EXPANDED PARTNER SERVICES

USING HIV/AIDS SURVEILLANCE DATA TO ADVANCE HIV PREVENTION PROGRAMMING IN NEW YORK STATE

James Tesoriero, Ph.D.
Director, Division of HIV/STD/HCV Prevention
AIDS Institute, NYSDOH

An Important Milestone
in
Ending the AIDS Epidemic

Decreasing new HIV infections to reduce the number of persons living with HIV in New York State for the first time.
The nation, as a whole, has seen no decrease in the number of HIV diagnoses.

New York State
- 40 percent reduction over the last decade.
- Decreases seen in HIV incidence across all races and risk groups.

BUILDING ON SUCCESS

- Transmission via blood products – ELIMINATED.
- Mother to child transmission - ELIMINATED (per CDC’s definition) in 2013.
- Injection drug use-related HIV DECREASED 90% since 1990s.
- To bend the curve, a 3-point program to reduce continuing HIV transmission is needed.
Bending the Curve: 3-Point Program

1. Identify all persons with HIV who remain undiagnosed and link them to health care.

2. Link and retain those with HIV in health care, to treat them with anti-retroviral therapy (ART) to maximize virus suppression so they remain healthy and prevent further transmission.

3. Provide Pre-Exposure Prophylaxis (PrEP) for high risk persons to keep them HIV negative.

Reduction in new HIV infections

- Reduce from 3,000 to 750 new HIV infections per year by 2020.
- Decrease the number of New Yorkers living with HIV for the first time.

Reduce by 50% the rate at which persons diagnosed with HIV progress to AIDS within two years.
What is the status of HIV treatment in New York State?

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated HIV Infected Persons</th>
<th>Persons Living w/ Diagnosed HIV Infection</th>
<th>Cases w/any HIV Care during the year*</th>
<th>Cases w/continuous care during the year**</th>
<th>Virally suppressed (n.d. or &lt;200/ml) at test closest to end...</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>154,000</td>
<td>132,000</td>
<td>86,000</td>
<td>75,000</td>
<td>68,000</td>
</tr>
</tbody>
</table>

* Any VL or CD4 test during the year
** At least 2 tests, at least 3 months apart

86% of infected
56% of infected
65% of PLWDHI
48% of infected
56% of PLWDHI
44% of infected
51% of PLWDHI
79% of cases w/any care

**BENDING THE CURVE 3-POINT PROGRAM**

**Diagnosis Gap:**
154,000 estimated HIV infected persons
132,000 persons diagnosed with HIV
22,000 undiagnosed persons need to be diagnosed and linked to care.

**Treatment Gap:**
132,000 estimated HIV infected persons
68,000 virally suppressed
64,000 persons currently diagnosed need therapy to achieve viral suppression

**Total Gap:**
86,000 persons needing diagnosis and treatment
Bending the curve: Key policies already enacted

<table>
<thead>
<tr>
<th>Identify all persons with HIV who remain undiagnosed and link them to health care.</th>
<th>2014 amendment to the NYS HIV Testing Law (PHL 2781) that allows the elimination of written consent for HIV testing to promote routine screening.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link and retain all persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission.</td>
<td>2014 amendment to the NYS HIV Testing Law (PHL 2135) that allows for enhanced data sharing between health departments and current health care providers for purposes of patient linkage and retention in care.</td>
</tr>
<tr>
<td>30% rent cap to maintain 10,000 HIV infected persons in stable housing resulting in increased retention and adherence in care.</td>
<td></td>
</tr>
</tbody>
</table>
Expanded Partner Services

**USING HIV/AIDS SURVEILLANCE DATA TO ADVANCE HIV PREVENTION PROGRAMMING IN NEW YORK STATE**

---

**Context**

- President’s National HIV/AIDS Strategy
- Program Collaboration and Service Integration
- High-Impact HIV Prevention
- Project Inform HIV Prevention
- NYS’ Bending the Curve Initiative
- Data to Care Initiatives
  - Health Department Model
Expanded Partner Services (ExPS)

Collaboration between the Division of HIV/STD/HCV Prevention and the Division of Epidemiology, Evaluation & Research

Utilized HIV surveillance data to identify previously known positive individuals who appear to be out-of-care
- Individuals with last medical provider / lab report for HIV in one of the four pilot counties who have no viral load (VL) or CD4 labs in the past 13 to 24 months were selected for the pilot

ExPS Pilot launched in September 2013
- PS Staff in Erie, Monroe, Westchester, & Onondaga LHDs, with coordination by AIDS Institute
- One year Pilot Period (New cases from Sept 13 – Aug 14)
ExPS in Action

Previously known positive persons identified as out-of-care are interviewed and offered comprehensive partner notification services, inclusive of:

1. Linkage to medical care;
2. Referrals for identified supportive services;
3. Risk reduction counseling; and
4. Safer sex supplies.

Identified partners are contacted and offered HIV and STD testing

VL and/or CD4 labs tracked over the course of six months to evaluate linkage to medical care and viral load suppression

ExPS Outcomes
ExPS Pilot Period Outcomes

Case outcomes based on information entered into NYS NYEHMS as of 11/13/14. Includes all ExPS cases generated and assigned from September 2013-August 2014. Data are subject to change pending lab updates, worker revisions, and/or data QA reclassifications.

---

ExPS Case Demographics (N=1,158)

**Gender Distribution**
- Male: 70.0%
- Female: 29.5%
- Transgender: 0.4%

**Age Distribution**
- 0-9: 1%
- 10-19: 14%
- 20-29: 14%
- 30-39: 17%
- 40-49: 20%
- 50-59: 27%
- >60: 13%

*Preliminary Data - Subject to Change*
**ExPS Case Demographics**
(N = 1,158)

### Patient Characteristic

<table>
<thead>
<tr>
<th>Sex</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>811</td>
<td>70.0%</td>
<td>100</td>
<td>70.4%</td>
<td>42</td>
<td>29.6%</td>
</tr>
<tr>
<td>Female</td>
<td>342</td>
<td>29.5%</td>
<td>71</td>
<td>80.7%</td>
<td>17</td>
<td>19.3%</td>
</tr>
<tr>
<td>Transgender</td>
<td>5</td>
<td>0.4%</td>
<td>2</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, Non-Hispanic</td>
<td>382</td>
<td>33%</td>
<td>54</td>
<td>76.1%</td>
</tr>
<tr>
<td>Black, Non-Hispanic</td>
<td>518</td>
<td>45%</td>
<td>95</td>
<td>77.2%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>140</td>
<td>12%</td>
<td>13</td>
<td>65.0%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>14</td>
<td>1%</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Other/Missing</td>
<td>104</td>
<td>9%</td>
<td>20</td>
<td>58.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20</td>
<td>7</td>
<td>1%</td>
<td>0</td>
<td>n/a</td>
<td>0</td>
<td>n/a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>160</td>
<td>14%</td>
<td>25</td>
<td>61.0%</td>
<td>5</td>
<td>16.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>194</td>
<td>17%</td>
<td>34</td>
<td>70.8%</td>
<td>14</td>
<td>29.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td>320</td>
<td>28%</td>
<td>46</td>
<td>76.7%</td>
<td>14</td>
<td>23.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-59</td>
<td>318</td>
<td>27%</td>
<td>53</td>
<td>79.1%</td>
<td>14</td>
<td>20.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;60</td>
<td>156</td>
<td>13%</td>
<td>15</td>
<td>93.8%</td>
<td>1</td>
<td>6.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>3</td>
<td>0%</td>
<td>0</td>
<td>n/a</td>
<td>0</td>
<td>n/a</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM/IDU</td>
<td>49</td>
<td>4%</td>
<td>3</td>
<td>75.0%</td>
<td>1</td>
<td>25.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IDU</td>
<td>190</td>
<td>16%</td>
<td>20</td>
<td>80.0%</td>
<td>5</td>
<td>20.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td>420</td>
<td>36%</td>
<td>62</td>
<td>72.9%</td>
<td>23</td>
<td>27.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>296</td>
<td>26%</td>
<td>54</td>
<td>78.3%</td>
<td>15</td>
<td>21.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female Presumed Hetero</td>
<td>70</td>
<td>6%</td>
<td>15</td>
<td>63.6%</td>
<td>15</td>
<td>36.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood</td>
<td>1</td>
<td>0%</td>
<td>0</td>
<td>n/a</td>
<td>0</td>
<td>n/a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric</td>
<td>22</td>
<td>2%</td>
<td>3</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>130</td>
<td>9%</td>
<td>19</td>
<td>70.4%</td>
<td>8</td>
<td>29.6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

12/5/2014
Implications for Program

Provider Engagement
- Strong relationships with HIV care providers and support agencies are essential to successful program outcomes
- Identifying “inadequate care” providers (e.g., nursing homes) for additional clinical education
- Expired HIPAA releases with social service agencies limit ability to work collaboratively

Health Department Operations
- Need to train re-linkage advocates beyond “disease investigation”
- These cases can take a lot of time to re-engage - important to empower advocates to keep focus on individual (and not on “closing the case”)
- Need for very clear guidelines and protocols, as well as their overlap with existing PS guidance
ExPS: Next Steps

Surveillance /Lab Matching to assess retention in care and clinical outcomes (in process)

Expansion of ExPS to five additional health departments & six regional offices
- Expanding in 2015 to Dutchess, Orange, Nassau, Suffolk, Albany & NYC
  - 2015 Goal: Link 500 out-of-care persons to care
  - 2016 Objective: Link 1,000 out-of-care persons to care

ExPS as a model for Continuous Quality Improvement
- Currently revising and updating protocols based on pilot experience
- Expanding access to key resources moving forward (e.g., RHIOs, Lexis Nexis®)
- Implementing quality controls, revising investigation protocols to improve data quality
- Time study of ExPS re-engagement process, cost-effectiveness modeling

Building on ExPS Success

Changes in NYS Public Health Law (2014)
- Allows for sharing of HIV surveillance data with healthcare providers to help improve identification and re-engagement of OOC individuals
- Medical providers will be able to request assistance from the AI in locating and re-linking patients to care

NYS High Impact Care and Prevention Project (NYS HICAPP)
- CDC and HRSA funded project (called P4C at the national level)
- NYSDOH partnering with 6 community health centers, the NYCDOHMH, the CDC, HRSA and a Technical Assistance Center
- 3 Year project with program implementation on 1/1/2015
Ending the AIDS Epidemic It’s Been a Long Time Coming

AI Priorities

Link and retain those with HIV in health care, to treat them with ART to maximize VS so they remain healthy and prevent further transmission.

Address issues of stigma and discrimination

Identify all persons with HIV who remain undiagnosed and link them to health care.

Provide PrEP for high risk persons to keep them HIV negative.

Expand Syringe Access
CHANGING THE HEADLINES:

“New York State, where AIDS Began, Bends the Curve for the first time”

Thank you!

In addition to the NYSDOH collaborative ExPS workgroup, a special acknowledgement to the ExPS staff in Erie, Monroe, Onondaga and Westchester County Health Departments, who made this work possible!

For More Information:

James Tesoriero, Ph.D. – Project Lead
- James.tesoriero@health.ny.gov

Megan Johnson, MPH – Project Coordinator
- Megan Johnson@health.ny.gov

Britney Johnson, MPH – Data Coordinator
- Britney.Johnson@health.ny.gov