Brooklyn Regional Group Meeting

January 30, 2018
9.00am to 2.00pm
Brooklyn Borough Hall, 209 Joralemon St, Brooklyn, NY 11201
Welcome, Introductions & Meeting Overview
Meeting Overview

• Brooklyn Co-Chairs: Clemens Steinbock, Zeenath Rehana

• Meeting Purpose
  – Strengthen the Brooklyn Regional Group as a platform for engaging providers and consumers in peer learning and networking
  – Provide context of other improvement initiatives in Brooklyn
<table>
<thead>
<tr>
<th>Agenda</th>
<th>Time</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration and Networking</td>
<td>9:00 - 9:15</td>
<td>Networking</td>
</tr>
<tr>
<td>Welcome, Introductions &amp; Meeting Overview</td>
<td>9:15 - 9:30</td>
<td>Clemens Steinbock, Zeenath Rehana</td>
</tr>
<tr>
<td>Update from Brooklyn ETE and Knows</td>
<td>9:30 - 9:45</td>
<td>Robert Jones, New York Knows, Project Officer – Brooklyn, NYCDOHMH, Bureau of HIV/AIDS Prevention and Control, David Matthews – ETE Co-Chair</td>
</tr>
<tr>
<td>Presentations from the Field: Lessons Learned</td>
<td>9:45 – 10:45</td>
<td>Bedford-Stuyvesant Family Health Center: Suzanne Robinson Davis and Germaine Harry, Brightpoint Health: Steve Hemraj, MetroPlus Health Plan: Sharard Jacques and Davina Manson</td>
</tr>
<tr>
<td>QI Exercise</td>
<td>10:45 - 11:15</td>
<td>Clemens Steinbock</td>
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<tr>
<td>Working Lunch</td>
<td>11:30 – 12:15</td>
<td>Networking &amp; QI Strategies Review</td>
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<tr>
<td>Introduction of 2018 Cascade and Group Work</td>
<td>12:15 – 1:00</td>
<td>Steven Sawicki, NYLinks Lead</td>
</tr>
<tr>
<td>TCQ Overview</td>
<td>1:00 – 1:20</td>
<td>Dana Diamond, CAC co-chair, Christopher Baljko, CAC member</td>
</tr>
<tr>
<td>Team Action Planning and Report Back</td>
<td>1:20 - 1:40</td>
<td>Agency Teams</td>
</tr>
<tr>
<td>Next Steps &amp; Evaluation</td>
<td>1:40 - 2:00</td>
<td>Clemens Steinbock, Zeenath Rehana</td>
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<td>Adjourn</td>
<td>2:00</td>
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</table>
Picture Consent

• You allow NQC to take pictures from our training events and to post them on our NQC websites, social media platforms, and NQC marketing materials for an undetermined period of time

• You have the right to revoke your consent for pictures that are publicly posted

• At no time, individual names will be used to identify you, unless you sign the appropriate release form
What is NY Links?
Defining the “End of AIDS”

A 3-Point plan announced by the Governor on June 29, 2014

1. Identify all persons with HIV who remain undiagnosed and link them to health care.

2. Link and retain those with HIV in health care, to treat them with anti-HIV therapy to maximize virus suppression so they remain healthy and prevent further transmission.

3. Provide Pre-Exposure Prophylaxis (PrEP) for persons who engage in high-risk behaviors to keep them HIV negative.

Reduce the number of new HIV infections to just 750 [from an estimated 3,000] by 2020
Public Release of the Blueprint

April 29, 2015

We must add AIDS to the list of diseases conquered by our society, and today we are saying we can, we must and we will end this epidemic. ~Governor Cuomo
Blueprint Recommendations (BPs)

Link and retain persons diagnosed with HIV in care to maximize virus suppression so they remain healthy and prevent further transmission.

**BP5:** Continuously act to monitor and improve rates of viral suppression

**BP7:** Use client-level data to identify & assist patients lost to care or not virally suppressed

**BP8:** Enhance & streamline services to support the non-medical needs of persons with HIV...

**BP29:** Expand & enhance the use of data to track and report progress
Overall Objectives

• Improve Linkage to Care
• Improve Engagement in Care
• Improve ART Adherence
• Improve Viral Load Suppression
Methods

• Involve Everyone
• Put our Public Health Hats on
• Think in terms of Region and Community
• Use Data
• Identify Gaps in Care
• Identify Interventions to fill Gaps
• Use Quality Improvement Methodology
• Share with Everyone
Engage all medical and non-medical organizations within Brooklyn geographic area to improve linkage to care, retention in care, and viral suppression

- Involve all types of organizations—hospitals, community health centers, CBOs, local health departments, NYS staff
- Involve all levels of individuals—consumers, front line staff, administrators, data staff, QI staff, CEOs, medical directors, medical providers
- Develop both an organizational and a regional approach to improvement
- Use data to improve performance
- Use QI strategies to design and assess performance
- Use peer learning to spread innovation
Update from Brooklyn ETE & Knows
Brooklyn Knows
Brooklyn Knows is a large-scale public health initiative to increase voluntary HIV testing and status-neutral linkage to care so that every Brooklyn resident learns his or her HIV status and has access to quality care and prevention.

- Followed the success of The Bronx Knows (2008-2011)
- Launched on World AIDS Day in 2010
- Rolled into larger New York Knows initiative on World AIDS Day in 2014
HIV Testing is the gateway to HIV Prevention and HIV Care Services

Goal 1: Provide a voluntary HIV test for every Brooklyn resident who has never been tested.
- Make HIV testing a routine part of care in Brooklyn.

Goal 2: Identify undiagnosed HIV-positive people in Brooklyn and link them to care.

Goal 3: Link HIV-negative persons to HIV Prevention Services, including PrEP.
- Promote STI testing.
Meeting Structure

• Monthly Steering Committee meetings
  – Directly followed by EtE Steering Committee bimonthly

• Monthly Subcommittee meetings
  – Events and Planning
  – Prevention & Linkage to Care
  – Policy
  – Immigrant Health
  – Youth
  – Project THRIVE Community Advisory Board working with MSM of color
  – Faith Based HIV Task Force

• All-partners meetings
Capacity Building and Technical Assistance

- Tailored Technical Assistance
- Capacity Building Workshops
- Learning Collaboratives
- Sharing of Best Practices
• Regular meetings and networking

• New York Knows Directory
  – Promote interagency collaboration
  – Increase awareness of the various services offered across the NYK network
  – Facilitate linkages of care spanning the HIV continuum
Thank You

Contacts

Robert Jones, rjones6@health.nyc.gov

Jeselle Eli, jeli@wyckoffhospital.org
Brooklyn Region
Ending the Epidemic
Steering Committee

David W. Matthews, MBA
Program Manager
Bridging Access To Care
BROOKLYN MEN (K)ONNECT [BM(K)]

Verneda Adele White, MBA
Founder + Creative Director
HUMAN INTONATION
Purpose of the Brooklyn Ending The Epidemic Regional Steering Committee

• To provide a forum to develop and execute on-going ETE related efforts in the Brooklyn region.

• Eliminate duplication and enhance coordination among regional clinical and non-clinical service providers, faith-based initiatives, non-traditional partners, consumers and networks including Brooklyn Knows and NY Links.

• To develop and implement a strategic plan to address identified needs and gaps in the Brooklyn region in alignment with the Regional Action Plan.

• To identify and address new emerging regional issues.
Lay of the Land in NYC

State and City ETE Structure

ETE Regional Group Steering Committee

NEW YORK KNOWS

GET TESTED. TREAT EARLY. STAY SAFE.
End AIDS.

NY Links
Brooklyn ETE Progression

- March 2016 – Kick-off! Conference call for interested community partners; determination of next steps

- July 2016 – 1st face-to-face meeting at Brooklyn Borough Hall
  - Prioritization exercise

- Five prioritized Blue Print Points:
  - BP#23: Promote comprehensive sexual health education
  - BP#8: enhance and streamline services to support the non-medical needs of persons with HIV
  - BP#’s 11 – 14: All items that facilitate access to pre-exposure prophylaxis
  - BP#1: Make routine HIV testing truly routine, and
  - GTZ#1: Single point of entry across all NYS for all low income persons with HIV/AIDS

- October 2016 – 2nd face-to-face meeting at Haitian –American Community Coalition, Inc.
  - SWOT Analysis

- December 2016 – 3rd face-to-face meeting at Housing Works
  - Consumer focus
Brooklyn ETE Progression – cont’d

• March 2017 – 4th face-to-face meeting at BrightPoint.
  – Development of Strategic Plan and formation of Sub-committees

• Next meeting – Tuesday, April 25th, 2017 - Community/consumer meeting – at Haitian – American Community Coalition, Inc. (HCC) location in Flatbush – this meeting is planned and scheduled to continue with the execution of the strategic plan and next steps for the sub-committees
  – All are welcomed! Consumers are encouraged to attend!
Thank you!

Please contact:
Dave Matthews,
dmatthews@bac-ny.org and
Verneda Adele White,
verned@vernedadele.com

etedashboardny.org

NYS ETE Dashboard
Presentations from the Field: Lessons Learned
Bedford Stuyvesant Family Health Center

QI Project
January 2018

Suzanne Robinson Davis
Project Manager
Mission

• To provide the most professional, courteous and highest quality health care, with dignity, to those we serve, especially the underserved population, without regard for their ability to pay.
Our last QI meeting of 2017 - it was proposed that the team revisit patients who were unsuppressed and have them get another VL before the end of 2017.

Embedded in that request was to also assess whether our interventions with our unsuppressed patients through-out the year have made an impact on viral suppression or the patient’s journey (i.e. identifying social determinants of health) to viral suppression.
QI Project Activities

» Health Education and Adherence Manager pulled data on patients who at their last lab were unsuppressed.

» Timeframe = first to third quarter of the year.

» 27 patients were identified.

» Patients were engaged by Health Educator, Case Managers and Providers.

» Health Educator followed through by sending telephone encounters to the Providers in our EMR to remind them to order VL.
QI Project Results

QI Results

- # of patients contacted: 27
- # of patients with a medical visit: 11
- # of patients with VL <200 copies: 6
QI Project Results

QI Results - Interventions

- # of patients with VL <200 copies: 6
- # of patients receiving TD sessions: 4
- # of Patients in RAP: 2

Legend:
- Orange: # of patients with VL <200 copies
- Gray: # of patients receiving TD sessions
- Purple: # of Patients in RAP
QI Project Next Steps

» Generate 2017 list of unsuppressed patients.
» Initiate early and focused interventions with patients.
» Engage our unsuppressed patients (and all patients) in the undetectable project being implemented by the Center.
» Increase monitoring.
» Document success stories.
Acknowledgements

» Germaine Harry, Case Manager/QI Specialist
» Hasani Escobar, Treatment Adherence and Care Coordinator
Thank you!!!

Suzanne Robinson Davis
Srobinsondavis@bsfhc.org
Partnership in Care (PIC)
ETE Population

Presented By:
Davina Manson – Member Engagement Coordinator
Sharard K. Jacques – Adherence Technology Coordinator
January 23rd, 2017
• MetroPlus is a Health Maintenance Organization (HMO) licensed to operate in:
  ➢ Manhattan, Brooklyn, Queens, The Bronx & Staten Island
• MetroPlus is a subsidiary of New York City Health and Hospitals Corporation
• MetroPlus has over 500,000+ members across nine different line of business.
  • 8500+ member are assigned to the PIC department
The mission of the HIV Services –Partnership in Care Department is to ensure optimal health and Wellness for every MetroPlus member assigned to our department through the provision of comprehensive care coordination, adherence engagement, health education and supportive services in a caring, nonjudgmental and empowering manner.
ETF Interventions

- **Street Outreach and Engagement**
  Addresses members who are lost to care
- **Adherence Technology**
  Focuses on Medication Adherence
- **Peer Care Connect**
  Educational & creative component

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<tr>
<th>CD4 Report 1/25/2018</th>
<th>EtE SNP Current Membership</th>
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<td>419</td>
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<td>EtE SNP Current Membership</td>
<td>846</td>
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<td>Suppressed Membership</td>
<td>419</td>
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<tr>
<td>Un-Suppressed Membership</td>
<td>427</td>
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<td>Bronx Membership</td>
<td>305</td>
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<tr>
<td>Brooklyn Membership</td>
<td>252</td>
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<tr>
<td>Manhattan Membership</td>
<td>211</td>
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<tr>
<td>Queens Membership</td>
<td>78</td>
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### Membership Count

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<tr>
<th>Nationality</th>
<th>Age Range</th>
<th>10-20</th>
<th>21-30</th>
<th>31-40</th>
<th>41-50</th>
<th>51+</th>
<th>Grand Total</th>
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<tbody>
<tr>
<td>American Indian or Alaskan Native</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td></td>
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<tr>
<td>Asian, Native Hawaiian or other Pacific Islander</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Black or African American</td>
<td></td>
<td>4</td>
<td>47</td>
<td>67</td>
<td>77</td>
<td>147</td>
<td>342</td>
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<tr>
<td>Hispanic or Latino</td>
<td></td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td></td>
<td>1</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>3</td>
<td>12</td>
<td>20</td>
<td>25</td>
<td>46</td>
<td>106</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>8</td>
<td>62</td>
<td>96</td>
<td>110</td>
<td>199</td>
<td>475</td>
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**Blue** = Female Membership  
**Red** = Male Membership
• Living In Brooklyn

<table>
<thead>
<tr>
<th>Facility</th>
<th>Bronx</th>
<th>Brooklyn</th>
<th>Manhattan</th>
<th>Queens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>14</td>
<td>367</td>
<td>68</td>
<td>26</td>
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</table>

• Not Living in Brooklyn

<table>
<thead>
<tr>
<th>Facility</th>
<th>Bronx</th>
<th>Brooklyn</th>
<th>Manhattan</th>
<th>Queens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>479</td>
<td>85</td>
<td>330</td>
<td>111</td>
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### Report as of 1/25/2018

#### Street Outreach

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<tr>
<th>Membership Type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
<td>346</td>
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</tr>
<tr>
<td>Re-Engaged Membership</td>
<td>180</td>
<td>52.02%</td>
</tr>
<tr>
<td>Not Re-Engaged Membership</td>
<td>166</td>
<td>47.98%</td>
</tr>
<tr>
<td>DisEnrolled Membership</td>
<td>68</td>
<td>19.65%</td>
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</table>

#### Brooklyn Membership

<table>
<thead>
<tr>
<th>Membership Type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
<td>116</td>
<td></td>
</tr>
<tr>
<td>Re-Engaged Membership</td>
<td>59</td>
<td>50.86%</td>
</tr>
<tr>
<td>Not Re-Engaged Membership</td>
<td>57</td>
<td>49.14%</td>
</tr>
<tr>
<td>DisEnrolled Membership</td>
<td>22</td>
<td>18.97%</td>
</tr>
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### Adherence Technology Intervention

305 EtE Identified Members Qualify for Adherence Technology Intervention. 101 EtE Members are located in Brooklyn.
HIV Service – Partnership in Care

Health & Wellness Advisors ensures that all members develop a plan of care that encompasses an assessment which addresses health and psychosocial needs.

Eligibility & Retention team are responsible for verifying member’s who qualify for the SNP (Special Needs Plan) plan.
Important Contacts

- MetroPlus Customer Services 1(800) 303–9626
- Medicare Customer Services 1(866) 986–0356
- CVS CareMark Prescriptions 1(800) 552–8159
- CVS CareMark PA Medicaid 1(877) 433–7643
- HealthPlex 1(888) 468–2189
- LogistiCare 1(877) 564–5922
- Beacon 1(885) 371–9228
- HIV Services fax 1(212) 908–8897
- UM fax 1(212) 908–8521/2
- Integra – DME 1(718) 369–0012
- PCS Fax 1(212) 908–5237
• Dr. Ross Hewitt  
  Associate Medical Director of Partnership in Care/HIV Services  
  Phone: (212)908-8518  
  Email: hewittr@metroplus.org

• Dr. Debra Williams  
  Administrative Director of Partnership in Care/ HIV Services  
  Phone: (212)908-5115  
  Email: williamdeb@metroplus.org

• Davina Manson  
  Member Engagement Coordinator  
  Phone: (212)908-8783  
  Email: mansonda@metroplus.org

• Sharard Jacques  
  Adherence Technology Coordinator  
  Phone: (212) 908-5280  
  Email: jacqus@metroplus.org
QI Exercise
The Marshmallow Challenge

Source: The Marshmallow Challenge by Peter Skillman; website by Tom Wujec - http://marshmallowchallenge.com
Group Competition: The Marshmallow Challenge

• Step 1: Form teams of 5 to 8 participants
• Step 2: Each team is given a Marshmallow Challenge tool set
• Step 3: Build the largest free standing tower

20 sticks of spaghetti + one yard tape + one yard string + one marshmallow
Rules for The Marshmallow Challenge

• **Build the Tallest Freestanding Structure** (measured from the table top surface to the top of the marshmallow)

• **The Entire Marshmallow Must be on Top**

• **Use as Much or as Little of the Kit** (no other items are allowed)

• **The Challenge Lasts 18 minutes** (touching or supporting the structure at the end will lead to disqualification)
Group Competition: The Marshmallow Challenge

Video

20 sticks of spaghetti  +  one yard tape  +  one yard string  +  one marshmallow
Debriefing Your Experience
2016 Surveillance Data for Brooklyn
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
January 30, 2017
HIV/AIDS IN BROOKLYN, 2016
BASIC STATISTICS

• 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
  – 8.5 deaths per 1,000 mid-year persons living with HIV/AIDS^ 

^Death rate is age-adjusted to the NYC Census 2010 population. Death data for 2016 are incomplete. As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
NEW HIV DIAGNOSES AND DEATHS AMONG DIAGNOSED PLWHA IN BROOKLYN IN 2016

New HIV diagnoses

• The rate of new HIV diagnoses is at an historic low
  – Although Brooklyn accounts for the largest number of HIV diagnoses, its diagnosis rate is the third highest once population size is accounted for

• MSM, young adults ages 20-29 and blacks continue to account for the largest number of HIV diagnoses

• Nearly a third of diagnoses are among persons born outside the US, and over a third of these are from the Caribbean

Deaths among diagnosed PLWHA

• Deaths are declining each year, although in 2016 the death rate in Brooklyn was higher than citywide (8.5 vs. 7.5 per 1,000 PLWHA)
  – About 2/3 deaths due to non-HIV disease
The rate of new HIV diagnoses decreased in all boroughs except Staten Island between 2012 and 2016. Brooklyn had the third highest rate.

New diagnosis rate for residences outside of NYC or unknown borough (N = 234 in 2016) not displayed.

As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
TIMELY INITIATION OF CARE AMONG PEOPLE NEWLY DIAGNOSED WITH HIV IN NYC AND BROOKLYN, 2012-2016

Timely initiation of care among people newly diagnosed with HIV remained stable in Brooklyn between 2012 and 2016, whereas it increased in NYC overall.

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 Brooklyn in 2016, transgender people were less likely to have timely initiation of care than non-transgender people.  

* The total number for this group is small and therefore the percentage 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.
Among people newly diagnosed with HIV in Brooklyn in 2016, Blacks were the least 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.)

Native American and multiracial groups not displayed. There were 1 Native American and 6 multiracial people newly diagnosed with HIV in 2016. As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
Among people newly diagnosed with HIV in Brooklyn in 2016, people under 50 years of age were the least 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.)

New diagnoses in the 0-12 age group not displayed. There was 1 child aged 0-12 years old newly diagnosed with HIV in NYC in 2016. As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
Among people newly diagnosed with HIV in Brooklyn in 2016, transgender people with sexual contact were less likely to have timely initiation of care.

* The total number for this group is small and therefore the percentage 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.)

TG-SC = Transgender people with sexual contact. New diagnoses with other/unknown transmission risk not displayed.

As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
Among people newly diagnosed with HIV in Brooklyn, US-born people 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 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.
Viral suppression among all people diagnosed with HIV/AIDS steadily increased in both Brooklyn and NYC between 2012 and 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 diagnosed PLWHA in Brooklyn, transgender people had a lower viral suppression proportion than non-transgender people.

Viral suppression is defined as most recent viral load in 2016 was ≤200 copies/mL. As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
Among diagnosed PLWHA in Brooklyn, blacks and Native Americans had the lowest viral suppression proportions among all racial/ethnic groups.

*The total number for this group is small and therefore the percentage should be interpreted with caution.

Viral suppression is defined as most recent viral load in 2016 was ≤200 copies/mL.

Unknown race not shown.

As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
Among diagnosed PLWHA in Brooklyn, those ages 13 to 19 had the lowest viral suppression proportions, and those ages 60 and older had the highest.

* The total number for this group is small and therefore the percentage should be interpreted with caution. Viral suppression is defined as most recent viral load in 2016 was ≤200 copies/mL. As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
VIRAL SUPPRESSION AMONG DIAGNOSED PLWHA BY TRANSMISSION RISK IN BROOKLYN, 2016

Among diagnosed PLWHA in Brooklyn, MSM and IDU had the highest viral suppression proportion, and people with perinatal transmission risk had the lowest.

Viral suppression is defined as most recent viral load in 2016 was ≤200 copies/mL.

TG-SC = Transgender people with sexual contact.

As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
Among diagnosed PLWHA in Brooklyn, US-born people were less likely to have a suppressed viral load.

Viral suppression is defined as most recent viral load in 2016 was ≤200 copies/mL. As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
VIRAL SUPPRESSION AMONG DIAGNOSED PLWHA BY BOROUGH IN NYC, 2016

Among diagnosed PLWHA in NYC, Manhattan residents had the highest viral suppression proportion.

Viral suppression is defined as most recent viral load in 2016 was ≤200 copies/mL. As reported to the New York City Department of Health and Mental Hygiene by March 31, 2017.
In Brooklyn in 2016, 74% of PLWHA had a suppressed viral load compared to 76% in NYC overall.
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 \(\leq 200\) copies/mL.

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 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.
• The rate of new HIV diagnoses is at a historic low
  – MSM, young adults ages 20-29, and blacks continue to account for the largest number of HIV diagnoses
  – Death rate declining but in 2016 was higher in Brooklyn than citywide

• 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
The 4 Brooklyn neighborhoods most impacted overall by HIV/AIDS in 2016 were:

- **Bedford Stuyvesant – Crown Heights**
- **East Flatbush – Flatbush**
- **East New York**
- **Williamsburg - Bushwick**

### Table: 2016 HIV/AIDS in Brooklyn by UHF Neighborhood

<table>
<thead>
<tr>
<th></th>
<th>Number of New HIV Diagnoses</th>
<th>Rate of New HIV Diagnoses&lt;sup&gt;1,2&lt;/sup&gt;</th>
<th>Number of PLWHA</th>
<th>PLWHA as % of Population&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Age-Adjusted Death Rate&lt;sup&gt;3&lt;/sup&gt;</th>
<th>% Linked to Care Within 3 Months</th>
<th>% Virally Suppressed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BROOKLYN</strong></td>
<td>581</td>
<td>22</td>
<td>29,738</td>
<td>1.1</td>
<td>8.5</td>
<td>70%</td>
<td>78%</td>
</tr>
<tr>
<td><strong>Bedford Stuyvesant - Crown Heights</strong></td>
<td>171</td>
<td>53.1</td>
<td>7,841</td>
<td>2.4</td>
<td>11.9</td>
<td>70%</td>
<td>76%</td>
</tr>
<tr>
<td><strong>East Flatbush - Flatbush</strong></td>
<td>89</td>
<td>29.5</td>
<td>5,226</td>
<td>1.7</td>
<td>6.1</td>
<td>64%</td>
<td>78%</td>
</tr>
<tr>
<td><strong>East New York</strong></td>
<td>75</td>
<td>39.7</td>
<td>3,411</td>
<td>1.8</td>
<td>8.6</td>
<td>68%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Williamsburg - Bushwick</strong></td>
<td>82</td>
<td>38.2</td>
<td>3,826</td>
<td>1.8</td>
<td>7.9</td>
<td>72%</td>
<td>75%</td>
</tr>
</tbody>
</table>

*Bolded font indicates that this UHF was the bottom for the indicator*

* Rates/percentages based on numerators less than or equal to 10 should be interpreted with caution.

1 This rate is per 100,000 population. HIV diagnoses include diagnoses of HIV without AIDS and HIV concurrent with AIDS.

2 Rates calculated using the intercensal 2015 NYC population.

3 Age-adjusted to the NYC Census 2010 population. People newly diagnosed with HIV at death were excluded from the numerator.
HOW TO FIND OUR DATA

• Our program publishes annual surveillance reports and slide sets, as well as special supplemental reports during the year.

• Data requests take about 2 weeks to complete:
  – email requests to HIVReport@health.nyc.gov

Thank you to >160 members of the HIV Epidemiology and Field Services Program staff for collection, management and analysis of these data.
Thank you!
Cristina Rodriguez-Hart
HIV Epidemiologic Liaison
crodriguezhart@health.nyc.gov
(347) 396-7634
APPENDIX 1: DEFINITIONS AND STATISTICAL NOTES

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.

Statistical notes:
- UHF boundaries in maps were updated for data released in 2010 and onward. Non-residential zones are indicated, and Rikers Island is classified with West Queens.
• “HIV-infected”: calculated as “HIV-diagnosed” divided by the estimated proportion of people living with HIV/AIDS (PLWHA) who had been diagnosed (95.0%), based on a back-calculation method.
  

• “HIV-diagnosed”: calculated as PLWHA “retained in care” plus the estimated number of PLWHA who were out of care, based on a statistical weighting method. This estimated number aims to account for out-migration from NYC, and therefore is different from the number of PLWHA published elsewhere.
  

• “Retained in care”: PLWHA with ≥1 VL or CD4 count or CD4 percent drawn in 2016, and reported to NYC HIV surveillance.
  
  Source: NYC HIV Surveillance Registry.

• “Prescribed ART”: calculated as PLWHA “retained in care” multiplied by the estimated proportion of PLWHA prescribed ART in the previous 12 months (93.5%), based on the weighted proportion of NYC Medical Monitoring Project participants whose medical record included documentation of ART prescription.
  

• “Virally suppressed”: calculated as PLWHA in care with a most recent viral load measurement in 2016 of ≤200 copies/mL, plus the estimated number of out-of-care 2016 PLWHA with a viral load ≤200 copies/mL, based on a statistical weighting method.
  
Working Lunch
Introduction of 2018 Cascade & Group work
2018 Quality of Care Review
The 2017 Care Cascade
Group Exercise

- Ensure that people who are newly diagnosed have a routine medical visit within 3 days

- Identify open patients (PLWH who access any service at an organization) to the extent that you can take action on the information

- Identify processes that can move viral suppression to 95% of patients with any visit during the year
TCQ Overview
Training of Consumers on Quality (TCQ) Overview

Brooklyn NYLINKS Meeting
January 30, 2018

Presented by:
Dana Diamond: Co-Chair, Quality of Care Consumer Advisory Committee
Christopher Baljko: Member Quality Of Care Consumer Advisory Committee
Why Involve Consumers in QI?

- It is a recognized right:
  - Domestic: Denver Principles, 1983
  - International: WHO Declaration of Alma Ata, 1978: “The people have the right and duty to participate individually and collectively in the **planning and implementation** of their health care.”
- Consumer involvement enhances self-reported patient experiences
- Consumers can directly contribute to the development, elaboration and expansion of quality standards and multidisciplinary guidelines
- Consumer feedback is an accurate determinant of hospital quality (Isaac et al, 2010)
- Consumers can identify potential hazards and successfully generate solutions to existing safety problems
- Consumer involvement is becoming an accepted quality measure
TCQ Purpose & Learning Objectives
TCQ Purpose

• To build capacity of consumers to be partners in the planning, implementation, and evaluation of quality improvement (QI) efforts at both clinical and regional levels

• To prepare people living with HIV/AIDS (PLWHA) to be formally engaged in facility-level quality management (QM) programs as members of internal QI teams/committees, and regional groups like
TCQ Learning Objectives

• Increased understanding of the Ryan White Program and its “quality” requirements/expectations
• Increased understanding of basic vocabulary with QI, tools, methodologies, activities and processes
• Increased competency to be a consumer champion in facility-level QM team/committee and regional group activities (i.e., NYLinks)
TCQ Learning Objectives

• Increased confidence participating on facility-level QM teams/committees
• Increased understanding of group dynamics, decision-making team roles, and steps to address specific aspects of HIV care
• Increased understanding of the various forms of individual and systematic consumer involvement and identification of appropriate methods of involvement
TCQ Learning Objectives

• Increased awareness of basic HIV care/treatment terminology to better understand indicator definitions and performance data reports

• Increased knowledge related to health numeracy and health literacy, and understanding of performance measurement, including indicator development, data collection methodologies and data reporting

• Exposure to other patients, consumer quality leaders, and peer experts in patient involvement who can provide community support and leadership
TCQ Participant Expectations
Pre-TCQ Participant Expectations

• Complete a standardized survey to assess basic QI competencies (1 hour)

• Complete pre-work assignments (3 hours total prior to actual training) on topics that include:
  – Overview of Ryan White quality expectations
  – Reading two essays on different methods of involvement including agitation, activism, and advocacy
  – Provider/patient relationships and peer mentoring (delivered first evening when participants arrive)
TCQ Participant Expectations
(During training)

• Attend and actively participate in face-to-face TCQ session
  – 2 training days scheduled February 22-23, 2018
  – Training Location
    • Las America, 55 Exchange Place, New York, NY
Post-TCQ Participant Expectations

• Get further involved and serve on internal QM teams/committees (clinical environments where PLWHA receive HIV services), and regional groups (i.e., NYLinks)
• Attend and actively participate in post-TCQ Webex
• Complete 6-month post evaluation assessment tool (4 hours)
Provider Pre-training Expectations

NY Links

• Nominate and select 1 consumer to participate in TCQ
  – Pre-training: submit written letter of support for participants
  – Post training: commit to further engage the TCQ participant in ongoing QI activities, for instance as members on internal quality management committee/team, and regional QI activities

• Assist TCQ participant with costs to attend training if resources can be identified within provider agency budget (cost is allowable under Ryan White Recipient funding).
Provider Expectations: Post TCQ

• Review and offer feedback to consumer participant on personalized goal statement developed during TCQ
• Coach/mentor TCQ participant and support active engagement in QI activities for continued capacity development
• Participate in post-training evaluation activities via webinars, focus groups or interviews to assess TCQ program impact on consumer involvement in QI
Selection Process
TCQ Participant Selection Process

- Nominations and letter of support from NY-Links providers must be received by February 2, 2018 along with:
  - Participant Resume and/or bio-sketch
  - Email to Sherine Bell at sherine.bell@health.ny.gov (Mr. Sawicki will be sending out follow-up email to all NY-Links providers reminding them to nominate and select consumers)
TCQ Selection Process

• Approximately 40 individuals will participate in TCQ representing NYLinks respective regional providers
Nominee Selection Process

- NY-Links providers should nominate and select one consumer who can successfully demonstrate previous experience(s) in HIV QI activities and select a consumer with ability to communicate and disseminate information with existing consumer networks in their local jurisdictions.
Post TCQ Activities
Post-TCQ Session Activities

Upon completion of the TCQ program, participants are expected to:

• Return to local supporting provider organization and work to implement goal statement developed during the TCQ

• Establish and sustain a collaborative relationship with a fellow TCQ participant for peer mentorship
  • Once the pool of TCQ graduates is established, these individuals may go on to be mentors themselves

• Complete a post-TCQ skills assessment
Post-TCQ Session Activities

• Participate in TCQ webinars and other activities to sustain a “community of learners”
  – Share lessons learned for consumer involvement in QI activities
  – Identification of emerging barriers to consumer involvement
  – Develop ongoing strategies to increase consumer involvement in QM programs and QI activities
Q&A
Contact Information

Daniel Tietz
Director, Consumer Affairs
NYS DOH AIDS Institute
ESP, Tower – Room 412
Albany, NY 12237
(518) 473-7542 (voice)
daniel.tietz@health.ny.gov
Team Action Planning and Report Back
Group Activity

• Sit with your agency representatives
• Develop an action plan going forward using the provided template
Next Steps
Moving Forward

• Ideas for our joint activities going forward
  – Face-to-face meetings 3x times a year – every 4 months
  – Webinars to allow peer sharing around specific content areas
    3x times a year – every 4 months
  – Data reporting expectations - TBD
Evaluation
Evaluation

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

Steve Sawicki, NYLinks Lead, steven.sawicki@health.state.ny.us

Regional Leads
Upper Manhattan—Susan Weigl, sweigl@yahoo.com
Lower Manhattan—Susan Weigl
Western NY—Nanette Brey Magnani, breymagnan@aol.com
Long Island—Steven Sawicki
Central NY & Southern Tier—Steve Sawicki
Mid & Lower Hudson—Steve Sawicki
Queens—Nova West, nova.west@health.ny.gov
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