Nebraska Links HIV Positive Patients to Care Services

[Integrating public health and primary care can both improve quality of care for a population and lower health costs. Both components of the health system share a common goal of health improvement, have similar funding streams and resources, and share many partnerships. If aligned, public health and primary care working together could achieve lasting, substantial improvements in individual and population health in the United States. State and territorial health agencies can make a significant impact in this area by decoding the key elements for successful integration, which can then be shared with others to promote further integration efforts, increase healthcare quality, lower costs, and improve overall population health.]

The Nebraska Department of Health and Human services (NE DHHS) built a strong HIV and sexually transmitted disease (STD) support system by linking internal HIV/STD-related programs and collaborating with universities, AIDS service organizations, and providers. Nebraska’s HIV prevention and care efforts focus on the geographic area with the highest HIV incidence, and span from HIV/AIDS awareness to linkage and retention in care.

BACKGROUND

Nebraska has a total population of almost two million people. Thirty-nine percent of the population lives in the Douglas, Sarpy, and Cass counties in the eastern part of the state. Douglas County contains 29 percent of the state’s total population, most of whom live in Omaha. Thirteen percent of Omaha’s population is African-American, which is significantly larger than the overall state rate of 4.5 percent.

One hundred and eleven new cases of HIV/AIDS were diagnosed in 2010, with 65 percent of these HIV positive individuals in Douglas County. Forty-nine percent of new cases in Douglas County were Caucasians, 42 percent were African-Americans, and 7 percent were Hispanics. The bulk of those infected were 15-44 years of age. Additionally, the associated increased risk from other STDs is elevated in this urban area. The rate of chlamydia infections is 1.6 times the Nebraska rate and 1.3 times the national rate. Gonorrheal infections are 2.8 times the Nebraska rate and 1.6 times the national rate.

Integration has been a part of the NE DHHS Infectious Disease Program for several years through internal partnerships. Integration efforts began in 2003 and 2004 when NE DHHS’ upper management decided to merge several programs into the state’s Infectious Disease Prevention Programs, supervised by the Infectious Disease Program Administrator. The merged programs included the HIV Prevention Program, Hepatitis Prevention Program, HIV Surveillance Program, Nebraska’s Ryan White Program, Nebraska’s STD Program, and Housing Opportunities for Persons with AIDS (HOPWA) Program.

In August 2007, CDC initiated the nationwide Program Collaboration and Service Integration (PCSI) process, a mechanism for organizing and blending interrelated health issues, activities, and prevention strategies to facilitate comprehensive delivery of services at the state and local levels.¹ NE DHHS’

Aim of the Integration:
To actualize concepts of the National HIV AIDS Strategy, which emphasizes identifying new HIV positive persons, linking them to care services, and monitoring retention in care.
Reintegration of Public Health and Healthcare

hepatitis program manager attended a PCSI workshop at CDC, brought back the information to Nebraska, and adapted the process with the state infectious disease programs in January 2008.

OVERVIEW OF THE INTEGRATION EFFORT
The integration effort’s goal was to actualize National HIV AIDS Strategy concepts: emphasizing identification of new HIV positive persons, linkage to care services, and monitoring retention in care through viral load measurements and the use of the care systems. NE DHHS staff reviewed the strategy’s concepts and applied them to Nebraska by developing the state’s first HIV treatment cascade with 2011 data. During this process, NE DHHS staff were interested in identifying disparities between racial/ethnic groups, age groups, and rural versus urban populations. Nebraska modified the national treatment cascade to fit its needs for HIV prevention and treatment.

NE DHHS determined that it needed to raise awareness of HIV to increase testing rates, which would help identify HIV positive people. In the past, the HIV Prevention Program supported multiple testing sites and other educational programs located in the Omaha/Douglas County area. Testing sites included the local health department, a federally qualified health center (FQHC), family planning sites, and the Nebraska AIDS Project (NAP), Nebraska’s only AIDS service organization. The state counseling and testing program, in collaboration with the Douglas County Health Department and NAP, expanded test sites within Omaha to non-traditional venues such as bars, homeless events, and libraries.

To ensure reach, the state HIV surveillance program works with disease intervention specialists (DIS) in the STD program to conduct partner notification with all newly diagnosed HIV cases in Nebraska. DIS work with each new HIV positive person to identify risk behaviors and obtain partner information, as well as partner HIV status (with testing if necessary). DIS then refer clients to NAP case managers who connect them to Ryan White, HOPWA, and other care services. The NAP case management system is key to ensuring clients are linked to and retained in care, as well as monitoring adherence to treatment. NE DHHS partnered with the University of Nebraska Medical Center (UNMC) HIV Program, which serves as the primary provider of care services, though private providers specializing in infectious diseases are also part of the system of care.

Another important element of the integration effort is the Nebraska HIV Prevention and Care Consortium (NHCPC). NHCPC was established in March 2000 to meet the federal requirements of the CDC/HRSA cooperative agreements awarded to Nebraska. NHCPC is a centralized planning group involving professionals, agencies, and consumers with common goals and objectives. NHCPC consists of 27 key stakeholders from across Nebraska and meets quarterly in an all-day meeting. When the 2011 treatment cascade for Nebraska was developed, the state HIV surveillance epidemiologist presented the cascade at the NHCPC quarterly meeting. The HIV surveillance program also works with NHCPC and the state HIV prevention program to develop target populations for interventions and utilize and disseminate data and information in the epidemiological profile. NHCPC members take information from quarterly meetings back to their organizations, communities, and healthcare providers to discuss and use for planning community programs and events targeting HIV positive individuals.

This example of primary care and healthcare integration demonstrates state-coordinated use of federal agency funding and resources from historically separate initiatives. Federal CDC grants support HIV surveillance and prevention, including the counseling and testing program. HRSA and the U.S.
Department of Housing and Urban Development federal programs support the state Ryan White and HOPWA programs, respectively.

RESULTS/BENEFITS
The Nebraska HIV surveillance system provides part of the ongoing measureable data regarding successes in the state Ryan White and HOPWA programs. NE DHHS has a sub-grant with the University of Nebraska College of Public Health to evaluate the HIV prevention and counseling and testing programs.

Key indicators of success in this endeavor rely on number of new positives identified, the number of people linked to care, the number of people retained in care, and the number of people who achieve an undetectable viral load. This can be seen in both raw numbers and in the HIV Treatment Cascade. Results from the 2011 HIV surveillance data reveal that 79 percent of infected persons were diagnosed with HIV, 65 percent of those diagnosed were linked to care, and 79 percent of those linked to care were retained in care. Data also showed that African-Americans were just as likely as Caucasians to get into care and stay in care. In addition to the 2011 Nebraska HIV surveillance data, staff plan to create a 2012 treatment cascade using 2012 HIV surveillance data. Both points of data will demonstrate the effectiveness of this integration and will be available upon request from the Nebraska HIV Surveillance Program.

INFRASTRUCTURE TO SUPPORT COLLABORATION AND SUSTAINABILITY
Over the years, NE DHHS has built a strong HIV support system using existing resources (e.g., local health departments, FQHCs, family planning sites, and NAP) matched with primary care resources (e.g., Nebraska healthcare providers, case managers, the Ryan White Program, and the UNMC HIV Program). The support system extends from awareness of HIV through actual testing, linkage to, and retention in care with HIV infectious disease specialists.

By sharing information, increasing communication, and discussing the data presented in the HIV cascade, a public health and healthcare system partnerships have solidified over time. This has lead to an improved system of health-directed and unified by population health goals.

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