Client Progress Report - AIDS Institute Guidance – (1/26/22)

This document details the process implemented by the New York State Department of Health AIDS Institute (AI) for purposes of operationalizing the 2017 amendments to the ***HIV/AIDS Testing, Reporting and Confidentiality of HIV Related Information*** regulations to include the sharing of HIV surveillance information through the implementation of the Client Progress Report (CPR). The CPR will be shared with care coordination entities for purposes of linkage and retention in HIV care. The revised regulation reflects amendments made pursuant to Chapter 461 of the Laws of 2016 and was promulgated on May 17, 2017.

10 New York Codes, Rules and Regulations (NYCRR) Section 63.4(c)(3) - Filing of reports defines care coordination as follows:

> (3) when used for purposes of linkage to and retention in care, in which case the protected individual's individually identifiable health information may be shared among state health departments, local health departments, health care providers as defined in section 63.1(k) of this Part, and entities engaged in care coordination that have a clinical, diagnostic, or public health interest in the patient. For purposes of this section, ***care coordination shall mean managing, referring to, locating, coordinating, and monitoring health care services for the individual to assure that all medically necessary health care services are made available to and are effectively used by the individual in a timely manner, consistent with patient autonomy. Care coordination shall be conducted by or with the participation of the individual's health care provider to the extent possible.***

The New York State Department of Health AI has further defined *care coordination as the integration of social and health care services based on an individual's needs to achieve optimum health outcomes. Care Coordination involves the deliberate transfer of information and sharing of responsibility in planning, organizing, and linking activities between two or more participants involved in providing HIV-related services to facilitate the appropriate delivery of health care services*. Access to HIV surveillance information is essential for AIDS Institute-funded providers to actively engage with and support the client(s) to maximize viral suppression so they remain healthy and prevent further transmission. Any agency receiving funding for any of the following services will be eligible to receive the CPR.

The Division of HIV/STD/HCV Prevention (DOP) defines *care coordination entities* as DOP-funded community-based organizations (CBOs) delivering HIV/STD/HCV prevention services that provide direct support services for people living with HIV. For clients enrolled in DOP-funded prevention services who acquire HIV, the established client relationship puts them in an excellent position to help support the client's transition from behavioral and biomedical HIV prevention interventions to HIV treatment.

DOP-funded *care coordination entities* include organizations contracted to deliver:

1. HIV navigation services;[i]
2. HIV testing with linkage to prevention and HIV medical care services for persons diagnosed with HIV; and
3. Pre-exposure Prophylaxis (PrEP) support programs[ii] (Client Progress Reports will be limited to those individuals who are diagnosed with HIV).

The Division of HIV and Hepatitis Health Care (DHHHC) funds programs that screen, diagnose and provide access to HIV ambulatory care and supportive services for persons living with HIV. These funded *care coordination entities* are hospitals, health centers, and CBOs delivering a continuum of HIV and HCV prevention and care services, including testing, HIV medical care, and direct support services for people living with HIV (PLWH) and co-infected with HIV/HCV. Clients enrolled in DHHHC-funded health care and supportive services receive comprehensive support to help them maintain viral load suppression and good health outcomes.

DHHHC-funded *care coordination entities* include organizations contracted to deliver:

1. Case management services[iii]

2. Health education[iv]
3. Treatment adherence services
4. Pre-exposure Prophylaxis (PrEP) support programs [ii] (Client Progress Reports will be limited to those individuals who are diagnosed with HIV).

AI-funded direct service providers using the AIDS Institute Reporting System (AIRS) currently submit the "AIRS HIV/AIDS Epidemiology Extract" through the HIV/AIDS Provider Portal via the Health Commerce System (HCS). This information is matched against the New York State HIV surveillance system and provides valuable information on linkage to care, retention in care, and viral load suppression for clients served by AI-funded programs. The new CPR will be generated using the matched data referenced above. This report will include information regarding dates of service and related viral load status for clients who match the report eligibility criteria.

The report will be run on a quarterly basis, 45 days after the end of each month and distributed to each eligible agency. The intent of this report is to identify clients who may require additional follow-up regarding their viral load status and to start a dialogue between the AI and the agency regarding those clients. This report will not be used to monitor performance or evaluate contract deliverables.

The AI conducted a pilot of this process with five select agencies. The pilot helped to inform the development of a final protocol for the creation and dissemination of this report as well as provide valuable insight into necessary report modifications. The pilot agencies represented a mix of DOP and DHHHC funded providers. Results from all pilots were discussed within the AI CPR workgroup and were used to finalize the CPR implementation process to be rolled out to eligible AI-funded providers.

Evaluation: (TBD) As stated earlier, this report will not be used to monitor performance or evaluate contract deliverables. The evaluation plan to be developed will be used to determine the effectiveness of this report related to positive client outcomes.

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CPR Overview:

The CPR (see sample below) will provide an individual list of clients using the TC_ID. This a unique ID for each client within AIRS. The agency can use the TC_ID to locate each client within their system. The report will also include the most recent date of service for each program within AIRS. The remaining information is derived from the matched HIV surveillance data. If the client is deceased in the HIV surveillance system, but still active in AIRS, an "X" will be included in the deceased column to indicate that the client should be closed out of AIRS. The date of the most recent viral load will be given using the month and the year. Based on that viral load test result, the viral load count column will indicate if the client is suppressed, unsuppressed (count >200), or has a high viral load (count >10,000). Using that viral load information, the client will be categorized accordingly in the remaining columns: needing follow-up for care, has no viral load in last six months, has no viral load in last 12 months, needs follow-up for viral load suppression. The specific criteria used to generate this report can be found in the attached CPR specifications document.

This report contain confidential data

Care Coordination Suveillance-Based Client Progress Report (CPR)

New York State Department of Health - AIDS Institute

Agency: ABC, Inc.

Run Date: 11/17/21

Data as of: 9/30/21

TC_ID	Most Recent Encounter Date	Program Delivering Service	Worker	Deceased	Date of Last Viral Load Test	Viral Load Count	Needs Follow-up for Care	Needs VL 6M	Needs VL 12M	Needs Follow-up for VL Suppresssion
AAAAAAA	11/08/21	Medical Transportation	Smith		11/2020	High VL	X	X		
AAAAAAA	10/22/21	CSP - Regional	Smith		11/2020	High VL	X	X		
BBBBBBB	10/26/21	Case Management	Jones		10/2021	High VL				X
BBBBBBB	10/26/21	Housing	Jones		10/2021	High VL				X
BBBBBBB	04/26/21	Housing	Smith		10/2021	High VL				X
BBBBBBB	02/22/21	Nutriition	Jones		10/2021	High VL				X
CCCCCCC	10/25/21	Housing	Jones	X						
DDDDDDD	11/01/21	CII	Jones		10/2021	Not Suppressed				X
EEEEEEE	10/14/21	Case Management	Jones		09/2021	Not Suppressed				X
EEEEEEE	10/14/21	Medical Transportation	Jones		09/2021	Not Suppressed				X
EEEEEEE	03/31/21	Emerging Communities	Smith		09/2021	Not Suppressed				X
EEEEEEE	03/19/21	MAI Outreach and Enrollment	Jones		09/2021	Not Suppressed				X
EEEEEEE	03/01/21	Nutrition	Smith		09/2021	Not Suppressed				X
FFFFFFF	10/26/21	Ryan White	Jones		No Record of VL Test		X	X	X	
GGGGGGG	10/25/21	Housing	Jones		03/2021	Suppressed	X	X		
HHHHHHH	10/28/21	Case Management	Jones		12/2020	Suppressed	X	X		
HHHHHHH	07/20/21	Medical Transportation	Smith		12/2020	Suppressed	X	X		
IIIIII	10/25/21	Housing	Jones		10/2021	Not Suppressed				X
JJJJJJ	05/07/21	State SEP	Smith		08/2020	Not Suppressed		X	X	
KKKKKKK	10/28/21	Housing	Jones		09/2021	Not Suppressed				X

[i] HIV Navigation Services assist persons living with HIV and individuals who engage in behaviors that put themselves at risk for HIV to obtain timely, essential and appropriate medical, prevention, and support services to optimize their health and prevent HIV transmission and acquisition.

[ii] DOP-funded PrEP Support Programs: identify potential clients for PrEP; screen for eligibility and link interested and eligible clients to PrEP prescribers with referrals to the NYS PrEP Assistance Program, and collaborate with medical provider(s) to provide supportive services as part of a comprehensive prevention plan that includes routine HIV and STD testing, risk reduction and adherence counseling, and education on condom use and safer sex practices.

[iii] A dynamic, highly proactive model of case management utilizing a multistep process that incorporates a diverse array of activities and interventions that are designed to encourage, support and enhance access to and engagement in care for PLWHA. Case management efforts are solution focused with frequent consumer and provider contacts, regular monitoring and medical updates, quarterly reassessments and case conferences, and improved health outcomes leading to viral suppression.

[iv] Health education services support the development of skills and access to systems that will culminate in self-management. The health education interventions provide a didactic forum for learning and opportunities to practice learned skills and process difficulties experienced in achieving treatment adherence.