Wednesday, September 17, 2025

D2C presentation script:

Introduction:

Good afternoon, I am Mukhtar Mohamad, the HIV/HCV Surveillance Coordinator for the Connecticut Department of Public Health. Today, I will be presenting the latest Data to Care (D2C) analysis that we conducted for this meeting. Please feel free to share your questions and comments at the end of the presentation.

According to the CDC, Data-to-Care (D2C) is a public health strategy that uses HIV surveillance and additional data to support the HIV Care Continuum. The purpose of D2C is to identify individuals living with HIV who need medical care or other services and to help them access these resources. The main objectives of D2C are to increase the number of diagnosed individuals engaged in HIV medical care and to boost the number who achieve viral suppression.

Methodology:

Connecticut Public Health implements its data-to-care (D2C) efforts using the following methods:

- Identifying newly diagnosed HIV-positive cases where the status of medical care is unknown.

- Tracking newly diagnosed HIV-positive individuals reported to the HIV Surveillance Program who have not had laboratory results for viral load or CD4 count within three months of their initial HIV diagnosis. These individuals are classified as "Never in Care."

- Monitoring previously diagnosed HIV-positive cases that have not had laboratory results for viral load or CD4 count in the past 15 months, despite having lab results in the prior 15 months. These individuals are classified as "Not in Care," which is the focus of this presentation.

To obtain the "not in care" list, we follow these steps:

1. We generate the "not in care" list by using a SAS Program provided by the CDC. This program identifies all cases that have not had a viral load or CD4 count in the past 15 months.

2. We then cross-reference this list with the CDC Soundex Match. This process removes cases from out-of-state by coordinating with other states that may have similar cases.

3. The program also checks additional in-house data systems, such as e2CT, ADAP, and CTEDSS, to gather more information.

4. The HIV Surveillance staff looks at the last known provider and checks the medical record information, if available.

5. The finalized not-in-care list is shared with the Disease Intervention Specialists (DIS) for outreach purposes.

6. Subsequently, the HIV surveillance program monitors any lab updates for these clients. If a case receives an updated lab result—either a viral load or CD4 count—they are considered to be receiving medical care. According to this presentation, this is how we define being "in care." Therefore, throughout this presentation, when we speak of 'in care,' we mean clients who had been identified as being out of care but have been successfully returned to care based on CD4 and VL lab data submissions to the program since the out of care list was generated. Following the above methodology, this presentation analyzes explicitly the data regarding D2C results for investigations of not-in-care clients initiated between 2021 and 2024, based on reports from the Enhanced HIV/AIDS Reporting System (eHARS) as of July 8, 2025. It examines various variables, including sex at birth, age, risk factors, county of residence, and viral load suppression, with particular emphasis on clients who are receiving care versus those who are not.

To protect confidentiality, we suppress data points with values of five or fewer. As a result, percentages may not sum to 100% due to rounding or confidentiality concerns.

Results:

The number of not-in-care clients was 519 in 2021, 367 in 2022, 421 in 2023, and 369 in 2024. In 2021, 74% of these clients were found to be in care, while in 2022, 67% were found to be in care, in 2023, 70% were found to be in care, and in 2024, 47% were found to be in care. We anticipate in care clients for 2024 to increase as more labs come in the department.

***Sex at birth:**

Similar to the prevalence of people with HIV, the not-in-care clients were primarily male (68%), highlighting a notable demographic trend regardless of their medical care status.

***Race/Ethnicity:**

The non-Hispanic Black population comprised the highest proportion at 35%, followed by Hispanic individuals at 31% and non-Hispanic White individuals at 29%, with nearly similar proportions of clients across care statuses. This is also in line with the prevalence among people with HIV.

***Age:**

A considerable percentage of clients on the D2C list, representing 56%, were aged 50 and above. In comparison, clients aged 30 to 39 made up 19% of the total, while those aged 20 to 29 accounted for only 6%. Notably, this distribution of ages has remained consistent over the four years, regardless of the clients' care status. This is also in line with the prevalence data among people with HIV.

***Risk factor:**

Regardless of care status, the data-to-care list over the past four years indicates that the highest risk factor was among men who have sex with men (MSM), accounting for 38% of the total cases. Closely following, 27.5% of cases were attributed to heterosexual transmission. Additionally, intravenous drug users (IDUs) represented 19.1% of the cases. The findings also reflect a similar trend observed among people living with HIV.

***County of residence:**

When examining the geographic distribution of these clients, Hartford County emerged as the area with the most out of care clients, accounting for 23.9% of the total. Following closely was New Haven County, representing 21.6%, while Fairfield County held a notable share of 19.4%. This illustrates a pronounced concentration of clients in these three counties, as already shown by the prevalence data in the state. These proportions were similar to those observed for clients who were reported to have received care. However, clients reported not being in care were mainly in New Haven County in 2021 and in Fairfield County in 2021 and 2024.

***Viral load**

Overall, 83% of these clients had achieved viral suppression based on the most recent viral load data.

Although the not-in-care clients did not have an updated lab result for the last 15 months, the data indicate that the initial viral load before not-in-care status of these clients was suppressed at a rate of 84%. In contrast, the clients who were in care after receiving an updated lab report had viral suppression of 82%.

Conclusion:

The data-to-care (D2C) findings almost follow similar trends/conclusions as the statewide prevalence data with people with HIV when it comes to all demographic factors examined in this analysis.

The most interesting aspect of this investigation is that, regardless of care status, the viral suppression rate for these populations is higher, indicating a high likelihood that these clients are in care but not represented in the data received from providers and laboratories.

Steps taken/ Future directions/Success Story:

Last year, the HIV Surveillance team conducted extensive outreach to gather lab data from major local and national laboratories. In 2024, we also completed a lab survey as required by the CDC to identify laboratories that were not submitting their data. As a result, the lab data received by the program has significantly improved.

In 2024, our program had the pleasure of welcoming two enthusiastic interns who took on the important task of evaluating the D2C initiative. Their dedication and hard work culminated in a successful poster presentation that truly resonated with everyone involved. The findings of the interns were consistent with those presented in this study regarding the demographic and risk factor categories of clients who are not receiving care. They acknowledged the necessity for the Department of Public Health (DPH) to integrate its various existing data systems. The interns compared our current systems with the Data to Care (D2C) implementations in other states, including Virginia and Ohio. They identified two key needs for Connecticut: first, to prioritize the D2C list, as Ohio has done, and second, to establish a “data exchange program” with neighboring states such as New York, Massachusetts, and Rhode Island, similar to the Virginia D2C model that closely works with neighboring states.

The HIV Surveillance team has also onboarded a new employee (Lynn Wilcox) for the initiative, who will play a crucial role in the continuation and success of this intervention.

In addition, we plan to conduct a detailed analysis of the D2C data using inferential statistics. Our approach will involve comparing key demographic factors and behavioral outcomes between two groups: clients who were initially not in care but are now receiving care, and those who remain out of care after the intervention.

Finally, I would like to conclude this presentation by sharing success stories of D2C efforts:

A young female never in care case was referred for DIS follow-up. DIS successfully located the patient and confirmed that she was not currently receiving HIV medication and had not visited an infectious disease specialist in approximately two years. The client shared with DIS that mental health challenges and financial barriers had prevented her from staying in care. DIS encouraged the patient to schedule an appointment to restart her medication. About two weeks later, DIS contacted the client again and was informed that she had an appointment scheduled for the upcoming week.

Another young female, never in care and potentially unaware of her status, was referred for DIS follow-up. The patient had a positive HIV confirmatory test 18 months earlier, in March 2022, with no subsequent follow-up testing. DIS contacted the patient and confirmed she was unaware of her positive result. In February 2024, the patient went to the ER for repeat testing and was informed of her positive status. DIS ensured the patient was linked to HIV care before closing the case.

I would be happy to address any questions or comments you may have at this time.

Thank you

Mukhtar Mohamed