



Data to Care Evaluation Report, 2019

Ohio Department of Health
Bureau of Infectious Diseases
HIV Surveillance

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Executive Summary

Acknowledgments: This report, and the findings within, would not have been possible without the incredibly dedicated staff and external partners that planned, designed, and implemented Data to Care (D2C) in Ohio. Extreme thanks go to the local public health staff and their facility/provider and HIV case management agency partners, who conducted follow-up with individuals to perform linkage, re-linkage, and offer referrals to the healthcare and other supportive systems.

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Round One: As part of the Centers of Disease Control and Prevention (CDC) funding opportunity PS18-1802: Integrated Human Immunodeficiency Virus (HIV) Surveillance and Prevention Programs for Health Departments, intensive D2C activities to support sustained viral suppression are required. To facilitate D2C activities in Ohio, the Ohio Department of Health (ODH) HIV Surveillance, Prevention and Ryan White (RW) programs collaborated to create a list of individuals identified as “presumptively not in care,” or a NIC list. The NIC list was divided by region (according to client’s last known residence) and distributed to relevant staff at HIV Prevention-funded local public health departments (regions). The regions then worked with facility/provider and HIV case management agency partners to follow up on the individuals to determine their care status, re-engage in care, and refer to support services, if necessary. The regions reported the data back to ODH, and the data were ultimately reported to CDC.

Key findings: During the first round of the D2C initiative (Round One), which took place from August through December 2019, the NIC list included persons who were diagnosed with HIV in the past five years who did not have evidence of care in the past 12 months. Columbus Public Health (CPH) had conducted two prior rounds of D2C, and requested the full NIC list, which included persons ever diagnosed with HIV who did not have evidence of care in the past 12 months. There was a total of 2,434 persons identified on the NIC list during Round One. Of those one the NIC list, 854 were prioritized for investigation. There were 95 persons who were confirmed to be NIC and of these, 17 percent (n=16) were re-engaged/linked to care.

Questions or comments: Questions and/or comments about this report should be directed to the ODH HIV Surveillance Program. Additional HIV surveillance data and reports are available on the ODH website: <https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/hiv-aids-surveillance-program>.

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Background

D2C is a public health strategy aimed at ensuring all persons diagnosed with HIV are receiving high-quality care and have achieved viral suppression (having a viral load (VL) result ≤ 200 copies/mL). D2C is a collaborative effort between HIV Surveillance, HIV Prevention, and RW programs at ODH, funded HIV/Sexually Transmitted Infections (STI) Prevention Planning Regions at local health departments (LHDs), and facility/provider and case management agency partners at the local level. Utilizing these data to take public health action and follow up with persons who may have fallen out of care, or have never accessed care, will ensure persons diagnosed with HIV are not only receiving the care they need, but will achieve viral suppression, effectively preventing sexual transmission of the virus and decreasing the number of new diagnoses.

The ultimate goals of D2C are to increase the percent of persons living with HIV who have received care, are retained in care, and are virally suppressed. D2C programs are also an opportunity to reduce stigma and educate others on 'Treatment as Prevention'. People living with HIV who take antiretroviral therapy (ART) and can maintain an undetectable viral load have no risk of sexually transmitting HIV to a partner.

Continuum of Care: The aim of D2C, over time, is to successfully link or re-engage persons on the NIC list into care, and to improve the measures reflected in the continuum of care. The measures for Receipt of Care, Retained in Care, and Virally Suppressed are calculated using the same denominator, but each measure uses a different numerator.

Receipt of Care Numerator: The number of persons in the denominator who had at least one CD4 and/or VL through the end of the following year (e.g., living with HIV as of 12/31/17 and having a CD4 and/or VL in 2018).

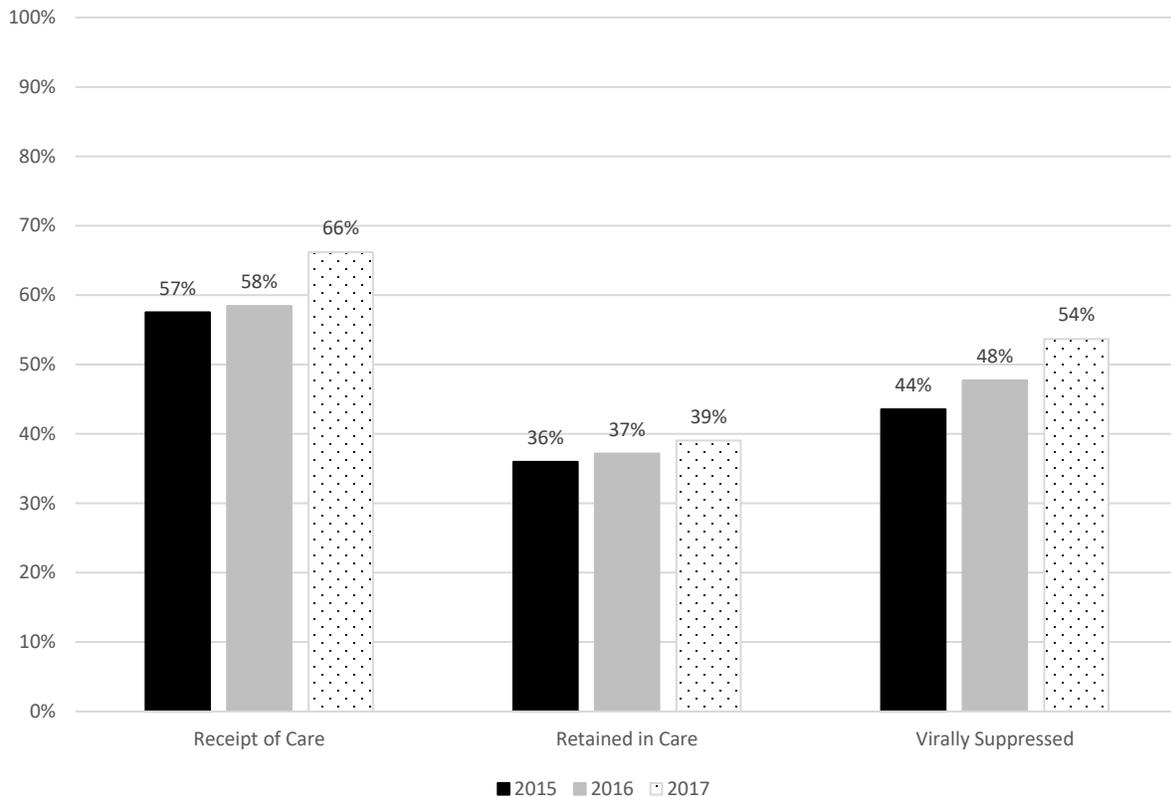
Retained in Care Numerator: The number of persons in the denominator who had at least two CD4 and/or VLs at least three months apart through the end of the following year (e.g., living with HIV as of 12/31/17 and having at least two CD4/VL tests three months apart in 2018).

Virally Suppressed Numerator: The number of persons in the denominator whose most recent VL test in the following year was ≤ 200 copies/mL (e.g., living with HIV as of 12/31/17 and the most recent VL test in 2018 was ≤ 200 copies/mL).

Denominator: The number of adults/adolescents living with HIV infection through the end of each year, and still living in Ohio at the end of the next year (e.g., living with HIV as of 12/31/17 and still living in Ohio as of 12/31/2018). Each of these measures uses the same denominator and thus the percentage for viral suppression may be higher than the percentage for retained in care (i.e., a person may be counted in the numerator for viral suppression because their most recent VL test was ≤ 200 , but not counted in the numerator for retained in care because they did not have at least two tests three months apart).

Of the persons living with diagnosed HIV in Ohio at the end of 2017, 66 percent were in receipt of care, 39 percent were retained in care, and 54 percent were virally suppressed. However, of persons who were in receipt of care, 81 percent were virally suppressed. Thirty-four percent of the persons living with HIV infection in Ohio at the end of 2017, and still living in Ohio at the end of 2018, did not have a CD4 or VL in 2017. These persons are considered to be 'out of care,' or, have an 'unmet need'.

Figure 1: Continuum of care among persons living with diagnosed HIV infection, Ohio, 2015-2017



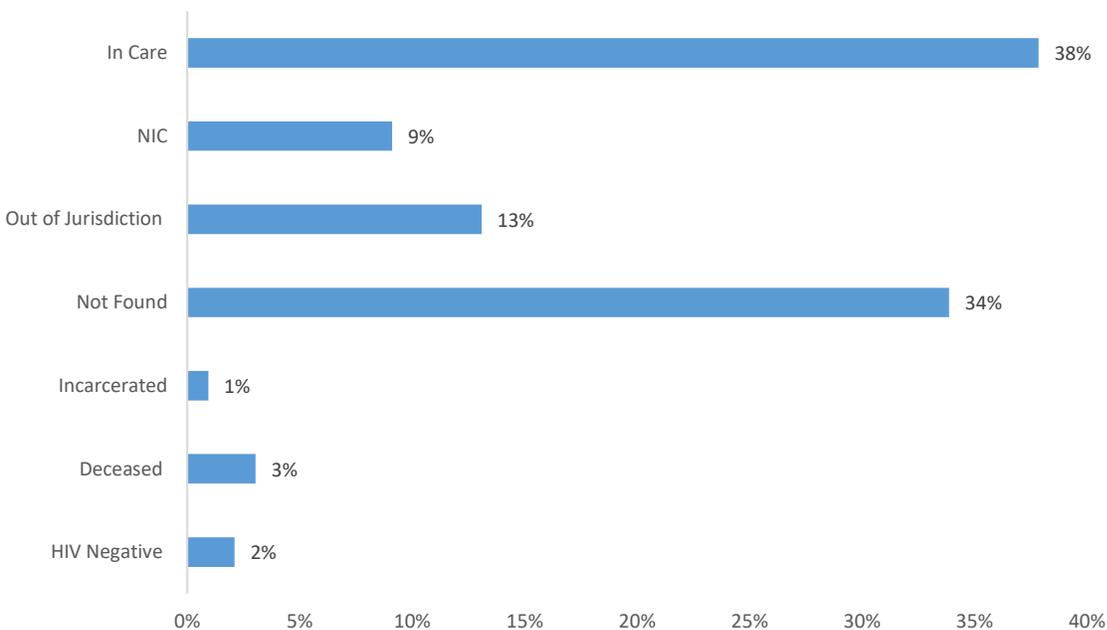
Source: Ohio Department of Health, HIV Surveillance Program. Data reported as of April 25, 2019.

Pilot

CPH is a large local health department in an urban setting, and a recipient of Ryan White Part A funds for the Columbus Transitional Grant Area (Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, and Union Counties). CPH had devoted staff and the necessary analytical capacity to position themselves as a candidate to implement a pilot program of D2C. In 2017 and 2018, NIC lists were generated for CPH of HIV positive individuals last known to be living within the Columbus Transitional Grant Area (TGA) with no care marker (i.e., CD4 count or viral load) reported to ODH in the previous 12 months. Clients were prioritized for investigation and outreach first by demographic information; African American males, transgender individuals, persons under 30, and those out of care longest were considered highest priority. A variety of databases and local electronic health records were used to investigate the care status of individuals. When determining the care status of an individual, CPH considered an individual to be in care if within the previous 12 months from the date of investigation the individual had one care marker (i.e., CD4 count, viral load, HIV medical appointment, anti-retroviral prescription, or other indicator of care such as a note from a medical case manager). Providers and, if contact information could be obtained, clients presumed to be out of care were contacted. If a client was not in care and was interested in engaging into care, they were offered linkage services, including direct access to HIV medical care and anti-retroviral medication.

When analyzing data from previous D2C cycles, some common barriers faced by individuals who were not in care included insurance issues, shame, denial, active substance use, alternative treatment options, lack of transportation, and simply feeling healthy enough not to pursue treatment. Regardless of barriers, many individuals who were not in care were willing to speak with HIV linkage coordinators and discuss HIV treatment and support services. All data obtained from investigations were reported back to ODH for data completeness and analysis and to help create subsequent NIC lists.

Figure 2: Columbus Public Health, Data to Care dispositions, July 2018-July 2019 (n=428)



Source: Columbus Public Health, Ryan White Part A Program. Data reported through February 20, 2020.

Round One

Planning: Beginning in early 2019, relevant staff at ODH held biweekly meetings to design and prepare for the first round of D2C. The experience and lessons learned by CPH in the two pilot rounds of D2C conducted heavily informed the planning process for Round One in Ohio. Because of how prevention planning regions are structured in Ohio, Linkage to Care (LTC) and Partner Services (PS) work is conducted at the local level by LTC Specialists and Disease Intervention Specialists (DIS), with the DIS sometimes performing both roles. The decision was made for the NIC list to be generated using HIV surveillance data at ODH, then distributed to the regions for necessary follow-up with clients. A protocol was created and included guidance on prioritization, working with facility/provider and HIV case management agency partners, and collecting and reporting data, as well as planned evaluation methods, an expected timeline, a data collection guide, a data dictionary, a data collection tool, a sample follow-up letter, and an optional phone script. A security and confidentiality (S&C) training was developed, as well as a general training for D2C and working with facility/provider and HIV case management agency partners. The S&C training occurred as a live webinar, which was recorded and made available to the regions, and the general training took place in person at a Combined Community Planning Group (CCPG) meeting, in which members of both the prevention and care communities

attended.

Security and confidentiality: A data sharing agreement (DSA) was created and was to be signed by all staff who would have access to D2C data, along with their immediate supervisor, the ODH HIV Surveillance Coordinator, and ODH Overall Responsible Party (ORP). All staff who would be conducting D2C activities were required to view an S&C training. In the training, the ORP stressed that all data used in D2C NIC activities should be handled in a secure and confidential manner, in accordance with the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Data Security and Confidentiality Guidelines:

(<http://www.cdc.gov/nchhstp/programintegration/docs/PCSIDataSecurityGuidelines.pdf>), This includes all instances in which data are shared with partners internal and external to the health department. The ORP also emphasized that all partners should be made aware and comply with security and confidentiality guidelines and protocols, including how data should be transferred, stored, and used.

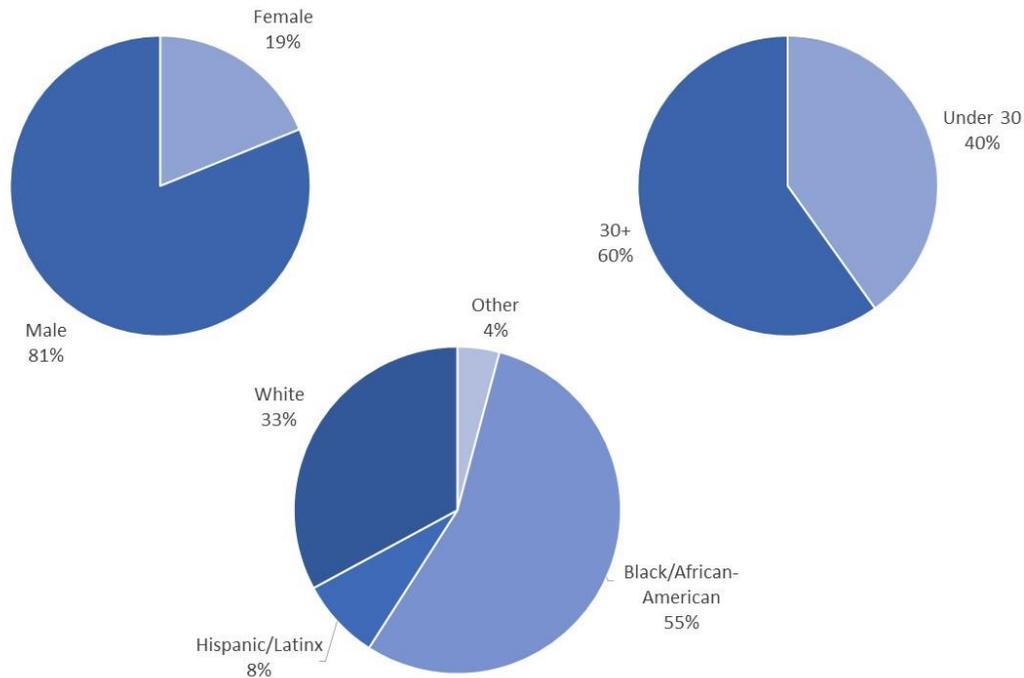
Technical Assistance: Teleconferences with the relevant staff in each region, including facility/provider and HIV case management agency partners, were held shortly after receipt of the NIC list, and again shortly before data were reported to ODH. This was an opportunity for the region staff and their partners to ask questions, provide feedback, and give insight into their local process, including successes and challenges. This was also an opportunity for ODH staff to provide guidance to the regions and their partners, clarify issues, and address concerns.

Implementation: To facilitate D2C activities in Ohio, ODH HIV Surveillance, Prevention and RW programs collaborated to create a list of individuals identified as “presumptively not in care,” or a NIC list. To generate the presumptive NIC list, records were pulled from the Enhanced HIV/AIDS Reporting System (eHARS) that had no evidence of care in the past 12 months. EHARS is a ‘linked’ database, meaning it is routinely and regularly updated with data from primary data sources (e.g., electronic lab reporting (ELR), provider/facility case report forms, other states) and additional sources (e.g., vital statistics, Ohio Disease Reporting System (ODRS), Ryan White Application Database (RWAD), CAREWare). For D2C Round One, someone was designated as not in care if they:

- Had been diagnosed with HIV in the past five years, and;
- Had a last known address in Ohio, and;
- Had no documented CD4 or VL lab results within the last 12 months;

The NIC list was then matched against RW databases RWAD and CAREWare at ODH to determine the client’s ‘last touch’ agency, which is defined as the case management agency from which the client last received case management or other services. The purpose of this was to determine which facility/provider and HIV case management agency partners could assist the regions with follow-up of the NIC list. The NIC list was divided by region (according to client’s last known residence) and included demographics, information on last known address, last reported CD4 and/or VL test and provider/facility, and other information.

Figure 3: Description of persons on NIC list, Ohio, Round One (8/1/19)

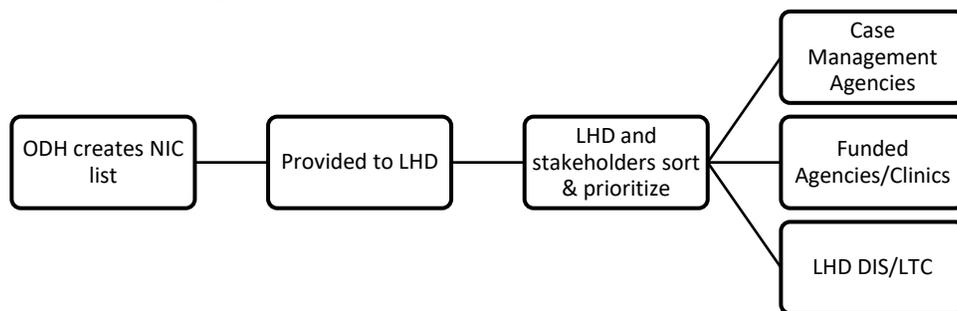


Source: Ohio Department of Health, HIV Surveillance Program. Data reported through August 1, 2019.

All regions received the NIC list via a Secure File Transfer Protocol (SFTP) site. Depending on each region's existing capacity, available systems for storing the NIC list, and total number of persons on the NIC list, regions were given different options for storing and working through the NIC list. Regions having fewer than 50 records on the NIC list could utilize a paper data collection tool to record information obtained in the follow-up investigation and fax the data collection tool to ODH for reporting. Regions with more than 50 records on the list were required to record the information in an Excel spreadsheet.

The regions were responsible for sorting the NIC list and distributing the appropriate client lists to facility/provider and HIV case management agency partners. Typically, if a 'last touch' agency was known for a client, the regions distributed those records to the appropriate partners, who conducted the D2C follow-up work on behalf of the region. Some regions were able to sort the NIC list by the facility/provider that ordered the most recent CD4 or VL test and distributed those records to the appropriate facility/provider, who conducted the D2C follow-up work on behalf of the region. If neither of those scenarios were applicable, LTC staff and/or DIS, or other LHD staff, conducted the D2C follow-up work themselves.

Figure 4: D2C process mapping



Prioritization: Round One was limited to those persons living with diagnosed HIV who have been diagnosed in the last five years with no evidence of care in the past 12 months. Regions could choose to further prioritize the list based on demographics and/or transmission category. ODH encouraged regions to prioritize persons for D2C follow-up based on the National HIV/AIDS strategy, but also directed regions to use their specific region’s epidemiological data to prioritize the most appropriate populations.

Figure 5: Sample prioritization

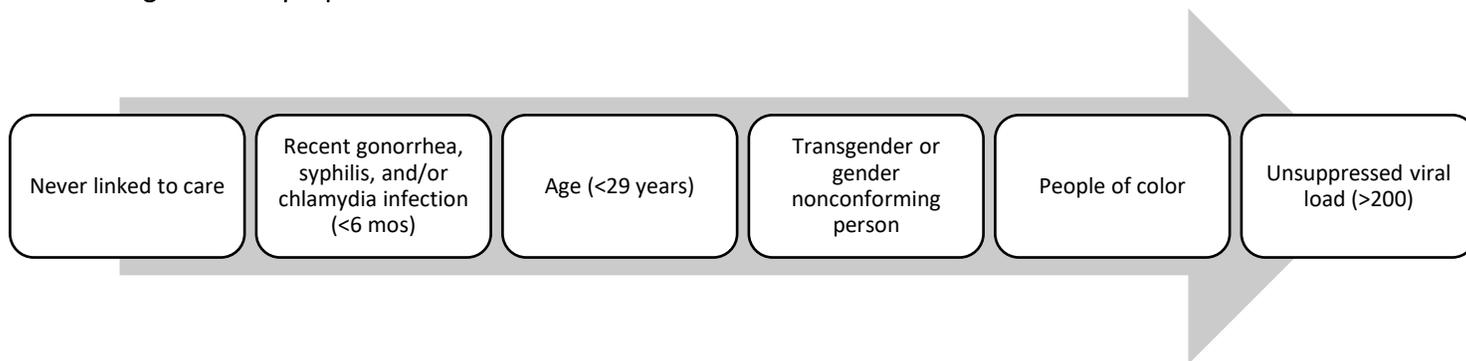


Table 1: Timeline of D2C activities

Activity	Performed By	Date
NIC list generated by ODH	ODH HIV Surveillance Program	Feb; Aug
NIC list distributed to designated regional health department	ODH HIV Surveillance Program	Feb; Aug
NIC list sorted and distributed to regional stakeholders	Regional Health Department	1-2 weeks later
NIC list investigation (all activities)	Regional Health Department and/or facility/provider and HIV case management agency partners	Feb – May; Aug – November
Data due back to regional health department	Facility/provider and HIV case management agency partners	Mid-May; Mid-November
Data reported to ODH Surveillance	Regional Health Department	Late May; Late November
Data reported to CDC	ODH HIV Surveillance Program	June; December

The regions then worked with facility/provider and HIV case management agency partners or independently to follow up on the individuals to determine their care status, re-engage in care and refer

to support services, if necessary. Although it was not required, it was recommended that regions try first to obtain information regarding the client’s care status utilizing accessible data systems, such as RWAD, CAREWare, the Ohio Disease Reporting System (ODRS), Electronic Medical Records (EMR), LexisNexis, the agency’s own database, or other avenues, such as communication with facilities/providers. If this proved unsuccessful, regions were then to attempt to contact the client, first with a letter, then a phone call, or other similar method of contact (e.g., text message, email, social media). If both attempts were unsuccessful, a field visit was recommended.

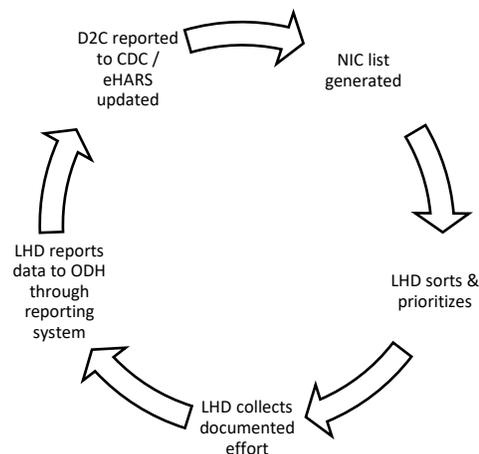
Documenting and reporting data to ODH: Regardless of the method selected for data storage and reporting, regions were responsible for reporting the required variables back to ODH. Even if persons were not investigated due to time or capacity restraints, records were to be reported back to ODH and denoted as not being included in investigation.

Regions with fewer than 50 records on the NIC list utilized a paper data collection tool to record information obtained in the follow-up investigation and faxed the data collection tool to ODH for reporting. Regions with more than 50 records on the list were required to record the information in an Excel spreadsheet. This spreadsheet was reported back to ODH using the same SFTP mechanism the regions used to obtain the NIC list.

If a person was determined to be out of care, regions and their facility/provider and HIV case management agency partners worked to re-engage/link the person into care and make referrals for other support services. If a person was determined to be in care but appeared on the NIC list because the documentation had not been forwarded to ODH, regions documented the appropriate information, such as CD4 and/or VL lab results, and forwarded information about [reporting requirements](#) to the facility/provider that ordered the tests. If a person was found to be living in another state, the region provided updated address information, and the ODH HIV Surveillance program confirmed that information with the relevant state.

Reporting data to CDC: Once the regions reported the data to ODH, staff in the HIV Surveillance program worked to verify and format the data to prepare for import into eHARS. HIV Surveillance staff communicated with counterparts in other states to confirm reported addresses outside of Ohio. The data were transferred to CDC during a routine monthly transfer, occurring in late December 2019.

Figure 6: D2C data cycle



Known challenges: Every effort is made to ensure the accuracy of data housed in eHARS. However, there are some instances where the data are outdated and/or incomplete. It may not be possible to locate a person because of limited or outdated address information. The last known address may contain a city, county, and/or zip code, but not a street address or phone number. There may also be instances where a person is deceased but ODH has not been notified and the person appears to be living and out of care. If a false positive report was reported to ODH, that person may appear on the NIC list if ODH did not receive any follow-up documentation of negative test results. Or the person may be in care, but their labs have not been reported accurately or timely to ODH.

Although regions made every effort to investigate all persons on the NIC list, persons who were not investigated due to time or capacity restraints, or who had no documentation of recent care, will appear on subsequent NIC lists until they have documentation of recent care or are documented as being deceased.

Additionally, persons who appear on the NIC list may actually be receiving care, but those lab results are not appropriately forwarded to the regions, and ultimately ODH. As a result of knowledge gained through this process, regions are taking steps to improve reporting practices in their area by working with local laboratories, facilities, and providers to ensure reporting compliance.

Lessons learned: Invaluable input was obtained from the regions prior to and throughout Round One, and adjustments are being made to improve the process for Round Two. For example, it was found that persons were on the NIC list, but were awaiting upcoming appointments, and thus 12 months may have been too short of a time period to accurately assess if someone had fallen out of care. Additionally, not allowing a choice in the method of reporting data to ODH by either the paper data collection tool, or the Excel spreadsheet, proved to be a barrier for some regions. Based on the outcomes of Round One and the input provided by the regions, the following changes will be made for Round Two:

- The NIC list in Round Two will include persons diagnosed in the last 10 Years (i.e., since 2009) with no evidence of care in the last 18 months.
- Any region may opt to use the data collection tool and submit via fax, or, use the Excel spreadsheet and submit via SFTP site to collect and submit data back to ODH.
- Clearer guidance will be provided to regions regarding completing the data collection tool and Excel spreadsheet. Extra safeguards will be put in place to ensure data validation (e.g., skip patterns, required fields).

Evaluation

Outcomes: During Round One, the NIC list included persons who were diagnosed with HIV in the past five years who did not have evidence of care in the past 12 months. CPH had conducted two prior rounds of D2C, and requested the full NIC list, which included persons ever diagnosed with HIV who did not have evidence of care in the past 12 months. There was a total of 2,434 persons identified on the NIC list during Round One. Ten persons were identified as having been reported with a false positive and were removed from the NIC list. Of those on the NIC list, 854 were prioritized for investigation. Ten persons were found to be deceased, leaving 844 persons investigated. Outreach attempts were made to 317 persons, but there were 390 persons whose care status was able to be determined without any outreach attempts to the client. There were 95 persons who were confirmed to be NIC and of these, 17

percent (n=16) were re-engaged/linked to care. Two percent (n=7) of the persons contacted were also offered a referral to one or more support services, but this is likely highly underestimated, and reflects a low rate of documentation, rather than gap in necessary referrals.

Table 2: Data to care evaluation, Ohio, Round One (8/1/19)

NIC list generated: 08/01/2019	Total	Percent (%)
Total # of persons presumed to be Not-in-Care (NIC) (a):	2,425*	
Total # of persons prioritized for investigation (b): <small>Included for investigation = Yes</small>	854^	35% (b/a)
Total # of persons investigated (c): <small>Included for investigation = Yes and not deceased</small>	844	99% (c/b)
Total # of persons contacted (d): <small>Patient contact/field investigation in addition to or in place of database/record search</small>	317	38% (d/c)
Total # of persons confirmed to be NIC (e): <small>Investigation Disposition = 4 – Not in care</small>	95	11% (e/c)
Total # of persons linked to care (f):	16	17% (f/e)
Total # of persons linked to support services (g):	7	2% (g/d)

*Original total = 2,434. Nine persons removed from NIC list (e.g., false positive).

^10 persons deceased.

Source: Ohio Department of Health, HIV Surveillance Program. Data reported through January 31, 2020.

Outcomes by region: Evaluation was also conducted and displayed by region. It is important to note, however, that the regions vary drastically in terms of morbidity, population, and sometimes reporting compliance. For example, a high number of persons on the NIC list may be indicative of a reporting issue, rather than a linkage to care issue. It is also important to note that CPH requested a NIC list with all persons ever diagnosed with HIV with no evidence of care in the past 12 months, whereas all other regions received a NIC list with persons diagnosed only in the past five years with no evidence of care in the past 12 months.

Figure 7: HIV Prevention-funded regions

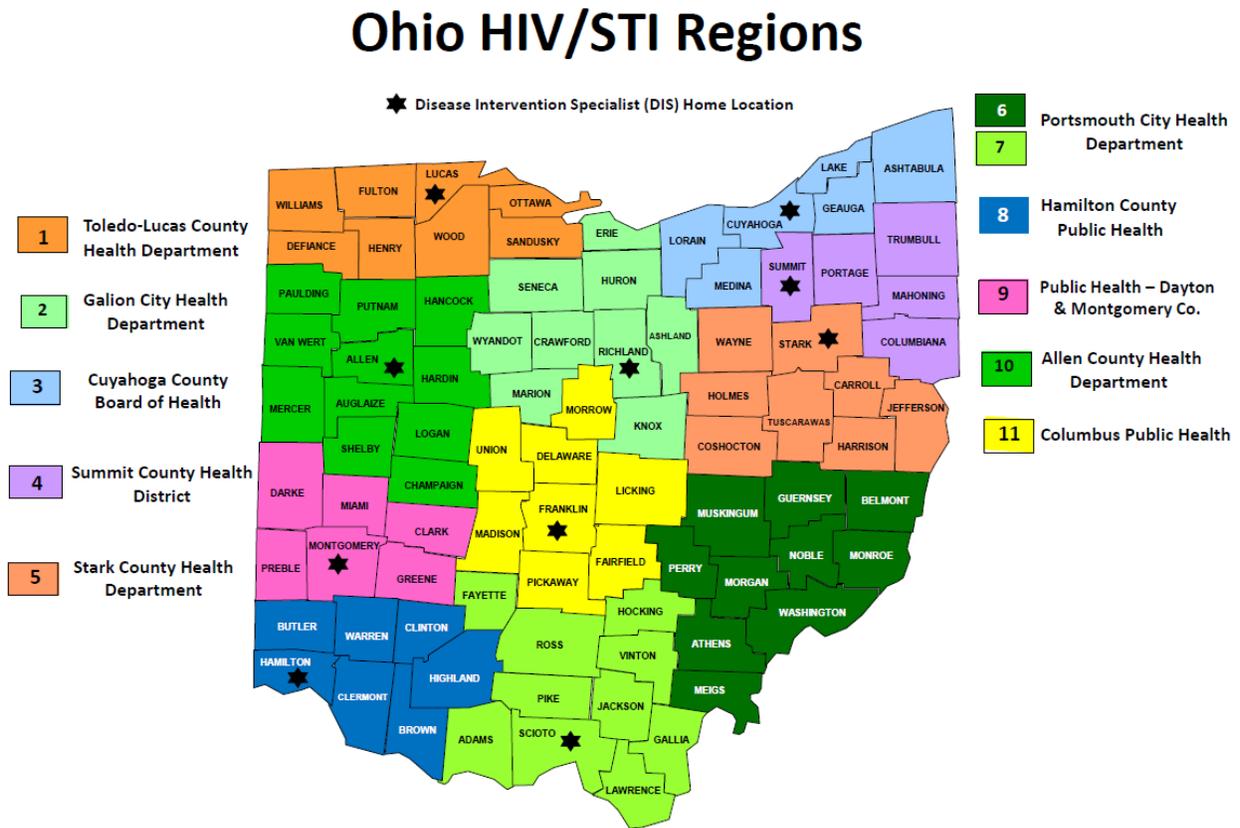


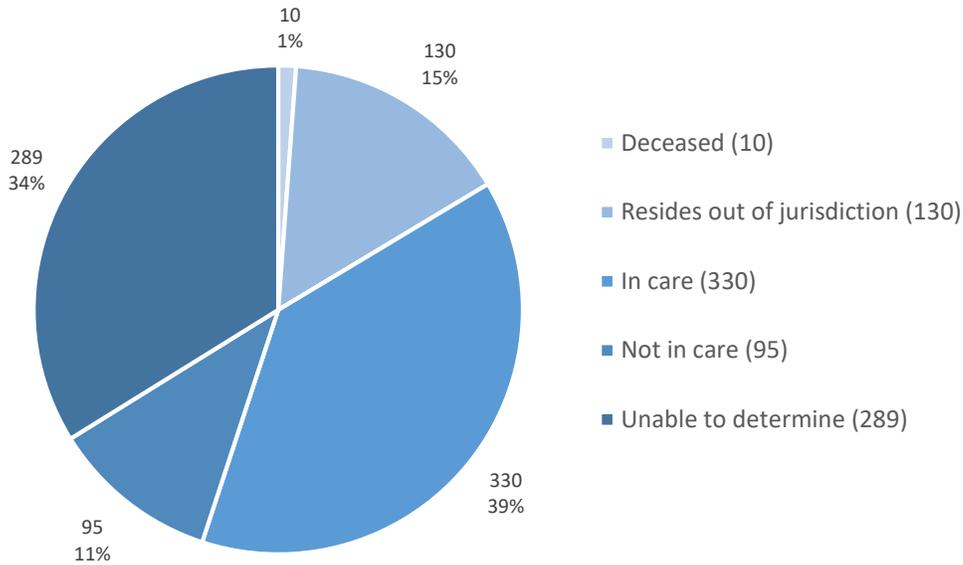
Table 3: Data to care evaluation by Region, Ohio, Round One (8/1/19)

NIC list generated 08/01/2019	Region 1 n(%)	Region 2 n(%)	Region 3 n(%)	Region 4 n(%)	Region 5 n(%)	Region 6 n(%)	Region 7 n(%)	Region 8 n(%)	Region 9 n(%)	Region 10 n(%)	Region 11 n(%)
Total # of persons presumed to be Not-in-Care (NIC):	39	14	207	206	36	22	10	231	73	23	1,564
Total # of persons prioritized for investigation:	39 (100)	13 (93)	151 (73)	161 (78)	36 (100)	22 (100)	10 (100)	229 (99)	59 (81)	23 (100)	111 (7)
Total # of persons investigated:	39 (100)	13 (100)	149 (99)	161 (100)	36 (100)	21 (95)	10 (100)	224 (98)	58 (98)	23 (100)	110 (99)
Total # of persons contacted:	13 (33)	8 (62)	33 (22)	77 (48)	33 (92)	11 (52)	7 (70)	107 (48)	19 (33)	1 (4)	8 (7)
Total # of persons confirmed to be NIC:	4 (10)	2 (15)	29 (19)	29 (18)	4 (11)	0	2 (20)	6 (3)	6 (10)	0	13 (12)
Total # of persons linked to care:	2 (50)	1 (50)	4 (14)	0	2 (50)	0	1 (50)	0	2 (33)	0	4 (31)
Total # of persons linked to support services:	3 (23)	1 (13)	0	1 (1)	1 (3)	0	0	0	1 (5)	0	0

Source: Ohio Department of Health, HIV Surveillance Program. Data reported through January 31, 2020.

Care status: Of the 854 persons prioritized for investigation, one percent (n=10) were deceased. Fifteen percent (n=130) were reported to be residing outside of Ohio, and 39 percent (n=330) were found to be in care. Eleven percent (n=95) were confirmed to be out of care, while the care status was unable to be determined for 34 percent (n=289).

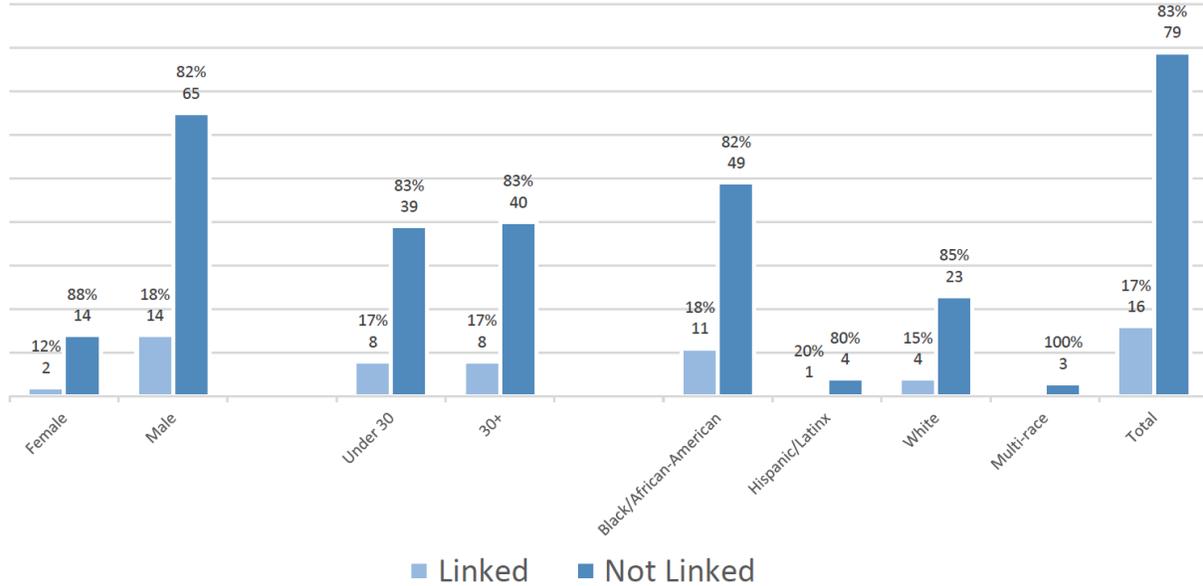
Figure 8: Persons prioritized for investigation (n=854), Ohio, Round One (8/1/19)



Source: Ohio Department of Health, HIV Surveillance Program. Data reported through January 31, 2020.

Confirmed not in care: Of the persons who were confirmed to be not in care, 17 percent (n=16) were re-engaged/linked to care. Twelve percent (n=2) of females confirmed to be not in care were re-engaged/linked to care, while 18 percent (n=14) of males confirmed to be not in care were re-engaged/linked to care. There was no difference in the percent of persons re-engaged/linked to care for persons under age 30 years and those aged 30 years and over; 17 percent (n=8) of both were re-engaged/linked to care. Eighteen percent (n=11) of blacks/African-Americans confirmed to be not in care were re-engaged/linked to care, 20 percent (n=1) of Hispanics/Latinx were re-engaged/linked to care, and 15 percent (n=4) of whites were re-engaged/linked to care.

Figure 9: Persons confirmed not in care (n=95), Ohio, Round One (8/1/19)



Source: Ohio Department of Health, HIV Surveillance Program. Data reported through January 31, 2020.

Barriers: The regions were asked to record barriers faced by the clients that might prevent access to care. This provided good information regarding reasons clients may have fallen out of care. The most common barriers reported were that the client moved (and did not initiate care with a new facility/provider) and transportation. Other barriers listed in the table below were reported a single time by a single individual.

Table 4: Identified client barriers, Ohio, Round One (8/1/19)

Barriers	
Moved (n=8)	Homeless
Transportation (n=3)	Language, transportation
Contact methods (phone gets disconnected)	Medical insurance
Depression	Not comfortable with facility
Fear of recognition	Recently lost job
Financial	Rehab
Heavy drug use, no transportation, mental health issues	Socioeconomic factors- job loss, aging mother, alcohol abuse
History of and current drug abuse, transportation, repeated incarceration	Too busy

Source: Ohio Department of Health, HIV Surveillance Program. Data reported through January 31, 2020.

Follow-up survey: The HIV Prevention program conducted a follow-up qualitative survey with the regions after the conclusion of Round One to gain insight on experiences with the data collection and submission process and working with partners, as well as key takeaways and thoughts and ideas for moving forward. Some notable thoughts:

“Overall a very positive experience.”

“All-in-all, it was a good and worthwhile experience. Re-engaged a few people into HIV care and cleaned up some missing data in ODRS.”

“Partners that we had an established relationship with were willing to help with no questions asked, but partners that we did not have that relationship with were either hesitant, refused to participate out of fear of breaking confidentiality, or unresponsive.”

“This was an easy process as community partners were helpful and engaging.”

“Partners were helpful and generous with staff time for patient identification.”

“Our biggest takeaway was that we needed to hire an HIV Patient Navigator to provide linkage to care and re-engagement. Our DIS did not have time to do partner services and this as well.”

“The few people from the list that fell out of care and were open to assistance getting back into care, or weren’t aware of their positive status and I was able to share that information and help them get into care, made me see the value in this project.”

“Be patient, and get ready to do some digging.”

“That it’s worthwhile, but definitely time consuming. I hope ODH staff realize the high volume of additional work.”

“It was a time consuming process and can be difficult with limited staff.”

Next Steps

Round Two: The second round of D2C will take place from February through June 2020. After incorporating feedback and lessons learned from Round One, adjustments were made for Round Two, making the process smoother and easing the burden for regions. Building upon the success of Round One, the NIC list in Round Two will include persons diagnosed with HIV in the previous 10 years who have no evidence of care in the past 18 months.

Future plans: Moving forward, Ohio plans to move to a new disease reporting system in late 2020, which will be used by the regions to document D2C follow-up activities. Allowing the staff to document the D2C follow-up investigations within a disease reporting system will ensure efficiencies in data collection, reporting, and evaluation. Staffing and capacity at the local level will be evaluated to determine if timelines used to generate the NIC list should be adjusted in future rounds.