July 18, 2018
9.30am to 12.00pm
Brooklyn
Opening Remarks
Opening Remarks

Charles Gonzalez, MD
Medical Director, NYS Department of Health
AIDS Institute
Oni Blackstock, MD, MHS
Assistant Commissioner, NYCDOHMH HIV/AIDS Prevention and Control
Overview
Meeting Overview

• Introduction of Brooklyn Co-Chairs: Clemens Steinbock, Zeenath Rehana

• Meeting Purpose
  – To strengthen the Brooklyn Regional Group as a platform for peer learning and regional improvements
  – To better understand Brooklyn Surveillance Data
  – To learn from presentations from the field
## Agenda

<table>
<thead>
<tr>
<th>Session</th>
<th>Time</th>
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<tbody>
<tr>
<td>Registration and Networking</td>
<td>9:00 - 9:20</td>
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<tr>
<td>Opening Remarks</td>
<td>9:20 - 9:35</td>
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<tr>
<td>Welcome, Introductions &amp; Meeting Overview</td>
<td>9:35 – 9:45</td>
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<tr>
<td>2016 Surveillance Data for Brooklyn: Community Profile</td>
<td>9:45 – 10:00</td>
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<tr>
<td>Presentations from the Field: Lessons Learned Organizational HIV Cascade, and how providers are involving consumers in QI</td>
<td>10:00 – 10:50</td>
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<td>Consumer Engagement: Living Cascade</td>
<td>10:50 – 11:05</td>
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<tr>
<td>QI Exercise and Team Action Plan</td>
<td>11:05 – 11:45</td>
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<tr>
<td>Next Steps &amp; Evaluation</td>
<td>11:45 - 12:00</td>
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<td>12:00</td>
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2016 Surveillance Data for Brooklyn: Community Profile

Cristina Rodriguez-Hart,
Epidemiologic Liaison, NYCDOHMH,
Bureau of HIV/AIDS Prevention and Control
HIV DIAGNOSES AND CLINICAL STATUS OF PEOPLE DIAGNOSED WITH HIV/AIDS IN BROOKLYN, 2016

Cristina Rodriguez-Hart, PhD
HIV Epi Liaison
HIV Epidemiology and Field Services Program
New York City Department of Health and Mental Hygiene

Presentation at Brooklyn Links Meeting
July 18, 2018
NYC medical providers and laboratories are required by state law to report HIV information to the health department

- Positive HIV test results, viral load and CD4 test results, and genotypes

When we receive a report, we check to see if there is an existing match in our HIV Registry and if not then we assign the case for field investigation

- Field investigation: patient interview and chart review

Data in the HIV Registry is used to guide service delivery and to ask for funding from the federal government to support HIV services in NYC
For all reported clinical outcomes we also collect patient socio-demographics:
- Gender, race/ethnicity, age, zip code of residence, area-based poverty, transmission risk (e.g. MSM)
- Do not have good information on mental health, incarceration, homelessness, detailed risk behavior

The information tells us which subpopulations are most impacted by the HIV epidemic and trends over time

It does not tell us why we have these clinical outcomes and disparities
- We can’t say why individuals are not linked to care in a timely manner or why they were not virally suppressed
• **29,738 persons living with HIV/AIDS in Brooklyn**
  – 1% of Brooklyn population

• **581 new HIV diagnoses**
  – 25% of all HIV diagnoses in NYC
  – Includes 110 HIV diagnoses concurrent with an AIDS diagnosis (19%)

• **322 new AIDS diagnoses**

• **369 deaths among persons with HIV/AIDS**
  – 8.9 deaths per 1,000 mid-year persons living with HIV/AIDS^  

^Death rate is age-adjusted to the NYC Census 2010 population. As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
The number and rate of new HIV diagnoses decreased in Brooklyn between 2012 and 2016. The rate was lower in Brooklyn than for NYC overall in these five years.

As reported to the New York City Department of Health and Mental Hygiene by March 31, 2018.
The age-adjusted death rate among PLWH decreased in Brooklyn and NYC during 2012-2016, and was lower in Brooklyn than NYC in 2016.

Age-adjusted to the NYC Census 2010 population. The overall rate includes people with unknown cause of death. Death data and cause of death data for 2016 are incomplete. As reported to the New York City Department of Health and Mental Hygiene by March 31, 2018.
Timely initiation of care among people newly diagnosed with HIV decreased in Brooklyn since 2013, whereas it increased in NYC from 2012 to 2016.

Timely initiation of care is defined as first CD4 or VL drawn within 3 months (91 days) of HIV diagnosis, following a 7-day lag (Sabharwal CJ, Braunstein SL, Robbins RS, Shepard CW. *JAIDS* 2014;65(5):571-578.)

As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
Among people newly diagnosed with HIV in NYC in 2016, Brooklyn and Staten Island residents were less likely to have timely initiation of care.

Timely initiation of care is defined as first CD4 or VL drawn within 3 months (91 days) of HIV diagnosis, following a 7-day lag (Sabharwal CJ, Braunstein SL, Robbins RS, Shepard CW. JAIDS 2014;65(5):571-578.)

As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
Among diagnosed PLWHA in Brooklyn, timely initiation of care was lower than the citywide average for 8 of the 11 neighborhoods in 2016.

Proportions based on numerators at or below 10 are marked with an asterisk (*) and should be interpreted with caution.

Timely initiation of care is defined as first CD4 or VL drawn within 3 months (91 days) of HIV diagnosis, following a 7-day lag (Sabharwal CJ, Braunstein SL, Robbins RS, Shepard CW. JAIDS 2014;65(5):571-578.)

As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
Viral suppression among all people diagnosed with HIV/AIDS steadily increased in both Brooklyn and NYC between 2012 and 2016.

Viral suppression is defined as viral load ≤200 copies/mL. As reported to the New York City Department of Health and Mental Hygiene by March 31, 2018.
Among diagnosed PLWHA in Brooklyn, viral suppression was lower than the citywide average for 7 of the 11 neighborhoods in 2016.

Viral suppression is defined as viral load ≤200 copies/mL. As reported to the New York City Department of Health and Mental Hygiene by March 31, 2018.
Among people newly diagnosed with HIV in 2016, a lower proportion achieved viral suppression within 3 months and within 6 months of diagnosis in Brooklyn than in NYC overall.

Viral suppression is defined as viral load ≤200 copies/mL. As reported to the New York City Department of Health and Mental Hygiene by March 31, 2018.
Among people newly diagnosed with HIV in NYC in 2016, Brooklyn residents were the least likely to have achieved viral suppression within 6 months of diagnosis.

Viral suppression is defined as viral load ≤200 copies/mL.

As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
HIV/AIDS IN BROOKLYN: WHERE WE STAND IN 2016

- The rate of new HIV diagnoses continues to decline
  - MSM, young adults ages 20-29, and blacks continue to account for the largest number of HIV diagnoses
  - Death rate has steadily declined

- Levels of timely initiation of care were lowest in Brooklyn and have not increased in past 4 years
  - Within Brooklyn, levels were lowest for transgender persons, blacks, adults younger than 50, lower poverty, and US born

- Viral suppression overall was similar in Brooklyn as for NYC, but timely viral suppression within 6 months for newly diagnosed individuals was lowest in Brooklyn
  - Within Brooklyn, viral suppression was lower for transgender persons, blacks, adolescents, those perinatally-infected, and US born
Our program publishes annual surveillance reports and slide sets, as well as special supplemental reports during the year.

- Care status reports (CSRs): [https://www1.nyc.gov/site/doh/health/health-topics/aids-hiv-care-status-reports-system.page](https://www1.nyc.gov/site/doh/health/health-topics/aids-hiv-care-status-reports-system.page)

Email data requests to: [HIVReport@health.nyc.gov](mailto:HIVReport@health.nyc.gov)
- 2 weeks minimum needed for requests to be completed
Thank you!

Cristina Rodriguez-Hart
HIV Epidemiologic Liaison

crodriguezhart@health.nyc.gov
(347) 396-7634

Thank you to >160 members of the HIV Epidemiology and Field Services Program staff for collection, management and analysis of these data.
Definitions:

- “HIV diagnoses” include diagnoses of HIV (non-AIDS) and HIV concurrent with AIDS (AIDS diagnosed within 31 days of HIV), unless otherwise specified.
- “New HIV diagnoses” include individuals diagnosed in NYC during the reporting period and reported in NYC.
- “Death rates” refer to deaths from all causes, unless otherwise specified.
- Data presented by “Transmission risk” categories include only individuals with known or identified transmission risk, except when an “unknown” category is presented.
- “PWHA” refers to people with HIV or AIDS during the reporting period (note: includes people with HIV/AIDS who remained alive or died during the reporting period); “PLWHA” refers to people living with HIV or AIDS during the reporting period.
- Female includes transgender women and Male includes transgender men. For more information on transgender surveillance in NYC, please see the “HIV among People identified as Transgender” slide set.
- Risk information is collected from people’s self-report, their diagnosing provider, or medical chart review. “Heterosexual contact” includes people who had heterosexual sex with a person they know to be HIV-infected, an injection drug user, or a person who has received blood products. For females only, also includes history of sex work, multiple sex partners, sexually transmitted disease, crack/cocaine use, sex with a bisexual male, probable heterosexual transmission as noted in medical chart, or sex with a male and negative history of injection drug use. “Transgender people with sexual contact” includes people identified as transgender by self-report, diagnosing provider, or medical chart review with sexual contact reported and negative history of injection drug use. “Other” includes people who received treatment for hemophilia, people who received a transfusion or transplant, and children with a non-perinatal transmission risk.
- The “men who have sex with men” risk category does not include anyone identified as transgender.
Presentations from the Field
Presenters

- Housing Works Community HealthCare: Leslie Pierce
- Brightpoint Health: Darshna Dave
- SUNY Downstate: Jameela Yusuff
Consumer Engagement: Living Cascade
Quantum Leap Frog
Evaluation

• Please complete the session evaluation form
• Complete our contact information sheet
Contact Information

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Long Island—Steven Sawicki
Central NY & Southern Tier—Steve Sawicki
Mid & Lower Hudson—Steve Sawicki
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Brooklyn—Clemens Steinbock, clemens.steinbock@health.ny.gov and Zeenath Rehana, zrehana@health.nyc.gov
Bronx—Dan Belanger, dan.belanger@health.ny.gov
Northeastern NY—Steve Sawicki
If not sure, info@newyorklinks.org
2017 HIV Care Cascade Submission

Housing Works
Leslie Pierce, MPH
Quality Improvement Specialist

Tempestt Perkins, LMSW
Managing Director of Retention and Adherence
Data Source

• Housing Work’s EMR, eClinicalWorks (eCW)

• CHCANYS Center for Primary Care Informatics (CPCI)
  • Platform that assists with ongoing monitoring of clinical quality measures
  • Nightly extract from eCW
  • Data extract used for eHIVQUAL indicator reporting
Methods

- HIV specific ICD 9 and 10 codes

- Defined PCP appointment defined by following visit types:
  - Initial
  - Comprehensive
  - Primary Care Follow Up
  - Primary Care Follow Up with Case Conference
  - Acute Primary Care

- Active patients removed those who were deceased, reported receiving their primary care elsewhere or only had acute visits in 2017
Methods Continued

Also included:

• Primary Housing Works Service Location
  • Downtown Brooklyn
  • Cylar House (East Village)
  • East New York

• Diagnosis Date

• Most recent viral load (vl) date with result

• Binary value for prescription for HIV treatment in 2017
Methods Continued

• Validation
  • Primary service location was matched to the location of the provider
  • Newly diagnosed patients and linkage to care were determined via:
    • Chart review,
    • Follow up with providers/testers, and
    • Verification through other reporting platforms.

• Proxies
  • Missing VL considered unsuppressed
  • Null VL results were replaced with the second to the last lab
Challenges and Lessons Learned

- Newly diagnosed patients
  - Documentation
  - Offsite testing
  - Data verification

- Patients in care elsewhere

- Incarceration Data
HIV Care Cascade

- **Active**: % of open patients with HIV visit in the measurement period
- **Prescribed ART**: % of open patients with ART prescription in the measurement period
- **Virally Suppressed (<200)**: % of open patients with viral load <200 copies/mL at last viral load test in the measurement period

**Data Source**: Housing Works EMR, eICARE, and CPCI

<table>
<thead>
<tr>
<th>Year</th>
<th>Active</th>
<th>Prescribed ART</th>
<th>Virally Suppressed (&lt;200)</th>
</tr>
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<tbody>
<tr>
<td>2016</td>
<td>100%</td>
<td>97%</td>
<td>70%</td>
</tr>
<tr>
<td>2017</td>
<td>100%</td>
<td>98%</td>
<td>78%</td>
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</table>

Target 80%
2017 Improvement Strategies, Goals and Outcomes

**Strategy 1: Rise Above Project** Targeted outreach for patients with VL<200 via retention adherence case managers (Jan – June)

**Goal:** 25% of patients with unsuppressed HIV viral loads will be reached and reengaged.

**Outcomes:**
- 225 patients outreached
- 70 reached (32%)
- 33 (15%) scheduled appointments
Goal: 25% of patients with v1 >200 copies/ml will be reengaged in care.

- Mass emails, text messages and previously recorded calls by the patient’s primary care provider were unsuccessful due to the high volume of out of date or inaccurate phone numbers and emails.

- While time consuming, attempting to contact patients on the phone is the most successful method of outreach.

- High effort, low impact.
2017 Improvement Strategies, Goals and Outcomes

**Strategy 2:** Relaunch the Undetectables (Jan-Feb 2017)

Intervention elements include:

- a. Initial case conference - client, provider and case manager;
- b. Quarterly $100 gift card incentive for patients whose viral loads <200 copies/mL;
- c. CBT adherence support groups;
- d. Adherence toolkit methods (i.e., pill boxing, medication reminders and DOT); and
- e. Case conferences when there is an increase or rebound in viral load.

**Goal:** 75 new patients will be newly enrolled in the Undetectables

**Outcome:** 189 new patients enrolled in the Undetectables
## 2017 Analysis: What is our Data “Telling” Us?

<table>
<thead>
<tr>
<th>Categories</th>
<th>Subcategories</th>
<th>Open</th>
<th>Active</th>
<th>Prescribed ART</th>
<th>Received Viral Load Test</th>
<th>Virally Suppressed (&lt;200)</th>
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<tr>
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<td>25-29 (n=127)</td>
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<td>40-49 (n=192)</td>
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<td>50-59 (n=269)</td>
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<td>96%</td>
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<td>60+ (n=110)</td>
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<td>97%</td>
<td>96%</td>
<td>91%</td>
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<td></td>
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<tr>
<td>Male (n=597)</td>
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<td>82%</td>
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<tr>
<td>Female (n=235)</td>
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<td>81%</td>
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<tr>
<td>Transgender (n=78)</td>
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<td>76%</td>
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<td>Non-Hispanic White (n=64)</td>
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<td>Non-Hispanic Black (n=653)</td>
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<td>96%</td>
<td>80%</td>
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<td>Hispanic (n=228)</td>
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<td>82%</td>
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<tr>
<td>Asian/Pacific Islander (n=2)</td>
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<td>100%</td>
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<td>50%</td>
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<td>100%</td>
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<td>Men who have Sex with Men (MSM) (n=470)</td>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>97%</td>
<td>81%</td>
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<td>Intravenous Drug Users (IDU) (n=88)</td>
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<td>100%</td>
<td>95%</td>
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<td>Heterosexual (n=312)</td>
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<td>50%</td>
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<td>Unstable Housing (n=38)</td>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>79%</td>
</tr>
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</table>
Refining Our Goals and Strategies

Strategy 1: Continue with the **UNDETECTABLES**

Strategy 2: At ENY site Youth and Prevention Services (YPS) launching a CBT group for all patients with viral load rates above 200 copies/ml (May 2018)

- E-CHATS model for CBT University of Pennsylvania
- Discussion of adherence challenges, feedback from peers and recommit to their personal goals
- Facilitated by Case Manager and/or Social Worker
- Meets weekly for 6 months

Strategy 3: **Rise Above Project** and YPS targeted outreach to individuals < 29 years-old and/or who identify as transgender

- Monthly report to identify population
- Outreach and engagement across all clinics
- Meeting patients in clinic during previously scheduled appointments to enroll in CM program
2018 Goals

**Goal 1:** Increase the VLS rate of the population of patients between 20 to 29 years-old from 60% (2017) to 70% by end of 2018.

**Goal 2:** Increase the VLS rate of the population of patients who identify as transgender from 76% (2017) to 80% by end of 2018.

**Goal 3:** Improve agency-wide viral load suppression from 78% (2017) to 80% by end of 2018.
Anticipated Challenges

• Out of date or inaccurate phone numbers and emails.

• YPS services only offered at ENY location.

• Patients may not be eligible for case management programs based on funder requirements.

• Staff time and capacity to conduct outreach calls.
Questions?

Contact: Leslie Pierce
Quality Improvement Specialist
l.pierce@housingworks.org

Contact: Tempestt Perkins
Managing Director of Retention and Adherence
t.perkins@housingworks.org
Methodology
List all sources of the data used to construct the cascades and data table(s)
Explain why each source of data was selected

• **Data Sources:**
  
  • **EMR (Ecw) was the primary source of data.**
    
    – The advantage of using EMR with our SQL reporting tool was that we were able to pull an accurate count of HIV patients along with their lab results, medication orders, demo and visit info. Lab results in the EMR are interfaced directly with the lab companies and get updated daily. Almost 99% of our Rx orders are ePrescribed.

  • **Data Warehouse was the second source.**
    
    – It integrates data from Health Home patients (from software RMA) and ADHC patients (from software Treat) with our EMR (Ecw). The Data Warehouse enabled us to identify Open patients. The Data Warehouse provided us with the count of HIV patients served by our Health Home and ADHC staff as they do not use our primary EMR (Ecw).
Limitations of each of the data source(s)

• Limitations of Data Sources:
  • Ecw & Data Warehouse:
    – While we do have data elements in the EMR to store specific information such as, ‘In care elsewhere for HIV treatment’, ‘Deceased’, ‘Incarcerated’ this data is not always documented or it is free texted in other areas of the progress note which cannot be accessed using SQL. However due to the high volume of HIV patients we serve running reports against the EMR is still a better approach.

  • Data Warehouse only:
    – The limitation to Health Home data is that is self-reported by the patient and collected and documented in TREAT by the care manager.
The number of patients newly diagnosed at the organization in 2017 was determined:

- Newly diagnosed HIV patients were reported with DOH, and this helped us tally our total newly diagnosed HIV patient count.

The number of patients newly diagnosed outside the organization in 2017 was determined:

- We are unable to determine this cohort as we do not consistently document the initial HIV diagnosis date or HIV determined by which practice in our ancillary EMRs such as Treat (for ADHC patients) and RMA (for Health Home patients).

The number of previously diagnosed new-to-care was determined:

- EMR (Ecw) documents the initial HIV diagnosis date. This initial HIV dx date along with the information from the EMR when these patients started receiving primary care at our organization with a HIV provider team helped determine these previously diagnosed new-to-care HIV patients at the organization.
The number of patients diagnosed patients who received any service at the organization was determined:

- From the EMR (Ecw) and Data Warehouse we were able to determine all HIV patients that were served by our organization in any service line (Primary Care, OB/GYN, Pediatrics, Podiatry, Dental, Health Home, ADHC, Mental Health/A31, Mobile Clinics, ADHC, Health Home and more) by any clinical/non-clinical provider in the year 2017.

Explain the methodology used to identify, determine and confirm the care status of open patients:

- HIV patients from ADHC & Health Home identified from the Data Warehouse were matched with HIV patients from Ecw using Medicaid IDs to prevent duplication. The unique count of HIV patients from both sources Data Warehouse and Ecw were identified as open patients.

Explain how patients were determined to be deceased, incarcerated or in care at an outside organization:

- While Ecw does have fields to document this information it is not necessarily documented. So, we used Nurse Tel encounters made to patients containing keywords related to deceased or incarcerated and then manually reviewed all these patients. For in care outside we used provider documentation in the Progress notes- HIV Treatment section that indicated patient is in care elsewhere or with a specialist for HIV.
• The methodology used to identify and confirm the care status of active patients:
  • Established HIV patients who were served by our HIV provider team in 2017 were identified as active patients. These would also be patients with a who are engaged in our primary care services. HIV Provider is a provider who prescribes ARVs and monitors HIV treatment.

• The service delivery point was determined and verified for non-active patients:
  • Using the visit types in our EMR (Ecw) and source of data ADHC/Health Home from the Data Warehouse we were able to determine the service lines for the non-active patients.

• Age, gender, race/ethnicity, risk category and housing status was determined and verified for active patients:
  • This information is documented in the demo/profile section in our EMR (Ecw).
Results
Newly Diagnosed/New to Care Patients (Organization Wide)

**NOTE:** Only 2 newly diagnosed patients, thus difficult to read colors on the graph

**Newly diagnosed/ new-to-care:** # of pts newly diagnosed with HIV in 2017 and all patients new to care in the HIV program in 2017, regardless of HIV diagnosed date

**Prescribed ART**: Percentage of newly diagnosed and new-to-care pts prescribed ART in 2017

**Received Viral Load Test**: Percentage of newly diagnosed and new-to-care pts with a documented viral load test in 2017

**Virally Suppressed**: Percentage of newly diagnosed and new-to-care with viral load <200 copies/mL

**Data Source:** eCW
2017 HIV Treatment Cascade, Previously Diagnosed Open Patients (Organization Wide)

**Open:** # PLWH, diagnosed before measurement year, with any visit in 2017, except those confirmed to be in care elsewhere (858), deceased (7), and incarcerated (7)

**Active:** Percentage of open patients with HIV visit in 2017

**Prescribed ART:** Percentage of open patients prescribed an ART in 2017

**Received Viral Load Test***: Percentage of open pts with a documented viral load test in 2017

**Virally Suppressed***: Percentage of open patients with viral load <200 copies/mL

Data Source: eCW
Previously Diagnosed Active Patients (Legacy Clinics)

**Active:** Percentage of patients (excluding new/ newly diagnosed) who received primary care services at the organization in 2017

**Prescribed ART:** Percentage of active patients prescribed an ART in 2017

**Received Viral Load Test**: Percentage of active pts with a documented viral load test in 2017

**Virally Suppressed**: Percentage of newly diagnosed and new-to-care with viral load <200 copies/mL

**Data Source:** eCW
Previously Diagnosed Active Patients (New Clinics)

Active: Percentage of patients (excluding new/ newly diagnosed) who received primary care services at the organization in 2017

Prescribed ART: Percentage of active patients prescribed an ART in 2017

Received Viral Load Test*: Percentage of active pts with a documented viral load test in 2017

Virally Suppressed*: Percentage of newly diagnosed and new-to-care with viral load <200 copies/mL

Data Source: eCW
## 2017 HIV Treatment Cascade, Service Delivery Points for Non-Active Patients

<table>
<thead>
<tr>
<th>Service Delivery Point</th>
<th># of non-active patients who received service in 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Svcs</td>
<td>120</td>
</tr>
<tr>
<td>Dental Clinics</td>
<td>72</td>
</tr>
<tr>
<td>Nursing Svcs</td>
<td>1</td>
</tr>
<tr>
<td>Case Mgt Svcs</td>
<td>25</td>
</tr>
<tr>
<td>Treat only</td>
<td>47</td>
</tr>
</tbody>
</table>
Previously Diagnosed Active Patients (Breakdown by Housing Status)

Active: Percentage of patients (excluding new/ newly diagnosed) who received primary care services at the organization in 2017

Total on ARVs: Percentage of active pts prescribed an ARV in 2017

Received Viral Load Test*: Percentage of active pts with a documented viral load test in 2017

Virally Suppressed*: Percentage of newly diagnosed and new-to-care with viral load <200 copies/mL

Data Source: eCW
Previously Diagnosed Active Patients (Breakdown by Age)

**Active:** Percentage of patients (excluding new/ newly diagnosed) who received primary care services at the organization in 2017

**Total on ARVs:** Percentage of active pts prescribed an ARV in 2017

**Received Viral Load Test***: Percentage of active pts with a documented viral load test in 2017

**Virally Suppressed***: Percentage of newly diagnosed and new-to-care with viral load <200 copies/mL

**Data Source:** eCW
Previously Diagnosed Active Patients (Breakdown by Race)

<table>
<thead>
<tr>
<th>Race</th>
<th>Active</th>
<th>Total OnARVs</th>
<th>Received Viral Load Test*</th>
<th>Virally Suppressed*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>98.4%</td>
<td>99.1%</td>
<td>97.3%</td>
<td>97.3%</td>
</tr>
<tr>
<td>Multi-Race</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Native American</td>
<td>92.4%</td>
<td>92.4%</td>
<td>94.5%</td>
<td>94.5%</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>62.2%</td>
<td>61.6%</td>
<td>66.7%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Unknown</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Active:** Percentage of patients (excluding new/ newly diagnosed) who received primary care services at the organization in 2017

**Total on ARVs:** Percentage of active pts prescribed an ARV in 2017

**Received Viral Load Test***: Percentage of active pts with a documented viral load test in 2017

**Virally Suppressed***: Percentage of newly diagnosed and new-to-care with viral load <200 copies/mL

**Data Source:** eCW
Previously Diagnosed Active Patients (Breakdown by Gender)

Active: Percentage of patients (excluding new/newly diagnosed) who received primary care services at the organization in 2017

Total on ARVs: Percentage of active pts prescribed an ARV in 2017

Received Viral Load Test*: Percentage of active pts with a documented viral load test in 2017

Virally Suppressed*: Percentage of newly diagnosed and new-to-care with viral load <200 copies/mL

Data Source: eCW
Previously Diagnosed Active Patients
Brightpoint Health (Breakdown by Risk)

**Active:** Percentage of patients (excluding new/ newly diagnosed) who received primary care services at the organization in 2017

**Total on ARVs:** Percentage of active pts prescribed an ARV in 2017

**Received Viral Load Test**: Percentage of active pts with a documented viral load test in 2017

**Virally Suppressed**: Percentage of newly diagnosed and new-to-care with viral load <200 copies/mL

**Data Source:** eCW
Improvement Plan
A list of improvement goals that are specific, measurable, time-bound, and relevant to HIV-positive patients. This list should include descriptions of proposed action steps to achieve these goals, as well as timelines for projected completion of action steps.

- **Established, New to Care, and Newly Diagnosed Patients at Legacy Clinical Sites**
  - Within 6 months, by 12/31/18, Brightpoint Health’s clinics will improve viral load suppression rates for HIV+ patients from 67% to 76%.

- **Established, New to Care, and Newly Diagnosed Patients at New Clinical Sites (clinics which began servicing patients in 2016 and 2017)**
  - Within 6 months, by 12/31/18, Brightpoint Health’s clinics will improve viral load suppression rates for HIV+ patients by 10% points (from 53% to 63%).
  - Within 12 months by 6/30/18, Brightpoint Health’s clinics will improve viral load suppression rates for HIV+ patients by 20% points (from 53% to 73%).

**For open/inactive patients, education and resources available to support self management support and ultimately VL suppression will be made available. U=U and Undetectable campaign materials will be provided to facilities/programs who enroll and engaged our open/inactive patients.**
A list of improvement goals that are specific, measurable, time-bound, and relevant to HIV-positive patients. This list should include descriptions of proposed action steps to achieve these goals, as well as timelines for projected completion of action steps.

• **Open Patients**
  • Within 6 months, by 12/31/18, Brightpoint Health will improve the tracking of open patients’ engagement in care by increasing documentation of care status and referrals to care’ at the Inwood Dental and ADHC programs, with the goal of spreading to other clinics across the system.
Thank you!
Care Cascade 2017

JAMEELA YUSUFF MD MPH FACP
MEDICAL DIRECTOR STAR HEALTH CENTER
JULY 18, 2018
Methods for newly diagnosed

1. Maintained a list since end of 2016 of all newly positive HIV patients
   - Ongoing basis (weekly), STAR Medical Director reviews new positives (identified by EMR alert) to assess if they need linkage to care (done by chart review)
   - Most patients are not newly diagnosed, and most newly diagnosed are STAR patients

2. Adult HIV clinic (STAR)—Ryan White Part C and data tracked in AIRS
   - IT calculates linkage (date of HIV diagnosis and HIV program enrollment)

3. Pediatric/Adolescent (HEAT)—also RW part D, tracks data and provides it to STAR Medical Director

4. Staff involved: STAR MD, STAR IT, Heat PA, and MPH Student
Methods for Open Cascade

- Hospital IT runs a list of all HIV patients who engaged in care at SUNY.
- Includes location, HIV Viral Load, ARV prescribed and PCP information.
- Manual Chart review conducted to determine where patients are engaged, incarcerated or died during 2017.
- Staff involved: SUNY IT, MPH Student.
HIV Care Cascade of Newly Diagnosed Patient 2017

- **Newly Diagnosed/ New to Care**: 100% (N=98)
- **Linked to Care within 3 Days**: 29% (N=28)
- **Prescribed Art**: 94% (N=93)
- **Received VL Test**: 94% (N=93)
- **VL Supression**: 72% (N=71)

**Total Newly DX**: Total number of patients newly diagnosed in 2017
**Linked in 3 days**: Total number of newly diagnosed patients link to HIV care with medical visit within 3 days
**Prescribed ART**: Total number of newly diagnosed Patients prescribed ART.
**Received Viral Load Test**: Percentage of active patients with a documented viral load test in 2017

**Data Source**: EMR, Healthbridge, Office Practicum, Cerner and T-System
Linkage Summary

OPEN: # of PLWH, diagnosed before measurement year, with any visit in 2017, except those who receive care elsewhere, incarcerated or deceased

ACTIVE: # of open patients who received HIV primary care services at the organization in 2017

PRESCRIBED ART: Percentage of active patients who were prescribed ART in 2017

RECEIVED Viral LOAD TEST: Percentage of active patients with a documented viral load test in 2017

VIRALLY SUPRESSED: Percentage of active patients who had < 20 copies/ml at viral load test of 2017

Data Source: EMR, Healthbridge, Office Practicum, Cerner and T-System
<table>
<thead>
<tr>
<th>Service Delivery Points</th>
<th>Number of Non-Active Patients who receive Services During CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>160</td>
</tr>
<tr>
<td>Outpatient Visit/ Ambulatory Care *</td>
<td>99</td>
</tr>
<tr>
<td>Nursing Station/ Inpatient</td>
<td>56</td>
</tr>
<tr>
<td>Midwood Clinic (Ophthalmology)</td>
<td>17</td>
</tr>
<tr>
<td>Bayridge Clinic (Ambulatory Surgery)</td>
<td>16</td>
</tr>
<tr>
<td>Gynecology/ Obstetrician</td>
<td>13</td>
</tr>
<tr>
<td>Suite J / Transitional Care</td>
<td>9</td>
</tr>
<tr>
<td>Specialty Care (Dialysis, Surgery, Employee Health)</td>
<td>6</td>
</tr>
</tbody>
</table>
HIV Treatment Cascade, Open Caseload 2017

**OPEN:** # of PLWH, diagnosed before measurement year, with any visit in 2017, except those who receive care elsewhere, incarcerated or deceased

**ACTIVE:** # of open patients who received HIV primary care services at the organization in 2017

**PRESCRIBED ART:** Percentage of active patients who were prescribed ART in 2017

**RECEIVED Viral LOAD TEST:** Percentage of active patients with a documented viral load test in 2017

**VIRALLY SUPRESSED:** Percentage of active patients who had < 20 copies/ml at viral load test of 2017

**Data Source:** EMR, Healthbridge, Office Practicum, Cerner and T-System

---

<table>
<thead>
<tr>
<th>Response Category</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open</td>
<td>1545</td>
<td>100%</td>
</tr>
<tr>
<td>Active</td>
<td>1169</td>
<td>75.66%</td>
</tr>
<tr>
<td>Prescribed ART</td>
<td>1167</td>
<td>75.53%</td>
</tr>
<tr>
<td>Received Viral Load Test</td>
<td>1162</td>
<td>75.21%</td>
</tr>
<tr>
<td>Virally Supressed</td>
<td>1013</td>
<td>65.57%</td>
</tr>
</tbody>
</table>

---
HIV Treatment Cascade
Active 2017

ACTIVE: # of open patients who received HIV primary Care services at the organization in 2017

Prescribed ART: Percentage of active patients who were prescribed ART in 2017

RECEIVED VIRAL LOAD TEST: Percentage of active patients with a documented viral load test in 2017

VIRALLY SUPRESSED: Percentage of active patients who had < 20 copies/ml at viral load test of 2017

Data Source: EMR, Healthbridge, Office Practicum, Cerner and T-System

HIV Treatment Cascade, Active Patients 2017

<table>
<thead>
<tr>
<th>Percentage of Patients</th>
<th>Active</th>
<th>Prescribed ART</th>
<th>Received VL Test</th>
<th>VL Suppression</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 1169</td>
<td>1167/1169</td>
<td>1162/1169</td>
<td>1013/1169</td>
</tr>
<tr>
<td>100%</td>
<td>99.83%</td>
<td>99.40%</td>
<td>86.66%</td>
<td></td>
</tr>
<tr>
<td>80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SUNY Downstate Medical Center
University Hospital of Brooklyn
Drill Down of Active Cascade 2017 by Gender

HIV Treatment Cascade, Active Patients, Breakdown by Gender

- **Prescribed ART**: Percentage of active patients who were prescribed ART in 2017
- **Received VL Test**: Percentage of active patients with a documented viral load test in 2017
- **Virally Suppressed**: Percentage of active patients who had < 20 copies/ml at viral load test of 2017

Data Source: EMR, Healthbridge, Office Practicum, Cerner and T-System
Drill Down of Active Cascade 2017 by Risk

HIV Treatment Cascade, Active Patients, Breakdown by Risk

Prescribed ART: Percentage of active patients who were prescribed ART in 2017

Received VL Test: Percentage of active patients with a documented viral load test in 2017

Virally Suppressed: Percentage of active patients who had < 20 copies/ml at viral load test of 2017

Data Source: EMR, Healthbridge, Office Practicum, Cerner and T-System
Drill Down of Active Cascade 2017 by Race

HIV Treatment Cascade, Active Patients, Breakdown by Race

- **Prescribed ART**: Percentage of active patients who were prescribed ART in 2017
- **RECEIVED VIRAL LOAD TEST**: Percentage of active patients with a documented viral load test in 2017
- **VIRALLY SUPRESSED**: Percentage of active patients who had < 20 copies/ml at viral load test of 2017

Data Source: EMR, Healthbridge, Office Practicum, Cerner and T-System
Drill Down of Active Cascade 2017 by Age

HIV Treatment Cascade, Active Patients, Breakdown by Age

- Prescribed ART: Percentage of active patients who were prescribed ART in 2017
- Received VL Test: Percentage of active patients with a documented viral load test in 2017
- Virally Suppressed: Percentage of active patients who had < 20 copies/ml at viral load test of 2017

Data Source: EMR, Healthbridge, Office Practicum, Cerner and T-System
Drill Down of Active Cascade 2017 by Housing

HIV Treatment Cascade, Active Patients, Breakdown by Housing

- **Prescribed ART**: Percentage of active patients who were prescribed ART in 2017
- **Received VIRAL LOAD TEST**: Percentage of active patients with a documented viral load test in 2017
- **VIRALLY SUPPRESSED**: Percentage of active patients who had < 20 copies/ml at viral load test of 2017

Data Source: EMR, Healthbridge, Office Practicum, Cerner and T-System
Consumer Input

- April 17, 2018, Care Cascade 2017 data was presented to Community Advisory Group
- Suggestions:
  - Peer involvement (Buddy system), meet greet with pts on the floor
  - Education to newly diagnosed
  - Explore barriers among younger demographic
  - Get an appointment same day as d/c
  - Follow up within one week
Progress Report of QI Interventions 2017

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Challenge</th>
<th>Modification</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAR Connect Phone</td>
<td>Reception Poor Awareness?</td>
<td>Text Only Increase Awareness</td>
<td>Implemented Exploring other text carriers</td>
</tr>
<tr>
<td>EMR Modification Outpatient</td>
<td>Time consuming to implement</td>
<td>Nothing</td>
<td>Finally Implemented By 12/2017</td>
</tr>
<tr>
<td>EMR Alerts</td>
<td>Too much for email</td>
<td>MD log in regularly</td>
<td>Successful but needs Tracking!</td>
</tr>
</tbody>
</table>
# QI Plan for 2018 based on 2017 Data

## Linkage
- STAR Connect
- EMR alerts
- Open slots for walk-ins for discharged pts
- Peer meet/greet
- HIV track MD/PA meet/greet

## VL Suppression
- Quarterly Viral Load report (RF, all VL, MD, Age, Sex)
- Clinical Pharmacist
- MCM enrollment
- Assessment of younger demographic*

## Open Cascade
- Structured field for ER for PCP
- Structured field for inpatient
- Outreach within our institution, particularly
  - Ophthalm
  - OB/GYN
  - Surgery specialty
Dissemination of Results

- Clinic Leadership Meeting: 4/13/18
- CAG Meeting: 4/18/18
- Clinic Staff Meeting: 5/3/18
- Ambulatory QI Meeting: 5/24/18
- Display Results in Clinic: 6/2018
- Post Results Social Media: 6/2018

- Post Results Social Media: 6/2018
Questions?
JAMEELA J. YUSUFF 718-270-6747
JAMEELA.YUSUFF@DOWNSTATE.EDU
The Living Cascade

Daniel Tietz, Director of Consumer Affairs
Freda Coren, Program Assistant
Brooklyn NYLinks, July 18, 2018
The Living Cascade

- Similar to Healthcare Stories Project
- Consumer-driven quality improvement tool
- Complement cascade data with patient voice along the cascade
- Use the patient voice to inform quality improvement
- Make the “n” come to life!
- Consumer education on quality improvement
Pilot Results

- October - November 2017

- Over 350 consumers completed the worksheet

- 6 organizations participated
  - Hudson River Healthcare
  - SUNY Upstate Pediatric
  - Brooklyn PATH
  - Cornerstone Family Healthcare
  - Evergreen Health
Feedback from Pilot

- Questions and definitions of “open” patients was confusing
- Remembering diagnosis can be triggering
- Helpful when worksheet completion was guided by staff
- Success with both electronic and paper versions
- Consumers are concerned about anonymity
- Consumers are willing to participate
- Doesn’t take too long to complete (5-10 minutes)
- QI plans can be developed from the Living Cascade!
From Pilot to Official Version

- New cascade guidance
- Simplified definitions
- Simplified language
- Streamlined questions
- “Open” patient questions are now linkage questions
- Official Spanish translation
Pilot “Results”

- **Cornerstone Family Healthcare - Linkage and Engagement**
- Many consumers began as open patients, so mock QI plan focuses on engagement
- Clinical staff in any department will refer HIV+ patients to the Positive Choices Department
- Clinical staff should ask if they have an HIV PCP and receive case management services
- Discussion with PCP and case management staff should be documented in the patient’s chart
**Evergreen Health - Retention**

- 77% of respondents identified some barrier to attendance of medical appointments

**Appointment availability**
- Daily dedicated appointment slots for each HIV specialty medical provider
- Train medical group’s scheduling staff on availability changes, and have a back-up provider available
- Pilot weekly “evening hours” time slots

**Transportation**
- Increase linkage and navigation activities surrounding access to transportation offered through Medicaid and Evergreen’s Transportation Program
- Make emergency transportation funds available
- Pilot a volunteer and/or ride share program
SUNY Upstate - Adherence

Found mostly restraining forces in answers to adherence questions.

“To support and improve positive forces (desire to stay health, self-confidence, good support system) that affect retention and adherence among patients who are HIV+ by providing affirming education about the social (self-confidence, self-empowerment) and medical (staying healthier, being untransmittable) benefits of reaching undetectable through medication adherence.”

Offer video on benefits of being undetectable, ask consumers to identify a goal, continually assess progress at subsequent visits.
Your Story of Coming to [Facility Name]

1) Did you receive your HIV diagnosis at [Facility name]?
   □ Yes           □ No

   1a) If yes, about how long did it take to get your first appointment for HIV primary care at [Facility name]?
       ___

   1b) If no, why did you choose [Facility Name] for your HIV primary care?
       ___

2) How did you get linked to care at [Facility Name]? Did any person help you make your first appointment?
   ___
   ___

3) Did you face any challenges getting your first appointment at [Facility Name], at another healthcare organization, or in your personal life? If yes, please describe the challenges.
   ___
   ___
An "Active" patient has at least one HIV medical visit each year - even if you’ve been positive or coming to [Facility Name] for a long time, you aren’t “Active” unless you have at least one appointment every year.

4) What was your first visit to the HIV program at [Facility Name] like?
   
   
5) Since becoming a patient at [Facility Name], have you ever gone more than a year without coming here for a medical visit?
   
   □ Yes
   □ No

5a) If yes, why?
   
   
6) What helps or motivates you to come to your appointments at [Facility Name]?
   
   
7) What makes it hard to come to or keep your appointments?
   
   
8) Is there any additional information you would like to share about your experience receiving health care at [Facility Name]?
Your Story of Getting on Antiretroviral Therapy (ART) at [Facility Name]

9) Have you been prescribed HIV medication, commonly known as ART, at [Facility Name]?
   □ Yes    □ No

9a) If yes, how soon after your HIV diagnosis did you start taking HIV medication?
   __________

9b) If no, why have you not been prescribed HIV medication by [Facility Name] staff?
   __________

10) Overall, do you take your HIV medication the way your healthcare provider recommends?
    □ Yes    □ No

10a) If no, why?
    __________

11) In the last five years, or since you began taking HIV medication at [Facility Name], have you ever stopped taking this medication for more than one week?
    □ Yes    □ No

11a) If yes, why did you stop? What helps you get back on track with taking your HIV medication?
    __________
12) Are you virally suppressed (defined as having a viral load of less than 200 copies/mL)?

☐ Yes   ☐ No

12a) What helped you become virally suppressed?

___  

___  

13) What has been the hardest part about regularly taking your HIV medication?

___  

___  

14) What helps you take your HIV medication?

___  

___  

14a) Do you have any tricks, tools, people, or things in your life that motivate you to stay on track with your HIV medication and stay engaged in your health care?

___  

___  

Not sure? Ask your doctor or nurse for the results of your most recent blood test!

An HIV viral load is the amount of the HIV virus in a milliliter of blood. A suppressed viral load is defined as less than 200 copies of the HIV virus per milliliter of blood.
Questions? Comments?

- Freda Coren
- freda.coren@health.ny.gov
- 212-417-4620
Quantum Leap Frog

Brooklyn Links

July 18, 2018
Agenda

• ETE Driver Diagram: Primary Divers to include 3-day linkage, open, non-active patient care engagement. Large group brainstorms secondary drivers.

• Small groups each develop a plan based on secondary drivers for each of the primary drivers, then pass their plan along to the next table. The next table can the further refine the other group’s plan or create a new plan for secondary drivers of their choice. This is repeated 3 times.
Driving to the End of the Epidemic

• PDSA cycles of change help you to leapfrog ahead with your process improvements.
• A driver diagram helps you to think strategically about what areas to focus on for improvement.
• This helps to focus your PDSA cycles in areas where improvements are most needed, helping you to improve by leaps and bounds.
• Planning your improvements with your peers will help you to make a quantum leap ahead in your improvements.
Driver Diagram

• A driver diagram is a visual tool to help understand and prioritize factors within a system that drive desired outcomes called the primary outcome.

• Primary drivers are the main factors that drive the primary outcome.

• Secondary factors are subsets of the primary factors, and drive these factors.

• The driver diagram can help you to think strategically about what changes you can make to your current system to achieve your improvement goal.
End The Epidemic Driver

Primary Outcome
End the Epidemic

Primary Drivers
- Viral Suppression
- 3-day linkage to care for newly diagnosed patients

Secondary Drivers: 3-day linkage
- Trained Providers - Education and Buy in
- Open Access to Care
- Develop Network of Providers
  think outside of Box
- Health and Innovation Learning Network
- Involvement of Faith Initiative

Secondary Drivers: viral suppression
- U=U
- Support Groups
- Community Outreach Education
- Modify DOT
- More Use of Peer Navigation
3 Days Linkage to Care:

• Trained Providers-Education and Buy in

• Open Access to Care
  • Aspect of transportations
  • Providers to patient home visits
  • Liaison, Skyping patient
  • Active patient portal
  • Open Communication
  • Follow-up progress note continuity of care

• Develop Network of Providers think outside of Box

• Health and Innovation Learning Network

• Involvement of Faith Initiative
Viral Load Suppression:

• U=U
  • Spread Knowledge

• Support Groups
  • Curriculum talks about Support groups
  • Promotional Peers

• Community Outreach Education
  • Establish relationship with community
  • Involve everyone
  • Diverse people involve
  • Focus on patients
  • Transparency between doc and consumers

• Modify Direct Observation Therapy (MDOT)
  • Take holistic approach
  • Whole person approh

• More Use of Peer Navigation
Time to play Quantum Leap

- Table One: Develops an improvement plan for the first secondary driver of viral suppression
- Table Two develops an improvement plan for the first secondary driver for 3-day linkage
- Table Three Develops an improvement plan for the second secondary derivative for viral suppression
- Table Four-develops a plan for the second secondary driver of 3-day linkage
Leap Frog

- Table One works on developing a plan for 3-day linkage
- Table Two works on developing a plan for the third secondary driver for viral suppression
- Table Three works on developing a plan for the fourth secondary driver for 3-day linkage
- Table Four works on developing a plan for the fourth secondary driver for viral suppression.
Report Back

Table One
Table Two
Table Three
Table Four

report back on their best improvement plan
Now we take the quantum leap from planning to doing—Let’s spring into action to end the epidemic!!!