



RECENT HIV DATA TO CARE (D2C) EXPERIENCES MARYLAND

**HIV HEALTH IMPROVEMENT AFFINITY GROUP
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MISSION AND VISION

MISSION

- The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

VISION

- The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.



Data to Care Activities

- Since 2012 Maryland has expanded its D2C activities
- Using HIV surveillance data to identify persons requiring linkage-to-care and re-engagement in care services
- Increased sharing of HIV surveillance data to state and local partners
- Expanded the size of STI/HIV Field Services program at the state and local levels
- Increased support to the HIV Surveillance program to improve data quality, timeliness, and availability
- Expanded data sharing with neighboring jurisdictions



Category C

- CDC HIV Prevention Cooperative Agreement 12-1201 Category C Demonstration Project
- March 2012-December 2015
- Enhanced linkage to and retention in care
- Programmatic use of CD4, viral load, and other surveillance data
- Highly cooperative/integrative activity for Maryland's HIV Prevention, HIV Surveillance, and STI/HIV Field Services programs
- Focused on four high morbidity counties, but developed sustainable infrastructure for statewide implementation



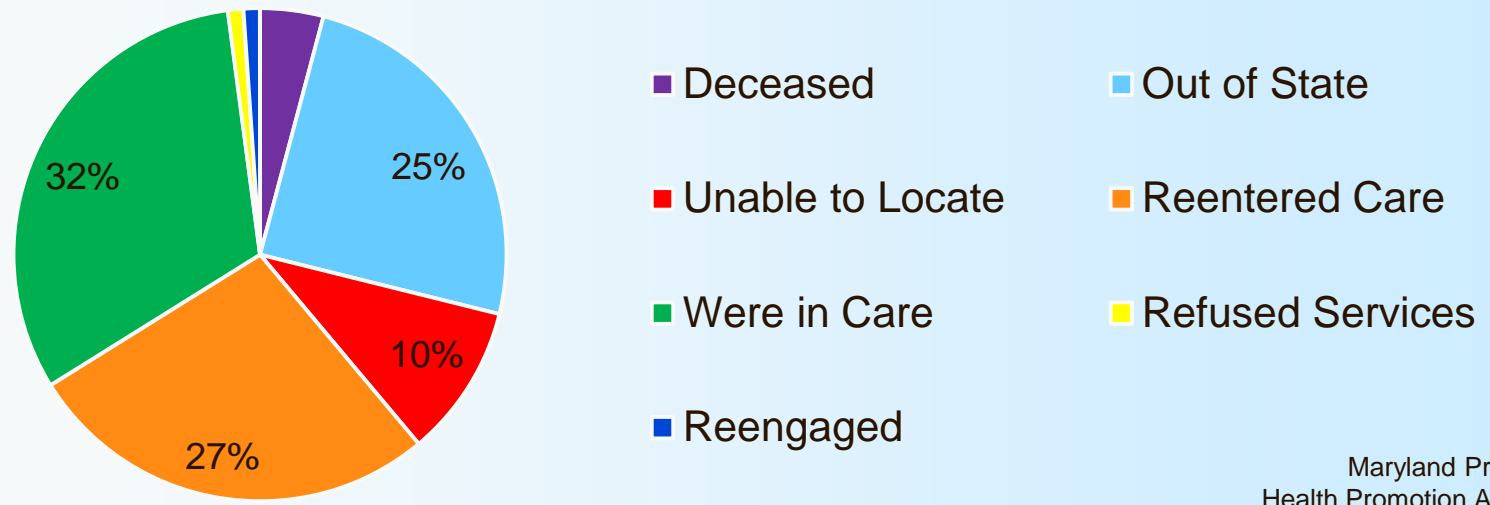
Category C Activities

- HIV surveillance process improvements
- Increased regional data sharing
- Use of HIV surveillance data to initiate and inform STI/HIV partner services and linkage-to-care
- Improvements to state and local health department linkage-to-care processes and documentation
- Data-to-care re-engagement outreach
- Modification and implementation of PRISM (statewide data system for STI surveillance and STI/HIV partner services investigations)



Category C Results

- 470% increase in initiation of partner services and linkage-to-care for newly diagnosed HIV cases
- 295% increase in newly diagnosed HIV cases being interviewed for partner services
- Identified 2,585 persons living with HIV that appeared to be out of care (CD4/VL 13-24 mo. ago, but not 0-13 mo.) – provided re-engagement services





Category C Lessons

- HIV surveillance doesn't know everything about all care
- Large amounts of cross-border care seeking
- Large amounts of migration within state and out-of-state
- Identification and coordination activities need to happen at the state-level with extensive inter-state communication
- Linkage activities at the local level need increased access to state-level data
- A lot of data work is needed in order to provide effectively targeted interventions of a reasonable size with a chance of success



Partnerships for Care (P4C)

- CDC/HRSA Joint Demonstration Project (CDC 14-1410)
- July 2014-September 2017
- Partnership of state health department, FQHC clinics (4), and local health departments (3)
- Expand routine HIV screening in clinics
- Expand capacity for HIV clinical services
- Enhance relationship of clinics and local health departments for linkage-to-care, re-engagement in care activities
- Establish sharing of clinical, surveillance, and partner services data between clinics and the state and local health departments



Partnerships for Care (P4C)

- Use case conferencing to monitor and improve status of clinic patients on the HIV care continuum
- Use surveillance data to identify PLWHA in clinic service areas that are out of care and have local health departments provide linkage-to-care and re-engagement in care services
- Developing sustainable methods for continuation and expansion to other clinics with large HIV caseloads



P4C Lessons (so far)

- Clinics do not test all their patients and are unaware of that many of their patients are HIV infected
- Many active clinic patients get their HIV care at other clinics
- Increased focus on partnership has resulted in increased and more timely linkage activities
- Case conferencing is improving the HIV continuum of care measures (preliminary data)



Impact (Project PrIDE)

- CDC HIV Prevention Cooperative Agreement 15-1506/1509 with Baltimore City Health Department for the Baltimore MSA (Maryland DHMH subcontractor)
- October 2015-September 2018
- Reduce HIV infection and increase engagement in care among MSM and transgender persons
- Increasing availability and use of PrEP
- Using surveillance data to identify PLWHA that are out of care and providing linkage/re-engagement services
 - Initial focus on MSM with high VL in Baltimore City



Statewide Activities

- Using combinations of state funds, HIV Prevention funds, and Ryan White funds to identify and provide linkage-to-care and re-engagement in care services, statewide, to all:
 - Previous diagnoses, never linked to care
 - New diagnoses, immediately after diagnosis
 - New diagnoses, not linked to care within 12 months
 - Living cases, with a history of care, but no recent care (18 months)
- Statewide surveillance data provided to Field Services programs at the state and Baltimore City for initiation to field staff at the local levels

Issues



- Not all care is reported
 - Care without testing
 - Out of state care
 - Providers not reporting
 - Federal facilities (VHA, DOD, NIH)
- Not all cases are on regular care schedules
 - 2 visits a year, at least 6 months apart – is this an appropriate measure?
- Migration (current address)
- Unable to locate
 - Incorrect information
 - Uncooperative cases



Expansion Activities

- Health Information Exchange (HIE) – CRISP in MD, DE, DC (some), WV (soon)
 - Using ENS (encounter notification services) on cases not in HIV care – what other care are they receiving and where?
 - Encouraging providers to use HIE to locate their out-of-care patients (why should public health do all the work?)
 - Establish a provider notification system? Push notices that a clinic's patient requires HIV services
- Incorporating ADAP prescription data into surveillance data (previously used only for case identification)
- Developing a Care Markers Database
 - Connecting HIV surveillance data with RW CAREWare data, Medicaid data, and other care data



More Activities

- Expanding regional data sharing
 - Routine lab data transfers
 - States notify each other that cases exist and resolve the earliest diagnosis and residence
 - They need to start exchanging ongoing care data
 - Black Box project (Georgetown Univ, DC, MD, VA)
 - NIH Pilot – established secure data matching/transfer mechanism
 - 1 in 6 MD HIV cases were also in DC's database, but only half were known to be in both
 - CDC RIDR – GU and 9 states to expand pilot for de-duplication activities
 - Multi-state expansion – GU, DC, MD, NY, VA, Oak Ridge National Laboratory to expand functionality for routine matching and data exchange (towards real-time surveillance)



Medicaid D2C Activities

- Medicaid Affinity Project
 - Establish routine matching between HIV surveillance and Medicaid
 - Analyze case utilization data
 - Incorporate care utilization data (more than just lab testing) into care markers database
 - Incorporate prescription data into surveillance and care markers databases
 - Establish QA process for out-of-care notification
 - Measure the HIV continuum of care for Medicaid populations
 - Measure HIV screening rates



Prevention and Health Promotion Administration

<http://phpa.dhmh.maryland.gov>