Strengthening Data Use & Data Systems for EHE Linkage to Care Strategies

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NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Disclosures

Rama Murali has no relevant financial interests to disclose.

Gloria Agosto Davis has no relevant financial interests to disclose.

Vinothini Panakkal has no relevant financial interests to disclose.

Lisa Muttiah has no relevant financial interests to disclose.

Claudia Yabrudy has no relevant financial interests to disclose.

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Learning Objectives

At the conclusion of this activity, participants will be able to:

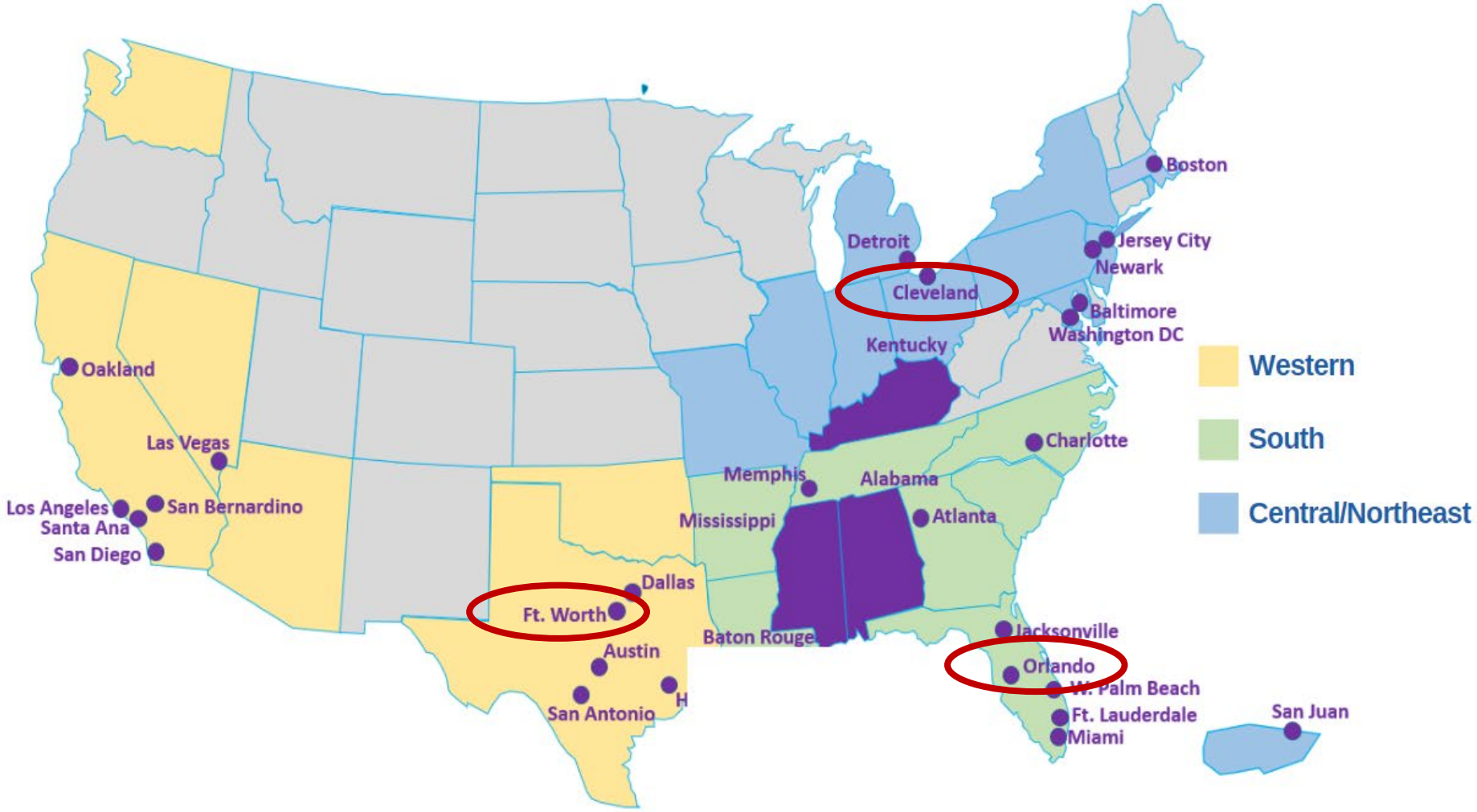
1. Describe TAP-In's approach to supporting EHE funded jurisdictions to identify and strengthen available data and data sources to prepare for successful implementation of EHE linkage to care strategies.
2. Learn from three EHE-funded jurisdictions about the ways in which the TA received by TAP-In contributed to their work to: identify gaps in data systems, navigate challenges related to obtaining and working with data, and develop tools and strategies used to strengthen those data systems.
3. Hear about key lessons learned and initial outcomes from the three EHE-funded jurisdictions about how this multi-level systems-building work led to enhanced readiness to implement EHE strategies to increase linkage to care for PWH and improve outcomes.

TAP-in: Technical Assistance Provider Innovation Network

Rama Murali
Jurisdictional TA Team Lead
TAP-in Project at CAI

Active Engagement with 32* Jurisdictions to Date

*32 of 47



Linkage to Care as a Critical Strategy in EHE

- Linkage to care is typically defined as the completion of a first medical clinic visit after HIV diagnosis

- Impact of Linkage to Care
  - Reaching those who are out of care
  - Improved continuum outcomes (necessary precursor to ART initiation)
  - Increased viral suppression

- Data plays a central role in successful linkage to care strategies: **Find your data and use it!**
  - Understand what is happening in the community
  - Improve processes and understand outcomes for linkage programs

Data-Centered Technical Assistance to Support Linkage to Care

- **Step 1:** Ask important questions to identify the key strategies you are seeking to implement to improve linkage to care:
  - What is the change that the jurisdiction wants to see?
  - What information/data do you already have?
  - Do you have the staff needed to support data systems and programmatic activities?

- **Step 2:** Ask powerful questions to understand data needs and priorities:
  - Do you have the right data sources?
    - What data exists?
    - What data is missing?
  - How will you measure and how frequently will you review?
  - Do you have the right partners in place to obtain data and strengthen systems?
    - What partnerships do you need to fill those gaps?

Examples from Three Jurisdictions' TA Requests

Jurisdiction	Key Linkage to Care Goal	Key TA
Cuyahoga County (Cleveland)	Strengthening data to care program	• Data systems support • Partnership with State • Protocol and Standards of Care • Evaluation
Orange County (Orlando)	Improving linkage to care of justice involved PWH post release	• Process Mapping • Data systems support
Tarrant County (Ft. Worth)	Improving tracking of newly diagnosed clients	• Exploring partnerships with State • Internal client level data systems support

Who you will hear from today

- Cuyahoga County
  - Gloria Agosto Davis and Vino Panakkal
- Orange County
  - Claudia Yabrudy
- Tarrant County
  - Lisa Muttiah

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Cuyahoga County Board of Health Cuyahoga County, Ohio

Gloria Agosto Davis, M.Ed., CHES, Ending the HIV Epidemic Supervisor

Vino Panakkal, MPH, Epidemiology Supervisor

Cuyahoga County, Ohio: Profile

- Located in northeast Ohio, home to the city of Cleveland
- Population: 1,264,817
- Demographics:
  - Black - 370,895 (29%)
  - Hispanic - 83,327 (6.5%)
- 17% of the county is living in poverty
- HIV Priority Populations:
  - Under age 30
  - African American
  - MSM

Data to Care Overview

- Utilizes a hybrid model for Data to Care (D2C) activities – local health department and Part A OAHS providers work together
- EHE-funded agencies receive any agency-specific not in care (NIC) list with individuals having a previous medical history at their agency
- Individuals not having any medical history with the EHE-funded agencies are assigned to internal EHE staff at CCBH to conduct outreach

Where the Jurisdiction Began

- Gaps and Needs for TA
- Evaluation Framework
- Standardizing Outreach
- Streamline CAREWare process

Data to Care TA Goals

- Micro level goals
  - Evaluation framework
  - Standardizing outreach
  - Streamline CAREWare process

- Macro level goals
  - Increase in linkage to medical care
  - Increase efficiency of project workflow

Initial Thoughts on TA Focus

- Improve D2C Outcomes
  - Are we reaching out targets?
  - What are our goals?
  - How are we defining success?
  - How are we prioritizing clients?
  - How can we improve service delivery?
- Reduce inefficiencies and time spent data cleaning
  - Cumbersome spreadsheet prone to errors
  - Misunderstandings of dispositions (grantee and subgrantee levels)
  - Understanding the process of developing the NIC list at the state level

TA Plan Development

- Health department NIC list and outreach
- Electronic matching
- Explore potential areas to expand activities
- Ohio Department of Health guidance
- Improve data quality
- Formalize outreach
- Implementation and outcome evaluation plan
- Prioritization of NIC list clients

Changes to D2C Activities

- Updated Standard of Care
- Updated Protocol, which included addition of guidance document as an appendix
- Implementation of REDCap and updates to CAREWare
- Added additional evaluation activities

Lessons Learned

- TA can be intensive but well worth the time and effort
- Communication
- Intentionality
- Evaluation
- Creativity

Next Steps

- Implementation Evaluation
  - Did we implement the revised program as planned?
- Outcome Evaluation
  - Did our changes lead to improved client reach and re-engagement?
  - Did our data quality improve?
  - Explore opportunities for multi-year evaluation/combining multi-year lists.
- Obtain Feedback from partners on changes
- Share Outcomes to partners & community stakeholders

Orange County Government Health Services Department Orlando, Florida

Claudia Yabrudy
Manager, Fiscal and Operational Support Division
Orange County Government

Objectives

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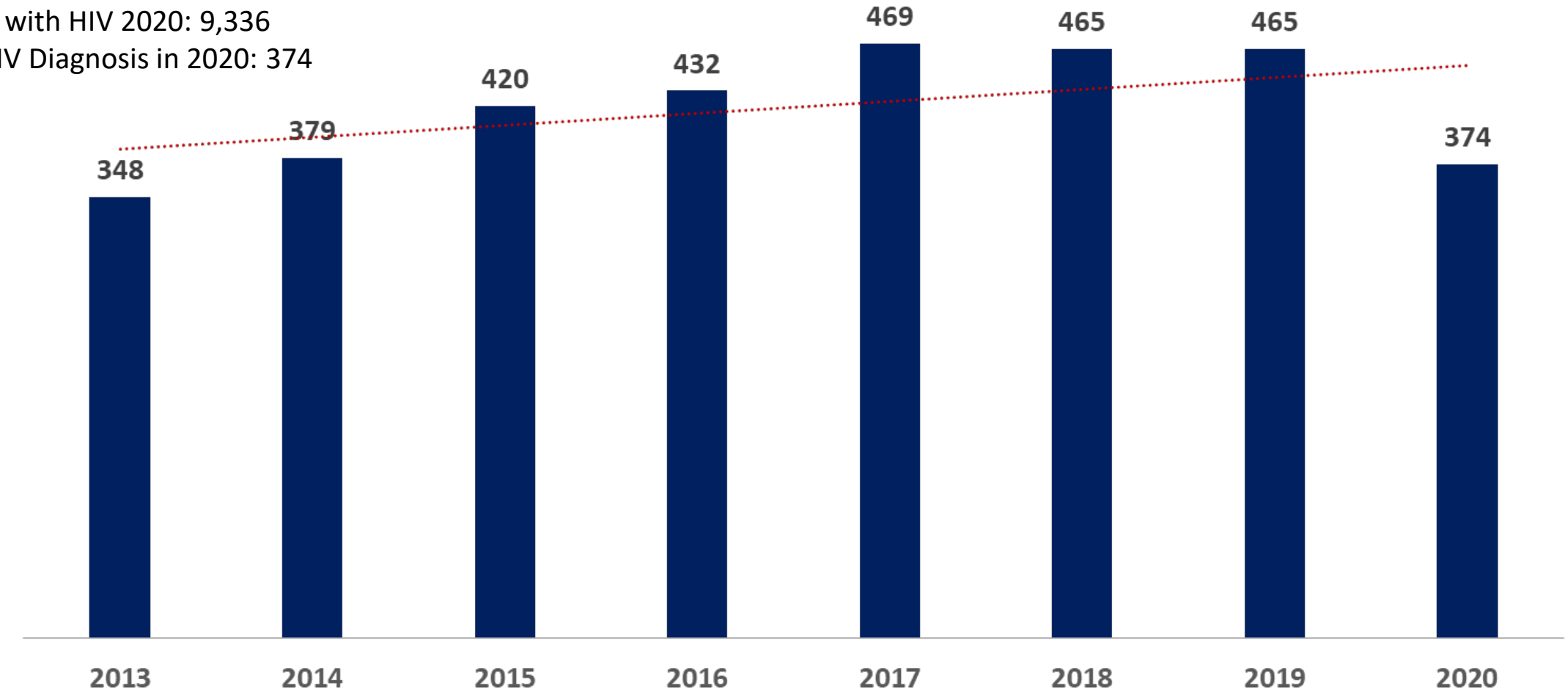
- Overview
- CAI Technical Assistance
- Linkage Process
- Lessons Learned
- Next Steps

New HIV Diagnosis, Orange County FL

People with HIV 2020: 9,336
New HIV Diagnosis in 2020: 374



Orange County Jail

- 76 -acre secure compound in Orlando, Florida
- Capacity to detain up to 4,100 inmates
- Average Length of Stay: 28 days
- Unduplicated Bookings (2021): 30,151
- Monthly Average of Inmates on HIV Medications: 98 persons

Orange County Jail, 2021

Race

White: 51%

Black/African American: 49%

Other: 0.04%

Gender

Male: 78%

Female: 22%

Average age: 35 with a range of 15-89

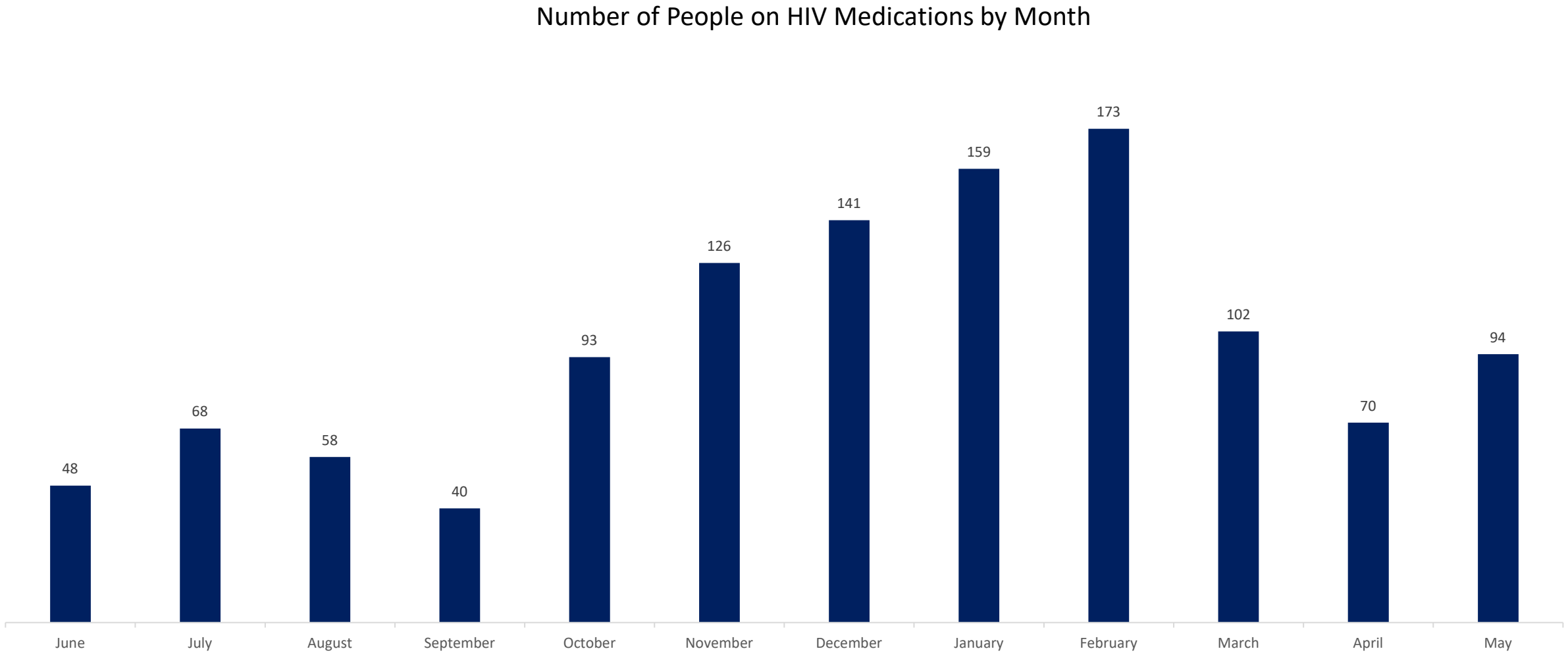
80% Pre-Trial

83% Felons

<1% Juveniles

- **HIV-** ~1.5% (363) of the patients had an HIV diagnosis recorded in their chart.

PWH in Orange County Jail 2021-22



Orange County Jail Linkage Program

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Person becomes an inmate of the Orange County Jail

Inmate notifies staff/tested for HIV and health information is entered in jail database.

Jail Linkage Coordinator receives notification of HIV positive inmate or preliminary positives.

Jail Linkage Coordinator connects with inmate within 24 hours of notification.

Jail Linkage Coordinator assesses and completes Ryan White Eligibility. Refers to MCM/RS/OAHS if applicable.

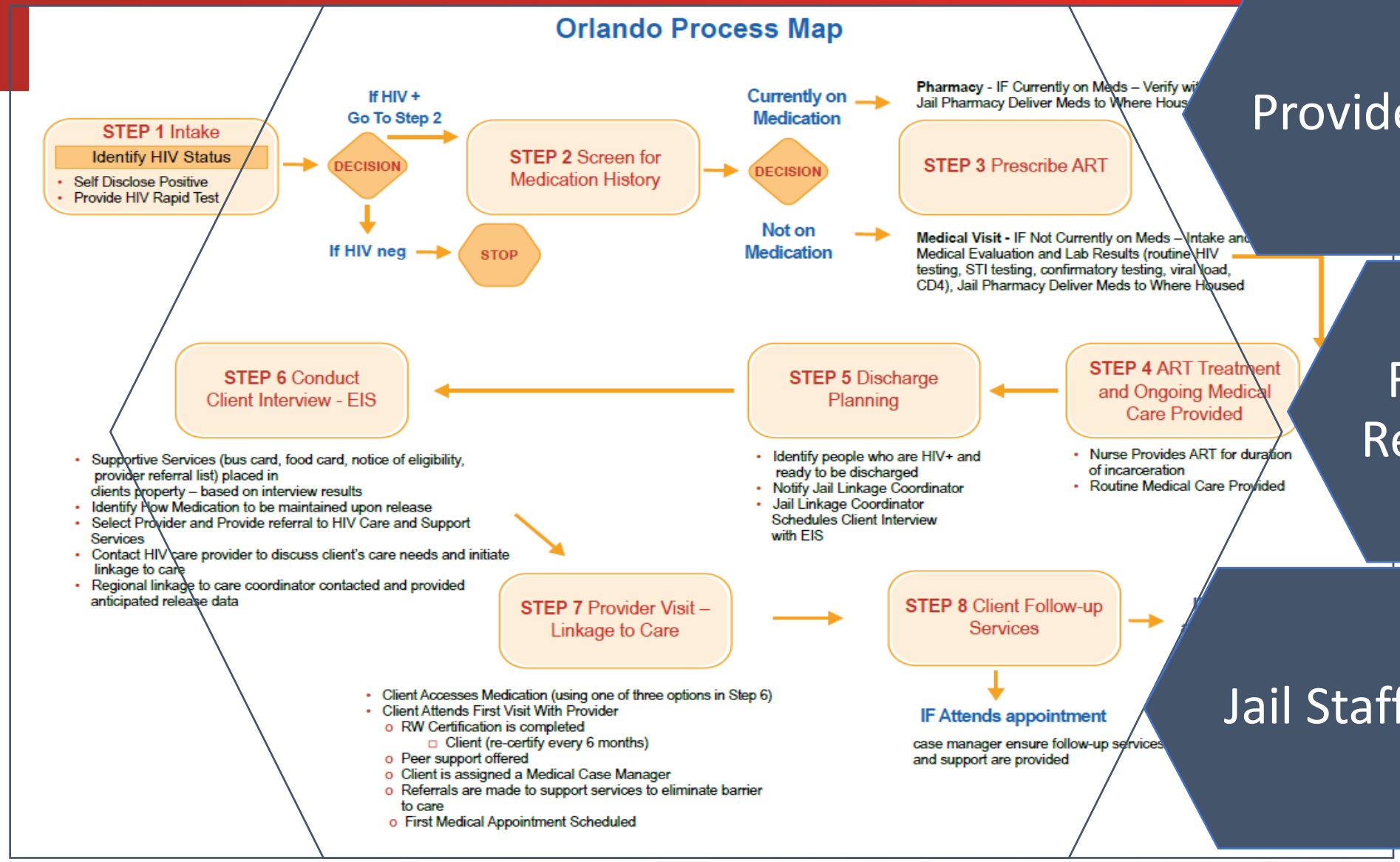
Jail Linkage Coordinator ensures connection to Ryan White Services upon release from jail.

TAP-In Technical Assistance: Objectives

Technical Assistance Provider innovation network

- Strengthen systems to collect, report, and use data to improve rates of linkage to care for people with HIV who have recently been released from jail
- Identify and implement strategies to improve processes that result in improved rates of linkage to care
- Conduct an exercise to map the process identifying and linking people with HIV released to the community to a regular source of HIV care and treatment

Getting to Outcomes-Process Mapping



Providers

Referral Resources

Jail Staff

Outcome Measures

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Viral Suppression on Release

- Number/percentage of clients virally suppressed at most recent viral load test before release date

Linkage to Care

- Number/percentage of clients with a medical visit, viral load or CD test within [30,60,90] days of release

Linkage to Viral Load Test

- Number/percent of clients with a viral load test within [30,60,90,180] days of release

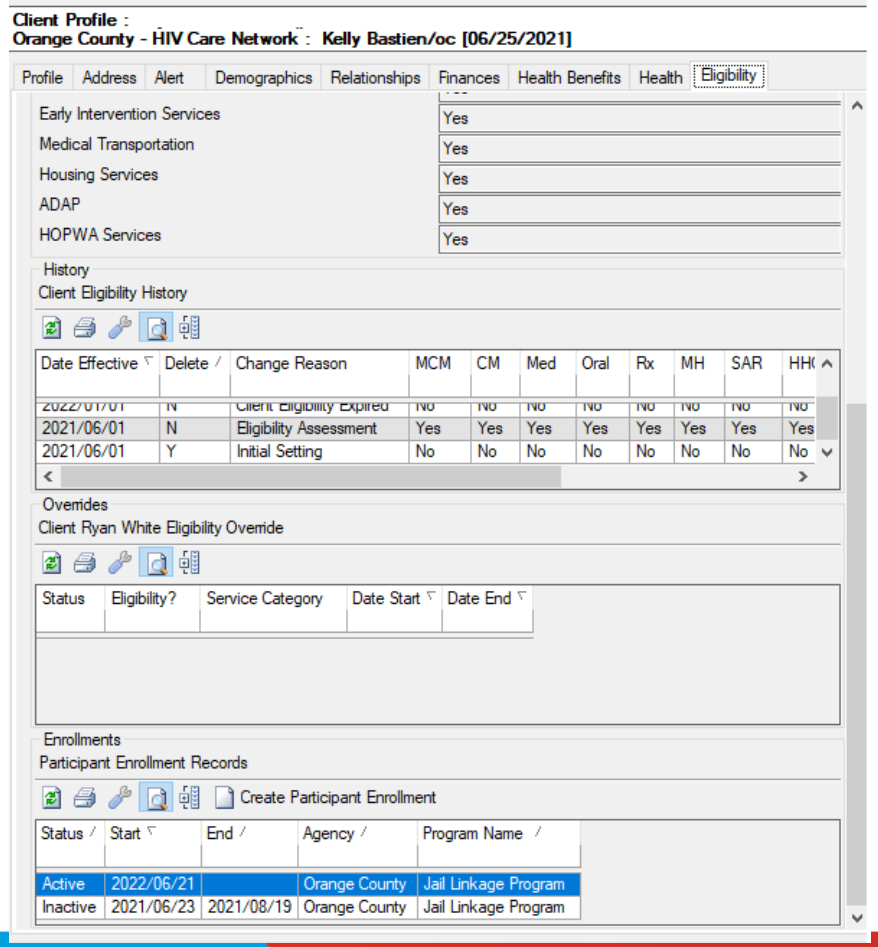
Viral Suppression

- Number/percent of clients virally suppressed within [90,180] days

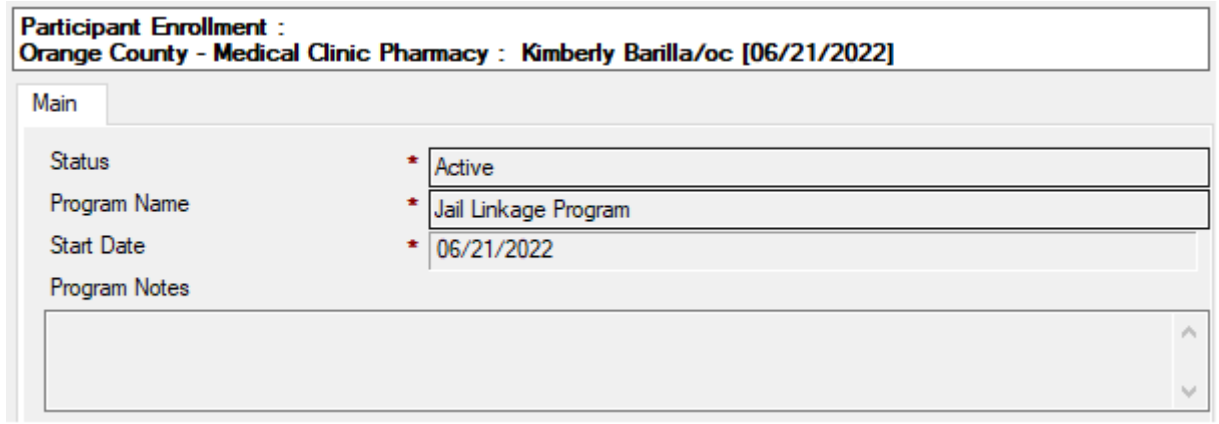
Database Enhancements

Added Participant Enrollments to Provide Enterprise to enhance the tracking of Jail Linkage Clients

Client Profile-Eligibility



Client Profile-Participant Enrollment



Database Enhancements continued

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Tableau Dashboard

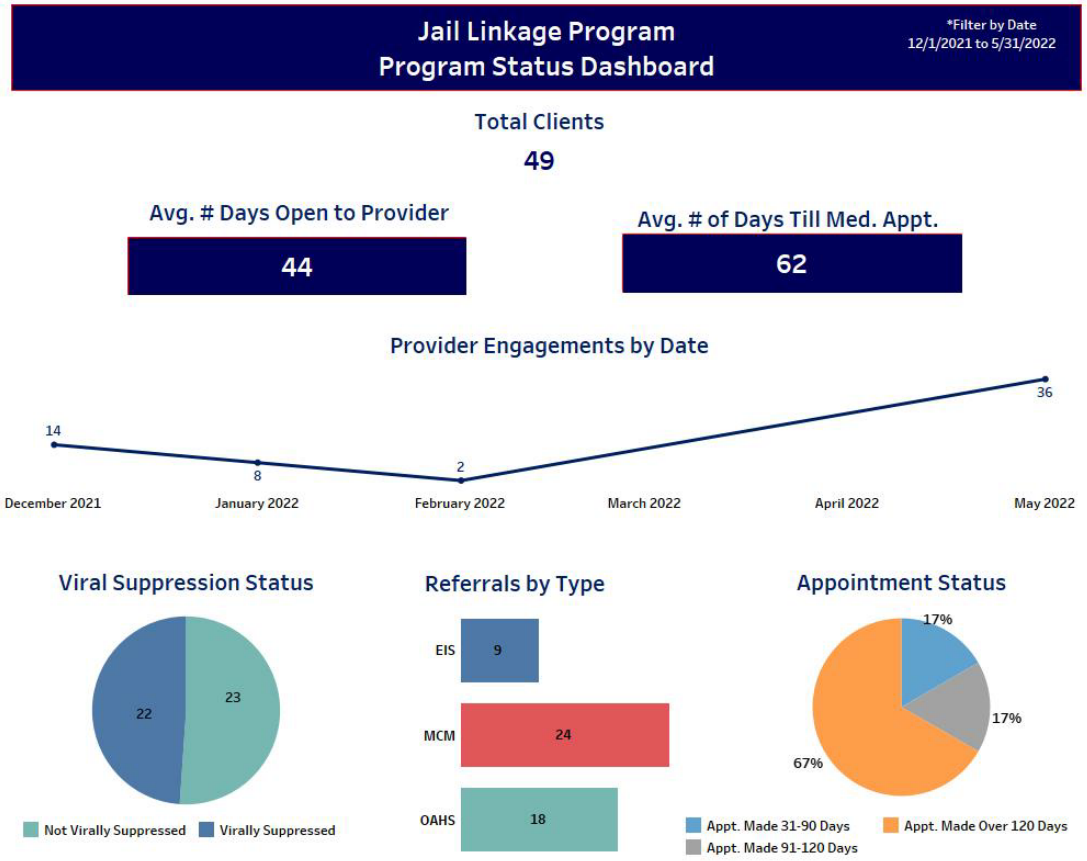
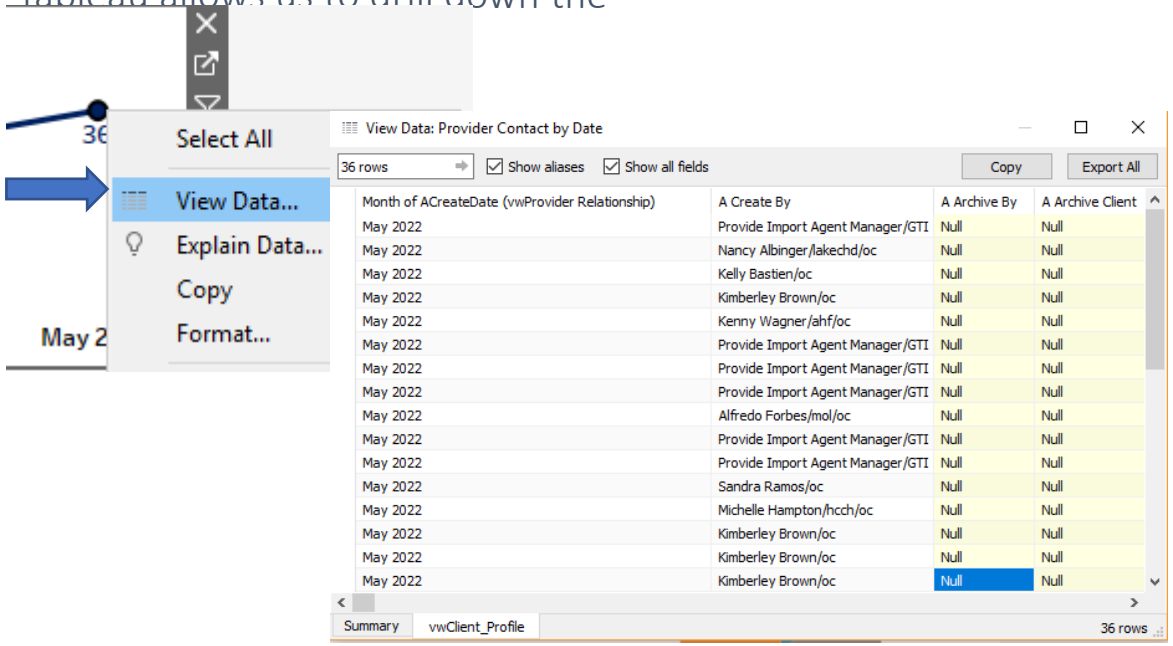
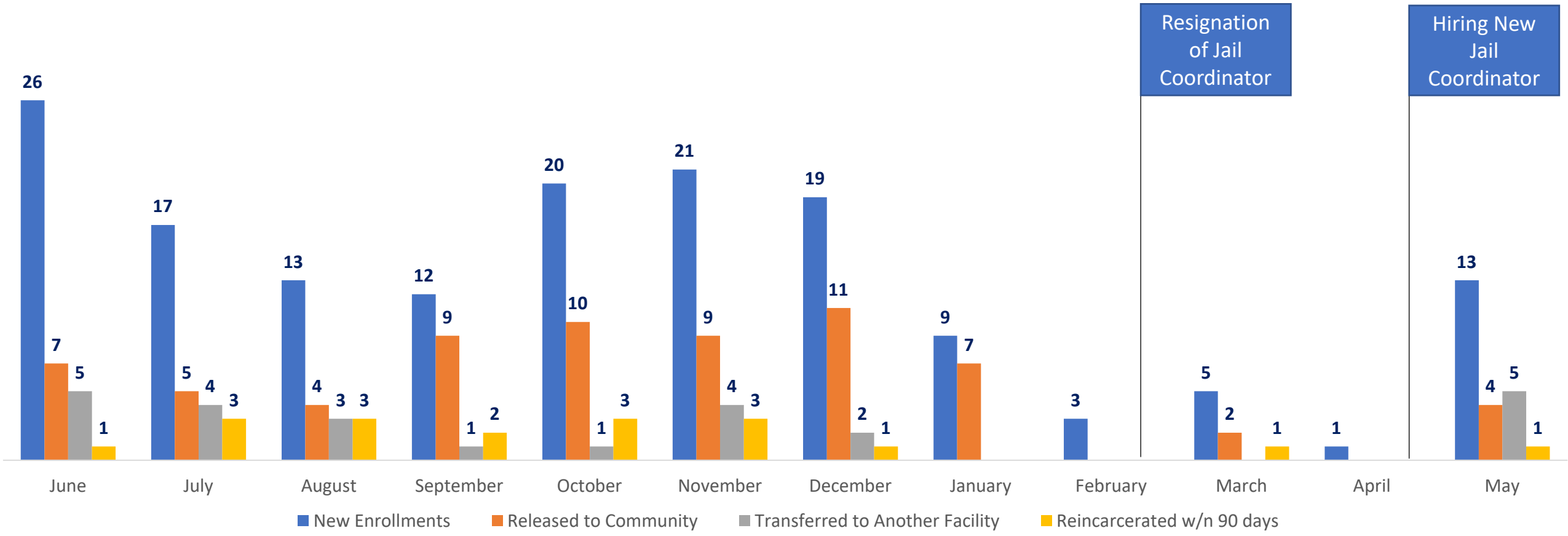


Tableau allows us to drill down the



Using Jail Linkage Program Data to track Clients 2021-22: Pre-release

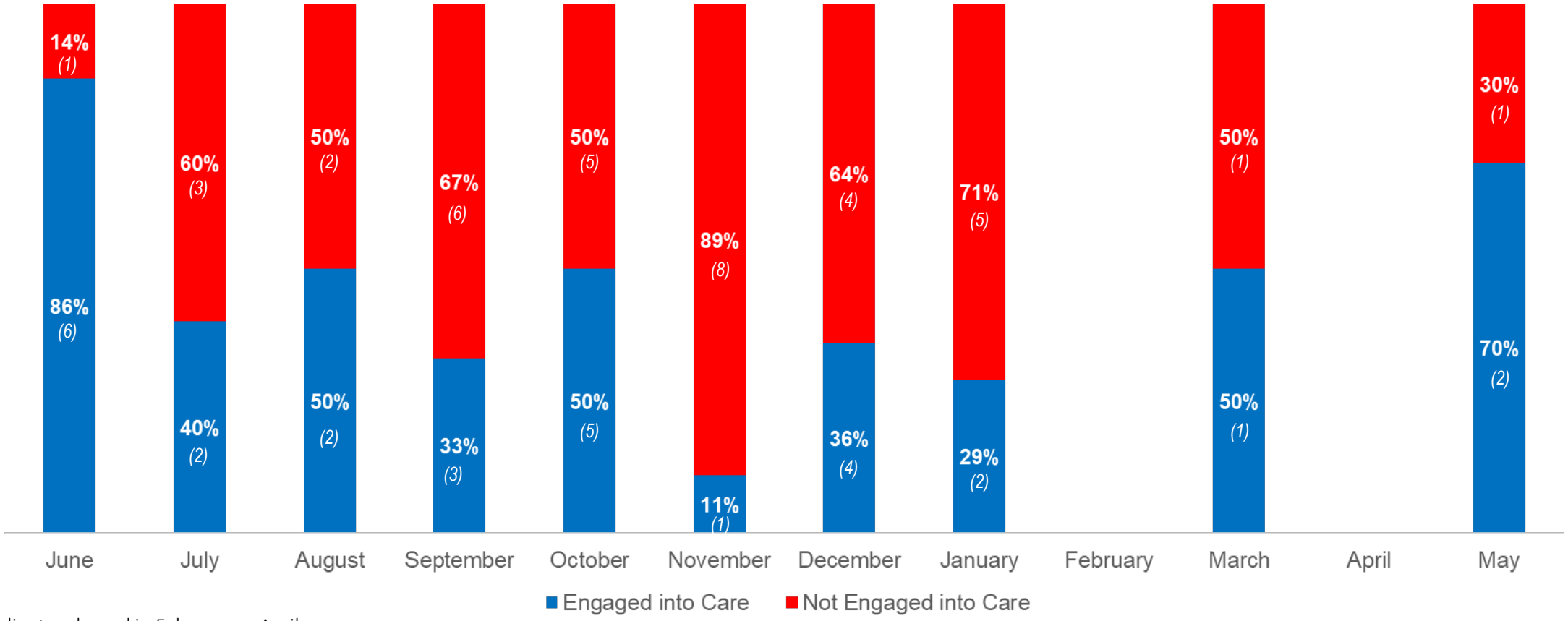


*New Enrolments include newly diagnosed clients and clients with an expired Ryan White eligibility. Last year there were on average 98 clients on HIV meds at the jail every month.

Jail Linkage Program Outcome Measures 2021-22

Linkage to Care

Percent of clients released to the community with a medical visit, supportive services visit, viral load or CD4 test after release.

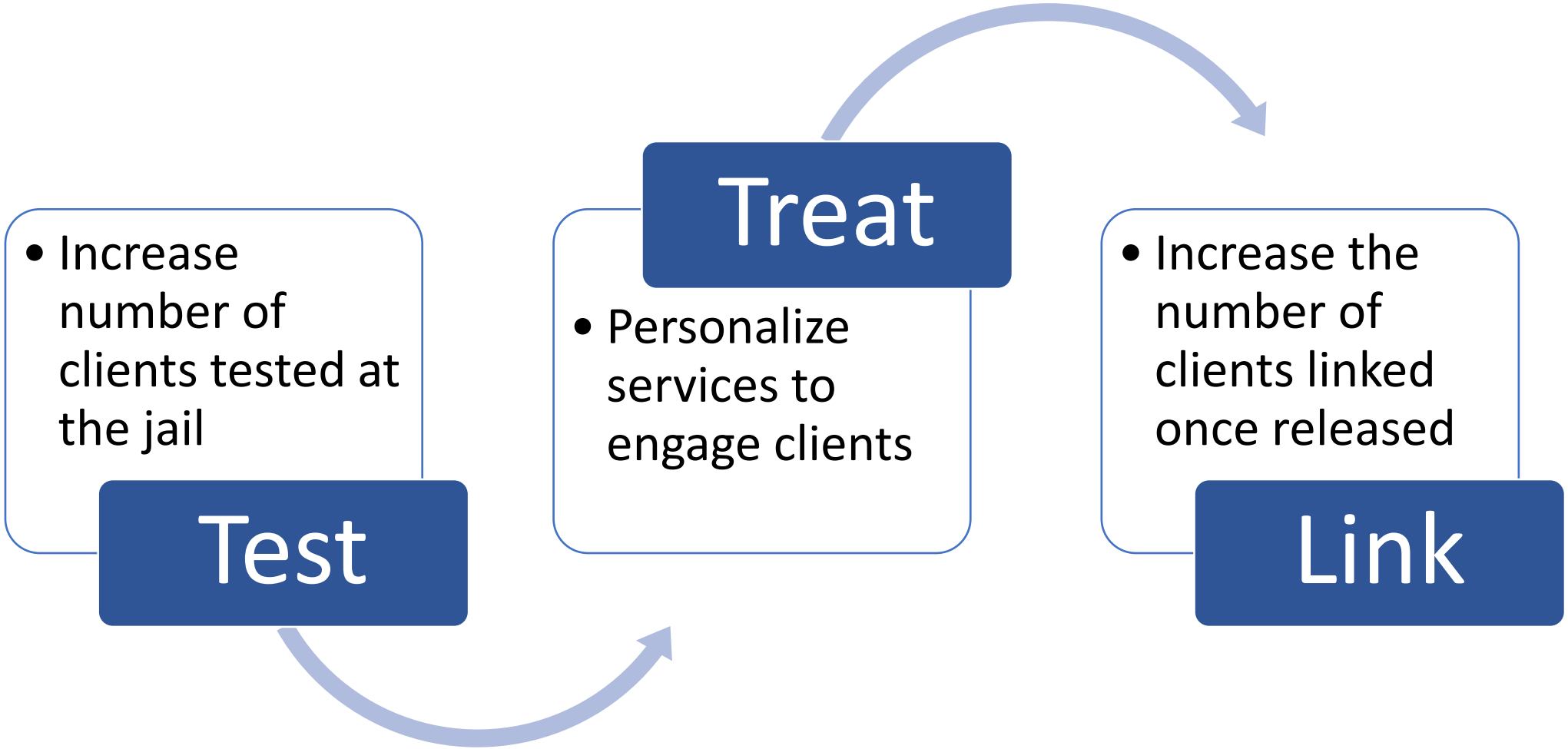


*No clients released in February or April

Lessons Learned

- Linkage Coordinator at the jail
- Warm handoff to outside network of providers able to coordinate medical care, transportation and housing
- Client incentives to link to care as soon as released
- Coordination with all levels at the jail
- Data and data system enhancements

Next Steps


Test
• Increase number of clients tested at the jail
Treat
• Personalize services to engage clients
Link
• Increase the number of clients linked once released

Tarrant County HIV Administrative Agency

Lisa Muttiah
HIV Grants Manager
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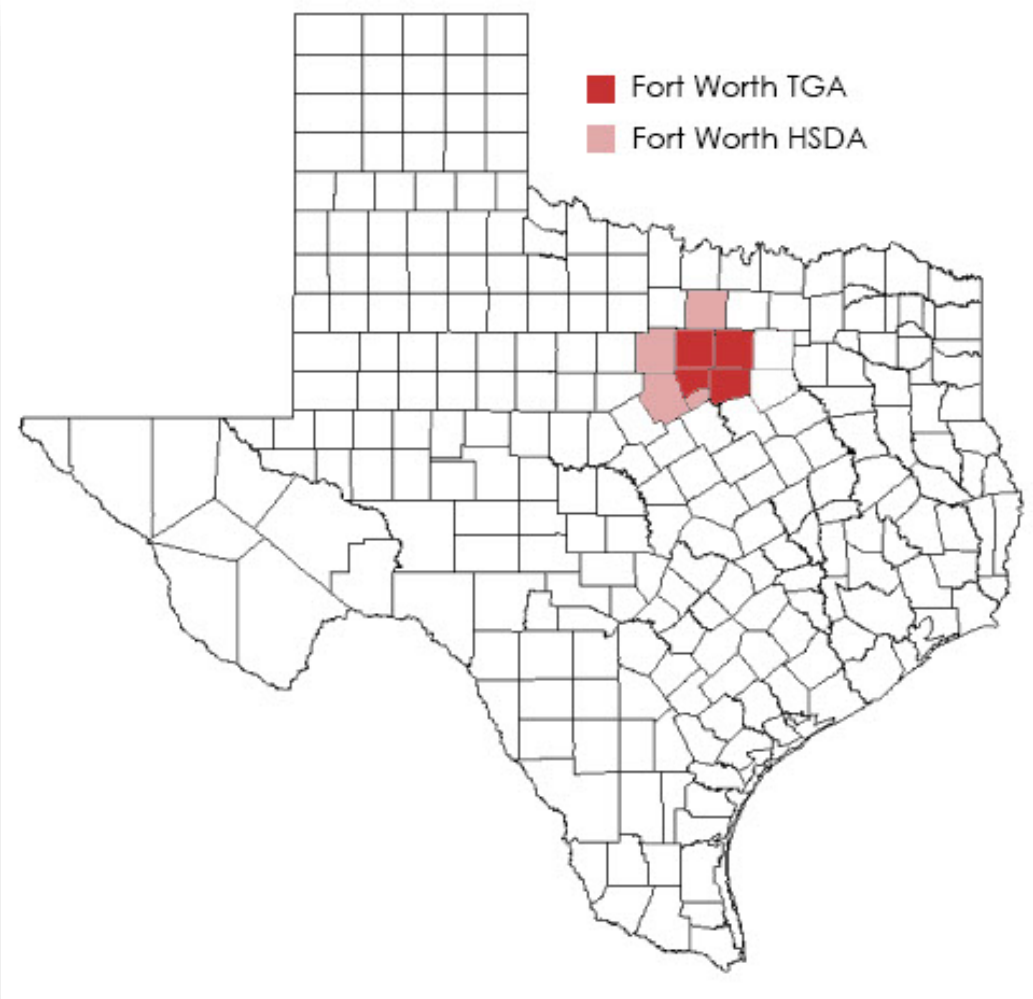
Fort Worth/Arlington Transitional Grant Area (TGA)

- Four north central Texas counties (Tarrant, Hood, Johnson, Parker)
- 2,918 square miles in the four-county TGA
- 85% (2,110,640*) of the TGA's general population reside in Tarrant within its 897 square mile area
- Two major cities within Tarrant County are Fort Worth (12th largest city in US) and Arlington
- 39 other suburban cities and towns within Tarrant County

*2020 Census



Fort Worth TGA, Fort Worth HSDA Map

Linkage to Care in Tarrant County

- Clearly identified need around linkage to care
  - Average linkage to care time is 42 days for a newly diagnosed PWH to attend their first HIV medical appointment
- Strategies to Address:
  - Implementing Rapid ART program in the ED
  - Exploring Strategies to reach priority populations and get them linked to care
- Regularly updated data on linkage to care for both RW and non-RW PWH in Tarrant County is key

Linkage to Care Data

- We wanted to look at linkage to care time across the jurisdiction regularly
  - Monitor impact of linkage to care and Rapid ART strategies
  - Understand more about non-RW clients

- Initial strategy:
  - Obtain surveillance data on non-Ryan White PWH

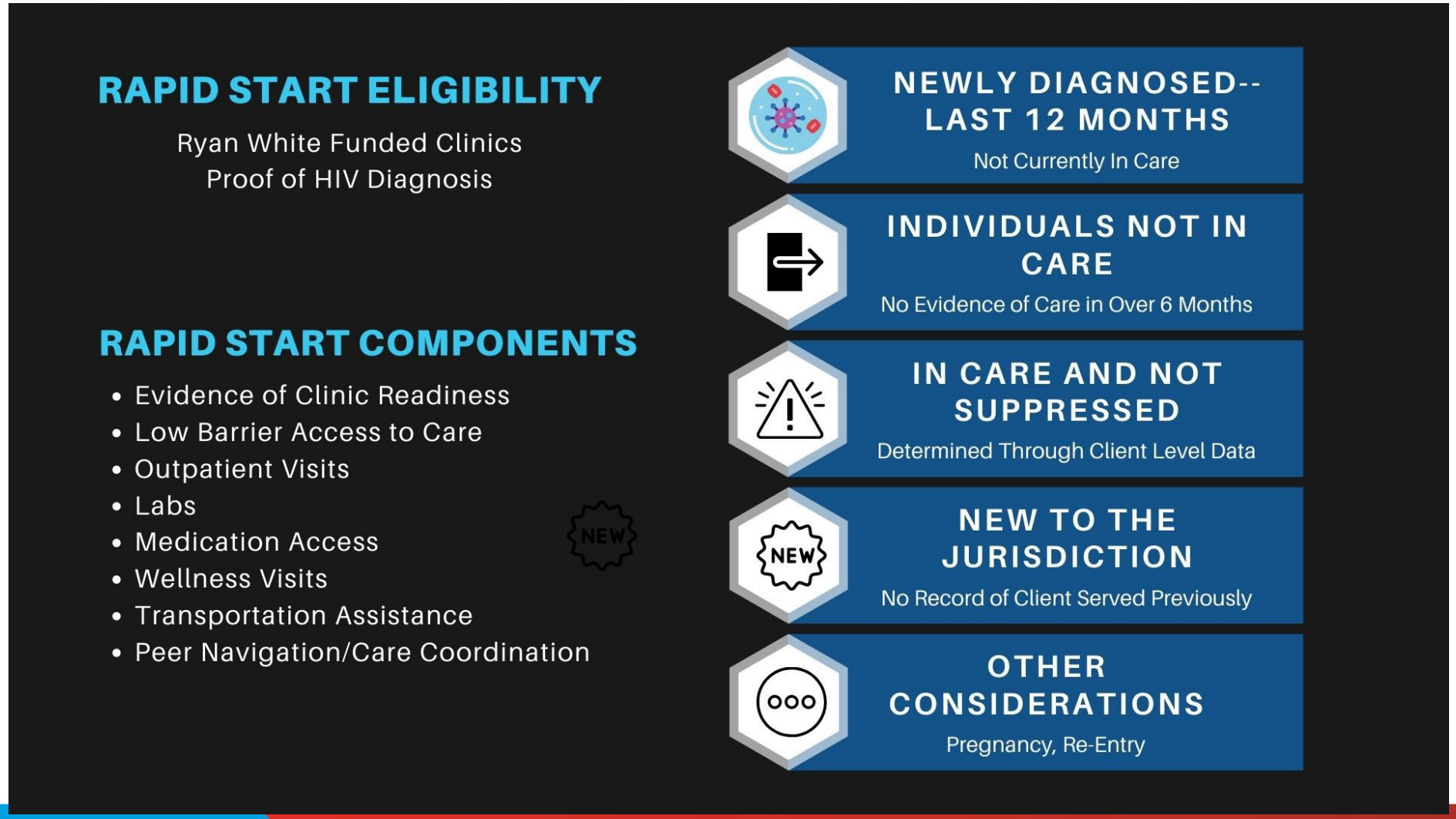
Data Sharing: Sounds Easy

- Tarrant County is an EHE Jurisdiction
- EHE Work Plan included establishing data sharing agreements
- Received TA from CAI TAP-IN
- Data sharing barriers:
  - Who does data belong to
  - Lack of support for data sharing
  - COVID impact on staffing
- Need for federal assistance to support data sharing

What Can We Control?

- Local client level data across multiple Ryan White parts
- Ability to modify data system, Provide Enterprise, to support EHE
- Enhancements to improve data collection around EHE metrics

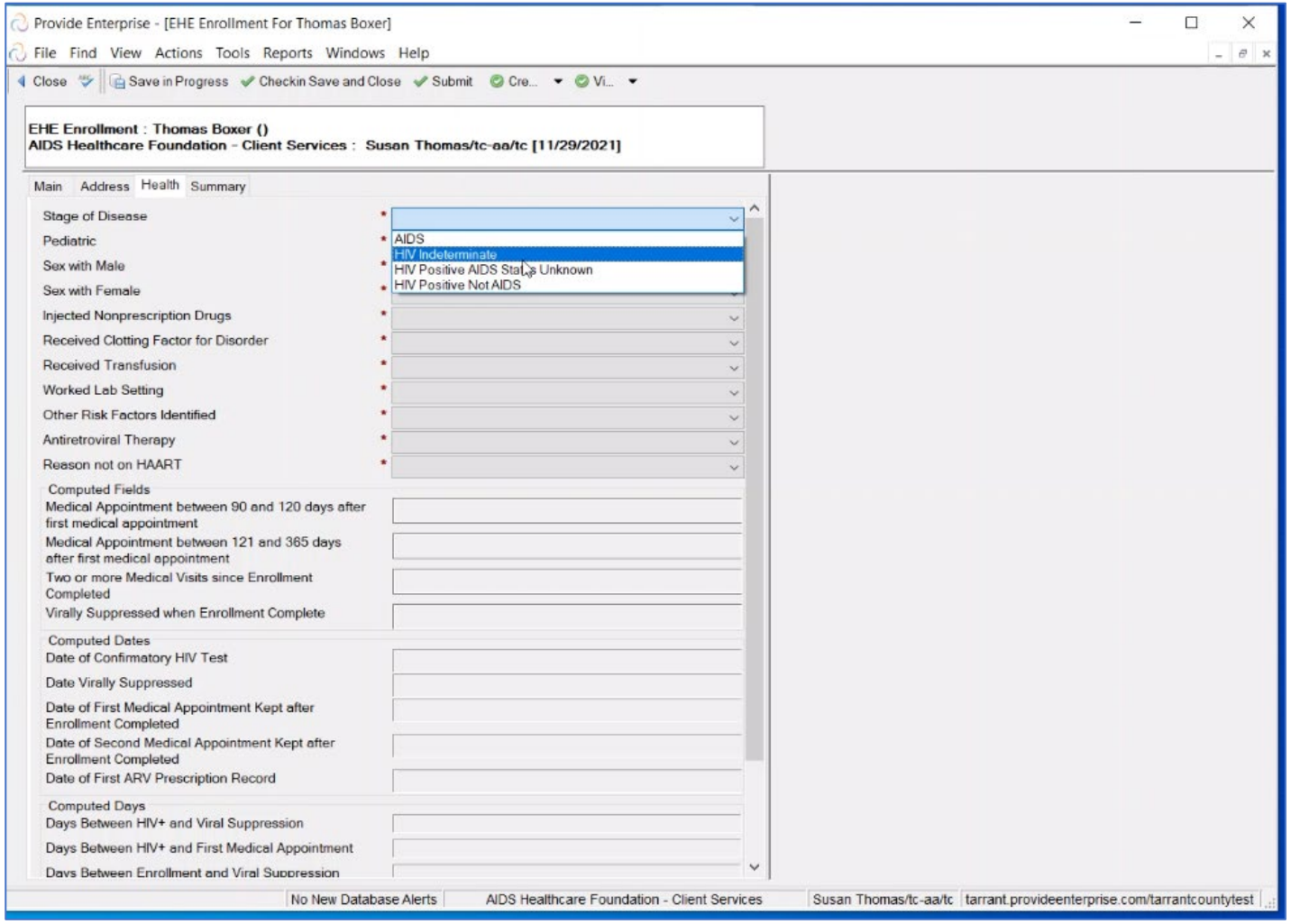
EHE Enrollment



Demonstrating Outcomes & Lessons Learned

Added computed fields to support metrics:

- Date of confirmatory HIV test
- Date of v/l suppression
- Diagnosis to 1st medical appt.
- Diagnosis to v/l suppression
- Enrollment to v/l suppression



Panel Discussion

Q&A

Thank you