Integration of Prevention and Surveillance through Data to Care

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Tennessee Department of Health
NASTAD National Prevention & Care Technical Assistance Meeting
July 20, 2017
Tennessee Integration

• Integrated since inception
  – HIV Prevention
  – HIV Surveillance
  – STD Prevention
  – Ryan White Part B
  – Viral Hepatitis added in 2015

• How D2C brought us closer together
Data to Care Staffing

- HIV Prevention Director
  - Assistant HIV Prevention Director
    - Re-engagement Program Coordinator
    - 3 Re-Engagement Specialists
  - HIV Epidemiologist
- Epidemiology Director
  - 2 Epidemiologists
- Ryan White Part B Program Director
  - Assistant Ryan White Part B Director
    - Consortia Coordinator
  - Medical Services Assistant
Data to Care – Prevention

• **Role of HIV Prevention**
  – Program started under HIV Prevention (CAPUS 12-1210)
  – Prevention hired, trained, implemented and managed the program
  – Prevention program staff reported data to CDC

• **Role of HIV Surveillance**
• **Role of Ryan White Part B**
• **Coordination**
Data Variables

A Total Cases Assigned via Prevention Epi
  - Total Cases Assigned

B Verified IN CARE Status (via 1st investigation in eHARS)
  - Verified in CARE
  - Presumed Not in Care (NIC)

C Investigation of Presumed NIC cases (via 2nd investigation)
  - Presumed NIC for Contact/Services
  - Deceased
  - Out of State/Jurisdiction

D "Eligible" NIC cases for services
  - Contact Attempts in Progress
  - Unable to Located

E Pts. actually contacted by DIS and offered services
  - Pending Medical Appointment
  - Refused Services at Time

F Pts. Linked to Medical Care
  - Pts. Linked to Medical Care
<table>
<thead>
<tr>
<th>Current Status of Care</th>
<th>Demographics</th>
<th>Contact Information</th>
<th>If Client in Care</th>
<th>If Client out of Care</th>
<th>Barrier Information</th>
<th>Resource Information</th>
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<tbody>
<tr>
<td></td>
<td>Social Security Number</td>
<td>Last Name (Last, First)</td>
<td>Race/ethnicity</td>
<td>Gender (M/F)</td>
<td>Risk Category</td>
<td># Attempts to contact client</td>
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# Cumulative Report Form

<table>
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<th>Time Period of Year 4</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
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<td>Number of Cases Assigned</td>
<td>Verified IN CARE</td>
<td>Presumed OUT of CARE</td>
<td>Deceased</td>
<td>Out of State/Jurisdiction</td>
<td>In-state, OUT CARE, Eligible for CAPUS Services</td>
<td>Contact Attempts in Progress</td>
<td>Unable to Contact/Locate</td>
<td>Refused CAPUS Services</td>
<td>Pending Appts for Re-engagement</td>
<td>Linked to CARE via CAPUS</td>
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**Definitions**

- **A - Number of Cases Assigned**: Number of CAPUS cases assigned to CAPUS DIS within an allotted period of time (average is 25/month)
- **B - Verified IN CARE (No need of CAPUS efforts)**: Pts. who are verified by CAPUS DIS to be in medical care within the past year; occurs via CAPUS DIS contact, eHARS record search, or provider call
- **C - OUT of CARE (Total cases for CAPUS investigation)**: Pts. who are out of care, and will be investigated by CAPUS DIS for HIV re-engagement
- **D - Deceased**: Pts. who are deceased thru investigation; CAPUS DIS verifies thru Office of Vital Statistics where death certificate is obtained
- **E - Out-of-State/ Jurisdiction**: Pts. who live outside CAPUS DIS' Jurisdiction OR pts. who live outside TN
- **F - In-state, OUT CARE (In need of CAPUS DIS services)**: Remaining CAPUS caseload who are out of care and will be contacted by CAPUS DIS, and eligible for CAPUS DIS re-engagement services
- **G - Contact Attempts in Progress**: Pts. whom the CAPUS DIS is currently locating or contacting
- **H - Unable to Contact/ Locate**: Pts. whose locating information cannot be found and contact attempts are exhausted by CAPUS DIS
- **I - Refused CAPUS Services**: Pts. who are out of care and contacted by CAPUS DIS, yet they refuse re-engagement services at that time
- **J - Pending Appts for Re-engagement**: Pts. who have a pending medical appt. in the near future, and are being re-engaged into care; pts. have an actual appt. scheduled w/ prompting by CAPUS DIS
- **K - Linked to CARE via CAPUS**: Pts. who were re-engaged back into medical care b/c of communication and support from CAPUS DIS; pts. actually attended medical appointment and appt. is verified via eHARS
Data to Care - Surveillance

• Role of HIV Prevention

• **Role of HIV Surveillance**
  – Generate Not in Care lists
  – Conduct Accuirint record searches
  – Upload list to RedCap
  – Oversee feedback loop

• Role of Ryan White Part B

• Coordination
• **Role of Ryan White Part B**
  

  – Funding role, management role, data reporting changes (HRSA v CDC)

<table>
<thead>
<tr>
<th>1. Objectives:</th>
<th>2. Service Unit Definition:</th>
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<tbody>
<tr>
<td>List SMART objectives that support the service goal listed above.</td>
<td>Define the service unit to be provided</td>
</tr>
<tr>
<td>a:  Link 95% of new PLWHA to medical services within 30 days of diagnosis.</td>
<td>15 Minutes of Linkage Activities</td>
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<tr>
<td>b:  Investigate at least 90% of PLWHA (referred to the program) with no known medical visits within the past 12 months to verify their current care status.</td>
<td>15 Minute Record Search</td>
</tr>
<tr>
<td>c:  Locate 50% of known PLWHA who had no known medical visits within the past 12 months.</td>
<td>15 minutes of Attempts to Contact/Locate (phone calls, field visits, letters)</td>
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<tr>
<td>d:  1) By March 31, 2017 DIS re-engagement specialists will re-engage and link 50% of known PLWHA (who were located and had no known medical visits within the past 12 months) within 6 months of locating the client.</td>
<td>15 minutes of Re-engagement Activities (provider communication, transportation, provider visits)</td>
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<td>d:  2) By March 31, 2017 DIS re-engagement specialists will re-engage and link 40% of known PLWHA (who were located and had no known medical visits within the past 12 months) within 30 days of locating the client.</td>
<td>15 minutes of Re-engagement Activities (provider communication, transportation, provider visits)</td>
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<td>e:  Follow up with PLWHA re-engaged in care and verify that 50% are retained in care</td>
<td>15 Minute Record Search</td>
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<tr>
<td>f:  Verify that 50% of PLWHA, with a known medical visit within the past 12 months, achieve viral suppression</td>
<td>15 Minute Record Search</td>
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</table>
Data to Care – Coordination

• Role of HIV Prevention
• Role of HIV Surveillance
• Role of Ryan White Part B

• Coordination
  – Bi-monthly meetings between leadership of all three programs
  – Quarterly staff meetings
Data to Care- Collaboration

Development of REDCap Database

- **REDCap** is a secure web application for building and managing online surveys and databases.

- **REDCap provides automated export procedures for seamless data downloads to Excel and common statistical packages (SPSS, SAS, Stata, R), as well as a built-in project calendar, a scheduling module, ad hoc reporting tools, and advanced features, such as branching logic, file uploading, and calculated fields.**

- **Join & Get REDCap:** [https://projectredcap.org/partners/join/](https://projectredcap.org/partners/join/)
The DIS re-engages a client to HIV care and discovers the client’s CD4 count and viral load are not present in eHARS. The DIS notifies the HIV Prevention Epi.

The HIV Prevention Epi will verify that the labs are in eHARS and notify the DIS.

Individual Provider - If the issue is concerning reporting from an individual provider, the epi assigned to the region at question will consult with the local field surveillance staff who will contact the provider.

Lab Provider - If the issue is concerning reporting from a lab provider, the Informatics Epi will follow up with the provider.

The Informatics Epi or HIV Surveillance Epi will provide updates to the HIV Prevention Epi until the labs are present in eHARS.

HIV Prevention Epidemiologist

Re-engagement Specialist

HIV Prevention Epidemiologist

Informatics Epidemiologist or HIV Surveillance Epidemiologist

The HIV Prevention Epi discusses the discrepancies with surveillance staff during the weekly surveillance staff meeting to determine who will follow up on the issue.
Data to Care- Successes

- More efficient data management
- Improving the NIC list
- Discovering laboratories and providers that are not reporting viral loads and CD4s
- Cleaner data in eHARS and true depiction of Continuum of Care
Data to Care- Opportunities

- Aligning the needs of all programs
- Reporting in multiple databases
- Outdated NIC list
- Tracking viral suppression
- Reporting responsibility of Prevention not Surveillance
Acknowledgements

**HIV/STD/VH**
Dr. Carolyn Wester
Dr. Shanell McGoy

**HIV Prevention**
Melissa Morrison
David Fields
Kayla Burgess
Sabrina Gandy
CAPUS Re-engagement Staff

**Shelby County Health Department**
Jan Hill
Shonda Bonner

**Ryan White Part B Program**
Tonya King
Harlyn Hardin
Joe Nault
Monti McClellan

**Surveillance**
Samantha Mathieson
Benn Daley