

Public Health Service

Centers for Disease Control and Prevention (CDC) Atlanta, GA 30329

March 29, 2016

Lorene Maddox Acting HIV Surveillance Program Manager Bureau of HIV/AIDS Florida Dept. of Health 4052 Bald Cypress Way, Bin # A09 Tallahassee, FL 32399-1715

Dear Ms. Maddox:

On behalf of CDC's HIV Incidence and Case Surveillance Branch, thank you for providing us an opportunity to learn about your HIV case surveillance system during our site visit, January 7-8, 2016. We appreciate the time and effort you and your staff and colleagues spent meeting with us at the Florida Department of Health.

Please find attached a report that outlines the topics we discussed during the visit, a summary of the conversation associated with those items, and our recommendations for your program.

Thank you again for your hospitality and the opportunity to visit with you to gain a better understanding of your program. We look forward to continued collaboration with you and your staff. Please do not hesitate to share with us questions or concerns you may have regarding the site visit or any other surveillance-related topic.

Sincerely,

Laurie Kinley

Laurie Linley Epidemiologist HIV Incidence and Case Surveillance Branch Division of HIV/AIDS Prevention National Center for HIV/AIDS, Hepatitis, STD, and TB Prevention

hall

H. Irene Hall Deputy Director, Acting, Surveillance, Epi & Lab Science Division of HIV/AIDS Prevention National Center for HIV/AIDS, Hepatitis, STD, and TB Prevention

Brown

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# Site Visit Report Form

Site: Florida Department of Health	Contact Name: Lorene Maddox - Acting HIV Surveillance Program Manager Phone: (850) 245-4444 Ext. 2613
Address of Site Visit: 4025 Esplanade Way, Tallahassee, FL, 32399	
Dates of Visit: January 7-8, 2016	
<b>Purpose of Visit:</b> The purpose of the visit is to ensure compliance with administrative and operational requirements pursuant to CDC funding of CDC-RFA-PS13-1302, National HIV Surveillance System (NHSS). Tasks include review of current HIV surveillance activities, technical requirements for eHARS, evaluation standards, case reporting, lab reporting, death ascertainment, dissemination of HIV infection data, security and confidentiality standards, and budget and administrative issues. The assessment is designed to support the program's efforts to sustain operational strengths and facilitate improvements in any area which may need assistance.	
Florida Department of Health HIV Surveillance Program Attendees: Della Buckles, Program Reporting Manager Becky Grigg, Surveillance Coordinator Nita Harrelle, Administrative Coordinator Jamie Henry, Asst. Incidence and Molecular Coordinator Marlene LaLota, HIV/AIDS Administrator Anna M. Likos, Division Director DCHP Lorene (Lory) Maddox, Data Analysis Manager Karalee Poschman, CDC Direct Assignee Jontae Sanders, Incidence and Molecular Coordinator Jeff Turner, Field Operations Manager	CDC Division of HIV/AIDS Prevention (DHAP) Attendees: Levator Brown, Project Officer, HIV Incidence and Case Surveillance Branch (HICSB) H. Irene Hall, Deputy Director, Acting, Surveillance, Epi & Lab Science, DHAP Laurie Linley, Epidemiologist, HICSB
Summary of Recommendations	
<ul> <li>Continue efforts to ensure meeting laboratory reporting criteria for inclusion in national HIV surveillance supplemental reports on monitoring HIV prevention and care indicators.</li> <li>Although the Florida Department of Health (FLDOH) HIV surveillance program has been meeting CDC RIDR requirements, we encourage the program's efforts to develop automated processes for future RIDR iterations for entering ancillary information from resolved RIDR cases into eHARS.</li> <li>Ensure the transmission of remnant specimens (collected from cases diagnosed in 2014 to a set of the set of</li></ul>	
<ul> <li>Ensure the transmission of remnant specimens (collected from cases diagnosed in 2014 to the present) from the Miami public health laboratory to the STARHS laboratory for recency testing.</li> <li>We encourage efforts to enhance the collection of information about the documented date of last HIV negative test, as this information is important for identifying acute and early HIV infection.</li> </ul>	

Continue working with laboratories on the electronic submission of genetic sequences.

Security and Confidentiality Findings:

- All programs in the Florida Bureau of Communicable Disease (including HIV, STD, TB, and Viral Hepatitis) follow the CDC PCSI security and confidentiality guidelines.
- The Florida security and confidentiality procedures were validated on April 10, 2015.

#### **Core Surveillance Findings**

- We commend the FLDOH HIV surveillance program for continued excellence and high levels
  of achievement in meeting all of the national HIV case surveillance process and outcome
  standards. The program has an excellent understanding and use of document-based
  surveillance methods.
- We laud the program's progress and success toward meeting national criteria for complete reporting of HIV-related laboratory results (the FLDOH HIV surveillance program should be able to meet these criteria beginning with data for cases diagnosed in 2015).
- The HIV surveillance program is housed within the Division of Disease Control and Health Protection in the Bureau of Communicable Diseases in the HIV/AIDS Section. The STD, TB, and Immunizations programs are also administered within the Bureau of Communicable Diseases. This organization has enabled excellent program integration and collaboration between HIV surveillance and the other disease surveillance and prevention programs. This program integration has been vital for improved data collection and facilitating the use of data for care and prevention activities, as well as evaluating and monitoring progress on key indicators of the National HIV/AIDS Strategy to reach goals of preventing HIV infection and related morbidity.
- The FLDOH has dual reporting of HIV cases by laboratories (i.e., person in charge of a laboratory receiving the initial order to perform an HIV-related test or collecting the specimen) within 3 days of a positive result and by physicians (i.e., who diagnose or treat an STD) within 2 weeks of diagnosis. Electronic laboratory reporting is mandatory for all notifiable conditions and reportable tests include all diagnostic tests, viral loads, p24 antigen, viral cultures, and all CD4 (counts and percent). The FLDOH regulations will soon be revised to require all reference laboratories to report in addition to the laboratories collecting or receiving the initial HIV test report.
- Laboratory reports are received via an integration broker "cloverleaf" and sorted into two • systems: ELR OLAP (for the HIV and STD programs) and ELR Classic (for the Epidemiology program). HIV reports are transmitted from ELR\_OLAP to the HIV surveillance program, imported into the FLDOH HIV AIDS Laboratory (HAL) database, and subsequently matched to the eHARS registry. Results requiring follow-up (e.g., indicating new diagnoses) are posted to field folders daily for follow up; results that match to existing cases are cleaned and imported into eHARS. The STD program independently extracts the HIV-related tests directly from ELR\_OLAP for importing into PRISM, which is the system used by DIS staff for patient and partner notification. Laboratory results submitted from the Counseling, Testing, and Referral Services (CTRS) program are similarly processed through ELR\_OLAP. Paper laboratory results that are received at headquarters and in the field are scanned and entered into Image API; information from these reports is matched with the eHARS registry, and then processed accordingly. When case investigation is completed, case managers enter data into eHARS; image files of scanned hardcopy records are maintained permanently. Documents are reviewed for completeness and accuracy before entry, and documents with incomplete or missing information are sent back to field staff for correction. Data edit check programs are routinely generated to monitor data quality.
- In 2016, the FLDOH is anticipating a migration from HAL to Merlin, which is a web-based system that will be able to integrate the Division's disease reporting systems.

- We commend the FLDOH for notable progress in improving electronic laboratory reporting, ensuring the routine and prompt entry into eHARS of all laboratory data received, and continuing to achieve outcome standards for completeness of CD4 and viral load results for reported cases. Data from CDC's local SAS program for core HIV surveillance indicators show that 72.4% of cases diagnosed in 2014 had a CD4 results within 3 months of diagnosis, 77.5% had a viral load result, and 81.3% had either a CD4 or viral load result. As of the beginning of 2015, laboratory data should meet the HICSB criteria for complete reporting of laboratory results. Improved laboratory data has enhanced the ability to monitor linkage to and retention in care and conduct data-to-care and other related activities.
- The HIV surveillance program works in close partnership with their STD program to ensure obtaining complete information for case surveillance and for linkage to care and prevention activities. HIV field staff obtain information for case surveillance from providers or through medical record review, but HIV staff also have PRISM access. The STD staff are the only staff that contact cases directly for follow-up and are able to get risk information and other information during interview that otherwise might not be available from providers or medical record review. Through this close collaboration with STD, the HIV surveillance program has been able to maintain notably high percentages of completeness for risk factor information (93.4%, for cases diagnosed in 2014). The STD program also refers and initiates linkage to care through a linkage coordinator, and linkage status is documented.
- The HIV surveillance program has collaborated with the HIV Patient Care Program and local Part A to gain access to these databases to more accurately assess care metrics. Lists of HIV surveillance cases with no evidence of CD4 or viral load data within the past 6 months are routinely generated and are matched with Ryan White and ADAP databases; resultant lists are sent to field staff to investigate, and disposition codes used to document investigation findings. As a result of these collaborative efforts, the percentage of persons living with diagnosed HIV infection who are defined as in care increased from about 60% in 2013 to over 70% in 2014. Data for 2014 from eHARS merged with CareWare and ADAP indicate that among persons living with diagnosed HIV infection, 90% have "ever" been in care (at least one laboratory result since HIV diagnosis), 71% are "in care" (at least one laboratory result in 2014), 67% are on ART (estimated from MMP data), and 58% have evidence of viral load suppression.
- In local areas and facilities with electronic medical record systems, the HIV surveillance
  program has been able to utilize these electronic records to improve efficiency of obtaining
  case information, e.g., being able to access multiple facilities within the system from just a
  single facility.
- Florida is in the process of implementing the Florida Health Information Exchange system; this system will enable HIV surveillance staff to directly access information from health care facilities participating within the system.
- The HIV surveillance program has continued to meet the process standards for RIDR within the timeframes specified by CDC HICSB. Information about duplicate pair resolution is timely entered into eHARS. Additional case information obtained during RIDR investigation is entered and maintained in an Access database, and is later entered into eHARS. Due to staffing, there was recently a backlog of entering this ancillary information from the Access database into eHARS, although the program now has more staff and is addressing this backlog. For future RIDR iterations, the surveillance program is developing automating procedures to enter this information.
- The FLDOH has an impressive HIV Surveillance Module training program for training field staff with best practices for collecting complete and accurate information for HIV case surveillance. This program is of such notable excellence, that other states have been sending their HIV surveillance staff to attend the Florida program for training.

- The HIV surveillance program also keeps in communication with providers and reporting laboratories and provides ongoing education and updates as needed. The FLDOH has also developed brochures to educate health care providers and laboratories about the reporting guidelines for reportable disease conditions.
- The FLDOH HIV surveillance program has made great progress in improving facility data and most recent address information, and is working on standardized coding for the list of providers in eHARS.
- The FLDOH has geocoded all applicable addresses in their entire eHARS database. We commend this, and appreciate the willingness of the FLDOH HIV surveillance program to participate in national HIV surveillance geocoding activities.
- We are impressed with the FLDOH HIV surveillance program's comprehensive practices for conducting death ascertainment activities, particularly with the implementation of an automated system for routinely matching all living cases in eHARS with all deaths reported in the state's Office of Vital Statistics electronic database, and importing all validated matches into eHARS. These imported records contain all essential death-related information, including cause of death and address. As well, annual matches are conducted with the SSDMF and NDI data as available. For records that match to these datasets, the FLDOH HIV surveillance program is also able to obtain additional death-related information that is missing from these sources for these records by pulling in the additional from the state vital statistics data.

#### Incidence Surveillance (HIS) Findings (if applicable)

- We commend the FLDOH HIV incidence program for continued excellence in meeting the CDC HICSB HIV incidence surveillance outcome standard related to collecting the testing and treatment history (TTH) information. For cases diagnosed in 2014, completeness of TTH information was 99.3%.
- Although STARHS recency result completeness dropped to 28.2% for cases diagnosed in 2014, primarily due to issues with staff turnover at a couple of key laboratory facilities, progress has been made toward improving STARHS recency result completeness. An incidence module within the HAL system is used for identifying, tracking, and monitoring the processing of specimens that are eligible for STARHS recency testing. The HIV incidence program has implemented automated programs to import STARHS results and has improved QA procedures, such as creating monthly local error reports. Additional laboratories have begun to participate in incidence specimen shipping activities (e.g., Baycare), and Quest Tampa has now resumed specimen shipments to the STARHS laboratory.
- Due to staff shortages, there is a backlog of about 5,000 specimens from 2014 through the
  present at the Miami public health laboratory that are pending processing for shipping to the
  STARHS laboratory, which includes specimens from Miami Quest. The FLDOH is interested in
  obtaining assistance to process the specimens that are identified as eligible for shipping to
  the STARHS laboratory.
- The FLDOH HIV incidence program is in the process of eliciting LabCorp Tampa's participation in incidence specimen shipping activities.

#### Molecular HIV Surveillance (MHS) Findings (if applicable)

- The FLDOH regulations require the reporting of HIV nucleotide sequences; however, a revision to the regulations has been submitted to clarify the language for this reporting requirement.
- HIV nucleotide sequences are also routed through the ELR integration broker and included in HAL.
- The FLDOH MHS program has made significant progress in obtaining genetic sequences for their diagnosed cases; the MHS program reported that the percentage of newly

diagnosed cases with at least one genetic sequence within 3 months of diagnosis increased from 17.7% in 2013 to 26.4% in 2014. Among persons diagnosed in 2014 whose first HIV sequence was obtained within 3 months of diagnosis, completeness of ARV use information was 99.2%.

- More laboratories are now submitting sequences as part of laboratory reporting activities, including Quest, LabCorp, Specialty, Bioreference, ARUP, and the state public health laboratory in Jacksonville.
- The FLDOH MHS program has been working with CDC HICSB on network analysis of injection drug user clusters.

## Perinatal HIV Exposure Surveillance (PHER) Findings (if applicable)

 Not applicable. The FLDOH HIV surveillance program has not received separate funding for this optional activity. The FLDOH has regulations requiring the reporting of HIV-exposed infants, so follow-up for HIV-exposed infants is conducted as part of routine surveillance.

## Geocoding and Data Linkage (GDL) (if applicable)

 Not applicable. The FLDOH HIV surveillance program has not received separate funding for this optional activity. However, the HIV surveillance program has expressed willingness to participate in HICSB geocoding activities; see additional notes under Core Surveillance Findings section.

## **CDC Actions**

- HICSB will explore options for providing direct assistance or contractual assistance for helping with the following activities:
  - o RIDR data entry
  - the backlog of specimens at the Miami public health laboratory that need to be transmitted to the STARHS laboratory
  - o support for ongoing HIV incidence-related laboratory activities
  - o staff development training
- HICSB will also follow up on providing further guidance for collecting information related to the dates of ARV use.

Additional/Optional Items:

Submitted by:

Date: