Brooklyn Regional Group Webinar

April 4, 2018
3:00pm to 4.30pm
Overview

1. **Introduce the Quality of Care Review: (Daniel Belanger)**
   a. To understand the purpose and expectations of the NYSDOH/AIDS Institute’s HIV Quality of Care Review.
   b. To learn about the components of the review, the key measures, and expectations for HIV care providers, including presentation, analysis and use of the review data for improvement, and the timelines for submission of completed quality of care review components.

2. **HIV treatment cascades guidance: (Anna Bezruki)**
   a. To understand the purpose and expectations of the Organizational HIV Treatment Cascade component of the 2018 Quality of Care Program Review.
   b. To gain an understanding of the each of the components of the submission, including the measures, the methodology section, and the analysis and improvement plan.
Overview

3. Measuring and Addressing Stigma in Healthcare Settings (Kelly Hancock)
   a. To learn about the various components of the stigma initiative, including the staff survey, consumer feedback, and stigma reduction action plan.
   b. To gain an understanding of stigma in healthcare facilities across NYS by learning about initial results from sites who completed the stigma work.

4. HIV Tobacco Cessation Improvement Campaign (Kelly Hancock & Dan Tietz)
   a. To learn about the campaign, the measures, and tools available through the campaign to assist you in this work.
Introduction to the Guidance for the Organizational HIV Treatment Cascades

Quality of Care Program
AIDS Institute
April 2018
Presentation Agenda

- Background
- Overview
- Timeline
- Requirements and Measurements
- Reporting Methodology
- Analysis and Improvement Plan
- What’s Next?
- Q&A
Organizational HIV Treatment Cascades

- Component of the annual Quality of Care Program Review
- Created to bring attention to gaps along the continuum of care for PLWH
- Implemented in 2017 by the Office of the Medical Director in the NYSDOH AIDS Institute as part of the strategy to End the Epidemic by 2020
  - Providers can visualize the quality of care being provided to PLWH at their own organization
2018 Quality of Care Review

- Organizational HIV Treatment Cascades
- Mortality Review (more information to come later this year)

- Organizations that have not yet completed the Stigma Reduction Survey will be expected to do so this year
- Continue submissions for Tobacco Cessation Improvement Campaign

- No eHIVQUAL
Results of 2017 Cascades

- In 2017, 97 organizations submitted cascades
  - Gaps in care identified at every step of the cascade
  - Magnitude of gaps varied greatly among organizations
    - Organizations reported between 0 and 4,288 open patients
Cascade Overview

- Cascades
  - Newly diagnosed/new-to-care (if applicable)
  - Previously diagnosed
    - Open
    - Active
- Drill-down of previously diagnosed caseload (in cascade or table format)
- Methodology Section
- Improvement Plan
Timeline

- March 2: Guidance Released
- Weekly webinars: Tuesdays, 12:00-1:00 p.m., through May 22nd
- May 31: Submissions Due
NEWLY DIAGNOSED/NEW-TO-CARE CASCADE
Newly Diagnosed/New-to-care Cascade

- **Purpose:** This cascade enables organizations to see the outcomes for a particularly vulnerable group of patients – those diagnosed within the measurement year (2017) and those new to care at an organization.

- **Terminology:**
  - Newly Diagnosed/New-to-care Caseload: All patients diagnosed in 2017 and all patients who are new to an organization’s HIV program in 2017, regardless of the year in which they were diagnosed.
### Newly Diagnosed/New-to-care Cascade: Summary

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Newly Diagnosed/New-to-care Caseload</strong></td>
<td>All newly diagnosed patients and all patients who are new to an organization’s HIV program, regardless of the year in which they were diagnosed.</td>
</tr>
<tr>
<td><strong>Linked to Care</strong></td>
<td>Percentage of people diagnosed with HIV at the organization in 2017 linked to care within 3 days.</td>
</tr>
<tr>
<td><strong>Prescribed ART</strong></td>
<td>Percentage of newly diagnosed and new-to-care patients who were prescribed ART in 2017. May exclude patients newly diagnosed at the organization who were linked externally.</td>
</tr>
<tr>
<td><strong>Received Viral Load Test</strong></td>
<td>Percentage of newly diagnosed and new-to-care patients with a recorded viral load test in 2017. May exclude patients newly diagnosed at the organization who were linked externally.</td>
</tr>
<tr>
<td><strong>Virally Suppressed</strong></td>
<td>Percentage of newly diagnosed and new-to-care patients with viral load &lt;200 copies/mL at last test of 2017. May exclude patients newly diagnosed at the organization who were linked externally.</td>
</tr>
</tbody>
</table>
Example: Newly Diagnosed/New-to-Care Cascade

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 diagnosis date.


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 pts with viral load <200 copies/mL.

Data Source: Infinity EMR.

*Denominator excludes 3 patients newly diagnosed with HIV at the organization who were linked to care externally.
Example: Newly Diagnosed/New-to-Care

Linked to Care Within 3 Days

- 65% (13/20) linked internally
- 20% (4/20) not linked to care within 3 days
- 15% (3/20) linked externally
PREVIOUSLY DIAGNOSED CASCADES
Terminology Overview

Previously diagnosed patients
All patients diagnosed with HIV before 2017, who received services from the organization during 2017

Open patients
Deceased by end of 2017
Incarcerated at end of 2017
Confirmed in HIV care elsewhere at end of 2017

Active patients
All open patients who received HIV primary care services within the organization in 2017. Exclude all new-to-care patients.

Non-Active Patients
All open patients who received services from the organization in 2017, but did not receive HIV primary care services.
Previously Diagnosed Cascades

- Two cascades for previously diagnosed patients
  - One for all open patients (active + non-active)
  - One for active patients (broken down by HIV care site, if multiple care sites)

- NOTE: Exclude all active patients who are new-to-care from the previously diagnosed cascade. That is, the previously diagnosed and newly diagnosed/new-to-care cascades are mutually exclusive
Open Caseload Cascade: Summary

**Open Caseload**
All previously diagnosed patients who received services from an organization within 2017, except those who were deceased by the end of the year, incarcerated at the end of the year, or were confirmed to be in care elsewhere by the end of the year.

**Active Caseload**
Percentage of open patients who received HIV primary care services within 2017.

**Prescribed ART**
Percentage of open patients who were prescribed ART in 2017.

**Received Viral Load Test**
Percentage of open patients with a recorded viral load test in 2017.

**Virally Suppressed**
Percentage of open patients with viral load <200 copies/mL at last test of 2017.
Example: Open Caseload Cascade

HIV Treatment Cascade, Previously Diagnosed Open Patient, 2017

- **Open** – # of PLWH, diagnosed before measurement year, with any visit in 2017, except those confirmed to be in care elsewhere, deceased, or incarcerated*
- **Active** – percentage of open patients with HIV visit in 2017
- **Prescribed ART** – percentage of open patients with ART prescription in 2017
- **Received Viral Load Test** – percentage of open patients with documented viral load test in 2017
- **Virally Suppressed** – percentage of open patients with viral load <200 copies/mL at last viral load test in 2017

Data Source – Infinity EMR

Note: Excludes patients who were previously diagnosed and new to care at the organization
Active Caseload Cascade: Summary

**Active Caseload**
All open patients who received HIV primary care services within the organization in 2017, except those new-to-care in 2017.

**Prescribed ART**
Percentage of active patients who were prescribed ART during 2017.

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

**Virally Suppressed**
Percentage of active patients with a viral load <200 copies/mL at last test of 2017.
Example: Active Caseload Cascade

HIV Treatment Cascade, Previously Diagnosed Active Patients, 2017

<table>
<thead>
<tr>
<th></th>
<th>Chestnut Street Clinic</th>
<th>Walnut Street Clinic</th>
<th>Elm Street Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIVE</td>
<td>N=90</td>
<td>96%</td>
<td>92%</td>
</tr>
<tr>
<td></td>
<td>87/90</td>
<td>97%</td>
<td>87/90</td>
</tr>
<tr>
<td>PRESCRIBED ART</td>
<td>N=64</td>
<td>86%</td>
<td>89%</td>
</tr>
<tr>
<td></td>
<td>59/64</td>
<td>57/64</td>
<td>23/27</td>
</tr>
<tr>
<td>RECEIVED VIRAL LOAD TEST</td>
<td>N=27</td>
<td>90%</td>
<td>24/27</td>
</tr>
<tr>
<td></td>
<td>23/27</td>
<td>83%</td>
<td>83%</td>
</tr>
<tr>
<td>VIRALLY SUPPRESSED</td>
<td></td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td></td>
<td>55/64</td>
<td>83%</td>
<td>23/27</td>
</tr>
</tbody>
</table>

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 SUPPRESSED: Percentage of active patients who had <200 copies/mL at last viral load test of 2017
DRILL DOWN NON-ACTIVE CASELOAD BY SERVICE DELIVERY POINT
Previously diagnosed patients
All patients diagnosed with HIV before 2017, who received services from the organization during 2017

Open patients

Deceased by end of 2017

Incarcerated at end of 2017

Confirmed in HIV care elsewhere at end of 2017

Active patients
All open patients who received HIV primary care services within the organization in 2017. Exclude all new-to-care patients

Non-Active Patients
All open patients who received services from the organization in 2017, but did not receive HIV primary care services
Identify Service Delivery Points for Non-active Caseload

- **Purpose:** To better target (re)engagement interventions to PLWH who may be out of care, find where they are touching the healthcare organization

- **Required components:** Report *service delivery points* for non-active patients, and how many non-active patients were seen at each
  - Looking at all previously diagnosed patients who did NOT receive HIV primary care services from the organization
Example: Identify Service Delivery Points for Non-active Patients

<table>
<thead>
<tr>
<th>Service delivery point</th>
<th>Number of non-active patients who received services during CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health services</td>
<td>88</td>
</tr>
<tr>
<td>Dental clinics</td>
<td>15</td>
</tr>
<tr>
<td>Emergency Departments</td>
<td>150</td>
</tr>
<tr>
<td>Inpatient units</td>
<td>123</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>8</td>
</tr>
<tr>
<td>Substance use services</td>
<td>64</td>
</tr>
<tr>
<td>Supportive housing services</td>
<td>35</td>
</tr>
</tbody>
</table>
DRILL DOWN ACTIVE CASELOAD BY KEY CHARACTERISTICS
Previously diagnosed patients

All patients diagnosed with HIV before 2017, who received services from the organization during 2017

Open patients

Deceased by end of 2017

Incarcerated at end of 2017

Confirmed in HIV care elsewhere at end of 2017

Active patients

All open patients who received HIV primary care services within the organization in 2017. Exclude all new-to-care patients

Non-Active Patients

All open patients who received services from the organization in 2017, but did not receive HIV primary care services
Drill Down by Key Characteristics

- **Purpose:** To identify disparities in care among key populations, allowing for targeted improvement work

- **Required Components:** Drill down (disaggregate) the active caseload by each of the following key characteristics
  - Age
  - Gender
  - Race/ethnicity
  - Risk Category
  - Housing status
  - Calculate for active caseload, prescription of ART, receipt of a viral load test, and viral suppression
  - Cascade or table format

- **Recommended:** Do the same for the open caseload, for one or more of the key characteristics

- **Recommended:** Drill down for multiple categories at once – e.g., by race/ethnicity and housing status
### Definitions: Drill Down by Key Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Categories (adapted from CDC, NYS Bureau of HIV/AIDS Epidemiology, and HUD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0-12; 13-19; 20-24; 25-29; 30-39; 40-49; 50-59; 60+; Unknown</td>
</tr>
<tr>
<td>Gender</td>
<td>Male; Female; Transgender; Unknown</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>Non-Hispanic White; Non-Hispanic Black; Hispanic; Asian/Pacific Islander; Native American; Multi-Race; Unknown</td>
</tr>
<tr>
<td>Risk Category</td>
<td>Men who have Sex with Men (MSM); Intravenous Drug Users (IDU); MSM/IDU; Heterosexual; Pediatric risk; Unknown/other</td>
</tr>
<tr>
<td>Housing Status</td>
<td>Stable permanent housing; Temporary housing; Unstable housing; Unknown</td>
</tr>
</tbody>
</table>

---

1. Organizations with transgender patients are encouraged to further disaggregate their transgender patient caseloads by male-to-female (MtF) and female-to-male (FtM).
2. Defined as short-term arrangement with family or friends, transitional housing or temporary institutional placement including substance abuse treatment facilities and psychiatric hospitals.
3. Defined as emergency shelters, jail/prison, places not meant for human habitation.
Example: Drill Down of Active Caseload

HIV Treatment Cascade, Previously Diagnosed Active Patients, Breakdown by Housing Status, 2017

Active: # of patients diagnosed with HIV before 2017, who received HIV primary care services in 2017, by housing status
Prescribed ART: percentage of active patients receiving ART prescription in 2017
Received Viral Load Test: percentage of active patients with a documented VL test in 2017
Virally suppressed: percentage of active patients who had VL <200 copies/mL in last VL test of 2017
Reminders of required components for all cascades

- **Title:** Clear font, specify the caseload, agency name, and year from which the data are drawn (2017)
- **Axes:** Label in clear font
- **Measures:** Label. Report both raw numbers and proportions.
- **Legend:** Include both definitions and sources for all measures in the cascade
METHODOLOGY & ANALYSIS AND IMPROVEMENT PLAN
Methodology Section

- **Purpose:** To allow internal and external stakeholders to understand how the cascade was constructed
- Responses to all specific questions in the guidance, at a *minimum*
  - For each data point, describe the data source(s) used to collect it
    - Which data source(s)
    - Why the data sources were selected
    - What the limitations of the data sources were
  - Who was involved in extracting, analyzing, and presenting cascade data?
Analysis and Improvement Plan

- Report progress on 2017 cascade improvement plan
- Analyze all gaps in care in 2017 data; compare to 2016 data
- Develop specific, time-bound, measurable goals for each gap identified in 2017 and steps/activities planned to achieve goals
- List staff responsible for implementing each step of the improvement plan
- Explain how consumers were involved in development of improvement plan and improvement activities
- Plan for dissemination of the cascades to stakeholders
Next Steps

• Submissions due no later than **Thursday, May 31**
  – Send as an email attachment to qocreviews@health.ny.gov and CC your QI coach
• Webinars will be offered from release of guidance until the deadline.
  – Weekly Webinars (on varied topics): every Tuesday, 12:00-1:00 p.m., through May 22nd
  – Contact your QI coach **before** submission for technical assistance and to make sure you are on track for approval.
What happens after submission?

- Confirmation of receipt from the AIDS Institute within 2 business days
- Reviewed by QOC staff and approved by senior medical staff
  - Assessment based on adherence to the criteria in guidance document
  - Importance of Analysis and Improvement Plan
  - Feedback will be provided
  - Do not wait to implement improvement plan until approval
- Beginning this month, organizations will be expected to provide updates to their QI coach, including:
  - Progress on cascade construction
  - Quarterly reports on QI activities to address gaps and disparities in cascade and measured outcomes
Summary

- As we enter the second year of the initiative, emphasizing the importance of:
  - Recognizing the opportunity to engage PLWH who receive services from an organization in ongoing HIV care
  - Rapid linkage to care for newly diagnosed patients
  - Intensified engagement strategies for patients new to care
  - Drilling down the active caseload to identify disparities in care among subpopulations
- Organizational HIV Treatment Cascades – and the improvement plans generated in the process – have an important role to play in Ending the Epidemic in NYS by 2020
Questions?

Contact me at Anna.Bezruki@health.ny.gov or the QOC team at qocreviews@health.ny.gov
Measuring and Addressing Stigma in Healthcare Settings
What is HIV-related stigma?

HIV-related stigma is defined as “prejudice, discounting, discrediting, and discrimination directed at people perceived to have HIV.”
Types of Stigma

• Internalized stigma (self)
  – “I feel ashamed of having HIV”

• Anticipated stigma (fear of)
  – “If I go in for an appointment, healthcare workers will treat me with less respect”

• Enacted stigma (discrimination)
  – “At my appointment, my doctor did not touch me without gloves on”
What discrimination look like?

• Physical
  – Isolation
  – Violence

• Social
  – Isolation
  – Loss of identity/role

• Language/Verbal
  – Gossip
  – Insults
  – Expressions of blame and shame
  – Labeling and use of derogatory words to describe PLWH

• Institutional
  – Differential treatment in health care settings
  – Differential treatment in public spaces
  – Media and public health messages and campaigns
Patient Experience with Stigma in NYS

According to the Medical Monitoring Project (MMP), a population-based surveillance system that assesses clinical outcomes and behaviors of PLWH receiving care in the US between 2009-2014, in NYS (excluding NYC) and NYC:

<table>
<thead>
<tr>
<th>MMP Statement</th>
<th>NYS (excluding NYC) (N=421)</th>
<th>NYC (N=1,577)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perceived Stigma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I hide my HIV status from others”</td>
<td>67%</td>
<td>47%</td>
</tr>
<tr>
<td>“It is difficult to tell people about my HIV infection”</td>
<td>74%</td>
<td>58%</td>
</tr>
<tr>
<td><strong>Discrimination Experiences</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reported healthcare providers exhibited hostility or a lack of respect during a healthcare visit</td>
<td>26%</td>
<td>13%</td>
</tr>
<tr>
<td>Reported said discrimination occurred because of HIV infection</td>
<td>92%</td>
<td>69%</td>
</tr>
</tbody>
</table>
April 25, 2018

Negative Health Effects of Stigma on PLWH


Moment-to-moment within-person associations between acts of discrimination and internalized stigma in people living with HIV: An experience sampling study.

Fazeli PL, Turan JM, Budhwani H, Smith W, Raper JL, Nugayero MU, Turan B.


Anticipated HIV Stigma and Delays in Regular HIV Testing Behaviors Among Sexually-Active Young Gay, Bisexual, and Other Men Who Have Sex with Men and Transgender Women.


Mechanisms for the Negative Effects of Internalized HIV-Related Stigma on Antiretroviral Therapy Adherence in Women: The Mediating Roles of Social Isolation and Depression

Bulent Turan, PhD, Whitney Smith, MPH, Marjorie H. Cohen, MD, Truson E. Wilson, PhD, Adaora A. MD, Daniel Memmott, MD, Adelola Adimokip, PhD, MPH, MEA, Ervil L. Woron, PhD, Antonina G. Foda, MSH, MPH, Lisa Nachte, PhD, Phyllis C. Tien, MD, Shen D. Weiss, MD, MPH, and Janet M. Turan, MD, MPH.


HIV-related stigma, racial discrimination, and gender discrimination: Pathways to physical and mental health-related quality of life among a national cohort of women living with HIV.


Experienced HIV-Related Stigma in Health Care and Community Settings: Mediated Associations With Psychosocial and Health Outcomes.

Kay ES, Rice WS, Crockett KB, Atkins GC, Batley DS, Turan B.
Why stigma reduction now?

- Impacts of stigma lead to negative health outcomes
  - PLWH avoid getting care or disclosing status because of fears of discrimination

Quality of Care Program Review

– *June 2015* – Quality of Care Clinical Advisory Committee (QAC)
  • Presentation from Laura Nyblade on work to develop a stigma measurement tool in healthcare settings
– *Early 2016* – Stigma-Subcommittee first convened
  • Consisted of members of the Quality of Care Clinical Advisory Committee (QAC) and members of the Consumer Advisory Committee (CAC)
Stigma Survey for Healthcare Staff

Health Policy Project’s “Measuring HIV Stigma and Discrimination Among Health Facility Staff”

• Background Information
  – Collecting demographics
• Health facility environment and health facility policies
  – Questions on practices and experiences in the health facility
  – Questions on facility policy and work environment
• Opinions about people living with HIV
  – Attitudes and willingness to care
• Questions on key populations (not found in original tool)
  – Men Who Identify as Gay or Bisexual, People of Transgender and Gender Non-Conforming Experience, Women, People with a Mental Health Diagnosis, People of Color
Measuring and Addressing Stigma in Healthcare Settings

Three Components:

1. Administer the survey to staff members
2. Solicit feedback from consumers
3. Create a stigma reduction action plan based off of results
Stigma Staff Survey – Findings/Themes

In general, survey respondents:
• Have not received training on HIV-related stigma and discrimination
• Did not have knowledge of policy against discrimination of key populations
• Agreed that infection occurs due to irresponsible behavior, and PLWH have had many sexual partners
• Observed people talking badly about:
  – Women
  – People of color
  – People with a mental health diagnosis
  – TG/GNC individuals
• Have lack of training:
  – Women's health
  – TG/GNC individuals
  – People with a mental health diagnosis
  – People who use drugs
Consumer Feedback – Findings/Themes

In general, consumers:

• In the healthcare setting:
  – Have feelings of discomfort in waiting room/front desk area
    • Lack of welcoming environment
    • Staff behavior, intake forms, loud talking
  – Experienced stigma in other areas of healthcare center (ER, dental, specialty providers, inpatient units)
  – Experienced staff providing extra infection control procedures
  – Observed staff talking badly about PLWH, TGNC folks, and people with a mental health diagnosis
  – Clinic location and name cause for concern for confidentiality and privacy

• In the community and personally:
  – Experience more stigma in the community than in the healthcare setting
    • Have worries about telling others about HIV status, worries about discrimination, and hide their status from others
    • Lack of knowledge in the community
Stigma Reduction Action Plan – Themes

• Increasing staff education
  – HIV-related stigma and discrimination trainings, key population trainings (TGNC, STI screening for LGBT population, mental health)
  – Train staff outside of clinics
• Welcoming, inclusive environment
  – Posters and resources for all populations (women, TGNC, PLWH), U=U
• Updating policies
  – Stigma and discrimination, sexual orientation and gender identity (SOGI) use
• Creation of stigma reduction work groups (consumers and staff)
• Creation of support groups for key populations
Questions?
HIV Tobacco Cessation Improvement Campaign

HIV+ smokers lose more years of life from smoking than from HIV.
HIV & Smoking in NYS

• Approximately 61% of deaths among PLWH can be attributed to tobacco smoking.¹

• According to 2014 eHIVQUAL data from New York State:
  – On average, 85% (n=17536) of patients living with HIV in NYS were asked by a healthcare provider if they smoked
  – On average, 75% (n=6457) of smokers living with HIV in NYS were counseled by the provider in the quit attempt

HIV Tobacco Cessation Improvement Campaign Origins

• Clinical (QAC) and Consumer (CAC) Advisory Committees

• 2014 Joint Meeting recommendation:
  – Prioritize tobacco cessation among HIV+ individuals

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

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

In the US, individuals living with HIV who smoke tobacco lose over six years of life expectancy due to the health complications of smoking tobacco compared to HIV positive individuals who do not smoke tobacco.

HIV Tobacco Cessation Improvement Campaign Measures

1. Screen
   1.1 Tobacco Cessation Screening

2. Intervene
   2.1 Tobacco Cessation Counseling
   2.2 Tobacco Cessation Pharmacotherapy

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

Created by the HIV Tobacco Cessation Improvement Campaign Steering Committee
Asking providers to report quarterly on the tobacco cessation measures:

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Report Submission Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>*August 1, 2017 – September 30, 2017</td>
<td>October 31, 2017*</td>
</tr>
<tr>
<td>October 1, 2017 – December 31, 2017</td>
<td>January 31, 2018</td>
</tr>
<tr>
<td>January 1, 2018 – March 31, 2018</td>
<td>April 30, 2018</td>
</tr>
<tr>
<td>April 1, 2018 – June 30, 2018</td>
<td>July 31, 2018</td>
</tr>
<tr>
<td>July 1, 2018 – September 30, 2018</td>
<td>October 31, 2018</td>
</tr>
</tbody>
</table>

* This denotes a baseline reporting period for the campaign.
Welcome to the HIV Tobacco Cessation Improvement Campaign!

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

Helping HIV+ New Yorkers Live Longer, Healthier Lives

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

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

The New York State Department of Health AIDS Institute designed this campaign to improve the health of PLWH by decreasing the morbidity and mortality of HIV+ smokers.

Campaign Related News!

HIV Stops with Me Spokesmodels Discuss Tobacco Use
Click here to read and join the discussion!

Enroll Here

If you are a former or current smoker, enroll here!
If you are a provider, enroll here!

Database Access

Sign-in to database

Have Questions About the Campaign?

Have any questions for us on the HIV Tobacco Cessation campaign? Feel free to contact us! Please put "Help" in the subject line.
Where is the data reported?
database.hivtobaccofreeny.org
Welcome to the HIV Tobacco Free Campaign!

As a participant in the HIV Tobacco Free New York Campaign, you are able to access data reports from providers across the state on the campaign measures (click on "Reports"). Also, you are able to update your profile information at any time (click on "User Profile").

**Data Entry**
To submit individual performance data based on predetermined indicators

**Reports**
To obtain individual data reports and generate benchmark reports based on search criteria

**User Profile**
To change your user profile and join a group

* View of providers database *
## Baseline Data Submission

**August 2017 – September 2017**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean</th>
<th>Total Number of Patients Reported</th>
<th>Number of Sites (Unique Facilities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Cessation Screening</td>
<td>60%</td>
<td>17,573</td>
<td>43 (26)</td>
</tr>
<tr>
<td>Tobacco Cessation Counseling</td>
<td>47%</td>
<td>6,380</td>
<td>38 (23)</td>
</tr>
<tr>
<td>Tobacco Cessation Pharmacotherapy</td>
<td>22%</td>
<td>5,688</td>
<td>37 (21)</td>
</tr>
<tr>
<td>Reduction in Tobacco Use</td>
<td>7%</td>
<td>4,901</td>
<td>30 (20)</td>
</tr>
<tr>
<td>7-Day Quit</td>
<td>5%</td>
<td>3,358</td>
<td>24 (20)</td>
</tr>
<tr>
<td>30-Day Quit</td>
<td>5%</td>
<td>3,358</td>
<td>24 (20)</td>
</tr>
</tbody>
</table>
# First Data Submission

**October 2017 – December 2017**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean</th>
<th>Total Number of Patients Reported</th>
<th>Number of Sites <em>(Unique Facilities)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Cessation Screening</td>
<td>63%</td>
<td>18,123</td>
<td>31 (18)</td>
</tr>
<tr>
<td>Tobacco Cessation Counseling</td>
<td>40%</td>
<td>6,692</td>
<td>30 (17)</td>
</tr>
<tr>
<td>Tobacco Cessation Pharmacotherapy</td>
<td>14%</td>
<td>6,508</td>
<td>30 (17)</td>
</tr>
<tr>
<td>Reduction in Tobacco Use</td>
<td>5%</td>
<td>5,333</td>
<td>23 (16)</td>
</tr>
<tr>
<td>7-Day Quit</td>
<td>2%</td>
<td>3,840</td>
<td>18 (15)</td>
</tr>
<tr>
<td>30-Day Quit</td>
<td>1%</td>
<td>3,840</td>
<td>18 (15)</td>
</tr>
</tbody>
</table>
Problems Identified

• Quit Measures
  – Information not in EMR
  – Time consuming
  – Lack of patient response
  – Quit lengths begin when?
Comments/Questions?