The New York State Department of Health AIDS Institute

Bronx Regional Group Meeting

Location: Lincoln Hospital, 234 E149 St, Bronx, NY 10451

May 12, 2017  9:00 AM -1:00 PM

Agenda*

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:20</td>
<td>Welcome, Introductions &amp; Meeting Overview</td>
<td>Dan Belanger</td>
</tr>
<tr>
<td>9:20-9:30</td>
<td>Bronx EtE Committee Update</td>
<td>Matt Gannon</td>
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<tr>
<td>9:30-10:30</td>
<td>Presentations from the Field: HIV Cascades</td>
<td>Individual presentations by sites</td>
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<tr>
<td>10:30-10:45</td>
<td>BREAK</td>
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<tr>
<td>10:45-12:15</td>
<td>Journey to the End of the Epidemic</td>
<td>Dan Belanger, Fiona Gambanga</td>
</tr>
<tr>
<td>12:15-12:45</td>
<td>Consumer Involvement</td>
<td>Dan Tietz</td>
</tr>
<tr>
<td>12:45-1:00</td>
<td>Next Steps and Evaluation</td>
<td>Dan Belanger</td>
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<tr>
<td>1:00</td>
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*Times are approximate and subject to change
SBH Health System
ETE Cascades
Ralph P. Belloise
Director of HIV Services
Pathways Center for Comprehensive Care
Newly diagnosed HIV+ in 2016

- All patients newly diagnosed HIV+ from 1/1/16 – 12/31/16 across the SBH Health System, including Union Community Health Center.
SBH Health System Newly Dx’ed - 2016

- **Newly Dx’ed**: 30 patients diagnosed HIV+ in 2016 (100%)
- **3 Day Linkage**: 7 patients meeting with their HIV Provider within 3 Days (23%)
- **ARV**: 25 patients prescribed Anti-Retrovirals in 2016 (83%)
- **Virally Suppressed**: 13 patients were virally suppressed (43%)

**Definitions**

- **Newly Dx’ed**: Patients diagnosed HIV+ in 2016. (30)
- **3 Day Linkage**: All patients meeting with their HIV Provider within 3 Days (7 of 30)
- **ARV**: Newly Diagnosed patients prescribed Anti-Retrovirals in 2016. (25 of 30)
- **Virally Suppressed**: Patients Newly Diagnosed in 2016 that were virally suppressed. (13 of 30)
Data Analysis

- 1 patient expired, 1 relocated to Florida, 3 sought care elsewhere
- 100% of patients seen at SBH placed on ARV
- 7 inpatients seen at the point of the “reactive” screening test by the ID Consult team – part of the current HIV testing protocol
Performance Improvement Plan

- Goal: 80% of all newly diagnosed patient in 2017 will be linked to an HIV PMD within 3 business days (SBH) or within 5 business days (community) of confirmatory diagnosis
- Reduce the appointment time from point of reactive test to PMD visit from 14 days to 7 days (allow for confirmatory to return)
- Overbook, or have patient walk in, to accommodate a visit within the 3 day timeframe at SBH (schedules are usually fully booked)
2016 Open Case List

- Any patient with an ICD-9 or ICD-10 diagnosis code for HIV/AIDS with at least one service 1/1/16-12/31/16.
- Seen at least once at any location across the SBH Health System (SBH, UCHC, Behavioral Health, Addiction Medicine, Hospice of New York)
- Care status defined as having an identified PMD, documented ARV therapy, or a statement that patient is compliant with ARV.
SBH Health System HIV Care Cascade - 2016

- **Open**: All HV+ seen in SBH for any Service (ED, BH, etc.)
- **Active**: All patients receiving Care at the SBH Pathways Center for Comprehensive Care.
- **On ART**: Active Patients prescribed HIV Anti-Retrovirals.
- **Virally Suppressed**: Active patients with a Viral Load of ≤200.

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open</td>
<td>100%</td>
<td>567</td>
</tr>
<tr>
<td>Active</td>
<td>28%</td>
<td>562</td>
</tr>
<tr>
<td>On Art</td>
<td>99%</td>
<td>373</td>
</tr>
<tr>
<td>Virally Suppressed</td>
<td>66%</td>
<td></td>
</tr>
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- 2008 total patients, 631 seen at Pathways – 567 active – 1377 non-Pathways patients.
- 46 expired, 2 incarcerated, 1113 in care elsewhere, 280 unknown care status (14%).
- 204 (73%) with unknown status were seen in the ED
- 119 HIV negative patients on the list prior to arriving at the 2008 total (probable coding errors).
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- Goal – Enroll 10% with unknown care status in care at the Pathways Center by 12/31/17
- ID Consult Team to notify Pathways Navigator of any inpatient without an identified PMD
- Request ED staff to enter data into the Provider Information field in the EHR if PMD is known
- Request ED staff to refer patients without a PMD to the Pathways Navigator
- IT to generate monthly report of all ED and Inpatient visits for HIV+ patients for Pathways outreach (Done)
- Work with Patient Accounts to remove any HIV related diagnosis codes for HIV negative patients
The Living Cascade

Draft Consumer Worksheet and Diagram

Bronx Links Meeting – May 12th 2017
Facility Level Cascade at Brooklyn Hospital
May 2016 - May 2017

DISCLAIMER: THIS IS FALSE DATA INVENTED FOR DEMONSTRATIVE PURPOSES
It does NOT reflect data submissions from Brooklyn Hospital Center in any way.
1) Before you became a patient at the PATH Center were you receiving HIV care somewhere else?
   - Yes, I was getting my HIV care at: _________________________
   - No

2) Have you ever accessed health services at Brooklyn Hospital outside of the PATH Center (our HIV outpatient clinic)?
   - Yes
   - No (if No, please skip to page 2)

3) Why did you access these services outside of our outpatient clinic? (write answer below)
   __________________________________________________________________________________________
   __________________________________________________________________________________________

4) At the time that you accessed these services at Brooklyn Hospital were you actively receiving HIV care at an HIV outpatient clinic in a different facility?
   - Yes
   - No

Patients get counted in the “open” bar if they have HIV and were seen by a healthcare professional in any part of Brooklyn Hospital. We count “open” patients because we want to make sure everyone with HIV who receives any service at Brooklyn Hospital – even if it is not in our HIV clinic – is engaged in HIV care.
Your Story of Becoming an "Active" Patient at Brooklyn Hospital

5) How were you referred to the PATH Center?

____________________________________________

6) Briefly describe your first visit at the PATH Center. Does anything stand out in your memory about conversations you had, things you saw in the clinic, or how you felt?

____________________________________________
____________________________________________
____________________________________________

7) What is the longest amount of time you have gone without medical visits at the PATH Center since you starting coming here?

Highest number of months/years between visits: ______________

Why was this gap between visits as long or short as it was?

____________________________________________
____________________________________________
____________________________________________

8) Why do you continue to receive your care at the PATH Center?

____________________________________________
____________________________________________
____________________________________________

Patients get counted in the “active” bar if they have HIV and received services in the PATH Center in the past year. If you came into the PATH Center for an appointment in the past year, or your first visit is today, you are an "active" patient.
Your Story of Getting on Antiretroviral Therapy (ART) at Brooklyn Hospital

9) Have you been prescribed ART at the PATH Center?
   - [ ] Yes
   - [ ] No (If No, skip to Question 9 on next page)

10) Why do you take your medication?

11) Do you take your ART as recommended by your healthcare provider?
   - [ ] Yes
   - [ ] No
   Why or why not?

12) Since starting on ART at the PATH Center have you ever stopped taking this medication? If yes, why did you stop?

13) What helped you get back on schedule with your ART?

Patients get counted in the “On ART” bar if they are “Active” (had an appointment at the PATH Center in the past year) AND were prescribed HIV meds in the past year. If you were given a prescription for ART at the PATH Center – even if you did not pick them up or take them – you would be counted in the “On ART” bar of the cascade.
Your Journey to Viral Load Suppression at Brooklyn Hospital

14) Are you virally suppressed (do you have a viral load of less than 200 copies/mL)?
☐ Yes  ☐ No

Why or why not? _____________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

15) What has been the hardest part about staying on your HIV meds?
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

16) What has made it easier for you to stay on your HIV meds?
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Patients get counted in the “Virally Suppressed” bar if they are “Active” (had an appointment at the PATH Center in the past year) AND had a viral load of less than 200 copies/mL at their last viral load test. If you do not know what your viral load is, you can ask your doctor at your next visit!
I came into the ER at Brooklyn Hospital in 2007 because I broke my wrist at my cousin’s house. At the time, I was a patient at the HIV outpatient clinic at Kings County. I moved in with my cousin and stopped going to Kings County because it was far. I ended up going to Brooklyn Hospital with pneumonia and they referred me to the PATH Center.

I didn’t go in for an appointment for 8 months once because I got in a fight with my cousin and lived with friends in Queens for a while. Transportation from Queens to Brooklyn is such a pain.

But I had to go back to the PATH Center because they are family. They connected me to housing services so I could move out of my cousin’s place.

I talked to a peer at the PATH Center who helped me feel comfortable. I didn’t always take my meds with dinner because I have friends over and don’t want them to see. I stopped taking my ART when they started giving me crazy dreams and couldn’t focus at work.

I don’t always take my meds with dinner because I have friends over and don’t want them to see. I stopped taking my ART when they started giving me crazy dreams and couldn’t focus at work.

I finally went to the PATH Center and they got me on a different regimen that doesn’t have such bad side effects. I also have a support group now and travel to the clinic with my buddy.

I am virally suppressed because I take my meds every day now. I hate having to take a pill every morning, but I am going to be a father soon, so want to keep myself healthy and watch my baby grow up.

DISCLAIMER: This story is fictional – it was made up for demonstrative purposes.
Journey to the End of the Epidemic

Bronx NYLinks Regional Group Meeting
Friday, May 12, 2017
Agenda

• Bronx EtE Committee Update
• The System of Profound Knowledge and the Six hats
• Cascade Presentations
• **BREAK**
• Consumer Involvement
• Six Helmets Process Investigation
• New QI plans to test out and see if they fly on your PDSA Ships
• Force Field Analysis-Next Steps
• Report back, Next steps and Evaluation
<table>
<thead>
<tr>
<th>appreciate the system</th>
<th>understand variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>psychology</td>
<td>theory of knowledge</td>
</tr>
</tbody>
</table>
Edward de Bono’s Six Hats

• Parallel thinking
• Separate thinking into six clear categories each identified by a different colored hat
• By switching hats, you switch your frame of thinking and redirect your focus
<table>
<thead>
<tr>
<th>Coloured Hat</th>
<th>Think Of:</th>
<th>Detailed Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITE</td>
<td>White paper</td>
<td>The white hat is about data and information. It is used to record information that is</td>
</tr>
<tr>
<td></td>
<td></td>
<td>currently available and to identify further information that may be needed.</td>
</tr>
<tr>
<td>RED</td>
<td>Fire and warmth</td>
<td>The red hat is associated with feelings, intuition, and emotion. The red hat allows</td>
</tr>
<tr>
<td></td>
<td></td>
<td>people to put forward feelings without justification or prejudice.</td>
</tr>
<tr>
<td>YELLOW</td>
<td>Sunshine</td>
<td>The yellow hat is for a positive view of things. It looks for benefits in a situation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This hat encourages a positive view even in people who are always critical.</td>
</tr>
<tr>
<td>BLACK</td>
<td>A stern judge</td>
<td>The black hat relates to caution. It is used for critical judgement. Sometimes it is</td>
</tr>
<tr>
<td></td>
<td></td>
<td>easy to overuse the black hat.</td>
</tr>
<tr>
<td>GREEN</td>
<td>Vegetation and rich growth</td>
<td>The green hat is for creative thinking and generating new ideas. This is your creative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>thinking cap.</td>
</tr>
<tr>
<td>BLUE</td>
<td>The sky and overview</td>
<td>The blue hat is about process control. It is used for thinking about thinking. The blue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>hat asks for summaries, conclusions and decisions.</td>
</tr>
</tbody>
</table>
Presentations from the Field: Organizational Treatment Cascades
2016 Legacy Clinics HIV Care Cascade for Established Patients
Brightpoint Health

Open Cases  Active Cases  Prescribed ART  VL<200

- Open – all HIV positive with any visit in the last 12 months
- Active – # of HIV patients under HIV Provider Care in 2016
- On ARV – From Active column those on ARV prescription
- VL<200 – From Active column patients with last VL Test result less than 200 copies/ml

Additional Programs: Alpha School, Bedford Health Center, Health Home & ADHC

Data Source: eCW & Data Warehouse
2016 Other Clinics HIV Care Cascade for Established Patients
Brightpoint Health

- **Open Cases**: all HIV positive with any visit in the last 12 months
- **Active Cases**: # of HIV patients under HIV Provider Care in 2016
- **On ARV**: From Active column those on ARV prescription
- **VL<200**: From Active column patients with last VL Test result less than 200 copies/ml

Data Source: eCW & Data Warehouse
Bronx-Lebanon Family Practice
2016 Care Cascades and Improvement Plan

Jose Tiburcio, MD and Octavia Lewis, MHA
Department of Family Medicine
Bronx-Lebanon Hospital Center
Family Medicine Background

- 5 outpatient clinics scattered across the South Bronx with a pain management clinic co-located in the Wellness clinic

- 80,000-100,000 patient visits every year

- Clinic staffs comprised of: primary care physicians (who are also HIV and Hep-C providers), social workers, community health workers (CHWs), psychiatrist, nurse practitioners, LPNs, MAs, PCTs, and nutritionist
Established Patients Methodology

• Main Data source: EMR (AllScripts, hospital wide)
  • Secondary data sources: HIV Care Status Report database
  • Incarceration databases

• Data Extraction: SQL code + chart reviews

• Definitions:
  • HIV+ = diagnosis documented in visit history/HIV+ lab result
  • Open – all HIV+ pts with any visit in last 12 months
  • Active - # of HIV+ pts with HIV medical visit in last 12 months.
  • On HAART - # of active patients with HAART prescription.
  • Viral Load <200 - # of active patients with viral load <200 copies/mL.
2016 Established Patients Cascade

Open – all HIV+ pts with any visit in last 12 months. Active - # of HIV + pts with HIV medical visit in last 12 months. On HAART - # of active patients with HAART prescription. Viral Load <200 - # of active patients with viral load <200 copies/mL.
2016 Open but not Active Patients

- 20 patients or 43%
- 11 patients or 24%
- 10 patients or 22%
- 5 patients or 11%

- No 2016 appointments (but appointments in 2017)
- Newly Diagnosed (reflected in second cascade)
- Receiving care elsewhere
- Unknown
Newly Diagnosed Patients Methodology

- Main Data source: EMR (AllScripts, hospital wide)
  - Secondary data sources: HIV Care Status Report database
  - Incarceration databases

- Data Extraction: SQL code + chart reviews

- Definitions:
  - HIV+ = diagnosis documented in visit history/HIV+ lab result
  - Newly Diagnosed: no prior knowledge documented or test before coming to Family Medicine
  - Linked: Newly diagnosed patients who attend a routine HIV medical visit within 3 calendar days of DX if linked within; and 5 calendar days if linked without.
  - On ART: Newly diagnosed patients that were prescribed ART during the measurement year.
  - Virally Suppressed: Newly diagnosed patients with a viral load <200 copies/mL at last viral load testing during the measurement year.
**2016 Newly Diagnosed Cascade**

**HIV Care Cascade Newly Diagnosed**

**FY 2016**

**BLHC - Family Medicine Fulton Clinics**

- **Newly Diagnosed**: Newly diagnosed with HIV during the measurement year.
- **Linked**: Newly diagnosed patients who attend a routine HIV medical visit within 3 calendar days of DX if linked within; and 5 calendar days if linked without.
- **On ART**: Newly diagnosed patients that were prescribed ART during the measurement year.
- **Virally Suppressed**: Newly diagnosed patients with a viral load <200 copies/mL at last viral load testing during the measurement year.

### Chart Details:

- **Newly Diagnosed**: 100.00%
- **Linked**: 45.00%
- **On HAART**: 16%
- **Virally Suppressed**: 40.00%

The chart illustrates the percentage of patients at each stage of the HIV care cascade for FY 2016.
Improvement Plan: Identified Gaps for Established Patients

Ensuring any HIV+ patients that passed through Family Medicine Door received HIV care aka LINKAGE TO CARE!

Ensuring those on HAART obtain viral load suppression

![Bar charts showing comparison of open and active patients, and on HAART and viral load suppression rates.](chart)
Improvement Plan: Identified Gaps for Newly Diagnosed Patients

Ensuring newly diagnosed patients are linked to care within three calendar days

Ensuring those on HAART obtain viral load suppression
Improvement Plan: Goals for Established Patients

**Ensuring any HIV+ patients that passed through Family Medicine Door received HIV care aka LINKAGE TO CARE!**

Increase the percentage of patients who are engaged in care by having a medical visit in the last twelve months to 90%.

- Current: 84.9%
- Goal: 90%
- Increase by 5 percentage points

**Ensuring those on HAART obtain viral load suppression**

Increase the percentage of patients whose viral loads are less than 200 copies/mL to 75%.

- Current: 72.9%
- Goal: 75%
- Increase by 2 percentage points
Improvement Plan: Goals for Newly Diagnosed

Ensuring newly diagnosed patients are linked to care within three calendar days

Increase the percentage of patients who are linked to a medical appointment within 3 days to 50%.

Ensuring those on HAART obtain viral load suppression

Increase the percentage of patients whose viral loads are less than 200 copies/mL to 45%.

50% 

Increase by 5 percentage points

45% 

Increase by 5 percentage points

40% 

45%
Improvement Plan: Interventions

• **External Partnerships:**
  • housing an Amida Care External Care Coordinator in two of its five clinics (2x a week who assists patients with appointments, ensuring receive necessary lab work, and address barriers to care to keep more patients in care and by receiving specialized attention, will see an impact on viral load suppression as well.
  • Family Medicine plans to expand by housing ECCs in all of their clinics within the next two/three months.

• **Community Health Workers:** Family Medicine hired 5 CHWs devoted to HIV+ patients that will provide similar services to the ECC in all five clinics (for those patients not insured under Amida Care).
  • All five are trained in care coordination and HIV care specifically
  • CHWs will also conduct outreach using data provided by Data Analyst on a daily basis, CHWs will reach out to those patients recently diagnosed so patients can be linked to care within three day window. First via phone calls, then home visits and escorting patients if need be.
Improvement Plan: Interventions con’t.

- Peers Collaboration: Family Medicine is finalizing a partnership with the Alliance for Positive Change
  - Housing a case manager and two peer workers to engage with those patients having a difficult time following up with their care or those having difficulty achieving viral load suppression.
  - In the next two months, case manager and peer workers should be on site to serve the five clinics.

- Addressing Barriers to Care:
  - Bio/Psycho/Social approach is a part of Family Medicine’s care, regardless of HIV status. However, it is especially important for HIV+ patients.
  - All CHWs will screen HIV positive patients in the next two months to determine who would benefit most from the program Health Leads.
  - Health Leads helps to screen for social service needs and refer to organizations in their community to address those needs.
  - Those that would benefit will be assigned a CHW to begin to determine their greatest needs and connect them to resources.
Improvement Plan: Evaluation

With the interventions implemented in the next three months, Family Medicine will evaluate the progress toward the outlined goals at quarterly HIV performance improvement meetings.
Improvement Plan: Evaluation con’t.

• Data used for the cascades (and quarterly updated data for new patients) will be drilled down.

• Those that made up the initial cascades will be tracked to determine if they have moved through the cascade to viral load suppression via chart reviews.

• If not, team will look at what specific interventions, they received and determine what the right intervention mix is for that patients.

• New patients will be looked at “point in time” during the review meetings to see where they would be in the cascade at that moment and if they need one of the interventions to move them along.
By fall of 2017, a quarter to a half of the growth anticipated is expected.

Established Patients:
For linkage to care:
- 87%
For Viral Load Suppression:
- 47%

Newly Diagnosed:
For Linkage to Care:
- 74%
For Viral Load Suppression:
- 43%
SBH Health System
ETE Cascades

Ralph P. Belloise
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Pathways Center for Comprehensive Care
Newly diagnosed HIV+ in 2016

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<table>
<thead>
<tr>
<th>Year</th>
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<th>Active</th>
<th>On Art</th>
<th>Virally Suppressed</th>
</tr>
</thead>
<tbody>
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<td>100%</td>
<td>28%</td>
<td>99%</td>
<td>66%</td>
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• IT to generate monthly report of all ED and Inpatient visits for HIV+ patients for Pathways outreach (Done)
• Work with Patient Accounts to remove any HIV related diagnosis codes for HIV negative patients
It's Time For A Break
Consumer Involvement
Dan Tietz, Maggie Brown
Journey to the End of the Epidemic

• You and your team of data analysts have travelled thousands of lightyears on your way back to earth on your ship, the PDSA Improve. You are returning home from a trip to Eartha, a planet that mirrors earth in every way except that it is lightyears ahead of earth.

• Accompanying you is an Eartha-Kin who will help you end the epidemic in NYS, then spread ETE to all of planet earth. But on the way home, your vessel was attacked by Space Pirates and Time Thieves. Luckily Emotional Changelings who happened to be in the area intuit that you are in trouble and come to your rescue.
Space Pirates and Time Thieves

- They limit your resources by diminishing time and space.
Journeying to ETE

• The Emotional Changelings are able to fight off the Space Pirates, but not before they have destroyed your Eartha Kits, which had everything in them that a planet needs to end an epidemic and all of the fuel the PDSA Improve needs to reach its targets. The Space Pirates have destroyed your navigation system so you can only guess the way back to Earth.

• Out of fuel, you had to make an emergency landing, and now find yourselves stranded on a hostile planet. But wait...this hostile planet is actually earth, which seems to be lightyears further behind where you thought it was when you left on your journey to Eartha.
Here are the crew members who made it:

Blue Helmet
PDSA Ship Lead

White Helmet
Data Analysts

Green Helmet
Earthling

Yellow Helmet
Eartha-Kin

Red Helmet
Emotional Changeling

Black Helmet
Space Pirate
Welcome to Earth! Thanks for dropping by!
PDSA Ship Crew members and their think modes

1. **Eartha-Kin**- One Eartha-Kin per PDDSA ship (table) explains how you ended the epidemic Eartha using the tools in your Eartha Kit (yellow helmet)

2. **Space Pirate/Time Thief**- After invading your ship hitched a ride, some of the Space Pirate-Time Thieves have travelled with you to Earth. They are bent on ruining your mission. the worst! (Black Helmet)

3. **Emotional Changeling**- Four have also made it back to Earth. They are highly intuitive and are always thinking about the feelings of others. This includes patients, staff, family members. (Red helmet)

4. **Earthling**- One every day Earthling who works in an HIV clinic for each PDSA ship (table) to discuss how you can take what you learned from Eartha, and tailor it creatively to meet the needs of Earth (Green Helmet)
The exercise

• Each table chooses a captain, an emotional changeling, an earthling, an Eartha-Kin, and a space pirate/time thief

• Each table uses their data from the cascade to inform the discussion with each of the discussion leads.

• Each PDSA ship has four 15 minute discussions and a final 20 minute discussion to develop their kit with 5 minutes per PDSA ship to present back at the end of the exercise and

• a few minutes to think about how they can implement these ideas at their own service sites.
Facilitating the exercise

1. Eartha Kin mode: the group can only mention positive ideas for improving cascade outcomes. Take notes on all your great improvement ideas.

2. Space Pirate/Time Thief mode: Group can only talk about why the improvement ideas won’t work, the resource limitations, the lack of time and space.

3. Emotional Changeling mode: Group can only talk about the emotional impact of making these changes on consumers, staff, family members and other stakeholders.

4. Earthling mode: Group can only talk about tailoring the great ideas creatively to make them work in the Bronx. Which of the ideas seem most feasible after going through these discussions?
Improvement Kits

- Each PDSA ship develops their own Improvement Kit to contribute to ending the epidemic in the Bronx through
  - using cascade data
  - innovative ideas
  - awareness of resource limitations
  - sensitivity to the emotional aspects of change for patients, family members, and staff.
  - Creatively tailoring improvement ideas to your own service sites here in the Bronx
  - Deciding which of your ideas are the strongest, most doable and most likely to get the results you are looking for.
Off we go!
Eartha-Kin Talking Points (15 min)

You lead the way, showing how earth communities can streamline efforts to do more with less. Though the Eartha-Kits have been destroyed, you will help recreate them based on your experiences with ending the epidemic on Eartha.

• What internal health center process changes can be made to improve VLS Outcomes?

• How can clinic team can work with the community to positively influence social determinants of healthcare outcomes
  • Mental Health
  • Substance Use
  • Housing
  • Transportation

• Why do you think these approaches will work?
Earthling Talking Points (15 min)

You must struggle to persevere but must also accept the limitations of earth. You have social and cultural knowledge that the Eartha-Kin do not have. You must map out the way to the end of the epidemic.

• How can you use the great ideas from the Eartha-Kin to tailor improvements for your clinic?
• What about your clinic setting needs to be taken into consideration?
• What new ideas do you have to overcome challenges in your clinic?
Space Pirate/Time Thief Talking Points (15 min)

Time and space can be expanded and contracted. Time can be used wisely or wasted. You are malleable. You listen to the details of the plans being discussed and are always keeping an eye on:

• how much time each will take as well and where time is being lost
• spatial concerns such as what happens when patients are not at clinic, how are patients transported to and from clinic, what kind of housing exists in the community.

• What may go wrong with the plans for improvement?
• Who or what will get in your way?
• What are the limitations of space and time that will obstruct your plans for improvement?
Emotional Changeling Talking Points (15 min)

You are very aware of the emotions of others and want everyone to take into account how the proposed changes will impact those involved.

• What are the impacts of the proposed changes on
  • Patients
  • Staff
  • Family Members

• Has everyone’s point of view been taken into account?
• If not, who else might you need to talk to?
Captain of the PDSA and Crew lead the way to ETE by 2020 (20 min)

You have been listening to all the great improvement ideas that your crew has been coming up with and it is now time to help bring it all together and take a closer look at the best ones.

- Create a list of all the improvement ideas that were discussed by the crew
- Ask the crew to decide on the top two improvement ideas and the guide them in performing a force field analysis on each
Report Back (15 minutes)

• Blue Helmet Captains report back
QI Plan-Map to ETE by 2020 (20 min)

• Using the ideas you have gained from your journey on the PDSA Ship, create a plan to improve cascade results in your service sites and communities to end the epidemic in the Bronx
Thank you!!!
HIV Tobacco Cessation Improvement Campaign

Daniel Tietz, Manager Consumer Affairs
New York State Department of Health AIDS Institute
daniel.tietz@health.ny.gov
Presentation Objectives

- Background on HIV and Tobacco
- Purpose of HIV Tobacco Cessation Improvement Campaign
- Walkthrough Campaign Website
- Share campaign provider and consumer toolkit resources
- Review dates/times for topic specific webinars
- Discussion/Q & A
HIV Tobacco Cessation Campaign Origins

- Clinical (QAC) and Consumer (CAC) Advisory Committees
- 2014 Joint Meeting recommendation:
  - Prioritize tobacco cessation among HIV+ individuals

Creation of HIV Tobacco Cessation Improvement Campaign. Managed by the working group and steering committee.
Why establish HIV Tobacco Cessation Improvement Campaign

• According to 2014 eHIVQUAL data from New York State,
  – 72% of HIV-infected smokers were virally suppressed at last test, compared to 85% of non-smoking PLWH
  – 87% of HIV-infected patients were asked by a healthcare provider if they smoked and
  – 82% of HIV-infected smokers were counseled by the provider in the quit attempt
• Approximately 61% of deaths among PLWH can be attributed to tobacco smoking.¹

Welcome to the HIV Tobacco Cessation Improvement Campaign!

HIV+ smokers lose more years of life from smoking than from HIV.

Helping HIV+ New Yorkers Live Longer, Healthier Lives

With advances in HIV treatment and management, HIV+ smokers now lose over six years of life expectancy from smoking, more than the HIV infection itself.

People living with HIV smoke at rates 2-3 times higher than the general population, putting themselves in danger for AIDS-related and non-AIDS related illnesses.

Enroll Here
If you are a smoker, click HERE!
If you are a provider, click HERE!

Provider Quarterly Data Submission
Sign-in to database

Have Questions?
Have any questions for us on the HIV Tobacco Cessation campaign? Feel free to contact us! Please put ‘Help’ in the subject line.
info@hivtobaccofreeny.org

Need help, have questions?
Call a coach at the NY State Department of Health
HIV Tobacco Cessation Campaign Website

About the Program

What
The HIV Tobacco Cessation Campaign aims to improve the health and decrease the morbidity and mortality of people living with HIV in New York State. The purpose of this campaign is to promote tobacco screening and tobacco cessation in this population.

Click here for background of campaign

Who
The New York State Department of Health AIDS Institute created the HIV Tobacco Cessation Campaign for both providers and consumers living in New York State

Partners
New York State Tobacco Control Program
New York Smokers’ Quitline
New York City Department of Health and Mental Hygiene
Clinical Education Initiative (CEI)
HIV Stops with ME
Positively Smoke Free

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HIV Tobacco Cessation Improvement Measures
(Created by the HIV Tobacco Cessation Improvement Campaign Steering Committee)

Campaign Measures and Definitions

The below measures will be collected quarterly from all participating sites. The review period refers to a rolling 3-month period leading up to the submission date.

Overview of Measures

1. Screen
   1.1 Tobacco Cessation Screening

2. Intervene
   2.1 Tobacco Cessation Counseling
   2.2 Tobacco Cessation Pharmacotherapy

3. Quit
   3.1 Reduction in Tobacco Use
   3.2 7-Day Quit
   3.3 30-Day Quit

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1. SCREEN
1.1 - Tobacco Cessation Screening: The percent of HIV-infected patients who were screened for tobacco use.

1.1a) Denominator 1.1b) Numerator
1. Screen:

1. Tobacco Cessation Screening

The percent of HIV-infected patients who were screened for tobacco use

<table>
<thead>
<tr>
<th>1.1a) Denominator</th>
<th>1.1b) Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>All HIV-infected patients with at least one HIV primary care visit during the 3-month review period.</td>
<td>All HIV-infected patients who were screened for tobacco use during the last HIV primary care visit during the 3-month review period.</td>
</tr>
</tbody>
</table>

Exclusions: HIV-infected patients under 13 years old or patients who died during the review period.
2. Intervene:

1. Tobacco Cessation Counseling

The percent of HIV-infected patients identified as tobacco users who received a documented tobacco cessation counseling intervention.

<table>
<thead>
<tr>
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<th>1.1b) Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>All HIV-infected patients with at least one HIV primary care visit during the 3-month review period who are screened and identified as a tobacco user.</td>
<td>All HIV-infected patients who were identified as a tobacco user and received at least one documented tobacco cessation counseling intervention during the last HIV primary care visit during the 3-month review period.</td>
</tr>
</tbody>
</table>

Exclusions: HIV-infected patients under 13 years old or patients who died during the review period.

Comments: Examples of counseling interventions include, but are not limited to: advise to quit, discussion of quit, refer to NYS Smokers Quitline, refer to mental health assistance, refer to substance abuse assistance, provided link to campaign website.
2. Intervene:

2. Tobacco Cessation Pharmacotherapy

The percent of HIV-infected patients screened and identified as tobacco users for whom tobacco cessation pharmacotherapy was prescribed

<table>
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<th>1.1b) Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>All HIV-infected patients with at least one HIV primary care visit during the 3-month review period who are screened and identified as a tobacco user.</td>
<td>All HIV-infected patients who were screened, identified as a tobacco user and prescribed tobacco cessation pharmacotherapy during the 3-month review period.</td>
</tr>
</tbody>
</table>

**Exclusions:** HIV-infected patients under 13 years old or patients who died during the review period.

**Comments:** Examples of pharmacotherapy prescribed may include, but not limited to: Nicotine replacement therapy (e.g. skin patch, chewing gum, lozenges, nasal spray, oral inhaler), Varenicline (Chantix), Bupropion SR.
### 3. Quit:

#### 1. Reduction of Tobacco Use

The percent of HIV-infected patients screened and identified as tobacco users with reduced tobacco use during review period.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>All HIV-infected patients with at least one HIV primary care visit during the 3-month review period who are screened and identified as a tobacco user.</td>
<td>All HIV-infected patients who self-reported reduced tobacco use during the 3-month review period.</td>
</tr>
</tbody>
</table>

**Exclusions:** HIV-infected patients under 13 years old or patients who died during the review period.
3. Quit:
2. 7-day Quit
The percent of HIV-infected patients screened and identified as tobacco users who abstained from using tobacco for at least a consecutive 7-days during review period.

<table>
<thead>
<tr>
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<th>1.1b) Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>All HIV-infected patients with at least one HIV primary care visit during the 3-month review period who are screened and identified as a tobacco user.</td>
<td>All HIV-infected patients who abstained from using tobacco for at least 7 consecutive days during the 3-month review period.</td>
</tr>
</tbody>
</table>

Exclusions: HIV-infected patients seen in the last month of the review period, HIV-infected patients under 13 years old or patients who died during the review period.
3. Quit:
2. 30-day Quit
The percent of HIV-infected patients screened and identified as tobacco users who abstained from using tobacco for at least a consecutive 30-days during review period.

<table>
<thead>
<tr>
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<th>1.1b) Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>All HIV-infected patients with at least one HIV primary care visit during the 3-month review period who are screened and identified as a tobacco user.</td>
<td>All HIV-infected patients who abstained from using tobacco for at least 30 consecutive days during the 3-month review period.</td>
</tr>
</tbody>
</table>

Exclusions: HIV-infected patients seen in the last month of the review period, HIV-infected patients under 13 years old or patients who died during the review period.
Toolkit for Providers

By helping your patients quit smoking, you are helping them live longer, better lives. Health encounters are opportunities for advising patients and increasing motivation to quit tobacco use. The resources below can help you assist your patients in this effort. Please utilize and share whichever resources you find most helpful.
Click on the tabs below for additional information.

Background

Positively Smoke Free: HIV and Smoking Information Guide
Quick fact sheet on smoking and HIV from Dr. Jonathan Shuter.

American Academy of Family Physicians: Treating Tobacco Dependence Manual (Ask and Act Tobacco Cessation Program)
Clinical guidelines to provide the best quality of care for HIV+ patients.

Guidelines

Academic Literature

Assessment and Screening Tools

Interventions/Counseling Tools

Enroll Here
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Toolkit Resources for Providers

• Clinical Education Initiative (CEI) courses for credit
• Smoking Cessation Leadership Center webinars
• Harm reduction approaches
  – Motivational interviewing
  – The 5 A’s of tobacco cessation
Toolkit Resources for Consumers

- NYS Smokers Quitline
- Positively Smoke Free website
- Links to Mobile apps and text services
- Personal Stories/Videos
- Brochures
- Cost calculator
- AI Tobacco Cessation consumer publication “It’s Time to Live”
Next Steps

– Introductory Kick-off Webinar
– Provider enrollment to enter and report on measures quarterly
– Consumer Enrollment for quarterly self-reporting on tobacco cessation and quit attempts
– Opportunity to join and collaborate as campaign partner
– Monthly Provider Coaching Webinars
– CEI developing provider video
– Peer-to-Peer facilitated monthly calls for consumers for coaching and support
Approximate Date of Campaign Webinars

- **Campaign Kick-off**: (April 1, 2017)
- Upcoming Webinars:
  - Campaign Overview (Tentatively scheduled for **May 30, 2017**)
  - Tobacco Control Program (**June 2017**)
- Monthly peer-to-peer support webinars for consumers who are attempting to quit tobacco
Discussion

What monthly webinar topics would benefit providers to address HIV Tobacco Cessation among patients?

Any questions about the campaign should be directed to:
info@hivtobaccofreeny.org
Special Thanks

• Bruce Agins, AIDS Institute Medical Director
• HIV Tobacco Cessation Improvement Campaign Steering Committee Members (Chaired by Dr. Kelly Ramsey)
• Kelly Hancock, AIDS Institute Intern
• Ryan Baxter-King, AIDS Institute Intern