Partner Services Data to Care Report, New York State (excluding New York City) 2015

EXPANDED PARTNER SERVICES, HIGH IMPACT CARE AND PREVENTION, AND EXPANDED PARTNER SERVICES IN DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION

AIDS INSTITUTE, NEW YORK STATE DEPARTMENT OF HEALTH

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CONTENTS

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CDC	Centers for Disease Control and Prevention
CD4	Cluster of Differentiation 4 cell (T4 cell, a receptor for HIV in humans)
DOCCS	Department of Corrections and Community Supervision
ExPS	Expanded Partner Services
ExPS in DOCCS	Expanded Partner Services in Department of Corrections and Community Supervision
HICAPP	High Impact Care and Prevention Project
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Service Administration
IDU	Injection drug use
MSM	Men who have sex with men
NYC	New York City
NYCDOHMH	New York City Department of Health and Mental Hygiene
NYS	New York State
NYSDOH	New York State Department of Health
OOC	Out of Care
P4C	Partnership for Care
PLWDHI	Persons living with diagnosed HIV infection
ROS	Rest of State (refers to the geographic area of NYS, excluding NYC)
STD	Sexually Transmitted Disease

EXECUTIVE SUMMARY

BACKGROUND

New York State has one of the most robust HIV prevention programs in the nation, supported by over $80 million in state and federal funding annually. The state's HIV prevention efforts include HIV testing and partner services; HIV prevention interventions targeted to HIV-positive individuals; interventions aimed at preventing infection among HIV negative persons (including an extensive and growing expanded syringe access program); and one of the nation's most comprehensive initiatives to reduce maternal-to-child HIV transmission. In addition, advances in HIV treatment have made HIV a manageable chronic disease for many. Thus, as a result of New York State's HIV prevention efforts and advances in HIV treatment, new cases of HIV infection have decreased markedly over time.

Despite these successes, HIV continues to be transmitted across New York State. There were 3,434 New York residents newly diagnosed with HIV infection in 2014. HIV testing is the first step in reducing transmission, as individuals who know their status can then be linked to medical care and treatment. It is also critical to ensure that people living with HIV receive ongoing care. Proper treatment is one of the most effective ways to protect their health and prevent the further spread of HIV. Effectively treating people with HIV lowers the amount of virus in their bodies and significantly reduces the risk of transmitting HIV to others.*

New York State HIV surveillance data suggest that about one-third of all New York residents diagnosed with HIV are not receiving the care they need to effectively manage their disease. Of the 111,900 New York residents living with diagnosed HIV at the end of 2015, 81% (~90,300) received HIV care at some point during 2015, 66% (~73,900) received continuous HIV care during the year, and 67% (~75,400) had a low or undetectable viral load at their last test of the year.

To address this challenge, the New York State Department of Health (NYSDOH) utilizes a High-Impact Public Health Prevention Strategy, Data to Care. This strategy is endorsed by the Centers for Disease Control and Prevention (CDC) and uses New York State HIV surveillance data to locate and re-link HIV-positive individuals to HIV-related medical care in order to improve health outcomes and reduce the risk of HIV transmission. This approach shows promise to further increase the impact of HIV prevention efforts – an essential step in achieving the goals of both the National HIV/AIDS Strategy and Governor Cuomo's Plan to End the AIDS Epidemic in NYS.

* For more information, see the following CDC Fact Sheets (released December 2013):
- Challenges in HIV Prevention: http://www.cdc.gov/nchhstp/newsroom/docs/HIVFactSheets/Challenges-508.pdf
- The Future of HIV Prevention: http://www.cdc.gov/nchhstp/newsroom/docs/HIVFactSheets/Future-508.pdf

OBJECTIVES OF THIS REPORT

This report presents a summary of the Partner Services-based Data to Care initiatives in New York State (NYS) as part of the NYSDOH's commitment to ongoing monitoring, evaluation, and quality improvement. More specifically, this report:

- Provides an overview of Partner Services-based Data to Care work in NYS (outside of New York City);
- Describes the implementation of three NYSDOH Data to Care Initiatives;
- Summarizes programmatic outcomes of NYSDOH Data to Care work; and
- Evaluates the health impact of NYSDOH Data to Care work for individuals who received re-linkage assistance.

USES

As this report highlights an innovative strategy for using routinely collected health data for purposes of improving the overall health of persons living within NYS, this document is geared towards public health professionals, medical providers, and community based organizations operating across various settings.

This report can be used specifically by state health departments or health authorities implementing or considering the implementation of Partner Services-based Data to Care programs. Information in this report may also be relevant to medical providers and community based organizations focusing on retention and re-engagement in HIV care.

KEY FINDINGS

- Over 3,000 Persons Living with Diagnosed HIV (PLWDHI) in NYS were identified as potentially not receiving HIV medical care (i.e., out of care) based on routinely collected HIV laboratory data that are reported to the NYSDOH. As a result of the Partner Services–based Data to Care programming outlined in this report, NYSDOH provided outreach to these individuals between September 2013 and the end of December 2015. Results of this outreach were:
    - Less than 20% of individuals initially presumed to be out of care were confirmed to actually be out of care. The vast majority were either in care without current labs, moved to another jurisdiction, or were deceased.
    - Of those not truly out of care, roughly 25% were found to be currently in HIV medical care. This indicates individuals might be under the care of a physician, but not receiving regular HIV lab work. These individuals need to be further evaluated.
    - There has been success in re-linking those individuals determined to be out of care back to HIV medical care, with a 72% re-linkage rate realized across all Partner Services-based Data to Care initiatives.
    - While re-linkage success is high, some individuals with high viral loads were not successfully re-linked to care due to individuals refusing assistance, or being lost to follow up. This group might benefit from multiple initiatives targeting returning to care.
- The viral load status of re-linked individuals indicates that nearly 7 in 10 were virally suppressed prior to their lapse in care. However, only 50% of these individuals were virally suppressed

indicating a decline in health status while out-of-care. The percent virally suppressed increased to over 70% at subsequent follow-up(s).

- This analysis demonstrates that Partner Services-based Data to Care is not only successful in re-engaging individuals back into care, but also provides medical evidence of improvement along the HIV care continuum, directly supporting the NYS objective to 'End the AIDS Epidemic'.
- Seropositivity among individuals in NYS Department of Corrections and Community Supervision (DOCCS) facilities continues to be among the highest in the nation, with 3% of inmates in NYS DOCCS facilities identified as HIV positive through a match conducted in 2015 with NYS HIV surveillance registry data. Roughly 90% of HIV-positive persons within NYS DOCCS facilities had disclosed their HIV status and were currently in HIV medical care. Similarly, following release to NYS communities, over 80% of HIV-positive persons had evidence of being re-linked to care in the community.

PROGRAM DESCRIPTION AND KEY TERMS

Data to Care initiatives utilize routinely collected HIV surveillance lab data and/or healthcare provider patient data to determine the care status of PLWDHI, and subsequently to offer comprehensive services to individuals suspected of being out of HIV medical care. The goal of Data to Care is to link PLWDHI not in HIV-related medical care back into care, and ultimately for each patient to reach and maintain HIV viral load suppression.

The NYSDOH AIDS Institute employs three Partner Services-based Data to Care program models: a Health Department Model, utilizing routinely collected prognostic lab results (viral load, CD4 or genotype) data to identify HIV-infected individuals who have not received HIV-related lab work in the past 13-24 months (Expanded Partner Services); a Combination Health Department/Healthcare Provider Model, in which partnering health centers submit patient names to NYSDOH for matching with the HIV surveillance registry to determine HIV care status (High Impact Care and Prevention Project); and a unique DOCCS Model utilizing census and inmate health data matched with the NYSDOH's HIV surveillance registry to determine HIV care status (Expanded Partner Services in DOCCS). Each program model varies slightly in defining "out of care"; however, each model is similar in that once a PLWDHI is identified as out of care, a case is assigned to NYSDOH or County Health Department Partner Services staff with the specific objective of re-linking these individuals to HIV medical care.

PLWDHI identified as "out of care" are also interviewed by Partner Services staff, asked to identify reasons for being out of care, and offered comprehensive partner notification services, inclusive of: linkage to medical care; referrals for supportive services; risk reduction counseling; and provision of safer sex supplies. Once HIV presumed "out of care" case assignments are completed, viral load and/or CD4 labs are tracked to evaluate the impact of linkage to medical care and individual viral load suppression.

Several key terms are used consistently throughout the three NYSDOH AIDS Institute Partner Services-based Data to Care program models, and within this report. They are outlined below.

Primary case outcomes, referred to as dispositions:

> Unable to Locate: This includes cases where the Partner Services staff is unable to locate the individual after several attempts using multiple investigative methods.
>
> The following closure dispositions apply to located individuals:
>
> Current to Care: This includes the following situations: cases are verified as participating in clinical drug trials; cases where HIV lab work was received by the NYSDOH after the case assignment; and cases verified as in care by the individual or by the individual's medical provider.
>
> Out of Jurisdiction: This includes cases residing in areas outside the NYSDOH's jurisdiction [(i.e. out of NYS or within New York City (NYC)]. Note that cases identified as NYC residents are transferred to the New York City Department of Health and Mental Hygiene (NYCDOHMH) for investigation and follow up.

Deceased: This includes individuals who were identified as deceased after case assignment.

Other Disposition: This includes individuals who were located and contacted but where the person was medically unable to respond, cases determined to be duplicate cases (i.e., individuals identified elsewhere in the NYSDOH surveillance registry), and cases failing to meet any of the other defined dispositions.

Out of Care: This includes individuals who were identified and contacted, and it was confirmed by the last known medical provider or the individual that they were out of HIV medical care at the time the Partner Services staff contacted them.

The following closure dispositions apply to cases confirmed to be out of care:

Re-linked to HIV Medical Care: This includes cases verified as attending at least one HIV medical appointment following case assignment.

Not Re-linked to Care: This includes cases where the individual was located and interviewed but refused all assistance, and cases where the individual was located and accepted assistance but the Partner Services staff were not able to verify that the patient attended at least one medical appointment subsequent to case assignment.

Secondary case outcomes:

Lapse in care: This refers to the time out of care for individuals who were confirmed to be out of care.

Re-engaged in medical care: For individuals re-linked to care, this includes individuals with at least one viral load test following case assignment.

First lab upon re-linkage: This includes viral load test values for the test conducted following case assignment for those who were re-linked to and re-engaged in medical care.

Retained in care: Among individuals who re-engaged in care, this includes individuals with at least two viral loads tests at least 30 days apart within the reporting period.

Last lab: This includes viral load test values for the last viral load test in the reporting period conducted among individuals retained in care.

EXPANDED PARTNER SERVICES

NYSDOH launched an Expanded Partner Services (ExPS) Pilot in September 2013 in four high HIV prevalence counties: Erie, Monroe, Westchester, and Onondaga. Based on the success of the pilot, ExPS expanded into a statewide initiative in March 2015. This was accomplished through six additional contracts with five counties containing the largest number of individuals presumed to be out of care, as identified by NYSDOH HIV surveillance data (i.e., Nassau, Suffolk, Orange, Dutchess, and Albany) and the NYCDOHMH. Additional NYSDOH Regional Office Partner Services staff were utilized for the remaining counties throughout NYS. See Map 1 below depicting the Partner Services jurisdictions of County and State Partner Services staff conducting ExPS (excluding NYC).

As previously mentioned, ExPS utilizes a CDC endorsed High-Impact Prevention Strategy, Health Department Data to Care program model, to locate and re-link PLWDHI in HIV related medical care. ExPS strategy uses routinely collected HIV surveillance data to identify previously diagnosed and reported HIV-positive individuals who appear to be out of care; more specifically, individuals diagnosed with HIV who have no viral load, CD4, or genotype labs reported to NYSDOH in the prior 13 to 24 months. Although ExPS is statewide, including NYC, this report is limited to only cases assigned outside of NYC. NYSDOH funds the NYCDOHMH to conduct that component of their Data to Care Partner Services.

Table 1 and Figures 1 through 10 provide information on various facets of the ExPS program, including descriptive statistics of the program participants, case assignment information, and primary and secondary program outcomes.

MAP 1: COUNTY AND REGIONAL OFFICES CONDUCTING EXPS (OUTSIDE NYC), 2015

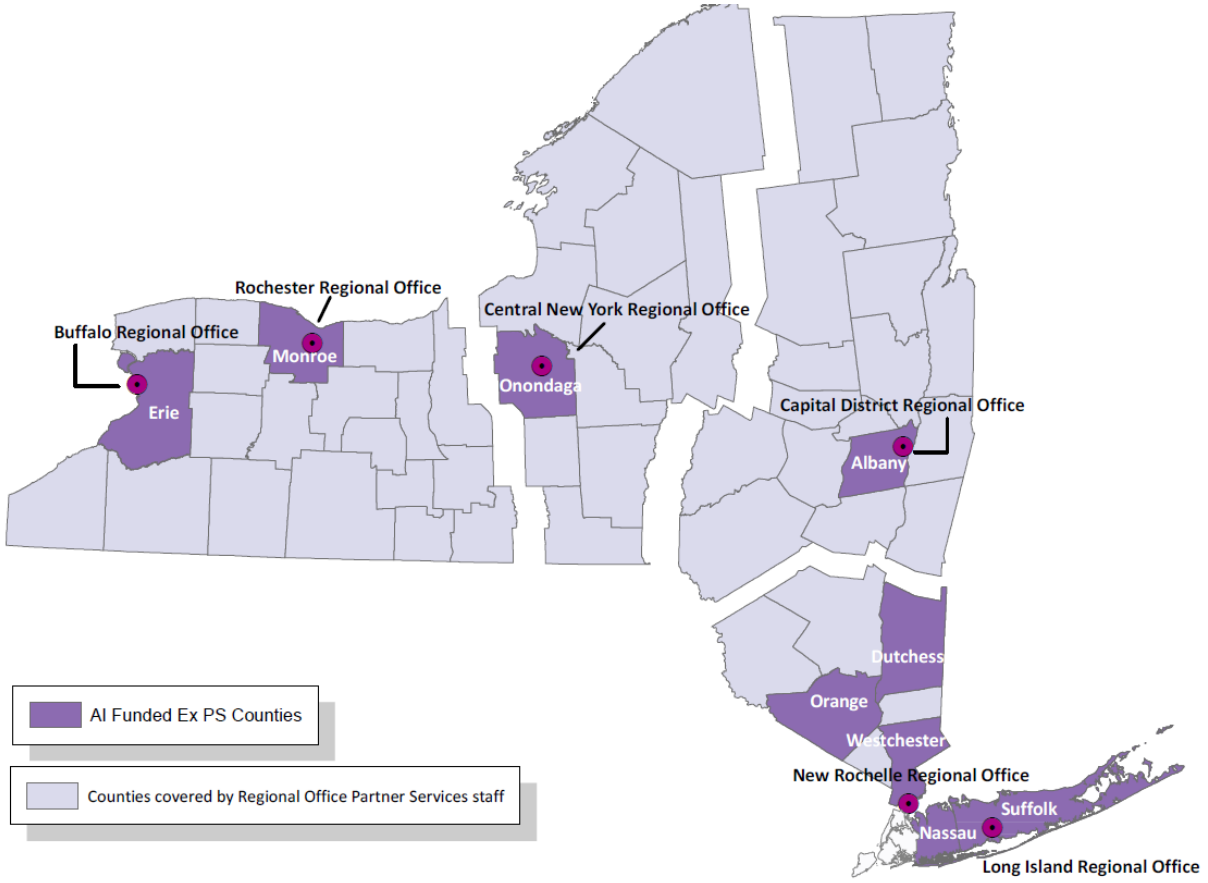


TABLE 1: EXPS, DESCRIPTIVE STATISTICS: CASES ASSIGNED BETWEEN SEPTEMBER 2013 AND 2015

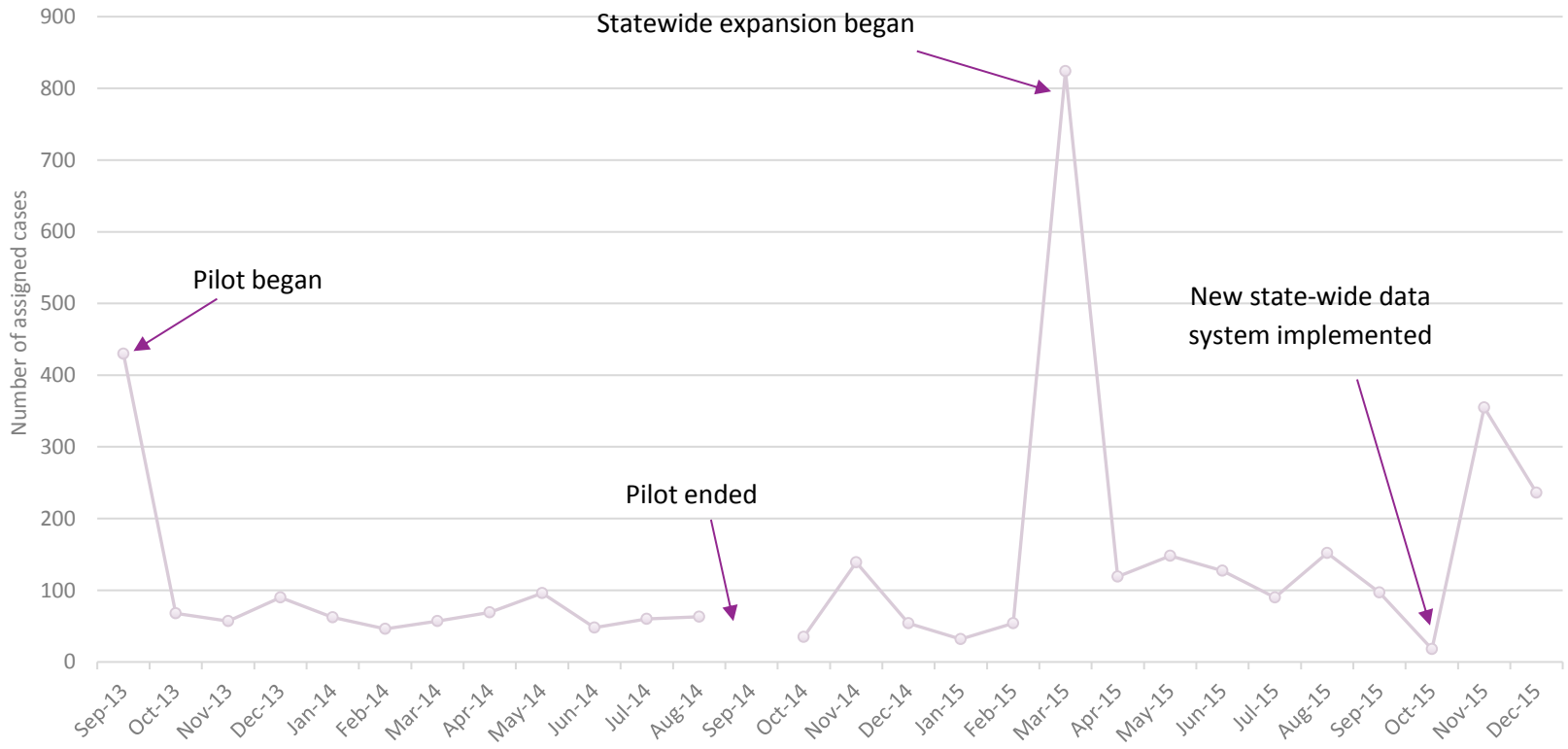
	N	%
All*	3,627	100.0
Age		
< 15	8	0.2
15-19	11	0.3
20-29	422	11.6
30-39	597	16.5
40-49	926	25.5
50-59	1,088	30.0
>60	562	15.5
Missing	13	0.4
Gender		
Male	2,568	70.8
Female	1,040	28.7
Transgender	14	0.4
Missing	5	0.1
Race/Ethnicity		
Black, Non-Hispanic	1,278	35.2
White, Non-Hispanic	1,140	31.4
Hispanic	675	18.6
Multi-race/Other, Non-Hispanic	455	12.5
Asian, Non-Hispanic	21	0.6
American Indian/Alaskan, Native Hawaiian/Pacific Islander, Non-Hispanic	7	0.2
Unknown or missing	51	1.4
Transmission risk		
Heterosexual†	890	24.5
Men who have sex with men (MSM)	1,166	32.1
Injection Drug Use (IDU)	499	13.8
MSM/IDU	151	4.2
Blood or pediatric	4	0.1
Unknown or missing	917	25.3
Duration of Infection in years (median and IQR)	11.0	13.0
Last known viral load at last lab before falling out of care (copies/mL)		
≤ 200	2,118	58.4
201-400	77	2.1
401-1,000	100	2.8
1,001-10,000	225	6.2
10,001-99,999	269	7.4
≥ 100,000	124	3.4
Missing‡	714	19.7

* Demographic distribution presented here is similar to the most recent data on HIV cases in NYS.

† Includes females with presumed heterosexual contact.

‡Those with missing viral load values had another HIV-related laboratory test within the NYSDOH HIV surveillance registry.

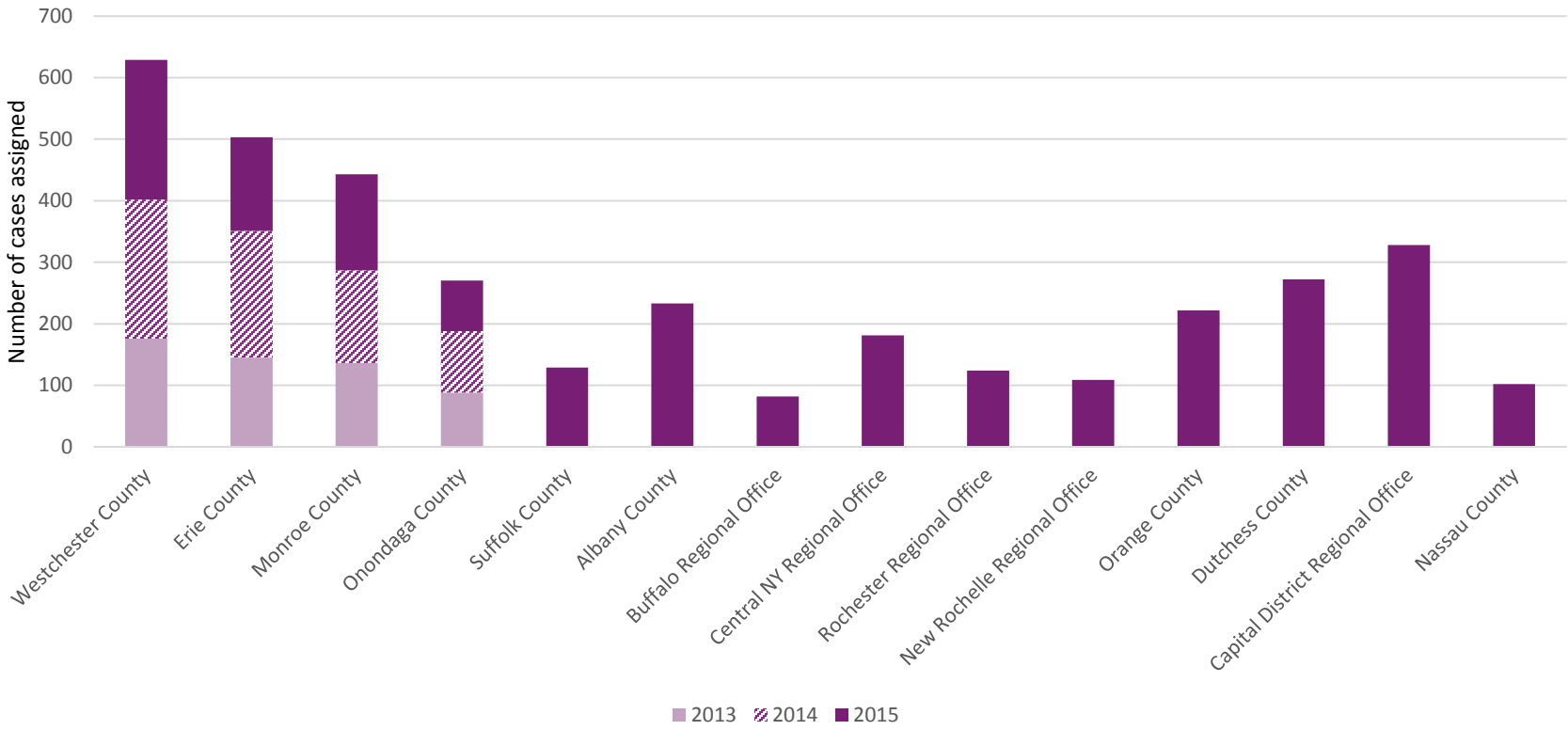
FIGURE 1: EXPS, CASE ASSIGNMENTS BY MONTH, SEPTEMBER 2013 TO DECEMBER 2015



NOTES

- High volumes of case assignments in September 2013 and March 2015 from the initial pilot and the subsequent statewide expansion are due to a back-log of individuals meeting case definition (these include all cases without labs for 13-24 months, whereas subsequent months' cases without labs for a longer duration have already been assigned).
- Interruption in caseload represents the month where pilot data were processed (September 2014), and no cases were assigned. Cases assigned from October 2014-February 2015 represent the continuation of ExPS in the four pilot counties.

FIGURE 2: EXPS, CASE ASSIGNMENTS BY JURISDICTION, SEPTEMBER 2013 TO DECEMBER 2015

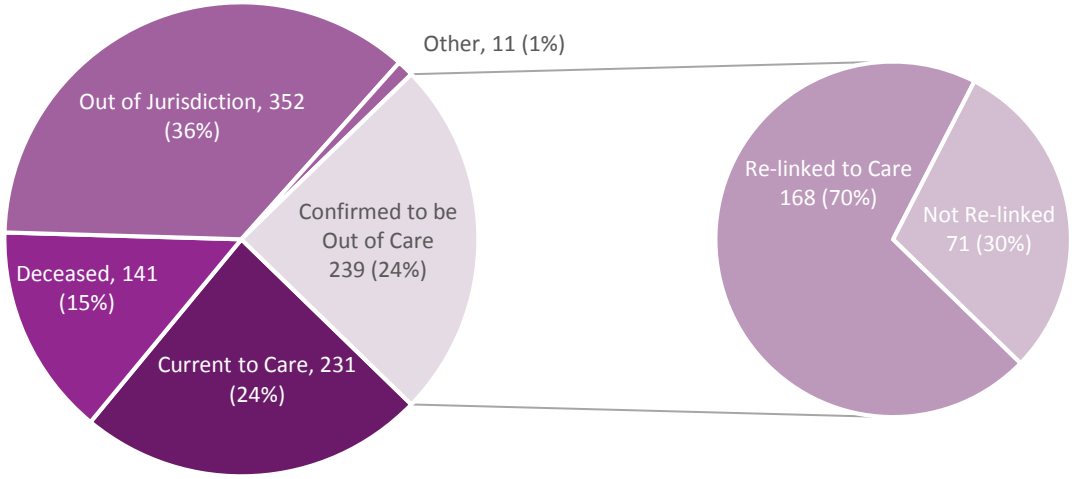


NOTES

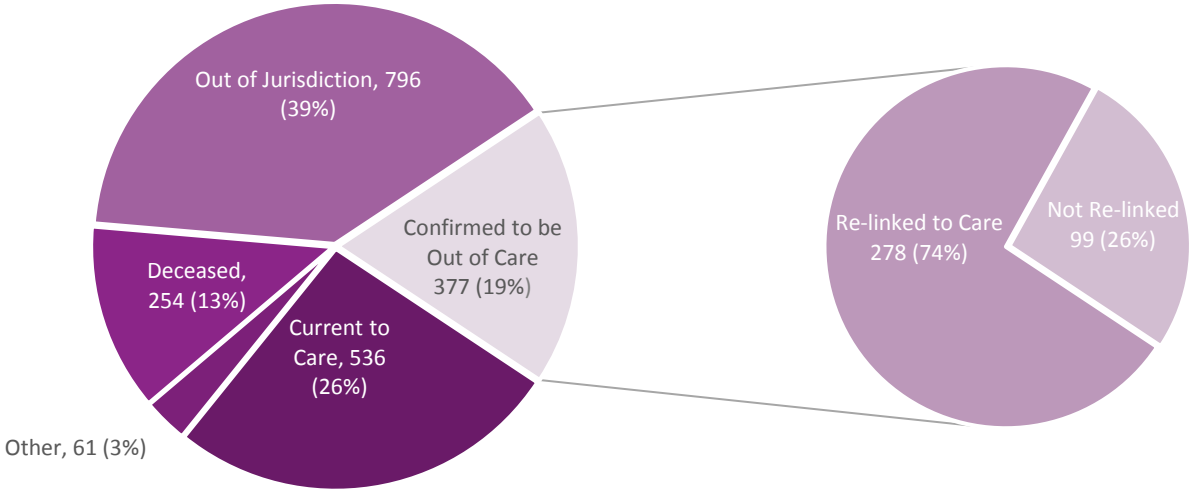
- Differences in case distribution are reflective of the overall prevalence of PLWDHI in each jurisdiction (covered by a funded county or regional office).
- Regional offices cover multiple counties, as shown in Map 1.
- 146 pilot cases were still out of care at the time of the statewide expansion (in March 2015) and were reassigned in 2015. These cases are only reflected as 2015 cases in this figure.

FIGURE 3: EXPS, DISPOSITIONS OF LOCATED AND CLOSED CASES, PILOT PERIOD COMPARED TO 2015

ExPS Pilot (Located Cases, n=974) September 1, 2013 to August 31, 2014



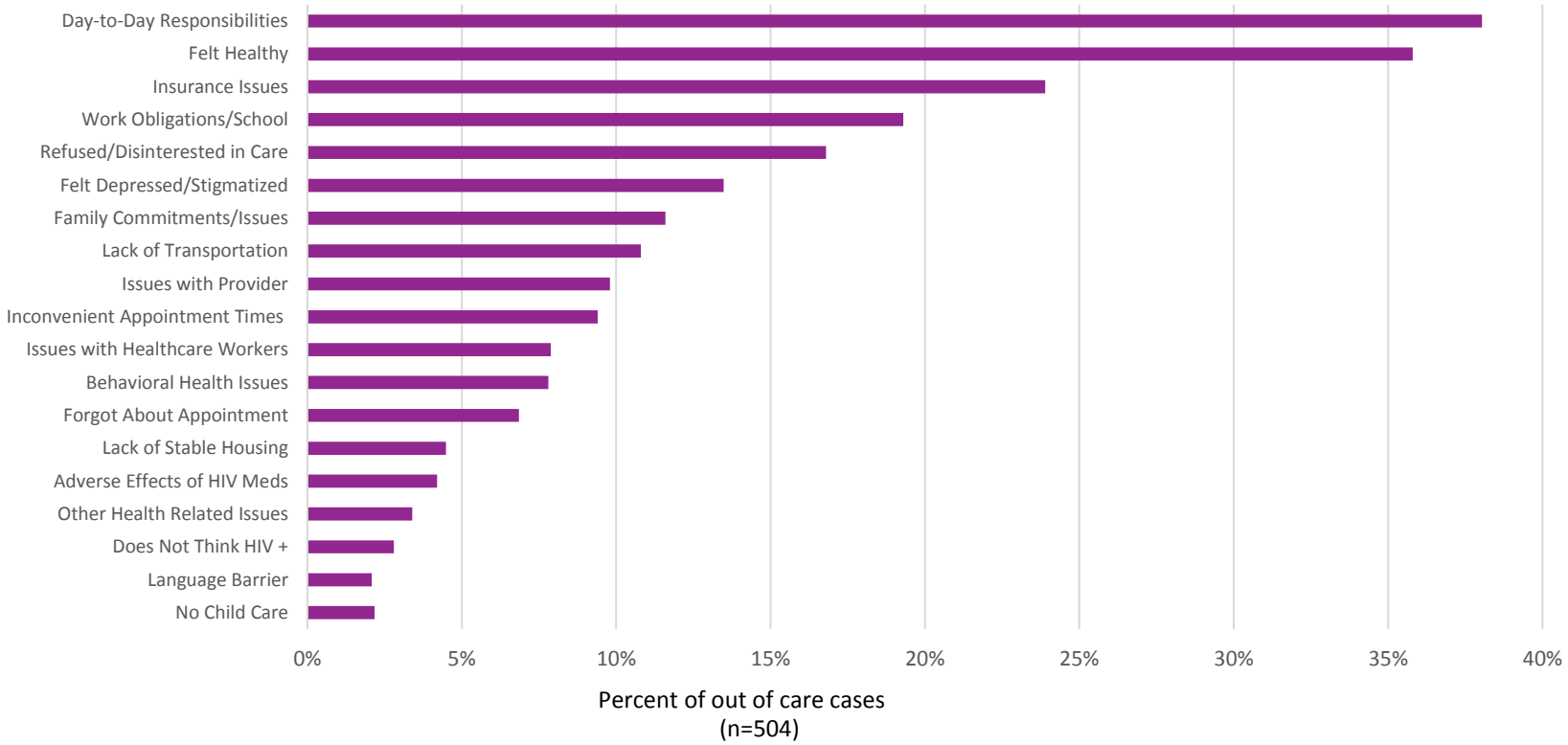
ExPS in 2015 (Located Cases, n=2,024) January 1, 2015 to December 31, 2015



NOTES

- Only individuals confirmed to be out of care are eligible to be re-linked to care. A re-linkage is defined as confirmation that an individual attended a medical appointment; it is not a measure of whether HIV-specific laboratory tests were done.
- Not all individuals were located. Of the pilot cases, 974 out of 1,146 (85%) were located. Of the ExPS cases in 2015, 2,024 out of 2,153 (94%) were located.

FIGURE 4: EXPS, REPORTED REASONS FOR BEING OUT OF CARE, SEPTEMBER 2013 TO DECEMBER 2015



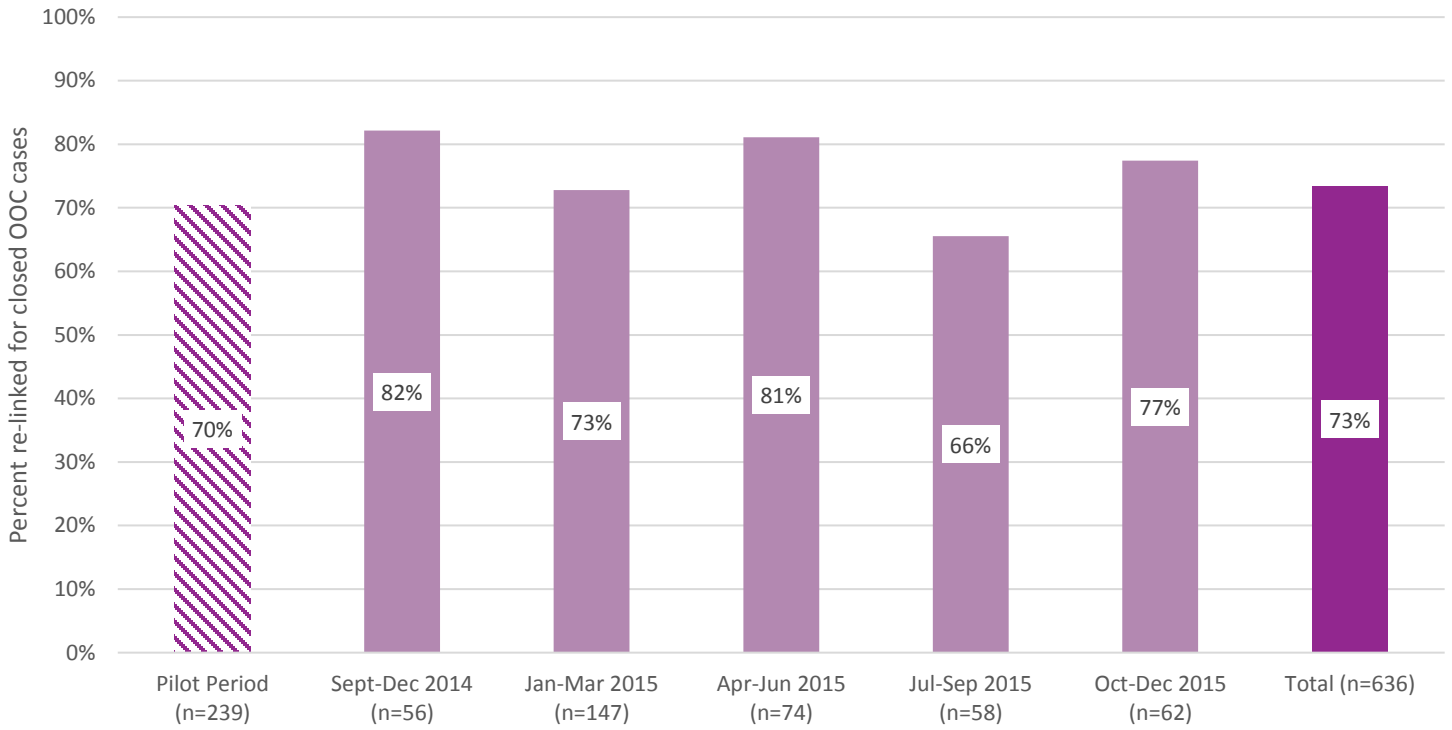
HIGHLIGHTED FINDING

- Within all reportable reasons for being out of care, the majority of patients relinked to care.

NOTES

- 504 out of 616 PLWDHI who were confirmed to be out of HIV-related medical care were located and provided reason(s) for being out of care. Individuals could provide multiple reasons for being out of care, therefore percentages do not add up to 100%.
- 29.0% (N=146) of patients provided an open-ended response and they were analyzed and recoded into one of the 19 categories above.

FIGURE 5: EXPS, RE-LINKAGES BY QUARTER, SEPTEMBER 2013 TO DECEMBER 2015



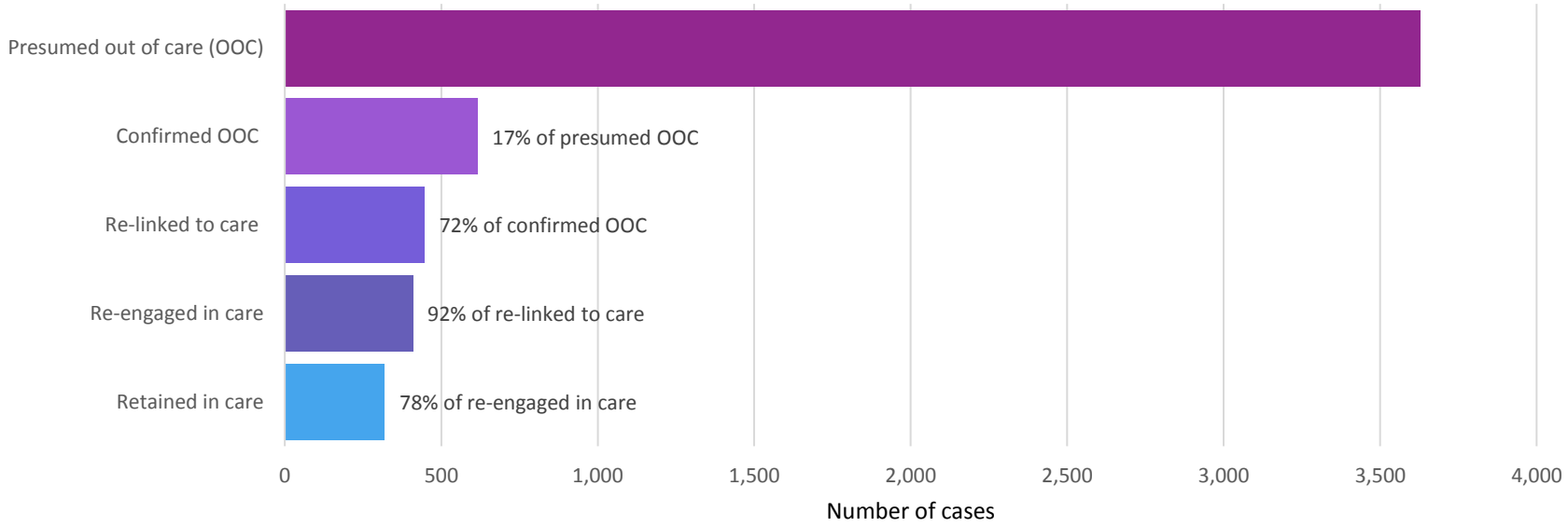
HIGHLIGHTED FINDING

- Percentage of closed out of care cases who re-linked to care remained relatively stable over time.

NOTES

- Only individuals confirmed to be out of care are eligible to be re-linked to care. Therefore, only individuals confirmed to be out of care are included in this figure.
- A re-linkage is defined as confirmation that an individual attended a medical appointment following contact from an ExPS staff; it is not a measure of whether HIV-specific laboratory tests were done.

FIGURE 6: EXPS, CASCADE FROM ASSIGNMENT TO RETENTION, SEPTEMBER 2013 TO DECEMBER 2015



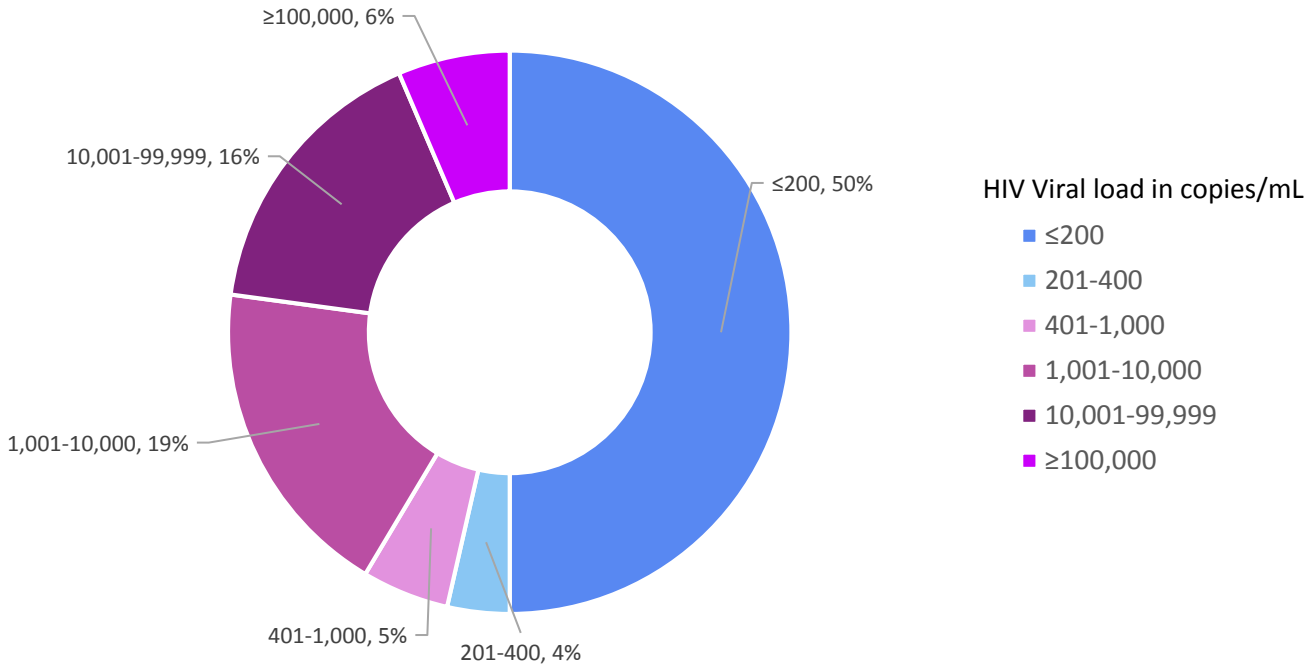
HIGHLIGHTED FINDINGS

- Less than one in five PLWDHI presumed to be out of care was verified as actually being out of care.
- High rates of re-linkage, re-engagement, and retention in care were achieved among those who were determined to be out of care.

NOTES

- Individuals were considered:
  - Re-linked if persons had a confirmed medical appointment,
  - Re-engaged in care if they received viral load test following re-linkage,
  - Retained in care if they had at least two viral load tests following re-linkage separated by at least 30 days.

FIGURE 7: EXPS, VIRAL LOAD PRIOR TO LAPSE IN CARE AMONG PERSONS NOT RE-LINKED TO CARE, SEPTEMBER 2013 TO DECEMBER 2015



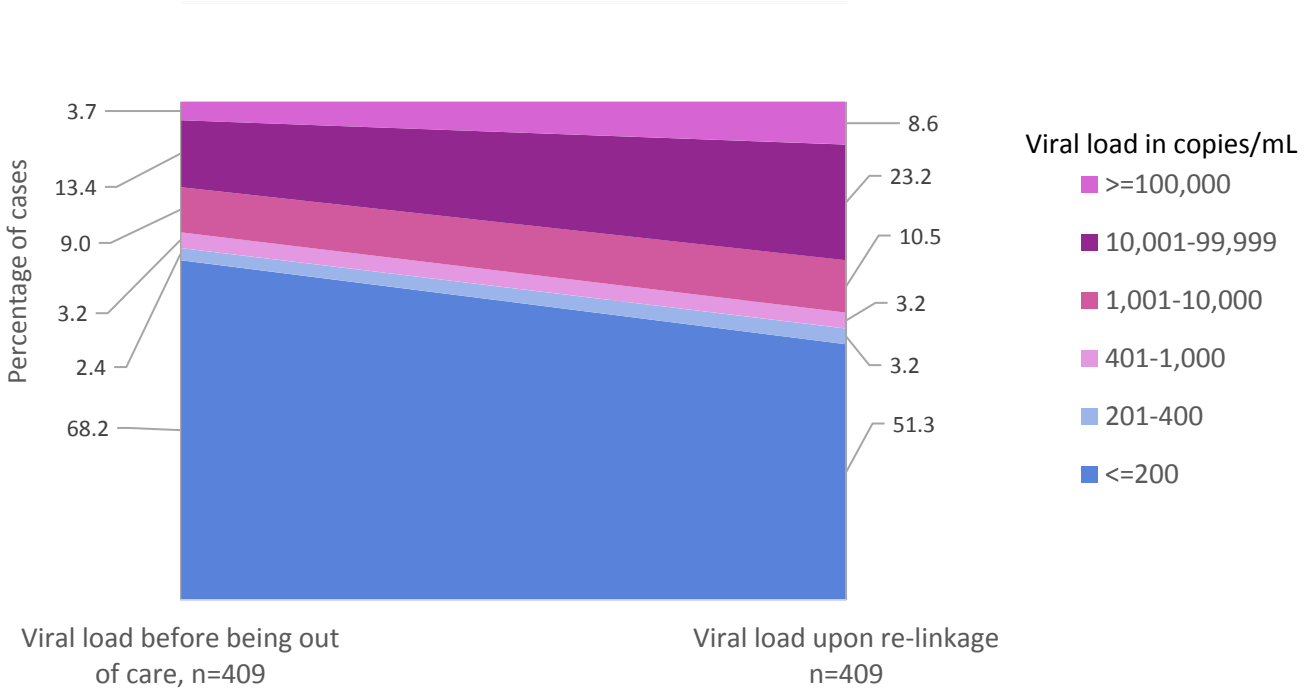
HIGHLIGHTED FINDING

- 22% of individuals not re-linked to care had a viral load of over 10,000 copies/mL.

NOTES

- Restricted to persons who had a viral load test within the NYS surveillance registry prior to case assignment (140/151 individuals not re-linked to care).

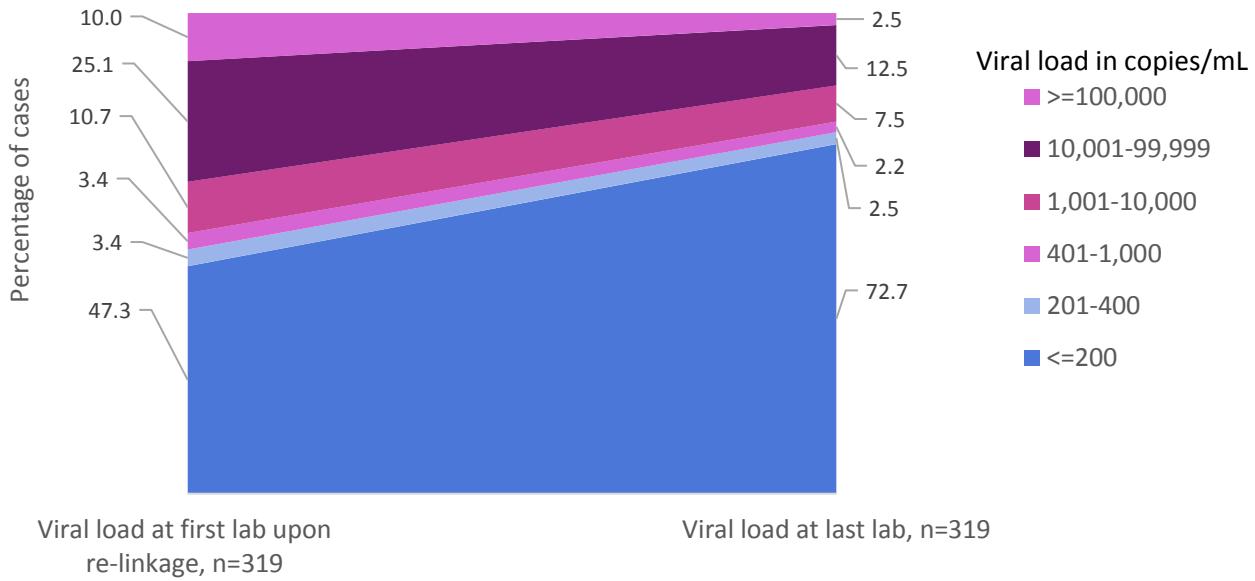
FIGURE 8: EXPS, VIRAL LOAD VALUE BEFORE FALLING OUT OF CARE AND AT FIRST LAB TEST UPON RE-LINKAGE, SEPTEMBER 2013 TO DECEMBER 2015



HIGHLIGHTED FINDINGS

- Among individuals who re-linked to care and who had available viral load information, the proportion of individuals who were virally suppressed (≤200 copies/mL) decreased from 68.0% to 51.3% while out of care.
- The proportion of individuals with higher viral load categories (≥10,000 copies/mL) increased from 17.1% to 31.8% while out of care.

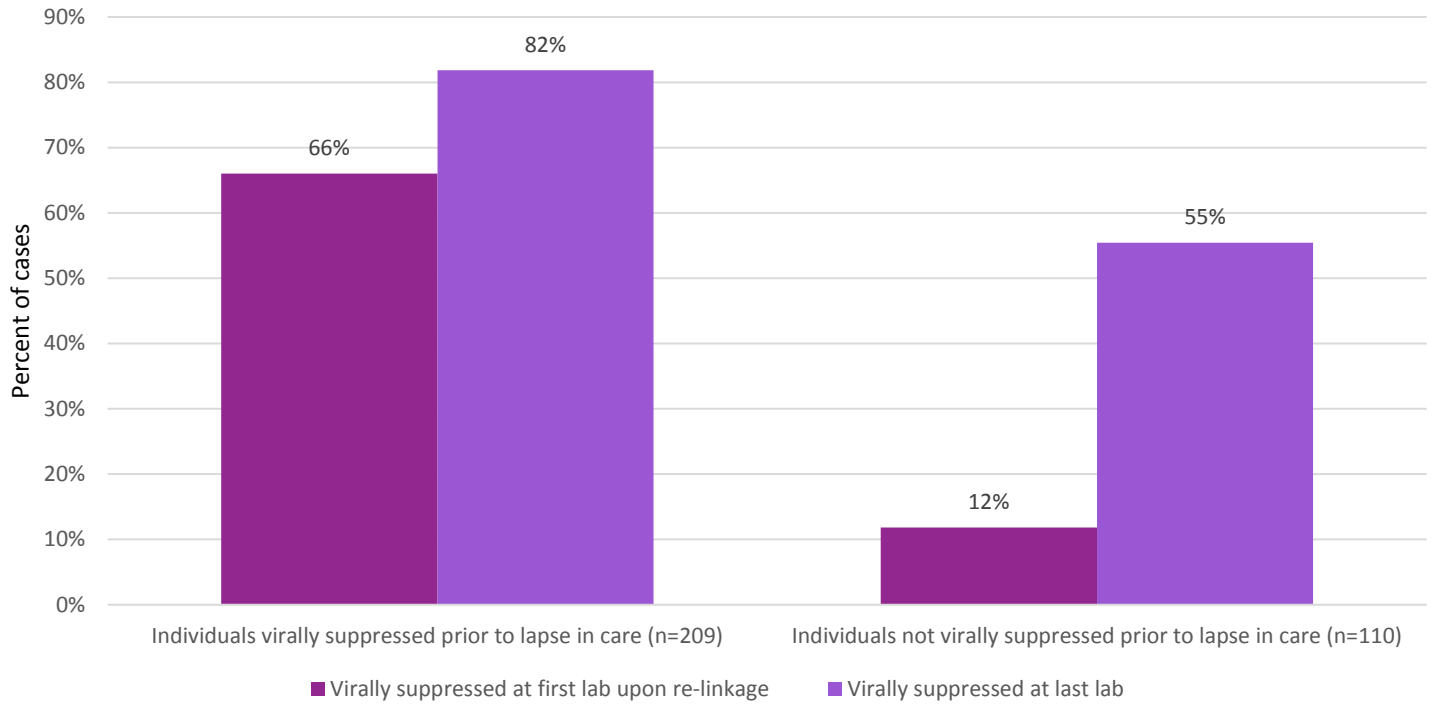
FIGURE 9: EXPS, VIRAL LOAD UPON RE-LINKAGE AND AT LAST LAB TEST OF PERSONS RETAINED IN CARE, SEPTEMBER 2013 TO DECEMBER 2015



HIGHLIGHTED FINDINGS

- Among individuals retained in care who had available viral load information, the proportion of individuals who were virally suppressed (≤ 200 copies/mL) increased from 47.3% at first lab upon re-linkage to 72.7% at last lab.
- The proportion of individuals with a viral load (> 10,000 copies/mL) decreased from 35.1% at first lab upon re-linkage to 15.0% at last lab.

FIGURE 10: EXPS, COMPARISON OF VIRAL LOAD VALUE BEFORE FALLING OUT OF CARE, AT FIRST LAB TEST UPON RE-LINKAGE, AND AT LAST LAB TEST AMONG PERSONS RETAINED IN CARE, SEPTEMBER 2013 TO DECEMBER 2015



HIGHLIGHTED FINDINGS

- Within-subject's comparison suggests that successfully re-linking individuals back into medical care impacts viral load suppression, which may prevent further transmission.

NOTES

- Only individuals retained in medical care are included in this figure.
- Retention in care was defined as at least two viral loads separated by at least 30 days following re-linkage.
- Duration of follow-up from case assignment to last lab varies for individuals included (average days of follow-up: 421; minimum days of follow-up: 36; maximum days of follow-up: 1,037).

HIGH IMPACT CARE AND PREVENTION PROJECT (HICAPP)

Partnership for Care (P4C) is a multi-agency three year demonstration project coordinated jointly by the CDC's Division of HIV/AIDS Prevention and Health Resources and Service Administration's (HRSA) Bureau of Primary Health Care at the federal level, and implemented by the NYSDOH AIDS Institute, NYCDOHMH, and six partnering federally qualified health centers throughout NYS and NYC. The NYSDOH receives funding for P4C from the CDC's PS14-1410 Secretary's Minority AIDS Initiative: Funding to Increase HIV Prevention and Care Service Delivery among Health Centers Serving High HIV Prevalence Jurisdictions.* HRSA funds the six partnering health centers and an HIV Training, Technical Assistance, and Collaboration Center to support the goals of P4C. In NYS, P4C is referred to as the High Impact Care and Prevention Project (HICAPP).

The goals of the project are to build sustainable partnerships between the NYSDOH, the NYCDOHMH, and the 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 all people living with HIV.

An integral part of HICAPP is a Partner Services-based Data to Care initiative. Similar to ExPS, HICAPP utilizes the NYSDOH's HIV surveillance data for identifying individuals presumed out of care. HICAPP employs a Combination Data to Care Model which involves sharing data and coordinating action from both the partnering health centers and the health departments (NYSDOH and NYCDOHMH). The partnering health centers identify patients they consider out of care from their patient caseload. The health departments then determine if these individuals meet the case definition for assignment through a review of NYS HIV surveillance data and, if so, assign them to trained NYSDOH or NYCDOHMH Partner Services staff (HICAPP Linkage Specialists). The Combination Model is a joint public health and clinical medicine approach that is patient-centered in practice. Due to the unique nature of this demonstration project, some outcomes from work conducted in NYC are presented in this report (NOTE: HICAPP work in NYC is restricted to four zip codes only).

HICAPP has four case definitions for out of care, presented below.

1) Health Center 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 that time;
2) Health Center Out of Care: Health center PLWDHI patients who have NOT had any HIV-related medical visit in the past 9 months, who are alive, residing in NYS, with no evidence of care elsewhere;

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3) Surveillance Never Linked to Care: PLWDHI whose HIV diagnosis date (as determined via diagnostic test, detectable viral load, or physician's diagnosis) was reported to the NYSDOH or NYCDOHMH within the HICAPP/P4C service areas at least 90 days prior to the current date with no viral load, CD4, or genotype labs reported since (going back to 2010);
4) Surveillance Out of Care: In NYC only, PLWDHI with no viral load or CD4 labs in the past 9 months, whose last known address of residence or provider was in the HICAPP/P4C service areas.

The first definition yielded two case assignments and is, therefore, not presented in this report. The last definition is pertinent to NYC only and is not being presented in this report.

Partnering health centers, selected and funded by HRSA for this initiative, are: Betances Health Center, Damian Family Care Center Inc., Bedford Stuyvesant Family Health Center, Cornerstone Family Healthcare, Community Health Center of Buffalo, Inc., and Anthony L. Jordan Health Center. HICAPP/P4C service areas are defined by the areas that the health centers serve (See Map 2)

Table 2 and Figures 11 through 13 provide information on various facets of HICAPP, including descriptive statistics of program participants, case assignment information, and primary programmatic outcomes.

MAP 2: HICAPP/PARTNERSHIP FOR CARE(P4C) SERVICE AREAS, 2015

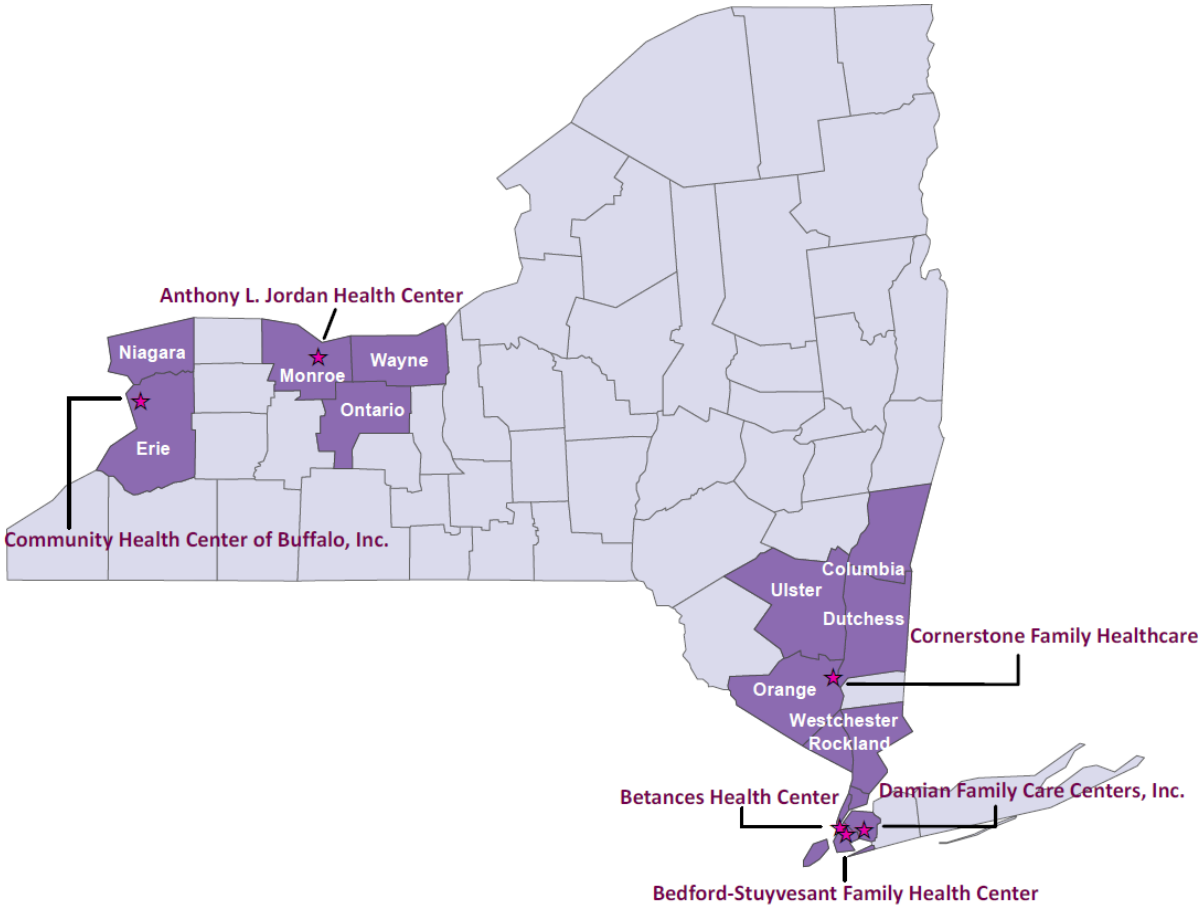


TABLE 2: HICAPP, DESCRIPTIVE STATISTICS, FROM JANUARY 2015 TO DECEMBER 2015

	Health Center Out of Care*		Surveillance Never Linked to Care*		Total†	
	N	%	N	N	N	%
All‡	36	100.0	81	100.0	117	100.0
Age						
20-29	5	13.9	18	22.2	23	19.7
30-39	9	25.0	22	27.2	31	26.5
40-49	9	25.0	10	12.3	19	16.2
50-59	12	33.3	22	27.2	34	29.1
>60	1	2.8	9	11.1	10	8.5
Gender§						
Male	28	77.8	62	76.5	90	76.9
Female	8	22.2	19	23.5	27	23.1
Race/Ethnicity**						
White, Non-Hispanic	2	5.6	17	21.0	19	16.2
Black, Non-Hispanic	21	58.3	31	38.3	52	44.4
Hispanic	7	19.4	12	14.8	19	16.2
Other	6	16.7	5	6.2	11	9.4
Unknown or missing	0	0	16	19.8	16	13.7
Transmission risk						
Heterosexual††	14	38.9	18	22.2	32	27.4
Men who have sex with men (MSM)	11	30.6	19	23.5	30	25.6
Injection Drug Use (IDU)	2	5.6	10	12.3	12	10.3
MSM/IDU	0	0.0	1	1.2	1	0.9
Unknown or missing	9	25.0	33	40.7	42	35.9

* Case types in this table: 1) Health Center Out of Care: Health center PLWDHI patients who have NOT had any HIV-related medical visit in the past 9 months, who are alive, residing in NYS, with no evidence of care elsewhere; 2) Surveillance Never Linked to Care: PLWDHI whose HIV diagnosis date (as determined via diagnostic test, detectable viral load, or physician's diagnosis) was reported to the NYSDOH or NYCDOHMH within the HICAPP/P4C service areas at least 90 days prior to the current date, and who have no viral load, CD4, or genotype labs reported since (going back to 2010).

† More than 85% of viral load status were missing for HICAPP case assignments; therefore, sections pertaining to viral load on HICAPP case assignments are excluded in this report.

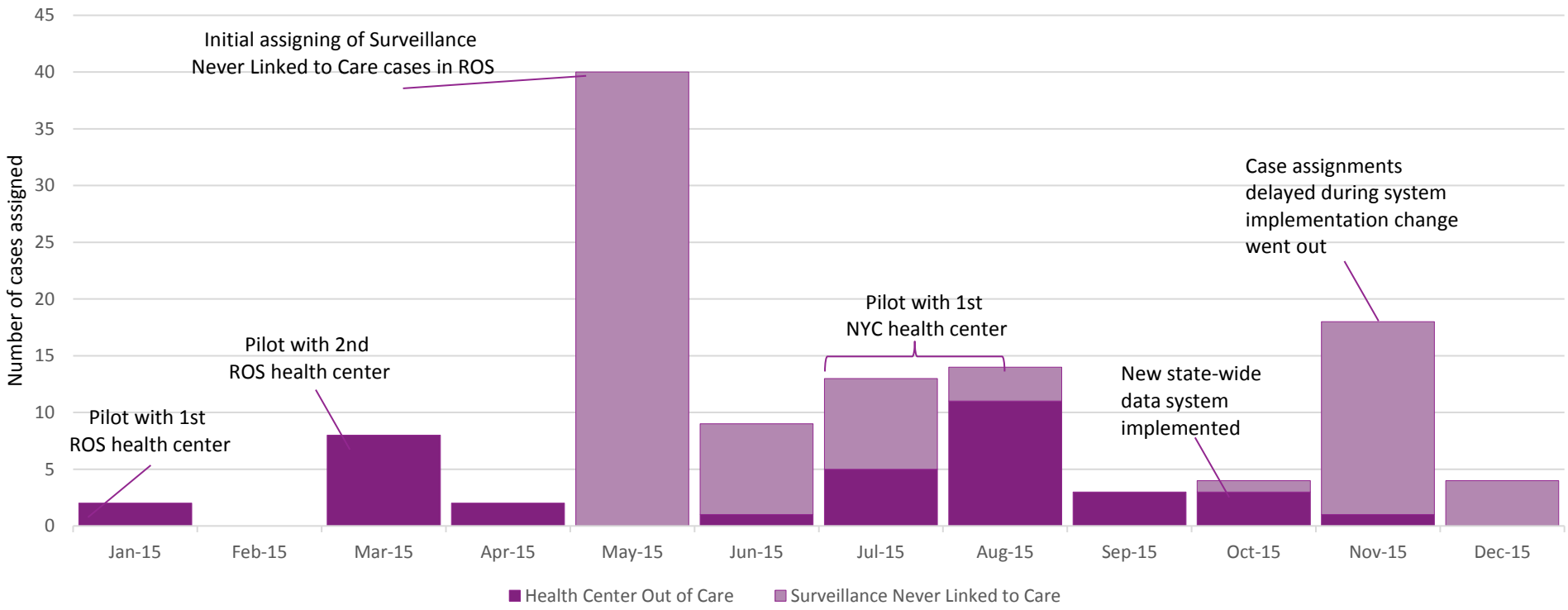
‡ Demographic distribution presented here is similar to the most recent data on HIV cases in NYS.

§ Current gender is collected for this initiative; however, no individuals identified as transgender.

** Race/Ethnicity categories presented here differ from that of Table 1 given small sample sizes for other racial/ethnic groups

†† Includes females with presumed heterosexual contact.

FIGURE 11: HICAPP, ASSIGNMENTS BY MONTH AND CASE TYPE, JANUARY 2015 TO DECEMBER 2015

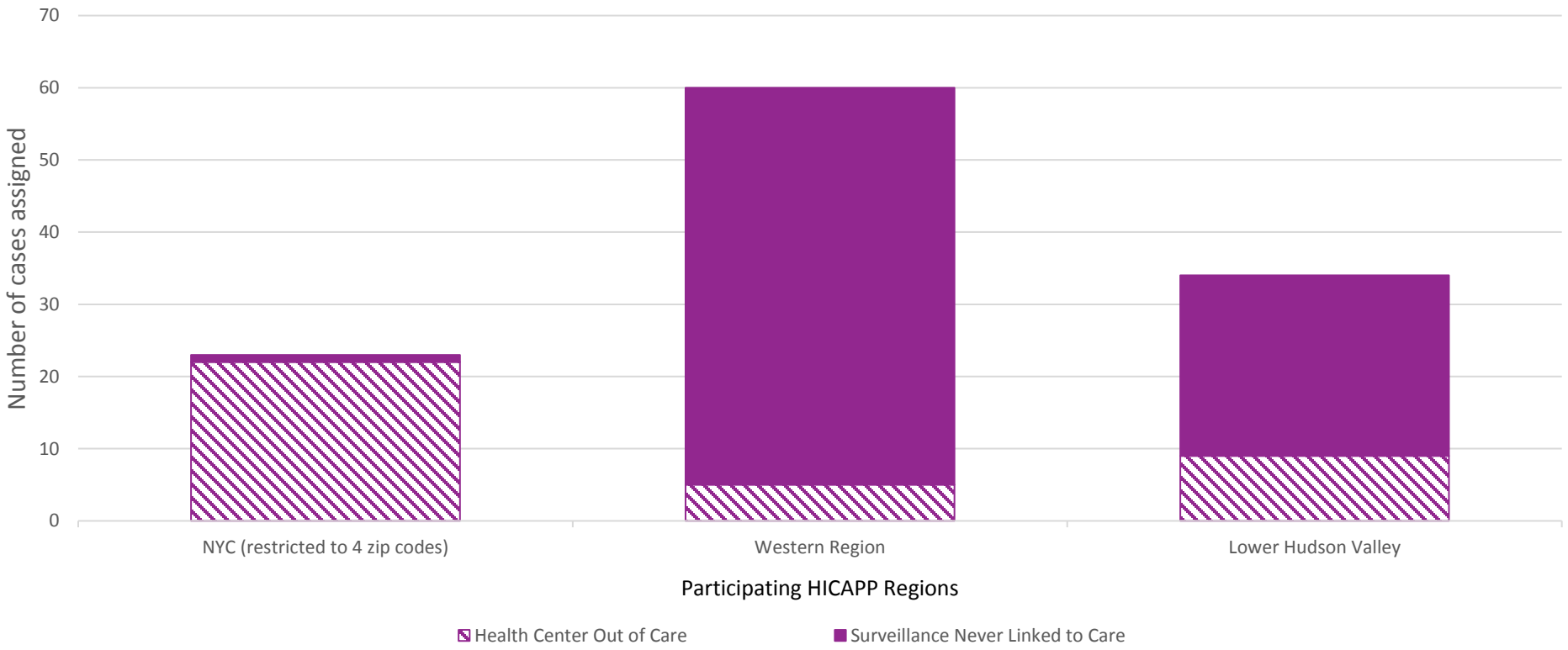


NOTES

- Case assignments went out monthly.
- Case types presented are specifically defined for HICAPP*.
- Variation in case assignments by month are due to case types being piloted and rolled out throughout the year. The large number of cases in May is due to the definition including cases diagnosed as far back as 2010. In October there was an electronic system transition which delayed case assignments by one month, resulting in a larger than normal number of cases in November, 2015.

* Case types in this figure: 1) Health Center Out of Care: Health center PLWDHI patients who have NOT had any HIV-related medical visit in the past 9 months, who are alive, residing in NYS, with no evidence of care elsewhere; 2) Surveillance Never Linked to Care: PLWDHI whose HIV diagnosis date (as determined via diagnostic test, detectable viral load, or physician's diagnosis) was reported to the NYSDOH or NYCDOHMH within the HICAPP/P4C service areas at least 90 days prior to the current date, and who have no viral load, CD4, or genotype labs reported since (going back to 2010).

FIGURE 12: HICAPP, ASSIGNMENTS BY REGION AND CASE TYPE, JANUARY 2015 TO DECEMBER 2015

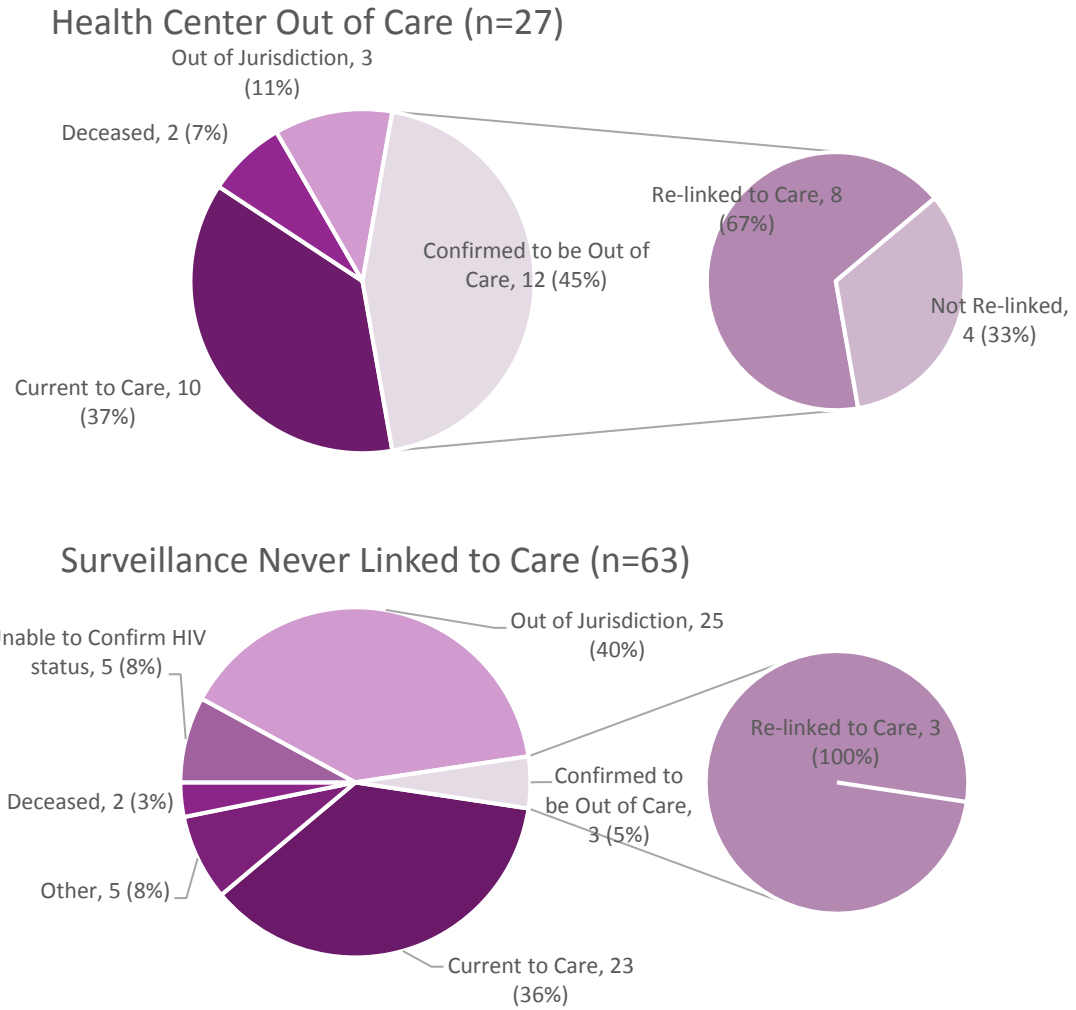


NOTES

- HICAPP cases were assigned to these regions in 2015.
- Regions are based on the service areas of the Health Centers funded to participate in Partnership for Care. Those service areas outside of NYC are further outlined in Map 2.
- Case types presented are specifically defined for HICAPP*.

* Case types in this figure: 1) Health Center Out of Care: Health center PLWDHI patients who have NOT had any HIV-related medical visit in the past 9 months, who are alive, residing in NYS, with no evidence of care elsewhere; 2) Surveillance Never Linked to Care: PLWDHI whose HIV diagnosis date (as determined via diagnostic test, detectable viral load, or physician's diagnosis) was reported to the NYSDOH or NYCDOHMH within the HICAPP/P4C service areas at least 90 days prior to the current date, and who have no viral load, CD4, or genotype labs reported since (going back to 2010)

FIGURE 13: HICAPP, DISPOSITION OF LOCATED AND CLOSED CASES BY CASE TYPE*, JANUARY 2015 TO DECEMBER 2015



NOTES

- Only individuals confirmed to be out of care are eligible to be re-linked to care. A re-linkage is defined as confirmation that an individual attended a medical appointment; it is not a measure of whether HIV-specific laboratory tests were done.
- A higher proportion of Health Center Out of Care cases (45%) were determined to be out of care than Surveillance Never Linked to Care cases (5%).
- In total, 73% of HICAPP cases determined to be out of care were re-linked to care.
- Differences in re-linkage by case type cannot be reliably analyzed given small numbers.

*Case types in this figure: 1) Health Center Out of Care: Health center PLWDHI patients who have NOT had any HIV-related medical visit in the past 9 months, who are alive, residing in NYS, with no evidence of care elsewhere; 2) Surveillance Never Linked to Care: PLWDHI whose HIV diagnosis date (as determined via diagnostic test, detectable viral load, or physician's diagnosis) was reported to the NYSDOH or NYCDOHMH within the HICAPP/P4C service areas at least 90 days prior to the current date, and who have no viral load, CD4, or genotype labs reported since (going back to 2010)

EXPANDED PARTNER SERVICES IN DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION (DOCCS)

NYS DOCCS houses approximately 52,000 inmates in 54 NYS correctional facilities. Historically, more individuals with HIV have been housed in NYS correctional facilities than any other State's criminal justice system.*

DOCCS is also responsible for approximately 36,000 parolees. Upon parolee release back into their communities, which are often characterized by high rates of poverty, crime, and inadequate access to healthcare, these individuals are at an elevated risk for HIV transmission.

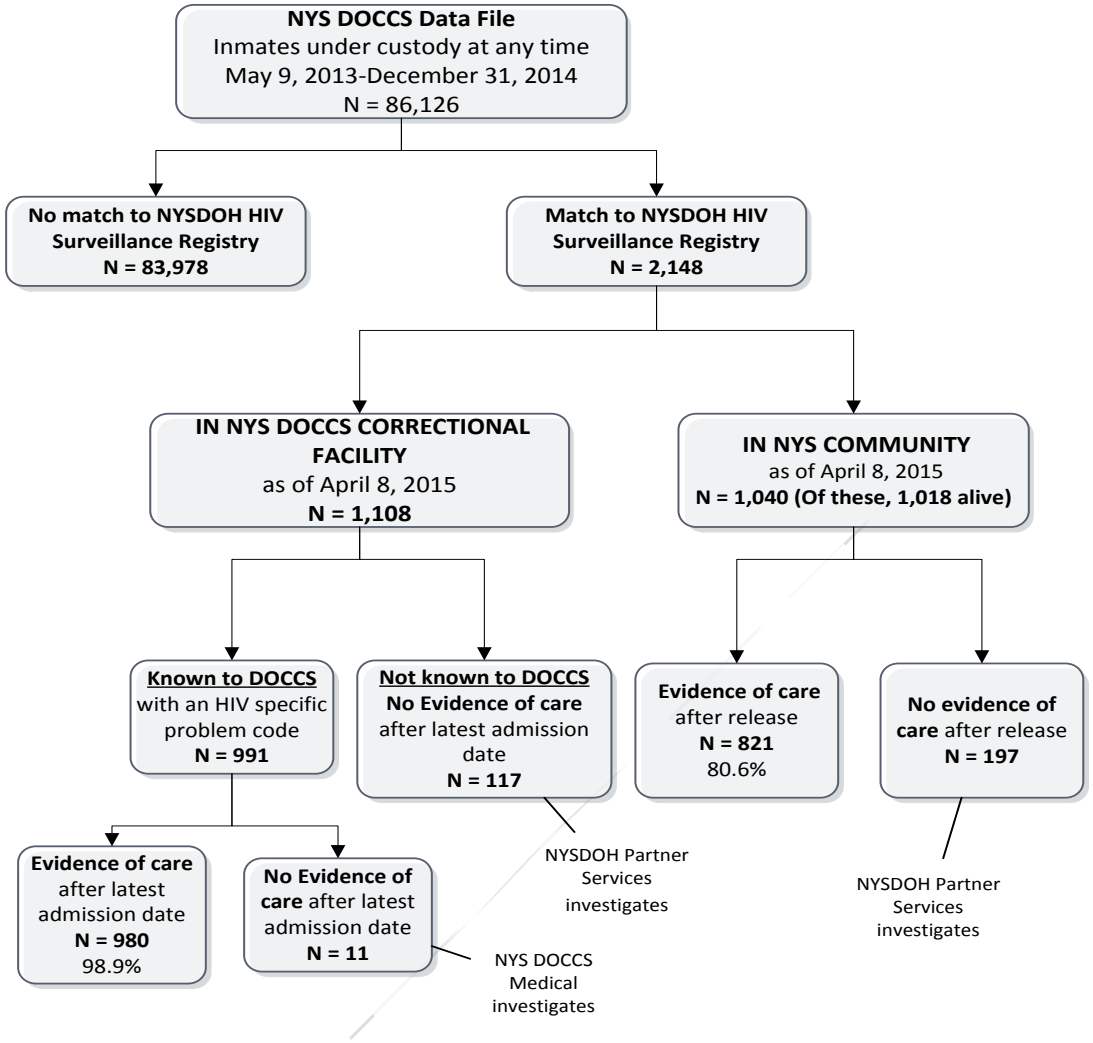
The NYSDOH and DOCCS have a longstanding partnership that bolsters public health services in NYS DOCCS facilities. Expanded Partner Services in DOCCS (ExPS in DOCCS) leverages this inter-agency collaboration to enhance the portfolio of services available to inmates and parolees. Similar to other NYSDOH Data to Care initiatives, the overarching goal of ExPS in DOCCS is to re-link HIV-positive individuals who have fallen out of care back to HIV medical care.

In 2015, DOCCS data (census and inmate health data) were matched to the NYSDOH HIV surveillance registry to identify inmates diagnosed with HIV who may be out of care (i.e. have no evidence of HIV labs while incarcerated), and parolees recently released with no evidence of care in the three months following their release. These presumed out of care individuals are prioritized for outreach with the specific objective of re-linkage to HIV medical care. DOCCS medical providers spearhead initial re-linkage to care efforts with HIV-positive inmates known to them. Trained NYSDOH Partner Services staff approach HIV-positive inmates whose status is unknown to DOCCS. Importantly, HIV status is never disclosed to DOCCS staff without inmate consent. Re-linkage to care activities in the community are performed by NYSDOH and NYS County Health Department Partner Services. All inmates and parolees identified as out of care are offered a referral to a NYSDOH funded agency providing HIV prevention programs.

Throughout 2015, intensive work was done prior to any case assignments going out to Partner Services staff. Case outcomes are not presented in this 2015 report as cases did not go out until October of 2015. For that reason, information included in this report is limited to the results of the initial match and lessons learned (see Figure 14). The initial match effort between the NYSDOH HIV surveillance registry and DOCCS data required significant time to make final determinations of the need for programmatic follow up. This involved confirming HIV status and locating individuals (i.e., incarcerated or released). It should be noted that this match effort confirmed there is a high standard of HIV care provided to individuals within DOCCS correctional facilities. Most notably, the vast majority of HIV positive persons within DOCCS correctional facilities disclosed their status and were current to HIV care.

* Maruschak, L. M., & Bronson, J. *HIV in Prisons, 2015 - Statistical Tables* (NCJ 250641, p. 10) (United States, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics). Retrieved from https://www.bjs.gov/content/pub/pdf/hivp15st.pdf

FIGURE 14: RESULTS OF MATCH FOR EXPS IN DOCCS



HIGHLIGHTED FINDINGS

- Of the 86,126 inmates, 2,148 (3%) were identified as HIV positive in the NYSDOH HIV surveillance registry.
- At the time of the match, about half of the matched cases (n=1,040) had been released into the community.
- Among those still in DOCCS facilities (n=1,108), the vast majority of HIV+ individuals (90%) were known to DOCCS Health Services.
- Among those known to DOCCS Health Services, almost all (99%) were receiving HIV-related medical care.
- Among those released, approximately 80% had evidence of being linked to care in the community (i.e., had HIV-related lab work following release). The community linkage to care rate was highest among those also in care in within DOCCS (91%; data not shown).
- Individuals identified as potentially out of care (N=325) were followed up on by DOCCS medical staff or by NYSDOH Partner Services staff for linkage to care within DOCCS or in the community.

CONCLUSION

The AIDS Institute Partner Services-based Data to Care programming began in 2012 with a concept paper. The pilot of ExPS began in 2013. Conversations about the roll out of additional Data to Care programs (HICAPP, and ExPS in DOCCS), as well as a statewide expansion of ExPS began in 2014. In 2015, HICAPP, ExPS in DOCCS, and statewide ExPS began. In the four years that Partner Services-based Data to Care has been part of the AIDS Institute, many lessons have been learned:

- Piloting a Partner Services-based Data to Care initiative is critical to enable smooth statewide roll out.
    - Determination of the best definition for cases in need of follow up requires preliminary analyses and post-implementation evaluation of a pilot program.
    - Data to Care work requires modification to the electronic infrastructure used for Partner Services case assignments and collection of programmatic outcomes. This process requires time to be successfully implemented.
    - Protocol development needs flexibility to reflect actual work processes.
- Data to Care is truly a cross sector approach, and collaborating and partnering with medical providers, state agencies, and community based organizations is imperative to the success of this work.
- Providing full-time equivalent employees to focus on Data to Care investigation and re-linkage activities is critical to ensuring consistent and focused interventions across the state.
- Data to Care work requires a patient-centered approach that can sometimes require months of work by Partner Services staff to ensure barriers to care are minimized and sustainable linkages to care are established. Thus, setting “case closure” target deadlines (as is done for more traditional Partner Services work) is not recommended for those engaging in Data to Care programming.
- Matching inter-agency data systems can be a cumbersome process that requires buy-in and persistence from all parties involved.