Data to Care or Link-Up Kent County

3/9/2018

What is Data to Care (D2C)?

CDC 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.”

Basic Concept:

- In Michigan, HIV labs are reported to MDHHS
  - Lab reports are used as a proxy to determine if an HIV-positive individual has been to a medical appointment
- MDHHS sends contact information (name, phone # address, place/date of diagnosis) to the local health department
- The local health department reaches out to these individuals to offer re-engagement into HIV medical care

What Does ‘Not in Care’ Mean?

Not in Care includes individuals that have been diagnosed with HIV, but are

- Never linked to HIV care, or
- Out of care

Not in Care includes individuals never linked

- Diagnosed between 90 and 365 days ago
  - With no CD4, viral load or genotype tests

    OR

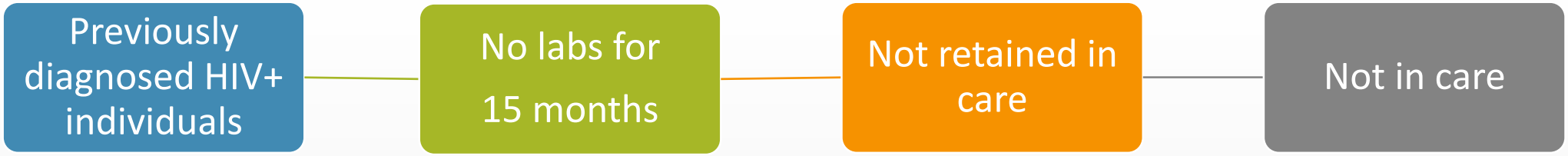
  - The only labs done were within 8 days of diagnosis (because sometimes initial labs are drawn right after diagnosis, but the individual does not engage in HIV medical care)

Not in Care includes individuals out of care

- Diagnosed over 365 days ago

  AND

- No CD4, viral load or genotype in previous 15 months



What is Data to Care?

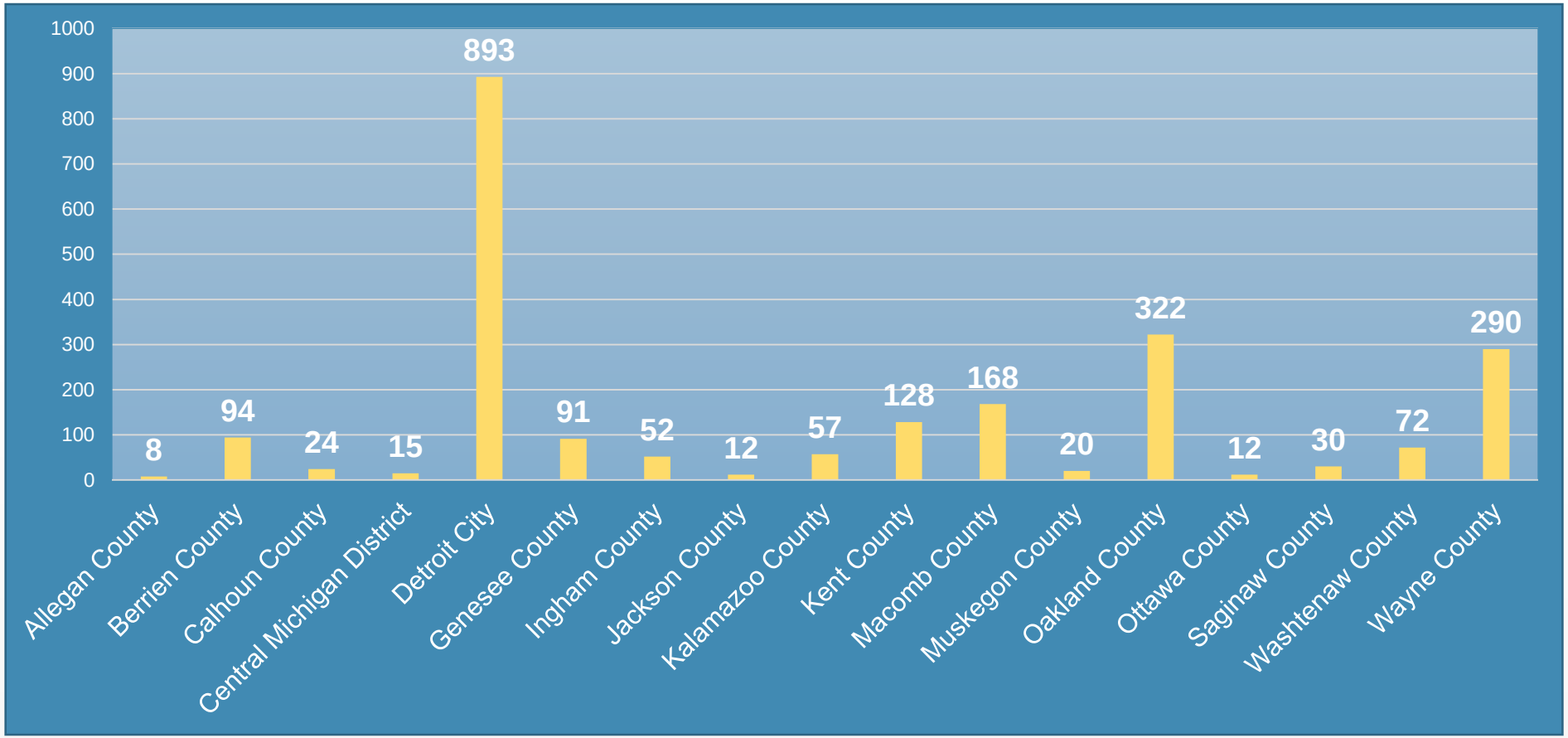
- Public health strategy
- Uses HIV Surveillance information to identify HIV-diagnosed individuals not in care (NIC)
- To link them to care
- And support the HIV Care Continuum

Michigan Public Act 514 requires all viral load, CD4 and genotype tests be reported to the local or state health department

This information is stored in the HIV/AIDS Reporting System (eHARS)

Why Does Michigan Need Data to Care?

PLWH Out of Care in Michigan, by high-morbidity county, Oct 2017



Source: *MDHHS Surveillance*

Why does Kent County need Data to Care?

- In **Michigan, in 2016,** there were **2,970** individuals not in care (NIC)
- These individuals are often NIC because they are dealing with multiple barriers to care (transportation issues, lack of insurance, lack of access/knowledge of access to medical care, stigma-related mental health issues, etc.). By reaching out and offering services, we can help these individuals access medical and non-medical services, address their barriers, and get them into HIV care.
- D2C has worked in Michigan – Specifically in Jackson County & Detroit
- D2C has been successful in other cities across the US – San Francisco, New York, Seattle
- D2C is a CDC strategy that is recognized for being a High Impact Prevention Strategy: https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/PublicHealthStrategies/DatatoCare.aspx

Examples – How D2C programs have worked in Michigan

Small Community (Jackson County) and Large Community (City of Detroit)

Jackson County D2C Program

D2C update, as of September 2017:

22 individuals determined to be NIC, and last known residence was Jackson county

- Contact was attempted for all 22 clients or clients physicians for follow up
- 3 clients identified as now residing and receiving care in another state
- 4 clients not ready to commit to care, 3 of whom agreed to receive future follow up calls from public health nurse (Reasons: 1. Not happy with care at ID doctor in Jackson 2. Feels fine and doesn't want to take medication 3 & 4. Client's using holistic therapies)
- 7 clients, not enough information/incorrect contact information, lost to follow up
- **8 clients re-engaged into care and were open to case management as well as public health follow up** (identified barriers to care: transportation, parent resources, other medical conditions, not emotionally ready, too much "red tape", depression & overwhelmed, issues with physician and partner influence)

Program Coordinator: Tracy Payne, RN, Communicable Disease/TB Control Nurse, Jackson County Health Department

Jackson County Health Department
Creating Healthy Communities

Progress – Link-Up Detroit (Detroit's D2C Program)

In 2016, there were 1,126 known HIV-positive individuals out of care in Detroit. Link-Up Detroit started on February 6, 2017.

As of September 15, 2017:

- Information has been received from MDHHS for 500 individuals
- Initiated 390 of the 500
  - 1,163 letters sent, to 313 individuals
  - 1,314 calls attempted, to 252 individuals
- 91 clients or family members have been successfully reached by staff calling them
- 45 clients or family members have initiated calls (because of a letter, text received, or voicemail left)
- 161 texts sent, to 85 individuals
- 218 voicemails left, to 94 individuals
- 101 Case Report Forms with updated contact sent back to MDHHS Surveillance

In Detroit, people have started to come to the D2C program for help accessing medical care or to keep from falling out of care.

External Referrals – 79 Received

Referral Outcomes:

61 of the 79 (77%) have been closed out

- 27 (44%) Emergency financial assistance
- **14 (23%) Linked to care**
- 7 (11%) In care
- 4 (7%) Unable to locate
- 4 (7%) Other
- 3 (5%) Provided emergency transport to med apt
- 1 (2%) Linked to insurance assistance
- 1 (2%) Moved out state

Referral Sources:

- 23 Community agency
- 20 from medical providers
- 11 self-referral (other)
- 7 self-referral from the website

Total of 38 (D2C) + 14 (external/self referrals) = **52 people linked into care**

Community Engagement Plan

Update this table as you go.

Meeting	Date	Audience
D2C Grantees Meeting	Oct 23, 2017	LHD Staff
Community Engagement Presentation	February 8, 2018	Mercy Health Infectious Disease
Community Engagement Presentation	March 2nd, 2018	Grand Rapids Red Project
Community Engagement Presentation	March 9, 2018	TIPS Meeting

What feedback or questions do you have?

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