

Data to Care: A Community of Practice

Webinar Series: Part 2 of 4
Thursday, April 16, 2015



U.S. Centers for Disease Control and Prevention - D2C Definition

- *Data to Care* is a new public health strategy that aims to use HIV surveillance data to identify HIV-diagnosed individuals not in care, link them to care, and support the HIV Care Continuum.
- CDC and John Snow Inc. (JSI) developed a D2C toolkit located on:
<https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/PublicHealthStrategies/DatatoCare.aspx>
- Resources include:
 - List of important considerations
 - Health Department Case Studies
 - Tools and Resources

Goal of D2C Community of Practice



- CoPs are working to strengthen public health as members learn, share expertise, and work together on solving common problems in their communities' domains.



- D2C CoP pilot is a series of interactive conversations between jurisdictions on strategies, challenges and practices.



Desired outcomes:

- Create a comprehensive list of best practices and challenges
- Select an idea, challenge or practice to work on as a team
- Create an active forum to share ideas and develop template for products

Participation in today's call

- Phones are muted. Please press *7 to unmute your line
- ***Today's call is an interactive discussion forum.*** Please ask questions during the presentation via chat box.
- We encourage all participants to respond to questions and share their experience via chat box as we move through the presentation.
- Please participate in polling throughout the call.

Learning Objectives

- Develop policies and procedures to navigate a new system.
- Explore the legalities of data sharing.
- Develop effective communication between programs.

Colorado Department of Public Health and Environment

Presenters:

Rebecca Jordan Yehle, Client-Based Prevention Program Manager

rebecca.jordan@state.co.us

Maria Chaidez, State Linkage to Care Coordinator

maria.chaidez@state.co.us

Kelly Voorhees, Surveillance Data Integration Unit Supervisor

kelly.voorhees@state.co.us

Anita Watkins, Surveillance Program Manager

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Problem Statement

- Too many people known to be HIV infected have not engaged in HIV care or have fallen out of care.
- We need to develop a process to determine who and where these clients are.
- We need to develop a process to engage and re engage clients in care.

Why did we implement Data to Care?

- Saw the need for finding people out of care.
- Wanted to learn the barriers keeping people from engaging in care, and how to eliminate these barriers.
- To identify resources available to address this problem.



Chat Discussion

- What challenges to linkage and retention in care has your jurisdiction identified among persons living with HIV in your state?

How did we do it?

- Used what we knew worked (DIS field investigations) as a model for conducting active LTC.
- Began working from referrals DIS provided when interviewing a person newly identified with HIV or had lapsed out of care.
- Initiated FRs with a LTC disease code and created dispositions specific to LTC.

Polling Question

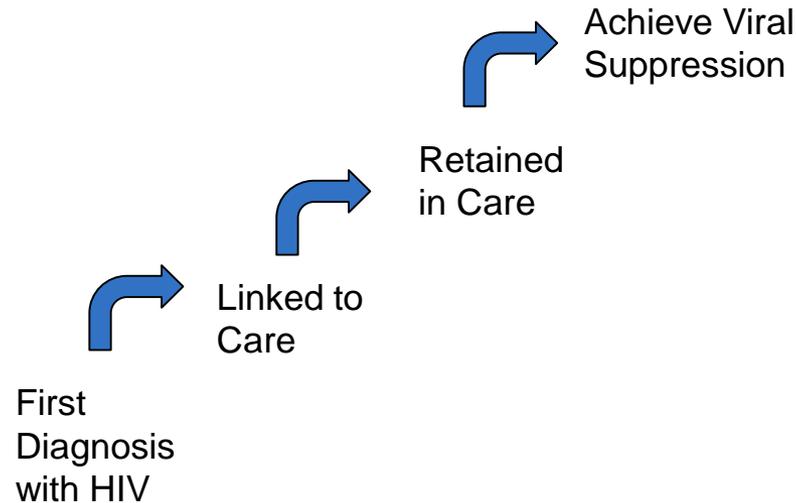
- Who is responsible for loss to care follow up?
 - A. Health Department Disease Intervention Specialist
 - B. Health Department Dedicated Linkage to Care Coordinators
 - C. Staff from Ryan White Funded Clinics
 - D. All of the Above
 - E. Others, please specify in chat box

How did we do it?

- **Light Bulb Moment:** Our Surveillance colleagues have CD4/VL data. They could cross tab that with persons known to be HIV infected to identify those persons with no CD4/VL reported.
- Employed DIS investigations skills to locate and engage with clients.
- Actively worked with clients thru each step of engagement in care.
- Sacrifice: Reassignment of an experienced DIS to this new program.

How do we measure our process?

Helping People Move Through the HIV Continuum of Care



Considerations



- Legalities of sharing data.
- Utilize your resources (i.e., discussions with CDC project and privacy officers).
- Program integration; not a concern for Colorado, but could be new territory for other jurisdictions.
- Building relationships; clients and providers to show them the benefits of the program.
- Building understanding of the LTC role both internally and externally.

In Progress



- Data Sharing Task Force.
- Clarification of the Board of Health, CRS 25-4-1404(b) .
- Continual education of staff and providers.
- Expansion of LTC to Linkage to Medical Home (LTMH).
- Continuation of the JSI technical assistance by staff to streamline the process across programs.

Tools Developed

- *CDPHE Data to Care: Not in Care Investigation Protocol.*
- Evolving D2C report from surveillance to client based prevention.
- Referral tools for providers to refer to D2C program.
- Initially used DIS D2C model and after JSI TA, developed a D2C collaborative, cross programmatic D2C model.
- Example:
 - DIS passive and active referrals to oversee every new positive in CO
 - Surveillance reports, development of Colorado HIV Care Continuum



Lessons Learned



- What's next?
 - Ability to change the system; working upstream.
 - Critical Events program to immediately address clients with the highest need to retain or reengage them in care.
 - Integrating up and coming interventions.
 - LTC model has been used for our PrEP program development
 - Program development with ACA changes; enrolling clients in insurance

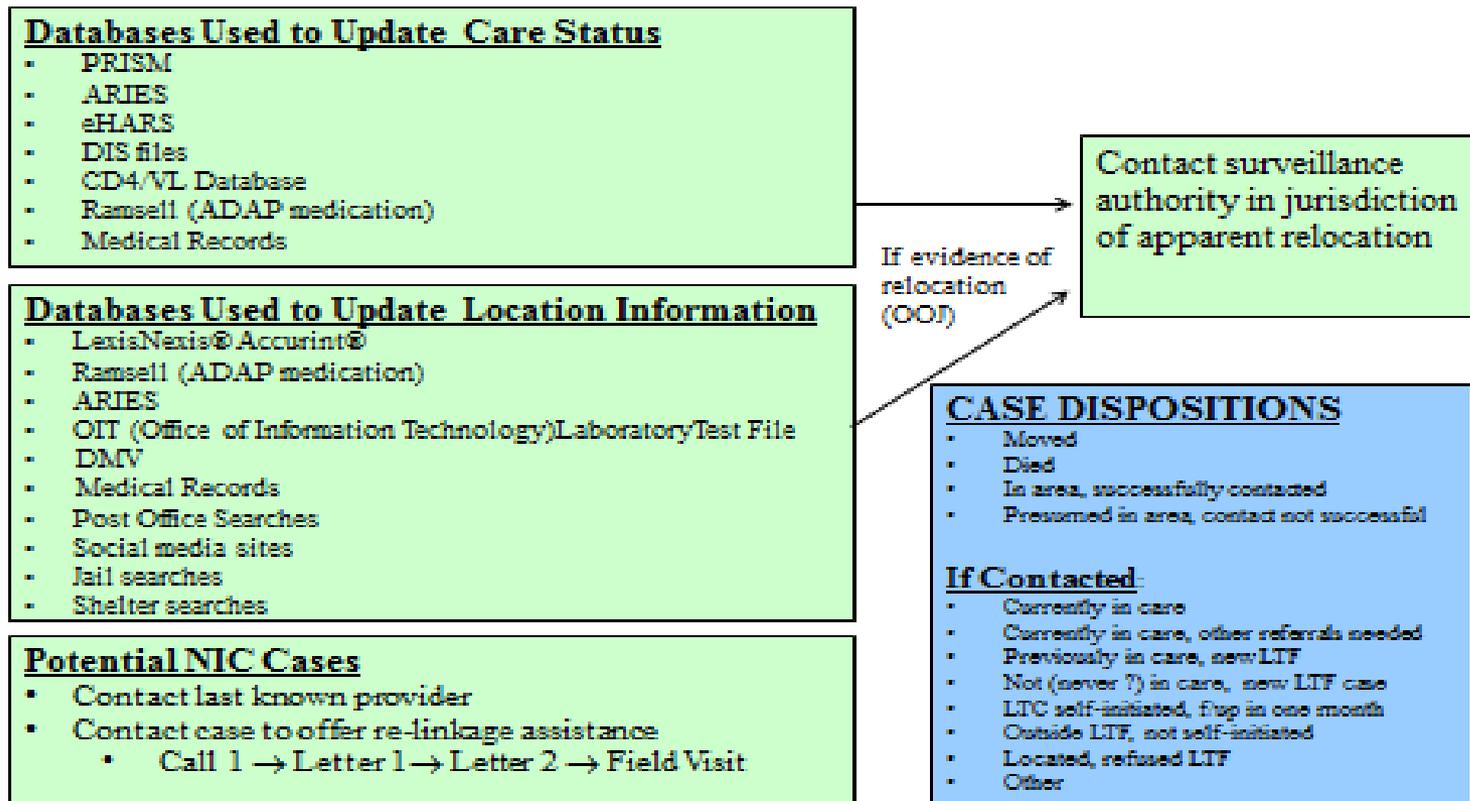
Colorado Share Screen

Process Maps

- Before
 - BOH rule; limited sharing of information
 - LTC Specialist; internal referrals
 - Surveillance reports; internal only
- After
 - BOH clarification; expanded process for sharing data for LTC
 - Statewide LTC Coordinator; internal and external referrals
 - Surveillance reports; “continuum of care” data

Investigation Protocol

Figure 1: Summary of NIC Case Investigation Protocol



Chat Question

- Colorado uses an extensive network of search engines to update their location information, does your jurisdiction also use these tools
- What other tools does your state use to update surveillance location information?

Shared Experiences

Louisiana and New York State

Louisiana: Tools to Help Prioritize Investigations

DEBBIE WENDELL, LOUISIANA STD/HIV PROGRAM



Polling Question

Is your jurisdiction considering changing how it prioritizes case investigations (reactor grid) to accommodate data to care activities?

- A. Yes we are or have considered changing how cases are prioritized for investigation
- B. No, we have not determined there is a need to change how cases are prioritized for investigation

Tools Needed-Colorado

- Legal ability to share surveillance data with prevention programs.
- Data systems to be able to produce reports.
- Skilled staff to extract and create data reports.
- Skilled staff for client interaction and investigation.
- Ability to identify gaps in the system and barriers for clients.
- Develop a network of resources.

Case Study in Developing Policies and Procedures, New York State

**MEGAN JOHNSON, DIVISION OF HIV/STD/HCV
PREVENTION SERVICES**





Department
of Health

AIDS
Institute

Data to Care in New York State

A Look at the Evolution of NYSDOH's
ExPanded Partner Services Program



Megan Johnson, MPH, CHES
New York State Department of Health
AIDS Institute
Division of HIV/STD/HCV Prevention Services



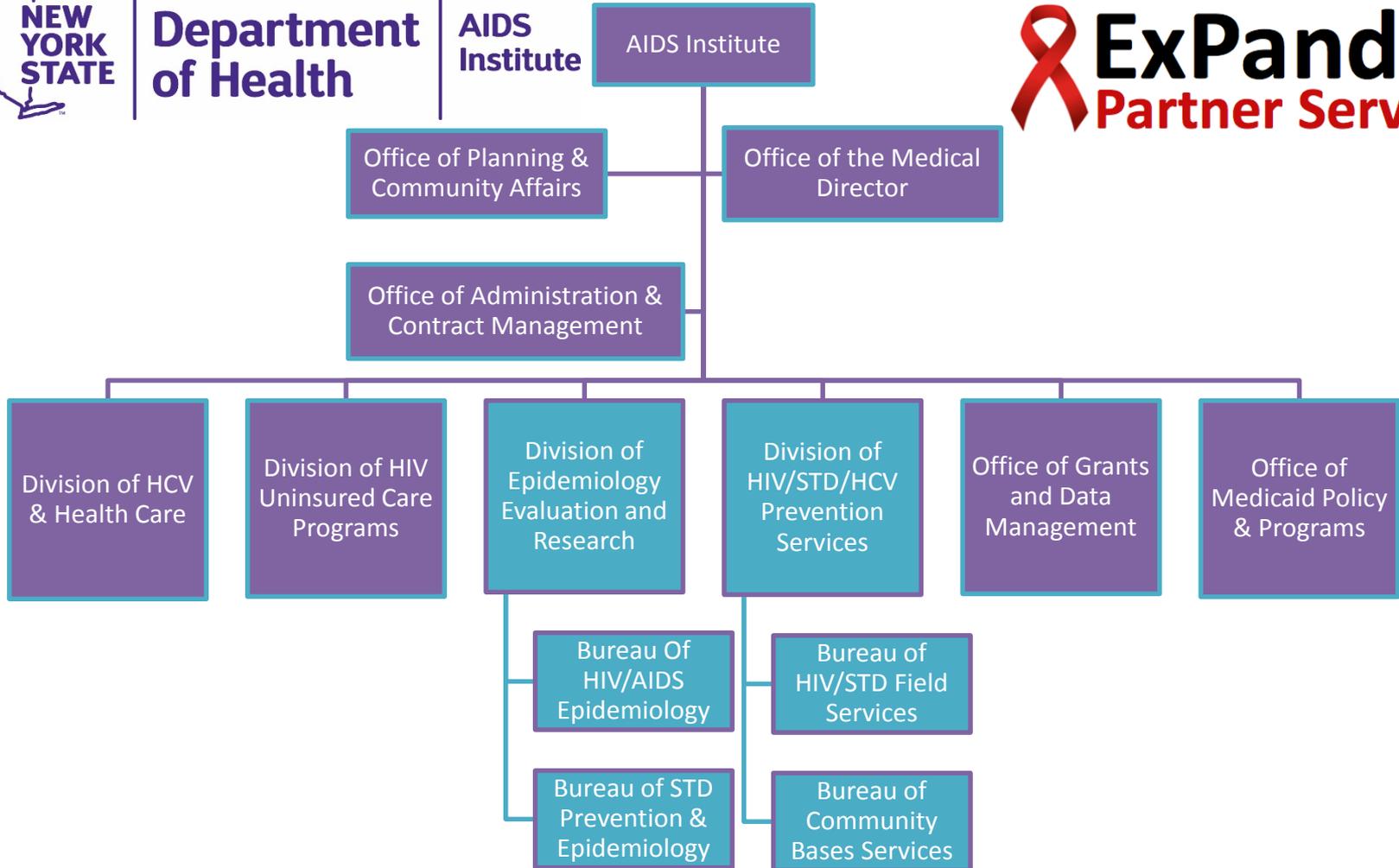
Objectives

- Discuss the major players within the NYSDOH, AIDS Institute
- Provide history and context for Data to Care in NYS
- NYSDOHs approach to developing protocols
 - Showcase Data to Care as a collaborative model of care in NYS from inception through service delivery
- Data to Care Job Aids
- Challenges for Data to Care in NYS
- Training Requirements for Linkage Specialist



Department of Health

AIDS Institute



Expanded Partner Services (ExPS)



Health Department Model

HIV surveillance data to identify individuals diagnosed with HIV who may be out-of-care

Patients with no recent VL or CD4 labs within New York's HIV Tracking System for 13-24 months

High Impact Care and Prevention Project (HICAPP)

Combination Model Health Department & Healthcare Provider

HIV surveillance data & selected health center's data to identify individuals diagnosed with HIV who may be out-of-care

4 definitions of out-of-care

ExPS in Department of Corrections and Community Supervision (DOCCS)

Health Department Model

Unique collaboration btw DOH and DOCCS

DOCCS custody data matched with HIV surveillance data to identify individuals diagnosed with HIV who may be out-of-care

2 definitions of out-of-care

NYS D2C TimeLine

▶ ExPS

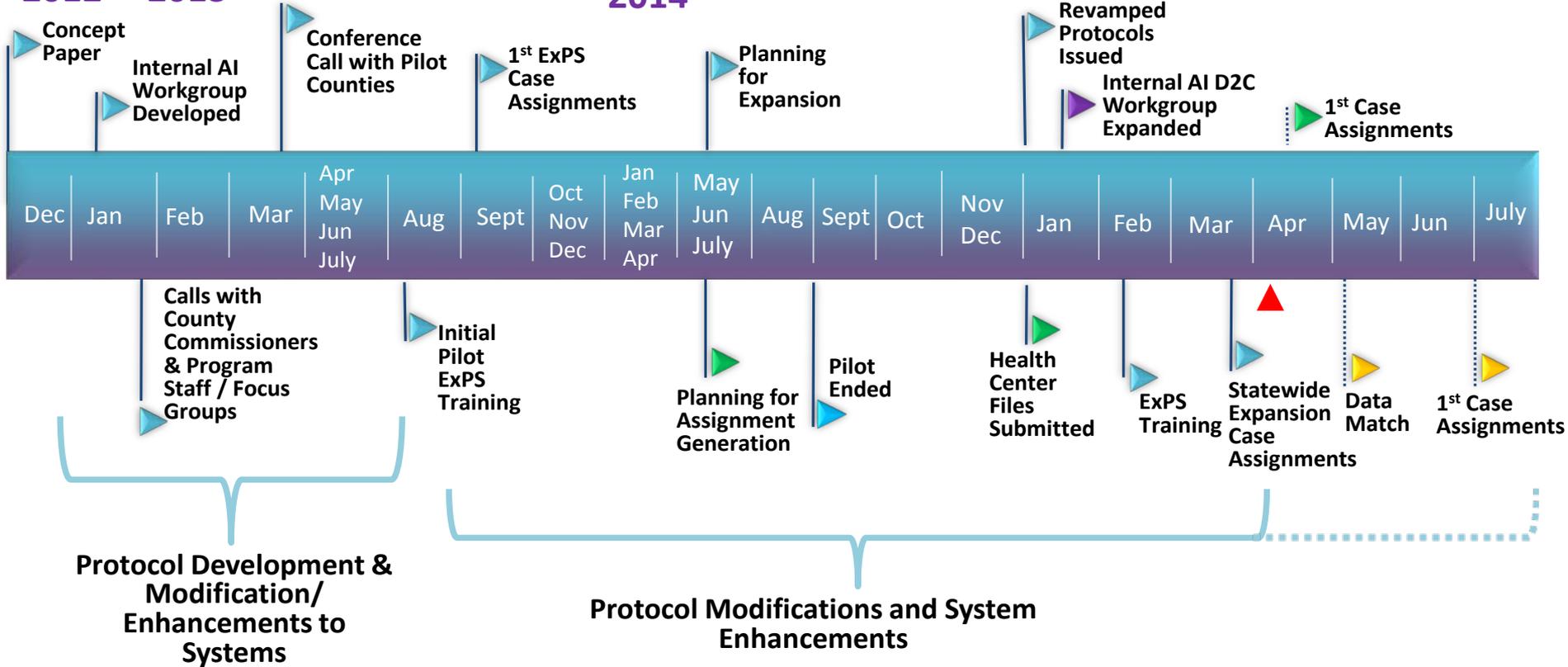
▶ ExPS in DOCCS

▶ HICAPP/P4C

2012 2013

2014

2015



Developing ExPS Protocols

Internal NYSDOH Players

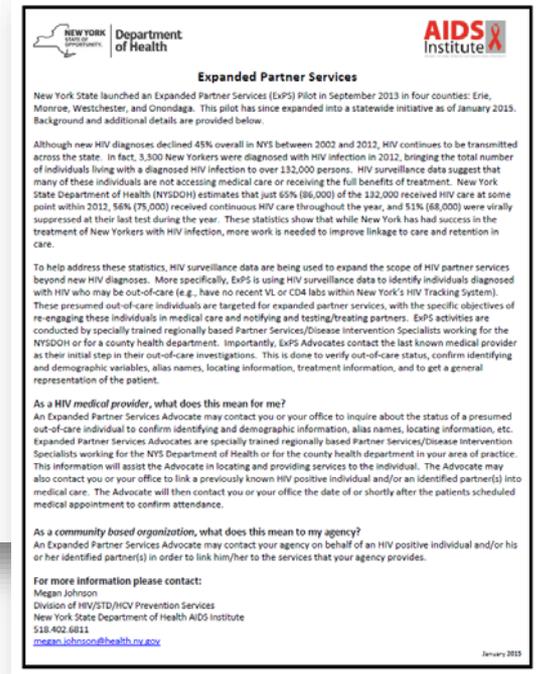
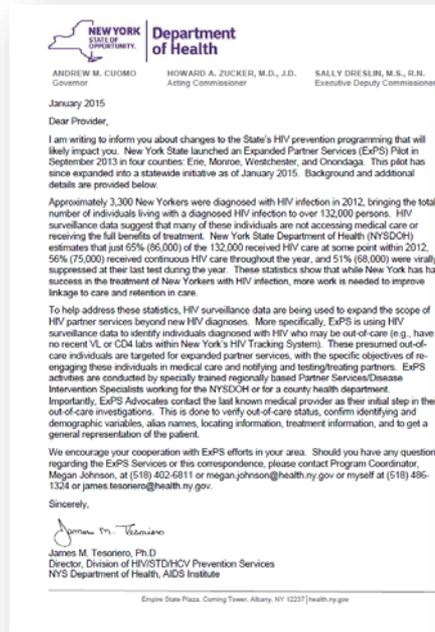
- Surveillance Teams
 - Bureau of HIV/AIDS Epidemiology
 - Bureau of STD Prevention and Epidemiology
- Bureau of HIV/STD Field Services
- Office of the Medical Director
 - Case definition on out-of-care
 - Step-by-step process for working with medical provider

External Players

- Other jurisdictions
 - New York City Department of Health and Mental Hygiene
- Local health departments

Community Engagement

- Focus groups in pilot counties
- Presented at several provider meetings across NYS & NYC
- Sent out 'Dear Provider' letters and program summary sheets
- Informed community based organizations (CBOs) & directed funding to support 'Linkage and Navigation' services
- Required local health departments to establish collaboration agreements/MOUs with medical providers & CBOs



Protocol Development

Expanded Partner Services Pilot

PURPOSE:

To delineate steps to identify patients who have no evidence of HIV; System/New York Electric supported Health Center offered comprehensive partner services, risk reduction, and coordinating and facilitating Partner Services Advocate the purpose of partner not testing or make an active

ELEMENTS OF THE

I. Roles and Responsibilities

a. County Health

i. Local

ii. External

EXPANDED PARTNER SERVICES PROTOCOLS – NYSDOH AIDS INSTITUTE PAGE | 8

EXPANDED PARTNER SERVICES PROTOCOLS – NYSDOH AIDS INSTITUTE

EXPANDED PARTNER SERVICES PROTOCOLS – NYSDOH AIDS INSTITUTE

DOCUMENTATION

VIII. CASE CLOSURE

C. In DOCCS, NYC

i. For Exposed Data

CONFIDENTIAL

Every effort of correct speak in lab cannot be

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C. Current to Care Cases

ExPS patients are considered medical care or treatment verified via RHOs, prove "before" the ExPS inter

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ExPanded Partner Services

Megan Johnson
Prevention Coordinator
Division of HIV/STD/HCV Prevention Services

Expanded Partner Services

A Quick Guide to Expanded Partner Services Acronyms and Terms
Division of HIV/STD/HCV Prevention Services

Acronym/Term	Definition
ADAP	AIDS Drug Assistance Program
Adherence	The extent to which a person takes medication in the way it is prescribed, including and involving parents, building patients' addressing barriers to adherence.
ART/Antiretroviral treatment or therapy	Medications used by persons with HIV to inhibit HIV replication and progression; prophylaxis by HIV-infected persons, to prevent Acquired Immunodeficiency Syndrome (AIDS).
ARTAS	Antiretroviral Treatment and Access to Services Study
Blood work	Completed Viral Load or CD4 Testing
CBQ/Social Services	Community Based Organizations, Nonclinical organizations or community-based HIV services, not including diagnostic and laboratory services.
CD4 count	The number of CD4+ T-lymphocyte cells per millimeter cubed (mm ³) in the blood. A low CD4 count is used to assign risk status, prognosis, and guide decisions about the need for treatment.
CD4 count	Measures white blood cells and is an indicator of an HIV positive person's immune system health.
CDCC	Centers for Disease Control and Prevention
CESS	Communicable Disease Electronic Surveillance System
Collaborative Agreement	A formal agreement between two or more organizations to work together on a specific project.
Correctional Facility	Prison
CO	County
CTC	County of Warren
EXP	Expanded Partner Services
DC	Department of Correction
DCU	Department of Correction Unit

Expanded Partner Services Program Contacts

Agency	Contact Name	Phone	Email
NYSDOH	Megan Johnson (EXP Program Coordinator)	518.402.6811	megan.johnson@health.ny.gov
	Britney Johnson (EXP Data Coordinator)	518.474.1387	britney.johnson@health.ny.gov
	Heldi Reukauf (EXP ODCS Program Coordinator)	518.402.5701	heldi.reukauf@health.ny.gov
Erie County Department of Health	Rebecca Sole (Program Supervisor)	716.858.7663	rebecca.sole@erie.gov
	Liza Gabriel-Austin (EXP Advocate)	716.858.7853	liza.gabriel-austin@erie.gov
Monroe County Department of Health	*Kim Smith (EXP Advocate & Supervisor)	585.753.5375	ksmith@monroecounty.gov
	Ana Rodriguez (EXP Advocate)	585.753.5361	arodriguez@monroecounty.gov
Westchester County Department of Health	Marylee Mathison (Program Supervisor)	914.813.5216	mwm1@westchestergov.com
	*Kim Bryant (EXP Advocate)	914.813.5633	kb@westchestergov.com
Orangeta County Health Department	Tawanna Morgan (Program Supervisor)	315.415.3239	tawanna.morgan@orangenvet.net
			kb@orangenvet.net

Sample QA Report (Cases Assigned from June-August)

closure_code	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Patient Died	6	10.34	6	10.34
Index Located, Refused Partner Services	5	8.62	11	18.97
Index OOI, No Partners On PRF	15	25.00	26	43.97
Investigation Complete - Interviewed Only By Private Provider	2	3.45	28	48.23
Investigation Complete - Interviewed By PRAP (Including RA Interview)	4	6.90	32	55.17
OOI Provider, OOI Residence	2	3.45	34	58.62
Unable To Locate Index Case, No Partner Services Provided	7	12.07	41	70.69
Other Specified Reason	2	3.45	43	74.14
Consent To Care	11	18.62	54	93.15
Index Located, Lost to ExPS Followup	4	6.90	58	100.00

10:51 Thursday, February 13, 2016

Transtheoretical Model of Behavior Change: Linkage-to-Care Strategies & Interventions

Stage of Change	Description	Target Behavior	Goal & Strategy	Strategies & Interventions
Pre-contemplative	In which the patient is not considering a behavior change and acts out his/her ambivalence about the behavior in question. (The stage where people have no intention of changing a behavior.)	Sees no need to do it or to work on it	The goal at this stage is to get the patient to start considering the costs and benefits of his/her behavior. Get a reaction through thoughts or feelings.	Give information and/or statistics → Information that directly relates to the patient's unique circumstances (e.g., last known CD4/VL labs) → "What do you already know about...?" → Show the cost/benefit and linguistically appropriate → Process the information with the patient: "What do you think this means for you?" Storytelling → "Take about another patient (without providing personally identifying information) with similar circumstances and what happened to them." → Address the emotional reactions through prevention → Alters perception of risk → Help patient "see" consequences Discuss impact of behavior on others → Helpful for patients who are fatalistic or say they don't care → "Talk with patient about how risk behavior could impact on the lives of others they care about." Identify Barriers → Utilize existing resources - make referrals to supporting services (e.g., transportation, housing, food pantry, etc.)
Contemplative	In which the patient is recognizing that his ambivalence about his/her behaviors. At this point, ambivalence is high but the possibility of change is unfocused. (The stage where people are thinking about making a change.)	Said need to, but... or "yeah, but I can't"	The goal now is to get the patient to consider the possible costs and benefits of change. Explore reasons behind ambivalence; help patient identify barriers. Focus on the "but" Identify Barriers → Utilize existing resources - make referrals to supporting services (e.g., transportation, housing, food pantry, etc.)	Empire Ambivalence → Pros and cons → Weigh personal pros and cons of the proposed change → Offer harm reduction substitutes → Discuss lower risk alternative behaviors for the patient to try → Patient needs to do the work; your role is to facilitate their thinking, attitudes, and feelings. Discuss Behavioral Reaction to Self-image → Ask patient to describe how they see themselves as a person - values and standards → Ask patient to explore how the specific risk behavior fits or doesn't fit with their self-image → Advocate linkage Specialists must remain values neutral Identify Barriers → Utilize existing resources - make referrals to supporting services (e.g., transportation, housing, food pantry, etc.)

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and high-risk...
and PEP and rPE

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plan/requirem...
work plan. The...
Health Officer...

Work

PROJECT NAME: CONTRACTOR SES PAYEE TEAM CONTRACT PERIOD:

Supplemental Expanded Partner Services Out of Care Case Investigation Form (CIF)
Form to be completed in full by the EXP Advocate for every EXP Assignment

Case No: _____ Worker Code: _____

Current Situation

Traced - Out of Care Traced - Current to Care Not Traced - Unable to Locate

Traced - Other
 Medically Unable to respond
 Refused: Located and refused to meet in person/phone
 Moved to Another Jurisdiction
 Deceased
 Other, Specify: _____

Complete on CIF and in Tracking System/PEP/MS any new and/or missing identifying information and eligibility variables for every EXP Assignment:
 First and last name: _____
 Alias name: _____
 SSN: _____
 Date of birth: _____
 Race: _____
 Ethnicity: _____
 Sex at birth: _____
 Risk: _____
 Residence at time of diagnosis: _____
 Current residence if different: _____
 County of birth: _____
 Date of death (anniversary year of death) if still alive: _____

Medical Provider Interview/Chart Review Notes

Interviewed for reasons out of care (check all that apply)

<input type="checkbox"/> Feat Health	<input type="checkbox"/> Do not have medical insurance
<input type="checkbox"/> Feat Depressed	<input type="checkbox"/> Did not trust health care workers
<input type="checkbox"/> Day-to-day responsibilities	<input type="checkbox"/> Adverse effect of self-medication
<input type="checkbox"/> Do not think 100 positive	<input type="checkbox"/> Inconsistent time of appointments
<input type="checkbox"/> Family Commitments	<input type="checkbox"/> Forget About Appointments
<input type="checkbox"/> Substance Use	<input type="checkbox"/> Did Not Feel Like Going to Appointment
<input type="checkbox"/> Too Child Care	<input type="checkbox"/> Did not Attend Appointment
<input type="checkbox"/> Lack of Stable Housing	<input type="checkbox"/> Appointment Wasn't with Preferred Provider
<input type="checkbox"/> Language Barrier	<input type="checkbox"/> Lack of Transportation
<input type="checkbox"/> Work Obligation	<input type="checkbox"/> Other, Specify: _____

Partner Interview Yes No **Case Interview** Yes No

Partner Interview/Chart Review (check all that apply)

<input type="checkbox"/> Discussion Completed	<input type="checkbox"/> Appointment or Referral for Non-Medical Services Made
<input type="checkbox"/> Risk Assessment Completed	<input type="checkbox"/> Discussion of Partner(s)
<input type="checkbox"/> Take Conditions Precedent	<input type="checkbox"/>
<input type="checkbox"/> Terms Conditions Provided	<input type="checkbox"/>

Medical Referral Information

Referred to (Name, Address, Phone): _____
 Date of first Medical Appointment Scheduled: ____/____/____
 Date of first Medical Appointment Attended: ____/____/____
 Date Medical Appointment Verified: ____/____/____

No show for appointments Lost to Follow Up Other, Specify: _____

Primary Linkage Disposition (only completed for patients who were traced and found to be out of care)

Linked to Care: Patient attends at least one medical appointment
 Not Linked to Care: No evidence of medical appointment

ExPS Job Aids



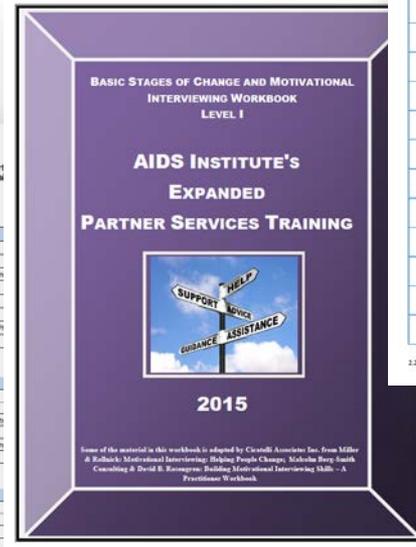
ExPS Training for Linkage Specialist

Comprehensive Three-Day Training

- Advance partner services skills to ensure staff are prepared to address the needs and challenges associated with re-engagement of individuals along the HIV care continuum
- Key goals and objectives of ExPS and data collection protocols
- Motivation Interviewing & transtheoretical model of behavior change

Expanded Partner Services Training Agenda	
New York State Department of Health, AIDS Institute - New Rochelle Office 145 Huguenot Street, 6th Floor, Room 612 New Rochelle, NY 10801-6790	
DAY ONE – Wednesday, February 25, 2015	
Time	Topic
8:00 – 8:15 PM	Arrive and Register
8:15 – 8:30 PM	Welcome and Introductions, Jim Tessitore, NYSDOH
8:30 – 9:15 PM	Director of AIDS Institute to Discuss Ending the Epidemic in New York State, Dan O'Connell
9:15 – 9:30 PM	Break
9:30 – 9:45 PM	Expanded Partner Services Overview, Mag Johnson, NYSDOH
9:45 – 10:45 PM	What We've Learned Thus Far: A Closer Look at ExPS, Britney Johnson, NYSDOH
10:45 – 4:15 PM	The Unique Role of Community Based Organizations, Lisa Demarco & Marilyn Alessi-P
4:15 – 4:30 PM	Wrap Up Day 1 and Adjourn
DAY TWO – Thursday, February 26, 2015	
Time	Topic
8:00 – 8:45 AM	Arrive and Sign In
8:45 – 9:00 AM	Welcome and Announcements
9:00 – 12:00 PM	Motivational Interviewing & Transtheoretical Model of Behavior Change – Part 1, Ruth
12:00 – 1:00 PM	Break for Lunch
1:00 – 4:15 PM	Motivational Interviewing & Transtheoretical Model of Behavior Change – Part 2, Ruth
4:15 – 4:30 PM	Wrap Up Day 2 and Adjourn
DAY THREE: Friday, February 27, 2015	
Time	Topic
8:00 – 8:45 AM	Arrive and Sign In
8:45 – 9:30 AM	Senior Advocate Panel, Kim Smith, MCPH & Rebecca Soti, ECH
9:30 – 10:30 AM*	ExPS Protocols Part 1, Mag Johnson & Britney Johnson, NYSDOH
10:30 – 10:45 AM	Break
10:45 – 11:15 AM*	ExPS Protocols Part 2 with MI & TBM Skills Development, Mag Johnson & Britney Johnson, NYSDOH
11:15 – 11:30 AM	Break
11:30 – 12:15 PM	ExPS in DOCS & RECAP, Heidi Reslauf & Rachel Malloy, NYSDOH
12:15 – 1:00 PM	Regional Breakfast Sessions, Rachel Malloy, NYSDOH
1:00 – 1:15 PM	Phone-in & NYC QI – West
1:15 – 1:30 PM	Long Island & NYC QI – West
1:30 – 1:45 PM	Long Island & NYC QI – West
1:45 – 2:00 PM	Central Region – Beth
2:00 – 2:15 PM	Central Region – Britney
2:15 – 2:30 PM	Central Region – Kim
2:30 – 2:45 PM	Central Region – Kim
2:45 – 3:00 PM	Central Region – Kim
3:00 – 3:15 PM	Closing Remarks and Adjourn

*For those participating via phone, the call information is as follows: Call in Number 1-866-094-2346 Conference Code 30779025



TRAINING AND SKILL DEVELOPMENT	
EXPANDED PARTNER SERVICES COMPETENCIES	
Rationale	
Staff members conducting case investigations as part of the Expanded Partner Services Initiative and other linkage-to-care interventions (such as HICAPP) need skills and training to ensure they are prepared to address the needs and challenges associated with re-engagement of individuals along the HIV care continuum. Activities related to ExPS and HICAPP are directly related to AIDS Institute priorities related to increasing HIV viral load suppression among people living with HIV/AIDS (PLWH).	
Expanded Partner Services Core Competencies	
1.	Communicate the goals of the ExPS pilot as it relates to high-impact HIV prevention and the Governor's goals to end the AIDS epidemic in NY
2.	Compare and contrast the goals of ExPS with other Partner Services programs and initiatives
3.	Summarize common barriers to engagement and retention in HIV care, and describe tools and resources available to address barriers (e.g., housing, transportation, mental health, substance use, insurance)
4.	Utilize investigative skills developed through HIV/STD Partner Services training to locate and contact individuals suspected to be out of care
5.	Apply principles of motivational interviewing and strengths based case management to help establish meaningful connections with patients
6.	Utilizing the Transtheoretical Model of Change ("Stages of Change"), distinguish between phases of re-engagement readiness and determine the resources needed to help a patient progress to the next stage
7.	Assist patients in formulating plans for re-engagement that reflect an understanding of their unique needs and circumstances
8.	Identify specific community agencies and medical providers who are able to assist in engagement and retention activities
9.	Describe the process of medical appointment scheduling and attendance to patients
10.	Assess patient's risk behaviors in order to deliver tailored risk reduction messages and referrals to appropriate prevention services (such as PrEP and rPEP, STD testing, HIV testing, etc.)
11.	Summarize the information available in the ExPS protocols and identify AI contacts for technical assistance and program coordination
12.	Demonstrate knowledge and understanding of the NYSDOH Tracking system as it relates to the documentation and data entry process for ExPS case investigations
2/23/2015	

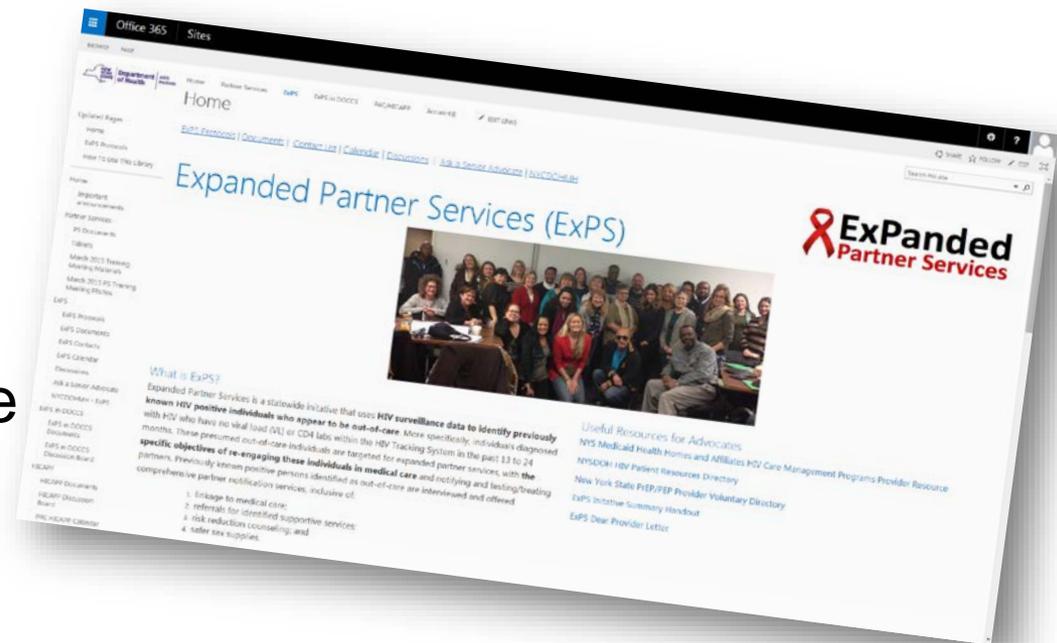


Department
of Health

AIDS
Institute

Challenges

- Monitoring of data quality
- Quality & processing of surveillance data for out-of-care work
- Coordination of initiative
 - Staffing at state level
 - Linkage Specialists
- Access to up-to-date protocols and job aids



Mid-Course Modifications

- Change of assignment basis from last known provider address to last known residence
 - Reduce number of cases classified as out-of-jurisdiction (and, in future, cases transferred)
- Changing date of case assignment “drop” to better coincide with surveillance lab processing schedule
 - Helped reduce cases “pulled back” due to lag in lab result receipt
- Requests for additional information to better match current to care cases
 - Utilize lab accession numbers, dates of last lab draw to “find” lab data
- Pursuit of Lexis Nexis® Accurint® for Unable to Locate Cases
 - Multiple confirmed relinkages as a result of Accurint person search tool

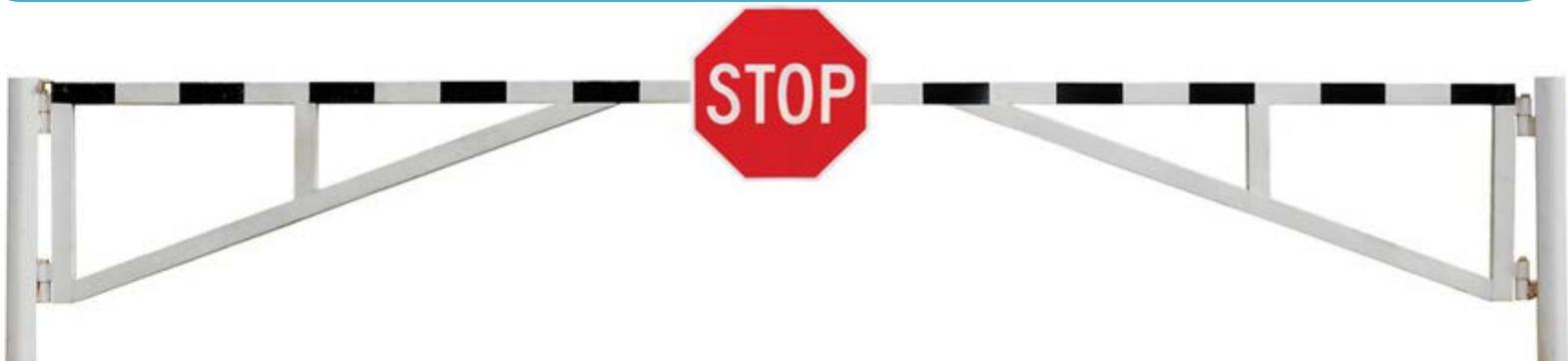
Importance of Flexibility



IX. TIMEFRAMES FOR EXPS CASE CLOSURE

For new diagnoses of HIV/STDs, timely and prompt intervention by PS staff is critical to ensuring patients and partners are tested and treated in order to prevent the spread of infection. While using similar methods, ExPS work for patients living with HIV focuses on a different step in the care continuum, and encourages a more holistic approach to patient preparedness and re-engagement in care.

ExPS Advocates are encouraged to work with patients to comprehensively address barriers to engagement and retention, and to work with medical providers and support services programs to facilitate effective and lasting engagement in HIV care. With this difference in mind, it is expected that ExPS cases may require more intensive work on the part of the ExPS advocate, and may be open for longer time periods than PS investigations for new HIV cases.



Megan Johnson, MPH, CHES

Prevention Services Coordinator
Division of HIV/STD/HCV Prevention Services
Megan.Johnson@health.ny.gov
518.402.6811

Britney Johnson, MPH

Data Coordinator
Bureau of HIV/STD Field Services
Britney.Johnson@health.ny.gov



*Unfortunately at this point NYSDOH materials are
unable to be shared externally.*



Thank you!

Questions?

Reminder: Next D2C Webinar

Thursday, May 14, 2015

- 5/14: Massachusetts and Community Engagement.



- **Share your experiences: EBascom@NASTAD.org**