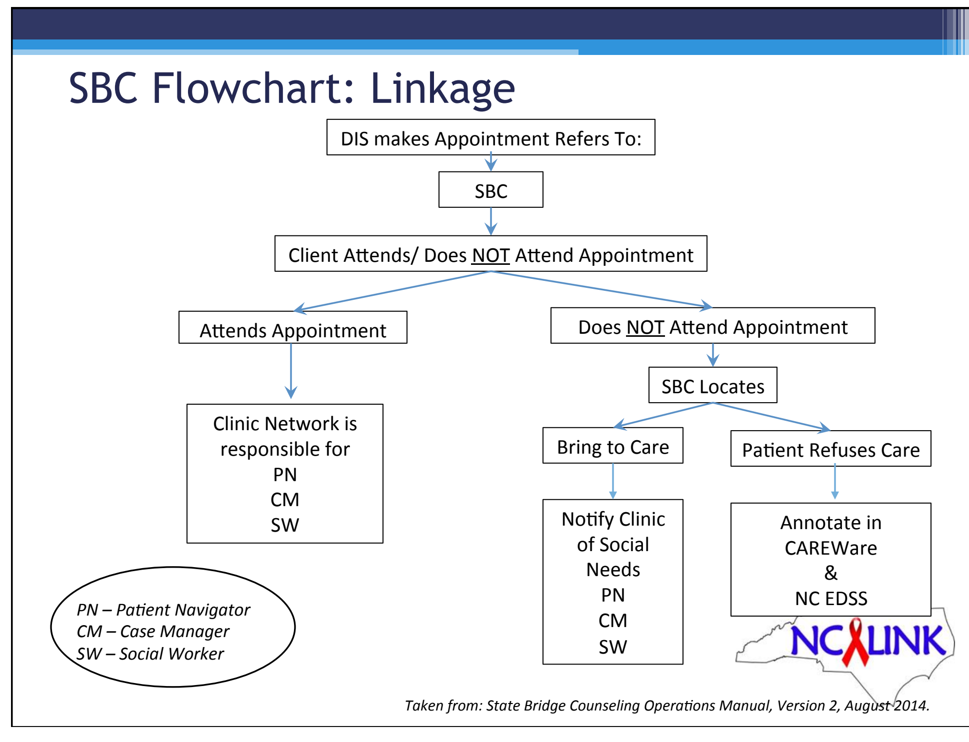
Linkage *and* Re-engagement by State Bridge Counselors

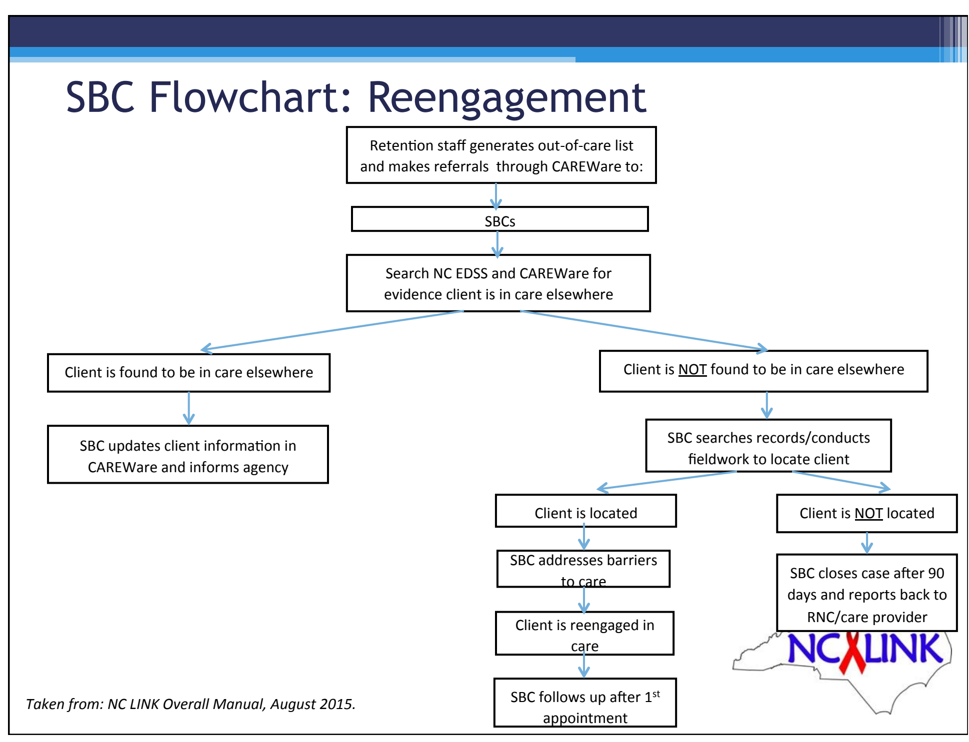
(Interventions #2, #4)

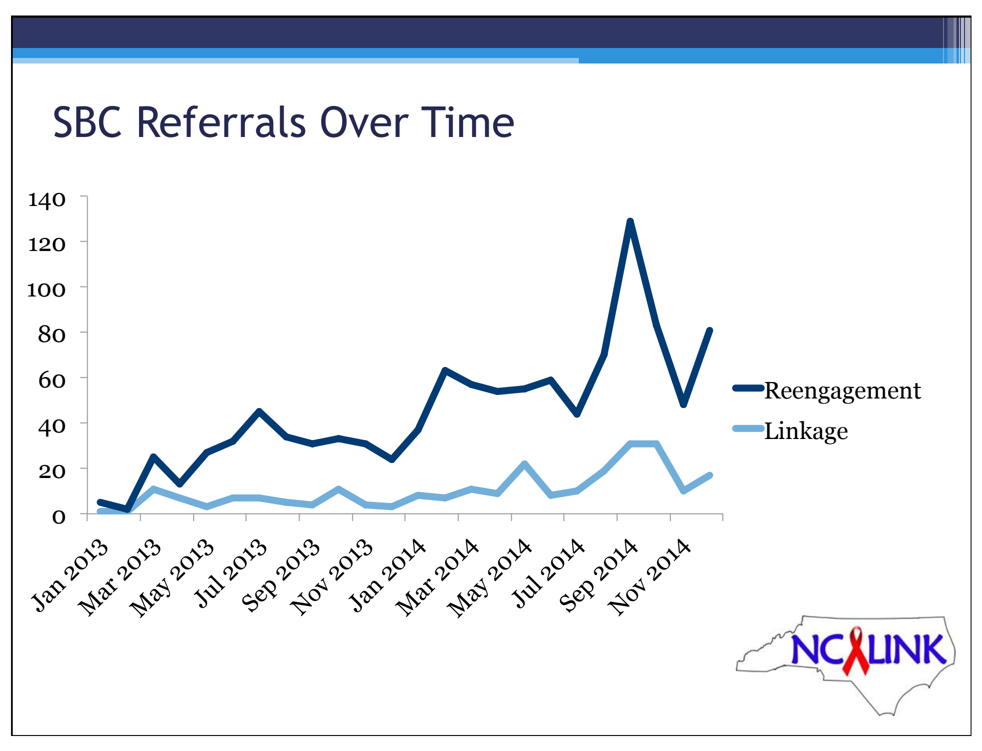
State Bridge Counselors (SBCs)

- Positions created within NC Dept of Health and Human Services in 2012
- Purpose is to improve linkage and re-engagement in HIV care
- Collaborate with DIS, case managers, and community partners
- Utilize protocol and strengths-based techniques




SBC Flowchart: Linkage
DIS makes Appointment Refers To:
SBC
Client Attends/ Does NOT Attend Appointment
Attends Appointment
Does NOT Attend Appointment
Clinic Network is responsible for PN CM SW
SBC Locates
Bring to Care
Patient Refuses Care
Notify Clinic of Social Needs PN CM SW
Annotate in CAREWare & NC EDSS
PN – Patient Navigator
CM – Case Manager
SW – Social Worker
NC LINK
Taken from: State Bridge Counseling Operations Manual, Version 2, August 2014.


SBC Flowchart: Reengagement
Retention staff generates out-of-care list and makes referrals through CAREWare to:
SBCs
Search NC EDSS and CAREWare for evidence client is in care elsewhere
Client is found to be in care elsewhere
Client is NOT found to be in care elsewhere
SBC updates client information in CAREWare and informs agency
SBC searches records/conducts fieldwork to locate client
Client is located
Client is NOT located
SBC addresses barriers to care
Client is reengaged in care
SBC follows up after 1st appointment
SBC closes case after 90 days and reports back to RNC/care provider
NC LINK
Taken from: NC LINK Overall Manual, August 2015.

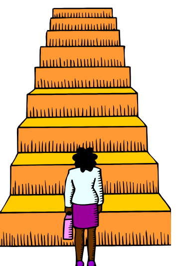


SBC Linkage and Reengagement in Care Outcomes

	Linkage (n=247)	Reengagement (n=835)
Viral Load w/in 90 days of referral	134 (54%)	289 (35%)
Viral Load w/in 180 days of referral	162 (66%)	393 (47%)
Demonstrates Viral Suppression (<200) within 180 days	101 (41%)	219 (26%)

Challenges of Implementation

- Role confusion and delineation
- Legal concerns –control measure violations
- Personnel– turnover, hiring freezes, etc.
- Large geographic distances covered
- Incomplete, out-of-date information in referrals



Summary of Strengths of SBC Program

- Utilization of CAREWare for referrals and documentation
- Ability to conduct fieldwork and provide transportation
- Strengths-based approach
- Unified statewide team with consistent procedures
- Leverage public health resources for client information

Summary of IT Support Requirements

- *Software requirements* for referrals and documentations
  - Data repository of client information
  - Location for documentation of activities/ outcomes
  - Make referrals and generate work lists for individual staff
- *Data Sharing* across jurisdictions

Conclusions

- Collaborative, multi-level approach necessary to significantly impact Continuum of Care within NC
- Statewide care data systems can be leveraged to enhance communication and coordination of efforts
- Utilization of existing resources will enhance sustainability of interventions
- Initial analyses suggest approach is effective; evaluation is ongoing.

North Carolina NC-LINK Leadership Team

Co-Principal Investigators: E. Byrd Quinlivan, MD[1] & Jacquelyn Clymore, MA[2]
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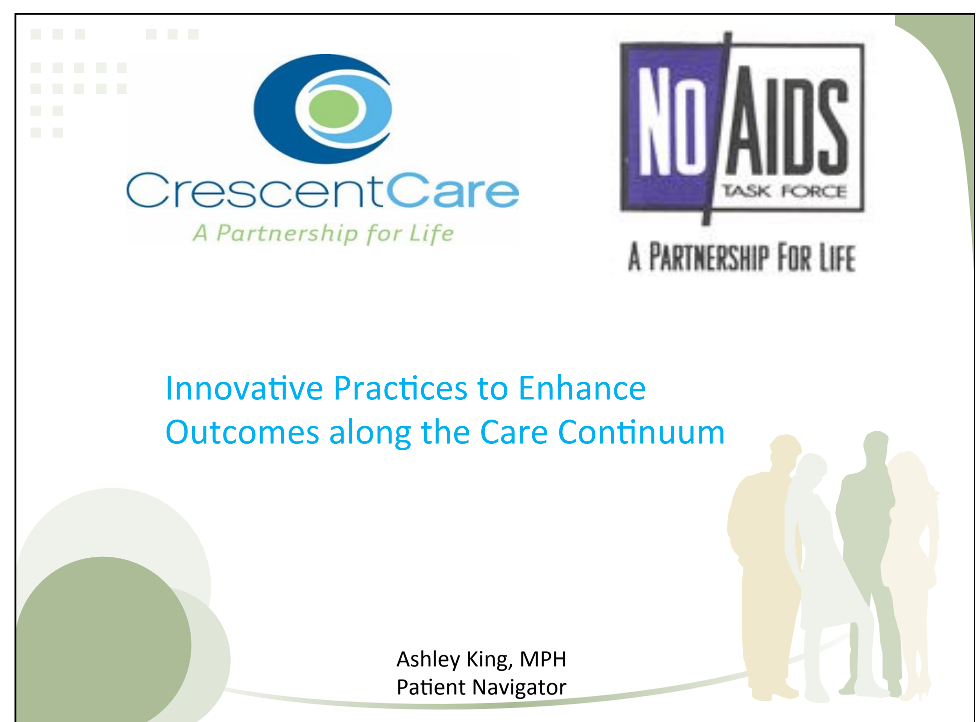
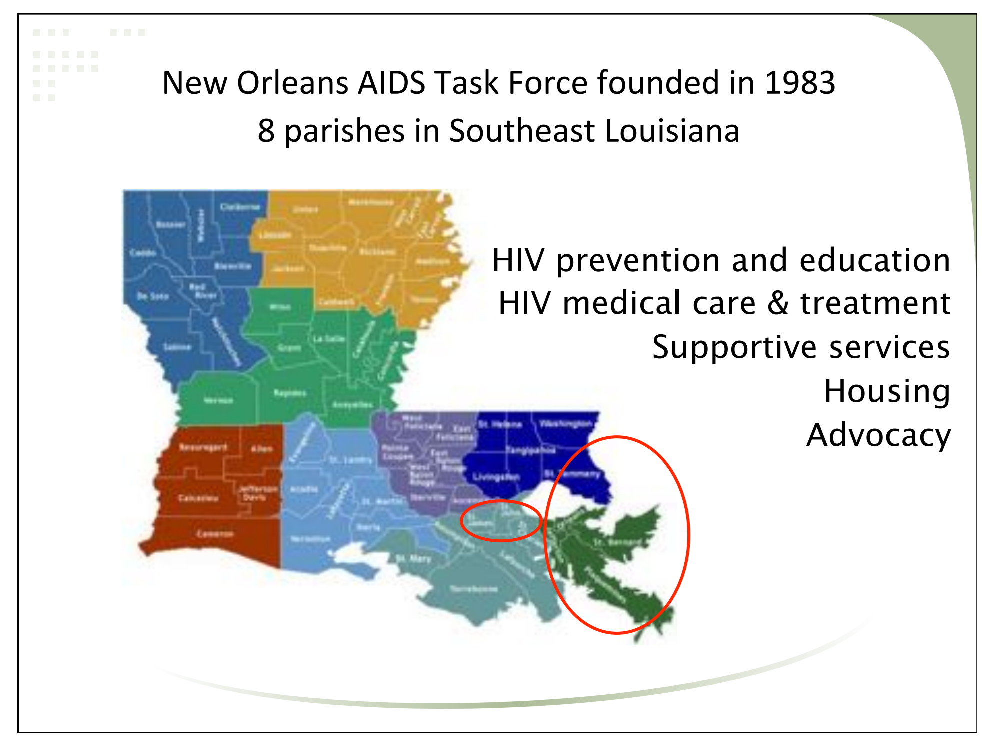


Overview

- History of CrescentCare
- Services Offered
- Transition to Federally Qualified Health Center (FQHC)
- Current Initiatives
  - Linkage to Care
  - Data Sharing



Mission Statement

NO/AIDS Task Force

"To reduce the spread of HIV infection, provide services, advocate empowerment, safeguard the rights and dignity of HIV-affected community, and provide for an enlightened public"

Tulane Tower (2601 Tulane Ave.) (CrescentCare Specialty Center)

- ✓ Primary Medical Care
- ✓ Behavioral Health
- ✓ Case Management
- ✓ Med. Nutrition Therapy
- ✓ Transportation
- ✓ Housing
- ✓ Peer Support

Tulane Tower (2601 Tulane Ave.)

- ✓ Contract Pharmacy
- ✓ Med. Assistance
- ✓ Food Pantry
- ✓ Support Groups
- ✓ HIV Testing and Counseling
- ✓ Legal Services
- ✓ Admin. Activities

Growth over the years

NO/AIDS Task Force founded in 1983

	2006	2008	2010	2011	2012	2013	2014	2015
Annual Budget	*$3.5m*	*$6.6m*	*$11.9m*	*$14.8m*	*$19m*	*$20m*	*$27m*	*$28m*
Paid Staff	*36*	*68*	*107*	*131*	*170*	*184*	*220*	*220+*
Volunteers	*150*	*350*	*400+*	*400+*	*400+*	*400+*	*400+*	*400+*

2013 *2,884 clients (HIV+) receiving supportive services*

- *1,522 in Primary Medical Care (PMC)*

2014 *4,275 clients (48% client increase)*

- *2,774 in PMC (82% PMC increase)*

Why become a FQHC?

- ✓ It's all about the community!
- ✓ Provide much needed services in a post-Katrina landscape
- ✓ Broaden our reach in the community
- ✓ Opportunity to expand services
- ✓ Ensure long-term organizational financial sustainability

New brand, new mission

CrescentCare

"To offer comprehensive health and wellness services to the community, to advocate empowerment, to safeguard the rights and dignity of individuals, and to provide for an enlightened public"

Family Care
Services Center
CrescentCare
(4640 So. Carrollton Ave.)
✓ Primary Medical Care
✓ Behavioral Health
✓ Case Management
✓ PrEP
✓ HIV CTR

Marine Building
(3308 Tulane Avenue)
CrescentCare
A Partnership for Life

CrescentCare
A Partnership for Life
New services
✓ Pediatrics
✓ Obstetrics/Gynecology
✓ Family Medicine
✓ Internal Medicine
✓ Integrated Behavioral Health
✓ Outreach/Enrollment
✓ Employment Services
✓ Medical/Legal Partnership
✓ Case Mgmt./Care Completion
✓ Patient/Community Education
✓ PrEP Clinic
✓ Dental Suite

• Patient Centered Medical Home
• CARF Accreditation
CrescentCare
A Partnership for Life

Successes

For the agency

- ✓ Sustainability
- ✓ Maintain organization legacy
- ✓ Personnel (skills/expertise)
- ✓ New partnerships

For the client

- ✓ Offer expanded services to the community transgender clinical care, dental services, OB/GYN, HCV testing and treatment, PrEP
- ✓ Improved patient experience (based on patient satisfaction survey)
- ✓ Less stigma
- ✓ Expanded capacity

Challenges

- Recruiting and on-boarding of multiple practitioners is time consuming
- Applying and securing new NPI numbers, 340b registration, CLIA waiver, occupational licenses
- Ensuring new providers are credentialed with 3rd party payers (insurance, Medicaid, Medicare)
- Keeping staff informed of strategic vision
- Building infrastructure

LINKAGE TO CARE INITIATIVE

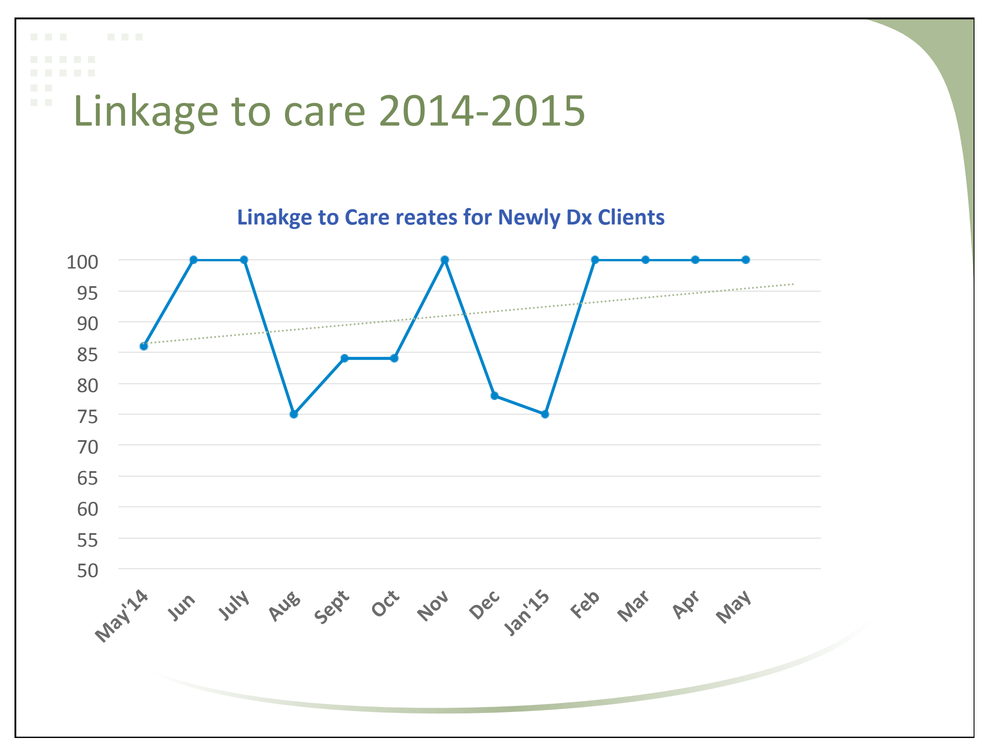
Linkage to Care

- Prior to our IAHCT (Increasing Access to Healthcare and Treatment) funding for a Patient Navigator (PN), linkage to care rates were around 50% and responsibilities were shared.
- In 2012 we received funding designated to facilitate linkage to care (L2C)/ patient navigation
- Within that year, L2C rates rose to 73% and have continually improved

Streamlining the Process

- All positive tests are funneled through the PN
- The PN ensures all paperwork is completed
- PN contacts the client within 24 hours
- PN meets with the client
- PN helps client enroll in case management
- PN schedules the clients first medical appointment
- Follow-up

Linkage to care 2014-2015



Lessons Learned

- ✓ Streamlining the process has increased our linkage to care rates
- ✓ Client is able to link to care immediately after receiving positive results
- ✓ Decreases lost to follow-up
- ✓ Provides for a smooth transition between departments
- ✓ Provides a strong support system for the client
- ✓ Identify competing priorities/barriers for the client and help reduce them

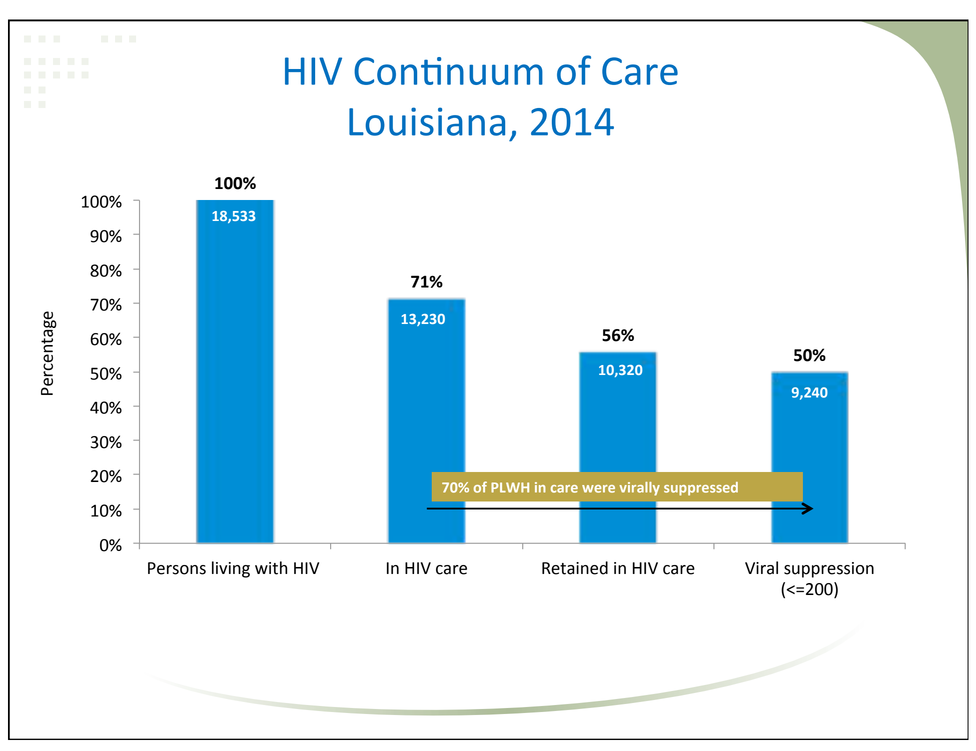
DATA SHARING INITIATIVE

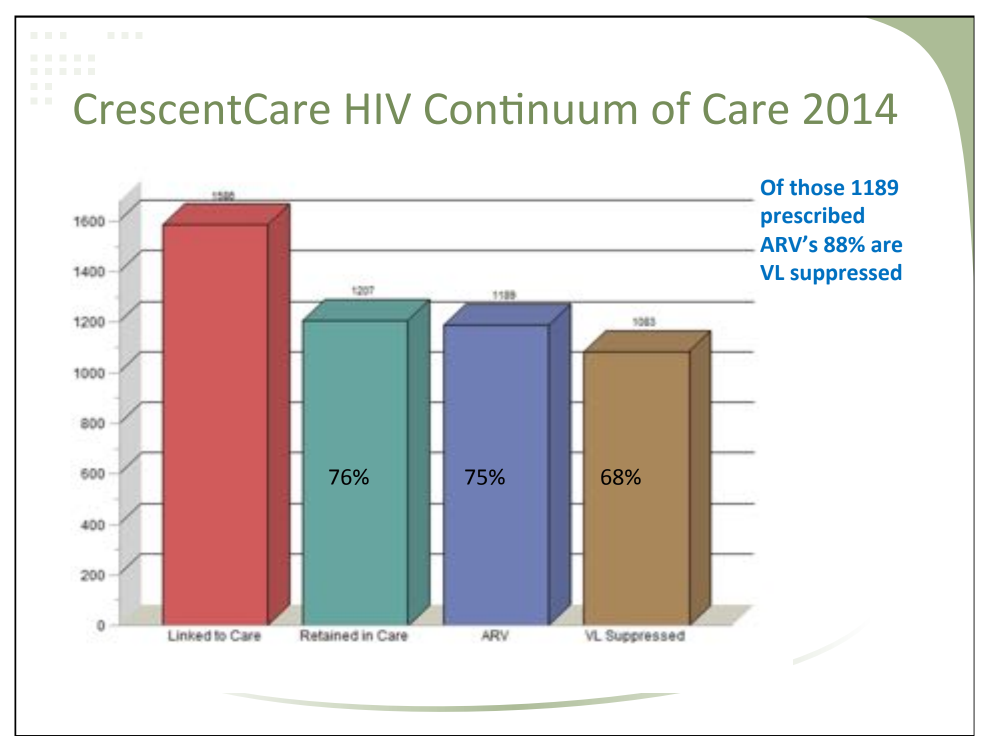
Data Sharing

- In January 2015, at the suggestion of our HIV quality consultant, CrescentCare along with six other agencies throughout the state formed the Louisiana HIV Clinical Quality Group.

Participants include:

- LSU sites
- RW agencies
- Louisiana Office of Public Health





Data sharing with Office of Public Health

- "Out of care" initiative
  - Out of Care
    - Patients who have not had provider appointment in over 180 days
- Compile Data
- Cleaning Data (OPH)
- Re- engaged out of care clients

Data sharing cont.

- Statewide surveillance data from OPH
- Clinics interested in establishing a regular feedback mechanism, using facility-based surveillance data
- Collaborative data analysis

Lessons Learned

- Take advantage of resources other organizations may have access too.
- Partnership has strengthen relationship with Office of Public Health
- Recognize necessity for re-engagement/ retention position
- Initiative still in early stages no hard data on re-engagement

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BREAK – 5 Minutes

BREAKOUT SESSION