Reaching Health Outcome Goals for Persons Living with HIV:
The HIV Continuum of Care and Data to Care Initiative in Virginia

Amanda Saia, MPH
HIV Surveillance Epidemiologist
HIV Continuum of Care:

A model that outlines the stages of HIV medical care that persons living with HIV (PLWH) go through from initial diagnosis to viral suppression, showing the % of PLWH engaged at each stage
Defining the HIV Continuum of Care in Virginia

What’s considered a care marker?

- **CD4 test**
- **Viral load test**
- **HIV medical care visit**
- **ART prescription**

**Linkage**
Evidence of a care marker within 30/90 days of initial HIV diagnosis

**Evidence of Care**
Evidence of at least one care marker in 12 months

**Retention**
2 or more care markers in 12 months at least 3 months apart

**Viral Suppression**
Last viral load <200 copies/mL in the time period being measured
HIV Continuum of Care in Virginia, 2015

- **Persons living with HIV as of 12/31/2015 (N=23,425)**
  - **100%**

- **Persons newly diagnosed in 2015 (N=967)**
  - **84%**

Retention and viral suppression outcomes for persons with evidence of HIV care in 2015:

- **Linkage to HIV care within 30 days**: **71%**
- **Evidence of HIV care in 2015**: **61%**
- **Retained in HIV care in 2015**: **47%**
- **Virally suppressed in 2015**: **46%**

Data reported to the Virginia Department of Health as of December 2016; Accessed February 2017.
HIV Continuum of Care in Virginia by Gender, 2015

- Men living with HIV as of 12/31/2015 (N=17,332)
- New diagnoses among men in 2015 (N=780)
- Women living with HIV as of 12/31/2015 (N=6,093)
- New diagnoses among women in 2015 (N=187)
- Linkage to HIV care within 30/90 days

- Evidence of HIV care in 2015
- Retained in HIV care in 2015
- Virally suppressed in 2015

**Persons diagnosed and living with HIV as of 12/31/2015:**
- Men: 17,331
- Women: 6,093

**Newly diagnosed and linked to HIV care within 30/90 days:**
- Men: 6,093 (75%)
- Women: 654 (70%)

**Evidence of HIV care in 2015:**
- Men: 10,298 (59%)
- Women: 3,934 (65%)

**Retained in HIV care in 2015:**
- Men: 7,929 (46%)
- Women: 3,176 (52%)

**Virally suppressed in 2015:**
- Men: 7,723 (45%)
- Women: 2,948 (48%)

Data reported to the Virginia Department of Health as of December 2016; Accessed February 2017.
HIV Continuum of Care in Virginia by Race/Ethnicity, 2015

Data reported to the Virginia Department of Health as of December 2016; Accessed February 2017; PLWH= persons living with HIV; NH= non-Hispanic; Number of PLWH is as of 12/31/2015.
Persons diagnosed and living with HIV as of 12/31/2015

- MSM PLWH (N=11,043)
  - New diagnoses in 2015: 11,438
  - Newly diagnosed and linked to HIV care within 30 days: 9,832
  - Evidence of HIV care in 2015: 9,096
  - Retained in HIV care in 2015: 8,944
  - Virally suppressed in 2015: 51%

- IDU PLWH (N=1,982)
  - New diagnoses in 2015: 1,982
  - Newly diagnosed and linked to HIV care within 30 days: 1,824
  - Evidence of HIV care in 2015: 1,568
  - Retained in HIV care in 2015: 1,344
  - Virally suppressed in 2015: 48%

- HET PLWH (N=4,558)
  - New diagnoses in 2015: 4,558
  - Newly diagnosed and linked to HIV care within 30 days: 3,788
  - Evidence of HIV care in 2015: 3,069
  - Retained in HIV care in 2015: 2,488
  - Virally suppressed in 2015: 41%

Data reported to the Virginia Department of Health as of December 2016; Accessed February 2017; MSM = men who have sex with men; IDU = injection drug use; HET = heterosexual contact; Number of PLWH is as of 12/31/2015.
HIV Continuum of Care in Virginia by Health Region, 2015

Data reported to the Virginia Department of Health as of December 2016; Accessed February 2017; Number of PLWH is as of 12/31/2015
The HIV Care Continuum Framework

Data
- Gaps in reporting labs, other care markers
- Lag time for reporting
- Gaps in reporting address change, vital status

Care/System
- What happens between the bars?
- How to re-engage people?
- Disparities in care

Prevention/Testing
- Influence bars before the bars
- Reduce those unaware of their infections
Virginia Innovations to Improve the HIV Care Continuum

e2VA

CMDB

Data to Care
Care Markers Database

External data sources (Medicaid, LexisNexis® Accurint®)

Supplemental HIV project data (CTR (HIV testing), Medical Monitoring Project (MMP), STD*MIS/MAVEN))

Ryan White data (e2Virginia and AIDS Drug Assistance Database (ADAP))

HIV surveillance data (Enhanced HIV/AIDS Reporting System (eHARS))
The Data to Care Initiative
Data to Care (DtC)

Use HIV Surveillance Data to:

- Support the HIV Continuum of Care
- Link/reengage out-of-care persons to HIV medical care
- Identify persons living with HIV who are out of care
The DtC Process

HIV Surveillance Data

Results Submitted to VDH

Generating the OOC List

Client Follow-up and Linkage to Care

OOC List Distribution

Results Submitted to VDH

Generating the OOC List

Client Follow-up and Linkage to Care

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Submitted to VDH

Generating the OOC List

Client Follow-up and Linkage to Care

OOC List Distribution
DtC Pilot Project Implementation

Pilot Phase 1
• Disease Intervention Specialists (DIS) at 5 health districts
• Out-of-Care (OOC) list included: clients whose last known residence was in the designated health districts

Pilot Phase 2
• 6 VDH contracted agencies
• OOC List included: clients who were last seen at that agency

Statewide OOC list included ~10,000 clients who had no labs in the last 5 years
Data to Care (DtC) Implementation in Virginia

- CDC starts conversation for Data to Care (DtC)
- VDH identified the need for data integration (Care Markers Database)
- DtC pilot project implemented
- SPNS HIT Key Stakeholders Meeting
- DtC Project Analyst hired
- Begin statewide expansion
- DtC module in e2Virginia under development
- New OOC definition implemented
- SPNS HIT Final Meeting

2011
- CDC starts conversation for Data to Care (DtC)
- VDH identified the need for data integration (Care Markers Database)

2012
- Care and Prevention in the United States (CAPUS) grant begins
- Special Programs of National Significance (SPNS) grant begins
- Care Markers Database is created

2013
- Inter-unit DtC Group is formed

2014
- DtC planning process begins

2015
- Ryan White Part B contract requirement
- DtC Linkage Coordinator hired
- Continued statewide expansion
- HIV Prevention 1509 grant requirement
- SPNS HIT Final Meeting

2016
- Ryan White Part B contract requirement
- DtC Linkage Coordinator hired
- Continued statewide expansion
- HIV Prevention 1509 grant requirement
DtC in 2017

• Collaborative project with HIV Surveillance, Prevention, Care Services and STD Operations and Data Administration (SODA)

• Expanded Statewide
  o Over 25 local health departments, medical sites and community-based organizations (CBOs) in Virginia are participating
  o DIS, Community Health Workers, Patient Navigators, Case Managers, and Other Linkage Staff are involved
OOC List Eligibility

- HIV+ and reported to eHARS
- Living with a last known address in Virginia
- 18 years or older
- Meet the OOC definition
The OOC Definition:

- Must have had a care marker in 2015
- Have not have evidence of care within 1 year of the date that the OOC list was generated.

**For example:** If I were to generate the OOC list on May 1, 2017, all clients who have not had a care marker since May 1, 2016, but who were in care in 2015, would be on the OOC list.
Generating the OOC List

1. **Care Markers Database**
   - eHARS

2. **Eligibility Criteria**
   - ≥18 years old
   - Living & in VA
   - HIV+ & reported to eHARS

3. **Apply OOC definition**
   - Care in reference year; no care in the past year

4. **Address and Vital Status Matches**
   - STD*MIS
   - LexisNexis

5. **Agency Matches**
   - e2VA/VACRS, ADAP, Prevention
   - eHARS

6. **The OOC List**
   - DIS
   - By Agency

**DtC Linkage Coordinator**
DtC Results

Final Outcome

- In Care: 47%
- Unable to Locate: 22%
- Relocated
  - Out of State: 12%
- Not in Care: 7%
- Deceased: 4%
- Other: 3%
- Discharged: 2%
- Incarcerated: 1%

N=361

Data reported to the Virginia Department of Health as of 4/27/2017
Clients Found “Not in Care”

Reported Barriers to Care:

- Lack Transportation
- Financial concerns
- Lack insurance or issues with insurance
- Privacy concerns
- Discrimination
- Not interested in being in care
- Feel well
- Not satisfied with medical provider
- Fear of disease
- Has a lot going on
- Was not told when to return

Refused 15%
Referred to Care 7%
Reengaged in Care 78%
DtC Linkage Coordinator Results

**Letters**
- Mailed 697 letters across the state
- 401 letters returned
- Incorrect addresses

**Phone Calls**
- Called 186 clients
- 114 wrong numbers
- 20 numbers disconnected
- Left 52 voicemails

**Results**
- 3 clients successfully linked to care
- 11 were in care
- 1 person relocated out of state
- 1 was deceased
DtC at Local Health Depts

- Disease Intervention Specialists
- Community Health Workers/Patient Navigators
- Case Managers
DIS and DtC

Process:

• DtC expanding to DIS by region
  ✓ Southwest region is already participating
  ✓ Next up: Eastern and Central regions
New DtC Page on Website

- Summary of what Data to Care is and how it works
- Current results
- Data to Care Electronic Resources
  - Protocol, data collection tool, CCSA form, FAQ’s
- Contact information

Future e2Virginia DtC Module

Currently in development and will launch in Spring 2017!

**OOC Lists**
- Files imported directly into e2VA
- Secure

**Screens**
- Tracking
- Contact Attempts
- Outcome

**Reports**
- Agency and State Outcomes
- Client Summary
Questions

Amanda Saia, MPH
HIV Surveillance Epidemiologist
Email: Amanda.Saia@vdh.virginia.gov
Phone: (804) 864-7862
Fax: (804) 864-7970