



Identifying previous out of jurisdiction HIV diagnoses in New York City

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Issue:

Increased opportunity for duplicate HIV patient reports by different jurisdictions

- Rising life expectancies of PLWHA
- PLWHA migration between jurisdictions
- Expansion of electronic laboratory reporting
- Launch of name based reporting in several high morbidity states

Efforts to minimize duplicate cases in national registry

- CDC and CSTE recommend interjurisdictional reciprocal notification processes
- CDC provides lists of potential duplicates through Routine Interstate Deduplication Review (RIDR)

CDC is limited by not having full identifying information on cases

Setting:

- NYC new HIV/AIDS cases
- Named reporting of AIDS (1981) and HIV (2000)
- Electronic lab reporting
 - All: VLs, CD4 counts and percents, genotypes
 - Positive Western Blots

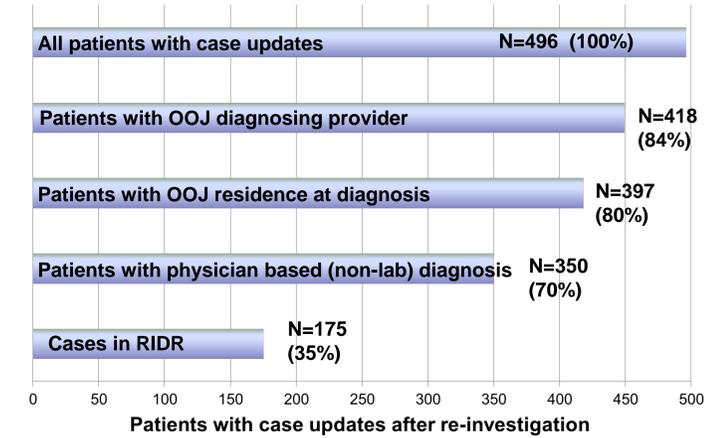
Jurisdictions that conduct deduplication activities outside of RIDR are more likely to identify shared cases.

OLD FORM Used from 6/2003- 3/2010

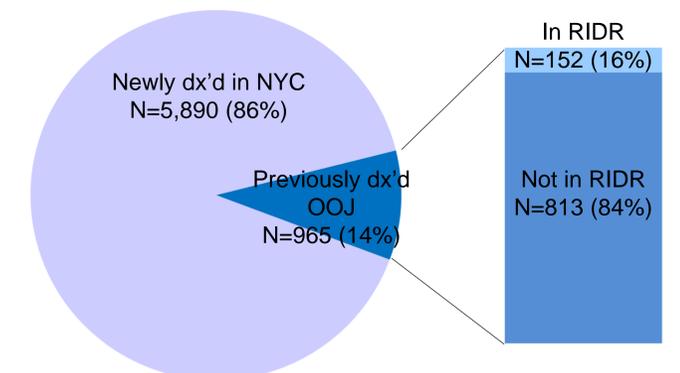
NEW FORM Used from 3/2010- present

- Out of Jurisdiction (OOJ) diagnoses were recorded in the comments on the old case investigation form.
- Re-abstracted cases reported from 1995 – 2011 with comments suggesting OOJ dx.
- Compared results of re-abstractation to eHARS data.
- Measured indicators of OOJ diagnosis.
- Checked whether RIDR correctly identified patients originally diagnosed OOJ.

Characteristics of patients with case updates after reinvestigation



OOJ and RIDR status for cases newly reported on new case investigation forms (3/15/10-12/31/2011)



Examples of OOJ suggestive comments from old case investigation forms

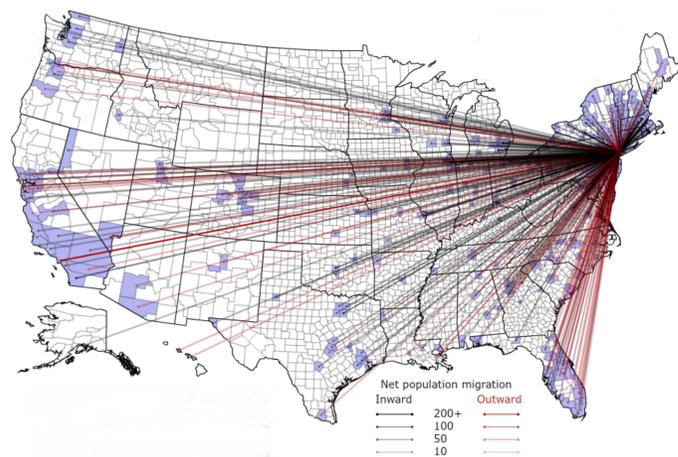
Results:

- Re-abstracted the medical records of 723 adults suspected to have been diagnosed OOJ.
 - 81% of these were reported in 2009 and 2010.
 - 99% originally listed a NYC diagnosing provider and 84% listed a NYC residence at diagnosis.
 - Field investigation yielded updates for 496 (69%) of these patients

Lessons Learned/Recommendations:

- A large percentage of newly reported cases may have been previously diagnosed OOJ.
- Physician based (non-lab) diagnosis and long lags between diagnosis and initiation of care are suggestive of OOJ diagnosis.
- Most cases diagnosed OOJ were not identified by RIDR.
- Local jurisdictions should conduct interjurisdictional deduplication efforts both inside and outside of RIDR in order to accurately maintain their registries.
- NYC DOHMH will reinitiate cases with suspected OOJ diagnoses for field investigation.
- Patient residence at diagnosis and facility of diagnosis will be updated in eHARS.

Migration Patterns – New York County, 2008



Source: Internal Revenue Service data. The IRS only reports inter-county moves for more than 10 people, so some moves are not shown on this map.

Project:

- March 2010- new NYC case investigation form includes facility and patient address at report PLUS facility and patient address at diagnosis