Overview

Data to Care (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 Ryan White programs at the Ohio Department of Health (ODH), funded HIV/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.

This protocol applies to agencies in Ohio receiving HIV/STI prevention funds and/or materials through the Ohio Department of Health (ODH) HIV and STI Prevention Programs. The protocol is aligned with the National HIV/AIDS Strategy (NHAS) whose three primary goals are: 1.) reducing the number of people who become infected with HIV; 2.) increasing access to care and improving health outcomes for people living with HIV; and 3.) reducing HIV-related health disparities and health inequities. This protocol also aligns with NHAS to achieve a coordinated response to the HIV epidemic by acting as a companion to the HIV Counseling, Testing, and Referral (CTR) Protocol, the Priority-based Testing Protocol, Linkage to Care Protocol and the Disease Intervention Specialist Standard Operating Procedures. This protocol is subject to change and will be reviewed annually.

PLWH who are not in care are at a greater risk for poor health outcomes, premature death and transmitting HIV. D2C reflects a shift from the standard use of HIV surveillance data to monitor and characterize the HIV epidemic to utilizing data to improve health outcomes for PLWH. The ultimate goals of ODH-funded D2C is to increase engagement in HIV care and achieve viral suppression. 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.

Prior to following-up with those persons identified to be out of care, re-engagement staff should be trained on the D2C protocol, data collection tools, confidentiality and data security, and reporting procedures.

Creating the NIC List

To facilitate D2C activities in the State of Ohio, ODH HIV Surveillance, Prevention and Care departments will collaborate to create a list of individuals identified as “Not-in-Care” or a NIC list.

To generate a presumptive NIC list, records are pulled from the Enhanced HIV/AIDS Reporting System (eHARS) that have 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). This high-level of quality will be integral when working to locate individuals.

The NIC list is divided by region (according to patient's last known residence) and includes demographics, information on last known address, last reported CD4 and/or VL test and provider/facility, and other information, and will be distributed via an encrypted, password-protected file.

For the State of Ohio, someone will be designated as **not in care** if they are:

- Living with diagnosed HIV and;
- Have a noted last known address in Ohio and;
- Have no documented HIV labs within the last 12 months;

Using Public Health Data

Public health surveillance has been defined as "the ongoing, systematic collection, analysis and interpretation of health-related data with the…purpose of preventing or controlling disease or injury and identifying unusual events of public health importance, followed by the dissemination and use of such information for public health action"[1]. Public health surveillance data is often collected without requiring individual patient consent. This practice is ethically and legally justified as a part of a government's responsibility to protect the public's health[2]. These justifications are strengthened by the state's responsibility to use data for public health purposes only, engage stakeholders and ensure protection of personal information.

In Ohio, it is mandated that healthcare and/or laboratory professionals notify public health authorities of cases of HIV within a specific timeframe. The ODH-funded local health district is considered the reporting authority for each of Ohio's regions.

County	Designated Local Health District for HIV Reporting
Defiance, Fulton, Henry, Lucas, Ottawa, Sandusky, Williams, Wood	Region 1: Toledo-Lucas County Health Department
Ashland, Crawford, Erie, Huron, Knox, Marion, Richland, Seneca, Wyandot	Region 2: Galion City Health Department
Ashtabula, Cuyahoga, Geauga, Lake, Lorain, Medina	Region 3: Cuyahoga County Board of Health
Columbiana, Mahoning, Portage, Summit, Trumbull	Region 4: Summit County Public Health
Carroll, Coshocton, Harrison, Holmes, Jefferson, Stark, Tuscarawas, Wayne	Region 5: Canton City Health Department
Athens, Belmont, Guernsey, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Washington, Adams, Fayette, Gallia, Jackson, Hocking, Lawrence, Pike, Ross, Scioto, Vinton	Region 6 & 7: Portsmouth City Health Department

[1] Lee LM, Thacker SB. Public health surveillance and knowing about health in the context of growing sources of health data. Am J Prev Med. 2011;41:636–40.

[2] Lee LM, Heilig CM, White A. Ethical justification for conducting public health surveillance without patient consent. Am J Public Health. 2012;102:38–44.

Brown, Butler, Clermont, Clinton, Hamilton, Highland, Warren	Region 8: Hamilton County Public Health
Clark, Darke, Greene, Miami, Montgomery, Preble	Region 9: Public Health -Dayton & Montgomery County
Allen, Auglaize, Champaign, Hancock, Hardin, Logan, Mercer, Paulding, Putnam, Shelby, Van Wert	Region 10: Allen County Health Department
Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, Union	Region 11: Columbus Public Health

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. All partners should be made aware and comply with security and confidentiality guidelines and protocols, including how data should be transferred, stored, and used.

All regional staff, as well as partner agency staff, who will have access to the NIC list will receive a Data Security and Confidentiality training and be required to sign a data sharing agreement.

Data Limitations

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 our Surveillance program. In any of these instances, or similar scenarios, please document any available information when reporting data back to ODH.

A note on incarcerated populations: the current residence information included for persons on the NIC list is the most updated residence information available, which may include jails and state and federal correctional facilities. It is possible that an incarcerated individual was released but an updated residence was not available or forwarded to ODH. If the last known address of a person on the NIC list is a state or federal prison, it will be denoted with the variable prison as 'Currently in prison.' If the last known address of a person on the NIC list is jail, it will have the street address of the jail, but not otherwise be denoted. The following websites may be useful for obtaining information on individuals incarcerated in state or federal prison:

- Ohio: https://appgateway.drc.ohio.gov/OffenderSearch
- Federal: https://www.bop.gov/inmateloc/

NIC List Distribution

Receiving the List

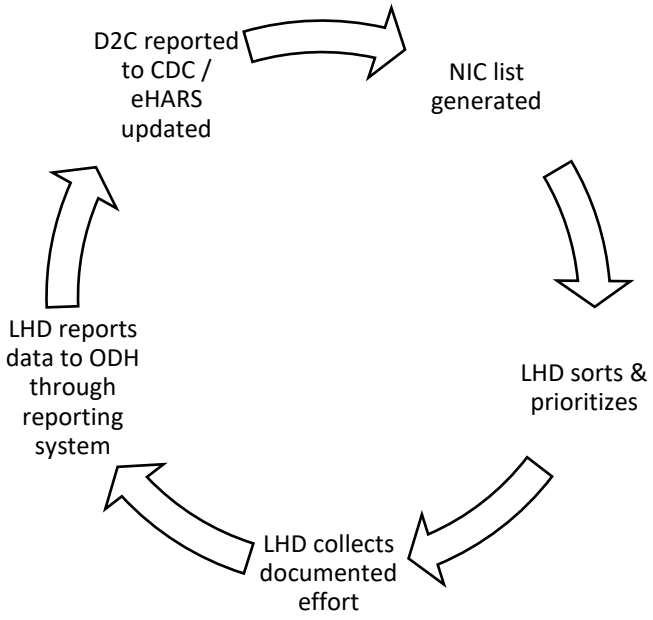
All regions will receive the NIC list in person via an encrypted, password-protected Excel File. Depending on each region's existing capacity, available systems for storing the NIC list, and total number of persons on the NIC list, regions may utilize different options for storing and working through the NIC list. Regions will complete Appendix A to indicate their selections. For example, in a pilot of D2C, the Columbus Public Health Part A program received a NIC list via a password-protected Excel File and uploaded the list into their local version of CareWare.

- **Careware:** CareWare may be utilized to upload the NIC list, store the data, track the clients, record the required variables, and output the information required to be reported to ODH (specifications below) into the original Excel document.
- **Excel:** Regions may choose to work through the NIC list using the provided Excel file, adding the required variables and submitting the updated Excel file back to ODH. Regions can submit the file via a Secure File Transfer Protocol (SFTP) site. Further guidance will be forthcoming for regions who select this option.
- **Paper:** Regions that have 50 or fewer records on the NIC list may choose to work through the list using the provided Excel file and record information using a paper version of the data collection tool (Appendix B). The forms can be securely faxed to HIV Surveillance (**614-564-2427**) for entry into eHARS.

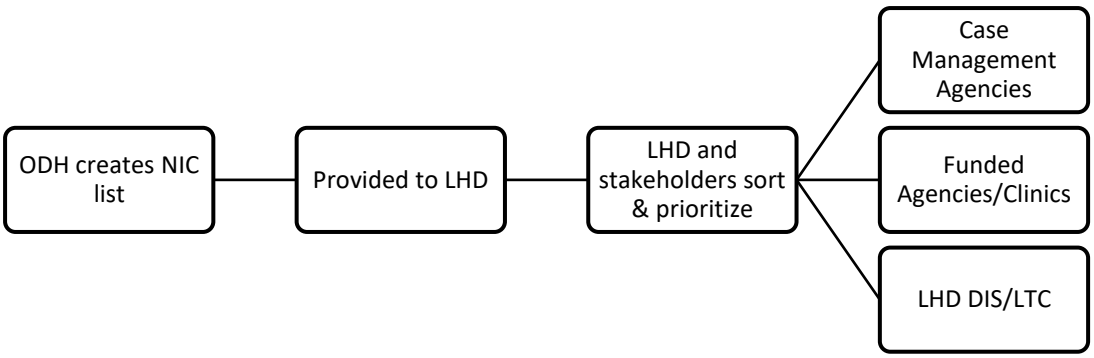
Sorting the NIC List

The LHD will be responsible for sorting the NIC list and distributing the appropriate client lists to stakeholders which have agreed to take part in D2C efforts and have completed the required trainings. The LHD may sort and distribute the appropriate clients to service providers within their region which have provided care or case management services to the client. The provider's "last touch" is determined by the last documented encounter with a client (i.e., labs ordered/performed, case management update, medication prescribed, etc.) $\leq$ 5 years. For those PLWH who have never been linked to a service provider, DIS/LTC, or other public health staff will be designated to follow-up. This aligns with the CDC's "Combination Health Department/Healthcare Provider Model." For those clients who have access Ryan White case management services, the last documented encounter will be noted from a match with our CareWare database team.

Below is the data cycle in D2C:



It is important to remember that a NIC list is a snap shot of information; it is only relevant for a short period of time. Due to the nature of a NIC list, once created, it requires near immediate action to distribute and perform re-engagement activities. Because of this, LHDs will sort and distribute individuals to their identified service providers within two weeks of receipt. The LHD should lead collaborations between local stakeholders to assign and distribute the NIC list based on need and capacity.



If the client is enrolled in case management, the client's agency should be notified so they may prioritize them for re-engagement or to update the data provided on the NIC list.

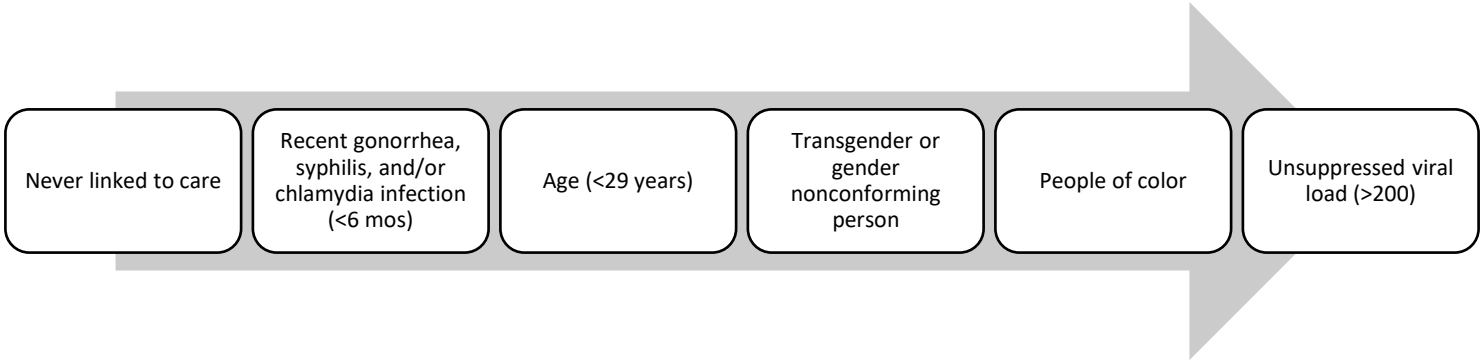
If the client is **not** enrolled in case management, designated staff may contact the last known provider (if possible) to re-engage the client (their patient). If the provider is unable to follow-up or declines, the designated staff should attempt to locate and re-engage the client.

Prioritizing the NIC List

The first iteration of NIC list will be 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 may choose to further prioritize the list based on demographics and/or transmission category. Although regions should make every effort to investigate all persons on the NIC list, persons who were not investigated due to time or capacity restraints, or who have no documentation of recent care, will appear on subsequent NIC lists until they have documentation of recent care or are documented as being deceased.

Consistent with the National HIV/AIDS strategy, below is a recommended prioritization for engaging with cases. Prioritization attempts to maximize the benefit for the individual's health and minimize HIV transmission in communities. Regions are encouraged to use this as a guideline but should consult their specific region's epidemiological data and determine the most appropriate prioritization within their priority populations that considers their disease burden and resources.

Sample prioritization from highest to lowest:



Documenting Re-Engaging Clients in Care

Documenting information in a timely manner ensures that future NIC lists will be as accurate as possible and reduces duplicate efforts. Whether it be case management, re-engagement specialists, linkage to care, nurses, DIS, or other public health workers, initiating D2C activities immediately will positively impact the effort.

Below are the general standards for executing and documenting re-engagement activities in a timely manner:

1. Data collection method identified.
2. Case initiated within two weeks of receipt.
3. Initial contact attempt made.
4. Re-engagement activities completed within 60 days of case initiation.
5. Re-engagement activities entered into the data collection tool as conducted (within two business days from encounter).
6. Regional data storage/reporting system updated no later than two weeks after the final attempt/activity.
7. Review both completed and unresolved cases two weeks before the reporting deadline. All efforts to re-engage or update contact information should be recorded.

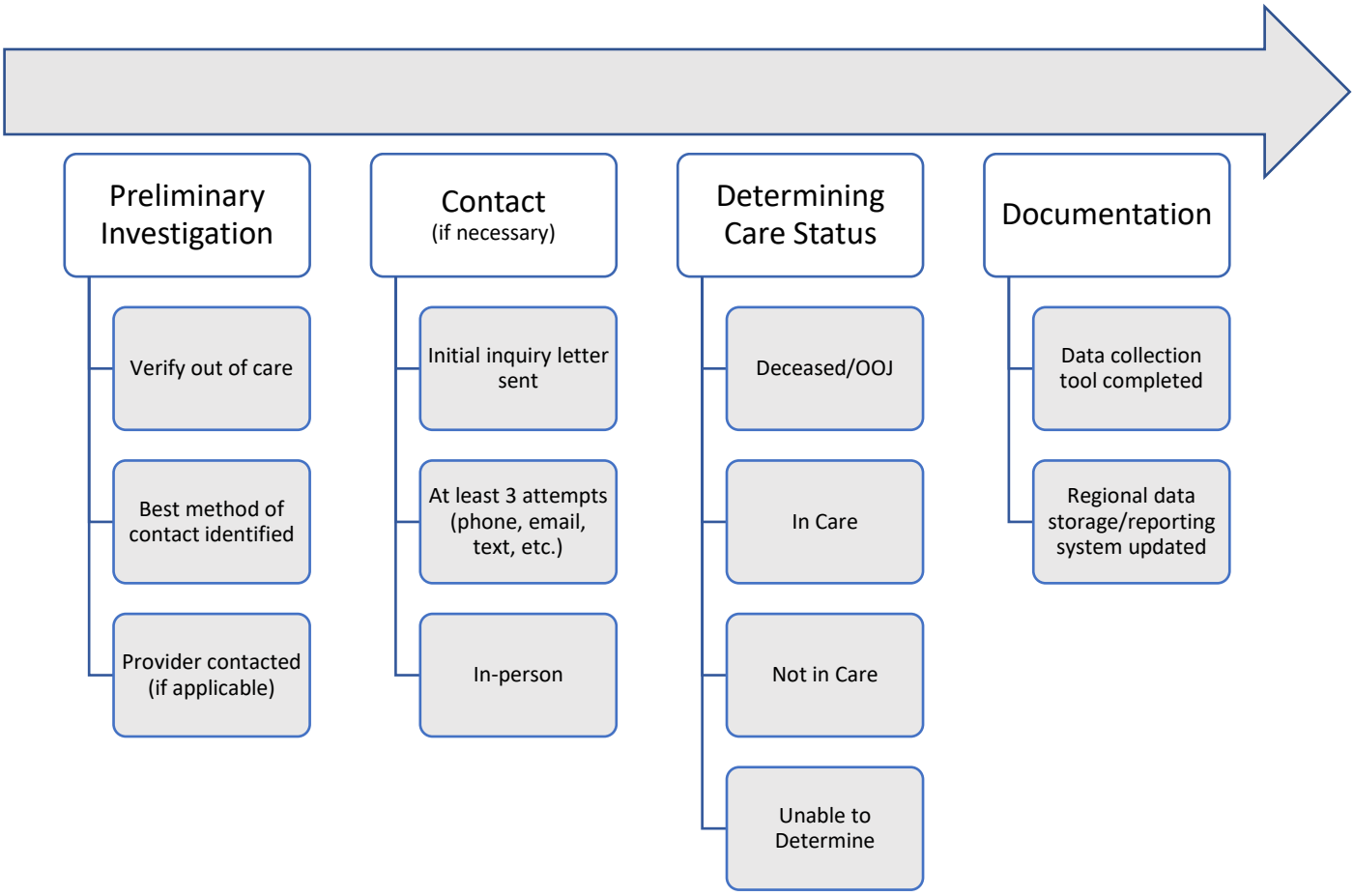
Conducting Re-Engagement

Good linkage requires individuals perform preliminary activities such as verifying out of care status, correct/most current address, identifying the client's last known service provider (if applicable) and the best method of contact. Contact may not be necessary if you are able to verify the client is engaged in care.

After the preliminary activities, an initial inquiry letter is sent to all known addresses (Appendix E), staff should make, at minimum, three additional attempts to contact a client (see sample phone script tool: Appendix F). These attempts should start no sooner than three days after an initial inquiry letter has been sent. It is important that a client's previous preferred contact method is identified and prioritized. Staff must exhaust all possible avenues until they either locate and speak with the client or determine that a client is in care, deceased, has moved out of state, or is unable to be located. Staff should only use methodologies consistent with their agency's standard practices and policies. Contact methods could include: review of internal medical records/databases, phone calls, text messages, emails, letters, field visits, and social media (see ODH DIS Standard Operating Procedures for guidance). Staff should attempt to make at least one face-to-face encounter with the client. **In no circumstances will staff discuss HIV without verifying identity.**

Suggested software access and tools for preliminary and re-engagement activities:

- RWAD (Ryan White Application Database)
- CAREWare
- Organization's data collection tool (i.e., ETO, RedCap, etc.)
- ODRS (if available)
- Electronic Medical/Health Records (EMR/EHRs)
- Medicaid data (if accessible)
- LexisNexis
- MOUs with regional partners for care coordination
- Established list of contacts within regional partners for future referral
- Cell phone/tablet for texting or use of social media



Client-Centered Linkage

Assess the client's readiness to re-engage in HIV medical care and/or other essential services. If the client agrees that they are ready to access HIV medical care, use the ODH HIV Linkage model to develop a plan. (see ODH HIV Linkage to Care Protocol).

1. Identify and prioritize referral needs – Your goal of connecting a client to HIV medical care may not align with their priorities.
   - Identify your client's greatest needs and provide necessary active referrals to accomplish the primary goal.
   - Service providers should aim to coordinate care and referrals alongside of a client's priorities to increase adherence to a referral plan.
2. Develop a plan
   - Elicit the client's strengths that can be used to achieve the plan.
   - Help clients identify potential challenges and barriers they may have in completing their plan and develop strategies to overcome these challenges.
   - Identify methods to use to help the client achieve their goals.
   - Consider holistic wellness. Together, plan how referrals will impact the client accessing care and successful future engagement in care.

Below is an example plan. Your plan may look less formal but should follow the same principle. Please note; the term "LTC" in the example could refer to anyone performing re-engagement activities (case management, re-engagement specialists, linkage to care, nurses, DIS, or other public health workers)

Goal: Re-engagement into Medical Care

Objective: Attend re-engagement medical appointment

Activity		Strengths and resources	Potential barriers	Solutions to barriers and challenges	Completion date	Person(s) responsible
1	Schedule doctor's appointment	-doctor's info - my cell phone	-lost info -out of minutes	-call LTC for info -email LTC to call doctor's office	September 6th, 2019	Client Maybe: LTC
2	Reminder of doctor's appointment	-service provider	-LTC can't call me	-LTC will email me	September 8th, 2019 in the morning	LTC
3	Set-up childcare	-Mom	-Mom is busy	-ask Brother	Today	Client & Mom Maybe: Brother
3	Go to doctor's appointment	-my car	-may be low on gas	-ask LTC for a gas card	September 9th, 2019	Client Maybe: LTC

Finally, plan how information will be communicated between client and service provider in the future. It is important that all documentation required to communicate with the client, and/or their designated contacts, be completed and a copy given to the client in addition to the copy that is kept in the service provider's file. Below is an example:

I prefer to be notified about appointments by:		I prefer to be notified about my diagnosis by being:	If I need to get in touch with my coordinator, I will:	If you can't reach me, you can contact:
1	Text	Called	Email them	Mom
2	Phone	Sent a letter	Call them	Brother

3. Facilitate access to services
   - Provide client with support needed to access referrals.
   - Ensure active referrals are culturally appropriate regarding the client's resources, age, gender, race, ethnicity, sexual orientation and per the client's request.
4. Follow-up - Consistent and regular follow-up is a valuable tool in eliminating barriers and challenges which increases adherence and engagement.
   - Assess client's ability to adhere to their appointments, treatment and medications.
   - Agree on a schedule for follow-up if necessary.
   - Confirm successful referrals and document linkage

Successful re-engagement is defined by the following outcomes:

- Client attends an HIV-specific appointment.
- Client has necessary lab-work completed to document CD4 count and a viral load.
- Eligibility determined for Ryan White services (e.g. case management, housing, AHDAP).
- Assessment and referrals for needed essential support services.
- Assessment of client's acuity to engage in their care past short-term health navigation and provide long-term service referrals if needed (i.e. re-engagement with case management or medical providers).

Reporting on D2C

Regardless of the method selected for data storage and reporting, regions are responsible for reporting the required variables back to ODH. Even if persons were not investigated due to time or capacity restraints, records must be reported back to ODH and denoted as not being included in investigation (invest incl = N). Regions may report information back to ODH in an Excel file submitted via a Secure File Transfer Protocol (SFTP) site. Further guidance will be forthcoming for regions who select this option.

Note: Whether regions report information back via the Excel file or faxing paper records, at minimum, the patient's state no (or other identifiers such as last name, first name, and date of birth) must be included to ensure accurate reporting.

- If a person is determined to be out of care, regions and case management agencies will work to re-engage/link the person into care and assist with other service referrals.
- If a person is determined to be in care but appeared on the NIC list because the documentation was not forwarded to ODH, regions will document the appropriate information, such as recent lab results. Forward information about reporting requirements to facility/provider that ordered the lab tests.

  Note on Reporting Requirements: As a reminder, health care providers in Ohio who diagnose and/or provide medical treatment to persons with HIV infection are required to report HIV diagnostic and associated prognostic lab results (e.g., viral load, CD4), as well as other pertinent information (e.g., risk factors/mode of transmission) on their patients/clients in accordance with Ohio Administrative Rule (OAC) 3701-3-12 and divisions (B) and (C) of section 3701.24 of the Ohio Revised Code (ORC). This information is critical for monitoring trends in HIV infection on a population level, including targeting prevention interventions, identifying persons who may have fallen out of care for linkage and re-engagement, and to support the determination of HIV resource allocations throughout state. More detailed information on public health reporting of HIV infections is available at: https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/infectious-disease-control-manual/section3/section-3-hiv-aids.

- If a person is found to be living in another state, provide as much address information as is available.
- If a person is found to be living in a different region within Ohio, provide as much information as is available, AND, communicate that information to the applicable region.

Information regarding the care status and other data will be communicated back to ODH and imported into eHARS, thus completing the feedback loop to HIV Surveillance. Moving forward, the presumptive NIC list will be generated twice a year (timeline to be determined).

In addition to the measures calculated using the CDC-required variables, ODH will be monitoring progress of D2C efforts using the following measurements:

Region:	**NIC list generated: MM/DD/YYYY**
Total # of persons presumed to be Not-in-Care (NIC):	
Total # of persons prioritized for outreach:	
Total # of persons investigated:	
Total # of persons contacted:	
Total # of persons confirmed to be NIC:	
Total # of persons linked to care:	
Total # of persons linked to support services:	

D2C Timeline

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 community partners	Feb – May; Aug – November
Data due back to regional health department	Facility/provider and community 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

Appendix A: Data Storage and Reporting Options to be communicated to ODH

Fax to HIV Surveillance at **614-564-2427** (Attn: Rhiannon Richman) or scan and email to Rhiannon.Richman@odh.ohio.gov.

Region: Click here to enter text.

Number of persons living with diagnosed HIV diagnosed in the last five years with no evidence of care in the past 12 months (i.e., how many persons are on the NIC list): Click here to enter text.

D2C Contact Person: Click here to enter text.

D2C Contact Phone: Click here to enter text.

D2C Contact Email: Click here to enter text.

D2C Data Storage (which option will your region select to store the data once you receive the NIC list?)**:**

☐Excel ☐CareWare

D2C Reporting Method (which option will your region select to report the required variables back to ODH?)**:**

☐Excel

☐ Individual paper data collection tools faxed to ODH Surveillance (only if <50 cases)

Appendix B: Data Collection Tool

Data to Care Data Collection Tool—Fax to HIV Surveillance (614-564-2427)			
State no:	**DOB:** (MM/DD/YYYY)	**Alias:**	
Last Name:	**First Name:**	**M.I.**	
Address Date: (MM/DD/YYYY)	**Phone Number:**		
Street:	**City:**		
County:	**State:**	**Zip:**	
How person was first identified as not in care (invest_ident_method): ☒ 02 – Health department integrated data system	**Date identified as not in care** (invest_ident_dt): 8/1/2019		
Included for investigation (invest_incl)? ☐ Yes ☐ No	**Date investigation opened** (invest_start_dt)**:**		
Disposition, care status investigation (invest_dispo)**:** ☐ 1 – Deceased ☐ 4 – Not in care (confirmed) ☐ 2 – Resides out of jurisdiction (other state) ☐ 5 – Unable to determine ☐ 3 – In care	**Investigation disposition date** (invest_dispo_dt)**:**		
Basis of care status disposition (invest_dispo_dt)**:** ☐ 1 – Database/record search only ☐ 3 – Database/record search and patient contact/field investigation ☐ 2 – Patient contact/field investigation only			
Disposition, linkage or re-engagement intervention (int_dispo)**:** ☐ 1 – No intervention initiated ☐ 2 – Linkage/re-engagement intervention declined by client ☐ 3 – Returned to care before intervention was initiated (enter date) ☐ 4 – Linkage/re-engagement initiated, not successfully linked to/re-engaged in care ☐ 5 – Linked to/re-engaged in care, documented* (enter date) ☐ 6 – Linked to/re-engaged in care, self-report (enter date) ☐ 7 – Linkage/re-engagement status unknown	**Date returned to, linked to, or re-engaged in care** (int_dispo_dt)**:** *Examples of types of documentation: laboratory data, report from medical provider (verbal or written), medical record review, other record review, other database, ARV prescription filled or refilled.		
Updated CD4 information:			
Performing Laboratory:	**Ordering Facility:**	**Ordering Provider:** (last, first)	
Date of specimen collection: (MM/DD/YYYY)	**CD4 Count:**	**CD4 Percent:**	
Updated VL information:			
Performing Laboratory:	**Ordering Facility:**	**Ordering Provider:** (last, first)	
Date of specimen collection: (MM/DD/YYYY)	**VL Result:**		
Additional information:			
Evidence of Care other than CD4/VL: (e.g., ARV use (list specific drug), case management visit, etc.) and source of information (e.g., EMR):		**Date of other care:** (MM/DD/YYYY)	
Barriers (if applicable, list any barriers faced by client that might prevent access to care):			
Referrals (if applicable, select all that apply): ☐ Behavioral Health Services ☐ Health Benefits Navigation and Enrollment ☐ Medication Adherence ☐ Social Services ☐ Other _____			
Comments (Record any additional information (e.g., sex, race/ethnicity, gender, risk (if missing), death date if deceased, etc.)**:**			

Appendix C: Data Dictionary for fields included in the NIC list (i.e., what regions will receive)

Variable Name	Description	Values/Format
RWagency	Ryan White Agency	
lastRWdate	Date of 'last touch' at Ryan White Agency	MM/DD/YYYY
stateno	State patient number	
last_name	Patient's last name	
first_name	Patient's first name	
middle_name	Patient's middle name or initial	
dob	Date of birth	YYYYMMDD Missing = .
cur_age	Patient's age as of date NIC list was generated	In years
birth_sex	The patient's sex at birth	(M)Male (F)Female
current_gender	The patient's current gender identity	(AD) Additional gender identity (F)Female (FM) Transgender—Female to male (M)Male (MF)Transgender—Male to female (U)Unknown
hiv_aids_dt	Earliest date of diagnosis	MM/DD/YY
newrace	The race of the patient	(1)American Indian/Alaska Native (2)Asian/Pacific Islander (3)Black, not Hispanic (4)Hispanic (5)White, not Hispanic (6)Multi-race (9)Unknown
trans_categ	Transmission category This calculated variable represents HIV exposure, based on a group of risk behaviors. The risk factors are grouped by adult and pediatric, based on the patient's age at diagnosis of HIV. The selection of the most likely route of transmission is based on a presumed hierarchical order of transmission.	(01)Adult male sexual cntct male (MSM) (02)Adult injection drug use (IDU) (03)Adult MSM & IDU (04)Adult rcvd clotting factor (05)Adult heterosexual contact (06)Adult rcvd transfusion/transplant (07)Perinatal exposure w/HIV age 13+ yrs (09)Adult no identified risk factor (NIR) (10)Adult no risk factor reported (NRR) (11)Child rcvd clotting factor (12)Perinatal exposure (19)Child no identified risk factor (NIR) (20)Child no risk factor reported (NRR)
dx_status	Diagnostic status	(1)Adult HIV (2)Adult AIDS (4)Pediatric HIV (5)Pediatric AIDS
prison	Prison status	Currently in Prison or blank
cur_street_address1	Street address of current residence	
cur_street_address2	Street address of current residence (line 2)	
cur_city_name	City of current residence	
cur_county_name	County of current residence	
cur_state_cd	State of current residence	
cur_zip_cd	ZIP Code of current residence	99999 999999999
cur_phone	Phone number of current residence	
cur_address_dt	The date the person was known to be living at the current address	YYYYMMDD Missing = .
hf_name1	Name1 of facility at HIV diagnosis	
hf_city_name	City of facility at HIV diagnosis	
hf_state_cd	State of facility at HIV diagnosis	
hf_provider_last_name	Last name of provider at HIV diagnosis	
hf_provider_first_name	First name of provider at HIV diagnosis	
af_name1	Name1 of facility at AIDS diagnosis	
af_city_name	City of facility at AIDS diagnosis	
af_state_cd	State of facility at AIDS diagnosis	
af_provider_last_name	Last name of provider at AIDS diagnosis	
af_provider_first_name	First name of provider at AIDS diagnosis	
cd4_recent_cnt_dt	Date of most recent CD4 count	YYYYMMDD

Variable Name	Description	Values/Format
		Missing = .
cd4_recent_cnt_value	Value of most recent CD4 count	
cd4_recent_pct_dt	Date of most recent CD4 percent	YYYYMMDD Missing = .
cd4_recent_pct_value	Value of most recent CD4 percent	
cd4cntnotes	Notes or comments regarding the cd4 count (cd4cnt). Provider/Facility information is sometimes included	
cd4cntfacname1	Name1 of facility that ordered the cd4cnt	
cd4cntfaccity	City of facility that ordered the cd4cnt	
cd4cntfacstate	State of facility that ordered the cd4cnt	
cd4cntprovlname	Last name of provider that ordered the cd4cnt	
cd4cntprovfname	First name of provider that ordered the cd4cnt	
cd4pctnotes	Notes or comments regarding the cd4 percent (cd4pct). Provider/Facility information is sometimes included	
cd4pctfacname1	Name1 of facility that ordered the cd4pct	
cd4pctfaccity	City of facility that ordered the cd4pct	
cd4pctfacstate	State of facility that ordered the cd4pct	
cd4pctprovlname	Last name of provider that ordered the cd4pct	
cd4pctprovfname	First name of provider that ordered the cd4pct	
vl_recent_dt	Date of most recent viral load	YYYYMMDD Missing = .
vl_recent_value	Value of most recent viral load	
vlnotes	Notes or comments regarding the viral load (vl). Provider/Facility information is sometimes included	
vlfacname1	Name1 of facility that ordered the vl	
vlfaccity	City of facility that ordered the vl	
vlfacstate	State of facility that ordered the vl	
vlprovlname	Last name of provider that ordered the vl	
vlprovfname	First name of provider that ordered the vl	
If a digit of a date is missing, it is indicated by a '.', even if the other digits are present (e.g., 200905.. when a date is missing but the year and month are known).		

Notes on facility names:

IP = Inpatient
MC = Medical Center
OP = Outpatient
OOS = Out of State
PPCOU = Private Physician, first three letters of County

Appendix D: Reporting D2C Variables to ODH-File Layout for required fields to be reported back to ODH.

Note: Whether regions report information back via the Excel file or faxing paper records, at minimum, the patient's state no (or other identifiers such as last name, first name, and date of birth) must be included to ensure accurate reporting.

D2C variables required by CDC	
Variable Description and Name	**Notes**
How person was first identified as not in care? (invest_ident_method)	02 – Health department integrated data system *Populated by ODH.*
Date first identified as not in care (invest_ident_dt)	MM/DD/YYYY *Populated by ODH as the date the NIC list was generated.*
Included for investigation? (invest_incl)	Y – Included in investigation N – Excluded from investigation *All records should be populated as 'Y' unless prioritization method was used and some records were not investigated.*
Date investigation opened (invest_start_dt)	MM/DD/YYYY *Date the investigation was started for that person.*
Disposition, care status investigation (invest_dispo)	1 – Deceased 2 – Resides out of jurisdiction (a different state, not another jurisdiction within Ohio) 3 – In care (there is evidence that the person in receiving regular HIV care (e.g., lab results, self-report, prescription)) 4 – Not in care (confirmed with the person) 5 – Unable to determine *Result of the investigation. Please note this is **NOT** referring to the disposition of a Field Record initiated by a Disease Intervention Specialist in ODRS, but rather the result of the investigation into the person's care status.*
Investigation disposition date (invest_dispo_dt)	MM/DD/YYYY *Date care status was determined.*
Basis of care status disposition (invest_dispo_method)	1 – Database/record search ONLY 2 – Patient contact/field investigation ONLY 3 – Database/record search AND patient contact/field investigation *How was the care status disposition determined?*

Disposition, linkage or re-engagement intervention (int_dispo)	1 – No intervention initiated (program did not offer any linkage or re-engagement intervention to the client) 2 – Linkage/re-engagement intervention declined by client (program offered intervention, but it was declined by the client) 3 – Returned to care before intervention was initiated (client entered or resumed care without any additional linkage intervention) 4 – Linkage/re-engagement intervention initiated, not successfully linked to/re-engaged in care (client did not enter or resume care, despite the program's intervention efforts) 5 – Linked to/re-engaged in care, documented (client was linked to/re-engaged in care, confirmed by documented lab results, medical provider report (verbal or written), medical or other record review, other database, ARV prescription filled of refilled) 6 – Linked to/re-engaged in care, client self-report (client was linked to/re-engaged in care, determined by client's self-report) 7 – Linkage/re-engagement status unknown *The outcome of the linkage/re-engagement attempt. Linkage or re-engagement is defined as an action taken by the program to facilitate a client's entry or re-entry into HIV medical care (e.g., ARTAS, scheduling the appointment, reminding the client of the appointment, accompanying the client to their appointment, follow-up to ensure that the appointment took place). Linked to or re-engaged in care is defined as the client attending an appointment for HIV medical care after having been identified as being NIC.*
Date returned to, linked to, or re-engaged in care (int_dispo_dt)	MM/DD/YYYY *If linkage/re-engagement was confirmed: Date of documented evidence that client attended an HIV medical care appointment, received a lab test, or had ARV prescription filled or refilled.* *If linkage/re-engagement was determined by client self-report: Date client reports having attended an HIV medical care appointment.*
D2C variables required by ODH	
alias	*Alias name of client*
address_date	MM/DD/YYYY Current address as of date
telephone	*Current phone number*
street	*Current street address of residence*
city	*Current city of residence*
county	*Current county of residence*
state	*Current state of residence*
zip	*Current zip of residence*
labcd4	*Laboratory that performed the CD4 test*
facilitycd4	*Ordering facility of CD4 test*
providercd4	*Ordering provider (last, first) of CD4 test*
collectdtcd4	MM/DD/YYYY *Date of specimen collection of CD4 test*
cd4county	*CD4 count result*
cd4percent	*CD4 percent result*
labvl	*Laboratory that performed the VL test*
facilityvl	*Ordering facility of VL test*

providervl	*Ordering provider (last, first) of VL test*
collectdtvl	*MM/DD/YYYY* *Date of specimen collection of VL test*
viralloadresult	*VL result*
othercare	*Evidence of care other than CD4/VL (ART use (list specific drug), case management visit, etc.) and source of information*
othercaredate	MM/DD/YYYY *Date of evidence of care other than CD4/VL*
barriers	*List any barriers faced by client that might prevent access to care (if applicable)*
refbehhlth	Y – Referred for Behavioral Health Services N – Not Referred for Behavioral Health Services *If applicable*
refhlthben	Y – Referred for Health Benefits Navigation and Enrollment N – Not Referred for Health Benefits Navigation and Enrollment *If applicable*
refmedad	Y – Referred for Medication Adherence N – Not Referred for Medication Adherence *If applicable*
refsocserv	Y – Referred for Social Services N – Not Referred for Social Services *If applicable*
refother	Y – Referred for Other Services N – Not Referred for Other Services *If applicable*
comments	Record any additional information (e.g., sex, race/ethnicity, gender, risk (if missing), death date if deceased, etc.)

Appendix E: Sample Initial Inquiry Letter

Date:

Dear Name of Contact

The Local Health District is supporting a regional program that links eligible residents to supplementary health care and social service providers. You have been selected to participate in this free, confidential and important health program.

We ask that you contact Linkage staff at direct phone number for linkage staff to verify your identity and began the process of linking you with important medical services.

All information will be kept confidential. Using the number listed above call between day/time.

If there is no answer, please leave your full name, number, and the best time to reach you on the secure and confidential voicemail. Linkage staff will promptly return your call.

Thank you in advance for your time,

Local health district or service provider

Appendix F: Data to Care Sample Phone Script

Voicemail Message: No one answers

*"This is **Sarah**, from **Acme County Health Department**, calling for **Steve Miller**, when this message is received, please return my call at **(xxx)-xxx-xxxx**. **Steve** has been selected to receive supplementary health care and/or social services. Please have **Steve Miller** contact me. Again, that number is **(xxx) xxx-xxxx** and my name is **Sarah** with the **Acme County Health Department**. Thank you and have a nice day!"*

Intro: When someone does answer

- Person answers the phone: *"Hello, my name is **Sarah** may I speak with **Steve Miller**, please?"*
- Person answering the phone: *"Who are you/what organization are you with?"*
- *"My name is **Sarah** and I'm with **Acme County Health Department"***
    - If available, skip to Step 1
    - If not available: *"Do you know when a good time would be to try and contact **Steve**?"* Document time for future follow-up call.

Step 1:

Patient identifies themselves: *"This is **Steve."***

- *"**Steve**- To confirm I am speaking to the correct person, would it be alright if verified some information?"*
    - If the person is hesitant to answer verification questions: *"To maintain privacy and confidentially I am only able to share details with **Steve Miller**. These questions are to ensure that their privacy is protected."*
        - If person agrees, proceed with verification
    - *"Thank you so much! When is your birthday?"*
    - If the person remains or refuses: *"I apologize, I cannot proceed without confirming **Steve Miller's** identity. When is a better time to call back?"* Document time for future follow-up call.

Step 2: Identifying HIV Status

- *"Thank you for answering my questions, **Steve**. Again, the reason I'm calling is I have some important health information I'd like to talk to you about.*
    - If the person starts asking, how you got their number, etc. continue calmly. *"Ohioans who have chronic health conditions are eligible for services, some which are free. Have you been diagnosed with a chronic health condition? These conditions are treatable with daily medications and most times are not life threating if treated in a timely matter."*
        - Chronic health conditions can be explained by giving a list of conditions that are defined as chronic; Diabetes, High Blood Pressure, Asthma, HIV, Obesity, and Heart Disease.
        - If they respond that they have been diagnosed with a chronic health condition, ask what health condition were you told you had? If they don't say HIV, ask were you told you have any other condition?
        - If yes and the patient identifies HIV: proceed to Step 3b.
    - If no or HIV not indicated, go to the next question. *"Do you recall being sick, hospitalized, or having any testing done at **Labcorp in Acme County*** (eHARS diagnosing facility*) in **July of 2014*** (date of diagnosis)? Date of last touch can also be used.
        - If yes: *"What were your results?"*
        - If yes and the patient identifies HIV: proceed to Step 3b.

- If no to either question: *"Do you remember being tested for any health conditions? Tests may have included having blood drawn or having your cheek swabbed?"* Could also ask about a hospital stay in and around the date of diagnosis.
  - If yes and HIV status has been identified, go to Step 3b

Step3a: HIV status has not been identified

"As I mentioned, you are receiving this call because you are eligible for free medical health services. Your medical history plays a major part in the services that you will receive."

- If the person does not want to discuss their HIV status further via phone, offer the individual the chance to talk face to face. Arrange a meeting with them offering to meet them where the they would feel the most comfortable; health department, library, local McDonald's, their home (if applicable).
- If person will continue to discuss their health status, ask again, *"Are there any other health conditions you have been diagnosed with?"*
  - If yes and HIV is indicated: Proceed to Step 3b.
  - If the person still doesn't state their HIV status, make one last attempt at using the questions from Steps 2 and 3a.
    - If HIV not disclosed: Follow-up with ODH Surveillance. An in-person visit may be necessary if person is not aware of diagnosis.

Step 3b: HIV-positive status known

- *"**Steve** this call is aimed at identifying Ohioans that could use support in accessing HIV services. Have you been seen by a doctor, nurse, or any other health professional about living with HIV in the last year?"*
  - If yes, go to Step 4
  - If no: Inform the patient that going regularly to see a doctor when living with HIV is very important. "If you are interested, I can help you get linked to an HIV specialist and any other services you may need. Are you ready to get linked to a doctor?"
    - If yes: Continue to Step 5
    - If not sure: Explain to them that a re-engagement specialist can help them with any barrier they've identified. Explain these services are FREE.
    - If no and willing to talk: Use ARTAS or similar client-centered model to help them to continue exploring going to the doctor. Schedule second session, in person if willing.

Step 4: Getting information on their HIV Care (identifying why they are on the NIC list)

- If they have been in care during the last year: collect all information required on the data collection tool, then end the call.
  - Sample Questions
    - *"Where have you received care for HIV in the past?"*
    - *"When was the last time you were seen by a doctor for HIV?"*
    - *"When was the last time you took meds?"*
    - *"When was the last time you had their blood drawn?" (CD4&Viral Load)*
    - *"Have you had a genotype test in the past year?"*

Step 5: Re-engaging in Care

- Depending on the person's readiness to re-engage in care, offering to connect them to a medical provider may be appropriate over the phone.
  - Notate best times and days for person to attend a medical appointment.

- Communicate that you will contact them with the exact date and time as soon as the appointment is made.
- Determine what things need to be in place for them to attend their appointment, transportation, childcare, etc.
    - If additional services are identified as needed, provide active referrals (see LTC Protocols)

- If the person identifies several barriers, more intensive support may be needed. Offer to arrange an in-person meeting (see LTC Protocols)