



**Department  
of Health**

**AIDS  
Institute**

## **Partnership for Care: Developing real and sustainable partnerships with health centers**

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Rachel Hart-Malloy- AIDS Institute, New York State Department of Health

# Outline

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NYSDOH

Project activities

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Description of procedures

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Highlighting outcomes

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Cornerstone

Success of partnership

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HIV Care Team

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Outreach Efforts

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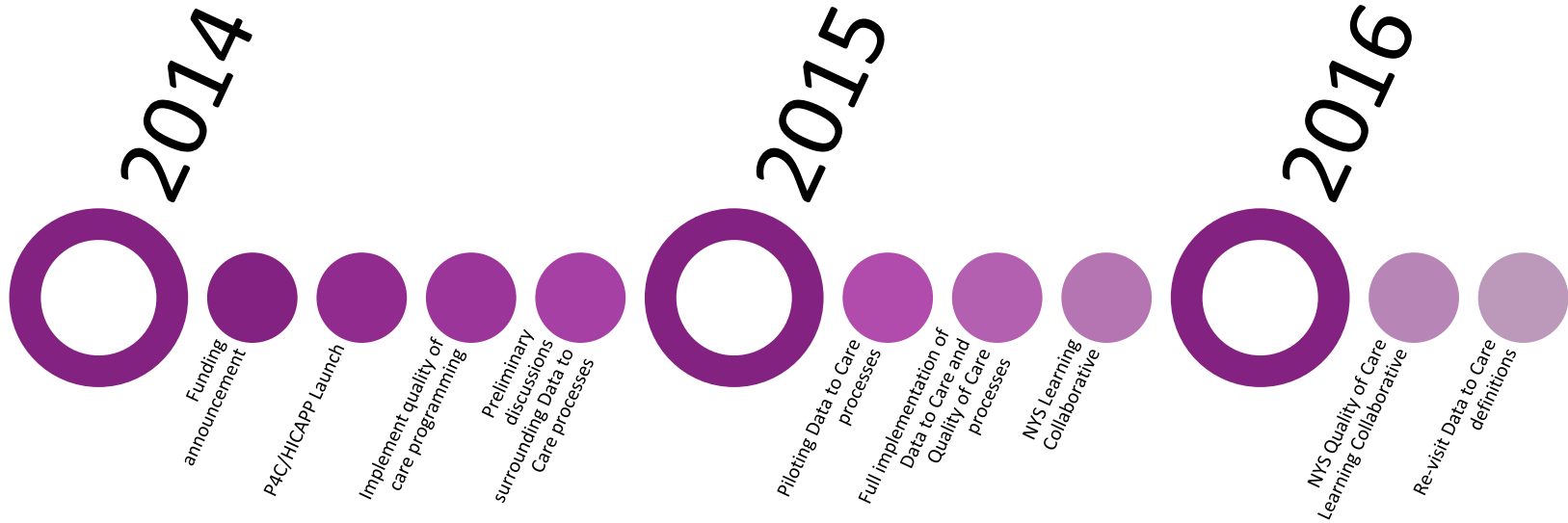
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# Project activities at a glance

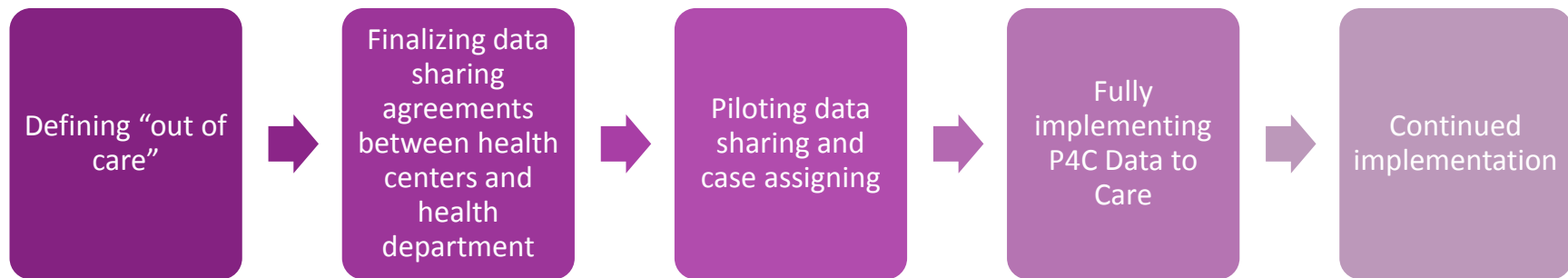
1. Use HIV surveillance data & health center patient data to improve health outcomes for PLWH
2. Expand partner notification, linkage, retention, and re-engagement with care services for PLWH
3. Support training and TA activities for health centers (e.g., expand routine HIV testing, prevention services for PLWH)
4. Develop Sustainable Partnerships with Health Centers

**Data to Care Initiative**  
**Quality of Care Initiative**  
**Creating partnerships**





# Data to Care initiative



# Defining “out of care”

- Four definitions developed with input from our health centers

### HICAPP/P4C Linkage to Health Center

1. Health Center past 9 months

2. Health Center past 9 months

3. Health Center past 9 months

4. Health Center past 9 months

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### HICAPP/P4C Case

1. Health Center Previously Undiagnosed HIV Person: Health center who had a new confirmed diagnosis of HIV. HIV Tracking/NTSEHG/CDEIS/ HCAPP, New ID P4C Evaluation Measure: H2

2. Health Department Previously Undiagnosed HIV Person: patient tested for HIV by the health center who through partner services. HIV Tracking/NTSEHG/CDEIS/ HCAPP, New ID P4C Evaluation Measure: H2I

3. Health Center PLVIN Out-of-Care: Health center medical visit with lab work (CD4/TL) in the past 9 months. Numerator: Number of health center visit with lab work (CD4/TL) in the past 9 months. Denominator: Number of HIV/AIDS patients. HIV Tracking/NTSEHG/CDEIS/ HCAPP, Old ID P4C Evaluation Measure: H2I

4. Health Center PLVIN Diagnosed but Never Linked to Care: PLVIN with no VL or CD4 labs within the last 90 days of current reporting date. Numerator: Number of health center patient with lab work (CD4/TL) within 90 days of current reporting date. Denominator: Number of HIV/AIDS patients at health center. HIV Tracking/NTSEHG/CDEIS/ HCAPP, Du, In, BU, F Evaluation Measure: H2I

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	Jordan Health	Community Health Center of Buffalo	GHYHC	DuSloan Family Care Centers	Beterans Health Center	Bedford Skyward Family Health Center
Counties	Wayne Monroe Ontario	Nagara Erie	Columbia Queens Dutchess Ulster Delaware	Queens Bronx New York Ulster	Queens Bronx New York Kings	Queens Bronx Kings

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# Final definitions for “out of care”

## HEALTH CENTER INITIATED CASE ASSIGNMENTS SUBMITTED TO HEALTH DEPARTMENTS

- **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
- **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

## SURVEILLANCE INITIATED CASE ASSIGNMENTS

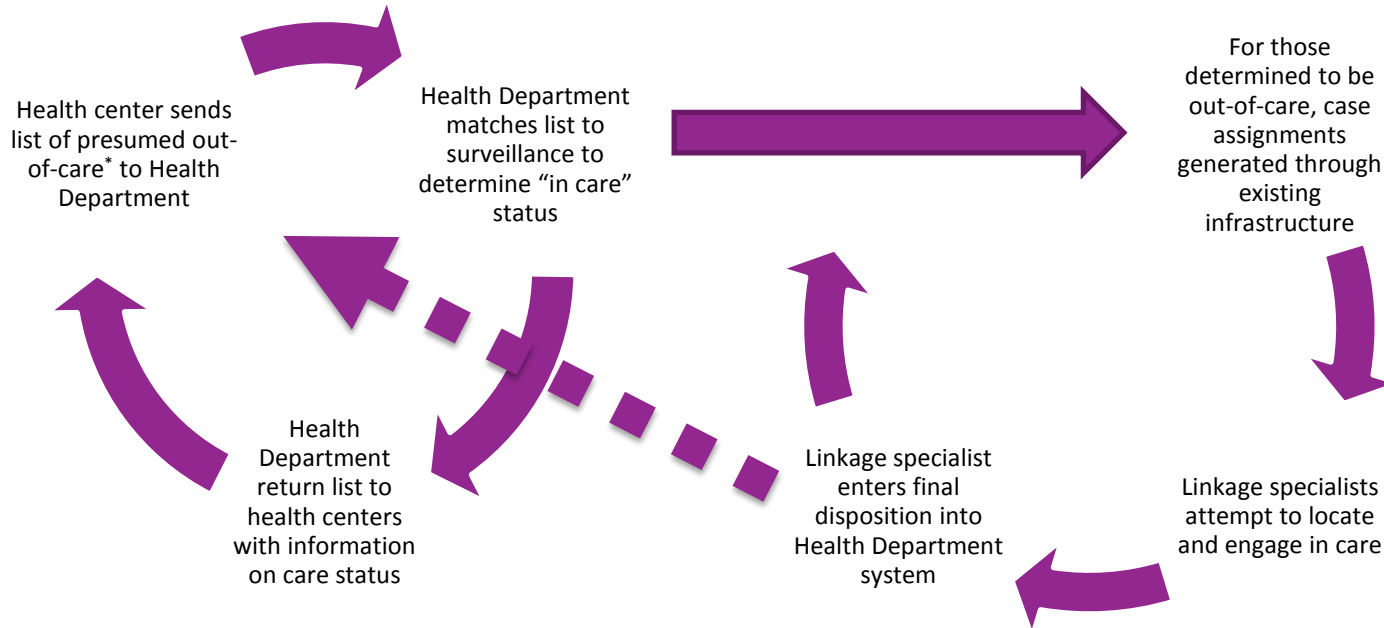
- **Surveillance PLWH Out-Of-Care:** PLWH with no VL or CD4 labs in the past 9 months in NYC, and 13 to 24 months in rest of state (ROS), whose last known address of residence was in the HICAPP/P4C service areas
- **Surveillance PLWH Diagnosed but Never Linked to Care:** PLWH whose HIV diagnosis date (as determined via diagnostic test, detectable VL, or physician’s diagnosis) was reported to the New York State Department of Health (NYSDOH) or New York City Department of Health and Mental Hygiene (NYCDOHMH) within the HICAPP/P4C service areas at least 90 days prior to the current date, who have no VL, CD4, or genotype labs reported since (going back five years)

# Data sharing agreements

In April 2014, changes to public health law permits that **HIV-related information** reported to the NYS Department of Health or a local department of health **can be shared between** authorized health department staff and medical providers treating HIV positive patients, **in order to promote linkage and retention in health care**

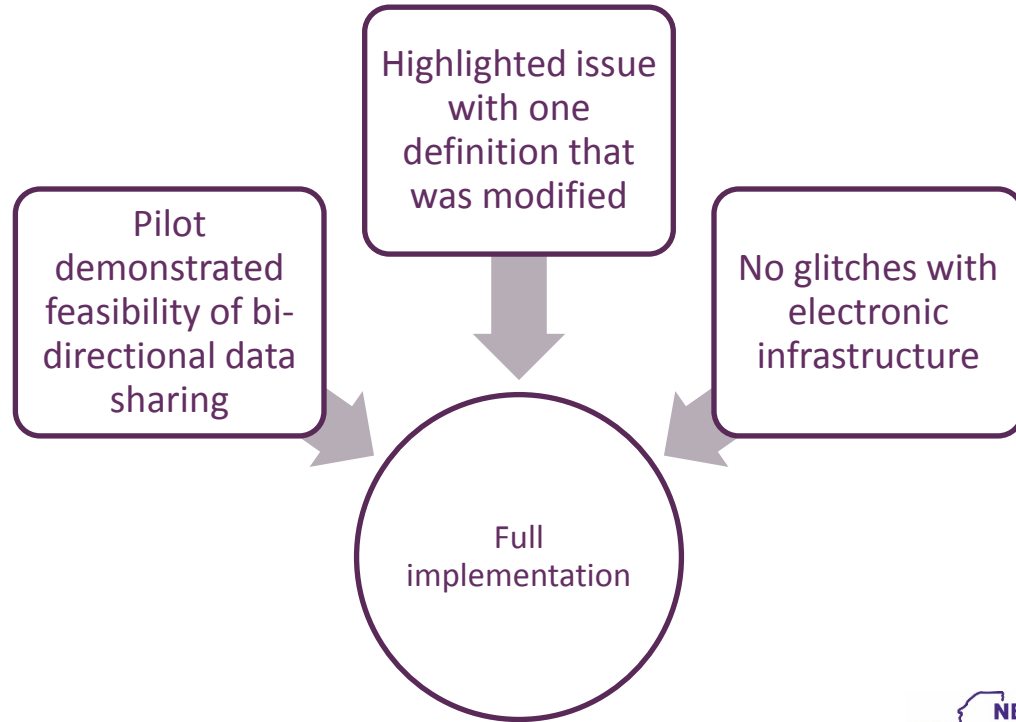


# Piloting data sharing process



\*Includes presumed diagnosed and never linked to care

# Implementing Data to Care



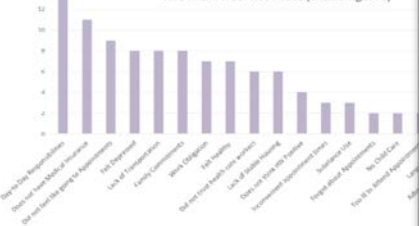
## Continued implementation requires:

- re-visiting definitions
- evaluating and sharing success of the program/definitions
- continuing open discussions about what works/what is not working

# P4C News Briefs

**Prepared by the Division of HIV/STD/HCV Prevention**  
 Reasons for being out-of-care are based on client-reported information collected by county and state health department field services staff during attempts to re-engage persons into HIV medical care. Includes cases confirmed in care, regardless of re-linkage success, in HICAPP service areas assigned and closed from January-September 2015. Reasons are not mutually exclusive (individuals can choose multiple reasons for being out-of-care).

Reasons for being out-of-care (OOC) among 61 individuals in NYS HICAPP Service Areas (excluding NYC)



Reason Out of Care	# Indicating yes
Day-to-Day Responsibilities	10
Does not have Medical Insurance	11
Did not feel like going to Appointments	8
Felt Depressed	8
Lack of Transportation	8
Family Commitments	8
Work Obligations	8
Lack of Motivation	7
Lack of Health Insurance	7
Lack of stable housing	7
Does not trust health care workers	7
Overweight/Obese/Unfit	7
Financial Issues	6
Religious Beliefs	6
Health-related Appointments	6
Have to travel a distance	6
Other	6

- Other Reasons Out of Care**
- Recent Surgery
  - Changed providers
  - Mental health issues
  - Financial reasons
  - Difficulty working with health facilities
  - Incarcerated, mental illness
  - Death in the Family
  - Fear of disclosure
  - Went out of the country for several months
  - Domestic violence victim
  - Just going through stuff

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## NYS HIGH IMPACT CARE AND PREVENTION PROJECT

New York State Department of Health AIDS Institute, Division of HIV/STD/HCV Prevention Project Brief #1 - Overview

### High Impact Care and Prevention Project (HICAPP) / Partnerships for Care (P4C)

P4C is a multi-agency three-year demonstration project coordinated jointly by the CDC's Division of HIV/AIDS Prevention and HRSA's Bureau of Primary Health Care at the federal level and between the NYSDOH AIDS Institute, NYCDOHMH, and six partnering federally qualified health centers throughout NYS and NYC. An HIV Training, Technical Assistance, and Collaboration Center is funded by this project to support the goals of P4C for NYSDOH, NYCDOHMH, and the six partnering health centers.

The goals of the project are to build sustainable partnerships between the NYSDOH, the NYCDOHMH, and six partnering health centers to support expanded HIV service delivery in communities highly affected by HIV, especially among racial/ethnic minorities. NYSDOH and NYCDOHMH along with the six partnering health centers are working together to increase the identification of undiagnosed HIV infection, establish new access points for HIV care and treatment, and improve HIV outcomes along the continuum of care for people living with HIV.

### NYS HICAPP Service Area



### Partnering Health Centers:

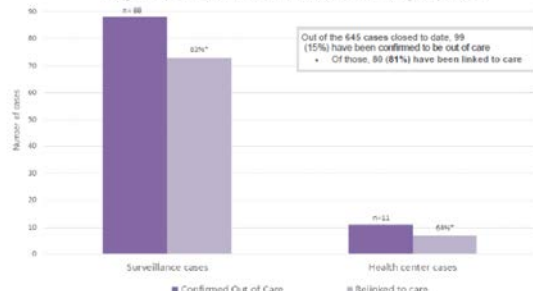
- Anthony L. Jordan Health Center
- The Greater Hudson Valley Family Health Center, Inc.
- Community Health Center of Buffalo, Inc.
- Bedford Shreeve Family Health Center, Inc.
- Belenas Health Center
- Damian Family Health Centers, Inc.

HICAPP is a cross-sector approach of high impact of HIV prevention efforts – an essential step in achieving the goals of the [National HIV/AIDS Strategy](#) and the Governor's Plan to [End the AIDS Epidemic in NYS](#). Fund made possible by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act.

### Prepared by the Division of HIV/STD/HCV Prevention

Linkage to care is defined by provider confirmation of a patient attending an HIV medical appointment. These data are based on client-reported information collected by county and state health department field services staff during attempts to re-engage persons into HIV medical care. Includes cases confirmed to be out-of-care, in HICAPP service areas in New York City (NYC) and the rest of the state (ROS) assigned and closed from January-December 2015. Data are subject to change pending lab updates, worker revisions, and/or data QA reclassifications.

Linkage to Care for HICAPP cases in New York State (including NYC) in 2015



\* Percent out of cases confirmed out of care

	Surveillance Cases			Health Center Cases		
	ROS	NYC	Total	ROS	NYC	Total
Confirmed Out of Care	80	8	88	5	6	11
Re-linked to care*	68	5	73	3	4	7
Re-linked to P4C Health Center	4	4	8	3	2	5

\* Includes those that re-linked to P4C Health Centers

### Additional notes

- Cases include ROS EAPD assignments in HICAPP service areas
- All but two health center cases that re-linked to care, re-linked to the P4C health center that initiated the case assignment
- Differences between NYC and the Rest of the State cannot be concluded at this time given small numbers in NYC
- Information on receipt of subsequent HIV specific laboratory testing cannot be determined at this time; these data will be included in the future
- Field Services staff responsible for re-linkage work are HICAPP Linkage Specialists and EAPD Coordinators
- Data from NYSDOH New York State Electronic Health Management System, and CDCDHM and NYCDOHMH Field Services Unit Database

For more information please contact:

Rachel Malloy, PhD, MPH  
 NYSDOH, AIDS Institute

AIDS Institute

# Quality of Care Program

The NYSDOH AIDS Institute's Quality of Care Program (QOC) conducts tailored trainings, technical assistance (TA), capacity-building, and coaching related to quality improvement (QI) activities for health centers (HCs) providing HIV care throughout NYS, including all P4C HCs.

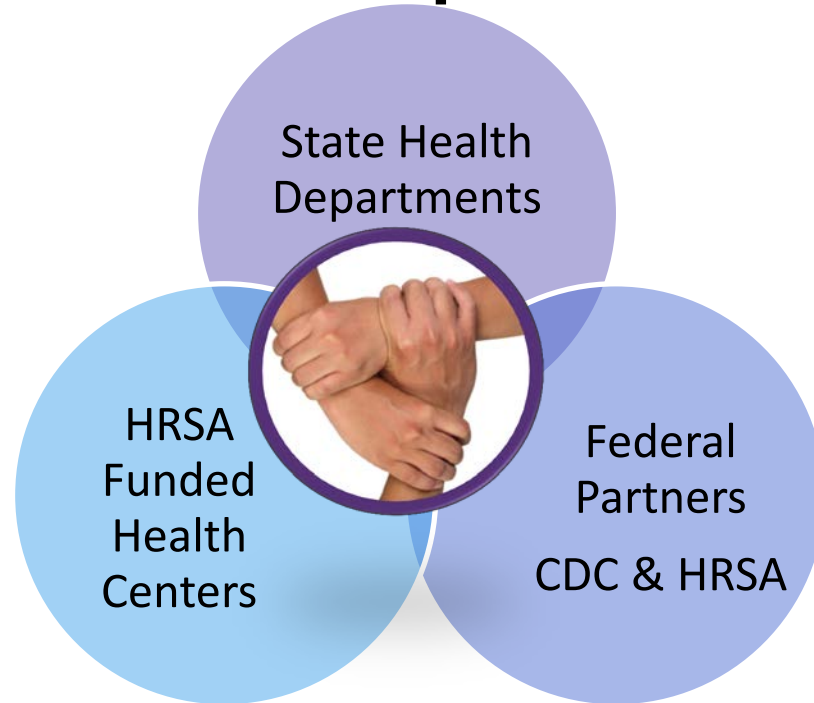
As part of the P4C/HICAPP initiative, the QOC Quality Program Coordinator conducts annual organizational assessments (OAs), ongoing TA, in-person or web-based trainings, tailored coaching, facility-level QI profiles, and resource sharing.



# Creating sustainable partnerships



# Additional partnerships



# Have we been successful?



## Data to Care

- As of July, 2016 29 lists of presumed out of care submitted to DOH for reconciliation (10 NYC, 19 ROS) (264 people in total)
- 73 individuals assigned for potential re-linkage work (20 ROS, 53 NYC)
- 11/15 (73%) individuals re-linked to care (7 to a P4C HC)



## Quality of Care

- 12 organizational assessments conducted
- 15 TA coaching sessions
- 4 QOC quarterly webinars
- 3 in-person QI trainings



## Sustainable partnerships

- 3 specialized trainings from DOH provided
- Peer-to-peer relationships established
- Connections created between health centers and DOH
- More on this from Marilyn...





# NYS DOH & Cornerstone Family Healthcare

- Improved relationship with NYS DOH
  - From authoritative body to a partnership
- Feedback was solicited and used to make decisions for the “final definitions”
- Outreach Specialist and Linkage Specialists worked together to bring patients back to care
- Ensuring newly diagnosed and new to the health center patients are linked to care and their partners were tested and linked (if applicable)
- Improved relationships with other P4C Health Centers
- Expansion of PrEP program
- HIV testing



# HIV Care Team

- 2 HIV Primary Care Providers
  - MD and FNP
- 1 Infectious Disease Provider
- 3 Case Managers
- 2 Nurses
  - RN and LPN



# Preventative Outreach Efforts

- Texting
- Vinelinks
- Pharmacy
- Home visits
- Use of alerts in EMR
- Insurance attainment
- Street outreach/search
- Transportation arrangements
- Case conferencing and Provider outreach
- Working with other agencies collaboratively
- Partnership with families and emergency contacts
- Close monitoring of patients with a history of being lost to care and keeping them engaged in services



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# Acknowledgements

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HICAPP Linkage Specialists: Nessie Tabe, Megan McPhail, Kate Herpin, Edwin Lopez

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AIDS Institute Bureau of HIV/AIDS Epidemiology

AIDS Institute Division of HIV/STD/HCV Prevention: Megan Johnson, MPH, CEPH

AIDS Institute Office of the Medical Director: Stephen Crowe, MSW

AIDS Institute Division of HIV/STD Epidemiology Evaluation and Partner Services

- James Tesoriero, PhD
- Mara Sanantonio-Gaddy, MSN
- Tarak Shrestha, MS

Partnering Health Centers

- Betances Health Center
- Bedford Stuyvesant Family Health Center
- Community Health Center of Buffalo
- Damian Family Care Centers
- Jordan Health
- Cornerstone Family Healthcare



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